21(-)

INPATIENT TREATMENT RECORD COVER SHEET (For Plate Imprinting)

For use of this form, see AR 40-400; the proponent agency is the Office of The Surgeon General.

PATIENT DATA ITEMS 1 - 30 (Excluding Items 25 & 26)

(b)(6)-4

LINE	LEGEND
1	REGISTER NO. - NAME - GRADE
2	SEX - AGE - RACE - RELIGION - LENGTH OF SVC - ETS - PREVIOUS ADMISSION
3	FMP - SSN - ORGANIZATION - WARD
4	FLY STAT - RATING/DESG - DEPT/BEN - BRANCH/CORPS - UIC/ZIP - TYPE CASE
5	SOURCE & AUTHORITY FOR ADMISSION - HOUR OF ADMISSION - CLINIC SVC
6	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
7	ADDRESS OF EMERGENCY ADDRESSEE - PHONE NO. - DATE OF THIS ADMISSION
8	NAME & LOCATION OF MEDICAL TREATMENT FACILITY DATE OF INITIAL ADMISSION

ADMISSION REMARKS

(b)(6)-2

32. UNIT OF BLOOD/COMPONENT TRANSFUSED

25. TYPE DISPOSITION: TRANS to Iraqi Hosp

26. DATE OF DISPOSITION: 4 Jul 03

31. SELECTED ADMINISTRATIVE DATA

☐ CHECK IF CONTINUED ON REVERSE

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Closed Head Injury (CHI) 873.8 ICD 9.1 [illegible]

~~Motor Vehicle Accident (MVA)~~

☐ CHECK IF CONTINUED ON REVERSE

35. TOTAL DAYS THIS FACILITY

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

36. TOTAL DAYS ALL FACILITIES

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

SIGNATURE OF ATTENDING MEDICAL OFFICER: (b)(6)-2

(b)(6)-2

ICAL RECORDS OFFICER

EDITION OF 1 AUG 76 IS OBSOLETE.

DA FORM 1 MAY 79 3647-1

MEDCOM - 1217

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
2003	OMFS Procedure Note
3JUL	DX: (L) parietal superficial lac x 4
0805	TX: Irrigate, cleanse and staple lac closed (lac repair x 2)
	Surg: Phillips asst: Sgt Eradore local and IV sed
	monitors on. Irrigate lac c̄ N/S. Palpate - no crepitus No fx.
	No debris - staple 1 cm and 4 cm lac closed.
	Bacitracin Pressure
	dressing. 2% lido c̄ epi 1:100,000
	infiltrate 1.8cc. OK given to medic -
	pt snoring - monitored in ER. (b)(6)-4
	(b)(6)-4
	100ug IV fentanyl for procedure
	10 mg IV haldol (total of 20mg from admit to procedure)
	1g IVPB ancef administered

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)	REGISTER NO.	WARD NO.

(b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

509-114

MEDCOM - 1218

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
	Staff Note - RP
3 July 03 1115	2 point restraints required for physical security measures - Detainee status and patient safety. 24 hour guard on patient @ this time.
	(b)(6)-2 [redacted]
	FAMILY PRACTICE
4 July 03 0924	Surgery note
	S: Pt. still slightly confused, disoriented
	Resting comfortably, C-collar in place
	O: 99.4 VSS VOP 2090
	Heart - RRR
	Lungs - CTA (B)
	Abd - soft, no NT, (+) BS
	Head - lac site repaired
	Neck - C-collar in place - X-rays could not visualize C-7

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			(b)(6)-2 [redacted]
	LAST	FIRST (Over)	MI	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		
PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)		REGISTER NO.	WARD NO. AAJ LC	

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11 203(b)(10)

509-114

MEDCOM - 1219

DATE	NOTES
4 July 03	Surg Staff Cont'd
0927	Alr: Pt. HO 2 S/p MVA c̄ CHI, scalp lac stable.
	(1) Leave C-collar in place - cannot clear due to inadequate films + disoriented mental status (post-concussive)
	(2) repeat labs
	(3) Pt. stable for transfer
	(b)(6)-2 [redacted]
4 JUL 03	OMFS NOTE MAJ [illegible]
	S/p lac scalp x ÷ repair in pt S/p
	MVA c̄ CHI, scalp lac
	hemostatic; (+) edema ⊕ crepitus
	see Gen Surg note
	stable for transfer.
	recommend staple removal 14 July.
	(b)(6)-2 [redacted]
	PHILLIPS LTC DDS MOD
04 Jul 03 0945	Nursing Notes: AM Assessment completed, see critical care flowsheet. (b)(6)-2 [redacted] LAN

FPI LEX Printed on Recycled Paper STANDARD FORM 509 (REV 5-99) BACK

MEDCOM - 1220

NSN 7540-01-075-3761

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp) (b)(3)-1

LOG NUMBER

ARRIVAL: DATE MONTH 07. YR. 03; TIME 0600

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☐ OTHER (Specify)

CURRENT MEDS. (Tetanus immunization and other data): ?

HISTORY OBTAINED FROM: ☒ PATIENT ☐ OTHER (Specify)

ALLERGIES: NKA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

COMPLAINT(S) (Include symptom(s), duration): MVA CH-I

SEX: M AGE

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: 0600

VITAL SIGNS

0600	0610		
110/74	115/68		
74	74		
22	18		
93%	95%		

CATEGORY (See reverse)
EMERGENT
URGENT
NON-URGENT

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

Head lac from back

Adult Iraqi male brought in by US forces. Involved in MVA in process of being detained. Brought in as head injury. 126 / 14.9 / 44.7 / 1.61

A - patent able to talk
B - equal BS (B) 3.3 / 3 | 10 | 11 18%
C - good pulses BP p 117 304
D - GCS 14 (Eyes) moves purposefully when commanded to
E - head lacerations

A - Ø
M - None
P - None
L - unknown
E - see HPI

FAST - NBS
Pelvis - Ø FX
CXR - poor insp effort, No obvious PTX, Hemothorax
C-spine - Lateral NO FX of C-spine - Lateral visualized thru C-6

10 Fr
IV established, C-spine precautions

2° Survey
HEENT: (L) occip. M scalp lac, (R) post-M scalp lac, PERRL, TMs clear, oral pharynx clear
Neck: Ø step offs
Chest: clear, sounds, small contusion (L) clavicle
Abd: soft, NT, ND
Pelvis stable
Back: Ø tenderness or injury
GU: normal male
Ext: No deformities, full ROM all joints
A/P (1) Closed head injury with scalp lacerations, wounds cleaned/irrigated, repaired with staples; Need to clinically clear C-spine at a later time

(CONTINUE ON SF 507, IF NEEDED)

ORDERS	INITS.	TIME
Spine		0600
FAST		
Pelvis		
CXR 2		0616
ABG 10		0727
Fluids 10 mg		

ASSESSMENT/DIAGNOSIS
1. Closed head injury
Scalp Lacerations

DISPOSITION (Check all that apply)
HOME ☐ FULL DUTY ☐
QUARTERS ☐ 24 Hrs. ☐ 48 Hrs. ☐ 72 Hrs.
MODIFIED DUTY UNTIL: DAY MONTH YEAR
REFERRED TO (Indicate clinic)
☐ EMERGENCY ☐ TODAY
☐ 72 HOURS ☐ ROUTINE
ADMIT TO HOSP. UNIT/SERVICE: ICU
CONDITION UPON RELEASE
☐ IMPROVED ☐ UNCHANGED
☐ DETERIORATED
TIME OF RELEASE:

ORDERS
Ancef 3 gm IV-0836 mw
Ivetan 50 mg 0845 mw
~~Haldol 10 mg IV-0737 mw~~
Fentanyl 100 mg IV-0744 mw

PROVIDER AND ID STAMP (b)(6)-2

INSTRUCTIONS TO PATIENT (Medications ordered, any limitations and follow-up plans)

PATIENT'S IDENTIFICATION (Mechanical imprint) (b)(6)-4
FOR WRITTEN ENTRIES GIVE: Name - last, first, middle; SSN; DOB, service status, name and relation of sponsor or next of kin. (IMPORTANT: LIST FACILITY HOLDING TREATMENT RECORD).

Iraqi Civ
Civ
Trauma

EMERGENCY CARE AND TREATMENT
Emergency Room Copy

STANDARD FORM 558 (REV. 6-82)
Prescribed by GSA and ICMR
FPMR (41 CFR) 101-11.806-8

MEDCOM - 1221

[illegible]	[illegible]	00	[illegible]	96%
0730	143/64	93	22	97%
	Placed on 2L N/C permd			
0744	127/73	99	20	100%
(0750 - Haldol 10mg IV - [illegible]) Dr (b)(6)-2 s OMF, stapling head laceration.	Fentanyl 100mcg IVP			
0800	142/82	88	24	98%
0815	121/55	84	22	96%
	Ancef 1G m IVPB↑ 1L RL↑ TKO (500cc NS infused) Complete			
0830	/	78	24	98%
	Labs - CBC, I Stat 8			
0845	104/62	HR 77	RR 22	100%

0900: Pt to Xray

0945: in Xray combative - unable to move table to litter.
119/66 HR75 RR16 98% Fentanyl 50mcg IVP XI

0950: Transfer pt from Xray to ICU #2. Report to MAJ (b)(6)-2

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	
DOS	
POD	

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2 MAT AN	(b)(6)-2
(b)(6)-2 Cpt AN	
(b)(6)-2 IDA	

Safety Checks	D	E	N
BVM at bedside			
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 MAT AN	ICU 2	3 Jul 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade; date; hospital or medical facility)*

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOWCHART

☐ OTHER EXAMINATION Or EVALUATION ☐ OTHER(*Specify*)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700
1 MAY 78

ACLU-RDI 1099 p.7

DOD 005275

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R										2				2				2					2	
	RADIAL L										2				2				2					2	
	DORSALIS PEDIS R										2				2				2					0	
	DORSALIS PEDIS L										2				2				2					2	
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale											1 3 8				2 3 9				1 3 8					1 3 8	
EDEMA											0				0				0					0	
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)											✓				✓				✓					✓	
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)											✓				✓				✓					✓	
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH																								
	FOLEY CARE														✓										
	ORAL CARE																								
MOBILITY	BEDREST														✓				✓					✓	
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE																							✓	
	HOB 30 DEGREES																								
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE										ULTA				ULTA				ULTA					AF	
	PAIN SCALE (1-10)																								
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended										2				2				2					2	
BOWEL SOUNDS (active all quads)											✓				✓				✓					✓	
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT																									
VOIDING CLEAR, YELLOW URINE q.s.															✓				✓					✓	
SKIN INTEGRITY	No Breakdown																								
Scalp Lac	Surgical Wounds										✓				✓				✓						
	Rashes, Lac's, etc																							✓	
DRESSING (Dry & Intact: specify site below)																									
#1																									
#2																									
#3																									

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
18ga IV	(R) AC	3jul03	CDI

PUPIL SIZE	PUPILS		MOTOR FUNCTION	CHART CODES
1 mm	=	Equal	0 = No Movement	Present ✓
2 mm	R	Reactive	1 = Slight Flicker/ Trace of Contraction	
3 mm	NR	NonReactive	2 = Active (Gravity Eliminated)	Not Applicable /Absent (blank) --
			3 = Active: against gravity, but not against resistance	
4 mm	L > R	Left Larger	4 = Active: Against Gravity and Resistance, not full strength	Refer to Nsg. Notes X
			5 = Full Strength against Examiners Resistance	
5 mm	R > L	Right Larger		No Change from Previous Assessment --

DATE:

TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (2) To Pain (3) To Voice (1) Does Not Open										4				4		4		4		4			4	
B. BEST VERBAL RESPONSE (5) Oriented (2) Garbled (4) Confused (1) No Response (3) Inappropriate Verbal Response										WTA				WTA		4		4		4			5	
C. BEST MOTOR RESPONSE (6) Obeys Commands (3) Flexion to Pain (5) Localizes to Pain (2) Extension to Pain (4) Withdraw to Pain (1) No Response										5				5		5		5		5			5	
GLASCOW COMA SCALE (A+B+C)														13		13		13		13			N	
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R									2+				2+		2+		4+		4+			+2	
	L									2+				2+		2+		4+		4+			+2	
MOVEMENT (See Motor Function Scale at Top of Page)	RUE									5				5		5		5		5			5	
	LUE									5				5		5		5		5			5	
	RLE									5				5		5		5		5			5	
	LLE									5				5		5		5		5			5	
GRIP (S) Strong (W) Weak (-) absent	R									5				5		5		5		5			5	
	L									5				5		5		5		5			5	
RESPIRATIONS	REGULAR									✓				✓		✓		✓		✓			✓	
	IRREGULAR																							
	UNLABORED									✓				✓		✓		✓		✓			✓	
	LABORED																							
	SHALLOW																							
	RETRACTIONS																							
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL									5				5				5					5	
	LUL									5				5				5					5	
	RLL									5				5				5					5	
	LLL									5				5				5					5	
	BOTH BASES									1				1				1					1	
COUGH	NONE									✓				✓				✓					✓	
	SPONTANEOUS																							
	PRODUCTIVE																							
	NONPRODUCTIVE																							
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																								
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																								
VENTILATOR	Vt																							
	FiO2																							
	RATE (SIMV/CMV)																							
	PEEP / CPAP																							
	PRESS. SUPPORT																							
OXYGEN DELIVERY DEVICE	NC (l/min)																							
	FM (l/min)																							
ETT #_____	NRBM (l/min)																							
	ETT _____cm gums																							
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED																								
INCENTIVE SPIROMETRY DONE																								
COUGH / DEEP BREATH																								
INITIALS										(b)(6)-2														

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200																	
0300																	
0400																	
0500																	
0600																	
0700																	
0800																	
0900																	
1000		78	24	108/61	93%												RA
1100																	
1200		81	20	113/67	94%												
																	RA
1300																	
1400	*97.6	* 103	42	*130/74	93												RA
1500					94												RA
1600		*98	20	*117/68	93												RA
1700					93												RA
1800		*107	28	*116/70	94												RA
1900					94												RA
2000		*101	14	*111/64	94												RA
2100																	
2200	100.4	*94	25	*120/74	96%												RA
2300																	
2400		92	18	115/73	94%												RA

ACLU-RDI 1099 p.10

DOD 005278

	INTAKE									OUTPUT							
	LR (EMT)	NS (EMT)							Total							Total	COMMENTS
0100																	
0200																	
0300																	
0400																	
0500																	
0600																	
0700																	
0800																	
8 HR									8 HR.							8 HR	
0900																	
1000	400 400	150 150	500														
1100		150 300															
1200		150 450															
1300																	
1400		150 600								700							
1500		150 750															
1600		150 900															
8 HR									16 HR.							16 HR.	
1700		150 1050															
1800		150 1200															
1900		160 1360								1000 1700							
2000		150 1510															
2100		150 1660								90 1790							UA sent to Lab.
2200		150 1810								300 2090							
2300		150 1960															
2400		150 1910															
8 HR		1910							24 HR.	2090						24 HR	

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
3 Jul 03	1000		Admit Note: (S) traq. pt speaking arabic, unable to verbalize (b)(6)- assess subjective data (O) Pt arrived via litter from EMT accompanied by RN/medics. Admitted to ICU bed #8. Sedated see flowsheet for complete assessment data. Cervical collar in place, alignment maintained during transfer. Scalp lac stapled, bacitracin applied. unable to place dsg due to position of laceration. Upper extremities & lower c̄ purposeful movement. (A) Pt S/P MVC c̄ closed head injury. (P) monitor neurological status sedated as needed. - Pmde/parts MAT/AN
	1100		Pt awake, agitated, upper extremities restrained, order obtained by (b)(6)-2 [redacted]. Ativan 2mg IV given for agitation c̄ good effect. Attempted x2 to start 2nd IV, attempted 18 ga in (R) hand's success. — (b)(6)-2 [redacted] MAT/AN
3 July 03	1400		Rec'd report from prev. shift. Eyes closed. Resp deep & even, Ø apparent distress. — (b)(6)-2 [redacted] Cpt AN
3 July 03	1430		16 Fr foley placed's diff. Immediate return of 500cc clr yellow urine. Assessment completed. Interpreter states that he is confused & asking to go to the hospital. Cervical collar intact but is tossing around trying to get up & take restraints off. Haldol 5mg given for agitation. VSS Continue to monitor. Lac on head is draining serosang fld. Chucks placed under head. — (b)(6)-2 [redacted] Cpt AN
3 July 03	1530		Thrasting around in bed. 2mg MSO4 given. — (b)(6)-2 [redacted] Cpt AN
3 July 03	1630		Resting quietly. VSS. Ø distress. — (b)(6)-2 [redacted] Cpt AN
3 July 03	1915		Sitting ↑ trying to get OOB & release restraints. Guard applied zipties. Circ remains good. c̄ sec. (b)(6)-2 [redacted] at bedside. Order for 5mg Haldol instead of Ativan. Cont to monitor. VSS p̄ Haldo. Currently resting. Eyes closed RR 16 — (b)(6)-2 [redacted] Cpt AN
3 July 03	2030		MSO4 for pain. Currently 8 of 10 per interpreter. Relaxed & eyes closed p̄ MSO4. RR 14-22 — (b)(6)-2 [redacted] Cpt AN
3 July 03	2200		Assumed care. Pt agitated. (b)(6)-2 [redacted] notified, ↑ Haldol order. Admin. Haldol 5mg & MSO4 2mg IVP. VSS. Denies pain. NS ~~LF~~ infusing @ 150 cc/°, BLE/BLE restrained. C-collar. (b)(6)-2 [redacted] 100/an

MEDCOM - 1228

(b)(3)-1

DARNALL ARMY COMMUNITY HOSPITAL

LOS DATA	
DOA	30 Jul 03
DOS	
POD	

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside			
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
		4 July 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade;date; hospital or medical facility)*

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOWCHART

☐ OTHER EXAMINATION Or EVALUATION ☐ OTHER(*Specify*)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 1229

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R			2					2				2												
	RADIAL L			2					2				2												
	DORSALIS PEDIS R			2					2				2												
	DORSALIS PEDIS L			2					2				2												
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale				1 3 8					1 3 8				1 3 8												
EDEMA				0																					
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)				✓					✓				✓												
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)				✓					✓				✓												
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH																								
	FOLEY CARE																								
	ORAL CARE																								
MOBILITY	BEDREST			✓					✓				✓												
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT																								
	LEFT																								
C-Spine precautions	SUPINE			✓					✓				✓												
	HOB 30 DEGREES																								
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE			✓					✓																
	PAIN SCALE (1-10)																								
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN (2) Soft & Flat (1) Distended				2					2				V												
BOWEL SOUNDS (active all quads)				✓					✓				V												
NG / ORTHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT				✓					✓				✓												
VOIDING CLEAR, YELLOW URINE q.s.				✓					✓				✓												
SKIN INTEGRITY	No Breakdown																								
	Surgical Wounds																								
head lac	Rashes, Lac's, etc			✓					✓				✓												
DRESSING (Dry & Intact: specify site below)																									
#1																									
#2																									
#3																									

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
18g	(R) AC	3 Jul 03	COT

PUPIL SIZE	PUPILS		MOTOR FUNCTION	CHART CODES
1 mm	=	Equal	0 = No Movement	Present ✓
2 mm	R	Reactive	1 = Slight Flicker/ Trace of Contraction	
3 mm	NR	NonReactive	2 = Active (Gravity Eliminated)	Not Applicable /Absent (blank)
			3 = Active: against gravity, but not against resistance	
4 mm	L > R	Left Larger	4 = Active: Against Gravity and Resistance, not full strength	Refer to Nsg. Notes X
			5 = Full Strength against Examiners Resistance	
5 mm	R > L	Right Larger	DATE: 4 Jul 03	No Change from Previous Assessment –

TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open		3		2		2		2		2		2												
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response		4		4		4		4		4		4												
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response		5		5		5		5		5		5												
GLASCOW COMA SCALE (A+B+C)		12		11		11		11		11		11												
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R	2+		2+		2+		2+		2+		2+												
	L	2+		2+		2+		2+		2+		2+												
MOVEMENT (See Motor Function Scale at Top of Page)	RUE	5		5		5		5		5		5												
	LUE	5		5		5		5		5		5												
	RLE	5		5		5		5		5		5												
	LLE	5		5		5		5		5		5												
GRIP (5) Strong (W) Weak (-) absent	R	S		S		S		S		S		S												
	L	S		S		S		S		S		S												
RESPIRATIONS	REGULAR		✓					✓																
	IRREGULAR																							
	UNLABORED		✓					✓				J												
	LABORED																							
	SHALLOW																							
	RETRACTIONS																							
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL		5					5				5												
	LUL		5					5				5												
	RLL		5					5				5												
	LLL		5					5				5												
	BOTH BASES		1					1				1												
COUGH	NONE		✓									✓												
	SPONTANEOUS																							
	PRODUCTIVE																							
	NONPRODUCTIVE																							
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																								
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																								
VENTILATOR	Vt																							
	FiO2																							
	RATE (SIMV/CMV)																							
	PEEP / CPAP																							
	PRESS. SUPPORT																							
OXYGEN DELIVERY DEVICE	NC (l/min)																							
	FM (l/min)																							
ETT #_____	NRBM (l/min)																							
	ETT _____cm gums																							
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED																								
INCENTIVE SPIROMETRY DONE																								
COUGH / DEEP BREATH																								
INITIALS		(b)(6)-2																						

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200		91	20	118/70	97%												RA
0300																	
0400		87	22	124/74	97%												RA
0500																	
0600	99.4	82	21	118/74	95%												RA
0700																	
0800	99.4	83	18	108/69	99%												RA
0900																	
1000																	
1100																	
1200	99.5	92	20	103/54	94%												
1300																	
1400																	
1500																	
1600																	
1700																	
1800																	
1900																	
2000																	
2100																	
2200																	
2300																	
2400																	

ACLU-RDI 1099 p.16

DOD 005284

	INTAKE									OUTPUT						
	NS								Total	Urine					Total	COMMENTS
0100	150															
0200	150 300															
0300	150 450									725 725						
0400	150 600															
0500	150 750									400 1125						
0600	150 900															
0700	150 1050															
0800	150 1200															
8 HR									8 HR.						8 HR	
0900	150															
1000	150 150 300									800 800						
1100	150 450															
1200	150 600															
1300	150 750															
1400	150 900															
1500																
1600																
8 HR									16 HR.						16 HR.	
1700																
1800																
1900																
2000																
2100																
2200																
2300																
2400																
8 HR									24 HR.						24 HR	

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
04 Jul 03	0700		Pt agitated and pulling at restraints. Administered Haldol 5mg IVP per prn order. [redacted] 100/AN
	0215		Pt lifting head up and yelling out. Administered Ativan 2mg IVP per prn order. [redacted] 100/AN
	0220		Neuro ✓ pupils PERRLA. Because of sedation, unable to assess mental status. Pt responds to painful stimuli [redacted] 100/AN
	0300		Pt lying comfortably in bed, sedated (pharmacologically) Restraints X4. CMS intact. Foley draining quantity suff. Clear yellow urine and is secured to leg. VSS. on RA - SaO_2 96%. C-collar in place, but not fixed properly - pt does not allow staff to apply correctly. NS infusing @ 150 cc/°, via (R) AC 18g. Will continue to monitor. [redacted] 100/AN
	0305		Head lac, c̄ dried blood at site - unable to apply bacitracin or drsg as pt. combative. Sheet under head at this time. [redacted] 100/AN
	0400		Neuro ✓ - Pt pharmacologically sedated. Sleeping at this time. Pupils +2, PERRLA. Moves all extremities spontaneously. Responds to painful stimuli. 4pt Restraints in place - good. CMS. [redacted] 100/AN
	0600		Pt resting quietly @ this time. [redacted] 100/AN
	0605		No A's on neuro assessment. BUE/BLE in place & secure. CMS good. [redacted] 100/AN
04 Jul 03	0610		Assumed pt care. Pt lying in bed, moaning, fighting wrist restraints, translator finds patients speech to be incoherent. C-spine brace in place, pt turning head on own (L) orbital abrasions and posterior skull laceration noted. Pt c̄ 4 point restraint, CMS intact. Neuro ✓, ~~pupils Perla~~ PERRLA,

(continued on next page)

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
04 Jul 03 0610	(Nursing Notes continued from previous page) · Resp distress noted. 18g IV cath in (b)(6)-2 patent & infusing NS @ 150cc/hr 5 difficulties. Will continue to monitor. (b)(6)-2
04 Jul 03 9:50	Nursing Notes: Pt agitated and fighting restraints, able to calm down momentarily, but pt ↑ level of combativeness even c positive assurance of pt's safety and health. Medicated pt c 5mg Haldol IV per prn physicians order. Will continue to monitor. (b)(6)-2
04 Jul 03 14:05	Nursing Notes: Pt transferred to Iraqi Civilian Hosp c personal belongings. Pt tolerated procedure well. (b)(6)-2 LPN

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME: LAST	FIRST	MI	SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT	

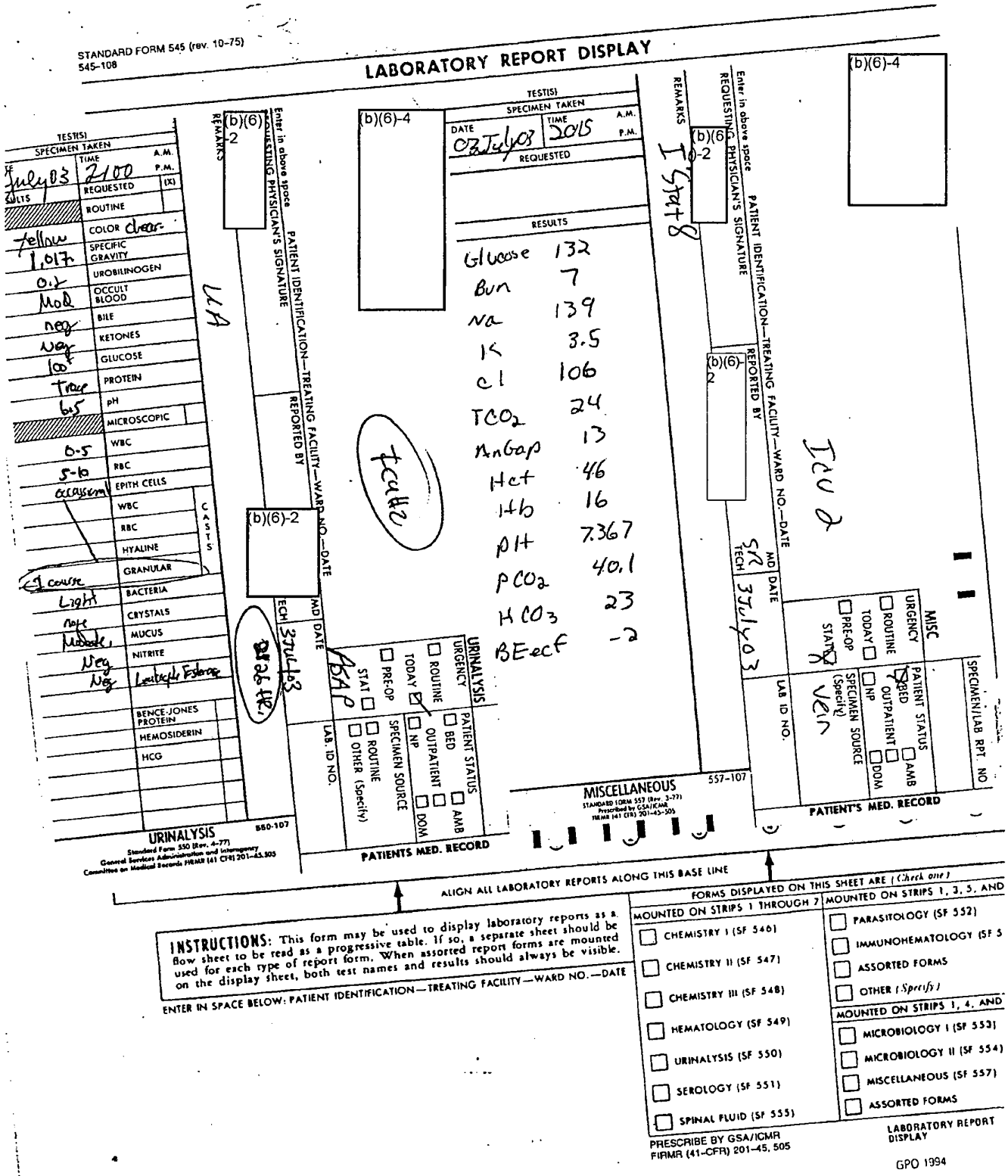
PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)	REGISTER NO.	WARD NO.
(b)(6)-4		

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11 203(b)(10)

509-114

MEDCOM - 1235


STANDARD FORM 545 (rev. 10-75)
545-108
LABORATORY REPORT DISPLAY
TEST(S)
SPECIMEN TAKEN
DATE
TIME
A.M.
P.M.
REQUESTED
RESULTS
REMARKS
Enter in above space
REQUESTING PHYSICIAN'S SIGNATURE
PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REPORTED BY
MD
TECH
DATE
ROUTINE
COLOR
SPECIFIC GRAVITY
UROBILINOGEN
OCCULT BLOOD
BILE
KETONES
GLUCOSE
PROTEIN
pH
MICROSCOPIC
WBC
RBC
EPITH CELLS
CASTS
HYALINE
GRANULAR
BACTERIA
CRYSTALS
MUCUS
NITRITE
BENCE-JONES PROTEIN
HEMOSIDERIN
HCG
URINALYSIS
Standard Form 550 (Rev. 4-77)
General Services Administration and Interagency Committee on Medical Records FIRMR (41 CFR) 201-45.505
550-107
URINALYSIS
STAT
PRE-OP
TODAY
ROUTINE
URGENCY
LAB. ID NO.
SPECIMEN SOURCE
OTHER (Specify)
NP
OUTPATIENT
DOM
BED
AMB
PATIENT STATUS
PATIENTS MED. RECORD
Glucose 132
Bun 7
Na 139
K 3.5
Cl 106
TCO2 24
AnGap 13
Hct 46
Hb 16
pH 7.367
pCO2 40.1
HCO3 23
BEecf -2
MISCELLANEOUS
STANDARD FORM 557 (Rev. 3-77)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505
557-107
MISC
PATIENT'S MED. RECORD
SPECIMEN/LAB RPT. NO.
ALIGN ALL LABORATORY REPORTS ALONG THIS BASE LINE
INSTRUCTIONS: This form may be used to display laboratory reports as a flow sheet to be read as a progressive table. If so, a separate sheet should be used for each type of report form. When assorted report forms are mounted on the display sheet, both test names and results should always be visible.
ENTER IN SPACE BELOW: PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
FORMS DISPLAYED ON THIS SHEET ARE (Check one)
MOUNTED ON STRIPS 1 THROUGH 7
CHEMISTRY I (SF 546)
CHEMISTRY II (SF 547)
CHEMISTRY III (SF 548)
HEMATOLOGY (SF 549)
URINALYSIS (SF 550)
SEROLOGY (SF 551)
SPINAL FLUID (SF 553)
MOUNTED ON STRIPS 1, 3, 5, AND
PARASITOLOGY (SF 552)
IMMUNOHEMATOLOGY (SF 5
ASSORTED FORMS
OTHER (Specify)
MOUNTED ON STRIPS 1, 4, AND
MICROBIOLOGY I (SF 553)
MICROBIOLOGY II (SF 554)
MISCELLANEOUS (SF 557)
ASSORTED FORMS
PRESCRIBE BY GSA/ICMR FIRMR (41-CFR) 201-45, 505
LABORATORY REPORT DISPLAY
GPO 1994

MEDCOM - 1236

TEST(S)

SPECIMEN TAKEN

DATE 03 July 03 TIME 2015 A.M. P.M.

RESULTS	REQUESTED	(X)
4.95	RBC COUNT	
14.4	HEMOGLOBIN	
44.8%	HEMATOCRIT	
90.6	MCV	
29.1	MCH	
32.1	MCHC (X)	
10.6	WBC COUNT	
	WBC DIFF AND BLOOD CELL MORPH: IMMATURE	
	NEUTRO-BANDS	
	NEUTROSEGS	
12.6	LYMPHS	
	EOSINOPHILS	
	BASOPHILS	
	MONOCYTES	
157	PLATELETS	
	RBC	
	SED. RATE	
	PLATELET COUNT	
	RETICULOCYTE COUNT	
	CLOTTING TIME	
	BLEEDING TIME	
	PTT CONTROL	
	PTT PATIENT	
	PROTHROMBIN CONTROL	
	PROTHROMBIN PATIENT	
	% ACTIVITY	
	RATIO	
	SICKLING TEST	
	LE PREP	
13	Lymph	

HEMATOLOGY 549-107

STANDARD FORM 549 (Rev. 7-78)
PRESCRIBED BY GSA/ICMR
FIRMR (41-CFR) 201-45.505

REMARKS

CBC

(b)(6)-2

Enter in above space REQUESTING PHYSICIAN'S SIGNATURE

PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

(b)(6)-4

REPORTED BY

(b)(6)-2

TECH 3 July 03

MD DATE

2038 HE

HEMATOLOGY

URGENCY ☐ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT ☒

PATIENT STATUS ☒ BED ☐ OUTPATIENT ☐ NP ☐ AMB ☐ DOM

SPECIMEN SOURCE ☒ VEIN ☐ OTHER (Specify) ☐ CAP

LAB. ID. NO.

SPECIMEN/LAB RPT. NO.

PATIENT'S MED. RECORD

TEST(S)

SPECIMEN TAKEN

DATE 04 July 03 TIME A.M. P.M.

RESULTS	REQUESTED	(X)
4.97	RBC COUNT	
14.2	HEMOGLOBIN	
44.6	HEMATOCRIT	
89.8	MCV	
28.7	MCH	
31.9	MCHC	
11.4	WBC COUNT	
	WBC DIFF AND BLOOD CELL MORPH: IMMATURE	
	NEUTRO-BANDS	
	NEUTROSEGS	
13.0	LYMPHS	
	EOSINOPHILS	
	BASOPHILS	
	MONOCYTES	
	PLATELETS	
	RBC	
	SED. RATE	
145	PLATELET COUNT	
	RETICULOCYTE COUNT	
	CLOTTING TIME	
	BLEEDING TIME	
	PTT CONTROL	
	PTT PATIENT	
	PROTHROMBIN CONTROL	
	PROTHROMBIN PATIENT	
	% ACTIVITY	
	RATIO	
	SICKLING TEST	
	LE PREP	
1.5	Ly#	

HEMATOLOGY 549-107

STANDARD FORM 549 (Rev. 7-78)
PRESCRIBED BY GSA/ICMR
FIRMR (41-CFR) 201-45.505

REMARKS

(b)(6)-2

Enter in above space REQUESTING PHYSICIAN'S SIGNATURE

PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

CBC

REPORTED BY

(b)(6)-2

TECH 4 Jul 03 1238

MD DATE

HEMATOLOGY

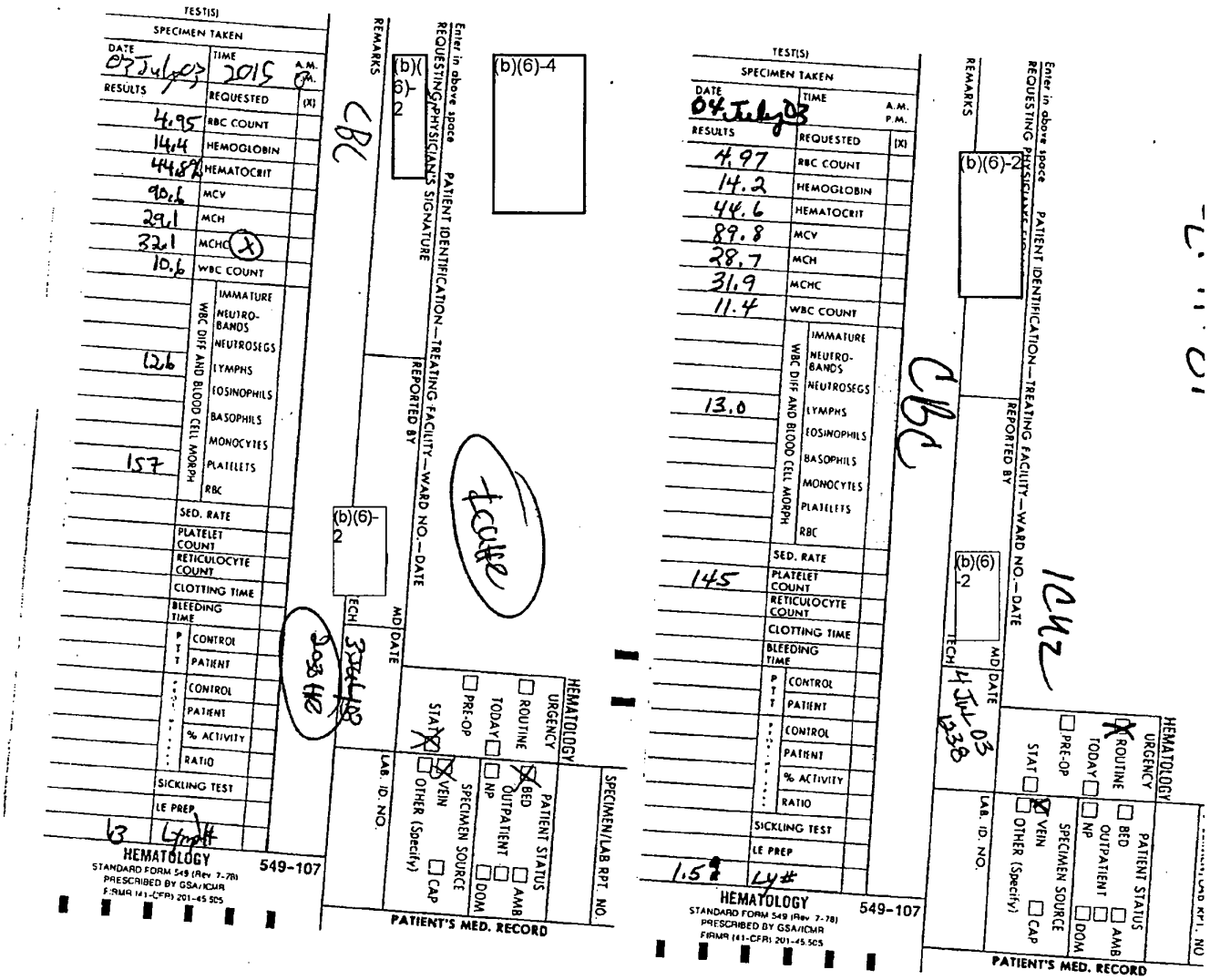
URGENCY ☒ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT ☐

PATIENT STATUS ☐ BED ☐ OUTPATIENT ☐ NP ☐ AMB ☐ DOM

SPECIMEN SOURCE ☒ VEIN ☐ OTHER (Specify) ☐ CAP

LAB. ID. NO.

PATIENT'S MED. RECORD



MEDCOM - 1237

ACLU-RDI 1099 p.21

DOD 005289

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

21st COMBAT SUPPORT HOSPITAL

LAST, FIRST, MI	UNIT	RANK	SSN
(b)(6)-4			

Physician:	Ward:	STAT / Routine	Date and Time:	Reported by:	Date and Time:
(b)(6)-2	EMT	Routine	25JUL03, 0849	(b)(6)-2	0924

I-STAT Chemistry (I-STAT)

X	TEST	RESULT	REF. RANGE
	Na	139	128-145 mmol/L
	K	3.3	3.3-4.7 mmol/L
	Cl	106	98-108 mmol/L
	pH	7.304	7.35-7.45
	PCO2	48.5	35-45 mmHg
	PO2		80-90 mmHg
	TCO2	26	18-33 mmol/L
	HCO3	24	22-28 mmol/L
	sO2		95-99%
	BEecf		(-2) - (+3)
	AGap	12	8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN	11	7-22 mg/dL
	Glu	188	73-118 mg/dL
	Creat		0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL

Chemistry (Piccolo Analyzer)

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-84 U/L
	ALT		10-47 U/L
	AMY		14-97 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat		0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		128-145 mmol/L

CBC Hematology

X	TEST	RESULT	REF. RANGE
X	WBC	12.6	4.8-10.8 x10(3)/uL
	RBC	4.91	4.2-6.1 x10(6)/uL
	Hgb	14.9	12.0-18.0 g/dL
	Hct	44.7	35.0-60.0%
	MCV	91.0	80.0-99.0 fl
	MCH	30.4	27.0-31.0 pg
	MCHC	33.4	33.0-37.0 g/dL
	Plt	161	130-400 x10(3)/uL
	LY%	7.0	15.0-55.0%
	LY#	0.9	0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Imm
RBC Morph:	
Plt verify:	
Spun Crit	35-60%

Urinalysis

Color		Straw/Yellow
Clarity		Clear
Glucose		Negative
Bilirubin		Negative
Ketone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative-Trace
Urobili		Negative
Nitrite		Negative
Leuko		Negative

Urine Microscopic

WBC		Epi	
RBC		Mucus	
Bacteria		Yeast	
Casts:			
Crystals:			
Other:			

Other:

Microbiology

Source:		
FecLeuk		Negative
Gram St		
WetPrep		Negative
KOH		No Fungal Elements
OccBld		Negative
O&P		No Ova/Parasite

Blood Bank

ABO/Rh		
T&C		
T&S		

HCG

Urine		Negative
Serum		Negative

Malaria Smear

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate

Sed Rate		1hr = 0-20 mm

Coagulation

PT		10-13 seconds
APTT		22.1-33.7 seconds
FDP		Negative

Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Negative

FORM BEARLAB 20 31 May 2003

ACLU-RDI 1099 p.22

DOD 005290

NSN 7540-01-165-7294 519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

EXAMINATION(S) REQUESTED

C-spine, chest, pelvis

AGE: SEX: M | (b)(6)-4 | WARD/CLINIC: EM1 | REGISTER NO.

FILM NO.

PREGNANT ☐ YES ☐ NO

REQUESTED BY *(Print)*: (b)(6)-2

TELEPHONE/PAGE NO.

SIGNATURE OF REQUESTOR: (b)(6)-2

DATE REQUESTED: 30 July 03

SPECIFIC REASON(S) FOR REQUEST *(Complaints and findings)*

High Speed MVA —

DATE OF EXAMINATION *(Month, day, year)* | DATE OF REPORT *(Month, day, year)* | DATE OF TRANSCRIPTION *(Month, day, year)*

RADIOLOGIC REPORT

C-spine

- Only $C_1 - C_6$ - cleared

Cannot see C_7

Chest No Acute Cardiopulm. Ds

pelvis ⊖ H

(b)(6)-2

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name — last, first, middle, Medical Facility)*

Iraq

(b)(6)-4

Civ ♂

Trauma

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT
1 — MEDICAL RECORD

STANDARD FORM 519-B (8-83)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.806-8

MEDCOM - 1239

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION: (b)(6)-4

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	3 Jul 03	0930 HOURS	
1	Admit to ICU / (b)(6)-2		
2	Closed head injury		
3	Stable		
4	Bedrest; spine precautions		
5	Continuous monitor; temp q8°		
	BP/p-ise q 0°		
	Neuro checks q 30		

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

	DATE OF ORDER	TIME OF ORDER
6	IV - NS 150cc/Hr HOURS	
7	NKDA	
8	NPO	
9	O2 / NC PRN for Sats <93%	
	Notify physician if require >4 Liters	
10	MSO4 2mg IV q 4° PRN pain	
	Ativan 2mg q 8° PRN agitation	
	Haldol 5mg IV q 8° PRN agitation	

Noted (b)(6)-2 3 Jul 03 0935 hrs

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

	DATE OF ORDER	TIME OF ORDER
11	Wound care: Leave dressing on for 24° unless soaked; then clean and apply bacitracin/antibiotic ointment BID to scalp lacerations	
12	CBC at 1500 and Z-stat 8	
13	UA	

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

PATIENT IDENTIFICATION

	DATE OF ORDER	TIME OF ORDER
	3 Jul 03	(b)(6)-2 HOURS
1	Physical restraints 2 point K24 hours. Continue physician prn re-evaluation Q 4 hours	

Noted (b)(6)-2 3 Jul 03 1030 hrs

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

FAMILY PRACTICE

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 2 JUL 03 TIME OF ORDER 1311 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) Foley to gravity

(2) Ativan 1 mg IV Q 4° PRN

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 30 July 03 TIME OF ORDER 1930 HOURS

(1) Mixed 5 mg Haldol now for agitation V.O. Dr (b)(6)-2

(b)(6)-2 (b)(6)-2 (b)(6)-2

noted (b)(6)-2 30 Jul 1930

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

DATE OF ORDER 3 July 03 TIME OF ORDER 2314 HOURS

(1) Haldol 5-10 mg IV Q 4° prn agitation.

(b)(6)-2 (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

4 July 03

PATIENT IDENTIFICATION

DATE OF ORDER 4 July 03 TIME OF ORDER 0910

(1) CBC, LYTES - 8

(b)(6)-2

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 1241

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
(b)(6)-4			4 July 03	1340 HOURS	
			(1) Transfer to civilian facility as scheduled		
				(b)(6)-2	
NURSING UNIT	ROOM NO.	BED NO.			

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
				HOURS	
NURSING UNIT	ROOM NO.	BED NO.			

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
				HOURS	
NURSING UNIT	ROOM NO.	BED NO.			

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
				HOURS	
NURSING UNIT	ROOM NO.	BED NO.			

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 1242

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo. ___ Yr. ___

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 3	4	5
3 Jul	(b)(6)-2	Bedrest - spine precautions	06	(b)(6)-2		
			14			
			22			
3 Jul		Continuous monitor -	06			
		Resp q 8°, B/P Pul x q 2°	14			
			22			
3 Jul		Neuro ✓ q 2°	06			
			14			
			22			
3 Jul		Wound care: Bacitracin	10			
		BID to scalp laceration	22			
3 Jul		Physical Restraints 2 pt	06			
		1 x 24° - consult physician	14			
		prior to removing	22			
3 Jul		2 days to gravity	06			
			14			
			22			
3 Jul		NPO	B			
			L			
			D			

ALLERGIES: ☐ YES ☑ NO

PRIMARY DIAGNOSIS: Closed Head Injury

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ___

PATIENT IDENTIFICATION:

(b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

D 8 9 10 11 12 13 14 15

E 16 17 18 19 20 21 22 23

N 24 01 02 03 04 05 06 07

DA FORM 1 OCT 78 4677 EDITION OF 1 DEC 77 MAY BE USED.

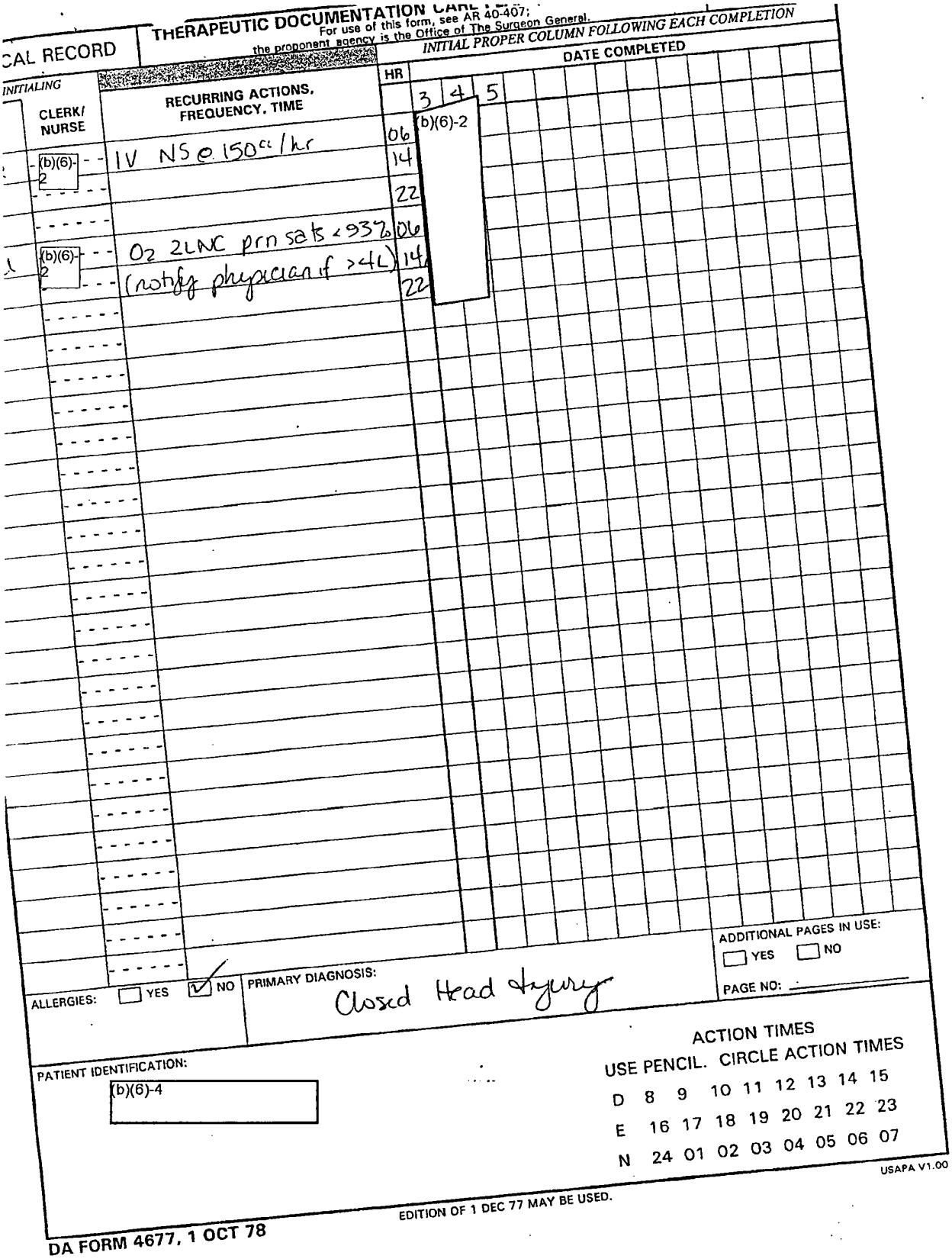
Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON MEDICATION)					Mo ____ Yr ____
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials	
3 Jul	(b)(6)-2	Admit to ICU – (b)(6)-2 (stable)	3 Jul	1000	1000	(b)(6)-2	
3 Jul		CBC c 1500 hrs & I Stat 8	3 Jul	1500	2000		
3 Jul		UA	3 Jul	ASAP	2000		
4 Jul		CBC & I Stat	4 Jul	Now			

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED

☆ U.S. GPO:1997-418-230/55267

ACLU-RDI 1099 p.28

DOD 005296



CAL RECORD

THERAPEUTIC DOCUMENTATION CARE [illegible]; For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

INITIALING CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 3	4	5
(b)(6)-2	IV NS @ 150cc/hr	06	(b)(6)-2		
		14			
		22			
(b)(6)-2	O2 2LNC prn sats <93%	06			
	(notify physician if >4L)	14			
		22			

ALLERGIES: ☐ YES ☑ NO

PRIMARY DIAGNOSIS: Closed Head Injury

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION: (b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D 8 9 10 11 12 13 14 15
E 16 17 18 19 20 21 22 23
N 24 01 02 03 04 05 06 07

USAPA V1.00

DA FORM 4677, 1 OCT 78 EDITION OF 1 DEC 77 MAY BE USED.

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) Mo ____ Yr ____

Verify by Initialing: Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
3 July	(b)(6)-2	Haldol 5mg IV now for agitation	3 July	now	1930	(b)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED
3 Jul	(b)(6)-2	MSO4 2mg IVq 4° prn pain	1530 2mg; 2030 2mg; 2310 2mg; 0155 2mg; 0320 2mg; (b)(6)-2
3 Jul		Ativan 2mg IVq 4° prn agitation	1100 2mg; 1915 2mg; 0155 2mg; 1040 2mg IV; (b)(6)-2
3 Jul		Haldol 5mg IVq 8° prn agitation	1430 5mg; 1930 5mg; 3 July; (b)(6)-2
3 Jul		Haldol 5-10mg IVP Q4° prn agitation	2315 5mg; 0000 5mg; 0515 5mg; 1005 5mg; 1040 5mg; 4 Jul; 4 Jul; (b)(6)-2

USAPA V1.00

ACLU-RDI 1099 p.30

DOD 005298

ADMISSION AND CODING INFORMATION

For use of this form, see AR 40-400; the proponent agency is OTSG

1. REPORTING MTF: (b)(3)-1
2. MTF LOCATION (State or Country Code.): I Z
3. REGISTER NUMBER: (b)(6)-4
NAME (Last, First, Middle Initial): Iraqi (b)(6)-4
4. PAY GRADE:
5. SEX: M
6. DATE OF BIRTH (Y Y Y Y M M D D):
7. AGE AT ADMISSION:
8. RACE: X
9. ETHNIC BACK-GROUND: 9
RELIGION:
10. LENGTH OF SERVICE:
ETS:
11. FMP: 98
12. SOCIAL SECURITY NUMBER: (b)(6)-4
ORGANIZATION (Active Duty Only):
13. MARITAL STATUS:
HOUR OF ADMISSION: 0715
BRANCH / CORPS:
14. FLYING STATUS:
15. BENEFICIARY CATEGORY: K 7 6
16. ZIP CODE OF RESIDENCE:
17. UNIT LOCATION (State or Country Code):
18. MOS:
19. TRAUMA:
PREV. ADMISSION YEAR: NO
20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: O
WARD: ICU 2
NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE:
ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code):
NAME AND (b)(3)-1 MEDICAL TREATMENT FACILITY: BCO (b)(3)-1 CSH, FWD
TELEPHONE NUMBER OF EMERGENCY ADDRESSEE:
21. TYPE: 21 Iraqi Hosp
22. MTF TRANSFERRED TO:
23. DATE OF DISPOSITION (Y Y Y Y M M D D): 20030704
24. CLINIC SVC - ADMITTING: BIAA
25. MTF TRANSFERRED FROM: (b)(3)-1
26. DATE THIS ADMISSION (Y Y Y Y M M D D): 20030703
27. LOCATION OF OCCURRENCE (Battle Casualty Only):
28. MTF OF INITIAL ADMISSION: (b)(3)-1
29. DATE INITIAL ADMISSION (Y Y Y Y M M D D): 20030703
FOR LOCAL USE
ADMITTING OFFICER (Signature, as required): (b)(6)-2
SIGNATURE OF ADMITTING CLERK: (b)(6)-2

DA FORM 2985, MAR 2000 EDITION OF MAR 89 USAPA V1.00

MEDCOM - 1247

(b)(3)-1

INPATIENT TREATMENT RECORD COVER SHEET *(For Plate Imprinting)*

For use of this form, see AR 40-400; the proponent agency is the Office of The Surgeon General.

PATIENT DATA ITEMS 1 - 30 *(Excluding Items 25 & 26)*

(b)(6)-4

Ben Cat K78
FMP 20

LINE	LEGEND
1	REGISTER NO. - NAME - GRADE
2	SEX - AGE - RACE - RELIGION - LENGTH OF SVC - ETS - PREVIOUS ADMISSION
3	FMP - SSN - ORGANIZATION - WARD
4	FLY STAT - RATING/DESG - DEPT/BEN - BRANCH/CORPS - UIC/ZIP - TYPE CASE
5	SOURCE & AUTHORITY FOR ADMISSION - HOUR OF ADMISSION - CLINIC SVC
6	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
7	ADDRESS OF EMERGENCY ADDRESSEE - PHONE NO. - DATE OF THIS ADMISSION
8	NAME & LOCATION OF MEDICAL TREATMENT FACILITY DATE OF INITIAL ADMISSION

ADMISSION REMARKS

ADMITTING OFFICER (b)(6)-2

32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED

25. TYPE DISPOSITION: D/C to cage

26. DATE OF DISPOSITION: 25 Sep 03

31. SELECTED ADMINISTRATIVE DATA

☐ CHECK IF CONTINUED ON REVERSE

33. CAUSE OF INJURY: explosion / bomb (887.1)

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

(1) Traumatic ~~[illegible]~~ below elbow amputation (L) UE 887.0 ICD9.02

(2) open (L) femur subtrochanteric fx c̄ large soft tissue loss 820.32 ICD9.02

(3) multiple (L) LE shrapnel wounds E991.9 ICD9.02

☐ CHECK IF CONTINUED ON REVERSE

35. TOTAL DAYS THIS FACILITY

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

36. TOTAL DAYS ALL FACILITIES

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

SIGN (b)(6)-2 ...DICAL OFFICER

SI (b)(6)-2 ...EDICAL RECORDS OFFICER

DA FORM 1 MAY 79 3647-1 EDITION OF 1 AUG ...

MEDCOM - 1248

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

PERTINENT HISTORY, CHIEF COMPLAINT, AND CONDITION ON ADMISSION *(Enter date of admission)*

Yg O Iraqi GPW Slp injury c̄ explosive device 8/24/03
Txled @ local Hospital c̄ amputation @ UE @ forearm & IRD
wounds @ hip & @ LE. Transferred for definitive management.
* Cio pain, ↑ c̄ motion & deformity @ LE

PMH	PSH	NKDA	Xmeds
HNP/DDD	Ø		
LS spine			

PHYSICAL EXAMINATION

(PE) huge soft tissue skin loss @ hip c̄ large area
exposed muscle & open @ femur fx
FHL, TA, GS, peroneals faint DP/PT pulses
good capillary refill
Traumatic amputation @ UE @ distal @ forearm level

(A): (1) Traumatic @ UE amputation @ distal forearm level
(2) open @ subtrochanteric femur fx c̄ huge soft tissue injury.

PROGRESS *(Enter date of discharge and final diagnosis)*

(P) (1) IRD all wounds
(2) Ex-Fix/limited internal Fixation @ femur.
(3) Revision @ UE amputation

SI (b)(6)-2		DATE 8/25/03	IDENTIFICATION NO.	ORGANIZATION

PATIENT'S IDENTIFICATION *(For typed or written entries give Name last, first, middle; grade; date; hospital or medical facility)*

REGISTER NO.	WARD NO.

(b)(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
USAPPC V1.00

MEDCOM - 1249

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
29 Aug 03	OP-NOTE
	Pre/Post-op Dx: (1) Traumatic (L) UE (L) wrist disarticulation.
	(2) Grade III B open (L) subtrachanteric femur fx c̄ huge 25cm x 20cm skin defect.
	(3) multiple (L) UE shrapnel wounds
	Procedure: ISD (L) UE/(L) Leg/thigh
	Circular amputation (L) UE BEA
	EX-Fix (L) femur c̄ limited internal fixation
	Prevost, Phillips, Choi
	9BC 200cc
	2 comps to RR instable cond
	(b)(6)-2 [redacted] MD
	Prevost

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)	REGISTER NO.	WARD NO.
(b)(6)-4 [redacted]		

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

509-114

MEDCOM - 1250

DATE	NOTES
26 Aug 03	Anesthesia
0928	- pt. awake and alert this am. and without complaint.
	Wound (LE) not examined - defer to Dr. Prevost. Antibiotic
meds:	coverage changed today to include Pen G.
1. Ancef Q8°	BP 159/81 HR 137 R 25 Sat 97% RA
2. Gent 80mg Q8°	Lungs: CTA (B) Heart: nl S1, S2, ø rlmlg
3. Pen G 4mu Q6°	CK 1735 H/H 9/30 130 / 3.8 | 110 / 26 | 12 / 0.6 < 161
3. Mannitol pm	Imp: POD #1 following revision of LUE hand amputation,
	Ex-fix of (L) femur. Large area of exposed thigh muscle.
4. MSO4	↑ SC CK and large blood in urine c̄ only 5 RBCs w/prisoner
	for ~~rh~~ rhabdomyolisis. Will continue to force diuresis
	& c̄ mannitol and aggressively hydrate.
	(b)(6)-2 MD (b)(6)-2
27 Aug 03	Anesthesia
0744	- pt. resting comfortably this am s̄ complaint. Events of concern overnight
	include a T 101+ and a desaturation episode to 88% on RA.
	CXR shot this am - result (P).
	HR 112 BP 145/86 R 16 Sat 96% (2l NC)
	Exam: lungs: (R) basilar rales; (B) diffuse quiet exp. wheezing
	CV, nl S1, S2, ø rlmlg.
	Wounds: defer to orthopedics.
	Labs: CK 685 H/H 7/22 133 / 3.9 | 102 | 12 / 0.9 < 130
	Imp/plan: - CK falling - reassuring w/r to my initial concern for rhabdo.
	Will check 2 more times then D/c. D/c mannitol. Change IVF to
	D5 1/2 NS c̄ 20 KCl. Institute Albuterol nebs Q8°, encourage coughing, deep
	breathing. To OR today for adjustment ex. fix, washout.

PROGRESS NOTES

L RECORD

NOTES

Anesthesia addendum

CXR - difficult to interpret this suboptimal portable exam. Poor inspiratory effort / lordotic film. Some suggestion of atelectasis vs. consolidation, RML / RLL.

(b)(6)-2

ATIONSHIP TO SPONSOR

SPONSOR'S NAME

LAST

FIRST

MI

SPONSOR'S ID NUMBER (SSN or Other)

PART./SERVICE

HOSPITAL OR MEDICAL FACILITY

RECORDS MAINTAINED AT

REGISTER NO.

WARD NO. ICU-2

TIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)

(b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

509-114

MEDCOM - 1252

MEDICAL RECORD | nursing notes

~~PROGRESS NOTES~~

~~NOTES~~

DATE

Aug 03 — 1500 transferred from recovery to ICU2 (same bed). Alert. 40 pain 4/10 via interpreter, O2 sat 99% on 1L of O2 N/C, O2 decreased to RA. Ø SOB observed, central line to (R) IJ CDI, LR infusing @ 80cc/hr, lungs clear, bowel sound Act nex 4 quads, Foley draining clear yellow urine, edema lt to (R) UE, (R) LE has scabs OTA pink in color, ABD has abrasions OTA white in color, Amputation site to (C) UE CDI c̄ Acewap, (C) LE c̄ pin site CDI will cont. to monitor pt (b)(6)-2

7 Aug 03 1900 — VSS (b)(6) T. 99.9. P-132. Other VSS. Urine output @ approximately 50cc/hr. Good pain control at this time. Eating grapes c̄ difficulty. Ancef given at 1800. Dr (b)(6)-2 by to see pt no Δ's in orders. Will continue to monitor. (b)(6)-2

27 Aug 03 2130 — Pt given Tylox (2) for pain. Temp ↑ 100.5. O2 sat ↑ 98% RA. Penicillin given IUPB. Sleeping comfortably since last note. ~~do~~ (b)(6)- Clear amber urine in foley. output 450cc for 4 hours.

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT	
		REGISTER NO.	WARD NO.

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade) . . .

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

509-114

MEDCOM - 1253

PROGRESS NOTES

:DICAL RECORD

NOTES

DATE

34 y/o @ c̄ (R) arm amputation BS Before Tx

1603 Coarse Rhonci throughout all lobes Sats 96% 2L NC

830 HR 106 Alb SD Q8 c̄ O2 6LPM S/p Tx

pt Sat 96 on ~~RA~~ no 2L O2 BS improved yet

consitant next Tx 1730 — (b)(6)-2 CA7 —

1 AUG03 pt given SD alb via neb c̄ 8L O2 During Tx

1630 99% Sat HR 134 BS improved c̄ Tx Next Tx 0030 no

2030 pt given SD AIB c̄ 10L O2 pt HR 132 Before Tx. BS s̄

3AUG tx improved but presistant Bilat coarse wheezing Bases pt Sat 96% s̄ Tx no

Aug03 0730 pt. alert, fowler position, HR 117, RR 18, SatO2 94/95 @ RA, B.BS. coarses, ↓ bases (R) side, inspiration wheezes, given HHN 0.5 cc albuterol/3.0 cc NSS, pt. tolerate tx. well — SGT (b)(6)-2

Aug03 1530 pt. alert, semifowler position, HR 118, RR 18/19, SatO2 93/94% @ RA, BBS ↓ bases, (R) side, ~~BBS~~ error give HHN 0.5 cc albuterol/3.0 cc NSS, pt. tolerate tx. well — SGT (b)(6)-2

Aug03 2330 pt. sleeping, HR 84/85, RR 11/12, SatO2 93/94% @ RA BBS ↓ (R) side, given HHN 0.5 cc albuterol/3.0 cc NSS

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI | SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade) | REGISTER NO. | WARD NO.

(b)(6)-4

Epw male

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11 203(b)(10)

509-114

MEDCOM - 1254

DATE	NOTES
continue	pt. tolerate tx. well ——— SGT (b)(6)-2
29 Aug 03	0800 Pt awake and alert. HR: 111 SpO_2: 96% on RA RR: 12 BS: BBS/diminished throughout c̄ wheezing. Pt gave 0.5cc albuterol c̄ 2.5cc NSS via SVN and aerosol mask. Pt tolerated tx c̄ adverse effects ——— SGT (b)(6)-2
30 Aug 03	0100 Pt awake HR: 120 RR: 14 SpO_2: 94% on RA. BS: BBS/ diminished throughout. Pt given 0.5cc albuterol c̄ 2.5cc NSS via SVN Pt tolerated tx c̄ adverse effects ——— SGT (b)(6)-2 9/V20
30AUG03	0800 pt tolerated tx well see note in other progress not SGT (b)(6)-2 9/V20
	1600 pt sat 95% ~~RR 12~~ up See other note SGT [illegible] 9/V20
	2200 pt sitting up tx given via mask well tolerated SGT (b)(6)-2 9/V20
	2325 pt placed on 3L NC Sat 89% HR119 (b)(6)-2 9/V20

MEDCOM - 1255

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
28 Aug 03 2145	Pt sleeping comfortably. Tylox effective for pain. Good use of IS use. Noticable drainage continues from operative site. PCN given. Will continue to monitor. (b)(6)-2 LRJ
28 August 03 @ 2210	Nurse note: Patient lying supine. HOB ≈ 30° Alert and oriented. Vital: see flow sheet. Lt @ 80cc. +1 pitting edema to RUE. (R) IJ patent. pending dressing A LUE bandage C/D/I. Below the elbow amputation. Bandages to LLE c external fixator to to thigh. (+) Drainage to dressing to thigh. Abdomen distented + firm. BS ↓ BS. Lungs clear to upper lobes ↓ in lower + bases. Dressing change to LLE pending. Encouraged deep breathing and use of I/S. Will continue to monitor for A. (b)(6)-2 CPTAU
28 Aug 03 @ 2300	Pt request cold water; given. Pt made aware c interpate of NPO status p MW. (b)(6)-2 CPTAU

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME (LAST, FIRST, MI) | SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade) | REGISTER NO. | WARD NO.

POTUS # (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

509-114

MEDCOM - 1256

PROGRESS NOTES

DICAL RECORD

NOTES

ATE

y03 2220 (continued) dressing guage c̄ tape CDI, (L) thigh external fixator bandaging CDI, LS CTA (R) radial pulse present normal BS normal active x 4 quads, abd distended/soft NAD Ø tenderness Ø pain to touch OTA abrasions to abd & legs bilaterally will continue with current plan of care (b)(6)-2

Aug. 03 530 Anesthesia procedure note
- Asked to change the patient's central line 2° to kinking. Sterile prep / drape / gown / glove. Introducer exchanged over a wire for a triple lumen catheter. All lumens aspirate and flush easily. Ø complications. CXR done, shows appropriate position. (b)(6)-2

Aug 03 0415 pt resting c/o thirst PO fluids provided, V/S stable NAD, Ø changes from last assessment (b)(6)-2

AUG 03 0800 pt Resting pt given SD A/B pt BS Base wheezes pt S/P Sp02 99% 91V20 Hx BS improved pt sleeping (b)(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		
PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)		REGISTER NO.	WARD NO.	

Potus (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

509-114

MEDCOM - 1257

ICAL RECORD

PROGRESS NOTES

NOTES

ATE	
603	pt given SD Alb via mask pt lying down
0	BS: wheezing throughout before tx
	pt Resting on RA 94% Sats HR 76
4U603	pt Resting given Alb SD via mask
200	BS Diminished pt Sats 116 HR 92
	Pt BS improved yet presistant c̄ Tx (b)(6)-2
00	

ELATIONSHIP TO SPONSOR

SPONSOR'S NAME: LAST | FIRST | MI

SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE

HOSPITAL OR MEDICAL FACILITY

RECORDS MAINTAINED AT

REGISTER NO.

WARD NO.

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)

Potus (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

509-114

MEDCOM - 1258

PROGRESS NOTES

AL RECORD

NOTES

Remarks

(b)(3)-1

PRBC's

403	0030	116	132/70 (91)	20	100^4 @ AX	
	0035	116	135/71 (92)	18	100^2 @ AX	
	0040	116	131/69 (90)	18	100^5 @ AX	
	0110	114	129/66 (90)	20	100^2 @ AX	
	0140	114	128/74 (94)	22	99^3 @ AX	
	0240	111	124/71 (92)	20	99^2 @ AX	
	0340	109	129/78 (92)	20	99^2 @ AX	
	0440	107	126/75 (91)	18	99^6 oral	completion
ug03	0455	107	128/78 (93)	18	99^9 oral	(b)(3)-1
405	0500	109	130/82 (98)	16		
	0505	109	129/82 (100)	18	98^5 @ AX	
	0535	109	132/82 (101)	16	99^2 @ ax. UOP 1100cc	
	0605	see flowsheet				(b)(6)-2 MAJ
	0705					
	0805					
	0905					

ug 03 0830 pt. alert, semifowler position, HR100/101, RR18/19, SatO2 94% @ RA, BBS CTA good air movement, given HHN 0.5cc albuterol/3.0cc NSS, pt. tolerate tx. well — SGT (b)(6)-2

SPONSOR'S NAME

SPONSOR'S ID NUMBER (SSN or Other)

ELATIONSHIP TO SPONSOR

LAST

FIRST

MI

RECORDS MAINTAINED AT

DEPART./SERVICE

HOSPITAL OR MEDICAL FACILITY

REGISTER NO.

WARD NO.

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)

Potus (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

509-114

MEDCOM - 1259

DATE	NOTES
1 Sep 03	ortho op Note
1330	Pre/postop Dx: (L) UE wound infection
	Op: (L) UE D/I washout ; (L) LE D/I washout & dress
	(b)(6)-2 / (b)(6)-2 (b)(6)-2 / (b)(6)-2 CRNA (b)(6)-2
	Minimal purulence (L) amputation site; (L) LE debrided fibrinous
	Fluid 700 cc LR tissue; friable muscle & gross
	UOP 300 cc I+O necrotic tissue
	EBL min
	& complications. Dressed open. wet to Dry. ACE wrap
	To ICU c̄ SV, VS WNL
	Note: Dr (b)(6)-2 did rectal exam -
	& Stool in vault / & impaction (b)(6)-2
	(b)(6)-2 LTCDDSN

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
2SEP03	Medical Nutr Therapy
0900 S	Consult for nutr support recs
O	Iraqi EPW S/P amputation m - fx, NPO since 30 Aug currently NGT to suction c distended abdomen & ileus wt 77kg Meds noted: ancef, e-mycin, demerol Labs Na 144 K 3.8 gluc 197 Bun/Cr 18/1.8 (2SEP) alb 1.4 (30 Aug) - likely 2' dilutional effects
A	Pt with ↑ nutr needs to support healing which may be compromised c extended NPO. Nutr needs est @ 1900-2300 Kcal/d (25-30 Kcal/kg) & 75-90 gm pro/d (1-1.2 gm/kg).
R	If able to feed enterally, use Vivonex, elemental formula at target rate 85cc/hr to provide 2040 kcal & 78 gm pro/d. Initiate at 20cc/hr & adv 20cc q 6-8 hr as tolerated. For TPN, provide 2040 Non protein Kcal + 80 gm pro maximally concentrated (450 gm D50 (900cc); 80 gm 15% aminosyn (533cc); 57 gm 20% lipid (285cc) + 150cc electrolytes. = 79cc/hr total volume 1868cc - Dextrose infusion rate would be 4 mg/kg/min below max of 5. Monitor K+ Mg +PO4 for refeeding.

(b)(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR (SSN or
	LAST	FIRST	MI	

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)	REGISTER NO.	WARD NO.

POTUS

(b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV 5-39)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

509-114

DATE	NOTES
	Nutr Note continued
P	Available to assist - will follow
	(b)(6)-2 [redacted] MS RD
	MAJ ISP
25 Sept 03	Gen Surg Note
1039.	Following pt. c̄ ortho for abd distension. KUB revealed dilated colon - SB + stomach not dilated. Exam revealed distended abd c̄ ↓ BS. pt. has clinical picture of ileus. After (c) arm stump was washed out yesterday, temp ↓ + WBC ↓ from 18 to 10. pt. currently has NGT. Abd is softer + less distended than yesterday. Non-tender. Ø peritoneal signs. Pt. currently on IV erythromycin. (+) BS Overall, pt. has ileus, which appears to be slowly improving.
	- Rec continued NPO, IVF
	- Cont NGT
	- Cont IV erythromycin
	- will cont to follow
	(b)(6)-2 [redacted]
	MAJ

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STANDARD FORM 509 (REV 6-99) BACK

MEDCOM - 1262

09-113 NSN 7540-00-634-4122

MEDICAL RECORD | PROGRESS NOTES

DATE					
7/2/03	PRBC's # 1				
	T	P	R	BP	SAT
1229	101°(A)	110	24	103/60	95%
1235	101°(A)	110	26	105/64	95%
1240	101.3(A)	109	24	106/64	97%
1255	101°(A)	110	25	107/64	97%
1310	100.9(A)	109	24	109/66	96%
1345	100.7(A)	105	22	109/65	97%
1445	100.4(A)	102	25	106/66	96%
1445	100(A)	104	23	105/67	96%
1510	99.9(A)	100	24	116/60	97% #2 PRBC's start
1515	101.1(B)	101	26	108/63	96%
1520	99.9(A)	101	27	113/72	96%
1525	99.9(A)	99	26	112/71	96%
1550	99.5(A)	100	29	103/71	95%
1605	99.9(A)	99	25	113/72	94%
1620	100.4(B)	100	25	114/74	94%
1630	#2 UNIT PRBC's stopped for IV meds				
RESTART 1700	100.5(A)	98	29	112/71	94%
1705	100.7(A)	98	24	116/73	94%
1710	100.7(A)	97	27	117/72	94%
1715	100.7(A)	96	26	111/73	95%
1720	100.5(B)	98	26	110/70	95%
1745	100.9(B)	101	26	109/76	94%

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)

POTUS # (b)(6)-4

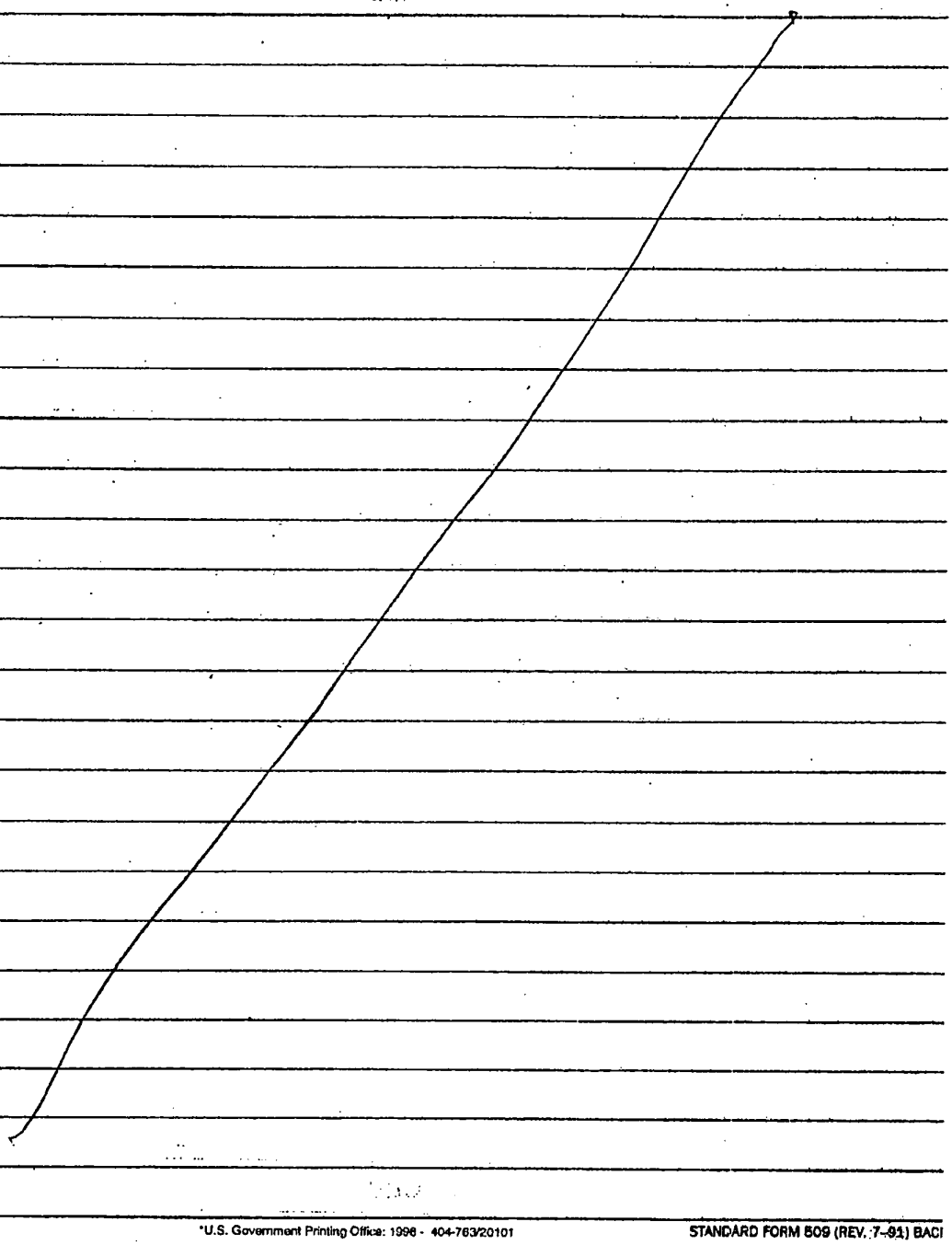
REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

PROGRESS NOTES

DATE	T	P	R	BP	SAT	
1800	100.5	101	28	114/71	94%	(b)(6)-4
1830	100.4	102	26	123/72	94%, Blood complete	
					95%	



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STANDARD FORM 509 (REV. 7-91) BACI

MEDCOM - 1264

NSN 7540-00-634-4122

9-113

MEDICAL RECORD | PROGRESS NOTES

DATE

2 Sep 03 ORTHOpaedic Surgery
VSS - Tmax 101?
pt alert.
ABd soft - per GS. + exam - still Distended
(L) Arm dressing DRY + INTACT.
(L) Hip dressing Intact
↓ HCT (22) WBC ↓ 10 (↓ fr 18)
(1) open Fx to Prox Femur (3) Anemia
(2) (1) BE Amputation
(3) infection (2) BE stump
(4) Illeus
Plan: (1) ADD gentamin
(2) T+C 2 units PRBC's
(3) KUB in AM
(4) ✓ Creatinine
(5) TO OR TOMORROW for
(L) ARM stump WASHOUT
(6) Continue BID Dressing Δ

(b)(6)-2

3 Sep 3 ORTHO Surg
- Hbg ↑ to 10; WBC - ↓ 9.3, STABLE, Belly softer.
- consent obtained → to OR this AM

(b)(6)-2

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)

REGISTER NO.

WARD NO.

Potus # (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 1265

PROGRESS NOTES

DATE

3 Sep 03 OP Note

Blast injury (L) ARM / (L) hip

SAME

1- I+D (L) ~~Bler~~ Below Elbow stump site

(2) I+D (L) Hip

(b)(6)-2 (b)(6)-2

GET

Elbow prepped + Draped - clean. No foul odor.

- 3 L WASHED Through. vessel loop used to Bring edges together $\bar{c}$ tension.

- (L) hip wound debrided. Foul odor from lateral side. No Abscesses to palpation.

- wound packed $\bar{c}$ wet 4X4.

- Pt washed. Returned to ICW-1 in stable condition

(b)(6)-2

MAJ

4 Sep 03 ORTho note

Tmax. 99.4

Pt comfortable. WOUND SANS AROMA. Dressing Δ^{d} last night + this AM

Hbg - 7.8 Cre - 0.8, WBC - 8.3

- Blast inj

- P: (1) Return to OR tomorrow I+D / Elbow / hip

(2) Continue Gentimicin

(b)(6)-2

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MEDCOM - 1266

NSN 7540-00-634-4122

.13

MEDICAL RECORD

PROGRESS NOTES

DATE

/Sep/03 OP Note

Blast injury - Below Elb Amp; ② open Hip Fx; infection

same

I&D Both sites

(b)(6)-2

EBL - min Comp.

Pt c̄ ↑ superficial pins at Elbow 3L washed through

c̄ pulsavac Area by Ex Fix pins washed multiple

times c̄ pulsevac Dead skin debrided.

vessel loops c̄ rubber bands used to keep flaps

pulled together. Packed c̄ Damp Kerlix.

- pt tolerated procedure well. To RR in satisfactory

condition

(b)(6)-2

6 Sep 03 POD#1

Tmax 100.1 (Ax) pulse other VS stable

pt stable Abd soft

⊕ drainage from arm

- Continue dressing changes

✓ Cr + H/H in AM 7 Sep 03

(b)(6)-2

- Discussed c̄ Dr (b)(6)-2 regularly

DIET

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)

REGISTER NO.

WARD NO.

POTUS# (b)(6)-4

PROGRESS NOTES

Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 1267

509-113 NSN 7540-00-634-4122

MEDICAL RECORD | PROGRESS NOTES

DATE

7 Sept 03 POD #2

VSS Afebrile

P.O. tolerated well. Pt c/o mouth pain - specifically tongue.

ABd soft

Dressing's Dry. Wound looked good on LE Amp site.

A: BEA L ARM; ② hip Fx c soft tissue defect.

P: IVF tomorrow. - Continue Dressing changes/ ARM/leg.

(b)(6)-2

MAJ (b)(6)-2

8 Sep 03 OP Note

② BE Amp

② Open Hip Fx c large soft tissue defect

IVD; shortening bone ② BE Amp.

wound Packing ② hip

(b)(6)-2

GET -

- Radius/Ulna shortened ~ 1 cm each.

- soft tissue closed around them Rubberband technique used to close wound. wet to dry packing used. Skin edges freshened.

② hip packed. small area of open packed c packing ½".

- tolerated procedure well.

(b)(6)-2

(b)(6)-2 MAJ

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)

POTUS #

(b)(6)-4

REGISTER NO.

ARD NO.

PROGRESS NOTES

Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 1268

NSN 7540-00-634-4122

PROGRESS NOTES

DICAL RECORD

TE
203 POD#1
VS Thur 103
pt not taking much orally.
- Abd soft. worms packing proceeding well.
No foul odor. ARM or leg. ↑ Crat 1.5 (90.8)
will ✓ CXR; ↓ Gent Dose, + Urine.
Nutrition ~~or~~ eval.

(b)(6)-2 [redacted]

sep03 PT note:
40 hrs. pnt. A & O X3, sitting in chair @ bedside — c̄ (L) LE propped
@ ~90° hipflexion (on chair) (~10°). pnt. able to perform AROM
c̄ ankle — restricted DF pnt. encouraged to ROM (L)
ankle. AAROM / PROM can achieve full ROM DF. Inv./
Eversion WNL / ~~PF~~ WNL. can wiggle toes. Instructed
pnt. (thru interpreter) that he needs to perform ankle
ROM x 4 planes of hour 10x each direction & wiggle toes.
(90° neutral DF) night splint (to stretch achillies) / can perform
achillies stretch (c̄ assistance) 5x throughout day.
Dr. asked therapist to instruct pnt. in Quad sets. —
therapist will return to instruct in further exercises
as pnt. is in ~~supine~~ / easier to perform quad sets in
Supine. (b)(6)-2 [redacted] . MPT/SSC/91WN9.

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)

REGISTER NO.

WARD NO.

PROGRESS NOTES

Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 1269

NSN 7540-00-634-4122

EDICAL RECORD

PROGRESS NOTES

DATE

p 03 OP Note

BE Amp / left open Hip Ex

Same

Ex D (L) BE Amp stump; wound dorsum A - (L) hip

(b)(6)-2 (b)(6)-2

Ans - GET

EBL min

tourn ∅ comp ∅

2 L taken through (L) BE Amp stump. Healthy granulation tissue under surface layer. Radius covered - Ulna not covered.

- Hip wound with good granulation tissue.

- Return to OR 2 DAYS

(b)(6)-2

Maj

13 Sep 03 Nutrition

Calorie count results for 12 Sep 03: ~ 1660 Kcal; 65 gm protein. Nursing reports ↑ appetite; currently NPO. Needs previously estimated @ ~ 2200 Kcal + 75-100 gm pro/d. Labs alb 1.5 ↓ - as expected c̄ fluids / open wound.

R/ If feeding tube is placed, consider Vivonex - elemental

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)

REGISTER NO.

WARD NO.

Potus

(b)(6)-4

PROGRESS NOTES

Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 1270

PROGRESS NOTES

DATE

Nutrition continued.

formula to start. Can transition to Jevity or Ensure later. Initiate at 20cc/hr and advance as tolerated to goal rate of 85cc/hr. Monitor K Mg Poy for refeeding.

② If oral intake continues Add on for Ensure to Carnation Instant Breakfast. Pt not drinking ensure but will drink milk. CIB will provide additional 5gm pro + 130kcal per pkt.

③ Will follow

(b)(6)-2

MS RD

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STANDARD FORM 509 (REV. 7-91) BACK

1660Kcal 71-106

NSN 7540-00-634-4122

DICAL RECORD | PROGRESS NOTES

E

Cal Count

Kcal	
	Breakfast
1150cal	1 carton milk (half cream white) 250cc
100	3/4 doughnut
120	2 bites pancake
60	1 carton OJ
	Snack
150	1 cup milk from family
0	100cc water
	Lunch
500	2 4-5 inch lamb cabob (~ 5 oz)
80	1 round bread
25	1/2 cup vegetables (olives, cucumbers, onions)
100	3/4 can pepsi
	Snack
150	Milk half-cream White ~~1/4~~ 250 cc
25	1/4 can pepsi
	Dinner - pepsi 150 coke 150

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)

REGISTER NO.

WARD NO.

PROGRESS NOTES

Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 1272

PROGRESS NOTES

DATE

Dinner

NOTE
12 Sep 03

COKE x 1
PEPSI x 1

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MEDCOM - 1273

STANDARD FORM 509 (REV. 7-91) BACK

NSN 7540-00-634-4122

PROGRESS NOTES

RD

L.M. Consult
Asked to see pt. D/T recurrent fevers
to 104 on 11 Dep + 101-102 (A)
since 34 y/o Iraqi DD detainee,
sustaining below-the-elbow (L) ampu-
tation (L) open subtrochanteric femur
fx + large open soft tissue
defect from (L) hip to (L) knee
ex-fix in place. (-) URI or
UTI Sx's. ATB's recently Δ'd
from Ancef, Bactrim, + gent to
Levaquin δ cont. of gent.
PE: T° 101.4° (A) 100.9° (A) - 118 - 24 - 127/75 -
93%, RA. Nontoxic + interacting
ENT ∅ (-) LAD L-CTA
RRR (tachy) (-) MOV G Ab distended,
(+) BS, soft, (-) M, T, or HSM. Wounds
not undressed. (-) calf tenderness or
cords ~ 4 x 6 cm blood blister on
lateral aspect (L) heel.
Malaria smears (-) x 3 8.4 9.9/26
u/A (9 Dep) 1.02 mod. bact, 567 k
δ (-) LE + nitrite.

(Continue on reverse side)

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle, grade, rank, rate; hospital or medical facility)

(b)(6)-4

Potus

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 1274

DATE

13 Sep 03

1143

cont

PROGRESS NOTES

Cr 0.8

alb 1.5

Ca 8.4 (corrected) 10.4

Portable CXR ⊖ infilt, motion artefact

A & Rec:

#1 - Continued fever δ clean LUE stump & healing open wound of ⊕ hip/thigh - diff of includes: wound infection vs. pneumonia doubt vs. UTI doubt vs. antibiotic associated colitis doubt vs. DVT (no evidence) vs. SBE (no evidence) vs. osteo vs. drug fever (fevers lower, but persist δ Δ of ATB) - re ✓ CXR, U/A, & ✓ ESR

#2 - ↓↓ alb δ calorie & peak malnutrition. It dislikes Ensure & Carnation Instant Breakfast res. to supplement diet

#3 - Note Ca++ slightly ↑d, when correct for ↓ alb. Probably not disease. Food diuresis & monit

Agree δ present ATB coverage

Will monitor

(b)(6)-2

(b)(6)-2

Lieutenant Colonel, [redacted] MD
Chief, Department of Medicine

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STANDARD FORM 509 (REV. 7-91) BACK

MEDCOM - 1275

NSN 7540-00-634-4122

PROGRESS NOTES

RD

restraints loosened on (R) arm and reapplied. (R) arm [redacted] (b)(6)-2

only extremity restrained @ this time-

report on pt - assumed care. Pt agitated / restrained c̄ soft restraints (R) UE.

dial pulse (+), CR<3 sec. NGT c̄ initial 60cc Ensure/H2O feeding complete -

monitor for s/s of complication. Pressings to (L) LE / (L) UE c/o/i - @ this time. (b)(6)-2

Haldol 5mg IV per prior shift - monitor effectiveness. (b)(6)-2

Spoke c̄ interpreter: Stated that Pt is calling staff members by Iraqi names - and

is not oriented to place or time - cont. monitor. (b)(6)-2 LPN.

5mg Ambien per NG - monitor effect.

60 cc. Ensure ↑ per NG - monitor ~~effectiveness~~ c̄ / for s/s of complication - (R)

5mg Ambien per NG repeated 2° continually crying out - restlessness. Restraint

(R) UE intact, circulation unimpaired - has been released occasionally. (b)(6)-2 LPN.

Cont. monitor.

Pt relaxed, well-medicated/sedated - Ambien effective. Pt. c̄ gross episode of

urinary incont. full linen change - Pt. OOB to chair for Δ. Pressings

to (L) LE soaked c̄ urine. ∴ Pressing Δ'd soft restraint placed back (b)(6)-2 LPN.

on (R) LE. Cont. monitor.

(Continue on reverse side)

REGISTER NO.

WARD NO.

PROGRESS NOTES

Medical Record

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 1276

NSN 7540-00-634-4122

PROGRESS NOTES

ORD

Pt agitated, yelling repeatedly, pt appears disoriented & hallucinating per interpreter calling female nurse his daughter & desk at car, etc. Pt was given 5 mg IV Haldol @ 2200 s̄ improvement. Staff has repeatedly attempted to reassure pt & 2 long discussions c̄ him, through interpreter.

A & P:
ICU psychosis (i.e. delirium) s̄ improvement c̄ Haldol. Will order Ambien 5 mg to assist c̄ pt relaxing & sleeping. This will be essential for his recovery.

(b)(6)-4

LTC

03 Ortho note
Temp Max 101 Ax; slight tachycardia
Dressing changes done. tolerated NG feedings.
- TRIES to pull out NG tube.
Abd soft. Pt c̄ Psychosis present
- H/H - 7.7, K+ - 2.4
A: ① ② BE Amp, Open hip Fx c̄ infection
② ↓ K+, ~~↓ T. AR~~ ↓ H/B. ↓ H/H
P: ① Transfus 2 units PRBCs, gm K+, Re ✓ labs

(Continue on reverse side)

REGISTER NO.

WARD NO.

T'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)

POTUS # (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 1277

DATE

PROGRESS NOTES

14 Sep 03 ORTHO

Discussed c̄ JM - consider covering acinobacter.

will START Unasyn 3.0 gm IV q̄ 6 (b)(6)-2

15 Sep 03 OP Note

① b E Amp

open Fem Rx -

- I&D all areas

- Graphic Zeneba

- Gen EDL - min

Findings - Abscess ① Forearm ; + Purulence on Fem

- sent to Recovery in satisfactory Condition (b)(6)-2

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STANDARD FORM 509 (REV. 7-91) BACK

MEDCOM - 1278

NSN 7540-00-634-4122

PROGRESS NOTES

(b)(6)-4

:ORD

lood transfusion)

IP	O_2 SAT	HR	TEMP	RESP	
2/65	93%	105	100.3	22	Blood start #1 unit
02/68	97%	103	100.6	22	
10/71	94%	98	100.6	21	
112/67	92%	99	100.7	21	
113/73	94%	97	100.8	19	
117/74	95%	110	100.5	22	
109/72	93%	117	100.1	24	
111/64	95%	119	100.0	25	
108/71	93%	113	100.5	27	
115/78	94%	113	99.8	24	
109/65	94%	111	100.0	20	
116/72	95%	104	100.2	26	#1 complete
123/76	94%	99	99.3	24	#2 unit started
113/75	97%	111	99.0	24	
114/80	95%	101	99.3	24	
100/69	96%	106	99.6	25	
139/78	95%	110	99.8	22	
121/75	96%	100	100.2	23	
119/79	93%	104	100.0	23	
116/75	93%	106	101.2	22	1gm Tylenol PO
115/79	94%	109	101.5	24	
111/69	95%	115	101.9	25	#2 unit complete

(b)(6)-4

(Continue on reverse side)

REGISTER NO.

WARD NO.

:NT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; ... medical facility)

(b)(6)-4

Pot us

PROGRESS NOTES

Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 1279

NSN 7540-00-634-4122

PROGRESS NOTES

ECORD

Nutrition
Nursing reports pt tolerating TF. Per nursing notes, pt eating small amounts at meals. This am - drank apple juice + ate roll.
Diet: regular c̄ 1 can Ensure q 6°
Pt is actually receiving Ensure Plus 4 pts ~~6~~ cans/d = 1440 Kcal + 52 gm pro. in addition to cal/pro in oral regular diet. Needs previously estimated @ 2200 Kcal + 75-100 gm pro/d.
Labs alb 1.6 (14 sep) & K 3.6 (16 sep)
Alb will not respond to refeeding x 21 days
R/P ① May want to increase 1 can q 4° to provide greater portion of pro/cal needs.
② Change order to Ensure plus. Please
③ will follow + monitor oral intake

(b)(6)-2 MS, RD

ORTHO
VSS - Tax 101.7
Tolerated dressing change on left thigh c̄ discomfort.
(2) ARM packing - still painful. - No residuals
A: ① ② GE Amp
② ② Open fem Rx
P: ① Δ to Cnsn plus ② -Δ sleeper ③ ZTG tomorrow

(Continue on reverse side)

NT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)

REGISTER NO. (b)(6)-2 WARD NO.

PROGRESS NOTES
Medical Record

POTUS (b)(6)-4

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 1280

DATE

PROGRESS NOTES

19Sep03 OP Note

AE Amp; open Fem Fx

Same

ITO Arm c̄ loose closure. Dressing change Left Lg

Graph

GET EBL min

Findings ø Abscess

Sent to RR in SATISFACTORY CONDITION (b)(6)-2 [redacted]

22Sep03 Nutrition - follow up

S Nursing reports pt eating very little - still prefers Pepsi to anything else. Interpretor brought in local cuisine

Pt consumed ~300 cal, 10gm pro in bread/chix/pepsi

Pt c/o feeling full 2' tube feeding

O Labs 9/22 gluc 305 K 3.1 Bun/Cr 15/1.1

Diet Ensure Plus via NGT 2cans q. 6hr + Reg diet

A Pt receiving 2880 Kcal + 100gm pro via tube - additional Kcal c̄ oral diet. Appears to be meeting estimated needs, however decubiti suggestive of inadequate pro intake

R/P Continue ensure plus 8 cans/d. Will monitor oral intake via calc + stress importance, ... (b)(6)-2 [redacted] team

MS, RD

MAJ, RD

*U.S. Government Printing Office: 1996 - 404-763/20101

STANDARD FORM 509 (REV. 7-91) BACK

MEDCOM - 1281

NSN 7540-00-634-4122

PROGRESS NOTES

RECORD

3 A.M.
Urinary frequency.
U/A 250 glu, large bl, + 300 prot,
20 + RBCi
Random glu 305

A+P:
#1 - Dig. hyperglycemia c̄ underlying infection
(?? osteo) + on Cusure Plus. It
also likes sodas. This may sig.
development of diabetes.
- Trial oral sulfonylureal. Sometimes
c̄ this degree of hyperglycemia, insulin
is required to control blood sugar
- follow FBS
#2 - Uncertain of cause of proteinuria, but
microhematuria may be trauma related
2° Foley, recently removed. Monitor.

(b)(6)-2

(b)(6)-2
[redacted] Medical Corps
Lieutenant Colonel, Medical Corps
Chief, Department of Medicine

22 Sep 03 ORTHO
Has been afebrile x24°.
- granulation tissue on surface very clean. No obvious
abscess around femur. Bone exposed c̄ packing. ARM
c̄ Abscess packing going well. Ø glu / Bloodcu
Post residual void
wires w/ ✓ (Continue on reverse side)

WARD NO.

REGISTER NO.

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; gra[illegible] rank; rate; hospital or medical facility)

(b)(6)-2

- Immote seen above

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

Pot US

(b)(6)-4

MEDCOM - 1282

DATE 23 Sep 03 1501

PROGRESS NOTES

K.M.

Pt. δ delirium m/b confusion, hallucinations, insomnia, + uncooperativeness.

FBS 221 U/A. 100 mg % glu, large bl. δ 10-15 RBC, ⊖ nitrite + LE

A+P:

#1- Discussed delirium δ Dr. (b)(6)-2 [redacted] psychiatry + started Ativan yesterday, @ his rec. Pt slept better - monitor + ↑ Ativan, if necessary

#2- Hyperglycemia improved - monitor + ↑ glipizide if FBS > 100

#3- Urinary incont. attributed to # 1 + to osmotic diuresis 2° #2. Attempting to dx post - void residual. No evidence of infection

#4- Persistent ↓ K+, prob. 2° diet - Augment δ p.o. KCl

#5- Grade II sacral decubitus - poor nutrition, impaired mobility, + hyperglycemia, will [illegible]

(b)(6)-2 [redacted]

Chief, Department of Medicine

*U.S. Government Printing Office: 1996 - 404-763/20101

STANDARD FORM 509 (REV. 7-91) BACK

MEDCOM - 1283

ACLU-RDI 1099 p.67

DOD 005335

NSN 7540-00-634-4122

PROGRESS NOTES

ECORD

changed pt's dressing, pt tolerated, VS stable temp 100° no action taken c this time. Changed chux beneath pt c̄ assistance. Assessment complete — (b)(6)-2 [redacted] 9/1/02

0300 MPCBS, interpreter CBS

0520 pt urinated in cup for U/A, Alert, slept poorly through night, continues to incorer person, talking to himself, breathing regular s̄ difficulty — (b)(6)-2 [redacted] 9/1/02

03 0615 - Assumed pt care. Pt A & OX3 c̄ c/o pain in (L) LE. DRSG's to (L) amputation of upper ext & (L) LE CDI. (L) HC IV in (L) medial ankle patent & flushes easily. NG tube placement assessed. Pt incontinent x 1. Will continue to monitor. — (b)(6)-2 [redacted]

p03 0845 - Δ'd Drsg to (L) LE and pt tolerated procedure well. — (b)(6)-2 [redacted] LIV

03 1400 Assumed care. Pt sitting in bed s̄ c/o at this time. Will continue to monitor — (b)(6)-2 [redacted] LIV

1500 Assisted pt OOB TC. Assisted c̄ personal hygiene. Will continue to monitor — (b)(6)-2 [redacted]

1730 Assisted pt back to bed p̄ dinner. Pt ate ~ 48%. Pt now sleeping. Will continue to monitor — (b)(6)-2 [redacted]

2200 resting @ this time a s/s of distress will cont to monitor pt — (b)(6)-2 [redacted]

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)

REGISTER NO.

WARD NO.

PROGRESS NOTES

Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 1284

AUTHORIZED

CORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)

1950 34 y/o ♂ to (b)(3)-1 via FLA litter – sp blast injury. Open fx ⓛ femur + amputation of ⓛ forearm

NCO accompanying pt reports pt was wearing a back pack w an explosive in it. Transferred from Nagi hospital. On arrival, pt dssg dry & intact. Foley w 350cc urine output.

18g IV started in ⓡFA running NS bolus. 1gm Ancef given. Surgeon @ BS.

1960 Pt to XR. – urine dk amber, clear. Incident occurred yesterday. See SF 558.

Pt to go to OR after xrays. (b)(6)-2 on.

OSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
PONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	
		REGISTER NO.	WARD NO.

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)

POTUS (b)(6)-4 PW)

OOC

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

MEDCOM - 1285

(See Instructions on Back of this Sheet)

...GENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp): 21CSH- Mosul, Iraq

LOG NUMBER

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER (Specify)

ARRIVAL: ...E ...TH ...5 YR. 03 TIME 1900

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☒ AMBULANCE ☐ OTHER (Specify)

CURRENT MEDS. (tetanus immunization and other data): Voltarine injections, PCN, Tylox

ALLERGIES: 0

HOME TELE. NO. (Inc. area code)

HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

...PLAINT(S) (Include symptom(s), duration): ...last, multiple injuries / (L) arm partial amputation

SEX: M AGE: 34

TIME SEEN BY PROVIDER: 1903

VITAL SIGNS: 1905, 25, 86, 130, 22, 101 (O), 95%

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

34 y/o Iraqi male EPW received from Mosul Hospital. Was wearing a backpack with an explosive in it yesterday. The explosive detonated. (L) arm partial amputee - (b)(6)-2

PMHx: "Disc prolapse in back"

PSHx: 0

Last meal: Today 1200hrs

...ATEGORY (See reverse): ...ERGENT, ...GENT, ...N-URGENT

ORDERS	INITS.	TIME
2L LR	(b)(6)-2	1935
stat 6 Cr		1935
		1935
...GM		1940

S. as above

Blast injury 24 hrs ago.

Tx'd @ Iraqi facility

ID'd injuries: (L) femur fx

(L) arm / forearm amputation

(L) thigh ST injury

(L) tib fib

(4) MFW MFWs. - (B) feet (L) tib fib

UA: large blood 1.030.

13' 98 222 29

127 | 104 | 18 | 23

4.0 | 21 | 0.9

CK 1305

XR

(1) (R) wrist / forearm - traumatic amp @ wrist (+) FB

(2) femur - comm midshaft fx.

(3) tib fib - MF, 0 fx

(4) (B) feet - mult small frags 0 fx.

(5) pelvis - 0 fx (+) penile FB

C - Alert, GCS 15. Airway intact

CV - tachy

lungs - (B) ctm

abd - S/NT 0 guarding

GU - 0 scrotal trauma. penis c̄ abrasions

(+) foul odor

(L) femur - massive st degloving of thigh c̄ exposure of quad

Intact PP - 2+ pulse. Moves foot

(L) forearm - wrist disarticulation

~~(L) thigh~~

abd: S/NT/ND burns to lower abd

pelvis - stable

back - atraumatic

...SSMENT/DIAGNOSIS: (L) femur fx c̄ massive soft-tissue degloving; (L) forearm amputation; rhabdomyolysis

...SPOSITION (Check all that apply): HOME | FULL DUTY

QUARTERS: 24 Hrs. | 48 Hrs. | 72 Hrs.

MODIFIED DUTY UNTIL: DAY | MONTH | YEAR

REFERRED TO (Indicate clinic): EMERGENCY | TODAY | 72 HOURS | ROUTINE

ADMIT. TO HOSP. UNIT/SERVICE: OR → ICU

CONDITION UPON RELEASE: IMPROVED | UNCHANGED | DETERIORATED

TIME OF RELEASE: 2020

(CONTINUE ON SF 507, IF NEEDED)

PATIENT'S IDENTIFICATION (Mechanical imprint) FOR WRITTEN ENTRIES GIVE: Name - last, first, middle; SSN; DOB, service status, name and relation of sponsor or next of kin. (IMPORTANT: LIST FACILITY HOLDING TREATMENT RECORD).

(b)(6)-4

EPW

...PROVIDER AND ID STAMP: (b)(6)-2 ... MAJ, MC

...imitations and follow-up

...plans)

To OR c̄ ortho.

IVF given - 2L NS. HR ↓ to 110's

EMERGENCY CARE AND TREATMENT

STANDARD FORM 558 (Rev. 6-82)

MEDCOM - 1286

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

For use of this form, see AR 40-407; the proponent agency is The Office of the Surgeon General.

1. AGE: 34
HEIGHT:
WEIGHT:

2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): NKDA

3. PREVIOUS SURGERY [X] NO [ ] YES (type):

4. PROPOSED SURGICAL PROCEDURE: I+D @ L E + Ex Fix
I+D @ upper extremity + Revision Amputation

Medical Hx: 0

5. ADDITIONAL INFORMATION:
NPO since AROM
ROM/Musculoskeletal Limited LUE
Skin Appearance WNL

Hardware/ Prosthesis 0
Significant Other Waiting 0
Psychological/LOC Alert
Language/Culmral Iraq

Lab ✓
H&P ✓
UHCG N/A
Consent ✓

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ___ Potential for anxiety related to o Procedure o Body Image o Family Separation o Surgical Outcome o Other	o Pt. verbalizes any specific anxiety. o Pt. exhibits relaxed body posture. o Demonstrates age specific coping mechanisms	o Allow pt. to verbalize freely o Explain OR environment and answer questions regarding surgery. o Offer comfort measures, (e.g., warm blanket, touch) o Explain all nursing procedures before they are done. o Remain with pt. whenever possible. o Maintain family interface.
B. AERATION ___ Potential for respiratory dysfunction due to o Sedation o Existing Pulmonary Problems	o PT. will be able to breathe without difficulty during immediate intra-operative phase.	o Offer to elevate head of litter or offer pillow. o Observe pt. while awaiting surgery for signs of distress o Assist anesthesia during intubation and extubation
C. INTEGUMENT ___ Potential impairment of skin integuity due to ___ o Immobilization o Prep Solution o Tourniquet o ESU o Positioning o SCD	o PT. will not exhibit signs of impair-ment of skin integrity (e.g., reddened areas.	o Utilize pressure preventing devices on OR table and accessories. o Check for proper positioning and support to maintain good body alignment. o Pad pressure points. o Place ESU ground pad on non compromised skin surface area. o Keep prep fluids from pooling. o Select appropriate size ESU pad

9. PATIENT'S IDENTIFICATION (For typed or written entries give: Name- last, first, middle; grade; date; hospital or medical facility)

IRAQI (b)(6)-4

DA FORM 5179, JUN 91 Previous editions are obsolete. FH MDA OP 176 USAPA V1.0
1 May 00 (Revised)

MEDCOM - 1287

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to o Positioning o Tourniquet o Preexisting CV Problems	o Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse).	o Check for support stockings or ace wraps. If none, check with doctors. o Check that safety straps are correctly applied. o Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. o Check that rings have been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to o Transfer o Positioning E.2. ✓ Potential discomfort due to o Positioning	o Pt. will be transferred to OR table without difficulty. o Pt. will not experience unnecessary physical discomfort.	o Have sufficient people available for transfer. o Insure proper body alignment. o Allow patient to lie in position of comfort while waiting for surgery. o Offer support (i.e., pillows, bathtowels, etc.) for positioning.
F. NEUROMUSCULAR CONTROL F.1. ✓ Disminished visual perception due to being Sld o Contacts o Glasses F.2. ✓ Potential for decreased communictaion due to Spa o Language o Hearing Aids F.3. Potential injury due to dentures.	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR table. o Pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt. from the side. o Validate pt.'s understanding of verbal communications. o Verify removal of dentures.
G. OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs. o Potential for Loss of Body Heat	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes. o Maintain Body Temperature	OTHER NURSING INTERVENTIONS. Or continuation of above interventions. o Increase Room Temp (pts. 65years & older) o Maintain Room Temp between 74-81 degrees for pediatric pts. o Provide Warm Sheets/Fluids o Assist with applying bear hugger, as needed.

10. (b)(6)-2

11.

ADDITIONAL INTEROPERATIVE INTERVENTIONS NOTED.

Maj/a 25 Aug 03 DATE

o Patient goals and outcomes were met
o Prep solutions removed
o ESU site:
o Prep site:

12. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title)

(b)(6)-2 maj/a

DATE: 25Aug03 TIME: 1930

13. POSTOPERATIVE EVALUATION PREPARED BY

(b)(6)-2

DATE: 25Aug03 TIME: 0800 OR 2389

REVERSE OF DA FORM 5179, JUN 91

USAPA V1.0

MEDCOM - 1288

MEDICAL RECORD — **INTRAOPERA...**

For use of this form, see AR 40-407, the proponent agency is the office ...

TRANSPORTED TO OPERATING ROOM BY ...	2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY (b)(6)-2 (b)(6)-2 Maj/Ar
TIME PATIENT ARRIVED IN SUITE	4. PATIENT IN ROOM / NUMBER #1 TIME

Aug 03

5. PREOPERATIVE EMOTIONAL STATUS

☒ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER (Specify)

NTS: NKDA

6. NURSING PERSONNEL

SIGNED RUB	Sgt (b)(6)-2	RELIEF SCRUB	
SSIGNED IRCULATOR	Maj	RELIEF CIRCULATOR	

OSITION AND POSITIONAL AIDS (Specify)

☐ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☒ LEFT SIDE UP ☒ RIGHT SIDE UP

MMENTS: Bean bag for positioning axillary roll @ axilla, pillow @ arm

B6-2

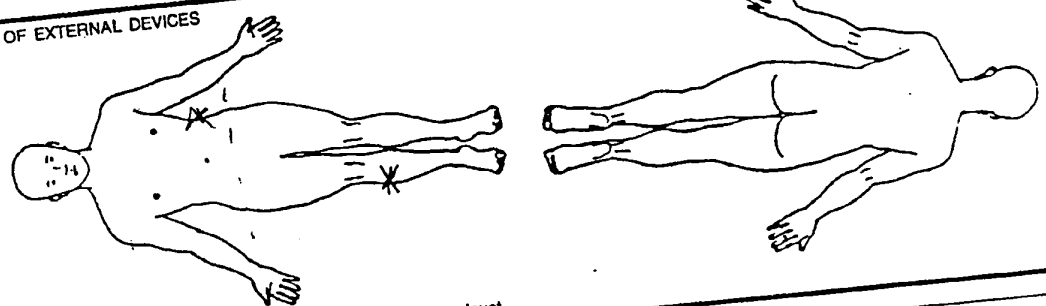
8. SKIN PREPARATION

AIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR
☐ CLIP

PREP SOLUTION (Specify) Beta/Beta
SITE: @ leg from dragon toes BY WHOM: [redacted]
SITE: @ arm BY WHOM: [redacted]
COMMENTS: no pooling or irritation

COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Strap --- Tourniquet

10. COUNTS		C = Correct I = Incorrect Other**	First Closing Count	Final Closing Count	SCRUB (b)(6)-2	CIRCULATOR (b)(6)-2
Sponge	☒ Yes ☐ No				Sgt	Maj
Needle Sharp	☒ Yes ☐ No					
Instrument	☒ Yes ☐ No					
Other	☐ Yes ☒ No					

11. PATIENT IDENTIFICATION (For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)

IRAQI (b)(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO

☒ ESU NO: Valleylab FX 000434
GROUND PAD: BRAND Valleylab E7507
LOT NO: 7611

☒ ESU NO: Valleylab FX 8006
GROUND PAD: BRAND Valleylab E7507
LOT NO: 70010

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE.

MEDCOM - 1289

13. PROSTHESIS, IMPLANTS ☒ YES ☐ NO

Wal # 0123003
34 x 2
36 x 1 > Screws
Leg Frag Set

IF YES NAME: ID NUMBER; MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☐

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

0.9% NS

OTHER ORDERS

Foley cath in place on arrival

	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE (b)(6)-2 [redacted]

15. X-RAY IN OPERATING ROOM YES ☒ NO ☐ IF YES, SITE L femur

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	NAME

TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1.	2.	3.
	Foley		
	Bader		

18. DRESSING/IMMOBILIZATION (Specify)

arm 4x8's Abd Kerlex ~~Ace wrap~~

leg 4x8's Xeroform Abd ~~Flex~~ Kerlex Ace wrap

ADDITIONAL INFORMATION

(b)(6)-2 [redacted]

(b)(6)-2 [redacted]

(b)(6)-2 [redacted]

OPERATION(S) PERFORMED

I & D L arm c̄ revision amputation

I & D L femur c̄ ex fix

PATIENT TRANSFERRED TO

ICU

REGISTERED NURSE (b)(6)-2 [redacted]

TIME Sep DA 7359

METHOD litter c̄ safety strap

SIGNATURE OF DA

MEDCOM - 1290

INTRAC[illegible]

MEDICAL RECORD

For use of this form, see AR 40-407, the proponent agency is the [illegible] REVIEWED AND PROCEDURE

T TRANSPORTED TO OPERATING ROOM
[illegible]ter BY anesthesia
TIME PATIENT ARRIVED IN SUITE
[illegible]Aug 03

2. PATIENT [illegible] (b)(6)-2 [redacted] May AD
VERIFIED BY [redacted] B

4. PATIENT [illegible] NUMBER
TIME

5. PREOPERATIVE EMOTIONAL STATUS

☑ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER (Specify)

NTS: alert

6. NURSING PERSONNEL

SIGNED RUB	Spc- (b)(6)-2 [redacted]	RELIEF SCRUB	
	Spc		
SSIGNED IRCULATOR	Maj	RELIEF CIRCULATOR	
	May		

OSITION AND POSITIONAL AIDS (Specify) Positioned on padded beanbag. Wax roll (R) arm positioned on padded Maj stand. Taped. Safety strapped to

☐ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☑ RIGHT SIDE UP

MMENTS: position

8. SKIN PREPARATION

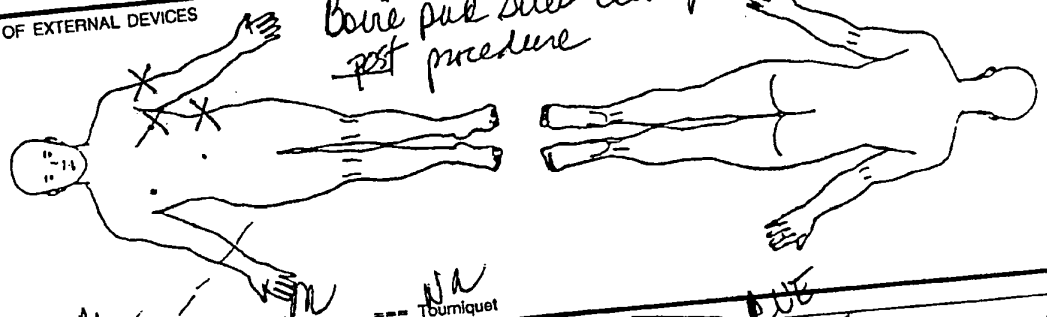
AIR REMOVAL ☐ YES ☑ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR
☐ CLIP

PREP SOLUTION (Specify) Betadine scrub/solution
SITE: (R) arm BY WHOM: Maj [redacted] B6-2
SITE: (R) leg. scrotum BY WHOM: Maj [redacted]
COMMENTS: No pooling noted

COMMENTS:

9. LOCATION OF EXTERNAL DEVICES

Bovie pad sites clear pre post procedure



LEGEND X Ground Pad M – Safety Strap M --- Tourniquet NA

10. COUNTS		C = Correct I = Incorrect Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☑ Yes ☐ No			C	(b)(6)-2 [redacted] RUE	(b)(6)-2 [redacted]
Needle Sharp	☑ Yes ☐ No			C	Spc (b)(6)-2 [redacted] RLE	
Instrument	☐ Yes ☑ No				Spc	
Other	☐ Yes ☑ No					

11. PATIENT IDENTIFICATION (For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)

Iraqi (b)(6)-4 [redacted]

12. ELECTROSURGERY DEVICE(S) (ESU) ☐ YES ☐ NO

☑ ESU NO: VAllefat 000434
GROUND PAD: BRAND Vallefat 75071
LOT NO: Exp 06May

☑ ESU NO: VAllefat 8006
GROUND PAD: BRAND Vallefat 75071
LOT NO: exp 06May

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE.

MEDCOM - 1291

13. PROSTHESIS, IMPLANTS ☑ YES ☐ NO

ASIF Screws

36 Cancel LLE

IF YES NAME: ID NUMBER; MANUFACTURER

14.

MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☐

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S):

09NS

OTHER ORDERS

	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM

YES ☑ NO ☐ LLE IF YES, SITE

16.

LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☐	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☐	NAME	NAME
CULTURE (C) YES ☐ NO ☐	NAME	NAME
AME	NAME	NAME
AME	NAME	NAME

TUBES, DRAINS/PACKING YES ☑ NO ☐

PE/SIZE	1.	2.	3.
18 Fr in	position prior to adm		
E	1.	2.	3.

18. DRESSING/IMMOBILIZATION (Specify)

4x8s, herlix, ace } LUE

4x8s LLE abds x4 herlix ace

ADDITIONAL INFORMATION

Unknown allergy status

(b)(6)-2

urgeons-

PERATION(S) PE

I:D LUE/LLE, Revision Stump amputation LUE

positioning LLE ExFix; Pinning LLE

TIENT TRANSFERRED TO

	TIME	METHOD
(b)(6)-2		litter c O2

May a

MEDCOM - 1292

MEDICAL RECORD

INTRAOPERATIVE

For use of this form, see AR 40-407, the proponent agency is the office of ...

1. TRANSPORTED TO OPERATING ROOM (b)(6)-2 BY (b)(6)-2 TIME PATIENT ARRIVED IN SUITE 0850

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY CPT (b)(6)-2

4. PATIENT IN ROOM TIME 0850 NUMBER 1

E 29/23

5. PREOPERATIVE EMOTIONAL STATUS

☒ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER (Specify)

MENTS: None

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC (b)(6)-2	top	RELIEF SCRUB	
	SPL	Bottom		
ASSIGNED CIRCULATOR	CPT		RELIEF CIRCULATOR	
	MAJ (b)(6)-2			

POSITION AND POSITIONAL AIDS (Specify)

☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

OMMENTS: none

8. SKIN PREPARATION

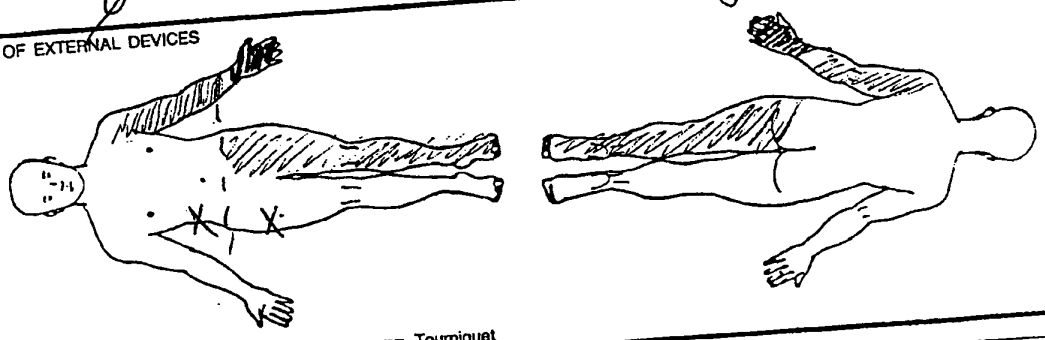
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR
☐ CLIP

COMMENTS: Ø

PREP SOLUTION (Specify) Betn S+S (b)(6)-2
SITE: LUE BY WHOM: MAJ
SITE: LLE BY WHOM: CPT (b)(6)-2

COMMENTS: no pooling of sol

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad – Safety Strap ═══ Tourniquet

10. COUNTS			C = Correct I = Incorrect Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes	☐ No		C	C	SPL (b)(6)-2	CPT (b)(6)-2
Needle Sharp	☒ Yes	☐ No		C	C	SPL	CPT
Instrument	☐ Yes	☒ No					
Other	☐ Yes	☒ No					

11. PATIENT IDENTIFICATION (For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)

Iraqi (b)(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO

☒ ESU NO: 000434 Valley Lab
GROUND PAD: BRAND
LOT NO: 75011 30/30

☒ ESU NO: 000429 Valley Lab
GROUND PAD: BRAND
LOT NO: 68536 30/30

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE.

MEDCOM - 1293

13. PROSTHESIS, IMPLANTS ☐ YES ☒ NO IF YES NAME: ID NUMBER; MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☒

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
Ø					

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):
LUE x 3Lt LLE x 3Lt.

OTHER ORDERS

	TIME	CARRIED OUT BY
Ø		

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM
YES ☐ NO ☒ IF YES, SITE

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	NAME

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 1/2" Penrose	2.	3.
SITE	1. LUE	2.	3.

18. DRESSING/IMMOBILIZATION (Specify)
LUE - xerofm, fluffs, Kerlix
LLE - xerofm, ABD's, Kerlix

19. ADDITIONAL INFORMATION

Dr. (b)(6)-2 - lower ext (L)

Dr. (b)(6)-2

Dr. (b)(6)-2 - upper ext (L)

OPERATION(S) PERFORMED
LUE stump revision
I & D LLE

PATIENT TRANSFERRED TO
I Cu 2 TIME 23 24 METHOD Primary

REGISTERED NURSE SIGNATURE (b)(6)-2

MEDCOM - 1294

ERSE OF DA FORM 5179-1 ...

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

For use of this form, see AR 40-407, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM
IA LITTLE BY MAT (b)(6)-2

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY MAT (b)(6)-2

3. DATE 1 SEPT 07 TIME PATIENT ARRIVED IN SUITE 1300

4. PATIENT IN ROOM TIME 1300 NUMBER 81

5. PREOPERATIVE EMOTIONAL STATUS

☐ CALM ☑ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS: PT INFORMED THRU TRANSLATOR, PT ON NARC'S

6. NURSING PERSONNEL

ASSIGNED SCRUB	(b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	MAT (b)(6)-2	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

☑ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

COMMENTS: ALL BONEY AREAS PADDED

8. SKIN PREPARATION

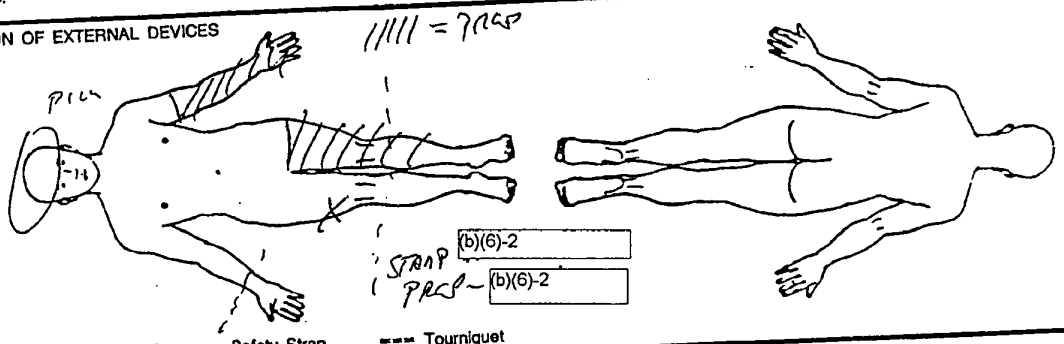
HAIR REMOVAL ☐ YES ☑ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* BETA / BETA
SITE: (L) ARM BY WHOM: MAT (b)(6)-2
SITE: (L) LEG BY WHOM: MAT

COMMENTS: NO POOLING OR REACTION

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad – Safety Strap ––– Tourniquet

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☑ Yes ☐ No			C	(b)(6)-2	(b)(6)-2
Needle Sharp	☑ Yes ☐ No			C		
Instrument	☐ Yes ☑ No					
Other	☐ Yes ☑ No					

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

IRAQI (b)(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☑ YES ☐ NO 40/40

☑ ESU NO: FOE 000434
GROUND PAD: BRAND Vollglet
LOT NO: 70011

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE.

MEDCOM - 1295

13. PROSTHESIS, IMPLANTS ☐ YES ☒ NO IF YES NAME: ID NUMBER; MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☐

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
None					

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S): N.S. PER P/LAVAGE

OTHER ORDERS IN & out CATH = 250 cc

	TIME	CARRIED OUT BY
	EOC	(b)(6)-2

PHYSICIAN'S SIGNATURE (b)(6)-2

15. X-RAY IN OPERATING ROOM YES ☐ NO ☒ IF YES, SITE

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

TYPE/SIZE	1.	2.	3.
SITE	1.	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
ARM = KERLIX, 4X8, ACE
LEG = KERLIX, 4X8, ACE

19. ADDITIONAL INFORMATION
SURGEON = (b)(6)-2
WC = IV CONTAMINATED

20. OPERATION(S) PERFORMED
I&D of (L) ARM & LEG

21. PATIENT TRANSFERRED TO ICU TIME 1400 METHOD LITTER

22. REGISTERED NURSE SIGNATURE (b)(6)-2

MEDCOM - 1296

MEDICAL RECORD — **INTRAOPERA... DOCUMENT**

For use of this form, see AR 40-407, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA litter BY Cpt (b)(6)-2

2. PATIENT IDENTIFIED ... PROCEDURE
VERIFIED BY (b)(6)-2 Mg AD

3. DATE 03 Sept 03 TIME PATIENT ARRIVED IN SUITE 0900

4. PATIENT IN ROOM TIME 0900 NUMBER 0900 (b)(6)-2

5. PREOPERATIVE EMOTIONAL STATUS

☑ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	Spc (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	Maj	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

Foam on < 90° padded armboard. Foam on double armboards. Safety strap over abd

☑ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

COMMENTS:

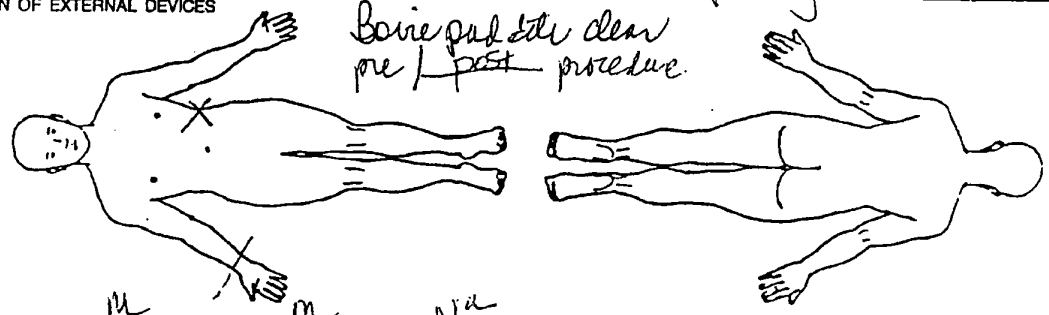
8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☑ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP
COMMENTS:

PREP SOLUTION *(Specify)* Betadine Scrub/Sol
SITE: (L) thumb BY WHOM: Maj (b)(6)-2
SITE: BY WHOM:
COMMENTS: No pooling noted

9. LOCATION OF EXTERNAL DEVICES

Bovie pad site clean pre/post procedure.



LEGEND X Ground Pad (M) – Safety Strap (M) === Tourniquet (NA)

10. COUNTS		C = Correct I = Incorrect: Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☐ Yes ☑ No					
Needle Sharp	☐ Yes ☑ No					
Instrument	☐ Yes ☑ No					
Other	☐ Yes ☑ No					

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

IRAQI (b)(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☑ YES ☐ NO

☑ ESU NO: Valleylab 00432
GROUND PAD: BRAND Valleylab F08742
LOT NO: exp 05/06

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE.

MEDCOM - 1297

ACLU-RDI 1099 p.81

DOD 005349

13. PROSTHESIS, IMPLANTS ☐ YES ☑ NO IF YES NAME: ID NUMBER; MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☐

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S):

09NS

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM YES ☐ NO ☑ IF YES, SITE

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☑	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☑	NAME	NAME
CULTURE (C) YES ☐ NO ☑	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

18. DRESSING/IMMOBILIZATION *(Specify)*

helix, fluffs, ace } L arm fluffs } leg

17. TUBES, DRAINS/PACKING YES ☐ NO ☑

TYPE/SIZE	1.	2.	3.
SITE	1.	2.	3.

19. ADDITIONAL INFORMATION

unknown allergy status

(b)(6)-2

20

I.D (L) Stump: Debriedment (D) Thigh

21. PATIENT TRANSFERRED TO ICU #1 TIME 0950 METHOD litter

22. (b)(6)-2

MEDCOM - 1298

REVERSE OF DA FORM 5170.1 PT

MEDICAL RECORD — **INTRAOPERATIVE DOCUMENT**

For use of this form, see AR 40-407, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Gurney BY [illegible]

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY CPT (b)(6)-2

3. DATE 9/5/03 TIME PATIENT ARRIVED IN SUITE 1545

4. PATIENT IN ROOM TIME 1545 NUMBER 4

5. PREOPERATIVE EMOTIONAL STATUS

☒ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS: none

6. NURSING PERSONNEL

ASSIGNED SCRUB	SRC (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT (b)(6)-2	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

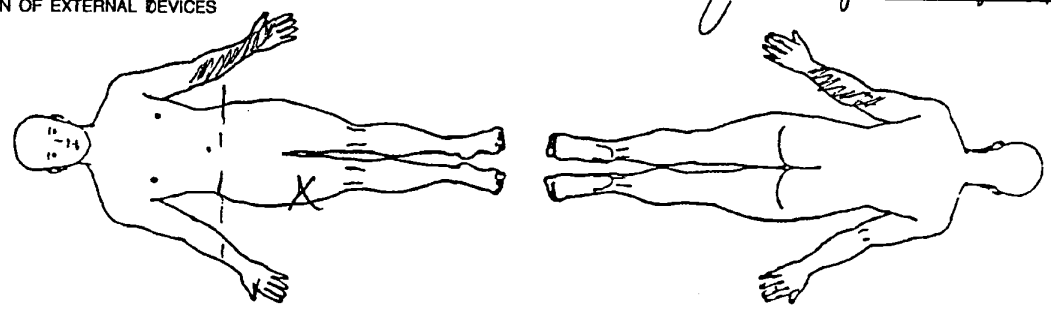
COMMENTS: none

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP
COMMENTS: Ø

PREP SOLUTION *(Specify)* Betadine STF
SITE: Left BY WHOM: SSG (b)(6)-2
SITE: BY WHOM:
COMMENTS: no grossly [illegible]

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad – Safety Strap ═══ Tourniquet

10. COUNTS		C = Correct I = Incorrect: Other**	First Closing Count	Final Closing Count
Sponge	☒ Yes ☐ No		C	C
Needle Sharp	☒ Yes ☐ No		C	C
Instrument	☐ Yes ☒ No			
Other	☐ Yes ☒ No			

SCRUB SRC (b)(6)-2 SRC

CIRCULATOR CPT (b)(6)-2 CPT

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

[illegible] (b)(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☐ YES ☒ NO

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:
☐ ESU NO:
GROUND PAD: BRAND
LOT NO:
☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACE FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE

MEDCOM - 1299

13. PROSTHESIS, IMPLANTS ☐ YES ☒ IF YES NAME: ID NUMBER; MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☒

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

(L) UE x 3 Lt. (L) thigh x 3 Lt

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM YES ☐ NO ☒ IF YES, SITE

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

18. DRESSING/IMMOBILIZATION (Specify)

(L) UE - Pluffs, Kerlix, ACE

(L) thigh - Kerlix

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

TYPE/SIZE	1.	2.	3.
SITE	1.	2.	3.

19. ADDITIONAL INFORMATION

Dr (b)(6)-2

20. OPERATION(S) PERFORMED

I+D (L) UE + (L) thigh

21. PATIENT TRANSFERRED TO [illegible] TIME [illegible] METHOD [illegible]

22. REGISTERED NURSE SIGNATURE (b)(6)-2 MEDCOM - 1300 [illegible]

REVERSE OF DA FORM 5179-1 [illegible]

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

For use of this form, see AR 40-407, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA LITER BY CAT (b)(6)-2

2. PATIENT IDENTIFIED AND PROCEDURE VERIFIED BY (b)(6)-2 RN

3. DATE 8 SEPT 07 TIME PATIENT ARRIVED IN SUITE 1040

4. PATIENT IN ROOM TIME 1040 NUMBER OR 2

5. PREOPERATIVE EMOTIONAL STATUS

☐ CALM ☒ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER (Specify)

COMMENTS: TRANSLATOR EXPLAINED PROCEDURE TO PT.

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	MAJ	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify)

☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

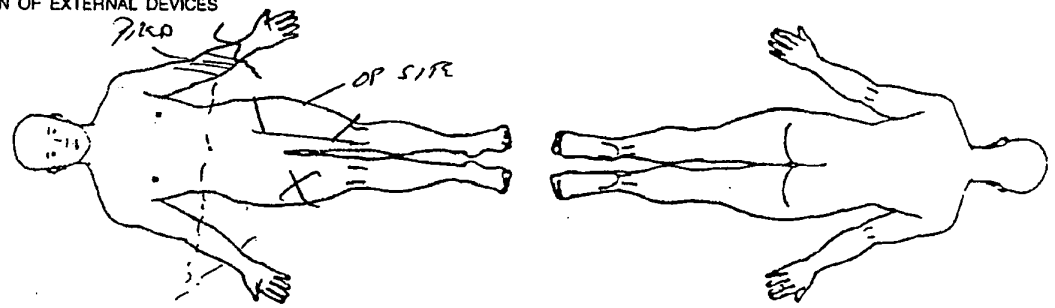
COMMENTS: ALL BONEY AREAS PADDED

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP
COMMENTS:

PREP SOLUTION (Specify) BETA / BETA
SITE: (L) ARM BY WHOM: MAJ [redacted]
SITE: BY WHOM:
COMMENTS: NO PROBLEMS OR REACTIONS. B6-2

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Strap === Tourniquet

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No		C	C	(b)(6)-2	(b)(6)-2
Needle Sharp	☒ Yes ☐ No					
Instrument	☐ Yes ☒ No					
Other	☐ Yes ☒ No					

11. PATIENT IDENTIFICATION (For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)

IRAQI (b)(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO 35/8T

☒ ESU NO: FOX 600497
GROUND PAD: BRAND Valleylab
LOT NO: 20111

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE.

MEDCOM - 1301

13. PROSTHESIS, IMPLANTS ☐ YES ☒ NO — IF YES NAME; ID NUMBER; MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☐

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
None					

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S): N. S.

OTHER ORDERS None	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE (b)(6)-2

15. X-RAY IN OPERATING ROOM YES ☐ NO ☒ IF YES, SITE

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	18. DRESSING/IMMOBILIZATION (Specify) FLUFFS, KERLIX, ACE WRAP

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

TYPE/SIZE	1.	2.	3.
SITE	1.	2.	3.

19. ADDITIONAL INFORMATION

SURGEON = DR (b)(6)-2

WC = WY

ESU POD SITE clean & Dry Pre & Post-OP

20. OPERATION(S) PERFORMED

(1) I & D — STUMP REVISION of (1) ARM

(2) LCC Dacron A

21. PATIENT TRANSFERRED TO ICU — TIME — METHOD Cart

22. REGISTERED NURSE SIGNATURE (b)(6)-2

REVERSE OF DA FORM 5179-1, OCT 81

MEDCOM - 1302

*U.S. GPO: 1998-404-813/40449

MEDICAL RECORD	INTRAOPERATIVE DOCUMENT For use of this form, see AR 40-407, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Gurney BY Anesthesia

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY (b)(6)-2

3. DATE 9/11/03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

☒ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS: Alert + Oriented

6. NURSING PERSONNEL

ASSIGNED SCRUB	Spc (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	Maj CPT	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

COMMENTS: none

8. SKIN PREPARATION

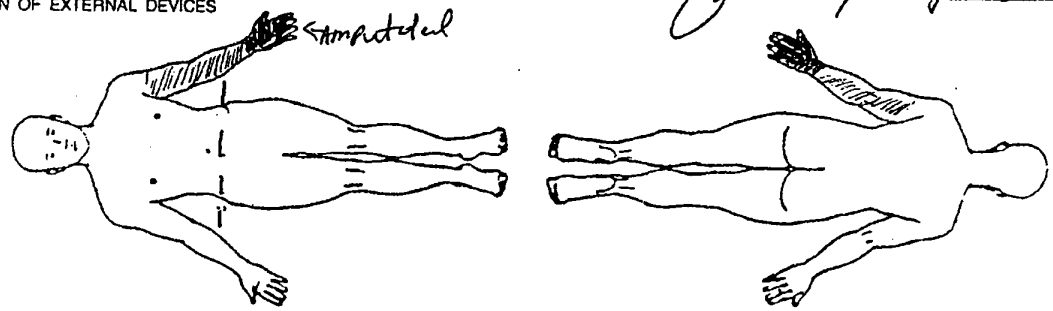
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS: B

PREP SOLUTION *(Specify)* Beta S & S
SITE: (L) UE BY WHOM: Maj [redacted]
SITE: BY WHOM: B6-2

COMMENTS: no pooling of solution

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Strap ▪▪▪ Tourniquet

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No		C	C	SPC (b)(6)-2	Maj (b)(6)-2
Needle Sharp	☒ Yes ☐ No		C	C	SPC	Maj
Instrument	☐ Yes ☒ No					
Other	☐ Yes ☒ No					

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

Frag: (b)(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☐ YES ☒ NO

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSO

MEDCOM - 1303

13. PROSTHESIS, IMPLANTS ☐ YES ☐ NO IF YES NAME: ID NUMBER MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☒

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

NSS X 2 Lt.

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM YES ☐ NO ☒ IF YES, SITE

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

TYPE/SIZE	1.	2.	3.
SITE	1.	2.	3.

18. DRESSING/IMMOBILIZATION (Specify)

(L)UE - Kerlix, Fluff, ACE.
(L)LE - Kerlia's

19. ADDITIONAL INFORMATION

Dr.
Dr

(b)(6)-2

20. OPERATION(S) PERFORMED

I + D of (L)UE + (L)thigh

21. PATIENT TRANSFERRED TO I Cu 1 TIME 1045 METHOD Gurney

22. REGISTERED NURSE SIGNATURE (b)(6)-2

REVERSE OF DA FORM 5179-1, OCT

MEDCOM - 1304

*U.S. GPO: 1996-404-613/40449

MEDICAL RECORD	INTRAOPERATIVE DOCUMENT For use of this form, see AR 40-407, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Litter BY (b)(6)-2

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY (b)(6)-2 Maj

3. DATE 13 Sept 03 TIME PATIENT ARRIVED IN SUITE 1805

4. PATIENT IN ROOM TIME 1805 NUMBER #1

5. PREOPERATIVE EMOTIONAL STATUS

☒ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER (Specify)

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	Spc (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	Maj	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify)

☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

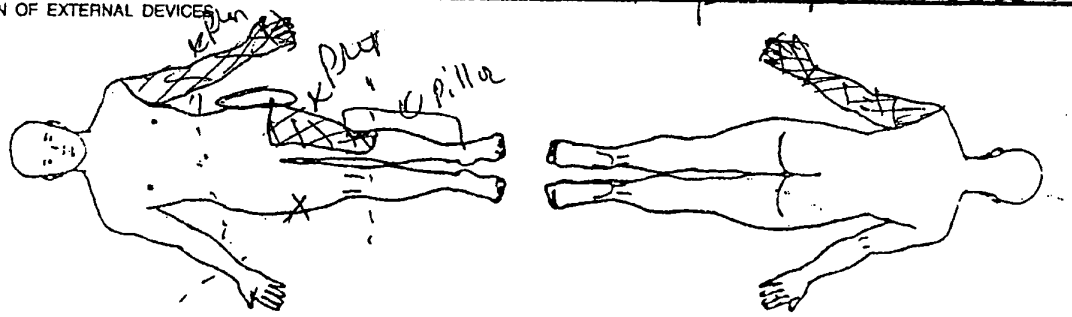
COMMENTS: Hip roll under (L) thigh & lower back - pillow between knees & under (L) knee

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP
COMMENTS:

PREP SOLUTION (Specify) Beta/Beta
SITE: (L) thigh & Exfix BY WHOM: [redacted] B6-2
SITE: (L) arm from stump to axilla circumferentially BY WHOM:
COMMENTS: no pooling or irritation

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Strap === Tourniquet

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☐ Yes ☐ No		C	C	(b)(6)-2	
Needle Sharp	☐ Yes ☐ No					
Instrument	☐ Yes ☐ No					
Other	☐ Yes ☐ No					

11. PATIENT IDENTIFICATION (For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)

IRAQI (b)(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☐ YES ☐ NO

☐ ESU NO: Valleylab 000434
GROUND PAD: BRAND E7507
LOT NO: 70011

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOL

MEDCOM - 1305

13. PROSTHESIS, IMPLANTS ☐ YES ☒ IF YES NAME: ID NUMBER: NUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☒

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

0.9% NS

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM YES ☐ NO ☒ IF YES, SITE

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) : YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	18. DRESSING/IMMOBILIZATION *(Specify)* fluffs kerlex ace wrap tape

17. TUBES, DRAINS/PACKING YES ☐ NO ☐

TYPE/SIZE	1.	2.	3.
SITE	1.	2.	3.

19. ADDITIONAL INFORMATION

(b)(6)-2

20. OPERATION(S) PERFORMED

I&D @ thigh wound
I&D @ arm stump, A-line placement

21. PATIENT TRANSFERRED TO ICU-1 TIME See DA 7384 METHOD Litter = safety straps

22. (b)(6)-2 Maj/A

REVERSE OF DA FORM 5179-1, OCT 87

*U.S. GPO: 1996-404-613/40449

MEDCOM - 1306

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

For use of this form, see AR 40-407, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OR VIA i/TTR BY (b)(6)-2

2. PATIENT IDENTIFIED AND PROCEDURE VERIFIED BY (b)(6)-2 MAS AD

3. DATE 15 Sept 07 TIME PATIENT ARRIVED IN SUITE 1422

4. PATIENT IN ROOM TIME 1422 NUMBER R2

5. PREOPERATIVE EMOTIONAL STATUS

☑ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER (Specify)

COMMENTS: Explained via Translator

6. NURSING PERSONNEL

ASSIGNED SCRUB	(b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	(b)(6)-2	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify)

☑ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

COMMENTS: all bony areas padded

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☑ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

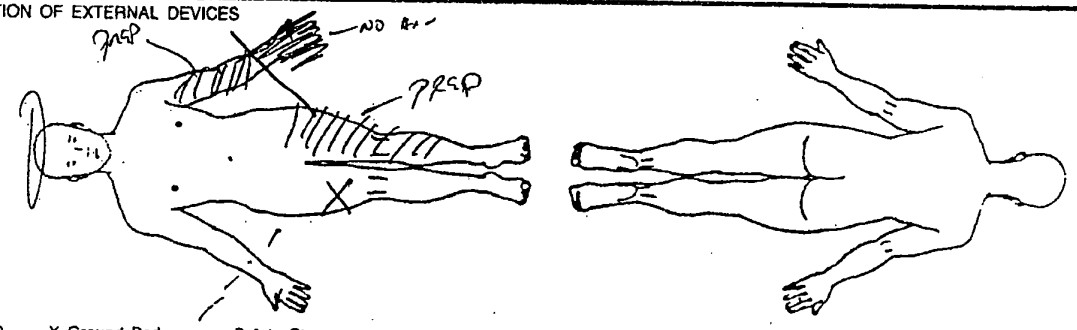
PREP SOLUTION (Specify) BETA/BETA

SITE: L ARM & LEG BY WHOM: (b)(6)-2

SITE: BY WHOM:

COMMENTS: NO POOLING OR REACTION

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Strap === Tourniquet

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count
Sponge	☑ Yes ☐ No		C	C
Needle Sharp	☑ Yes ☐ No		C	C
Instrument	☐ Yes ☑ No			
Other	☐ Yes ☑ No			

SCRUB (b)(6)-2

CIRCULATOR (b)(6)-2

11. PATIENT IDENTIFICATION (For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)

IRAQ (b)(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☑ YES ☐ NO

☑ ESU NO: FOE000434

GROUND PAD: BRAND Valleylab

LOT NO: 69621

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPL[illegible] DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBS[illegible] E.

MEDCOM - 1307

13. PROSTHESIS, IMPLANTS ☐ YES ☑ NO IF YES NAME: ID NUMBE MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☐

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
None					

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S):
N.S.

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE (b)(6)-2

15. X-RAY IN OPERATING ROOM YES ☐ NO ☑ IF YES, SITE

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☑	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☑	NAME	NAME
CULTURE (C) YES ☐ NO ☑	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☑ NO ☐

TYPE/SIZE	1. 16 Fr Foley	2.	3.
SITE	1.	2.	3.

18. DRESSING/IMMOBILIZATION (Specify)
Fluffs, KERLIX, ACE, IODAFORM

19. ADDITIONAL INFORMATION
SURGEON = (b)(6)-2
WC = 4
ECU pad site clean & dry Pre-OP, and POST-OP

20. OPERATION(S) PERFORMED
I & D of STump (L) ARM, AND (L) LEG

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU 1	SEE ANESTHESIA	LITTER

22. REGISTERED NURSE SIGNATURE (b)(6)-2 MAT AN

REVERSE OF DA FORM 5179-1, OCT 87

*U.S. GPO: 1996-404-813/40449

MEDCOM - 1308

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

For use of this form, see AR 40-407, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Gurney BY Anesthesia

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY CPT (b)(6)-2

3. DATE 9/29/03 TIME PATIENT ARRIVED IN SUITE 1115

4. PATIENT IN ROOM TIME 1115 NUMBER 2

5. PREOPERATIVE EMOTIONAL STATUS

☒ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS: none

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT V	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

COMMENTS: none

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

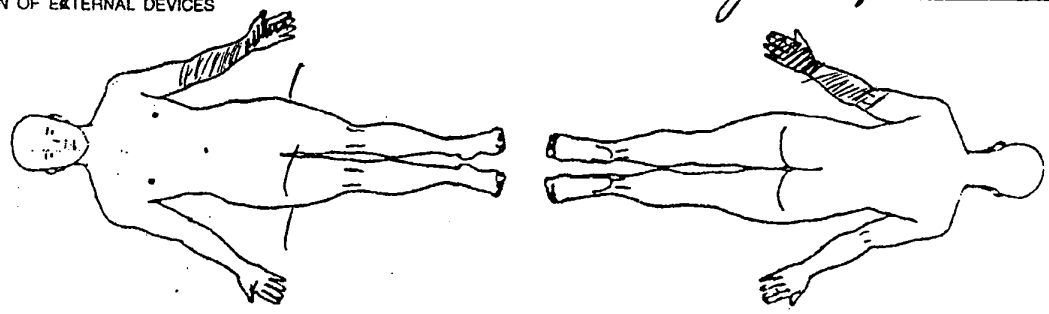
PREP SOLUTION *(Specify)* Betadine SRS

SITE DLE BY WHOM: CPT (b)(6)-2

SITE: BY WHOM:

COMMENTS: no shaving of site

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Strap === Tourniquet

10. COUNTS

C = Correct I = Incorrect

		Other**	First Closing Count	Final Closing Count
Sponge	☒ Yes ☐ No		C	C
Needle Sharp	☒ Yes ☐ No		C	C
Instrument	☐ Yes ☒ No			
Other	☐ Yes ☒ No			

SCRUB SPC (b)(6)-2

CIRCULATOR CPT (b)(6)-2 CPT

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

(b)(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☐ YES ☒ NO

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE.

MEDCOM - 1309

13. PROSTHESIS, IMPLANTS ☐ YES ☑ NO IF YES NAME: ID NUMBER; MANUFACTURER

8

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☑

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S):

NSS X 1 Wd

OTHER ORDERS	TIME	CARRIED OUT BY

8

PHYSICIAN'S SIGNATURE (b)(6)-2 19 Sep 03

15. X-RAY IN OPERATING ROOM YES ☐ NO ☑ IF YES, SITE

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☑	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☑	NAME	NAME
CULTURE (C) YES ☐ NO ☑	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

18. DRESSING/IMMOBILIZATION *(Specify)*

Fluffs, Kerlix, Ace

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 1/4" Iodoform	2.	3.
SITE	1. LUE stump	2.	3.

19. ADDITIONAL INFORMATION

Dr (b)(6)-2

20. OPERATION(S) PERFORMED

I+D LUE

21. PATIENT TRANSFERRED TO ICU TIME 1203 METHOD Cart

22. REGISTERED NURSE SIGNATURE (b)(6)-2 CPT, A

REVERSE OF DA FORM 5179-1, OCT 87

MEDCOM - 1310

*U.S. GPO: 1996-404-813/40449

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	25 Aug 03
DOS	25 Aug 03
POD	0

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	(b)(6)-2

Safety Checks	D	E	N
BVM at bedside			
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title) (b)(6)-2 | Department/Service/Clinic ICU-2 | DATE 26 Aug 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade; date; hospital or medical facility)*

Potus (b)(6)-4 (EPW)

☐ HISTORY PHYSICAL ☒ FLOWCHART

☐ OTHER EXAMINATION Or EVALUATION ☐ OTHER(Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 1311

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R			2			2			2			2		2				—						2
	RADIAL L			UTA			UTA			UTA			UTA		✱				—						UTA
	DORSALIS PEDIS R			2			2			2			2		2				—						UTA
	DORSALIS PEDIS L			2			2			2			2		2				—						UTA
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale				1 3 7			1 3 7			1 3 7			1 3 7		1 3 7				— — —						1 3 7
EDEMA																									
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)				✓			✓			✓			✓		R				—						✓
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)				NSR			NSR			NSR			NSR		NSR				—						NST
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH			✓			✓			✓			✓												
	FOLEY CARE														✓				—						
	ORAL CARE																								
MOBILITY	BEDREST			✓			✓			✓			✓		✓				—						✓
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE			✓			✓			✓			✓		✓				—						✓
	HOB 30 DEGREES														✓				—						✓
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)				✱																					
PAIN	PAIN FREE			✓			✓			✓			✓		✱	✱		✓							✱
	PAIN SCALE (1-10)																								
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended			2 ✓			2			2			2		2				2						2
BOWEL SOUNDS (active all quads)															✓				✓						✓
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT				✓			✓			✓			✓		✓				—						✓
VOIDING CLEAR, YELLOW URINE q.s.				✓			✓			✓			✓		✓				—						✓
SKIN INTEGRITY	No Breakdown																								
	Surgical Wounds																								
(R) Abd Scar	Rashes, Lac's, etc			✓			✓			✓			✓		✱				—						✓
DRESSING (Dry & Intact: specify site below)																									
#1 (L) LE	Fixator			✓			✓			✓			/		✱				—						
#2 (L) LE				/			/			/			/		✱				—						✓
#3 (R) ANKLE				✓			/			/			/		✱				—						✓

(b)(6)-2

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
CL	(R) IJV	25 Aug 03	CDI, patent
Foley	Brown	25 Aug 03	patent

ACLU-RDI 1099 p.96

DOD 005364

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable /Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment --

DATE: 28 Aug 03

TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open			3			4			4			4		4				-						3
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response			4			4			4			4		X				-						4
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response			5			5			5			5		X				-						5
GLASCOW COMA SCALE (A+B+C)			12			13			13			13		X				-						12
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — R														3R				-						
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — L														3R				-						
MOVEMENT (See Motor Function Scale at Top of Page) — RUE			4			4			4					4				-						4
MOVEMENT (See Motor Function Scale at Top of Page) — LUE			2			2			2					2				-						2
MOVEMENT (See Motor Function Scale at Top of Page) — RLE			3			3			3					2				-						2
MOVEMENT (See Motor Function Scale at Top of Page) — LLE			0			0			0					1				-						1
GRIP (S) Strong (W) Weak (-) absent — R			W			S			S					S				-						W
GRIP (S) Strong (W) Weak (-) absent — L			PWP			PWP			PWP					W				-						WP
RESPIRATIONS — REGULAR			✓			✓			✓									-						✓
RESPIRATIONS — IRREGULAR																								
RESPIRATIONS — UNLABORED			✓			✓			✓					✓				-						✓
RESPIRATIONS — LABORED																								
RESPIRATIONS — SHALLOW																								
RESPIRATIONS — RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RUL			5			5			5					5				-						5
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — LUL			5			5			5					5				-						5
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RLL			5			5			5					5				-						5
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — LLL			5			5			5					5				-						5
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — BOTH BASES			✓			✓			✓					✓				-						✓
COUGH — NONE			✓			✓			✓					✓				-						✓
COUGH — SPONTANEOUS																								
COUGH — PRODUCTIVE																								
COUGH — NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																								
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																								
VENTILATOR — Vt			RA			RA			RA															
VENTILATOR — FiO2																								RA
VENTILATOR — RATE (SIMV/CMV)																								
VENTILATOR — PEEP / CPAP																								
VENTILATOR — PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE — NC (l/min)														RA				-						
OXYGEN DELIVERY DEVICE — FM (l/min)																								
OXYGEN DELIVERY DEVICE — NRBM (l/min)																								
ETT #_____ — ETT _____cm gums																								
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED																								
INCENTIVE SPIROMETRY DONE						✓			✓					✓				✓						
COUGH / DEEP BREATH																								
INITIALS						(b)(6)-2																		

ACLU-RDI 1099 p.97

DOD 005365

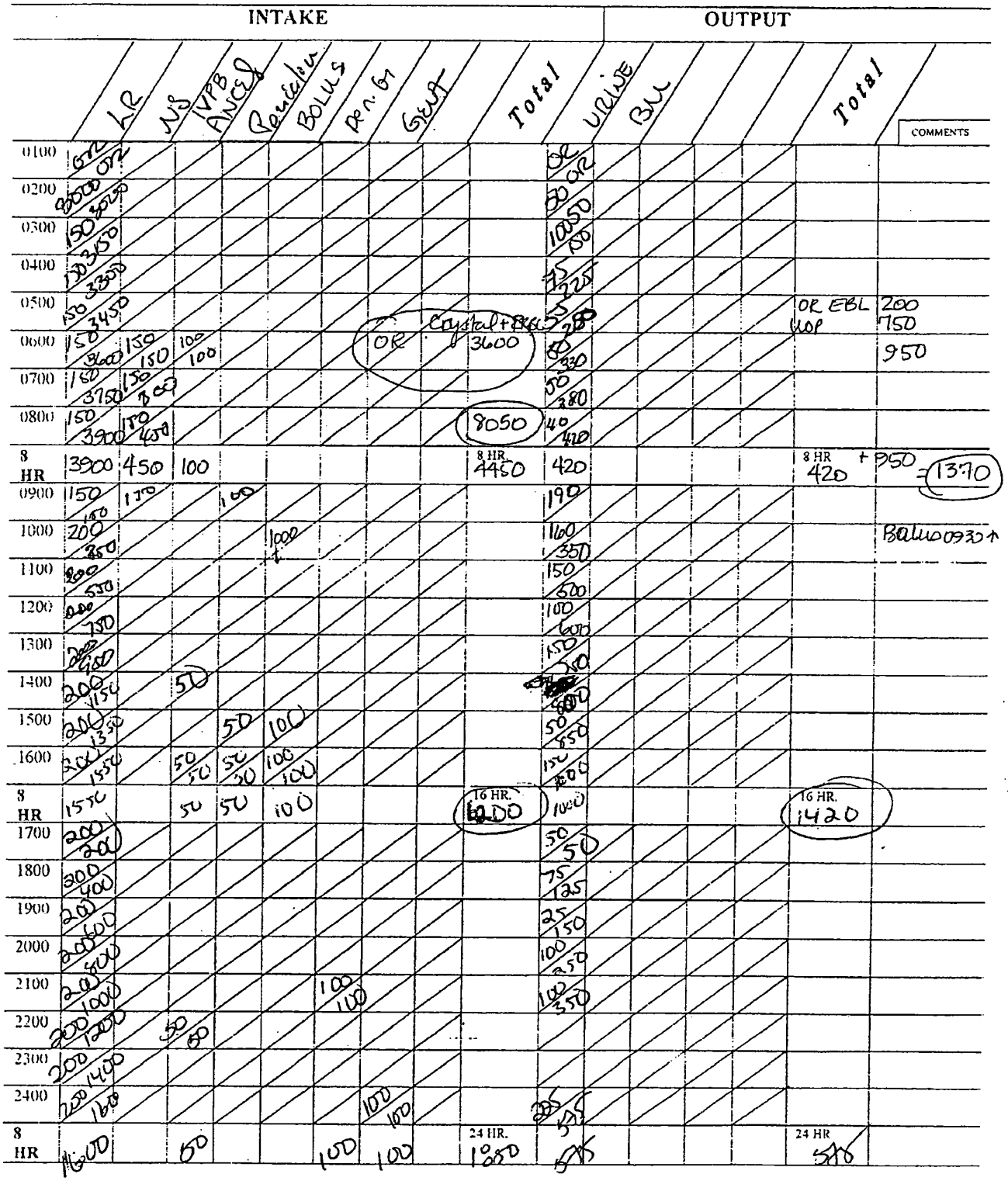
VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0145	95.4	115	19	131/82	95		103										RA
0200																	
0300	96.8	122	19	122/80	94		95										RA
0400	97.4	128	22	129/91	97		106										RA
0500	98.4	127	20	119/87	98		99										RA / NAD
0600	98.1	132	20	134/83	96%		105										RA/
0700	99.2	128	20	127/79	95%		98										RA
0800	98.6	128	18	133/84	96%		105										RA
0900	98.4	125	15	132/71	98%		102										RA
1000		131	23	137/85	95%	RA	107										
1100		136	20	147/81	95%		106										RA
1200		142	17	120/80	96%												USO4 4mg IVP
1300																	
1400	101.9	75	28	132/75	96%		101										see MAR for ↑ temp.
1500																	
1600	101.7	147	21	113/64	96%		84										
1700	101.7																
1800	100.6	136	19	129/75	97%		96										
1900																	
2000	99.2	137	22	159/86	93%		111										
2100																	
2200	100.4	127	19	131/64	90		103										RA/NAD
2300																	
2400	100.6	131	19	137/64	94		106										RA

ACLU-RDI 1099 p.98

DOD 005366

	INTAKE									OUTPUT						
	LR	NS	IVPB ANCEF	Penicillin	BOLUS	Pen. G	GENT		Total	URINE	BM				Total	COMMENTS
0100	OR OR									OR OR						
0200	8000 8000									50 50						
0300	150 3150									100 50 150						
0400	150 3300									75 225						
0500	150 3450									55 280					OR EBL UOP	200 750
0600	150 3600	150 150	100 100				OR		Crystal + [illegible] 3600	50 330						950
0700	150 3750	150 300								50 380						
0800	150 3900	150 450							8050	40 420						
8 HR	3900	450	100						8 HR. 4450	420					8 HR 420	+ 950 = 1370
0900	150 150	150		100						190						
1000	200 350				1000					160 350						Bolus 0930 ↑
1100	200 550									150 500						
1200	200 750									100 600						
1300	200 950									150 750						
1400	200 1150		50							[illegible] 800						
1500	200 1350			50	100					50 850						
1600	200 1550		50 50	50 50	100 100					150 1000						
8 HR	1550		50	50	100				16 HR. 6200	1000					16 HR. 1420	
1700	200 200									50 50						
1800	200 400									75 125						
1900	200 600									25 150						
2000	200 800									100 250						
2100	200 1000					100 100				100 350						
2200	200 1200		50 50													
2300	200 1400															
2400	200 1600						100 100			225 575						
8 HR	1600		50			100	100		24 HR. 1050	575					24 HR 575	



MEDCOM - 1315

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
26 Aug 03	0300		Pt resting NAD v/s stable MP CBS ASSESSMENT complete dressings intact LR @ 150 cc/hr to CL to (R) SV, UO 100cc will continue to monitor [b)(6)-2]
26 Aug 03	0410		Administered by RN on duty MS04 3mg pain pain via IV [b)(6)-2]
26 Aug 03	0530		Collected blood via JV per physicians instruction d/t low UO order rebally changed from CBC, Chem 7 to just Chem 7, no CBC, pt recieving 500cc bolus of NS as well as IV medication also per physician instruction [b)(6)-2]
	0600		Pt resting S/S/S of distress AM assessment completed (1) femur fracture dressing dry and intact (1) hand amputation dressing dry and intact, abdominal wounds midline foley catheter patent 60cc/hr @ 0700 ~~Acti~~ JV line infusing NS @ 150cc/hr patent. [b)(6)-2]
	0715		pt c/o pain 9-140 MS04 3mg given as per doctors Order [b)(6)-2]
	1000		Δ IVF to LR 200cc/hr as per doctors order started Pen G IV 2 million units 96 per doctors order Tetanus IG 250 units administered IM as per doctors order, D, 3mg OT IM @ 0900 as per doctors order see [b)(6)-2]
26 Aug 03		1400	received report from day shift nurse, pt. Ø S/S of SOB, C/O pain to (L) leg (via interpreter) pain medication given see MAR. Dressing to (L) leg c̄ moderate yellow drainage, (L) UE Amp site CDI, scrapes to ABD OTA & pink, scrapes to (R) LE OTA & scabbed over, ~~C/O~~ error will cont to monitor pt [b)(6)-2]
26 Aug 03		1530	Temp still elevated (see Vital sign sheet) wool blanket removed cotton sheet replaced, cool towel applied to head, Dr. [b)(6)-2] into see pt. Dressing Δ'd c̄ Dr. [b)(6)-2] to (L) LE, will cont. to monitor pt [b)(6)-2]
26 Aug 03		1630	C/O pain (via interpretor) pain meds given see MAR [b)(6)-2]

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	25 Aug 03
DOS	
POD	

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	(b)(6)-2
(b)(6)-2	
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside			
Monitor Alarms On		(b)(6)-2	
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2	ICU-2	27 Aug 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade;date; hospital or medical facility)*

Potus (b)(6)-4 (EPW)

☐ HISTORY/PHYSICAL ☑ FLOWCHART

☐ OTHER EXAMINATION Or EVALUATION ☐ OTHER(*Specify*)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 1317

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R			2			2									2							2		
	RADIAL L			UTA			UTA									A							DTA		
	DORSALIS PEDIS R			UTA			UTA									B							2		
	DORSALIS PEDIS L			UTA			UTA									B							2		
SKIN (1) Dry (4) Cool (7) Jaundiced (2) Clammy (5) Flushed (8) Color Normal (3) Warm (6) Cyanotic (9) Pale				1			1									1							1		
				3			3									3							3		
				7			7									7							7		
EDEMA																A									
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)				✓			✓									R									
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)				NSR												NSR									
SWAN GANZ CATHETER -(Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH																								
	FOLEY CARE															✓									
	ORAL CARE																								
MOBILITY	BEDREST			✓			✓									✓									
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE			✓			✓									✓									
	HOB 30 DEGREES			✓			✓									/									
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)				A			A																		
PAIN	PAIN FREE															A									
	PAIN SCALE (1-10)			✓			✓																		
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN (2) Soft & Flat (1) Distended				2			2									2									
BOWEL SOUNDS (active all quads)				✓			✓									✓									
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT				✓			—									—									
VOIDING CLEAR, YELLOW URINE q.s.				✓			—									/									
SKIN INTEGRITY	No Breakdown						—																		
	Surgical Wounds						—									A									
(R) abd 12e	Rashes, Lac's, etc			✓			✓																		
DRESSING (Dry & Intact: specify site below)																									
#1 (L) 2E fixator				✓			✓									D									
#2 (L) 2E amp				✓			✓									A									
#3 (R) ankle				✓			✓									A									

(b)(6)-2

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
CL	(R) IJ	25 July 03	CDI patent
Foley	Brown	25 July 03	patent

ACLU-RDI 1099 p.102

DOD 005370

PUPIL SIZE	PUPILS		MOTOR FUNCTION	CHART CODES
1 mm	=	Equal	0 = No Movement	Present ✓
2 mm	R	Reactive	1 = Slight Flicker/ Trace of Contraction	
3 mm	NR	NonReactive	2 = Active (Gravity Eliminated)	Not Applicable /Absent (blank)
4 mm	L > R	Left Larger	3 = Active: against gravity, but not against resistance 4 = Active: Against Gravity and Resistance, not full strength	Refer to Nsg. Notes X
5 mm	R > L	Right Larger	5 = Full Strength against Examiners Resistance	No Change from Previous Assessment --

DATE: 27 Aug 03

TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open			3			3									4			4						
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response			4			4									5			5						
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response			5			5									6			6						
GLASCOW COMA SCALE (A+B+C)			12			12									15			5						
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — R															2+			2+						
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — L															2+			2+						
MOVEMENT (See Motor Function Scale at Top of Page) — RUE			2			2									4			4						
MOVEMENT — LUE			AMP			AMP									A			A						
MOVEMENT — RLE			2			2									2			2						
MOVEMENT — LLE			1			1									2			2						
GRIP (S) Strong (W) Weak (-) absent — R			W			W									S			W						
GRIP (S) Strong (W) Weak (-) absent — L			AMP			AMP									A			A						
RESPIRATIONS — REGULAR			✓			✓									✓			✓						
RESPIRATIONS — IRREGULAR																								
RESPIRATIONS — UNLABORED			✓			✓									✓			✓						
RESPIRATIONS — LABORED																								
RESPIRATIONS — SHALLOW																								
RESPIRATIONS — RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RUL			5			5									5									
BREATH SOUNDS — LUL			5			5									5									
BREATH SOUNDS — RLL			5			5									5									
BREATH SOUNDS — LLL			5			5									5									
BREATH SOUNDS — BOTH BASES			✓			✓									✓									
COUGH — NONE			✓			✓									✓									
COUGH — SPONTANEOUS																		✓						
COUGH — PRODUCTIVE																								
COUGH — NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																								
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																								
VENTILATOR — Vt																								
VENTILATOR — FiO2																		R						
VENTILATOR — RATE (SIMV/CMV)																		C						
VENTILATOR — PEEP / CPAP																		O						
VENTILATOR — PRESS. SUPPORT																		M						
OXYGEN DELIVERY DEVICE — NC (l/min)			2			2									A			A						
OXYGEN DELIVERY DEVICE — FM (l/min)																		I						
OXYGEN DELIVERY DEVICE — NRBM (l/min)																		R						
ETT #_____ — ETT _____cm gums																								
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED																								
INCENTIVE SPIROMETRY DONE																								
COUGH / DEEP BREATH						✓												✓						
INITIALS	(b)(6)-2																							

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200	98.9	123	21	133/68	98		91										2LNC
0300	/	122	12	142/46	97		100										2LNC
0400	99.8	118	14	134/78	98		102										2LNC
0500																	
0600	98.4	112	14	142/85	98%		106										2LNC
0700		109	16	145/56	95%		107										2LNC
0800																	
0900	98.6	105	14	160/77	97%		122										2LNC
1000																	
1100																	
1200																	
1300																	
1400																	
1500	100.6	142	15	139/78	97%		97										1LNC
1600																	
1700	100.9	136	10	122/70	93%		89										RA
1800																	
1900	99.9	132	11	115/7	92%												RA
2000																	
2100	100.5	123	18	128/78	97%												
2200																	
2300	101.5	129	16	122/68	95%												RA
2400																	
0030																	

ACLU-RDI 1099 p.104

DOD 005372

	INTAKE								OUTPUT					
	LR	NS	ANCEF	GENT	PEN G	Dilaudid 2mg/cc	OR	Total	URINE	BM	OR		Total	COMMENTS
0100	200 200								115 115					
0200	200 400													
0300	200 600				50 50									
0400	200 800													
0500	200 1000								220 220					
0600	100 1100								150 370					
0700	100 1200			10 10					60 430					
0800	200 1400								60 490					
8 HR	200 1600							8 HR 1700 1650					8 HR 420	
0900					50 50	110 110			120 120					
1000														
1100														
1200														
1300														
1400	80 80						900 900			950 950				
1500	80 160				100 150				150 270					
1600	80 240			100 100					100 370					
8 HR	240			100	150	110	900	16 HR.	370	950			16 HR.	
1700	80 80								50 50					
1800	80 160		50 50						75 125					
1900	80 240								100 225					
2000	80 320								125 350					
2100	80 400		100 150						100 450					
2200	80 480								50 500					
2300	80 560								75 575					
2400	80 640		50 200						50 625					
8 HR								24 HR.					24 HR	

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
26 Aug 03		2200	received report from previous shifts 2220 drew lab from pt central line 2230 provided IVPB Antibiotic 2300 collected UA [redacted] 91WM6
26 Aug 03		2345	Assessment complete LRC 200cc/hr to (R) IS, Monitor c̄ alarms on B/P cuff to (R) arm Blood probes on chest PSO_2 probe on (R) toe (R) ankle gauze wrapping CDI, UTA pulse, cap refill <3sec, (R) thigh OTA abrasions, gelej to gravity, attached to (R) thigh patent c̄ yellow urine NAD (L) LE gauze c̄ tape over pins @ thigh bloody saturation to thigh no Δ per physicians instruction UTA (L) pedial pulse d/t dressing to toes (L) UE Cup c̄ ace wrapping CDI, ID bracelette attached to (L) shoulder LS CTA abd flat abrasions along waist pt not alert (R) IS patent, bandaging blood tinged MPCBS, UTA pain level interpreter CBS [redacted] 91WM6
27 Aug 03	0015		Hep flushed (R) IS by RN on duty 0115 pt put on 2L O_2 via NC PSO_2 89% by RT [redacted] 91WM6
27 Aug 03	0020		pt informed of NPO status [redacted] 91WM6
27 Aug 03	0285		pt c/o discomfort to (R) LE, RN on duty administered MSO4 [redacted] 91WM6
27 Aug 03	0300		Assessment complete PSO_2 probe (L) ear, pt on O_2 via 20% NCC 2L 97% no other changes from previous assessment. [redacted] 91WM6
	0600		AM Assistant completed VS P112. B/P 142/85 R 14 T98.4 IVF 1(R) 200cc/hr (L) Lung CTA, Congested (R) Lung. all Lobes SSg [redacted] 91WM6
	0900		Ded 1R IVF Δ for D5½ 20Kch as per data for ordering SSg [redacted] 91WM6
	1100		Pt in route to OR SSg [redacted] 91WM6

MEDCOM - 1322

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	Aug 25 03
DOS	25 Aug
POD	~~25 Aug 03 (DDS)~~ 1

24 HOUR DATA	
24 Hour Balance	+1565
24 Hour Intake	3890
24 Hour Output	-2325
Weight on Admission	unknown
Weight Yesterday	unknown
Weight Today	unknown
hospital balance	

NURSE'S SIGNATURE	Initials
(b)(6)-2	(b)(6)-2

Safety Checks	D	E	N
BVM at bedside			✓
Monitor Alarms On			✓
ID Bracelet On		JT	✓
Allergy Bracelet On			
Call Light Within Reach			N/A
Side Rails Up			N/A
Bed in Low Position			N/A

(b)(6)-2	Title) RN	Department/Service/Clinic ICU-2	DATE Aug 28, 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade; date; hospital or medical facility)*

POTUS (b)(6)-4 (EPW)

- ☐ HISTORY/PHYSICAL
- ☒ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☒ OTHER(Specify) Nursing notes
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 1323

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R		2		2				2						2								2		
	RADIAL L		UTA		UTA				UTA						UTA								UTA		
	DORSALIS PEDIS R		UTA		1				1						1								UTA		
	DORSALIS PEDIS L		UTA		1				1						1								UTA		
SKIN (1) Dry (4) Cool (7) Jaundiced (2) Clammy (5) Flushed (8) Color Normal (3) Warm (6) Cyanotic (9) Pale			1 3 7		1 3 7				1 3 7						1 3 7								1 3 8		
EDEMA (R arm)					✓																		✱		
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)			✓		✓										✓								✓		
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)			✓		✓										✱								ST		
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH								✓						✓										
	FOLEY CARE								✓						✓										
	ORAL CARE																								
MOBILITY	BEDREST																								
	BSC																								
	DANGLE																								
	CHAIR										✓														
POSITIONED	RIGHT																						4		
	LEFT																						5		
	SUPINE																						1		
	HOB 30 DEGREES		✓		✓				✓						✓								5		
FALLS PROTOCOL INITIATED																							✓		
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE		✓		✓																				
	PAIN SCALE (1-10)								5/10																
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN (2) Soft & Flat (1) Distended			2		2				2						1								1		
BOWEL SOUNDS (active all quads)			✓		✓				✓						✓								✓x4		
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT			✓		✓				✓						✓								✓		
VOIDING CLEAR, YELLOW URINE q.s.																									
SKIN INTEGRITY	No Breakdown																								
	Surgical Wounds		✓		✓				✓						✓								✓		
SCARS	Rashes, Lac's, etc																						✓		
DRESSING (Dry & Intact: specify site below)																									
#1 (L) LE Flexion			✓		✓				✓						✓								✓		
#2 (L) UE Amp			✓		✓				✓						✓								✓		
#3 (R) Ankle			✓		✓				✓						✓								✓		
									✓																

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
CL	(R) IJ	25 Aug 03	Intact
Foley	Groins	Aug 25, 03	Patent

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable /Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment --

DATE: 28 AUGUST 05

TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open		4		4								4		4								4		
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response		5		5								5		5								5		
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response		6		6								6		6								6		
GLASCOW COMA SCALE (A+B+C)		15		15								15		15								15		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — R		+2		+2								+2		+2								+3		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — L		+2		+2								+2		+2								+3		
MOVEMENT (See Motor Function Scale at Top of Page) — RUE		4		4								4		4								4		
MOVEMENT (See Motor Function Scale at Top of Page) — LUE		*		*								*		*								4A		
MOVEMENT (See Motor Function Scale at Top of Page) — RLE		2		2								2		2								2		
MOVEMENT (See Motor Function Scale at Top of Page) — LLE		2		2								2		2								2		
GRIP (S) Strong (W) Weak (-) absent — R		W		W								W		W								W		
GRIP (S) Strong (W) Weak (-) absent — L		*		*								*		*								*		
RESPIRATIONS — REGULAR		✓		✓								✓		✓								✓		
RESPIRATIONS — IRREGULAR																								
RESPIRATIONS — UNLABORED		✓		✓								✓		✓								✓		
RESPIRATIONS — LABORED																								
RESPIRATIONS — SHALLOW																								
RESPIRATIONS — RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RUL		5		5								5		5								5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — LUL		5		5								5		5								5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RLL		1		1								1		1								1		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — LLL		1		1								1		1								1		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — BOTH BASES		1/		1/								1/		1/								✓		
COUGH — NONE		✓		✓								✓		✓										
COUGH — SPONTANEOUS																								
COUGH — PRODUCTIVE																								
COUGH — NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																								
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																								
VENTILATOR — Vt																								
VENTILATOR — FiO2																								
VENTILATOR — RATE (SIMV/CMV)																								
VENTILATOR — PEEP / CPAP																								
VENTILATOR — PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE — NC (l/min)																								
OXYGEN DELIVERY DEVICE — FM (l/min)																								
ETT # _____ — NRBM (l/min)																								
ETT # _____ — ETT _____ cm gums																								
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED																								
INCENTIVE SPIROMETRY DONE														✓								✓		
COUGH / DEEP BREATH		✓		✓								✓		✓								✓		
INITIALS	(b)(6)-2																							

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200	101.7	115	16	120/73	95%												RA
0300																	
0400	99.3	116	18	118/70	96%												RA
0500																	
0600																	
	100.2	118	20	129/72	95%												RA
0700																	
0800																	
0900																	
1000																	
	98.7																
1100																	
1200																	
1300																	
1400	101.9	130	22	119/59	95%												RA
1500																	
1600																	
1700																	
1800																	
1900	99.9																
2000																	
2100																	
2200	100.9	120	20	137/73	93%	—	93										
2300																	
2400																	

ACLU-RDI 1099 p.110

DOD 005378

	INTAKE									OUTPUT						
	LR	~~IVPB Ancef~~	~~Gen~~	~~Pet~~	~~OR~~	PO			Total	Urine					Total	COMMENTS
0100	80 / 80									75						
0200	80 / 160									50 / 125						
0300	80 / 240	50 / 50		~~50~~						100 / 225						
0400	80 / 320									75 / 300						
0500	80 / 400									75 / 375						
0600	80 / 480	50 / 100								50 / 425						
0700	80 / 560									50 / 475						
0800	80 / 640	50 / 150				240 / 240				50 / 525						
8 HR	640	150				240			8 HR. 1030	525					8 HR 525	
0900	80 / 80									100 / 100						
1000	80 / 160					120 / 120				100 / 200						
1100	80 / 240									100 / 300						
1200	80 / 320	50 / 50				60 / 180				50 / 350						
1300	80 / 400					100 / 280				50 / 400						
1400	80 / 480					150 / 430				100 / 500						
1500	80 / 560	100 / 150				100 / 530				100 / 600						
1600	80 / 640	100 / 250				100 / 630				100 / 700						
8 HR	640	250				630			16 HR. ~~1520~~ 2550	700					16 HR. ~~700~~ 1225	
1700	80 / 80					250 / 550				100 / 100						
1800	80 / 160	50 / 50				150 / 400				100 / 200						
1900	80 / 240									100 / 300						
2000	80 / 320									100 / 400						625
2100	80 / 400	100 / 150								~~200~~ / ~~625~~						
2200	80 / 480									100 / ~~625~~						
2300	80					100				300						
2400	80	50								75						
8 HR	640	200				500			24 HR. 3890	1100					24 HR 2325	

MEDCOM - 1327

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
Aug 28, 03	0130		Resting well eyes closed. rises and fall of chest noted. Ø % discomfort at this time. Will cont to monitor per the order. (b)(6)-2
	0400		Sleeping NAD doing well. Ø Δ's from prior assessment. (b)(6)-2
	0600		received pt. NAD; resting c̄ eyes closed — (b)(6)-2
	0830		pt. received 2 mg MSO4 prior to sitting in chair; pt. had difficulty c̄ transfer to chair c̄ 75% assist; bath was given will cont. to monitor (b)(6)-2
	1230		wound care on LLE done; pt. premedicated before dx Δ; will cont. to monitor — (b)(6)-2
		1445	Assessment completed. (R) IV infusing LR @ 80cc/hr. Ø S/S of infection. (L) upper extremity amputation, dressing CDI, clear serosanguinous fluid noted on (L) leg at opertive sites. Foley draining clear dark yellow urine, Abdomen distended, but normal active bowel sounds x4. Abrasions on abdomen C+D, Breath sounds CTA, c̄ diminished bases bilaterally. (b)(6)-2
		1800	Medicated c̄ MSO4 per orders for transfer to chair. (b)(6)-2
		1745	Pt medicated c̄ MSO4 per orders for pain. Pt sitting up in chair. Pt ate 30% of meal. ~~PO~~ Pt Good PO fluid intake (b)(6)-2
		1830	Pt medicated c̄ ¼ Tylox per physician's order. Pt transferred Back to bed. moderate amount of drainage still noted from opertive site on (L) lower extremity. ~~will cont~~ Pt Good IS use. (b)(6)-2

MEDCOM - 1328

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	25 Aug 03
DOS	25 Aug 03
POD	2

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	
Hospital Balance	

NURSE'S SIGNATURE	Initials
(b)(6)-2 [signature]	(b)(6)-2
(b)(6)-2 BPC 91WMC	
(b)(6)-2 (CRN)	
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside			
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 [signature]	ICU-2	29 Aug 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade;date; hospital or medical facility)*

POTUS (b)(6)-4 (EPW)

- ☐ HISTORY/PHYSICAL
- ☐ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☒ OTHER(*Specify*) Nursing Note
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 1329

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R		2						2														2		
	RADIAL L		UTA						UTA						AmP								UTA		
	DORSALIS PEDIS R		UTA						UTA														UTA		
	DORSALIS PEDIS L		UTA						UTA														UTA		
SKIN (1) Dry (4) Cool (7) Jaundiced (2) Clammy (5) Flushed (8) Color Normal (3) Warm (6) Cyanotic (9) Pale			1 3 8						1 3 8														1 3 8		
EDEMA (R) arm			*						*						*								-		
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)			✓						✓						✓								✓		
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)			ST						✓						ST								✓		
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH								✓																
	FOLEY CARE																								
	ORAL CARE																								
MOBILITY	BEDREST																						✓		
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT																								
	LEFT																						✓		
	SUPINE																								
	HOB 30 DEGREES								✓						✓										
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE			PF				✓															*		
	PAIN SCALE (1-10)														7/10								✓		
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended														1								1		
BOWEL SOUNDS (active all quads)				WS				↓							WNL								X4		
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT				✓				✓							✓								✓		
VOIDING CLEAR, YELLOW URINE q.s.																									
SKIN INTEGRITY	No Breakdown																								
	Surgical Wounds			✓				✓							✓								✓		
	Rashes, Lac's, etc			✓				✓							✓								✓		
DRESSING (Dry & Intact: specify site below)																									
#1 (L) LE ex fix				✓				✓							✓								✓		
#2 (L) UE				✓				✓							✓										
#3 (R) ankle				✓				✓							✓								✓		
				(b)(6)-2																					

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
central line	(R) IJ	27 Aug 03	Opsite.

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable /Absent (blank)
Refer to Nsg. Notes N
No Change from Previous Assessment --

DATE: 29 August 03

TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open				4				4						4								4		
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response				5				5						5								5*		
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response				6				6						6								6		
GLASCOW COMA SCALE (A+B+C)				15				15						15								15*		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — R				3+				3+																
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — L				3+				3+																
MOVEMENT (See Motor Function Scale at Top of Page) — RUE				4				4						4								4		
MOVEMENT (See Motor Function Scale at Top of Page) — LUE BEA				*				*						*								—		
MOVEMENT (See Motor Function Scale at Top of Page) — RLE				4				4						4								4		
MOVEMENT (See Motor Function Scale at Top of Page) — LLE				3				3						3								3		
GRIP (S) Strong (W) Weak (-) absent — R				W				W						W								W		
GRIP (S) Strong (W) Weak (-) absent — L				—				—						—								AMP		
RESPIRATIONS — REGULAR				✓				✓						✓								✓		
RESPIRATIONS — IRREGULAR																								
RESPIRATIONS — UNLABORED				✓				✓						✓								✓		
RESPIRATIONS — LABORED																								
RESPIRATIONS — SHALLOW																								
RESPIRATIONS — RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RUL				5				5						5								5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — LUL				5				5						5								5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RLL				1				1						1								1		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — LLL				1				1						1								1		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — BOTH BASES				1				1						✓								✓		
COUGH — NONE				✓				✓						✓								✓		
COUGH — SPONTANEOUS																								
COUGH — PRODUCTIVE																								
COUGH — NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																								
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																								
VENTILATOR — Vt																						RA		
VENTILATOR — FiO2																								
VENTILATOR — RATE (SIMV/CMV)																								
VENTILATOR — PEEP / CPAP																								
VENTILATOR — PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE — NC (l/min)														2L										
OXYGEN DELIVERY DEVICE — FM (l/min)																								
ETT # _____ — NRBM (l/min)																								
ETT # _____ — ETT _____cm gums																								
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED																								
INCENTIVE SPIROMETRY DONE														✓										
COUGH / DEEP BREATH				✓				✓						✓										
INITIALS			(b)(6)-2																					

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200																	
0300																	
0400																	
0500																	
0600																	
0700																	
0800	100.3	111	14	140/81	95%											—	RA
0900																	
1000																	
1100																	
1200																	
1300																	
1400	102.1	130	21	103/58	94%												2L O2 NC
1500																	
1600																	
1700	99.7																
1800																	
1900																	
2000	99.4																
2100																	
2200																	
2220	98.6	107	19	127/75	83%		94										RA, NAD
2300																	
2400																	

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DOD 005384

	INTAKE										OUTPUT							
	LR	JUPD	OR	RR	PO					Total	Urine						Total	COMMENTS
0100	80 / 80										50							
0200	80 / 160																	
0300	80 / 240	50 / 50																
0400	80 / 320										400 / 450							
0500	80 / 400																	
0600	80 / 480	50 / 100																
0700	80 / 560																	
0800	80 / 640										500 / 950							
8 HR	640	100								8 HR. 740	950						8 HR 950	
0900	80 / 720																	
1000																		
1100	80 / 800																	
1200	80 / 880																	
1300	80 / 960																	
1400	80 / 40				100 / 100						500 / 500							
1500	80 / 120	100 / 100			100 / 200													
1600					100 / 300													
8 HR	480	100			200					16 HR.	500						16 HR.	
1700	80 / 560	100 / 100			240 / 240													
1800	80 / 640										560 / 500							
1900	80 / 720	100 / 200			100 / 340													
2000	80 / 800										125 / 625							
2100	80 / 880	100 / 300			100 / 440						150 / 775							
2200	80 / 960										150 / 925							
2300	80 / 1040																	
2400	80 / 1120																	
8 HR										24 HR.							24 HR	

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DOD 005385

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
29 Aug 03	04		Pt sleeping, easily arousable. 0 complaints @ this time. Encouraged a position change. done c̄ assist. Assessment complete pt back to sleep.
	0530		Pt request med for (L) arm pain. MSO4 IV given. Reminded of NPO status. Given H_2O to rinse mouth and spot. Complete corporation. Assistance given to move up in bed. [redacted] (b)(6)-2
	0800		recieved pt this AM; NAD; VSS; pt. NPO for surgery; will cont. to monitor [redacted] (b)(6)-2
	1025		pt. returned from surgery; NAD; VSS; will cont to monitor [redacted] (b)(6)-2
	1230		T max 103.7; [redacted] (b)(6)-2 informed; 650mg Tylenol given; will cont. to monitor [redacted] (b)(6)-2
		1410	Pt T-102.1. JS and CDB done. Pt uncovered, and cooling measures initiated. Assessment completed. A+O x 3. Breath sounds CTA c̄ diminished bases bilaterally. ~~Moderate~~ Minimal drainage from operative site noted at this time. ↓ Bowel sounds x4. Good po fluid intake. Non tender to palpation. Will continue to monitor - J Flaming
		1650	Occulsion noted from JS. Attempts to flush unsuccessful. [redacted] (b)(6)-2 notified. O_2 Sat 95% on RA [redacted] (b)(6)-2 RN
29 Aug 03		2210	pt received 650 mg Tylenol prn pain [redacted] (b)(6)-2
		2220	Assessment complete LR @ 80 cc/hr to (R) JS, patent & intact, b/p cuff to (R) arm PSO_2 monitor to (L) Earlobe, (L) Amp LE Elevated pt responds to commands, opens eyes spontaneously, interpretes CBS, MP CBS ID bracelette to (R) wrist (R) ankle guage wrap c̄ small amount of yellow fluid drainage to toes, (L) LE elevated, calf

(b)(3)-1

DARNALL ARMY COMMUNITY HOSPITAL

LOS DATA	
DOA	25 Aug 03
DOS	25 Aug 03
POD	4

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2 9/Aug/03	(b)(6)-2
(b)(6)-2 SRC 9/Aug/03	
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside			
Monitor Alarms On		(b)(6)-	
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 9/Aug/03	ICU-2	30 Aug 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle: grade; date; hospital or medical facility)*

Potus (b)(6)-4 (EPW)

☐ HISTORY PHYSICAL ☐ FLOWCHART

☐ OTHER EXAMINATION Or EVALUATION ☒ OTHER(Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 1335

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R				2		.		2															2	
	L				VTA				VTA															VTA	
	DORSALIS PEDIS R				VTA				VTA															VTA	
	L				VTA				VTA															VTA	
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale					3 8				1 3 8															1 3 8	
EDEMA					—				✓															NX	
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)					✓				—															✓	
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)					NSR				✓															NSR	
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH																								
	FOLEY CARE																								
	ORAL CARE																								
MOBILITY	BEDREST				✓				✓															✓	
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE				✓																			✓	
	HOB 30 DEGREES								✓															✓	
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)					—																			NX	
PAIN	PAIN FREE				✓				—															✓	
	PAIN SCALE (1-10)																								
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN (2) Soft & Flat (1) Distended					1				1															1	
BOWEL SOUNDS (active all quads)					X4				X4															X4	
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT					✓				✓															✓	
VOIDING CLEAR, YELLOW URINE q.s.																									
SKIN INTEGRITY	No Breakdown				✓				.															✓	
	Surgical Wounds								✓															✓	
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1 (L) LE ExFix					✓				✓															✓	
#2 (R) LE					✓				✓															✓	
#3 (R) ANKLE					✓				✓															✓	
					(b)(6)-2																				

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
CL	(R) IJ	27Aug13	Intact
Foley	GROW	25Aug13	patent

ACLU-RDI 1099 p.120

DOD 005388

PUPIL SIZE	PUPILS		MOTOR FUNCTION	CHART CODES
1 mm	=	Equal	0 = No Movement	Present ✓
2 mm	R	Reactive	1 = Slight Flicker/ Trace of Contraction	
3 mm	NR	NonReactive	2 = Active (Gravity Eliminated)	Not Applicable /Absent (blank)
4 mm	L > R	Left Larger	3 = Active: against gravity, but not against resistance 4 = Active: Against Gravity and Resistance, not full strength	Refer to Nsg. Notes X
5 mm	R > L	Right Larger	5 = Full Strength against Examiners Resistance	No Change from Previous Assessment –

DATE: 30 Aug 03

TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open				4				4						4									4	
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response				5				5						5									5	
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response				6				6						6									6	
GLASCOW COMA SCALE (A+B+C)				15				15						15									15	
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) R																								
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) L																								
MOVEMENT (See Motor Function Scale at Top of Page) RUE				4				4						4									4	
MOVEMENT (See Motor Function Scale at Top of Page) LUE				AMP				AMP						AMP									AMP	
MOVEMENT (See Motor Function Scale at Top of Page) RLE				3				3						3									3	
MOVEMENT (See Motor Function Scale at Top of Page) LLE				2				2						2									2	
GRIP (5) Strong (W) Weak (-) absent R				W				W						W									W	
GRIP (5) Strong (W) Weak (-) absent L				—				AMP						AMP									AMP	
RESPIRATIONS REGULAR				✓				✓						✓										
RESPIRATIONS IRREGULAR																								
RESPIRATIONS UNLABORED				✓				—						✓									✓	
RESPIRATIONS LABORED																								
RESPIRATIONS SHALLOW																							✓	
RESPIRATIONS RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished RUL				—				5						5									3	
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished LUL				—				5						5									3	
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished RLL				—				1						1									1	
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished LLL				—				1						1									1	
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished BOTH BASES				✓				✓						1/1									✓	
COUGH NONE				✓				✓															✓	
COUGH SPONTANEOUS														✓										
COUGH PRODUCTIVE																								
COUGH NONPRODUCTIVE														—										
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																								
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																								
VENTILATOR Vt				RA				RA						RA									RA	
VENTILATOR FiO2																								
VENTILATOR RATE (SIMV/CMV)																								
VENTILATOR PEEP / CPAP																								
VENTILATOR PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE NC (l/min)																								
OXYGEN DELIVERY DEVICE FM (l/min)																								
ETT #_____ NRBM (l/min)																								
ETT #_____ ETT _____cm gums																								
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED																								
INCENTIVE SPIROMETRY DONE														✓										
COUGH / DEEP BREATH								✓						✓										
INITIALS				(b)(6)-2																				

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200																	
0300																	
0400																	
0500																	
0600	100.4	70	20	121/74	91%												
0700																	
0800																	
0900																	
1000	102.6(A)	116	18	120/78	91%												
1100																	
1200																	
1300																	
1400	101.9	118	24	116/56	93%												RA
1500																	
1600	100.9																
1700	100.4																
1800																	
1900																	
2000																	
2100																	
2200																	
2300																	
2320	100.9	117	20	108/72	90%		91										RA/NAD
2400																	

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	INTAKE									Total	OUTPUT						Total	COMMENTS
	LR	PO	IVPB								URINE	BM						
0100	80 80																	
0200	80 160																	
0300	80 240																	
0400	80 320	100 100																
0500	80 400		50 50								975 975							
0600	80 480		100 150															
0700	80 560																	
0800	80 640										400 1375							
8 HR	640		150							8 HR. 790	1375						8 HR 1375	
0900	80 80																	
1000	80 160	120 120																
1100	80 240																	
1200	80 320	120 240																
1300	80 400	240 480																
1400	80 480	100 580	100 100								60 60							
1500	80 560	100 680	100 200								100 750							
1600	80 640	100 780	100 300								125 875							
8 HR	640	780	300							16 HR.	875						16 HR.	
1700	80 80	240 240									100 100							
1800	80 160		100 100								125 225							
1900	80 240		100 200															
2000	80 320																	
2100	80 400																	
2200	80 480										700 925							
2300	80 560																	
2400	80 640		50 350															
8 HR										24 HR.							24 HR	

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DOD 005391

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
8/30/03			
0600			recieved pt this AM; NAD; VSS; will cont to monitor [redacted]
		1400	Pt received in bed. Moderate drainage noted from (L) leg. (L) Amputation of ↑ extremities CDI. Lung sounds CTA c̄ diminished bases. Abdomen grossly distended, minimal bowel sounds. JS g 1°. IJ TLC CDI ∅ S/S of infection noted. NST. Will continue monitor. [redacted]
		1645	Pt remedicated c̄ 4mg MSO4 to get 60% Drainage from operative site, still moderate Will continue to monitor [redacted]
		1730	Pt medicated c̄ ⅟₂ Tylox for pain Dr [redacted] notified of Abdominal distention Pt Per Dr [redacted] ∅ solid foods. Will continue to monitor. [redacted] LBN
Aug 30, 03		2330	pt put on suplimental O2 via NC C 4L q/t PSO2 C 90% current PSO2 93% [redacted]
		2335	Assessment complete (L) UE ace wrapped cap CDI, (R) IJ CL CDI, patent (R) UE non-pitting edema ∅ c/o numbness cap refill <3sec. MPC BS (L) LE stitches OTA CDI, Lacerations from thigh to ankle (R) foot edematous, cap refill <3sec sluggish. Lacerations to (R) LE, pt moves extremities x4, abd rounded, distended, LS Rhonchi upper lobes, diminished lower lobes pt resting supine c̄ HOB elevated 30 degrees PSO2 probe on ~~Rig~~ Error (R) hand c̄ constant supervision, 80 cc/hr LR infusing into CL (R) IJ [redacted]
		2345	Administered Tylenol for elevated temp 100° will reassess temperature [redacted]
	0025		Began blood administration [redacted]
Aug 31, 03	0310		Assessment complete B/p cuff on (R) ARM

CRITICAL CARE FLOW SHEET

(b)(6)-2

LOS DATA	
DOA	31 Aug 03.
DOS	
POD	

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	(b)(6)-2

Safety Checks	D	E	N
BVM at bedside		(b)(6)-2	(b)(6)-2
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 LAC.	ICU #1	31 Aug 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade;date; hospital or medical facility)*

Lopez # (b)(6)-4

☐ HISTORY-PHYSICAL ☐ FLOWCHART

☐ OTHER EXAMINATION Or EVALUATION ☐ OTHER(*Specify*)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

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1 MAY 78

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		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R																2						2		
	RADIAL L																2						2		
	DORSALIS PEDIS R																1						1		
	DORSALIS PEDIS L																1						1		
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale																	1/0/18						1/3/8		
EDEMA																	+1						1		
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)																									
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)																									
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH																								
	FOLEY CARE																p								
	ORAL CARE																e								
MOBILITY	BEDREST																r								
	BSC																A								
	DANGLE																M								
	CHAIR																|								
POSITIONED	RIGHT																|								
	LEFT																|								
	SUPINE																|								
	HOB 30 DEGREES																|								
FALLS PROTOCOL INITIATED																	✓					✓			
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE																0					0			
	PAIN SCALE (1-10)																/10					/10			
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat																								
	(1) Distended																1		1				1		
BOWEL SOUNDS (active all quads)																	*						*		
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT																	✓								
VOIDING CLEAR, YELLOW URINE q.s.																	✓								
SKIN INTEGRITY	No Breakdown																								
	~~Surgical Wounds~~																%						%		
	Rashes, Lac's, etc																*								
DRESSING (Dry & Intact: specify site below)																									
#1																									
#2																									
#3																									

(b)(6) (b)(6)-2

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
(R) IJ	(R) IJ	27 Aug 03	c/b/l -

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DOD 005394

PUPIL SIZE	PUPILS		MOTOR FUNCTION	CHART CODES
1 mm	=	Equal	0 = No Movement	Present ✓
2 mm	R	Reactive	1 = Slight Flicker/ Trace of Contraction	
3 mm	NR	NonReactive	2 = Active (Gravity Eliminated)	Not Applicable /Absent (blank)
			3 = Active: against gravity, but not against resistance	
4 mm	L > R	Left Larger	4 = Active: Against Gravity and Resistance, not full strength	Refer to Nsg. Notes X
5 mm	R > L	Right Larger	5 = Full Strength against Examiners Resistance	No Change from Previous Assessment --

DATE: 31 Aug 03

TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open			4			4																		
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response			5			5																		
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response			6			6																		
GLASCOW COMA SCALE (A+B+C)			15			15																		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R					–																		
	L					–																		
MOVEMENT (See Motor Function Scale at Top of Page)	RUE		3			4																		
	LUE		WNL			–																		
	RLE		3			3																		
	LLE		3			3																		
GRIP (5) Strong (W) Weak (-) absent	R		5			5																		
	L		WNL			–																		
RESPIRATIONS	REGULAR					✓																		
	IRREGULAR																							
	UNLABORED		✓			✓																		
	LABORED																							
	SHALLOW		✓																					
	RETRACTIONS																							
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL		3			5																		
	LUL		3			5																		
	RLL		1			1																		
	LLL		1			1																		
	BOTH BASES		✓			1																		
COUGH	NONE		✓			✓																		
	SPONTANEOUS																							
	PRODUCTIVE																							
	NONPRODUCTIVE																							
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																								
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																								
VENTILATOR	Vt																							
	FIO2																							
	RATE (SIMV/CMV)																							
	PEEP / CPAP																							
	PRESS. SUPPORT																							
OXYGEN DELIVERY DEVICE	NC (l/min)		4L			1																		
	FM (l/min)																							
ETT #_____	NRBM (l/min)					--																		
	ETT _____ cm gums																							
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED																								
INCENTIVE SPIROMETRY DONE																								
COUGH / DEEP BREATH																								
INITIALS			(b)(6)-2																					

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0110	100.2	~~114~~ 110	20	129/66	94%		90										4L NC/NAD
0200																	
0240	99.2	111	20	124/71	94%		92										4L NC
0300																	
0340	99.2	109	20	129/78	95%		96										RA
0400																	
0440	99.6	107	18	126/75	97%		91										RA/NSOY
0500																	
0505	98.5	109	18	129/82	97%		100										
0600		109	20	132/81													RA/NAD
0700	100	105	18	121/78			97%	RA									
0800	99.5	105	18	129/78													2nd u PPBT complete
0900																	
1000																	
1100																	
1200	101.9																Tylenol
1300																	
1400																	
1500																	
1600																	
1700																	
1800																	
1900																	
2000																	
2100																	
2200																	
2300																	
2400																	

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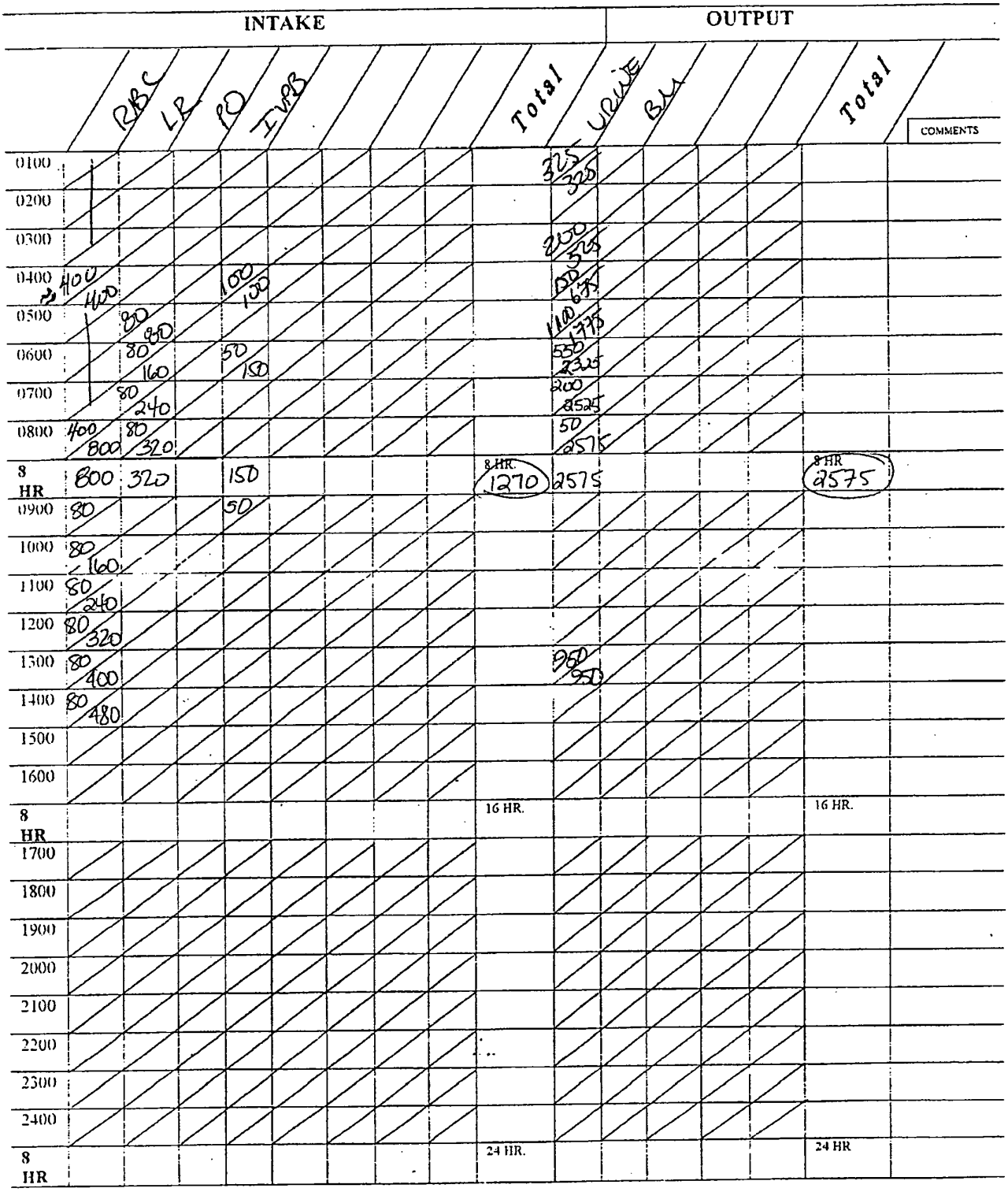
DOD 005396

	INTAKE									OUTPUT						
	RBC	LR	PO	IVPB					Total	URINE	BM				Total	COMMENTS
0100										325 / 325						
0200																
0300										200 / 525						
0400	400 / 400			100 / 100						150 / 675						
0500		80 / 80								1100 / 1775						
0600		80 / 160		50 / 150						550 / 2325						
0700		80 / 240								200 / 2525						
0800	400 / 800	80 / 320								50 / 2575						
8 HR	800	320		150					8 HR. 1270	2575					8 HR 2575	
0900	80			50												
1000	80 / 160															
1100	80 / 240															
1200	80 / 320															
1300	80 / 400									950 / 950						
1400	80 / 480															
1500																
1600																
8 HR									16 HR.						16 HR.	
1700																
1800																
1900																
2000																
2100																
2200																
2300																
2400																
8 HR									24 HR.						24 HR	



MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
31 Aug 03	0310		(continued) PSO2 monitor on (R) hand RBC transfusion continuing into (R) IJ CL, pt continues to place pressure on line, MPC BS abd causing pt discomfort but pt denies pain to that area, UO remains adequate — (b)(6)-2 [illegible]
	0330		pt's efforts to stop flow of blood had dislodged NC, NC was removed, client currently sats @ 97% @ RA will continue to monitor — (b)(6)-2 [illegible]
31 Aug 03	0425		First unit of RBCs administered — (b)(6)-2 [illegible]
	0455		Initiated 2nd Unit PRBC Unit # 55 T20133. See separate progress note for vitals. Pt remains alert and request H_2O. H_2O given to rinse and spit. NPO status effective. Blood infusing ↓ difficulty. Ø reaction observed in 1st 15 minutes. Will continue to monitor c LOS care. — (b)(6)-2 [illegible]
31 Aug 03	0600 hrs		Report received, assumed care of pt. #2 U PRBCs ↑ infusing into (R) IJ TLC. See flowsheet for details of assessment. Pt using incentive spirometer. Abd cont distended, mildly firm + tympanic to palpation. BS x4, ~~tinkling~~ tinkling and high pitched in all 4 quads. (L) LE incision open to air, sutures in tact ø drainage noted. — (b)(6)-2 [illegible]
		0800 hrs	2nd U PRBCs completed. Pt medicated c Sylox TIPO ~~[illegible]~~ to get OOB. — (b)(6)-2 [illegible]
		1000 hrs	Pt back to bed, up in chair x 1 hr. Dulcolax suppository given per Dr (b)(6)-2 Pt placed on bedpan. Repeat labs done. — (b)(6)-2 [illegible]
		1245 hrs.	Pt requested bedpan. Sm amt smearing of stool ø BM. (R) IJ TLC continues very positional, o/w infusing/indifferent (b)(6)-2

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	25 Aug 03
DOS	
POD	

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	(b)(6)-2
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside			
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2	ICU-2	31 Aug 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade;date; hospital or medical facility)*

Potts (b)(6)-4 EPW

☐ HISTORY PHYSICAL ☐ FLOWCHART

☐ OTHER EXAMINATION Or EVALUATION ☒ OTHER(Specify) PROGRESS NOTES

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700
1 MAY 78

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CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	25 Aug 03
DOS	
POD	

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2 9 Nurse 2	(b)(6)-2
(b)(6)-2 MAS RN	

Safety Checks	D	E	N
BVM at bedside			
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 9 Nurse 2	ICU-2	31 Aug 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade; date; hospital or medical facility)*

Potus (b)(6)-4 EPW

☐ HISTORY/PHYSICAL ☐ FLOWCHART

☐ OTHER EXAMINATION Or EVALUATION ☒ OTHER(Specify) PROGRESS NOTES

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 1348

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200																	
0300																	
0400																	
0500																	
0600																	
0700																	
0800																	
0900																	
1000																	
1100																	
1200																	
1300																	
1400																	
1500																	
1600	101.5	90	18	125/74													
1700																	
1800	100.8																
1900																	
2000																	
2100																	
2200																	
2300																	
2400																	

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DOD 005401

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable /Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment –

DATE:

TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open																4						4		
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response																5						5		
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response																6						6		
GLASCOW COMA SCALE (A+B+C)																15						15		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — R																+								
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — L																+								
MOVEMENT (See Motor Function Scale at Top of Page) — RUE																5						5		
MOVEMENT (See Motor Function Scale at Top of Page) — LUE																0						2		
MOVEMENT (See Motor Function Scale at Top of Page) — RLE																3						3		
MOVEMENT (See Motor Function Scale at Top of Page) — LLE																3						3		
GRIP (S) Strong (W) Weak (-) absent — R																5-						5		
GRIP (S) Strong (W) Weak (-) absent — L																-								
RESPIRATIONS — REGULAR																						5		
RESPIRATIONS — IRREGULAR																5								
RESPIRATIONS — UNLABORED																						5		
RESPIRATIONS — LABORED																5								
RESPIRATIONS — SHALLOW																								
RESPIRATIONS — RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RUL																						5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — LUL																5						5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RLL																5						4		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — LLL																4						4		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — BOTH BASES																5						4		
COUGH — NONE																						✓		
COUGH — SPONTANEOUS																								
COUGH — PRODUCTIVE																								
COUGH — NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																								
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																								
VENTILATOR — Vt																								
VENTILATOR — FIO2																								
VENTILATOR — RATE (SIMV/CMV)																								
VENTILATOR — PEEP / CPAP																								
VENTILATOR — PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE — NC (l/min)																								
OXYGEN DELIVERY DEVICE — FM (l/min)																								
OXYGEN DELIVERY DEVICE — NRBM (l/min)																								
ETT #_____ — ETT _____cm gums																								
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED																								
INCENTIVE SPIROMETRY DONE																								
COUGH / DEEP BREATH																								
INITIALS																(b)(6)-2								

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DOD 005402

	INTAKE									OUTPUT						
	IV	IGPB							Total						Total	COMMENTS
0100																
0200																
0300																
0400																
0500																
0600																
0700																
0800																
8 HR									8 HR.						8 HR	
0900																
1000																
1100																
1200																
1300																
1400																
1500																
1600																
8 HR									16 HR.						16 HR.	
1700		260/450														
1800		225/500								350					Foley o/k'd	
1900																
2000																
2100																
2200																
2300																
2400																
8 HR									24 HR.						24 HR	

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
31 Aug 03		1530	Pt. arrived/assisted transport from icu #2. VSS-febrile @ 101.5 - previously given tylenol. Will re-assess later, promote is use. Pressing Intact - c̄ ⊕ weeping ⊕ thigh. [redacted]
		1730	Pt. ↑ - used BSC - ⊕ loose stool - approx 100cc. Pnt CXR per order - temp re-check @ 100°. Interpreter called several times to explain NPO status. Pain med - Tylox x2 for c/o leg pain ⊕ LE. Positioned for comfort. Cont. monitor. [redacted]
31AUG03		2100	IJ d/cat following KCL infusion. Stitches removed/pressure applied for 5min. OPSITE IN PLACE OVER 2x2 - ⊖ drng noted @ this time [redacted]
		2150	Assumed care of pt. Drsg Δ performed pt tolerated well. Redressed per order.
		2250	Pt c̄ c/o pain to LLE. Δ Clinic aware. orders given. pt medicated per order. will monitor for effect. [redacted]
		2300	assessment per flowsheet. ⊕ needs c̄ opsite and 2x2 drsg D&I, abd distended hypoactive bowel sounds x3 quads shrunk LUQ, most active RLQ. Tympany to percussion LLE are wrap D&I ⊕ drainage noted LLE Drsg D&I small out of drainage noted posterior lateral portion. [redacted]

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	1 Sep 25 Aug 03
DOS	
POD	

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	(b)(6)-2
(b)(6)-2	
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On	NA		
Call Light Within Reach	NA	(b)(6)-2	
Side Rails Up	NA		
Bed in Low Position	NA		

PREPARED (b)(6)-2 (Rank and Title) RD | Department/Service/Clinic ICU 1 | DATE 1 Sep 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade; date; hospital or medical facility)*

Potus (b)(6)-4

- ☐ HISTORY/PHYSICAL ☐ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION ☐ OTHER(*Specify*)
- ☐ DIAGNOSTIC STUDIES 9VI
- ☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 1353

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R							2							2										
	L							NA							NA										
	DORSALIS PEDIS R							2							2										
	L							2							2										
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale								1 3 8							1 3 8										
EDEMA								+1							+1										
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)								✓							✓										
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)								✓							✓										
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH							✓																	
	FOLEY CARE																								
	ORAL CARE							✓																	
MOBILITY	BEDREST							✓							✓										
	BSC																								
	DANGLE																								
	CHAIR							✓																	
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE							✓							✓										
	HOB 30 DEGREES							✓							✓										
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE														✓										
	PAIN SCALE (1-10)							1/4																	
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended							2							1										
BOWEL SOUNDS (active all quads)								+/yo							no										
NG / DOBHOFF PLACEMENT VERIFIED															✓										
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT																									
VOIDING CLEAR, YELLOW URINE q.s.																									
SKIN INTEGRITY	No Breakdown																								
	Surgical Wounds							✓							✓										
	Rashes, Lac's, etc														✓										
DRESSING (Dry & Intact: specify site below)																									
#1 (L) thigh								Δ							CDI										
#2 (L) UE																									
#3																									

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
IVP	(R) Arm	~~1 Sept~~ 31 Aug 03	ØSS inf, CDI, patent
PIV	(L) arm	31 Aug	Ø S/S of infection / infiltration

PUPIL SIZE		PUPILS	MOTOR FUNCTION	CHART CODES
1 mm	=	Equal	0 = No Movement	Present ✓
2 mm	R	Reactive	1 = Slight Flicker/ Trace of Contraction	
3 mm	NR	NonReactive	2 = Active (Gravity Eliminated)	Not Applicable /Absent (blank)
			3 = Active: against gravity, but not against resistance	
4 mm	L > R	Left Larger	4 = Active: Against Gravity and Resistance, not full strength	Refer to Nsg. Notes X
			5 = Full Strength against Examiners Resistance	
5 mm	R > L	Right Larger		No Change from Previous Assessment --

DATE:

TIME		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (2) To Pain (3) To Voice (1) Does Not Open								4							4										
B. BEST VERBAL RESPONSE (5) Oriented (2) Garbled (4) Confused (1) No Response (3) Inappropriate Verbal Response								5							~~5~~ MOM										
C. BEST MOTOR RESPONSE (6) Obeys Commands (3) Flexion to Pain (5) Localizes to Pain (2) Extension to Pain (4) Withdraw to Pain (1) No Response								6							6										
GLASCOW COMA SCALE (A+B+C)								15							15										
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R																								
	L																								
MOVEMENT (See Motor Function Scale at Top of Page)	RUE							5							5										
	LUE							~~X~~							N/A										
	RLE							5							5										
	LLE							2							2										
GRIP (S) Strong (W) Weak (-) absent	R							5							5										
	L							~~NT~~							N/A										
RESPIRATIONS	REGULAR							✓							✓										
	IRREGULAR																								
	UNLABORED							✓							✓										
	LABORED																								
	SHALLOW																								
	RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL							5							5										
	LUL							5							5										
	RLL							5							5										
	LLL							5							5										
	BOTH BASES							5							5										
COUGH	NONE							✓							✓										
	SPONTANEOUS																								
	PRODUCTIVE																								
	NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																									
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																									
VENTILATOR	Vt																								
	FIO2																								
	RATE (SIMV/CMV)																								
	PEEP / CPAP																								
	PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE	NC (l/min)														3										
	FM (l/min)																								
ETT #_____	NRBM (l/min)																								
	ETT _____cm gums																								
ETT CARE / POSITION CHANGE																									
ETT / NT SUCTIONED																									
INCENTIVE SPIROMETRY DONE																									
COUGH / DEEP BREATH																									
INITIALS								(b)(6)-2																	

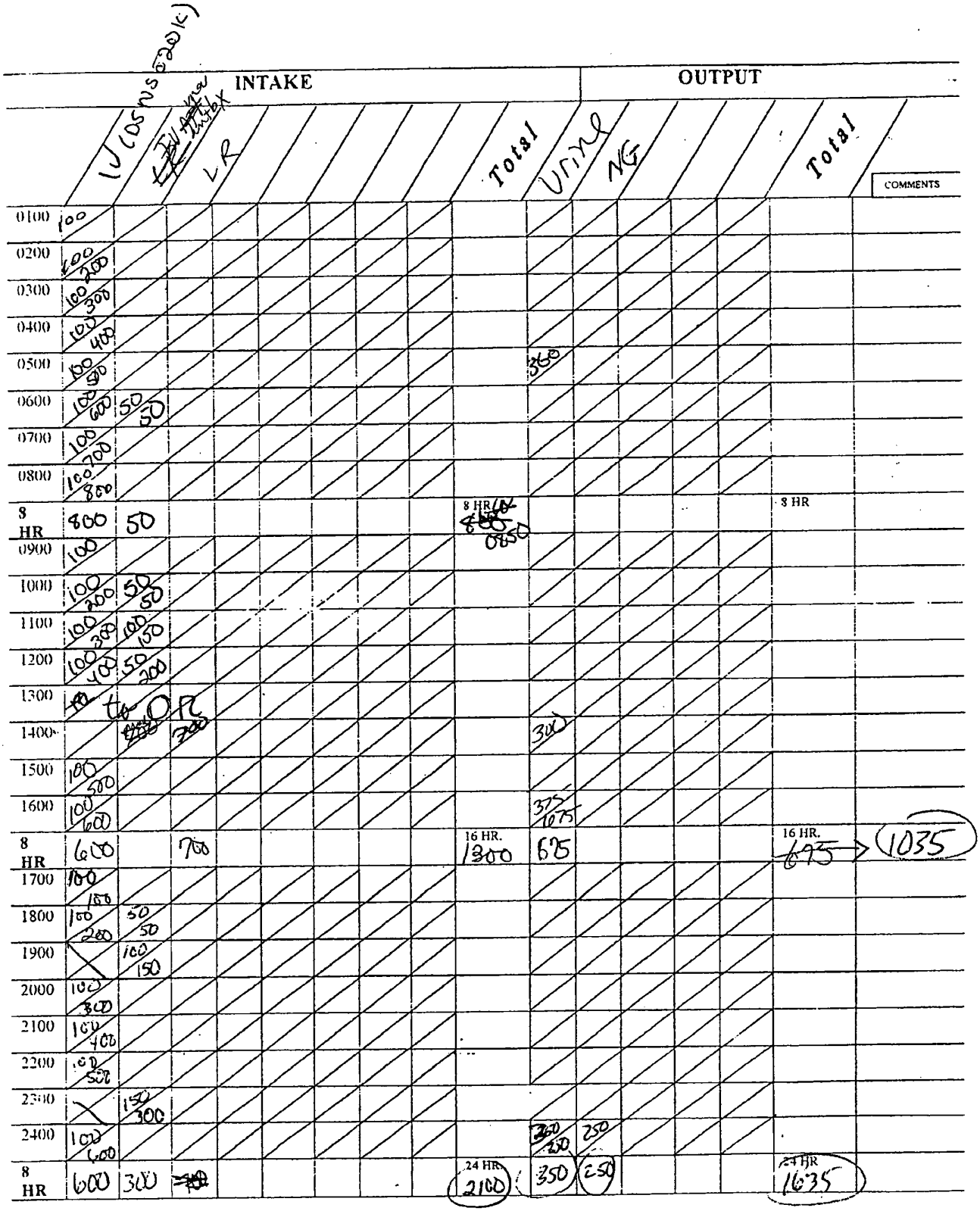
VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200	102.8	129	27	113/64	93%												
0300																	
0330	101																
0400																	
0500																	
0600																	
0700																	
0800																	
0900	98.7																
0930		116	30	132/83	93%												
1000	101.6 (A)	108															
1100																	
1200																	
1300																	
1400																	
1500																	
1600	100.4 ax	130	32	123/74	94%	on 1 L nC											Tylenol given
1700																	
1800	101 6 nx																
1900																	
	101.2																
2000	100°	124	20	114/75	95%	2 L nc											
2100																	
2200																	
2300																	
2400																	

ACLU-RDI 1099 p.140

DOD 005408

	INTAKE									OUTPUT							
	IV (DSNS 520K)	~~IV~~ ~~LR~~	LR						Total	Urine	NG				Total	COMMENTS
0100	100															
0200	100 / 200															
0300	100 / 300															
0400	100 / 400															
0500	100 / 500									360						
0600	100 / 600	50 / 50														
0700	100 / 700															
0800	100 / 800															
8 HR	800	50							8 HR ~~800~~ 0850						8 HR	
0900	100															
1000	100 / 200	50 / 50														
1100	100 / 300	100 / 150														
1200	100 / 400	50 / 200														
1300	~~100~~	to OR														
1400		~~200~~	700							300						
1500	100 / 500															
1600	100 / 600									375 / 1075						
8 HR	600		700						16 HR. 1300	675					16 HR. ~~675~~	1035
1700	100 / 100															
1800	100 / 200	50 / 50														
1900		100 / 150														
2000	100 / 300															
2100	100 / 400															
2200	100 / 500															
2300		150 / 300														
2400	100 / 600									360 / 250	250					
8 HR	600	300	~~[illegible]~~						24 HR. 2100	350	250				24 HR 1635	



NSN 7540-00-634-4123

MEDICAL RECORD — DATE	HOUR A.M.	HOUR P.M.	NURSING NOTES (Sign all notes) — OBSERVATIONS Include medication and treatment when indicated
15Sep03	0100		Pt sleeping soundly. Resp even and unlabored, will continue to monitor (b)(6)-2
	0215		VSS as charted. Tylenol 650 gm per order pt ∃ distress. ∅ change in assessment
	0402		Pt sleeping well, ∃ complaints, RR-20 will continue to monitor (b)(6)-2
	0530		Pt voided @5, dark clear amber urine. ∅ complaints or difficulty. (b)(6)-2
	0745		Dsg D/C'd to ∅thigh) pain meds. adm., pt has BEAD ace wrap to it. Exfix ∅thigh) Will cont to monitor (b)(6)-2
	1100		@1030 NGT placed: Placement good, to LIS pt O2 sat @ 88% order obtained for prn O2 @ 3L NC. Temp @ 101.6 ∅F. Tylenol PR admin will cont to monitor. (b)(6)-2
	1315		@ 1305 pt to OR (b)(6)-2
15Sep03	1400		PT back from OR - Refer to PACU sheets for details. (b)(6)-2
16Sep03		1830	Rec'd report and assumed care of Pt. VSS - Tylenol @ 101°. Pt. rec'd anti-emetic @ 1040 - monitor temp. No % pain. NGT - LIS - Approx 600cc greenish drainage. IV infusing ∃ % complication. Dressings intact - Pt. resting ∃ % of acute distress. Cont. monitor. (b)(6)-2
11		1940	T @ 101°. Antiemetic rec'd @ 1040 - will recheck temp and administer (b)(6)-2
17Sep03			Pt Temp √ - 100° - antipyretic on hand - No % pain - Initially % danger / risk ; however, declined assist + ambulation due to NPO status. N/V cont. monitor and encourage to use. (b)(6)-2
		2115	Topical antibiotic ∃ dressings reinforced - IV - Dry. Pt. Pain Pt. tolerated well. ∅ Phys ∃ Activity Tissue - (+) Edema Purple edges. N/V cont monitor. (b)(6)-2
		2200	Assumed care of pt. ∅ distress noted SGT (b)(6)-2 (b)(6)-2 will continue primary care.

ACLU-RDI 1099 p.142

DOD 005410

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	25 Aug 03
DOS	1 Sep 03
POD	1

24 HOUR DATA	
24 Hour Balance	+465
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2 LPN.	(b)(6)-2
(b)(6)-2	
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 LPN.	ICU #1	2 Sep 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade; date; hospital or medical facility)*

Lotus # (b)(6)-4

- ☐ HISTORY/PHYSICAL ☒ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION ☐ OTHER(*Specify*)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 1359

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R				2				2				2		2									2	
	Brachial L				2				2				2		2									2	
	DORSALIS PEDIS R				1				2				2		2									2	
	L				1				2				2		2									2	
SKIN (1) Dry (4) Cool (7) Jaundiced (2) Clammy (5) Flushed (8) Color Normal (3) Warm (6) Cyanotic (9) Pale					1/3/8				1/3/8				1/3/8		1/3/8									1/3/8	
EDEMA															1+									1+	
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)					✓				✓				✓		✓									✓	
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)					ST				ST				ST		ST									ST	
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH								✓																
	FOLEY CARE										✓														
	ORAL CARE				✓								✓		✓										
MOBILITY	BEDREST								✓				✓		✓									✓	
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE				✓				✓				✓		✓									✓	
	HOB 30 DEGREES				✓				✓				✓		✓									✓	
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE				✓				✓				✓		✓										
	PAIN SCALE (1-10)																							✓	
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended				1				1				1		1									1	
BOWEL SOUNDS (active all quads)					*				Hyper +4				Hyper +4		WNL									✓	
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT																									
VOIDING CLEAR, YELLOW URINE q.s.					*																				
SKIN INTEGRITY	No Breakdown								✓				✓		✓									✓	
	Surgical Wounds				✓				✓				✓		✓									✓	
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1 (L) Thigh									✓				✓		✓									✓	
#2 (L) Above Amputation									✓				✓		✓									✓	
#3																									
															(b)(6)-2										

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
(R) 4 Arm.	(R) 4 ARM.	31 Aug 03	4cli - Patent. 0700 2L 1100 gr
(L) Arm 18GA	"	31 AUG 03	DSL of Inf/Infiltrate, Dr 1700

ACLU-RDI 1099 p.144

DOD 005412

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable /Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment --

DATE:

TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open				4			4					4		4									4	
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response				5			5					5		5									5	
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response				6			6					6		6									6	
GLASCOW COMA SCALE (A+B+C)				15			15					15		15									15	
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — R				+										+										
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — L				+										+										
MOVEMENT (See Motor Function Scale at Top of Page) — RUE				4			4					4		4									4	
MOVEMENT (See Motor Function Scale at Top of Page) — LUE				/			3					3		3									3	
MOVEMENT (See Motor Function Scale at Top of Page) — RLE				4			4					4		4									4	
MOVEMENT (See Motor Function Scale at Top of Page) — LLE				3			2					2		2									2	
GRIP (S) Strong (W) Weak (-) absent — R				5			5					5		5									5	
GRIP (S) Strong (W) Weak (-) absent — L				/										—									—	
RESPIRATIONS — REGULAR				✓			✓					✓		—									✓	
RESPIRATIONS — IRREGULAR																								
RESPIRATIONS — UNLABORED				✓			✓					✓		✓									✓	
RESPIRATIONS — LABORED																								
RESPIRATIONS — SHALLOW																								
RESPIRATIONS — RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RUL				5			5					5		5									5	
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — LUL				5			5					5		5									5	
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RLL				5			5/1					5/1		5									5	
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — LLL				5			5/1					5/1		5									5	
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — BOTH BASES							5/1					5/1		5									5	
COUGH — NONE				✓			✓					✓		✓									✓	
COUGH — SPONTANEOUS																								
COUGH — PRODUCTIVE																								
COUGH — NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																								
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																								
VENTILATOR — Vt																								
VENTILATOR — FIO2																								
VENTILATOR — RATE (SIMV/CMV)																								
VENTILATOR — PEEP / CPAP																								
VENTILATOR — PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE — NC (l/min)							2L					2L		2L									0	
OXYGEN DELIVERY DEVICE — FM (l/min)																								
OXYGEN DELIVERY DEVICE — NRBM (l/min)																								
ETT #_____ — ETT _____cm gums																								
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED																								
INCENTIVE SPIROMETRY DONE							(b)(6)-2																	
COUGH / DEEP BREATH																								
INITIALS																								

(b)(6)-2

MEDCOM - 1361

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100	101.4																
0200																	
0300																	
0400	100.3	110	18	117/71	98% RA												
0500																	
0600																	
0700	99.7 (A)	107	26	109/67	95%												
0800																	
0900																	
1000																	
1100	102.2 (A)	116	36	95/68	90%												
1105		114	28	114/69	95%												
1200																	
1300																	
1400																	
1500																	
1600																	
1700																	
1800																	
1830	100.4	102	26	123/32	95%												
1900																	
2000																	
2100																	
2145	100.4	109	30	114/69	96%												
2200																	
2300																	
2400																	

ACLU-RDI 1099 p.146

DOD 005414

	INTAKE									OUTPUT						
	P.V	iVPB	PO	PRBCs					Total	URINE	NGT				Total	COMMENTS
0100	100/100									550/550						
0200	100/200															
0300	100/300															
0400	100/400									400/950	100/100					
0500	100/500															
0600	100/600	50/50								300/1250	~~100~~/~~40~~					
0700	100/700															
0800	100/800	50/100														
8 HR	800	100							8 HR. 900	1250	100				8 HR 1350	~~40~~ 25-450
0900	100/100															
1000	100/200	50/50								450/450						
1100	100/300															
1200	100/400	100/150														
1300	50/450			50/50						125/575						
1400	0/450			100/150							200/200					
1500	100/450			100/250						600/1175						
1600	100/650			50/300						500/1675						
8 HR	450	150		300					16 HR. 800	1675	200				16 HR. 1875	
1700	50/50									550/550						
1800	100/150									400/950						
1900	50/200	50/50														
2000	50/250	50/100								400/1350						
2100	100/350															
2200	100/450															
2300	100/550									250/1600						
2400	100/650	50/150														
8 HR	650	150							24 HR. 2600	1600					24 HR 3475	

MEDCOM - 1363

NSN 7540-00-634-4123

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
2 Sep 03	0100		Pt sleeping & s/s of acute distress. Has voided 550cc d/y urine.
			No c/o pain. No Δ in assessment. Dressing - w/o - (+) breakthrough
			drainage. Reinforced - Cont. monitor. [redacted] LPN
	0140		T@ 101.4 ∴ 650mg Tylenol PR per order. Monitor effect. [redacted] LPN
			Addition: Pt turned toward (R) side to relieve pressure from
			backside - will attempt to reposition frequently. [redacted] LPN
	0400		Pt awake & void via urinal. No c/o pain - Temp ↓ to 100.3 -
			placed supine. NG - 100 ml drainage 24-04. Cont. monitor.
			Dressing reinforced c̄ combine. [redacted] LPN
9/2/03	0700		Linen Δ'd & bed bath given. NAD noted. Continues to have
			Clear to Serous drainage from LLE. ⊖ c/o discomfort.
			EX-FIX to LLE intact. ACE DRSG to LUE CD&I. VSS
			will Continue to Monitor. [redacted] ICT, A
9/2/03	1100		DRSG Δ to LLE. Small amt of Sanguineous drainage. ⊖ odor (foul)
			TISSUE DULL PINK color. ⊖ purulent discharge. NS Wet to
			dry DRSG reapplied. Pt tolerated procedure well [redacted] ICT, A
9/2/03		1230	Began 1st unit of PRBC's. See SF 509 for Vg. Maintenance
~~25EP03~~			IV stopped by Dr [redacted] until p̄ blood [redacted] ICT, A.
25EP03		1830	2d unit of PRBC complete. IV site changed to (R) hand
			18GA. due to pt c/o pain @ prior site. Pt resting
			comfortably @ this time. [redacted] LPN
		2200	Assumed care of pt, assessment per flowsheet.
		2230	pt c̄ c/o continued pain. Medicated @ 2100
			for c/o pain. Discussed c̄ Dr [redacted] 1X order
			given. [redacted]
		2300	Pt medicated, repositioned, will monitor
			for effect. [redacted]

MEDCOM - 1364

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	25 Aug 03
DOS	1 SEP 03
POD	2

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	(b)(6)-2

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

PREPARED BY (b)(6)-2 (Title)	Department/Service/Clinic	DATE
RN	ICU 1	3 Sep 03

PATIENT'S IDENTIFICATION (*For typed or written entries give: Name-last, first, Middle; grade;date; hospital or medical facility*)

Potus (b)(6)-4

☐ HISTORY/PHYSICAL ☒ FLOWCHART

☐ OTHER EXAMINATION Or EVALUATION ☐ OTHER(*Specify*)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 1365

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R							2			2				2									2	
	BRACHIAL L							2			2				2									2	
	DORSALIS PEDIS R							2			2				2									2	
	L							2			2				2									2	
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale (10) HOT								1 8 10			1 8 10				1 8 10									1 3 8	
EDEMA							LES	1+			1+				+1									+	
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)								✓			✓				✓									✓	
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)								ST			ST				ST									ST	
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)										✓															
HYGIENE	BED BATH	✓																							
	FOLEY CARE																								
	ORAL CARE	✓						✓			✓														
MOBILITY	BEDREST																								
	BSC																								
	DANGLE																								
	CHAIR														✓										
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE														✓										
	HOB 30 DEGREES			✓				✓			✓				✓									✓	
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)								✓			✓				✓										
PAIN	PAIN FREE																								
	PAIN SCALE (1-10)			✓																					
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat							1 SOFT			1 SOFT				1 SOFT									1	
	(1) Distended																								
BOWEL SOUNDS (active all quads)								HYPO			HYPO				HYPO									X	
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT																									
VOIDING CLEAR, YELLOW URINE q.s.								✓			✓				✓									✓	
SKIN INTEGRITY	No Breakdown							✓			✓				✓									✓	
	Surgical Wounds																								
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)								✓			SD				✓									✓	
#1 LUE								SD			SD				SD									✓	
#2 LLE																									
#3															(b)(6)-2										

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
18g	(R) Hand	25Sep03 0700/03 JL	patent, no erythema, edema, phlebitis
16g	LEJ	2Sep03 1435 25Sep03 (b)(6)-2	Patent & S/Sx of infection or infiltration
			" " "

ACLU-RDI 1099 p.150

DOD 005418

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable /Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment –

DATE:

TIME		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open								4			4				4									4	
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response								5			5				5									5	
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response								6			6				6									6	
GLASCOW COMA SCALE (A+B+C)								15			15				15									15	
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R														+2										
	L														+2										
MOVEMENT (See Motor Function Scale at Top of Page)	RUE							4			4				4									4	
	LUE							3			3				3									3	
	RLE							4			4				4									4	
	LLE							2			2				2									2	
GRIP (S) Strong (W) Weak (-) absent	R							5			5				5									5	
	L							N/A			N/A				N/A									–	
RESPIRATIONS	REGULAR							✓			✓				✓									✓	
	IRREGULAR							✓			✓				✓									✓	
	UNLABORED																								
	LABORED																								
	SHALLOW																								
	RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL							5			5				5									5	
	LUL							5			5				5									5	
	RLL							5/1			5/1				5/1									5	
	LLL							5/1			5/1				5/1									5	
	BOTH BASES							5/1 ✓			5/1 ✓				5/1 ✓									5	
COUGH	NONE							✓			✓				✓									✓	
	SPONTANEOUS																								
	PRODUCTIVE																								
	NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																									
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																									
VENTILATOR	Vt																								
	FIO2																								
	RATE (SIMV/CMV)																								
	PEEP / CPAP																								
	PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE	NC (l/min)							3L			5L				5L									2L	
	FM (l/min)																								
ETT #_____	NRBM (l/min)																								
	ETT _____ cm gums																								
ETT CARE / POSITION CHANGE																									
ETT / NT SUCTIONED																									
INCENTIVE SPIROMETRY DONE																									
COUGH / DEEP BREATH																									
INITIALS								(b)(6)-2																	

ACLU-RDI 1099 p.151

DOD 005419

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200																	
0300																	
0400																	
0500	102.6	107	22	117/70	94												
0600																	
0700	102.7 (A)	114	32	117/70	95												
0800	102.4 (A)																
0900	OR →																
1000	100.1 (A)	112	16	119/78	91%												
1100																	
1200	101.5 (A)	114	16	117/71	92%												
1300		111	15	117/72	93%												
1400	101.9 (A)	109	18	121/88	100%												
1500																	
1600	102.8 (A)	111	18	116/71	97%												
1700	101.5 (A)																
1800	100.6	107	18	120/62	97%												
1900																	
2000	99.5	101	15	111/70	94%												
2100																	
2200																	
2300	100.7	101	18		97												
2400																	

ACLU-RDI 1099 p.152

DOD 005420

	INTAKE									OUTPUT						
	DSNS=20KCL	WPB	LR						Total	Urine	Stool	NG			Total	COMMENTS
0100	100/100															
0200	100/100	50/50								200/200						
0300	50/250															
0400	100/350									250/450						
0500	100/450									220/670						
0600	100/550											100/100				
0700	100/650	50/100								200/~~200~~						
0800	100/750									890						
8 HR	750	100							8 HR. 850	890		100			8 HR 990	-140
0900	100/100	50/50														
1000	OR —		800/800													
1100	100/200	50/100														
1200	100/300	250/350														
1300	100/400	50/400														
1400	100/500											50/50				
1500	100/600															
1600	50/650	50/450								500/500						
8 HR	650	450	800						16 HR. ~~1900~~ 2750	1390		50			16 HR. 2430	
1700	100/100															
1800	100/100	100/100								500						
1900	100/200															
2000	100/300															
2100	100/400															
2200	100/500															
2300	100/600															
2400	50/650	50/150														
8 HR									24 HR.						24 HR	

MEDCOM - 1369

NSN 7540-00-634-4123

MEDICAL RECORD — DATE	HOUR A.M.	HOUR P.M.	NURSING NOTE (Sign all notes) — OBSERVATIONS Include medication and treatment when indicated
3 Sep 03	0045		Pt linen changed, washed pt after scant liquid stool, no substance in stool allowed pt to rinse & spit. Tolerated entirety of procedure well. (b)(6)-2
	0310		Pt c/o pain, unable to get clear numeric rating through interpreter. Repositioned for comfort at present. (b)(6)-2
	0520		Pt sitting in high fowler's, leg repositioned. Labs drawn. will monitor. (b)(6)-2
	0530		pt treated for T (O2) & (A). Linen change tolerated well. (b)(6)-2
3 Sep 03	0700		Portable KUB done. NAD (E) c/o discomfort. VSS Tem 102°. Will continue to monitor (b)(6)-2
3 Sep 03	0850		TO OR via Litter. NAD noted. (b)(6)-2
3 Sep 03	1000		RTD from OR see CC flowsheets PACU flowsheet (b)(6)-2
3 Sep 03		1225	Medicated c Tylenol 650 mg PR for temp (b)(6)-2
3 Sep 03		1500	Pt moved back to bed tolerated transfer WELL Resting quietly @ this time (b)(6)-2
"		1600	Pt medicated c 1gm Tylenol as per MD. Temp (b)(6)-2
"		2130	MD to D dsg. V→D dsg c wound packing replaced. Pt tolerated procedure well (b)(6)-2
		2200	Assumed care of pt, @ distress, repositioned for comfort. (b)(6)-2
		2300	Assessment per flowsheet, (L) BJ site = S/S of infiltration, Replock to (R) hand patent also = S/S of infiltration, abd remains distended c hypoactive bowel sounds. NGT retained. Placement verified via aspiration and auscultation. (b)(6)-2

MEDCOM - 1370

INPATIENT TREATMENT RECORD COVER SHEET *(For Plate Imprinting)*

For use of this form, see AR 40-400; the proponent agency is the Office of The Surgeon General.

(b)(3)-1

PATIENT DATA ITEMS 1 - 30 *(Excluding Items 25 & 26)*

(b)(6)-4 (detainee)

(b)(6)-4

LINE	LEGEND
1	REGISTER NO. - NAME - GRADE
2	SEX - AGE - RACE - RELIGION - LENGTH OF SVC - ETS - PREVIOUS ADMISSION
3	FMP - SSN - ORGANIZATION - WARD
4	FLY STAT - RATING/DESG - DEPT/BEN - BRANCH/CORPS - UIC/ZIP - TYPE CASE
5	SOURCE & AUTHORITY FOR ADMISSION - HOUR OF ADMISSION - CLINIC SVC
6	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
7	ADDRESS OF EMERGENCY ADDRESSEE - PHONE NO. - DATE OF THIS ADMISSION
8	NAME & LOCATION OF MEDICAL TREATMENT FACILITY DATE OF INITIAL ADMISSION

ADMISSION REMARKS

ADMITTING OFFICER (b)(6)-2

32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED

25. TYPE DISPOSITION: DC

26. DATE OF DISPOSITION: 29AUG03

31. SELECTED ADMINISTRATIVE DATA

☐ CHECK IF CONTINUED ON REVERSE

33. CAUSE OF INJURY

WIF wounds

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

(1) open (R) Thumb P1 fx & mc fx 817.1 ICD9.02
(2) open (R) TiTia fx 823.90 ICD9.02
(3) multple (L)+(R) LE open wounds c retained Shrapnel E991.9 ICD9.02
(4) open (L) Knee 891.0 ICD9.02
(5) (R) Thumb ~~EPL~~ lac (R) foot ~~EPL~~ lac
(6) I&D wounds / open arthrotomy (L) Knee
(7) Pinning (R) Thumb / (L) endme
(8) Ex Fix (R) TTLia

☐ CHECK IF CONTINUED ON REVERSE

35. TOTAL DAYS THIS FACILITY

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

36. TOTAL DAYS ALL FACILITIES

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

SIGNATURE OF ATTENDING MEDICAL OFFICER (b)(6)-2

SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER (b)(6)-2

DA FORM 1 MAY 79 3647-1 EDITION OF 1 AUG

MEDCOM - 1371

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

PERTINENT HISTORY, CHIEF COMPLAINT, AND CONDITION ON ADMISSION (Enter date of admission)

Iraqi male now 48 hours out from flight c apache Helicopter
Txfed @ Iraqi hospital. Referred c multiple wounds (L)&(R) LE
(R) LE. Radiographs reveal open (R) Tibia fx, open (R) Thumb
MCP S c fx's P1/MC, and soft tissue defect (R) calf
c fx (L) Tibial plateau

PMH PSH meds

PHYSICAL EXAMINATION

(PE) open (R) Thumb @ MCPs
open (R) Tibia fx
open wounds (L)&(R) LE's

(R):

PROGRESS (Enter date of discharge and final diagnosis)

(P) I&D extremity wounds
(2) Pinning (R) Thumb MCP P1/MC fx
(3) Ex-Fix (R) Tibia
(4) Remove Staples

(b)(6)-2	DATE 7/26/03	IDENTIFICATION NO.	ORGANIZATION
		REGISTER NO.	WARD NO.

TION (For typed or written entries give Name last, first, middle; grade; date; hospital or medical facility)

Iraqi (b)(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539
GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FPMR 101-11.806-8
OCTOBER 1975 539-108

ACLU-RDI 1099 p.156

DOD 005424

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	OR-note
	Pre-op Dx: ① open Ⓡ Tibia fx
	② open Ⓔ knee
	③ open Ⓛ foot and MT fx
	④ open Ⓡ Thumb Proximal phalanx fx
	⑤ Ⓡ foot other lac (b)(6)-2
	⑥ Ⓡ Thumb EPL lac
	⑦ multiple Ⓛ & Ⓡ LE & Ⓡ UE wounds
	Procedure: ① I&D all wounds
	② open ex-fixation Ⓔ knee
	③ Ex-fix Ⓡ Tibia
	④ Pinning Ⓛ foot and MT fx
	⑤ Pinning Ⓡ Thumb MC / Proximal phalanx
	GEN (b)(6)-2
	ABL 1000cc 6 Units
	(b)(6)-2
	To ICU in stable condition
	(b)(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)	REGISTER NO.	WARD NO.

Frag, (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

MEDCOM - 1373

509-113 NSN 7540-00-634-4122

MEDICAL RECORD	PROGRESS NOTES
DATE	Op-note
7/28/03	
	Pre-op Dx: / open (R) Tibia fx c̄ EHL lac
	Post-op Dx open (R) Thumb fx c̄ EPL lac
	open (L) Knee
	Procedure: I&D (L) & (R) LE & (R) UE
	Repair EPL,
	wound closures / Adjust Ex
	Pleasant Phillips, San Juan, Brisquela
	EBL min
	TTTQ
	TOTTR instable cond
	(b)(6)-2
	MD
30 July 03	Preop/Postop Dx: open (R) thumb fx c̄ EPL lac
	open (L) foot 2nd MT fx
	Procedure: (R) AICBG to (R) thumb and (L) foot
	I&D (R) LE; skin flap (R) hand
	wound closure,
	(b)(6)-2, (b)(6)-2, (b)(6)-2 anesthesia (b)(6)-2 (b)(6)-2
	EBL 100cc Fluids 800cc UOP NM Φ foley
	Φ complications to PCU c̄ SV, US WNL (b)(6)-2

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)

Iraq 1# (b)(6)-4

REGISTER NO. (b)(6)-2 WARD NO. LTC (b)(6)-2

PROGRESS NOTES

Medical Record

MEDCOM - 1374

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

509-113 NSN 7540-00-634-4122

MEDICAL RECORD | PROGRESS NOTES

DATE

2003 orthonote

31 Jul POD #1 S/P (R) AICBG to R/ hand, L/ ft... Abx: Ancef.

2030 S) Pt seems to be doing better c̄ less narcotic requirement IV. motrin and tylox - rests well. PO intake OK but not full meals. c/o pain (L) leg

O) T'm 100.2 at 1400 tid to 99.5 c̄ IS. P= 80's - 105 BP WNL

Resting quietly.

Earlier in day, (R) hand dressing removed - viable skin flap, no necrotic or dusky edges. Good position of digits ∅ S/Sx infex (L) foot good alignment and all incisions/lacs c/d/i s̄ S/Sx infex. Splint placed on foot/leg.

(R) tib ex fix in good alignment s̄ S/Sx infex at pin sites - tissue healthy. Hip dressing intact/dry CV RRR lungs GAB Abd soft NTND

plain films reveal good alignment of bone grafts to (R) thumb; (L) 2nd MT

good position of ex fix.

A) S/P (R) AICBG to (R) thumb and (L) foot in addition to ex fix - multiple lacs, tendon repair since 26 July. Doing well s̄ S/Sx of infection and continued viability of hand skin flap.

D) continue present mgt c̄ newly placed splint (L) LE, dressing changes, wound care. will encourage IS, PO intake & OOB.

(b)(6)-2

(b)(6)-2 LTC DDS

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)

REGISTER NO. | WARD NO.

1 Mar (b)(6)-4

PROGRESS NOTES

Medical Record

MEDCOM - 1375

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

PROGRESS NOTES

DATE
2003

3 aug ortho note

POD #4 S/P (R) ATCBG to (R) hand / (L) foot c̄ skin flap

no major complaints x̄ some paresthesia of (L) toes (2nd, great) x 2 days

Family food brought in and using incentive spirometry and supplementing diet c̄ Enaix. Has been OOB more the last few days. wounds cleaned / dressed bid

AF vs WNL

A/O bright, enthusiastic moving well.

all abrasions / lacs are healing well c̄ clean margins, good granulation, gd suture approximation. Skin flap viable on (R) hand (R) hip harvest site c̄ intact steristrips

Ø hematoma, Serome

(L) great toe can feel pressure, pinching, moderate touch

(L) 2nd toe not feeling pinch / eight touch

(L) LE in cast

Assessment / Healing well p̄ major trauma to (R) UE (hand), (R) LE c̄ (R) LE exfix, (R) hand skin flap, bone graft to thumb, (L) foot bone graft, tendon repairs - No S/Sx infex. Small amt of (L) toe paresthesia. granulating skin flap donor site - tendon areas s̄ epithelial covering

Plan CPM, cont. to dress wounds

Plan suture removal and anticipate skin grafts

(b)(6)-2

(b)(6)-2

*U.S. Government Printing Office: 1996 - 404-763/20101

STANDARD FORM 509 (REV. 7-91) BACK

MEDCOM - 1376

509-113 NSN 7540-00-634-4122

MEDICAL RECORD | PROGRESS NOTES

DATE

4 Aug 03 1188 Nurses report one watery - loose BM yesterday & another this A.M. (b)(6)-2

Lieutenant (b)(6)-2 Corps
Chief, Department of Medicine

2003 ortho op note

5 aug preop/postop DX: (R) LE ex fix, tendon repair
(R) hand bone graft, skin flap potential infection/wound edge dehiscence; macerated tissue

Operation: (R) hand skin flap modification, debridement, repair
(R) LE debride/irrigate

(b)(6)-2 / (b)(6)-2 / (b)(6)-2 EBL min Fluids · see anesthes

Findings: good granulation (R) hand donor site. No purulence around bone graft / cortical + cancellous grafts intact. Debrided wound edges. 3.0 nylon to reapproximate - good reapproximation

Dressed c̄ xeroforms, fluffs, Kerlix

Tolerated well. Extubated c̄ difficulty TO PACU / ICU c̄ SV. VSWNL

1g IVPB Ancef

(b)(6)-2

(b)(6)-2 UCDIX

6 Aug 03 0800: T=98', P=76 R=16, BP=115/50, Sat=98. PT refuses breakfast - will offer Ensure in 1-2 hrs. Denies pain - c/o ace wrap (R) LE tight - re-wrapped +

(Continue on reverse side) (b)(6)-2

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility) | REGISTER NO. | WARD NO.

Tragi (b)(6)-4

PROGRESS NOTES
Medical Record

MEDCOM - 1377

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

PROGRESS NOTES

DATE	
6 AUG 03 0800	cont performed dressing Δ. PT states ⌀ leg feels better now. Pulses good (DP) bil. VSS. Will defer (R) hand dressing Δ to physicians since this is the first dressing Δ since surg yest. [redacted]
6 AUG 03	1000 - [redacted] did (R) hand dressing Δ - will use Xeroform dressing to graft site, dry gauze between thumb + 1st finger - then Kerlex wrap.
[redacted]	PT drank 1 can Ensure + ate 2 cookies - [redacted]
06 Aug 03	Assumed care of dressing. VSS - afebrile No c/o pain. Cont. monitor - [redacted]
2003	surgeon note
6 Aug 03	s/p multiple ortho procedures, ex fix, modify skin flap.
	Pt still picky c̄ eating - will do Ensure and family bringing food.
	VS WNL AF
	Removed (R) hand dressing - macerated web space. ⌀ necrosis or dehiscence - bone graft covered. (+) sensation to digits (IF slightly less light touch)
	Dressing Δ c̄ xeroform, dry gauze, kerlex bid (done c̄ LE chevron)
	(R) LE ex fix intact, pins s̄ B/SX infex. (L) LE 2nd digit ↓'d sensation c/w initial injury (also where bone graft placed b/o injury) cast OK fit, NV intact. ⌀ B/SX infex. Hip Aite intact. Sensation intact.
	A) Pt doing well - (R) hand flap revision vital. web space macerated pending skin grafts for tendon covering
	P) continue wound care. will d/c w→d to avoid maceration will continue to observe for dehiscence/wound breakdown anticipate skin graft before d/c [redacted]

*U.S. Government Printing Office: 1996 - 404-763/20101

STANDARD FORM 509 (REV. 7-91) BACK

MEDCOM - 1378

509-113 NSN 7540-00-634-4122

MEDICAL RECORD | **PROGRESS NOTES**

DATE	
6 Aug 03 @ 1200	Refused lunch, initially, however, requested food & threw away. Provided soup & MRE - refused. ½ can ensure consumed - interpreter and physician discussed nutrition. Monitor effect of teaching (b)(6)-2
6 AUG 03 1715	Pt consumed approx 95% of lunch meal without incident or diff. Pt & VSS. Dsgs (b)(6)-2 1400 cc clear yellow urine. Resting comfortably @ this time. SSG
6 AUG 03 1800	Pt c/o pain to (R) LE. Administered IV Tylox. Will (b)(6)-2 effectiveness. SSG LPN.
6 AUG 03 2000	Assessment completed VSS. 113/54 T. 99' R 16 P 87 Rx 96% RA. ZANTAC Given. Dressing changes to (R) LE & (R) HAND completed. Tolerated well. Resting @ this time. Will continue to monitor (b)(6)-2 SSG BPN
6 Aug 03 @ 2200.	Rec'd report and assumed care of pt VSS - afebrile. No c/o pain @ this time. Dressings c/d/i; dsl - (R) forearm sutured c NS - patent - site c/d/i. ~ IV d/c'd 2° 3d placement. 20ga dsl initiated (R) forearm - patent - c/d/i. Interpreter called - pt. c/o slight numbness (R) LE. Physicians aware - cont. monitor. Currently eating food brought in by interpreter. Cont. monitor. (b)(6)-2
6 Aug 03 2300 4'11/56 -85 99'- 16	Pt. c Abx therapy infusing c no s/s of complications. Consumed a "meals worth" of food provided by interpreter c vegetables/breads. (b)(6)-2 can-
@ 0025	A% pain @ achilles area - (R) LE. Dressing removed, wet/dry d'd and gauze and kerlix wrap reduced in order to prevent pressure. Interpreter assisted c communication. Cont. monitor (b)(6)-2
@ 0400	No d/c's - pt has been sleeping c no s/s of acute distress. (b)(6)-2
7 AUG 03 0700	Assumed care of pt. Vital signs: BP 113/62 HR 89 Temp 98.7 Pulse ox 94% Resp 14. Assessment complete, brisk cap refill on upper extremities, popliteal pulses normal, cap

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility) | REGISTER NO. | WARD NO.

(b)(6)-4

PROGRESS NOTES
Medical Record

MEDCOM - 1379

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

PROGRESS NOTES

DATE	
Cont.	refill on lower extremities brisk. Pt complaining of pain under cast on LLE. Motrin 800mg PO given AS ordered.
6 AUG 03	Dressings on extremities C, D & I. Pt complaining on pressure/throbbing in (D) FA IV site. Site WAS patent and without sign of infiltration. Heplock WAS flushed. Lung sounds clear, S1 and S2, bowel sounds active. Asked doctor if Heplock can be DC'd and pt put on PO Antibiotics – denied. Will place a new Heplock site on (D) FA, due to pt discomfort and oncef running very slowly in current heplock. SPC (b)(6)-2
7 AUG 03 1251	Assisted Dr. (b)(6)-2 in removing LLE cast and some of the patient's stitches from wounds on LLE and (R) shoulder. Dr will remove remaining stitches at a later date. SPC (b)(6)-2
7AUG03 1430	Pt assessed @ this time. Wounds on upper body healing well. Lungs CTA BL laterally, BS x 4, HS - S1/S2, Pt drsgs on RUE, LLE, RLE C/D/I. RLE Drsg to be D'd by nursing staff. (b)(6)-2 VSS - BP 107/69, HR 99, T-99.4, R-16, O2sat - 95%.
7AUG03 2030	Drsg D to RLE completed. Wound looks red and beefy c minimal exudate present. Pt tolerated W→D D well. However, had 2 tylox prior for complaints of pain in LLE. MD aware (b)(6)-2 CAD
7Aug03	V/S areas follows: HR: 99 RR: 16 B/P: 103/62 Temp: 98.7 O_2 Sat: 95% Pt assessment as follows, Pt is A+O x3 PERRLA (B) hand grip strength is strong. Pt is able to wiggle all fingers and toes. Pt's has RRR S1 S2 pulses are strong in (B) UE, cap refill <2 sec x4 extremities. Pt is c/o pain @ this time. Will continue to monitor. SPC (b)(6)-2 RLE LVM

*U.S. Government Printing Office: 1998 - 404-763/20101

STANDARD FORM 509 (REV. 7-91) BACK

ACLU-RDI 1099 p.164

DOD 005432

509-113 NSN 7540-00-634-4122

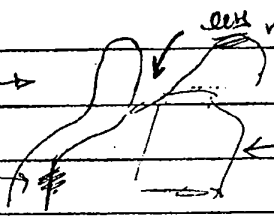
MEDICAL RECORD | PROGRESS NOTES

DATE

2003 7aug

ortho brief note

(R) hand dressing change →



slight maceration exudate today

(b)(6)-2

will d/c IV antibiotics and change to po clindamycin for time being.

1430 8AUG03 Pt VSS: BP 86/45, HR 92, T-99.3, O_2 sats 96%, R-12. Pt took 1 can of ensure. Had loose stool approx 300cc. Pt drsg on RUE, RLE, LLE are CDI @ this time. Physical exam other than lacerations/drsg unremarkable. (b)(6)-2 [illegible]

2030 8AUG03 W→D drsg Δ to RLE. Pt tol. well and assisted c̄ pin care. Wound appears beefy, red c̄ minimal exudate. W→D drsg reapplied; c̄ splint (b)(6)-2 [illegible]

8/9/03

opnote

Pre/postop Dx: Infected (R) Thumb fasion
Infected (L) foot graft

Procedure: Removal grafts / I&D
antibiotic cement spacer (R) thumb
wound closures

(b)(6)-2

[illegible] space [illegible] TCR
in stable Cond

(continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; gra[illegible] hospital or medical facility) (b)(6)-2 WARD NO:

Iraqi # (b)(6)-4

Prevs

PROGRESS NOTES
Medical Record

MEDCOM - 1381

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

509-113 NSN 7540-00-634-4122

MEDICAL RECORD | PROGRESS NOTES

DATE	
8 AUG 03	
0700	Vital signs: HR-106 BP-115/59 Temp-99.0 PulseOx-95% Resp-14 Assumed care of pt. SPC (b)(6)-2
8 AUG 11:35	Pt has had diarrhea x2 this morning. He requested Meds, however Dr (b)(6)-2 says if diarrhea continues he will prescribe meds. Dressing on (R) leg changed as ordered. Small amount of bloody drainage and tissue by achiles tendon looks white today. Dr. changed (R) hand dressing and will change (L) leg dressing tomorrow. Assessment complete, vital signs normal, brisk cap refill, pt experiencing numbness in (L) leg. Doctor states is normal for injury. Abrasions and lacerations appear to be healing well. Bowel sounds active x4, clear lung sounds, S^1 and S^2 heart sounds, 0 pain. SPC (b)(6)-2
8 Aug 03	Vital signs are as follows: HR-100 RR-12 BP-103/49 Temp-99.3 O2 Sat-%
2245	Pt report received. Pt is A+O x3, PERRLA and pt is able to move all extremities. Pt c/o no pain, but does c/o numbness to the toe next to the great toe on (L) foot and pt has very little strength to that toe. Pt has also c/o slight numbness to (R) index finger, strength is appropriate (R) hand grip strength strong and cap refill <2 sec ±2+ radial pulse. Cap refill for all extremities <2 sec. Will continue to monitor. SPC (b)(6)-2 91C LVN
8 Aug 03	(Late note) Dressing d done per Dr (b)(6)-2 instructions. Wound is dark
2340	pink and meaty. 6 inches of Kerlex moistened then squeezed damp (cont.)

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last; first, middle; grade; rank; rate; hospital or medical facility) | REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

MEDCOM - 1382

STANDARD FORM 509 (REV. 7-91)
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PROGRESS NOTES

DATE	
8 Aug 03 2348	(cont.) placed over wound and Dry Kerlex was wrapped around pt's hand. Dressing secured c̄ 2" silk tape. Will continue to monitor. — SPC (b)(6)-2 [redacted]
9 AUG 03	
0700	Assumed care of pt. Vitals: BP-109/68 HR-101 Temp-97.7° Pulse OX-96% Resp-14. Assessment complete, lung sounds clear, S1+S2 heart sounds, bowel sounds Active x4, pt had diarrhea x1 today, Dr. (b)(6)-2 [redacted] changed (L) foot and (R) hand bandages, nursing staff changed (R) leg dressing. Wound looks red and meaty. Pt to surgery @1500 for (R) Hand washout, NPO after 0800 breakfast. IV started in (L) FA, 18 g, patent and ∅ sign of infiltration. IV Ancef prescribed and given as ordered. Pt reports ∅ pain. SPC (b)(6)-2 [redacted]
1400	Assumed care of pt. sitting up in bed, ∅ distress VS: 106/60, P-96, R-16, T-99.2 SaO2-95. Pt NAD, ~~Alert~~ Alert & cooperative. lungs CTA (B), ∅ W RR heart RRR, S1 S2 ∅ murmur or rubs Abd soft & flat, (+) BS x 4 q. ∅ masses, tenderness or organomegaly ∅ BS. peripheral pulses 2+ (B) UE & LE. (=) strength & ROM all extremities. ∅ drainage to drsgs on wounds (b)(6)-2 [redacted]
1450	Pt to OR. Pt with loose stool x1. ∅ distress noted. linens changed on bed. (b)(6)-2 [redacted]
1620	Pt to bed. see Postop note. (b)(6)-2 [redacted]
1735	Pt awake, offered food. pt refused. (b)(6)-2 [redacted]

*U.S. Government Printing Office: 1996 - 404-763/20101 STANDARD FORM 509 (REV. 7-91) BACK

MEDCOM - 1383

ACLU-RDI 1099 p.167

DOD 005435

PROGRESS NOTES

DATE	
9Aug03 2220	Pt report received. Pt is A+O x3 PERRLA (L) hand grip strong. Pt is able to move all ~~finger~~ (b)(6)-2 fingers and toes. Cap refill on all fingers and toes is <2sec. Pt c/o pain to (L) Lower Leg and (R) hand. Pt medicated c̄ ii tylo. Will continue to monitor. SPC (b)(6)-2 9K LVN
10Aug03 0315	VS are as follows: HR-82, RR-16, BP-113/59, Temp-99.2°, O, Sat-94% on RA. Will continue to monitor. SPC (b)(6)-2 9K LVN
10AUG03 0800	Assumed care of pt. Vital Signs: Temp-97.3°, Resp-14 HR-95 BP-115/62 Pulse ox-94%. SPC (b)(6)-2 WM6
10AUG03 0900	Assessment complete. (R) LE needed one more steri strip applied by doctor due to separation of remaining stitches on top surface of foot. (R) heel wound looks red and meaty. Overall appearance of skin was dry and scaling so lotion was applied after bed bath. @ 0830 output of 825cc urine, light yellow via bedside urinal. Cap refill <2 seconds in all extremities, pulses normal, lung sounds clear, S1+S2 heart sounds, pt complaining of itching on LLE, no complaints after lotion applied. Pt reports ∅ pain. Bowel sounds present x4. SPC (b)(6)-2 9K WM6
10Aug03 1100	I concour c̄ above assessment (b)(6)-2
10AUG03 1300	Dr. (b)(6)-2 to change dressing tonight only - due to surgery yesterday - no morning dressing change. Pt had output of 450cc urine, clear and light yellow. Pt complaining of (L) leg + (R) hand pain. 2 Tylox given as ordered. IV running LR @ 60cc/hr to (L) FA, patent and ∅ sign of infection. Pt drinking plenty of PO fluids. SPC (b)(6)-2

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MEDCOM - 1384

ACLU-RDI 1099 p.168

DOD 005436

509-113 NSN 7540-00-634-4122

MEDICAL RECORD | PROGRESS NOTES

DATE

1430 10AUG03 Pt assessment complete. VS 109/54, HR-89, Pulse Ox-95%, Temp 99° (o). Lungs CTA Bilaterally, HS-S1/S2, BS x 4 quads, IVF @ 60cc/hr (L) FA. Pt consumed 90% of evening meal. Drsg on (L) hand and both lower extremities C/D/I. Drsg Δ to be completed this evening to RLE — (b)(6)-2 [redacted] UTAN

2030 10AUG03 Pt drsg's changed on URE/~~LLE~~. Both wounds appear red and beefy c̄ minimal exudate on ~~LR~~ (b)(6)-2 (R) LE also c̄ sanguinous drainage. Both drsgs replaced as per MD instructio (b)(6)-2 [redacted] no

2230 10AUG03 VS: 98/37 T 99.5 P 95 96% RA R 15 LR infusing @ 60cc/hr into (L) FA, site patent ~~o~~ s/sx infection/infiltration lungs CTA (B) Cardiac S1S2 c̄ murmur BS Active x4 peripheral pulses +2 in all extremities. (LLE, RUE, LUE) Pt 40 itching to lower extremities Dressings CDI. — (b)(6)-2 [redacted] UTAN

11 AUG 03 0700 Assumed care of pt. Doc ordered NPO, possible skin grafting today. Output of 500cc medium yellow urine. Vital signs - BP 109/55 HR 97 Temp 98.8 Pulse ox 96 Resp 12 (R) leg wound looking white near stitches on Achiles tendon, other areas more red with bloody drainage during dressing change. Pedal pulses normal, LUE normal ~~pedal~~ radial LS pulse, RUE bandage is C, D, + I. Cap refill brisk in all extremities, lung sounds clear, S1 + S2, bowel sounds active x4. LR infusing @ 60cc/hr to (L) FA, patient and sign of infiltration — SPC (b)(6)-2 [redacted] UTAN

(Continued on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility) | REGISTER NO. | WARD NO.

Iraqi (b)(6)-4 [redacted]

PROGRESS NOTES

Medical Record

MEDCOM - 1385

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

PROGRESS NOTES

DATE

Continued

11 AUG 03 0820 Pt told several times not to pick at scabs. Pt reports ∅ pain, however complaining of abdominal discomfort ∅ diarrhea. —— SPC [redacted] WM6

11 AUG 03 0900 Dr. [redacted] said pt will not be getting skin graft today, pt no longer NPO —— SPC [redacted]

11 AUG 03 1320 Assisted Dr. [redacted] with (R) Hand + (L) Foot Drsg Δ's. Skin grafting may take place on Wednesday. No complaints and ∅ pain, pt had diarrhea x 1 @ 1100 hrs. SPC [redacted]

11 Aug 03 @ 1430 Rc'd report and assumed care of Pt VSS-afebrile. Dressings c/o/i. No c/o pain

99⁴-80-110/56 18 @ this time. PIV c̄ LR @ 60/HR - (L) AC - c̄ S/S of complication. Cont. monitor. [redacted] CA

@ 1830 Pt consumed an approx. 40% of evening meal, and drank .5L bottle of gatorade. Has remained c̄ complaint. IVPB and currently infusing [redacted] LPN

Addition: Void via urinal: 500cc c/y urine. [redacted] LPN

@ 2150 Dressing Δ to (R) LE - Wet to Dry per order. Red/Healing looking tissue c̄ two areas approx 5mm-6mm c̄ slight purulence. Voided 350 cc c/y urine. Medicated for c/o pain (verified by interpreter) c̄ Tylox × II. Report status to on-coming shift. [redacted] LPN

12 AUG 03 0800 Assumed care of pt, VSS and afebrile. (R) Hand dressing

97², 82, 113/58 14 has serous drainage on bandage, to be changed this AM by Dr. [redacted] (R) LE Drsg changed, site looks very good, the wound is approximating and color is good. AM care complete w/Assistance, bedding changed today. Pt used bedside commode, loose stool with 500cc light yellow urine. Lung sounds clear, S¹ and S², normal radial and pedal pulses and caprefill is brisk. ∅ complaints, ∅ pain, pt eating a good breakfast of fruit and MRE. SPC [redacted]

U.S. Government Printing Office: 1996 - 404-763/20101 STANDARD FORM 509

MEDCOM - 1386

509-113 NSN 7540-00-634-4122

MEDICAL RECORD | PROGRESS NOTES

DATE	
12 AUG 03 0900	Drsg Δ by Dr (b)(6)-2 (R) thumb needs washout. NPO until surgery later this afternoon (1500hrs). — SPC (b)(6)-2 1400 16
12 AUG-03 0915	Interpreter explained to pt that (R) thumb will be worked on in surgery, NPO until after surgery. Interpreter gave pt 2 bags of food, soda, and cookies from pt's family (b)(6)-2
12 Aug 03 @ 1430 994-16 1138-5L 12 Aug 03 1650	VSS-afebrile. Assessment completed. Dressings C/D/I. Pt. remains NPO 2° scheduled surgery. No complaints @ this time. Cont. monitor. (b)(6)-2 LVN — Pt. recovered from procedure. S/P Washout (R) Hand. Pain controlled c MSO4 during recovery (See Procedure Flowsheet). Administered Tylox ii PO for further c/o pain upon completion of recovery. Dressings remain C/D/I. Post op Cont. monitor. (b)(6)-2 LVN —
@ 1800 2120	Pt. tolerated food brought by interpreter. Currently resting in bed in acute distress. (b)(6)-2 Concur c above assessment (b)(6)-2 RN/A
12 Aug 03 2220	VS as follows: HR-85 RR-16 BP-116/57 Temp-98.3 O2 Sat-97% Pt is A+O x3 PERRLA, pt is able to move all fingers and toes. Pt has RRR pulse is 2+ in (L) UE cap refill is <2 sec. Pt is c/o pain to (R) hand. Pt medicated c ii tylox. Will continue to monitor. — SPC (b)(6)-2 RN LVN
12 Aug 03 0235	pt resting will cont to monitor (b)(6)-2
0330	Pt. consulted Sgt (b)(6)-2 stated she will be in this afternoon for stretcher and getting him to chair will cont to monitor (b)(6)-2

(Continue on reverse side)

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PROGRESS NOTES
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Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

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509-113 NSN 7540-00-634-4122

MEDICAL RECORD | PROGRESS NOTES

DATE

13 Aug 03 0920 1020 ~ @ 0930 Dr [redacted] in @ BS to Δ dsg to (R) hand
BP-116/57 dsg to (R) LE Δ^ed ~~[illegible]~~ [redacted] wet → Dry, pin care
P-85 completed. lung ~~[illegible]~~ assessment CTA. pulses
R-12 +2 ped + rad. pt had BM c̄ urine this AM. Stool
T-99.3 was soft + non formed. cap refil brisk. pt
refused Breakfast. Interpeter brought in food.
TV Δ^ed in (L) FA. patient + ADI. Dsg Δ^ed to (L) foot
sm ~~amt~~ amt of drainage to stitches. Non adhesive
dsg placed, BSA, will cont to monitor [redacted]
13 Aug 03 1300 PT note: pnt. is Iraqi male c̄ multiple wounds - Ex. Fix (R)
LE Tib/Fib/ankle & wounds to (L) ankle. % N/T
in (L) LE down to toes. pnt has wound to (R)
hand - skin flap - unable to use thumb.
pnt. instructed (thru interpreter) in ex. program for bed activity.
: Quad sets x 10 reps c̄ 3 sec. hold (B) LE q 3°,
SLR's 10 reps c̄ 3 sec. hold (B) LE q 3°, ankle pumps
and ankle circles (L) ankle x 10 each q 3° - wiggle
toes (B) and II-V digits (R) hand throughout the
day. pnt. ambulation status in question -
WB status for (R) LE ex. fix ? & (R) hand expressly
(R) thumb. status for WB through it for use of
crutches? therapist will consult Dr. [redacted] &
return for further ambulation coaching. will
progress pnt. c̄ exercises & WB/ambulation as
tolerated.

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, hospital or medical facility) [redacted] [redacted] WARD NO. MPT/SGT/91WN9

Iraq [redacted]

PROGRESS NOTES
Medical Record

MEDCOM - 1388

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

PROGRESS NOTES

DATE	
13 AUG 03	Recieved Pt VSS = Oral temp 99.4, RR 16, HR 99, BP 102/55 O2SAT
1430	99% RA, CTA X5, BSA X4 Quads, Peripheral pulses Strong equal Ø
	Complaints at this time Will continue to monito [redacted] sgt 91WM6
13Aug03	Received pt. VS areas follows: HR-84 RR-16 BP-109/56 Temp-99.2
2225	O_2Sat-96%, Pt is A+O PERRLA grip strength strong on (L) UE, pt
	can move all fingers and toes. Cap refill <2 sec x4 extremities
	Pulses 2+ x (B) UE. Pt is ∓ c/o pain. Will continue to monitor.
	SPC [redacted] 91C LVN
14 AUG 03 0800	T=98.8, P=89, R=12, BP=98/52, sat=99 on RA. PT awoken
	for VS + assessment. PT refuses breakfast +
	am care. Cardiac - RRR ∓ MRB, Lungs - CTA, BS active x4,
	Pulses 2+ Bil - (L) DP + radial. (R) DP can't be assessed
	due to dressing. Good cap refill. Skin warm + dry. IV
	LR @ 60 cc/hr. in (L) FA ∓ S/S of infection or infiltration.
	Dressing (R) hand - small area of serous drainage.
	(R) LE - ex. fix. remains in place as well as splint c
	wrap. [redacted] MATTAN
0945	- PT OOB to chair - transferred himself ∓
	diff. [redacted] MATTAN
1500	Recieved Pt VSS = 99.1°, HR85, BP 100/58 RR16 SAO2 98% RA, CTA X5, BSA X4
	Quads peripheral pulses +2 Equal strong Ø complaints at this time
	will continue to monitor [redacted] SGT 91WM6 LVN
2200	Pt Vop = 1200 cc This shift [redacted] SGT 91WM6 LVN
14Aug 03	Pt voided 425cc of clear yellow urine. Pt is A+O x3 PERRLA
2235	(L) UE grip strength strong. Pt can move all fingers and toes. Cap refill
	is <2 sec x4 extremities. VS are as follows: HR-94 RR-16 BP-105/48
	Temp-99.0 SaO_2 98%. Will continue to monitor. — SPC [redacted]

*U.S. Government Printing Office: 1996 - 404-763/20101

STANDARD FORM 509 (REV. 7-91) BACK

509-113 NSN 7540-00-634-4122

MEDICAL RECORD	PROGRESS NOTES
DATE 15 AUG 03	Assumed care of pt. VSS, afebrile. Lung sounds
0720	clear, S1 and S2, bowel sounds active x4, pt
98.4o, 98%	refused breakfast. Bandages C, D, + E, brisk
85 HR, 107/59	cap refill, LR @ 60 cc/hr to (L) FA, patent and a sign of infection -
14 Resp	SPC (b)(6)-2
15 AUG 03	
0750	Pt had loose stool x1 and 575 cc Medium yellow urine. SPC (b)(6)-2
15 AUG 03	
1005	Pt complaining of dry, flaking skin on scalp. Morning
	care Complete, Drsg Δ's as Ordered. No drainage on
	dressings, wounds looking good SPC (b)(6)-2 AUWMC
15AUG03	Pt Assessment complete. VS - BP 107/62, HR - 89, T - 98.8, O2 - 98%,
1430	R - 16. LS - CTA B=bat., HS - S1, S2, BS x4 quads. NEURO VS WNL. IVF
	Hlocked as per MD order (b)(6)-2 CAHN
2110	Pt UOP - 700cc for shift. Drsg Δ's on RUE, RLE, LLE complete
	wounds c mod. exudate / appear red and beefy (b)(6)-2 CAHN
15AUG03	VS: 98.5, 102/55, 81, 98% RA R 18 Pt AOx3
2330	Lungs CTA (B), Heart RRR s murmur, BS Active x4 IVin (D) RA
	flushes well no s/s infection/infiltration. Pt neuro vase. WNL
	on RUE, and (B) LE. Pt resting in bed (b)(6)-2 CAHN
16Aug03	
0730	Lung assessment CTA, A+Ox3 BS (D) 4Q flex + Extend
BP 107/62	(B) LE not full strength pulses +2 (B) L.S + (B) UE, dsg
P 78	Δ'd W→D on (B) LE. (L) foot dsg Δ'd. Bacitracin
R 18	+ mono adhesive dsg applied. Bath complete
T 98.8°	well - Cont to monitor (b)(6)-2
O2 99%	

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility) | REGISTER NO. | WARD NO.

Fragt (b)(6)-4

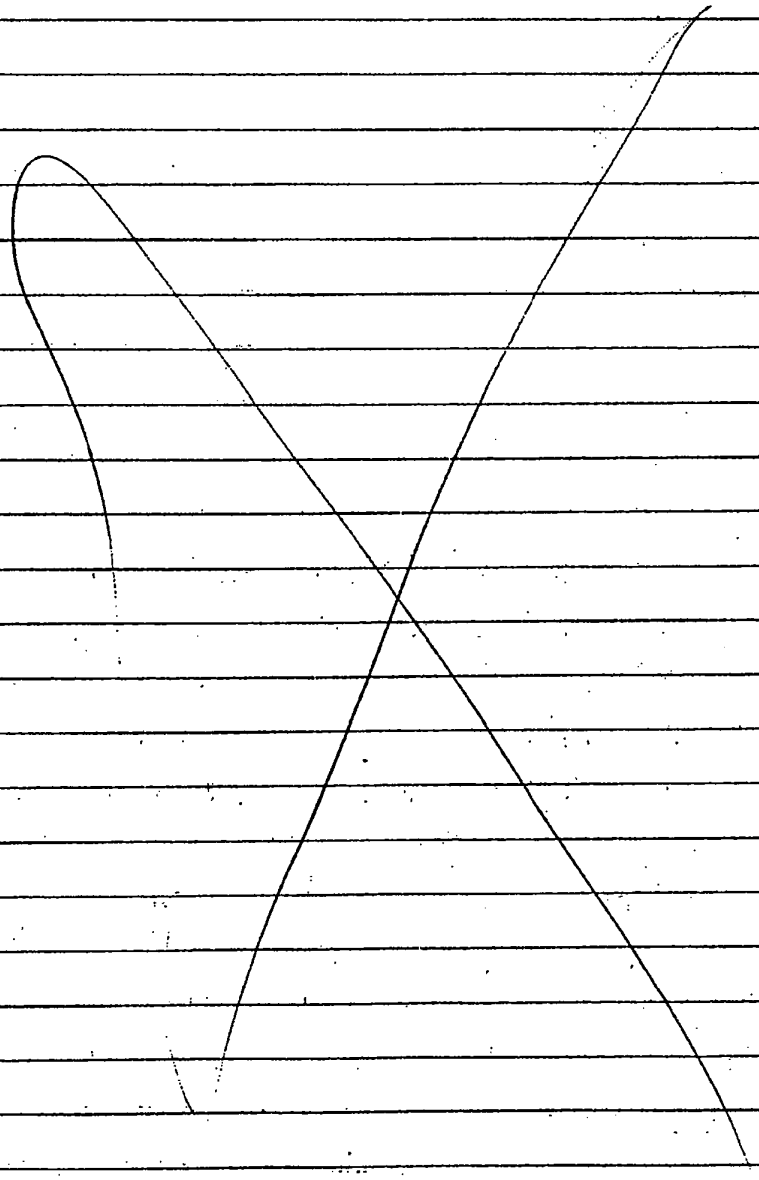
PROGRESS NOTES
Medical Record

MEDCOM - 1390

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

PROGRESS NOTES

DATE	
1040 16Aug03	@ 0900 pt has sm watery BM & urine ↑ to BSC. pt ate late breakfast Early lunch. Interpeter brought in meal. will cont to monitor (b)(6)-2



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MEDCOM - 1391

509-113 NSN 7540-00-634-4122

MEDICAL RECORD	PROGRESS NOTES

DATE 2003 16 Aug

ORTHO PROGRESS NOTE

HD # 22 (26 July 03) s/p multiple ortho injuries / operations

issues: skin graft (R) hand, (R) LE (over tendon)

strengthening exercises guards

nutrition

ex fix (R) LE

multiple healing wounds - sutures, scar tissue, (also s/p bone graft removal (R) hand, (L) foot 2° infection)

? (R) thumb retention vs. amputation

remains AF, vs WNL

PT has consulted c̄ pt and pt has lis doing exercises per her recommendation.

interpreter brings pt meals; apparently throws some food away - but is eating better through day - will recommend supplement c̄ Ensure

wounds daily dressed - ① c/o infection currently since PMMA/vanc (cement) placed 12 Aug 03 - No fluctuance, no purulence / exudate expressed.

Doing well currently c̄ (R) LE ex fix, bone graft removal from infected (R) hand, (L) Foot c̄ placement of 2nd vanc bone cement (PMMA) to (R) thumb. Sites keeply red and healthy for skin graft. (R) thumb/hand currently s̄ infex.

will continue to follow, monitor dressing Δ's / inspect wounds / push nutrition + exercise

Pending skin graft

(b)(6)-2

(b)(6)-2 [signature]

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)

REGISTER NO.

WARD NO.

IRAQ 1 (b)(6)-4

PROGRESS NOTES

Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 1392

509-113 NSN 7540-00-634-4122

MEDICAL RECORD	PROGRESS NOTES
DATE	
16AUG03 1400	Assumed care of pt NAD, awake watching TV. VS - T. 98.6 P - 89 BP 109/58 R - 20 Lungs CTA, ZWR. Heart RRR, abd soft; flat (+) BS x4, quads skin warm dry intact. Moves ext. x4 (=) = 5/5 strength (B), neurovascular check intact. drsgs dry ∓ drainage. IV (L) FA patent, ∓ enfl or edema (b)(6)-2
1700	Pt eating dinner, Ø distress noted (b)(6)-2
1910	Pt c̄ % pain to (R) LE. Medicated per order. (b)(6)-2
2120	Drsg Δ performed, pt tolerated well. good granulat tissue noted (b)(6)-2
16AUG03 2215 ~~1015~~ MAW	VS - T=97.8, P=80, R=16, BP=110/60 Sat=98% . PT denies pain. Assessment complete - VSS, cardiac - RRR ∓ MRS, Lungs CTA, ABD - BS x4 - ØTTP - Dressings (R) hand, (L) foot, (R) LE CDI. Ex fix remains in place (R) LE - ABLE to all extremities - good strength, good cap refill. HL (L) FA ∓ S/S of infection. (b)(6)-2 MAW
17 AUG 03 0800 98.10 - 99% 78-14 - 111/63	VSS, 750 cc medium yellow urine, lung sounds clear, Bowel sounds Active x4, HepLoc in (L) FA patent and without sign of infiltration. Brisk cap refill, good strength and movement. Pt denies pain. SPC (b)(6)-2
17 AUG 03 1155	Pt IV infiltrated. New Heploc placed in (L) Hand. SPC (b)(6)-2

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility) | REGISTER NO. | WARD NO.

IRAQ (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 1393

PROGRESS NOTES

(M) AMGDATE	
1335	Pt refused Ensure @ 1000 hrs. SP (b)(6)-2
17AUG03 1335	Concur w above assessment (b)(6)-2
17AUG03 1530	Pt assessment complete. VS - BP 100/60, HR-97, O_2 SATS - 99%, T - 99°. Lungs CTA bilaterally, HR - RRR, BS x 4 quads, Good neuro VS + cap refill, Drsgs on RUE, RLE, LLE - CDI (b)(6)-2
17AUG03 2230	T 98.3 @ BP 111/64 P 88 R 16 S_aO_2 99% Pt AOx3, informed about NPO status pMN pt ate chips and drank water. HRRR murmur S_1S_2 Lungs CTA @ Pt has 0 complaints on assessment BS Active x4 Neurovasc WNL on all extremities (b)(6)-2 UTAN
18AUG03 0900	Pt to go to Surgery this A.M.; NPO, VSS, AM CARE
100%-87HR	complete, assessment done, lung sounds clear, S_1S_2,
98.2 oral 14	Bowel sounds x 4, brisk cap refill, DRSG D's AS
112/55	ordered - wounds are approximating. SP (b)(6)-2 UMG
18AUG03	
1300	Pt recovered from surgery. DRSG D's to LLE and (R) Foot only. Dr (b)(6)-2 to change skin graft site and donor site in 3 days. Pt given MSO4 for pain as ordered, developed raised, irregular mounds on (L) FA, No SOB. Pt given Benadryl as ordered, raised patches dissolved.
18 AUG	SP (b)(6)-2
1525	Pt complaining of pain at IV site when flushed. New Heplock placed in (L) FA per SG Carbee. No
98.8 oral	evidence of infiltration at site, however new line
105/58 97HR	was put in. SP (b)(6)-2
14 Resp.	
98% RA	

*U.S. Government Printing Office: 1996 - 404-763/20101

509-113 NSN 7540-00-634-4122

MEDICAL RECORD	PROGRESS NOTES

DATE

Ortho Op Note

2003 Pre/postop Dx: (R) hand (dorsum) and (R) Achilles tendon open wound
18 Aug (skin avulsion)

Op: skin graft (R) hand (dorsum) and (R) achilles tendon c̄
(R) ant. thigh donor site

Surg (b)(6)-2 / (b)(6)-2 / (b)(6)-2 / (b)(6)-2 CRNA (b)(6)-2

EBL min Fluids 700cc UOP Φ nm 19 Ancef IVPB

Findings: good grafts obtained, pie crusted, stapled, vaseline gauze/wet
bolster sutured, kerlix wrap good results. Photos x 12)
Extubated c̄ difficulty - P PACU (1 cu) c̄ SV, VSWNL

(b)(6)-2

(b)(6)-2 [illegible]

18 AUG 03 VS: T 97.9 BP 103/32 R16 P80 SaO_2 98% RA Pt AOX3
2240 Lungs CTA (B) Cardiac RRR c̄ murmur S_1S_2 pt has ∅ c/o
pain @ graft site on hand or at graft donor site on
thigh. BS Active X4 Neurovasc ✓ WNL on all
extremities pt resting comfortably in bed — (b)(6)-2 [illegible]

19 AUG 03 0830 T=98.7, P=85, R=16, BP=112/57, Sat=99% on RA - pt awoken
for VS & assessment. Pt A & OX3. Cardiac - RRR c̄ MRS
lungs - CTA, abd - BS active X4, skin warm &
" dry - extremities c̄ good cap refill & pulses Bil.
pressings! - (R) hand, CDI, (R) thigh - mod amt
serous drainage, (R) ankle - CDI. EX fix
remains in place (R) LE, pt denies pain.

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility) | REGISTER NO. | WARD NO. cont.

1RAQ1 (b)(6)-4

PROGRESS NOTES
Medical Record

MEDCOM - 1395

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

PROGRESS NOTES

DATE	
19 Aug 0830	cont. HL (L) anteub - Ø S/S of infection or infiltration. (b)(6)-2 [redacted]
19 Aug 1430	Temp-99°, Resp-12, HR 94, BP 112/59, 97% RA. (L) Foot had very dry skin, lotion applied in order to discourage pt from picking. Assessment complete. Moderate amount of serous drainage on (R) thigh DRSG, (R) Hand (R) leg ~~and~~ LS (L) LS DRSG's all clean, dry, and intact. All pulses normal, brisk cap refill, lung sounds clear, S1+S2 heart sounds, bowel sounds active x4. (R) leg external fixator in place. Ø pain, Ø complaints, pt OOB to chair. Stool x1 and 500cc medium yellow urine. SPC (b)(6)-2 [redacted] WM6
19 Aug 03 1900	Recieved pt Ø Complaints VSS = HR 70 BP 114/64 ORAl temp 97.5° RR 16 CTA x5, BSA x4 Quads, Voiding yellow urine, Ø pain, Nausea Will continue to monitor (b)(6)-2 [redacted] 9 WM6 LVN
20 Aug 0820	T=98.3, P=83, R=16, BP=110/67, Sat=98%. PT AVOX3 HL (L) anteub area 5 S/S of infection. Dressing (R) hand = CDI, (R) thigh - mod serous drainage - reinforced c̄ Kerlex, (R) ankle - CDI. Exfix still intact RLE. Cardiac - RRR 5 MHs, lungs CTA, ABD - BS x4. PT denies pain, want for breakfast or desire for am care at this time. (b)(6)-2 [redacted]
20 Aug 03 1530	T. 99.2 P. 89 R-20 B/P 119/68 SPO2 99%. Pt admitted from ICU1. Assessment completed. PERRLA, AVOX3, Breath sounds CTA (B) Apex to base Edema noted on (R) foot, ~~Hex~~ Peripheral pulses present x4. Bowel sounds normal active x4. Dressings to (R) hand, thigh, and ankle CDI. Pt up to chair. Ø C/O pain, discomfort, S/S of distress (b)(6)-2 [redacted]

*U.S. Government Printing Office: 1996 - 404-763/20101 STANDARD FORM 50

MEDCOM - 1396

509-113 NSN 7540-00-634-4122

MEDICAL RECORD	PROGRESS NOTES
DATE	
2230 Aug 20 03	A/O X3 - PERRL - LS, CTA BS ⊕ 4Q MAE (R) Hand dressing C-D-I (L) FA IV Hyploc ORIF (R) LE SR @ 80's T 98³ P80 R16 B/P 115-63. PT Has MP at the bedside. Has ∅ c/o discomfort at this time, per translator will con't to monitor per orders (b)(6)-2
0200 Aug 21, 03	Doing well has No c/o at this time. say's doing ok per the translator. Will con't to monitor. (b)(6)-2
0430 Aug 21, 03	Resting well NAD will con't to monitor (b)(6)-2

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)

REGISTER NO.

WARD NO.

IRAQ 1 (b)(6)-4

PROGRESS NOTES

Medical Record

MEDCOM - 1397

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

PROGRESS NOTES

DATE	
22 Aug 2003	0605: (Nursing Notes Continued from reverse). (R) pedal pulse strong. (D) anterior foot suture line s̄ redness, edema, or pain. Pt makes ∅ c/o pain or discomfort. Will continue to monitor. (b)(6)-2 [redacted] LPN
22 Aug 2003	0730: Pt output per urinal 400cc & difficulties. Will continue to monitor. (b)(6)-2 [redacted] LPN
22 Aug 2003	0950: Nursing Notes: Pt defecated in BSC, had large amt of liquid stool, denies abd pain. Will continue to monitor. (b)(6)-2 [redacted]
22 Aug 03	(-1400) - denies c/o pain, ∅SOB, dressing to (R) lower ext. CDI to pin site & thigh; dressing to (R) hand CDI, IV to (R) AC CDI s̄ redness, pain, or swelling. will cont to monitor pt (b)(6)-2 [redacted]
2230 22 Aug 03	Took over care. VSS T 98.3 P 77 R 18 BP 113/59 Sat's 94% RA A/O x 3 PERRL Chest CTA HEAR + RRR Abd ⊕ BS x4 non-distended - non-tenderness MAE (R) Hand S/Graft. C-D-I (R) LE ORIF + S/Graft C-D-I. Will cont to monitor per orders. Has ∅% discomfort at this time. (b)(6)-2 [redacted]
Aug 23, 03 0120	Sleeping eyes closed rises and fall of chest noted will cont to monitor per order. (b)(6)-2 [redacted]
0900	T 98.2F, BP 117/66, HR 80, RR 14, SPO2 100% on RA, NAD VSS, Dx to RLE CDI, lung sounds clear, bowel sounds active x4 quad., pt sitting up in bed (b)(6)-2 [redacted]

*U.S. Government Printing Office: 1990-262-081/20138

STANDARD FORM 509 BACK (Rev. 11-77)

MEDCOM - 1398

MEDICAL RECORD	PROGRESS NOTES
DATE 21 Aug 03 1015	Pt assessment complete. Pt VS - 116/63, 80 Bpm, 100% SPO2, 97°, RR 15. Lung fields CTA. Ø cough. + Pulses x4, good cap. refill. Pt able to move all extremities. Dressings changed by Dr's. Ø signs of infection. Dressings CDI. Bowel sounds + x4. Pt up to Chair. Pt states thru interpreter "I feel fine;" Will continue to monitor. (b)(6)-2
21 Aug 03 1400	pt resting c̄ guard @ bedside, shows no s/s of difficulty breathing, denies c/o pain through hand motions, dressing to (R) leg (pin site: thigh) CDI, dressing to (R) hand CDI, IV site shows no s/s of redness, swelling or pain. (b)(6)-2
2200 Aug 21, 03	Resting well NAD VSS T 99° P 94 R 18 B/P 112/63. A/O x3 PERRL SR BS CTA MAE will con't to monitor per the orders (b)(6)-2
22 Aug 03	0605: ~~Assumed~~ ERROR (b)(6) Nursing Notes: Assumed pt care. VSS: BP 116/70, P83, T 98.5, RR 16, Pulse ox 99% on Room Air. IV HL in (R) FA patent & flushes easily, site s̄ redness, edema, or pain. (R) hand dressing CDI. NSR, Ø ectopy, Ø murmurs, PPP. (B) lungs CTA, cap refill (+) 1 sec. BS (+) hyperactive X4 quads. (R) upper leg drsg. CDI. (R) Ext Fix to (D) lower leg c̄ drsg @ pin site proximal ankle.

(Continue on reverse side) (b)(6)-2

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)

Iraqi (b)(6)-4

REGISTER (b)(6)-2

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FIRMR (41 CFR) 201-45.505
509-111

MEDCOM - 1399

MEDICAL RECORD	PROGRESS NOTES
DATE	
23 Aug 03 1430	V/S: T-99.1 P-91 R-20 B/P 111/59 SPO2-100% RA Assessment completed. Lungs CTA A/B (B). Bowel sounds active x4 Peripheral pulses strong x4. A+O x3. PERRLA, Dressings CDI, ∅ S/S of infection
23/8/03	Ortho Skin grafts (R) calf (R) Dorsum of hand c̄ 95% + take ∅ Drainage from (R) Thumb (P) (1) If wounds healing well, Transfer to GPW camp 8/29/03 (Friday) (2) WBAT (L) LE (3) PT instruction c̄ SGT Hauser for ambulation c̄ Crutches (4) Daily Dressing Changes until wounds c/o (5) NWB (R) LE x 2 weeks
	(b)(6)-2
	(Continue on revers (b)(6)-2

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)

(b)(6)-4

Iraqi (b)(6)-4

WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FIRMR (41 CFR) 201-45.505
509-111

MEDCOM - 1400

PROGRESS NOTES

DATE	
23AUG03 2210	VS - T-98.5 HR 91 Sat 99% BP 118/64 RR 12
	Pt appears to be sleeping in bed, NAD. Dresg to (R)UE + (R)LE
	CDI. NO c/o pain Will continue to monitor — (b)(6)-2 [redacted]
24Aug03 1040	VS - BP 112/62, HR 81, RR 12, SpO2 100% on RA, T 98.4
	IV in (R)fa was DC'd; lungs sounds clear, BS active
	x4 quad.; Dr (b)(6)-2 [redacted] did dressing Δ's to (R) hand
	+ RLE; CDI; pt. given Lesquin PO; NAD, VSS
	pt. sitting up eating will cont to monitor — (b)(6)-2 [redacted]
25AUG03 0530	Pt slept well Through night. Voiced no c/o pain/discomfort.
	Voided QS clear yellow urine/urinal. — (b)(6)-2 [redacted]
25Aug03	1000 - Pt resting quietly in bed; ∅ c/o pain or dis-
	comfort. VSS P98.2, P83, RR 16, Pulse ox 100%,
	BP 118/69. Pt breathing even and unlabored. Will
	continue to monitor. — (b)(6)-2 [redacted]
25Aug03	1200 - Pt has 350 cc output of dark, yellow
	urine per urinal. Pt refused breakfast
	& lunch. Will continue to monitor. (b)(6)-2 [redacted]
25Aug03	1330 - Pt requested equipment in order
	to bed bathe self. Gave pt the equip-
	ment & pt executed a self bed bath
	∃ difficulty or assistance. (b)(6)-2 [redacted]

*U.S. Government Printing Office: 1990-262-081/20138 STANDARD FORM 509 BACK (Rev. 11-77)

MEDCOM - 1401

ACLU-RDI 1099 p.185

DOD 005453

AUTHORIZED FOR LOCAL REPRODUCTION

...L RECORD — PROGRESS NOTES

...TE | NOTES

Aug 03 1400 pt resting comfortably, 0% c/o pain, 0 S/S of SOB will continue to monitor pt [(b)(6)-2]

25 Aug 03 0% pain, discomfort. 0 S/S of distress. BM x1, 2145. Ambulating c difficulty OOB for 1° AM care, food. Stood on crutches x 10 minutes. Personal hygiene completed. Resting comfortably. [(b)(6)-2]

Aug 25 03 2300 Have pt in bed resting, looking at a book. VSS T 98.3 P 78 R 12 BP 115/64 S.A.'s 99% RA. PERRL A/O x 3 Chest CTA Heart RRR Abd Soft-Nontender NABS Has drsg to (R) hand. Intact c good sensation. Ofif to (R) LE. Drsg to upper (R) leg intact. Has 0% discomfort at this time. Will cont to monitor. per the orders [(b)(6)-2] [(b)(6)-2]

Aug 26, 03 0200 Resting well eyes closed. NAD will cont to monitor per orders. [(b)(6)-2] [(b)(6)-2]

Aug 26, 03 0530 NO N/s in states [(b)(6)-2] [(b)(6)-2]

26 Aug 03 0800: Pt appears to be resting comfortably. No distress noted. [(b)(6)-2]

26 Aug 03 0900: Drs [(b)(6)-2] in, Dsgs N/d to Achilles graft site x 4 thigh graft sites. All remaining staples removed. DSD reapplied by Dr [(b)(6)-2] sites clean, & purulent drainage. [(b)(6)-2]

26 Aug 03 1400 Sitting T in bed. Voices 0 %. 0 apparent distress. Continue to monitor [(b)(6)-2] CPT AN

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI | NUMBER

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)

Iraqi [(b)(6)-4]

REGISTER NO. | WARD NO. [(b)(6)-2]

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

MEDCOM - 1402

DATE	NOTES
Aug 26, 03 2215	Sleeping eyes closed. NAD guard at the bedside. Rises and fall of chest noted. Will con't to monitor over the orders. [redacted]
Aug 27, 03 0110	Resting in bed NAD [redacted]
Aug 27, 03 0530	Resting well setting up in bed. NAD Ø c/o [illegible] at this time. [redacted]
27 Aug 1000	BP 117/62 HR 89 RR 18 SpO2 100% RA T 96.9. Pt drank & can ensure. Resting quietly in bed. [redacted]
27 Aug 1800	↑ to amb + use BSC x3. Some loose stools. Walking on crutches c̄ diff. Voices Ø c/o. Ø apparent distress [redacted]
28 Aug 03 2205	Pt up ambulated c̄ crutches. (+) BM - loose stool. Ø difficulties c̄ urination. awake talking c̄ MP. Will continue to monitor for Δ. [redacted] (0035) c/o pain in leg p̄ ambulation. Medicated c̄ tylox. [redacted]
28 Aug 1050	BP 119/65 HR 89 SpO2 100% T 96.5. Pt resting this morning c̄ complaints. [redacted]
8/28/03	Ortho wounds O/D/I Skin grafts c̄ 98% take Ø Drainage walking c̄ crutches, bearing weight on (L) LE + PWB (R) LE ambulates short distance on (Plan) (R) Thumb MCPJ fusion c̄ ICBG in 2-3 months p̄ wounds healed / (R) LE fx healed / Ø evidence infection

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STANDARD FORM 509 (REV. 5-99) BACK

[redacted]

MEDCOM - 1403

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EDICAL RECORD | PROGRESS NOTES

DATE	NOTES
August 03 @ 2330	Pt sitting up in bed picking ears. A&O. Pleasant disposition. Ambulate on crutches c SGT (b)(6)-2 O complaints @ this time. Will continue to monitor and prepare for d/c. (b)(6)-2
29 August 03 06:15	Nursing Notes: Assumed pt care. VSS: T 97.1, BP 114/64, P 78, Pulse Ox 99% on room air, RR 17. Pt resting quietly in bed c eyes opened. Lungs CTA, O resp distress noted. NSR, O ectopy, O murmurs. O IV access, ppp, MAE. Pt refused breakfast tray. O c/o pain. Will continue to monitor pt. (b)(6)-2 RN
29 August 03 10:21	Nursing Notes: Pt DC'd to EPW Camp via HMMV accompanied by 3 MP's c his personal belongings, medicine and crutches. Pt ambulated c crutches c difficulty & slow, steady gait. (b)(6)-2 RN

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)

REGISTER NO.	WARD NO.

Iraq (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

MEDCOM - 1404

558-103 (See Instructions on Back of this ...) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp)

LOG NUMBER

ARRIVAL

DATE			TIME
DAY	MONTH	YR.	
26	Jul	03	1800

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☑ OTHER (Specify)

CURRENT MEDS. (tetanus immunization and other data): unknown

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES: NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration)

SEX: M AGE: 22

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: on arrival

VITAL SIGNS

TIME	1800		
BP	104/50		
PULSE	110		
RESP.	24		
TEMP.	99.6		
WT. (Child)	99%		

CATEGORY (See reverse)
- EMERGENT
- URGENT
- NON-URGENT

ORDERS	INITS.	TIME
L+ R Femur PA+LAT	[redacted]	
L+ (R) Tib/Fib	[redacted]	
Bb-2 I Stat 6 Cr CBC	[redacted]	1800
Bolus T Liter N/S	[redacted]	1800
(R) hand Xray	[redacted]	
2mg Mso4	[redacted]	1802

ASSESSMENT/DIAGNOSIS: MULTIPLE PENETRATING WOUNDS, EXTREMITIES

DISPOSITION (Check all that apply)
- HOME
- FULL DUTY

QUARTERS: 24 Hrs. / 48 Hrs. / 72 Hrs.

MODIFIED DUTY UNTIL: DAY / MONTH / YEAR

REFERRED TO (Indicate clinic): ORTHOPEDICS
- EMERGENCY
- TODAY
- 72 HOURS
- ROUTINE

ADMIT. TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE
- IMPROVED
- UNCHANGED
- DETERIORATED

TIME OF RELEASE:

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

22y IRAQI ♂ brought to CSH in custody of military police from local hospital. Individual sustained GSW and fragmentation wounds to (R) and (L) shoulders, (R) hand and B/L lower extremities and feet. Operated (?) debrided at local facility, details of care not available.

PMHx: Ø Meds: unknown Habits: unknown

PSxHx: Ø Allergies: NKDA

GENERAL: Thin Iraqi ♂ alert/answers questions through interprete 6.9 8.7 26.7 152

INTEG: Warm + dry Ø rashes - wounds as noted 137 106 91 1.0 3.0 10

NEENT: Frag wounds + abrasions (L) chin sutured scalp laceration (R) parietal area

LUNGS: CTAB3 w/RR - chest rise symmetric

CV: HRR, tachycardic, NL S1/S2

ABDO: Soft/NT/ND/Ø mass abrasions (R) LQ

~~[illegible]~~

CHEST: Healing penetrating wounds (L) and (R) shoulders

BACK: Healing grazing wounds upper back no penetrating trauma

GU: Ø penetrating trauma

BUTTOCKS: Ø trauma

EXTREM: Penetrating wounds LE's feet BL (R) hand & partial amputation (R) thumb

(CONTINUE ON SF 507, IF NEEDED)

PATIENT'S IDENTIFICATION (Mechanical imprint) FOR WRITTEN ENTRIES GIVE: Name - last, first, middle; SSN; DOB, service status, name and relation of sponsor or next of kin. (IMPORTANT: LIST FACILITY HOLDING TREATMENT RECORD).

(b)(6)-4

SIGNATURE OF PROVIDER AND TITLE: (b)(6)-2 (b)(6)-2 LTC, MC

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans)

Transfer x-rays show (L) Tib-fib fracture

Care transitioned to orthopedic surgery at 1830

EMERGENCY CARE AND TREATMENT

STANDARD FORM 558 (Rev. 6-82)

MEDCOM - 1405

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	26 JUL 03
DOS	26 JUL 03
POD	

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside			(b)(6)-2
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			(b)(6)-2
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title)
(b)(6)-2 MSDA

Department/Service/Clinic: ICU 1

DATE: 26 JUL 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade; date; hospital or medical facility)*

I raq (b)(6)-4

- ☐ HISTORY/PHYSICAL
- ☐ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☐ OTHER(*Specify*)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 1406

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R																			brachial				2	
	L																							3	
	DORSALIS PEDIS R																			Unable to assess				X	
	L																							X	
SKIN (1) Dry (4) Cool (7) Jaundiced (2) Clammy (5) Flushed (8) Color Normal (3) Warm (6) Cyanotic (9) Pale																								4	
																								8	
EDEMA																								0	
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)																								✓	
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)																								4	
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH																								
	FOLEY CARE																								
	ORAL CARE																								
MOBILITY	BEDREST																							L	
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE																							✓	
	HOB 30 DEGREES																							✓	
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE																								
	PAIN SCALE (1-10)																							8	
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN (2) Soft & Flat (1) Distended																								2	
BOWEL SOUNDS (active all quads)																								✓	
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT																									
VOIDING CLEAR, YELLOW URINE q.s.																									
SKIN INTEGRITY	No Breakdown																								
	Surgical Wounds																								
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1																									
#2																									
#3																									

(b)(6)-2 pte

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
PIV	(L) FA 18g	26 JUL	D/S/S of infection in FA

ACLU-RDI 1099 p.191

DOD 005459

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable /Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment –

DATE:

TIME		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open																								4	
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response																								5	
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response																								6	
GLASCOW COMA SCALE (A+B+C)																								15	
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R																							2	
	L																							2	
MOVEMENT (See Motor Function Scale at Top of Page)	RUE																							4	
	LUE																							4	
	RLE																							4	
	LLE																							4	
GRIP (S) Strong (W) Weak (-) absent	R																							3	
	L																							4	
RESPIRATIONS	REGULAR																							✓	
	IRREGULAR																								
	UNLABORED																								
	LABORED																							✓	
	SHALLOW																								
	RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL																							5	
	LUL																							5	
	RLL																							5	
	LLL																							5	
	BOTH BASES																							5	
COUGH	NONE																							✓	
	SPONTANEOUS																								
	PRODUCTIVE																								
	NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																									
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																									
VENTILATOR	Vt																								
	FIO2																								
	RATE (SIMV/CMV)																								
	PEEP / CPAP																								
	PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE	NC (l/min)																							2	
	FM (l/min)																								
ETT #_____	NRBM (l/min)																								
	ETT _____cm gums																								
ETT CARE / POSITION CHANGE																									
ETT / NT SUCTIONED																									
INCENTIVE SPIROMETRY DONE																									
COUGH / DEEP BREATH																									
INITIALS																								(b)(6)-2	

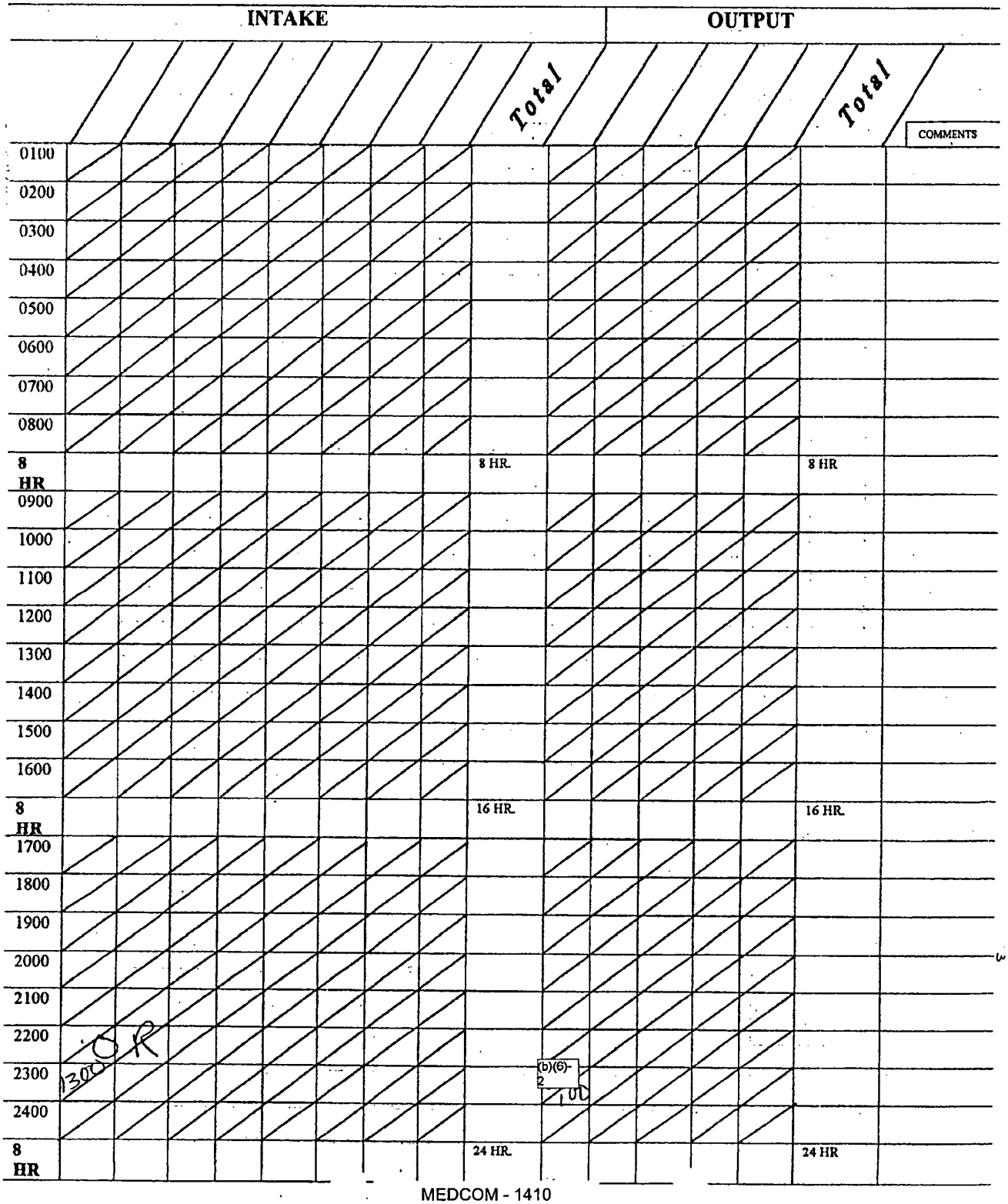
MEDCOM - 1408

NSN 7540-00-634-4123

MEDICAL RECORD — NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
26JUL		2325	From Recovery - Refer to PACU flowsheet nursing care problems section re multiple lacerations, surgical wounds, dressings. PT received a total of 20 mg MSO4 in recovery as well as Tylox ½ PO @ 2315. PT now resting quietly, cont. on 2 l NC - will cont to wean O2 off as PT tolerates. (b)(6)-2 MSN

MEDCOM - 1409


INTAKE
OUTPUT
Total
Total
COMMENTS
0100
0200
0300
0400
0500
0600
0700
0800
8 HR
8 HR.
8 HR
0900
1000
1100
1200
1300
1400
1500
1600
8 HR
16 HR.
16 HR.
1700
1800
1900
2000
2100
2200
2300
2400
8 HR
24 HR.
24 HR
1300 IR
(b)(6)-2
100

MEDCOM - 1410

CRITICAL CARE FLOW SHEET

(b)(6)-2

LOS DATA	
DOA	26Jul03
DOS	26Jul03
POD	

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2 (b)(6)-2 LT An 1G/M	(b)(6)-2

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 SGT LVN	ICU #1	26Jul03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade; date; hospital or medical facility)*

Iraqi (b)(6)-4

- ☐ HISTORY-PHYSICAL
- ☐ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☐ OTHER *(Specify)*
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700 MEDCOM - 1411

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R		*					UTA							UTA								UTA		
	L		2					2							2								2		
	DORSALIS PEDIS R		*					UTA							UTA								UTA		
	L		*					UTA							UTA								UTA		
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale			1 3 8					1 3 8							1 3 8								1 3 8		
EDEMA			*												ft										
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)			✓					✓							✓								S1S2		(b)(6)-2
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)			✓					✓							SR								✓		
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH																								
	FOLEY CARE																								
	ORAL CARE																								
MOBILITY	BEDREST														✓										
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT		3					3															3		
	LEFT		3					3															3		
	SUPINE		1					1							✓								1		
	HOB 30 DEGREES														✓										
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE		✓					✓							✓										
	PAIN SCALE (1-10)																						*		
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN (2) Soft & Flat (1) Distended			2					2							2								2		
BOWEL SOUNDS (active all quads)			+					✓															✓		
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT																									
VOIDING CLEAR, YELLOW URINE q.s.																									
SKIN INTEGRITY	No Breakdown		✓					✓							✓								✓		
	Surgical Wounds														✓								✓		
	Rashes, Lac's, etc																						✓		
DRESSING (Dry & Intact: specify site below)															✓										
#1 (R) shoulder			✓					✓							✓								✓		
#2 (R) Forearm/Hand			✓					✓							✓								✓		
#3 (L) Calf/Foot			✓					✓							✓								✓		
#4 (R) Calf/Foot			*					✓							✓								*		

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
PIV 18G	(R) Forearm	??? (26 Jul 03)	3 s/sx infx or infiltration
PIV 18G	LFA	? 26 July 03	PATENT 5 s/sx of infection or infiltration
PIV 18G	(R) FA	26 July 03	patent; 0 s/sx of infection or infiltration
PIV 18G	(L) Forearm	?26 Jul 03?	patent 5 s/sx infection or infiltration

MEDCOM - 1412

PUPIL SIZE	PUPILS		MOTOR FUNCTION	CHART CODES
1 mm	=	Equal	0 = No Movement	Present ✓
2 mm	R	Reactive	1 = Slight Flicker/ Trace of Contraction	
3 mm	NR	NonReactive	2 = Active (Gravity Eliminated)	Not Applicable /Absent (blank)
4 mm	L > R	Left Larger	3 = Active: against gravity, but not against resistance 4 = Active: Against Gravity and Resistance, not full strength	Refer to Nsg. Notes X
5 mm	R > L	Right Larger	5 = Full Strength against Examiners Resistance	No Change from Previous Assessment --

DATE: 27 Jul 03

TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (2) To Pain (3) To Voice (1) Does Not Open		4					4							4								4		
B. BEST VERBAL RESPONSE (5) Oriented (2) Garbled (4) Confused (1) No Response (3) Inappropriate Verbal Response		through intub 5					5							UTA								N/A		
C. BEST MOTOR RESPONSE (6) Obeys Commands (3) Flexion to Pain (5) Localizes to Pain (2) Extension to Pain (4) Withdraw to Pain (1) No Response		6					6							6								6		
GLASCOW COMA SCALE (A+B+C)		15					15							15								15		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — R		2+																				2+		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — L		2+																				2+		
MOVEMENT (See Motor Function Scale at Top of Page) — RUE		4					4							4								4		
MOVEMENT (See Motor Function Scale at Top of Page) — LUE		5					5							5								5		
MOVEMENT (See Motor Function Scale at Top of Page) — RLE		3					3							4								4		
MOVEMENT (See Motor Function Scale at Top of Page) — LLE		4					4							4								4		
GRIP (S) Strong (W) Weak (-) absent — R		*					UTA							UTA								UTA		
GRIP (S) Strong (W) Weak (-) absent — L		5					5							5								5		
RESPIRATIONS — REGULAR		✓					✓							✓								✓		
RESPIRATIONS — IRREGULAR																								
RESPIRATIONS — UNLABORED		✓					✓							✓								✓		
RESPIRATIONS — LABORED																								
RESPIRATIONS — SHALLOW																								
RESPIRATIONS — RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RUL		5					5							5								5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — LUL		5					5							5								5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RLL		5					5							5								5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — LLL		5					5							5								5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — BOTH BASES																								
COUGH — NONE		✓					✓							✓								✓		
COUGH — SPONTANEOUS																								
COUGH — PRODUCTIVE																								
COUGH — NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																								
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																								
VENTILATOR — Vt																								
VENTILATOR — FIO2																								
VENTILATOR — RATE (SIMV/CMV)																								
VENTILATOR — PEEP / CPAP																								
VENTILATOR — PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE — NC (l/min)		1L					1L							1L								1L		
OXYGEN DELIVERY DEVICE — FM (l/min)																								
OXYGEN DELIVERY DEVICE — NRBM (l/min)																								
ETT #_____ — ETT _____cm gums																								
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED																								
INCENTIVE SPIROMETRY DONE																								
COUGH / DEEP BREATH																								
INITIALS	(b)(6)-2																							

(b)(6)-2

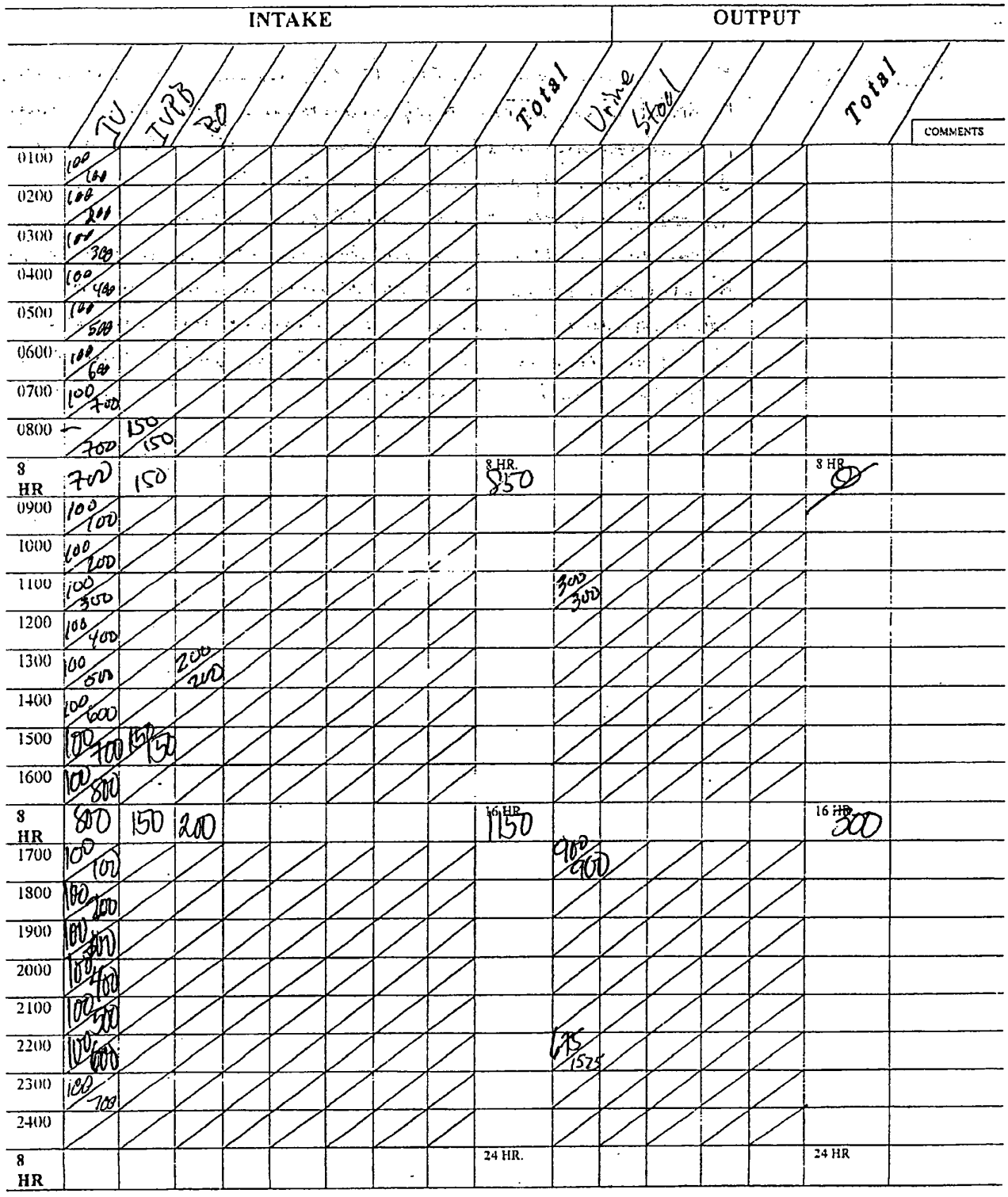
MEDCOM - 1413

1

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100		95	13	119/61	96%												
0200		~~85~~	13	~~113/61~~	~~96%~~	(b)(6)-2											
		85	12	108/47	96%												
0300		92	10	113/57	96%												
0400		86	8	99/49	96%												
		~~81~~	9	103/46	96%	(b)(6)-2											
0500		81	9	103/46	96%												
0600		89	9	104/45	98%												
0700	97.4	89	11	102/48	98%	IL/NC											
0800		68	12	105/43	96%	IL/NC											
0900		99	17	96/49	91%	IL/NC											
1000		77	12	115/53	98%	IL/NC											
1100		82	12	111/52	98	IL/NC											
1200		83	15	108/50	97%	IL/NC											
1300		87	16	111/54	100%	IL											
1400	99.2	93	19	113/54	98%	IL											
1500		87	13	104/49	96%	IL/NC											
1600		89	12	104/46	97%	IL/NC											
1700		106	13	115/57	97%	on IL/NC											
1800		92	15	118/48	96%	on IL/NC											
1900		86	18	118/53	98%	on IL/NC											
2000	99.6	89	19	118/56	100%	on IL/NC											
2100		89	22	104/49	96%	on IL/NC											
2200		82	13	104/54	100%	on IL/NC											
2300	99.7	94	10	124/62	96%	on IL/NC											
2400																	

MEDCOM - 1414


INTAKE
OUTPUT
IV
IVPB
PO
Total
Urine
Stool
Total
COMMENTS
0100
0200
0300
0400
0500
0600
0700
0800
8 HR
0900
1000
1100
1200
1300
1400
1500
1600
8 HR
1700
1800
1900
2000
2100
2200
2300
2400
8 HR
8 HR.
16 HR.
24 HR.
8 HR
16 HR
24 HR

MEDCOM - 1415

NSN 7540-00-634-4123

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
27Jul03	0230		Pt assessment complete. Pt is A+Ox3 (assessed through interpretor) PERRLA (L) grip is strong (R) grip unable to assess due to fx and bandage. pt is able to move all fingers on (R) hand. Cap refill on (R) hand and (R) feet <2 sec. 2+ pulse on (L) radial artery. Pt is able to wiggle all toes and all fingers on (R) hand. Fingers on (R) hand is slightly edematous and toes are also slightly edematous. All dressing except (R) calf/foot are C.D.I. (R) calf/foot dressing has small amount (inch diameter) of serosanguenous drainage. Drainage has been circled on dressing & date and time. Pt has yet to urinate this shift. Will continue to monitor. ——— SPC (b)(6)-2
27JUL	0335		Auscultation done - cardiac - RRR, no MRGs lungs CTA, abd - (+) BS all quads. (b)(6)-2
27Jul	0700		A+Ox3. VSS. (-) pain. Refused breakfast. No Δ from previous assessment. ——— (b)(6)-2 LCT,
27JUL03	0945		Pt has not voided. TRANSLATION STATES Pt. said he does not have to urinate and he is not having pain. Pt states he would let us know if he does. (b)(6)-2 LCT,
27JUL03		1030	Voided DARK amber urine 300cc (b)(6)-2 LCT,
27JUL03		1330	ATE CAKE & drank one juice. Refused the rest of lunch meal. Medicated c TYLOX II (b)(6)-2 145
27 Jul 03		1445	Pt. resting in bed; HOB @ 30°; able to communicate through sign language; answers yes/no; responds appropriately. Cards given as ordered. No other concerns @ this time. Ext. fixator in place in RLE; LLE covered c ace bandage. (+) CMS; toes WNL. edematous @ +1; (R) groin/ear c bulky dsg. open wounds to (R) lat. groin/ear; COI; (R) hand also covered c bandage; (+) CMS. Will continue to assess and monitor. ——— (b)(6)-2 LCT/pm
		2007	Pt c/o "ouchy", pointing to (R) knee; given 10mg IV MSO4 IVP as ordered. Will continue to reassess and monitor. ——— (b)(6)-2 LCT/pm

MEDCOM - 1416

509-113 NSN 7540-00-634-4122

MEDICAL RECORD | PROGRESS NOTES

DATE	
27 Jul 03 @ 2100	Portable xrays done as ordered. Pt. reported relief from pain; now resting in bed comfortably; BLE ↑ c̄ folded blankets. Anticipating washout in gm. — (b)(6)-2 [redacted]
@ 2200	No significant Δ. Report given to incoming Griff (b)(6)-2 [redacted]
27 Jul 03 2240	Report received from off going nurse. Pt resting comfortably in bed.
	PERRLA. Cap refill <2 sec x4 extremities and pt is able to wiggle all fingers and toes. Grip strength strong on (L) hand. No significant Δ in dress. Pt is NPO p̄ MN. Will get interpreter to explain this to the pt. Will continue to monitor. — SPC (b)(6)-2 [redacted]
(b)(6)-2 [redacted] 2245	Auscultation complete lungs CTA (B) S_1S_2, RRR ≅ murmur BS Active x4 — (b)(6)-2 [redacted]
28 Jul 03 2100	called to eval pt's pain p̄ receiving Tylox @ 1800 and 9 mg IV MSO4. 9/10 pain along (R) lateral aspect of leg - throbbing. mild relief with dorsiflexion. Good cap refill; ft warm, + pulse. Will bolus MSO4 + continue to monitor (b)(6)-2 [redacted]
	TM 99.3 AF VS NL
29 Jul 03 1045	Ortho POD #1 after 2nd Hip to OR s/p multi ortho fx, lact, tendon repair of (R) LE, (R) UE. Pt c̄ a lot of pain last evening/ through night. Changed ACE wrap on (R) LE c̄ relief. Required ½ additional MSO4 bolus. noted to be sleeping through the am. all wounds dressed, clean, dry. Ex fix in place. Extremities warm c̄ good cap refill. Issue of eating addressed c̄ dietician and c̄ pt through interpreter. Ate good dinner tray - will work to ensure maintains adequate po intake. Dietician consulted & currently c̄ pt and interpreter. Anticipate return to OR in am (b)(6)-2 [redacted]

POSTOP Rads - evaluation of ex fix (R) LE c̄ improved location of distal pins - adequate index

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)

REGISTER NO. (b)(6)-2 [redacted] NO. [illegible]

Iraqi (b)(6)-4 [redacted]

PROGRESS NOTES

Medical Record

MEDCOM - 1417

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

PROGRESS NOTES

DATE	
29 JUL 03	Nutrition Note:
	Spoke c pt this am c interpretor. Consulted by MD care team re: pt. not eating. Pt stated he had eggs, milk + some potatoes @ breakfast this am. Asked for and given milk (250mL) by nsg. at bedside during my consult. Verbalized to pt. importance of adequate calorie/protein intake to assist c healing. He verbalized understanding. Will continue to follow while in house. CPT (b)(6)-2 RD LD (b)(6)-2

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	26 Jul 03
DOS	26 Jul 03
POD	

24 HOUR DATA	
24 Hour Balance	+ 1925
24 Hour Intake	4900
24 Hour Output	2975
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	(b)(6)-2

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			
Side Rails Up			
Bed in Low Position	(b)(6)-2		

(b)(6)-2 | Department/Service/Clinic: SECURITY FCU#1 | DATE: 28 Jul 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade;date; hospital or medical facility)*

Iraqi (b)(6)-4

☐ HISTORY PHYSICAL ☒ FLOWCHART

☐ OTHER EXAMINATION Or EVALUATION ☐ OTHER(*Specify*)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700
MAY 78

MEDCOM - 1419

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R		*					*																X	
	L		2					2								2								2	
	DORSALIS PEDIS R		*					*																X	
	L		*					*																X	
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale			1 3 0					1 3 8								1 3 8								1 3 8	
EDEMA			0					-								-								-	
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)								✓								✓								✓	
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)								✓								✓								✓	
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH																								
	FOLEY CARE																								
	ORAL CARE																								
MOBILITY	BEDREST							✓								✓								✓	
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT		S													S									
	LEFT		S													S									
	SUPINE		S													Bed								✓	
	HOB 30 DEGREES		✓													-									
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									JG
PAIN	PAIN FREE		✓													✓									
	PAIN SCALE (1-10)							*2	(b)(6)-2															(b)(6)-2	TTH
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended							2								2								2	
BOWEL SOUNDS (active all quads)								✓								✓								✓	
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT																									
VOIDING CLEAR, YELLOW URINE q.s.								✓								✓								✓	
SKIN INTEGRITY	No Breakdown																								
	Surgical Wounds															*									
	Rashes, Lac's, etc															*									
DRESSING (Dry & Intact: specify site below)																✓									
#1 (R) shoulder																✓									
#2 (R) forearm/hand																✓									
#3 (L) calf/foot																✓									
Dry (R) calf/foot																✓									

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
PIV 18G	(L) Forearm	?26 JUL 03?	patent, ~~no~~ signs of infiltration
PIV 18G	(L) Forearm	28 JUL 03	patent, no signs infiltration
some PIV -	1500 26 JUL - ø site	infection, PIV	
PIV 18G	(L) FA	28 JUL 03	ø S/S of I IF JG

MEDCOM - 1420

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable /Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment --

DATE: 28/1/03

TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open		4					4								4								4	
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response							5								5								5	
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response		6					6								6								6	
GLASCOW COMA SCALE (A+B+C)		15					15								15								15	
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) R		+					+								+								+	
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) L		+					+								+								+	
MOVEMENT (See Motor Function Scale at Top of Page) RUE							4								4								4	
MOVEMENT (See Motor Function Scale at Top of Page) LUE							5								5								5	
MOVEMENT (See Motor Function Scale at Top of Page) RLE							4								4								4	
MOVEMENT (See Motor Function Scale at Top of Page) LLE							3								3								3	
GRIP (S) Strong (W) Weak (-) absent R							5								5								5	
GRIP (S) Strong (W) Weak (-) absent L		5					5								5								5	
RESPIRATIONS REGULAR		✓					✓								✓								✓	
RESPIRATIONS IRREGULAR																								
RESPIRATIONS UNLABORED		✓					✓								✓								✓	
RESPIRATIONS LABORED																								
RESPIRATIONS SHALLOW																								
RESPIRATIONS RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished RUL							5								5								5	
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished LUL							5								5								5	
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished RLL							5								5								5	
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished LLL							5								5								5	
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished BOTH BASES							5								5								5	
COUGH NONE		✓					✓								✓								✓	
COUGH SPONTANEOUS																								
COUGH PRODUCTIVE																								
COUGH NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																								
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																								
VENTILATOR Vt																								
VENTILATOR FIO2															40									
VENTILATOR RATE (SIMV/CMV)																								
VENTILATOR PEEP / CPAP																								
VENTILATOR PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE NC (l/min)		1L					1L NC								1L								1L NC	
OXYGEN DELIVERY DEVICE FM (l/min)																								
OXYGEN DELIVERY DEVICE NRBM (l/min)																								
ETT # _____ ETT _____ cm gums																								
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED																								
INCENTIVE SPIROMETRY DONE																								
COUGH / DEEP BREATH																								
INITIALS															I									

MEDCOM - 1421

1

VITAL SIGNS

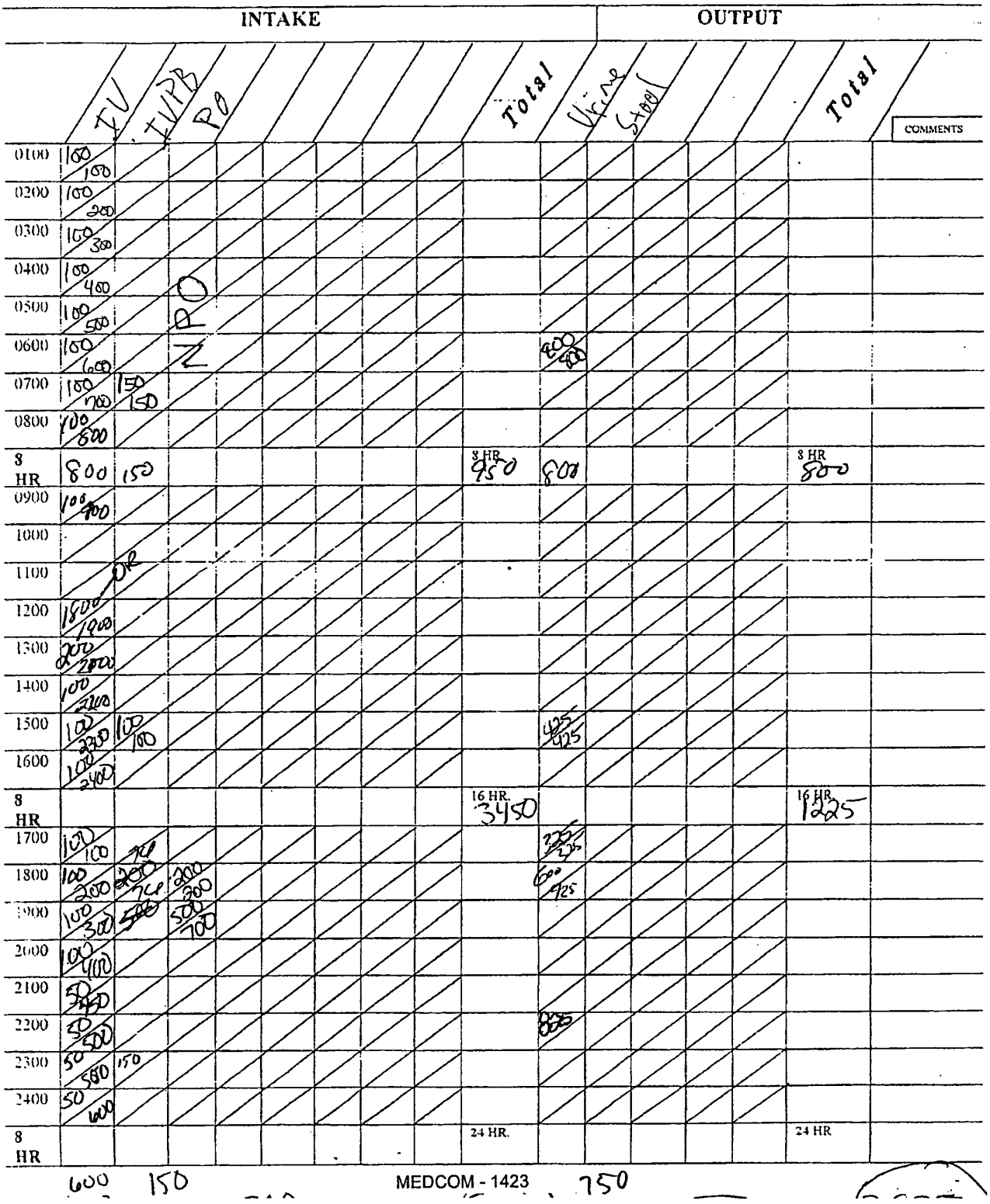
TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200		88	14	112/58	95%	(b)(6)-2											
0300																	
0400																	
0500																	
0600	99.3	92	21	112/59	100%	(b)(6)-2											
0700																	
0800																	
0900																	
1000																	
1100																	
1200																	
1300		Skipped notes															
1400		100	14	127/53	94%												
1500	100.3 ox	104	20	129/51	95%	(b)(6)-2											
1600	100.8 ox	105	12	123/63	97												
1700	101.0	116	14	124/60	94												
1800	101.8	91	20	120/62	98												
1900	100.8	98	14	122/59	96												
2000		93	19	127/64	96												
2100	99.3	88	18	118/59	100%												
2200																	
2300	99.4	92	19	120/61	99%	(b)(6)-2											
2400																	

MEDCOM - 1422

	INTAKE									OUTPUT						
	IV	IVPB	PO						Total	Urine	Stool				Total	COMMENTS
0100	100 / 100															
0200	100 / 200															
0300	100 / 300															
0400	100 / 400															
0500	100 / 500		NPO													
0600	100 / 600									800 / 800						
0700	100 / 700	150 / 150														
0800	100 / 800															
8 HR	800	150							8 HR 950	800					8 HR 800	
0900	100 / 900															
1000																
1100		OR														
1200	1800 / 1900															
1300	200 / 2000															
1400	100 / 2100															
1500	100 / 2300	100 / 100								425 / 425						
1600	100 / 2400															
8 HR									16 HR. 3450						16 HR. 1225	
1700	100 / 100									225 / 225						
1800	100 / 200	74 / 200 / 74	200 / 300							600 / 425						
1900	100 / 300	500	500 / 700													
2000	100 / 400															
2100	50 / 450															
2200	50 / 500									825						
2300	50 / 550	150														
2400	50 / 600															
8 HR									24 HR.						24 HR	

600 150 750

MEDCOM - 1423



NSN 7540-00-634-4123

MEDICAL RECORD — DATE	HOUR A.M.	HOUR P.M.	NURSING NOTES (Sign all notes) — OBSERVATIONS Include medication and treatment when indicated
28 Jul 03	0520		(Late note) Pt assessment complete. No significant changes since his last assessment. Will continue to monitor. SPC (b)(6)-2
28 Jul 03	0700		Assumed care of pt. Pt motioning to staff that LLE is painful. Pt given 2 Tylox as ordered. Pt assessment complete, Ancef and Dextran pain IVPB's given as ordered. Pt resting SPC (b)(6)-2
28 July 03	0815		Concours will above assessment. Pt npo waiting surgery. (b)(6)-2
28 July		1500	Pt assessment complete. Pt denies pain at present. MM/L abrasions head to toe. Able to assess (L) radial pulse but (R) radial area covered c bandage as well as both DP pulses. Dressing (R) shoulder, (R) FA + hand, (L) wrist + hand, Bil LE. Able to wiggle all fingers + toes. Good cap refill all fingers + toes. Voiding QS (b)(6)-2
28 Jul		1800	Pt refused dinner tray. Nsg staff states that he has not been eating at all. Interpreter notified + asked to explain to the pt the importance of eating for his wound healing. Interpreter said pt now c/o pain — Given 1/1 Tylox + then pt ate meatballs, green beans, fruit cocktail, cake, + juicy juice. (b)(6)-2
28 Jul		2100	Pt c/o Throbbing pain (R) LE. Given total of 6mg MSO4 per LG (b)(6)-2. Ace wrap loosened per Dr. (b)(6)-2 — Pt got instant relief. C/d coban dressing to Ace wrap). (b)(6)-2 MSO4
28 Jul 03		2300	Pt assesment complete See flow sheet, USS, Complains of 10/10 pain in (R) Leg Tylox 1/1 given will continue to monitor (b)(6)-2 LVN

MEDCOM - 1424

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	26 Jul 03
DOS	
POD	

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2 SGT USMC LVN	(b)(6)-2
(b)(6)-2 SPC	
(b)(6)-2 SPC	
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On	N/A	N/A	N/A
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 SGT USMC LVN	ICU 1	29 Jul 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade; date; hospital or medical facility)*

IRAQI (b)(6)-4

☐ HISTORY PHYSICAL ☒ FLOWCHART

☐ OTHER EXAMINATION Or EVALUATION ☐ OTHER *(Specify)*

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 1425

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R		X					X							X								—		
	L		2					2							2								2		
	DORSALIS PEDIS R		X					X							X								—		
	L		X					X							X								—		
SKIN (1) Dry (4) Cool (7) Jaundiced (2) Clammy (5) Flushed (8) Color Normal (3) Warm (6) Cyanotic (9) Pale			1 3 8					1 3 8							1 3 8								(b)(6)-2		
EDEMA			Ø					Ø							Ø								Ø		
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)			✓					✓							✓								✓		
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)			✓					✓							✓								✓		
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH							✓																	
	FOLEY CARE																								
	ORAL CARE																								
MOBILITY	BEDREST							✓							✓										
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT																						✓		
	LEFT																					(b)(6)-2			
	SUPINE		✓																						
	HOB 30 DEGREES														✓										
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)			✓																						
PAIN	PAIN FREE		✓												✓								✓		
	PAIN SCALE (1-10)							10																	
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended		✓					2							2								2		
BOWEL SOUNDS (active all quads)															x4								✓		
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph			(b)(6)-2																						
FOLEY CATHETER PATENT																									
VOIDING CLEAR, YELLOW URINE q.s.			✓					✓							✓										
SKIN INTEGRITY	No Breakdown																								
	Surgical Wounds																								
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1																									
#2																									
#3																									

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
18 G PIV	(L) FA	28 Jul	IV patent & S/S of I/I

MEDCOM - 1426

PUPIL SIZE	PUPILS		MOTOR FUNCTION	CHART CODES
1 mm	=	Equal	0 = No Movement	Present ✓
2 mm	R	Reactive	1 = Slight Flicker/ Trace of Contraction	
3 mm	NR	NonReactive	2 = Active (Gravity Eliminated)	Not Applicable /Absent (blank)
4 mm	L > R	Left Larger	3 = Active: against gravity, but not against resistance 4 = Active: Against Gravity and Resistance, not full strength	Refer to Nsg. Notes X
5 mm	R > L	Right Larger	5 = Full Strength against Examiners Resistance	No Change from Previous Assessment --

DATE: 29 Jul 03

TIME		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (2) To Pain (3) To Voice (1) Does Not Open			4					4							4										
B. BEST VERBAL RESPONSE (5) Oriented (2) Garbled (4) Confused (1) No Response (3) Inappropriate Verbal Response			5					5							5								(b)(6)-2		
C. BEST MOTOR RESPONSE (6) Obeys Commands (3) Flexion to Pain (5) Localizes to Pain (2) Extension to Pain (4) Withdraw to Pain (1) No Response			6					6							6										
GLASCOW COMA SCALE (A+B+C)			15					15							15								15		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R		2+					2+							2+										
	L		2+					2+							2+										
MOVEMENT (See Motor Function Scale at Top of Page)	RUE		3					3							3								3		
	LUE		3					3							3								3		
	RLE		2					2							2								3		
	LLE		2					2							2								3		
GRIP (S) Strong (W) Weak (-) absent	R		-					W							-								-		
	L		-					W							-								-		
RESPIRATIONS	REGULAR		✓					✓							✓								✓		
	IRREGULAR		/																						
	UNLABORED		✓					✓							✓								✓		
	LABORED																								
	SHALLOW																								
	RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL		5					5							5										
	LUL		5					5							5										
	RLL		5					5							5										
	LLL		5					5							5										
	BOTH BASES		5					5							5										
COUGH	NONE		✓					✓							✓								✓		
	SPONTANEOUS																								
	PRODUCTIVE																								
	NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																									
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																									
VENTILATOR	Vt																								
	FIO2																								
	RATE (SIMV/CMV)																								
	PEEP / CPAP																								
	PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE	NC (l/min)																								
	FM (l/min)																								
ETT #_____	NRBM (l/min)																								
	ETT _____cm gums																								
ETT CARE / POSITION CHANGE																									
ETT / NT SUCTIONED																									
INCENTIVE SPIROMETRY DONE																									
COUGH / DEEP BREATH																									
INITIALS			(b)(6)-2																						

MEDCOM - 1427

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200	99.3	109	18	119/64	96%	RA											
0300																	
0400																	
0500																	
0600	99.1°	85	14	124/58	93%	RA											
0700	98.0	90	22	123/45	96%	RA											
0800																	
0900																	
1000																	
1100	99°	95	18	120/54	95%	RA											
1200																	
1300																	
1400																	
1500	99.6	104	20	111/58	96%	RA											
1600																	
1700																	
1800																	
1900	99.9	82	20	119/69	94%	RA											
2000																	
2100																	
2200	100.3	103	18	124/58	95%	RA											
2300																	
2400																	

ACLU-RDI 1099 p.212

DOD 005480

	INTAKE									OUTPUT						
	IV	IVPB	PO						Total	Urine	Poop				Total	COMMENTS
0100	50/50															
0200	50/100									600/600						
0300	50/150		100/150													
0400	50/200															
0500	50/250															
0600	50/300		190/340							700/1300						
0700	50/350	200/300														
0800	50/400															
8 HR	400	200							8 HR.	1300					8 HR	
0900	50/50															
1000	50/100															
1100	50/150									550/550						
1200	50/200															
1300	50/250															
1400	50/300									650/1200						
1500	—/300	100/100														
1600	50/350															
8 HR	350	100							16 HR.	1200					16 HR.	
1700	50/50															
1800	50/100															
1900	50/150															
2000	50/200															
2100	50/250									500/500						
2200	50/300															
2300	50/350	246														
2400																
8 HR									24 HR.						24 HR	

MEDCOM - 1429

NSN 7540-00-634-4123

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
29 Jul 03	0330		PT c/o 10/10 pain to (R) LE given 4 mg MSO4, ⅡⅡ Tylox pain remained DR ~~giv~~ order from Emt for 4mg more MSO4 given pt pain controlled will continue to monitor pain Level (b)(6)-2 SGT 91WM6 LUN
29 Jul 03	0730		Assumed care of pt. Pt complaining of pain, rating of "10" on pain scale. Morphine and Tylox given as ordered. Pt given bed bath, encouraged to eat breakfast. Assessment complete. Will monitor. SPC (b)(6)-2 WM6
29 Jul 03	1750		Changed pt's wet to dry dressings on (L) shoulder and neck. Drainage moderate on (L) shoulder, neck dressing only small amount of dried drainage. SPC (b)(6)-2
29 Jul 03	1150		PT RECEIVED 4 mg MSO4 @ 1100 ⅡⅡ Tylox given @ 1120. PT still c/o 10/10 PAIN. DO FOR ADDITIONAL 2 mg MSO4 PT RECEIVED @ this time. will continue to monitor SSG (b)(6)-2 LPN
29 Jul 03	1300		Pt was offered Lunch meal but refused. Pt wanted Drinks of water & was given his juice. Will attempt to provide Lunch meal later on shift. SSG (b)(6)-2 LPN
29 Jul 03	1340		Pt was offered Lunch meal again, but refused. (b)(6)-2 LPN
29 JUL 03	1445		Pt assessed @ this time. USS ⊖ pain @ this time (b)(6)-2 LPN
29 Jul 03	2320		Pt assessment complete. Pt is informed of NPO status p̄ MN and encouraged to eat before then. Pt is currently eating pound cake and drinking water. Will continue to monitor. SPC (b)(6)-2

MEDCOM - 1430

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	26Jul03
DOS	
POD	

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	(b)(6)-2
(b)(6)-2	
LVN	

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On	NA	NA	—
Call Light Within Reach			—
Side Rails Up			—
Bed in Low Position			—

(b)(6)-2

9/CLVN | Department/Service/Clinic: ICU #1 | DATE: 30Jul03

PATIENT'S IDENTIFICATION (*For typed or written entries give: Name-last, first, Middle; grade;date; hospital or medical facility*)

Iraqi (b)(6)-4

- ☐ HISTORY-PHYSICAL
- ☒ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☐ OTHER(*Specify*)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

MEDCOM - 1431

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R							X								X									
	L							2								2									
	DORSALIS PEDIS R							X								X									
	L							X								X									
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale			1 3 8					1 3 8								1 3 8							1 3 8		
EDEMA								–								–							–		
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)								✓								✓									
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)								✓								✓							✓		
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH							✓																	
	FOLEY CARE																								
	ORAL CARE							✓																	
MOBILITY	BEDREST							✓																	
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE																								
	HOB 30 DEGREES																								
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE							✓																	
	PAIN SCALE (1-10)		*													1/10							5/6		
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended		2					2								2							2		
BOWEL SOUNDS (active all quads)								✓								✓									
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT																									
VOIDING CLEAR, YELLOW URINE q.s.			✓					✓								✓							✓		
SKIN INTEGRITY	No Breakdown																								
	Surgical Wounds																								
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact; specify site below)																									
#1																									
#2																									
#3																									

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
PIV 18G	(L) FA	28 Jul	patent ≡ s/sf of infxer infiltration
PIV 18G	(L) FA	assessed	Patent Ø s/s of I/I
PIV 18G	(L) FA	28 Jul	patent ≡ s/sx of infxer infiltration

PUPIL SIZE	PUPILS		MOTOR FUNCTION	CHART CODES
1 mm	=	Equal	0 = No Movement	Present ✓
2 mm	R	Reactive	1 = Slight Flicker/ Trace of Contraction	
3 mm	NR	NonReactive	2 = Active (Gravity Eliminated)	Not Applicable /Absent (blank)
			3 = Active: against gravity, but not against resistance	
4 mm	L > R	Left Larger	4 = Active: Against Gravity and Resistance, not full strength	Refer to Nsg. Notes X
			5 = Full Strength against Examiners Resistance	
5 mm	R > L	Right Larger	DATE: 30 Jul 93	No Change from Previous Assessment –

TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (2) To Pain (3) To Voice (1) Does Not Open		4					4								4							4		
B. BEST VERBAL RESPONSE (5) Oriented (2) Garbled (4) Confused (1) No Response (3) Inappropriate Verbal Response		5					5								5							5		
C. BEST MOTOR RESPONSE (6) Obeys Commands (3) Flexion to Pain (5) Localizes to Pain (2) Extension to Pain (4) Withdraw to Pain (1) No Response		6					6								6							6		
GLASCOW COMA SCALE (A+B+C)		15					15								15							15		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — R							2+								2+							2+		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — L							2+								2+							2+		
MOVEMENT (See Motor Function Scale at Top of Page) — RUE							3								3							3		
MOVEMENT (See Motor Function Scale at Top of Page) — LUE							2								2							3		
MOVEMENT (See Motor Function Scale at Top of Page) — RLE							2								2							2		
MOVEMENT (See Motor Function Scale at Top of Page) — LLE							3								3							3		
GRIP (S) Strong (W) Weak (-) absent — R							W								–							–		
GRIP (S) Strong (W) Weak (-) absent — L							W								–							5		
RESPIRATIONS — REGULAR		✓					✓								✓							✓		
RESPIRATIONS — IRREGULAR																								
RESPIRATIONS — UNLABORED		✓					✓								✓							✓		
RESPIRATIONS — LABORED																								
RESPIRATIONS — SHALLOW																								
RESPIRATIONS — RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RUL							5								5									
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — LUL							5								5									
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RLL							5								5									
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — LLL							5								5									
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — BOTH BASES							5								5									
COUGH — NONE		✓					✓								✓							✓		
COUGH — SPONTANEOUS																								
COUGH — PRODUCTIVE																								
COUGH — NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																								
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																								
VENTILATOR — Vt																								
VENTILATOR — FiO2																								
VENTILATOR — RATE (SIMV/CMV)																								
VENTILATOR — PEEP / CPAP																								
VENTILATOR — PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE — NC (l/min)		2L					RA																	
OXYGEN DELIVERY DEVICE — FM (l/min)																								
ETT #_____ — NRBM (l/min)																								
ETT #_____ — ETT _____ cm gums																								
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED																								
INCENTIVE SPIROMETRY DONE																								
COUGH / DEEP BREATH																								
INITIALS	(b)(6)-2																							

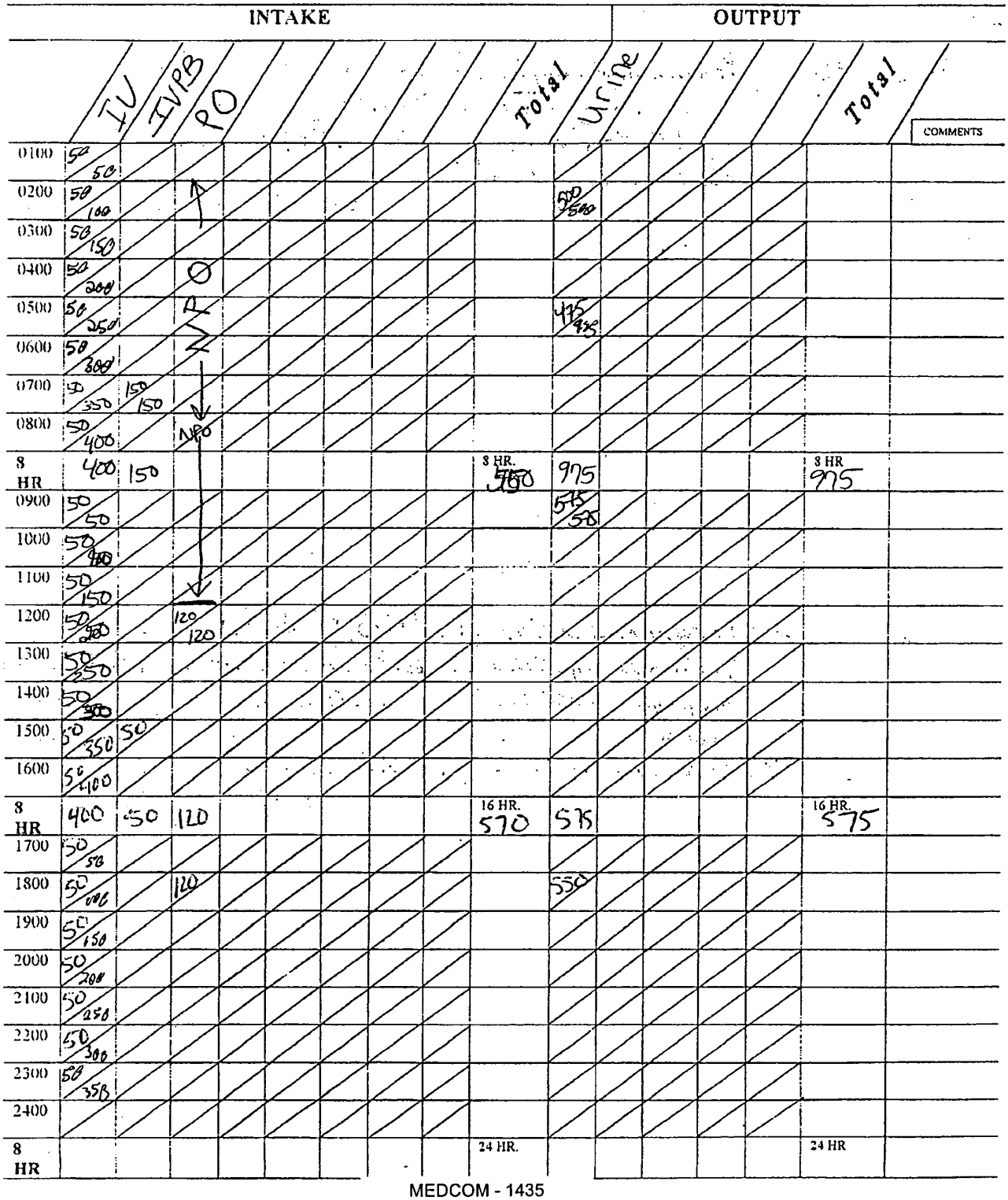
MEDCOM - 1433

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200		101	20	113/61	91%	RA											
0300																	
0400																	
0500																	
0600	99.0	89	16	118/63	99%	RA											
0700																	
0800																	
0900																	
1000																	
1100																	
1200	97.1	129	23	123/67	97%	RA											
1300																	
1400																	
1500	99.8	101	14	113/56	93%	RA											
1600																	
1700																	
1800																	
1900																	
2000																	
2100																	
2200	100.2	112	19	105/46	99%	RA											
2300																	
2400																	

ACLU-RDI 1099 p.218

DOD 005486


INTAKE
OUTPUT
IV
IVPB
PO
Total
Urine
Total
COMMENTS
0100
0200
0300
0400
0500
0600
0700
0800
8 HR
0900
1000
1100
1200
1300
1400
1500
1600
8 HR
1700
1800
1900
2000
2100
2200
2300
2400
8 HR
NPO
8 HR.
16 HR.
24 HR.
8 HR
16 HR
24 HR

MEDCOM - 1435

NSN 7540-00-634-4123

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
30Jul03	0235		Pt assessment complete. I asked him if he was in pain. He nodded. 2 tylox given @ 0145. Pt still complaining of pain @ 0210. Pt given 4mg of MSO4. Pt put on O2 monitor to observe O2 status. Will continue to monitor. SPC (b)(6)-2 ARB LVN
30Jul03	0700		Assumed care of pt, assessment complete, bed bath and oral care done, meds given as ordered, pt has 0 complaints of pain. Pt NPO for surgery at 0900. NS running @ 50cc/hr to (L) FA, patent and 0 sign of infection. SPC (b)(6)-2
	0900		Pt to surgery for washout of wounds and bone and skin grafting to (R) thumb. SPC (b)(6)-2
	1157		Pt received from OR and recovered. SPC (b)(6)-2
30Jul03		1500	Pt Recieved VSS, 0 complaints of Pain / NAUSEA See flowchart for ASSESSMENT Will continue to monitor (b)(6)-2 RN/WMC LVN
30Jul03		2300	Pt report received VSS, pt is A+Ox3, PERRLA. Pt c/o pain 5-6/10 in the (R) foot esp. 4th phalanx. Pt also c/o heartburn. Pt instructed on proper nutrition for healing. Pt assessment complete. Will Continue to monitor. SPC (b)(6)-2
		0010	Pt recieved 2 tylox for pain will continue to monitor. SPC (b)(6)-2 qlc LVN

ACLU-RDI 1099 p.220

DOD 005488

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	26 Jan 03
DOS	
POD	

24 HOUR DATA	
24 Hour Balance	-205
24 Hour Intake	1730
24 Hour Output	1935
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	(b)(6)-2

Safety Checks	D	E	N
BVM at bedside			(b)(6)-2
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			—
Side Rails Up			—
Bed in Low Position			—

(b)(6)-2	SICU	Department/Service/Clinic ICU #1	DATE 31 Jul

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade; date; hospital or medical facility)*

Iraqi (b)(6)-4

☐ HISTORY PHYSICAL ☐ FLOWCHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER(Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 3700 MEDCOM - 1437

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R		*												*								*		
	L		2							2					2								2		
	DORSALIS PEDIS R		*												*								*		
	L		*					--	--						*								*		
SKIN (1) Dry (4) Cool (7) Jaundiced (2) Clammy (5) Flushed (8) Color Normal (3) Warm (6) Cyanotic (9) Pale			1 3 8							1 3 8					1 3 8								1 3 8		
EDEMA										-					-								Ø		
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)										✓					✓								✓		
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)										✓					✓								✓		
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH																								
	FOLEY CARE																								
	ORAL CARE																								
MOBILITY	BEDREST																								
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT		Side							Side					Side								Side		
	LEFT																								
	SUPINE									Supine					Supine										
	HOB 30 DEGREES									✓					✓								✓		
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE		✓							✓													✓		
	PAIN SCALE (1-10)														5/10										
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN (2) Soft & Flat (1) Distended			2							2					2								2		
BOWEL SOUNDS (active all quads)										✓					✓								✓		
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT																									
VOIDING CLEAR, YELLOW URINE q.s.										✓					✓										
SKIN INTEGRITY	No Breakdown																								
	Surgical Wounds																								
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1 (R) Forearm/hand			✓							✓					✓								✓		
#2 (R) Shoulder			✓							✓					✓								NA		
#3 (R) Calf/foot			✓							✓					✓								✓		
(L) Calf/foot			✓							✓					✓								NA		

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
PIV 20G	(L) Forearm	31Jul03	patent & s/s of infiltration
PIV 20G	(L) Forearm	31JUL03 ~~1452~~	~~0~~ s/s of infiltration
PIV 20G	(L) FA	31Jul03	patent & s/s of infiltration

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable /Absent (blank)
Refer to Nsg. Notes N
No Change from Previous Assessment –

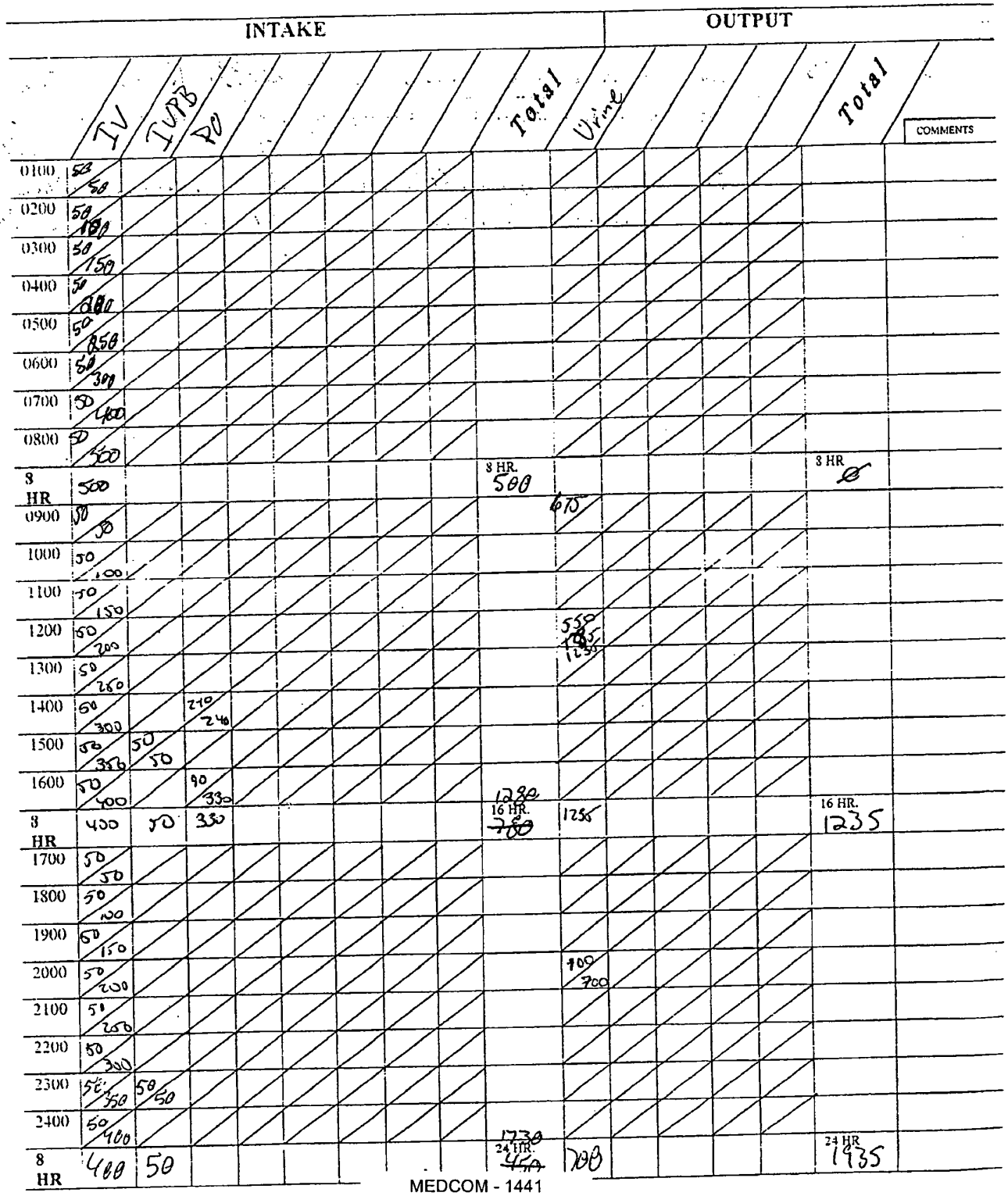
DATE: 31Jul23

TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open		4							4					4								4		
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response		5							5					5								5		
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response		6							6					6								6		
GLASCOW COMA SCALE (A+B+C)		15							15					15								15		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) R		2+							2+					2+								2+		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) L		2+							2+					2+								2+		
MOVEMENT (See Motor Function Scale at Top of Page) RUE									3					3								4		
MOVEMENT (See Motor Function Scale at Top of Page) LUE									3					3								4		
MOVEMENT (See Motor Function Scale at Top of Page) RLE									2					2								3		
MOVEMENT (See Motor Function Scale at Top of Page) LLE									3					2								3		
GRIP (S) Strong (W) Weak (-) absent R									–					✓								NA		
GRIP (S) Strong (W) Weak (-) absent L														S								S		
RESPIRATIONS REGULAR		✓							L					✓								✓		
RESPIRATIONS IRREGULAR																								
RESPIRATIONS UNLABOREL		✓							U					✓								✓		
RESPIRATIONS LABORED																								
RESPIRATIONS SHALLOW																								
RESPIRATIONS RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished RUL									5					5								5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished LUL									5					5								5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished RLL									5					5								5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished LLL									5					5								5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished BOTH BASES									5					5								5		
COUGH NONE		✓							✓					✓								✓		
COUGH SPONTANEOUS																								
COUGH PRODUCTIVE																								
COUGH NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																								
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																								
VENTILATOR Vt																								
VENTILATOR FIO2																								
VENTILATOR RATE (SIMV/CMV)																								
VENTILATOR PEEP / CPAP																								
VENTILATOR PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE NC (l/min)																								
OXYGEN DELIVERY DEVICE FM (l/min)																								
ETT # _____ NRBM (l/min)																								
ETT _____cm gums																								
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED																								
INCENTIVE SPIROMETRY DONE																								
COUGH / DEEP BREATH																								
INITIALS	(b) MEDCOM - 1439																							

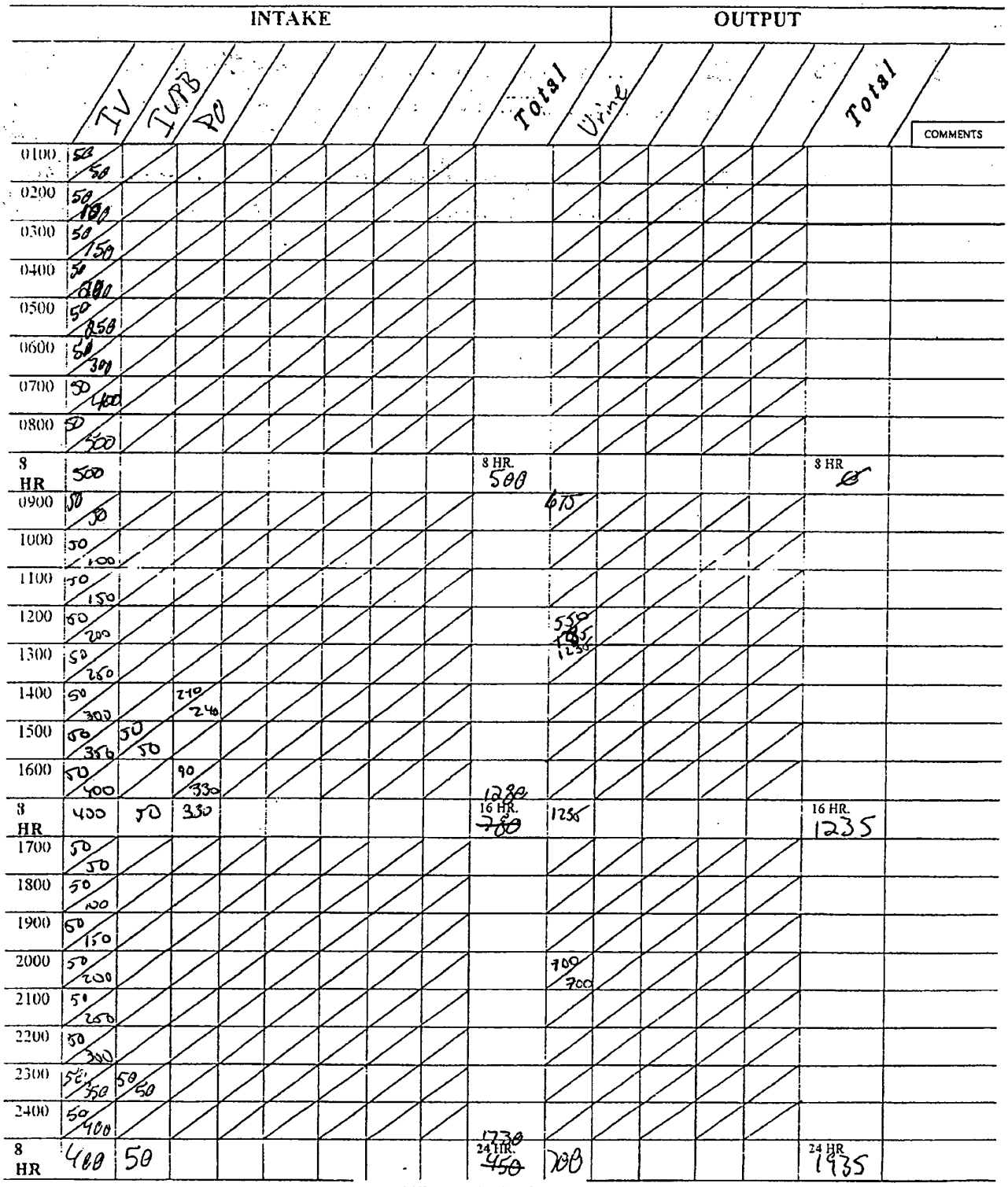
VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200	98.2	90	15	112/54	96%	on RA											
0300																	
0400																	
0500																	
0600	98.0	101	20	103/40	99%	on RA											
0700																	
0800																	
0900																	
1000	98.4	95	16	113/51	98%	RA											
1100																	
1200																	
1300																	
1400	100.2	105	20	116/50	96%	RA											
1410	99.3																PIS use
1500																	
1600																	
1700																	
1800																	
1900																	
2000																	
2100																	
2200	99.3	101	19	110/47	97%	RA											
2300																	
2400																	

MEDCOM - 1440


INTAKE
OUTPUT
IV
IVPB
PO
Total
Urine
Total
COMMENTS
0100
0200
0300
0400
0500
0600
0700
0800
8 HR
0900
1000
1100
1200
1300
1400
1500
1600
8 HR
1700
1800
1900
2000
2100
2200
2300
2400
8 HR
8 HR.
16 HR.
24 HR.
MEDCOM - 1441

	INTAKE									OUTPUT						
	IV	IVPB	PO						Total	Urine					Total	COMMENTS
0100	50/50															
0200	50/100															
0300	50/150															
0400	50/200															
0500	50/250															
0600	50/300															
0700	50/400															
0800	50/500															
8 HR	500								8 HR. 500						8 HR Ø	
0900	50/50									675						
1000	50/100															
1100	50/150															
1200	50/200									550 ~~785~~ 1235						
1300	50/250															
1400	50/300		210/240													
1500	50/350	50/50														
1600	50/400		90/330													
8 HR	400	50	330						16 HR. ~~780~~ 1280	1235					16 HR. 1235	
1700	50/50															
1800	50/100															
1900	50/150															
2000	50/200									700/700						
2100	50/250															
2200	50/300															
2300	50/350	50/50														
2400	50/400															
8 HR	400	50							24 HR. ~~450~~ 1730	700					24 HR 1935	



MEDCOM - 1442

NSN 7540-00-634-4123

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
31Jul03	0030		New IV started tubing A'd. New IV is 20G RN to (R) Forearm c̄ s/sx infection or infiltration. IV infusing well. Will continue to monitor. SPC (b)(6)-2 [redacted]
31Jul03	0230		Pt assessment complete. Pt is resting comfortably. No s/sx of distress Will continue to monitor. SPC (b)(6)-2 [redacted]
31Jul03	0820		PT Resting @ this time. ϕ s/sx of Distress. Ancef given @ 0800. Will Attempt to wake Pt to Provide Morning meal within 30 minutes. SSG (b)(6)-2 [redacted]
31Jul03	0915		Assessment completed Pt consumed Approx. 40% of morning meal. Voided 675cc of urine. ϕ c/o pain @ this time. SSG (b)(6)-2 [redacted]
31Jul03	1130		PT c/o Heart burn Received 30cc Maalox Per DO. SSG (b)(6)-2 [redacted]
31JUL03	1500		Pt assessment complete. Pt T-100.2 encouraged IS use & 10. T-99° MD aware. MD to change W-D drsg on (R) Achelles, Short cast to LLE. Pt premedicated c̄ 2 tylox. (b)(6)-2 [redacted]
31JUL03	1530		MD to Δ drsg (R) hand. Drsg to (L) shoulder. RLQ both changed by RN minimal drng noted (b)(6)-2 [redacted]
31Jul03	2235		Report received from off going shift. Pt is A+O×3 PERRLA pt assessment complete. Due to bandage and injuries pt is unable to grip c̄ (R) hand. Could not assess pulses in (R) hand and (B) LE due to bandages and cast on (L) LE. Dressings to (R) hand and (R) LE are CDI. Dressing to (R) shoulder has been removed. Pt sat up @ bedside. Will continue to monitor. SPC (b)(6)-2 [redacted]
	0015		Pt c/o heartburn. Will continue to monitor. SPC (b)(6)-2 [redacted]

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	26Jul03
DOS	
POD	

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	(b)(6)-2

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On	N/A		—
Call Light Within Reach			—
Side Rails Up			—
Bed in Low Position			—

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 SGT LVN	ICU #1	1 Aug 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade; date; hospital or medical facility)*

Iraqi (b)(6)-4

- ☐ HISTORY PHYSICAL
- ☐ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☐ OTHER(*Specify*)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 1444

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R											VTA			*								*		
	L											2			2								2		
	DORSALIS PEDIS R											VTA			*								*		
	L											VTA			*								*		
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale												1 3 8			1 3 8								1 3 8		
EDEMA															0								0		
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)												✓			✓								✓		
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)												✓ ST			✓										
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH									✓															
	FOLEY CARE																								
	ORAL CARE									✓															
MOBILITY	BEDREST																								
	BSC																								
	DANGLE																								
	CHAIR									✓	x 2 hrs.														
POSITIONED	RIGHT									SELF					SELF								SELF		
	LEFT																								
	SUPINE																								
	HOB 30 DEGREES																								
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE									✓		✓			✓								✓		
	PAIN SCALE (1-10)																								
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended											2			2								2		
BOWEL SOUNDS (active all quads)												✓			—								✓		
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT																									
VOIDING CLEAR, YELLOW URINE q.s.												✓			✓										
SKIN INTEGRITY	No Breakdown									✓					✓								✓		
	Surgical Wounds									✓					✓								✓		
	Rashes, Lac's, etc									✓					✓								✓		
DRESSING (Dry & Intact: specify site below)																									
#1 (R) Hand										✓					✓								✓		
#2 (R) LE										✓					✓								✓		
#3 (L) LL (cast)										✓					✓								✓		
* (R) HIP										✓					✓								✓		

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
PIV	(L) Forearm	31 Jul	patent ≡ s/sx of infx or infiltration / 1 AUG 0900
SV	(L) fa	"	0 s/s of Inf / Infiltration 1400 1 AUG 03
PIV 20G	(L) Forearm	31 Jul 03	patent ≡ s/sx of infx or infiltration

B6-2

MEDCOM - 1445

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable /Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment --

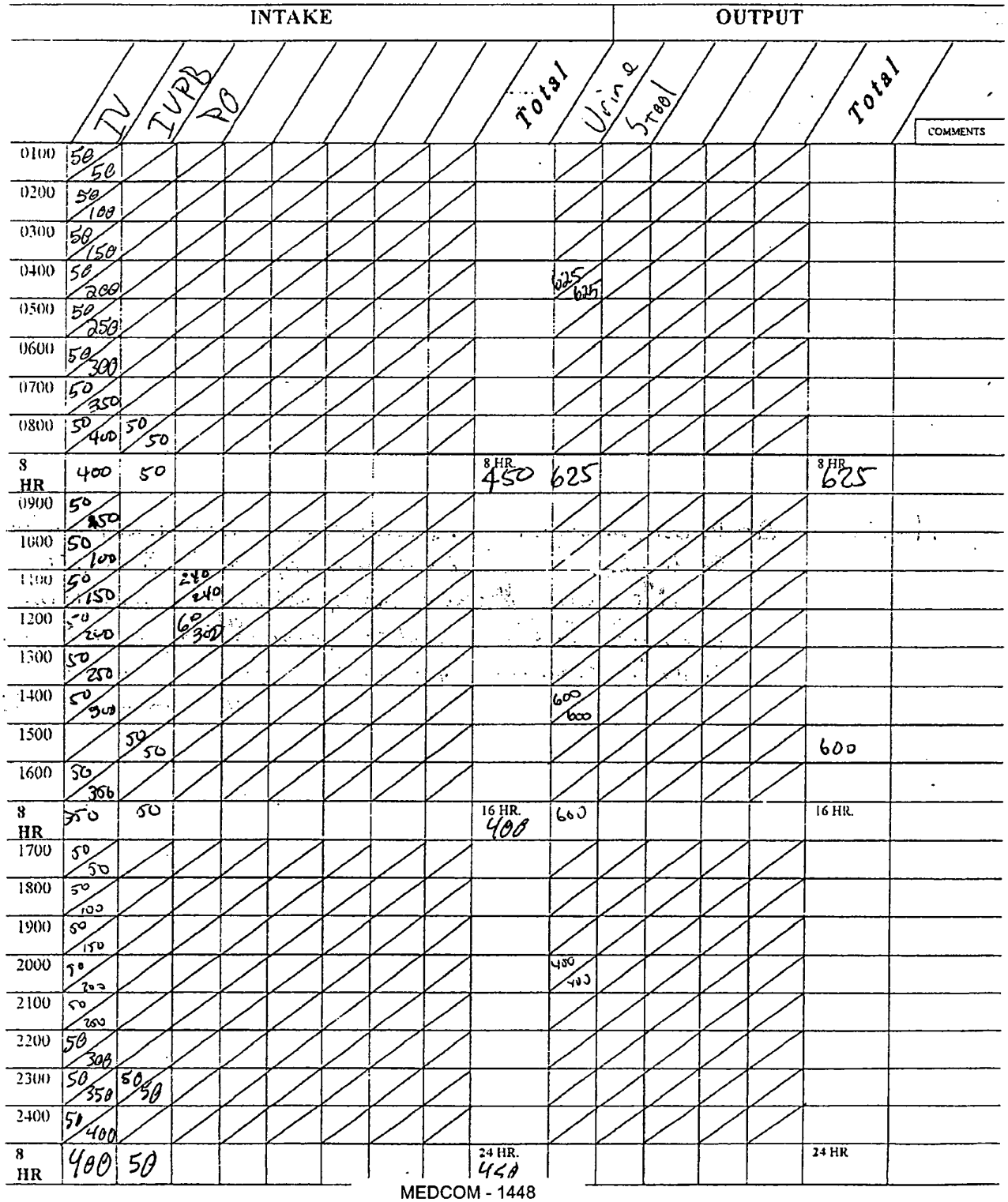
DATE: 1 Aug 03

TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (2) To Pain (3) To Voice (1) Does Not Open									4					4								4		
B. BEST VERBAL RESPONSE (5) Oriented (2) Garbled (4) Confused (1) No Response (3) Inappropriate Verbal Response									5					5								5		
C. BEST MOTOR RESPONSE (6) Obeys Commands (3) Flexion to Pain (5) Localizes to Pain (2) Extension to Pain (4) Withdraw to Pain (1) No Response									6					6								6		
GLASCOW COMA SCALE (A+B+C)									15					15								15		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — R																								
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — L																								
MOVEMENT (See Motor Function Scale at Top of Page) — RUE									4					4								5		
MOVEMENT (See Motor Function Scale at Top of Page) — LUE									4/5					5								5		
MOVEMENT (See Motor Function Scale at Top of Page) — RLE									4					4								4		
MOVEMENT (See Motor Function Scale at Top of Page) — LLE									4					4								4		
GRIP (S) Strong (W) Weak (-) absent — R									N/a					/								*		
GRIP (S) Strong (W) Weak (-) absent — L									S					S								S		
RESPIRATIONS — REGULAR									✓					✓								✓		
RESPIRATIONS — IRREGULAR																								
RESPIRATIONS — UNLABORED									✓					✓								✓		
RESPIRATIONS — LABORED																								
RESPIRATIONS — SHALLOW																								
RESPIRATIONS — RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RUL										5				5								5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — LUL										5				5								5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RLL										5				5								5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — LLL										5				5								5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — BOTH BASES										5				5								5		
COUGH — NONE																						✓		
COUGH — SPONTANEOUS																								
COUGH — PRODUCTIVE									✓					✓										
COUGH — NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear									5					5										
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin									3					1										
VENTILATOR — Vt																								
VENTILATOR — FiO2																								
VENTILATOR — RATE (SIMV/CMV)																								
VENTILATOR — PEEP / CPAP																								
VENTILATOR — PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE — NC (l/min)																								
OXYGEN DELIVERY DEVICE — FM (l/min)																								
ETT #_____ — NRBM (l/min)																								
ETT #_____ — ETT _____cm gums																								
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED																								
INCENTIVE SPIROMETRY DONE									✓					✓										
COUGH / DEEP BREATH																								
INITIALS														KbV6\-2										

MEDCOM - 1446

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200																	
0300																	
0400																	
0500																	
0600																	
0700																	
0800																	
0900																	
1000																	
1100	99'	105	16	116/52													
1200																	
1300																	
1400	106²	100	20	104/53	96%												IS x 10
	99'																
1500																	
1600																	
1700																	
1800																	
1900																	
2000																	
2100																	
2200	97.4	78	16	113/61	98% on RA												
2300																	IS x 0
2400																	


INTAKE
OUTPUT
IV
IVPB
PO
Total
Urine
Stool
Total
COMMENTS
0100
0200
0300
0400
0500
0600
0700
0800
8 HR
0900
1000
1100
1200
1300
1400
1500
1600
8 HR
1700
1800
1900
2000
2100
2200
2300
2400
8 HR
8 HR.
16 HR.
24 HR.
MEDCOM - 1448

NSN 7540-00-634-4123

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
1Aug03	0430		Pt is resting comfortably, ∓ s/sx of distress. Will continue to monitor. SPC (b)(6)-2 [redacted]
1AUG03		1100	Pt resting comfortably ∓ c/o pain. VSS. No Δ's from previous assessments. DRSG Δ's Done. Serous drainage ∓ yellowish exudate to RLE wound & superficial wounds to neck, back & shoulder. ⊖ odor noted. Wounds cleaned and redressed. Tolerating PO diet. Drank ~~[illegible]~~ Ensure XL can. Will continue to monitor. (b)(6)-2 [redacted] ICT
1AUG03		1400	Pt AOx3, ⊖ pain @ this time. Drsg c/o LE. Will Δ drsg to ⊕ foot @ 2000. (b)(6)-2 [redacted]
1AUG03		1800	Pt drsg Δ'd to ⊕LE. Pin care provided. ⊖ s/s of inf @ this time. MD Δ'd drsg to ⊕ hand. (b)(6)-2 [redacted]
1Aug03		2300	Pt assessment complete. Incentive Spirometry done, 10 repetitions. All dressings CDI. Unable to assess grip strength ⊕ hand. Pt can ~~will~~ BDT wiggle all BDT fingers and cap refill is <2sec. Unable to assess pulses in ⊕LE. ⊕LE cap refill <2sec and pt ~~will~~ BDT can wiggle all toes. Pt ate 3/4 of a package of apricots. Will continue to monitor. SPC (b)(6)-2 [redacted]

MEDCOM - 1449

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	26Jul03
DOS	
POD	

24 HOUR DATA	
24 Hour Balance	+1050
24 Hour Intake	+2100
24 Hour Output	-1050
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			—
Call Light Within Reach	N/A		—
Side Rails Up			—
Bed in Low Position			—

(b)(6)-2	9CLV#1	Department/Service/Clinic: ICU#1	DATE: 2Aug03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade; date; hospital or medical facility)*

Iraqi (b)(6)-4

- ☐ HISTORY PHYSICAL
- ☒ FLOWCHART
- ☐ OTHER EXAMINATION or EVALUATION
- ☐ OTHER(*Specify*)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700 MEDCOM - 1450

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R								2						2								*		
	L								2						2								2		
	DORSALIS PEDIS R								2						/								*		
	L								2						/								*		
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale									1 3 8						1 B B								1 3 8		
EDEMA									–						/								Ø		
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)									✓						✓								✓		
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)									✓						✓								✓		
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH								✓																
	FOLEY CARE																								
	ORAL CARE																								
MOBILITY	BEDREST								✓						✓										
	BSC														✓										
	DANGLE																								
	CHAIR								✓						✓										
POSITIONED	RIGHT																								
	LEFT								Self						Self								Self		
	SUPINE																								
	HOB 30 DEGREES																								
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE								✓						✓								✓		
	PAIN SCALE (1-10)														–										
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended								2						2								2		
BOWEL SOUNDS (active all quads)									✓						✓								✓		
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT																									
VOIDING CLEAR, YELLOW URINE q.s.									✓						✓										
SKIN INTEGRITY	No Breakdown																								
	Surgical Wounds																								
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1 RLE									✓						✓								✓		
#2 RUE									✓						✓								*		
#3 (R) side of neck									✓						✓								✓		
DIET									2%				15%										✓		

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
20G (L) FA	(L) FA	31 Jun 03	patent and ⊘ sign infection
20G (L) FA	(L) FA	"	patent ⊖ s/s of self / infection 1400 2AM

MEDCOM - 1451

PUPIL SIZE

1 mm
2 mm
3 mm
4 mm
5 mm

PUPILS

= Equal
R Reactive
NR NonReactive
L > R Left Larger
R > L Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable /Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment --

DATE: 2Aug03

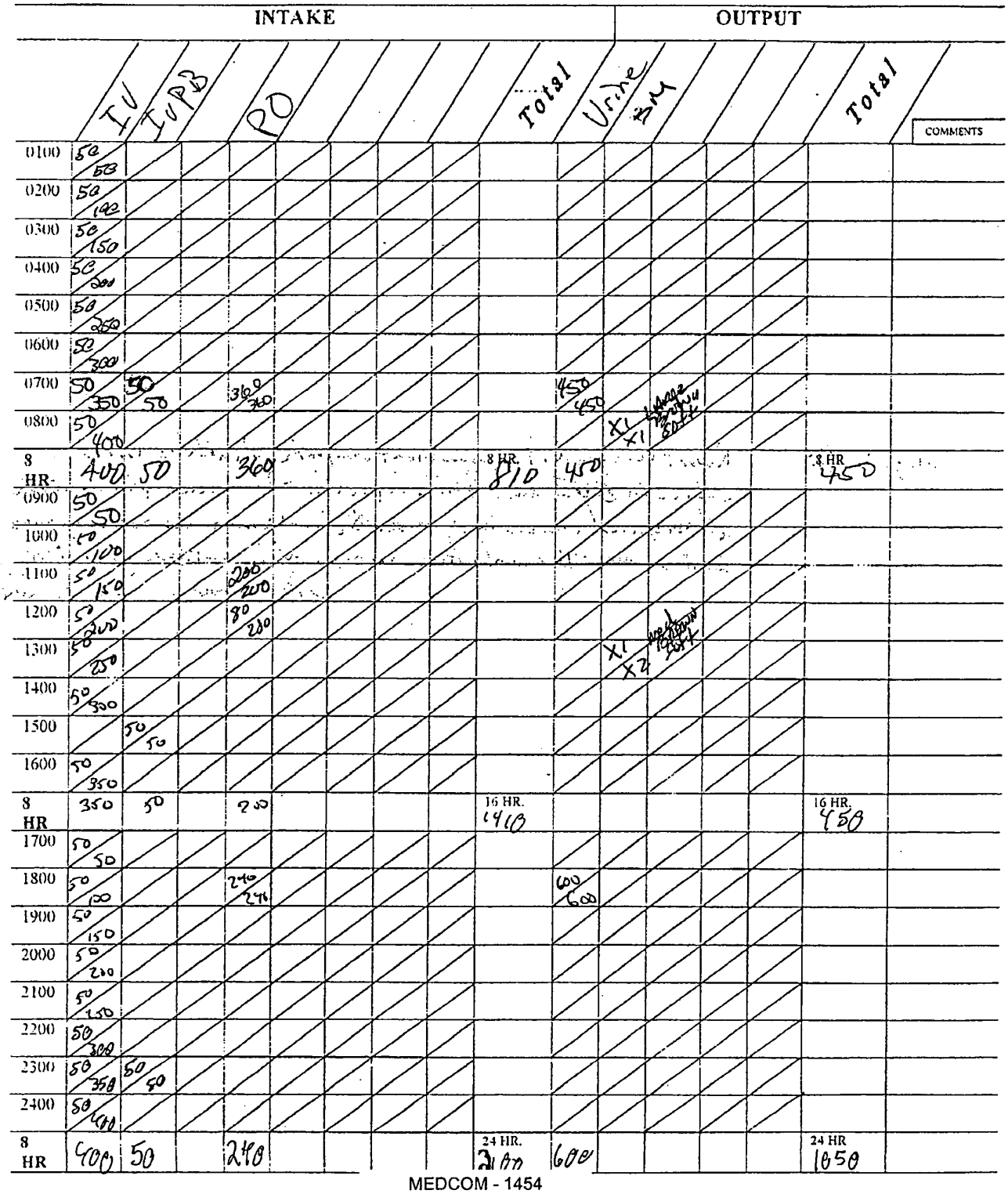
TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open								4						4								4		
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response								5						5								5		
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response								6						6								6		
GLASCOW COMA SCALE (A+B+C)								15						15								15		
PUPIL RESPONSE Size (mm). React to Light (+) No Response (-) — R								2+						2+								2+		
PUPIL RESPONSE Size (mm). React to Light (+) No Response (-) — L								2+						2+								2+		
MOVEMENT (See Motor Function Scale at Top of Page) — RUE								2						2								4		
MOVEMENT (See Motor Function Scale at Top of Page) — LUE								3						3								4		
MOVEMENT (See Motor Function Scale at Top of Page) — RLE								2						2								3		
MOVEMENT (See Motor Function Scale at Top of Page) — LLE								2						2								3		
GRIP (S) Strong (W) Weak (-) absent — R								W						S								*		
GRIP (S) Strong (W) Weak (-) absent — L								W						S								*		
RESPIRATIONS — REGULAR								✓						✓								✓		
RESPIRATIONS — IRREGULAR																								
RESPIRATIONS — UNLABORED								✓						✓								✓		
RESPIRATIONS — LABORED																								
RESPIRATIONS — SHALLOW																								
RESPIRATIONS — RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RUL								5						5								5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — LUL								5						5								5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RLL								5						5								5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — LLL								5						5								5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — BOTH BASES								5						5								5		
COUGH — NONE								5						5								5		
COUGH — SPONTANEOUS								✓						✓								✓		
COUGH — PRODUCTIVE																								
COUGH — NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear														✓										
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin														5										
VENTILATOR — Vt														1										
VENTILATOR — FiO2																								
VENTILATOR — RATE (SIMV/CMV)																								
VENTILATOR — PEEP / CPAP																								
VENTILATOR — PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE — NC (l/min)																								
OXYGEN DELIVERY DEVICE — FM (l/min)																								
OXYGEN DELIVERY DEVICE — NRBM (l/min)																								
OXYGEN DELIVERY DEVICE — ETT _____cm gums																								
ETT # _____							RA																	
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED																								
INCENTIVE SPIROMETRY DONE																								
COUGH / DEEP BREATH														✓								✓		

MEDCOM - 1452

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200																	
0300																	
0400																	
0500																	
0600																	
0700	98	96	14	122/58	96%												
0800																	
0900																	
1000																	
1100																	
200.																	
1300																	
1400	99.2	98	16	114/56	95												
1500																	
1600																	
1700																	
1800																	
1900																	
2000																	
2100																	
2200																	
2300	98.8	140/58 80T	16	114/57	98%												
2400																	

MEDCOM - 1453


INTAKE
OUTPUT
IV
IVPB
PO
Total
Urine
BM
Total
COMMENTS
0100
0200
0300
0400
0500
0600
0700
0800
8 HR-
0900
1000
1100
1200
1300
1400
1500
1600
8 HR
1700
1800
1900
2000
2100
2200
2300
2400
8 HR
8 HR.
16 HR.
24 HR.
MEDCOM - 1454

NSN 7540-00-634-4123

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
2AUG03	0700		Assumed care of pt, assessment complete. Bandages and dressings changed with small amount of serous drainage. Hygiene done, pt resting. SPC (b)(6)-2 WM6
2AUG03	1400		Pt assessmet complete. Bacitracin applied to wounds on shoulders and neck. Will complet W→D drsg D c̄ MD present later in shift. (b)(6)-2
2AUG03	1645		W→D drsg D'd on both URE/LRE. MD present at D. Minimal serosanguinous drainage noted. Pt tolerate/assisted c̄ drss D. Required ⊖ pain medication. Pin care also provided. ⊖ s/s of infection present. (b)(6)-2
2Aug03	2315		Report received. Pt assessment complete. Unable to assess pulses in (R)UE and (R)LE. Cap refill <2sec and pt can wiggle all toes, and fingers in (R) hand. (R)UE dressing has serosanguenous drainage near (R) thumb. Area marked. Will continue to monitor. SPC (b)(6)-2 LUK

MEDCOM - 1455

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	26 Jul 03
DOS	
POD	

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On	NA	/	–
Call Light Within Reach	NA	/	–
Side Rails Up	NA	/	–
Bed in Low Position	NA	/	–

(b)(6)-2	(e) 9ICLVN	Department/Service/Clinic ICU #1	DATE 3 Aug 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade;date; hospital or medical facility)*

Iraqi (b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOWCHART

☐ OTHER EXAMINATION Or EVALUATION ☐ OTHER(Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700 MEDCOM - 1456

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R									2						✓							✳		
	L									2						2							2		
	DORSALIS PEDIS R									2						✓							✳		
	L									2						✓							✳		
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale										1 3 2						1 3 2							1 3 2		
EDEMA										Ø													Ø		
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)										✓						✓									
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)										✓						✓							✓		
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH									✓															
	FOLEY CARE																								
	ORAL CARE									✓						✓									
MOBILITY	BEDREST									✓						✓									
	BSC															✓									
	DANGLE																								
	CHAIR									✓						✓									
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE																								
	HOB 30 DEGREES																								
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)										✓															
PAIN	PAIN FREE															✓							✓		
	PAIN SCALE (1-10)																								
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN (2) Soft & Flat (1) Distended										2						2									
BOWEL SOUNDS (active all quads)										x4						✓									
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT																									
VOIDING CLEAR, YELLOW URINE q.s.																									
SKIN INTEGRITY	No Breakdown																						✓		
	Surgical Wounds									✓						✓							✓		
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1 Cast @ leg										✓						✓							✓		
#2 Dsg @ leg										✓						✓							✓		
#3 Dsg @ R hand										✓						✓							✓		
numerous stitches on body										✓						✓							✓		

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
I&(P) D/C'd	ⓁFA	31 July 03	CDI Ø SS infection patent
PIV	ⓁFA	3 Aug 03	CDI Ø SS infect pat
IV	ⓁFA	3 AUG 03	D/S of IV/IV fr NSH

MEDCOM - 1457

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable /Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment --

DATE: 3 Aug 03

TIME		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open										4						4							4		
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response										5						5							5		
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response										6						6							6		
GLASCOW COMA SCALE (A+B+C)										15						15							15		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R															2							3+		
	L															2							3+		
MOVEMENT (See Motor Function Scale at Top of Page)	RUE									1						2							4		
	LUE									5						3							4		
	RLE									1						2							3		
	LLE									1						2							3		
GRIP (S) Strong (W) Weak (-) absent	R									5						✓							5		
	L									5						3							5		
RESPIRATIONS	REGULAR									✓						✓							✓		
	IRREGULAR																								
	UNLABORED									✓						✓							✓		
	LABORED																								
	SHALLOW																								
	RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL									5						5									
	LUL									5						5									
	RLL									5						5									
	LLL									5						5									
	BOTH BASES									5						5									
COUGH	NONE																						✓		
	SPONTANEOUS									✓						✓									
	PRODUCTIVE									✓															
	NONPRODUCTIVE															✓									
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear										1						5									
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin										2 1						1									
VENTILATOR	Vt																								
	FiO2																								
	RATE (SIMV/CMV)																								
	PEEP / CPAP																								
	PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE	NC (l/min)																								
	FM (l/min)																								
ETT #_____	NRBM (l/min)																								
	ETT _____cm gums																								
ETT CARE / POSITION CHANGE																									
ETT / NT SUCTIONED																									
INCENTIVE SPIROMETRY DONE																✓									
COUGH / DEEP BREATH																									
INITIALS										(b)(6)-2															

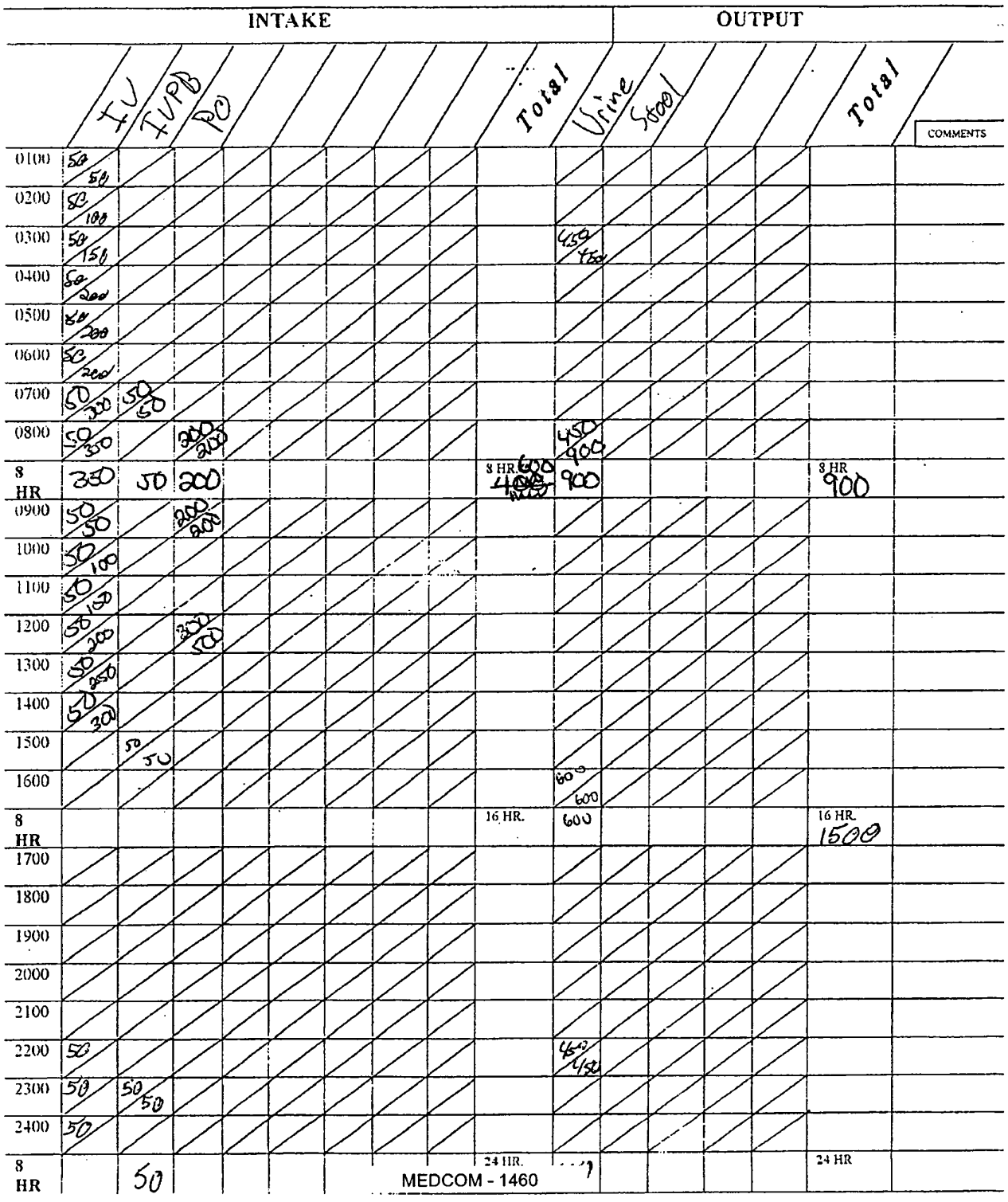
MEDCOM - 1458

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200																	
0300																	
0400																	
0500																	
0600																	
0700																	
0800	99.6	107	18	121/48	97%	RA											
0900																	
1000																	
1100																	
1200																	
1300																	
1400																	
1500	100.3	104	16	113/59	95	RA											D3x10
	99.5																
1600																	
1700																	
1800																	
1900																	
2000																	
2100																	
2200	98.7	104	16	99/48	95%	on RA											
2300																	
2400																	

ACLU-RDI 1099 p.243

DOD 005511


INTAKE
OUTPUT
IV
IVPB
PO
Total
Urine
Stool
Total
COMMENTS
0100
0200
0300
0400
0500
0600
0700
0800
8 HR
0900
1000
1100
1200
1300
1400
1500
1600
8 HR
1700
1800
1900
2000
2100
2200
2300
2400
8 HR
8 HR
16 HR.
16 HR.
24 HR.
24 HR
MEDCOM - 1460

NSN 7540-00-634-4123

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
3 Aug 03	0900		Pt presently resting ~~pw~~ Dsgs Δ^ed in (R)LE dsg has bleeding, W→D dsg applyed, pin care done. pt sat up. C&DB. Will cont to monitor [redacted] (b)(6)-2
	0930		Interpeter brought food from family pt ate some and drank a little pop will cont to monitor [redacted] (b)(6)-2
	1320		pt ate own food for lunch. pt sat in chair for lunch. pt sat up in bed as well. IV Δ^ed in (L)FA will cont to monitor [redacted] (b)(6)-2
3AUG03	1500		Pt assessment complete. IS used. W→D drsg to be Δ'd later with MD supervision [redacted] (b)(6)-2
	1800		W→D drsg on (L) hand/RLE Δd. MD present. → s/s of infection. Pt tolerated well & need of pain meds [redacted] (b)(6)-2
3Aug03		2235	Pt assessment complete. Pt ~~assessment complete~~ c/o numbnes to #3+4 toes on (L) foot. Elevated (L)LE to relieve possible ~~numbness~~ edema causing numbness. Unable to assess pulses on (B)LE + (R)UE, caprefill on those extremities <2sec and pt is able to wiggle all toes and fingers. Will continue to monitor [redacted] SPC (b)(6)-2
3Aug03		2245	Pt is now c/o pain to (L)LE. Will medicate c̄ 2 tylox. Will continue to monitor. [redacted] SPC (b)(6)-2

MEDCOM - 1461

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	26 Jul 03
DOS	
POD	

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

PREPARED BY
(b)(6)-2 | 96CLVN | Department/Service/Clinic: FCU#1 | DATE: 4 Aug 03

PATIENT'S IDENTIFICATION (For typed or written entries give: Name-last, first, Middle; grade; date; hospital or medical facility)

Iraqi (b)(6)-4

- ☐ HISTORY-PHYSICAL
- ☐ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☐ OTHER(Specify)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA ..... Form

MEDCOM - 1462

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R						2														2		*		
	RADIAL L						2														2		2		
	DORSALIS PEDIS R						2														3		*		
	DORSALIS PEDIS L						2														2		*		
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale							1 3 8														1 3 8		1 3 8		
EDEMA							Ø														Ø		Ø		
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)							✓														✓				
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)							✓														✓		✓		
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH									✓															
	FOLEY CARE																								
	ORAL CARE									✓															
MOBILITY	BEDREST						✓														✓				
	BSC										✓								✓						
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE																								
	HOB 30 DEGREES						✓														✓				
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE						✓														✓		✓		
	PAIN SCALE (1-10)																								
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN (2) Soft & Flat (1) Distended							2														2		2		
BOWEL SOUNDS (active all quads)							x4																		
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph -																									
FOLEY CATHETER PATENT																									
VOIDING CLEAR, YELLOW URINE q.s.																									
SKIN INTEGRITY	No Breakdown																								
	Surgical Wounds						✓														✓		✓		
	Rashes, Lac's, etc						✓														✓		✓		
DRESSING (Dry & Intact: specify site below)																									
#1 RLE cast																									
#2 RLE Ex fix + dressing																							✓		
#3 RUE Dressing																							✓		
																							✓		

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
PIV	LFA	3Aug03	Ø5Scalp inf. CDI patient
PIV	LFA	34ug03	Esclexed intx acinetic/fracture

MEDCOM - 1463

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable /Absent (blank)
Refer to Nsg. Notes N
No Change from Previous Assessment –

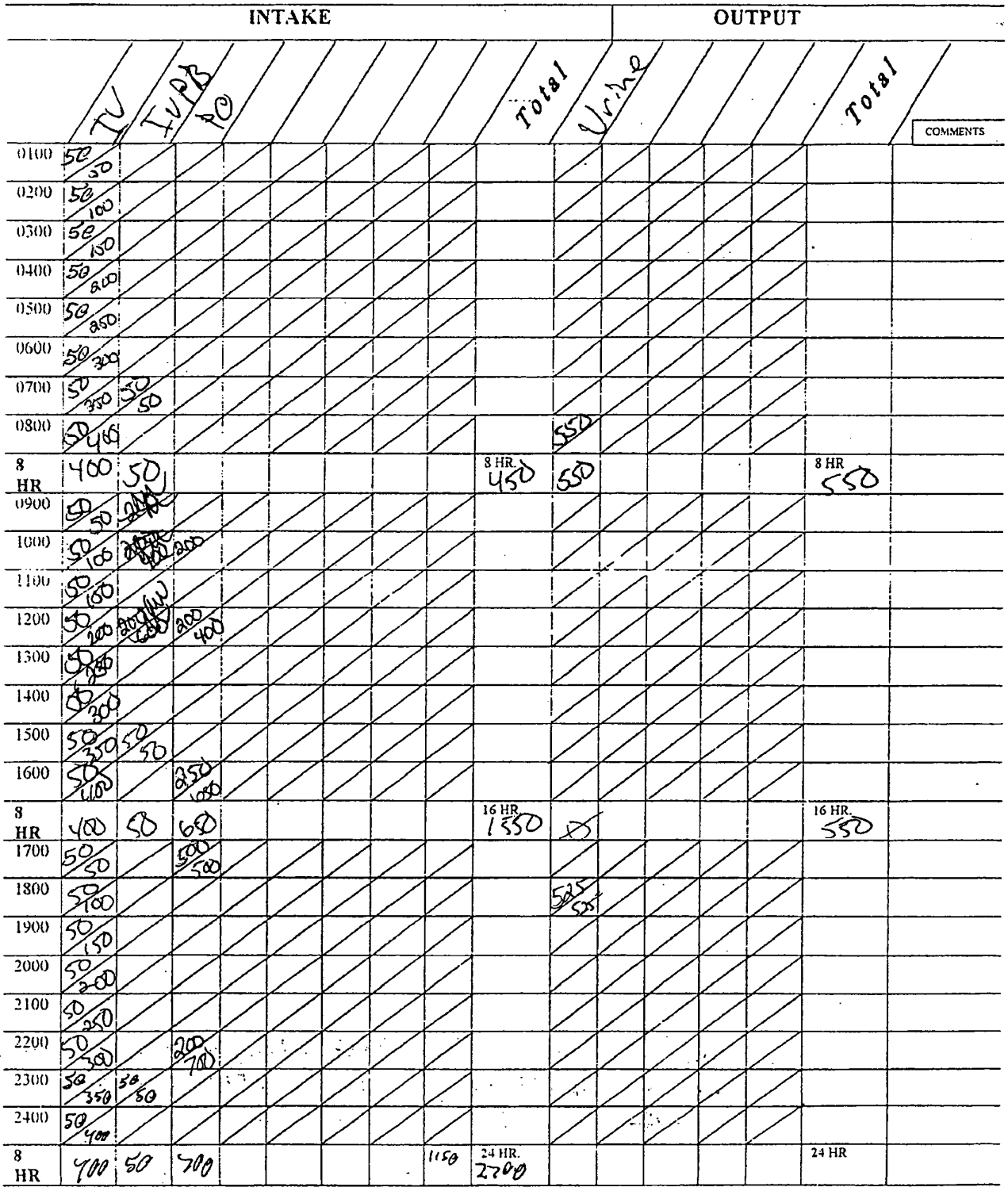
DATE: 4 Aug 03

TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open						4														C1		4		
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response						5														5		5		
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response						6														6		6		
GLASCOW COMA SCALE (A+B+C)						15														15		15		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — R																						2+		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — L																						2+		
MOVEMENT (See Motor Function Scale at Top of Page) — RUE						1														4		4		
MOVEMENT (See Motor Function Scale at Top of Page) — LUE						4														4		4		
MOVEMENT (See Motor Function Scale at Top of Page) — RLE						1														4		3		
MOVEMENT (See Motor Function Scale at Top of Page) — LLE						1														4		3		
GRIP (S) Strong (W) Weak (-) absent — R						5														–		X		
GRIP (S) Strong (W) Weak (-) absent — L						5														5		W		
RESPIRATIONS — REGULAR						✓														✓		✓		
RESPIRATIONS — IRREGULAR																								
RESPIRATIONS — UNLABORED						✓																		
RESPIRATIONS — LABORED																				✓		✓		
RESPIRATIONS — SHALLOW																								
RESPIRATIONS — RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RUL						5														5				
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — LUL						5														5				
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RLL						5														5				
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — LLL						5														5				
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — BOTH BASES						5														5				
COUGH — NONE																				✓		✓		
COUGH — SPONTANEOUS						✓																		
COUGH — PRODUCTIVE						✓																		
COUGH — NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear						1																		
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin						1																		
VENTILATOR — Vt																								
VENTILATOR — FiO2																								
VENTILATOR — RATE (SIMV/CMV)																								
VENTILATOR — PEEP / CPAP																								
VENTILATOR — PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE — NC (l/min)																								
OXYGEN DELIVERY DEVICE — FM (l/min)																								
OXYGEN DELIVERY DEVICE — NRBM (l/min)																								
ETT #_____ — ETT _____ cm gums																								
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED																								
INCENTIVE SPIROMETRY DONE																								
COUGH / DEEP BREATH																								
INITIALS																								

MEDCOM - 1464

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200																	
0300																	
0400																	
0500																	
0600	98.8	88	12	117/63	99%												
0700																	
0800																	
0900																	
1000																	
1100																	
1200																	
1300																	
1400																	
1430	98.8	100	12	104/55	97%												
1500																	
1600																	
1700																	
1800																	
1900																	
2000																	
2100																	
2200	99.6	86	16	104/51	95%	RA											
2300																	
2400																	


INTAKE
OUTPUT
TV
IVPB
PO
Total
Urine
Total
COMMENTS
0100
0200
0300
0400
0500
0600
0700
0800
8 HR
0900
1000
1100
1200
1300
1400
1500
1600
8 HR
1700
1800
1900
2000
2100
2200
2300
2400
8 HR
8 HR. 450
8 HR 550
16 HR. 1550
16 HR. 550
24 HR. 2700
24 HR

MEDCOM - 1466

NSN 7540-00-634-4123

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
4Aug03	0640		Pt quiet assessment completed will cont to monitor (b)(6)-2
	0730		Dsg Δ^ed W→Dry on (R) LE and (R) hand. pt refused Breakfast states he is not hungry now and does not want to get washed up right now either will offer again later will cont to monitor (b)(6)-2
	1030		pt was c/o little n/t in (L) LE. pt can wiggle toes but 2^ed toe numb. Dr (b)(6)-2 aware. stated that is ~~wh~~ where he was shot and to expect some numbness. Interpeter told pt + pt understood. pt resting now. had liquid BM mod-lg. asked Dr to D/C Colace will cont to monitor (b)(6)-2
	1320		Pt resting. pt encouraged to keep leg elevated. Pt keeps placing leg back on bed. pt ~~has~~ had what the interpeter brought in for lunch. Consisted of chicken, bread and vegetables. Will cont to monitor (b)(6)-2
	1915		PT ate very well - Iraqi food brought in - drank 2 milks + 1 pepsi. PT up to chair - transferred by himself. no c/o pain. (b)(6)-2
	2100		Dressing Δ done - wet to dry over skin graft area site only on (R) hand + open area (R) LE. Telfa non stick over (R) thumb. Bacitratin applied to all superficial cuts + suture areas.
	2125		loose stool - liquid. (b)(6)-2
4Aug03		2225	Report received. Pt is A+O×3 PERRLA. Pt is able to move all fingers and toes, caprefill <2sec ×4 extremities. Pt was sleeping in bed ~~when~~ when I left. Will continue to monitor. SPC (b)(6)-2

MEDCOM - 1467

509-113 NSN 7540-00-634-4122

MEDICAL RECORD	PROGRESS NOTES
DATE	
06AUG03	PT CO 9/10 pain given ii Tylox given will continue to monitor
0310	(b)(6)-2 [redacted] SGT 91WM6 LVN
0400	PT VSS = RR 14, HR 20 Bp. 118/58 will continue to monitor (b)(6)-2 [redacted]
06Aug 03	~~Rec report and assumed care of A. VSS afebrile pressing c/o/i - Hand dressing & awaiting~~
@ 1030	~~presence of physician. Has had no c/o pain thru [illegible] Pont. monitor.~~ (b)(6)-2 [redacted] ~~LPN~~
	(b)(6)-2 [redacted]
	(b)(6)-2 [redacted]

(Continue on reverse side)

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)*

REGISTER NO.

WARD NO.

PROGRESS NOTES

Medical Record

MEDCOM - 1468

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	26 Jul 03
DOS	
POD	

24 HOUR DATA	
24 Hour Balance	+ 1000
24 Hour Intake	2650
24 Hour Output	1650
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	
(b)(6)-2	(b)(6)-2

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach	\		
Side Rails Up	\		
Bed in Low Position	\		

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 S/C CLK	ICU #1	5 Aug 03

PATIENT IDENTIFICATION (*For typed or written entries give: Name-last, first, Middle; grade;date; hospital or medical facility*)

Iraqi (b)(6)-4

- ☐ HISTORY/PHYSICAL
- ☒ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☐ OTHER(*Specify*)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

MEDCOM - 1469

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R								2				2		✓										
	RADIAL L								2				2		2										
	DORSALIS PEDIS R								2				–		✓										
	DORSALIS PEDIS L								X				-		✓										
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale									1 3 8				1/ 3/ 8		1 3 8										
EDEMA									-						✓										
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)									✓				✓		✓										
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)									✓				✓		✓										
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH								✓																
	FOLEY CARE																								
	ORAL CARE								✓						✓										
MOBILITY	BEDREST								✓						✓										
	BSC																								
	DANGLE																								
	CHAIR														✓										
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE																								
	HOB 30 DEGREES																								
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE								✓				✓		✓										
	PAIN SCALE (1-10)																								
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN (2) Soft & Flat (1) Distended									2				2		2										
BOWEL SOUNDS (active all quads)									✓				✓		✓										
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT																									
VOIDING CLEAR, YELLOW URINE q.s.									✓																
SKIN INTEGRITY	No Breakdown																								
	Surgical Wounds																								
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1 BLE Gaze									C,D,I						c/DI										
#2 BLE dressing									C,D,I				dressings		c/DI										
#3 RUE dressing									C,D,I				changed		c/DI										
															✓										

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
20g	(L) FA	3AUG03	patent and D. Sign of infection
20g PIV	(R) FA	3AUG03	& s/s of ext/infiltrates

PUPIL SIZE	PUPILS		MOTOR FUNCTION	CHART CODES
1 mm	=	Equal	0 = No Movement	Present ✓
2 mm	R	Reactive	1 = Slight Flicker/ Trace of Contraction	
3 mm	NR	NonReactive	2 = Active (Gravity Eliminated)	Not Applicable /Absent (blank)
4 mm	L > R	Left Larger	3 = Active: against gravity, but not against resistance 4 = Active: Against Gravity and Resistance, not full strength	Refer to Nsg. Notes X
5 mm	R > L	Right Larger	5 = Full Strength against Examiners Resistance	No Change from Previous Assessment --

DATE: 5 Aug 03

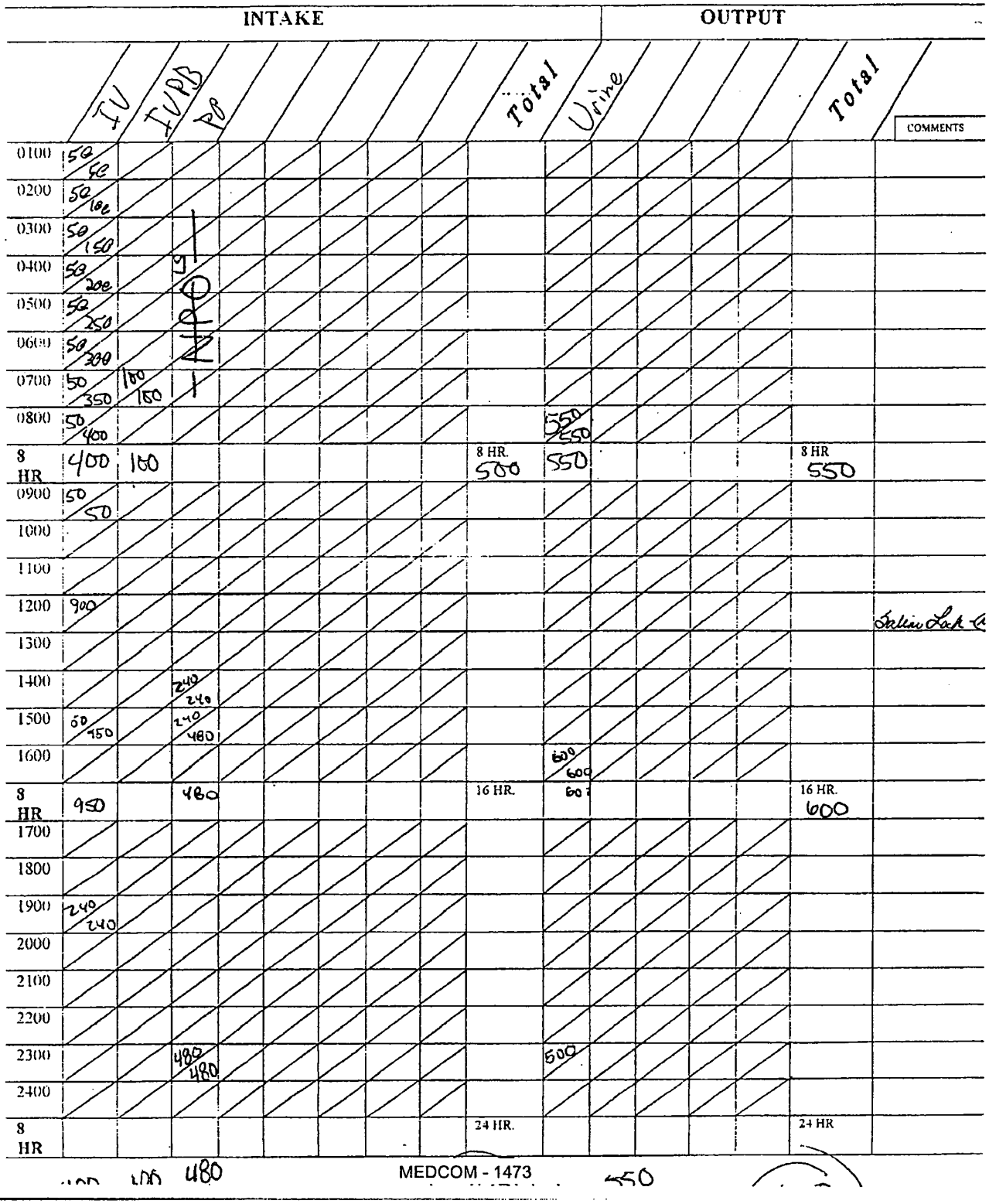
TIME		0 1	0 2	0 3	0 4	0 5	0 6	0 7	0 8	0 9	1 0	1 1	1 2	1 3	1 4	1 5	1 6	1 7	1 8	1 9	2 0	2 1	2 2	2 3	2 4
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open									4				4		4									4	
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response									5				5		5									5	
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response									6				6		6									6	
GLASGOW COMA SCALE (A+B+C)									15				15		16									15	
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R								2+				+		2									2	
	L								2+				+		2									2	
MOVEMENT (See Motor Function Scale at Top of Page)	RUE								3				2		3									3	
	LUE								2				3		2									2	
	RLE								2				2		2									2	
	LLE								2				2		2									2	24
GRIP (S) Strong (W) Weak (-) absent	R								W				S-		/									~~2~~	
	L								W				S-		S									~~2~~	14
RESPIRATIONS	REGULAR								✓				✓		✓									✓	
	IRREGULAR																								
	UNLABORED								✓				✓		✓									✓	
	LABORED																								
	SHALLOW																								
	RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL								5				5		5									5	
	LUL								5				5		5									5	
	RLL								5				5		5									5	
	LLL								5				5		5									5	
	BOTH BASES								5						5									5	
COUGH	NONE								✓				✓		✓									✓	
	SPONTANEOUS																								
	PRODUCTIVE																								
	NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																									
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																									
VENTILATOR	Vt																								
	FIO2																								
	RATE (SIMV/CMV)																								
	PEEP / CPAP																								
	PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE	NC (l/min)																								
	FM (l/min)																								
ETT #_____	NRBM (l/min)																								
	ETT _____cm gums																								
ETT CARE / POSITION CHANGE																									
ETT / NT SUCTIONED																									
INCENTIVE SPIROMETRY DONE									✓				✓		✓									✓	
COUGH / DEEP BREATH																									
INITIALS								(b)(6)-2																	

MEDCOM - 1471

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200																	
0300																	
0400																	
0500																	
0600																	
0700	99°	92	14	115/62	97%												
0800																	
0900																	
1000																	
100																	
[illegible]	98⁵	88	14	114/62	96%	eq											Recovery Complete
1300																	
1400	98⁵	95	12	119/57	95%	RA											
1500																	
1600																	
1700																	
1800	99²	101	17	105/50	98%	RA											
1900																	
2000																	
2100																	
2130	98⁶	103	16	119/59	94%	RA											
2200																	
2300																	
2400	98.4⁹	92	16	107/57	98%	RA											

MEDCOM - 1472


INTAKE
OUTPUT
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0800
8 HR
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8 HR
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8 HR
8 HR. 500
550
8 HR 550
16 HR.
16 HR. 600
24 HR.
24 HR
MEDCOM - 1473

NSN 7540-00-634-4123

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
5AUG03	0700		Assumed care of pt. Pt refused breakfast. Bed bath and oral care done. Meds given as ordered. Dressings changed, Dr. [redacted] observed RUE and decided to do A washout this morning on the thumb, NPO until surgery. No complaints, no pain. SPC [redacted]
5Aug03		1300	Pt recovery complete - s/p Washout and Skin flap Modification - (R) ↓ ↑ Ext. dressings to surgical site c/d/i. Piv Δ to Saline Lock - Patent - c/d/i. No c/o pain. VSS - afebrile. Cont. Monitor. — [redacted]
5AUG03		1500	Pt assessment complete. Pt consumed several items of food brought from outside / plus ensure. Pt drsgs c/d/i. Drsg Δ deferred as per Dr [redacted] BID W → D to ↑ begin in AM — [redacted]
5AUG03		2300	Recieved pt VSS = Ø complaints at this time, see flowsheet for assessment, will continue to monitor [redacted] SGT aiwmcLVN

MEDCOM - 1474

MEDICAL RECORD - PATIENT RELEASE / DISCHARGE INSTRUCTIONS

For use of this form, see MEDCOM Circular 40-5

DIRECTIONS: To be completed by attending provider and other staff at time of patient release following an outpatient procedure, extended care/treatment or discharge from an inpatient hospital stay.

SECTION I
TO BE COMPLETED BY PRIVILEGED PROVIDER

1. DATE OF PROCEDURE/ADMISSION: 26/July
2. ADMITTING/DIAGNOSIS: multiple extremity wounds
3. PERTINENT LAB, X-RAY, FINDINGS:
   (1) (R) Thumb partial amputation c̄ open fxs of mc/P1 c̄ skin loss
   (2) open (R) Achilles Tendon Tear
   (3) open (R) Tibia fx
   (4) open (L) Knee
4. PROCEDURES, TREATMENT, HOSPITAL COURSE:
   (5) closed (L) Tibia fx
   (6) open (L) 3rd MT fx
   (7) (R) foot EHL lac c̄ degloving in July
5. FINAL DIAGNOSIS AND CONDITION AT DISCHARGE:
   (1) S/p Ex Fix (R) Tibia
   (2) s/p failed DCBG to (R) Thumb for MCPJ fusion
   (3) s/p placement antibiotic cement
6. ACTIVITY: spare (R) Thumb & rotational
7. DIET: skin flap
8. MEDICATIONS: (4) S/p STGs to Dorsum (R) hand and Achilles Tendon
   ☐ Medications have been prescribed for home use. See separate list and special instructions or see below.
   (5) s/p (L) Knee arthrotomy & I&D
   (6) s/p I&D (L) 3rd MT fx
9. INSTRUCTIONS (To Home Health Providers, Patient, etc):
   D/c to CPW Camp.
   Daily Dressing Changes by medic @ CPW Camp
   F/c 21st CSH on 7 Sept 03 @ 0900 hrs.
10. DISCHARGING PROVIDER: (b)(6)-2 (Signature) (b)(6)-2 (Printed or Stamped Name)

PATIENT IDENTIFICATION

Iraq. (b)(6)-4

SECTION II
TO BE COMPLETED BY OTHER STAFF, AS APPROPRIATE

1. DISPOSITIONED TO: ☐ HOME ☐ DUTY ☑ OTHER EPW Camp
   ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER
2. ACCOMPANIED BY: ☐ FAMILY ☐ FRIEND ☑ OTHER MP's
3. PATIENT EDUCATION:
   Completed and patient prepared for home care. ☑ YES ☐ NO
   If no, explain:
   Patient ☐ states ☑ demonstrates understanding of home care needs.
   Printed educational materials provided:
4. Clinical outcomes met and post-discharge/release referrals made.
   ☑ YES ☐ NO If no, explain:
5. If transferred to another health care facility, report called to nurse.
   ☐ YES ☐ NO If no, explain:
6. NUTRITION CARE - Comments:
   Regular Diet
7. MEDICATIONS:
   Explained by: ☐ NURSE ☐ PHYSICIAN ☐ PHARMACIST
   Printed medication literature provided. ☐ YES ☐ NO
   Patient states understanding of prescribed medications. ☐ YES ☐ NO
8. EQUIPMENT/SUPPLIES PROVIDED:
   Crutches
9. FOLLOW-UP APPOINTMENTS, POINT OF CONTACT & PHONE:
   FWB (L) LE
   25% WB (R) LE
   NWB (R) Thumb
   Crutches for ambulation
10. FOR PROBLEMS OR EMERGENCY, CONTACT & PHONE:
    Levoquin 500mg PO 62 day x 7 days
11. COMPLETED BY:
    (b)(6)-2 (Signature) CPT AN 29 Aug 03 / 10:12 (Date and Time)

I HAVE RECEIVED A COPY OF AND UNDERSTAND THESE INSTRUCTIONS.

(b)(6)-2 (Patient/Responsible Adult's Signature) MP 29 AUG 03 / 10:12 (Date and Time)

MC V1.00

MEDCOM FORM 691-R (TEST) (MCHO) MAR 99 PREVIOUS EDITIONS ARE OBSOLETE

MEDCOM - 1475

MC Approved 28 Sep 98

MEDICAL RECORD	PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT For use of this form, see AR 40-407; the proponent agency is The Office of the Surgeon General.
1. AGE: 22y/o HEIGHT: WEIGHT:	2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): NKDA 3. PREVIOUS SURGERY [ ] NO [ ] YES (type):

4. PROPOSED SURGICAL PROCEDURE: ① open R thumb MCPJ ≡ Fx s/p IM ② open R tibia IM ③ multiple R & L facial lacerations ≡ GSW ④ L tibia ex-fix Medical Hx:

5. ADDITIONAL INFORMATION:
NPO since Labbo x 4 hrs ago
ROM/Musculoskeletal limited
Skin Appearance WNL

Hardware/ Prosthesis Ø
Significant Other Waiting Ø
Psychological/LOC Alert
Language/Cultural IRAQ

Lab ✓
H&P ✓
UHCG N/A
Consent ✓

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to o Procedure o Body Image o Family Separation o Surgical Outcome o Other	o Pt. verbalizes any specific anxiety. o Pt. exhibits relaxed body posture. o Demonstrates age specific coping mechanisms	o Allow pt. to verbalize freely. o Explain OR environment and answer questions regarding surgery. o Offer comfort measures, (e.g., warm blanket, touch) o Explain all nursing procedures before they are done. o Remain with pt. whenever possible. o Maintain family interface.
B. AERATION ___ Potential for respiratory dysfunction due to o Sedation o Existing Pulmonary Problems	o PT. will be able to breathe without difficulty during immediate intra-operative phase.	o Offer to elevate head of litter or offer pillow. o Observe pt. while awaiting surgery for signs of distress o Assist anesthesia during intubation and extubation
C. INTEGUMENT ✓ Potential impairment of skin integuity due to o Immobilization o Prep Solution o Tourniquet o ESU o Positioning o SCD	o PT. will not exhibit signs of impairment of skin integrity (e.g., reddened areas.	o Utilize pressure preventing devices on OR table and accessories. o Check for proper positioning and support to maintain good body alignment. o Pad pressure points. o Place ESU ground pad on non compromised skin surface area. o Keep prep fluids from pooling. o Select appropriate size ESU pad

9. PATIENT'S IDENTIFICATION (For typed or written entries give: Name- last, first, middle; grade; date; hospital or medical facility)

IRAQ (b)(6)-4

D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to o Positioning o Tourniquet o Preexisting CV Problems	o Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse).	o Check for support stockings or ace wraps. If none, check with doctors. o Check that safety straps are correctly applied. o Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. o Check that rings have been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to o Transfer o Positioning E.2. ✓ Potential discomfort due to o Positioning	o Pt. will be transferred to OR table without difficulty. o Pt. will not experience unnecessary physical discomfort.	o Have sufficient people available for transfer. o Insure proper body alignment. o Allow patient to lie in position of comfort while waiting for surgery. o Offer support (i.e., pillows, bathtowels, etc.) for positioning.
F. NEUROMUSCULAR CONTROL F.1. ✓ Disminished visual perception due to being Sld o Contacts o Glasses F.2. ✓ Potential for decreased communictaion due to Sld o Language o Hearing Aids F.3. Potential injury due to dentures.	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR table. o Pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt. from left/right side. o Validate pt.'s understanding of verbal communications. o Verify removal of dentures.
G. OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs. o Potential for Loss of Body Heat	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes. o Maintain Body Temperature	OTHER NURSING INTERVENTIONS. Or continuation of above interventions. o Increase Room Temp (pts. 65years & older) o Maintain Room Temp between 74-81 degrees for pediatric pts. o Provide Warm Sheets/Fluids o Assist with applying bear hugger, as needed.

10. OR NURSING INTERVENTIONS COMPLETED. ADDITIONAL INTEROPERATIVE INTERVENTIONS NOTED.

(b)(6)-2 maj USA 26 July 03 DATE

11. POSTOPERATIVE EVALUATION:

d Patient goals and outcomes were met
d Prep solutions removed
d ESU site:
d Prep site:

12. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title)	13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title)
(b)(6)-2 maj USA DATE: 26 July 03 TIME: 1825	(b)(6)-2 maj USA DATE: 26 July 03 TIME: 1989

REVERSE OF DA FORM 5179, JUN 91

USAPA V1.0

ACLU-RDI 1099 p.261

DOD 005529

LSEC Approved 28 Sep 98

MEDICAL RECORD	PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT For use of this form, see AR 40-407; the proponent agency is The Office of the Surgeon General.
1. AGE: 22 y/o HEIGHT: WEIGHT:	2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): NKDA 3. PREVIOUS SURGERY [ ] ... NO [X] YES (type): I+D gr LE ② ① Tibia ex-fix ③ ② thumb PCP

4. PROPOSED SURGICAL PROCEDURE: I+D RLE + ② hand

Medical Hx:

5. ADDITIONAL INFORMATION:
NPO since NN
ROM/Musculoskeletal see above
Skin Appearance see above

Hardware/ Prosthesis yes
Significant Other Waiting Ø
Psychological/LOC alert
Language/Cultural Fragi

Lab ✓
H&P ✓
UHCG N/A
Consent ✓

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to ✓ o Procedure o Body Image ✓ o Family Separation ✓ o Surgical Outcome o Other	✓ o Pt. verbalizes any specific anxiety. ✓ o Pt. exhibits relaxed body posture. ✓ o Demonstrates age specific coping mechanisms Through Interpret	o Allow pt. to verbalize freely. o Explain OR environment and answer questions regarding surgery. ✓ o Offer comfort measures, (e.g., warm blanket, touch) o Explain all nursing procedures before they are done. ✓ o Remain with pt. whenever possible. ✓ o Maintain family interface.
B. AERATION ✓ Potential for respiratory dysfunction due to ✓ o Sedation o Existing Pulmonary Problems	o PT. will be able to breathe without difficulty during immediate intra-operative phase.	✓ o Offer to elevate head of litter or offer pillow. ✓ o Observe pt. while awaiting surgery for signs of distress ✓ o Assist anesthesia during intubation and extubation
C. INTEGUMENT ✓ Potential impairment of skin integuity due to ✓ o Immobilization ✓ o Prep Solution o Tourniquet ✓ o ESU ✓ o Positioning o SCD	✓ o PT. will not exhibit signs of impairment of skin integrity (e.g., reddened areas.	✓ o Utilize pressure preventing devices on OR table and accessories. ✓ o Check for proper positioning and support to maintain good body alignment. ✓ o Pad pressure points. o Place ESU ground pad on non compromised skin surface area. ✓ o Keep prep fluids from pooling. ✓ o Select appropriate size ESU pad

9. PATIENT'S IDENTIFICATION (For typed or written entries give: Name- last, first, middle; grade; date; hospital or medical facility)

(b)(6)-4

DA FORM 5179, JUN 91 Previous editions are obsolete. FH MDA OP 176 USAPA V1.0
1 May 00 (Revised)

MEDCOM - 1478

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ___ Potential for inadequate tissue perfusion due to o Positioning o Tourniquet o Preexisting CV Problems	o Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse).	o Check for support stockings or ace wraps. If none, check with doctors. o Check that safety straps are correctly applied. o Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. o Check that rings have been removed.
E. NEUROMUSCULAR CONTROL E.1. ___ Potential impairment of mobility due to o Transfer o Positioning E.2. ___ Potential discomfort due to o Positioning	o Pt. will be transferred to OR table without difficulty. o Pt. will not experience unnecessary physical discomfort.	o Have sufficient people available for transfer. o Insure proper body alignment. o Allow patient to lie in position of comfort while waiting for surgery. o Offer support (i.e., pillows, bathtowels, etc.) for positioning.
F. NEUROMUSCULAR CONTROL F.1. ___ Disminished visual perception due to being o Contacts o Glasses F.2. ___ Potential for decreased communictaion due to o Language o Hearing Aids F.3. Potential injury due to dentures.	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR table. o Pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt. from ___ side. o Validate pt.'s understanding of verbal communications. o Verify removal of dentures.
G. OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs. o Potential for Loss of Body Heat	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes. o Maintain Body Temperature	OTHER NURSING INTERVENTIONS. Or continuation of above interventions. o Increase Room Temp (pts. 65years & older) o Maintain Room Temp between 74-81 degrees for pediatric pts. o Provide Warm Sheets/Fluids o Assist with applying bear hugger, as needed.

10. OR NURSING INTERVENTIONS COMPLETED/ADDITIONAL INTEROPERATIVE INTERVENTIONS NOTED.

(b)(6)-2 CRT, A 7/28/03 DATE

11. POSTOPERATIVE EVALUATION:

o Patient goals and outcomes were met
o Prep solutions removed
o ESU site:
o Prep site: Clean

12. PREOPERTIVE EVALUATION PREPARED BY

(b)(6)-2 CRT, A

DATE: 7/28/03 TIME:

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title)

(b)(6)-2 CRT, A

DATE: 7/28/03 TIME: 1141

REVERSE OF DA FORM 5179, JUN 91

USAPA V1.0

ACLU-RDI 1099 p.263

DOD 005531

SEC Approved 28 Sep 98

MEDICAL RECORD	PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT For use of this form, see AR 40-407; the proponent agency is The Office of the Surgeon General.
1. AGE: 22 HEIGHT: WEIGHT:	2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): NKDA 3. PREVIOUS SURGERY [ ] NO [X] YES (type): ① (R) tibia ex. fix ② I+D (R) hand ③ I+D (L) hand

4. PROPOSED SURGICAL PROCEDURE: I+D (b)(6)-2 [redacted]

Medical Hx: Ø/Ø Ø/Ø

5. ADDITIONAL INFORMATION:
NPO since 8/00
ROM/Musculoskeletal ✓
Skin Appearance ✓
Hardware/Prosthesis Yes
Significant Other Waiting no
Psychological/LOC Alert
Language/Cultural Iraqi
Lab ✓
H&P ✓
UHCG N/A
Consent ✓

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to ✓ Procedure o Body Image o Family Separation ✓ Surgical Outcome o Other	✓ Pt. verbalizes any specific anxiety. ✓ Pt. exhibits relaxed body posture. ✓ Demonstrates age specific coping mechanisms Thought Fatigue	o Allow pt. to verbalize freely. ✓ Explain OR environment and answer questions regarding surgery. o Offer comfort measures, (e.g., warm blanket, touch) o Explain all nursing procedures before they are done. o Remain with pt. whenever possible. ✓ Maintain family interface.
B. AERATION ✓ Potential for respiratory dysfunction due to ✓ Sedation o Existing Pulmonary Problems	✓ PT. will be able to breathe without difficulty during immediate intra-operative phase.	✓ Offer to elevate head of litter or offer pillow. ✓ Observe pt. while awaiting surgery for signs of distress ✓ Assist anesthesia during intubation and extubation
C. INTEGUMENT ✓ Potential impairment of skin integuity due to ✓ Immobilization ✓ Prep Solution o Tourniquet o ESU ✓ Positioning o SCD	✓ PT. will not exhibit signs of impairment of skin integrity (e.g., reddened areas.	o Utilize pressure preventing devices on OR table and accessories. ✓ Check for proper positioning and support to maintain good body alignment. ✓ Pad pressure points. ✓ Place ESU ground pad on non compromised skin surface area. ✓ Keep prep fluids from pooling. ✓ Select appropriate size ESU pad

9. PATIENT'S IDENTIFICATION (For typed or written entries give: Name- last, first, middle; grade; date; hospital or medical facility)

(b)(6)-4 [redacted]

DA FORM 5179, JUN 91 Previous editions are obsolete. FH MDA OP 176 USAPA V1.0
1 May 00 (Revised)

MEDCOM - 1480

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ___ Potential for inadequate tissue perfusion due to o Positioning o Tourniquet o Preexisting CV Problems	o Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse).	o Check for support stockings or ace wraps. If none, check with doctors. o Check that safety straps are correctly applied. o Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. o Check that rings have been removed.
E. NEUROMUSCULAR CONTROL E.1. ___ Potential impairment of mobility due to o Transfer o Positioning E.2. ___ Potential discomfort due to o Positioning	o Pt. will be transferred to OR table without difficulty. o Pt. will not experience unnecessary physical discomfort.	o Have sufficient people available for transfer. o Insure proper body alignment. o Allow patient to lie in position of comfort while waiting for surgery. o Offer support (i.e., pillows, bathtowels, etc.) for positioning.
F. NEUROMUSCULAR CONTROL F.1. ___ Disminished visual perception due to being o Contacts o Glasses F.2. ___ Potential for decreased communictaion due to o Language o Hearing Aids F.3. Potential injury due to dentures.	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR table. o Pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt. from ___ side. o Validate pt.'s understanding of verbal communications. o Verify removal of dentures.
G. OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs. o Potential for Loss of Body Heat	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes. o Maintain Body Temperature	OTHER NURSING INTERVENTIONS. Or continuation of above interventions. o Increase Room Temp (pts. 65years & older) o Maintain Room Temp between 74-81 degrees for pediatric pts. o Provide Warm Sheets/Fluids o Assist with applying bear hugger, as needed.

10 (b)(6)-2 TED/ADDITIONAL INTEROPERATIVE INTERVENTIONS NOTED.

CPT, A 8/8/03 DATE

11. POSTOPERATIVE EVALUATION:

o Patient goals and outcomes were met
o Prep solutions removed
o ESU site:
o Prep site:

12. PREOPERTIVE EVALUATION PREPARED BY	13. POSTOPERATIVE EVALUATION PREPARED
(b)(6)-2 CPT, A	(b)(6)-2 CPT, AN
DATE: 8/8/03 TIME: 1430	DATE: 8/8/03 TIME: 1430

REVERSE OF DA FORM 5179, JUN 91 USAPA V1.0

ACLU-RDI 1099 p.265

DOD 005533

MEDICAL RECORD | **INTRAOPE[illegible]/E DOCUMENT**

For use of this form, see AR 40-407, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Litter BY LTC (b)(6)-2	2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY (b)(6)-2 Maj/[illegible]
3. DATE 26 June 03 TIME PATIENT ARRIVED IN SUITE 1955	4. PATIENT IN [illegible] TIME 1955 NUMBER #1

5. PREOPERATIVE EMOTIONAL STATUS

☒ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS: NKDA

6. NURSING PERSONNEL

ASSIGNED SCRUB	Spc (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	Maj (b)(6)-2	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

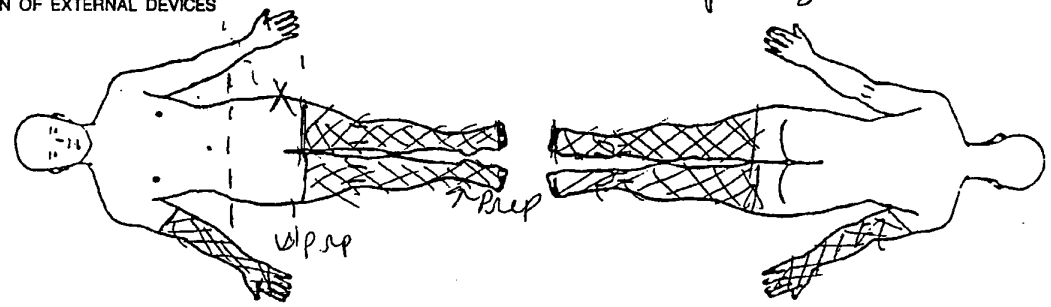
COMMENTS: Head resting on folded towel. Arms on padded armboard - Arm with padded armstrap - Arm manipulated by surgeon. Both legs prepped and uncrossed

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP
COMMENTS:

PREP SOLUTION *(Specify)* Beta/Beta
SITE: R leg B leg BY WHOM: [redacted]
SITE: R arm BY WHOM: [redacted] B6-2
COMMENTS: No pooling or irritation

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad – Safety Strap ---- Tourniquet

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No	✓	C	C	Spc (b)(6)-2	Maj (b)(6)-2
Needle Sharp	☒ Yes ☐ No	✓				
Instrument	☒ Yes ☐ No					
Other	☐ Yes ☐ No					

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

IRAQ # (b)(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☐ YES ☐ NO

☐ ESU NO: Valleylab FX 000434
GROUND PAD: BRAND Valleylab E7507
LOT NO: 68986

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 PLACES [illegible] WHICH IS OBSOLETE.

MEDCOM - 1482

13. PROSTHESIS, IMPLANTS ☒ YES ☐ NO IF YES NAME: ID NUMBER; MANUFACTURER

EX Fix (b)(6)-2

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☐

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

0.9% NS

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM IF YES, SITE

YES ☒ NO ☐

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☐ NO ☐

TYPE/SIZE	1. Penrose	2.	3.
SITE	[illegible]	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

Xeroform
fluffs
Kerlex
ace wrap

19. ADDITIONAL INFORMATION

Dr (b)(6)-2
Dr

20. OPERATION(S) PERFORMED

① EX Fix @ tibia Fx = I+D
② Pins @ thumb = I+D
③ I+D @ lower extremety wounds

21. PATIENT TRANSFERRED TO PACU TIME See DA7359 METHOD litter = safety straps

22. REGISTER (b)(6)-2 [illegible]

REVERSE OF DA FORM 3(1)3-1, 2

*U.S. GPO: 1996-404-613/40449

MEDCOM - 1483

MEDICAL RECORD — **INTRAOPERATIVE DOCUMENT**

For use of this form, see AR 40-407, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Gurney BY [illegible]

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY CRT (b)(6)-2

3. DATE 7/28/03 TIME PATIENT ARRIVED IN SUITE 0905

4. PATIENT IN ROOM TIME 0905 NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

☒ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPL (b)(6)-2	RELIEF SCRUB	
	SSC (b)(6)-2 (Did not scrub)		
ASSIGNED CIRCULATOR	CRT (b)(6)-2	RELIEF CIRCULATOR	
	MAJ (b)(6)-2		

7. POSITION AND POSITIONAL AIDS *(Specify)*

☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

COMMENTS: n/a

8. SKIN PREPARATION

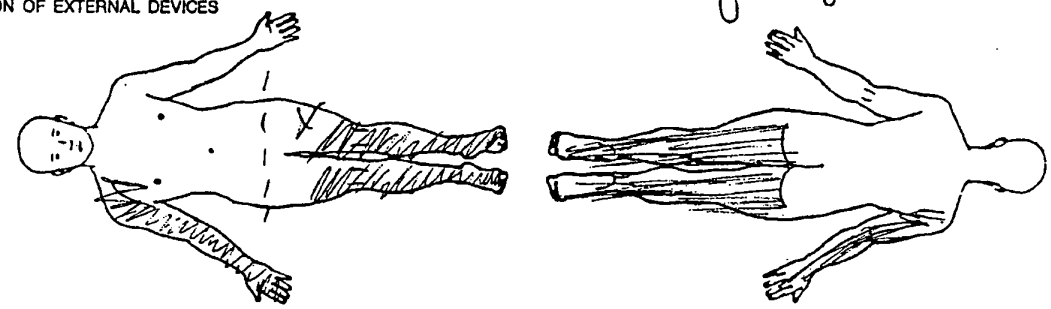
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine Surgical Scrub
SITE: LLE BY WHOM: MAJ (b)(6)-2
SITE: RLE BY WHOM: CPT (b)(6)-2

COMMENTS: no pooling of solution

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Strap ═══ Tourniquet

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count
Sponge	☒ Yes ☐ No		C	C
Needle Sharp	☒ Yes ☐ No		C	C
Instrument	☐ Yes ☒ No			
Other	☐ Yes ☒ No			

SCRUB: SBC (b)(6)-2 SDC
CIRCULATOR: CRT (b)(6)-2 CPT (b)(6)-2

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

(b)(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ (b)(6)-2

☐ ESU NO: 0504541 3/30
GROUND PAD: BRAND Valleylab
LOT NO: 68934 05-03

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 PLACES D[illegible]CH. OBSOLETE.

MEDCOM - 1484

13. PROSTHESIS, IMPLANTS ☐ YES ☒ NO IF YES NAME: ID NUMBER; MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☐

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):
① hand - 3Ltr. NSS ② Tibia - NSS x 2L ③ knee - NSS x 2Lt.

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM YES ☐ NO ☒ IF YES, SITE

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	18. DRESSING/IMMOBILIZATION *(Specify)* ① RUE - xeroform, 4x4's, kerlix, Ace ② RLLE - xeroform, 4x4's, kerlix, Ace.

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

	1.	2.	3.
TYPE/SIZE			
SITE			

19. ADDITIONAL INFORMATION

(b)(6)-2

20. OPERATION(S) PERFORMED
① Adjust ② Tibial Ex-fix ④ I+D ⑤ hand & shoulder
② I+D of lower Ext. & closure ⑤ ⑫ achilles tendon repair
③ ⑫ hand thumb tendon repair

21. PATIENT TRANSFERRED TO FCH 1 TIME METHOD Gurney

22. REGISTERED NURSE SIGNATURE (b)(6)-2

REVERSE OF DA FORM 5179-1,

*U.S. GPO: 1996-404-813/40449

MEDCOM - 1485

MEDICAL RECORD | **INTRAOP[illegible] [illegible]IV[illegible] DOCUMENT**

For use of this form, see AR 40-407, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Gurney BY [illegible]	2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY CPT (b)(6)-2
3. DATE 7/30/03 TIME PATIENT ARRIVED IN SUITE 0905	4. PATIENT IN ROOM TIME 0905 NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

☒ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS: none

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC (b)(6)-2	RELIEF SCRUB	
	SPC		
ASSIGNED CIRCULATOR	MA	RELIEF CIRCULATOR	
	CPT		

7. POSITION AND POSITIONAL AIDS *(Specify)*

☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

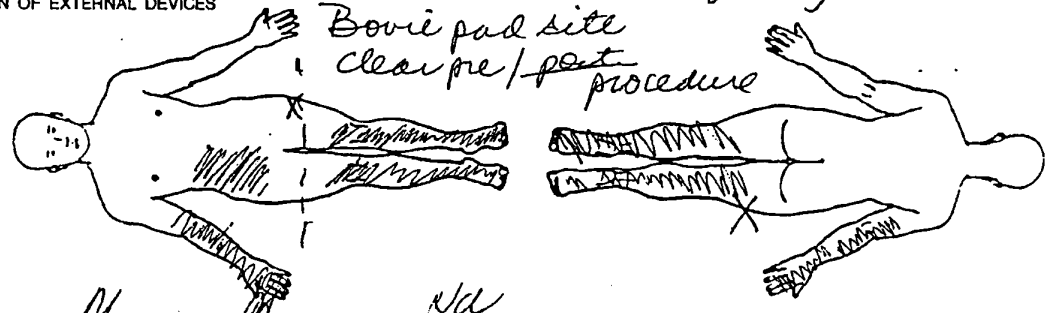
COMMENTS: none

8. SKIN PREPARATION

HAIR REMOVAL ☒ YES ☐ NO
DONE BY: ☒ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP
COMMENTS: no nick or cuts

PREP SOLUTION *(Specify)* Betn S+S
SITE: Bil lower ext. BY WHOM: MAJ (b)(6)-2
SITE: RUE + (R) illiac crest BY WHOM: CPT (b)(6)-2
COMMENTS: no pooling of solution

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad NL – Safety Strap --- Tourniquet NL

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB (b)(6)-2	CIRCULATOR (b)(6)-2
Sponge	☒ Yes ☐ No		E	E	SPC	MAJ
Needle Sharp	☒ Yes ☐ No					
Instrument	☐ Yes ☒ No					
Other	☐ Yes ☒ No					

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

Iraqi (b)(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO

☐ ESU NO: 000434 40/40
GROUND PAD: BRAND Valley Lab
LOT NO: 68936 05-03

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 PLACES DA FORM 5179-1 (TEST), DEC 82, WHICH [illegible] OBSOLETE.

MEDCOM - 1486

13. PROSTHESIS, IMPLANTS ☐ YES ☒ NO IF YES NAME: ID NUMBER; MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☐

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S):
ONS 3000 x 3

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM YES ☐ NO ☑ IF YES, SITE

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☑	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☑	NAME	NAME
CULTURE (C) YES ☐ NO ☑	NAME	NAME
NAME	NAME	NAME
NAME	NAME	18. DRESSING/IMMOBILIZATION *(Specify)* Xeroform, steri strip – grafted site Xeroform, telfa, 4x8s, kerlix, ace ® hand net-dry + kerlix, splint, ace ® LE Xeroform, 4x8s, kerlix, ace LLE

17. TUBES, DRAINS/PACKING YES ☐ NO ☑

TYPE/SIZE	1.	2.	3.
SITE	1.	2.	3.

19. ADDITIONAL INFORMATION
NKDA

20. OPERATION(S) PERFORMED
I & D ® hand, (L) LE, Graft, Hip to RLE, RUE

21. PATIENT TRANSFERRED TO ICU | TIME 1200 | METHOD Litter

22. (b)(6)-2 Major

REV[illegible]

*U.S. GPO: 1998-404-613/40449

MEDCOM - 1487

MEDICAL RECORD — **INTRAOPERATIVE DOCUMENT**

For use of this form, see AR 40-407, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Gurney BY Anesthesia

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY CPT (b)(6)-2

3. DATE 8/5/05 TIME PATIENT ARRIVED IN SUITE 1150

4. PATIENT IN ROOM TIME 1155 NUMBER 2

5. PREOPERATIVE EMOTIONAL STATUS

☒ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS: none

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT (b)(6)-2	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

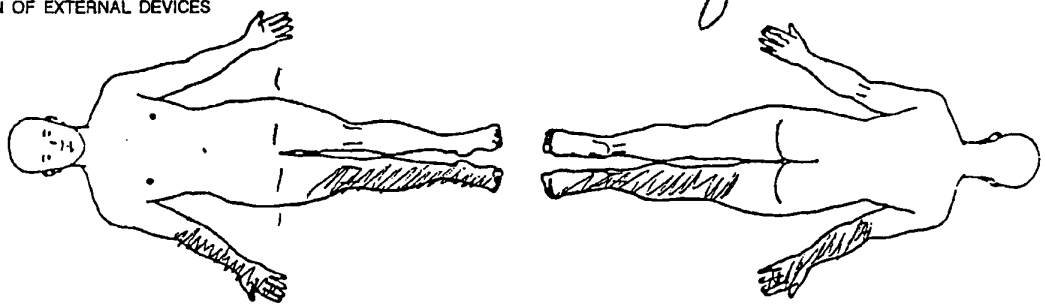
COMMENTS: none

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP
COMMENTS:

PREP SOLUTION *(Specify)* Betadine
SITE: Head BY WHOM: CPT (b)(6)-2
SITE: RLE BY WHOM: CPT (b)(6)-2
COMMENTS: no grading of skin

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad – Safety Strap --- Tourniquet

10. COUNTS		C = Correct I = Incorrect: Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No		C	C	SPC (b)(6)-2	CPT (b)(6)-2
Needle Sharp	☒ Yes ☐ No		C	C	SPC	CPT
Instrument	☐ Yes ☒ No					
Other	☐ Yes ☒ No					

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

Iraqi # (b)(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☐ YES ☒ NO

☐ ESU NO: _____
GROUND PAD: BRAND _____
LOT NO: _____

☐ ESU NO: _____
GROUND PAD: BRAND _____
LOT NO: _____

☐ BIPOLAR NO: _____

DA FORM 5179-1, OCT 87 PREVIOUS EDITIONS OF THIS FORM ARE OBSOLETE.

MEDCOM - 1488

13. PROSTHESIS, IMPLANTS ☐ YE ☒ NO IF YES NAME: ID NU R; MANUFACTURER

Ø

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☒

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
Ø					

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

NSS X 3L

OTHER ORDERS	TIME	CARRIED OUT BY
Ø		

PHYSICIAN'S SIGNATU (b)(6)-2

15. X-RAY IN OPERATING ROOM IF YES, SITE

YES ☐ NO ☒

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

18. DRESSING/IMMOBILIZATION (Specify)

① 4x4's, kulix, - (R) hand

② 4x4's, kulix, splint, Ace - ME

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

TYPE/SIZE	1.	2.	3.
SITE	1.	2.	3.

19. ADDITIONAL INFORMATION

(b)(6)-2

Dr

Dr.

Dr.

MD

20. OPERATION(S) PERFORMED

① I+D (R) hand

② I+D (R) calf

21. PATIENT TRANSFERRED TO I Cul TIME 1211 METHOD Gurney

22. REGISTERED NURSE SIGNATURE (b)(6)-2 CPT

REVERSE OF DA FORM 5179-1, C

*U.S. GPO: 1996-404-613/40449

MEDCOM - 1489

MEDICAL RECORD | **INTRAOPERATIVE DOCUMENT**

For use of this form, see AR 40-407, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Gurney BY [illegible]

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY COT (b)(6)-2

3. DATE 8/9/03 TIME PATIENT ARRIVED IN SUITE 1505

4. PATIENT IN ROOM TIME 1508 NUMBER 2

5. PREOPERATIVE EMOTIONAL STATUS

☑ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS: none

6. NURSING PERSONNEL

ASSIGNED SCRUB	SRC (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	COT (b)(6)-2	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

☑ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

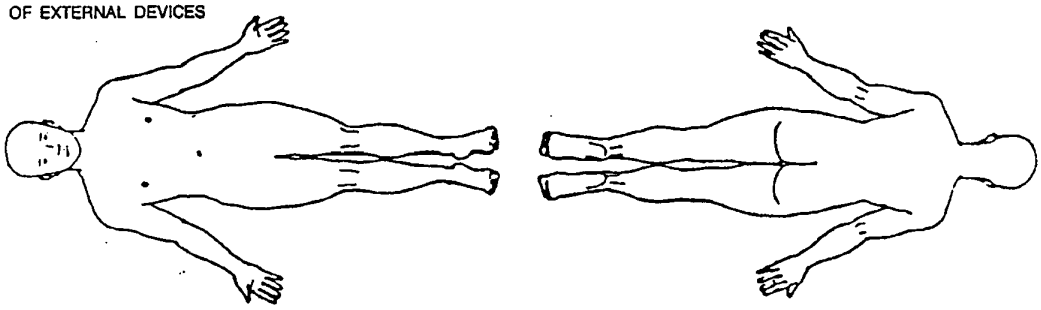
COMMENTS: none

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☐ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP
COMMENTS:

PREP SOLUTION *(Specify)*
SITE: BY WHOM:
SITE: BY WHOM:
COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Strap ═══ Tourniquet

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☑ Yes ☐ No		C	C	SRC (b)(6)-2	COT (b)(6)-2
Needle Sharp	☑ Yes ☐ No		C	C	SRC	COT
Instrument	☐ Yes ☑ No					
Other	☐ Yes ☑ No					

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

Iraq (b)(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☐ YES ☑ NO

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:
☐ ESU NO:
GROUND PAD: BRAND
LOT NO:
☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES [illegible] WHICH OBSOLETE.

MEDCOM - 1490

13. PROSTHESIS, IMPLANTS ☐ YE IF YES NAME: ID NU... NUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☒

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

NSS x 3Lt,

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM YES ☐ NO ☒ IF YES, SITE

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

18. DRESSING/IMMOBILIZATION *(Specify)*

① Xeroform, 4x4's, Kerlix

② Xeroform, 4x4's, Kerlix

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 1" Penrose	2.	3.
SITE	1. Ⓛ foot	2.	3.

19. ADDITIONAL INFORMATION

(b)(6)-2

Dr

D.

20. OPERATION(S) PERFORMED

① I + D ⓛ foot

② I + D ⓡ thumb

21. PATIENT TRANSFERRED TO	TIME	METHOD
I Carl	1620	Gurney

22. REGISTERED NURSE SIGNATURE (b)(6)-2 CRT, A

REVERSE OF DA FORM 5179-1, OCT 87

*U.S. GPO: 1996-404-613/40449

MEDCOM - 1491

MEDICAL RECORD | **INTRAOP...ATIVE DOCUMENT**

For use of this form, see AR 40-407, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA litter BY anesthesia

2. PATIENT IDEN... VERIFIED BY (b)(6)-2 ...D PROCEDURE

3. DATE 12 Aug 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN R... TIME 1445 NUMBER 5

5. PREOPERATIVE EMOTIONAL STATUS

☐ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS: Alert/oriented

6. NURSING PERSONNEL

ASSIGNED SCRUB	Spc (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	Maj (b)(6)-2	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)* ...et arms on double armboards. Safety strap over thighs

☑ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

COMMENTS:

8. SKIN PREPARATION

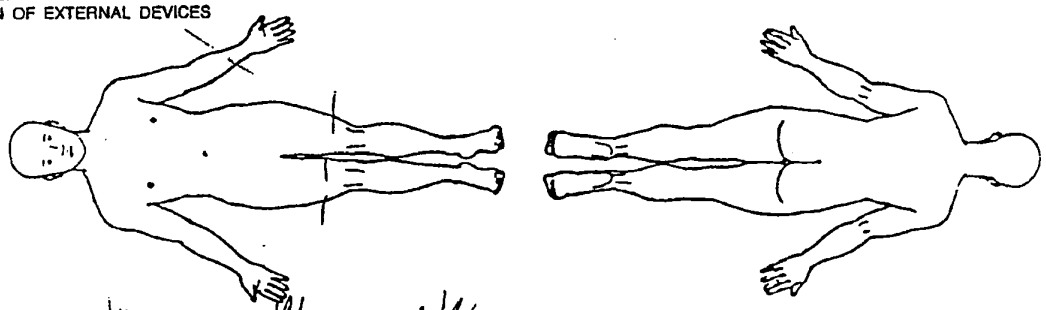
HAIR REMOVAL ☐ YES ☑ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine scrub/sol
SITE: R arm BY WHOM: Maj
SITE: BY WHOM: (b)(6)-2

COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Strap ---- Tourniquet

10. COUNTS		C = Correct I = Incorrect Other**	First Closing Count	Final Closing Count
Sponge	☐ Yes ☐ No			C
Needle Sharp	☐ Yes ☐ No			C
Instrument	☐ Yes ☑ No			
Other	☐ Yes ☑ No			

SCRUB (b)(6)-2 Spc

CIRCULATOR (b)(6)-2 Maj

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

Drage (b)(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☐ YES ☐ NO

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 ...EPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH ...BSOLETE.

MEDCOM - 1492

13. PROSTHESIS, IMPLANTS ☐ YE. IF YES NAME ID NU...E. ...FACTURER

Surgical Simplex® P
RADIOPAQUE BONE CEMENT
Distributed by:
Stryker®
Howmedica
Osteonics Mahwah, New Jersey
Full Dose
Cat. No. 6191 1 001
Control No. RG1321

14. MEDICATIONS/ORI

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ☐ NO ☐

MEDICATIONS/SOLUTION	DOSAGE	TIME	...RED BY	GIVEN BY
Vancomycin 2gm / methyl Methacrylate	antibiotic beads			

WOUND IRRIGATION ☐ YES ☐ NO, TYPE(S):

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM YES ☐ NO ☑ IF YES, SITE

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☑	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☑	NAME	NAME
CULTURE (C) YES ☐ NO ☑	NAME	NAME
NAME	NAME	NAME
NAME	NAME	18. DRESSING/IMMOBILIZATION *(Specify)* Xeroform 4x8s Kerlix

17. TUBES, DRAINS/PACKING YES ☐ NO ☑

TYPE/SIZE	1.	2.	3.
SITE	1.	2.	3.

19. ADDITIONAL INFORMATION

NKDA

Surgeons - (b)(6)-2

20. OPERATION(S) PERFORMED

I.D; Placement antibiotic Beads ® thumb

21. PATIENT TRANSFERRED TO Pali TIME 1550 METHOD litter

22. (b)(6)-2 Mayo

REVERSE OF DA FORM 5179-1, OCT 87

*U.S. GPO: 1996-404-613/40449

MEDCOM - 1493

MEDICAL RECORD — **INTRAO[illegible]E DOCUMENT**

For use of this form, see AR 40-407, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA litter BY anesthesia

2. PATIENT VERIFIED BY (b)(6)-2 [illegible]ND PROCEDURE MayAN

3. DATE 18 AUG 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT TIME NUMBER (b)(6)-2

5. PREOPERATIVE EMOTIONAL STATUS

☑ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER (Specify)

COMMENTS: Alert: oriented

6. NURSING PERSONNEL

ASSIGNED SCRUB	Doe (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	May (b)(6)-2	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify) Frogegged. Safety strap over thighs. Arms on

☑ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

COMMENTS: bil. armboards < 90°.

8. SKIN PREPARATION

HAIR REMOVAL ☑ YES ☐ NO per mey (b)(6)-2

DONE BY: ☑ OR ☐ NURSING

METHOD: ☐ DEPILATORY ☑ RAZOR

☐ CLIP

COMMENTS:

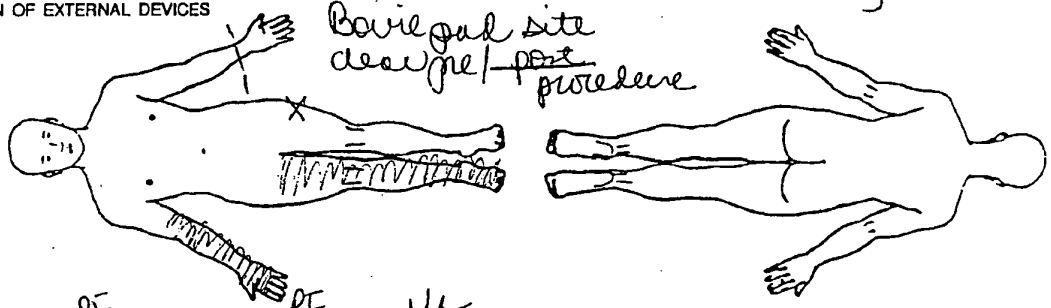
PREP SOLUTION (Specify) Betadine scrub/Sol.

SITE: (R) arm, BY WHOM: May (b)(6)-2

SITE: (R) leg BY WHOM: SSG (b)(6)-2

COMMENTS: no pooling noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad – Safety Strap --- Tourniquet

10. COUNTS		C = Correct I = Incorrect: Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☐ Yes ☑ No				(b)(6)-2	(b)(6)-2
Needle Sharp	☑ Yes ☐ No			C		
Instrument	☐ Yes ☑ No					
Other	☐ Yes ☑ No					

11. PATIENT IDENTIFICATION (For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)

Dragi (b)(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☑ YES ☐ NO

☑ ESU NO: Valleylab 00434 (b)(6)-2

GROUND PAD: BRAND Valley 00434

LOT NO: 70011

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REF[illegible]S DA FORM 5179-1 (TEST), DEC 82, WHICH IS OB[illegible]TE.

MEDCOM - 1494

13. PROSTHESIS, IMPLANTS ☐ YES ☐ NO IF YES NAME: ID NUMBER, MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☐

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S):
0.9NS

OTHER ORDERS	TIME	CARRIED OUT BY

PH (b)(6)-2

15. X-RAY IN OPERATING ROOM YES ☐ NO ☑ IF YES, SITE

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☑	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☑	NAME	NAME
CULTURE (C) YES ☐ NO ☑	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

18. DRESSING/IMMOBILIZATION *(Specify)*
Ⓑ leg: vaseline gauze, 4x8 kerlix
Ⓒ thigh: zeroform gauze, thigh
Ⓓ hand: vaseline gauze, 4x8, kerlix

17. TUBES, DRAINS/PACKING YES ☐ NO ☑

TYPE/SIZE	1.	2.	3.
SITE	1.	2.	3.

19. ADDITIONAL INFORMATION
NKDA

Surgeon (b)(6)-2

20. OPERATION(S) PERFORMED
Skin Grafts for Ⓑ thigh → Ⓓ achilles area & Ⓒ hand

21. PATIENT TRANSFERRED TO SICU #1 TIME 1037 METHOD litter

22. RE (b)(6)-2 May RN

REVERSE OF DA FORM 5179-1,

*U.S. GPO: 1995-404-613/40449

MEDCOM - 1495

(b)(6)-4

Prag

12 AUG 03

	INTAKE									OUTPUT						
	iV	PO	iVPB						Total	Urine					Total	COMMENTS
0100																
0200																
0300																
0400																
0500																
0600																
0700																
0800																
8 HR									8 HR.						8 HR	
0900																
1000																
1100																
1200																
1300																
1400	60/60															
1500	60/120									325/325						
1600	400/520								OR							
8 HR	520								16 HR. 520	325					16 HR. 325	
1700	60/66	250/250														
1800	60/120	350/600														
1900	60/180															
2000	60/240															
2100	60/300	350/950														
2200	60/360	240/1190														
2300	60/420															
2400	60/480								1670	400/400						
8 HR	480	1190							24 HR. 2190	400					24 HR 725	

MEDCOM - 1496

13 Aug 03

	INTAKE										OUTPUT							
	T-V	IVPB	PO							Total	Urine	Stool					Total	COMMENTS
0100	60																	
	120																	
0200	60																	
	180																	
0300	60	100																
	240																	
0400	60	100																
	300																	
0500	60																	
	360																	
0600	60																	
	420																	
0700	60																	
	480																	
0800	60																	
8 HR	480									8 HR.							8 HR	
0900	60										XL	XL						
1000	60																	
	120																	
1100	60	100																
	180																	
1200	60	100	240															
	240	200																
1300	60																	
	300																	
1400	60											300						
	360																	
1500	60																	
1600	60																	
8 HR										16 HR.							16 HR.	
1700	60		100								500							
1800	60											~~400~~						
1900	60	50																
2000	60											-400-						
2100	60																	
2200	60																	
2300																		
2400																		
8 HR										24 HR.							24 HR	

MEDCOM - 1497

Critical value on "K" reported to cuscuk

21st COMBAT SU[illegible] HOSPITAL

BORATORY RESULTS FORM
ect to Privacy Act of 1974)

LAST, FIRST, [illegible]	UNIT	RANK	SSN
Iraqi (b)(6)-4	(b)(6)-4		(b)(6)-4

Physician:	Ward:		Date and Time:	Reported by:	Date and Time:
(b)(6)-2	EMT	STAT / Routine	26Jul03@1800	(b)(6)-2	26Jul03@1830

Chemistry (i-STAT)

X	TEST	RESULT	REF. RANGE
	Na	137	128-145 mmol/L
	K	3.0	3.3-4.7 mmol/L
	Cl	106	98-108 mmol/L
	pH		7.35-7.45
	PCO2		35-45 mmHg
	PO2		80-90 mmHg
	TCO2		18-33 mmol/L
	HCO3		22-28 mmol/L
	sO2		95-99%
	BEecf		(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN	10	7-22 mg/dL
	Glu	91	73-118 mg/dL
X	Creat	1.0	0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL

Chemistry (Piccolo Analyzer)

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-84 U/L
	ALT		10-47 U/L
	AMY		14-97 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat		0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		128-145 mmol/L

Hematology

X	TEST	RESULT	REF. RANGE
	WBC	6.9	4.8-10.8 x10(3)/uL
	RBC	2.88	4.2-6.1 x10(6)/uL
	Hgb	8.7	12.0-18.0 g/dL
	Hct	26.7	35.0-60.0%
	MCV	92.6	80.0-99.0 fl
	MCH	30.2	27.0-31.0 pg
	MCHC	32.7	33.0-37.0 g/dL
	Plt	152	130-400 x10(3)/uL
	LY%	23.2	15.0-55.0%
	LY#	1.6	0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Imm
RBC Morph:	
Plt verify:	
Spun Crit	35-60%

Urinalysis

Color		Straw/Yellow
Clarity		Clear
Glucose		Negative
Bilirubin		Negative
Ketone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative-Trace
Urobili		Negative
Nitrite		Negative
Leuko		Negative

Urine Microscopic

WBC		Epi
RBC		Mucus
Bacteria		Yeast
Casts:		
Crystals:		
Other:		
Other:		

Microbiology

Source:		
FecLeuk		Negative
Gram St		
WetPrep		Negative
KOH		No Fungal Elements
OccBld		Negative
O&P		No Ova/Parasite

Blood Bank

ABO/Rh	O	positive
T&C		
T&S		

HCG

Urine		Negative
Serum		Negative

Malaria Smear

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate

Sed Rate		1hr = 0-20 mm

Coagulation

PT		10-13 seconds
APTT		22.1-33.7 seconds
FDP		Negative

Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Negative

I-stat 6 w/creat CBC, ABL; RH

(b)(6)-2 BEARLAB 20 31 May 2003

MEDCOM - 1498

Standard Form 517

22 Y.O. NKDA 1945

CLINICAL RECORD — ANESTHESIA

ANESTHETIC(S)	2000	30	2100	30	2200
VERSED	2				
FENT	100	100	50		
PROPOFOL	100	20			
SUX	100				
MSO_4		22	22	24	22
% KERANE	2	1.5	2	3	2.5
L OXYGEN	8	1	1	1	1
ET CO_2 ABSORP.	38	41	40	38	40
SpO_2	98	99	99	99	100
LEVEL OF ANAL-ANES.	5R	5R	5R	5R	5R

	2100	30	2200
% KERANE	3.5	3.0	2.5
L OXYGEN	1	1	1
ET CO_2 ABSORP.	36	43	52
SpO_2	100	100	100
LEVEL OF ANAL-ANES.	5R	5R	5R

CODE
- ● PULSE
- ○ RESP.
- V B. P.
- X ANES.
- ⓪ OPER.
- T TOURN.

117/54

74 99%

FLUIDS
- B BLOOD
- N SALINE
- G 5% G/W
- DX EXPAND.

220, 200, 180, 160, 140, 120, 100, 80, 60, 40, 20

VENT: S C C S S S S S S S

NUMBERS FOR REMARKS	610	600	280	300	300	220	240	330
VT	610	600	280	300	300	220	240	330
TIDE	8	8	18	17	21	14	11	11
PIP	21	21						

IV FLUIDS: LR (500) — 800 — 1000 — 1200 — 1300

LR (1000) — 500

+20 MEQ KCL

POSITION: Q ① NOM PATIENT SUPPORT

AGENTS AND TECHNICS: GEOA RSI c̄ CCP

INDUCTION

SATIS.

UNSATIS AND WHY.

REMARKS

1945 - IN ROOM STD MONITORS PRE-O2 RSI c̄ CCP

2000 - 2gm ANCEF IVPB

2020 - 80 mg GENT IVPB

2004

2215 - MOUTH SK ④ HEAD LIFT OPENS EYES EXHALATION c̄ SV

2220 - TO ICU #1 c̄ SV

119 131/40 99%

2030/2204

ENDOTRACHEAL: SIZE 8.0 BLADE MAC 3 ORO X NASO CUFF ↑ MOP PACK

REMARKS: 24 cm @ LIP ④ BBS=, ⊕ E, CO_2 KG EYES INTO, ORAL ATRIUM

OPERATION PERFORMED: D&I BILAT LE EX-FIX

TOTAL FLUIDS: LR 1300; EBL - 100; UOP - NM

NAME(S) OF SURGEON(S): (b)(6)-2

(b)(6)-2 CRNA

Signature of Anesthetist

RECOVERY
- REFLEX IN O.R.
- EMESIS
- ASPIR.
- EXCITEMENT
- HYPOTENSION
- OTHERS

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; Grade; date; hospital or medical facility)

IRAQI (b)(6)-4

REGISTER NO.

WARD NO.

DATE: 26 JUL 03

ANESTHESIA

Standard Form 517
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.506
OCTOBER 1975

517-111

MEDCOM - 1499

IRAQ I (b)(6)-4

PREANESTHETIC SUMMARY

OPERATION PROPOSED	AGE	WEIGHT (LBS.)	SPECIAL INFORMATION
D&I RIGHT LE, HAND EX-FIX	22	60 Kg	

PHYSICAL STATUS: 1 (2) 3 4 5 6 7 E

URINALYSIS
NORMAL .....
ABNORMAL AND WHY?

HEMATOLOGY
HGB ..... RBC ..... HCT .....
OTHER
137 / 3.0 / 106 / 10 / 91 / 10 / 69 / 8.7 / 267 / 452

BLOOD CHEMISTRY

RESPIRATORY SYSTEM	CIRCULATORY SYSTEM	CENTRAL NERVOUS SYSTEM	OTHER SYSTEMS
(X-RAY, ASTHMA, OTHER PATHOLOGY) 0 + tobacco	BP ..... PULSE ..... ECG (IF PERTINENT)	(CEREBROVASCULAR, POLIO, NEUROLOGICAL) ? (L) EAR HEARING LOSS - ACCIDENT	(ALLERGIES) NKDA

PREVIOUS ANESTHETICS AND COMPLICATIONS
0

PRESENT DRUG THERAPY; E.G., STEROIDS, TRANQUILIZERS
0

PREOPERATIVE DIAGNOSIS

PREMEDICATION

SIGNATURE OF EVALUATING PHYSICIAN (b)(6)-2 CAWA **DATE** 26 JUL 03

POSTANESTHETIC VISITS

RECORD ALL PERTINENT COMPLICATIONS

*U.S. Government Printing Office: 1994 — 300-892/10029

MEDCOM - 1500

Standard Form 517

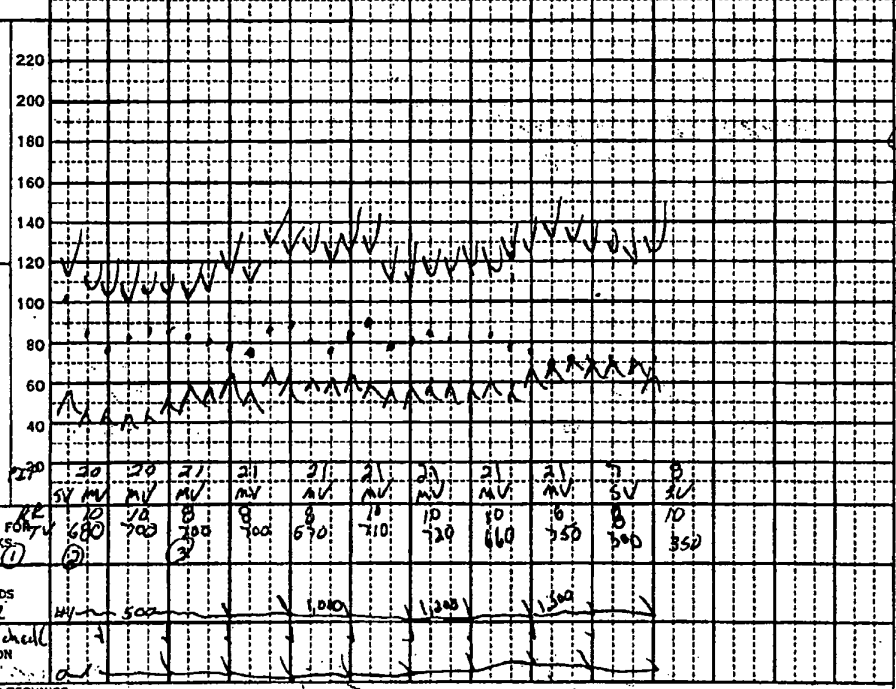
CLINICAL RECORD — ANESTHESIA

0900 x 30 x 1000 x 30 x 1100 x 30 x 1200

ANESTHETIC(S)	HOUR									
Fentanyl	250					50	50	25		
Propofol mg	120							40		
Succ mg	100									
MSO4 mg			4	4	2	2	2	2	2	2
Iso	1.5	1.5	1.5	2.0	1.0	1.5	1.0	1.0	2.0	0.80
FiO2	1.0	.47	.47	.46	.46	.57	.48	.49		.49
O2 sat OXYGEN	100	100	100	100	100	100	100	100	100	98
ETCO2 CO2 ABSORP.	40	36	33	36	36	36	31	32	36	38
LEVEL OF ANAL-ANES.										

CODE: ● PULSE; ○ RESP.; V/Λ B. P.; X ANES.; ◎ OPER.; T TOURN.

FLUIDS: B BLOOD; N SALINE; G 5% G/W; DX EXPAND.



PIT	20 SV MV	20 MV	21 MV	21 MV	21 MV	21 MV	21 MV	21 MV	21 MV	7 SV	8 SV
RR	10	10	8	8	8	10	10	10	6	8	10
TV	680	700	700	700	670	710	720	660	750	300	350
NUMBERS FOR REMARKS	①	②	③								
IV FLUIDS LR	44	500			1,000		1,200		1,500		
Pressure point check POSITION											

AGENTS AND TECHNICS: GETA

INDUCTION: 375 mg; 180; 100 mg; 20 mg; SATIS yes; UNSATIS AND WHY

REMARKS:
① Pt identified, Chart reviewed, all pt questions answered
② Pt to OR, ASA monitor, O2 applied. Pt induced, intubated & diff.
③ Pt tolerated procedure start well.
④ Pt RR 8, TV 300 pt suctioned, then extubated
⑤ Pt to RR. Report given to ICT (b)(6)-2 V/S, O2 sat 99%, P-114, 132/68, 24 T-953 Pt given 50 mg Fentanyl

ENDOTRACHEAL: SIZE 8.0 BLADE MAC 3 ORO ..... NASO ..... CUFF 8 PACK .....

REMARKS: DLX2 MAC 3 (grade 1 view) ETT placed/secured @ 22 cm teeth ⊕ BBS

OPERATION PERFORMED	TOTAL FLUIDS	NAME(S) OF SURGEON(S)
Washout I raqi (b)(6)-4	LR - 1,800	(b)(6)-2
		(b)(6)-2 CPT, CRNA
		Signature of Anesthetist.

RECOVERY: REFLEX IN O.R. ⊕; EMESIS ⊖; ASPIR. ⊖; EXCITEMENT ⊖; HYPOTENSION ⊖; OTHERS .....

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)

REGISTER NO. | WARD NO. | DATE 28 July 03

ANESTHESIA

Standard Form 517
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-46.505
OCTOBER 1975

517-111

MEDCOM - 1501

PREANESTHETIC SUMMARY

OPERATION PROPOSED	AGE	WEIGHT (LBS.)	SPECIAL INFORMATION
Wash out	22	60	MRI, teeth O loose, Neck - FLOM DL & diff on 26 July 03

PHYSICAL STATUS: 1 2 3 4 5 6 7

URINALYSIS	HEMATOLOGY	BLOOD CHEMISTRY
NORMAL ..... ABNORMAL AND WHY? Ø	HGB ..... RBC ..... HCT ..... OTHER 8.7/26.7 — min blood loss expected for procedure	Ø

RESPIRATORY SYSTEM (X-RAY, ASTHMA, OTHER PATHOLOGY)	CIRCULATORY SYSTEM BP ..... PULSE ..... ECG (IF PERTINENT)	CENTRAL NERVOUS SYSTEM (CEREBROVASCULAR, POLIO, NEUROLOGICAL)	OTHER SYSTEMS (ALLERGIES)
(+) tobacco	Ø	Ø	NKOA

PREVIOUS ANESTHETICS AND COMPLICATIONS	PRESENT DRUG THERAPY; E.G., STEROIDS, TRANQUILIZERS
Ø	Ø

PREOPERATIVE DIAGNOSIS	PREMEDICATION

SIGNATURE OF EVALUATING PHYSICIAN	DATE
(b)(6)-2 LPT, CRNA	28 July 03

POSTANESTHETIC VISITS

RECORD ALL PERTINENT COMPLICATIONS

*U.S. Government Printing Office: 1994 — 300-892/10029

MEDCOM - 1502

Standard Form 517

CLINICAL RECORD — ANESTHESIA

0900 — 45

ANESTHETIC(S)	15	30	45	1000	15	30	HOUR	1100	15	30	45	1200
Fentanyl (µg)	<250>	50/50	50/50	100	100/50	200	160	50	100	50/50	50	100
propofol (µg)	200											
Succ (µg)	100											
Vec (µg)	1											
Iso (%)		2.0	2.5	1.5	1.0	1.5	1.5	1.5	1.0	.4	X	
(L/min) OXYGEN	6	1	1	1	1	1	1	1	1	1.5	8	8
ET CO2 ABSORP.	4	38	55	55	45	48	52	51	51	50	47	47
SaO2 %	100	100	100	100	100	100	100	100	100	100	100	100
LEVEL OF ANAL-ANES.												
ECG	ST	ST	ST	ST	ST	ST	ST	ST	ST	ST	ST	ST

CODE
● PULSE
○ RESP.
V B. P.
X ANES.
◎ OPER.
T TOURN.

220 200 180 160 140 120 100 80 60 40 20

FLUIDS
B BLOOD
N SALINE
G 5% G/W
DX EXPAND.

TV →	620	230	390	480	380	470	500	580	650	470
RR →	7	11	11	14	8	7	9	9	7	9
PIP →	18	—	—	—	—	—	—	—	—	—

NUMBERS FOR REMARKS

IV FLUIDS
LR → 200 → → → 400 → → 700 → → 800 →

POSITION
Supine → → → → → →

AGENTS AND TECHNICS
EBL → → → 100 → → →

INDUCTION
SATIS ✓
UNSATIS AND WHY

REMARKS

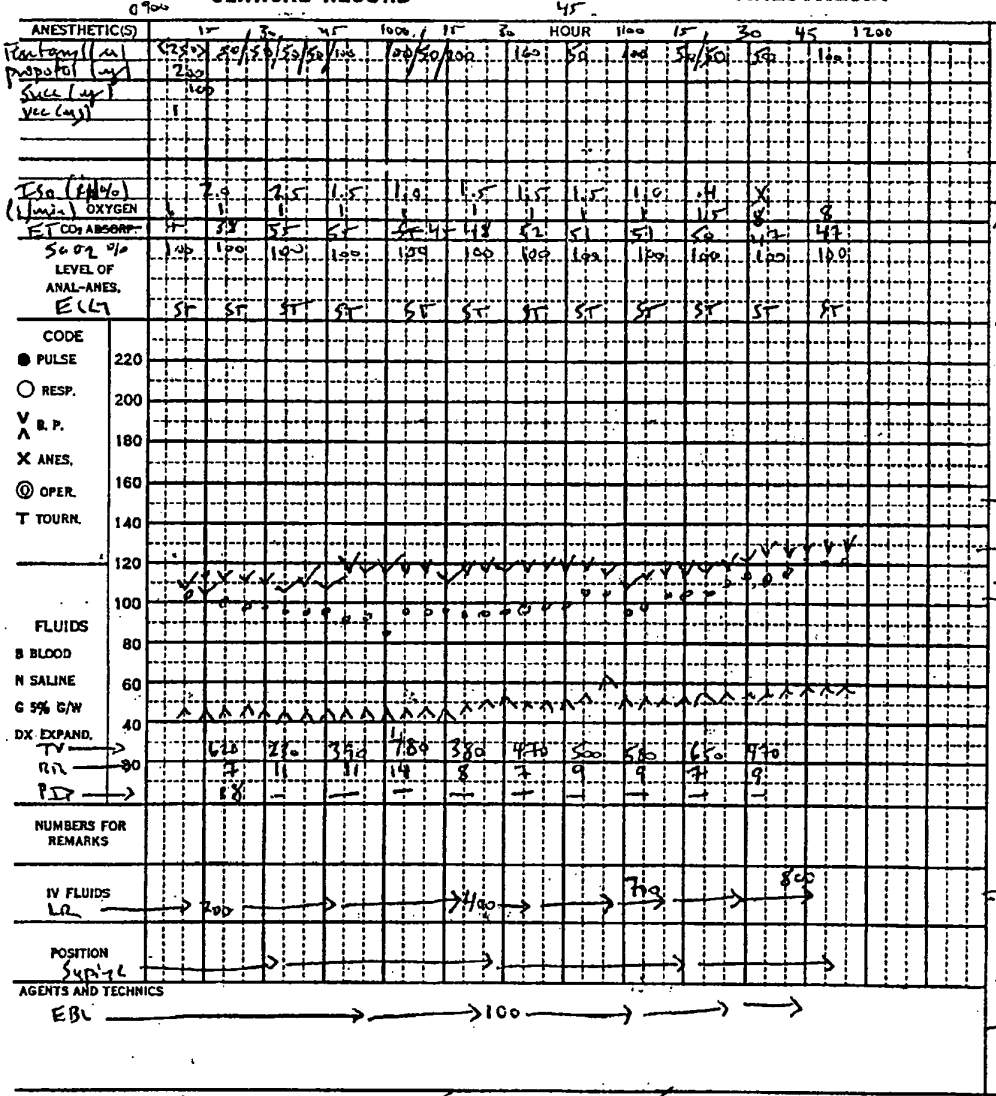
	Start	End
Anes	0905	1158
Surg	0931	1140

- pt. safely to OR, Ast monitors, pre-ox; smooth Iv induction → See below.

Ancef ÷ gm Iv 091

1016 - Ancef ÷ gm Iv

- case concluded; smooth emergence/extubation; patent airway; safe to Icu, report given



ENDOTRACHEAL: SIZE 8.0 BLADE Mill 2 ORO ✓ NASO ..... CUFF ✓ PACK .....

REMARKS: Smooth Iv induction, easy mask vent. easy DL ÷ Mill 2, grade I view. 8.0 ETT; ⊕ etco2, EBBS, sec. @ 22 cm, tec'th.

OPERATION PERFORMED
Washout, LLE, RUE; iliac crest graft to (L) foot and (R) hand.

TOTAL FLUIDS
exc - 800
uop - ∅
EBL - 100

NAME(S) OF SURGEON(S)
(b)(6)-2
(b)(6)-2 (b)(6)-2
Sig... MD ...esthetist.

RECOVERY
REFLEX IN O.R. .....
EMESIS .....
ASPIR. .....
EXCITEMENT .....
HYPOTENSION .....
OTHERS .....

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)
Iraqi (b)(6)-4

REGISTER NO. | WARD NO. | DATE 30 July 03

ANESTHESIA

Standard Form 517
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.608
OCTOBER 1975

517-111

PREANESTHETIC SUMMARY

OPERATION PROPOSED	AGE	WEIGHT (LBS.)	SPECIAL INFORMATION
Washout, iliac crest bone graft (R) hand, (L) foot	22	60 kg	Airway favorable (2 previous easy intubations)
	PHYSICAL STATUS: 1 (2) 3 4 5 6 7		

URINALYSIS
NORMAL .....
ABNORMAL AND WHY?

HEMATOLOGY
HGB ..... RBC ..... HCT .....
OTHER
~~H/H: 8.7~~
24 July: H/H: 8.7/26.7

BLOOD CHEMISTRY

RESPIRATORY SYSTEM (X-RAY, ASTHMA, OTHER PATHOLOGY)	CIRCULATORY SYSTEM BP 134/40 PULSE 67 ECG (IF PERTINENT)	CENTRAL NERVOUS SYSTEM (CEREBROVASCULAR, POLIO, NEUROLOGICAL)	OTHER SYSTEMS (ALLERGIES)
(+) tobacco use lungs CTA (B)	Sin 97-10 RA ϕ Hx Nl S1, S2, ϕ murmur heart	ϕ Hx	NKDA

PREVIOUS ANESTHETICS AND COMPLICATIONS	PRESENT DRUG THERAPY; E.G., STEROIDS, TRANQUILIZERS
1. Multiple fracture I & Ds, & pinning x 2	1. Morphine 4. Tylenol 2. Demerol 5. Ancef 1 gm q8° 3. phenergan 6. Gent 80 mg q8°

PREOPERATIVE DIAGNOSIS	PREMEDICATION
multiple fractures	(see opposite)

SIGNATURE OF EVALUATING PHYSICIAN (b)(6)-2 DATE 24 July 03

POSTANESTHE

RECORD ALL PERTINENT COMPLICATIONS

*U.S. Government Printing Office: 1994 — 300-892/10029

ACLU-RDI 1099 p.288

DOD 005556

22/60
ASA 2
NKDA

Standard Form 517

CLINICAL RECORD — ANESTHESIA

1100 X 30 X 1800 X 30 HOUR 1500

ANESTHETIC(S)
Fentanyl 150 125 — 25 — 10/10
Propofol 120 — 10/10
SUX 70
N2O4 2 2 2 2 2

150 Air/O2 — 1.2 1.2 1.2 / 1.1 1.1 1.1
SAO2 OXYGEN — 100 100 100 / 100 100 100
CO2 ABSORP. — 4.5 4.5 4.5
VENT LEVEL GAT ANAL-ANES AP — 5 5 5 / 600 600 1230 / 10 10

CODE
● PULSE
○ RESP.
V B. P.
X ANES.
Ⓞ OPER.
T TOURN.

220 200 180 160 140 120 100 80 60 40 20

11/58 88

FLUIDS
B BLOOD
N SALINE
G 5% G/W
DX EXPAND.

NUMBERS FOR REMARKS — Ⓐ Ⓑ Ⓒ

NS — 200 X
IV FLUIDS LR — 250 500 700
POSITION supine

INDUCTION
SATIS. yes
UNSATIS AND WHY

REMARKS
① pt seen & chart Reviewed. To OR. Moved to table. Monitors ON. INDUCED
② Sectioned
③ Sectioned
EXCUBATED. MASK O2 on Spont Resp.
④ To ICU / USS Spont Resp & c/o PAIN, Rapax Given.
124/70 98
97%

AGENTS AND TECHNICS BETA: PREOX. INDUCED. EXPOSED XT = MAC 3 GRADE I VIEW. INTUBATED W 8.0 ETT TO 22cm @ TEETH. BS = Ⓑ ETCO2 XU. ETT SECURED, EYES TAPED & ORAL AIRWAY IN.

ENDOTRACHEAL: SIZE 8.0 BLADE MAC 3 ORO X NASO ____ CUFF X PACK ____
REMARKS: BETA

OPERATION PERFORMED
Ⓐ THUMB WASHOUT
RLE WASHOUT

TOTAL FLUIDS
NS 200
LR 700

NAME(S) OF SURGEON(S)
(b)(6)-2
(b)(6)-2

CRT / CRNA
anesthetist.

RECOVERY
REFLEX IN O.R. ____
EMESIS ____
ASPIR. ____
EXCITEMENT ____
HYPOTENSION ____
OTHERS ____

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)
IRAQI #

REGISTER NO. | WARD NO. ICU | DATE 5 AUG 03

ANESTHESIA

Standard Form 517
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
517-111

ACLU-RDI 1099 p.289

DOD 005557

PREANESTHETIC SUMMARY

OPERATION PROPOSED	AGE	WEIGHT (LBS.)	SPECIAL INFORMATION
RVE WASHOUT	22	60	MPII FROM 3 FB'S TEETH INTACT SIP OF MILK
	PHYSICAL STATUS		
	1 (2) 3 4 5 6 7		

URINALYSIS	HEMATOLOGY	BLOOD CHEMISTRY
NORMAL ..... ABNORMAL AND WHY? Ø	HGB ..... RBC ..... HCT ..... OTHER	

RESPIRATORY SYSTEM	CIRCULATORY SYSTEM	CENTRAL NERVOUS SYSTEM	OTHER SYSTEMS
(X-RAY, ASTHMA, OTHER PATHOLOGY)	BP ..... PULSE ..... ECG (IF PERTINENT)	(CEREBROVASCULAR, POLIO, NEUROLOGICAL)	(ALLERGIES)
SMOKER	Ø	Ø	NKDA

PREVIOUS ANESTHETICS AND COMPLICATIONS	PRESENT DRUG THERAPY: E.G., STEROIDS, TRANQUILIZERS
	ANCEF + Gm @ 0700 MOTRIN 800mg po 0800 ZANTAC 150 po 1000

PREOPERATIVE DIAGNOSIS	PREMEDICATION
(R) THUMB infection	

(b)(6)-2

ING PHYSICIAN	DATE
- CPT CRNA	5 AUG 03

POSTANEST

RECORD ALL PERTINENT COMPLICATIONS

*U.S. Government Printing Office: 1994 — 300-892/10029

MEDCOM - 1506

PREANESTHETIC SUMMARY

OPERATION PROPOSED	AGE	WEIGHT (LBS.)	SPECIAL INFORMATION
(R) hand wash-out	22	60	NPO since 1830
	PHYSICAL STATUS		
	1 (2) 3 4 5 6 7		MPII, FROM, 3FB's, teeth intact

URINALYSIS	HEMATOLOGY	BLOOD CHEMISTRY
NORMAL ..... ABNORMAL AND WHY?	HGB ..... RBC ..... HCT ..... OTHER	
Ø	Ø	

RESPIRATORY SYSTEM	CIRCULATORY SYSTEM	CENTRAL NERVOUS SYSTEM	OTHER SYSTEMS
(X-RAY, ASTHMA, OTHER PATHOLOGY)	BP ..... PULSE ..... ECG (IF PERTINENT)	(CEREBROVASCULAR, POLIO, NEUROLOGICAL)	(ALLERGIES)
tobacco	Ø	Ø	NKDA

PREVIOUS ANESTHETICS AND COMPLICATIONS	PRESENT DRUG THERAPY; E.G., STEROIDS, TRANQUILIZERS
GA Multiple over last several days ↓ complication	Ancef, Clindamycin, Zantac

PREOPERATIVE DIAGNOSIS	PREMEDICATION
	Ø

SIGNATURE OF EVALUATING PHYSICIAN	DATE
(b)(6)-2 CPT, CRNA	9Aug03

POSTANESTHETIC VISITS

RECORD ALL PERTINENT COMPLICATIONS

I rmq (b)(6)-4

*U.S. Government Printing Office: 1994 — 300-892/10029

MEDCOM - 1507

MEDICAL RECORD - ANESTH

use of this form, see AR 40-66; the proponent ... is the ...OG

ANESTHETIC AGENTS AND DRUGS

CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML, "I" = CONSTANT INFUSION

DRUG	(Units)	1500	30	1600	30	1700	30	1800
Fentanyl	(ug)	250						
Propofol	(mg)	150	50					
Succ	(mg)	100						
MgSO4	(mg)			3	2	1	2	2
	( )							
	( )							
VOLAT AGENT: Iso	% del	2.0	1.5	1.2	1.0	.8	.6	
	% e.t.							
AIR	L/Min			1	1	1	X	
N2O	L/Min							
O2	L/Min	8	2	2	1	1	2	

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS →

TOTALS	TOTAL EBL
250ug	min
200mg	
100mg	TOTAL URINE
20mg	0

FLUIDS - SUMMARY

CRYSTALLOID- 1,100

COLLOID- 0

BLOOD- 0

FLUIDS

LINE site		1500	30	1600	30	1700	30	1800	
LL	☐ Warmed		500			600			1,100
	☐ Warmed								
	☐ Warmed								
	☐ Warmed								

LOSSES									
EST BLOOD LOSS		—	—	—	—	—	—	—	min
URINE -		—	—	—	—	—	—	—	0

REMARKS

Code drugs with numbers, events with letters

1445-PA: identified, chart reviewed, all pt questions answered. 1500. Pt to OR. ASA monitors/O2 applied. Pt induced & intubated, difficult. 1520 Pt tolerated procedure/start well.

Pt sv. TV pt sectioned, extub

P+ to CR. Report given to CAT

VS: 123/67, 103 Osat 93%

PHYS STATUS	TIME →	1500	30	1600	30	1700	30	1800
1 2 3 4 5 E	SYMBOLS :							
BODY WEIGHT: 60 KG LB	BP by cuff V							
HEMATOCRIT:	Heart rate ^							
INITIAL DATA:	Resp rate ●							
BP- 106/60	BR (transduced)							
HR- 96	TOURNIQUET							
EQUIP CHECK	T-T							
OK?- Y N	ANES- X-X							
PATIENT	PROC- ⊕-⊖							
OK for PROCEDURE? YES	220							
TIME- 1445	200							
	180							
	160							
	140							
	120							
	100							
	80							
	60							
	40							
	20							

VENTIL

VT - ml	710	720	710	740	760	
f - breaths/min	10	8	8	8	6	27
Peak inf pres / ~~PEEP~~	24	20	20	20	20	12
MODE - S(pon), A(ssist), C(on)	C	C	C	C	C	S

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	36	37	31	33	37	45
BP/oth	FIO2 (Frac or %)	1.0	1.0	1.0	.34	.33	1.0
ART line	SpO2 (%)	100	98	99	99	99	99
Steth- PC/ES	ECG	NSR	ST	ST	NSR	NSR	NSR	NSR
Gas analyzer	TEMP-site							
	N-M Block (T/4)			4/4	ST			
Warming blkt	Warm blanket on pt		✓	✓	✓	✓	✓	
Conv warmer								

Mark with letters & symbols, explain under REMARKS — EVENTS Position → O/

RECOVERY AT

PACU (CU) (Specify)

OTHER

CONDITION: stable

RESP- 20 SpO2- 93 RA

BP- 123/67 HR- 104

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1445	1500	1630
PROC	Ready	Begin	End
	1505	1520	1625

PROCEDURES and CPT Codes:

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

GETA

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*

Iraqi (b)(6)-4

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*

DL x1 Miller 2, grade 1 view, 8.0 ETT placed, secured (22) @ lips

SURGEONS: (b)(6)-2

ANES: (b)(6)-2 STS: V CAT II

PROCEDURE:

DATE: 9 Aug 03

PAGE 1 OF 1

DA FORM 7389, FEB 1998 — MEDCOM - 1508 — Y 1 - PATIENT'S MEDICAL RECORD — USAPA V1.00

MEDICAL RECORD - ANESTH

NKDA. ASAII Sx ... of this form, see AR 40-66; the proponent a ... TSG NPO since 0800.

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML. "I" = CONSTANT INFUSION

DRUG (Units)				
VERSED (mg)	2			
FENTANYL (ug)	150	60	50	
PROPOFOL (mg)	160		20	
SCH (mg)	80			
( )				
( )				

VOLAT AGENT: Forane % del 2.5/1.5 I X; % e.t.

AIR L/Min

N2O L/Min

O2 L/Min 4 — 1 → 2/4

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS

FLUIDS — LINE site 18G (L) ☐ Warmed ☐ Warmed ☐ Warmed ☐ Warmed — LL

LOSSES — EST BLOOD LOSS — URINE -

PHYS STATUS 1 2 3 4 5 E

BODY WEIGHT: 60 KG LB

HEMATOCRIT: N/A

INITIAL DATA:

BP- 117/61

HR- 100.

EQUIP CHECK OK?- (Y) N

PATIENT

OK for PROCEDURE? Y

TIME- 1442

TIME 1430 15. 30 16

SYMBOLS

- BP by cuff: V ^
- Heart rate: ●
- Resp rate
- BR (transduced)
- TOURNIQUET: T—T
- ANES- X-X
- PROC-⊙-Ø

220 200 180 160 140 120 100 80 60 40 20

VENTIL

VT - ml	700
f - breaths/min	12 16
Peak inf pres / PEEP	
MODE - S(pon), A(ssist), C(on)	SV CVCV SV SV

MONITORS/ACCESSORIES

☑ BP/Auto Cuff	ET CO2 (torr)	(+) 30
BP/oth	FIO2 (Frac or %)	T-08 3 0.89 0.60
ART line	SpO2 (%)	100 100 100 100
Steth- PC/ES	EGG	SR SR SR SR
Gas analyzer	TEMP-site	
	N-M Block (T/4)	
Warming blkt		
Conv warmer		

Mark with letters & symbols, explain under REMARKS — EVENTS Position → Ø →

TOTALS — TOTAL EBL: MIN — TOTAL URINE: Ø

FLUIDS - SUMMARY

CRYSTALLOID- 600

COLLOID- 0

BLOOD-

REMARKS *Code drugs with numbers, events with letters*

1B 30 SVR. Sustained Ø Purposeful Movement Extubated. 1540 TO PACU 5U

RECOVERY AT

PACU ICU Ø#1 (Specify)

OTHER SURA

CONDITION

RESP- 20 SpO2- 98.

BP- 137/71 HR- 90

ANESTHESIA/PROCEDURE TIMES

	Start	Room	End
ANES	1430	1440	
PROC	Ready	Begin	End
	1446	1456	1535

PROCEDURES and CPT Codes: IAD @ MAND

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility* IRAQI # (b)(6)-4

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* GETA OETT Forane/O2.

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* Nxt MIL 2 Grade 1 8.0 ETT @ ETCO2 @ BBS

SURGEON (b)(6)-2

AN (b)(6)-2 (b)(6)-2 MASCAL

PROCEDURE

DATE 8/12/03

PAGE / OF /

DA FORM 7389, FEB 1998 — MEDCOM - 1509 — PATIENT'S MEDICAL RECORD — USAPA V1.00

22 /

ANCEF TGM
IV @ 0930

MEDICAL RECORD - ANESTH

use of this form, see AR 40-66; the proponent is the OTSG

ASA-2
NKDA

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML, "I" = CONSTANT INFUSION

DRUG	(Units)					
Versed	(MG)	2				
Fentanyl	(MCG)	150	100			
Propofol	(MG)	120				
Sux	(MG)	80				
MSO4	(MG)	2	2	2	2	2
	( )					
VOLAT AGENT 180	% del	1.2	1.2	1.0	X	
	% e.t.					
AIR	L/Min		1	1	1	X
~~N2O~~	L/Min					
O2	L/Min	10	1	1	1	10

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS

FLUIDS — LINE site @ WRIST ☐ Warmed ☐ Warmed ☐ Warmed ☐ Warmed

	300	400	500	700	

LOSSES — EST BLOOD LOSS / URINE -

TOTALS 2/3 250/0 — **TOTAL EBL** MIN — **TOTAL URINE** 10/0 Ø

FLUIDS - SUMMARY
CRYSTALLOID- LR 700
COLLOID- Ø
BLOOD- Ø

REMARKS
Code drugs with numbers, events with letters
① Pt seen. Chart ✓'d. To OR. Moved to table. Induced.
② ancef TGM
③ Suction extubated. VSS. Spont Resp
④ To ICU VSS. Spont Resp. Ø c/o PAIN. Report Given

PHYS STATUS 1 2 3 4 5 E

BODY WEIGHT: 67 KG LB

HEMATOCRIT:

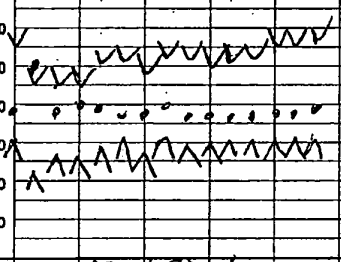
INITIAL DATA:
BP- 111 / 62
HR- 78

EQUIP CHECK
OK?- Y N

PATIENT
OK for PROCEDURE? Y
TIME- 0900

TIME → x 0930 x 1000 x 30 x 1100 x 30 x 1200

SYMBOLS: BP by cuff (L) Heart rate ● Resp rate; BR (transduced); TOURNIQUET T—T; ANES- X-X; PROC- ⊙-Ø



VENTIL

VT - ml	—	800	600	610	
f - breaths/min	16	8	8	8	
Peak inf pres / PEEP	—	19	19	20	
MODE - S(pon), A(ssist), C(on)	S A	C	C	C	S

MONITORS/ACCESSORIES

X BP/Auto Cuff	X ET CO2 (torr)	—	32	33	30	48
BP/oth	X FIO2 (Frac or %)	100	.74	.60	.55	1.0
ART line	X SpO2 (%)	100	100	99	100	100
Steth- PC/ES	X ECG	SR	SR	SR	SR	SR
Gas analyzer	TEMP-site AVAILABLE	—	—	—	—	
	N-M Block (T/4)	0/4		4/4	→	
Warming blkt						
Conv warmer		①	②		③	④

Mark with letters & symbols, explain under REMARKS — EVENTS Position → Pressure points checked & padded

RECOVERY AT 1035
PACU ICU (Specify)
OTHER T= 94.3
CONDITION: STABLE
RESP- 15 SpO2- 99%
BP- 101/65 HR- 74

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0900	0910	1045
	Ready	Begin	End
PROC	0920	0930	1020

PROCEDURES and CPT Codes: SKIN GRAFT X2

PATIENT IDENTIFICATION: Typed or written entries: Name, Grade/Rate, Medical facility

IRAQI (b)(6)-4

ANESTHETIC TECHNIQUES: Describe block technique under Remarks GETA: PREOX INDUCED. EXPOSED X1 2 MAC 3. GRADE 1 view INTUBATED C 8.0 ETT to 22cm @ teeth. BS = ③ ETCO2 X4 TUBE SECURED & EYES TAPED.

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
BITE BLOCK IN

SURGEONS: (b)(6)-2 (b)(6)-2

ANESTHETISTS: (b)(6)-2 CPT CFNA

PROCEDURE

DATE: 18 Aug 03

PAGE 1 OF 1

DA FORM 7389, FEB 1998 — MEDCOM - 1510 — COPY 1 - PATIENT'S MEDICAL RECORD — USAPA V1.00

A-165-7294 519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

EXAMINATION(S) REQUESTED: B/L T1 6 - Sib; B/L Seet (L) knee (R) SHOULDER (R) HANDS

AGE | SEX | SSN (Sponsor): (b)(6)-4 | WARD/CLINIC | REGISTER NO.

FILM NO.

PREGNANT: ☐ YES ☒ NO

REQUESTED BY (Print): (b)(6)-2 | TELEPHONE/PAGE NO.

SIGNATURE OF REQUESTOR: SGT (b)(6)-2 | DATE REQUESTED: 26 JUL 03

SPECIFIC REASON(S) FOR REQUEST *(Complaints and findings)*: GSW

DATE OF EXAMINATION *(Month, day, year)*	DATE OF REPORT *(Month, day, year)*	DATE OF TRANSCRIPTION *(Month, day, year)*

RADIOLOGIC REPORT

linear non displaced fx posterior (L) TIB/FIB

√ (L) TIB/FIB ⊕ fx's multiple 1-4mm metallic pieces c schrapnel ant & post soft tissues of leg & knee

√ (R) TIB/FIB ⊕ spiral fx distal shaft / 2-5mm schrapnel in ant & post soft tissues lower leg & post (R) knee

(R) Hand severely shattered 1st MC & 1st prx phalanx c schrapnel in thumb, volar distal forearm soft tissues and in 3rd - 5th digits

√ (R) foot ⊕ fx (R) talus c chip fragments in dorsal soft tissues, metalic schrapnel in heel (plantar soft tissue & anterolat soft tissue)

√ (L) foot shattered 2nd MT c numerous 2-4 mm schrapnel throughout L foot

R shoulder ⊖ fx

(L) Knee ⊕ A/F level in joint c/w open wound / multiple small 1-4mm schrapnel fragments in & around knee joint

(b)(6)-2 MD

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name — last, first, middle, Medical Facility)*: (b)(6)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTAT. IT

MEDCOM - 1511

STANDARD FORM 519-B (8-83)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.806-8

NSN 7540-01-165-7294 519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

EXAMINATION(S) REQUESTED	AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
(R) Tib/Fib AP/lateral (L) foot AP/lateral (R) hand series				ICU 1	
	FILM NO.				PREGNANT ☐ YES ☐ NO
	REQUESTED BY (Print) (b)(6)-2				TELEPHONE/PAGE NO.
	SIGNATURE OF REQUESTER (b)(6)-2				DATE REQUESTED 7/27/03

SPECIFIC REASON(S) FOR REQUEST *(Complaints and findings)*

S/p Ex-Fix Tibia
+ pinning (L) foot
+ (R) thumb

DATE OF EXAMINATION *(Month, day, year)*	DATE OF REPORT *(Month, day, year)*	DATE OF TRANSCRIPTION *(Month, day, year)*

RADIOLOGIC REPORT

(R) TIB/FIB S/P ex/fix placement
TIB spiral fx in anatomic alignment

S/P K-wire placement through comminuted/K
2nd (L) MT - major fracture
fragments are aligned
subcapital - again noted

(R) hand S/P surgical resection distal aspect 1st
MC K wire passes through & 1st long
prox phalangeal fx is aligned

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name — last, first, middle, Medical Facility)*	LOCATION OF MEDICAL RECORDS
Iraqi (b)(6)-4	LOCATION OF RADIOLOGIC FACILITY
	SIGNATURE

MEDCOM - 1512

RADIOLOGIC CONSULTATION STANDARD FORM 519-B (8-83)

NSN 7540-01-165-7294 519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

EXAMINATION(S) REQUESTED	AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
(R) Tibia AP // lateral					
	FILM NO.				PREGNANT ☐ YES ☐ NO
	REQUES (b)(6)-2				TELEPHONE/PAGE NO.
	SIGNATURE OF REQUESTOR (b)(6)-2				DATE REQUESTED 28 July 03

SPECIFIC REASON(S) FOR REQUEST *(Complaints and findings)*

S/p Adjust ex Fx

DATE OF EXAMINATION *(Month, day, year)*	DATE OF REPORT *(Month, day, year)*	DATE OF TRANSCRIPTION *(Month, day, year)*
28 July 03		

RADIOLOGIC REPORT

— S/p placement of ex/fx on right TIBIA spiral fx. alignment's near anatomic

— Schrapnel again noted.

(b)(6)-2

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name — last, first, middle, Medical Facility)*

Iraqi (b)(6)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

MEDCOM - 1513

RADIOLOGIC CONSULTATION STANDARD FORM 519-B (8-83)

MEDICAL RECORD	REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

A. IDENTIFICATION

1. OPERATION OR PROCEDURE I & D Leg wounds & (R) arm/hand wounds Pinning (R) Thumb / Ex-Fix (R) Tibia / washout (L) knee

B. STATEMENT OF REQUEST

1. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be _____ (Description of operation or procedure in layman's language)

washout wounds
Pinning (R) Thumb washout (L) knee
Ex-Fix (R) Tibia

which is to be performed by or under the direction of Dr. (b)(6)-2

2. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the below-named medical facility, during the course of the above-named operation or procedure.

3. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the below-named medical facility.

4. Exceptions to surgery or anesthesia, if any, are: None (If "none", so state)

5. I request the disposal by authorities of the below-named medical facility of any tissues or parts which it may be necessary to remove.

6. I understand that photographs and movies may be taken of this operation, and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and observation of the operation by authorized personnel, subject to the following conditions:

a. The name of the patient and his/her family is not used to identify said pictures.
b. Said pictures be used only for purposes of medical/dental study or research.

(Cross out any parts above which are not appropriate)

C. SIGNATURES (Appropriate items in Parts A and B must be completed before signing)

1. COUNSELING PHYSICIAN/DENTIST: I have counseled this patient as to the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above.

(b)(6)-2
(Signature of Counseling Physician/Dentist)

2. PATIENT: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(Signature of Witness, excluding members of operating team)	(Signature of Patient)	26 JUL 03 2040 (Date and Time)

3. SPONSOR OR GUARDIAN: (When patient is a minor or unable to give consent) I, _____ sponsor/guardian of _____ understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(Signature of Witness, excluding members of operating team)	(Signature of Sponsor/Legal Guardian)	(Date and Time)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)	REGISTER NO.	WARD NO.
Fragi (b)(6)-4		

STANDARD FORM 522 (Rev. 10-76)
General Services Administration &
Interagency Comm. on Medical Records
FIRMR (41 CFR) 201-45.505
522-110

*U.S. Government Printing Office: 1991 — 312-071/40193

MEDCOM - 1514

NSN 7540-00-634-4165

MEDICAL RECORD	REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

A. IDENTIFICATION

1. OPERATION OR PROCEDURE I&D Ⓡhand, Ⓛ&Ⓡlegs adjust ex-fix, repair Tendons

B. STATEMENT OF REQUEST

1. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be

(Description of operation or procedure in layman's language)

I&D Ⓡhand, Ⓛ&Ⓡ legs

Adjust ex-fix, repair Tendons

which is to be performed by or under the direction of Dr. (b)(6)-2

2. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the below-named medical facility, during the course of the above-named operation or procedure.

3. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the below-named medical facility.

4. Exceptions to surgery or anesthesia, if any, are: None

(If "none", so state)

5. I request the disposal by authorities of the below-named medical facility of any tissues or parts which it may be necessary to remove.

6. I understand that photographs and movies may be taken of this operation, and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and observation of the operation by authorized personnel, subject to the following conditions:

a. The name of the patient and his/her family is not used to identify said pictures.

b. Said pictures be used only for purposes of medical/dental study or research.

(Cross out any parts above which are not appropriate)

C. SIGNATURES *(Appropriate items in Parts A and B must be completed before signing)*

1. COUNSELING PHYSICIAN/DENTIST: I have counseled this patient as to the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above.

(b)(6)-2 MD

(Physician/Dentist)

2. PATIENT: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(b)(6)-2 (b)(6)-2 7/28/03

(Signature of operating team) *(Signature of Patient)* *(Date and Time)*

3. SPONSOR OR GUARDIAN: (When patient is a minor or unable to give consent) I, _____ sponsor/guardian of _____ understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(Signature of Witness, excluding members of operating team) *(Signature of Sponsor/Legal Guardian)* *(Date and Time)*

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; rank; rate; hospital or medical facility)*	REGISTER NO.	WARD NO.
Fraga (b)(6)-4		

REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

Medical Record

STANDARD FORM 522 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)

USAPPC V2.00

MEDCOM - 1515

MEDICAL RECORD	REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

A. IDENTIFICATION

1. OPERATION OR PROCEDURE I&D ORBLE, RLE RIGHT, CICU Map ....

B. STATEMENT OF REQUEST

1. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be _____ (Description of operation or procedure in layman's language)
washout ORBLE, RLE
Done Gastr to Right Thumb - Effort
Skin Flap RT Thumb

which is to be performed by or under the direction of Dr. (b)(6)-2

2. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the below-named medical facility, during the course of the above-named operation or procedure.

3. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the below-named medical facility.

4. Exceptions to surgery or anesthesia, if any, are: none (If "none", so state)

5. I request the disposal by authorities of the below-named medical facility of any tissues or parts which it may be necessary to remove.

6. I understand that photographs and movies may be taken of this operation, and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and observation of the operation by authorized personnel, subject to the following conditions:

a. The name of the patient and his/her family is not used to identify said pictures.
b. Said pictures be used only for purposes of medical/dental study or research.

(Cross out any parts above which are not appropriate)

C. SIGNATURES (Appropriate items in Parts A and B must be completed before signing)

1. COUNSELING PHYSICIAN/DENTIST: I have counseled this patient as to the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above.

(b)(6)-2
(Dentist)

2. PATIENT: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(b)(6)-2
(Signature of Patient or Person Authorized to Consent for Patient) (Witness, excluding members of operating team)

(b)(6)-2

30 Jul 03 8:30
(Date and Time)

3. SPONSOR OR GUARDIAN: (When patient is a minor or unable to give consent) I, _____ sponsor/guardian of _____ understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(Signature of Witness, excluding members of operating team) (Signature of Sponsor/Legal Guardian) (Date and Time)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)

IRAQ, (b)(6)-4

REGISTER NO. | WARD NO.

STANDARD FORM 522 (Rev. 10-76)
General Services Administration &
Interagency Comm. on Medical Records
FIRMR (41 CFR) 201-45.505
522-111

MEDCOM - 1516

*U.S. Government Printing Office: 1991 — 312-071/40193

NSN 7540-00-634-4165

MEDICAL RECORD	REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

A. IDENTIFICATION

1. OPERATION OR PROCEDURE I&D @ hand, @ foot, @ calf.

B. STATEMENT OF REQUEST

1. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be

(Description of operation or procedure in layman's language)

wash out @ hand, @ foot, @ calf

which is to be performed by or under the direction of Dr. (b)(6)-2

2. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the below-named medical facility, during the course of the above-named operation or procedure.

3. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the below-named medical facility.

4. Exceptions to surgery or anesthesia, if any, are: None

(If "none", so state)

5. I request the disposal by authorities of the below-named medical facility of any tissues or parts which it may be necessary to remove.

6. I understand that photographs and movies may be taken of this operation, and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and observation of the operation by authorized personnel, subject to the following conditions:

a. The name of the patient and his/her family is not used to identify said pictures.

b. Said pictures be used only for purposes of medical/dental study or research.

(Cross out any parts above which are not appropriate)

C. SIGNATURES *(Appropriate items in Parts A and B must be completed before signing)*

1. COUNSELING PHYSICIAN/DENTIST: I have counseled this patient as to the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above.

(b)(6)-2

(Signature of Counseling Physician/Dentist)

2. PATIENT: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(b)(6)-2 CPT (AN

(Signature of operating team)

(b)(6)-2

(Signature of Patient)

8/9/07

(Date and Time)

3. SPONSOR OR GUARDIAN: (When patient is a minor or unable to give consent) I, _____ sponsor/guardian of _____ understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(Signature of Witness, excluding members of operating team) | *(Signature of Sponsor/Legal Guardian)* | *(Date and Time)*

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; rank; rate; hospital or medical facility)*

(b)(6)-4

Iraq

REGISTER NO.

WARD NO.

REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

Medical Record

STANDARD FORM 522 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)

USAPPC V2.00

MEDCOM - 1517

ACLU-RDI 1099 p.301

DOD 005569

MEDICAL RECORD	REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDUR

A. IDENTIFICATION

1. OPERATION OR PROCEDURE F&D @ Thumb, cement/antibiotic spacer

B. STATEMENT OF REQUEST

1. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be _____
(Description of operation or procedure in layman's language)

cashout @ Thumb, cement/antibiotic spacer

which is to be performed by or under the direction of Dr. (b)(6)-2

2. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the below-named medical facility, during the course of the above named operation or procedure.

3. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the below-named medical facility.

4. Exceptions to surgery or anesthesia, if any, are: NONE
(If "none", so state)

5. I request the disposal by authorities of the below-named medical facility of any tissues or parts which it may be necessary to remove

6. I understand that photographs and movies may be taken of this operation, and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and observation of the operation by authorized personnel, subject to the following conditions:

a. The name of the patient and his/her family is not used to identify said pictures.
b. Said pictures be used only for purposes of medical/dental study or research.

(Cross out any parts above which are not appropriate)

C. SIGNATURES (Appropriate items in Parts A and B must be completed before signing)

1. COUNSELING PHYSICIAN/DENTIST: I have counseled this patient as to the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above.

(b)(6)-2 MD
(Signature of Counseling Physician/Dentist)

2. PATIENT: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above and hereby request such procedure(s) be performed.

(b)(6)-2 (b)(6)-2 8/12/03
(Signature of operating team) (Date and Time)

3. SPONSOR OR GUARDIAN: (When patient is a minor or unable to give consent) I, _____ sponsor/guardian of _____ understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(Signature of Witness, excluding members of operating team) (Signature of Sponsor/Legal Guardian) (Date and Time)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle name; date; hospital or medical facility)

Iraqi (b)(6)-4

REGISTER NO. WARD NO.

STANDARD FORM 522 (Rev. 10-78)
General Services Administration &
Interagency Comm. on Medical Records
FIRMR (41 CFR) 201-45.505
522-11

MEDCOM - 1518

*U.S. Government Printing Office: 1991 — 312-071/4019

ACLU-RDI 1099 p.302

DOD 005570

MEDICAL RECORD	REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

A. IDENTIFICATION

1. OPERATION OR PROCEDURE Partial thickness vs Full thickness skin graft to (R) hand & (R) Calf

B. STATEMENT OF REQUEST

1. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be _____ *(Description of operation or procedure in layman's language)*

Partial thickness vs Full thickness skin graft to (R) hand & (R) Calf

which is to be performed by or under the direction of Dr. (b)(6)-2

2. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the below-named medical facility, during the course of the above-named operation or procedure.

3. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the below-named medical facility.

4. Exceptions to surgery or anesthesia, if any, are: None *(If "none", so state)*

5. I request the disposal by authorities of the below-named medical facility of any tissues or parts which it may be necessary to remove.

6. I understand that photographs and movies may be taken of this operation, and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and observation of the operation by authorized personnel, subject to the following conditions:

a. The name of the patient and his/her family is not used to identify said pictures.

b. Said pictures be used only for purposes of medical/dental study or research.

(Cross out any parts above which are not appropriate)

C. SIGNATURES *(Appropriate items in Parts A and B must be completed before signing)*

1. COUNSELING PHYSICIAN/DENTIST: I have counseled this patient as to the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above.

(b)(6)-2

2. PATIENT: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(b)(6)-2 (Signature of Witness, excluding members of operating team)

(b)(6)-2 (Signature of Patient)

8/18/03 (Date and Time)

3. SPONSOR OR GUARDIAN: (When patient is a minor or unable to give consent) I, _____ sponsor/guardian of _____ understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(Signature of Witness, excluding members of operating team) (Signature of Sponsor/Legal Guardian) (Date and Time)

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle, grade; date; hospital or medical facility)*

Fragi (b)(6)-4

REGISTER NO. WARD NO.

STANDARD FORM 522 (Rev. 10-75)
General Services Administration &
Interagency Comm. on Medical Records
FIRMR (41 CFR) 2[illegible] 45.505
522-110

MEDCOM - 1519

*U.S. Government Printing Office: 1991 — 312-071/40193

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

(b)(6)-4

IRAQI

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 26 JULY 2003 TIME OF ORDER 2215 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) Admit to ICU, by (b)(6)-2 , MD

(2) DX: (R) tibia fx s/p ex fix (open tibia fx)
GSW (R) UE, (R) LE
open (L) knee, open (L) foot 2nd MTfx
open (R) thumb prox. phalanx + MC fx (b)(6)-2

(3) cond: stable

(4) vitals: q 1°

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER

(5) Diet: clears to regular diet as tolerated HOURS

(6) IVF: NS 100 cc/° until adequate po intake + 80 cc/

(7) meds:
ancef 1g IVPB q 8°
gentamicin 80mg IVPB q 8°
Tylox 1-2 po q 4-6° prn pain
MSO4 2mg-4mg q 1° prn breakthrough pain.

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER

(8) Act: Bedrest c BRP HOURS

(9) Allergies

(10) Nonweight bearing (R) LE

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

chart V 27JUL03 0100 (b)(6)-2 (b)(6)-2 MSG

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

* U.S. GOVERNMENT PRINTING OFFICE: 1994-383-710

MEDCOM - 1520

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

IRAQI (b)(6)-4

DATE OF ORDER 26 JUL 03 TIME OF ORDER 2225 HOURS

LIST TIME ORDER NOTED AND SIGN

1) MSO_4 1-5 mg Q5min IV TOTAL 20 mg NSM

2) WEAN O_2 TO KEEP SpO_2 ≥ 95%

(b)(6)-2

(b)(6)-2

CANA

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER _____ HOURS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER _____ HOURS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER _____ HOURS

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 1521

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION: (b)(6)-4 (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 27 July 03 | TIME OF ORDER: 0800 HOURS | LIST TIME ORDER NOTED AND SIGN

(1) NPO p̄ MN

(b)(6)-2

(b)(6)-2 [illegible]

)(6

LT, JK 7/27/03 1020

PATIENT IDENTIFICATION: (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 27 Jul 03 | TIME OF ORDER: 1008 HOURS

(1) in/out catheter now please since 0 (or if no void - leave in if residual >< 100 cc. Thank mucho :)

(2) (if no void 6° p̄ last void, may see #1 order) This date

(b)(6)-2 (b)(6)-2 [illegible]

LT, JK 7/27/03 1020 PT [illegible]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 27 Jul 03 | TIME OF ORDER: 2145 HOURS

(1) Δ vitals to q shift

(b)(6)-2 [illegible]

[illegible] 2220 27 Jul (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

✓ 27 July 03 2345 (b)(6)-2 [illegible]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 1522 ICE: 1994-363-710

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 28 July 2003 TIME OF ORDER 1130 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) admit ICU 1, ortho, Dr (b)(6)-2

(2) Dx: multiple ortho injuries (R) UE, (L) UE (b)(6)-2

ORIF EXFix, I+D, tendon repair

(3) ward: good

(4) vitals: q 1° x one shift then q 4° if stable

(5) all: NKDA

(6) act: Bedrest; Non weight bearing (R) UE

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER

(7) Diet: clears → FOG as tolerated HOURS

(8) IVF: NS @ 100cc/o until adequate PO then ↓ to 50cc/o

(9) meds:

ancef 1 g IVPB q 8°

Gentamicin 80mg IVPB q 8°

Tylox ii PO q 4-6° prn pain relief

MSO4 2mg - 4mg IV q 1° prn breakthrough pain.

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

(10) Radiograph order see request per Dr (b)(6)-2

(11) ~~Keep chest tube~~

(12) Please keep wounds on (L) arm and (R) neck clean/moist 4x4 Open undressed wounds with ABD pad and kerlix (b)(6)-2 (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 28 July 03 TIME OF ORDER 1210 HOURS

MSO4 1-3 mg IV q 8 minutes PRN not to exceed 20 mg Thank you (b)(6)-2 (b)(6)-2 (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

(Grant 28 JUL 2003) (b)(6)-2 (b)(6)-2

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 1523

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION: (b)(6)-4

IW#1

DATE OF ORDER: 28 JUL 03 — TIME OF ORDER: 1700 HOURS — LIST TIME ORDER NOTED AND SIGN

Tylenol 650 mg po Q4 hrs pm

V.O. Dr. (b)(6)-2 (b)(6)-2 1710

(b)(6)-2 MAJ (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 28 JUL 03 — TIME OF ORDER: 2100 HOURS

① MSO4 2mg bolus IVP now for severe pain and may repeat in 1/2 hour if still severe pain. 2115 (b)(6)-2

(b)(6)-2

PHILLIPS LTC (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

√ 28 Jul 03 / 2320 (b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER: 29 JUL 03 — TIME OF ORDER: 0400 HOURS

MSO4 - 2-4 mg IVq 1° pm breakthrough

Noted (b)(6)-2 29 JUL 03 0420

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

Start 29 JUL 0825 (b)(6)-2

PATIENT IDENTIFICATION (b)(6)-2

DATE OF ORDER: 29 JUL 03 — 1044 HOURS

① continue to encourage, pointake through days

② NPO ⊼ MN in anticipation of OR in the am.

(b)(6)-2

(b)(6)-2 LTC

NURSING UNIT | ROOM NO. | BED NO.

√ 29 Jul 03 2340 (b)(6)-2

4256 REPLACES EDITIO... BE USED.

MEDCOM - 1524

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

(b)(6)-4

(b)(6)-2

ICU #1

DATE OF ORDER 29 Jul 03 TIME OF ORDER 1150 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) MSO4 2mg IVP now for breakthrough pain

(b)(6)-2

(b)(6)-2 UCDDS (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 29 Jul 03 TIME OF ORDER 1730 HOURS

Noted 1730

(b)(6)-2

(1) demerol 25mg IV & 12.5mg phenergan slow IVP now; may repeat 25mg demerol in 1/2 hr if need more relief

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

29 Jul 03 2340

(b)(6)-2 USAF

PATIENT IDENTIFICATION

TIME OF ORDER

HOURS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER

HOURS

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 1525

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION: (b)(6)-2

DATE OF ORDER: 30 July 2003 TIME OF ORDER: 1145 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Admit to ICU, Dr (b)(6)-2 ortho
2. Dx: multiple ortho procedures bone graft (R) ACB (L) hand, (R) foot Ex Fix on (R) LE
3. cond: good
4. Vitals: routine
5. All: NKDA
6. Act: OOB to chair c̄ asst at least bid;

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION: (b)(6)-2

DATE OF ORDER TIME OF ORDER HOURS

a) non weight bearing (B) LE
b) Encourage deep breathing tid or incentive spirometry qid
7. Diet: Pleas to regular as tolerated
8. meds:
   a) ancef 1 g IVPB q 8° (b)(6)-2
   b) ~~gentamicin 80mg~~ (b)(6)-2 q8
   c) Tylox ii po q4 6° pm pain relief

NURSING UNIT | ROOM NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

d) mottin 800mg po tid scheduled —
e) MSO4 2mg - 4mg IVP q 1° pm breakthrough pain
f) colace 100mg po bid
9. NF NS @ 100cc/° until adequate po intake then ↓ to 50cc/°
10. Encourage po intake - supplement c̄ Ensure / soft diet pm —

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

11. Dressing changes:
   a) leave alone (R) hand and (L) leg
   b) clean / dress / thin bacitracin on neck, arm wound (L) (superficial wounds)
   c) dressing changes to (R) leg - wet to dry bid & replace splint / ACE wrap (to start in 24°, Dr (b)(6)-2 to asst 1st time) (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

√30 Jul 03 2240 (b)(6)-2

DA FORM 1 APR 79 4256 REP (b)(6)-2 1 JUL 77, WHICH MAY BE USED. LTC (b)(6)-2

MEDCOM - 1526

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION: (b)(6)-4

DATE OF ORDER: 30 Jul 03 — TIME OF ORDER: 2300 HOURS — LIST TIME ORDER NOTED AND SIGN

Maalox 30cc p.o. x1 now 2010 31 Jul 03 (b)(6)-2

V.O. (b)(6)-2 LTAN

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 31 July 03 — TIME OF ORDER: 1730 HOURS (b)(6)-2

① Maalox 30cc po q 6° prn, Heartburn. (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 31 July 2003 — TIME OF ORDER: 2030 HOURS

① ensure ÷ can bid to increase protein intake (b)(6)-2 (b)(6)-2 (b)(6)-2 LTAN

Noted 31 Jul 2030

NURSING UNIT | ROOM NO. | BED NO.

✓ 31 Jul 03 2155 (b)(6)-2 LTAN

PATIENT IDENTIFICATION

(b)(6)-2

TIME OF ORDER: 0340 HOURS

1 Ag qs

① Zantac 150 ÷ p.o. BID

(b)(6)-2

✓ FAMILY PRACTICE

NURSING UNIT | ROOM NO. | BED NO.

✓ 1 Aug 03 (b)(6)-2 LTAN 2205

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 1527

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION: (b)(6)-2

DATE OF ORDER: 1AUG03 — TIME OF ORDER: 2200 HOURS — LIST TIME ORDER NOTED AND SIGN

Benadryl 50mg PO q 6° prn
itching UO (b)(6)-2

(b)(6)-2

(b)(6)-2

(b)(6)-2

NURSING UNIT: √ 1AUG03 — ROOM NO: (b)(6)-2 — UTAN 2205

PATIENT IDENTIFICATION

DATE OF ORDER: 4 Aug 03 — TIME OF ORDER: 1137 HOURS

① KD/C Cola (b)(6)-2

(b)(6)-2 Lieutenant Colonel, MD, Chief, Department of Medicine, Corps

Noted

(b)(6)-2

NURSING UNIT: √ 5AUG03 — ROOM NO.: 0715 — BED NO.: (b)(6)-2

(b)(6)-2

PATIENT IDENTIFICATION: (b)(6)-2

(b)(6)-2

(b)(6)-2

(b)(6)-2

ICT Pre 5/03 1515

8/4/03

NURSING UNIT: (b)(6)-2 — ROOM NO — NO.

DATE OF ORDER: 5 Aug 03 — TIME OF ORDER: 1210 HOURS

1) admit to ICU, Prevost, ortho
2) Dx: multi ortho trauma, S/P washout, modify skin flap - debride
3) cchd: good
4) ALL: NFDA
5) act: Nonweight bearing (B) LE; OOB tid into chair - can ast briefly c̄ (L) LE

PATIENT IDENTIFICATION

DATE OF ORDER: Encourage deep breathing; — TIME OF ORDER: 15 HOURS

6) Vitals: routine
7) Diet: clears to regular as tolerated supplement c̄ ensure ; can bid
8) Meds: ancef 1g IVPB q 8°
Tylox ÷ ÷ po q 4-6° prn
Motrin 800mg ÷ po tid prn pain relief
~~INF NS or LR @ 50cc~~/° HLIV (D) (cont'd)

NURSING UNIT: √ 5AUG03 — ROOM NO.: 0200 — BED NO.: (b)(6)-2

(b)(6)-2

DA FORM 1 APR 79 4256 — REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 1528

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION (b)(6)-2 [redacted]

DATE OF ORDER: 5 aug 03 — TIME OF ORDER: 1210 HOURS — LIST TIME ORDER NOTED AND SIGN (b)(6)-2

✓ 10) (R) hand dressing changes ~~by surgeon~~

✓ 11) (R) leg dressing changes wet to dry bid - replace splint / ACE wrap

✓ 12) continue cleansing remaining lacs/abrasions - thin layer bacitracin BID (b)(6)-2

NURSING UNIT | NO. | BED NO.

✓ 5 AUG 03 0100 (b)(6)-2 [redacted] UTAN (b)(6)-2

PATIENT IDENTIFICATION (b)(6)-2 [redacted] 8/4/03

DATE OF ORDER: 6 aug 03 — TIME OF ORDER: 0930 HOURS — LTCDR

(1) Zantac 150mg po bid please (b)(6)-2 [redacted]

LTCDR

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION (b)(6)-2 [redacted] 8/6/03

DATE OF ORDER: 6 aug 03 — TIME OF ORDER: 1130 HOURS

(1) (R) hand dressing changes bid - clean gently. xeroform over donor site. Dry dressing in webspace & over incisions. Kerlix - no more wet to dry. thanx (most welcome) (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

✓ 6 AUG 03 2300 (b)(6)-2 [redacted] (b)(6)-2 (b)(6)-2 LTCDR

PATIENT IDENTIFICATION (b)(6)-2 [redacted]

DATE OF ORDER: 7 aug 03 — TIME OF ORDER: 1937 HOURS

(1) clindamycin 150mg po qid

(2) DC IV and IV Abx

(3) D/C (R) hand dressing changes - Dr will do hand dressings (b)(6)-2 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

✓ 7 AUG 03 2225 (b)(6)-2 [redacted] UTAN (b)(6)-2 [redacted] TC DDSWD

DA FORM 1 APR 79 4256 REPLACES ... WHICH MAY BE USED.

MEDCOM - 1529

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

(b)(6)-4

noted 8 Aug 03 0832

(b)(6)-2

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
8 Aug 03	0830 HOURS	

(1) Just do dressing Δ's on (R) LE until surgeon determines (L) LE -

(2) Routine bathing / cleaning OK for superficial lacs / abrasions on torso - can d/c bacitracin

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

(b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	
9 Aug 03	HOUR	(b)(6)-2

- IV Ancef 98° Tgram

- NPO → plan IV D (R) Thurs @ 1500 hrs

1150 9 Aug 03

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-2

DATE OF ORDER	TIME OF ORDER	
8/9/03 1110	HOUR	(b)(6)-2

D/C CLINDOMYCIN.

V.O. sim. (b)(6)-2 / ICT (b)(6)-2

8/9/03 1110

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER
	HOURS

Chart [redacted]

(b)(6)-2

0452

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77 WHICH MAY BE USED.

MEDCOM - 1530

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
(b)(6)-2			8/9/03	HOURS	
			TO ICU I Dr (b)(6)-2		
			Dy: Slp (R) Thumb I&D		
			(L) foot I&D		
			Regular Diet		
			NEDA		
NURSING UNIT	ROOM NO.	BED NO.	Vitals 90°		
			NW (R) LE		
PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	(b)(6)-2
			meds:	HOURS	
			Tylox 1-2 Tabs Po q 6°		
			prn pain		
			Ancef ↑ gram IV 98°		
			CRC 60cc hr		
			Resume dressing changes		
NURSING UNIT	ROOM NO.	BED NO.	(R) calf RID wet to		
			Dry		
PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
			(R) hand dressings	HOURS	
			to be changed by		
			Dr (b)(6)-2 RID		
			(b)(6)-2		
			chart 10AUG03 1500		
NURSING UNIT	ROOM NO.	BED NO.	(b)(6)-2		
PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
				HOURS	
NURSING UNIT	ROOM NO.	BED NO.			

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 1531

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

(b)(6)-4 [redacted]

Noted 10 AUG 03

(b)(6)-2 [redacted]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 8/10/03 — TIME OF ORDER: _____ HOURS

Δ pain meds to 94-6 hrs prn, pain

(b)(6)-2 [redacted]

LIST TIME ORDER NOTED AND SIGN

PATIENT IDENTIFICATION

(b)(6)-2 [redacted]

Noted AUG-03 100[redacted]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 10 Aug 03 — TIME OF ORDER: 1000 HOURS

(1) Patient may have food brought in from outside

(b)(6)-2 [redacted] MD

LTC, MC

(b)(6)-2 [redacted]

FAMILY PRACTICE

PATIENT IDENTIFICATION

Noted 10 AUG 03 1830 [redacted]

(b)(6)-2 [redacted]

NURSING UNIT	ROOM NO.	BED NO.
	✓ 10 AUG 03 2210	

DATE OF ORDER: 10 Aug 03 — TIME OF ORDER: 1700 HOURS

(1) Benadryl 50mg po q 6°, prn itching

(b)(6)-2 [redacted]

(b)(6)-2 [redacted] LTC DDS MD

(b)(6)-2 [redacted] UTAN

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

ORDER — TIME OF ORDER: _____ HOURS

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 1532

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION: (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 8/12/03 | TIME OF ORDER: _____ HOURS | LIST TIME ORDER NOTED AND SIGN

TO ICU 7 Dr (b)(6)-2
s/o I&D (R) Thumb
vitals q 8°
NKDA
NWB (R) LE WBAT (L) LE
LRC (b)(6)-2
Ancef 1 Gram IV q 8°

Noted RAV (b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

Gentamycin 80mg IV q 8° X 72 hours
Tylox 1-2 PRN q 4-6 prn pain
OOB to chair TID
SGT (b)(6)-2 to see for ambulation assistance & Quad strengthening

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER (b)(6)-2 | ORDER | HOURS

[redacted] (b)(6)-2

/12/03 1600
Anesthesia Post Op Recovery
Morphine 2-4mg IV PRN Pain
May Repeat q 5 minutes for total dose of 20mg in 2 hrs.

NURSING UNIT | ROOM NO. | BED

8° C/C (b)(6)-2

CPT/AW 2120 (b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

17 Aug 03 2314.

Benadryl 50mg PCV 1

(b)(6)-2

noted (b)(6)-2 2320 (b)(6)-2

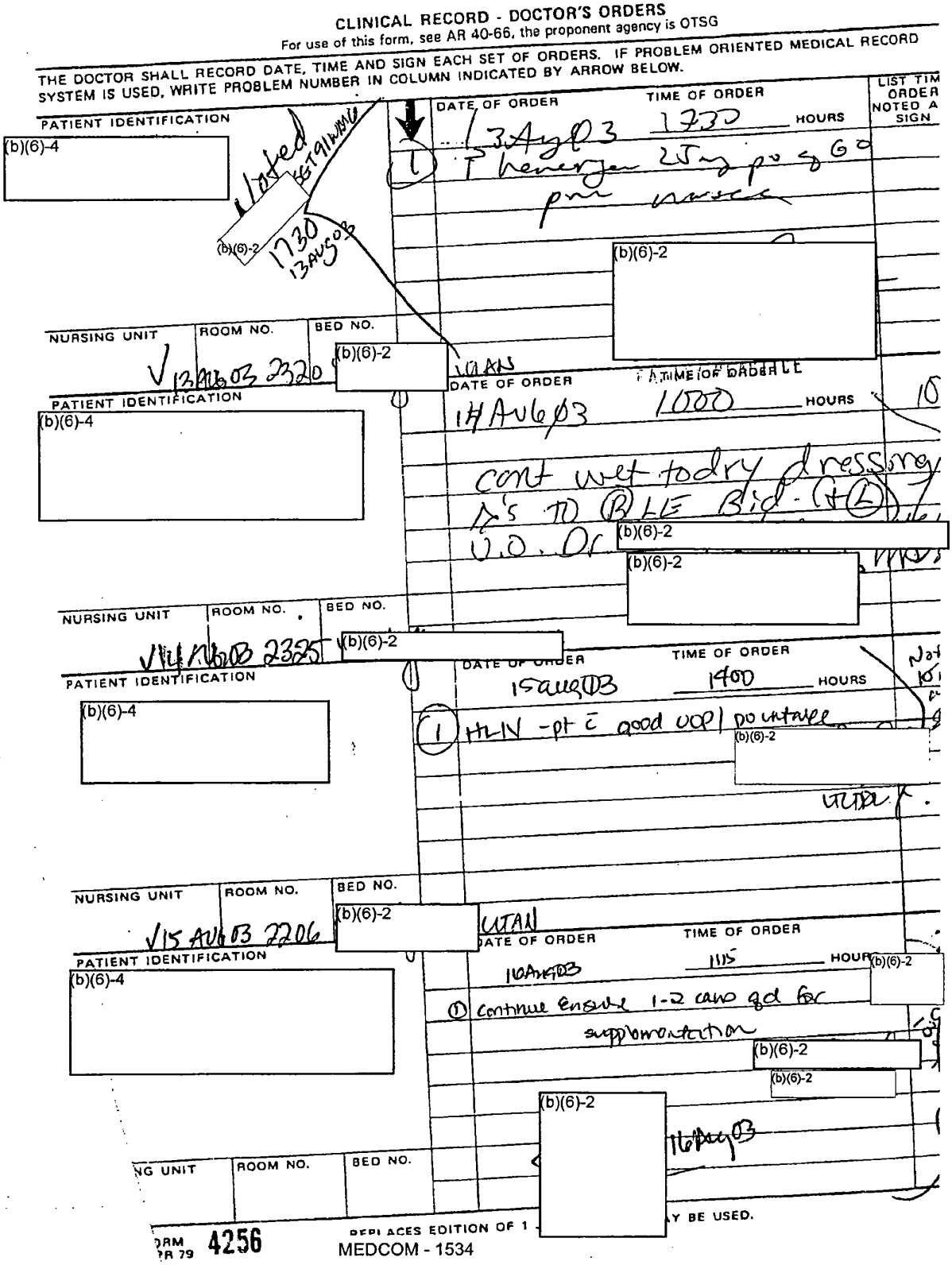
NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

CPT/AW 0720

ES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 1533



CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION: (b)(6)-4

Noted (b)(6)-2 1730 13AUG03

DATE OF ORDER: 13Aug03 TIME OF ORDER: 1730 HOURS

(1) Phenergan 25mg po qg 60 pm nausea

(b)(6)-2

LIST TIM ORDER NOTED A SIGN

NURSING UNIT: V 13AUG03 ROOM NO.: 2320 BED NO.: (b)(6)-2

UTAN

PATIENT IDENTIFICATION: (b)(6)-4

DATE OF ORDER: 14Aug03 TIME OF ORDER: 1000 HOURS

cont wet to dry dressing Δ's TO (B) LE Bid (+(L)) U.O. Dr (b)(6)-2

(b)(6)-2

NURSING UNIT: V 14AUG03 ROOM NO.: 2325 BED NO.: (b)(6)-2

PATIENT IDENTIFICATION: (b)(6)-4

DATE OF ORDER: 15aug03 TIME OF ORDER: 1400 HOURS

(1) HLIV - pt c̄ good UOP/ po intake (b)(6)-2

UTAN

NURSING UNIT: V 15AUG03 ROOM NO.: 2206 BED NO.: (b)(6)-2

PATIENT IDENTIFICATION: (b)(6)-4

DATE OF ORDER: 16Aug03 TIME OF ORDER: 1115 HOURS (b)(6)-2

(1) continue Ensure 1-2 cans qd for supplementation

(b)(6)-2

(b)(6)-2

(b)(6)-2 16Aug03

NG UNIT | ROOM NO. | BED NO.

FORM 4256 REPLACES EDITION OF 1 ... Y BE USED.

MEDCOM - 1534

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
(b)(6)-4	17 aug 03	0925 HOURS	Noted
	(1) NPO p̄ MN	(b)(6)-2	17 AUG 2100
	(2) surgery in am	GRDM	(b)(6)-2

NURSING UNIT	ROOM NO.	BED NO.
V	17 AUG 03 2240	(b)(6)-2

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER
(b)(6)-2	18 AUG 03	0100 HOURS
	AMBIEN 10mg PO	
	(ONE TIME ORDER ONLY)	
	0100	(b)(6)-2

NURSING UNIT	ROOM NO.		
Shift Chart	8/18/03	1130	(b)(6)-2

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER
		HOURS

NURSING UNIT	ROOM NO.	BED NO.

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER
		HOURS

NURSING UNIT	ROOM NO.	BED NO.

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 1535

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION: (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 18 aug 03 — TIME OF ORDER: 1015 HOURS — LIST TIME ORDER NOTED AND SIGN

1. admit to ICU, (b)(6)-2
2. (b)(6)-2 9P skin grafts
3. Cond: good
4. Vitals: Monitor
5. All: Ø NKA
6. Act: bedrest / Non wt bearing @ LE
7. Diet: clears → Reg as tolerated

PATIENT IDENTIFICATION: (b)(6)-2

NURSING UNIT | BED NO.

DATE OF ORDER — TIME OF ORDER — HOURS

8. NF NS or LR @ 100 cc/hr until adequate po then TKO
9. meds: Vanc 1g IVPB q 8° x 5 days; Tylox po q 4-6° pm pain relief; Motrin 800mg po q 8° pm pain relief; MSO4 1-4mg IVP q 1° pm severe / breakthrough pain
10. Do not Δ dressing on (R) hand or (R) LEG — can change dressing as previously done on (L) LE → wash + dry foot — pt can try c̄ (L) hand
11. continue Ensure 1-2 cans po for supplementation
12. Phenergan 25mg po q 6° pm Nausea

(b)(6)-2 — (b)(6)-2 — (b)(6)-2 — (b)(6)-2 — (b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 18 aug 03 — TIME OF ORDER: 1112 HOURS

1. Benadryl 25mg IVP now for drug rxn - localized
2. Demerol 50mg IV with Phenergan 12.5mg slow IVP x 1 dose for breakthrough pain

(b)(6)-2 — (b)(6)-2 — (b)(6)-2

Chart 18 Aug

DA FORM 1 APR 79 4256 — REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED. — MEDCOM - 1536

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION: (b)(6)-4

DATE OF ORDER: 18 Aug 03 — TIME OF ORDER: 1430 HOURS — LIST TIME ORDER NOTED AND SIGN

(1) HLN ...

(2) (1) reg - keep foot clean / dry - pt can / 1430

asst c̄ hygiene

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

✓ 18 Aug 03 2210 (b)(6)-2 UTAN ✓ 19 Aug 03 2230 (b)(6)-2 UTAN

PATIENT IDENTIFICATION: (b)(6)-4

DATE OF ORDER: 20 Aug 03 — TIME OF ORDER: 1340 HOURS

(1) Transfer to RCUZ / Dr (b)(6)-2

(2) Dx: S/p skin graft

(3) Care good

(4) MKDA

(5) Uites - Q shift

(6) Diet - regular - May

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER — TIME OF ORDER — HOURS

ponsure outside food brought by family.

(7) HLN.

(8) Meds: Ancef 1 gm IVPB q 60 x 5 days total

- Tylox 1-2 po q 4-60 pm pons

- Motrin 800 po TID pm pm

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER — TIME OF ORDER — HOURS breakthrough

- M504 1-4 mg IV q 2 pm

(9) Diet - Ensure / can per meal

(10) Phenergan 25 mg IV q 60 q 4-60

(11) Beradryl 25 mg PPH pm if [illegible]

NURSING UNIT | ROOM NO. | BED NO.

24b ✓ (b)(6)-2 TW/AN 27 AUG 03 2235 (b)(6)-2

DA FORM 1 APR 79 42[illegible] REPLACES EDITION OF 1 JUL 77, WHICH MAY

FAMILY PRACTICE

MEDCOM - 1537

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

(b)(6)-4

(EPW)

DATE OF ORDER | TIME OF ORDER | LIST TIME ORDER NOTED AND SIGN

8/24/03 _____ HOURS

- WBAT (L) LE
- Toe touch weight bearing (R) LE
- OOB to Chair TID
- Crutches for ambulation
- SAT (b)(6)-2 to see for ambulation assistance

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-4

(EPW)

noted [illegible]

OF ORDER | TIME OF ORDER

- D/C IV _____ HOURS
- Levoquin 500mg PO QD.
- Dessing Δ's by MD
- Δ vitals to 90ac

(b)(6)-2

NURSING (b)(6)-2 [redacted] BED NO. 25 AVE 03

0200

PATIENT IDENTIFICATION

(b)(6)-4

(EPW)

DATE OF ORDER | TIME OF ORDER

8/28/03 _____ HOURS

- D/C to ASW Camp 8/29/03
- Plan 21st SH on 7 Sept 03 @ 0900hrs
- Rx Levoquin
- WBAT (L) LE 25% WB (R) LE

(b)(6)-2

NURSING UNIT | ROOM NO.

PATIENT IDENTIFICATION

(b)(6)-4

(EPW)

DATE OF ORDER | TIME OF ORDER

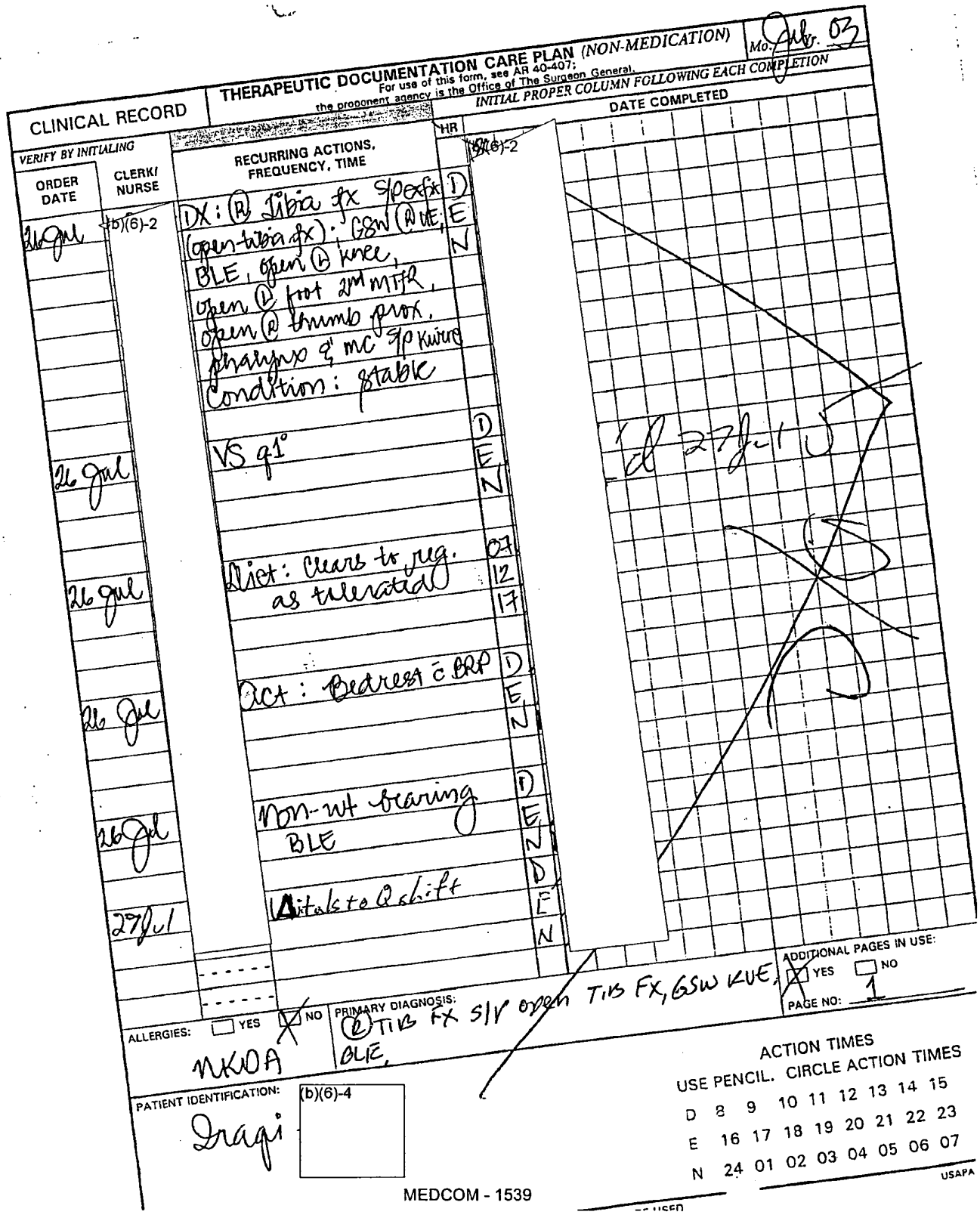
Non weight bearing (R) Thumb _____ HOURS

(b)(6)-2

MD

NURSING UNIT | ROOM NO. | BED NO. | (b)(6)-2

MEDCOM - 1538



CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*

For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo. Jul. 03

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

VERIFY BY INITIALING: ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED
26 Jul	(b)(6)-2	DX: (R) Tibia fx S/P ex fix (open tibia fx); GSW (R) UE, BLE, open (L) knee, open (L) foot 2nd MTFR, open (R) thumb prox. phalynx & mc S/P Kwire Condition: stable	D E N	(b)(6)-2
26 Jul		VS q1°	D E N	27 Jul
26 Jul		Diet: Clears to reg. as tolerated	07 12 17	
26 Jul		Act: Bedrest c̄ BRP	D E N	
26 Jul		Non-wt bearing BLE	D E N	
27 Jul		Vitals to Q shift	D E N	

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO: 1

ALLERGIES: ☐ YES ☒ NO NKDA

PRIMARY DIAGNOSIS: (R) TIB FX S/P open TIB FX, GSW KUE, BLE.

PATIENT IDENTIFICATION: Iraqi (b)(6)-4

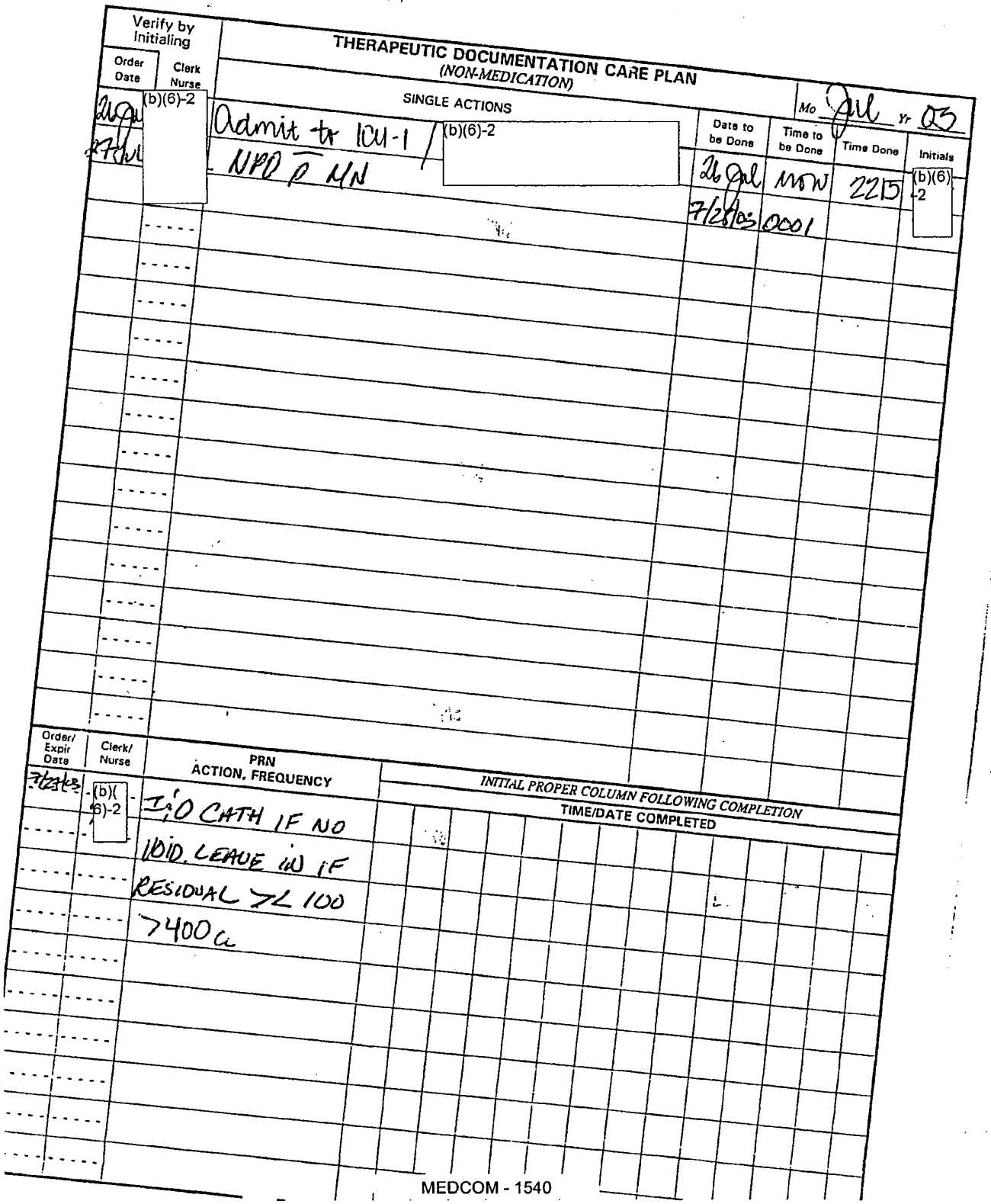
ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

USAPA

MEDCOM - 1539



Verify by Initialing

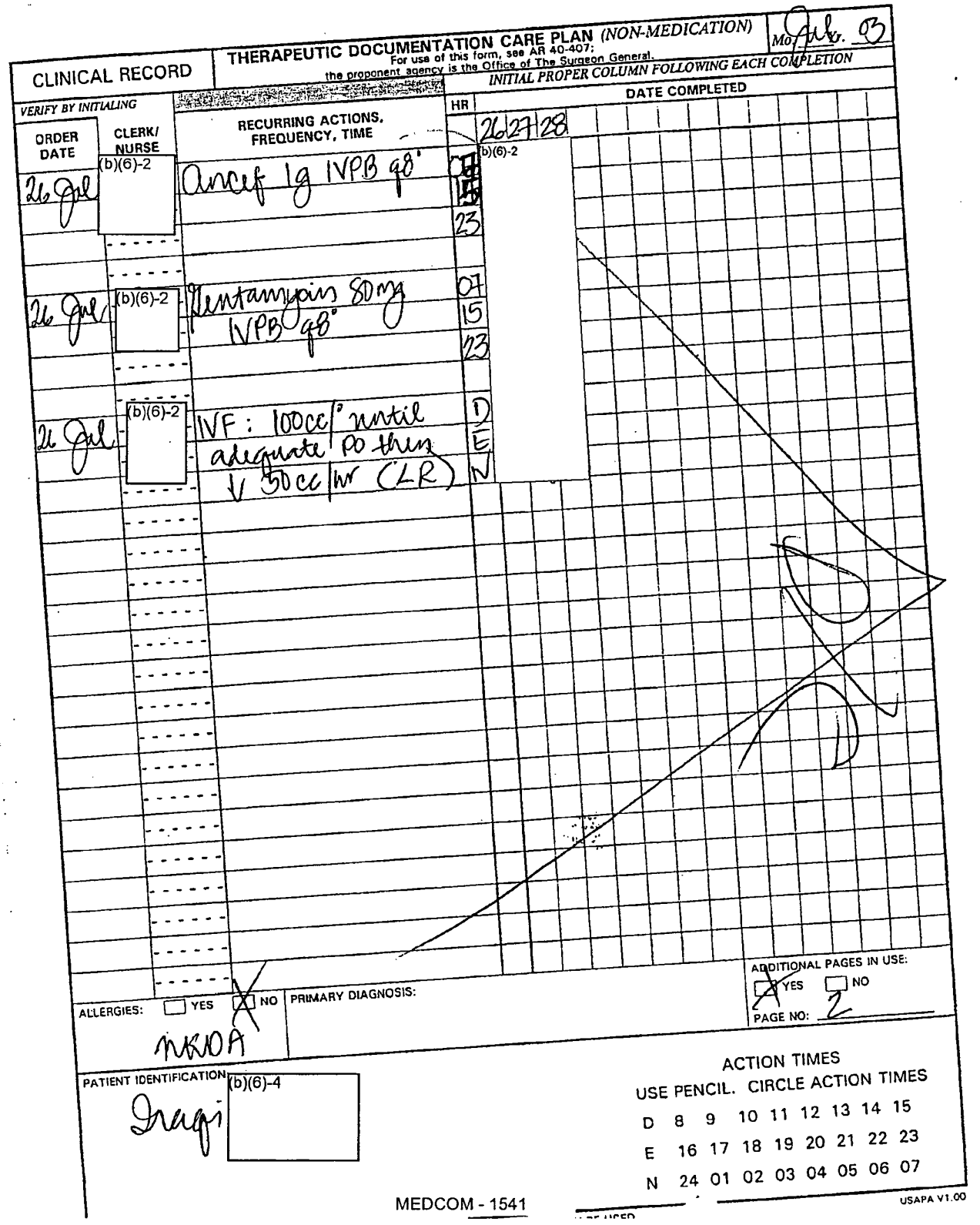
THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo Jul Yr 03

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
26 Jul	(b)(6)-2	Admit to ICU-1 / (b)(6)-2	26 Jul	NOW	2215	(b)(6)-2
27 Jul		NPO after MN	7/28/03	0001		

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED
7/28/03	(b)(6)-2	I&O CATH IF NO VOID. LEAVE IN IF RESIDUAL >L 100 >400 cc	

MEDCOM - 1540



CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo Jul Yr 03

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

VERIFY BY INITIALING

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 26 27 28
26 Jul	(b)(6)-2	Ancef 1g IVPB q8°	07 15 23	(b)(6)-2
26 Jul	(b)(6)-2	Zentamycin 80mg IVPB q8°	07 15 23	
26 Jul	(b)(6)-2	IVF: 100cc/hr until adequate PO then V 50cc/hr (LR)	D E N	

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO
PAGE NO: 2

PATIENT IDENTIFICATION
Iraqi
(b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15	
E	16	17	18	19	20	21	22	23	
N	24	01	02	03	04	05	06	07	

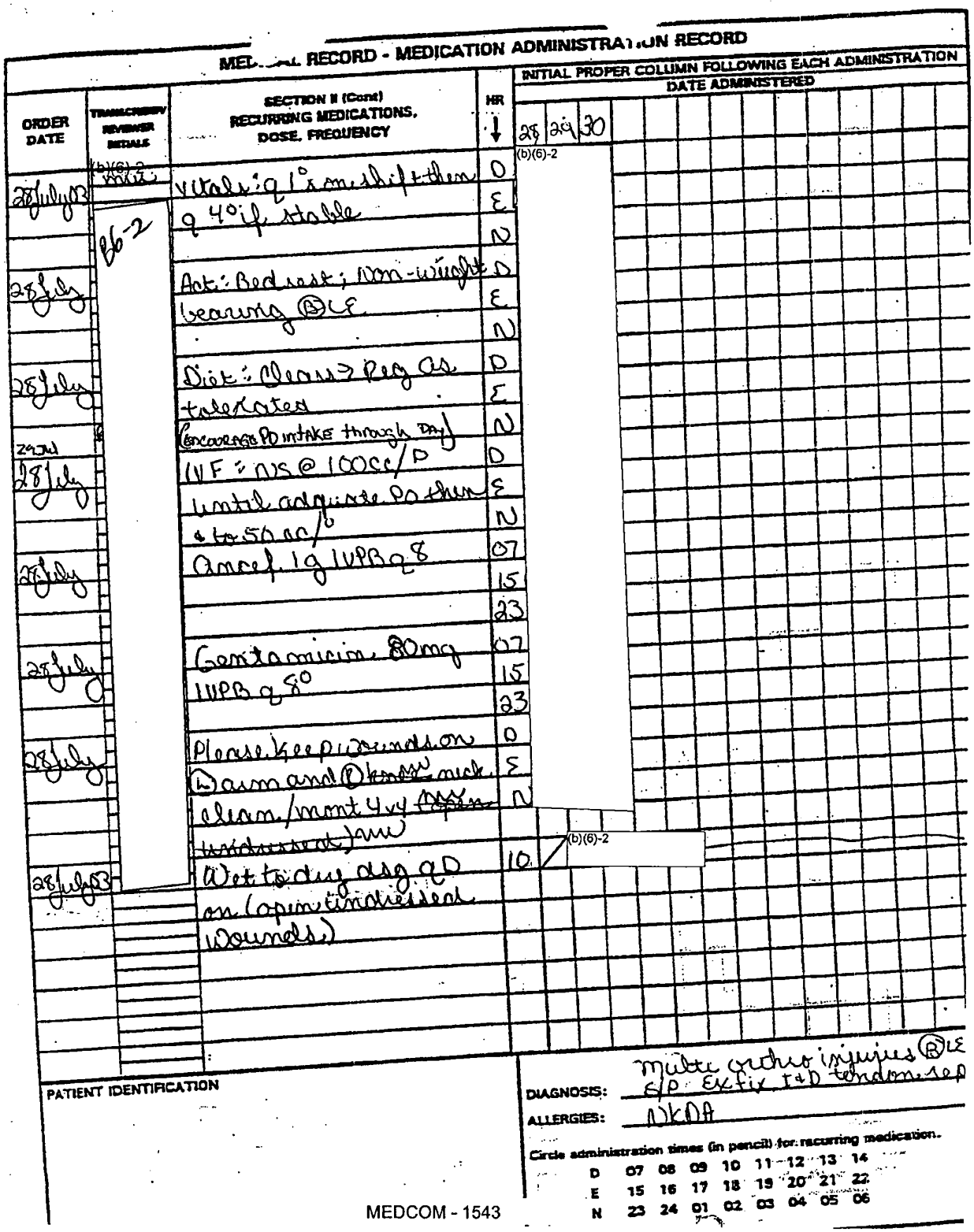
MEDCOM - 1541

USAPA V1.00

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo ____ Yr ____
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED
24 Jul	(b)(6)-2	Tylox T-II PO q4-6° PRN pain	(b)(6)-2
24 Jul	(b)(6)-2	MSO4 2mg-4mg q1° PRN breakthrough pain	

MEDCOM - 1542



MEDICAL RECORD - MEDICATION ADMINISTRATION RECORD

ORDER DATE	TRANSCRIBER/ REVIEWER INITIALS	SECTION II (Cont) RECURRING MEDICATIONS, DOSE, FREQUENCY	HR ↓	INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION — DATE ADMINISTERED: 28	29	30
28 July 03	(b)(6)-2 mw	Vitals: q 1° on shift then	D	(b)(6)-2		
		q 4° if stable	E			
	B6-2		N			
28 July		Act: Bed rest; Non-weight	D			
		bearing (B) LE	E			
			N			
28 July		Diet: Clears → Reg as	D			
		tolerated	E			
29 Jul		(Encourage PO intake through Day)	N			
28 July		IVF: NS @ 100cc/D	D			
		until adquate PO then	E			
		↓ to 50 cc/°	N			
28 July		Ancef 1g IVPB q 8	07			
			15			
			23			
28 July		Gentamicin 80mg	07			
		IVPB q 8°	15			
			23			
28 July		Please keep wounds on	D			
		(L) arm and (R) ~~knee~~ neck	E			
		clean/mont 4x4 ~~(open~~	N			
		~~undressed)~~ mw				
28 July 03		Wet to dry dsg qD	10	(b)(6)-2		
		on (open undressed				
		wounds)				

PATIENT IDENTIFICATION

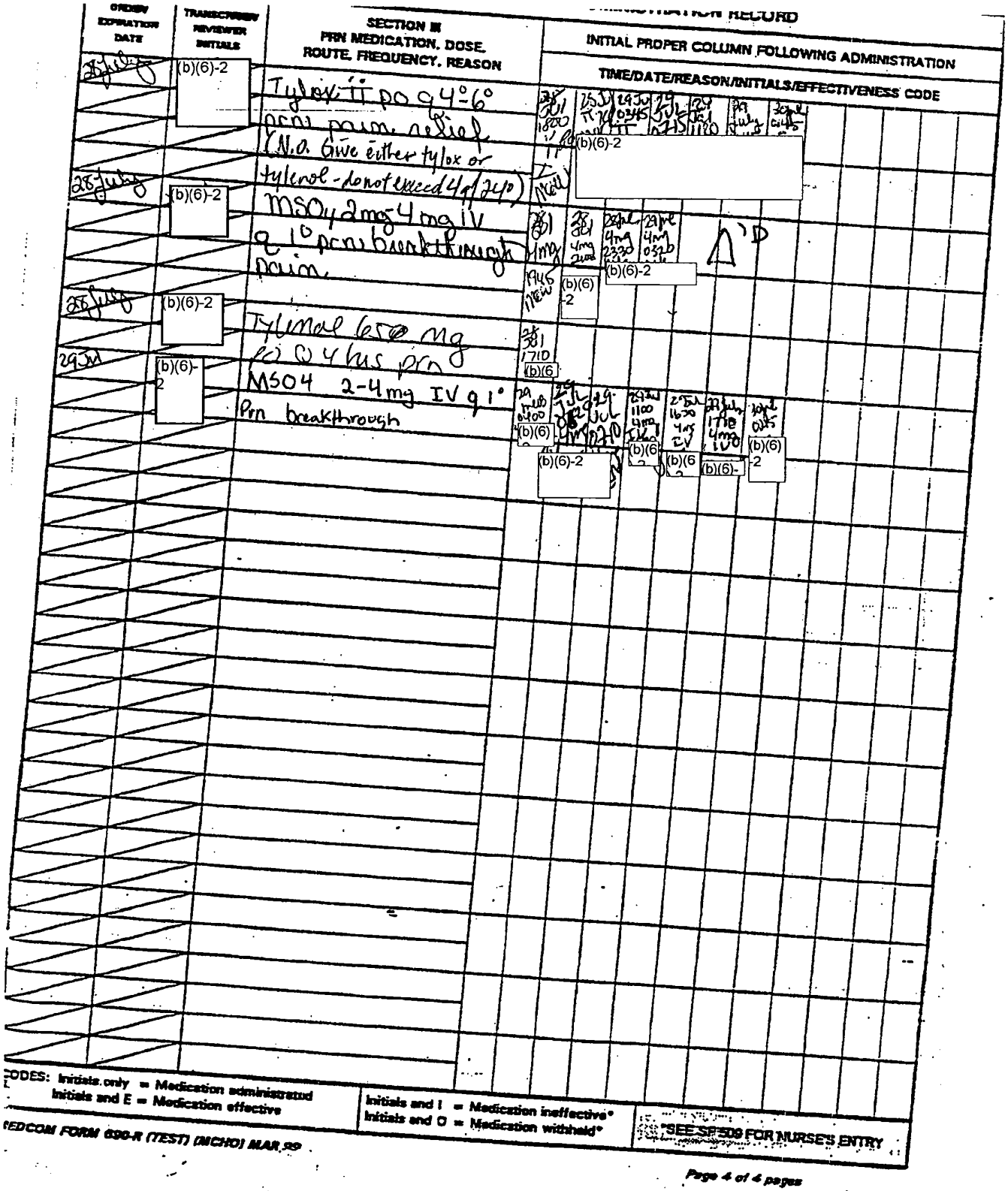
DIAGNOSIS: Multi ortho injuries (B) LE S/P Ex fix I+D tendon rep

ALLERGIES: NKDA

Circle administration times (in pencil) for recurring medication.

D	07	08	09	10	11	12	13	14
E	15	16	17	18	19	20	21	22
N	23	24	01	02	03	04	05	06

MEDCOM - 1543


ORDER EXPIRATION DATE
TRANSCRIBER REVIEWER INITIALS
SECTION III PRN MEDICATION, DOSE, ROUTE, FREQUENCY, REASON
INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION
TIME/DATE/REASON/INITIALS/EFFECTIVENESS CODE
Tylox II po q4°-6° prn pain relief (N.O. Give either tylox or tylenol - do not exceed 4g/24h)
MSO4 2mg-4mg IV q 1° prn breakthrough pain.
Tylenol 650 mg po q4hrs prn
MSO4 2-4mg IV q1° Prn breakthrough
(b)(6)-2
CODES: Initials only = Medication administered
Initials and E = Medication effective
Initials and I = Medication ineffective*
Initials and O = Medication withheld*
*SEE SF 509 FOR NURSE'S ENTRY
MEDCOM FORM 690-R (TEST) (MCHO) MAR 99
Page 4 of 4 pages

MEDICAL RECORD - MEDICATION ADMINISTRATION RECORD

For use of this form, see MEDCOM Circular 40-5

ORDER DATE	TRANSCRIBER/REVIEWER INITIALS	SECTION I DELAYED SINGLE ACTION ORDERS & PREOPERATIVES	DATE/TIME TO BE GIVEN	DATE/TIME GIVEN AND INITIALS
28 July 03	(b)(6)-2	Admit to ICU #1, Othro, (b)(6)-2	28 July 03	(b)(6)-2
28 Jul		Radiograph order see request per	28 Jul 03	
		Do (b)(6)-2		
28 July		MSO4 2mg Ivp now for severe pain	28 Jul 2[illegible]	
		may Repeat in 1/2 hr if still severe pain	28 Jul 2130	
29 Jul		NPO p MN in Anticipation of OR in the Am	30 Jul 03 0001	
29 Jul		MSO4 2mg IVP Now For Breakthrough Pain	29 Jul 03 1150	
29 Jul		Demerol 25mg c̄ 12.5mg Phenergan slow IVP now;	29 Jul 03 1930	
		may repeat 25mg demerol in 1/2 hr if need more relief		

PATIENT IDENTIFICATION

(b)(6)-4

DIAGNOSIS: S/P Ex fix, I&D, tendon repair OX Multiarthro injuries (B)LE, (B)U

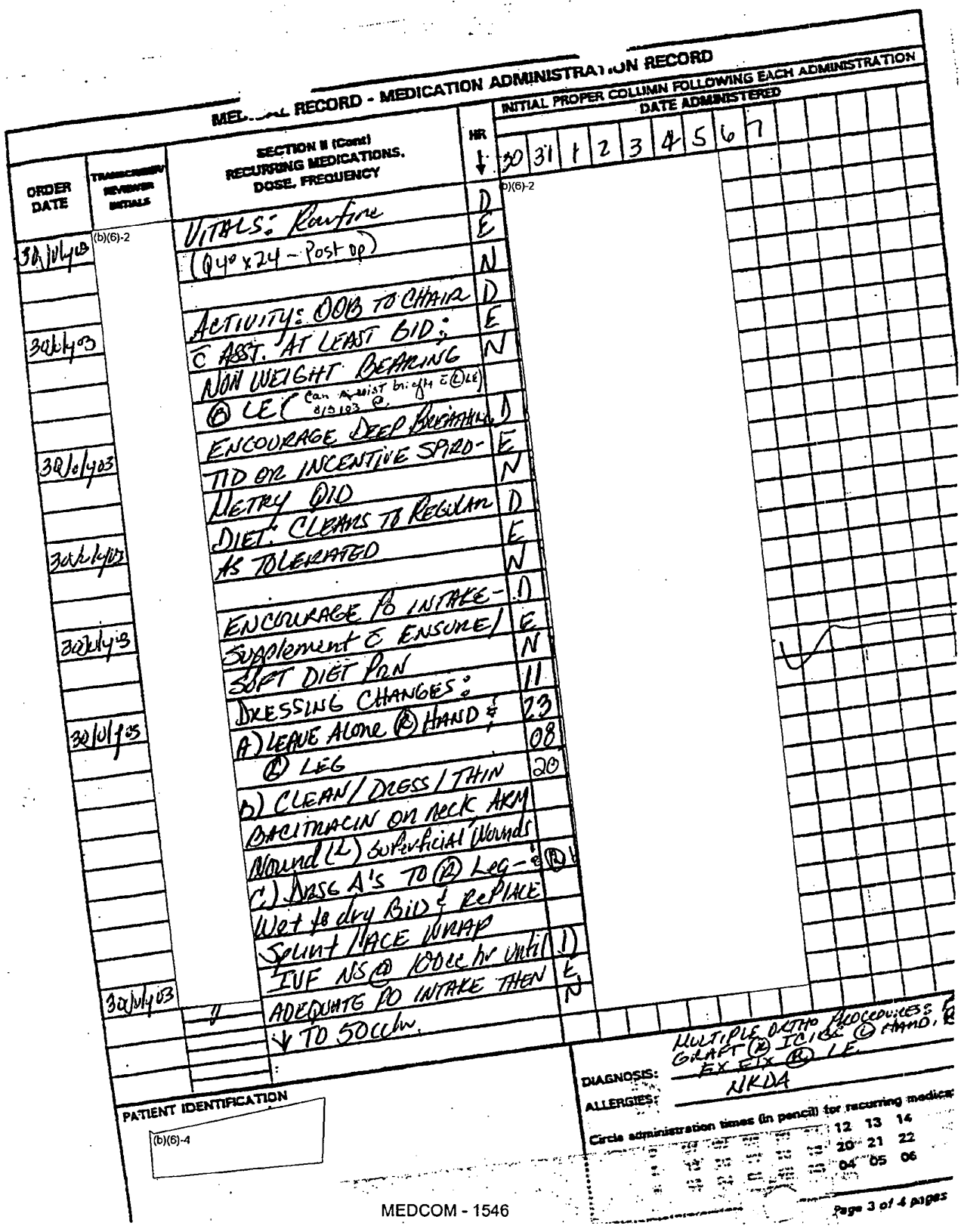
ALLERGIES: NKDA

Circle administration times (in pencil) for recurring medication.

D	07	08	09	10	11	12	13	14
E	15	16	17	18	19	20	21	22
N	23	24	01	02	03	04	05	06

MEDCOM - 1545

MC V1.80



MEDICAL RECORD - MEDICATION ADMINISTRATION RECORD

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

DATE ADMINISTERED: 30 31 1 2 3 4 5 6 7

ORDER DATE	TRANSCRIBER/ REVIEWER INITIALS	SECTION II (Cont) RECURRING MEDICATIONS, DOSE, FREQUENCY	HR ↓
30/01/03	(b)(6)-2	VITALS: Routine	D
		(Q4° x 24 - Post op)	E
			N
		ACTIVITY: OOB TO CHAIR	D
30/01/03		C̄ ASST. AT LEAST BID;	E
		NON WEIGHT BEARING	N
		(R) LE (Can assist briefly c̄ (L) LE) 8/5/03 @	
		ENCOURAGE DEEP BREATHING	D
30/01/03		TID OR INCENTIVE SPIRO-	E
		METRY QID	N
		DIET: CLEARS TO REGULAR	D
30/01/03		AS TOLERATED	E
			N
		ENCOURAGE PO INTAKE-	D
30/01/03		Supplement c̄ ENSURE/	E
		SOFT DIET PRN	N
		DRESSING CHANGES:	11
30/01/03		A) LEAVE ALONE (R) HAND &	23
		(L) LEG	08
		B) CLEAN/DRESS/THIN	20
		BACITRACIN ON NECK ARM	
		Wound (L) superficial Wounds	
		C) DRSG A's TO (R) Leg - & (R)	
		Wet to dry BID & REPLACE	
		Splint/ACE WRAP	
		IVF NS @ 100cc hr until	D
30/01/03		ADEQUATE PO INTAKE THEN	E
		↓ TO 50cc hr.	N

(b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-4

DIAGNOSIS: MULTIPLE ORTHO PROCEDURES: GRAFT (R) ICIC (L) HAND, EX FIX (R) LE.

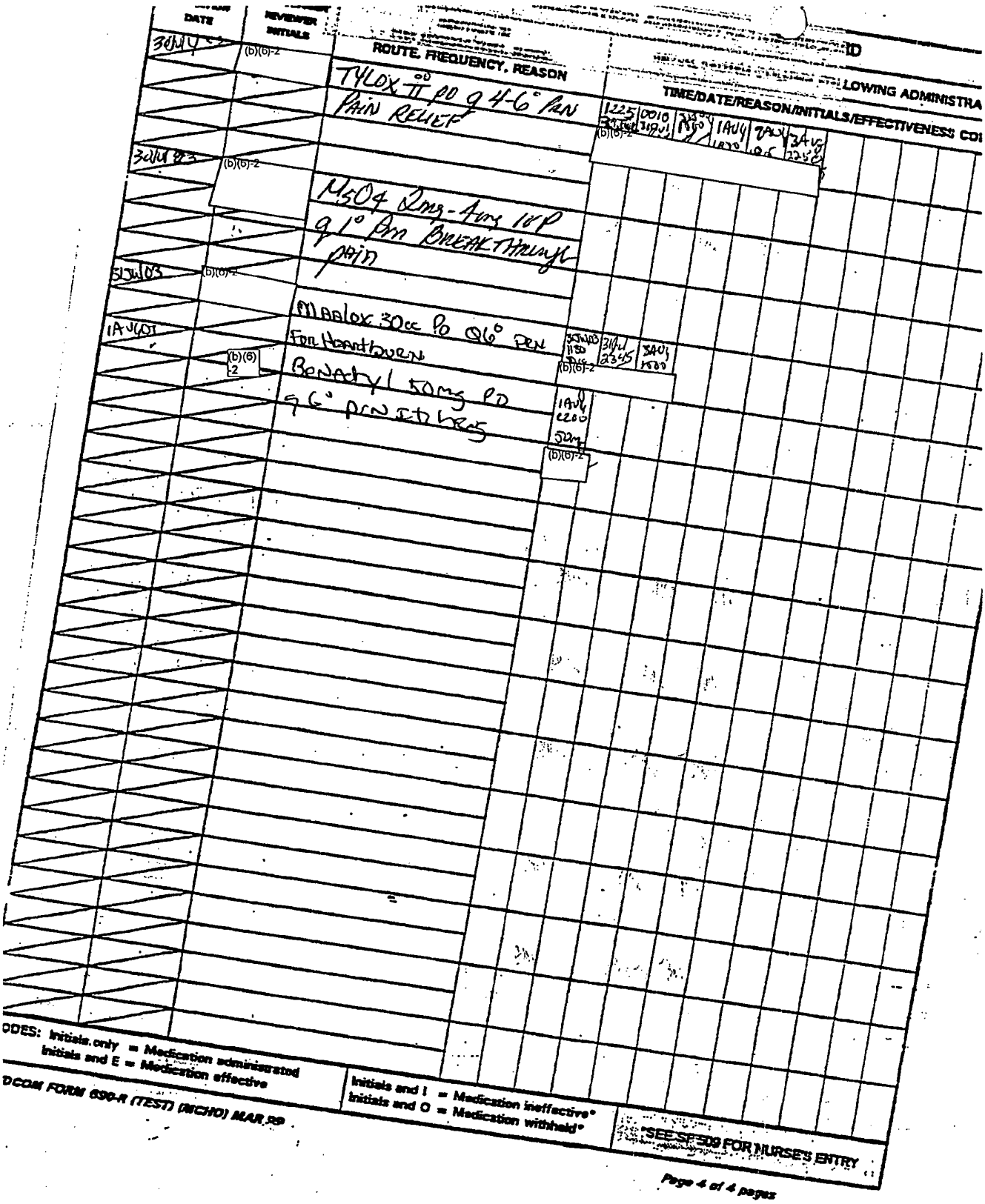
ALLERGIES: NKDA

Circle administration times (in pencil) for recurring medica

12 13 14
20 21 22
04 05 06

MEDCOM - 1546

Page 3 of 4 pages


DATE
REVIEWER INITIALS
ROUTE, FREQUENCY, REASON
TIME/DATE/REASON/INITIALS/EFFECTIVENESS
TYLOX II PO q 4-6° PAIN
PAIN RELIEF
MSO4 2mg-4mg IVP
q 1° Pm BREAKTHROUGH
pain
MAALOX 30cc PO Q6° PRN
For Heartburn
BENADRYL 50mg PO
q 6° PRN ITCHES
(b)(6)-2
CODES: Initials only = Medication administrated
Initials and E = Medication effective
Initials and I = Medication ineffective*
Initials and O = Medication withheld*
*SEE SF 509 FOR NURSE'S ENTRY
DCOM FORM 690-R (TEST) (RICHO) MAR 99
Page 4 of 4 pages

MEDICAL RECORD - MEDICATION ADMINISTRATION RECORD

ORDER DATE	TRANSCRIBER/ REVIEWER INITIALS	SECTION II RECURRING MEDICATIONS, DOSE, FREQUENCY	HR ↓	INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION — DATE ADMINISTERED: 30	31	1	2	3	4	5	6
30 Jul 03	b)(6)-2	ANCEF 1g IVPB Q8°	07	b)(6)-2							
			15								
			23								
30 Jul 03		Motrin 800mg PO tid	08								
		SCHEDULED C FOOD or MILK	16								
			24								
30 Jul 03		Celebrex 100mg PO BID	10								Y
			22								
31 JUL 03		ENSURE T CAN BED TO	10								
		INCREASE PROTEIN INTAKE	22								
1 AUG 03		ZANTAC 150mg T PO	10								
		BID	22								

ORDER DATE	TRANSCRIBER/ REVIEWER INITIALS	SECTION I DELAYED SINGLE ACTION ORDERS & PREOPERATIVES	DATE/TIME TO BE GIVEN	DATE/TIME GIVEN AND INITIALS
30/7/03	(b)(6)-2	Admit to ICU, Dr (b)(6)-2 ORTHO. Cond. GOOD	30/7/04	30/7/04 1145
30/7/03		DRESSING A's to start in 24° - Dr (b)(6)-2	31/7/04	(b)(6)-2
		TO ASSIST 1ST TIME		

PATIENT IDENTIFICATION
(b)(6)-4

DIAGNOSIS: MULTIPLE ORTHO PROCEDURES: BONE GRAFT (R) TIB & FIB, (L) HAND, (R) FOOT EX FIX (R) & (L)

ALLERGIES: NKDA

Circle administration times (in pencil) for recurring medication.

D	07	08	09	10	11	12	13	14
E	15	16	17	18	19	20	21	22
N	23	24	01	02	03	04	05	06

MEDCOM FORM 690-R (TEST) (MCHO) MAR 99 PREVIOUS EDITIONS ARE OBSOLETE *Page 1 of 4 pages* MC V1.00

ACLU-RDI 1099 p.333

DOD 005601

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo. 8 Yr. 03

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

VERIFY BY INITIALING			HR	DATE COMPLETED 5 6 7 8 9 10 11 12 13
ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME		(b)(6)-2
8/4/03	(b)(6)-2	Act: Nonweight bearing (R) LE;	D	
		DOB tid - chair	E	
		Can assist briefly c (R) LE.	N	
8/4/03		Encourage deep breathing; IS	D	
			E	
			N	
8/4/03		V. Vals - Routine (q Shift)	D	
			E	
			N	
8/4/03		Diet: Clear to Reg as Tol	07	
		c Ensure - T cal Bid.	12	
			17	
8/4/03		Accu 1 Gm IVBB q8°	07	
			15	
			23	
8/4/03		(R) Hand dressing A/S Bid	08	
			20	
8/4/03		(R) Leg dressing A/S Akt to Aay Bid	09	
8AUG03		(Replace Splint/ACE Wrap)	21	
8/4/03		Cont. Cleansing Remaining LACS/	09	
		Abrasions - Thin layer Bcr. Bid	21	
8/4/03		HLIV (Flush q Shift)	D	
			E	
			N	
8/4/03		Zantac 150mg PO Bid	08	
			20	

D/C 8AUG03 0832 LS

D/C 7 Aug 03

ALLERGIES: ☐ YES ☑ NO — NKDA

PRIMARY DIAGNOSIS: Multi-Oppo Trauma. S/p washout, Skin Flap Modification c Debride

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION: (b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D 8 9 10 11 12 13 14 15
E 16 17 18 19 20 21 22 23
N 24 01 02 03 04 05 06 07

MEDCOM - 1550

USAPA V1.00

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
8/5	(b)(6)-2	Admit to FCU, PREVOST, ORTHO	8/5/03	[illegible]	1210	(b)(6)-2
		Condition Good				
(b)(6)-2 Aug 9 Aug03		~~Restart~~ (b)(6)-2 IV				
		NPO → Plan I+D Thumb @1500	9 Aug03	1500		

Mo Aug Yr 03

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED			
8/4/03	(b)(6)-2	Tylox I-II PO q4-6° PRN Pain Relief.	5AUG 1003	5AUG 1[illegible]	5AUG 1[illegible] PO	5AUG 1[illegible]
8/4/03		Motrin 800mg I PO TID PRN	(b)(6)-2			
			(b)(6)-2			

MEDCOM - 1551

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo. Aug Yr. 03

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

VERIFY BY INITIALING

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 12 13 14 15 16 17 18 19 20 21 22 23 24 25
12AUG	(b)(6)-2	Vitals q 8°	D E N	(b)(6)-2
12AUG		NWB @ LE WBAT @ LE	D E N	
12AUG		LR @ 60cc/hr	D E N	
12AUG		Ancef ÷ gram IV q 8°	03 11 19	
12AUG		Gentamycin 80mg IV q 8° x 72 hours	04 12 20	
12AUG		OOB to chair TID	D E N	written 16AUG 2237 (b)(6)-2
14AUG03		cont wet to dry dressing Δs to (R) + (L) LE Bid	10 22	
15AUG03		HL Flush	D E N	
16Aug03		Continue ensure 1-2 cans qd for supplement	10 22	

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
s/p I&D @ thumb

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
PAGE NO:

PATIENT IDENTIFICATION:
(b)(6)-2

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIM'
D 8 9 10 11 12 13 14
E 16 17 18 19 20 21
N 24 01 02 03 04 05

MEDCOM - 1552

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo AUG Yr 03
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
12AUG	(b)(6)-2	To ICU 1 Dr (b)(6)-2	12AUG	/	/	(b)(6)-2
12AUG		SGT (b)(6)-2 to see for ambulation			13AUG (b)(6)-2	
		ASSISTANCE & quad strengthening				
12AUG03		Benadryl 50mg PO X1	12AUG03	2315	Done	
15AUG		HL IV c̄ good uop/po intake	15AUG	/	/	
17AUG		NPO p̄ MN	18AUG	MN	Done	
17AUG		Surgery IN AM	18AUG	AM		
18AUG03		Ambien 10mg po (one time order only)	18AUG	0100	Done	

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED				
12AUG	(b)(6)-2	Tylox 1-2 tabs	Date 15 Aug	12 AUG 1645	12 Aug 2230	16 Aug 1910	17 AUG 2010
		po q 4-6° prn	Amt	2	2	3	3
		pain	Int I/E	2	BKT	(b)(6)-2	
12AUG		Phenegrar 25mg PO	=1730				
		q 6° Prn Nausea					

MEDCOM - 1553

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo 08 Yr. 03

VERIFY BY INITIALING — *INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION*

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 18 19 20 21 22 23 24 25 26
8/18/03	(b)(6)-2	VITALS: Routine	D	(b)(6)-2
			E	
			N	
8/18/03		ACT: BEDREST	D	
		NON WT BEARING	E	
		(B) LE (R) LE WBAT (L) LE	N	
8/18/03		DIET: CLEARS ⇒ REG	D	
		AS TOLERATED	E	
			N	
8/18/03		IVF: NS or LR @	D	(b)(6)-2 30
		100cc/hr Until Adequate	E	
		PO THEN TKO	N	
8/18/03		ANCEF Q 8° X 5 DAYS	02	
		(Iqm)	10	
			18	
8/18/03		Do NOT A dress's	D	
		on (R) HAND on (R)	E	
		LEG	N	
8/18/03		WET TO DRY DRSG	10	(b)(6)-2
		A TO (L) LE BID	22	
8/18/03		ENSURE 1-2 CANS	10	
		PO FOR SUPPLEMENTATION	22	
18 AUG		HL IV	22	
	------	no. FLUSH ashift	10	
	------		18	

ALLERGIES: ☐ YES ☒ NO — NKDA

PRIMARY DIAGNOSIS: MULTI ORTHO S/P SKIN GRAFTS

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO — PAGE NO: 1

PATIENT IDENTIFICATION: (b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D 8 9 10 11 12 13 14 15
E 16 17 18 19 20 21 22 23
N 24 01 02 03 04 05 06 07

MEDCOM - 1554

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo 08 Yr 03

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
18 AUG 03	(b)(6)-2	Admit to ICU #1 (b)(6)-2 ORTHO	8/18		1015	(b)(6)-2
18 AUG 03		Condition: Good	8/18		1015	
18 AUG 03		BENADRYL 25mg IVP NOW FOR	8/18	NOW	1112	
		DRUG REACTION LOCALIZED				
18 AUG		DEMEROL 50mg IV & PHENERGAN				
		12.5 mg SLOW IVP x 1 dose for				
		BREAKTHROUGH PAIN				

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED
8/18	(b)(6)-2	TYLOX T-II PO Q	8/18 1100 (b)(6)-2
		4-6° PRN PAIN RELIEF	(b)(6)-2 (b)(6)-2
8/18		Motrin 800mg PO	
		Q8° PRN Pain Relief	
8/18		MSO4 4mg IVP	8/18 0555
		Q1° PRN SEVERE	4mg IV
		BREAKTHROUGH	(b)(6)-2
		Pain	

MEDCOM - 1555

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)
For use of this form, see AR 40-407;
The proponent agency is the Office of The Surgeon General.

No. 8 Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 23 24 25 26 27 28 29
20 AUG	-----	Vitals – Q shift	D	/
	-----		E	/ D/C 24 Aug 03
	-----		N	(b)(6)-2
24 AUG	-----	Diet – Regular	B	/
	-----	may have food from	L	/
	-----	family – I can ensure per agreement	D	/
24 Aug	(b)(6)-2	WBAT (L) LE; Toe touch	D	/
	-----	wt bearing (R) LE	E	/
	-----		N	/
24 Aug	-----	OOB to Chair TID	D	/
	-----		E	/
	-----		N	/
	-----	Crutches for ambulation	D	/
	-----	(Sgt Hunsinger see for amb.	E	/
	-----	instruction)	N	/
24 Aug	(b)(6)-2	DSD's By MD	D	/
24 Aug		Vitals q day	D	/

ALLERGIES: ☐ YES ☐ NO — NKDA

PRIMARY DIAGNOSIS: S/P Skin grafts

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO — PAGE NO: _____

PATIENT IDENTIFICATION:

(b)(6)-4

(EPW)

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

0 8 9 10 11 12 13 14 15

1 16 17 18 19 20 21 22 23

MEDCOM - 1556 2 24 31 32 33 34 35 36 37

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON MEDICATION)

Mo 8 Yr 03

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
23 AUG	(b)(6)-2	Transfer to ICU-2 DR (b)(6)-2	/	NOTED	/	/
/		cond stable - good				
28		D/C to EPW Camp 8/29/03	8/29	ASAP		
28		Flu @ 21st CSH on 7 Sept 03 @ 0900				
		Rx Levoquin				
		WBAT (BLE		D/C		
		25% WB to LE		notes/		
		Non Wt bearing to therapy		orders.		

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED

MEDCOM - 1557

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)
For use of this form, see AR 40-407;
the proponent agency is the Office of The Surgeon General.

26 8 03

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 23 24 25 26 27 28 29
20 AUG	(b)(6)-2	IV - Heplock - flush	D	/ \
	-----	@ shift	E	/ \ D/C 24 Aug @ 0300
	-----		N	(b)(6)-2 /
24 Aug	(b)(6)-2	Levaquin 500mg po qd	10	/ (b)(6)-2

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
S/P skin grafts

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
PAGE NO: _____

PATIENT IDENTIFICATION:

(b)(6)-4

(EPW)

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES
D 8 9 10 11 12 13 14 15
E 16 17 18 19 20 21 22 23
N 24 01 02 03 04 05 06 07

MEDCOM - 1558

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON MEDICATION)				Mo 8 Yr 03
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
20 AUG	(b)(6)-2	Tylox T-II po Q4-6°	28 Aug 2035 (3)	28 Aug 2115												
		prn pain	(b)(6)-2													
20 AUG		Motrin 800mg po														
		TID prn														
20 AUG		MSO4 1-4mg IV Q2°														
		prn														
20 AUG		Phenergan 25mg IV														
		Q6°														
20 AUG		Benedryl 25mg IV														
		Q4-6° prn itching														

MEDCOM - 1559

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*
For use of this form, see AR 40-407;
the proponent agency is the Office of The Surgeon General.

Mo 08 Yr. 03

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

VERIFY BY INITIALING				DATE COMPLETED															
ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	18	19	20	21	22	23	24	25	26							
28 Aug 6	(b)(6)-2	① leg - Keep foot	n	(b)(6)-2															
		clean/dry - PT can	E																
		assist c̄ hygiene	n																

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS: MULTI ORTHO S/P skin GRAFT

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO
PAGE NO: 2

PATIENT IDENTIFICATION:
(b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

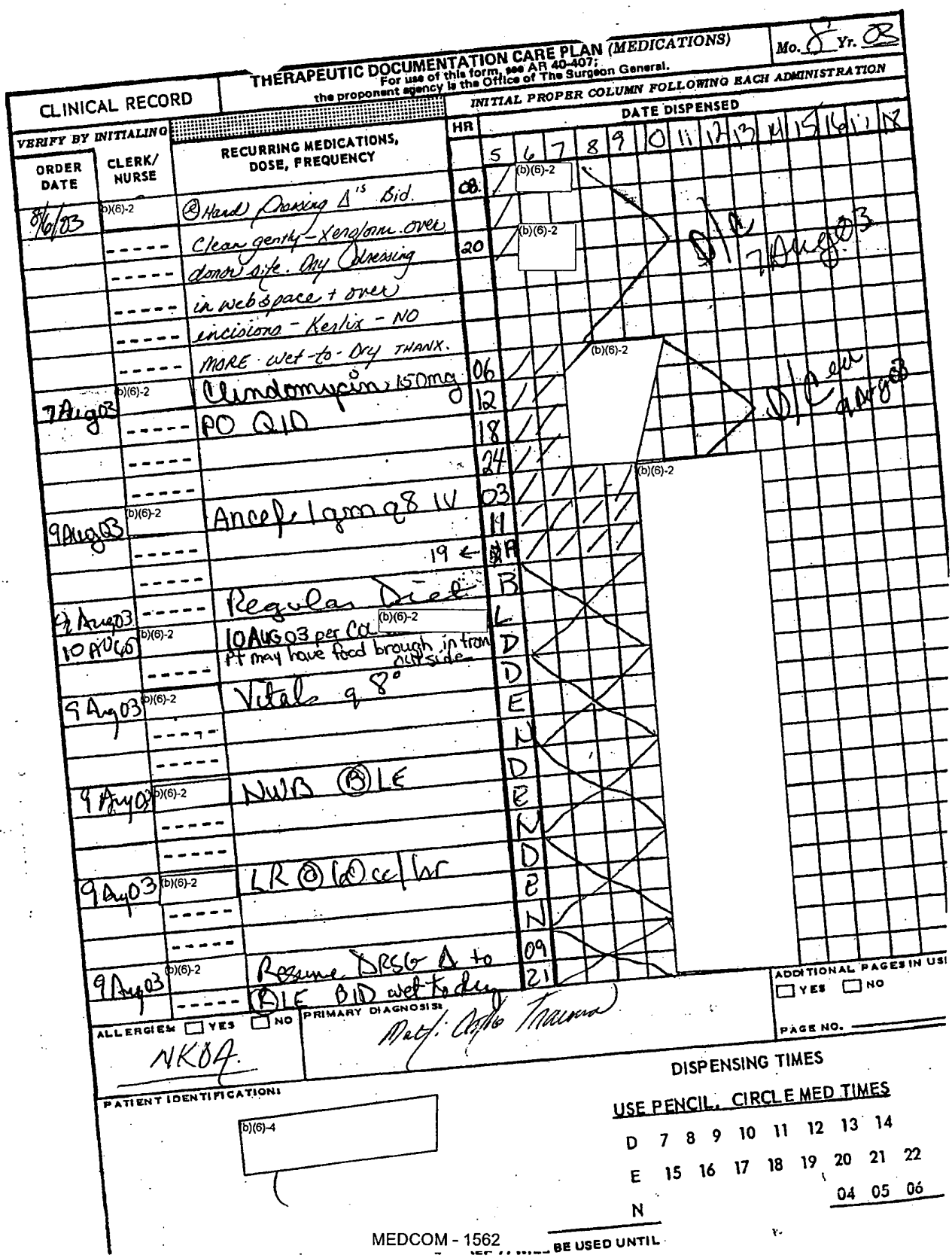
MEDCOM - 1560

USAPA V1.00

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*				Mo _____ Yr _____
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING COMPLETION* TIME/DATE COMPLETED
8/18	(b)(6)-2	PHENERGAN 25mg	
		PO Q6° PRN	
		NAUSEA	

MEDCOM - 1561



CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo. 8 Yr. 03

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

VERIFY BY INITIALING

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 5 6 7 8 9 10 11 12 13 14 15 16 17 18
8/6/03	(b)(6)-2	(R) Hand Dressing Δ's Bid.	08	(b)(6)-2
	-----	Clean gently - Xeroform over		
	-----	donor site. Dry dressing	20	(b)(6)-2
	-----	in web space + over		
	-----	incisions - Kerlix - NO		
	-----	MORE wet-to-Dry THANX.		
7Aug03	(b)(6)-2	Clindomycin 150mg	06	(b)(6)-2
	-----	PO QID	12	
	-----		18	
	-----		24	
9Aug03	(b)(6)-2	Ancef 1gm q8 IV	03	(b)(6)-2
	-----		11	
	-----	19 ←	A	
9Aug03	-----	Regular Diet	B	
10AUG03	(b)(6)-2	10AUG03 per Col (b)(6)-2	L	
	-----	Pt may have food brough in from outside	D	
9Aug03	(b)(6)-2	Vitals q 8°	D	
	-----		E	
	-----		N	
9Aug03	(b)(6)-2	NWB (B) LE	D	
	-----		E	
	-----		N	
9Aug03	(b)(6)-2	LR @ 60cc/hr	D	
	-----		E	
	-----		N	
9Aug03	(b)(6)-2	Resume DRSG Δ to	09	
	-----	(R) LE BID wet to dry	21	

D/C 7Aug03

D/C ed 9Aug03

ADDITIONAL PAGES IN USE ☐ YES ☐ NO

PAGE NO.

ALLERGIES: ☐ YES ☐ NO
NKDA.

PRIMARY DIAGNOSIS: Mat. Ortho Trauma

PATIENT IDENTIFICATION:

(b)(6)-4

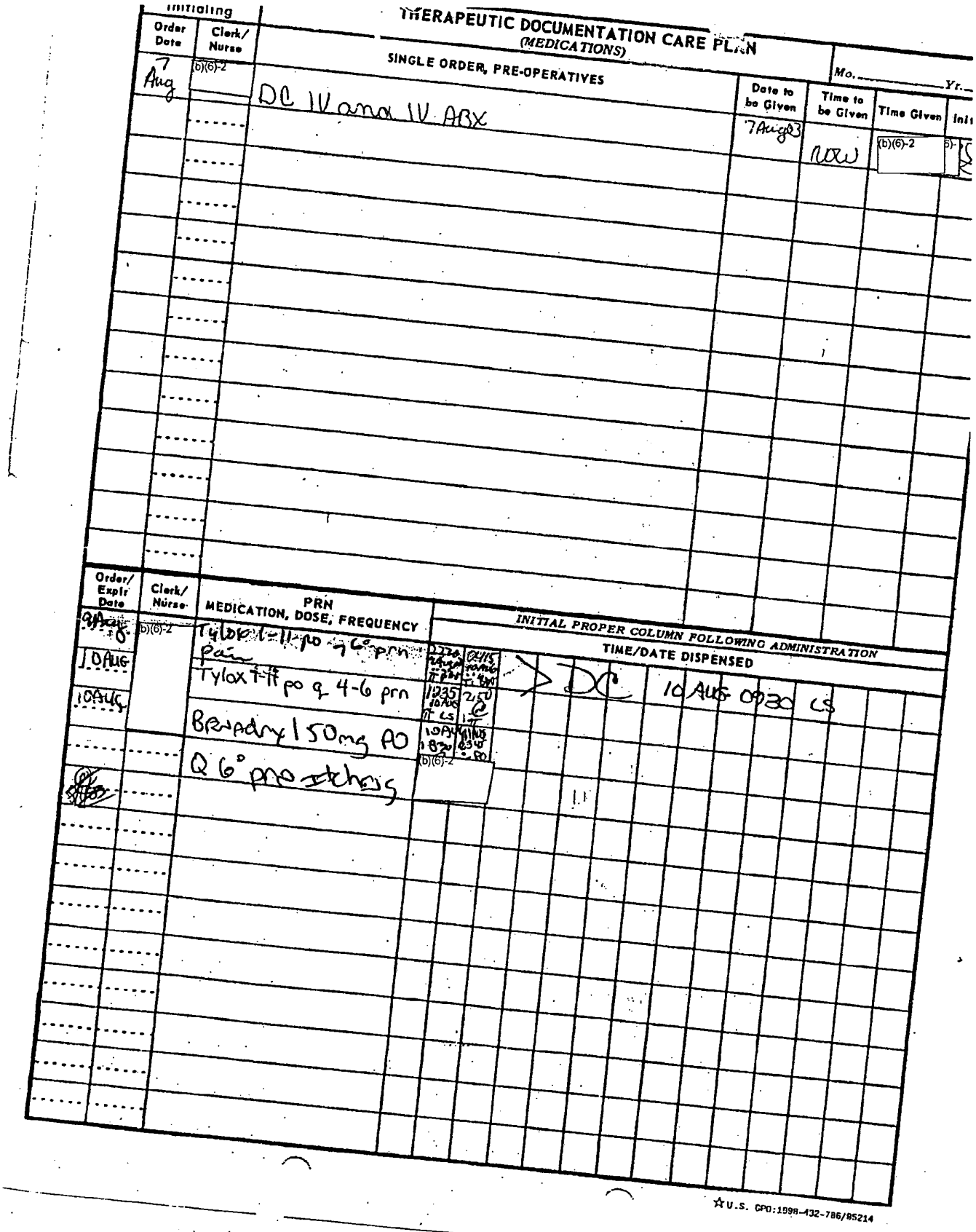
DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

D	7	8	9	10	11	12	13	14
E	15	16	17	18	19	20	21	22
N						04	05	06

MEDCOM - 1562

BE USED UNTIL



Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. Yr.

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Init
7 Aug	(b)(6)-2	DC IV and IV ABX	7Aug03	NOW	(b)(6)-2	(b)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED
8	(b)(6)-2	Tylox 1-11 po q 6° prn Pain	
10 Aug		Tylox 1-11 po q 4-6 prn	
10 Aug		Benadryl 50mg PO Q 6° pro itching	DC 10 Aug 0930 CS

☆U.S. GPO:1998-432-786/85214

MEDCOM - 1563

...CAL RECORD - MEDICATION ADMINIST... ...TION RECORD

ORDER DATE	TRANSCRIBER/ REVIEWER INITIALS	SECTION II RECURRING MEDICATIONS, DOSE, FREQUENCY	HR ↓	INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRAT. DATE ADMINISTERED 9 10 11 12 13 14 15 16 17 18 19 20 22
9Aug03	(b)(6)-2	BHAND DRSG Δ by	09	X (b)(6)-2 (b)(6)-2 NO DR
		DR (b)(6)-2 BID	21	(b)(6)-2
16AUG03		OOB to chair TID	10	✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓
			14	✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓
			18	✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-400; the proponent agency is The Office of The Surgeon General

REPORT TITLE: POST ANESTHESIA CARE UNIT FLOWSHEET

OTSG APPROVED (Date): 17 Jan 80

(b)(6)-2

PROCEDURE: washout (L) leg / (R) thumb amp ex Ex/P (L) leg

PHYSICIAN: (b)(6)-2

ANESTHESIA BY: (b)(6)-2

(Gen) Spinal MAC Axillary
Local Bier Epidural Other

ALLERGIES: Ø

AIRWAYS: ____ Time DC'D ____
ETT Nasal Oral Trach

OXYGEN:
Mask Nasal Face Blow-By
Prongs Tent
Liter/min. ____ ____ %

ASA ___ History Ø X Tobacco ohs
Cardiac Rhythm ____
IV#1 ____ Patent Infiltrated
Site ____ Rate ____ Gauge ____
IV#2 ____ Patent Infiltrated
Site ____ Rate ____ Gauge ____

VITAL SIGNS						PAR SCORE						OTHER	
Time	B/P	P	R	O2SA	Temp	Act	Resp	Circ	LOC	Skin	PARS	COMMENTS	Neuro-Vascular
PRE-OP	/												Extr: L R Upper Lower; Pulse DP PT RAD; Blanche Warm Pulse Moves Y N
PRE-OP	177/94	74											
2225	131 MD	126	28	98	98.3 ax	1	2	2	1	0	6	Ø Face Mask	
2230	121/77	114	25	94	98.0 ax							2l NC	
2235	141/79	108	28	99								2l	
2240	139/79	112	22	95%	95 ax	2	2	2	1	2	9	1L	
2300	121/57	69	12	99									
2315	124/63	75	12	95									
Refer to ICU Flowsheet for further info.													
	/												
	/												
	/												
	/												
	/												

POST ANESTHESIA RECOVERY SCORE "PARS"

Activity - General Anesthesia
2--Maintain head lift and open eyes
1--Unable to maintain head lift and open eyes
0--Unable to lift head and open eyes

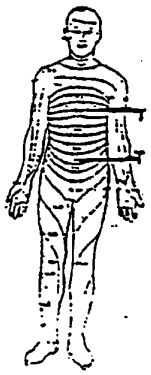
Activity - SAB or Subarachnoid Block
2--Moves all four extremities with control
1--Moves both upper extremities

Respirations
2--Spontaneous respiration; needs no support
1--Limited effort; needs artificial airway or jaw support
0--Needs ventilator; no spontaneous respiration

Circulation
2--BP 20% preanesthetic level
1--BP ~~20~~ - 50% preanesthetic level
0--BP 50% or more preanesthetic level

Level of Consciousness
2--Awake and alert; seldom dozes
1--Awakens when gently stimulated
0--Awakens only when vigorously stimulated

Skin
2--Normal skin color & temperature greater than 96°
1--Skin is pale, blotchy, dusky &/or temperature 95 - 96°
0--Cyanotic &/or temperature less than 95°



DRESSING: Status Location

Gauze		
Opsite		
Bandaid		
Steri-strips		
Collodian		
Peri-pad		
Coban		
Cotton Balls		
Ace Wrap		

TUBES AND DRAINS: Hemovac Foley NGT Chest Jackson-Pratt

(Continue on reverse)

(b)(6)-2

DEPARTMENT/SERVICE/CLINIC: PACU/ICU

DATE: 26JU/03

IDENTIFICATION (For typed or written entries give: Name-last, first, middle; grade; date; hospital or medical facility)

(b)(6)-2

22 y.o.

☐ HISTORY/PHYSICAL ☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)
☐ DIAGNOSTICS STUDIES
☐ TREATMENT

DA FORM 1 MAY 78 4700 MEDCOM - 1565 4 OP 132-11a (Rev)

LEX FIX
(R) shoulder

2 ma versed
250 = ent
20 MSO4
during case

2 gms Ancef 2000
Gent 2020

INTAKE			OUTPUT		
TIME	TYPE	AMT	TIME	TYPE	AMT
OR	1300 RL		OR	EBL	100
			OR	Urine	Ø
TOTAL			TOTAL		

PACU NURSING NOTES: NURSING CARE PROBLEM NO.'S IDENTIFIED. Refer to FH MDA OP 39

NURSING CARE PROBLEMS: 1. RESP; 2. CIRC; 3. ACT; 4. LOC; 5. TEMP; 6. PAIN; 7. SAFETY; 8. ANXIETY; 9. EDUC; 10. OTHER

1045 - PT arrived to PACU 1025 - turning in bed, crying - mult lacerations covering most of body
Face - 3 lacerations on chin - d2 2l NC sats 94%
(L) arm - open wound on shoulder, IV (L) FA
5 s/s of infection or infiltration - LR ± 00 KCl @ 100cc
mult. laceration (L) ~~arm~~ hand - major wound middle fing
(R) arm: shoulder ~~dra~~ dressing CDI, 2 lacerations near elbow, wrist/arm - dressings CDI
abd: abrasions - old - healing well
(L) leg: mult small lacerations on thigh, ace wrap to entire lower 1/2 of (L) leg - CDI - able to wiggle toes - good cap refill
(R) leg: mult. small healing laceration on thigh, ex fix on lower 1/2 extremity - dressing CDI, good cap refill - able to wiggle toes

Refer to critical care Flow sheet for more details

MEDICATION GIVEN BY: (b)(6)-2

MEDICATION RECEIVED IN PACU/ICU (b)(6)-2

DRUG	DOSE	ROUTE	TIME	PAIN LEVEL	EFFECTIVENESS
~~5~~ MSO4	5 mg	IV	1025		
MSO4	5 mg	IV	1030		
MSO4	5 mg	IV	1040		
MSO4	5 mg	IV	1055		
Tylox	2	PO	2315		

DISPOSITION SUMMARY: Nursing Care Problems No.'s _____ Resolved; No.'s _____ Continue.
Patient was transferred from PACU/ICU recovery room via litter/crib with siderails raised, or held by parent in wheelchair.
Dressing status: _____
Report given to _____ MEDCOM - 1566 ore _____ Safety Straps _____
Time out _____ ... sheet released by Anesthesia

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-400; the proponent agency is The Office of The Surgeon General

REPORT TITLE: POST ANESTHESIA CARE UNIT FLOWSHEET

OTSG APPROVED (Date): 17 Jan 80

nilles
ndon
epair

PROCEDURE: (R) Tibia Ex-fix, I+D LE
(R) Hand tendon repair, I+D (R) Hand & Shoulder
PHYSICIAN: (b)(6)-2
ANESTHESIA BY: (b)(6)-2
(Gen) Spinal MAC Axillary
Local Bier Epidural Other

ALLERGIES: NKDA
AIRWAYS: _____ Time DC'D _____
ETT Nasal Oral Trach
OXYGEN:
Mask (Nasal) Face Blow-By
Prongs Tent
Liter/min. 6 %

ASA ___ History _____
Cardiac Rhythm _____
IV#1 (L) FA (Patent) cc/hr Infiltrated
Site _____ Rate 100 Gauge 18g
IV#2 _____ Patent LR Infiltrated
Site _____ Rate _____ Gauge _____

Time	B/P	P	R	O2SA	Temp	Act	Resp	Circ	LOC	Skin	PARS	COMMENTS	Neuro-Vascular
PRE-OP	/												Extr: L R Upper Lower Pulse DP PT RAD
PRE-OP	112/59	92	21	100%	99.3 O								Blanche Pulse Warm Moves Y N
1135	132/68	118	25	100%	94.3 AX	2	2	2	1	1	8	Received from OR	Blanche Pulse Warm Moves Y N
1140	143/94	107	32	100%	94.5 AX	2	2	2	1	1	8	6L NC	Blanche Pulse Warm Moves Y N
1145	135/79	121	24	99%	95.4 AX	2	2	2	2	1	9		Blanche Pulse Warm Moves Y N
1200	136/75	115	22	98%	97.2 AX	2	2	2	2	2	10		Blanche Pulse Warm Moves Y N
1215	143/63	98	23	97%	97.8 AX	2	2	2	2	2	10	3L NC Sat 97%	Blanche Pulse Warm Moves Y N
1230	141/60	95	21	97%	98.6 O	2	2	2	2	2	10	Pt recoverd, Kept	Blanche Pulse Warm Moves Y N
	/											on ICU#1	Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N

POST ANESTHESIA RECOVERY SCORE "PARS"

Activity - General Anesthesia
2--Maintain head lift and open eyes
1--Unable to maintain head lift and open eyes
0--Unable to lift head and open eyes

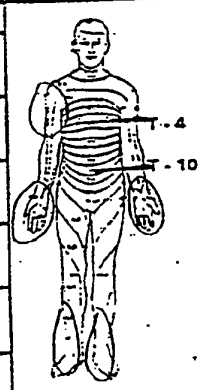
Activity - SAB or Subarachnoid Block
2--Moves all four extremities with control
1--Moves both upper extremities

Respirations
2--Spontaneous respiration; needs no support
1--Limited effort; needs artificial airway or jaw support
0--Needs ventilator; no spontaneous respiration

Circulation
2--BP 20% preanesthetic level
1--BP ~~20~~ - 50% preanesthetic level
0--BP 50% or more preanesthetic level

Level of Consciousness
2--Awake and alert; seldom dozes
1--Awakens when gently stimulated
0--Awakens only when vigorously stimulated

Skin
2--Normal skin color & temperature greater than 96°
1--Skin is pale, blotchy, dusky &/or temperature 95 - 96°
0--Cyanotic &/or temperature less than 95°



DRESSING:	Status	Location
Gauze	(R) Hand gauze has small amount	
Opsite	of bloody drainage	
Bandaid	(L) Hand C, D, & I dressing	
Steri-strips	Both lower extremities	
Collodian	have ace wraps, (R) LE	
Peri-pad	has ex-fixator	
Coban		
Cotton Balls		
Ace Wrap		

TUBES AND DRAINS: Hemovac Foley NGT Chest Jackson-Pratt

(Continue on reverse)

PREPARED BY (Signature & Title): (b)(6)-2 9/WM6

DEPARTMENT/SERVICE/CLINIC: ICU#1

DATE: 28 JUL 03

PATIENT'S IDENTIFICATION ... entries give: Name--last, first, middle; grade; date; hospital or medical facility)

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)
☐ DIAGNOSTICS STUDIES
☐ TREATMENT

DA FORM 1 MAY 78 4700

FH MDA OP 132-11a (Rev)
1 Sep 99

MEDCOM - 1567

INTAKE			OUTPUT		
TIME	TYPE	AMT	TIME	TYPE	AMT
OR	1800 LR		OR	EBL	Minimal
	LR	200	OR	Urine	none
TOTAL		2000	TOTAL		

PACU NURSING NOTES: NURSING CARE PROBLEM NO.'S IDENTIFIED. Refer to FH MDA OP 39

NURSING CARE PROBLEMS: 1. RESP; 2. CIRC; 3. ACT; 4. LOC; 5. TEMP; 6. PAIN; 7. SAFETY; 8. ANXIETY; 9. EDUC; 10. OTHER

Received pt from OR via liter @ 1135. Pt complaining of pain and positioning of RLE. Pain medication administered as ordered. O_2 @ 6L NC, changed to 3L (See front). Pt had x-ray of RLE. Pt IV site in LFA infitrated, anesthesia replaced a new line in (L) FA, which infiltrated as well. Anesthesia placed another line which has remained patent, LR at 100 cc/hr. Pt has ace bandages wrapped around both lower extremities, C, D, + I. RLE has external fixator. L+R Hands have gauze and ace wraps, a small amount of drainage on (R) Hand gauze. (R) Shoulder also has ace wrap, C, D + I. Pt recovered to ward (ICU #1).

SPC (b)(6)-2 [redacted] 1WM6

Pt VSS. Pain Controlled. No Δ's [redacted] assessment Concur c above

(b)(6)-2 [redacted] ICT, A

MEDICATION GIVEN BY: (b)(6)-2 [redacted]

MEDICATION RECEIV[redacted]

	DRUG	DOS[redacted]	ROUTE	TIME	PAIN LEVEL	EFFECTIVENESS
	Fentanyl	25 ~~mg~~ ug	IV	1140		(−)
ICT	Fentanyl	25 ug	IV	1143		(−)
ICT	MSO4	5 mg	IV	1200		(−)
ICT	MSO4	5 mg	IV	1210		(−)
ICT	MSO4	5 mg	IV	1220		(−)
	MSO4	5 mg	IV	1238		(+)

DISPOSITION SUMMARY: Nursing Care Problems No.'s _____ Resolved; No.'s _____ Continue.
Patient was transferred from PACU/ICU recovery room via litter/crib with siderails raised, or held by parent in wheelchair.
Dressing status: CD&I
Report given to N/A PAR Score 10 Safety Straps N/A
Time out N/A Nurses Signature MEDCOM - 1568 [redacted] (b)(6)-2

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-400; the proponent agency is The Office of The Surgeon General

OTSG APPROVED (Date): 17 Jan 80

REPORT TITLE: POST ANESTHESIA CARE UNIT FLOWSHEET

PROCEDURE: LE washout, bone graft, (R) Hand washout, LE washout

PHYSICIAN: (b)(6)-2

ANESTHESIA: (Gen) Spinal MAC Axillary Local Bier Epidural Other

ALLERGIES: NKDA

AIRWAYS: Time DC'D

ETT Nasal Oral Trach

OXYGEN: RA

Mask Nasal Face Blow-By Prongs Tent

Liter/min. %

ASA History

Cardiac Rhythm

IV#1 (L) FA Patent Infiltrated

Site Rate 50 cc/hr Gauge 18 g

IV#2 Patent Infiltrated

Site Rate Gauge

Time	B/P	P	R	O2SA	Temp	Act	Resp	Circ	LOC	Skin	PARS	COMMENTS	Neuro-Vascular
PRE-OP	/												Extr: L R Upper Lower Pulse DP PT RAD
PRE-OP	118/63	89	16	99%	99°								Blanche Warm Pulse Moves Y N
1157	123/67	129	23	97%	97.1°	2	2	2	1	2	9	RA Received from OR	Blanche Warm Pulse Moves Y N
1202	113/54	116	19	93%	97.4°	2	2	2	1	2	9	All extremities X4	Blanche Warm Pulse normal Moves (Y) N
1207	118/62	135	29	94%	97.4°	2	2	2	2	2	10		Blanche Warm Pulse Moves Y N
1222	115/55	131	39	95%		2	2	2	2	2	10		Blanche Warm Pulse Moves Y N
1237	103/51	133	29	100%		2	2	2	2	2	10		Blanche Warm Pulse Moves Y N
1252	119/60	108	13	99%	98°	2	2	2	2	2	10	Recovered \ stay ICU #1	Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N

POST ANESTHESIA RECOVERY SCORE "PARS"

Activity - General Anesthesia
2—Maintain head lift and open eyes
1—Unable to maintain head lift and open eyes
0—Unable to lift head and open eyes

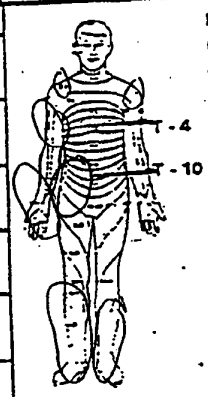
Activity - SAB or Subarachnoid Block
2—Moves all four extremities with control
1—Moves both upper extremities

Respirations
2—Spontaneous respiration; needs no support
1—Limited effort; needs artificial airway or jaw support
0—Needs ventilator; no spontaneous respiration

Circulation
2—BP 20% preanesthetic level
1—BP ~~20~~ - 50% preanesthetic level
0—BP 50% or more preanesthetic level

Level of Consciousness
2—Awake and alert; seldom dozes
1—Awakens when gently stimulated
0—Awakens only when vigorously stimulated

Skin
2—Normal skin color & temperature greater than 96°
1—Skin is pale, blotchy, dusky &/or temperature 95 - 96°
0—Cyanotic &/or temperature less than 95°



DRESSING:	Status	Location
Gauze	C, D, & I	LE
Opsite	C, D, & I	(L) shoulder
Bandaid	LS (R) Sh C, D, I	(R) shoulder
Steri-strips	C, D, + I	(R) upper arm
Collodian	C, D, + I	(R) forearm and hand
Peri-pad	C, D + I	(R) LE
Coban	C, D, & I	(R) Abdomen
Cotton Balls		
Ace Wrap		

TUBES AND DRAINS: Hemovac Foley NGT Chest Jackson-Pratt

(Continue on reverse)

PREPARED BY (Sig) SPC (b)(6)-2

DEPARTMENT/SERVICE/CLINIC: ICU #1

DATE: 30 JUL 03

PATIENT'S IDENTIF... written entries give: Name—last, first, middle; grade; date; hospital or medical facility)

Iraqi (b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTICS STUDIES

☐ TREATMENT

DA FORM 1 MAY 78 4700

FH MDA OP 132-11a (Rev) Sep 99

MEDCOM - 1569

INTAKE			OUTPUT		
TIME	TYPE	AMT	TIME	TYPE	AMT
OR	800 cc LR	800	OR	EBL 100 cc	100cc
			OR	Urine no urine	0
TOTAL		800	TOTAL		100cc

PACU NURSING NOTES: NURSING CARE PROBLEM NO.'S IDENTIFIED. Refer to FH MDA OP 39

NURSING CARE PROBLEMS: 1. RESP; 2. CIRC; 3. ACT; 4. LOC; 5. TEMP; 6. PAIN; 7. SAFETY; 8. ANXIETY; 9. EDUC; 10. OTHER

Received pt @ 1157 from OR via litter. Pt bandages and dressings all intact (see front). Pt complaining from pain from (R) Abdomen graft. Pt given Tylox as ordered. Pt sats 97% on RA. Pt able to move all fingers and toes. IV NS infusing @ 50cc/hr to (D)FA 18g, patent and (D) sign of infection or infiltration. Pt recovered, to stay on ward.

SPC (b)(6)-2

1200. Pt A&Ox3. VSS. Moves all extremities. Cap refill < 3 secs. Dx56 CD&I. External fixation + splint to RLE CD&I

(b)(6)-2

MEDICATION RECEIVED IN PACU/ICU

MEDICATION GIVEN BY:	DRUG	DOSE	ROUTE	TIME	PAIN LEVEL	EFFECTIVENESS
SRC (b)(6)-2	Tylox	2 tabs	PO	1225		

DISPOSITION SUMMARY: Nursing Care Problems No.'s _____ Resolved; No.'s _____ Continue.
Patient was transferred from PACU/ICU recovery room via litter/crib with siderails raised, or held by parent in wheelchair.
Dressing status: CD&I PAR Score 10 Safety Straps X
Report given to N/A released by Anesthesia (b)(6)-2
Time out 1152. Nurse Signature (b)(6)-2

MEDCOM - 1570

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-400; the proponent agency is The Office of The Surgeon General

REPORT TITLE: POST ANESTHESIA CARE UNIT FLOWSHEET

OTSG APPROVED (Date): 17 Jan 80

PROCEDURE: Debridement / Closure

PHYSICIAN: (b)(6)-2

ANESTHESIA BY: (b)(6)-2

(Gen) Spinal MAC Axillary
Local Bier Epidural Other

ALLERGIES: NKDA
AIRWAYS: Time DC'D
ETT Nasal Oral... Trach
OXYGEN:
Mask Nasal Face Blow-By
Prongs Tent
Liter/min. RA %

ASA II History Smoke
Cardiac Rhythm SR
IV#1 ✓ Patent Infiltrated
Site (A) ASM Rate TKO Gauge 18
IV#2 Patent Infiltrated
Site Rate Gauge

VITAL SIGNS / PAR SCORE / OTHER

Time	B/P	P	R	O2SA	Temp	Act	Resp	Circ	LOC	Skin	PARS	COMMENTS	Neuro-Vascular
PRE-OP	/												Extr: L R Upper Lower: Pulse DP PT RAD; Blanche Warm; Pulse Moves Y N
PRE-OP	/												Blanche Warm; Pulse Moves Y N
1210	134/78	95	15	96%	97.5	2	2	2	1	2	9	R.L.	Blanche Warm; Pulse Moves Y N
1215	132/80	91	15	95%		2	2	2	1	2	9		Blanche Warm; Pulse Moves Y N
1220	128/68	104	16	96%	98.5	2	2	2	1	2	9		Blanche Warm; Pulse Moves Y N
1225	136/85	95	15	95%		2	2	2	1	2	9		Blanche Warm; Pulse Moves Y N
1240	114/62	88	13	96%	98.5	2	2	2	1	2	9	Tx - Skin Care	Blanche Warm; Pulse Moves Y N
	/												Blanche Warm; Pulse Moves Y N
	/												Blanche Warm; Pulse Moves Y N
	/												Blanche Warm; Pulse Moves Y N
	/												Blanche Warm; Pulse Moves Y N
	/												Blanche Warm; Pulse Moves Y N
	/												Blanche Warm; Pulse Moves Y N
	/												Blanche Warm; Pulse Moves Y N

POST ANESTHESIA RECOVERY SCORE "PARS"

Activity - General Anesthesia
2–Maintain head lift and open eyes
1–Unable to maintain head lift and open eyes
0–Unable to lift head and open eyes

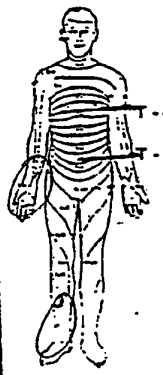
Activity - SAB or Subarachnoid Block
2–Moves all four extremities with control
1–Moves both upper extremities

Respirations
2–Spontaneous respiration; needs no support
1–Limited effort; needs artificial airway or jaw support
0–Needs ventilator; no spontaneous respiration

Circulation
2–BP 20% preanesthetic level
1–BP ~~20~~ - 50% preanesthetic level
0–BP 50% or more preanesthetic level

Level of Consciousness
2–Awake and alert; seldom dozes
1–Awakens when gently stimulated
0–Awakens only when vigorously stimulated

Skin
2–Normal skin color & temperature greater than 96°
1–Skin is pale, blotchy, dusky &/or temperature 95 - 96°
0–Cyanotic &/or temperature less than 95°



DRESSING:	Status	Location
Gauze	C/D/I	(R) IV EXT.
Opsite		
Bandaid		
Steri-strips		
Collodion		
Peri-pad		
Coban		
Cotton Balls		
Ace Wrap		

TUBES AND DRAINS: Hemovac Chest Foley Jackson-Pratt NGT

(Continue on reverse)

PREPARED BY (Signature & Title): (b)(6)-2 LPN

DEPARTMENT/SERVICE/CLINIC: ICU #1

DATE: 5 Aug 03

PATIENT'S IDENTIFICATION (If typed or written entries give: Name-last, first, middle; grade; date; hospital or medical facility)

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)
☐ DIAGNOSTICS STUDIES
☐ TREATMENT

FORM MAY 78 4700

FH MDA OP 132-11a (Rev) Sep 99

MEDCOM - 1571

INTAKE			OUTPUT		
TIME	TYPE	AMT	TIME	TYPE	AMT
OR	LR	900	OR	EBL	/
			OR	Urine	/
TOTAL			TOTAL		/

PACU NURSING NOTES: NURSING CARE PROBLEM NO.'S IDENTIFIED. Refer to FH MDA OP 39

NURSING CARE PROBLEMS: 1. RESP; 2. CIRC; 3. ACT; 4. LOC; 5. TEMP; 6. PAIN; 7. SAFETY; 8. ANXIETY; 9. EDUC; 10. OTHER

Rcd from OR via gurney - see icu Pt. flowsheet for further assessment. (b)(6)-2 [redacted] UN.

MEDICATION GIVEN BY:

MEDICATION RECEIVED IN PACU/ICU

DRUG	DOSE	ROUTE	TIME	PAIN LEVEL	EFFECTIVENESS

DISPOSITION SUMMARY: Nursing Care Problems No.'s_____ Resolved; No.'s_____ Continue.
Patient was transferred from PACU/ICU recovery room via litter/crib with siderails raised, or held by parent in wheelchair.
Dressing status: N/A ~ icu #1 Recovery PAR Score_____ Safety Straps_____
Report given to_____
Time out_____. Nu[illegible] Si[illegible] MEDCOM - 1572 [illegible]nesthesia_____

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-400; the proponent agency is The Office of The Surgeon General

REPORT TITLE: POST ANESTHESIA CARE UNIT FLOWSHEET

OTSG APPROVED (Date): 17 Jan 80

PROCEDURE: S/P WASHOUT

PHYSICIAN: (b)(6)-2

ANESTHESIA BY: (b)(6)-2

(Gen) Spinal MAC Axillary
Local Bier Epidural Other

ALLERGIES: NKDA

AIRWAYS: _____ Time DC'D _____

ETT Nasal Oral Trach

OXYGEN:

Mask Nasal Face Blow-By
Prongs Tent

Liter/min. _____ %

ASA ___ History _____

Cardiac Rhythm _____

IV#1 _____ Patent Infiltrated
Site L (H) ARM. Rate ____ Gauge ____

IV#2 _____ Patent Infiltrated
Site _____ Rate ____ Gauge ____

VITAL SIGNS						PAR SCORE						OTHER	
Time	B/P	P	R	O2SA	Temp	Act	Resp	Circ	LOC	Skin	PARS	COMMENTS	Neuro-Vascular
PRE-OP	/												Extr: L R Upper Lower: Pulse DP PT RAC
PRE-OP	115/60	100											Blanche Pulse Warm Moves Y N
1545	107/76	89	17	98%	97.7 (A)	1	2	2	1	2	8	R/U -> OR.	Blanche Pulse Warm Moves Y N
1550	119/68	89	19	98%		1	2	2	1	2	8		Blanche Pulse Warm Moves Y N
1555	131/69	94	16	98%		2	2	2	1	2	9		Blanche Pulse Warm Moves Y N
1610	123/71	84	15	99%		2	2	2	1	2	9	4mg MSO4 @	Blanche Pulse Warm Moves Y N
1625	124/66	86	13	96%	98.3 (O)	2	2	2	2	2	10	4mg MSO4 - @	Blanche Pulse Warm Moves Y N
1640	135/61	84	16	99%	-	2	2	2	2	2	10		Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N

POST ANESTHESIA RECOVERY SCORE "PARS"

Activity - General Anesthesia
2--Maintain head lift and open eyes
1--Unable to maintain head lift and open eyes
0--Unable to lift head and open eyes

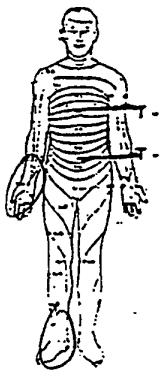
Activity - SAB or Subarachnoid Block
2--Moves all four extremities with control
1--Moves both upper extremities

Respirations
2--Spontaneous respiration; needs no support
1--Limited effort; needs artificial airway or jaw support
0--Needs ventilator; no spontaneous respiration

Circulation
2--BP 20% preanesthetic level
1--BP ~~20~~ - 50% preanesthetic level
0--BP 50% or more preanesthetic level

Level of Consciousness
2--Awake and alert; seldom dozes
1--Awakens when gently stimulated
0--Awakens only when vigorously stimulated

Skin
2--Normal skin color & temperature greater than 96°
1--Skin is pale, blotchy, dusky &/or temperature 95 - 96°
0--Cyanotic &/or temperature less than 95°



DRESSING: Status / Location

	Status	Location
Gauze	C/D/I	(R) 7th EXT.
Opsite		
Bandaid		
Steri-strips		
Collodian		
Peri-pad		
Coban		
Cotton Balls		
Ace Wrap		

TUBES AND DRAINS: Hemovac Foley NGT Chest Jackson-Pratt

(Continue on reverse)

PREPARED BY (Signature & Title): (b)(6)-2 LPN.

DEPARTMENT/SERVICE/CLINIC: ICU #1

DATE: 12 Aug 03

PATIENT'S (If typed or written entries give: Name--last, first, middle; grade; date; hospital or medical facility)

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)
☐ DIAGNOSTICS STUDIES
☐ TREATMENT

DA FORM 1 MAY 78 4700

(b)(6)-2

MEDCOM - 1573

FH MDA OP 132-11a (Rev)

9

INTAKE			OUTPUT		
TIME	TYPE	AMT	TIME	TYPE	AMT
OR	LR	400	OR	EBL	—
			OR	Urine	—
TOTAL			TOTAL		

PACU NURSING NOTES: NURSING CARE PROBLEM NO.'S IDENTIFIED. Refer to FH MDA OP 39

NURSING CARE PROBLEMS: 1. RESP; 2. CIRC; 3. ACT; 4. LOC; 5. TEMP; 6. PAIN; 7. SAFETY; 8. ANXIETY; 9. EDUC; 10. OTHER

MEDICATION GIVEN BY:

(b)(6)-2

MEDICATION RECEIVED IN PACU/ICU

DRUG	DOSE	ROUTE	TIME	PAIN LEVEL	EFFECTIVENESS
MSO4	4mg	IV	1608		
MSO4	4mg	IV	1631		

DISPOSITION SUMMARY: Nursing Care Problems No.'s_____ Resolved; No.'s_____ Continue.
Patient was transferred from PACU/ICU recovery room via litter/crib with siderails raised, or held by parent in wheelchair.
Dressing status: N/A Recovered to Unit.
Report given to_____ PAR Score_____ Safety Straps_____
Time out_____ Nurse Si MEDCOM - 1574 Anesthesia_____

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-400; the proponent agency is The Office of The Surgeon General

REPORT TITLE: POST ANESTHESIA CARE UNIT FLOWSHEET

OTSG APPROVED (Date): 17 Jan 80

PROCEDURE: Debride wound

PHYSICIAN: (b)(6)-2

ANESTHESIA BY:

(Gen) Spinal MAC Axillary
Local Bier Epidural Other

ALLERGIES:

AIRWAYS: Time DC'D

ETT Nasal Oral Trach

OXYGEN:

Mask Nasal Face Blow-By
Prongs Tent

Liter/min. %

ASA History

Cardiac Rhythm

IV#1 1/100 Patent Infiltrated
Site (L) AC Rate Gauge

IV#2 Patent Infiltrated
Site Rate Gauge

Time	VITAL SIGNS B/P	P	R	O2SA	Temp	PAR SCORE Act	Resp	Circ	LOC	Skin	PARS	COMMENTS	OTHER Neuro-Vascular
1627 PO STOP	~~PRE-OP~~ 123/67	110	20	94	98.5								Exp: L R Upper Lower; Pulse DP PT RAC; Blanche Pulse; Warm Moves Y N
1627	~~PRE-OP~~ 115/63	105	24	94									Blanche Pulse; Warm Moves Y N
1632	122/64	106	20	92									Blanche Pulse; Warm Moves Y N
1637	128/63	109	20	93									Blanche Pulse; Warm Moves Y N
1642	129/62	110	24	92									Blanche Pulse; Warm Moves Y N
1647	115/66	117	20	95									Blanche Pulse; Warm Moves Y N
1702	122/64	110	20	94									Blanche Pulse; Warm Moves Y N
1707	/												Blanche Pulse; Warm Moves Y N
	/												Blanche Pulse; Warm Moves Y N
	/												Blanche Pulse; Warm Moves Y N
	/												Blanche Pulse; Warm Moves Y N
	/												Blanche Pulse; Warm Moves Y N
	/												Blanche Pulse; Warm Moves Y N
	/												Blanche Pulse; Warm Moves Y N

POST ANESTHESIA RECOVERY SCORE "PARS"

Activity - General Anesthesia
2--Maintain head lift and open eyes
1--Unable to maintain head lift and open eyes
0--Unable to lift head and open eyes

Activity - SAB or Subarachnoid Block
2--Moves all four extremities with control
1--Moves both upper extremities

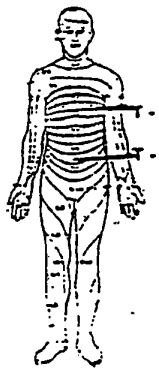
Respirations
2--Spontaneous respiration: needs no support
1--Limited effort: needs artificial airway or jaw support
0--Needs ventilator: no spontaneous respiration

Circulation
2--BP 20% preanesthetic level
1--BP ~~20~~ - 50% preanesthetic level
0--BP 50% or more preanesthetic level

Level of Consciousness
2--Awake and alert; seldom dozes
1--Awakens when gently stimulated
0--Awakens only when vigorously stimulated

Skin
2--Normal skin color & temperature greater than 96°
1--Skin is pale, blotchy, dusky &/or temperature 95 - 96°
0--Cyanotic &/or temperature less than 95°

PREPARED BY (Signature & Title)



DRESSING:	Status	Location
Gauze		
Opsite		
Bandaid		
Steri-strips		
Collodian		
Peri-pad		
Coban		
Cotton Balls		
Ace Wrap		

TUBES AND DRAINS: Hemovac Foley NGT Chest Jackson-Pratt

(Continue on reverse)

DEPARTMENT/SERVICE/CLINIC

DATE: 12 Aug 03

PATIENT'S IDENTIFICATION (For typed or written entries give: Name--last, first, middle; grade; date; hospital or medical facility)

(b)(6)-4

- ☐ HISTORY/PHYSICAL
- ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER (Specify)
- ☐ DIAGNOSTICS STUDIES
- ☐ TREATMENT

DA FORM 1 MAY 78 4700

FH MDA OP 132-11a (Rev) 1 Sep 99

MEDCOM - 1575

INTAKE			OUTPUT		
TIME	TYPE	AMT	TIME	TYPE	AMT
OR			OR	EBL	
			OR	Urine	
TOTAL			TOTAL		

PACU NURSING NOTES: NURSING CARE PROBLEM NO.'S IDENTIFIED. Refer to FH MDA OP 39

NURSING CARE PROBLEMS: 1. RESP; 2. CIRC; 3. ACT; 4. LOC; 5. TEMP; 6. PAIN; 7. SAFETY; 8. ANXIETY; 9. EDUC; 10. OTHER

1620 Assumed care of pt fm OR. 20g to ⓓ FH. NS@KVO
keeping arousable to physical stimuli. (b)(6)-2
1645 Pt awakens to verbal stimuli
1700 Pt transferred to ICU care. Will follow via progress
notes. (b)(6)-2

MEDICATION GIVEN BY:	MEDICATION RECEIVED IN PACU/ICU DRUG	DOSE	ROUTE	TIME	PAIN LEVEL	EFFECTIVENESS

DISPOSITION SUMMARY: Nursing Care Problems No.'s _____ Resolved; No.'s _____ Continue.
Patient was transferred from PACU/ICU recovery room via litter/crib with siderails raised, or held by parent in wheelchair.
Dressing status: _____
Report given to _____ PAR Score _____ Safety Straps _____
Time out _____ Nurse Signature _____ MEDCOM - 1576 Anesthesia _____ _____

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-400; the proponent agency is The Office of The Surgeon General

REPORT TITLE

POST ANESTHESIA CARE UNIT FLOWSHEET

OTSG APPROVED (Date) 17 Jan 80

PROCEDURE: Skin graft x 2

PHYSICIAN: (b)(6)-2

ANESTHESIA BY: (b)(6)-2

(Gen) Spinal MAC Axillary Local Bier Epidural Other

ALLERGIES: NKDA

AIRWAYS: — Time DC'D —

ETT Nasal Oral Trach

OXYGEN: RA

Mask Nasal Face Blow-By Prongs Tent

Liter/min. NA %

ASA 2 History

Cardiac Rhythm NSR

IV#1 (L) Hand (Patent) Infiltrated

Site (L) Hand Rate 100 cc/hr Gauge 18 g

IV#2 Patent Infiltrated

Site Rate Gauge

Time	B/P	P	R	O2SA	Temp	Act	Resp	Circ	LOC	Skin	PARS	COMMENTS	Neuro-Vascular
PRE-OP	/												Extr: L R Upper Lower Pulse DP PT RAD
PRE-OP	141/62	78											Blanche Warm Pulse normal Moves (Y) N
1045	101/65	100	19	98%	94.3 AX	1	2	2	0	1	6	Received pt from OR	Blanche Warm Pulse normal Moves (Y) N
1050	111/62	75	19	95%	94.5 AX	2	2	2	1	1	8		Blanche Warm Pulse normal Moves (Y) N
1055	119/79	77	13	100%	94.3 AX	2	2	2	1	1	8		Blanche Warm Pulse normal Moves (Y) N
1100	133/71	70	12	99%	94.7 AX	2	2	2	2	1	9		Blanche Warm Pulse Moves Y N
1115	115/70	71	12	99%	94.4 O	2	2	2	2	1	9		Blanche Warm Pulse Moves Y N
1130	122/71	65	11	97%	95.3 O	2	2	2	2	1	9	Pt recovered	Blanche Warm Pulse Moves Y N
1140	/				96.0	2	2	2	2	2	10	to ward	Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N

POST ANESTHESIA RECOVERY SCORE "PARS"

Activity - General Anesthesia
2—Maintain head lift and open eyes
1—Unable to maintain head lift and open eyes
0—Unable to lift head and open eyes

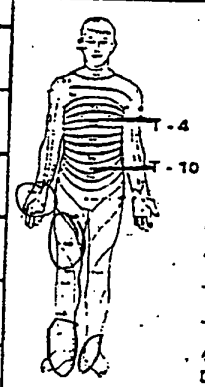
Activity - SAB or Subarachnoid Block
2—Moves all four extremities with control
1—Moves both upper extremities

Respirations
2—Spontaneous respiration; needs no support
1—Limited effort; needs artificial airway or jaw support
0—Needs ventilator; no spontaneous respiration

Circulation
2—BP 20% preanesthetic level
1—BP ~~20~~ - 50% preanesthetic level
0—BP 50% or more preanesthetic level

Level of Consciousness
2—Awake and alert; seldom dozes
1—Awakens when gently stimulated
0—Awakens only when vigorously stimulated

Skin
2—Normal skin color & temperature greater than 96°
1—Skin is pale, blotchy, dusky &/or temperature 95 - 96°
0—Cyanotic &/or temperature less than 95°



DRESSING:	Status	Location
Gauze	C, D & I	(R) Hand
Opsite	C, D & I	(R) LE
Bandaid	C, D & I	(R) thigh
Steri-strips		
Collodian		
Peri-pad		
Coban		
Cotton Balls		
Ace Wrap		

TUBES AND DRAINS: Hemovac Foley NGT Chest Jackson-Pratt

(Continue on reverse)

PREPARED BY (Signature) (b)(6)-2 SPC

DEPARTMENT/SERVICE/CLINIC ICU 1

DATE 18 AUG 03

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTICS STUDIES

☐ TREATMENT

DA FORM 1 MAY 78 4700

FH MDA OP 132-11a (Rev) 1 Sep 99

MEDCOM - 1577

2 Versed
250 fentanyl
10mg morphine

- 4 morphine
- 2 Tylox
1112 25mg Benadryl

INTAKE			OUTPUT		
TIME	TYPE	AMT	TIME	TYPE	AMT
OR	700cc LR	700cc	OR	EBL Minimal	Minimal
			OR	Urine Ø	Ø
TOTAL		700cc	TOTAL		Minimal

PACU NURSING NOTES: NURSING CARE PROBLEM NO.'S IDENTIFIED. Refer to FH MDA OP 39

NURSING CARE PROBLEMS: 1. RESP; 2. CIRC; 3. ACT; 4. LOC; 5. TEMP; 6. PAIN; 7. SAFETY; 8. ANXIETY; 9. EDUC; 10. OTHER

@ 1045 Received pt from OR via litter. Pt had skin graft x 2 with bandage over donor site ® thigh, clean, dry, and intact. Bandages on ®Hand, ®LE, and ©LE all clean, dry, and intact. All pulses strong, brisk cap refill. Pt complaining of pain, given 4mg MSO4 @ 1055, pt had localized systemic reaction (b)(6)-2 from IV site in © Hand extending up to the elbow. Pt was itching ® Arm and complaining of pain, arm had multiple patches of raised and irregularly shaped patches. Pt given Benadryl as ordered. The raised patches dissolved within minutes. Pt had ↓ SOB vital signs stable. SPC (b)(6)-2 RN/LPN

MEDICATION GIVEN BY:

LT (b)(6)-2
SPC (b)(6)-2
LT

MEDICATION RECEIVED IN PACU/ICU

DRUG	DOSE	ROUTE	TIME	PAIN LEVEL	EFFECTIVENESS
morphine	4mg	IV	1055		
Tylox	2 tabs	PO	1100		
Benadryl	25mg	IV	1112		

DISPOSITION SUMMARY: Nursing Care Problems No.'s _____ Resolved; No.'s _____ Continue.
Patient was transferred from PACU/ICU recovery room via litter/crib with siderails raised, or held by parent in wheelchair.
Dressing status: _____
Report given to _____ PAR Score _____ Safety Straps _____
Time out _____ Nurse _____ Patient released by Anesthesia _____

MEDCOM - 1578

ADMISSION AND CODING INFORMATION

For use of this form, see AR 40-400; the proponent agency is OTSG

1. REPORTING MTF: (b)(3)-1
MTF LOCATION (State or Country Code.)

3. REGISTER NUMBER: 00 (b)(6)-4

NAME (Last, First, Middle Initial): (b)(6)-4 (detainee)

4. PAY GRADE:

5. SEX: M

6. DATE OF BIRTH (Y Y Y Y M M D D):

7. AGE AT ADMISSION:

8. RACE: 30

9. ETHNIC BACK-GROUND: 31

RELIGION:

10. LENGTH OF SERVICE:

ETS:

11. FMP: 98

12. SOCIAL SECURITY NUMBER: 000 00 0 (b)(6)-4

ORGANIZATION (Active Duty Only):

13. MARITAL STATUS: 46

HOUR OF ADMISSION: 1800

BRANCH / CORPS: ~~Army~~

14. FLYING STATUS: 47 48 49

15. BENEFICIARY CATEGORY: 50 51 52 K78

16. ZIP CODE OF RESIDENCE: 53 54 55 56 57 58 59 60 61

17. UNIT LOCATION (State or Country Code): 62 63

18. MOS: 64 65 66 67 68 69 70

19. TRAUMA: 71

PREV. ADMISSION: YEAR ☐ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: 72 0

WARD: TCU1

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE:

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code):

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: B CO, 21st Combat Support Hospital, Mosul, Iraq

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE:

21. TYPE OF DISPOSITION: 73 74 01

22. MTF TRANSFERRED TO: 75 76 77 78 79 80

23. DATE OF DISPOSITION (Y Y Y Y M M D D): 81 82 83 84 85 86 87 88 20030829

24. CLINIC SVC - ADMITTING: 89 90 91 92 BJAA

25. MTF TRANSFERRED FROM: 93 94 95 96 97 98

26. DATE THIS ADMISSION (Y Y Y Y M M D D): 99 100 101 102 103 104 105 106 20030726

27. LOCATION OF OCCURRENCE (Battle Casualty Only): 107 108

28. MTF OF INITIAL ADMISSION: 109 110 111 112 113 114 (b)(3)-1

29. DATE INITIAL ADMISSION (Y Y Y Y M M D D): 115 116 117 118 119 120 121 122 20030726

FOR LOCAL USE

(b)(6)-2

(b)(6)-4

(b)(6)-2

(b)(6)-2

V1.00

DA FORM 2985, MAR 2000 MEDCOM - 1579

INPATIENT TREATMENT RECORD COVER SHEET (For Auto Imprinting)

For use of this form, see AR 40-400; the proponent agency is the Office of The Surgeon General.

PATIENT DATA ITEMS 1 - 30 *(Excluding Items 25 & 26)*

Iraqi ID # [b)(6)-4] (EPW)

[b)(6)-4]

[b)(6)-4]

(b)(3)-1

LINE	LEGEND
1	REGISTER NO. - NAME - GRADE
2	SEX - AGE - RACE - RELIGION - LENGTH OF SVC - ETS - PREVIOUS ADMISSION
3	FMP - SSN - ORGANIZATION - WARD
4	FLY STAT - RATING/DESG - DEPT/BEN - BRANCH/CORPS - UIC/ZIP - TYPE CASE
5	SOURCE & AUTHORITY FOR ADMISSION - HOUR OF ADMISSION - CLINIC SVC
6	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
7	ADDRESS OF EMERGENCY ADDRESSEE - PHONE NO. - DATE OF THIS ADMISSION
8	NAME & LOCATION OF MEDICAL TREATMENT FACILITY DATE OF INITIAL ADMISSION

ADMISSION REMARKS

(b)(6)-4

184

ADMITTING OFFICER

Brizuela

25. TYPE DISPOSITION: D/C

26. DATE OF DISPOSITION: 24 Aug 03

32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ CHECK IF CONTINUED ON REVERSE

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

- GSW to (R) abdomen 879.2 ICD9FY02
- Exploratory lap 54.11 ICD9FY02
- Repair of liver laceration. 50.61 ICD9FY02

☐ CHECK IF CONTINUED ON REVERSE

35. TOTAL DAYS THIS FACILITY

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

36. TOTAL DAYS ALL FACILITIES

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED	f. TOTAL SICK DAYS
				[b)(6)-2]	

[b)(6)-2] OFFICER [b)(6)-2]

DA FORM 1 MAY 79 3647-1 EDITION OF 1 AUG 76 IS OBSOLETE.

ACLU-RDI 1099 p.364

DOD 005632

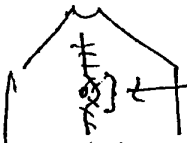
MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

PERTINENT HISTORY, CHIEF COMPLAINT, AND CONDITION ON ADMISSION *(Enter date of admission)*

IBVO Iraqi CIV shooting that was hit by an RPG. He was taken to FST where he underwent Exp lap for hemoperitoneum, liver lac repair (RL lobe). EBL 200 cc. He was transported via ~~AEROMED~~ to 21st CSH for further evaluation. Pt had a Tmax of 101 ~~[illegible]~~ prior to departure.

PHYSICAL EXAMINATION

HEN: AOX3, NAD
HEENT: unremarkable
HEART: RRR ⊕M/R/G
LUNGS: CTA Bl ⊕W/R
BACK: Dressing located ® flank
ABD: BS⊕ | ND | surgically tender, Midline incision c staples in place, Some suppuration noted at the umbilical area
EXT: ⊕ edema, ⊕ cyanosis



PROGRESS *(Enter date of discharge and final diagnosis)*

A: ① S/P Ex lap
② Liver lac repair

P: - admit to ICU 2
- See orders.

[b)(6)-2]		DATE	IDENTIFICATION NO.	ORGANIZATION
	MW	21AUG08		
PATIENT'S IDENTIFICATION *(For typed or written entries give Name last, first, middle; grade; date; hospital or medical facility)*			REGISTER NO.	WARD NO.

[b)(6)-2]

Iraqi Civ [b)(6)-4] (EPW)

[b)(6)-4]

ABBREVIATED MEDICAL RECORD
Standard Form 539

GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
USAPPC V1.00

MEDCOM - 1581

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
17 Aug 03	BRIEF OP NOTE:
0215	PROCEDURE: Exploratory lap, Cauterization and drainage of ® lobe liver laceration, Irrigation / debridement ® flank wound
	PRE-OP DIAGNOSIS: hemoperitoneum
	POST-OP DIAGNOSIS: Liver laceration, GSW ® flank
	SURGEON: (b)(6)-2 ASSISTANT: (b)(6)-2
	EBL: 200 cc
	FLUIDS: 3800 cc Crystalloid, ÷ u PRBC
	UOP: 1300 cc
	TT: Ø ⊕ NGT
	POST-OP PLAN: JP Drain in RUQ
	(b)(6)-2 MJ

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)	REGISTER NO.	WARD NO.
LOG#: 1 RAQ1 National SSAN#: (b)(6)-4 NAME:		

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

MEDCOM - 1582

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MEDICAL RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17 Aug 03	Received pt from OR, S/P exp lap & liver lac
0220HRS	repair. Pt sleepy, arousable to verbal commands,
VS BB 130/70	follows simple commands. ABC to the mod degree.
R-28 POx 98%	breath sft, guarded abdomen. 18 F NG to RT
P-130 T 98.0	nare clamped @ this time, placement verified
	via auscultation. O2 3L via NC. Lungs CTA, resp
	even. Pt on Vitz in stirrups for @ this time. D
	ecking noted. Large midline Lx & dsg to Abd
	c/d/I @ this time. JP drain + RLQ. T small
	amount sloody drainage & Sub suction. [b)(6)-2]
	hypoactive @ this time. Lx & dsg to Rt lower
	back c/d/I. Foley cath draining clear yellow
	urine in quality. 1/4 NS w/ Rt brst & NS
	@ 100 mg IV to KVO AC infusing. CR @ 100cc/hr
	With continued current care. Spc [b)(6)-2] SLC
0230HRS	Pt resting quietly, VS: BP- 130/65 HR-100 R-26
	SBO2 95% on 3LO2 via NC. Spc [b)(6)-2] SLC
0235HRS	Toradol 30mg IV administered @ this time
	as per MD order, Ø adverse reactions noted. Spc [b)(6)-2] SLC
0240HRS	Ancef 1 gram administered IVP @ this time as
	per MD orders, Ø adverse reactions noted.
	Spc [b)(6)-2] SLC

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	REC
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* | REGISTER NO. | WARD NO.

IRAQI National
[b)(6)-4]

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

MEDCOM - 1583

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
0245 HRS	VS BP-134/72 P-103 R-26 SPO2 98% on 3L O2 via NC, Blood drawn for lab as per MD order @ this time, awaiting results. Pt resting quietly @ this time, resp even/unlabored. Will continue c̄ current care — Spec [redacted] 91C —
0250 HRS	Received lab results, WNL, Labs attached to SFL100 @ this time. — Spec [redacted] 91C —
0300 HRS	Pt resting quietly w/bed VS BP-120/68 P-97 R-20 SPO2 98% remain on 3L O2 via NC. Pt ∅ complaint @ this time. Remains on file in NSR, ∅ ectopy noted. Will continue current care — Spec [redacted] 91C —
0315 HRS	Pt moaning @ this time, asked pt if in pain, pt nodded yes and gaurded abd. VS BP-128/66 P-92 R-24 SPO2 98% on 3L O2 via NC. MSO4 2mg IV administered @ this time. Pt tolerated well. Will continue c̄ current care — Spec [redacted] 91C
0325 HRS	Zanfer 50g administered IV @ this time — Spec [redacted] 91C
0330 HRS	VS BP-120/62 HR 85 R-21 SPO2 100% O2 3L via NC. Asked pt if pain has improved to ABd, pt nodded yes. pt resting quietly. Mod amount bloody drainage noted to JP Bulb, small amount bloody drainage present to ~~the~~ ABd dosing @ mid dosing, ∅ active bleeding noted. Will continue current care — Spec [redacted] 91C
Late Entry	0230 HRS 1400cc clear yellow urine drained from foley — Spec [redacted] 91C —

STANDARD FORM 600 (REV. 6-97) BACK

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MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17 Aug 03 0310HRS	30cc bloody drainage drained from JP
	Sulb @ this time —— Spc [redacted]
0400hrs	Pt resting quietly. VS BP 117/63 P-93 R-19 SPO2 98%
	Pt on RA @ this time. Will continue c̄ current
	Care —— Spc [redacted]
0420HRS	VS BP-125/58 P-94 R-22 SPO2 96% on RA. NG to
	Rt nare clamped @ this time, pt denies nausea.
	O2 DC'd. Lungs CTA. Abd soft tender, [redacted]
	hypoactive & 4 quads. Mid abd dsg c̄ small
	amount bloody drainage @ mid dsg, JP drain c̄
	small amount bloody drainage @ this time. IV
	to Lt Arm DC'd, Ld infusing @ 100 cc/hr to Rt
	~~Arm~~ Wr IV. Foley remains draining clear
	yellow urine in sufficient amounts. Dsg
	to Rt lower back c̄ small amount bloody
	drainage present. Report given to Spc [redacted] 91V.
	Spc verbally stated understanding. Pt to be transferred
	to patient Hold. Pt medicated c̄ 3mg MgO4 IV
	@ this time for pain prior to movement.
	Monitor DC'd @ this time. Pt transferred
	to Patient Hold. —— Spc [redacted]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* | REGISTER NO. | WARD NO.

IRAQI National

[redacted]

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

MEDCOM - 1585

5-112 NSN 7540-00-634-4123

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
17 Aug 03		0430	Iraqi Civilian admitted into Pt hold via litter;
VS-> 0440			Pt is sedated, recovering from GS wound to the back
BP-130/64			4th 1000cc LR bag @ 100cc/hr. 800cc of yellow urine
PR-99			drained from Drain bag — SPC [redacted] 91w
RR-18		0530	SPO2 lever is @ 89%, O2 given via Nasal Canula SPC
SPO2-91% on 2			SPO2 level went up to 96% — SPC [redacted]
		0711	Bag #5 500cc LR hung to infuse 100cc/hr — SPC [redacted]
VS=> 0800		0740	800cc yellow urine drained from bag — SPC [redacted]
BP 119/71		0815	Pt alert and responsive, Pt is answering questions SPC [redacted]
PR-74	0930	VS=	BP 110/61 P72 R16 SpO2 97% RA T 97.4 orally
RR-18			300cc clear yellow urine emptied from foley bag
SPO2-100%			20cc bloody drainage from JP drain. Pt arouses
			to voice, answers questions appropriately & able
			to follow commands. Moaning intermittently
			but declines med for pain when offered. [redacted]
—VS—	1130	—	BP 109/59 P90 R16 SpO2 96% — [redacted]
		1240	2mg MS IV - pt c/o pain to abd, moaning Tina Mulle
—VS—		1430	BP 111/57 P87 R16 SpO2 96% - ÷ gram Ancef
			mixed in 10cc NS given IV over 10 min. [redacted] PN
		1550	Pt c/o pain to abd - & pain to IV site - IV restarted
			in LAC c̄ 18g Jelco. 3mg MS given for pain
			[redacted] PT, Ar
		1600	Bag #6 500cc LR hung to infuse — [redacted] R

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)

REGISTER NO.

WARD NO.

Iraqi Civilian

[redacted]

NURSING NOTES

Medical Record

STANDARD FORM 510 (REV. 7-91)
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NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
— V S —		1630	BP 118/60 P81 R. 16 SpO2 96% RA - T 98.7
			600cc clear yellow urine emptied from foley
			Pt resting quietly - NAD — [b)(6)-2] RN
— VS —		1830	BP 111/63 P88 R 14 SpO2 96% [b)(6)-2]
		2130	Pt moaned & c/o ~~DRSG~~ PAIN @ INCISION
VS @ 2130 —			2mg MSO4 IVP — [b)(6)-2] RN —
BP 115/63		2230	Pt easily aroused to voice. NG TUBE D/C'D
P 85			per surgeon. Currently resting supine
R 16			NAD — [b)(6)-2] RN
O2 96% on RA		2230	* NOTE -> Pt up to chair as tolerated /
TMP 98.8° ORAL			ZANTAC PO in the A.M. — [b)(6)-2] RN
— 18 AUG 03 —		0230	Tg ANCEF IVPB. 2mg MSO4 IVP & 10cc NS FLUSH
			500cc DRK. YEL. URINE DRAINED VIA FOLEY.
— VS @ 0530			20cc BLOODY DRAINAGE VIA JP EMPTIED — [b)(6)-2] RN
BP 126/73		0530	BAG #7 500cc LR @ 150cc/hr. IV SITE OKAY — [b)(6)-2] RN
P 90		0800	2mg MSO4 IVP & 10cc NS FLUSH — [b)(6)-2] RN
R 16			
O2 96% on RA		0800	DRSG CDI, Ø FOUL ODOR NTD — [b)(6)-2] RN
TMP 99.6° ORAL		1140	2mg MSO4 IVP & 10cc NS flush — [b)(6)-2] RN

ACLU-RDI 1099 p.371

DOD 005639

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MEDICAL RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17 Aug 03 1030 IA	Surgeon's Note No Problems overnight Af, VSS UO - adequate Abd - Soft, hypoactive BS JP Drainage ~ 20 cc P/ Evacuate to CSH today OOB → chair Continue NG (b)(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

REGISTER NO.	WARD NO.

Iraqi POW #1

(b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*

18 AUG 03

History and physical

18 yo Iraqi EPW says he was Wt by RPG. to FST where ex Lap performed for Hemoperitoneum. findings @ Rt Lobe Liver Lac. Hemostasis Achieved EBL 200.

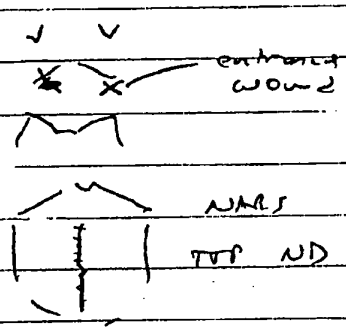
JP left in Abd. Now Tx for care.

NKDA Psm as Above meds

PMH Ø TOB Ø

exam

NCAT Back



Neck NT Ø deformity

Chest CBTA

ext Ø CCR Abd

Lab wnl

LABs 149 / 244 47.6 136 104 7 100 3.7 23 0.6 TP 6.6 Alb 3.4 LFT WNL

A/D Liver. Lac stable post op.

Admit ICU x 24 hrs

IVF

Clears.

(b)(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth, Rank/Grade.)*

REGISTER NO.

WARD NO. J, CV2

EPW

(b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*

18 AUG 03

History and physical

18 yo Iraqi EPW says he was wt by

RPG. to FST where ex Lap performed

for Hemoperitoneum. findings @ Rt Lobe

Liver Lac. Hemostasis Achieved EBL 200.

JP left in Abd. Now Tx for care.

NKDA Psm as Above meds

PMH Ø TOR Ø

exam

NCAT Back

Neck NT Ø deformity

Chest CBTA

ext Ø CCE Abd

entrance wound

NABS

TTP ND

Lu wnl

LABS 149 / 244 47.6 136 104 7 100 3.7 23 0.6 TP 6.6 Alb 3.4

LFT WNL

A/D Liver. Lac stable post op.

Admit ICU x24 hrs

IVF

Clears.

(b)(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex, Date of Birth, Rank/Grade.)*

REGISTER NO.

WARD NO. J.CV2

EPW

(b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
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MEDCOM - 1590

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
19 Aug 03 -	S/P X/Lg Drg well liquid Diet. Will DC JP today
	[redacted]
20 AUG 03	PROGRESS NOTE
	Pt stable S/P 3L-lap c̄ liver lac
	VSS Tmp 101
	Lungs: CTA
	Cor: RRR
	ABD: soft mild TP ABS
	RP: stable
	Plan Clone liquid Diet
	Ambulate
	DC [redacted]
21 Aug	C/o Nausea in flight.
	Pnt Given phenergan @ 2100 hours
	[redacted] Flt medic

STANDARD FORM 600 (REV. 6-97) BACK

USAPA V2.00

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
19 Aug 03 -	
	S/P X/Leg Drug well legal Diet.
	Will DC JP today
	(b)(6)-2 [redacted]
20 AUG 03	PROGRESS NOTE
	Rt STABLE S/P 38-LAP c̄ LIVER LAC
	VSS Tmp 101
	LUNGS: CTA
	CVR: RRR
	ABD: SOFT, MILD TTP BBS
	BP: STABLE
	PLAN Clone liquid Diet
	Ambulate
	DC (b)(6)-2 [redacted]

STANDARD FORM 600 (REV. 6-97) BACK
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MEDCOM - 1592

MEDICAL RECORD	PROGRESS NOTES

DATE

21 Aug 03 (2200) Admitted to ICU2 via litter c̄ x2 restraints to UE, NAD, moves s̄ difficulty from litter to bed, breathing regular, unlabored Alert, movement x4 extremities, responds to commands, speaks small amount of English MPC BS [redacted] /WM2

21 Aug 03 (2230) VS PSO2 97%, P=79, B/P 143/72 (98) R=14 bpm T=99³ UO 475cc yellow c̄ sediment [redacted] M2

21 Aug 03 (2250) 2mg MSO4 administered by RN on duty, physicians check lower midline abd incision, a wet to dry dressing placed over abd [redacted] WM2

21 Aug 03 (2300) Assessment complete, Alert, responds to commands PERRLA, skin warm dry no Breakdown pulses present normal x4 extremities, midline incision clean, intact, bandage (gauze c̄ tape) CDI abd flat, ridged, tender, client c/o pain to abd when palpated, (2) FA hepcock CDI no sx of infiltration, Ø c/o numbness to LE's, Bandage to back intact, dry, urinated c̄ difficulty s̄ pain, will continue to monitor per physicians instruction [redacted] 2

21 Aug 03 2300 Restraints to bed MPC BS [redacted] 9/WM2

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)

Iraqi # [redacted]

REGISTER NO.

WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
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FIRMR (41 CFR) 201-45.505
509-111

MEDCOM - 1593

PROGRESS NOTES

DATE	
22 Aug 03	(0245) inserted IV heplock to (R) AC, client tolerated D/C (L) FA heplock, catheter intact (0250) provided pain meds (0215) V/S 16bpm T=96.8 B/P 120/62 (83) P=75 PSO2 97% client resting c̄ HOB elevated drinking fluids s̄ difficulty, breathing regular unlabored — [redacted]
22 Aug 03	0615 - Nursing Notes: Assumed pt care. Pt AFOX3, speaks English well, ∅ c/o pain. SB 55, VSS, BP 117/65, RR 18, Pulse ox 98% on room air, T 96.8 Pt denies being a prisoner, pt also states he "will not drink water or eat food." IV HL in (R) AC patent & flushes easily. Pt has midline abdominal incision c̄ staples c̄ dressing to lower portion of suture line. Exit wound (R) ~~mid~~ Exp 2 lateral back 1 cm deep & 1 cm diameter c̄ small amt of exudate repacked wet to dry. Abdominal incision approximately 25 cm in length. (B) lungs CTA.
Gen	Surg Note [redacted] LPN
22 Aug 03	HD#2 POD HS s/p Ex lap / Liver lac repair
0855	VSS. Afebrile. Pain control c̄ po meds. Wounds 1 Back & front C/D. Minimal secretion noted on front ABD incision. ∅ erythema ∅ calor. Tolerating po clear diet. Will continue with post op care. Needs to ambulate [redacted] MD
	MAJ, MC, USA

*U.S. Government Printing Office: 1990-262-081/20138

STANDARD FORM 509 BACK (Rev. 11-77)

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MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
22Aug03	0840 = Nursing Notes: Pt urinated 150cc of clear yellow urine per urinal. [b)(6)-2]
22Aug03	0900-Nursing Noty: Abd dressing changed, abd open section of incision 7.75 cm long & 5cm wide, wound pink & minimal bleeding, ∅ odor, ∅ exudate. Will continue to monitor. [b)(6)-2]
22Aug03	0930: Nursing Notes: Pt sitting up in chair @ bedside. Pt ambulated & minimal difficulty, Pt medicated previously @ 0835 & Tylox ×× po per prn physician pain order. Will continue to monitor. [b)(6)-2]
22Aug03	1400- B/P 121/66, P-72, T-97.9, R-20, mean-88, Denies C/O pain, ∅ SOB, Staples to midline ABD CDI, Dressing to mid lower ABD. CDI, Dressing to (R) LOWER BACK CDI, IV to (R) AC & redness, swelling or warmth. will continue to monitor pt, urine clear & yellow 300 cc [b)(6)-2]
22Aug03 2200	V/S 97% R=18bpm P=93 B/P 126/66 (89) T=99.8 Motrin administered, pt alert obeys commands NPO CBS temp warm dry, resting & HOB elevated 30° midline incision CDI, wet to dry lower midline

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI | SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade) | REGISTER NO. | WARD NO.

Iraqi CIV [b)(6)-4] (EPW)

[b)(6)-4]

509-114

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

DATE	NOTES
22Aug03 2200	(continued) incision CDI, tender abd c/o pain denies pain medication @ this time, bandage to (R) lower back intact, Ointment to (L) heel where breakdown is apparent. Gauze c̄ tape over blister on lateral (R) heel. pulses present x4 LS CTA, breaths deep, regular, unlabored, Ø SOB NAD, moves ext x4 pupils reacting to light, Flushed (R) AC heplock Heplock CDI, patent s̄ sx of infiltration s̄ c/o pain @ site. [redacted] 9/WU2
23Aug03	(0015) Set @ side of bed s̄ difficulty [redacted] 9/WU2
23Aug03	(0050) Urinated in urinal s̄ difficulty c/o pain to abd UTA pain scale. Administered pain medication per physicians instruction, pt resting comfortable following medication administration [redacted] 9/WU2
23Aug03	(0215) V/S R=18bpm P=78 b/p= 115/65, T=98.6, PSO2 97% Ø SOB Ø c/o pain, will continue to monitor [illegible]
0840	T 98°F BP 123/73, HR 94, RR 16, SpO_2 97% on RA; NAD; VSS; dressings Δ'd; CDI; MD looked at wounds; lung sounds clear, bowel sounds active x4 quad; pt sitting up in chair eating breakfast [redacted] 9/WU2

STANDARD FORM 509 (REV. 5-99) BACK

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MEDICAL RECORD	PROGRESS NOTES
DATE 23 AUG 03 1025	HD#3 POD#6 (DOS 17 AUG 03) S/P EXLAP / Liver Lac Repair

Currently remains afebrile, tolerating diet, pain control c pomeds. Continue c wound care Vertical abdominal incision → staples in place @ signs of erythema. Small area at the umbilical was noted c serosanguinous and it was open and currently undergoing wet to dry dressing changes. (R) back wound cutaneous (about 2-3cm in circumference with no sign of infection Continues c BID dressing changes.

Plan: - Staples to be removed by tomorrow AM
- pending transfer to EPW camp where he will continue to have dressing changes BID and F/u @ (b)(3)-1 in a week after his transfer.
- Will continue on po Meds for his pain control.

(b)(6)-2

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)

REGISTER NO. | WARD NO.

Iraqui # (b)(6)-4 EPW

(b)(6)-4 (b)(6)-4

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
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509-111

ACLU-RDI 1099 p.381

DOD 005649

MEDICAL RECORD | **PROGRESS NOTES**

DATE

AUG 03

DOS

HD#4 POD#7 (DOS 17AUG03)

S/P Exlap / Liver Lac repair.

Pt is doing well today. Remains afebrile, ambulating, voiding without difficulties. Back wound c̄ no signs of infection. Abdominal wound continues to heal well. Rest of the incision with ∅ signs of infection. Staples removed and steristrips applied.

plan: ① will continue c̄ pomeds for his pain

② start on Colace 100 mg PO QD

③ pending transfer to EPW camp. Once D/C he will have Dressing changes BID and F/u in 3 days. to assure no infection present.

[redacted] MD

(Continue on reverse side)

REGISTER NO. | WARD NO.

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
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509-111

MEDCOM - 1598

PROGRESS NOTES

DATE	
23 Aug 03 1425	V/S: T-98.6 P-83 R-16 B/P 120/68 SPO2 97% RA. Assesment completed. A+O x3. Breath sounds CTA Apex to Base (B) Peripheral pulses strong, Bowels sounds active x4. Midline abdominal incision c̄ staples CDI, dressings to abdomen and Back intact. IV site CDI, Ø S/S of infections. 2 c/o pain. Resting comfortably. Motin 800 mg po given. [redacted] (b)(6)-2 (LB)
23 Aug 03 1930	T-98.7 P-88 R-16 B/P 131/71 SPO2 - 98%
23 Aug 03 2230	Took over care VSS T 98.8 P 86 R 12 BP 122/69 sat's 99% A/O x3, PERRL Chest CTA Heart RRR Abd (B) soft (+) tenderness Stapel mid Abd. C-D-I MAE Has Ø c/o discomfort at this time. IV site to (R) FA patent. Will cont to monitor per the orders [redacted] (b)(6)-2
0300 Aug 24, 03	Resting with eyes closed NAD Will cont to monitor per orders. [redacted] (b)(6)-2
0315 Aug 24, 03 0915	T 98.8 P 76 R 12 BP 120/60 sat's 99% RA [redacted] BP 121/52, HR 91, RR 14, SpO2 97% on RA, T 97.2 VSS; NAD; lung sounds clear, BS active x4 quad. [redacted] (b)(6)-2 WMLC DC

MEDICAL RECORD — PROGRESS NOTES

DATE	
24AUG03 1105	IV DC'd; catheter was intact; will cont to monitor [b)(6)-2]
24AUG03 2030	D/C'd c MP's vitals within normal limits [b)(6)-2] medications & discharge instructed sent c MP's

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; unit; hospital or medical facility)

REGISTER NO.

WARD NO.

Iraqi # [b)(6)-4]

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
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509-111

MEDCOM - 1600

DIRECTIONS: To be completed by attending provider and other staff at time of patient release following an outpatient procedure, extended care/treatment or discharge from an inpatient hospital stay.

SECTION I TO BE COMPLETED BY PRIVILEGED PROVIDER	SECTION II TO BE COMPLETED BY OTHER STAFF, AS APPROPRIATE
1. DATE OF PROCEDURE/ADMISSION: 21 AUG 03	1. DISPOSITIONED TO: ☐ HOME ☐ DUTY ☐ OTHER _____
2. ADMITTING/DIAGNOSIS: Ex lap / Liver Lac	☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER
3. PERTINENT LAB, X-RAY, FINDINGS:	2. ACCOMPANIED BY: ☐ FAMILY ☐ FRIEND ☒ OTHER _____
	3. PATIENT EDUCATION:
	Completed and patient prepared for home care. ☐ YES ☐ NO
	If no, explain:
4. PROCEDURES, TREATMENT, HOSPITAL COURSE: -GSW to (R) back -s/p Ex Lap -s/p (R) lobe liver lac repair.	Patient ☐ states ☐ demonstrates understanding of home care needs. Printed educational materials provided:
	4. Clinical outcomes met and post-discharge/release referrals made.
	☒ YES ☐ NO If no, explain:
5. FINAL DIAGNOSIS AND CONDITION AT DISCHARGE: - GSW to (R) back - s/p Ex lap -s/p (R) lobe liver lac	5. If transferred to another health care facility, report called to nurse. ☐ YES ☐ NO If no, explain:
	6. NUTRITION CARE - Comments:
6. ACTIVITY: Ad lib 7. DIET: regular	7. MEDICATIONS:
8. MEDICATIONS: ☒ Medications have been prescribed for home use. See separate list and special instructions or see below. Motrin 800mg PO TID PRN Tylox 1-2 tab PO Q3-4P PRN Colace 100mg PO QD PRN constipation	Explained by: ☐ NURSE ☐ PHYSICIAN ☐ PHARMACIST Printed medication literature provided. ☐ YES ☒ NO Patient states understanding of prescribed medications. ☐ YES ☒ NO Error on MD
	8. EQUIPMENT/SUPPLIES PROVIDED:
9. INSTRUCTIONS *(To Home Health Providers, Patient, etc)*: 1) Need BID Dressing Changes for (R) back wound and abdominal wound 2) F/u in 3 days at Spec Clinic @ 1030AM	9. FOLLOW-UP APPOINTMENTS, POINT OF CONTACT & PHONE:
10. DISCHARGING PROVIDER: [b)(6)-2] MD MAJ, MC, USA *(Printed or Stamped Name)*	10. FOR PROBLEMS OR EMERGENCY, CONTACT & PHONE:
PATIENT IDENTIFICATION [b)(6)-4] Iraqi #	[b)(6)-2] 24 AUG 03 *(Date and Time)*
[b)(6)-4]	I HAVE RECEIVED A COPY OF AND UNDERSTAND THESE INSTRUCTIONS. *(Patient/Responsible Adult's Signature)* *(Date and Time)*

MEDCOM FORM 691-R (TEST) (MCHO) MAR 99 PREVIOUS EDITIONS ARE OBSOLETE MC V1.00

INTRA... ...RAT ...UCUMENT

MEDICAL RECORD

For use of this form, see AR 40-66; the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Litter BY ATLS
3. DATE 17 Aug 03 TIME PATIENT ARRIVED IN SUITE 0105

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY Spc (b)(6)-2
4. PATIENT IN ROOM TIME 0105 NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

☒ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER (Specify)

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	Spc (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	Spc (b)(6)-2 Spc (b)(6)-2	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify)

☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

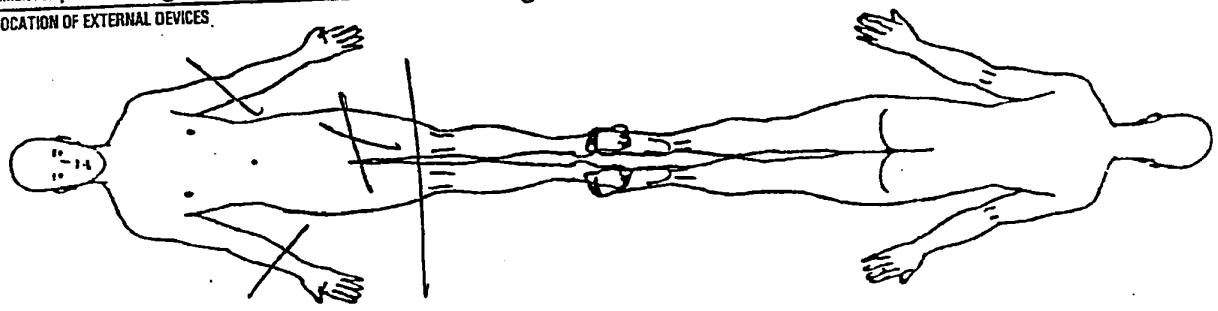
COMMENTS: x1 Roll under Bilat Shoulders

8. SKIN PREPARATION

HAIR REMOVAL DONE BY: ☒ YES ☐ NO ☒ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP
COMMENTS: Removal Midline ABd + Lt thigh

PREP SOLUTION (Specify) Beta/Beta BY WHOM: Spc (b)(6)-2
SITE: Mid Abd
SITE: BY WHOM:
COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad – Safety Strap --- Tourniquet

10. COUNTS (C – Correct I – Incorrect)

		Other**	First Closing Count 0152	Final Closing Count 0200
Sponge	☒ Yes ☐ No	5+5	10	10
Needle Sharp	☒ Yes ☐ No	16+3+1	19+1	20
Instrument BLADE	☒ Yes ☐ No	2+1	3	3
Other Bovie Tip	☒ Yes ☐ No	1	1	1

SCRUB (b)(6)-2 Spc
CIRCULATOR Spc (b)(6)-2

11. PATIENT IDENTIFICATION (For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility)

LOG# (b)(6)-4
SSAN#
NAME:

IRAQI CIVILIAN

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO

☐ ESU NO: Cut 30 / Coag 30
GROUND PAD: BRAND
LOT NO:

☐ ESU NO: Cut 80 / Coag 80
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

USAPA V1.01

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE.

MEDCOM - 1602

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☒

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☐ YES ☒ NO, TYPE(S):

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE MAJ (b)(6)-2 MO

15. X-RAY IN OPERATING ROOM YES ☐ NO ☒ IF YES, SITE

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☐	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☐	NAME	NAME
CULTURE (C) YES ☐ NO ☐	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☐ NO ☐

TYPE/SIZE	1. Foley 16F	2. NG 18F	3. Jason Pratt
SITE	1.	2. Rt Nare	3. RLQ

18. DRESSING/IMMOBILIZATION (Specify)
Xeroform & 4x4
Mia Afd.
Large Bulky

19. ADDITIONAL INFORMATION
Assisted By Dr (b)(6)-2
Foley cath placed by Dr (b)(6)-2 clear yellow urine present. NG placed to Rt nare per anesthesia.

IN 0105
CUT 0123
CLOSE 0152
OUT 0219 HRS

LOG # 1RAQ1 National
SSAN#
NAME: (b)(6)-4

20. OPERATION(S) PERFORMED
Exploratory Lap
Repair Liver Lac
JP placement

21. PATIENT TRANSFERRED TO ICU TIME 0219 hrs. METHOD Litter

22. REGISTERED NURSE S (b)(6)-2 SPC 76C

REVERSE OF DA FORM 5179-1, OCT 87 USAPA V1.01

MEDCOM - 1603

13. PROSTHESIS, IMPLANTS ☒ NO IF YES NAME: ID NUMB... ...RER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☒

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☐ YES ☒ NO, TYPE(S):

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE MAJ (b)(6)-2 MO

15. X-RAY IN OPERATING ROOM YES ☐ NO ☒ IF YES, SITE

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☐	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☐	NAME	NAME
CULTURE (C) YES ☐ NO ☐	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☐ NO ☐

TYPE/SIZE	1. Foley 16F	2. NG 18F	3. Jason Pratt
SITE	1.	2. Rt Nare	3. RLQ

18. DRESSING/IMMOBILIZATION (Specify)
Xeroform & 4x4
Mia Abd.
Large Bulky

19. ADDITIONAL INFORMATION
Assisted By Dr (b)(6)-2
Foley cath placed by Dr (b)(6)-2 clear yellow urine present. NG placed to Rt nare per anesthesia.

IN 0105
CUT 0123
CLOSE 0152
OUT 0219 HRS

LOG # 1RAQI National
SSAN# (b)(6)-4
NAME:

20. OPERATION(S) PERFORMED
Exploratory LAP
Repair Liver Lac
JP placement

21. PATIENT TRANSFERRED TO ICU TIME 0219 hrs METHOD Litter

22. REGISTERED NURSE SI... (b)(6)-2 SPC

REVERSE OF DA FORM 51... MEDCOM - 1604 USAPA V1.01

MEDICAL RE[illegible] -SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA APPR 08MAR8

INITIAL SHIFT ASSESSMENT

		Time: 1700 Initals:	Time: Initals:
NEURO	Pupils		
	Sensorium		
	LOC / GCS		
CARDIAC	Cardiac Rhythm		
	PRI: / QRS:		
	Pulse Strength		
	Cap Refil / JVD		
	Edema		
	Chest Pain		
RESP	Respiratory Pattern		
	Breath Sounds		
	Secretions		
	Cough		
SKIN	Color		
	Integrity		
	Backside		
IV	Access Devices		
	Location		
	Condition		
GI	Abdomen		
	Bowel Sounds		
	Stoma/Ostomy		
GU	Device		
	Color / Clarity		

(Continue on reverse)

(b)(6)-2

DEPARTMENT/SERVICE/CLINIC: ICU3, (b)(3)-1

DATE: 18 Aug 03

n entries give: Name – last, first, middle; grade; date; hospital or medical facility)

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER *(Specify)*

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, MAY 78

USAPPC V2.00

MEDCOM - 1605

ICU1

Patients Name: [redacted] Date: 18 Aug 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line															129/		135/	131/	133/	141/	129/	138/	135/	130/	131/	
NBP											147/65	139/71		135/61	109		123	105	104	114	103	109	103	102	102	
TEMP											99.9				100.5		100.1		100.5				100.3			
HR											106	96		88	97	98	102	95	101	106	100	107	107	104	107	
RR											23	23		22	24	23	20	15	18	20	24	24	21	18	20	
SaO2											97	97		96	95	98	96	97	95	94	95	96	93	95	94	
FIO2											RA	RA		RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	
Source																										
MAP																										

...TAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Tota
IVF											150	150		150	150	150	150	150	150	150	150	150	150	150	150	
IVPB											50									50						
NGT																										
PO												50														
Subtotal											200	200														
PO																										
Total											200	400		550	700	850	1000	1150	1300	1500	1650	1800	1950	2100	2250	2250

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
U											800	800		30				250					250		100	
N																										
STOOL																										
DRAIN/LP												25			Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	30	Ø	Ø	
Subtotal												825		855				1105					385		1485	1485
Total												825														

MEDCOM - 1606

DOD 005658

ACLU-RDI 1099 p.390

ICU1

Patients Name: EPW # [redacted] Date: 19 AUG 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line	124/71		120/73	129/65		135/72	140/72		138/64	137/60																
NBP																										
TEMP	100					1005			1005																	
HR	93		93	97		105	117	123	127	102																
RR	98		19	25		19	24	24	27	19																
SaO2	98		98	99		96	97	96	98	97																
FiO2	RA		RA	RA		RA		RA	RA																	
Source																										
MAP																										

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
IVF LR	150	150	150	150	150	150	150	150	150	150	150	150														
IVPB			50								50															
NGT																										
PO													1900													
Total	150	300	450	600	750	900	1050	1200	1350	1500	1650	1800														

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
[illegible]			300	300	200	200	200		300	150	150	350														
NGT																										
STOOL																										
DRAIN JP	0									30	DC															
Total	0		300	600	800	1000	1200		1500	1680	1830	2180														

DOD 005659
MEDCOM - 1607
ACLU-RDI 1099 p.391

Drawn 17 Aug 03 0248hrs

EC8+

Pt Name:_____

Glu_____129 mg/dL
BUN_____10 mg/dL
Na_____142 mmol/L
K_____3.8 mmol/L
Cl_____111 mmol/L
TCO2_____21 mmol/L
AnGap_____15 mmol/L
Hct_____41 %PCV
Hb*_____14 g/dL
*via Hct
PH_____7.262
PCO2_____44.0 mmHg
HCO3_____20 mmol/L
BEecf_____-7 mmol/L

Sample Type_:

17AUG03 02:44

Oper: 1111

(b)(6)-2

Physician:

per# 43006

Ver: JAM5046A
CLEW A93

MEDCOM - 1608

MEDICAL RECORD — ANESTHESIA

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MD / MCG / ML, "1" = CONSTANT INFUSION

DRUG	Units	
Thiopental	mg	225
Anectine	mg	120
Narcuron	mg	8
Mscy	mg	10
Neostigmine	( )	
Cobinul	( )	
VOLAT. AGENT: Sevo	% del	2 — 2 — 2
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	5 — 5

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS

FLUIDS: LINE site Rt Lt — ☐ Warmed ☐ Warmed ☐ Warmed ☐ Warmed

LOSSES: EST BLOOD LOSS — URINE –

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 70 KG LB

HEMATOCRIT:

INITIAL DATA: BP 151 / 90 — HR– 114

EQUIP CHECK: OK?– Y N

PATIENT RECHECK: OK for PROCEDURE? TIME– 0100

TIME → 0100 / 30 / 0200

SYMBOLS: BP by cuff V Λ — Heart rate ● — Resp rate — BP (transduced) — TOURNIQUET T — ANES– X-X — PROC– ⊙ – Ø

220 200 180 160 140 120 100 80 60 40 20

VENTILATION: VT – ml; f – breaths/min; Peak inf pres / PEEP; MODE– S(pon) A(ssist), C(on) S C C C S S

BP/Auto Cuff	ET CO2 (torr)	+	+	+	+	
BP / oth	FIO2 (Frac or %)	.3	.3	.3	.3	
ART line	SpO2 (%)	100	100	100	100	
Steth- PC/ES	ECG	ST	ST	ST	SR	
Gas analyzer	TEMP- site					
	N-M Block (T/4)	4/4	4/4	4/4	4/4	4/4
Warming blkt						
Conv warmer						

FST

Mark with letters & symbols, explain under REMARKS — EVENTS — Position

PROCEDURES and CPT Codes: Liver Laceration Repair + Drain Ex Lap

PATIENT IDENTIFICATION– Typed or written entries: Name, Grade/Rate, Medical Facility

(b)(6)-4

ANESTHETIC TECHNIQUES: Describe block technique under Remarks — GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: RST c̄ CP, DL#1 c̄ 3 mac, grade I, 8.0 DETT, atraumatic intubation BBS⊙ (+) ETCO2 spaced 22cm @ incisor

SURGEONS (b)(6)-2 (b)(6)-2

ANESTHETIC (b)(6)-2

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED 1 Jan 99

TOTALS: 225 mg, 120 mg, 8 mg, 10 mg, 4 mg, 0.8 mg — TOTAL EBL 200 — TOTAL URINE 1300

FLUIDS SUMMARY: CRYSTALLOID– 3800 — COLLOID– — BLOOD– 350

REMARKS– Code drugs with numbers, events with letters

2772274

0210 Reversed. ST, TOF, SV, oropharynx suctioned. Extubated.

RECOVERY AT 0218: PACU CU (Specify) — OTHER — CONDITION: Alert, SV — RESP– 24 — SpO2– 97% — BP– 122/70 — HR– 105

TIME: PROCEDURE TIMES

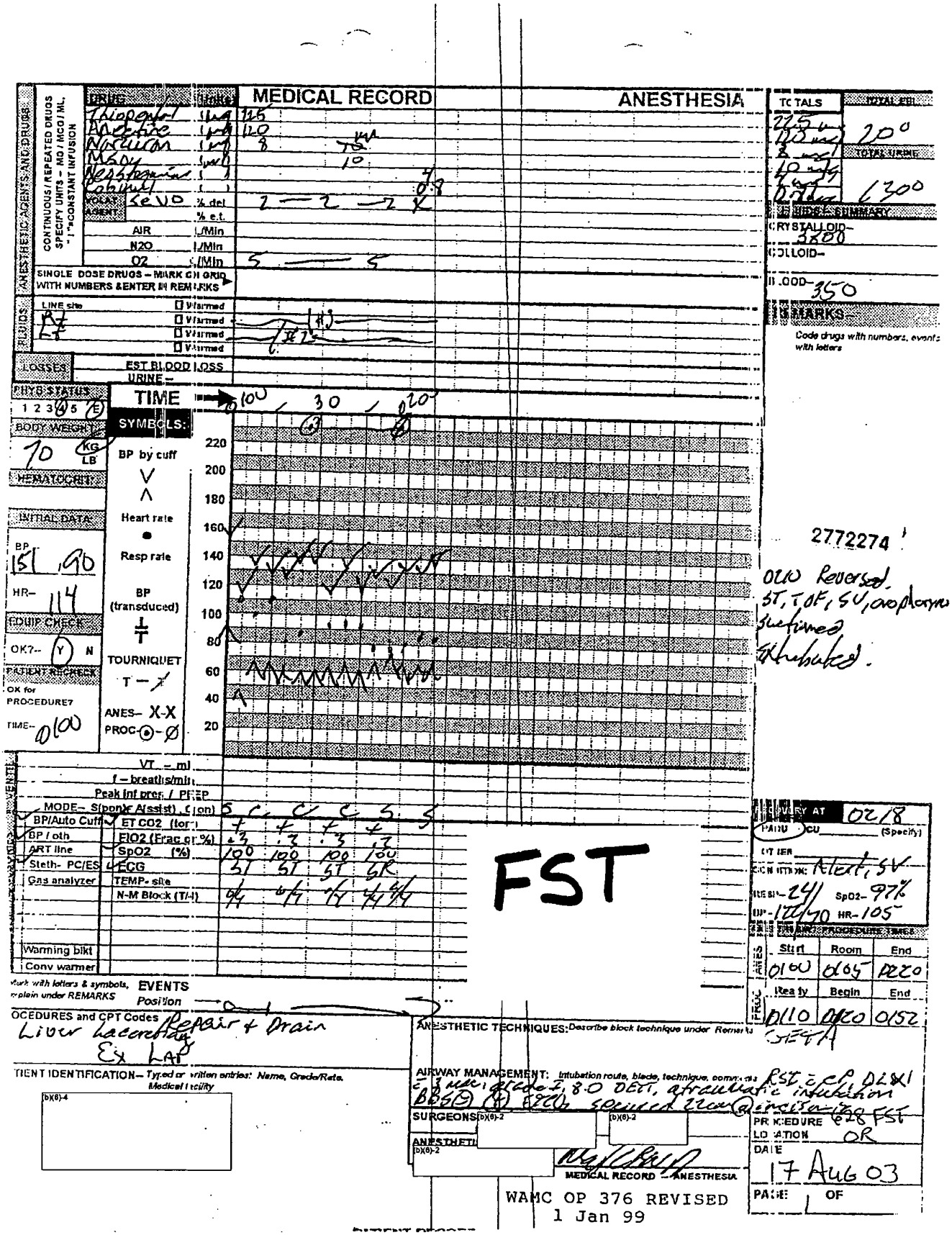
	Start	Room	End
ANES	0100	0105	0220
PROC	Ready	Begin	End
	0110	0120	0152

PROCEDURE LOCATION: 628 FST OR

DATE: 17 AUG 03

PAGE 1 OF

MEDCOM - 1609



Doctor's Orders—Post-OP 126th OP 4256

Nurse Complete	Dr.'s Select	DATE: TIME:
☐	☑	1. Admit to: ☐ OR ☑ PACU ☐ ICW ☐ Patient Holding
☐	☑	2. Diagnosis: S/P Exploratory lap, liver laceration
☐	☑	3. Condition: ☐ Critical ☐ Guarded ☒ Stable ☐ VSI ☐ SI
☐	☑	4. Allergies: See SF 558 Ø
☐	☑	5. Vitals: ☒ Unit SOP ☐ Notify Dr. for SBP < 80 or > 160 DBP < 40 or > 100, HR < 60 or > 130, RR < 6 or > 30, or Temp > 38.5
☐	☑	6. Activities: ☒ Bed Rest, ☐ BRP, ☐ OOB ASAP w/ assist, ☐ Sit up and dangle when stable ☐ Other:
		7. NRSG:
☐	☑	a. Propaq monitor w/ Pulse-ox
☐	☑	b. O_2 to maintain SAT's above 94%
☐	☐	c. Maintain Vent settings at MODE=_____ Vt=_____ RR=_____ PEEP= FIO_2=
☐	☑	d. ☒ Reinforce or ☐ Change dressing for bleed-through X1 then notify Dr.
☐	☑	e. I's & O's
☐	☑	c. Suction NT ETT PRN
☐	☐	d. ~~CT to ☐ H_2O seal or ☐ Suction at~~
☐	☑	8. Diet: ☒ NPO ☐ Clear fluids as tolerated ☐ Other:
☐	☑	9. IV: ☐ NS or ☒ LR TRA 100cc/hr ☐ ~~DEXTRAN or~~ ☐ Hespan X 500 cc bolus titrated then _____cc/hr ☐ ~~Albumin 100cc X~~ ____ TRA _____cc/hr ☒ ~~When tolerating PO~~ fluids, complete current fluid then SL.
☐	☐	10. ~~BLOOD~~: ☐ T&S or ☐ T&C _____units ☐ Transfuse ____ units ☐ PRBCs or ☐ Whole Blood
		11. Medications:
☐	☐	a. Tobramycin 300mg IV Q12hrs X | e ☐ Ceftriaxone 750 mg IV
☐	☐	b. Clindamycin 600mg IV | f ☐ PEN G 2 million Units IV
☐	☑	c. Cefazolin 1 gram IV q 12h x 4 doses 1st dose @ 0245hrs ea
☐	☑	d. Phenergan 12-25mg Titrate ☒ IV ☐ IM Q4hrs PRN nausea/vomiting
☐	☐	g. Droperidol 1mg ☐ IV ☐ IM X 1 PRN Nausea/Vomiting
☐	☑	h. MSO_4 1-3mg Titrate ☒ IV ☐ IM Q10min PRN Pain
☐	☑	i. Robinul 0.1mg IV X 1
☐	☑	j. Zantac 50 mg ☒ IV or ☐ IM or ☐ 6.25mg/hr infusion q 12h 1st dose @ 0225hrs ea
☐	☐	k. Tetanus Immune Globulin
☐	☑	l. Toradol ☒ IV 30mg or ☐ IM 60 mg Done @ 0235hrs ea
☐	☐	~~m. Maintain sedation~~/paralysis w/ Rocuronium and MSO_4 PER SOP
☐	☑	12. LABS: a. iSTAT ☐ Glucose ☐ ABG ☐ BMP ☒ CMP Done @ 0248hrs ea
		13. Additional:
		NG → Clamp, ✓ Residual q 4h + PRN
		~~CWS or Gravity drainage~~
		Foley → urimeter
		JP — Bulb suction
		Signature: [b)(6)-2] [b)(6)-4] PT SSAN# 10JAN03

[b)(6)-2]

LOG# 1 AM OJ 0230hrs. PT NAME: [b)(6)-4]

MEDCOM - 1610

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

Iraqi CIV # [redacted] (EPW)

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	21 AUG 03	2230 HOURS	
1	Admit to ICU 2		
2	Diagnosis: sp Exp lap Liver Lac Repair		
3	condition stable		
4	Service: Gen Surgery Dr. [redacted]		B6-2
5	Vitals: Q 4°		
6	Allergies: NKDA		

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	
	↓↓	↓↓ HOURS	
7	Diet: clears and advanced as tolerated		
8	Tylox 1-2 tab po PRN pain Q3-4hrs		
9	Motrin 800 mg po tid		
10	phenergan 25mg po Q 6° PRN N/V		
11	Dressing change on wound on hip back BID		
12	Morphine 2mg IV now X 1		

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	
	↓↓	↓↓ HOURS	
13	Heplock IV site DC old one and place new one		
14	Abdominal wound wet to dry changes BID		
	[redacted]		MD
	MAJ, MC, USA		

NURSING UNIT | ROOM NO. | BED NO.

Chart ✓ AMB 21 Aug 03 @ 2345

PATIENT IDENTIFICATION

	DATE OF ORDER	TIME OF ORDER	
	24 Aug 03	1000 HOURS	
1	D/C staples.		
2	Colace 100mg QD		
3	Continue Dressing changes for back and abdominal wounds. BID		B6-2 [redacted] [redacted]
	[redacted]		MD
	MAJ, MC, USA		

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1 APR 79 4256 REPLACES ED[illegible] MAY BE USED.

MEDCOM - 1611

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
Iraqi # (b)(6)-4	24aug03	1000hrs HOURS	
	VO Dr (b)(6)-2 / (b)(6)-2	MAJ	
	Vs to a [illegible]		
	(b)(6)-2	MD	
	MAJ, MC, USA		

NURSING UNIT	ROOM NO.	BED NO.

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER
Iraqi # (b)(6)-4	24AUG03	1035 HOURS
	① D/C to EPW camp -	
	(b)(6)-2	MD
	MAJ, MC, USA	

NURSING UNIT	ROOM NO.	BED NO.

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER
Iraqi # (b)(6)-4		HOURS

NURSING UNIT	ROOM NO.	BED NO.

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER
Iraqi # (b)(6)-4		HOURS

NURSING UNIT	ROOM NO.	BED NO.

DA FORM 1 APR 79 4256 REPLACES ED MEDCOM - 1612 Y BE USED.

(GREEN) EPW

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	18 8 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 21	22	23	24
21 Aug	(b)(6)-2	Vitals: Q4°	D	/	(b)(6)-2		
			E	/	(b)(6)-2		24 aug 03
			N	(b)(6)-2			
21 Aug	(b)(6)-2	Diet: clears &	D	/	(b)(6)-2		
		advanced as tolerated	E	/	(b)(6)-2		
			N	(b)(6)-2			
21 Aug	(b)(6)-2	Dressing Δ on wound	08	/	(b)(6)-2		
		on his back BID	20	/	(b)(6)-2		
			/	/	/		
21 Aug	(b)(6)-2	Abdominal wound	08	/	(b)(6)-2		
24 aug	(b)(6)-2	wet to dry Δ BID	20	/	(b)(6)-2		
		Vitals q shift	D	/	/	/	(b)(6)-2
			E	/	/	/	
			N	/	/	/	

ALLERGIES: ☐ YES ☒ NO — NKDA

PRIMARY DIAGNOSIS: GSW to (R) abd / Exp lap

ADDITIONAL PAGES IN USE: ☐ YES ☒ NO — PAGE NO:

PATIENT IDENTIFICATION:

Iraqi # (b)(6)-4 EPW

(b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 1 OCT 78 — EDITION OF 1 DEC 77 MAY BE USED.

MEDCOM - 1613

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON MEDICATION)

Mo 08 Yr 03

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
21	b(6)-2	Admit to ICU2/6en Surgery Dr b(6)-2	21Aug ~~2100~~	2200	2200	b(6)-2
21		Condition Stable	21Aug	2200	2200	

Order/ Start Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED

MEDCOM - 1614

EPW (MAR)

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)
For use of this form, see AR 40-407;
the proponent agency is the Office of The Surgeon General

AUG 8 TH 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 21 22 23 24
21 Aug	[b)(6)-2]	Motrin 800mg PO	08	[b)(6)-2]
		TID	14	[b)(6)-2]
			22	[b)(6)-2]
21 Aug	[b)(6)-2]	IV Heplock	D	[b)(6)-2]
			E	[b)(6)-2]
			N	[b)(6)-2]
24 Aug	[b)(6)-2]	Celebrex 100mg PO QD	08	/ / /

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS:
GSW to (R) abd / Ex lap

ADDITIONAL PAGES IN USE: ☐ YES ☒ NO
PAGE NO: _____

PATIENT IDENTIFICATION:
Iraqi # [b)(6)-4] EPW

[b)(6)-4]

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES
D 8 9 10 11 12 13 14 15
E 16 17 18 19 20 21 22 23
N 24 01 02 03 04 05 06 07

FORM [illegible]

MEDCOM - 1615

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON MEDICATION)				Mo 08 Yr 03
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
21	(b)(6)-2	Morphine 2mg IV now x 1	21AUG	NOW	2250	(b)(6)-2
21		Heplock IV site D/C old one &	22Aug	0245	0245	
		place new one	–	–	–	–

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED														
21AUG	(b)(6)-2	Tylox ÷ - ii tabs	22AUG 2600	03 22AUG 2003	23AUG 2003	24AUG 0900											
		PO PRN q3-4hrs pain	0250	0835 BC-C	0050	ii											
21AUG	(b)(6)-2	Phenergan 25 mg															
		PO Q6° PRN N/V															

MEDCOM - 1616

ADMISSION AND CODING INFORMATION

For use of this form, see AR 40-400; the proponent agency is OTSG

1. REPORTING MTF	2. MTF LOCATION (State or Country Code.)	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
A (b)(3)-1	C2	(b)(6)-4	Iraqi CIV H (b)(6)-4		M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
	18Y	X	9	

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
		99	(b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
		2200	

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
	LT76	

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION
			YEAR ☒ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
1	FCU2	

NATURE OF MEDICAL TREATMENT (b)(3)-1 (b)(6)-4 (b)(3)-1	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYYYMMDD)
05	A	20030824

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM 28th CSH	26. DATE THIS ADMISSION (YYYYMMDD)
*KACAA	A14A1	20030821

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYYYMMDD)
	A14A1	20030821

FOR LOCAL USE

Dx: 86415
86813
E9912
Trauma
9

Px: 5061
8622
Chest tube
569

ADMITTING OFFICER (Signature as required) (b)(6)-2	SIGNATURE OF ADMITTING CLERK (b)(6)-2
MD	

WHT, MC, USA

DA FORM 2985, MAR 2000 EDITION OF MAR 89 IS OBSOLETE USAPA V1.00

MEDCOM - 1617

21(-)

INPATIENT TREATMENT RECORD COVER SHEET *(For Plate Imprinting)*

...of this form, see AR 40-400; the proponent agency is the Office of The Surgeon General.

ENT DA (b)(6)-4 [redacted]

Tragi CIV # [redacted]

(b)(6)-4 [redacted]

LINE	LEGEND
1	REGISTER NO. - NAME - GRADE
2	SEX - AGE - RACE - RELIGION - LENGTH OF SVC - ETS - PREVIOUS ADMISSION
3	FMP - SSN - ORGANIZATION - WARD
4	FLY STAT - RATING/DESG - DEPT/BEN - BRANCH/CORPS - UIC/ZIP - TYPE CASE
5	SOURCE & AUTHORITY FOR ADMISSION - HOUR OF ADMISSION - CLINIC SVC
6	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
7	ADDRESS OF EMERGENCY ADDRESSEE - PHONE NO. - DATE OF THIS ADMISSION
8	NAME & LOCATION OF MEDICAL TREATMENT FACILITY DATE OF INITIAL ADMISSION

ADMISSION REMARKS

(b)(6)-4 [redacted]

ADMITTING OFFICER (b)(6)-2 [redacted]

32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED

5. TYPE DISPOSITION RTD

26. DATE OF DISPOSITION 23 Aug03

11. SELECTED ADMINISTRATIVE DATA

☐ CHECK IF CONTINUED ON REVERSE

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

shrapnel wound (L) occiput 873.0 ICDFY02

(R) arm plegia - too broad of dx

(R) pneumothorax 56 chest tube 512.1 ICD9FY02

☐ CHECK IF CONTINUED ON REVERSE

35. TOTAL DAYS THIS FACILITY

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

36. TOTAL DAYS ALL FACILITIES

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

SIGNAT (b)(6)-2 [redacted] ...ORDS OFFICER

SIGNATURE (b)(6)-2 [redacted]

...EDITION OF 1 AUG 76 IS OBSOLETE.

DA FORM 1 MAY 79 3647-X

MEDCOM - 1618

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

PERTINENT HISTORY, CHIEF COMPLAINT, AND CONDITION ON ADMISSION *(Enter date of admission)*

Pt. 43y/o EPW transferred from 28th CSH. Pt. S/p shrapnel wound to (L) occipital & (R) arm plegia. Also, Pt. had (R) PTX and is S/p chest tube - removed 19 Aug. Pt. complains of (R) arm plegia & (R) leg paresthesia. He also reports 28th CSH did not remove shrapnel from brain. No neurosurgical note available. Dic note reports shrapnel in frontal lobe & no exit wound. reports shrapnel in

PMHx	PSHx	Allergies	Meds
Arthritis	ϕ	Aka SA	Ibuprofen 800 mg QHS Zantac 150mg BID

PHYSICAL EXAMINATION

Gen - NAD
HEENT - healing incision (L) occipital & small frontal lobe
EOMI
Heart - RRR
Lungs - CTA (R)
Chest - dressing (R) chest S/p chest tube pull
Abd - soft, ND, NT, (+) BS
Ext - (R) arm - plegia, minimal movement & strength

Ext Gait
(R) leg - paresthesia w/ Rom & strength
(L) arm & leg - wnl Rom & strength

PROGRESS *(Enter date of discharge and final diagnosis)*

AG: Pt. 43y/o EPW S/p shrapnel wound (L) occipital & (R) chest. Shrapnel still present frontal lobe. (R) PTX resolved S/p chest tube.

1. Admit to ICU 2
2. Labs CXR in AM
3. PT
4. Discuss about placement

(b)(6)-2

	DATE	IDENTIFICATION NO.	ORGANIZATION
Yes			

PATIENT'S IDENTIFICATION *(For typed or written entries give Name last, first, middle initial; date; hospital or medical facility)*

REGISTER NO.	WARD NO.

Iraqi

(b)(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
USAPPC V1.00

ECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)

Discharge Summary

DOA → 17 AUG 03

DO Transfer → 21 AUG 03

Iraqi EPW male with fragment wound to the (L) occiput and (R) arm plegia. Also took shrapnel to (R) chest with (R) sided pneumothorax → needle thoracostomy tube into (R) chest tube. Patient awake, alert and appropriate from time of annual follow commands. No RUE movement since time of admission. Small 1cm (L) occipital entrance. Skull Xray revealed fragment from parietal → occiput → frontal lobe (no exit wound). Chest tube removed 19 AUG without pneumothorax. Pt conversant, cooperative on wood. Transferred at this time to 21BSH [see neurosurgical notes]

Transfer meds

(1) Dilantin 300mg po QHS

(2) saline lock

(3) Zantac 150mg po BID

Diagnosis (1) (R) arm monoplegia

(2) (L) occiput shrapnel wound

(3) (R) hemithorax fragments with (R) pneumothorax

(b)(6)-2

MD

RECORDS MAINTAINED AT

HOSPITAL OR MEDICAL FACILITY

STATUS

RELATIONSHIP TO SPONSOR

SSN/ID NO.

REGISTER NO.

WARD NO. ICU3

SPONSOR'S NAME

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

USAPA V2.00

(b)(6)-4

MEDCOM - 1620

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
2200 21Aug03	Arrived from EMT via gremey. NAD VSS T98[8] P91 R18 BP 123-76 Sat's 98% RA. A10X3 PERRL Has stack to back of head. Red marks over (R) eye. Chest CTA c̄ dressing to (R) upper chest from prior CT C-DT. (+) BS Unable to move (R) UE. Will cont to monitor per the orders [redacted] (b)(6)-2 (b)(6)(2)
0200 22Aug03	Sleeping well. NAD rises and fall of chest noted. will cont to monitor per order. Guard is in place. [redacted] (b)(6)-2
0500 22Aug03	AM Labs done at this time. Tolerated well [redacted] (b)(6)-2 (b)(6)-2
22Aug03 0705	Pt resting in bed VS- 120/72, 84, 97[9], 96%, 14. Pt in NAD. PERRLA, lung fields CTA + Pulses to all extremities. Good Cap. refill. Pt moves all extremities except RUE. + BS x4. dressing C/D/I. Will continue to monitor. [redacted] (b)(6)-2
22Aug03 1000	IV D5 1/2NS + 20KCl Started @ 100cc/hr. [redacted] (b)(6)-2
22Aug03 1200	750 ml clear yellow urine. [redacted] (b)(6)-2 (b)(6)(2)
22Aug03 1230	VS- 115/62, 85, 98[2], 97, SPO2, RR14. [redacted] (b)(6)-2
1400	Assumed care. Pt appears to be sleeping in bed, in NAD. D5 1/2NS + 20K infusing via #[illegible] (L) UE PIV. No S/S infection/infiltration. CDI. Passive Rom performed. Pt tolerated well. Will continue to monitor [redacted] (b)(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or writ[redacted] give: Name - last, first, middle; ID No or SSN; Se[redacted]rth; Rank/Grade)	REGISTER NO.	WARD NO.

EPW # [redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

509-114

MEDCOM - 1621

DATE	NOTES
22 Aug 03	Surg note
0852	S: Pt. resting comfortably, Tol PO-liquid
	O: Afebrile, VSS
	Heart - RRR Chest - dressing in place (R) chest
	Lungs - CTA (B)
	Abd - soft, ND, NT, (+) BS
	~~CB (+)~~ 7.6 > 13.7/37 < 446
	CXR - ∅ PTX, (+) shrapnel
	Skull - (+) shrapnel
	A/P: Pt. c̄ shrapnel wound Head/(R) chest -
	(R) arm paresis - stable.
	(1) Place IV & start fluids until
	pt. tol PO well
	(2) Plan ~~[illegible]~~ removal of
	(R) chest dressing tomorrow
	(3) Cont passive movement (R) arm
	(4) Attempt to obtain neurosurgery
	note from (b)(3)-1 [redacted] (b)(6)-2 [redacted]

MAJ MC

MEDICAL RECORD | **PROGRESS NOTES**

DATE

22Aug03 1430. Assessment completed. A&O X3. PERRLA - lungs CTA (B) Heart - RRR - Abd - BS active X4 non-tender, non-distended. (R) UE paralysis. elevated on pillow X1. Scalp hematoma / stitches CDI - open to air. HOB ↑ 30°. Pt denies pain/discomfort other than (R) UE c̄ passive ROM. Drsg to (R) flank CDI - old CT site. Will continue to monitor — [redacted] (b)(6)-2

1730 Pt c/o HA. Notified DR [redacted] (b)(6)-2 Administered Tylenol 650 mg po. Pt sitting ↑ @ BS eating dinner. — [redacted] (b)(6)-2

1800 Pt ambulated for ~5 min unassisted. Placed RUE in cravat d/T hemiparesis. Pt c/o slight "dizziness" but showed steady gait. Pt sitting in chair @ BS. Will continue to monitor — [redacted] (b)(6)-2

1815 VS - BP 129/91 HR 94 RR 14 POX 96% T - 98.3.

22Aug03 2215 Took over curve A/O X3 VSS T 97° P 84 R 12 BP 119/64 Sat's 99% PERRL Chest CTA. Heart RRR Abd (+) BS X4 Ø tenderness - non distended (R) sided Paralysis, scalp hematoma c̄ stitches. CDI open to air. HOB ↑ 20° Has Ø c/o discomfort at this time. Will cont to monitor. — [redacted] (b)(6)-2

0130 23Aug03 Sleeping eyes closed. NAD will cont to monitor per orders. — [redacted] (b)(6)-2

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)

REGISTER NO. | WARD NO.

EPW # [redacted] (b)(6)-4

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FIRMR (41 CFR) 201-45.505
509-111

MEDCOM - 1623

PROGRESS NOTES

DATE	
23Aug03 0630	Pt assessment complete - Bp 121/73, P-83, T 98.3, SpO2 96% RR14 Pt resting in bed NAD, PERRLA, Lungs CTA. Heart RRR, + Pulses to all extremities, Cap refill less than 3 secs. + BS x4. (R) UE paralysis. Scalp hematoma & stitches CDI open to air. Drsg to (R) flank CDI. Pt has D5 ½ NS +20 KCL @ 100 cc/hr. Will continue to monitor for any changes. [b)(6)-2] HA
23 Aug 03	0900 - 700 ml clear urine.
23 Aug 03	1200 - VS 124/78, SpO2 97%, T 98.2, Pulse 100, RR 14
23 Aug 03 1400	Rec'd pt in chair. Voices ø C/o. AAOx3. Lungs CTA. Heart RRR @ 96. Pulses palpable. CR < 3 sec. BS(+) x 4 quads. 3 staples to scalp. Healed. Well approximated. Dressing CDI to (R) flank. IV HL'd @ AC & S/Sx of infection. Continue to monitor [b)(6)-2] cpl SN
23 Aug 03 1800	Pt showing difficulty VSS @ T 98.0 B/p 124/72 Pulse 100. Voices ø C/o. Pt ambulated. Gait steady. Slow [b)(6)-2] cpl SN
23 Aug 03 1940	To EPW Compound MP's. Condition stable. Took all belongings [b)(6)-2] cpl HL

PROGRESS NOTES

DATE
Aug 03
2858

Sing note
of new changes
pt. tol po
pt. has been OOB to chair
(R) arm paresis & paresthesia (R) leg
stable, (R) chest tube site healing ~~and~~ (R) well
A/m: pt. s/p shrapnel wound to head/
(R) chest stable.
(1) Cont passive motion (R) arm
(2) Await neurosurgery note/recs
from (b)(3)-1
(3) Heplock IV when
tol po well

(b)(6)-2

MAJ NC

Addendum
After discussion pt. is ready to
go to EPW Camp. will at
Dilantin & d/c pt. to EPW
Camp.

(b)(6)-2

MAJ NC

STANDARD FORM 509 BACK (Rev. 11-77)

*U.S. Government Printing Office: 1990-262-081/20138

MEDCOM - 1625

care/treatment or discharge from an inpatient hospital stay.

SECTION I
TO BE COMPLETED BY PRIVILEGED PROVIDER

1. DATE OF PROCEDURE/ADMISSION: 21 Aug 03
2. ADMITTING/DIAGNOSIS: Shrapnel wounds/ (R) Arm [illegible]
3. PERTINENT LAB, X-RAY, FINDINGS:
   ALG-3.0 Bun-12
   ALT-29 Cr-0.8
   Ang-29
   AST-5
   TG-0.5
4. PROCEDURES, TREATMENT, HOSPITAL COURSE:
   Dilantin 300 QHS
   No seizures — Ambulatory
   — No jaundice
   — No fever
   — Tolerating po
5. FINAL DIAGNOSIS AND CONDITION AT DISCHARGE:
   (1) Shrapnel wound (L) occipital
   (2) Shrapnel wound (R) thorax
   (3) (R) PTX s/p CT
   (4) (R) Arm Magic
6. ACTIVITY: Ambulatory
7. DIET: Local Camp Diet
8. MEDICATIONS:
   ☒ Medications have been prescribed for home use. See separate list and special instructions or see below.
   Dilantin 300 mg QHS
9. INSTRUCTIONS *(To Home Health Providers, Patient, etc)*:
   F/U pm
   Monitor drug interactions
10. [illegible]RGING PROVIDER: (b)(6)-2 MC
    (b)(6)-2 (Signature) (b)(6)-2 (Printed or Stamped Name)

PATIENT IDENTIFICATION
Frag: # (b)(6)-4

SECTION II
TO BE COMPLETED BY OTHER STAFF, AS APPROPRIATE

1. DISPOSITIONED TO: ☐ HOME ☐ DUTY ☑ OTHER EPW camp
   ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER
2. ACCOMPANIED BY: ☐ FAMILY ☐ FRIEND ☑ OTHER MPS
3. PATIENT EDUCATION:
   Completed and patient prepared for home care. ☑ YES ☐ NO
   If no, explain:
   Patient ☐ states ☐ demonstrates understanding of home care needs.
   Printed educational materials provided:
4. Clinical outcomes met and post-discharge/release referrals made.
   ☑ YES ☐ NO If no, explain:
5. If transferred to another health care facility, report called to nurse.
   ☐ YES ☐ NO If no, explain:
6. NUTRITION CARE - Comments:
   Regular Diet
7. MEDICATIONS: given to Medic
   Explained by: ☐ NURSE ☐ PHYSICIAN ☐ PHARMACIST
   Printed medication literature provided. ☐ YES ☐ NO
   Patient states understanding of prescribed medications. ☐ YES ☐ NO
8. EQUIPMENT/SUPPLIES PROVIDED:
   No
9. FOLLOW-UP APPOINTMENTS, POINT OF CONTACT & PHONE:
10. FOR PROBLEMS OR EMERGENCY, CONTACT & PHONE:
11. COMPLETED BY:
    (b)(6)-2 (b)(6)-2 CPT AN 23 Aug 03 1940
    (Signature and Title) (Date and Time)

I HAVE RECEIVED A COPY OF AND UNDERSTAND THESE INSTRUCTIONS.

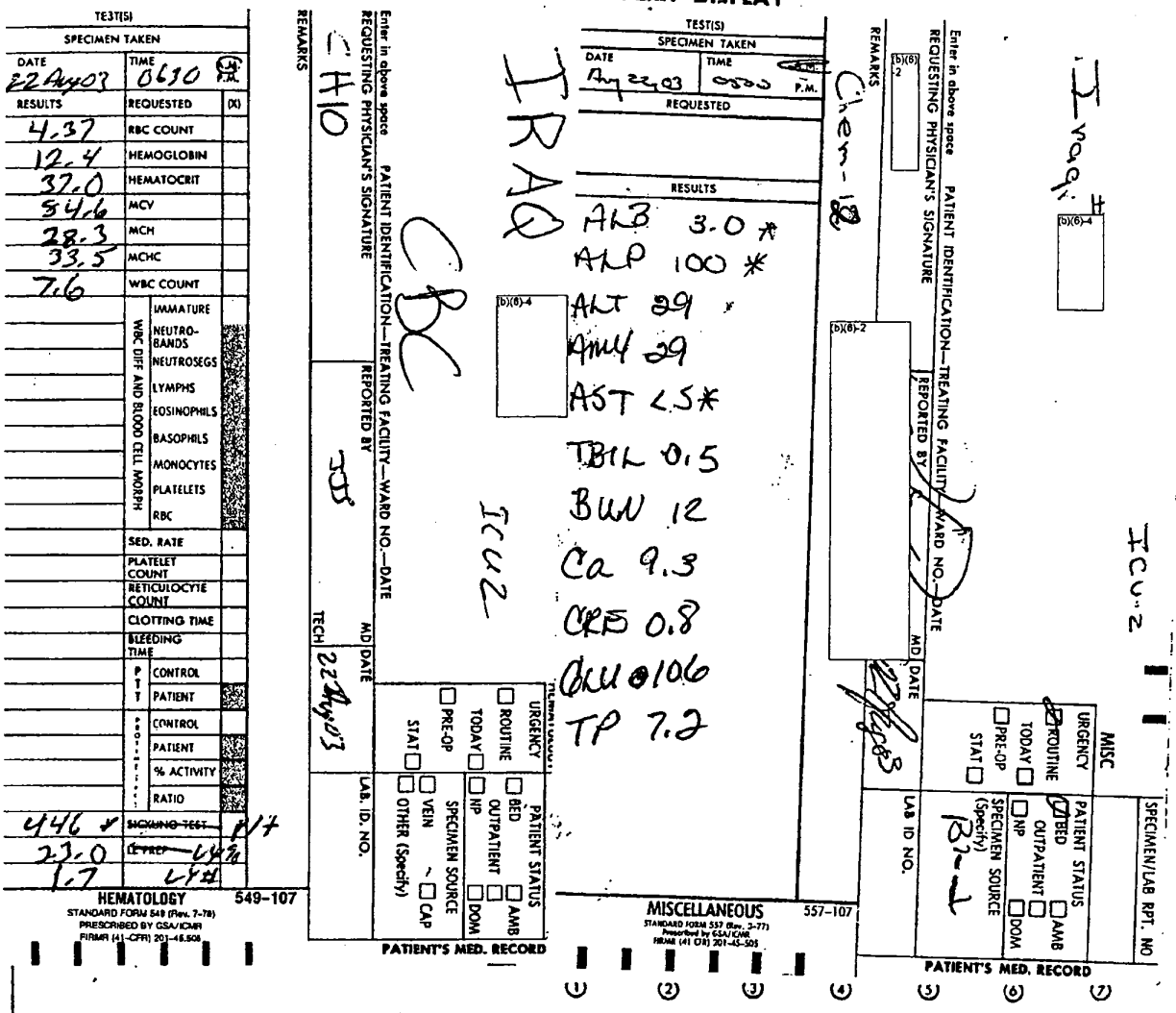
(Patient/Responsible Adult's Signature) (Date and Time)

MEDCOM FORM 691-R (TEST) (MCHO) MAR 99 PREVIOUS EDITIONS ARE OBSOLETE MC V1.00

MEDCOM - 1626

STANDARD FORM 545 Rev.
10-75 545-108

LABORATORY REPORT DISPLAY



ALIGN ALL LABORATORY REPORTS ALONG THIS BASE LINE

INSTRUCTIONS: This form may be used to display laboratory reports as a flow sheet to be read as a progressive table. If so, a separate sheet should be used for each type of report form. When assorted report forms are mounted on the display sheet, both test names and results should always be visible.

SPACE BELOW: PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

FORMS DISPLAYED ON THIS SHEET ARE (Check one)

MOUNTED ON STRIPS 1 THROUGH 7
- ☐ CHEMISTRY I (SF 546)
- ☐ CHEMISTRY II (SF 547)
- ☐ CHEMISTRY III (SF 548)
- ☐ HEMATOLOGY (SF 549)
- ☐ URINALYSIS (SF 550)
- ☐ SEROLOGY (SF 551)
- ☐ SPINAL FLUID (SF 555)

MOUNTED ON STRIPS 1, 3, 5, AND 7
- ☐ PARASITOLOGY (SF 552)
- ☐ IMMUNOHEMATOLOGY (SF 556)
- ☐ ASSORTED FORMS
- ☐ OTHER (Specify)

MOUNTED ON STRIPS 1, 4, AND 7
- ☐ MICROBIOLOGY I (SF 553)
- ☐ MICROBIOLOGY II (SF 554)
- ☐ MISCELLANEOUS (SF 557)
- ☐ ASSORTED FORMS

General Services Administration and Interagency Committee on Medical Records
Prescribed by GSA ICMR
FIRMR (41 CFR) 201-45.505

LABORATORY REPORT DISPLAY

☆ GPO—1991—304—610

MEDCOM - 1627

NSN 7540-01-165-7294 519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

EXAMINATION(S) REQUESTED	AGE / SEX / SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
(1) CXR- ~~RAD/LAT~~ AP (Port) P+PART. PARALY (2) LAT SKULL	43 / ♂ [b)(6)-2]	ICU 2	
	FILM NO.		PREGNANT ☐ YES ☒ NO
	REQUESTED BY (Print) [b)(6)-2]		TELEPHONE/PAGE NO. OR .
	SIGNATURE OF REQUESTOR [b)(6)-2]		DATE REQUESTED 21 AUG 03

SPECIFIC REASON(S) FOR REQUEST *(Complaints and findings)*

43yo EPW transferred from [(b)(3)-1] Sp (R) PTX (shrapnel) & (L) parieto-occipital entrance head wound - shrapnel. please do admission films for baseline ~ resolution of PTX, location head frags

DATE OF EXAMINATION *(Month, day, year)*	DATE OF REPORT *(Month, day, year)*	DATE OF TRANSCRIPTION *(Month, day, year)*

RADIOLOGIC REPORT

Chest — Clear lungs, nl heart, neg fxs shrapnel projects over (R) axilla and over R hemidiaphragm - need lateral film to tell exactly where pcs are

Lat skull — 3 pcs ? shrapnel project over lateral skull - (parietal bone)

[b)(6)-2]

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name — last, first, middle, Medical Facility)*	LOCATION OF MEDICAL RECORDS
IRAQI # [b)(6)-4] ICU-2	LOCATION OF RADIOLOGIC FACILITY
	SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT
1 — MEDICAL RECORD

STANDARD FORM 519-B (8-83)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.806-6

MEDCOM - 1628

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

PRAQI # (b)(6)-4

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
21 aug 03	2220 HOURS	
✓(1) admit to icu-2, Dr Choi, Gen Surg		
✓(2) DX: Serrapnel wound (R) thorax and head		
(1) occipital scalpel, (R) PTX s/p CT, (R) arm hemiplegia		
✓(3) condition: good		
✓(4) NKDA		
✓(5) Diet: Regular		
✓(6) Vitals: q 6'		

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	
✓(7) activity: ad lib	HOURS	
✓(8) Dilantin 300mg po qhs		
~~Zantac (10)~~		
✓(9) Passive ROM (R) UE tid		
✓(10) CBC, Chem 10 ~~as admission~~ in AM		
✓(11) CXR Lat/PA and lat skull in am please.		

NURSING UNIT (b)(6)-2 | ROOM NO. 21 Aug 03 @ 2320 | BED NO. (b)(6)-2 PTAM (b)(6)-2 (b)(6)-2 LTC, DDS, MD

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	
	HOURS	

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	
	HOURS	

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 1629

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
IRAQI [redacted]	22 Aug 03	0856 HOURS	
	(1) Start IV		
	Run D5½ NS c̄ 20mg KCl		
	at 100 cc/hr		
	[redacted]		
NURSING UNIT / ROOM NO. / BED NO.			

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
Iraqi # [redacted]	22 AUG 03	1730 HOURS	
	VO OR [redacted]	[redacted] 100/hr	
	(1) Tylenol 650 mg PO Q4° prn pain		
	[redacted] MD		
	[redacted] LTC MC		
	(b)(6)(2) [redacted] PRACTICE		
NURSING UNIT / ROOM NO. / BED NO. 1730			

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
Iraqi # [redacted]	23 Aug 03	1920 HOURS	
	(1) D/C to MPs		
	(2) D/C [redacted] (b)(6)(2)		
	[redacted] MD		
	[redacted] MC		
	(b)(6)(2) [redacted] FAMILY PRACTICE		
NURSING UNIT / ROOM NO. / BED NO.			

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
Iraqi # [redacted]		HOURS	
NURSING UNIT / ROOM NO. / BED NO.			

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 1630

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 8 Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 21	22	23
21Aug03	(b)(6)-2	Condition: Good	D	/	BC	(b)(6)-2
			E	/	[illegible]	
			N	[illegible]	[illegible]	
21Aug03	(b)(6)-2	Diet - Reg	B	/	BC	
			L	/	[illegible]	
			D	/	[illegible]	
21Aug03	(b)(6)-2	Vital's q 6°	D	/	BC	
			E	/	[illegible]	
			N	[illegible]	[illegible]	(b)(6)-2
21Aug03	(b)(6)-2	Act: Ab Lib	D	/	BC	
		(MP @ bedside)	E	/	[illegible]	
			N	[illegible]	[illegible]	(b)(6)-2
21Aug03	(b)(6)-2	Passive ROM (R) UE TID	D	/	BC	
			E	/	[illegible]	
			N	[illegible]	[illegible]	(b)(6)-2
22Aug03	(b)(6)-2	D5 ½ NSC 20 meq KCl	D	/	BC	(b)(6)-2
		at 100 cc/hr	E	/	[illegible]	
			N	/	[illegible]	

ALLERGIES: ☐ YES ☑ NO

NKDA

PRIMARY DIAGNOSIS: Serrapenil wound (R) thorax and head (L) Occipital scaplae, (R) PTX s/p CT, (R) Arm hemplage

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

Iraqi (b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	
N	24	01	02	03	04	05	0	

DA FORM 1 OCT 73 1677 EDITION OF 1 DEC 77 MAY BE USED.

MEDCOM - 1631

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON MEDICATION)

Mo 8 Yr 03

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
Aug 21,03	[redacted]	Admit to ICU-2 Dr [redacted] Gen Surg		Done	—	[redacted]
Aug 21,03	[redacted]	CBC, Chem-10 in AM	22Aug03	0500	[redacted]	
Aug 21,03	[redacted]	CXR, LAT/PA, LAT SKULL in AM	22Aug03	0700	0545	

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED

ACLU-RDI 1099 p.416

DOD 005684

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATION)

For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

DATA 8 JUL 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 21	22	23
21 Aug 03	(b)(6)-2	Dilantin 300 mg PO q HS	22	/ (b)(6)-2		

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS: Scalp wound (R) Thorax and head (L) Occipital Scalp (R) PTx s/p CT (L) Arm Hemiplegic

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

Iraqi # (b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

0 3 9 10 11 12 13 14 15

E 16 17 18 19 20 21 22 23

I 24 01 02 03 04 05 06 07

FORM SET-3

EDITION OF 1 DEC 77 MAY BE USED.

MEDCOM - 1633

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON MEDICATION)			Mo _____ Yr _____	
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED															
22 Aug	(b)(6)-2	Tylenol 650mg po Q4° per	1730 22 Aug (b)(6)-2															

MEDCOM - 1634

ADMISSION AND CODING INFORMATION

For use of this form, see AR 40-400; the proponent agency is OTSG

1. REPORTING MTF: A (b)(3)-1
2. MTF LOCATION (State or Country Code.): F 7
3. REGISTER NUMBER: (b)(6)-4
NAME (Last, First, Middle Initial): Iraqi CIV # (b)(6)-2
4. PAY GRADE: CIV
5. SEX: M
6. DATE OF BIRTH (Y Y Y Y M M D D):
7. AGE AT ADMISSION:
8. RACE: 30
9. ETHNIC BACK-GROUND: 31
RELIGION:
10. LENGTH OF SERVICE:
ETS:
11. FMP: 99
12. SOCIAL SECURITY NUMBER: (b)(6)-4
ORGANIZATION (Active Duty Only):
13. MARITAL STATUS: 46
HOUR OF ADMISSION: 2200
BRANCH / CORPS:
14. FLYING STATUS:
15. BENEFICIARY CATEGORY: 12 7 6
16. ZIP CODE OF RESIDENCE:
17. UNIT LOCATION (State or Country Code):
18. MOS:
19. TRAUMA:
PREV. ADMISSION: YEAR: NO: X
20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: 72 1
WARD: ICU2
NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE:
ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code):
TELEPHONE NUMBER OF EMERGENCY ADDRESSEE:
(b)(3)-1 AT (b)(3)-1 NT FACILITY (b)(6)-2
ISPOSITION: 73 74: 0 1
22. MTF TRANSFERRED TO:
23. DATE OF DISPOSITION (Y Y Y Y M M D D): 20030823
24. CLINIC SVC - ADMITTING: A6AA
25. MTF TRANSFERRED FROM: [redacted]
26. DATE THIS ADMISSION (Y Y Y Y M M D D): 20030821
27. LOCATION OF OCCURRENCE (Battle Casualty Only):
28. MTF OF INITIAL ADMISSION: A1 4 A1
29. DATE INITIAL ADMISSION (Y Y Y Y M M D D): 20030823
FOR LOCAL USE

Dx: 80059
8601
34440
E9919

Px 3839
3404
8659

Trauma 9

Dr Chung 590

(b)(6)-2

(b)(6)-2 (b)(6)-2 (b)(6)-2 (

21(E)

INPATIENT TREATMENT RECORD COVER SHEET *(For Plate Imprinting)*

For use of this form, see AR 40-400; the proponent agency is the Office of The Surgeon General.

ITEMS 1 - 30 *(Excluding Items 25 & 26)*

b)(6)-4

LINE	LEGEND
1	REGISTER NO. - NAME - GRADE
2	SEX - AGE - RACE - RELIGION - LENGTH OF SVC - ETS - PREVIOUS ADMISSION
3	FMP - SSN - ORGANIZATION - WARD
4	FLY STAT - RATING/DESG - DEPT/BEN - BRANCH/CORPS - UIC/ZIP - TYPE CASE
5	SOURCE & AUTHORITY FOR ADMISSION - HOUR OF ADMISSION - CLINIC SVC
6	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
7	ADDRESS OF EMERGENCY ADDRESSEE - PHONE NO. - DATE OF THIS ADMISSION
8	NAME & LOCATION OF MEDICAL TREATMENT FACILITY DATE OF INITIAL ADMISSION

ADMISSION REMARKS

(b)(6)-4

R4/

b)(6)-2

32. UNITS OF BLOOD/COMPONENT TRANSFUSED

Transfer for 28th CSR

25. TYPE DISPOSITION D/C

26. DATE OF DISPOSITION 24 Aug 03

31. SELECTED ADMINISTRATIVE DATA

☐ CHECK IF CONTINUED ON REVERSE

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES 876.0 879.2 ICD9FY02

Gunshot Wound to Back/Abd 45.79 46.10 NES ICD9FY02

S/P Ex lap c̄ Colectomy, (R) colon colostomy

958.3 ICD9FY02

Wound Infection c̄ small area fascial dehiscence POD#16 998.3 ICD9FY02

Right Leg weakness 780.79 ICD9FY02

☐ CHECK IF CONTINUED ON REVERSE

35. TOTAL DAYS THIS FACILITY

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

36. TOTAL DAYS ALL FACILITIES

a. ABSENT SICK DAYS	b. OTHER	c. CONV LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

SIGN b)(6)-2 b)(6)-2 b)(6)-2 b)(6)-2 OR MEDICAL RECORDS OFFICER SSG

DITION OF 1 AUG 76 IS OBSOLETE.

DA FORM 1 MAY 79 3647-1

MEDCOM - 1636

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

PERTINENT HISTORY, CHIEF COMPLAINT, AND CONDITION ON ADMISSION *(Enter date of admission)*

24yo EPW who on 5 Aug sustained a GSW to (R) back which apparently caused a (R) colon injury. He underwent laparotomy and (R) colon colostomy. Post op developed a wound infection and small area of fascial dehiscence. Presents c/o (R) leg weakness, tolerating diet, no apparent signs of sepsis. Wound care to paramedian incision.

PmHx - Ø PsHx as above Meds - None NKDA

Denies Pain

PHYSICAL EXAMINATION

WDWN ♂ NAD A&OX3, conversant through interpretor

HEENT - WNL

Neck - small healed wound (L) neck

L - CTA

CV - RRR3 (R) (R) (g)

Abd NABS, soft nontender, Ø peritoneal signs:

(R) Paramedian incision open, granulating well

No bowel visible. Colostomy viable, stool in bag

PROGRESS *(Enter date of discharge and final diagnosis)*

Ext - Ø Evidence trauma

Neuro nonfocal x̄ (R) leg 4/5 strength to hip flexion.

Pt relate Le can walk c̄ assistance

A/P 5/p GSW to Abd → colostomy, wound granulating well.

(R) leg weakness - CS pain X rays

(b)(6)-2	DATE 8/21/03	IDENTIFICATION NO.	ORGANIZATION
		REGISTER NO.	WARD NO.

...n entries give Name last, first, middle; grade; date; hospital or medical facility)

Iraqi (b)(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
USAPPC V1.00

MEDCOM - 1637

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
21 Aug 03 @ 2200	Admission note: Patients transfered from (b)(3)-1 as a direct admit to ICU2. Arrived @ unit via litter. Translator present, MP guard available. VSS: Bp 104/43, HR 72, RR 16, Temp. 98.3, SAT 98%. Dressing to abdomin, packed (+) exudate in wound and on dressing. colostomy to (R) side (+) drainage. Dressing to lower back. (+) drainage. New dressings applied to all sites. Pt states weakness / numbness to (R) leg. (B) upper + lower extremeties full strength. Neuro vascular intact. Pulses normal. (+) Bowel sounds. Will continue to monitor — (b)(6)-2 CPT/AE
22 Aug 03 (0200)	Bp: 103/50, HR 70, Temp 99.3, SAT, 98%, RR 16 / Pt continues to sleep. 0 complaints @ this time. — (b)(6)-2 CPT/AE

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		
PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)		REGISTER NO.	WARD NO.	

Iraqi # (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

509-114

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
27 AUG 03 @ 1800	TRANSFER SUMMARY 23 yo 5/p GSW to Abdomen / Back c̄ fx of Transverse Process L3, presented s/p operation at Iraqi Hospital c̄ Colostomy + paramedian wound. He did well but developed wound infection. On POD #13 we opened the wound. He had a small fascial dehiscence and with everything so socked in I decided it best to let everything granulate c̄ ventral Hernia formation, to be fixed if the ostomy ends up being taken down. He is presently doing well + getting dressing Δ's. (b)(6)-2 (b)(6)-2 MAJ (b)(6)-2 1st FST (b)(3)-1

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

REGISTER NO.	WARD NO.

(b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1 USAPA V2.00

MEDCOM - 1639

PROGRESS NOTES

EDICAL RECORD

Pt VS- 107/52, T99[8], Bpm 76, SPO2 97%, BR14. Pt resting in bed NAD, PERRA, Pt lung fields CTA., + Pulses x4. Good Cap refill. Pt has (R) sided colostomy minimal drainage. + BS x3 dressing over 4th area. Pt moves all extremities. Will continue to monitor.

(b)(6)-2 [redacted]

(b)(6)-2 [redacted]

Aug 03 G Surgery
Pt resting comfortably
Vss Tmax < 100
Abd soft, benign
wound granulating well
WBC 12.3 Lyts-wnl w/A(-) CX R(-)

P/P S/P GSW to abd
Continue wound care
Ambulate c̄ assistance

(b)(6)-2 [redacted]

(b)(6)-2 [redacted]

(b)(6)-2 [redacted]

(Continue on reverse side)

REGISTER NO.

WARD NO.

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)

(b)(6)-4 [redacted]

Iraqi #

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FIRMR (41 CFR) 201-45.505
509-111

MEDCOM - 1640

DATE	PROGRESS NOTES
22 Aug 03 0900	Pt's dressing D'd. Abd abd wound football shaped approx 2x1 inch beefy red, white discharge noted slight odor from wound noted. Wound on back 1 cm in diameter, no signs of infection noted. Pt ambulated c minimal assistance needed. (b)(6)-2
1400	Assumed care. Pt resting comfortably in bed, in NAD VSS – T-99.6 BP – 106/49 HR – 73 Sat 98% RR-14 Assessment completed. PERRLA. Lungs CTA (B). Heart - RRR. Abd - BS active x4. NL abd dsg. CDI. RLQ colostomy c mod - semi formed brown stool. RUE/BLE NV intact. No % pain/discomfort. Will cont. to monitor (b)(6)-2
1730	Pt ate 50% of dinner. Encouraged & assisted pt to ambulate ~50 steps. Pt c/o (8) high pain and limped. Pt now resting in bed. (b)(6)-2
2000	Dsg Δ to ABD Completed. Tissue red & beefy c small amt. puss-like discharge. Packed a Kerlex soaked in Sterile H2O per order. Covered c 4x4. Pt tolerated c moderate discomfort. Premedicated c Tylox T po 30 prior (b)(6)-2

MEDICAL RECORD | PROGRESS NOTES

ATE

ug 03 @ 2200 Nurse note: Pt sleeping but easily arousable. Dressing to abdomen c/D/I. same @ back L3. Colostomy c̄ small amount of liquid stool. Strong grip strength. Pulse +2 x all extremities. N/V intact. ~~Will~~ Denies pain / discomfort @ this time.
Vitals: Bp 98/47, HR 63, SAT 99%, RR 16, Temp 99°
Will continue to monitor for change. b)(6)-2

ug 03 0200 VS - Bp 107/50, HR 64, RR, 16, SAT 99% - Temp 98°
Ø complaints, voiding clear yellow urine s̄ difficulty. Respiration even/unlabored will cont. to monitor. b)(6)-2

Aug 03 0645 Pt assessment complete VS - 110/56, 72, 98%, 99°/12.
Pt alert. PERRLA, lung fields CTA, Cap refil <3 sec. + Pulses to all extremities. Pt able to move all extremities. (R) side Colostomy CDI, back and Abd dressing CDI. + BS x3, abd dressing covering 4th. Will continue to monitor for any changes. b)(6)-2

3 Aug 03 Surgery
Pt doing well, tolerating diet, Ambulating
VSS Temp <100
L-CTA Abd-negative, [illegible]
Wind [illegible]

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)

REGISTER NO. | WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FIRMR (41 CFR) 201-45.505
509-111

(b)(6)-4

MEDCOM - 1642

PROGRESS NOTES

DATE

P/p S/y Exchange - Colostomy
(1) Mobilization
(2) Wound care
(3) ↑ PO Nutrition

(b)(6)-2

LTC MC

23 Aug 03 1020

G Surgery
Overall plan is to teach patient colostomy care. If pg able to recieve wound care at EPW camp maybe discharged c̄ every few day following to ocens wound healing.

(b)(6)-2

LTC MC

23 Apr 03 1500

Voices ø c/o. Colostomy reinforced 2° drainage V33 @ T98.6 B/P 122/50 HR84, AAOx3, MAE's (5)(B) Lungs CTA Pulses palpable, Dressings CAT. Continue to monitor

(b)(6)-2

Gplod

*U.S. Government Printing Office: 1990-262-081/20138

MEDCOM - 1643

STANDARD FORM 500 BACK

MEDICAL RECORD | **PROGRESS NOTES**

DATE	
03	VSS Bp 116/54, HR 55, RR 16, Temp 98.6, Pox 100%
20	Pt A+oriented. Requesting pain meds. Tylox ii
	given po. Dressing changed to lower back.
	Ostomy care done. Stoma pink c̄ fatty tissue
	around stoma. ⊕ formed stool. Pulses +2 all
	extremities. MAEW. Tolerating fluids. Will
	Continue to monitor for change — [redacted] (b)(6)-2 CP/Pa
Aug 03	Report received, assumed care of patient. Appears
0400	to be asleep @ this time, respirations regular + unlab-
	bored. — [redacted] (b)(6)-2
Aug 03	G Surgery
	Pt doing well, no Ex's, no other problems
	Vs A [illegible]
	[illegible] CV-RRR
	Wound granulating well
	A/P 1/P Exhaust - stable
	May be discharged when learns
	colostomy care
	Flu for wound check every 2-3 days —
	[redacted] (b)(6)-2

(Continue on rev

REGISTER NO.

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)

Potus / EPW # [redacted] (b)(6)-4

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FIRMR (41 CFR) 201-45.505
509-111

MEDCOM - 1644

PROGRESS NOTES

DATE	
24 May 1015	BP 108/48 / T 98° / O2 sat 98% / HR 58. Midline abdominal dsg Δ'd NS W→D. Small amt purulent drainage noted. Trank bleeding + granulation noted. Dr [redacted] in to see patient [redacted] RAT AN
24 May 03 1430	Assumed Care of pt. VSS 102/49 P 66 T 99² R 20. Resting quietly AOx3. Lungs CTA(B) HR RRR. Bowel sounds active. Brown formed stool in colostomy bag in RUQ. All pulses palpable. Ø IV. Ø HL. Voices Ø C/O. Continue to monitor [redacted] cpt AN
24 May 03 1600	MP's at bedside to learn colostomy care c̄ pt. Pt Δ'd Colostomy 3 diff. Medic to Δ dressing until closed. Will be back to take to EPW Camp at 1800. Cont to monitor. Ø Δ in wound from AM. [redacted] cpt AN
2030	DC to EPW Camp c̄ all belongings. Sent c̄ dressing + colostomy supplies. Accompanied by MP's. VSS. Condition stable. [redacted] cpt AN

*U.S. Government Printing Office: 1990-262-081/20138 MEDCOM - 1645

For use of this form, see MEDCOM Circular 40-5

DIRECTIONS: To be completed by attending provider and other staff at time of patient release following an outpatient procedure, extended care/treatment or discharge from an inpatient hospital stay.

SECTION I
TO BE COMPLETED BY PRIVILEGED PROVIDER

1. DATE OF PROCEDURE/ADMISSION: 21 Aug 03
2. ADMITTING/DIAGNOSIS: Ex Lap, Colostomy
3. PERTINENT LAB, X-RAY, FINDINGS:
Operation at Iraqi Hospital
(L) Colectomy, Colostomy POD #19
(R) Back Entry Wound
OPEN PACKED DRAIN Wound
4. PROCEDURES, TREATMENT, HOSPITAL COURSE:
Wound care only at 21st CSH
5. FINAL DIAGNOSIS AND CONDITION AT DISCHARGE:
GSW to Back/Abd
S/P Ex Lap ± Colectomy (L) colon
Colostomy
Wound Infection ± Debrided
6. ACTIVITY: Adlib
7. DIET: Regular
8. MEDICATIONS:
☐ Medications have been prescribed for home use. See separate list and special instructions or see below.
None
9. INSTRUCTIONS *(To Home Health Providers, Patient, etc)*:
Wet to dry Wound care
Twice a Day

[b)(6)-2] [b)(6)-2] [b)(6)-2]
Emergency
(Printed or Stamped Name)

[b)(6)-4]
Iraqi

SECTION II
TO BE COMPLETED BY OTHER STAFF, AS APPROPRIATE

1. DISPOSITIONED TO: ☐ HOME ☐ DUTY ☑ OTHER EPW Camp
☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER
2. ACCOMPANIED BY: ☐ FAMILY ☐ FRIEND ☑ OTHER MP's
3. PATIENT EDUCATION:
Completed and patient prepared for home care. ☑ YES ☐ NO
If no, explain:
Patient ☐ states ☑ demonstrates understanding of home care needs.
Printed educational materials provided:
Ø
4. Clinical outcomes met and post-discharge/release referrals made.
☑ YES ☐ NO If no, explain:
5. If transferred to another health care facility, report called to nurse.
☐ YES ☐ NO If no, explain:
6. NUTRITION CARE - Comments:
Reg Diet
7. MEDICATIONS: Ø
Explained by: ☐ NURSE ☐ PHYSICIAN ☐ PHARMACIST
Printed medication literature provided. ☐ YES ☐ NO
Patient states understanding of prescribed medications. ☐ YES ☐ NO
8. EQUIPMENT/SUPPLIES PROVIDED:
Ostomy + Colorectal Care Supplies
9. FOLLOW-UP APPOINTMENTS, POINT OF CONTACT & PHONE:
10. FOR PROBLEMS OR EMERGENCY, CONTACT & PHONE:
11. COMPLETED BY: DC 2030
[b)(6)-2] [b)(6)-2] CPT AN 24 Aug 03 1745
(Signature and Title) *(Date and Time)*

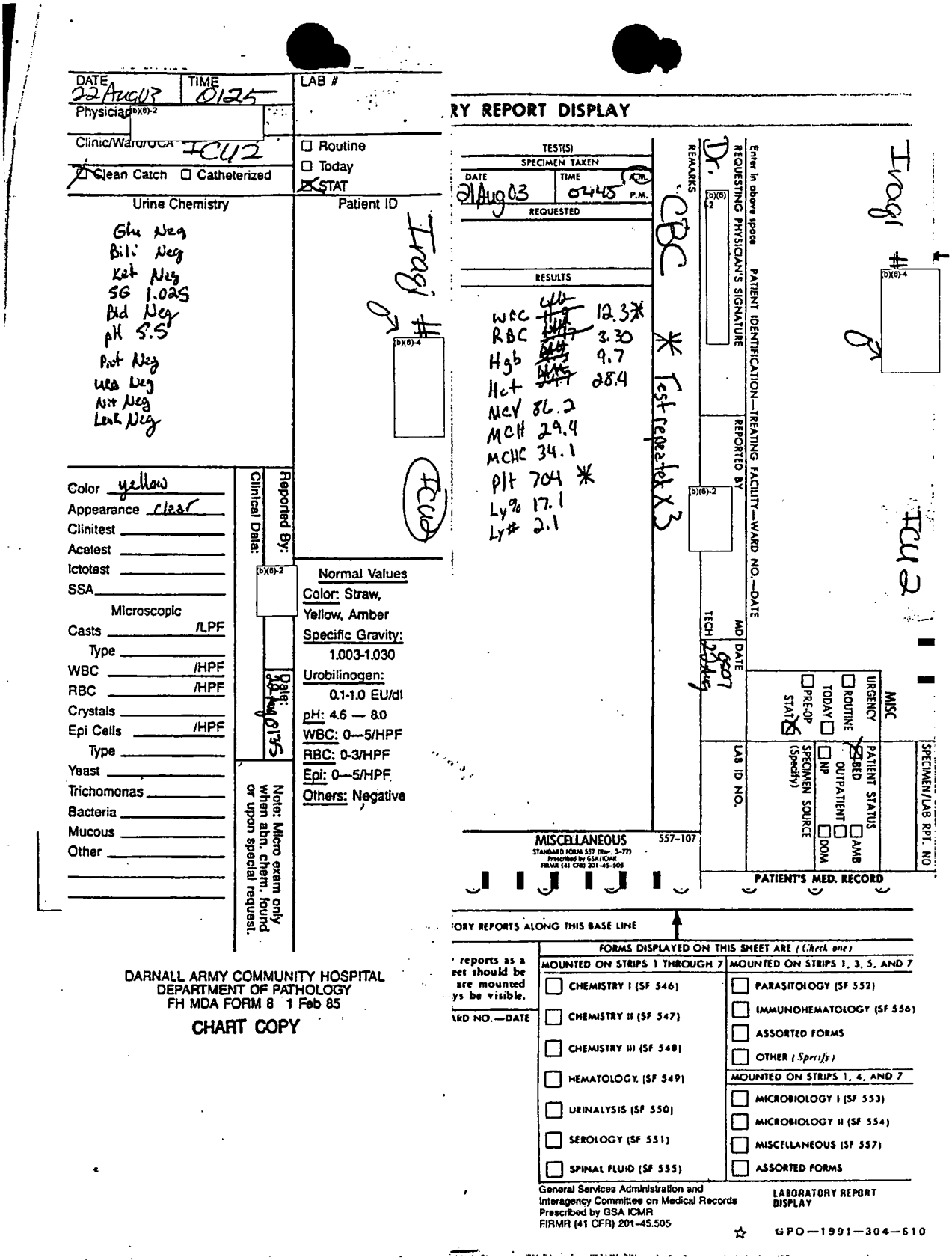
I HAVE RECEIVED A COPY OF AND UNDERSTAND THESE INSTRUCTIONS.

(Patient/Responsible Adult's Signature) *(Date and Time)*

MEDCOM FORM 691-R (TEST) (MCHO) MAR 99 PREVIOUS EDITIONS ARE OBSOLETE MC V1.00

ACLU-RDI 1099 p.430

DOD 005698



DATE 22Aug03 | TIME 0125 | LAB #
Physician [b)(6)-2]
Clinic/Ward/OCA ICU2
☒ Clean Catch ☐ Catheterized
☐ Routine ☐ Today ☒ STAT
Urine Chemistry
Patient ID
Iraqi #1
[b)(6)-4]
ICU2
Glu Neg
Bili Neg
Ket Neg
SG 1.025
Bld Neg
pH 5.5
Prot Neg
Uro Neg
Nit Neg
Leuk Neg
Color yellow
Appearance clear
Clinitest
Acetest
Ictotest
SSA
Microscopic
Casts /LPF
Type
WBC /HPF
RBC /HPF
Crystals
Epi Cells /HPF
Type
Yeast
Trichomonas
Bacteria
Mucous
Other
Clinical Data:
Reported By:
[b)(6)-2]
Date: 22Aug0125
Normal Values
Color: Straw, Yellow, Amber
Specific Gravity: 1.003-1.030
Urobilinogen: 0.1-1.0 EU/dl
pH: 4.6 — 8.0
WBC: 0—5/HPF
RBC: 0-3/HPF
Epi: 0—5/HPF
Others: Negative
Note: Micro exam only when abn. chem. found or upon special request.

DARNALL ARMY COMMUNITY HOSPITAL
DEPARTMENT OF PATHOLOGY
FH MDA FORM 8 1 Feb 85
CHART COPY

RY REPORT DISPLAY
TEST(S)
SPECIMEN TAKEN
DATE 21Aug03 TIME 0245 A.M. P.M.
REQUESTED
RESULTS
WBC 12.3*
RBC 3.30
Hgb 9.7
Hct 28.4
MCV 86.2
MCH 29.4
MCHC 34.1
plt 704 *
Ly% 17.1
Ly# 2.1
REMARKS
CBC * Test repeated X3
Dr.
Iraqi #1
[b)(6)-4]
ICU2
Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REQUESTING PHYSICIAN'S SIGNATURE
[b)(6)-2]
REPORTED BY
[b)(6)-2]
MD
TECH
DATE 21Aug03
MISC
URGENCY ☐ ROUTINE ☒ TODAY ☐ PRE-OP ☒ STAT
PATIENT STATUS ☒ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM
SPECIMEN SOURCE (Specify)
LAB ID NO.
SPECIMEN/LAB RPT. NO.
MISCELLANEOUS
STANDARD FORM 557 (Rev. 3-77)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505
557-107
PATIENT'S MED. RECORD
ORY REPORTS ALONG THIS BASE LINE
reports as a eet should be are mounted ys be visible.
ARD NO.—DATE

FORMS DISPLAYED ON THIS SHEET ARE (Check one)

MOUNTED ON STRIPS 1 THROUGH 7
- ☐ CHEMISTRY I (SF 546)
- ☐ CHEMISTRY II (SF 547)
- ☐ CHEMISTRY III (SF 548)
- ☐ HEMATOLOGY (SF 549)
- ☐ URINALYSIS (SF 550)
- ☐ SEROLOGY (SF 551)
- ☐ SPINAL FLUID (SF 555)

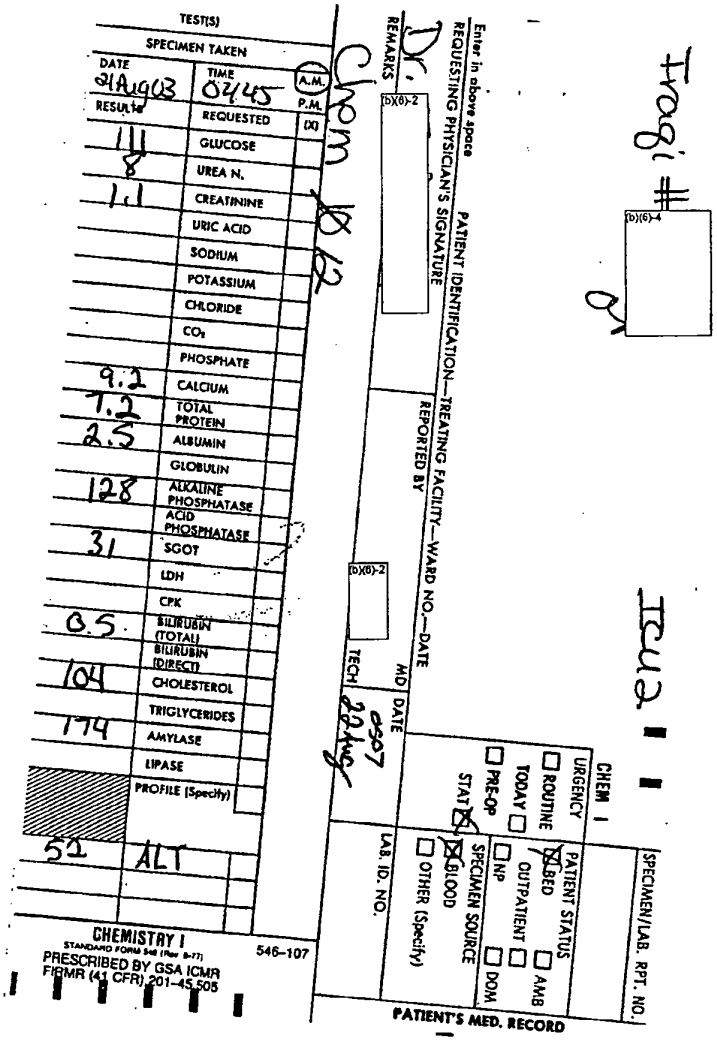
MOUNTED ON STRIPS 1, 3, 5, AND 7
- ☐ PARASITOLOGY (SF 552)
- ☐ IMMUNOHEMATOLOGY (SF 556)
- ☐ ASSORTED FORMS
- ☐ OTHER (Specify)

MOUNTED ON STRIPS 1, 4, AND 7
- ☐ MICROBIOLOGY I (SF 553)
- ☐ MICROBIOLOGY II (SF 554)
- ☐ MISCELLANEOUS (SF 557)
- ☐ ASSORTED FORMS

General Services Administration and Interagency Committee on Medical Records
Prescribed by GSA ICMR
FIRMR (41 CFR) 201-45.505
LABORATORY REPORT DISPLAY
☆ GPO—1991—304—610

MEDCOM - 1647

ACLU-RDI 1099 p.431


TEST(S)
SPECIMEN TAKEN
DATE
TIME
A.M.
P.M.
RESULTS
REQUESTED
GLUCOSE
UREA N.
CREATININE
URIC ACID
SODIUM
POTASSIUM
CHLORIDE
CO2
PHOSPHATE
CALCIUM
TOTAL PROTEIN
ALBUMIN
GLOBULIN
ALKALINE PHOSPHATASE
ACID PHOSPHATASE
SGOT
LDH
CPK
BILIRUBIN (TOTAL)
BILIRUBIN (DIRECT)
CHOLESTEROL
TRIGLYCERIDES
AMYLASE
LIPASE
PROFILE (Specify)
ALT
CHEMISTRY I
546-107
PRESCRIBED BY GSA ICMR
FIRMR (41 CFR) 201-45.505
REMARKS
Enter in above space
REQUESTING PHYSICIAN'S SIGNATURE
PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REPORTED BY
TECH
MD
DATE
CHEM I
URGENCY
ROUTINE
TODAY
PRE-OP
STAT
PATIENT STATUS
BED
AMB
OUTPATIENT
DOM
NP
SPECIMEN SOURCE
BLOOD
OTHER (Specify)
LAB. ID. NO.
SPECIMEN/LAB. RPT. NO.
PATIENT'S MED. RECORD

NSN 7540-01-165-7294 ARC 519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

EXAMINATION(S) REQUESTED	AGE	SEX	SSN *(Sponsor)*	WARD/CLINIC	REGISTER NO.
CXR					
	FILM NO.				PREGNANT ☐ YES ☒ NO
	REQUESTED BY (Rank) Dr. [redacted]				TELEPHONE/PAGE NO.
	SIGNATURE OF REQUESTOR [redacted] CPT/AN				DATE REQUESTED

SPECIFIC REASON(S) FOR REQUEST *(Complaints and findings)*

R/O effusion

DATE OF EXAMINATION *(Month, day, year)*	DATE OF REPORT *(Month, day, year)*	DATE OF TRANSCRIPTION *(Month, day, year)*

RADIOLOGIC REPORT

Normal portable chest film

⊖ effusion

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name — last, first, middle, Medical Facility)*

Iraqi # [redacted] ICU2

LOCATION OF MEDICAL RECORDS [redacted]

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT
1 — MEDICAL RECORD

STANDARD FORM 519-B (8-83)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.806-8

MEDCOM - 1649

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

Iraqi #

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 8/21/03 TIME OF ORDER: 2230 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) Admit to ICM (b)(6)-2

(2) Dx; S/P GSW (b)(6)-2

(3) Condition: Stable

(4) Vitals, Routine

(5) Activity ad lib

PATIENT IDENTIFICATION

noted CPT [illegible] 21 Aug 03 @ 2300 (b)(6)-2

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

(6) Change Abdominal with wet to dry dressing of Kerlex / sterile water q 12°

(7) Change (R) back bandage QD

(8) Diet; Regular

(9) IV; None

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

(10) Med - Tylox 1-2 po q 4-6 prn

(11) CBC, Clem 10, U/A in AM

(12) CXR in AM

R/O effusion

(13) ~~Spine series in AM~~

~~(14) Key weakness~~

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 8/24/03 TIME OF ORDER: 1620 HOURS

(1) Discharge to EPW Comp (b)(6)-2 LTC, MC, USA

(b)(6)-2

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 1650

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)
For use of this form, see AR 40-407;
the proponent agency is the Office of The Surgeon General.

No. 8 Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 21	22	23	24
21	(b)(6)-2	Vitals Routine	D	/	(b)(6)-2		
			E	/			
			N	(b)(6)-2			
21	(b)(6)-2	Activity ad lib	D	/	(b)(6)-2		
		(MP @ bedside)	E	/			
			N	(b)(6)-2			
21	(b)(6)-2	Change abdominal	08	/	(b)(6)-2		
		wound with wet to	20	(b)(6)-2			
		dry dressing of Kerlex/					
		sterile water @ 12°					
21	(b)(6)-2	Change (R) back	08	200 (b)(6)-	(b)(6)-2		
		bandage QD					
21	(b)(6)-2	Diet: Regular	B	/	(b)(6)-2		
			L	/	/ (b)(6)-2		
			D	/	(b)(6)-2		

ALLERGIES: ☐ YES ☐ NO
NKDA per patient

PRIMARY DIAGNOSIS:
S/P GSW Abdomen

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
PAGE NO:

PATIENT IDENTIFICATION:
Iraqi # (b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES
0 8 9 10 11 12 13 14 15
16 17 18 19 20 21 22 23
24 01 02 03 04 05 06 07

FORM 1 OCT 73 EDITION OF 1 DEC 77 MAY BE USED.

MEDCOM - 1651

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON MEDICATION)

Mo 8 Yr 03

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
21	(b)(6)-2	Admit to ICU - Eastman	8/21/03	on arrival	2200	(b)(6)-2
21	(b)(6)-2	Condition Stable	8/21/03	on arrival	noted	
21	(b)(6)-2	CBC, Chem 10, U/A in AM	8/22/03	0500	0445	
21	(b)(6)-2	CXR in AM (R/O effusion)	8/22/03	0500	0530	

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED

ACLU-RDI 1099 p.436

DOD 005704

MAR

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)
For use of this form, see AR 40-407;
the proponent agency is the Office of The Surgeon General.

No. 8 Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED
				21 22 23 24
21	[redacted]	IV: None	D	/ [redacted]
			E	/ [redacted]
			N	[redacted]

ALLERGIES: ☐ YES ☐ NO
NKDA (per patient)

PRIMARY DIAGNOSIS:
S/p GSW Abdomen

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
PAGE NO:

PATIENT IDENTIFICATION:
Iraqi # [redacted]

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

FORM 1 OCT 73 EDITION OF 1 DEC 77 MAY BE USED.

MEDCOM - 1653

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON MEDICATION)				Mo _____ Yr _____
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED														
8/21/03	(b)(6)-2	Tylox 1-2 po q 4-6 prn	22 Aug 1930 T A	23 Aug 1315 T	23 Aug 2200 TT [illegible]												

ADMISSION AND CODING INFORMATION

For use of this form, see AR 40-400; the proponent agency is OTSG

1. REPORTING MTF	1 2 3 4 5 6 — A (b)(3)-1
2. MTF LOCATION (State or Country Code.)	7 8 — I Z
3. REGISTER NUMBER	9 10 11 12 13 14 15 — (b)(6)-4
NAME (Last, First, Middle Initial)	(b)(6)-4
4. PAY GRADE	16 17
5. SEX	18 — M
6. DATE OF BIRTH (Y Y Y Y M M D D)	19 20 21 22 23 24 25 26
7. AGE AT ADMISSION	27 28 29
8. RACE	30
9. ETHNIC BACK-GROUND	31
RELIGION	
10. LENGTH OF SERVICE	32 33 34
ETS	
11. FMP	35 36 — 9 9
12. SOCIAL SECURITY NUMBER	37 38 39 40 41 42 43 44 45 — (b)(6)-4
ORGANIZATION (Active Duty Only)	
13. MARITAL STATUS	46
HOUR OF ADMISSION	2200
BRANCH / CORPS	
14. FLYING STATUS	47 48 49
15. BENEFICIARY CATEGORY	50 51 52 — K 7 6
16. ZIP CODE OF RESIDENCE	53 54 55 56 57 58 59 60 61
17. UNIT LOCATION (State or Country Code)	62 63
18. MOS	64 65 66 67 68 69 70
19. TRAUMA	71
PREV. ADMISSION	YEAR ☐ NO
20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	72 — 2
WARD	ICU2
NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	
ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	
(b)(3)-1 DOCTRINE OF MEDICAL TREATMENT FACILITY	(b)(3)-1
TELEPHONE NUMBER OF EMERGENCY ADDRESSEE	
21. TYPE OF DISPOSITION	73 74 — 0 5
22. MTF TRANSFERRED TO	75 76 77 78 79 80
23. DATE OF DISPOSITION (Y Y Y Y M M D D)	81 82 83 84 85 86 87 88 — 2 0 0 3 0 8 2 4
24. CLINIC SVC - ADMITTING	89 90 91 92 — A B A A
25. MTF TRANSFERRED FROM	93 94 95 96 97 98 — 28th CSH
26. DATE THIS ADMISSION (Y Y Y Y M M D D)	99 100 101 102 103 104 105 106 — 2 0 0 3 0 8 2 1
27. LOCATION OF OCCURRENCE (Battle Casualty Only)	107 108
28. MTF OF INITIAL ADMISSION	109 110 111 112 113 114
29. DATE INITIAL ADMISSION (Y Y Y Y M M D D)	115 116 117 118 119 120 121 122

FOR LOCAL USE

Dx: 72989
V553
V6543
9060
59990

ADMITTING OFFICER (S... (b)(6)-2 — etc memo

SIGNATURE (b)(6)-2 ...TING CLERK — SS

DA FORM 2986, MAR 2000 — EDITION OF MAR 89 IS O... TE — USAPA V1.00

MEDCOM - 1655

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	25 Aug 03
DOS	3 Sep 03
POD	~~DOS~~ 1

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	(b)(6)-2
(b)(6)-2	(b)(6)-2

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

PREPARED BY (b)(6)-2 (Title) | Department/Service/Clinic: ICU | DATE: 4 Sep 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade; date; hospital or medical facility)*

POTUS (b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOWCHART

☐ OTHER EXAMINATION Or EVALUATION ☐ OTHER(*Specify*)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 1656

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R								2								2						2		
	RADIAL L								*								/								
	DORSALIS PEDIS R								2								2							2	
	DORSALIS PEDIS L								2								2							2	
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale									1 3 8								1 3 8							1 3 8	
EDEMA									+1								+1							+	
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)									✓								✓							✓	
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)									✓								✓							✓	
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH								✓																
	FOLEY CARE																								
	ORAL CARE								✓			✓													
MOBILITY	BEDREST								✓								✓								
	BSC																								
	DANGLE																								
	CHAIR											✓	✓												
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE								✓								✓								
	HOB 30 DEGREES								✓								✓							✓	
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE								✓								✓							✓	
	PAIN SCALE (1-10)																								
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN (2) Soft & Flat (1) Distended									1								1							1	
BOWEL SOUNDS (active all quads)									Ø																
NG / DOBHOFF PLACEMENT VERIFIED									✓				OK												
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT																									
VOIDING CLEAR, YELLOW URINE q.s.																									
SKIN INTEGRITY	No Breakdown								✓															✓	
	Surgical Wounds								✓								✓							✓	
	Rashes, Lac's, etc								✓								✓							✓	
DRESSING (Dry & Intact: specify site below)																									
#1 (L) thigh ex fix									✓								✓							✓	
#2																									
#3																									

(b)(6)-2

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
~~(R)~~ IJ IV	(L)	3 Sept 03	CDI, OSS infusion
ET	(L)	3 SEP 03	D S/S Tot.

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable /Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment --

DATE:

TIME		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open									4								4							4	
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response									5								5							5	
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response									6								6							6	
GLASCOW COMA SCALE (A+B+C)									15								15							15	
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R																								
	L																								
MOVEMENT (See Motor Function Scale at Top of Page)	RUE								5								5							5	
	LUE								*								*							2	
	RLE								3								3							3	
	LLE								2								2							2	
GRIP (S) Strong (W) Weak (-) absent	R								5								5							5	
	L								NA															—	
RESPIRATIONS	REGULAR								✓								✓							✓	
	IRREGULAR																								
	UNLABORED								✓								✓							✓	
	LABORED																								
	SHALLOW																								
	RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL								5								5							5	
	LUL								5								5							5	
	RLL								5								5							5	
	LLL								5								5							5	
	BOTH BASES								5								5							5	
COUGH	NONE								✓								✓							✓	
	SPONTANEOUS																								
	PRODUCTIVE																								
	NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																									
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																									
VENTILATOR	Vt																								
	FiO2																								
	RATE (SIMV/CMV)																								
	PEEP / CPAP																								
	PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE	NC (l/min)								2	Ø	2	2	2	2	2		2							2	
	FM (l/min)																								
ETT #_____	NRBM (l/min)																								
	ETT _____cm gums																								
ETT CARE / POSITION CHANGE																									
ETT / NT SUCTIONED																									
INCENTIVE SPIROMETRY DONE											✓	✓	✓	✓			✓								
COUGH / DEEP BREATH									(b)(6)-2																
INITIALS											(b)(6)-2						✓							(b)(6)-2	

ACLU-RDI 1099 p.442

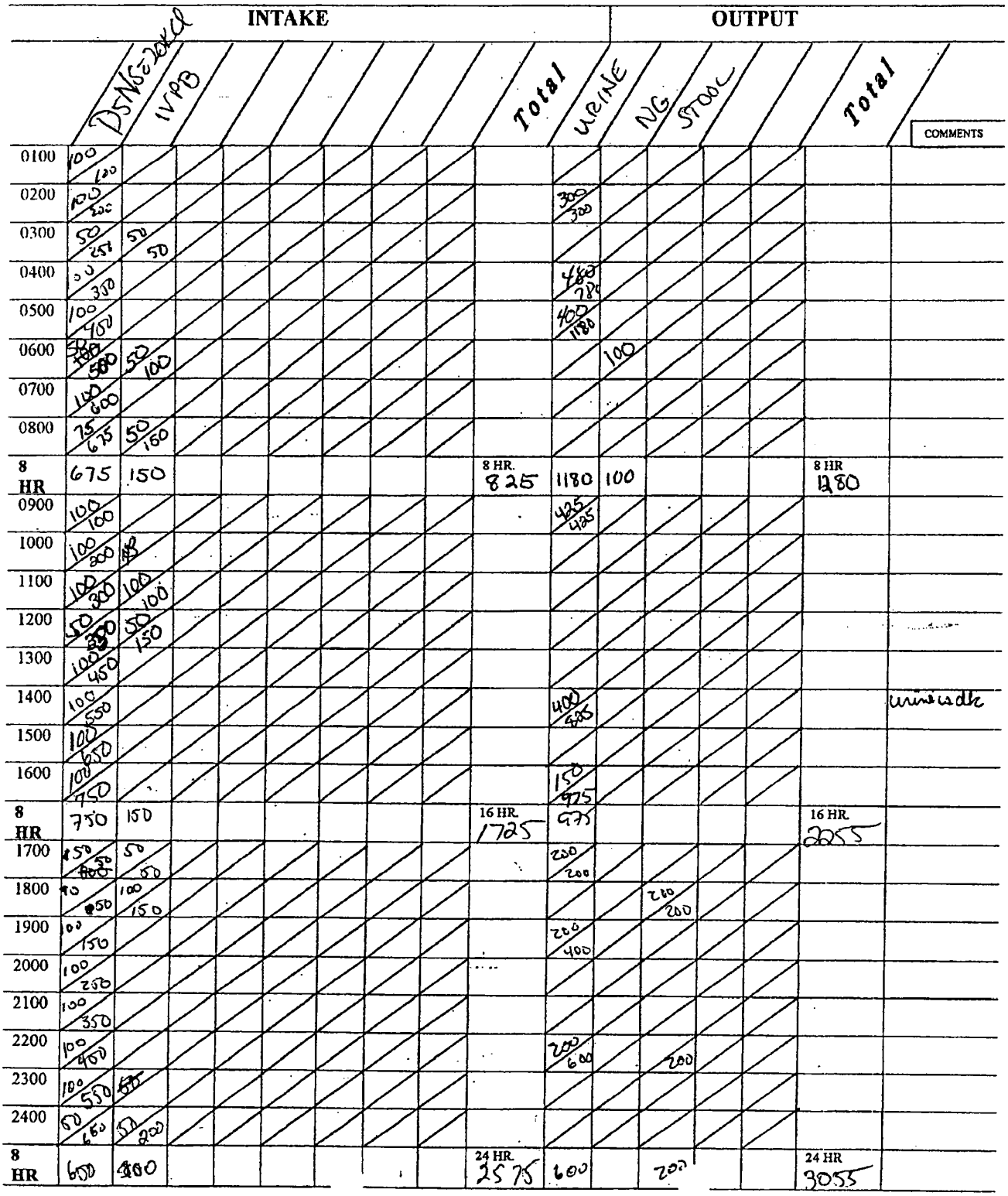
DOD 005710

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200																	
0300	99.4	102	20	114/79	97												
0400																	
0500																	
0600																	
0700	98.9 (A)	97	24	126/81	96%												
0800																	
0900																	
1000	99.9 (A)	102	20	119/75	96%												
1100																	
1200																	
1300																	
1400	100.6 (A)	104	23	131/76	96%												
1500																	
1600	100.5 (A)	107	24	122/77	94%												
1700																	
1800	100 (A)	98	24	117/67	95%												
1900																	
2000																	
2100																	
2200																	
2300	100.1	99	22	127/79	97												
2400																	

ACLU-RDI 1099 p.443

DOD 005711


INTAKE
OUTPUT
D5NS+20KCl
IVPB
Total
URINE
NG
STOOL
Total
COMMENTS
0100
0200
0300
0400
0500
0600
0700
0800
8 HR
675
150
8 HR.
825
1180
100
8 HR
1980
0900
1000
1100
1200
1300
1400
1500
1600
8 HR
750
150
16 HR.
1725
975
16 HR.
2055
1700
1800
1900
2000
2100
2200
2300
2400
8 HR
600
400
24 HR.
2575
600
200
24 HR
3055
urine sdk

MEDCOM - 1660

NSN 7540-00-634-4123

MEDICAL RECORD			NURSING NOTE (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
4 Sept 03	0015		Pt resting. T c/s 98 ℄ (A). will continue to monitor. (b)(6)-2
	0130		Pt c/o pain to LLE. Medicated per order. (b)(6)-2
	0300		Pt assessment & change. ~~c/o~~ complaints pt c/o pt repositioned for comfort. (b)(6)-2
	0530		Pt labs drawn (R) hand Heplock d/c'd. unable to flush or draw blood. (b)(6)-2
4Sept 03	0615		Received pt from previous shift. Pt resting will cont to monitor (b)(6)-2
4Sept 03	0820		Pt resting. (O) AEA. Ex fix on (R) thigh. dsg slightly moist (LS → D). pt has numerous stitches on legs. abd non tender, med tone. will cont to monitor (b)(6)-2
4Sept 03	1015		@0945 dsg D/ed. LS → D. ~~c~~ NS. ~~Scattered~~ ~~c~~ drainage very sm amt of bleeding. will cont to monitor. (b)(6)-2
4Sept 03	1130		Pt OOB to chair ~~c~~ (L) leg elevated. started @ 1100 will cont to monitor (b)(6)-2
4Sept 03	1250		@1200 NGT D/C'ed. pt asked for pain meds early obtained order for ~~more~~ pain meds early @1215. pt now sleeping will cont to monitor (b)(6)-2 (b)(6)-2
4Sept 03	1400		@1345 adm tylenol suppository 1gm for AX temp of 100.6° pt sitting up in bed I/S encouraged & done will cont to monitor (b)(6)-2
4SEP03	1800		Pt to BS commode. 200 light brown stool
4SEP03	2100		Dsg D/d LLE. TISSUE looks red and beefy ~~c~~ minimal Exudate. Dsg replaced/packed ~~c~~ DAKINS soaked gauze and Kerlex (b)(6)-2
	2200		Assumed care of pt sleeping ~~c~~ resting. (b)(6)-2
	2300		assessment per flowsheet, abd remains mildly distended hypoactive bowel sounds noted. (O) pt at ~~5~~ 5/5 of infusion.

MEDCOM - 1661

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	25 Aug 03
DOS	3 Sep 03
POD	2

24 HOUR DATA	
24 Hour Balance	+50
24 Hour Intake	3050
24 Hour Output	3000
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On	✓		
Call Light Within Reach	—		
Side Rails Up	—		
Bed in Low Position	—		

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 RN	ICU 1	5 Sep 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade; date; hospital or medical facility)*

Potus (b)(6)-4

- ☐ HISTORY/PHYSICAL
- ☒ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☐ OTHER *(Specify)*
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 1662

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R							2							2										
	BRACHIAL L							2							2										
	DORSALIS R							2							2										
	PEDIS L							2							2										
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale (10) HOT								1 5 8							1 3 8										
EDEMA								1+							1+										
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)								✓							✓										
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)								ST							ST										
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH																								
	FOLEY CARE																								
	ORAL CARE																								
MOBILITY	BEDREST							✓																	
	BSC																								
	DANGLE																								
	CHAIR														✓										
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE							✓							✓										
	HOB 30 DEGREES							✓							✓										
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE							✓							✓										
	PAIN SCALE (1-10)																								
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended							1 Hypo							1 Hypo										
BOWEL SOUNDS (active all quads)																									
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT																									
VOIDING CLEAR, YELLOW URINE q.s.								DRY AMBER							✓										
SKIN INTEGRITY	No Breakdown							✓							✓										
	Surgical Wounds							✓							✓										
	Rashes, Lac's, etc							✓																	
DRESSING (Dry & Intact: specify site below)																									
#1 LUE								✓							✓										
#2 LLE								✓ (b)(6)-2							✓										
#3																									

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
(L) EJ 18g		3 Sep 03	3 S/S of infiltration
(R) FA 18g		5 Sep 03	3 S/S of infiltration, opposite in place
(L) FA 18g	(L) FA	0700 [illegible]	
		5 Sep 03 [illegible]	S/S of inf / infil

MEDCOM - 1663

PUPIL SIZE	PUPILS		MOTOR FUNCTION	CHART CODES
1 mm	=	Equal	0 = No Movement	Present ✓
2 mm	R	Reactive	1 = Slight Flicker/ Trace of Contraction	
3 mm	NR	NonReactive	2 = Active (Gravity Eliminated)	Not Applicable /Absent (blank)
			3 = Active: against gravity, but not against resistance	
4 mm	L > R	Left Larger	4 = Active: Against Gravity and Resistance, not full strength	Refer to Nsg. Notes X
			5 = Full Strength against Examiners Resistance	
5 mm	R > L	Right Larger		No Change from Previous Assessment --

DATE:

TIME		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (2) To Pain (3) To Voice (1) Does Not Open								4							4								4		
B. BEST VERBAL RESPONSE (5) Oriented (2) Garbled (4) Confused (1) No Response (3) Inappropriate Verbal Response								5							5										
C. BEST MOTOR RESPONSE (6) Obeys Commands (3) Flexion to Pain (5) Localizes to Pain (2) Extension to Pain (4) Withdraw to Pain (1) No Response								6							6										
GLASCOW COMA SCALE (A+B+C)								15							15										
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R																								
	L																								
MOVEMENT (See Motor Function Scale at Top of Page)	RUE							4							4										
	LUE							2							2										
	RLE							4							4										
	LLE							2							2										
GRIP (S) Strong (W) Weak (-) absent	R							5							5										
	L							N/A							N/A										
RESPIRATIONS	REGULAR							✓							✓										
	IRREGULAR																								
	UNLABORED							✓							✓										
	LABORED																								
	SHALLOW																								
	RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL							5							5										
	LUL							5							5										
	RLL							5/1							5										
	LLL							5/1							5										
	BOTH BASES							5/1 ✓							5 ✓										
COUGH	NONE							✓							✓										
	SPONTANEOUS																								
	PRODUCTIVE																								
	NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																									
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																									
VENTILATOR	Vt																								
	FIO2																								
	RATE (SIMV/CMV)																								
	PEEP / CPAP																								
	PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE	NC (l/min)							2L							2L										
	FM (l/min)																								
ETT #_____	NRBM (l/min)																								
	ETT _____cm gums																								
ETT CARE / POSITION CHANGE																									
ETT / NT SUCTIONED																									
INCENTIVE SPIROMETRY DONE																									
COUGH / DEEP BREATH																									
INITIALS								(b)(6) -2							(b)(6) -2										

ACLU-RDI 1099 p.448

DOD 005716

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200																	
0300																	
0400	99.8 (A)	91	22	125/76	96												
0500																	
0600																	
0700	100.4 (A)	101	25	122/73	92												
0740	100 (A)																
0800																	
0900																	
1000																	
1030	100 (A)																
1100																	
1200																	
1300	100.4 (A)	96	25	121/71	93%												
1400																	
1500	100.5 (A)	97	20	117/68	93%												
1600																	
1700																	
1800																	
1900																	
2000	99.6 (A)	92	24	143/84	100%												
2100																	
2200																	
2300																	
2400																	

ACLU-RDI 1099 p.449

DOD 005717

	INTAKE									OUTPUT							
	DSNS@2Wkd	LVPB	PO						Total	Urine	Stool				Total	COMMENTS
0100	100/100	—														
0200	50/150	50/50														
0300	100/250									X1						
0400	100/350															
0500	100/450									400/400+X1						
0600	100/550															
0700	100/650	50/50								275/675X1						
0800	100/750	50/100								300/[illegible]						
8 HR	750	850							8 HR 850	675+X1					8 HR 675+X1	+175+X1
0900	100/100									300/300						
1000	100/200	50/50														
1100	100/300									375/675						
1200	100/400	250/300 ~~250~~								325/1000						
1300	100/500	50/350								325/1325						
1400	100/600									1325						
1500	100/700															
1600	300/1000	50/400														
8 HR	1000	400							16 HR 2250	1325					16 HR 2000	+250
1700	100/100									200/200						
1800	50/150	50/50														
1900	100/250															
2000	100/350									400/600						
2100	100/450															
2200	100/550															
2300	100/650															
2400	50/700	50/100								400/1000						
8 HR	700	100							24 HR 3050	1000					24 HR 3000	+50

MEDCOM - 1666

NSN 7540-00-634-4123

MEDICAL RECORD			NURSING NOTE (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
5 Sep 03	0015		Pt c̄ % neck pain. IV site s̄ erythema or edema. ∅ firmness or site swelling noted. Tape reapplied and reinforced. Pt also c̄ leg pain. Repositional s̄ relief will medicate per order. (b)(6)-2
	0645		Through interpreter, % pain to neck & leg continued. (L) EJ IV D/C'd. pressure applied for 4-5 minute. IV 18g to (R) FA x1 attempt pt tolerated well. Fluids continued at this site. Pt medicated for leg pain. (b)(6)-2
	0300		Voided x1, pt remains s̄ distress. ~~Afebrile~~ T 99.9 Low grade fever, skin warm/dry to touch. Assessment s̄ change. (b)(6)-2
9/5/03		0900	PT s̄ complaint. VSS. AM care given. Pt remains NPO for OR this am. Will continue to monitor (b)(6)-2
9/15/03		1400	OVSG D'd OOB to chair. Medicated c̄ Tylenol 50mg ~~Pr~~ Pr for temp 100⁴(A) (b)(6)-2
"		2000	Pt recoved s/p washout of LUE/LLE. Pt VSS AOx3. Tolerating pain meds w/ (b)(6)-2
5 Sep 03		2200	Assumed care of pt. sleeping soundly. (b)(6)-2

MEDCOM - 1667

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	25Aug03
DOS	~~3~~ 5Sep03
POD	

24 HOUR DATA	
24 Hour Balance	-175
24 Hour Intake	2850
24 Hour Output	3025
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2 [redacted]	

Safety Checks	D	E	
BVM at bedside	(b)(6)-2 [redacted]		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On	N/A	N/A	—
Call Light Within Reach			—
Side Rails Up			—
Bed in Low Position			—

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 [redacted] 91C LVN	ICU#1	6Sep03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade; date; hospital or medical facility)*

EPW# (b)(6)-4

- ☐ HISTORY/PHYSICAL
- ☐ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☐ OTHER(*Specify*)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 1668

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R		2						2						2								2		
	Brachial L		2						2						2								2		
	DORSALIS PEDIS R		2						2						2								2		
	L		2						2						2								2		
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale			1 3 8						1 3 8						1 3 8								1 3 8		
EDEMA																									
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)			✓						✓						✓								✓		
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)			ST						✓						✓								✓		
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH									✓															
	FOLEY CARE																								
	ORAL CARE									✓															
MOBILITY	BEDREST								✓						✓										
	BSC																								
	DANGLE																								
	CHAIR											✓			✓										
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE		✓						✓						✓								✓		
	HOB 30 DEGREES		✓						✓						✓								✓		
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE								✓						✓								✓		
	PAIN SCALE (1-10)		5																						
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN (2) Soft & Flat (1) Distended			1						1						2								2		
BOWEL SOUNDS (active all quads)			Hypo						Hypo						✓								✓		
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT																									
VOIDING CLEAR, YELLOW URINE q.s.			✓						Dark Yellow/Amber						Dark ✓								✓		
SKIN INTEGRITY	No Breakdown		✓						✓						✓								✓		
	Surgical Wounds		✓						✓						✓								✓		
	Rashes, Lac's, etc		✓						✓						✓								✓		
DRESSING (Dry & Intact: specify site below)									✓						✓										
#1 LUE																							✓		
#2 LLE																							✓		
#3																									

(b)(6)-2

(b)(6)-2

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
RFA 18G PIV	R FA	5 Sep	patent & s/sx of infx or infiltration
18G	R FA	5 Sep	" "
PIV 18G	R FA	5 Sep	patent & s/sx of infx or infiltration

(b)(6)-2

MEDCOM - 1669

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable /Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment --

DATE: 6 Sep 03

TIME		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open			4					4							4								4		
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response			5					5							5								5		
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response			6					6							6								6		
GLASCOW COMA SCALE (A+B+C)			15					15							15								15		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R		+												+								2+		
	L		+												+								2+		
MOVEMENT (See Motor Function Scale at Top of Page)	RUE		4					4							4								4		
	LUE		2					3							3								3		
	RLE		4					4							4								4		
	LLE		2					2							2								2		
GRIP (S) Strong (W) Weak (-) absent	R		3					3							3								3		
	L		N/A					N/A							3(A								N/A		
RESPIRATIONS	REGULAR		✓					✓							✓								✓		
	IRREGULAR																								
	UNLABORED		✓					✓							✓								✓		
	LABORED																								
	SHALLOW																								
	RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL							5							5								2		
	LUL							5							5								5		
	RLL							5							5								2		
	LLL							5							5								2		
	BOTH BASES							5							5								2		
COUGH	NONE		✓					✓							✓								✓		
	SPONTANEOUS																								
	PRODUCTIVE																								
	NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																									
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																									
VENTILATOR	Vt																								
	FIO2																								
	RATE (SIMV/CMV)																								
	PEEP / CPAP																								
	PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE	NC (l/min)		2L					2L							2L								2L		
	FM (l/min)																								
ETT #_____	NRBM (l/min)																								
	ETT _____ cm gums																								
ETT CARE / POSITION CHANGE																									
ETT / NT SUCTIONED																									
INCENTIVE SPIROMETRY DONE																									
COUGH / DEEP BREATH																									
INITIALS		(b)(6)-2						(b)(6)-2							(b)(6)-2								(b)(6)-2		

ACLU-RDI 1099 p.454

DOD 005722

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200	100.1	100	19	95 124/74	99%	on 2LNC											
0300																	
0400																	
0500																	
0600																	
0700	99° (A)	97	20	124/78	97%	2L/NC											
0800																	
0900																	
1000	101.2 (A)																
1100		113	23	118/74	97%												
1200																	
1300																	
1400	99% (A)	97	14	116/62	96%												
1500																	
1600																	
1700																	
1800	99.2	87	25	119/80	97%												
1900																	
2000																	
2100																	
2200	100.9	90	26	117/70	97%	on 2LNC											
2300																	
2400																	

ACLU-RDI 1099 p.455

DOD 005723

	INTAKE										OUTPUT						
	IV	IVPB	PO							Total	Urine					Total	COMMENTS
0100	100/100																
0200	100/200	50/50									450/450						
0300	100/300																
0400	100/400										400/850						
0500	100/500																
0600	100/600										575/1425						
0700	100/700																
0800	100/800		60/60														
8 HR	800	50	60							8 HR. 910	1425					8 HR 1425	-485
0900	100/100	50/50															
1000	100/200																
1100	100/300	50/100															
1200	100/400	50/150	60/60														
1300	100/100		120/80								500/500						
1400	100/600																
1500	100/700																
1600	60/760	50/200	30/110								300/800					2225	-255
8 HR	760	200	110							1060 16 HR. 1970	800					16 HR. 800 BDr	+1100 BDr
1700	100/100																
1800	100/200										500/500						
1900	100/300																
2000	100/400																
2100	100/500										300/800						
2200	100/600		30/30														
2300	100/700																
2400	100/800	50/50															
8 HR	800	50	30							880 24 HR. 2850	800					24 HR 3028	-175

ACLU-RDI 1099 p.456

DOD 005724

NSN 7540-00-634-4123

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
6Sep03	0230		Pt continues to c/o pain to (L) upper leg. Pt informed that he couldn't have any more pain meds until 0430. Will continue to monitor. SPC (b)(6)-2 [redacted] 91C LUN
	0500		Pt medicated c̄ 25mg Demerol/12.5mg Phenergan by CPT Welden. Will continue to monitor. SPC (b)(6)-2 [redacted] 91C LUN
	0530		Demerol/Phenergan Effective. Will continue to monitor. SPC (b)(6)-2 [redacted] 91C LUN
6Sep	0550		(Late note 0215) Pt assessment complete on flowsheet Pt c/o pain to (L) upper extremity. Will medicate c̄ Demerol/Phenergan. Will continue to monitor SPC (b)(6)-2 [redacted] 91C LUN
6Sep03	0850		DRSG TO LLE D'd. MODERATE AMT of Serous Sanguinous drainage c̄ foul odor. Wound Packed c̄ NS soaked GAUZE. ELASTIC BANDS & staples intact. Tolerated procedure well. VSS. Will continue to monitor [redacted]
6Sep03	1200		Medicated c̄ 1gm Tylenol PL for ↑ te[redacted] 101 [redacted]
6SEP03	1930		Pt drsg D'd on LUE/LLE. Pt premedicated c̄ 25mg Demerol/12.5 phenergan. Pt tolerated well. Dr (b)(6)-2 [redacted] to see both wounds. Wounds appeared red and beefy c̄ minimal exudate noted. Dry pack and redressed c̄ W→D packing (b)(6)-2 [redacted]
6Sep03	2255		Report received from offgoing nurse. Pt assessment complete and on flowsheet. Pt is currently painfree. Will continue to monitor. SPC (b)(6)-2 [redacted] 91C LUN

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CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	25 Aug 03
DOS	5 Sep 03
POD	

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach	N/A	N/A	
Side Rails Up			
Bed in Low Position			

(b)(6)-2	97CLVN	Department/Service/Clinic: ICU #1	DATE: 7 Sep 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade:date: hospital or medical facility)*

EPW# (b)(6)-4

- ☐ HISTORY PHYSICAL
- ☒ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☐ OTHER *(Specify)*
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 1674

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R							2								2								2	
	BRACHIAL L							2								2								2	
	DORSALIS PEDIS R							2								2								2	
	L							2								2								2	
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale								1 3 8								1 3 8								1 3 8	
EDEMA																									
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)								✓								✓								✓	
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)								ST								ST									
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH																								
	FOLEY CARE																								
	ORAL CARE																								
MOBILITY	BEDREST							✓								✓								✓	
	BSC																								
	DANGLE																								
	CHAIR															✓									
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE							✓								✓								✓	
	HOB 30 DEGREES							✓								✓								✓	
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE							✓								✓									
	PAIN SCALE (1-10)																							X	
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN (2) Soft & Flat (1) Distended								2								2								X	
BOWEL SOUNDS (active all quads)								HYPO								HYPO								✓	
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT																									
VOIDING CLEAR, YELLOW URINE q.s.								Dk Amber								DARK									
SKIN INTEGRITY	No Breakdown							✓								✓								✓	
	Surgical Wounds							✓								✓								✓	
	Rashes, Lac's, etc							✓								✓								✓	
DRESSING (Dry & Intact: specify site below)																									
#1 LUE								✓								✓								✓	
#2 LLE								55								55								✓	
#3																									

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
18G PIV	RD FA	5Sep03	patent s/s/s of inf. or infiltration / D700 (b)(6)-
18G	LDFA	7Sep03	D/C'd S/S Inf/=fs. Intact 2

ACLU-RDI 1099 p.459

DOD 005727

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable /Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment --

DATE: 7 Sep 03

TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open							4								4								4	
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response							5								5								5	
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response							6								6								6	
GLASCOW COMA SCALE (A+B+C)							15								15								15	
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — R																								
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — L																								
MOVEMENT (See Motor Function Scale at Top of Page) — RUE							4								4								4	
MOVEMENT (See Motor Function Scale at Top of Page) — LUE							2								2								2	
MOVEMENT (See Motor Function Scale at Top of Page) — RLE							4								4								4	
MOVEMENT (See Motor Function Scale at Top of Page) — LLE							2								2								2	
GRIP (S) Strong (W) Weak (-) absent — R							5								5								5	
GRIP (S) Strong (W) Weak (-) absent — L							NA								NA								NA	
RESPIRATIONS — REGULAR							✓								✓								✓	
RESPIRATIONS — IRREGULAR																								
RESPIRATIONS — UNLABORED							✓								✓								✓	
RESPIRATIONS — LABORED																								
RESPIRATIONS — SHALLOW																								
RESPIRATIONS — RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RUL							5								5								5	
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — LUL							5								5								5	
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RLL							5								5								5	
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — LLL							5								5								5	
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — BOTH BASES							5								5								5	
COUGH — NONE							✓								✓								✓	
COUGH — SPONTANEOUS																								
COUGH — PRODUCTIVE																								
COUGH — NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																								
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																								
VENTILATOR — Vt																								
VENTILATOR — FiO2																								
VENTILATOR — RATE (SIMV/CMV)																								
VENTILATOR — PEEP / CPAP																								
VENTILATOR — PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE — NC (l/min)							12								1L								1L	
OXYGEN DELIVERY DEVICE — FM (l/min)																								
ETT #_____ — NRBM (l/min)																								
ETT #_____ — ETT _____cm gums																								
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED							✓								✓									
INCENTIVE SPIROMETRY DONE							✓								✓									
COUGH / DEEP BREATH																								
INIT							(b)(6								(b)(6)-2								(b)(6	

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VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200																	
0300																	
0400																	
0500																	
0600																	
0700	101.7 (A)	107	20	124/73	94%												
0800																	
0900																	
1000																	
1100	99.4 (A)	98	20	122/73	94%												
1200																	
1300																	
1400																	
1500	99.7 (A)	100	18	116/74	95%												
1600																	
1700																	
1800																	
1900																	
2000	100.7 (A)	109	20	117/69	94%												
2100																	
2200	100.2 (A)																
2300	101.6	114	24	133/79													
2400	103.0																

ACLU-RDI 1099 p.461

DOD 005729

	INTAKE										OUTPUT							
	IV	IVPB	PO							Total	Urine						Total	COMMENTS
0100	100 / 100		30 / 30															
0200	100 / 200	50 / 50																
0300	100 / 300										325							
0400	100 / 400																	
0500	100 / 500																	
0600	100 / 600										450 / 775							
0700	100 / 700																	
0800	100 / 800																	
8 HR	800	50	30							8 HR 880	775						8 HR 775	+105
0900	100 / 100	50 / 50																
1000	100 / 200		120 / 120															
1100	100 / 300	50 / 100									340 / 340							
1200	100 / 400	50 / 150	240 / 360															
1300	100 / 500																	
1400	100 / 600																	
1500	100 / 700										300 / 640							
1600	50 / 750	50 / 200																
8 HR	750	200	360							16 HR. 2190	640						16 HR. 1415	+675
1700	100 / 100																	
1800	50 / 150	50 / 50									400 / 400							
1900	100 / 250																	
2000	100 / 350																	
2100	100 / 450																	
2200	100 / 550																	
2300	100 / 650																	
2400	50 / 700	50 / 100																
8 HR										24 HR 2990	1600						24 HR 1815	+1175

NSN 7540-00-634-4123

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
7Sep03	0800		Pt C/O pain to (L) arm. Will medicate c̄ Demerol/Phenergan 25/12.5 via Maj [redacted] (b)(6)-2 Will continue to monitor. SAC [redacted] (b)(6)-2 9IC LPN
7SEP03	0700		Assessment Completed. See flowsheet. NAD. ⊖ C/O discomfort Tolerated approximately 10% of Regular diet. Tolerating PO Liquids. ↑ Temp 7/01. Will Cont. to monit [redacted] (b)(6)-2 LPN
7Sep03	1030		Premedicated Pt c̄ Tylox ⅔ PO & Dem 25mg c 12.5mg Phenergan IVP for DRSG Δ. W⇒D to DRSG to LUE & LLE. LUE Packed c̄ gauze. Small amt of purulent discharge to LLE. IV restarted in RFA c̄ 16g angio. IV patent & c̄ S/Sx of infection or infiltration. 18g to RUE dcd c̄ cath intact & ⊖ S/Sx of infection. [redacted] (b)(6)-2 LPN, AN
7Sep03		1300	TOLERATED Approx 5-10% [redacted] diet. LPN, AN
7SEP03		1900	Pt moved to chair c̄ Aid of [redacted] Aff members. Pt AOx3 @ this time [redacted]
		2200	assumed care of pt. Remain Febrile & with ↓ pain. medicated c̄ Tylox x2 [redacted] will monitor affect. [redacted] (b)(6)-2
		2345	Pt temp as documented. blanket removed to allow for ambient cooling. assessment per flowsheet. Abd firm but not tense, (+)BS x4 qr. NAD, Respiration even and unlabored. IV (R) FA patent c̄ S/S of infiltration [redacted] (b)(6)-2

MEDCOM - 1679

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	25 Aug 03
DOS	5 Sep 03
POD	

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	

Safety Checks	(b)(6)-2
BVM at bedside	
Monitor Alarms On	
ID Bracelet On	
Allergy Bracelet On	
Call Light Within Reach	
Side Rails Up	
Bed in Low Position	

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2	ICU	8 Sep 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade;date; hospital or.medical facility)*

POTUS / EPW (b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOWCHART

☐ OTHER EXAMINATION Or EVALUATION ☐ OTHER(*Specify*)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 1680

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R							2					2				2							2	
	BRACHIAL L							2					2				2							2	
	DORSALIS PEDIS R							2					2				2							2	
	L							2					2				2							2	
SKIN (1) Dry (4) Cool (7) Jaundiced (2) Clammy (5) Flushed (8) Color Normal (3) Warm (6) Cyanotic (9) Pale								1					1				1							1	
								3					3				3							3	
								8					8				8							8	
EDEMA								✓					✓												
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)								✓									✓							✓	
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)								ST					SR ST				ST							ST	
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH																								
	FOLEY CARE																								
	ORAL CARE							✓					✓				✓								
MOBILITY	BEDREST																								
	BSC																								
	DANGLE																								
	CHAIR																✓								
POSITIONED	RIGHT																								
	LEFT							✓					✓											✓	
	SUPINE							✓					✓											✓	
	HOB 30 DEGREES																								
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)								✓									✓							✓	
PAIN	PAIN FREE																								
	PAIN SCALE (1-10)												7												
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN (2) Soft & Flat (1) Distended								Soft Sl. Distended					Soft Sl. Distended				Soft Sl. Distended							X	
BOWEL SOUNDS (active all quads)								HYPO					✓				HYPO							✓	
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT																									
VOIDING CLEAR, YELLOW URINE q.s.								DARK yellow									dark								
SKIN INTEGRITY	No Breakdown							✓					✓												
	Surgical Wounds							✓					✓				✓							✓	
	Rashes, Lac's, etc							✓					✓				✓							✓	
DRESSING (Dry & Intact: specify site below)								✓					✓				✓							✓	
#1 LUE								✓					✓				✓							✓	
#2 RUE LLE																									
#3																									

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
PIV 18g	RFA	7SEP03	PATENT & s/sx of infection or infiltration
PIV 16g	RFA	8SEP03	PATENT & s/sx of infection or infiltration

ACLU-RDI 1099 p.465

DOD 005733

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200																	
0300																	
0400	99°	94	16	118/68	94%												
0500																	
0600																	
0700	99 (CA)	105	20	122/69	95												
0800																	
0900																	
1000																	
1100	↑																
	OR																
1200	↓																
1300	98.5 (A)	101	13	132/84	95%												
1400																	
1500	102.3 (A)	139	12	137/67	94%												
1600	102.4	139	20	110/60	97%												
1700																	
1800	102.2 (CA)	126	20		96%												
1900																	
2000	102.2																
2100																	
2200																	
2300	99.3	116	24	104/62	95												
2400																	

ACLU-RDI 1099 p.466

DOD 005734

PUPIL SIZE	PUPILS		MOTOR FUNCTION	CHART CODES
1 mm	=	Equal	0 = No Movement	Present ✓
2 mm	R	Reactive	1 = Slight Flicker/ Trace of Contraction	
3 mm	NR	NonReactive	2 = Active (Gravity Eliminated)	Not Applicable /Absent (blank)
			3 = Active: against gravity, but not against resistance	
4 mm	L > R	Left Larger	4 = Active: Against Gravity and Resistance, not full strength	Refer to Nsg. Notes X
			5 = Full Strength against Examiners Resistance	
5 mm	R > L	Right Larger		No Change from Previous Assessment –

DATE:

TIME		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open								4					4				4							4	
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response								5					5				5							5	
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response								6					6				6							6	
GLASCOW COMA SCALE (A+B+C)								15					15				15							15	
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R																								
	L																								
MOVEMENT (See Motor Function Scale at Top of Page)	RUE							4					4				4							4	
	LUE							2					2				4							2	
	RLE							4					4				4							4	
	LLE							2					2				2							2	
GRIP (S) Strong (W) Weak (-) absent	R							5					5				5							5	
	L							N/A					N/A				N/A							N/A	
RESPIRATIONS	REGULAR							✓					✓				✓							✓	
	IRREGULAR																								
	UNLABORED							✓					✓				✓							✓	
	LABORED																								
	SHALLOW																								
	RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL							5					5				5							5	
	LUL							5					5				5							5	
	RLL							5					5				5							5	
	LLL							5					5				5							5	
	BOTH BASES							5					5				5							5	
COUGH	NONE							✓					✓				✓							✓	
	SPONTANEOUS																								
	PRODUCTIVE																								
	NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																									
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																									
VENTILATOR	Vt																								
	FIO2																								
	RATE (SIMV/CMV)																								
	PEEP / CPAP																								
	PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE	NC (l/min)												2L												
	FM (l/min)																								
ETT #_____	NRBM (l/min)																								
	ETT _____cm gums																								
ETT CARE / POSITION CHANGE																									
ETT / NT SUCTIONED																									
INCENTIVE SPIROMETRY DONE																	✓								
COUGH / DEEP BREATH																									
INITIALS								(b)(6)-2					(b)(6)-2											(b)(6)-	

ACLU-RDI 1099 p.467

DOD 005735

	INTAKE									OUTPUT						
	DSNS 20KCO	IVPB	PO	LR OR					Total	URINE	Stool				Total	COMMENTS
0100	100/100									500/500						
0200	50/150	50/50														
0300	100/250									250/750						
0400	100/250															
0500	100/350															
0600	100/450									375/1125						
0700	100/550		30/30													
0800	100/650	50/100														
8 HR	650	100	30						8 HR 780	1125					8 HR 1125	-345
0900	100/100									250/250						
1000	100/200															
1100	100/300	50/50								250/500						
1200	100/400	50/100		1000/1000												
1300	100/500															
1400	100/600															
1500	100/700									375/875						
1600	100/800	50/150														
8 HR									16 HR. 2730						16 HR. 2000	
1700	100/100															
1800	100/200	50	800/800							325						
1900	100/300															
2000	100/400									250						
2100	100/500		240													
2200																
2300																
2400	50	50														
8 HR	500	100	1040						24 HR. 4370	575					24 HR 2775	

MEDCOM - 1684

NSN 7540-00-634-4123

MEDICAL RECORD			NURSING NO. (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
8Sep03	0025		T - 101.8 will continue to monitor [redacted] (b)(6)-2
	0245		T - 99.8 will continue to monitor [redacted]
	0400		Assessment unchanged, NAD, ~~o~~ needs identified [redacted] (b)(6)-2
8Sep03	1100		NAD noted. VSS TO OR via Litter [redacted] (b)(6)-2 LT/n.
8Sep03		1200	RTD from OR. VSS. EX-FIX to LLE I[redacted] DRSGS to LLE & LLE CD&I. Will Continue to monitor [redacted] LT/n
	1500		Tylox ii PO given for fever + pain [redacted] (b)(6)-2
	1600		PT OOB 1510 - Back to bed 1630. PT currently drinking Vanilla Ensure + eating crackers. [redacted] (b)(6)-2 MATA
	1700		Tolerated only 1/4 can of Ensure, 1 c cracker, + 1 bite of fish. States stomach not feeling like eating. Will cont. to push Ensure. [redacted] (b)(6)-2
	1800		Finished ensure, drank 1 cup grape juice + 1 pepsi. [redacted] (b)(6)-2 MATA
8Sep03		2200	Preformed dressing changes to both Right stump area and Right thigh, (R) thigh wet to dry dressing c̄ 7 pieces of Iodoform 1/2", Left tabs for locations Packed lower Portion of wound with sterile 4X4 dampened. (R) stump Packed c̄ damp Iodoform covered ~~in d~~ with damp [redacted] (b)(6)-2 with dry curlex under sterile technique SGT 91WM6 LVN
		2250	Pt desires sleeping medications. will monitor effect. [redacted] (b)(6)-2
		2330	Assessment per flowsheet, ~~o~~ distress, pt doesn't indicate any need at present. old distended ~~fat~~ but safe. [redacted] (b)(6)-2
		2335	Hep locks x 2 patent; ≡ S/S of infiltration. [redacted] (b)(6)-2

MEDCOM - 1685

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	25 Aug 03
DOS	8 Aug 03
POD	1

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

PREPARED (b)(6)-2 | Department/Service/Clinic: ICU 1 | DATE: 9 Sep 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade; date; hospital or medical facility)*

POTUS DETAINEE (b)(6)-4

- ☐ HISTORY PHYSICAL
- ☒ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☐ OTHER(*Specify*)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 1686

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R							2							2								2		
	Brachial L							2							2								2		
	DORSALIS PEDIS R							2							2								2		
	L							2							2								2		
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale								1 5 8							1 3 8								1/3/8		
EDEMA																									
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)								✓							✓								✓		
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)								ST							NS										
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH																								
	FOLEY CARE																								
	ORAL CARE																								
MOBILITY	BEDREST							✓							✓										
	BSC																								
	DANGLE																								
	CHAIR														✓								✓		
POSITIONED	RIGHT																								
	LEFT																						SELF		
	SUPINE																								
	HOB 30 DEGREES							✓							✓								✓		
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE							✓							✓										
	PAIN SCALE (1-10)																								
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended							2							2								2		
BOWEL SOUNDS (active all quads)								✓							✓								✓		
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT																									
VOIDING CLEAR, YELLOW URINE q.s.								Dark Amber							Dark								✓		
SKIN INTEGRITY	No Breakdown							✓							✓										
	Surgical Wounds							✓							✓								✓		
	Rashes, Lac's, etc							✓							✓										
DRESSING (Dry & Intact: specify site below)																									
#1 LUE								✓							✓								✓		
#2 ~~RUE~~ LLE								*							U-D								✓*		
#3																									

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
~~18 PIV H/L~~	~~(R) FA~~	~~9 Sep~~	~~5 s/sx of infection or infiltration~~
~~16 PIV H/L~~	~~(R) Lateral AC~~	~~8 Sep~~	~~3 s/sx of infection or infiltration~~

MEDCOM - 1687

PUPIL SIZE	PUPILS		MOTOR FUNCTION	CHART CODES
1 mm	=	Equal	0 = No Movement	Present ✓
2 mm	R	Reactive	1 = Slight Flicker/ Trace of Contraction	
3 mm	NR	NonReactive	2 = Active (Gravity Eliminated)	Not Applicable /Absent (blank)
			3 = Active: against gravity, but not against resistance	
4 mm	L > R	Left Larger	4 = Active: Against Gravity and Resistance, not full strength	Refer to Nsg. Notes X
			5 = Full Strength against Examiners Resistance	
5 mm	R > L	Right Larger		No Change from Previous Assessment --

DATE:

TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (2) To Pain (3) To Voice (1) Does Not Open							4							4								4		
B. BEST VERBAL RESPONSE (5) Oriented (2) Garbled (4) Confused (1) No Response (3) Inappropriate Verbal Response							5							5								5		
C. BEST MOTOR RESPONSE (6) Obeys Commands (3) Flexion to Pain (5) Localizes to Pain (2) Extension to Pain (4) Withdraw to Pain (1) No Response							6							6								6		
GLASCOW COMA SCALE (A+B+C)							15							15								15		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — R														2+								+		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — L														2+								+		
MOVEMENT (See Motor Function Scale at Top of Page) — RUE							4							4								4		
MOVEMENT (See Motor Function Scale at Top of Page) — LUE							2							2								2		
MOVEMENT (See Motor Function Scale at Top of Page) — RLE							4							4								4		
MOVEMENT (See Motor Function Scale at Top of Page) — LLE							2							2								2		
GRIP (S) Strong (W) Weak (-) absent — R							S							S								S		
GRIP (S) Strong (W) Weak (-) absent — L							—							N/A								—		
RESPIRATIONS — REGULAR							✓							✓								✓		
RESPIRATIONS — IRREGULAR																								
RESPIRATIONS — UNLABORED							✓							✓								✓		
RESPIRATIONS — LABORED																								
RESPIRATIONS — SHALLOW																								
RESPIRATIONS — RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RUL							5							5								5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — LUL							5							✓								5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RLL							5							5								5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — LLL							5							5								5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — BOTH BASES							5							5										
COUGH — NONE							✓							✓								✓		
COUGH — SPONTANEOUS																								
COUGH — PRODUCTIVE																								
COUGH — NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																								
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																								
VENTILATOR — Vt																								
VENTILATOR — FIO2																								
VENTILATOR — RATE (SIMV/CMV)																								
VENTILATOR — PEEP / CPAP						--																		
VENTILATOR — PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE — NC (l/min)																								
OXYGEN DELIVERY DEVICE — FM (l/min)																								
ETT #_____ — NRBM (l/min)																								
ETT #_____ — ETT _____cm gums																								
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED																								
INCENTIVE SPIROMETRY DONE												(b)(6)-2												
COUGH / DEEP BREATH							(b)(6)-							(b)(6)-2										
INITIALS																						(b)(6)-2		

MEDCOM - 1688

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200																	
0300																	
0400																	
0500																	
0600	103.3 (A)	132	20	113/70	93												
0700																	
0800	98.4 (A)																
0900																	
1000																	
1100	98.3 (A)	98	20	118/75	94												
1200																	
1230	100.2 (A)																
1300																	
1400	100.2 (A)																
1500																	
1600	99.4 (A)	88	18	115/71	93%												
1700																	
1800																	
1900																	
2000	101.4 (A)	116	20	117/56	93%												
2100																	
2200	98.6 (A)	103	18	114/71	94%												
2300																	
2400																	

ACLU-RDI 1099 p.473

DOD 005741

	INTAKE									OUTPUT							
	IV meds	PO							Total	Urine					Total	COMMENTS
0100	50/50															
0200																
0300		240														
0400																
0500																
0600																
0700										425/425						
0800		350/350														
8 HR	50	590							8 HR. 640	425					8 HR 425	+ 215
0900	50/50	~~50~~ 2/~~50~~ 2														
1000		120/120														
1100	50/100	60/180								350/350						
1200	50/150	60/240														
1300	~~240~~/~~390~~	240/480														
1400	~~100~~/~~490~~	100/580														
1500																
1600	50/200									400/750						
8 HR	~~780~~ 200	580							16 HR. 1420	750					16 HR. 1175	+245
1700																
1800	100/100															
1900										450/450						
2000																
2100																
2200																
2300																
2400																
8 HR									24 HR.						24 HR	

MEDCOM - 1690

NSN 7540-00-634-4123

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
~~9Sep03~~ 0030			Pt sleeping & distress or complaint, will monitor (b)(6)-2
0400			Pt ē distress - LAB'S drawn & change in status (c) leg. repositional for comfort. (b)(6)-2
9Sep03 0700	0700		Assessment completed. Temp 103° Medicated c̄ Tylox ⅔ PO Linen saturated c̄ serous drainage from LLE wound. Linens Δ'd. NAD noted. Will Δ DRSG'S & will cont to monitor. (b)(6)-2
9Sep03	0800		Consumed approximately 5% of [illegible] diet
9Sep03		1200	DRSG TO LUE & LLE Δ'd. Packing to LLE [illegible] Purulent exudate. Packing to LUE clean. Both extremities c̄ pink → red color of wounds. Both extremities re-packed c̄ wet drsg. Portable CXR done @ BS. Pt OOB TO Chair. Instructed via interpreter of importance of ↑ PO intake. Will cont to monitor VSS. (b)(6)-2
error @		~~1810~~	~~A recd Tylox x(2) for % pain @ 8/10 - for effect. [illegible]~~ (b)(6)-2
9SEP03		1800	Pt to chair given ~~to~~ two tylox PO for drsg Δ/temp, Pt tol. drsg Δ well. Minimal exudate on wound packing noted @ this time. Wound on both LUE/LLE appears red and beefy (b)(6)-2
		2200	Assessment completed - VSS - afebrile. LLE dressing intact c̄ (+) breakthrough drainage. PIV x(2) d/c'd 2° infiltration - will attempt to re-start. No % pain @ this time. Cont. monitor. (b)(6)-2

MEDCOM - 1691

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	25 Aug 03
DOS	8 Sep 03
POD	2

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On	NA	(b)(6)-2	(b)(6)-2
Call Light Within Reach	NA		
Side Rails Up	NA		
Bed in Low Position	NA		

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2	ICU #1	10 Sep 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade; date; hospital or medical facility)*

(b)(6)-4

☐ HISTORY PHYSICAL ☐ FLOWCHART

☐ OTHER EXAMINATION Or EVALUATION ☐ OTHER(Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 1692

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R				2				2						2									2	
	Brachial L				2				2						2									2	
	DORSALIS PEDIS R				2				2						2									2	
	L				2				2						2									2	
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale					1/3/8				1 3 8						1 3 8									1 3 8	
EDEMA									Ø						/										
HEART SOUNDS: (Clear, Regular, No Rubs, No Murmurs)					✓				✓						✓									✓	
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)									✓						✓									✓	
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH				PATIENT																			✓	
	FOLEY CARE																								
	ORAL CARE														✓										
MOBILITY	BEDREST														✓										
	BSC				SELF																				
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT								SELF						✓										
	LEFT																								
	SUPINE														✓									✓	
	HOB 30 DEGREES				✓										✓									✓	
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE				✓										✓										
	PAIN SCALE (1-10)								✓															✓	
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN (2) Soft & Flat (1) Distended					2				2						2									2	
BOWEL SOUNDS (active all quads)					✓				✓						✓									✓	
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph -																									
FOLEY CATHETER PATENT																									
VOIDING CLEAR, YELLOW URINE q.s.					✓				OK						Dark										
SKIN INTEGRITY	No Breakdown																								
	Surgical Wounds				✓				✓						✓									✓	
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1 LUE GAUZE WRAP									*						✓									✓	
#2 LLE GAUZE WRAP									*						✓									✓	
#3																									

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
20ga SL	(R) Hand	10 Sep 03	c/o/i - PATENT MW 0800
18g IVP	(R) AC	10 Sept 03	CDI, ØSS inf, patient
18g (P) IV	(R) AC	10 SEP 03	ØS/S Infiltration/Infection

MEDCOM - 1693

PUPIL SIZE	PUPILS		MOTOR FUNCTION	CHART CODES
1 mm	=	Equal	0 = No Movement	Present ✓
2 mm	R	Reactive	1 = Slight Flicker/ Trace of Contraction	
3 mm	NR	NonReactive	2 = Active (Gravity Eliminated)	Not Applicable /Absent (blank)
			3 = Active: against gravity, but not against resistance	
4 mm	L > R	Left Larger	4 = Active: Against Gravity and Resistance, not full strength	Refer to Nsg. Notes X
			5 = Full Strength against Examiners Resistance	
5 mm	R > L	Right Larger		No Change from Previous Assessment --

DATE:

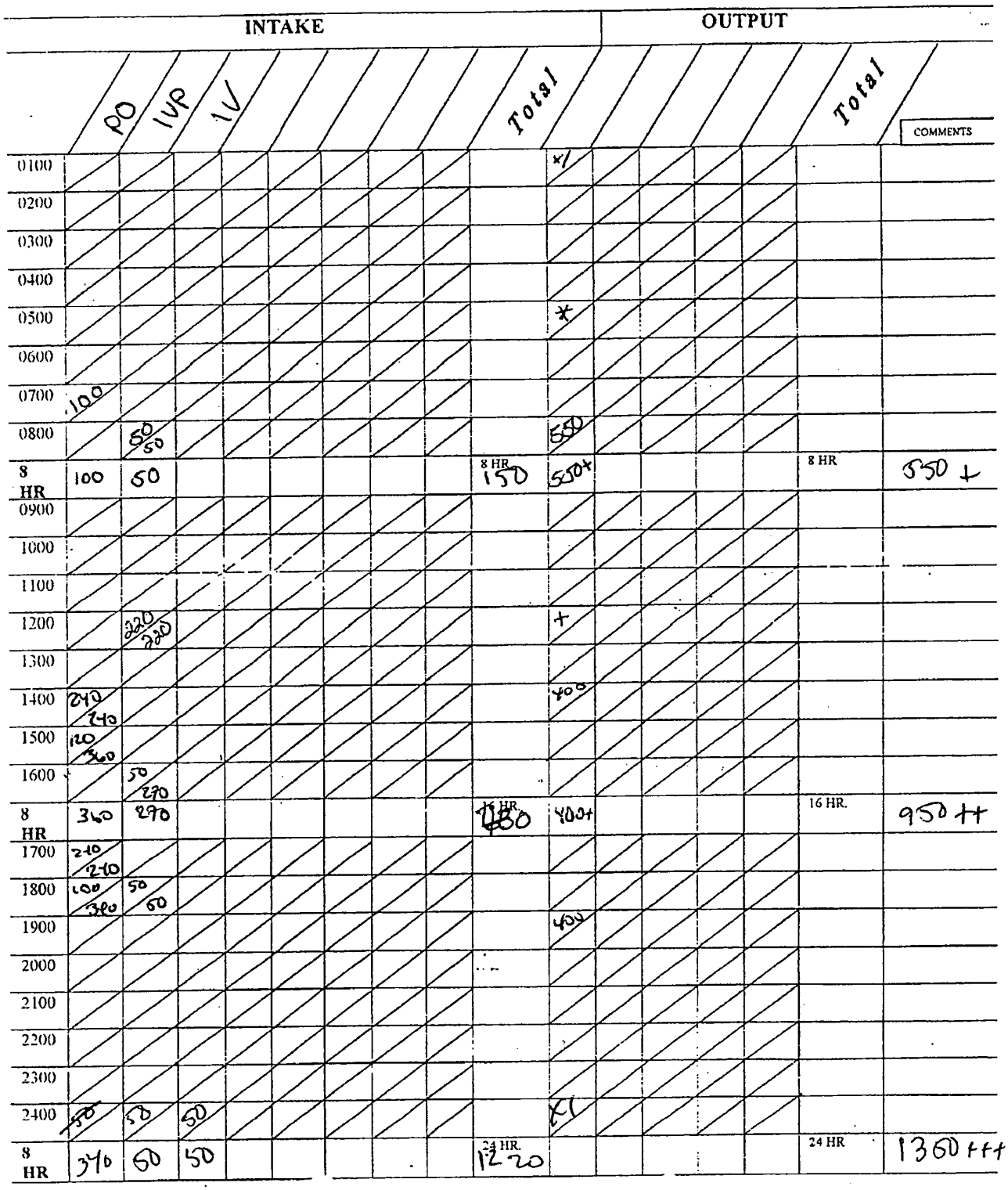
TIME		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (2) To Pain (3) To Voice (1) Does Not Open					4				4						4									4	
B. BEST VERBAL RESPONSE (5) Oriented (2) Garbled (4) Confused (1) No Response (3) Inappropriate Verbal Response					5				5						5									5	
C. BEST MOTOR RESPONSE (6) Obeys Commands (3) Flexion to Pain (5) Localizes to Pain (2) Extension to Pain (4) Withdraw to Pain (1) No Response					6				6						6									6	
GLASCOW COMA SCALE (A+B+C)					15				15						14									15	
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R				+										+2										
	L				+										+2										
MOVEMENT (See Motor Function Scale at Top of Page)	RUE				5				5						5									5	
	LUE				/				-						3									3	
	RLE				3				3						3									4	
	LLE				3				3						3									3	
GRIP (S) Strong (W) Weak (-) absent	R				S-				S						S									S	
	L				S-				S						/										
RESPIRATIONS	REGULAR				✓				✓						✓									✓	
	IRREGULAR																								
	UNLABORED				✓				✓						✓									✓	
	LABORED																								
	SHALLOW																								
	RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL				5				5						5									5	
	LUL				5				5						5									5	
	RLL				5				5						5									5	
	LLL				C				5						5									5	
	BOTH BASES								5						5									5	
COUGH	NONE				✓				✓						✓									✓	
	SPONTANEOUS																								
	PRODUCTIVE																								
	NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																									
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																									
VENTILATOR	Vt																								
	FIO2																								
	RATE (SIMV/CMV)																								
	PEEP / CPAP																								
	PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE	NC (l/min)																								
	FM (l/min)																								
ETT #_____	NRBM (l/min)																								
	ETT _____cm gums																								
ETT CARE / POSITION CHANGE																									
ETT / NT SUCTIONED																									
INCENTIVE SPIROMETRY DONE																									
COUGH / DEEP BREATH																									
INITI					(b)(				(b)(6						(b)(6) -2									(b)(6) -2	

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200																	
0300																	
0400	101.4 (R)	120	18	117/72													
0500																	
	99.8 (A)																
0600																	
0700																	
0800	97.2 (O)	93	20	114/78	95%												
0900																	
1000																	
1100																	
1200	97.6 (A)	94	16	105/69	89%												
1300	99.6 (O)																
1400	103.6 (A)																
1500	102 (A)																
1600	101.4 (A)	115	18	99/59	93%												
1700																	
1800	100 (A)																
1900																	
2000	99.4 (A)	105	20	108/64	94%												
2100																	
2200																	
2300																	
2400	102.0	110	24	126/67	94%												

ACLU-RDI 1099 p.479

DOD 005747



	INTAKE									Total	OUTPUT					Total	COMMENTS
	PO	IVP	IV														
0100											+/						
0200																	
0300																	
0400																	
0500											*						
0600																	
0700	100																
0800		50/50									550						
8 HR	100	50								8 HR 150	550+					8 HR	550 +
0900																	
1000																	
1100																	
1200		220/220									+						
1300																	
1400	240/240										400						
1500	120/360																
1600		50/290															
8 HR	360	290								16 HR 480	400+					16 HR.	950 ++
1700	210/210																
1800	100/310	50/50															
1900											400						
2000																	
2100																	
2200																	
2300																	
2400	30/30	50/50	50/50								X						
8 HR	340	50	50							24 HR 1220						24 HR	1360 +++

MEDCOM - 1696

NSN 7540-00-634-4123

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
10 Sep 03	0010		Multiple iv attempts unsuccessful. 20gm PV @ hand infiltrated per anesthesia. No Δ's - Cont. monitor. [redacted] LPN.
	0315		Pt c̄ % pain - VS ✓ @ this time - T @ 101⁴, Tylox ×2 - will monitor for effect as pain control and antipyretic. Positioned for comfort. Linens ✓'d - Dry @ this time - Cont. monitor. - [redacted] LPN
	0500		Pt. turned and draw sheet Δ'd - soaked 2° urine, tolerated well - no s/s of acute distress. Ate a package of crackers - 2 cups of soda. Foot drop cast taken of upon request. Cont. monit [redacted] LPN.
			Received pt from prev shift pt resting. no signs of distress. will cont to monitor [redacted]
	0915		pt now resting had 60% watermellon and sipps of Ensure & water. Dsg on (L) LE. ~~drain~~ moist ∅ dripping drainage. (L) UE. stump CDI m cd @ 0730 2 tylox well cont to monitor [redacted]
	1125		dsg Δed W-D. ∅ nec tissue. on (L) thigh ac (L) stump. ~~will~~ IV starter in (R) AC. will cont to monitor [redacted]
	1330		pt ↑ in chair [redacted]
10SEP03	1600		Range of Motion exercises performed c̄ LUE/LLE. Pt tol. well / participated actively. [redacted]
10SEP03	1800		Pt to chair c̄ complete assist. Pt premedicated and tolerated well [redacted]
	2200		Assumed care of pt. [redacted]
	2330		Pt c̄ 102 fever. Assessment per flowsheet. Through interpreter: (1) desires something for sleep, incontinent of urine large amt. Pt medicated per orders for pain and fever. linens changed pt cleaned. [redacted]

MEDCOM - 1697

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	25 Aug 03
DOS	8 Sep 03
POD	3

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

PREP (b)(6)-2 re and Title) | Department/Service/Clinic: ICU 1 | DATE: 11 Sep 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade;date; hospital or medical facility)*

POTUS (b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOWCHART

☐ OTHER EXAMINATION Or EVALUATION ☐ OTHER(*Specify*)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 1698

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R								2												2				
	L								2												2				
	DORSALIS PEDIS R								2												2				
	L								2												2				
SKIN (1) Dry (4) Cool (7) Jaundiced (2) Clammy (5) Flushed (8) Color Normal (3) Warm (6) Cyanotic (9) Pale									1 3 8												1/3/8				
EDEMA																									
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)									✓												✓				
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)																									
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH																								
	FOLEY CARE																								
	ORAL CARE																								
MOBILITY	BEDREST																								
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE																								
	HOB 30 DEGREES																								
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE								PF												PF				
	PAIN SCALE (1-10)																								
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended								2												2				
BOWEL SOUNDS (active all quads)									✓												✓				
NG / DOBHOFF PLACEMENT VERIFIED																					~~✓~~				
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT																									
VOIDING CLEAR, YELLOW URINE q.s.									DARK												✓				
SKIN INTEGRITY	No Breakdown																								
	Surgical Wounds								✓												✓				
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1 LUE gauze wrap									* Seep												✓				
#2 LLE gauze wrap									* not												✓				
#3																									

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
~~18g~~	~~RAC~~ P/C	10 Sep	patent 5 S/S of infiltrat
~~20g~~	~~R hand~~ P/C	11 Sep	patent 5 S/S of infiltration
20g	(L) FOOT	11 Sep 03	40% - Patent

MEDCOM - 1699

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable /Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment –

DATE:

TIME		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open									4												4				
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response									5												5				
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response									6												6				
GLASCOW COMA SCALE (A+B+C)									15												15				
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R								2+												+				
	L								2+												+				
MOVEMENT (See Motor Function Scale at Top of Page)	RUE								4												4				
	LUE								2												2				
	RLE								4												4				
	LLE								2												2				
GRIP (S) Strong (W) Weak (-) absent	R								S												S				
	L								NA												/				
RESPIRATIONS	REGULAR								✓												✓				
	IRREGULAR																								
	UNLABORED								✓												✓				
	LABORED																								
	SHALLOW																								
	RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL								5												5				
	LUL								5												5				
	RLL								5												5				
	LLL								5												5				
	BOTH BASES								5																
COUGH	NONE								✓												✓				
	SPONTANEOUS																								
	PRODUCTIVE																								
	NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																									
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																									
VENTILATOR	Vt																								
	FiO2																								
	RATE (SIMV/CMV)																								
	PEEP / CPAP																								
	PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE	NC (l/min)																								
	FM (l/min)																								
ETT #_____	NRBM (l/min)																								
	ETT _____cm gums																								
ETT CARE / POSITION CHANGE																									
ETT / NT SUCTIONED																									
INCENTIVE SPIROMETRY DONE																									
COUGH / DEEP BREATH																									
INITIALS									(b)(6)												(b)(6)				

ACLU-RDI 1099 p.484

DOD 005752

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200	100 2																
0300																	
0400	98 1	103	20	116/66	93												
0500																	
0600																	
0700	102 6 AX	113	19	109/69	94%												
0745	101 2 AX																
0800																	
0840	101 AX																
0900		110	16	111/59	94%												
1000																	
1100																	
1200	99 2 AX	116	19	145/90	99%												
1300	104 AX	133	21	117/66	93%												
1400	104 4 AX																
1500																	
1600																	
1700																	
1800	99 8 (A)																
1900																	TYLOR ATTENT
2000	102	121	20	114/65	95% RA												
2100																	
2200	102 (A)																
2300	104 3 (A)																in packs (A)
2400	100 7	118	22	117/70													

MEDCOM - 1701

	INTAKE									OUTPUT						
	IV	IVP	PO						Total	urine	Stool				Total	COMMENTS
0100	100 / 100															
0200	50 / 150	50 / 50														
0300	100 / 250															
0400	100 / 350															
0500	100 / 450															
0600	100 / 550															
0700	100 / 650															
0800	50 / 700	50 / 100														
8 HR	700	100							8 HR. 800						8 HR	
0900	100 / 100									400 / 400						
1000	100 / 200	50 / 50														
1100	100 / 300	50 / 100								200 / 600						
1200	75 / 375															
1300	75 / 450															
1400	75 / 525															
1500	75 / 600									400 / 1000						
1600	75 / 675															
8 HR	675	100							16 HR. 775						16 HR.	
1700																
1800																
1900																
2000																
2100																
2200																
2300																
2400																
8 HR									24 HR.						24 HR	

NSN 7540-00-634-4123

MEDICAL RECORD			NURSING NO. (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
11 Sep 03	0110		20 g IV to (R) hand started x 1 attempt. (R) AC site patent and ∓ S/S of infiltration. AC site heplocked. (b)(6)-2
	0350		Pt sleeping soundly & change in assessment. IV fluid infusing ∓ problem (b)(6)-2
11 Sep 03	0845		AM care complete. Pt complained of LLE and LUE pain, 2 Tylox given as ordered, pt also febrile (↑ temp of 102.6 AX). Temperature is going down. Assessment complete. Pt is NPO due to surgery, AM DRSG Δ's to be done at that time. IV infusing at 100cc/hr to (R) Hand, Patent and ∓ sign of infiltration. SPC (b)(6)-2
11 Sep 03		1230	Pt recovered from surgery and is resting. Last temp taken 99.2 AX. SPC (b)(6)-2
		1730	Pt febrile, Tylox given for pain/fever. Pt OOB to chair for 45 minutes. Pt ate some food sent in from his family, and small amount of evening meal. SPC (b)(6)-2
11 Sep 03		2100	Assessment completed - Pt. ∓ c/o pain @ this time - Full line Δ 2° urinary soakage. Drsng Δ'd - will notify physician changed necessary due to urine. Cont. monitor (b)(6)-2
		2200	T@102' - Tylox x(2) PO: however chewed and spit out - interpreter talked c̄ Physician + Pt. → Pt. under impression that Physician is an Iraqi Doctor - administer Tylox x(2) to cover c/o pain and febrile condition - Cont. monitor. (b)(6)-2
		2300	P.V x(2) c/c'd 2° - status. (R) A/C - would not flush/flow, no return, (R) Hand - Painful upon flush, and would not flow. 20 gm initiated successfully - (L) Foot flowing - cont. monitor. (b)(6)-2 Note - Tylox x(1) taken - refused 2nd Tylox. Monitor Pain/Temp. LR
		2330	ice packs applied 2° ↑ temp. monitor effectiveness. (b)(6)-2 LR

MEDCOM - 1703

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	25 Aug 03
DOS	11 Sep 03
POD	#1

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On	(b)(6)-2		(b)(6)-2
Call Light Within Reach	NA	N/A	
Side Rails Up	NA		
Bed in Low Position	NA		

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 LAC	ICU #1	12 Sep 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade;date; hospital or medical facility)*

Lopez, [redacted] (b)(6)(4)

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOWCHART

☐ OTHER EXAMINATION Or EVALUATION ☐ OTHER(*Specify*)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 1704

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R (Brachial)		+		+				~~NA~~ 2							NA					2				
	L		+		+				~~2~~ NA						2	2					2				
	DORSALIS PEDIS R		+		+				2						2	2					2				
	L		+		+				2						2	2					2				
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale			1/3/8		1/3/8				1 3 8						1 3 8	1 3 8					1/3/8				
EDEMA									Ø							Ø									
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)			✓		✓				✓						✓	✓					✓				
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)									✓						✓	✓									
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH									✓					✓	✓									
	FOLEY CARE																								
	ORAL CARE										✓														
MOBILITY	BEDREST								✓						✓										
	BSC																								
	DANGLE																								
	CHAIR											✓			✓	✓	✓				✓				
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE		✓		✓				✓						✓	✓					✓				
	HOB 30 DEGREES		✓		✓				✓						✓	✓					✓				
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE		✓		✓				✓						✓	✓					✓				
	PAIN SCALE (1-10)																								
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended		2		2				2						2	2					2				
BOWEL SOUNDS (active all quads)			✓		✓				✓						✓	✓					✓				
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT																									
VOIDING CLEAR, YELLOW URINE q.s.			✓		✓				OK						OK	OK					✓				
SKIN INTEGRITY	No Breakdown																								
	Surgical Wounds		✓		✓				✓						✓	✓					✓				
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1 (L) ee			✓		✓				✓						✓	✓					✓				
#2 (L) LE			✓		✓				✓						✓	✓					✓				
#3																									

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
20 ga	(L) FOOT	12 Sep 03	C/D/I - PATENT. (b)(6)-2

MEDCOM - 1705

PUPIL SIZE	PUPILS		MOTOR FUNCTION	CHART CODES
1 mm	=	Equal	0 = No Movement	Present ✓
2 mm	R	Reactive	1 = Slight Flicker/ Trace of Contraction	
3 mm	NR	NonReactive	2 = Active (Gravity Eliminated)	Not Applicable /Absent (blank)
4 mm	L > R	Left Larger	3 = Active: against gravity, but not against resistance 4 = Active: Against Gravity and Resistance, not full strength	Refer to Nsg. Notes N
5 mm	R > L	Right Larger	5 = Full Strength against Examiners Resistance	No Change from Previous Assessment --

DATE:

TIME		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open					4				4							4					4				
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response					5				5							5					5				
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response					6				6							6					6				
GLASCOW COMA SCALE (A+B+C)					15				15							15					15				
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R				+																+				
	L				+																+				
MOVEMENT (See Motor Function Scale at Top of Page)	RUE				4				4				1			4					4				
	LUE				/				stand							stop					3				
	RLE				4				4							4					4				
	LLE				2				2							2					2				
GRIP (S) Strong (W) Weak (-) absent	R				s-				w							w					s-				
	L				/				-							NP					/				
RESPIRATIONS	REGULAR				✓				✓							✓					✓				
	IRREGULAR																								
	UNLABORED				✓				✓							✓					✓				
	LABORED																								
	SHALLOW																								
	RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL				5				5							5					5				
	LUL				5				5							5					5				
	RLL				5				5							5					5				
	LLL				5				5							5					5				
	BOTH BASES								5							5					5				
COUGH	NONE				✓				✓							✓					✓				
	SPONTANEOUS																								
	PRODUCTIVE																								
	NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																									
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																									
VENTILATOR	Vt																								
	FiO2																								
	RATE (SIMV/CMV)																								
	PEEP / CPAP																								
	PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE	NC (l/min)																								
	FM (l/min)																								
ETT #_____	NRBM (l/min)																								
	ETT _____cm gums																								
ETT CARE / POSITION CHANGE																									
ETT / NT SUCTIONED																									
INCENTIVE SPIROMETRY DONE		✓			✓																				
COUGH / DEEP BREATH									✓	✓															
INITIALS					(b)(6)-2				(b)(6)-2												(b)(6)-2				

ACLU-RDI 1099 p.490

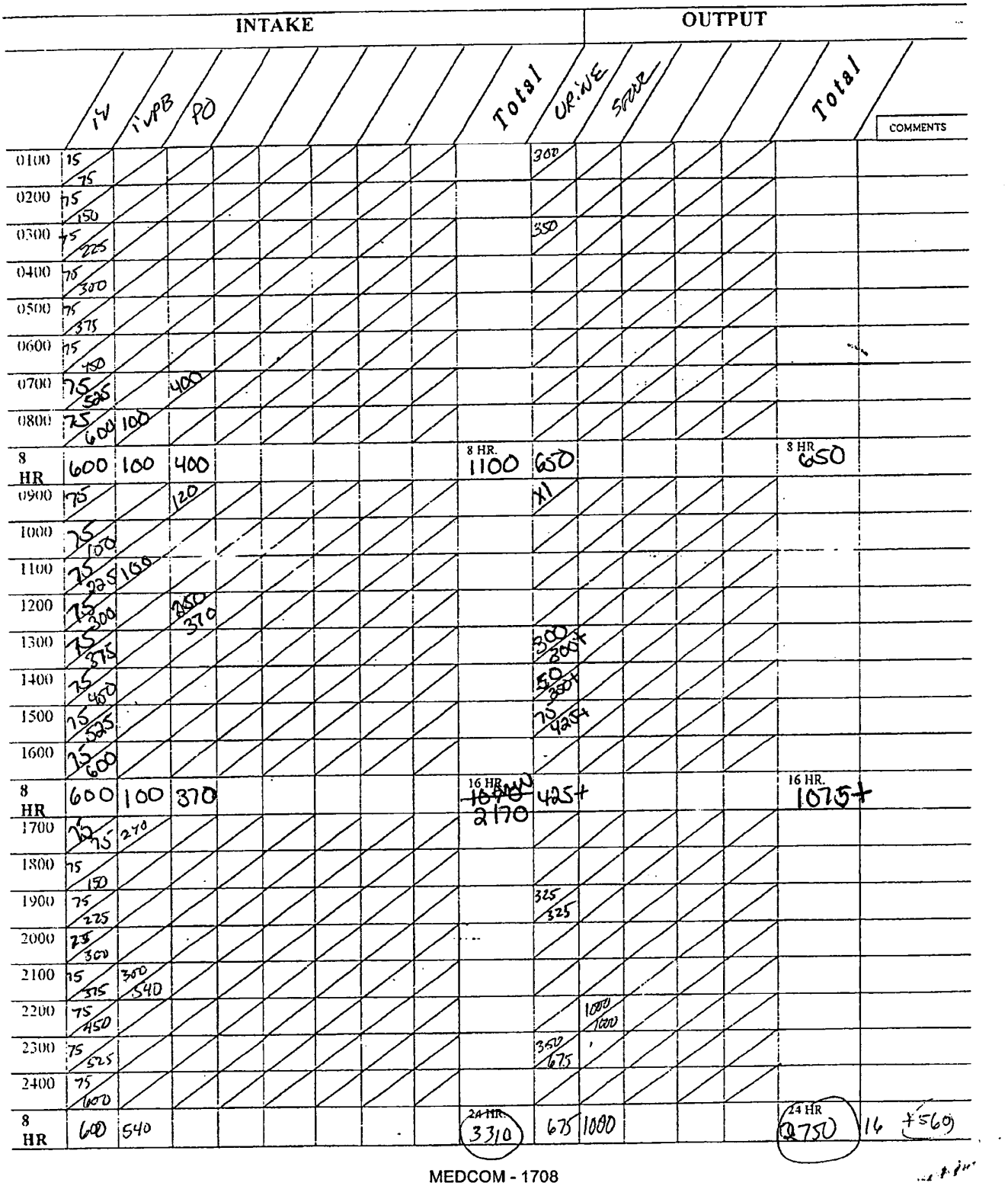
DOD 005758

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100	100.7 (A)																i> performed
0200	99.8																
0300																	
0400	101.6	128	18	118/65	—												
0500	100.6																
0600																	
0700																	
0800	99.1° (A)	100	12	103/69	98%												
0900																	
1000																	
1100																	
1200	100.5 (oral)	126	16	118/63	93%												
1300	100.2 (A)																
1400	98.8° (A)																
1500																	
1600																	
1700																	
1800	101.2	130	20	139/73													Tylenol 1 Gm
1900																	
2000	101.8							.....									
2100																	
2200	100.9	111	20	117/73													
2300																	
2400																	

ACLU-RDI 1099 p.491

DOD 005759



	INTAKE										OUTPUT							
	IV	IVPB	PO							Total	URINE	STOOL				Total		COMMENTS
0100	15 / 75										300							
0200	75 / 150																	
0300	75 / 225										350							
0400	75 / 300																	
0500	75 / 375																	
0600	75 / 450																	
0700	75 / 525		400															
0800	75 / 600	100																
8 HR	600	100	400							8 HR. 1100	650					8 HR 650		
0900	75		120								X1							
1000	75 / 100																	
1100	75 / 235	160																
1200	75 / 300		260 / 370															
1300	75 / 375										300 / 300+							
1400	75 / 450										50 / 350+							
1500	75 / 525										75 / 425+							
1600	75 / 600																	
8 HR	600	100	370							16 HR. ~~1070~~ 2170	425+					16 HR. 1075+		
1700	75	240																
1800	75 / 150																	
1900	75 / 225										325 / 325							
2000	75 / 300																	
2100	75 / 375	300 / 540																
2200	75 / 450											1000 / 1000						
2300	75 / 525										350 / 675							
2400	75 / 600																	
8 HR	600	540								24 HR. 3310	675	1000				24 HR 0750	16	+560

MEDCOM - 1708

NSN 7540-00-634-4123

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
12 Sep 03	0200		Pt T@ 99.8 - ⊕ void via urinal. Cont. monitor - No Δ's (b)(6)-2 LPN.
	0415		T@ 101.4 ∴ Tylox x(2) PO - swallowed c̄ difficulty - Dressing ✓'d -
			dry/intact. Monitor effect of Tylox - will touch c̄ on-coming
			shift re: antipyretic medication ordered. - (b)(6)-2 LPN.
	0500		Pt. turned to Δ chest underneath. - slight amt. drainage
			No c/o pain - T@ 100.6 Cont. Monitor (b)(6)-2 LPN
	0700		Pt eating breakfast currently. Ø signs of
			distress will cont to monitor (b)(6)-2
	0945		pt resting ft boards to (B) LE placed. will cont
			to monitor (b)(6)-2
	1025		ROM @ 0900 and at 1015. x4 ext. passive
			(b)(6)-2
	1035		@1030 med for pain c̄ tylox (b)(6)-2
	1445		pt ↑ @ 1130 ↑ for 1hr. labs drawn. pt stood
			for transfer to chair c̄ full assist
			pt back to bed ate & tol lunch. - (b)(6)-2
			will cont to monitor (b)(6)-2
	1545		pt up OOB to chair drank some milk +
			pepsi 1/4 can. will cont to monitor (b)(6)-2
	1635		pt to bed c̄ full assist (b)(6)-2
		1800	Rel report. Assessment completed. 455 - T@ 101.2 ∴ Tylenol po per
			order. Monitor for effectiveness. (b)(6)-2 LPN.
		2100	Dressing Δ'd. T@ 101 will recheck p̄ ↑ to chair. (L) LE + (L) UE
			dressings Δ'd c̄ wet guage / Kerlix wrap. Cont. monitor (b)(6)-2 LPN
		2200	Pt. has been ↑ in chair x 30 min. assisted to bed - given food
			to eat. Utilized BSC - Approx: 1000 ml loose stool. Pt. did not
			consume food -
		2300	Reinforced / Δ'd iv dressing site - c/o/. Patent. (b)(6)-2 LPN

MEDCOM - 1709

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	25 Aug 03
DOS	11 Sep 03
POD	#2

24 HOUR DATA	
24 Hour Balance	(b)(6)-2
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2	(b)(	(b)(6)-2
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On	NA		
Call Light Within Reach	NA	N/A	(b)(6)-2
Side Rails Up	NA		
Bed in Low Position	NA		

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 LPN	ICU #1	13 Sep 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade:date; hospital or medical facility)*

(b)(6)-4

☐ HISTORY PHYSICAL ☐ FLOWCHART

☐ OTHER EXAMINATION Or EVALUATION ☐ OTHER(Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 1710

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R				2				2						2								2		
	RADIAL L				2				2						2								2		
	DORSALIS PEDIS R				2				2						2								2		
	DORSALIS PEDIS L				2				2						2								2		
SKIN (1) Dry (4) Cool (7) Jaundiced (2) Clammy (5) Flushed (8) Color Normal (3) Warm (6) Cyanotic (9) Pale					1/3/8				1 3 8						1 3 8								1/3/8		
EDEMA									∅						—										
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)					✓				✓						✓								✓		
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)									✓						✓										
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH									✓															
	FOLEY CARE																								
	ORAL CARE	✓							✓	✓															
MOBILITY	BEDREST														✓								✓		
	BSC																								
	DANGLE											✓													
	CHAIR																								
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE				✓				✓						✓										
	HOB 30 DEGREES				✓				✓						✓								✓		
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																							✓		
PAIN	PAIN FREE				✓				✓						✓								✓		
	PAIN SCALE (1-10)																								
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended				2				2						2								2		
BOWEL SOUNDS (active all quads)					✓				✓						✓								✓		
NG / DOBHOFF PLACEMENT VERIFIED																							✓		
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT																									
VOIDING CLEAR, YELLOW URINE q.s.					✓				DK						Dark										
SKIN INTEGRITY	No Breakdown																								
	Surgical Wounds				✓				✓						✓								✓		
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1 (L) UE					✓				✓						✓								✓		
#2 (L) LE					✓				✓						✓								✓		
#3																									

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
20ga PIV	(L) foot	11 Sep 03	c/o/i - Patent. (b)(6)-2
20g PIV	(L) foot	13SEP03	patent @ s/s of inf. (b)(6)-2

MEDCOM - 1711

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable /Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment –

DATE:

TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (2) To Pain (3) To Voice (1) Does Not Open				4				4						4								4		
B. BEST VERBAL RESPONSE (5) Oriented (2) Garbled (4) Confused (1) No Response (3) Inappropriate Verbal Response				5				5						5								3		
C. BEST MOTOR RESPONSE (6) Obeys Commands (3) Flexion to Pain (5) Localizes to Pain (2) Extension to Pain (4) Withdraw to Pain (1) No Response				6				6						6								6		
GLASCOW COMA SCALE (A+B+C)				15				15						15								13		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — R				2										2								2		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — L				2										2								2		
MOVEMENT (See Motor Function Scale at Top of Page) — RUE				4				4						4								4		
MOVEMENT — LUE				/				NA						2								2		
MOVEMENT — RLE				3				3						3								3		
MOVEMENT — LLE				3				2						2								2		
GRIP (S) Strong (W) Weak (-) absent — R				5-				W						W								5-		
GRIP — L				/				NA						/								/		
RESPIRATIONS — REGULAR				✓				✓						✓								✓		
RESPIRATIONS — IRREGULAR																								
RESPIRATIONS — UNLABORED				✓				✓						✓								✓		
RESPIRATIONS — LABORED																								
RESPIRATIONS — SHALLOW																								
RESPIRATIONS — RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RUL				5				5						5								5		
BREATH SOUNDS — LUL				5				5						5								5		
BREATH SOUNDS — RLL				5				5						6								5		
BREATH SOUNDS — LLL				5				5						5								5		
BREATH SOUNDS — BOTH BASES								5						5										
COUGH — NONE				✓				✓						✓								✓		
COUGH — SPONTANEOUS																								
COUGH — PRODUCTIVE																								
COUGH — NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																								
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																								
VENTILATOR — Vt																								
VENTILATOR — FIO2																								
VENTILATOR — RATE (SIMV/CMV)																								
VENTILATOR — PEEP / CPAP																								
VENTILATOR — PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE — NC (l/min)																								
OXYGEN DELIVERY DEVICE — FM (l/min)																								
OXYGEN DELIVERY DEVICE — NRBM (l/min)																								
ETT #_____ — ETT _____cm gums																								
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED																								
INCENTIVE SPIROMETRY DONE																								
COUGH / DEEP BREATH																								
INITIALS				(b)(6)-2				(b)(6)-2						(b)(								(b)(6)-2		

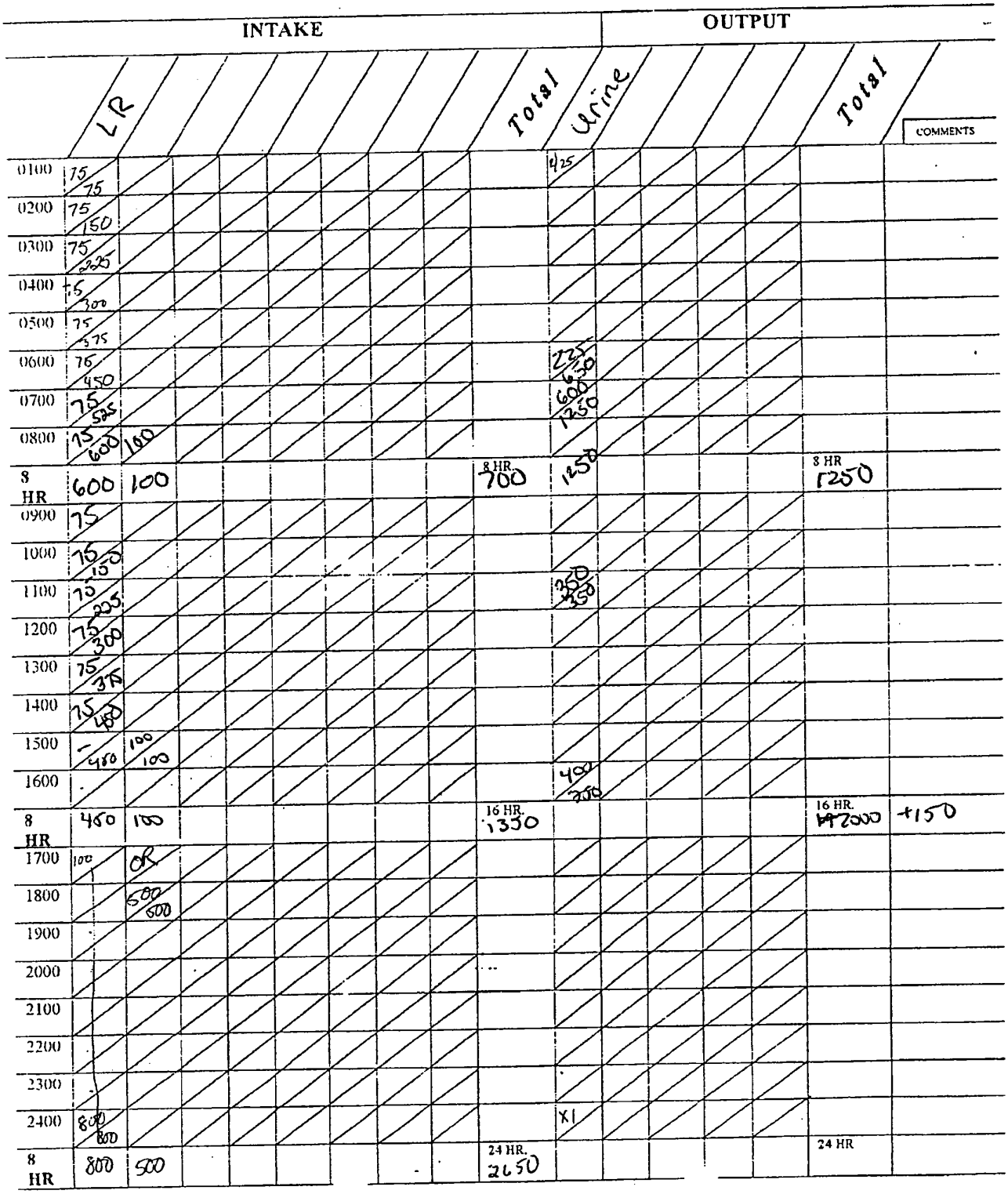
ACLU-RDI 1099 p.496

DOD 005764

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200	101 (B)	127	22	121/75													
0300																	
0400	99 (B)																
0500																	
0600																	
0700																	
0730	100.7 (A)	115	24	127/75	93%												
0800																	
0900																	
1000	100.9 (A)	130	24	—	94%												(b)(6)-2
1100																	
1200	101.4 (A)	130	24	127/77	94%												
1300	100.0 (A)																
1400	98.4 (A)																
1500																	
1600	98.5 (A)	107	22	111/72	93%												
1700																	
1800																	
1900																	
2000																	
2100	98.7 (A)	140	18	143/92	95%												
2200																	
2300																	
2400	101	119	20	107/55	—												Comes Back @

MEDCOM - 1713


INTAKE
OUTPUT
LR
Total
Urine
Total
COMMENTS
0100
0200
0300
0400
0500
0600
0700
0800
8 HR
0900
1000
1100
1200
1300
1400
1500
1600
8 HR
1700
1800
1900
2000
2100
2200
2300
2400
8 HR
8 HR.
700
16 HR.
1350
24 HR.
2650
8 HR
1250
16 HR.
2000
+150
24 HR
MEDCOM - 1714

NSN 7540-00-634-4123

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
	0015		T@ 103° - Tylenol 975 mg PO - monitor effect. Blanketing decreased -
			cont. monitor / will re-check x1° and apply cold packs prn. (b)(6)-2
	0200		Pt disgruntled - talked c̄ interpreter re. desire to get outside
			and to see his family. Interpreter explained that he could
			not. Wanted water - explained NPO status 2° pending surgery.
			T@ 101° - covers off. cont monitor - speaking c̄ interpreter -
			Pt very agitated - Haldo per order - monitor effect. - (b)(6)-2 LPN
	0250		Pt recieved 5mg Haldol - delayed administration due to clarification
			of order. Will monitor effect - Physician ordered increase
			prn. c̄ parmaters. (b)(6)-2 LPN
	0450		Pt. had been resting quietly; however, 20gm PIV pulled from
			(L) foot. Anesthesia talk to regarding IV - will wait since
			central line to be initiated this am. Cont. monitor - (b)(6)-2 LPN
	0530		20gm IV initiated during obtaining AM labs - infusing LR @ 75cc/hr
			per order. s/s of complication. Cont. monitor. (b)(6)-2 LPN
	0830		Pt A wake, moving around. Med c̄ MSO4 2mg
			for pain @ 0820 2mg MSO4 adm see assessment
			will cont to monitor (b)(6)-2
	0930		@0850 ~~IV~~ MSO4 2mg IV for pain will cont
			to monitor (b)(6)-2
	1000		Bed Bath c̄ ROM x4 ext.
	1145		@1130 pt OOB
	1230		Eyes ~~are~~ have a ~~small~~ little yellow tint to
			them (B), on (D) heal quarter size blood blister
			noted (b)(6)-2 aware will cont
			to monitor. (b)(6)-2
	1330		Pt temp ↓ to 100.0° (A) from 101.4° (A) cold pack
			given. ~~pt keeps on moving it pt~~ will cont to
			monitor (b)(6)-2
	1630		Pt to OR via gurney LPN
	2100		Pt recovered. NG tube placed x rays taken
			physician to confirm placement (b)(6)-2 LPN

MEDCOM - 1715

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	25 Aug 03
DOS	13 Sep 03
POD	#1

24 HOUR DATA	
24 Hour Balance	+1190
24 Hour Intake	4540
24 Hour Output	3350
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On	NA		NKA
Call Light Within Reach	NA	N/A	
Side Rails Up	NA		
Bed in Low Position	NA		

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 LPN.	ICU #1	14 Sep 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade; date; hospital or medical facility)*

Papus # (b)(6)-4

- ☐ HISTORY PHYSICAL
- ☐ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☐ OTHER(*Specify*)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 1716

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL Radial R		2						2	2	2	2	2	2	~~2~~		2								
	Brachial L		2						2								2								
	DORSALIS PEDIS R		2						2								2								
	L		2						2								2								
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale			1/3/8						1 3 T. (Slight)								1 3 8								
EDEMA									~~0~~								Slight								
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)			✓						✓								✓								
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)									✓								✓								
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH		Partial								✓														
	FOLEY CARE		Linen Δ									✓													
	ORAL CARE		Peri-Care								✓														
MOBILITY	BEDREST		✓								✓						✓								
	BSC																								
	DANGLE																								
	CHAIR		✓																						
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE		✓						✓								✓								
	HOB 30 DEGREES		✓						✓								✓								
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)			✓						✓								✓								
PAIN	PAIN FREE		✓						✓								✓								
	PAIN SCALE (1-10)																								
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended		2						2								2								
BOWEL SOUNDS (active all quads)			✓						✓								✓								
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT												✓					✓								
VOIDING CLEAR, YELLOW URINE q.s.			✓						✓								✓								
SKIN INTEGRITY	No Breakdown																								
	Surgical Wounds		✓						✓								✓								
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1 (L) VE			Δ						✓								✓								
#2 (L) LE			Δ						✓								✓								
#3																									

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
Central	(R) Subclavian	13 Sep 03	c/o 1. Patent (b)(6)-2
IVP	(R) AC	14Sept03	CDI, patent, ØSS infection

MEDCOM - 1717

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable /Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment --

DATE:

TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open		4						3								4								
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response		3						3								4/3								
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response		6						5								6								
GLASCOW COMA SCALE (A+B+C)		13						11								14/13								
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) R		x						+								+2								
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) L		y						+								+2								
MOVEMENT (See Motor Function Scale at Top of Page) RUE		4						4								4								
MOVEMENT (See Motor Function Scale at Top of Page) LUE		2						2								2								
MOVEMENT (See Motor Function Scale at Top of Page) RLE		3						3								3								
MOVEMENT (See Motor Function Scale at Top of Page) LLE		2						2								2								
GRIP (S) Strong (W) Weak (-) absent R		S-						S-								S-								
GRIP (S) Strong (W) Weak (-) absent L		✓						NA								✓								
RESPIRATIONS REGULAR		✓						✓								✓								
RESPIRATIONS IRREGULAR																								
RESPIRATIONS UNLABORED		✓						✓								✓								
RESPIRATIONS LABORED																								
RESPIRATIONS SHALLOW																								
RESPIRATIONS RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished RUL		5						5								5								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished LUL		5						5								5								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished RLL		5						5								5								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished LLL		5						5								5								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished BOTH BASES																								
COUGH NONE		✓						✓								✓								
COUGH SPONTANEOUS																								
COUGH PRODUCTIVE																								
COUGH NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																								
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																								
VENTILATOR Vt																								
VENTILATOR FiO2																								
VENTILATOR RATE (SIMV/CMV)																								
VENTILATOR PEEP / CPAP																								
VENTILATOR PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE NC (l/min)																								
OXYGEN DELIVERY DEVICE FM (l/min)																								
ETT #_____ NRBM (l/min)																								
ETT #_____ ETT _____cm gums																								
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED																								
INCENTIVE SPIROMETRY DONE																								
COUGH / DEEP BREATH								✓								✓								
INITIAL		(b)(6)-2						(b)(6)-2								(b)(6)-2								

ACLU-RDI 1099 p.502

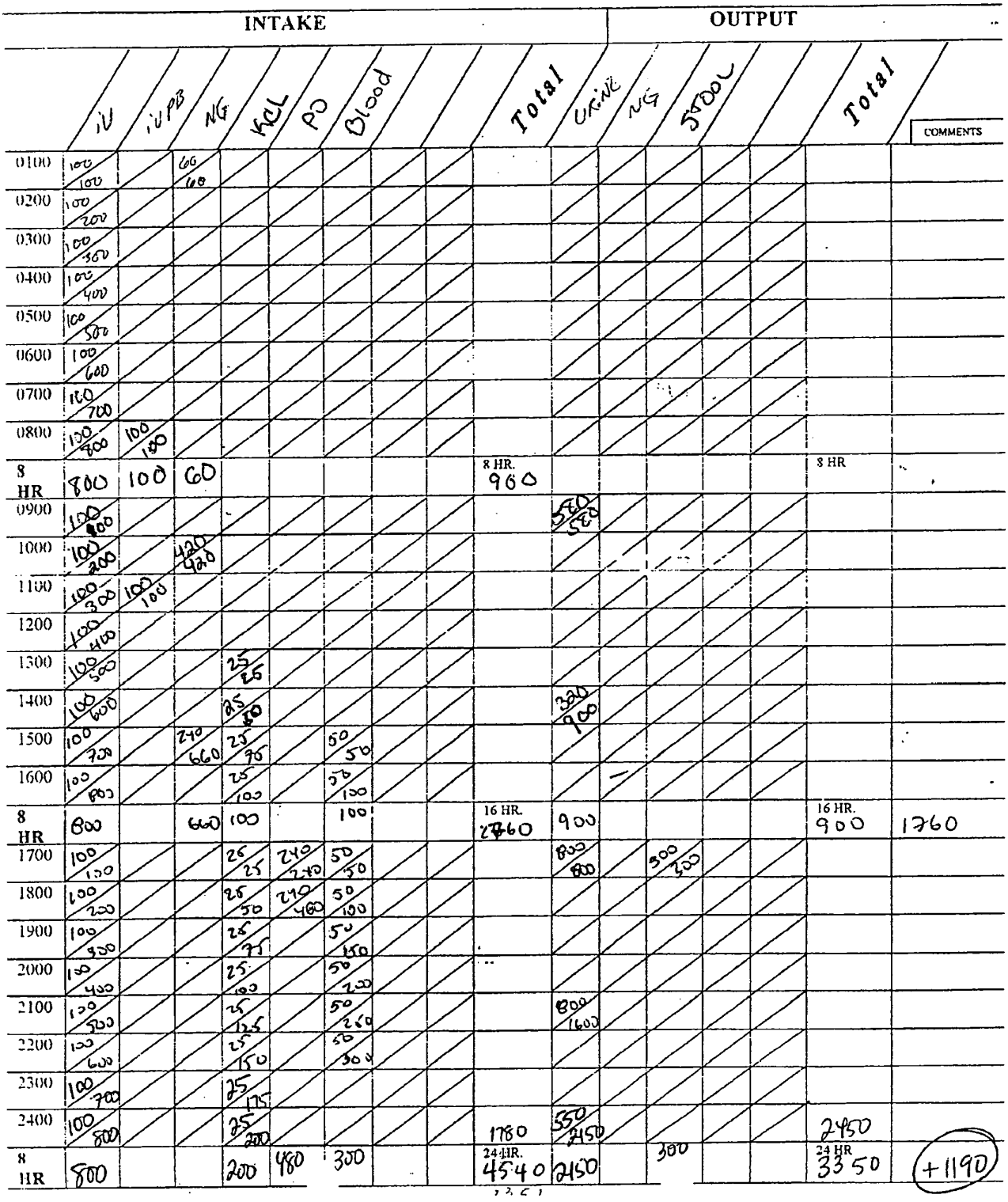
DOD 005770

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200																	
0300																	
0400	101.5	111	20	110/66	—												
0500																	
	101.0																
0600																	
0700																	
0800	100.3 (B)	115	12	121/66	98%												
0900																	
1000																	
1030	99.7 (A)																
1100																	
1200	100.2 (B)	107	12	112/66	96%												
1300	99.8 (A)																
1400																	
1500																	
1600																	
1700																	
1800																	
1900																	
2000																	
2100																	
2200																	
2300	100.6 (A)	107	16	124/69	95%												
2400																	

ACLU-RDI 1099 p.503

DOD 005771



	INTAKE									OUTPUT						
	IV	IV PB	NG	KCL	PO	Blood			Total	URINE	NG	STOOL			Total	COMMENTS
0100	100/100		60/60													
0200	100/200															
0300	100/300															
0400	100/400															
0500	100/500															
0600	100/600															
0700	100/700															
0800	100/800	100/100														
8 HR	800	100	60						8 HR. 960						8 HR	
0900	100/900									560/560						
1000	100/200		420/420													
1100	100/300	100/100														
1200	100/400															
1300	100/500			25/25												
1400	100/600			25/50						340/900						
1500	100/700		240/660	25/75		50/50					—					
1600	100/800			25/100		50/100										
8 HR	800		660	100		100			16 HR. 2760	900					16 HR. 900	1760
1700	100/100			25/25	240/240	50/50				800/800		300/300				
1800	100/200			25/50	240/480	50/100										
1900	100/300			25/75		50/150										
2000	100/400			25/100		50/200										
2100	100/500			25/125		50/250				800/1600						
2200	100/600			25/150		50/300										
2300	100/700			25/175												
2400	100/800			25/200					1780	550/2150					2450	
8 HR	800			200	480	300			24 HR. 4540	2150		300			24 HR 3350	+1190

MEDCOM - 1720

NSN 7540-00-634-4123

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
14 Sep 03	0330		Pt resting - occasional verbal outbursts. Sd't restraint @ UE intact. circulation (+). Cont. monitor - T @ 101.5, No anti ~~emetic~~ pyrectic order per physician. Hourly monitor (b)(6)-2
	0530		AM labs drawn from peripheral site - Pt sedated. T @ 101° No s/s of acute distress. Cont monitor. (b)(6)-2
	0700		@0600 received pt from prev shift no apparent signs of distress pt sleeping will cont to monitor (b)(6)-2
	1320		pt sleeping most of shift responds to pain and stimulus. @ 0800 dsg Δ ed. ~~[illegible]~~ W→D. @0900 tube feedings adm. ~~[illegible]~~ pt tol. 8cc residual. pt now receiving 100meq KCL over 10 hrs. pt on ~~[illegible]~~ card monitor. foley placed @ 1130. central line dsg CDI. 20g IVP in ⓡAC started @ 1200. Rom of 4 ext. x 2 for shift 2 units of PRBC to be infused will cont to monitor (b)(6)-2
	1400		pt in 1 pt restraint attempted to pull out NG ✓ pulse 91° Rom x ~~[illegible]~~ 3. c̄ ⓡUE will cont to monitor (b)(6)-2
14SEP03	~~1410~~	1410	Pt VSS + max 100°. Blood transfusion started (b)(6)-2
	~~1700~~	1700	Pt oriented to self but not to time and place. Pt denies pain @ this time (b)(6)-2
		2100	Drsg Δ on LUE/LLE. pt tol ~~[illegible]~~ requiring ~~[illegible]~~ pain meds. 2nd unit of blood complete 2045. Pt resting quietly. Restraint to RUE removed @ this time (b)(6)-2

MEDCOM - 1721

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	25AUG03
DOS	13SEP03
POD	#2

24 HOUR DATA	
24 Hour Balance	+330
24 Hour Intake	5155
24 Hour Output	4825
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On	NA		N/A
Call Light Within Reach	NA		X
Side Rails Up	NA		
Bed in Low Position	NA		

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 USAN	ICU#1	15SEP03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade; date; hospital or medical facility)*

Pothus # (b)(6)-4

- ☐ HISTORY/PHYSICAL
- ☐ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☐ OTHER *(Specify)*
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 1722

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R	2							2										2						
	Bradial L	/							2										/						
	DORSALIS R	2							2										2						
	PEDIS L	2							2										2						
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale		1 3 8							1 3 8										1 3 8						
EDEMA		Ø							Ø										Ø						
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)		S1S2							✓										✓						
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)		ST							✓										ST						
SWAN GANZ CATHETER (Zeroed & calibrated)		Ø																							
ARTERIAL LINE (zeroed & calibrated)		Ø																							
HYGIENE	BED BATH								✓																
	FOLEY CARE								✓																
	ORAL CARE								✓				✓						✓						
MOBILITY	BEDREST	✓							✓										✓						
	BSC									✓	✓														
	DANGLE																								
	CHAIR																				✓				
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE	✓							✓										✓						
	HOB 30 DEGREES	✓							✓										✓						
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE	PF							✓										✓						
	PAIN SCALE (1-10)																								
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN (2) Soft & Flat (1) Distended		2							2										2						
BOWEL SOUNDS (active all quads)		X4							X4										X4						
NG / DOBHOFF PLACEMENT VERIFIED		*																	CXR						
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT		✓							✓										✓						
VOIDING CLEAR, YELLOW URINE q.s.																									
SKIN INTEGRITY	No Breakdown																								
	Surgical Wounds	✓							✓										✓						
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1 RUE gauze + ace		✓							✓										✓						
#2 RLE Kerlix		✓							✓										✓						
#3																									

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
Central Cordis	(R) IJ	13SEP03	CDI Patent Ø S/S infection/infiltration
PIV IVP	(R) AC	14Sept03	CDI, Patient, Ø S/S inf — D/C in OR
PICC	(R) IJ	13 Sep 03	Ø S/S of infection or infiltration

MEDCOM - 1723

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable /Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment --

DATE: 15SEP03

TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open	4							4										4						
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response	3							5										5						
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response	6							6										6						
GLASCOW COMA SCALE (A+B+C)	13							15										15						
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — R	+																							
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — L	+																							
MOVEMENT (See Motor Function Scale at Top of Page) — RUE	5							5										5						
MOVEMENT (See Motor Function Scale at Top of Page) — LUE	4							3/4										4						
MOVEMENT (See Motor Function Scale at Top of Page) — RLE	3							3										3						
MOVEMENT (See Motor Function Scale at Top of Page) — LLE	2							2										2						
GRIP (S) Strong (W) Weak (-) absent — R	S							S										S						
GRIP (S) Strong (W) Weak (-) absent — L	✓							✓										✓						
RESPIRATIONS — REGULAR	✓							✓										✓						
RESPIRATIONS — IRREGULAR																								
RESPIRATIONS — UNLABORED	✓							✓										✓						
RESPIRATIONS — LABORED																								
RESPIRATIONS — SHALLOW																								
RESPIRATIONS — RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RUL	5							5										5						
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — LUL	5							5										5						
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RLL	5							5										5						
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — LLL	5							5										5						
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — BOTH BASES																								
COUGH — NONE	✓							✓										✓						
COUGH — SPONTANEOUS																								
COUGH — PRODUCTIVE																								
COUGH — NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																								
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																								
VENTILATOR — Vt																								
VENTILATOR — FIO2																								
VENTILATOR — RATE (SIMV/CMV)																								
VENTILATOR — PEEP / CPAP																								
VENTILATOR — PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE — NC (l/min)																								
OXYGEN DELIVERY DEVICE — FM (l/min)																								
OXYGEN DELIVERY DEVICE — NRBM (l/min)																								
ETT #_____ — ETT _____cm gums																								
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED																								
INCENTIVE SPIROMETRY DONE																								
COUGH / DEEP BREATH																								
INITIALS	(b)(6)-2							(b)(6)-2										(b)(6)-2						

MEDCOM - 1724

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100	99.3 Ax																
0200																	
0300																	
0400	97.8 Ax																
0500																	
0600																	
0700																	
0800	100.8 (A)	103	16	122/78	94												
0900																	
1000																	
1100																	
1200	101.3 (A)	108	16	130/82	95%												
1300																	
1330	100.3 (A)																
1400																	
1500																	
1600		129	18	137/81	98												
1700	101.5 Ax	132	25	134/84	94												
1800	101.2 Ax	130	25	132/80	92												
1900																	
2000	100.6 Ax																
2100																	
2200	100.5	135	26	128/75													
2300																	
2400																	

ACLU-RDI 1099 p.509

DOD 005777

	INTAKE									OUTPUT						
	IVF	IVPB	PO. Kcl	Kcl	PO	Nut Ensure			Total	Urine					Total	COMMENTS
0100	100/100	100/100														
0200	100/200															
0300	100/300															
0400	100/400									500/500						
0500	120/520															
0600	100/620	160/260								375/875						
0700	100/720															
0800	100/820	100/360								230/1105						
8 HR	800	300							8 HR 1100	1105					8 HR 1105	
0900	100/160															
1000	100/200															
1100	100/300															
1200	100/400	100/100								PO 720						
1300	100/500															
1400	100/600									250/970						
1500	200/800									400/1370						
1600	100/900	100	25/25							100/1470						
8 HR									16 HR 2125						16 HR 2575	
1700	100/100		25/25		530											
1800	100/200	100/100	25/50							500/500						
1900	100/300		25/75													
2000	100/400		25/100			240/240	Water			101/1401						
2100	100/500		25/125			60/300										
2200	100/600		25/150		1010/1530					300/1701						
2300	100/700		25/175													
2400	100/800	100/200	25/200						3030	550/2250					2250	*5155
8 HR	800	200	200		1530	300			24 HR 3230 5155	2250					24 HR 4825	4825 +330

MEDCOM - 1726

NSN 7540-00-634-4123

MEDICAL RECORD			NURSING NO. (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
14SEP03		2350	Pt pulled NG c̄ ® hand which was free of restraints.
			Dr (b)(6)-2 advised not to replace NGT tonight. Pt remains
			confused ® hand restrained again. Pt given 2mg
			MSO4 for pain to ⓛLE. Resting comfortably (b)(6)-2 (b)(6)(2)
15Sept03	0836		pt now resting. pt continues to ask for water
			despite being told no and told he will be going
			to surgery. ∅c/o pain. see assessment
			will con to monitor NPO waiting
			surgery (b)(6)-2
	1245		@1100 dsg Δ due to post ponement. W→D. ∅ drainage
			~~[illegible]~~ suitable tissue. ∅ action on temp
			∅ added ↑ will cont to monitor (b)(6)-2
15Sep03	1800		Assessment completed. ⓛ antecub HL p'cd in OR -
			IV access - RIJ. NG inserted in OR + sutured
			in nose ® Hand & remains restrained so he won't
			pull on NGT. Circ. U's UML (b)(6)-2
	2000		OOB to chair. NG Tube placement verified
			via xray. ⊕ Gastric bubble heard. started
			Ensure Ican via NGT. PT refuses to drink
			ensure. Ate well for dinner - mod. amt
			chicken + drank Reps; + lots of grape juice +
			water. Medicated for pain @ 1850 - 4mg MSO4 -
			effective. (b)(6)-2
	2100		Back to bed. Dressings remain c/DI. (b)(6)-2
	2145		10 mg ambien given for sleep. (b)(6)-2

MEDCOM - 1727

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	25 AUG03
DOS	/1356 AUG03/1554 AUG03
POD	3/1

24 HOUR DATA	
24 Hour Balance	-220
24 Hour Intake	5330
24 Hour Output	5550
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2 UTAN	(b)(6)-2
(b)(6)-2	
(b)(6)-2	
(b)(6)-2 91WM6 LVN	

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 UTAN	CU #1	16 SEP 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade; date; hospital or medical facility)*

Pohus # (b)(6)-4

- ☐ HISTORY-PHYSICAL
- ☑ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☐ OTHER *(Specify)*
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700 MEDCOM - 1728

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R	2							2						2						2				
	Brachial L	2							2						2						2				
	DORSALIS PEDIS R	2							2						2						2				
	L	2							2						2						2				
SKIN (1) Dry (4) Cool (7) Jaundiced (2) Clammy (5) Flushed (8) Color Normal (3) Warm (6) Cyanotic (9) Pale		1 3 8							1 3 8						1 3 8						1 3 8				
EDEMA		0							0						/						/				
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)		S/S2							✓						✓						✓				
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)		ST							ST						ST						ST				
SWAN GANZ CATHETER (Zeroed & calibrated)		0																							
ARTERIAL LINE (zeroed & calibrated)		0																							
HYGIENE	BED BATH										✓														
	FOLEY CARE										✓														
	ORAL CARE									✓															
MOBILITY	BEDREST	✓							✓						✓										
	BSC																								
	DANGLE																								
	CHAIR														✓										
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE	✓							✓						✓										
	HOB 30 DEGREES	✓							✓						✓						✓				
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE	PF							PF						✓						✓				
	PAIN SCALE (1-10)																								
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN (2) Soft & Flat (1) Distended		2							2						2						2				
BOWEL SOUNDS (active all quads)		x4							x4						x4						✓				
NG / DOBHOFF PLACEMENT VERIFIED		✓							✓						✓						✓				
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT		✓							✓						✓						✓				
VOIDING CLEAR. YELLOW URINE q.s.																									
SKIN INTEGRITY	No Breakdown																								
	Surgical Wounds	✓							✓						✓						✓				
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1 OUE gauze + ace		✓							✓						✓						✓				
#2 OLE Kerlix & ExFix		✓							✓						✓						✓				
#3																									

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
Central	(R) IJ	13SEP03	Patent dressing D/d 15SEP03 0945x intact/clean/dry/intact
CVC	(R) IJ	13SEP03	D/S of CVP/TPN/Heparin patent

ACLU-RDI 1099 p.513

DOD 005781

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable /Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment --

DATE: 165ep03

TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open	4							4						4						4				
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response	4							5						5						5				
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response	6							6						6						6				
GLASCOW COMA SCALE (A+B+C)	14							15						15						15				
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — R	+													+2						+2				
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — L	+													+2						+2				
MOVEMENT (See Motor Function Scale at Top of Page) — RUE	5							5						5						5				
MOVEMENT (See Motor Function Scale at Top of Page) — LUE	4							4						4						4				
MOVEMENT (See Motor Function Scale at Top of Page) — RLE	3							3						3						3				
MOVEMENT (See Motor Function Scale at Top of Page) — LLE	2							2						2						2				
GRIP (S) Strong (W) Weak (-) absent — R	5							5						5						5				
GRIP (S) Strong (W) Weak (-) absent — L	✓							✓						✓						✓				
RESPIRATIONS — REGULAR	✓							✓						✓										
RESPIRATIONS — IRREGULAR	✓																							
RESPIRATIONS — UNLABORED	✓							✓						✓						✓				
RESPIRATIONS — LABORED																								
RESPIRATIONS — SHALLOW																								
RESPIRATIONS — RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RUL	5							5						5						5				
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — LUL	5							5						5						5				
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RLL	5							5						5						5				
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — LLL	5							5						5						5				
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — BOTH BASES								5						5						5				
COUGH — NONE	✓							✓						✓						✓				
COUGH — SPONTANEOUS																								
COUGH — PRODUCTIVE																								
COUGH — NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																								
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																								
VENTILATOR — Vt																								
VENTILATOR — FIO2																								
VENTILATOR — RATE (SIMV/CMV)																								
VENTILATOR — PEEP / CPAP																								
VENTILATOR — PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE — NC (l/min)																								
OXYGEN DELIVERY DEVICE — FM (l/min)																								
ETT #_____ — NRBM (l/min)																								
ETT #_____ — ETT _____cm gums																								
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED																								
INCENTIVE SPIROMETRY DONE									✓	✓				✓										
COUGH / DEEP BREATH																								
INITIALS	(b)(6)-2							(b)(6)-2						(b)(6)						(b)(6)-2				

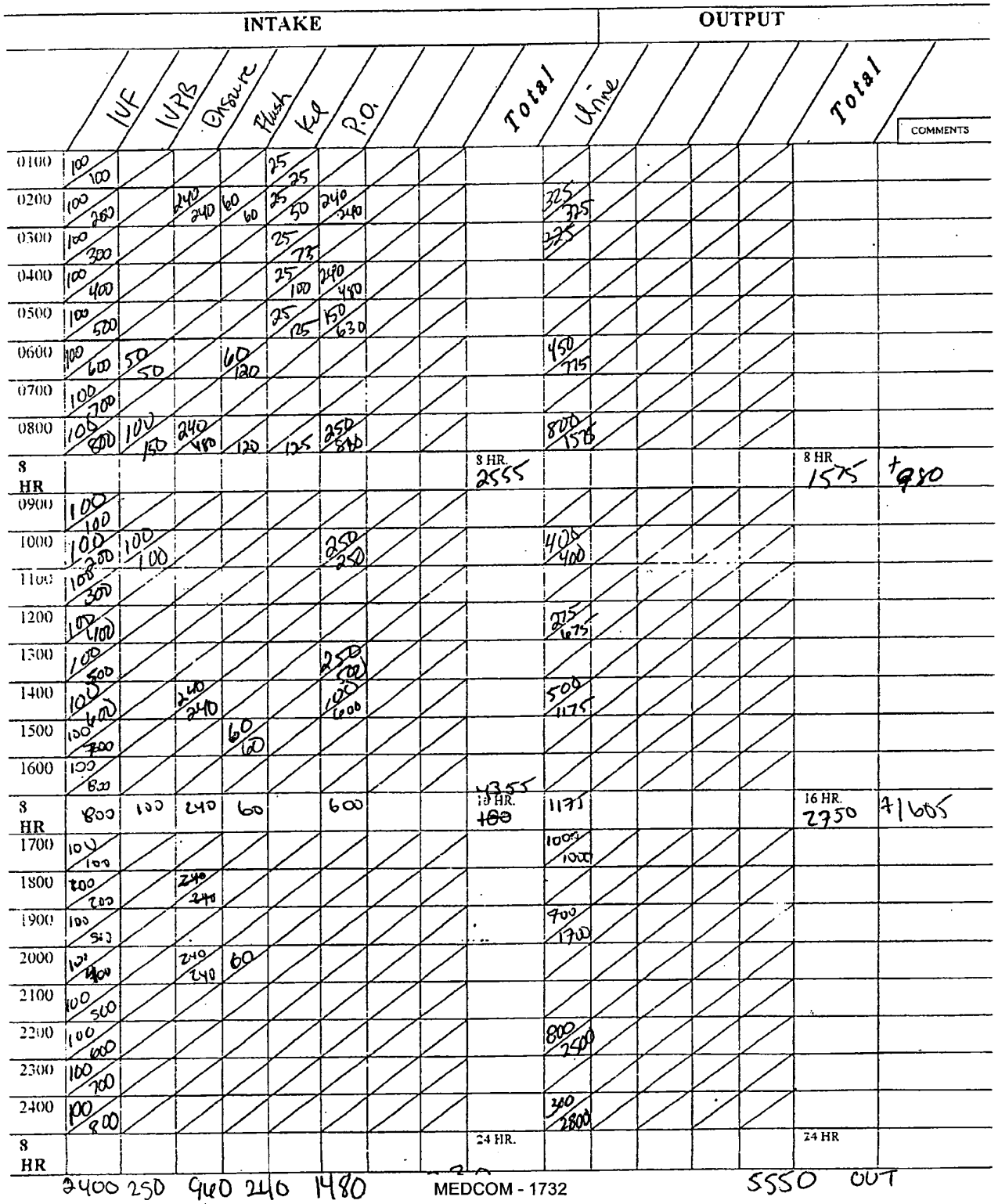
ACLU-RDI 1099 p.514

DOD 005782

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
	102.7 AX	122	21														
0200																	
	101.6																
0300																	
0400																	
0500																	
0600	99.7 AX	101	20	119/74	95%												
0700																	
0800	100.7 AX																
0900																	
1000	100.0 AX																
1100																	
1200																	
1300																	
1400	99.1 AX	109	24	111/75	97%												
1500																	
1600																	
1700																	
1800	103.2																
1900																	
2000	100.4																
2100																	
2200	99.2 AX	111	14	115/74	94% RA												
2300																	
2400																	

MEDCOM - 1731


INTAKE
OUTPUT
IUF
IVPB
Ensure
Flush
KCl
P.O.
Total
Urine
Total
COMMENTS
0100
0200
0300
0400
0500
0600
0700
0800
8 HR
0900
1000
1100
1200
1300
1400
1500
1600
8 HR
1700
1800
1900
2000
2100
2200
2300
2400
8 HR
8 HR. 2555
8 HR 1575 + 980
16 HR. 2750 + 1605
24 HR.
24 HR
2400 250 940 240 1480
MEDCOM - 1732
5550 OUT

NSN 7540-00-634-4123

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
15SEP03	2300		(R) IJ dressing D'd, new opsite placed cleansed c̄ betadine. Pt resting in bed p̄ receiving dose of ambien at 2200. (b)(6)-2
16SEP03	0230		Tylenol 650mg given per NGT, Ensure I can infused followed by 60cc H_2O flush. Given 2mg MSO4 for pain in (L) thigh (b)(6)-2 JAN
16 sep 03	0800		PT drank apple juice and ate roll for breakfast. Refused pancakes, eggs, n sausage. NG placement verified + started ensure. T = 100° ax - given Tylenol PO but PT spit the tabs out - Given Tylenol PR. PT oriented currently. (b)(6)-2 MAJ/AN
16sep	1100 ~~1000~~		Dressing Δ to (L) LE and (L) UE @ 1000 = wet to dry. Tissue pink + healthy looking. OOB to chair after dressing Δ ~ 1030. (b)(6)-2
16sep	1130		Back to bed (b)(6)-2 SMAJ
	1200		No unasyn in theater currently. (b)(6)-2 aware. (b)(6)-2 MAJ
	1230		Ate a couple bites of chicken, 2 spoonfuls of rice, small serving of cake, + drank 1 Pepsi for lunch. (b)(6)-2
16SEP03		1430	Assessment complete. Pt presently unrestrained and resting quietly. (b)(6)-2 PT/AN
		1015	Pt medicated c̄ 650mg Tylenol while up to chair for 60 minutes (b)(6)-2
		2000	Pt medicated c̄ 10mg morphine IVP prior to drsg Δ. Pt tolerated drsg Δ well. Wounds appear red and beefy c̄ minimal exudate. Pt resting @ this time (b)(6)-2
		2000	Recieved Pt VSS, Ø complaints @ this time see flow chart for assessment (b)(6)-2 SGT 91WM6 LW
		2130	Pt medicated with 5mg MSO4 for pain will monitor effect (b)(6)-2 SGT 91WM6 LW
		2200	Pt Pain Reduced (b)(6)-2 SGT 91WM6 LW
		2400	2400 dose of unasyn not given pharmacy out of drug (b)(6)-2 SGT 91WM6 LW

MEDCOM - 1733

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	25 AUG 03
DOS	
POD	

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On	NA		NKDA
Call Light Within Reach	NA	NA	
Side Rails Up	NA		
Bed in Low Position	NA		

(b)(6)-2 (Signature and Title)	Department/Service/Clinic	DATE
GIWMO LVN	ICU 1	17 SEP 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade;date; hospital or medical facility)*

POTUS #(b)(6)-4

☐ HISTORY/PHYSICAL ☒ FLOWCHART

☐ OTHER EXAMINATION Or EVALUATION ☐ OTHER(Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 1734

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R	2								~~2~~					2								2		
	Brachial L	2								2					2								2		
	DORSALIS PEDIS R	2								2					2								2		
	L	2								2					2								2		
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale		1 3 8								1 ~~8~~ 3					1 3 8								1 3 8		
EDEMA		✓								Ø					✓								Ø		
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)		✓								✓					✓								✓		
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)		~~SR~~ AF								✓					✓								✓		
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH										✓														
	FOLEY CARE										✓														
	ORAL CARE										✓														
MOBILITY	BEDREST														✓										
	BSC																								
	DANGLE																								
	CHAIR											✓				✓			✓						
POSITIONED	RIGHT												✓	✓											
	LEFT																								
	SUPINE									✓					✓		✓			✓					
	HOB 30 DEGREES	✓								✓							✓								
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)															✓								✓		
PAIN	PAIN FREE	✓																							
	PAIN SCALE (1-10)										SK					mw					5				
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN (2) Soft & Flat (1) Distended		2								2					2								2		
BOWEL SOUNDS (active all quads)		✓								✓					✓								✓		
NG / DOBHOFF PLACEMENT VERIFIED		✓								✓					✓								✓		
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT		✓								✓					✓								✓		
VOIDING CLEAR, YELLOW URINE q.s.																									
SKIN INTEGRITY	No Breakdown																								
(L) LE Gauze+Ace cdt	Surgical Wounds	✓								✓					✓								✓		
(L) UE Gauze+Ace cdt	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1																									
#2																									
#3																									

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
Central	(R) IJ	13Sep03	Ø S/S OR I/E (b)(6)-2
Central	IJ (L)	13SEP03	Ø S/S of Inf / Infiltrates 1400 (b)(6)-2
Central	(R) IJ	13 Sep 03	Ø S/S of I/E 2200 17 Sep03

ACLU-RDI 1099 p.519

DOD 005787

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200	97.2AX																
0300																	
0400																	
0500																	
0600	99.8AX																
0700																	
0800																	
0900	100.4@	124	20	120/78	95%												
1000																	
1100																	
1200																	
1300	98.8@A																
1400	98@A	114	18	117/67	97%												
1500																	
1600																	
1700																	
1800	99@A																
1900																	
2000																	
2100																	
2200	101.5AX	129	16	135/78	95%	RA											
2300																	
2400																	

ACLU-RDI 1099 p.520

DOD 005788

PUPIL SIZE **PUPILS**

1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable /Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment –

DATE:

TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (2) To Pain (3) To Voice (1) Does Not Open	4								4					4								4		
B. BEST VERBAL RESPONSE (5) Oriented (2) Garbled (4) Confused (1) No Response (3) Inappropriate Verbal Response	5								5					5								4		
C. BEST MOTOR RESPONSE (6) Obeys Commands (3) Flexion to Pain (5) Localizes to Pain (2) Extension to Pain (4) Withdraw to Pain (1) No Response	6								6					6								6		
GLASCOW COMA SCALE (A+B+C)	15								15					15								14		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — R	+													/								+		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — L	+													/								+		
MOVEMENT (See Motor Function Scale at Top of Page) — RUE	5								5					5								5		
MOVEMENT (See Motor Function Scale at Top of Page) — LUE	4								3					4								4		
MOVEMENT (See Motor Function Scale at Top of Page) — RLE	3								3					5								3		
MOVEMENT (See Motor Function Scale at Top of Page) — LLE	2								2					2								2		
GRIP (S) Strong (W) Weak (-) absent — R	5								5					5								5		
GRIP (S) Strong (W) Weak (-) absent — L	/								/					/								/		
RESPIRATIONS — REGULAR	/								/					/								/		
RESPIRATIONS — IRREGULAR																								
RESPIRATIONS — UNLABORED	✓								✓					✓								✓		
RESPIRATIONS — LABORED																								
RESPIRATIONS — SHALLOW																								
RESPIRATIONS — RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RUL	5								5					5								5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — LUL	5								5					5								5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RLL	5								5					5								5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — LLL	5								5					5								5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — BOTH BASES	5								5					5								5		
COUGH — NONE	✓								✓					✓								✓		
COUGH — SPONTANEOUS																								
COUGH — PRODUCTIVE																								
COUGH — NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																								
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																								
VENTILATOR — Vt																								
VENTILATOR — FIO2																								
VENTILATOR — RATE (SIMV/CMV)																								
VENTILATOR — PEEP / CPAP																								
VENTILATOR — PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE — NC (l/min)																								
OXYGEN DELIVERY DEVICE — FM (l/min)																								
ETT #_____ — NRBM (l/min)																								
ETT #_____ — ETT _____cm gums																								
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED																								
INCENTIVE SPIROMETRY DONE											✓	✓		✓								✓		
COUGH / DEEP BREATH									/	✓														
INITIALS	(b)(6)-2								(b)(6)-2													(b)(6)-2		

ACLU-RDI 1099 p.521

DOD 005789

	INTAKE									OUTPUT						
	IVF	PO	IVPB	ENSURE	FLUSH				Total	URINE	EMESIS	BM			Total	COMMENTS
0100	100 / 100															
0200	100 / 200			240 / 240												
0300	100 / 300				70 / 70					925 / 925						
0400	100 / 400															
0500	100 / 500	450 / 450														
0600	100 / 600									725 / 1650						
0700	100 / 700	200 / 650														
0800	100 / 800		100	240 / 480	120 / 190											
8 HR	800	650	100	480	190				8 HR. 2210	1650					8 HR 1650	
0900	100 / 100	800 / 200			[illegible]											
1000	100 / 200	120 / 320														
1100	100 / 300	120 / 440								1000 / 1650						
1200	100 / 400	60 / 500	100 / 100													
1300	100 / 500															
1400	100 / 600			240 / 240	40 / 40					600 / 1600						
1500	100 / 700				30 / 70											
1600	100 / 800	200 / 700								300 / 1900						
8 HR	800	700	100	240	70				16 HR. IV 1910 / 4120	1900					16 HR. 3550	
1700	100 / 100															
1800	– / 100		100 / 100							650						
1900	100 / 200	240 / 240														
2000	100 / 300			240 / 240	30 / 30					1100 / 1700						
2100	100 / 400															
2200	100 / 500									400 / 2100						
2300	100 / 600															
2400																
8 HR									24 HR.						24 HR	

ACLU-RDI 1099 p.522

DOD 005790

NSN 7540-00-634-4123

MEDICAL RECORD			NURSING NO. (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
17Sept	0710		Ø signs of destress, pt requested pain meds 2mg MSO_4 adm pt ate a couple bites of diet tol currently resting will cont to monitor (b)(6)-2
	1040		pt now resting. Dsgs Δ'ed W→D, ROM Text, pt drinking water regularly will cont to monitor (b)(6)-2
	1230		pt currently resting in bed on (R) side. ↑OOB to chair for last hour. 2sm size s/sat skin break-down on upper back and one small area on sacral area. Lotion applyed will cont to monitor (b)(6)-2
17 Sep 03	~~1630~~	1630	↑ into chair @ 1500, required 100% staff assistance. c/o pain once in chair, (L) hip, 3mg MSO_4 IVP given @ 1510. Appears to have had moderate relief c̄ MSO_4. Back to bed @ 1600 requiring staff assistance. Pt able to support ~50% weight on (R) leg. Appears to be rest comfortably @ this time. Interpreter @ bedside. (b)(6)-2 MAJ AN
17 Sep 03		1830	OOB to chair x 30 minutes. Ate 1/2 hamburger patty, drank 240cc fluid. Appears to be alert & oriented. (b)(6)-2 MAJ AN
		2000	~~Pt~~ Δ'd pt drsg LUE/LLE, Pt hap 8mg morphene IVP. MD present @ change. Wounds appears red beefy c̄ exudate on LUE site (b)(6)-2
		2200	Recieved pt VSS pt disoriented thinks his in line at Hotel, Ø c/o pain, N/V, UOP Great, will continue to monitor V Flow chart for ASSESSMENT. (b)(6)-2 SET 9 IWM6 LVN

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	25 AUG 03
DOS	
POD	

24 HOUR DATA	
24 Hour Balance	+325
24 Hour Intake	5250
24 Hour Output	4925
Weight on Admission	
Weight Yesterday	
Weight Today	
Last BM	16 Sep 03

NURSE'S SIGNATURE	Initials
(b)(6)-2 LUN, CRT/D MAJ AN	(b)(6)-2
(b)(	

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On	NA		NKDA
Call Light Within Reach	NA		
Side Rails Up	NA		
Bed in Low Position	NA		

(b)(6)-2	Signature and Title) SGT 91W MC LUN	Department/Service/Clinic ICU A	DATE 18 Sep 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade; date; hospital or medical facility)*

Potus # (b)(6)-4

☐ HISTORY/PHYSICAL ☒ FLOWCHART

☐ OTHER EXAMINATION Or EVALUATION ☐ OTHER(*Specify*)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 1740

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R								2								2								
	Bracheal L								2								2								
	DORSALIS PEDIS R								2								2								
	L								2								2								
SKIN (1) Dry (4) Cool (7) Jaundiced (2) Clammy (5) Flushed (8) Color Normal (3) Warm (6) Cyanotic (9) Pale									1 3 8								1 3 8								
EDEMA									Ø								Ø								
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)									✓								✓								
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)									✓																
SWAN GANZ CATHETER (Zeroed & calibrated)																	Ø								
ARTERIAL LINE (zeroed & calibrated)																	Ø								
HYGIENE	BED BATH									✓															
	FOLEY CARE									✓															
	ORAL CARE									✓									✓						
MOBILITY	BEDREST																								
	BSC																								
	DANGLE																								
	CHAIR										✓	✓				✓			✓						
POSITIONED	RIGHT																				✓				
	LEFT																								
	SUPINE								✓	✓							✓			✓					
	HOB 30 DEGREES								✓	✓							✓								
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE											✓													
	PAIN SCALE (1-10)									strong															
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																	Ø								
ABDOMEN	(2) Soft & Flat (1) Distended								2								2								
BOWEL SOUNDS (active all quads)									x4								hyper								
NG / DOBHOFF PLACEMENT VERIFIED									✓																
RESIDUAL ASSESSED															4cc						4cc				
Ph																									
FOLEY CATHETER PATENT									✓								✓								
VOIDING CLEAR, YELLOW URINE q.s.									✓																
SKIN INTEGRITY	No Breakdown																								
	Surgical Wounds								✓								✓								
	Rashes, Lac's, etc																✓								
DRESSING (Dry & Intact: specify site below)																									
#1 (L) thigh									✓								wet				4'd				
#2 (L) stump									✓								✓				4'd				
#3																									

(b)(6)-2

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
[illegible]	[illegible]		
central	[illegible] (R) IJ	13 Sep 03	Ø S/S of IJ (b)(6)-2

MEDCOM - 1741

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable /Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment --

DATE: 1850903

TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (2) To Pain (3) To Voice (1) Does Not Open								4								4								
B. BEST VERBAL RESPONSE (5) Oriented (2) Garbled (4) Confused (1) No Response (3) Inappropriate Verbal Response								5								4								
C. BEST MOTOR RESPONSE (6) Obeys Commands (3) Flexion to Pain (5) Localizes to Pain (2) Extension to Pain (4) Withdraw to Pain (1) No Response								6								6								
GLASCOW COMA SCALE (A+B+C)								~~NS~~ 15								14								
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — R																PERRLA								
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — L																3								
MOVEMENT (See Motor Function Scale at Top of Page) — RUE								4								4								
MOVEMENT (See Motor Function Scale at Top of Page) — LUE								3								4								
MOVEMENT (See Motor Function Scale at Top of Page) — RLE								4								4								
MOVEMENT (See Motor Function Scale at Top of Page) — LLE								2								2								
GRIP (S) Strong (W) Weak (-) absent — R								S-								W								
GRIP (S) Strong (W) Weak (-) absent — L								Stump								stump								
RESPIRATIONS — REGULAR								✓								✓								
RESPIRATIONS — IRREGULAR																								
RESPIRATIONS — UNLABORED								✓								✓								
RESPIRATIONS — LABORED																								
RESPIRATIONS — SHALLOW																✓								
RESPIRATIONS — RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RUL								5								5								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — LUL								5								5								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RLL								5								1								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — LLL								5								1								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — BOTH BASES								5								1								
COUGH — NONE								✓								✓								
COUGH — SPONTANEOUS																								
COUGH — PRODUCTIVE																								
COUGH — NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																NA								
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																NA								
VENTILATOR — Vt																								
VENTILATOR — FiO2																								
VENTILATOR — RATE (SIMV/CMV)																								
VENTILATOR — PEEP / CPAP																								
VENTILATOR — PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE — NC (l/min)																								
OXYGEN DELIVERY DEVICE — FM (l/min)																								
OXYGEN DELIVERY DEVICE — NRBM (l/min)																								
ETT # _____ — ETT _____ cm gums																								
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED																								
INCENTIVE SPIROMETRY DONE										✓	✓	✓			✓	✓		✓		✓				
COUGH / DEEP BREATH								✓							✓	✓		✓						
INITIALS								(b)(6)-2							(b)(6)-2									

ACLU-RDI 1099 p.526

DOD 005794

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200																	
0300	101.7 AX																
0400																	
0500																	
0600																	
0700																	
0800	98.6 A	115	24	119/75	94%												
0900																	
1000																	
1100																	
1200	99.3 A																
1300																	
1400	101.2 A																
1500																	
1600	101.3 AX	120	26	112/70	94%												(b)(6)-2 T, P, R
1700																	
1800																	
1900																	
2000	99.3 AX																
2100																	
2200	1																
2300	101.3	129	24	123/83	97%												
2400																	

ACLU-RDI 1099 p.527

DOD 005795

	INTAKE										OUTPUT						
	IVF	IVPB	Po	ENSURE	FLUSH				Total		Urine					Total	COMMENTS
0100	100/100																
0200	100/200	100/100	100/100	240/240	100/100												
0300	100/300																
0400	100/400																
0500	100/500										1300/1300						
0600	100/600	100/200															
0700	100/700		120/120														
0800	100/800		100/220	240/480	90/190												
8 HR	800	200	220	480	190				8 HR 1890		1300					8 HR 1300	
0900	100										550/1850						
1000	100/200																
1100	100/300	100															
1200	100/400	100/200	100														
1300	100/500		200/300														
1400	100/600			480/480	30/30						725/1325						
1500	100/700																
1600	100/800		60/360														
8 HR	800	200	360	480	30				16 HR 1870 3760		1325					16 HR 2625	
1700	100/100		60/60														
1800	100	100/100															
1900	100/200																
2000	100/300			480/480							1100/1100						
2100	100/400				30/30						200/1300						
2200	100/500																5750
2300	100/600		120/120								1000/2300						4925 / 325
2400	100/700								1490							2300	
8 HR	700	100	180	480	30				24 HR 5250		2300					24 HR 4925	

MEDCOM - 1744

NSN 7540-00-634-4123

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
18 Sept 03	0715		pt resting currently Ø signs of distress will cont to monitor [redacted]
	1005		pt currently eating. Dsg Δ'ed W>D on (L) thigh + (L) stump. Bed bath complete. pt ate own food. central line dsg Δ'ed will cont to monitor [redacted]
	1355		pt dozing on and off. tube feedings infusing per gravity 4cc residual prior to 1400 feedings Dsg intact will cont to monitor [redacted]
18 Sep 03		1600	Pt appears alert, follows commands, only oriented to person. T 101.3(ax), HR-120, R-26, SpO_2-94% - Δ. [redacted] notified. Breath sounds very diminished @ bases. CBC c̄ diff and CXR ordered. [redacted] MJ AN
18 Sep 03		2000	LUE stump dsg Δ'd. Iodoform gauze packed into medial aspect of wound. Small amt of red blood coming from wound. Wet Kerlix gauze applied over stump. Stump wrapped c̄ dry kerlix and ace bandage. (L) thigh wound dsg Δ'd, wet → dry c̄ kerlix roll. Deep wounds packed c̄ wet kerlix. No active bleeding noted. No S/Sx infection noted. Ex-fix intact. Sat in chair from 1830 - 1930. Received 5mg MSO_4 IVP @ 1930 upon return to bed and another 5mg MSO_4 IVP @ 1935 prior to dsg Δ. Pt tolerated dsg Δ well. ate 0% of dinner. 2 cans ensure given @ 2000. Will continue to monitor pt. [redacted] MJ AN

MEDCOM - 1745

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	25AUG03
DOS	
POD	

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	
Last BM	16 Sep 03

NURSE'S SIGNATURE	Initials
(b)(6)-2	(b)(6)-2

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			N/A
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 USAN	ICU 1	19 SEP 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade; date; hospital or medical facility)*

Pohus # (b)(6)-4

- ☐ HISTORY/PHYSICAL
- ☒ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☐ OTHER *(Specify)*
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 1746

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R	2						2					2			2					2				
	Brachial L	2						2					2			2					2				
	DORSALIS PEDIS R	2						2					2			2					2				
	L	2						2					2			2					2				
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale		1 3 8						1 3 8					1 3 8			1 3 8					1/3/8				
EDEMA		0																							
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)		SISc						✓					✓			✓					✓				
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)		ST						ST					ST			ST									
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH													✓											
	FOLEY CARE													✓		✓									
	ORAL CARE													✓							✓				
MOBILITY	BEDREST							✓					✓												
	BSC																								
	DANGLE																								
	CHAIR													✓		✓					✓				
POSITIONED	RIGHT																								
	LEFT																				SELF				
	SUPINE	✓						✓					✓												
	HOB 30 DEGREES	✓						✓					✓												
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE	PF						✓					✓			✓									
	PAIN SCALE (1-10)																								
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended	2						2					2			2					2				
BOWEL SOUNDS (active all quads)		X4						✓					✓			✓					✓				
NG / DOBHOFF PLACEMENT VERIFIED		✓						✓													✓				
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT		✓						✓					✓			✓									
VOIDING CLEAR, YELLOW URINE q.s.																✓									
SKIN INTEGRITY	No Breakdown							✓					✓			✓					*				
	Surgical Wounds	✓																			✓				
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1 QUE		✓						✓					✓			✓					*				
#2 QLE - thigh		✓						✓					✓			✓					*				
#3																									

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
Central	Q/J	13 SEP 03	OSK infection / infiltration / 0700/1200

MEDCOM - 1747

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable /Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment –

DATE: 19SEP13

TIME		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (2) To Pain (3) To Voice (1) Does Not Open		4						4					4			4									
B. BEST VERBAL RESPONSE (5) Oriented (2) Garbled (4) Confused (1) No Response (3) Inappropriate Verbal Response		4						4					4			4									
C. BEST MOTOR RESPONSE (6) Obeys Commands (3) Flexion to Pain (5) Localizes to Pain (2) Extension to Pain (4) Withdraw to Pain (1) No Response		6						6					6			6									
GLASCOW COMA SCALE (A+B+C)		14						14					14			14									
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R	2														+									
	L	2														+									
MOVEMENT (See Motor Function Scale at Top of Page)	RUE	5						5					5			5									
	LUE	3						3					3			3									
	RLE	4						4					4			4									
	LLE	2						2					2			2									
GRIP (S) Strong (W) Weak (-) absent	R	5						5					5			5									
	L	✓						✓					✓			✓									
RESPIRATIONS	REGULAR	✓						✓								✓									
	IRREGULAR	✓						✓					✓			✓									
	UNLABORED																								
	LABORED																								
	SHALLOW																								
	RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL	5						5					5			5									
	LUL	5						5					5			5									
	RLL	1						5/1					5/1			1									
	LLL	1						5/1					5/1			1									
	BOTH BASES	✓						5/✓					5/✓			✓									
COUGH	NONE	✓						✓					✓			✓									
	SPONTANEOUS																								
	PRODUCTIVE																								
	NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																									
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																									
VENTILATOR	Vt																								
	FIO2																								
	RATE (SIMV/CMV)																								
	PEEP / CPAP																								
	PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE	NC (l/min)																								
	FM (l/min)																								
ETT #_____	NRBM (l/min)																								
	ETT _____cm gums																								
ETT CARE / POSITION CHANGE																									
ETT / NT SUCTIONED																									
INCENTIVE SPIROMETRY DONE		✓												✓		✓									
COUGH / DEEP BREATH																									
INITIALS		(b)(6)-2						(b)(6)-2					(b)(6)-2			(b)(6)-2									

MEDCOM - 1748

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200	100.6																
0300																	
0400																	
0500	98.8																
0600																	
0700	98.2 (A)	103	20	113/69													
0800																	
0900																	
1000																	
1100																	
1200	97.6 (A)	110	23	126/80	95%	RA											
1300																	
1400																	
1500	96.2 O	117	18	114/73	94%	~~RA~~											
1600																	
1700																	
1800																	
1900																	
2000	100.3 (A)	124	16	104/78	—	—											
2100																	
2200																	
	102.5 (A)																
2300																	
2400																	

ACLU-RDI 1099 p.533

DOD 005801

	INTAKE									OUTPUT						
	IVF	IVPB	PO	Ensure	Flush				Total	Urine					Total	COMMENTS
0100	100/100	100/100														
0200	100/200			480/480	30/30					750/750						
0300	100/300															
0400	125/425															
0500	125/550															
0600	125/675															
0700	125/800	50/50														
0800	125/925															
8 HR	925	150		180	30				8 HR. 1585	750					8 HR 750	+ 835
0900	125/125	100/100								525/525						
1000	125/250															
1100	125/375	100/200								230/755						
1200	800/1175	50/250	← OR							100/855	← OR					
1300	100/1275		150/150													consumed 10% of Reg diet
1400	100/1375			360/360	30/30					450/1295						
1500	100/1495		120/270													
1600	100/1575									500/1795						
8 HR	1575	250	270	360	30				16 HR. 2485	1795					16 HR. 1795	
1700	100/100	50/50								525/525						
1800	100/200															
1900	100/300									300						
2000	100/400															
2100	100/500															
2200	100/600									600/1425						
2300	100/700															
2400	100/800									650						
8 HR	800	50							24 HR. 3335	2075					~~24 HR~~ 5870	

MEDCOM - 1750

NSN 7540-00-634-4123

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
19SEP03	0005		Pt resting quietly in bed. Incentive spirometry done. Ⓛ leg placed in splint. Ⓡ leg splint too long. Hurting Ⓡ leg/knee of pt. Pt currently not restrained. Explained via interpreter importance of not tugging on foley cath. Pt feels like he needs to urinate despite foley cath and told interpreter the urinal worked better. (b)(6)-2 [redacted] LTAN
	0220		Medicated c̄ 650mg tylnol via NGT, ensure hanging and infusing via NGT. Medicated c̄ 5mg MSO4 @ 0050 for pain in Ⓛ leg. Repositioned leg and placed blanket under exfix. (b)(6)-2 [redacted] LTAN
9/19/03	0600		Remains NPO for Surgery this 2 pm. Tamiza not given. Will Can't to monitor. (b)(6)-2 [redacted] ILT, AN.
9/19/03	1100		Picked up by OR staff via Gurney. NAD noted (b)(6)-2 [redacted] ILT, AN
9/19/03		1205	RTD from OR. See PACU & Critical flow Sheet. VSS NAD noted. (b)(6)-2 [redacted] ILT, AN
9/19/03		1300	Tolerated approximately 10% of Reg diet. (b)(6)-2 [redacted] ILT, AN.
		1700	Pt rested most of afternoon. OOB to chair w/o problems. SPC (b)(6)-2 [redacted]
		1820	Pt ↑ in chair - refused pm meal - consumed water + c̄ can of soda. No S/S of acute distress. VSS - T @ 100² - monitor. (b)(6)-2 [redacted] LAN.
		1910	3mg MSO4 following transfer from chair to bed. Dressing Ⓛ UE - c/o/i. Ⓛ LE c̄ breakthrough drainage - re-reinforced. (b)(6)-2 [redacted] LAN.
		2000	Ensure - 480ml ↑ via NGT - Gravity feed. monitor tolerance, assisted OOB to chair. (b)(6)-2 [redacted] LAN.
		2200	Pt assisted to bed - Dressings Δ'd for Ⓛ U/L extremities. Stage II Breakdown area upper back noted - dressing c/o/i. Stage II @ Coccyx area noted - clean - left open to air. turned toward Ⓡ side. 5mg MSO4 IV for pain control. Monitor (b)(6)-2 [redacted] LAN. Addition: 50mg Benadryl PO per order - monitor effectiveness. (b)(6)-2 [redacted] LAN.
		2230	102⁵ Ⓡ ∴ Tylox x② - Pt c̄ % ⊕ Pain and febrile condition - monitor effectiveness for pain control and ant. ~~emetic~~ Pyretic. (b)(6)-2 [redacted] LAN.

MEDCOM - 1751

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	25 Aug 03
DOS	19 Sep 03
POD	005

24 HOUR DATA	
24 Hour Balance	-535
24 Hour Intake	3335
24 Hour Output	3870
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2 LPN.	(b)(6)-2
LVT A	

Safety Checks	D	E	N
BVM at bedside			
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			N/A
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

(b)(6)-2

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 LPN.	ICU #1	20 Sep 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade; date; hospital or medical facility)*

(b)(6)-4

- ☐ HISTORY/PHYSICAL ☐ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION ☐ OTHER(*Specify*)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 1752

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R				2			2							2								2		
	Brachial L				2			2							2								2		
	DORSALIS PEDIS R				2			2							2								2		
	L				2			2							2								2		
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale					1/3/8			1/3/8							1/3/8								1/3/8		
EDEMA								0							—								—		
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)					✓			✓							✓								✓		
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)								ST																	
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH										✓														
	FOLEY CARE										✓														
	ORAL CARE										✓														
MOBILITY	BEDREST										✓												✓		
	BSC															✓									
	DANGLE								✓																
	CHAIR										✓														
POSITIONED	RIGHT			✓																					
	LEFT							✓		✓															
	SUPINE							✓	✓	✓	✓					✓									
	HOB 30 DEGREES																						✓		
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE			✓				✓															✓		
	PAIN SCALE (1-10)																								
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN (2) Soft & Flat (1) Distended				2				2								1							2		
BOWEL SOUNDS (active all quads)				✓				✓							✓								✓		
NG / DOBHOFF PLACEMENT VERIFIED				✓					✓						✓								✓		
RESIDUAL ASSESSED				✓					✓																
Ph																									
FOLEY CATHETER PATENT				✓				✓																	
VOIDING CLEAR, YELLOW URINE q.s.				✓				✓				✓											✓		
SKIN INTEGRITY	No Breakdown			—				* Foley Cyanotic Penile															✓		
	Surgical Wounds			✓				✓															✓		
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1 ② VE				✓				✓							✓								✓		
#2 ① LE				✓				✓							✓								✓		
#3																									
				(b)(6)-2				(b)(6)-2							(b)(6)-2										

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
⑤ IJ	⑤ IJ		6Fr - Robert 10700

PUPIL SIZE	PUPILS		MOTOR FUNCTION	CHART CODES
1 mm	=	Equal	0 = No Movement	Present ✓
2 mm	R	Reactive	1 = Slight Flicker/ Trace of Contraction	
3 mm	NR	NonReactive	2 = Active (Gravity Eliminated)	Not Applicable /Absent (blank)
			3 = Active: against gravity, but not against resistance	
4 mm	L > R	Left Larger	4 = Active: Against Gravity and Resistance, not full strength	Refer to Nsg. Notes X
			5 = Full Strength against Examiners Resistance	
5 mm	R > L	Right Larger		No Change from – Previous Assessment

DATE: 20 Sep 03

TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (2) To Pain (3) To Voice (1) Does Not Open				4			4							4								4		
B. BEST VERBAL RESPONSE (5) Oriented (2) Garbled (4) Confused (1) No Response (3) Inappropriate Verbal Response				5			5							5								5		
C. BEST MOTOR RESPONSE (6) Obeys Commands (3) Flexion to Pain (5) Localizes to Pain (2) Extension to Pain (4) Withdraw to Pain (1) No Response				6			6							4								6		
GLASCOW COMA SCALE (A+B+C)				15			15							15								15		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — R				+																				
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — L				+																				
MOVEMENT (See Motor Function Scale at Top of Page) — RUE				4			4							4								4		
MOVEMENT (See Motor Function Scale at Top of Page) — LUE				3			3							3								3		
MOVEMENT (See Motor Function Scale at Top of Page) — RLE				4			4							4								4		
MOVEMENT (See Motor Function Scale at Top of Page) — LLE				3			2							2								2		
GRIP (S) Strong (W) Weak (-) absent — R				S-			S							S								S		
GRIP (S) Strong (W) Weak (-) absent — L				–			✓							–								=		
RESPIRATIONS — REGULAR				✓			✓							✓								✓		
RESPIRATIONS — IRREGULAR																								
RESPIRATIONS — UNLABORED				✓			✓							✓								✓		
RESPIRATIONS — LABORED																								
RESPIRATIONS — SHALLOW																								
RESPIRATIONS — RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RUL				5										5								5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — LUL				5										5								5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RLL				5										5								5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — LLL				5										5								5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — BOTH BASES				✓			✓							5								1		
COUGH — NONE				✓			✓							✓								✓		
COUGH — SPONTANEOUS																								
COUGH — PRODUCTIVE																								
COUGH — NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																								
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																								
VENTILATOR — Vt																								
VENTILATOR — FiO2																								
VENTILATOR — RATE (SIMV/CMV)																								
VENTILATOR — PEEP / CPAP																								
VENTILATOR — PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE — NC (l/min)																								
OXYGEN DELIVERY DEVICE — FM (l/min)																								
ETT #_____ — NRBM (l/min)																								
ETT #_____ — ETT _____cm gums																								
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED																								
INCENTIVE SPIROMETRY DONE								✓		✓														
COUGH / DEEP BREATH																								
INITIALS			(b)(6)-2				(b)(6)-2		(b)(6)-2				(b)(6)-2									(b)(6)-2		

MEDCOM - 1754

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100	101 (A)																
0200																	
0300	98.9 (A)																
0400		109	16	124/60													
	97°																
0500																	
0600																	
0700																	
0800	97.7 (A)	111	18	128/74	93												
0900																	
1000																	
1100																	
1200																	
1300	99.8 (A)	124	24	115/74	96%	DOB	in Chair										
1400																	
1500																	
1600																	
1700																	
1800																	
1830	99.2	116	22	112/73													
1900																	
2000																	
2100																	
2200	98.4	118	20	125/47	97%												
2300																	
2400																	

ACLU-RDI 1099 p.539

DOD 005807

	INTAKE									OUTPUT						
	IVF	IVPB	PO	ENSURE NG					Total	URINE					Total	COMMENTS
0100	100 / 100	50 / 50	240 / 240													
0200	100 / 200		~~480~~ / 720	480 / 480						600						
0300	100 / 300		60 / ~~780~~ / 300													
0400	100 / 400															
0500	100 / 500									650 / 1250						
0600	100 / 600															
0700	100 / 700	50 / 100														
0800	100 / 800		250 / ~~1030~~							600 / 1850						
8 HR	800	100	500 / ~~1030~~	480					8 HR 1930 ~~1380~~	1850					8 HR	+80
0900	100 / 100	100 / 100														
1000	100 / 200		300 / 300													
1100	100 / 300	50 / 150								500 / 500						
1200	100 / 400															
1300	100 / 500		180 / 480							550 / 1050						
1400	200 / 500	150	480							200 / 1250						
1500										120 / 1370						
1600				480 / 480						280 / 1650						
8 HR	500	150	480	480					16 HR 3540						16 HR 3800	+40
1700			360 / 360							0						
1800		50 / 50	240 / 600							200 / 200						
1900																
2000																
2100																
2200																
2300										800 / 700						
2400		50 / 100	240 / 840	200 / 200												
8 HR		100	840	200					24 HR						24 HR 1190	

MEDCOM - 1756

NSN 7540-00-634-4123

MEDICAL RECORD			NURSING NOTE (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
20Sep 03	0010		Reduce ✓ for NGT = 10cc. Pt. wished roll be taken from (L) side - positioned supine c̄ sponge donut under coccyx area. (b)(6)-2 LAN.
	0030		T@101.5 - comes reduced - will monitor temperature closely. (b)(6)-2 LAN.
	0300		T@98.9(A) - Pt. provided water and positioned back to (R) side (b)(6)-2 LAN.
	0430		T@97(A) - covered c̄ blanket, positioned for comfort, cont. monitor (b)(6)-2
20Sep 03	1100		Pain free. DVSG's to ~~RUE~~ LUE & RUE Δ'd W⇒D. (-) EXUDATE or foul odor observed. STAGE II Decubitus Ulcer in Coccyx area between Gluteal fold. approximately 2" in diameter. (-) Exudate. Stage II Small multiple decubiti to area below neck approximate 1/4" in size. Sites cleaned c̄ hibiclen - patient turned to (R) side. VSS. NAD noted (b)(6)-2 ILT, [illegible]
20Sep 03		1325	Foley Dc'd. Pt tolerated [illegible] Attempted IV start X3 unsuccessful. Will try again later. Pt refused restart. (b)(6)-2 ILT, [illegible]
		1430	Assumed [illegible] of pt. Ø distress presently on (R) side. Post ~~void~~ foley D/c'ing void obtained. NG feeding proceeding (b)(6)-2
		1515	Pt to BSC. tolerated well. (b)(6)-2
		1545	Pt back to bed. ⊖ stool scant urine c̄ clots. (b)(6)-2
		1715	Pt refuses food. unable to convince to eat (b)(6)-2
		1820	18g IV to (L) fool x 1 attempt. pt tolerated well good blood draw. (b)(6)-2
		1900	Report given to MAJ Laporte ICU 2. Pt transported via stretcher tolerated transfer well. (b)(6)-2
20Sep 03	1900		Pt received in transfer from ICU 1. Settled in bed, stable condition. (b)(6)-2
	2300		Assumed care. Pt resting quietly in bed. Will continue to monitor (b)(6)-2

MEDCOM - 1757

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	25 AUG 03
DOS	
POD	

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside			
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 MD	ICU-2	21 Sep 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade; date; hospital or medical facility)*

POTUS # (b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOWCHART

☐ OTHER EXAMINATION Or EVALUATION ☐ OTHER(*Specify*)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 1758

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R						2		2			-			2									2	
	brachial L						2		2			-			2									2	
	DORSALIS PEDIS R						2		2			-			2									2	
	L						2		2			-			2									2	
SKIN (1) Dry (4) Cool (7) Jaundiced (2) Clammy (5) Flushed (8) Color Normal (3) Warm (6) Cyanotic (9) Pale							1 3 3		1 3 3			-			1 3 3									1 3 3	
EDEMA							Ø		✓			-			Ø										
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)							✓		✓			-			✓									✓	
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)							NS		✓			-			✓									NS	
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH						✓									✓									
	FOLEY CARE						~~✓~~																		
	ORAL CARE															✓									
MOBILITY	BEDREST						✓																	✓	
	BSC								✓			-													
	DANGLE																								
	CHAIR						✓		✓			-				✓									
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE																							✓	
	HOB 30 DEGREES														✓									✓	
FALLS PROTOCOL INITIATED							✓		✓			-			✓									✓	
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE						✓		✓			-			✓									✓	
	PAIN SCALE (1-10)																								
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN (2) Soft & Flat (1) Distended							2		2			-			2									2	
BOWEL SOUNDS (active all quads)							✓		✓			-			✓									✓	
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT																									
VOIDING CLEAR, YELLOW URINE q.s.							✓		✓			-			✓									✓	
SKIN INTEGRITY	No Breakdown																								
	Surgical Wounds																								
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1 DUE							✓		✓			-			✓									✓	
#2 DLE							✓		✓			-			✓									✓	
#3																									

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
#18g	(L) foot	20 Sep 03	CDI

ACLU-RDI 1099 p.543

DOD 005811

PUPIL SIZE	PUPILS	MOTOR FUNCTION	VERBAL SCALE
1 mm = Equal		0 = No Movement	Present ✓
2 mm R Reactive		1 = Slight Flicker/ Trace of Contraction	
3 mm NR NonReactive		2 = Active (Gravity Eliminated)	Not Applicable /Absent (blank)
		3 = Active: against gravity, but not against resistance	
4 mm L > R Left Larger		4 = Active: Against Gravity and Resistance, not full strength	Refer to Nsg. Notes X
		5 = Full Strength against Examiners Resistance	
5 mm R > L Right Larger		DATE: 21Sep03	No Change from -- Previous Assessment

TIME		0100	0200	0300	0400	0500	0600	0700	0800	0900	1000	1100	1200	1300	1400	1500	1600	1700	1800	1900	2000	2100	2200	2300	2400
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (2) To Pain (3) To Voice (1) Does Not Open							4		4			-			4									4	
B. BEST VERBAL RESPONSE (5) Oriented (2) Garbled (4) Confused (1) No Response (3) Inappropriate Verbal Response							5		5			-			4 per Resp.									5	
C. BEST MOTOR RESPONSE (6) Obeys Commands (3) Flexion to Pain (5) Localizes to Pain (2) Extension to Pain (4) Withdraw to Pain (1) No Response							6		6			-			6									6	
GLASCOW COMA SCALE (A+B+C)							15		15			-			14									15	
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R						+		+2			-			+2									+2	
	L						+		+2			-			+2									+2	
MOVEMENT (See Motor Function Scale at Top of Page)	RUE						4		4			-			5									4	
	LUE						3		3			-			4									3	
	RLE						4		4			-			4/5									4	
	LLE						2		2			-			2									2	
GRIP (S) Strong (W) Weak (-) absent	R						5		5			-			5									5	
	L						0		0			-			-									WK	
RESPIRATIONS	REGULAR						✓		✓			-			✓									✓	
	IRREGULAR																								
	UNLABORED														✓									✓	
	LABORED																								
	SHALLOW																								
	RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL						5		5			-			5									5	
	LUL						5		5			-			5									5	
	RLL						5		5			-			5									5	
	LLL						5		5			-			5									5	
	BOTH BASES						✓		✓			-			1									✓	
COUGH	NONE						✓								✓									✓	
	SPONTANEOUS																								
	PRODUCTIVE																								
	NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																									
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																									
VENTILATOR	Vt																								
	FIO2																								
	RATE (SIMV/CMV)																								
	PEEP / CPAP																								
	PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE	NC (l/min)																							EA	
	FM (l/min)																								
ETT #_____	NRBM (l/min)																								
	ETT _____cm gums																								
ETT CARE / POSITION CHANGE																									
ETT / NT SUCTIONED																									
INCENTIVE SPIROMETRY DONE							✓		✓			-													
COUGH / DEEP BREATH									✓			-													
INITIALS							(b)(6)-2		(b)(			-			(b)(6)-2									(b)(6)-2	

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DOD 005812

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200																	
0300																	
0400																	
0500																	
0600	98.6	81	16	118/81	98%												R/A
0700																	
0800																	
0900																	
1000	98.2	88	16	120/88	99%												RA
1100																	
1200																	
1300																	
1400	98.4	119	18	127/81	97%	RA											
1500																	
1600																	
1700																	
1800																	
1900																	
2000																	
2100																	
2200																	
2300	97.6	109	16	118/77	96%		92										RA
2400																	

ACLU-RDI 1099 p.545

DOD 005813

	INTAKE									OUTPUT						
	IVF	IVPB	PO	NGT					Total	Uprine					Total	COMMENTS
0100																
0200																
0300																
0400																
0500		100 100								750						
0600																
0700										200 50						
0800		50 150		~~480~~						100						
8 HR		150		~~480~~					8 HR.	1050					8 HR	
0900			200													
1000			50 250							300 200						
1100			100 350	50						100 300						
1200			75 425							225 525						
1300			230 655							—						
1400				480												
1500																
1600																
8 HR									16 HR.						16 HR.	
1700																
1800										400 725						
1900																
2000																
2100																
2200																
2300																
2400																
8 HR									24 HR.						24 HR	

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
21 Sep 03	0330		Pt attempted to pull NGT out. Firmly explained that pt would be placed in Restraints if any further attempts continued. Pt appeared to understand. Pt did not sleep entire shift, frequently yelling out, but denying pain or other needs. Will continue to monitor. (b)(6)-2
	0600		Assumed patient care USS - S C/O pain NO SS of distress SS (b)(6)-2
	1040		Dressing Δ'd to LLE Tolerated well will [illegible] to monitor per orders (b)(6)-2
	1115		Dressing Δ'd to LUE Tolerated well will [illegible] to monitor per orders. (b)(6)-2
		1240	OOB to chair tolerated well. NAD (b)(6)-2
		1330	Back to bed. Doing well needed help to [illegible] from chair to bed. (b)(6)-2
	1400		Assumed care. Pt sitting in bed voicing no [illegible] this time. Will continue to monitor (b)(6)-2
		1500	Performed extensive personal hygiene to include shampoo, oral care and bed bath. Pt participated minimally. Pt now sitting up in chair. Will continue to monitor (b)(6)-2
		2000	Dsg change completed to LLE in WAD fashion. Wound red & beefy. Pt tolerated well. Will continue to monitor (b)(6)-2
21 Sept 03		2300	Client c̄ NAD (L) arm wrapping CDI, (L) foot Heplock flushed, patent CDI (L) external fixator CDI LE drains to abd OTA, NG tube (L) nare Ø fluids running C this time moves (L) LE c̄ difficulty, skin worn dry Lac to LE's x2 MPC BS (b)(6)-2
22 Sept 03	0200		Began pt on ensure per physicians instruction checked placement pt talking to elle trying to dislodge NG tubing (b)(6)-2

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	25 Aug 03
DOS	
POD	

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	(b)(6)-2
LPN	

Safety Checks	D	E	N
BVM at bedside			
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title) (b)(6)-2

Department/Service/Clinic: ICU-2

DATE: 22 Sept 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade; date; hospital or medical facility)*

Patient # (b)(6)-4

☐ HISTORY-PHYSICAL ☐ FLOWCHART

☐ OTHER EXAMINATION Or EVALUATION ☐ OTHER(*Specify*)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 1764

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R								2						2								2		
	L								AMP						UTA								~~2~~		
	DORSALIS PEDIS R								2						2								2		
	L								2						2								2		
SKIN (1) Dry (4) Cool (7) Jaundiced (2) Clammy (5) Flushed (8) Color Normal (3) Warm (6) Cyanotic (9) Pale									1 3 8						1 3 8								1 3 8		
EDEMA									Ø						Ø								Ø		
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)									✓						✓								R		
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)									✓						✓								NSR		
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH								✓														✓		
	FOLEY CARE																								
	ORAL CARE								✓														✓		
MOBILITY	BEDREST														✓										
	BSC																								
	DANGLE																								
	CHAIR								✓							✓									
POSITIONED	RIGHT																						3		
	LEFT																						4		
	SUPINE																						5		
	HOB 30 DEGREES								✓																
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE								✓														✓		
	PAIN SCALE (1-10)																								
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended								2						2								2		
BOWEL SOUNDS (active all quads)									✓						✓								✓		
NG / DOBHOFF PLACEMENT VERIFIED									✓						✓								✓		
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT																									
VOIDING CLEAR, YELLOW URINE q.s.									*						Inc										✓
SKIN INTEGRITY	No Breakdown																								
	Surgical Wounds								✓						Coccyx										
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1 (L) UE									✓						✓										✓
#2 (L) UE									✓						✓										✓
#3																									

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
18G	(L) Foot	20 Sept 03	CDI

MEDCOM - 1765

PUPIL SIZE	PUPILS		MOTOR FUNCTION	CHART CODES
1 mm	=	Equal	0 = No Movement	Present ✓
2 mm	R	Reactive	1 = Slight Flicker/ Trace of Contraction	
3 mm	NR	NonReactive	2 = Active (Gravity Eliminated)	Not Applicable /Absent (blank)
			3 = Active: against gravity, but not against resistance	
4 mm	L > R	Left Larger	4 = Active: Against Gravity and Resistance, not full strength	Refer to Nsg. Notes X
			5 = Full Strength against Examiners Resistance	
5 mm	R > L	Right Larger		No Change from Previous Assessment --

DATE: 22 Sep 03

TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (2) To Pain (3) To Voice (1) Does Not Open								4						4										4
B. BEST VERBAL RESPONSE (5) Oriented (2) Garbled (4) Confused (1) No Response (3) Inappropriate Verbal Response								5						4										4
C. BEST MOTOR RESPONSE (6) Obeys Commands (3) Flexion to Pain (5) Localizes to Pain (2) Extension to Pain (4) Withdraw to Pain (1) No Response								6						6										6
GLASCOW COMA SCALE (A+B+C)								15						14										14
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — R								3+						3+										3
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — L								3+						3+										3
MOVEMENT (See Motor Function Scale at Top of Page) — RUE								5						5										5
MOVEMENT (See Motor Function Scale at Top of Page) — LUE								4						4										4
MOVEMENT (See Motor Function Scale at Top of Page) — RLE								3						3										3
MOVEMENT (See Motor Function Scale at Top of Page) — LLE								3						3										3
GRIP (S) Strong (W) Weak (-) absent — R								5						5										5
GRIP (S) Strong (W) Weak (-) absent — L								amp						amp										amp
RESPIRATIONS — REGULAR																								
RESPIRATIONS — IRREGULAR																								
RESPIRATIONS — UNLABORED								✓																✓
RESPIRATIONS — LABORED																								
RESPIRATIONS — SHALLOW																								
RESPIRATIONS — RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RUL								5						5										5
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — LUL								5						5										5
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RLL								5						5										5
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — LLL								5						5										5
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — BOTH BASES								5						5										5
COUGH — NONE								✓						✓										✓
COUGH — SPONTANEOUS																								
COUGH — PRODUCTIVE																								
COUGH — NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																								
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																								
VENTILATOR — Vt																								
VENTILATOR — FiO2								RA																
VENTILATOR — RATE (SIMV/CMV)																								
VENTILATOR — PEEP / CPAP																								
VENTILATOR — PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE — NC (l/min)																								
OXYGEN DELIVERY DEVICE — FM (l/min)																								
OXYGEN DELIVERY DEVICE — NRBM (l/min)																								
ETT # _____ — ETT _____ cm gums																								
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED																								
INCENTIVE SPIROMETRY DONE																								
COUGH / DEEP BREATH																								
INITIALS								(b)(6)-2						(b)(6)-2										(b)(6)-2

ACLU-RDI 1099 p.550

DOD 005818

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200																	
0300																	
0400																	
0500																	
0600																	
0700																	
0800	97.7	110	18	120/80	99%	RA											
0900																	
1000																	
1100																	
1200																	
1300																	
1400																	
1500																	
1600																	
1700																	
1800	98.1	108	18	112/76	99%												
1900																	
2000																	
2100																	
2200																	
2300																	
2400																	

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DOD 005819

	INTAKE									OUTPUT							
	N.G.	IVPB	PO						Total	Urine						Total	COMMENTS
0100																	
0200																	
0300																	
0400																	
0500																	
0600										80cc							
0700			100 100							200 400							
0800			880 980														
8 HR			980						8 HR.	400						8 HR	
0900																	
1000																	
1100																	
1200																	
1300																	
1400			250 250							x1 inc.							
1500			100 350							x1 inc.							
1600																	
8 HR									16 HR.							16 HR.	
1700																	
1800																	
1900																	
2000																	
2100																	
2200																	
2300																	
2400	350	100								x1							Incontinent
8 HR									24 HR.							24 HR	

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DOD 005820

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
22Sept03	0400		pt pulling @ tubing and fluids, removing ace bandaging to (L) arm UE, throwing bedding, applied soft restraint to (R) UE — [redacted]
	0700		got pt up to chair; bed bath done; pt. is having urgency + frequency with urination; noticed blood in urine; will send UA c̄ next void — [redacted]
	0900		UA sent; pt. sitting up in bed eating food from home. — [redacted]
22Sep03	1400		Report received, assumed care of patient. Pt continues to be loud, yelling @ times, incontinent of urine, attempting to pull out NGT. (R) hand restrained @ this time. See flowsheet for details — [redacted]
	1700		OOB → chair x 2 hrs. — [redacted]
	2100		Back to bed, OOB → chair x 2 more hours [redacted]
22Sept03		2200	sleeping @ this time; Ø S/S of resp. distress, NGT in place will continue to monitor pt — [redacted]

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	25 Aug 13
DOS	
POD	

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	(b)(6)-2

Safety Checks	D	E	N
BVM at bedside			
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

(b)(6)-2

Department/Service/Clinic: ICU2

DATE: 23sept13

PATIENT'S IDENTIFICATION (*For typed or written entries give: Name-last, first, Middle; grade;date: hospital or medical facility*)

Potus # (b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOWCHART

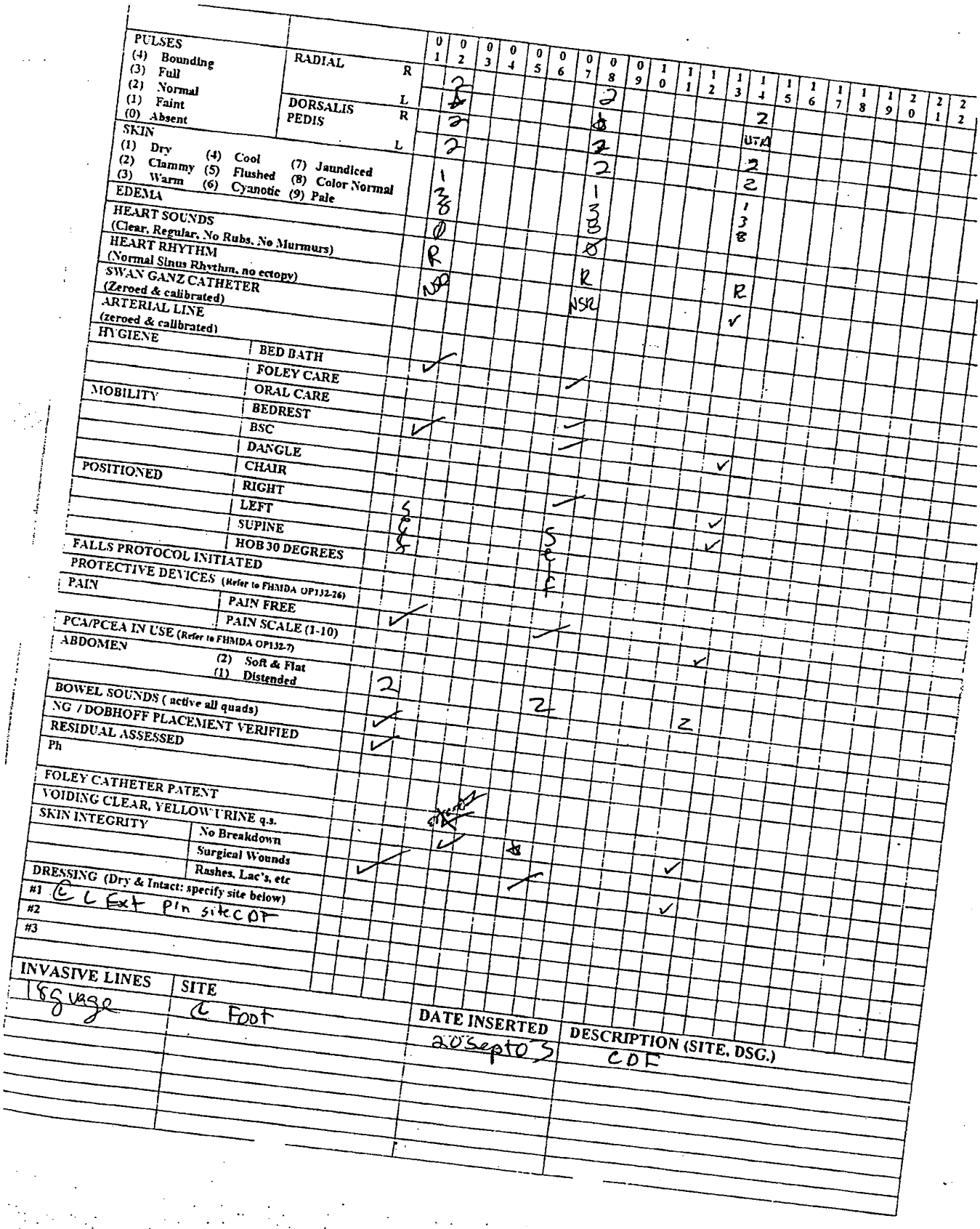
☐ OTHER EXAMINATION Or EVALUATION ☐ OTHER(*Specify*)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 1770



		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R		2						2						2								
	RADIAL L		2						2						UTA								
	DORSALIS PEDIS R		2						2						2								
	DORSALIS PEDIS L		2						2						2								
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale																							
EDEMA			1						1						1								
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)			3						3						3								
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)			0						0						8								
SWAN GANZ CATHETER (Zeroed & calibrated)			R						R														
ARTERIAL LINE (zeroed & calibrated)			NS						R						R								
HYGIENE	BED BATH	✓					NSR																
	FOLEY CARE						✓								✓								
	ORAL CARE																						
MOBILITY	BEDREST						✓																
	BSC	✓					✓																
	DANGLE						✓																
	CHAIR														✓								
POSITIONED	RIGHT						✓																
	LEFT	S																					
	SUPINE	E				S							✓										
	HOB 30 DEGREES	S				E							✓										
FALLS PROTOCOL INITIATED						F																	
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																							
PAIN	PAIN FREE																						
	PAIN SCALE (1-10)	✓					✓																
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																							
ABDOMEN (2) Soft & Flat (1) Distended												✓											
BOWEL SOUNDS (active all quads)		2				2					2												
NG / DOBHOFF PLACEMENT VERIFIED		✓																					
RESIDUAL ASSESSED		✓																					
Ph																							
FOLEY CATHETER PATENT																							
VOIDING CLEAR, YELLOW URINE q.s.																							
SKIN INTEGRITY	No Breakdown																						
	Surgical Wounds																						
	Rashes, Lac's, etc																						
DRESSING (Dry & Intact: specify site below)																							
#1 C L Ext Pin site CDF																							
#2																							
#3																							

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
18g vage	C Foot	20Sep03	CDF

PUPIL SIZE	PUPILS		MOTOR FUNCTION	CHART CODES
1 mm	=	Equal	0 = No Movement	Present ✓
2 mm	R	Reactive	1 = Slight Flicker/ Trace of Contraction	Not Applicable /Absent (blank)
3 mm	NR	NonReactive	2 = Active (Gravity Eliminated)	Refer to Nsg. Notes X
4 mm	L > R	Left Larger	3 = Active: against gravity, but not against resistance	
5 mm	R > L	Right Larger	4 = Active: Against Gravity and Resistance, not full strength	No Change from Previous Assessment --
			5 = Full Strength against Examiners Resistance	

TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open		4						4						4										
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response		4						4						4										
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response		6						6						6										
GLASCOW COMA SCALE (A+B+C)														14										
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) R		2						2						2										
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) L		2						2						4										
MOVEMENT (See Motor Function Scale at Top of Page) RUE		4						4						3										
MOVEMENT (See Motor Function Scale at Top of Page) LUE		4						4						4										
MOVEMENT (See Motor Function Scale at Top of Page) RLE		4						2						2										
MOVEMENT (See Motor Function Scale at Top of Page) LLE		4						5						5										
GRIP (S) Strong (W) Weak (-) absent R		5						5						5										
GRIP (S) Strong (W) Weak (-) absent L		S						W						W										
RESPIRATIONS REGULAR		✓						✓						✓										
RESPIRATIONS IRREGULAR																								
RESPIRATIONS UNLABORED																								
RESPIRATIONS LABORED																								
RESPIRATIONS SHALLOW																								
RESPIRATIONS RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished RUL		5						5						5										
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished LUL		5						5						5										
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished RLL		5						5						5										
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished LLL		5						5						5										
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished BOTH BASES		5						5						✓										
COUGH NONE																								
COUGH SPONTANEOUS																								
COUGH PRODUCTIVE																								
COUGH NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																								
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																								
VENTILATOR Vt																								
VENTILATOR FiO2																								
VENTILATOR RATE (SIMV/CMV)																								
VENTILATOR PEEP / CPAP																								
VENTILATOR PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE NC (l/min)																								
OXYGEN DELIVERY DEVICE FM (l/min)																								
OXYGEN DELIVERY DEVICE NRBM (l/min)																								
ETT #_____ ETT _____cm gums																								
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED																								
INCENTIVE SPIROMETRY DONE																								
COUGH / DEEP BREATH															✓									
INITIALS		(b)(6)-2							(b)(6)-2															

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200	98.6	62	16	114/56	100%												
0300																	
0400																	
0500																	
0600																	
0700																	
0800	96.4	103	116	122/79	99%												
0900																	
1000																	
1100																	
1200																	
1300																	
1400																	
1500	97.0	98	18	130/82	100%												
1600																	
1700																	
1800																	
1900																	
2000																	
2100																	
2200																	
2300																	
2400																	

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DOD 005825

	INTAKE									OUTPUT							
	NG	IVPB	PO						Total	Urine	BM				Total	COMMENTS
0100																
0200	240															
0300																
0400																
0500										X1						Incontinent
0600		100														
0700																
0800																
8 HR									8 HR.						8 HR	
0900																
1000											X1 LG					
1100																
1200																
1300																
1400			200													
1500																
1600																
8 HR									16 HR.						16 HR.	
1700																
1800																
1900																
2000																
2100																
2200																
2300																
2400																
8 HR									24 HR.						24 HR	

NSN 7540-00-634-4123

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
23sept03	0200		- sleeping @ this time, will continue to monitor pt (b)(6)-2
	0700		pt. resting with eyes closed; NAD; will cont. to monitor (b)(6)-2
	1030		pt voiding dark yellow urine; VA was sent (b)(6)-2
		1430	Resting well NAD VSS will cont to monitor per orders (b)(6)-2
		1615	Incontent of urine. (b)(6)-2
		1645	In & Out cath. 80cc cloud yellow urine will inform MD of finding (b)(6)-2
		1655	↑ to chair tolerating well. NAD will cont to monitor per orders (b)(6)-2
		~~1830~~ 1700	Received Tylox x ii for leg pain. will cont to monitor per orders. (b)(6)-2
		1830	In chair eating some food. NAD (b)(6)-2
		1845	MD Mondragon notify of In & Out results. (b)(6)-2
		1910	Back to bed tolerated well. Needed lots of help to stand. (b)(6)-2

CRITICAL CARE FLOW SHEET

DARNALL ARMY COMMUNITY HOSPITAL

LOS DATA	
DOA	25 Aug 03
DOS	
POD	

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside			
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 9MED6	ICU	24 Sept 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade; date; hospital or medical facility)*

(b)(6)-4 (EDC)

☐ HISTORY/PHYSICAL ☐ FLOWCHART

☐ OTHER EXAMINATION Or EVALUATION ☐ OTHER(*Specify*)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 1776

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R	2		2				2							2								2		
	Brachial L	2	(b)(6)-2	2				UTA							2								2		
	DORSALIS PEDIS R	2		2				2							2								2		
	L	2		2				2							2								2		
SKIN (1) Dry (4) Cool (7) Jaundiced (2) Clammy (5) Flushed (8) Color Normal (3) Warm (6) Cyanotic (9) Pale		1		1				1							1								1		
EDEMA				3				3							3								3		
				8				8							8								8		
				0											0										
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)				✓				✓							✓								✓		
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)				NSR				SR							SR								NSR		
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH																								
	FOLEY CARE																								
	ORAL CARE																						✓		
MOBILITY	BEDREST			✓				✓							✓										
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT							S																	
	LEFT							✓																	
	SUPINE			✓				✓															✓		
	HOB 30 DEGREES			✓				✓																	
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)				*																					
PAIN	PAIN FREE			✓				n/a							*								✓		
	PAIN SCALE (1-10)																								
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended			2				2							2								2		
BOWEL SOUNDS (active all quads)																							✓		
NG / DOBHOFF PLACEMENT VERIFIED								✓							✓								✓		
RESIDUAL ASSESSED								✓																	
Ph																									
FOLEY CATHETER PATENT																									
VOIDING CLEAR, YELLOW URINE q.s.				✓				✓							✓								✓		
SKIN INTEGRITY	No Breakdown			✓																					
	Surgical Wounds																								
LE Lac	Rashes, Lac's, etc			✓				✓							✓								✓		
DRESSING (Dry & Intact: specify site below)				✓																					
#1 (L) LE ext fix				✓				✓							✓								✓		
#2 (L) LE cmp								✓							✓								✓		
#3																									
			(b)(6)-2				(b)(6)-2																		

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
NG	(L) nare		
18G	(L) post	20 Sept 08	CVL

ACLU-RDI 1099 p.561

DOD 005829

PUPIL SIZE		PUPILS	MOTOR FUNCTION	CHART CODES
1 mm	=	Equal	0 = No Movement	Present ✓
2 mm	R	Reactive	1 = Slight Flicker/ Trace of Contraction	
3 mm	NR	NonReactive	2 = Active (Gravity Eliminated)	Not Applicable /Absent (blank)
			3 = Active: against gravity, but not against resistance	
4 mm	L > R	Left Larger	4 = Active: Against Gravity and Resistance, not full strength	Refer to Nsg. Notes X
			5 = Full Strength against Examiners Resistance	
5 mm	R > L	Right Larger	DATE: 24 Sept 03	No Change from Previous Assessment --

TIME		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (2) To Pain (3) To Voice (1) Does Not Open				4				4							4								4		
B. BEST VERBAL RESPONSE (5) Oriented (2) Garbled (4) Confused (1) No Response (3) Inappropriate Verbal Response				*5				5							5								5		
C. BEST MOTOR RESPONSE (6) Obeys Commands (3) Flexion to Pain (5) Localizes to Pain (2) Extension to Pain (4) Withdraw to Pain (1) No Response				6				6							6								6		
GLASCOW COMA SCALE (A+B+C)				15				15							15								15		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R							12							12								2		
	L							12							12								2		
MOVEMENT (See Motor Function Scale at Top of Page)	RUE			3				3							4								4		
	LUE			2				2							3								3		
	RLE			3*				3							3								3		
	LLE			2				2							2								2		
GRIP (S) Strong (W) Weak (-) absent	R			3				3							3								5		
	L			GR				—							—								—		
RESPIRATIONS	REGULAR			✓				✓							✓								✓		
	IRREGULAR																								
	UNLABORED			✓				✓							✓								✓		
	LABORED																								
	SHALLOW																								
	RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL			5				5							5								→		
	LUL			5				5							5								→		
	RLL			5				5							5								→		
	LLL			5				5							5								→		
	BOTH BASES			✓				✓							5								→		
COUGH	NONE			✓											✓								✓		
	SPONTANEOUS																								
	PRODUCTIVE																								
	NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																									
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																									
VENTILATOR	Vt																								
	FiO2																								
	RATE (SIMV/CMV)																								
	PEEP / CPAP																								
	PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE	NC (l/min)			RA				RA																	
	FM (l/min)																								
ETT #_____	NRBM (l/min)																								
	ETT _____ cm gums																								
ETT CARE / POSITION CHANGE																									
ETT / NT SUCTIONED																									
INCENTIVE SPIROMETRY DONE																									
COUGH / DEEP BREATH																									
INITIALS				(b)(6)-2				(b)(6)-2							(b)(6)-2								(b)(6)-2		

ACLU-RDI 1099 p.562

DOD 005830

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0140	100.4	113	18	134/74	96%		96										(b)(6)-2
0200																	
0300																	
0400																	
0500																	
0600																	
0700	99.6	104	16	126/73	97%		94										(b)(6)-2
0800																	
0900																	
1000																	
1100																	
1200																	
1300																	
1400	97.1	106	16	122/74	96%	(b)(6)-2											
1500																	
1600																	
1700																	
1800																	
1900																	
2000																	
2100																	
2200																	
2300																	
2400	97.5	128	16	120/63	97%												(b)(6)-2

ACLU-RDI 1099 p.563

DOD 005831

CRITICAL CARE FLOW SHEET

DARNALL ARMY COMMUNITY HOSPITAL

LOS DATA	
DOA	25 Aug 03
DOS	25 ~~Sep~~ 03
POD	

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2 CPN	(b)(6)-2
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside			
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 CPN	ICU	25 sept 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade; date: hospital or medical facility)*

(b)(6)-4

☐ HISTORY PHYSICAL ☐ FLOWCHART

☐ OTHER EXAMINATION Or EVALUATION ☐ OTHER *(Specify)*

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 1780

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R							2																	
	L							2																	
	DORSALIS PEDIS R							2																	
	L							2																	
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale								1 3 8																	
EDEMA																									
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)								✓																	
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)								5																	
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH							✓																	
	FOLEY CARE																								
	ORAL CARE																								
MOBILITY	BEDREST																								
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE																								
	HOB 30 DEGREES																								
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE							7/10																	
	PAIN SCALE (1-10)																								
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended							✓																	
BOWEL SOUNDS (active all quads)								✓																	
NG / DOBHOFF PLACEMENT VERIFIED								✓																	
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT																									
VOIDING CLEAR, YELLOW URINE q.s.								✓																	
SKIN INTEGRITY	No Breakdown																								
LE LAC	Surgical Wounds							✓																	
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1 (L) LE Amp								✓																	
#2 (L) LE Ext fix & open wound								✓																	
#3																									

(b)(6)-2

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
NS	(L nostril)		
18g	(L IDU)	20 Sept 03	CDI

MEDCOM - 1781

PUPIL SIZE	PUPILS		MOTOR FUNCTION	CHART CODES
1 mm	=	Equal	0 = No Movement	Present ✓
2 mm	R	Reactive	1 = Slight Flicker/ Trace of Contraction	
3 mm	NR	NonReactive	2 = Active (Gravity Eliminated)	Not Applicable /Absent (blank)
			3 = Active: against gravity, but not against resistance	
4 mm	L > R	Left Larger	4 = Active: Against Gravity and Resistance, not full strength	Refer to Nsg. Notes X
			5 = Full Strength against Examiners Resistance	
5 mm	R > L	Right Larger	DATE: 25 Sep 2005	No Change from Previous Assessment --

TIME		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (2) To Pain (3) To Voice (1) Does Not Open								4																	
B. BEST VERBAL RESPONSE (5) Oriented (2) Garbled (4) Confused (1) No Response (3) Inappropriate Verbal Response								5																	
C. BEST MOTOR RESPONSE (6) Obeys Commands (3) Flexion to Pain (5) Localizes to Pain (2) Extension to Pain (4) Withdraw to Pain (1) No Response								6																	
GLASCOW COMA SCALE (A+B+C)								15																	
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R							+2																	
	L							+2																	
MOVEMENT (See Motor Function Scale at Top of Page)	RUE							3																	
	LUE							3																	
	RLE							3																	
	LLE							3																	
GRIP (S) Strong (W) Weak (-) absent	R							W																	
	L							-																	
RESPIRATIONS	REGULAR							✓																	
	IRREGULAR																								
	UNLABORED							✓																	
	LABORED																								
	SHALLOW																								
	RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL							5																	
	LUL							5																	
	RLL							5																	
	LLL							5																	
	BOTH BASES							1																	
COUGH	NONE																								
	SPONTANEOUS																								
	PRODUCTIVE																								
	NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																									
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																									
VENTILATOR	Vt																								
	FIO2																								
	RATE (SIMV/CMV)																								
	PEEP / CPAP																								
	PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE ETT #_____	NC (l/min)																								
	FM (l/min)																								
	NRBM (l/min)																								
	ETT _____cm gums																								
ETT CARE / POSITION CHANGE																									
ETT / NT SUCTIONED																									
INCENTIVE SPIROMETRY DONE																									
COUGH / DEEP BREATH								(b)(6)-2																	
INITIALS																									

ACLU-RDI 1099 p.566

DOD 005834

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200																	
0300																	
0400																	
0500																	
0600																	
0700	99°																
0800																	
0900																	
1000																	
1100																	
1200																	
1300																	
1400																	
1500																	
1600																	
1700																	
1800																	
1900																	
2000																	
2100																	
2200																	
2300																	
2400																	

ACLU-RDI 1099 p.567

DOD 005835

	INTAKE									OUTPUT						
	PO	IVPB							Total	Urine					Total	COMMENTS
0100																
0200																
0300																
0400																
0500																
0600	120	50								100cc						
	120	50														
0700	340	60														
0800	80	30														
	340	80														
8 HR									8 HR.						8 HR	
0900																
1000																
1100																
1200																
1300																
1400																
1500																
1600																
8 HR									16 HR.						16 HR.	
1700																
1800																
1900																
2000																
2100																
2200																
2300																
2400																
8 HR									24 HR.						24 HR	

MEDCOM - 1784

NSN 7540-00-634-4123

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR		OBSERVATIONS Include medication and treatment when indicated
	A.M.	P.M.	
25 Sep 05	0800		- cont to rest comfortably Ø S/S of distress Ø distressing breathing. RN cont to monitor. pt (b)(6)-2

MEDCOM - 1785

MEDICAL ... ORD - PATIENT RELEASE / DISCHARGE ...NSTRUCTIONS

For use of this form, see MEDCOM Circular 40-5

DIRECTIONS: To be completed by attending provider and other staff at time of patient release following an outpatient procedure, extended care/treatment or discharge from an inpatient hospital stay.

SECTION I
TO BE COMPLETED BY PRIVILEGED PROVIDER

1. DATE OF PROCEDURE/ADMISSION:
2. ADMITTING/DIAGNOSIS:
3. PERTINENT LAB, X-RAY, FINDINGS:

See chart

4. PROCEDURES, TREATMENT, HOSPITAL COURSE:

See chart

5. FINAL DIAGNOSIS AND CONDITION AT DISCHARGE:

1) L Arm Amputee 2° IED
2) ST LOS 2° Sepsis
3) HTN 2° PTSD

6. ACTIVITY:
7. DIET:
8. MEDICATIONS:

☒ Medications have been prescribed for home use. See separate list and special instructions or see below.

Keflex
Levaquin
Ciprofloxacin

9. INSTRUCTIONS *(To Home Health Providers, Patient, etc)*:

10. (b)(6)-2 (b)(6)(2) [redacted]
(Signature) *(Printed or Stamped Name)*

PATIENT IDENTIFICATION
(b)(6)-4

SECTION II
TO BE COMPLETED BY OTHER STAFF, AS APPROPRIATE

1. DISPOSITIONED TO: ☐ HOME ☐ DUTY ☒ OTHER EPW (b)(6)-4 (b)(6)(4) [redacted]
☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER
2. ACCOMPANIED BY: ☐ FAMILY ☐ FRIEND ☒ OTHER EPW (b)(6)-4 (b)(6)(4) [redacted]
3. PATIENT EDUCATION:
Completed and patient prepared for home care. ☒ YES ☐ NO
If no, explain:
Patient ☐ states ☐ demonstrates understanding of home care needs.
Printed educational materials provided:
4. Clinical outcomes met and post-discharge/release referrals made.
☒ YES ☐ NO If no, explain:
5. If transferred to another health care facility, report called to nurse.
☐ YES ☐ NO If no, explain: N/A
6. NUTRITION CARE - Comments:
Reg diet, 4 fluids
7. MEDICATIONS:
Explained by: ☒ NURSE ☐ PHYSICIAN ☐ PHARMACIST
Printed medication literature provided. ☐ YES ☒ NO
Patient states understanding of prescribed medications. ☒ YES ☐ NO
8. EQUIPMENT/SUPPLIES PROVIDED:
Kerlix, Intraform, Kling, Cotton Balls, 4X4's, Static Items
9. FOLLOW-UP APPOINTMENTS, POINT OF CONTACT & PHONE:
(b)(6)-2 1300 with
Dr (b)(6)-2 at the (b)(6)-2
21st CSH Specialty Clinic
MJ (b)(6)-2
10. FOR PROBLEMS OR EMERGENCY, CO (b)(6)-2
21st CSH EMT 570 (b)(3)-1
11. COMPLETED BY: (b)(6)-2 LPN 25Sep03/11c
(Signature and Title) *(Date and Time)*
I HAVE RECEIVED A COPY OF AND UNDERSTAND THESE INSTRUCTIONS. EPW MEDIC 25Sep03/11c
(b)(6)-2
(Patient/Responsible Adult's Signature) *(Date and Time)*

MEDCOM FORM 691-R (TEST) (MCHO) MAR 99 PREVIOUS EDITIONS ARE OBSOLETE MC V1.00

MEDCOM - 1786

MEDICAL RECORD - MEDICATION ADMINISTRATION RECORD

For use of this form, see MEDCOM Circular 40-5

ORDER DATE	PHYSICIAN SIGNATURE INITIALS	SECTION I DELAYED SINGLE ACTION ORDERS & PREOPERATIVES	DATE/TIME TO BE GIVEN	DATE/TIME GIVEN AND INITIALS
5 SEP	(b)(6)-2	Admit to ICU1 Dr (b)(6)-2	5 SEP	(b)(6)-2
5 SEP		CBC IN AM 7 SEP 03 Sunday	7 SEP	(b)(6)-2
7 SEP 03		CREATININE TODAY	7 SEP 03	7 SEP 03 0930
7 SEP 03		NPO @ Midnight	8 SEP 0001	(b)(6)-2 7 SEP 03 2148

PATIENT IDENTIFICATION

(b)(6)-4

DIAGNOSIS: _____

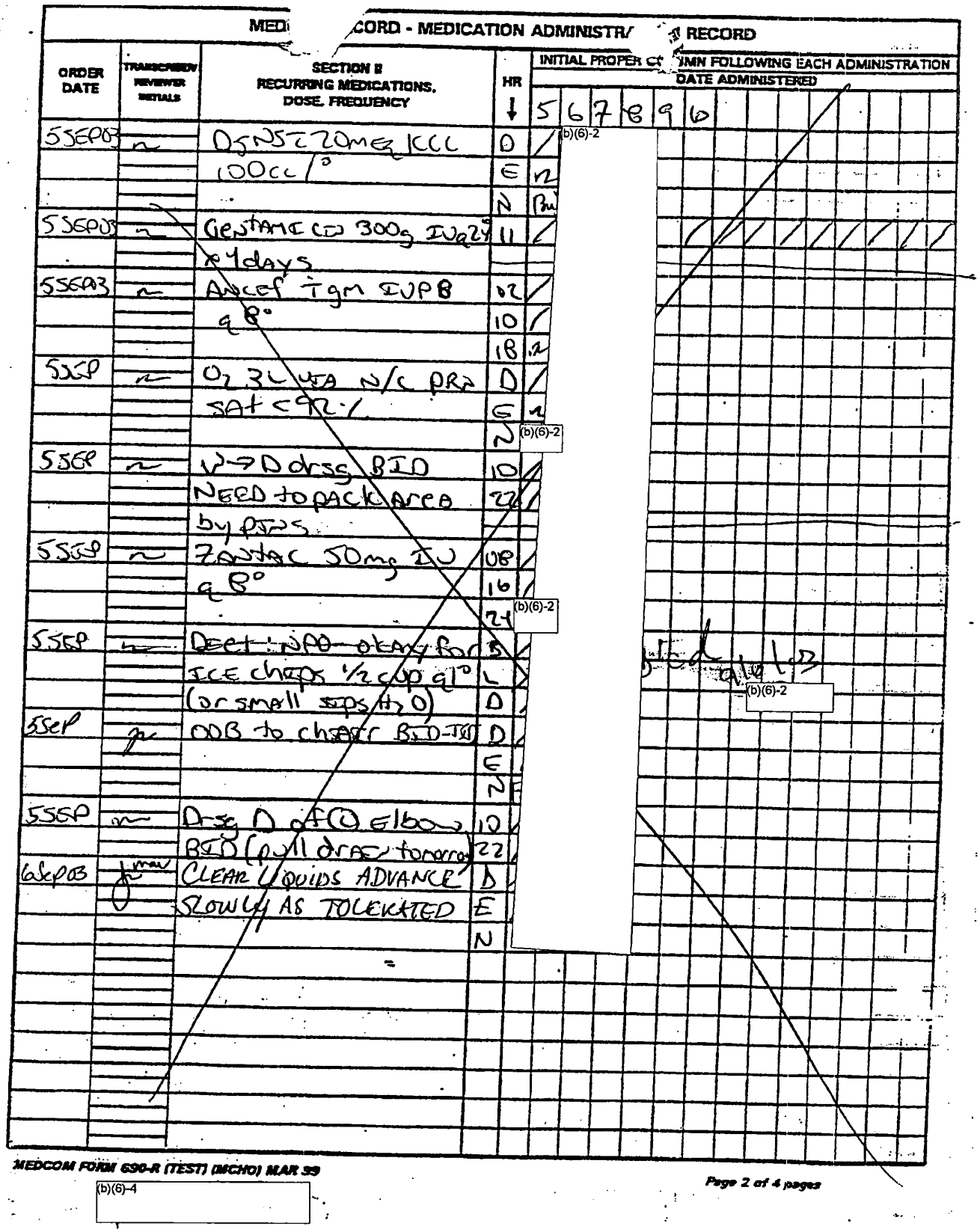
ALLERGIES: _____

Circle administration times (in pencil) for recurring medication.

D	07	08	09	10	11	12	13	14
E	15	16	17	18	19	20	21	22
N	23	24	01	02	03	04	05	06

MEDCOM FORM 690-R (TEST) (P) (O) MAR 99 PREVIOUS EDITIONS ARE O TE Page 1 of 4 pages MC V1.00

MEDCOM - 1787



MED[illegible]CORD - MEDICATION ADMINISTR[illegible] RECORD

ORDER DATE	TRANSCRIBER/ REVIEWER INITIALS	SECTION II RECURRING MEDICATIONS, DOSE, FREQUENCY	HR ↓	INITIAL PROPER C[illegible]MN FOLLOWING EACH ADMINISTRATION DATE ADMINISTERED 5 6 7 8 9 10
5SEP03	~	DSNS 20mEq KCL	D	/ (b)(6)-2
		100cc/°	E	2
			N	Bu
5SEP03	~	Gentamicin 300g IVq24°	11	/
		x4days		
5SEP03	~	Ancef 1gm IVP8	02	/
		q8°	10	/
			18	2
5SEP	~	O_2 3L via N/C PRN	D	/
		SAT <92%	E	2
			N	(b)(6)-2
5SEP	~	W→D drsg BID	10	/
		NEED to pack area	22	/
		by PINS		
5SEP	~	Zantac 50mg IV	08	/
		q8°	16	/
			24	(b)(6)-2
5SEP	~	Diet: NPO okay for	5	/
		ICE chips 1/2 cup q1°	L	/
		(or small sips H_2O)	D	/
5SEP	~	OOB to chair BID-TID	D	/
			E	
			N	
5SEP	~	Drsg D of (1) elbow	10	/
		BID (pull drain tomorrow)	22	/
6SEP03	[illegible]	CLEAR LIQUIDS ADVANCE	D	/
		SLOWLY AS TOLERATED	E	
			N	

[illegible] 9/6/03

(b)(6)-2

MEDCOM FORM 690-R (TEST) (MCHO) MAR 99

(b)(6)-4

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MEDCOM - 1788

MEDICAL RECORD - MEDICATION ADMINISTRATION RECORD

ORDER EXPIRATION DATE	TRANSCRIBER REVIEWER INITIALS	SECTION III PRN MEDICATION, DOSE, ROUTE, FREQUENCY, REASON	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE/REASON/INITIALS/EFFECTIVENESS CODE
5Sep 0550	(b)(6)-2	Demerol 25mg IV 12.5 phenergan IV q 4-6 prn pain	Date 6Sep 6Sep 6Sep 7Sep 7Sep Time 0030 0500 1830 0300 1030 Amt 25/12.5 25/12.5 25/12.5 25/12.5 25/12.5 Init (b)(6)-2 E/C I E E E E
5Sep	(b)(6)-2	Tylenol 650-1000mg PR (Supp) q 4-6° prn temp >101°F	Date 8/6 9/7 Time 2200 0730 Amt 1gm 1gm Init (b)(6)-2 E/C E E DC'd 9/7/03
7Sep	(b)(6)-2	Ambien 5mg q HS prn	7Sep 2000 5mg Init E DC'd 9/7/03 (b)(6)-2
7Sep	(b)(6)-2	AMBIEN 10mg SR PO q HS PRN	
7Sep	(b)(6)-2	Tylenol 650-1000mg PO Q 4-6° PRN Temp >101°F	9/7 0230 1000mg Init (b)(6)-2 E
7Sep	(b)(6)-2	Tylox T=II PO q 4-6° PRN PAIN	9/7 1000 PO 7Sep 1800 T II 7Sep 2200 T II 8Sep 0630 T PO (b)(6)-2 E E E

CODES: Initials only = Medication administrated | Initials and I = Medication ineffective* | Initials and O = Medication withheld* | *SEE SF 509 FOR NURSE'S ENTRY

MEDCOM FORM 690-R (TEST) (MCHO) MAR 99

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(b)(6)-4

ACLU-RDI 1099 p.573

DOD 005841

MEDICAL RECORD - MEDICATION ADMINISTRATION RECORD
For use of this form, see MEDCOM Circular 40-5

ORDER DATE	TRANSCRIBER/ REVIEWER INITIALS	SECTION I DELAYED SINGLE ACTION ORDERS & PREOPERATIVES	DATE/TIME TO BE GIVEN	DATE/TIME GIVEN AND INITIALS
9/8/03	(b)(6)-2	CBC c Diff on 9SEP03	9/9/03 0530	(b)(6)-2 0430
9/9/03		CHEST X-RAY TODAY CAP/LAT in RADIOLOGY	9/9/03	9/9/03 1130 (b)(6)-2
9/9/03		URINE FOR UA	9/9/03	9/9/03 1930
9/9/03		NUTRITIONAL ASSESSMENT AGAIN to ASSESS FOR ENTERAL FEEDINGS	9/9/03	
9SEP03	(b)(6)-2	NPO PAST MIDNIGHT	10SEP03	11SEP03

PATIENT IDENTIFICATION
(b)(6)-4

DIAGNOSIS: (L) BE AMP / (R) OPEN FEMUR FX IED E SHORTENING of BONE WOUND PACKING
ALLERGIES: NKDA

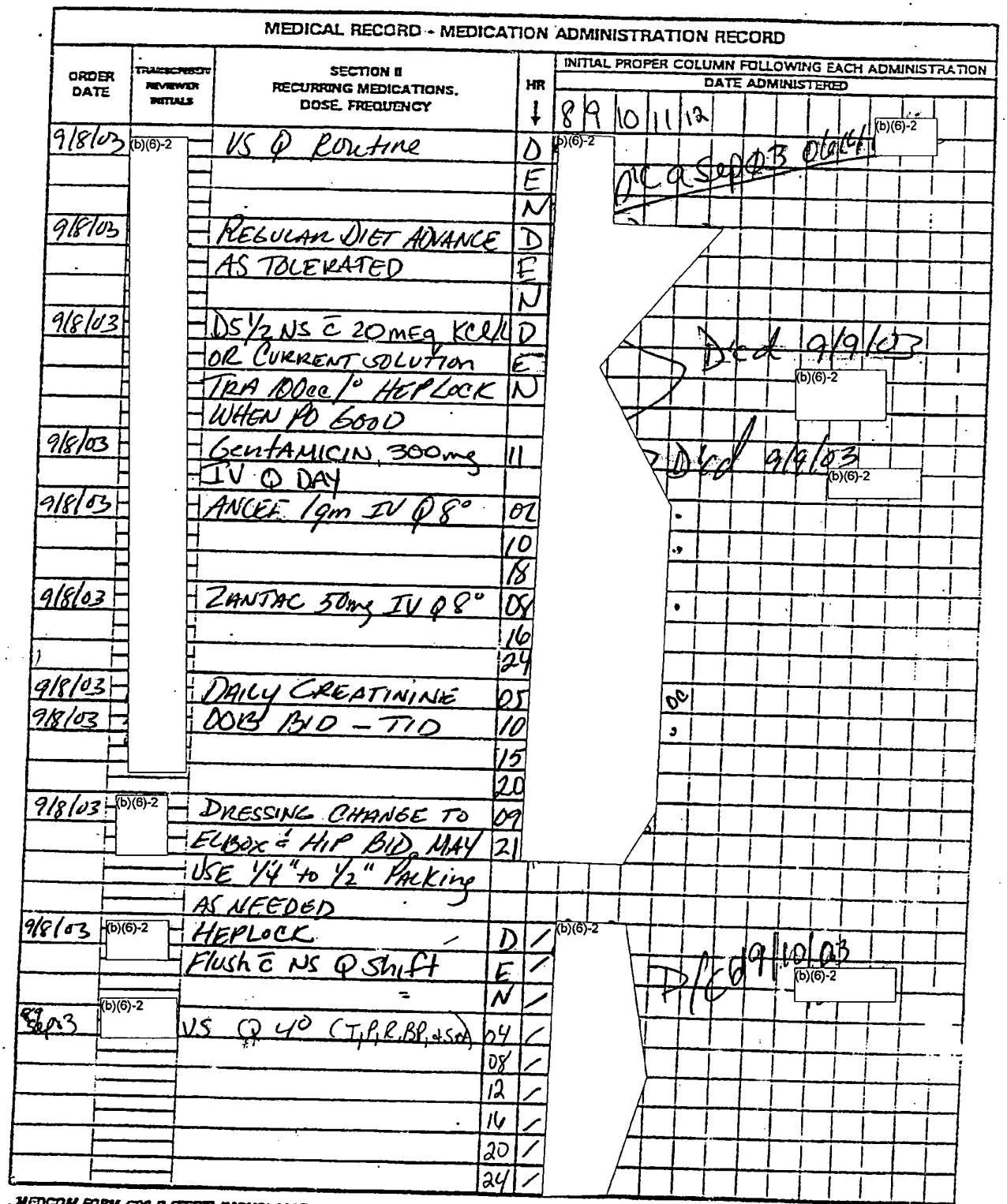
Circle administration times (in pencil) for recurring medication.

D	07	08	09	10	11	12	13	14
E	15	16	17	18	19	20	21	22
N	23	24	01	02	03	04	05	06

MEDCOM FORM 690-R (TEST) (MCHO) MAR 99 PREVIOUS EDITIONS ARE OBSOLETE Page 1 of 4 pages MC V1.00

ACLU-RDI 1099 p.574

DOD 005842



MEDICAL RECORD - MEDICATION ADMINISTRATION RECORD

ORDER DATE	TRANSCRIBER/ REVIEWER INITIALS	SECTION II RECURRING MEDICATIONS, DOSE, FREQUENCY	HR ↓	INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION — DATE ADMINISTERED: 8 9 10 11 12
9/8/03	(b)(6)-2	VS Q Routine	D	(b)(6)-2 (b)(6)-2
			E	DC 9 Sep 03 0614
			N	
9/8/03		REGULAR DIET ADVANCE	D	
		AS TOLERATED	E	
			N	
9/8/03		DS 1/2 NS c̄ 20 mEq KCl/L	D	
		OR CURRENT SOLUTION	E	D'cd 9/9/03
		TRA 100cc/° HEPLOCK	N	(b)(6)-2
		WHEN PO GOOD		
9/8/03		GENTAMICIN 300mg	11	D'cd 9/9/03
		IV Q DAY		(b)(6)-2
9/8/03		ANCEF 1gm IV Q 8°	02	
			10	
			18	
9/8/03		ZANTAC 50mg IV Q 8°	08	
			16	
			24	
9/8/03		DAILY CREATININE	05	DC
9/8/03		OOB BID - TID	10	
			15	
			20	
9/8/03	(b)(6)-2	DRESSING CHANGE TO	09	
		ELBOX & HIP BID, MAY	21	
		USE 1/4" to 1/2" PACKING		
		AS NEEDED		
9/8/03	(b)(6)-2	HEPLOCK	D /	(b)(6)-2
		Flush c̄ NS Q Shift	E /	D/C 9/10/03
			N /	(b)(6)-2
8 Sep 03	(b)(6)-2	VS Q 4° (T, P, R, BP, & SOA)	04 /	
			08 /	
			12 /	
			16 /	
			20 /	
			24 /	

MEDCOM FORM 690-R (TEST) (MCHO) MAR 99

(b)(6)-4

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MEDCOM - 1791

MEDICAL RECORD - MEDICATION ADMINISTRATION RECORD

ORDER DATE	TRANSCRIBER/ REVIEWER INITIALS	SECTION II (Cont) RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION — DATE ADMINISTERED: 9	10	11
9/9/03	NO. 2 (b)(6)-2	Frequently Assess	D	(b)(6)-2		
		DRSG's For DRAINAGE	E			
		& Reinforce if appropriate	N			
9/9/03	(b)(6)-2	↓ GENTAMICIN 200mg	11			
		IV QDAY				
10SEP03	(b)(6)-2	Bactrim DS ÷ PO BID	10	/	/	
			22	/	(b)(6)-2	
10SEP03	(b)(6)-2	DS ½ NS c̄ 20mEq (b)(6)-2	D	/		
		TRA 100cc/1°	E	/		
			N	/		

PATIENT IDENTIFICATION

(b)(6)-4

DIAGNOSIS: (L) BE AMP (L) OPEN FEMUR FX I & D c̄ SHORTENING of Bone Wound Packing

ALLERGIES: NKDA

Circle administration times (in pencil) for recurring medication.

D	07	08	09	10	11	12	13	14
E	15	16	17	18	19	20	21	22
N	23	24	01	02	03	04	05	06

MEDCOM FORM 690-R (TEST) (MCHO) MAR 99

Page 3 of 4 pages

MEDCOM - 1792

MEDICAL RECORD - MEDICATION ADMINISTRATION RECORD

ORDER/ EXPIRATION DATE	TRANSCRIBER/ REVIEWER INITIALS	SECTION III PRN MEDICATION, DOSE, ROUTE, FREQUENCY, REASON	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE/REASON/INITIALS/EFFECTIVENESS CODE
9/5/03	(b)(6)-2	AMBIEN 10mg PO q̄ HS PRN INSOMNIA	9/8 2260 (b)(6)-2 / 9/10 2330 (b)(6)-2
9/8/03	(b)(6)-2	TYLENOL 650-1000mg PO Q 6° PRN TEMP > 100°5	
9/8/03	(b)(6)-2	DEMEROL 25mg IV Q 4-6° PRN Pain c 12.5mg Phenergan	9/8 1230 HRS IV (b)(6)-2 / 8 Sep 2045 (b)(6)-2 / 9 Sep 0915 (b)(6)-2 E
9/8/03	(b)(6)-2	TYLOX ♀-♀♀ PO Q 4-6 PRN Pain	8 Sep 1445 (b)(6)-2 / 8 Sep 1845 (b)(6)-2 / 8 Sep 2230 / 9 Sep 0630 E / 9 Sep 1115 PO E / 9 Sep 1800 PO E / 10 Sep 0110 E / 10 Sep 0730 SPO (b)(6)-2 / 10 Sep 1300 E / 10 Sep 2340 / 11 Sep 0640 (b)(6)-2 E

CODES: Initials only = Medication administrated
Initials and E = Medication effective
Initials and I = Medication ineffective*
Initials and O = Medication withheld*
*SEE SF 509 FOR NURSE'S ENTRY

MEDCOM FORM 690-R (TEST) (MCHO) MAR 99

(b)(6)-4

Page 4 of 4 pages

MEDCOM - 1793

MEDICAL RECORD - MEDICATION ADMINISTRATION RECORD

For use of this form, see MEDCOM Circular 40-5

ORDER DATE	TRANSCRIBER/ REVIEWER INITIALS	SECTION I DELAYED SINGLE ACTION ORDERS & PREOPERATIVES	DATE/TIME TO BE GIVEN	DATE/TIME GIVEN AND INITIALS
11 Sep 03	(b)(6)-2	CBC in Am (12 Sep 03)	12 Sep 03 0500	(R)
11 Sep 03		S/P I+D to LUE Stump, DRSG Δ by Dr. Gupta	—	—
11 Sep 03		Next planned washout 13 Sep 03	13 Sep 03	
11 Sep 03		Malaria smears q 8° x 3 or if #1	2000 11 Sep	(R)
		temp goes >101. #2	0400 11 Sep	(R)
		#3	1200 12 Sep	12 Sept 1245 (b)(6)
12 Sept		Send LFTs	NOW	12 Sept 1245 (b)(6)-2
12 Sept		NPO p̄ MN	0000 13 Sept	(b)(6)-2
13 Sept		Portable CXR	NOW	
13 Sept		U/A	when write	
13 Sept		ESR ē next bloodwork & then QOD	today	

PATIENT IDENTIFICATION

(b)(6)-4

DIAGNOSIS: S/P I+D to (L) UE Stump, Δ DRSG

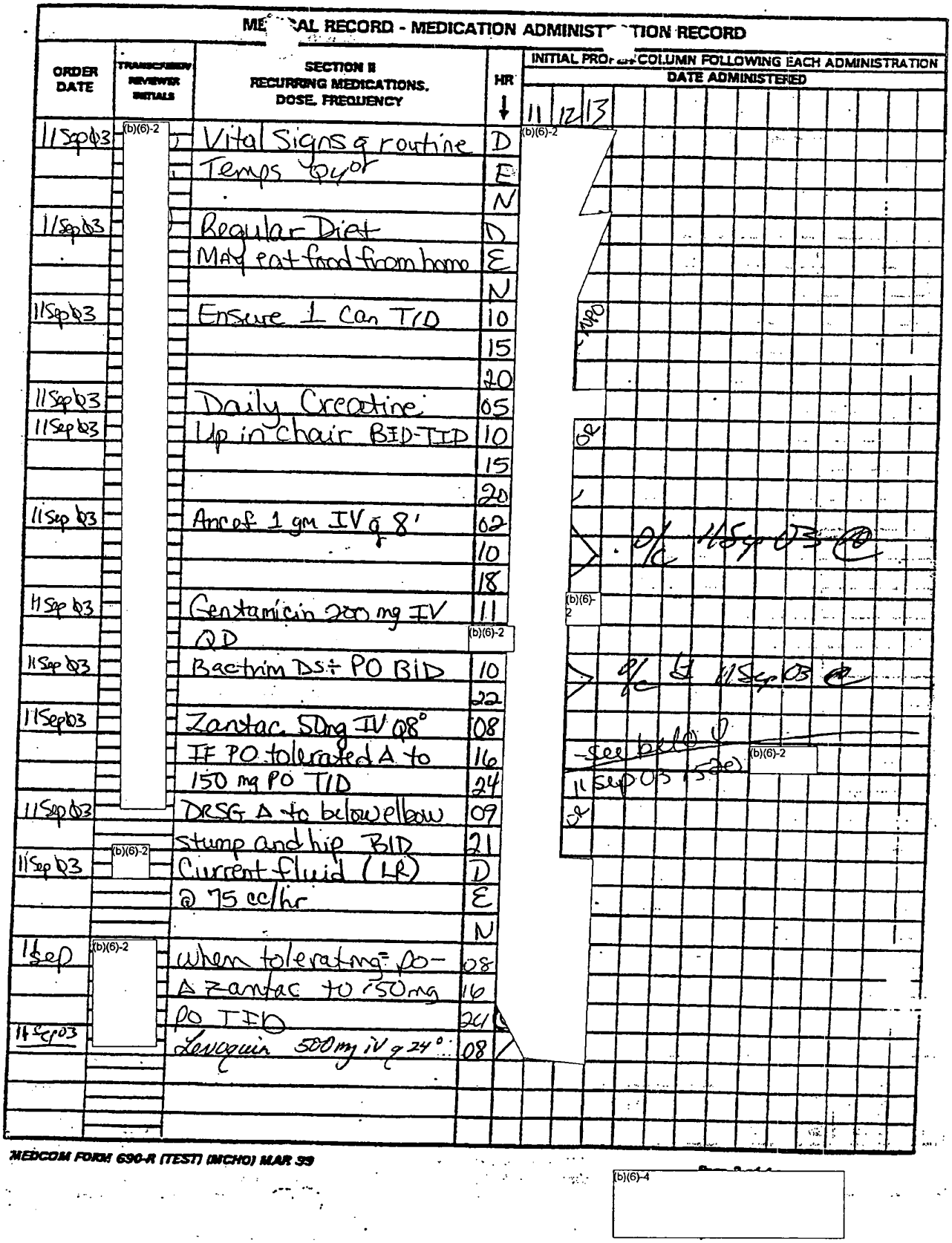
ALLERGIES: NKDA

Circle administration times (in pencil) for recurring medication.

D	07	08	09	10	11	12	13	14
E	15	16	17	18	19	20	21	22
N	23	24	01	02	03	04	05	06

MEDCOM FORM 690-R (TEST) (ECHO) MAR 99 PREVIOUS EDITIONS ARE OBSOLETE Page 1 of 4 pages MC V1.00

MEDCOM - 1794



MEDICAL RECORD - MEDICATION ADMINISTRATION RECORD

ORDER DATE	TRANSCRIBER/ REVIEWER INITIALS	SECTION II RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION — DATE ADMINISTERED 11 12 13
11Sep03	(b)(6)-2	Vital Signs q routine	D	(b)(6)-2
		Temps TID PO	E	
			N	
11Sep03		Regular Diet	D	
		May eat food from home	E	
			N	
11Sep03		Ensure 1 Can TID	10	
			15	
			20	
11Sep03		Daily Creatine	05	
11Sep03		Up in chair BID-TID	10	
			15	
			20	
11Sep03		Ancef 1 gm IV q 8'	02	
			10	
			18	
11Sep03		Gentamicin 200 mg IV	11	(b)(6)-2
		QD	(b)(6)-2	
11Sep03		Bactrim DS ÷ PO BID	10	
			22	
11Sep03		Zantac 50mg IV Q8°	08	
		IF PO tolerated A to	16	
		150 mg PO TID	24	
11Sep03		DRSG A to below elbow	09	
		stump and hip BID	21	
11Sep03	(b)(6)-2	Current fluid (LR)	D	
		@ 75 cc/hr	E	
			N	
11Sep	(b)(6)-2	when tolerating PO-	08	
		A Zantac to 150mg	16	
		PO TID	24	
11Sep03		Levaquin 500mg IV q 24°	08	

MEDCOM FORM 690-R (TEST) (MCHO) MAR 99

(b)(6)-4

MEDICAL RECORD - MEDICATION ADMINISTRATION RECORD

ORDER DATE	TRANSCRIBER/ REVIEWER INITIALS	SECTION II (Cont) RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION — DATE ADMINISTERED 13	14	15
13 Sep 03	(b)(6)-2	1/2 q shift	D	(b)(6)-2		
			E			
			N			
13 Sep 03		OOB Bid - TID	D			
			E			
			N			
13 Sep 03		05½ 20K @ 100/HR	D			
			E			
			N			
13 Sep 03		Levoquin 500mg iV q 24°	08			
13SEP03		Gentamycin 150 mg iV q24°	11			
13 Sep 03		Routine Central Line Care	D			
			E			
			N			
13 Sep 03		Pressing Δ Bid	10			
			22			
13 Sep 03		T Can ensure q shift	D			
		VIA NG	E			
			N			
14Sept		Foley to ~~QA~~ DD	D			
			E			
			N			
14Sept		Ensure 1 can p̄ 6°	03			
			09			
			15			
			21			
14Sept03		Adv diet as	B			
		tolerated	L			
			D			

(b)(6)-2 14Sept03 (b)(6)(2)

PATIENT IDENTIFICATION

(b)(6)-4

DIAGNOSIS: s/p (L) UE Amp / (L) LE Femur Fx

ALLERGIES: NKDA.

Circle administration times (in pencil) for recurring medication.

D	07	08	09	10	11	12	13	14
E	15	16	17	18	19	20	21	22
N	23	24	01	02	03	04	05	06

MEDICAL RECORD - MEDICATION ADMINISTRATION RECORD

ORDER/ EXPIRATION DATE	TRANSCRIBER/ REVIEWER INITIALS	SECTION III PRN MEDICATION, DOSE, ROUTE, FREQUENCY, REASON	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE/REASON/INITIALS/EFFECTIVENESS CODE			
13 Sep 03	(b)(6)-2	Haldol 5mg iV q6° PRN	1380 2200 5mg			
		Psychosis				
		I/E	(b)(6)-2			
		INITIALS				
17 Sep 03	(b)(6)-2	MSO4 2-10mg iV q1°-2°	0800 2mg MO 14sep	1700 2mg N 1-15	14sep 2mg 2015	
		PRN Pain				
		I/E		E	E	
		INITIALS		(b)(6)-2		
13 Sep 03	(b)(6)-2	Phenergan 12.5mg iV q4°				
		PRN N/V				
		I/E				
		INITIALS				(b)(6)-2
14 Sep 03	(b)(6)-2	Ambien 5mg PO qHS	13sep 03 @ 2330	14sep 03 @ 0030	~~14sep 03 @ 2330~~	
		PRN Insomnia				
		MAY REPEAT x T IF I/E	I		O	
		INNEFFECTIVE, MAY GIVE VIA NG (INITIALS)	(b)(6)-2			

CODES: Initials only = Medication administrated
Initials and E = Medication effective
Initials and I = Medication ineffective*
Initials and O = Medication withheld*
*SEE SF 509 FOR NURSE'S ENTRY

MEDCOM FORM 690-R (TEST) (MCHO) MAR 99

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MEDICAL RECORD - MEDICATION ADMINISTRATION RECORD

For use of this form, see MEDCOM Circular 40-5

ORDER DATE	TRANSCRIBER/REVIEWER INITIALS	SECTION I DELAYED SINGLE ACTION ORDERS & PREOPERATIVES	DATE/TIME TO BE GIVEN	DATE/TIME GIVEN AND INITIALS
13Sep03	(b)(6)-2	LBE AMP (L) open fem. fx.	13Sep	(b)(6)-2
13Sep03		S/P Central line placement, NG and discharge	13Sep	
13Sep03		CBC ē DIFF, 2MA-7, LFT's in AM	0500 19Sep03	05
13Sep03		Creatinine in AM	0500 14Sep03	05
13 Sept 03		AP (L) Hip XRay in AM	14Sep03	(b)(6)-2
13Sep03		U/S - Liver - Gallbladder in AM	14Sep03	(b)(6)-2
13Sep03		Foot Plate Aft Placement - NGT.	18Sep03	Done (b)(6)-2 2100
13Sep03		① Ensure: Mix 50/50 ē H2O - 60cc VIA NG. OVER 20 min -	① 13Sep03	2230 -
		② If tolerated, may use Ensure Full Strength. 60cc over 20 minutes.	② 13Sep03	2400
		③ If tolerated ē N/V - ↑ can Ensure q shift VIA NGT.	③ 13 Sep 03	0100
13SEP03		4XR - placement of central line - portable	13SEP03 NOW	Done (b)(6)-2
13Sep03		Ambien 5mg PO NOW + HS PRN insomnia, May repeat x1 if		
		ineffective - MAY give through NG Tube	13Sep 2330	2330
14Sept		T&C 2 units PRBC transfuse 1 over ① NOW	NOW	(b)(6)-2
		4hrs. Give both units	② 5th unit	(b)(6)-2 (b)(6)-2
14Sept		KCL 100 mEq in 250cc NS over 10hrs	NOW	14Sept03 (b)(6)-2
14Sept		Repeat K+ level after KCL infusion	5th	Done (b)(6)-2
14Sept		Check H/H 4° after last transfusion	15SEP 0045	Done
14SEP		Tylenol 1gm POx1 PRN	14SEP03	(b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-4

DIAGNOSIS: (L) UE Amp / (L) LE Femur Fx.

ALLERGIES: NKDA

Circle administration times (in pencil) for recurring medication.

D	07	08	09	10	11	12	13	14
E	15	16	17	18	19	20	21	22
N	23	24	01	02	03	04	05	06

MEDICAL RECORD - MEDICATION ADMINISTRATION RECORD

ORDER DATE	TRANSCRIBER REVIEWER INITIALS	SECTION II RECURRING MEDICATIONS, DOSE, FREQUENCY	HR ↓	INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION — DATE ADMINISTERED 14	15
1458	(b)(6)-2	UNASYN 3.0gm IV	06	/ (b)(6)-2	
		q6°	12	/	
			18	(b)(6)-2	
			24		

MEDCOM FORM 690-R (TEST) (MCHO) MAR 99

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MEDICAL RECORD - MEDICATION ADMINISTRATION RECORD

ORDER DATE	TRANSCRIBER REVIEWER INITIALS	SECTION II (Cont) RECURRING MEDICATIONS, DOSE, FREQUENCY	HR ↓	INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION — DATE ADMINISTERED: 11	12	13	14	15										
13Sept	(b)(6)-2	ESR Q OD	05	/	/	/	/	(b)(6)-2	/		/		/					

PATIENT IDENTIFICATION

(b)(6)-4

DIAGNOSIS: S/P I+D to © 4E stump, A DRSG

ALLERGIES: NKDA

Circle administration times (in pencil) for recurring medication.

D	07	08	09	10	11	12	13	14
E	15	16	17	18	19	20	21	22
N	23	24	01	02	03	04	05	06

MEDICAL RECORD - MEDICATION ADMINISTRATION RECORD

ORDER/ EXPIRATION DATE	TRANSCRIBER/ REVIEWER INITIALS	SECTION III PRN MEDICATION, DOSE, ROUTE, FREQUENCY, REASON	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE/REASON/INITIALS/EFFECTIVENESS CODE
11Sep03	(b)(6)-2	Demerol 25 mg IV q 4-6 PRN pain c̄ phenergan 12.5 mg	12Sep 0020 (b)(6)-2
11Sep03	(b)(6)-2	Tylox ⅟-⅟ po q 4-6 prn pain	11Sep ⅟ 0440; 11Sep ⅟ 1335; 11Sep ⅟ 1750; 11Sep ② 2100; 11Sep ① 2200; 12Sep ② 0400; 12Sep 2DO 1035 (b)(6)-2; PT spit pus; E; E
12Sep03	(b)(6)-2	Tylenol 1000mg po q 6° PRN temp	1210 nw 3 tabs 12Sept; 1820 12Sept 3 mss (b)(6)-2; 1220 13Sept (b)(6)- 3 tabs; E
12Sep03	(b)(6)-2	haldol 5mg IV q 4° for psychosis PRN	13Sep 1615; E
12Sep03	(b)(6)-2	MSO4 2-10mg IV q 2° PRN Pain/dsg	0820 (b)(6)-2 2mg 13Sept; 0850 2mg 13Sept; 1200 2mg 13Sept; 1200 4mg 13Sept
13Sep03	(b)(6)-2	meloria smears q 8° x 3 or if temp goes >101°	1030 (b)(6)-2 13Sept

CODES: Initials only = Medication administrated; Initials and E = Medication effective; Initials and I = Medication ineffective*; Initials and O = Medication withheld*; *SEE SF 509 FOR NURSE'S ENTRY

MEDCOM FORM 690-R (TEST) (MCHO) MAR 99

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(b)(6)-4

MEDCOM - 1801

MEDICAL RECORD - MEDICATION ADMINISTRATION RECORD

For use of this form, see MEDCOM Circular 40-5

ORDER DATE	TRANSCRIBER/ REVIEWER INITIALS	SECTION I DELAYED SINGLE ACTION ORDERS & PREOPERATIVES	DATE/TIME TO BE GIVEN	DATE/TIME GIVEN AND INITIALS
15 sep	(b)(6)-2	Admit ICU-1 - DH (b)(6)-2	15 sep	1600 (b)(6)
15 sep		KCl 100 mEq in 250 cc D5W. Run	↑15 sep	↑1600 mEq
		in over 10 hr		
15 sep		Flate plate abd for NG tube placement	15 sep	15 sep 1730 mEq (b)
15 sep		CBC c̄ diff on 17 sep	17 sep 03	0500 (b)(6)-2 [redacted] (6)
15 sep		Remove sutures		15 sep 2045 mEq (2)
18 sep		NPO p̄ 0300 am (19 sep) (6° before surg)	19 sep 0300	(b)(6)-2 Done
18 sep		D5NS TRA 125cc after 0300 19 sep	19 SEP 03 0300	Done
18 sep		Creatine / K+ in am	19 sep 03	[illegible]
18 Sep 03		Port CXR - AP + LAT	18 Sep 03	1630
18 Sep		CBC c̄ diff	18 Sep 03	1640

PATIENT IDENTIFICATION

(b)(6)-4

DIAGNOSIS: S/P I+D (2) Hip + (2) Elbow stom

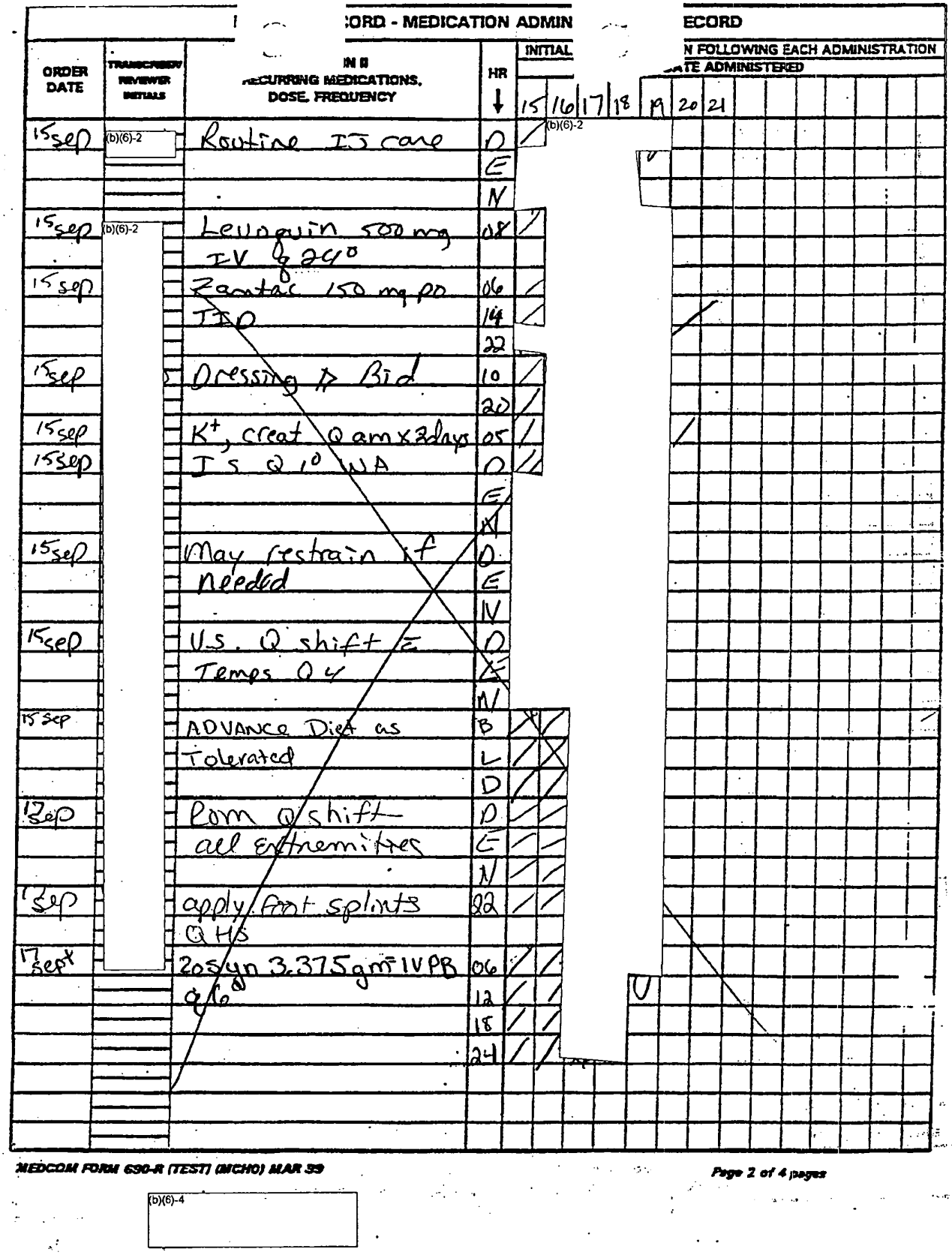
ALLERGIES: NKDA

Circle administration times (in pencil) for recurring medication.

D	07	08	09	10	11	12	13	14
E	15	16	17	18	19	20	21	22
N	[illegible]				03	04	05	06

MEDCOM FORM 690-R (TES AR 99 PREVIOUS EDITIONS Page 1 of 4 pages MC V1.00

MEDCOM - 1802



[illegible]CORD - MEDICATION ADMIN[illegible]ECORD

ORDER DATE	TRANSCRIBER/ REVIEWER INITIALS	[illegible]N II RECURRING MEDICATIONS, DOSE, FREQUENCY	HR ↓	INITIAL[illegible]N FOLLOWING EACH ADMINISTRATION [illegible]ATE ADMINISTERED 15	16	17	18	19	20	21
15 sep	(b)(6)-2	Routine IJ care	D	/	(b)(6)-2					
			E							
			N							
15 sep	(b)(6)-2	Levoquin 500 mg	08	/						
		IV q 24°								
15 sep		Zantac 150 mg po	06	/						
		TID	14	/					/	
			22							
15 sep		Dressing ▷ Bid	10	/						
			20	/						
15 sep		K+, creat Q am x 3 days	05	/					/	
15 sep		IS Q 1° WA	D	/						
			E							
			N							
15 sep		May restrain if	D							
		needed	E							
			N							
15 sep		V.S. Q shift E	D							
		Temps Q 4	E							
			N							
15 sep		ADVANCE Diet as	B	/	/					
		Tolerated	L	/	/					
			D	/	/					
17 sep		Rom Q shift	D	/	/					
		all extremities	E	/	/					
			N	/	/					
17 sep		apply foot splints	22	/	/					
		QHS								
17 sept		20 syn 3.375 gm = IVPB	06	/	/					
		q 6°	12	/	/			U		
			18	/	/					
			24	/	/					

MEDCOM FORM 690-R (TEST) (MCHO) MAR 99

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(b)(6)-4

MEDCOM - 1803

MEDICAL RECORD - MEDICATION ADMINISTRATION RECORD

ORDER DATE	TRANSCRIBER/ REVIEWER INITIALS	SECTION II (Cont) RECURRING MEDICATIONS, DOSE, FREQUENCY	HR ↓	INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION — DATE ADMINISTERED: 15 16 17 18 19
15sep	(b)(6)-2	OOB Bid - TID	D	(b)(6)-2
			E	
15sep		NG for feeding	D	
		tube	E	
			N	
15sep		Advance diet as	D	
		tolerated	E	
			n	
15sep		Ensure + can q6°	02	
		over 20-30 min	08	
			14	
			20	
15sep		D5 ns c̄ 20 Kcl/l	D	
		TRA 100 cc/°	E	
			N	
15sep		Foley to gravity	D	
		drainage	E	
			N	
15sep		Unasyn 3.0 gm IV	06	
		q6°	12	(b)(6)-2
			18	
			24	*
15sep		~~Gentamicin +~~		
		Gentamycin 150 mg	11	(b)(6)-2
		IV Q24°		
15sep		Ambien 5-10 mg PO	22	(b)(6)-2
		QHS for sundowners		
		See next page		

1 pk 18sep03 0930 (b)(6)-2

D/C Dec

D/C

PATIENT IDENTIFICATION

(b)(6)-4

DIAGNOSIS: S/P I+D (L) Hip + (L) Elbow stump

ALLERGIES: NKDA

Circle administration times (in pencil) for recurring medication.

D	07	08	09	10	11	12	13	14
E	15	16	17	18	19	20	21	22
N	23	24	01	02	03	04	05	06

MEDCOM FORM 690-R (TEST) (MCHO) MAR 99

MEDCOM - 1804

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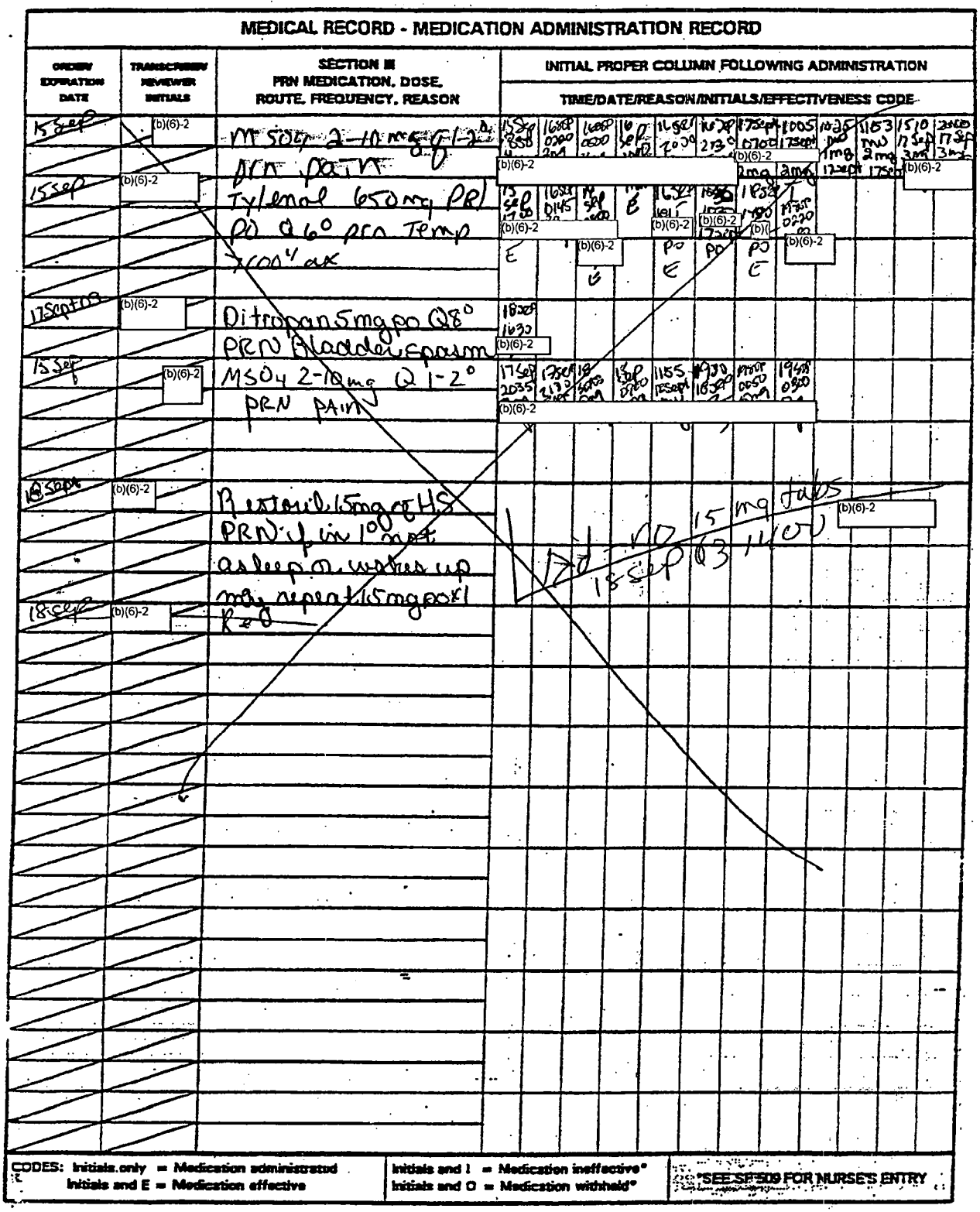

MEDICAL RECORD - MEDICATION ADMINISTRATION RECORD

ORDER/ EXPIRATION DATE	TRANSCRIBER/ REVIEWER INITIALS	SECTION III PRN MEDICATION, DOSE, ROUTE, FREQUENCY, REASON	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE/REASON/INITIALS/EFFECTIVENESS CODE
15 Sep	(b)(6)-2	MSO4 2-10 mg Q 1-2° prn pain	15 Sep 1850 (b)(6)-2; 16 Sep 0200 2mg; 16 Sep 0600; 16 Sep 1600; 16 Sep 2030; 17 Sep 0700 (b)(6)-2; 17 Sep 1005 (b)(6)-2 2mg; 1025 mo 1mg 17 Sep; 1153 mo 2mg 17 Sep; 1510 17 Sep 3mg (b)(6)-2; 2000 17 Sep 3mg
15 Sep	(b)(6)-2	Tylenol 650 mg PR/PO Q 6° prn Temp 7100 ax	15 Sep 1700 (b)(6)-2 E; 16 Sep 0145 (b)(6)-2 E; 16 Sep 1600 (b)(6)-2 E; 16 Sep 1600 (b)(6)-2 PO E; 16 Sep 1800 (b)(6)-2 PO; 17 Sep 1800 (b)(6)-2 PO E; 17 Sep 0220 (b)(6)-2
17 Sept 03	(b)(6)-2	Ditropan 5 mg po Q 8° PRN Bladder spasm	18 Sep 1630 (b)(6)-2
15 Sep	(b)(6)-2	MSO4 2-10 mg Q 1-2° PRN PAIN	17 Sep 2035 (b)(6)-2; 17 Sep 2130; 18 Sep 0200; 18 Sep 0700; 1155 18 Sept; 1930 18 Sep; 1950 0050; 1950 0300
18 Sept	(b)(6)-2	Restoril 15 mg of HS PRN if in 1° not asleep or wakes up may repeat 15 mg po x 1 Red	(b)(6)-2
18 Sep	(b)(6)-2		

Dd - no 15 mg tabs 18 Sep 03 1400

CODES: Initials only = Medication administrated; Initials and E = Medication effective; Initials and I = Medication ineffective*; Initials and O = Medication withheld*; *SEE SF 509 FOR NURSE'S ENTRY

MEDCOM FORM 690-R (TEST) (MCHO) MAR 99

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MEDICAL RECORD - MEDICATION ADMINISTRATION RECORD

ORDER DATE	TRANSCRIBER/REVIEWER INITIALS	SECTION II (Cont) RECURRING MEDICATIONS, DOSE, FREQUENCY	HR ↓	INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION — DATE ADMINISTERED 18	19	20
18Sep	(b)(6)-2	Ensure Plus 1-2	02	✓	(b)(6)-2	
		cans q6°	08	✓	O	
		N.O. check residuals	14	(b)(6)-2		
		prior to feeding, hold	20			
		if over 50cc				
18Sep	(b)(6)-2	Restoril 30mg po q	22			
		HS				

PATIENT IDENTIFICATION

(b)(6)-4

DIAGNOSIS: S/P I+D Rt hip + Elbow stump

ALLERGIES: NKDA

Circle administration times (in pencil) for recurring medication.

D	07	08	09	10	11	12	13	14
E	15	16	17	18	19	20	21	22
N	23	24	01	02	03	04	05	06

MEDICAL RECORD - MEDICATION ADMINISTRATION RECORD

For use of this form, see MEDCOM Circular 40-5

ORDER DATE	TRANSCRIBER/ REVIEWER INITIALS	SECTION I DELAYED SINGLE ACTION ORDERS & PREOPERATIVES	DATE/TIME TO BE GIVEN	DATE/TIME GIVEN AND INITIALS
19 Sept	(b)(6)-2	admit to ICU-1 (b)(6)-2	—	(b)(6)-2
19 Sep		K+ Creatine on 21 Sep 03	21 Sep 05	05 (b)(6)-2
20 Sep 03		D/C Foley	9/20/03 (b)(6)-2	9/20/03 1325 (b)(6)-2
20 Sep 03		U/A Post foley removal	9/20/03 (b)(6)-2	9/20/03 1430 (b)(6)-2
20 Sep 03		START IV	9/23/03	20 Sep 03 1820
20 Sep 03		Transfer to ICU-2 @ 1800 hrs	9/23/03 1800	(b)(6)-2
21 Sep		K, CR on 21 Sep	21 Sep	1400 21 Sep (b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-4

DIAGNOSIS: SYP I+D Delbow stump

ALLERGIES: NKDA

Circle administration times (in pencil) for recurring medication.

D	07	08	09	10	11	12	13	14
E	15	16	17	18	19	20	21	22
N	23	24	01	02	03	04	05	06

MEDCOM FORM 690-R (TEST) (M[illegible]) MAR 99 PREVIOUS EDITIONS ARE OBS[illegible]TE Page 1 of 4 pages MC V1.00

MEDIC[illegible]RD - MEDICATION ADMINISTRA[illegible]N RECORD

ORDER DATE	TRANSCRIBER/ REVIEWER INITIALS	SECTION II RECURRING MEDICATIONS, DOSE, FREQUENCY	HR ↓	INITIAL PROPER[illegible]UMN FOLLOWING EACH ADMINISTRATION DATE ADMINISTERED 19 20 21 22 23
19 Sep	(b)(6)-2	Zosyn 3.375 gm IVPB q6°	06 12 18 24	(b)(6)-2
19 Sep	(b)(6)-2	Levaquin 500 mg IV q 24°	08 /	
19 Sep	(b)(6)-2	Zantac 150 mg po BID	06 14 22	
19 Sep	(b)(6)-2	Change Dressings Bid	10 20	
19 Sep	(b)(6)-2	May restrain as needed	D E N	
19 Sep	(b)(6)-2	OOB to chair 5 or 6 times a day	08 11 14 18 21	

MEDCOM FORM 690-R (TEST) (MCHO) MAR 99

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(b)(6)-4

MEDCOM - 1808

MEDICAL RECORD - MEDICATION ADMINISTRATION RECORD

ORDER DATE	TRANSCRIBER / REVIEWER INITIALS	SECTION II (Cont) RECURRING MEDICATIONS, DOSE, FREQUENCY	HR ↓	INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION — DATE ADMINISTERED: 19 20 21 22 23
19Sept	(b)(6)-2	OOB QID-5-6 X a day	D	
			E	
			N	
19Sept		Turn on side q2	D	
			E	
			N	
19Sept		NG for feeding tube	D	
			E	
			N	
19Sept		Re-turn ~~Foley~~ Cath.	D	DC'd 9/19/03
			E	
			N	
19Sept		Advance oral diet as tolerated	B	
			L	
			D	
19Sept		Ensure (plus) + 1-2 cans q 6°	02	
			08	
			14	
			20	
19Sept		D5 NS ☒ 20meq KCL/L TRA 100cc/L°	D	DC'd 9/20/03
			E	
			N	
19Sept		Keplock when po good	D	
			E	
			N	
19Sept		Ceftriaxone 1Gm IV q 24°	11	DC'd 9/20/03
1959	(b)(6)-2	Benadryl 50mg PO q HS	22	

PATIENT IDENTIFICATION

(b)(6)-4

DIAGNOSIS: S/P Blast Injury - S/P ☒ ☒

ALLERGIES: NKDA

Circle administration times (in pencil) for recurring medication.

D	07	08	09	10	11	12	13	14	
E	15	16	17	18	19	20	21	22	
N	23	24	01	02	03	04	05	06	

MEDICAL RECORD - MEDICATION ADMINISTRATION RECORD

ORDER/ EXPIRATION DATE	TRANSCRIBER/ REVIEWER INITIALS	SECTION III PRN MEDICATION, DOSE, ROUTE, FREQUENCY, REASON	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE/REASON/INITIALS/EFFECTIVENESS CODE			
19 Sept	(b)(6)-2	MSO4 2-10mg IV q 1-2° PRN Pain	9/19 1245 2mg	9/19 1910 3mg	9/19 2130 5mg	9/20 [illegible]
		I	(b)(6)-2			
		I/E	(b)(6)-	E	E	E
19 Sept	(b)(6)-2	Tylox 1-2 po q 6° PRN pain	9/18 2230	9/19 0430	20 Sep 1930 2 [illegible]	21 Sep 2100 [illegible]
		I	(b)(6)-2			
		E	E			
19 Sep	(b)(6)-2	Ditropan 5mg po q 8° prn bladder spasm				
19 Sep	(b)(6)-2	Restoril 30mg po q HS prn insomnia	9			
9/20/03	(b)(6)-2	IF Temp > 101° OBTAIN Blood Cultures X2 SITES X2				

CODES: Initials only = Medication administrated
Initials and E = Medication effective
Initials and I = Medication ineffective*
Initials and O = Medication withheld*
*SEE SF 509 FOR NURSE'S ENTRY

MEDCOM FORM 690-R (TEST) (MCHO) MAR 99

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21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI	UNIT	DOB	RANK	SSN
(b)(6)-4	1			

Physician:	Ward:		STAT	Specimen Date and Time:	Reported by:	Date and Time:
Dr (b)(6)-2	ICU #1	R	Routine	19 SEP 03 0530	(b)(6)-2	19 Sep 0540

Chemistry (I-STAT)

6+ 7+ 8+ Glu (Crea)

X	TEST	RESULT	REF. RANGE
	Na		128-145 mmol/L
X	K	3.6	3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH		7.35-7.45
	PCO2		35-45 mmHg
	PO2		80-90 mmHg
	TCO2		18-33 mmol/L
	HCO3		22-28 mmol/L
	sO2		95-99%
	BEecf		(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
X	Creat	0.6	0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL
	Lactate		0.90-1.70 mmol/L

Urinalysis

	Color		Straw/Yellow
	Clarity		Clear
	Glucose		Negative
	Bilirubin		Negative
	Ketone		Negative
	SG		1.010-1.025
	Blood		Negative
	pH		5.0-8.0
	Protein		Negative-Trace
	Urobili		Negative
	Nitrite		Negative
	Leuko		Negative

Urine Microscopic

	WBC		Epi
	RBC		Mucus
	Bacteria		Yeast
	Casts:		Spermatozoa
	Crystals:		Amorph Sed
	Other:		
	Other:		

Chemistry (Piccolo Analyzer)

Chem 12 MetLyte8 BMP Liver

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-84 U/L
	ALT		10-47 U/L
	AMY		14-97 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat		0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		128-145 mmol/L

Misc. Chemistry

	Mono		Negative
	RPR		Negative
	HIV		Negative
	Meningitis		Negative
	DOA		Negative
	CK-MB		< 4.3 ng/mL
	Troponin I		< 0.19 ng/mL
	Myoglobin		< 107 ng/mL

Microbiology

	Source:		
	FecLeuk		Negative
	Gram Stain		
	WetPrep		Negative
	KOH		No Fungal Elements
	OccBld		Negative
	O&P		No Ova/Parasite

HCG

	Urine		Negative
	Serum		Negative

Hematology

CBC Malaria H/H

X	TEST	RESULT	REF. RANGE
	WBC		4.8-10.8 x10(3)/uL
	RBC		4.2-6.1 x10(6)/uL
	Hgb		12.0-18.0 g/dL
	Hct		35.0-60.0%
	MCV		80.0-99.0 fl
	MCH		27.0-31.0 pg
	MCHC		33.0-37.0 g/dL
	Plt		130-400 x10(3)/uL
	LY%		15.0-55.0%
	LY#		0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Immature cells

	RBC Morph:	
	Plt verify:	
	Spun Crit	35-60%

Malaria Smear

	Thin	No Plasmodium Se
	Thick	No Plasmodium Se

Sed Rate

	Sed Rate	1hr = 0-20 mm

Coagulation

	PT	10-13 seconds
	APTT	22.1-33.7 seconds
	FDP	Negative
	D-Dimer	Negative
	Fibrinogen	200-400 mg/dL

Blood Bank

	ABO/Rh	
	T&C	
	T&S	

MEDCOM - 1811

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI: (b)(6)-4 | UNIT | DOB | RANK | SSN

Physician: (b)(6)-2 | Ward: icu #1 | STAT / Routine | Specimen Date and Time: 9/20/03 0530 | (b)(6)-2 | Date and Time: 20 590

Chemistry (i-STAT)

6+ 7+ 8+ Glu Crea

X	TEST	RESULT	REF. RANGE
	Na		128-145 mmol/L
	K		3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH		7.35-7.45
	PCO2		35-45 mmHg
	PO2		80-90 mmHg
	TCO2		18-33 mmol/L
	HCO3		22-28 mmol/L
	sO2		95-99%
	BEecf		(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL
	Lactate		0.90-1.70 mmol/L

Urinalysis

	Color		Straw/Yellow
	Clarity		Clear
	Glucose		Negative
	Bilirubin		Negative
	Ketone		Negative
	SG		1.010-1.025
	Blood		Negative
	pH		5.0-8.0
	Protein		Negative-Trace
	Urobili		Negative
	Nitrite		Negative
	Leuko		Negative

Urine Microscopic

	WBC		Epi
	RBC		Mucus
	Bacteria		Yeast
	Casts:		Spermatozoa
	Crystals:		Amorph Sed
	Other:		
	Other:		

Chemistry (Piccolo Analyzer)

Chem 12 MetLyte8 BMP Liver

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-84 U/L
	ALT		10-47 U/L
	AMY		14-97 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
X	Creat	0.5*	0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu		73-118 mg/dL
X	K	3.3	3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		128-145 mmol/L

Misc. Chemistry

	Mono		Negative
	RPR		Negative
	HIV		Negative
	Meningitis		Negative
	DOA		Negative
	CK-MB		< 4.3 ng/mL
	Troponin I		< 0.19 ng/mL
	Myoglobin		< 107 ng/mL

Microbiology

	Source:		
	FecLeuk		Negative
	Gram Stain		
	WetPrep		Negative
	KOH		No Fungal Elements
	OccBld		Negative
	O&P		No Ova/Parasite

HCG

	Urine		Negative
	Serum		Negative

Hematology

CBC Malaria H/H

X	TEST	RESULT	REF. RANGE
	WBC		4.8-10.8 x10(3)/uL
	RBC		4.2-6.1 x10(6)/uL
	Hgb		12.0-18.0 g/dL
	Hct		35.0-60.0%
	MCV		80.0-99.0 fl
	MCH		27.0-31.0 pg
	MCHC		33.0-37.0 g/dL
	Plt		130-400 x10(3)/uL
	LY%		15.0-55.0%
	LY#		0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Immature cells

	RBC Morph:	
	Plt verify:	
	Spun Crit	35-60%

Malaria Smear

	Thin	No Plasmodium Se
	Thick	No Plasmodium Se

Sed Rate

	Sed Rate	1hr = 0-20 mm

Coagulation

	PT	10-13 seconds
	APTT	22.1-33.7 seconds
	FDP	Negative
	D-Dimer	Negative
	Fibrinogen	200-400 mg/dL

Blood Bank

	ABO/Rh	
	T&C	
	T&S	

MEDCOM - 1812

ACLU-RDI 1099 p.596

DOD 005864

21st COMBAT SUPPORT HOSPITAL	LABORATORY RESULTS FORM (Subject to Privacy Act of 1974)

LAST, FIRST, MI. (b)(6)-4	UNIT	RANK	SSN

Physician: (b)(6)-2	Ward: icu #1	STAT / Routine	Date and Time: 13 Sep 03 @ 0500	Reported by: (b)(6)-2	Date and Time: 14 Sep 03 @ 0720

Chemistry (i-STAT)

X	TEST	RESULT	REF. RANGE
	Na		128-145 mmol/L
	K		3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH		7.35-7.45
	PCO2		35-45 mmHg
	PO2		80-90 mmHg
	TCO2		18-33 mmol/L
	HCO3		22-28 mmol/L
	sO2		95-99%
	BEecf		(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL

Urinalysis

Color		Straw/Yellow
Clarity		Clear
Glucose		Negative
Bilirubin		Negative
Ketone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative-Trace
Urobili		Negative
Nitrite		Negative
Leuko		Negative

Urine Microscopic

WBC		Epi
RBC		Mucus
Bacteria		Yeast
Casts:		
Crystals:		
Other:		
Other:	Chem 7 LFT. Creat	

Chemistry (Piccolo Analyzer)

X	TEST	RESULT	REF. RANGE
A	ALB	1.6	3.3-5.5 g/dL
A	ALP	145	26-84 U/L
	ALT	22	10-47 U/L
	AMY	29	14-97 U/L
A	AST	42	11-38 U/L
	Tbil	1.2	0.2-1.6 mg/dL
	BUN	9	7-22 mg/dL
	Ca	8.2	8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
A	CL	91	98-108 mmol/L
	TCO2	29	18-33 mmol/L
	Creat	0.8	0.6-1.2 mg/dL
	GGT		5-65 U/L
A	Glu	201	73-118 mg/dL
A	K	2.4	3.3-4.7 mmol/L
	TProtein	7.1	6.4-8.1 g/dL
	Na	134	128-145 mmol/L

Microbiology

Source:		
FecLeuk		Negative
Gram St		
WetPrep		Negative
KOH		No Fungal Elements
OccBld		Negative
O&P		No Ova/Parasite

Blood Bank

ABO/Rh		
T&C		
T&S		

HCG

Urine		Negative
Serum		Negative

Hematology

X	TEST	RESULT	REF. RANGE
	WBC	9.2	4.8-10.8 x10(3)/uL
	RBC	2.64	4.2-6.1 x10(6)/uL
	Hgb	7.7	12.0-18.0 g/dL
	Hct	22.7	35.0-60.0%
	MCV	85.8	80.0-99.0 fl
	MCH	29.1	27.0-31.0 pg
	MCHC	34.0	33.0-37.0 g/dL
	Plt	594	130-400 x10(3)/uL
	LY%	14.4	15.0-55.0%
	LY#	1.3	0.7-4.3 x10(3)/uL

Differential

Segs	69	Mono	8
Bands	12	Eos	
Lymph	8	Baso	
Atyp Ly	3	Imm	
RBC Morph:	N/N		
Plt veri	(b)(6)-2		30-35 (T [illegible]
Spun Crit			35-60%

Malaria Smear

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate

Sed Rate		1hr = 0-20 mm

Coagulation

PT		10-13 seconds
APTT		22.1-33.7 seconds
FDP		Negative

Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Negative

MEDCOM - 1813

UDC, Creatinine

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI	UNIT	RANK	SSN
[b)(6)-4			

Physician:	Ward:		STAT / Routine	Date and Time:	Reported by:	Date and Time:
[b)(6)-2	ICU			13Sep03 0520	[b)(6)-2	13Sep03 0531

Chemistry (I-STAT)

X	TEST	RESULT	REF. RANGE
	Na		128-145 mmol/L
	K		3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH		7.35-7.45
	PCO2		35-45 mmHg
	PO2		80-90 mmHg
	TCO2		18-33 mmol/L
	HCO3		22-28 mmol/L
	sO2		95-99%
	BEecf		(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat	0.8	0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL

Unnalysis

	Color		Straw/Yellow
	Clarity		Clear
	Glucose		Negative
	Bilirubin		Negative
	Ketone		Negative
	SG		1.010-1.025
	Blood		Negative
	pH		5.0-8.0
	Protein		Negative-Trace
	Urobili		Negative
	Nitrite		Negative
	Leuko		Negative

Urine Microscopic

	WBC		Epi
	RBC		Mucus
	Bacteria		Yeast
	Casts:		
	Crystals:		
	Other:		

Other

Chemistry (Piccolo Analyzer)

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-84 U/L
	ALT		10-47 U/L
	AMY		14-97 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat		0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		128-145 mmol/L

Microbiology

	Source:		
	FecLeuk		Negative
	Gram St		
	WetPrep		Negative
	KOH		No Fungal Elements
	OccBld		Negative
	O&P		No Ova/Parasite

Blood Bank

	ABO/Rh		
	T&C		
	T&S		

HCG

	Urine		Negative
	Serum		Negative

Hematology

X	TEST	RESULT	REF. RANGE
	WBC	9.9	4.8-10.8 x10(3)/uL
	RBC	3.05	4.2-6.1 x10(6)/uL
	Hgb	8.4	12.0-18.0 g/dL
	Hct	26.0	35.0-60.0%
	MCV	85.4	80.0-99.0 fl
	MCH	27.4	27.0-31.0 pg
	MCHC	32.1	33.0-37.0 g/dL
	Plt	567	130-400 x10(3)/uL
	LY%	10.8	15.0-55.0%
	LY#	1.1	0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Imm
RBC Morph:	
Plt verify:	
Spun Crit	35-60%

Malaria Smear

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate

Sed Rate		1hr = 0-20 mm

Coagulation

PT		10-13 seconds
APTT		22.1-33.7 seconds
FDP		Negative

Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Negative

MEDCOM - 1814

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST [redacted] | UNIT ICU #1 | RANK — | SSN [redacted]

Physician [redacted] | Ward: ICU #1 | STAT / Routine | Date and Time: 1240 / 12Sept03 | Reported by: | Date and Time:

Chemistry (i-STAT)

X	TEST	RESULT	REF. RANGE
	Na		128-145 mmol/L
	K		3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH		7.35-7.45
	PCO2		35-45 mmHg
	PO2		80-90 mmHg
	TCO2		18-33 mmol/L
	HCO3		22-28 mmol/L
	sO2		95-99%
	BEecf		(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL

Urinalysis

	Color		Straw/Yellow
	Clarity		Clear
	Glucose		Negative
	Bilirubin		Negative
	Ketone		Negative
	SG		1.010-1.025
	Blood		Negative
	pH		5.0-8.0
	Protein		Negative-Trace
	Urobili		Negative
	Nitrite		Negative
	Leuko		Negative

Urine Microscopic

	WBC		Epi
	RBC		Mucus
	Bacteria		Yeast
	Casts:		
	Crystals:		
	Other:		

Other: [redacted]

Chemistry (Piccolo Analyzer)

X	TEST	RESULT	REF. RANGE
	ALB	1.5 #	3.3-5.5 g/dL
	ALP	162 #	26-84 U/L
	ALT	23	10-47 U/L
	AMY	26	14-97 U/L
	AST	53 #	11-38 U/L
	Tbil	1.0	0.2-1.6 mg/dL
	BUN	10	7-22 mg/dL
	Ca	8.4	8.0-10.3 mg/dL
	Chol	84 #	100-200 mg/dL
	CK		30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat	0.8	0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu	183 #	73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein	7.5	6.4-8.1 g/dL
	Na		128-145 mmol/L

Microbiology

	Source:		
	FecLeuk		Negative
	Gram St		
	WetPrep		Negative
	KOH		No Fungal Elements
	OccBld		Negative
	O&P		No Ova/Parasite

Blood Bank

	ABO/Rh		
	T&C		
	T&S		

HCG

	Urine		Negative
	Serum		Negative

Hematology

X	TEST	RESULT	REF. RANGE
	WBC		4.8-10.8 x10(3)/uL
	RBC		4.2-6.1 x10(6)/uL
	Hgb		12.0-18.0 g/dL
	Hct		35.0-60.0%
	MCV		80.0-99.0 fl
	MCH		27.0-31.0 pg
	MCHC		33.0-37.0 g/dL
	Plt		130-400 x10(3)/uL
	LY%		15.0-55.0%
	LY#		0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Imm

	RBC Morph:		
	Plt verify:		
	Spun Crit		35-60%

Malaria Smear

	Thin		No Plasmodium Seen
	Thick		No Plasmodium Seen

Sed Rate

	Sed Rate		1hr = 0-20 mm

Coagulation

	PT		10-13 seconds
	APTT		22.1-33.7 seconds
	FDP		Negative

Misc. Chemistry

	Mono		Negative
	RPR		Negative
	HIV		Negative
	Meningitis		Negative

MEDCOM - 1815

(5)(6)(4)

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI	UNIT	RANK	SSN
(b)(6)-4	ICU #1		

Physician	Ward:		STAT	Date and Time:	Reported by:	Date and Time:
(b)(6)-2	ICU #1	C	Routine	12 Sep 03 0430	(b)(6)-2	12 Sep 0430

Chemistry (i-STAT)

X	TEST	RESULT	REF. RANGE
	Na		128-145 mmol/L
	K		3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH		7.35-7.45
	PCO2		35-45 mmHg
	PO2		80-90 mmHg
	TCO2		18-33 mmol/L
	HCO3		22-28 mmol/L
	sO2		95-99%
	BEecf		(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL

Urinalysis

	Color		Straw/Yellow
	Clarity		Clear
	Glucose		Negative
	Bilirubin		Negative
	Ketone		Negative
	SG		1.010-1.025
	Blood		Negative
	pH		5.0-8.0
	Protein		Negative-Trace
	Urobili		Negative
	Nitrite		Negative
	Leuko		Negative

Urine Microscopic

	WBC		Epi
	RBC		Mucus
	Bacteria		Yeast
	Casts:		
	Crystals:		
	Other:		

Other:

Chemistry (Piccolo Analyzer)

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-84 U/L
	ALT		10-47 U/L
	AMY		14-97 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
X	Creat	6.1	0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		128-145 mmol/L

Microbiology

	Source:		
	FecLeuk		Negative
	Gram St		
	WetPrep		Negative
	KOH		No Fungal Elements
	OccBld		Negative
	O&P		No Ova/Parasite

Blood Bank

	ABO/Rh		
	T&C		
	T&S		

HCG

	Urine		Negative
	Serum		Negative

Hematology

X	TEST	RESULT	REF. RANGE
	WBC		4.8-10.8 x10(3)/uL
	RBC		4.2-6.1 x10(6)/uL
	Hgb		12.0-18.0 g/dL
	Hct		35.0-60.0%
	MCV		80.0-99.0 fl
	MCH		27.0-31.0 pg
	MCHC		33.0-37.0 g/dL
	Plt		130-400 x10(3)/uL
	LY%		15.0-55.0%
	LY#		0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Imm

	RBC Morph:	
	Plt verify:	
	Spun Crit	35-60%

Malaria Smear

	Thin		No Plasmodium Seen
	Thick		No Plasmodium Seen

Sed Rate

	Sed Rate	1hr = 0-20 mm

Coagulation

	PT		10-13 seconds
	APTT		22.1-33.7 seconds
	FDP		Negative

Misc. Chemistry

	Mono		Negative
	RPR		Negative
	HIV		Negative
	Meningitis		Negative

MEDCOM - 1816

21st COMBAT SUPPORT HOSPITAL	LABORATORY RESULTS FORM (Subject to Privacy Act of 1974)

LAST, FIRST, MI	UNIT	RANK	SSN
(b)(6)-4 EPW	ICU #1	NA	(b)(6)-4 (b)(6)-4

Physician:	Ward:	STAT / Routine	Date and Time:	Reported by:	Date and Time:
(b)(6)-2				(b)(6)-2	11 Apr 03 @ 0740

Chemistry (i-STAT)

X	TEST	RESULT	REF. RANGE
	Na		128-145 mmol/L
	K		3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH		7.35-7.45
	PCO2		35-45 mmHg
	PO2		80-90 mmHg
	TCO2		18-33 mmol/L
	HCO3		22-28 mmol/L
	sO2		95-99%
	BEecf		(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat	0.9	0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL

Urinalysis

Color		Straw/Yellow
Clarity		Clear
Glucose		Negative
Bilirubin		Negative
Ketone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative-Trace
Urobili		Negative
Nitrite		Negative
Leuko		Negative

Urine Microscopic

WBC		Epi
RBC		Mucus
Bacteria		Yeast
Casts:		
Crystals:		
Other:		
Other		

Chemistry (Piccolo Analyzer)

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-84 U/L
	ALT		10-47 U/L
	AMY		14-97 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat		0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		128-145 mmol/L

Microbiology

Source:		
FecLeuk		Negative
Gram St		
WetPrep		Negative
KOH		No Fungal Elements
OccBld		Negative
O&P		No Ova/Parasite

Blood Bank

ABO/Rh		
T&C		
T&S		

HCG

Urine		Negative
Serum		Negative

Hematology

X	TEST	RESULT	REF. RANGE
	WBC		4.8-10.8 x10(3)/uL
	RBC		4.2-6.1 x10(6)/uL
	Hgb		12.0-18.0 g/dL
	Hct		35.0-60.0%
	MCV		80.0-99.0 fl
	MCH		27.0-31.0 pg
	MCHC		33.0-37.0 g/dL
	Plt		130-400 x10(3)/uL
	LY%		15.0-55.0%
	LY#		0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Imm
RBC Morph:	
Plt verify:	
Spun Crit	35-60%

Malaria Smear

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate

Sed Rate		1hr = 0-20 mm

Coagulation

PT		10-13 seconds
APTT		22.1-33.7 seconds
FDP		Negative

Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Negative

MEDCOM - 1817

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI: (b)(6)-4 (b)(6)-4 | UNIT: [illegible] | RANK: SGT | SSN: (b)(6)-4

Physician: (b)(6)-2 | Ward: ICU #1 | STAT / Routine | Date and Time: 10 SEP 03 0830 | Re: (b)(6)-2 | Date and Time: 10 Sep 0549

Chemistry (I-STAT)

X	TEST	RESULT	REF. RANGE
	Na		128-145 mmol/L
	K		3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH		7.35-7.45
	PCO2		35-45 mmHg
	PO2		80-90 mmHg
	TCO2		18-33 mmol/L
	HCO3		22-28 mmol/L
	sO2		95-99%
	BEecf		(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL

Urinalysis

	Color		Straw/Yellow
	Clarity		Clear
	Glucose		Negative
	Bilirubin		Negative
	Ketone		Negative
	SG		1.010-1.025
	Blood		Negative
	pH		5.0-8.0
	Protein		Negative-Trace
	Urobili		Negative
	Nitrite		Negative
	Leuko		Negative

Urine Microscopic

	WBC		Epi
	RBC		Mucus
	Bacteria		Yeast
	Casts:		
	Crystals:		
	Other:		

Other

Chemistry (Piccolo Analyzer)

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-84 U/L
	ALT		10-47 U/L
	AMY		14-97 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
X	Creat	0.9	0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		128-145 mmol/L

Microbiology

	Source:		
	FecLeuk		Negative
	Gram St		
	WetPrep		Negative
	KOH		No Fungal Elements
	OccBld		Negative
	O&P		No Ova/Parasite

Blood Bank

	ABO/Rh		
	T&C		
	T&S		

HCG

	Urine		Negative
	Serum		Negative

Hematology

X	TEST	RESULT	REF. RANGE
	WBC		4.8-10.8 x10(3)/uL
	RBC		4.2-6.1 x10(6)/uL
	Hgb		12.0-18.0 g/dL
	Hct		35.0-60.0%
	MCV		80.0-99.0 fl
	MCH		27.0-31.0 pg
	MCHC		33.0-37.0 g/dL
	Plt		130-400 x10(3)/uL
	LY%		15.0-55.0%
	LY#		0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Imm

RBC Morph:		
Plt verify:		
Spun Crit		35-60%

Malaria Smear

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate

Sed Rate		1hr = 0-20 mm

Coagulation

PT		10-13 seconds
APTT		22.1-33.7 seconds
FDP		Negative

Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Negative

MEDCOM - 1818

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI	UNIT	RANK	SSN
(b)(6)-4			

Physician:	Ward:		STAT	Date and Time:	Reported by:	Date and Time:
(b)(6)-2	ICU 1	X	Routine	9SEP03/1920	(b)(6)-2	9Sep 1940

Chemistry (I-STAT)

X	TEST	RESULT	REF. RANGE
	Na		128-145 mmol/L
	K		3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH		7.35-7.45
	PCO2		35-45 mmHg
	PO2		80-90 mmHg
	TCO2		18-33 mmol/L
	HCO3		22-28 mmol/L
	sO2		95-99%
	BEecf		(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL

Chemistry (Piccolo Analyzer)

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-84 U/L
	ALT		10-47 U/L
	AMY		14-97 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat		0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		128-145 mmol/L

Hematology

X	TEST	RESULT	REF. RANGE
	WBC		4.8-10.8 x10(3)/uL
	RBC		4.2-6.1 x10(6)/uL
	Hgb		12.0-18.0 g/dL
	Hct		35.0-60.0%
	MCV		80.0-99.0 fl
	MCH		27.0-31.0 pg
	MCHC		33.0-37.0 g/dL
	Plt		130-400 x10(3)/uL
	LY%		15.0-55.0%
	LY#		0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Imm
RBC Morph:	
Plt verify:	
Spun Crit	35-60%

Urinalysis

X			
	Color	yellow	Straw/Yellow
	Clarity	Clear	Clear
	Glucose	Neg	Negative
	Bilirubin	small	Negative
	Ketone	Neg	Negative
	SG	1.020	1.010-1.025
	Blood	Small	Negative
	pH	5.5	5.0-8.0
	Protein	30	Negative-Trace
	Urobili	Pos	Negative
	Nitrite	Neg	Negative
	Leuko	Neg	Negative

Urine Microscopic

WBC		Epi
RBC		Mucus light
Bacteria	Mod	Yeast
Casts:		
Crystals:		
Other:		

Microbiology

Source:		
FecLeuk		Negative
Gram St		
WetPrep		Negative
KOH		No Fungal Elements
OccBld		Negative
O&P		No Ova/Parasite

Blood Bank

ABO/Rh		
T&C		
T&S		

HCG

Urine		Negative
Serum		Negative

Malaria Smear

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate

Sed Rate		1hr = 0-20 mm

Coagulation

PT		10-13 seconds
APTT		22.1-33.7 seconds
FDP		Negative

Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Negative

Other:

MEDCOM - 1819

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI	UNIT	RANK	SSN
(b)(6)-4		CIV	(b)(6)-4

Physician:	Ward:	STAT / Routine	Date and Time:	Reported by:	Date and Time:
(b)(6)-2	EMT	X STAT	25 Aug 03 1920hrs		

Chemistry (i-STAT)

X	TEST	RESULT	REF. RANGE
	Na		128-145 mmol/L
	K		3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH		7.35-7.45
	PCO2		35-45 mmHg
	PO2		80-90 mmHg
	TCO2		18-33 mmol/L
	HCO3		22-28 mmol/L
	sO2		95-99%
	BEecf		(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL

Urinalysis

Color	Amber	Straw/Yellow
Clarity	clear	Clear
Glucose	Neg	Negative
Bilirubin	Neg	Negative
Ketone	trace	Negative
SG	1.030	1.010-1.025
Blood	large	Negative
pH	6.0	5.0-8.0
Protein	trace	Negative-Trace
Urobili	Neg	Negative
Nitrite	Neg	Negative
Leuko	Neg	Negative

Urine Microscopic

WBC	0-5	Epi	
RBC	3-10	Mucus	light
Bacteria	light	Yeast	
Casts:			
Crystals:			
Other:			

Chemistry (Piccolo Analyzer)

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-84 U/L
	ALT		10-47 U/L
	AMY		14-97 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN	18	7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK	1305	30-170 U/L
	CL	104	98-108 mmol/L
	TCO2	21	18-33 mmol/L
	Creat	0.9	0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu	231	73-118 mg/dL
	K	4.0	3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na	127	128-145 mmol/L

Microbiology

	Source:		
	FecLeuk		Negative
	Gram St		
	WetPrep		Negative
	KOH		No Fungal Elements
	OccBld		Negative
	O&P		No Ova/Parasite

Blood Bank

X	ABO/Rh	O pos	
	T&C		
X	T&S		

HCG

Urine		Negative
Serum		Negative

Hematology

X	TEST	RESULT	REF. RANGE
	WBC	13.1	4.8-10.8 x10(3)/uL
	RBC	3.47	4.2-6.1 x10(6)/uL
	Hgb	9.8	12.0-18.0 g/dL
	Hct	29.3	35.0-60.0%
	MCV	84.4	80.0-99.0 fl
	MCH	28.2	27.0-31.0 pg
	MCHC	33.4	33.0-37.0 g/dL
	Plt	232	130-400 x10(3)/uL
	LY%	9.2	15.0-55.0%
	LY#	1.2	0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Imm
RBC Morph:	
Plt verify:	
Spun Crit	35-60%

Malaria Smear

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate

Sed Rate		1hr = 0-20 mm

Coagulation

PT		10-13 seconds
APTT		22.1-33.7 seconds
FDP		Negative

Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Negative

Other: CBC, Istat 6 2Cr, Met 8, ABO, UA, T+S

MEDCOM - 1820

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI	UNIT	RANK	SSN
(b)(6)-4	ICU #1		

Physician:	Ward:	STAT / Routine	Date and Time:	Reported by:	Date and Time:
(b)(6)-2	ICU #1	X Routine	1300/ 14Sept03	(b)(6)-2	14Sep03

Chemistry (I-STAT)

X	TEST	RESULT	REF. RANGE
	Na		128-145 mmol/L
	K		3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH		7.35-7.45
	PCO2		35-45 mmHg
	PO2		80-90 mmHg
	TCO2		18-33 mmol/L
	HCO3		22-28 mmol/L
	sO2		95-99%
	BEecf		(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL

Urinalysis

	Color	dkY	Straw/Yellow
	Clarity	s/t Cldy	Clear
	Glucose	Neg	Negative
	Bilirubin	Neg	Negative
	Ketone	Neg	Negative
	SG	1.013	1.010-1.025
	Blood	mod/sm	Negative
	pH	7.0	5.0-8.0
	Protein	30	Negative-Trace
	Urobili	2	Negative
	Nitrite	Neg	Negative
	Leuko	Neg	Negative

Urine Microscopic

	WBC	0-3	Epi 0 cl.
	RBC	0-5	Mucus trace
	Bacteria	light	Yeast
	Casts:		
	Crystals:		
	Other:		

Other: UA

Chemistry (Piccolo Analyzer)

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-84 U/L
	ALT		10-47 U/L
	AMY		14-97 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat		0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		128-145 mmol/L

Microbiology

	Source:		
	FecLeuk		Negative
	Gram St		
	WetPrep		Negative
	KOH		No Fungal Elements
	OccBld		Negative
	O&P		No Ova/Parasite

Blood Bank

	ABO/Rh		
	T&C		
	T&S		

HCG

	Urine		Negative
	Serum		Negative

Hematology

X	TEST	RESULT	REF. RANGE
	WBC		4.8-10.8 x10(3)/uL
	RBC		4.2-6.1 x10(6)/uL
	Hgb		12.0-18.0 g/dL
	Hct		35.0-60.0%
	MCV		80.0-99.0 fl
	MCH		27.0-31.0 pg
	MCHC		33.0-37.0 g/dL
	Plt		130-400 x10(3)/uL
	LY%		15.0-55.0%
	LY#		0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Imm

	RBC Morph:	
	Plt verify:	
	Spun Crit	35-60%

Malaria Smear

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate

Sed Rate		1hr = 0-20 mm

Coagulation

PT		10-13 seconds
APTT		22.1-33.7 seconds
FDP		Negative

Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Negative

MEDCOM - 1821

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI: (b)(6)-4 | UNIT | RANK | SSN

Physician: DO (b)(6)-2 | Ward: ICU #1 | X STAT / Routine | Date and Time: 15SEP03 0100 | Reported by: (b)(6)-2 | Date and Time: 15SEP03 0224

Chemistry (i-STAT)

X	TEST	RESULT	REF. RANGE
	Na		128-145 mmol/L
X	K	2.8	3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH		7.35-7.45
	PCO2		35-45 mmHg
	PO2		80-90 mmHg
	TCO2		18-33 mmol/L
	HCO3		22-28 mmol/L
	sO2		95-99%
	BEecf		(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL

Urinalysis

	Color		Straw/Yellow
	Clarity		Clear
	Glucose		Negative
	Bilirubin		Negative
	Ketone		Negative
	SG		1.010-1.025
	Blood		Negative
	pH		5.0-8.0
	Protein		Negative-Trace
	Urobili		Negative
	Nitrite		Negative
	Leuko		Negative

Urine Microscopic

	WBC		Epi
	RBC		Mucus
	Bacteria		Yeast
	Casts:		
	Crystals:		
	Other:		
	Other:	* ESR	

Chemistry (Piccolo Analyzer)

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-84 U/L
	ALT		10-47 U/L
	AMY		14-97 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat		0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		128-145 mmol/L

Microbiology

	Source:		
	FecLeuk		Negative
	Gram St		
	WetPrep		Negative
	KOH		No Fungal Elements
	OccBld		Negative
	O&P		No Ova/Parasite

Blood Bank

	ABO/Rh		
	T&C		
	T&S		

HCG

	Urine		Negative
	Serum		Negative

Hematology

X	TEST	RESULT	REF. RANGE
	WBC	11.3	4.8-10.8 x10(3)/uL
	RBC	3.39	4.2-6.1 x10(6)/uL
	Hgb	9.7	12.0-18.0 g/dL
	Hct	28.9	35.0-60.0%
	MCV	86.2	80.0-99.0 fl
	MCH	28.9	27.0-31.0 pg
	MCHC	33.5	33.0-37.0 g/dL
	Plt	510	130-400 x10(3)/uL
	LY%	15.8	15.0-55.0%
	LY#	1.8	0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Imm

	RBC Morph:		
	Plt verify:		
	Spun Crit		35-60%

Malaria Smear

	Thin		No Plasmodium Seen
	Thick		No Plasmodium Seen

Sed Rate

X	Sed Rate	128	1hr = 0-20 mm

Coagulation

PT		10-13 seconds
APTT		22.1-33.7 seconds
FDP		Negative

Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Negative

MEDCOM - 1822

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI	UNIT	DOB	RANK	SSN
(b)(6)-4				

Physician:	Ward:		Specimen Date and Time:	Date and Time:
Dr (b)(6)-2	ICU #1	STAT / Routine	16 SEP 03 0500	(b)(6)-2 16 SEP 0530

Chemistry (i-STAT) — 6+ 7+ 8+ Glu Crea

X	TEST	RESULT	REF. RANGE
	Na		128-145 mmol/L
X	K	3.6	3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH		7.35-7.45
	PCO2		35-45 mmHg
	PO2		80-90 mmHg
	TCO2		18-33 mmol/L
	HCO3		22-28 mmol/L
	sO2		95-99%
	BEecf		(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
X	Creat	0.9	0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL
	Lactate		0.90-1.70 mmol/L

Urinalysis

	Color		Straw/Yellow
	Clarity		Clear
	Glucose		Negative
	Bilirubin		Negative
	Ketone		Negative
	SG		1.010-1.025
	Blood		Negative
	pH		5.0-8.0
	Protein		Negative-Trace
	Urobili		Negative
	Nitrite		Negative
	Leuko		Negative

Urine Microscopic

	WBC		Epi
	RBC		Mucus
	Bacteria		Yeast
	Casts:		Spermatozoa
	Crystals:		Amorph Sed
	Other:		
	Other:		

Chemistry (Piccolo Analyzer) — Chem 12 MetLyte8 BMP Liver

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-84 U/L
	ALT		10-47 U/L
	AMY		14-97 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat		0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		128-145 mmol/L

Misc. Chemistry

	Mono		Negative
	RPR		Negative
	HIV		Negative
	Meningitis		Negative
	DOA		Negative
	CK-MB		< 4.3 ng/mL
	Troponin I		< 0.19 ng/mL
	Myoglobin		< 107 ng/mL

Microbiology

	Source:		
	FecLeuk		Negative
	Gram Stain		
	WetPrep		Negative
	KOH		No Fungal Elements
	OccBld		Negative
	O&P		No Ova/Parasite

HCG

	Urine		Negative
	Serum		Negative

Hematology — CBC Malaria H/H

X	TEST	RESULT	REF. RANGE
	WBC		4.8-10.8 x10(3)/uL
	RBC		4.2-6.1 x10(6)/uL
	Hgb		12.0-18.0 g/dL
	Hct		35.0-60.0%
	MCV		80.0-99.0 fl
	MCH		27.0-31.0 pg
	MCHC		33.0-37.0 g/dL
	Plt		130-400 x10(3)/uL
	LY%		15.0-55.0%
	LY#		0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Immature cells

	RBC Morph:	
	Plt verify:	
	Spun Crit	35-60%

Malaria Smear

	Thin	No Plasmodium Se
	Thick	No Plasmodium Se

Sed Rate

	Sed Rate	1hr = 0-20 mm

Coagulation

	PT	10-13 seconds
	APTT	22.1-33.7 seconds
	FDP	Negative
	D-Dimer	Negative
	Fibrinogen	200-400 mg/dL

Blood Bank

	ABO/Rh	
	T&C	
	T&S	

MEDCOM - 1823

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI. (b)(6)-4 | UNIT N/A | DOB N/A | RANK N/A | SSN (b)(6)-4

Physician: (b)(6)-2 | Ward: ICU 1 | STAT | X Routine | Specimen Date and Time: 17Sep03 | Reported by: (b)(6)-2 | Date and Time: 17Sep03

Chemistry (i-STAT)

6+ 7+ 8+ Glu Crea

X	TEST	RESULT	REF. RANGE
	Na		128-145 mmol/L
X	K	3.2	3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH		7.35-7.45
	PCO2		35-45 mmHg
	PO2		80-90 mmHg
	TCO2		18-33 mmol/L
	HCO3		22-28 mmol/L
	sO2		95-99%
	BEecf		(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
X	Creat	0.8	0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL
	Lactate		0.90-1.70 mmol/L

Urinalysis

	Color		Straw/Yellow
	Clarity		Clear
	Glucose		Negative
	Bilirubin		Negative
	Ketone		Negative
	SG		1.010-1.025
	Blood		Negative
	pH		5.0-8.0
	Protein		Negative-Trace
	Urobili		Negative
	Nitrite		Negative
	Leuko		Negative

Urine Microscopic

	WBC		Epi
	RBC		Mucus
	Bacteria		Yeast
	Casts:		Spermatozoa
	Crystals:		Amorph Sed
	Other:		
	Other:		

Chemistry (Piccolo Analyzer)

Chem 12 MetLyte8 BMP Liver

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-84 U/L
	ALT		10-47 U/L
	AMY		14-97 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat		0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		128-145 mmol/L

Misc. Chemistry

	Mono		Negative
	RPR		Negative
	HIV		Negative
	Meningitis		Negative
	DOA		Negative
	CK-MB		< 4.3 ng/mL
	Troponin I		< 0.19 ng/mL
	Myoglobin		< 107 ng/mL

Microbiology

	Source:		
	FecLeuk		Negative
	Gram Stain		
	WetPrep		Negative
	KOH		No Fungal Elements
	OccBld		Negative
	O&P		No Ova/Parasite

HCG

	Urine		Negative
	Serum		Negative

Hematology

CBC Malaria H/H

X	TEST	RESULT	REF. RANGE
	WBC	10.2	4.8-10.8 x10(3)/uL
	RBC	3.22	4.2-6.1 x10(6)/uL
	Hgb	9.7	12.0-18.0 g/dL
	Hct	27.8	35.0-60.0%
	MCV	86.4	80.0-99.0 fl
	MCH	30.2	27.0-31.0 pg
	MCHC	35.0	33.0-37.0 g/dL
	Plt	487	130-400 x10(3)/uL
	LY%	14.4	15.0-55.0%
	LY#	1.5	0.7-4.3 x10(3)/uL

Differential

Segs	81	Mono	9
Bands		Eos	
Lymph	3	Baso	
Atyp Ly		Blast (immature cells)	1

RBC Morph: Hanisocytosis N/N

Plt verify: slt Increased

	Spun Crit		35-60%

Malaria Smear

	Thin		No Plasmodium See
	Thick		No Plasmodium See

Sed Rate

	Sed Rate		1hr = 0-20 mm

Coagulation

	PT		10-13 seconds
	APTT		22.1-33.7 seconds
	FDP		Negative
	D-Dimer		Negative
	Fibrinogen		200-400 mg/dL

Blood Bank

	ABO/Rh		
	T&C		
	T&S		

MEDCOM - 1824

ACLU-RDI 1099 p.608

DOD 005876

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST FIRST MI	UNIT	DOB	RANK	SSN
(b)(6)-4				

Physician:	Ward:		Specimen Date and Time:	Reported by:	Date and Time:
(b)(6)-2	ICU 1	STAT / Routine	18 Jul 03 1645	(b)(6)-2	18 Jul 03

Chemistry (I-STAT)

6+ 7+ 8+ Glu Crea

X	TEST	RESULT	REF. RANGE
	Na		128-145 mmol/L
	K		3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH		7.35-7.45
	PCO2		35-45 mmHg
	PO2		80-90 mmHg
	TCO2		18-33 mmol/L
	HCO3		22-28 mmol/L
	sO2		95-99%
	BEecf		(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL
	Lactate		0.90-1.70 mmol/L

Urinalysis

	Color		Straw/Yellow
	Clarity		Clear
	Glucose		Negative
	Bilirubin		Negative
	Ketone		Negative
	SG		1.010-1.025
	Blood		Negative
	pH		5.0-8.0
	Protein		Negative-Trace
	Urobili		Negative
	Nitrite		Negative
	Leuko		Negative

Urine Microscopic

	WBC		Epi
	RBC		Mucus
	Bacteria		Yeast
	Casts:		Spermatozoa
	Crystals:		Amorph Sed
	Other:		
	Other:		

Chemistry (Piccolo Analyzer)

Chem 12 MetLyte8 BMP Liver

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-84 U/L
	ALT		10-47 U/L
	AMY		14-97 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat		0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		128-145 mmol/L

Misc. Chemistry

	Mono		Negative
	RPR		Negative
	HIV		Negative
	Meningitis		Negative
	DOA		Negative
	CK-MB		< 4.3 ng/mL
	Troponin I		< 0.19 ng/mL
	Myoglobin		< 107 ng/mL

Microbiology

	Source:		
	FecLeuk		Negative
	Gram Stain		
	WetPrep		Negative
	KOH		No Fungal Elements
	OccBld		Negative
	O&P		No Ova/Parasite

HCG

	Urine		Negative
	Serum		Negative

Hematology

CBC Malaria H/H

X	TEST	RESULT	REF. RANGE
	WBC	10.8	4.8-10.8 x10(3)/uL
	RBC	3.49 L	4.2-6.1 x10(6)/uL
	Hgb	10.0 L	12.0-18.0 g/dL
	Hct	29.9 L	35.0-60.0%
	MCV	85.6	80.0-99.0 fl
	MCH	28.7	27.0-31.0 pg
	MCHC	33.5	33.0-37.0 g/dL
	Plt	462 H	130-400 x10(3)/uL
	LY%	11.2 L	15.0-55.0%
	LY#	1.2	0.7-4.3 x10(3)/uL

X Differential

Segs	86	Mono	9
Bands		Eos	
Lymph	4	Baso	1
Atyp Ly		Immature cells	

RBC Morph: N/N

Plt verify: S/H increased

Spun Crit		35-60%

Malaria Smear

Thin		No Plasmodium Seer
Thick		No Plasmodium Seer

Sed Rate

Sed Rate		1hr = 0-20 mm

Coagulation

PT		10-13 seconds
APTT		22.1-33.7 seconds
FDP		Negative
D-Dimer		Negative
Fibrinogen		200-400 mg/dL

Blood Bank

ABO/Rh		
T&C		
T&S		

MEDCOM - 1825

TEST(S)

SPECIMEN TAKEN

DATE	TIME	A.M. / P.M.
23 Sep 03	0525	

RESULTS	REQUESTED	(X)
	GLUCOSE	
	UREA N.	
	CREATININE	
	URIC ACID	
	SODIUM	
3.0	POTASSIUM	
	CHLORIDE	
	CO_2	
	PHOSPHATE	
	CALCIUM	
	TOTAL PROTEIN	
	ALBUMIN	
	GLOBULIN	
	ALKALINE PHOSPHATASE	
	ACID PHOSPHATASE	
	SGOT	
	LDH	
	CPK	
	BILIRUBIN (TOTAL)	
	BILIRUBIN (DIRECT)	
	CHOLESTEROL	
	TRIGLYCERIDES	
	AMYLASE	
	LIPASE	
	PROFILE (Specify)	

REMARKS

X Potassium

(b)(6)-2

Enter in above space

REQUESTING PHYSICIAN'S SIGNATURE

PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

(b)(6)-4

(SPW)

ICU-2

REPORTED BY

(b)(6)-2

MD

TECH

DATE

23 Sep 0545

CHEM I

URGENCY

☒ ROUTINE

☐ TODAY

☐ PRE-OP

☐ STAT

PATIENT STATUS

☒ BED ☐ AMB

OUTPATIENT ☐

☐ NP ☐ DOM

SPECIMEN SOURCE

☒ BLOOD

☐ OTHER (Specify)

LAB. ID. NO.

SPECIMEN/LAB. RPT. NO.

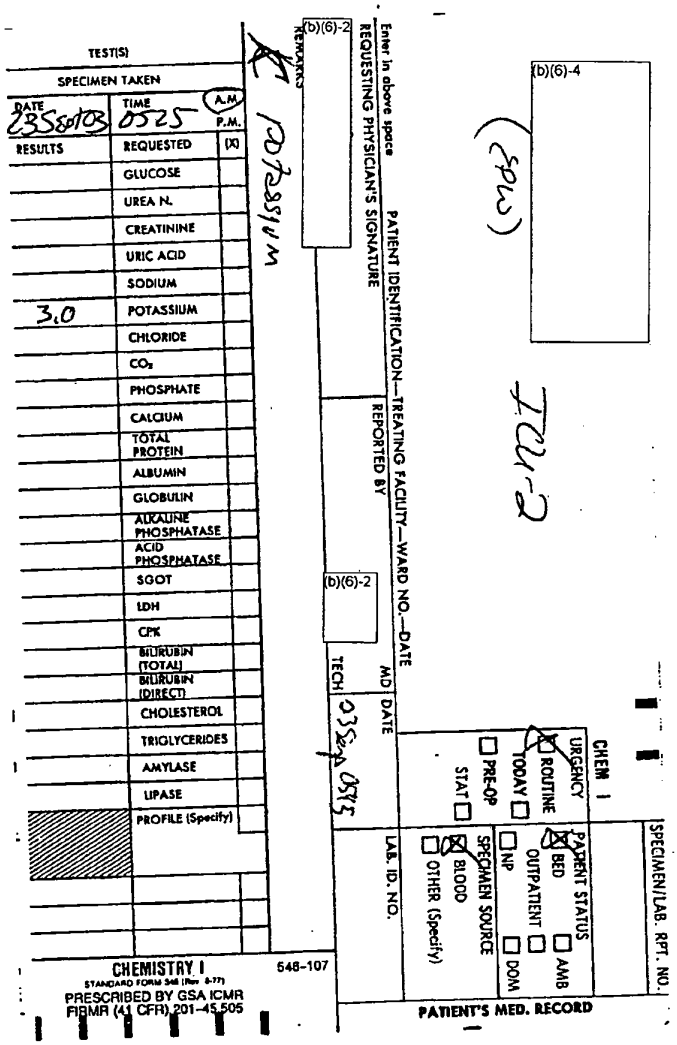
PATIENT'S MED. RECORD

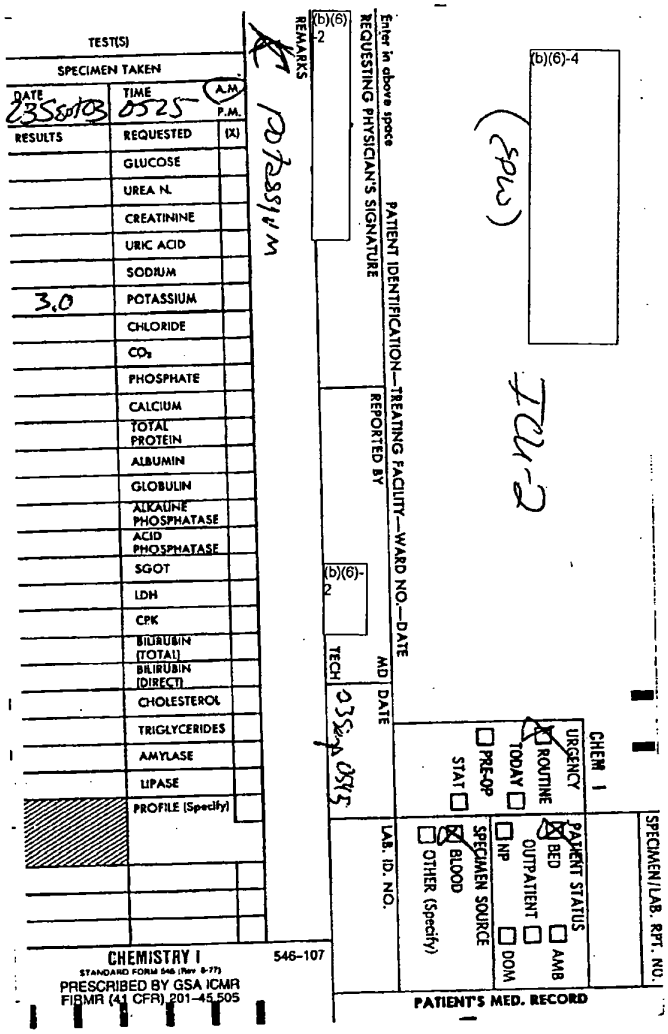
CHEMISTRY I

STANDARD FORM 546 (Rev. 8-77)

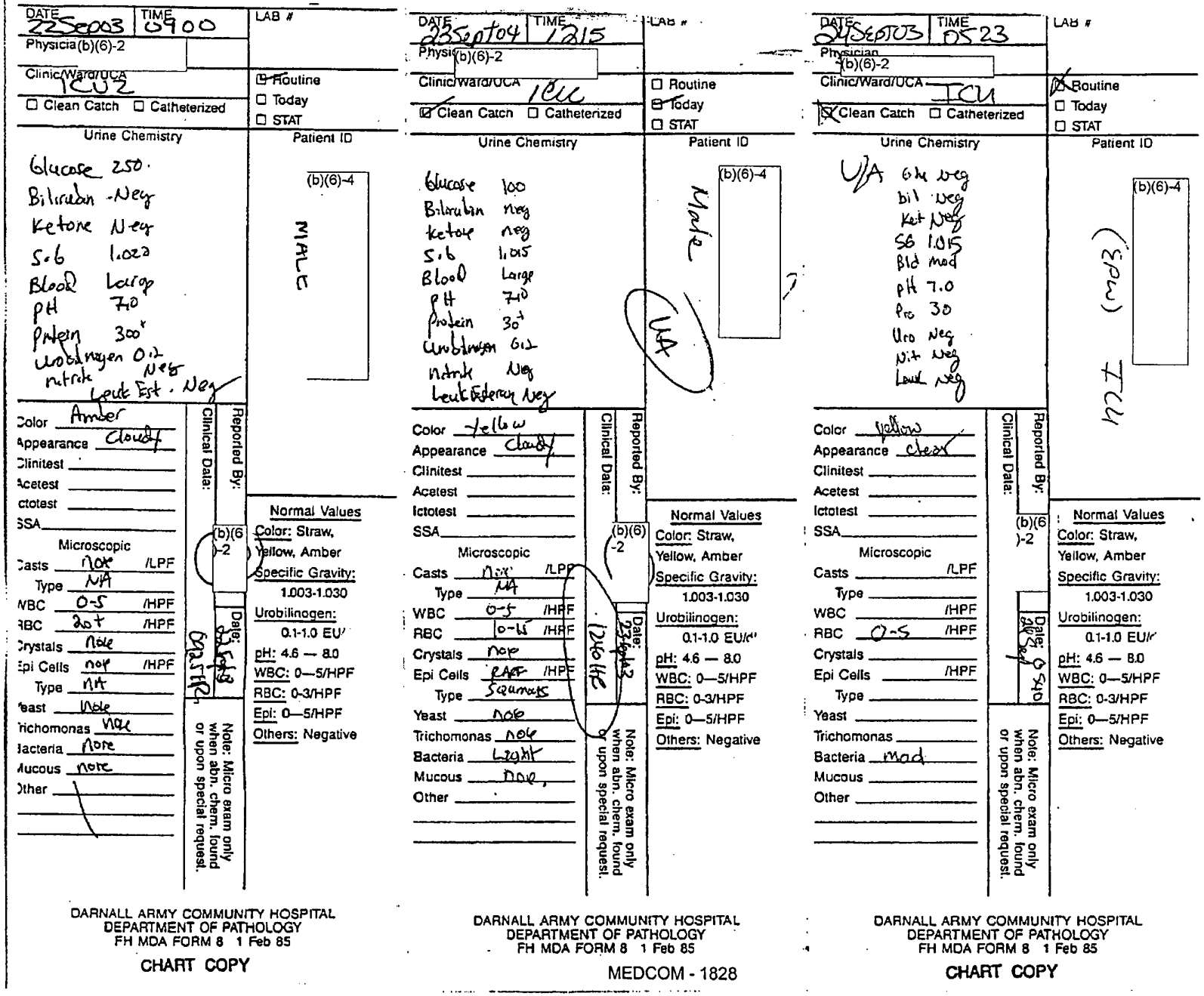
PRESCRIBED BY GSA ICMR FIRMR (41 CFR) 201-45.505

546-107




TEST(S)
SPECIMEN TAKEN
DATE 23 Sep 03
TIME 0525
A.M.
P.M.
RESULTS
REQUESTED
(X)
GLUCOSE
UREA N.
CREATININE
URIC ACID
SODIUM
3.0
POTASSIUM
CHLORIDE
CO2
PHOSPHATE
CALCIUM
TOTAL PROTEIN
ALBUMIN
GLOBULIN
ALKALINE PHOSPHATASE
ACID PHOSPHATASE
SGOT
LDH
CPK
BILIRUBIN (TOTAL)
BILIRUBIN (DIRECT)
CHOLESTEROL
TRIGLYCERIDES
AMYLASE
LIPASE
PROFILE (Specify)
REMARKS
(b)(6)-2
Enter in above space
REQUESTING PHYSICIAN'S SIGNATURE
PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REPORTED BY
(b)(6)-2
TECH
MD
DATE
23 Sep 03
(b)(6)-4
(spw)
ICU-2
CHEM 1
URGENCY
ROUTINE
TODAY
PRE-OP
STAT
PATIENT STATUS
BED
OUTPATIENT
AMB
NP
DOM
SPECIMEN SOURCE
BLOOD
OTHER (Specify)
LAB. ID. NO.
SPECIMEN/LAB. RPT. NO.
PATIENT'S MED. RECORD
CHEMISTRY I
STANDARD FORM 546 (Rev 8-77)
PRESCRIBED BY GSA ICMR
FIRMR (41 CFR) 201-45.505
546-107

ACLU-RDI 1099 p.612



DATE 22Sep03 | TIME 0900 | LAB #
Physician (b)(6)-2
Clinic/Ward/UCA ICU2
☐ Clean Catch ☐ Catheterized
☐ Routine ☐ Today ☐ STAT
Urine Chemistry
Glucose 250
Bilirubin Neg
Ketone Neg
S.G 1.023
Blood Large
pH 7.0
Protein 300+
Urobilinogen 0.2
nitrite Neg
Leuk Est. Neg
Patient ID
(b)(6)-4
MALE
Color Amber
Appearance Cloudy
Clinitest
Acetest
Ictotest
SSA
Microscopic
Casts None /LPF
Type NA
WBC 0-5 /HPF
RBC 20+ /HPF
Crystals None
Epi Cells None /HPF
Type NA
Yeast None
Trichomonas None
Bacteria None
Mucous None
Other
Clinical Data: (b)(6)-2
Reported By:
Date: 22Sep03
Note: Micro exam only when abn. chem. found or upon special request.
Normal Values
Color: Straw, Yellow, Amber
Specific Gravity: 1.003-1.030
Urobilinogen: 0.1-1.0 EU/
pH: 4.6 — 8.0
WBC: 0—5/HPF
RBC: 0-3/HPF
Epi: 0—5/HPF
Others: Negative

DARNALL army COMMUNITY HOSPITAL
DEPARTMENT OF PATHOLOGY
FH MDA FORM 8 1 Feb 85
CHART COPY

DATE 23Sep03 | TIME 1215 | LAB #
Physician (b)(6)-2
Clinic/Ward/UCA ICU
☑ Clean Catch ☐ Catheterized
☐ Routine ☐ Today ☐ STAT
Urine Chemistry
Glucose 100
Bilirubin neg
ketone neg
S.G 1.015
Blood Large
pH 7.0
Protein 30+
Urobilinogen 0.2
Nitrite Neg
Leuk Esterase Neg
Patient ID
(b)(6)-4
Male
UA
Color Yellow
Appearance Cloudy
Clinitest
Acetest
Ictotest
SSA
Microscopic
Casts None /LPF
Type NA
WBC 0-5 /HPF
RBC 0-5 /HPF
Crystals None
Epi Cells RARE /HPF
Type Squamous
Yeast None
Trichomonas None
Bacteria Light
Mucous None
Other
Clinical Data: (b)(6)-2
Reported By:
Date: 23Sep03
Note: Micro exam only when abn. chem. found or upon special request.
Normal Values
Color: Straw, Yellow, Amber
Specific Gravity: 1.003-1.030
Urobilinogen: 0.1-1.0 EU/
pH: 4.6 — 8.0
WBC: 0—5/HPF
RBC: 0-3/HPF
Epi: 0—5/HPF
Others: Negative

DARNALL ARMY COMMUNITY HOSPITAL
DEPARTMENT OF PATHOLOGY
FH MDA FORM 8 1 Feb 85
MEDCOM - 1828

DATE 24Sep03 | TIME 0523 | LAB #
Physician (b)(6)-2
Clinic/Ward/UCA ICU
☒ Clean Catch ☐ Catheterized
☒ Routine ☐ Today ☐ STAT
Urine Chemistry
UA
Glu Neg
bil Neg
Ket Neg
SG 1.015
Bld Mod
pH 7.0
Pro 30
Uro Neg
Nit Neg
Leuk Neg
Patient ID
(b)(6)-4
NCT (mdz)
Color Yellow
Appearance Clear
Clinitest
Acetest
Ictotest
SSA
Microscopic
Casts /LPF
Type
WBC /HPF
RBC 0-5 /HPF
Crystals
Epi Cells /HPF
Type
Yeast
Trichomonas
Bacteria Mod
Mucous
Other
Clinical Data: (b)(6)-2
Reported By:
Date: 24Sep03
Note: Micro exam only when abn. chem. found or upon special request.
Normal Values
Color: Straw, Yellow, Amber
Specific Gravity: 1.003-1.030
Urobilinogen: 0.1-1.0 EU/
pH: 4.6 — 8.0
WBC: 0—5/HPF
RBC: 0-3/HPF
Epi: 0—5/HPF
Others: Negative

DARNALL ARMY COMMUNITY HOSPITAL
DEPARTMENT OF PATHOLOGY
FH MDA FORM 8 1 Feb 85
CHART COPY

DOD 005880

TEST(S)
SPECIMEN TAKEN
DATE 13Sept03 TIME 1040 A.M. P.M.
REQUESTED
marlar Smear
RESULTS

Thin smear → No plasmodium species observed
Thick smears pending
1100 HRS 14 Sept → sample in cold - please resubmit
(b)(6)-2

MISCELLANEOUS
STANDARD FORM 557 (Rev. 3-77)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45-505
557-107

REMARKS
Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REQUESTING PHYSICIAN'S SIGNATURE (b)(6)-2
REPORTED BY (b)(6)-2
MD TECH
DATE 13 Sept 03
LAB ID NO.
SPECIMEN/LAB RPT. NO.

(b)(6)-4
34 yo male
tep of 100.9° Aux
ICU 1

MISC
URGENCY ☒ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT
PATIENT STATUS ☒ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM
SPECIMEN SOURCE (Specify)

PATIENT'S MED. RECORD

TEST(S)
SPECIMEN TAKEN
DATE 20Sep03 TIME 1430 A.M. P.M.
RESULTS REQUESTED (X)
ROUTINE
red/orange COLOR
cloudy SPECIFIC GRAVITY Clarity
2 UROBILINOGEN
large OCCULT BLOOD
neg BILE
neg KETONES
>2000 GLUCOSE
100 PROTEIN
8.0 pH
MICROSCOPIC
0-1 WBC
TNTC RBC
rare EPITH CELLS
WBC
RBC
HYALINE
GRANULAR
CASTS
Trace BACTERIA
CRYSTALS
MUCUS
NITRITE
BENCE-JONES PROTEIN
HEMOSIDERIN
HCG
1.019 SG
neg Nitrite
neg leuko

URINALYSIS
Standard Form 550 (Rev. 4-77)
General Services Administration and Interagency
Committee on Medical Records FIRMR (41 CFR) 201-45.505
B50-107

REMARKS
Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REQUESTING PHYSICIAN'S SIGNATURE (b)(6)-2
REPORTED BY (b)(6)-2
MD TECH
DATE 20Sep03
LAB. ID NO.
SPECIMEN/LAB RPT NO

(b)(6)-4
ICU 1
20 Sep 03
1430

URINALYSIS
URGENCY ☐ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT
PATIENT STATUS ☐ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM
SPECIMEN SOURCE ☐ ROUTINE ☐ OTHER (Specify)

PATIENTS MED. RECORD

(b)(6)-4
ICU 1

MISC
URGENCY ☐ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT
PATIENT STATUS ☐ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM
SPECIMEN SOURCE (Specify)

PATIENT'S MED. RECORD

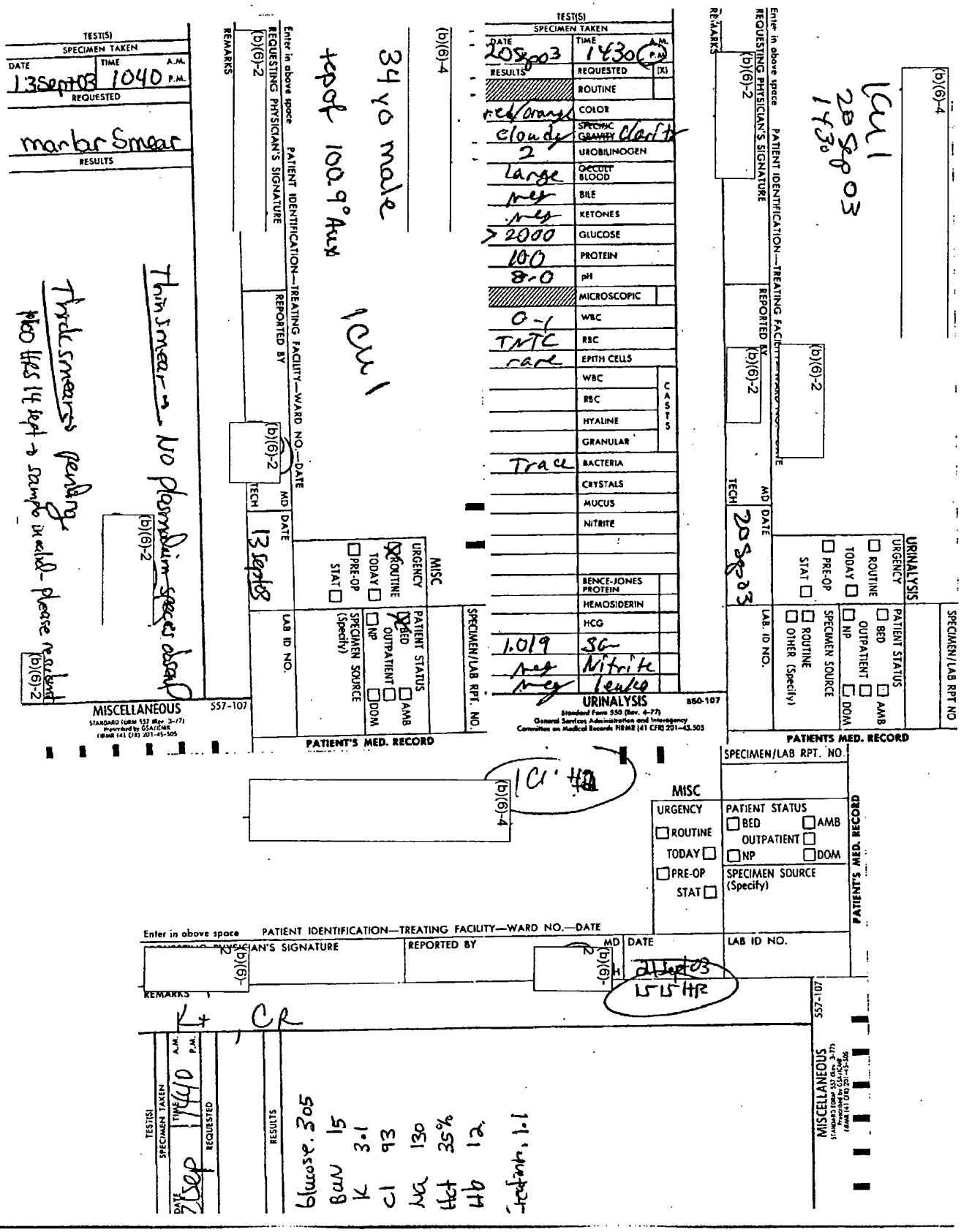
Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REQUESTING PHYSICIAN'S SIGNATURE (b)(6)-2
REPORTED BY (b)(6)-2
MD TECH
DATE 21Sept03
1515 HR
LAB ID NO.

REMARKS
K+, CR

TEST(S)
SPECIMEN TAKEN
DATE 21Sep TIME 1440 A.M. P.M.
REQUESTED
RESULTS
glucose 305
BUN 15
K 3.1
Cl 93
Na 130
Hct 35%
Hb 12
Creatinine 1.1

MISCELLANEOUS
STANDARD FORM 557 (Rev. 3-77)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45-505
557-107

MEDCOM - 1829



TEST(S)
SPECIMEN TAKEN
DATE 9/11/02 TIME 2200 A.M. P.M.
REQUESTED
MALARIAL SMEAR
RESULTS

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REQUESTING PHYSICIAN'S SIGNATURE (b)(6)-2
REMARKS
Malarial Smear
Thin no plasmodium seen
Thick - no plasmodium spp. seen
(b)(6)-2
(b)(6)-2
MD DATE 12 Sept
(b)(6)-4
ICU #1
MISC
URGENCY ☐ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT
PATIENT STATUS ☐ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM
SPECIMEN SOURCE (Specify)
LAB ID NO.
SPECIMEN/LAB RPT. NO.
PATIENT'S MED. RECORD
MISCELLANEOUS 557-107
STANDARD FORM 557 (Rev. 3-77) Prescribed by GSA/ICMR FIRMR (41 CFR) 201-45-505

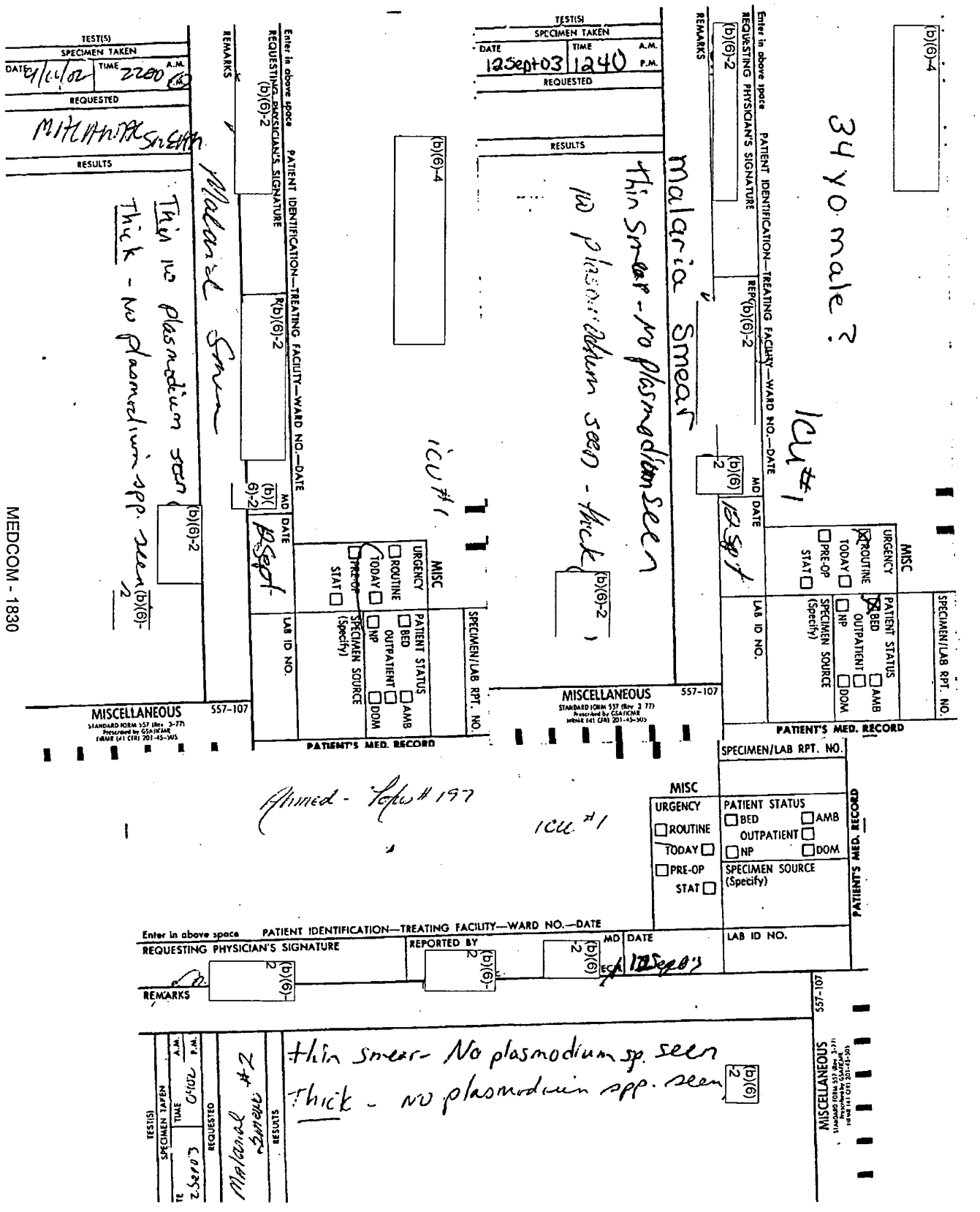
TEST(S)
SPECIMEN TAKEN
DATE 12Sept03 TIME 1240 A.M. P.M.
REQUESTED
RESULTS
Malaria Smear
Thin Smear - no plasmodium seen
no plasmodium seen - thick
(b)(6)-2
REMARKS
Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REQUESTING PHYSICIAN'S SIGNATURE (b)(6)-2
REP (b)(6)-2
MD DATE 12 Sept
(b)(6)-2
(b)(6)-4
34 yo male ?
ICU #1
MISC
URGENCY ☒ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT
PATIENT STATUS ☒ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM
SPECIMEN SOURCE (Specify)
LAB ID NO.
SPECIMEN/LAB RPT. NO.
PATIENT'S MED. RECORD
MISCELLANEOUS 557-107
STANDARD FORM 557 (Rev. 3-77) Prescribed by GSA/ICMR FIRMR (41 CFR) 201-45-505

Ahmed - Lopes # 197
ICU #1

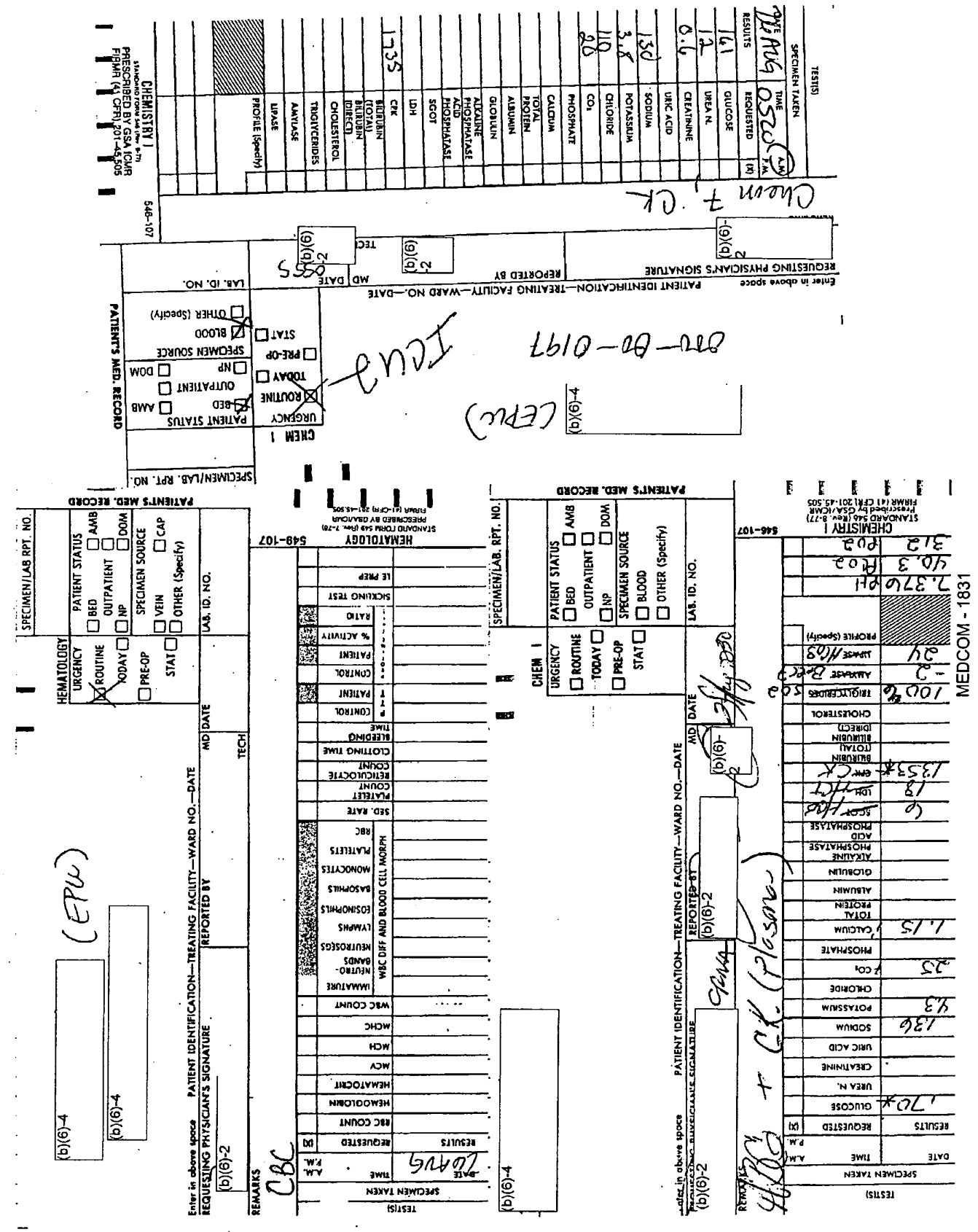
MISC
URGENCY ☐ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT
PATIENT STATUS ☐ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM
SPECIMEN SOURCE (Specify)
LAB ID NO.
SPECIMEN/LAB RPT. NO.
PATIENT'S MED. RECORD

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REQUESTING PHYSICIAN'S SIGNATURE (b)(6)-2
REPORTED BY (b)(6)-2
MD (b)(6)-2 DATE 12Sept03
REMARKS
(b)(6)-2
MISCELLANEOUS 557-107
STANDARD FORM 557 (Rev. 3-77) Prescribed by GSA/ICMR FIRMR (41 CFR) 201-45-505

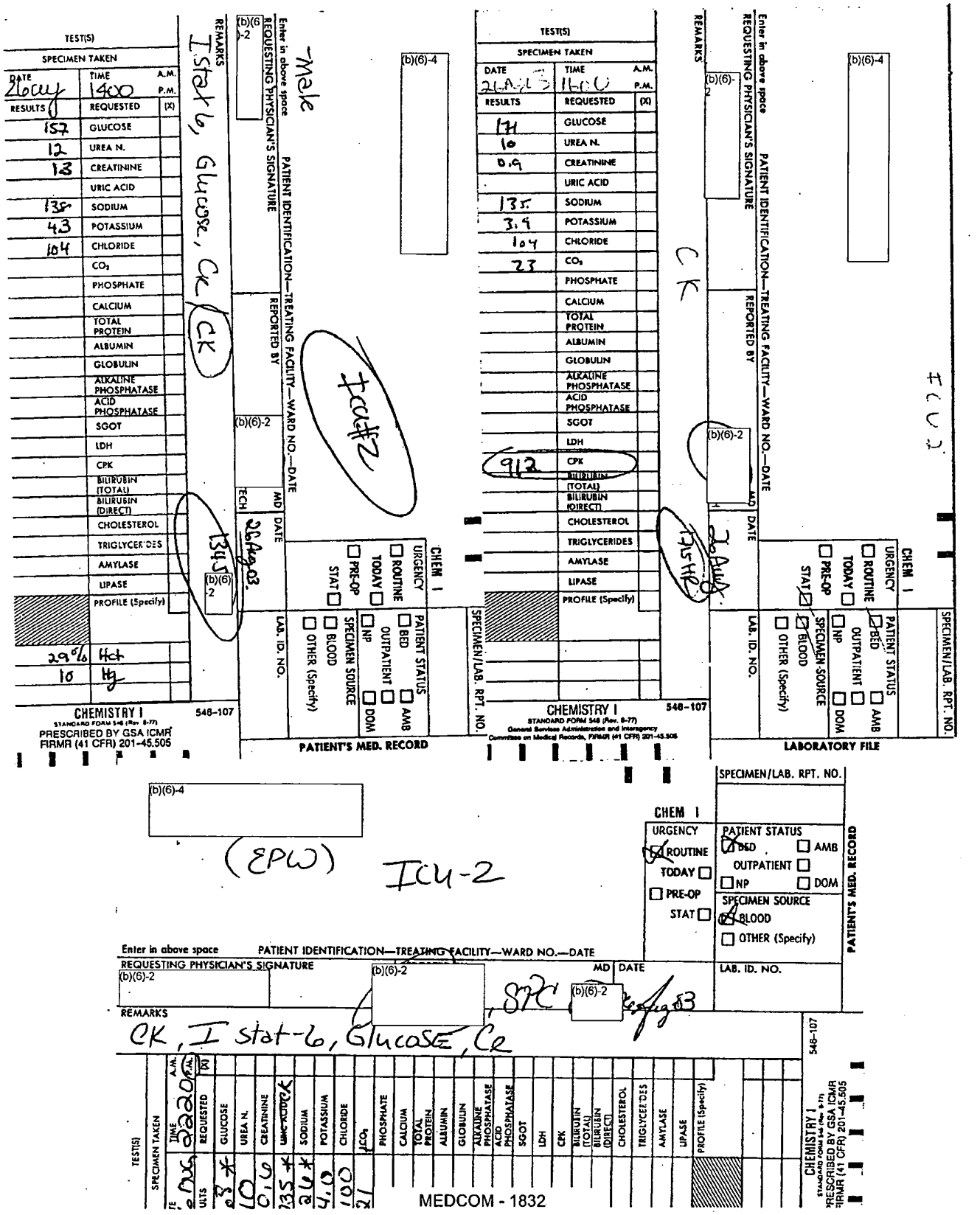
TEST(S)
SPECIMEN TAKEN
DATE 12Sept03 TIME 0402 A.M. P.M.
REQUESTED
Malarial Smear #2
RESULTS
thin smear - No plasmodium sp. seen
thick - no plasmodium spp. seen
(b)(6)-2



MEDCOM - 1830



MEDCOM - 1831


TEST(S)
SPECIMEN TAKEN
DATE
TIME
A.M. P.M.
RESULTS
REQUESTED
(X)
GLUCOSE
UREA N.
CREATININE
URIC ACID
SODIUM
POTASSIUM
CHLORIDE
CO2
PHOSPHATE
CALCIUM
TOTAL PROTEIN
ALBUMIN
GLOBULIN
ALKALINE PHOSPHATASE
ACID PHOSPHATASE
SGOT
LDH
CPK
BILIRUBIN (TOTAL)
BILIRUBIN (DIRECT)
CHOLESTEROL
TRIGLYCERIDES
AMYLASE
LIPASE
PROFILE (Specify)
REMARKS
Enter in above space
REQUESTING PHYSICIAN'S SIGNATURE
PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REPORTED BY
MD
DATE
CHEM 1
URGENCY
ROUTINE
TODAY
PRE-OP
STAT
PATIENT STATUS
BED
AMB
OUTPATIENT
NP
DOM
SPECIMEN SOURCE
BLOOD
OTHER (Specify)
LAB. ID. NO.
SPECIMEN/LAB. RPT. NO.
CHEMISTRY 1
548-107
PRESCRIBED BY GSA ICMR
FIRMR (41 CFR) 201-45.505
PATIENT'S MED. RECORD
LABORATORY FILE
Male
I stat 6, Glucose, CK
CK
Icu #2
157
12
13
135
4.3
104
29%
10
Hct
Hg
1345
26 Aug 03
(b)(6)-2
(b)(6)-4
TEST(S)
SPECIMEN TAKEN
DATE
TIME
A.M. P.M.
RESULTS
REQUESTED
(X)
171
10
0.9
135
3.9
104
23
912
CK
26 Aug 03
1515
REMARKS
Enter in above space
REQUESTING PHYSICIAN'S SIGNATURE
PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REPORTED BY
MD
DATE
CHEM 1
URGENCY
ROUTINE
TODAY
PRE-OP
STAT
PATIENT STATUS
BED
AMB
OUTPATIENT
NP
DOM
SPECIMEN SOURCE
BLOOD
OTHER (Specify)
LAB. ID. NO.
SPECIMEN/LAB. RPT. NO.
CHEMISTRY 1
548-107
PRESCRIBED BY GSA ICMR
FIRMR (41 CFR) 201-45.505
ICU
(EPW)
ICU-2
PATIENT'S MED. RECORD
CK, I stat-6, Glucose, Cr
26 Aug 03
MEDCOM - 1832

DATE 26 AUG 03 | TIME 2310 | LAB #

Physician (b)(6)-2

Clinic/Ward/UCA ICU-2

☐ Clean Catch ☒ Catheterized

☒ Routine ☐ Today ☐ STAT

Urine Chemistry

U/A c̄ micro

glu - Neg
bili - Neg
Ket Neg
SG 1.018
Bid pos
pH 5.5
prot Neg
uro Neg
Nit Neg
Leuk Neg

Patient ID (b)(6)-4

(CB)

Color yellow
Appearance clear
Clinitest
Acetest
Ictotest
SSA

Microscopic
Casts /LPF
Type
WBC 0-5 /HPF
RBC 5-10 /HPF
Crystals
Epi Cells Few /HPF
Type
Yeast
Trichomonas
Bacteria light
Mucous mod
Other

Clinical Data: (b)(6)-2

Reported By:

Date: 26 Aug 03

Note: Micro exam when abn. chem. or upon special re

Normal Values
Color: Straw, Yellow, Amber
Specific Gravity: 1.003-1.030
Urobilinogen: 0.1-1.0 EU/dl
pH: 4.6 — 8.0
WBC: 0—5/HPF
RBC: 0-3/HPF
Epi: 0—5/HPF
Others: Negative

DATE 26 Aug 03 | TIME 10 | LAB #

Physician (b)(6)-2

Clinic/Ward/UCA ICU 2

☐ Clean Catch ☒ Catheterized

☐ Routine ☐ Today ☒ STAT

Urine Chemistry

Glucose Neg
Bilirubin Neg
Ketone Neg
Sub - 1.030
Blood - Mod
pH 5.0
Protein Trace
urobilinogen Ok

Nitrite Neg
Leukocyte Neg

Patient ID (b)(6)-4

(Male)

EPN

ICU #2

Color yellow
Appearance clear
Clinitest
Acetest
Ictotest
SSA

Microscopic
Casts none /LPF
Type NA
WBC 0-5 /HPF
RBC 0-5 /HPF
Crystals none
Epi Cells none /HPF
Type NA
Yeast none
Trichomonas none
Bacteria Light
Mucous none
Other

Clinical Data: (b)(6)-2

Reported By:

Date: 26 Aug 03

1045 HR

Note: Micro exam when abn. chem. or upon special re

Normal Values
Color: Straw, Yellow, Amber
Specific Gravity: 1.003-1.030
Urobilinogen: 0.1-1.0 EU/dl
pH: 4.6 — 8.0
WBC: 0—5/HPF
RBC: 0-3/HPF
Epi: 0—5/HPF
Others: Negative

(b)(6)-4

(b)(6)-4

ICU-2

SPECIMEN/LAB RPT. NO.

HEMATOLOGY

URGENCY
☐ ROUTINE
TODAY ☐
☐ PRE-OP
STAT ☒

PATIENT STATUS
☐ BED ☐ AMB
OUTPATIENT ☐
☐ NP ☐ DOM

SPECIMEN SOURCE
☐ VEIN ☐ CAP
☐ OTHER (Specify)

PATIENTS MED. RECORD

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE (b)(6)-2

REPORTED BY (b)(6)-2

MD DATE 0127

TECH (b)(6)-2 03

LAB. ID. NO.

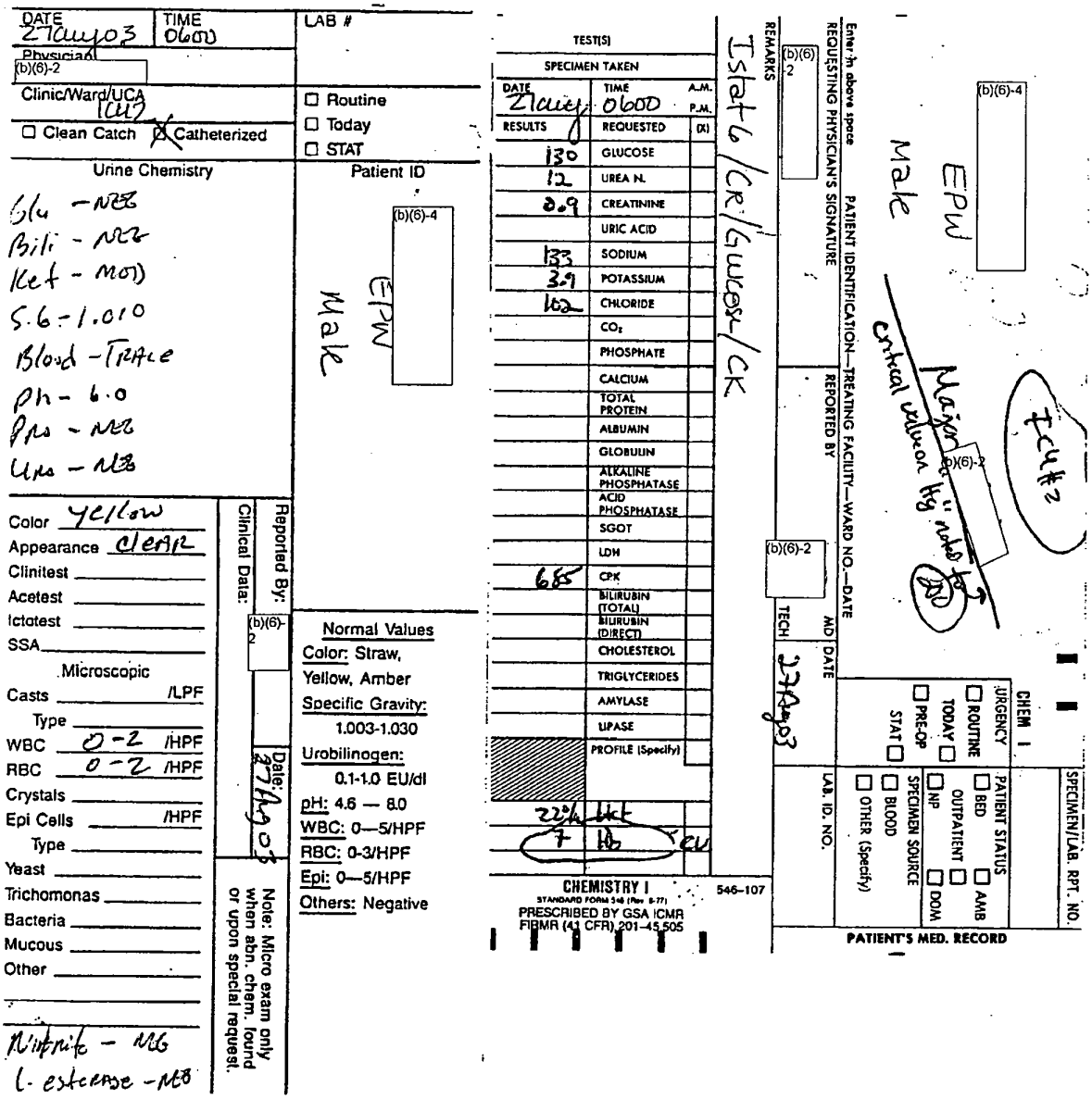
REMARKS CBC

549-107

TEST(S)	SPECIMEN TAKEN	TIME A.M. P.M.	REQUESTED (X)	RBC COUNT	HEMOGLOBIN	HEMATOCRIT	MCV	MCH	MCHC	WBC COUNT	WBC DIFF AND BLOOD CELL MORPH: IMMATURE	NEUTRO-BANDS	NEUTROSEGS	LYMPHS	EOSINOPHILS	BASOPHILS	MONOCYTES	PLATELETS	RBC	SED. RATE	PLATELET COUNT	RETICULOCYTE COUNT	CLOTTING TIME	BLEEDING TIME	PTT CONTROL	PTT PATIENT	CONTROL	PATIENT	% ACTIVITY	RATIO	SICKLING TEST	LE PREP	Ly #
	DATE 26 AUG		RESULTS	3.46	9.6	36.0	86.7	27.7	32.0	12.4				3.9				25															2.6

HEMATOLOGY
STANDARD FORM 549 (Rev. 2-78)
Prescribed by GSA/ICMR
FIRMR (41-CFR) 201-45.505

MEDCOM - 1833



DATE 27Aug03 | TIME 0600 | LAB #

Physician (b)(6)-2

Clinic/Ward/UCA ICU

☐ Clean Catch ☒ Catheterized

☐ Routine
☐ Today
☐ STAT

Urine Chemistry

Glu - NEG
Bili - NEG
Ket - MOD
S.G - 1.010
Blood - TRACE
Ph - 6.0
Pro - NEG
Uro - NEG

Patient ID (b)(6)-4

EPW
Male

Color Yellow
Appearance clear
Clinitest
Acetest
Ictotest
SSA

Microscopic
Casts /LPF
Type
WBC 0-2 /HPF
RBC 0-2 /HPF
Crystals
Epi Cells /HPF
Type
Yeast
Trichomonas
Bacteria
Mucous
Other

Nitrite - NEG
L. esterase - NEG

Reported By: (b)(6)-2
Clinical Data:
Date: 27Aug03

Note: Micro exam only when abn. chem. found or upon special request.

Normal Values
Color: Straw, Yellow, Amber
Specific Gravity: 1.003-1.030
Urobilinogen: 0.1-1.0 EU/dl
pH: 4.6 — 8.0
WBC: 0—5/HPF
RBC: 0-3/HPF
Epi: 0—5/HPF
Others: Negative

TEST(S)

SPECIMEN TAKEN

DATE	TIME	A.M. / P.M.
27Aug	0600	

RESULTS	REQUESTED	(X)
130	GLUCOSE	
12	UREA N.	
0.9	CREATININE	
	URIC ACID	
133	SODIUM	
3.9	POTASSIUM	
102	CHLORIDE	
	CO_2	
	PHOSPHATE	
	CALCIUM	
	TOTAL PROTEIN	
	ALBUMIN	
	GLOBULIN	
	ALKALINE PHOSPHATASE	
	ACID PHOSPHATASE	
	SGOT	
	LDH	
685	CPK	
	BILIRUBIN (TOTAL)	
	BILIRUBIN (DIRECT)	
	CHOLESTEROL	
	TRIGLYCERIDES	
	AMYLASE	
	LIPASE	
	PROFILE (Specify)	
22%	Hct	
7	Hb	

REMARKS: Istat 6/CR/Glucose/CK

CHEMISTRY I
STANDARD FORM 546 (Rev. 8-77)
PRESCRIBED BY GSA ICMR
FIRMR (41 CFR) 201-45.505
546-107

Enter in above space
REQUESTING PHYSICIAN'S SIGNATURE (b)(6)-2
PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REPORTED BY (b)(6)-2
MD DATE
TECH 27Aug03

(b)(6)-4
EPW
Male

Major
critical value on Hg notes to DD
ICU#2
(b)(6)-2

CHEM I
URGENCY ☐ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT ☐
PATIENT STATUS ☐ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM
SPECIMEN SOURCE ☐ BLOOD ☐ OTHER (Specify)
LAB. ID. NO.
SPECIMEN/LAB. RPT. NO.
PATIENT'S MED. RECORD

DARNALL ARMY COMMUNITY HOSPITAL
DEPARTMENT OF PATHOLOGY
FH MDA FORM 8 1 Feb 85

CHART COPY

MEDCOM - 1834

TEST(S)

SPECIMEN TAKEN

DATE	TIME
82803	0700 A.M. P.M.

REQUESTED

RESULTS

WBC - 10.8
RBC - 2.56
Hgb - 7.7
Hct - 22.5
MCV - 87.9
MCH - 29.9
MCHC - 34.0
PLT - 241
Ly % - 17.4
Ly # - 1.9

REMARKS

(b)(6)-2

CBC

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE

(b)(6)-4

(EPW)

MALE

ICU-2

REPORTED BY

(b)(6)-2

MD

DATE 28 Aug 03

MISC

URGENCY ☑ ROUTINE TODAY ☐ PRE-OP STAT ☐

PATIENT STATUS ☑ BED ☐ AMB OUTPATIENT ☐ ☐ NP ☐ DOM

SPECIMEN SOURCE (Specify) Blood

LAB ID NO.

SPECIMEN/LAB RPT. NO.

PATIENT'S MED. RECORD

MISCELLANEOUS 557-107

STANDARD FORM 557 (Rev. 2-77) Prescribed by GSA/ICMR FIRMR (41 CFR) 201-45-505

TEST(S)

SPECIMEN TAKEN

DATE	TIME
82803	0700 A.M. P.M.

RESULTS	REQUESTED	(X)
140	GLUCOSE	
11	UREA N.	
0.6	CREATININE	
	URIC ACID	
133	SODIUM	
4.0	POTASSIUM	
98	CHLORIDE	
24	CO_2	
	PHOSPHATE	
7.4	CALCIUM	
	TOTAL PROTEIN	
	ALBUMIN	
	GLOBULIN	
	ALKALINE PHOSPHATASE	
	ACID PHOSPHATASE	
	SGOT	
	LDH	
621	CPK	
	BILIRUBIN (TOTAL)	
	BILIRUBIN (DIRECT)	
	CHOLESTEROL	
	TRIGLYCERIDES	
	AMYLASE	
	LIPASE	
	PROFILE (Specify)	

Chem-7

REMARKS

(b)(6)-2

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE

(b)(6)-4

(EPW)

MALE

ICU-2

REPORTED BY

(b)(6)-2

MD

DATE 28 Aug 03

CHEM 1

URGENCY ☑ ROUTINE TODAY ☐ PRE-OP STAT ☐

PATIENT STATUS ☑ BED ☐ AMB OUTPATIENT ☐ ☐ NP ☐ DOM

SPECIMEN SOURCE ☑ BLOOD ☐ OTHER (Specify)

LAB. ID. NO.

SPECIMEN/LAB. RPT. NO.

PATIENT'S MED. RECORD

CHEMISTRY I 546-107

STANDARD FORM 546 (Rev. 8-77) PRESCRIBED BY GSA ICMR FIRMR (41 CFR) 201-45-505

(b)(6)-4

SPECIMEN/LAB. RPT. NO.

CHEM 1

URGENCY ☐ ROUTINE TODAY ☐ ☐ PRE-OP STAT ☐

PATIENT STATUS ☐ BED ☐ AMB OUTPATIENT ☐ ☐ NP ☐ DOM

SPECIMEN SOURCE ☐ BLOOD ☐ OTHER (Specify)

PATIENT'S MED. RECORD

ICU-2

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE

(b)(6)-2

REPORTED BY

(b)(6)-2

MD

(b)(6)-2

DATE 30 Aug 03

LAB. ID. NO.

REMARKS

~~SMA-7, LFTs~~ Istat 6, Cr. Istat 12

TEST(S)

SPECIMEN TAKEN

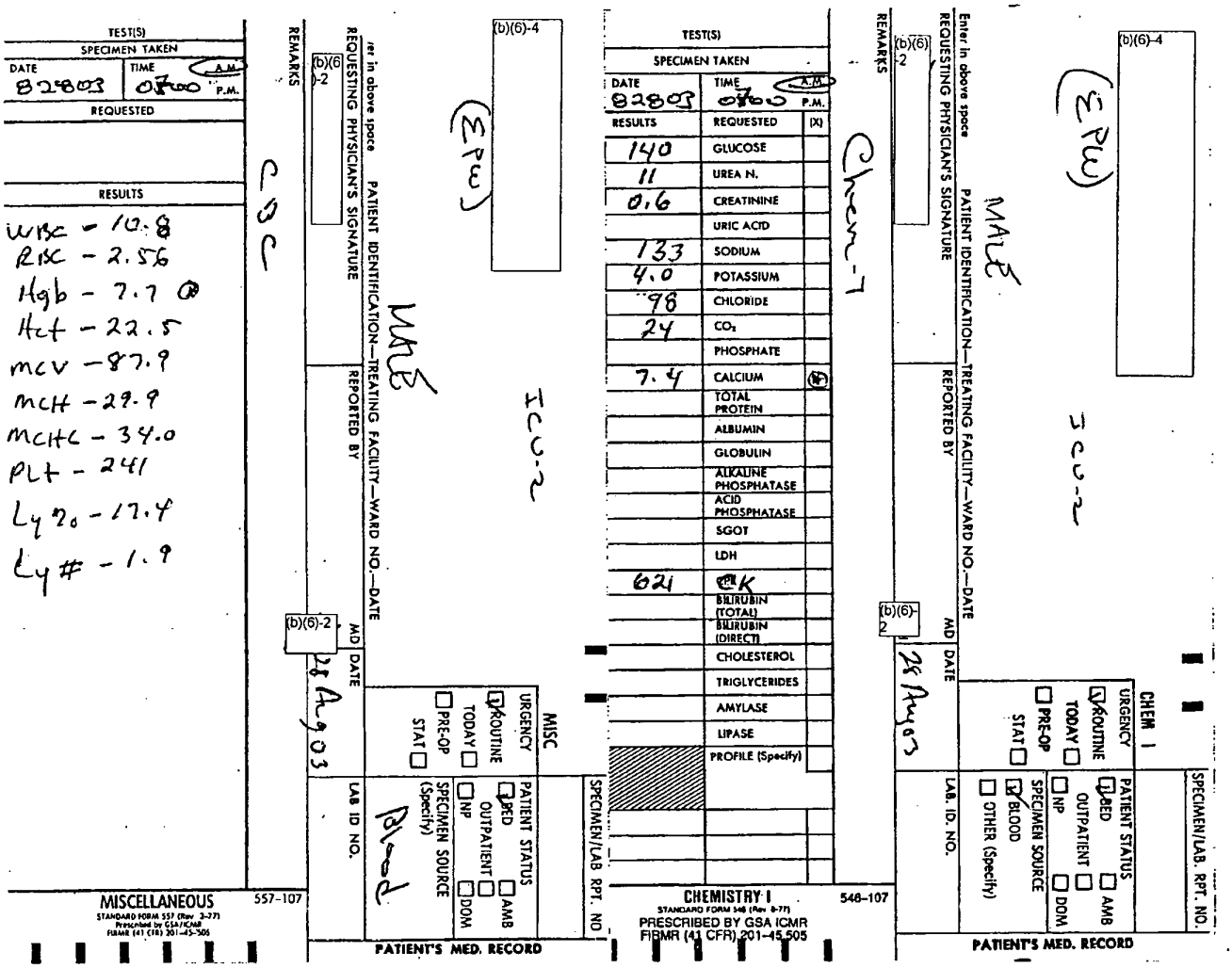
DATE	TIME	A.M.	P.M.
30 Aug			

RESULTS	REQUESTED	(X)
187	GLUCOSE	
15	UREA N.	
0.9*	CREATININE	
	URIC ACID	
129	SODIUM	
3.2	POTASSIUM	
95	CHLORIDE	
	CO_2	
	PHOSPHATE	
7.6*	CALCIUM #	
5.3*	TOTAL PROTEIN	
1.4*	ALBUMIN	
	GLOBULIN	
97*	ALKALINE PHOSPHATASE	
	ACID PHOSPHATASE	
	SGOT	
	LDH	
	CPK	
1.0	BILIRUBIN (TOTAL)	
	BILIRUBIN (DIRECT)	
90*	CHOLESTEROL	
	TRIGLYCERIDES	
25	AMYLASE	
	LIPASE	
	PROFILE (Specify)	
27	ALT	
65*	AST	

546-107

CHEMISTRY I

STANDARD FORM 546 (Rev. 8-77) PRESCRIBED BY GSA ICMR FIRMR (41 CFR) 201-45-505



MEDCOM - 1835

TEST(S)

SPECIMEN TAKEN

DATE	TIME	A.M. P.M.
31 Aug 03	0437	

RESULTS	REQUESTED	(X)
2.30	RBC COUNT	
6.8	HEMOGLOBIN	
20.2	HEMATOCRIT	
87.7	MCV	
29.8	MCH	
34.0	MCHC	
18.2	WBC COUNT	
	WBC DIFF AND BLOOD CELL MORPH: IMMATURE	
	NEUTRO-BANDS	
	NEUTROSEGS	
	LYMPHS	
	EOSINOPHILS	
	BASOPHILS	
	MONOCYTES	
	PLATELETS	
	RBC	
	SED. RATE	
318	PLATELET COUNT	
	RETICULOCYTE COUNT	
	CLOTTING TIME	
	BLEEDING TIME	
	PTT: CONTROL	
	PATIENT	
	PTT: CONTROL	
	PATIENT	
	% ACTIVITY	
	RATIO	
	SICKLING TEST	
5.7	Lg %	
1.0	Lg #	

REMARKS: CBC

(b)(6)-2

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE

REPORTED BY

MD DATE 31 Aug 03

(b)(6)-4

FCU-2

HEMATOLOGY

URGENCY: ☐ ROUTINE ☒ PRE-OP ☐ TODAY ☐ STAT ☐

PATIENT STATUS: ☒ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM

SPECIMEN SOURCE: ☒ VEIN ☐ CAP ☐ OTHER (Specify)

LAB. ID. NO.

SPECIMEN/LAB RPT. NO.

PATIENT'S MED. RECORD

HEMATOLOGY 549-107

STANDARD FORM 549 (Rev. 7-78)
PRESCRIBED BY GSA/ICMR
FIRMR (41-CFR) 201-45 505

TEST(S)

SPECIMEN TAKEN

DATE	TIME	A.M. P.M.
31 Aug	0930	

RESULTS	REQUESTED	(X)
3.26	RBC COUNT	
9.6	HEMOGLOBIN	
28.5	HEMATOCRIT	
87.6	MCV	
29.5	MCH	
33.7	MCHC	
21.5	WBC COUNT	
3	WBC DIFF AND BLOOD CELL MORPH: IMMATURE	
23	NEUTRO-BANDS	
65	NEUTROSEGS	
7	LYMPHS	
0	EOSINOPHILS	
0	BASOPHILS	
2	MONOCYTES	
3-6 Adequate	PLATELETS Giant platelets	
Aniso & Poikilocytosis		
	SED. RATE	
406.	PLATELET COUNT	
	RETICULOCYTE COUNT	
	CLOTTING TIME	
	BLEEDING TIME	
	PTT: CONTROL	
	PATIENT	
	PTT: CONTROL	
	PATIENT	
	% ACTIVITY	
	RATIO	
	SICKLING TEST	
5.0	Lg %	
1.1	Lg #	

REMARKS

(b)(6)-2

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE

REPORTED BY

MD DATE 31 Aug 03

(b)(6)-4

Mdc.

FCU#2

1055 HR

HEMATOLOGY

URGENCY: ☐ ROUTINE ☐ PRE-OP ☐ TODAY ☐ STAT ☐

PATIENT STATUS: ☐ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM

SPECIMEN SOURCE: ☐ VEIN ☐ CAP ☐ OTHER (Specify)

LAB. ID. NO.

SPECIMEN/LAB RPT. NO.

PATIENT'S MED. RECORD

HEMATOLOGY 549-107

STANDARD FORM 549 (Rev. 7-78)
PRESCRIBED BY GSA/ICMR
FIRMR (41-CFR) 201-45 505

(b)(6)-4

FCU#2

Male

Differential pending

HEMATOLOGY

URGENCY: ☐ ROUTINE ☐ TODAY ☐ PRE-OP ☒ STAT

PATIENT STATUS: ☐ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM

SPECIMEN SOURCE: ☐ VEIN ☐ CAP ☐ OTHER (Specify)

PATIENT'S MED. RECORD

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE (b)(6)-2

REPORTED BY (b)(6)-2

DATE 31 Aug 03

LAB. ID. NO.

REMARKS: CBC

0944 HR

TEST(S)

SPECIMEN TAKEN

DATE	TIME	A.M. P.M.
31 Aug	0930	

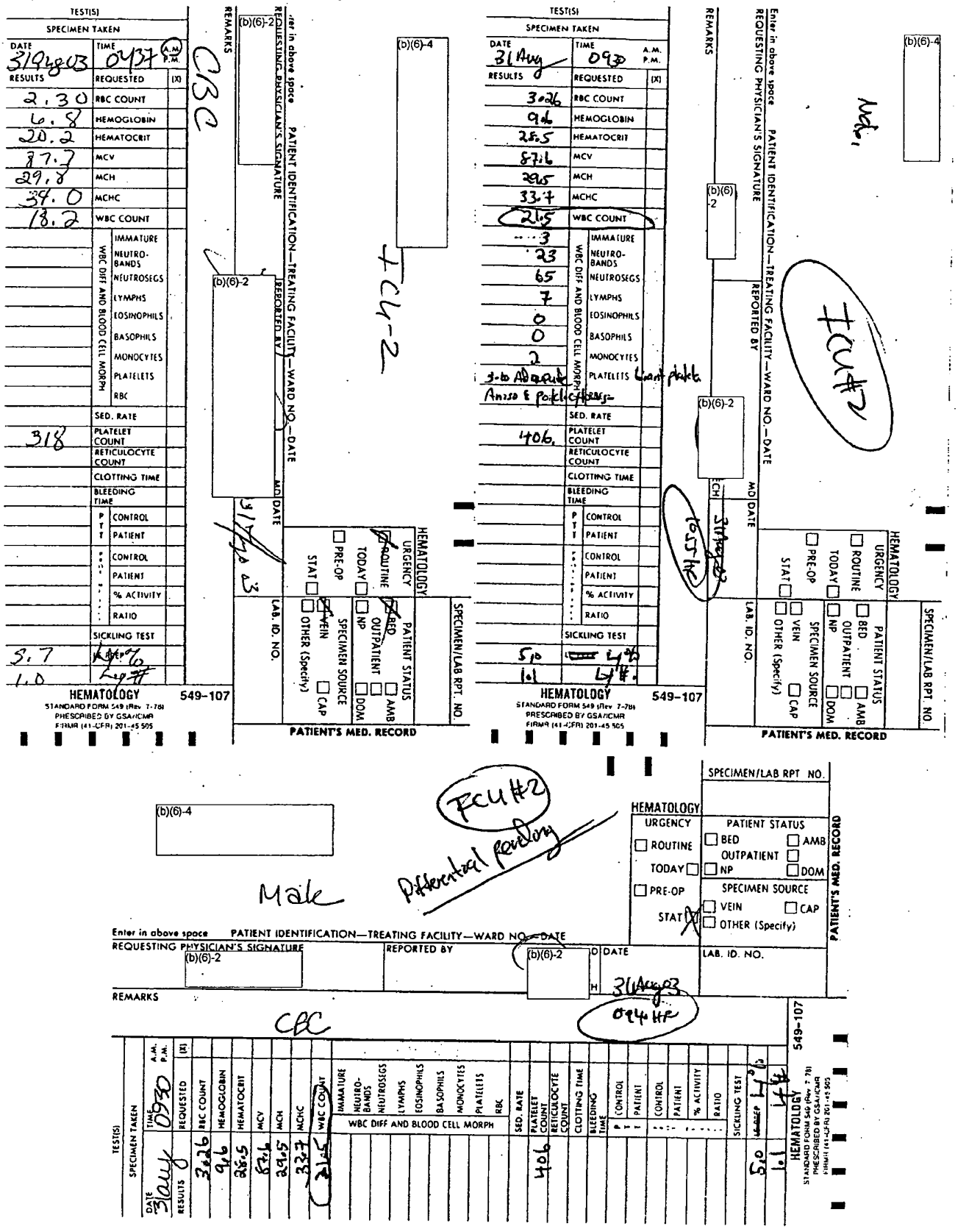
RESULTS	REQUESTED	(X)
3.26	RBC COUNT	
9.6	HEMOGLOBIN	
28.5	HEMATOCRIT	
87.6	MCV	
29.5	MCH	
33.7	MCHC	
21.5	WBC COUNT	

WBC DIFF AND BLOOD CELL MORPH: IMMATURE, NEUTRO-BANDS, NEUTROSEGS, LYMPHS, EOSINOPHILS, BASOPHILS, MONOCYTES, PLATELETS, RBC

SED. RATE	PLATELET COUNT	RETICULOCYTE COUNT	CLOTTING TIME	BLEEDING TIME	PTT CONTROL	PTT PATIENT	CONTROL	PATIENT	% ACTIVITY	RATIO	SICKLING TEST	LG %	LG #
	406											5.0	1.1

HEMATOLOGY 549-107

STANDARD FORM 549 (Rev. 7-78)
PRESCRIBED BY GSA/ICMR
FIRMR (41-CFR) 201-45 505



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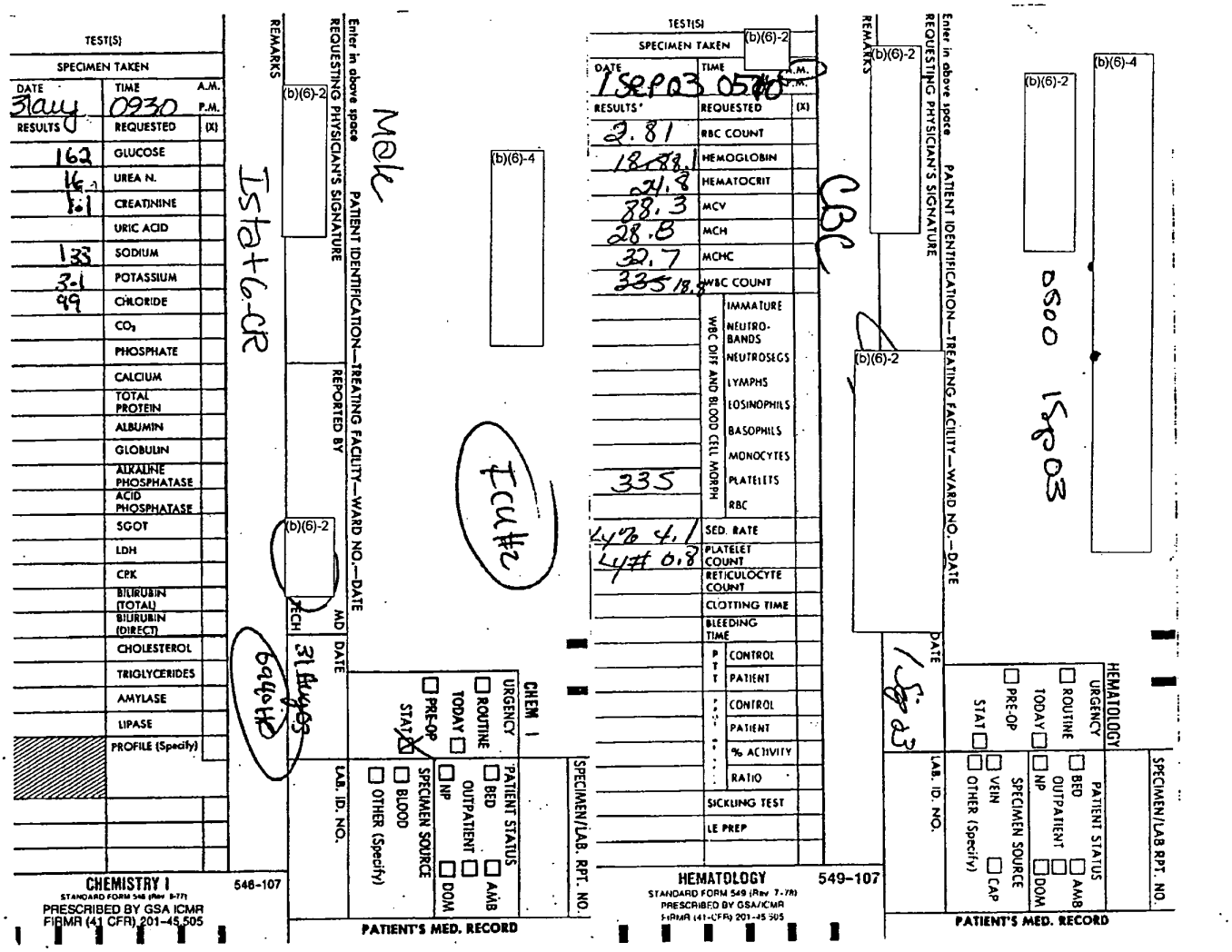


TEST(S)

SPECIMEN TAKEN

DATE	TIME	A.M. / P.M.
31 Aug	0930	

RESULTS	REQUESTED	(X)
162	GLUCOSE	
16	UREA N.	
1.1	CREATININE	
	URIC ACID	
133	SODIUM	
3.1	POTASSIUM	
99	CHLORIDE	
	CO_2	
	PHOSPHATE	
	CALCIUM	
	TOTAL PROTEIN	
	ALBUMIN	
	GLOBULIN	
	ALKALINE PHOSPHATASE	
	ACID PHOSPHATASE	
	SGOT	
	LDH	
	CPK	
	BILIRUBIN (TOTAL)	
	BILIRUBIN (DIRECT)	
	CHOLESTEROL	
	TRIGLYCERIDES	
	AMYLASE	
	LIPASE	
	PROFILE (Specify)	

REMARKS

Ista+6-CR

(b)(6)-2

Enter in above space REQUESTING PHYSICIAN'S SIGNATURE

Mole

PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

(b)(6)-4

REPORTED BY

(b)(6)-2

TECH

MD

DATE

31 Aug 03

0940 HP

ICU #2

CHEM I

URGENCY ☐ ROUTINE ☐ TODAY ☐ PRE-OP ☒ STAT

PATIENT STATUS ☐ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM

SPECIMEN SOURCE ☐ BLOOD ☐ OTHER (Specify)

LAB. ID. NO.

SPECIMEN/LAB. RPT. NO.

PATIENT'S MED. RECORD

CHEMISTRY I

STANDARD FORM 548 (Rev 8-77)

PRESCRIBED BY GSA ICMR

FIRMR (41 CFR) 201-45.505

548-107

TEST(S)

SPECIMEN TAKEN

(b)(6)-2

DATE	TIME	A.M. / P.M.
1 Sep 03	0500	

RESULTS	REQUESTED	(X)
2.81	RBC COUNT	
18.88.1	HEMOGLOBIN	
24.8	HEMATOCRIT	
88.3	MCV	
28.8	MCH	
32.7	MCHC	
335 18.8	WBC COUNT	
	WBC DIFF AND BLOOD CELL MORPH: IMMATURE	
	NEUTRO-BANDS	
	NEUTROSEGS	
	LYMPHS	
	EOSINOPHILS	
	BASOPHILS	
	MONOCYTES	
335	PLATELETS	
	RBC	
Ly% 4.1	SED. RATE	
Ly# 0.8	PLATELET COUNT	
	RETICULOCYTE COUNT	
	CLOTTING TIME	
	BLEEDING TIME	
	PTT CONTROL	
	PTT PATIENT	
	PT CONTROL	
	PT PATIENT	
	% ACTIVITY	
	RATIO	
	SICKLING TEST	
	LE PREP	

REMARKS

(b)(6)-2

CBC

(b)(6)-2

Enter in above space REQUESTING PHYSICIAN'S SIGNATURE

PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

(b)(6)-2

(b)(6)-4

0500 1 Sep 03

DATE

1 Sep 03

HEMATOLOGY

URGENCY ☐ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT

PATIENT STATUS ☐ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM

SPECIMEN SOURCE ☐ VEIN ☐ CAP ☐ OTHER (Specify)

LAB. ID. NO.

SPECIMEN/LAB RPT. NO.

PATIENT'S MED. RECORD

HEMATOLOGY

STANDARD FORM 549 (Rev 7-78)

PRESCRIBED BY GSA/ICMR

FIRMR (41-CFR) 201-45.505

549-107

TEST(S)

SPECIMEN TAKEN

DATE 9/2/03 TIME 0600 A.M. P.M.

RESULTS	REQUESTED	(X)
2.57	RBC COUNT	
7.4	HEMOGLOBIN	
22.6	HEMATOCRIT	
87.7	MCV	
28.7	MCH	
32.7	MCHC	
10.0	WBC COUNT	
	WBC DIFF AND BLOOD CELL MORPH: IMMATURE	
	NEUTRO-BANDS	
	NEUTROSEGS	
	LYMPHS	
	EOSINOPHILS	
	BASOPHILS	
	MONOCYTES	
251	PLATELETS	
	RBC	
	SED. RATE	
251	PLATELET COUNT	
	RETICULOCYTE COUNT	
	CLOTTING TIME	
	BLEEDING TIME	
	PTT: CONTROL	
	PATIENT	
	PTT: CONTROL	
	PATIENT	
	% ACTIVITY	
	RATIO	
	SICKLING TEST	
8.2	LE [illegible]	
0.8	LY#	

CBC

HEMATOLOGY 549-107

STANDARD FORM 549 (Rev. 7-78)
PRESCRIBED BY GSA/ICMR
FIRMR (41-CFR) 201-45.505

REMARKS (b)(6)-2

Enter in above space REQUESTING PHYSICIAN'S SIGNATURE

PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

(b)(6)-4

(b)(6)-2

(b)(6)-2

MD DATE 9/2/03

HEMATOLOGY: URGENCY ☑ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT

PATIENT STATUS: ☐ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM

SPECIMEN SOURCE: ☐ VEIN ☐ CAP ☐ OTHER (Specify)

LAB. ID. NO.

SPECIMEN/LAB RPT. NO.

PATIENT'S MED. RECORD

ICU #2

TEST(S)

SPECIMEN TAKEN

DATE 9/2/03 TIME 0600 A.M. P.M.

RESULTS	REQUESTED	(X)
197	GLUCOSE	
18	UREA N.	
0.8	CREATININE	
	URIC ACID	
144	SODIUM	
3.8	POTASSIUM	
111	CHLORIDE	
	CO_2	
	PHOSPHATE	
	CALCIUM	
	TOTAL PROTEIN	
	ALBUMIN	
	GLOBULIN	
	ALKALINE PHOSPHATASE	
	ACID PHOSPHATASE	
	SGOT	
	LDH	
	CPK	
	BILIRUBIN (TOTAL)	
	BILIRUBIN (DIRECT)	
	CHOLESTEROL	
	TRIGLYCERIDES	
	AMYLASE	
	LIPASE	
	PROFILE (Specify)	X
	iSTAT-6	
	Creat	X

CHEMISTRY I 546-107

STANDARD FORM 546 (Rev. 8-77)
PRESCRIBED BY GSA ICMR
FIRMR (41 CFR) 201-45.505

REMARKS (b)(6)-2

Enter in above space REQUESTING PHYSICIAN'S SIGNATURE

PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

(b)(6)-4

(b)(6)-2

(b)(6)-2

REPORTED BY

(b)(6)-2

MD DATE 9/2/03

CHEM I: URGENCY ☐ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT

PATIENT STATUS: ☐ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM

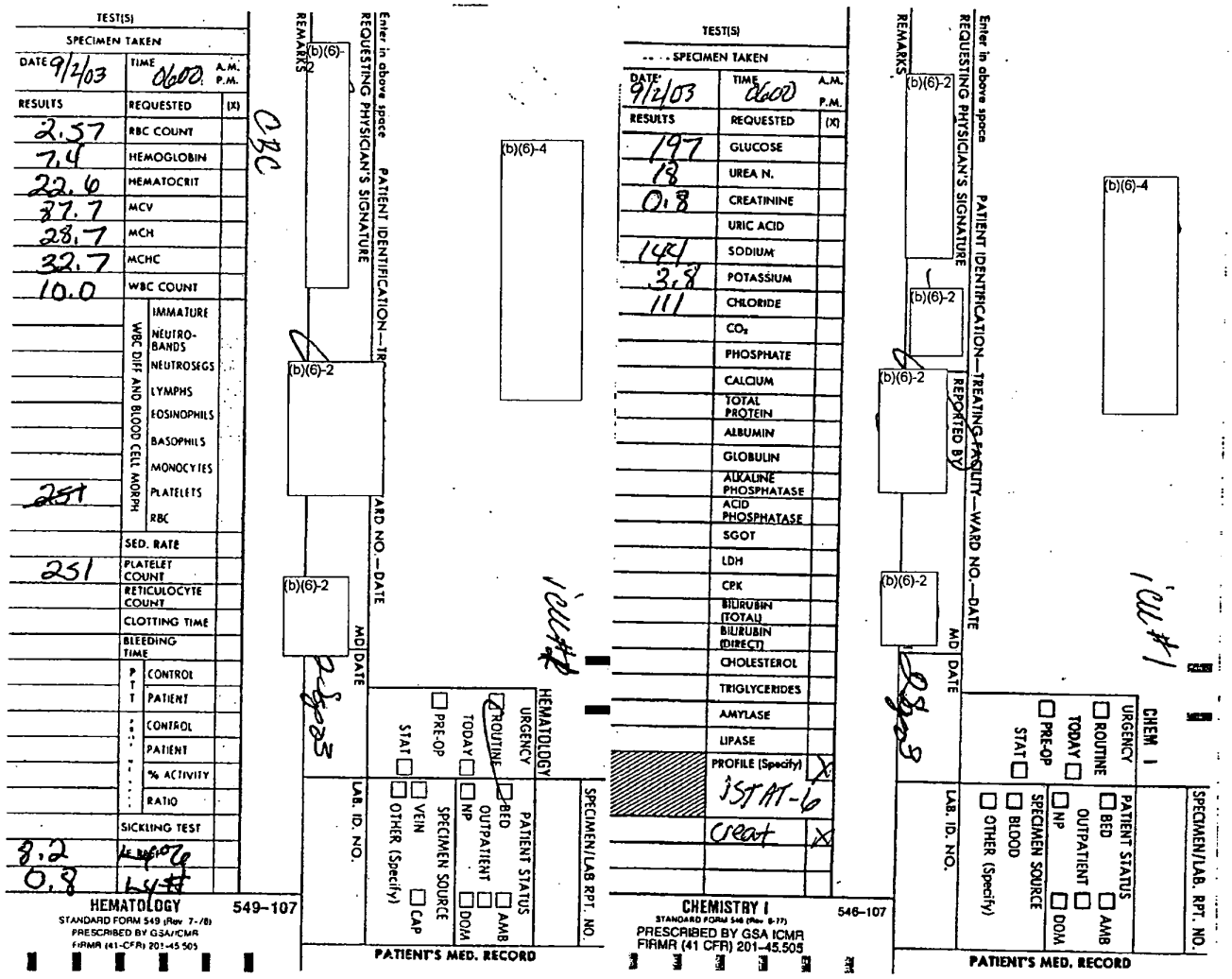
SPECIMEN SOURCE: ☐ BLOOD ☐ OTHER (Specify)

LAB. ID. NO.

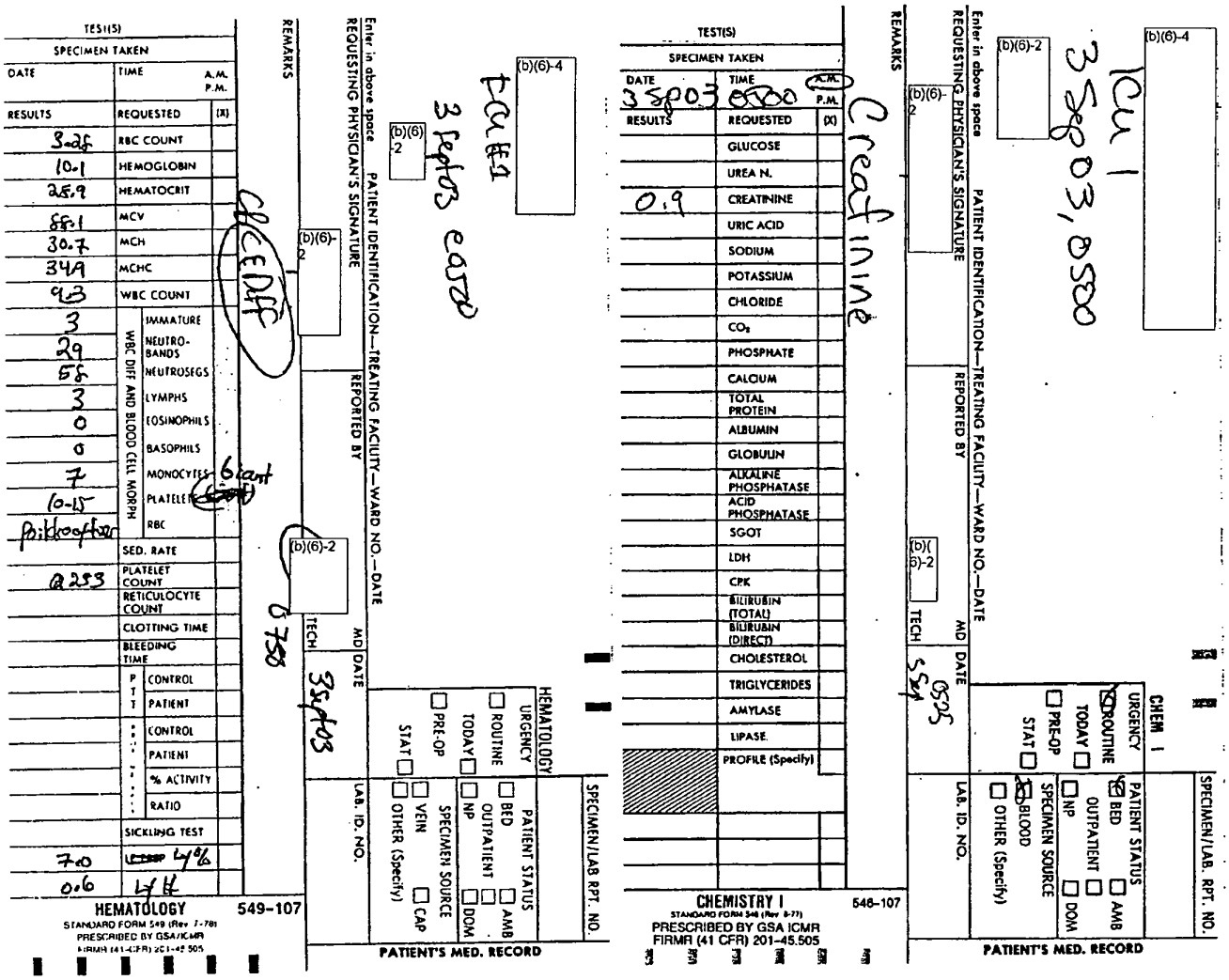
SPECIMEN/LAB. RPT. NO.

PATIENT'S MED. RECORD

ICU #1

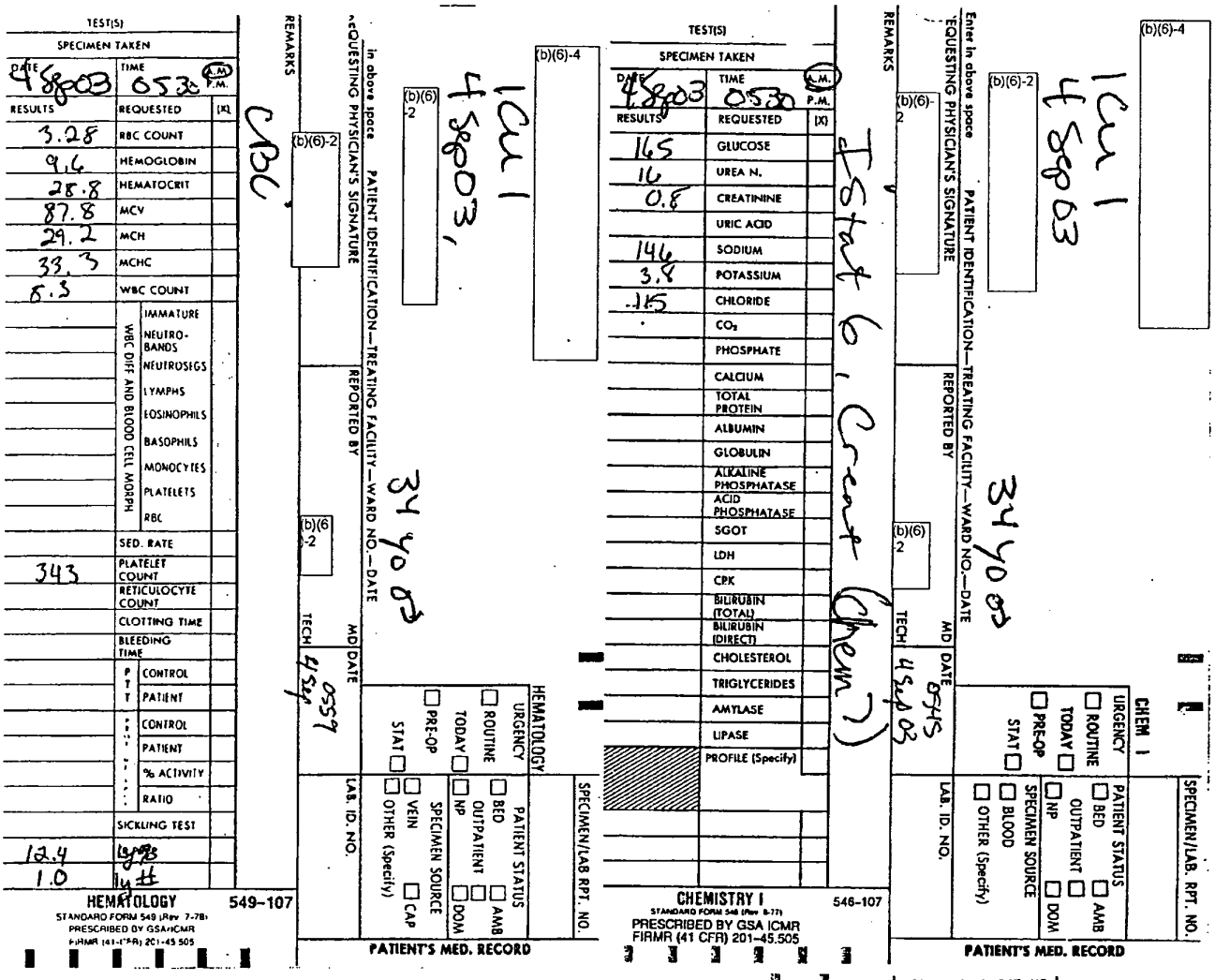


MEDCOM - 1838

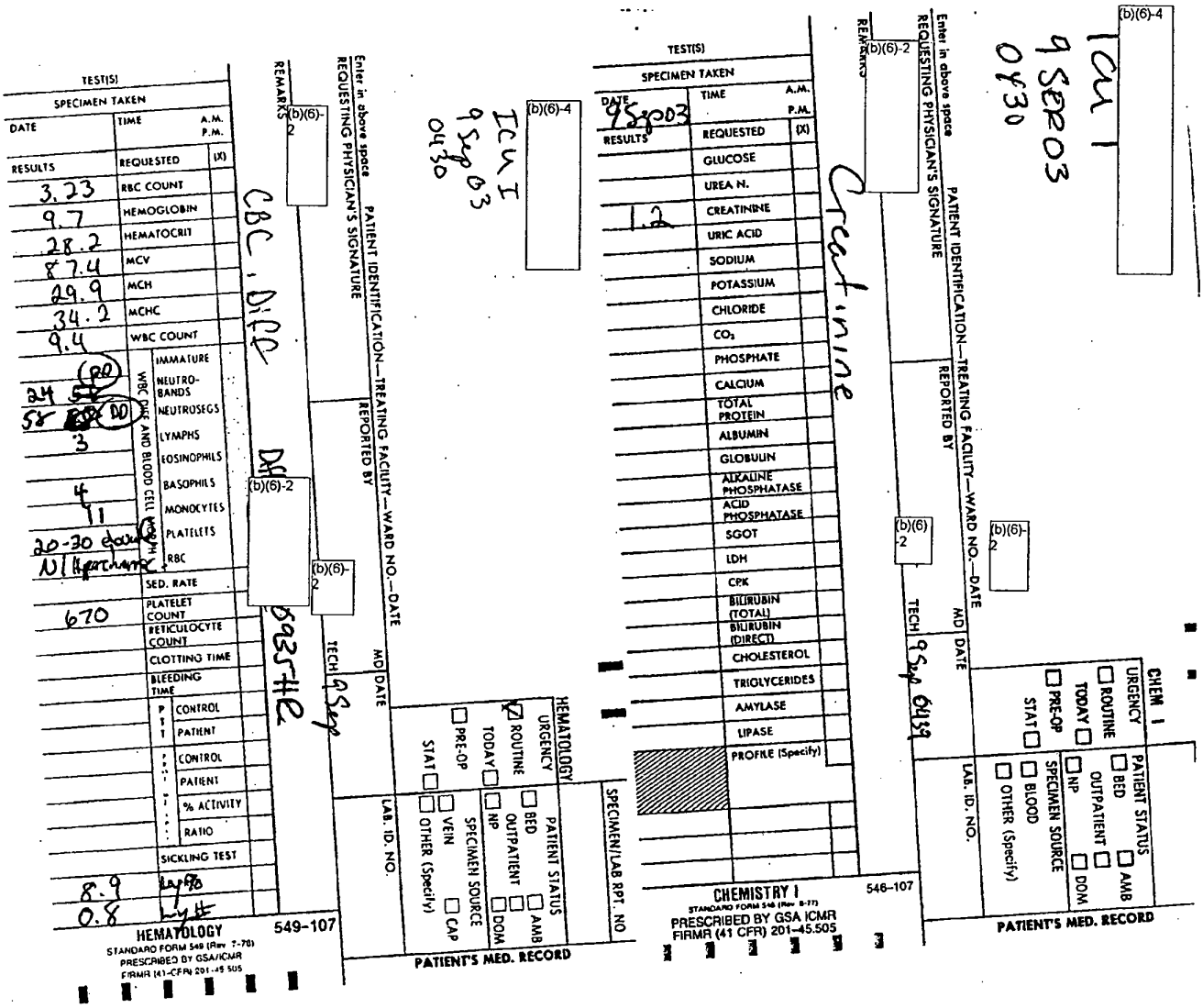


ACLU-RDI 1099 p.623

DOD 005891


TEST(S)
SPECIMEN TAKEN
DATE 4 Sep 03
TIME 0530 A.M. P.M.
RESULTS
REQUESTED
3.28 RBC COUNT
9.6 HEMOGLOBIN
28.8 HEMATOCRIT
87.8 MCV
29.2 MCH
33.3 MCHC
5.3 WBC COUNT
IMMATURE
WBC DIFF AND BLOOD CELL MORPH
NEUTRO-BANDS
NEUTROSEGS
LYMPHS
EOSINOPHILS
BASOPHILS
MONOCYTES
PLATELETS
RBC
SED. RATE
343 PLATELET COUNT
RETICULOCYTE COUNT
CLOTTING TIME
BLEEDING TIME
PTT CONTROL
PTT PATIENT
CONTROL
PATIENT
% ACTIVITY
RATIO
SICKLING TEST
12.4 Hgb
1.0 Hct
CBC
REMARKS
Enter in above space
REQUESTING PHYSICIAN'S SIGNATURE
PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REPORTED BY
MD
DATE
TECH
(b)(6)-2
(b)(6)-4
1 Cu 1 4 Sep 03
34 yo ♂
STAT
PRE-OP
TODAY
ROUTINE
URGENCY
HEMATOLOGY
BED
OUTPATIENT
NP
DOM
AMB
PATIENT STATUS
VEIN
CAP
OTHER (Specify)
SPECIMEN SOURCE
LAB. ID. NO.
SPECIMEN/LAB. RPT. NO.
PATIENT'S MED. RECORD
HEMATOLOGY
STANDARD FORM 549 (Rev 7-78)
PRESCRIBED BY GSA/ICMR
FIRMR (41 CFR) 201-45.505
549-107
TEST(S)
SPECIMEN TAKEN
DATE 4 Sep 03
TIME 0530 A.M. P.M.
RESULTS
REQUESTED
16.5 GLUCOSE
16 UREA N.
0.8 CREATININE
URIC ACID
146 SODIUM
3.8 POTASSIUM
115 CHLORIDE
CO2
PHOSPHATE
CALCIUM
TOTAL PROTEIN
ALBUMIN
GLOBULIN
ALKALINE PHOSPHATASE
ACID PHOSPHATASE
SGOT
LDH
CPK
BILIRUBIN (TOTAL)
BILIRUBIN (DIRECT)
CHOLESTEROL
TRIGLYCERIDES
AMYLASE
LIPASE
PROFILE (Specify)
Start 6 Creat (Chem 7)
REMARKS
Enter in above space
REQUESTING PHYSICIAN'S SIGNATURE
PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REPORTED BY
MD
DATE
TECH
(b)(6)-2
(b)(6)-4
1 Cu 1 4 Sep 03
34 yo ♂
4 Sep 03 0545
STAT
PRE-OP
TODAY
ROUTINE
URGENCY
CHEM 1
BED
OUTPATIENT
NP
DOM
AMB
PATIENT STATUS
BLOOD
OTHER (Specify)
SPECIMEN SOURCE
LAB. ID. NO.
SPECIMEN/LAB. RPT. NO.
PATIENT'S MED. RECORD
CHEMISTRY I
STANDARD FORM 546 (Rev 8-77)
PRESCRIBED BY GSA ICMR
FIRMR (41 CFR) 201-45.505
546-107
(b)(6)-4
1 Cu #1
CHEM 1
URGENCY
ROUTINE
TODAY
PRE-OP
STAT
PATIENT STATUS
BED
AMB
OUTPATIENT
NP
DOM
SPECIMEN SOURCE
BLOOD
OTHER (Specify)
SPECIMEN/LAB. RPT. NO.
PATIENT'S MED. RECORD
Enter in above space
PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REQUESTING PHYSICIAN'S SIGNATURE
REPORTED BY
MD
DATE
LAB. ID. NO.
(b)(6)-2
(b)(6)-2
TECH
5 Sep 03
0635 HP
REMARKS
Creatanine
TEST(S)
SPECIMEN TAKEN
DATE 5 Sep 03
TIME 0615 A.M. P.M.
RESULTS
REQUESTED
GLUCOSE
UREA N.
0.8 CREATININE
URIC ACID
SODIUM
POTASSIUM
CHLORIDE
CO2
PHOSPHATE
CALCIUM
TOTAL PROTEIN
ALBUMIN
GLOBULIN
ALKALINE PHOSPHATASE
ACID PHOSPHATASE
SGOT
LDH
CPK
BILIRUBIN (TOTAL)
BILIRUBIN (DIRECT)
CHOLESTEROL
TRIGLYCERIDES
AMYLASE
LIPASE
PROFILE (Specify)
CHEMISTRY I
STANDARD FORM 546 (Rev 8-77)
PRESCRIBED BY GSA ICMR
FIRMR (41 CFR) 201-45.505
546-107

MEDCOM - 1840



ACLU-RDI 1099 p.625

DOD 005893

34/77 Kg

MEDICAL RECORD - ANESTH

f this form, see AR 40-66; the proponent agency is OTSG

ASA 1
NKDA

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML, "I" = CONSTANT INFUSION

DRUG	(Units)												
VERSED	(MG)	1											
FENTANYL	(MCG)	100		50			100						
PROPOFOL	(MG)	100											
SUX	(MG)	100											
VEC	(MG)			5	3		2			2		2	1
MSO4	(MG)			2	2	2	2						
VOLAT AGENT	600 % del	/	1.5	1.2	1.2	1.2	1.5	.7	.7	.8	.8	.8	.8
	% e.t.			1.2									
AIR	L/Min												
N2O	L/Min												
O2	L/Min	10	2	2	2	2	2	1	1	1	1	1	1

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS

TOTALS | TOTAL EBL | TOTAL URINE

FLUIDS - SUMMARY
CRYSTALLOID- LR
COLLOID-
BLOOD-

FLUIDS — LINE site: 18 (R) WRIST Warmed LR — 600 — 700 1000 — 500 — 2000 — 2500 →
☐ Warmed
☐ Warmed
☐ Warmed

LOSSES — EST BLOOD LOSS: 50 — URINE - Trey: 100 — 150/300 > 1 unit

PHYS STATUS: 1 2 3 4 5 (E)
BODY WEIGHT: 77 KG LB
HEMATOCRIT: 29
INITIAL DATA:
BP- 129/74
HR- 110
EQUIP CHECK
OK?- (Y) N
PATIENT
OK for PROCEDURE? (Y)
TIME- 1900

TIME → 2000 × 2100 × 2130 × 2200 × 2230 × 2300

SYMBOLS:
BP by cuff (R)
Heart rate ●
Resp rate
BR (transduced)
TOURNIQUET T—T
ANES- X-X
PROC- ⊙-⊙

220 200 180 160 140 120 100 80 60 40 20

REMARKS
Code drugs with numbers, events with letters
① Pt scan } interval per INTERPRETER chart review and Procedure explain
② To OR. ON TABLE Monitors & INDUCED
Ancef 1gm 2040
Gent 80mg 2045
Mannitol 25gm IV 2045
(E) Foley c-cure by sterile technique → mod. bellingen → good urine/flow.
mannitol 12.5gm IV 2208
2220 ABG: 7.37/46/214/24/-2
H/H 6/18
CK 1353 Hgb 17.2
K 4.3
RECOVERY AT
PACU ICU [Specify]
OTHER
CONDITION:
RESP- SpO2-
BP- HR-

VENTIL

VT - ml	14	600	570	610	600	660	500	560	570	560	510	530
f - breaths/min		8	9	10	10	9	6	6	6	6	6	6
Peak Inf pres / PEEP		28	28	25	26	26	27	27	27	27	26	26
MODE - S(pon), A(ssist), C(on)	S	C	C	C	C	C	C	C	C	C	C	C

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	32	36	36	33	30	35	37	36	31	31	38
BP/oth	FIO2 (Frac or %)	.83	.83	.84	.84	.84	.85	.85	.85	.85	.85	.85
ART line	SpO2 (%)	100	100	100	100	100	100	100	100	100	100	100
Steth- PC/ES	ECG	ST	ST	ST	ST	ST	SR	SR	SR	SR	SR	SR
Gas analyzer	TEMP-site AXIL.											
	N-M Block (T/4)	0/4	0/4	0/4	0/4	0/4	0/4	4/4	4/4			
Warming blkt												
Conv warmer												

Mark with letters & symbols, explain under REMARKS

EVENTS / Position: (L) (R) (N) ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ⑪ ⑫ ⑬ ⑭ ⑮ ⑯ ⑰ ⑱ ⑲ ⑳ ㉑ ㉒ ㉓ ㉔ ㉕ ㉖ ㉗ ㉘ ㉙ ㉚ ㉛ ㉜ ㉝ ㉞ ㉟ ㊱ ㊲ ㊳ ㊴ ㊵ ㊶ ㊷ ㊸ ㊹ ㊺ ㊻ ㊼ ㊽ ㊾ ㊿

RECOVERY AT
PACU ICU [Specify]
OTHER
CONDITION:
RESP- SpO2-
BP- HR-

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1930	2015	0100
PROC	Ready	Begin	End
	2035	2105	2405

PROCEDURES and CPT Codes: 1ED LUE & LLE EX-FIX ① FEMUR & REVISE LUE AMPUTATION

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GOA: PRE-OX. INDUCED. EXPOSED X 2 IMAC 3. GRADE II VIEW INTUBATED = 8.0 ETT TO 27 CM @ TEETH. EYES TAPED FACE DRAPED. TUBE SECURED. R/U BLOCK IN

PATIENT IDENTIFICATION: Typed or written entries: Name, Grade/Rate, Medical facility

(b)(6)-4

ARRIVAL MANAGEMENT: Intubation route, blade, technique, comments

SURGEONS: (b)(6)-2 (b)(6)-2 (b)(6)-2

PROCEDURE

DATE: 25 AUG 05

MEDCOM - 1842

ASA: 1

ALL: NKDA

OPERATION	AGE	WT	SPECIAL INFO
LUE Amp Revision I&D LUE THIGH WOUNDS	34	77	ATF @ 1200 TOURN INTACT FROM >3 FB's MP II

U/A

Heme

Chem

Resp

WNL

CVC

CNS

OTHER

HR 135

125/86

RR 22

BHX

Ø

Meds

VOLTAREN pRN

ACLU-RDI 1099 p.627

DOD 005895

V lytes / CK 98°

MEDICAL RECORD - ANESTH

of this form, see AR 40-66; the proponent agenc OTSG

2315

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML, "I" = CONSTANT INFUSION

DRUG	(Units)	30	45	2400	15	30	45	0100
Vec	(mg)	1						
Fentanyl	(m)		50					
Neostig/glyco	(mg)			5/1 mm x				
	( )							
	( )							
	( )							
VOLAT AGENT Iso	% del	.8	.6	.6	.6	.4	x	
	% e.t.							
AIR	L/Min							
N2O	L/Min							
O2	L/Min	1	1	1	1	8	8	

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS

FLUIDS

LINE site	☐ Warmed	
#18 PIV (R) hand	☐ Warmed	2700 → 3000
PRBC	☑ Warmed	1 1
	☐ Warmed	

LOSSES

EST BLOOD LOSS	1 unit
URINE	150/450 → 300/750

TOTALS

TOTAL EBL	TOTAL URINE
2 units	750

FLUIDS - SUMMARY

CRYSTALLOID- 5000

COLLOID- —

BLOOD- 2 units

REMARKS

Code drugs with numbers, events with letters

- Case concluded → pt. turned supine
- (R) fem. art. line pulled out during movement → pressure held for 15 min.
- (R) neck prep/drap sterile fashion →
- (R) IJ v. cannulated c̄ 18 ga angiocath → conf. venous by manometry → mod. sell technique, 8.5 FR introducer passed. ∅ comp. CXR (P).
- Smooth emergence, extubation → patent airway.

PHYS STATUS (1) 2 3 4 5 (E)

BODY WEIGHT: 77 (KG) LB

HEMATOCRIT: 29

INITIAL DATA:

BP- 127/74

HR- 110

EQUIP CHECK

OK?- (Y) N

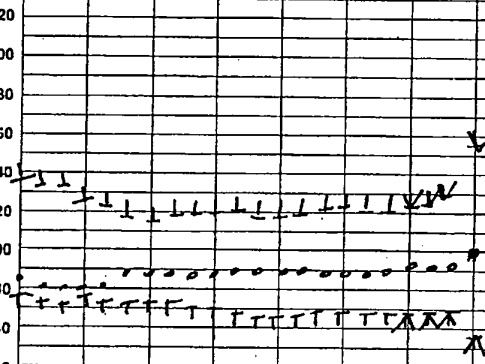
PATIENT

OK for PROCEDURE? Y

TIME- 1900

TIME →

SYMBOLS: BP by cuff V Λ Heart rate ● Resp rate BR (transduced) ╪ TOURNIQUET T—T. ANES- X-X PROC- ⊙-∅



VENTIL

VT - ml	510	510	510	510	510	510	800
f - breaths/min	6	5	5	5	5	5	11
Peak inf pres / PEEP	27	27	27	27	27	27	-
MODE - S(pon), A(ssist), C(on)	C	C	C	C	C	C	S

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	38	40	41	41	41	41	41
BP/oth	FIO2 (Frac or %)	.85	.85	→				
ART line	SpO2 (%)	100	100	100	100	100	99	99
Steth- PC/ES	ECG	SR	SR	SR	SR	SR	SR	ST
Gas analyzer	TEMP-site							
	N-M Block (T/4)		1/4				4/4 gust. Tet.	
Warming blkt								
Conv warmer								

Mark with letters & symbols, explain under REMARKS

EVENTS Position → RLD →

RECOVERY AT

PACU (ICU) 2 (Specify)

OTHER

CONDITION: Good

RESP- 16 SpO2- 94

BP- 148/91 HR- 115

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1930	2015	0100
PROC	Ready	Begin	End
	2050	2105	2405

PROCEDURES and CPT Codes: Ex-fix (L) femur, revision (L) UE amputation

ANESTHETIC TECHNIQUES: Describe block technique under Remarks GETA

PATIENT IDENTIFICATION: Typed or written entries: Name, Grade/Rate, Medical facility

(b)(6)-4

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments easy DL c̄ MAC 3 (see p. 1) 8.0 ETT.

SURGEONS: (b)(6)-2 (b)(6)-2 (b)(6)-2

PROCEDURE

DATE:

ANESTHETISTS:

MEDCOM - 1844

MEDICAL RECORD - ANESTHESIA

For use of this form, see AR 40-66; the proponent agency is the OTSG

34Y.O. NKDA

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML "I" - CONSTANT INFUSION

DRUG	(Units)
VERSED	(MG)
FENT	(MCG)
PROPOFOL	(MG)
VEC/ROC/NUC	(MG)
NESDR	(MG)
	( )
VOLAT AGENT	
AIR	L/Min
N2O	L/Min
O2	L/Min

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS

FLUIDS

LINE site	☐ Warmed
LR - 1000 (600)	☐ Warmed
	☐ Warmed
D5 1/2 NS c 20 KCl	☐ Warmed

LOSSES: EST BLOOD LOSS; URINE -

PHYS STATUS: 1 2 3 A 5 E

BODY WEIGHT: KG / LB

HEMATOCRIT: 22/7

INITIAL DATA:

BP- 134/84

HR- 122

EQUIP CHECK

OK? (Y) N

PATIENT RECHECK

OK for PROCEDURE? Y

TIME- 1100

TIME 1100 · 30 · 1200 · 30 · 1300 · 30 · 1400

SYMBOLS: BP by cuff V Λ; Heart rate ●; Resp rate; BR (transduced); TOURNIQUET T—T; ANES- X-X; PROC- ⊕-Ø

220 200 180 160 140 120 100 80 60 40 20

VENTIL

VT - ml		600	620	600	620	620	320	450	400	620		
f - breaths/min		10	10	10	10	10	11	15	19	17		
Peak Inf pres / PEEP		29	28	29	28	28						
MODE - S(pon), A(assist), C(on)	3	C	C	C	C	C	S	S	S	S	S	

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	4	40	36	26	34	33	44	40	39	35	
BP/oth	FIO2 (Frac or %)	1.0										
ART line	SpO2 (%)	100	100	100	100	100	100	100	100	100	100	100
Steth- PC/ES	ECG	ST	ST	ST	ST	ST	ST	ST	ST	ST	ST	
Gas analyzer	TEMP-site											
	N-M Block (T/4)											
	Foley	650						200/850				
Warming blkt												
Conv warmer												

Mark with letters & symbols, explain under REMARKS — EVENTS Position → L → OR

TOTALS: 1L; 250 — TOTAL EBL: 100 — TOTAL URINE: 250 / 850

FLUIDS - SUMMARY: CRYSTALLOID- 900; COLLOID-; BLOOD- 0

REMARKS

Code drugs with numbers, events with letters

1110 - IN ROOM

STD MONITORS

PASS 2

1220 - IGA TUBE IVSV

1313 MOVED SL

1320 MOUTH SC [illegible] L/S (R) CLS clear EXTUBATED IVSV

1325 - TO ICU IVSV

RECOVERY AT: 1335

PACU ICU 2 (Specify)

OTHER

CONDITION:

RESP. 23 SpO2. 95

BP 112/58 HR. 104

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1100	1110	1345
PROC	Ready	Begin	End
	1120	1145	1345

PROCEDURES and CPT Codes:

R-FEX ADJ SST, (L) ARM STUMP D'BRI

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

GETA

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*

(b)(6)-4

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*

OLX1, MAC 3, 6.5 ETT, 9.0 ETT2, 2 CUFF @ 22, @ 23, @ CC x6

[illegible]

SURGEONS:

(b)(6)-2

PROCEDURE LOCATION:

DATE:

MEDCOM - 1845

(b)(6)-4

PREANESTHETIC SUMMARY

OPERATION PROPOSED	AGE	WEIGHT (LBS.)	SPECIAL INFORMATION

PHYSICAL STATUS

1 2 3 4 5 6 7

URINALYSIS	HEMATOLOGY	BLOOD CHEMISTRY
NORMAL	HGB 7 ..... RBC ..... HCT 22	133 / 102 / 12
ABNORMAL AND WHY?	OTHER	3.9 / BO / .9
		CPK-685

RESPIRATORY SYSTEM	CIRCULATORY SYSTEM	CENTRAL NERVOUS SYSTEM	OTHER SYSTEMS
(X-RAY, ASTHMA, OTHER PATHOLOGY)	BP ..... PULSE ..... ECG (IF PERTINENT)	(CEREBROVASCULAR, POLIO, NEUROLOGICAL)	(ALLERGIES)
	SGG H&P 25 AMB03 NO SIG A's		NKDA

PREVIOUS ANESTHETICS AND COMPLICATIONS	PRESENT DRUG THERAPY; E.G., STEROIDS, TRANQUILIZERS

PREOPERATIVE DIAGNOSIS	PREMEDICATION	
160/97 109 18 96% NC O2		
	SIGNATURE OF EVALUATING PHYSICIAN	DATE

POSTANESTHETIC VISITS

RECORD ALL PERTINENT COMPLICATIONS

*U.S. Government Printing Office: 1994 — 300-892/10029

ACLU-RDI 1099 p.630

DOD 005898

MEDICAL RECORD - ANESTHESIA

For use of this form, see AR 40-66; the proponent agency is the OTSG

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML. "T" = CONSTANT INFUSION

DRUG (Units)														
$MgSO_4$ (mg)		5	5	5	5	5								
Fentanyl (mcg)	250													
Propofol (mg)	180				20									
Succ (mg)	100													
( )														
Esmolol (mg)					30									
VOLAT AGENT — % del														
I_{so} % e.t.	20	2.0	2.0	2.0	2.0	2.0	1.0 2.0							
AIR L/Min	/	/	/	1	1	1 X								
N2O L/Min	/	/	/	/	/	/								
O2 L/Min	6	2	2	1	1	1 2								

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS: (1) (2) (3) (4) (5) (6)

FLUIDS

LINE site														
LR	☐ Warmed	#1					500	400	1000					
	☐ Warmed													
	☐ Warmed													
	☐ Warmed													

LOSSES

EST BLOOD LOSS	/	/	/	/	/	/	/							
URINE	/	/	/	/	150	/	/							

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 77 KG / LB

HEMATOCRIT: 22.5

INITIAL DATA

BP: 133 187

HR: 140

EQUIP CHECK

OK? (Y) N

PATIENT RECHECK

OK for PROCEDURE? Yes

TIME: 0830

TIME 0745 0800 X 30 X 1000 X 30 X 1130 X 30

SYMBOLS: BP by cuff V ^ — Heart rate ● — Resp rate — BR (transduced) + — TOURNIQUET T—T — ANES- X-X PROC- ⊙-⊙

220 200 180 160 140 120 100 80 60 40 20

VENTIL

VT - ml		700	720	420	440	430	460	470
f - breaths/min		10	10	15	17	10	10	19
Peak Inf pres / PEP		28	29	3	3	3	3	3
MODE - S(pon), A(assist), C(on)		C	C	S	S	S	S	S

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	41	37	39	39	46	47	1.0
BP/oth	FIO2 (Frac or %)	1.0	1.0	1.0	.47	.53	.53	1.0
ART line	SpO2 (%)	100	100	100	100	100	100	100
Steth- PC/ES	ECG	ST	ST	ST	ST	ST	ST	ST
Gas analyzer	TEMP-site	—	—	—	—			
	N-M Block (T/4)			4/4	3/4			
Pressure points	checkd. padd'd	✓	✓	✓	✓	✓	✓	✓
Warming blkt		/	/	/	/	/	/	/
Conv warmer								

Mark with letters & symbols, explain under REMARKS — EVENTS Position

TOTALS: 30 mg; 250 ug; 200; 100 — TOTAL EBL: min — TOTAL URINE: 150

FLUIDS - SUMMARY

CRYSTALLOID: LR - 1,000

COLLOID: 0

BLOOD: 0

REMARKS

Code drugs with numbers, events with letters

① Pt interviewed, chart reviewed.

② At 0 OR, ASA mon. applied. Pt induced, intubated & difficult

③ 0915 Pt extubated pt start well.

④ PtSV, TV 480, Pt suct then extubated.

⑤ Pt to ICU 1.5. Report given to CRT (b)(6)-2

RECOVERY AT: 1025

PACU (ICU) 2 (specify)

OTHER

CONDITION: Stable

RESP. 26 SpO2 98

BP 153/80 HR 147

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0830	0840	1030
PROC	Ready	Begin	End
	0855	0915	1015

PROCEDURES and CPT Codes:

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

GETA

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*

(b)(6)-4

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*

Eyes taped OLx1 (MAC 4) grade II view, ETT 8.0 advanced to 23cm @ teeth, @ 385 ETT secured.

SURGEONS: (b)(6)-2 (b)(6)-2

PROCEDURE LOCATION:

DATE:

MEDCOM - 1847

2

PREANESTHETIC SUMMARY

OPERATION PROPOSED	AGE	WEIGHT (LBS.)	SPECIAL INFORMATION
Washout (R) Arm stump, (R) thigh	34	77	NPO since MN 28 Aug 03
	PHYSICAL STATUS: (1) 2 3 4 5 6 7		MPI - teeth ⊘ loose, 3FB mouthopen, Neck-Flam

URINALYSIS	HEMATOLOGY	BLOOD CHEMISTRY
NORMAL ..... ABNORMAL AND WHY?	HGB ..... RBC ..... HCT ..... OTHER: 108 \ 7.7 / 22.5 \ 241; 4.0 \ 11 / 24.6 \ 140	

RESPIRATORY SYSTEM (X-RAY, ASTHMA, OTHER PATHOLOGY)	CIRCULATORY SYSTEM BP ..... PULSE ..... ECG (IF PERTINENT)	CENTRAL NERVOUS SYSTEM (CEREBROVASCULAR, POLIO, NEUROLOGICAL)	OTHER SYSTEMS (ALLERGIES)
⊘	133/87 145 16 97%	⊘	NKDA

PREVIOUS ANESTHETICS AND COMPLICATIONS	PRESENT DRUG THERAPY; E.G., STEROIDS, TRANQUILIZERS
Previous washout, X2 c̄ Amputation (L) forearm	(b)(6)-2

PREOPERATIVE DIAGNOSIS	PREMEDICATION
	(b)(6)-2

SIGNATURE OF EVALUATING PHYSICIAN	DATE
(b)(6)-2 CPT, CRNA	29 Aug 03

POSTANESTHETIC VISITS

RECORD ALL PERTINENT COMPLICATIONS

*U.S. Government Printing Office: 1994 — 300-892/10029

MEDCOM - 1848

MEDICAL RECORD - ANESTHESIA

For use of this form, see AR 40-66; the proponent agency is the OTSG

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML, "I" = CONSTANT INFUSION

DRUG	(Units)													
VERSED	(mg)	1.5/1												
FENTANYL	(mg)	(250)		100/50										
PROPOFOL	(mg)	140												
SCH	(mg)	80												
	( )													
	( )													
VOLAT AGENT Forane	% del	2/1/2 X												
	% s.t.													
AIR	L/Min													
N2O	L/Min													
O2	L/Min	6 — 2	4 — 7											

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS

FLUIDS

LINE-site														
(L)	☐ Warmed													
	☐ Warmed	(R100)-												
	☐ Warmed													
	☐ Warmed													

LOSSES — EST BLOOD LOSS; URINE -

PHYS STATUS 1 (2) 3 4 5 E

TIME 13 30

BODY WEIGHT: 77 (KG) LB

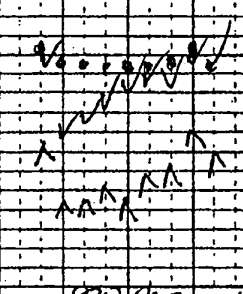
HEMATOCRIT: 24

INITIAL DATA: BP- 137 83; HR- 116

EQUIP CHECK OK? (Y) N

PATIENT RECHECK OK for PROCEDURE? Y TIME 1255

SYMBOLS: BP by cuff V ∧ Heart rate ● Resp rate BR (transduced) ✚ TOURNIQUET T—T ANES- X-X PROC- ⊙-Ø



VENTIL				
VT - ml		830	860	
f - breaths/min		10	10	14
Peak inf pres / PEEP		34	34	
MODE - S(pon), A(ssist), C(on)	SV	CV	CV	SV

MONITORS/ACCESSORIES

✓ BP/Auto Cuff	✓ ET CO2 (torr)	34	33	32
BP/oth	✓ FIO2 (Frac or %)	.87	.87	0.89
ART line	✓ SpO2 (%)	100	100	100
Stath- PC/ES	✓ ECG	ST	ST	ST
✓ Gas analyzer	TEMP-site Skin	103	103	103
	N-M Block (T/4)			
Warming blkt				
Conv warmer				

Mark with letters & symbols, explain under REMARKS — EVENTS Position → OS →

TOTALS — TOTAL EBL: MIN; TOTAL URINE: 300

FLUIDS - SUMMARY
CRYSTALLOID- 700
COLLOID-
BLOOD-

REMARKS
Code drugs with numbers, events with letters

1335 I10 Cath 300cc

1340 SV/RR Suctioned (+) Purposeful Movement Extubated

RECOVERY AT
PACU (CU) 7 (Specify)
OTHER
CONDITION: ✓ NC 4L/M
RESP 20 SpO2 95
BP 134/86 HR 124

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1230	1250	134
	Ready	Begin	End
PROC	1300	1312	133

PROCEDURES and CPT Codes: IAD (L) Arm (L) Leg

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate,*
(b)(6)-4

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*
GEMA c̄ Forane/O2.

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* DL x 1 (+) cricoid MIL 2 Grade T 8.0 ETT (-) Stylet (+) BBS (+) ETCO2

SURGEONS: (b)(6)-2 (b)(6)-2

PROCEDURE LOCATION: OR 1
DATE: 2/1/02

MEDCOM - 1849

PREANESTHETIC SUMMARY

OPERATION PROPOSED	AGE	WEIGHT (LBS.)	SPECIAL INFORMATION
(b)(6)-4 I+D (L) axilla.	34	77 Kg	

PHYSICAL STATUS: 1 (2) 3 4 5 6 7

URINALYSIS	HEMATOLOGY	BLOOD CHEMISTRY
NORMAL ..... ABNORMAL AND WHY?	HGB ..... RBC ..... HCT ..... OTHER 18.8 / 8.1 / 24.8 (335) 1 Sep	129 / 95 / 15 / 187 ; 3.2 / 0.9 30 Aug

RESPIRATORY SYSTEM	CIRCULATORY SYSTEM	CENTRAL NERVOUS SYSTEM	OTHER SYSTEMS
(X-RAY, ASTHMA, OTHER PATHOLOGY) WNL -	BP ..... PULSE ..... ECG (IF PERTINENT) WNL. 132/83 - 116 R 36 SaO2 93% T 98	(CEREBROVASCULAR, POLIO, NEUROLOGICAL) WNL -	(ALLERGIES) NKDA (+) 11/Aug ENGT NPO since 31 Aug 03

PREVIOUS ANESTHETICS AND COMPLICATIONS	PRESENT DRUG THERAPY; E.G., STEROIDS, TRANQUILIZERS
Geta for I+D's Q Cx.	Erythromycin 250mg IV Q6 Demerol 25 Phenergan 12.5 IV PRN. Zantac 50mg IVq 8 Ancef 1GM Q6 (12N)

PREOPERATIVE DIAGNOSIS

PREMEDICATION

(b)(6)-2 (b)(6)-2 DATE 9/1/03

POSTANESTHETIC VISITS

RECORD ALL PERTINENT COMPLICATIONS

(b)(6)-4

*U.S. Government Printing Office: 1994 — 300-892/10029

MEDCOM - 1850

MEDICAL RECORD - ANESTHESIA

For use of this form, see AR 40-66; the proponent agency is the OTSG

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML "I" = CONSTANT INFUSION

DRUG	(Units)															TOTALS
Fentanyl	(ug)	250														250
Prop	(mg)	140														140
Succ	(mg)	100														100
MSO4	(mg)		10	7	5	3	2									20
	( )															
	( )															
VOLAT AGENT	% del															
Iso	% e.t.	1.5	1.4	1.0	1.0 X											
AIR	L/Min															
N2O	L/Min															
O2	L/Min	6	1	1	1	1	6									

TOTAL EBL: min

TOTAL URINE: 0

FLUIDS SUMMARY
CRYSTALLOID: 800
COLLOID: 900 Hes
BLOOD: 0

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS (1) (2)

FLUIDS

LINE site		
LL	☐ Warmed	#1 — 950
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOSSES: EST BLOOD LOSS; URINE

REMARKS

Code drugs with numbers, events with letters

① Pt identified, chart reviewed.
② Pt to OR, ASA monitors, O2 applied, Pt induced/intubated difficulty.
③ Pt tolerated procedure well.
④ Pt SVR rate 12 7 V 480s, positioned, prepped, draped.
⑤ Pt to ICU #1 report given to ILT [(b)(6)-2] VS stable as indicated.

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 77 KG / LB

HEMATOCRIT: 10.1/25.9

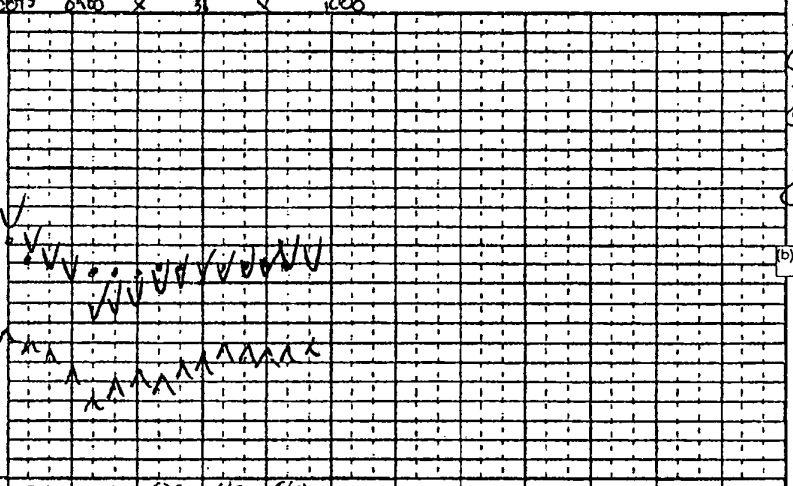
INITIAL DATA:
BP- 129/72
HR- 119

EQUIP CHECK: OK? Y N

PATIENT RECHECK: OK for PROCEDURE? Yes — TIME- 0835

TIME — PHYS 0900 X 5 X 1000

SYMBOLS: BP by cuff V ^ ; Heart rate ● ; Resp rate ; BR (transduced) + ; TOURNIQUET T—T ; ANES- X-X ; PROC- ⊙-⊙



VENTIL

VT - ml		760	710	520	560	560
f - breaths/min		10	10	16	12	10
Peak Inf pres / PEEP		30	31	3 [(b)(6)-2]		
MODE - S(pon), A(ssist), C(on)		S C	C	S	S	S

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	49	42	46	47	44
BP/oth	FIO2 (Frac or %)	1.0	1.0	1.0	1.0	1.0
ART line	SpO2 (%)	98	97	98	99	98
Stath- PC/ES	ECG	ST	ST	ST	ST	ST
Gas analyzer	TEMP-site	—	—	—	—	—
	N-M Block (T/4)		4/4	ST		
Warming blkt						
Conv warmer						

Mark with letters & symbols, explain under REMARKS — EVENTS / Position

RECOVERY AT: 0955
PACU ICU 2 (Specify)
OTHER
CONDITION: Stable
RESP- O SpO2- 97
BP- 126/79 HR- 117

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0830	0845	0958
PROC	Ready	Begin	End
	0850	0915	1000

PROCEDURES and CPT Codes:
Stump revision (L) Arm

PATIENT IDENTIFICATION: Typed or written entries: Name, Grade/Rate, Medical facility
[(b)(6)-4]

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
DL x1 (Miller 3) grade II view ETT 8.0 placed to 23cm @ teeth @ ABS, and secured

SURGEONS:

PROCEDURE LOCATION:

DATE:

MEDCOM - 1851 (6)-2

PREANESTHETIC SUMMARY

OPERATION PROPOSED	AGE	WEIGHT (LBS.)	SPECIAL INFORMATION
	34	77	MPI, teeth intact, Neck-Flom, mouth opening 3F.
	PHYSICAL STATUS: (1) 2 3 4 5 6 7		

URINALYSIS	HEMATOLOGY	BLOOD CHEMISTRY
NORMAL ..... ABNORMAL AND WHY?	HGB ..... RBC ..... HCT ..... OTHER: 9.3 / 10.1 / 25.9 / 253 3 Sept 03	25 Sept 03 144 / 111 / 18 / 197 3.8 / .8

RESPIRATORY SYSTEM (X-RAY, ASTHMA, OTHER PATHOLOGY)	CIRCULATORY SYSTEM BP ..... PULSE ..... ECG (IF PERTINENT)	CENTRAL NERVOUS SYSTEM (CEREBROVASCULAR, POLIO, NEUROLOGICAL)	OTHER SYSTEMS (ALLERGIES)
Ø	100.4, 102, 26 123/72 94%	Ø	NKDA

PREVIOUS ANESTHETICS AND COMPLICATIONS	PRESENT DRUG THERAPY; E.G., STEROIDS, TRANQUILIZERS
None c̄ 3 prior GA's during hospitalization since 25 Aug 03	—

PREOPERATIVE DIAGNOSIS	PREMEDICATION

SIGNATURE OF EVALUATING PHYSICIAN	DATE
(b)(6)-2 CPT CRNA	3 Sept 03

POSTANESTHETIC VISITS

RECORD ALL PERTINENT COMPLICATIONS

*U.S. Government Printing Office: 1994 — 300-892/10029

MEDCOM - 1852

MEDICAL RECORD - ANESTHESIA

For use of this form, see AR 40-66; the proponent agency is the OTSG

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML. "I" = CONSTANT INFUSION

DRUG	(Units)													
VERSED	(mg)	2.5												
FENTANYL	(cc)		2	2	1	1	1	2						
PROPOFOL	( )	200												
V2C/SUX	(mg)	1/100												
	( )													
	( )													
VOLAT AGENT: FOR	% del	1.5	1.5	1.0	X									
	% e.t.													
AIR	L/Min													
N2O	L/Min													
O2	L/Min	6	1	1	1	1	6							

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS

FLUIDS

LINE site														
	☐ Warmed													
	☐ Warmed													
By (R) F.A.	☐ Warmed	→	→	→										
	☐ Warmed													

LOSSES — EST BLOOD LOSS / URINE

PHYS STATUS: (2) 3 4 5 E

BODY WEIGHT: APPROX 80 (KG) LB

HEMATOCRIT:

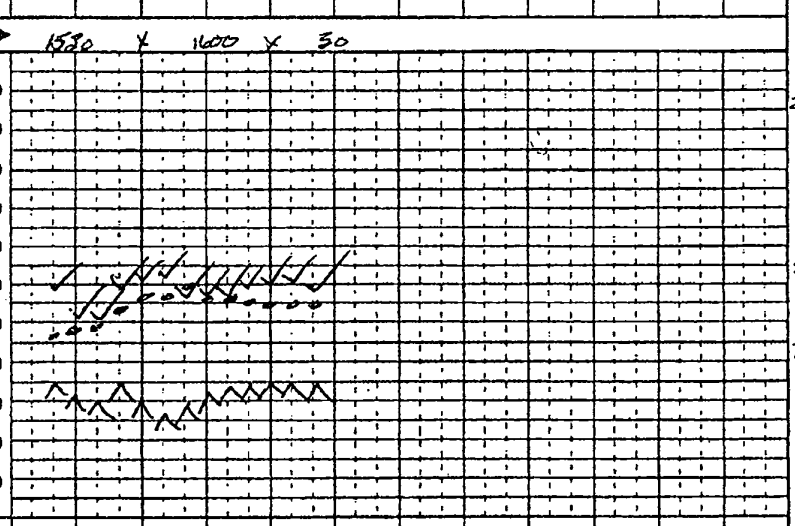
INITIAL DATA:
BP- 119 170
HR- 92
SpO2 99

EQUIP CHECK: OK? (Y) N

PATIENT RECHECK: OK for PROCEDURE? (C)
TIME- 1515

TIME → 1530 X 1600 X 30

SYMBOLS: BP by cuff V Λ; Heart rate ●; Resp rate; BR (transduced) ✚; TOURNIQUET T—T; ANES- X-X; PROC- ⊙-Ø



VENTIL

VT - ml						
f - breaths/min	22	15	18	12	10	14
Peak inf pres / PEEP						
MODE - S(pon), A(assist), C(on)	SV	AV	AV	AV	AV	SV

MONITORS/ACCESSORIES

X BP/Auto Cuff	X ET CO2 (torr)	45	50	43	45	42
BP/oth	X FIO2 (Frac or %)	.99	.99	.99	.99	.99
ART line	X SpO2 (%)	100	98	98	97	98
Steth- PC/ES	X ECG	SR	SR	SR	SR	SR
X Gas analyzer	TEMP-site					
	N-M Block (T/4)	4/4				
Warming blkt						
Conv warmer						

Mark with letters & symbols, explain under REMARKS — EVENTS Position → (2)

TOTALS — TOTAL EBL: MIN — TOTAL URINE: NO FOLEY

FLUIDS - SUMMARY
CRYSTALLOID- 300cc
COLLOID- Ø
BLOOD- Ø

REMARKS
Code drugs with numbers, events with letters
(1) CHART REVIEW
(2) PT TO O.R. MONITORS & STRAPS SMOOTH I&I @ 1534
Ø REVERSAL
SV GOOD VT
RESPONSIVE
EXTUBATED
3 PROBLEMS
TO ICU STABLE REPORT.

RECOVERY AT: (PACU) ICU ____ (Specify)
OTHER ____

CONDITION:
RESP- 18 SpO2- 95
BP- 137/84 HR- 102

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1515	1525	1635
PROC	Ready	Begin	End
	1530	1594	1630

PROCEDURES and CPT Codes: (L) F.A. WASH OUT (L) THIGH

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* GETA, SCCA

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* DL X1 E 2MIL, ATRAUMATIC BEBS (+) ETCO2

(b)(6)-4

SURGEONS:

PROCEDURE LOCATION: 21CSH

DATE: 1 . 1

MEDCOM - 1853

PREANESTHETIC SUMMARY

OPERATION PROPOSED	AGE	WEIGHT (LBS.)	SPECIAL INFORMATION

PHYSICAL STATUS

1 2 3 4 5 6 7

URINALYSIS	HEMATOLOGY	BLOOD CHEMISTRY
NORMAL ..... ABNORMAL AND WHY?	HGB ..... RBC ..... HCT ..... OTHER	

ANES

RESPIRATORY SYSTEM	CIRCULATORY SYSTEM	CENTRAL NERVOUS SYSTEM	OTHER SYSTEMS
(X-RAY, ASTHMA, OTHER PATHOLOGY)	BP ..... PULSE ..... ECG (IF PERTINENT)	(CEREBROVASCULAR, PSYCHO, NEUROLOGICAL)	(ALLERGIES)

SEE PREVIOUS WORK UP. REPEAT SURGERY PT

PREVIOUS ANESTHETICS AND COMPLICATIONS	PRESENT DRUG THERAPY; E.G., STEROIDS, TRANQUILIZERS
PREOPERATIVE DIAGNOSIS	PREMEDICATION
	SIGNATURE OF EVALUATING PHYSICIAN / DATE

POSTANESTHETIC VISITS

RECORD ALL PERTINENT COMPLICATIONS

*U.S. Government Printing Office: 1994 — 300-892/10029

ACLU-RDI 1099 p.638

DOD 005906

MEDICAL RECORD - ANESTHESIA

For use of this form, see AR 40-66; the proponent agency is the OTSG

ANESTHETIC AGENTS AND DRUGS (CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML, "I" = CONSTANT INFUSION)

DRUG (Units)														
Fentanyl (ug)	150 I													
MSO4 (mg)	10 I		3	2	1	2	1							
Propofol (mg)	180 I													
Succ (mg)	100 I													
VOLAT AGENT Iso % del														
Iso % e.t.	1.5	1.5	1.0	1.0										
AIR L/Min														
N2O L/Min														
O2 L/Min	6	1	1	12	2									

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS: (1) (3) (4)

FLUIDS

LINE site		
(6) LL 16	☐ Warmed	H1 — 300 — 200
(R) LL 16	☐ Warmed	H2
	☐ Warmed	

LOSSES: EST BLOOD LOSS; URINE: Self voided 1030 in CV

PHYS STATUS: (P) 2 3 4 5 E

BODY WEIGHT: 75 KG / LB

HEMATOCRIT:

INITIAL DATA: BP- 145 / 72; HR- 106

EQUIP CHECK: OK? (Y) N

PATIENT RECHECK: OK for PROCEDURE? Yes; TIME- 1015

TIME (SYMBOLS: BP by cuff V ^; Heart rate ●; Resp rate; BR (transduced); TOURNIQUET T—T; ANES- X-X; PROC- ⊖-⊖)

220 200 180 160 140 120 100 80 60 40 20

VENTIL

VT - ml	680	640	640	320	390	500	500	
f - breaths/min	10	10	10	10	7	7	7	
Peak Inf pres / PEEP	26	26	26	—	—	—	—	
MODE - S(pon), A(assist), C(on)	S	C	C	S	S	S	S	

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	39	36	31 38	46	46	44	44
BP/oth	FIO2 (Frac or %)	1.0	.87	.87	.67	.87	.86	.86
ART line	SpO2 (%)	99	98	98	97	97	97	97
Steth- PC/ES	ECG	ST	ST	ST	ST	ST	ST	ST
Gas analyzer	TEMP-site	—	—	—	—	—	—	—
	N-M Block (T/4)	—	—	—	—	—	—	—
Pressure points	checked & padded	✓	✓	✓	✓	✓	✓	✓
Warming blkt	Use a blanket applied	✓						
Conv warmer								

Mark with letters & symbols, explain under REMARKS — EVENTS Position

TOTALS: 350 Dex; 30 n; 100 1; 80 mg — **TOTAL EBL**: min

TOTAL URINE: Self voided prior to SURGERY

FLUIDS - SUMMARY: CRYSTALLOID- LR- 1,000; COLLOID- 0; BLOOD- 0

REMARKS

Code drugs with numbers, events with letters

(1) Pt identified, chart reviewed, all pt quest answered.

(3) Pt tolerated procedure well.

(4) Cefazolin 300mg IV infused @ VCR 45 minutes

(5) PPW 9, TV 510, pt suctioned, then extubated

(6) Pt to PACU Reports, via to ILT (b)(6)-2

RECOVERY AT: 1200

PACU (ICU) / (Specify)

OTHER

CONDITION: stable

RESP- 10 SpO2- 97

BP- 137/76 HR- 103

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1030	1040	1200
PROC	Ready	Begin	End
	1045	1055	1150

PROCEDURES and CPT Codes: Washout (b)(6), Stump revision

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*: GETA

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*: (b)(6)-4

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*: M. RSI c CP OLx1 (Miller 4) grade 1 views, ETT 8.0 placed @ 0855, ETT secured @ 22cm @ the teeth

SURGEONS:

PROCEDURE LOCATION: OR

DATE: 11 / 12

MEDCOM - 1855

PREANESTHETIC SUMMARY

OPERATION PROPOSED	AGE	WEIGHT (LBS.)	SPECIAL INFORMATION

PHYSICAL STATUS

1 2 3 4 5 6 7

URINALYSIS	HEMATOLOGY	BLOOD CHEMISTRY
NORMAL ..... ABNORMAL AND WHY?	HGB ..... RBC ..... HCT ..... OTHER	

RESPIRATORY SYSTEM	CIRCULATORY SYSTEM	CENTRAL NERVOUS SYSTEM	OTHER SYSTEMS
(X-RAY, ASTHMA, OTHER PATHOLOGY)	BP ..... PULSE ..... ECG (IF PERTINENT)	(CEREBROVASCULAR, POLIO, NEUROLOGICAL)	(ALLERGIES)

PREVIOUS ANESTHETICS AND COMPLICATIONS	PRESENT DRUG THERAPY: E.G., STEROIDS, TRANQUILIZERS

PREOPERATIVE DIAGNOSIS	PREMEDICATION	
	SIGNATURE OF EVALUATING PHYSICIAN	DATE

POSTANESTHETIC VISITS

RECORD ALL PERTINENT COMPLICATIONS

*U.S. Government Printing Office: 1994 — 300-892/10029

ACLU-RDI 1099 p.640

DOD 005908

MEDICAL RECORD - ANESTHESIA

For use of this form, see AR 40-66; the proponent agency is the OTSG

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML, "I" = CONSTANT INFUSION

DRUG	(Units)	
FENTANYL	(Ug)	250
PROPOFOL	(Mg)	140
SCH	(Mg)	60
	( )	
	( )	
	( )	
VOLAT AGENT	% del / % e.t.	4 1/1.5 X
AIR	L/Min	
N2O	L/Min	
O2	L/Min	6 2 2 2 7

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS

FLUIDS — LINE-site

(L)	☐ Warmed	1000 →
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOSSES — EST BLOOD LOSS; URINE -

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 71 (KG) (LB)

HEMATOCRIT: N/A

INITIAL DATA:

BP- 111/59

HR- 110.

EQUIP CHECK:

OK? (Y) N

PATIENT RECHECK:

OK for PROCEDURE? Y

TIME- 945.

SYMBOLS: BP by cuff V ^ ; Heart rate ● ; Resp rate ; BR (transduced) ✚ ; TOURNIQUET T—T ; ANES- X-X ; PROC- ⊙-⊙

TIME → 945 10 30 11

220 200 180 160 140 120 100 80 60 40 20

VENTIL / MONITORS/ACCESSORIES

	VT - ml	700			
	f - breaths/min	10	10	10	
	Peak inf pres / PEEP	24			
	MODE - S(pon), A(asist), C(on)	SVC	SV	SV	SV
BP/Auto Cuff	ET CO2 (torr)	35	42	40	
BP/oth	FIO2 (Frac or %)	1.0	.84	.93	.95
ART line	SpO2 (%)	99	99	100	99
Steth- PC/ES	ECG	Sin	Sin	Sin	Sin
Gas analyzer	TEMP-site				
	N-M Block (T/4)				
Warming blkt					
Conv warmer					

Mark with letters & symbols, explain under REMARKS — EVENTS Position → Q5

TOTALS: 500. — TOTAL EBL: (b)(6)-2

TOTAL URINE: Spont Void

FLUIDS - SUMMARY

CRYSTALLOID: 300

COLLOID:

BLOOD:

REMARKS — Code drugs with numbers, events with letters

955 Ancef TGN 1 USP.

1038 SVIRR

① Purposeful Movement Extubated

RECOVERY AT: 1047

PACU ICU #1 (Specify)

OTHER SVN 3/M

CONDITION:

RESP. 10 SpO2 98%

BP 123/78 HR. 103

ANESTHETIST PROCEDURE

TIMES

	Start	Room	End
ANES	930	944	1047
PROC	Ready	Begin	End
	955	1008	1038

PROCEDURES and CPT Codes: I&D (2) ARM.

PATIENT IDENTIFICATION: Typed or written entries: Name, Grade/Rate, Medical facility

(b)(6)-4

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GETA OETT

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: DL ETT MIL Grade 1 8.0 ETT Styl Oral BBS Bright

SURGEON(S): (b)(6)-2

PROCEDURE LOCATION: OR #1

DATE: 11/1/12

MEDCOM - 1857

PREANESTHETIC SUMMARY

OPERATION PROPOSED	AGE	WEIGHT (LBS.)	SPECIAL INFORMATION
I&D	34	77 kg	NPO since MN.

PHYSICAL STATUS: 1 (2) 3 4 5 6 7

URINALYSIS	HEMATOLOGY	BLOOD CHEMISTRY
NORMAL ..... ABNORMAL AND WHY?	HGB ..... RBC ..... HCT ..... OTHER	
	No Recent H/H	No Recent

RESPIRATORY SYSTEM	CIRCULATORY SYSTEM	CENTRAL NERVOUS SYSTEM	OTHER SYSTEMS
(X-RAY, ASTHMA, OTHER PATHOLOGY)	BP ..... PULSE ..... ECG (IF PERTINENT)	(CEREBROVASCULAR, POLIO, NEUROLOGICAL)	(ALLERGIES) NKDA
	111/59-110 101(A)-16 R4 94%.		

PREVIOUS ANESTHETICS AND COMPLICATIONS	PRESENT DRUG THERAPY; E.G., STEROIDS, TRANQUILIZERS
GETA $\bar{5}$ Cx Numerous $\bar{6}$ this admission	Ancef 10AM Ertal Cent 11AM Buetrin PO ~10 (NPO)

PREOPERATIVE DIAGNOSIS	PREMEDICATION
	Tylox II @ 0600

(b)(6)-2

Cava DATE 9/11/03

POSTANESTH

RECORD ALL PERTINENT COMPLICATIONS

*U.S. Government Printing Office: 1994 — 300-892/10029

MEDCOM - 1858

MEDICAL RECORD - ANESTHESIA

For use of this form, see AR 40-66; the proponent agency is the OTSG

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML, "I" = CONSTANT INFUSION

DRUG (Units)	1500	15	30	45	1900	15	30	45	2000
Thiopental (mg)	250		50						
Succ (mg)	80								
Fentanyl (mcg)	250	100	50	100					
( )									
( )									
( )									
VOLAT AGENT: I-50 % del		1.5	1.5	1.5	1.2 X				
% e.t.									
AIR L/Min									
N2O L/Min									
O2 L/Min	8	1	1	1	6	8			

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS

FLUIDS

		15	30	45	1900	15	30	45	2000
LINE site ☐ Warmed									
(R) IJ 8.5 F ☐ Warmed	LR →	→	→	→	→	300 →	500		
☐ Warmed									
☐ Warmed									

LOSSES

EST BLOOD LOSS						30			
URINE -						ϕ			

PHYS STATUS: 1 2 (3) 4 5 E

BODY WEIGHT: 65 (G) LB

HEMATOCRIT: 26

INITIAL DATA:

BP- 100 / 66

HR- 95

EQUIP CHECK

OK? - (Y) N

PATIENT RECHECK

OK for PROCEDURE? J

TIME- 1902

TIME — SYMBOLS: BP by cuff V ^ | Heart rate ● | Resp rate | BR (transduced) + | TOURNIQUET T—T | ANES- X-X PROC- ⊖-⊖

220 200 180 160 140 120 100 80 60 40 20

VENTIL

	15	30	45	1900	15	30	45	2000
VT - ml	5V	550	250	330	460	450		
f - breaths/min	↓	10	10	12	9	11		
Peak Inf pres / PEEP	↓	27	—	—	—	—		
MODE - S(pon), A(assist), C(on)		C	S	S	S	S		

MONITORS/ACCESSORIES

		15	30	45	1900	15	30	45	2000
BP/Auto Cuff	ET CO2 (torr)	4	40	45	47	47	47		
BP/oth	FIO2 (Frac or %)	1.0	1.0	1.0	1.0	1.0	1.0		
ART line	SpO2 (%)	100	100	100	100	100	100		
Steth- PC/ES	ECG	SR	SR	SR	SR	SR	SR		
Gas analyzer	TEMP-site	Avail →	→	→	→	→	→		
	N-M Block (T/4)			4/4					
Warming blkt									
Conv warmer									

Mark with letters & symbols, explain under REMARKS — EVENTS Position → Supine (hip hump) → →

TOTALS

TOTAL EBL	TOTAL URINE
30	ϕ

FLUIDS - SUMMARY

CRYSTALLOID- 500

COLLOID- ϕ

BLOOD- ϕ

REMARKS

Code drugs with numbers, events with letters

Pt. taken to OR; pre ox; see below for airway →

F induction, (R) nasal prep / drape → (R)

IJ cannulated & 18ga angiocath →

Cont. venous by manometry →

8.5 Fr introducer placed by mod. Seldinger →

ϕ comp.

1900 - Absorbent exhausted → flow increased to comp. sedate.

- case concluded →

Smooth emergence - ext. criteria met - smooth extubation - patent airway → to ICU → report.

RECOVERY AT 1938

PACU (ICU) ____ (Specify)

OTHER ____

CONDITION: Good

RESP. 11 SpO2. 97

BP- 149/84 HR- 100 reg

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1902	1902	1943
PROC	Ready	Begin	End
	1922	1850	1922

PROCEDURES and CPT Codes:

I&D, LLE and LUE / central line placement

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

Gen

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*

(b)(6)-4

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*

pre-ox; smooth IV induction; easy mask vent; easy DL x 1 w/ 3; Grade I view; 8.0 ETT; (R) axilla, ETCO2; 22 cm teeth

SURGEONS:

PROCEDURE LOCATION: OR

DATE:

MEDCOM - 1859

PREANESTHETIC SUMMARY

OPERATION PROPOSED	AGE	WEIGHT (LBS.)	SPECIAL INFORMATION
- I & D LUE, LLE - Central line placement	34	65 kg	- NPO since noon (clears) Airway favorable - several unremarkable intubations recently.

PHYSICAL STATUS: 1 2 (3) 4 5 6 7

URINALYSIS	HEMATOLOGY	BLOOD CHEMISTRY
NORMAL ..... ABNORMAL AND WHY?	HGB ..... RBC ..... HCT ..... OTHER 9.9 / 8.4 / 26.0 / 567	0.8

RESPIRATORY SYSTEM	CIRCULATORY SYSTEM	CENTRAL NERVOUS SYSTEM	OTHER SYSTEMS
(X-RAY, ASTHMA, OTHER PATHOLOGY) Ros ⊖ x̄ for Tob. Hx. Lungs:	BP 111/72 PULSE ~~72~~ 107 ECG (IF PERTINENT) 93% (RA) ~~Lu~~ CV:	(CEREBROVASCULAR, POLIO, NEUROLOGICAL) Ros ⊖	(ALLERGIES) NKDA

PREVIOUS ANESTHETICS AND COMPLICATIONS	PRESENT DRUG THERAPY; E.G., STEROIDS, TRANQUILIZERS
multiple washouts / stump revisions. ∅ complications (all GETA)	1. Levaquin 500mg q 24° 2. Haldol prn 3. Prn MSO4 4. Tylenol prn

PREOPERATIVE DIAGNOSIS	PREMEDICATION
- amputation, LUE - large area avulsion, LLE	Fentanyl

SIGNATURE OF EVALUATING PHYSICIAN	DATE
(b)(6)-2 MD (b)(6)-2	13 Sep 03

POSTANESTHETIC VISITS

RECORD ALL PERTINENT COMPLICATIONS

(b)(6)-4

*U.S. Government Printing Office: 1994 — 300-892/10029

MEDCOM - 1860

MEDICAL RECORD - ANESTHESIA

For use of this form, see AR 40-66; the proponent agency is the OTSG

1417

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML. "I" = CONSTANT INFUSION

DRUG (Units)	7a	45	1500	15	30	45	1600	15
Fentanyl (M)	(250)	50	50	50	50			
Propofol (mg)	150							
Succ (mg)	60							
( )								
( )								
( )								
VOLAT AGENT: Iso % del		1.5	1.5	1.5	.6 K			
% e.t.								
AIR L/Min								
N2O L/Min								
O2 L/Min	8	1	1	1	1	8		

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS

FLUIDS

LINE site		7a	45	1500	15	30	45	1600	15
(R) IJ 8.5 Fr	☐ Warmed	12	→	150	→	→	200		
	☐ Warmed								
	☐ Warmed								
	☐ Warmed								

LOSSES

	7a	45	1500	15	30	45	1600	15
EST BLOOD LOSS								
URINE	(300)				400			

PHYS STATUS: 1 2 (3) 4 5 E

BODY WEIGHT: 65 (KG) LB

HEMATOCRIT: 28.9

INITIAL DATA:

BP- 130 / 87

HR- 109

EQUIP CHECK

OK? (Y) N

PATIENT RECHECK

OK for PROCEDURE? Y

TIME- 1405

TIME — SYMBOLS: BP by cuff V ^ | Heart rate ● | Resp rate | BR (transduced) + | TOURNIQUET T—T | ANES- X-X | PROC- ⊕-∅

220 200 180 160 140 120 100 80 60 40 20

VENTIL

	7a	45	1500	15	30	45	1600	15
VT - ml	SV	270	410	400	430			
f - breaths/min	/	15	12	11	9			
Peak Inf pres / PEEP		–	–	–	–			
MODE - S(pon), A(assist), C(on)	✓	S	S	S	S			

MONITORS/ACCESSORIES

		7a	45	1500	15	30	45	1600	15
BP/Auto Cuff	ET CO2 (torr)		45	43	43	45			
BP/oth	FIO2 (Frac or %)	1.0	1.0	1.0	1.0	1.0			
ART line	SpO2 (%)	99	98	98	98	99			
Steth- PC/ES	ECG	ST	ST	ST	ST	ST			
Gas analyzer	TEMP-site	Axil	→	→	→	→			
	N-M Block (T/4)	4/4							
Warming blkt									
Conv warmer									

Mark with letters & symbols, explain under REMARKS — EVENTS / Position → Supine →

TOTALS

TOTAL EBL	TOTAL URINE
min.	400

FLUIDS SUMMARY

CRYSTALLOID- 200

COLLOID- ∅

BLOOD- ∅

REMARKS

Code drugs with numbers, events with letters

- Pt. Safely to OR
Asst monitors;
pre-ox; see
below for
airway induct

- case concluded;
Smooth emergence
Smooth extubation
Patent airway
Safely to ICU →
Report given.

RECOVERY AT

PACU (ICU) ___ (Specify)

OTHER ___

CONDITION: Good

RESP- 16 SpO2-

BP- 130/72 HR- 127

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1422	1422	1540
PROC	Ready	Begin	End
	1422	1444	1525

PROCEDURES and CPT Codes:

I & D, LLE / LUE

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

GETA

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*

(b)(6)-4

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*

pre-ox; Smooth IV induction; easy mask vent; eqv DL x 1; 8.0 ETT @ 22cm/EGO2; sec. ⊙ 22 cm, teeth

PROCEDURE LOCATION: OR

MEDCOM - 1861

ACLU-RDI 1099 p.645

DOD 005913

PREANESTHETIC SUMMARY

OPERATION PROPOSED	AGE	WEIGHT (LBS.)	SPECIAL INFORMATION
I&D, LLE / LUE.	74	65 kg	Favorable airway — known easy intubation.
	PHYSICAL STATUS: 1 2 (3) 4 5 6 7		

URINALYSIS
NORMAL .....
ABNORMAL AND WHY?

HEMATOLOGY
HGB ..... RBC ..... HCT .....
OTHER
11.3 / 9.7 / 28.9 / 510

BLOOD CHEMISTRY
2.5

RESPIRATORY SYSTEM	CIRCULATORY SYSTEM	CENTRAL NERVOUS SYSTEM	OTHER SYSTEMS
(X-RAY, ASTHMA, OTHER PATHOLOGY) Lungs: Good (B) air exchange. Clear (B).	BP ..... PULSE ..... ECG (IF PERTINENT) 170/82 108 R18 T 101.3 CV: rrl S1, S2, ϕ r/m/g heard	(CEREBROVASCULAR, POLIO, NEUROLOGICAL) See previous 73891s	(ALLERGIES) NKDA

PREVIOUS ANESTHETICS AND COMPLICATIONS
- multiple I&Ds / Revisions of LUE amputation
- ϕ difficulties

PRESENT DRUG THERAPY; E.G., STEROIDS, TRANQUILIZERS
1. Unasyn 3 gm IV q6°
2. Haldol prn
3. Ambien prn
4. Levaquin 500 q24° ~~qD~~
5. Gent 150 q24°
~~6. Unasyn~~
~~6. Ativan prn~~
7. Tylenol prn

PREOPERATIVE DIAGNOSIS
- open (L) thigh / s/p LUE amp.

PREMEDICATION

SIGNATURE OF EVALUATING PHYSICIAN
(b)(6)-2 MD (b)(6)-2

DATE
1-5-03

POSTANESTHETIC VISITS

RECORD ALL PERTINENT COMPLICATIONS

(b)(6)-4

*U.S. Government Printing Office: 1994 — 300-892/10029

ACLU-RDI 1099 p.646

DOD 005914

MEDICAL RECORD - ANESTHESIA

For use of this form, see AR 40-66; the proponent agency is the OTSG

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML. "I" = CONSTANT INFUSION

DRUG	(Units)		
Fentanyl	(mg)	250	
Propofol	(mg)	180	
Succ	(mg)	100	
MSO4	( )	(5)	(5)
	( )		
	( )		
VOLAT AGENT	% del		
	T50 % e.t.	1.5	1.5
AIR	L/Min		
N2O	L/Min		
O2	L/Min	8 2	2

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS → ① ② ③ ④

FLUIDS

LINE site			
NS c̄ 20mg KCl	☐ Warmed		
	☐ Warmed		
	☐ Warmed		
	☐ Warmed		

LOSSES

EST BLOOD LOSS			
URINE	/	/	/

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 75 KG LB

HEMATOCRIT: 29/10

INITIAL DATA:

BP- 120 / 76

HR- 109

EQUIP CHECK

OK?- Ⓨ N

PATIENT RECHECK

OK for PROCEDURE? yes

TIME- 1045

TIME → 1115 30 X 1200 X 30 X 1300 X 30 X 1400

SYMBOLS:

BP by cuff V Λ

Heart rate ●

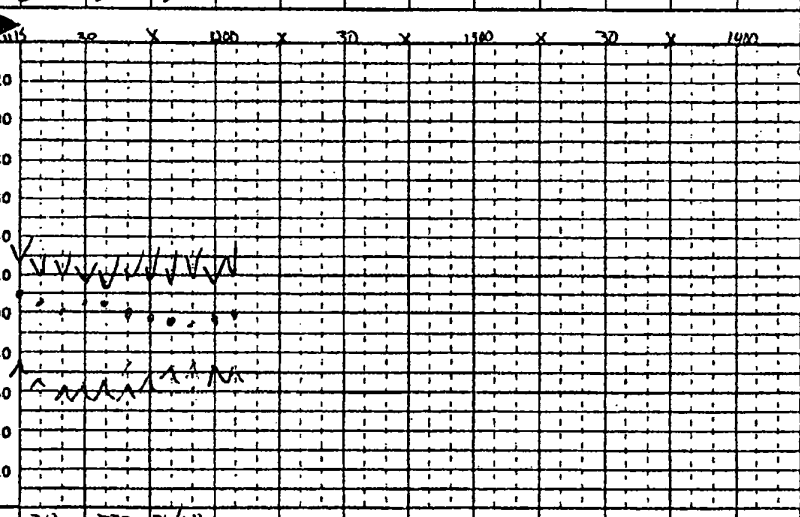
Resp rate

BR (transduced)

TOURNIQUET T—T

ANES- X-X

PROC- ⊙-Ø



VENTIL

VT - ml	710	730	710/400
f - breaths/min	10	10	10/13
Peak inf pres / PEEP	23	24	–
MODE - S(pon), A(assist), C(on)	S C	C	C/S

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	46	41	39
BP/oth	FIO2 (Frac or %)	1.0	1.0	1.0
ART line	SpO2 (%)	99	99	99
Steth- PC/ES	ECG	ST	ST	NSL
Gas analyzer	TEMP-site	–	–	–
	N-M Block (T/4)	–	–	–
Pressure points checked - padded		✓	✓	✓
Warming blkt	Warm sheets applied			
Conv warmer				

Mark with letters & symbols, explain under REMARKS — EVENTS Position →

TOTALS

TOTAL EBL (b)(6)-2

TOTAL URINE 100

FLUIDS - SUMMARY

CRYSTALLOID- 60 - NS c̄ 20mg KCl

COLLOID- Ø

BLOOD- Ø

REMARKS

Code drugs with numbers, events with letters

① Pt interviewed, chart reviewed.
② Pt to OR, monitor O2 applied. Pt induced intubated c̄ difficult
③ Pt tolerated procedure start well.
④ Zosyn 3.25 gm IV infused over 30 minutes. —
⑤ Pt SV @ rate 12 TV 410, pt suctioned then extubated, oral airway in place.
⑥ Pt transported to ICU, report given to ICT (b)(6)-2

RECOVERY AT 1205

PACU ICU #1 (Specify)

OTHER

CONDITION: stable

RESP- 18 SpO2- 96%

BP- 119/72 HR- 109

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1045	1115	1210
	Ready	Begin	End
PROC	1120	1135	1205

PROCEDURES and CPT Codes:

Stump closure to ① Acm

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*

(b)(6)-4

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

GETA

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*

RSI (modified) c̄ CP DLX1 (grade 1 view) 8.0 ETT placed to 22cm @ teeth @ BBS, ETT secured

SURGEONS:

PROCEDURE LOCATION:

DATE:

MEDCOM - 1863

PREANESTHETIC SUMMARY

OPERATION PROPOSED	AGE	WEIGHT (LBS.)	SPECIAL INFORMATION
Washout	34	75	NPO since 0300 19 Sept 03

PHYSICAL STATUS: 1 **6** 3 4 5 6 7

URINALYSIS
NORMAL .....
ABNORMAL AND WHY?

HEMATOLOGY
HGB ..... RBC ..... HCT .....
OTHER
~~10~~ / 10.8 / 10.8 / 29.9 / 462

BLOOD CHEMISTRY
134 / 2.4 / 91 / 39 / 3.6 / 6.9 / 201

RESPIRATORY SYSTEM	CIRCULATORY SYSTEM	CENTRAL NERVOUS SYSTEM	OTHER SYSTEMS
(X-RAY, ASTHMA, OTHER PATHOLOGY)	BP ..... PULSE ..... ECG (IF PERTINENT)	(CEREBROVASCULAR, POLIO, NEUROLOGICAL)	(ALLERGIES) NKDA

PREVIOUS ANESTHETICS AND COMPLICATIONS	PRESENT DRUG THERAPY; E.G., STEROIDS, TRANQUILIZERS
PREOPERATIVE DIAGNOSIS	PREMEDICATION

SIGNATURE OF EVALUATING PHYSICIAN: (b)(6)-2 CPT, CRNA
DATE: 19 Sep 03

POSTANESTHETIC VISITS

RECORD ALL PERTINENT COMPLICATIONS

*U.S. Government Printing Office: 1994 — 300-892/10029

ACLU-RDI 1099 p.648

DOD 005916

MEDICAL RECORD	REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

A. IDENTIFICATION

1. OPERATION OR PROCEDURE I → D ⓛ Thigh wound possible ex-Fix
I → D ⓡ forearm amputation + revision ⓡ flexor
amputation

B. STATEMENT OF REQUEST

1. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be

(Description of operation or procedure in layman's language)

without wounds ⓡ arm + ⓛ Thigh
Ex-Fix ⓛ hip/flexor

which is to be performed by or under the direction of Dr. (b)(6)-2 (b)(6)-2 / (b)(6)-2

2. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the below-named medical facility, during the course of the above-named operation or procedure.

3. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the below-named medical facility.

4. Exceptions to surgery or anesthesia, if any, are: none

(If "none", so state)

5. I request the disposal by authorities of the below-named medical facility of any tissues or parts which it may be necessary to remove.

6. I understand that photographs and movies may be taken of this operation, and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and observation of the operation by authorized personnel, subject to the following conditions:

a. The name of the patient and his/her family is not used to identify said pictures
b. Said pictures be used only for purposes of medical/dental study or research

(Cross out any parts above which are not appropriate)

C. SIGNATURES (Appropriate items in Parts A and B must be completed before signing)

1. COUNSELING PHYSICIAN/DENTIST: I have counseled this patient as to the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above

(b)(6)-2

(Signature of Counseling Physician/Dentist)

2. PATIENT: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(b)(6)-2 SSG.

(Signature of members of operating team)

(b)(6)-4 (b)(6)-4

(Signature of Patient)

1900 8/5/03

(Date and Time)

3. SPONSOR OR GUARDIAN: (When patient is a minor or unable to give consent) I, _____ sponsor/guardian of _____ understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(Signature of Witness, excluding members of operating team) | (Signature of Sponsor/Legal Guardian) | (Date and Time)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; unit; hospital or medical facility)

(b)(6)-4

REGISTER NO.

WARD NO.

STANDARD FORM 522 (Rev. 10-76)
General Services Administration &
Interagency Comm. on Medical Records
FIRMR (41 CFR) 201-45.505
522-110

*U.S. Government Printing Office: 1991 — 312-071/40193

MEDCOM - 1865

522-113 NSN 7540-00-634-4165

MEDICAL RECORD

REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

A. IDENTIFICATION

1. OPERATION OR PROCEDURE I+D ⓛarm / ⓛleg wounds
Adjust ex-fix / Revise Amputation ⓛ arm

B. STATEMENT OF REQUEST

1. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be washout ⓛarm /ⓛleg wounds (Description of operation or procedure in layman's language)
Adjust ex-fix/ Revise Amputation ⓛarm

which is to be performed by or under the direction of Dr. (b)(6)-2

2. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the below-named medical facility, during the course of the above-named operation or procedure.

3. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the below-named medical facility.

4. Exceptions to surgery or anesthesia, if any, are: none (If "none", so state)

5. I request the disposal by authorities of the below-named medical facility of any tissues or parts which it may be necessary to remove.

6. I understand that photographs and movies may be taken of this operation, and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and observation of the operation by authorized personnel, subject to the following conditions:

a. The name of the patient and his/her family is not used to identify said pictures.

b. Said pictures be used only for purposes of medical/dental study or research.

(Cross out any parts above which are not appropriate)

C. SIGNATURES *(Appropriate items in Parts A and B must be completed before signing)*

1. COUNSELING PHYSICIAN/DENTIST: I have counseled this patient as to the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above.

(b)(6)-2
(Signature of Counseling Physician/Dentist)

2. PATIENT: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(b)(6)-2 CPT
(Signature of Witness, excluding members of operating team)

(b)(6)-4
(Signature of Patient)

8/27/03
(Date and Time)

3. SPONSOR OR GUARDIAN: (When patient is a minor or unable to give consent) I, _____ sponsor/guardian of _____ understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(Signature of Witness, excluding members of operating team) (Signature of Sponsor/Legal Guardian) (Date and Time)

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)*

(b)(6)-4

REGISTER NO. WARD NO.

REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

Medical Record

STANDARD FORM 522 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

☆ U.S. GOVERNMENT PRINTING OFFICE: 1996-390-857

MEDCOM - 1866

522-113 NSN 7540-00-634-4165

MEDICAL RECORD

REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

A. IDENTIFICATION

1. OPERATION OR PROCEDURE I&D @ arm & @ Thigh
revise amputation @ arm

B. STATEMENT OF REQUEST

1. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be

(Description of operation or procedure in layman's language)

I&D @ arm & @ Thigh
revise amputation @ arm

which is to be performed by or under the direction of Dr. (b)(6)-2, (b)(6)-2

2. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the below-named medical facility, during the course of the above-named operation or procedure.

3. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the below-named medical facility.

4. Exceptions to surgery or anesthesia, if any, are: none

(If "none", so state)

5. I request the disposal by authorities of the below-named medical facility of any tissues or parts which it may be necessary to remove.

6. I understand that photographs and movies may be taken of this operation, and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and observation of the operation by authorized personnel, subject to the following conditions:

a. The name of the patient and his/her family is not used to identify said pictures.

b. Said pictures be used only for purposes of medical/dental study or research.

(Cross out any parts above which are not appropriate)

C. SIGNATURES *(Appropriate items in Parts A and B must be completed before signing)*

1. COUNSELING PHYSICIAN/DENTIST: I have counseled this patient as to the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above.

(b)(6)-2

(Signature of Counseling Physician/Dentist)

2. PATIENT: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(b)(6)-2 (b)(6)-4 29 Aug03 0855

(Signature of Witness, excluding members of operating team) *(Signature of Patient)* *(Date and Time)*

3. SPONSOR OR GUARDIAN: (When patient is a minor or unable to give consent) I, _____ sponsor/guardian of _____ understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(Signature of Witness, excluding members of operating team) *(Signature of Sponsor/Legal Guardian)* *(Date and Time)*

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)* | REGISTER NO. | WARD NO.

(b)(6)-4

REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

Medical Record

☆ U.S. GOVERNMENT PRINTING OFFICE: 1995-390-867

STANDARD FORM 522 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 1867

MEDICAL RECORD	REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

A. IDENTIFICATION

1. OPERATION OR PROCEDURE

I+D left ARM STUMP, change Dressing

B. STATEMENT OF REQUEST

1. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be _____ *(Description of operation or procedure in layman's language)*

cleaning WOUNDS

which is to be performed by or under the direction of Dr. (b)(6)-2

2. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the below-named medical facility, during the course of the above-named operation or procedure.

3. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the below-named medical facility.

4. Exceptions to surgery or anesthesia, if any, are: None *(If "none", so state)*

5. I request the disposal by authorities of the below-named medical facility of any tissues or parts which it may be necessary to remove.

6. I understand that photographs and movies may be taken of this operation, and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and observation of the operation by authorized personnel, subject to the following conditions:

a. The name of the patient and his/her family is not used to identify said pictures.
b. Said pictures be used only for purposes of medical/dental study or research.

(Cross out any parts above which are not appropriate)

C. SIGNATURES *(Appropriate items in Parts A and B must be completed before signing)*

1. COUNSELING PHYSICIAN/DENTIST: I have counseled this patient as to the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above.

(b)(6)-2

(Signature of Counseling Physician/Dentist)

Interpreter present

2. PATIENT: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and request such procedure(s) be performed.

(b)(6)-2 (b)(6)-4

ILT, AN X 8/3/03

(Signature of Witness, excluding members of operating team) (Signature of Patient) (Date and Time)

(b)(6)-2

3. SPONSOR OR GUARDIAN: (When patient is a minor or unable to give consent) I, _____ sponsor/guardian of _____ understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(Signature of Witness, excluding members of operating team) (Signature of Sponsor/Legal Guardian) (Date and Time)

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; grade; unit; hospital or medical facility)*

(b)(6)-4

REGISTER NO. WARD NO.

STANDARD FORM 522 (Rev. 10-76)
General Services Administration &
Interagency Comm. on Medical Records
FIRMR (41 CFR) 201-45.505
522-110

MEDCOM - 1868

*U.S. Government Printing Office: 1991 — 312-071/40193

MEDICAL RECORD	REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

A. IDENTIFICATION

1. OPERATION OR PROCEDURE

I+D (L) hip, (L) Elbow, possible closed (L) Elbow

B. STATEMENT OF REQUEST

1. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be _____
(Description of operation or procedure in layman's language)

WASHOUT

which is to be performed by or under the direction of Dr. (b)(6)-2

2. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the below-named medical facility, during the course of the above-named operation or procedure.

3. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the below-named medical facility.

4. Exceptions to surgery or anesthesia, if any, are: none
(If "none", so state)

5. I request the disposal by authorities of the below-named medical facility of any tissues or parts which it may be necessary to remove.

6. I understand that photographs and movies may be taken of this operation, and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and observation of the operation by authorized personnel, subject to the following conditions:

a. The name of the patient and his/her family is not used to identify said pictures.
b. Said pictures be used only for purposes of medical/dental study or research.

(Cross out any parts above which are not appropriate)

C. SIGNATURES *(Appropriate items in Parts A and B must be completed before signing)*

1. COUNSELING PHYSICIAN/DENTIST: I have counseled this patient as to the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above.

X (b)(6)-2
(Signature of Counseling Physician/Dentist)

2. PATIENT: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(b)(6)-2
(Signature of Witness, excluding members of operating team)

X (b)(6)-4
(Signature of Patient)

9/5/03 @ 1515
(Date and Time)

(b)(6)-2

3. SPONSOR OR GUARDIAN: (When patient is a minor or unable to give consent) I, _____ sponsor/guardian of _____ understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(Signature of Witness, excluding members of operating team) | (Signature of Sponsor/Legal Guardian) | (Date and Time)

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; grade; unit; hospital or medical facility)*

REGISTER NO. | WARD NO.

STANDARD FORM 522 (Rev. 10-78)
General Services Administration &
Interagency Comm. on Medical Records
FIRMR (41 CFR) 201-45.505
522-110

MEDCOM - 1869

*U.S. Government Printing Office: 1991 — 312-071/40193

MEDICAL RECORD	REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

A. IDENTIFICATION

1. OPERATION OR PROCEDURE

I&D (L) BE Amputation, Dressing Change

B. STATEMENT OF REQUEST

1. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be

(Description of operation or procedure in layman's language)

WASHOUT

which is to be performed by or under the direction of Dr. (b)(6)-2

2. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the below-named medical facility, during the course of the above-named operation or procedure.

3. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the below-named medical facility.

4. Exceptions to surgery or anesthesia, if any, are: None

(If "none", so state)

5. I request the disposal by authorities of the below-named medical facility of any tissues or parts which it may be necessary to remove.

6. I understand that photographs and movies may be taken of this operation, and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and observation of the operation by authorized personnel, subject to the following conditions:

a. The name of the patient and his/her family is not used to identify said pictures.
b. Said pictures be used only for purposes of medical/dental study or research.

(Cross out any parts above which are not appropriate)

C. SIGNATURES *(Appropriate items in Parts A and B must be completed before signing)*

1. COUNSELING PHYSICIAN/DENTIST: I have counseled this patient as to the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above.

(b)(6)-2

(Signature of Counseling Physician/Dentist)

2. PATIENT: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(b)(6)-2

(Signature of Witness, excluding members of operating team)

X (b)(6)-4

(Signature of Patient)

10Sep03-2000

(Date and Time)

3. SPONSOR OR GUARDIAN: (When patient is a minor or unable to give consent) I, _____ sponsor/guardian of _____ understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(Signature of Witness, excluding members of operating team)

(Signature of Sponsor/Legal Guardian)

(Date and Time)

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)*

(b)(6)-4

REGISTER NO.

WARD NO.

STANDARD FORM 522 (Rev. 10-76)
General Services Administration &
Interagency Comm. on Medical Records
FIRMR (41 CFR) 201-45.505
522-110

MEDCOM - 1870

...Government Printing Office: 1991 — 312-071/40193

ACLU-RDI 1099 p.654

DOD 005922

MEDICAL RECORD	REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

A. IDENTIFICATION

1. OPERATION OR PROCEDURE

IVD, closure of left Amp site

B. STATEMENT OF REQUEST

1. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be _____
(Description of operation or procedure in layman's language)

which is to be performed by or under the direction of Dr. (b)(6)-2

2. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the below-named medical facility, during the course of the above-named operation or procedure.

3. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the below-named medical facility.

4. Exceptions to surgery or anesthesia, if any, are: None
(If "none", so state)

5. I request the disposal by authorities of the below-named medical facility of any tissues or parts which it may be necessary to remove.

6. I understand that photographs and movies may be taken of this operation, and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and observation of the operation by authorized personnel, subject to the following conditions:

a. The name of the patient and his/her family is not used to identify said pictures.
b. Said pictures be used only for purposes of medical/dental study or research.

(Cross out any parts above which are not appropriate)

C. SIGNATURES *(Appropriate items in Parts A and B must be completed before signing)*

1. COUNSELING PHYSICIAN/DENTIST: I have counseled this patient as to the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above.

(b)(6)-2
(Signature of Counseling Physician/Dentist)

2. PATIENT: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(b)(6)-2 LCpl
(Signature of Witness, excluding members of operating team)

(b)(6)-4
(Signature of Patient)

9/18/03 0800
(Date and Time)

(b)(6)-2

3. SPONSOR OR GUARDIAN: (When patient is a minor or unable to give consent) I, _____ sponsor/guardian of _____ understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(Signature of Witness, excluding members of operating team) | (Signature of Sponsor/Legal Guardian) | (Date and Time)

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; grade; unit; hospital or medical facility)*

(b)(6)-4

REGISTER NO.

WARD NO.

STANDARD FORM 522 (Rev. 10-76)
General Services Administration &
Interagency Comm. on Medical Records
FIRMR (41 CFR) 201-45.505
522-110

MEDCOM - 1871

*U.S. Government Printing Office: 1991 — 312-071/40193

MEDICAL RECORD	REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

A. IDENTIFICATION

1. OPERATION OR PROCEDURE

I&D Left Forearm c shortening of Bone wound Packing Chip

B. STATEMENT OF REQUEST

1. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be _____
(Description of operation or procedure in layman's language)

Blast injury

which is to be performed by or under the direction of Dr. _____

2. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the below-named medical facility, during the course of the above-named operation or procedure.

3. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the below-named medical facility.

4. Exceptions to surgery or anesthesia, if any, are: None
(If "none", so state)

5. I request the disposal by authorities of the below-named medical facility of any tissues or parts which it may be necessary to remove.

6. I understand that photographs and movies may be taken of this operation, and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and observation of the operation by authorized personnel, subject to the following conditions:

a. The name of the patient and his/her family is not used to identify said pictures
b. Said pictures be used only for purposes of medical/dental study or research.

(Cross out any parts above which are not appropriate)

C. SIGNATURES (Appropriate items in Parts A and B must be completed before signing)

1. COUNSELING PHYSICIAN/DENTIST: I have counseled this patient as to the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above

(b)(6)-2

ing Physician/Dentist)

2. PATIENT: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(b)(6)-2

(b)(6)-2

CPT

mbers of operating team)

(b)(6)-4

(Signature of Patient)

(Date and Time)

3. SPONSOR OR GUARDIAN: (When patient is a minor or unable to give consent) I, _____ sponsor/guardian of _____ understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(Signature of Witness, excluding members of operating team) | (Signature of Sponsor/Legal Guardian) | (Date and Time)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)

REGISTER NO. | WARD NO.

STANDARD FORM 522 (Rev. 10-75)
General Services Administration &
Interagency Comm. on Medical Records
FIRMR (41 CFR) 201-45.505
522-110

*U.S. Government Printing Office: 1991 — 312-071/40193

MEDCOM - 1872

MEDICAL RECORD	REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

A. IDENTIFICATION

1. OPERATION OR PROCEDURE I&D @ arm & @ Thigh

B. STATEMENT OF REQUEST

1. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be _____ *(Description of operation or procedure in layman's language)*

without @ arm & @ Thigh

which is to be performed by or under the direction of Dr. _____

2. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the below-named medical facility, during the course of the above-named operation or procedure.

3. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the below-named medical facility.

4. Exceptions to surgery or anesthesia, if any, are: none *(If "none", so state)*

5. I request the disposal by authorities of the below-named medical facility of any tissues or parts which it may be necessary to remove.

6. I understand that photographs and movies may be taken of this operation, and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and observation of the operation by authorized personnel, subject to the following conditions:

   a. The name of the patient and his/her family is not used to identify said pictures.
   b. Said pictures be used only for purposes of medical/dental study or research.

(Cross out any parts above which are not appropriate)

C. SIGNATURES *(Appropriate items in Parts A and B must be completed before signing)*

1. COUNSELING PHYSICIAN/DENTIST: I have counseled this patient as to the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above.

(b)(6)-2

(Signature of Counseling Physician/Dentist)

2. PATIENT: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(b)(6)-2 (b)(6)-4

(Signature of Witness, excluding members of operating team) (Signature of Patient) (Date and Time)

3. SPONSOR OR GUARDIAN: (When patient is a minor or unable to give consent) I, _____ sponsor/guardian of _____ understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(b)(6)-2

(Signature of Witness, excluding members of operating team) (Signature of Sponsor/Legal Guardian) (Date and Time)

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)*

(b)(6)-4

REGISTER NO. WARD NO.

STANDARD FORM 522 (Rev. 10-78)
General Services Administration &
Interagency Comm. on Medical Records
FIRMR (41 CFR) 201-45.505
522-110

*U.S. Government Printing Office: 1991 — 312-071/40193

MEDCOM - 1873

ACLU-RDI 1099 p.657

DOD 005925

MEDICAL RECORD	REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

A. IDENTIFICATION

1. OPERATION OR PROCEDURE

Washout LUE/LLG

B. STATEMENT OF REQUEST

1. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be _____
(Description of operation or procedure in layman's language)

which is to be performed by or under the direction of Dr. _____

2. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the below-named medical facility, during the course of the above-named operation or procedure.

3. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the below-named medical facility.

4. Exceptions to surgery or anesthesia, if any, are: _____
(If "none", so state)

5. I request the disposal by authorities of the below-named medical facility of any tissues or parts which it may be necessary to remove.

6. I understand that photographs and movies may be taken of this operation, and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and observation of the operation by authorized personnel, subject to the following conditions:

a. The name of the patient and his/her family is not used to identify said pictures.
b. Said pictures be used only for purposes of medical/dental study or research.

(Cross out any parts above which are not appropriate)

C. SIGNATURES *(Appropriate items in Parts A and B must be completed before signing)*

1. COUNSELING PHYSICIAN/DENTIST: I have counseled this patient as to the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above

_____
(Signature of Counseling Physician/Dentist)

2. PATIENT: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed. (b)(6)-4

_____ (Signature of Witness, excluding members of operating team)

_____ (Signature of Patient)

_____ (Date and Time)

3. SPONSOR OR GUARDIAN: (When patient is a minor or unable to give consent) I, _____ sponsor/guardian of _____ understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(b)(6)-2

_____ (Signature of Witness, excluding members of operating team)

_____ (Signature of Sponsor/Legal Guardian)

_____ (Date and Time)

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; grade; unit; hospital or medical facility)*

REGISTER NO. | WARD NO.

STANDARD FORM 522 (Rev. 10-78)
General Services Administration &
Interagency Comm. on Medical Records
FIRMR (41 CFR) 201-45.505
522-110

MEDCOM - 1874

*U.S. Government Printing Office: 1991 — 312-071/40183

518-124

NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED (Check one)

- [x] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS (Pool of _____ units)
- [ ] CRYOPRECIPITATE (Pool of _____ units)
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER (Specify) _____

VOLUME REQUESTED (If applicable) 450 ML

REMARKS:

TYPE OF REQUEST (Check ONLY if Red Blood Cell Products are requested.)

- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED

DATE AND HOUR REQUIRED

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION (Specify) [redacted] CRNA

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN (Print) (b)(6)-2 MD

DIAGNOSIS OR OPERATIVE PROCEDURE LGD LUE & LLE

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

DATE [redacted]ED 25 AUG 03

TIME VERIFIED 2230

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. 4713296

TRANSFUSION NO.

PATIENT NO.

DONOR

ABO O

Rh POS

RECIPIENT

ABO O

Rh POS

TEST INTERPRETATION

ANTIBODY SCREEN: not performed

CROSSMATCH: Comp

PREVIOUS RECORD CHECK:

- [ ] [redacted]
- [x] NO [redacted]

[redacted]RSON [redacted]G TEST (b)(6)-2

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT [redacted]QUEST (b)(6)-2 DATE 25 Aug 03

REMARKS: Due to the critical condition of the below named patient, the requesting physician named above requests the immediate release of this blood product for transfusion without complete testing and is accepting full responsibility for the administration of this transfusion.

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

[redacted] INSPECTED AND ISSUED BY (Signature) (b)(6)-2 [redacted]

(b)(6)-2

[redacted] (Ho[redacted] 2248 ON (Date) 25 Aug 03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER (Signature) (b)(6)-2

2nd VERIFIER (Signature) (b)(6)-2 MD

PRE-TRANSFUSION

TEMP. 95° PULSE 83 BP 129/71

DATE OF TRANSFUSION 25 Aug. 03

TIME STARTED 2255

POST-TRANSFUSION DATA

AMOUNT GIVEN All ML

TIME/DATE COMPLETED/INTERRUPTED 2305 | 25 Aug 03

REACTION [x] NONE [ ] SUSPECTED

TEMPERATURE 95°

PULSE 85

BLOOD PRESSURE 135/80

If reaction is suspected—IMMEDIATELY:

1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION OF REACTION

- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER (Specify)

OTHER DIFFICULTIES (Equipment, clots, etc.)

- [x] NO
- [ ] YES (Specify)

SIGNATURE OF PERSON NOTING ABOVE (b)(6)-2 MD

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle, grade, rank, rate; hospital or medical facility)

SEX M

WARD OR

NAME/RANK

FMP/SS#

DOB

(b)(6)-4

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 1875

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED (Check one)
- [x] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS (Pool of ____ units)
- [ ] CRYOPRECIPITATE (Pool of ____ units)
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER (Specify) ____

VOLUME REQUESTED (If applicable): 450 ML

REMARKS:

TYPE OF REQUEST (Check ONLY if Red Blood Cell Products are requested.)
- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED

DATE AND HOUR REQUIRED

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION (Specify)

IF PATIENT IS FEMALE, IS THERE HISTORY OF:
RhIG TREATMENT? DATE GIVEN: ____
HEMOLYTIC DISEASE OF NEWBORN? ____

REQUESTING PHYSICIAN (Print): (b)(6)-2 [redacted] MCP

DIAGNOSIS OR OPERATIVE PROCEDURE: LED LUE & LLE

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER: (b)(6)-2 [redacted] CM CRNA

DATE VERIFIED: 25 AUG 03

TIME VERIFIED: 1130

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.	TRANSFUSION NO.	TEST INTERPRETATION: ANTIBODY SCREEN	TEST INTERPRETATION: CROSSMATCH
W0013 03 011107	PATIENT NO.	not performed	Comp
DONOR	RECIPIENT		
ABO O	ABO O		
Rh POS	Rh POS		

PREVIOUS RECORD CHECK: [ ] RECORD [x] NO RECORD

SIGNATURE OF PERFORMING TEST: (b)(6)-2 [redacted]

DATE: 25 Aug 03

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

REMARKS: Due to the critical condition of the below named patient the requesting physician named above requests the immediate release of this blood product for transfusion without complete testing and is accepting full responsibility for the administration of this transfusion.

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

(b)(6)-2 [redacted]

INSPECTED AND ISSUED BY (Signature) (b)(6)-2 [redacted]

(b)(6)-2 [redacted]

(b)(6)-2 [redacted]

AT (Hour) 0220 / 25 Aug

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER (Signature): (b)(6)-2 [redacted] MD

2nd VERIFIER (Signature): (b)(6)-2 [redacted] Maj/A

PRE-TRANSFUSION

TEMP. 94.9 PULSE 85 BP 134/78

DATE OF TRANSFUSION: 25 Aug. 03

TIME STARTED: 2312

POST-TRANSFUSION DATA

AMOUNT GIVEN: All ML

TIME / DATE / COMPLETED / INTERRUPTED: 2325 / 25 Aug. 03

REACTION: [x] NONE [ ] SUSPECTED

If reaction is suspected – IMMEDIATELY:
1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION
- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER ____

OTHER DIFFICULTIES (Equipment, clots, etc.)
- [x] NO
- [ ] YES (Specify) ____

SIGNATURE OF PERSON NOTING ABOVE: (b)(6)-2 [redacted] MD

SEX: M

WARD: OR

PATIENT IDENTIFICATION - USE EMBOSSER (For typed or written entries give: NAME - Last, first, middle; rank/rate; hospital number and name of facility.)

Name/Rank (b)(6)-4 [redacted]

FMP/SS#

DOB

Unit

BLOOD OR BLOOD COMPONENT TRANSFUSION STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

MEDCOM - 1876

MEDICAL RECORD COPY

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED (Check one)
- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS (Pool of ____ units)
- [ ] CRYOPRECIPITATE (Pool of ____ units)
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER (Specify) ____

TYPE OF REQUEST (Check ONLY if Red Blood Cell Products are requested.)
- [ ] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED: 30 AUG 03

DATE AND HOUR REQUIRED: ASAP

REQUESTING PHYSICIAN (Print): (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE: tibia fx, S/P explosion – (L) BEA

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

VOLUME REQUESTED (If applicable): 1 unit ML

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION (Specify): NA

SIGNATURE OF VERIFIER: (b)(6)-2 105

REMARKS:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:
RhIG TREATMENT? DATE GIVEN: NA
HEMOLYTIC DISEASE OF NEWBORN? ____

DATE VERIFIED: 30 AUG 03

TIME VERIFIED: 2105

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.: EXP Sep 8 2003 SST20133 SCO# L2 898253

TRANSFUSION NO.:

PATIENT NO.:

TEST INTERPRETATION

ANTIBODY SCREEN: not performed

CROSSMATCH: Compatible

PREVIOUS RECORD CHECK: [X] RECORD [X] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST: (b)(6)-2

DONOR: ABO O, Rh POS

RECIPIENT: ABO O, Rh POS

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED DATE: 30 Aug 03

REMARKS: due to the critical condition of the below named pt, the requesting MD named above requests the immediate release of this blood product for transfusion w/out complete testing and is accepting full responsibility for the admin. of this transfusion

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY (Signature): (b)(6)-2 SPC

AT (Hour): 0415 0425 ON (Date): 31 Aug 03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER (Signature): (b)(6)-2 CPT/AN

2nd VERIFIER (Signature): (b)(6)-2 (b)(6)-2

PRE-TRANSFUSION TEMP. 99.6 PULSE 107 BP 126/75

DATE OF TRANSFUSION: 31 Aug 03

TIME STARTED: 0455

POST-TRANSFUSION DATA

AMOUNT GIVEN: 1 U ML

TIME DATE COMPLETED: 0800 31 Aug

INTERRUPTED

REACTION: [X] NONE [ ] SUSPECTED

If reaction is suspected – IMMEDIATELY:
1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION
- [ ] URTICARIA [ ] CHILL [ ] FEVER [ ] PAIN
- [ ] OTHER T: 99.5 BP 129/78 HR 105

OTHER DIFFICULTIES (Equipment, clots, etc.)
- [X] NO [ ] YES (Specify) ____

SIGNATURE OF PERSON NOTING ABOVE: (b)(6)-2 CAT AN

PATIENT IDENTIFICATION - USE EMBOSSER (For typed or written entries give: NAME - Last, first, middle; rank/rate; hospital number and name of facility.)

(b)(6)-4

SEX: (b)(6)-2

WARD: ICU-2

BLOOD OR BLOOD COMPONENT TRANSFUSION STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

MEDCOM - 1877

MEDICAL RECORD COPY

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*
- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of ____ units)*
- [ ] CRYOPRECIPITATE *(Pool of ____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* ____

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*
- [ ] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED: 30 AUG 03

DATE AND HOUR REQUIRED: ASAP

REQUESTING PHYSICIAN *(Print)*: (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE: S/P explosive injury, ① tibia ② Bern

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

VOLUME REQUESTED *(If applicable)*: 1 unit ML

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*: NA

SIGNATURE OF VERIFIER: (b)(6)-2

REMARKS:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:
RhIG TREATMENT? DATE GIVEN: NA
HEMOLYTIC DISEASE OF NEWBORN? ____

DATE: 30 AUG 03

TIME VERIFIED: 2105

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.: (b)(6)-4

TRANSFUSION NO.:

PATIENT NO.:

DONOR: ABO O; Rh POS

RECIPIENT: ABO O; Rh POS

TEST INTERPRETATION

ANTIBODY SCREEN: not performed

CROSSMATCH: compatible

PREVIOUS RECORD CHECK: [X] RECORD [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST: (b)(6)-2

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED | DATE

REMARKS: DIT the critical cond. of this pt. (below named) the requesting MD (above) requests the immediate release of this blood product for transfusion w/o complete testing and is accepting full resp. for the admin. of this transfusion

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

(b)(6)-2 SPC

AT *(Hour)* 0015 ON *(Date)* 31 Aug 03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER *(Signature)*: (b)(6)-2 RN/AN

2nd VERIFIER *(Signature)*: (b)(6)-2

PRE-TRANSFUSION

TEMP. 100.3 PULSE 116 BP 135/69

DATE OF TRANSFUSION: 31 AUG 03

TIME STARTED: 0025

POST-TRANSFUSION DATA

AMOUNT GIVEN: ____ ML

TIME DATE COMPLETED INTERRUPTED: 0025 31 AUG 03 0425

REACTION: [X] NONE [ ] SUSPECTED

If reaction is suspected – IMMEDIATELY:
1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION
- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER NA

OTHER DIFFICULTIES *(Equipment, clots, etc.)*: [X] NO [ ] YES *(Specify)* ____

SIGNATURE OF PERSON NOTING ABOVE: (b)(6)-2 [signature]

PATIENT IDENTIFICATION - USE EMBOSSER *(For typed or written entries give: NAME - Last, first, middle; rank/rate; hospital number and name of facility.)*

(b)(6)-4

SEX: Male

WARD: ICU-2

BLOOD OR BLOOD COMPONENT TRANSFUSION STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

MEDCOM - 1878

MEDICAL RECORD COPY

518-124 NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*
- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of _____ units)*
- [ ] CRYOPRECIPITATE *(Pool of _____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* _____

VOLUME REQUESTED *(If applicable)* 1 unit ML

REMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*
- [ ] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED 14 Sept 03

DATE AND HOUR REQUIRED 14 Sept 03/1110

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)* None

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: —

HEMOLYTIC DISEASE OF NEWBORN? —

REQUESTING PHYSICIAN *(Print)* Dr (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE s/P (L) UE Amp (L) LE Femur F

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER (b)(6)-2 CPT/AN

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. (b)(6)-4

TRANSFUSION NO.

PATIENT NO.

DONOR (pn)
ABO O
Rh positive

RECIPIENT (pn)
ABO O
Rh positive

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
Not performed	compatible

PREVIOUS RECORD CHECK: (b)(6)-2
- [X] RECORD
- [X] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST (b)(6)-2

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 14 Sept 03

REMARKS: Due to the critical condition of the below named patient, the requesting physician named above requests the immediate release of this blood product without complete testing and is accepting the (OD) full responsibility for the administration of this transfusion.

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*

AT *(Hour)* ON *(Date)*

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER *(Signature)* (b)(6)-2 CPT/AN

2nd VERIFIER *(Signature)* (b)(6)-2 CPT AN

PRE-TRANSFUSION
TEMP. 100.3 PULSE 106 BP 112/65

DATE OF TRANSFUSION 14 SEP 03

TIME STARTED 1410

POST-TRANSFUSION DATA

AMOUNT GIVEN 250 ML

TIME/DATE (COMPLETED)/~~INTERRUPTED~~ 1800 14 SEP 03

REACTION
- [X] NONE
- [ ] SUSPECTED

TEMPERATURE 100.2 PULSE 104 BLOOD PRESSURE 116/72

If reaction is suspected—IMMEDIATELY:
1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION OF REACTION
- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER *(Specify)*

OTHER DIFFICULTIES *(Equipment, clots, etc.)*
- [X] NO
- [ ] YES *(Specify)*

SIGNATURE OF PERSON NOTING ABOVE (b)(6)-2 CPT/AN

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle; grade; rank; rate; hospital or medical facility)

(b)(6)-4

SEX M

WARD ICU #1

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 1879

Medical Record Copy

518-124 NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*
- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of _____ units)*
- [ ] CRYOPRECIPITATE *(Pool of _____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* _____

VOLUME REQUESTED *(If applicable)*: 1 unit ML

REMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*
- [ ] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED: 14 Sept 03

DATE AND HOUR REQUIRED: 14Sept03/1110

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*: None

IF PATIENT IS FEMALE, IS THERE HISTORY OF:
RhIG TREATMENT? DATE GIVEN: —
HEMOLYTIC DISEASE OF NEWBORN? —

REQUESTING PHYSICIAN *(Print)*: Dr (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE: s/p GSW Amp/LLE femur F;

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER: (b)(6)-2 cpt/an

DATE VERIFIED: 14Sept03 (b)(6)-2

TIME VERIFIED: 1230

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.: (b)(6)-4

TRANSFUSION NO.

PATIENT NO.

DONOR (b)(6)
ABO: O
Rh: Positive

RECIPIENT (b)(6)-2
ABO: O
Rh: Positive

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
Not performed	Compatible

PREVIOUS RECORD CHECK: [X] RECORD [X] (b)(6)-2

SIGNATURE OF PERSON PERFORMING TEST: (b)(6)-2

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED DATE 14 Sept 03

REMARKS: Due to the critical condition of the below named patient the requesting physician named above requests the immediate release of this blood product for transfusion without complete testing and is accepting full responsibility for the administration of this transfusion

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*

AT *(Hour)* | ON *(Date)*

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER *(Signature)*: (b)(6)-2 (b)(6)-2 CPT CA

2nd VERIFIER *(Signature)*: (b)(6)-2

PRE-TRANSFUSION
TEMP. 99.3 | PULSE 99 | BP 123/72

DATE OF TRANSFUSION: 14SEP03 | TIME STARTED: 1815

POST-TRANSFUSION DATA

AMOUNT GIVEN: 250 ML

TIME/DATE COMPLETED/INTERRUPTED: 14SEP03/2045

REACTION: [X] NONE [ ] SUSPECTED

TEMPERATURE: 101.9 | PULSE: 115 | BLOOD PRESSURE: 111/69

If reaction is suspected—IMMEDIATELY:
1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION OF REACTION
- [ ] URTICARIA [ ] CHILL [ ] FEVER [ ] PAIN
- [ ] OTHER *(Specify)*

OTHER DIFFICULTIES *(Equipment, clots, etc.)*
- [X] NO [ ] YES *(Specify)*

SIGNATURE OF PERSON NOTING ABOVE: (b)(6)-2 (b)(6)-2 CPT AP

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle; grade; rank; rate; hospital or medical facility)

(b)(6)-4

SEX: M

WARD: ICU 4

BLOOD OR BLOOD COMPONENT TRANSFUSION
Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 1880

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of ____ units)*
- [ ] CRYOPRECIPITATE *(Pool of ____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* ____

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*

- [ ] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED: 9/2/03

DATE AND HOUR REQUIRED: 9/2/03 ASAP

REQUESTING PHYSICIAN *(Print)*: DR (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE: S/P LUE AMPUTATION LLE EXT FIXATOR

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

VOLUME REQUESTED *(If applicable)*: ____ ML

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*:

SIGNATURE OF VERIFIER: CLOT IN BLOOD BANK

REMARKS:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: ____

HEMOLYTIC DISEASE OF NEWBORN? ____

DATE VERIFIED:

TIME VERIFIED:

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.: (b)(6)-4

TRANSFUSION NO.:

PATIENT NO.:

TEST INTERPRETATION

ANTIBODY SCREEN: NOT performed

CROSSMATCH: comp

PREVIOUS RECORD CHECK: [X] RECORD [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST: (b)(6)-2

DONOR: ABO O, Rh POS

RECIPIENT: ABO O, Rh POS

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED DATE 2 Sep 03

REMARKS: Due to the critical condition of the below named patient the requesting physician named above requests the immediate release of this product w/o complete testing and accepting full responsibility for the administration of this transfusion.

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*: (b)(6)-2

AT *(Hour)*: 1727 ON *(Date)*: 2 Sep 03

IDENTIFICATION:

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER *(Signature)*: (b)(6)-2 MAT/AN

2nd VERIFIER *(Signature)*: (b)(6)-2 ILT, AN

PRE-TRANSFUSION

TEMP. 101°(A) PULSE 110 BP 103/60

DATE OF TRANSFUSION: 9/2/03

TIME STARTED: 1230

POST-TRANSFUSION DATA

AMOUNT GIVEN: 250 ML

TIME DATE COMPLETED: 1500 2 SEP 03

INTERRUPTED: N/A

REACTION: [X] NONE [ ] SUSPECTED

If reaction is suspected – IMMEDIATELY:

1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION

- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER ____

OTHER DIFFICULTIES *(Equipment, clots, etc.)*

- [X] NO
- [ ] YES *(Specify)* ____

SIGNATURE OF PERSON NOTING ABOVE: (b)(6)-2 OT LAN

PATIENT IDENTIFICATION - USE EMBOSSER *(For typed or written entries give: NAME - Last, first, middle; rank/rate; hospital number and name of facility.)*

(b)(6)-4

SEX: M

WARD: ICU # 1

BLOOD OR BLOOD COMPONENT TRANSFUSION STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

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MEDICAL RECORD COPY

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*
- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of ____ units)*
- [ ] CRYOPRECIPITATE *(Pool of ____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* ____

VOLUME REQUESTED *(If applicable)*: ____ ML

REMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*
- [ ] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED: 9/2/03

DATE AND HOUR REQUIRED: 9/2/03

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: ____

HEMOLYTIC DISEASE OF NEWBORN? ____

REQUESTING PHYSICIAN *(Print)*: DR (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE: S/P LUE AMPUTATION LLE EX FIX

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER: CLOT IN BLOOD BANK

DATE VERIFIED

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. (b)(6)-4

TRANSFUSION NO.

PATIENT NO.

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NOT performed	comp

PREVIOUS RECORD CHECK:
- [X] RECORD
- [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST: (b)(6)-2

DONOR	RECIPIENT
ABO O	ABO O
Rh POS	Rh POS

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 25 Sep 03

REMARKS: Due to the critical condition of the below named patient, the requesting physician named above requests the immed. release of this product for transfusion w/o complete testing and is accepting full responsibility for the administration of this transfu

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*: (b)(6)-2

AT *(Hour)*: 1500

ON *(Date)*: 25 Sep 03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER *(Signature)*: (b)(6)-2 CA-LAN

2nd VERIFIER *(Signature)*: (b)(6)-2

PRE-TRANSFUSION (b)(6)-2

TEMP. ~~100~~ 99° (b)(6)-2 PULSE ~~98~~ 100 BP 116/60

DATE OF TRANSFUSION: 25 Sep 03

TIME STARTED: ~~1700~~ 1510 (b)(6)-2

PATIENT IDENTIFICATION - USE EMBOSSER *(For typed or written entries give: NAME - Last, first, middle; rank/rate; hospital number and name of facility.)*

(b)(6)-4

POST-TRANSFUSION DATA

AMOUNT GIVEN	TIME DATE COMPLETED	INTERRUPTED
250 ML	1800 25Sep03	@ 1630

REACTION
- [X] NONE
- [ ] SUSPECTED start @ 1700

If reaction is suspected – IMMEDIATELY:
1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION
- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER ____

OTHER DIFFICULTIES *(Equipment, clots, etc.)*
- [X] NO
- [ ] YES *(Specify)* ____

SIGNATURE OF PERSON NOTING ABOVE: (b)(6)-2

SEX: M

WARD: ICU #1

BLOOD OR BLOOD COMPONENT TRANSFUSION
STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

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NSN 7540-01-165-7294 519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

EXAMINATION(S) REQUESTED	AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
KUB ABD	34	M		ICU 1	
	FILM NO.				PREGNANT ☐ YES ☐ NO
	REQUESTED BY (Print) (b)(6)-2				TELEPHONE/PAGE NO.
	SIGNATURE OF REQUESTOR				DATE REQUESTED 3 Sep 03

SPECIFIC REASON(S) FOR REQUEST *(Complaints and findings)*

s/p Explosion. Distended Abd & Illeus

DATE OF EXAMINATION *(Month, day, year)*	DATE OF REPORT *(Month, day, year)*	DATE OF TRANSCRIPTION *(Month, day, year)*

RADIOLOGIC REPORT

Persistent gaseous distension & large bowel not significantly changed from 2 days ago.

(b)(6)-2

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name — last, first, middle, Medical Facility)*

(b)(6)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

MEDCOM - 1883

STANDARD FORM 519-B (8-83)

NSN 7540-01-165-7294 519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

EXAMINATION(S) REQUESTED	AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
KUB ABD	34	M		ICU 1	
	FILM NO.				PREGNANT ☐ YES ☐ NO
	REQUESTED BY (Print) (b)(6)-2				TELEPHONE/PAGE NO.
	SIGNATURE OF REQUESTOR				DATE REQUESTED 3 Sep 03

SPECIFIC REASON(S) FOR REQUEST *(Complaints and findings)*

s/p Explosion. Distended Abd & Illeus

DATE OF EXAMINATION *(Month, day, year)*	DATE OF REPORT *(Month, day, year)*	DATE OF TRANSCRIPTION *(Month, day, year)*

RADIOLOGIC REPORT

Persistent gaseous distension & large bowel not significantly changed from 2 days ago.

(b)(6)-2

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name — last, first, middle, Medical Facility)*

(b)(6)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

MEDCOM - 1884

RADIOLOGIC CONSULTATION

STANDARD FORM 519-B (8-83)

NSN 7540-01-165-7294 519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

EXAMINATION(S) REQUESTED

(2) FEMUR PORTABLE

AGE | SEX | SSN (Sponsor)

WARD/CLINIC: ICU #1

REGISTER NO.

FILM NO.

PREGNANT ☐ YES ☐ NO

REQUESTED BY (Print): FOR DR (b)(6)-2

TELEPHONE/PAGE NO.: (b)(3)-1

SIGNATURE OF REQUESTOR: (b)(6)-2 LT, AN

DATE REQUESTED: 9/3/03

SPECIFIC REASON(S) FOR REQUEST (Complaints and findings)

(2) Femur FX
S/P EXTERNAL FIXATOR
S/P WASH-OUT

DATE OF EXAMINATION (Month, day, year)

DATE OF REPORT (Month, day, year)

DATE OF TRANSCRIPTION (Month, day, year)

RADIOLOGIC REPORT

- L femur ex fix in place
  fx alignment is anatomic
- scattered small schrapnel fragments in ward measuring 1-4 mm

(b)(6)-2

PATIENT'S IDENTIFICATION (For typed or written entries give: Name — last, first, middle, Medical Facility)

(b)(6)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

MEDCOM - 1885

STANDARD FORM 519-B (8-83)

NSN 7540-01-165-7294 519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

EXAMINATION(S) REQUESTED

CHEST X-RAY
AP / LAT

AGE | SEX | SSN (Sponsor) | WARD/CLINIC: ICU #1 | REGISTER NO.

FILM NO. | PREGNANT ☐ YES ☐ NO

REQUESTED BY (Print): F, Dr (b)(6)-2 | TELEPHONE/PAGE NO.: (b)(3)-1

(b)(6)-2 | QUESTOR: LCT, MC | DATE REQUESTED: 9/9/03

SPECIFIC REASON(S) FOR REQUEST (Complaints and findings)

LUE BE AMPUTATION
(2) OPEN FEMUR FX & EXTERNAL FIXATOR

DATE OF EXAMINATION (Month, day, year) | DATE OF REPORT (Month, day, year) | DATE OF TRANSCRIPTION (Month, day, year)

RADIOLOGIC REPORT

Motion artifact but
clear lungs / nl heart

(-) Pneumonia

(b)(6)-2

PATIENT'S IDENTIFICATION (For typed or written entries give: Name — last, first, middle, Medical Facility)
(b)(6)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

MEDCOM - 1886 RADIOLOGIC CONSULTATION

STANDARD FORM 519-B (8-83)

NSN 7540-01-165-7294 519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

EXAMINATION(S) REQUESTED	AGE / SEX / SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
Central Line Placement (CXR)			
	FILM NO.		PREGNANT ☐ YES ☐ NO
	REQUESTED BY (Print)		TELEPHONE/PAGE NO.
	SIGNATURE OF REQUESTOR (b)(6)-2		DATE REQUESTED 15Sep

SPECIFIC REASON(S) FOR REQUEST *(Complaints and findings)*

s/p Central Line Placement.

DATE OF EXAMINATION *(Month, day, year)*	DATE OF REPORT *(Month, day, year)*	DATE OF TRANSCRIPTION *(Month, day, year)*

RADIOLOGIC REPORT

— (R) IJ tip in SVC

NG tip at EG junction

— lungs clear

Heart / OCM

(b)(6)-2

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name — last, first, middle, Medical Facility)*	LOCATION OF MEDICAL RECORDS
(b)(6)-4	LOCATION OF RADIOLOGIC FACILITY
	SIGNATURE

MEDCOM - 1887 RADIOLOGIC CONSULTATION STANDARD FORM 519-B (8-83)

NSN 7540-01-165-7294 519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

EXAMINATION(S) REQUESTED	AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
Abd - Placement NG					
	FILM NO.				PREGNANT ☐ YES ☐ NO
	REQUESTED BY (Print)				TELEPHONE/PAGE NO.
	SIGNATU (b)(6)-2				DATE REQUESTED 13 Sep

SPECIFIC REASON(S) FOR REQUEST (Complaints and findings)

S/p Washout - NGT Placement Check.

DATE OF EXAMINATION (Month, day, year)	DATE OF REPORT (Month, day, year)	DATE OF TRANSCRIPTION (Month, day, year)

RADIOLOGIC REPORT

- NG Tip projects over duodenal bulb
- T tube & small bowel gas c/w ileus
- 8mm schwpnl RLQ again noted

(b)(6)-2

PATIENT'S IDENTIFICATION (For typed or written entries give: Name — last, first, middle, Medical Facility)	LOCATION OF MEDICAL RECORDS
(b)(6)-4	LOCATION OF RADIOLOGIC FACILITY
	SIGNATURE

MEDCOM - 1888 RADIOLOGIC CONSULTATION STANDARD FORM 519-B (8-83)

NSN 7540-01-165-7294 519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

EXAMINATION(S) REQUESTED	AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
Portable CXR				ICU #1	
	FILM NO.				PREGNANT ☐ YES ☐ NO
	REQUESTED BY (Print)				TELEPHONE/PAGE NO.
	SIGNATURE OF REQUESTOR (b)(6)-2				DATE REQUESTED 13 Sep 03

SPECIFIC REASON(S) FOR REQUEST (Complaints and findings)

34 y/o Iraqi 07 S/P KUE (BTE) amputation + LLE open fx. Continues to have fevers. Any evidence atelectasis or infiltrate

DATE OF EXAMINATION (Month, day, year)	DATE OF REPORT (Month, day, year)	DATE OF TRANSCRIPTION (Month, day, year)

RADIOLOGIC REPORT

Motion artifact but
clear lungs, nl heart
⊖ CHF

(b)(6)-2

PATIENT'S IDENTIFICATION (For typed or written entries give: Name — last, first, middle, Medical Facility)

(b)(6)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

MEDCOM - 1889

RADIOLOGIC CONSULTATION STANDARD FORM 519-B (8-83)

NSN 7540-01-165-7294 519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

EXAMINATION(S) REQUESTED	AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
Plate plate abd for placement NG Tube					
	FILM NO.				PREGNANT ☐ YES ☐ NO
	REQUESTED BY (Print) Dr. (b)(6)-2				TELEPHONE/PAGE NO.
	SIGNATURE OF REQUESTOR				DATE REQUESTED 15 Sep 03

SPECIFIC REASON(S) FOR REQUEST *(Complaints and findings)*

NG tube placement verification

DATE OF EXAMINATION *(Month, day, year)*	DATE OF REPORT *(Month, day, year)*	DATE OF TRANSCRIPTION *(Month, day, year)*

RADIOLOGIC REPORT

NG-tip probably in duodenum
in - left of midline

(b)(6)-2

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name — last, first, middle, Medical Facility)*

(b)(6)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

MEDCOM - 1890
RADIOLOGIC CONSULTATION

STANDARD FORM 519-B (8-83)

NSN 7540-01-165-7294 519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

EXAMINATION(S) REQUESTED	AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
US – Liver/ Gallbladder					
	FILM NO.				PREGNANT ☐ YES ☐ NO
	REQUESTED BY (Print)				TELEPHONE/PAGE NO.
	SIGNATURE OF REQUESTOR				DATE REQUESTED

SPECIFIC REASON(S) FOR REQUEST (Complaints and findings)

Explosion injury, (R) BE Amputee / Femur fx
Febrile condition c significant tylenol administration.

DATE OF EXAMINATION (Month, day, year)	DATE OF REPORT (Month, day, year)	DATE OF TRANSCRIPTION (Month, day, year)

RADIOLOGIC REPORT

RUQ Sonogram

Liver is WNL
Normal caliber intra + extrahepatic ducts
GB nl, ⊖ Stones, ⊖ Wall thickening, ⊖ pericholecystic fluid
Nl (R) kidney
pancreas non-vis 2° bowel gas

(b)(6)-2

PATIENT'S IDENTIFICATION (For typed or written entries give: Name — last, first, middle, Medical Facility)

(b)(6)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

MEDCOM - 1891

STANDARD FORM 519R (R-83)

NSN 7540-01-165-7294 519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

EXAMINATION(S) REQUESTED	AGE	SEX	SSN *(Sponsor)*	WARD/CLINIC	REGISTER NO.
Portable CXR & PA/LAT					
	FILM NO..				PREGNANT ☐ YES ☐ NO
	REQUESTED BY *(Print)*				TELEPHONE/PAGE NO.
	SIGNATURE OF REQUESTOR				DATE REQUESTED

SPECIFIC REASON(S) FOR REQUEST *(Complaints and findings)*

DATE OF EXAMINATION *(Month, day, year)*	DATE OF REPORT *(Month, day, year)*	DATE OF TRANSCRIPTION *(Month, day, year)*

RADIOLOGIC REPORT

IJ in SVC

Lungs clear
Heart nl, ⊖ CHF
NG tip in. stom & EG junction

(b)(6)-2

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name — last, first, middle, Medical Facility)*

(b)(6)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

MEDCOM - 1892

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION: (b)(6)-4

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
26 Aug 03	0015 HOURS	

1. admit icu 2, OAUO, Prevost
2. Dx: (L) femur fx; (L) hand/forearm amputation
   s/p ex fix; guillotine amputation; possible Rhabdomyolysis
3. cond: guarded (soft tissue injury) (stomach burn)
4. vitals: q 1° (routine for icu)
5. NKDA
6. act: bedrest

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	
	HOURS	

7. diet: clear to regular as tolerated
8. IVF: N/S @ 150 cc/°
9. cancef 1g IVPB tid
   gentamicin 80mg IVPB q 8°
10. CBC, chem 7, in am
11. CK q 8°
12. Tylox 1-2 po q 4-6° pm pain relief
13. MSO4 2-4mg IVP q 1° pm pain relief

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

0700 26 Aug 03

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	
	HOURS	

14. leave dressings for physicians to change - anticipate return to OR 28 Aug
15. Please ask pharmacy to make up 2 bottles of Dakins solution (irrigation bottles) & have @ bedside
16. I/O to be recorded

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	
	HOURS	

17. mannitol 25g IVP q 4° pm
    UOP < 150 cc/°
18. CBC X1 now -

(b)(6)-2

done 0700

NURSING UNIT | ROOM NO. | BED NO.

240 (b)(6)-2 100 710

MEDCOM - 1893

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION: (b)(6)-4 (EPW)

DATE OF ORDER: 26 AUG 03 — TIME OF ORDER: 0520 HOURS — LIST TIME ORDER NOTED AND SIGN

10 Dr (b)(6)-2 DIX / (b)(6)-2

(1) 500 cc Bolus of NS X1 now

done 0530 (2) Do not draw CBC c̄ Ann Color

(b)(6)-2

(b)(6)-2 MD

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION: (b)(6)-4 (EPW)

DATE OF ORDER: 8/26/03 — TIME OF ORDER: HOURS

- Tetanus IG 250 units Im
- ~~Tetanus toxoid~~ 0.5 mg Im

dT (b)(6)-2 MD

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION: (b)(6)-4 (EPW)

DATE OF ORDER: 8/26/03 — TIME OF ORDER: HOURS

Pen G IV 4 million units

96°

NPO

(b)(6)-2 (b)(6)-2

noted

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION: (b)(6)-4 (EPW)

DATE OF ORDER: 8/26/03 — TIME OF ORDER: 0916 HOURS

(1) change fluids to LR @ 200 cc/hr ✓

(2) Bolus 1l LR now

(3) With Q8° labs, please include & I-stat 6 + glucose

(4) If uop < 100 cc/hr for 4 hrs, mannitol 25 gm IV.

(5) UA c̄ micro. exam Q8° (b)(6)-2 MD (b)(6)-2

B6-2 noted [redacted]

NURSING UNIT | ROOM NO. | BED NO.

MEDCOM - 1894

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

(b)(6)-4

EPW
Male

DATE OF ORDER: 27 Aug. 03 — TIME OF ORDER: 0805 HOURS

(1) Albuterol nebs (std. adult dose) 98°.

(b)(6)-2 MD

(b)(6)-2

LIST TIME ORDER NOTED AND SIGN

(b)(6)-2

27 Aug 0833

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 27 Aug. 03 — TIME OF ORDER: 0834 HOURS

(1) T&C x 2 units. - done 0900hrs 27 Aug

(b)(6)-2 MD

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 8/27/03 — TIME OF ORDER: 1800hrs HOURS

Do not P/C Foley

(b)(6)-2

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 28 Aug 03 — TIME OF ORDER: 1000hrs HOURS

(b)(6)-2 (b)(6)-2 MATSU

Vital signs 98°

(b)(6)-2

(b)(6)-2

LTC. VC

(b)(6)-2

FAMILY PRACTICE

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

MEDCOM - 1895

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER 8/28/03 TIME OF ORDER HOURS

LIST TIME ORDER NOTED AND SIGN

- Transfer to ICU II D (b)(6)-2
- 4 I&D (L)UE & (L)LE
- Revision (L)UE amputation &
- Revision (L)LE ex-Fix
- Regular Diet NKDA
- COB to Chair BID
- Strict NWB (R)LE

Vitals 98°

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

- BID Dressing Changes to (R) thigh @ 25%
- Dakin's Solution
- MSO4 1-4 mg IV q 1°, pro pain
- Tylox 1-2 Tabs PO q 6° pro pain
- Ancef 1 gram IV q 6°
- Gentamycin 300mg IV q day

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

- Penicillin G IV 6 million units QID
- LTR @ 80cc/hr
- D/C Foley in AM 8/28/03
- CBC / Chem 7 in AM

(b)(6)-2 MD

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER (b)(6)-2

27 AUG 03 1334 HOURS

1) MSO4 1-5 mg IV Q 5 MIN MAX 15 mg

(b)(6)-2 CAVA

NURSING UNIT | ROOM NO. | BED NO.

MEDCOM - 1896

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION: (b)(6)-4

DATE OF ORDER | TIME OF ORDER _____ HOURS | LIST TIME ORDER NOTED AND SIGN

(1) Give 650 mg Tylenol on Q 4-6° prn
V.O. Dr (b)(6)-2 (b)(6)-2 cpt AW
(b)(6)-2 Aug 03 ML 1700
(b)(6)-2
(b)(6)-2
FAULTY PRACTICE

NURSING UNIT | ROOM NO. | BED NO.

24° chart V (b)(6)-2 CP Kr 30 Aug 03 0001

PATIENT IDENTIFICATION: (b)(6)-4

DATE OF ORDER: 29 Aug. 03 | TIME OF ORDER: 2334 HOURS

(1) D/c daily chemistry, CK.
continue daily CBC
(b)(6)-2 mo
(b)(6)-2

noted 30 Aug 03 1300

NURSING UNIT | ROOM NO. | BED NO. (b)(6)-2

PATIENT IDENTIFICATION: (b)(6)-4

DATE OF ORDER | TIME OF ORDER _____ HOURS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION: (b)(6)-4

DATE OF ORDER | TIME OF ORDER _____ HOURS

NURSING UNIT | ROOM NO. | BED NO.

MEDCOM - 1897

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION: (b)(6)-4

DATE OF ORDER: 8/30/03 — TIME OF ORDER: _____ HOURS — LIST TIME ORDER NOTED AND SIGN

✓ - NPO
x - KUB
x - CBC, SMA-7, LFTS

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION: (b)(6)-4

DATE OF ORDER: 8/30/03 — TIME OF ORDER: _____ HOURS

✓ Dulcolux supp ⊤ PR
NOW & QD ag PRN

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION: (b)(6)-4

DATE OF ORDER: 8/30/03 — TIME OF ORDER: _____ HOURS

Transfuse ⊤ units
PRBC now
each unit over 4 hours
c̄ 20 mg DV lasix
p̄ each unit

#/H
6.7
22.4

(b)(6)-2

NURSING (b)(6)-2 | NO. | BED NO.
2400 30AUG03 2320 2110

(b)(6)-2 (b)(6)-2

PATIENT IDENTIFICATION: (b)(6)-4

DATE OF ORDER: 30 AUG 03 — (b)(6)-2 — HOURS

(b)(6)-2 (b)(6)-2

① leave (L) LE below knee wounds open to air
② leave (R) foot wounds open to air

NURSING (b)(6)-2 | NO. | BED NO.
2400 | 252

MEDCOM - 1898

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER: 31 Aug 03 — TIME OF ORDER: 100930 hrs HOURS — LIST TIME ORDER NOTED AND SIGN

(b)(6)-2

Repeat CBC, Istat 6, Creat p̄ transfusion

- D/C Foley
- D/C Penicillin G
- D/C Gentamicin

noted

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2 MD

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER: 8/31/03 — TIME OF ORDER: (b)(6)-2 HOURS

1600 31 Aug 03 (N) LDN

(b)(6)-2

0.25% Dakins solon to (L) Thigh BID c̄ Dressing Changes

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER: 31 Aug. 03 — 1455 HOURS

Noted 31 Aug 03 (N)

(b)(6)-2

1. Change IVF to ~~NS~~ DS NS c̄ 20 kcl 100 cc/hr
2. Kcl 40 meq IV over 2 hrs x 2
3. Portable CXR

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2 MD

(b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER: ~~31 Aug. 03~~ 31 Aug. 03 — TIME OF ORDER: 1612 HOURS

1. After Kcl complete, D/C central line.
2. D/C Hebs

Noted 31 Aug 03 2055 BD

(b)(6)-2 MD

NURSING UNIT | ROOM NO. | BED NO.

8° c/c (b)(6)-2

(b)(6)-2

MEDCOM - 1899

~1120

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
(b)(6)-4	31AUG03	2100 HOURS	
	1) D/C Tylox		
	2) Demerol 25mg c̄ 12.5mg Phenergan		
	q4-6hrs IV prn PAIN.		
	VO Dr (b)(6)-2 / CPT (b)(6)-2 (b)(6)-2		
NURSING UNIT / ROOM NO. / BED NO.	(b)(6)-2		

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
	31Aug03	2200 HOURS	
	① Demerol 25mg c̄ 12.5mg Phenergan		
	WP NOW.		
	VO Dr (b)(6)-2 (b)(6)-2 (b)(6)-2		
	(b)(6)-2		
NURSING UNIT / ROOM NO. / BED NO.	FAMILY PRACTICE	31Aug03	

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
(b)(6)-4	31Aug03	HOURS	
	① CXR & KUB c̄ AM		
	VO Dr (b)(6)-2 (b)(6)-2		
	(b)(6)-2		
NURSING UNIT / ROOM NO. / BED NO.	(b)(6)-2	31Aug03	
	FAMILY PRACTICE		

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
(b)(6)-4	Sep 02	2400 HOURS	
	① Zantac 50mg IVG, 8		
	(b)(6)-2		
NURSING UNIT / ROOM NO. / BED NO.			

1Sep03 1020

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 1900

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
(b)(6)-4	1 Sept 03	0750 HOURS	
	① Erythromycin 250 mg IV piggyback Q6°		note (b)(6)-2 1020 1Sept03
	(b)(6)-2		
NURSING UNIT / ROOM NO. / BED NO.			

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
	1 Sept	1015 HOURS	
	① Place NGT		note
	② NGT to LIS		
	VO. (b)(6)-2		(b)(6)-2 1030 1Sept03
	for (b)(6)-2		
	(b)(6)-2		
NURSING UNIT / ROOM NO. / BED NO.			

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
	9/1/03	1040 HOURS	
	Tylenol supp ? PR		note
	960 prn temp > 101°F		(b)(6)-2 1120 1Sept03
	O2 by nc 3l prn sats		
	(b)(6)-2		82%
NURSING UNIT / ROOM NO. / BED NO.			

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
		HOURS	
NURSING UNIT / ROOM NO. / BED NO.			

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 1901

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION: (b)(6)-4

ICW #1

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 01 Sep 03 — TIME OF ORDER: 1330 HOURS

LIST TIME ORDER NOTED AND SIGN

1. admit ICW-1, (b)(6)-2 OKCO
2. Dx: (L) LLE amp; (L) LE ex fix
   sp beast injury and I/D
3. cond's fair
4. NKDA
5. NPO
6. act ↑ OOB to chair tid

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER — TIME OF ORDER

7. Vitals: routine ~~for ICW~~ HOURS
8. IVF: DSNS c̄ 20 mEq KCl @ 100 cc/°
9. meds:
   ancef 1 g IVPB q 8
   erythromycin 250mg IVPB q 6°
   Demerol 25mg c̄ 12.5mg phenergan IV
   q 4-6° prn pain
   Tylenol 650mg - 1000mg PR (suppository)

1 Sep 03 1500

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER — TIME OF ORDER

q 4-6° prn T > 101°F HOURS

10. N/C O2 3L prn sats < 92%
11. NGT to LIWS series
12. Radiology: (L) shoulder PA ~~+ lat~~ views
13. wet to dry dressings (L) LE bid please
    (no Dakins)
14. CBC, Chem 7 in am
15. Zantac 50mg IV q 8°

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

(b)(6)-2 ...id) TI... (b)(6)-2 HOURS

1500 1 Sep 03

Time

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MEDCOM - 1902

CLINICAL RECORD - DOCTOR'S ORDERS

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PATIENT IDENTIFICATION: (b)(6)-4

NURSING UNIT: ICU III | ROOM NO. | BED NO.: 5

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	25 Sept 03	10:50 HOURS	
1	AC 2 units PRBC's.		
	TRANSFuse over 4° each.		
2	CBC & Diff in AM		
3	KUB ABD 1st AM.		
4	Lasix 20mg IV after Each unit of		
	PRBC's.		
5	Gentamicin 300mg IV q DAY x 3 DAYS		

PATIENT IDENTIFICATION: (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	
		HOURS	
6	Creatinine q DAILY	(b)(6)-2	
	(b)(6)-2	AP	
	MAJOR.		

PATIENT IDENTIFICATION: (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	
		25 Sept 03 0010	

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	
	25 Sept 03	2240 HOURS	
1	Repeat done of Renewal 25mg		
	and Phenergan 12.5mg IVP		
	Now.		
	V.O. Dr (b)(6)-2	(b)(6)-2 (b)(6)-2	
	RT: 25 Sep 03 0449		

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	
		HOURS	

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 1903

CLINICAL RECORD · DOCTOR'S ORDERS

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THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION: (b)(6)-4

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
03 Sep 03	0946 HOURS	

ADMIT to ICU-1 (b)(6)-2

(D) Below Elbow Amp, (D) LE

Cx fix

S/P Blast Injury, + ITD

Cond: FAIR

NKDA

NPO

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER HOURS

OOB to chair BID - ↑ as

VSTMC - routine

D5 NS @ 20 mls KVO TKO 100 cc/o meds -

Ancef 1 gm IVPB q 8°.

Erythromycin 250 mg IVPB q 6°

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER HOURS

Gentamicin 300 mg q IVP q day x 10 days. (b)(6)-2

Demerol 25 mg @ 12.5 phenergan 12.5 IV q 4-6 PRN Pain

Tylenol 650-1000 mg PR (Supp) q 4-6 PRN T > 101 °F

NURSING UNIT | ROOM NO. | BED NO.

N/C @ 3L PRN SAT < 92 %

NGT to LWS

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER HOURS

XRAY - (D) Femur Portable

Wet to dry dressing (D) leg c packing of wound BID please

Tylenol 500 mg IV q 8°

CBC, chem 7 in AM (4 Sept 03)

NURSING UNIT | ROOM NO. | BED NO. (b)(6)-2

wet wash cloth if patient wants fluids.

(b)(6)-2

(b)(6)-2 (b)(6)-2

MAJ

ORTHO

DA FORM 1 APR 79 4256 * CES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 1904

3809031125

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | LIST TIME ORDER NOTED AND SIGN

4Sept03 0945 HOURS

(1) Continue Gentamicin 300 mg IV q DAY.

(2) DAILY Creatinine (b)(6)-2

(b)(6)-2 1000 4Sept03

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

4Sept03 1200 HOURS

(1) D/C NGT

VO Dr (b)(6)-2

(b)(6)-2 cpt/sw

(b)(6)-2

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

4Sept03 1215 HOURS

(1) Demerol 25mg + 12.5mg Phenergan IV q1 hour PRN

V.O Dr (b)(6)-2

(b)(6)-2 cpt/sw

(b)(6)-2

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

HOURS

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH M[illegible]E USED.

MEDCOM - 1905

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION			DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
			5 Sep 03 _____ HOURS	
			1 Post-op. Jt @ ARM / Hip	
			2 ADMIT to ICUI - Dr (b)(6)-2	
			3 D5 NS c̄ 20 mg KCL/L to Run at 100 cc/°	
			4 Gentamicin 300 mg IV q̄ 24° x 4 DAYS	
			5 Ancef T gm NPB q̄ 8°	
NURSING UNIT	ROOM NO.	BED NO.	6 Demoral 25 mg c̄ 12.5 phenergen	
			IV q 4-6 PRN Pain	Noted 5 Sep 03 (b)(6)-2
PATIENT IDENTIFICATION			DATE OF ORDER / TIME OF ORDER _____ HOURS	
			Tylenol 650-1000 mg PR (supp)	
			q̄ 4-6 PRN Temp > 101.5°	
			O2 3L via NC PRN SAT < 92%	
			Wet to DRY Dressing BID.	
			Need to PACK area by pins	
NURSING UNIT	ROOM NO.	BED NO.	ZANTAC 50 mg IV q̄ 8°	
			NPO-	
PATIENT IDENTIFICATION			DATE OF ORDER / TIME OF ORDER _____ HOURS	
			OK for ice chips 1/2 cup q̄	
			1° (or small sips H2O)	
			If tolerated may advance clear liq	
			DIET.	
			OOB to chair BID TID	
NURSING UNIT	ROOM NO.	BED NO.	CBC on AM 7 Sep 03 (Sunday)	
			Dressing A of (L) ELBOW (b)(6)-2	
PATIENT IDENTIFICATION			DATE OF ORDER / TIME OF ORDER _____ HOURS	
			Did Pull Drain tomorrow	
			(b)(6)-2 5 Sep 03 2225 (b)(6)-2	
NURSING UNIT	ROOM NO.	BED NO.		

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 1906

CLINICAL RECORD - DOCTOR'S ORDERS

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PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
(b)(6)-4	6 Sep 03	HOURS	
	clear liquids Advance slowly as tolerated.		
		(b)(6)-2	
NURSING UNIT / ED NO.	Chart 6 Sep 03		

Noted 9/6/03 1135

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
	7 Sep 03	0005 HOURS	7 Sep 0668
	Ambien 5 mg QHS prn		
	U.O.	(b)(6)-2 (b)(6)-2	
	(b)(6)-2	7 Sept 03	
NURSING UNIT / ROOM NO. / BED NO.	7 Sep 03		
	1. ↑ Ambien 10 mg sig T po q HS PRN		
	2. Δ Tylenol to P.O. same Dosage.		

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
		HOURS	
	3. Tylox T-II po q 4-6° PRN Pain		
	4. Creatinine today.	(b)(6)-2	
	5. NPO PO Midnight		
NURSING UNIT / ROOM NO. / BE			
	24' Chart Check	(b)(6)-2	8 Sep 03

Noted 9/7/03 0205

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
		HOURS	
NURSING UNIT / ROOM NO. / BED NO.			

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 1907

CLINICAL RECORD - DOCTOR'S ORDERS

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THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL R
SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

8 Sep 03

(1) BE Amp / (2) Open fem fx.
I&D c̄ shortening of bone, would
VS q̄ Routine
Reg DIET Advance as tolerate
Ds ½ NS c̄ 25 mfc KCL/L OR
current solution TRA 100 cc/
Heplock when PO good

PATIENT IDENTIFICATION

(b)(6)-2

Noted
ICT
9/8/03
1255

NURSING | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

(1) Ambien 10mg PO q̄ HS PRN insom
(2) Gentamicin 300 mg IV q̄ DAY
(3) CBC c̄ diff on 9 Sep 03
(4) Daily Creatinine
(5) Ancef 1 gm IV q 8°
~~(6) MSO4~~
(7) Tylenol 650-1000 mg PO

PATIENT IDEN

DATE OF ORDER | TIME OF ORDER | HOU

TEMP > 100.5
(8) Demoral 25mg IV q̄ 4-6
c̄ 125 mg phenergen
(9) Tylox I-II PO q̄ 4-6 PRN
(10) Zantac 50mg IV q̄ 8°
(11) OOB BID TID

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | H

(12) Dressing change to Elbow
Hip BID MAY ~~used~~
¼" to ½" Packing as n
~~(13)~~

24° Chest Check

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 1908

CLINICAL RECORD - DOCTOR'S ORDERS

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PATIENT IDENTIFICATION (b)(6)-2

DATE OF ORDER | TIME OF ORDER | HOURS | LIST TIME ORDER NOTED / SIGN

1. chest XRAY today - CAP 1 lat in Radiology
2. VRM for UA;
3. ~~Hold Gentim~~ ↓ Gentimi to 200g IVq DA
4. ~~Calorie~~ Nutritional assessment Agni to assess for enteral feedings.

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

10 Sep 03

1. NPO Post midnight
2. D5 1/2 NS = 20 mb KCL / L TRA 100 cc/p.
3. BACTRIM DS T PA. BID.
4.

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

24° Chart Check

11 Sep 03

1. S/P I+D to ⊕ BE Stump; Dress
2. (b)(6)-2
3. VS q Routine
4. Reg DIET -
5. Ensure T CAN TID
6. MAY East Food from Home

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

7. Daily Gentimi
8. CBC in AM. (12 Sep 03)
9. Up in chair BID - TID
10. Ancef T gm IVq 8
11. Gentamicin 200g IVq DAY
12. BACTRIM DS T PO q BID
13. ~~Mgy~~ Demoral 25g IVq 4-6 PI
14. pheneg

NURSING UNIT | ROOM NO. | BED NO.

REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

(b)(6)-2

DA FORM 1 APR 79 4256

Chart 11 Sep 03 : 5000 ...

MEDCOM - 1909

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION: (b)(6)-4

NURSING UNIT: (b)(6)-2 | BED NO.

DATE OF ORDER: 11 Sep 03 | TIME OF ORDER: _____ HOURS | LIST TIME ORDER NOTED AND SIGN

14. Tylox T-π po q 4-6° PRN Pain
15. Zantac 50 mg IV q 8°. IF P.O. tolerated
A to 150 mg p.o. TID.
16. Dressing change to BE Amp + Hyp Bio.
17. Next planned washout - 13 Sep 03.
18. Current flut @ 75cc/° (b)(6)-2
charted 11 Sep 03 1500 (b)(6)-2

noted 11 Sep 03 (b)(6)-2 1200

PATIENT IDENT

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 11 Sep 03 | TIME OF ORDER: 1950 HOURS

(1) Malaria smears q 8° x 3 or if temp goes >10 (b)(6)-2 (b)(6)-2 (b)(6)-2

Noted (b)(6)-2

FAMILY PRACTICE

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

(1) D/C BACTRIM DS
(2) D/C Ancef
(3) Lenoquin 500 mg IV q 24°

(b)(6)-2 (b)(6)-2

24°V - [illegible] 12 Sep 03 @ 0700

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 12 Sep 03 | TIME OF ORDER: 1100 HOURS

1. Tylenol 1000 mg po q 6° PRN Temp
2. ~~Hold Tylox~~ disregard
(3) D/C Tylox
(4) Haldol 5 mg IV q 4° for psychosis (PRN)

(b)(6)-2 (b)(6)-2 (b)(6)-2

12 Sep 1115

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 1910

CLINICAL RECORD - DOCTOR'S ORDERS

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PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
(b)(6)-4			12 Sep 03	1103 HOURS	
			(1) Send LFTs		
			(2) D/c demerol and phenergan		Not
			(3) ~~Instead: MSO4 2-10 mg IV Q 2° pvn pain and~~		(b)(6)-2 1115 12 Sept
			MSO4 2-10 mg IV Q 2° pvn pain / dressing		
NURSING UNIT	ROOM NO.	BED NO.	(4) D/c tylox	(b)(6)-2	

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
			12 Sept 03	1430 HOURS	noted
			(1) NPO p̄ MN		(b)(6)-2 1445 12 Sept 03
			VO. D/c (b)(6)-2		
			(b)(6)-2	opt/Am	
			(b)(6)-2	MD 12 Sep 03	
NURSING UNIT	ROOM NO.	BED NO.			
			24 hr 12 Sep 03 @ 2350 (b)(6)-2		

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
			13 Sep 03	1140 HOURS	
			(1) Portable CXR		Not 1349
			(2) U/A		(b)(6)-2 13 Sept 03
			(3) ESR c̄ next bloodwork & then Q 00		
			(b)(6)-2	MD Lieutenant Colonel, Medical Corps Chief, Department of Medicine	
NURSING UNIT	ROOM NO.	BED NO.			

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
			13 Sep 03	1410 HOURS	
			(1) D/c Melanin smears		
			(b)(6)-2		
			(b)(6)-2	MD	
			(b)(6)-2		
			FAMILY PRACTICE		
NURSING UNIT	ROOM NO.	BED NO.			

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MEDCOM - 1911

CLINICAL RECORD - DOCTOR'S ORDERS

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PATIENT IDENTIFICATION: (b)(6)-4

DATE OF ORDER: 13 Sep 03 — TIME OF ORDER: 1946 HOURS — LIST TIME ORDER NOTED AND SIGN

(b)(6)-2

~~(1) Tylenol 650 mg po Q4° pro fever~~

(2) phenergan 12.5 mg IV Q4° pro N/V.

(3) CXR - placement of central line for [illegible]

(4) Flat plate Abd - placement [illegible]

(b)(6)-2 (b)(6)-2 1900

NURSING UNIT | ROOM NO. | BED NO.

√ 13SEP03 2020 (b)(6)-2 UTAN (b)(6)-2 (b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER: 13 Sep 03 — TIME OF ORDER: 2316 HOURS

(1) Ambien 5 mg p.o. now & HS prn insomnia. May repeat x 1, if [illegible] - may give NG tube (crushed)

(b)(6)-2 (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

Chart √ 14SEP0330 (b)(6)-2 LTC (b)(6)-2 MK

PATIENT IDENTIFICATION

DATE OF ORDER: ~~13~~ Sep 03 — TIME OF ORDER: 1110 HOURS

(1) T&C 2 units PRBC's. TRANSfuse + one 4°. Give both units.

(2) ~~K phos~~ KCL 100 mEq in 250 cc NS

~~(2) over 2°. X 3~~ over 10 hours

(3) Repeat K+ level after KCL infusion.

(4) Check H/H 4° After last transfusion

(b)(6)-2 1140 14 Sep

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: — TIME OF ORDER: HOURS

(5) Foley to DD

(6) ENSURE T can q 6°

(7) Cancel US of AB [illegible]

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

√ 14SEP03 2215 (b)(6)-2 UTAN

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MEDCOM - 1912

CLINICAL RECORD - DOCTOR'S ORDERS

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PATIENT IDENTIFICATION: (b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
13 Sep 03	HOURS	
1	LBE... AMP, (L) open Fem. Fx.	
2.	S/P central line placement, NG, and WASH out.	
3	VS q Shift	
4	OOB BID - TID	
5	D5 1/2 NS c̄ 20 mEq KCL/L TRA 100 cc D. Heplock.	

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	
	HOURS	
6	CBC c̄ diff. SMA-7; LFT's in AM.	
7	creatinine in AM.	
8	Levoquin 500mg IVq 24°	
9	Gentimycin 150mg IVq 24°.	
10	Haldol 5 mg IV q 6° PRN Psychosis.	
11	AP (L) hip XRAY in AM	
12	ultrasound Liver-gallbladder in AM.	

PATIENT IDENTIFICATION: (b)(6)-2 13 Sep 03 2020

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	
	HOURS	
13	Ensure - ~~[illegible]~~ Mix 50/50 c̄ H2O - 60 cc VIA NG over 20 minutes. IF tolerates this; may use Ensure full strength 60cc over Twenty minutes. IF tolerated; W/V - 1 CAN	
14	Ensure q Shift VIA NG	

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	
	HOURS	
14	Routine central line care	
15	Dressing changes BID.	
~~16~~	~~DC Tylenol. Motrin~~ Disregard	
17	MSO4 2-10mg IVq 1-2° PRN Pain	

(b)(6)-2

NURSING UNIT	ROOM NO.	BED NO.
	✓ 13SEP03	2020

(b)(6)-2 UTAN

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 1913

CLINICAL RECORD - DOCTOR'S ORDERS

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PATIENT IDENTIFICATION: (b)(6)-2

(b)(6)-2 Noted

LCT, AN 9/14/03

NURSING UNIT: ICU #1 | ROOM NO.: 1155 | BED NO.:

DATE OF ORDER: 9/14/03 | TIME OF ORDER: 1145 HOURS | LIST TIME ORDER NOTED AND SIGN

Advance DIET as Tolerated

V.O. Dr (b)(6)-2 / (b)(6)-2 LCT, AN

(b)(6)-2 9/14/03

PATIENT IDENTIFICATION

DATE OF ORDER: 9/14/03 | TIME OF ORDER: _____ HOURS

(1) Unasyn 3.0 gm IV q 6 h (b)(6)-2 (b)(6)-2

Noted 14SEP03 1650

14SEP03/1955

(1) Tylenol 1 gm PO x1 VO (b)(6)-2 (b)(6)-2 LCT, AN

Noted 14SEP03 1955

NURSING UNIT | ROOM NO.: ✓ 14SEP03 2215 | BED NO.: (b)(6)-2 UTAN (b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER: 15 Sep 03 | TIME OF ORDER: 1620 HOURS

Δ IVF to D5-NS c̄ 20 KCl

V.O. Dr. (b)(6)-2 / (b)(6)-2 MAPM

also

Δ KCl bolus to 100 meq KCl in 250 cc D5W.

V.O. Dr. (b)(6)-2 / (b)(6)-2 MAPM

1120 17 Sept 03

NURSING UNIT: 8°C/C | ROOM NO.: (b)(6)-2 | BED NO.:

PATIENT IDENTIF

DATE OF ORDER | TIME OF ORDER _____ HOURS

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 1914

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION: (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	15 Sep	1600 HOURS	
1.	ADMIT to ICU-1		
2.	S/P IJ TO Hip + (2) EIBlock Stop		
3.	(b)(6)-2		
4.	OOB BID – TID		
5	NG for feeding tube		
6.	Advance DIET As tolerated		
7.	Ensure 1 can q 6° over 20 – 30 min.		
8.	D5 ½ NS @ 20 mEq KCL/L TKO @ 150 cc/°		
9.	KCL 100 mEq in 250 cc NS. Run in over 10°.		(Order by V.O. 9/15/03)
10	Foley to DS		
11.	Unasyn 3.0 gm IVq 6°		1, 9/15/03
12.	Gentamicin 150 mg IVq 24°		
13.	Ambien 5-10 g PO q HS for [illegible]		(b)(6)-2
14.	MSO4 - 2-10 mg q 1-2° PRN. HOURS		
15.	Flat plate Abdomen for placement NG tube.		
16	Tylenol 650 mg PR/PO q 6° PRN Temp > 100.4 (Axilla)		
17.	Routine IJ Care		
18	Levaquin 500 mg IVq 24°		
19	ZANTAC 150 mg PO TID.		
20	Protonix BID.		
21.	~~CBC~~ CBC & diff on 17 Sep 03		
22	K, Creatine q AM x 2 days.		
23	IS q 1° WA.		
24.	May restrain if needed.		
25	Remove Suture		

NURSING UNIT: 8° c/c | ROOM NO.: 1 Isolation 03 | BED NO.: 38

(b)(6)-2

(b)(6)-2

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 1915

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

(b)(6)-4

ICU 1

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 16 Sep 03 — TIME OF ORDER: _____ HOURS

(1) ~~NPO p 0300 Am~~ (b)(6)-2

Disregard (b)(6)-2

LIST TIME ORDER NOTED AND SIGN: Noted 2135 [illegible] (b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 9/17/03 — TIME OF ORDER: 1110 HOURS

Ditropan 5mg po Q8°

p/n Bladder Spasm

(b)(6)-2

(b)(6)-2

1120 17 Sept 03

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 17 Sep 03 — TIME OF ORDER: 1145 HOURS

(1) D/C Unasyn

(2) Zosyn 3.375 gm

IVPB Q 6°

(b)(6)-2

(b)(6)-2 Noted

1148 17 Sept 03

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.
	18 Sep 03	2320

(b)(6)-2

[illegible] OF ORDER — TIME OF ORDER: _____ HOURS

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

MEDCOM - 1916

77, WHICH MAY USED.

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

(b)(6)-2

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
18 Sep 03	0900 HOURS	

(1) (1) Δ to Ensure plus 1-2 cans q 6°
(2) NPO p̄ 3:00 Am (6° Before surgery)
(3) D5NS Era 125 cc After 3:00 Am
(4) Creat / K+ in Am 18 Sep 03

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	
18 Sep 03	1030 HOURS	

(1) Restoril 15mg PO q HS x PRN. If in 1° Not asleep or Ales may Repeat 15mg po x T.

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	
18 Sep 03	1400 HOURS	1400

Restoril to 30 mg PO QHS
U.O. Dr

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	
18 Sep 03	1625 HOURS	18 Sep 1625

CBC c̄ diff
Portable CXR - AP + ~~Lat~~

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

18 SEP 03 2320

(b)(6)-2

DA FORM 4256 MEDCOM - 1917 WHICH M

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | LIST TIME ORDER NOTED AND SIGN

19Sept03 _____ HOURS

Admit to ICU-1

(b)(6)-2

OOB QID — 5 or 6 times (b)(6)-2

Turn on side q 2°.

NG for feeding the

Routine IT CARE

Advance - oral DIET As tolerated

Noted

(b)(6)-2

1250

19Sept

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

_____ HOURS

Ensure(+) T-TT cans q 6°.

D5NS c̄ 20 mEq KCL / L TRA 100 c/°.

Heplock when p.o good.

~~Foley to~~

Gentiman 150mg IV q 24°

MSO4 2-10mg IV q 1-2° PRN Pain

Tylox T-TT p.o. q 6° PRN Pain

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

_____ HOURS

Zosyn 3.375 gm IVPB q 6°.

Ditropan 5mg po q 8° PRN Bladder spasm

Levoquin 500mg IV q 24°

ZANTAC 150mg p.o. TID

change Dressing BID.

K, Creatin, ON 21 Sep 03

May Restrain as needed.

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

(b)(6)-2

Restoril 30mg PO q HS.

PRN insomnia

19Sep03

(b)(6)-2

DA FORM 4256 MEDCOM - 1918 ...ICH MAY BE ...ED.

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION (b)(6)-2

DATE OF ORDER: 19 Sep 03 TIME OF ORDER: 2130 HOURS

LIST TIME ORDER NOTED AND SIGN (b)(6)-2

(1) Benedryl 50 mg PO qHS (b)(6)-2 (b)(6)-2

9/19 2200

NURSING UNIT | ROOM NO. | BED NO.

1986 03 2240 (b)(6)-2 UTAN

PATIENT IDENTIFICATION

DATE OF ORDER: 20 Sep 03 TIME OF ORDER: 1300 HOURS

(1) D/C foley -

(2) D/C VA After foley removed

(3) START New IV site

(4) D/C IT.

(5) D/C Gentamicin.

(6) If Temp > 101° obtain Blood cultures x 2 sites x 2.

noted 1/20/03 1340 (b)(6)-2

NURSING UNIT | ROOM | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER (b)(6)-2

(7) TRANSFER to ICU-2 @ 1800 hrs

(8) Reinstate previous ORDER'S (b)(6)-2

noted independent

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 22 Sep 03 TIME OF ORDER: 1054 HOURS

(1) Start glipiside 5 mg PO to lunch today & then to breakfast & supper tomorrow

(2) FBS Q A.M.

(3) U/A Q A.M.

noted (b)(6)-2 SPC 9/19

NURSING UNIT | ROOM NO. | BED NO.

23 Sept 03 2355 (b)(6)-2

Lieutenant Co... (b)(6)-2 Chief, Departm... (b)(6)-2

MEDCOM - 1919

DA FORM 4256

04
12
20

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 22 Sep 03 — TIME OF ORDER: ____ HOURS

(1) Post-void residual.
(2) Packing c̄ IODOFORM, DAMP to DRY Dressings.
(3) ~~K+ KCL 40 mEq KCL in 50 cc NS TRT over~~
(3) KCL 40 mEq KCL in 50cc NS to run in over 7°.

LIST TIME ORDER NOTED AND SIGN: noted (b)(6)-2 SPC 9 HWM

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: ____ — TIME OF ORDER: ____ HOURS

(4) K+ in AM (b)(6)-2
(5) (R) ARM Restraint as needed PRN (b)(6)-2
(6) ↓ [illegible] plug to T [illegible] 6°.
(7) Portable (L) ~~[illegible]~~ Hip XRAY. (b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 22 Sep 03 — TIME OF ORDER: 1213 HOURS

(1) Alibaug 2 mg IV now & then T-2 mg IV Q8°
(2) Post void residual urine

noted (b)(6)-2 9 HWM

(b)(6)-2
Lieutenant Colonel, Medical Corp
Chief, Department of Medicine

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.
	23 Sep 03	2358

(b)(6)-2 9 HWM

DATE OF ORDER: 23 Sep 03 — TIME OF ORDER: 1500 HOURS

(1) KCL 16 meq p.o. TID (3 times a day), preferably c̄ food
(2) D/C HS Benadryl

noted (b)(6)-2 (b)(6)-2
Chief, Department of Medicine

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

MEDCOM - 1920

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS | LIST TIME ORDER NOTED AND SIGN

23 Sep 03 1623

(1) Please do in + out cath to assess bladder volume

(2) Δ KCl to 20 meq p.o. TID of food or drink

(b)(6)-2

(b)(6)-2

(b)(6)-2

Lieutenant Colonel, Medical Corps
Chief, Department of Medicine

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

25 Sep 03 0500

(1) Transfer to EPW Camp

(2) D/C IV

(3) D/C NGT

(4) F/U Surdex 1300 Spec Clinic Dr.

(b)(6)-2

(b)(6)-2

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

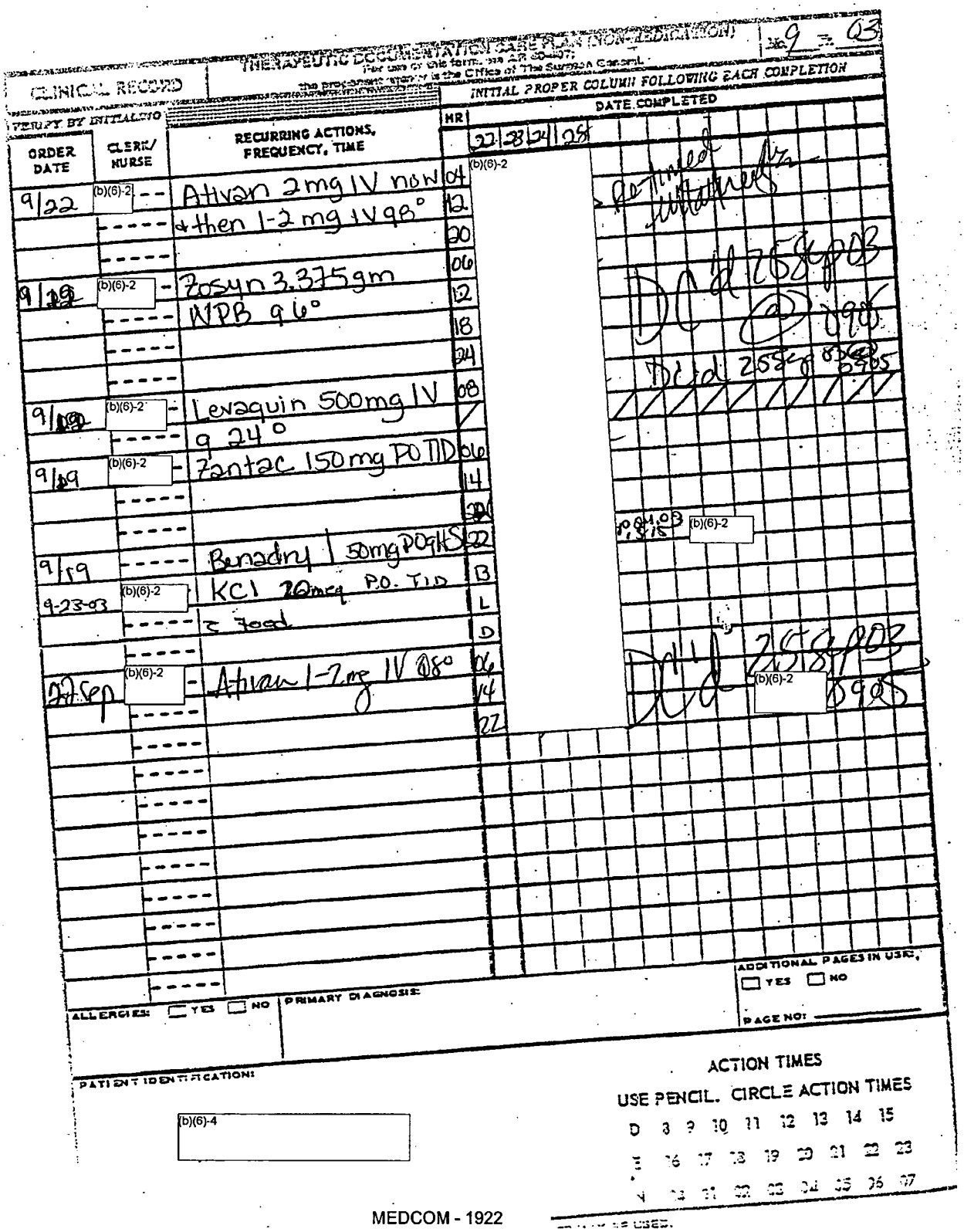
DATE OF ORDER | HOURS

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

MEDCOM - 1921



CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

No. 9 - 03

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

VERIFY BY INITIALING: ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 22	23	24	25
9/22	(b)(6)-2	Ativan 2mg IV now	04	(b)(6)-2			Retimed [illegible]
		& then 1-2 mg IV 98°	12				
			20				
			06				
9/22	(b)(6)-2	Zosyn 3.375gm	12				DC'd 25 Sep 03 @ 0905
		NPB 96°	18				
			24				DC'd 25 Sep 03 @ 0905
			08				
9/22	(b)(6)-2	Levaquin 500mg IV					
		9 24°					
9/19	(b)(6)-2	Zantac 150mg PO TID	06				
			14				
			20				
			22				0,04,03 1,5,15 (b)(6)-2
9/19		Benadry 50mg PO qHS	B				
9-23-03	(b)(6)-2	KCl 20meq P.O. TID	L				
		c food	D				
27 Sep	(b)(6)-2	Ativan 1-2mg IV 98°	06				DC'd 25 Sep 03 0905
			14				(b)(6)-2
			22				

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

PATIENT IDENTIFICATION:

(b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

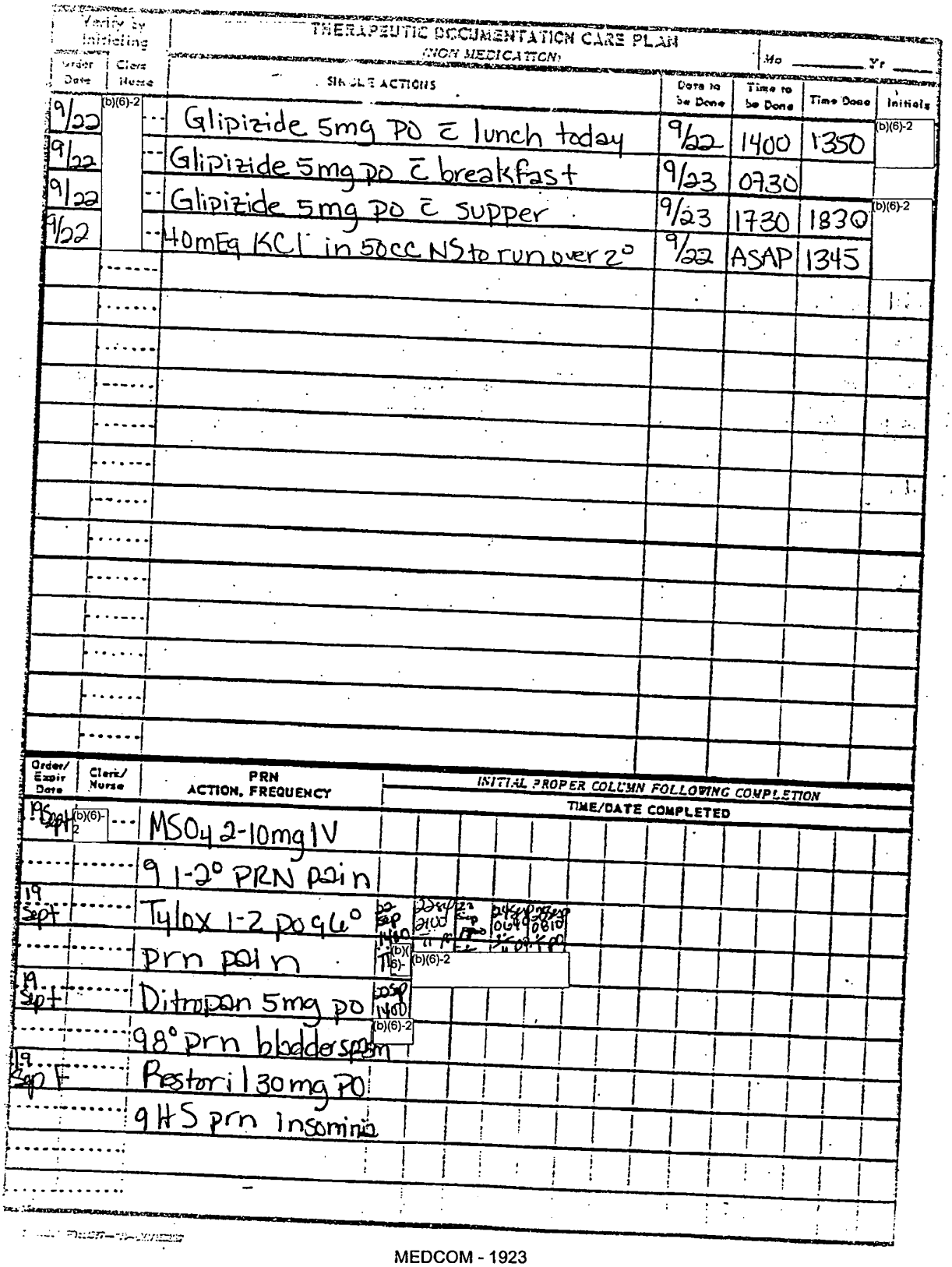
D 8 9 10 11 12 13 14 15

E 16 17 18 19 20 21 22 23

N 24 01 02 03 04 05 06 07

MEDCOM - 1922

[illegible] USED.



THERAPEUTIC DOCUMENTATION CARE PLAN
(NON MEDICATION)

Verify by Initialing

Mo _____ Yr _____

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
9/22	(b)(6)-2	Glipizide 5mg PO c lunch today	9/22	1400	1350	(b)(6)-2
9/22		Glipizide 5mg PO c breakfast	9/23	0730		
9/22		Glipizide 5mg PO c supper	9/23	1730	1830	(b)(6)-2
9/22		40mEq KCl in 50cc NS to run over 2°	9/22	ASAP	1345	

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED
19 Sept	(b)(6)-2	MSO4 2-10mg IV	
		q 1-2° PRN pain	
19 Sept		Tylox 1-2 PO q6°	
		prn pain	
19 Sept		Ditropan 5mg PO	
		98° prn bladderspasm	
19 Sept		Restoril 30mg PO	
		qHS prn insomnia	

MEDCOM - 1923

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)
For use of this form, see AR 40-407;
the proponent agency is the Office of The Surgeon General.

No. 8 Sr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 25	26	27
26AUG	(b)(6)-2	Vitals - Q1° (routine	D	/	(b)(6)-2	
	-----	for ICU)	E	/		D/C'd see new order
	-----		N	(b)(6)-2		
26AUG	(b)(6)-2	Activity - BR	D	/		
	-----		E	/		
	-----		N	(b)(6)-2		
26AUG	(b)(6)-2	Diet - clears → REG	B	/		
	-----	as tol	L	/		
	-----		D	/		
26AUG	(b)(6)-2	CK Q8°, I stat-6,	06	/		
	-----	Glucose, Cr, UA & MICRO	14	/		
	-----		22	/		
26AUG	(b)(6)-2	Leave drsgs for MD	D	/		
	-----	to Δ	E	/		
	-----		N	/		
26AUG	(b)(6)-2	Intake/Output -	D	/		
	-----	if < 150cc/° for 4hrs	E	/		
	-----	(give mannitol prn)	N	(b)(6)-2		
26aug	(b)(6)-2	If pt needs Joly cathete	D	/		
	-----	replaced or Δ'd, col	E	/		
	-----	Bozanski must do it	N	/		
26AUG	(b)(6)-2	Δ VS to q 2 hrs	D	/		
	-----		E	/		
	-----		N	/		

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS: poss. Rhabdo
S/P I&D LUE/LLE, LUE BEA

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
PAGE NO:

PATIENT IDENTIFICATION: EX-FIX (L) FEMUR & limited internal fixation

(b)(6)-4

(EPW

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

D 8 9 10 11 12 13 14 15

E 16 17 18 19 20 21 22 23

MEDCOM - 1924

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON MEDICATION)				Mo 8 Yr 03
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
26 AUG	(b)(6)-2	Admit ICU-2, Ortho — Dr Prevost	/	NOTED	/	/
		cond. guarded				
26 AUG	(b)(6)-2	(b)(6)-2 ~~CBC~~, Chem 7 in AM	26AUG	0600	0520	(b)(6)-2
26 AUG		CK Q8	26AUG	0600		
26 AUG		Please ask pharmacy to make up 2 bottles	/	(b)(6)-2 ~~1400~~	/	/
		of Deykin's solution — have 1 @ BS	26AUG	ASAP ~~2200~~		
26 aug	(b)(6)-2	NPO	26aug	0800	done	(b)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED

MEDCOM - 1925

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)

For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 22	23	24	25
9/22	(b)(6)-2	FBS QAM	05				
9/22		U/A QAM	05				
9/22		Change Dressings BID	10				
		Packing Clodoform Damp Dry	20				
9/22		@ Arm Restraint as	D				
		needed PRN	E				
9			N				
9/22	(b)(6)-2	Ensure plus 1 can	02				
		9 60°	08				
			14				
			00				
9/19	(b)(6)-2	OOB to chair 5 or	08				
		6 times per day	11				
			14				
			18				
			21				
9/19		Benadryl 50mg PO HS	20				

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

(b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

D 8 9 10 11 12 13 14 15

E 16 17 18 19 20 21 22 23

MEDCOM - 1926

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON MEDICATION)

Mo _____ Yr _____

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
9/22	(b)(6)-2	Post Void Residual	9/22	ASAP		(b)(6)-2
9/22		K+ in AM	9/23	0500	0500	
9/22		Portable (D) hip X-ray	9/22	ASAP	1400	
9/25		Transfer to EPW Camp	9/25	TODAY		
9/25		D/C IV	9/25	Done	Done	
9/25		D/C NGT	9/25	ASAP	0930	

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED
9/30		If Temp >101°	
		Obtain Blood	
		Cultures x2 sites x2	

MEDCOM - 1927

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)
For use of this form, see AR 40-407;
the proponent agency is the Office of The Surgeon General.

26 Aug 03

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 25	26	27	28
26AUG	(b)(6)-2	IVF - NS@150cc/°	D	/ (b)(6)-2			
			E	/	D/C 26 May 03		
			N	(b)(6)-2			
26AUG		Ancef 1gm IVPB TID	06	/ (b)(6)-2			
			14	/			
			22	/			
26AUG		Gentamicin 80mg IVPB	07	/			
		Q8°	15	/			
			23	/			
26 May 03		Pen G IV 4 million	03	/			
		units q 6°	09	/			
			15	/			
			21	/			
26 May		LR @ 200 cc/hr	D	/			
			E	/	D/C 27 May @ 0800		
			N	/			
27 May		D5 1/2 NS ε 20 KCL @	D	/			
	-----	110 cc/hr	E	/			
	-----		N	/			
27 May	-----	Albuterol Neb	06	/			
	-----	(std. adult dose) Q8°	14	/ /			
	-----		22	/ /			

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
S/P I & D LUE/LLE, LUE BEA
EX-FIX - LLE (femur) ε INTRAmed FIX

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
PAGE NO: _____

PATIENT IDENTIFICATION:
Poss Rhabdo

(b)(6)-4

(CEPW)

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES
D 8 9 10 11 12 13 14 15
E 16 17 18 19 20 21 22 23

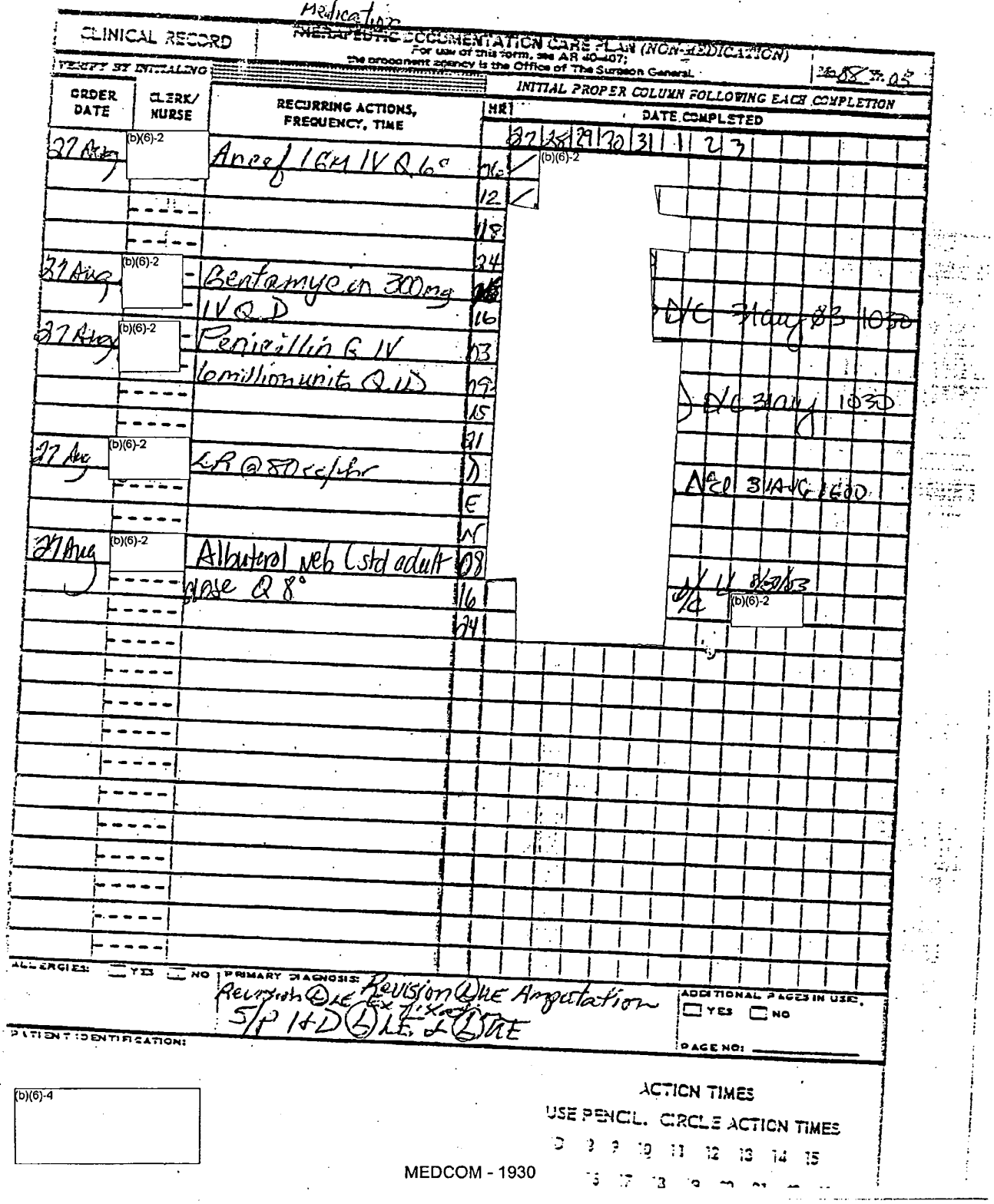
MEDCOM - 1928

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON MEDICATION)				Mo 0 Yr 03
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
26 Aug	(b)(6)-2	dt 0.5 mg IM	26 Aug	0830	0832 (R) delt	(b)(6)-2
26 Aug		Tetanus IG 250 Units IM	26 Aug	0830	0830 (R) quad	
26 Aug		Bolus TL LR non	26 Aug	0930	0930	
		CBC = afternoon labs	27 Aug	1400		
27 Aug		T&C x2 units	27 Aug	0840	0840	

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED					
26 AUG	(b)(6)-2	Tylox T-II pu Q4-6°	26 Aug 1420	27 Aug 0035				
		prn pain	[illegible]	2300 (b)(6)-2				
26 AUG		USO4 2-4 mg IVP Q1°	26 Aug 0400	26 Aug 0730	26 Aug 1205	26 Aug 1630	26 Aug 2100	27 Aug 0300
		prn pain	3 mg (b)(6)-2	3 mg	4 mg	4 mg	4 mg	(b)(6)-
26 AUG		Mannitol 25g IVP	26 Aug 25g					
		Q4° prn UOP < 100 cc/ 150 cc/ 26 Aug	0500 (b)(6)-					

D/C 27 Aug 03 0800

MEDCOM - 1929



CLINICAL RECORD

Medication
~~THERAPEUTIC~~ DOCUMENTATION CARE PLAN (NON-MEDICATION)
For use of this form, see AR 40-407;
the proponent agency is the Office of The Surgeon General.

VERIFY BY INITIALING

MO 88 Yr 05

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 27	28	29	30	31	1	2	3
27 Aug	(b)(6)-2	Ancef 1GM IV Q 6°	06	✓	(b)(6)-2						
			12	✓							
			18								
			24								
27 Aug	(b)(6)-2	Gentamycin 300mg	[illegible]								
		IV Q D	16						D/C 31 Aug 83 1030		
27 Aug	(b)(6)-2	Penicillin G IV	03								
		6 million units Q 1D	09								
			15						D/C 31 Aug 1030		
			21								
27 Aug	(b)(6)-2	LR @ 80cc/hr	D								
			E						NCl 31 AUG 1600		
			N								
27 Aug	(b)(6)-2	Albuterol neb (std adult	08								
		dose Q 8°	16						D/C 8/30/83		
			24							(b)(6)-2	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Revision (L) LE Revision (L) UE Amputation
Ex fixation
S/P I+D (L) LE & (L) UE

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION:

(b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES
8 9 10 11 12 13 14 15
16 17 18 19 20 21 22 23

MEDCOM - 1930

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON MEDICATION)

Mo 08 Yr 03

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
	(b)(6)-2					(b)(6)-2
27 Aug		MSO4 1-5mg IV Q 5min max 15mg	27 Aug			
30 Aug		Dulcolax Supp ÷ PR Now	30 Aug	2130	2130	
31 Aug		Transfuse 1 unit packs to 4 hrs	31 Aug	1/2 gtt	0045	
31 Aug		Transfuse 1 unit packs to 4 hrs	31 Aug	1/2 gtt	0455	
31 Aug		Lasix 20mg IV ÷ 1st unit packs	31 Aug	1st unit	0420	
31 Aug		lasix 20mg IV ÷ 2nd unit packs	31 Aug		0830	
31 Aug		Istat 6, Chem CBC ÷ transfusion	31 Aug		0930	
31 Aug		25mg Demerol / IM 1225 Pharmacy WP [illegible]	31 Aug		1225	

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED
27 Aug 30 Aug	(b)(6)-2	MSO4 1-4 mg IV Q 1°	31 Aug 0820 · 4mg · 4mg · 4mg · 0530 · 4mg · 2145 · 2210 · 0200 · 0800
		pain pain	4mg · tank · 3mg · 3mg · 2145 · 2210 · 0200 · 0800
27 Aug 30 Aug		Tylox 1-2 tabs po	27 Aug 1345 · 1330 · 2050 · 0800
		Q6° pain pain	1/1 · 1330 · 2050 · 0800
27 Aug		MSO4 1-3 mg IVP Q5min	28 Aug 1745
		max 15mg	1745 · 2045
29 Aug		650mg Tylenol q	29 Aug · 29 Aug · 30 Aug · 31 Aug
		4-6° prn as needed	1300 · 2200 · 0800 · 1230
30 Aug		Dulcolax Supp ÷ PR	31 Aug 1038
		QD prn	

POST Operative Single action

Discont 31 Aug

(b)(6)-2

MEDCOM - 1931

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)
For use of this form, see AR 40-407;
the proponent agency is the Office of The Surgeon General.

No. 08 Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 27 28 29 30 31 01 02 03 04 05 06
27 Aug	(b)(6)-2	Regular Diet	B	(b)(6)-2
			L	Δ 30 Aug 03
			D	
8/27		OOB to Chair TID	D	
			E	
			N	
8/27		Strict NWB (L) LE	D	
			E	
			N	
8/27		BD dressing changes	10	
		to (L) thigh, 25% Dakins	29	
		Solution		
27 Aug 03		~~vitals q 2hrs~~	D	
28 Aug 03		vital signs q 8°	E	
			N	
30 Aug		CBC q'd	05	
30 Aug		NPO	B	
			L	
			D	
30 Aug		leave (L) LE below	D	
		knee & (R) foot wounds	E	
		open to air	N	
31 Aug 03		4 IVF to 05NS ≈ 20K @ 100 cc/hr	D	
	-----		E	
	-----		N	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Revision (L) UE amputation
S/P I+D (L) UE + (L) LE, Revision (L) LE ex fix

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION:

(b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

D 8 9 10 11 12 13 14 15

E 16 17 18 19 20 21 22 23

MEDCOM - 1932

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON MEDICATION)				Mo 08 Yr 03
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
8/27	(b)(6)-2	Transfer to ICU II Dr (b)(6)-2	8/27	Return OK	1345	(b)(6)-2
8/27		D/C Foley in AM 8/29/03	8/28	DO NOT D		
8/27		CBC Chem 7 in AM	8/28		0700	
8/28		NPO p̄ MW	8/29	0001	p̄MN	
30 Aug		KUB	8/30	ASAP	1900	
30 Aug		CBC SMA-7, LFT's	8/30	ASAP	1900	
31 Aug		D/C Foley catheter	31 Aug	—	—	
31 AUG 03		KCL 40 meq iV over 2 hours x 2	31 AUG	#1 1600	—	
		[illegible]	31 AUG	#2 1825	—	
31 AUG 03		Port CXR	31 AUG	1610	—	
31 AUG 03		After - KCL complete - d/c central line	31 AUG 03	2100		
31 Aug		CXR c̄ KUB in AM	1 Sept 03	0600	0600	

(b)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED		
31 AUG 25 Sep	(b)(6)-2	Demerol 25 mg c̄	2100 31 AUG	2250 31 AUG	0650 (b)(6)-2 25 mg
		Phenergan 12.5 mg	25 mg 12	25 mg 12	12 Sep 13 Sept
		IV q 4-6 hrs	(b)(6)-2		

See 1 Tangerine

MEDCOM - 1933

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. ___ Yr. ___

VERIFY BY INITIALING — *INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION*

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 1	2	3	4	5
1Sept03	(b)(6)-2	Zantac 50mg IVq 8°	02					
			10	(b)(6)-2				
			18					
1Sept03	(b)(6)-2	Erythromycin 250mg IV piggyback Q6°	05					
			11	(b)(6)-2				
			17					
			23					
1Sept03	(b)(6)-2	NGT to LIS	D	(b)(6)-2				
			E					
			N					

Rewritten 1 Sep 03 1550

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

(b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

MEDCOM - 1934

DA FORM 4677, 1 OCT 79

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

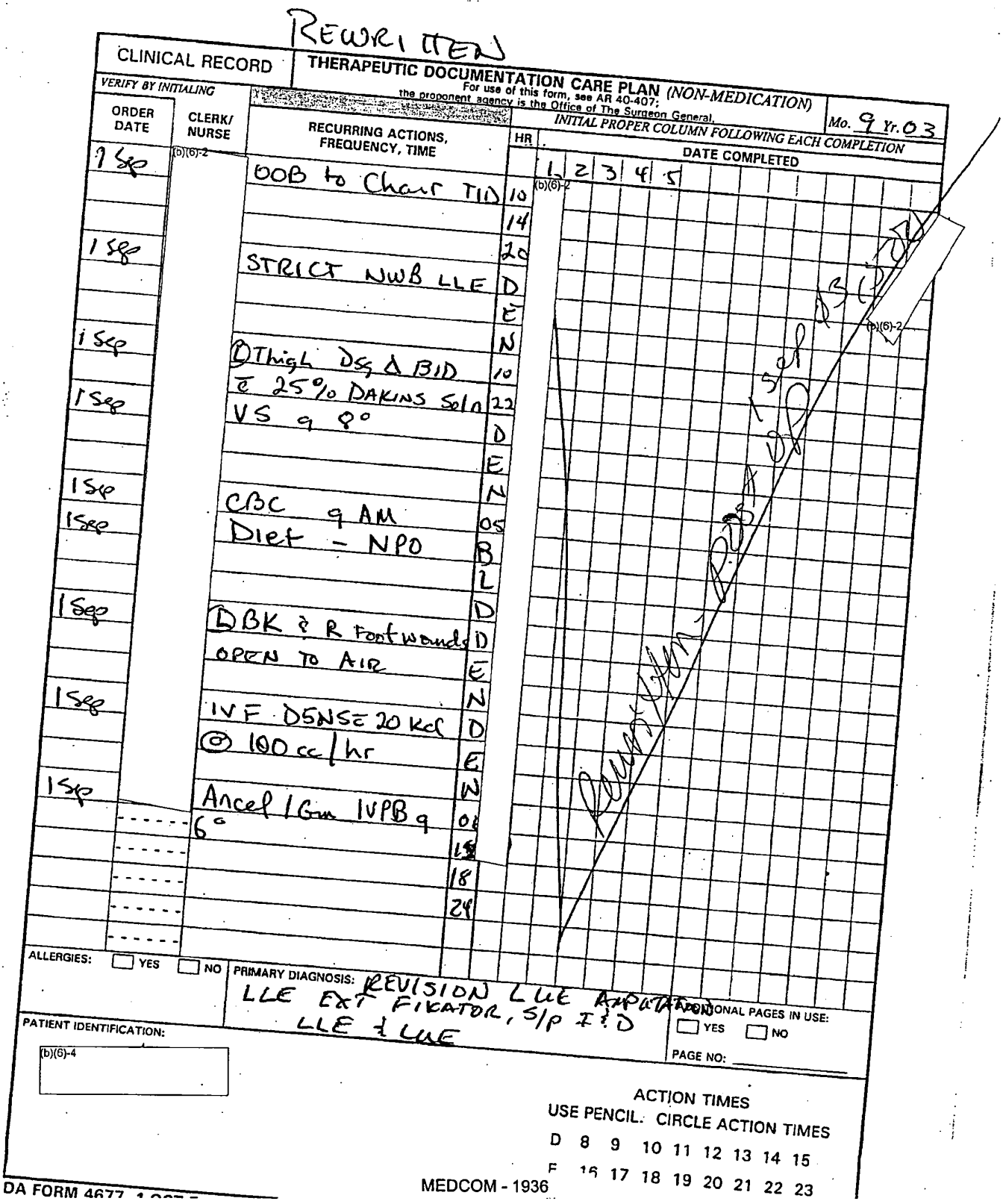
Mo _____ *Yr* _____

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING COMPLETION* TIME/DATE COMPLETED

MEDCOM - 1935

USAPA V1.00



REWRITTEN

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo. 9 Yr. 03

VERIFY BY INITIALING

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR
9 Sep	(b)(6)-2	OOB to Chair TID	10
			14
1 Sep		STRICT NWB LLE	20
			D
			E
1 Sep		Thigh DSG Δ BID	N
		@ 25% DAKINS Soln	10
1 Sep		VS q 8°	22
			D
			E
1 Sep		CBC q AM	N
1 Sep		Diet = NPO	05
			B
			L
1 Sep		BK & R Footwounds	D
		OPEN TO AIR	D
			E
1 Sep		IVF D5NSS 20 KCl	N
		@ 100 cc/hr	D
			E
1 Sep		Ancef 1 Gm IVPB q	N
		6°	02
			06
			10
			14
			18
			22

DATE COMPLETED: 1 | 2 | 3 | 4 | 5

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: REVISION LLE AMPUTATION
LLE EXT FIXATOR, S/P I&D
LLE & LUE

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION:

(b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES
D 8 9 10 11 12 13 14 15
E 16 17 18 19 20 21 22 23

DA FORM 4677

MEDCOM - 1936

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo _____ Yr _____

Verify by Initialing: Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
1 Sept	(b)(6)-2	Place NGT	1 Sept	NOW	1030 ~~110~~ (b)(6)	(b)(6)-2

Re-written (Sep 03 1500 postop

INITIAL PROPER COLUMN FOLLOWING COMPLETION

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	TIME/DATE COMPLETED		
1 Sep	(b)(6)-2	Demeral 25 mg / Phenergan 12.5 mg IVP q 4-6 hrs	0650 NW 1 Sept 25/12.5		
1 Sep		Ducolax Supp T PR QD PRN			
1 Sep		Tylenol 650 mg PO q 4-6° prn			
1 Sep		MSO4 1-4 mg IVP Q1° prn pain	0220 (b)(6)-2 2 mg	911 0855 4 mg (b)(6)-2	9/2 1050 4 mg (b)(6)-2
1 Sept		Tylenol Sup 1 PR q 6° PRN Temp >101.°F	1100 (b)(6)-2 1 Sept TPR		
1 Sept		O2 Rev NC 3L PRN Stat			

MEDCOM - 1937

USAPA V1.00

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	MoSepYr 23

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 1 2 3 4 5 6
1sep	(b)(6)-2	NPO	D	(b)(6)-2
			E	
			N	
1sep		Act: OOB to chair	10	
		tid	14	
			20	
1sep		vitals - routine	06	
		for ICU	14	
		no. Q8 if WNL	22	
1sep		IVF: D5NS c̄	D	
		20 mEq KCl @ 100 ml/hr	E	
			N	
1sep		ancef 1g IVPB	02	
		Q8	10	
			18	
1sep		Erythromycin 250	06	
		mg IVPB q6°	12	
			18	
			24	
1sep		N/C O2 3 l prn	D	
		suts L92%	E	
			N	
1sep		NGT to LIWS	D	
			E	
			N	
		See next Page		

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: (1) UE amp; (1) LE ex fix sp blast injury & I/D

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO: 1

PATIENT IDENTIFICATION:

(b)(6)-4

(b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 MEDCOM - 1938 ED. USAPA V1.00

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo ____ Yr ____
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
1 Sep	(b)(6)-2	cond's fair	1 Sep	03		(b)(6)-2
Sep		Radiology: ② shoulder series	Sep	—	—	
Sep		CBC, chem 7 in am	2 Sep	0500	—	
2 Sep		T&C 2 units PRBCS TRANSFUSE	9/2	UNIT#1 ASAP	1230	
		OVER 4° EACH UNIT #2	9/2	1 hr's PRT #1	1510	
2 Sep 03		LASIX 20mg IVP EACH unit of PRBCs	9/2	P# 1	1600	
			9/2	P# 2	1830	
2 Sep 03		CBC & Diff in AM	9/3	0500	0800	
2 Sep 03		KUB AP OD in A.M.	9/3	0600	0615	
2 Sept 03		Repeat Done of Demerol 25mg & Phenergan 12.5mg IVP Now	9/2	2300	done	

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED															
1 Sep	(b)(6)-2	Demerol 25mg	2560	3545														
-----	-----	& 12.5mg phenergan	2100	0330														
-----	-----	IV q 4-6° prn pain	25/12.5	25/12.5	(b)(6)-2													
1 Sep	(b)(6)-2	Tylenol (650-1000mg	1400	0145 2 Sep	9/2 1050	9/3 0535												
-----	-----	PR (Suppository)	1600	(b)(6)-2	(b)(6)-2	(b)(6)-2												
-----	-----	q 4-6° prn T>101°F	(b)(6)-2															
-----	-----																	
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CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo. Sept Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 1	2	3	4	5	6
1 Sep	(b)(6)-2	Wet to dry dressings	10	(b)(6)-2					
		(L) LE bid please	22						
		(no Pakins)							
1 Sep		Zantac 50 mg	08						
		IV q 8°	16						
			24						
2 Sep 03		GENTAMICIN 300mg	11			/	/	/	/
		IV Q DAY X 3 DAYS	/	/	/	/	/	/	/
3 Sep 03		CREATINE Q DAY	05						

ALLERGIES: ☐ YES ☑ NO

PRIMARY DIAGNOSIS: (L) UE amp, (L) LE ex fix
S/P blast injury @ E/D

ADDITIONAL PAGES IN USE: ☑ YES ☐ NO

PAGE NO: 2

PATIENT IDENTIFICATION:

(b)(6)-4

(b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 MEDCOM - 1940 D. USAPA V1.00

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*				Mo _____ Yr _____
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
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Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING COMPLETION* TIME/DATE COMPLETED													
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MEDCOM - 1941

USAPA V1.00

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 09 Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 3 4 5 6 7 8 9 10
3Sept	(b)(6)-2	Diet: NPO	B	(b)(6)-2
			L	
			D	
3Sept		OOB to chair BID	D	
		-tid	E	
			N	
3Sept		Vitals routine	D	
			E	
			N	
3Sept		D5NS c̄ 20meq KCl	D	
		100cc/°	E	
			N	
3Sept		Ancef 1gm IVPB	02	
		q8°	10	
			18	
3Sept		Erythromycin 250mg	06	
		IVPB q 6°	12	
			18	
			24	
3Sept		Gentamicin 300mg	11	
		q day x 2 days		
3Sept		NGT to LIS	D	
			E	
			N	
3Sept		Wet to dry dressing	10	
		(L) leg c̄ packing of	22	
		wound BID please		

See New

New order 4 Sept 03

D/C'd 5 Sep 03 1200

ALLERGIES: ☐ YES ☒ NO NKDA

PRIMARY DIAGNOSIS: S/P Blast injury + 1+D (L) Below Elbow Amp (L) LE Ex fix

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION:

(b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 MEDCOM - 1942 USAPA V1.00

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo ____ Yr ____
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
3 Sept	(b)(6)-2	Admit to ICU #1				(b)(6)-2
3 Sept		Cond: fair				
3 Sept		X-Ray-(L) femur, Portable	3Sept	post-op	1145	
3 Sept		CBC, Chem 7 in AM	4Sept	AM	0570	
4 Sept		Demerol 25mg/Phenergan 12.5mg 1V x 1 now	4Sept	now	1215	
4 Sept		D/C NGT	4Sept	NOW	1200	

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
3 Sept	(b)(6)-2	Demerol 25mg c̄ 12.5mg phenergan 1V q̄ 4-6 PRN	9/3 1315 (b)(6)-2 E	3SEP 1150 (b)(6)-2	0140 4Sep (b)(6)	0910 4Sept (b)(6)- 25/R-2 E	See single action (b)(6)-	2000 2000 2.5m (b)(6) G	0045 5Sep (b)(6)- E	5Sep 1030 (b)(6)- E						
		Pain														
3 Sept		Tylenol 650-1000mg PR (Supp) q̄ 4-6 PRN	9/3 1225 (b)(6)-2 E	3SEP 1600 1gm (b)(6)-2	4Sept 1345 (b)(6) 1gm	5Sep 1350 (b)(6)										
		T >101°F														
3 Sept		N/C O2 3L PRN SAT < 92%														

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo. 09 Yr. 03

VERIFY BY INITIALING | *INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION*

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 3 4 5 6 7
3Sept	(b)(6)-2	Zantac 50mg IV q8°	08	(b)(6)-2
			16	
			24	
3Sept	(b)(6)-2	Wet Washcloth if patient wants fluids	D	
			E	
			N	
3Sept	(b)(6)-2	O2 to keep Sats >92 (3L/NC)	D	
			E	
			N	
3Sept	(b)(6)-2	Continue Gentamicin 300mg IV q day	11	
3Sept	(b)(6)-2	Daily Createnine	08	

ALLERGIES: ☐ YES ☒ NO — NKDA

PRIMARY DIAGNOSIS: S/P Blast injury & I+D ⓛ Below Elebow amp ⓡ LE Exfix

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO — PAGE NO: _____

PATIENT IDENTIFICATION:

(b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 — MEDCOM - 1944 — USAPA V1.00

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*				Mo _____ Yr _____
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
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	- - - - -					
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Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING COMPLETION* TIME/DATE COMPLETED													
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- - - - -	- - - - -															

MEDCOM - 1945

USAPA V1.00

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-400; the proponent agency is The Office of The Surgeon General

REPORT TITLE

POST ANESTHESIA CARE UNIT FLOWSHEET

OTSG APPROVED (Date) 17 Jan 80

PROCEDURE: I&D LUE
DSG D TO LUE
PHYSICIAN: DR (b)(6)-2
ANESTHESIA BY:
(Gen) Spinal MAC Axillary
Local Bier Epidural Other

ALLERGIES: NKDA
AIRWAYS: Time DC'D
ETT Nasal Oral Trach
OXYGEN:
Mask Nasal Face Blow-By
Prongs Tent
Liter/min. %

ASA 2 History MULT DEATH injuries
Cardiac Rhythm ST @ ectopy
IV#1 Patent Infiltrated
Site RTJ Rate 125 Gauge
IV#2 Patent Infiltrated
Site Rate Gauge

VITAL SIGNS						PAR SCORE						OTHER	
Time	B/P	P	R	O2SA	Temp	Act	Resp	Circ	LOC	Skin	PARS	COMMENTS	Neuro-Vascular
PRE-OP	/												Extr: L R Upper: Lower: Pulse DP PT RAC
PRE-OP	/												Blanche Pulse Warm Moves Y N
1205	126/80	110	23	95%	97.4	2	2	2	1	2	9		Blanche Pulse Warm Moves Y N
1210	124/80	110	19	98%		2	2	2	1	2	9		Blanche Pulse Warm Moves Y N
1215	125/87	110	21	96%		2	2	2	1	2	9		Blanche Pulse Warm Moves Y N
1220	136/84	108	14	96%		2	2	2	1	2	9		Blanche Pulse Warm Moves Y N
1245	129/84	111	22	95%		2	2	2	2	2	10		Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N

POST ANESTHESIA RECOVERY SCORE "PARS"

Activity - General Anesthesia
2--Maintain head lift and open eyes
1--Unable to maintain head lift and open eyes
0--Unable to lift head and open eyes

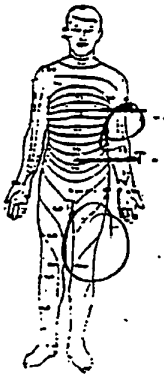
Activity - SAB or Subarachnoid Block
2--Moves all four extremities with control
1--Moves both upper extremities

Respirations
2--Spontaneous respiration; needs no support
1--Limited effort; needs artificial airway or jaw support
0--Needs ventilator; no spontaneous respiration

Circulation
2--BP 20% preanesthetic level
1--BP ~~20~~ - 50% preanesthetic level
0--BP 50% or more preanesthetic level

Level of Consciousness
2--Awake and alert; seldom dozes
1--Awakens when gently stimulated
0--Awakens only when vigorously stimulated

Skin
2--Normal skin color & temperature greater than 96°
1--Skin is pale, blotchy, dusky &/or temperature 95 - 96°
0--Cyanotic &/or temperature less than 95°



DRESSING: Status Location

	Status	Location
(Gauze)	CD&I	LUE AMPUTATION
Opsite	CD&I	(L) THIGH
Bandaid		
Steri-strips		
Collodian		
Peri-pad		
Coban		
Cotton Balls		
(Ace Wrap)		

TUBES AND DRAINS: Hemovac Foley NGT Chest Jackson-Pratt

(Continue on reverse)

PREPARED BY (Name & Title) (b)(6)-2 LT AN

DEPARTMENT/SERVICE/CLINIC ICU #1

DATE 9/19/03

PATIENT IDENTIFICATION (For typed or written entries give: Name-last, first, middle; grade; date; hospital or medical facility)

(b)(6)-4

☐ HISTORY/PHYSICAL ☒ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)
☐ DIAGNOSTICS STUDIES
☐ TREATMENT

DA FORM 1 MAY 78 4700

FH MDA OP 132-11a (Rev) 1 Sep 99

MEDCOM - 1946

INTAKE			OUTPUT		
TIME	TYPE	AMT	TIME	TYPE	AMT
OR	D5NS	800	OR	EBL	Min
		100	OR	Urine	100
TOTAL	D5NS T 20KCl	900	TOTAL		100

PACU NURSING NOTES: NURSING CARE PROBLEM NO.'S IDENTIFIED. Refer to FH MDA OP 39

NURSING CARE PROBLEMS: 1. RESP; 2. CIRC; 3. ACT; 4. LOC; 5. TEMP; 6. PAIN; 7. SAFETY; 8. ANXIETY; 9. EDUC; 10. OTHER

1205 Transfer from OR via litter. Transfer to bed Connected Propaq. VSS
See flowsheet for Assessment. (b)(6)-2 [redacted] (LT), [illegible]
1245 Pt Alert. VSS. (b)(6)-2 [redacted] (LT), [illegible]

MEDICATION RECEIVED IN PACU/ICU

MEDICATION GIVEN BY:	DRUG	DOSE	ROUTE	TIME	PAIN LEVEL	EFFECTIVENESS
20SYN OR	20SYN		IVP	1130		
LT (b)(6)-2 [redacted]	MSD4	2mg	IVP	1245		(+)

DISPOSITION SUMMARY: Nursing Care Problems No.'s_____ Resolved; No.'s_____ Continue.
Patient was transferred from PACU/ICU recovery room via litter/crib with siderails raised, or held by parent in wheelchair.
Dressing status:_____ PAR Score_____ Safety Straps_____
Report given to_____. Patient released by Anesthesia_____
Time out_____. Nurse Signature:_____

MEDCOM - 1947

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-400; the proponent agency is The Office of The Surgeon General

REPORT TITLE: POST ANESTHESIA CARE UNIT FLOWSHEET

OTSG APPROVED (Date): 17 Jan 80

PROCEDURE: Wisdom (2) E

PHYSICIAN: (b)(6)-2

ANESTHESIA BY: DC (b)(6)-2

Gen Spinal MAC Axillary
Local Bier Epidural Other

ALLERGIES:

AIRWAYS: Time DC'D

ETT Nasal Oral Trach

OXYGEN:

Mask Nasal Prongs Face Tent Blow-By

Liter/min. %

ASA History

Cardiac Rhythm

IV#1 Patent Infiltrated
Site Rate Gauge

IV#2 Patent Infiltrated
Site Rate Gauge

VITAL SIGNS						PAR SCORE						OTHER	
Time	B/P	P	R	O2SA	Temp	Act	Resp	Circ	LOC	Skin	PARS	COMMENTS	Neuro-Vascular
PRE-OP	/												Extr: L R Upper Lower Pulse DP PT RAC Blanche Pulse Warm Moves Y N
PRE-OP	/												Blanche Pulse Warm Moves Y N
1515	134/84	125	18	96%	99.6	2	2	2	2	2	10		Blanche Pulse Warm Moves Y N
1550	146/84	130	14	96%									Blanche Pulse Warm Moves Y N
1555	130/72	131	18	92									Blanche Pulse Warm Moves Y N
~~1600~~	~~128/84~~												Blanche Pulse Warm Moves Y N
1600	137/81	129	18	98%									Blanche Pulse Warm Moves Y N
1615	/	see		Tc		notes							Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N

POST ANESTHESIA RECOVERY SCORE "PARS"

Activity - General Anesthesia
2--Maintain head lift and open eyes
1--Unable to maintain head lift and open eyes
0--Unable to lift head and open eyes

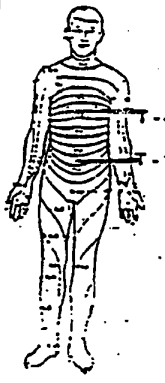
Activity - SAB or Subarachnoid Block
2--Moves all four extremities with control
1--Moves both upper extremities

Respirations
2--Spontaneous respiration; needs no support
1--Limited effort; needs artificial airway or jaw support
0--Needs ventilator; no spontaneous respiration

Circulation
2--BP 20% preanesthetic level
1--BP 20 - 50% preanesthetic level
0--BP 50% or more preanesthetic level

Level of Consciousness
2--Awake and alert; seldom dozes
1--Awakens when gently stimulated
0--Awakens only when vigorously stimulated

Skin
2--Normal skin color & temperature greater than 96°
1--Skin is pale, blotchy, dusky &/or temperature 95 - 96°
0--Cyanotic &/or temperature less than 95°



DRESSING:	Status	Location
Gauze		
Opsite		
Bandaid		
Steri-strips		
Collodian		
Peri-pad		
Coban		
Cotton Balls		
Ace Wrap		

TUBES AND DRAINS: Hemovac Foley NGT Chest Jackson-Pratt

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC

DATE

PATIENT'S IDENTIFICATION (For typed or written entries give: Name--last, first, middle; grade; date; hospital or medical facility)

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)
☐ DIAGNOSTICS STUDIES
☐ TREATMENT

DA FORM 1 MAY 78 4700

FH MDA OP 132-11a (Rev) 1 Sep 99

MEDCOM - 1948

INTAKE			OUTPUT		
TIME	TYPE		TIME	TYPE	AMT
OR	LR	200	OR	EBL min	~~400~~ (b)(6)-2
			OR	Urine	400
TOTAL			TOTAL		

PACU NURSING NOTES: NURSING CARE PROBLEM NO.'S IDENTIFIED. Refer to FH MDA OP 39

NURSING CARE PROBLEMS: 1. RESP; 2. CIRC; 3. ACT; 4. LOC; 5. TEMP; 6. PAIN; 7. SAFETY; 8. ANXIETY; 9. EDUC; 10. OTHER

1545 - PT to ICU1 from OR. NGT (b)(6)-2 placed + sutured to nares: PT attempting to pull NGT - tied (R) hand to bed. IV 0°C in OR. Still has (R) IJ currently infusing LR. Ex fix (L) femur intact - dressing CDI. (L) UE dressing CDI. Foley intact. cardia cmonitor c̄ ST - 130s. Sats 96% on RA. (b)(6)-2 MAJ/ON

Refer to ICU Flow sheet for further details.

(b)(6)-2 MAJ/ON

MEDICATION RECEIVED IN PACU/ICU

MEDICATION GIVEN BY:	DRUG	DOSE	ROUTE	TIME	PAIN LEVEL	EFFECTIVENESS

DISPOSITION SUMMARY: Nursing Care Problems No.'s_____ Resolved; No.'s_____ Continue.
Patient was transferred from PACU/ICU recovery room via litter/crib with siderails raised, or held by parent in wheelchair.
Dressing status:_____ PAR Score_____ Safety Straps_____
Report given to_____. Patient released by Anesthesia_____
Time out_____. Nurse Signature:_____

MEDCOM - 1949

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-400; the proponent agency is The Office of The Surgeon General

REPORT TITLE

POST ANESTHESIA CARE UNIT FLOWSHEET

OTSG APPROVED (Date) 17 Jan 80

PROCEDURE: I&D LWE/LLE
JJ PLACEMENT
PHYSICIAN: (b)(6)-2
ANESTHESIA BY: Dr (b)(6)-2
(Gen) Spinal MAC Axillary
Local Bier Epidural Other

ALLERGIES: NKDA
AIRWAYS: _____ Time DC'D _____
ETT Nasal Oral Trach
OXYGEN:
Mask Nasal Face Blow-By
Prongs Tent
Liter/min. _____ %

ASA ___ History _____
Cardiac Rhythm _____
IV#1 _____ Patent Infiltrated
Site _____ Rate _____ Gauge _____
IV#2 _____ Patent Infiltrated
Site _____ Rate _____ Gauge _____

VITAL SIGNS						PAR SCORE						OTHER	
Time	B/P	P	R	O2SA	Temp	Act	Resp	Circ	LOC	Skin	PARS	COMMENTS	Neuro-Vascular
PRE-OP	/												Extr: L R Upper Lower Pulse DP PT RAD
PRE-OP	/												
1945	124/86	109	11	97	96.8								Blanche Warm Pulse Moves Y N
1950	125/87	119	22	96									Blanche Warm Pulse Moves Y N
1955	135/87	120	19	97									Blanche Warm Pulse Moves Y N
2000	138/77	128	19	95		2	2	2	2	2	10		Blanche Warm Pulse Moves Y N
2015	135/66	133	20	98%									Blanche Warm Pulse Moves Y N
2045	143/77	145	18	95									Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N

POST ANESTHESIA RECOVERY SCORE "PARS"

Activity - General Anesthesia
2—Maintain head lift and open eyes
1—Unable to maintain head lift and open eyes
0—Unable to lift head and open eyes

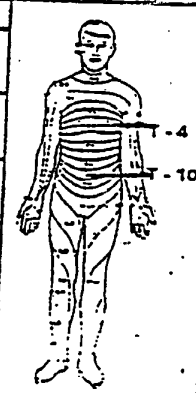
Activity - SAB or Subarachnoid Block
2—Moves all four extremities with control
1—Moves both upper extremities

Respirations
2—Spontaneous respiration; needs no support
1—Limited effort; needs artificial airway or jaw support
0—Needs ventilator; no spontaneous respiration

Circulation
2—BP 20% preanesthetic level
1—BP ~~20~~ - 50% preanesthetic level
0—BP 50% or more preanesthetic level

Level of Consciousness
2—Awake and alert; seldom dozes
1—Awakens when gently stimulated
0—Awakens only when vigorously stimulated

Skin
2—Normal skin color & temperature greater than 96°
1—Skin is pale, blotchy, dusky &/or temperature 95 - 96°
0—Cyanotic &/or temperature less than 95°



DRESSING:	Status	Location
Gauze	C/D/I.	LWE/LLE
Opsite		
Bandaid		
Steri-strips		
Collodian		
Peri-pad		
Coban		
Cotton Balls		
Ace Wrap		

TUBES AND DRAINS: Hemovac Foley NGT Chest Jackson-Pratt

PREPARED BY (b)(6)-2 [redacted] GT/AN

DEPARTMENT/SERVICE/CLINIC ICU 1

(Continue on reverse)

DATE 13SEP03

(b)(6)-2 [redacted] or written entries give: Name—last, first, middle; grade; date; hospital or m[redacted]acility)

(b)(6)-4 [redacted]

☐ HISTORY/PHYSICAL ☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)
☐ DIAGNOSTICS STUDIES
☐ TREATMENT

DA FORM 1 MAY 78 4700

FH MDA OP 132-11a (Rev)
1 Sep 99

MEDCOM - 1950

INTAKE			OUTPUT		
TIME	TYPE	AMT	TIME	TYPE	AMT
OR	500 LR	500	OR	EBL 30	30
			OR	Urine 0	
TOTAL		500	TOTAL		30

PACU NURSING NOTES: NURSING CARE PROBLEM NO.'S IDENTIFIED. Refer to FH MDA OP 39

NURSING CARE PROBLEMS: 1. RESP; 2. CIRC; 3. ACT; 4. LOC; 5. TEMP; 6. PAIN; 7. SAFETY; 8. ANXIETY; 9. EDUC; 10. OTHER

1945 - Pt arrived from OR via gurney. Pt has COT dsg on LUE/LLE IJ = PLACE INFUSING LR @ 100cc/hr. Pt Alert and disoriented at this time. Pt dislodged NC tube. HS - RRR, LS - CTA bilaterally, BS x4 quads. Moves all extremeties c good neuro ✓S (b)(6)-2

MEDICATION RECEIVED IN PACU/ICU

MEDICATION GIVEN BY:	DRUG	DOSE	ROUTE	TIME	PAIN LEVEL	EFFECTIVENESS

DISPOSITION SUMMARY: Nursing Care Problems No.'s _____ Resolved; No.'s _____ Continue.
Patient was transferred from PACU/ICU recovery room via litter/crib with siderails raised, or held by parent in wheelchair.
Dressing status: C/D/I PAR Score 10 Safety Straps _____
Report given to CPT (b)(6)-2 Patient released by Anesthesia Dr (b)(6)-2
Time out 1945 Nurse Signature: (b)(6)-2

MEDCOM - 1951

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-400; the proponent agency is The Office of The Surgeon General

REPORT TITLE: **POST ANESTHESIA CARE UNIT FLOWSHEET**

OTSG APPROVED (Date): 17 Jan 80

PROCEDURE: IND of (L) ARM

PHYSICIAN: (b)(6)-2

ANESTHESIA BY: (b)(6)-2

(Gen) Spinal MAC Axillary Local Bier Epidural Other

ALLERGIES: NKDA

AIRWAYS: _____ Time DC'D _____

ETT Nasal Oral Trach

OXYGEN: Mask (Nasal) Face Blow-By Prongs Tent

Liter/min. 32 %

ASA ___ History _____

Cardiac Rhythm _____

IV#1 _____ Patent Infiltrated

Site (L) Hand Rate 100 cc/hr Gauge ____

IV#2 _____ Patent Infiltrated

Site _____ Rate ____ Gauge ____

Time	VITAL SIGNS B/P	P	R	O2SA	Temp	PAR SCORE Act	Resp	Circ	LOC	Skin	PARS	OTHER COMMENTS	Neuro-Vascular
PRE-OP	/												Ext: L R Upper Lower Pulse DP PT RAC
PRE-OP	111 59	110	16	94%									Blanche Warm Pulse Moves Y N
1050	123/78	102	9	98%	98.6 AX	1	2	2	1	2	8	Received from OR	Blanche Warm Pulse Moves Y N
1055	122/76	100	9	99%		1	2	2	1	2	8		Blanche Warm Pulse Moves Y N
1100	123/78	99	9	97%	98.1 AX	2	2	2	1	2	9		Blanche Warm Pulse Moves Y N
1115	124/76	108	14	98%		2	2	2	1	2	9		Blanche Warm Pulse Moves Y N
1130	149/85	110	18	97%		2	2	2	2	2	10		Blanche Warm Pulse Moves Y N
1145	145/90	116	19	99%	99.2 AX	2	2	2	2	2	10	Recovered	Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N

POST ANESTHESIA RECOVERY SCORE "PARS"

Activity - General Anesthesia
2—Maintain head lift and open eyes
1—Unable to maintain head lift and open eyes
0—Unable to lift head and open eyes

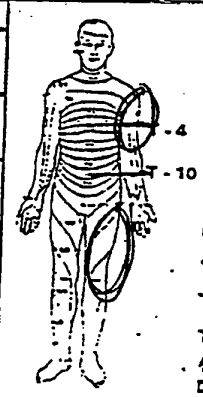
Activity - SAB or Subarachnoid Block
2—Moves all four extremities with control
1—Moves both upper extremities

Respirations
2—Spontaneous respiration; needs no support
1—Limited effort; needs artificial airway or jaw support
0—Needs ventilator; no spontaneous respiration

Circulation
2—BP 20% preanesthetic level
1—BP ~~20~~ - 50% preanesthetic level
0—BP 50% or more preanesthetic level

Level of Consciousness
2—Awake and alert; seldom dozes
1—Awakens when gently stimulated
0—Awakens only when vigorously stimulated

Skin
2—Normal skin color & temperature greater than 96°
1—Skin is pale, blotchy, dusky &/or temperature 95 - 96°
0—Cyanotic &/or temperature less than 95°



DRESSING:	Status	Location
Gauze	C, D, I	LUE, LLE
Opsite		
Bandaid		
Steri-strips		
Collodian		
Peri-pad		
Coban		
Cotton Balls		
Ace Wrap		

TUBES AND DRAINS: Hemovac Foley NGT Chest Jackson-Pratt

(Continue on reverse)

PREPARED BY (S) (b)(6)-2 SPC 91WM6

DEPARTMENT/SERVICE/CLINIC: ICU #1

DATE: 11 SEP 03

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTICS STUDIES

☐ TREATMENT

DA FORM 1 MAY 78 4700

FH MDA OP 132-11a (Rev)
1 Sep 99

MEDCOM - 1952

500 fentanyl Ancef 1g

INTAKE			OUTPUT		
TIME	TYPE	AMT	TIME	TYPE	AMT
OR	300 LR		OR	EBL Minimal	
			OR	Urine Spontaneous void	
TOTAL			TOTAL		

PACU NURSING NOTES: NURSING CARE PROBLEM NO.'S IDENTIFIED. Refer to FH MDA OP 39

NURSING CARE PROBLEMS: 1. RESP; 2. CIRC; 3. ACT; 4. LOC; 5. TEMP; 6. PAIN; 7. SAFETY; 8. ANXIETY; 9. EDUC; 10. OTHER

Received pt from OR via litter @1050. Pt put on 3 L O^2 NC w/ sat of 98%, LUE bandage is C,D, and ✗, LLE DRSG A is C,D+✗. VSS, LR infusing to ⓔ Hand @ 100cc/hr, IV line is patent and ✗ sign of infiltration or infection. Pt recovered to RAU #1.

SPC (b)(6)-2 7/14/14

MEDICATION RECEIVED IN PACU/ICU

MEDICATION GIVEN BY:	DRUG	DOSE	ROUTE	TIME	PAIN LEVEL	EFFECTIVENESS

DISPOSITION SUMMARY: Nursing Care Problems No.'s_____Resolved; No.'s_____Continue.
Patient was transferred from PACU/ICU recovery room via litter/crib with siderails raised, or held by parent in wheelchair.
Dressing status:_____ PAR Score_____ Safety Straps_____
Report given to_____. Patient released by Anesthesia_____
Time out_____. Nurse Signature:_____

MEDCOM - 1953

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-400; the proponent agency is The Office of The Surgeon General

REPORT TITLE

POST ANESTHESIA CARE UNIT FLOWSHEET

OTSG APPROVED (Date) 17 Jan 80

PROCEDURE: (1) BE AMP / (2) Open Femur FX IsDE Shortening of Bone
PHYSICIAN: DR (b)(6)-2
ANESTHESIA BY: CRNA (b)(6)-2
(Gen) Spinal MAC Axillary
Local Bier Epidural Other

ALLERGIES: NKDA
AIRWAYS: Time DC'D
ETT (Nasal) Oral Trach
OXYGEN:
Mask Nasal Face Blow-By
Prongs Tent
Liter/min. 4 l/min %

ASA 1 History Multiple Orthopedic Surgery
Cardiac Rhythm NSR
IV#1 (Patent) Infiltrated
Site RFA Rate Gauge 18g
IV#2 (Patent) Infiltrated
Site RFA Rate Gauge 16g

Time	B/P	P	R	O2SA	Temp	Act	Resp	Circ	LOC	Skin	PARS	COMMENTS	Neuro-Vascular
PRE-OP	/												Extr: L R Upper Lower Pulse DP PT RAD
PRE-OP	/												
1200	134/85	94	10	95%	94.5	2	2	2	2	1	9		Blanche Warm Pulse Moves Y N
1205	131/89	97	12	95%		2	2	2	2	1	9		Blanche Warm Pulse Moves Y N
1210	126/87	95	9	97%		2	2	2	2	1	9	↓ O2 2 l/min	Blanche Warm Pulse Moves Y N
1215	127/81	94	10	100%	94.8	2	2	2	2	1	9		Blanche Warm Pulse Moves Y N
1230	141/93	94	19	100%	95° AX	2	2	2	2	2	9		Blanche Warm Pulse Moves Y N
1245	130/85	99	12	98%	96	2	2	2	2	2	10		Blanche Warm Pulse Moves Y N
1300	132/84	101	13	95%	95.5 AX	2	2	2	2	2	10		Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N

POST ANESTHESIA RECOVERY SCORE "PARS"

Activity - General Anesthesia
2--Maintain head lift and open eyes
1--Unable to maintain head lift and open eyes
0--Unable to lift head and open eyes

Activity - SAB or Subarachnoid Block
2--Moves all four extremities with control
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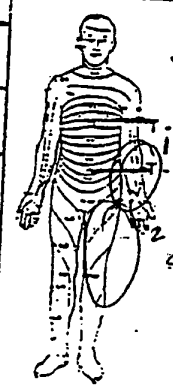
Respirations
2--Spontaneous respiration; needs no support
1--Limited effort; needs artificial airway or jaw support
0--Needs ventilator; no spontaneous respiration

Circulation
2--BP 20% preanesthetic level
1--BP ~~20~~ - 50% preanesthetic level
0--BP 50% or more preanesthetic level

Level of Consciousness
2--Awake and alert; seldom dozes
1--Awakens when gently stimulated
0--Awakens only when vigorously stimulated

Skin
2--Normal skin color & temperature greater than 96°
1--Skin is pale, blotchy, dusky &/or temperature 95 - 96°
0--Cyanotic &/or temperature less than 95°



DRESSING:	Status	Location
Gauze	CDjI	LUE
Opsite	CDjI	KLF
Bandaid		
Steri-strips		
Collodian		
Peri-pad		
Coban		
Cotton Balls		
Ace Wrap		

TUBES AND DRAINS: Hemovac Foley NGT Chest Jackson-Pratt

(b)(6)-2 Title: ILT AR

DEPARTMENT/SERVICE/CLINIC: ICU# 1

(Continue on reverse)

DATE: 9/8/03

(b)(6)-2 IDENTIFICATION (For typed or written entries give: Name-last, first, de; date; hospital or medical facility)

(b)(6)-4

☐ HISTORY/PHYSICAL ☒ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)
☐ DIAGNOSTICS STUDIES
☐ TREATMENT

DA FORM 1 MAY 78 4700

FH MDA OP 132-11a (Rev)
1 Sep 99

MEDCOM - 1954

INTAKE			OUTPUT		
TIME	TYPE	AMT	TIME	TYPE	AMT
OR	LR	1000	OR	EBL	Min
	D5NS c 20KCl	100	OR	Urine	0
TOTAL		1100	TOTAL		Min

PACU NURSING NOTES: NURSING CARE PROBLEM NO.'S IDENTIFIED. Refer to FH MDA OP 39

NURSING CARE PROBLEMS: 1. RESP; 2. CIRC; 3. ACT; 4. LOC; 5. TEMP; 6. PAIN; 7. SAFETY; 8. ANXIETY; 9. EDUC; 10. OTHER

1200 Transfer from OR via Litter Connected to Propad & O_2 4L/NC Ice, Critical Care Flowsheet & PACU Flowsheet for assessment (b)(6)-2 [redacted] 1Ltjm

(b)(6)-2 [redacted]

MEDICATION RECEIVED IN PACU/ICU

MEDICATION GIVEN BY:	DRUG	DOSE	ROUTE	TIME	PAIN LEVEL	EFFECTIVENESS
(b)(6)-2 [redacted]	Demerol	~~12.5~~ 25 mg	IV	1230	7	
(b)(6)-2 [redacted]	Phenergan	12.5 mg	IV	1230	7	

DISPOSITION SUMMARY: Nursing Care Problems No.'s 6 Resolved; No.'s _____ Continue.
Patient was transferred from PACU/ICU recovery room via litter/crib with siderails raised, or held by parent in wheelchair.
Dressing status: CD&I PAR Score 10 Safety Straps N/A
Report given to N/A Patient released by Anesthesia CRNA (b)(6)-2 [redacted]
Time out 1300 Nurse's Signature (b)(6)-2 [redacted] 1Ltjm

(b)(6)-2 [redacted]

MEDCOM - 1955

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-400; the proponent agency is The Office of The Surgeon General

REPORT TITLE

POST ANESTHESIA CARE UNIT FLOWSHEET

OTSG APPROVED (Date) 17 Jan 80

PROCEDURE: Washout LUE/LLE

PHYSICIAN: (b)(6)-2

ANESTHESIA BY: (b)(6)-2

Gen Spinal MAC Axillary
Local Bier Epidural Other

ALLERGIES: NKDA

AIRWAYS: _____ Time DC'D _____

ETT Nasal Oral Trach

OXYGEN:

Mask Nasal Face Blow-By
Prongs Tent

Liter/min. _____ %

ASA 2 History _____

Cardiac Rhythm ST

IV#1 _____ Patent Infiltrated

Site _____ Rate ____ Gauge ____

IV#2 _____ Patent Infiltrated

Site _____ Rate ____ Gauge ____

VITAL SIGNS

Time	B/P	P	R	O2SA	Temp
PRE-OP	/				
PRE-OP	/				
1645	137/84	104	17	93	98.8
1650	136/78	99	18	92	
1655	143/88	94	17	93	
1710	138/85	91	12	100	
1725	135/91	93	19	94	
1740	136/92	98	16	95	
1810	125/84	92	20	97	
1840	141/92	97	18	94	98.6
2000	143/84	92	24	100	99.6
	/				
	/				
	/				

PAR SCORE

Act	Resp	Circ	LOC	Skin	PARS
2	2	2	2	2	10

OTHER

COMMENTS

2L O2

Neuro-Vascular

Extr: L R Upper Lower
Pulse DP PT RAC

Blanche Pulse
Warm Moves Y N

POST ANESTHESIA RECOVERY SCORE "PARS"

Activity - General Anesthesia
2–Maintain head lift and open eyes
1–Unable to maintain head lift and open eyes
0–Unable to lift head and open eyes

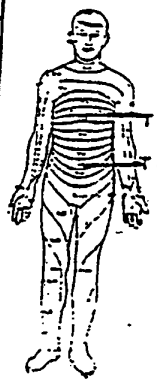
Activity - SAB or Subarachnoid Block
2–Moves all four extremities with control
1–Moves both upper extremities

Respirations
2–Spontaneous respiration; needs no support
1–Limited effort; needs artificial airway or jaw support
0–Needs ventilator; no spontaneous respiration

Circulation
2–BP 20% preanesthetic level
1–BP 20 - 50% preanesthetic level
0–BP 50% or more preanesthetic level

Level of Consciousness
2–Awake and alert; seldom dozes
1–Awakens when gently stimulated
0–Awakens only when vigorously stimulated

Skin
2–Normal skin color & temperature greater than 96°
1–Skin is pale, blotchy, dusky &/or temperature 95 - 96°
0–Cyanotic &/or temperature less than 95°



DRESSING:	Status	Location
Gauze		
Opsite		
Bandaid		
Steri-strips		
Collodian		
Peri-pad		
Coban		
Cotton Balls		
Ace Wrap		

TUBES AND DRAINS: Hemovac Foley NGT Chest Jackson-Pratt

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC

DATE

(Continue on reverse)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name–last, first, middle; grade; date; hospital or medical facility)

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTICS STUDIES

☐ TREATMENT

DA FORM 1 MAY 78 4700

FH MDA OP 132-11a (Rev) 1 Sep 99

MEDCOM - 1956

INTAKE			OUTPUT		
TIME	TYPE	AMT	TIME	TYPE	AMT
OR	8mg Fentanyl		OR	EBL Minimal	
OR	300 LR		OR	Urine	
TOTAL			TOTAL		

PACU NURSING NOTES: NURSING CARE PROBLEM NO.'S IDENTIFIED. Refer to FH MDA OP 39

NURSING CARE PROBLEMS: 1. RESP; 2. CIRC; 3. ACT; 4. LOC; 5. TEMP; 6. PAIN; 7. SAFETY; 8. ANXIETY; 9. EDUC; 10. OTHER

1645 - Pt arrived from OR. New c/o/e dress on LUE/LLE. Pt denies pain. Lungs CTA bilaterally, HR cont ST. Bowel Sounds hypoactive. Pt A/O @ this time (b)(6)-2 RN

MEDICATION RECEIVED IN PACU/ICU

MEDICATION GIVEN BY:	DRUG	DOSE	ROUTE	TIME	PAIN LEVEL	EFFECTIVENESS
(b)(6)-2	Fentanyl	50mcg	IV	1655	9/10	
(b)(6)-2	Demerol	25mg	IV	1835	9/10	

DISPOSITION SUMMARY: Nursing Care Problems No.'s_____ Resolved; No.'s_____ Continue.
Patient was transferred from PACU/ICU recovery room via litter/crib with siderails raised, or held by parent in wheelchair.
Dressing status:_____ PAR Score_____ Safety Straps_____
Report given to_____. Patient released by Anesthesia_____
Time out_____. Nurse's Signature:_____

MEDCOM - 1957

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-400; the proponent agency is The Office of The Surgeon General

REPORT TITLE: POST ANESTHESIA CARE UNIT FLOWSHEET

OTSG APPROVED (Date): 17 Jan 80

PROCEDURES: P Stump revision LVE Washout LLR

PHYSICIAN: DVL (b)(6)-2

ANESTHESIA BY: CRNA (b)(6)-2

Gen Spinal MAC Axillary Local Bier Epidural Other

ALLERGIES: NKDA

AIRWAYS: ____ Time DC'D ____

ETT Nasal Oral Trach

OXYGEN: Mask Nasal Face Blow-By Prongs Tent

Liter/min. 5 %

ASA 1 History ____

Cardiac Rhythm ST Ø ectopy

IV#1 ____ Patent Infiltrated

Site LEJ Rate 100 Gauge 16 g

IV#2 ____ Patent Infiltrated

Site ____ Rate ____ Gauge ____

Time	B/P	P	R	O2SA	Temp	Act	Resp	Circ	LOC	Skin	PARS	COMMENTS	Neuro-Vascular
PRE-OP	/												Extr: L R Upper Lower Pulse DP PT RAD
PRE-OP	/												Blanche Warm Pulse Moves Y N
1000	119/78	112	16	91%	100'CA	2	2	2	1	2	9	Placed on O, 6L/min	Blanche Warm Pulse Moves Y N
1005	119/76	111	11	94%		2	2	2	1	2	9		Blanche Warm Pulse Moves Y N
1010	122/77	109	11	95%		2	2	2	2	2	10		Blanche Warm Pulse Moves Y N
1015	118/77	111	12	94%		2	2	2	2	2	10		Blanche Warm Pulse Moves Y N
1030	122/74	111	15	91%		2	2	2	2	2	10		Blanche Warm Pulse Moves Y N
1045	120/72	109	11	93%		2	2	2	2	2	10		Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N

POST ANESTHESIA RECOVERY SCORE "PARS"

Activity - General Anesthesia
2—Maintain head lift and open eyes
1—Unable to maintain head lift and open eyes
0—Unable to lift head and open eyes

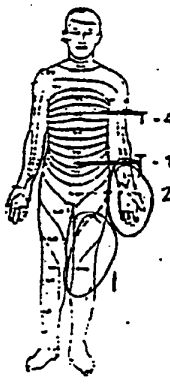
Activity - SAB or Subarachnoid Block
2—Moves all four extremities with control
1—Moves both upper extremities

Respirations
2—Spontaneous respiration; needs no support
1—Limited effort; needs artificial airway or jaw support
0—Needs ventilator; no spontaneous respiration

Circulation
2—BP 20% preanesthetic level
1—BP 20 - 50% preanesthetic level
0—BP 50% or more preanesthetic level

Level of Consciousness
2—Awake and alert; seldom dozes
1—Awakens when gently stimulated
0—Awakens only when vigorously stimulated

Skin
2—Normal skin color & temperature greater than 96°
1—Skin is pale, blotchy, dusky &/or temperature 95 - 96°
0—Cyanotic &/or temperature less than 95°



DRESSING:	Status	Location
Gauze 1	SS	(C) THIGH
Opsite	CD&I	LVE
Bandaid		
Steri-strips		
Collodian		
Peri-pad		
Coban		
Cotton Balls		
Ace Wrap 2		

TUBES AND DRAINS: Hemovac Foley NGT Chest Jackson-Pratt

(Continue on reverse)

(b)(6)-2 ...e & Title) ILT, Am

DEPARTMENT/SERVICE/CLINIC: ICU#1

DATE: 9/3/03

(b)(6)-2 ...S IDENTIFICATION (For typed or written entries give: Name—last, first, ...rade; date; hospital or medical facility)

(b)(6)-4

☐ HISTORY/PHYSICAL ☒ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTICS STUDIES

☐ TREATMENT

DA FORM 1 MAY 78 4700

FH MDA OP 132-11a (Rev) 1 Sep 99

MEDCOM - 1958

INTAKE			OUTPUT		
TIME	TYPE	AMT	TIME	TYPE	AMT
OR	LR	800	OR	EBL	Min
1000	D5NS c̄ 20KCl	100	OR	Urine	0
TOTAL		900	TOTAL		0

PACU NURSING NOTES: NURSING CARE PROBLEM NO.'S IDENTIFIED. Refer to FH MDA OP 39

NURSING CARE PROBLEMS: 1. RESP; 2. CIRC; 3. ACT; 4. LOC; 5. TEMP; 6. PAIN; 7. SAFETY; 8. ANXIETY; 9. EDUC; 10. OTHER

1000 Transfer from OR. Moved to bed by 4 STAFF members. Connected to PrPAQ & O2 @ 6L/min. See Critical Care Flowsheet for Assessment (b)(6)-2 [redacted]

1100 Pt recovered c̄ complications. VSS. — (b)(6)-2 [redacted] (b)(6)-2 [redacted]

MEDICATION GIVEN BY:

MEDICATION RECEIVED IN PACU/ICU

DRUG	DOSE	ROUTE	TIME	PAIN LEVEL	EFFECTIVENESS

DISPOSITION SUMMARY: Nursing Care Problems No.'s _____ Resolved; No.'s _____ Continue.
Patient was transferred from PACU/ICU recovery room via litter/crib with siderails raised, or held by parent in wheelchair.

Dressing status: LLE-SS LUE CD&I PAR Score 10 Safety Straps N/A

Report given to N/A Patient released by Anesthesia (b)(6)-2 [redacted]

Time out 1100 Nurse Signature (b)(6)-2 [redacted] (b)(6)-2 [redacted]

MEDCOM - 1959

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-400; the proponent agency is The Office of The Surgeon General

REPORT TITLE

POST ANESTHESIA CARE UNIT FLOWSHEET

OTSG APPROVED (Date) 17 Jan 80

PROCEDURE: [illegible] (R)

PHYSICIAN: (b)(6)-2

ANESTHESIA BY: (b)(6)-2

(Gen) Spinal MAC Axillary
Local Bier Epidural Other

ALLERGIES:

AIRWAYS: Time DC'D

ETT Nasal Oral Trach

OXYGEN:

Mask Nasal Face Blow-By
Prongs Tent

Liter/min. %

ASA History

Cardiac Rhythm

IV#1 2R Patent Infiltrated
Site Rate Gauge

IV#2 Patent Infiltrated
Site Rate Gauge

VITAL SIGNS						PAR SCORE						OTHER	
Time	B/P	P	R	O2SA	Temp	Act	Resp	Circ	LOC	Skin	PARS	COMMENTS	Neuro-Vascular
PRE-OP	/												Extr: L R Upper Lower Pulse DP PT RAC
PRE-OP	132/85	116											Blanche Pulse Warm Moves Y N
1405	141/86	124	20	94%	101 ax	1	2	2	0	2	7	O2 4l	Blanche Pulse Warm Moves Y N
1410	143/94	124	18	98%	101 ax	1	2	2	0	2	7		Blanche Pulse Warm Moves Y N
1415	138/93	120	18	100%	101 ax	1	2	2	1	2	8		Blanche Pulse Warm Moves Y N
1430	142/86	118	21	97%	100 ax	2	2	2	1	2	9	O2 3l	Blanche Pulse Warm Moves Y N
1445	134/87	124	22	99%	100.7 ax	2	2	2	1	2	9	O2 3l	Blanche Pulse Warm Moves Y N
1500	135/86	121	28	98%	101.3 ax	2	2	2	2	2	10	O2 3l	Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N

POST ANESTHESIA RECOVERY SCORE "PARS"

Activity - General Anesthesia
2--Maintain head lift and open eyes
1--Unable to maintain head lift and open eyes
0--Unable to lift head and open eyes

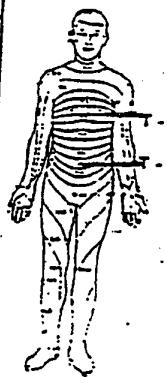
Activity - SAB or Subarachnoid Block
2--Moves all four extremities with control
1--Moves both upper extremities

Respirations
2--Spontaneous respiration; needs no support
1--Limited effort; needs artificial airway or jaw support
0--Needs ventilator; no spontaneous respiration

Circulation
2--BP 20% preanesthetic level
1--BP 20 - 50% preanesthetic level
0--BP 50% or more preanesthetic level

Level of Consciousness
2--Awake and alert; seldom dozes
1--Awakens when gently stimulated
0--Awakens only when vigorously stimulated

Skin:
2--Normal skin color & temperature greater than 96°
1--Skin is pale, blotchy, dusky &/or temperature 95 - 96°
0--Cyanotic &/or temperature less than 95°



DRESSING: Status Location

Gauze
Opsite
Bandaid
Steri-strips
Collodian
Peri-pad
Coban
Cotton Balls
Ace Wrap

TUBES AND DRAINS: Hemovac Foley NGT Chest Jackson-Pratt

PREPARED BY (Signature & Title)

(b)(6)-2

DEPARTMENT/SERVICE/CLINIC ICU

DATE 15 Sep 03

(Continue on reverse)

(Typed or written entries give: Name-last, first, middle; grade; date; hospital or medical facility)

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)
☐ DIAGNOSTICS STUDIES
☐ TREATMENT

DA FORM 1 MAY 78 4700

FH MDA OP 132-11a (Rev) 1 Sep 99

MEDCOM - 1960

INTAKE			OUTPUT		
TIME	TYPE	AMT	TIME	TYPE	AMT
OR	LR	700	OR	EBL	Min
			OR	Urine	300
TOTAL			TOTAL		

PACU NURSING NOTES: NURSING CARE PROBLEM NO.'S IDENTIFIED. Refer to FH MDA OP 39

NURSING CARE PROBLEMS: 1. RESP; 2. CIRC; 3. ACT; 4. LOC; 5. TEMP; 6. PAIN; 7. SAFETY; 8. ANXIETY; 9. EDUC; 10. OTHER

1430 PT back from OR 1405. PT groggy but will open eyes + lift head on command. O2 - 3 l nc but ↑ to 4 l 1407. O2 ↓ to 3 l nc 1430 - sats 97%. IV D5 NS c̄ 20 KCl @ 100 cc/hr (R) FA c̄ s/s infection/infiltration. (L) arm - amputated below the elbow dressing (Kerlex) CDI. (L) ex fix in place (L) femur - dressing currently CDI - small area of open ~~over wound~~ main wound upper thigh - covered c̄ 4x4 due to oozing. (L) DP pulse palpable + PT able to move toes. NG to LIS - minimal bile colored drainage. ABD distended - ⊘ BS. Mult abrasions abd + lower extremities. (b)(6)-2

MAT/AM

MEDICATION RECEIVED IN PACU/ICU

MEDICATION GIVEN BY:	DRUG	DOSE	ROUTE	TIME	PAIN LEVEL	EFFECTIVENESS

DISPOSITION SUMMARY: Nursing Care Problems No.'s_____Resolved; No.'s_____Continue.
Patient was transferred from PACU/ICU recovery room via litter/crib with siderails raised, or held by parent in wheelchair.
Dressing status:_____ PAR Score_____ Safety Straps_____
Report given to_____. Patient released by Anesthesia_____
Time out_____. Nurses Signature:_____

MEDCOM - 1961

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-400; the proponent agency is The Office of The Surgeon General

REPORT TITLE: POST ANESTHESIA CARE UNIT FLOWSHEET

OTSG APPROVED (Date): 17 Jan 80

PROCEDURE: Washout @ LE7 LUE

PHYSICIAN: (b)(6)-2

ANESTHESIA BY: (b)(6)-2

Gen Spinal MAC Axillary
Local Bier Epidural Other

ALLERGIES: NKA

AIRWAYS: Time DC'D

ETT Nasal Oral Trach

OXYGEN:

Mask (Nasal) Face Blow-By
Prongs Tent

Liter/min. 3L/mm %

ASA History

Cardiac Rhythm ST

IV#1 RU (Patent) Infiltrated
Site LR Rate KO Gauge

IV#2 Patent Infiltrated
Site Rate Gauge

VITAL SIGNS

Time	B/P	P	R	O2SA	Temp
PRE-OP	/				
PRE-OP	/				
1025	153/82	146	34	98	99.3
1030	164/87	144	17	97%	
1035	155/85	140	22	97%	
1045	160/92	131	16	99%	
1100	157/87	130	18	99%	
1115	148/93	148	20	98%	102.7
1130	149/87	142	14	99%	
1200	137/76	137	8	99%	
1230	138/79	134	18	98%	103.7
1300	135/67	132	20	96%	
	/				
	/				

PAR SCORE

Act	Resp	Circ	LOC	Skin	PARS
1	2	2	1	2	8
1	2	2	1	2	8
1	2	2	1	2	8
2	2	2	2	2	10
2	2	2	2	2	10
2	2	2	2	2	10
2	2	2	2	2	10
2	2	2	2	2	10
2	2	2	2	2	10
2	2	2	2	2	10

OTHER

COMMENTS	Neuro-Vascular
	Extr: L R Upper: Lower: Pulse DP PT RAC
RA;	Blanche Pulse Warm Moves Y N
6L O2 NC	Blanche Pulse Warm Moves Y N
	Blanche Pulse Warm Moves Y N
	Blanche Pulse Warm Moves Y N
5L O2 NC	Blanche Pulse Warm Moves Y N
O2 off; Incentive spirometry	Blanche Pulse Warm Moves Y N
5L O2 NC	Blanche Pulse Warm Moves Y N
5L O2 NC	Blanche Pulse Warm Moves Y N
	Blanche Pulse Warm Moves Y N
2L O2 NC	Blanche Pulse Warm Moves Y N
	Blanche Pulse Warm Moves Y N
	Blanche Pulse Warm Moves Y N

POST ANESTHESIA RECOVERY SCORE "PARS"

Activity - General Anesthesia
2—Maintain head lift and open eyes
1—Unable to maintain head lift and open eyes
0—Unable to lift head and open eyes

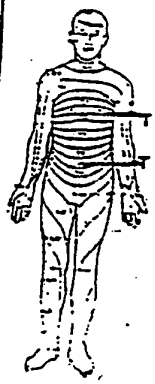
Activity - SAB or Subarachnoid Block
2—Moves all four extremities with control
1—Moves both upper extremities

Respirations
2—Spontaneous respiration; needs no support
1—Limited effort; needs artificial airway or paw support
0—Needs ventilator; no spontaneous respiration

Circulation
2—BP 20% preanesthetic level
1—BP 20 - 50% preanesthetic level
0—BP 50% or more preanesthetic level

Level of Consciousness
2—Awake and alert; seldom dozes
1—Awakens when gently stimulated
0—Awakens only when vigorously stimulated

Skin
2—Normal skin color & temperature greater than 96 °
1—Skin is pale, blotchy, dusky &/or temperature 95 - 96 °
0—Cyanotic &/or temperature less than 95 °



DRESSING:	Status	Location
Gauze Kerlix	LLE-CDI	LLE
Opsite		
Bandaid		
Steri-strips		
Collodian		
Peri-pad		
Coban		
Cotton Balls		
Ace Wrap	CDI	LUE
ExFix		LLE

TUBES AND DRAINS: Hemovac Foley NGT Chest Jackson-Pratt

PREPARED BY (Name & Title): (b)(6)-2 SPC

DEPARTMENT/SERVICE/CLINIC: ICU2

(Continue on reverse)

DATE: 29 Aug 03

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)
☐ DIAGNOSTICS STUDIES
☐ TREATMENT

DA FORM 1 MAY 78 4700

FH MDA OP 132-11a (Rev) 1 Sep 99

MEDCOM - 1962

INTAKE			OUTPUT		
TIME	TYPE	AMT	TIME	TYPE	AMT
OR	LR	1L	OR	EBL	
			OR	Urine	150cc
TOTAL			TOTAL		

PACU NURSING NOTES: NURSING CARE PROBLEM NO.'S IDENTIFIED. Refer to FH MDA OP 39

NURSING CARE PROBLEMS: 1. RESP; 2. CIRC; 3. ACT; 4. LOC; 5. TEMP; 6. PAIN; 7. SAFETY; 8. ANXIETY; 9. EDUC; 10. OTHER

MEDICATION RECEIVED IN PACU/ICU

MEDICATION GIVEN BY:	DRUG	DOSE	ROUTE	TIME	PAIN LEVEL	EFFECTIVENESS
OR	M504	30mg	IV			
OR	Fentanyl	50mcg	IV			
OR	Esmolol		IV			

DISPOSITION SUMMARY: Nursing Care Problems No.'s_____Resolved; No.'s_____Continue. Patient was transferred from PACU/ICU recovery room via litter/crib with siderails raised, or held by parent in wheelchair.

Dressing status:_____ PAR Score_____ Safety Straps_____

Report given to_____. Patient released by Anesthesia_____

Time out_____. Nurse Signature:_____.

MEDCOM - 1963

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-400; the proponent agency is The Office of The Surgeon General

REPORT TITLE: POST ANESTHESIA CARE UNIT FLOWSHEET

OTSG APPROVED (Date): 17 Jan 80

PROCEDURE: Washout

PHYSICIAN: (b)(6)-2

ANESTHESIA BY:

(Gen) Spinal MAC Axillary
Local Bier Epidural Other

ALLERGIES: Unknown
AIRWAYS: ____ Time DC'D ____
ETT Nasal Oral Trach
OXYGEN:
Mask (Nasal) Face Blow-By
Prongs Tent
Liter/min: 3L %

ASA ___ History Unknown
Cardiac Rhythm NSR
IV#1 LR (Patent) Infiltrated
Site RIJ Rate 80 Gauge ___
IV#2 ___ Patent Infiltrated
Site ___ Rate ___ Gauge ___

VITAL SIGNS						PAR SCORE						OTHER	
Time	B/P	P	R	O2SA	Temp	Act	Resp	Circ	LOC	Skin	PARS	COMMENTS	Neuro-Vascular
PRE-OP	/												Extr: L R Upper Lower; Pulse DP PT RAC; Blanche Pulse; Warm Moves Y N
PRE-OP	/												Blanche Pulse; Warm Moves Y N
1315	144/80	140	20	97%	98.2	0	2	2	0	2	6	3L O2	Blanche Pulse; Warm (Moves Y) N
1350	133/86	140	15	98%	99.4	0	2	2	0	2	6	3L O2	Blanche Pulse; Warm (Moves Y) N
1355	130/83	139	20	99%	99.6	0	2	2	0	2	6	3L O2	Blanche Pulse; Warm (Moves Y) N
1400	132/88	141	22	99%	100.4	0	2	2	0	2	6	3L O2	Blanche Pulse; Warm Moves Y N
1405	139/85	140	19	99%		0	2	2	0	2	6	3L O2	Blanche Pulse; Warm Moves Y N
1410	138/84	139	19	99%	100.6	0	2	2	0	2	6	3L O2	Blanche Pulse; Warm Moves Y N
1425	147/88	141	17	98%	98.9	0	2	2	0	2	6	1L O2	Blanche Pulse; Warm Moves Y N
1440	133/87	145	16	97%	10.9	2	2	2	2	2	10	1L O2	Blanche Pulse; Warm Moves Y N
	/												Blanche Pulse; Warm Moves Y N
	/												Blanche Pulse; Warm Moves Y N
	/												Blanche Pulse; Warm Moves Y N
	/												Blanche Pulse; Warm Moves Y N

POST ANESTHESIA RECOVERY SCORE - PARS*

Activity - General Anesthesia
2—Maintain head lift and open eyes
1—Unable to maintain head lift and open eyes
0—Unable to lift head and open eyes

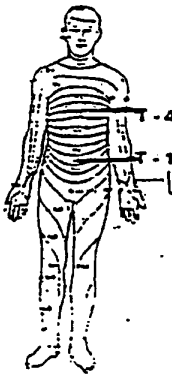
Activity - SAB or Subarachnoid Block
2—Moves all four extremities with control
1—Moves both upper extremities

Respirations
2—Spontaneous respiration; needs no support
1—Limited effort; needs artificial airway or jaw support
0—Needs ventilator; no spontaneous respiration

Circulation
2—BP 20% preanesthetic level
1—BP ~~20~~ - 50% preanesthetic level
0—BP 50% or more preanesthetic level

Level of Consciousness
2—Awake and alert; seldom dozes
1—Awakens when gently stimulated
0—Awakens only when vigorously stimulated

Skin
2—Normal skin color & temperature greater than 96°
1—Skin is pale, blotchy, dusky &/or temperature 95 - 96°
0—Cyanotic &/or temperature less than 95°



DRESSING:	Status	Location
Gauze	Acewrap CDI	(R) UE Amp
Opsite	CDI	(R) LE pin site
Bandaid	DTA	ABD
Steri-strips	DTA, Scabbed	(L) leg
Collodian		
Peri-pad		
Coban		
Cotton Balls		
Ace Wrap		

TUBES AND DRAINS: Hemovac Foley NGT Chest Jackson-Pratt

(Continue on reverse)

PREPARED BY (Signature & Title): (b)(6)-2

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: 27 Aug 03

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)
☐ DIAGNOSTICS STUDIES
☐ TREATMENT

DA FORM 1 MAY 78 4700

FH MDA OP 132-11a (Rev) 1 Sep 99

MEDCOM - 1964

INTAKE			OUTPUT		
TIME	TYPE	AMT	TIME	TYPE	AMT
OR	900 Error [b)(6)- Crystalloid	900	OR	EBL 100 [b)(6)-2	100
1445	LR	80	OR	Urine 850	850
TOTAL			TOTAL		

PACU NURSING NOTES: NURSING CARE PROBLEM NO.'S IDENTIFIED. Refer to FH MDA OP 39

NURSING CARE PROBLEMS: 1. RESP; 2. CIRC; 3. ACT; 4. LOC; 5. TEMP; 6. PAIN; 7. SAFETY; 8. ANXIETY; 9. EDUC; 10. OTHER

1345 - transferred from OR via litter, sleeping, O2 sat 99%, ø s/s of SOB observed, O2 3L NC, Abrasions to ABD OTA White in color, Amputation site to R UE ACE wrapped/ CDI, Scabb to L leg OTA pink in color, Dressing to R LE CDI & pins in place, Foley draining clear yellow urine, Edema 1+ to R UE, Lungs clear, bowel sounds slow x 4 quads will continue to monitor pt [b)(6)-2 (RN)

1445 transferred from recovery to ICU, Alert c pain level 6 via interpreter, pain med given (see below) for pain & temp, will continue to monitor O2 sat 93% on 1L of O2 NC [b)(6)-2

MEDICATION GIVEN BY [b)(6)-2 (RN)

MEDICATION RECEIVED IN PACU/ICU

DRUG	DOSE	ROUTE	TIME	PAIN LEVEL	EFFECTIVENESS
Tylox	1	PO	1445	6	

DISPOSITION SUMMARY: Nursing Care Problems No.'s _____ Resolved; No.'s _____ Continue.
Patient was transferred from PACU/ICU recovery room via litter/crib with siderails raised, or held by parent in wheelchair.
Dressing status: _____ PAR Score _____ Safety Straps _____
Report given to _____ Patient released by Anesthesia _____
Time out _____ Nurse's Signature: _____

MEDCOM - 1965

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-400; the proponent agency is The Office of The Surgeon General

REPORT TITLE

POST ANESTHESIA CARE UNIT FLOWSHEET

OTSG APPROVED (Date) 17 Jan 80

PROCEDURE: I&D LUE/LLE
LUE BEA, LLE-EX FIX
PHYSICIAN: (b)(6)-2
ANESTHESIA BY:
(Gen) Spinal MAC Axillary
Local Bier Epidural Other

ALLERGIES: NKDA
AIRWAYS: Time DC'D
ETT Nasal (Oral) Trach
OXYGEN:
Mask Nasal Face Blow-By
Prongs Tent
Liter/min. RA %

ASA 1 History
Cardiac Rhythm NSR
IV#1 PIV Patent Infiltrated
Site (R) Hand Rate Gauge 18
IV#2 CL Patent Infiltrated
Site JV Rate Gauge

Time	B/P	P	R	O2SA	Temp	Act	Resp	Circ	LOC	Skin	PARS	COMMENTS	Neuro-Vascular
PRE-OP	127/74	110	20	95	/								Exp (L) R Upper (Lower) Pulse (DP) PT RAC
PRE-OP	/												Blanche Warm Pulse Moves Y N
0045 ~~0050~~	141/96	119	21	97	92[8]	1	2	2	1	0	6	RA	Blanche Warm Pulse Moves (Y) N
0050	158/96	116	19	95	/	2	2	1	1	0	6		Blanche Warm Pulse Moves (Y) N
0055	148/91	114	19	95	/	2	2	2	1	0	7		Blanche Warm Pulse Moves (Y) N
0100	155/98	118	25	95	/	2	2	1	1	0	6		Blanche Warm Pulse Moves (Y) N
0105	148/93	113	20	95	93[4]	2	2	2	1	0	7		Blanche Warm Pulse Moves (Y) N
0110	136/94	116	23	96	/	2	2	2	1	0	7		Blanche Warm Pulse Moves (Y) N
0115	148/97	115	24	95	94[1]	2	2	2	1	0	7		Blanche Warm Pulse Moves (Y) N
0130 ~~0145~~	131/83	112	18	91	94[5]	2	2	2	1	0	7		Blanche Warm Pulse Moves (Y) N
0145	131/82	115	19	95	95[4]	2	2	2	1	1	8		Blanche Warm Pulse Moves (Y) N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N

POST ANESTHESIA RECOVERY SCORE "PARS"

Activity - General Anesthesia
2—Maintain head lift and open eyes
1—Unable to maintain head lift and open eyes
0—Unable to lift head and open eyes

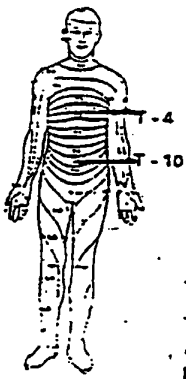
Activity - SAB or Subarachnoid Block
2—Moves all four extremities with control
1—Moves both upper extremities

Respirations
2—Spontaneous respiration; needs no support
1—Limited effort; needs artificial airway or jaw support
0—Needs ventilator; no spontaneous respiration

Circulation
2—BP 20% preanesthetic level
1—BP ~~20~~ - 50% preanesthetic level
0—BP 50% or more preanesthetic level

Level of Consciousness
2—Awake and alert; seldom dozes
1—Awakens when gently stimulated
0—Awakens only when vigorously stimulated

Skin
2—Normal skin color & temperature greater than 96°
1—Skin is pale, blotchy, dusky &/or temperature 95 - 96°
0—Cyanotic &/or temperature less than 95°



DRESSING:	Status	Location
Gauze	CDI	(R) ANKLE
~~Opsite~~ Guaze	Intact, bloodied	(L) LE
Bandaid		
Steri-strips		
Collodian		
Peri-pad		
Coban		
Cotton Balls		
Ace Wrap	CDI	(L) LLE

TUBES AND DRAINS: Hemovac (Foley) NGT Chest Jackson-Pratt

(Continue on reverse)

PREPARED BY (Signature & Title) (b)(6)-2 1 MD/R

DEPARTMENT/SERVICE/CLINIC 1CU-2

DATE 26 AUG 03

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility).

(b)(6)-4

(EPU)

☐ HISTORY/PHYSICAL ☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)
☐ DIAGNOSTICS STUDIES
☐ TREATMENT

DA FORM 1 MAY 78 4700

FH MDA OP 132-11a (Rev)
1 Sep 99

MEDCOM - 1966

INTAKE			OUTPUT		
TIME	TYPE	AMT	TIME	TYPE	AMT
OR	RBC	900	OR	EBL 500-1000 cc	
OR	LR 3000	~~2000~~	OR	Urine	750 cc
TOTAL			TOTAL		

PACU NURSING NOTES: NURSING CARE PROBLEM NO.'S IDENTIFIED. Refer to FH MDA OP 39

NURSING CARE PROBLEMS: 1. RESP; 2. CIRC; 3. ACT; 4. LOC; 5. TEMP; 6. PAIN; 7. SAFETY; 8. ANXIETY; 9. EDUC; 10. OTHER

0045 Pt admitted to PACU-ICU-2 @ 0045 via litter semi-conscious responds to commands, received fluids via jugular central line (R) & (R) hand 18G PIV LR & NS @ 150cc hour RA; breaths regular unlabored. (L) LE gauze wrapped c̄ blood staining to thigh (R) LE ace bandaging CDI, (R) ankle gauze wrap intact s̄ staining. Extremities x3 cold pulses x3 normal present WP @ BS [redacted] 9 [illegible]

0055 X-rays taken of pt's chest & (L) LE [redacted] 9 [illegible]

0110 Pain medication administered [redacted] 9 [illegible]

0200 Pt moved to ICU status [redacted] 9 [illegible]

0135 D/C (R) hand PIV d/t infiltration & per physician instruction [redacted] 9 [illegible]

MEDICATION RECEIVED IN PACU/ICU

MEDICATION GIVEN BY	DRUG	DOSE	ROUTE	TIME	PAIN LEVEL	EFFECTIVENESS
[redacted]	Mannitol	50	IV	0110		

DISPOSITION SUMMARY: Nursing Care Problems No.'s _____ Resolved; No.'s _____ Continue.
Patient was transferred from PACU/ICU recovery room via litter/crib with siderails raised, or held by parent in wheelchair.
Dressing status: Intact blood soaked PAR Score 8 Safety Straps N/A
Report given to N/A Patient released by Anesthesia
Time out 0200 Nurse Signature: [redacted]

MEDCOM - 1967

ADMISSION AND CODING INFORMATION

For use of this form, see AR 40-400; the proponent agency is OTSG

1. REPORTING MTF	2. MTF LOCATION (State or Country Code.)	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
A14A1	12	(b)(6)-4	(b)(6)-4 (b)(6)-4		M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
	N/A	99	(b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
		1900	

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
	IC7L	

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION YEAR / NO
E2			

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
D	ICU2	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: BC 21 CSH

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYYYMMDD)
01 D/C to cage		20030925

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYYYMMDD)
AEAA		20030925

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYYYMMDD)
	A14A1	20030825

FOR LOCAL USE

Dx: 8870
82032
8910
E9919

Inj Trauma
549 9

Procedure: 7713 843 8874
8605 8961 8962
7715 9904 (8)
7815 8744 8827
7855 8819 8779
8628

ADMITTING (b)(6)-2

SIGNATURE OF ADMITTING CLERK (b)(6)-2

MEDCOM - 1968

INPATIENT TREATMENT RECORD COVER SHEET *(For Plate Imprinting)*

For use of this form, see AR 40-400; the proponent agency is the Office of The Surgeon General.

21(-)

PATIENT DATA ITEMS 1 - 30 *(Excluding Items 25 & 26)*

(b)(6)-4

(b)(6)-4

LINE	LEGEND
1	REGISTER NO. - NAME - GRADE
2	SEX - AGE - RACE - RELIGION - LENGTH OF SVC - ETS - PREVIOUS ADMISSION
3	FMP - SSN - ORGANIZATION - WARD
4	FLY STAT - RATING/DESG - DEPT/BEN - BRANCH/CORPS - UIC/ZIP - TYPE CASE
5	SOURCE & AUTHORITY FOR ADMISSION - HOUR OF ADMISSION - CLINIC SVC
6	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
7	ADDRESS OF EMERGENCY ADDRESSEE - PHONE NO. - DATE OF THIS ADMISSION
8	NAME & LOCATION OF MEDICAL TREATMENT FACILITY DATE OF INITIAL ADMISSION

ADMISSION REMARKS

DOB 19840101

ADMITTING OFFICER

(b)(6)-2

32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED

25. TYPE DISPOSITION: D/C

26. DATE OF DISPOSITION: 17Sep03

31. SELECTED ADMINISTRATIVE DATA

☐ CHECK IF CONTINUED ON REVERSE

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

S/P Re-exploration — 54.0 ICD9FY02

Abd closure — V55.9 ICD9FY02

☐ CHECK IF CONTINUED ON REVERSE

35. TOTAL DAYS THIS FACILITY

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
	(b)(6)-2				

36. TOTAL DAYS ALL FACILITIES

a. ABSENT SICK (b)(6)-2	b. OTHER DAYS	c. CONV LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

SIGNATURE OF ATTENDING MEDICAL OFFICER — FAMILY PRACTICE

SIGNATURE OF RAD OR MEDICAL RECORDS OFFICER (b)(6)-2

DA FORM 1 MAY 79 3647-1 EDITION OF 1 AUG 76 IS OBSOLETE.

MEDCOM - 1969

(b)(6)-2

PATIENT'S IDENTIFICATION *(For plate imprint, typewriter or hand)*

PATIENT DEPOSIT RECORD
For use of this form, see AR 40-2; the proponent agency is the Office of The Surgeon General.

I have been informed that any funds or valuables in my possession while a patient in this hospital are retained at my own risk and that I may and should deposit same in the patient trust fund.

I do ☐ *do not* ☒ *wish to make a deposit at this time.*

(b)(6)-2 1LT AV.

(b)(6)-2 *'s signature (or witness's, if patient is unable to sign)*

FUNDS & VALUABLES RECEIVED IN FULL *(Patient's or witness's signature and date)*

FUNDS

DATE	DEPOSITS	WITHDRAWALS	BALANCE	SIGNATURE

VALUABLES

NUMBER	DESCRIPTION OF VALUABLES	DEPOSITS		WITHDRAWALS	
		DATE	SIGNATURE (Custodian)	DATE	SIGNATURE (Patient or intermediate individual)
1	Silver Ring	12 Sep 03	(b)(6)-2		

DA FORM 1 DEC 77 3696 REPLACES EDITION OF 1 AUG 76, WHICH MAY BE USED. ★U.S.GPO:1991-0-301-988

MEDCOM - 1970

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

PERTINENT HISTORY, CHIEF COMPLAINT, AND CONDITION ON ADMISSION *(Enter date of admission)*

Pt. 19 y6 Iraqi. GSW (L) Flank. Pt. complaint of abd pain. Pt. also c̄ back pain. Pt. brought to ER by medics.

PMHx	PSHx	Allergies
ϕ	ϕ	NKDA

PHYSICAL EXAMINATION

98.9 111/81 111 22

See SF 558

PROGRESS *(Enter date of discharge and final diagnosis)*

Alp: pt. c̄ GSW (L) flank.
(+) FAST exam. ϕ exit wound.
Shrapnel near spine on Abd X-ray
(1) Pt. to OR for exploration

(b)(6)-2	DATE 11 Sept 03	IDENTIFICATION NO.	ORGANIZATION
	give Name last, first, ...l or medical facility)	REGISTER NO.	WARD NO.

MAJ MC

ABBREVIATED MEDICAL RECORD
Standard Form 539

GENERAL SERVICES ADMINISTRATION AND INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
USAPPC V1.00

MEDCOM - 1971

NSG Note

NSN 7540-00-634-4176 AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
9/10/03	Prehospital - 20 ish y/o ♂ Iraqi c̄ GSW to (L) Flank. -
(2337)	Arrived litter c̄ Pressure dsg / NRB @ 15 Lpm.
(2338)	Arrival - Monitors Placed. v.ss O2 via NRB @ 15 Lpm.
	# 16 ga PIV Placed c̄ difficulty (L) AC. NS ↑ @ Bolus.
	LABS Sent. 18 fr Foley Inserted c̄ difficulty c̄ ~30 cc
	Frank Blood Return.
(2340)	Airway Patent. GCS-15. Lgs CTAB. ABD diffuse Point
	Tenderness c̄ guarding. FAST EXAM Reveals (+) Retroperitoneal
	Hematoma.
(2342)	(B) Lower Extremities Unremarkable. Pt unable to Move Legs.
	(−) Motor (+) Sensory.
(2343)	Pt Rolled c̄ Log Roll for Posterior exam. Posterior Unremarkable.
	Rectal Flaccid ø Tone. (+) Priapism.
(2350)	XR @ Bedside for PCXR / Pelvis. v.ss. Surgery Consulted.
(2352)	Pt Placed on Backboard c̄ Soft Restraints. Given Meds for
	Sedation. v.ss.
(0002)	Pt to X-ray c̄ Monitors / Attendant x ⅡT.
(0020)	Repeat CBC - X-match for ⅡT Units.
(0025)	Pt Given IVP Dye for IVP Procedure. Remains on Monitor. v.ss.
	IVF's ↑ Bolus. O2 via NRB @ 15 Lpm.
(0055)	Anesthesia @ Bedside. Report Given to CPT (b)(6)-2 Pt T'ported
	to OR c̄ difficulty. v.ss.

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	OVER

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* | REGISTER NO. | WARD NO.

(b)(6)-4

(b)(6)-4

Iraqi Civ ♂ Trac

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

MEDCOM - 1972

Vitals

2335 $\frac{111}{81}$ - 111 - 24 - 98.9(a) - 100%

2345 $\frac{133}{92}$ - 93 - 20 - 99%

0005 $\frac{123}{67}$ - 92 - 20 - 99%

0020 $\frac{132}{72}$ - 89 - 20 100%

0040 $\frac{128}{78}$ - 96 - 22 - 100%

0055 $\frac{136}{76}$ - 92 - 20 - 100%

Meds

2345 MSO4 5 g IVP

2352 MSO4 5 g IVP

0002 MSO4 5 g IVP

0012 MSO4 5 g IVP

0025 Versed 2.5 g IVP

0040 Versed 2.5 g IVP

0055 Unasyn ~~III~~ 1.5g IVPB

(b)(6)-2

I&O

IVF's 2400 cc

UA 450 cc

MEDCOM - 1973

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
11 Sept 03	Brief Op note
0415	1) Pre-op Dx - GSW (L) Flank
	2) Post-op Dx - GSW (L) Flank, large Retroperitoneal Hematoma, Duodenal Injury X 2, Gallbladder Injury, ~~Liver Lac~~, IVC injury at origin of (R) renal vein, (L) renal laceration, Through & Through liver injury
Lumbar Spine FX	
	3) Procedure - Ex Lap, Removal of Bullet Fragments from liver & lumbar spine, Repair of Duodenal Injury X 2, Repair of IVC, Cholecystectomy, Bogota Bag
	4) Surgeons - (b)(6)-2 (b)(6)-2 (b)(6)-2 (b)(6)-2
	5) Anesthesia - GETA
	6) Findings - Bullet Fragment on dome of liver, Bullet fragment in lumbar spine, 2 duodenal injuries (distal 2nd portion of duodenum), Hole in GB, IVC tear, (L) renal laceration X 3, NL ureters, NL aorta, Large retroperitoneal hematoma
	7) EBL - 850 cc
	(over) GV

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME		(b)(6)-2
	LAST	FIRST	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAIN	

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)

(b)(6)-4

REGISTER NO. WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

MEDCOM - 1974
509-114

DATE	NOTES
	Brief note Cont'd
	8) Fluids - 4000 cc Cryst, 1000 cc Hetastarch, 4u PRBC
	9) UOP - 600 cc
	10) Complications - 0

(b)(6)-2

MAJ MC

Problem List
DRAFT

509-113 NSN 7540-00-634-4122

MEDICAL RECORD | PROGRESS NOTES

DATE

11 Sep 93 — GSW to Abdomen → Ex Lap (L) Flank
— Gross Hematuria → Nonc IVP ~~AGU~~ RUG
— (L) Kidney Lacerations 2° Shock wave
— Spinal cord transection by bullet/GS @ ___ level c̄ resulting paraplegia
— Retroperitoneal Hematoma
— Duodenal injury x 2
— Gallbladder injury → cholecystectomy
— IVC GS injury @ origin (R) renal vein
— Lumbar Spine Fracture Transverse process
— Liver Laceration — THT
— Blood transfusions x4 - 11 Sep 93
— A line
— ~~Paraplegia~~ Mechanical Ventilation

2003 11 Sep OMFS/
Pt noted to have lid lac on right eye by nursing staff. examined.
Dx: 1½ cm superficial lac OD just inferior to brow
Op: Repair eyelid lac Phillips / Arst Dunn local anesthesia
(1.5cc) 2% lido c̄ epi 1:100,000 (1.5cc) 0.5% bupi c̄ epi 1:200,000 5.0 FAC for drop
5.0 prolene interrupted to close epithelium. Bacitracin.
To remove in 5-7 dys

(Continue on reverse side)

(b)(6)-2 (b)(6)-2 LTC DDSms

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility) | REGISTER NO. | WARD NO.

(b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 1976

Respiratory

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
17Sep03	pt rcvd From OR @ 0455 c 8.0 ET Tube placed on vent c Settings VT 700ml RR 12 Fio2 80% peep 5 I:E 1:2 pt no ABG Drawn Upon Arrival and vent Set up Ph 7.326 Pco2 57.0 Po2 98 Hco3 19 So2 160% B/E -7 ↓ Fio2 80%
0530	↓ 70% Result of ABG Po2 298 Sats 100% HR 74 BP 120/92 RR 12 BS — (b)(6)-2 SGT 9/1/20
1100	Pt FiO_2 Δ↓ to 60% — SGT (b)(6)-2 9/1/20
1130	Pt FiO_2 Δ↓ to 50% — SGT 9/1/20
1600	Pt FiO_2 Δ↓ to 40% — SGT 9/1/20
2000	pt FiO_2 Δ↓ to 35% — SGT 9/1/20
0600	Order Written Keep sats ↑ 95 Fio2 40% Fio2 Δ From 35% - 40% — SGT (b)(6)-2 9/2/20
1200	pt Resting c 8.0 2#@lip on vent — SGT (b)(6)-2 9/2/20
1600	pt intubated c 8.0 24@lip BS CTA — SGT (b)(6)-2 9/2/20
2200	pt intubated c 8.0 24@lip BS CTA, HME On Ciecit pt Vent Settings Verified — SGT (b)(6)-2 9/2/20
2340	pt intubated c 8.0 24@24lip BS CTA — SGT (b)(6)-2 9/2/20
0400	pt intubated c 8.0 24@lip added Board inline Suctioned c minimum Secretions — SGT (b)(6)-2 9/2/20
0800	Wean ↓ Rate Moved to 10 — SGT (b)(6)-2 9/2/20

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME (LAST, FIRST, MI) | SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade) (b)(6)-4 | REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

MEDCOM - 1977

DATE	NOTES
9/14 1003	Rate ↓ 8 pt stable 128/68 129 21 100% — (b)(6)-2 9/10
9/14 1052	Vent Failure pt hooked up to BVM
	and Ventalated pt hooked Backup — SGT (b)(6)-2
1617	Pt MDorderd Suction Q2 c̄ pulm tail —
1400	Suctioned inline c̄ Ballard used 2.0
	cc NS pt HR 131 124/60 FiO2 100%
	pt Hyperoxygenated c̄ 100% FiO2 3min
	prior to suction No adverse Rx — SGT (b)(6)-2 96
1900	pt suctioned Trace Bloody Secretions
	Pt Moves a lot easly adsitated — (b)(6)-2
2100	pt suctioned before suction HR 1R BP 122/60
	used 2.5 NS Thick Bloody Secretions
	No adverse Rx post tx 144 122/60 — SGT (b)(6)-2
1010	↓ RR 10 attempt to wean — SGT (b)(6)-2
1515	Sutioned No adverse rx — SGT (b)(6)-2 RT
1530	Small amount thick yellow Secretions no NS used — SGT (b)(6)-2
1600	attempted to wean pt dec at ↓ 85% Pt
	Bvm ~~Mas~~ 20 Sats ↑ 100% pt placed Back on
	RR of 12 VT 700 FiO2 40% Suctioned Pt
	had few thick secretions — SGT (b)(6)-2 9/10 20

FPI LEX Printed on Recycled Paper

STANDARD FORM 509 (REV. 5-99) BACK

MEDCOM - 1978

509-113 NSN 7540-00-634-4122

MEDICAL RECORD | PROGRESS NOTES

DATE 12 Sept 03 0930

Surg ICU note

ϕ sig Δs overnight

Neuro - Sedated on versed, Paralyzed c̄ Necuronium

CV - BP = 104-129/59-80 HR = 81-106

RRR

Pulm - Pale (B), equal breath sound

Intubated - vent SIMV R=12 TV=700

PEEP=5 FIO_2=40%

ABG - 7.462/34.1/186/BE=2

Sats = 99-100%

GI - abd c̄ bogata bag, ϕ BS

NGT in place - 25cc over put 8 hrs

Abd - soft

I/O = 4168/2595

ID - On Unasyn WBC = 11.3

H/H = 10.5/29.8 PH = 126

L 136 105 18 / 128 7.6
4.7 23 0.9

A/P: Pt. POD1 ex lap/duodenal repair/ IVC repair ~~dc~~ (2) Stable

(1) Cont vent/sedation/paralytic

(2) Plan to take pt. to OR for washout/ abd closure tomorrow

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)

REGISTER NO. (b)(6)-2

Medical Record

MAJ MC

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 1979

509-113 NSN 7540-00-634-4122

MEDICAL RECORD	PROGRESS NOTES
DATE	
13 Sept 03	Brief Op Note
1445	1) Pre-op Dx - GSW (R) Flank / S/p IVC & duodenal repair / (L) renal lac / open Abdom
	2) Post-op Dx - SAA
	3) Procedure - Re-exploration / washout / G-tube / J-tube / Placement of drain RUQ / Closure of abd / Incidental Appendect
	4) Surgeons - (b)(6)-2 / (b)(6)-2 / (b)(6)-2
	5) Anesthesia - GETA
	6) Findings - IVC & duodenal repair intact
	7) EBL - minimal
	8) Fluids - 1200 cc crys
	9) VOP - 100 cc
	10) Complication - ∅
	11) Condition - stable to SICU
	12) See urology note for cysto findings
	(b)(6)-2
9/13/03	Urology
	cysto under anesthesia.
	Nml Bladder + Urethra, cap. + drain 450 cc
	Rose' efflux left UO, clear Right U.
	17 fr. Scope. Foley Placed
	(b)(6)-2

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility) WARD NO.

Coy MC PROGRESS NOTES

Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 1980

509-113 NSN 7540-00-634-4122

MEDICAL RECORD | PROGRESS NOTES

DATE

14 Sept 03 Surg ICU note

0915 Sig events - ∅ overnight

Neuro - sedated on fentanyl + versed

CV - BP = 112-122/61-71 HR = 115-132

Tachy

Pulm - vent SIMV R=12 TV=700 PEEP=5

FIO_2 = 40%

(+) rales (B)

ABG = 7.37/45.2/120/100%

GI - Abd - soft, dressings in place

∅ BS

G-tube - ∅ J-tube - ∅ JP = 355 cc serosanguinous

I/O = 1206/885 over past 8 hours

H/H = 7.8/22.5 PH = 164

ID - Unasyn day 4 WBC = 7.4 T_m = 100.6 T_c = 100

F/E/R - 139/105/16/124 / 3.5/28/1.0

A/P: Pt. POD 3/1 Ex lap/Abd washout/

Repair of IVC + duodenum/J-tube/G-tube

stable on vent

(1) Wean off vent in attempt to extubate

(2) Lasix

(3) Continue current management

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)

REGISTER NO.

(b)(6)-2

Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 1981

509-113 NSN 7540-00-634-4122

MEDICAL RECORD | PROGRESS NOTES

DATE 15 Sept 03 0950

Surg ICU note

Sig Events - attempted to wean off vent yesterday - failed

Neuro - sedated on versed & fentanyl

CV - BP = 109-134/52-59 HR = 107-128 tachy

Pulm - Vent R = 12 TV = 700 PEEP = 5

FIO_2 = 40%

ABG last night - 7.407/49.9/222/100%

This AM ABG = 7.327/60.7/97/96%

Roles (B)

GI - Soft, wo, ↓ BS

Incision C/D/I c̄ staples

G-tube = 575 cc J-tube = 345

JP = 300 cc

I/O - 4654/4590 Past 8 yrs - 1132/2250

~~135 98 9~~ 4.1 24 1.0 (112 Ca = 7.8

H/H = 7.6/22.2 plt = 207

ID - Tm = 102.5 Tc = 101° WBC = 6.8

A. on unasyn

Alg: Pt. POD 4/2 Ex lap/ Repair of IVC & duodenum/ Abd washout/ G-tube/ J-tube Stable on vent.

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)

(b)(6)-4

REGISTER NO. (b)(6)-2 NO.

ES

Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 1982

PROGRESS NOTES

DATE

15 Sep 03
1000

ICU note Cont'd

(1) Attempt to wean offvent
(2) Plan to start small feeds through J-tube
(3) Leave JP in place
(4) G-tube - continue to gravity drain

(b)(6)-2

MAJ MC

*U.S. Government Printing Office: 1998 - 404-763/20101

STANDARD FORM 509 (REV. 7-91) BACK

MEDCOM - 1983

509-113 NSN 7540-00-634-4122

MEDICAL RECORD | PROGRESS NOTES

DATE

16 Sept 03 Surg ICU Note

0915 Sig events - failed wean off vent yest

Neuro - Sedated on versed & fentanyl

CV - BP = 102-120/49-58 HR = 117-144

Tachy

Pulm - Vent SIMV R = 12 TV = 700 PEEP = 5

FIO2 - 40%

ABG - 7.42/53/141/99% BE = 10

CXR = ~~[illegible]~~ few atelectasis, o/w clear

GI - soft, no, few BS

Incision C/D/I c̄ Staples

JP = 40 G-tube = 1575 J-tube - Vivonex at 20cc/hr

I/O = 2764/7010 Urine clear

H/H = 7.8/22.4 Plt = 272

ID - WBC = 8.8 Tm = 103.2 101.7

Vancomycin day 6

128/97/9 / 4.5/26/0.9 / 125 Ca = 7.9

Alg: Pt. POD 5/3 Ex lap/ duodenal & IVC repair

Appy / J-tube / G-tube stable on vent

1. Attempt to wean again today
2. Cont Abx
3. Cont Tube feeds
4. ↓ IVF & switch to MS

(b)(6)-2

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)

REGISTER NO.

(b)(6)-4

PROGRESS NOTES

Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 1984

509-113 NSN 7540-00-634-4122

MEDICAL RECORD | PROGRESS NOTES

DATE

17 Sept 03 Surgery Transfer note

0920 Pt. brought to ER after gunshot wound to the left flank. IVP negative. Patient taken to OR for exploratory laparotomy on 11 Sept 03 - patient found to have through & through injury to the liver - bullet fragment removed from dome of (R) lobe of the liver. Pt. also found to have bullet fragment in lumbar spine between the IVC & aorta. IVC was lacerated near junction of (R) renal vein - repaired with prolene suture. Pt. was found to have injury to the 2nd portion of the duodenum (distal) X 2. Small lacerations repaired in 2 layers. The right kidney was normal. The left kidney had 3 lacerations. Bilateral ureters were normal. A Bogota bag was placed due to edema of the bowel. Patient taken for re-exploration 2 days later - 15 Sept 03. Washout performed.

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)

REGISTER NO.

(b)(6)-2

(b)(6)-4

Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 1985

PROGRESS NOTES

DATE

17 Sept 03 0925

Surg Note Cont'd

Repairs were intact. JP drain placed near the duodenum. G-tube & J-tube placed. Abd was closed. Cystoscope was done due to blood in the urine - no significant pathology found. Urine cleared during the hospitalization. Pt. has been intubated throughout. Vent settings SIMV R=12 TV=700 PEEP=5 FIO_2=40%. Pt. started on Vivonex Tube feeds - 20 cc/hr through the J-tube. G-tube to gravity. Foley catheter in place. Pt. has been stable. (b)(6)-2 On arrival originally to ER, pt. had no sensation or movement of the lower extremities.

Injuries

Spinal fracture (lumbar) - log roll
Left Renal laceration
IVC laceration - repaired
Duodenal Injury X 2 - repaired
Through & Through liver injury
Incidental Appendectomy

(b)(6)-2

WAT a C

*U.S. Government Printing Office: 1996 - 404-763/20101

STANDARD FORM 509 (REV. 7-91) BACK

MEDCOM - 1986

558-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Name): (b)(3)-1 "N"

LOG NUMBER

ARRIVAL — DATE: DAY 10 MONTH Sep YR. 03 — TIME 23:37

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☐ OTHER (Specify)

CURRENT MEDS. (tetanus immunization and other data): unk?

HISTORY OBTAINED FROM: ☒ PATIENT ☐ OTHER (Specify)

ALLERGIES: Unk?

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code):

HOME TELE. NO. (Inc. area code):

CHIEF COMPLAINT(S) (Include symptom(s), duration): GSW

SEX: M AGE: 20 ish

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: OA

VITAL SIGNS

TIME	2337	0045
BP	111/81	129/75
PULSE	111	94
RESP.	22	21
TEMP.	98.9 (R)	
WT. (Child)	100% NRB	

CATEGORY (See reverse)
- EMERGENT
- ✓ URGENT
- NON-URGENT

ORDERS	INITS.	TIME
MSO4 - 20mg IV		
Versed 5mg IV	titrate	
Unasyn 3g IV		

ASSESSMENT/DIAGNOSIS
1. GSW (L) flank
2. spinal cord injury

DISPOSITION (Check all that apply): HOME / FULL DUTY

QUARTERS: 24 Hrs. / 48 Hrs. / 72 Hrs.

MODIFIED DUTY UNTIL: DAY / MONTH / YEAR

REFERRED TO (Indicate clinic): EMERGENCY / TODAY / 72 HOURS / ROUTINE

ADMIT. TO HOSP. UNIT/SERVICE: CR

CONDITION UPON RELEASE: IMPROVED / ✓ UNCHANGED / DETERIORATED

TIME OF RELEASE: 0010

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

20ish yo Iraqi of civilian s/p GSW (L) flank. Brought by medics 502nd. Stable en route. c/o back/abd pain

P/4
S/4
LPG ~19

C - WD WN ∅ distress.
A - intact, speaking
B - B = BS
C - CR < 2S
D - GCS 15. ∅ moving lower exts.

HEENT - small 2cm lac (R) supraorbital area c/w nl.
CV - reg ∅ m lungs - CTA (B)
abd - diffuse tp c̄ vol/invol guarding ∅ mass
neuro - flaccid paralysis (B) LE
rectal - ∅ gross blood - ∅ tone areflexic ∅ sensation (+) priapism
back - GSW (L) flank

CXR (-)
pelvis (-)
FAST U (+) retrope hemat

44
10
UA/32
gross hemat

EDC - Stable initial VS. Foley placed c̄ gross hematuria. FAST c̄ Retroperitoneal hematoma. SOD (Eastman) notified. Ortho notified.

(CONTINUE ON SF 507, IF NEEDED)

PATIENT'S IDENTIFICATION (Mechanical imprint) FOR WRITTEN ENTRIES GIVE: Name - last, first, middle; SSN; DOB, service status, name and relation of sponsor or next of kin. (IMPORTANT: LIST FACILITY HOLDING TREATMENT RECORD).

(b)(6)-4

(b)(6)-4

SIGNATURE OF PROVIDER AND ID STAMP: (b)(6)-2 MAT, MC

IN... medications ordered, any limitations and follow-up plans)

Spinal prec. maintained throughout ~~to OR~~ No indication for rods since penetrating trauma.
To CR for ex lap c̄ SOD.
One shot IVP -

(b)(6)-2

EMERGENCY CARE AND TREATMENT

STANDARD FORM 558 (Rev. 6-82)
Prescribed by GSA and ICMR

MEDCOM - 1987

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	11 Sep 03
DOS	11 Sep 03
POD	DOS

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2	ICU	11 Sep 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade;date; hospital or medical facility)*

(b)(6)-4

- ☐ HISTORY/PHYSICAL
- ☐ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☐ OTHER(*Specify*)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 1988

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R					2			~~2~~				*			*							2		
	L					2			2				2			2							2		
	DORSALIS PEDIS R					2			2				2			2							2		
	L					2			2				2			2							2		
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale						1 4 8			1 4 8				1 4 8			1 4 8							1 4 8		
EDEMA						—			Ø				Ø			Ø							—		
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)						✓			✓				✓			✓							✓		
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)						✓			✓				✓			✓							✓		
SWAN GANZ CATHETER (Zeroed & calibrated)						—																			
ARTERIAL LINE (zeroed & calibrated)						BW			✓				✓			✓							✓		
HYGIENE	BED BATH						Not					✓													
	FOLEY CARE											✓											✓		
	ORAL CARE																								
MOBILITY	BEDREST					✓			✓				✓			✓							✓		
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE					✓			✓				✓			✓							✓		
	HOB 30 DEGREES																								
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE																								
	PAIN SCALE (1-10)																								
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN (2) Soft & Flat (1) Distended						X			*				*			*							*		
BOWEL SOUNDS (active all quads)						X			*				*			*							*		
NG / DOBHOFF PLACEMENT VERIFIED						✓			✓				✓			✓							✓		
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT						✓			✓				✓			✓							✓		
VOIDING CLEAR, YELLOW URINE q.s.						X			*				*			OMA							*		
SKIN INTEGRITY	No Breakdown																								
	Surgical Wounds					✓			✓				✓			✓							✓		
	Rashes, Lac's, etc																						✓		
DRESSING (Dry & Intact: specify site below)																									
#1 Midline - open Bogatabag						✓			✓				✓			✓							✓		
#2 (L) Flank GSW																							✓		
#3																									

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
16 G	L AC	11 Sep 03	OPSITE, Silk Tape, patent
18 G	R AC Heplock	11 Sep 03	OPSITE, SILK TAPE, patent
A-line	R Radial	11 Sep 03	Sutured OPSITE, Silk Tape

MEDCOM - 1989

PUPIL SIZE	PUPILS		MOTOR FUNCTION	CHART CODES
1 mm	=	Equal	0 = No Movement	Present ✓
2 mm	R	Reactive	1 = Slight Flicker/ Trace of Contraction	
3 mm	NR	NonReactive	2 = Active (Gravity Eliminated)	Not Applicable /Absent (blank)
			3 = Active: against gravity, but not against resistance	
4 mm	L > R	Left Larger	4 = Active: Against Gravity and Resistance, not full strength	Refer to Nsg. Notes X
			5 = Full Strength against Examiners Resistance	
5 mm	R > L	Right Larger		No Change from Previous Assessment –

DATE:

TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open					X			1				1			1							1X		
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response					X			1				1			1							1X		
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response					X			1				1			1							1X		
GLASCOW COMA SCALE (A+B+C)					X			3				3			3							3X		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — R								2				2			2									
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — L								2				2			2									
MOVEMENT (See Motor Function Scale at Top of Page) — RUE					X			0				0			0							X		
MOVEMENT (See Motor Function Scale at Top of Page) — LUE					X			0				0			0							X		
MOVEMENT (See Motor Function Scale at Top of Page) — RLE					X			0				0			0							X		
MOVEMENT (See Motor Function Scale at Top of Page) — LLE					X			0				0			0							X		
GRIP (S) Strong (W) Weak (-) absent — R								1				1			1							1		
GRIP (S) Strong (W) Weak (-) absent — L								1				1			1							1		
RESPIRATIONS — REGULAR								✓				✓			✓							VENT		
RESPIRATIONS — IRREGULAR																								
RESPIRATIONS — UNLABORED																								
RESPIRATIONS — LABORED																								
RESPIRATIONS — SHALLOW								✓				✓			✓									
RESPIRATIONS — RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RUL					5			5				5			5							5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — LUL					5			5				5			5							5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RLL					5			5				5			5							5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — LLL					5			5				5			5							5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — BOTH BASES					5			5				5			5							5		
COUGH — NONE								X				✓			✓									
COUGH — SPONTANEOUS																								
COUGH — PRODUCTIVE																								
COUGH — NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																								
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																								
VENTILATOR — Vt					700			700				700			700							700		
VENTILATOR — FiO2					100%			100%				50%			40%							35		
VENTILATOR — RATE (SIMV/CMV)					12			12				12			12							12		
VENTILATOR — PEEP / CPAP					5			5				5			5							5		
VENTILATOR — PRESS. SUPPORT					–			–				–			–							–		
OXYGEN DELIVERY DEVICE — NC (l/min)																								
OXYGEN DELIVERY DEVICE — FM (l/min)																								
ETT #_____ — NRBM (l/min)																								
ETT #_____ — ETT 23 cm gums																								
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED																								
INCENTIVE SPIROMETRY DONE																								
COUGH / DEEP BREATH																								
INITIALS					(b)(6)-2			(b)(6)-2				(b)(6)-2			(b)(6)-2							(b)(6)-2		

MEDCOM - 1990

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200																	
0300																	
0400																	
0500	94°	76	13	130/80	100	131/90											
0600		77	13/12		100	127/81											
0700	93.2	72	16/12		100	118/77											
0800	94	80	22/12	124/70	100	116/67											
0900	94.6	78	12/12		100	110/63											
1000	94.8 (A)	80	16/12		100	107/66											
1100	95.3 (A)	82	12/12		100	112/65											
1200	95.9 (A)	84	12/12	109/64	100	118/71											
1300	96.9 (A)	99	12/12		100%	115/68											
1400	96 (A)	110	12/12	[illegible]/62	100%	113/62											
1500	97 (A)	114	12/12		100%	111/60											
1530																	10mg Epi
1600	97 (A)	97	12/12	121/64	100%	108/61											
1700	98 (A)	106	12/12	[illegible]	100%	118/61											
1800	98 (A)	110	12/12		100%	116/59											
1900	97 (A)	108	12/12		100%	105/52											
2000	97 (A)	111	12/12		100%	124/68											
2100	97	120	12/12		100%	114/60											
2200	98	106	12/12	115/73	100%	118/68											
2300	98	104	12	117/67	100%	123/69											
2400	98	103	12		99	132/74											

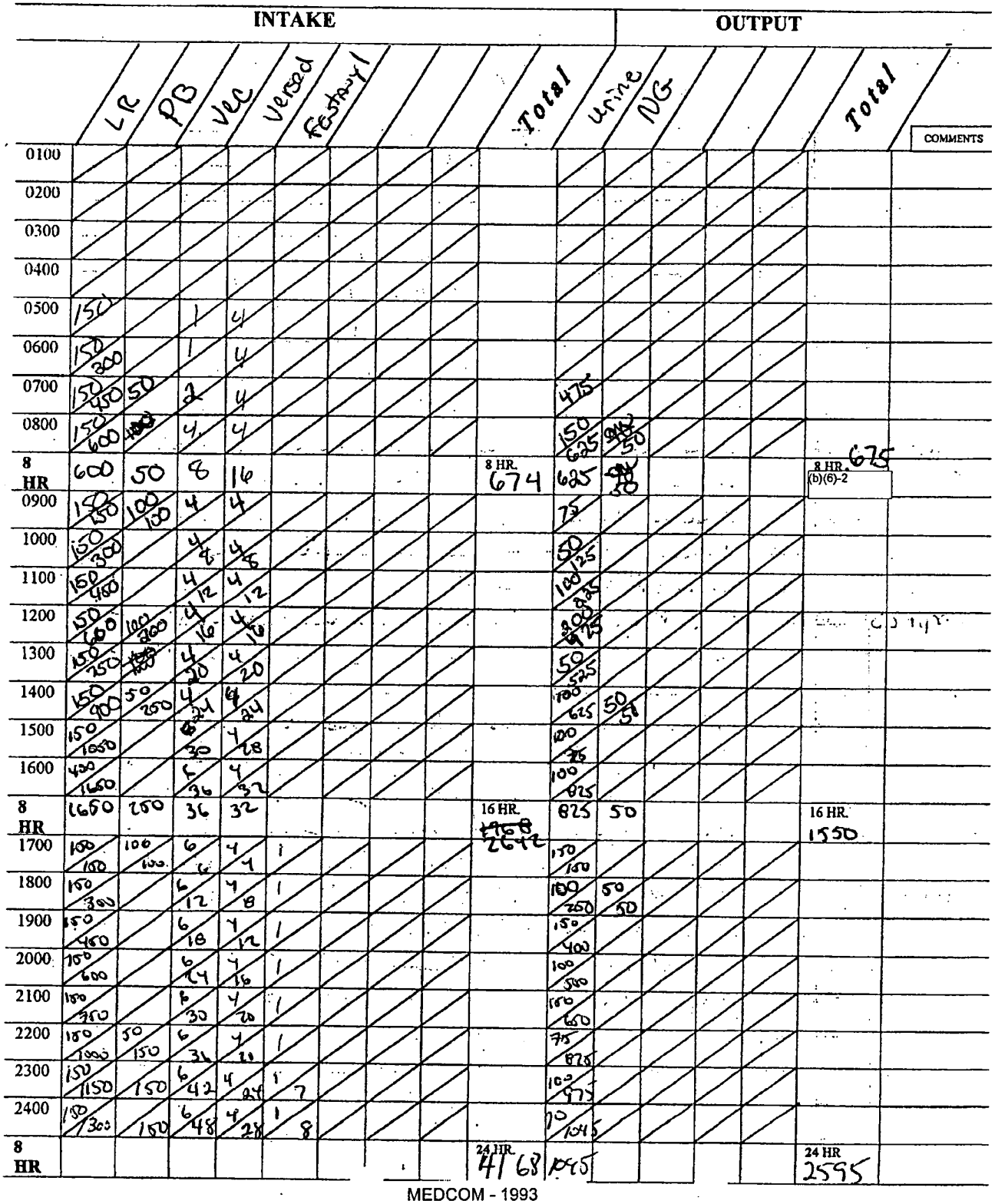
MEDCOM - 1991

NSN 7540-00-634-4123

MEDICAL RECORD — NURSING NOTES (Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
11Sep03	0500		Pt to ICU 1 from OR. placed on cardiac & pulse oximetry monitors. Vent. set up and operational. settings and assessment per flowsheet. Pt currently sedated on versed and Vecuronium gtts. Cree medsheet. Abd & opsite over lap sponge. Open incision & bogota bag in place per surgeon. Dressing (b)(6)-2
	0530		Currently paralyzed ~~& train of fourth~~ train of four. Reprocessed instrument ad obtained train of 1 to (b)(6)-2 temple. (b)(6)-2
11Sept03	0855		received pt from prev shift @0600. pt remains see flow sheet. abd dsg (b)(6)-2 draining bloody discharge. reinforced ~~TOF~~ 4-5x urine (b)(6)-2 draining (b)(6)-2 dk pink. BS (b)(6)-2 ~~Dopp~~ (b)(6)-2 my hypo will cont to monit (b)(6)-2
11Sept03	1100		FiO_2 @ 60%. PT brought it & will cont to follow (b)(6)-2
11Sept03	1300		pt has 1/4 TOF, (b)(6)-2
	1340		@1322 adm. ~~lorazepam~~ for restlessness pt now calm TOF 1/4 (b)(6)-2 no apparent distress. NS draining foley to gravity. draining med pk urine dsg to abd reinforced dsg to back reinforced @ 1430 will cont to monitor (b)(6)-2
11Sep03	1600		Pt BP ↓ to 60-70/30-40 pt given LR bolus 400cc + 10mg ephedrine IVP BP up to 115/60 (b)(6)-2
	1630		Dr (b)(6)-2 to suture LAC over (b)(6)-2 eye (b)(6)-2
	1800		Drsg on back D'd due to saturated (b)(6)-2
	2200		Assumed care of pt. Sedated. Paralyzed vols. Ice dsg reinforcement at change of (b)(6)-2 responsible.
	2230		Assessment per flowsheet midline incision (CDI).

MEDCOM - 1992


INTAKE
OUTPUT
LR
PB
Vec
Versed
Fentanyl
Total
Urine
NG
Total
COMMENTS
0100
0200
0300
0400
0500
0600
0700
0800
8 HR
0900
1000
1100
1200
1300
1400
1500
1600
8 HR
1700
1800
1900
2000
2100
2200
2300
2400
8 HR
8 HR. 674
16 HR. 2642
24 HR 4168
8 HR. 675
(b)(6)-2
16 HR. 1550
24 HR 2595

MEDCOM - 1993

509-113 NSN 7540-00-634-4122

MEDICAL RECORD | PROGRESS NOTES

DATE

11Sep03 (Cont) 2230 continue to drain mild amt serosanguinous fluid under right side of drsg. Cardiac monit ad pulse oximetry on and working. (B) Ac IV site patent & S/S of infiltration. Foley patent draining amber urine. A-line & erythema or edema. ABP corresponding to NBP. (b)(6)-2

(Continue on reverse side)

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)*

(b)(6)-4

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

MEDCOM - 1994

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	11 Sep 03
DOS	11 Sep 03
POD	1

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2	ICU 1	12 Sep 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade; date; hospital or medical facility)*

(b)(6)-4

- ☐ HISTORY/PHYSICAL
- ☒ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☐ OTHER *(Specify)*
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 1995

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R				2			2				2			2								2		
	RADIAL L				2			2				2			2								2	-	
	DORSALIS PEDIS R				2			1				1			1								2		
	DORSALIS PEDIS L				2			1				1			1								2		
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale					1 3 8			1 3 8				1 3 8			1 3 8								1 3 8		
EDEMA					-			1+				1+			1+								1		
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)					✓			✓				✓			✓								✓		
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)					✓			✓				✓			✓								✓		
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)					✓			✓			✓				✓								✓		
HYGIENE	BED BATH										✓														
	FOLEY CARE										✓														
	ORAL CARE																								
MOBILITY	BEDREST				✓			✓				✓			✓								✓		
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE				✓			✓				✓			✓								✓		
	HOB 30 DEGREES														✓										
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)												SSF													
PAIN	PAIN FREE							Scheduled Percocet															X		
	PAIN SCALE (1-10)																								
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN (2) Soft & Flat (1) Distended					X				*			WNL			BS								X		
BOWEL SOUNDS (active all quads)					X				*			WNL			A								X		
NG / DOBHOFF PLACEMENT VERIFIED					✓																				
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT					✓				✓ Amber			--			✓								X		
VOIDING CLEAR, YELLOW URINE q.s.												--			DARK										
SKIN INTEGRITY	No Breakdown								✓																
	Surgical Wounds				✓				✓			--			✓								✓		
	Rashes, Lac's, etc				✓							--			✓								✓		
DRESSING (Dry & Intact: specify site below)												--													
#1 ANT Midline					✓				Changed Saturday			--			✓								✓		
#2 CSW OFLANE					✓							--			✓								✓		
#3																									

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
18g	RAC	11 Sep	OPSITE, Silk tape 1100
16g	L AC	11 Sep	OPSITE, Silk tape 1110
A-line	R Radial	11 Sep	Sutures opsite silk tape 1020
18 GA	RAC	11SEP	D3/S Inf/patent (b)(6)-2 1400
16 GA	LAC	11SEP	D3/S Inf/patent 1400
ALINE	Radial	11SEP	D3/S Inf/patent 1400

MEDCOM - 1996

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable /Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment –

DATE:

TIME		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (2) To Pain (3) To Voice (1) Does Not Open					1			1				1				1							X		
B. BEST VERBAL RESPONSE (5) Oriented (2) Garbled (4) Confused (1) No Response (3) Inappropriate Verbal Response					1			1 T				1 T				1							X		
C. BEST MOTOR RESPONSE (6) Obeys Commands (3) Flexion to Pain (5) Localizes to Pain (2) Extension to Pain (4) Withdraw to Pain (1) No Response					1			1				1				1							Y		
GLASCOW COMA SCALE (A+B+C)					3X			3T				3T				3							X		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R							2+				--				2+									
	L							2+				--				2+									
MOVEMENT (See Motor Function Scale at Top of Page)	RUE				X			0				0				/							X		
	LUE				X			0				0				/							X		
	RLE				X			0				0				/							X		
	LLE				X			0				0				/							X		
GRIP (S) Strong (W) Weak (-) absent	R				X			0				0				/							X		
	L				X			0				0				/							X		
RESPIRATIONS	REGULAR				Vent			V				V				V							V		
	IRREGULAR																								
	UNLABORED							L				L				N							L		
	LABORED							N T				N T				T							P T		
	SHALLOW							T				T													
	RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL				5			5				5				5							5		
	LUL				5			5				5				5							5		
	RLL				5			5				5				5							5		
	LLL				5			5				5				5							5		
	BOTH BASES				5			5				5				5							5		
COUGH	NONE				✓			✓				✓				✓							✓		
	SPONTANEOUS																								
	PRODUCTIVE																								
	NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																									
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																									
VENTILATOR	Vt				700			700				700				700							700		
	FIO2				35			35				40				40							40		
	RATE (SIMV/CMV)				12			12				12				12							12		
	PEEP / CPAP				5			5				5				5							5		
	PRESS. SUPPORT				—			/				0				0							—		
OXYGEN DELIVERY DEVICE	NC (l/min)																								
	FM (l/min)																								
ETT # 8	NRBM (l/min)																								
	ETT 21 cm gums	BITE Block										--				✓							✓		
ETT CARE / POSITION CHANGE																									
ETT / NT SUCTIONED																									
INCENTIVE SPIROMETRY DONE																									
COUGH / DEEP BREATH																									
INITIALS				(b)(6)-2				(b)(6)-2			(b)(6)-2					✓							(b)(6)-2		

MEDCOM - 1997

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100	98.2	106	12	114/74	99	135/75											
0200		88	12	104/55	100	120/59											
0300	97.2	80	12	127/70	100	146/72											
0400		81	12	127/75	100	147/73											
0500	98.2	99	12	129/80	100	146/88											
0600	96.4(A)	93	12	124/75	100	139/72											
0700	96.5(A)	89	12	123/72	100	138/69	89										
0800	96.5(A)	86	12	112/62	100	130/61	79										
0900	97.1(A)	86 ~~89~~	12	104/59	100	120/59	76										
1000	97.3(A)	93	12	103/60	100	107/53	73										
1100	97.1(A)	97	12	110/59	100	126/61	78										
1200	97.3(A)	99	12	113/60	100%	135/84	83										
1300	97.7(A)	99	12	114/62	100%	136/63 ~~130/57~~	81										
1400	98.1(A)	100	12	115/60	100%	138/61	81										
1500	98.2(A)	101	12	115/62	100%	145/62	81										
1600	98.8(A)	104	12	116/64	100%	141/58	79										
1700	99.1(A)	101	12	114/61	100%	134/53	88										
1800	98.9(A)	97	12	114/58 (b)(6)-2	100%	131/56	84										
1900	99.2(A)	94	12	111/58	100%	135/56	79										
2000	99.9(A)	101	12	122/70	100%	133/58	97 ~~102~~										
2100	99.7(A)	94	12	113/54	100%	131/56	73										
		~~92~~	(b)(6)-2 ~~12~~	~~115/59~~	~~100%~~	~~138/60~~	~~83~~										
2200	98.1(A)	92	12	115/59	100%	138/60	83										
2300	98.9	90	12	110/57	100	125/61											
2400	98.6	86	12		100	130/60											

NSN 7540-00-634-4123

MEDICAL RECORD			NURSING ES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
12 Sep 03	0130		Assessment c̄ change.
	0145		SBP ↓ to 80. 10 mg Epinephrine, LR Bolus Started
			Discussed c̄ Dr. (b)(6)-2 (b)(6)-2
	0100		SBP to 102, will continue to monitor (b)(6)-2
	0200		SBP 116 - will continue to monitor (b)(6)-2
	0300		(R) Lateral drsg changed. urine output ↓ but still QS. (b)(6)-2
12 Sep 03		0700	Pt supine & flat. VSS. NAD noted. Versed gtt @ 4 mg/hr Vecuronium @ 6 mg/hr & Fentanyl @ 1cc/hr IV. See flowsheet for assessment. ~~AMP~~ Abdomen c̄ ⊖ B/S slightly tense. Midline drsg c̄ op site saturated. Will cont to monitor (b)(6)-2 LLT, AM
12 Sep 03	←	0800	F_iO_2 ↑ 40% per CCU orders (b)(6)-2 LT, AM
12 Sep 03	←	1100	No Δ's from previous assessment. VSS. Will continue to monitor (b)(6)-2 LLT, AM
12 Sep 03		1430	Pt assessment complete. Pt cont on same IVF/meds as previous shift to apply Lacrilube to eye (b)(6)-2
		2100	Drsg on back D'd - 250cc sanguinous fluid drained from front opsite. (b)(6)-2 [illegible]
		2700	Assumed care of pt. Remains sedated. Continues c̄ seco sanguinous fluids from around midline incision. Invasive lines x 3 patent, sites c̄ S/S of infiltration. Assessment per flowsheet. Continues c̄ sedation and paralyzed, pt appears c̄ mild generalized edema since admission. NGT c̄ dark green aspirate. abd c̄ BS drsg remain intact c̄ drainage as noted previous. Urine c̄ blood tinge, QS. (b)(6)-2

MEDCOM - 1999

	INTAKE										OUTPUT						
	LR	Versed	Vecuronium	Fentanyl	IVPB	BOLUS				Total	URINE	STOOL	NG	BLOODY DRAINAGE		Total	COMMENTS
0100	150 / 150	4 / 4	6 / 6	1 / 1	100 / 100						70 / 70						
0200	50 / 200	4 / 8	6 / 12	1 / 2	~ / 100	400 / 400					50 / 120						
0300	150 / 350	4 / 12	6 / 18	1 / 3	100 /	400					40 / 160						
0400	150 / 500	4 / 16	6 / 24	1 / 4	100 /	400					50 / 210						
0500	150 / 650	4 / 20	6 / 30	1 / 5	100 /	400					80 / 290						
0600	100 / 800	4 / 24	6 / 36	1 / 6	50 / 150	400					80 / 370						
0700	150 / 950	4 / 28	6 / 42	1 / 7	0 / 150						45 / 415	25 / 25					
0800	150 / 1100	4 / 32	6 / 48	5 / 12	50 / 200						75 / 490						
8 HR	1100	32	48	12	200	400				8 HR 1792	490	25				8 HR 515	+ 1277
0900	150 / 150	4 / 4	6 / 6	5 / 5							55 / 545						
1000	150 / 300	4 / 8	6 / 12	5 / 10							50 / 105						
1100	150 / 450	4 / 12	6 / 18	5 / 15							60 / 165						
1200	150 / 600	4 / 16	6 / 24	5 / 20	100 / 100						60 / 225						
1300	150 / 750	4 / 20	6 / 30	5 / 25							↓						
1400	150 / 900	4 / 24	6 / 36	5 / 30							75 / 300	25					
1500	150 / 1050	4 / 28	6 / 42	5 / 35	100 / 200						100 / 400						
1600	150 / 1200	4 / 32	6 / 48	5 / 40							50 / 450						
8 HR	1200	32	48	40	200					16 HR 3312	450	25				16 HR 990	+ 2322
1700	150 / 150	4 / 4	6 / 6	5 / 5							30 / 480						
1800	150 / 300	4 / 8	6 / 12	5 / 10	100 / 100						50 / 530						
1900	150 / 450	4 / 12	6 / 18	5 / 15							75 / 605			250 / 250			
2000	150 / 600	4 / 16	6 / 24	5 / 20							75 / 680						
2100	150 / 750	4 / 20	6 / 30	5 / 20							50 / 730						
2200	150 / 900	4 / 24	6 / 36	5 / 25	150 / 150									20			
2300	150 / 1050	4 / 28	6 / 42	5 / 30	150 / 150						75 / 805						
2400	150 / 1200	4 / 32	6 / 48	5 / 35	100 / 250					1585	50 / 855			270		1125	+ 440
8 HR										24 HR 4877						24 HR 2115	+ 2762

MEDCOM - 2000

CRITICAL CARE FLOW SHEET

(b)(6)-2

LOS DATA	
DOA	11 Sep 03
DOS	11 Sep 03
POD	2

24 HOUR DATA	
24 Hour Balance	+ 2367
24 Hour Intake	5062
24 Hour Output	2695
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On	—		
Call Light Within Reach	—		
Side Rails Up	—		
Bed in Low Position	—		

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2	ICU 1	13SEP03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade; date; hospital or medical facility)*

(b)(6)-4

- ☐ HISTORY/PHYSICAL ☒ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION ☐ OTHER *(Specify)*
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 2001

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R						2				2						2						2	-	
	RADIAL L						2				2						2						2		
	DORSALIS PEDIS R						2				2						2						2		
	DORSALIS PEDIS L						2				2						2						2		
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale							1 3 8				1 3 8						1 3 8						1 3 8		
EDEMA							Generalized				--						*						1+		
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)							✓				✓						S1S2						✓		
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)							SR-ST				SR-ST						SR						ST		
SWAN GANZ CATHETER (Zeroed & calibrated)							✓																✓		
ARTERIAL LINE (zeroed & calibrated)							✓										✓						✓		
HYGIENE	BED BATH																								
	FOLEY CARE																								
	ORAL CARE																								
MOBILITY	BEDREST						✓				✓						✓						✓		
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT																								
	LEFT						✓				✓						✓						✓		
	SUPINE										✓						✓						✓		
	HOB 30 DEGREES																								
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE						Splinted Pain Free				--						Splinted Pain Free						Grandchildren Pain Free		
	PAIN SCALE (1-10)																								
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN (2) Soft & Flat (1) Distended							2										2						2		
BOWEL SOUNDS (active all quads)							⊖				--						⊖						⊖		
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph				-																					
FOLEY CATHETER PATENT							✓										✓						✓		
VOIDING CLEAR YELLOW URINE q.s.							DCD Bypassed				--						Pink						Pink		
SKIN INTEGRITY	No Breakdown						✓				✓														
	Surgical Wounds						✓				1,						✓						✓		
	Rashes, Lac's, etc						✓										✓								
DRESSING (Dry & Intact; specify site below)																									
#1 Aut Abd midline							Saturated Bandaged				--						✓						✓		
#2 GSW (L) Flank											--						✓						✓		
#3																									

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
18g	(R) AC	11 Sep	Opsite Silk tape / 06002 / 1000
16g	(L) AC	11 Sep	Opsite Silk tape / 06002 / 1000
A-Line	(R) RADIAL	11 Sep	Sutures Opsite 4x4 / 06002 / 1000

PUPIL SIZE		PUPILS
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable /Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment --

DATE: 13 Sept 03

TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open						1				1						Sedated + Paralyzed						Sedated		
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response						1 T				1 T														
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response						1				1														
GLASCOW COMA SCALE (A+B+C)						3T				3T														
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) R						2+				2+						2+						2+		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) L						2+				2+						2+						2+		
MOVEMENT (See Motor Function Scale at Top of Page) RUE						0				0						0 Paralyzed						0		
MOVEMENT (See Motor Function Scale at Top of Page) LUE						0				0						0						0		
MOVEMENT (See Motor Function Scale at Top of Page) RLE						0				0						0						0		
MOVEMENT (See Motor Function Scale at Top of Page) LLE						0				0						0						0		
GRIP (S) Strong (W) Weak (-) absent R						0				0						0						0		
GRIP (S) Strong (W) Weak (-) absent L						0				0						0						0		
RESPIRATIONS REGULAR																								
RESPIRATIONS IRREGULAR																								
RESPIRATIONS UNLABORED										Vent												Vent		
RESPIRATIONS LABORED						Vent																		
RESPIRATIONS SHALLOW																								
RESPIRATIONS RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished RUL						5				5						5						5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished LUL						5				5						5						5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished RLL						1				1						1						1		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished LLL						1				1						1						1		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished BOTH BASES						1 ✓				1 ✓						1 ✓						1 ✓		
COUGH NONE																✓						✓		
COUGH SPONTANEOUS																								
COUGH PRODUCTIVE																								
COUGH NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																								
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																								
VENTILATOR Vt						700				700						700						700		
VENTILATOR FiO2						40%				40%						40%						40%		
VENTILATOR RATE (SIMV/CMV)						12				12						12						12		
VENTILATOR PEEP / CPAP						5				5						5						5		
VENTILATOR PRESS. SUPPORT						0				0														
OXYGEN DELIVERY DEVICE NC (l/min)																								
OXYGEN DELIVERY DEVICE FM (l/min)																								
ETT # 8 NRBM (l/min)																								
ETT # 8 ETT 23 cm gums										✓						✓						✓		
ETT CARE / POSITION CHANGE										✓														
ETT / NT SUCTIONED										✓												Opal		
INCENTIVE SPIROMETRY DONE																								
COUGH / DEEP BREATH																								
INITIALS						(b)(6)-2				(b)(6)-2						(b)(6)-2						(b)(6)-2		

ACLU-RDI 1099 p.787

DOD 006055

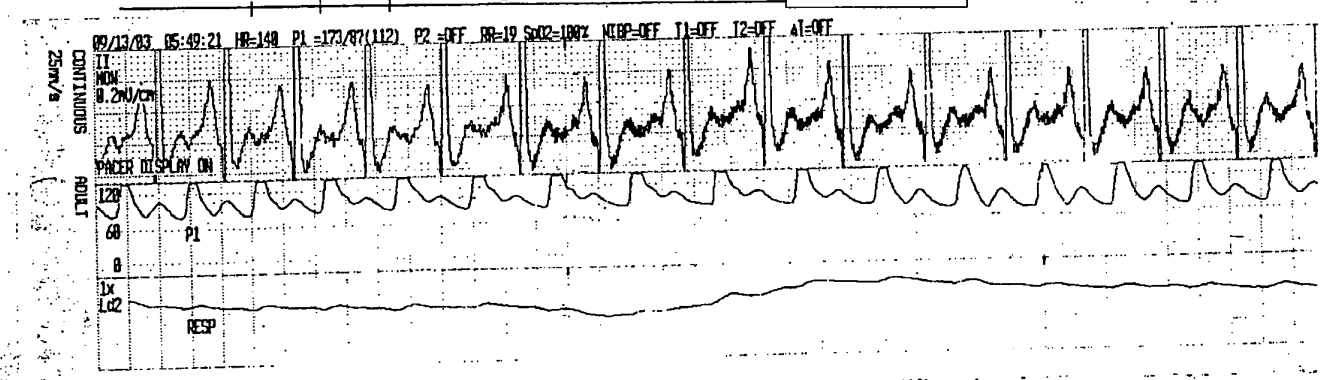
VITAL SIGNS

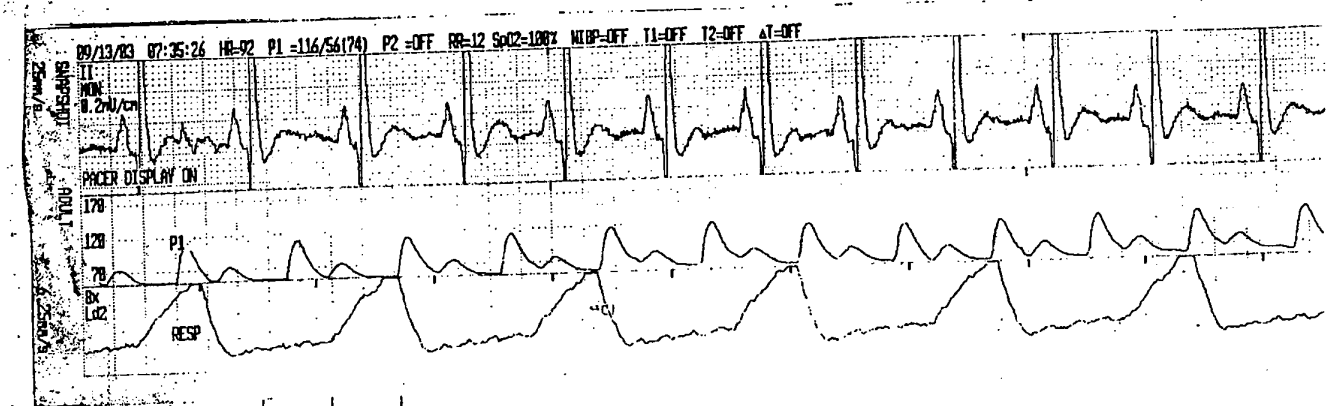
TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100	98.3	91	12	113/53	100	131/59											
0200	98.1	82	12	118/50	100	127/57											
0300	98.5	86	12	123/57 134/66	100	135/61											
0400	98.3	95	12	~~132~~/63	100	130/63											
0500	98.5	87	12	116/63	100	137/59											
0600	97.9 (A)	97	12	123/62	100%	144/64	84										
0700	97.1	94	12	110/53	100%	114/51	70										
0800	98.4	97	12	118/57	100%	120/59	78										
0900	98.6 (A)	98	12	126/64 (b)(6)-2	100%	139/63	83										
1000	99 (A)	104	12	126/66	100%	142/62	83										
1100	99.4 (A)	101	13	116/54	100	133/55	77										
1200	99.2 (A)	144 100%	12	140/80	100% ~~100%~~	185/86	104	→ PT RECEIVING BED BATH									
1300																	
1400		TO OR															
1500																	
1600		Recovery															
1700	96.6	86	12	130/73	100%	150/72	95										
1800	97.5	92	12	122/63	100%	142/67	85										
1900	97.8	94	12	121/66	100%	141/69	88										
2000	98.3	97	12	123/66	100%	143/69	90										
2100	98.6	107	15	123/64	100%	145/66	88										
2200		115	24/12	MAY/62	100%												
2230	99.3 ax	112	24/12	121/61	100%	142/66	86										
2300	99.4 ax	126	24/12	124/64	100%	143/65	91										
2400	99.2 ax	109	12/12	110/62	100	145/56	85										

MEDCOM - 2004

NSN 7540-00-634-4123

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
13 Sep 03	0105		Assessment c̄ change. VSS. will monitor (b)(6)-2
	0300		Pt dis c̄ continued leakage of serosanguineous
			fluid from midline wound pads changed
			disposable chux change, skin care given (b)(6)-2
	0530		Ø Δ in status. (b)(6)-2
9/13/03	0630		Pt c̄ TRANSIENT EPISODES of TACHY Cardia 130-140's & c̄
			Hypertension 160-170/90's. PT given 100mcg
			boluses of Fentanyl which brought HR & BP back to
			120's/50's HR 90's. Pt c̄ ~~Cornea~~ sclerotic & generalized
			edema. Continues to have large amount of serous
			sanguinous drainage from Buzata bag & GSW site
			DRSG's reinforced. See flowsheet for further
			assessment. (b)(6)-2 LT. A





MEDCOM - 2005

	INTAKE									OUTPUT						
	LR	VERSED	VECURONIUM	FENTANYL	IVPB	BOLUS			Total	URINE	STOOL	NG	FOLEY CATHETER / DRAINAGE	JP	Total	COMMENTS
0100	150 / 150	4 / 4	6 / 6	5 / 5						75 / 75						
0200	150 / 300	4 / 8	6 / 12	5 / 10						50 / 125						
0300	150 / 450	4 / 12	6 / 18	5 / 15						50 / 175						
0400	150 / 600	4 / 16	6 / 24	1 / 16						100 / 275						
0500	150 / 750	4 / 20	6 / 30	1 / 17						50 / 325						
0600	150 / 900	4 / 24	6 / 36	1 / 17	100 / 100					75 / 400	300 / 300					
0700	150 / 1050	6 / 30	6 / 42	1 / 18	50 / 150					50 / 450						
0800	150 / 1200	6 / 36	6 / 48	1 / 19						50 / 500						
8 HR	1200	36	48	19	150				8 HR 1453	500		300			8 HR 800	+ 653
0900	150 / 150	6 / 6	6 / 6	1 / 1						75 / 75						
1000	150 / 300	6 / 12	6 / 12	1 / 2						100 / 175						
1100	150 / 450	6 / 18	6 / 18	1 / 3						75 / 250						
1200	150 / 600	6 / 24	6 / 24	1 / 4						75 / 325						
1300	150 / 750	6 / 30	6 / 30	1 / 5	100 / 100					100 / 425	175 / 175					
1400																
1500 OR	1400 / 2150								OR	75 / 500			100	102	165 / 175 / 0	
1600	125 / 2275	6 / 36	6 / 6	1 / 1					2353	300 / 800				55		
8 HR	2275	36	36	6					16 HR. 3806	800		175	100	55	16 HR. ~~1130~~	1930
1700	125 / 125	6 / 6	OFF	1 / 1												
1800	~~250~~ 125 / 250	6 / 12	OFF	1 / 2	100 / 100					125 / 125				40 / 40		
1900	125 / 375	6 / 18		1 / 3												
2000	125 / 500	6 / 24		1 / 4						150 / 275				40 / 80		
2100	125 / 625	6 / 30		1 / 5												
2200	125 / 750	6 / 36		1 / 6						150 / 425				30 / 110		
2300	125 / 875	6 / 42		1 / 7						100 / 525						
2400	125 / 1000	6 / 48		1 / 8	100 / 200					100 / 625				30 / 140		
8 HR								1254	24 HR 5062						24 HR 2695	+ 2367

MEDCOM - 2006

509-113 NSN 7540-00-634-4122

MEDICAL RECORD | PROGRESS NOTES

DATE	
9/13/03 1000	NO Δ's from previous assessment. [redacted] ICT, [illegible]
9/13/03 1300	Picked up by OR staff & transported to OR via Gurney NAD noted VSS [redacted], ICT, [illegible]
1700	Pt returned from OR, went to recovery. NGT taken out in OR. J tube G tube placed to gravity drain, JP to RUQ sanguinous drainage. Urine pink-tinged per foley cath. Vec turned off @ 1630, Versed infusing @ 6mg/hr, Tentanyl @ 50meg/hr, D5 1/2 NS c̄ 20kcl @ 125cc/hr @ll infusing to ⓛAC. ⓡAC HL. Dressing on ⓛ flank removed and D'd packed c̄ wet saline 4x4 gauze. Covered c̄ abd pad and tape [redacted] UTA
2200	Pt dressing on ⓛ flank changed @ 2100. Serosanguinous drng on drsg. G tube and J tube s̄ drng. [redacted] UTAN
2300	Dr. [redacted] notified of ST. Will repeat CBC if HR stays 130's. MSOY given ~~2230~~ 2230 + 2300. Cuff BP reading SBP ~20 mm lower than Aline. Pt moving hands but not following commands or opening eyes. [redacted]

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility) [redacted]

REGISTER NO. | WARD NO.

PROGRESS NOTES

Medical Record

MEDCOM - 2007

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

CRITICAL CARE FLOW SHEET

(b)(6)-2

LOS DATA	
DOA	11 Sep 03
DOS	11 Sep / 13 Sep
POD	3 / 1

24 HOUR DATA	
24 Hour Balance	+64
24 Hour Intake	4654
24 Hour Output	4590
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 MAJ/DN	ICU	14 Sep 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade; date; hospital or medical facility)*

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOWCHART

☐ OTHER EXAMINATION Or EVALUATION ☐ OTHER(*Specify*)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R		2					2				2				2				2					
	RADIAL L		2					2				2				2				2				-	
	DORSALIS PEDIS R		2					2				2				2				2					
	DORSALIS PEDIS L		2					2				2				2				2					
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale			1					1				1				1				1					
			3					3				3				3				3					
			8					8				8				8				8					
EDEMA			Gen					Gen				Gen				Gen				Gen					
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)			✓					✓				✓				✓				✓					
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)			ST					ST				ST				ST				✓					
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)			✓																						
HYGIENE	BED BATH															✓									
	FOLEY CARE																								
	ORAL CARE		✓																						
MOBILITY	BEDREST		✓					✓				✓				✓				✓					
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE		✓					✓				✓				✓				✓					
	HOB 30 DEGREES							15°				15°													
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE		Comfy																						
	PAIN SCALE (1-10)		2					VFA				VFA													
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN (2) Soft & Flat (1) Distended			2					2				2				2				2					
BOWEL SOUNDS (active all quads)			–					–				–				–				–					
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph								✓				✓													
FOLEY CATHETER PATENT			✓					✓				✓				✓				✓					
VOIDING CLEAR, YELLOW URINE q.s.			Pink					Ruddy				Pink				X									
SKIN INTEGRITY	No Breakdown							✓				✓													
	Surgical Wounds		✓					✓				✓				✓				✓					
	Rashes, Lac's, etc		✓					✓				✓				✓				✓					
DRESSING (Dry & Intact: specify site below)																									
#1 ant. abd midline			✓					✓				✓				✓				✓					
#2 GSW ⓓ Flank			✓					✓				✓				✓				✓					
#3																									

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
18g	ⓡ AC	11 Sep 03	ø s/s of infection or infiltration
16g	ⓛ AC	11 Sep 03	ø s/s of infection or infiltration
DOD A-line	ⓡ Radial	11 Sep 03	sutured/opsite – ø s/s infection/infiltrate
18g	ⓛ Bicep	14 Sep 03	patent. spike, silkotape

MEDCOM - 2009

PUPIL SIZE		PUPILS
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable / Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment –

DATE:

TIME		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open			2					1				1				1				3					
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response			ET					1 T				1 T				ET				ET					
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response								4				4				4				4					
GLASCOW COMA SCALE (A+B+C)								6T				6T				6T				6T					
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R		2+					2+				2+													
	L		2+					2+				2+													
MOVEMENT (See Motor Function Scale at Top of Page)	RUE		4					4				4				5				5					
	LUE		4					4				4				5				5					
	RLE		4					0				0				–				–					
	LLE		4					0				0				–				–					
GRIP (S) Strong (W) Weak (-) absent	R		3					4				4				5				5					
	L		3					4				4				5				5					
RESPIRATIONS	REGULAR		✓																						
	IRREGULAR		X					X				X													
	UNLABORED		✓					✓				✓				VENT				VENT					
	LABORED		✓					✓				✓													
	SHALLOW																								
	RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL		4					3				3				3				3					
	LUL		4					3				3				3				3					
	RLL		4					3				3				3				3					
	LLL		4					3				3				3				3					
	BOTH BASES		1					3				3				3				3					
COUGH	NONE		✓					✓				✓				✓									
	SPONTANEOUS																			✓					
	PRODUCTIVE																								
	NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear			✓													white clear				X					
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																									
VENTILATOR	Vt		700					700				700				700				700					
	FiO2		40					40				40				40				40					
	RATE (SIMV/CMV)		12					12				6				12				12					
	PEEP / CPAP		5					5				5				5				5					
	PRESS. SUPPORT							0				0													
OXYGEN DELIVERY DEVICE	NC (l/min)																								
	FM (l/min)																								
ETT # 8	NRBM (l/min)																								
	ETT 23 cm gums							✓				✓				✓				✓					
ETT CARE / POSITION CHANGE																									
ETT / NT SUCTIONED			✓					✓		✓		✓				✓		✓		✓					
INCENTIVE SPIROMETRY DONE																									
COUGH / DEEP BREATH																									
INITIALS			(b)(6)-2					(b)(6)-2				(b)(6)-2				(b)(6)-2				(b)(6)-2					

ACLU-RDI 1099 p.794

DOD 006062

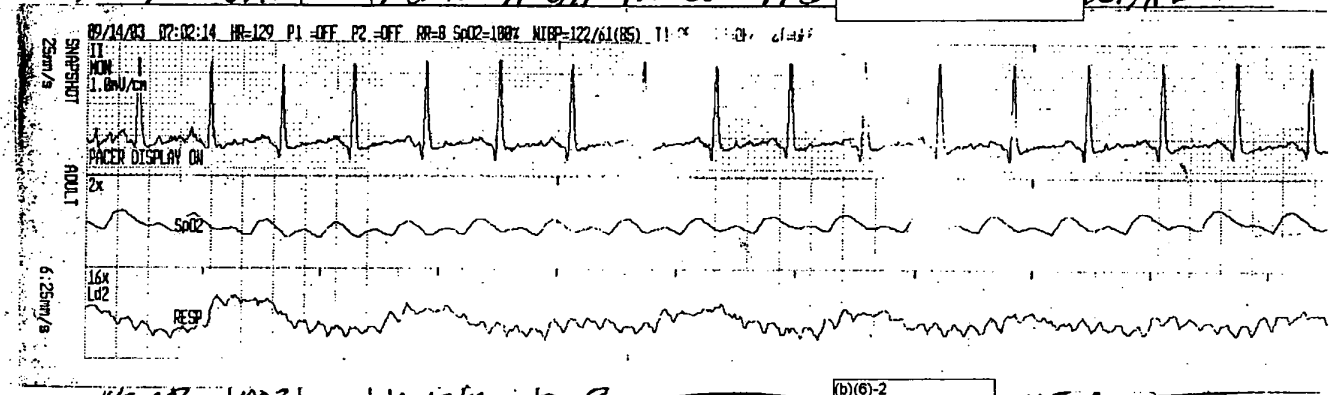
VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100	99.4 ax	115	11/12	120/62	100%	148/58	82										
0200	100.2 ax	119	12		100	142/63	87										
	100 ax																
0300		125	22/12	120/62	100%	126/87	100										
0400	100.6 ax	125	12	120/63	100%	138/77	94										
0500	100.3 ax	121	16/12	124/60	100%	138/68 124/93	90 108										
0600	100.3	132	12	112/71	100%												
0700	100.1 (A)	128	12	122/61	100												
0800	100.1 (A)	133	10	121/61	100												
0900	100.4 A	137	15	125/65	100												
1000	100.4 (A)	136	21	125/58	100												
1100	100.1 (A)	131	22	123/62	100												
1200	100.8 (A)	139	22	116/62	95												
1300	101 (A)	137	22	113/63	100												
1400		127	22	114/53	100												
1500	100.2	130	22	124/60	100												
1600	101.1	121	21	129/62	100												
1700		122	21	122/59	100												
	100.5																
1800		115	22	128/66	100												
	100.3																
1900		112	22	134/64	100												
2000		110	20	129/63	100												
	99.8																
2100		109	21	122/60	100												
	100.1																
2200																	
2300	100.1	103	20	117/52	100%												
2400																	

MEDCOM - 2011

NSN 7540-00-634-4123

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
14Sep03	02		Dressing ↑ to (L) flank. Mod. amt but not soaked to chux. HR ↑ 130's - CBC Sent. T = 100° ax - notified LTC [redacted] who will notify surgeon in OR. Instructed to give Tylenol 650 mg PR now. Assessement done - Generalized edema. PT moving upper extremities c̄ strong grip at times but not following commands. [redacted] MAT/An
14Sep03	0530		Unable to flush or draw blood off A line - cath D'C - ϕ s/s of infection @ site. Cath. intact. [redacted] MAT/An
14Sep03	0700		See flowsheet for assessment. Pt c̄ episodes of agitation Flexing Arms towards Chest c̄ ↑ HR 130's-140's. Pt does not follow Commands. G & J Tubes to drainage bags c̄ drainage. JP Patent, L intact c̄ ~~Ro~~ Serous Sanguine drainage. Generalized edema to include sclera. Will Continue to monitor. [redacted] ICT, An
14Sep03	0919		↓ Vent rate to 10. NAD Noted. VSS [redacted] ICT, An
14Sep03	0935		Lasix 20mg IV given [redacted] ICT, An
14Sep03	0945		Fentanyl att turned off [redacted] ICT, An



14Sep03	1003		↓ rate to 8 [redacted] ICT, An
14Sep03	1102		↓ rate ~~off~~ to 6 [redacted] ICT, An
14Sep03		1220	Pt ~~Sat~~ desaturated 80's. placed vent rate back to 12 BPM. Versed ↑ 2mg/hr. SAT ↑ 100%. Will Cont. to monitor. [redacted] ICT/An

MEDCOM - 2012

	INTAKE										OUTPUT						
	PIV	Versed	Fentanyl	IVPB						Total	Urine	G-tube	SP	J-tube		Total	COMMENTS
0100	125 125	6 6	1 1								75 75						
0200	125 250	6 12	1 2								100 175		30 30				
0300	125 375	6 18	1 3								125 300		30 60				
0400	125 500	6 24	1 4								100 400		30 90				
0500	125 625	6 30	1 5								100 500						
0600	125 750	6 36	1 6	150							50 550		30 120				
0700	125 875	6 42	1 7								100 650						
0800	125 1000	6 48	1 8								75 725		40 160				
8 HR	1000	48	8	150						8 HR. 1206	725		160			8 HR. 885	④321
0900	125 125	6 6	1 1								100 100						
1000	125 250	3 9	.5 1.5								800 900		35 35				LASIX 20mg IV @ 0855
1100	125 375	1 10	0 1.5								600 1500						
1200	125 500	1 11									125 1625						
1300	125 625	1 12		100 100							225 1850						
1400	125 750	2 14									100 1950		40 75				
1500	125 875	2 16									150 2100						
1600	125 1000	2 18		50 150						1169	125 2225					2325	
8 HR	1000	18	1.5	150						16 HR. 2375	2260		75			16 HR. 3210	
1700	125 125	2 2									125 125						
1800	125 250	2 4									75 200						
1900	125 375	2 6		100 100							100 300		25 25				
2000	125 500	2 8									150 450						
2100	125 625	2 10									75 525		+75	175			
2200	125 750	2 12									100 625		25 50	25 175			
2300	125 875	4 19	6 6	50 150							200 825						4654 4590 64
2400	125 1000	2 21	2 8	100 250						2279	150 1070		15 65	50 245		1380	
8 HR	1000	21	8	250						24 HR. 4654	1070		65	245		24 HR. 4590	+64

MEDCOM - 2013

509-113 NSN 7540-00-634-4122

MEDICAL RECORD | PROGRESS NOTES

DATE 14 Sep 03 (1400) Assumed care of pt. Drsg change and linen change posterior GSW c̄ wel/dry drsg, scant bleeding noted c̄ removal of drsg ~~[illegible]~~ (b)(6)-2

(1500) Assessment per flowsheet. Lungs c̄ mild rhonchi throughout, ~~sputum suction~~ ETT suctioned for scant white → clear secretions. Pt aggitated with procedure restrains maintained to protect tubes and drains. Abd midline drsg dry & intact. remains c̄ absent bowel sounds. Continues c̄ blood tinged urine, QS.

(1530) Pt appears more aggitated c̄ increased contraction of upper extremities, MSO4 given per order (b)(6)-2

(1630) Pt c̄ continued fever. GS aware, orders written (b)(6)-2

(1730) Temp 100.5. will continue to assess (b)(6)-2

(1915) Pt c̄ bloody secretions on suctioning ETT. Noted bloody sputum coming up ETT. HO notified will monitor (b)(6)-2

(1930) Pt c̄ ↑ aggitation MSO4 2mg given, will monitor (b)(6)-2

2010 Pt fighting against restraints. MSO4 2mg given will monitor

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility) (b)(6)-4

REGISTER NO. | WARD NO.

PROGRESS NOTES

Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 2014

CRITICAL CARE FLOW SHEET

(b)(6)-2

LOS DATA	
DOA	11SEP03
DOS	11 SEP / 13 SEP
POD	1/2

24 HOUR DATA	
24 Hour Balance	-4246
24 Hour Intake	2764
24 Hour Output	7010
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			X
Side Rails Up			X
Bed in Low Position			X

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 USAN	ICU #1	15 SEP 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade; date; hospital or medical facility)*

(b)(6)-4

- ☐ HISTORY/PHYSICAL
- ☒ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☐ OTHER *(Specify)*
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R	2						2								2									
	L	2						2								2									
	DORSALIS PEDIS R	2						2								2									
	L	2						2								2									
SKIN (1) Dry (4) Cool (7) Jaundiced (2) Clammy (5) Flushed (8) Color Normal (3) Warm (6) Cyanotic (9) Pale		1 3 8						1 3 8								1 3 8									
EDEMA		*														X									
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)		SR						✓								✓									
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)		ST						ST								ST									
SWAN GANZ CATHETER (Zeroed & calibrated)		0																							
ARTERIAL LINE (zeroed & calibrated)		0																							
HYGIENE	BED BATH																								
	FOLEY CARE																								
	ORAL CARE																								
MOBILITY	BEDREST	✓						✓								✓									
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE	✓						✓								✓									
	HOB 30 DEGREES																								
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE	Sedated					Sedated								Sedated										
	PAIN SCALE (1-10)	Kalayaqit																							
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended	*														X									
BOWEL SOUNDS (active all quads)		0						~~0~~	~~0~~							✓									
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT		✓						✓								✓									
VOIDING CLEAR, YELLOW URINE q.s.								✓								✓									
SKIN INTEGRITY	No Breakdown							✓								✓									
	Surgical Wounds	✓						✓								✓									
	Rashes, Lac's, etc															~~✓~~									
DRESSING (Dry & Intact: specify site below)																									
#1 Midline silktape 4x4s		✓						✓								✓									
#2																									
#3																									

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
PIV 18G	(R) AC	11SEP03	0 S/S infection/infiltration
PIV 18G	(L) bicep	14SEP03	patented 0 S/Sx infection/infiltration/0700
PIV 18G	(R) wrist	15SEP03	0 S/Sx infection/infiltration/0700

MEDCOM - 2016

PUPIL SIZE / PUPILS

1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable /Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment –

DATE: 15 SEP 08

TIME		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open		Intubated						1								1									
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response		Intubated						1								1									
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response		Extubated						4								4									
GLASCOW COMA SCALE (A+B+C)								6T								6T									
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R	2						2+																	
	L	2						2+																	
MOVEMENT (See Motor Function Scale at Top of Page)	RUE	4						4								4									
	LUE	4						4								4									
	RLE	0						0								0									
	LLE	0						0								0									
GRIP (S) Strong (W) Weak (-) absent	R	S						S								S									
	L	S						S								S									
RESPIRATIONS	REGULAR	✓						✓																	
	IRREGULAR																								
	UNLABORED	✓						✓								VENT									
	LABORED																								
	SHALLOW																								
	RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL	S						3								S									
	LUL	S						3								S									
	RLL	1						3								3									
	LLL	1						3								3									
	BOTH BASES																								
COUGH	NONE	✓						✓								✓									
	SPONTANEOUS																								
	PRODUCTIVE																								
	NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear		3																							
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																									
VENTILATOR	Vt	700						700								700									
	FiO2	40%						40								40									
	RATE (SIMV/CMV)	12						12								12									
	PEEP / CPAP	5						5								5									
	PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE ETT # 8.0	NC (l/min)																								
	FM (l/min)																								
	NRBM (l/min)																								
	ETT 23 cm gums	✓						✓								✓									
ETT CARE / POSITION CHANGE								✓	✓	✓	✓	✓	✓												
ETT / NT SUCTIONED																									
INCENTIVE SPIROMETRY DONE																									
COUGH / DEEP BREATH																									
INITIALS		(b)(6)-2						(b)(6)-2								(b)(6)-2									

MEDCOM - 2017

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100	99.9 M	107	22	128/68	98%												
0200		111	21	123/55	99%												
0300	102 Ax	120	20	119/54	97%												
0400		128	22	134/52	100%												Tylenol Sy
	102.5																650mg
0500		128	23	107/54	99%												
	102.2																
0600	101.9	123	21	121/54	100%												
0700	101.4 (A)	117	21	120/59	100%												
0800	101.8 (A)	119	20	123/56	100%												
0900	101 (E)	112	20	122/59	100%												
1000	101 (A)	113	19	121/56	100%												
1100	101.7 (A)	121	23	109/53	100%												
1200	100.7 (A)	125	20	120/56	100												
1300	101.8 (A)	129	22	121/53	100%												
1400	101 (A)	125	21	96/49	98												
1500	101.9	123	20	115/52	97												
1600																	
1700	103.8	134	21	99/37	100												
1800	102.5	136	24	112/47	100												
1900		134	22	121/31	98												
2000	101.6	134	12	119/52	100												
2100	100.6	125	20	111/57	98												
2200	100.2	114	20	112/54	100%												
2300		115	20	108/58	99%												
2400	100.4	119	21	104/49	100%												

ACLU-RDI 1099 p.802

DOD 006070

NSN 7540-00-634-4123

MEDICAL RECORD			NURSIN[illegible]OTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
15SEP03	0030		Pt agitated and sats ↓ to 85%, Dr [redacted] (b)(6)-2 @ bedside Fentanyl turned on and 100mcg bolus given @ 2230. Rate set @ 100mcg/hr. Continued agitation but sats ↑ing rebolused @ 2300. ABG drawn and sent to lab. No vent Ds p̄ ABG. Generalized edema especially to sclera. JP drainage serosanguinous, J tube drainage green. OG tube drainage. [redacted] (b)(6)-2 LT, AN
	0400		Pt HR ↑ to 120s, temp ↑ to 102°, notified Dr [redacted] (b)(6)-2 pt given 650mg hydrol PR [redacted] (b)(6)-2 LT, AN
	0430		IV in (R) AC Dc'd ∅ signs of infiltration but patent 72 hours 18G placed in (R) wrist and blood drawn [redacted] (b)(6)-2 LT, AN
15Sep03	0630		Supine c̄ soft restraints. Generalized edema. J & G Tubes to drainage patent c̄ greenish liquid drainage. JP drain Patent c̄ serous drainage. D5½NS c̄ 20mEq KCl @ 125cc/hr. Versed 2mg/hr & Fentanyl 100mcg/hr. See flowsheet for further assessment. [redacted] (b)(6)-2 LT, AN
15Sep03	0745		Desaturation to 88 RR 23 ST 120's. Pt suctioned. Given Bolus of Versed 2mg, Fentanyl 100mcg & MSO4 2mg IV. Sats ↑ 97-98%. RR 22 ST 120's. Will Continue to monitor. Will notify Physician when in [redacted] (b)(6)-2 LT, AN
15Sep03	1100		No Δ's from previous assessment. Dr [redacted] (b)(6)-2 informed of previous desaturations. No new orders. [redacted] (b)(6)-2
15Sep03		1320	Episodes of desaturation to 80's. RR ↑ 20's. ETT & oral suctioned c̄ NS. frequently. Thick brown/yellow secretions. Continues to desat. Dr [redacted] (b)(6)-2 informed. Instructed to ↑ rate from 8 back to 12. Will Continue to monitor. [redacted] (b)(6)-2 LT, AN
15Sep03		1415	Pt's BP ↓ 96/49 HR 125 RR 21 O_2 SAT 98%. Dr [redacted] (b)(6)-2 informed. Saw Pt. RAN 2 Consecutive BP Checks 98/41 & 99/39 respectively. INSTRUCTED TO watch Pt. EVENING SHIFT Nursing Staff informed. [redacted] (b)(6)-2 LT, AN

[redacted] (b)(6)-2

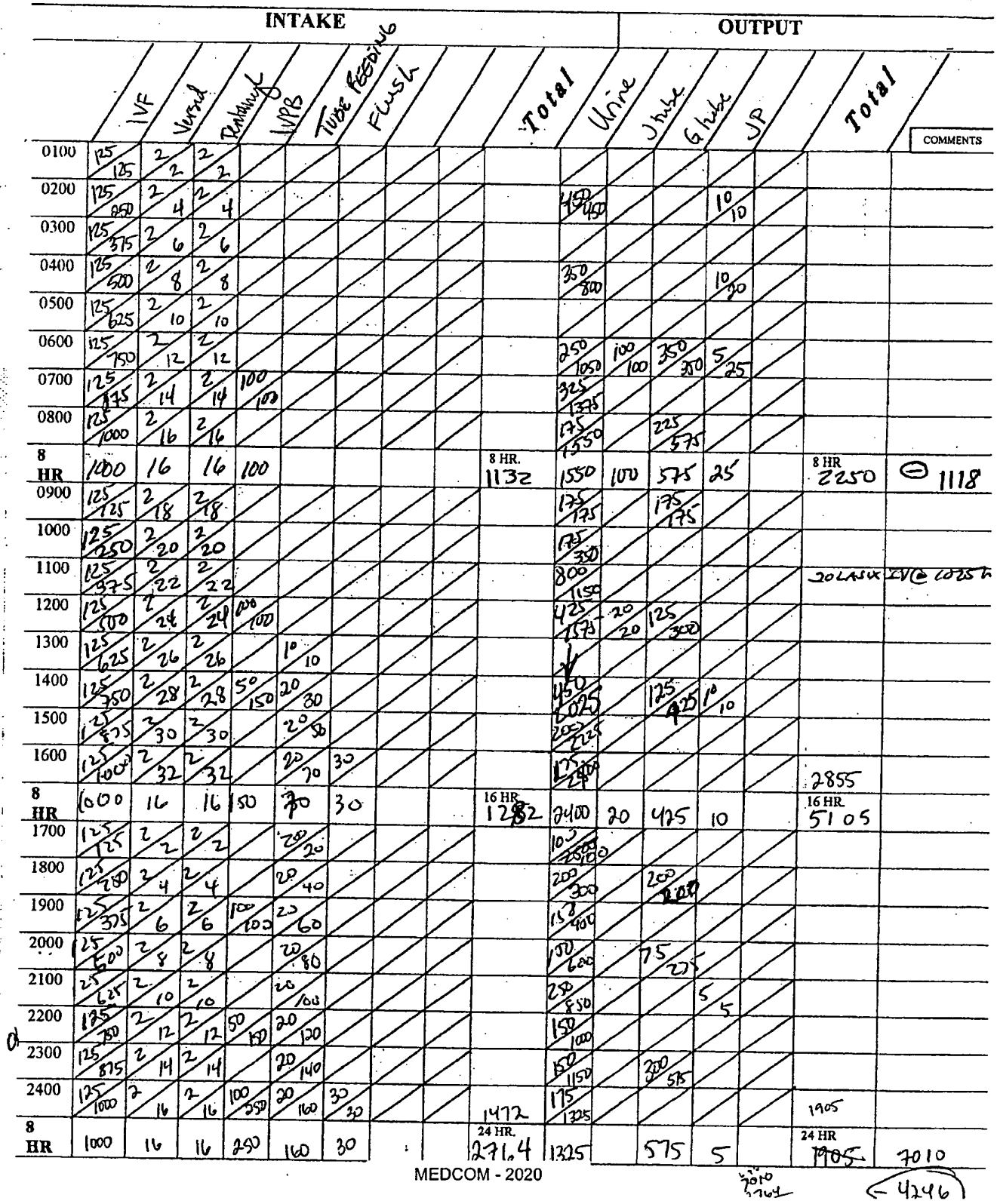
MEDCOM - 2019

	INTAKE									OUTPUT						
	IVF	Versed	Rehamnyl	IVPB	Tube Feeding	Flush			Total	Urine	J tube	G tube	JP		Total	COMMENTS
0100	125 / 125	2 / 2	2 / 2													
0200	125 / 250	2 / 4	2 / 4							450 / 450			10 / 10			
0300	125 / 375	2 / 6	2 / 6													
0400	125 / 500	2 / 8	2 / 8							350 / 800			10 / 20			
0500	125 / 625	2 / 10	2 / 10													
0600	125 / 750	2 / 12	2 / 12							250 / 1050	100 / 100	350 / 350	5 / 25			
0700	125 / 875	2 / 14	2 / 14	100 / 100						325 / 1375						
0800	125 / 1000	2 / 16	2 / 16							175 / 1550		225 / 575				
8 HR	1000	16	16	100					8 HR. 1132	1550	100	575	25		8 HR 2250	⊖ 1118
0900	125 / 125	2 / 18	2 / 18							175 / 175		175 / 175				
1000	125 / 250	2 / 20	2 / 20							175 / 350						
1100	125 / 375	2 / 22	2 / 22							800 / 1150					20 LASIX	IV @ 1025 h
1200	125 / 500	2 / 24	2 / 24	100 / 100						425 / 1575	20 / 20	125 / 300				
1300	125 / 625	2 / 26	2 / 26		10 / 10											
1400	125 / 750	2 / 28	2 / 28	50 / 150	20 / 30					450 / 2025		125 / 425	10 / 10			
1500	125 / 875	2 / 30	2 / 30		20 / 50					200 / 2225						
1600	125 / 1000	2 / 32	2 / 32		20 / 70	30				175 / 2400					2855	
8 HR	1000	16	16	150	70	30			16 HR. 1282	2400	20	425	10		16 HR. 5105	
1700	125 / 125	2 / 2	2 / 2		20 / 20					100 / 2500 / 100						
1800	125 / 250	2 / 4	2 / 4		20 / 40					200 / 300		200 / 200				
1900	125 / 375	2 / 6	2 / 6	100 / 100	20 / 60					150 / 400						
2000	125 / 500	2 / 8	2 / 8		20 / 80					150 / 600		75 / 275				
2100	25 / 625	2 / 10	2 / 10		20 / 100					250 / 850			5 / 5			
2200	125 / 750	2 / 12	2 / 12	50 / 150	20 / 120					150 / 1000						
2300	125 / 875	2 / 14	2 / 14		20 / 140					150 / 1150		200 / 575				
2400	125 / 1000	2 / 16	2 / 16	100 / 250	20 / 160	30 / 30			1472	175 / 1325					1905	
8 HR	1000	16	16	250	160	30			24 HR. 2764	1325		575	5		24 HR ~~1905~~	7010

MEDCOM - 2020

7010
2764

← 4246



509-113 NSN 7540-00-634-4122

MEDICAL RECORD | PROGRESS NOTES

DATE	
1930 18 Sep 03	Assumed care of pt, assessment per flowsheet pt c fever 101° Dr (b)(6)-2 aware, no orders given. (b)(6)-2
1715	Pt c fever Temp 103° A. Kepalos applied to groin and armpits. will monitor. (b)(6)-2
1800	Pt c change in status Temp 102°. ⊖ change in VS or physical status. (b)(6)-2
(1930)	Pt SII suctioned x 2 passes. small amt of white mucus c blood tinging. Pt tolerated well. continue to be febrile. (b)(6)-2
(2100)	⊖ change in status. assessment unchanged cont c fever. will continue to monitor (b)(6)-2

(Continue on reverse side)

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)* | REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

MEDCOM - 2021

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

CRITICAL CARE FLOW SHEET

(b)(6)-2

LOS DATA	
DOA	11SEP03
DOS	11 SEP/13SEP
POD	2 5/3

24 HOUR DATA	
24 Hour Balance	-1034
24 Hour Intake	3126
24 Hour Output	4160
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside			
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

(b)(6)-2

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 1LT AN	ICU#1	16 SEP 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade;date; hospital or medical facility)*

(b)(6)-4

- ☐ HISTORY/PHYSICAL
- ☐ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☐ OTHER(*Specify*)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 2022

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R	2			2			2				2			2					2				-	
	RADIAL L	2			2			2				2			2					2					
	DORSALIS PEDIS R	2			2			2				2			2					2					
	DORSALIS PEDIS L	2			2			2				2			2					2					
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale		1			1			1				1			1					1					
		3			3			3				3			3					3					
		8			8			8				8			8					8					
EDEMA		*			—			Generalized				—								+1					
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)		S1S2			S1S2			✓				✓			✓					✓					
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)		ST			ST			ST				ST			ST					ST					
SWAN GANZ CATHETER (Zeroed & calibrated)		ø			ø										/					/					
ARTERIAL LINE (zeroed & calibrated)		ø			ø										/					/					
HYGIENE	BED BATH											✓													
	FOLEY CARE											✓													
	ORAL CARE											✓													
MOBILITY	BEDREST	✓			✓			✓				✓			✓					✓					
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE	✓			✓			✓				✓			✓					✓					
	HOB 30 DEGREES																								
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE	Resting			Resting			Resting				Resting			Resting					Resting					
	PAIN SCALE (1-10)	9			9			9				9			9					5					
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat	2			2			2				2			2					2					
	(1) Distended																								
BOWEL SOUNDS (active all quads)		X4			X4			X4				X4			X4					X4					
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT		✓			✓			✓				✓			✓					✓					
VOIDING CLEAR, YELLOW URINE q.s.																									
SKIN INTEGRITY	No Breakdown																								
	Surgical Wounds	✓			✓			✓				✓			✓					✓					
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1 tube dressings		✓			✓			✓				✓			✓					✓					
#2																									
#3																									

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
PIV 18G	⑨Bicep	14SEP03	Patent DS/SX infection/infiltration /1400
PIV 18G	⑧Wrist	15SEP03	Patent DS/SX infection/infiltration/1900
18G IVP	⑤Bicep	14SEP03	DS/S Inf/Infiltration patent 1400/1900
18G IVP	⑩WRIST	15SEP03	DS/S Inf/Infiltration patent 1420/1920

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable /Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment --

DATE: 16SEP08

TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open	4			4			2				2			2					2					
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response	ETT			AT			T				T			ETT					1					
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response	4			4			4				4			4					4					
GLASCOW COMA SCALE (A+B+C)	8			8			T				T			7					7					
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — R	3+			3+			2+				2+			2+					2+					
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — L	3+			3+			2+				2+			2+					2+					
MOVEMENT (See Motor Function Scale at Top of Page) — RUE	4			4			4				4			1/2					1/2					
MOVEMENT (See Motor Function Scale at Top of Page) — LUE	4			4			4				4			1/2					1/2					
MOVEMENT (See Motor Function Scale at Top of Page) — RLE	0			0			0				0			0					0					
MOVEMENT (See Motor Function Scale at Top of Page) — LLE	0			0			0				0			0					0					
GRIP (S) Strong (W) Weak (-) absent — R	S			S			4				S			/					/					
GRIP (S) Strong (W) Weak (-) absent — L	S			S			4				S			/					/					
RESPIRATIONS — REGULAR	V			V			V				V			V					V					
RESPIRATIONS — IRREGULAR	E			E			E				E			E					E					
RESPIRATIONS — UNLABORED	N			N			N				E			N					N					
RESPIRATIONS — LABORED	T			T			T				N			T					T					
RESPIRATIONS — SHALLOW											T													
RESPIRATIONS — RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RUL	5			5			3				3			5					5					
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — LUL	5			5			3				3			5					3					
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RLL	1			1			1/3				1/3			1/3					1/3					
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — LLL	1			1			1/3				1/3			1/3					1/3					
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — BOTH BASES							1/3				1/3			1/3					1/3					
COUGH — NONE	✓			✓			Suction				~			✓					✓					
COUGH — SPONTANEOUS				✓																				
COUGH — PRODUCTIVE																								
COUGH — NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear							5				~								/					
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin							3				~								/					
VENTILATOR — Vt	700			700			700			700	700	700		700					700					
VENTILATOR — FIO2	40%			40%			40%			40%	40%	40%		40%					40%					
VENTILATOR — RATE (SIMV/CMV)	12			12			12			11	10	10		8					12					
VENTILATOR — PEEP / CPAP	5			5			5			5	5	5		5					5					
VENTILATOR — PRESS. SUPPORT							0			0	0	0		0					0					
OXYGEN DELIVERY DEVICE — NC (l/min)																								
OXYGEN DELIVERY DEVICE — FM (l/min)																								
OXYGEN DELIVERY DEVICE — NRBM (l/min)																								
ETT # 8.0 — ETT 23 cm gums	✓			✓			✓							✓					✓					
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED		✓		✓		✓	✓		✓		✓	✓		✓					✓					
INCENTIVE SPIROMETRY DONE																								
COUGH / DEEP BREATH																								
INITIALS	(b)(6)-2																		(b)(6)-2					

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100		117	20	112/56	100%												
0200	101'	130	21	120/90	97%												
0300	102.4	120	22	107/55	100%												
0400	103'	126	23	118/56	100%												
0500	103.2	128	19	102/49	99%												
0600	103'	144	25	110/56	95%												
0700	101.0(A)	131	18	115/56	100												
0800	101.5(A)	129	22	116/58	100												
0900	101.2(A)	134	29	118/60	100												
1000	102.3(A)	125	19	111/56	100	RATE OF 11 ON Vent											
1100	103.2(A)	139	22	121/42	97%	VENT RR 10											
1200	103.6(A)	144	22	102/40	100%												
1300	103.2(A)	135	22	113/51	100%	Vent RR 9											
1400	102.3(A)	123	18	104/56	100%	VENT RR 8											
1500	101.7(A)	120	18	115/55	98%	VENT RR 6											
1600	101.3(A)	125	21	108/55	99%												
1700	100.4(A)	114	18	102/51	99%	VENT to 12											
1800	99.4(A)	100	16	113/59	100%												
1900	99.1(A)	102	15	116/56	100%												
2000	99.0(A)	120	26	115/54	100%												
2100	100.1(A)	120	24	112/55	100%												
2130	101(A)																
2200	101.5 A	125	20	124/61	86%	9 to 100%											
2300	102.3 A	131	23		100%												
2400	100.4 A	119	18	109/56	100%												

	INTAKE									OUTPUT						
	IVF	IVPB	Tube Feed	~~Ad~~	Fent	VERSED			Total	Urine	Glube	JP			Total	COMMENTS
0100	105 / 105		20 / 20	25 / 25	2 / 2	2 / 2										
0200	105 / 200		240 20 / 240	25 / 50	2 / 4	2 / 4				325 / 325	175 / 175					
0300	125 / 375		60 20 / 300	25 / 75	2 / 6	2 / 6										
0400	125 / 500		20 / 80		2 / 8	2 / 8				250 / 575						
0500	125 / 625		20 / 100		2 / 10	2 / 10										
0600	125 / 750		20 / 120		2 / 12	2 / 12				225 / 800	350 / 525					
0700	125 / 875	20	175 / 240		2 / 14	2 / 14				150 / 950	175 / 700					
0800	125 / 1000	100 / 100	20 / 160		2 / 16	2 / 16				125 / 1075						
8 HR	1000	100	160		16	16			8 HR 1292	1075	700	0			8 HR 1775	−483
0900	125 / 125		20 / 20		2 / 2	2 / 2			1292	125 / 125						
1000	75 / 200		20 / 40		2 / 4	2 / 4				175 / 300						
1100	75 / 275		20 / 60		2 / 6	2 / 6				100 / 400						
1200	75 / 350	100 / 100	20 / 80		2 / 8	2 / 8				150 / 550						
1300	75 / 425		20 / 100		2 / 10	2 / 10				175 / 725	275 / 275					
1400	75 / 500	50 / 150	20 / 120		2 / 12	2 / 12				150 / 875	50 / 325	15 / 15				
1500	75 / 575	9	20 / 140		2 / 14	2 / 14				100 / 975	200 / 525					
1600	75 / 650		20 / 160		2 / 16	2 / 16				75 / 1050	75 / 600					
8 HR	650	150	160		16	16			16 HR. 2284	1050	60	15			16 HR. 2900	−616
1700	75 / 75		20 / 20		2 / 2	2 / 2				50 / 50	25 / 25					
1800	75 / 150		20 / 40		2 / 4	2 / 4				200 / 250	125 / 150					
1900	75 / 225		20 / 60		2 / 6	2 / 6				50 / 300	50 / 200					
2000	75 / 300		20 / 80		2 / 8	2 / 8				100 / 400	50 / 250	10 / 10				
2100	75 / 375		20 / 100		2 / 10	2 / 10										
2200	75 / 450	50 / 50	20 / 120		2 / 12	2 / 12										
2300	75 / 525		20 / 140		2 / 14	2 / 14			810							5 4160
2400	75 / 600		20 / 160		2 / 16	2 / 16			842	375 / 775	225 / 475				1260	3126 / 1034
8 HR	600	50	160		16	16			24 HR. 3126	775	475	10			24 HR 4160	−1034

MEDCOM - 2026

NSN 7540-00-634-4123

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
16SEP03	0010		Pt remains sedated c̄ 2mg/hr versed and 100 meq Fentanyl for pain. Sclerol edema ①. Incision midline open to air staples present & drainage. Heparin given SQ to ① upper arm. Pt remains restrained [redacted] LTAN
	0220		~~Tylenol 650mg given per NGT, ensure 1 can infused followed by 60cc H2O. IS completed c̄ pt 15x~~ [redacted] LTAN
	0400		Temp continues to ↑, suctioned @ 0200 and @ 0350 brownish mucus and bloody tinges suctioned also wet washcloths placed in axilla, pt uncovered and fan placed on pt [redacted] LTAN
9/16/03	0700		Pt c̄ Periodic episodes of desats into 80's, suctioned 4X's. SAT fluctuating between 90-100% [redacted] LCT, AN
9/16/03	0900		Dr [redacted] informed of temp spikes desaturations; ⊖ Unasyn in pharmacy [redacted] LCT, AN
9/16/03	1100		T 103° (A). Tepid bath given. Linen removed from patient. Temp 102° (A) will cont to monitor. [redacted] LCT, AN
9/16/03		1245	Medicated c̄ Tylenol 650mg PR supp [redacted] LCT, AN
16SEP03		1600	Pt ABG drawn. Pt has desated for 3rd time requiring manuel vent. c̄ bag. MD informed [redacted]
		1700	Pt vent setting returned to 12 bpm [redacted]
		2000	Pt drsg Δ'd as it has soaked through [redacted]
		2130	Pt desated to mid 70's requiring several minutes of manuel ventilation c̄ bag value ~~bag~~ Pt temp 101° @ this time O2 sat back to 100%. [redacted] LTAN

MEDCOM - 2027

CRITICAL CARE FLOW SHEET

(b)(6)-2

LOS DATA	
DOA	11
DOS	11SEP03 / 13SEP03
POD	6/4

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			X
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 LTA N	ICU #1	17SEP03

PATIENT'S IDENTIFICATION (*For typed or written entries give: Name-last, first, Middle; grade; date; hospital or medical facility*)

(b)(6)-4

- ☐ HISTORY/PHYSICAL
- ☒ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☐ OTHER(*Specify*)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 2028

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R	2			2			2																	
	L	2			2			2																	
	DORSALIS PEDIS R	2			2			2																	
	L	2			2			2																	
SKIN (1) Dry (4) Cool (7) Jaundiced (2) Clammy (5) Flushed (8) Color Normal (3) Warm (6) Cyanotic (9) Pale		1 3 8			1 3 8			1 3 8																	
EDEMA																									
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)		S1S2			S1S2			✓																	
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)		ST			ST			ST																	
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH																								
	FOLEY CARE																								
	ORAL CARE				✓			✓																	
MOBILITY	BEDREST	✓			✓			✓																	
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE	✓			✓			✓																	
	HOB 30 DEGREES																								
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE	Fent			Fent			[illegible]																	
	PAIN SCALE (1-10)	9H			9H			[illegible]																	
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended	2			2			2																	
BOWEL SOUNDS (active all quads)		X4			X4			✓																	
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT		✓			✓			✓																	
VOIDING CLEAR, YELLOW URINE q.s.		\																							
SKIN INTEGRITY	No Breakdown							✓																	
	Surgical Wounds	✓			✓			✓																	
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1 J tube G tube JP drain 4x4		✓			✓			✓																	
#2																									
#3																									

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
PIV 18G	(R) bicep	16SEP03/2300	Patent 0S/SX infection/infiltration/0700
PIV 18G #2	(L) forearm	16SEP03/2300	Patent 0S/SX infection/infiltration/0700

MEDCOM - 2029

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable /Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment –

DATE: 17SEP03

TIME		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open		4			4			4																	
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response		ETT			ETT			1 T																	
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response		4			4			4																	
GLASCOW COMA SCALE (A+B+C)								9T																	
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R	2+			2+			2+																	
	L	2+			2+			2+																	
MOVEMENT (See Motor Function Scale at Top of Page)	RUE	4			4			4																	
	LUE	4			4			4																	
	RLE	0			0			0																	
	LLE	0			0			0																	
GRIP (S) Strong (W) Weak (-) absent	R	S			S			U																	
	L	S			S			U																	
RESPIRATIONS	REGULAR																								
	IRREGULAR	V			V			V																	
	UNLABORED	E			E			E																	
	LABORED	N			N			N																	
	SHALLOW	T			T			T																	
	RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL	5			5			5																	
	LUL	5			5			5																	
	RLL	1			1			5/1																	
	LLL	1			1			5/1																	
	BOTH BASES							5/1																	
COUGH	NONE																								
	SPONTANEOUS	✓			✓																				
	PRODUCTIVE																								
	NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																									
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																									
VENTILATOR	Vt	700			700			700																	
	FiO2	40%			40%			40%																	
	RATE (SIMV/CMV)	12			12			12																	
	PEEP / CPAP	5			5			5																	
	PRESS. SUPPORT							0																	
OXYGEN DELIVERY DEVICE	NC (l/min)																								
	FM (l/min)																								
ETT # 8.0	NRBM (l/min)																								
	ETT 23 cm gums							✓																	
ETT CARE / POSITION CHANGE																									
ETT / NT SUCTIONED			✓		✓			✓																	
INCENTIVE SPIROMETRY DONE																									
COUGH / DEEP BREATH																									
INITIALS		(b)(6)-2			(b)(6)-2			(b)(6)-2																	

MEDCOM - 2030

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100	101.5 (A)	116	18	109/53	100%												
0200	101.9	128	19	117/52	98%												
0300	102.2	127	19	109/62	99%												
0400	101.9	119	18	103/53	100%												
0500	102.5	122	18	113/42	100%												
0600	102.6	123	18	107/54	100%												
0700	102.4 (A)	133	19	113/51	100%												
0800	102.1 (A)	122	18	116/55	100%												
0900																	
1000																	
1100																	
1200																	
1300																	
1400																	
1500																	
1600																	
1700																	
1800																	
1900																	
2000																	
2100																	
2200																	
2300																	
2400																	

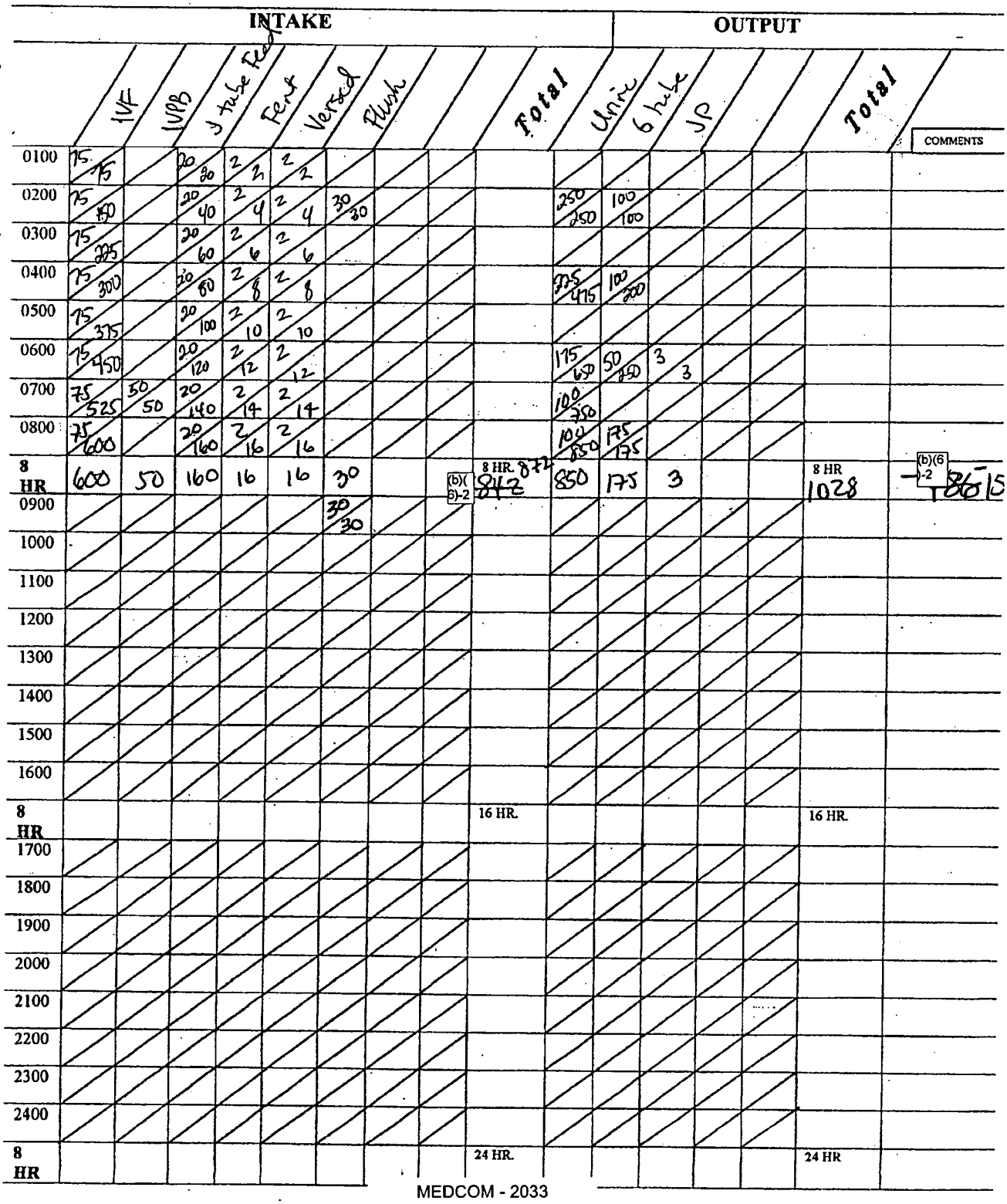
ACLU-RDI 1099 p.815

DOD 006083

NSN 7540-00-634-4123

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
17 SEP 03	0015		Temp ↑; ice pack to groin and axillae also wet washcloth to neck. IV's dc'd in (L) bicep and (R) wrist; 18G placed in ~~(L) bicep and~~ (R) bicep and (L) forearm. Betadine placed to midline incision staples because redness around staples. (b)(6)-2 [redacted]
	0200		Pt suctioned; yellow thick sputum pt spontaneously cyclis (b)(6)-2 [redacted]
	0400		Pt suctioned, lung CTA (B) p̄ suctioning remain diminished in bases oral care complete (b)(6)-2 [redacted]
17 SEP 03		0620	NAD noted. D5NS c̄ 20 mEq KCl @ 75cc/hr. VERSED 2mg/h & Fentanyl @ 100mcg/hr. J-Tube Patent infusing VIVONEX @ 20cc/hr. G Tube c̄ Moderate amt of green liquid drainage. JP Patent c̄ minimal amt. of serous fluid. See flowsheet for further assessment will continue to monitor & prepare for 1000 hrs transfer to civilian facility — (b)(6)-2 [redacted]

MEDCOM - 2032


INTAKE
OUTPUT
IVF
IVPB
J tube Feed
Free
Versed
Flush
Total
Urine
G tube
JP
Total
COMMENTS
0100
0200
0300
0400
0500
0600
0700
0800
8 HR
0900
1000
1100
1200
1300
1400
1500
1600
8 HR
1700
1800
1900
2000
2100
2200
2300
2400
8 HR
8 HR. 842
16 HR.
24 HR.
8 HR 1028
16 HR.
24 HR
(b)(6)-2
(b)(6)-2

MEDCOM - 2033

MEDIC[illegible] CORD - PATIENT RELEASE / DISCH[illegible] INSTRUCTIONS

For use of this form, see MEDCOM Circular 40-5

DIRECTIONS: To be completed by attending provider and other staff at time of patient release following an outpatient procedure, extended care/treatment or discharge from an inpatient hospital stay.

SECTION I
TO BE COMPLETED BY PRIVILEGED PROVIDER

1. DATE OF PROCEDURE/ADMISSION: 11 Sept 01
2. ADMITTING/DIAGNOSIS: Gunshot wound Left Flank
3. PERTINENT LAB, X-RAY, FINDINGS:
   Lumbar Spine fracture.
   Lumbar Fracture, Left Renal laceration
   Repair of duodenum + IVC
   Appendectomy
4. PROCEDURES, TREATMENT, HOSPITAL COURSE:
   Exploratory laparotomy - repair of IVC, Duodenum. Found to have left renal laceration
   Nl left ureter. Through + Through injury to liver. Pogata bag placed.
   Pt. taken back to OR 2 days later
5. ~~FINAL DIAGNOSIS AND CONDITION AT DISCHARGE~~:
   for re-exploration. G-tube, J-tube, JP drain placed. Abdomen closed
   Pt. on tube feeds - Vivonex 20cc/hr
   Pt. on logroll procedure for spine fracture.
6. ACTIVITY: Bedrest / Logroll
7. DIET: NPO / Tube Feeds
8. MEDICATIONS:
   ☐ Medications have been prescribed for home use. See separate list and special instructions or see below.
   Verred 5mg in syringe
   Fentanyl 50ug in syringe
   MSO4 5mg in syringe
   Levaquin 500mg IV QD
9. INSTRUCTIONS *(To Home Health Providers, Patient, etc)*:
   Pt. intubated - on verred + fentanyl drips. Vivonex tube feeds. G-tube to drainage. JP to bulb suction
   Logroll only - Spine fracture
10. DISCHARGING PROVIDER: (b)(6)(2) [redacted]
    (b)(6)-2

PATIENT IDENTIFICATION
(b)(6)-4

SECTION II
TO BE COMPLETED BY OTHER STAFF, AS APPROPRIATE

1. DISPOSITIONED TO: ☐ HOME ☐ DUTY ☐ OTHER
   ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER
2. ACCOMPANIED BY: ☐ FAMILY ☐ FRIEND ☐ OTHER
3. PATIENT EDUCATION:
   Completed and patient prepared for home care. ☐ YES ☐ NO
   If no, explain:
   Patient ☐ states ☐ demonstrates understanding of home care needs.
   Printed educational materials provided:
4. Clinical outcomes met and post-discharge/release referrals made.
   ☐ YES ☐ NO If no, explain:
5. If transferred to another health care facility, report called to nurse.
   ☐ YES ☐ NO If no, explain:
6. NUTRITION CARE - Comments:
7. MEDICATIONS:
   Explained by: ☐ NURSE ☐ PHYSICIAN ☐ PHARMACIST
   Printed medication literature provided. ☐ YES ☐ NO
   Patient states understanding of prescribed medications. ☐ YES ☐ NO
8. EQUIPMENT/SUPPLIES PROVIDED:
9. FOLLOW-UP APPOINTMENTS, POINT OF CONTACT & PHONE:
10. FOR PROBLEMS OR EMERGENCY, CONTACT & PHONE:
11. COMPLETED BY:

(Signature and Title) *(Date and Time)*

I HAVE RECEIVED A COPY OF AND UNDERSTAND THESE INSTRUCTIONS.

(Patient/Responsible Adult's Signature) *(Date and Time)*

MEDCOM FORM 691-R (TEST) (MCHO) MAR 99 PREVIOUS EDITIONS ARE OBSOLETE MC V1.00

MEDCOM - 2034

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

For use of this form, see AR 40-407, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA LITTER BY CPT (b)(6)-2

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY MAF (b)(6)-2

3. DATE 11 SEPT 07 TIME PATIENT ARRIVED IN SUITE 0100

4. PATIENT IN ROOM TIME 0400 NUMBER R #1

5. PREOPERATIVE EMOTIONAL STATUS

☐ CALM ☑ ANXIOUS ☑ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS: EMERGENT PROCEDURE

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	MAF (b)(6)-2	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

☑ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

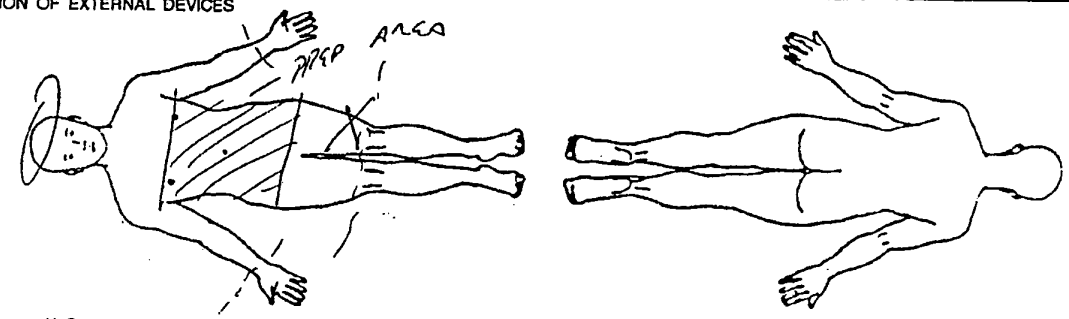
COMMENTS: all bony areas padded

8. SKIN PREPARATION

HAIR REMOVAL ☑ YES ☐ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☑ RAZOR ☐ CLIP
COMMENTS: No Blood or Nicks

PREP SOLUTION *(Specify)* BETA / BETA
SITE: NIPPLES TO PUBIS BY WHOM: MAF (b)(6)-2
SITE: BY WHOM:
COMMENTS: No Pooling or Reaction

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Strap ═══ Tourniquet

10. COUNTS		C = Correct I = Incorrect: Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☑ Yes ☐ No		C	C		
Needle Sharp	☑ Yes ☐ No		C	C	(b)(6)-2	
Instrument	☑ Yes ☐ No		C	C		(b)(6)-2
Other	☐ Yes ☐ No					

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

(b)(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☑ YES ☐ NO 35/95

☑ ESU NO: FOC 000434
GROUND PAD: BRAND Valleylab
LOT NO: 07N11

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

MEDCOM - 2035

14. MEDICATIONS/ORDERS					
IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☐					
MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
None					

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S):
N.S.

OTHER ORDERS None	TIME	CARRIED OUT BY

(b)(6)-2

PHYSICIAN'S SIGNATURE Yay

15. X-RAY IN OPERATING ROOM YES ☐ NO ☑ IF YES, SITE

16. LABORATORY SPECIMENS		
SPECIMEN (S) YES ☐ NO ☑	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☑	NAME	NAME
CULTURE (C) YES ☐ NO ☑	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

18. DRESSING/IMMOBILIZATION *(Specify)*
BOGTA BAC c̄ WET LAPS
COVERED BY ZOBAN DRESSING
SIDE WOUND GAUZE DRESSING

17. TUBES, DRAINS/PACKING YES ☐ NO ☐			
TYPE/SIZE	1. 16 Fr Foley	2.	3.
SITE	1.	2.	3.

19. ADDITIONAL INFORMATION
SURGEONS = MAT (b)(6)-2, LTC (b)(6)-2
WC = 4
ESU PAD SITE clean & Dry Pre & Post-OP

20. OPERATION(S) PERFORMED
EXP LAP

21. PATIENT TRANSFERRED TO	TIME	METHOD
PACU	0450	LITTER

22. REGISTERED NURSE SIGNATURE (b)(6)-2

REVERSE OF DA FORM 5179-1, OCT 87

*U.S. GPO: 1996-404-613/40449

MEDCOM - 2036

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

For use of this form, see AR 40-407, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: litter BY: Cpt (b)(6)-2

2. PATIENT IDENTIFIED AND PROCEDURE VERIFIED BY: (b)(6)-2 RN

3. DATE: 13 Sept 03 TIME PATIENT ARRIVED IN SUITE:

4. PATIENT IN ROOM TIME: NUMBER: B

5. PREOPERATIVE EMOTIONAL STATUS

☐ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER (Specify)

COMMENTS: Intubated

6. NURSING PERSONNEL

ASSIGNED SCRUB	Spc (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	Maj (b)(6)-2	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify)

☑ SUPINE #1 #2 ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

COMMENTS: Arms on bil armboards < 90°. Safety strap over thighs

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☑ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

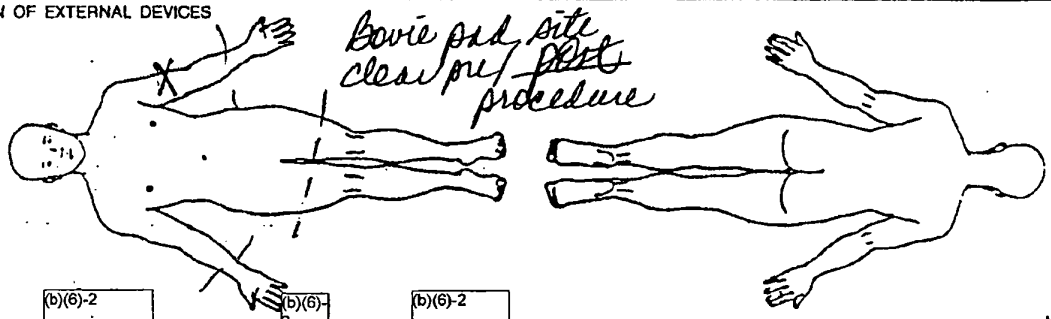
PREP SOLUTION (Specify): Betadine scrub/sol

SITE: abd BY WHOM: Maj

SITE: Scrotum BY WHOM: (b)(6)-2

COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety S(b)(6)-2 === Tourniquet (b)(6)-2 (b)(6)-2

15/6/2

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☐ Yes ☐ No		C	C	(b)(6)-2	(b)(6)-2
Needle Sharp	☐ Yes ☐ No				Spc	Maj
Instrument	☐ Yes ☐ No					
Other	☐ Yes ☐ No					

11. PATIENT IDENTIFICATION (For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)

(b)(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☑ YES ☐ NO

☐ ESU NO: Valleylab 00438

GROUND PAD: BRAND Valleylab LOT NO: 70011, exp 2005-04

☐ ESU NO:

GROUND PAD: BRAND LOT NO:

☐ BIPOLAR NO:

MEDCOM - 2037

14. MEDICATIONS/ORDERS					
IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA)				YES ☐	NO ☐
MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S):
0 9N S

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIG (b)(6)-2 [redacted] MAJ [illegible]

15. X-RAY IN OPERATING ROOM YES ☐ NO ☑ IF YES, SITE

16. LABORATORY SPECIMENS		
SPECIMEN (S) YES ☑ NO ☐	NAME appendix (S) discarded	NAME
FROZEN SECTION (FS) YES ☐ NO ☐	NAME	NAME
CULTURE (C) YES ☐ NO ☐	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING	YES ☑	NO ☐	
TYPE/SIZE JP drains x 1	1.	2. abd	3.
SITE RR #16F x 1	1.	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
4x8s
silk tape

19. ADDITIONAL INFORMATION
18F x 1

Surgeons - (b)(6)-2 [redacted] / (b)(6)-2 [redacted] / (b)(6)-2 [redacted] / (b)(6)-2 [redacted]

20. OPERATION(S) PERFORMED
~~Exp Lap~~ Drain, Removal Bogata Bag, Washout Abd, Gastrostomy Tube Closure Wd, ~~Cy~~ Cysto, Placement J tube

21. PATIENT TRANSFERRED TO	TIME	METHOD
SICU #1	1525	letter

22. REGISTERED NURSE S (b)(6)-2 [redacted] May [illegible]

REVERSE OF DA FORM 5179-1, OCT 87

*U.S. GPO: 1996-404-613/40449

MEDCOM - 2038

Ventilator Flow Sheet

Date	Time	Mode	V_T	Rate	FiO2	PEEP	PIP	MAP	SpO_2	HR	BP	I:E	RT Init
9/11	0600	SIMV	700	12	70	5	24	10	100	65	127/87	1:2.3	(b)(6)-2
9/11	0800	SIMV	700	12	70	5	23	11	100	77	125/78	1:2.3	
9/11	1000	SIMV	700	12	70	5	23	10	100	75	109/68	1:2.3	
9/11	1200	SIMV	700	12	50	5	23	10	100	91	114/65	1:2.3	
9/11	1400	SIMV	700	12	50	5	22	10	100	108	114/66	1:2.3	
9/11	1600	SIMV	700	12	40	5	23	11	100	96	120/61	1:2.3	
9/11	1800	SIMV	700	12	40	5	25	11	100	111	105/61	1:2.3	
9/11	2000	SIMV	700	12	40	5	22	11	100	114	113/64	1:2.3	
9/11	2200	SIMV	700	12	35	5	23	9	100	103	114/68	1:2.3	
9/12	2400	SIMV	700	12	35	5	24	10	99	105	121/74	1:2.5	
9/12	0200	SIMV	700	12	35	5	23	9	100	89	132/78	1:2.3	
9/12	0400	SIMV	700	12	35	5	25	11	100	82	114/73	1:2.3	
9/12	0600	SIMV	700	12	35	5	30	12	100	98	135/73	1:2.3	
9/12	0800	SIMV	700	12	40	5	26	12	100%	85	128/61	1:2.3	
9/12	1000	SIMV	700	12	40	5	26	12	100%	94	115/69	1:2.3	
9/12	1200	SIMV	700	12	40	5	26	11	100%	96	120/65	1:2.3	
9/12	1400	SIMV	700	12	40	5	26	11	100%	101	138/66	1:2.3	
9/12	1600	SIMV	700	12	40	5	26	12	100%	102	132/70	1:2.3	
9/12	1800	SIMV	700	12	40	5	26	11	100%	95	135/51	1:2.3	
9/12	2000	SIMV	700	12	40	5	26	10	100	106	114/68	1:2.3	
9/12	2200	SIMV	700	12	40	5	26	11	100%	89	134/63	1:2.3	
9/12	2400	SIMV	700	12	40	5	27	10	100%	91	142/66	1:2.3	
9/13	0200	SIMV	700	12	40	5	30	12	100%	88	131/65	1:2.3	
9/13	0400	SIMV	700	12	40	5	24	12	100	96	143/66	1:2.3	
9/13	0600	SIMV	700	12	40	5	28	10	100	106	140/67	1:2.3	
9/13	0800	SIMV	700	12	40	5	26	11	100	99	130/66	1:2.3	
9/13	1000	SIMV	700	12	40	5	27	12	100	101	137/64	1:2.3	
9/13	1200	SIMV	700	12	40	5	25	11	100	140	124/78	1:2.3	
9/13	1800	SIMV	700	12	40	5	27	11	100	92	141/67	1:2.3	

(b)(6)-4

ACLU-RDI 1099 p.823

DOD 006091

Ventilator Flow Sheet

Date	Time	Mode	V_T	Rate	FiO2	PEEP	PIP	MAP	SpO_2	HR	BP	I:E	RT Init
9/13	2000	SIMV	700	12	40	5	27	12	100	94	151/74	1:2.3	(b)(6)-2
9/13	2200	SIMV	700	12	40	5	27	12	100	107	143/65	1:2.3	
9/14	2400	SIMV	700	12	40	5	26	11	100	110	147/63	1:2.3	
9/14	0200	SIMV	700	12	40	5	25	10	100	135	117/66	1:2.3	
9/14	0400	SIMV	700	12	40	5	27	12	100	121	115/61	1:2.3	
9/14	0600	SIMV	700	12	40	5	25	12	100	132	129/71	1:2.3	
9/14	0800	SIMV	700	12	40	5	26	12	100	131	129/64	1:2.3	
9/14	0956	SIMV	700	10									
9/14	1003	SIMV	700	8	40	5	16	11	100	129	114/54	1:2.3	
9/14	1102			6									
9/14	1200	SIMV	700	6	40	5	26	12	100	140	116/62	1:2.3	
9/14	1400	SIMV	700	6	40	5	26	12	100	135			
9/14	1600	SIMV	700	12	40	5	27	14	100	148	135/75	1:2.3	
9/14	1620	SIMV	700	12	40	5	12	9	100	150	134/64	1:2.3	
9/14	1700	SIMV	700	12	40	5	21	12	100	115	126/60	1:2.3	
9/14	2000	SIMV	700	12	40	5	21	12	100	110	129/73	1:2.3	
9/14	2200	SIMV	700	12	40	5	22	12	100	111	122/68	1:2.3	
9/14	2400	SIMV	700	12	40	5	26	9	100	101	124/64	1:2.3	
9/15	0200	SIMV	700	12	40	5	24	6	99	110	123/71	1:2	
9/15	0400	SIMV	700	12	40	5	25	11	93	159	112/61	1:1.2	
9/15	0600	SIMV	700	12	40	5	23	13	100	115	121/54	1:2.1	
9/15	0800	SIMV	700	12	40	5	24	11	99	121	109/69	1:2.1	
9/15	1000	SIMV	700	12	40	5	18	10	100	115	121/62	1:2.1	
9/15	1030	SIMV	700	11	40	5							
9/15	1115	SIMV	700	10	40	5							
9/15	1215	SIMV	700	9	40	5							
9/15	1230	SIMV	700	9	40	5	23	12	100	123	112/53	1:2.3	
9/15	1315	SIMV	700	8	40	5							
9/15	1345	SIMV	700	12	40	5							

Suction

Time	Int
1700	(b)(6)-2
1901	
2400	
0315	

(b)(6)-4

Ventilator Flow Sheet

Date	Time	Mode	V_T	Rate	FiO_2	PEEP	PIP	MAP	SpO_2	HR	BP	I:E	RT Init
9/15	1400	SIMV	700	12	40	5	21	13	99	125	66/49	1:2.1	(b)(6)-2
9/15	1600	SIMV	700	12	40	5	22	12	97	131	113/48	1:2.1	
9/15	1800	SIMV	700	12	40	5	22	13	100	135	107/40	1:2.1	
9/15	2000	SIMV	700	12	40	5	23	12	100	126	119/50	1:2.1	
9/15	2200	SIMV	700	12	40	5	20	11	100	114	114/59	1:2.1	
9/16	2400	SIMV	700	12	40	5	17	9	98	119	106/44	1:2.1	
9/16	0200	SIMV	700	12	40	5	22	7	100	126	120/56	1:2.1	
9/16	0400	SIMV	700	12	40	5	18	11	100	129	118/56	1:2.1	
9/16	0600	SIMV	700	12	40	5	43	15	95	146	100/49	1:2.1	
9/16	0800	SIMV	700	12	40	5	22	12	100	121	12/61	1:2.1	
9/16	0925	SIMV	700	11	40	5							(b)(6)-2
9/16	1010	SIMV	700	10	40	5							
9/16	1020	SIMV	700	10	40	5	21	10	100	133	111/56	1:2.1	(b)(6)-2
9/16	1235	SIMV	700	9	40	5							
9/16	1315	SIMV	700	8	40	5							
9/16	1350	SIMV	700	8	40	5	11	4	100	125	112/56	1:2.1	
9/16	1600	SIMV	700		40	5	18	5	100	118	105/50	1:2.1	
9/16	1830	SIMV	700	12	40	5	19	6	100	101	111/59	1:1.9	
9/16	2000	SIMV	700	12	40	5	24	12	100	110		1:1.9	
9/16	2200	SIMV	700	12	40	5	28	14	100	125		1:1.9	
9/17	0000	SIMV	700	12	40	5	19	10	100	117	117/61	1:1.9	
9/17	0200	SIMV	700	12	40	5	18	11	100	123	110/52	1:1.9	
9/17	0425	SIMV	700	12	40	5	22	7	100	123	108/53	1:1.9	

(b)(6)-4

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI	UNIT	RANK	SSN
(b)(6)-4		CIV	(b)(6)-4 (b)(6)-4

Physician:	Ward:	X STAT / Routine	Date and Time:	Reported by:	Date and Time:
Maj (b)(6)-2	EMT		10Sep 2340	(b)(6)-2	10Sep 2350

Chemistry (I-STAT)

X	TEST	RESULT	REF. RANGE
	Na	141	128-145 mmol/L
	K	2.9	3.3-4.7 mmol/L
	Cl	104	98-108 mmol/L
	pH		7.35-7.45
	PCO2		35-45 mmHg
	PO2		80-90 mmHg
	TCO2		18-33 mmol/L
	HCO3		22-28 mmol/L
	sO2		95-99%
	BEecf		(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN	16	7-22 mg/dL
	Glu	213 *	73-118 mg/dL
	Creat	1.7 +	0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL

Urinalysis

Color		Straw/Yellow
Clarity		Clear
Glucose		Negative
Bilirubin		Negative
Ketone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative-Trace
Urobili		Negative
Nitrite		Negative
Leuko		Negative

Urine Microscopic

WBC		Epi
RBC		Mucus
Bacteria		Yeast
Casts:		
Crystals:		
Other:		

Chemistry (Piccolo Analyzer)

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-84 U/L
	ALT		10-47 U/L
	AMY		14-97 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat		0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		128-145 mmol/L

Microbiology

Source:		
FecLeuk		Negative
Gram St		
WetPrep		Negative
KOH		No Fungal Elements
OccBld		Negative
O&P		No Ova/Parasite

Blood Bank

ABO/Rh	B	POS
T&C		
T&S		

HCG

Urine		Negative
Serum		Negative

Hematology

X	TEST	RESULT	REF. RANGE
	WBC	18.5 *	4.8-10.8 x10(3)/uL
	RBC	4.76	4.2-6.1 x10(6)/uL
	Hgb	15.2	12.0-18.0 g/dL
	Hct	45.5	35.0-60.0%
	MCV	95.6	80.0-99.0 fl
	MCH	31.9	27.0-31.0 pg
	MCHC	33.4	33.0-37.0 g/dL
	Plt	323	130-400 x10(3)/uL
	LY%	26.5	15.0-55.0%
	LY#	4.9	0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Imm
RBC Morph:	
Plt verify:	
Spun Crit	35-60%

Malaria Smear

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate

Sed Rate		1hr = 0-20 mm

Coagulation

PT		10-13 seconds
APTT		22.1-33.7 seconds
FDP		Negative

Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Negative

Other: Type: ~~Cross~~, I-Stat 6, Cl, CBC, UH

MEDCOM - 2042

FiO2 80% Temp: 94.0

ABG & CBC

21st COMBAT SUPPORT HOSPITAL	LABORATORY RESULTS FORM (Subject to Privacy Act of 1974)		
LAST FIRST MI (b)(6)-4 [redacted]	UNIT	RANK	SSN -
Physician: (b)(6)-2 [redacted] Ward: ICU1	X STAT / Routine — Date and Time: 0510 11 Sep 03	Reported by: (b)(6)-2 [redacted]	Date and Time: 11 Sept 03

X Chemistry (I-STAT)

X	TEST	RESULT	REF. RANGE
	Na		128-145 mmol/L
	K		3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH	7.326	7.35-7.45
	PCO2	37.0	35-45 mmHg
	PO2	298	80-90 mmHg
	TCO2	20	18-33 mmol/L
	HCO3	19	22-28 mmol/L
	sO2	100%	95-99%
	BEecf	-7	(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL

Urinalysis

Color		Straw/Yellow
Clarity		Clear
Glucose		Negative
Bilirubin		Negative
Ketone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative-Trace
Urobili		Negative
Nitrite		Negative
Leuko		Negative

Urine Microscopic

WBC		Epi
RBC		Mucus
Bacteria		Yeast
Casts:		
Crystals:		
Other:		
Other:		

X Chemistry (Piccolo Analyzer)

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-84 U/L
	ALT		10-47 U/L
	AMY		14-97 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat		0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		128-145 mmol/L

Microbiology

Source:		
FecLeuk		Negative
Gram St		
WetPrep		Negative
KOH		No Fungal Elements
OccBld		Negative
O&P		No Ova/Parasite

Blood Bank

ABO/Rh		
T&C		
T&S		

HCG

Urine		Negative
Serum		Negative

Hematology

X	TEST	RESULT	REF. RANGE
	WBC	15.6	4.8-10.8 x10(3)/uL
	RBC	4.00	4.2-6.1 x10(6)/uL
	Hgb	12.4	12.0-18.0 g/dL
	Hct	37.7	35.0-60.0%
	MCV	94.2	80.0-99.0 fl
	MCH	30.9	27.0-31.0 pg
	MCHC	32.9	33.0-37.0 g/dL
	Plt	89	130-400 x10(3)/uL
	LY%	7.3	15.0-55.0%
	LY#	1.1	0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Imm
RBC Morph:	
Plt verify:	
Spun Crit	35-60%

Malaria Smear

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate

Sed Rate		1hr = 0-20 mm

Coagulation

PT		10-13 seconds
APTT		22.1-33.7 seconds
FDP		Negative

Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Negative

MEDCOM - 2043

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

, FIRST, MI: (b)(6)-4 | UNIT | DOB | RANK | SSN

sician: | Ward: OR | STAT / Routine | Specimen Date and Time: | Reported by: (b)(6)-2 | Date and Time: 11 Sep 0315

Chemistry (i-STAT)

6+ 7+ 8+ Glu Crea

X	TEST	RESULT	REF. RANGE
	Na		128-145 mmol/L
	K		3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH	7.309	7.35-7.45
	PCO2	30.3	35-45 mmHg
	PO2	335	80-90 mmHg
	TCO2		18-33 mmol/L
	HCO3	15	22-28 mmol/L
	sO2	100	95-99%
	BEecf	-11	(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL
	Lactate		0.90-1.70 mmol/L

Chemistry (Piccolo Analyzer)

Chem 12 MetLyte8 BMP Liver

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-84 U/L
	ALT		10-47 U/L
	AMY		14-97 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat		0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		128-145 mmol/L

Hematology

CBC Malaria H/H

X	TEST	RESULT	REF. RANGE
	WBC	14.3	4.8-10.8 x10(3)/uL
	RBC	2.71	4.2-6.1 x10(6)/uL
	Hgb	8.9	12.0-18.0 g/dL
	Hct	25.5	35.0-60.0%
	MCV	94.0	80.0-99.0 fl
	MCH	32.8	27.0-31.0 pg
	MCHC	34.9	33.0-37.0 g/dL
	Plt	115	130-400 x10(3)/uL
	LY%	10.9	15.0-55.0%
	LY#	1.6	0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Immature cells

RBC Morph:

Plt verify:

Spun Crit | | 35-60%

Urinalysis

Color		Straw/Yellow
Clarity		Clear
Glucose		Negative
Bilirubin		Negative
Ketone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative-Trace
Urobili		Negative
Nitrite		Negative
Leuko		Negative

Urine Microscopic

WBC		Epi	
RBC		Mucus	
Bacteria		Yeast	
Casts:		Spermatozoa	
Crystals:		Amorph Sed	
Other:			
Other:			

Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Negative
DOA		Negative
CK-MB		< 4.3 ng/mL
Troponin I		< 0.19 ng/mL
Myoglobin		< 107 ng/mL

Microbiology

Source:		
FecLeuk		Negative
Gram Stain		
WetPrep		Negative
KOH		No Fungal Elements
OccBld		Negative
O&P		No Ova/Parasite

HCG

Urine		Negative
Si		ve

MEDCOM - 2044

Malaria Smear

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate

Sed Rate		1hr = 0-20 mm

Coagulation

PT		10-13 seconds
APTT		22.1-33.7 seconds
FDP		Negative
D-Dimer		Negative
Fibrinogen		200-400 mg/dL

Blood Bank

ABO/Rh		
T&C		
T&S		

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST FIRST MI (b)(6)-2	UNIT ICU #1	RANK	SSN (b)(6)-2
Physician (b)(6)-2	Ward:	STAT / Routine	Date and Time: 11 Sep 03 1200
Reported [redacted] (b)(6)-2	19/6/12	Date and Time: 11 Sept 1200 HR	

Chemistry (i-STAT) 1230 HR

X	TEST	RESULT	REF. RANGE
	Na	141	128-145 mmol/L
	K	4.9	3.3-4.7 mmol/L
	Cl	113	98-108 mmol/L
	pH	7.306	7.35-7.45
	PCO2	41.9	35-45 mmHg
	PO2	232	80-90 mmHg
	TCO2	23	18-33 mmol/L
	HCO3	21	22-28 mmol/L
	sO2	100%	95-99%
	BEecf	-5	(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN	17	7-22 mg/dL
	Glu	157	73-118 mg/dL
	Creat		0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL

Chemistry (Piccolo Analyzer)

X	TEST	RESULT	REF. RANGE
	ALB	3.4	3.3-5.5 g/dL
	ALP	78	26-84 U/L
	ALT	27	10-47 U/L
	AMY	40	14-97 U/L
	AST	45 ↑	11-38 U/L
	Tbil	0.6	0.2-1.6 mg/dL
	BUN	7 14	7-22 mg/dL
	Ca	9.1 7.2	8.0-10.3 mg/dL
	Chol	135	100-200 mg/dL
	CK		30-170 U/L
	CL	106	98-108 mmol/L
	TCO2	20	18-33 mmol/L
	Creat	PD 1.0 0.8	0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu	88 157	73-118 mg/dL
	K	5.0	3.3-4.7 mmol/L
	TProtein	8.9	6.4-8.1 g/dL
	Na	138	128-145 mmol/L

Hematology

X	TEST	RESULT	REF. RANGE
	WBC	12.7	4.8-10.8 x10(3)/uL
	RBC	4.32	4.2-6.1 x10(6)/uL
	Hgb	13.4	12.0-18.0 g/dL
	Hct	40.7	35.0-60.0%
	MCV	94.0	80.0-99.0 fl
	MCH	31.0	27.0-31.0 pg
	MCHC	33.0	33.0-37.0 g/dL
	Plt	145	130-400 x10(3)/uL
	LY%	7.6	15.0-55.0%
	LY#	1.0	0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Imm
RBC Morph:	
Plt verify:	
Spun Crit	35-60%

Urinalysis

Color		Straw/Yellow
Clarity		Clear
Glucose		Negative
Bilirubin		Negative
Ketone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative-Trace
Urobili		Negative
Nitrite		Negative
Leuko		Negative

Urine Microscopic

WBC		Epi
RBC		Mucus
Bacteria		Yeast
Casts:		
Crystals:		
Other:		

Microbiology

Source:		
FecLeuk		Negative
Gram St		
WetPrep		Negative
KOH		No Fungal Elements
OccBld		Negative
O&P		No Ova/Parasite

Blood Bank

ABO/Rh		
T&C		
T&S		

HCG

Urine		Negative
Serum		Negative

Malaria Smear

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate

Sed Rate		1hr = 0-20 mm

Coagulation

PT		10-13 seconds
APTT		22.1-33.7 seconds
FDP		Negative

Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Negative

Other: CBC, ABG, [illegible] Vent - FiO2 50% TV 700 [illegible]

MEDCOM - 2045

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST (b)(6)-4	UNIT ICU 1	RANK	SSN -
Physician: Ward:	STAT / Routine — Date and Time: 11 Sep 1240	Reported by: (b)(6)-2	Date and Time: 11 Septe 1306

Chemistry (I-STAT)

X	TEST	RESULT	REF. RANGE
	Na	141	128-145 mmol/L
	K	5.0	3.3-4.7 mmol/L
	Cl	112	98-108 mmol/L
	pH		7.35-7.45
	PCO2		35-45 mmHg
	PO2		80-90 mmHg
	TCO2		18-33 mmol/L
	HCO3		22-28 mmol/L
	sO2		95-99%
	BEecf		(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN	17	7-22 mg/dL
	Glu	163	73-118 mg/dL
	Creat	1.1	0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL

Urinalysis

Color		Straw/Yellow
Clarity		Clear
Glucose		Negative
Bilirubin		Negative
Ketone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative-Trace
Urobili		Negative
Nitrite		Negative
Leuko		Negative

Urine Microscopic

WBC		Epi
RBC		Mucus
Bacteria		Yeast
Casts:		
Crystals:		
Other:		
Other:		

Chemistry (Piccolo Analyzer)

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-84 U/L
	ALT		10-47 U/L
	AMY		14-97 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN	15	7-22 mg/dL
	Ca	7.1	8.0-10.3 mg/dL
	Chol	100	100-200 mg/dL
	CK		30-170 U/L
	CL	106	98-108 mmol/L
	TCO2	20	18-33 mmol/L
	Creat	1.1	0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu	159	73-118 mg/dL
	K	5.0	3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na	138	128-145 mmol/L

Microbiology

Source:		
FecLeuk		Negative
Gram St		
WetPrep		Negative
KOH		No Fungal Elements
OccBld		Negative
O&P		No Ova/Parasite

Blood Bank

ABO/Rh		
T&C		
T&S		

HCG

Urine		Negative
Serum		Negative

Hematology

X	TEST	RESULT	REF. RANGE
	WBC		4.8-10.8 x10(3)/uL
	RBC		4.2-6.1 x10(6)/uL
	Hgb		12.0-18.0 g/dL
	Hct		35.0-60.0%
	MCV		80.0-99.0 fl
	MCH		27.0-31.0 pg
	MCHC		33.0-37.0 g/dL
	Plt		130-400 x10(3)/uL
	LY%		15.0-55.0%
	LY#		0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Imm
RBC Morph:	
Plt verify:	
Spun Crit	35-60%

Malaria Smear

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate

Sed Rate		1hr = 0-20 mm

Coagulation

PT		10-13 seconds
APTT		22.1-33.7 seconds
FDP		Negative

Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Negative

Patient Istel

MEDCOM - 2046

ABG, CBC, PA-7 TEMP 98.4

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI	UNIT	RANK	SSN
(b)(6)-2	ICU		

Physician:	Ward:	STAT / Routine	Date and Time:	Reported by:	Date and Time:
(b)(6)-2	ICU 1	Routine	12Sep03 0500	(b)(6)-2	12Sep 0515

Chemistry (i-STAT)

X	TEST	RESULT	REF. RANGE
	Na		128-145 mmol/L
	K		3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH	7.462	7.35-7.45
	PCO2	34.1	35-45 mmHg
	PO2	186	80-90 mmHg
	TCO2		18-33 mmol/L
	HCO3	26	22-28 mmol/L
	sO2	100	95-99%
	BEecf	2	(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL

Urinalysis

	Color		Straw/Yellow
	Clarity		Clear
	Glucose		Negative
	Bilirubin		Negative
	Ketone		Negative
	SG		1.010-1.025
	Blood		Negative
	pH		5.0-8.0
	Protein		Negative-Trace
	Urobili		Negative
	Nitrite		Negative
	Leuko		Negative

Urine Microscopic

	WBC		Epi
	RBC		Mucus
	Bacteria		Yeast
	Casts:		
	Crystals:		
	Other:		

Other:

Chemistry (Piccolo Analyzer)

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-84 U/L
	ALT		10-47 U/L
	AMY		14-97 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN	18	7-22 mg/dL
	Ca	7.6	8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	CL	105	98-108 mmol/L
	TCO2	23	18-33 mmol/L
	Creat	0.9	0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu	128	73-118 mg/dL
	K	4.2	3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na	136	128-145 mmol/L

Microbiology

	Source:		
	FecLeuk		Negative
	Gram St		
	WetPrep		Negative
	KOH		No Fungal Elements
	OccBld		Negative
	O&P		No Ova/Parasite

Blood Bank

	ABO/Rh		
	T&C		
	T&S		

HCG

	Urine		Negative
	Serum		Negative

Hematology

X	TEST	RESULT	REF. RANGE
	WBC	11.3	4.8-10.8 x10(3)/uL
	RBC	3.16	4.2-6.1 x10(6)/uL
	Hgb	10.5	12.0-18.0 g/dL
	Hct	29.8	35.0-60.0%
	MCV	94.2	80.0-99.0 fl
	MCH	33.2	27.0-31.0 pg
	MCHC	35.3	33.0-37.0 g/dL
	Plt	126	130-400 x10(3)/uL
	LY%	14.2	15.0-55.0%
	LY#	1.6	0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Imm
RBC Morph:	
Plt verify:	
Spun Crit	35-60%

Malaria Smear

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate

Sed Rate		1hr = 0-20 mm

Coagulation

PT		10-13 seconds
APTT		22.1-33.7 seconds
FDP		Negative

Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Negative

MEDCOM - 2047

98.4 q 4hr CBC, ABG, + STAT 6, Creat

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI: (b)(6)-4 | UNIT | RANK | SSN

Physician: (b)(6)-2 | Ward: ICU1 | STAT / Routine | Date and Time: 13 Sep 03 0515 | Reported by: (b)(6)-2 | Date and Time: 13 Sep 03 0530

Chemistry (I-STAT)

X	TEST	RESULT	REF. RANGE
	Na	140	128-145 mmol/L
	K	3.4	3.3-4.7 mmol/L
	Cl	105	98-108 mmol/L
	pH	7.455	7.35-7.45
	PCO2	40.7	35-45 mmHg
	PO2	218	80-90 mmHg
	TCO2	30	18-33 mmol/L
	HCO3	29	22-28 mmol/L
	sO2	100%	95-99%
	BEecf	5	(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN	19	7-22 mg/dL
	Glu	101	73-118 mg/dL
	Creat	1.0	0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL

Urinalysis

	Color		Straw/Yellow
	Clarity		Clear
	Glucose		Negative
	Bilirubin		Negative
	Ketone		Negative
	SG		1.010-1.025
	Blood		Negative
	pH		5.0-8.0
	Protein		Negative-Trace
	Urobili		Negative
	Nitrite		Negative
	Leuko		Negative

Urine Microscopic

	WBC		Epi
	RBC		Mucus
	Bacteria		Yeast
	Casts:		
	Crystals:		
	Other:		

Other:

Chemistry (Piccolo Analyzer)

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-84 U/L
	ALT		10-47 U/L
	AMY		14-97 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat		0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		128-145 mmol/L

Microbiology

	Source:		
	FecLeuk		Negative
	Gram St		
	WetPrep		Negative
	KOH		No Fungal Elements
	OccBld		Negative
	O&P		No Ova/Parasite

Blood Bank

	ABO/Rh		
	T&C		
	T&S		

HCG

	Urine		Negative
	Serum		Negative

Hematology

X	TEST	RESULT	REF. RANGE
	WBC	9.5	4.8-10.8 x10(3)/uL
	RBC	2.68	4.2-5.1 x10(6)/uL
	Hgb	8.4	12.0-18.0 g/dL
	Hct	25.0	35.0-60.0%
	MCV	93.2	80.0-99.0 fl
	MCH	31.4	27.0-31.0 pg
	MCHC	33.7	33.0-37.0 g/dL
	Plt	135	130-400 x10(3)/uL
	LY%	12.0	15.0-55.0%
	LY#	1.0	0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Imm

	RBC Morph:	
	Plt verify:	
	Spun Crit	35-60%

Malaria Smear

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate

Sed Rate		1hr = 0-20 mm

Coagulation

PT		10-13 seconds
APTT		22.1-33.7 seconds
FDP		Negative

Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Negative

MEDCOM - 2048

21st COMBAT SUPPORT HOSPITAL	LABORATORY RESULTS FORM (Subject to Privacy Act of 1974)		
LAST, FIRST, MI (b)(6)-2	UNIT ICU 1	RANK	SSN -
Physician: (b)(6)-2 Ward:	STAT / X Routine — Date and Time: 1400/13 Sept 0	Reported by: (b)(6)-2	Date and Time: 13 Sept e 1520 H

Chemistry (i-STAT)

X	TEST	RESULT	REF. RANGE
	Na		128-145 mmol/L
	K		3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH		7.35-7.45
	PCO2		35-45 mmHg
	PO2		80-90 mmHg
	TCO2		18-33 mmol/L
	HCO3		22-28 mmol/L
	sO2		95-99%
	BEecf		(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL

Urinalysis

	Color		Straw/Yellow
	Clarity		Clear
	Glucose		Negative
	Bilirubin		Negative
	Ketone		Negative
	SG		1.010-1.025
	Blood		Negative
	pH		5.0-8.0
	Protein		Negative-Trace
	Urobili		Negative
	Nitrite		Negative
	Leuko		Negative
	Urine Microscopic		
	WBC		Epi
	RBC		Mucus
	Bacteria		Yeast
	Casts:		
	Crystals:		
	Other:		
	Other		

Chemistry (Piccolo Analyzer)

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-84 U/L
	ALT		10-47 U/L
	AMY		14-97 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat		0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		128-145 mmol/L

Microbiology

	Source:		
	FecLeuk		Negative
	Gram St		
	WetPrep		Negative
	KOH		No Fungal Elements
	OccBld		Negative
	O&P		No Ova/Parasite

Blood Bank

	ABO/Rh		
	T&C		
	T&S		

HCG

	Urine		Negative
	Serum		Negative

Hematology

X	TEST	RESULT	REF. RANGE
	WBC		4.8-10.8 x10(3)/uL
	RBC		4.2-6.1 x10(6)/uL
	Hgb		12.0-18.0 g/dL
	Hct		35.0-60.0%
	MCV		80.0-99.0 fl
	MCH		27.0-31.0 pg
	MCHC		33.0-37.0 g/dL
	Plt		130-400 x10(3)/uL
	LY%		15.0-55.0%
	LY#		0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Imm
RBC Morph:	
Plt verify:	
Spun Crit	35-60%

Malaria Smear

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate X 2 Runs (b)(6)-2

Sed Rate	>140mm	1hr = 0-20 mm

Coagulation

PT		10-13 seconds
APTT		22.1-33.7 seconds
FDP		Negative

Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Negative

C.SR

MEDCOM - 2049

ABG 100% FiO2

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIR (b)(6)-4	UNIT	RANK	SSN
Physician: ICU	X STAT / Routine — Date and Time: 14Sep03	Reported by: (b)(6)-2	Date and Time: 14Sep03

Chemistry (I-STAT)

X	TEST	RESULT	REF. RANGE
	Na	136	128-145 mmol/L
	K	3.4	3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH	7.699	7.35-7.45
	PCO2	21.8	35-45 mmHg
	PO2	87	80-90 mmHg
	TCO2	27	18-33 mmol/L
	HCO3	27	22-28 mmol/L
	sO2	99	95-99%
	BEecf	7	(-2) - (+3)
	AGap		8-16 mmol/L
	iCa	0.85	0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.2 mg/dL
	Hct	20	35.0-60.0%
	Hgb	7	12.0-18.0 g/dL

Urinalysis

Color		Straw/Yellow
Clarity		Clear
Glucose		Negative
Bilirubin		Negative
Ketone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative-Trace
Urobili		Negative
Nitrite		Negative
Leuko		Negative

Urine Microscopic

WBC		Epi
RBC		Mucus
Bacteria		Yeast
Casts:		
Crystals:		
Other:		

Chemistry (Piccolo Analyzer)

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-84 U/L
	ALT		10-47 U/L
	AMY		14-97 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat		0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		128-145 mmol/L

Microbiology

Source:		
FecLeuk		Negative
Gram St		
WetPrep		Negative
KOH		No Fungal Elements
OccBld		Negative
O&P		No Ova/Parasite

Blood Bank

ABO/Rh		
T&C		
T&S		

HCG

Urine		Negative
Serum		Negative

Hematology

X	TEST	RESULT	REF. RANGE
	WBC		4.8-10.8 x10(3)/uL
	RBC		4.2-6.1 x10(6)/uL
	Hgb		12.0-18.0 g/dL
	Hct		35.0-60.0%
	MCV		80.0-99.0 fl
	MCH		27.0-31.0 pg
	MCHC		33.0-37.0 g/dL
	Plt		130-400 x10(3)/uL
	LY%		15.0-55.0%
	LY#		0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Imm
RBC Morph:	
Plt verify:	
Spun Crit	35-60%

Malaria Smear

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate

Sed Rate		1hr = 0-20 mm

Coagulation

PT		10-13 seconds
APTT		22.1-33.7 seconds
FDP		Negative

Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Negative

MEDCOM - 2050

Venous ABC FiO2 @ 40% Temp - 100.8 (A)

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST (b)(6)-4 | UNIT | RANK | SSN

Physician: (b)(6)-2 | Ward: | X STAT / Routine | Date and Time: 140903 1220 | Reported by: (b)(6)-2 | Date and Time: 1430809

Chemistry (i-STAT)

X	TEST	RESULT	REF. RANGE
	Na	138	128-145 mmol/L
	K	3.5	3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH	7.366	7.35-7.45
	PCO2	51.5	35-45 mmHg
	PO2	37	80-90 mmHg
	TCO2	31	18-33 mmol/L
	HCO3	29	22-28 mmol/L
	sO2	63 ↓	95-99%
	BEecf	4	(-2) - (+3)
	AGap		8-16 mmol/L
	iCa	1.12	0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.2 mg/dL
	Hct	19	35.0-60.0%
	Hgb	6	12.0-18.0 g/dL

Urinalysis

	Color		Straw/Yellow
	Clarity		Clear
	Glucose		Negative
	Bilirubin		Negative
	Ketone		Negative
	SG		1.010-1.025
	Blood		Negative
	pH		5.0-8.0
	Protein		Negative-Trace
	Urobili		Negative
	Nitrite		Negative
	Leuko		Negative

Urine Microscopic

	WBC		Epi
	RBC		Mucus
	Bacteria		Yeast
	Casts:		
	Crystals:		
	Other:		

Other

Chemistry (Piccolo Analyzer)

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-84 U/L
	ALT		10-47 U/L
	AMY		14-97 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat		0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		128-145 mmol/L

Microbiology

	Source:		
	FecLeuk		Negative
	Gram St		
	WetPrep		Negative
	KOH		No Fungal Elements
	OccBld		Negative
	O&P		No Ova/Parasite

Blood Bank

	ABO/Rh		
	T&C		
	T&S		

HCG

	Urine		Negative
	Serum		Negative

Hematology

X	TEST	RESULT	REF. RANGE
	WBC		4.8-10.8 x10(3)/uL
	RBC		4.2-6.1 x10(6)/uL
	Hgb		12.0-18.0 g/dL
	Hct		35.0-60.0%
	MCV		80.0-99.0 fl
	MCH		27.0-31.0 pg
	MCHC		33.0-37.0 g/dL
	Plt		130-400 x10(3)/uL
	LY%		15.0-55.0%
	LY#		0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Imm

RBC Morph:

Plt verify:

Spun Crit		35-60%

Malaria Smear

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate

Sed Rate		1hr = 0-20 mm

Coagulation

PT		10-13 seconds
APTT		22.1-33.7 seconds
FDP		Negative

Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Negative

MEDCOM - 2051

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI: (b)(6)-4 | UNIT: ICU | RANK | SSN

Physician: (b)(6)-2 | Ward: | X STAT / Routine | Date and Time: 14Sep1945 | Received by: (b)(6)-2 | Date and Time: 14Sep03 0250

Chemistry (i-STAT)

X	TEST	RESULT	REF. RANGE
	Na		128-145 mmol/L
	K		3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH		7.35-7.45
	PCO2		35-45 mmHg
	PO2		80-90 mmHg
	TCO2		18-33 mmol/L
	HCO3		22-28 mmol/L
	sO2		95-99%
	BEecf		(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL

Urinalysis

	Color		Straw/Yellow
	Clarity		Clear
	Glucose		Negative
	Bilirubin		Negative
	Ketone		Negative
	SG		1.010-1.025
	Blood		Negative
	pH		5.0-8.0
	Protein		Negative-Trace
	Urobili		Negative
	Nitrite		Negative
	Leuko		Negative

Urine Microscopic

	WBC		Epi
	RBC		Mucus
	Bacteria		Yeast
	Casts:		
	Crystals:		
	Other:		

Other:

Chemistry (Piccolo Analyzer)

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-84 U/L
	ALT		10-47 U/L
	AMY		14-97 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat		0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		128-145 mmol/L

Microbiology

	Source:		
	FecLeuk		Negative
	Gram St		
	WetPrep		Negative
	KOH		No Fungal Elements
	OccBld		Negative
	O&P		No Ova/Parasite

Blood Bank

	ABO/Rh		
	T&C		
	T&S		

HCG

	Urine		Negative
	Serum		Negative

Hematology

X	TEST	RESULT	REF. RANGE
	WBC	7.0	4.8-10.8 x10(3)/uL
	RBC	2.44	4.2-6.1 x10(6)/uL
	Hgb	7.8	12.0-18.0 g/dL
	Hct	22.8	35.0-60.0%
	MCV	93.7	80.0-99.0 fl
	MCH	32.0	27.0-31.0 pg
	MCHC	34.2	33.0-37.0 g/dL
	Plt	161	130-400 x10(3)/uL
	LY%	12.9	15.0-55.0%
	LY#	0.9	0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Imm
RBC Morph:	
Plt verify:	
Spun Crit	35-60%

Malaria Smear

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate

Sed Rate		1hr = 0-20 mm

Coagulation

PT		10-13 seconds
APTT		22.1-33.7 seconds
FDP		Negative

Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Negative

MEDCOM - 2052

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, (b)(6)-4 | UNIT | RANK | SSN

(b)(6)-2 | Ward: ICU1 | STAT / Routine | Date and Time: 14 Sep / 0515 | Reported by: (b)(6)-2 | Date and Time: 14 Sep 13 0539

Chemistry (i-STAT)

X	TEST	RESULT	REF. RANGE
	Na	139	128-145 mmol/L
	K	3.5	3.3-4.7 mmol/L
	Cl	105	98-108 mmol/L
	pH	7.373	7.35-7.45
	PCO2	45.2	35-45 mmHg
	PO2	170	80-90 mmHg
	TCO2	28	18-33 mmol/L
	HCO3	26	22-28 mmol/L
	sO2	100	95-99%
	BEecf	1	(-2) - (+3)
	AGap	11	8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN	16	7-22 mg/dL
	Glu	124	73-118 mg/dL
	Creat	1.0	0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL

Urinalysis

Color		Straw/Yellow
Clarity		Clear
Glucose		Negative
Bilirubin		Negative
Ketone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative-Trace
Urobili		Negative
Nitrite		Negative
Leuko		Negative

Urine Microscopic

WBC		Epi
RBC		Mucus
Bacteria		Yeast
Casts:		
Crystals:		
Other:		

Chemistry (Piccolo Analyzer)

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-84 U/L
	ALT		10-47 U/L
	AMY		14-97 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat		0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		128-145 mmol/L

Microbiology

Source:		
FecLeuk		Negative
Gram St		
WetPrep		Negative
KOH		No Fungal Elements
OccBld		Negative
O&P		No Ova/Parasite

Blood Bank

ABO/Rh		
T&C		
T&S		

HCG

Urine		Negative
Serum		Negative

Hematology

X	TEST	RESULT	REF. RANGE
	WBC	7.4	4.8-10.8 x10(3)/uL
	RBC	2.38	4.2-6.1 x10(6)/uL
	Hgb	7.8	12.0-18.0 g/dL
	Hct	22.5	35.0-60.0%
	MCV	94.5	80.0-99.0 fl
	MCH	32.8	27.0-31.0 pg
	MCHC	34.8	33.0-37.0 g/dL
	Plt	164	130-400 x10(3)/uL
	LY%	12.2	15.0-55.0%
	LY#	0.9	0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Imm
RBC Morph:	
Plt verify:	
Spun Crit	35-60%

Malaria Smear

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate

Sed Rate		1hr = 0-20 mm

Coagulation

PT		10-13 seconds
APTT		22.1-33.7 seconds
FDP		Negative

Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Negative

Other: ABO, PA-Tube T- [illegible] 40%

FiO2 40% Temp 100.1

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI	UNIT	DOB	RANK	SSN
(b)(6)-4				

Physician	Ward:	STAT / Routine	Specimen Date and Time:	Reported by:	Date and Time:
(b)(6)-2	ICU 1	Routine	14 Sep 03 2302	(b)(6)-	14Sep03 2317

Chemistry (i-STAT) — 6+ 7+ 8+ Glu Crea

X	TEST	RESULT	REF. RANGE
	Na	136	128-145 mmol/L
	K	3.7	3.3-4.7 mmol/L
	Cl	101	98-108 mmol/L
	pH	7.407	7.35-7.45
	PCO2	49.9	35-45 mmHg
	PO2	222	80-90 mmHg
	TCO2	33	18-33 mmol/L
	HCO3	31	22-28 mmol/L
	sO2	100%	95-99%
	BEecf	7	(-2) - (+3)
	AGap		8-16 mmol/L
	iCa	1.12	0.11-1.23 mmol/L
	BUN	9	7-22 mg/dL
	Glu	112	73-118 mg/dL
	Creat	1.1	0.6-1.2 mg/dL
	Hct	21	35.0-60.0%
	Hgb	7	12.0-18.0 g/dL
	Lactate		0.90-1.70 mmol/L

Urinalysis

	Color		Straw/Yellow
	Clarity		Clear
	Glucose		Negative
	Bilirubin		Negative
	Ketone		Negative
	SG		1.010-1.025
	Blood		Negative
	pH		5.0-8.0
	Protein		Negative-Trace
	Urobili		Negative
	Nitrite		Negative
	Leuko		Negative

Urine Microscopic

	WBC		Epi
	RBC		Mucus
	Bacteria		Yeast
	Casts:		Spermatozoa
	Crystals:		Amorph Sed
	Other:		
	Other		

Chemistry (Piccolo Analyzer) — Chem 12 MetLyte8 BMP Liver

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-84 U/L
	ALT		10-47 U/L
	AMY		14-97 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat		0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		128-145 mmol/L

Misc. Chemistry

	Mono		Negative
	RPR		Negative
	HIV		Negative
	Meningitis		Negative
	DOA		Negative
	CK-MB		< 4.3 ng/mL
	Troponin I		< 0.19 ng/mL
	Myoglobin		< 107 ng/mL

Microbiology

	Source:		
	FecLeuk		Negative
	Gram Stain		
	WetPrep		Negative
	KOH		No Fungal Elements
	OccBld		Negative
	O&P		No Ova/Parasite

HCG

	Urine		Negative

Hematology — CBC Malaria H/H

X	TEST	RESULT	REF. RANGE
	WBC		4.8-10.8 x10(3)/uL
	RBC		4.2-6.1 x10(6)/uL
	Hgb		12.0-18.0 g/dL
	Hct		35.0-60.0%
	MCV		80.0-99.0 fl
	MCH		27.0-31.0 pg
	MCHC		33.0-37.0 g/dL
	Plt		130-400 x10(3)/uL
	LY%		15.0-55.0%
	LY#		0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Immature cells

	RBC Morph:		
	Plt verify:		
	Spun Crit		35-60%

Malaria Smear

	Thin		No Plasmodium See
	Thick		No Plasmodium See

Sed Rate

	Sed Rate		1hr = 0-20 mm

Coagulation

	PT		10-13 seconds
	APTT		22.1-33.7 seconds
	FDP		Negative
	D-Dimer		Negative
	Fibrinogen		200-400 mg/dL

Blood Bank

	ABO/Rh		
	T&C		
	T&S		

MEDCOM - 2054

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI	UNIT	DOB	RANK	SSN
(b)(6)-4				

Physician:	Ward:			Specimen Date and Time:	Reported by:	Date and Time:
(b)(6)-2	ICU 2	X	STAT	15 Sep 03	(b)(6)-2	15 Sep 0845
			Routine			

Chemistry (I-STAT) — 6+ 7+ 8+ Glu Crea

X	TEST	RESULT	REF. RANGE
	Na	135	128-145 mmol/L
	K		3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH	7.327	7.35-7.45
	PCO2	60.7	35-45 mmHg
	PO2	97	80-90 mmHg
	TCO2	33	18-33 mmol/L
	HCO3	31	22-28 mmol/L
	sO2	96	95-99%
	BEecf	6	(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL
	Lactate		0.90-1.70 mmol/L

Urinalysis

	Color		Straw/Yellow
	Clarity		Clear
	Glucose		Negative
	Bilirubin		Negative
	Ketone		Negative
	SG		1.010-1.025
	Blood		Negative
	pH		5.0-8.0
	Protein		Negative-Trace
	Urobili		Negative
	Nitrite		Negative
	Leuko		Negative

Urine Microscopic

	WBC		Epi
	RBC		Mucus
	Bacteria		Yeast
	Casts:		Spermatozoa
	Crystals:		Amorph Sed
	Other:		
	Other:		

Chemistry (Piccolo Analyzer) — Chem 12 MetLyte8 BMP Liver

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-84 U/L
	ALT		10-47 U/L
	AMY		14-97 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN	9	7-22 mg/dL
	Ca	7.8	8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	CL	98	98-108 mmol/L
	TCO2	24	18-33 mmol/L
	Creat	1.0	0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu	112	73-118 mg/dL
	K	4.1	3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		128-145 mmol/L

Misc. Chemistry

	Mono		Negative
	RPR		Negative
	HIV		Negative
	Meningitis		Negative
	DOA		Negative
	CK-MB		< 4.3 ng/mL
	Troponin I		< 0.19 ng/mL
	Myoglobin		< 107 ng/mL

Microbiology

	Source:		
	FecLeuk		Negative
	Gram Stain		
	WetPrep		Negative
	KOH		No Fungal Elements
	OccBld		Negative
	O&P		No Ova/Parasite

HCG

	Urine		Negative
	Serum		Negative

Hematology — CBC Malaria H/H

X	TEST	RESULT	REF. RANGE
	WBC	6.8	4.8-10.8 x10(3)/uL
	RBC	2.34	4.2-6.1 x10(6)/uL
	Hgb	7.6	12.0-18.0 g/dL
	Hct	22.2	35.0-60.0%
	MCV	95.0	80.0-99.0 fl
	MCH	32.4	27.0-31.0 pg
	MCHC	34.1	33.0-37.0 g/dL
	Plt	207	130-400 x10(3)/uL
	LY%	14.6	15.0-55.0%
	LY#	1.0	0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Immature cells

	RBC Morph:	
	Plt verify:	
	Spun Crit	35-60%

Malaria Smear

	Thin	No Plasmodium Seen
	Thick	No Plasmodium Seen

Sed Rate

	Sed Rate	1hr = 0-20 mm

Coagulation

	PT	10-13 seconds
	APTT	22.1-33.7 seconds
	FDP	Negative
	D-Dimer	Negative
	Fibrinogen	200-400 mg/dL

Blood Bank

	ABO/Rh	
	T&C	
	T&S	

ACLU-RDI 1099 p.839

DOD 006107

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI: (b)(6)-4 | UNIT | DOB | RANK | SSN

Physician: (b)(6)-2 | Ward: ICU1 | STAT / Routine | Specimen Date and Time: 16SEP03 0500 0530 | (b)(6)-2 | Date and Time: 16 Sep 03

Chemistry (i-STAT)

6+ 7+ 8+ Glu Crea

X	TEST	RESULT	REF. RANGE
	Na	134	128-145 mmol/L
	K	4.1	3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH	7.419	7.35-7.45
	PCO2	53.2	35-45 mmHg
	PO2	141	80-90 mmHg
	TCO2	35	18-33 mmol/L
	HCO3	34	22-28 mmol/L
	sO2	99	95-99%
	BEecf	10	(-2) - (+3)
	AGap		8-16 mmol/L
	iCa	1.08	0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL
	Lactate		0.90-1.70 mmol/L

Urinalysis

	Color		Straw/Yellow
	Clarity		Clear
	Glucose		Negative
	Bilirubin		Negative
	Ketone		Negative
	SG		1.010-1.025
	Blood		Negative
	pH		5.0-8.0
	Protein		Negative-Trace
	Urobili		Negative
	Nitrite		Negative
	Leuko		Negative

Urine Microscopic

	WBC		Epi
	RBC		Mucus
	Bacteria		Yeast
	Casts:		Spermatozoa
	Crystals:		Amorph Sed
	Other:		
	Other:		

Chemistry (Piccolo Analyzer)

Chem 12 MetLyte8 BMP Liver

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-84 U/L
	ALT		10-47 U/L
	AMY		14-97 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN	9	7-22 mg/dL
	Ca	7.9	8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	CL	97	98-108 mmol/L
	TCO2	26	18-33 mmol/L
	Creat	0.9	0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu	125	73-118 mg/dL
	K	4.5	3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na	128	128-145 mmol/L

Misc. Chemistry

	Mono		Negative
	RPR		Negative
	HIV		Negative
	Meningitis		Negative
	DOA		Negative
	CK-MB		< 4.3 ng/mL
	Troponin I		< 0.19 ng/mL
	Myoglobin		< 107 ng/mL

Microbiology

	Source:		
	FecLeuk		Negative
	Gram Stain		
	WetPrep		Negative
	KOH		No Fungal Elements
	OccBld		Negative
	O&P		No Ova/Parasite

HCG

	Urine		Negative
	Serum		Negative

Hematology

CBC Malaria H/H

X	TEST	RESULT	REF. RANGE
	WBC	8.8	4.8-10.8 x10(3)/uL
	RBC	2.36 *	4.2-6.1 x10(6)/uL
	Hgb	7.8 *	12.0-18.0 g/dL
	Hct	22.4 *	35.0-60.0%
	MCV	94.7	80.0-99.0 fl
	MCH	33.0 *	27.0-31.0 pg
	MCHC	34.9	33.0-37.0 g/dL
	Plt	272	130-400 x10(3)/uL
	LY%	11.7 *	15.0-55.0%
	LY#	1.0	0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Immature cells

RBC Morph:

Plt verify:

Spun Crit | | 35-60%

Malaria Smear

Thin		No Plasmodium See
Thick		No Plasmodium See

Sed Rate

Sed Rate		1hr = 0-20 mm

Coagulation

PT		10-13 seconds
APTT		22.1-33.7 seconds
FDP		Negative
D-Dimer		Negative
Fibrinogen		200-400 mg/dL

Blood Bank

ABO/Rh		
T&C		
T&S		

MEDCOM - 2056

QNS request repeat Draw

21st COMBAT SUPPORT HOSPITAL — LABORATORY RESULTS FORM

(Subject to Privacy Act of 1974)

LAST, FIRST, MI	UNIT	DOB	RANK	SSN
(b)(6)-4	ICU #1			

Physician:	Ward:	STAT / Routine	Specimen Date and Time:	Re	Date and Time:
(b)(6)-2				(b)(6)-2	1635 Hrs 1Left

Chemistry (i-STAT)

6+ 7+ 8+ Glu Crea

X	TEST	RESULT	REF. RANGE
	Na		128-145 mmol/L
	K		3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH	7.480	7.35-7.45
	PCO2	46.2	35-45 mmHg
	PO2	72	80-90 mmHg
	TCO2	32	18-33 mmol/L
	HCO3	31	22-28 mmol/L
	sO2	93	95-99%
	BEecf	7	(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL
	Lactate		0.90-1.70 mmol/L

Urinalysis

	Color		Straw/Yellow
	Clarity		Clear
	Glucose		Negative
	Bilirubin		Negative
	Ketone		Negative
	SG		1.010-1.025
	Blood		Negative
	pH		5.0-8.0
	Protein		Negative-Trace
	Urobili		Negative
	Nitrite		Negative
	Leuko		Negative

Urine Microscopic

	WBC		Epi
	RBC		Mucus
	Bacteria		Yeast
	Casts:		Spermatozoa
	Crystals:		Amorph Sed
	Other:		
	Other:		

Chemistry (Piccolo Analyzer)

Chem 12 MetLyte8 BMP Liver

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-84 U/L
	ALT		10-47 U/L
	AMY		14-97 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat		0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		128-145 mmol/L

Misc. Chemistry

	Mono		Negative
	RPR		Negative
	HIV		Negative
	Meningitis		Negative
	DOA		Negative
	CK-MB		< 4.3 ng/mL
	Troponin I		< 0.19 ng/mL
	Myoglobin		< 107 ng/mL

Microbiology

	Source:		
	FecLeuk		Negative
	Gram Stain		
	WetPrep		Negative
	KOH		No Fungal Elements
	OccBld		Negative
	O&P		No Ova/Parasite

HCG

	Urine		Negative
	Serum		Negative

Hematology

CBC Malaria H/H

X	TEST	RESULT	REF. RANGE
	WBC		4.8-10.8 x10(3)/uL
	RBC		4.2-6.1 x10(6)/uL
	Hgb		12.0-18.0 g/dL
	Hct		35.0-60.0%
	MCV		80.0-99.0 fl
	MCH		27.0-31.0 pg
	MCHC		33.0-37.0 g/dL
	Plt		130-400 x10(3)/uL
	LY%		15.0-55.0%
	LY#		0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Immature cells

	RBC Morph:	
	Plt verify:	
	Spun Crit	35-60%

Malaria Smear

	Thin	No Plasmodium See
	Thick	No Plasmodium See

Sed Rate

	Sed Rate	1hr = 0-20 mm

Coagulation

	PT	10-13 seconds
	APTT	22.1-33.7 seconds
	FDP	Negative
	D-Dimer	Negative
	Fibrinogen	200-400 mg/dL

Blood Bank

	ABO/Rh	
	T&C	
	T&S	

MEDCOM - 2057

4.01

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI: (b)(6)-4 | UNIT | DOB | RANK | SSN

Physician: (b)(6)-2 | Ward: ICU#1 | X STAT / Routine | Specimen Date and Time: 17SEP13 0530 | Reported by: (b)(6)-2 | Date and Time: 17SEP13 0558

Chemistry (I-STAT)

6+ (7+) 8+ Glu (Crea)

X	TEST	RESULT	REF. RANGE
	Na	134	128-145 mmol/L
	K	4.1	3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH	7.419	7.35-7.45
	PCO2	50.9	35-45 mmHg
	PO2	191	80-90 mmHg
	TCO2	34	18-33 mmol/L
	HCO3	32	22-28 mmol/L
	sO2	100%	95-99%
	BEecf	8	(-2) - (+3)
	AGap		8-16 mmol/L
	iCa	1.11	0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat	1.2	0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL
	Lactate		0.90-1.70 mmol/L

Urinalysis

	Color		Straw/Yellow
	Clarity		Clear
	Glucose		Negative
	Bilirubin		Negative
	Ketone		Negative
	SG		1.010-1.025
	Blood		Negative
	pH		5.0-8.0
	Protein		Negative-Trace
	Urobili		Negative
	Nitrite		Negative
	Leuko		Negative

Urine Microscopic

	WBC		Epi
	RBC		Mucus
	Bacteria		Yeast
	Casts:		Spermatozoa
	Crystals:		Amorph Sed
	Other:		
	Other:		

Chemistry (Piccolo Analyzer)

Chem 12 MetLyte8 BMP Liver

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-84 U/L
	ALT		10-47 U/L
	AMY		14-97 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN	13	7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	CL	97	98-108 mmol/L
	TCO2	24	18-33 mmol/L
	Creat		0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu	118	73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		128-145 mmol/L

Misc. Chemistry

	Mono		Negative
	RPR		Negative
	HIV		Negative
	Meningitis		Negative
	DOA		Negative
	CK-MB		< 4.3 ng/mL
	Troponin I		< 0.19 ng/mL
	Myoglobin		< 107 ng/mL

Microbiology

	Source:		
	FecLeuk		Negative
	Gram Stain		
	WetPrep		Negative
	KOH		No Fungal Elements
	OccBld		Negative
	O&P		No Ova/Parasite

HCG

	Urine		Negative
			Negative

Hematology

CBC Malaria H/H

X	TEST	RESULT	REF. RANGE
	WBC	13.0	4.8-10.8 x10(3)/uL
	RBC	2.39	4.2-6.1 x10(6)/uL
	Hgb	7.7	12.0-18.0 g/dL
	Hct	22.8	35.0-60.0%
	MCV	95.5	80.0-99.0 fl
	MCH	32.2	27.0-31.0 pg
	MCHC	33.7	33.0-37.0 g/dL
	Plt	266	130-400 x10(3)/uL
	LY%	21.3	15.0-55.0%
	LY#	2.8	0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Immature cells
RBC Morph:	
Plt verify:	
Spun Crit	35-60%

Malaria Smear

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate

Sed Rate		1hr = 0-20 mm

Coagulation

PT		10-13 seconds
APTT		22.1-33.7 seconds
FDP		Negative
D-Dimer		Negative
Fibrinogen		200-400 mg/dL

Blood Bank

ABO/Rh		
T&C		
T&S		

MEDCOM - 2058

03 001926 Q

PRBC's 2456472 -#3

-#1 4825749 -#4

1262955 -#2

MEDICAL RECORD - ANESTHESIA

For use of this form, see AR 40-66; the proponent agency is the OTSG

ANESTHETIC RECORD — CONTINUOUS/REPETITIVE ENTRIES - SPECIFY UNITS - MG/MCG/ML - "I" - CONSTANT INFUSION

DRUG (Units)														
Propofol	(mg)	80												
Ketamine	(mg)	100												
Fentanyl	(mcg)													
Succ / Vec	(mg)	100	5		5							25	35	50
Phenylephrine	(mg)		100	100						5				5
Ephedrine	(mg)													
VOLAT AGENT	% del		10											
	Iso % e.t.	1.5	1.0	.8	1.2	.6	.6	.6	.20	.6	.4	1.0	1.0	
AIR	L/Min			.6	.6									
N2O	L/Min													
O2	L/Min	8	1	.6	.6	1	1	1	1	1	1	1	1	

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS ① ② ③ ④ ⑤ ⑥ ⑦

FLUIDS

LINE site LR 14g ⓔ	☐ Warmed	# 4
Hetastarch 6%	☐ Warmed	#1 500cc #2 (1000)
PRBC	☐ Warmed	#1/Unit → #2 Unit →
LR 3L 16	☐ Warmed	#5

LOSSES: EST BLOOD LOSS; URINE 100 (redistrib) 400

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 70 KG / LB

HEMATOCRIT: 10/32

INITIAL DATA: BP- 145 185; HR- 92

EQUIP CHECK: OK? Y N

PATIENT RECHECK: OK for PROCEDURE? Y/S; TIME- 0045

SYMBOLS: BP by cuff V ^; Heart rate ●; Resp rate; BR (transduced); TOURNIQUET T—T; ANES- X-X; PROC- ⊙-⊙

TIME → 0115 30 ∨ 0200 × 30 ∝ 0300 ∨ 30 × 0400

220 200 180 160 140 120 100 80 60 40 20

VT - ml		710	720	680	690	690	690	690	690	690	710	690	670
f - breaths/min		10	10	8	8	8	8	8	8	8	8	10	10
Peak Inf pres / PEEP		7	26	24	23	24	26	25	24	25	25	24	24
MODE - S(pon), A(assist), C(on)		S	C	C	C	C	C	C	C	C	C	C	C
BP/Auto Cuff	ET CO2 (torr)		39	36	30	29	30	28	29	28	29	26	27
BP/oth	FIO2 (Frac or %)	1.0	1.0	.57	.59	.60	.6	.80	.80	.80	.80	.80	.80
ART line	SpO2 (%)	100		100	100	100	100	100	100	100	100	100	100
Stath- PC/ES	ECG	NSR	NSR	NSR	NSR	NSR	NSR	NSR	NSR	NSR	NSR	NSR	NSR
Gas analyzer	TEMP-site	—	—	—	—	—	—	—	—	—	—	—	—
	N-M Block (T/4)		4/4	0/4	2/4	0/4	0/4	0/4	0/4	2/4	0/4	0/4	0/4
Pressure points checked and padded		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Warming blkt	Warm sheets applied												
Conv warmer	Room warmed												

EVENTS with letters & symbols, Position → supine

PROCEDURES and CPT Codes: Ex-lap

PERSONNEL IDENTIFICATION: Typed or written entries: Name, Grade/Rate, Medical facility

(b)(6)-4

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GETA - RSI & CP - eyes taped prior to DL

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
DL x 1 (Miller) grade 2 view ETT 8.0 placed, @ 22cm, secured @ 22cm @ teeth

SURGEON

PROCEDURE

TOTALS	TOTAL EBL
80mg	850
100 25	
100 mg	TOTAL URINE
100 125 mg	
600 mg	600
10 mg	

FLUIDS - SUMMARY
CRYSTALLOID- 4000
COLLOID- 1000
BLOOD- 4 Units PRBC's

REMARKS

Code drugs with numbers, events with letters
① Pt identified, chart reviewed, all pt questions answered via interpreter.
② At FOR, ASA monitors applied. Pt induced & intubated w difficulty
③ Pt tolerated procedure & extubated well
④ Versed 3mg infused
⑤ Line started @ 0150
⑥ Entry out of sequence: NGT placed, moderate amount of yellowish drainage retrieved, flushed.
⑦ CBC sent, results in MAR
⑧ H/H 8.9/25.5 Two units PRBCs sent for
⑨ Surgeon stated bleeding is under control at present.
⑩ 2nd two units PRBC's infusing.
⑪ PT/PTT sent via runner

RECOVERY AT
PACU (ICU) (Specify)
OTHER
CONDITION:
RESP. SpO2
BP. HR.

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0030	0145	0445
PROC	Ready	Begin	End
	0110	0125	0500

MEDCOM - 2059

0409 PT-16.0 INR-1.77

PREANESTHETIC SUMMARY

OPERATION PROPOSED	AGE	WEIGHT (LBS.)	SPECIAL INFORMATION
X-lap	19	70Kg	-
	PHYSICAL STATUS		
	1 2 3 4 5 6 7		MPII, teeth bloody, intact, Neck-FROM

URINALYSIS	HEMATOLOGY	BLOOD CHEMISTRY
NORMAL ..... ABNORMAL AND WHY?	HGB ..... RBC ..... HCT ..... OTHER	-

RESPIRATORY SYSTEM (X-RAY, ASTHMA, OTHER PATHOLOGY)	CIRCULATORY SYSTEM BP ..... PULSE ..... ECG (IF PERTINENT)	CENTRAL NERVOUS SYSTEM (CEREBROVASCULAR, POLIO, NEUROLOGICAL)	OTHER SYSTEMS (ALLERGIES)
Ø	Pt T&S in ER Pt T&C for 2Units	Ø	NKDA

PREVIOUS ANESTHETICS AND COMPLICATIONS	PRESENT DRUG THERAPY; E.G., STEROIDS, TRANQUILIZERS
None	

PREOPERATIVE DIAGNOSIS	PREMEDICATION
Unable to move bilateral LE GSW to @ flank	Ø

SIGNATURE OF EVALUATING PHYSICIAN	DATE
(b)(6)-2 CPT, CRNA	11Sept03

V/S-90 RR-20 145/85

POSTANESTHETIC VISITS

RECORD ALL PERTINENT COMPLICATIONS

O2 sat 100% on NRB

*U.S. Government Printing Office: 1994 — 300-892/10029

(b)(6)-4 EPW

MEDCOM - 2060

MEDICAL RECORD - ANESTHESIA

For use of this form, see AR 40-66; the proponent agency is the OTSG

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML, "I" = CONSTANT INFUSION

DRUG	(Units)
	( )
	( )
	( )
	( )
	( )
	( )

VOLAT AGENT	% del	
Iso	% e.t.	.6 X
AIR	L/Min	
N2O	L/Min	
O2	L/Min	1

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS → (12) (12) (13)

FLUIDS

LINE site		
	☐ Warmed	
	☐ Warmed	
LR	☐ Warmed	#9
LR	☐ Warmed	#8

LOSSES

EST BLOOD LOSS	
URINE -	600

TOTALS — TOTAL EBL: –

TOTAL URINE:

FLUIDS - SUMMARY

CRYSTALLOID-

COLLOID- see page #1

BLOOD-

REMARKS

Code drugs with numbers, events with letters

(12) Pt transported to ICU via Ambu ventilat ℃ O2. Report given CPT (b)(6)-2 V/S stable

(13) Vent setting - 12, 700, Peep 5, FiO2 .8

PHYS STATUS: 1 2 3 4 5 6

BODY WEIGHT: KG LB

HEMATOCRIT:

INITIAL DATA:

BP- see page #1

HR-

EQUIP CHECK

OK? Y N

PATIENT RECHECK

OK for PROCEDURE?

TIME-

TIME → 0415 30 Y 0500 X 30 Y 0600 Y 30 Y 0700

SYMBOLS: BP by cuff V Λ; Heart rate ●; Resp rate; BR (transduced); TOURNIQUET T—T; ANES- X-X; PROC- ⊙-Ø

220, 200, 180, 160, 140, 120, 100, 80, 60, 40, 20

VENTIL

VT - ml		640	690
f - breaths/min		8	8
Peak inf pres / PEEP		26	26
MODE - S(pon), A(asist), C(on)		C	C

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	26	26
BP/oth	FIO2 (Frac or %)	.83	.83
ART line	SpO2 (%)	100	100
Steth- PC/ES	ECG	NSR	NSR
Gas analyzer	TEMP-site	/	/
	N-M Block (T/4)	0/4	0/4
Pressure Points checked and padded		1	1
Warming blkt		/	/
Conv warmer		/	/

Mark with letters & symbols, explain under REMARKS — EVENTS Position →

RECOVERY AT 0455

PACU ICU ____ Specify

OTHER ____

CONDITION: stable

RESP- 12 SpO2- 100

BP- 132/86 HR- 75

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES			
PROC	Ready	Begin	End

PROCEDURES and CPT Codes:

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*

(b)(6)-4

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

see page #1

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*

SURGEONS:)-2 (b)(6)-2

PROCEDURE LOCATION:

DATE:

MEDCOM - 2061

13/75
ASA 2
NKDA

MEDICAL RECORD - ANESTHESIA

For use of this form, see AR 40-66; the proponent agency is the OTSG

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML. "I" = CONSTANT INFUSION

DRUG (Units)									
VERSED (mg)	2 mg	5 mg	10 mg						
FENTANYL (mcg)	225	150	100	100	50				
JSL (mg)	5				5				
NUBAIN (mg)		3	2	3	2				
EPHEDRINE (mg)			5	5	5	5	5	....	
( )									
VOLAT AGENT 150 % del / % e.t.	/	1.2	1.0	1.0	1.0	1.0	1.0	1.0	
AIR L/Min									
N2O L/Min									
O2 L/Min	10	2	2	2	2	2	2	2	

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS

FLUIDS

LINE site								
☐ Warmed		200	300	400	500	600	700	
☐ Warmed		100	250	500	500	600	700	
☐ Warmed								
☐ Warmed								

LOSSES: EST BLOOD LOSS — URINE: 75 — minimal — 100

TOTALS	TOTAL EBL
2/0	min
500/0	
10/0	TOTAL URINE 100

FLUIDS - SUMMARY
CRYSTALLOID LR 1400
COLLOID 0
BLOOD- 0

REMARKS
Code drugs with numbers, events with letters
① to OR intubated & PNAEly 2mg
② 4 Zantac IVPB
③ Skin closure
④ To ICU VSS. Report Given

PHYS STATUS: 1 2 3 4 5 E
BODY WEIGHT: 75.25 KG / LB
HEMATOCRIT: 35
INITIAL DATA:
BP- 118/56
HR- 120
EQUIP CHECK: OK? (Y) N
PATIENT RECHECK: OK for PROCEDURE? Y TIME- 1430

TIME: 1400 x 30 x 1430 x 30 x 1500 x 30 x

SYMBOLS: BP by cuff V ^ | Heart rate ● | Resp rate | BR (transduced) + | TOURNIQUET T—T | ANES- X-X PROC- ⊙-⊙

220 200 180 160 140 120 100 80 60 40 20

VENTIL

VT - ml	630	620	740	690	670	680	670	650
f - breaths/min	10	8	8	8	8	8	7	8
Peak inf pres / PEEP	26	28	24	23	23	25	26	25
MODE - S(pon), A(ssist), C(on)	C	C	C	C	C	C	C	C

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	30	30	29	31	30	30	31	31
BP/oth	FIO2 (Frac or %)	.89	.89	.89	.88	.88	.89	.88	.89
ART line	SpO2 (%)	100	100	100	100	100	100	100	100
Steth- PC/ES	ECG	ST	ST	ST	ST	SR	ST	ST	SR
Gas analyzer	TEMP-site	AXILLARY							
	N-M Block (T/4)	0/4	0/4	0/4	0/4	0/4	0/4	0/4	0/4
Warming blkt									
Conv warmer									

RECOVERY AT 1515
PACU (ICU) (Specify)
OTHER T= 95.2
CONDITION: STABLE
RESP. 12 SpO2 100
BP- 132/70 HR- 92

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1400	1500	1520
PROC	Ready	Begin	End
	1505	1514	1605

Mark with letters & symbols, explain under REMARKS — EVENTS Position

PROCEDURES and CPT Codes: I&D WASHOUT & CLOSURE, G-TUBE placed, APPY, J-WAC PLACED, cystoscopy

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: From ICU IVF to Intubated (R)

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: Bites taped, ETCO2 x4, Tube secure

PATIENT IDENTIFICATION: Typed or written entries: Name, Grade/Rate, Medical facility
(b)(6)-4
(b)(6)-4
HEADQ

SURGEONS:

PROCEDURE LOCATION:

DATE: 6.10.15

MEDCOM - 2062

See P Hx

PREANESTHETIC SUMMARY

OPERATION PROPOSED	AGE	WEIGHT (LBS.)	SPECIAL INFORMATION
ABD WASHOUT & Closure		75	
	PHYSICAL STATUS 1 2 3 4 5 6 7		

URINALYSIS	HEMATOLOGY	BLOOD CHEMISTRY
NORMAL ..... ABNORMAL AND WHY?	HGB ..... RBC ..... HCT ..... OTHER	

RESPIRATORY SYSTEM	CIRCULATORY SYSTEM	CENTRAL NERVOUS SYSTEM	OTHER SYSTEMS
(X-RAY, ASTHMA, OTHER PATHOLOGY)	BP ..... PULSE ..... ECG (IF PERTINENT)	(CEREBROVASCULAR, POLIO, NEUROLOGICAL)	(ALLERGIES)

PREVIOUS ANESTHETICS AND COMPLICATIONS	PRESENT DRUG THERAPY; E.G., STEROIDS, TRANQUILIZERS
	Dec Unasyn @ 1800 Zantac @ 1400

PREOPERATIVE DIAGNOSIS	PREMEDICATION

(b)(6)-2

[illegible] DATE 13 Sep

POSTAN

RECORD ALL PERTINENT COMPLICATIONS

*U.S. Government Printing Office: 1994 — 300-892/10029

MEDCOM - 2063

518-124 NSN 7540-00-634-4159

MEDICAL RECORD — BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*
- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of _____ units)*
- [ ] CRYOPRECIPITATE *(Pool of _____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* _____

VOLUME REQUESTED *(If applicable)*: 1 unit ML

REMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*
- [X] TYPE AND SCREEN
- [ ] CROSSMATCH

DATE REQUESTED: 9/10/03

DATE AND HOUR REQUIRED: 2358 9/10/03

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:
RhIG TREATMENT? DATE GIVEN: _____
HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)*: (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE: ABD GSW

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER: (b)(6)-2

DATE VERIFIED: 9/11/03

TIME VERIFIED: 0046

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.: (b)(6)-4

TRANSFUSION NO.

PATIENT NO.

TEST INTERPRETATION

ANTIBODY SCREEN: not performed

CROSSMATCH: comp

DONOR — ABO: O Rh: POS

RECIPIENT — ABO: B Rh: POS

PREVIOUS RECORD CHECK: [ ] RECORD [X] NO RECORD (b)(6)-2

(b)(6)-2

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPO[redacted] REC (b)(6)-2 DATE 11 Sept 03

REMARKS: Due to the critical condition of below named patient, the requesting phy sician named above request the immediate release of this product for the transfusion without complete testing and is accepting full responsibility for the administration of the transfusion

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*

AT *(Hour)* | ON *(Date)*

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER *(Signature)*

2nd VERIFIER *(Signature)*: (b)(6)-2

PRE-TRANSFUSION TEMP. | PULSE 106 | BP 92/62

DATE OF TRANSFUSION: 9/11/03 | TIME STARTED: 0120

POST-TRANSFUSION DATA

AMOUNT GIVEN: 367 - ML

TIME/DATE COMPLETED/INTERRUPTED: 9/11/03

REACTION: [X] NONE [ ] SUSPECTED | TEMPERATURE | PULSE 105 | BLOOD PRESSURE 91/51

If reaction is suspected—IMMEDIATELY:
1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION OF REACTION
- [ ] URTICARIA [ ] CHILL [ ] FEVER [ ] PAIN
- [ ] OTHER *(Specify)*

OTHER DIFFICULTIES *(Equipment, clots, etc.)*
- [X] NO [ ] YES *(Specify)*

SIGNATURE OF PERSON NOTING ABOVE: (b)(6)-2

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle; grade; rank; (b)(6)-4 edical facility)

SEX: M | WARD: EMT

BLOOD OR BLOOD COMPONENT TRANSFUSION
Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 2064

Medical Record Copy

ACLU-RDI 1099 p.848

DOD 006116

518-124 NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED (Check one)
- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS (Pool of _____ units)
- [ ] CRYOPRECIPITATE (Pool of _____ units)
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER (Specify) _____

VOLUME REQUESTED (If applicable) _____ ML

REMARKS:

TYPE OF REQUEST (Check ONLY if Red Blood Cell Products are requested.)
- [X] TYPE AND SCREEN
- [ ] CROSSMATCH

DATE REQUESTED: 9/10/03

DATE AND HOUR REQUIRED: 2358 9/10/03

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION (Specify)

IF PATIENT IS FEMALE, IS THERE HISTORY OF:
RhIG TREATMENT? DATE GIVEN: _____
HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN (Print): Maj (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE: ABD GSW

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER: (b)(6)-2

DATE VERIFIED: 9/12/03

TIME VERIFIED: 0046

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.: (b)(6)-4

TRANSFUSION NO.

PATIENT NO.

DONOR
ABO: O
Rh: POS

RECIPIENT
ABO: B
Rh: POS

TEST INTERPRETATION
ANTIBODY SCREEN: not performed
CROSSMATCH: COMP

PREVIOUS RECORD CHECK:
- [ ] RECORD
- [X] NO RECORD

(b)(6)-2

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 11 SEP 03

REMARKS: Due to the critical condition of below named patient, the requesting physician named above request the immediate release of the product for the transfusion without complete testing, and is accepting full responsibility for the administration of the transfusion

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY (Signature)

AT (Hour) | ON (Date)

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER (Signature): (b)(6)-2 CIT, CLS

2nd VERIFIER (Signature): (b)(6)-2 CRNA

PRE-TRANSFUSION
TEMP. 98 | PULSE 104 | BP 72/52

DATE OF TRANSFUSION: 9/10/03

TIME STARTED: 0830

POST-TRANSFUSION DATA

AMOUNT GIVEN: 200 ML

TIME/DATE COMPLETED/INTERRUPTED: 0140 9/11/03

REACTION	TEMPERATURE	PULSE	BLOOD PRESSURE
[X] NONE [ ] SUSPECTED	98	105	93/56

If reaction is suspected—IMMEDIATELY:
1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION OF REACTION
- [ ] URTICARIA [ ] CHILL [ ] FEVER [ ] PAIN
- [ ] OTHER (Specify)

OTHER DIFFICULTIES (Equipment, clots, etc.)
- [X] NO [ ] YES (Specify)

SIGNATURE OF PERSON NOTING ABOVE: (b)(6)-2 CRNA

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle; grade; rank; rate; hospital or medical facility)

SEX: M

WARD: 2 MT

Name/Rank
FMP/SSN
DOB
unit

BLOOD OR BLOOD COMPONENT TRANSFUSION
Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 2065

Medical Record Copy

518-124 NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*
- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of _____ units)*
- [ ] CRYOPRECIPITATE *(Pool of _____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* _____

VOLUME REQUESTED *(If applicable)* 1 UNIT ML

REMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*
- [ ] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED 9/11/03

DATE AND HOUR REQUIRED 0300

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)* (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE

GSW FLANK

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER (b)(6)-2

DATE VERIFIED 9/10/03

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. (b)(6)-4

TRANSFUSION NO.

PATIENT NO.

TEST INTERPRETATION

ANTIBODY SCREEN: not performed

CROSSMATCH: Comp

PREVIOUS RECORD CHECK:
- [ ] RECORD
- [ ] NO RECORD

(b)(6)-2

DONOR
ABO O
Rh POS

RECIPIENT
ABO AB
Rh POS

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPON (b)(6)-2 10 SEPT 03

REMARKS: Due to the critical condition of the above-named patient, the requesting physician named above requests the immediate release of this blood product for transfusion without complete testing and is accepting full responsibility for the administration of this transfusion.

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

(b)(6)-2

AT (Hour) 0308 ON (Date) 11 Sept 2003

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER *(Signature)* (b)(6)-2 CPT, CLNC

(b)(6)-2

PRE-TRANSFUSION
TEMP. 98 PULSE 77 BP 104/69

DATE OF TRANSFUSION 9/11/03 TIME STARTED 0330

POST-TRANSFUSION DATA

AMOUNT GIVEN 459 ML

TIME/DATE COMPLETED/INTERRUPTED 9/11/03 0345

REACTION	TEMPERATURE	PULSE	BLOOD PRESSURE
[X] NONE [ ] SUSPECTED	98	76	107/87

If reaction is suspected—IMMEDIATELY:
1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION OF REACTION
- [ ] URTICARIA [ ] CHILL [ ] FEVER [ ] PAIN
- [ ] OTHER *(Specify)*

OTHER DIFFICULTIES *(Equipment, clots, etc.)*
- [X] NO [ ] YES *(Specify)*

SIGNATURE OF PERSON NOTING ABOVE (b)(6)-2

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle; grade; rank; rate; hospital or medical facility)

Name/Rank (b)(6)-4

FMP SSN

DOB

Unit

SEX MALE WARD O.R

BLOOD OR BLOOD COMPONENT TRANSFUSION
Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 2066

Medical Record Copy

518-124

NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

- [X] ~~RED~~ BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of _____ units)*
- [ ] CRYOPRECIPITATE *(Pool of _____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* _____

VOLUME REQUESTED *(If applicable)*: 1 UNIT ML

REMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*

- [ ] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED: 9/11/03

DATE AND HOUR REQUIRED: 0300

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*: NONE

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: N/A

HEMOLYTIC DISEASE OF NEWBORN?

REQUESTING PHYSICIAN *(Print)*: (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER: (b)(6)-2

DATE VERIFIED: 9/10/03

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.: (b)(6)-4

TRANSFUSION NO.

PATIENT NO.

DONOR: ABO O Rh POS

RECIPIENT: ABO B Rh POS

TEST INTERPRETATION

ANTIBODY SCREEN: not performed

CROSSMATCH: comp

PREVIOUS RECORD CHECK:

- [ ] RECORD
- [X] NO RECORD

(b)(6)-2 [redacted] (b)(6)-2

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED [redacted]

DATE: 11 Sept 03

REMARKS: Due to the critical condition of the below named patient the requesting physician named above requests the immediate release of this blood product without complete testing and is taking full responsibility for the transfusion with the administration of this transfusion

SECTION III – RECORD OF TRANSFUSION

(b)(6)-2 A

AT (Hour): 0325 ON (Date): 11 Sept 03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER *(Signature)*: (b)(6)-2 CPT, CLNA

2nd VERIFIER *(Signature)*: (b)(6)-2 CPT

PRE-TRANSFUSION

TEMP. PULSE 76 BP 107/86

DATE OF TRANSFUSION: 9/11/03 TIME STARTED: 0345

POST-TRANSFUSION DATA

AMOUNT GIVEN: 270 ML

TIME/DATE ~~COMPLETED~~/INTERRUPTED: 0400

REACTION: [X] NONE [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
	79	161/58

If reaction is suspected—IMMEDIATELY:

1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION OF REACTION

- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER *(Specify)*

OTHER DIFFICULTIES *(Equipment, clots, etc.)*

- [X] NO
- [ ] YES *(Specify)*

SIGNATURE OF PERSON NOTING ABOVE: (b)(6)-2 CPT, CLNA

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle initial; rate; hospital or medical facility)

SEX: MALE WARD: OR

(b)(6)-4

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 2067

Medical Record Copy

NSN 7540-01-165-7294 519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

EXAMINATION(S) REQUESTED: PORTABLE CXR

AGE | SEX | SSN (Sponsor): (b)(6)-2

WARD/CLINIC: ICU #1

REGISTER NO.:

FILM NO.:

PREGNANT: ☐ YES ☒ NO

REQUESTED BY (Print): Dr (b)(6)-2

TELEPHONE/PAGE NO.: (b)(3)-1

(b)(6)-2

F REQUESTOR: 1LT, AF

DATE REQUESTED: 9/16/03

SPECIFIC REASON(S) FOR REQUEST (Complaints and findings):

INTUBATED
FEBRILE ↑ 104
J-TUBE
G-TUBE
LUMBAR SPINE FX

DATE OF EXAMINATION (Month, day, year):

DATE OF REPORT (Month, day, year):

DATE OF TRANSCRIPTION (Month, day, year):

RADIOLOGIC REPORT

- ET tip 3cm above carina
- mediastinum stable but no evidence of pneumonia RLL streaky atelectasis

(b)(6)-2

PATIENT'S IDENTIFICATION (For typed or written entries give: Name — last, first, middle, Medical Facility)

(b)(6)-4

LOCATION OF MEDICAL RECORDS:

LOCATION OF RADIOLOGIC FACILITY:

SIGNATURE:

MEDCOM - 2068

STANDARD FORM 519-R (8-83)

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION: (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
1	11 Sept 03	0430 HOURS	
2	Admit to ICU		
3	Dx - Gsw ASA 1/2 Ex L-r/ Duodenal Repair / IVC repair, Lumbar Fx		
4	Condition - stable		
5	Vitals Q1°		
6	Activity - bedrest		
7	Allergies - PRODA		

PATIENT IDENTIFICATION

NURSING UNIT: (b)(6)-2 | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	
8	IVF LR at 150 cc/hr	HOURS	
9	Diet - NPO		
10	Foley to gravity		
11	NGT to suction ~~(Low)~~ - low intermittent suction		
12	I+O		
13	L.s - CBC, PA->, ABG on arrival		

PATIENT IDENTIFICATION Powell

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	
14	Vent settings - SIMV -	HOURS	(b)(6)(2)
	R=12 TV=700		(b)(6)(2)
	FIO2 - 100% PEEP=5		
15	Meds		
	versed 1-4mg IV q 15 minutes PRN agitation -		
	Vecuronium 4mg IV Q1° for train of 4		
	MSO4 1-2-3 IV Q15 min PRN pain		
	Unasyn 3.0g - IV Q6°		
	Zantac 150mg IV Q8°		
16	Call MD for UOP < 30cc/hr		
17	Bed Plt - strict log roll only		(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED

MEDCOM - 2069 (b)(6)(2)

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
(b)(6)-4	11 Sep 03	0630 HOURS	
	Δ versed prn to versed gtt 1-4 mg/hr		
	V.O. Dr (b)(6)-2	(b)(6)-2	
	(b)(6)-2		
	(b)(6)-2		
NURSING UNIT / ROOM NO. / BED NO.			

Noted (b)(6)-2 0930 11 Sept 03

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
	11 Sep 03	0920 HOURS	
	1) Bolus 2mg Vec IV Now. Recheck Train of Four (TOF) in 5 min. Give Additional 1mg Bolus Vec IV until Barely 1/4 Twitches		
	(b)(6)-2	CRNA	
NURSING UNIT / ROOM NO. / BED NO.			

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
	11 Sept 03	0945 HOURS	
	1) CBC, ABG, PA-7 at 1200 hrs		
	(b)(6)-2		
NURSING UNIT / ROOM NO. / BED NO.			

Noted 1000 11 Sept 03

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
	11 Sep 03	1420 HOURS	
	Vecuronium bolus 2mg now - then ↑ gtt to 6-8 mg/hr		
	V.O. Dr (b)(6)-2	ron / (b)(6)-2	
	(b)(6)-2		
NURSING UNIT / ROOM NO. / BED NO.	24° chart dr (b)(6)-2	2220 11 Sep 03	
	(b)(6)-2		

Noted 1430 11 Sept 03

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH [illegible]SED.

MEDCOM - 2070

(5)(6)(2)

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 11 Sep. 03 — TIME OF ORDER: 1441 HOURS

(1) D/C Morphine

(2) Fentanyl ~~gtt~~ gtt @ 50 Mcg/hr.

X10

(b)(6)-2 MD

(b)(6)-2

LIST TIME ORDER NOTED AND SIGN: Noted 11SEP03 1545 (b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 11 Sep 03 — TIME OF ORDER: 1530 HOURS

(1) 10 mg Ephedrine IVP now

(2) LR Bolus 400 cc now

V.O. Dr. (b)(6)-2 (b)(6)-2 (b)(6)-2

(b)(6)-2 MD

(b)(6)(2) LT [redacted] 12 Sep 03 1200

(b)(6)-2

FAMILY PRACTICE

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 11 Sept 03 — TIME OF ORDER: 1811 HOURS

(1) ABG, CBC, PA-7 in Am

(b)(6)-2

Noted 11SEP03 0612 (b)(6)-2

MAT

24° Chest Check 2200 1148

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 12 Sep 03 — TIME OF ORDER: 0145 HOURS

10 mg Ephedrine IVP Now

LR Bolus 400 cc Now

V.O. (b)(6)-2 (b)(6)-2

(b)(6)-2 MD

(b)(6)-2

12 Sep 03 1200

Noted 11 Sep 03 2000

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH BE USED.

MEDCOM - 2071

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION (b)(6)-4

DATE OF ORDER 12 Sept 03 TIME OF ORDER 0815 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) FIB fo 40%

(b)(6)-2

Noted 9/12/03 0830

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 12 Sept 03 TIME OF ORDER 0915 HOURS

(1) CBC, ABG, PA-7 in AM

(b)(6)-2

Noted 9/12/03 1000

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 9/12/03 TIME OF ORDER 1405 HOURS

~~LACRYLUBE~~ ARTIFICIAL TEARS

ii drops OU QID

V.O. OK

(b)(6)-2

Noted 9/12/03 1435

NURSING UNIT | ROOM | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 12 Sept 03 TIME OF ORDER 1514 HOURS

(1) Aspirin 325 mg Supp PR QD - 1st dose now

(2) Heparin 5000 u SQ BID 1st dose now

Noted 12 Sept 03 1515

(b)(6)-2

24° Chart Check 2330 12 Sept 03

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 2072

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION: (b)(6)-4

DATE OF ORDER: 13 Sept 03 TIME OF ORDER: 1445 HOURS

LIST TIME ORDER NOTED AND SIGN

1. To ICU-1
2. Dx - S/p Re-exploration / washout / G-tube / J-tube / JP drain / Abd closure
3. Condition - stable
4. Vitals Q 1°
5. Activity - bed rest - log

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: roll only TIME OF ORDER: HOURS

6. Allergies - NKDA
7. IVF D5½NS c̄ 20 meq KCl at 125 cc/hr
8. Diet - NPO
9. Foley to gravity
10. ~~NPO~~ I & O
11. J-tube to gravity drain

Note: 13 Sept 03 1655 (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: TIME OF ORDER: HOURS

12. G-tube to gravity drain
13. JP to bulb suction
14. Labs - CBC ABG, PA-7 in AM
15. Vent setting SIMV R=12 TV=700 PEEP=5 FIO_2=40%
16. Meds

Versed 6mg/hr drip

Fentanyl ~~25mg~~ (b)(6)-2 80 cc/hr ~~0.3 mg/kg/min~~ drip

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: TIME OF ORDER: HOURS

Artificial drops (tears) 2 drops QID OU

Aspirin 325mg supp PR QD

Heparin 5000u SQ BID

Mgoy 1-2mg IV Q15min PRN

Unasyn 3.0gm IV Q6°

Zantac 50mg IV Q8°

NURSING UNIT | ROOM NO. | BED NO.

✓ 13 SEP 03 1655 (b)(6)-2 USAN

(b)(6)-2

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MAJ MC

MEDCOM - 2073

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION: (b)(6)-4

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	13Sep03	0615 HOURS	(b)(6)-2
①	Versed 1-2 mg q15"		
	V.O. MAJ (b)(6)-2	(b)(6)-2	13Sep03 0615

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER ____ HOURS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER ____ HOURS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER ____ HOURS

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 2074

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION: (b)(6)-4

DATE OF ORDER: 14 Sep — TIME OF ORDER: 0300 HOURS — LIST TIME ORDER NOTED AND SIGN

Tylenol 650 mg PR now
V.O. MAT (b)(6)-2 (b)(6)-2 (b)(6)-2 (b)(6)-2 (b)(6)-2

NURSING UNIT: Chart ✓ — ROOM NO.: 9/14/03 0815 (b)(6)-2

PATIENT IDENTIFICATION: (b)(6)-2

DATE OF ORDER: ✓ 14 Sept 03 — TIME OF ORDER: 0911 HOURS

(1) Lasix 20 mg IV X 1 now
(2) ↓ Rate to 10 now + slowly wean to rate of 6 - call HO if RR > 30
(3) ABG 1 hr after rate of 6 is reached (b)(6)-2

NURSING UNIT — ROOM NO. — BED NO.

PATIENT IDENTIFICATION: (b)(6)-2

DATE OF ORDER — TIME OF ORDER — HOURS

(4) wean Fentanyl to off
(5) ↓ versed (b)(6)-2

NURSING UNIT — ROOM NO. — BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER — TIME OF ORDER — HOURS

NURSING UNIT — ROOM NO.: ✓ 14 Sep 03 0130 — BED NO.: (b)(6)-2

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 2075

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION: (b)(6)-2

DATE OF ORDER: 14 Sept 03 TIME OF ORDER: 1514 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Keep vent rate at 12
2. Portable CXR
3. Versed gtt @ 2mg/hr (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 14 Sep 03 TIME OF ORDER: 1625 HOURS

1. Suction ETT / pulmonary toilet q 2°
2. Tylenol 650 mg supp PR now (b)(6)-2
3. CBC, DA-7, ABG in AM.

VO Dr (b)(6)-2 (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

√ 15SEP03 0730 (b)(6)-2 UTAN

FAMILY PRACTICE

PATIENT IDENTIFICATION

DATE OF ORDER: 14SEP03 TIME OF ORDER: 2230 HOURS

1. ABG now and Pa-7
2. Fentanyl 100meg bolus now then run gtt @ 100meg/hr.
3. Repeat Fentanyl bolus of 100meg in 30 minutes if pt remains agitated

V.O. Dr (b)(6)-2 (b)(6)-2 UT (b)(6)-2 MU

noted 15SEP03 0030

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 15SEP03 TIME OF ORDER: 0350 (b)(6)-2

1. Tylenol 650mg PR x1 now

V.O. Dr (b)(6)-2 (b)(6)-2 UTAN 15 Sep MU

FAMILY PRACTICE

(b)(6)-2 (b)(6)(2)

NURSING UNIT | ROOM NO. | BED (b)(6)-2

√ 9/16/03 0930 UTAN

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 2076

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION (b)(6)-4

DATE OF ORDER 15 Sept 03 TIME OF ORDER 1020 HOURS

LIST TIME ORDER NOTED AND SIGN

1 Vivonex TF 20 cc/hr through J-tube
Flush J-tube c̄ 30 cc water Q shift
2 Lasix 20 mg IV X1 now slowly mean rate to goal of 6 over next

NURSING UNIT | ROOM NO. (b)(6)-2 | BED NO.

Noted 1 Sept 03 1045

PATIENT IDENTIFICATION

DATE OF ORDER 4 hrs TIME OF (b)(6)-2

MAJ

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 15 Sept 03 TIME OF ORDER 2001 HOURS

1 RR to 12
2 CBC, ABG, PA-7 in AM

(b)(6)-2 15 Sept 03 2001

(b)(6)-2

(b)(6)-2

NURSING UNIT Chart | ROOM NO. 9/16/03 | BED NO. 0930

PATIENT IDENTIFICATION

DATE OF ORDER 16 Sept 03 TIME OF ORDER 0920 HOURS

1 RR to 10
2 CBC, ABG, PA-7 in AM
3 Switch IV to D5 NS c̄ 20 mg KCl at 75 cc/hr

Noted 1 Sept 03 9/16/03 0930

(b)(6)-2

(b)(6)-2

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

MAJ

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 2077

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION (b)(6)-4

DATE OF ORDER 16 Sept 03 TIME OF ORDER 1020 HOURS

LIST TIME ORDER NOTED AND SIGN

1) D/C Unasyn
2) Levaquin 500mg IV QD - 1st dose now

(b)(6)-2

NURSING UNIT | ROOM NO. (b)(6)-2

noted 9/16/03 1105

PATIENT IDENTIFICATION

DATE OF ORDER 16 Sept 03 TIME OF ORDER 1231 HOURS

1) Tylenol 650mg supp PR X 1 now
2) ↓ rate to 8

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

noted 9/16/03 1230

PATIENT IDENTIFICATION

DATE OF ORDER 16 Sept 03 TIME OF ORDER 1505 HOURS

1) ↓ rate to 6
2) ABG 1 hour after rate of 6

Noted 1505 16SEP03

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 16SEP03 TIME OF ORDER 1700 HOURS

1) ↑ rate to 12 VO Dr (b)(6)-2 (b)(6)-2

Noted 16SEP03 1720

(b)(6)-2

chart 17SEP03 0642

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 2078

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
			17 Sept 03	0920 HOURS	
			(1) Versed 5 mg IV at 1000 ms		
			(2) Fentanyl 50 mg IV at 1000 ms		
			(3) Dlc drips		
NURSING UNIT	ROOM NO.	BED NO.			

(b)(6)-2

PATIENT IDENTIFICATION			DATE OF ORDER	TIME O	
NURSING UNIT	ROOM NO.	BED NO.			

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
				HOURS	
NURSING UNIT	ROOM NO.	BED NO.			

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
				HOURS	
NURSING UNIT	ROOM NO.	BED NO.			

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 2079

MEDICAL RECORD - MEDICATION ADMINISTRATION RECORD

For use of this form, see MEDCOM Circular 40-5

ORDER DATE	TRANSCRIBER/ REVIEWER INITIALS	SECTION I DELAYED SINGLE ACTION ORDERS & PREOPERATIVES	DATE/TIME TO BE GIVEN	DATE/TIME GIVEN AND INITIALS
11 Sep 03	(b)(6)-2	Admit to ICU #1		(b)(6)-2
		DX: GS- ASA 3/p EX LAP, CYSTOENAL REPAIR/LIVER REPAIR LUMBAR FX		(b)(6)-2
11 Sep 03		Condition Stable		(b)(6)-2
11 Sep 03		CBC, PA-7 ABG ON ARRIVAL	11 Sep 0500	0500 (b)(6)-2
11 Sept 03		Bolus 2mg Vec IV NOW	NOW	0820 (b)(6)-2
11 Sept 03		Recheck Train of four (TOF) in five	5 min	0825 (b)(6)-2
11 Sept 03		CBC, ABG, PA-7 @ 1200 hrs	1200 11 Sept	1200 11 Sept (b)(6)-2
11 Sept		Vecuronium bolus 2mg NOW	NOW	1425 11 Sept (b)(6)-2
11 SEP		D/C morphine		(b)(6)-2
11 SEP		10mg Ephedrine IVP NOW	NOW	(b)(6)-2
11 SEP		CR Bolus 400 cc	NOW	(b)(6)-2
11 SEP		ABG, CBC, PA-7 IN AM	12 SEP 03 0500	12 Sep 03 0445
12 Sep		EPHEDRINE 10mg IVP/ NOW	9/12 NOW	12 Sep 03 0145
12 Sep		LR Bolus 400cc / NOW	9/12 NOW	12 Sep 03 0145
12 Sep		CBC, ABG, PA-7 IN AM	9/13 0500	13 Sep 03 (b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-4

DIAGNOSIS: S/P EXLAP/ LUMBAR FX

ALLERGIES: NKDA

Circle administration times (in pencil) for recurring medication.

D	07	08	09	10	11	12	13	14
E	15	16	17	18	19	20	21	22
N	23	24	01	02	03	04	05	06

MEDCOM FORM 690-R (TEST) (MCHO[illegible] MEDCOM - 2080 NS ARE OBSOLETE Page 1 of 4 pages MCV1.00

MEDICAL RECORD - MEDICATION ADMINISTRATION RECORD

ORDER DATE	TRANSCRIBER/ REVIEWER INITIALS	SECTION II RECURRING MEDICATIONS, DOSE, FREQUENCY	HR ↓	INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION — DATE ADMINISTERED: 11	12	13	14	15
11 sep	(b)(6)-2	Δ versed prn to versed gtt 1-4 mg/hr	D E N	/ Permitted 11 sep 03				

MEDCOM FORM 690-R (TEST) (MCHO) MAR 99

(b)(6)-4

Page 2 of 4 pages

MEDCOM - 2081

MEL... RECORD - MEDICATION ADMINISTRATION RECORD

ORDER DATE	TRANSCRIBER / REVIEWER INITIALS	SECTION II (Cont) RECURRING MEDICATIONS, DOSE, FREQUENCY	HR ↓	INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION — DATE ADMINISTERED: 10	11	12	13	14
11 Sep 03	(b)(6)-2	VENT SETTINGS = SIMV	D	✓	(b)(6)-2			
		RATE = 12 TV = 700 FiO2 = 100%	E	✓				
		PEEP = 5	N	✓				
		~~FiO2 60~~ (b)(6)-2						
12Sep03	(b)(6)-2	VENT SETTINGS: SIMV	D			(b)(6)-2		
		RATE = 12 TV = 700 FiO2 = 40%	E					
		PEEP = 5 PS = 0	N			(b)(6)-2		

PATIENT IDENTIFICATION

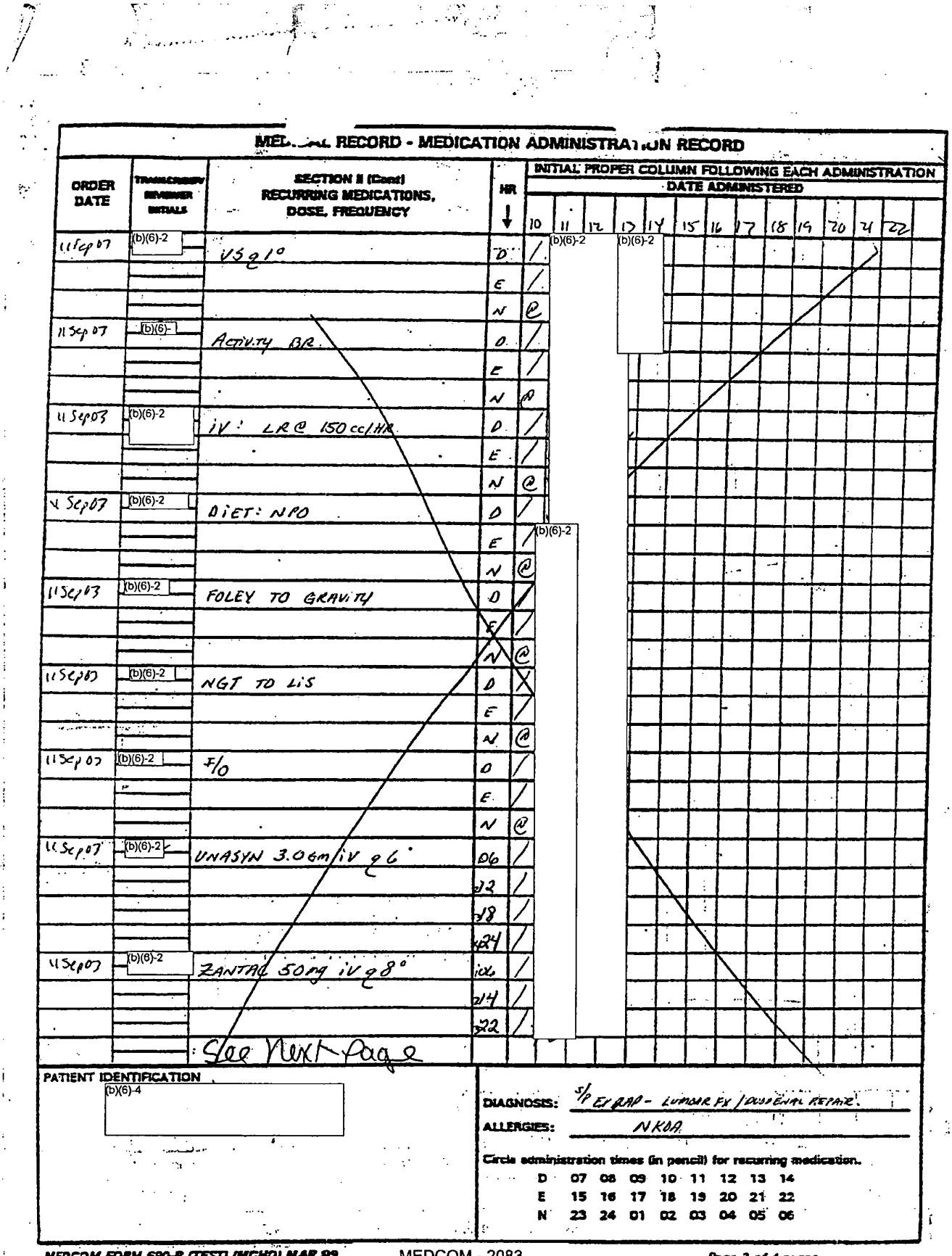
(b)(6)-4

DIAGNOSIS: S/P EXCAT) LUMBAR FX

ALLERGIES: NKDA

Circle administration times (in pencil) for recurring medication.

D	07	08	09	10	11	12	13	14
E	15	16	17	18	19	20	21	22
N	23	24	01	02	03	04	05	06



MEDICAL RECORD - MEDICATION ADMINISTRATION RECORD

ORDER DATE	TRANSCRIBER SIGNATURE INITIALS	SECTION II (Cont) RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION — DATE ADMINISTERED: 10 11 12 13 14 15 16 17 18 19 20 21 22
11Sep07	(b)(6)-2	VSq1°	D	/
			E	/
			N	@
11Sep07	(b)(6)-	Activity BR	D	/
			E	/
			N	@
11Sep07	(b)(6)-2	IV: LR @ 150 cc/HR	D	/
			E	/
			N	@
11Sep07	(b)(6)-2	DIET: NPO	D	/
			E	/
			N	@
11Sep07	(b)(6)-2	FOLEY TO GRAVITY	D	/
			E	/
			N	@
11Sep07	(b)(6)-2	NGT TO LIS	D	/
			E	/
			N	@
11Sep07	(b)(6)-2	F/O	D	/
			E	/
			N	@
11Sep07	(b)(6)-2	UNASYN 3.0Gm IV q6°	06	/
			12	/
			18	/
			24	/
11Sep07	(b)(6)-2	ZANTAC 50mg IV q8°	10	/
			14	/
			22	/
		See Next Page		

PATIENT IDENTIFICATION
(b)(6)-4

DIAGNOSIS: S/P EX LAP - LUMBAR FX / DUODENAL REPAIR.

ALLERGIES: NKDA

Circle administration times (in pencil) for recurring medication.

D	07	08	09	10	11	12	13	14
E	15	16	17	18	19	20	21	22
N	23	24	01	02	03	04	05	06

MEDCOM FORM 690-R (TEST) (MCHO) MAR 99 MEDCOM - 2083 Page 3 of 4 pages

MEDICAL RECORD - MEDICATION ADMINISTRATION RECORD

ORDER EXPIRATION DATE	TRANSCRIBER REVIEWER INITIALS	SECTION III PRN MEDICATION, DOSE, ROUTE, FREQUENCY, REASON	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE/REASON/INITIALS/EFFECTIVENESS CODE											
11sept03	(b)(6)-2	MSO4 1-2 mg IV q 15 min	11 sep 2mg 0815	11 sep 2mg 1830	11 sep 2mg 0915	11 sep 2mg 0900	11 sept 2mg 0915 (b)(6)-2	11 sep 2mg 1045	1326 11sept 2mg	1430 11sept (b)(6)-2				
		PRN PAIN I/E	(b)(6)-2 I	I	I			E						
11sept03	(b)(6)-2	Versed 1-2mg IV Q15min prn adjtation	Reur Her 11 sep 03 0630 (b)(6)-2											
11sept	(b)(6)-2	Give additional 1mg bulus vec IV until Berely 1/4 Twitches	1035 1mg (b)(6)-2	1130 1mg	(b)(6)-2 1mg 1320									

CODES: Initials only = Medication administrated
Initials and E = Medication effective
Initials and I = Medication ineffective*
Initials and O = Medication withheld*
*SEE SF 509 FOR NURSE'S ENTRY

MEDCOM FORM 690-R (TEST) (MCHO) MAR 99

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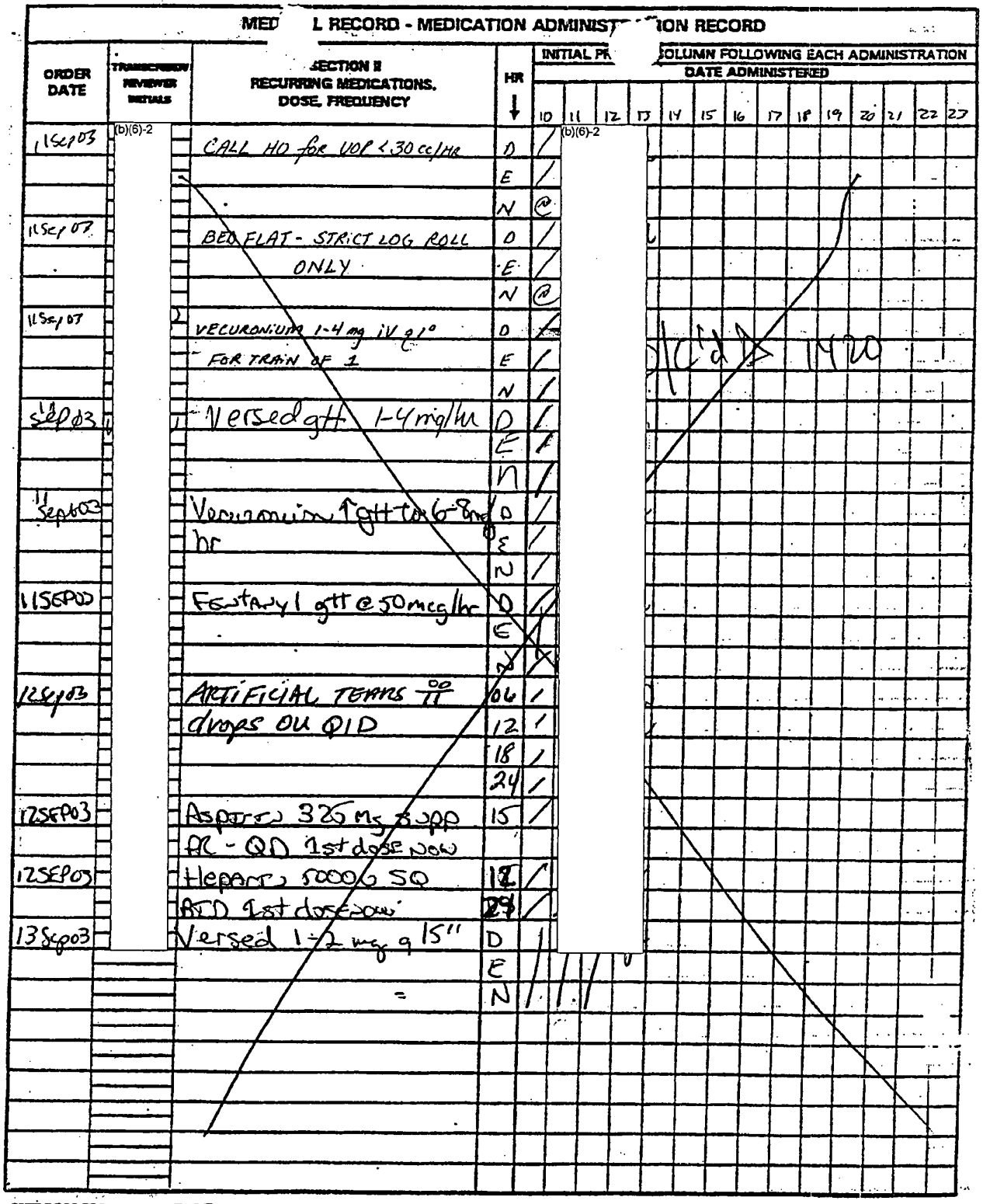
MEDCOM - 2084



MED L RECORD - MEDICATION ADMINIST ION RECORD

ORDER DATE	TRANSCRIBER/REVIEWER INITIALS	SECTION II RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	INITIAL PR COLUMN FOLLOWING EACH ADMINISTRATION — DATE ADMINISTERED 10 11 12 13 14 15 16 17 18 19 20 21 22 23
10Sep03	(b)(6)-2	CALL MD for UOP < 30 cc/HR	D	/ (b)(6)-2
			E	/
			N	@
11Sep03		BED FLAT - STRICT LOG ROLL ONLY	D	/
			E	/
			N	@
11Sep03		VECURONIUM 1-4 mg IV q1° FOR TRAIN OF 1	D	/
			E	/
			N	/
11Sep03		Versed gtt 1-4 mg/hr	D	/
			E	/
			N	/
11Sep03		Vecuronium gtt to 6-8 mg/hr	D	/
			E	/
			N	/
11SEP03		Fentanyl gtt @ 50 mcg/hr	D	/
			E	/
			N	/
12Sep03		ARTIFICIAL TEARS ou drops OU QID	06	/
			12	/
			18	/
			24	/
12SEP03		Aspirin 325 mg, supp PR - QD 1st dose now	15	/
12SEP03		Heparin 5000u SQ BID 1st dose now	18	/
			21	/
13Sep03		Versed 1-2 mg q 15"	D	/
			E	/
		=	N	/

MEDCOM FORM 690-R (TEST) (MCHO) MAR 99

(b)(6)-4

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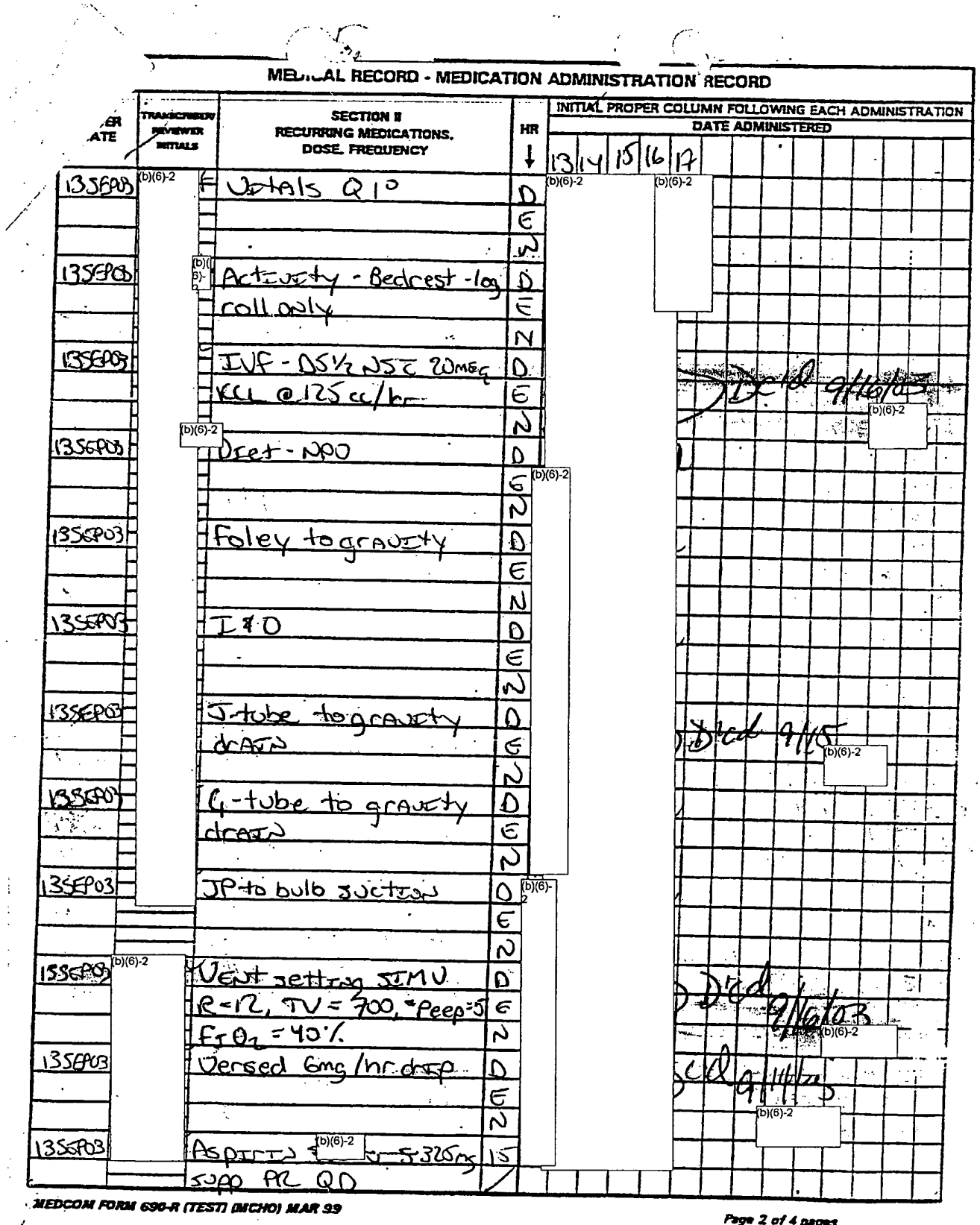
ACLU-RDI 1099 p.869

DOD 006137



MEDICAL RECORD - MEDICATION ADMINISTRATION RECORD

...ER ...ATE	TRANSCRIBER/ REVIEWER INITIALS	SECTION II RECURRING MEDICATIONS, DOSE, FREQUENCY	HR ↓	INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION — DATE ADMINISTERED: 13	14	15	16	17
13SEP03	(b)(6)-2	Vitals Q1°	D	(b)(6)-2		(b)(6)-2		
			E					
			N					
13SEP03	(b)(6)-2	Activity - Bedrest - log	D					
		roll only	E					
			N					
13SEP03		IVF - D5½ NSI 20mEq	D					D'cd 9/16/03
		KCL @125 cc/hr	E					(b)(6)-2
			N					
13SEP03	(b)(6)-2	Diet - NPO	D					
			E	(b)(6)-2				
			N					
13SEP03		Foley to gravity	D					
			E					
			N					
13SEP03		I & O	D					
			E					
			N					
13SEP03		J-tube to gravity	D					D'cd 9/15
		drain	E					(b)(6)-2
			N					
13SEP03		G-tube to gravity	D					
		drain	E					
			N					
13SEP03		JP to bulb suction	D	(b)(6)-2				
			E					
			N					
13SEP03	(b)(6)-2	Vent setting SIMV	D					D'cd 9/16/03
		R=12, TV=700, Peep=5	E					(b)(6)-2
		FiO_2 = 40%	N					
13SEP03		Versed 6mg/hr drip	D					D'cd 9/14/03
			E					(b)(6)-2
			N					
13SEP03		Aspirin (b)(6)-2 ... 325mg	15					
		supp PR QD						

MEDCOM FORM 690-R (TEST) (MCHO) MAR 99

Page 2 of 4 pages

MEDCOM - 2086

MEL... RECORD - MEDICATION ADMINISTR...ON RECORD

For use of this form, see MEDCOM Circular 40-5

ORDER DATE	TRANSCRIBER/ REVIEWER INITIALS	SECTION I DELAYED SINGLE ACTION ORDERS & PREOPERATIVES	DATE/TIME TO BE GIVEN	DATE/TIME GIVEN AND INITIALS
13SEP03	(b)(6)-2	To ICU - 1	13SEP03	(b)(6)-2
13SEP03		Cont to ICU - stable	13SEP03	
13SEP03		Labs - CBC, ABG, PA-7 in AM	13SEP03	
14Sep		Tylenol 650mg PR now see below	14SEP03 AM	(b)(6)-2 (b)(6)-2
14Sep		Tylenol 650mg PR now	14Sep	0300 (b)(6)-2
14Sep03		LASIX 20mg IV x 1 NOW	14 Sep NOW	14 Sep 0935
14Sep03		↓ rate to 10 NOW & Slowly wean to rate of 6 - Call MD if RR > 30	Sep	(b)(6)-2 14 Sep 1003 ↓8 14 Sep 1102 ↓6 RK
14Sep03		ABG 1 hr after rate of 6 is reached		
14Sep03		Wean Fentanyl to off	9/14/03	9/14/03 0945 (b)(6
14Sep03		↓ Versed	9/14/03	9/14 0919 ↓ 1013 ↓
14Sep03		Int CXR	9/14/03	9/14 (b)(6)-2 (b)(6)-2
14Sep03		Keep vent rate @ 12	9/14/03	9/14/03 1450
14Sep03		Tylenol 650mg supp RR Now		14Sep03 1630 (b)(6)-
14Sep03	(b)(6)-2	CBC, PA-7, ABG in AM	15SEP03 @0500	(b)(6)-2 0420
14SEP03		ABG now + PAT	2300	14SEP03 (b)(6)-2
14SEP03		Fentanyl bolus 100mg now	2230	(b)(6)-2 (b)(6)-2
14SEP03		Repeat Fentanyl bolus in 30min 100mg IV if remains agitated	2300	14SEP03
14SEP03		Tylenol 650mg PR x1 now	0400	15SEP03 (b)(6)-2
15SEP03		LASIX 20mg IV x1 Now	9/15/03 (b)(6)-2	9/15/0 1035 (b)(6)-2
15SEP03		Slowly WEAN RATE TO GOAL of 6 OVER NEXT 4 hrs	9/15 R11	9/15 1030
			R10	9/15 1115
			R9	9/15 1215
			R8	1310
			R7	
			R6	
15Sep	(b)(6)-2	CBC, ABG and PA-7 in AM	16SEP03 @0500	(b)(6)-2 0530
16SEP03		↓ RR to 10	9/16/03	10 0405 (b)(6)-2 10 1015

PATIENT IDE...ION

(b)(6)-4

S/P re-exploratory laparotomy washout/G tube

DIAGNOSIS: J-tube/JP drain/ABD closure

ALLERGIES: NKDA

Circle administration times (in pencil) for recurring medication.

D	07	08	09	10	11	12	13	14
E	15	16	17	18	19	20	21	22
N	23	24	01	02	03	04	05	06

ME[illegible] RECORD - MEDICATION ADMINIST[illegible]ON RECORD

ORDER DATE	TRANSCRIBER/ REVIEWER INITIALS	SECTION II (Cont.) RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION — DATE ADMINISTERED 13 14 15 16 17
1350P03	(b)(6)-2	Fentanyl 50mcg/hr	D	(b)(6)-2
		drip	6	
			2	
1350P03		Artificial drops	06	
		(tears) 2 drops QID	12	
		DU	18	
			24	
1350P03		Heparin 5000u SQ	12	
		BID	24	
1350P03		UNASYN 3.0gm IV	06	
		Q6°	12	
			18	
			24	
1350P03		ZANTAC 50mg IV Q8°	06	
			14	
			22	
1480P03		Versed gtt @ 2mg/hr	D	
			E	
			N	
1480P03		Suction ETT/Pulmonary	D	
		Toilet q 2° (RT)	E	
		Odd hours c NS	N	
1450P03	M	Fentanyl 100mcg/hr	D	
		gtt	E	
			N	
1550P03		VIVONEX TF 20cc/hr	D	
		through J TUBE	E	
			N	

PATIENT IDENTIFICATION
(b)(6)-4

DIAGNOSIS: s/p re-exploratory washout/4 tube
ALLERGIES: NKDA J-tube/JP drain/ABD closure

Circle administration times (in pencil) for recurring medication.

D	07	08	09	10	11	12	13	14
E	15	16	17	18	19	20	21	22
N	23	24	01	02	03	04	05	06

MEDCOM FORM 690-R (TEST) (MCHO) MAR 99

Page 3 of 4 pages

ACLU-RDI 1099 p.872

DOD 006140

MEDICAL RECORD - MEDICATION ADMINISTRATION RECORD

ORDER EXPIRATION DATE	TRANSCRIBER/ REVIEWER INITIALS	SECTION III PRN MEDICATION, DOSE, ROUTE, FREQUENCY, REASON	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE/REASON/INITIALS/EFFECTIVENESS CODE
13 16	(b)(6)-2	MSO4 1-2mg IV q15 min PRN	Date 13 Sep 13 Sep 14 Sep 14 Sep 14

MED[illegible] RECORD - MEDICATION ADMINIST[illegible]ON RECORD

ORDER DATE	TRANSCRIBER/ REVIEWER INITIALS	SECTION II RECURRING MEDICATIONS, DOSE, FREQUENCY	HR ↓	INITIAL PR[illegible] COLUMN FOLLOWING EACH ADMINISTRATION — DATE ADMINISTERED: 15	16	17	18
15SEP03	(b)(6)-2	FLUSH J-TUBE c̄ 30cc	08	(b)(6)-2			
		WATER Q SHIFT	16				
			24				
16Sep03	(b)(6)-2	D5NS c̄ 20meg KCl @	D				
		75cc/hr p̄ present bag	E				
			N				
16Sep03	(b)(6)-2	LEVAQUIN 500mg IV	11				
		QID					
16Sep03	(b)(6)-2	VENT SETTINGS: SIMV	D				
		TV 700 RR10 F_iO_2 40%	E				
		PEEP 5	N				
16Sep03	(b)(6)-2	Vent: SIMV TV 700	D				
		RR 8 F_iO_2 40% Peep 5	E				
			N				
16Sep03	(b)(6)-2	Vent: SIMV TV 700	D				
		RR12 F_iO_2 40% Peep 5	E				
			N				

Dec'd 9/16/03

(b)(6)-2

MEDCOM FORM 690-R (TEST) (MCHO) MAR 99

Page 2 of 4 pages

(b)(6)-4

MEDCOM - 2090

MEDICAL RECORD - MEDICATION ADMINISTRATION RECORD

For use of this form, see MEDCOM Circular 40-5

ORDER DATE	TRANSCRIBER/ REVIEWER INITIALS	SECTION I DELAYED SINGLE ACTION ORDERS & PREOPERATIVES	DATE/TIME TO BE GIVEN	DATE/TIME GIVEN AND INITIALS
9/16	(b)(6)-2	CBC, ABG, PA-7 in AM	9/17 0500	0520 (b)(6)-2
9/16		Tylenol 650mg Supp PR X 1 Now	9/16	9/16 1245 (b)(6)-2
9/16		↓ rate to 8	9/16	9/16 9-1235 8 1315 (b)(6)-2
16SEP		↓ rate to 6	9/16	1500 (b)(6)-2
16SEP		ABG 1hour after rate of 6	9/16	1600 (b)(6)-2
16SEP		↑ rate to 12	16SEP	(b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-4

DIAGNOSIS:

ALLERGIES:

Circle administration times (in pencil) for recurring medication.

D	07	08	09	10	11	12	13	14
E	15	16	17	18	19	20	21	22
N	23	24	01	02	03	04	05	06

MEDCOM FORM 690-R (TEST) (O) MAR 99 PREVIOUS EDITIONS ARE OBSOLETE *Page 1 of 4 pages* MC V1.00

MEDCOM - 2091

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-400; the proponent agency is The Office of The Surgeon General

REPORT TITLE: POST ANESTHESIA CARE UNIT FLOWSHEET

OTSG APPROVED (Date): 17 Jan 80

PROCEDURE: S/P exploration Washout Tube Tube Jedrain

PHYSICIAN: and closure (b)(6)-2

ANESTHESIA BY: (b)(6)-2

Gen Spinal MAC Axillary Local Bier Epidural Other

ALLERGIES: NKDA

AIRWAYS: ____ Time DC'D ____

ETT Nasal Oral Trach

OXYGEN: 8.0 @ 23 lip/teeth

Mask Nasal Face Blow-By Prongs Tent

Liter/min. ____ %

ASA ____ History ____

Cardiac Rhythm ____

IV#1 Patent Infiltrated Site DAC Rate 125 Gauge 16

IV#2 Patent HL Infiltrated Site DAC Rate 125 Gauge 14

Time	B/P	P	R	O2SA	Temp	Act	Resp	Circ	LOC	Skin	PARS	COMMENTS	Neuro-Vascular
PRE-OP	/												Extr: L R Upper Lower Pulse DP PT RAD
PRE-OP	/												Blanche Warm Pulse Moves Y N
1525	119/63	86	31	100%	95[2]								Blanche Warm Pulse Moves Y N
1530	125/67	87	17	100%									Blanche Warm Pulse Moves Y N
1535	126/64	86	18	100%									Blanche Warm Pulse Moves Y N
1540	109/58	85	13	100%									Blanche Warm Pulse Moves Y N
1600	131/66	84	12	100%									Blanche Warm Pulse Moves Y N
1615	119/64	86	14	100%	96[3]								Blanche Warm Pulse Moves Y N
1630	125/69	85	12	100%									Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N

Sedated Paralyzed

POST ANESTHESIA RECOVERY SCORE "PARS"

Activity - General Anesthesia
2--Maintain head lift and open eyes
1--Unable to maintain head lift and open eyes
0--Unable to lift head and open eyes

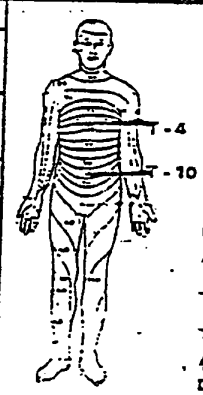
Activity - SAB or Subarachnoid Block
2--Moves all four extremities with control
1--Moves both upper extremities

Respirations
2--Spontaneous respiration; needs no support
1--Limited effort; needs artificial airway or jaw support
0--Needs ventilator; no spontaneous respiration

Circulation
2--BP 20% preanesthetic level
1--BP ~~20~~ - 50% preanesthetic level
0--BP 50% or more preanesthetic level

Level of Consciousness
2--Awake and alert; seldom dozes
1--Awakens when gently stimulated
0--Awakens only when vigorously stimulated

Skin
2--Normal skin color & temperature greater than 96°
1--Skin is pale, blotchy, dusky &/or temperature 95 - 96°
0--Cyanotic &/or temperature less than 95°



DRESSING:	Status	Location
Gauze		
Opsite		
Bandaid		
Steri-strips		
Collodian		
Peri-pad		
Coban		
Cotton Balls		
Ace Wrap		

TUBES AND DRAINS: Hemovac Foley NGT Chest Jackson-Pratt

(Continue on reverse)

PREPARED BY (Signature & Title): (b)(6)-2 UTAN

DEPARTMENT/SERVICE/CLINIC: ICU #1

DATE: 13 Sep 03

PATIENT'S IDENTIFICATION (If typed or written entries give: Name-last, first, middle; grade; date; hospital or medical facility)

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTICS STUDIES

☐ TREATMENT

DA FORM 1 MAY 78 4700

FH MDA OP 132-11a (Rev) 1 Sep 99

MEDCOM - 2092

INTAKE			OUTPUT		
TIME	TYPE	AMT	TIME	TYPE	AMT
OR	LR	1400	OR	EBL	100
			OR	Urine	75
TOTAL		1400	TOTAL		175

PACU NURSING NOTES: NURSING CARE PROBLEM NO.'S IDENTIFIED. Refer to FH MDA OP 39

NURSING CARE PROBLEMS: 1. RESP; 2. CIRC; 3. ACT; 4. LOC; 5. TEMP; 6. PAIN; 7. SAFETY; 8. ANXIETY; 9. EDUC; 10. OTHER

See assessment in ICU flowsheet.

(b)(6)-2

MEDICATION RECEIVED IN PACU/ICU

MEDICATION GIVEN BY:	DRUG	DOSE	ROUTE	TIME	PAIN LEVEL	EFFECTIVENESS

DISPOSITION SUMMARY: Nursing Care Problems No.'s_____ Resolved; No.'s_____ Continue.
Patient was transferred from PACU/ICU recovery room via litter/crib with siderails raised, or held by parent in wheelchair.
Dressing status:_____ PAR Score_____ Safety Straps_____
Report given to_____. Patient released by Anesthesia_____
Time out_____. Nurse Signature:_____

MEDCOM - 2093

Original given to LT Chewoni.

609496

RECEIPT FOR PRISONER OR DETAINED PERSON

RECEIVED FROM (Unit or A[redacted]nd Station) 101ST CAGE [redacted]OSUL IRAQ	TIME	DATE 16 SEP 03
LAST NAME — FIRST N[redacted] — MIDDLE INITIAL [redacted] (b)(6)-4 (b)(6)(4)	SERVICE NUMBER/SSN	GRADE
ORGANIZATION	STATION	
OFFENSE ATTA[redacted]n COALITION FORCES		
PERSONAL PR[redacted] (b)(6)-2 [redacted]e		
REMARKS Gunshot wound to Lower Back		
NAME AND TITLE OF PERSON RECEIVING ABOVE INDIVIDUAL (Typed or Printed) Kapeem Saleem	SERVICE NUMBER/SS[redacted]	GRADE
RECEIVING UNIT OR AGENCY AND STATION Al-Zahrawi Hos[redacted]al	SIGNATURE [redacted]	

DD FORM 1 MAR 58 629 [redacted]N OF 1 MAR 52, IS OBSELETE. (b)(6)(4) U.S[redacted]ent Printing Office: 1992 — 311-830/65132

(b)(3)-1 (b)(6)-4 (b)(6)-4

MEDCOM - 2094

ADMISSION AND CODING INFORMATION

For use of this form, see AR 40-400; the proponent agency is OTSG

1. REPORTING MTF	2. LOCATION (State or Country Code.)	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
A14A1	IZ	(b)(6)-4	Iraqi (b)(6)-4	C/V FRA	M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
(b)(6)-4		X	9	

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
			(b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
EPW Iraqi		2337	

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
	K76 K18	

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION YEAR / NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
0	ICU1	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY
B C0, 21st Combat Support Hospital, Mosul, Iraq

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYYYMMDD)
01		20030917

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYYYMMDD)
A6AA		20030910

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYYYMMDD)
	A14A1	20030910

FOR LOCAL USE

Trauma 9

Injury

Dx: 86414 86612 86331 8065 86812 8708 5997 86814 88912

Px: 8622 (x4) 5060 5681 4671 0820 0881 5122 4719 9904 (x4) 4311 4639 5732 5412 9659 5794

(b)(6)-2 (b)(6)-2 (b)(6)-2 MD (b)(6)-2 FAMILY PRACTICE

SIGNATURE OF ADMITTING CLERK (b)(6)-2

DA FORM 2985, MAR 2000 EDITION OF MAR 89 IS V1.00

MEDCOM - 2095

(b)(3)-1

INPATIENT TREATMENT RECORD COVER SHEET *(For Plate Imprinting)*

For use of this form, see AR 40-400; the proponent agency is the Office of The Surgeon General.

PATIENT DATA ITEMS 1 - 30 *(Excluding Items 25 & 26)*

Iraq (b)(6)-4

(b)(6)-4

Reg # (b)(6)-4

LINE	LEGEND
1	REGISTER NO. - NAME - GRADE
2	SEX - AGE - RACE - RELIGION - LENGTH OF SVC - ETS - PREVIOUS ADMISSION
3	FMP - SSN - ORGANIZATION - WARD
4	FLY STAT - RATING/DESG - DEPT/BEN - BRANCH/CORPS - UIC/ZIP - TYPE CASE
5	SOURCE & AUTHORITY FOR ADMISSION - HOUR OF ADMISSION - CLINIC SVC
6	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
7	ADDRESS OF EMERGENCY ADDRESSEE - PHONE NO. - DATE OF THIS ADMISSION
8	NAME & LOCATION OF MEDICAL TREATMENT FACILITY DATE OF INITIAL ADMISSION

ADMISSION REMARKS

(b)(6)-2

32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED

25. TYPE DISPOSITION: D/C

26. DATE OF DISPOSITION: 16 Oct 03

31. SELECTED ADMINISTRATIVE DATA

☐ CHECK IF CONTINUED ON REVERSE

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

- GSW to ABDOMEN and Exisceration
- GSW to (L) thigh — E985.3 ICD9FY02
- S/P Exploratory Laparotomy — 54.11 ICD9FY02
- S/P Small bowel resection — 45.51 ICD9FY02
- S/P Large Bowel repair — 45.52
- S/P appendectomy — 47.09 ICD9FY02
- (B) Chest Tubes — 40 Oct 03
- Hypoxia (Acute) 799.0 ICD9FY02 S/O Acute Pulmonary Embolism — 40 Oct 03 Anticoagulation

20 Oct 03

780.6 ICD9FY02 — Fever — 40 Oct 03

— Intubation — 40 Oct 03

38.87 ICD9FY02

☐ CHECK IF CONTINUED ON REVERSE

35. TOTAL DAYS THIS FACILITY

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

36. TOTAL DAYS ALL FACILITIES

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

(b)(6)-2 | FICER MD | (b)(6)-2 | MEDICAL RECORDS OFFICER

DA FORM 1 MAY 79 3647-1 EDITION OF 1 AUG 76 IS OBSOLETE.

MEDCOM - 2096

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

PERTINENT HISTORY, CHIEF COMPLAINT, AND CONDITION ON ADMISSION *(Enter date of admission)*

See H&P by Dr.
SF 558

(b)(6)-2

PHYSICAL EXAMINATION

PROGRESS *(Enter date of discharge and final diagnosis)*

(b)(6)-2

	DATE	IDENTIFICATION NO.	ORGANIZATION
MD	07207		

PATIENT'S IDENTIFICATION *(For typed or written entries give Name last, first, middle; grade; date; hospital or medical facility)*

REGISTER NO.	WARD NO.

(b)(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
USAPPC V1.00

ACLU-RDI 1099 p.881

DOD 006149

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
2 Oct 03 2050	Pt cont. to c/o severe abd pain. HR remains 140's, RR 22-32. Dr. (b)(6)-2 aware of VS, ordered demerol 25mg + phenergan 12.5mg IV @4° prn breakthrough pain. 4mg MSO4 IV given @ 2040. Will continue to monitor pt. (b)(6)-2 MAJ, AD
2 Oct 03 2230	Resting supine. Performing IS c difficulty. HR 140's, RR 22-25. Assessment completed. IV's to RLC's patent. Pulses palpable. AOX3 per interpreter. Dressings CDI. Continue to monitor. (b)(6)-2 CPT, USN
3 Oct 03 0030	Resting quietly. VSS. HR ↓ to 140's & 160's. Demerol / Phenergan given at 2230 for c/o's pain. HR 160's. Post demerol Rest to teens from high 20's & 30's ROP adq. ∅ intervention by phys. Cont. to monitor. (b)(6)-2 CPT, USN

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)*		REGISTER NO.	WARD NO.	

(b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

MEDCOM - 2098

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
3 Oct 03	Surg Note
0920	S: Pt. stable, ϕ sig events overnight
	pain controlled
	O: 100? 121/66 127-140 19-31 Sats 100% SL-O
	Heart - tachy ϕ murmurs
	Lungs - CTA (B)
	Abd - soft, ND, approp TTP
	minimal BS
	NGT = 205 cc
	I/O = 11550/1631
	over past 8 hrs - 1300/750
	9.8 11.5 34.9 (185 - 122 104 3.7 23 0.9 (117
	Alp: Pt. POD1 Ex lap/SB resection c̄
	anastomosis/Sigmoid repair x 2
	doing well
	(1) Cont NPO/NGT
	(2) IVF
	(3) Cont dressing change (2) lower
	abd & (2) thigh
	(4) will D/c NGT when bowel fxn returns

b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK
USAPA V1.00

MEDCOM - 2099

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
4 Oct 03	Surg note
0855	S: Overnight, pt. placed on NRB for ↓ sats
	Currently, pt. comfortably, no new
	complaints
	O: 100³ 132/75 117-134 28-42 sats 94-95%
	100% NRB
	Heart - tachy
	Lungs - Ronchi R > L
	Abd - soft, ND, approp TTP
	hypoactive BS, Incision C/D/I c̄ staples
	NGT = min LLQ wound - healing slowly
	I/O - 3625/2675 CXR - pulm edema,
	9.7 > 10 / 28.5 < 160 136 / 3.5 / 103 / 26 / 8 / 0.7 < 96 atelectasis
	A/P: Pt. POD 2 Ex lap / SB resection c̄
	anastomosis / sigmoid repair X2
	stable but ↓ sats probably due
	to atelectasis / pulm edema. Pt. not
	compliant c̄ IS.
	(1) Cont NGT until return of bowel fxn - advance tube
	(2) Lasix for diuresis
	(3) OOB to chair / aggressive IS
	(4) Cont dressing DS
	(5)

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME		SPONSOR'S ID NUMBER
	LAST [redacted]	FIRST LLQ	(b)(6)-2
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS	
(b)(6)(2)			

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)

REGISTER NO.

(b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(18)

509-114

MEDCOM - 2100

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
50ct03	2115: Pt turned to (R) side. Sub Q emphysema continues to upper sternal area. Lung Sounds to (R) lobes & (L) lobes have inspiratory and exp wheezes and rhonchi. Oral care complete. Chest tube drainage counted and marked (b)(6)-2
50ct03 2200	Rec'd on (R) side. VSS. Assessment completed. Crepitus to (R) sub clavicular area. Vecuronium, Fentanyl, + versed infusing to (R) AC. See assess flowsheet for vent settings + drip rates. VSS & Cont. (b)(6)-2 cpt RN
	to monitor.
50ct03 2300	Pt placed supine from (R) side. No apparent distress. VSS. Cont to (b)(6)-2 cpt RN
	monitor.
~~50ct03~~	
error ~~0100~~	

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI | SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade) | REGISTER NO. | WARD NO.

(b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 8-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

509-114

ACLU-RDI 1099 p.885

DOD 006153

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
7 Oct 03 1845 (cont)	to command. Pt followed no commands to move extremities. ABG @ 1800: pH 7.53, pCO_2 - 37, pO_2 - 134, HCO_3 - 30, BE-8, SO_2-99%. Dr. [b)(6)-2] notified → FiO_2 ↓ to 0.50, Rate ↓ to 23. ABG due @ 1915. Cont to suction ETT for ∅ secretions. Ins + Ex wheezing noted in (B) bases and LUL. [b)(6)-2] MAJ AN
7 Oct 03 1930	ABG @ 1915: pH·7.52, PCO_2 - 37.4, PO_2 - 138, HCO_3 - 30. Dr [b)(6)-2] aware → ↓ FiO_2 to 0.45, ↓ rate to 23. [b)(6)-2] MAJ AN
7 Oct 03 2200	At 2000, pt became very agitated, bucking vent, thrashing about in bed. HR ↑, SpO_2 ↓ to 88, RR ↑ to 30-40. Dr. [b)(6)-2] notified and came to bedside. Pt seemed to calm down ~~when~~ when disconnected from vent and bagged c ambu. Multiple med boluses were given to calm pt down: total of 25mg versed and 6mg ativan in addition to maintenance doses/drips. Fentanyl drip maintained @ 200μg/hr, versed ↑ to 8mg/hr., FiO_2 ↑ to 0.60. Unable to given IV med thru (R) wrist saline lock → discontinued. Another saline lock, 18G, was started in (R) wrist above previous site. IV inserted c good flashback, flushed p insertion. [b)(6)-2] MAJ AN
2210	Continues to be agitated c RT @ bedside bagging c phy c/s MAJ @ bedside, Ativan ↑ to 3cc/hr [b)(6)-2]
2220	continues to show S/S of agitation, Ativan ↑ to 4cc/hr

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME (LAST / FIRST / MI) | SPONSOR'S ID NUMBER (SSN or Other)

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[(b)(6)-4]

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

509-114

MEDCOM - 2102

DATE	NOTES
	will conti to monitor pt (b)(6)-2
2245	Diplivan started for agitation, Ativan D/Cld (b)(6)-2
	& chest x ray done (b)(6)-2 CPW

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
4 Oct 03 2130	1st unit PRBCs finished @ 2000. No S/Sx transfusion rxn noted. Second of 2 units started @ 2020, no adverse effects noted c unit #2 thus far. Pt easily arousable, responds appropriately to yes/no questions per interpreter. Denies pain, appears uncomfortable c ETT + bite block. ETT suctioned for small amount of frothy, white secretions, + gag reflex. Vivonex tube feedings cont. c 10cc residual x 2 this ~~shift~~ shift; no S/Sx aspiration noted. Unable to hear bowel sounds on auscultation; abd soft, non-distended. LLQ abd dsg d/d-small amt blood noted on wound, no purulent discharge noted. Chest tubes x2 ((R)+(L)) remain on -20cm H_2O suction each c small amt drainage, mainly serous. Course clonchi throughout all lung fields. Pt re-assured thru interpreter. [b)(6)-2] MAJ AP
5 Oct 03 2200	Report recieved from evening shift nurse, pt resting bt slightly agitated, moving arms & hands, IV fluids cont to infuse as ordered, Blood (2nd unit) infusing c S/S of side effects, cont. suction to B/L chest tubes, will cont to monitor pt [b)(6)-2]
2300	- pt now extremely agitated, unable to calm pt down c assistance of interpreter & 2 other nurses; doctor informed new orders recieved, prn given (see MAR) to sedate pt [b)(6)-2]

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST / FIRST / MI | SPONSOR'S ID NUMBER (SSN or Other)

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(b)(6)-4

PROGRESS NOTES
Medical Record

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509-114

MEDCOM - 2104

DATE	NOTES
2300 cont	Infusion of Blood transfusing complete $\bar{S}$ S/S of near side effects will continue to monitor pt [redacted]
10 Oct 03	Assumed pt from previous nurse pt sedated lying
0200	supine, continuous suction, NG to (R) nare, CT x2 bilateral monitors on UTA pain, NAD [redacted]
0230	Assessment complete consult DA form 4700 for more information. D5NS @125 cc/hr to triple lumen central line, Propofol 60ml/hr, Vec, Fentanyl, versed & vivonex running into pt. NG to (R) nare c̄ ITT to continuous suction, monitors on, ID bracelet to (L) wrist b/p cuff to (L) UE, soft restraints x2 to UE's L/R bilateral CT's, patent, PSO_2 monitor (L) hand, A-line (R) wrist, midline incision CTA staples CDI, (L) lower abd bandage CDI $\bar{S}$ saturation, foley intact patent attached, tubing, to (R) thigh non-pitting generalized edema UTA (R) radial d/t taping around wrist & A-line positioning, pulses present normal x3 ext. conducted foley care, will continue to monitor per ICU SOP [redacted]
0430	NG residual assessed 8cc residual fluid [redacted]
0520	CXR performed by radiology [redacted]

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
11/Oct 03 (800)	Surgery Pt has been extubated 24hrs, respiratory status markedly improved Vss Apt L-CTA Sat 98% CXR this am c̄ bilateral PTX, chest tubes re drained, Pleur-EVAC's Δ'd repeat xray and CW-NSR HR 70-80 BP stable Abd-NABS, soft incisional tenderness Tol clear liquid B/o UOP adequate Labs - see flow sheet A/p 5/p GSW Abd - marked improvement last 36hrs. (1) Pt activity (2) Advance diet as tol (3) Continue CD @ 200 [illegible] (4) D/c Abd

(b)(6)-2

RELATIONSHIP TO SPONSOR	SPONS	SOR'S ID NUMBER or Other)
	LAST	

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PROGRESS NOTES
Medical Record

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
13Oct03 2045	Pt awake, IS complete able to take in inspiration to raise 1 ball and 2nd ball halfway. Productive cough when using IS. [redacted]
13Oct03	2200- Awake in bed, requesting pill for insomnia, (see MAR) will continue to monitor [redacted]
30Oct03	2230- resting @ this time [redacted]
13Oct03	0001- C/O pain to ABD via hand motions pain med given (see MAR) will continue to monitor pt [redacted]
14OCT03 0145	Assumed pt, pt resting supine c̄ HOB ↑, Breathing regular unlabored, DSNS c̄ 20KCL to TLC patent intact, O_2 via NC @ 8L feet slightly elevated, MP @ BS, interpreter @ BS [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)*

REGISTER NO.	WARD NO.

[redacted]

PROGRESS NOTES
Medical Record

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USAPA V1.00

MEDCOM - 2107

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
12.20.03	G Surgery
	Pt ≡ % abd distension ⊖ flatus/BM
	Oss Aqt
	L-CTA Sat 99% 2L
	CXR-Ø PTX CT-Ø air leak
	CV-NSR, HR 60-70
	BP stable
	B/O adequate UOP CR 0.6
	WBC 8K
	P/S S/P GSW to abd/ARDS
	(1) CT to water seal
	(2) D/C foley
	(3) Dulcolax suppp

(b)(6)-2

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
11 Oct 03 1930	Pt c/o chest/abd pain → 5mg MSO4 IVP given @ this time. This dose appears to keep pain tolerable × ~1.5 hrs. (R) radial A-line d/c'd per MD order. Pressure held to site × 5 minutes p̄ d/c and pressure dsg applied. No s/sx infection, infiltration, bleeding, or hematoma noted. — [redacted] MAJ AN
11 Oct 03 2120	Uses incentive spirometry q 1-2 hrs, able to raise one ball ~10 times, well not C+DB p̄ IS. Does cough mod amt c̄ light yellow/tan, thick secretions on own. Poor po intake, only ~300 cc over last 8 hrs. — [redacted] MAJ AN
11 Oct 03 2200	Assumed pt. pt sleeping supine c̄ HOB ↑ 30°, NAD, Bilateral CT to suction per order, D5NS to TLC @125cc/hr NC@3L on pt PSO2 99%, monitors on, BVM @ BS — [redacted]
12 Oct 03 0001	pt has high pitched wheezes x2 LL's, RT reassessed this UOP ↓ to 40cc/hr from 95cc/hr @ 2200, full assessment on DA form 4700, generalized edema non-pitting pulses easily palpated x4 extremities, breathing regular, unlabored will continue to monitor, — [redacted]
12 Oct 03 0500	drag Δ, pt tolerated c̄ minimal complaint, dressing packed tightly previously minimal drainage, bright red blood c̄ small amount of yellow drainage, pulled skin around edges of bandage — [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)*

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(b)(6)-4

PROGRESS NOTES
Medical Record

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MEDCOM - 2109

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
120703	0540 Radiology came to do CXR [redacted] (b)(6)-2

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MEDICAL RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
2 Oct 03	Brief op note
0535	1) Pre-op Dx - GSW Abd / Evisceration of Small bowel in exit wound @ lower abd
	2) Post-op Dx - GSW Abd / multiple SB enterotomies & 2 areas of transection of Small bowel, Sigmoid Injury X 2
	3) Procedure - Ex Lap / Small bowel resection c primary anastomosis / Sigmoid Repair X 2, Incidental Appendectomy
	4) Surgeon - (b)(6)-2 / (b)(6)-2
	5) Anesthesia - GETA
	6) Findings - 30 cm Small bowel resected - 2 enterotomies & 2 transections contained in the 30 cm, two small injuries to the sigmoid colon - minimal contamination.
	7) EBL - 300 cc UOP - 500
	8) Fluids - 5800 cc crys 250 5% Alb
	9) Complications - ∅
	10) Condition - Stable to ICU

(b)(6)-2

NAT NC

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* | REGISTER NO. | WARD NO.

(b)(6)-4

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MEDICAL RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
10/2/03	Prehospital - Received [illegible] s/p GSW to ABD (L)
0220	Thigh. 2 IV 16g (R) AC Patent. 18 in Tolly L Plane.
	ABD Dress L Plane. O2 via NRB @ 15 Lpm
0221	Awake - A&Ox3. GCS-15. Lgs CTAB. ABD GSW to
	(3) (E) RUQ/LUQ. (+) Bowel sounds. ∅ Exit. (+)
	GSW to (L) Thigh. ∅ Exit. Bleeding Controlled. —
0222	Monitors Placed. V.SS. O2 via NRB @ 15 Lpm. PM
	16g Placed (L) AC. Labs Sent. Type/X-match x III.
0226	X-ray @ Bedside. NS + Bolus x2 Liters. Tolly Foley-
	Placed Amber UA. (+) Pedal Pulses L (L) Foot.
0235	Ultrasound III Lgs + IVC. Lesions .5 Fm.
0250	X-ray Complete. V.SS. Pt Prepped for OR. —

	Vitals	Meds
0220	124/52 - 54 - 28 - 97.6(R) 100%	0230 Ultrasound III Gen IVC
0230	128/60 - 90 - 30 - 100%	0234 Lesions .5 cm Fm
0240	120/64 - 86 - 30 - 100%	
0250	128/70 - 90 - 30 - 100%	I&O
		IVF's 2000 cc —
		UA - 520 cc

HOSPITAL OR MEDICAL FACILITY | DEPART./SERVICE | RECORDS MAINTAINED AT

SPONSOR'S NAME | SSN/ID NO. | RELATIONSHIP TO SPONSOR

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* | REGISTER NO. | WARD NO.

(b)(6)-2

(b)(6)-4

Civ GSW Trauma

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MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
	— Transfer Note —
10/2/03 0135	Encounter ∂ 1/187 (apparent attack) → 1 fatality + 3 Iraqi WIAs. This pt has:
	(A) LLQ GSW ∂ small bowel evisceration/open area of small bowel
	*(packed ∂ sterile 4x4/saline/Dressing)
	(B) RUQ GSW, no hemodynamic instabil (140-150 BP) SaO_2 90-92%, but CXR ∂ fragments in RUQ
	(C) (b) lat thigh entrance wound, round in lat thigh muscle (Xray copies sent)
	Rxs (1) Toradol 30/Phen 125 IV
	(2) Rocephin 1gm IV (no Flagyl here)
	(3) O_2 / IV x 2 l
	(4) 21 CSH by 50th AA

HOSPITAL OR MEDICAL FACILITY	STATUS
SPONSOR'S NAME	SSN/ID NO.

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, mi Date of Birth; Rank/Grade.)

(b)(6)-4

Iraqi Combatant (b)(6)-4

(b)(3)-1

(b)(6)-2

ONSOR MD LTC, MC, FS

TER NO. | WARD NO. 626 FSB

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MEDICAL RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
4 Oct 03	
1000	Pt intubated c size 7.5 ET tube placed 22cm @ the teeth. Placed on Impact Uni-Vent mode: SIMV VT: 700 RR: 12 PEEP: 10 FiO_2: 100% —SGT [b)(6)-2] 9/V20
04 Oct 03 1420	Notify about CXRay showing (R) pneumothorax after noting desaturation. Chest tes tube placed in a sterile fashion (Brunelle/choi) and placement verify by another CXR, pt currently intubated and saturation in 89's %. Concerned for possible PE. pt will be started on Heparin load 10,000 U and then on heparin drip to keep INR ≥ 2.5
	[b)(6)-2] MD
4 Oct. 03 2044	drip, mfg, USP Chest tube insertion, left:
	- Sterile prep of left chest, sterile drape. Local anesthesia c 1% lidocaine @ 5th Ic space, mid-ax. line. Incision at this site, 3cm in length to SQ fat. Pleural penetrated c Kelly clamp, chest tube advanced into pleural space causing egress of bloody fluid and air. Tube secured c Suture. CxR pending.
	[b)(6)-2] [b)(6)-2]

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PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* | REGISTER NO. | WARD NO.

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CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
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MEDCOM - 2114

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
4oct0322100	pt given 10puffs Alb via inline MDI pt SpO2 91
	BP 164/70 HR 116 IV given NO adverse RX — [redacted] 9/11/20
4oct.03	CXR reviewed - chest tube in good position, lung well-expanded.
2203	
0100 4oct03	pt given 10puff 5 alb 10puffs via inline [redacted]
	MDI HR 112 BP 118/61 SpO2 92 — [redacted]
5 Oct 03	
0900	pt given 10 puff albuterol via aerovent spacer
	HR: 93 SpO2: 100% BP: 53/49 — SGT [redacted] 9/11/20

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MEDICAL RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
4 Oct 03 2130 (cont'd)	(L) chest tube = 95cc serosang drainage initially. Vent rate ↑ from 15-17 @ 2000. Lasix 80mg IVP given @ 2100. Port CXR done following CT insertion. O_2 sat @ this time are 90-93%, pH-7.25, PCO_2-77.7 and PO_2-96, HCO_3-34, BE 7. HR ↓ to 115-120. BP stable, A-line ~ 20mm Hg above cuff BP (sys). Solu-medrol 500mg IVPB given @ 2030. [b)(6)-2] MS AN
4 Oct 03 2200	Report received assumed care of pt. See flowsheet for complete assessment. Drs [b)(6)-2] in to see pt. (T) sq emphysema noted (R) lateral neck, ∅ other appreciated. NGT drainage appears coffee ground, Dr [b)(6)-2] notified. ∅ air leaks noted on chest tube. (R) ∅ drainage noted, (L) smart serosang. drainage. [b)(6)-2] HM

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MEDCOM - 2116

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
	Surgery ICU Note
10/05/03	Events of last 24 hrs significant for
1030	(1) Acute respiratory failure
	(2) Pneumothorax on (R)
	(3) Bilateral CT for PTX/effusion
	(4) Pt started on Imipenem
	(5) Steroid pulse for acute lung injury
	Marked Improvement in Resp status overnight
	USS Trex 102
	Resp - L-occ rhonchi
	Sat 100% → FIO2 80% 10 PEEP
	PAP - 30's
	Last ABG 7.35/226/73.6/[illegible]
	cxr - better aeration
	L Lymphadenopathy
	Still Larger (R) diaphragm
	CV - RRR/ST 90-100's BP 100/56
	scalated E Vessel/Fentanyl

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
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MEDCOM - 2117

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
	Abd - (2) BS, soft, nondistended
	NG ≅ 200cc/24hr
	I/O - (-) 5000 24hr
	WBC 9.1 Hct stable
	K - 3.5 CR 0.9
	A/p S/p GSW Abd respiratory failure - mild improvement
	(1) Wean Vent as tolerated
	(2) Continue diuresis
	b)(6)-2 [redacted]
	LIC mcus/NV

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MEDICAL RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
6 Oct. 03	Icu note
0814	Pt stable overnight, ø sig. events. Icu D# 4 POD # 3
	VSS: 111 141/73 15 95-10 (50% FiO_2)
	Neuro: Sedated, paralyzed
	Pulm: SIMV R17 TV 600 FiO_2 50% PEEP 10 PIP 20s
(B) Chest tubes on suc, ø air leak, min. drainage	cxam - good (B) air exchange. Diffuse rhonchi
	CVI stable. mild tachycardia / HTN. nl S1, S2, III/VI SEM @ RUSB.
	GI/Hepatic: tbd soft, min. distension. Wound healthy.
	(+) Bowel sounds. LFTs wnl.
	Renal: excellent ongoing diuresis.
	Acid/base: PCO_2 45. Met. alkalosis ē pH app. 7.5: Most likely cause is diuretic and NG suction. on D5 NS
	@ 75cc/hr - look for it to correct.
	CXR: Effusions clearing, (B) hemidiaphragms visible. ETT position good. NG position - distal esophagus? Stomach well-decompressed. ↑ radiodensity on (L). ↓ radiodensity on (R).
	Imp/plan: S/P ex. lap for GSW. Improving pulmonary status ē PCO_2 in nl range and PaO_2 in low 100s on 50% FiO_2. Iatrogenic & ~~compensatory~~ met. alkalosis being treated ē NS.
	over →

- Fentanyl gtt
- versed gtt
- Zantac
- Lovenox 80 SQ bid
- Imipenem 500 q6°
- Albuterol MDI q4°

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
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CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
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FIRMR (41 CFR) 201-9.202-1

MEDCOM - 2119

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
	– ↓ vent. rate to 15
	– ↓ fio2 to 40%
	– D/C vecuronium
	– once alkalosis corrects, move toward extubation.
	[b)(6)-2] MD [b)(6)-2]
4 Feb 03	Icu Note
0730	– The patient doing well this am, ↓ Sig. changes overnight. ~~Continues to have~~
	By systems: Neuro: sedated, paralyzed
	CV: Hyperdynamic – hypertensive, mildly tachycardic.
	Heart sounds difficult to hear 2° to rhonchorous breath
	Sounds.
	Resp: oxygenation more than adequate. Po2 179 on Fio2 40%
Chest tubes on	diffuse crackles / exp. wheezes on exam. Resp. acidosis. ↑ Pco2 57
Sux. ↓ air	Abd: soft, (+) BS, minimal distension. NG ↑ OP – appears
leak. Minimal	to be in duodenum. Will pull back.
O.P.	Renal: ↓ renal fct. electrolytes WNL. Met. alkalosis continues.
CXR: improved	Expect to correct.
over yesterday.	Nutrition – none
(B) lungs well-	Plan: – ↑ vent. rate to 16.
expanded.	– ↑ withdraw ~~NG~~ NG into stomach.
ETT - good posn.	– D/C vec.
NGT – in	– Consider spont. vent. trial today once vec.
duodenum	wears off. Will D/W Dr. [b)(6)-2]
	[b)(6)-2] MD [b)(6)-2]

N 7540-00-4176

MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

AUTHORIZED FOR LOCAL REPRODUCTION

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
06 OCT 03 1845	D/C'd 14g IV to (R) AC D/T leaking @ site. No evidence infection noted. Restarted 18g in (L) H. (b)(6)-2
1900	Rolled pt to (L) side, ensured proper body alignment. Cleaned eyes & administered eye gtts on. Will continue to monitor. (b)(6)-2
2035	Repositioned to supine c̄ HOB @ 30°. Body in proper alignment. Will continue to monitor. (b)(6)-2
2125	IV to (R) Hand inadvertantly D/C'd. Attempted to restart x 6. Gave report to next shift. (b)(6)-2
2200	received report from Eve shift nurse, pt paralyzed via medication (see MAR); IV, 20 guage to (R) AC started c̄ difficulty on first try, vent rates continue (see Dr. Orders) Ø Respi distress noted; all dressings CDI, Ø leakage noted to chest tubes #1 or #2, NG tube LIS c̄ dark green secretions, ET tube in place, A-line; IV sites to C & (R) AC CDI, IV fluids infusing as ordered will continue to monitor pt (b)(6)-2
7 Oct 03 0200	Assumed pt, pt sedated receiving IV medications to bilateral AC's, pt on respirator, has bilateral CT's, foley to gravity, (R) ~~her~~ eron wrist A-line, lying supine, turned to (R) side c̄ assist, pt also has NG tube, will continue to monitor. (b)(6)-2
0250	Assessment complete, consult D4 form 4700 for full assess-

SPITAL OR MEDICAL FACILITY

ONSOR'S NAME	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

IENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)

(b)(6)-4

6 Oct 03

REGISTER NO.

WARD NO. ICU

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

MEDCOM - 2121

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
ct03	ment, (R) LE pedial pulse faint, pt has generalized non-
2250	putting edema, skin cool dry pale, L/R AC PIV
tinued)	patent CDI flushed (R) AC, (L) fluids running per
	order by physician, (R) wrist A-line patent CDI, zeroed
	L/R CT's c̄ little to Ø fluid expelled operating properly
	pt has NG c̄ int suctioning to (R) nare, foley to gravity
	putting out 100-200 cc/hr yellow y urine S sediment
	conducted foley care. pt heavily sedated does not actively
	more extremities [redacted]
Ø25Ø	increased pt dose g Vecurrin from 5ml/hr to 2ml/hr [redacted]
	d/t pt tremors & ↑ R. to 32bpm [redacted]
Ø31Ø	pt stopped tremors, NAD
0435	increased pt dose g Vec d/t increased tremors during [redacted]
	dressing Δ [redacted]
0520	Portable CXR taken

STANDARD FORM 600 (REV. 6-97) BACK

FPL LE Printed on Recycled Paper

MEDCOM - 2122

N 7540-00-834-4176

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
8 Oct 03	Surgery ICU Note
1430	Pt bed desaturation last pm requiring ↑'d
	FIO_2 and paralysis to improve oxygenation
	VSS 101.6
	L- diffusion shrinkage b'd BS (R) bone
	CXR-RLL atelectasis
	Current Vent- FIO_2 90 PEEP 10 TV 600 IMV 16
	Sat 99%
	Pt bronch'd x2 c̄ removal large amt
	secretion
	CV-ST, RRR 100's
	Abd-soft, ⊕ BS, incision Cleaning well
	⊕ distension
	NG ≅ 200 last shift
	S/O WOP - adequate - 997 cast 24hr
	WBC 10.8 Hct 29 Hgb 10.1
	K 3.3 Amy 208 Tbili 0.3
	A/P S/P GSW - Abdomen
	(1) Diagnostic Respiratory Tactics
	(2) Central line placed
	(3) Kcl Replacement. (4) Start trophic feed.
	(3) Lovenox to 30 mg SQQ 12

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; S... Date of Birth; Rank/Grade.)*

(b)(6)-4

(b)(6)-2

(b)(6)-2

WARD NO.

LTC McKinney

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

MEDCOM - 2123

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
90 Oct 03	ICU Note
1500	Pt relatively stable overnight, paralyzing weaned, relatively [illegible]
	Vss Aqb (Trex 100)
	L-coarse [illegible]
	cxr improved aeration (R) base
	ABG 60% → 7.5/175/33.8/-6 Sat 100
	CT-minimal output
	CV-ST 100's
	BP-stable
	Abd-NABS, soft [illegible]
	tube feed @ 10cc/hr [illegible]
	[illegible]
	[illegible]
	P/P 8/p GSW Abd
	(1) Wean Vent as tol
	(2) Transfuse [illegible] PRBC
	(3) ↑ tube feed to 20cc/hr

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE (b)(6)-2	[illegible] ECO[illegible] [illegible]NTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SP[illegible]	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

REGISTER NO.	WARD NO.

(b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

MEDCOM - 2124

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
10 Oct 03	(Continued) breathing rapid/shallow, midline incision OTA intact
2250	Rhonchi to lungs, (R) pedial faint (L) radial & pedial ~~[illegible]~~ pulses
	normal present, UTA (R) radial d/t bandaging cap refill 2 sec, moves
	fingers c̄ difficulty, skin warm & dry c̄ generalized non-pitting edema
	A&O x3 c̄ interpreter C BS, MPC BS — [redacted]
10 Oct 03	(2255) MSO4 administered by RN on duty PRN pain — [redacted]
10 Oct 03	(2345) changed CT x2 to water seal per orders — [redacted]
10 Oct 03	pt had a respiration rate of 50bpm manually, physician was
0100	notified by RT, pt's breathing continues to be rapid & shallow
	physician orders on ABG — [redacted]
11 Oct 03	(0130) placed mask on pt for pt comfort Ø O2 administered at this
	time PSO2 set 95% RA — [redacted]
11 Oct 03	(0135) physician visit, looked C ABG results decides not to
	intubate, will continue monitoring per physician orders [redacted]
11 Oct 03	(0247) MSO4 administered by RN on duty PRN for pain [redacted]
11 Oct 03	pt A&O; generalized edema noticibly lessened in UE's, HOB
0315	elevated 30 degrees, BS hyperactive x4 quads LS LDL & LLU
	Rales audible from front & back, rhonchi to (R) ~~[illegible]~~ lung
	skin warm & dry, pt talks to himself often, UOP exceeds
	D5NS input, color yellow c̄ sediment, MPC BS — [redacted]
11 Oct 03	(0500) X-ray came, pt tolerated — [redacted]
11 Oct 03	(0515) pt resting c̄ HOB elevated O2 C 22 via NC PSO2 set 94%

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* | REGISTER NO. | WARD NO.

(b)(6)-4 [redacted]

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

MEDCOM - 2125

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
11 OCT 03 0515	(continued) 0430 dressing Δ, (L) lower abd purulent drainage blood staining to removed dressing. (R) CT dressing Δ, saturated around chest tube opening, reinforced tape on (L) chest tube. pt continues to talk to self — [redacted]
11 OCT 03	(0540) D/C NC O_2, pt sat C 94% RA — [redacted]
11 OCT 03 0615	Pt Continuously moaning. Requesting O_2 MASK. O_2 SAT 93-95%. Pt c̄ shallow respirations 40-50's. Placed O_2 NC 3l/min Medicated c̄ MSO_4 4mg IVP. CT #2 c̄ AIR LEAK. CT #1 ∅ air leak. TLC Patent c̄ s/sx of infection. D5NS c̄ 20KCal @ 125cc hr. O_2 SATS 96-97. See flowsheet for assessment. — [redacted] LT, A
11 OCT 0900	CT DYSGS Δ (B). New Pleurovacs placed on suction. Portable cxr done. Toradol 30mg IV given for pain. [redacted] LT, A
11 Oct 03 1430	Pt c/o generalized abd pain and (L) chest pain around CT insertion site. Received 5mg MSO_4 IV @ 1330; due for toradol 30mg IV @ 1500. Pt has spontaneous cough for mod amt of thick, tan secretions. Appears alert & oriented, answering questions appropriately per interpreter. (R) + (L) CT → 20cm H_2O suction. (L) triple lumen - subclavian - patent, s/sx infection or infiltration. (R) radial A line → transducer/monitor c̄ good waveform. [redacted] MAJ, AN
11 Oct 1510	Toradol 30mg IV given @ 1450. c/o pain → 5mg MSO_4 IV given @ 1505. Will continue to monitor. — [redacted] MAJ AN
11 Oct 1630	Up in chair, only supported ~50% of weight. c/o hunger, asking for bread. Hair washed. — [redacted] MAJ AN
11 Oct 1830	Pt went back to bed p̄ attempting BM - no results. Ate ~25% of t̄ jello and drank small amt 7-up + water (total ~120cc). [redacted] MAJ AN
11 Oct 1900	UOP steadily ↓ throughout day, 21cc last hr; Dr. [redacted] aware → 500cc LR IV bolus hung per order. — [redacted] MAJ, AN

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STANDARD FORM 600 (REV. 6-97) BACK

MEDCOM - 2126

7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
13 Oct 03	Surgery
	Pt tol dist
	Vss Agent
	LCTA
	cw RRR
	Did not [illegible]
	wound [illegible]
	P/p S/p GSW [illegible]
	(1) D/c Tranquilizer / [illegible]
	(2) D/c [illegible]
	(3) Po [illegible]
	(4) Ambulate [illegible]
	(5) D/c [illegible]
	(6) [illegible] D/c [illegible] 48°

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

REGISTER NO.	WARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

MEDCOM - 2127

AUTHORIZED FOR LOCAL REPRODUCTION

NSN 7540-00-634-4176

MEDICAL RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
14Oct03	2300 - C/O PAIN to ABD 7/10 via interpreter, PAIN medication given (see MAR) will continue to monitor pt (b)(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*		REGISTER NO.	WARD NO.

(b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

MEDCOM - 2128

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
11 Oct 03	Surgery
0900	Pt tolerating reg diet, Ag/b, Ambulatory
	Uss Aff
	L-OA
	Abd-soft, nondistended
	Wound healing
	A/ S/p GSW to Abd
	D/c to MP's
	Wound care LLQ BID
	F/u Q week for wound ✓

(b)(6)-2

LTC [illegible]

FPI. LEX. Printed on Recycled Paper

STANDARD FORM 600 (REV. 6-97) BACK

MEDCOM - 2129

558-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp)

LOG NUMBER

ARRIVAL

DATE			TIME
DAY	MONTH	YR.	
02	Oct	03	0220

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☑ AMBULANCE ☐ OTHER (Specify)

CURRENT MEDS. (tetanus immunization and other data): ? denies

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES: ? denies

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration): GSW abdomen

SEX: M AGE: 23

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

VITAL SIGNS

TIME	0228
BP	124/52
PULSE	84
RESP.	31
TEMP.	97.6
WT. (Child)	100 %

(b)(6)-2

CATEGORY (See reverse)

- EMERGENT
- ✓ URGENT
- NON-URGENT

ORDERS	INITS.	TIME
CXR (P)	(b)(6)-2	
(R) (L) femur		
CBC, 1stat6,3		
2L NS bolus		
VA		

ASSESSMENT/DIAGNOSIS: GSW ABD

DISPOSITION (Check all that apply)

- HOME
- FULL DUTY

QUARTERS: 24 Hrs. / 48 Hrs. / 72 Hrs.

MODIFIED DUTY UNTIL: DAY / MONTH / YEAR

REFERRED TO (Indicate clinic)

- EMERGENCY
- TODAY
- 72 HOURS
- ROUTINE

ADMIT. TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE

- IMPROVED
- UNCHANGED
- DETERIORATED

TIME OF RELEASE:

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

TIME SEEN BY PROVIDER: 0220

S/P GSW abdomen x2, small bowell evisceration. Seen in @ Tallfar + transfer here for further care. Stable enroute, wl. vitals. Also noted small FW to (L) thigh / lat aspect. Bowel dressed c̄ saline / gauze.

P - ¢
S - ¢

109 / 912

141 / 105 / 15 / 16
3.2 / 1.2

C - WDWN. Mild distress. Alert.
A - speaking
B - BBS =
C - strong fem pulses
HEENT - atraumatic, NC
neck - ¢ HP.
CV - Reg ¢ m
lungs - B = BS
chest - atraumatic
neuro - MAE, GCS15
back - ¢ injury seen.

D - GCS15
MAE to command
(L) leg - thigh - (lat aspect small FW
abd - GSW to RUQ + LLQ. LLQ c̄ evisceration of bowel, pink, swollen. penetrating (+) stool @ bowel injury to exam

CxR
elevated (R) hemi-diaph ¢ptx

(L) thigh
Frag
Lat. thigh

EDC - To CR c̄ Gen Surgery - Eastman for ex-lap.

(CONTINUE ON SF 507, IF NEEDED)

PATIENT'S IDENTIFICATION (Mechanical imprint) FOR WRITTEN ENTRIES GIVE: Name - last, first, middle; SSN; DOB, service status, name and relation of sponsor or next of kin. (IMPORTANT: LIST FACILITY HOLDING TREATMENT RECORD).

Ivagere

(b)(6)-4

(b)(6)-2

MAJ MC

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans)

- To CR -

EMERGENCY CARE AND TREATMENT

MEDCOM - 2130

STANDARD FORM 558 (Rev. 6-82)

Prescribed by CSA and ICMP

MEDICAL RECORD | **INTRAOPERATIVE DOCUMENT**

For use of this form, see AR 40-407, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Litter BY Maj (b)(6)-2 CRNA

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY Maj (b)(6)-2

3. DATE 02Oct03 TIME PATIENT ARRIVED IN SUITE 0305

4. PATIENT IN ROOM TIME 0305 NUMBER OR #1

5. PREOPERATIVE EMOTIONAL STATUS

☐ CALM ☒ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER (Specify)

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC (b)(6)-2 RD	RELIEF SCRUB	
	SPC (b)(6)-2 66F (b)(3)-1		
ASSIGNED CIRCULATOR	Maj (b)(6)-2 66E	RELIEF CIRCULATOR	
	Maj (b)(6)-2 66E (b)(3)-1		

7. POSITION AND POSITIONAL AIDS (Specify)

☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

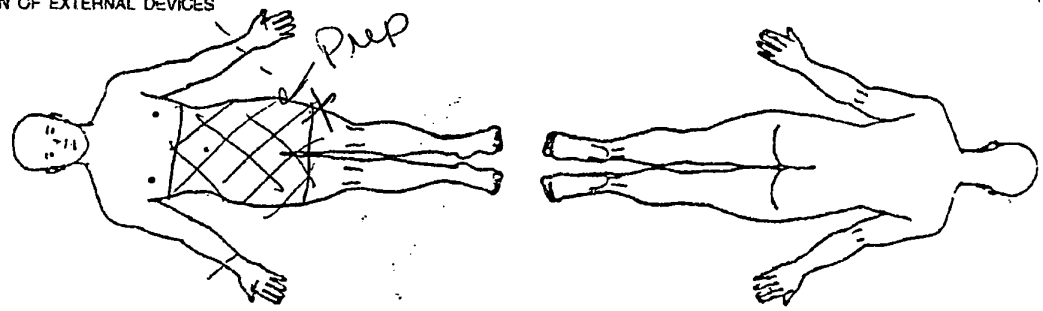
COMMENTS: Body alignment

8. SKIN PREPARATION

HAIR REMOVAL ☒ YES ☐ NO
DONE BY: ☒ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP
COMMENTS: No irritation

PREP SOLUTION (Specify) Betad/Beta
SITE: Abd BY WHOM: Maj (b)(6)-2
SITE: (See Below) BY WHOM:
COMMENTS: NO irritation noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Strap ═══ Tourniquet

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count
Sponge	☒ Yes ☐ No		C	C
Needle Sharp	☒ Yes ☐ No		C	C
Instrument	☒ Yes ☐ No		C	
Other	☒ Yes ☐ No			

SCRUB SPC (b)(6)-2 SPC

CIRCULATOR Maj (b)(6)-2 Maj

11. PATIENT IDENTIFICATION (For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)

(b)(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO

☐ ESU NO: 000434
GROUND PAD: BRAND Valleylab Polyhesive II
LOT NO: 69671 04/05

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

MEDCOM - 2131

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☒

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

0.9% NS

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM YES ☐ NO (b)(6)-2 IF YES, SITE

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

18. DRESSING/IMMOBILIZATION *(Specify)*

4x8's tape

17. TUBES, DRAINS/PACKING YES ☐ NO ☐

TYPE/SIZE	Kerlex → moist	2.	3.
SITE	1. L side	2.	3.

19. ADDITIONAL INFORMATION

(b)(6)-2

20. OPERATION(S) PERFORMED

Ex lap

21. PATIENT TRANSFERRED TO + Cu TIME See DA 3889 METHOD litter c̄ safety straps

22. REGISTERED NURSE (b)(6)-2 Mg/n

REVERSE OF DA FO

*U.S. GPO: 1996-404-613/40449

MEDCOM - 2132

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	20ct Ø3
DOS	20ct Ø3
POD	DO8

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	MAT AN
	MAT AN

Safety Checks	D	E	N
BVM at bedside		(b)(6)-2	
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On		N/A	
Call Light Within Reach		N/A	
Side Rails Up		N/A	
Bed in Low Position		N/A	

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 MAT AN	ICU	20ct Ø3

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade; date; hospital or medical facility)*

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOWCHART

☐ OTHER EXAMINATION Or EVALUATION ☐ OTHER(*Specify*)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 2133

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R								2						2								2		
	RADIAL L								2						A-Line								2		
	DORSALIS PEDIS R								1						1								1		
	DORSALIS PEDIS L								1						1								1		
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale									1 4 8						2 3								1 3 8		
EDEMA									Ø						Trace dependent pitting								(b)(6)-2		
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)									✓						✓								✓		
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)									✓						ST								ST		
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)									✓						✓								✓		
HYGIENE	BED BATH																								
	FOLEY CARE																								
	ORAL CARE																								
MOBILITY	BEDREST								✓						✓								✓		
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE								✓						✓								✓		
	HOB 30 DEGREES														✓								✓		
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE																						9/16		
	PAIN SCALE (1-10)																								
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN (2) Soft & Flat (1) Distended									2						2								2		
BOWEL SOUNDS (active all quads)									Ø						Ø								Ø		
NG / DOBHOFF PLACEMENT VERIFIED									✓						✓								✓		
RESIDUAL ASSESSED									Suction						Suction								Suction		
Ph																									
FOLEY CATHETER PATENT									✓						✓								✓		
VOIDING CLEAR, YELLOW URINE q.s.									✓						✓										
SKIN INTEGRITY	No Breakdown																								
	Surgical Wounds								✓						✓								✓		
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1 Ex Lap - Midline ABD															✓								✓		
#2 L thigh															✓								✓		
#3																									

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
Dradial Aline	Dradial	2 Oct 03	
16fa	DAC	2 Oct 03	
14fa	DAC	2 Oct 03	

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable/Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment –

DATE: 20 Oct 03

TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open								2						3								3		
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response								5						5								5		
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response								6						6								6		
GLASCOW COMA SCALE (A+B+C)								13						14								14		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — R								2S						4+								3+		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — L								2S						4+								3+		
MOVEMENT (See Motor Function Scale at Top of Page) — RUE								4						3								3		
MOVEMENT (See Motor Function Scale at Top of Page) — LUE								4						3								3		
MOVEMENT (See Motor Function Scale at Top of Page) — RLE								4						3								3		
MOVEMENT (See Motor Function Scale at Top of Page) — LLE								4						3								3		
GRIP (S) Strong (W) Weak (-) absent — R														W								W		
GRIP (S) Strong (W) Weak (-) absent — L														W								W		
RESPIRATIONS — REGULAR								✓						✓								✓		
RESPIRATIONS — IRREGULAR																								
RESPIRATIONS — UNLABORED								✓						✓								✓		
RESPIRATIONS — LABORED																								
RESPIRATIONS — SHALLOW														✓								✓		
RESPIRATIONS — RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RUL								3						5								5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — LUL								3						5								5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RLL								1						1								1		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — LLL								1						1								1		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — BOTH BASES								1						1								1		
COUGH — NONE								✓						✓								✓		
COUGH — SPONTANEOUS																								
COUGH — PRODUCTIVE																								
COUGH — NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear														Ø										
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																								
VENTILATOR — Vt																								
VENTILATOR — FIO2																								
VENTILATOR — RATE (SIMV/CMV)																								
VENTILATOR — PEEP / CPAP																								
VENTILATOR — PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE — NC (l/min)								5L						5L								5L/M		
OXYGEN DELIVERY DEVICE — FM (l/min)																								
OXYGEN DELIVERY DEVICE — NRBM (l/min)																								
ETT #_____ — ETT _____ cm gums																								
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED																								
INCENTIVE SPIROMETRY-DONE														✓	✓	✓		✓	✓			✓		
COUGH / DEEP BREATH																			✓			✓		
INITIALS								(b)(6)-2						(b)(6)-2				(b)(6)-2				(b)(6)-2		

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DOD 006187

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200																	
0300																	
0400																	
0500																	
0600																	
0700				(b)(6)-2													
0800	97.2	125	25	146/77	100	SLNC											
0900	98.7	136	27	145/79	100	SLNC											
1000		142	28	143/77	100	SLNC											
1100	100.5	137	30	142/78	100	SLNC											
1200																	
1300	100.7	148	32	117/75	100%	117/74											
1400	100	156	32	114/72	99%	117/70	83										
1500	101.2	150	28	111/72	99%	120/67	84	(b)(6)-2									
					99	~~117/61~~	~~78~~										
1600	99.8	153	32	111/68	99	117/64	78										
1700	99.8	152	32	110/72	99	124/68											
1800	100.3	144	26	114/66	100	137/71	~~137/69~~	(b)(6)-2									
							~~86~~										
1900	100.1	146	28	112/65	100	137/69	86										
2000	100.2	145	28	111/65	100	132/64											
2100		146	26	116/66	99	133/62											
2200	100.4	144	24	114/66	100	140/65											
2300		160	18	118/54	98	122/56	86										
2400	~~99.7~~ 100.4	139	22	114/65	100	123/64	84										

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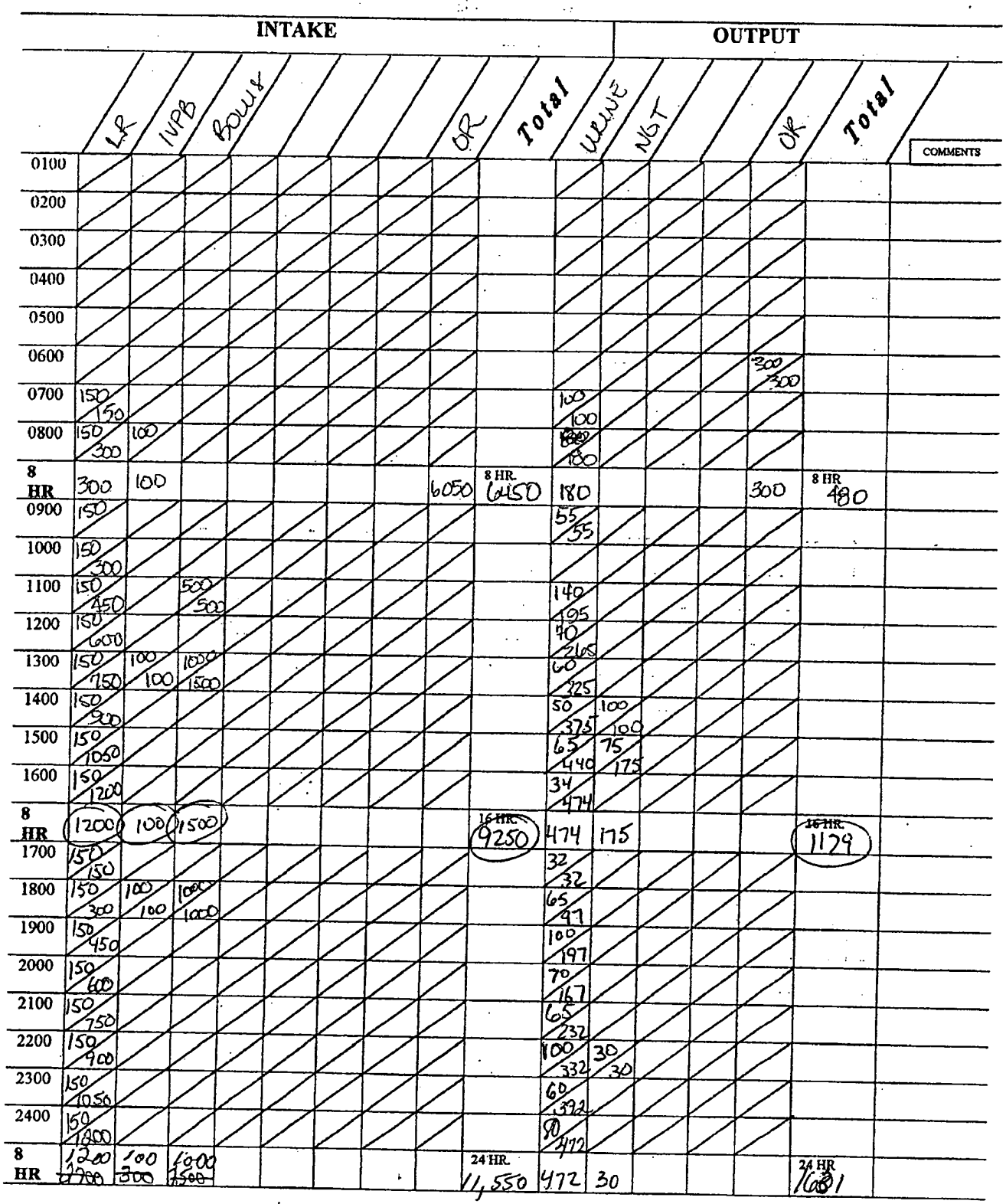
INTAKE
OUTPUT
LR
IVPB
BOLUS
OR
Total
URINE
NGT
OR
Total
COMMENTS
0100
0200
0300
0400
0500
0600
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0800
8 HR
0900
1000
1100
1200
1300
1400
1500
1600
8 HR
1700
1800
1900
2000
2100
2200
2300
2400
8 HR
8 HR. 6450
16 HR. 9250
24 HR. 11,550
8 HR 480
16 HR. 1129
24 HR 1681

MEDCOM - 2137

MEDICAL RECORD

NURSIN[illegible]OTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
2 Oct 03	0730		Pt discharged from recovery, see flowsheet for assessment details. MP guard c bedside. [redacted] MAJ/AN
	1030		Maj [redacted] (anes) in to see pt, informed of non persistent HR 140's. Fluid bolus ordered, hung.
	1130		(L) thigh dsgs Δ'd. Lg amt sang drg. 1cm area x2 (L) lateral thigh. Interior thigh packing left in place, dsd applied over. Moderate/lg. amt sanguinous drainage noted. [redacted] MAJ AN
	1150		Dr [redacted] in to see pt, aware of tachycardia, labs sent. [redacted] MAJ AN
	1230		Labs back, 1L NS bolus hung [redacted] MAJ AN
2 Oct 03		1430	Midline abd dsg and (L) hip/thigh dsg dry and intact. NG → LIS c̄ small amt light brown drainage. Pt easily arousable and appears oriented per interpreter. Abd soft, ~~none dist~~ non-distended. Ø bowel sounds heard. A-line zeroed, correlates well c̄ cuff BP. (B) AC IV's appear intact c̄ S/Sx infiltration, infection, bleeding from site. [redacted] MAJ AN
		1545	Per interpreter, pt states good relief of pain (abd) c̄ 4mg MSO4 given @ 1515. [redacted] MAJ AN
		1600	Attempting to use incentive spirometer q hour. Pt refuses/unable to lift first ball. Will continue to encourage IS and C+DB. [redacted] MAJ AN
		1720	↓UOP to 30-35cc/hr × 2 hrs. HR remains in 150's, SYS BP 115-120. Dr. [redacted] notified of ↓UOP → ordered c̄ L fluid bolus NS, hung @ this time. [redacted] MAJ AN
		1735	Continues to refuse incentive spirometer stating his abd hurts. 4mg MSO4 IVP given @ this time. [redacted] MAJ AN
		2000	LLQ abd and (L) lateral thigh dsgs Δ's, W → D dsg covered c̄ sterile 4×4 and ABD dressings. Mod to lg. amt sang. drainage noted from both wounds. Pt medicated c̄ 4mg MSO4 IVP prior to dsg Δ. [redacted] MAJ AN

Cont. notes on attached sheet.

[redacted]

MEDCOM - 2138

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	20 Oct 03
DOS	20 Oct 03
POD	~~DOS~~ 1

24 HOUR DATA	
24 Hour Balance	+950
24 Hour Intake	~~11,550~~ 3625
24 Hour Output	~~4607~~ 2675
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	(b)(6)-2
(b)(6)-2	
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach	U		
Side Rails Up	A		
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2	ICU	30 Oct 03

PATIENT'S IDENTIFICATION (For typed or written entries give: Name-last, first, Middle; grade;date; hospital or medical facility)

(b)(6)-4

- ☐ HISTORY/PHYSICAL
- ☒ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☐ OTHER(Specify)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700
1 MAY 78

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		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R		2		2			2				2					2				2			2	
	RADIAL L		2		2			2				2					2				2			2	
	DORSALIS PEDIS R		1		1			1				1					1				1			1	
	DORSALIS PEDIS L		2		2			2				2					2				2			2	
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale			1 3 8		2 3 5			2 3 8				1 3 8					1 3 8				1 3 5			1 3 5	
EDEMA			BLE		BLE			Gen				Gen					Gen				Gen			Gen	
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)			✓		✓			✓				✓					Sin				L			✓	
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)			ST		ST			ST				ST					ST				ST			ST	
SWAN GANZ CATHETER (Zeroed & calibrated)								✓																	
ARTERIAL LINE (zeroed & calibrated)											✓						✓				✓			✓	
HYGIENE	BED BATH										✓														
	FOLEY CARE										✓														
	ORAL CARE										✓	✓					✓								
MOBILITY	BEDREST		✓		✓			✓													✓			✓	
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE		✓		✓			✓				✓					✓				✓			✓	
	HOB 30 DEGREES		✓		✓			✓				✓					✓				✓			✓	
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE		X		✓			✓																	
	PAIN SCALE (1-10)		5/10									4/10									4/10			5/10	
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended		2		2			2				2					2				2			2	
BOWEL SOUNDS (active all quads)			Ø		Ø			Hypo				Hypo					Hypo				Hypo			Hypo	
NG / DOBHOFF PLACEMENT VERIFIED			✓		✓																				
RESIDUAL ASSESSED L15			✓		✓																				
Ph																									
FOLEY CATHETER PATENT			✓		✓			✓				✓					✓				✓			✓	
VOIDING CLEAR, YELLOW URINE q.s.								✓				✓					✓				✓				
SKIN INTEGRITY	No Breakdown																								
	Surgical Wounds		✓		✓			✓				✓					✓				✓			✓	
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1 Ex lap - Midline Abd			✓		✓			✓				✓					✓				✓			✓	
#2 (R) thigh			✓		✓			✓				✓					✓				✓			*	
#3																									

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
(L) Radial Alvia	(L) Radial	20 Oct 03	Patent & S/Sx of infection or infiltration 0700
16 ga	(L) AC	20 Oct 03	Patent & S/Sx of infection or infiltration 0700
18 ga	(R) AC	20 Oct 03	Patent & S/Sx of infection or infiltration 0700

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DOD 006192

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable/Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment –

DATE: 30403

TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open		3	3				(b)(6)-2				4					4				4			4	
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response		5	5				5				5					5				5			5	
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response		6	6				6				6					6				6			6	
GLASCOW COMA SCALE (A+B+C)		14	14				15				15					15				15			15	
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — R		3↓	3↓																					
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — L		3↓	3↓																					
MOVEMENT (See Motor Function Scale at Top of Page) — RUE		4	4				4				4					4				4			4	
MOVEMENT (See Motor Function Scale at Top of Page) — LUE		4	4				4				4					4				4			4	
MOVEMENT (See Motor Function Scale at Top of Page) — RLE		4	4				4				4					4				4			4	
MOVEMENT (See Motor Function Scale at Top of Page) — LLE		4	4				4				4					4				4			4	
GRIP (S) Strong (W) Weak (-) absent — R		W	W				W				W					W				W			W	
GRIP (S) Strong (W) Weak (-) absent — L		W	W				W				W					W				W			W	
RESPIRATIONS — REGULAR		✓	✓				✓				✓					✓				✓			✓	
RESPIRATIONS — IRREGULAR																							✓	
RESPIRATIONS — UNLABORED		✓	✓				✓				✓													
RESPIRATIONS — LABORED																							✓	
RESPIRATIONS — SHALLOW		✓	✓													✓				✓			✓	
RESPIRATIONS — RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RUL		5	5				5				5					3,2				3,2			3	
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — LUL		5	5				5				5					3,2				3,2			3	
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RLL		1	1				5				5					2				2			1	
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — LLL		1	1				5				5					2				2			1	
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — BOTH BASES		1	1				1				1					1				1			1	
COUGH — NONE		✓	✓				✓				✓													
COUGH — SPONTANEOUS																✓				✓			✓	
COUGH — PRODUCTIVE																								
COUGH — NONPRODUCTIVE																✓				✓			✓	
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																								
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																								
VENTILATOR — Vt																								
VENTILATOR — FIO2																								
VENTILATOR — RATE (SIMV/CMV)																								
VENTILATOR — PEEP / CPAP																								
VENTILATOR — PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE — NC (l/min)		5L	5L				5L				3L					3L				3L			3L	
OXYGEN DELIVERY DEVICE — FM (l/min)																								
OXYGEN DELIVERY DEVICE — NRBM (l/min)																								
ETT #_____ — ETT _____cm gums																								
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED																								
INCENTIVE SPIROMETRY DONE		✓	✓				✓				✓					✓				✓			✓	
COUGH / DEEP BREATH		✓	✓				✓													✓			✓	
INITIALS		(b)(6)-2					(b)(6)-2				(b)(6)-2													

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DOD 006193

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100		136	19	127/65	99	138/70	89										SL
0200	99.8 A	138	23	123/68	98	149/73	89										
0300		139	27	122/64	98	147/70	87										
0400	99.9	137	23	129/67	99	154/73	90										
0500		136	26	—	96	160/72	92										
0600		140	29	(b)(6)-2 ~~160/72~~	92%	160/72	92										
0700	100.3 (O)	135	21	(b)(6)-2 ~~160/72~~ 129/66	99%	152/76	94										
0800		127	22	132/74	99%	156/75	92										
0900	100.2 (A)	132	31	121/66	100	158/75	94										
1000		123	23	131/73	98%	168/73	97										
1100	99.4 (O)	122	25	125/70	98%	169/74	98										
1200		125	23	129/71	99%	174/76	100										
1300	100.2 (A)	127	22	132/69	98%	177/77	101										
1400		127	19	133/67	97%	162/76	97										
1500	99.7 (O)	118	22	127/72	99%	170/76	°										
1600		123	22	120/75	98%	178/75											
1700		125	25	133/61	97%	187/72											
1800	100.9 A	135	30	129/65	93%	194/71											
1900	100.8	135	31	116/68	92%	186/73											
2000	101.3	140	29	122/67	98%	167/74											Tylenol
2100	102.3	148	32	104/67	92%	99/67											1S/Cough
2200	100.9	141	32	116/64	90	163/73	87										
2300	100.7	133	26	120/62	93	146/72	83										
2400		134	37	128/62	91	150/75	96										

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DOD 006194

NSN 7540-00-634-4123

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
3 Oct 03	0200		MS04 given for 5/10 abd pain. Pulse has improved in (L) LE. Lungs remain clear. VSS. HR in 140's. RR 20's. O_2 Sat 98-100%. UOP adq. Cont to monitor — [redacted] (b)(6)-2 Cpt AN
3 Oct 03	0245		Cont c/o pain. Demerol/Phenergan give. Appears to have some relief. VS remain stable. Cont. to monitor — [redacted] (b)(6)-2 Cpt AN
3 Oct 03	0445		Resting quietly c̄ distress. VSS. Ø further c/o pain. Dressings remain CDI. — [redacted] (b)(6)-2 Cpt AN
3 Oct 03	0625		Pt moaning. Medicated c̄ MS04 4mg IVP see flowsheet for assessment. — [redacted] (b)(6)-2 LCT, AN
3 Oct 03		1300	PT c̄ NAD throughout shift. VSS. A-line not correlating c̄ NIBP. DVSG's remain CD&I. Voiding, QS via foley. Medicated c̄ MS04 for pain control. [redacted] (b)(6)-2 LCT, AN
		1600	attempted IS c̄ pt. explained importance of recovery. Pt unable to lift one ball of IS when inhaling. Also tried to encourage cough — [redacted] (b)(6)-2 LCT AN
		1730	4mg MS04 given for pain to abd. — [redacted] (b)(6)-2 LCT AN
		1810	IS complete @ bedside c̄ help of interpreter, completely understands per interpreter. Able to pull 600 cc/sec. Art. BP not correlating c̄ NIBP. — [redacted] (b)(6)-2 LCT AN
		1820	Dressing change for evening not complete per day shift nurse speaking c̄ physician. [redacted] (b)(6)-2 LCT AN
		2000	Pt medicated c̄ 4mg MS04 for abd pain. [redacted] (b)(6)-2
		2140	25mg Demerol/12.5mg Phenergan admin. for breakthrough pain — [redacted] (b)(6)-2
3 Oct 03		2215	c/o pain. 2mg MS04 given. A-line zeroed. Cont to monitor. — [redacted] (b)(6)-2 Cpt AN
3 Oct 03		2330	Dressings reinforced. CHUX + Dressing saturated from exit wound on back. VSS. Assessment complete. Performing IS c̄ encouragement. Cont. to monitor. — [redacted] (b)(6)-2 Cpt AN
3 Oct 03		2400	O_2 Sats decreasing. O_2 to 5L/NC. Resp at 36 bpm. IS + CB performed. Continue to monitor. — [redacted] (b)(6)-2 Cpt AN

MEDCOM - 2143

	INTAKE										OUTPUT						
	IV	Ensure Hadasa	Dsure 20 kcal							Total	Urine	NGT				Total	COMMENTS
0100	150 / 150										85 / 85						
0200	150 / 300										100 / 185						
0300	150 / 450										85 / 270						
0400	150 / 600										120 / 390						
0500	150 / 750										60 / 450						
0600	150 / 900	100 / 100									↓						
0700	150 / 1050										175 / 625						
0800	150 / 1200										125 / 750						
8 HR	1200	100								8 HR 1300	750					8 HR 750	(A) 450
0900	150 / 150										35 / 785						
1000			125 / 125								135 / 170						
1100			125 / 250								125 / 295						
1200		100 / 100	125 / 375								135 / 430						
1300			125 / 500								100 / 530						
1400			125 / 625								130 / 660						
1500			125 / 750								90 / 750						
1600			125 / 875							1425	160 / 910					910	
8 HR	150	100	875							16 HR 2425	910					16 HR 1760	
1700			125 / 1000								140						
1800		100 / 100	125 / 250								115 / 255						
1900			125 / 375														
2000			125 / 500								350 / 635						
2100			125 / 625														
2200			125 / 750								80 / 715						
2300			125 / 875								90 / 805						
2400		100 / 200	125 / 1000							1200	110 / 915					915	
8 HR		300	1000							24 HR 3625	~~915~~					24 HR 2675	

ACLU-RDI 1099 p.928

DOD 006196

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	30 Oct 03
DOS	30 Oct 03
POD	1

24 HOUR DATA	
24 Hour Balance	-4719
24 Hour Intake	~~3825~~ 2996
24 Hour Output	~~2675~~ 7715
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	Cpt AN
(b)(6)-2	LCT AN
(b)(6)-2	1LT AN
(b)(6)-2	MAJ AN

(b)(6)-2

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On	N		
Call Light Within Reach			
Side Rails Up	A		
Bed in Low Position			

(b)(6)-2	Department/Service/Clinic	DATE
Cpt AN	ICU	40ct03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade; date; hospital or medical facility)*

(b)(6)-4

(EPW)

☐ HISTORY/PHYSICAL ☒ FLOWCHART

☐ OTHER EXAMINATION Or EVALUATION ☐ OTHER(*Specify*)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 2145

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R			2			2					2			2 A line				Mins				2		
	RADIAL L			2			2					2			A-line (b)(6)				2				2		
	DORSALIS PEDIS R			1			1					1			1				1				BT 2		
	DORSALIS PEDIS L			2			2					2			2				2				2		
SKIN (1) Dry (4) Cool (7) Jaundiced (2) Clammy (5) Flushed (8) Color Normal (3) Warm (6) Cyanotic (9) Pale				1 3 8			1 3 8					1 3 8			1 3 8				1 3 8				1 3 8		
EDEMA				Mild			Gen					Gen			Gen				Gen				+		
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)				✓			✓					✓			✓				✓				✓		
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)				ST			ST					ST			ST				ST				ST		
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)															✓				✓				✓		
HYGIENE	BED BATH																								
	FOLEY CARE																								
	ORAL CARE																								
MOBILITY	BEDREST			✓			✓					✓			✓				✓				✓		
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT																								
	LEFT											✓			✓								✓		
	SUPINE			✓			✓					✓													
	HOB 30 DEGREES			✓			✓					✓			✓										
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE			✓			✓				Ø				Fentanyl drip				Meds				Sedated		
	PAIN SCALE (1-10)																								
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended			2			2					2			1				1				1		
												✓													
BOWEL SOUNDS (active all quads)				Hypo			Hypo					✓			Ø				Ø				Ø		
NG / DOBHOFF PLACEMENT VERIFIED				✓											✓								✓		
RESIDUAL ASSESSED LS				✓						✓															
Ph												✓													
FOLEY CATHETER PATENT				✓			✓					✓			✓				✓				✓		
VOIDING CLEAR, YELLOW URINE q.s.							✓					✓			✓				✓				✓		
SKIN INTEGRITY	No Breakdown																								
	Surgical Wounds			✓			✓					✓			✓				✓				✓		
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1 Ex Lab - Hidline clsd.				✓			✓					✓			✓				✓				✓		
#2 (R) thigh				✓			✓					✓			✓				✓				✓		
#3 CT (R)																							✓		
CT (L)																							✓		

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
16 ga PIV	(R) AC	2 Oct 03	Patent S/Sx of infection or infiltration/
18 ga PIV	(R) AC	2 Oct 03	H/L'd. Ø S/Sx of infection/

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable/Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment –

DATE: 4 OCT 03

TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open			4			4					1			1				1				1		
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response			5			5					1			1				1				T		
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response			6			6					4			1				1				1		
GLASCOW COMA SCALE (A+B+C)			15			15					6T			3 (intub)				5 (Mech				2T		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — R			3+																			2+		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — L			3+																			2+		
MOVEMENT (See Motor Function Scale at Top of Page) — RUE			4			4					0			0				0				0		
MOVEMENT (See Motor Function Scale at Top of Page) — LUE			4			4					0			0				0				0		
MOVEMENT (See Motor Function Scale at Top of Page) — RLE			4			4					0			0				0				0		
MOVEMENT (See Motor Function Scale at Top of Page) — LLE			4			4					0			0				0				0		
GRIP (S) Strong (W) Weak (-) absent — R			W			W					0			0				0				1		
GRIP (S) Strong (W) Weak (-) absent — L			W			W					0			0				0				1		
RESPIRATIONS — REGULAR			✓			✓					✓			✓				✓				✓		
RESPIRATIONS — IRREGULAR											e							E				E		
RESPIRATIONS — UNLABORED																								
RESPIRATIONS — LABORED						✓					N			EN				N				N		
RESPIRATIONS — SHALLOW			✓			✓					T							T				✓		
RESPIRATIONS — RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RUL			3			3								3				3				3		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — LUL			3			3								3				3				3		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RLL			3			3								3				3				3		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — LLL			1			3								3				3				3		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — BOTH BASES			1			1					✓			3				1				1		
COUGH — NONE			✓			✓					✓			✓				✓				✓		
COUGH — SPONTANEOUS			✓																					
COUGH — PRODUCTIVE																								
COUGH — NONPRODUCTIVE			✓																					
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																								
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																								
VENTILATOR — Vt											700			550				580 550				560		
VENTILATOR — FIO2											100			100				100 100				1.0		
VENTILATOR — RATE (SIMV/CMV)											12			16				15 17				17		
VENTILATOR — PEEP / CPAP											10			10				5 10				10		
VENTILATOR — PRESS. SUPPORT											∅													
OXYGEN DELIVERY DEVICE — NC (l/min)																								
OXYGEN DELIVERY DEVICE — FM (l/min)																								
OXYGEN DELIVERY DEVICE — NRBM (l/min)			10L			10L					✓													
ETT # 7.5 — ETT 22 cm gums											✓							✓				✓		
ETT CARE / POSITION CHANGE											✓	✓		✓										
ETT / NT SUCTIONED																								
INCENTIVE SPIROMETRY DONE			✓																					
COUGH / DEEP BREATH			✓																					
INITIALS			(b)(6)-2			(b)(6)-2								(b)(6)-2				(b)(6)-2				(b)(6)-2		

ACLU-RDI 1099 p.931

DOD 006199

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100	100.7	134	42	117/61	88	150/71	93										
0200		138	30	117/66	85	D/C											
0300	101.0	128	28	116/68	93	—	85										
0400	99 (A)	120	21	120/72	94	—	97										
0500		122	30	121/70	93	—	98										
0600	100 (A)	124	35	121/72	95%		90	100%		NRB	13L/Min						
0700		121	29	123/73	94%		91										
0800	100 (A)	117	35	132/75	95%		96										
0900		122	34	126/62	91		86										
1000	100 (A)	144	47	127/77	75%		97										
1100		144	13	131/76	96%	171/82	125										
1200	100 (A)	143	12		100%	186/75	110										
1300	101 (A)	146	16		99%	146/73	102										
1400																	
1500		144		150/70	91%	190/74	105										
1600	101 (ax)	149	16	142/77	92	189/67	104										
1700	101.8 (A)	145	15	135/77	86	163/71	101										
1800	102 (A)	139	10/15	148/78	95	145/70	96										
1900	101.8 (A)	126	17	132/75	88	171/80	110										
2000		129	21		82	159/69	97										
2100	101.4 (A)	119	24/17		89	165/75	100										
2200	102	115	34/17	141/69	87%	130/64											
2300		112	24/17		94%	125/65	HEM										
2400	101	111	22/17		97%	125/64	88										

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DOD 006200

MEDICAL RECORD			NURSING .ES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
4 Oct 03	0100 →	0200	O_2 Sat to 75%. Placed on NRM. Sat to 85%. Had pt use IS + cough DB. ∅ change to O_2 sats. ABG drawn. Pt's breaths very shallow + labored. ABG drawn. Sent to lab. Phys. notified. ~~MSOC~~ Demerol/Phenergan given for pain. O_2 Sat to 90% Resp to 27 bpm. Continue to monitor. [redacted] cpt AN
4 Oct 03	0300		O_2 Sats + Resp improved c̄ pain control. HR 120's. Resp 28. O_2 Sat 95%. Cont to monitor. [redacted] cpt AN
4 Oct 03	0500		Resting quietly. Eyes closed. Resp deep + even. VSS. ∅ apparent distress. [redacted] cpt AN
4 Oct 03	0840		Dr [redacted] informed of Pt's Respiratory status. New orders initiated. CBC, PA-7/metlytes sent to lab. PCCR ordered. D5NS c̄ 20KCl ↓ 75cc/hr. VSS. Will cont to monitor [redacted] cct, AN
4 Oct 03	1100		PT c̄ continued desaturation on 100% NRB. O_2 SATS ↓ 70's when pt OOB in chair. Pt returned to bed & intubated. IV D5½NS c̄ 20 KCl @ 75cc/hr. Versed gtt @ 2mg/hr. Fentanyl gtt @ 100mcg/hr & Vecuronium @ 4mg/hr. See flowsheet for assessment [redacted] LCT, AN
4 Oct 03		1300	DeSATS 70-80's despite suctioning & bvm. Dr [redacted] @ BS. ABG's sent. ↑ RR to 16. X-ray ordered [redacted] LL, AN
4 Oct 03		1500	CXR showed RUL pneumo → CT inserted per (L). [redacted] (+) rush of air on insertion and ~100cc serosang drainage. CT → pleurevac @ -20cc H_2O suction. Pt on vec, fentanyl, and versed drips. ETT → SIMV 16, FiO_2 100%, P-10, V_T-550cc. ETT suctioned for min secretions. Course rhonchi throughout all lung fields. SpO_2 remains mid-upper 80's. Pt rolled to (L) side. Lasix 20mg IV given. Midline incision c̄ staples intact; ∅ S/Sx infection or evisceration. LLQ and (L) hip dsg c̄ mod amt serous drainage. [redacted] MS AN
4 Oct 03		2130	Pt cont c̄ ↓ SpO_2 → lower 80's @ 2000. Fentanyl 150μ. Vec 5mg + Versed 5mg IVP given. ETT suctioned for min white secretions. Dr. Choi notified. CXR done → (L) pleural effusion → (L) CT inserted → -20cm H_2O suction.

See progress note for continuation (attached) [redacted]

MEDCOM - 2149

	INTAKE									OUTPUT #1						
	D5½NS(20K)	Zosyn/NPB	Vexed	Vecuronium	Fentanyl	Heparin			Total	Urine	Chest tube	NG tube	Chest tube #2		Total	COMMENTS
0100	125 / 125									100 / 100						
0200	125 / 250									110 / 120						
0300	125 / 375															
0400	125 / 500									170 / 290						
0500	125 / 625									110 / 400						
0600	125 / 750	100 / 100								120 / 520						
0700	125 / 875									155 / 655						
0800	125 / 1000									160 / 815						
8 HR	1000	100							8 HR. 1100	815					8 HR 815	(+) 285
0900	75 / 75									145 / 145						
1000	75 / 150														Lasix	
1100	75 / 225															
1200	75 / 300		2 / 2	4 / 4	2 / 2					1190 / 1335						
1300	75 / 375	100 / 100	2 / 4	4 / 8	2 / 4					180 / 1515						
1400	75 / 450		2 / 6	4 / 12	2 / 6							100 / 100				
1500	75 / 525	100 / 200	3 / 9	4 / 16	2 / 8	10 / 10				300 / 1815	105 / 105					
1600	75 / 600		3 / 12	5 / 21	3 / 11	25 / 35				750 / 2565	0 / 105					
8 HR	600	200	12	21	11	35		879	16 HR. 1979	2565	105	100		2670	16 HR. 3485	-691 (5)(6)(2) ~~-1508~~
1700	75 / 75		3 / 3	5 / 5	3 / 3	25 / 25				425 / 425	15 / 15					
1800	75 / 150		5 / 8	5 / 10	3 / 6	25 / 50				120 / 545	20 / 35	100 / 100				
1900	75 / 225		5 / 13	5 / 15	3 / 9	25 / 75				120 / 665	20 / 55					
2000	75 / 300		5 / 18	5 / 20	3 / 12	30 / 95				160 / 825	10 / 65		95 / 95			
2100	75 / 375		5 / 23	5 / 25	3 / 15	30 / 125				160 / 825	10 / 65		45 / 140			
2200	75 / 450		5 / 28	5 / 30	3 / 18	30 / 155				1900 / 2725						
2300	75 / 525	50	5 / 33	5 / 35	3 / 21	30 / 185				900 / 3625						
2400	75 / 600	50 / 100	5 / 38	5 / 40	3 / 24	30 / 215				350 / 3925						-1234 (5)(6)(2) ~~-1234~~
8 HR	600	100	38	40	24	215		1017	24 HR. 2996	3925	65	100	140	4230	24 HR 7715	

MEDCOM - 2150

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	3 oct 03
DOS	3 oct 03
POD	2

24 HOUR DATA	(b)(6)(2) (b)(6)(2)
24 Hour Balance	~~-4719~~ 217
24 Hour Intake	~~2996~~ 2988
24 Hour Output	~~4915~~ 2771
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2 MAT MN	(b)(6)-2
(b)(6)-2 LCT AN	
(b)(6)-2 MAN	
(b)(6)-2 CPT AN	

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On	N	N/A	
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 MAT MN	ICU	5 oct 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade; date; hospital or medical facility)*

(b)(6)-4

- ☐ HISTORY/PHYSICAL
- ☒ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☐ OTHER(*Specify*)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 2151

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R		2				2					2			2				2				2		
	RADIAL L		2				2					2			2				2				2		
	DORSALIS PEDIS R		1				1					1			1				1				1		
	DORSALIS PEDIS L		2				2					1			1				1				2		
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale			1 3 8				1 3 8					1 3 8			1 3 8				1 3 8				1 3 8		
EDEMA			gen				gen					gen			gen				gen				gen		
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)			✓				✓					✓			S/S2				S/S2				✓		
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)			ST				✓					✓			NSR				NSR				NSR		
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)			✓				✓					✓			✓				✓				✓		
HYGIENE	BED BATH				✓							✓													
	FOLEY CARE				✓							✓							✓						
	ORAL CARE											✓													
MOBILITY	BEDREST				✓		✓					✓											✓		
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT																					✓	✓		
	LEFT		✓														✓								
	SUPINE				✓		✓					✓			✓				✓				✓	✓	
	HOB 30 DEGREES		✓		✓		✓					✓			✓		✓		✓			✓	✓	✓	
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE		UTA				UTA					UTA			Pleat				Pleat				Pleat		
	PAIN SCALE (1-10)														off				off						
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended		1				2					2			2				2				2		
												✓													
BOWEL SOUNDS (active all quads)			Ø				– ✓					✓			Hypo ✓				Hypo				Hypo		
NG / DOBHOFF PLACEMENT VERIFIED			✓				✓																✓		
RESIDUAL ASSESSED	q15																								
Ph																									
FOLEY CATHETER PATENT			✓				✓					✓			✓				✓				✓		
VOIDING CLEAR, YELLOW URINE q.s.			✓				✓					✓													
SKIN INTEGRITY	No Breakdown																								
(R) hip	Surgical Wounds		✓				✓					✓			✓				✓				✓		
ABD	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1 ABD (STAPLES)			✓		open		✓					✓			✓				✓				✓		
#2 (L) thigh			✓		✓		✓					✓			✓				✓				✓		
#3 CT #1					✓		✓					✓			✓				✓				✓		
CT #2					✓																		✓		

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
14 fr	(R) AC	3oct03	A'd 5oct Patent ∃ s/sx of infiltration or infiltration
16 fr	(L) AC	3oct03	A'd 5oct Patent ∃ s/sx of infiltration or infiltration
chest tube	(R)	4oct03	A'd 5oct Patent Ø AIR LEAK
chest tube	(L)	4oct03	✓CDI Patent Ø AIR LEAK

ACLU-RDI 1099 p.936

DOD 006204

PUPIL SIZE	PUPILS
1 mm	= Equal
2 mm	R Reactive
3 mm	NR NonReactive
4 mm	L > R Left Larger
5 mm	R > L Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable /Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment --

DATE: 5 Oct 03

TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open		1				1					1			1				1				2		
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response		T				1 T					1 T			ETT				ETT				T		
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response		1				1					1			1				1				1		
GLASCOW COMA SCALE (A+B+C)		2T				3T					3T			2T				2T				3T		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) R		2+				2+					2+			2+				2+				2+		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) L		2+				2+					2+			2+				2+				2+		
MOVEMENT (See Motor Function Scale at Top of Page) RUE		Paralyzed				Restrained / Immobilized					Restrained / Immobilized			Paralyzed				Paralyzed				Paralyzed		
MOVEMENT (See Motor Function Scale at Top of Page) LUE																								
MOVEMENT (See Motor Function Scale at Top of Page) RLE																								
MOVEMENT (See Motor Function Scale at Top of Page) LLE																								
GRIP (S) Strong (W) Weak (-) absent R																								
GRIP (S) Strong (W) Weak (-) absent L																								
RESPIRATIONS REGULAR																								
RESPIRATIONS IRREGULAR																								
RESPIRATIONS UNLABORED		VENT				VENT					2/Vent			Vent				Vent				Vent		
RESPIRATIONS LABORED																								
RESPIRATIONS SHALLOW																								
RESPIRATIONS RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished RUL		3/2				3/2					3			3/2				3/2				3		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished LUL		3/2				3/2					3			3/2				3/2				3		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished RLL		3/2				3/2					3			3				3/2				3		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished LLL		3/2				3/2					3			3/2				3/2				3		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished BOTH BASES		3/2				1					1			1				1				1		
COUGH NONE		✓				✓					✓			✓				✓				✓		
COUGH SPONTANEOUS																								
COUGH PRODUCTIVE																								
COUGH NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																								
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																								
VENTILATOR Vt		550				550					600			600	600		620	600				600		
VENTILATOR FIO2		1.0				100					80			60	50		70	50				50		
VENTILATOR RATE (SIMV/CMV)		17				17					17			17	17		17	17				17		
VENTILATOR ~~PEEP/CPAP~~		10				10					10			10	10		10	10				10		
VENTILATOR PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE NC (l/min)																								
OXYGEN DELIVERY DEVICE FM (l/min)																								
OXYGEN DELIVERY DEVICE NRBM (l/min)																								
ETT # 7.5 ETT 22 cm gums						✓					✓			✓			✓					✓		
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED						✓					✓							✓		✓				
INCENTIVE SPIROMETRY DONE																								
COUGH / DEEP BREATH																								
INITIALS		(b)(6)-2				(b)(6)-2					(b)(6)-2			(b)(6)-2				(b)(6)-2				(b)(6)-2		

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100	99[2]	109	21/17		98%	125/62	88										
0200		105	20/17		100%	117/63	81										
0300		101	18/17		100%	119/62	80										
0400	98[8]	97	17/17		100%	107/56	73										
0500		93	17/17		100%	105/55	72										
0600	100[5] (A)	94	17/17		100%	103/54	68										
0700	99[4] (A)	89	17/17		100%	102/53	68										
0800	99[4] (A)	90	17/17		100%	115/60	77										
0900	99[4] (A)	88	17/17		100%	97/53	67										
1000	98[9] (A)	90	17/17		100%	96/51	65										
1100	97[5] (A)	89	17/17		100%	104/54	70										
						~~114/60~~	~~7~~										
1200	99[5] (A)	97	17/17		99%	114/60	77										
1300	98[5] (A)	100	17/17		98%	128/63	83										
1400	98[6] (A)	94	17/17	105/50	100%	101/52	67										
																	↓Fent gtt
1500	99[3] (A)	94	17/17		98%	99/52	65										to 100mg/hr
															↓FiO_2 50%		↓Versed to 2mg
1600	99[4] (A)	95	17/17		99%	96/51	65										
1700	99[9] (A)	116	17/17		96%	131/71	92										40% FiO_2
1800	100[1] (A)	103	17/17		94%	114/60	77										
1900	100[1] (A)	96	17/17		97%	112/59	76										
2000	99[5]	92	17/17		96%	106/56	72										
2100	99[7] (A)	107	21/17		100%	123/71	88										
2200	99[5] A	105	17/17		96	136/74	92										↑Versed 3mg
2300	99[9]	96	17/17		97	114/72											
2400		92	17/17		98	122/70	85										

	INTAKE									OUTPUT						
	DSNS:DOK	IVPB	Vecuronium	Fentanyl	Versed	Aline Flush	Kcl		Total	Urine	NGT	CT #1	CT #2		Total	COMMENTS
0100	75/75	50/50	5/5	3/3	5/5	3/3				190/190						
0200	75/150		5/10	3/6	5/10	3/6				100/290						
0300	75/225		5/15	3/9	5/15	3/9				80/370						
0400	75/300		5/20	3/12	5/20	3/12				40/410						
0500	75/375		5/25	3/15	5/25	3/15				100/510	∅	20	45			
0600	75/450	50/100	5/30	3/18	5/30	3/18				100/610						
0700	75/525	100/200	5/35	3/21	5/35	3/21				85/695						
0800	75/600		5/40	3/24	5/40	3/24				215/910						
8 HR	600	200	40	24	40	24			8 HR. 928	910		20	45		8 HR 975	-47
0900	75/75		5/5	3/3	5/5	3/3				500/500						
1000	75/150		5/10	3/6	5/10	3/6				80/580						
1100	75/225		4/14	3/9	4/14	3/9				65/645						
1200	75/300	100/100	4/18	3/12	4/18	3/12				60/705						
1300	75/375		4/22	3/15	4/22	3/12				70/775		40/40	160/160			
1400	75/450		4/26	3/18	4/26	3/15				55/830						
1500	75/525	100/200	4/30	2/20	4/30	3/18				55/885						
1600	75/600		4/34	2/22	2/34	3/21			909	50/935					1135	
8 HR	600	200	34	22	32	21			16 HR. 1837	935		40	160		16 HR. 2110	-273
1700	75/75		4/4	1/1	2/2	3/3				55/55						
1800	75/150	100/100	5/9	2/3	3/5	3/6				60/115						
1900	75		5/14	2/5	3/8	3/9	100/100			50/165						
2000			5/19	2/7	3/11	3/12	100/200			45/210						
2100			5/24	2/9	3/14	3/15	100/300			70/280		6/6	30/190			
2200			5/29	2/11	3/17	3/18	100/400						30			
2300		100/200	5/34	2/13	3/20	3/21	100/500			120/400						
2400		100/300	5/39	2/15	3/23	3/24	100/600			65/465						
8 HR	150	300	39	15	23	24	600	1151	24 HR. 2988	465		6	190		24 HR 2771	+217

MEDCOM - 2155

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
4 Oct 03	2400		Pt stable, ↔Δ in subq emphysema, CT & air leak noted, O2 sats continue to improve. [b(6)-2] LAT, RN
	0200		No Δ, O2 sats good, see flowsheet for assessment. [b(6)-2]
	0400		AM completed. ⓑ CT dsg Δ'd - old dsg non adherent. ⓑ sup dsg Δ'd, old packing & sero sang drainage noted. Pt now awake, readings stable. [b(6)-2] LAT, RN
5 OCT 03	0600		NAD. VERSED 3mg/hr, VECURONIUM 3mg/hr & Fentanyl @ 150mg/hr. DSNS c 20meq KCl @ 75cc/hr. Pt c SQ Emphysema to C/clavicular & cervical area. VSS. Pt not breathing over vent set rate. will con't to monitor. [b(6)-2] LCT, RN
5 OCT 03	0734		F_iO_2 ↓ 90% O_2 SAT 100% — [b(6)-2] LCT, RN
5 OCT 03	0930		F_iO_2 ↓ 80% O_2 SAT 100%. VSS. Minimal sero-sanguinous drainage from ⓑ CT's — [b(6)-2] LCT, RN
5 OCT 03	1025		↓ Versed to 4mg/hr & ↓ Vecuronium to 4mg/hr to ↑ BP. NAD NOTED VSS — [b(6)-2] LCT, RN
5 OCT 03	1130		↓ F_iO_2 70%. SATS 100%. VSS [b(6)-2] LCT, RN
5 OCT 03		1230	↓ F_iO_2 60%. SATS 97-99%. PT CONTINUES TO NOT Breath over set rate. CT ⓑ c small amount of serous sanguinous drainage. VSS [b(6)-2] LCT, RN
5 OCT 03		1430	Assessment complete. Subq emphysema present. Good inspiratory wheeze to ⓑ lung fields & air leak present in CT ⓑ. Pt paralyzed sufficiently - not overbreathing vent. ⓑ drainage on dressings to ⓑ lat & chest tube sights. Sats 98-100% on 60% F_iO_2. Eye drops to eyes ⓑ for lubrication [b(6)-2] LCT, RN
		1500	↓ F_iO_2 to 50% SaO_2 99% ↓ Versed to 2mg/hr for ↓ BP Fentanyl ↓ @ 1430 to 100 mcg/hr — [b(6)-2] RN
		1700	↓ F_iO_2 to 40% pt positioned on ⓑ side. Sats 96% [b(6)-2] RN
		1800	↑ F_iO_2 to 50% Sats 93-95% on 40% F_iO_2. Pt rolled to back and suctioned. ⓑ sputum suctioned. [b(6)-2] RN
		1815	Pt lung sounds more diminished than previous assessment. Sats not improving much on 50% F_iO_2 94-95%. Dressing to LLQ and ⓑ thigh changed @ 1600 Drsg carriers dsng on LLQ and dsg. Thinsal dsng on ⓑ thigh dsg. Pt keeps pulling [b(6)-2] RN

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R		2					2				2			2				2				2		
	L		2					2				2			2				2				2		
	DORSALIS PEDIS R		1					2				2			2				2				2		
	L		2					2				2			2				2				2		
SKIN (1) Dry (4) Cool (7) Jaundiced (2) Clammy (5) Flushed (8) Color Normal (3) Warm (6) Cyanotic (9) Pale			1 3 8					1 3 8				1 3 8			1 3 8				1 3 8				1 3 8		
EDEMA			Gen					Gen				Gen			Gen				Gen						
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)			✓					✓				✓			✓				✓				✓		
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)			NSR					✓				SR			ST				ST				ST		
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)															✓								✓		
HYGIENE	BED BATH										✓														
	FOLEY CARE		✓								✓												✓		
	ORAL CARE										✓								✓						
MOBILITY	BEDREST		✓					✓				✓			✓				✓				✓		
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT														✓										
	LEFT		✓					✓				✓				✓		✓							
	SUPINE							✓				✓				✓		✓			✓				
	HOB 30 DEGREES		✓					✓				✓									✓		✓		
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE		Ctrl					Ctrl				Ctrl			Ctrl				Ctrl						
	PAIN SCALE (1-10)																								
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN (2) Soft & Flat (1) Distended			2					2				2			2				2				2		
BOWEL SOUNDS (active all quads)			Hypo					Hyp				Hyp			Hypo				Hypo						
NG / DOBHOFF PLACEMENT VERIFIED			✓					✓							✓				✓				✓		
RESIDUAL ASSESSED L I S			✓												✓				✓						
Ph																									
FOLEY CATHETER PATENT			✓					✓				✓			✓				✓				✓		
VOIDING CLEAR, YELLOW URINE q.s.																									
SKIN INTEGRITY	No Breakdown																								
(R) Hip	Surgical Wounds		✓					✓				✓			✓				✓				✓		
Abd	Rashes, Lac's, etc														✓				✓						
DRESSING (Dry & Intact: specify site below)																									
#1 Abd Staples			✓					✓				✓			✓				✓				✓		
#2 CT #1			✓					✓				✓			✓				✓				✓		
#3 CT #2			✓					✓				✓			✓				✓				✓		
(L) Thigh			✓					✓				✓			✓				✓				✓		

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
14 ga	(R) AC	30 Oct 03	Patient c S/Sx of infection/cellulitis/10700 D/C'd 1700 6 Oct
16 Ga	(L) AC	30 Oct 03	Patient c S/Sx of infection/infiltration/10700
Chest tube	(R)	4 Oct 03	Patient @ air leak 10700
Chest tube	(L)	4 Oct 03	Patient @ air leak 10700
NGT	(R) NARE	2 Oct 03	Patient to suction
18g	(L) HAND	6 Oct 03	

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DOD 006209

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	3 Oct 03
DOS	3 Oct 03
POD	3

24 HOUR DATA	
24 Hour Balance	(b)(6)-2 ~~+277~~ -1261
24 Hour Intake	(b)(6)-2 ~~2958~~ 2596
24 Hour Output	(b)(6)-2 ~~2777~~ 3857
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	(b)(6)-2
(b)(6)-2 LCT	
(b)(6)-2	
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 [redacted] CPT AN	ICU	6 Oct 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade;date; hospital or medical facility)*

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOWCHART

☐ OTHER EXAMINATION Or EVALUATION ☐ OTHER(*Specify*)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 2158

PUPIL SIZE		PUPILS
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable /Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment –

DATE: 6 Oct 03

TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (2) To Pain (3) To Voice (1) Does Not Open		1					1				1			1				1				1		
B. BEST VERBAL RESPONSE (5) Oriented (2) Garbled (4) Confused (1) No Response (3) Inappropriate Verbal Response		ETT					1 T				1 T			1 (T)				1 (T)				1		
C. BEST MOTOR RESPONSE (6) Obeys Commands (3) Flexion to Pain (5) Localizes to Pain (2) Extension to Pain (4) Withdraw to Pain (1) No Response		Purple					1				1			1				1				1		
GLASCOW COMA SCALE (A+B+C)		2T					3T				3T			3T				3T				3		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — R		2+					2+				2+			2+				2+				2		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — L		2+					2+				2+			2+				2+				2		
MOVEMENT (See Motor Function Scale at Top of Page) — RUE		P					P				S			P				B				X		
MOVEMENT (See Motor Function Scale at Top of Page) — LUE		Red					Restrained				Restrained			Restrained				E						
MOVEMENT (See Motor Function Scale at Top of Page) — RLE		-Yes					Restrained				Restrained			Restrained				D						
MOVEMENT (See Motor Function Scale at Top of Page) — LLE		Yes					Restrained				Restrained			Restrained				A						
GRIP (S) Strong (W) Weak (-) absent — R		/					1				1			NA				NA				X		
GRIP (S) Strong (W) Weak (-) absent — L		/					1				1			NA				NA				X		
RESPIRATIONS — REGULAR		V					V				V			V				V				V		
RESPIRATIONS — IRREGULAR		V					V				V			V				V				V		
RESPIRATIONS — UNLABORED		V					V				V			V				V				V		
RESPIRATIONS — LABORED		V					V				V			V				V				V		
RESPIRATIONS — SHALLOW		V					V				V			V				V				V		
RESPIRATIONS — RETRACTIONS		V					V				V			V				V				V		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RUL		3					3				3			3				3				2		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — LUL		3					3/2				3/2			3/2				3/2				2		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RLL		3					3				3			3/2				3/2				2		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — LLL		3					3/2				3/2			3/2				3/2				2		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — BOTH BASES		1					1				1			3/2				1				2		
COUGH — NONE		✓					✓				✓			✓				✓				✓		
COUGH — SPONTANEOUS																								
COUGH — PRODUCTIVE																								
COUGH — NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																								
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																								
VENTILATOR — Vt		600					600				600			600				600				600		
VENTILATOR — FIO2		50%					50				40			45%				45%				45		
VENTILATOR — RATE (SIMV/CMV)		17					17				15			15				15				15		
VENTILATOR — PEEP / CPAP		10					10				6			8				8				10		
VENTILATOR — PRESS. SUPPORT		–																						
OXYGEN DELIVERY DEVICE — NC (l/min)																								
OXYGEN DELIVERY DEVICE — FM (l/min)																								
ETT # 7.5 — NRBM (l/min)																								
ETT # 7.5 — ETT 22 cm gums		✓					✓				✓			✓				✓				✓		
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED																								
INCENTIVE SPIROMETRY DONE																								
COUGH / DEEP BREATH		✓																						
INITIALS		(b)(6)-2					(b)(6)-2				(b)(6)-2			(b)(6)-2				(b)(6)-2				(b)(6)-2		

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DOD 006211

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100	97.8 A	119	17/17	154/83	99	151/83	89										
0200		97	17/17		99	127/60	79										
0300	97.9 A	102	17/17		100	142/75	96										
0400		106	17/17		100	134/71	82										
0500	98.9	98	17/17		97	115/61	78										
0600	98.5 (A)	91	17/17		98	97/49	61										
0700		99	17/17		98%	126/63	85										
0800	98.7 (A)	112	17/17	129/71	96%	141/76	100										
0900	98.8 (A)	113	31	141/70	96%	140/71	95										
1000		115	37	126/59	92%	126/65	84										
1100	99 (A)	118	53*	141/69	83*	139/71	96										
1200	100.2 (A)	109	15	136/68	92	122/72	91	FiO2 60%									
1300	99.3 (A)	117	15		91*	143/81	104										
1400	99.1 (A)	110	16/15	137/66	94	132/75	97	FiO2 45%									
1500	100.1 (A)	110	15/15		94	134/76	98										ABG
1600	99.1 (A)	94	16/15		96	119/67	82										
1700	99.3 (A)	107	15/15		96	141/80	109										
1800	99.4 (A)	97	15/15	137/73	95	138/74	96										
1900	99.3 (A)	86	15/15		98	125/61	81										
2000	99.6 (A)	103	15/15		98	154/78	98										
2100		102	15/15		98	152/81	102										
2200	97.6	97	15/15		99%	155/82	110										
2300	99.4	102	17/15		99%	149/80	104										
2400	99.4	82	15/15		99%	143/71	90										

ACLU-RDI 1099 p.944

DOD 006212

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
6 Oct 03	0200		Placed on (L) side. VS remain stable. Ø Signs of distress. FiO_2 remains at 50%. O_2 Sat 99%. Cont. to monitor [b(6)-2] cpt RN
6 Oct 03	0430		Placed supine. Dressings Changed. VSS. O_2 Sat 99%. Ø apparent distress. CT's x2 min drainage. Ø drainage from NGT. [b(6)-2] Cpt RN
6 OCT 03	0630		PT ō systolics in 90's; Diastolic in 40's. ↓ Versed to 2mg hr. NIBP 100's/40's. CT (R) ō minimal serous sanguinous drainage. See flowsheet for assessment. [b(6)-2] ILT, RN
6 OCT 03	0700		BP 120-130's/50-60's ↑ Versed 3mg/hr. [b(6)-2] ILT, RN
6 OCT 03	1130 0930		INFORMED BY RT PEEP is @ Ø. Informed Dr [b(6)-2]. PEEP placed on 8. Pt bucking vent ō ↑ RR 40-50's. DESAT into 70's-80's Bolused ō Approximately 20mg Versed in 5mg increments over 30 mins. Pt Sectional & FiO_2 ↑ 100% SATS ↑ 95-97% RR ↓ 20's. Attempted to wean down FiO_2 ō resultant ↓ O_2 Sats ↑ 80's. FiO_2 placed on 60%. O_2 SATS 90-93%. Dr [b(6)-2] informed. Placed on Vecuronium gtt @ 5mg/hr ō 5mg bolus. Will cont to monitor & ↓ FiO_2 [b(6)-2] ILT, RN
6 OCT 03		1300	VT 445%. Sats ↓ 88-89% @ 40% FiO_2. Unable to start I.V. ō 6 attempts. Dr [b(6)-2] aware. Fentanyl @ 100mcg hr Versed @ 3mg/hr & Vecuronium @ 5mg/hr. VSS. [b(6)-2] ILT, RN
6 OCT 03		1400	Assumed care. See flowsheet for details. Pt on (R) side. Ø skin breakdown noted. Pt paralyzed & sedated, ō no evidence of pain/discomfort. VSS. Low grade fever. adequate UOP - clear yellow. Minimal NGT output on LIS from (R) nare. No air leaks noted on Chest tube #1 or #2. Dsg to LLQ L thigh CDI. Staples on midline incision ō S/S of infection - no drainage noted. Will continue to monitor [b(6)-2] RN
		1530	Dsg Δ to LLQ (L) thigh completed. Moderate drainage (serous) noted to LLQ dsg. No evidence of infection. Minimal serous drainage noted to L thigh [b(6)-2] RN

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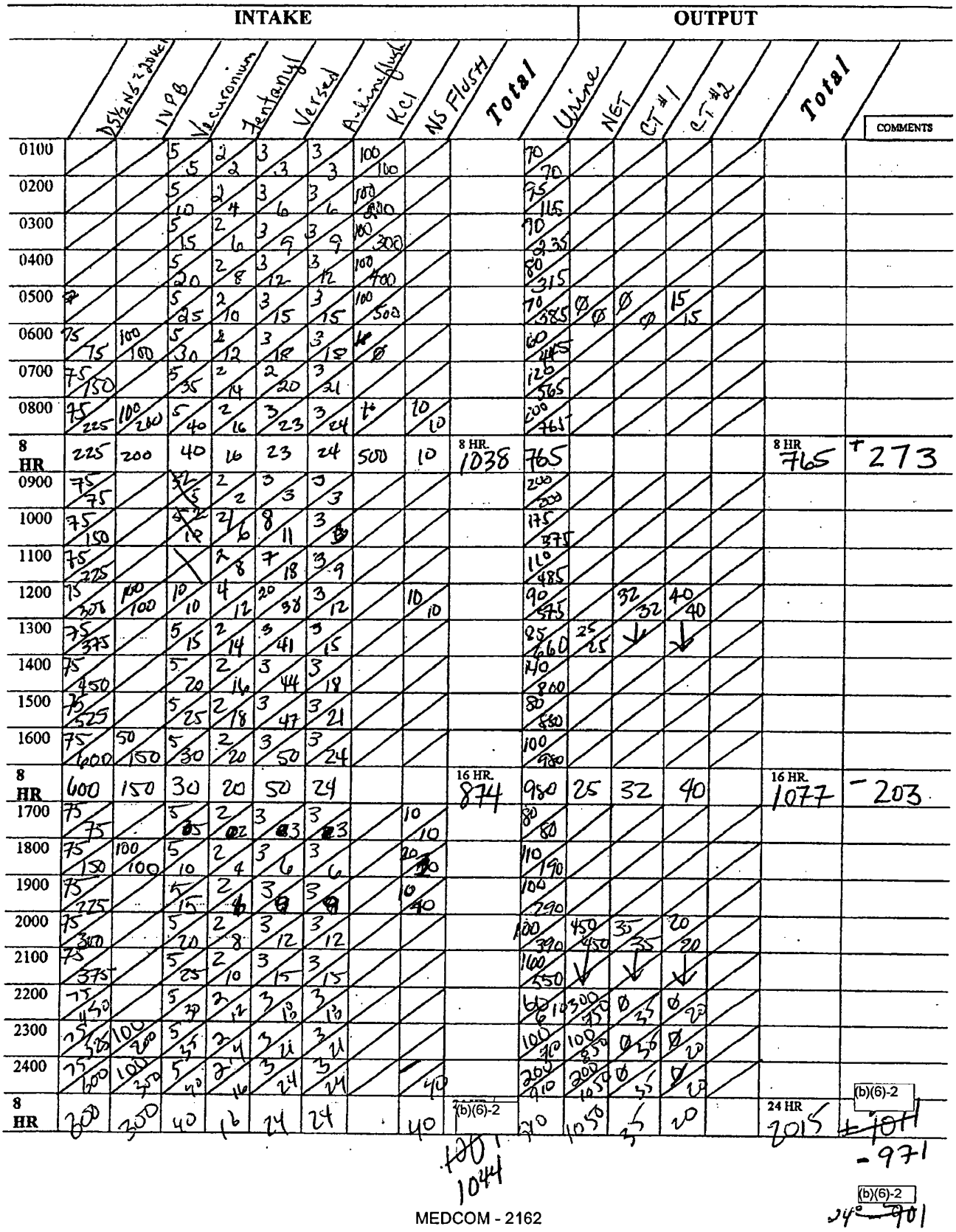
DOD 006213


INTAKE
OUTPUT
D5½NS + 20mEq
IVPB
Vecuronium
Fentanyl
Versed
A-line flush
KCl
NS Flush
Total
Urine
NGT
CT #1
CT #2
Total
COMMENTS
0100
0200
0300
0400
0500
0600
0700
0800
8 HR
1038
765
765
+273
0900
1000
1100
1200
1300
1400
1500
1600
8 HR
600
150
30
20
50
24
16 HR
874
980
25
32
40
16 HR
1077
-203
1700
1800
1900
2000
2100
2200
2300
2400
8 HR
300
350
40
16
24
24
40
(b)(6)-2
24 HR
2015
+101
-971
(b)(6)-2
MEDCOM - 2162

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R		2					2				2			2				2				–		
	L		2					2				2			2				2				–		
	DORSALIS PEDIS R		1					1				1			1				1				–		
	L		2					2				2			2				2				–		
SKIN (1) Dry (4) Cool (7) Jaundiced (2) Clammy (5) Flushed (8) Color Normal (3) Warm (6) Cyanotic (9) Pale			1					1				1			1				1				–		
			3					3				3			3				3				–		
			8					8				8			8				8				–		
EDEMA			*					Gen				Gen			Gen hard pitting				gen				–		
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)			✓					✓				✓													
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)			SR					SR ST				SR			ST				SR ST				–		
SWAN GANZ CATHETER (Zeroed & calibrated)								✓																	
ARTERIAL LINE (zeroed & calibrated)			✓					✓							✓				✓				–		
HYGIENE	BED BATH																								
	FOLEY CARE		✓																						
	ORAL CARE																								
MOBILITY	BEDREST		✓					✓				✓			✓				✓				–		
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT		✓																	✓					
	LEFT																	✓	✓						
	SUPINE							✓				✓			✓								✓		
	HOB 30 DEGREES							✓				✓			✓			✓	✓	✓			✓		
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE		UTA					UTA				UTA			UTA				UTA				–		
	PAIN SCALE (1-10)																								
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN (2) Soft & Flat (1) Distended			2					2				2			2				2				2		
BOWEL SOUNDS (active all quads)			x4 NP					⊖				⊖			⊖				⊖				–		
NG / DOBHOFF PLACEMENT VERIFIED			NP												✓				✓				–		
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT			✓					✓				✓			✓				✓				–		
VOIDING CLEAR, YELLOW URINE q.s.			✓					✓				✓			✓				✓				–		
SKIN INTEGRITY	No Breakdown		✓					✓																	
midline incision	Surgical Wounds		✓					✓							✓				✓				–		
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1 (4) Lower abd			✓					✓				✓			✓				✓				–		
#2 (2) upper thigh Retard			✓					✓				✓			✓				D				–		
#3 CT¹ (R) Chest								✓				✓			✓				✓				–		
#4 CT² (L) chest								✓				✓			✓				✓				✓		

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
4 Fr A-line	(R) radial		CDI /TDD
20 gauge	(R) AC		Patent & S/Sx of infection or infiltration 10700
18 gauge	(L) AC		Patent & S/Sx of infection or infiltration 10700
NGT	(N) NARE		
PIV 18g	(W) wrist	10/7/03	Patent & S/Sx of infection or infiltration
PIV 18g	(R) wrist	10/7/03	Patent & S/Sx of infection or infiltration
PIV 18g	(L) wrist	7 Oct 03	Saline lock appears patent.

ACLU-RDI 1099 p.947

DOD 006215

CRITICAL CARE FLOW SHEET

(b)(6)-4

LOS DATA	
DOA	03 Oct 03
DOS	03 Oct 03
POD	3

24 HOUR DATA	
24 Hour Balance	−997.5
24 Hour Intake	3737.5
24 Hour Output	4735
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	CPW
(b)(6)-2 ILT A	(b)(6)-2
(b)(6)-2 MW AN	

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On	N/A	N/A	
Call Light Within Reach			
Side Rails Up			
Bed in Low Position		(b)(6)-2	

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 CR	ICU2	04 Oct 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade;date; hospital or medical facility)*

(b)(6)-4

- ☐ HISTORY/PHYSICAL
- ☒ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☐ OTHER(*Specify*)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700.
1 MAY 78

MEDCOM - 2164

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100		81	15/15	114/83	98%		88										
0200	99.5 (BA)	97	24/15	138/100	100%	128/72	93										VENT
0300	99° (BA)	90	23/15		95%	112/60	75										VENT
0400	98.2 (BA)	94	18/15		99%	155/74	94										VENT
0500	99° (BA)	94	17/15		97%	121/62	78										VENT
0600	100° (A)	101	22/15	137/69	98%	137/74	95										
0700		104	15/15	140/74	97%	165/87	112										
0800	99.3 (A)	94	22/15	137/65	96%	154/75	98										
0900		94	26/15	118/54	96%	123/63	82										
1000	99.4 (A)	82	16/16	122/61	97%	122/67	83										
1100		90	16/16	116/61	97%	119/65	81										
1200	100° (A)	111	23/16	122/57	98%	127/68	86										
1300	101°	114	33/16	122/58	89%	126/67	85										
1400	101° (A)	119	25/25	105/54	92	108/58	73										
1500	101.6 (A)	111	25/25	102/54	94	111/62	76										
1600	101.6 (A)	103	25/25	107/57	94	102/56	70										
1700	100.3 (A)	99	25/25	119/63	99	119/68	84										
1800	100.7 (A)	100	25/25	110/62	97	110/64	78										
1900	100.5 (A)	100	23/23	118/66	97	111/68	82										
2000	100.0 (A)	107	36/20	122/82	88	124/81	95										
2100	98.2 (A)	106	38/20	123/76	92	131/83	98										
2200	97.8	111	43/20	125/84	98		107										
2300		95	19		95%	85/44											
2330						134/72											
2400	98.5	104	20		97%	163/92	113										

ACLU-RDI 1099 p.949

DOD 006217

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable/Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment –

DATE: 7 OCT 08

TIME		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open			1					1				1			1			2	2				–		
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response			1					1 T				1			1			H	1T				–		
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response			1					1 1				1 T			4			4	4				–		
GLASCOW COMA SCALE (A+B+C)			3T					3T				3T			6			T	7t				–		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R							2t				2t			2+										
	L							2t				2t			2+										
MOVEMENT (See Motor Function Scale at Top of Page)	RUE														1			1	2				–		
	LUE														1			2	2				–		
	RLE														1			1	2				–		
	LLE														1			2	2				–		
GRIP (S) Strong (W) Weak (-) absent	R														VTA				VTA				–		
	L														VTA				VTA				–		
RESPIRATIONS	REGULAR														V										
	IRREGULAR							X				X			E				t						
	UNLABORED														N										
	LABORED							for				for			T				Sats				for		
	SHALLOW																								
	RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL		3					3				3		3	3				3				–		
	LUL		3					3				3		3	3				2				–		
	RLL		3					3				3		3	2								–		
	LLL		3					3				3		3	2				2				–		
	BOTH BASES		✓					1				1		✓	2				3				✓		
COUGH	NONE		✓					✓				✓		✓	✓				✓				✓		
	SPONTANEOUS																								
	PRODUCTIVE																								
	NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear															Ø										
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																									
VENTILATOR	Vt		600					600				600			600			600	600	600	600	600			
	FIO2		45%					45				40			0.60			0.60	0.60	0.5	0.45	0.60			
	RATE (SIMV/CMV)		15					15				16			25			25	25	23	20	20			
	PEEP / CPAP		8					8				6			6			6	6	6	6	6			
	PRESS. SUPPORT		–												Ø										
OXYGEN DELIVERY DEVICE	NC (l/min)																								
	FM (l/min)																								
ETT # 7.5	NRBM (l/min)																								
	ETT 22 cm gums							✓				✓			✓			✓	✓						
ETT CARE / POSITION CHANGE								✓						✓											
ETT / NT SUCTIONED								✓						✓	✓			√	√						
INCENTIVE SPIROMETRY DONE																									
COUGH / DEEP BREATH																									
INITIALS		(b)(6)-2						(b)(6)-2				(b)(6)-2			(b)(6)-2			(b)(6)-2					(b)(6)-2		

ACLU-RDI 1099 p.950

DOD 006218

	INTAKE									OUTPUT						
	DSNS20KCL	Versad	Fentanyl	Vcc	IVPB	A-Line	Ativan	CR	Total	Urine	NG	Chest #1	Chest #2		Total	COMMENTS
0100	75/75	3/3	2/2	5/5	100/100	3/3				45/45	Ø/Ø	Ø/Ø	Ø/Ø			
0200	75/150	3/6	2/4	5/10	Ø/100	3/6				100/145	Ø/Ø	Ø/Ø	Ø/Ø			
0300	75/225	3/9	3/7	6/16	—/100	3/9				90/235	—/Ø	—/Ø	—/Ø			
0400	75/300	3/12	3/10	6/22	—/100	3/12				70/305	—/Ø	—/Ø	—/Ø			
0500	75/375	4/16	3/13	7/29	—/100	3/15				135/440	—/Ø	—/Ø	10/10			
0600	75/450	4/20	3/16	7/26		3/18				125/565						
0700	75/525	7/27	3/19	7/33	100/200	3/21				180/745						
0800	75/600	7/34	3/22	3.5/36.5	100/300	3/24				135/880						
8 HR	600	34	22	36.5	300	24			8 HR. 1016.5	880					8 HR 880	136.5
0900	75/75	7/7	4/4	0/0		3/3				140/140						
1000	75/150	7/14	4/8			3/6				125/265						
1100	75/225	7/21	4/12			3/9				200/465						
1200	75/300	7/28	6/18		100/100	3/12				255/720						
1300	75/375	17/45	6/24			3/15				200/920	400/400	15/15	20/20			
1400	15/450	22/67	8/26			3/18				250/1170						
1500	50/500	13/80	5/31		100/200	3/21	1/1			140/1310						
1600	50/550	8/88	5/36			3/24	2/3			140/1450		15/30	15/35			
8 HR	550	88	36		200	24	3 901		16 HR. 1917.5	1450	400	30	35	1915	16 HR. 2795	-877.5
1700	50/50	8/8	5/5			3/3	2/2			160/160		15/15	5/5			
1800	50/100	8/16	5/10		100/100	3/6	2/4			140/300						
1900	50/150	8/24	5/15			3/9	2/6			170/470						
2000	50/200	6/30	4/19			3/12	2/8			180/650						
2100	50/250	6/36	4/23		21/121	3/15	2/10			170/820						
2200	50/300	8/44	4/27			3/18	2/12			160/980	450/450	30/45	25/30			
2300	50/350	8/52	4/31	4/0	100/221	3/21		1000/1000		150/1130	75/525	25/70	Ø			
2400	50/400	8/60	4/35	0/4	100/321	3/24				160/1290	25/550	Ø	Ø			
8 HR	400	60	35	4	321			1000	24 HR. 1820	1290	550	70	30		24 HR 1940	

MEDCOM - 2167

MEDICAL RECORD | NURSING NOTES (Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
10/7/03	0745		NAD VSS. ↑ VENT RR to 16. D/c'd Vecuronium gtt. Albuterol MDI given by RT d/t. Expiratory wheezing. Fentanyl 150 mcg bolus IV & ↑ Fentanyl gtt to 200 mcg/hr ↓ IVF to 75 cc/hr. See flowsheet for assessment. [redacted] (b)(6)-2 ILT, AN
10/7/03	0930		PEEP ↓ 6. VSS O_2 SATS > 95% [redacted] (b)(6)-2 ILT, AN
10/7/03		1230	Pt agitated. Turning head side to side & pulling against restraints. Unable to verbally calm down. O_2 SATS ↓ Lows 80's. Bolused c̄ 10 mg Versed & notified Dr [redacted] (b)(6)-2 Pt bagged c̄ BV. SATS ↑ 100%. Placed back on vent & suctioned q̄ minimal secretions. Pt calm p̄ 10-15 mins [redacted] (b)(6)-2 ILT AN
10/7/03		1200 ~~1230~~	(LATE ENTRY) IV's 18g started in (B) wrists. Patent & s̄ sx of infection or infiltration. (B) AC IV's D/c'd c̄ caths intact & (-) s/sx of infection or infiltration [redacted] (b)(6)-2 ILT, AN
10/7/03		1315	Pt once again agitated. Thrashing in bed. Bolused c̄ approximately 20 mg Versed & 200 mcg Fentanyl. BV d/t power outage. O_2 SATS > 95%. RTD to Ventilator 100% F_iO_2. MDI given. Will continue to monitor [redacted] (b)(6)-2 ILT, AN
7 Oct 03		1445	Ax temp 101. MD notified → Tylenol prn ordered. Tylenol supp 650 mg ī PR given. [redacted] (b)(6)-2 MAJ AN
7 Oct 03		1530	ETT suctioned c̄ in-line catheter → Ø secretions. [redacted] (b)(6)-2 MAJ
7 Oct 03		1630	LLQ and (L) hip dsgs Δ'd. Small area of necrosis noted of inferior-medial subcutaneous tissue on LLQ wound. (L) hip/upper leg wound appears closed, Ø drainage, left open to air. Pt opened eyes and withdrew to pain while packing abd wound. ETT suctioned for Ø secretions. [redacted] (b)(6)-2 MJ AN
7 Oct 03		1700	Physician ordered for maintenance IV D_5 ½ NS c̄ 20 mEq KCl per liter @ 50 cc/hr. Pharmacy is out of D_5 ½ NS, pt has D_5 NS + 20 KCl @ 50 cc/hr hanging. MD's aware. [redacted] (b)(6)-2 MJ AN
7 Oct 03		1845	Attempted to communicate c̄ pt using interpreter. Pt turned head towards voice and attempted to open eyes

(con't on attached sheet)

[redacted] (b)(6)-2

MEDCOM - 2168

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	03 Oct 03
DOS	
POD	

24 HOUR DATA	
24 Hour Balance	+10
24 Hour Intake	3689
24 Hour Output	-3659
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	(b)(6)-2
(b)(6)-2	
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach	N/A		
Side Rails Up		X	
Bed in Low Position			

PREPARED BY (Signature and Title)
(b)(6)-2 LPN

Department/Service/Clinic: ICU

DATE: 080ct03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade;date; hospital or medical facility)*

(b)(6)-4

☐ HISTORY/PHYSICAL ☒ FLOWCHART

☐ OTHER EXAMINATION Or EVALUATION ☐ OTHER(*Specify*)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 2169

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R		2				2					2			2				2				2		
	L		2				2					2			2				2				2		
	DORSALIS POSTIS R		2				1					2			2				1				2		
	PEDIS L		D				2					2			2				2				D		
SKIN (1) Dry (4) Cool (7) Jaundiced (2) Clammy (5) Flushed (8) Color Normal (3) Warm (6) Cyanotic (9) Pale			1 3 8				1 3 8					1 3 8			1 3 8				1 3 8				1 3 8		
EDEMA			gen				gen					gen			gen				gen				gen		
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)			R				✓					✓			S1S2				S1S2				R		
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)			NSR				ASYST					ST			ST				SR				NSR		
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)			✓				✓			✓					✓				✓				✓		
HYGIENE	BED BATH									✓															
	FOLEY CARE		✓							✓									✓				✓		
	ORAL CARE									✓															
MOBILITY	BEDREST		✓				✓					✓			✓								✓		
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT											✓			✓										
	LEFT																								
	SUPINE		✓				✓												✓				✓		
	HOB 30 DEGREES		✓				✓					✓			✓				✓				✓		
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE		A				VSA					S			Pain				Pain				A		
	PAIN SCALE (1-10)														9/10				SW						
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended		2				2					2			2				2				2		
BOWEL SOUNDS (active all quads)			WNL				Hyp					Hyp			Hyp				a bs				A		
NG / DOBHOFF PLACEMENT VERIFIED			✓				✓								✓				✓						
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT			✓				✓					✓			✓				✓				✓		
VOIDING CLEAR, YELLOW URINE q.s.			✓				✓					✓											✓		
SKIN INTEGRITY	No Breakdown						✓					✓													
	Surgical Wounds		✓				✓					✓			✓				✓				✓		
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1 L thigh DTA			✓				✓					✓			✓				✓				✓		
#2 ABD Incision + staples DTA			✓				✓					✓			✓				✓				✓		
#3 Chest tubes #1 & #2 CDI			✓				✓					✓			✓				✓				✓		
L ABD CDI			✓																						

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
A-Line	(R) wrist		CDI /0600 /1100 /1800
16G x 2	(R) hand	7 OCT	CDI /0600 /1100
16G x 2	(L) AC	7 OCT	CDI /0600 /1100
NGT	(R) NARE	3 OCT	Patent /0600 /1100 /1800
Central TLC	(L) subclavian	8 OCT 03	Patent all 3 lumen CDI RSB infection
18G PIV	(L) wrist	7 OCT 03	CDI 1800

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DOD 006222

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100		102	20	159/85			114										
0200	98.3	104	18	162/90	97%		115										
0300		104	23	165/93	95%		109										
0400	98.2	102	19	158/85	97%		111										
0500		95	16	133/76	96%		95										
0600	100.3 (A)	100	16/16		98%	152/85	106										
0700		89	16/20		95%	125/72	88										
0800	100 (A)	90	16/16		96	127/73	90										
0900		86	16/16		95	129/72	91										
1000	99 (A)	101	16/19		98%	149/78	101										
1100		109	16/16		97%	125/73	89										
1200		108	16/16		95%	120/74	89										
1300	99.3 (A)	108	16/18		100%	100/65	78										
1400		110	35/18		96%	97/57	69										
1500	99 (A)	105	16/16		94%	105/63	77										
1600		94	16/16	103/57	96%	102/56	75										
1700	99.8 (A)	96	16/16		97%	107/63	78										
1800		101	16/16		98%	112/65	81										
1900	99.7 (A)	99	14/14		98	110/66	81										
2000	100.8 (A)	101	14/14		97	108/64	79										
2100	99 (A)	113	24/14		98	115/67	80										RT TX
2200	101.5 (A)	113	19/12		96	124/70	79										
2300	101.6	109	19/12	110/52	96	121/69	86										
2400	101.8	109	14/12	117/58	97	116/68	109										

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PUPIL SIZE	PUPILS		MOTOR FUNCTION	CHART CODES
1 mm	=	Equal	0 = No Movement	Present ✓
2 mm	R	Reactive	1 = Slight Flicker/ Trace of Contraction	
3 mm	NR	NonReactive	2 = Active (Gravity Eliminated)	Not Applicable /Absent (blank)
			3 = Active: against gravity, but not against resistance	
4 mm	L > R	Left Larger	4 = Active: Against Gravity and Resistance, not full strength	Refer to Nsg. Notes X
			5 = Full Strength against Examiners Resistance	
5 mm	R > L	Right Larger	6 = Paralyzed & Sedated	No Change from Previous Assessment –

DATE: 8OCT03

TIME		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (2) To Pain (3) To Voice (1) Does Not Open			1				1					1			1				1				1		
B. BEST VERBAL RESPONSE (5) Oriented (2) Garbled (4) Confused (1) No Response (3) Inappropriate Verbal Response			1 T				1 T					1 T			1 T				1 T				1		
C. BEST MOTOR RESPONSE (6) Obeys Commands (3) Flexion to Pain (5) Localizes to Pain (2) Extension to Pain (4) Withdraw to Pain (1) No Response			1				1					1			1				1				1		
GLASCOW COMA SCALE (A+B+C)			3T				3T					3T			3T				3T				3T		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R		2+				2+					2+			2+				2+				2+		
	L		2+				2+					2+			2+				2+				2+		
MOVEMENT (See Motor Function Scale at Top of Page)	RUE		P				P/S					6			6				6				6		
	LUE		A									6			6				6				6		
	RLE		5									6			6				6				6		
	LLE		6									6			6				6				6		
GRIP (S) Strong (W) Weak (-) absent	R						P/S					6			6				6				6		
	L											6			6				6				6		
RESPIRATIONS	REGULAR		✓				V								V				V				V		
	IRREGULAR						L					X			L				E				E		
	UNLABORED		/				A					N			A				N				A		
	LABORED						T					P			N				T				T		
	SHALLOW											N			T				T						
	RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL		2				3/1					3			3/1				3/1				2/1		
	LUL		2				3					3/2			3/2				3/2				2/1		
	RLL		2				5					3			1				1				2/1		
	LLL		2				3					3			3				3				2/1		
	BOTH BASES		2				1					1			1				1				1		
COUGH	NONE		/				✓					✓			✓								✓		
	SPONTANEOUS																		✓						
	PRODUCTIVE																								
	NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																									
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																									
VENTILATOR	Vt		600				600					600			600		750		800			550			
	FIO2		100				50					100			40		60		60			50			
	RATE (SIMV/CMV)		12				16					16			16		16		14			12			
	PEEP / CPAP		8				8					8			10		10		10			10			
	PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE	NC (l/min)																								
	FM (l/min)																								
ETT # 7.5	NRBM (l/min)																								
	ETT 22 cm gums											22 ✓			✓		✓		✓				✓		
ETT CARE / POSITION CHANGE												✓													
ETT / NT SUCTIONED										✓	✓														
INCENTIVE SPIROMETRY DONE																									
COUGH / DEEP BREATH																									
INITIALS			(b)(6)-2				(b)(6)-2					(b)(6)-2			(b)(6)-2		(b)(6)-2		(b)(6)-2				(b)(6)-2		

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DOD 006224

MEDICAL RECORD

NURSING . . ES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
	0200		Cont nonmovement as result of medication for paralysis (see MAR), vitals within normal limits IV sites to (L) AC, (R) hand; Art line to (R) wrist CDI, Incisions to ABD CDI, cont. suction to chest tubes, NG to LIS, vent continued c̄ resp therapie to assist (see MAR for settings) Foley draining clear yellow urine [redacted] (b)(6)-2
10/8/03	0730		Temp 100³(A) Medicated c̄ Tylenol 650mg supp. PR. D5NS @ 50 cc/hr. Fentanyl @ 200mcg/hr, Versed @ 6mg/hr & Vecuronium @ 7mg/hr. FiO_2 ↓ 40%. O_2 SATS 95%. (R) CT's c̄ minimal serosanguinous drainage @ air leak. See flowsheet for assessment. [redacted] (b)(6)-2 ILT
10/8/03	1000		Broncoscopy performed by DR's [redacted] (b)(6)-2 ~~[illegible]~~ Thick brown secretions aspirated c̄ suction p̄ copious amounts of NS lavages. Pt tolerated procedure well. FiO_2 kept @ 100% to allow pt to recover. Will cont to monitor & titrate ↓ FiO_2 appropriately. VSS. [redacted] (b)(6)-2 ILT,
10/8/03		1130	Pt c̄ break in skin in scral area ☐ (size). Area cleaned. Turned to (R) side. VSS. Will cont to monitor [redacted] (b)(6)-2 ILT
		1600	Current Addition Fent 200mcg/hr Versed 6mg/hr Vecuronium 7mg/hr. Vivonex feed @ 10cc/hr residual V'd was zero. Kcl infusion @ 25cc/hr to TLC. Chest tube #2 seems doing chest tube #1 drains as well. [redacted] (b)(6)-2 LTAW
		1630	Pt turned to (L) side dressing ▷ complete [redacted] (b)(6)-2 LTAW
		1800	Assumed care. Pt turned to supine @ 1855. Proper body alignment maintained. Will continue to monitor [redacted] (b)(6)-2
		1015	↓ FiO_2 to 50%, ↓ RR to 12 per DR [redacted] (b)(6)-2 [redacted] (b)(6)-2
		2120	↑ Tvol to 850 per DR [redacted] (b)(6)-2 [redacted]
		2200	↓ change from previous shift assessment, Tube feedings via NG cont. as ordered via NG tube, ventilation cont. as ordered, lung sounds diminished all lobes c̄ wheezing, IV fluids infusing via central line to (L) subclavian as ordered, HL to (L) wrist CDI, Art line zeroed to (R) wrist, Incision c̄ [illegible] ABD DTA, Dressings to chest tube sites CDI [illegible] ABD CDI [illegible]

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	INTAKE									OUTPUT						
	DSNS c 20 KCL	Fentanyl	Versed	Vecuanium	IUPB	Vivonex	KCL		Total	Urine	NG	Chest #1	Chest #2	Residual NGT	Total	COMMENTS
0100	50 / 50	4 / 4	4 / 4	4 / 4						100 / 100	200 / 200	Ø	Ø			
0200	50 / 100	4 / 8	4 / 8	4 / 8						100 / 200	Ø	Ø	Ø			
0300	50 / 150	4 / 12	4 / 12	4 / 12						140 / 340	Ø	Ø	Ø			
0400	50 / 200	4 / 16	4 / 16	4 / 16						250 / 440	100 / 100	Ø	Ø			
0500	50 / 250	4 / 20	4 / 20	4 / 20						160 / 600	100 / 400	5	Ø			
0600	50 / 300	4 / 24	4 / 24	4 / 24						125 / 725	~~400~~ 400	0 / 5	0 / 0			
0700	50 / 350	6 / 30	4 / 28	9 / 31	100 / 100					105 / 830						
0800	50 / 400	8 / 38	6 / 34	7 / 38	100 / 200					120 / 950						
8 HR	400	38	34	38	200				8 HR. 710	954	400	5	0		8 HR 1359	~~-649~~
0900	50 / 450	8 / 8	6 / 6	7 / 7						80 / 80						
1000	50 / 500	8 / 16	6 / 12	7 / 14						85 / 165						
1100	50 / 550	16 / 32	6 / 18	7 / 21						130 / 295						
1200	50 / 600	8 / 40	6 / 24	7 / 28						75 / 370						
1300	50 / 650	8 / 48	6 / 30	7 / 35						65 / 435	400 / 400	95 / 95	40 / 40			
1400	50 / 700	8 / 56	6 / 36	7 / 42						80 / 515						
1500	125 / 825	8 / 64	6 / 42	7 / 49						65 / 580						
1600	125 / 950	8 / 72	6 / 48	7 / 56	100	10	25		1261	65 / 645					1180	
8 HR	950	72	48	56	100	10	25		16 HR. 1971	645	400	95	40		16 HR. 2539	-568
1700	125 / 125	8 / 8	6 / 6	7 / 7		10 / 10	25 / 25			80 / 80						
1800	125 / 250	8 / 16	6 / 12	7 / 14	100 / 100	10 / 20	25 / 50			120 / 200						
1900	125 / 375	8 / 24	6 / 18	7 / 21		10 / 30	25 / 75			160 / 360						
2000	125 / 500	8 / 32	6 / 24	7 / 28		10 / 40	25 / 100			90 / 450				25 / 25		
2100	125 / 725	8 / 40	6 / 30	7 / 35		10 / 50	25 / 125			100 / 550		80 / 80	15 / 15	- / 25		
2200	125 / 750	8 / 48	6 / 36	7 / 42		10 / 60	25 / 150			110 / 660	Ø	Ø	Ø	Ø		
2300	125 / 975	8 / 56	6 / 42	7 / 49		10 / 70	50 / 200			120 / 780		Ø	Ø	Ø		
2400	125 / 1100	8 / 64	6 / 48	7 / 56		10 / 80	50 / 250		1698	120 / 1000		Ø	Ø	10	1120	
8 HR	1100	64	48	56	100	80	250		24 HR. 3669	1000		80	15	25	24 HR 3659	

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		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R		2				2					2			2				2				2		
	RADIAL L		2				2					2			2				2				2		
	DORSALIS PEDIS R		2				2					2			2				2				2		
	DORSALIS PEDIS L		1				2					2			2				2				1		
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale			1 3 8				1 3 8					1 3 8			1 3 8				1 3 5 8 face				1 3 8		
EDEMA			Gen				Gen					Gen			Gen				Gen				Gen		
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)			R				R					R			ST/R				R				R		
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)			NSR				NSR					NSR			ST				ST				NSR		
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)			✓				✓					✓			✓				✓				✓		
HYGIENE	BED BATH											✓													
	FOLEY CARE		✓									✓											✓		
	ORAL CARE																								
MOBILITY	BEDREST		✓				✓					✓			✓		✓		✓				✓		
	BSC																								
	DANGLE																								
	CHAIR											✓					✓								
POSITIONED	RIGHT																								
	LEFT		✓				✓								✓				✓						
	SUPINE		✓												✓								✓		
	HOB 30 DEGREES		✓				✓					✓			✓		✓		✓				✓		
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE																		✓ (on interpreter)						
	PAIN SCALE (1-10)																								
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended		2				2					2			2				2				2		
BOWEL SOUNDS (active all quads)			Low				Hypo active					Hypo active			Ø								Low		
NG / DOBHOFF PLACEMENT VERIFIED			✓				✓								✓				✓						
RESIDUAL ASSESSED															10cc				5cc						10
Ph																									
FOLEY CATHETER PATENT			✓				✓					✓			✓				✓				✓		
VOIDING CLEAR, YELLOW URINE q.s.			✓				✓					✓			✓				✓				✓		
SKIN INTEGRITY	No Breakdown																								
	Surgical Wounds		✓				✓					✓			✓				✓				✓		
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1 Chest tube @ chest / @ chest			✓				✓					✓			✓				✓				✓		
#2 ABD - Incision staples OTA			✓				✓					✓			✓				✓				✓		
#3 @ L AB - CDF @ thigh OTA			✓				✓					✓			✓				✓				✓		

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
NG tube	@ nasal		
TLC	@ subclavian	DC'd	
18 gage	@ wrist		
A-line	@ radial		

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DOD 006227

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	03Oct03
DOS	
POD	

24 HOUR DATA	
24 Hour Balance	+3820
24 Hour Intake	6180
24 Hour Output	-2360
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2 LPN	(b)(6)-2
(b)(6)-2 SPC 91WMC	
(b)(6)-2 MTAN	
(b)(6)-2 MAJ AN	
[illegible]	

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On		N/A	
Call Light Within Reach		N/A	N
Side Rails Up		N/A	A
Bed in Low Position		N/A	

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2	ICU	09Oct03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade;date; hospital or medical facility)*

(b)(6)-4

- ☐ HISTORY/PHYSICAL
- ☐ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☐ OTHER(*Specify*)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 2176

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100		106	12/12	105/58	97	114/58	81										
0200	101.1	110	12/12	111/56	96	113/69	82										
0300		110	12/12	116/46	97	113/68	82										
0400	101.8	104	12/12	109/56	99	116/66	84										
0500		107	12/12	119/71	100%	117/68	87										
0600																	
		103	12/12	118/58	100%	117/	81										
0700	100.8	105	14/12	113/59	100%	112/70	81										
0800		100	12/12	114/60	100%	117/60	81										
0900		106	12/12	108/59	100%	108/62	78										
1000		109	17/10	138/77	97%												
1100	101	101	10/10	136/76	99%	140/70	100										
1200		115	11/10	135/76	98%	134/74	106										
1300		120	10/10	124/70	100%	114/51	89										
1400	100.8 (A)	123	15/15	116/63	95	116/62	78										
1500	100.5 (A)	116	13/15	113/60	99	114/58	77										
1600	101.3 (A)	102	16/12	120/64	100	105/70	84										
1700	100.5 (A)	114	12/12	110/65	100	116/64	81										
1800	100.1 (A)	106	14/12	112/65	99	117/65	80										
1900	100.8 (A)	102	20/12	133/71	99	125/67	85										
2000	99.7 (A)	95	12/12	121/64	99	124/60	77										
2100	100.8 (A)	101	16/10	132/61	100	130/66	85										
2200	100.2	98		124/54	100												
2300	100.2	102		124/58	100												
2400		105	24/2	109/54	98%	104/96											

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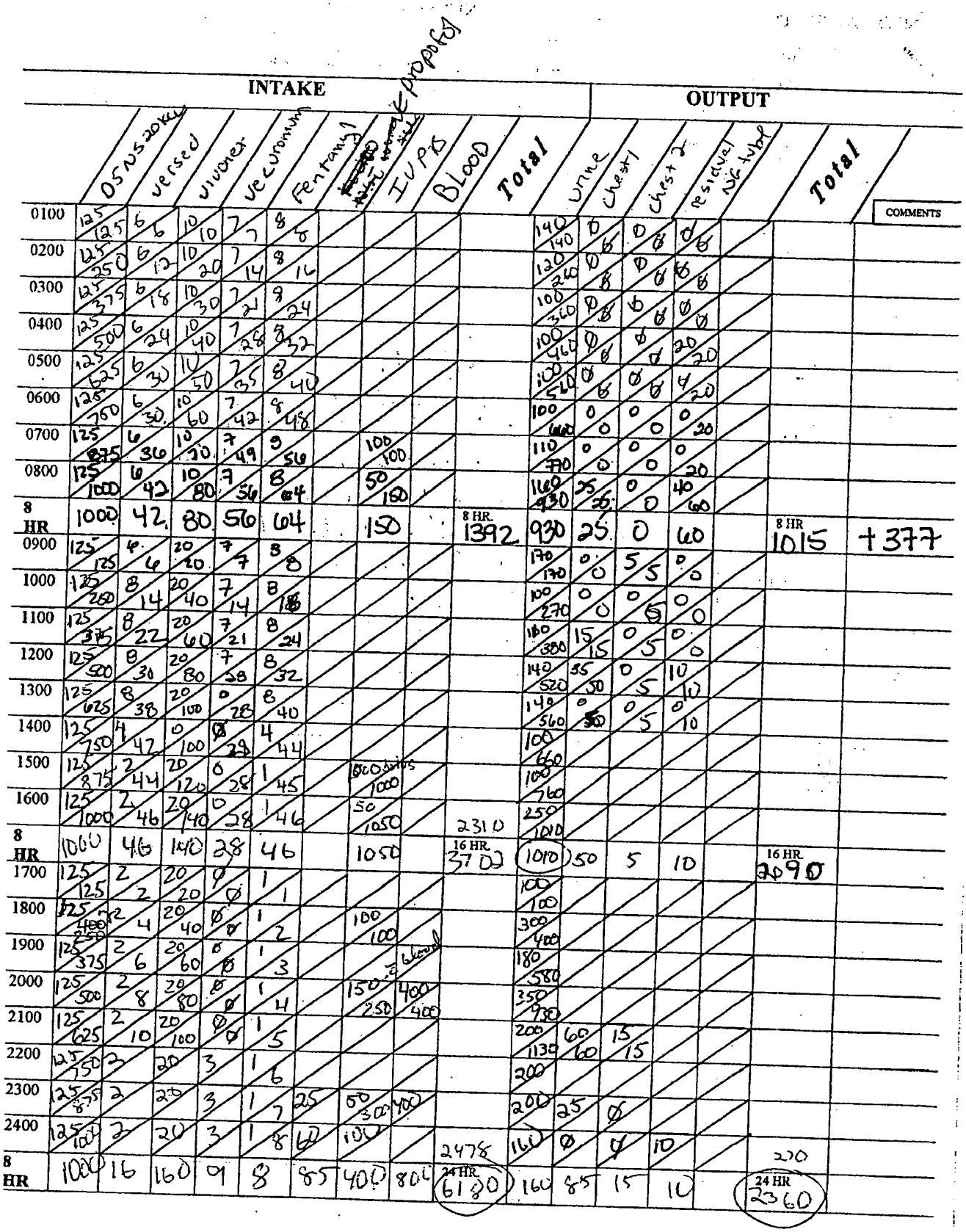
DOD 006229

PUPIL SIZE		PUPILS	MOTOR FUNCTION	CHART CODES
1 mm	=	Equal	0 = No Movement	Present ✓
2 mm	R	Reactive	1 = Slight Flicker/ Trace of Contraction	
3 mm	NR	NonReactive	2 = Active (Gravity Eliminated)	Not Applicable /Absent (blank)
			3 = Active: against gravity, but not against resistance	
4 mm	L > R	Left Larger	4 = Active: Against Gravity and Resistance, not full strength	Refer to Nsg. Notes X
			5 = Full Strength against Examiners Resistance	
5 mm	R > L	Right Larger	b/ paralyzed (medication)	No Change from Previous Assessment –

DATE:

TIME		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (2) To Pain (3) To Voice (1) Does Not Open			1				1					1			1				4				1		
B. BEST VERBAL RESPONSE (5) Oriented (2) Garbled (4) Confused (1) No Response (3) Inappropriate Verbal Response			1				1					1			1				ETT 1				1		
C. BEST MOTOR RESPONSE (6) Obeys Commands (3) Flexion to Pain (5) Localizes to Pain (2) Extension to Pain (4) Withdraw to Pain (1) No Response			1				1					1			3				4				1		
GLASCOW COMA SCALE (A+B+C)			4				4					4			5				9				4		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R		2+				2+					2+			2-3 +								2+		
	L		2+				2+					2+			2-3 +								2+		
MOVEMENT (See Motor Function Scale at Top of Page)	RUE		6				6					6			2				2				6		
	LUE		6				6					6			2				2				6		
	RLE		6				6					6			2				2				6		
	LLE		6				6					6			2				2				6		
GRIP (S) Strong (W) Weak (-) absent	R		6				6					6			6				6				6		
	L		6				6					6			6				6				6		
RESPIRATIONS	REGULAR						✓					✓			✓				✓				✓		
	IRREGULAR																								
	UNLABORED		✓				✓					✓			✓				✓				✓		
	LABORED																								
	SHALLOW																								
	RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL		1/2				3					3			3				3				3		
	LUL		1/2				3					3			3				3				3		
	RLL		1/2				3/1					3/1			3				3				3		
	LLL		1/2				3					3			3				3				3		
	BOTH BASES						1					1			1				1				1		
COUGH	NONE		✓				✓					✓			✓				✓				✓		
	SPONTANEOUS																								
	PRODUCTIVE																								
	NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																			2			1			
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																			2			2			
VENTILATOR	Vt		850				850					800			1000	1000	1000		1000	1000					
	FIO2		50				50					40			60	40	40		40	40					
	RATE (SIMV/CMV)		12				12					10			15	12	12		12	10					
	PEEP / CPAP		10				10					10			10	10	10		10	8					
	PRESS. SUPPORT														Ø	Ø	Ø		Ø	Ø					
OXYGEN DELIVERY DEVICE	NC (l/min)																								
	FM (l/min)																								
ETT #_____	NRBM (l/min)																								
	ETT _____cm gums		✓				✓					✓			✓				✓				✓		
ETT CARE / POSITION CHANGE			✓				✓					✓			✓								✓		
ETT / NT SUCTIONED																						✓			
INCENTIVE SPIROMETRY DONE				✓																					
COUGH / DEEP BREATH																									
INITIALS		(b)(6)-2				(b)(6)-2				(b)(6)-2				(b)(6)-2					(b)(6)-2						

	INTAKE									OUTPUT						
	D5NS 20KCL	versed	vivonex	vecuronium	Fentanyl	~~[illegible]~~ propofol	IVPB	BLOOD	Total	urine	chest 1	chest 2	residual NG tube		Total	COMMENTS
0100	125 / 125	6 / 6	10 / 10	7 / 7	8 / 8					140 / 140	0 / 0	0 / 0	0 / 0			
0200	125 / 250	6 / 12	10 / 20	7 / 14	8 / 16					120 / 260	0 / 0	0 / 0	0 / 0			
0300	125 / 375	6 / 18	10 / 30	7 / 21	8 / 24					100 / 360	0 / 0	0 / 0	0 / 0			
0400	125 / 500	6 / 24	10 / 40	7 / 28	8 / 32					100 / 460	0 / 0	0 / 0	20 / 20			
0500	125 / 625	6 / 30	10 / 50	7 / 35	8 / 40					100 / 560	0 / 0	0 / 0	0 / 20			
0600	125 / 750	6 / 30	10 / 60	7 / 42	8 / 48					100 / 660	0 / 0	0 / 0	0 / 20			
0700	125 / 875	6 / 36	10 / 70	7 / 49	8 / 56		100 / 100			110 / 770	0 / 0	0 / 0	0 / 20			
0800	125 / 1000	6 / 42	10 / 80	7 / 56	8 / 64		50 / 150			160 / 930	25 / 25	0 / 0	40 / 60			
8 HR	1000	42	80	56	64		150		8 HR. 1392	930	25	0	60		8 HR 1015	+377
0900	125 / 125	6 / 6	20 / 20	7 / 7	8 / 8					170 / 170	0 / 0	5 / 5	0 / 0			
1000	125 / 250	8 / 14	20 / 40	7 / 14	8 / 16					100 / 270	0 / 0	0 / 5	0 / 0			
1100	125 / 375	8 / 22	20 / 60	7 / 21	8 / 24					110 / 380	15 / 15	0 / 5	0 / 0			
1200	125 / 500	8 / 30	20 / 80	7 / 28	8 / 32					140 / 520	35 / 50	0 / 5	10 / 10			
1300	125 / 625	8 / 38	20 / 100	0 / 28	8 / 40					140 / 560	0 / 50	0 / 5	0 / 10			
1400	125 / 750	4 / 42	0 / 100	0 / 28	4 / 44					100 / 660						
1500	125 / 875	2 / 44	20 / 120	0 / 28	1 / 45		1000 drips / 1000			100 / 760						
1600	125 / 1000	2 / 46	20 / 140	0 / 28	1 / 46		50 / 1050		2310	250 / 1010						
8 HR	1000	46	140	28	46		1050		16 HR. 3702	1010	50	5	10		16 HR. 2090	
1700	125 / 125	2 / 2	20 / 20	0 / 0	1 / 1					100 / 100						
1800	125 / 250	2 / 4	20 / 40	0 / 0	1 / 2		100 / 100			300 / 400						
1900	125 / 375	2 / 6	20 / 60	0 / 0	1 / 3					180 / 580						
2000	125 / 500	2 / 8	20 / 80	0 / 0	1 / 4		150 / 250	400 / 400		350 / 930						
2100	125 / 625	2 / 10	20 / 100	0 / 0	1 / 5					200 / 1130	60 / 60	15 / 15				
2200	125 / 750	2	20	3	1 / 6					200						
2300	125 / 875	2	20	3	1 / 7	25	50 / 300	400		200	25	0				
2400	125 / 1000	2	20	3	1 / 8	60	100		2478	160	0	0	10		270	
8 HR	1000	16	160	9	8	85	400	800	24 HR. 6180	160	85	15	10		24 HR 2360	



MEDCOM - 2179

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
9Oct03	0200		Non movement of pt, paralysis (see MAR), fen edema noted, Ø Bowel sounds heard to ABD, NG tube & tube feedings as ordered, TLC to R subclavian & IV fluids as ordered, A-line to R wrist secured, HC 1% to R wrist CDI, Cont suctioning to chest tubes #1 & 2, Incision to ABD DTA & staples CDI, Dressing to L IJ ABD CDI, Incision to L thigh DTA, will cont to monitor pt while on vent as ordered [b)(6)-2]
	0600		received pt this AM; NAD; assessment completed; R subclavian flushed w/o difficulty; will cont to monitor
	0745		A-line tubing & NS d'd; break down to R hand from moisture; coban used to hold A-line in place so that hand will get more air [b)(6)-2]
	0845		vent settings d'd to TV 950 mL, FiO_2 40%, PEEP @ 10, rate 12; tube feeding increased to 20 cc/hr; [b)(6)-2]
	1030		Vecuronium decreased to 3 mg/hr; will cont to monitor [(b)(6)-2]
	1300		Vecuronium turned off; will cont to monitor [(b)(6)-2]
9Oct03		1420	Versed ↓ to 2 mg/hr; Fentanyl ↓ to 50 µ/hr [b)(6)-2] MJ AN
		1430	~~500 cc~~ 1000 cc LR Bolus IV given, 1000 cc [b)(6)-2] MAJ AN
		1630	Vent settings d'd per Dr. [b)(6)-2] + A/C - 12, V_T ↑ 1000 cc, FiO_2 - 40%, PEEP - 10. O2 sats > 95%, RR 18, A-line positional. NG tube position √'d; 10 cc residual - replaced. Tube feedings (Vivonex) cont @ 20 cc/hr. ETT cuff inflated, HOB elevated. Temp @ 1600 was 101.3 (A) → Tylenol Supp 650 mg PR given @ 1615. Versed @ 2 mg/hr; Fentanyl @ 25 µ/hr, Vec is d/c'd. Pt moving all extremities spontaneously and opening eyes. Follows no commands. [b)(6)-2] MJ AN
		1830	Pt appears more awake, opening eyes spontaneously. Shaking head "yes" and "no" appropriately per interpreter. Moves all extremities but followed no commands. Turns head to voice. 7 unit PRBCs hung @ 1730 in R SCV triple lumen. No transfusion reactions noted this pm. See flow sheet (DA 4700 pp 132-116) for vitals. [b)(6)-2] MAS AN

ACLU-RDI 1099 p.964

DOD 006232

CRITICAL CARE FLOW SHEET

(b)(6)-4

LOS DATA	
DOA	03 Oct 03
DOS	
POD	

24 HOUR DATA	
24 Hour Balance	-115
24 Hour Intake	4493
24 Hour Output	4608
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2 LPN	(b)(6)-2
(b)(6)-2 RN	
(b)(6)-2 LPT, A	
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		(b)(6)-2
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach	N		N
Side Rails Up	A		A
Bed in Low Position			

(b)(6)-2	Department/Service/Clinic	DATE
	ICU	10 Oct 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade;date; hospital or medical facility)*

(b)(6)-4

- ☐ HISTORY/PHYSICAL
- ☑ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☐ OTHER(*Specify*)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 2181

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R		WP				2				2				2				—				WP		
	L		2				2				2				2				—				2		
	DORSALIS PEDIS R		2				2				2				2				—				2		
	L		2				2				2				2				—				2		
SKIN (1) Dry (4) Cool (7) Jaundiced (2) Clammy (5) Flushed (8) Color Normal (3) Warm (6) Cyanotic (9) Pale			138				138				138				138				—				138		
EDEMA			*				Gen				Gen				GEN				—				*		
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)			✓				✓				✓				✓				—				✓		
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)			SR				SR-ST				SR				SR				—				SR		
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)			✓				✓				✓				✓				—				✓		
HYGIENE	BED BATH										✓														
	FOLEY CARE		✓								✓				✓				—				✓		
	ORAL CARE										✓														
MOBILITY	BEDREST		✓				✓				✓				✓				—				✓		
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT										✓														
	LEFT																								
	SUPINE						✓																		
	HOB 30 DEGREES		✓				✓				✓				✓				—				✓		
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)			*																				*		
PAIN	PAIN FREE		WP				WP				WP*				✓				—				WP		
	PAIN SCALE (1-10)																								
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN (2) Soft & Flat (1) Distended			2				2				2				1				—				2		
BOWEL SOUNDS (active all quads)			x4				Hypo				Hypo				Hypo				—				x4		
NG / DOBHOFF PLACEMENT VERIFIED							✓				✓														
RESIDUAL ASSESSED					✓		14cc				10cc														
Ph																									
FOLEY CATHETER PATENT			✓				✓				✓				✓				—				✓		
VOIDING CLEAR, YELLOW URINE q.s.			✓				Amber				Amber												✓		
SKIN INTEGRITY	No Breakdown																								
	Surgical Wounds																								
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)											✓														
#1 Incision ABD OTA Staples			✓				✓				✓				✓				—				✓		
#2 Chest tube #1 5th CDT			✓				✓				✓				✓				—				✓		
#3 ⓒ ↓ ABD CDF			✓				✓				✓				✓				—				✓		
ⓒ thigh OTA Incision			✓				✓				✓				✓				—				✓		

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
NG tube	Ⓡ nostril		CDI 1600/1000
A-line	Ⓡ radial		CDF 6000/1000
TLC	ⓒ subclavian		CDI 1600/1000

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DOD 006234

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance
6 = SEDATED

CHART CODES

Present ✓
Not Applicable /Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment –

DATE: 10 OCT 03

TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open		1				1				1				4				–				4		
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response		1				1T				1T				5				–				5		
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response		1				1				1				6				–				6		
GLASCOW COMA SCALE (A+B+C)		3				3T				3T				15				–				15		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) R						5+				3+				+3				–				13		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) L						5+				3+				+3				–				13		
MOVEMENT (See Motor Function Scale at Top of Page) RUE		2e				6				6				5				–				5		
MOVEMENT (See Motor Function Scale at Top of Page) LUE		2e				6				6				5				–				5		
MOVEMENT (See Motor Function Scale at Top of Page) RLE		1e				6				6				5				–				5		
MOVEMENT (See Motor Function Scale at Top of Page) LLE		1e				6				4				5				–				5		
GRIP (S) Strong (W) Weak (-) absent R		=				6				4				=				=				3		
GRIP (S) Strong (W) Weak (-) absent L		=				6				4				=				=				3		
RESPIRATIONS REGULAR		✓				Vent				Vent				✓				–				✓		
RESPIRATIONS IRREGULAR																								
RESPIRATIONS UNLABORED		—																						
RESPIRATIONS LABORED																								
RESPIRATIONS SHALLOW																								
RESPIRATIONS RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished RUL		3				3				3				3				–				3		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished LUL		3				3				3				3				–				3		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished RLL		3				3				3/1				3				–				3		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished LLL		3				3				3/1				3				–				3		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished BOTH BASES		1				1				1				1				–				1		
COUGH NONE		✓				✓				✓				✓										
COUGH SPONTANEOUS																	✓					✓		
COUGH PRODUCTIVE																	✓					✓		
COUGH NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear		1																						
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin		1															1					1		
VENTILATOR SIMV Vt		1000				1000				1000												3		
VENTILATOR SIMV FiO2		40				40				40														
VENTILATOR SIMV RATE (SIMV/CMV)		10				10				10														
VENTILATOR SIMV PEEP / CPAP		6				6				5														
VENTILATOR SIMV PRESS. SUPPORT		=																						
OXYGEN DELIVERY DEVICE NC (l/min)																								
OXYGEN DELIVERY DEVICE VM (l/min) VM 40%														✓										
OXYGEN DELIVERY DEVICE NRBM (l/min)																		–						
ETT # 7.5 ETT 22 cm gums										✓														
ETT CARE / POSITION CHANGE										✓														
ETT / NT SUCTIONED		✓							✓															
INCENTIVE SPIROMETRY DONE																								
COUGH / DEEP BREATH																						✓		
INITIALS	(b)(6)-2				(b)(6)-2				(b)(6)-2				(b)(6)-2				(b)(6)-2				(b)(6)-2			

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DOD 006235

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100		99	20	106/48	99%	111/47	71										
0200	99¹	102	29	118/60	99	119/60	74										Vent
0300	99²	95	15	/	100	109/53	76										Vent
0400	99¹	92	18	/	100	103/52	66										Vent
0500	98³	90	12	/	100	105/49	66										Vent
0600	98³(R)	97	20/15		99%	121/56	73										
0700		97	19/16		99%	138/66	85										
0800	98³(A)	97	16/21		100	136/66	85										
0900		94	19/17		100%	135/64	82										
1000		101	20/28		99%	149/75	95										
1100	99⁵(A)	103	16/28		99%	141/70	85										
1200		105	20/48		100%	135/65	88										
1300	100⁷(A)	100	40		99	141/71	92	T-Piece									
1400	99²	100	32		100	150/64	87				↓						
1500		92	28		[illegible]	124-68	88			VM	40%						
1600		96	30		100	140-66											
1700		93	16		100	126-71	86										
1800	98³	86	33		100%	137-65	85										
1900		80	28		100	140-65	97										
2000	99³	87	36		100	133-68	86										
		~~81~~	~~28~~			~~122-54~~	~~72~~										
2100		81	28		100	122-54	72			VM	40%						
2200																	
2245	99⁵	91	28	/	95%	141/63	84										(b)(6)-2
2300		85	33	/	96%	123/54	73										
2400	99⁶	89	34	/	94%	134/67	86										

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DOD 006236

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
10/10/03	0630		Well sedated. D5NS c̄ 20KCl @ 125cc/hr, Fentanyl 25mcg/hr, VERSED 2mg/hr. Vivonex NGT Feeding @ 20cc/hr. VSS See flow sheet for assessment. (b)(6)-2 [redacted] ICT, Am.
10/10/03		1325	Placed on T-PIECE blow by c̄ 40% O2. Maintained Sats >95%. HR & BP stable. RR 20-40's. Pt restless. Propofol turned off. Fentanyl ↓ 25mcg/hr & Versed ↓ 1mg/hr. Vivonex turned off & NGT placed on ILWS. Temp 100.7 (A) Medicated c̄ Tylenol 650mg Supp PR. (b)(6)-2 [redacted] ICT, Am.
10/10/03		1330	Pt extubated & placed on 40% VM. O2 SATS >97%. NGT DC'd. Fentanyl & Versed turned off. VSS (b)(6)-2 [redacted] ICT, Am.
		1430	Extubated c̄ VM @ 40% sat's 99% Respond to to interpreter question. ABG done. MD notified of results. CT Dressing Changed by MD tolerated well. See DD Form 4400 for assessment. Will cont to monitor per cardiop.
		1620	(b)(6)-2 [redacted] OOB to w/c tolerated needed lots assistance with move. Translator at the bedside explaining what was going on. (b)(6)-2 [redacted]
		1800	Back to bed tolerated well. ABG done results shown to MD (b)(6)-2 [redacted] (b)(6)-2 [redacted]
		1815	MSO4 given for pain
		1825	Resting well NAD. Dressing D's done at this time. Tolerated well. (b)(6)-2 [redacted]
		2000	Movery short in bed. HOB 30° VM involved [illegible] to C.B. Will cont to monitor. (b)(6)-2 [redacted]
10 Oct 03	2200		Assumed pt., pt supine c̄ HOB elevated NAD — (b)(6)-2 [redacted]
	2250		Assessment complete, monitors on ID bracelet (L) wrist PSOL probe (L) hand, A-line to (R) wrist, D5NS to triple lumen central line cath, venturi mask CBS, moves ext x4, c/o pain to abd c̄ moaning. L/R bilateral CT notion, gauze bandaging c̄ tape CDT (R) hand padding around A-line

MEDCOM - 2185

	INTAKE									OUTPUT						
	DSNS 20KCL	Versed	Fentanyl	Vec	Vivonex	Propofol	IVPB	Flush A-line	Total	Urine	Chest 1	Chest 2	NGT		Total	COMMENTS
0100	125/125	2/2	1/1	3/3	20/20	60/60			3/3	180/180	Ø/Ø	Ø/Ø				
0200	125/250	2/4	1/2	3/6	20/40	60/120			3/6	170/350	Ø/Ø	Ø/Ø				
0300	125/375	2/6	1/3	3/9	20/60	60/180			3/9	120/470	Ø/Ø	Ø/Ø				
0400	125/500	2/8	1/4	3/12	20/80	60/240		20/20	3/12	180/650	–/Ø	–/Ø				
0500	125/625	2/10	1/5	3/15	20/100	60/300		–/20	3/15	175/820	–/Ø	–/Ø				
0600	125/750	2/12	1/6		20/120	60/360			3/18	175/995						
0700	125/875	2/14	1/7		20/140	60/420	100/100		3/21	115/1110						
0800	125/1000	2/16	2/9		20/160	60/480	50		3/24	220/1330						
8 HR	1000	16	9		160	480			8 HR. 1665	1330					8 HR 1330	+335
0900	125/125	2/2	2/2		20/20	60/60	150/150	20/20	3/27	240/240						
1000	125/250	2/4	2/4		20/40	40/100			3/30	180/420						
1100	125/375	2/6	2/6		20/60	40/140			3/33	160/580						
1200	125/500	2/8	2/8		20/80	40/180	100/250	10/30	3/36	190/770						
1300	125/625	1/9	1/9		0/80	0/180			3/39	190/960	20/20	20/20	150/150			
1400	125/750	0	0		0	0				310/1270						
1500	125/875									210/1480						
1600	120/1000						50/300			200/1680						
8 HR	1000	9	9		80	180	300		16 HR. 1578	1680	20	20	150		16 HR. 1870	+292
1700	125									500						
1800	125/250						100/100			200/500						
1900	125/375									100/600						
2000	125/500									120/720						
2100	125/625									278/998						
2200	125/750									100/1098						
2300	125/875						50/150			100/1198						
2400	125/1000						100/250			210/1408						
8 HR	1000						250		24 HR. 1250	1408					24 HR 1408	−158

−115

MEDCOM - 2186

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	02 MAY Oct 03
DOS	02 MAY Oct 03
POD	MAY 9

24 HOUR DATA	
24 Hour Balance	+2224
24 Hour Intake	4809
24 Hour Output	2585
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2 91WS2	(b)(6)-2
(b)(6)-2 LCT L	
(b)(6)-2 MAJ AN	

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On	N/A	N	N
Call Light Within Reach			
Side Rails Up		✓	A
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 SSG, 91WS2	ICU	11 Oct 03

ION (*For typed or written entries give: Name-last, first, Middle; grade; date; hospital or medical facility*)

(b)(6)-4

- ☐ HISTORY/PHYSICAL
- ☒ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☒ OTHER (*Specify*) Nursing notes
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 2187

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL (b)(6)- R			2				2				2			2				2						2
	RADIAL L			2				2				2			2				2						2
	DORSALIS PEDIS R			2				2				2			2				2						2
	DORSALIS PEDIS L			2				2				2			2				2						2
SKIN (1) Dry (4) Cool (7) Jaundiced (2) Clammy (5) Flushed (8) Color Normal (3) Warm (6) Cyanotic (9) Pale				1 3 8				1 3 8				1 3 8			1 3 8				1 3 8						1 3 8
EDEMA				1				Gen				Gen			gen				gen						1
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)				✓				✓				✓			✓				✓						✓
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)				SR				SR				SR			SR				SR						SR
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)				✓				✓				✓			✓				✓						
HYGIENE	BED BATH																		* HAIR WASH						
	FOLEY CARE			✓																					✓
	ORAL CARE																								
MOBILITY	BEDREST			✓				✓				✓			✓										✓
	BSC																								
	DANGLE																								
	CHAIR																	✓	✓						
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE							✓				✓			✓					✓					✓
	HOB 30 DEGREES			✓				✓				✓			✓			✓	✓	✓					✓
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)				—																					
PAIN	PAIN FREE											✓				+			+	+					✓
	PAIN SCALE (1-10)			0												0 TA			0 TA						
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended			2				2				2			2				2						2
BOWEL SOUNDS (active all quads)				x4				IHP				✓			✓				✓						x4
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT				✓				✓				✓			✓				✓	✓					✓
VOIDING CLEAR, YELLOW URINE q.s.				✓				✓				✓			✓ amber										✓
SKIN INTEGRITY	No Breakdown																								
HID LINE AND STAPLES	Surgical Wounds			.				✓				✓			✓				✓						✓
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1 (L) Upper abd				✓				✓				✓			✓				✓						✓
#2 Midline incision OTA				✓				✓				/			✓				✓						✓
#3 L/R CT #1 & #2				✓				✓				/			✓				✓						✓
(L) thigh OTA				✓				✓				/			✓				✓						✓

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
TLC	(L) subclavian		Intact, patent 0700/1010/2400
A-line	(R) radial		CDI 0700/1100
Foley	GROIN		Intact, patent 0700/1100/2200

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DOD 006240

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable /Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment –

DATE: 11 OCT 03

TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open			4				4				4			4				4						4
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response			5				5				5			5				5						5
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response			6				6				6			6				6						6
GLASCOW COMA SCALE (A+B+C)			15				15				15			15				15						15
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R		3				3+							3+				3+						3+
	L		3				3+							3+				3+						3+
MOVEMENT (See Motor Function Scale at Top of Page)	RUE		4				4				4			4				4						4
	LUE		5				4				4			4				4						4
	RLE		5				4				4			4				4						4
	LLE		5				4				4			4				4						4
GRIP (5) Strong (W) Weak (-) absent	R		5				WA				WA			WA				4						5
	L		WA				5				5			4				4						5
RESPIRATIONS	REGULAR		✓				✓				✓			✓				✓						✓
	IRREGULAR		✓				✓				✓			✓				✓						✓
	UNLABORED		✓				✓							✓				✓						✓
	LABORED																							
	SHALLOW		✓				✓							✓				✓						
	RETRACTIONS																							
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL		3				3				5			5				5						5
	LUL		*				3				5			2				5						5
	RLL		3				3				5			5				2						2
	LLL		*				3				5			5				2						2
	BOTH BASES		✓				✓				1			1				2						*
COUGH	NONE																							
	SPONTANEOUS		✓				✓				✓			✓				✓						✓
	PRODUCTIVE		✓											✓				✓						✓
	NONPRODUCTIVE																							
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear			1								5			5				5						1
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin			3								3			3				3						3
VENTILATOR	Vt																							
	FIO2																							
	RATE (SIMV/CMV)																							
	PEEP / CPAP																							
	PRESS. SUPPORT																							
OXYGEN DELIVERY DEVICE	NC (l/min)		2L				3L				3L			3L		3L		3L				3L		3L
	FM (l/min)																							
ETT #_____	NRBM (l/min)																							
	ETT _____ cm gums																							
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED																								
INCENTIVE SPIROMETRY DONE							✓	✓			✓			✓	✓	✓	✓	✓		✓				
COUGH / DEEP BREATH			✓																					✓
INITIALS			(b)(6)-2				(b)(6)-2				(b)(6)-2			(b)(6)-2				(b)(6)-2						(b)(6)-2

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DOD 006241

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100		86	50	124/62	96	/	85										(b)(6)-2
0200	99.2	87	46	12 /	94	133/59	81										
0300		85	34	/	95	130/60	79										
0400	99.2	80	35	121/62	95	125/58	85 NIBP										
0500		80	36	/	98	134/63	84										
0600	98.7 (A)	87	41		95	131/58	83										
0700		85	49		97	132/62	83										
0800		83	33		94%	130/60	83										
0900		87			96%	142/74	96										
1000	99.3 (A)	80	29		98%	120/56	75										
1100		76	26		98%	122/57	76										
1200		77	31		96%	124/58	77										
1300	99.5 (A)	78	28		98%	122/56	75										
1400	99.2 (O)	78	28		97	121/55	72										
1500		74	25		98	122/55	74										
1600		69	21		99	117/55	74										
1700	99.3 (A)	80	22	108/55	100												
1800		84	19	117/60	98												
1900																	
2000																	
2100																	
2200	/	71	20	/	99	/	/										(b)(6)-2
2300																	
2300	/	69	19	/	99	/	/										(b)(6)-2
2400	98.6	68	24	107/52	99	/	74										

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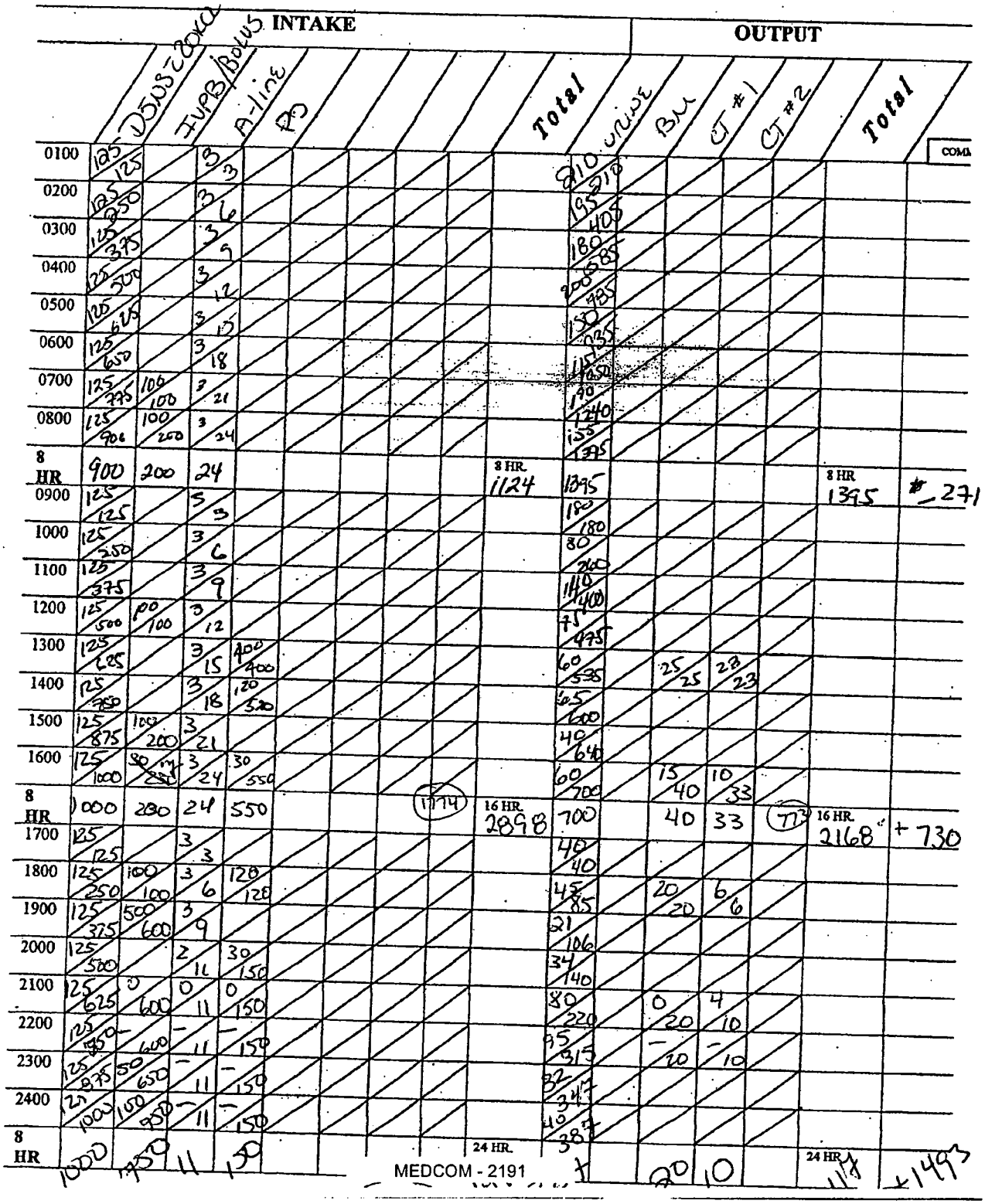
INTAKE
OUTPUT
D5W/S 20KCl
IVPB/Boluses
A-line
PO
Total
Urine
BM
CT #1
CT #2
Total
COMM
0100
0200
0300
0400
0500
0600
0700
0800
8 HR
900
200
24
8 HR
1124
8 HR
1395
#271
0900
1000
1100
1200
1300
1400
1500
1600
8 HR
1000
280
24
550
1774
16 HR
2898
700
40
33
773
16 HR
2168
+730
1700
1800
1900
2000
2100
2200
2300
2400
8 HR
1000
1459
11
150
24 HR
MEDCOM - 2191
20
10
24 HR
1147
+1493

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R				2					2					2				2				2		
	RADIAL L				2					2					2				2				2		
	DORSALIS PEDIS (POST TIB) R				2					2					2				1				2		
	DORSALIS PEDIS (POST TIB) L				2					2					2				2				2		
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale					1					1					1				1				1		
					3					3					3				3				3		
					8					8					8				8				8		
EDEMA					-					Cen					Gen Extr				Gen				0		
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)					✓					✓					✓				0, S2 ✓				✓		
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)					SR					SR					SR				NSR				SR		
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH																								
	FOLEY CARE																								
	ORAL CARE																								
MOBILITY	BEDREST				✓					✓													✓		
	BSC																								
	DANGLE																								
	CHAIR														✓										
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE				✓					✓					✓				✓				✓		
	HOB 30 DEGREES				✓					✓					✓				✓				✓		
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)					—																		X		
PAIN	PAIN FREE									✓					PR				✓						
	PAIN SCALE (1-10)				✓																		✓		
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended				2					2					2				2				2		
BOWEL SOUNDS (active all quads)					x4					✓					x4				x4				x4 hy		
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT										✓															
VOIDING CLEAR, YELLOW URINE q.s.					Patent					Pt Ambl					✓				✓				✓		
SKIN INTEGRITY	No Breakdown				—																				
Midline incision	Surgical Wounds				✓					✓					✓				✓				✓		
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1 (L) Lower Abd					✓					✓					✓				✓				✓		
#2 (L) + (R) CT					✓					✓					✓				✓				✓		
#3 Midline OTA incision					✓					✓					✓				✓				✓		
(L) lateral thigh OTA					✓					✓					✓				✓				✓		

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
foley to gravity	GROIN		Intact, patent / 0500 / 0400 / 1800 > Dc'd 0730
TLC	(L) subclavian		Intact, patent / 0500 / 0400 / 1800

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DOD 006244

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	3 OCT 03
DOS	
POD	

24 HOUR DATA	
24 Hour Balance	-92
24 Hour Intake	4170
24 Hour Output	4262
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2 9/22/06	(b)(6)-2
(b)(6)-2 LT. AN	
(b)(6)-2 MAN	
(b)(6)-2 MAN	

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach	N/A	X	N/A
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 9/22/06	ICU	12

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade;date; hospital or medical facility)*

(b)(6)-4

- ☐ HISTORY/PHYSICAL
- ☒ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☐ OTHER(*Specify*)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 2193

PUPIL SIZE **PUPILS**

1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable/Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment –

DATE: 120403

TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open				4					4					4				4				4		
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response				5					5					5				5				5		
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response				6					6					6				6				6		
GLASCOW COMA SCALE (A+B+C)				15					15					15				15				15		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — R				3+										3+				3+				3+		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — L				3+										3+				3+				3+		
MOVEMENT (See Motor Function Scale at Top of Page) — RUE				4					4					5				5				5		
MOVEMENT (See Motor Function Scale at Top of Page) — LUE				4					4					5				5				5		
MOVEMENT (See Motor Function Scale at Top of Page) — RLE				4					4					5				5				5		
MOVEMENT (See Motor Function Scale at Top of Page) — LLE				4					4					5				5				5		
GRIP (S) Strong (W) Weak (-) absent — R				5					5					5				5				5		
GRIP (S) Strong (W) Weak (-) absent — L				5					5					5				5				5		
RESPIRATIONS — REGULAR				✓					✓					✓				✓				✓		
RESPIRATIONS — IRREGULAR																								
RESPIRATIONS — UNLABORED				✓					✓					✓				✓				✓		
RESPIRATIONS — LABORED																								
RESPIRATIONS — SHALLOW																		✓						
RESPIRATIONS — RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RUL				5					3/2					3/2	3			3/2				5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — LUL				3					3/2					3/2	3			3/2				5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RLL				2					1					2	3/2			3/2				5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — LLL				2					1					2	3/2			3/2				5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — BOTH BASES				✓					1					1	1			1				✓		
COUGH — NONE																								
COUGH — SPONTANEOUS				✓					✓									✓				✓		
COUGH — PRODUCTIVE									✓									✓				✓		
COUGH — NONPRODUCTIVE				✓																				
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear									1/5									1/5				1		
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin									3									3				3		
VENTILATOR — Vt																								
VENTILATOR — FIO2																								
VENTILATOR — RATE (SIMV/CMV)																								
VENTILATOR — PEEP / CPAP																								
VENTILATOR — PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE — NC (l/min)			RA						3L									3L				3L		
OXYGEN DELIVERY DEVICE — FM (l/min)																								
OXYGEN DELIVERY DEVICE — NRBM (l/min)																								
OXYGEN DELIVERY DEVICE — ETT _____ cm gums																								
ETT # _____																								
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED																								
INCENTIVE SPIROMETRY DONE													✓		✓		✓	✓	✓	✓				
COUGH / DEEP BREATH			✓						✓				✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
INITIALS			(b)(6)-2						✓								(b)(6)-2							

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DOD 006246

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200																	
0300																	
0400	99.6 PO	69	20	104/60	95	—	70										(b)(6)-2
0500																	
0600																	
0700																	
0800																	
0900	98°(A)	69	22	114/57	98%		79										
1000																	
1100																	
1200																	
1300	98°(A)	63	25	113/58	100%		79										
1400																	
1500																	
1600																	
1700	99.3(A)	79	25	121/57	99%		81										
1800																	
1830	99.3(A)	80	31	121/62	95	3/uc	85										
1900																	
2000																	
2100																	
2200	99.8	68	23	114/57	97	—	79										(b)(6)-2
2300																	
2400																	

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DOD 006247

NSN 7540-00-634-4123

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
10/12/03		0930	(B) CT Placed on H_2O Seal. Ø leaks. Dulcolax 10mg Supp. PR X1 Foley Dc'd. U/A Sent to lab VSS. NAD. See flowsheet for assessments. [redacted] ICT, A
10/12/03	1130	1	OOB TO BSC. BM MOD amt, Brown, soft & formed. IN CHAIR FOR 1hr. Tolerated well. RTO TO BED [redacted] ICT, A
10/12/03		1330	Pt refused breakfast & Lunch. ↓ Appetite [redacted] ICT, A.
		1430	Assessment complete. pt refused jello wants "Draju food" per interpreter. Pt sat up at bedside c̄ assistance and ambulated to wheelchair c̄ assist. [redacted] CAW
		1630	Pt up in chair for 1.5 hours. Pain medicine MSO4 5mg given p̄ patient got back in bed and voided into urinal. HOB 30° pt requested to be lower but told he cannot. CT to water seal Serous straw colored fluid, draining (B). [redacted] CAW
		1800	Assumed care. Pt A&Ox3, cheerful. Denies pain, but c/o "being cold" via interpreter. Blankets x2. VSS. low grade fever @ 99.3(b). Pt voiding / urinal QS - yellow urine. Encouraged frequent TS use. Pt c/o being hungry, but denies clear liquid diet. CT x2 to water seal. No air leaks noted. Connections secured. LLQ drsg CDI. ML incision c̄ staples - noted redness around staples. O_2 @ 3L/NC. Sats 97-99%. Will continue to monitor [redacted]
		1900.	Pt c/o pain @ CT insertion sites. Administered 5mg MSO4 IVP. [redacted]
12 Oct 03		2200	Assumed pt, pt supine c̄ HOB ↑ D5NS @ 125cc/hr to TLC patent, intact, A&Ox3 via interpreter @ BS, MP @ BS, O_2 @ 3L via NC, Breathing regular unlabored, spontaneous cough productive thin, clear void x2 urinal clear of sediment, yellow, Ø s/s of infiltration, infection to TLC, full assessment DA form 4700 TLC fluses s̄ difficulty [redacted]

MEDCOM - 2196

	INTAKE									OUTPUT					
	D5W/S	IVPB	PO						Total	Urine	BM	CT #1	CT #2	Total	COMMENTS
0100	125/125								32	32					
0200	125/250								60	92					
0300	125/375	1/1							55	147					
0400	125/500								55	202					
0500	125/625								65	267	10/10	15/15			
0600	125/750								60	327					
0700	125/875								65	392					
0800	125/1000	200/200							65	457					
8 HR	1000	200							8 HR 1200	457		10	15	8 HR 482	+ 718
0900	125/125		100/100							140/140					Foley DC'd 0930
1000	125/250									100/240					
1100	125/375									300/540	X1/X1			←	Post Foley VOID
1200	125/500	100/100													
1300	125/625											53/53	19/19		
1400	125/750									625/1165					
1500	125/875														
1600	125/1000	50/150	100/200							475/1640					
8 HR	1000	150	200						16 HR 2570	1640	X1	53	19	16 HR 2194	+376
1700	125/125														
1800	125/250		200/250							460/460					
1900	125/375	100/100								408/868					
2000	125/500														
2100	125/625		200/400							425/1225		28/28	15/15		
2200	125/750									375/1600					
2300	125/875	50/150								1600					
2400	125/1000									425/2025					
8 HR	1000	150	450						24 HR 1170	2025		28	15	24 HR 4262	- 92

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DOD 006249

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	3 OCT 03
DOS	
POD	

24 HOUR DATA	
24 Hour Balance	-85
24 Hour Intake	3290
24 Hour Output	3375
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	(b)(6)-2

Safety Checks	D	E	N
BVM at bedside			
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

(b)(6)-2

PREPARED BY (Signature and Title) (b)(6)-2 Department/Service/Clinic ICU DATE 13 Oct 03

PATIENT'S IDENTIFICATION (*For typed or written entries give: Name-last, first, Middle; grade;date; hospital or medical facility*)

(b)(6)-4

☐ HISTORY PHYSICAL ☒ FLOWCHART

☐ OTHER EXAMINATION Or EVALUATION ☐ OTHER(*Specify*)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 2198

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R		2					2							2				2				2		
	L		2					2							2				2				2		
	DORSALIS PEDIS POST TIB R		2					2							2				2				2		
	L		2					2							2				2				2		
SKIN (1) Dry (4) Cool (7) Jaundiced (2) Clammy (5) Flushed (8) Color Normal (3) Warm (6) Cyanotic (9) Pale			1 3 8					1 3 8							1 3 8				1 3 8				1 3 8		
EDEMA			Gen					Gen							Min				L				Gen		
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)			R					✓							S1S2 ✓				S1S2				R		
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)			NSR					NSR							NSR				NSR				NSR		
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH																								
	FOLEY CARE																								
	ORAL CARE																								
MOBILITY	BEDREST		✓					✓							✓										
	BSC																								
	DANGLE																								
	CHAIR																		✓						
POSITIONED	RIGHT		S																S				S		
	LEFT		E																E				E		
	SUPINE		L					✓							✓				L				L		
	HOB 30 DEGREES		F					✓							✓				F				F		
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE		*												✓				PF	*			✓		
	PAIN SCALE (1-10)																			—					
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended		2					2							2				2				2		
								✓																	
BOWEL SOUNDS (active all quads)															X4				X4				X4		
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT																									
VOIDING CLEAR, YELLOW URINE q.s.			✓					✓							✓				✓				✓		
SKIN INTEGRITY	No Breakdown																								
	Surgical Wounds																		✓						
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1 2 chest tube @ R CDI								1							✓				M/C						
#2 @ left ABD CDF								1							✓				✓				✓		
#3 ABD Incision OTA								1							✓				✓				✓		
@ thigh OTA Incision								1							✓				✓				✓		

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
TLC	@ subclavian		CDF / 0700 / 1400

PUPIL SIZE	PUPILS		MOTOR FUNCTION	CHART CODES
1 mm	=	Equal	0 = No Movement	Present ✓
2 mm	R	Reactive	1 = Slight Flicker/ Trace of Contraction	
3 mm	NR	NonReactive	2 = Active (Gravity Eliminated)	Not Applicable /Absent (blank)
4 mm	L > R	Left Larger	3 = Active: against gravity, but not against resistance 4 = Active: Against Gravity and Resistance, not full strength	Refer to Nsg. Notes X
5 mm	R > L	Right Larger	5 = Full Strength against Examiners Resistance	No Change from Previous Assessment –

DATE: 13 OCT 03

TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (2) To Pain (3) To Voice (1) Does Not Open		4					4							4				4				4		
B. BEST VERBAL RESPONSE (5) Oriented (2) Garbled (4) Confused (1) No Response (3) Inappropriate Verbal Response		4					5							5				5				5		
C. BEST MOTOR RESPONSE (6) Obeys Commands (3) Flexion to Pain (5) Localizes to Pain (2) Extension to Pain (4) Withdraw to Pain (1) No Response		6					6							6				6				6		
GLASCOW COMA SCALE (A+B+C)		14					15							15				15				15		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) R		2+												3+								2+		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) L		2+												3+								2+		
MOVEMENT (See Motor Function Scale at Top of Page) RUE		5					4							4				5				5		
MOVEMENT (See Motor Function Scale at Top of Page) LUE		5					4							4				5				5		
MOVEMENT (See Motor Function Scale at Top of Page) RLE		5					4							4				5				5		
MOVEMENT (See Motor Function Scale at Top of Page) LLE		5					4							4				5				5		
GRIP (S) Strong (W) Weak (-) absent R		5					5							5				5				5		
GRIP (S) Strong (W) Weak (-) absent L		5					5							5				5				5		
RESPIRATIONS REGULAR							✓							✓				✓						
RESPIRATIONS IRREGULAR		—																				/		
RESPIRATIONS UNLABORED							✓							✓				✓						
RESPIRATIONS LABORED																						/		
RESPIRATIONS SHALLOW																		✓						
RESPIRATIONS RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished RUL		2					5							3				5				2		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished LUL		2					5							3				5				2		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished RLL		1					5							3				3				1		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished LLL		1					5							3				5				1		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished BOTH BASES														1				1						
COUGH NONE		—																				✓		
COUGH SPONTANEOUS							✓							✓				✓						
COUGH PRODUCTIVE							✓							✓				✓						
COUGH NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear							1							1				1						
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin							3							3				3						
VENTILATOR Vt																								
VENTILATOR FIO2																								
VENTILATOR RATE (SIMV/CMV)																								
VENTILATOR PEEP / CPAP																								
VENTILATOR PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE NC (l/min)							3L							3L				3L						
OXYGEN DELIVERY DEVICE FM (l/min)																								
OXYGEN DELIVERY DEVICE NRBM (l/min)																								
ETT # _____ ETT _____ cm gums																								
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED																								
INCENTIVE SPIROMETRY DONE														✓	✓					✓				
COUGH / DEEP BREATH		✓																✓		✓				
INITIALS	(b)(6)-2						(b)(6)-2							(b)(6)-2				(b)(6)-2						

MEDCOM - 2200

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200	99.3	70	28	117/62	97%		83										
0300																	
0400																	
0500																	
0600																	
0700	99°(A)	66	30	107/56	97%		75										
0800																	
0900																	
1000																	
1100																	
1200	99°(A)	69	29	115/52	96%		76										
1300																	
1400																	
1500																	
1600	100.4	74	18	93/47	97%	34[illegible]C	(b)(6)-2										IS
1700																	
1800																	
1900																	
2000	100°(A)	71	24	109/48	95%		71										
2100																	
2200																	
2300																	
2400	102	68	20	117/56	97%(V)												

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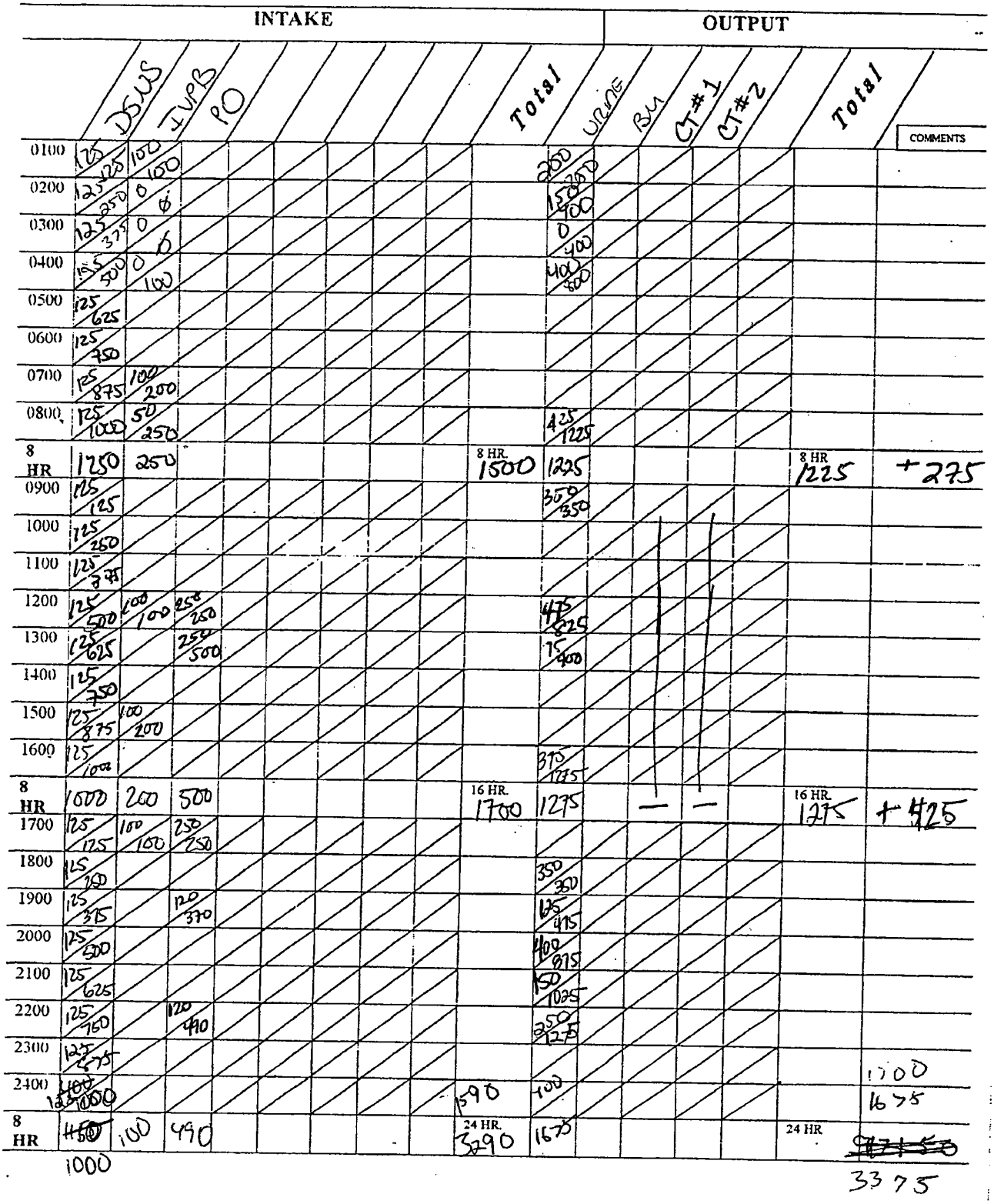
DOD 006253


INTAKE
OUTPUT
D5W/S
IVPB
PO
Total
URINE
BM
CT#1
CT#2
Total
COMMENTS
8 HR
1250
250
8 HR.
1500
1225
8 HR
1225
+275
16 HR.
1700
16 HR
1275
+425
24 HR.
3390
24 HR
3375

MEDCOM - 2202

NSN 7540-00-634-4123

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
12 Oct 03		2200	(continued) (B) CT to H_2O seal v'd Pur leaks Ø leaks found (B) CT bandaging CDI, LLQ bandaging CDI OTA (L) thigh abrasions closing cool to touch, midline OTA incision CDI, pt c/o discomfort when touched but no actual pain to touch, RN on duty admin 3mg MSO4 + Benedryl 25mg to help pt sleep. Will continue to monitor [redacted]
13 Oct 03	0200	0200	resting @ this time will continue to monitor pt [redacted]
13 Oct 03	0230		c/o pain through hand motions to ABD; prn (medication given) see MAR; will cont. to monitor pt [redacted]
13 Oct 03	0300		sleeping @ this time will continue to monitor pt [redacted]
13 Oct 03	0930		(B) CT) Dcid c̄ Petroleum impregnated gauze & 4x4's securely placed c̄ tape. Pt tolerated well. Medicated c̄ MSO4 5mg IVP VSS. [redacted]
13 Oct 03		1315	Pt ambulated approximately 4 ft c̄ Bat in chair. for > 1hr. Tolerated well [redacted]
13 Oct 03	LATE ENTRY	1245	Tolerated approximately 15% of Reg diet [redacted]
13 Oct 03		1400	Assumed care. Per report, pt just got back in bed from chair. Pt denies pain/discomfort. Will continue to monitor [redacted]
		1530	Drsg Δ to LLQ completed. Wound red beefy c̄ small amt serous drainage on drsg. Pt tolerated well. Low grade fever @ 100.4°. Encouraged IS. Will continue to monitor [redacted]
		1800	Pt ate ~10% of dinner meal. Stated that "he did not like it" but was hungry. Offered other food but pt refused. Will continue to monitor. [redacted]
		1900	ambulated pt from bed up and down ward. Steady on fut but slow. Sats ↓ to 92% on room air. MSO4 5mg given @ 1850 for pain to LLQ (exit wound), and pain in Ⓛ leg. Resting in bed currently [redacted]

MEDCOM - 2203

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	030CT05
DOS	
POD	

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	(b)(6)-2
(b)(6)-2	
(b)(6)-2	
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside		(b)(6)-2	
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			
Side Rails Up			
Bed in Low Position		(b)(6)-2	

PREPARED BY (Signature and Title)
(b)(6)-2 CPN

Department/Service/Clinic: ICU

DA (b)(6)-2 14 OCT 3

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade; date; hospital or medical facility)*

(b)(6)-4

- ☐ HISTORY PHYSICAL
- ☐ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☐ OTHER(*Specify*)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 2204

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R					2		2							3								2		
	L					2		2							2								2		
	DORSALIS PEDIS R					2		2							2								2		
	L					2		2							2								2		
SKIN (1) Dry (4) Cool (7) Jaundiced (2) Clammy (5) Flushed (8) Color Normal (3) Warm (6) Cyanotic (9) Pale						1 3 0 0		1 3 8							1 3 8								1 3 8		
EDEMA						—		—							Ø										
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)						✓		✓							✓								R		
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)						SR		NR															NSR		
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH																								
	FOLEY CARE																								
	ORAL CARE																								
MOBILITY	BEDREST					✓		✓															✓		
	BSC																								
	DANGLE																								
	CHAIR															✓					✓				
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE														✓		✓		✓			✓			
	HOB 30 DEGREES					✓		✓							✓		✓		✓			✓	✓		
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE					✓		✓							✓									A	
	PAIN SCALE (1-10)																								
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended					2		2							2								2		
BOWEL SOUNDS (active all quads)						x4		x4							x4 hyper								✓		
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT																							✓		
VOIDING CLEAR, YELLOW URINE q.s.						✓ *		✓									✓								
SKIN INTEGRITY	No Breakdown																								
midline incision	Surgical Wounds					✓	-	✓							✓								✓		
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1 (L) + (R) CT site						✓		✓							✓				✓				✓		
#2 (L) 2Q						✓		✓							✓				✓				✓		
#3 OTA midline incision						✓		✓							✓				✓				✓		
(L) OTA lateral thigh						✓		✓							✓				✓				✓		

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
TLC	(L) subclavian		CDT/0500 D/C'd 14 Oct 03

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable /Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment –

DATE: 14 OCT 03

TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open					4		4							4				4				4		
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response					5		5							5				5				5		
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response					6		6							6				6				6		
GLASCOW COMA SCALE (A+B+C)					15		15							15				15				15		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) R					3x		3+							4+								2+		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) L					3x		3+							4+								2+		
MOVEMENT (See Motor Function Scale at Top of Page) RUE					5		5							4				4				5		
MOVEMENT (See Motor Function Scale at Top of Page) LUE					5		5							4				4				5		
MOVEMENT (See Motor Function Scale at Top of Page) RLE					5		5							4				4				5		
MOVEMENT (See Motor Function Scale at Top of Page) LLE					5		5							4				4				5		
GRIP (S) Strong (W) Weak (-) absent R					5		5							4				4				5		
GRIP (S) Strong (W) Weak (-) absent L					5		5							4				4				5		
RESPIRATIONS REGULAR					✓		✓							✓				✓				✓		
RESPIRATIONS IRREGULAR																								
RESPIRATIONS UNLABORED					✓		✓							✓				✓				✓		
RESPIRATIONS LABORED																								
RESPIRATIONS SHALLOW																								
RESPIRATIONS RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished RUL					5		5							5								5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished LUL					5		5							5								5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished RLL					5		5							4								1		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished LLL					5		5							4								1		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished BOTH BASES					1		1							1								1		
COUGH NONE					✓									✓								✓		
COUGH SPONTANEOUS							✓								✓	✓	✓	✓	✓	✓				
COUGH PRODUCTIVE															✓	✓	✓	✓	✓	✓				
COUGH NONPRODUCTIVE														✓										
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear							1							1	1	1	1	1	1	1				
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin							2								2	→		→						
VENTILATOR Vt																								
VENTILATOR FiO2																								
VENTILATOR RATE (SIMV/CMV)																								
VENTILATOR PEEP / CPAP																								
VENTILATOR PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE NC (l/min)				3L		3L								2L	3L	→		2L	1L	Ø				
OXYGEN DELIVERY DEVICE FM (l/min)																								
ETT #_____ NRBM (l/min)																								
ETT #_____ ETT _____cm gums																								
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED																								
INCENTIVE SPIROMETRY DONE														✓						✓				
COUGH / DEEP BREATH														✓				✓		✓				
INITIALS				[b)(6)-2		[b)(6)-2								[b)(6)-2				[b)(6)-2		[b)(6)-2		[b)(6)-2		

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DOD 006258

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200																	
0300																	
0400																	
0500	98?	70	20	113/53	98		75										3LNC
0600	98.6	75	16	116/70	96%												3LNC
0700																	
0800																	
0900																	
1000	98.2	82	16	113/60	99%												3LNC
1100																	
1200																	
1300																	
1400	98 oral	69	24	107/56	93%												3LNC
1500																	
1600																	
1700																	
1800	99 oral	67	24	121/54	96%												3LNC
1830															↓O_2 →		2LNC
1900		70			97%												
1920															↓O_2 →		1LNC
2000		67			96%										O_2 d/c'd		
2030		84			92%										up in chair - 8 O_2		
2100		78			94%												
2145		~~88~~ 86			95%												
2200	99.0	68	20	136/56	97%												
2300																	
2400																	

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DOD 006259

	INTAKE									OUTPUT							
	D5 NS 20 KCl	PO	Zantac	Primaxin					Total	Urine	BM				Total	COMMENTS
0100	125	125														
0200	125	250														
0300	125	375														
0400	125	500														
0500	125	625								575						
0600	125	750	50							575						
0700	125	875		100												
0800	125	1100		100						100						
8 HR	1100		50	100					8 HR. 1250						8 HR 975	
0900	125	125	120	120												
1000	125	250														
1100																
1200																
1300																
1400																
1500																
1600										375						
8 HR									16 HR.						16 HR.	
1700																
1800																
1900										200						
2000																
2100																
2200																
2300																
2400																
8 HR									24 HR. 1620						24 HR 1900	

NSN 7540-00-634-4123

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
14 Oct 03			
	0600		pt resting quietly s s/s of distress V/SS. (1) Abdominal dressing CDI, midline abdominal incision OTA, dressing CDI, (1) thigh OTA Dressing CDI, (1) Subclavian TLC patent. SSC [redacted] (b)(6)-2 [illegible]
	0800		Pt tolerated 40% of breakfast s s/s of distress Ø c/o pain will continue to monitor SSC [redacted] (b)(6)-2 [illegible]
	1000		pt c/o pain 7mg MS04 given [illegible] Ordered will continue to monitor SSC [redacted] (b)(6)-2 [illegible]
14 Oct 03		1430	Pt ambulated c̄ minimal assistance to main hallway, to OR door → ICU entrance → ICU and up + down ICU ×2. Cough × 2-3 times, loose, did not cough up secretions. Ambulated on RA. SpO_2 on RA p̄ walk is 89-90%, HR 80. Placed on ~3L O_2 via NC in chair c̄ SpO_2 92-93%. [redacted] (b)(6)-2 MAJ AN
14 Oct 03		1630	LLQ dsg Δ'd, w→Δ. Wound bed is beefy red c̄ minimal blood upon removal of old dsg. No S/Sx infection or discharge noted. Pt sat in chair × 1 hr, tolerated well. [redacted] (b)(6)-2 MAJ AN
14 Oct 03		1815	Pt ate ~25% of dinner, drinking fluids well. Appears to ~~relate~~ receive adequate pain relief with ~~pestol~~ percocet for ~4 hrs. Pt is pleasant and cooperative, will continue to monitor. [redacted] (b)(6)-2 MAJ AN
14 Oct 03		2015	Attempted to ambulate, more unsteady @ this time, only walked to ICU entrance and back → chair @ this time on RA c̄ O_2 sat 91-93%. Resp shallow and rapid d/t ↑ pain c̄ deep respirations (per interpreter). [redacted] (b)(6)-2 MAJ AN
14 Oct 03		2145	Neb tx completed @ 2130, lungs CTA in all lobes, diminished in bases. Ø wheezing noted @ this time. Pt used IS and C+DB p̄ neb tx → loose cough productive for mod. → lg amt white, frothy secretions. SpO_2 95-96% on RA @ this time. [redacted] (b)(6)-2 MAJ AN

MEDCOM - 2209

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	03 Oct 03
DOS	
POD	

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	(b)(6)-2
(b)(6)-2 CLT, AN	
(b)(6)-2 LT/AN	
(b)(6)-2 RAN	

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On	N/A		
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title)
(b)(6)-2 LPN

Department/Service/Clinic: ICU

DATE: 15 Oct 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade; date; hospital or medical facility)*

(b)(6)-4

- ☐ HISTORY/PHYSICAL
- ☐ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☐ OTHER(Specify)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 2210

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R		2							2						2							2		
	RADIAL L		2							2						2							2		
	DORSALIS POST TIB R		2							2						2							2		
	PEDIS L		2							2						2							2		
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale			1 3 8							1 3 8						1 3 8							1 3 8		
EDEMA			0							0						0							0		
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)			R							✓						✓							R		
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)			NSR							✓						✓							NSR		
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH																								
	FOLEY CARE																								
	ORAL CARE																								
MOBILITY	BEDREST		✓							✓						✓									
	BSC																								
	DANGLE																								
	CHAIR										✓														
POSITIONED	RIGHT		S							S						S							S		
	LEFT		L							L						L							L		
	SUPINE		L							L						L							L		
	HOB 30 DEGREES		F							F						F							F		
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE		✓													✓							✓		☆
	PAIN SCALE (1-10)																								
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN (2) Soft & Flat (1) Distended			2							12						2							2		
BOWEL SOUNDS (active all quads)			✓							✓						✓							✓		
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT																									
VOIDING CLEAR, YELLOW URINE q.s.			✓							✓						✓							✓		
SKIN INTEGRITY	No Breakdown																								
	Surgical Wounds		✓							✓						✓							✓		
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)										✓						✓							✓		
#1 Incision ABD sternotomy			—							✓						✓							✓		
#2 CVP/ABD WD dressing CDI			—							✓						✓							✓		
#3 C thigh Incision OTA			—							✓						✓							✓		
Chest tube sites #1 & #2 CDI																									

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)

ACLU-RDI 1099 p.995

DOD 006263

PUPIL SIZE / PUPILS

1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable /Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment

DATE: 15 OCT 03

TIME		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (2) To Pain (3) To Voice (1) Does Not Open			4							4						4							4		
B. BEST VERBAL RESPONSE (5) Oriented (2) Garbled (4) Confused (1) No Response (3) Inappropriate Verbal Response			5							5						5							5		
C. BEST MOTOR RESPONSE (6) Obeys Commands (3) Flexion to Pain (5) Localizes to Pain (2) Extension to Pain (4) Withdraw to Pain (1) No Response			6							6						6							6		
GLASGOW COMA SCALE (A+B+C)			15							15						15							15		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R		2+																						
	L		2+																						
MOVEMENT (See Motor Function Scale at Top of Page)	RUE		5							4						4							5		
	LUE		5							4						4							5		
	RLE		5							4						4							5		
	LLE		5							4						4							5		
GRIP (S) Strong (W) Weak (-) absent	R		5							5						5							5		
	L		W							✓						✓							✓		
RESPIRATIONS	REGULAR																								
	IRREGULAR		✓							✓						✓							✓		
	UNLABORED																								
	LABORED																								
	SHALLOW																								
	RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL		1							5						5							5		
	LUL		1							5						5							5		
	RLL		1							5/1						5/1							1		
	LLL		1							5/1						5/1							1		
	BOTH BASES									1						1							1		
COUGH	NONE															✓									
	SPONTANEOUS		✓							✓						✓									
	PRODUCTIVE		✓																						
	NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear			White							1						1									
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin			3							3						3									
VENTILATOR	Vt																								
	FiO2																								
	RATE (SIMV/CMV)																								
	PEEP / CPAP																								
	PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE	NC (l/min)																								
	FM (l/min)																								
ETT #_____	NRBM (l/min)																								
	ETT _____cm gums																								
ETT CARE / POSITION CHANGE																									
ETT / NT SUCTIONED																									
INCENTIVE SPIROMETRY DONE			✓																				✓		
COUGH / DEEP BREATH			✓																						
INITIALS			(b)(6)-2							(b)(6)-2						(b)(6)-2							(b)(6)-2		

ACLU-RDI 1099 p.996

DOD 006264

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200	98.3	66	16	124/52	100%												
0300																	
0400																	
0500																	
0600																	
0700																	
0800																	
0900	98.2(A)	79	22	97/53	95%		69										
1000																	
1100																	
1200																	
1300																	
1400																	
1500	99.5(O)	75	19	104/52	98%		72										
1600																	
1700																	
1800																	
1900																	
2000																	
2100																	
2200	99.2	68	16	113/56	99%												
2300																	
2400																	

ACLU-RDI 1099 p.997

DOD 006265

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
15OCT03	0001		resting comfortably will continue to monitor pt [illegible]
15OCT03	0830		Tolerated 10-15% Regular diet. VSS. NAD. [redacted] ICT
15OCT03	0930		c/o abd pain. Ambulated. Pt belching [redacted]
			To see Pt. ordered acute abd series [redacted] ICT
15OCT03		1245	Pt OOB in Chair X2 hrs. Ambulated X2. Pt c̄ unsteady gait Tolerated well. Consumed approx 10% of regular diet. [redacted] ICT
		1500.	Pt resting comfortably in bed. Got up OOB X1 to use urinal. Moved well tolerated c̄ minimal discomfort. Will continue to monitor [redacted]
		1730	Pt tolerated ~ 10% dinner. Pt stated that he was "not hungry" per interpretor. [redacted]
		1735	Drsg Δ completed in sterile fashion. Wound red & beefy c̄ small pocket of mucous like drainage. Sm. amt. Serous drainage noted on drsg. Pt tolerated well. Dr [redacted] removed drsgs. to (B) CT sites. No s/s of infection noted [redacted]
		1810	Pt c/o pain to abd area. Medicated c̄ 2 percocet per pt request. [redacted]
		1830	Pt ambulated around ward and in hall past ICW and back c̄ difficulty or complaint. [redacted]
16OCT03		2200	resting comfortably ∅ s/s of resp. distress will cont. to monitor pt [redacted]

MEDCOM - 2214

	INTAKE									OUTPUT						
	PO								Total	Urine	BM				Total	COMMENTS
0100																
0200										300/200						
0300																
0400																
0500																
0600																
0700																
0800	200/200															
8 HR	200								8 HR 200	200					8 HR 200	
0900										300/300						
1000																
1100																
1200	120/120															
1300																
1400																
1500										375/675						tea-colored
1600	240/360															
8 HR	360								16 HR.	675					16 HR.	
1700																
1800	60/60									250/250						
1900																
2000																
2100																
2200																
2300										200	x1					
2400																
8 HR									24 HR.						24 HR	

ACLU-RDI 1099 p.999

DOD 006267

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	03 Oct 03
DOS	
POD	

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	(b)(6)-2

Safety Checks	D	E	N
BVM at bedside			
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 CRL	ICU	16 Oct 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade; date; hospital or medical facility)*

(b)(6)-4

- ☐ HISTORY/PHYSICAL
- ☐ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☐ OTHER *(Specify)*
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 2216

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R		2					2																	
	RADIAL L		2					2																	
	DORSALIS PEDIS R		2					2																	
	DORSALIS PEDIS L		2					2																	
SKIN (1) Dry (4) Cool (7) Jaundiced (2) Clammy (5) Flushed (8) Color Normal (3) Warm (6) Cyanotic (9) Pale			1					1																	
			3G					3																	
								0																	
EDEMA			0					0																	
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)			R					R																	
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)			NSR					NSR																	
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH																								
	FOLEY CARE																								
	ORAL CARE																								
MOBILITY	BEDREST							✓																	
	BSC		/																						
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT		S																						
	LEFT		P																						
	SUPINE		L																						
	HOB 30 DEGREES		S					✓																	
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)			✓																						
PAIN	PAIN FREE							✓																	
	PAIN SCALE (1-10)																								
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended		2					2																	
			✓																						
BOWEL SOUNDS (active all quads)								X4																	
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT																									
VOIDING CLEAR, YELLOW URINE q.s.			✓					✓																	
SKIN INTEGRITY	No Breakdown																								
	Surgical Wounds		/					/																	
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1 Incision ABD staristrips			—					✓																	
#2 L thigh Incision OTA			—					✓																	
#3 L VAC WD Dressing CDE			—					✓																	
Old chest tube Sits								✓																	

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)

ACLU-RDI 1099 p.1001

DOD 006269

PUPIL SIZE		PUPILS	MOTOR FUNCTION	CHART CODES
1 mm	=	Equal	0 = No Movement	Present ✓
2 mm	R	Reactive	1 = Slight Flicker/ Trace of Contraction	
3 mm	NR	NonReactive	2 = Active (Gravity Eliminated)	Not Applicable/Absent (blank)
			3 = Active: against gravity, but not against resistance	
4 mm	L > R	Left Larger	4 = Active: Against Gravity and Resistance, not full strength	Refer to Nsg. Notes X
			5 = Full Strength against Examiners Resistance	
5 mm	R > L	Right Larger		No Change from Previous Assessment –

DATE:

TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (2) To Pain (3) To Voice (1) Does Not Open		4					4																	
B. BEST VERBAL RESPONSE (5) Oriented (2) Garbled (4) Confused (1). No Response (3) Inappropriate Verbal Response		5					5																	
C. BEST MOTOR RESPONSE (6) Obeys Commands (3) Flexion to Pain (5) Localizes to Pain (2) Extension to Pain (4) Withdraw to Pain (1) No Response		6					6																	
GLASCOW COMA SCALE (A+B+C)		15					15																	
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) R		2+					2+																	
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) L		2+					2+																	
MOVEMENT (See Motor Function Scale at Top of Page) RUE		5					5																	
MOVEMENT (See Motor Function Scale at Top of Page) LUE		5					5																	
MOVEMENT (See Motor Function Scale at Top of Page) RLE		5					5																	
MOVEMENT (See Motor Function Scale at Top of Page) LLE		5					5																	
GRIP (S) Strong (W) Weak (-) absent R		5					5																	
GRIP (S) Strong (W) Weak (-) absent L		5					5																	
RESPIRATIONS REGULAR							✓																	
RESPIRATIONS IRREGULAR																								
RESPIRATIONS UNLABORED		✓					✓																	
RESPIRATIONS LABORED																								
RESPIRATIONS SHALLOW																								
RESPIRATIONS RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished RUL		5					5																	
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished LUL		5					5																	
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished RLL		1					1																	
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished LLL		1					1																	
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished BOTH BASES							1/1																	
COUGH NONE		✓					✓																	
COUGH SPONTANEOUS																								
COUGH PRODUCTIVE																								
COUGH NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																								
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																								
VENTILATOR Vt																								
VENTILATOR FIO2																								
VENTILATOR RATE (SIMV/CMV)																								
VENTILATOR PEEP / CPAP																								
VENTILATOR PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE NC (l/min)																								
OXYGEN DELIVERY DEVICE FM (l/min)																								
ETT #_____ NRBM (l/min)																								
ETT #_____ ETT _____cm gums																								
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED																								
INCENTIVE SPIROMETRY DONE																								
COUGH / DEEP BREATH		✓					✓																	
INITIALS		b)(6)-2					b)(6)-2																	

ACLU-RDI 1099 p.1002

DOD 006270

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200	99.8	56	16	134/48	99%												
0300																	
0400																	
0500																	
0600																	
0700																	
	98.7	72	16	109/51	97%		73										
0800																	
0900																	
1000																	
1100																	
1200																	
1300																	
1400																	
1500																	
1600																	
1700																	
1800																	
1900																	
2000																	
2100																	
2200																	
2300																	
2400																	

ACLU-RDI 1099 p.1003

DOD 006271

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR		OBSERVATIONS
	A.M.	P.M.	Include medication and treatment when indicated
16 Oct 03	0030		- c/o pain (prn med given see MAR) will continue to monitor pt — [b)(6)-2]
16 Oct 03	0230		- sleeping @ this time @ s/s of resp. distress will continue to monitor pt — [b)(6)-2]
16 Oct 03	0330		pt. resting in bed; NAD; VSS; Pt c/o pain gen. 1 percocet given; assesstment completed; pt now resting c eyes closed; will cont to monitor — [b)(6)-2]
	0915		Pt discharged to custody of MPs. MP given d/c instructions (Cpl [b)(6)-1] and pt left ambulatory. [b)(6)-2] MAT w

ACLU-RDI 1099 p.1004

DOD 006272

	INTAKE									OUTPUT						
	PO								Total	Urine	BM				Total	COMMENTS
0100																
0200																
0300																
0400																
0500																
0600																
0700																
0800																
8 HR									8 HR.						8 HR.	
0900																
1000																
1100																
1200																
1300																
1400																
1500																
1600																
8 HR									16 HR.						16 HR.	
1700																
1800																
1900																
2000																
2100																
2200																
2300																
2400																
8 HR									24 HR.						24 HR	

MC E R. ORD - PATIENT RELEASE / DISCHARGE INSTRUCTIONS

For use of this form, see MEDCOM Circular 40-5

DIRECTIONS: To be completed by attending provider and other staff at time of patient release following an outpatient procedure, extended care/treatment or discharge from an inpatient hospital stay.

SECTION I
TO BE COMPLETED BY PRIVILEGED PROVIDER

1. DATE OF PROCEDURE/ADMISSION: 20 Oct 03
2. ADMITTING/DIAGNOSIS: GSW to Abdomen
3. PERTINENT LAB, X-RAY, FINDINGS:
Pt presented after sustaining a GSW to Abd c 3 feet of evisceration small bowel
4. PROCEDURES, TREATMENT, HOSPITAL COURSE:
Ex lap W/ Resection 30 cm small bowel c primary anastomosis
Sigmoid Repair x2 - 20 Oct 03
Bilateral CHEST tubes 20/Oct/03
5. FINAL DIAGNOSIS AND CONDITION AT DISCHARGE:
GSW to Abd W/ small bowel / Sigmoid injuries
(R) PTX - Resolved
ARDS - Resolved
6. ACTIVITY: No lifting >10lbs for 4wks
7. DIET: Regular
8. MEDICATIONS:
☒ Medications have been prescribed for home use. See separate list and special instructions or see below.
Percocet 1-2 po q 4-6 prn
9. INSTRUCTIONS *(To Home Health Providers, Patient, etc)*:
wet to dry dressing LLQ wound (small exit site) twice a day
Follow up weekly 21st CSH on Sunday for wound check @ 10am
10. DISCHARGING PROVIDER
(b)(6)-2 LTC MC USA
(Signature) *(Printed or Stamped Name)*

PATIENT IDENTIFICATION
(b)(6)-4

SECTION II
TO BE COMPLETED BY OTHER STAFF, AS APPROPRIATE

1. DISPOSITIONED TO: ☐ HOME ☐ DUTY ☐ OTHER (DOC)
☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER
2. ACCOMPANIED BY: ☐ FAMILY ☐ FRIEND ☐ OTHER MP
3. PATIENT EDUCATION:
Completed and patient prepared for home care. ☐ YES ☐ NO
If no, explain:
Patient ☐ states ☐ demonstrates understanding of home care needs.
Printed educational materials provided:
4. Clinical outcomes met and post-discharge/release referrals made.
☐ YES ☐ NO If no, explain:
5. If transferred to another health care facility, report called to nurse.
☐ YES ☐ NO If no, explain:
6. NUTRITION CARE - Comments:
7. MEDICATIONS:
Explained by: ☐ NURSE ☐ PHYSICIAN ☐ PHARMACIST
Printed medication literature provided. ☐ YES ☐ NO
Patient states understanding of prescribed medications. ☐ YES ☐ NO
8. EQUIPMENT/SUPPLIES PROVIDED:
9. FOLLOW-UP APPOINTMENTS, POINT OF CONTACT & PHONE:
10. FOR PROBLEMS OR EMERGENCY, CONTACT & PHONE:
11. COMPLETED BY:
(b)(6)-2 LT MC USN 16 Oct 03
(Signature and Title) *(Date and Time)*

I HAVE RECEIVED A COPY OF AND UNDERSTAND THESE INSTRUCTIONS.
(b)(6)-2 16 Oct 03
(Patient/Responsible Adult's Signature) *(Date and Time)*

MEDCOM FORM 691-R (TEST) (MCHO) MAR 99 PREVIOUS EDITIONS ARE OBSOLETE MC V1.00

ACLU-RDI 1099 p.1006

DOD 006274

Ventilator Flow Sheet

Date	Time	Mode	V_T	Rate	FiO_2	PEEP	PIP	MAP	SpO_2	HR	BP	I:E	RT Init
4 Oct 03	1100	SIMV	700	12	100	10	48	29	97	146	172/53	1:1.1	(b)(6)-2
4 Oct 03	1300	SIMV	700	16	100	10	41	25	77	144	146/52	1:1.1	
4 Oct 03	1500	SIMV	550	16	100	10	31	24	91	143	209/74	1:1.1	
4 Oct 03	1815	SIMV	550	15	100	10	42	26	91	136	150/72	1:1.1	
4 Oct 03	2000	SIMV	550	17	100	10	40	28	90	132	163/70	1:1.5	
4 Oct 03	2330	SIMV	550	17	100	10	44	24	92	115	149/61	1:1.5	
5 Oct 03	2330	SIMV	550	17	100	10	42	28	95	111	132/64	1:1.5	
5 Oct 03	0130	SIMV	550	17	100	10	39	22	100	109	114/64	1:1.5	
5 Oct 03	0300	SIMV	550	17	100	10	35	13	100	105	118/62	1:1.5	
5 Oct 03	0500	SIMV	550	17	100	10	31	20	100	96	132/61	1:1.5	
5 Oct 03	0700	SIMV	550	17	100	10	32	21	100	91	103/58	1:1.5	
5 Oct 03	0734				90%								
5 Oct 03	0930	SIMV	600	17	80%	10	33	18	100	92	137/80	1:1.5	(b)(6)-2
5 Oct 03	1130	SIMV	600	17	70%	10	35	20	100%	102	124/60	1:1.5	
5 Oct 03	1330	SIMV	600	17	60%	10	36	20	95%	97	117/70	1:1.5	
5 Oct 03	1530	SIMV	600	17	50%	10	35	20	99%	94	96/51	1:1.5	
5 Oct 03	1930	SIMV	600	17	50%	10	36	22	98	105	134/68	1:1.5	
5 Oct 03	2100	SIMV	600	17	50%	10	34	21	100	105	127/70	1:1.5	(b)(6)-2
5 Oct 03	2330	SIMV	600	17	50%	10	35	22	96	94	114/65	1:1.5	
6 Oct 03	0130	SIMV	600	17	50%	10	32	20	98	111	144/87	1:1.5	
6 Oct 03	0330	SIMV	600	17	50	10	33	22	98	91	112/52	1:1.5	
6 Oct 03	0530	SIMV	600	17	50	10	32	20	97	91	96/60	1:1.5	
6 Oct 03	0730	SIMV	600	17	50	10	35	10	97	100	125/62	1:1.5	
6 Oct 03	0930	SIMV	600	15	40	[redacted]	22	5	92	102	105/52	1:1.9	
6 Oct 03	1330	SIMV	600	15	45	8	37	18	94	104	128/70	1:1.9	
6 Oct 03	1530	SIMV	600	15	45	8	35	10	96	93	128/64	1:1.9	
6 Oct 03	1730	SIMV	600	15	45	8	34	17	97	99	144/78	1:1.9	(b)(6)-2
6 Oct 03	1930	SIMV	600	15	45	6	33	12	99	109	160/82	1:1.9	
6 Oct 03	2130	SIMV	600	15	45	8	37	13	98	99	160/84	1:1.9	

(b)(6)-4

ACLU-RDI 1099 p.1007

DOD 006275

Ventilator Flow Sheet

Date	Time	Mode	V_T	Rate	FiO_2	PEEP	PIP	MAP	SpO_2	HR	BP	I:E	RT Init
10/6/03	2330	SIMV	600	15	45	8	35	18	99	85	15/77	1:9	(b)(6)-2
10/7/03	0130	SIMV	600	15	45	8	33	15	100	79	10/62	1:9	
10/7/03	0330	SIMV	600	15	45	8	34	16	98	87	111/66	1:19	
10/7/03	0530	SIMV	600	15	45	8	33	18	97	95	124/66	1:19	
10/7/03	0730	SIMV	600	16	40	8	34	19	97	97	154/74	1:1.7	
10/7/03	0930	SIMV	600	16	40	6	24	12	97	87	121/64	1:1.7	
10/7/03	1130	SIMV	600	16	40	6	31	16	96	97	125/66	1:1.7	
10/7/03	1530	SIMV	600	25	60	6	38	18	96	107	101/55	1:1.7	
10/7/03	1730	SIMV	600	25	60	6	37	18	97	100	106/61		
10/7/03	1930	SIMV	600	23	45	6	38	18	94	94	100/61	1:17	
10/7/03	2135	SIMV	600	20	60	6	33	12	96	97	100/55	1:15	(b)(6)-2
10/7/03	2335	SIMV	600	16	50	8	34	15	97	100	142/83	1:5	
10/8/03	0135	SIMV	600	16	50	8	39	22	96	99	164/59	1:15	
10/8/03	0330	SIMV	600	16	50	8	36	20	97	78	154/69	1:15	
10/8/03	0530	SIMV	600	16	50	8	41	15	96	94	140/70	1:15	
10/8/03	0625				40				~~97~~ 98	~~100~~	~~158/89~~		
10/8/03	0730	SIMV	600	16	40	8	36	19	97	100	158/89	1:1.5	(b)(6)-2
10/8/03	1130	SIMV	600	16	100	8	42	22	100	110	123/71	1:1.5	
10/8/03	1530	SIMV	750	16	70	10	41	21	95	104	99/61	1:1.5	
10/8/03	1930	SIMV	800	14	60	10	39	22	97	107	111/62	1:19	(b)(6)-2
10/8/03	2130	SIMV	850	12	60	10	38	20	94	110	118/68	1:19	
10/8/03	2330	SIMV	850	12	50	10	40	15	96	110	114/64	1:18	
10/9/03	0135	SIMV	850	12	50	10	42	25	95	110	113/64	1:18	
10/9/03	0330	SIMV	850	12	50	10	44	26	98	115	116/68	1:18	
10/9/03	0730	SIMV	850	12	50	10	36	21	100	101	123/71	1:1.8	
10/9/03	1130	SIMV	1000	10	40	10	30	18	98	112	157/74	1:2.3	
10/9/03	1330	SIMV	1000	10	40	10	42	23	94	128	153/79	1:2.3	
10/9/03	1530	~~SIMV~~ A/C	1000	12	40	10	40	20	98	109	118/68	1:21	
10/9/03	1930	A/C	1000	12	40	10	32	18	99	103	121/55	1:21	

(b)(6)-4

Ventilator Flow Sheet

Date	Time	Mode	V_T	Rate	FiO_2	PEEP	PIP	MAP	SpO_2	HR	BP	I:E	RT Init
10/9/03	2000	A/C		↓10		↓8							
10/9/03	2130	A/C	1L	10	40	8	31	24	100	97	124/8	1:21	(b)(6)-2
10/9/03	2330	A/C	1L	10	40	8	32	14	97	109	1[illegible]/51	1:18	
10/9/03	0145	A/C	1L	10	40	8	36	16	99	104	1[illegible]/51	1:18	
10/9/03	0330	A/C	1L	10	40	16	33	14	100	94	1[illegible]	1:19	
10/9/03	0530	A/C	1L	10	40	6	38	14	100	98	1[illegible]/78	1:19	
10/10/03	0730	AC	1000	10	40	6	32	17	99	91	131/68	1:1.9	
10/10/03	0930	SIMV	1000	10	40	5	38	14	100	96	140/72	1:1.9	
10/10/03	1130	SIMV	1000	10	40	5	34	16	99	105	153/70	1:1.9	

(b)(6)-4

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI.	UNIT	RANK	SSN
FRAQ‡ [redacted]			[redacted]

Physician:	Ward:		Date and Time:	Re[redacted]	Date and Time:
Maj [redacted]	EMT	X STAT / Routine	20ct03 0225	[redacted]	20cte

Chemistry (I-STAT)

X	TEST	RESULT	REF. RANGE
	Na	141	128-145 mmol/L
	K	3.2	3.3-4.7 mmol/L
	Cl	105	98-108 mmol/L
	pH		7.35-7.45
	PCO2		35-45 mmHg
	PO2		80-90 mmHg
	TCO2		18-33 mmol/L
	HCO3		22-28 mmol/L
	sO2		95-99%
	BEecf		(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN	15	7-22 mg/dL
	Glu	168	73-118 mg/dL
	Creat	1.2	0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL

Urinalysis

Color		Straw/Yellow
Clarity		Clear
Glucose		Negative
Bilirubin		Negative
Ketone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative-Trace
Urobili		Negative
Nitrite		Negative
Leuko		Negative

Urine Microscopic

WBC		Epi
RBC		Mucus
Bacteria		Yeast
Casts:		
Crystals:		
Other:		

Chemistry (Piccolo Analyzer)

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-84 U/L
	ALT		10-47 U/L
	AMY		14-97 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat		0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		128-145 mmol/L

Microbiology

Source:		
FecLeuk		Negative
Gram St		
WetPrep		Negative
KOH		No Fungal Elements
OccBld		Negative
O&P		No Ova/Parasite

Blood Bank

ABO/Rh	A'B Neg	
T&C		
T&S		

HCG

Urine		Negative
Serum		Negative

Hematology

X	TEST	RESULT	REF. RANGE
	WBC	10.9	4.8-10.8 x10(3)/uL
	RBC	4.61	4.2-6.1 x10(6)/uL
	Hgb	14.9	12.0-18.0 g/dL
	Hct	41.2	35.0-60.0%
	MCV	89.4	80.0-99.0 fl
	MCH	32.4	27.0-31.0 pg
	MCHC	36.3	33.0-37.0 g/dL
	Plt	317	130-400 x10(3)/uL
	LY%	21.0	15.0-55.0%
	LY#	2.3	0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Imm
RBC Morph:	
Plt verify:	
Spun Crit	35-60%

Malaria Smear

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate

Sed Rate		1hr = 0-20 mm

Coagulation

PT		10-13 seconds
APTT		22.1-33.7 seconds
FDP		Negative

Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Negative

Other: I stat 6, CBC, Creat, Typ and Cross 4

FORM LEARLAB 20 01 May 2003 MEDCOM - 2226

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI.	UNIT	DOB	RANK	SSN
IRAQ5 (b)(6)-4				

Physician:	Ward:		Specimen Date and Time:	Re[redacted]	Date and Time:
Dr (b)(6)-2	OR	STAT / Routine	2 Octe 0400 HR	(b)(6)-2	2 octe 0410 HR

Chemistry (i-STAT) — 6+ 7+ 8+ Glu Crea

X	TEST	RESULT	REF. RANGE
	Na		128-145 mmol/L
	K		3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH		7.35-7.45
	PCO2		35-45 mmHg
	PO2		80-90 mmHg
	TCO2		18-33 mmol/L
	HCO3		22-28 mmol/L
	sO2		95-99%
	BEecf		(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL
	Lactate		0.90-1.70 mmol/L

Urinalysis

	Color		Straw/Yellow
	Clarity		Clear
	Glucose		Negative
	Bilirubin		Negative
	Ketone		Negative
	SG		1.010-1.025
	Blood		Negative
	pH		5.0-8.0
	Protein		Negative-Trace
	Urobili		Negative
	Nitrite		Negative
	Leuko		Negative

Urine Microscopic

	WBC		Epi
	RBC		Mucus
	Bacteria		Yeast
	Casts:		Spermatozoa
	Crystals:		Amorph Sed
	Other:		

Chemistry (Piccolo Analyzer) — Chem 12 MetLyte8 BMP Liver

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-84 U/L
	ALT		10-47 U/L
	AMY		14-97 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat		0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		128-145 mmol/L

Misc. Chemistry

	Mono		Negative
	RPR		Negative
	HIV		Negative
	Meningitis		Negative
	DOA		Negative
	CK-MB		< 4.3 ng/mL
	Troponin I		< 0.19 ng/mL
	Myoglobin		< 107 ng/mL

Microbiology

	Source:		
	FecLeuk		Negative
	Gram Stain		
	WetPrep		Negative
	KOH		No Fungal Elements
	OccBld		Negative
	O&P		No Ova/Parasite

HCG

	Urine		Negative
	Serum		Negative

Hematology — CBC Malaria H/H

X	TEST	RESULT	REF. RANGE
	WBC	4.1	4.8-10.8 x10(3)/uL
	RBC	3.92	4.2-6.1 x10(6)/uL
	Hgb	12.4	12.0-18.0 g/dL
	Hct	35.4	35.0-60.0%
	MCV	90.4	80.0-99.0 fl
	MCH	31.6	27.0-31.0 pg
	MCHC	34.9	33.0-37.0 g/dL
	Plt	161	130-400 x10(3)/uL
	LY%	19.7	15.0-55.0%
	LY#	0.4	0.7-4.3 x10(3)/uL

Differential

Segs			Mono
Bands			Eos
Lymph			Baso
Atyp Ly			Immature cells
	RBC Morph:		
	Plt verify:		
	Spun Crit		35-60%

Malaria Smear

	Thin		No Plasmodium Seen
	Thick		No Plasmodium Seen

Sed Rate

	Sed Rate		1hr = 0-20 mm

Coagulation

	PT		10-13 seconds
	APTT		22.1-33.7 seconds
	FDP		Negative
	D-Dimer		Negative
	Fibrinogen		200-400 mg/dL

Blood Bank

	ABO/Rh		
	T&C		
	T&S		

Other:

CBC

MEDCOM - 2227

Fio2 100% Temp 101.8

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LA (b)(6)-4	UNIT FCU	DOB	RANK	SSN
Physician: (b)(6)-2 Ward:	X STAT / Routine — Specimen Date and Time: 4oct03 1930	Reported by: (b)(6)-2		Date and Time: 4oct03 2000 HR

Chemistry (i-STAT) — 6+ / 7+ / 8+ / Glu / Crea

X	TEST	RESULT	REF. RANGE
	Na	135	128-145 mmol/L
	K	3.7	3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH	7.260	7.35-7.45
	PCO2	50.4	35-45 mmHg
	PO2	87.	80-90 mmHg
	TCO2	38	18-33 mmol/L
	HCO3	35	22-28 mmol/L
	sO2	93%	95-99%
	BEecf	9	(-2) - (+3)
	AGap		8-16 mmol/L
	iCa	1.05	0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.2 mg/dL
	Hct	25%	35.0-60.0%
	Hgb	10.	12.0-18.0 g/dL
	Lactate		0.90-1.70 mmol/L

Urinalysis

	Color		Straw/Yellow
	Clarity		Clear
	Glucose		Negative
	Bilirubin		Negative
	Ketone		Negative
	SG		1.010-1.025
	Blood		Negative
	pH		5.0-8.0
	Protein		Negative-Trace
	Urobili		Negative
	Nitrite		Negative
	Leuko		Negative

Urine Microscopic

	WBC		Epi
	RBC		Mucus
	Baderia		Yeast
	Casts:		Spermatozoa
	Crystals:		Amorph Sed
	Other:		
	Other:		

Chemistry (Piccolo Analyzer) — Chem 12 / MetLyte8 / BMP / Liver

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-84 U/L
	ALT		10-47 U/L
	AMY		14-97 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat		0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		128-145 mmol/L

Misc. Chemistry

	Mono		Negative
	RPR		Negative
	HIV		Negative
	Meningitis		Negative
	DOA		Negative
	CK-MB		< 4.3 ng/mL
	Troponin I		< 0.19 ng/mL
	Myoglobin		< 107 ng/mL

Microbiology

	Source:		
	FecLeuk		Negative
	Gram Stain		
	WetPrep		Negative
	KOH		No Fungal Elements
	OccBld		Negative
	O&P		No Ova/Parasite

HCG

	Urine		Negative
	Serum		Negative

Hematology — CBC / Malaria / H/H

X	TEST	RESULT	REF. RANGE
	WBC		4.8-10.8 x10(3)/uL
	RBC		4.2-6.1 x10(6)/uL
	Hgb		12.0-18.0 g/dL
	Hct		35.0-60.0%
	MCV		80.0-99.0 fl
	MCH		27.0-31.0 pg
	MCHC		33.0-37.0 g/dL
	Plt		130-400 x10(3)/uL
	LY%		15.0-55.0%
	LY#		0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Immature cells

RBC Morph:		
Plt verify:		
Spun Crit		35-60%

Malaria Smear

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate

Sed Rate		1hr = 0-20 mm

Coagulation

PT		10-13 seconds
APTT	33.1	22.1-33.7 seconds
FDP		Negative
D-Dimer		Negative
Fibrinogen		200-400 mg/dL

Blood Bank

ABO/Rh		
T&C		
T&S		

MEDCOM - 2228

FORM BEABI AB 20 23, July 2003

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST FIRST MI	UNIT	DOB	RANK	SSN
(b)(6)-4	ICU			

Physician:	Ward:		Specimen Date and Time:	Reported by:	Date and Time:
(b)(6)-2	ICU	X STAT / Routine	10/5/03 0750	(b)(6)-2	5Oct03 0917

Chemistry (I-STAT)

6+ 7+ 8+ Glu Crea

X	TEST	RESULT	REF. RANGE
	Na		128-145 mmol/L
	K		3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH		7.35-7.45
	PCO2		35-45 mmHg
	PO2		80-90 mmHg
	TCO2		18-33 mmol/L
	HCO3		22-28 mmol/L
	sO2		95-99%
	BEecf		(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL
	Lactate		0.90-1.70 mmol/L

Urinalysis

	Color		Straw/Yellow
	Clarity		Clear
	Glucose		Negative
	Bilirubin		Negative
	Ketone		Negative
	SG		1.010-1.025
	Blood		Negative
	pH		5.0-8.0
	Protein		Negative-Trace
	Urobili		Negative
	Nitrite		Negative
	Leuko		Negative

Urine Microscopic

	WBC		Epi
	RBC		Mucus
	Bacteria		Yeast
	Casts:		Spermatozoa
	Crystals:		Amorph Sed
	Other:		
	Other:		

Chemistry (Piccolo Analyzer)

Chem 12 MetLyte8 BMP Liver

X	TEST	RESULT	REF. RANGE
(X)	ALB	1.9	3.3-5.5 g/dL
	ALP	49	26-84 U/L
	ALT	42	10-47 U/L
	AMY	78	14-97 U/L
(X)	AST	56	11-38 U/L
	Tbil	0.2	0.2-1.6 mg/dL
	BUN	10	7-22 mg/dL
	Ca	7.9	8.0-10.3 mg/dL
	Chol	151	100-200 mg/dL
	CK		30-170 U/L
	CL	97	98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat	0.9	0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu	142	73-118 mg/dL
	K	3.5	3.3-4.7 mmol/L
	TProtein	6.0	6.4-8.1 g/dL
	Na	137	128-145 mmol/L

Misc. Chemistry

	Mono		Negative
	RPR		Negative
	HIV		Negative
	Meningitis		Negative
	DOA		Negative
	CK-MB		< 4.3 ng/mL
	Troponin I		< 0.19 ng/mL
	Myoglobin		< 107 ng/mL

Microbiology

	Source:		
	FecLeuk		Negative
	Gram Stain		
	WetPrep		Negative
	KOH		No Fungal Elements
	OccBld		Negative
	O&P		No Ova/Parasite

HCG

	Urine		Negative
	Serum		Negative

Hematology

CBC Malaria H/H

X	TEST	RESULT	REF. RANGE
	WBC		4.8-10.8 x10(3)/uL
	RBC		4.2-6.1 x10(6)/uL
	Hgb		12.0-18.0 g/dL
	Hct		35.0-60.0%
	MCV		80.0-99.0 fl
	MCH		27.0-31.0 pg
	MCHC		33.0-37.0 g/dL
	Plt		130-400 x10(3)/uL
	LY%		15.0-55.0%
	LY#		0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Immature cells

RBC Morph:		
Plt verify:		
Spun Crit		35-60%

Malaria Smear

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate

Sed Rate		1hr = 0-20 mm

Coagulation

PT		10-13 seconds
APTT		22.1-33.7 seconds
FDP		Negative
D-Dimer		Negative
Fibrinogen		200-400 mg/dL

Blood Bank

ABO/Rh		
T&C		
T&S		

LIVER PANEL

MEDCOM - 2229

Critical value on ... reported to ... (b)(6)-2

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST FIRST MI: (b)(6)-4 | UNIT: ICU | DOB | RANK | SSN

Phys: (b)(6)-2 | Ward: ICU | STAT / Routine | Specimen Date and Time: 6 Oct 03 | Reported by: (b)(6)-2 | Date and Time: 6 Oct 03 0530

Chemistry (~~STAT~~) ABG

6+ 7+ 8+ Glu Crea

X	TEST	RESULT	REF. RANGE
	Na	144	128-145 mmol/L
	K	3.9	3.3-4.7 mmol/L
	Cl		98-108 mmol/L
X	pH	7.504	7.35-7.45
X	PCO2	45.2	35-45 mmHg
X	PO2	169	80-90 mmHg
	TCO2	37	18-33 mmol/L
X	HCO3	36	22-28 mmol/L
X	sO2	100	95-99%
X	BEecf	13	(-2) - (+3)
X	AGap		8-16 mmol/L
	iCa	1.12	0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.2 mg/dL
X	Hct	22	35.0-60.0%
X	Hgb	7	12.0-18.0 g/dL
	Lactate		0.90-1.70 mmol/L

Urinalysis

Color		Straw/Yellow
Clarity		Clear
Glucose		Negative
Billrubin		Negative
Ketone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative-Trace
Urobili		Negative
Nitrite		Negative
Leuko		Negative

Urine Microscopic

WBC		Epi	
RBC		Mucus	
Bacteria		Yeast	
Casts:		Spermatozoa	
Crystals:		Amorph Sed	
Other:			
Other:			

Chemistry (Piccolo Analyzer)

Chem 12 / MetLyte8 BMP Liver

X	TEST	RESULT	REF. RANGE
	ALB	2.0	3.3-5.5 g/dL
	ALP	45	26-84 U/L
	ALT	30	10-47 U/L
	AMY	74	14-97 U/L
	AST	46	11-38 U/L
	Tbil	0.4	0.2-1.6 mg/dL
	BUN	14	7-22 mg/dL
	Ca	8.4	8.0-10.3 mg/dL
	Chol	167	100-200 mg/dL
	CK		30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat	0.7	0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu	131	73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein	5.9	6.4-8.1 g/dL
	Na		128-145 mmol/L

Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Negative
DOA		Negative
CK-MB		< 4.3 ng/mL
Troponin I		< 0.19 ng/mL
Myoglobin		< 107 ng/mL

Microbiology

Source:		
FecLeuk		Negative
Gram Stain		
WetPrep		Negative
KOH		No Fungal Elements
OccBld		Negative
O&P		No Ova/Parasite

HCG

Urine		Negative
Serum		Negative

Hematology

CBC / Malaria H/H

X	TEST	RESULT	REF. RANGE
	WBC	8.1	4.8-10.8 x10(3)/uL
	RBC	2.73	4.2-6.1 x10(6)/uL
	Hgb	8.3	12.0-18.0 g/dL
	Hct	24.9	35.0-60.0%
	MCV	91.0	80.0-99.0 fl
	MCH	30.3	27.0-31.0 pg
	MCHC	33.3	33.0-37.0 g/dL
	Plt	231	130-400 x10(3)/uL
	LY%	8.4	15.0-55.0%
	LY#	0.9	0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Immature cells

RBC Morph:

Plt verify:

Spun Crit | | 35-60%

Malaria Smear

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate

Sed Rate		1hr = 0-20 mm

Coagulation

PT		10-13 seconds
APTT		22.1-33.7 seconds
FDP		Negative
D-Dimer		Negative
Fibrinogen		200-400 mg/dL

Blood Bank

ABO/Rh		
T&C		
T&S		

ABG 98.9 50%

CCL, Chem 17

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI. Iraqi #[b)(6)-4] | UNIT ICU | RANK | SSN

Physician: | Ward: | STAT / Routine | Date and Time: | Rep[b)(6)-2] | Date and Time: 6 Jun 12

Chemistry (I-STAT)

X	TEST	RESULT	REF. RANGE
	Na		128-145 mmol/L
	K		3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH		7.35-7.45
	PCO2		35-45 mmHg
	PO2		80-90 mmHg
	TCO2		18-33 mmol/L
	HCO3		22-28 mmol/L
	sO2		95-99%
	BEecf		(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL

Urinalysis

Color		Straw/Yellow
Clarity		Clear
Glucose		Negative
Bilirubin		Negative
Ketone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative-Trace
Urobill		Negative
Nitrite		Negative
Leuko		Negative

Urine Microscopic

WBC		Epi	
RBC		Mucus	
Bacteria		Yeast	
Casts:			
Crystals:			
Other:			

Chemistry (Piccolo Analyzer)

X	TEST	RESULT	REF. RANGE
	ALB	2.4	3.3-5.5 g/dL
	ALP	46	26-84 U/L
	ALT	27	10-47 U/L
	AMY	205	14-97 U/L
	AST	47	11-38 U/L
	Tbil	0.3	0.2-1.6 mg/dL
	BUN	11	7-22 mg/dL
	Ca	8.4	8.0-10.3 mg/dL
	Chol	156	100-200 mg/dL
	CK		30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat	0.7	0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu	107	73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein	6.5	6.4-8.1 g/dL
	Na		128-145 mmol/L

Microbiology

Source:		
FecLeuk		Negative
Gram St		
WetPrep		Negative
KOH		No Fungal Elements
OccBld		Negative
O&P		No Ova/Parasite

Blood Bank

ABO/Rh		
T&C		
T&S		

HCG

Urine		Negative
Serum		

Hematology

X	TEST	RESULT	REF. RANGE
	WBC	10.8	4.8-10.8 x10(3)/uL
	RBC	3.15	4.2-6.1 x10(6)/uL
	Hgb	10.1	12.0-18.0 g/dL
	Hct	29.0	35.0-60.0%
	MCV	91.9	80.0-99.0 fl
	MCH	32.1	27.0-31.0 pg
	MCHC	34.9	33.0-37.0 g/dL
	Plt	398	130-400 x10(3)/uL
	LY%	17.6	15.0-55.0%
	LY#	1.9	0.7-4.3 x10(3)/uL

Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp Ly		Imm	
RBC Morph:			
Plt verify:			
Spun Crit			35-60%

Malaria Smear

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate

Sed Rate		1hr = 0-20 mm

Coagulation

PT		10-13 seconds
APTT		22.1-33.7 seconds
FDP		Negative

Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Negative

MEDCOM - 2231

ABG, CBC, Chem 12 40 to 99' = T

21st COMBAT SUPPORT HOSPITAL	LABORATORY RESULTS FORM (Subject to Privacy Act of 1974)		
LAST, FIRST, MI (b)(6)-4	UNIT MA	RANK	SSN
Physician (b)(6)-2 Ward: ICU	STAT / X Routine	Date and Time: 10 OCT 03 0455 ~~0505~~	Reported by: (b)(6)-2 Date and Time: 10 Oct 03

Chemistry (i-STAT)

X	TEST	RESULT	REF. RANGE
	Na	136	128-145 mmol/L
	K	3.7	3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH	7.428	7.35-7.45
	PCO2	41.2	35-45 mmHg
	PO2	46	80-90 mmHg
	TCO2	28	18-33 mmol/L
	HCO3	27	22-28 mmol/L
	sO2	93	95-99%
	BEecf	3	(-2) - (+3)
	AGap		8-16 mmol/L
	iCa	1.13	0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL

Urinalysis

Color		Straw/Yellow
Clarity		Clear
Glucose		Negative
Bilirubin		Negative
Ketone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative-Trace
Urobili		Negative
Nitrite		Negative
Leuko		Negative

Urine Microscopic

WBC		Epi
RBC		Mucus
Bacteria		Yeast
Casts:		
Crystals:		
Other:		

Chemistry (Piccolo Analyzer)

X	TEST	RESULT	REF. RANGE
	ALB	2.1	3.3-5.5 g/dL
	ALP	54	26-84 U/L
	ALT	42	10-47 U/L
	AMY	93	14-97 U/L
	AST	126	11-38 U/L
	Tbil	1.1	0.2-1.6 mg/dL
	BUN	8	7-22 mg/dL
	Ca	8.2	8.0-10.3 mg/dL
	Chol	144	100-200 mg/dL
	CK		30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat	0.6	0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu	113	73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein	5.8	6.4-8.1 g/dL
	Na		128-145 mmol/L

Microbiology

Source:		
FecLeuk		Negative
Gram St		
WetPrep		Negative
KOH		No Fungal Elements
OccBld		Negative
O&P		No Ova/Parasite

Blood Bank

ABO/Rh		
T&C		
T&S		

HCG

Urine		Negative
Seru		

Hematology

X	TEST	RESULT	REF. RANGE
	WBC	11.9	4.8-10.8 x10(3)/uL
	RBC	3.29	4.2-6.1 x10(6)/uL
	Hgb	10.1	12.0-18.0 g/dL
	Hct	30.1	35.0-60.0%
	MCV	91.3	80.0-99.0 fl
	MCH	30.6	27.0-31.0 pg
	MCHC	33.5	33.0-37.0 g/dL
	Plt	287	130-400 x10(3)/uL
	LY%	15.5	15.0-55.0%
	LY#	1.8	0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Imm
RBC Morph:	
Plt verify:	
Spun Crit	35-60%

Malaria Smear

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate

Sed Rate		1hr = 0-20 mm

Coagulation

PT		10-13 seconds
APTT		22.1-33.7 seconds
FDP		Negative

Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Negative

MEDCOM - 2232

ABG, CBC, CHEM 12 T=99 RA

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, M (b)(6)-4 | UNIT | RANK N/A | SSN

Physician: (b)(6)-2 | Ward: ICU | STAT / Routine | Date and Time: 11 OCT 03 0455 | Reported by: (b)(6)-2 | Date and Time: 11 oct 03 @ 0536 (HR)

Chemistry (i-STAT)

X	TEST	RESULT	REF. RANGE
	Na	134	128-145 mmol/L
	K	3.7	3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH	7.524	7.35-7.45
	PCO2	32.8	35-45 mmHg
	PO2	220	80-90 mmHg
	TCO2	28	18-33 mmol/L
	HCO3	27	22-28 mmol/L
	sO2	100	95-99%
	BEecf	4	(-2) - (+3)
	AGap		8-16 mmol/L
	iCa	1.09	0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.2 mg/dL
	Hct	29	35.0-60.0%
	Hgb	10	12.0-18.0 g/dL

Urinalysis

Color		Straw/Yellow
Clarity		Clear
Glucose		Negative
Bilirubin		Negative
Ketone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative-Trace
Urobili		Negative
Nitrite		Negative
Leuko		Negative

Urine Microscopic

WBC		Epi	
RBC		Mucus	
Bacteria		Yeast	
Casts:			
Crystals:			
Other			

Chemistry (Piccolo Analyzer)

X	TEST	RESULT	REF. RANGE
	ALB	2.4	3.3-5.5 g/dL
	ALP	73	26-84 U/L
	ALT	62	10-47 U/L
	AMY	57	14-97 U/L
	AST	122	11-38 U/L
	Tbil	0.5	0.2-1.6 mg/dL
	BUN	6	7-22 mg/dL
	Ca	8.6	8.0-10.3 mg/dL
	Chol	185	100-200 mg/dL
	CK		30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat	0.7	0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu	106	73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein	6.6	6.4-8.1 g/dL
	Na		128-145 mmol/L

Microbiology

Source:		
FecLeuk		Negative
Gram St		
WetPrep		Negative
KOH		No Fungal Elements
OccBld		Negative
O&P		No Ova/Parasite

Blood Bank

ABO/Rh		
T&C		
T&S		

HCG

Urine		Negative
Serum		

Hematology

X	TEST	RESULT	REF. RANGE
	WBC	12.8	4.8-10.8 x10(3)/uL
	RBC	2.95	4.2-6.1 x10(6)/uL
	Hgb	11.0	12.0-18.0 g/dL
	Hct	26.6	35.0-60.0%
	MCV	90.3	80.0-99.0 fl
	MCH	37.3	27.0-31.0 pg
	MCHC	413	33.0-37.0 g/dL
	Plt	237	130-400 x10(3)/uL
	LY%	14.8	15.0-55.0%
	LY#	1.9	0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Imm
RBC Morph:	
Plt verify:	
Spun Crit	35-60%

Malaria Smear

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate

Sed Rate		1hr = 0-20 mm

Coagulation

PT		10-13 seconds
APTT		22.1-33.7 seconds
FDP		Negative

Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Negative

MEDCOM - 2233

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI	UNIT	DOB	RANK	SSN
[redacted] (b)(6)-4	ICU			

Physician: (b)(6)-2	Ward:	STAT / Routine	Specimen Date and Time:	Reported by: (b)(6)-2	Date and Time:
DM		Routine	10/7/03 0925		7 OCT 03

Chemistry (I-STAT)

6+ 7+ 8+ Glu Crea

X	TEST	RESULT	REF. RANGE
	Na		128-145 mmol/L
	K		3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH		7.35-7.45
	PCO2		35-45 mmHg
	PO2		80-90 mmHg
	TCO2		18-33 mmol/L
	HCO3		22-28 mmol/L
	sO2		95-99%
	BEecf		(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL
	Lactate		0.90-1.70 mmol/L

Urinalysis

	Color		Straw/Yellow
	Clarity		Clear
	Glucose		Negative
	Bilirubin		Negative
	Ketone		Negative
	SG		1.010-1.025
	Blood		Negative
	pH		5.0-8.0
	Protein		Negative-Trace
	Urobili		Negative
	Nitrite		Negative
	Leuko		Negative

Urine Microscopic

	WBC		Epi
	RBC		Mucus
	Bacteria		Yeast
	Casts:		Spermatozoa
	Crystals:		Amorph Sed
	Other:		

Other:

Chemistry (Piccolo Analyzer)

Chem 12 MetLyte8 BMP Liver

X	TEST	RESULT	REF. RANGE
	ALB	2.2 *	3.3-5.5 g/dL
	ALP	44	26-84 U/L
	ALT	29	10-47 U/L
	AMY	120 *	14-97 U/L
	AST	38	11-38 U/L
	Tbil	0.4	0.2-1.6 mg/dL
	BUN	15	7-22 mg/dL
	Ca	8.2	8.0-10.3 mg/dL
	Chol	218 *	100-200 mg/dL
	CK		30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat	0.6	0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu	103	73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein	5.8 *	6.4-8.1 g/dL
	Na		128-145 mmol/L

Misc. Chemistry

	Mono		Negative
	RPR		Negative
	HIV		Negative
	Meningitis		Negative
	DOA		Negative
	CK-MB		< 4.3 ng/mL
	Troponin I		< 0.19 ng/mL
	Myoglobin		< 107 ng/mL

Microbiology

	Source:		
	FecLeuk		Negative
	Gram Stain		
	WetPrep		Negative
	KOH		No Fungal Elements
	OccBld		Negative
	O&P		No Ova/Parasite

HCG

	Urine		Negative
	Serum		Negative

Hematology

CBC Malaria H/H

X	TEST	RESULT	REF. RANGE
	WBC	7.9	4.8-10.8 x10(3)/uL
	RBC	2.60 *	4.2-6.1 x10(6)/uL
	Hgb	8.4 *	12.0-18.0 g/dL
	Hct	24.0 *	35.0-60.0%
	MCV	92.2	80.0-99.0 fl
	MCH	32.3 *	27.0-31.0 pg
	MCHC	35.1	33.0-37.0 g/dL
	Plt	297	130-400 x10(3)/uL
	LY%	23.3	15.0-55.0%
	LY#	1.8	0.7-4.3 x10(3)/uL

Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp Ly		Immature cells	

	RBC Morph:		
	Plt verify:		
	Spun Crit		35-60%

Malaria Smear

	Thin		No Plasmodium Seen
	Thick		No Plasmodium Seen

Sed Rate

	Sed Rate		1hr = 0-20 mm

Coagulation

	PT		10-13 seconds
	APTT		22.1-33.7 seconds
	FDP		Negative
	D-Dimer		Negative
	Fibrinogen		200-400 mg/dL

Blood Bank

	ABO/Rh		
	T&C		
	T&S		

ACLU-RDI 1099 p.1018

DOD 006286

CBC ; Chem 12

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI	UNIT	RANK	SSN
(b)(6)-4	E —	N/A	—

Physician:	Ward:		Date and Time:	Reported by:	Date and Time:
(b)(6)-2	ICU	[X] Routine	120603 0530	(b)(6)-2	12 oct e

Chem 12 Chemistry (i-STAT)

X	TEST	RESULT	REF. RANGE
	Na		128-145 mmol/L
	K		3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH		7.35-7.45
	PCO2		35-45 mmHg
	PO2		80-90 mmHg
	TCO2		18-33 mmol/L
	HCO3		22-28 mmol/L
	sO2		95-99%
	BEecf		(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL

Urinalysis

	Color		Straw/Yellow
	Clarity		Clear
	Glucose		Negative
	Bilirubin		Negative
	Ketone		Negative
	SG		1.010-1.025
	Blood		Negative
	pH		5.0-8.0
	Protein		Negative-Trace
	Urobili		Negative
	Nitrite		Negative
	Leuko		Negative

Urine Microscopic

	WBC		Epi
	RBC		Mucus
	Bacteria		Yeast
	Casts:		
	Crystals:		
	Other:		
	Other:		

Chemistry (Piccolo Analyzer)

X	TEST	RESULT	REF. RANGE
	ALB	2.1	3.3-5.5 g/dL
	ALP	70	26-84 U/L
	ALT	54	10-47 U/L
	AMY	106	14-97 U/L
	AST	53	11-38 U/L
	Tbil	0.6	0.2-1.6 mg/dL
	BUN	12	7-22 mg/dL
	Ca	8.1	8.0-10.3 mg/dL
	Chol	131	100-200 mg/dL
	CK		30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat	0.5	0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu	102	73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein	6.2	6.4-8.1 g/dL
	Na		128-145 mmol/L

Microbiology

	Source:		
	FecLeuk		Negative
	Gram St		
	WetPrep		Negative
	KOH		No Fungal Elements
	OccBld		Negative
	O&P		No Ova/Parasite

Blood Bank

	ABO/Rh		
	T&C		
	T&S		

HCG

	Urine		Negative
	Serum		Negative

Hematology

X	TEST	RESULT	REF. RANGE
	WBC	8.0	4.8-10.8 x10(3)/uL
	RBC	3.19	4.2-6.1 x10(6)/uL
	Hgb	10.0	12.0-18.0 g/dL
	Hct	28.5	35.0-60.0%
	MCV	90.1	80.0-99.0 fl
	MCH	31.2	27.0-31.0 pg
	MCHC	34.7	33.0-37.0 g/dL
	Plt	250	130-400 x10(3)/uL
	LY%	21.7	15.0-55.0%
	LY#	1.7	0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Imm
RBC Morph:	
Plt verify:	
Spun Crit	35-60%

Malaria Smear

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate

Sed Rate		1hr = 0-20 mm

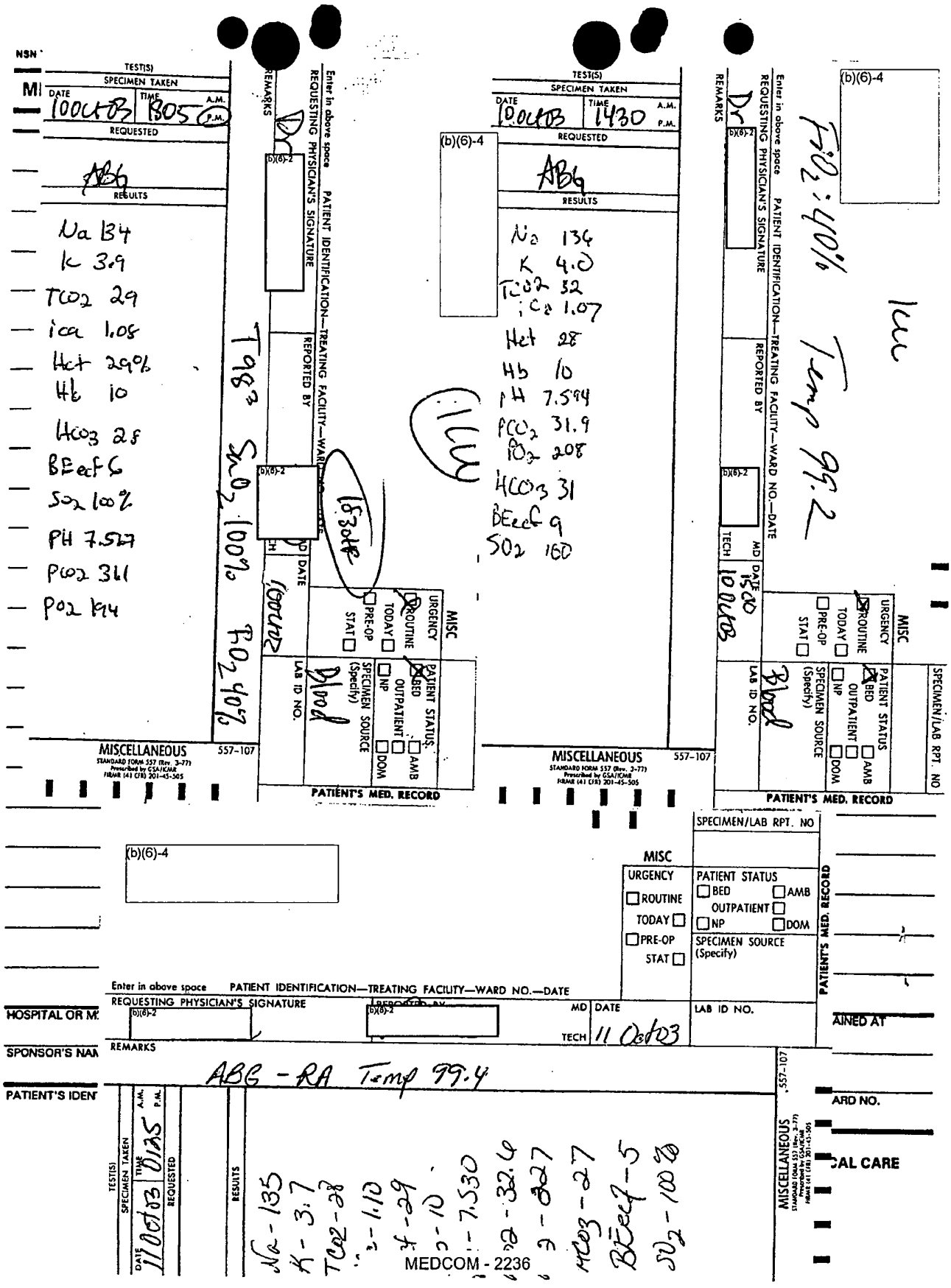
Coagulation

PT		10-13 seconds
APTT		22.1-33.7 seconds
FDP		Negative

Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Negative

MEDCOM - 2235


MISCELLANEOUS
557-107
PATIENT'S MED. RECORD
REQUESTING PHYSICIAN'S SIGNATURE
REMARKS
REPORTED BY
TEST(S)
SPECIMEN TAKEN
REQUESTED
RESULTS
URGENCY
ROUTINE
TODAY
PRE-OP
STAT
PATIENT STATUS
BED
AMB
OUTPATIENT
NP
DOM
SPECIMEN SOURCE (Specify)
LAB ID NO.
SPECIMEN/LAB RPT. NO
MISC
Blood
ABG - RA Temp 99.4
Na - 135
K - 3.7
Tco2 - 28
ica - 1.10
Hct - 29
Hb - 10
pH - 7.530
pco2 - 32.4
po2 - 827
Hco3 - 27
BEecf - 5
So2 - 100%
MEDCOM - 2236

NSN 7540-00-634-4176

TEST(S)

SPECIMEN TAKEN

DATE 09Oct03 TIME 0400 A.M. P.M.

REQUESTED

RESULTS

WBC 12.2
RBC 2.92
Hgb 9.3
Hct 26.5
MCV 90.7
MCH 31.7
MCHC 35.0
PH 354
L/% 12.8
L/# 1.6
ALB 2.3 CHOL 147
ALP 40 CRE 0.8
ALT 22 GLU 114
AMY 113 TP 6.1
AST 28
TBIL 0.6
BUN 10
CA 8.4

REMARKS

CBC, Chem 12

(b)(6)-2

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE

REPORTED BY

(b)(6)-2

MD TECH

DATE 9Oct03

ICU

URGENCY ☐ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT ☑

PATIENT STATUS ☑ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM

SPECIMEN SOURCE (Specify) Blood

LAB ID NO.

MISCELLANEOUS STANDARD FORM 557 (Rev. 3-77) Prescribed by GSA/ICMR FIRMR (41 CFR) 201-45-505 557-107

PATIENT'S MED. RECORD

(b)(6)-4

TEST(S)

SPECIMEN TAKEN

DATE 09Oct03 TIME 1450 A.M. P.M.

REQUESTED

RESULTS

Na - 134
K - 4.5
iCa - 29
TCO2 - 1.10
CPT Temp
PH - 7.532
PCO2 - 33.8
PO2 - 175
HCO3 - 28
BEecf - 6
SO2 - 100

REMARKS

ABG

F:O2 - 60%

T 100.6 ax

(b)(6)-2

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE

REPORTED BY

(b)(6)-2

MD TECH

DATE 9Oct03

(b)(6)-4

CU

MISC

URGENCY ☐ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT ☐

PATIENT STATUS ☐ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM

SPECIMEN SOURCE (Specify)

LAB ID NO.

SPECIMEN/LAB RPT. NO.

MISCELLANEOUS STANDARD FORM 557 (Rev. 3-77) Prescribed by GSA/ICMR FIRMR (41 CFR) 201-45-505 557-107

PATIENT'S MED. RECORD

(b)(6)-4

Critical value on Hgb reported to

CPT

(b)(6)-2 CU

(b)(6)-2

(b)(6)-2

MISC

URGENCY ☐ ROUTINE ☐ TODAY ☐ PRE-OP ☑ STAT ☑

PATIENT STATUS ☑ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM

SPECIMEN SOURCE (Specify) A-line

PATIENT'S MED. RECORD

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE

(b)(6)-2

REPORTED BY

(b)(6)-2

MD TECH

DATE 0545 HR 9Oct03

LAB ID NO.

REMARKS

ABG Temp 101, O2 ~~B~~ 102 50%

HOSPITAL OR MED

SPONSOR'S NAMI

PATIENT'S IDENTI

(b)(6)-4

SPECIMEN TAKEN

DATE 09.00 TIME 0500 A.M. P.M.

REQUESTED

RESULTS

Na 134
K 4.5
TCO2 30
iCa 1.07
Hct 24%
Hb F CU
HCO3 29
BEecf 6
SO2 100%
PH 7.493
PCO2 38.3
PO2 263

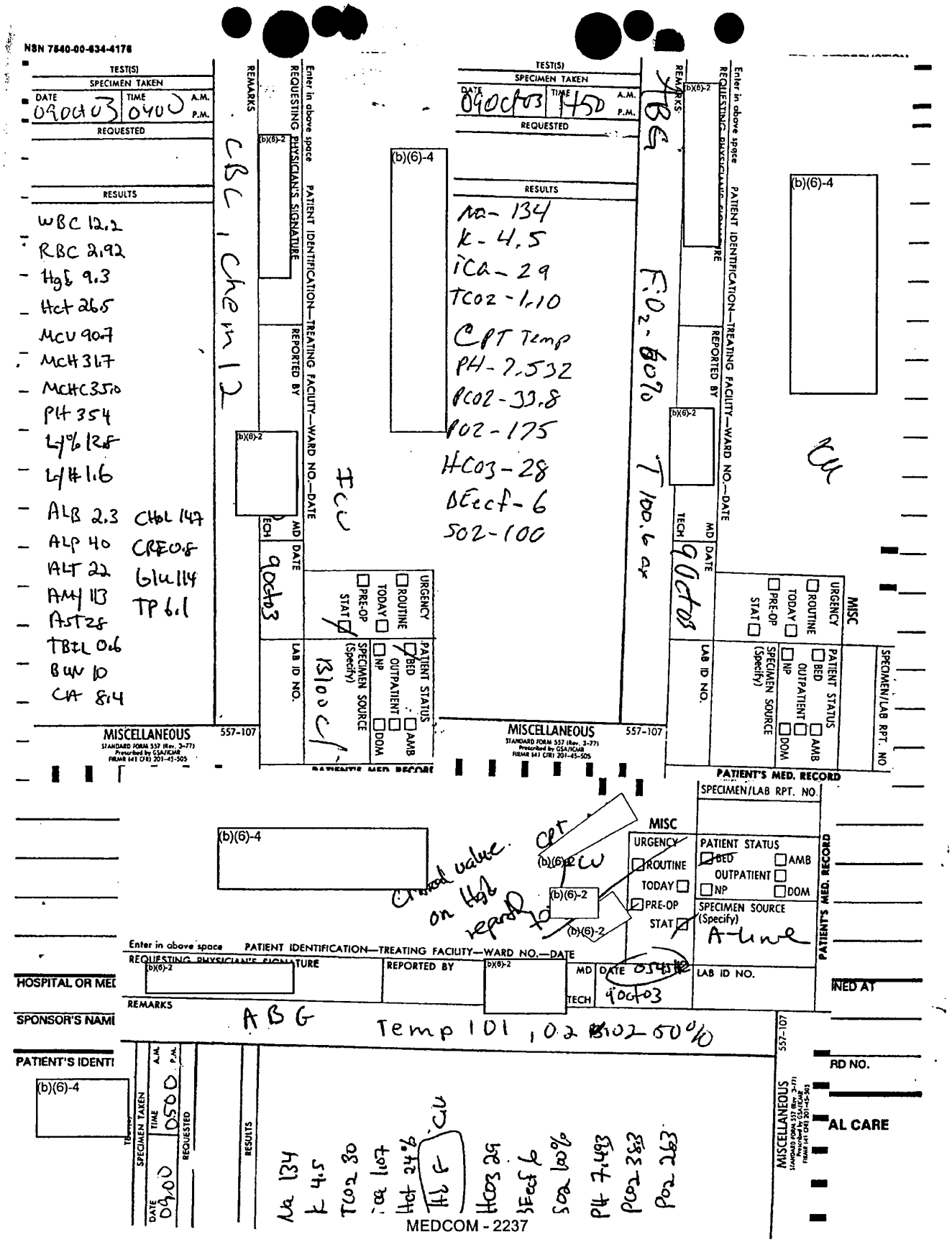
MISCELLANEOUS STANDARD FORM 557 (Rev. 3-77) Prescribed by GSA/ICMR FIRMR (41 CFR) 201-45-505 557-107

INED AT

RD NO.

AL CARE

MEDCOM - 2237



STANDARD FORM 600 (REV. 6-97) BACK

FPL LEX Printed on Recycled Paper

(b)(6)-4

FiO_2: 40% Temp: 100.7

SPECIMEN/LAB RPT. NO

MISC

URGENCY
☐ ROUTINE
TODAY ☐
☐ PRE-OP
STAT ☐

PATIENT STATUS
☐ BED ☐ AMB
OUTPATIENT ☐
☐ NP ☐ DOM

SPECIMEN SOURCE (Specify)

PATIENT'S MED. RECORD

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

(b)(6)-2 S SIGNATURE

REMARKS

REPORTED BY (b)(6)-2 MD TECH

DATE 10 Oct 03

LAB ID NO.

TEST(S) REQUESTED	SPECIMEN TAKEN DATE	TIME A.M. P.M.	RESULTS
ABG	10-10-03	1251	Na-136 K-3.9 iCa-1.05 TCO2-29 HCO3-28 BE(ecf)-6 SO2-100 @ pt temp PH-7.550 PCO2-32.2 PO2-200

557-107 MISCELLANEOUS

SYMPTOMS, DIAGNOSIS, TREATING ORGANIZATION (Sign each entry) DATE

MEDCOM - 2238

AUTHORIZED FOR LOCAL REPRODUCTION

ICU

TEST(S)

SPECIMEN TAKEN

DATE 7Oct03 TIME 1915 A.M. P.M.

REQUESTED

RESULTS

Na- 140
K- 3.4
TCO2-31
iCa-1.09
Hct-25
Hb-9
@pt temp
ph-7.520
PCO2-37.4
PO2-138

HCO3-30
BEecf-8
SO2-99%

HBG FIO2 50% Vent P100.5

(b)(6)-2

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

(b)(6)-4

(b)(6)-2

(b)(6)-2

MD DATE 7Oct03

MISC

URGENCY ☐ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT

PATIENT STATUS ☐ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM

SPECIMEN SOURCE (Specify) Blood

LAB ID NO.

MISCELLANEOUS 557-107

STANDARD FORM 557 (Rev. 3-77) Prescribed by GSA/ICMR FIRMR (41 CFR) 201-45-505

PATIENT'S MED. RECORD

TEST(S)

SPECIMEN TAKEN

DATE 7Oct03 TIME 1800 A.M. P.M.

REQUESTED

ABG

RESULTS

Na 139
K 3.4
TCO2 31
iCa 1.06
Hct 25%
Hb 9
HCO3 30
BEecf 8
SO2 99%
pH 7.525
PCO2 37.0
PO2 134
patient Temp - 100.7
FIO2 97

U

T-100.7

FIO2 60% SaO2 97%

REMARKS

Dr

(b)(6)-2

REQUESTING PHYSICIAN'S SIGNATURE

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REPORTED BY

(b)(6)-2

(b)(6)-4

ICU

MD DATE 7Oct03

MISC

URGENCY ☒ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT

PATIENT STATUS ☒ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM

SPECIMEN SOURCE (Specify) Blood

LAB ID NO. 18STHR

SPECIMEN/LAB RPT. NO

MISCELLANEOUS 557-107

STANDARD FORM 557 (Rev. 3-77) Prescribed by GSA/ICMR FIRMR (41 CFR) 201-45-505

PATIENT'S MED. RECORD

(b)(6)-4

RELATION

DEPART./S

PATIENT'S

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE (b)(6)-2

REPORTED BY

MD DATE 8 Oct 03

(b)(6)-2

SPECIMEN/LAB RPT. NO

MISC

URGENCY ☐ ROUTINE ☐ TODAY ☐ PRE-OP ☒ STAT

PATIENT STATUS ☐ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM

SPECIMEN SOURCE (Specify)

LAB ID NO.

PATIENT'S MED. RECORD

R'S ID NUMBER

Other)

ID NO.

REMARKS 50% 98.5

TEST(S)

SPECIMEN TAKEN

TIME A.M. P.M.

03 0010

REQUESTED

RESULTS

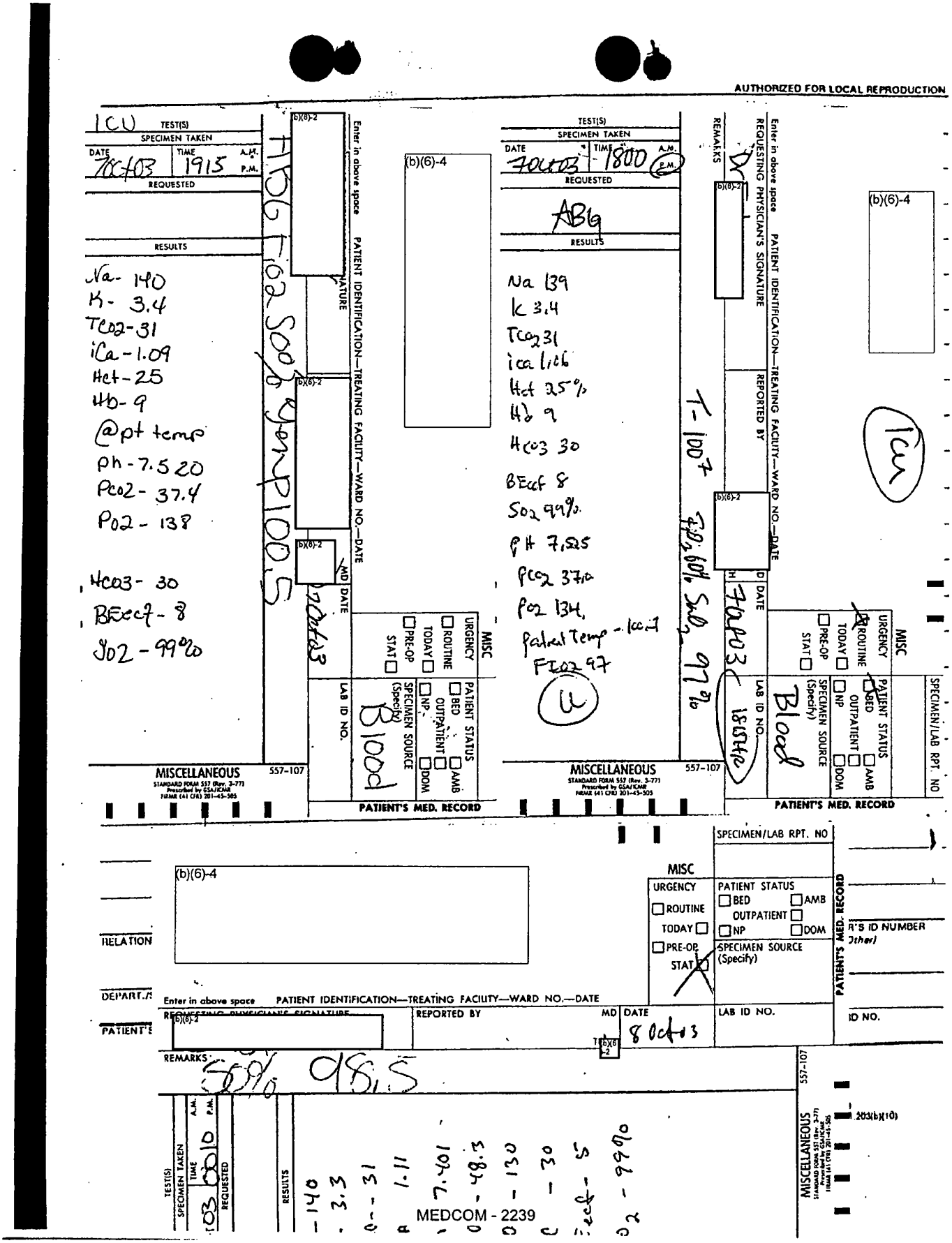
-140
-3.3
-31
1.11
7.401
-48.3
-130
-30
Eecf-5
O2-99%

MISCELLANEOUS 557-107

STANDARD FORM 557 (Rev. 3-77) Prescribed by GSA/ICMR FIRMR (41 CFR) 201-45-505

203(b)(10)

MEDCOM - 2239



NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

TEST(S)
SPECIMEN TAKEN
DATE 10/8/03 TIME 2150 A.M. P.M.
REQUESTED

RESULTS
Na - 138
K - 4.2
TCO2 - 31
iCa - 1.09
Hct - 26
Hb - 9
HCO3 - 29
BEect - 6
SO2 - 97%
@ pt. temp.
ph - 7.453
PCO2 - 42.7
PO2 - 96

(b)(6)-2
Enter in above space
PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REQUESTING PHYSICIAN'S SIGNATURE
REP
(b)(6)-2
(b)(6)-2
(b)(6)-4

FiO2 50 Temp 101.5

MISC
URGENCY
☐ ROUTINE
TODAY ☐
☐ PRE-OP
STAT ☒
PATIENT STATUS
☒ BED ☐ AMB
☐ OUTPATIENT
☐ NP ☐ DOM
SPECIMEN SOURCE (Specify)
LAB ID NO.
Aline

MISCELLANEOUS 557-107
STANDARD FORM 557 (Rev. 3-77)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45-505

TEST(S)
SPECIMEN TAKEN
DATE 6 Oct 03 TIME 1453 A.M. P.M.
REQUESTED

RESULTS
Na - 144
K - 3.9
TCO2 - 38
iCa - 1.08
HCO3 - 36
BEect - 12
SO2 - 100
PH - 7.415
PCO2 - 57.1
PO2 - 190
@ pt temp

FiO2 - 45% T - 99.7

REMARKS
(b)(6)-2
Enter in above space
REQUESTING PHYSICIAN'S SIGNATURE
PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REPORTED BY
(b)(6)-2
MD
TECH
DATE 6 Oct 03
LAB ID NO.
(b)(6)-4
ICU

MISC
URGENCY
☐ ROUTINE
TODAY ☐
☐ PRE-OP
STAT ☐
PATIENT STATUS
☐ BED ☐ AMB
☐ OUTPATIENT
☐ NP ☐ DOM
SPECIMEN SOURCE (Specify)
SPECIMEN/LAB RPT. NO.

MISCELLANEOUS 557-107
STANDARD FORM 557 (Rev. 3-77)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45-505

SPECIMEN/LAB RPT. NO.
CORD

(b)(6)-4
ICU

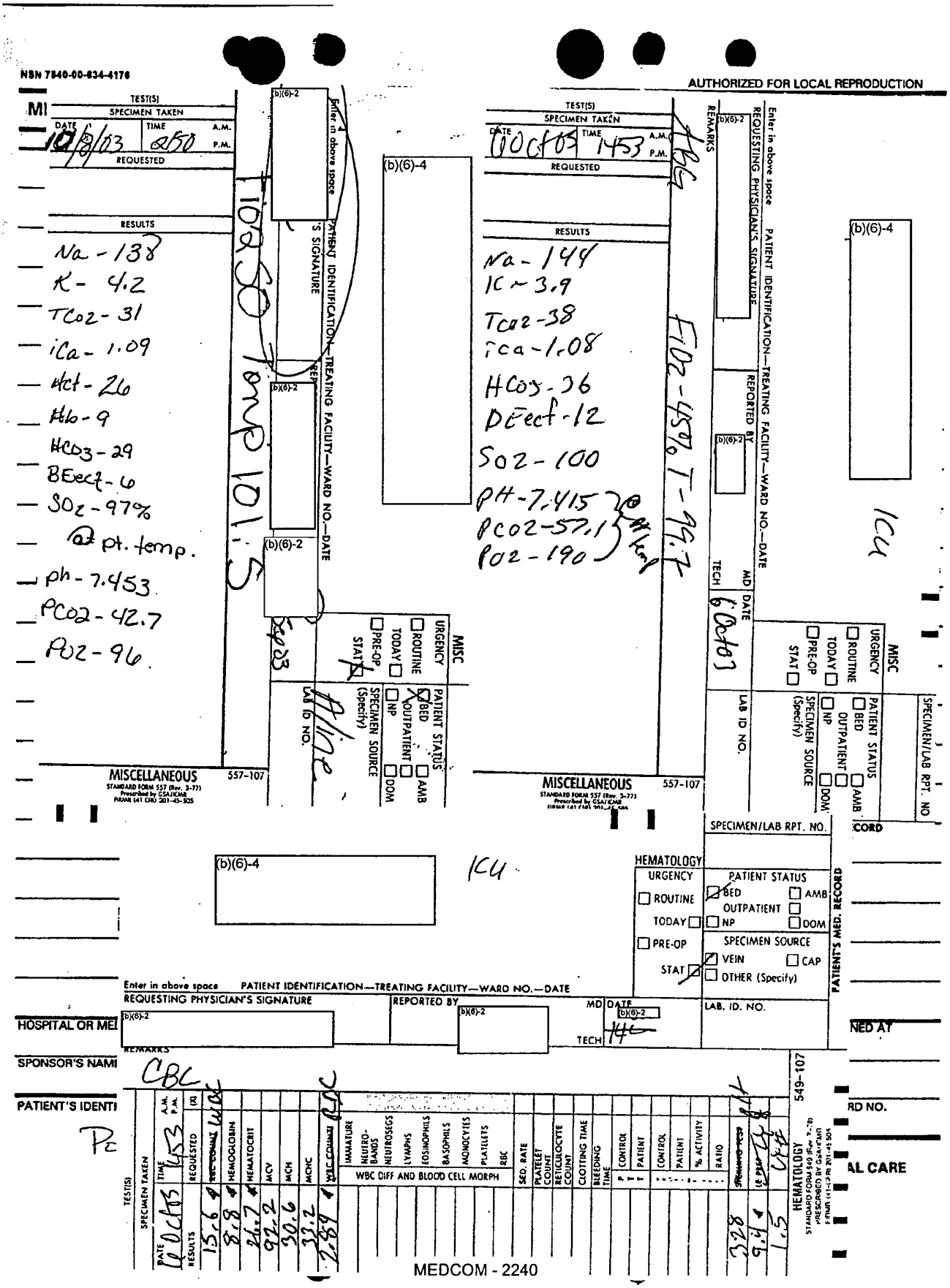
HEMATOLOGY
URGENCY
☐ ROUTINE
TODAY ☐
☐ PRE-OP
STAT ☒
PATIENT STATUS
☒ BED ☐ AMB
☐ OUTPATIENT
☐ NP ☐ DOM
SPECIMEN SOURCE
☒ VEIN ☐ CAP
☐ OTHER (Specify)
PATIENT'S MED. RECORD

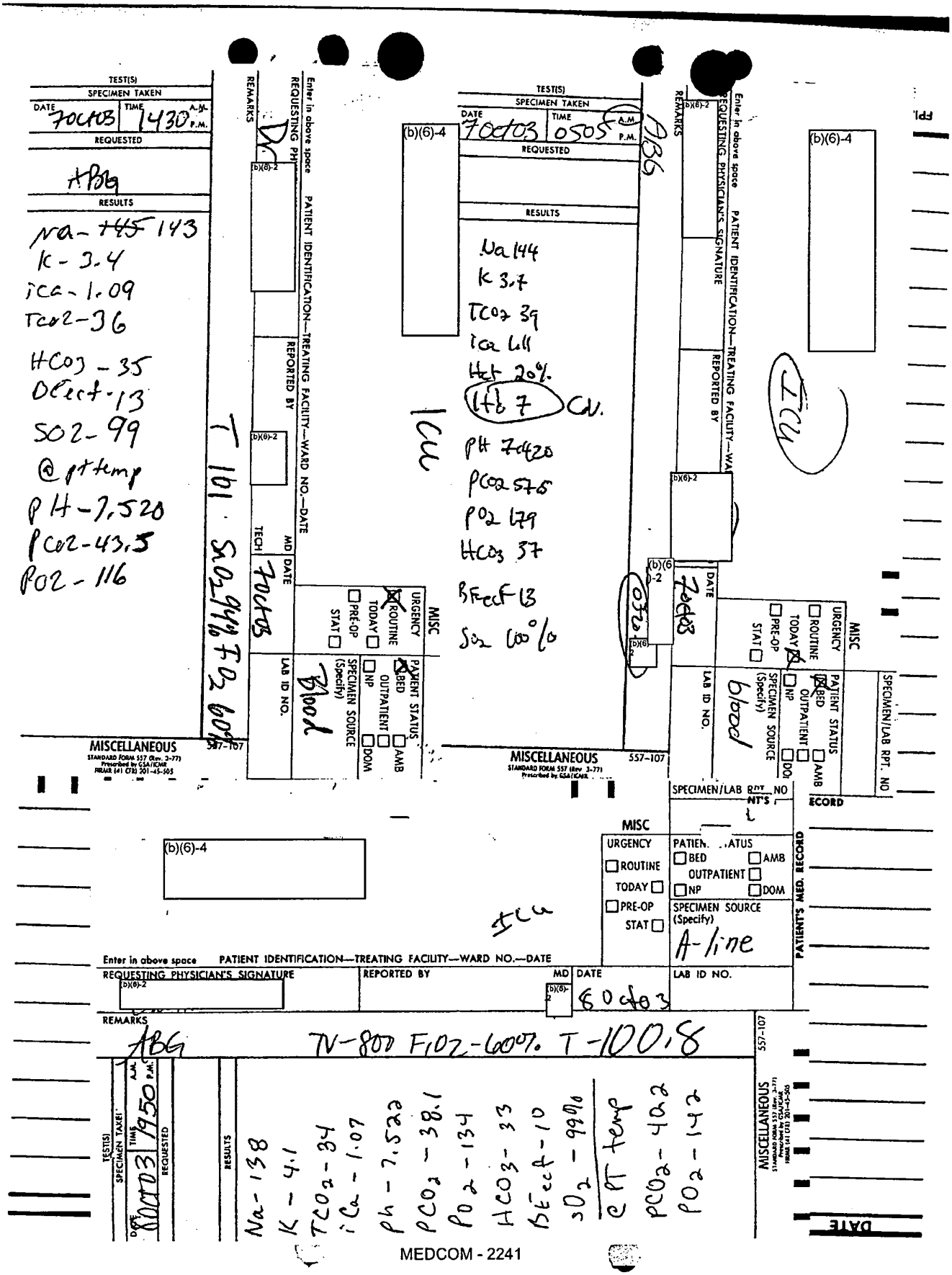
Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REQUESTING PHYSICIAN'S SIGNATURE
REPORTED BY
(b)(6)-2
(b)(6)-2
MD
DATE
(b)(6)-2
TECH
LAB. ID. NO.

HOSPITAL OR MEI
NED AT
SPONSOR'S NAMI
REMARKS
CBC
PATIENT'S IDENTI
RD NO.
Pc
AL CARE

TEST(S)
SPECIMEN TAKEN
DATE 6 Oct 03 TIME 1453 A.M. P.M.
REQUESTED (X)
RESULTS
15.6 WBC
8.8 HEMOGLOBIN
26.7 HEMATOCRIT
92.2 MCV
30.6 MCH
33.2 MCHC
2.89 WBC COUNT RBC
IMMATURE
NEUTRO-BANDS
NEUTROSEGS
LYMPHS
EOSINOPHILS
BASOPHILS
MONOCYTES
PLATELETS
RBC
WBC DIFF AND BLOOD CELL MORPH
SED. RATE
PLATELET COUNT
RETICULOCYTE COUNT
CLOTTING TIME
BLEEDING TIME
CONTROL
PATIENT
CONTROL
PATIENT
% ACTIVITY
RATIO
328
9.4
1.5
549-107
HEMATOLOGY
STANDARD FORM 549 (Rev. 7-78)
PRESCRIBED BY GSA/ICMR
FIRMR (41 CFR) 201-45-505

MEDCOM - 2240




MISCELLANEOUS
MISC
PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REQUESTING PHYSICIAN'S SIGNATURE
REPORTED BY
LAB ID NO.
SPECIMEN SOURCE (Specify)
A-line
MEDCOM - 2241

TEST(S)
SPECIMEN TAKEN
DATE 5 Oct 03 TIME 1630 A.M. P.M.
REQUESTED
ABG
RESULTS
Na 139
K 3.3
TCO_2 41
iCa 1.05
Hct 22
Hb 7
pH 7.509
PCO_2 50.2
PO_2 209
HCO_3 40
BEecf 17
SO_2 100

SaO_2 100% FiO_2 50% T 99.4 Ax

REMARKS
Dr
(b)(6)-2
Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REQUESTING PHYSICIAN'S SIGNATURE
REPORTED BY
(b)(6)-2
MD DATE 5 Oct 03 1645
TECH
LAB ID NO.
MISC
URGENCY ☒ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT
PATIENT STATUS ☒ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM
SPECIMEN SOURCE (Specify) Blood
MISCELLANEOUS 557-107
STANDARD FORM 557 (Rev. 3-77)

(b)(6)-4

ICU

TEST(S)
SPECIMEN TAKEN
DATE 5 Oct 03 TIME 1200 A.M. P.M.
REQUESTED
ABG
RESULTS
Na 137
K 3.4
TCO_2 42
iCa 1.00
Hct 24
Hb 8
pH 7.400
PCO_2 64.9
PO_2 165
HCO_3 40
BEecf 15
SO_2 99

(b)(6)-2
Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REQUESTING PHYSICIAN'S SIGNATURE
REPORTED BY
(b)(6)-2
MD DATE 5 Oct 1205
TECH
LAB ID NO.
MISC
URGENCY ☐ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT
PATIENT STATUS ☐ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM
SPECIMEN SOURCE (Specify)
SPECIMEN/LAB RPT. NO.
MISCELLANEOUS 557-107
STANDARD FORM 557 (Rev. 3-77)

(b)(6)-4

FiO_2: 70% Temp: 99.5

ICU

(b)(6)-4

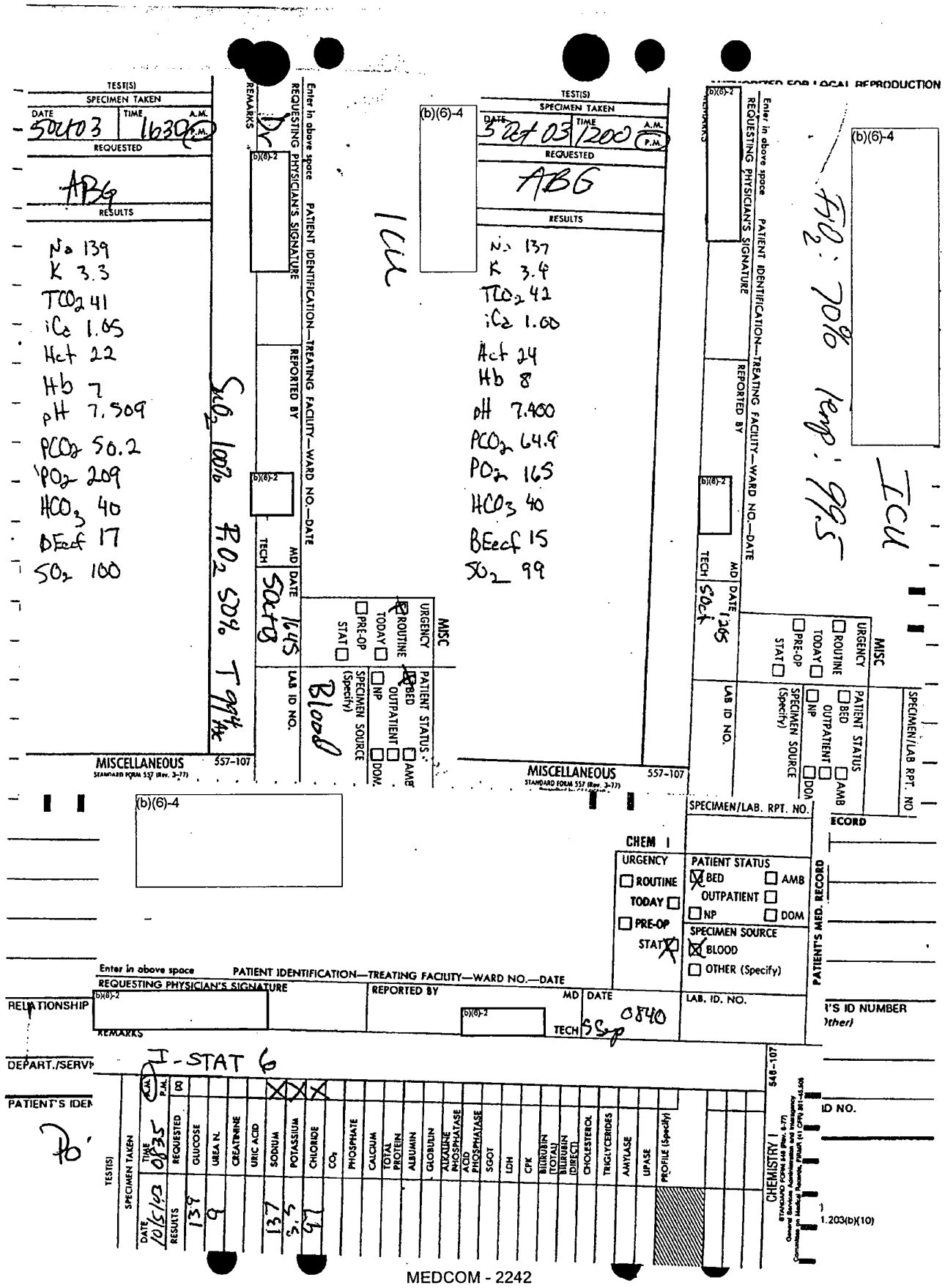
SPECIMEN/LAB. RPT. NO.
RECORD
CHEM I
URGENCY ☐ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT ☒
PATIENT STATUS ☒ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM
SPECIMEN SOURCE ☒ BLOOD ☐ OTHER (Specify)
PATIENT'S MED. RECORD
Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REQUESTING PHYSICIAN'S SIGNATURE
(b)(6)-2
REPORTED BY
(b)(6)-2
MD DATE 5 Sep 0840
TECH
LAB. ID. NO.
RELATIONSHIP
DEPART./SERVI
PATIENT'S IDEN
Po'
REMARKS
I-STAT 6

TEST(S)	SPECIMEN TAKEN		REQUESTED	GLUCOSE	UREA N.	CREATININE	URIC ACID	SODIUM	POTASSIUM	CHLORIDE	CO_2	PHOSPHATE	CALCIUM	TOTAL PROTEIN	ALBUMIN	GLOBULIN	ALKALINE PHOSPHATASE	ACID PHOSPHATASE	SGOT	LDH	CPK	BILIRUBIN (TOTAL)	BILIRUBIN (DIRECT)	CHOLESTEROL	TRIGLYCERIDES	AMYLASE	LIPASE	PROFILE (Specify)
	DATE 10/5/03	TIME 0835 A.M. P.M.																										
	RESULTS			139	9			137	3.5	97																		

CHEMISTRY I 548-107
STANDARD FORM 548 (Rev. 8-77)
General Services Administration and Interagency
Committee on Medical Records, FPMR (41 CFR) 201-45.505

ID NO.
1.203(b)(10)

MEDCOM - 2242



STANDARD FORM 509 (REV. 5-89) BACK

FPI LEX Printed on Recycled Paper

TEST(S)

SPECIMEN TAKEN

DATE	TIME	A.M. / P.M.
5oct03	0500	

REQUESTED

RESULTS

Na 136
K 3.7
TCO2 43
ica 1.01
Hct 24%
Hb 8 C.V.
HCO3 41
BEef 15
SO2 100%
patient Temp 98.8
FIO2 1.0.
PH - 7.345
PCO2 73.6
PO2 226

REMARKS ABG

(b)(6)-2

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE

(b)(6)-4

REPORTED BY

FIO2 1.0
T 988

(b)(6)-2

MD ECH

DATE 5oct03

0530 (b)(6)-2

MISC

URGENCY ☐ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT

PATIENT STATUS ☐ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM

SPECIMEN SOURCE (Specify)

LAB ID NO.

SPECIMEN/LAB RPT. NO

MISCELLANEOUS 557-107

STANDARD FORM 557 (Rev. 3-77) Prescribed by GSA/ICMR FIRMR (41 CFR) 201-45-505

PATIENT'S MED. RECORD

TEST(S)

SPECIMEN TAKEN

DATE	TIME	A.M. / P.M.
5oct03	0500	

RESULTS	REQUESTED	(X)
2.94	RBC COUNT	
9.4	HEMOGLOBIN	
26.5	HEMATOCRIT	
90.1	MCV	
31.9	MCH	
35.4	MCHC	
9.1	WBC COUNT	
	WBC DIFF AND BLOOD CELL MORPH: IMMATURE	
	NEUTRO-BANDS	
	NEUTROSEGS	
	LYMPHS	
	EOSINOPHILS	
	BASOPHILS	
	MONOCYTES	
	PLATELETS	
	RBC	
	SED. RATE	
181	PLATELET COUNT	
	RETICULOCYTE COUNT	
	CLOTTING TIME	
	BLEEDING TIME	
	PTT: CONTROL	
	PATIENT	
	PROTHROMBIN: CONTROL	
	PATIENT	
	% ACTIVITY	
	RATIO	
	SICKLING TEST	
5.6	~~[illegible]~~ 4%	
0.5	4#	

CBC

REMARKS

(b)(6)-2

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE

(b)(6)-4

REPORTED BY

ICU

(b)(6)-2

MD ECH

DATE 5oct03

0535 (b)(6)-2

HEMATOLOGY

URGENCY ☐ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT

PATIENT STATUS ☐ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM

SPECIMEN SOURCE ☐ VEIN ☐ CAP ☐ OTHER (Specify)

LAB. ID. NO.

SPECIMEN/LAB RPT. NO.

HEMATOLOGY 549-107

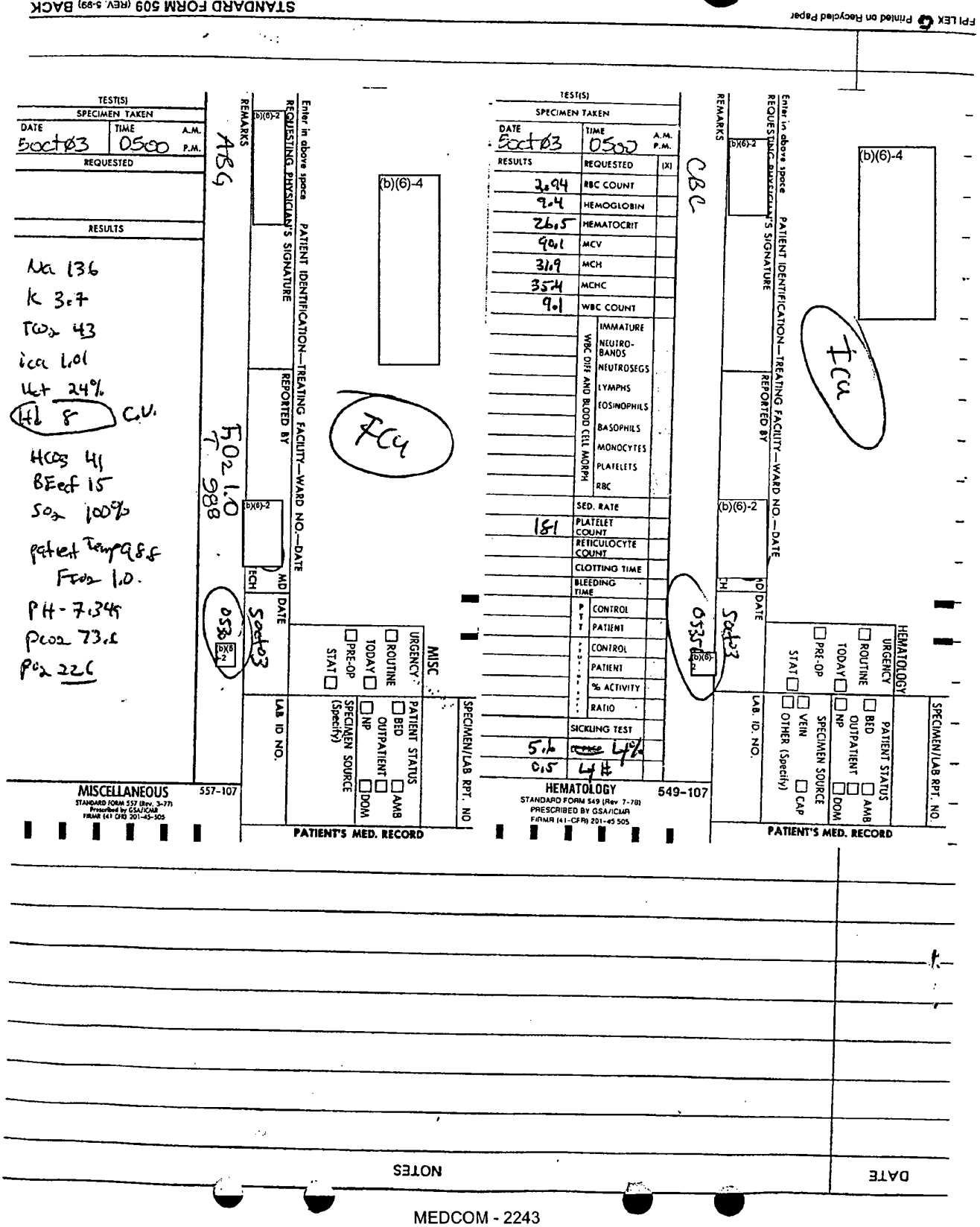
STANDARD FORM 549 (Rev. 7-78) PRESCRIBED BY GSA/ICMR FIRMR (41-CFR) 201-45 505

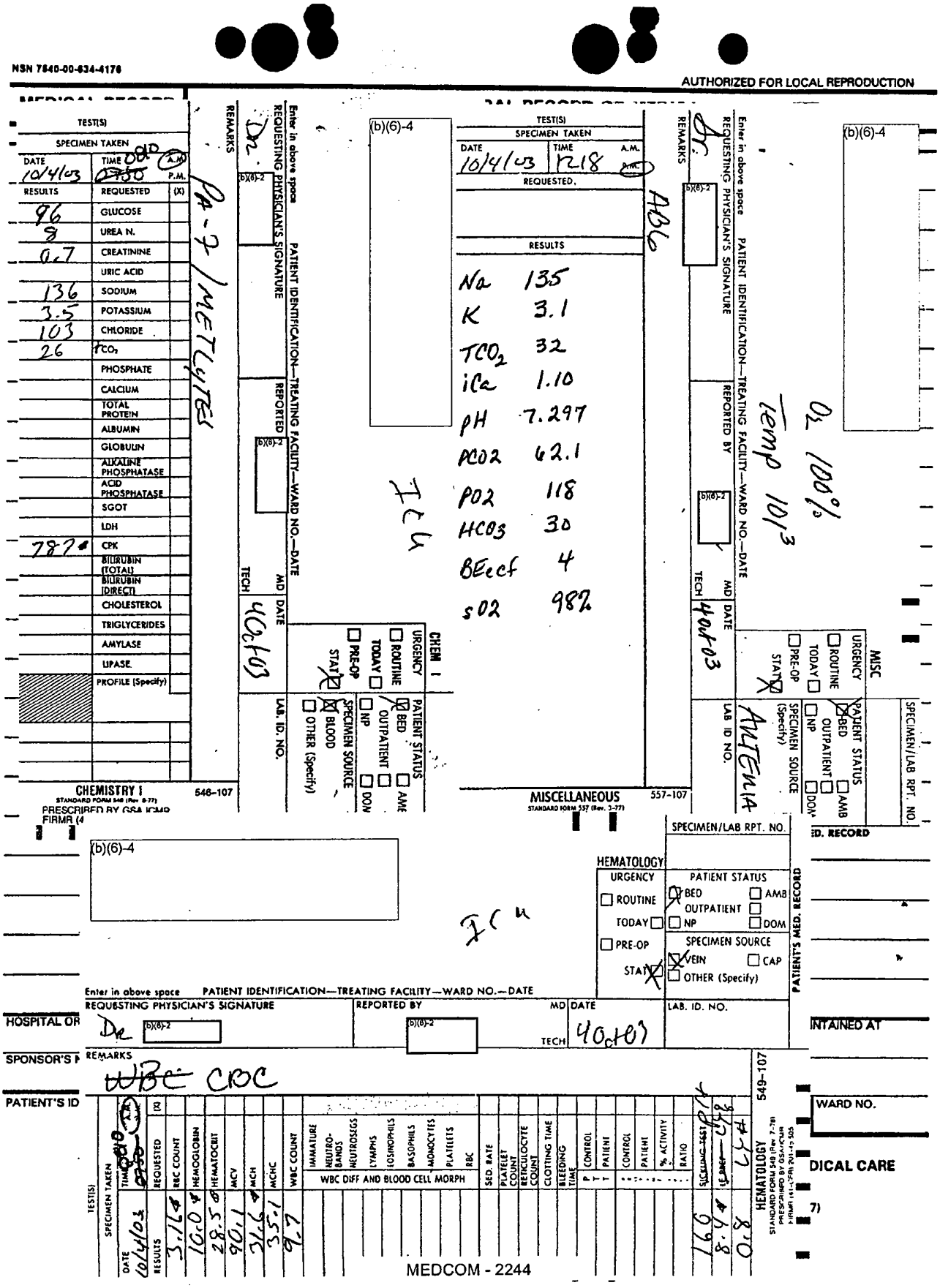
PATIENT'S MED. RECORD

NOTES

DATE

MEDCOM - 2243





NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

CHEMISTRY I
STANDARD FORM 548 (Rev. 8-77)
546-107

MISCELLANEOUS
STANDARD FORM 557 (Rev. 3-77)
557-107

HEMATOLOGY
STANDARD FORM 549 (Rev. 7-78)
549-107

MEDCOM - 2244

TEST(S)
SPECIMEN TAKEN
DATE 4Oct03 TIME 1802 A.M. P.M.
REQUESTED
RESULTS
Na - 135
K - 3.6
TCO_2 - 36
iCa - 1.04
HCT - 29
HGB - 10
pH - 7.219
PCO_2 - 85.4
PO_2 - 170

ABG

FIO_2 - 100%

T - 102.5

REMARKS
(b)(6)-2
REQUESTING PHYSICIAN'S SIGNATURE
(b)(6)-2
REPORTED BY
(b)(6)-2
MD
TECH
DATE 4Oct03 1814
LAB ID NO.
MISC
URGENCY ☐ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT
PATIENT STATUS ☐ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM
SPECIMEN SOURCE (Specify)
Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
(b)(6)-4

ICU

MISCELLANEOUS
STANDARD FORM 557 (Rev. 3-77)
Prescribed by GSA/ICMR
557-107

TEST(S)
SPECIMEN TAKEN
DATE 4Oct03 TIME 1831 A.M. P.M.
REQUESTED
RESULTS
Na - 135
K - 3.3
TCO_2 - 33
iCa - 1.06
@pt temp
pH - 7.255
PCO_2 - 70.9
PO_2 - 107
HCO_3 - 31
BEecf - 4
SO_2 - 96

ABG

FIO_2 - 100%
T - 101.7

REMARKS
(b)(6)-2
REQUESTING PHYSICIAN'S SIGNATURE
(b)(6)-2
REPORTED BY
(b)(6)-2
MD
TECH
DATE 4Oct03
LAB ID NO.
MISC
URGENCY ☐ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT ☒
PATIENT STATUS ☐ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM
SPECIMEN SOURCE (Specify)
SPECIMEN/LAB RPT. NO.
PATIENT'S MED. RECORD
(b)(6)-4

MISCELLANEOUS
STANDARD FORM 557 (Rev. 3-77)
Prescribed by GSA/ICMR
557-107

(b)(6)-4

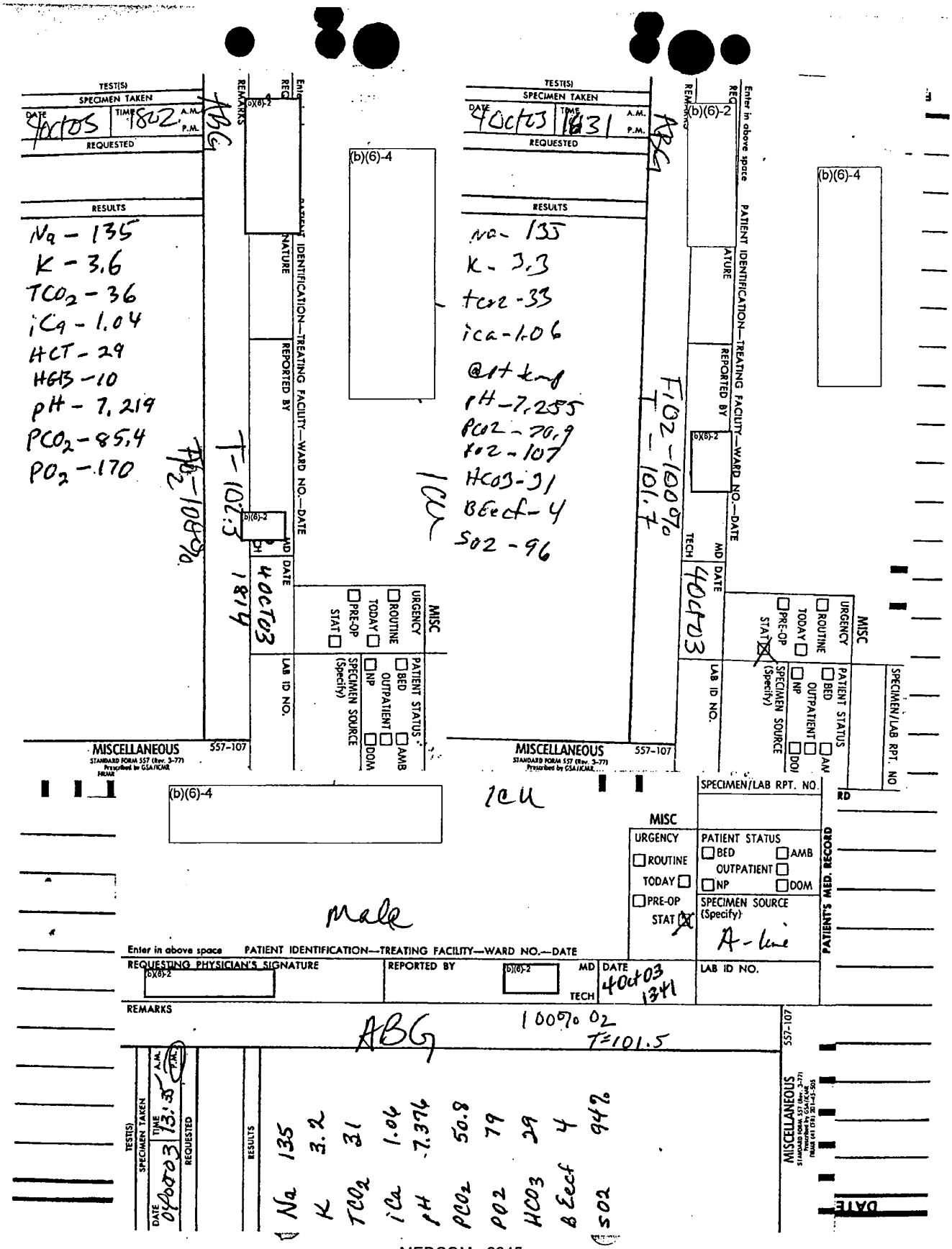
ICU

Male

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REQUESTING PHYSICIAN'S SIGNATURE
(b)(6)-2
REPORTED BY
(b)(6)-2
MD
TECH
DATE 4Oct03 1341
LAB ID NO.
REMARKS
ABG
100% O_2
T=101.5

TEST(S)
SPECIMEN TAKEN
DATE 04Oct03 TIME 13:35 A.M. P.M.
REQUESTED
RESULTS
Na 135
K 3.2
TCO_2 31
iCa 1.06
pH 7.376
PCO_2 50.8
PO_2 79
HCO_3 29
BEecf 4
SO_2 94%

MISCELLANEOUS
STANDARD FORM 557 (Rev. 3-77)
Prescribed by GSA/ICMR
557-107



MEDCOM - 2245

ACLU-RDI 1099 p.1029

DOD 006297

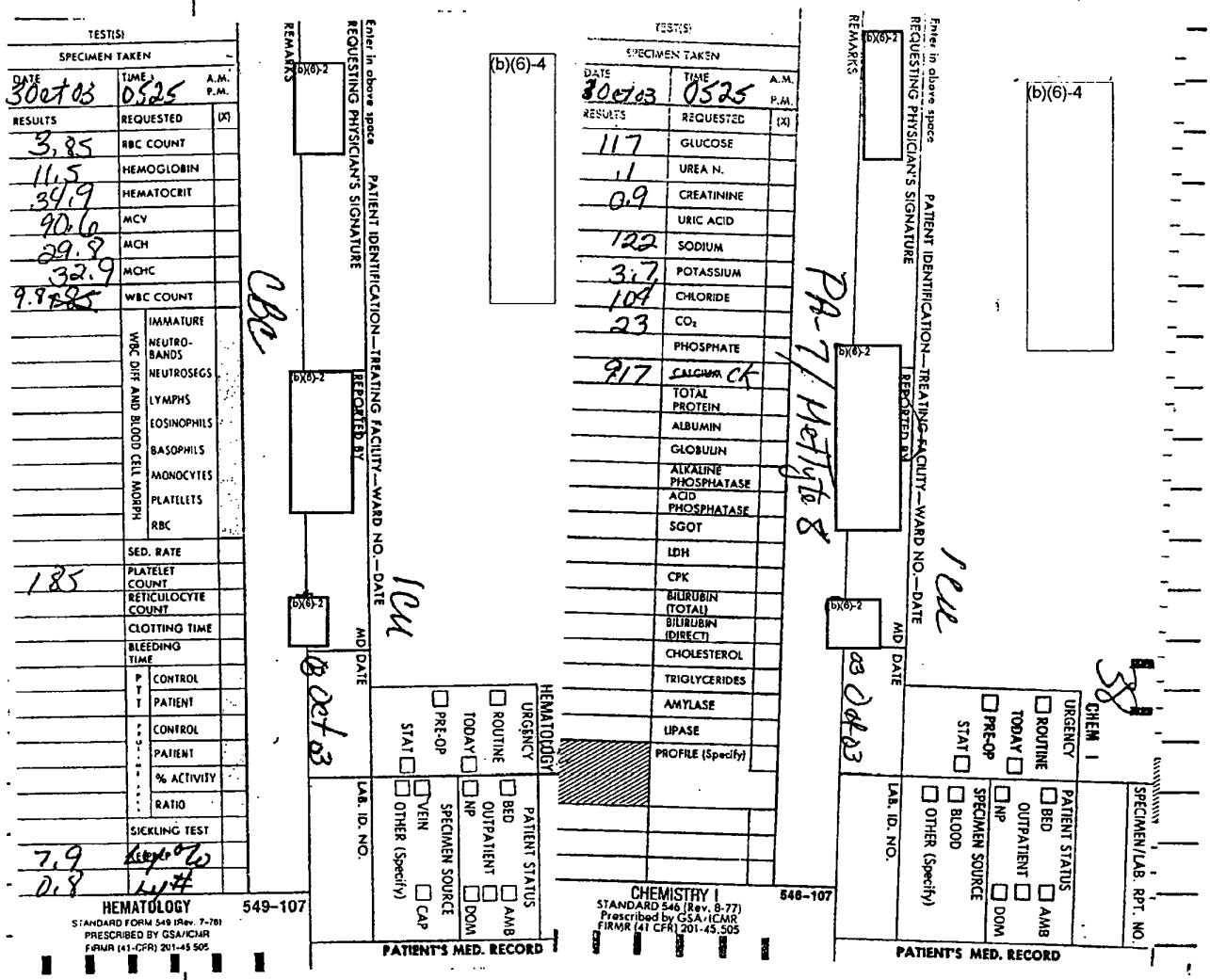
NSN 7540-00-634-4176

LABS

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — ~~CHRONOLOGICAL RECORD OF MEDICAL CARE~~

DATE | SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*



HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* | REGISTER NO. | WARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

MEDCOM - 2246

STANDARD FORM 600 (REV. 6-97) BACK

FPI, LEX Printed on Recycled Paper

TEST(S)

SPECIMEN TAKEN

DATE 4oct TIME 2121 A.M. P.M.

REQUESTED

RESULTS

Na 134
K 3.7
TCO2 36
ica 1.03
Hct 25
Hg 9
ACO3 34
BEecf 7
SO2 95%
PH 7.252
PCO2 77.7
PO2 96
Temp 101.6
FIO2 100

100%

101.6

Tmcoutp. 2135HR

(b)(6)-2

REMARKS

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD

REQUESTING PHYSICIAN'S SIGNATURE

REPORTED BY

(b)(6)-2

DATE 4oct03 2121

LAB ID NO.

URGENCY ☐ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT

PATIENT STATUS ☐ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM

SPECIMEN SOURCE (Specify)

MISCELLANEOUS 557-107

STANDARD FORM 557 (Rev. 3-77) Prescribed by GSA/ICMR FIRMR (41 CFR) 201-45-505

PATIENT'S MED. RECOR

(b)(6)-4

ICU

TEST(S)

SPECIMEN TAKEN

DATE 4oct03 TIME 0153 A.M. P.M.

REQUESTED

RESULTS

Na 135
K 3.2
TCO2 29
ica 1.15
Hct 20%
Hb 7
HCO3 28
BEecf 4
SO2 85%
PH 7.439
PCO2 41.2
PO2 52.
FIO2 100%
Temp 100.7°F

C.V. reported to CPT Vandelaar

REMARKS

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—W

REQUESTING PHYSICIAN'S SI

REPORTED BY

(b)(6)-2

(b)(6)-2

DATE 4oct03 0220HR

LAB ID NO.

URGENCY ☐ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT

MISC

PATIENT STATUS ☐ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM

SPECIMEN SOURCE (Specify)

SPECIMEN/LAB RPT. NO.

MISCELLANEOUS 557-107

STANDARD FORM 557 (Rev. 3-77) Prescribed by GSA/ICMR FIRMR (41 CFR) 201-45-505

PATIENT'S MED. RECORD

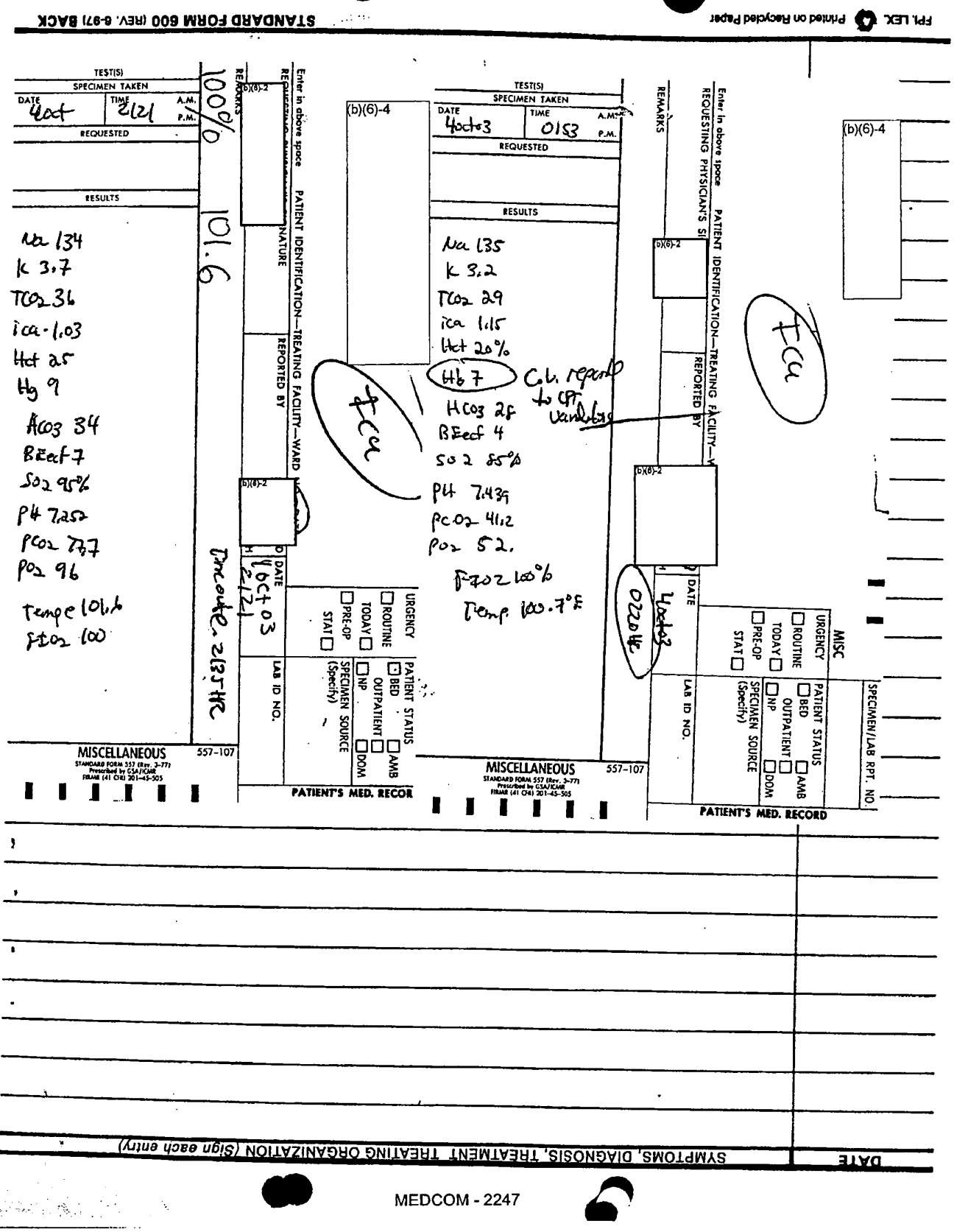
(b)(6)-4

ICU

DATE

SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)

MEDCOM - 2247



TEST(S)

SPECIMEN TAKEN

DATE	TIME	A.M. / P.M.
2oct	1200	

RESULTS	REQUESTED	(X)
128	GLUCOSE	
13	UREA N.	
0.7	CREATININE	
	URIC ACID	
138	SODIUM	
4.0	POTASSIUM	
107	CHLORIDE	
	CO_2	
	PHOSPHATE	
	CALCIUM	
	TOTAL PROTEIN	
	ALBUMIN	
	GLOBULIN	
	ALKALINE PHOSPHATASE	
	ACID PHOSPHATASE	
	SGOT	
	LDH	
	CPK	
	BILIRUBIN (TOTAL)	
	BILIRUBIN (DIRECT)	
	CHOLESTEROL	
	TRIGLYCERIDES	
	AMYLASE	
	LIPASE	
	PROFILE (Specify)	

REMARKS: Ista+6/Ca

(b)(6)-2

(b)(6)-4

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE

REPORTED BY

(b)(6)-2

MD / TECH

DATE: 2oct03

LAB. ID. NO.

CHEM I

URGENCY: ☐ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT

PATIENT STATUS: ☐ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM

SPECIMEN SOURCE: ☐ BLOOD ☐ OTHER (Specify)

PATIENT'S MED. RECORD

CHEMISTRY I

STANDARD 546 (Rev. 8-77)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505

546-107

TEST(S)

SPECIMEN TAKEN

DATE	TIME	A.M. / P.M.
2oct03	1200	

RESULTS	REQUESTED	(X)
4.48	RBC COUNT	
14.0	HEMOGLOBIN	
39.9	HEMATOCRIT	
89.1	MCV	
31.7	MCH	
35.0	MCHC	
3.9	WBC COUNT	
	WBC DIFF AND BLOOD CELL MORPH: IMMATURE	
	NEUTRO-BANDS	
	NEUTROSEGS	
	LYMPHS	
	EOSINOPHILS	
	BASOPHILS	
	MONOCYTES	
	PLATELETS	
	RBC	
	SED. RATE	
	PLATELET COUNT	
	RETICULOCYTE COUNT	
	CLOTTING TIME	
	BLEEDING TIME	
	PTT: CONTROL	
	PTT: PATIENT	
	PROTHROMBIN: CONTROL	
	PROTHROMBIN: PATIENT	
	PROTHROMBIN: % ACTIVITY	
	PROTHROMBIN: RATIO	
234	SICKLING TEST	
16.1	LE PREP	LT
0.6		4#

REMARKS: CBC

(b)(6)-2

(b)(6)-4

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE

REPORTED BY

(b)(6)-2

MD / TECH

DATE: 2oct03

LAB. ID. NO.

HEMATOLOGY

URGENCY: ☐ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT

PATIENT STATUS: ☐ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM

SPECIMEN SOURCE: ☐ VEIN ☐ CAP ☐ OTHER (Specify)

SPECIMEN/LAB RPT NO

PATIENT'S MED. RECORD

HEMATOLOGY

STANDARD FORM 549 (Rev. 7-78)
PRESCRIBED BY GSA/ICMR
FIRMR (41-CFR) 201-45.505

549-107

(b)(6)-4

HEMATOLOGY

URGENCY: ☐ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT

PATIENT STATUS: ☐ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM

SPECIMEN SOURCE: ☐ VEIN ☐ CAP ☐ OTHER (Specify)

PATIENT'S MED. RECORD

1Cu

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE: Dr

(b)(6)-2

REPORTED BY

(b)(6)-2

MD / TECH

DATE: 2oct03

LAB. ID. NO.

REMARKS: CBC

TEST(S)

SPECIMEN TAKEN

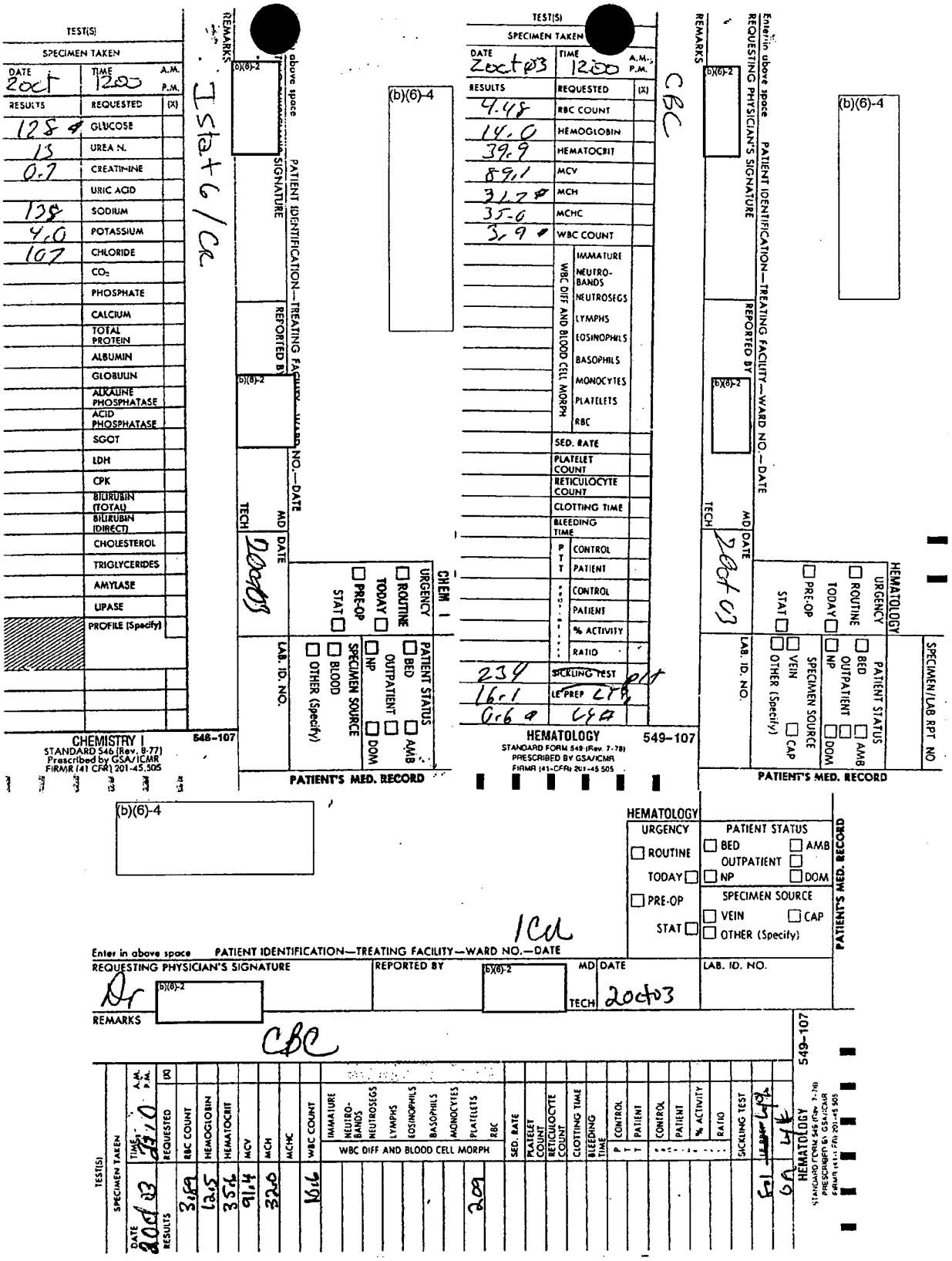
DATE	TIME	A.M. / P.M.
2oct03	1200	

RESULTS	REQUESTED	(X)
3.89	RBC COUNT	
12.5	HEMOGLOBIN	
35.6	HEMATOCRIT	
91.4	MCV	
32.0	MCH	
	MCHC	
16.6	WBC COUNT	
	WBC DIFF AND BLOOD CELL MORPH: IMMATURE	
	NEUTRO-BANDS	
	NEUTROSEGS	
	LYMPHS	
	EOSINOPHILS	
	BASOPHILS	
	MONOCYTES	
	PLATELETS	
	RBC	
209	SED. RATE	
	PLATELET COUNT	
	RETICULOCYTE COUNT	
	CLOTTING TIME	
	BLEEDING TIME	
	PTT: CONTROL	
	PTT: PATIENT	
	PROTHROMBIN: CONTROL	
	PROTHROMBIN: PATIENT	
	PROTHROMBIN: % ACTIVITY	
	PROTHROMBIN: RATIO	
	SICKLING TEST	
501	LE PREP	LT
0.6		4#

HEMATOLOGY

STANDARD FORM 549 (Rev. 7-78)
PRESCRIBED BY GSA/ICMR
FIRMR (41-CFR) 201-45.505

549-107



AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — ~~PROGRESS NOTES~~

TEST(S)
SPECIMEN TAKEN
DATE 14Oct03 | TIME 0650 A.M. P.M.
REQUESTED

RESULTS

WBC - 10.7
RBC - 3.38
Hgb - 10.7
Hct - 30.5
MCV - 90.3
MCH - 31.7
MCHC - 35.1
Plt - 353
RDW - 14.3
LYM - 1.5

CBC

REMARKS (b)(6)-2

Enter in above space — REQUESTING PHYSICIAN'S SIGNATURE — PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REPORTED BY (b)(6)-2

TECH MD DATE 14Oct03

URGENCY: ROUTINE TODAY ☐ PRE-OP ☐ STAT ☐

LAB ID NO.

PATIENT STATUS: BED ☐ OUTPATIENT ☐ NP ☐ AMB ☐ DOM ☐

SPECIMEN SOURCE (Specify)

MISCELLANEOUS 557-107
STANDARD FORM 557 (Rev. 3-77) Prescribed by GSA/ICMR FIRMR (41 CFR) 201-45.505

PATIENT'S MED. RECORD

(b)(6)-4

TEST(S)
SPECIMEN TAKEN
DATE 14Oct | TIME 0600 A.M. P.M.

RESULTS	REQUESTED	
107	GLUCOSE	
9	UREA N.	
0.8	CREATININE	
	URIC ACID	
	SODIUM	
	POTASSIUM	
	CHLORIDE	
	CO_2	
	PHOSPHATE	
8.9	CALCIUM	
7.9	TOTAL PROTEIN	
3.6	ALBUMIN	
	GLOBULIN	
104	ALKALINE PHOSPHATASE	
	ACID PHOSPHATASE	
	SGOT	
	LDH	
	CPK	
0.8	BILIRUBIN (TOTAL)	
	BILIRUBIN (DIRECT)	
141	CHOLESTEROL	
	TRIGLYCERIDES	
118	AMYLASE	
	LIPASE	
	PROFILE (Specify)	
91	ALT	
53	AST	

CHEMISTRY I 548-107
STANDARD 546 (Rev. 8-77) Prescribed by GSA/ICMR FIRMR (41 CFR) 201-45.505

PATIENT'S MED. RECORD

REMARKS chem 12

(b)(6)-2

Enter in above space — REQUESTING PHYSICIAN'S SIGNATURE — PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REPORTED BY (b)(6)-2

TECH MD DATE 14Oct03

(b)(6)-4

ICU

CHEM I

URGENCY: ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT ☐

LAB. ID. NO.

PATIENT STATUS: BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM ☐

SPECIMEN SOURCE: BLOOD ☐ OTHER (Specify) ☐

SPECIMEN/LAB RPT. NO.

PATIENT'S MED. RECORD

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME (LAST, FIRST, MI) | SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)*

(b)(6)-4

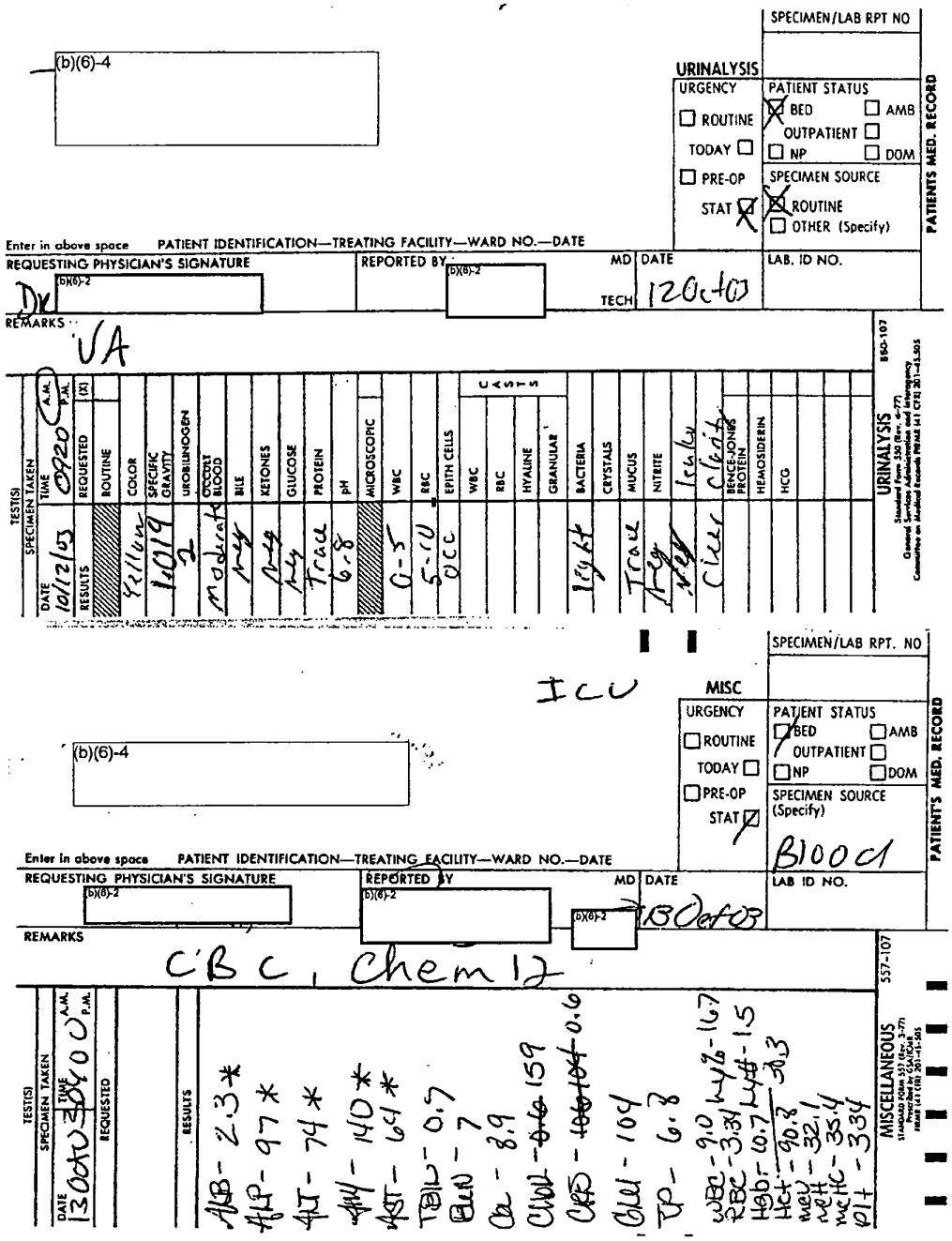
REGISTER NO. | WARD NO.

(b)(6)-2

Pr

(REV. 5/1999
-11.203(b)(10
USAPA V1.00

MEDCOM - 2249



(b)(6)-4

SPECIMEN/LAB RPT NO

URINALYSIS

URGENCY: ☐ ROUTINE ☐ TODAY ☐ PRE-OP STAT ☒

PATIENT STATUS: ☒ BED ☐ AMB OUTPATIENT ☐ NP ☐ DOM

SPECIMEN SOURCE: ☒ ROUTINE ☐ OTHER (Specify)

PATIENTS MED. RECORD

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE: Dr (b)(6)-2

REPORTED BY: (b)(6)-2 MD TECH

DATE: 12 Oct 03

LAB. ID NO.

REMARKS: VA

TEST(S) SPECIMEN TAKEN: DATE 10/12/03 TIME 0920 A.M. P.M.

REQUESTED (X)

RESULTS	ROUTINE	COLOR	SPECIFIC GRAVITY	UROBILINOGEN	OCCULT BLOOD	BILE	KETONES	GLUCOSE	PROTEIN	pH	MICROSCOPIC	WBC	RBC	EPITH CELLS	CASTS: WBC	RBC	HYALINE	GRANULAR	BACTERIA	CRYSTALS	MUCUS	NITRITE	leukocytes	BENCE-JONES PROTEIN	HEMOSIDERIN	HCG
		Yellow	1.019	2	moderate	neg	neg	neg	Trace	6.8		0-5	5-10	occ					light		Trace	neg	neg	Clear			

URINALYSIS 860-107 Standard Form 550 (Rev. 4-77) General Services Administration and Interagency Committee on Medical Records FIRMR (41 CFR) 201-45.505

ICU

SPECIMEN/LAB RPT. NO

MISC

URGENCY: ☐ ROUTINE ☐ TODAY ☐ PRE-OP STAT ☒

PATIENT STATUS: ☒ BED ☐ AMB OUTPATIENT ☐ NP ☐ DOM

SPECIMEN SOURCE (Specify): Blood

PATIENT'S MED. RECORD

(b)(6)-4

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE: (b)(6)-2

REPORTED BY: (b)(6)-2 MD (b)(6)-2

DATE: 13 Oct 03

LAB ID NO.

REMARKS: CBC, Chem 12

TEST(S) SPECIMEN TAKEN: DATE 13 Oct 03 TIME 0400 A.M. P.M.

REQUESTED

RESULTS

ALB - 2.3*
ALP - 97*
ALT - 74*
AMY - 140*
AST - 64*
TBIL - 0.7
BUN - 7
Ca - 8.9
Chol - ~~0.6~~ 159
CRE - ~~106~~ ~~104~~ 0.6
Glu - 104
TP - 6.8
WBC - 9.0 Lyg% - 16.7
RBC - 3.34 Lyg# - 1.5
Hgb - 10.7
Hct - 30.3
MCV - 90.8
MCH - 32.1
MCHC - 35.4
PLT - 334

MISCELLANEOUS 557-107 STANDARD FORM 557 (Rev. 3-77) Prescribed by GSA/ICAR FIRMR (41 CFR) 201-45.505

MEDCOM - 2250

PREANESTHETIC SUMMARY

OPERATION PROPOSED	AGE	WEIGHT (LBS.)	SPECIAL INFORMATION
EX LAP	24 yo	170 APPROX	
	PHYSICAL STATUS: 1 (2) 3 4 5 6 7		

URINALYSIS	HEMATOLOGY	BLOOD CHEMISTRY
NORMAL ..... ABNORMAL AND WHY? Ø	HGB ..... RBC ..... HCT ..... OTHER Hct-39	K 3.1

RESPIRATORY SYSTEM	CIRCULATORY SYSTEM	CENTRAL NERVOUS SYSTEM	OTHER SYSTEMS
(X-RAY, ASTHMA, OTHER PATHOLOGY) Ø	BP ..... PULSE ..... ECG (IF PERTINENT) Ø	(CEREBROVASCULAR, POLIO, NEUROLOGICAL) Ø	(ALLERGIES) NKDA Ø

PREVIOUS ANESTHETICS AND COMPLICATIONS	PRESENT DRUG THERAPY; E.G., STEROIDS, TRANQUILIZERS
Ø	Ø

PREOPERATIVE DIAGNOSIS	PREMEDICATION
CSW ABD	NONE

SIGNATURE OF EVALUATING PHYSICIAN	DATE
b)(6)-2 CRNA	10/2/02

POSTANESTHETIC VISITS

RECORD ALL PERTINENT COMPLICATIONS

*U.S. Government Printing Office: 1994 — 300-892/10029

ACLU-RDI 1099 p.1035

DOD 006303

UNASYN 3gm PRE OP.

MEDICAL RECORD - ANESTHESIA

For use of this form, see AR 40-66; the proponent agency is the OTSG

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML. "I" = CONSTANT INFUSION

DRUG	(Units)												
FENTANYL	(cc)	2	1	1	1		1	.5	.5		1		1
PROPOFOL	(mg)	120											
SUX	(mg)	50	6										
VEC	(mg)	1	5			1	1						
	( )												
VERSED	(mg)			3									
VOLAT AGENT	% del	1.0	1.5	1.5	1.0	1.0	1.0	1.0	X				
	% e.t.												
AIR	L/Min												
N2O	L/Min												
O2	L/Min	8	2	1	1	1	1	1	1	8			

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS

FLUIDS

LINE site	☐ Warmed												
18g (R) AC	☐ Warmed		#4	1000		#5		#7					
18g (L) AC	☐ Warmed	#3	1000					#6					
	☐ Warmed			5% ALB.			250						
LOSSES: EST BLOOD LOSS			200										
LOSSES: URINE -				400									

PHYS STATUS: (2) 3 4 5 (E)

BODY WEIGHT: KG LB

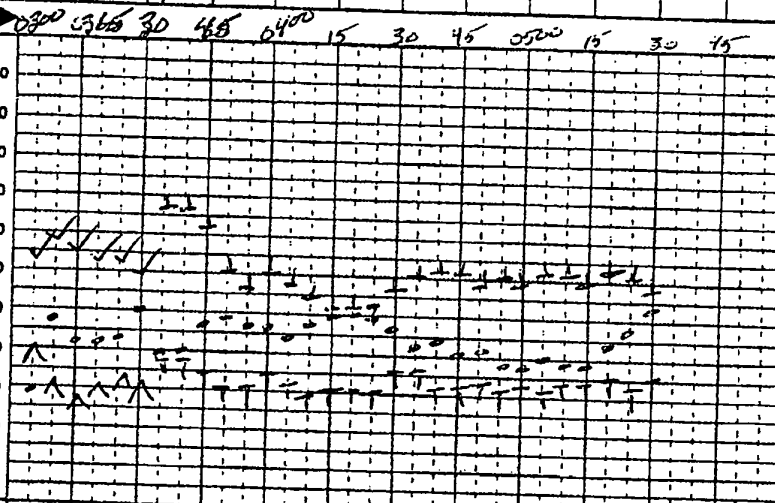
HEMATOCRIT:

INITIAL DATA: BP- 128 180 HR- 62

EQUIP CHECK: OK?- (Y) N

PATIENT RECHECK: OK for PROCEDURE? TIME- 0245

SYMBOLS: BP by cuff V Λ Heart rate ● Resp rate BR (transduced) TOURNIQUET T—T ANES- X-X PROC- ⊙-Ø



VENTIL

VT - ml	620	600	620	660	620	620	
f - breaths/min	[illegible]	[illegible]	10	10	10	10	
Peak inf pres / PEEP	22	24	24	26	24	26	
MODE - S(pon), A(assist), C(on)	C	C	C	C	C	C	C

MONITORS/ACCESSORIES

X BP/Auto Cuff	X ET CO2 (torr)	34	31	31	30	30	31	32
BP/oth	X FIO2 (Frac or %)	.80	.80	.81	.8	.8	.8	.8
X ART line	X SpO2 (%)	100	100	100	100	100	100	100
Steth- PC/ES	X ECG	SR	ST	SR	SR	SR	SR	SR
X Gas analyzer	X TEMP-site SKIN	35(C)	35	35	35	35	35	
	N-M Block (T/4)	4/4						
Warming blkt								
Conv warmer								

Mark with letters & symbols, explain under REMARKS — EVENTS Position (1) (2)

TOTALS — TOTAL EBL: 300 cc — TOTAL URINE:

FLUIDS - SUMMARY

CRYSTALLOID- 5800

COLLOID- 250

BLOOD- 4

REMARKS

Code drugs with numbers, events with letters

(1) PT EVAL IN EMT CHART REVIEW

(2) TO O.R. MONITORS & STRAPS PRE O2 SMOOTH IDT

(3) NG PLACED 5 PROBLEMS

(4) A-LINE

(L) RADIAL ART.

REVERSAL NEOSTIGMINE 4mg ROBINOL 4mg @ 0530

PT OPENING EYES OXYGENATED EXTUBATED

TO ICU REPORT TO (b)(6)-2 WILL RECOVER

RECOVERY AT: PACU ICU ____ (Specify) OTHER ____

CONDITION: RESP- 20 SpO2- 98 BP- 170/72 HR- 120

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0230	0305	
PROC	Ready	Begin	End
	0308	0325	

PROCEDURES and CPT Codes: EX Lap / EBR = REANTAROSIS

ANESTHETIC TECHNIQUES: Describe block technique under Remarks GETA ECCA = HME

PATIENT IDENTIFICATION: Typed or written entries: Name, Grade/Rate, Medical facility (b)(6)-4

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments RSI = CRICOID, DL x 1 c 2 mil, ATRAUMATIC BEBS QETCO2, 24 LAP LIP.

SURGEONS: (b)(6)-2 (b)(6)-2

PROCEDURE LOCATION: T-1

DATE: 19/2/03

PAGE 1 OF

DA FORM 7389, FEB 1998 MEDCOM - 2252 CRNA

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*
- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of ____ units)*
- [ ] CRYOPRECIPITATE *(Pool of ____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* ____

VOLUME REQUESTED *(If applicable)*: ____ ML

REMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*
- [X] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED: 9 Oct 03

DATE AND HOUR REQUIRED: ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*: N/A

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT/DATE GIVEN: N/A

HEMOLYTIC DISEASE OF NEWBORN? ____

REQUESTING PHYSICIAN *(Print)*: (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE: Respiratory distress 3/p Ex lap

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER: (b)(6)-2

DATE VERIFIED: 09 Oct 03

TIME VERIFIED: 1439

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.: (b)(6)-4

TRANSFUSION NO.

PATIENT NO.

DONOR
ABO: O
Rh: Neg

RECIPIENT
ABO: AB
Rh: Neg

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

REMARKS:

PREVIOUS RECORD CHECK:
- [X] RECORD
- [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST: (b)(6)-2

DATE

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

IN: (b)(6)-2

AT *(Hour)*: 2016 HRS

ON *(Date)*: 9 Oct 03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER *(Signature)*: (b)(6)-2 MAJ AN

2nd VERIFIER *(Signature)*: (b)(6)-2 1LT

PRE-TRANSFUSION

TEMP. 100.6 (A) PULSE 94 BP 117/56

DATE OF TRANSFUSION: 09 Oct 03

TIME STARTED: 2020

PATIENT IDENTIFICATION - USE EMBOSSER *(For typed or written entries give NAME - Last, first, middle; rank/rate; hospital number and name of facility.)*

(b)(6)-4

POST-TRANSFUSION DATA

AMOUNT GIVEN: 1 unit ML

TIME DATE COMPLETED: 2330 9 Oct 03

INTERRUPTED

REACTION
- [X] NONE
- [ ] SUSPECTED

If reaction is suspected – IMMEDIATELY:
1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION
- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER ____

OTHER DIFFICULTIES *(Equipment, clots, etc.)*
- [X] NO
- [ ] YES *(Specify)* ____

SIGNATURE OF PERSON NOTING ABOVE: (b)(6)-2 SOC, 9 Oct 03

SEX: M

WARD: ICU

BLOOD OR BLOOD COMPONENT TRANSFUSION
STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

MEDICAL RECORD COPY

MEDCOM - 2253

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*
- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of ____ units)*
- [ ] CRYOPRECIPITATE *(Pool of ____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* ____

VOLUME REQUESTED *(If applicable)*: ____ ML

REMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*
- [X] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED: 9 Oct 03

DATE AND HOUR REQUIRED: ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*: N/A

IF PATIENT IS FEMALE, IS THERE HISTORY OF:
RhIG TREATMENT? DATE GIVEN: N/A
HEMOLYTIC DISEASE OF NEWBORN? ____

REQUESTING PHYSICIAN *(Print)*: (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE: Sepsis Resp. distress

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER: (b)(6)-2

DATE VERIFIED: 09 Oct 03

TIME VERIFIED: 1439

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.: (b)(6)-4

TRANSFUSION NO.

PATIENT NO.

DONOR
ABO: O
Rh: Neg

RECIPIENT
ABO: AB
Rh: Neg

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/P	Comp

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED | DATE

REMARKS:

PREVIOUS RECORD CHECK:
- [X] RECORD
- [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST: (b)(6)-2

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*: (b)(6)-2

AT *(Hour)*: 1725 ON *(Date)*: 9 Oct 03

IDENTIFICATION:

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER *(Signature)*: (b)(6)-2 MAJ, AN

2nd VERIFIER *(Signature)*: (b)(6)-2 MAJ AN

PRE-TRANSFUSION
TEMP. 100.7 PULSE 111 BP 118/63

DATE OF TRANSFUSION: 9 Oct 03

TIME STARTED: 1730

POST-TRANSFUSION DATA

AMOUNT GIVEN	TIME	DATE	COMPLETED	INTERRUPTED
400 ML	2000	9 Oct 03		

REACTION
- [X] NONE
- [ ] SUSPECTED

BP 121/64 P 95 R 12 T 99.7 AK

If reaction is suspected – IMMEDIATELY:
1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION
- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER ____

OTHER DIFFICULTIES *(Equipment, clots, etc.)*
- [X] NO
- [ ] YES *(Specify)* ____

SIGNATURE OF PERSON NOTING ABOVE: (b)(6)-2 MAJ AN

PATIENT IDENTIFICATION - USE EMBOSSER *(For typed or written entries give: NAME - Last, first, middle; rank/rate; hospital number and name of facility.)*

(b)(6)-4

SEX: M

WARD: ICU

BLOOD OR BLOOD COMPONENT TRANSFUSION
STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

DICAL RECORD COPY

MEDCOM - 2254

SN 7540-01-165-7294

519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

EXAMINATION(S) REQUESTED

(P) CXR

AGE | SEX | SSN (Sponsor)

WARD/CLINIC: ICU

REGISTER NO.

PREGNANT ☐ YES ☐ NO

FILM NO.

TELEPHONE/PAGE NO.

REQUESTED BY (Print)

DATE REQUESTED: 40ct03

SIGNATURE OF REQUESTOR

(b)(6)-2

SPECIFIC REASON(S) FOR REQUEST (Complaints and findings)

"S/p Intubation"

DATE OF EXAMINATION (Month, day, year)

DATE OF REPORT (Month, day, year)

DATE OF TRANSCRIPTION (Month, day, year)

RADIOLOGIC REPORT

1st post intubation film

- Large (R) Pneumothorax mediastinal air / Neck subQ emphysema

post chest tube placement

- Rt pleural tube - tip in apex
- RUL atelectasis
- (-) pneumothorax

(b)(6)-2

PATIENT'S IDENTIFICATION (For typed or written entries give: Name — last, first, middle, Medical Facility)

(b)(6)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

MEDCOM - 2255 IIC CONSULTATION REQUEST/REPORT

STANDARD FORM 5
Prescribed by GSA/IC
FPMR (41 CFR) 101-

N 7540-01-165-7294

519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

EXAMINATION(S) REQUESTED: PCXR

WARD/CLINIC: ICU

REGISTER NO.

AGE | SEX | SSN (Sponsor)

PREGNANT ☐ YES ☐ NO

FILM NO.

TELEPHONE/PAGE NO.: 570 2122

REQUESTED BY (Print): For DR (b)(6)-2

DATE REQUESTED: 10/9/03

(b)(6)-2

F REQUESTOR: LT, A

SPECIFIC REASON(S) FOR REQUEST (Complaints and findings)

S/P EX LAP/SM Bowel repair / APPY / LRG Bowel Repair

↓ O_2 SATS

DATE OF EXAMINATION (Month, day, year) | DATE OF REPORT (Month, day, year) | DATE OF TRANSCRIPTION (Month, day, year)

RADIOLOGIC REPORT

- Hypoinflated lungs
- Atelectasis RUL
- Bilateral LL opacities / ? effusions and/or atelectasis
- also patchular densities - c/w pulm edema
- need better inspiratory effort for better quality film.

(b)(6)-2

PATIENT'S IDENTIFICATION (For typed or written entries give: ... first, middle, Medical Facility)

(b)(6)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

...NDARD FORM 51
...ed by GSA/ICM
...CFR 101-1

MEDCOM - 2256

519-301

ISN 7540-01-165-7294

RADIOLOGIC CONSULTATION REQUEST/REPORT

(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

EXAMINATION(S) REQUESTED: Portable AP CXR	AGE: 23	SEX: M	SSN (Sponsor):	WARD/CLINIC:
	FILM NO.:			REGISTER NO.:
	REQUESTED BY (Print): Dr. [redacted] (b)(6)-2			PREGNANT ☐ YES ☐ NO
	SIGNATURE OF REQUESTOR: [redacted] (b)(6)-2			TELEPHONE/PAGE NO.:
				DATE REQUESTED: 4 Oct 03

SPECIFIC REASON(S) FOR REQUEST *(Complaints and findings)*

s/p (R) pneumo

DATE OF EXAMINATION *(Month, day, year)*	DATE OF REPORT *(Month, day, year)*	DATE OF TRANSCRIPTION *(Month, day, year)*

RADIOLOGIC REPORT

ET - tube 4cm above carina
NG tip in distal esophagus
Rt pleural tube tip in apx R chest
c̄ clearing of RUL atelectasis
since last film
Bilat lower lobe densities
atelectasis / possibly small effusions
↓ neck SUG & emphysema

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name — last, first, middle, Medical Facility)*

[redacted] (b)(6)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

MEDCOM - 2257

CONSULTATION REQUEST/REPORT

STANDARD FORM 519
Prescribed by GSA/ICMF
FPMR (41 CFR) 101-11

05

SN 7540-01-165-7294

519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

EXAMINATION(S) REQUESTED: PCXR	AGE / SEX / SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
	FILM NO.		PREGNANT ☐ YES ☐ NO
	REQUESTED BY (Print) (b)(6)-2		TELEPHONE/PAGE NO.
	SIGNATURE OF REQUESTOR C		DATE REQUESTED

SPECIFIC REASON(S) FOR REQUEST (Complaints and findings)
s/p Blat CT / intubation

DATE OF EXAMINATION (Month, day, year)	DATE OF REPORT (Month, day, year)	DATE OF TRANSCRIPTION (Month, day, year)

RADIOLOGIC REPORT

New (L) pleural tube
rest tubes/lines stable
persistent lower lobe opacities

(b)(6)-2

PATIENT'S IDENTIFICATION (For typed or written entries give: Name — last, first, middle, Medical Facility)
(b)(6)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

MEDCOM - 2258 ...GIC CONSULTATION ...QUEST/REPORT STANDARD FORM Prescribed by GSA/I

NSN 7540-01-165-7294

519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

EXAMINATION(S) REQUESTED

CXR

AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
	M		ICU	

FILM NO.

REQUESTED (b)(6)-2

PREGNANT ☐ YES ☒ NO

TELEPHONE/PAGE NO.

SPECIFIC REASON(S) FOR REQUEST *(Complaints and findings)* (b)(6)-2 ept sw

DATE REQUESTED 6 Oct 03

DATE OF EXAMINATION *(Month, day, year)*	DATE OF REPORT *(Month, day, year)*	DATE OF TRANSCRIPTION *(Month, day, year)*

RADIOLOGIC REPORT

ET tube.
L + R pleural tubes } stable position
distal tip of OG tube in esophagus
⊖ ptx
patchy densities both lungs L>R
⊖ effusions

PATIENT'S IDENTIFICATION *(For typed or written entries give: name — last, first, middle, Medical Facility)*

(b)(6)-4

LOCATION OF MEDICAL RECORDS (b)(6)-2

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

MEDCOM - 2259

519-301

NSN 7540-01-165-7294

RADIOLOGIC CONSULTATION REQUEST/REPORT

(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
24	M		ICU	

PREGNANT ☐ YES ☐ NO

FILM NO.

TELEPHONE/PAGE NO.

REQUESTED BY (Print)

(b)(6)-2

DATE REQUESTED 7 Oct 03

SIGNATURE OF REQUESTOR

(b)(6)-2

Capt AN

EXAMINATION(S) REQUESTED

CXR

SPECIFIC REASON(S) FOR REQUEST (Complaints and findings)

Vent/ETT placement

DATE OF EXAMINATION (Month, day, year)

DATE OF REPORT (Month, day, year)

DATE OF TRANSCRIPTION (Month, day, year)

RADIOLOGIC REPORT

Tubes + lines stable

1 opacity R lower heme thorax

Prob combination of RLL atelectasis

and a R effusion

L lung unchanged mostly clear

(b)(6)-2

PATIENT'S IDENTIFICATION (For typed or written entries give: Name — last, first, middle, Medical Facility)

(b)(6)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

STANDARD FORM
Prescribed by GSA/
FPMR (41 CFR) 10

MEDCOM - 2260

OGIC CONSULTATION
QUEST/REPORT

SN 7540-01-165-7294

519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

EXAMINATION(S) REQUESTED: CXR

AGE: 23 | SEX: M | SSN (Sponsor)

WARD/CLINIC: ICU

REGISTER NO.

PREGNANT: ☐ YES ☒ NO

FILM NO.

TELEPHONE/PAGE NO.

REQUESTED BY (Print): (b)(6)-2

DATE REQUESTED: 7 OCT 03

SIGNATURE OF REQUESTOR: (b)(6)-2 SPC, 91W2U6

SPECIFIC REASON(S) FOR REQUEST (Complaints and findings)

S/P ex lap, Appy, Intubated

DATE OF EXAMINATION (Month, day, year)

DATE OF REPORT (Month, day, year)

DATE OF TRANSCRIPTION (Month, day, year)

RADIOLOGIC REPORT

Diffuse patchy densities slightly ↑ since yesterday

tube/lines stable

0 ptx

(b)(6)-2

PATIENT'S IDENTIFICATION (For typed or written entries give: Name — last, first, middle, Medical Facility)

(b)(6)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

MEDCOM - 2261 ...C CONSULTATION EST/REPORT

STANDARD FORM 5... Prescribed by GSA/ICP... FPMR (41 CFR) 101-...

519-301

NSN 7540-01-165-7294

RADIOLOGIC CONSULTATION REQUEST/REPORT

(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

EXAMINATION(S) REQUESTED

(P) CXR

AGE 23 | SEX M | SSN (Sponsor) —

WARD/CLINIC ICU

REGISTER NO.

PREGNANT ☐ YES ☒ NO

FILM NO.

TELEPHONE/PAGE NO.

REQUESTED BY (Print) (b)(6)-2

SIGNATURE OF REQUESTER (b)(6)-2 SPC, USAR

DATE REQUESTED 10 OCT 03

SPECIFIC REASON(S) FOR REQUEST (Complaints and findings)

S/P Intubation

DATE OF EXAMINATION (Month, day, year)

DATE OF REPORT (Month, day, year)

DATE OF TRANSCRIPTION (Month, day, year)

RADIOLOGIC REPORT

ET tip 4 cm above carina
⊖ PTX
R lung opacities resolved
lungs much clearer
pleural tubes stable

(b)(6)-2

PATIENT'S IDENTIFICATION (For typed or written entries give: Name — last, first, middle, Medical Facility)

(b)(6)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

MEDCOM - 2262

STANDARD FORM 519-B
Prescribed by GSA/ICMR

519-301

NSN 7540-01-165-7294

RADIOLOGIC CONSULTATION REQUEST/REPORT

(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

EXAMINATION(S) REQUESTED	AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
(P)CXR		M	N/A	ICU	
	FILM NO.			PREGNANT ☐ YES ☒ NO	
	REQUESTED BY (Print) (b)(6)-2			TELEPHONE/PAGE NO.	
	SIGNATURE OF REQUESTOR (b)(6)-2			DATE REQUESTED 11 OCT 03	

SPECIFIC REASON(S) FOR REQUEST (Complaints and findings)

DATE OF EXAMINATION (Month, day, year)	DATE OF REPORT (Month, day, year)	DATE OF TRANSCRIPTION (Month, day, year)

RADIOLOGIC REPORT

(+) b/lat pneumothoraces

lungs otherwise much clearer -

tubes lines stable.

(b)(6)-2

PATIENT'S IDENTIFICATION (For typed or written entries give: Name — last, first, middle, Medical Facility)

(b)(6)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

MEDCOM - 2263

STANDARD FORM 519-B (
Prescribed by GSA/ICMR

519-301

NSN 7540-01-155-7294

RADIOLOGIC CONSULTATION REQUEST/REPORT

(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

EXAMINATION(S) REQUESTED

PORTABLE CXR @ 1200hrs

AGE | SEX | SSN (Sponsor)

WARD/CLINIC: ICU

REGISTER NO.

FILM NO.

PREGNANT ☐ YES ☐ NO

TELEPHONE/PAGE NO.: (b)(3)-1

R (b)(6)-2

(b)(6)-2

F REQUESTOR

DATE REQUESTED: 10/11/03

SPECIFIC REASON(S) FOR REQUEST *(Complaints and findings)*

(B) CT's (CHEST TUBES)

S/P SMALL & LARGE BOWEL REPAIR

DATE OF EXAMINATION *(Month, day, year)*	DATE OF REPORT *(Month, day, year)*	DATE OF TRANSCRIPTION *(Month, day, year)*

RADIOLOGIC REPORT

Resolution of bilateral pl fx

lungs clear

pleural tube positions stable

(b)(6)-2

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name — last, first, middle, Medical Facility)*

(b)(6)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

MEDCOM - 2264

RADIOLOGIC CONSULTATION

STANDARD FORM 519-B (8-
Prescribed by GSA/ICMR
FPMR 141 CFR 101-11.806-8

NSN 7540-01-165-7294

5 7 9-101

RADIOLOGIC CONSULTATION REQUEST/REPORT

(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

EXAMINATION(S) REQUESTED
STAT UPRIGHT CXR

AGE | SEX | SSN (Sponsor)

WARD/CLINIC
ICU

REGISTER NO.

FILM NO.

PREGNANT ☐ YES ☐ NO

REQUESTED BY (Print)
(b)(6)-2

TELEPHONE/PAGE NO.
(b)(3)-1

(b)(6)-2

REQUESTOR
ICU, AM

DATE REQUESTED
10/1/03

SPECIFIC REASON(S) FOR REQUEST (Complaints and findings)
(B) CHEST TUBES
S/P EXTUBATION

DATE OF EXAMINATION (Month, day, year)

DATE OF REPORT (Month, day, year)

DATE OF TRANSCRIPTION (Month, day, year)

RADIOLOGIC REPORT

— ET tube removed
— (+) Rt pneumo
— lungs much clearer
(+) motion artifact
pt tubes & lines removed

(b)(6)-2

PATIENT'S IDENTIFICATION (For typed or written entries give: Name — last, first, middle, Medical Facility)

(b)(6)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

MEDCOM - 2265
RADIOLOGIC CONSULTATION

STANDARD FORM 519-B (8-83)
Prescribed by GSA/ICMR

519-301

NSN 7540-01-165-7294

RADIOLOGIC CONSULTATION REQUEST/REPORT

(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

EXAMINATION(S) REQUESTED

(P)CXR

AGE: M | SEX | SSN (Sponsor): — | WARD/CLINIC: ICU | REGISTER NO.

FILM NO.

PREGNANT: ☐ YES ☒ NO

REQUESTED BY (Print): (b)(6)-2

TELEPHONE/PAGE NO.

SIGNATURE OF REQUESTOR: (b)(6)-2 SPC, 9/22/06

DATE REQUESTED

SPECIFIC REASON(S) FOR REQUEST (Complaints and findings)

S/p Intubation (L)>(R) CT

DATE OF EXAMINATION (Month, day, year) | DATE OF REPORT (Month, day, year) | DATE OF TRANSCRIPTION (Month, day, year)

RADIOLOGIC REPORT

Tubes stable / Hypo inflated lungs but mostly clear asymmetric elevation (R) hemiD (-) ptx.

(b)(6)-2

PATIENT'S IDENTIFICATION (For typed or written entries give: Name — last, first, middle, Medical Facility)

(b)(6)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

MEDCOM - 2266 CONSULTATION REQUEST/REPORT

STANDARD FORM 519-B
Prescribed by GSA/ICMR
FPMR 141 CFR 101-11.8

519-301

NSN 7540-01-165-7294

RADIOLOGIC CONSULTATION REQUEST/REPORT

(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

EXAMINATION(S) REQUESTED: Portable STAT CXR

AGE | SEX | SSN (Sponsor): (b)(6)-2

WARD/CLINIC: ICU

REGISTER NO.:

FILM NO.:

PREGNANT: ☐ YES ☐ NO

REQUESTED BY (Print): (b)(6)-2

TEL. PHONE/PAGE NO.: (b)(3)-1

(b)(6)-2

OF REQUESTOR: , ICU, AN

DATE REQUESTED: 10/12/05

SPECIFIC REASON(S) FOR REQUEST (Complaints and findings)

(B) CHEST TUBES
S/P EXP LAP

DATE OF EXAMINATION (Month, day, year)

DATE OF REPORT (Month, day, year)

DATE OF TRANSCRIPTION (Month, day, year)

RADIOLOGIC REPORT

mod hypo inflation
pleural tubs stable
(-) pneumothorax
lungs clear / heart sz nl

(b)(6)-2

PATIENT'S IDENTIFICATION (For typed or written entries give: Name — last, first, middle, Medical Facility)

(b)(6)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

ACLU-RDI 1099 p.1051

DOD 006319

519-301

NSN 7540-01-165-7294

RADIOLOGIC CONSULTATION REQUEST/REPORT

(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

EXAMINATION(S) REQUESTED
STAT Portable CXR

AGE | SEX | SSN (Sponsor)

WARD/CLINIC
ICU

REGISTER NO.

FILM NO.

PREGNANT ☐ YES ☐ NO

REQUESTED BY (Print)
(b)(6)-2

TELEPHONE/PAGE NO.
(b)(3)-1

F REQUESTOR
(b)(6)-2
ICU, Rm.

DATE REQUESTED
10/12/03

SPECIFIC REASON(S) FOR REQUEST (Complaints and findings)
S/P (R) CHEST TUBE REMOVAL

DATE OF EXAMINATION (Month, day, year)

DATE OF REPORT (Month, day, year)

DATE OF TRANSCRIPTION (Month, day, year)

RADIOLOGIC REPORT

S/P Rt at chest tube removal

(-) PTX

lungs clear

(b)(6)-2

PATIENT'S IDENTIFICATION (For typed or written entries give: Name — last, first, middle, Medical Facility)
(b)(6)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

MEDCOM - 2268
RADIOLOGIC CONSULTATION

STANDARD FORM 519-B (8-2
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.806-8

519-301

NSN 7540-01-185-7294

RADIOLOGIC CONSULTATION REQUEST/REPORT

(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

EXAMINATION(S) REQUESTED

(P)CXR

AGE | SEX: M | SSN (Sponsor): —

WARD/CLINIC: —

REGISTER NO.: —

FILM NO.:

PREGNANT: ☐ YES ☒ NO

REQUESTED BY (Print): (b)(6)-2

TELEPHONE/PAGE NO.:

SIGNATURE OF REQUESTOR: (b)(6)-2 SPC, USA

DATE REQUESTED: 14 OCT 03

SPECIFIC REASON(S) FOR REQUEST *(Complaints and findings)*

s/p CT (B) removal

DATE OF EXAMINATION *(Month, day, year)*	DATE OF REPORT *(Month, day, year)*	DATE OF TRANSCRIPTION *(Month, day, year)*

RADIOLOGIC REPORT

Lordotic view
small amt L base atelectasis
(-) pft.

(b)(6)-2

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name — last, first, middle, Medical Facility)*

(b)(6)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

MEDCOM - 2269

RADIOLOGIC CONSULTATION

STANDARD FORM 519-B (8-
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.806-8

519-301

NSN 7540-01-165-7294

RADIOLOGIC CONSULTATION REQUEST/REPORT

(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

EXAMINATION(S) REQUESTED: ACUTE ABD SERIES

AGE | SEX | SSN (Sponsor): (b)(6)-2

WARD/CLINIC: ICU

REGISTER NO.:

FILM NO.:

PREGNANT: ☐ YES ☐ NO

REQUESTED BY (Print): (b)(6)-2

TELEPHONE/PAGE NO.: (b)(3)-1

(b)(6)-2 OF REQUESTOR: ILT, A

DATE REQUESTED: 10/15/03

SPECIFIC REASON(S) FOR REQUEST (Complaints and findings): R/O OBSTRUCTION

DATE OF EXAMINATION (Month, day, year)	DATE OF REPORT (Month, day, year)	DATE OF TRANSCRIPTION (Month, day, year)

RADIOLOGIC REPORT

Chest clear lungs

(-) obstructed

(-) ileus

(b)(6)-2

PATIENT'S IDENTIFICATION (For typed or written entries give: Name — last, first, middle, Medical Facility)

(b)(6)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

MEDCOM - 2270 RADIOLOGIC CONSULTATION

STANDARD FORM 519-B (8-8)
Prescribed by GSA/ICMR

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION: (b)(6)-4

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
Ø20CT03	0545 HOURS	

1. Admit to ICU
2. Service Gen Surg (b)(6)-2 (b)(6)-2
3. Diagnosis s/p Ex lap / small bowel resection Appendectomy / large Bowel repair
4. Condition: stable
5. IVF 150 cc/hr of ~~NS or~~ LR (b)(6)-2
6. Diet: NPO

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER ↓↓ TIME OF ORDER ↓↓ HOURS

7. NG tube low Intermitent suction
8. Foley to gravity
9. Vitals Q4H Q 1°
10. Morphine 2-4mg IV Q 1°hr PRN pain
11. Unasyn 3grams IV Q 6°hr
12. Wet to dry (LLQ) Open wound and (L) thigh BID starting this evening

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER ↓↓ TIME OF ORDER ↓↓ HOURS

13. CBC ↓↓
14. CBC/chem 7 today @ 1200
15. F/O recording.
16. activity: Bed Rest
17. Incentive Spirometer exercises

(b)(6)-2 noted 20CT03 0730

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER (b)(6)-2 HOURS

Ø20CT03 0613

1. D/C Unasyn order
2. Levaquin 500mg IV QD
3. Flagyl 500mg IV Q12°

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

MAS, MCpl

(b)(6)-2

DA FORM 1 APR 79 4256 REPLACES ... 1 JUL 77, WHICH MAY BE USED.

ACLU-RDI 1099 p.1055

DOD 006323

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
(b)(6)-4	2 Oct 03	1285 HOURS	
	NS 1 L bolus now		
(b)(6)-2	(b)(6)-2		
NURSING UNIT / ROOM NO. / BED NO.		MAJ NC	

notified 2 Oct 03

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
	2 Oct 03	1242 HOURS	
	1 D/C Levaquin		
	2 D/C Flagyl		
	3 Unasyn 3.0gm IV Q6°		
	(b)(6)-2		
NURSING UNIT / ROOM NO. / BED NO.		MAJ NC	

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
Chart ✓ 0030 30 Oct 03	(b)(6)-2		
		HOURS	
NURSING UNIT / ROOM NO. / BED NO.			

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
		HOURS	
NURSING UNIT / ROOM NO. / BED NO.			

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 2272

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
2 Oct 03	1720 HOURS	

1. TL NS flush bolus now — 2 Oct 03 1720

VO: Dr. (b)(6)-2 / (b)(6)-2 - MJ.AN (b)(6)-2

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER
2 Oct 03	2045 HOURS

1. Demerol 25mg / Phenergan 12.5mg IV Q4O PRN Breakthrough pain — 2 Oct 03 2045
2. CBC, PA-7 in AM

(b)(6)-2

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

Chart ✓ 03 Oct 03 0130 (b)(6)-2 CpT AN

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER
3 Oct 03	0925 HOURS

1. Δ IVF to D5 ½ NS @ 75cc/hr
2. ✓ 20meq KCl q 1L

Naked (b)(6)-2 Pt 3 Oct 0925

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

MAT RN

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER
3 Oct 03	2007 HOURS

VO DR (b)(6)-2 / (b)(6)-2 IN/AN

1. Tylenol 650mg PO Q4-6PRN

(b)(6)-4

(b)(6)-2

(b)(6)-2 CpT/AN PRACTICE

24° Chart ✓ 4 Oct 03 0100

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77 WHICH MAY BE USED.

MEDCOM - 2273

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION: (b)(6)-4 (b)(6)-2

DATE OF ORDER: 3 Oct 03 TIME OF ORDER: 2111 HOURS

LIST TIME ORDER NOTED AND SIGN

Change unasyn to Zosyn 3.375 gm IV q6°

(b)(6)-2 MD

(b)(6)-2

NURSING UNIT: 240 chart ✓ ROOM NO. BED NO.

3 Oct 03 2130

(b)(6)-2 0100 (b)(6)-2 CPT AN

PATIENT IDENTIFICATION

DATE OF ORDER: 10/4/03 TIME OF ORDER: 0740 HOURS

STAT Portable CXR

STAT CBC

↓ IVF 75cc/hr D5½S c̄ 20mEq KCl

V.O. DR (b)(6)-2 (b)(6)-2 (b)(6)-2 CUT

(b)(6)-2

NURSING UNIT: RO BED NO.

Noted (b)(6)-2 10/4/03 0800

(b)(6)-2 MAJ

PATIENT IDENTIFICATION

DATE OF ORDER: 4 Oct 03 TIME OF ORDER: 0906 HOURS

(1) Levix 20mg IV X1 now

(2) 000 to (b)(6)-2 TID

(3) IS Q1°

(4) Chart PT QID

(b)(6)-2

(b)(6)-2

NURSING UNIT: ROOM BED NO.

4 Oct 03 1105

MAJ

PATIENT IDENTIFICATION

DATE OF ORDER: 10/4/03 TIME OF ORDER: 1050 HOURS

(1) Vecuronium drip @ 4mg/hr

(2) Versed drip @ 2mg/hr

(3) Fentanyl drip @ 100mg/hr

(b)(6)-2

NURSING UNIT: ROOM NO. BED NO.

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED

MEDCOM - 2274

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

(b)(6)-4 (b)(6)-2

(b)(6)-2

40ct03 1105

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER 10/4/03 TIME OF ORDER 1100 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) Vent
SIMV 12
TV 700 FIO2 100
Rate 12 PEEP 10
(2) Portable CXR
S/p Intubation

(b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER TI

NURSING UNIT	ROOM NO.	BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 4 Oct 03 TIME OF ORDER 1430 HOURS

(4) Zintac 50mg IV Q8 — 1445 Done
(5) Heparin 10,000 u IV now — 1448 Done
(3) Heparin drip 1000u/hr
(4) PT/PTT in 4 hrs

(b)(6)-2

NURSING UNIT	ROOM NO.

PATIENT IDENTIFICATION

(b)(6)-2

1570 40ct03

DATE OF ORDER 4 Oct 03 TIME OF ORDER 1505 HOURS

(1) Lasit 20mg IV now
(2) ↑ vent rate to 16 &
↓ TV to 550
(3) ABG
(4) Titrate versed &
Vecuranium
as needed

(b)(6)-2

NURSING UNIT	ROOM NO.	BED NO.

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77 WHICH MAY BE USED.

MEDCOM - 2275

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

(b)(6)-2

NURSING UNIT: ICU | ROOM NO. | BED NO.

DATE OF ORDER: 4 Oct. 03 | TIME OF ORDER: 1543 HOURS | LIST TIME ORDER NOTED AND SIGN

1. ↑ Vec. to 5mg/hr
2. Vec. bolus ~~5mg~~ 5mg x 1
3. ↑ fentanyl 1 gtt to 150 ml/hr
4. fentanyl 1 gtt bolus 150 ml x 1

noted 4 Oct 03 1550

(b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT: ICU | ROOM NO. | BED NO.

DATE OF ORDER: 4 Oct. 03 | TIME OF ORDER: ~~1530~~ 1650 HOURS

1. ↑ versed gtt to 5mg/hr
2. Versed ~~5mg~~ 5mg IV x 1
3. Vec. bolus 5mg x 1
4. ~~↑ versed gtt to~~ MPH
5. ↑ TV to 580
6. ↓ RR to 15
9. ↑ PEEP to 5 cm H2O

done 1700 4 Oct

(b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT: ICU | ROOM NO. | BED NO.

DATE OF ORDER: 4 Oct. 03 | TIME OF ORDER: 1706 HOURS

1. Albuterol nebs Q4°
2. ↑ PEEP to 7 (VO II)
3. ↓ PEEP to 5, ↑ TV to 750 (")

1710 4 Oct

(b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-2

NURSING UNIT: ICU | ROOM NO. | BED NO.

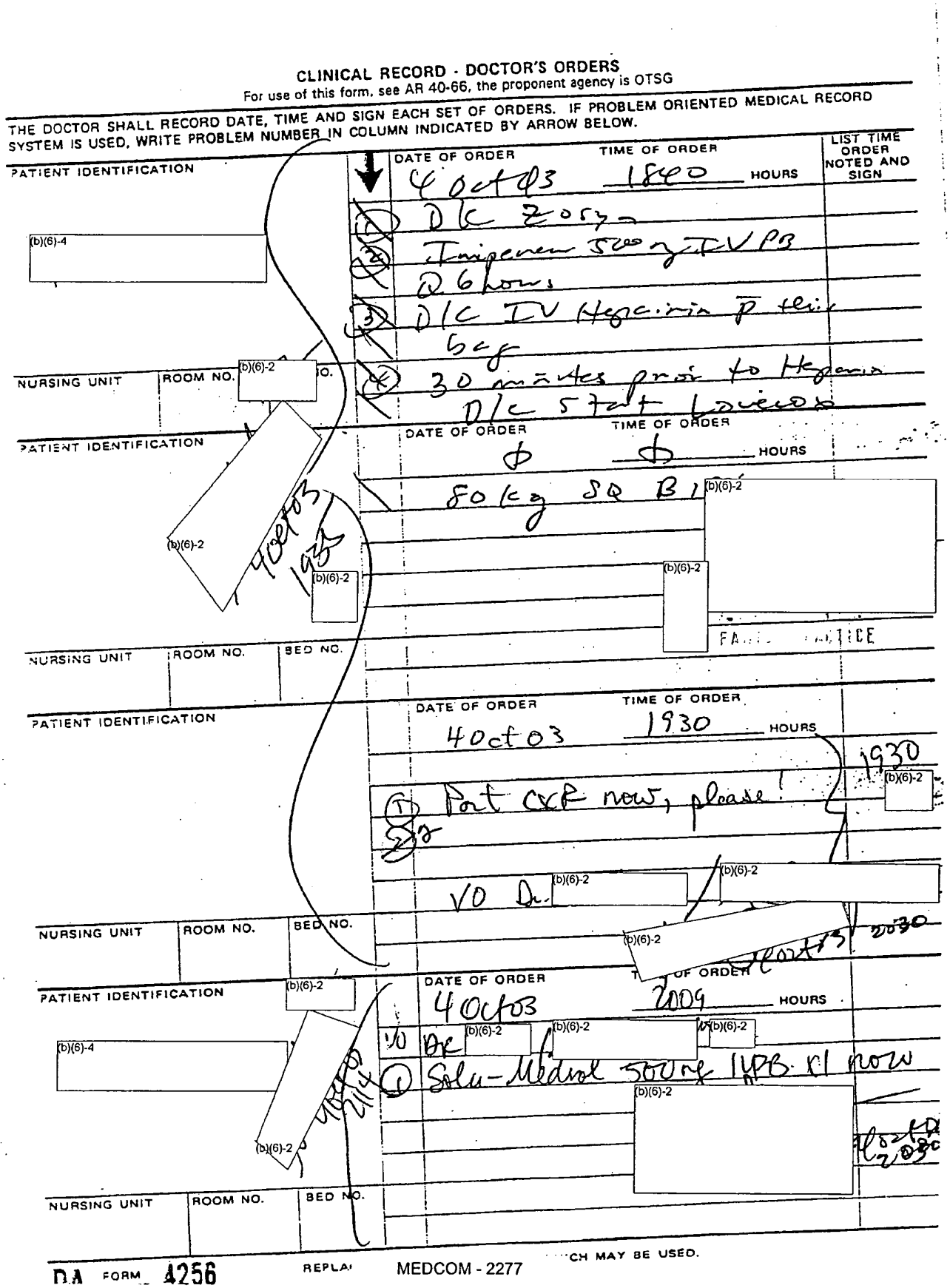
DATE OF ORDER: 4 Oct 03 | TIME OF ORDER: 1825 HOURS

1. ↓ rate to 17
2. ~~↑~~ TV to 550
3. PEEP to 10
4. check ABG
5. CXR in AM

1900 4 Oct

(b)(6)-2

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.



CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION (b)(6)-4

DATE OF ORDER: 4 Oct 03 — TIME OF ORDER: 1840 HOURS — LIST TIME ORDER NOTED AND SIGN

1. D/C Zosyn
2. Imipenem 500 mg IV PB Q 6 hours
3. D/C IV Heparin $\bar{p}$ this bag
4. 30 minutes prior to Heparin D/C Stat Lovenox

NURSING UNIT | ROOM NO. (b)(6)-2 | BED NO.

PATIENT IDENTIFICATION (b)(6)-2 (b)(6)-2

DATE OF ORDER: Ø — TIME OF ORDER: Ø HOURS

80 kg SQ B1 (b)(6)-2 (b)(6)-2

4 Oct 03 1935

FA... ...TICE

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 4 Oct 03 — TIME OF ORDER: 1930 HOURS

1930 (b)(6)-2

1. Port CXR now, please!
2. 2

VO Dr. (b)(6)-2 (b)(6)-2 (b)(6)-2

4 Oct 03 2030

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION (b)(6)-2 (b)(6)-4 (b)(6)-2

DATE OF ORDER: 4 Oct 03 — TIME OF ORDER: 2009 HOURS

VO Dr (b)(6)-2 (b)(6)-2 (b)(6)-2

1. Solu-Medrol 500 mg IVPB x1 now

(b)(6)-2

4 Oct 03 2114

4 Oct 03 2030

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 4256 REPLA... ...CH MAY BE USED.

MEDCOM - 2277

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION (b)(6)-4 (b)(6)-2 (b)(6)-2

DATE OF ORDER 4 Oct 03 TIME OF ORDER 2058 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) Lasix 80mg IV now (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

2114 4 Oct 03

PATIENT IDENTIFICATION (b)(6)-4 (b)(6)-2

DATE OF ORDER 4 Oct 03 TIME OF ORDER 2109 HOURS

(1) versed 2-5mg IV Q1° prn agitation

NURSING UNIT | ROOM NO. | BED NO.

240 ✓ [illegible] (b)(6)-2 (b)(6)-2

2115 4 Oct 03

PATIENT IDENTIFICATION (b)(6)-4 (b)(6)-2

DATE OF ORDER 5 Oct 03 TIME OF ORDER 0730 HOURS

(1) Lasix 20mg IV 0740

(2) Warm FIO2 to keep sats >95%

(3) Liver profile clem-10

(4) CXR portable (b)(6)-2 (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

Noted LCT AR 10/5/03 0755

PATIENT IDENTIFICATION (b)(6)-4 (b)(6)-2

DATE OF ORDER 5 Oct 03 TIME OF ORDER 1015 HOURS

(1) ↑ Tidal Volume to 600

(2) ABG @ 1200 (b)(6)-2 (b)(6)-2

NURSING UNIT | ROOM NO.

240 Chart ✓ 0100 Oct 03 (b)(6)-2 801 ON

Noted LCT AR 10/5/03 1045

FORM 4256 REPLACES MEDCOM - 2278 MAY BE USED.

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER: 5 Oct 03 TIME OF ORDER: 1820 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) Kcl 100 meq in 1 L NS
Run over 10 hrs (100 cc/hr)
(2) Hold maintenance IV when running problem

(b)(6)-2 noted 5 Oct 03 1820 LTA

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER: 5 Oct 03 2500 HOURS

(1) CBC Chem-12 in AM
(2) CXR in AM
(3) ABG in AM

noted 2315 5 Oct 03

(b)(6)-2 (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

24° Chart ✓ 6 Oct 03 0100 (b)(6)-2 Cpt AN

PATIENT IDENTIFICATION

DATE OF ORDER: 6 Oct. 03 0805 HOURS

(1) ↓ vent. rate to 15
(2) D/c vecuronium gtt
(3) ↓ f_{IO_2} to 40%

noted LTA 10/6/03 0955

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2 (b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER: 6 Oct 03 TIME OF ORDER: 1050 HOURS

(1) PEEP to 8

noted LTA 10/6/03 1115

(b)(6)-2

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

24° Chart ✓ 2215 6 Oct 03 (b)(6)-2 Cpt AN

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 2279

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

(b)(6)-4

(b)(6)-2

NURSING UNIT | R | BED NO.

DATE OF ORDER: 6 Oct 03 | TIME OF ORDER: 1400 HOURS | LIST TIME ORDER NOTED AND SIGN

(1) Vecuronium @ 5mg/hr
titrate per paralysis
(2) ABG @ 1500 ~

(b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-4

done 1435 6 Oct

NURSING UNIT | ROOM NO.

(b)(6)-2

DATE OF ORDER: 6 Oct 03 1445 HOURS

(1) CBC c̄ next blood draw

(b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-4

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

24° Chart ✓ 22 is 6 Oct 03

DATE OF ORDER: 6 Oct 03 | TIME OF ORDER: 1819 HOURS

verced 2mg in xr

(b)(6)-2

(b)(6)-2

(b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

TIME OF ORDER: HOURS

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 2280

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION: (b)(6)-4

DATE OF ORDER: 7 Oct 03 — TIME OF ORDER: 0735 HOURS — LIST TIME ORDER NOTED AND SIGN

(1) ↑ vent. rate to 16
(2) D/C Vecuronium
(3) Albuterol MDI now
(4) Fentanyl 150 μ IV, ↑ inf. to 200 μ/hr
(5) ↓ maintenance IVF to 50 cc/hr

(b)(6)-2

Noted TIA 10/7/03 0810

NURSING UNIT: 1CU — ROOM NO.: — (b)(6)-2 — MD (b)(6)-2

PATIENT IDENTIFICATION: (b)(6)-4

DATE OF ORDER: 7 Oct 03 — TIME OF ORDER: 0920 HOURS

(1) CBC, Chem-12 now and QAM
(2) CXR in AM and QD
(3) ↓ PEEP to 6

(b)(6)-2

NURSING UNIT: 1CU — ROOM NO.: — BED NO.:

PATIENT IDENTIFICATION: (b)(6)-4

DATE OF ORDER: 7 Oct 03 — TIME OF ORDER: 1355 HOURS

(1) Ativan drip titrate to light sedation
(2) ABG 1430
(3) ↑ Rate to 25
(4) Ativan 4 mg
(5) Tylenol Supp 650 mg PR q 6 p-w T>101

(b)(6)-2

NAS MD 7 Oct 03 1426

1426

NURSING UNIT: 1CU — ROOM NO.: — BED: (b)(6)-2

PATIENT IDENTIFICATION: (b)(6)-4

DATE OF ORDER: 7 Oct 03 — TIME OF ORDER: 1515

(1) ABG @ 1800

(b)(6)-2

7 Oct 03 1515

NURSING UNIT: 1CU — ROOM NO.: — BED NO.:

FORM 4256 REPLAC MEDCOM - 2281 H MAY BE USED.

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER: 7 oct. 03 TIME OF ORDER: 1817 HOURS

LIST TIME ORDER NOTED AND SIGN

7Oct03 1815 (b)(6)-2

① ↓ vent. rate to 23

② ↓ FiO_2 to 50%

③ ABG in 1 hr

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2 MD

(b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER: 7 oct. 03 TIME OF ORDER: 2137 HOURS

7Oct03 2145 (b)(6)-2

When Ativan runs out:

pro agitation: propofol 100 mcg/kg/min — titrate to effect

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2 MD

(b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER: 7 Oct 03 TIME OF ORDER: 2300 HOURS

[redacted]

② Vecuronium drip - titrate for paralysis

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER

HOURS

NURSING UNIT | ROOM NO. | BED NO.

4256 REPLACES EDI MEDCOM - 2282 BE USED.

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION: (b)(6)-4

DATE OF ORDER: 10/7/03 TIME OF ORDER: 2320 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) Vent - TV 600
/ SIMV 16
/ PEEP 8
/ Wean FIO_2 to keep Sats > 92

(2) Vecuronium drip - start @ 4 mg/hr
titrate for paralysis

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

(3) Vecuronium 10 mg IV - done
(4) LR 1000cc bolus Done
(5) D/C Propofol Done
(6) Versed @ 4 mg/hr Done
(7) Fentanyl @ 100 mg/hr Done
(8) ABG @ 2400

noted (b)(6)-2 0030 8 Oct 03

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER: 10/8/03 TIME OF ORDER: 1445 HOURS

(1) Δ TV to 750

(b)(6)-2

noted (b)(6)-2 8 Oct 03 1545

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1 APR 79 4256 REPLACES EC MEDCOM - 2283 Y BE USED.

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

(b)(6)-2

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
80d03	14.00 HOURS	

√(1) Vivonex @ 10cc/hr via NG tube
Dietary has Vivonex
√(2) Vent
IMV 16 PEEP 10
Sighs on TV 600

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER

FIO2 to maintain Sats >92% HOURS

√(3) Fentanyl/Versed to maintain light sedation
√(4) ↓ Covenox to 30mg SQ BID
√(5) Albuterol and mucomyst Nebs q4°

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER

√(6) CXR Portable ASAP HOURS
s/p bronch/central line placement
√(7) HOB @ 30 degrees all times
√(8) Check residual q4° (NG tube) if >200cc stop Vivonex
(9) ~~NS 1L with 100meq Kcl Run over 10hrs~~ (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER

HOURS

√(10) Kcl 100meq in 250cc NS run over 10hrs.
√(11) ↑ Maintenance IV to DsNS c̄ 20Kcl/l @ 125cc/hr
√(12) ABG QAM c̄ labs

NURSING UNIT | ROOM NO. | BED NO.

24° chart ✓ 0115 90ct03 (b)(6)-2 Cpt AN (b)(6)-2

DA FORM 4256 REPLACES MEDCOM - 2284 MAY BE

(b)(6)-2

ACLU-RDI 1099 p.1068

DOD 006336

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER: 8 Oct 03 TIME OF ORDER: 1810 HOURS

LIST TIME ORDER NOTED AND SIGN

1. ↑TV to 800, ↓Rate to 14
2. ABG @ 2000

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

1875 8 Oct 03

(b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER: 8 Oct 03 TIME OF ORDER: 2015 HOURS

VO bre (b)(6)-2 (b)(6)-2

1. ↓ FiO2 to 60%
2. ↓ Rate to 12
3. ↑TV 850

8 Oct 2015

NURSING UNIT | ROOM (b)(6)-2 | BED NO.

240 C. Gart V 9 Oct 03 0115 (b)(6)-2 (b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER: 0900 9 Oct 03 TIME OF ORDER: HOURS

1. ↑TV to 950
2. FIO2 to 40%
3. ↑ Vivonex to 20 cc/h

noted (b)(6)-2 91WML

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER: 9 Oct 03 TIME OF ORDER: 0930 HOURS

1. ↑TV to 1000
2. ↓ TMV to 1[illegible]

noted (b)(6)-2 91WML

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1 APR 79 4256 REPLACES ED MEDCOM - 2285 BE USED.

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
9 Oct 03	1420 HOURS	

(1) 2.5mg Neostigmine / 0.4mg Robinol & V - done
(2) ↓ Versed to 4mg/hr
(3) ↓ Fentanyl to 100mg/hr
(9) Vent AC 15
TV 1000

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

9 Oct 03 1450

(b)(6)-2

DATE OF ORDER	TIME OF ORDER
	FIO2 60
	PEEP 10

(3) D/C Vecuronium
(4) ABG @ 1445

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

9 Oct 03 1445

(b)(6)-2

DATE OF ORDER	TIME OF ORDER
9 Oct 03	1430 HOURS

(1) CR 1 liter bolus - done
(2) Type & cross 2 units PRBC
(3) Transfuse 2 units PRBC each over 3 hrs.
(9) ↓ FIO2 to 50

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER	TIME OF ORDER
9 Oct 03	1500 HOURS

(1) ↓ Vent Rate to 12
(2) ↓ FIO2 to 40

(b)(6)-2

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO. 9 Oct 03

DA FORM 1 APR 79 4256 REPLACES EDI MEDCOM - 2286 BE USED.

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

(b)(6)-4

(b)(6)-2

DATE OF ORDER: 90ct03 TIME OF ORDER: 2000 HOURS

LIST TIME ORDER NOTED AND SIGN

1. ↓ AC to 10
2. ↓ PEEP to 8

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER: 90ct03 TIME OF ORDER: 2200 HOURS

1. ↓ PEEP to 6 @ 0200 10/10/03
2. May give Versed 2mg IV q 1 prn

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER: 90ct03 TIME OF: 2330

1. ↓ Vent to SIMV done
2. Propofol for sedation
3. Versed 2mg IV - done

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER | TIME OF ORDER | HOURS

Propofol RATE 20-50 mcg/kg/min
INFUSION RATE @ 60-120 cc/hr
(10 mg/ml 100 ml BOTTLE).

(b)(6)-2

80 kg

(b)(6)-2

CPM

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1 APR 79 4256 REPLACES ED MEDCOM - 2287 Y BE USED.

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION: (b)(6)-4

DATE OF ORDER: 10/10/03 — TIME OF ORDER: 0830 HOURS — LIST TIME ORDER NOTED AND SIGN

Vent SIMV
Rate - 10
DEEP - 5
FIO_2 40
TV 1000

(b)(6)-2

NURSING UNIT | ROOM NO.

PATIENT IDENTIFICATION: (b)(6)-4

DATE OF ORDER: 10/028/03 — 1430 HOURS

D/c Versed
D/c Sentanyl
D/c Propofol
D/c NG tube
D/c Uvonix
Change Chest tube drain PRN
Venti mask 90%

NURSING UNIT | ROOM NO.

PATIENT IDENTIFICATION: (b)(6)-2 (b)(6)-4

DATE OF ORDER: (b)(6)-2

ABG 1430

1000 1430

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION: (b)(6)-4

DATE OF ORDER: 10/10/03 — TIME OF ORDER: 1800 HOURS

ABG now
Morphine 2-4 q2 prn

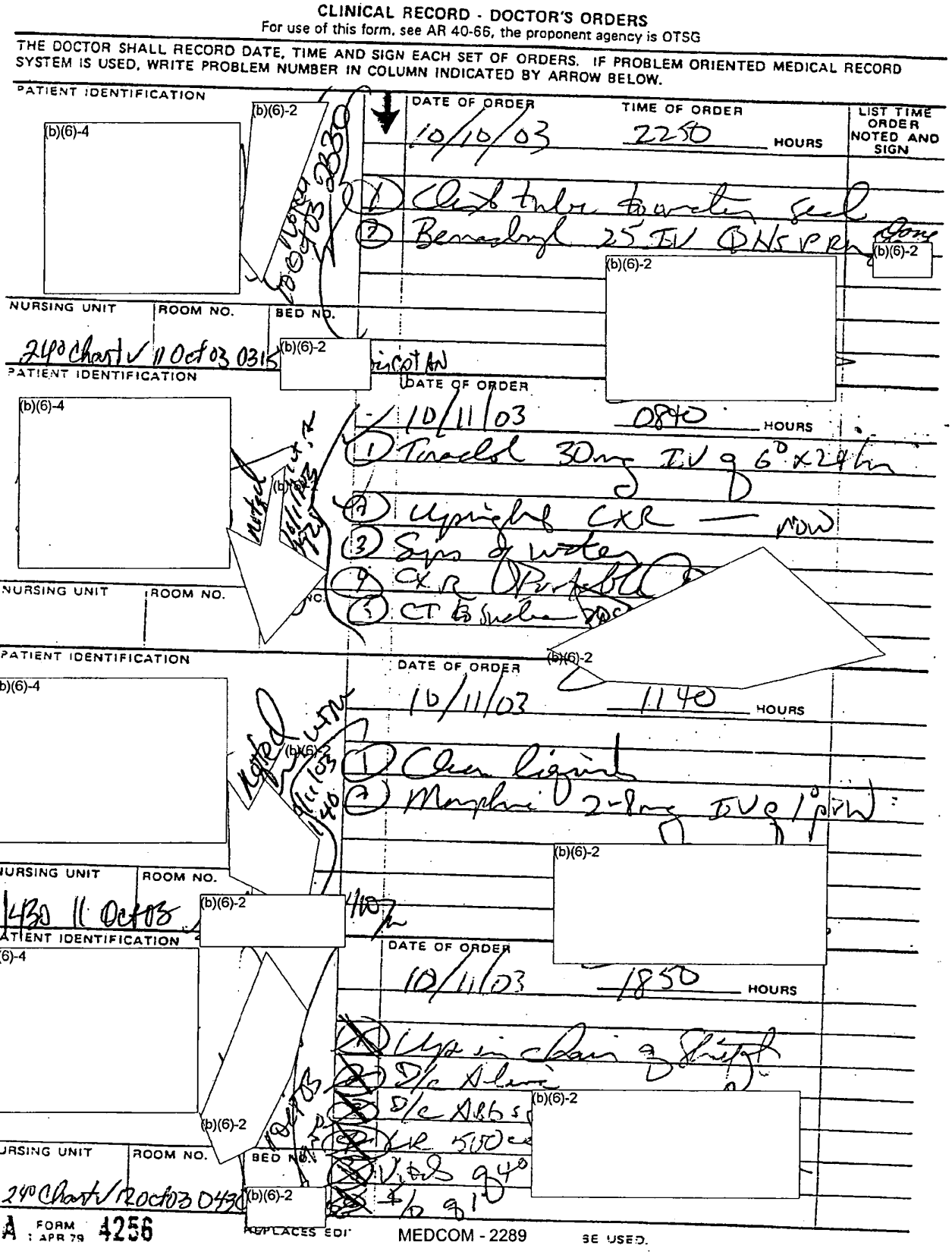
(b)(6)-2

noted

NURSING UNIT | ROOM NO. | BED NO.

24° Chart 0300 11 Oct 03 (b)(6)-2 Gotan

RM 4256 REPLACES : MEDCOM - 2288 MAY BE USED.



CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

(b)(6)-4 (b)(6)-2

DATE OF ORDER: 10/10/03 TIME OF ORDER: 2250 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Chest tube to water seal
2. Benadryl 25 IV QHS PRN done

(b)(6)-2 (b)(6)-2

NURSING UNIT: 240 Chart ✓ ROOM NO.: 11 Oct 03 0315 BED NO.: (b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER: 10/11/03 0840 HOURS

1. Toradol 30mg IV q 6° x 24 hrs
2. Upright CXR — now
3. Sys of water
4. CXR Portable
5. CT to Sucker

(b)(6)-2

NURSING UNIT ROOM NO.

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER: 10/11/03 1140 HOURS

1. Clear liquid
2. Morphine 2-8mg IV q 1° prn

(b)(6)-2

NURSING UNIT: 1430 11 Oct 03 ROOM NO.: (b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER: 10/11/03 1850 HOURS

1. Up in chair q Shift
2. D/c Alive
3. D/c Abbs
4. LR 500cc
5. Vitals q 4°
6. I/O q 1°

(b)(6)-2

NURSING UNIT: 240 Chart ✓ ROOM NO.: 12 Oct 03 0430 BED NO.: (b)(6)-2

DA FORM 1 APR 79 4256 REPLACES EDI MEDCOM - 2289 BE USED.

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION: (b)(6)-4

DATE OF ORDER: 10/12/03 — TIME OF ORDER: 0900 HOURS — LIST TIME ORDER NOTED AND SIGN

1) D/c foley
2) CT to water seal
3) Dulcolax supp 1/1 PR now

NURSING UNIT: ICU — ROOM — BED NO.: (b)(6)-2

noted ICT 10/12/03 0915

PATIENT IDENTIFICATION: (b)(6)-4

DATE OF ORDER: 10/13/03 — TIME OF ORDER: 0915 HOURS

2) Ambulate q shift
3) Portable CXR S/P CT removal
3) Reg diet

NURSING UNIT: ICU — ROOM — BED NO.: (b)(6)-2

noted ICT 10/13/03 0923

PATIENT IDENTIFICATION: (b)(6)-4

DATE OF ORDER: 10/14/03 — TIME OF ORDER: 1028 HOURS

1) D/c Imipenem
2) D/c Central line
3) ~~Pecac~~ DPC Pevegcat 1/1-1/11 po q 6° prn
4) D/c Zantac
5) D/c Labs
6) D/c Morphine
7) D/c X rays
8) D/c Staples / steri Str
9) Ambulate q shift

NURSING UNIT: ICU — ROOM NO. — BED NO.: (b)(6)-2

noted ICT 10/14/03 1105

PATIENT IDENTIFICATION: (b)(6)-4

DATE OF ORDER: — TIME OF ORDER: HOURS

NURSING UNIT: ICU — ROOM NO. — BED NO.: (b)(6)-2

noted

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77 WHICH MAY BE USED

MEDCOM - 2290

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER 10/15/03 TIME OF ORDER 0930 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) Acute Abd series
R/o obstruction

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 10/15/03 TIME OF ORDER 1025 HOURS

(1) Dulcolax 10mg po NOW

(b)(6)-2

NURSING UNIT | ROOM NO.

PATIENT IDENTIFICATION

DATE OF ORDER 10/15/03 TIME OF ORDER 1310 HOURS

D/C NEBULIZER T
V.O. Dr (b)(6)-2

(b)(6)-2

16 oct 03
0600

NURSING UNIT | ROOM | BED NO.

(b)(6)-2

16 oct 03
0900

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER 10/16/03 TIME OF ORDER 0850 HOURS

Discharge to MP's

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1 APR 79 4256 REPLACES EDI MEDCOM - 2291 BE USED.

...OD TRANSFUSION FLOW SHEET (VITALS)

...ICAL RECORD - SUPPLEMENTAL MED. ...DATA

For use of this form, see AR 40-400; the proponent agency is the Office of The Surgeon General.

REPORT TITLE: CONTINUED POST-ANESTHESIA CARE UNIT FLOW SHEET | OTSG APPROVED 17 Jan 80

	VITAL SIGNS						PAR SCORE							OTHER	
	Time	B/P	P	R	O_2Sat	T Ax/Tym	Act	Resp	Circ	LOC	Skin	PARS	Other	Neuro-Vascular	COMMENTS
unit	PRE-OP	/												Extr: L R Upper Lower Pulse: DP PT RAD	
#1	1730	118/63	111	18		100.7	- Pre-transfusion							Blanche Pulse / Warm Moves Y N	
	1735	119/66	110	17		100.7								Blanche Pulse / Warm Moves Y N	
	1740	120/60	110	15		100.4								Blanche Pulse / Warm Moves Y N	
	1745	119/64	104	16		101.0								Blanche Pulse / Warm Moves Y N	
	1800	112/65	106	14		100.7								Blanche Pulse / Warm Moves Y N	
	1830	128/74	100	15		100.7								Blanche Pulse / Warm Moves Y N	
	1900	133/71	102	20		100.5								Blanche Pulse / Warm Moves Y N	
:1	1930	121/66	99	14		99.8								Blanche Pulse / Warm Moves Y N	
...wn	2000	124/64	95	12		99.7								Blanche Pulse / Warm Moves Y N	
12		/												Blanche Pulse / Warm Moves Y N	
	2020	114/58	93	12		100.9	- Pre-transfusion							Blanche Pulse / Warm Moves Y N	
	2025	118/60	97	14		100.7								Blanche Pulse / Warm Moves Y N	
	2030	/				...my								Blanche Pulse / Warm Moves Y N	
	2035	128/62	95	11		100.7								Blanche Pulse / Warm Moves Y N	
	2050	132/61	98	15		100.6								Blanche Pulse / Warm Moves Y N	
	2100	132/61	101	16		100.6								Blanche Pulse / Warm Moves Y N	
	2115	/	106	16		100.2								Blanche Pulse / Warm Moves Y N	
	2130	121/65	101	13		100.4								Blanche Pulse / Warm Moves Y N	
	2200	124/54	98	15		100.2								Blanche Pulse / Warm Moves Y N	
	2230	131/58	108	20		100.2								Blanche Pulse / Warm Moves Y N	
	2300	126/58	102	16		100.2								Blanche Pulse / Warm Moves Y N	
		/												Blanche Pulse / Warm Moves Y N	
		/												Blanche Pulse / Warm Moves Y N	
		/												Blanche Pulse / Warm Moves Y N	
		/												Blanche Pulse / Warm Moves Y N	
		/												Blanche Pulse / Warm Moves Y N	
		/												Blanche Pulse / Warm Moves Y N	
		/												Blanche Pulse / Warm Moves Y N	
		/												Blanche Pulse / Warm Moves Y N	

PREPARED BY (Signature and Title) (b)(6)-2 MAJ AN | DEPARTMENT/SERVICE/CLINIC (b)(3)-1 CSH ICU | DATE 9 Oct 03

(Continue on reverse)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 1 MAY 78 4700 MEDCOM - 2292 ...OP 1b (Revised)

ACLU-RDI 1099 p.1076

DOD 006344

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)
For use of this form, see AR 40-407;
the proponent agency is the Office of The Surgeon General.

Mo. Oct Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 8	9	10	11	12
8 Oct 03	(b)(6)-2	HOB 30° at all	D	(b)(6)-2				
		times	E					
			N					
8 Oct 03		Check residual Qy°	D					
		(NGT) if >200cc stop	E					
		Vivonex	N					
8 Oct 03		ABG q AM c̄ labs	05					
8 Oct 03		CBC, Chem 12 Q AM	05					
8 Oct 03		CXR QD	05					
10 Oct 03		Diet - NPO	B					
			L					
			D					
10/11/03		SIPS OF WATER	D					
			E					
			N					
10/11/03		DIET: CLEAR LIQUIDS	D					
			E					
			N					
11 Oct 03		NIO: FLUSH TLC QShift	D					
			E					
			N					

Dated 10/12/03 (b)(6)-2

Dated 10/11/03 (b)(6)-2

Dated 10/11/03

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/p Ex lap appy S/p Chest labs x2 Resp Failure

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION:

(b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

D 8 9 10 11 12 13 14 15

E 16 17 18 19 20 21 22 23

N 24 01 02 03 04 05 06 07

FORM

MEDCOM - 2293

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON MEDICATION)

Mo _____ Yr _____

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
10 Oct	(b)(6)-2	D/C NGT	10Oct	1330		done
10 Oct		ABG @ 1430	10Oct	1430		
10 Oct		ABG now	10 OCT	NOW	1815	
Oct 11		UPRIGHT Portable CXR	11 Oct	Now	0900	
Oct 11		UPRIGHT CXR @ 1200	11 Oct	1200	1200	
11 Oct		D/C A-line	11Oct	1900	1920	
12 Oct		D/C Foley	12Oct	Now	0930	

(b)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED

MEDCOM - 2294

Vent Settings

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo. Oct Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 7 8 9 10
7OCT	(b)(6)-2	VENT SETTINGS: SIMV	D	(b)(6)-2
		RR 16 TV 600	E	D/C'd/Δ'd 7Oct03 1400 (b)(6)-2
		F_iO_2 40% PEEP 6	N	
7Oct	(b)(6)-2	VENT SETTINGS: SIMV	D	(b)(6)-2
		RR 16 V_T 600	E	(b)(6)-2
		F_iO_2 0.40 PEEP 8	N	Δ'd 8Oct03
8OCT03	(b)(6)-2	Vent Settings: SIMV 14	D	
8OCT03		Peep 10 TV 800	E	(b)(6)-2
		Sighs on F_{iO_2} to	N	Δ'd 8Oct (b)(6)-2
		Maintain Sats > 92%		
8Oct	(b)(6)-2	Vent - SIMV 12	D	
		V_T 850 F_iO_2 50%	E	(b)(6)-2 Δ'd 9Oct 031430 (b)(6)-2
		PEEP - 10, Sighs on F_{iO_2} to	N	
		Maintain SaO_2 > 92%		
9Oct	(b)(6)-2	Vent: SIMV 10	D	(b)(6)-2
		TV - 1000 F_iO_2 40	E	(b)(6)-2 D'cd 10/10/03
		PEEP 8, Maintain	N	
		SaO_2 792%		(b)(6)-2
10/10	(b)(6)-2	VENT SIMV RR 10	D	(b)(6)-2
		F_iO_2 40 TV 1000	E	D'cd 10/10/03
		PEEP 5	N	(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P EX LAP, APPY
S/P CHEST TUBES X2 RESP FAILURE

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION: (b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 1 OCT 78 4677 EDITION OF 1 DEC 77 MAY ...

MEDCOM - 2295

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON MEDICATION)				Mo Oct Yr 03
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
7 Oct	(b)(6)-2	ABG @ 1430	7 Oct	1430	1430	(b)(6)-2
7 Oct		↑ rate (vent) to 25	7 Oct	1400	noted	
7 Oct		Ativan 4mg IV	7 Oct	now	1400	
7 Oct		ABG @ 1800	7 Oct	1800	1800	
7 Oct		↓ vent rate to 23, ↓ FiO_2 to 50%	7 Oct	now	1815	
7 Oct		ABG in 1 hour	7 Oct	1915	1915	
08 Oct		ABG @ 2400	08 Oct	2400	2400	
7 Oct		Vent TV 600, SIMV 16, PEEP 8, FiO_2 to Keep Sat 2929	7 Oct	now	2320	
8 Oct		CXR portable - ASAP s/p central line placement	8 Oct	ASAP	Done	(b)(6)-2
8 Oct		ABG @ 2000	8 Oct	2000	2000	
9 Oct		Type and Cross 2 units PRBC	9 Oct	now	1445	
9 Oct		ABG @ 1445	9 Oct	1445	1450	
9 Oct		↓ FiO_2 to 50%	9 Oct	now	1450 done	
9 Oct		↓ Peep to 6 @ 0200 10/10/03	10 Oct 03	0200	0200	

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
7 Oct	(b)(6)-2	Tylenol Supp 650mg	7 Oct 1445	8 Oct 0930	9 Oct 1615	10/10 1310										
		T PR 96° prn T>101	T	T PR	T PR	T PR										

(b)(6)-2

☆ U.S. GPO:1997-418-290/55267

MAR RECOPIED 10/12/03

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General

Mo. 10 Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 12	13	14	15	16
10/11/03	RECOPIED (b)(6)-2	DIET: CLEAR LIQUIDS	D	(b)(6)-2				
			E					
			N					
10/11/03	RECOPIED (b)(6)-2	VITALS Q 4°	D					
			E					
			N					
10/11/03	RECOPIED (b)(6)-2	UP IN CHAIR Q SHIFT	D					
			E					
			N					
10/8/03	RECOPIED (b)(6)-2	HOB 30° at all TIMES	D					
			E					
			N					
10/8/03	RECOPIED (b)(6)-2	I&O RECORDING Q1°	D					
			E					
			N					
10/2/03	RECOPIED (b)(6)-2	INFT TO DRY LLQ OPEN WOUND AND (b) THIGH	04					
		BID	16					
10/12/02	RECOPIED (b)(6)-2	CHEST TUBES TO WATER SEAL	D					
			E					
			N					
16OCT03	D/C (b)(6)-2	N/O: FLUSH TLC Q SHIFT	D					
			E					
			N					
10/5/03	RECOPIED (b)(6)-2	CBC, CHEM 12 Q AM	05					
10/8/03	RECOPIED (b)(6)-	CXR QD	05					

DC'd 10/12/03 (b)(6)-2

DC'd 10/14/03 (b)(6)-2

DC'd 10/14/03 (b)(6)-2

DC'd 10/14/03 (b)(6)-2

DC'd 10/12/03 (b)(6)-2

DC'd 10/14/03 (b)(6)-2

ALLERGIES: YES X NO

PRIMARY DIAGNOSIS: S/P (b) CHEST TUBES D/T (b) PULMONARY RESP FAILURE EX LAP SM BOWEL REPAIR. APPY. LLC BOWEL REPAIR

ADDITIONAL PAGES IN USE: X YES NO

PAGE NO: _____

PATIENT IDENTIFICATION:

(b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

FORM

EDITION OF 1 DEC 72 IS OBSOLETE

MEDCOM - 2297

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON MEDICATION)					Mo _____ Yr _____
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials	
10/12	(b)(6)-2	Portable CXR s/p Chest TUBE Removal	10/12	ASAP			
10/14		D/C Central Line	10/14	NOW	1040	(b)(6)-2	
10/14		D/C Staples / Steri Strips	10/14	NOW	1050		
10/15		ACUTE ABD series	10/15	NOW	0945		

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED
10/10	Deleted (b)(6)-	Δ CT DRSG's PRN	

☆ U.S. GPO:1987-418-298/55267

ACLU-RDI 1099 p.1082

DOD 006350

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 10 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED
				10/11/12
10 Oct	(b)(6)-2	Chest tube to water seal	D	(b)(6)-2
			E	[signature] 10/11/03
			N	(b)(6)-2
10/11/03		CHEST TUBE TO SUCTION	D	
		20cm	E	[signature] 10/12/03
			N	(b)(6)-2
10/12/03		CHEST TUBES TO WATER	D	
		SEAL	E	
			N	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P Ex lap appy S/P Chest tube x2 Resp failure

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO: 2/2

PATIENT IDENTIFICATION:

(b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

FORM 1 OCT 73 457

EDITION OF 1 DEC 77 MAY BE USED.

MEDCOM - 2299

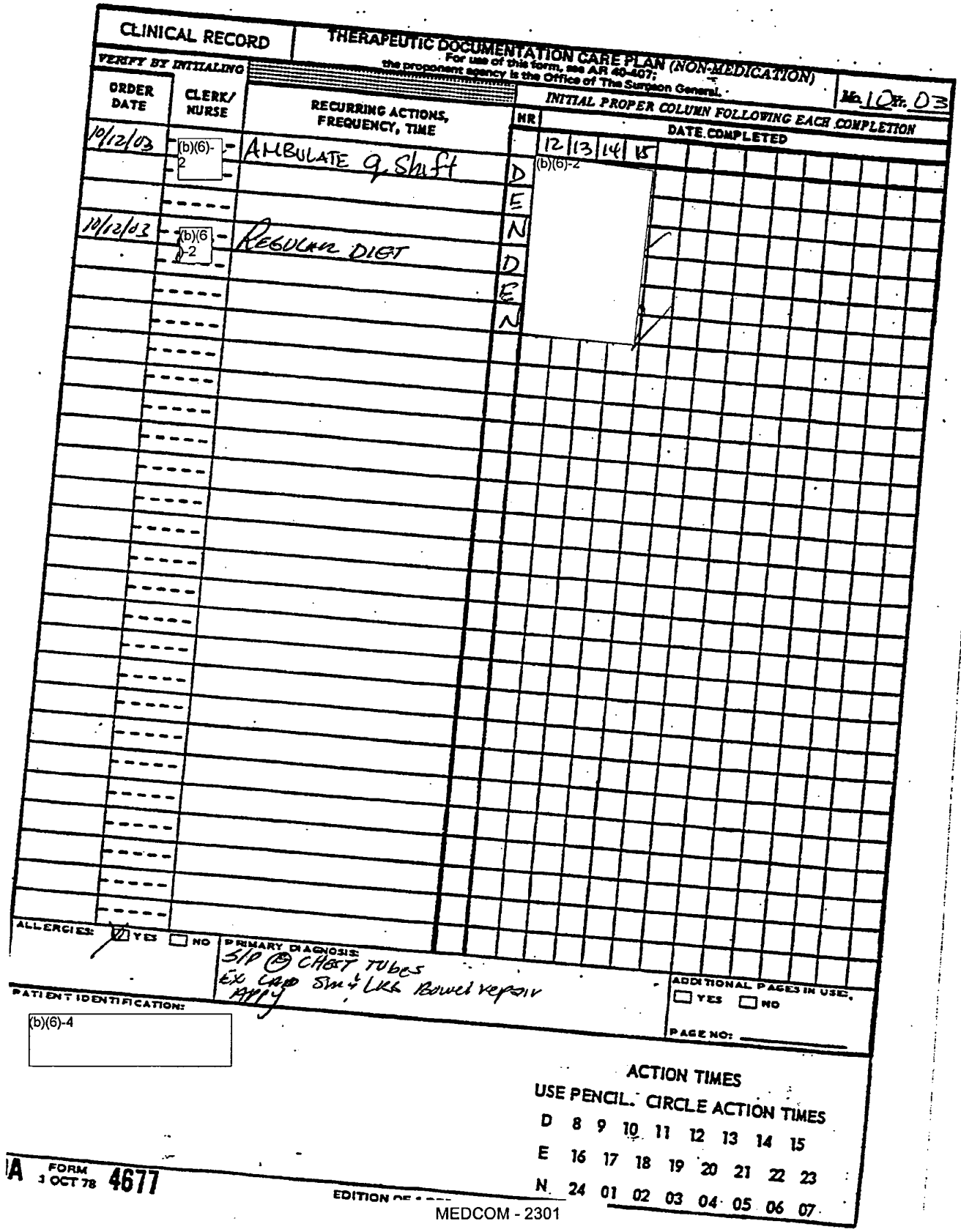
Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON MEDICATION)				Mo _____ Yr ____
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED														

☆ U.S. GPO:1987-418-230/55267

ACLU-RDI 1099 p.1084

DOD 006352



CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)

For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo. 10 Yr. 03

VERIFY BY INITIALING

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION — DATE COMPLETED 12 13 14 15
10/12/03	(b)(6)-2	AMBULATE q. Shift	D	(b)(6)-2
			E	
10/12/03	(b)(6)-2	REGULAR DIET	N	
			D	
			E	
			N	

ALLERGIES: ☑ YES ☐ NO

PRIMARY DIAGNOSIS: S/P (B) CHEST TUBES EX LAP SM & LRG Bowel repair APPY

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION: (b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

A FORM 1 OCT 78 4677

EDITION OF ...

MEDCOM - 2301

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo. 10 Yr. 03

VERIFY BY INITIALING

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR
2oct	(b)(6)-2 --	Diet-NPO	B
	--		L
	--		D
2oct03	--	NG → Low intermittent	D
	--	suction	E
	--		N
2oct	--	Foley to gravity	D
	--		E
	--		N
2oct	--	Vitals q 1° QH°	D
	--		E
	--		N
2oct	--	Wet to dry LLQ open	01
	--	wound and Dtrsg	16
	--	BID	/
2oct	--	Activity - bedrest	D
	--	~~OOB ↑~~ OOB TC	E
	--	QShift	N
2oct	--	I+O recordery Q1°	D
	--		E
	--		N
2oct	--	dncentrespirometer	D
	--	exercises	E
	--		N
40ct	--	Chest PT QD	D
	-----		E
	-----		N

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

DATE COMPLETED

2	3	4	5	6	7	8	9	10	11	12

(b)(6)-2

(b)(6)-2

(b)(6)-2

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P Ex Lap/Sm Bowel Repair/Resection Appy
LS Bowel Repair

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO: 1/2

PATIENT IDENTIFICATION:

(b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 1 OCT 78 4677

EDITION OF 1 OCT 78 IS OBSOLETE.

MEDCOM - 2302

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON MEDICATION)				Mo _____ Yr _____
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
2 Oct	(b)(6)-2	Admit to ICU - Gen Surg Choi/Brizuela	2 Oct 03	0545	0600	(b)(6)-2
2 Oct		Condition - stable	2 Oct	0545	0600	
		CBC, Chem 7 today @ 1200	2 Oct	1200	1200	
2 Oct		CBC PA-7 in AM	3 Oct	0500	0515	
4 Oct		(P) CXR "S/P intubation"	4 Oct	1100	1320	
4 Oct		PTT @ 1845	4 Oct	1845	1925	
4 Oct		ABG	4 Oct	1340	1341	
4 Oct		ABG	4 Oct	1925	1925	
4 Oct		CBC in AM	5 Oct	0500	0500	
4 Oct		(P) CXR x1 now	4 Oct	1935	1945	
4 Oct		PTT @ 0030	5 Oct	0030		
5 Oct		Liver Profile, Chem 10	5 Oct	Now	0845	
5 Oct		CXR Portable	5 Oct		[redacted]	b(6)2
5 Oct		CBC, Chem 12 in AM, ABG in AM	6 Oct	Am	0510	
5 Oct		CXR in AM	6 Oct	Am	0520	
6 Oct		ABG @ 1500	6 Oct	1500	1455	
7 Oct		CBC, CSTEM 12 Now	7 Oct	Now	0925	

Order/ Expir Date		PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED
10 Oct		ΔCT disg prn	

★ U.S. GPO:1987-418-290/55267

MEDCOM - 2303

WAR cont

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo. 10 Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 2 3 4 5 6 7 8
2oct	(b)(6)-2	LR 150cc hr	D	(b)(6)-2
			E	Dc'd 10/3/03
			N	(b)(6)-2
2oct	(b)(6)-2	Levaquin 500mg IV qd	08	
2oct		Flagyl 500mg IV q 12°	/	D/C 2oct03
2oct		Unasyn 3.0g IV q 6°	06	
			12	D/C 2111
			18	3oct03 (b)(6)-2
			24	
10/3/03	(b)(6)-2	D5NS c̄ 20meq KCl @	D	
		125cc hr	E	Dc'd 10/4/03
			N	(b)(6)-2
10/3/03	(b)(6)-2	FLUSH H/L TO ② AC	D	
		Q shift	E	
			N	
3oct	(b)(6)-2	Zosyn 3.375gm IVPB	06	
		Q6°	12	D/c'd
			18	4oct 1930 hr
			24	
4oct	(b)(6)-2	Vecuronium gtt 4mg/hr	D	
		titrate to effect	E	Dc'd 10/6/03
		5mg/hr	N	(b)(6)-2
4oct	(b)(6)-2	Versed gtt 2mg/hr	D	
		titrate to effect	E	
		8mg/hr	N	Rewritten 8oct03

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P Ex Lap/Sm Bowel Repair/Appy Resection. Lg Bowel Repair

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION:

(b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 1 OCT 78 4677

EDITION OF 1 DEC 77 MAY BE USED

MEDCOM - 2304

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON MEDICATION)				Mo ____ Yr ____
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
2 oct	(b)(6)-2	NS bolus ¼ liter now	2 oct	1230	1230	(b)(6)-2
2 Oct		NS ¼ Liter fluid bolus now	2 Oct	1720	1720	
4 Oct		Lasix 20mg IV X1 now	4 Oct	0904	0915	
4 Oct		Heparin 10,000 u IVP X 1 now	4 Oct	1445	1445	
4 Oct		lasix 20mg IVP X1 now	4 oct	1445	1445	
4 oct		Vec bolus 5mg x ¼	4 Oct	1550	1550	
4 Oct		Fentanyl bolus 150μ x ¼	4 Oct	1550	1550	
4 oct		Vec 5mg IVP now	4 oct	now	1650	
4 Oct		Versed 5mg IVP now	4 Oct	Now	1700	
4 Oct		Soln-Medrol 500mg IVPB X1 now	4 Oct	2030	2030	
4 Oct		Lasix 80mg IVP X1 now	4 oct	2113	2115	
5 OCT		LASIX 20mg IV	5 OCT	NOW	0734	
5 OCT		AB6 @ 1200	5 OCT	1200	1200	
5 OCT 03		Kcl 100meq in 1L NS - run over 10hrs (100ml/hr)	5 OCT	1830	started	
5 OCT 03		Hold maintainence IV while running potassium	/	/	/	
7 OCT		ALBUTEROL MDI NOW	7 OCT	Now	0740	
7 OCT		Fentanyl 150meq IV NOW	7 OCT	Now	0745	

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
2 oct	(b)(6)-2	Morphine 2-4mg IV	2 oct 4mg IV 0935	2 oct 4mg IV 1345	2 Oct 4mg 1515	2 oct 4mg 1735	2 Oct 4mg 1910	2 oct 4mg 2040	2 oct 4mg 2150	2 Oct 4mg 0200	3 oct 0625 4mg IV	3 oct 0855 4mg IV	3 oct 1130 4mg IV	3 oct 1245 4mg IV	3 oct 1732	3 oct 2000 4mg
		q 1° prn pain	(b)(6)-2													
2 Oct		Demerol 25mg and	2 oct 2245	0013 0245	3 oct 1345	3 oct 2140										
		Phenergan 12.5mg	(b)(6)-2													
		IV Q4° prn breakthrough pain														
3 Oct		Acetaminophen 650mg po 04-6° prn	2010 3 oct	4 oct 2230												
2 oct		M50 4 2-4mg Q1° prn	3 oct 0030	4 oct 0555	4 oct 0845	4 oct 0955										
		pain	4mg	2mg IV	4mg IV	2mg IV										
4 Oct		Versed 2-5mg IV Q1°	4 Oct 2000	7 Oct 2115	7 Oct 2125											
		prn	5mg	5mg	5mg											

Expired

Rewritten Oct 8 03 1400 (b)(6)-2

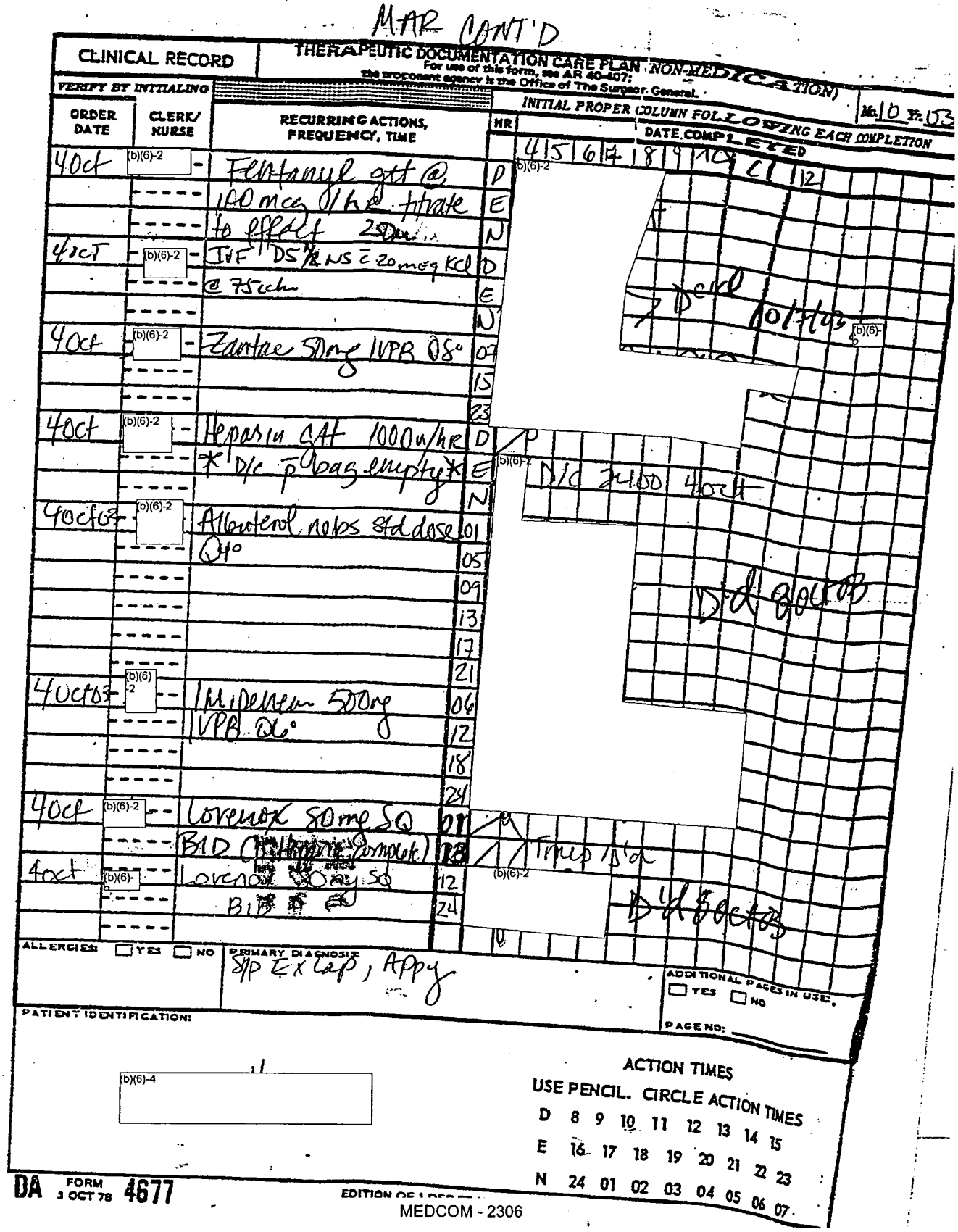
Expired

Expired

(b)(6)-2

☆ U.S. GPO:1997-418-290/55267

MEDCOM - 2305



MAR CONT'D

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

Mo. 10 Yr. 03

DATE COMPLETED 4 5 6 7 8 9 10 11 12

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR
4Oct	(b)(6)-2	Fentanyl gtt @	D
		100 mcg/hr titrate	E
		to effect 25	N
4Oct	(b)(6)-2	IVF D5 ½ NS ē 20meq KCl	D
		@ 75cchr	E
			N
4Oct	(b)(6)-2	Zantac 50mg IVPB Q8°	09
			15
			23
4Oct	(b)(6)-2	Heparin SAT 1000u/hr	D
		* D/c pump bag empty *	E
			N
4Oct03	(b)(6)-2	Albuterol neb's std dose	01
		Q4°	05
			09
			13
			17
			21
4Oct03	(b)(6)-2	Midazolam 50mg	06
		IVPB Q2°	12
			18
			24
4Oct	(b)(6)-2	Lorenox 80mg SQ	01
		BID (Hold for Sys BP < 100)	12
4Oct	(b)(6)-	Lorenox 80mg SQ	12
		BID	24

(b)(6)-2 D/C 2400 4Oct

(b)(6)-2 D/C 0600 4Oct

(b)(6)-2 D/C 0600 4Oct

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P Ex Lap, Appy

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION:

(b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D 8 9 10 11 12 13 14 15
E 16 17 18 19 20 21 22 23
N 24 01 02 03 04 05 06 07

DA FORM 3 OCT 78 4677

EDITION OF 1 DEC

MEDCOM - 2306

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON MEDICATION)				Mo ____ Yr ____
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
		~~may give vers dang IV P~~ [redacted]				
11 OCT	[redacted]	TORADOL 30mg IV Q6° X 24 h	10/11/03	NOW	0900	[redacted]
			10/11/03		1500	
			10/11/03		2100	
			10/12/03		0300	
10/12/03	[redacted]	DULCOLAX SUPPOSITORY T PR NOW	10/12/03	NOW	0930	

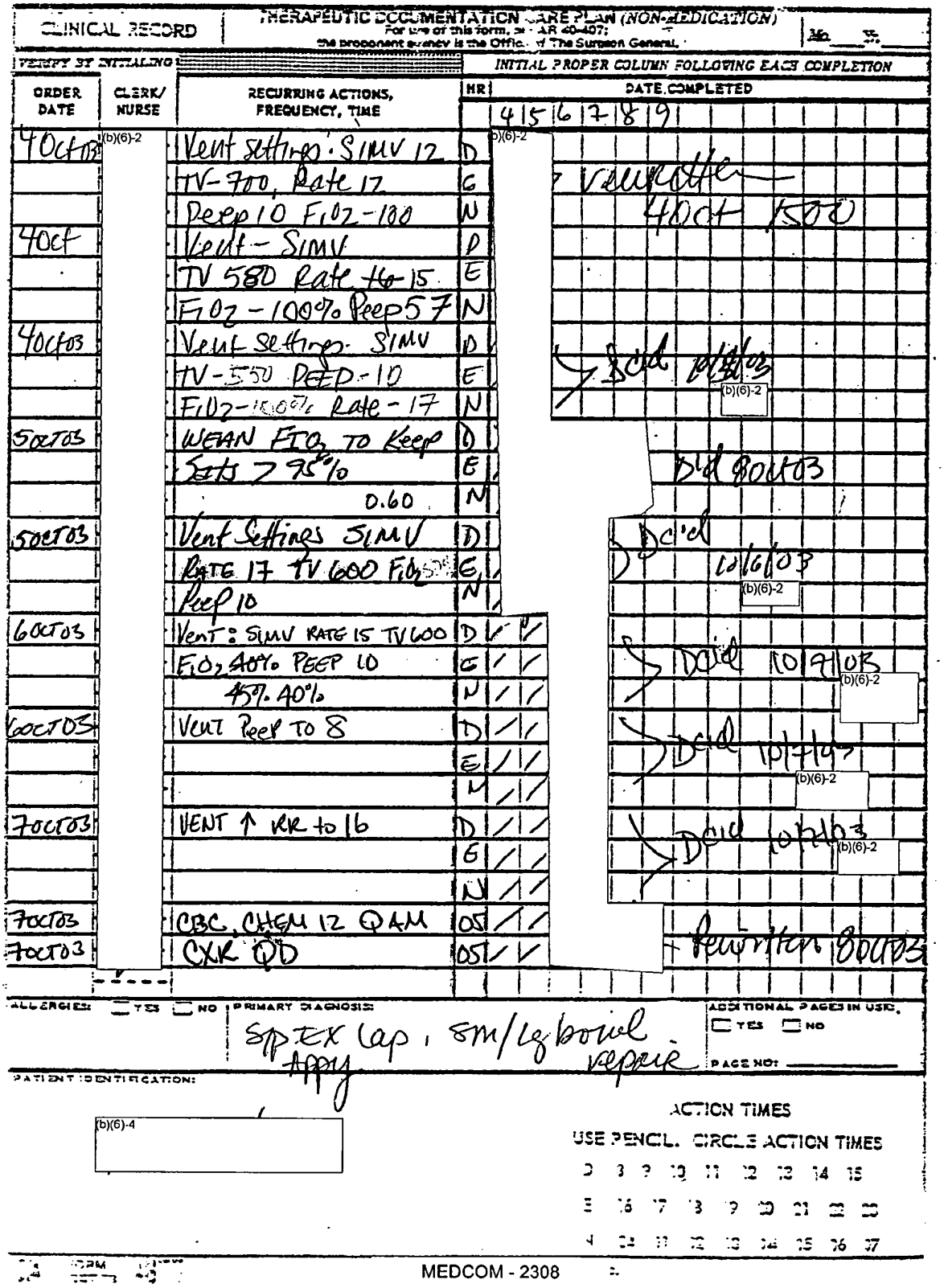
Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													
10 OCT 03	[redacted]	versed 2mg IV Q														
		1 hrs prn														
10 OCT 03		MS04 2-4mg IV q2° PRN	10 OCT 1815	10 OCT 2015	10 OCT 0250	10 OCT 0050	11 OCT 0250	11 OCT 0530	11 OCT [illegible]	[illegible]	11 OCT 1000					
			4mg IV	4mg IV	2mg	4mg	4mg	[illegible]	IV	IV	IV					
			[redacted]													
10 OCT 03		Benadryl 25IV QHS PRN	10 OCT 2250													
		b(6)2	[illegible]													
		~~Toradol 30mg IV Q6~~														
10/11/03		MS04 2-8mg IV Q1°	10/11 1440	10/11 1330	11 OCT 1505	11 OCT 1630	11 OCT 1750	11 OCT 1930	11 OCT 2145	11 OCT 2360	12 OCT 0150	12 OCT 0430	12 OCT 0520	12 OCT 0740		
		PRN	8mg IV	[illegible]	5mg IV	5mg	5mg	5mg	[illegible]	5mg	5mg	5mg	5mg	5mg IV		
			[redacted]													

DC'd 10/11/03 [redacted]

DC'd 10/12/03 [redacted]

☆ U.S. GPO:1997-418-290/55267

MEDCOM - 2307



CLINICAL RECORD

THERAPEUTIC DOCUMENTATION/CARE PLAN (NON-MEDICATION)
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 4 5 6 7 8 9
4Oct03	(b)(6)-2	Vent Settings: SIMV 12	D	(b)(6)-2
		TV-700, Rate 12	G	Resp Care
		Peep 10 FiO2-100	N	4Oct 1500
4Oct		Vent - SIMV	D	
		TV 580 Rate to 15	E	
		FiO2 - 100% Peep 5 7	N	
4Oct03		Vent Settings: SIMV	D	
		TV-550 PEEP-10	E	D/C'd 10/14/03
		FiO2-100% Rate-17	N	(b)(6)-2
5Oct03		WEAN FiO2 TO Keep	D	
		Sats > 95%	E	D/C'd 8Oct03
		0.60	N	
5Oct03		Vent Settings SIMV	D	D/C'd
		Rate 17 TV 600 FiO2	G	10/6/03
		Peep 10	N	(b)(6)-2
6Oct03		Vent: SIMV RATE 15 TV 600	D	D/C'd 10/9/03
		FiO2 40% PEEP 10	G	(b)(6)-2
		45% 40%	N	
6Oct03		Vent Peep to 8	D	D/C'd 10/14/03
			E	(b)(6)-2
			N	
7Oct03		VENT ↑ RR to 16	D	D/C'd 10/21/03
			G	(b)(6)-2
			N	
7Oct03		CBC, CHEM 12 QAM	05	
7Oct03		CXR QD	05	Rewritten 8Oct03

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Sp EX lap, SM/Lg bowel repair Appy.

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

(b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15

16 17 18 19 20 21 22 23

24 25 26 27 28 29 30 31 32 33 34 35 36 37

MEDCOM - 2308

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON MEDICATION)	Mo _____ Yr _____			
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED

MEDCOM - 2309

(MAR CONT.)

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo. 10 Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 6 7 8 9 10 11 12
10/6/03	(b)(6)-2	VECURONIUM @ 5mg/hr	D	(b)(6)-2
		TITRATE FOR PARALYSIS	E	DC'd 7 Oct 03
			N	(b)(6)-2
10/7/03	(b)(6)-2	D5 1/2 NS c̄ 20mEq KCl	D	
		@ 50cc/hr	E	
		D5NS c̄ 20mEq KCl	N	D'd 8 Oct 03
7 Oct 03	(b)(6)-2	Ativan drip - titrate	D	
		to light sedation	E	
		2mg/hr	N	
7 Oct 03	(b)(6)-2	PRN agitation : PROPOFOL	D	D/C 7 Oct 03
		100μ/Kg/min - titrate	E	
		to effect	N	
7 Oct 03	(b)(6)-2	Vecuronium drip start @	D	
		4mg/hr titrate for paralysis	E	N/C'd 9 Oct 03 (b)(6)-2
		7mg	N	
8 Oct 03	(b)(6)-2	Vivonex @ 10cc/hr via	D	
		NGT (dietary has vivonex)	E	DC'd 10/1/03
			N	(b)(6)-2
8 Oct 03	(b)(6)-2	Fentanyl/versed to	D	
		maintain light sedation	E	
		200 mcg	N	
8 Oct 03	(b)(6)-2	Lovenox 30mg SQ	12	
		BID	24	
8 Oct 03	(b)(6)-2	↑ maintainence IV to	D	
		D5NS c̄ 20kcl/L @ 125cc/hr	E	
			N	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P EX LAP APPY

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION: (b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 1 OCT 78 4677 EDITION OF 1 DEC 77 MAY BE ...

MEDCOM - 2310

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON MEDICATION)

Mo Oct Yr 03

Verify by Initialing: Order Date	Verify by Initialing: Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
8Oct03	(b)(6)-2	Kcl 100mEq in 250cc NS run over	8Oct03	Start 1900	[redacted]	(b)(6)-2
		10 hrs				
9Oct		LR 1 liter bolus	9Oct	now	1430	
9Oct	(b)(6)-2	Transfuse 2 units PRBC each #1	9Oct	ASAP	1730	
		over 3 hrs #2	9Oct		2020	
9 Oct	(b)(6)-2	2.5mg Neostigmine / 0.4mg Robinul IV	9Oct	now	anes 1415	
9 Oct	(b)(6)-2	Reversed to 4mg/hr.	9 Oct	noted		
9 Oct	(b)(6)-2	↓ Fentanyl to 100µ/hr	9 Oct	noted		
11 Oct	(b)(6)-2	Toradol 30mg IV				(b)(6)-2
11 Oct	(b)(6)-2	500 cc LR Bolus X1 now	11Oct	1900	1900	

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED

☆ U.S. GPO:1997-418-298/55257

MEDCOM - 2311

MAR RECORED 10/12/03

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo. 10 Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 12 13 14 15 16
10/8/03	RECORDED (b)(6)-2	↑ IV TO DSNS @ 20MEQ	D	(b)(6)-2
	-----	KCL @ 125cc/hr	E	
	-----		N	
10/4/03	RECORDED (b)(6)-2	ZANTAC 50mg IVPB	07	
	-----	Q8°	15	
	-----		23	
10/4/03	RECORDED (b)(6)-2	IMIPENEM 500mg	06	
	-----	IVPB Q 6°	12	
	-----		18	
	-----		24	
10/8/03	RECORDED (b)(6)-2	LOVENOX 30mg SQ	12	
	-----	BID	24	
10/8/03	RECORDED (b)(6)-2	ALBUTEROL SOL NEBS STD.	01	
	-----	DOSE & MUCOMYST 3cc	05	
	-----	Q 4°	09	
	-----		13	
	-----		17	
	-----		21	

DC'd 10/4/03 (b)(6)-2

DC'd 10/15/03 (b)(6)-2

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: S/P (B) CHEST TUBES D/T (B) PNEUMO EX LAP SM BOWEL REPAIR. APPY 2KG BOWEL REPAIR

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION (b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

D 8 9 10 11 12 13 14 15

E 16 17 18 19 20 21 22 23

N 24 01 02 03 04 05 06 07

DA FORM OCT 78 4017

EDITION OF 1 DEC 77 MAY BE USED.

MEDCOM - 2312

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON MEDICATION)				Mo _____ Yr _____
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
10/15/03	(b)(6)-2	DULCOLAX 70mg PO NOW	10/15	NOW	1035	(b)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
10 OCT	(b)(6)-2	BENADRYL 25mg IV QHS	12 Oct 2155													
		PRN	(b)(6)-2													
10/11/03		MS04 2-8mg IV Q1°	10/12 1060	10/12 1125	10/12 1335	12 Oct 1630	12 Oct 1900	12 Oct 2265	13 Oct 0230	13 Oct 0705	10/13 1830	13 Oct 1850	13 Oct 2400	13 Oct 0820	13 Oct 1000	D/C'd 14 Oct
		PRN	5mg IV (b)(6)-2	5mg IV	5mg	(b)(6)-2	5mg (b)(6)-2	3mg (b)(6)-2	3mg (b)(6)-2	4mg IV (b)(6)-2	5mg IV	5mg IV (b)(6)	5mg (b)(6)-2	3mg IV (b)(6)-2	3mg IV	(b)(6)-2
			E	E	E					E						
10/7		TYLENOL Supp 650mg PR														
		Q6° PRN T > 101														
10/14/03		PERCOCET I-II PO	10/14 1100	14 Oct 1700	14 Oct 2300	15/15 0620	10/15 1230	15 Oct 1800	16 Oct 0030	10 Oct 0715						
		Q6° PRN	II PO (b)(6)-2	II	II	II PO	II PO	II PO	II	(b)(6)-2						

☆ U.S. GPO:1997-418-290/55267

MEDCOM - 2313

MAR

CLINICAL RECORD | **THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)** For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General. | Month Yr. 03

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 8 9 10 11 12
8 Oct 03	(b)(6)-2	Albuterol nebs std. dose and mucomyst q4°	01 05 09 13 17 21	(b)(6)-2
8 Oct 03	(b)(6)-2	Versed gtt 2mg/hr titrate to effect	D E N	(b)(6)-2
090CT03	(b)(6)-2	propofol Rate 20-50mcg/kg/min infusion rate @ 60-120cc/hr (10mg/mL 100mL Bottle) pt 80 KG	D E N	(b)(6)-2
090CT03	(b)(6)-2	propofol for sedation	D E N	
090CT03	(b)(6)-2	↑ Vironex to 20cc/hr	D E N	
10 Oct	(b)(6)-2	O2 @ 40% via Venti Mask	D E N	Void 10/11/03 (b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/p exp lap SmBowell Repair Appy Chest tube x2 Resp Failure

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO PAGE NO: _____

PATIENT IDENTIFICATION: (b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES
D 8 9 10 11 12 13 14 15
E 16 17 18 19 20 21 22 23
N 24 01 02 03 04 05 06 07

DA FORM 1 OCT 78 4677 EDITION OF 1 DEC 77 MAY BE USED.
MEDCOM - 2314

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON MEDICATION)				Mo _____ Yr _____
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED
8 Oct	(b)(6)-2	Hydromorphone 650mg	10/8 1350 (b)(6)-2
		Supp. PO Q4-6° prn, T 7/01	

☆ U.S. GPO:1997-418-290/55267

ACLU-RDI 1099 p.1099

DOD 006367

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-400; the proponent agency is The Office of The Surgeon General

REPORT TITLE: POST ANESTHESIA CARE UNIT FLOWSHEET

OTSG APPROVED (Date): 17 Jan 80

PROCEDURE: Ex Lap/sm Bowel repair/Appy/Lg Bowel repair

PHYSICIAN: Br (b)(6)-2

ANESTHESIA BY: (b)(6)-2

Gen Spinal MAC Axillary
Local Bier Epidural Other

ALLERGIES: NKA

AIRWAYS: ____ Time DC'D ____

ETT Nasal Oral Trach

OXYGEN:

Mask Nasal Prongs Face Tent Blow-By

Liter/min. 12L Facemask %

ASA 2E History NO HISTORY

Cardiac Rhythm

IV#1 ____ Patent Infiltrated

Site RAC Rate ____ Gauge ____

IV#2 ____ Patent Infiltrated

Site C radial Rate ____ Gauge A-Line

VITAL SIGNS						PAR SCORE						OTHER	
Time	B/P	P	R	O2SA	Temp	Act	Resp	Circ	LOC	Skin	PARS	COMMENTS	Neuro-Vascular
PRE-OP	/												Extr: L R Upper Lower; Pulse DP PT RAD; Blanche Warm Pulse Moves Y N
PRE-OP	129/80												Blanche Warm Pulse Moves Y N
0555	172	144	26	97%	99.5	0	2	1	0	2	5	12L Facemask	Blanche Warm Pulse Moves Y N
0600	169	117	16	95%	94.5	0	2	1	0	2	5	12L Facemask	Blanche Warm Pulse Moves Y N
0605	171/69	130	19	96%		0	2	2	0	2	6	10L	Blanche Warm Pulse Moves Y N
0620	170/69	139	24	99%		0	2	2	0	2	6	10L	Blanche Warm Pulse Moves Y N
0635	173/80	110	22	100	97.2	0	2	2	0	2	6	10L.	Blanche Warm Pulse Moves Y N
0650	154/77	109	19	100		0	2	2	0	2	6		Blanche Warm Pulse Moves Y N
0705	149/77	115	24	100		0	2	2	0	2	6		Blanche Warm Pulse Moves Y N
	See ICU Flowsheet					0	2	2	0	2	6		Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N

POST ANESTHESIA RECOVERY SCORE "PARS"

Activity - General Anesthesia
2—Maintain head lift and open eyes
1—Unable to maintain head lift and open eyes
0—Unable to lift head and open eyes

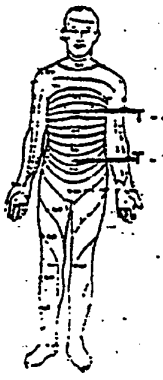
Activity - SAB or Subarachnoid Block
2—Moves all four extremities with control
1—Moves both upper extremities

Respirations
2—Spontaneous respiration; needs no support
1—Limited effort; needs artificial airway or jaw support
0—Needs ventilator; no spontaneous respiration

Circulation
2—BP 20% preanesthetic level
1—BP 20 - 50% preanesthetic level
0—BP 50% or more preanesthetic level

Level of Consciousness
2—Awake and alert; seldom dozes
1—Awakens when gently stimulated
0—Awakens only when vigorously stimulated

Skin
2—Normal skin color & temperature greater than 96°
1—Skin is pale, blotchy, dusky &/or temperature 95 - 96°
0—Cyanotic &/or temperature less than 95°



DRESSING:	Status	Location
Gauze		
Opsite		
Bandaid		
Steri-strips		
Collodian		
Peri-pad		
Coban		
Cotton Balls		
Ace Wrap		

TUBES AND DRAINS: Hemovac Foley NGT Chest Jackson-Pratt

(Continue on reverse)

PREPARED BY (Signature & Title): (b)(6)-2 CPT

DEPARTMENT/SERVICE/CLINIC: ICU-2

DATE: 020ct03

PATIENT'S IDENTIFICATION (For typed or written entries give: Name-last, first, middle; grade; date; hospital or medical facility)

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTICS STUDIES

☐ TREATMENT

DA FORM 1 MAY 78 4700

FH MDA OP 132-11a (Rev)

MEDCOM - 2316

MEDCOM - 2317

INTAKE			OUTPUT		
TIME	TYPE	AMT	TIME	TYPE	AMT
OR	crystal	5800	OR	EBL	300
	colloid	250	OR	Urine	500
TOTAL			TOTAL		

PACU NURSING NOTES: NURSING CARE PROBLEM NO.'S IDENTIFIED. Refer to FH MDA OP 39

NURSING CARE PROBLEMS: 1. RESP; 2. CIRC; 3. ACT; 4. LOC; 5. TEMP; 6. PAIN; 7. SAFETY; 8. ANXIETY; 9. EDUC; 10. OTHER

0545: 24 y/o dragi male received via ~~to~~ litter from OR accompanied by anesthesia providers. Ex lap dsg @ thigh dsg dry, intact. fmdefoundi
0700: Pt Δ from 10LFM → SWC dsg d+i — fmdefoundi MAPW
0730 - see ICU flowsheet for notes d/c recovery status fmdefoundi

(b)(6)-2

MEDICATION RECEIVED IN PACU/ICU

MEDICATION GIVEN BY:	DRUG	DOSE	ROUTE	TIME	PAIN LEVEL	EFFECTIVENESS

DISPOSITION SUMMARY: Nursing Care Problems No.'s_____ Resolved; No.'s_____ Continue.
Patient was transferred from PACU/ICU recovery room via litter/crib with siderails raised, or held by parent in wheelchair.
Dressing status:_____ PAR Score_____ Safety Straps_____
Report given to_____. Patient released by Anesthesia_____
Time out_____. Nurses Signature:_____

1. DATE AND TIME OF CAPTURE	2. SERIAL NO.	
20031201/2305 hrs	(b)(6)-4	A
3. NAME		4. DATE OF BIRTH
(b)(6)-4		1964
5. RANK	6. SERVICE NO.	
CIV		
7. UNIT OF EPW	8. CAPTURING UNIT	
N/A	(b)(3)-1	
9. LOCATION OF CAPTURE *(Grid coordinates)*		
10. CIRCUMSTANCES OF CAPTURE	11. PHYSICAL CONDITION OF EPW	12. WEAPONS, EQUIPMENT, DOCUMENTS
attacking US Forces	severely wounded	

DD FORM 2745, MAY 96

REPLACES DA FORM 5976, JAN 91, USABLE UNTIL EXHAUSTED.

ADMISSION AND CODING INFORMATION

For use of this form, see AR 40-400; the proponent agency is OTSG

1. REPORTING MTF	A 1 4 A 1
2. MTF LOCATION (State or Country Code.)	I Z
3. REGISTER NUMBER	(b)(6)-4
NAME (Last, First, Middle Initial)	(b)(6)-4
4. PAY GRADE	CIV
5. SEX	M
6. DATE OF BIRTH (Y Y Y Y M M D D)	
7. AGE AT ADMISSION	
8. RACE	X
9. ETHNIC BACK-GROUND	9
RELIGION	
10. LENGTH OF SERVICE	
ETS	
11. FMP	9 9
12. SOCIAL SECURITY NUMBER	(b)(6)-4
ORGANIZATION (Active Duty Only)	CIV
13. MARITAL STATUS	
HOUR OF ADMISSION	2230
BRANCH / CORPS	
14. FLYING STATUS	
15. BENEFICIARY CATEGORY	K 7 6
16. ZIP CODE OF RESIDENCE	
17. UNIT LOCATION (State or Country Code)	
18. MOS	
19. TRAUMA	
PREV. ADMISSION	YEAR ☒ NO
20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	0
WARD	ICU
NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	
ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	(b)(3)-1 CSH FWD
TELEPHONE NUMBER OF EMERGENCY ADDRESSEE	
21. TYPE OF DISPOSITION	05
22. MTF TRANSFERRED TO	Tranfer to Civilian Hospital
23. DATE OF DISPOSITION (Y Y Y Y M M D D)	2 0 0 3 1 0 1 6
24. CLINIC SVC - ADMITTING	A B A A
25. MTF TRANSFERRED FROM	A 1 4 A 1
26. DATE THIS ADMISSION (Y Y Y Y M M D D)	2 0 0 3 1 0 0 2
27. LOCATION OF OCCURRENCE (Battle Casualty Only)	
28. MTF OF INITIAL ADMISSION	A 1 4 A 1
29. DATE INITIAL ADMISSION (Y Y Y Y M M D D)	
FOR LOCAL USE	

Dx: 86354, 86330, 5128, 5185, E9912

Rx: 4502, 4533, 4561, 4591, 4675, 3464.52, 9670, 3893

5794

Trauma 9

Injury 569

(b)(6)-2

(b)(6)-2

MAJ, MC USA

SIGNATURE OF ADMITTING CLERK

(b)(6)-2

4 (x2) PAD USA

DA FORM 2985, MAR 2000 EDITION OF MAR 89 IS OBSOLETE ISAPA V1.00

MEDCOM - 2319

INPATIENT TREATMENT RECORD COVER SHEET *(For Plate Imprinting)*

For use of this form, see AR 40-400; the proponent agency is the Office of The Surgeon General.

PATIENT DATA ITEMS 1 - 30 *(Excluding Items 25 & 26)*

Iraqi # (b)(6)-4

(b)(6)-4

(b)(6)-4

(b)(3)-1

LINE	LEGEND
1	REGISTER NO. - NAME - GRADE
2	SEX - AGE - RACE - RELIGION - LENGTH OF SVC - ETS - PREVIOUS ADMISSION
3	FMP - SSN - ORGANIZATION - WARD
4	FLY STAT - RATING/DESG - DEPT/BEN - BRANCH/CORPS - UIC/ZIP - TYPE CASE
5	SOURCE & AUTHORITY FOR ADMISSION - HOUR OF ADMISSION - CLINIC SVC
6	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
7	ADDRESS OF EMERGENCY ADDRESSEE - PHONE NO. - DATE OF THIS ADMISSION
8	NAME & LOCATION OF MEDICAL TREATMENT FACILITY DATE OF INITIAL ADMISSION

ADMISSION REMARKS

(b)(6)-4

(b)(6)-4

(b)(6)-2

32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED

25. TYPE DISPOSITION: D/C to cage

26. DATE OF DISPOSITION: 3 Oct 03

31. SELECTED ADMINISTRATIVE DATA

☐ CHECK IF CONTINUED ON REVERSE

33. CAUSE OF INJURY

GSW to (R) leg; c̄ Femur Fracture

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Supracondylar femur fx. open c̄ GSW to leg. E922.9 ICD9.02

- External Fixation device
- Incision and drainage V45.2

☐ CHECK IF CONTINUED ON REVERSE

35. TOTAL DAYS THIS FA[illegible]

a. ABSENT SICK DAYS	b. [illegible]	c. CONV LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

36. TOTAL DAYS ALL [illegible]

a. ABSENT SICK DAYS	b. [illegible]	c. CONV LV/COOP [illegible]	d. SUPPLEM[illegible] CARE [illegible]	e. [illegible]	f. TOTAL SICK DAYS

SIGNATURE OF ATTEN[illegible] [illegible]EDICAL OFFICER [illegible] [illegible]FFICER

FLY PRACTICE

DA FORM 1 MAY 79 3647-1 EDITIO[illegible]

(b)(6)-2

MEDCOM - 2320

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

PERTINENT HISTORY, CHIEF COMPLAINT, AND CONDITION ON ADMISSION *(Enter date of admission)*

25y/o Iraqi Male I GSW to (R) leg. WAS Attempting to FIRE RPG at 1st ~~bat~~ HQ in Talifar. Return fire injured man.

NKA
mads ø

PHYSICAL EXAMINATION

HEENT-NCAT, Abd-soft,
NVI to (R) Foot, DP 1/4.
Entrance wound Lat thigh; Exit Anterior Lat Knee ~ 8 mm
(L) leg, ARMS INTACT.
XRAYS: (R) comminuted supracondylar Fx.

PROGRESS *(Enter date of discharge and final diagnosis)*

- Admitted to ~~I~~ ID, Application Ex Fixator (R) leg.
- D

(b)(6)-2

SIG	DATE	IDENTIFICATION NO.	ORGANIZATION
	2 Oct 03		

PATIENT'S IDENTIFICATION *(For typed or written entries give Name last, first, middle; grade; date; hospital or medical facility)*	REGISTER NO.	WARD NO.

ABBREVIATED MEDICAL RECORD
Standard Form 539

GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
USAPPC V1.00

MEDCOM - 2321

834-4176

CHRONOLOGICAL RECORD OF MEDICAL CARE

CAL RECORD

SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)

DATE

: 134/88 (3) Vomit, GSW (R) Knee poss fx dist femur

88 - Splint / Dress 1L

- involved in GSW incident 1-187 region

.16 - Notes some discomfort @ (R) Knee

: 97.4 - Periodic nausea / vomitting

PMdHx ∅

PSxHx ∅

Allergies NKDA (?)

Meds Received @ 2400 hr

A. Morphine 10mg IM

B. 1g Ancef

C. 1l IVF

(O) VITALS → noted

GEN: (A+O)x4. MMMoist. Capefill instant

HEENT: Head NC c̄ laceration noted @ (R) Eyebrow.

~3-4mm length

NECK: Full ROM. ∅ Spinous TTP

LUNGS: CTAOL

CV: HRRR s̄ @ 1/2 lg. ∅ S3, S4

(R) LE: Knee c̄ entry @ suprapatellar to patella region

c̄ 3+ Effusion.

+2 pulses @ (R) LE c̄ capefill 1-2 sec

XRAYS → Distal 3rd Femur fracture noted, comminuted

(A)/(P) 1. GSW to (R) Knee — c̄ (R) Distal 3rd of Femur (R)

— IVFs 2l

— Splint in place

— Morphine (dose)

— Phenergan 12.5mg IV

— To evac to 26st CVH

2. (R) Eyebrow laceration

— Cleaned c̄ H_2O_2 + Irrigated

— For suture @ 26st

3. (L) foot abrasion

— Cleaned + redressed

(b)(6)-2

(b)(6)-2 MAJ, MC,

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	REGISTER NO. / WARD NO.

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)

CHRONOLOGICAL RECORD OF MEDICAL CAR

Medical Record

STANDARD FORM 600 (REV. 6-97)

Prescribed by GSA/ICMR

FIRMR (41 CFR) 201-9.202-1

USP

Bed #2

PRINTED ON RECYCLED PAPER

MEDCOM - 2322

CHRONOLOGICAL RECORD OF MEDICAL C...

SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)

RECORD

03 Prehospital - Received 25 yo Iraqi ♂ c̄ GSW to (R)
20) Anterior Leg. PIV infiltrated. NRB @ 15 Lpm.
21) Airway - Monitors Placed. GCS-15. Airway Patent.
Lgs CTAB. ABD Soft. Pelvis Stable. (+) entrance to
Posterior (R) Femur. (+) Exit. (+) Pedal Pulse.
Bleeding Controlled.
0224) PIV 18 ga (R) AC Placed. LABS Sent. Type / X-match x IV
0228) Ancef + gm IVPS. Tetanus .5 cc IM. V.S.S.
0235) X-ray @ Bedside. Given MSO4 5 mg IVP
0300) Ortho @ Bedside. X-rays Complete. V.S.S.
0330) V.S.S. Awaiting for OR.
0530) V.S.S. Awaiting for OR

Meds
0235 Ancef + Gm IVPS
0235 Tetanus .5 cc IM

Vitals
0220 101/64 - 77 - 20 - 98.3 - 100%
0300 112/72 - 80 - 20 - 100%
0330 107/85 - 77 - 20 - 100%
0400 104/62 - 74 - 24 - 99%
0525 115/70 - 70 - 22 - 99% - Ortho

IVF's - 2100 cc

UA - Ø

(b)(6)-2

HOSPITAL OR MEDICAL FACILITY	SSN/ID NO.	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME		RELATIONSHIP TO SPONSOR	WARD NO.
		REGISTER NO.	

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)

(b)(6)-4

Porus #
Civ ♂ Iraqi
Trauma -

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

USP LVN

PRINTED ON RECYCLED PAPER

MEDCOM - 2323

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
2 Oct 03 1615	Reinforced Drsg to Ex fix site – RLE – Moderate amt Serosanguinous fluid noted. Pt assisted in turning / rotating leg. [redacted]
1830	Pt tolerated dinner well. ~50% [redacted]
2130	Noted Bright red blood saturated thru RLE drsg. Notified Dr [redacted] of ↑ in drainage. VSS. Afebrile. VOP – OS, Reinforced drsg ± ABD pad & Kerlex. Pt tolerated c̄ minimal pain. Will continue to monitor [redacted]
2230 Oct 02, 03	Doing well NAD % RLE pain recived M30Y 5mg for pain 7/10 will re-✓ effect in 10-15 min. A10x3 See DA Form 4700 for assessment [redacted]
2245 Oct 02, 03	Sleeping rises and fall off chest noted. [redacted]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

REGISTER NO.

WARD NO. ICU

POTUS # [redacted]

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

MEDCOM - 2324

NSN 7540-00-634-4178

AUTHORIZED FOR LOCAL REPRODUCTION

ISG Note

MEDICAL RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
10/2/03	Evacuation - Pleural 25 gr Incis & ~ GSW to (R)
0220	Anterior Lg. RV Infiltrated. NAD & IS Lg.
0221	Anesthesia - Monitors Placed. GCS - 15. Airway Patent. Lgs CTAB. ABD Soft. Pelvis Stable. (+) actions to Restrain (R) Femur. (+) EBL. (+) Pedal Pulses. Bleeding Controlled.
0224	RN Begin (R) AC Placed. LABS Sent. Type/X-match x IU
0228	Anes + Dr IVPs. Tetanus .5 cc IM. V.SS.
0235	X-ray & Bedside. Chest NSG 5 y IVP
0300	Ortho & Bedside. X-rays Complete. VSS.
0330	V.SS. Awaiting for OR.
0530	V.SS. Awaiting for OR

Vitals

0220	101/64 - 77 - 20 - 98.3 - 100%
0300	112/72 - 80 - 20 - 100%
0330	107/85 - 77 - 20 - 100%
0400	104/62 - 74 - 24 - 99%
0525	115/70 - 72 - 22 - 99%

Meds

0235	Anes + Cefaz IVPs
0235	Tetanus .5cc IM
	IVF's = 2100 cc
	UA - 0

HOSPITAL OR MEDICAL FACILITY		DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* | REGISTER NO. | WARD NO.

Potus # [redacted]

Civ & Invol

Trauma -

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1
USP LVN

MEDCOM - 2325

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
30 Oct 03	OP Note
	Pre Op Dx - GSW to (R) DISTAL Femur
	Post Op Dx - same
	Proced 1. ITD GSW
	2. Application of Ex Fix
	(b)(6)-2 [redacted]
	GET
	TF - 1,500 cc EBL - 20 cc
	DRAINS: T penrose
	Complications - ø
	FINDINGS: Communited supracondylar Fx.
	Ex-fix placed. Sent to ICU in stable condition.
	(b)(6)-2 [redacted]
	MAJ (b)(6)-2 [redacted]
02 Oct 03	Nursing Notes: Pt admission & AM assessment performed. See Critical Care Flowsheet.
	(b)(6)-2 [redacted]
30 Oct 03	Ortho Attend
	USS Afebrile
	WOUND clean. Reinforced 2 times.
	(+) DF/PF. Had breakthrough Pain. H/H 13/39.

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	(b)(6)-2 [redacted]
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	(b)(6)-2 [redacted]

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

REGISTER NO. MAJ (b)(6)-2 [redacted] | WARD NO.

/ (b)(6)-4 [redacted]

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

USP LVN

MEDCOM - 2326

558-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp)

LOG NUMBER

ARRIVAL

DATE DAY	MONTH	YR.	TIME
01	10	03	0220

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☐ OTHER (Specify)

CURRENT MEDS. (tetanus immunization and other data): Ø

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES: NKA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration): GSW (R) Femur

SEX: M AGE: 25

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

VITAL SIGNS

TIME	0245	0323	
BP	101/64	107/85	Ø
PULSE	77	77	
RESP.	20	21	
TEMP.	100.1	98.3	
WT. (Child)	100%	100%	

CATEGORY (See reverse)
- EMERGENT
- URGENT
- ✓ NON-URGENT 6/6/2

ORDERS	INITS.	TIME
Ancef 1g IV	[redacted]	0300
dTC 5cc IM	[redacted]	0300
MSO4 8mg IV	[redacted]	✓

ASSESSMENT/DIAGNOSIS: (R) Knee distal femur fx.

DISPOSITION (Check all that apply): HOME / FULL DUTY

QUARTERS: 24 Hrs. / 48 Hrs. / 72 Hrs.

MODIFIED DUTY UNTIL: DAY / MONTH / YEAR

REFERRED TO (Indicate clinic)

EMERGENCY / TODAY / 72 HOURS / ROUTINE

ADMIT. TO HOSP. UNIT/SERVICE: OR

CONDITION UPON RELEASE: ✓ IMPROVED / UNCHANGED / DETERIORATED

TIME OF RELEASE: 0515

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

TIME SEEN BY PROVIDER: 0 22C.

25 yo Iraqi civilian s/p GSW to (R) knee in Talifor. Seen there by Dr. Rivers. Transfer here for care.

P - Ø
S - Ø.

23.6 / 39.3 / 210

140 / 10.1 / 12 / 12
3.1 / 1.2

C-\ UDUN.

HEENT
CV
back
lungs
abd
neuro - ACx4. MAE. Nonfocal.
extr - (R) knee GSW EW ant superior knee.
Ø EW (+) crepitus
DP 2+ Moves toes
Sensation intact
Ø other injuries

CXR
abd XR

XR
comminuted distal femur fx (R) leg.
Ø frags.

Ancef → OR - ORTHO (Gup to) for ex-fix.
+ Gen. Surgery (Eastman / Choi)

(CONTINUE ON SF 507, IF NEEDED)

PATIENT'S IDENTIFICATION (Mechanical imprint)
FOR WRITTEN ENTRIES GIVE: Name - last, first, middle; SSN; DOB, service status, name and relation of sponsor or next of kin. (IMPORTANT: LIST FACILITY HOLDING TREATMENT RECORD).

Potus # (b)(6)-4

SIGN (b)(6)-2 MMT MC

INST... ...ons ordered, any limitations and follow-up plans)

→ OR for ORIF.

EMERGENCY CARE AND TREATMENT

STANDARD FORM 558 (Rev. 6-82)
Prescribed by GSA and KMR

MEDCOM - 2327

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	02 Oct 03
DOS	02 Oct 03
POD	

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside			
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

(b)(6)-2 PN | Department/Service/Clinic: ICU | DATE: 02 Oct 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade;date; hospital or medical facility)*

POTUS 44 (b)(6)-2

☐ HISTORY/PHYSICAL ☐ FLOWCHART

☐ OTHER EXAMINATION Or EVALUATION ☐ OTHER(Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 2328

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R									2					2								2		
	RADIAL L									2					2								2		
	DORSALIS PEDIS R									2					2								2		
	DORSALIS PEDIS L									2					2								2		
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale										1 3 8					1 3 8								1 3 8		
EDEMA										Ø					Ø										
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)										✓					✓								✓		
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)										NSR					NSR								✓		
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH								✓																
	FOLEY CARE								✓																
	ORAL CARE																								
MOBILITY	BEDREST									✓					✓								✓		
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT									S													S		
	LEFT									S													E		
	SUPINE		—							✓													L		
	HOB 30 DEGREES									✓					✓								F		
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE																								
	PAIN SCALE (1-10)									5/10					6/10								✓	7/10	
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended														2									2	
BOWEL SOUNDS (active all quads)															✓									Lx0	
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT										✓					✓									✓	
VOIDING CLEAR, YELLOW URINE q.s.										✓					✓									✓	
SKIN INTEGRITY	No Breakdown																								
(R) LE Ext Fix (D) Ant Foot	Surgical Wounds Rt foot sutures									✓					✓									✓	
	Rashes, Lac's, etc									✓					✓									✓	
DRESSING (Dry & Intact: specify site below)																									
#1 R L E Ext Fix (Coban Guard)										✓					✓									✓	
#2																									
#3																									
										[b)(6)-2															

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
18g IV	(R) AC	02 Oct 03	Opsite, tape, CDI

SIZE	PUPILS	MOTOR FUNCTION	Not Applicable /Absent (blank)
mm	= Equal	0 = No Movement	Refer to Nsg. Notes X
mm	R Reactive	1 = Slight Flicker/ Trace of Contraction	
mm	NR NonReactive	2 = Active (Gravity Eliminated)	
mm	L > R Left Larger	3 = Active: against gravity, but not against resistance	No Change from Previous Assessment –
mm	R > L Right Larger	4 = Active: Against Gravity and Resistance, not full strength	
		5 = Full Strength against Examiners Resistance	

DATE: 02 Oct 03

TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
BEST EYE-OPENING RESPONSE																								
(4) Opens Spontaneously (2) To Pain									4					4								4		
(3) To Voice (1) Does Not Open																								
BEST VERBAL RESPONSE																								
(5) Oriented (2) Garbled									5					5								5		
(4) Confused (1) No Response																								
(3) Inappropriate Verbal Response																								
BEST MOTOR RESPONSE																								
(6) Obeys Commands (3) Flexion to Pain									6					6								6		
(5) Localizes to Pain (2) Extension to Pain																								
(4) Withdraw to Pain (1) No Response																								
GLASCOW COMA SCALE (A+B+C)									15					15								15		
PUPIL RESPONSE R									2+					2+								+2		
Size (mm), React to L									2+					2+								+2		
Light (+) No Response (-)									5					5								5		
MOVEMENT RUE									5					5								5		
(See Motor Function LUE									3					3								3		
Scale at Top of Page) RLE									5					5								5		
LLE									5					5								5		
GRIP (S) Strong R									5					5								✓		
(W) Weak (-) absent L									✓					✓								✓		
RESPIRATIONS REGULAR																								
IRREGULAR																								
UNLABORED																								
LABORED																								
SHALLOW																								
RETRACTIONS																								
BREATH SOUNDS RUL										5				5/2								5		
(5) Clear LUL										5				5/2								5		
(4) Crackles																								
(3) Rhonchi RLL										5				4								4		
(2) Wheeze																								
(1) Diminished LLL										5				4								4		
BOTH BASES										5				4								4		
COUGH NONE																								
SPONTANEOUS																								
PRODUCTIVE																								
NONPRODUCTIVE										5				4								✓		
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																								
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																								
VENTILATOR Vt																								
FIO2																								
RATE (SIMV/CMV)																								
PEEP / CPAP																								
PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE NC (l/min)																								
FM (l/min)																								
NRBM (l/min)																								
ETT #_____ ETT _____cm gums																								
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED																								
INCENTIVE SPIROMETRY DONE																								
COUGH / DEEP BREATH																								
INITIALS																								

(b)(6)-2

(b)(6)-2

(b)(6)-2

ACLU-RDI 1099 p.1114

DOD 006382

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200																	
0300																	
0400																	
0500																	
0600																	
0700																	
0800																	
0900	100°	68	17	127/78	100%												[b)(6)-2]
1000																	
1100																	
1200																	
1300																	
1400	100.5	79	14	122/73	98%												[b)(6)-2]
1500																	
1600																	
1700																	
1800																	
1900																	
2000																	
2100																	
2200	99.5	88	16	126/69	99%												
2300																	
2400																	

ACLU-RDI 1099 p.1115

DOD 006383

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable /Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment –

DATE: 02 Oct 03

TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (2) To Pain (3) To Voice (1) Does Not Open									4					4								4		
B. BEST VERBAL RESPONSE (5) Oriented (2) Garbled (4) Confused (1) No Response (3) Inappropriate Verbal Response									5					5								5		
C. BEST MOTOR RESPONSE (6) Obeys Commands (3) Flexion to Pain (5) Localizes to Pain (2) Extension to Pain (4) Withdraw to Pain (1) No Response									6					6								6		
GLASCOW COMA SCALE (A+B+C)									15					15								15		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — R									2+					2+								+2		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — L									2+					2+								+2		
MOVEMENT (See Motor Function Scale at Top of Page) — RUE									5					5								5		
MOVEMENT (See Motor Function Scale at Top of Page) — LUE									5					5								5		
MOVEMENT (See Motor Function Scale at Top of Page) — RLE									3					3								3		
MOVEMENT (See Motor Function Scale at Top of Page) — LLE									5					5								5		
GRIP (S) Strong (W) Weak (-) absent — R									5					5								5		
GRIP (S) Strong (W) Weak (-) absent — L									5					5								5		
RESPIRATIONS — REGULAR									✓					✓								✓		
RESPIRATIONS — IRREGULAR																								
RESPIRATIONS — UNLABORED									✓					✓								✓		
RESPIRATIONS — LABORED																								
RESPIRATIONS — SHALLOW																								
RESPIRATIONS — RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RUL									5					5/2								5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — LUL									5					5/2								5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RLL									5					4								4		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — LLL									5					4								4		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — BOTH BASES									5					4								4		
COUGH — NONE									✓					✓								✓		
COUGH — SPONTANEOUS																								
COUGH — PRODUCTIVE																								
COUGH — NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																								
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																								
VENTILATOR — Vt																								
VENTILATOR — FiO2																								
VENTILATOR — RATE (SIMV/CMV)																								
VENTILATOR — PEEP / CPAP																								
VENTILATOR — PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE — NC (l/min)																								
OXYGEN DELIVERY DEVICE — FM (l/min)																								
ETT #_____ — NRBM (l/min)																								
ETT #_____ — ETT _____cm gums																								
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED																								
INCENTIVE SPIROMETRY DONE														(b)(6)-2										
COUGH / DEEP BREATH									✓													✓		
INITIALS									(b)(6)-2													(b)(6)-2		

ACLU-RDI 1099 p.1116

DOD 006384

	INTAKE									OUTPUT							
	IVF Maint	PO	IVPB						Total	urine						Total	COMMENTS
0100																	
0200																	
0300																	
0400																	
0500																	
0600																	
0700																	
0800																	
8 HR									8 HR.							8 HR	
0900	100/100																
1000	100/200	80/80								625/625							
1100	100/300																
1200	100/400	140/220								375/1000							
1300	100/500																
1400	100/600		50/50							400/1400							
1500	100/700																
8 HR	100/800	220	50						16 HR. 1070	1400/700/800						16 HR.	
1700																	
1800																	
1900																	
2000																	
2100																	
2200		200/420	100/100							100/200							
2300																	
2400																	
8 HR		420	100						24 HR. 1590							24 HR	2900

NSN 7540-00-634-4123

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
02Oct03	0900		Pt OR recovery complete. Admitted to ICU, pt A & OX3, speaks and understands English well. Pt has 2.5 cm long suture line above (R) eyebrow. PERRLA 2+ c̄ slow accommodation to light. Lungs CTA (B), pulse ox 99% on Room Air, pt understands cough, deep breath teaching. 18g IV cath patent & infusing D5NS c̄ 20 mEq KCL @ 100 cc per dial-a-flo s̄ difficulty. (R) ext fixator intact c̄ guage dressings & coban wrap c̄ sm amt of bright red drainage from proximal pins, dressing reinforced. (L) anterior foot circular wound 2.5 cm in diameter clean & dry c̄ Φ dressings. Foley catheter patent & draining clear yellow urine into closed drainage system s̄ difficulty, cath holder applied to upper (R) thigh. Pt denies need for medication, pt grimaces when moving (R) leg on own. Pt denies pain or discomfort. Will continue to monitor pt. (b)(6)-2 [redacted] KAN
02Oct03	11:30		Pt offered water. Pt drank 80 cc s̄ N or V. While continue to monitor. (b)(6)-2 [redacted] KAN
02Oct03	66.2	12:15	Pt ate <25% of lunch s̄ N or V. Will continue to monitor. (b)(6)-2 [redacted] KAN
02Oct03		1400	Assumed care. Pt resting in bed, HOB @ 30°. D5NS c̄ 20 K infusing @ 100 cc/°. IV to (R) AC CDI ø s/s infection/infiltration A & OX3. c/o "Alem" pointing to RLE. Administered Percocet ii per pin order. Will monitor effectiveness. VSS - although slightly febrile @ 100.5 s/congn/deep breaths encouraged. RLE N/V intact. cap refill <3 sec. + 2 pulses. Slight drng noted @ pin sites - bright red blood. Dhux undern[illegible] will continue to monitor (b)(6)-2 [redacted] KAN

MEDCOM - 2334

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	02 Oct 03
DOS	03 Oct 03
POD	1

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	1590
24 Hour Output	2900
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside			
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

(b)(6)-2

Department/Service/Clinic: ICU

DATE: Oct 3, 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade;date; hospital or medical facility)*

PO TO2 (b)(6)-4

- ☐ HISTORY/PHYSICAL
- ☐ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☐ OTHER(*Specify*)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 2335

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R	2						2																	
	L	2						2																	
	DORSALIS PEDIS R	2						2																	
	L	2						2																	
SKIN (1) Dry (4) Cool (7) Jaundiced (2) Clammy (5) Flushed (8) Color Normal (3) Warm (6) Cyanotic (9) Pale		1 3 8						1 3 8																	
EDEMA																									
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)		✓						✓																	
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)		✓																							
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH																								
	FOLEY CARE																								
	ORAL CARE																								
MOBILITY	BEDREST	✓						✓																	
	BSC																								
	DANGLE	S						S																	
	CHAIR	E						E																	
POSITIONED	RIGHT	L						L																	
	LEFT	F						F																	
	SUPINE																								
	HOB 30 DEGREES							✓																	
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE																								
	PAIN SCALE (1-10)	7/10						7/10																	
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended	2						2																	
BOWEL SOUNDS (active all quads)		↓						hypo																	
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT		✓						✓																	
VOIDING CLEAR, YELLOW URINE q.s.		✓						✓																	
SKIN INTEGRITY	No Breakdown																								
(R) LE Ext Fix	Surgical Wounds	✓						✓																	
Eyebrow Suture	Rashes, Lac's, etc	✓						✓																	
DRESSING (Dry & Intact: specify site below)																									
#1 (R) LE Ext Fix		✓						✓																	
#2 (L) Ant Foot		✓						✓																	
#3																									

(b)(6)-2

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
89	(R) AC	02 Oct 03	CAI

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PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable /Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment –

DATE: 030CT03

TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open	4						4																	
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response	5						5																	
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response	6						6																	
GLASCOW COMA SCALE (A+B+C)	15						15																	
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — R	2+						2+																	
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — L	2+						2+																	
MOVEMENT (See Motor Function Scale at Top of Page) — RUE	5						5																	
MOVEMENT (See Motor Function Scale at Top of Page) — LUE	3						5																	
MOVEMENT (See Motor Function Scale at Top of Page) — RLE	5						5																	
MOVEMENT (See Motor Function Scale at Top of Page) — LLE	3						3																	
GRIP (S) Strong (W) Weak (-) absent — R	5						5																	
GRIP (S) Strong (W) Weak (-) absent — L	5						5																	
RESPIRATIONS — REGULAR	✓						✓																	
RESPIRATIONS — IRREGULAR																								
RESPIRATIONS — UNLABORED	✓						✓																	
RESPIRATIONS — LABORED																								
RESPIRATIONS — SHALLOW																								
RESPIRATIONS — RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RUL	5						5																	
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — LUL	5						5																	
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RLL	4						1																	
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — LLL	4						1																	
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — BOTH BASES	4						1																	
COUGH — NONE	✓						✓																	
COUGH — SPONTANEOUS																								
COUGH — PRODUCTIVE																								
COUGH — NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																								
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																								
VENTILATOR — Vt																								
VENTILATOR — FiO2																								
VENTILATOR — RATE (SIMV/CMV)																								
VENTILATOR — PEEP / CPAP																								
VENTILATOR — PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE — NC (l/min)							6																	
OXYGEN DELIVERY DEVICE — FM (l/min)							9																	
OXYGEN DELIVERY DEVICE — NRBM (l/min)							1																	
ETT #_____ — ETT _____cm gums							8																	
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED																								
INCENTIVE SPIROMETRY DONE																								
COUGH / DEEP BREATH	✓						✓																	
INITIALS	(b)(6)-2						(b)(6)-2																	

ACLU-RDI 1099 p.1121

DOD 006389

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200																	
0300																	
0400																	
0500																	
0600																	
0700																	
* 0800	99.1	98	17	122/68	99%	—	88	—									(b)(6)-2
0900																	
1000																	
1100																	
1200																	
1300	99.1																
1400																	
1500																	
1600																	
1700																	
1800																	
1900																	
2000																	
2100																	
2200																	
2300																	
2400																	

ACLU-RDI 1099 p.1122

DOD 006390

NSN 7540-00-634-4123

MEDICAL RECORD			NURSING . TES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
3Oct03	0100		Received prn med (Percocet II) for pain LRE 8-10 will re-v in 35-40 min. [redacted]
	0420		Labs done tolerated well [redacted]
03OCT03	0605		Assumed pt care. Pt c/o (R) LE pain, 7/10 on pain scale. (R) AC HL 18g IV Cath patent & flushes easily. Suture line above right eyebrow ē s/s of infection. (R) LE EXT FIX intact c̄ gauze & coban dressings reinforced. (R) anterior foot circular wound CDI. Tmax 99.1. Will continue to monitor pt. [redacted]
03OCT03	11:27		Pt c/o (R) LE pain, 9/10 on pain scale. Medicated pt c̄ Percocet II po prn per pain order. Will continue to monitor. [redacted]
03OCT03		13:15	Pt has Tmax of 99.7; will inform on coming shift. [redacted]
03OT03		13:20	Pt attempted urination per urinal c̄ Ø output. Pt stated through translator that he will attempt later. Foley DCd @ 0950 and pt teaching reinforced of urinating on own c̄ in 6-8 hrs after urinary cath removal. Pt verbalized understanding. [redacted]

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	INTAKE									OUTPUT						
	PO	IVPB							Total	Urine					Total	COMMENTS
0100																
0200	100															
0300																
0400	50 150															
0500	100 250									550						
0600	120 370	50	50													
0700																
0800																
8 HR									8 HR						8 HR	
0900	30 30									450 450						
1000																
1100	160 190															
1200	60 250															
1300	100 350															
1400																
1500																
1600																
8 HR									16 HR						16 HR	
1700																
1800																
1900																
2000																
2100																
2200																
2300																
2400																
8 HR									24 HR						24 HR	

b)(6)-2

MEDCOM - 2340

MEDIC... .CORD - PATIENT RELEASE / DISCH... INSTRUCTIONS

For use of this form, see MEDCOM Circular 40-5

DIRECTIONS: To be completed by attending provider and other staff at time of patient release following an outpatient procedure, extended care/treatment or discharge from an inpatient hospital stay.

SECTION I
TO BE COMPLETED BY PRIVILEGED PROVIDER

1. DATE OF PROCEDURE/ADMISSION: 2 Oct 03
2. ADMITTING/DIAGNOSIS: Right Femoral Supracondylar Fx
3. PERTINENT LAB, X-RAY, FINDINGS:
   open Commeanted (R) Femur Fx.
4. PROCEDURES, TREATMENT, HOSPITAL COURSE:
   I-TD (R) Femur; App Ex Fix (R) Knee.
5. FINAL DIAGNOSIS AND CONDITION AT DISCHARGE:
   Same Good.
6. ACTIVITY: Up to chair BID as tolerated
7. DIET: Reg
8. MEDICATIONS:
   ☐ Medications have been prescribed for home use. See separate list and special instructions or see below.
   1. ~~Percocet~~ TYLOX [redacted] b6-2 T-II p.o. q 4-6 PRN Pain
   ~~2. MVI T p.o. q DAY~~ [redacted] b6-2
   3. Keflex 500 mg T p.o. q 8° x 7 DAYS. (0600, 1400, 2200)
9. INSTRUCTIONS (To Home Health Providers, Patient, etc):
   1. DAILY Pin cleaning with Hydrogen Peroxide / Sterile WATER (50-50 mix)
   2. Dressing change (R) leg.
   3. F/U Sunday at 1000 if still here.
10. DISCHARGING PROVIDER:
    (b)(6)-2
    (Signature) (Printed or Stamped Name)

PATIENT IDENTIFICATION

POTUS # (b)(6)-4

SECTION II
TO BE COMPLETED BY OTHER STAFF, AS APPROPRIATE

1. DISPOSITIONED TO: ☐ HOME ☐ DUTY ☐ OTHER
   ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER
2. ACCOMPANIED BY: ☐ FAMILY ☐ FRIEND ☐ OTHER
3. PATIENT EDUCATION:
   Completed and patient prepared for home care. ☐ YES ☐ NO
   If no, explain:
   Patient ☐ states ☐ demonstrates understanding of home care needs.
   Printed educational materials provided:
4. Clinical outcomes met and post-discharge/release referrals made.
   ☐ YES ☐ NO If no, explain:
5. If transferred to another health care facility, report called to nurse.
   ☐ YES ☐ NO If no, explain:
6. NUTRITION CARE - Comments:
7. MEDICATIONS:
   Explained by: ☐ NURSE ☐ PHYSICIAN ☐ PHARMACIST
   Printed medication literature provided. ☐ YES ☐ NO
   Patient states understanding of prescribed medications. ☐ YES ☐ NO
8. EQUIPMENT/SUPPLIES PROVIDED:
9. FOLLOW-UP APPOINTMENTS, POINT OF CONTACT & PHONE:
10. FOR PROBLEMS OR EMERGENCY, CONTACT & PHONE:
11. COMPLETED BY:
    (b)(6)-2 [signature] 1545
    (Signature and Title) (Date and Time)

I HAVE RECEIVED A COPY OF AND UNDERSTAND THESE INSTRUCTIONS.

(b)(6)-1 CPL, MP
(Patient/Responsible Adult's Signature) (Date and Time)

MEDCOM FORM 691-R (TEST) (MCHO) MAR 99 PREVIOUS EDITIONS ARE OBSOLETE MC V1.00

MEDCOM - 2341

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT
For use of this form, see AR 40-407, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA litter BY Maj (b)(6)-2
2. PATIENT IDENTIFIED VERIFIED BY (b)(6)-2 AND PROCEDURE
3. DATE 02 Oct TIME PATIENT ARRIVED IN SUITE 0600
4. PATIENT IN ROOM TIME 0600 NUMBER 3

5. PREOPERATIVE EMOTIONAL STATUS

☐ CALM ☑ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER (Specify)

COMMENTS: Alert; No pain

6. NURSING PERSONNEL

ASSIGNED SCRUB	Spc (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	Maj (b)(6)-2	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify) Arms on bilateral armboards < 10° Safety

☑ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

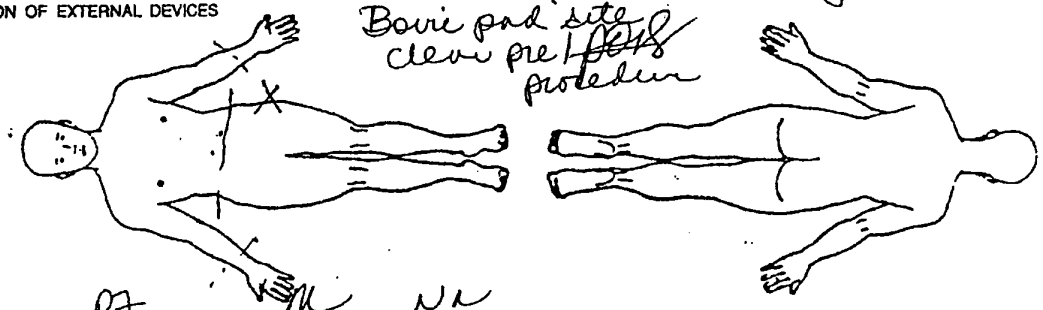
COMMENTS: Strap over Chest.

8. SKIN PREPARATION

HAIR REMOVAL ☑ YES ☐ NO per Surgeon
DONE BY: ☑ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP
COMMENTS: No nicks noted

PREP SOLUTION (Specify) Betadine scrub/sol
SITE: Ⓡ leg BY WHOM: Maj
SITE: BY WHOM: Fortner
COMMENTS: No pooling noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Strap --- Tourniquet

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count
Sponge	☑ Yes ☐ No		C	C
Needle/Sharp	☑ Yes ☐ No		C	C
Instrument	☐ Yes ☐ No			
Other	☐ Yes ☐ No			

SCRUB (b)(6)-2 Spc
CIRCULATOR (b)(6)-2 Maj

11. PATIENT IDENTIFICATION (For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)

Maj (b)(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☑ YES ☐ NO

☑ ESU NO: Valleylab 00432
GROUND PAD: BRAND Valleylab
LOT NO: 696710, exp 2005-04

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

MEDCOM - 2342

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☐

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):
09NS

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM YES ☒ NO ☐ IF YES, SITE

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	18. DRESSING/IMMOBILIZATION *(Specify)* Xeroform fluffs kerlix ace

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 1" penrose	2. anterior thigh	3.
SITE	1.	2.	3.

19. ADDITIONAL INFORMATION
unknown allergy status

Surgeons - [b)(6)-2]

20. OPERATION(S) PERFORMED
I&D (A) thigh, Ex-fix (B) L femur

21. PATIENT TRANSFERRED TO ICU TIME 0840 METHOD litter

22. REGISTER [b)(6)-2] My OR

REVERSE OF DA FORM [illegible]

*U.S. GPO: 1998-404-613/40449

MEDCOM - 2343

ACLU-RDI 1099 p.1127

DOD 006395

MISCELLANEOUS

557-107

TEST(S) REQUESTED | SPECIMEN TAKEN DATE 03 | TIME 635 A.M. P.M. | RESULTS

REMARKS

Enter in above space

PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REPORTED BY | MD | DATE 0692 20Oct03 | TECH (b)(6)-2

N'S SIGNATURE (b)(6)-2

PATIENT'S MED. RECORD

SPECIMEN/LAB RPT. NO.

MISC

URGENCY: ROUTINE / TODAY / PRE-OP / STAT

PATIENT STATUS: BED / AMB / OUTPATIENT / NP / DOM

SPECIMEN SOURCE (Specify)

LAB ID NO.

O.R.

Potus #

(b)(6)-4

PATIENTS MED. RECORD

SPECIMEN/LAB. RPT. NO.

CHEM 1

URGENCY: ROUTINE / TODAY / PRE-OP / STAT

PATIENT STATUS: BED / AMB / OUTPATIENT / NP / DOM

SPECIMEN SOURCE: BLOOD / OTHER (Specify)

LAB. ID. NO.

3 Oct 03

MD | DATE | (b)(6)-2

PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

Enter in above space

REQUESTING PHYSICIAN'S SIGNATURE (b)(6)-2

(b)(6)-4

ICU

POTUS

CHEMISTRY 1

STANDARD FORM 546 (Rev. 8-77)
PRESCRIBED BY GSA ICMR
FIRMR (41 CFR) 201-45.505

546-107

TEST(S)	SPECIMEN TAKEN DATE	TIME A.M. P.M.	RESULTS	REQUESTED (pd)
GLUCOSE			103	
UREA N.			7	
CREATININE			1.0	
URIC ACID				
SODIUM			135	
POTASSIUM			4.1	
CHLORIDE			99	
CO_2			93	
PHOSPHATE				
CALCIUM			8.6	
TOTAL PROTEIN				
ALBUMIN				
GLOBULIN				
ALKALINE PHOSPHATASE				
ACID PHOSPHATASE				
SGOT				
LDH				
CPK				
BILIRUBIN (TOTAL)				
BILIRUBIN (DIRECT)				
CHOLESTEROL				
TRIGLYCERIDES				
AMYLASE				
LIPASE				
PROFILE (Specify)				

Chem-7 or Metabolic profile

PATIENTS MED. RECORD

SPECIMEN/LAB RPT. NO

MISC

URGENCY: ROUTINE / TODAY / PRE-OP / STAT

PATIENT STATUS: BED / AMB / OUTPATIENT / NP / DOM

SPECIMEN SOURCE (Specify) Blood

LAB ID NO.

03 Oct 03

MD | DATE | (b)(6)-2

PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

Enter in above space

REQUESTING PHYSICIAN'S SIGNATURE (b)(6)-2

REMARKS

CBC & DDD

(b)(6)-4

ICU

POTUS

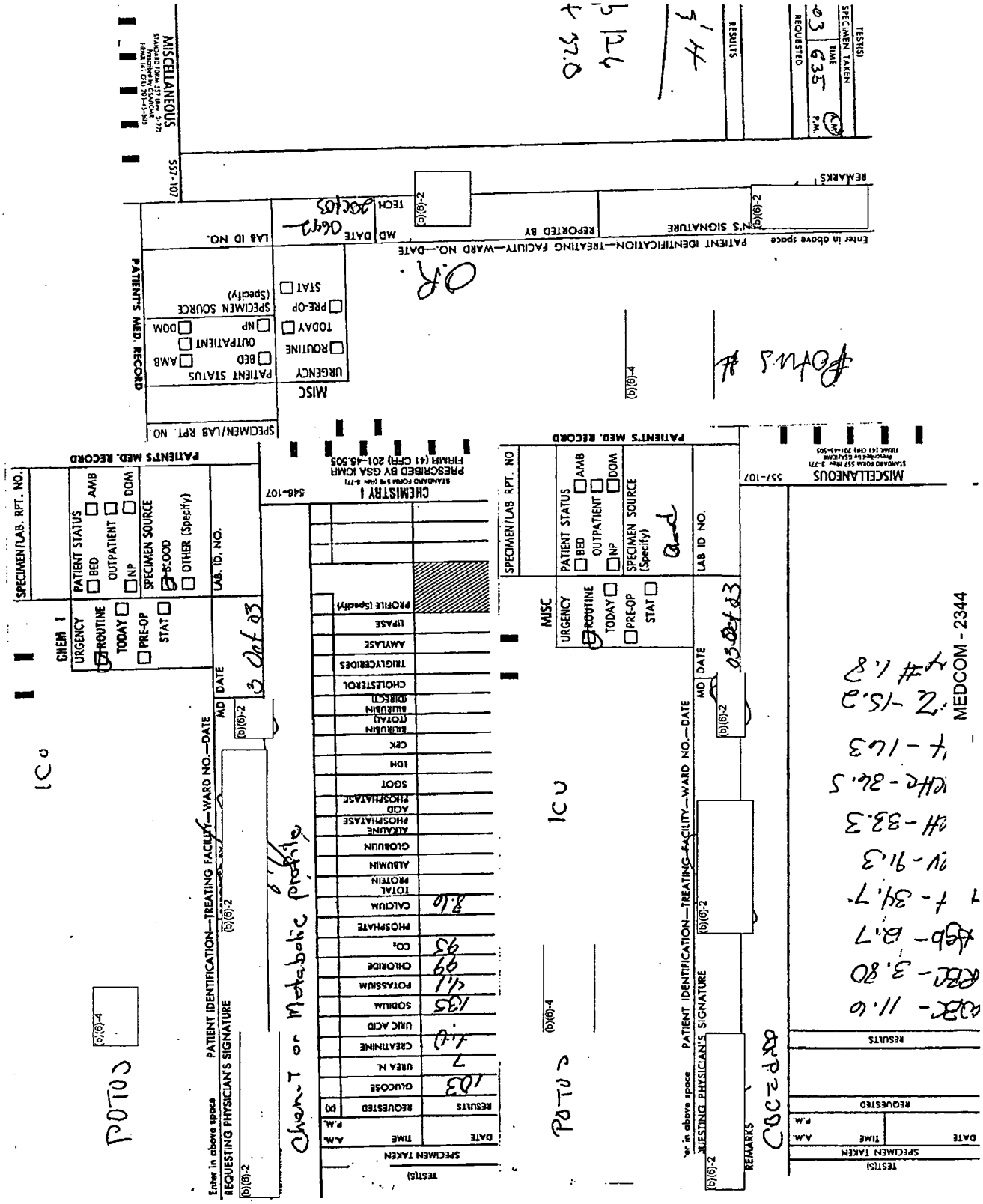
MISCELLANEOUS

557-107

TEST(S) | SPECIMEN TAKEN DATE | TIME A.M. P.M. | REQUESTED | RESULTS

MEDCOM - 2344

WBC - 11.6
RBC - 3.80
Hgb - 12.7
Hct - 34.7
MCV - 91.3
MCH - 33.3
MCHC - 36.5
Plt - 163
Neut - 15.2 #1.8



Critical value on "K" reported to Maj Kildre

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI.	UNIT	RANK	SSN
Iraqi # [redacted]			98/000000286

Physician:	Ward:		Date and Time:		Date and Time:
[redacted]	EMT	X STAT / Routine	20ct03 0230	[redacted]	20ct@0245

Chemistry (I-STAT) 6

X	TEST	RESULT	REF. RANGE
✓	Na	140	128-145 mmol/L
	K	3.1	3.3-4.7 mmol/L
	Cl	104	98-108 mmol/L
	pH		7.35-7.45
	PCO2		35-45 mmHg
	PO2		80-90 mmHg
	TCO2		18-33 mmol/L
	HCO3		22-28 mmol/L
	sO2		95-99%
	BEecf		(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN	12	7-22 mg/dL
	Glu	124	73-118 mg/dL
X	Creat	1.2	0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL

Urinalysis

Color		Straw/Yellow
Clarity		Clear
Glucose		Negative
Bilirubin		Negative
Ketone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative-Trace
Urobili		Negative
Nitrite		Negative
Leuko		Negative

Urine Microscopic

WBC		Epi
RBC		Mucus
Bacteria		Yeast
Casts:		
Crystals:		
Other:		

Chemistry (Piccolo Analyzer)

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-84 U/L
	ALT		10-47 U/L
	AMY		14-97 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat		0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		128-145 mmol/L

Microbiology

Source:		
FecLeuk		Negative
Gram St		
WetPrep		Negative
KOH		No Fungal Elements
OccBld		Negative
O&P		No Ova/Parasite

Blood Bank

X	ABO/Rh	B positive
	T&C	
	T&S	

HCG

Urine		Negative
Serum		Negative

Hematology

X	TEST	RESULT	REF. RANGE
	WBC	23.6	4.8-10.8 x10(3)/uL
	RBC	4.32	4.2-6.1 x10(6)/uL
	Hgb	14.7	12.0-18.0 g/dL
	Hct	39.3	35.0-60.0%
	MCV	91.1	80.0-99.0 fl
	MCH	34.1	27.0-31.0 pg
	MCHC	37.4	33.0-37.0 g/dL
	Plt	210	130-400 x10(3)/uL
	LY%	6.5	15.0-55.0%
	LY#	2.0	0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Imm
RBC Morph:	
Plt verify:	
Spun Crit	35-60%

Malaria Smear

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate

Sed Rate		1hr = 0-20 mm

Coagulation

PT		10-13 seconds
APTT		22.1-33.7 seconds
FDP		Negative

Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Negative

Other: I Stat 6 c c

MEDCOM - 2345

Trans

ANCEF 1gm @ 0630

MEDICAL RECORD - ANESTHESIA

For use of this form, see AR 40-66; the proponent agency is the OTSG

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML. "I" = CONSTANT INFUSION

DRUG (Units)												
FENT (cc)	2	1		1			1					
VERSED (mg)	2.5											
PROPOFOL (mg)	150											
SUX/VEC (mg)	60/	5	4				2					
( )												
( )												
VOLAT AGENT for % del	1.5	1.5	1.5	1.0	1.0	1.0	1.0		X			
% e.t.												
AIR L/Min												
N2O L/Min												
O2 L/Min	8 -	2 -	1 -	1 -	1 -	1 -	1 -	1 -	1 -	8		

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS

FLUIDS

LINE site												
	☐ Warmed											
	☐ Warmed											
18g (R) AC	☐ Warmed	#3	1000	#4								
	☐ Warmed											

LOSSES

EST BLOOD LOSS												
URINE -			300		200					200/700		

TIME 0600 x 30 x 0700 x 30 x 0800 x 30 x

PHYS STATUS 1 (2) 3 4 5 (E)

BODY WEIGHT: 150 KG (LB)

HEMATOCRIT:

INITIAL DATA:

BP- 118 166

HR- 62

EQUIP CHECK

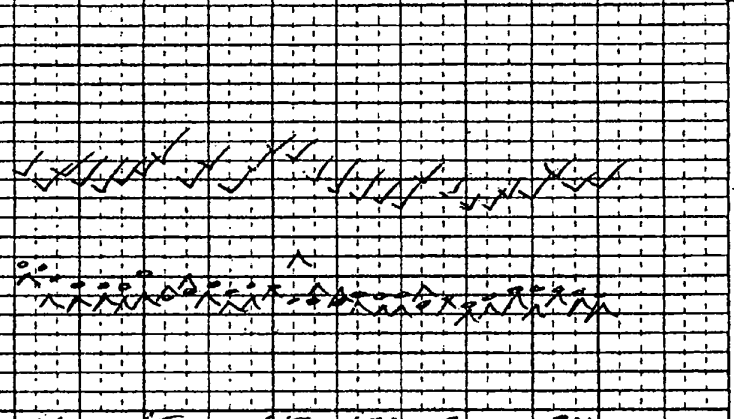
OK?- (Y) N

PATIENT RECHECK

OK for PROCEDURE? (Y)

TIME- 0600

SYMBOLS: BP by cuff V Λ; Heart rate ●; Resp rate; BR (transduced); TOURNIQUET T—T; ANES- X-X; PROC- ⊙-Ø



VENTIL

VT - ml	660	—	650	—	660		620	—	700	—	900	
f - breaths/min	10	—	10	—	10	—	10	—	10	—	10	
Peak inf pres / PEEP	22	—	22	—	22	—	21	—	22		22	
MODE - S(pon), A(assist), C(on)	C	—	C		C		C	—	C	—	AV	

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	32	-	34	-	33	-	34	-	34	-	32
BP/oth	FIO2 (Frac or %)	.80	-	.84	-	.80	-	.81	-	.81	-	.84
ART line	SpO2 (%)	100		100	-	100	-	100	—	100	-	100
Steth- PC/ES	ECG	SR	-	SR	-	SR	-	SR	—	SR	—	SR
Gas analyzer	TEMP-site SKIN	37	-	37	-	37	-	37	-	37	—	
	N-M Block (T/4)			3/4				4/4	—	4/4	—	4/4
Warming blkt												
Conv warmer												

Mark with letters & symbols, explain under REMARKS — EVENTS Position → (1) (2)

TOTALS

TOTAL EBL	TOTAL URINE
60cc	700cc

FLUIDS - SUMMARY

CRYSTALLOID- V 600 V-(4000) (EMT) 2500

COLLOID- Ø

BLOOD- Ø

REMARKS

Code drugs with numbers, events with letters

(1) PT + CHART REVIEW IN EMT

(2) TO O.R. STABLE @ 0600

(3) SMOOTH I&I ē RSI + CRICOID

4. PT RESPONSIVE OXYGENATED EXTUBATED ē PROBLEMS

TO ICU. REPORT - TO RN

RECOVERY AT 0830

PACU ICU ____ (Specify)

OTHER T-98

CONDITION: STABLE

RESP- 20, SpO2- 99

BP- 135/81 HR- 108

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0600	0605	0845
	Ready	Begin	End
PROC	0612	0630	0820

PROCEDURES and CPT Codes: EX FIX (R) FEMUR

ANESTHETIC TECHNIQUES: Describe block technique under Remarks GETA

PATIENT IDENTIFICATION: Typed or written entries: Name, Grade/Rate, Medical facility

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments DL X 1 ē RSI + CRICOID, ATTEMPTS, ATRAUMATIC BEBS (+) ETCO2

O — . , # (b)(6)-4

MEDCOM - 2346

PROCEDURE LOCATION: T-1

PREANESTHETIC SUMMARY

OPERATION PROPOSED	AGE	WEIGHT (LBS.)	SPECIAL INFORMATION
6SW ⓑ Femur			
	PHYSICAL STATUS: 1 2 3 4 5 6 7		

URINALYSIS	HEMATOLOGY	BLOOD CHEMISTRY
NORMAL ..... ABNORMAL AND WHY?	HGB ..... RBC ..... HCT ..... OTHER 39 I	

RESPIRATORY SYSTEM	CIRCULATORY SYSTEM	CENTRAL NERVOUS SYSTEM	OTHER SYSTEMS
(X-RAY, ASTHMA, OTHER PATHOLOGY) Ø	BP ..... PULSE ..... ECG (IF PERTINENT) Ø	(CEREBROVASCULAR, POLIO, NEUROLOGICAL) Ø	(ALLERGIES) NKDA Ø

PREVIOUS ANESTHETICS AND COMPLICATIONS	PRESENT DRUG THERAPY: E.G., STEROIDS, TRANQUILIZERS
PREOPERATIVE DIAGNOSIS	PREMEDICATION
	SIGNATURE OF EVALUATING PHYSICIAN / DATE

POSTANESTHETIC VISITS

RECORD ALL PERTINENT COMPLICATIONS

*U.S. Government Printing Office: 1994 — 300-892/10029

ACLU-RDI 1099 p.1131

DOD 006399

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
POTUS (b)(6)-4	2 Oct 03	HOURS	
	ADMIT to ICU		
	Dx - GSW to (R) Femur		
	VS q shift		
	Reg DIET		
	P5 NS c̄ 20 mEq KCL/LTRA 100 cc/°		
NURSING UNIT: ICU / ROOM NO. / BED NO.	Heplock when P.O. good		

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
(b)(6)-2		HOURS	
	MAY RIENFORCE Dressing as needed		
	NV ✓ (R) LE q 2° X4, then q shift		
	BATH As needed		
	M SO4 2-6 mg IV q 1-2° PRN Pain		
NURSING UNIT / ROOM NO. / BED NO.	Phenergen 25 mg IV q 6° PRN N/V.		
	Percocet T-II PO q 4-6 PRN Pain		

Noted 2 Oct 03 1970

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
		HOURS	
	Ancef T gm IV q 8°		
	CBC c̄ diff in AM 3 Oct 03		
	Chem-7 or metabolic [illegible] in AM		
	(b)(6)-2		
	MAJ (b)(6)-2		
NURSING UNIT / ROOM NO. / BED NO.			
24° Chart ✓ 0100 3 Oct 03	(b)(6)-2	Cpt AN	

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
		HOURS	
	(1) D/C Foley		
	(2) up out of Bed in chair		
	(3) Dress D - q DAY		
	(4) Clean Pins BID with 50/50 Hydrogen Peroxide + H_2O		
NURSING UNIT / ROOM NO. / BED NO.	(5) ok to discharge today		

NOTED 10/3/03 0950 LT AN

(b)(6)-2

(b)(6)-2

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED

MEDCOM - 2348

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION			↓	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
					3 Oct 03 HOURS	
			①	MAY Discharge to EPW CAMP.		
			②	F/U Sunday - if still here.		
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
					HOURS	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
					HOURS	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
					HOURS	
NURSING UNIT	ROOM NO.	BED NO.				

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 2349

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo. 10 Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 2 3 4
2 Oct	[redacted]	Vital Signs q shift	D	[redacted]
			E	
			N	
2 Oct	[redacted]	Reg Diet	B	
			L	
			D	
2 Oct	[redacted]	May reinforce dsg	D	
		as needed	E	
			N	
2 Oct	[redacted]	N/V ✓ (R) LE q 2° x 4, then	D	
		q shift	E	
			N	
2 Oct	[redacted]	Both as needed	D	
			E	
			N	
30 OCT 03	[redacted]	OOB IN CHAIR	10	✓
			20	✓
30 OCT 03	[redacted]	DRSG Δ Q DAY	10	✓
30 OCT 03	[redacted]	CLEAN PINS BID	10	✓
		C 50/50 Hydrogen	21	✓
		PEROXIDE + H_2O		

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW (R) Femur

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

POTUS [redacted]

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

D 8 9 10 11 12 13 14 15

E 16 17 18 19 20 21 22 23

N 24 01 02 03 04 05 06 07

DA FORM [redacted]

MEDCOM - 2350

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON MEDICATION)		Mo ____ Yr ____		
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
2 Oct	[redacted]	Admit to ICU	2 Oct	0900		[redacted]
2 Oct	[redacted]	CBC diff, Chem 7 or metabolic profile in AM	3 Oct	0500	0500	[redacted]
3 OCT	[redacted]	DIC [redacted]	3 Oct	NOW	0950	[redacted]
3 OCT	[redacted]	OK TO DISCHARGE TODAY	3 OCT	TODAY		

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED

☆ U.S. GPO:1987-418-290/55257

MEDCOM - 2351

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo. 10 Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 2	3	4
2 oct	[b)(6)-2]	D5NS ē 20KCL/L TRA	D	[b)(6)-2]		
		100 c/Hr. Heplock when	E	[b)(6)-2]		
		po good.	N			
2 oct	[b)(6)-2]	Ancef 1 gm IV q 8°	06	[b)(6)-2]		
			14			
			22	[b)(6)-2]		

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW ® Femur

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

POTUS [b)(6)-4]

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D 8 9 10 11 12 13 14 15

E 16 17 18 19 20 21 22 23

N 24 01 02 03 04 05 06 07

DA FORM 4856

MEDCOM - 2352

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON MEDICATION)		Mo _____ Yr _____		
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED															
2oct	[b)(6)-2]	MSO4 2-6 mg IV q 1-2°	2oct 1830	2oct 2300	3oct 0110	03oct 0800												
		prn	4mg	9mg	5mg	15mg												
2oct	[b)(6)-2]	Phenergan 25mg IV																
		q6° prn N/V																
2oct	[b)(6)-2]	Percocet 1-11 PO	1420 2oct	1945 2oct	0015 3oct	0630 3oct	1120 03oct											
		q 4-6° prn	11	11	11	11	11											

★ U.S. GPO:1997-418-298/55267

MEDCOM - 2353

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-400; the proponent agency is The Office of The Surgeon General

REPORT TITLE: POST ANESTHESIA CARE UNIT FLOWSHEET

OTSG APPROVED (Date): 17 Jan 80

PROCEDURE: (L) Femur FX Ex fix

PHYSICIAN: [redacted] (b)(6)-2

ANESTHESIA BY: [redacted] (b)(6)-2

Gen Spinal MAC Axillary Local Bier Epidural Other

ALLERGIES: NKDA

AIRWAYS: ____ Time DC'D ____

ETT Nasal Oral Trach

OXYGEN: Mask Nasal Face Blow-By Prongs Tent

Liter/min. ____ %

ASA 2 History ____

Cardiac Rhythm ____

IV#1 ____ Patent Infiltrated Site ____ Rate ____ Gauge ____

IV#2 ____ Patent Infiltrated Site ____ Rate ____ Gauge ____

Time	B/P	P	R	O2SA	Temp	Act	Resp	Circ	LOC	Skin	PARS	COMMENTS	Neuro-Vascular
PRE-OP	/												Extr: L R Upper Lower Pulse DP PT RAD
PRE-OP	118/66	62											Blanche Warm Pulse Moves Y N
0840	139/81	89	22	99%	97% (A)	1	2	2	1	2	8		Blanche Warm Pulse Moves Y N
0845	123/74	81	24	99%		1	2	2	1	2	8		Blanche Warm Pulse Moves Y N
0850	137/73	71	22	98%		1	2	2	1	2	8		Blanche Warm Pulse Moves Y N
0855	128/72	66	22	99%		1	2	2	1	2	8		Blanche Warm Pulse Moves Y N
0910	124/73	67	21	99%		1	2	2	1	2	8		Blanche Warm Pulse Moves Y N
0925	123/71	65	21	100%		2	2	2	1	2	8		Blanche Warm Pulse Moves Y N
0940	127/78	68	17	100%		2	2	2	1	2	9		Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N

Gentyl 5cc
2 Ancef 0630

POST ANESTHESIA RECOVERY SCORE "PARS"

Activity - General Anesthesia
2—Maintain head lift and open eyes
1—Unable to maintain head lift and open eyes
0—Unable to lift head and open eyes

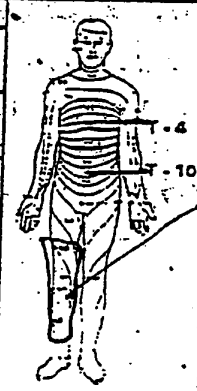
Activity - SAB or Subarachnoid Block
2—Moves all four extremities with control
1—Moves both upper extremities

Respirations
2—Spontaneous respiration; needs no support
1—Limited effort; needs artificial airway or jaw support
0—Needs ventilator; no spontaneous respiration

Circulation
2—BP 20% preanesthetic level
1—BP ~~20~~ - 50% preanesthetic level
0—BP 50% or more preanesthetic level

Level of Consciousness
2—Awake and alert; seldom dozes
1—Awakens when gently stimulated
0—Awakens only when vigorously stimulated

Skin
2—Normal skin color & temperature greater than 96°
1—Skin is pale, blotchy, dusky &/or temperature 95 - 96°
0—Cyanotic &/or temperature less than 95°



DRESSING:	Status	Location
Gauze		
Opsite		
Bandaid		
Steri-strips		
Collodian		
Peri-pad		
Coban	(R) CDI	(R) CE
Cotton Balls		
Ace Wrap		

TUBES AND DRAINS: Hemovac Foley NGT Chest Jackson-Pratt

(Continue on reverse)

[redacted] (b)(6)-2

SSGT/LPN

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: 02 OCT 03

written entries give: Name—last, first, middle; grade; date; hospital or medical facility)

DOTUS # [redacted] (b)(6)-4 EPW

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTICS STUDIES

☐ TREATMENT

DA FORM 1 MAY 78 4700

FH MDA OP 132-11a (Rev)
1 Sep 99

MEDCOM - 2354

INTAKE			OUTPUT		
TIME	TYPE	AMT	TIME	TYPE	AMT
OR	OR	1500	OR	EBL	60cc
	EMT	2500	OR	Urine	700cc
TOTAL		4000	TOTAL		760cc

PACU NURSING NOTES: NURSING CARE PROBLEM NO.'S IDENTIFIED. Refer to FH MDA OP 39

NURSING CARE PROBLEMS: 1. RESP; 2. CIRC; 3. ACT; 4. LOC; 5. TEMP; 6. PAIN; 7. SAFETY; 8. ANXIETY; 9. EDUC; 10. OTHER

Pt received from OR 1g IV in (L) AC patent & infusing 1K @ TKO. (R) suture approx 2.5 cm in length over eyebrow. Foley urinary catheter patent & draining clear yellow urine in closed drainage system. (R) ext fix from mid-thigh to mid calf c min serosanguinous drainage on dressing surrounding upper leg pins. Coban dressing covering (R) dressings. (L) foot anterior proximal of large toe c a 2cm in diameter [redacted] abrasions.

MEDICATION RECEIVED IN PACU/ICU

MEDICATION GIVEN BY:	DRUG	DOSE	ROUTE	TIME	PAIN LEVEL	EFFECTIVENESS

DISPOSITION SUMMARY: Nursing Care Problems No.'s_____ Resolved; No.'s_____ Continue.
Patient was transferred from PACU/ICU recovery room via litter/crib with siderails raised, or held by parent in wheelchair.
Dressing status:_____ PAR Score_____ Safety Straps_____
Report given to_____. Patient released by Anesthesia_____
Time out_____. Nurse Signature:_____

MEDCOM - 2355

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-400; the proponent agency is The Office of The Surgeon General

REPORT TITLE: POST ANESTHESIA CARE UNIT FLOWSHEET

OTSG APPROVED (Date): 17 Jan 80

PROCEDURE: L Femur FX

PHYSICIAN: [redacted]

ANESTHESIA BY:

Gen Spinal MAC Axillary
Local Bier Epidural Other

ALLERGIES: NKDA

AIRWAYS: Time DC'D

ETT Nasal Oral Trach

OXYGEN:

Mask Nasal Face Blow-By
Prongs Tent

Liter/min. %

ASA 2 History

Cardiac Rhythm

IV#1 Patent Infiltrated
Site Rate Gauge

IV#2 Patent Infiltrated
Site Rate Gauge

VITAL SIGNS						PAR SCORE						OTHER	
Time	B/P	P	R	O2SA	Temp	Act	Resp	Circ	LOC	Skin	PARS	COMMENTS	Neuro-Vascular
PRE-OP	/												Extr: L R Upper Lower; Pulse DP PT RAC
PRE-OP	118/64	62											Blanche Pulse; Warm Moves Y N
0840	139/81	89	22	99%	97.8	1	2	2	1	2	8		
0845	123/74	81	24	99%		1	2	2	1	2	8		
0850	137/73	71	22	99%		1	2	2	1	2	8		
0855	128/72	66	22	99%		1	2	2	1	2	8		
0910	124/73	67	21	99%		1	2	2	1	2	8		
0925	123/71	65	21	100%		2	2	2	1	2	9		
0940	127/78	68	17	100%		2	2	2	1	2	9		
	/												
	/												
	/												
	/												
	/												

POST ANESTHESIA RECOVERY SCORE "PARS"

Activity - General Anesthesia
2—Maintain head lift and open eyes
1—Unable to maintain head lift and open eyes
0—Unable to lift head and open eyes

Activity - SAB or Subarachnoid Block
2—Moves all four extremities with control
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Respirations
2—Spontaneous respiration; needs no support
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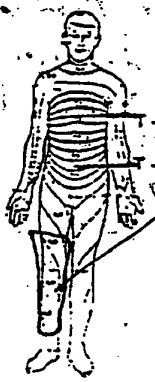
Circulation
2—BP 20% preanesthetic level
1—BP 20 - 50% preanesthetic level
0—BP 50% or more preanesthetic level

Level of Consciousness
2—Awake and alert; seldom dozes
1—Awakens when gently stimulated
0—Awakens only when vigorously stimulated

Skin
2—Normal skin color & temperature greater than 96°
1—Skin is pale, blotchy, dusky &/or temperature 95 - 96°
0—



DRESSING: Status Location

Gauze
Opsite
Bandaid
Steri-strips
Collodian
Peri-pad
Coban
Cotton Balls
Ace Wrap

TUBES AND DRAINS: Hemovac Foley NGT Chest Jackson-Pratt

(Continue on reverse)

(b)(6)-2

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: 02 OCT 03

PATIENT'S IDENTIFICATION (If of typed or written entries give: Name-last, first, middle; grade; date; hospital or medical facility)

POTUS # [redacted] EPW

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTICS STUDIES

☐ TREATMENT

DA FORM 1 MAY 78 4700

FH MDA OP 132-11a (Rev) 1 Sep 99

MEDCOM - 2356

ADMISSION AND CODING INFORMATION

For use of this form, see AR 40-400; the proponent agency is OTSG

1. REPORTING MTF	1 2 3 4 5 6 / A (b)(3)-1
2. MTF LOCATION (State or Country Code.)	7 8 / I Z
3. REGISTER NUMBER	9 10 11 12 13 14 15 / (b)(6)-4
NAME (Last, First, Middle Initial)	Iraqi (b)(6)-4 EPW
4. PAY GRADE	16 17
5. SEX	18 / M
6. DATE OF BIRTH (Y Y Y Y M M D D)	19 20 21 22 23 24 25 26
7. AGE AT ADMISSION	27 28 29 / 2 5 Y
8. RACE	30 / X
9. ETHNIC BACK-GROUND	31 / 9
RELIGION	
10. LENGTH OF SERVICE	32 33 34
ETS	
11. FMP	35 36 / 9 9
12. SOCIAL SECURITY NUMBER	37 38 39 40 41 42 43 44 45 / (b)(6)-4
ORGANIZATION (Active Duty Only)	CW
13. MARITAL STATUS	46
HOUR OF ADMISSION	0230
BRANCH / CORPS	CW
14. FLYING STATUS	47 48 49
15. BENEFICIARY CATEGORY	50 51 52 / K 7 6
16. ZIP CODE OF RESIDENCE	53 54 55 56 57 58 59 60 61
17. UNIT LOCATION (State or Country Code)	62 63
18. MOS	64 65 66 67 68 69 70
19. TRAUMA	71
PREV. ADMISSION	YEAR ☐ NO
20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	72 / 0
WARD	ICU
NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	
ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	
TELEPHONE NUMBER OF EMERGENCY ADDRESSEE	
NAME OF MEDICAL TREATMENT FACILITY	(b)(3)-1 (b)(3)-1 (b)(3)-1
21. TYPE OF DISPOSITION	73 74 / 0 1
22. MTF TRANSFERRED TO	75 76 77 78 79 80
23. DATE OF DISPOSITION (Y Y Y Y M M D D)	81 82 83 84 85 86 87 88 / 2 0 0 3 1 0 0 3
24. CLINIC SVC - ADMITTING	89 90 91 92 / B 1 A A
25. MTF TRANSFERRED FROM	93 94 95 96 97 98
26. DATE THIS ADMISSION (Y Y Y Y M M D D)	99 100 101 102 103 104 105 106 / 2 0 0 3 1 0 0 2
27. LOCATION OF OCCURRENCE (Battle Casualty Only)	107 108
28. MTF OF INITIAL ADMISSION	109 110 111 112 113 114 / A 1 4 A 1
29. DATE INITIAL ADMISSION (Y Y Y Y M M D D)	115 116 117 118 119 120 121 122 / 2 0 0 3 1 0 0 2

FOR LOCAL USE

82133
89912.

Pr. 7965
7815

ADMITT (b)(6)-2 MD (b)(6)-2

DA FORM 2357, MAR 2000 MEDCOM - 2357 USAPA V1.00

(b)(3)-1

INPATIENT TREATMENT RECORD COVER SHEET *(For Plate Imprinting)*

For use of this form, see AR 40-400; the proponent agency is the Office of The Surgeon General.

PATIENT DATA ITEMS 1 - 30 (E... ...s 25 & 26)

EPW - (b)(6)-4

(b)(6)-4

(b)(6)-4

LINE	LEGEND
1	REGISTER NO. - NAME - GRADE
2	SEX - AGE - RACE - RELIGION - LENGTH OF SVC - ETS - PREVIOUS ADMISSION
3	FMP - SSN - ORGANIZATION - WARD
4	FLY STAT - RATING/DESG - DEPT/BEN - BRANCH/CORPS - UIC/ZIP - TYPE CASE
5	SOURCE & AUTHORITY FOR ADMISSION - HOUR OF ADMISSION - CLINIC SVC
6	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
7	ADDRESS OF EMERGENCY ADDRESSEE - PHONE NO. - DATE OF THIS ADMISSION
8	NAME & LOCATION OF MEDICAL TREATMENT FACILITY DATE OF INITIAL ADMISSION

ADMISSION REMARKS

(b)(6)-4

25. TYPE DISPOSITION: DC

26. DATE OF DISPOSITION: 070403

ADMITTING ... (b)(6)-2

31. SELECTED ADMINISTRATIVE DATA

32. ... OF WHOLE BLOOD/COMPONENT TRANSFUSED

33. CAUSE OF INJURY

☐ CHECK IF CONTINUED ON REVERSE

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

GSW (L) neck & shoulder 880.00 ICD9FY02

S/P I&D 874.8 ICD9.FY02

86.09 ICD9FY02

...AL DAYS THIS FACILITY
...NT SICK | b. OTHER DAYS | c. CONV LV/COOP CARE DAYS | d. SUPPLEMENTAL CARE DAYS | e. BED DAYS | f. TOTAL SICK DAYS

☐ CHECK IF CONTINUED ON REVERSE

...L DAYS ALL FACILITIES
...T SICK | b. OTHER DAYS | ...LV/COOP ...YS | d. SUPPLEMENTAL CARE DAYS | e. BED DAYS | f. TOTAL SICK DAYS

(b)(6)-2

SIG

EDITION OF 1... MEDCOM - 2358 ...RECORD...

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

PERTINENT HISTORY, CHIEF COMPLAINT, AND CONDITION ON ADMISSION *(Enter date of admission)*

Iraqi National Shot in: (L) Shoulder $\bar{p}$ failed attack on U.S. Soldiers.

All: PCN
PMH: 0
Tob – 0

233 13.4 10.2 37.7

143 112 10 16.2 3.6 1.2

VS BP-130/79 P-95 R-22 T-97.8

PHYSICAL EXAMINATION

Gen'l – WDWN 07; mildly distressed
HEENT – 1cm x 2cm wound base of neck, posterior + left.
(L) Shoulder + Clavicular region c̄ large hematoma; No exit wound.
Radial Pulse 2/4; Moves arm + hand normally
CV – RRR $\bar{s}$ @
Lungs – CTA B/L
Abd – Soft, NT/ND Back – 0 Injury C-Spine Non-tender

PROGRESS *(Enter date of discharge and final diagnosis)*

X-Ray: (L) Shoulder c̄ metallic fragments posterior + lateral to joint. Fx'd distal clavicle
C-Spine Neg.! Chest – Neg.
A/P GSW (L) Shoulder c̄ large hematoma, NVID. No chest involvement apparent. Poss. venous injury. Plan I+D to wound in OR

(b)(6)-2	DATE 20Oct03	IDENTIFICATION NO.	ORGANIZATION

PATIENT'S IDENTIFICATION *(For typed or written entries give Name last, first, middle; grade; date; hospital or medical facility)*

REGISTER NO.	WARD NO.

Iraqi (b)(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

GENERAL SERVICES ADMINISTRATION AND INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
USAPPC V1.00

MEDCOM - 2359

509-113

MEDICAL RECORD

PROGRESS NOTES

NSN 7540-00-634-

DATE	
02 Oct 03	37 y/o male presents to EMT ambulatory to
2225	Trauma bed # 2 (two). A+O. Resp even & nonlabored
	Drsgs intact. IV 18g in (R) AC 1000cc W/R infusing
	well. Attempt to start IV in both feet x 3
	$\bar{S}$ success. Blood drawn from (L) foot by Dr (b)(6)-2
	Sample clotted. Redrawn from (R) hand, IV
	Shut off before draw. Xray here. Ortho here.
	Pt stable @ this time. Foley 16fr placed
	c̄ 900cc clear urine returned. Ut to lab.
	Ready for OR. (b)(6)-2 CAT AR

V/S	2225	2315	2330	
T	97.8	97.8	/	IV 3000cc
P	93	95	89	Urine 1000cc
R	16	22	15	Meds - Clindy 900mg @ 2300
BP	149/91 (R) arm	130/79 (L)	128/79 (R)	
2	97% RA	97% RA	95%	

IDENTIFICATION (For typed or write

(Continue on reverse side)

(b)(6)-4

ame—last, first, middle; grade; rank; rate;

REGISTER NO.

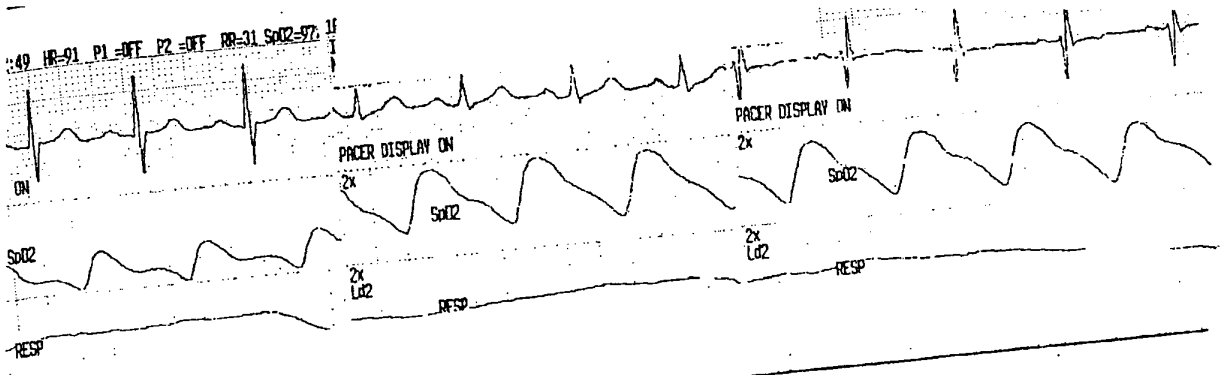
WARD NO.

(b)(6)-4

(b)(6)-4

MEDCOM - 2360

PROGRESS NOTES



23:20	89	96	121 / 71	90	16
23:10	95	96	128 / 79	98	21
23:06	93	97	130 / 79	99	21
23:00	92	95	128 / 75	95	28
22:50	95	95	139 / 83	103	26
22:40	99	98	141 / 78	104	20
22:30	00	00	[illegible]	[illegible]	
22					
22					

*U.S. Government Printing Office: 1998 - 404-763/20101

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
2 OCT 2003	Surgery
2319	37 yo ♂ GSW vs shrapnel (L) posterior inferior
	neck. 1/0 (L) shoulder pain only. & reported
& PMH	LOC or other injuries. stable during
& PSH	transport.
& Meds	Assessment - Airway - clear
All: PCN	Breathing - CXR (B)
	BP 145/80 (B) palpable pul
	reg @ 8.0
	HEENT - AT/NC PERRLA EOMI
	NP/OP clear TMs clear -
	Neck - NT midline + c̄ motion
CXR - & pts orbits	cleared by exam. Dauthor
Shoulder - (L) lat	(L) post/inf wound c̄ mild
clavicle	venous bleeding easily controlled
	Large hematoma lat clavicle
	Chest - CXA (B) S1 S2 reg NT
	Abd - S/NT/ND/ABS
	GU - & injuries noted
	Ext - Strength 5/5 RUE + BLE
	LUE c̄ painful ROM at shoulder
	Pulse 2+ rad (B) / fem (B) / DP/PT (B)
	cover)

(b)(6)-2 (b)(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* REGISTER NO. WARD NO.

POTUS # (b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

USP LVN

MEDCOM - 2362

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
20222003	(Cont'd)
2319	Neuro GCS 15
	Sens/motor intact globally
	specifically (L) tricep 4+/5 limited
	s/g pain
	tricep 4+/5 as above
	WF/WE 5/5 Grip 5/5
	Imp - (L) clavicle injury by GSW vs shrapnel
	& chest injury
	& ant neck injury
	& major arterial injury suspected
	Suspect venous injury
	Plan - washout wound
	Will cautiously explore wound/
	not hematoma + irrigate.
	& extension debridement planned
	at this time.
	(b)(6)-2 [redacted]
30Oct03	OP Note MAJ [illegible]
0100	Dx: GSW (L) shoulder + Posterior Neck
	Proc: R+D (L) shoulder wound
	Surg: Shiout / Sanborn
	Anesth: General
	Fluids: 900cc LR M ; 1000cc U.O.P. ; 150cc EBL
	Findings: Minimal muscle debridement of trapezius
	GSW Fx'd distal clavicle; Removed several bone pieces
	~~Ø apparent~~ major vessel injury
	Comp's: Ø
	(b)(6)-2 [redacted]

STANDARD FORM 600 (REV. 6-97) BACK

MEDCOM - 2363

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
	Ortho
3 Oct 03	POD #1 S/P I+D GSW (L) Shoulder + Neck
0830	Medicated c̄ MSO4 twice through night
	Dressing Δ'd at 0545 for saturation.
	Tm-100³ P-84 - R-15 BP-138/78
	Sat. - 96% on R.A. H/H 11.9/34.8
	Dressing - clean, dry, + intact
	AP Stable.
	Cont. current ungrant
	Back to OR tomorrow. [redacted] (b)(6)-2
	LTC, MC
4 Oct 03	Ortho
0925	POD #2 S/P I+D GSW (L) Shoulder
	Comfortable.
	Tm-100, VSS
	Dressing - C/D/I
	Stable.
	Repeat I+D c̄ DPC over drain today.
	Discussed procedure c̄ pt. through [redacted] (b)(6)-2
	translator
	LTC, MC

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST		

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)	REGISTER NO.	WARD NO.

Iraqi # [redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

509-114

MEDCOM - 2364

STANDARD FORM 509 (REV 5-99) BACK

FPI LEX Printed on Recycled Paper

4 Oct 03 OP Note

- GSW to (L) shoulder
- Same
  I+D (L) GSW
  Shrout / Gupta
  EBL ~~30~~ 150 TF 350 comp
  DRAINS - T penrose Drain
  Findings - clean wound c̄ minimal necrotic tissue.
  Bone covered c̄ muscle

(b)(6)-2 [redacted]

MAJ (b)(6)-2 [redacted]

6 Oct 03 ortho Attendg
NVSS Afebrile
DIET good
(+) sensation to all fingers
- stayed out of bed yesterday
DIC to authorities today
Keflex - 3 DAYS
tylox = # 30
Tmotrin - #60
F/U Oct 12 for ~~suture~~ staple removal.
If patient sent elsewhere staples can be removed by medic in 10-14 DAYS

(b)(6)-2 [redacted]

Maj (b)(6)-2 [redacted]

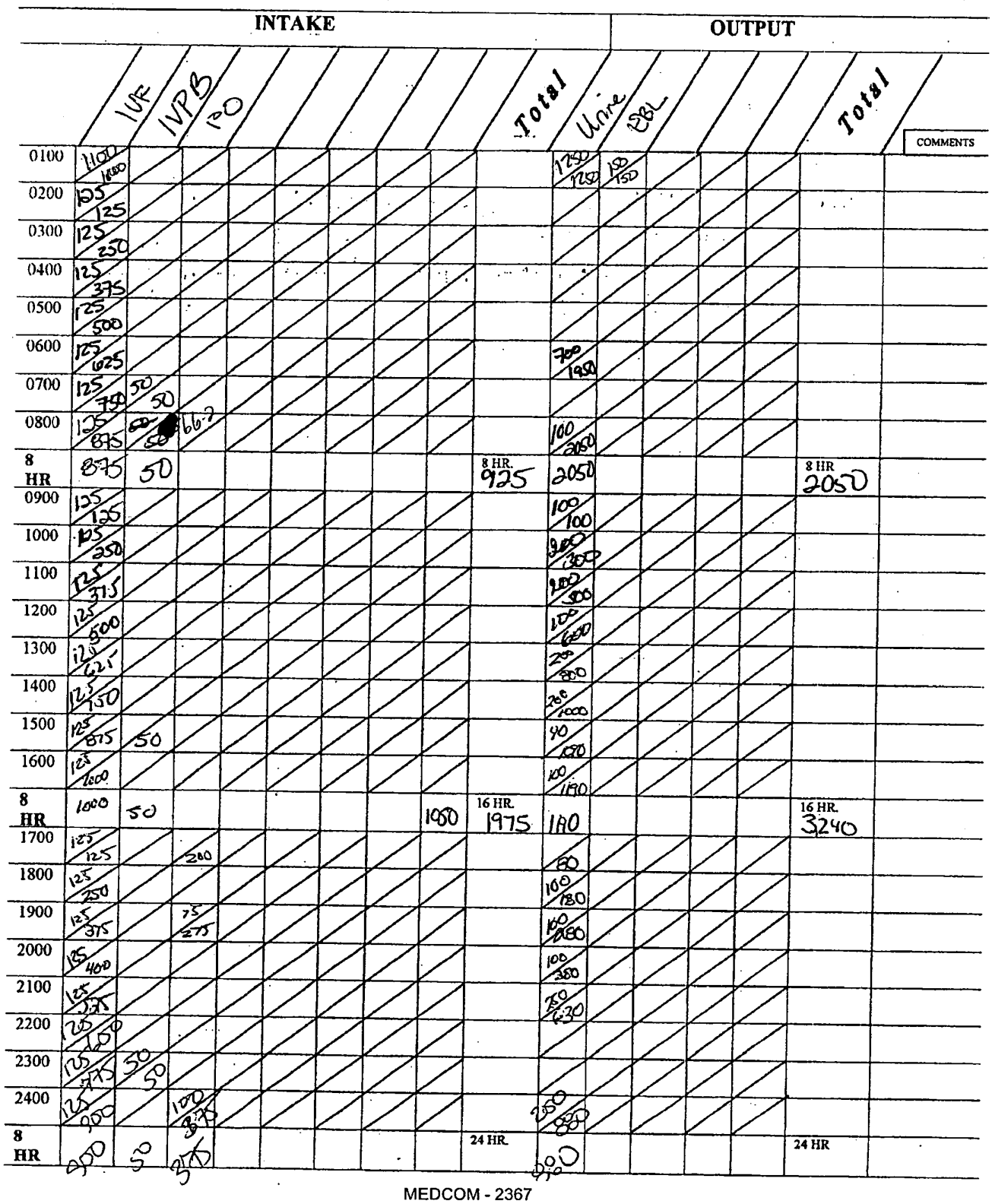
NOTES

DATE

NSN 7540-00-634-4123

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
30cto3	0145		recieved pt this AM; pt. finished w/recovery from ~~post op~~ 66-2 I-D of (L) shoulder; dressing is CDI; pt. does not complain of any pain; resting w/eyes closed; VSS; NAD; will cont. to monitor — (b)(6)-2
	0545		6mg MSO_4 given for dressing Δ; dressing was saturated with blood on the left shoulder; dressing reinforced; pt resting in bed; will cont to monitor — (b)(6)-2
	1005		6mg MSO_4 given for pain; will cont. to monitor (b)(6)-2
	1100		pt offered Δ bunch tray but denied vertigo with minimum C/o pain V/S HR 80 BP 12P/68 Or 99% on RA Temp. 99.2 Will cont. to monitor 386 (b)(6)-2 [illegible]
		1500	Doing well NAD will cont to monitor per orders See DA Form 4700 for assessment (b)(6)-2
		1700	Ate 10% of dinner will cont to monitor per order (b)(6)-2
30ct03		2200	received report on pt from previous shift pt resting supine c̄ HOB elevated NAD Ø c/o pain, weakness to (L)UE fluids @ 25cc/hr to 18G (R)AC PIV, MP C BS — (b)(6)-2
4Oct03	0001		Assessment complete V/S stable, refer to DA form 4700 for full assessment, PIV patent CDI, dressing to (L) neck & shoulder saturated c̄ blood, pt Ø S/S of lightheadedness N/V, breathing deep unlabored ØSOB Ø dyspnea — (b)(6)-2
4Oct03	0050		reinforced dressing pt awareg NPO of solid foods p̄ MN, PO 100cc H_2O tolerated well — (b)(6)-2
4Oct03	0420		MP C BS ØΔ's from previous assessment (b)(6)-2

MEDCOM - 2366


INTAKE
OUTPUT
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PO
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Urine
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Total
COMMENTS
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0200
0300
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8 HR
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1200
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1400
1500
1600
8 HR
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1900
2000
2100
2200
2300
2400
8 HR
8 HR. 925
16 HR. 1975
24 HR.
8 HR 2050
16 HR. 3240
24 HR
MEDCOM - 2367

NSN 7540-00-634-4123

MEDICAL RECORD

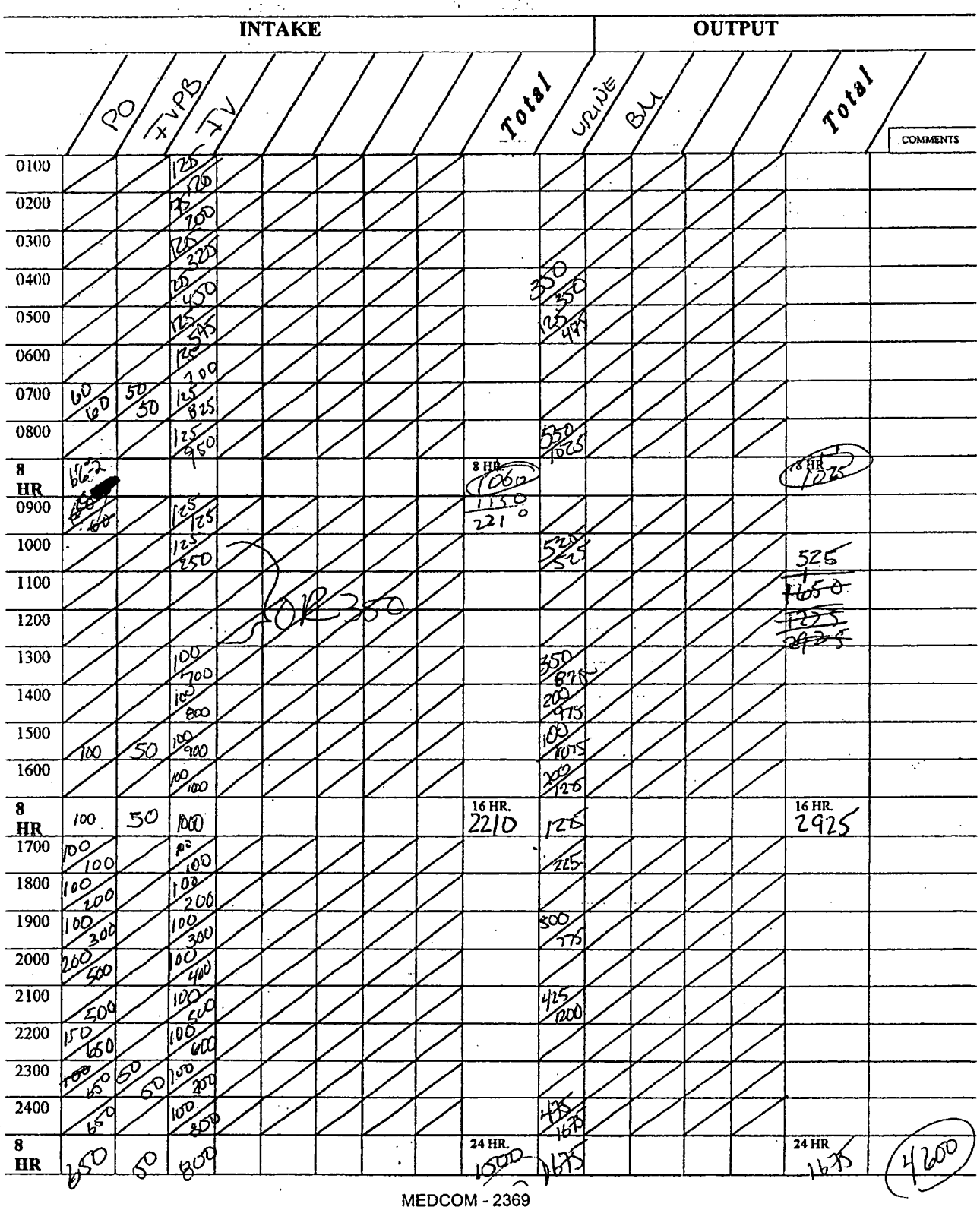
NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
04OCT03	0610		Assumed pt care. Pt A&OX3 per translator & pt speaks a small amt of English. (L) neck & shoulder drsg CDI, pt c/o pain only c̄ movement of (L) UE. 18g IV cath in (R) AC patent & infusing LR @ 125cc/hr s̄ difficulty, site s̄ redness, edema, or pain. Foley patent & draining into closed drainage system. Pt performed AM ADL's ~~pt~~ error c̄ minimal assistance. Pt still denies need for medication. Will continue to monitor. [redacted]
04OCT03	0430		Pt c/o slight pain in (L) shoulder & neck area. Pt medicated c̄ MSO4 5mg per prn pain order. Will continue to monitor & reassess pain management. [redacted]
04OCT03	10:45		Pt to OR via litter carrier c̄ OR staff. [redacted]
04OCT03		12:25	Pt returned from OR via litter carrier via litter accompanied by OR staff. (L) neck & shoulder new dressings. (R) hand 18g IV patent & infusing D5NS c̄ 20mEq KCL @ 100cc/° per dial-a-flo set. [redacted]
		1500	In bed rest. Has ∅ % discomfort at this time. That's what he say. But can tell has some discomfort. Will cont to monitor per order and discomfort. See DA Form 4700 for assessment [redacted]
		1700	Sleeping well NAD ~~to~~ rises and fall of chest noted. Will cont to monitor. [redacted]
04Oct03		2200	Received report from previous shift, pt resting supine D5~~1/2~~ error NS infusing c̄ 100cc/hr to (R) hand RIV, foley patent, urine yellow s̄ sediment, c/o ∅ pain NAD, (L) shoulder bandage CDI [redacted]
04Oct03		2220	Assessment complete consult DA 4700 MPCBS [redacted]

MEDCOM - 2368

	INTAKE									OUTPUT						
	PO	+VPB	IV						Total	URINE	BM				Total	COMMENTS
0100			125 / 125													
0200			75 / 200													
0300			125 / 325													
0400			125 / 450							350 / 350						
0500			125 / 575							125 / 475						
0600			125 / 700													
0700	60 / 60	50 / 50	125 / 825													
0800			125 / 950							550 / 1025						
8 HR	662								8 HR. 1060						8 HR 1025	
0900	~~650~~ / ~~60~~		125 / 125						1150 / 2210							
1000			125 / 250							525 / 525					525	
1100															~~1650~~	
1200															~~1225~~ ~~2925~~	
1300			100 / 700							350 / 875						
1400			100 / 800							200 / 975						
1500	100	50	100 / 900							100 / 1075						
1600			100 / 100							200 / 125						
8 HR	100	50	1000						16 HR. 2210	125					16 HR. 2925	
1700	100 / 100		100 / 100							225						
1800	100 / 200		100 / 200													
1900	100 / 300		100 / 300							500 / 775						
2000	200 / 500		100 / 400													
2100	500		100 / 500							425 / 1200						
2200	150 / 650		100 / 600													
2300	~~100~~ 650	50 / 50	100 / 700													
2400	650		100 / 800							475 / 1675						
8 HR	650	50	800						24 HR. 1500	1675					24 HR 1675	4200

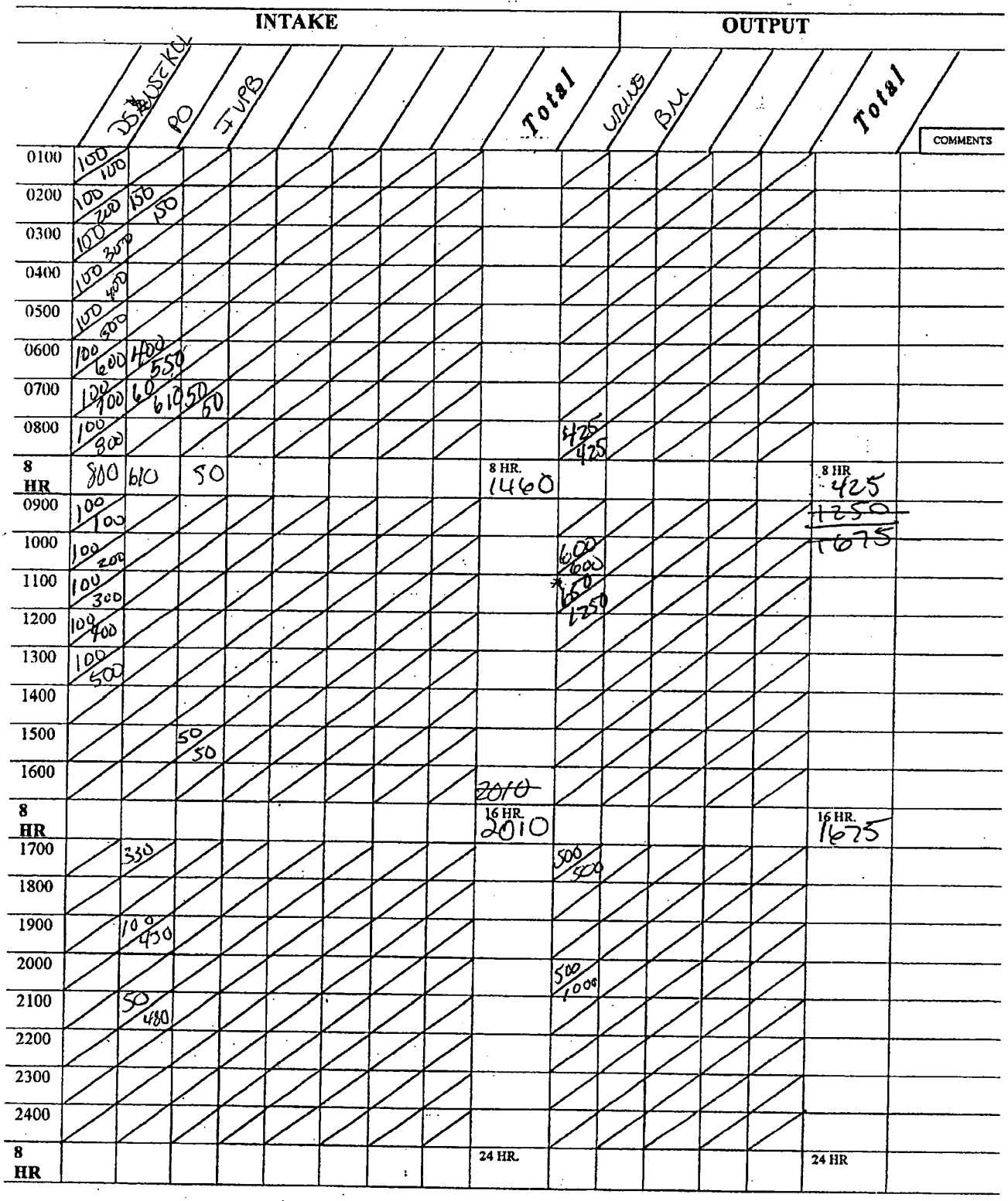
OR 350



MEDCOM - 2369

NSN 7540-00-634-4123

MEDICAL RECORD — DATE	HOUR A.M.	HOUR P.M.	NURSING NOTES (Sign all notes) — OBSERVATIONS Include medication and treatment when indicated
4Oct03		2230	D/C foley pt tolerated well, conducted pt Teaching on use of urinal, pt verbalized understanding — [b)(6)-2]
4Oct03		2255	I/S conducted pt. @ dyspnea @ SaO2 — [b)(6)-2]
5Oct03	0030		pt c/o pain administered pain med — [b)(6)-2]
5Oct03	0400		@ A/S from previous assessment, small amount drainage from back @ (L) neck/shoulder dressing will continue to monitor — [b)(6)-2]
05Oct03	0605		Assumed pt care. Previous shift reported removing pt's urinary catheter @ 2230. At this time, pt has not voided, has been approx 8 hrs since foley urinary catheter removed. Charge nurse notified and IV fluids for pt orally has begun. Pt attempted to urinate once this AM, pt not successful. 18IV cath in (R) hand, patent & infusing D5NS c 20 meq KCL @ 100cc/hr c difficulty, site c pain, edema, or redness. Pt up in chair @ own request following voiding attempt & ADL's completed. Will continue to monitor pt. — [b)(6)-2]
05Oct03	0710		Neurovascular checks completed, pt has full sensation, EOM able to wriggle (R) hand & fingers, all pulses present, Cap Refill < 2 seconds. Pt grimaces when moving (L) arm, but denies need for medication. Will continue to monitor. — [b)(6)-2]
05Oct03	0815		Pt successfully voided 425cc/urinal c slight difficulty. Pt teaching given that pain during urination would eventually subside. Will continue to monitor. — [b)(6)-2] RN
05Oct03	0830		Pt ambulated on ward after sitting in chair for 20 minutes. — [b)(6)-2] LRN


INTAKE
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URINE
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0300 100 300
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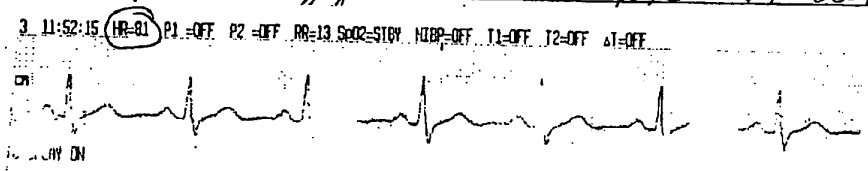
1100 100 300 660 1260
1200 100 400
1300 100 500
1400
1500 50 50
1600 2010
8 HR 16 HR. 2010 16 HR 1675
1700 330 500 500
1800
1900 100 430
2000 500 1000
2100 50 480
2200
2300
2400
8 HR 24 HR. 24 HR

MEDCOM - 2371

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
05 OCT 03	Nursing Notes: (10:00) Pt c/o neck & shoulder pain, 7/10 on pain scale. Medicated pt c̄ percocet ÷ po per pain order. Will continue to monitor. [redacted]
05 OCT 03	12:05 - Pt c/o "fluttering in heart & dizziness" per translator, after staff informed pt he would be discharged soon to the EPW Camp. Rhythm strip taken, Ø s/s of acute distress noted, pt LOC intact, Ø speech dysfunction or N.V.D. Pt denied any



dizziness after moving from chair to bed. Will continue to monitor. [redacted]

05 Oct 03	13:45 - Nursing Notes - Assisted physician in Δ'ing pt neck & shoulder dressing; pt tolerated well. Will continue to monitor. [redacted]
05 Oct 03 1500	Recieved Pt. Resting well hob 30°. VSS Ø complaints at this time See flow chart for assessment will continue to monitor [redacted] GT 91WM6 [redacted]
06 Oct 03 0007	MPC BS VS stable Ø c/o pain. Ⓡ hand H2 patent HOB Elevated pt moves ext x4 s̄ difficulty. [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)	REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

MEDCOM - 2372
509-114

DATE	NOTES
06 Oct 03 0300	VS PSO2=97% HR=78 R=18bpm T=98° B/P=116/66 (83) Ø c/o pain (L) shoulder/neck bandage CDI, HOB elevated Ø other complaints @ this time, will continue to monitor [redacted]
6 Oct 03 0850	T 99°, BP 117/65, HR 84, RR 17, SPO2 96% on RA, pt. ambulated this AM; sat up in chair + ate breakfast; voiding clear, yellow urine; No lock to (R) hand CDI - patent; NAD, lung sounds clear (B); BS active x4 quad.; dressing to (L) shoulder CDI; pt c/o pain ∏ percocet given PO; pt. now resting in bed; pulses normal + palpable (B) radial, will cont to monitor [redacted] 91WM6
6 OCT 03 1500	Recieved pt Resting well, VSS, Ø complaints @ this time, pt meds and Dressing change 78 materials Ready for pt evac to mp custody will Continue to monitor [redacted] GT 91WM6 [redacted]
6 Oct 03 1740	D/C to MP's Instruction given "states understanding of the D/C orders" Supplies givens for the next 5-6 days. Instructed to come back or call with any concern of care [redacted]

FPI LEX Printed on Recycled Paper

STANDARD FORM 509 (REV. 5-99) BACK

MEDCOM - 2373

558-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp): (b)(3)-1

LOG NUMBER

ARRIVAL — DATE: DAY 2, MONTH 10, YR. 03 — TIME: 2225

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☒ AMBULANCE ☐ OTHER (Specify)

CURRENT MEDS. (tetanus immunization and other data): Ø

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES: PCN

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration): GSW neck — SEX: M — AGE: 37

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: 2250.

VITAL SIGNS

TIME	2225	2315	2330
BP	149/91	130/79	128/79
PULSE	93	95	89
RESP.	16	22	15
TEMP.	97.8	97.8	—
SPO2 WT. (Chd)	97	97% RA	95%

CATEGORY (See reverse)
- EMERGENT
- URGENT
- ✓ NON-URGENT

ORDERS	INITS.	TIME
CBC, lstat6, Cr	[redacted]	2235
UA	[redacted]	2305
CXR, cspine,	[redacted]	2300
(L) humerus.	[redacted]	2300
T+C x 4 c	[redacted]	2235
Clindamycin 900mg IV		2300

b6-2

ASSESSMENT/DIAGNOSIS: GSW (L) neck

DISPOSITION (Check all that apply): HOME / FULL DUTY

QUARTERS: 24 Hrs. / 48 Hrs. / 72 Hrs.

MODIFIED DUTY UNTIL: DAY / MONTH / YEAR

REFERRED TO (Indicate clinic)

EMERGENCY / TODAY / 72 HOURS / ROUTINE

ADMIT. TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE: IMPROVED / UNCHANGED / DETERIORATED

TIME OF RELEASE:

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

S: 37 y/o ♂ GSW to neck and shoulder.

37 y/o EPW s/p GSW c̄ M-4 to (L) lat neck. Stable en route. Speaking c̄ airway involvement.

C - A - nl voice
1° B - B=/symmetric BS 1xLB IV
C - CK<25, DP 2+
D - GCS 15, MAE

2° HEENT - lat post zone 2 neck GSW c̄ 20 significant venous oozing.
Chest - (L) shoulder/ant peck ecchymotic hematoma.
(L) Shoulder - GSW c̄ FB pulp post, small EW
CV - Reg & m
lungs - CTA (B)
abd - S/NT/ND
pelvis stable
back - ¢ inj
neuro - symmetric MM 5/5 ULE, Reflex 2+

GDC - SOD (Sanborn) eval'd pt. ¢ airway involvement. ¢ htx/ptx.
Abx given.

PMH - Ø
PSH - 15 year ago warm
Tob - Ø
Last Oral Int 24hr

Cxr ¢ptx ¢htx
Cspine
humerus

(CONTINUE ON SF 507, IF NEEDED)

PATIENT'S IDENTIFICATION (Mechanical imprint) FOR WRITTEN ENTRIES GIVE: Name - last, first, middle; SSN; DOB, service status, name and relation of sponsor or next of kin. (IMPORTANT: LIST FACILITY HOLDING TREATMENT RECORD).

Iraqi # (b)(6)-4

(b)(6)-4

SIGNATURE OF PROVIDER AND ID STAMP: (b)(6)-2 MAJ, MC

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans)

To OR

MEDCOM - 2374

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	30 OCT 03
DOS	
POD	

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside			(b)(6)-2
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 UTAH	ICU	30 OCT 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade; date; hospital or medical facility)*

Pohus (b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOWCHART

☐ OTHER EXAMINATION Or EVALUATION ☐ OTHER(*Specify*)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 2375

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200	97.7 Ax	80	12	128/21	94%												
0300																	
0400																	
0500																	
0600	100.3	84	15	138/78	98%		99										
0700																	
0800																	
0900																	
1000	99.9	78	18	123/62	98%		85										
1100																	
1200																	
1300																	
X1400																	
1500	100	88	15	130/68	96		90										
1600																	
1700																	
1800																	
(1900)		86	16	130-68	96												
2000																	
2100																	
2200																	
2300																	
2400	98.4	96	18	133/74	96		97										(b)(6)-2

ACLU-RDI 1099 p.1160

DOD 006428

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	3 Oct 03
DOS	4 Oct 03
POD	

24 HOUR DATA	
24 Hour Balance	890
24 Hour Intake	3710
24 Hour Output	4600
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside			(b)(6)-2
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title)		Department/Service/Clinic	DATE
(b)(6)-2	[illegible]	ICU	4 Oct 03

PATIENT'S IDENTIFICATION (For typed or written entries give: Name-last, first, Middle; grade; date; hospital or medical facility)

Potus (b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOWCHART

☐ OTHER EXAMINATION Or EVALUATION ☐ OTHER(Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 2377

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R				2			2								2							2		
	RADIAL L				2			2								2							2		
	DORSALIS PEDIS R				2			2								2							2		
	DORSALIS PEDIS L				2			2								2							2		
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale					3			1								1							1		
					3			3								3							3		
					0			8								8							8		
EDEMA					✓																				
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)					✓			✓								✓							✓		
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)					NSR			SR								SR							SR		
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH							✓																	
	FOLEY CARE				✓			✓								✓							✓		
	ORAL CARE																								
MOBILITY	BEDREST				✓			✓															✓		
	BSC																								
	DANGLE															S									
	CHAIR															E									
POSITIONED	RIGHT															L									
	LEFT															F									
	SUPINE				✓			✓															✓		
	HOB 30 DEGREES				✓			✓								✓									
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)					—																		X		
PAIN	PAIN FREE				✓			✓								✓							QF		
	PAIN SCALE (1-10)																								
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN (2) Soft & Flat (1) Distended					2			2								2							2		
BOWEL SOUNDS (active all quads)					x4			x4								✓							x4		
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT					✓			✓								✓							✓		
VOIDING CLEAR, YELLOW URINE q.s.					✓			✓								✓							✓		
SKIN INTEGRITY	No Breakdown				✓			✓								✓							✓		
(L) neck/shoulder	Surgical Wounds				✓			✓								✓							✓		
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1 (L) neck/shoulder/back					✓			✓								✓							✓		
#2																									
#3																									
					✓			1602								H							✓		

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
~~X36 PIV~~	(L) AC	30 Oct 03	CDI @ 0900
18G IV cath	(R) HAND	040CT03	CDI @ 10:30

(b)(6)-2

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable /Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment --

DATE: 04 Oct 03

TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open				4			4								4							4		
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response				5			5								5							5		
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response				6			6								6							6		
GLASCOW COMA SCALE (A+B+C)				15			15								15							15		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — R				+2			+2								+2							+2		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — L				+2			+2								+2							+2		
MOVEMENT (See Motor Function Scale at Top of Page) — RUE				4			4								4							4		
MOVEMENT (See Motor Function Scale at Top of Page) — LUE				3			3								3							3		
MOVEMENT (See Motor Function Scale at Top of Page) — RLE				5			5								5							5		
MOVEMENT (See Motor Function Scale at Top of Page) — LLE				5			5								5							5		
GRIP (S) Strong (W) Weak (-) absent — R				S			S								S							S		
GRIP (S) Strong (W) Weak (-) absent — L				W			W								W							W		
RESPIRATIONS — REGULAR				✓			✓								✓							✓		
RESPIRATIONS — IRREGULAR																								
RESPIRATIONS — UNLABORED				✓			✓								✓							✓		
RESPIRATIONS — LABORED																								
RESPIRATIONS — SHALLOW																								
RESPIRATIONS — RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RUL				5			5								5							5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — LUL				5			5								5							5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RLL				5			5								5							5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — LLL				5			5								5							5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — BOTH BASES				✓			✓								✓							✓		
COUGH — NONE				✓			✓								✓							✓		
COUGH — SPONTANEOUS																								
COUGH — PRODUCTIVE																								
COUGH — NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																								
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																								
VENTILATOR — Vt																								
VENTILATOR — FiO2																								
VENTILATOR — RATE (SIMV/CMV)																								
VENTILATOR — PEEP / CPAP																								
VENTILATOR — PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE — NC (l/min)				RA			RA								R							RA		
OXYGEN DELIVERY DEVICE — FM (l/min)																								
OXYGEN DELIVERY DEVICE — NRBM (l/min)																								
ETT # _____ — ETT _____ cm gums																								
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED																								
INCENTIVE SPIROMETRY DONE																								
COUGH / DEEP BREATH															✓									
INITIALS			(b)(6)-2			(b)(6)-2									(b)(6)-2							(b)(6)-2		

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200																	
0300																	
0400	99.2	94	13	129/73	98		94										RA 2L NC
0500																	
0600																	
0700																	
*0800	99.3	94	16	131/76	96%		95										RA
0900																	
1000																	
1100																	
1200																	
1300																	
1400																	
1500	99.9	97	14	124/73	97		91										RA
1600																	
1700																	
1800																	
1900																	
2000																	
2100																	
2200																	
2220	99.2	86	15	129/68	97		91										RA, NAC
2300																	
2400																	

ACLU-RDI 1099 p.1164

DOD 006432

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	3 Oct 05
DOS	5 Oct 05
POD	1

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside			(b)(6)-2
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 9/nurs	ICU	5 Oct 05

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, middle; grade; date; hospital or medical facility)*

(EPW) POTUS (b)(6)-4

- ☐ HISTORY/PHYSICAL
- ☐ FLOWCHART
- ☐ OTHER EXAMINATION or EVALUATION
- ☐ OTHER *(Specify)*
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

FORM 4700 MEDCOM - 2381

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R		2					2								2									2
	RADIAL L		2					2								2									2
	DORSALIS PEDIS R		2					2								2									2
	DORSALIS PEDIS L		2					2								2									2
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale			1 3 8					1 3 8								1 3 8									1 3 3 0
EDEMA			✓					✓								✓									✓
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)			✓																						SR
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)			SR													SR									
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH							✓																	
	FOLEY CARE							✓																	
	ORAL CARE							✓																	✓
MOBILITY	BEDREST		✓					✓																	
	BSC																								
	DANGLE								✓																
	CHAIR																								
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE																✓								✓
	HOB 30 DEGREES		✓						✓																
FALLS PROTOCOL INITIATED			—														✓								
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)									✓																RF
PAIN	PAIN FREE		RF																						
	PAIN SCALE (1-10)																								
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									2
ABDOMEN	(2) Soft & Flat (1) Distended		2						2								2								
									✓																✓
BOWEL SOUNDS (active all quads)																									
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT			P/C							✓							✓								✓
VOIDING CLEAR, YELLOW URINE q.s.			—							✓															✓
SKIN INTEGRITY	No Breakdown		—							✓							✓								✓
(L) neck/shoulder	Surgical Wounds																								
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)			✓							✓							✓								✓
#1 (L) neck/shoulder																									
#2																									
#3																									

b(6)-2

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
18G	(R) hand	4 Oct 03	CDI
18G	R HAND	4 Oct 03	Ø's of IV

ACLU-RDI 1099 p.1166

DOD 006434

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable / Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment –

DATE: 5 Oct 03

TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open		4					4								4									4
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response		5					5								5									5
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response		6					6								6									6
GLASCOW COMA SCALE (A+B+C)		15					15								15									15
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — R		2+					2+								2+									2+
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — L		2+					2+								2+									2+
MOVEMENT (See Motor Function Scale at Top of Page) — RUE		4					4								4									4
MOVEMENT (See Motor Function Scale at Top of Page) — LUE		3					3								3									4
MOVEMENT (See Motor Function Scale at Top of Page) — RLE		5					5								5									5
MOVEMENT (See Motor Function Scale at Top of Page) — LLE		5					5								5									5
GRIP (S) Strong (W) Weak (-) absent — R		3					3								3									3
GRIP (S) Strong (W) Weak (-) absent — L		W					W								W									W
RESPIRATIONS — REGULAR		✓					✓								✓									✓
RESPIRATIONS — IRREGULAR																								
RESPIRATIONS — UNLABORED		/					✓								/									✓
RESPIRATIONS — LABORED																								
RESPIRATIONS — SHALLOW																								
RESPIRATIONS — RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RUL		5					5								5									5
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — LUL		5					5								5									5
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RLL		5					5								5									5
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — LLL		5					5								5									5
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — BOTH BASES		/					✓								/									✓
COUGH — NONE		/					✓								/									✓
COUGH — SPONTANEOUS																								
COUGH — PRODUCTIVE																								
COUGH — NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																								
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																								
VENTILATOR — Vt																								
VENTILATOR — FiO2																								
VENTILATOR — RATE (SIMV/CMV)																								
VENTILATOR — PEEP / CPAP																								
VENTILATOR — PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE — NC (l/min)		RA					RA								RA									RA
OXYGEN DELIVERY DEVICE — FM (l/min)																								
ETT # _____ — NRBM (l/min)																								
ETT # _____ — ETT _____ cm gums																								
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED																								
INCENTIVE SPIROMETRY DONE							4																	
COUGH / DEEP BREATH							4																	
INITIALS	[b)(6)-2]					[b)(6)-2]									[b)(6)-2]								[b)(6)-2]	

ACLU-RDI 1099 p.1167

DOD 006435

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200																	
0300																	
0400																	
0500																	
0600																	
0700																	
0800	99.1	86	17	128/70	97%	—	91	—									RA
0900																	
1000																	
1100																	
1200																	
1300	99.3	74	16	136/69	94%	96% RA											
1400																	
1500																	
1600																	
1700																	
1800																	
1900																	
2000																	
2100																	
2200																	
2300																	
2400																	

ACLU-RDI 1099 p.1168

DOD 006436

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT
For use of this form, see AR 40-407, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA litter BY LTC [b)(6)-2]

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY [(b)(6)-2] May RN

3. DATE 20 Oct 03 TIME PATIENT ARRIVED IN SUITE 2333

4. PATIENT IN ROOM TIME 2335 NUMBER [(b)(6)-4]

5. PREOPERATIVE EMOTIONAL STATUS

☑ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER (Specify)

COMMENTS: PCN

6. NURSING PERSONNEL

ASSIGNED SCRUB	Spc [b)(6)-2]	RELIEF SCRUB	
	Spc [b)(6)-2] Carol [b)(3)-1]		
ASSIGNED CIRCULATOR	May [b)(6)-2]	RELIEF CIRCULATOR	
	May [b)(6)-2] [b)(3)-1]		

7. POSITION AND POSITIONAL AIDS (Specify)

☑ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

COMMENTS: beam bag used @ tilt position

8. SKIN PREPARATION

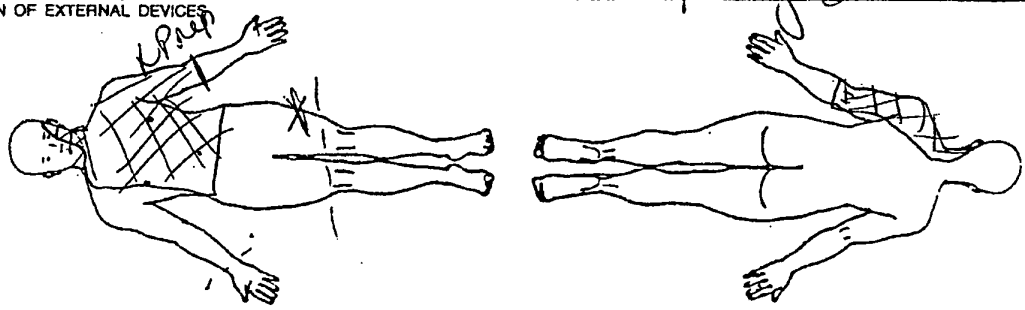
HAIR REMOVAL ☑ YES ☐ NO
DONE BY: ☑ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☑ RAZOR ☐ CLIP

COMMENTS: NO nicks or irritation

PREP SOLUTION (Specify) Beta/Beta
SITE: ☑ Neck, Chest BY WHOM: May [b)(6)-2]
SITE: arm to elbow BY WHOM:

COMMENTS: NO pooling or irritation

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad – Safety Strap --- Tourniquet

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☑ Yes ☐ No				(b)(6)-2	(b)(6)-2
Needle Sharp	☑ Yes ☐ No		C	C		
Instrument	☐ Yes ☐ No					
Other	☐ Yes ☐ No					

11. PATIENT IDENTIFICATION (For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)

IRAQI # [b)(6)-4]

12. ELECTROSURGERY DEVICE(S) (ESU) ☑ YES ☐ NO

☐ ESU NO: Valleylab 1000434
GROUND PAD: BRAND ~~Bovie~~ Valleylab E7507
LOT NO: 6486210

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

MEDCOM - 2385 AR NO:

14. MEDICATIONS/ORDERS					
IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA)				YES ☐	NO ☒
MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

0.9% NS

OTHER ORDERS	TIME	CARRIED OUT BY
Foley cath in place on arrival draining clear yellow urine		

PHYSICIAN'S SIGNATUR (b)(6)-2 [redacted] (b)(6)-2 [redacted], MD LTC, MC

15. X-RAY IN OPERATING ROOM IF YES, SITE
YES ☐ NO ☒

16. LABORATORY SPECIMENS		
SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

18. DRESSING/IMMOBILIZATION *(Specify)*
4X8's
tape

17. TUBES, DRAINS/PACKING	YES ☐	NO ☐	
TYPE/SIZE	1. 1½" penrose	2.	3.
SITE	(L) Shoulder	2.	3.

19. ADDITIONAL INFORMATION
(b)(6)-2 [redacted] (b)(3)-1 [redacted]
(b)(6)-2 [redacted]

20. OPERATION(S) PERFORMED
I&D (L) neck

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU	See DA7389	litter c̄ safety straps

22. REGISTE (b)(6)-2 [redacted] maj/n

REVERSE OF DA FORM 5179-1, OCT 87

*U.S. GPO: 1996-404-613/40449

MEDCOM - 2386

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

For use of this form, see AR 40-407, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA litter BY [redacted]

2. PATIENT IDENTIFIED AND PROCEDURE VERIFIED BY [redacted]

3. DATE 04 Oct 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME NUMBER

5. PREOPERATIVE EMOTIONAL STATUS

☑ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER (Specify)

COMMENTS: Alert.

6. NURSING PERSONNEL

ASSIGNED SCRUB	Spc [redacted]	RELIEF SCRUB	
ASSIGNED CIRCULATOR	[redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify) on blanket, rolled 100% L. Safety strap over thighs ©

☑ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

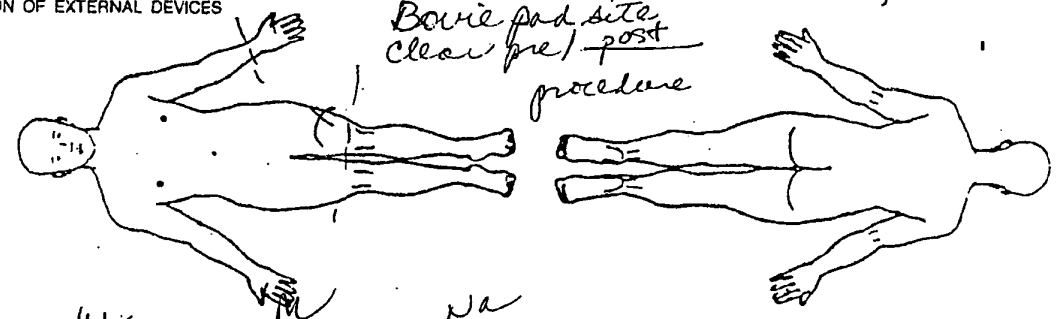
COMMENTS: arm free

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☑ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP
COMMENTS:

PREP SOLUTION (Specify) Betadine scrub/sol
SITE: Rneck BY WHOM: [redacted]
SITE: arm BY WHOM: Fortune
COMMENTS: ∅ pooling noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Strap === Tourniquet NA

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR [redacted]
Sponge	☐ Yes ☐ No			C		
Needle Sharp	☐ Yes ☐ No			C	Spc [redacted]	[redacted]
Instrument	☐ Yes ☑ No					
Other	☐ Yes ☑ No					

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

Angi [redacted]

12. ELECTROSURGERY DEVICE(S) (ESU) ☐ YES ☐ NO

☐ ESU NO: Valleylab 00432
GROUND PAD: BRAND Valleylab 69671
LOT NO: Exp 2005-09

☐ ESU NO: _____
GROUND PAD: BRAND _____
LOT NO: _____

MEDCOM - 2387 LAR NO: _____

14. MEDICATIONS/ORDERS					
IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA)				YES ☐	NO ☐
MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☐ YES ☐ NO, TYPE(S):
O9NS

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM
YES ☐ NO ☑ IF YES, SITE

16. LABORATORY SPECIMENS		
SPECIMEN (S) YES ☐ NO ☑	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☑	NAME	NAME
CULTURE (C) YES ☐ NO ☑	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING	YES ☐	NO ☐	
TYPE/SIZE 1" penrose (L) shoulder	1.	2.	3.
SITE	1.	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
fluffs
4x4's
foam tape

19. ADDITIONAL INFORMATION
unknown allergy status

Surgeons - Stroud / Gupta

20. OPERATION(S) PERFORMED
S.D (L) Shoulder - Neck Wds

21. PATIENT TRANSFERRED TO SICU	TIME	METHOD litter
22. REGISTERED NURSE (b)(6)-2		Maj AT

REVERSE OF DA FORM 5179-1, OCT 87

*U.S. GPO: 1996-404-613/40449

MEDCOM - 2388

MEDI[illegible] RE[illegible]D - PATIENT RELEASE / DISCH[illegible] [illegible]TRUCTIONS

[illegible]r use of this form, see MEDCOM Circular 40-5

DIRECTIONS: To be completed by attending [illegible]ovider and other staff at time of patient release following an outpatient procedure, extended care/treatment or discharge from an inpatient hospital stay.

SECTION I
TO BE COMPLETED BY PRIVILEGED PROVIDER

1. DATE OF PROCEDURE/ADMISSION: 2 Oct 03
2. ADMITTING/DIAGNOSIS: GSW to (2) shoulder
3. PERTINENT LAB, X-RAY, FINDINGS: clavicle fracture c̄ No MAJOR vessel involvement
4. PROCEDURES, TREATMENT, HOSPITAL COURSE: I+D, (2) GSW c̄ Exploration Axilla I+D, closure
5. FINAL DIAGNOSIS AND CONDITION AT DISCHARGE: GSW to (2) shoulder
6. ACTIVITY: As tolerated. Should do Range of Motion in 5-7 days
7. DIET: as tolerated
8. MEDICATIONS:
   - [x] Medications have been prescribed for home use. See separate list and special instructions or see below.
   - 1. Tylox ī-ii po q̄ 4-6 PRN pain #30
   - 2. Motrin 800mg ī po q̄ 4-6 PRN pain #60
   - 3. Keflex ī po q̄ 6 x 3 days #12
9. INSTRUCTIONS (To Home Health Providers, Patient, etc): Sling as needed. Daily dressing change. F/u in ~10 days (Oct 17) for staple removal. May be done by medic if everything OK
10. DISCHARGING PROVIDER: (b)(6)-2 [redacted] (Signature) MAJ (b)(6)-2 [redacted] (Print[illegible])

PATIENT IDENTIFICATION

POTUS # (b)(6)-4 [redacted]

(b)(6)-4 [redacted]

SECTION II
TO BE COMPLETED BY OTHER STAFF, AS APPROPRIATE

1. DISPOSITIONED TO: [ ] HOME [ ] DUTY [x] OTHER detainee camp
   [x] AMBULATORY [ ] CRUTCHES [ ] WHEELCHAIR [ ] STRETCHER
2. ACCOMPANIED BY: [ ] FAMILY [ ] FRIEND [ ] OTHER
3. PATIENT EDUCATION:
   Completed and patient prepared for home care. [x] YES [ ] NO
   If no, explain:
   Patient [x] states [ ] demonstrates understanding of home care needs.
   Printed educational materials provided:
4. Clinical outcomes met and post-discharge/release referrals made.
   [x] YES [ ] NO If no, explain:
5. If transferred to another health care facility, report called to nurse.
   [ ] YES [ ] NO If no, explain:
6. NUTRITION CARE - Comments: Reg diet
7. MEDICATIONS:
   Explained by: [x] NURSE [ ] PHYSICIAN [ ] PHARMACIST
   Printed medication literature provided. [ ] YES [ ] NO
   Patient states understanding of prescribed medications. [ ] YES [ ] NO
8. EQUIPMENT/SUPPLIES PROVIDED: yes, 4x4's + tape for dry sterile dressing.
9. FOLLOW-UP APPOINTMENTS, POINT OF CONTACT & PHONE: 17 Oct 03 f/u @ Specialty Clinic
10. FOR PROBLEMS OR EMERGENCY, CONTACT & PHONE: 570-2112 - EMT
11. COMPLETED [illegible] (b)(6)-2 [redacted] (b)(6)-2 [redacted] DWMLE PC (Signature and Title) 6 Oct 03 (Date and Time)

I HAVE RECEIVED A COPY OF AND UNDERSTAND THESE INSTRUCTIONS.

(Patient/Responsible Adult's Signature) (Date and Time)

MEDCOM FORM 691-R (TEST) (MCHO) MAR 99 PREVIOUS EDITIONS ARE OBSOLETE MC V1.00

MEDCOM - 2389

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI: [b)(6)-4] Iraqi #1 | UNIT | RANK | SSN

Physician: [b)(6)-2] May | Ward: CWT | STAT [X] | Routine [ ] | Date and Time: 20Oct03 20:40 | R[(b)(6)-2] | Date and Time: 20Oct 2300hr

Chemistry (I-STAT)

X	TEST	RESULT	REF. RANGE
	Na	143	128-145 mmol/L
	K	3.6	3.3-4.7 mmol/L
	Cl	112	98-108 mmol/L
	pH		7.35-7.45
	PCO2		35-45 mmHg
	PO2		80-90 mmHg
	TCO2		18-33 mmol/L
	HCO3		22-28 mmol/L
	sO2		95-99%
	BEecf		(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN	1607 10	7-22 mg/dL
	Glu	162	73-118 mg/dL
	Creat	1.2	0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL

Chemistry (Piccolo Analyzer)

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-84 U/L
	ALT		10-47 U/L
	AMY		14-97 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat		0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		128-145 mmol/L

Hematology

X	TEST	RESULT	REF. RANGE
	WBC	10.2	4.8-10.8 x10(3)/uL
	RBC	4.19	4.2-6.1 x10(6)/uL
	Hgb	13.4	12.0-18.0 g/dL
	Hct	37.7	35.0-60.0%
	MCV	90.0	80.0-99.0 fl
	MCH	32.1	27.0-31.0 pg
	MCHC	35.6	33.0-37.0 g/dL
	Plt	233	130-400 x10(3)/uL
	LY%	11.4	15.0-55.0%
	LY#	1.2	0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Imm
RBC Morph:	
Plt verify:	
Spun Crit	35-60%

Urinalysis

Color	Straw	Straw/Yellow
Clarity	Clear	Clear
Glucose	Neg	Negative
Bilirubin	Neg	Negative
Ketone	Neg	Negative
SG	1.025	1.010-1.025
Blood	Large	Negative
pH	5.0	5.0-8.0
Protein	Trace	Negative-Trace
Urobili	Neg	Negative
Nitrite	Neg	Negative
Leuko	Neg	Negative

Urine Microscopic

WBC	0-5	Epi	Rare squams
RBC	0-5	Mucus	Mod
Bacteria	Light	Yeast	
Casts:	Hyaline	0-2	
Crystals:	None		
Other:			

Microbiology

Source:		
FecLeuk		Negative
Gram St		
WetPrep		Negative
KOH		No Fungal Elements
OccBld		Negative
O&P		No Ova/Parasite

Blood Bank

ABO/Rh	AB Positive	
T&C		
T&S		

HCG

Urine		Negative
Serum		Negative

Malaria Smear

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate

Sed Rate		1hr = 0-20 mm

Coagulation

PT		10-13 seconds
APTT		22.1-33.7 seconds
FDP		Negative

Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Negative

Other: ISTAT 6 CREAT

MEDCOM - 2390

Crossmatch Methods & (Nocor Form)

MEDICAL RECORD - ANESTHESIA

For use of this form, see AR 40-66; the proponent agency is the OTSG

B/F Y.O. ALL PCN

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML. "T" = CONSTANT INFUSION

DRUG	(Units)	
FENT	(MCG)	100 150
ANCEF	( )	2g 1g
SUX	(Mg)	100
	( )	
MIDA	(Mg)	2 2
	( )	
VOLAT AGENT	ISO SEV DES	3 — 2.5 — 2 — 2 1/2 — X
AIR	L/Min	
N2O	L/Min	
O2	L/Min	8 — 1 — 1 — 1 — 1 — 2 — 8 — X

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS

FLUIDS

LINE site	☐ Warmed
	☐ Warmed
	☐ Warmed
LAC 1000	☐ Warmed — 500 — 400 — 900

LOSSES — EST BLOOD LOSS; URINE -

PHYS STATUS (1) 2 3 4 5 (E)

BODY WEIGHT: 185 (KG) LB

HEMATOCRIT: 37/13

INITIAL DATA:

BP- 135/80

HR- 104

EQUIP CHECK

OK? (Y) N

PATIENT RECHECK

OK for PROCEDURE?

TIME-

TIME → 2330 · 2400 · 0030 · 0100 · 30 · 0200

SYMBOLS:

BP by cuff: V ^

Heart rate: ●

Resp rate:

BR (transduced):

TOURNIQUET: T—T

ANES- X-X

PROC- ⊙-⊙

220 200 180 160 140 120 100 80 60 40 20

VENTIL

VT - ml		630	660	660	470	410
f - breaths/min		10	10	10	6	9
Peak inf pres / PEEP		20	20	21		
MODE - S(pon), A(ssist), C(on)	S	C	C	C	S	S S

MONITORS/ACCESSORIES

✓ BP/Auto Cuff	✓ ET CO2 (torr)	+	37	32	30	38	47	
BP/oth	✓ FIO2 (Frac or %)	1.0						
ART line	✓ SpO2 (%)	97	97	97	97	97	99	99
Steth- PC/ES	✓ ECG	ST	SR	SR	SR	SR	SR	
Gas analyzer	TEMP-site SKIN		37.0					
	N-M Block (T/4)							
	FOLEY		1000					
Warming blkt								
Conv warmer								

Mark with letters & symbols, explain under REMARKS — EVENTS Position → O2 ON @ 2330 SATS 97% ON 3L NC

TOTALS	TOTAL EBL
250	150
	TOTAL URINE
4	1000

FLUIDS - SUMMARY

CRYSTALLOID- 900

COLLOID- 0

BLOOD- 0

REMARKS

Code drugs with numbers, events with letters

2335 IN ROOM STD MONITORS RSI

0055 - MOUTH SUCTIONED FOLLOWED CUFFS INFLATED ETT

0109 - TO ICU VIA CSV

RECOVERY AT 0115

PACU ICU #2 (Specify)

OTHER

CONDITION: T PAT

RESP- 22 SpO2- 98

BP- 152/88 HR- 100

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	2310	2335	0120
	Ready	Begin	End
PROC	2345	0015	0055

PROCEDURES and CPT Codes:

(L) NECK D&I

PATIENT IDENTIFICATION: Typed or written entries: Name, Grade/Rate, Medical facility

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

GETA - RSI

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

DL x1, MAC 3, 6.5 II, 25 ETT x1 24cm @ LIP @ BBS = W EtCO2 x6 CHEST RISES, ORAL AIRWAY

SURGEON: (b)(6)-2

PROCEDURE LOCATION:

DATE:

(b)(6)-4

MEDCOM - 2391

POTUS #

(b)(6)-4

PREANESTHETIC SUMMARY

OPERATION PROPOSED	AGE	WEIGHT (LBS.)	SPECIAL INFORMATION
D&I (L) NECK/Shoulder	37		
	PHYSICAL STATUS 1 2 3 4 5 6 7		

URINALYSIS	HEMATOLOGY	BLOOD CHEMISTRY
NORMAL ..... ABNORMAL AND WHY?	HGB ..... RBC ..... HCT ..... OTHER	

RESPIRATORY SYSTEM	CIRCULATORY SYSTEM	CENTRAL NERVOUS SYSTEM	OTHER SYSTEMS
(X-RAY, ASTHMA, OTHER PATHOLOGY)	BP ..... PULSE ..... ECG (IF PERTINENT) 128/79 90 97%	(CEREBROVASCULAR, POLIO, NEUROLOGICAL)	(ALLERGIES) PCN ALLERGY

PREVIOUS ANESTHETICS AND COMPLICATIONS	PRESENT DRUG THERAPY; E.G., STEROIDS, TRANQUILIZERS
PREOPERATIVE DIAGNOSIS	PREMEDICATION CLINDAMYCIN - 900 mg IN OUT
	SIGNATURE OF EVALUATING PHYSICIAN / DATE

POSTANESTHETIC VISITS

RECORD ALL PERTINENT COMPLICATIONS

*U.S. Government Printing Office: 1994 — 300-892/10029

ACLU-RDI 1099 p.1176

DOD 006444

MEDICAL RECORD - ANESTHESIA

For use of this form, see AR 40-66; the proponent agency is the OTSG

1100

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML. "I" = CONSTANT INFUSION

DRUG (Units)	1500	1510	1520	1530	1540	1550	1600	1610	1620	1630	1640	1650	1700
Fentanyl (ug)	250	50											
Propofol (mg)	150												
Succ (mg)	80												
( )													
( )													
( )													
VOLAT AGENT Iso % del		1.5	2.0	1.5	1.5	X							
% e.t.													
AIR L/Min													
N2O L/Min													
O2 L/Min	8	1	1	1	8 →								

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS

FLUIDS

LINE site ☐ Warmed													
#18 IV LA ☐ Warmed	>	700	→	→	350								
☐ Warmed													
☐ Warmed													

LOSSES — EST BLOOD LOSS / URINE

PHYS STATUS: ASA 1 2 3 4 5 E

BODY WEIGHT: 87 KG LB

HEMATOCRIT: 39.9

INITIAL DATA: BP- 130/68 HR- 86

EQUIP CHECK: OK? Y N

PATIENT RECHECK: OK for PROCEDURE? J TIME- 1100

TIME →

SYMBOLS: BP by cuff V ^ | Heart rate ● | Resp rate | BR (transduced) | TOURNIQUET T—T | ANES- X-X PROC-⊙-⊘

220 200 180 160 140 120 100 80 60 40 20

VENTIL

	1500	1510	1520	1530	1540
VT - ml	5V	500	780	330	410
f - breaths/min	↓	7	9	8	7
Peak Inf pres / PEEP		20	–	–	–
MODE - S(pon), A(assist), C(on)		c	S	S	S

MONITORS/ACCESSORIES

		1500	1510	1520	1530	1540
BP/Auto Cuff	ET CO2 (torr)	+	40	57	57	51
BP/oth	FIO2 (Frac or %)	1.0	1.0	1.0	1.0	1.0
ART line	SpO2 (%)	100	98	98	98	97
Steth- PC/ES	ECG	SR	SR	SR	SR	SR
Gas analyzer	TEMP-site	Axil	→	→		
	N-M Block (T/4)					
Warming blkt						
Conv warmer						

Mark with letters & symbols, explain under REMARKS — EVENTS Position → Supine / ⓛ Shoulder bump ↑ →

PROCEDURES and CPT Codes: ⓛ Shoulder I&D.

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*

Iraqi # [b)(6)-4]

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* GETA

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* IV induction, easy mask vent; cric pt c MAI; Size II view; 7.5 ETT; ⊕ c CO2, ETT 22 cm, teeth

SURGEONS: [b)(6)-2]

TOTALS

TOTAL EBL	TOTAL URINE
30	≠ 50

FLUIDS - SUMMARY

CRYSTALLOID- 350

COLLOID- ∅

BLOOD- ∅

REMARKS

Code drugs with numbers, events with letters

-pt. safely to OR, Anesthesia monitors, Pre-ox; see below for induction

case concluded → Smooth emergence/ extubation → Patent airway → Safely to ICU → Report given.

RECOVERY AT

PACU ☐ _____ Specify

OTHER _____

CONDITION: Good

RESP- 17 SpO2 100% on 3

BP- 123/77 HR- 101

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1100	1100	1225
PROC	Ready	Begin	End
	1110	1130	1203

PROCEDURE LOCATION: OR

DATE:

MEDCOM - 2393

PREANESTHETIC SUMMARY

OPERATION PROPOSED	AGE	WEIGHT (LBS.)	SPECIAL INFORMATION
I & D, (B) Shoulder	37	87	airway favorable - easy intubation
	PHYSICAL STATUS: (1) 2 3 4 5 6 7		

URINALYSIS
NORMAL .....
ABNORMAL AND WHY?

HEMATOLOGY
HGB ..... RBC ..... HCT .....
OTHER
11.9 / 6.0 / 253 / 34.9

BLOOD CHEMISTRY

RESPIRATORY SYSTEM (X-RAY, ASTHMA, OTHER PATHOLOGY)	CIRCULATORY SYSTEM	CENTRAL NERVOUS SYSTEM (CEREBROVASCULAR, POLIO, NEUROLOGICAL)	OTHER SYSTEMS (ALLERGIES)
ROS: ⊖ ϕ tobacco Exam: CTA (B).	BP 130/68 PULSE 86 ECG (IF PERTINENT) 96% RA ROS: Exam: NR S1, S2, ϕ Murm - vague h/o dysrhythmia - apparently transient did not interfere duties as military officer	ROS: ⊖	PCN

PREVIOUS ANESTHETICS AND COMPLICATIONS

PRESENT DRUG THERAPY; E.G., STEROIDS, TRANQUILIZERS
1. Clindamycin 600 IV q 8h
2. Morphine

PREOPERATIVE DIAGNOSIS

PREMEDICATION

SIGNATURE OF EVALUATING PHYSICIAN (b)(6)-2

DATE Feb. 03

POSTANESTHETIC VISITS

RECORD ALL PERTINENT COMPLICATIONS

Iraqi # (b)(6)-4

*U.S. Government Printing Office: 1994 — 300-892/10029

MEDICAL RECORD	REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

A. IDENTIFICATION

1. OPERATION OR PROCEDURE

Irrigation + Debridement (L) Shoulder

B. STATEMENT OF REQUEST

1. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be _____ (Description of operation or procedure in layman's language)

Extend wound at base of neck + wash-out wound

which is to be performed by or under the direction of Dr. Shrout / Sanborn

2. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the below-named medical facility, during the course of the above-named operation or procedure.

3. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the below-named medical facility.

4. Exceptions to surgery or anesthesia, if any, are: None (If "none", so state)

5. I request the disposal by authorities of the below-named medical facility of any tissues or parts which it may be necessary to remove.

6. I understand that photographs and movies may be taken of this operation, and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and observation of the operation by authorized personnel, subject to the following conditions:

a. The name of the patient and his/her family is not used to identify said pictures.

b. Said pictures be used only for purposes of medical/dental study or research.

(Cross out any parts above which are not appropriate)

C. SIGNATURES (Appropriate items in Parts A and B must be completed before signing)

1. COUNSELING PHYSICIAN/DENTIST: I have counseled this patient as to the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above

(b)(6)-2

(Signature of Counseling Physician/Dentist)

2. PATIENT: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(Signature of Witness, excluding members of operating team) (Signature of Patient) (Date and Time)

3. SPONSOR OR GUARDIAN: (When patient is a minor or unable to give consent) I, _____ sponsor/guardian of _____ understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(Signature of Witness, excluding members of operating team) (Signature of Sponsor/Legal Guardian) (Date and Time)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, grade; date; hospital or medical facility)

(b)(6)-4

Iraq!

REGISTER NO. | WARD NO

STANDARD FORM 522 (Rev. 10-76)
General Services Administration &
Interagency Comm. on Medical Records
FIRMR (41 CFR) 201-45.505
522-110

*U.S. Government Printing Office: 1991 — 312-071/40193

MEDCOM - 2395

MEDICAL RECORD	REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

A. IDENTIFICATION

1. OPERATION OR PROCEDURE

Irrigation & Debridement Left Shoulder

B. STATEMENT OF REQUEST

1. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be _____ (Description of operation or procedure in layman's language)

Open Wound on left shoulder, remove any dead or devitalized tissue, & wash wound out

which is to be performed by or under the direction of Dr. Shrout

2. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the below-named medical facility, during the course of the above-named operation or procedure.

3. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the below-named medical facility.

4. Exceptions to surgery or anesthesia, if any, are: None. (If "none", so state)

5. I request the disposal by authorities of the below-named medical facility of any tissues or parts which it may be necessary to remove.

6. I understand that photographs and movies may be taken of this operation, and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and observation of the operation by authorized personnel, subject to the following conditions:

a. The name of the patient and his/her family is not used to identify said pictures.

b. Said pictures be used only for purposes of medical/dental study or research.

(Cross out any parts above which are not appropriate)

C. SIGNATURES (Appropriate items in Parts A and B must be completed before signing)

1. COUNSELING PHYSICIAN/DENTIST: I have counseled this patient as to the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above.

b)(6)-2

LTC, MC

2. PATIENT: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(Signature of Witness, excluding members of operating team) (Signature of Patient) (Date and Time)

3. SPONSOR OR GUARDIAN: (When patient is a minor or unable to give consent) I, _____ sponsor/guardian of _____ understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(Signature of Witness, excluding members of operating team) (Signature of Sponsor/Legal Guardian) (Date and Time)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, [illegible]e; grade; date; hospital or medical facility)

Iraqi # b)(6)-4

REGISTER NO. | WARD NO.

STANDARD FORM 522 (Rev. 10-76)
General Services Administration & Interagency Comm. on Medical Records
FIRMR (41 CFR) 201-45.505
522-110

MEDCOM - 2396

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

DATE OF ORDER: 3 OCT 2003 — TIME OF ORDER: 0037 HOURS — LIST TIME ORDER NOTED AND SIGN

- To ICU - SHROUT
- Dx - GSW (L) neck/shoulder
- Cond - Guarded
- Allergies - PCN
- Vitals per ICU routine
- I's/O's: foley to gravity
- LR @ 125 cc/hr

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER — TIME OF ORDER — HOURS

- Activity - EPW/out of bed to chair in AM
- Diet - NPO
- MSO4 (Morphine) 1-6 mg IV q 1° prn pain
- Clinda 600 mg IV q 8°
- CBC in AM
- May reinforce dressing.

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER — TIME OF ORDER — HOURS

- If this is repeated, notify MD

3 OCT 03 0022

(1) Demerol 12.5 mg IV NOW FOR POST-OP SHIVERING - MAY REPEAT DOSE IN 10 MIN IF NECESSARY X 1

(2) MSO4 1-5 mg IV Q 5 MIN MAX 10 mg PRN POST-OP PAIN

CRNA

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER: 3 Oct 03 — TIME OF ORDER: 1000 HOURS

- Reinforce dressing as needed
- [redacted] NPO p MN; Reg. Diet [illegible]
- On Call for OR tomorrow

66-2

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

240 Chart ✓ 4 Oct 03 [illegible]

MEDCOM - 2397

MD

ACLU-RDI 1099 p.1181

DOD 006449

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
Iraqi # (b)(6)-4	304.03	2028 HOURS	
	✓ - pt. may have clear liquids until 0800		noted 04 303 2030 (b)(6)-2
	✓ - no solids after MN		

NURSING UNIT	ROOM NO.	BED NO.	
24° Chart ✓	0100	40ct03 (b)(6)-2	cpt AN (b)(6)-2

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER
	40ct03	HOURS
	1. ✓ S/P I+D G&W to left neck	
	2. ✓ Dr (b)(6)-2 / (b)(6)-2	
	3. ✓ D5 NS c̄ 20 mEq KCL/L. TRA 100cc/° Keplock when pos good.	
	4. ✓ I/O's, foley to gravity	
	5. ✓ Up in chair in AM	
	6 ✓ All - PCN	

NURSING UNIT	ROOM NO.	BED NO.

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER
		HOURS
	7 ✓ Clinda myrin 600g IV q̄ 8°	
	8 ✓ MAY RIENFORCE DRESSING	
	9. ✓ MSO4 1-6 mg IV q 1° PRN Pain	
	10. ✓ Percocet I-II po q̄ 4-6 PRN Pain	
	11. ✓ IS q̄ 1° WA	
	12 ✓ VS q̄ shift	
	13. ✓ MAY WALK as tolerated	

NURSING UNIT	ROOM NO.	BED NO.

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER
	14 ✓ DIET Regular	HOURS
	15 ✓ To ICU	
	16. ✓ Sling to (L) ARM when upright	
	17 ✓ NV ✓ (L) UE c̄ VS X24°	
	(b)(6)-2	

NURSING UNIT	ROOM NO.	BED NO.

MAJ (b)(6)-2

Noted DAN 04 Oct 03 @ 13:05

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 2398

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

POTUS # (b)(6)-4

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
4 Oct 03	2230 hrs HOURS	
-10 Dr (b)(6)-2	(b)(6)-2	
D/C Foley		

5 Oct 03 1100

NURSING UNIT	ROOM NO.	BED NO.
	5 Oct 03	0210

(b)(6)-2 SPC, 91WM2

PATIENT IDENTIFICATION

Noted 6 Oct 03 1500 JCR

DATE OF ORDER	TIME OF ORDER
6 Oct 03	HOURS
(1) D/C Heplock	
(2) Discharge to DM	
(3) please copy History / physical + Op Notes for patient (He requested it)	
(4) Sling for (2) ARM	

NURSING UNIT	ROOM NO.	BED NO.

(b)(6)-2 MAD (b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER
	HOURS

NURSING UNIT	ROOM NO.	BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER
	HOURS

NURSING UNIT	ROOM NO.	BED NO.

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 2399

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Jan 10 Sep 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR.	DATE COMPLETED 2 3 4 5 6
30 Oct 03	[redacted]	Vitals per icu routine (q shift)	D	[redacted]
			E	
			N	[redacted]
30 Oct 03	[redacted]	I's + O's, foley to gravity	D	[redacted]
			E	
			N	[redacted]
30 Oct 03	[redacted]	EPW/OOB to chair in AM	D	[redacted]
			E	
			N	
30 Oct 03	[redacted]	Diet NPO DC'd Regular Diet	D	[redacted]
			E	
			N	[redacted]
30 Oct 03	[redacted]	May reinforce dressing ~~(if this is repeated call MD)~~ DC'd	D	[redacted]
			E	
			N	[redacted]
04 OCT 03	[redacted]	IS q 1° W/A (while awake)	D	[redacted]
			E	
			N	
04 Oct 03	[redacted]	May walk as tolerated	D	
			E	
			N	
04 Oct 03	[redacted]	Sling to (L) arm when upright	D	
			E	
			N	
04 Oct 03	[redacted]	(L) UE c̄ VS X 24°	D	
			E	
			N	

D/C td 2230 40 Oct 03 [redacted]

ALLERGIES: ☑ YES ☐ NO
PCN

PRIMARY DIAGNOSIS:
GSW (L) neck/shoulder

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
PAGE NO:

PATIENT IDENTIFICATION:
EPW [redacted]

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES
D 8 9 10 11 12 13 14 15
E 16 17 18 19 20 21 22 23

MEDCOM - 2400

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON MEDICATION)

Mo 10 Yr 03

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
30 Oct	(b)(6)-2	To ICU - SHRAPNEL, Condition Guarded	30 Oct	ADMIT	0010	(b)(6)-2
30 Oct	(b)(6)-2	CBC in AM	662 30 Oct	AM	0515	
30 Oct	(b)(6)-2	NPO after midnight; on call for OR	30 Oct	0001	0001	
30 Oct	(b)(6)-2	May have Clear liquids until 0000	40ct			
		no solids after MN	30ct	0001	0001	
04 Oct	(b)(6)-2	S/P I&D GSW to left neck	04 Oct	12:25	12:25	
04 Oct	(b)(6)-2	Dr (b)(6)-2 / (b)(6)-2	04 Oct	12:25	12:25	
04 Oct	(b)(6)-2	To ICU	04 Oct	12:25	12:25	
6 Oct	(b)(6)-2	D/C Heplock	6 Oct	1500	1500	

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED

MEDCOM - 2401

RECORD - MEDICATION ADMIN[illegible]ON RECORD

For use of this form, see MEDCOM Circular 40-5

ORDER DATE	TRANSCRIBER/ REVIEWER INITIALS	SECTION I DELAYED SINGLE ACTION ORDERS & PREOPERATIVES	DATE/TIME TO BE GIVEN	DATE/TIME GIVEN AND INITIALS
30 Jul 03	(b)(6)-2	Demerol 12.5 mg IV now for post op shivering. May repeat dose in 10 min if necessary x1.	30 1003	0015 (b)(6)-2
30 Jul 03	(b)(6)-2	MSO4 1-5mg IV Q 5 min, Max 10mg for post op pain		

PATIENT IDENTIFICATION

Potus Ernest (b)(6)-1

DIAGNOSIS: GSW (L) neck/shoulder

ALLERGIES: PCN

Circle administration times (in pencil) for recurring medication.

D	07	08	09	10	11	12	13	14
E	15	16	17	18	19	20	21	22
N	23	24	01	02	03	04	05	06

MEDCOM FORM 690-R (TEST) (MCHO) MAR 99 PREVIOUS EDITIONS ARE OBSOLETE *Page 1 of 4 pages* MC V1.00

M[illegible]AL RECORD - MEDICATION ADMINI[illegible]ATION RECORD

ORDER DATE	TRANSCRIBER/ REVIEWER INITIALS	SECTION II (Cont) RECURRING MEDICATIONS, DOSE, FREQUENCY	HR ↓	INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION — DATE ADMINISTERED: 02	03	04	05	06
3 Oct 03	(b)(6)-2	Clindamycin 600mg IV Q8°	07	/	(b)(6)-2			
			15	/				
	(b)(6)-2		23	(b)(6)-2				
3 Oct 03	(b)(6)-2	LR 125cc/hr	D	/	(b)(6)-2			
			E	/	(b)(6)-2			
			N	✓				
04 Oct 03	(b)(6)-2	D5NS c̄ 20 mEq KCL/L	D	/	/	(b)(6)-2		
		TRA 100cc/° Heplock	E	/	/			
		when po good.	N	/	/			

DC'd 04 Oct 03 (b)(6)-2 2:55

PATIENT IDENTIFICATION

Potus (EPW) (b)(6)-4

DIAGNOSIS: GSW (L) Neck/Shoulder

ALLERGIES: PCN

Circle administration times (in pencil) for recurring medication.

D	07	08	09	10	11	12	13	14
E	15	16	17	18	19	20	21	22
N	23	24	01	02	03	04	05	06

MEDCOM FORM 690-R (TEST) (MCHO) MAR 99

Page 3 of 4 pages

MEDCOM - 2403

ACLU-RDI 1099 p.1187

DOD 006455

MEDICAL RECORD - MEDICATION ADMINISTRATION RECORD

ORDER/ EXPIRATION DATE	TRANSCRIBER/ REVIEWER INITIALS	SECTION III PRN MEDICATION, DOSE, ROUTE, FREQUENCY, REASON	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE/REASON/INITIALS/EFFECTIVENESS CODE
30Oct03	(b)(6)-2	MSO4 1-6 mg IV Q10 prn pain	30Oct 4 mg 0 [illegible] (b)(6)-2; 30Oct 6 mg 0530; 10/3 1005 6 mg IV [illegible]; 30Oct 2300 4 mg [illegible]; 4Oct 0[illegible] 5 mg (b)(6)-2; 4Oct 2020 5 mg
04Oct03	(b)(6)-2	Percocet i-ii po q 4-6° prn pain	4Oct 2020 (b)(6)-2; 5Oct 0240; 05Oct 10:00 [illegible] po (b)(6)-2; 5Oct 2000 ii 20; 6Oct 0845 [illegible]

CODES: Initials only = Medication administrated
Initials and E = Medication effective

Initials and I = Medication ineffective*
Initials and O = Medication withheld*

*SEE SF 509 FOR NURSE'S ENTRY

MEDCOM FORM 690-R (TEST) (MCHO) MAR 99

Page 4 of 4 pages

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-400; the proponent agency is The Office of The Surgeon General

REPORT TITLE: POST ANESTHESIA CARE UNIT FLOWSHEET

900mg Clindamycin in EMS

OTSG APPROVED (Date): 17 Jan 80

PROCEDURE: (L) neck 1+D Washout

PHYSICIAN: (b)(6)-2

ANESTHESIA BY: (b)(6)-2

(Gen) Spinal MAC Axillary Local Bier Epidural Other

50 Pu 1 MSO 2430

ALLERGIES: PLN

AIRWAYS: # Time DC'D

ETT Nasal Oral Trach

OXYGEN: Mask Nasal Face Blow-By Prongs Tent

Liter/min. %

ASA History

Cardiac Rhythm

IV#1 LR (Patent) Infiltrated

Site (Rac) Rate Gauge 18

IV#2 Patent Infiltrated

Site Rate Gauge

Time	B/P	P	R	O2SA	Temp	Act	Resp	Circ	LOC	Skin	PARS	COMMENTS	Neuro-Vascular
PRE-OP	135/80	104											Extr: L R Upper Lower Pulse DP PT RAD
PRE-OP	/												Blanche Warm Pulse Moves Y N
0100	152/88	50	18	98	94%	1	2	2	0	1	6		Blanche Warm Pulse Moves Y N
0105	129/73	91	21	94		1	2	2	0	1	6		Blanche Warm Pulse Moves Y N
0110	134/79	89	17	93%		1	2	2	0	1	6		Blanche Warm Pulse Moves Y N
0115	133/75	85	17	94%		1	2	2	0	1	6		Blanche Warm Pulse Moves Y N
0130	123/69	82	13	93%									Blanche Warm Pulse Moves Y N
0145	145/69	99	14	94%									Blanche Warm Pulse Moves Y N
0200	128/71	80	12	94									Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N

POST ANESTHESIA RECOVERY SCORE (PARS)

Activity - General Anesthesia
2—Maintain head lift and open eyes
1—Unable to maintain head lift and open eyes
0—Unable to lift head and open eyes

Activity - SAB or Subarachnoid Block
2—Moves all four extremities with control
1—Moves both upper extremities

Respirations
2—Spontaneous respiration; needs no support
1—Limited effort; needs artificial airway or jaw support
0—Needs ventilator; no spontaneous respiration

Circulation
2—BP 20% preanesthetic level
1—BP ~~20~~ - 50% preanesthetic level
0—BP 50% or more preanesthetic level

Level of Consciousness
2—Awake and alert; seldom dozes
1—Awakens when gently stimulated
0—Awakens only when vigorously stimulated

Skin
2—Normal skin color & temperature greater than 96°
1—Skin is pale, blotchy, dusky &/or temperature 95 - 96°
0—Cyanotic &/or temperature less than 95°



DRESSING:	Status	Location
Gauze		
Opsite		
Bandaid		
Steri-strips		
Collodian		
Peri-pad		
Coban		
Cotton Balls		
Ace Wrap		

TUBES AND DRAINS: Hemovac Foley NGT Chest Jackson-Pratt

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: 30 Oct 03

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)

Potus (b)(6)-4 (EPW)

3740

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTICS STUDIES

☐ TREATMENT

DA FORM 1 MAY 78 4700

FH MDA OP 132-11a (Rev)

1 Sep 99

MEDCOM - 2405

INTAKE			OUTPUT		
TIME	TYPE	AMT	TIME	TYPE	AMT
OR	LR	900	OR	EBL	150
			OR	Urine	1000
			RR	urine	250
					1400
TOTAL		900	TOTAL		1150

PACU NURSING NOTES: NURSING CARE PROBLEM NO.'S IDENTIFIED. Refer to FH MDA OP 39

NURSING CARE PROBLEMS: 1. RESP; 2. CIRC; 3. ACT; 4. LOC; 5. TEMP; 6. PAIN; 7. SAFETY; 8. ANXIETY; 9. EDUC; 10. OTHER

0130- Pt assessment complete. Sleeping soundly snoring. Lungs CTA(B) Heart RRR S1S2 ⊼ ectopy. NSR. BS active x4. Dressing to (R) shoulder intact clean and dry. Neurovasc ✓ to RUE intact radial pulses +2 (B) dorsalis pedis +2(B). Wound to (R) side of neck ⊼ mild edema and dried blood. ∂drainage from wound site. Pt covered ⊼ 2 blanket to ↑temp Foley to gravity - clear yellow urine [b)(6)-2] CTAR

MEDICATION GIVEN BY: [b)(6)-2] TMW

MEDICATION RECEIVED IN PACU/ICU

DRUG	DOSE	ROUTE	TIME	PAIN LEVEL	EFFECTIVENESS
Inderal	12.5mg	IV	0115	for shivering	✓

DISPOSITION SUMMARY: Nursing Care Problems No.'s_____ Resolved; No.'s_____ Continue.
Patient was transferred from PACU/ICU recovery room via litter/crib with siderails raised, or held by parent in wheelchair.
Dressing status:_____ PAR Score_____ Safety Straps_____
Report given to_____. Patient released by Anesthesia_____
Time out_____. Nurse Signature:_____

ACLU-RDI 1099 p.1190

DOD 006458

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-400; the proponent agency is The Office of The Surgeon General

REPORT TITLE: **POST ANESTHESIA CARE UNIT FLOWSHEET**

OTSG APPROVED (Date): 17 Jan 80

PROCEDURE: I&D (L) Shoulder & neck wounds

PHYSICIAN: [b)(6)-2]

ANESTHESIA BY: [b)(6)-2]

Gen Spinal MAC Axillary Local Bier Epidural Other

ALLERGIES:

AIRWAYS: _____ Time DC'D _____

ETT Nasal Oral Trach

OXYGEN:

Mask Nasal Face Blow-By Prongs Tent

Liter/min. _____ %

ASA ___ History _____

Cardiac Rhythm _____

IV#1 _____ Patent Infiltrated

Site (R) hand Rate ___ Gauge 18g

IV#2 _____ Patent Infiltrated

Site _____ Rate ___ Gauge ___

VITAL SIGNS						PAR SCORE						OTHER	
Time	B/P	P	R	O2SA	Temp	Act	Resp	Circ	LOC	Skin	PARS	COMMENTS	Neuro-Vascular
PRE-OP	/												Extr: L R Upper Lower Pulse DP PT RAC
PRE-OP	/												Blanche Pulse Warm Moves Y N
12:25	133/77	100	18	98%	96.4	1	2	2	1	2	8	BL SFM	Blanche Pulse Warm Moves Y N
12:30	128/76	86	15	95%		1	2	2	1	2	8		Blanche Pulse Warm Moves Y N
12:35	131/77	86	15	96%		1	2	2	1	2	8		Blanche Pulse Warm Moves Y N
12:40	127/75	87	23	98%		1	2	2	1	2	8	Δd to 4L NC	Blanche Pulse Warm Moves Y N
12:55	124/76	83	13	97%		2	2	2	1	2	9		Blanche Pulse Warm Moves Y N
13:10	130/75	82	14	99%		2	2	2	1	2	9	D'd to 2L NC	Blanche Pulse Warm Moves Y N
13:25	134/77	83	16	98%		2	2	2	1	2	9	D'c'd NC	Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N

POST ANESTHESIA RECOVERY SCORE (PARS)

Activity - General Anesthesia
2--Maintain head lift and open eyes
1--Unable to maintain head lift and open eyes
0--Unable to lift head and open eyes

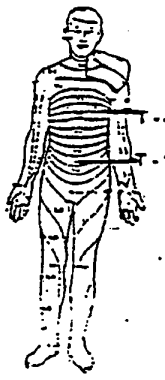
Activity - SAB or Subarachnoid Block
2--Moves all four extremities with control
1--Moves both upper extremities

Respirations
2--Spontaneous respiration; needs no support
1--Limited effort; needs artificial airway or jaw support
0--Needs ventilator; no spontaneous respiration

Circulation
2--BP 20% preanesthetic level
1--BP 20 - 50% preanesthetic level
0--BP 50% or more preanesthetic level

Level of Consciousness
2--Awake and alert; seldom dozes
1--Awakens when gently stimulated
0--Awakens only when vigorously stimulated

Skin
2--Normal skin color & temperature greater than 96°
1--Skin is pale, blotchy, dusky &/or temperature 95 - 96°
0--Cyanotic &/or temperature less than 95°



DRESSING: Status / Location

	Status	Location
Gauze	PT to OR	(L) Neck & Shoulder
Opsite		
Bandaid		
Steri-strips		
Collodian		
Peri-pad		
Coban		
Cotton Balls		
Ace Wrap		

TUBES AND DRAINS: Hemovac Foley NGT Chest Jackson-Pratt

(Continue on reverse)

[b)(6)-2]

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: 04 Oct 23

PATIENT'S IDENTIFICATION (For typed or written entries give: Name-last, first, middle; grade; date; hospital or medical facility)

POTUS # [b)(6)-4]

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTICS STUDIES

☐ TREATMENT

DA FORM 1 MAY 78 4700

FH MDA OP 132-11a (Rev)

MEDCOM - 2407

99

INTAKE			OUTPUT		
TIME	TYPE	AMT	TIME	TYPE	AMT
OR		350	OR	EBL	150
			OR	Urine	
TOTAL			TOTAL		

PACU NURSING NOTES: NURSING CARE PROBLEM NO.'S IDENTIFIED. Refer to FH MDA OP 39

NURSING CARE PROBLEMS: 1. RESP; 2. CIRC; 3. ACT; 4. LOC; 5. TEMP; 6. PAIN; 7. SAFETY; 8. ANXIETY; 9. EDUC; 10. OTHER

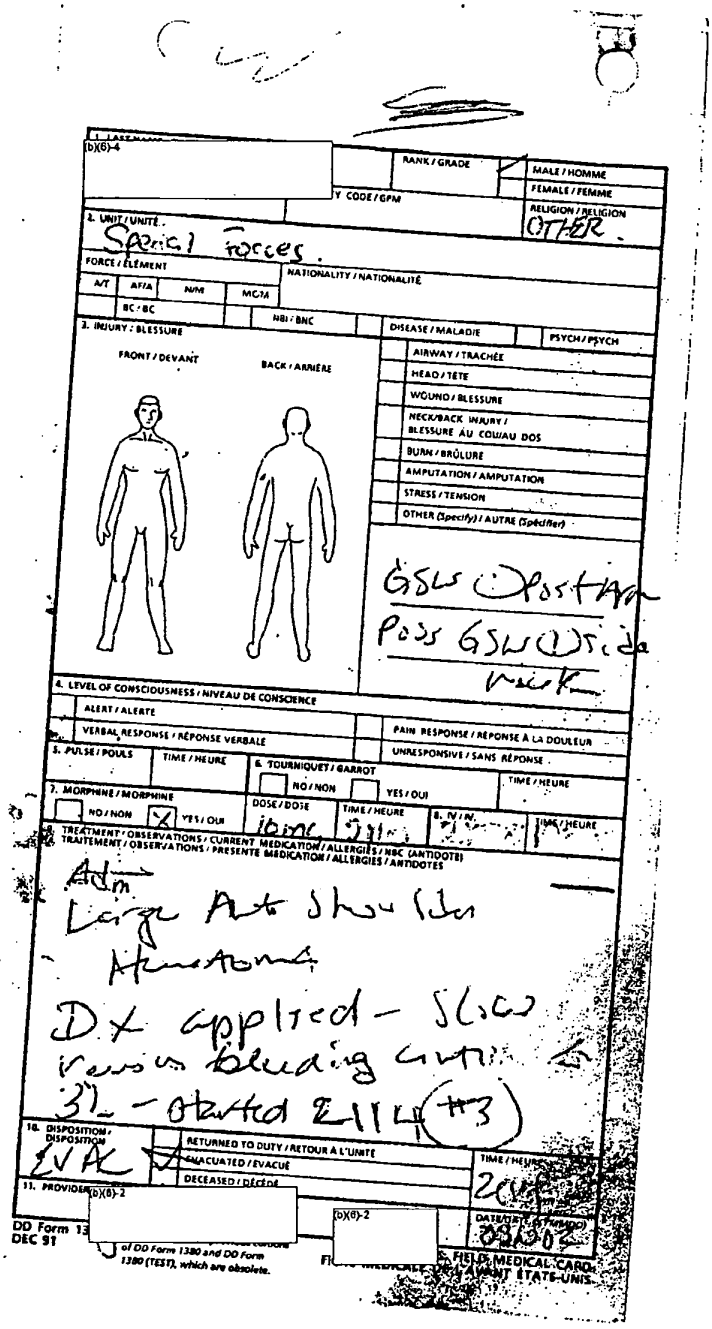
MEDICATION RECEIVED IN PACU/ICU

MEDICATION GIVEN BY:	DRUG	DOSE	ROUTE	TIME	PAIN LEVEL	EFFECTIVENESS

DISPOSITION SUMMARY: Nursing Care Problems No.'s_____ Resolved; No.'s_____ Continue.
Patient was transferred from PACU/ICU recovery room via litter/crib with siderails raised, or held by parent in wheelchair.
Dressing status:_____ PAR Score_____ Safety Straps_____
Report given to_____. Patient released by Anesthesia_____
Time out_____. Nurse's Signature:_____

ACLU-RDI 1099 p.1192

DOD 006460



(b)(6)-4

RANK / GRADE

MALE / HOMME

FEMALE / FEMME

Y CODE / GPM

RELIGION / RELIGION

OTHER

2. UNIT / UNITÉ

Special Forces.

FORCE / ÉLÉMENT

A/T | AF/A | N/M | MC/M

BC / BC | NBI / BNC

NATIONALITY / NATIONALITÉ

3. INJURY / BLESSURE

FRONT / DEVANT

BACK / ARRIÈRE

DISEASE / MALADIE

PSYCH / PSYCH

AIRWAY / TRACHÉE

HEAD / TÊTE

WOUND / BLESSURE

NECK/BACK INJURY / BLESSURE AU COU/AU DOS

BURN / BRÛLURE

AMPUTATION / AMPUTATION

STRESS / TENSION

OTHER (Specify) / AUTRE (Spécifier)

GSW (1) Post Arm

Poss GSW (1) side

rock

4. LEVEL OF CONSCIOUSNESS / NIVEAU DE CONSCIENCE

ALERT / ALERTE

VERBAL RESPONSE / RÉPONSE VERBALE

PAIN RESPONSE / RÉPONSE À LA DOULEUR

UNRESPONSIVE / SANS RÉPONSE

5. PULSE / POULS

TIME / HEURE

6. TOURNIQUET / GARROT

NO / NON

YES / OUI

TIME / HEURE

7. MORPHINE / MORPHINE

NO / NON

X YES / OUI

DOSE / DOSE

10mc

TIME / HEURE

8. IV / IV

TIME / HEURE

9. TREATMENT / OBSERVATIONS / CURRENT MEDICATION / ALLERGIES / NBC (ANTIDOTE)

TRAITEMENT / OBSERVATIONS / PRESENTE MEDICATION / ALLERGIES / ANTIDOTES

Adm

Large Ant Shoulder

Hematoma

Dx applied - Slow

venous bleeding cont

3L - started 2114 (#3)

10. DISPOSITION / DISPOSITION

EVAC

RETURNED TO DUTY / RETOUR À L'UNITÉ

EVACUATED / ÉVACUÉ

DECEASED / DÉCÉDÉ

TIME / HEURE

2014

11. PROVIDER (b)(6)-2

(b)(6)-2

DATE (YYYYMMDD)

DD Form 13

DEC 91

of DD Form 1380 and DD Form 1380 (TEST), which are obsolete.

FIELD MEDICAL CARD

AVANT ÉTATS-UNIS

MEDCOM - 2409

ADMISSION AND CODING INFORMATION

For use of this form, see AR 40-400; the proponent agency is OTSG

ORTING MTF	2	3	4	5	6	2. MTF LOCATION (State or Country Code.) 7	8	
A	1	4	A	1	[redacted]	I	2	

3. REGISTER NUMBER	9	10	11	12	13	14	15	NAME (Last, First, Middle Initial)	4. PAY GRADE	16	17	5. SEX	18		
	0	0	2	3	8	2	3	EPW # (b)(6)-4		C	I	V	M		

6. DATE OF BIRTH (Y Y Y Y M M D D)	19	20	21	22	23	24	25	26	7. AGE AT ADMISSION	27	28	29	8. RACE	30	9. ETHNIC BACK-GROUND 31
													X		9

RELIGION

10. LENGTH OF SERVICE	32	33	34	ETS	11. FMP	35	36	12. SOCIAL SECURITY NUMBER	37	38	39	40	41	42	43	44	45
						9	8		0	0	0	0	0	0	2	9	0

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS 46	HOUR OF ADMISSION 1037	BRANCH / CORPS

14. FLYING STATUS	47	48	49	15. BENEFICIARY CATEGORY	50	51	52	16. ZIP CODE OF RESIDENCE	53	54	55	56	57	58	59	60	61

17. UNIT LOCATION (State or Country Code)	62	63	18. MOS	64	65	66	67	68	69	70	19. TRAUMA 71	PREV. ADMISSION YEAR	NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION 72 D	WARD ICW	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	
		ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(6)-2 21st CSH		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE	

21. TYPE OF DISPOSITION	73	74	22. MTF TRANSFERRED TO	75	76	77	78	79	80	23. DATE OF DISPOSITION (Y Y Y Y M M D D)	81	82	83	84	85	86	87	88
	0	5									2	0	0	3	1	0	0	7

24. CLINIC SVC - ADMITTING	89	90	91	92	25. MTF TRANSFERRED FROM	93	94	95	96	97	98	26. DATE THIS ADMISSION (Y Y Y Y M M D D)	99	100	101	102	103	104	105	106
	A	B	A	A									2	0	0	3	1	0	0	2

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	107	108	28. MTF OF INITIAL ADMISSION	109	110	111	112	113	114	29. DATE INITIAL ADMISSION (Y Y Y Y M M D D)	115	116	117	118	119	120	121	122
				A	1	4	A	1										

FOR LOCAL USE

Dx: 88010
8749
E9912

Trauma
9

Px: 8622(X4)
8659(X2)

Injury
[illegible]

ADMITTIN (b)(6)-2	SIGNATURE OF ADMITTING CLERK (b)(6)-2

MEDCOM - 2410

(b)(3)-1

INPATIENT TREATMENT RECORD COVER SHEET *(For Plate Imprinting)*

For use of this form, see AR 40-400; the proponent agency is the Office of The Surgeon General.

PATIENT DATA ITEMS 1 - 30 *(Excluding Items 25 & 26)*

Potus # (b)(6)-4 [redacted] Detainee

(b)(6)-4 [redacted]

K78 M
K78 CIU
FMP20

LINE	LEGEND
1	REGISTER NO. - NAME - GRADE
2	SEX - AGE - RACE - RELIGION - LENGTH OF SVC - ETS - PREVIOUS ADMISSION
3	FMP - SSN - ORGANIZATION - WARD
4	FLY STAT - RATING/DESG - DEPT/BEN - BRANCH/CORPS - UIC/ZIP - TYPE CASE
5	SOURCE & AUTHORITY FOR ADMISSION - HOUR OF ADMISSION - CLINIC SVC
6	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
7	ADDRESS OF EMERGENCY ADDRESSEE - PHONE NO. - DATE OF THIS ADMISSION
8	NAME & LOCATION OF MEDICAL TREATMENT FACILITY DATE OF INITIAL ADMISSION

ADMISSION REMARKS

(b)(6)-2 [redacted] OFFICER

32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED

25. TYPE DISPOSITION: D/C

26. DATE OF DISPOSITION: 27 Oct 03

31. SELECTED ADMINISTRATIVE DATA

☐ CHECK IF CONTINUED ON REVERSE

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

- Multiple Fragment Wounds (MFW) 19 Oct 03 879.8 ICD9 FY02
- (L) Shoulder - Shrapnel wound
- Penis - abrasion 033.0 ICD9.FY02
- (L) Hand - tissue laceration
- Closed Head Injury / Altered Mental Status 000.9 ICD9 FY02 [redacted] 66.2
- Leukocytosis 288.8 ICD9.FY02 Microhematuria 599.7 ICD9.FY02

880.0 ICD9.FY02
- multiple scalp fragments
- Shrapnel @ iliac crest

☐ CHECK IF CONTINUED ON REVERSE

35. TOTAL DAYS THIS FACILITY

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

36. TOTAL DAYS ALL FACILITIES

a. ABSENT SICK DAYS	b. OTHER	c. CONV LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

(b)(6)-2 [redacted] (b)(6)-2 [redacted] ORDS OFFICER

SIGNATURE (b)(6)-2 [redacted]

(b)(6)-2 [redacted]

EDITION OF 1 AUG 76 IS OBSOLETE.

DA FORM 1 MAY 79 3647-1

MEDCOM - 2411

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

PERTINENT HISTORY, CHIEF COMPLAINT, AND CONDITION ON ADMISSION *(Enter date of admission)*

See 558 for details

S/p Convoy Attack w/multiple

small fragment Wounds

Now 9 hrs after event. Still to some

altered mental status → given demerol/phenergan

PHYSICAL EXAMINATION

Plan admit for observation

PROGRESS *(Enter date of discharge and final diagnosis)*

(b)(6)-2 [redacted]

DATE 10/19/03	IDENTIFICATION NO.	ORGANIZATION
	REGISTER NO.	WARD NO.

PATIENT IDENTIFICATION *(For typed or written entries give Name last, first, ... de; date; hospital or medical facility)*

(b)(6)-2 [redacted]

Lee McUSA

Potus (b)(6)-4 [redacted]

ABBREVIATED MEDICAL RECORD
Standard Form 539

GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
USAPPC V1.00

MEDCOM - 2412

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
19 Oct 03	(E) CC/HPI: s/p Grenade Throwing Attack/Event (1-187 BAS) — Meds ?
0110	— Iraqi patient involved in grenade incident (per reports, was attempting to throw grenade)
3/P 136/72	— Pt initially seen @ 1-187 BAS, then transferred
Pul: 128	— Currently verbalizing ± difficulty
	— Pt does not speak ENGLISH and does not respond to translator.
	Allergies ?
VITALS @ 0150	(O)
	VITALS — noted * no translator present
BP 140/90	GEN: Iraqi Male in mild to moderate distress. MMMoist.
P 130s	Capillefill instant
O2 Sat @ 99-100%	HEENT: Abrasion/laceration @ (R) Temporal Area
Meds ordered	NECK: ? Abrasion/Puncture @ (R) neck
1) Demerol 50mg IV x 1 (done)	LUNGS: CTA (L), (R) ± some ↓ breath sound
	HEART: Tachy ± @/rlg. Φ S3, S4
	ABDOM: Active BS. Mild guarding, rigidity. @ LUQ/Pelvic region ± possib entry/puncture ± bruising @ (R) upper pelvis. (R) UQ ± puncture
2) Phenergan 25mg IV x 1	EXTREMS:
	(L) (A) Shoulder — puncture noted ~ 2-3 mm
3) IVF Bolus 2l (done)	(R) PENIS — @ (R) Glans, abrasion noted ± abrasion also @ dorsum (@ coronal region)
Vitals @ 0817	(L) HAND — b6-2 @ middle finger/distal phalanx — pad, soft tissue [redacted] laceration
BP 138/85	Thumb also seen ± puncture injury.
P 124	(A) (P) 1. Multiple shrapnel injuries — concerning involvement to abdomen, (L) Hand
SpO2 98	— Analgesia ± Demerol/Phenergan (see (L) margin)
	— IVFs x 2l Bolus, then KVO
	— Clean and re-dress areas of involvement
	— To (b)(3)-1 for GEN. SX. (Abdomen) and confirmed wound care
	(b)(6)-2 (b)(6)-2 MAJ, MC, FS (b)(6)-2 Surgeon
	— over —

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* — REGISTER NO. — WARD NO.

Local (b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-8.202-1
USP LVN

PRINTED ON RECYCLED PAPER

MEDCOM - 2413

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
19 OCT 03 (Cont')	Belderdum — XRAYS 1) Head/(R) Temporal Region — ? shrapnel retained 2) (R) Neck — ϕ involvement (on AP) 3) CXR — ϕ Evid of Pneumothorax 4) KUB — (Flat) Retained shrapnel seen @ LLQ, ϕ Free Air 5) (L) Hand — ϕ Evid of Fx, ? shrapnel retained @ 2nd Finger (b)(6)-2 [redacted] T.O.
190CT03 0340 hrs	Addendum (S) AirAmbulance had to return to FOB 2° To Weather (Fog) (L) Once middle finger cleaned + prepped, digital block applied c 1% Lidocaine, 4 Ethilon Sutures applied loosely to site after debridement done. Dressing applied Pressure dressings applied to 1st + 2nd Fingers of (L) Hand. Additional 25mg Demerol IV x 1 given to patient @ 0300 hrs To please in pt hold until able to evac. (b)(6)-2 [redacted] T.O.

#308

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
19 OCT 03 @ 0245	HOLDING ORDERS
	1) Dx: Multiple Shrapnel c̄ possible intraabdominal involvement
	2) VITALS: Every 4 hours with Pulse Ox
	3) IVFs: LR @ Maintenance
	4) Nothing by mouth!!!
	5) Meds: a) Demerol 50mg / Phenergan 25mg IV q ~~6-8 hrs~~ 6 hrs [redacted] b6-2 as needed for pain (last dose @ ~ 0100 hrs)
	b) Ancef 1g IV q 6° : next dose @ 0700 hrs
	6) Continue O_2
	7) To head out / evac to (b)(3)-1 @ soonest possible time (tc weather clearing or convoy) (b)(6)-2 [redacted] MAJ, MC, FS
19 OCT 03 @ 0430	Progress Note / Addendum
	(S) Redressed areas involved c̄ shrapnel and penis. Pt still uncooperative and not responding to interpreter.
	(O) V — BP 135/78 P 110s-120s R 16-20 T 99.7 (Axillary)
	O_2 Sat 100% (6l mask)
	~ ~~89-90%~~ 98 (Room Air)
	Pt received 3l IVF ~~4l~~ (LR). On 1l currently of IVF (b)(6)-2 [redacted] o.o.
	→ OVER →

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)

REGISTER NO. | WARD NO.

IRAQI (b)(6)-4 [redacted]

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

USP LVN

PRINTED ON RECYCLED PAPER

MEDCOM - 2415

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
19OCT03 (CONT')	(O) GEN: Mildly combative LUNGS: Good air movement BL. CTABL. HEART: Tachy $\bar{s}$ (M)/r/g. Ø S3,S4 ABDOM: ✓ BS. Some guarding appreciated PENIS: Abrasions appreciated (P) (R) Glans and dorsal shaft. Direct/pressure dressing applied
	(A)/(P) 1. Multiple shrapnel injuries $\bar{c}$? abdominal involvement — must also consider mild compensatory shock vs. intraabdom involvement — Cont $\bar{c}$ IVF and ANCEF IV — Analgesia as previously ordered — Cont routine checks; if no urine output in one hour, place FOLEY.

[b)(6)-2

MEDCOM - 2416

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
19 Oct 03	1640 Surgery
	Pt c̄ Temp 101.2 Repeat WBC = 14.2 (↑)
	Exam: Abd: Tender, Guarding, ± Rebound
	Bowel Sounds Hypo-Active.
	Pt's clinical condition is worse c̄ Temp, ↑WBC,
	Abd Tenderness.
	Plan Exp Lap. [redacted] (b)(6)-2
	Pt remains slightly somnolent and refuses to converse with us thru interpreter. I feel clinically the surgery is indicated as pt appears uncomfortable from abd pain, has ↑HR, ↑Temp, increasing WBC. [redacted] (b)(6)-2
19 Oct 03	Surgery
1650	I agree with above assessment. I agree pt should undergo emergent laparotomy to R/o intrabdominal injury. Has ↑'d WBC, tachycardia and Temp of 101.2. Still c̄ altered mental status.

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | [redacted] (b)(6)-2 | R'S ID NUMBER (Other)

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade) | REGIS | D NO.

Potus # [redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

MEDCOM - 2417

DATE	NOTES
19 Oct 03	2100 Op Note
	Pre-op Dx: Shrapnel Wounds to Abdomen
	Post-op Dx: Shrapnel Wounds to Abd c Sm Bowel + Colonic Injury
	Proc: Exp Lap, Repair of Sigmoid Colon Enterotomy, Repair of Small Bowel Enterotomy Resection of Small Bowel Injury with Stapled Anastamosis. Appendectomy
	Surgeon: [b)(6)-2]
	Anesth: GETA EBL = 200 Fluids: 5000
	Findings:
	Small 3-4mm Sigmoid Colon Injury, Opened Slightly & Minimally Debrided. Closed in Two Layers c Interrupted 3-0 Silk
	1cm Prox Sm Bowel Injury - Repaired in Two Layers with Interrupted 3-0 Silk
	3cm Prox Sm Bowel Injury. Resected & Repaired c Stapled Side to Side (Functional End to End) Anastamosis.
	Incidental Appendectomy Performed
	[b)(6)-2]

ACLU-RDI 1099 p.1202

DOD 006470

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
	GYN Staff Note
20OCT03	S: pt seen problems discussed through interpreter
0912	Pt having pain in abdomen "can't talk" would like
	something for pain. long MS since surgery. S/P 1U
	PRBC transfusion. No other c/o's.
	O: VSS Tmax 99.6° since surgery
	lungs CTA b/c SWRI
	heart RRI (m) clinic sub
	abd soft NTND; masses neg; Bandage dry (+) tender
	ext PPP = of strong ⊕ e/c/c
	LAB: 10 / 130 / .9 Bili T 2.5 AST 81 ALT 74 12.2) 12.9 (234 37.4
	Jul: (1) S/P Partial SBR, reanast; large + small bowel
	enterotomy repairs; appy POP # 1
	PLAN: (1) consider tube feedings
	(2) continue abx, 10 fluids
	(3) reeval pm

(b)(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)

REGISTER NO.	WARD NO.

POTUS (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

MEDCOM - 2419

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
20 Oct 03	Nutrition Consult
S	Consult for nutrition support recs.
O	Iraqi ♂ s/p partial SBR, reanastomosis, large + small bowel enterotomy repairs; POD # 1
	Diet: NPO ⊖ bowel sounds Meds: Unasyn, zantac
	Labs (10/20) gluc 130, Bun/Cr 10/9, alb 2.5, chol ~ 20
	Height/weight: N/A weight est @ 135# height ~ 65"
A	Nutr dx statement
	(1) Possible malnutrition based on lab/anthropometric data. ↓alb could be 2° hydration/fluid shifts + is not a ~~reliable indicator of nutr status in critically ill.~~
	(2) ↑ needs to support healing
	Nutr needs est @ 1800-2100 Kcal/d (30-35 kcal/kg) + 75-90 gm pro/d (1.2-1.5 gm/kg.)
R/P	Enteral feeding @ return of bowel fxn to improve nutr states + promote healing.
	Osmolite HN - initiate at 20 cc/hr & advance q 6-8 hr as tolerated to goal rate of 80 cc/hr to provide 85 gm pro and ~2000 Kcal, 1600 cc free waters. Will need additional 400 ml H_2O to meet fluid needs. Monitor Mg, K, PO_4 for refeeding syndrome. Will follow.
	b(6)-2 MAJ, SP, MD, RD

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME (LAST, FIRST, MI) | SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)* | REGISTER NO. | WARD NO.

POTUS b(6)-4

PROGRESS NOTES
Medical Record
STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

MEDCOM - 2420

ACLU-RDI 1099 p.1204

DOD 006472

LAST NAME	(b)(6)-4	FIRST NAME	MIDDLE INITIAL	ID NUMBER
POTUS #				

DATE	NOTES
	GYN/Surg Note
21 OCT 03 1000	SPt seen problems discussed through interpreter. Pt pain better and minimal pain med requested. Patient has some "dysuria, difficulty urinating" but has catheter in. Mobilizing more fluid c̄ drop in HCT, ↓ in abd pain overall. ⊖ flatus ⊖ BM. (R) knee sore near knee cap
	O: VSS Tmax 100.9° I ≈ 0, ~100cc NG output
	lungs CTA bil c̄ ugs
	heart MRS @ clin sub
	abd soft NTND c̄ masses neg. (+) BS (min) in 3 quad, min serous drainage on bandage, dressing Δ'd last pm
	ext PPP & strong ⊗ e/c/c; (R) knee palpated ⊗ edema crepitence or swelling ⊖ Homans ⊖ Mose
	LAB: 120 / 99 / 10 (133 6.2) 9.1 (195 4.0 / 27 / 1.8 26.6
	IMP: (1) SIP ex lap, small + large bowel enterotomy repairs, partial SB resection c̄ 1° peanastamosis, appy POD #2
	PLAN: (1) monitor I+O orally → consider pulling NG tube if output low
	(2) tube feed/oral intake when bowel fnx
	(3) ice chips, ambulation
	(4) seen c̄ Dr (b)(6)-2 (b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK
USAPA V1.00

MEDCOM - 2421

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | PROGRESS NOTES

DATE | NOTES

21 Oct 03 2100

Temp 101.8, Pt in now distress
- Wound Open & Clean
- Chest → ↓BS (R) Base

CXR → Atelectasis (R) Base
LG in Duodenum
Had Pt do Incentive Spirometry.
Also did N-T Stimulation c Moderate Effort Cough.
(A) Temp most likely do to atelectasis
(P) Continue I.S & Coughing.

[redacted]

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME (LAST, FIRST, MI) | SPONSOR'S ID NUMBER (SSN or Other)

DEPART. SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade) | REGISTER NO. | WARD NO.

Patus [redacted]

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

509-114

MEDCOM - 2422

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
	POD #3
22OCT03	S: pt seen problems discussed Interpreter not
0950	available. "Water hurts" and pt is ambulating,
	so Foley could be pulled. Not coughing/expectorating
	effectively due to pain. Abd pain better. No N/V,
	but sipping water causes his stomach to "hurt"
	O: US Tmax 101.8 ax
	Lungs + BS in (R) lower field, otherwise CTA b/c SWM
	heart MS MCR x̄ tachy
	abd bandage dry, min BS, NTND s marses neg
	ext PPP = 1 strong ø ll clc
	Imp: (1) S/P appy, exlap, enterotomy repair (SB+LB), part
	SB resection c̄ 1° reanast – POD #3 (stable)
	(2) FUO – suspect atelectasis/bronch vs WTI
	PLAN: (1) remove Foley today
	(2) await better BS before clamp NG tube + consider D/C
	or tube feeding,
	(3) replace Na+

(b)(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)	REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

509-114

DATE	GYN note	NOTES
22 Oct 03	S: pt seen problems discussed through interpreter.	
2000	Called to eval pt re: 102.8° temperature. Rectal	
	tylenol given - Pt reports 2 voids since Foley	
	removed → no dysuria or difficulty. (+) better cough	
	effort → still not forceful. Ambulating c̄ difficulty	
	(+) Flatus (−) BM, (+) belching. Tolerating sips of H_2O	
	c̄ N/V. Abdominal pain low baseline well controlled	
	O: VSS Tmax 102.8° (on Primaxin)	
	lungs CTAB/L c̄ wk (+) rocchi (L) base clear c̄ cough	
	heart RRR c̄ (m) click rub	
	abd: incision dry - no rubor/calor, ∅ ecchymosis or	
	erythema, NTND c̄ masses neg (+) BS all 4 quad (−) rebound	
	ext ppp = qs strong ∅ e/c/c	
	LAB: u/A sm. bacteria (−) nit (−) LE sm blood	
	IMP: (1) S/P enterotomy repairs (SB+LB), partial	
	SBR c̄ 1° reanastomosis, ex lap + appy POD#3	
	(2) FUO suspect atelectasis vs bronchitis/pneumonia	
	PLAN: (1) Δ'd abx, encourage cough + expectoration + IS	
	(2) Foley, NG out	
	(3) clear liquids as tolerated	
	(4) continue present management	

(b)(6)-2

20 Oct 03 2045

As Above.

Lung Exam: Breathsounds Absent (R) Base.

Pt N-T Suctioned, Good Cough + Sputum.

Re-Exam: Much Better Breathsounds (R) Base

(b)(6)-2

FPI LEX Printed on Recycled Paper

RD FORM 509 (REV. 1-99) BACK

MEDCOM - 2424

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MEDICAL RECORD | PROGRESS NOTES

DATE | NOTES

23 Oct 03 0936 Surgery POD #4

+ Pt ambulating

- Tm 102.4 (Current 100.6)

Lungs: Decreased @ Base, But Improved.

Pt with improved Resp effort & cough.

Abd: Wound Open, Clean.

$\frac{23}{219}$ / 5.5 $\frac{136}{3.6}$ | $\frac{99}{24}$ | $\frac{12}{1.0}$ / 117

- Pt stable overall

Improved Resp Status but still c Atelectasis vs Pneumonia @ Base

- Cont pulm Rx - Nebs, C-T Suction

Primaxin [(b)(6)-2]

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME (LAST, FIRST, MI) | SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade) | REGISTER NO. | WARD NO.

Potus [(b)(6)-4]

PROGRESS NOTES
Medical Record

STANDARD FORM 509 REV 5-99)
Prescribed by GSA/ICMR FPMR 141 CFR) 101-11.203(b)(10)

509-114

MEDCOM - 2425

ISN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
23 Oct 04	(2230) Nurse note: Pt sleeping supine position; easily arousable to gentle touch. Pleasant disposition; cooperative. Denies pain @ this time. D5NS c̄ 20 KCL infusing to 186 PIV to (R) FA. Ø S/S of complications. Midline incision dressing c/D/I. Active BS x 4 quadrants. Lung sounds diminished in middle + lower lobes. (+) Spontaneous productive cough. thick / yellow + bloody. Return demonstration given for I/S use. Will continue to monitor for Δ in status — [redacted] CRT
24 Oct 03	(0130) - DOB to BSC unassisted; movements slow and steady. Ambulated from unit to DFAC. Staff and MP escort present. Urine not as concentrated as before. (+) small amount mucusy stool. Pt back to bed and sleeping @ present time. — [redacted] CRT
	(0400) Vitals - Bp 123/57 - RR -14 - HR 99 - Temp 100.7 Pox - 99%.
	0730 VS - BP 123/71, HR 102, RR 16, SpO2 96% on RA T 101° pt had med BM; IS used + was able to achieve 3 balls x4; NAD; pt. now resting in bed; does not c/o any pain; has not required any pain med — [redacted]
	@ 0930 VSS BP 120/26, HR 101, RR 14 SpO2 99% RA T 101° Tylenol given 650 mg PR per doctor orders —

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.) | REGISTER NO. | WARD NO.

Potus [redacted]

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

MEDCOM - 2426

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
24 Oct 03 @ 1030	Ø c/o pain at this time will continue to monitor [illegible] pt up to chair, walked 3 times to DEFAC and back. Tolerated well Ø c/o pain Dizziness or Lightheaded. Will continue to monitor [redacted]
1230	VS BP 123/70, HR 101, RR 14, SpO2 98% on RA; T 99°; pt ate (drank) 50% of clear liquid diet; Ø c/o pain; tolerated well; IS used + achieved 3 balls x6; NAD. pt. now resting in bed; will cont. to monitor [redacted]
1500	Pt ambulated hall x3 s̄ difficulties. Able to get self out of bed s̄ assistance. Used IS when returned from ambulation. Able to maintain suspension on all 3 balls on IS. Dressings to fingers on ⓛ hand bacitracin applied. IVF D5 ½ NS c̄ 20mEq kcl/L infusing @ 50cc/hr to 18G in ® FA. Tolerating P.O. BS Active x4. Pt cooperates c̄ commands. Lungs clear throughout but diminished in ® base. Continues c̄ productive cough [redacted]
1600	T 99° ⓞ BP 117/65 P97 R 18 SaO2 100% pt back in bed. Voided clear yellow urine [redacted]
1705	c/o 2-3/10 abd pain, states pain ↑ to 6-7/10 p̄ drinking cold fluids. Percocet ī po given for abd. pain. Had very [illegible] hard stool, gets in/out of bed s̄ assist. [redacted]
1900	T 100° ⓞ BP 119/66 HR 97 SaO2 98% R 18 Pt c/o mild headache [redacted]
2030	Pt ambulated to radiology for PA/lat CXR. Pt c/o feeling dizzy from medication (Percocet). Used IS. Also explained thigh intermittent need for pt to ↑ po fluid intake [redacted]
2130	IV in ® forearm d/c'd because pt c/o pain. [illegible] started in ® upper arm [redacted]

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ANDARD FORM 600

. 7540-00-634-4176

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
240 0103	Surg Note POD #5
0900	Pt seen problems discussed thru interpreter. Pain
	continues to improve ∅ new c/o's. Pt walking,
	urinating ≡ difficulty (+) Flatus (+) BM (x3) since
	yesterday. Pt doing IS + also breathing txs.
	Fever persists + resp. effort still ↓
	O: VS) Tmax 101° @ 0730 today
	lungs CTA bil ≡ WR. ⊕ Ronchi/? rales (R) side
	heart RR ≡ (m) click hub
	abd soft NTND ≡ massening lucision dry well opposed,
	@ BS all 4 quad
	Ext PPP = ∅ strong ∅ elel
	EAG: 6.3) 9.3 (328 136/98/11 (112
	26.9 4.0/22/17
	Iap: (1) S/P ex lap, partial SB resection ≡ reanast,
	small + large bowel enterotomy repairs, appy POD #5
	PLAN: (1) ↑ dilt to clears (2) FUO - doubt belly @ this time
	(2) continue breathing txs, IS
	(3) encourage ambulation

(b)(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* | REGISTER NO. | WARD NO.

POTUS (b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

MEDCOM - 2428

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

24Oct03 @ 2215 Nurse note: Vitals Bp 125/68, AR 104, Temp 100.0, RR20, Pox 97%. Pt sitting up ☐ N-T suctioning. Ⓐ bloody secretions. m/n amount. 20 PIV to Ⓡ arm. BS clear except to RLL (diminished) BS x4 quadrants. Dressing to midline incision intact ☐ 2 small areas of drainage. Encourage deep cough/breathing and use of IS. Will continue to monitor. A&O x 4 states — [b)(6)-2] CP7

2345 Dressing Ned to midline incision. Incision moist ☐ open areas Ⓐ minimum drainage. Staples + sutures in place to keep incision approximated. Ⓐ S/S of infection. Pt tolerated well. — [b)(6)-2] CP7

25Oct03 0000 – Vitals – Bp 118/55, Pulse 85, Pox 98%, Temp 99, RR 20 – Easily arousable. Ⓐ complaints @ this time. IS used – [b)(6)-2]

0630 – VS HR 101, BP 129/67, SpO2 100%, RR 14, T 100.4; lung sounds clear Ⓑ in all lobes; BS active x4 quad.; pulses Ⓐ + normal Ⓑ radial + Ⓑ pedal; NAD; VSS; pt denies having any pain; IS was used + pt able to maintain 3 balls for 2-3 sec. each time; pt is resting ☐ eyes closed; stated he would like to wait on breakfast; will cont. to monitor — [b)(6)-2] CP7

1030 T 100.3, BP 128/69, HR 107, 98% SpO2 on RA; pt was up out of bed this AM, ambulated up + down corridor x3; pt

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI | SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade) | REGISTER NO. | WARD NO.

Potus # [b)(6)-4]

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

509-114

DATE	NOTES
25Oct03	1030 cont. then sat in chair for 1 hr. + did personel hygiene; dressings were Δ'd on (L) hand; IS was used again + was able to maintain 3 balls; had med. BM (liquidy in consistence); now is resting in bed; MD is changing dressing to abdominal incision; NAD; VSS; will cont. to monitor [redacted] [illegible]
25 Oct 03 1450	VS: BP 127/63, T-101.2 oral, P-108, RR-40, SpO_2 96% on RA. Awake, alert, appears oriented, (B) grips equal + strong, MAE, PERLA. Heart sounds normal, tachycardic. Lungs CTA in all lobes, ↓↓ diminish in RLL. Pt c/o (R) upper chest pain c̄ deep inspiration. Abd flat, soft, non-distended. (B) radial + pedal pulses 2+, skin warm, dry, brisk cap. refill. + bowel sounds x 4 quadrants. (R) bicep IV c̄ DS NS + 20KCl @ 50cc/hr, site s̄ S/Sx infiltration or infection. Abd dsg d+i. Voiding dark yellow urine in urinal, qs. [redacted] MAJ AN
1500	RR remains 40, shallow, appears unlabored. Will consult c̄ physician [redacted] MAJ AN
1555	Dr. [redacted] in to assess pt @ ~1505. STAT CBC + UA ordered and sent. Pt appears in no acute distress. WBC-WNL [redacted] MAJ AN
1600	Tylenol ii po given @ 1530 for T-101.2 oral @ 1450. Current temp is 101.5 oral; Dr. [redacted] aware. [redacted] MAJ AN
1900	VS @ 1855: BP-124/70, T-99.4 oral, P-112, RR-36, SpO_2-98% on RA. Remains tachypneic, resp. are shallow and unlabored. Ate 10-20% of dinner. Ambulated to MWR → ER/Radiology → back x 2 c̄ Ø assistance. Had one BM, minimal amt of lt brown flakes/specks. [redacted] MAJ AN
1930	No changes in physical assessment noted since previous one (1450 today) [redacted] MAJ AN

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	Surg Note
25OCT03 0945	S: pt seen problems discussed (s̄ interpreter): walking s̄ difficulty, ~~[illegible]~~ ~~[illegible]~~ s̄ difficulty ⊕ Flatus ⊕ BM, switched to oral pain meds c̄ good control
	O: OSS Tmax 100.1°
	lung: OAbilsm
	heart RRs̄ ⊕ chick
	abd soft NTND s̄ masses neg Incision dry ⊕ BS
	ext PPP - of strong
	IMP: ① POD #6 enterotomy repairs, SB anast, appy
	② FUO - responding
	PLAN: ① 24° more afebrile, consider d/c planning
	② continue care
	③ ↑ ditto
25Oct03	1630 T = 101.5 Pt c̄
	No Complaints
	Lungs: ↓BS ⓡ Base
	Abd: Soft. ⊕ Bowel Sounds. Wound Clean
	UA ⊖ WBC 7.9
	Reviewed CXR Again - Still Residual Atelectasis/Infiltrate ⓡ Base
	Will Cover c̄ po Levaquin

(b)(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	

(b)(6)-2

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)*

REGISTER NO.	WARD NO.

Potus (b)(6)-4

PROGRESS NOTES
Medical Record
STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
25 Oct 03 2100	T- 100.4 oral. Cont. to use IS well, lifting all 3 balls, has poor cough, mainly clearing throat for mod-lg amt of white, frothy secretions. Denies further pain in RU chest c deep inspiration. Poor po intake, UOP ~ 200 dark yellow urine per hour. [redacted] MAJ AV
25 Oct 03 2245	T 101°, Bp 135/60, RR 32 (shallow), HR 120, Sa 96%. - Small BM OOB to chair for deep breathing + cough. Pt does not understand concept. Interpreter present and assisting unsuccessfully. I/S used c better results. Tylenol 650 mg po given. Dressing to midline incision intact c old drainage. IVF infusing c difficulty. Will continue to encourage deep breathing and monitor temperature. [redacted] CPT [redacted]
26 Oct 03 @ 0100	Lungs clear in upper lobes, diminished in middle + bases. Pt's Temp 99° orally. - OOB to BSC used I/S x 10. [redacted] CPT [redacted]
0800	- 130/65, 85, 98°, 28, 100% - Pt c/o pain. Pt not sleeping @ this time. encourage Cough + deep breathing. - [redacted] Medicated — [redacted] (5)(6)(2)

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		
PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)		REGISTER NO.		WARD NO.

POTUS [redacted]

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

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MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
26 OCT 03 0700	Nursing Notes: VSS: T 97.8, Pulse ox 98%, BP 117/59, P [redacted], RR 16. Pt cooperative, A+O X3, pt ate 50% breakfast. Pt OOB in bedside chair, pt amb ↓ difficulty. 22 g IV cath in upper (R) arm, patent & infusing D5 NS ↓ 20 mEq KCL @ 50 cc/hr ↓ difficulty, site ↓ redness, edema, or pain. Midline abdominal incision ↓ dressing CDI. Pt performed IS and coughed deep breathe. Will continue to monitor. — [redacted]
26 Oct 03 1100	Surgery – Pt without complaints. Ate 40-50% Breakfast – VAD. Pleasant Abd: Soft. ⊕ Bowel Sounds. WBC = 9.4 No Pain ↓ Palpation Hct = 27 Lungs: ↓ BS @ Base – Stable. Temp down this a.m. Still concerned ↓ Possible Pneumonitis Still Concerned ↓ abd process/abscess, but abd exam at this time is Benign – Continue po Levaquin. Cont to follow closely [redacted]

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME (LAST, FIRST) | NUMBER

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)* | REGISTER NO. | WARD NO.

Potts [redacted]

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

MEDCOM - 2433

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
26 OCT 03	11:00 - T98⁶
26 OCT 03 1430	T99⁸ HR98 BP 120/63 SaO₂ 98% R 18 Pt assessment complete Pulses 2+ in all extremities BS Active x4. Pt voids quantsiff clear yellow wine lungs clear in upper roles (B) Remains diminished in (R) LL. Coughs, deep breathes and urs IS. [redacted] LLTAN
1645	Pt ambulated halls and to outside at his request. Sitting in chair @ bedside. [redacted] LLTAN
1720	T99² @ pt back in bed. Consumed 50% of dinner [redacted] LLTAN
1900	T100⁴ @ IS complete 10x, Cough + deep breathe [redacted] LLTAN
2100	T99⁹ @ BP 118/61 HR 92 SaO₂ 98% R-18 [redacted] LAN
2300	T100⁶ BP 123/60 HR 114 SaO₂ 99% RA RR18. Pt ambulated c̄ difficulty using incentive spirometer 3 balls ↑ x10. (R) base cont ↓, BS x4 midline abd dsg d+i Voiding qs — [redacted] LATAN
27 OCT 03 0500	T99⁶ BP 117/66 HR 99 SaO₂ 98 RR16. Incentive spirometer done. [redacted] LATAN
27 OCT 03 0700	NAD. Negative Complaints. A&OX3 Lungs CTA (B) ✓ BS (R) BASE. ABD soft & nontender (+) BS X4 QUADS. 2+ peripheral pulses. [redacted], ILT, AN
27 OCT 03 0930	OOB to Chair. Ambulated in hospital Corridors & outside. AM care done T98⁷ P 94 BP 119/65. NAD - [redacted] ILTAN.
27 OCT 03 1235	Released to MV's. Discharge instructions given to MV's (Medications & Dvsg Δ's) HIL dcid c̄ Cath intact & no sisx of infection or infiltration NAD. [redacted] ILT NAN.

STANDARD FORM 509 (REV. 5/1999) BACK
USAPA V1.00

MEDCOM - 2434

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
27OCT03	Surg Note POD # 8
0930	S: pt seen problems discussed thru interpreter.
	No pain. Ambulating, voiding, eating s difficulty.
	(When I asked him why he eats so little – is it type of
	foods or pain – he indicated he only eats small meal
	he is hungry + eats until full) (+) Flatus (+) Bs.
	O: VSS Tmax 100.6 present T 98.7°
	lungs CTABL s/m
	heart ML s/m [illegible]
	abd soft NOND s/m [illegible]. Incision dry, closing
	ext [illegible] s/s [illegible]
	LAB: 136 | 97 | 8 (98 9.9) 9.5 (640
	4.1 | 25 | 1.0 27.8
	Imp: (1) S/P ex lap, appy, partial SB resection, 1° re-
	anastamosis + small + large bowel enterotomy
	repairs POD # 8
	PLAN: (1) ensure supplements
	(2) Ambien 10mg qhs prn sleep
	(b)(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* REGISTER NO. WARD NO.

Potus # (b)(6)-2

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

MEDCOM - 2435

558-103

(See Instructions on Back of this Sheet)

NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp)

LOG NUMBER

ARRIVAL				TRANSPORTATION TO HOSPITAL (Attach care enroute sheet)	CURRENT MEDS. (tetanus immunization and other data)	HISTORY OBTAINED FROM
DATE			TIME	☐ PRIVATE VEHICLE ☐ AMBULANCE ☐ OTHER (Specify)	UNKNOWN	☐ PATIENT ☐ OTHER (Specify)
DAY	MONTH	YR.				ALLERGIES
19	OCT	03	0900			UNKNOWN

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration)

SEX: M AGE: UNK

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: OM ARRIVAL

VITAL SIGNS			
TIME	0910		
BP	124/73		
PULSE	91	SEE FLOWSHEET	
RESP.	29		
TEMP.	—		
WT. (Child)	91%		

CATEGORY (See reverse)

- [X] EMERGENT
- [ ] URGENT
- [ ] NON-URGENT

ORDERS	INITS.	TIME
MAINTAIN IV NS or LR TKO		
2ND IV NS or LR TKO		
FOLEY TO GRAVITY		
CBC, UA, T+S		
X-rays - CHEST, ABDO, PELVIS, SKULL		

ASSESSMENT/DIAGNOSIS: MULTIPLE FRAGMENTATION WOUNDS

DISPOSITION (Check all that apply)

- HOME
- FULL DUTY

QUARTERS: 24 Hrs. / 48 Hrs. / 72 Hrs.

MODIFIED DUTY UNTIL: DAY / MONTH / YEAR

REFERRED TO (Indicate clinic): GENERAL SURGERY

- EMERGENCY
- TODAY
- 72 HOURS
- ROUTINE

ADMIT. TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE

- IMPROVED
- UNCHANGED
- DETERIORATED

TIME OF RELEASE:

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

Adult ♂ local national of unknown age transferred from FSB at TALIFAR p̄ sustaining injuries in grenade attack. Subject is alleged perpetrator of attack, arrived in custody of US personnel, will not speak or answer questions. Rec'd 4L crystalloid

urine 950ml

AMPLE history - unobtainable - prior to transfer

A - patent and maintainable Nasal trumpet in place

B - Breath sounds symmetric

C - Small amount of bleeding from fragmentation wounds BP normal, pulse ~ 100

D - GCS-12+ (? sedation) PERL, MAE

E - Completely exposed, rolled

125 > 11.4 / 32.4 < 279

UA - SG = 1.022 large blood 20-30 RBC

GENERAL: Thin ♂ adult ♂ sedated, arousable but noncommunicative

INTEG: Warm + dry

HEENT: MC c̄ small penetrating wound (R) temporal area. PERL/EOM/Sclera clean (L) nostril c̄ Nasal trumpet TM's not well visualized Ø blood in EAC Small penetrating wound (R) anterior neck

ABO/Rh O-Pl 3

- CXR - Ø PTX or Fmg
- ABDO/PELVIS - Fragments vic iliac crests
- SKULL - superficial fragments

LUNGS: CTAB c̄ W/R/R

CV: HRR c̄ (m) ul S1/S2

CHEST: Numerous small penetrating wounds

ABDO: Sophoid/soft/NT c̄ scattered small fragments

RECTAL: Normal tone/NT - blood perineal area c̄ scrotum wounds

(CONTINUE ON SF 507, IF NEEDED)

PATIENT'S IDENTIFICATION (Mechanical imprint) FOR WRITTEN ENTRIES GIVE: Name - last, first, middle; SSN; DOB, service status, name and relation of sponsor or next of kin. (IMPORTANT: LIST FACILITY HOLDING TREATMENT RECORD).

POTUS (b)(6)-4 (detainee)

(b)(6)-4

(b)(6)-2

LTC, MC

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans)

EXTREM - Fragmentation wound (L) shoulder (L) Thumb c̄ open laceration at distal pad (L) 3rd digit laceration sutured closed prior to arrival

GU: Foley in place, glans c̄ contusion scrotum c̄ two small areas of penetrating trauma Ø scrotal edema

EMERGENCY CARE AND TREATMENT

STANDARD FORM 558 (Rev. 6-82)

Prescribed by GSA and KCMP

MEDCOM - 2436

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	19 Oct 03
DOS	
POD	

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside		(b)(6)-2	
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On		unknown allergies	
Call Light Within Reach		X	
Side Rails Up		X	
Bed in Low Position		X	

PREPARED BY (Signature and Title) (b)(6)-2 MAJ [illegible] | Department/Service/Clinic ICU | DATE 19 Oct 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade;date; hospital or medical facility)*

Potus (b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOWCHART

☐ OTHER EXAMINATION Or EVALUATION ☐ OTHER(*Specify*)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 2437

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R										2				2								2		
	RADIAL L										2				2								2		
	DORSALIS PEDIS R										2				2								2		
	DORSALIS PEDIS L										2				2								2		
SKIN (1) Dry (4) Cool (7) Jaundiced (2) Clammy (5) Flushed (8) Color Normal (3) Warm (6) Cyanotic (9) Pale											1 3 8				1 3 8								1 3 8		
EDEMA											ø				ø								ø		
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)											✓				S1S2								✓		
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)															NSR								ST		
SWAN GANZ CATHETER (Zeroed & calibrated)															ø										
ARTERIAL LINE (zeroed & calibrated)															ø										
HYGIENE	BED BATH																								
	FOLEY CARE																								
	ORAL CARE																								
MOBILITY	BEDREST														✓								✓		
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE														✓								✓		
	HOB 30 DEGREES										✓				✓								✓		
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE														*								✓		
	PAIN SCALE (1-10)																								
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN (2) Soft & Flat (1) Distended											2				2								2		
BOWEL SOUNDS (active all quads)											✓				x4								✓		
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT															✓								✓		
VOIDING CLEAR, YELLOW URINE q.s.																									
SKIN INTEGRITY	No Breakdown																								
mult frag wounds	Surgical Wounds										✓				✓								✓		
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1																									
#2																									
#3																									

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
18 (b)(6)-2	(R) AC	18 OCT 03	CDI Heplocked
18 (b)(6)-	(L) AC	19 OCT 03	CDI

1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

Present ✓
Not Applicable /Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment --

DATE: 19OCT03

TIME		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open											3		4		4		4						3		
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response											1*		5		5		5						5		
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response											5		5		5		5						5		
GLASCOW COMA SCALE (A+B+C)											9		14		14		14						13		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R										4+		3+		3+		3+						13		
	L										4+		3+		3+		3+						13		
MOVEMENT (See Motor Function Scale at Top of Page)	RUE										4				4		4						4		
	LUE										4				4		4						4		
	RLE										4				4		4						4		
	LLE										4				4		4						4		
GRIP (S) Strong (W) Weak (-) absent	R										W				W		W						W		
	L										W				W		W						W		
RESPIRATIONS	REGULAR										✓				✓										
	IRREGULAR																								
	UNLABORED										✓				✓										
	LABORED																								
	SHALLOW																								
	RETRACTIONS																						5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL										3				5								5		
	LUL										3				5								5		
	RLL										5				5								5		
	LLL										5				5								5		
	BOTH BASES										1				1								1		
COUGH	NONE										✓				✓								✓		
	SPONTANEOUS																								
	PRODUCTIVE																								
	NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																									
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																									
VENTILATOR	Vt																								
	FIO2																								
	RATE (SIMV/CMV)																								
	PEEP / CPAP–																								
	PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE	NC (l/min) 2										✓				2 NM								SB/NC		
	FM (l/min)																								
ETT #_____	NRBM (l/min)																								
	ETT _____cm gums																								
ETT CARE / POSITION CHANGE																									
ETT / NT SUCTIONED																									
INCENTIVE SPIROMETRY DONE																									
COUGH / DEEP BREATH																									
INITIALS											(b)(6)-2				(b)(6)-2								(b)(6)-2		

ACLU-RDI 1099 p.1223

DOD 006491

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200																	
0300																	
0400																	
0500																	
0600																	
0700																	
0800																	
0900																	
1000																	
	100.5 AX	101	14	129/71	100%		90										4LNC
1100																	
1200	99.6 TY	102	14	117/71	100%												2LNC
1300																	
1400	100.5 AX	114	26	123/75	100%		94										2LNC
1500																	
1600	101 AX 101.2 ORAL	109	23	127/77	100%		96										RA
1700																	
1800																	
1900																	
2000																	
2100																	
2200																	
2300	99.9	126	26 24 20	143/80	95		105										RA
2400	99.1	139	20	147/72 136/81	100		103										

ACLU-RDI 1099 p.1224

DOD 006492

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
19 OCT 03	1030		Pt received from EMT accompanied by nsg personnel and hospital guard. See flowsheet for complete assessment. Pt opens eyes spontaneously and with vigorous tactile stimulation. Not responding verbally & following commands. Spontaneous movement ∅4 extremities noted. HOB ↑ 30° — [redacted] MATAN
	1130 hrs		Dr [redacted] in to see pt, MP guard @ bedside — [redacted] MATAN
	1420		Pt Moaning in bed c/o pain to LLQ bandages in place at sight. (L) middle finger ⊥ bandage covering sh tches CDI. Multiple frag wounds on (B) LE and chest. Ecchymosis to penis but no hematoma visible. Opens eyes spontaneously and moves all extremities. Nasal trupet in place to (R) nare. IV in (R) ac flushes well & s/sx infection/infiltration (L) AC infusing D5 1/2 NS @ 100 ml/hr. Pt ignores interpreter when trying to talk to him. — [redacted] MATAN
	1630		Pt O_2 ↓ to RA sats 100%, guarding abd. c/o pain when he opens eyes. — [redacted] MATAN
	1640		Dr [redacted] and [redacted] @ bedside - will take pt to OR for exploration
~~20~~ 19 Oct 03	2200	→	Assumed care of pt. VSS. Recovery completed by previous shift. Attempted to open eyes on verbal command. Lungs clr. HR 120's NST by monitor. Placed on 3L 2° O_2 sat 89%. ML ad incision & (R) hand dressings CDI. Pulses palp. All extremities. Numerous superficial wounds from schrapnel noted. Cont to monitor. IV (L) infusing at 125 ml/hr via pump's s/sx of infiltration or infection. Continue to monitor — [redacted] CGTAN
	~~2330~~	2330	HR to 140's. Phys notified. New Orders noted. Cont. to monitor.
20 Oct 03		0045	1st unit up. CBC shows H & H of 31 & H.3. HR remains 120's-130's. Cont. to monitor. — [redacted] CGTAN

	INTAKE									OUTPUT							
	D5½NS	IVPB							Total	Urine	EBL	NGT			Total	COMMENTS
0100																
0200																
0300																
0400																
0500																
0600																
0700																
0800																
8 HR									8 HR.						8 HR	
0900																
1000																
1100	100 100	50 50														
1200	100 200									300 300						
1300	100 300	50								250 550						
1400	100 400	50														
1500	100 500															
1600	100 600									325 875						
8 HR	600	50							16 HR. 650	875					16 HR. 875	
1700	100 700									125 125						
1800																
1900	O K									O K						
2000																
2100	5000 5100									250 350	200 200					
2200			150							100 350						
2300		100	150 300	1000						100 450						
2400			150 450						6550	42 492					692	
8 HR									24 HR. 7100						24 HR 1567	

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	19 Oct 03
DOS	19 Oct 03
POD	1

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	7200
24 Hour Output	1567
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		(b)(6)-2
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach	N/A		N
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 SPC AN	ICU	20 Oct 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle: grade; date: hospital or medical facility)*

Potts (b)(6)-4

- ☐ HISTORY/PHYSICAL
- ☒ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☐ OTHER *(Specify)*
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 2443

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R		2						2		2				2				-				2		
	RADIAL L		2						2		2				2				-				2		
	DORSALIS PEDIS R		2						2		2				2				-				2		
	DORSALIS PEDIS L		2						2		2				2				-				2		
SKIN (1) Dry (4) Cool (7) Jaundiced (2) Clammy (5) Flushed (8) Color Normal (3) Warm (6) Cyanotic (9) Pale			1 3 8						1 3 8		1 3 8				1 3 8				-				1 3 8		
EDEMA			Ø						Ø		9cm				✓				-				Ø		
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)			✓						✓		✓				✓				-				R		
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)			NSR						ST		ST				✓				-				NSR		
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH								✓																
	FOLEY CARE		✓												✓				-				✓		
	ORAL CARE								✓		✓				✓				-						
MOBILITY	BEDREST		✓						✓		✓				.								✓		
	BSC																								
	DANGLE											✓													
	CHAIR																								
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE		✓						✓		✓														
	HOB 30 DEGREES		✓						✓		✓				✓				-				✓		
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE		✓						✓						✓				-				✓		
	PAIN SCALE (1-10)																								
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN (2) Soft & Flat (1) Distended			2						2		2				2				-				2		
			.																						
BOWEL SOUNDS (active all quads)			✓						Ø		-				Ø				-				Ø		
NG / DOBHOFF PLACEMENT VERIFIED			✓						✓						✓				-						
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT			✓						✓		✓				✓				-				✓		
VOIDING CLEAR, YELLOW URINE q.s.											✓				✓				-				✓		
SKIN INTEGRITY	No Breakdown																								
	Surgical Wounds		✓						✓		✓				✓				-				✓		
SCATTERED Puncture Bruising	Rashes, Lac's, etc										✓				✓				-						
DRESSING (Dry & Intact: specify site below)																									
#1 Rt Abd			✓						✓		✓				✓				-				✓		
#2 (R)-hand			✓						✓		✓				✓				-						
#3																									

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
(L) AC	18 ga	19 Oct	3 S/SK of infiltration, LR@150cc/hr 1000
(R) Rad	18 ga	19 Oct	3 S/SK of infection / blood

PUPIL SIZE	PUPILS		MOTOR FUNCTION	CHART CODES
1 mm	=	Equal	0 = No Movement	Present ✓
2 mm	R	Reactive	1 = Slight Flicker/ Trace of Contraction	
3 mm	NR	NonReactive	2 = Active (Gravity Eliminated)	Not Applicable /Absent (blank)
4 mm	L > R	Left Larger	3 = Active: against gravity, but not against resistance 4 = Active: Against Gravity and Resistance, not full strength	Refer to Nsg. Notes X
5 mm	R > L	Right Larger	5 = Full Strength against Examiners Resistance	No Change from Previous Assessment --

DATE: 20OCTØ3

TIME		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open			4						4		4				4				–				4		
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response			5						5		5				5				–				5		
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response			6						6		6				6				–				6		
GLASCOW COMA SCALE (A+B+C)			15						15		15				15				–				15		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R		3+						2+		2+				12				–				2		
	L		3+						2+		2+				12				–				2		
MOVEMENT (See Motor Function Scale at Top of Page)	RUE		4						4		4				4				–				4		
	LUE		4						4		4				4				–				4		
	RLE		4						4		4				4				–				4		
	LLE		4						4		4				4				–				4		
GRIP (S) Strong (W) Weak (-) absent	R		W						W		W				S				–				S		
	L		W						W		W				S				–				S		
RESPIRATIONS	REGULAR		✓						✓		✓				✓				–				✓		
	IRREGULAR																								
	UNLABORED		✓						✓		✓				✓				–				✓		
	LABORED																								
	SHALLOW																								
	RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL		5						5		5				5				–				5		
	LUL		5						5		5				5				–				5		
	RLL		5						5		3				3				–				5		
	LLL		5						5		3				3				–				5		
	BOTH BASES		1						1		1				1				–				✓		
COUGH	NONE		✓						✓		✓														
	SPONTANEOUS																						✓		
	PRODUCTIVE																								
	NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																							2		
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																									
VENTILATOR	Vt																								
	FiO2																								
	RATE (SIMV/CMV)																								
	PEEP / CPAP																								
	PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE	NC (l/min) RA								✓		✓				✓				–						
	FM (l/min)																								
ETT #_____	NRBM (l/min)					--																			
	ETT _____cm gums																								
ETT CARE / POSITION CHANGE																							✓		
ETT / NT SUCTIONED																									
INCENTIVE SPIROMETRY DONE															✓				–						
COUGH / DEEP BREATH																			✓				✓		
INITIALS		[b)(6)-2]						[b)(6)-2]		[b)(6)-2]				[b)(6)-2]				[b)(6)-2]				[b)(6)-2]			

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100	99.1	120	20	138/81	100		103										3L NC
0200		112	20	130/76	95		98										RA
0300		116	22	137/84	95		103										RA
0400		111	16	135/78	97		102										RA
0500	99.9	114	25	136/83	95		103										RA
0600		111	19	139/74	97%		98										RA
0700		112	24	142/79	98%		101										RA
0800	98.5	109	24 97	135/74	97%		99										RA
0900		111	22	142/71	100%		99										
1000		118	26	143/69	95%		98										
1100	100.9 (OA)	123	34	127/66	95%		91										RA
1200																	
1300																	
1400		103	19	136-74	96		98										RA
1500																	
1600																	
1700																	
1800	97.6	104	20	131-76	100		97										
1900																	
2000																	
2100																	
2200	100.7	112	24	131/62	99%												
2300																	
2400																	

ACLU-RDI 1099 p.1230

DOD 006498

	INTAKE									OUTPUT						
	LR	IVPB	PRBC's						Total	Urine	NGT				Total	COMMENTS
0100	150 / 150	50	1L @3000							125 / 125						
0200	150 / 300									100 / 225						
0300	150 / 450									125 / 350						
0400	150 / 600									120 / 470						
0500	150 / 750	100 / 150								80 / 550						
0600	150 / 900															
0700	150 / 1050															
0800	150 / 1100	50 / 200								450 / 1000						
8 HR	1100	200							8 HR. 1300	1000					8 HR 1000	
0900	100 / 100															
1000	100 / 200									450 / 450						
1100	150 / 350	100 / 100								300 / 750						
1200	125 / 475									225 / 975						
1300	125 / 600									100 / 1075	200 / 200					
1400	125 / 725									200 / 1275						
1500	125 / 850									225 / 1500						
1600	125 / 975	100 / 200								300 / 1800						
8 HR	975	200							16 HR. 2475						16 HR. 3000	
1700	125 / 125	100 / 100								500						
1800	125 / 250									275 / 775						
1900	125 / 375									125 / 900						
2000	125 / 500									200 / 1100						
2100	125 / 625									100 / 1200						
2200	125 / 750									175 / 1375						
2300	125 / 875	100 / 200								40 / 1415						
2400	125 / 1000	100 / 300								300 / 1715						
8 HR	1000	300							24 HR. 3775	1715					24 HR 4715	

MEDCOM - 2447

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
20 Oct 03	0145		1st unit Blood finished. VSS. Will await to infuse 2nd unit p AM CBC results. Continue to monitor - Currently on RA p attempts by pt to take off NC. O2 Sat 94%. HR to 110's. Continue to monitor. [b)(6)-2]
20 Oct 03	0400		Eyes closed. Snoring softly. Ø pain med p MSO4 @ 2230. VSS p blood. HR remains 110's. LR @ 150 cc/hr. Remains on RA. Continue to monitor. [b)(6)-2]
20 OCT 03	0600		Report received, assumed care of patient. Appears asleep, no distress noted. [b)(6)-2]
	0800hrs		AM care done, see flowsheet for assessment. Ø hand soaked, dry sterile dsg applied. Dsg's d'd to fingerwood stays dry. [b)(6)-2]
10/20/03	1115		Temp 100.9 CAT. Medicated c MSO4 6mg IVP. OOB To Chair c assistance of 2 staff members. Tolerated well. See flowsheet for assessment [b)(6)-2]
Oct 20, 03		1400	Sleeping with NAD noises and Fell of chest noted. Awake to sound of voices. ML RUA dressing intact with some drainage. Dressing to R/L hands intact. NB to Ø nose intact. Has some pain but refuses any med at this time. ID will be used with. Understand my instruction about care. With translator has no question at this time. [b)(6)-2]
		1815	OOB to chair. Tolerated well need some assist. [b)(6)-2] received 3mg MSO4 for abd pain [b)(6)-2]
		1850	↓ in pain will cont to monitor and assess [b)(6)-2]
		1945	Resting to bed tolerated well. Smiles responds at this time. Will cont to monitor [b)(6)-2]
20 OCT 03		2200	resting @ this time, assessment completed c Ø S/S of pain shown, Ø S/S of resp distress, All dressing CDI, Ø Bowel sounds heard @ this time [b)(6)-2]

ACLU-RDI 1099 p.1232

DOD 006500

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	19Oct03
DOS	
POD	

24 HOUR DATA	
24 Hour Balance	+425
24 Hour Intake	1900
24 Hour Output	1475
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	(b)(6)-2

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2	(b)(6)-2	
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach	N/A	N/A	
Side Rails Up			
Bed in Low Position		(b)(6)-2	

(b)(6)-2	Title	Department/Service/Clinic	DATE
	4PN	ICU	21Oct03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle: grade;date: hospital or medical facility)*

POTUS # (b)(6)-4

- ☐ HISTORY/PHYSICAL
- ☐ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☐ OTHER(*Specify*)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 2449

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R		2				2				2				2				2						
	L		2				2				2				2				2						
	DORSALIS PEDIS R		2				2				2				2				2						
	L		2				2				2				2				2						
SKIN (1) Dry (4) Cool (7) Jaundiced (2) Clammy (5) Flushed (8) Color Normal (3) Warm (6) Cyanotic (9) Pale			1				1				1				1				1						
			3				3				3				3				3						
			3				3				3				3				3						
EDEMA			Ø				Gen				Gen				Ø				Ø						
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)			WNL				✓				✓				✓				✓						
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)							✓				ST				ST				ST						
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH		✓								✓														
	FOLEY CARE										✓														
	ORAL CARE										✓														
MOBILITY	BEDREST		✓				✓																		
	BSC																								
	DANGLE																								
	CHAIR										✓									✓	✓				
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE						✓								✓										
	HOB 30 DEGREES		✓				✓								✓	✓	✓	✓	✓			✓			
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE		✓												min	+		+			+				
	PAIN SCALE (1-10)										✓														
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN (2) Soft & Flat (1) Distended			2				2				2				2				2						
BOWEL SOUNDS (active all quads)			Ø	✓			Ø				Ø	✓			+LLQ				X						
NG / DOBHOFF PLACEMENT VERIFIED							✓				✓				✓				✓						
RESIDUAL ASSESSED															N/A										
Ph																									
FOLEY CATHETER PATENT															✓										
VOIDING CLEAR, YELLOW URINE q.s.															✓				✓						
SKIN INTEGRITY	No Breakdown														✓				✓						
	Surgical Wounds		✓				✓				✓				✓				✓						
	Rashes, Lac's, etc																		✓						
DRESSING (Dry & Intact: specify site below)																									
#1 ABD - CDI			✓				✓				✓				✓				✓						
#2 @ Hmrel CDI			✓				✓				✓				✓				✓						
#3																									

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
@ AL	18G	14 OCT 03	CDI /0600 /1000 /1400 mf
@ RA	18G	14 OCT 03	CDI /0600 /1000 D/Cd

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DOD 006502

PUPIL SIZE		PUPILS	
1 mm	=	Equal	
2 mm	R	Reactive	
3 mm	NR	NonReactive	
4 mm	L > R	Left Larger	
5 mm	R > L	Right Larger	

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable /Absent (blank) --
Refer to Nsg. Notes X
No Change from Previous Assessment --

DATE: 21 OCT 03

TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open		4				4				4				4				4						
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response		5				5				5				5				5						
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response		6				6				6				6				6						
GLASGOW COMA SCALE (A+B+C)		15				15				15				15				15						
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) R		2												4+				4+						
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) L		2												4+				4+						
MOVEMENT (See Motor Function Scale at Top of Page) RUE		4				4				4				4				4						
MOVEMENT (See Motor Function Scale at Top of Page) LUE		4				4				4				4				4						
MOVEMENT (See Motor Function Scale at Top of Page) RLE		4				4				4				4				4						
MOVEMENT (See Motor Function Scale at Top of Page) LLE		4				4				4				4				4						
GRIP (S) Strong (W) Weak (-) absent R		S				W				W				4				4						
GRIP (S) Strong (W) Weak (-) absent L		S				W				W				4				4						
RESPIRATIONS REGULAR		✓				✓				✓				✓				✓						
RESPIRATIONS IRREGULAR																								
RESPIRATIONS UNLABORED		✓				✓				✓				✓				✓						
RESPIRATIONS LABORED																								
RESPIRATIONS SHALLOW														✓				✓						
RESPIRATIONS RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished RUL		5				5				5				5				5						
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished LUL		5				5				5				5				5						
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished RLL		5				5				5				5/1				5/1						
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished LLL		5				5				5				5				5						
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished BOTH BASES		✓				✓				1				1				1						
COUGH NONE		✓				✓								✓										
COUGH SPONTANEOUS		✓								✓								✓						
COUGH PRODUCTIVE										✓								✓						
COUGH NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear		5								5				X				1						
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin										3				3				2						
VENTILATOR Vt																								
VENTILATOR FIO2																								
VENTILATOR RATE (SIMV/CMV)																								
VENTILATOR PEEP / CPAP																								
VENTILATOR PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE NC (l/min)					RA					RA				RA				RA						
OXYGEN DELIVERY DEVICE FM (l/min)																								
OXYGEN DELIVERY DEVICE NRBM (l/min)																								
ETT # _____ ETT _____ cm gums																								
ETT CARE / POSITION CHANGE		✓																						
ETT / NT SUCTIONED		✓								✓				✓	✓			✓	✓					
INCENTIVE SPIROMETRY DONE		✓				✓				✓				✓	✓			✓	✓					
COUGH / DEEP BREATH		✓				✓				✓				✓	✓			✓	✓					
INITIALS		(b)(6)-2				(b)(6)-2				(b)(6)-2				(b)(6)-2				(b)(6)-2						

ACLU-RDI 1099 p.1235

DOD 006503

(3)(6)(2)

VITAL SIGNS

(3)(6)(2)

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
~~0100~~ ~~0200~~	~~100³~~	~~113~~	~~26~~	~~130/66~~	~~98~~	[redacted]	~~90~~										~~BT, RAD~~
0200	100³	113	26	130/66	98		90										RA, NAD
0300																	
0400																	
0500																	
0600	99⁹ (A)	106	20	130/58	95		85										
0700																	
0800																	
0900																	
1000	100⁹ (A)	121	38	142/63	96		89										
1100																	
1200	100⁰ (A)																
1300																	
1400	100² (A)	110	20	119/64	98		87										
1500																	
1600																	
1700																	
1800	101⁶ (D)	104	28	127/67	98		89										
1900																	
2000	101⁸ (D)																
2100																	
2130	101⁰ (D)																
2200	100¹⁴	105	20	131/61	99		88										
2300																	
2400																	

MEDCOM - 2452

	INTAKE									OUTPUT						
	DS NS20 ~~10~~ KCL	IVPB							Total	Urine	NG				Total	COMMENTS
0100	125 / 125									100 / 100						
0200	125 / 100									100 / 200						
0300	125 / 375															
0400	125 / 500															
0500	125 / 625									575 / 775						
0600	125 / 750									100 / 875						
0700	125 / 875									↓						
0800	125 / 1000									400 / 1275						
8 HR	1000								8 HR. 1000	1275					8 HR 1275	~~275~~
0900	125 / 125									↓						
1000	125 / 250	100 / 100								325 / 325						
1100	75 / 325									↓						
1200	75 / 400	100 / 200								225 / 550						
1300	75 / 475									↓	300 / 300					
1400	75 / 550									125 / 675						
1500	75 / 625															
1600	75 / 700	100 / 300								250 / 925	300 / 600					
8 HR	700	300							16 HR. 2000	925	600				16 HR. 2800	~~800~~
1700	75 / 75	100 / 100								200 / 200						
1800	75 / 150									100 / 300	200 / 200					
1900	75 / 225									200 / 500						
2000	75 / 300									75 / 575						
2100	75 / 375									100 / 675	200 / 400					
2200	75 / 450									75 / 750	150 / 550					
2300	75 / 525	100 / 200								25 / 775	150 / 700					
2400	75 / 600	100 / 300								150 / 925	50 / 750				1675	
8 HR	600	300							24 HR. ~~2900~~	925	750				24 HR 4475	

4900

MEDCOM - 2453

MEDICAL RECORD — NURSING NOTES (Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
21 Oct 03 1400 mj		1400	Pt used IS c encouragement, able to lift ball #2 x 3. C+DB c IS c abd splinting → thick, dark brown sputum, looks like dried blood. States has only slight pain in abd per interpreter. NG → LIS c dark green drainage. (L) AC IV patent c S/Sx infiltration or infection. (b)(6)-2 MS AW
21 Oct		1900	C/o abd pain x 2 this shift. 4mg MSO4 IVP given @ 1645 and 1845. Pt appears able to rest b doses. Hypoactive bowel sounds heard in LUQ and LLQ; Ø heard on (R) abd. Midline abd dsg c no new drainage this shift; dsg d'd per Dr. (b)(6)-2 Temp @ 1800 was 101.6 oral → Tylenol supp given. (b)(6)-2 MT AW
		1930	Pt ambulated to EMT entrance and back with minimal assistance; sat in chair @ bedside. Cont to cough up mod-lg amt frothy, white secretions.
21 Oct		2040	Dr. (b)(6)-2 notified of pt temp (101.8 oral). Lung sounds ↓↓ diminished RLL → NT stimulation c 14 Fr catheter thru (R) nare → 2-3 deep coughs for small amt thick, yellow, blood-tinged secretions. Do IS q1° while awake and Ø q2° when sleeping. Per X-ray, NG → in duodenum, pulled back to 60 in by Dr. (b)(6)-2 NG continues to drain lg amt dark green fluid. (b)(6)-2 MT AW
		2215	Ø c/o pain up to chair c difficulty, Ø S/S of resp distress will cont to monitor pt (b)(6)-2 CE
		2300	c/o pain after return to bed, pain meds given (see MAR) will cont to monitor (b)(6)-2
		2336	sleeping @ this time (b)(6)-2 CP

ACLU-RDI 1099 p.1238

DOD 006506

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	19Oct03
DOS	
POD	

24 HOUR DATA	
24 Hour Balance	+650
24 Hour Intake	3405
24 Hour Output	1755
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On		NA	
Call Light Within Reach	A		
Side Rails Up	N		
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 LPN	ICU	22Oct03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade; date; hospital or medical facility)*

Potus # (b)(6)-4

- ☐ HISTORY/PHYSICAL ☑ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION ☐ OTHER *(Specify)*
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 2455

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R		2					2							2								2		
	RADIAL L		2					2							2								2		
	DORSALIS PEDIS R		2					2							2								2		
	DORSALIS PEDIS L		2					2							2								2		
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale			1 3 8					1 3 8							1 3 8								1 3 8		
EDEMA			Ø					Gen							Gen								Ø		
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)			R					✓							✓										
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)			NSR					ST							SR								NSR		
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH		✓																						
	FOLEY CARE																								
	ORAL CARE																								
MOBILITY	BEDREST		✓					✓							✓										
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE		✓					✓															✓		
	HOB 30 DEGREES		✓					✓							✓								✓		
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE		A												X										
	PAIN SCALE (1-10)							1							X										
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended		2					2							2								2		
BOWEL SOUNDS (active all quads)			Ø					Ø																	
NG / DOBHOFF PLACEMENT VERIFIED								✓															LOC		
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT			✓					✓																	
VOIDING CLEAR, YELLOW URINE q.s.			✓					✓															✓		
SKIN INTEGRITY	No Breakdown							✓																	
	Surgical Wounds																								
BLE surgical	Rashes, Lac's, etc														✓										
DRESSING (Dry & Intact: specify site below)																									
#1 ABD-CDI			✓					✓							✓								✓		
#2																									
#3																									

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
L AC	L FA	19 Oct 03	CDI 1000
NGT G	(1) NARE	19 Oct 03	Patent, intact to LWLS 1400 D/C'd 10/22 10:00 hrs

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable /Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment –

DATE:

TIME																								
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open																								
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response																								
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response																								
GLASGOW COMA SCALE (A+B+C)																								
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R																							
	L																							
MOVEMENT (See Motor Function Scale at Top of Page)	RUE																							
	LUE																							
	RLE																							
	LLE																							
GRIP (S) Strong (W) Weak (-) absent	R																							
	L																							
RESPIRATIONS	REGULAR																							
	IRREGULAR																							
	UNLABORED																							
	LABORED																							
	SHALLOW																							
	RETRACTIONS																							
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL																							
	LUL																							
	RLL																							
	LLL																							
	BOTH BASES																							
COUGH	NONE																							
	SPONTANEOUS																							
	PRODUCTIVE																							
	NONPRODUCTIVE																							
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																								
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																								
VENTILATOR	Vt																							
	FiO2																							
	RATE (SIMV/CMV)																							
	PEEP / CPAP																							
	PRESS. SUPPORT																							
OXYGEN DELIVERY DEVICE	NC (l/min)																							
	FM (l/min)																							
ETT = _____	NRBM (l/min)																							
	ETT _____ cm gums																							
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED																								
INCENTIVE SPIROMETRY DONE																								
COUGH / DEEP BREATH																								
INITIALS		(b)(6)-2																						

ACLU-RDI 1099 p.1241

DOD 006509

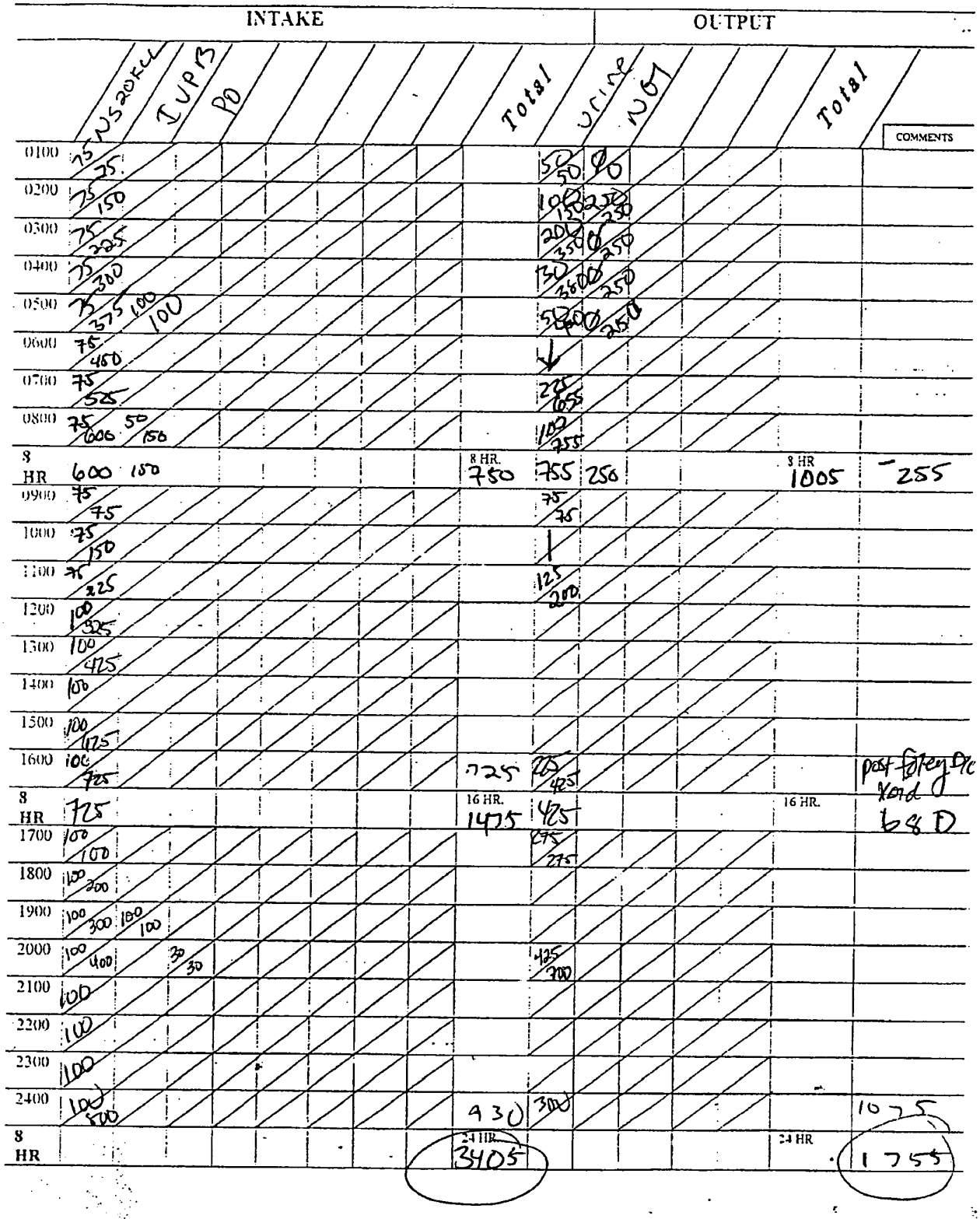
VITAL SIGNS

TIME	T	P	R	BP	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200	98.5	101	20	128/67	99%		89										
0300																	
0400																	
0500																	
0600																	
0700	101.8 (O)	121	18	133/68	95		90										
0800																	
0900	101.8 (O)	111	20	ERROR 130/63			89										
1000																	
1100																	
1200	101.0	111	20	130/63			89										
1300																	
1400	100.1 (O)	99	17	130/60	97												
1500																	
1600																	
1700																	
1800	102.4 (O)	118	24	134/70	98%												
1900																	
2000	101.2 (O)																
2100																	
2200																	
2300																	
2400																	

ACLU-RDI 1099 p.1242

DOD 006510

	INTAKE									OUTPUT					
	NS20KCL	IVPB	PO						Total	Urine	NGT			Total	COMMENTS
0100	75 / 75									50 / 50	0 / 0				
0200	75 / 150									100 / 150	250 / 250				
0300	75 / 225									200 / 350	0 / 250				
0400	75 / 300									130 / 380	0 / 250				
0500	75 / 375	100 / 100								50 / 400	0 / 250				
0600	75 / 450									↓					
0700	75 / 525									225 / 655					
0800	75 / 600	50 / 150								100 / 755					
8 HR	600	150							8 HR. 750	755	250			8 HR 1005	-255
0900	75 / 75									75 / 75					
1000	75 / 150														
1100	75 / 225									125 / 200					
1200	100 / 325														
1300	100 / 425														
1400	100														
1500	100 / 125														
1600	100 / 725								725	225 / 425					post foley D/C void 68D
8 HR	725								16 HR. 1475	425				16 HR.	
1700	100 / 100									275 / 275					
1800	100 / 200														
1900	100 / 300	100 / 100													
2000	100 / 400		30 / 30							425 / 700					
2100	100														
2200	100														
2300	100														
2400	100 / 500								930	300					1075
8 HR									24 HR. 3405					24 HR	1755



MEDCOM - 2459

MEDICAL RECORD | NURSING NOTES (Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
22 OCT 03	0215		-C/O pain via interpreter, pain medication given (see MAR) will continue to monitor pt
22 OCT 03	0715		Temp 101°(A). IS used c̄ consistant elevation of 2 balls. Medicated c̄ Tylenol 650mg T PR. & 145mg 4mg IVP. See flow sheet for assessment. [redacted] ICT, AN
22 OCT 03	1025		OOB to chair over 1 hr. Ambulated to MWR & back. Tolerated well. Continue frequent IS Able to get third ball up c̄ coaching. Ineffective cough. N-T suction per Dr [redacted] RTD TO BED. NGT Dc'd. [redacted] ICT, AN
		1400	Assumed care. Pt resting comfortably in bed. Encouraged IS and deep cough. Pt c/o "alem" c̄ cough. RT induced cough c̄ N-T sxn. Abd drsg. c̄ scant serous drainage on upper 2/3, sm. all serosanguinous drainage on lower 1/3. Will continue to monitor. [redacted] 9/a
		1430	~~RT~~ Pt c/o mild pain on lateral side of ⓛ foot. Encouraged pt. to move foot thru entire ROM. [redacted] 100/an
		1580	lung sounds improved p̄ RT deep sxn and deep cough. Pt sitting @ 90° in bed. [redacted] 100/an
		2000	Pt ambulated to EMT doorway there down to DFAC and back s̄ difficulty. Pt continues use c̄ IS and pulls enough air to raise all 3 balls. Encouraging coughing. Pt sat @ bedside for 1°. New IV started in ⓡ FA. IV in ⓛAC dc'd 1/t leaking and sins of phlebitis. [redacted] TAN
		2100	D[redacted] @ bedside, NT suction complete, large cough produced bloody sputum. IS complete [redacted] TAN

MEDCOM - 2460

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	19Oct03
DOS	23OCT03
POD	

24 HOUR DATA	
24 Hour Balance	+1100
24 Hour Intake	2000
24 Hour Output	-900
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside			
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title) (b)(6)-2 | Department/Service/Clinic: ICU | DATE: 23Oct03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade; date; hospital or medical facility)*

Potus # (b)(6)-4

- ☐ HISTORY PHYSICAL ☐ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION ☐ OTHER(*Specify*)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 2461

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R		2				2				2				2								2	2	
	RADIAL L		2				2				2				2								2	2	
	DORSALIS PEDIS R		2				2				2				2								2	2	
	DORSALIS PEDIS L		2				2				2				2								2	2	
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale			1 3 8				1 3 8				1 3 8				1 3 8									1 3 8	
EDEMA			0				0				0													0	
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)			R				✓	(b)(6)(7)(C)			✓				✓									✓	
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)			NSR				NSR ST				ST				ST									SR	
SWAN GANZ CATHETER (Zeroed & calibrated)			NSR																						
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH							✓																	
	FOLEY CARE																								
	ORAL CARE																								
MOBILITY	BEDREST																								
	BSC		✓																						
	DANGLE																								
	CHAIR						✓				✓												✓		
POSITIONED	RIGHT																						S		
	LEFT																						C		
	SUPINE																								
	HOB 30 DEGREES		✓												✓								E		
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE						0/10	0/10			✓				✓ 7/10								PF		
	PAIN SCALE (1-10)						↓	↓							↓										
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN (2) Soft & Flat (1) Distended			2				2	2			1				2								2		
BOWEL SOUNDS (active all quads)			HSW				hyp				hypo				Hypo								X4		
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT																									
VOIDING CLEAR, YELLOW URINE q.s.							dark				dark												COM		
SKIN INTEGRITY	No Breakdown																								
	Surgical Wounds		✓				✓				✓				✓								✓		
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1 INCISION ABD (midline			✓				✓				✓				✓								✓		
#2																									
#3																									

(b)(6)-2

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
RIV 18G	(R) FA	220ct03	CDI

PUPIL SIZE		PUPILS	
1 mm	=	Equal	
2 mm	R	Reactive	
3 mm	NR	NonReactive	
4 mm	L > R	Left Larger	
5 mm	R > L	Right Larger	

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable/Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment –

DATE: 23 OCT 03

TIME																								
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open		4				4				4				4										4
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response		5				5				5				5										5
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response		6				6				6				6										6
GLASGOW COMA SCALE A+B+C		15				15				15				15										15
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R	2+				2+				2+				2										3+
	L	2+				2+				2+				2										3+
MOVEMENT (See Motor Function Scale at Top of Page)	RUE	4				4				4				4										4
	LUE	4				4				5				4										4
	RLE	4				4				4				4										4
	LLE	4				4				5				4										4
GRIP (5) Strong (N) Weak (-) Absent	R	S				S				S				S										N
	L	S				S				S				S										N
RESPIRATIONS	REGULAR	✓				✓				✓				✓										✓
	IRREGULAR																							
	UNLABORED	✓				✓				✓				✓										✓
	LABORED																							
	SHALLOW																							
	RETRACTIONS																							
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL	5				5				5				5										5
	LUL	5				5				5				5										5
	RLL	1				1				1				1										1
	LLL	1				1				1				1										1
	BOTH BASES					1				1				1										1
COUGH	NONE																							
	SPONTANEOUS	✓				✓				✓				✓										✓
	PRODUCTIVE	✓				✓				✓				✓										✓
	NONPRODUCTIVE																							
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear		2				5				5				5										5
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin		3				3				3				3										3
VENTILATOR	Vt																							
	FIO2																							
	RATE (SIMV/CMV)																							
	PEEP CPAP																							
	PRESS. SUPPORT																							
OXYGEN DELIVERY DEVICE	NC (l/min)																							
	FM (l/min)																							
ETT #_____	NRBM (l/min)																							
	ETT _____cm gums																							
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED																								
INCENTIVE SPIROMETRY DONE						✓				✓				✓										✓
COUGH / DEEP BREATH		✓				✓				✓				✓										✓
INITIALS		(b)(6)-2				(b)(6)-2				(b)(6)-2				H										(b)(6)-2

ACLU-RDI 1099 p.1247

DOD 006515

VITAL SIGNS

TIME	T	P	R	BP	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200	98.9	110	IL	116/58	99%												
0300																	
0400																	
0500																	
0600	100.2	109	16	125/68	97%												
0700																	
0800																	
0900																	
1000	100.2	109	18	116/59	96%												
1100																	
1200																	
1300	[redacted] (5/16/12)																
1400	100.8	105	16	125/63	97%												
1500																	
1600																	
1700	101.3																
1800																	
1900	99.6	101	16	124-70	98%												
2000																	
2100																	
2200																	
2300	98.3	94	16	120/76	99%	—	93										
2400																	

ACLU-RDI 1099 p.1248

DOD 006516

	INTAKE					OUTPUT			
	NS20KCL	PO	IVPB		Total	Urine		Total	COMMENTS
0100	100								
0200	100								
0300	100								
0400	100					100			
0500	100								
0600	100 600	90 90	100 100						
0700	100 700					175 275			
0800	100 800		50 150						
8 HR	800	90	150		8 HR 1040			8 HR 275	+
0900	100 100								
1000	100 200	[redacted]							
1100	100 300					75 75			
1200	100 400		100 100						
1300	100 500					100 175			
1400	100 600					150 325			
1500	100 700								
1600	100 800		50 150						
8 HR	800		150		16 HR 950	325		16 HR 600+	
1700	100								
1800	100 200		100						
1900	100 300								
2000	100								
2100	100								
2200	100								
2300	100		50 150			300			
2400	100		100 250					900+	
8 HR	800		250		24 HR 2000			24 HR 900+	

MEDCOM - 2465

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
	0200		resting @ this time will continue to monitor pt [redacted]
23OCT03	0600		Pt cooperative & alert & oriented X3. VS. Tmax 100°, encouraged pt to cough, deep breath & ↑ fluid intake. Pt attempted to eat Jello, finished <20% & drank water s̄ N or V; pt c/o abd pain from sitting up in chair during breakfast, pain scale 3/10. Pt making effort to cough up dark tan & brown sputum. Pt urinated 200 cc dark yellow urine, pt encouraged to ↑ fluids; Pt cooperative and verbalized understanding. 18 g IV in (R) FA patent & infusing maintainence IV fluids. Will continue to monitor. [redacted]
23OCT03	0700		Pt c/o pain 6/10 abdominal pain; medicated pt c̄ MSO4 4mg IV per prn pain order. Pt received immediate relief & asked to stay in chair at bedside instead of bed. Will continue to monitor pt. [redacted]
		1445	MD at the bedside doing NT suction tolerating well. NAD encourage couging and Deep breathing. See DA Form 4700 for assessment. Will con't to monitor per the orders. [redacted]
		1640	↑ OOB walking hall NAD. Doing well needed very little assil just getting out of bed. ↑ Seting in chair and working on IS. Will con't to monitor per orders → [redacted]
		1840	Back to bed NAD doing well. will con't to monitor per order. [redacted]
		2110	Sleeping & eyes closed rises and fall of chest noted. [redacted]

MEDCOM - 2466

DIRECTIONS: To be completed by attending provider and other staff at time of patient release following an outpatient procedure, extended care/treatment or discharge from an inpatient hospital stay.

SECTION I
TO BE COMPLETED BY PRIVILEGED PROVIDER

1. DATE OF PROCEDURE/ADMISSION: 19 Oct 03
2. ADMITTING/DIAGNOSIS: Abd Shrapnel Wounds
3. PERTINENT LAB, X-RAY, FINDINGS:
~~Small Bowel Injur~~
CXR Normal Except Elevated Right Diaphram
4. PROCEDURES, TREATMENT, HOSPITAL COURSE:
Exp Lap 19 Oct with Repair of Small Bowel Injury X2 and Sigmoid Colon Injury X 1
5. FINAL DIAGNOSIS AND CONDITION AT DISCHARGE:
Shrapnel Wounds to Abdomen with Small & Large Bowel Injury
6. ACTIVITY: As Tolerated
7. DIET: Regular
8. MEDICATIONS:
☐ Medications have been prescribed for home use. See separate list and special instructions or see below.
Levaquin 500mg twice a day until gone
Zantac 150mg twice a day until gone
Tylenol ~~650mg~~ 325mg One or Two every 4° As Needed for Pain
9. INSTRUCTIONS (To Home Health Providers, Patient, etc):
Drink Fluids - Extra
10. DISCHARGING PROVIDER:
[redacted] [redacted] ...ped Name)

PATIENT IDENTIFICATION
POTUS [redacted]

SECTION II
TO BE COMPLETED BY OTHER STAFF, AS APPROPRIATE

1. DISPOSITIONED TO: ☐ HOME ☐ DUTY ☒ OTHER MP's
☒ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER
2. ACCOMPANIED BY: ☐ FAMILY ☐ FRIEND ☒ OTHER MP's
3. PATIENT EDUCATION:
Completed and patient prepared for home care. ☒ YES ☐ NO
If no, explain:
Patient ☒ states ☐ demonstrates understanding of home care needs.
Printed educational materials provided:
4. Clinical outcomes met and post-discharge/release referrals made.
☒ YES ☐ NO If no, explain:
5. If transferred to another health care facility, report called to nurse.
☐ YES ☐ NO If no, explain:
6. NUTRITION CARE - Comments:
Regular
7. MEDICATIONS:
Explained by: ☒ NURSE ☐ PHYSICIAN ☐ PHARMACIST → TO MP's
Printed medication literature provided. ☐ YES ☒ NO
~~Patient~~ MP's states understanding of prescribed medications. ☒ YES ☐ NO
8. EQUIPMENT/SUPPLIES PROVIDED:
4X4's & 2X2's TAPE
CHAnge DRSG EVERY 1-2 days.
IF increased redness or drainage Notify CSH
9. FOLLOW-UP APPOINTMENTS, POINT OF CONTACT & PHONE:
10. FOR PROBLEMS OR EMERGENCY, CONTACT & PHONE:
CSH or unit MEDIC

[redacted] BY:
...ILT, AN 10/27/03 1230
...ure and Title) (Date and Time)
...A COPY OF AND UNDERSTAND THESE INSTRUCTIONS.
[redacted] 27 OCT 03 1231
...nature) (Date and Time)

MEDCOM FORM 691-R (TEST) (MCHO) MAR 99 PREVIOUS EDITIONS ARE OBSOLETE MC V1.00

MEDCOM - 2467

MEDICAL RECORD	INTRAOPERATIVE DOCUMENT For use of this form, see AR 40-407, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Cranny BY [illegible]

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY CDT (b)(6)-2

3. DATE 15/12/03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM
TIME NUMBER

5. PREOPERATIVE EMOTIONAL STATUS

☐ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☒ OTHER (Specify)

COMMENTS: will not respond to interpreter any questions, or us being next to him

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC (b)(6)-2	RELIEF SCRUB	Sgt (b)(6)-2 1745-EOC
ASSIGNED CIRCULATOR	CDT (b)(6)-2	RELIEF CIRCULATOR	Maj (b)(6)-2 745-EOC

7. POSITION AND POSITIONAL AIDS (Specify)

☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

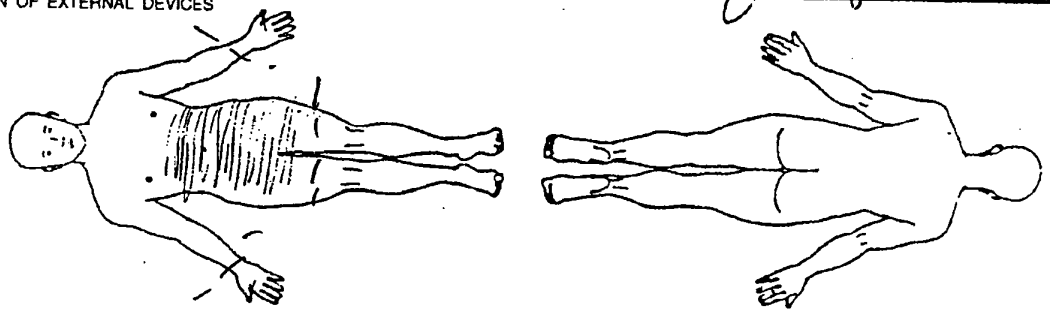
COMMENTS: none

8. SKIN PREPARATION

HAIR REMOVAL ☒ YES ☐ NO
DONE BY: ☒ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP
COMMENTS: no nicks or cuts noted

PREP SOLUTION (Specify) 3 etc [illegible]
SITE: abdominal BY WHOM: CDT [illegible]
SITE: BY WHOM:
COMMENTS: no pooling of sol.

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Strap === Tourniquet

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No		C	C	(b)(6)-2	(b)(6)-2
Needle Sharp	☒ Yes ☐ No					
Instrument	☒ Yes ☐ No					
Other	☐ Yes ☐ No					

11. PATIENT IDENTIFICATION (For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)

Potus # (b)(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO

☒ ESU NO: 000934 50/50
GROUND PAD: BRAND Valley Lab
LOT NO: 696171 05/07

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE.

MEDCOM - 2468

13. PROSTHESIS, IMPLANTS ☐ YES ☒ NO IF YES NAME: ID NUMBER; MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☒

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

NSS

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM YES ☐ NO ☒ IF YES, SITE

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☐	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. #16 Fr foley	2.	3.
SITE	1. Bladder	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

2x2's
4x8's
Lape

19. ADDITIONAL INFORMATION

Dr
Dr

(b)(6)-2

20. OPERATION(S) PERFORMED

Ex Lap, appey, part-sm-bowel resection, reanastomosis
Sm & Lg Bowel Enter. repairs —

21. PATIENT TRANSFERRED TO ICU TIME See D METHOD litter - safety strap

22. REG (b)(6)-2 major

REVERS

MEDCOM - 2469

*U.S. GPO: 1996-404-613/40449

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM _____ HOURS
TO _____ HOURS
TOTAL HOURS COVERED
DATE 24 Oct 03

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
1130	clear liquids	500	500
1800	Jello	50	550
1800	Water	120	670
2030	Gatorade	200	870
2255	jello	50	920

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
0200	1000	D5 NS ē 20 KCL	400	0600	400
0530	100	primaxin	100	0600	500
0730	50	Zantac	50	0815	550
1130	100	Primaxin	100	1230	1050
1400	800	D5 NS ē 20KCl	800	1400	1450
1600	50	Zantac	50	1630	1500
1800	100	Primaxin	100	1900	1600
2200	400	D5 ½ NS ē 20kcl	400	2200	2000
2330	50	Zantac	50	2350	2050

~~IRRIGATIONS (N.G., Bladder, etc.)~~ IV Cont.

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl, Alb, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE +2970

USAPPC V1.00

Potus # (b)(6)-4

ACLU-RDI 1099 p.1254

DOD 006522

OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
0145	200	200			
0330	400	600			
1406	700	1300			
1600	250	1550			
1800	250	1800			
2130	300	2100			

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL

CHEST

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL
0130	light	mucousy	SM	
0900	light brown	soft stool	Med	
1345	"	"	"	
1800	light brown	hard formed	sm	

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL

GRAND TOTAL OUTPUT

REMARKS

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)*

Potus # (b)(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

MEDICINE GLASS (1 oz)	30	HALF PINT MILK	240
SMALL FRUIT CUP	120	LARGE SOUP BOWL	240
COFFEE CUP	160	LARGE WATER GLASS	240
LARGE COFFEE MUG	180	PLASTIC OR PAPER JUICE CONTAINER	180

DD FORM 792, JAN 74 EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3630(TEMP) 1 JUL 72 WHICH MAY BE USED. USAPPC V1.00

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM _____ HOURS
TO _____ HOURS

TOTAL HOURS COVERED

DATE 25 Oct 03

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
1600	Gatorade	90	90
1800	Gatorade	60	150

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
0080	100	Primaxcin	100	0100	100
0545	100	Primaxin	100	0615	200
2200	400	D5NS E 20 KCl	400	0600	600

IRRIGATIONS (N G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl, Alb, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE [redacted] 750

USAPPC V1.00

POTUS # [redacted] (b)(6)-4

(b)(6)(2)

ACLU-RDI 1099 p.1256

DOD 006524

OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
0215	400	400			
0420	350	750			
1500	225	975			
1555	120	1095			
1650	200	1295			
1830	~200	1495			
2030	225	1720			
2300	300	2020			

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL

CHEST

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL
1830	lt brown	flakes/specks	smear	min
2245	green	smear	small	small

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL

GRAND TOTAL OUTPUT

REMARKS

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)*

INTAKE EQUIVALENTS *(Serving levels cc)*

MEDICINE GLASS *(1 oz)*	30	HALF PINT MILK	240
SMALL FRUIT CUP	120	LARGE SOUP BOWL	240
COFFEE CUP	160	LARGE WATER GLASS	240
LARGE COFFEE MUG	180	PLASTIC OR PAPER JUICE CONTAINER	180

DD FORM 792, JAN 74 EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3630(TEMP) 1 JUL 72 WHICH MAY BE USED. USAPPC V1.00

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM _____ HOURS
TO _____ HOURS
TOTAL HOURS COVERED
DATE 20Oct03

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
0605	Water Po	100cc	100cc
0800	Water Po	120cc	220cc
1000	Water	90cc	310cc
1400	Water	240	550
1600	Water	240	790
1700	Soda	300	1090
2100	Water	240	1330

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
0000	1000	D5NS ō 2KCL	300		300

IRRIGATIONS (N.G. Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl. Alb. P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE 1630

USAPPC V1.00

Potus #1 (b)(6)-4

ACLU-RDI 1099 p.1258

DOD 006526

OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
0230	200	200			
0730	375	~~575~~ 575			
1100	375	1050			
1530	350	1400			
1600	350	1750			
1700	275	2025			
1800	250	2275			
1900	300	2575			
2030	250	2825			

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL

CHEST

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL
1330	Brown	Semi-solid	Sm	X1

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL

GRAND TOTAL OUTPUT 2825

REMARKS

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)*

INTAKE EQUIVALENTS *(Serving levels cc)*

MEDICINE GLASS (1 oz)	30	HALF PINT MILK	240
SMALL FRUIT CUP	120	LARGE SOUP BOWL	240
COFFEE CUP	160	LARGE WATER GLASS	240
LARGE COFFEE MUG	180	PLASTIC OR PAPER JUICE CONTAINER	180

DD FORM 792, JAN 74 EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3630(TEMP) 1 JUL 72 WHICH MAY BE USED. USAPPC V1.00

OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
0800	1000	1000			

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL

CHEST

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL

GRAND TOTAL OUTPUT

REMARKS

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)*

POTUS [b)(6)-4]

INTAKE EQUIVALENTS *(Serving levels cc)*

MEDICINE GLASS *(1 oz)*	30	HALF PINT MILK	240
SMALL FRUIT CUP	120	LARGE SOUP BOWL	240
COFFEE CUP	160	LARGE WATER GLASS	240
LARGE COFFEE MUG	180	PLASTIC OR PAPER JUICE CONTAINER	180

DD FORM 792, JAN 74 EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3630(TEMP) 1 JUL 72 WHICH MAY BE USED. USAPPC V1.00

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST: (b)(6)-4 | UNIT: | RANK: | S: (b)(6)-4

Physician: Dr. (b)(6)-2 Ward: | X STAT / Routine | Date and Time: 19Oct03 1020 | Reported by: (b)(6)-2 | Date and Time: 19Oct03

Chemistry (I-STAT)

X	TEST	RESULT	REF. RANGE
	Na		128-145 mmol/L
	K		3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH		7.35-7.45
	PCO2		35-45 mmHg
	PO2		80-90 mmHg
	TCO2		18-33 mmol/L
	HCO3		22-28 mmol/L
	sO2		95-99%
	BEecf		(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL

Urinalysis

Color	Yellow	Straw/Yellow
Clarity	s/t Cldy	Clear
Glucose	250	Negative
Bilirubin	neg	Negative
Ketone	neg	Negative
SG	1.022	1.010-1.025
Blood	large	Negative
pH	6.0	5.0-8.0
Protein	neg	Negative-Trace
Urobili	norm	Negative
Nitrite	neg	Negative
Leuko	neg	Negative

Urine Microscopic

WBC	0-3	Epi	rare
RBC	20-30	Mucus	Trace
Bacteria	light	Yeast	
Casts:			
Crystals:			
Other:			

Other: CBC, Type screen, UA

Chemistry (Piccolo Analyzer)

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-84 U/L
	ALT		10-47 U/L
	AMY		14-97 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat		0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		128-145 mmol/L

Microbiology

Source:		
FecLeuk		Negative
Gram St		
WetPrep		Negative
KOH		No Fungal Elements
OccBld		Negative
O&P		No Ova/Parasite

Blood Bank

ABO/Rh		
T&C		
T&S	O	pos

HCG

Urine		Negative
Serum		Negative

Hematology

X	TEST	RESULT	REF. RANGE
	WBC	12.5 *	4.8-10.8 x10(3)/uL
	RBC	3.63 *	4.2-6.1 x10(6)/uL
	Hgb	11.4 *	12.0-18.0 g/dL
	Hct	32.4 *	35.0-60.0%
	MCV	89.3	80.0-99.0 fl
	MCH	31.4 *	27.0-31.0 pg
	MCHC	35.1	33.0-37.0 g/dL
	Plt	279	130-400 x10(3)/uL
	LY%	4.7 *	15.0-55.0%
	LY#	0.6 *	0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Imm
RBC Morph:	
Plt verify:	
Spun Crit	35-60%

Malaria Smear

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate

Sed Rate		1hr = 0-20 mm

Coagulation

PT		10-13 seconds
APTT		22.1-33.7 seconds
FDP		Negative

Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Negative

MEDCOM - 2477

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI: (b)(6)-4 | UNIT: NA ICU | RANK: NA | SSN: (b)(6)-4

Physician: (b)(6)-2 | Ward: ICU | STAT | X Routine | Date and Time: 19 Oct 1530 | Reported by: (b)(6)-2 | Date and Time: 19 Oct 03 0537

Chemistry (i-STAT)

X	TEST	RESULT	REF. RANGE
	Na		128-145 mmol/L
	K		3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH		7.35-7.45
	PCO2		35-45 mmHg
	PO2		80-90 mmHg
	TCO2		18-33 mmol/L
	HCO3		22-28 mmol/L
	sO2		95-99%
	BEecf		(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL

Urinalysis

	Color		Straw/Yellow
	Clarity		Clear
	Glucose		Negative
	Bilirubin		Negative
	Ketone		Negative
	SG		1.010-1.025
	Blood		Negative
	pH		5.0-8.0
	Protein		Negative-Trace
	Urobili		Negative
	Nitrite		Negative
	Leuko		Negative

Urine Microscopic			
	WBC		Epi
	RBC		Mucus
	Bacteria		Yeast
	Casts:		
	Crystals:		
	Other:		

Other: CBC

Chemistry (Piccolo Analyzer)

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-84 U/L
	ALT		10-47 U/L
	AMY		14-97 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat		0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		128-145 mmol/L

Microbiology

	Source:		
	FecLeuk		Negative
	Gram St		
	WetPrep		Negative
	KOH		No Fungal Elements
	OccBld		Negative
	O&P		No Ova/Parasite

Blood Bank

	ABO/Rh		
	T&C		
	T&S		

HCG

	Urine		Negative
	Serum		Negative

Hematology

X	TEST	RESULT	REF. RANGE
	WBC	14.2	4.8-10.8 x10(3)/uL
	RBC	4.08	4.2-6.1 x10(6)/uL
	Hgb	11.7	12.0-18.0 g/dL
	Hct	36.5	35.0-60.0%
	MCV	89.5	80.0-99.0 fl
	MCH	28.7	27.0-31.0 pg
	MCHC	32.1	33.0-37.0 g/dL
	Plt	270	130-400 x10(3)/uL
	LY%	5.8	15.0-55.0%
	LY#	0.8	0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Imm
RBC Morph:	
Plt verify:	
Spun Crit	35-60%

Malaria Smear

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate

Sed Rate		1hr = 0-20 mm

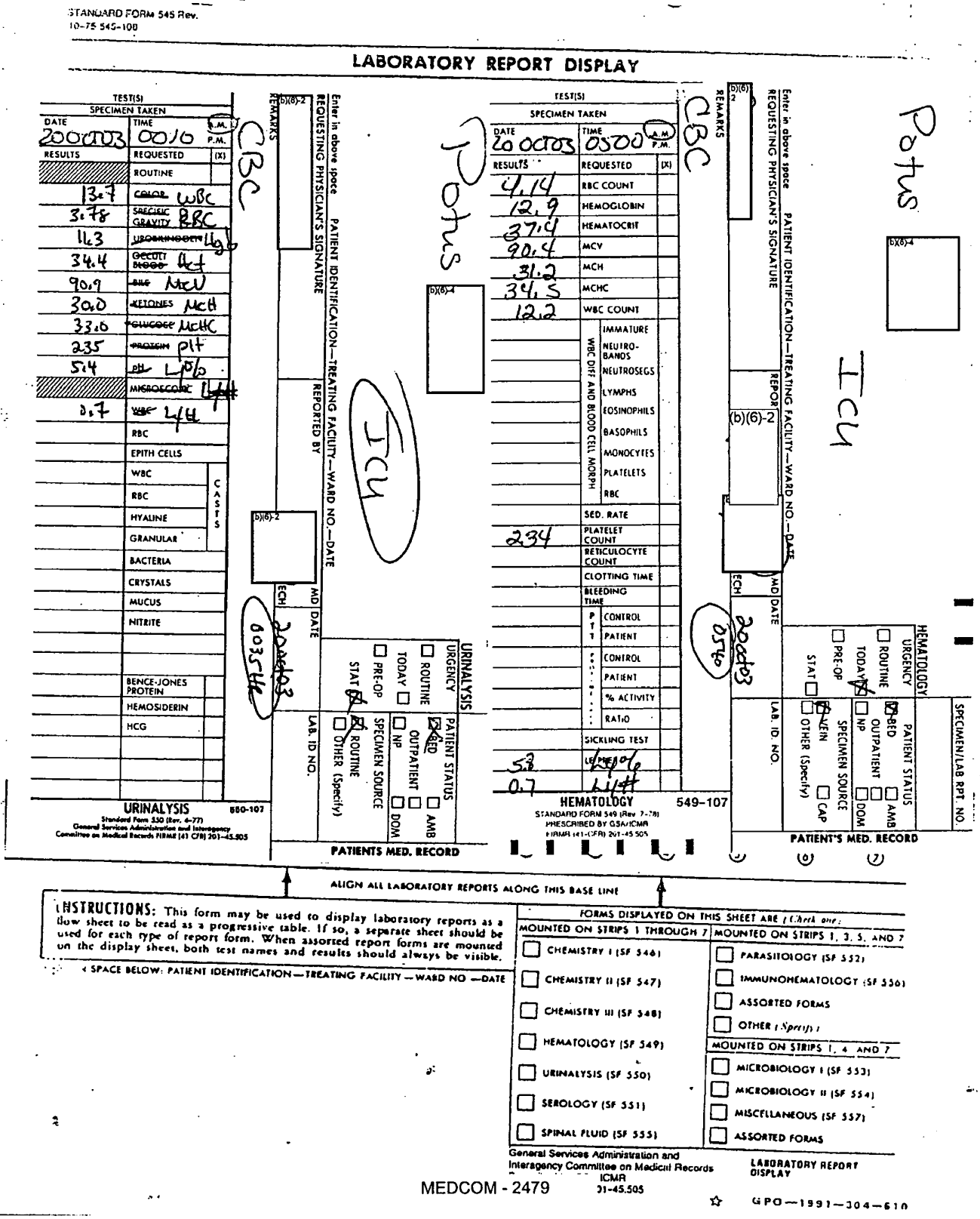
Coagulation

PT		10-13 seconds
APTT		22.1-33.7 seconds
FDP		Negative

Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Negative

MEDCOM - 2478



STANDARD FORM 545 Rev.
10-75 545-108

LABORATORY REPORT DISPLAY

TEST(S)
SPECIMEN TAKEN
DATE 20 OCT 03
TIME 0010 A.M. P.M.
RESULTS | REQUESTED | (X)
ROUTINE
13.7 COLOR WBC
3.78 SPECIFIC GRAVITY RBC
11.3 UROBILINOGEN Hgb
34.4 OCCULT BLOOD Hct
90.9 BILE MCV
30.0 KETONES MCH
33.0 GLUCOSE MCHC
235 PROTEIN plt
5.4 pH L/D
MICROSCOPIC L/H
0.7 WBC L/H
RBC
EPITH CELLS
CASTS: WBC, RBC, HYALINE, GRANULAR
BACTERIA
CRYSTALS
MUCUS
NITRITE
BENCE-JONES PROTEIN
HEMOSIDERIN
HCG

REMARKS: CBC
b(6)-2
Enter in above space
REQUESTING PHYSICIAN'S SIGNATURE
PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REPORTED BY
MD
DATE
ECH
20 OCT 03
0035Hr
URINALYSIS
URGENCY: ROUTINE, PRE-OP, STAT
TODAY
PATIENT STATUS: BED, AMB
OUTPATIENT: NP, DOM
SPECIMEN SOURCE: ROUTINE, OTHER (Specify)
LAB. ID NO.
PATIENTS MED. RECORD
URINALYSIS 550-107
Standard Form 550 (Rev. 6-77)
General Services Administration and Interagency Committee on Medical Records FIRMR (41 CFR) 201-45.505

TEST(S)
SPECIMEN TAKEN
DATE 20 OCT 03
TIME 0500 A.M. P.M.
RESULTS | REQUESTED | (X)
4.14 RBC COUNT
12.9 HEMOGLOBIN
37.4 HEMATOCRIT
90.4 MCV
31.2 MCH
34.5 MCHC
12.2 WBC COUNT
WBC DIFF AND BLOOD CELL MORPH: IMMATURE, NEUTRO-BANDS, NEUTROSEGS, LYMPHS, EOSINOPHILS, BASOPHILS, MONOCYTES, PLATELETS, RBC
SED. RATE
234 PLATELET COUNT
RETICULOCYTE COUNT
CLOTTING TIME
BLEEDING TIME
PT: CONTROL, PATIENT
PTT: CONTROL, PATIENT
% ACTIVITY
RATIO
SICKLING TEST
5.3 Hgb L/D
0.7 Hct L/H

REMARKS: CBC
b(6)-2
Enter in above space
REQUESTING PHYSICIAN'S SIGNATURE
PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REPORTED BY
MD
DATE
ECH
20 OCT 03
0540
HEMATOLOGY
URGENCY: ROUTINE, PRE-OP, STAT
TODAY
PATIENT STATUS: BED, AMB
OUTPATIENT: NP, DOM
SPECIMEN SOURCE: OTHER (Specify), CAP
LAB. ID NO.
SPECIMEN/LAB RPT. NO.
PATIENT'S MED. RECORD
HEMATOLOGY 549-107
STANDARD FORM 549 (Rev 7-78)
PRESCRIBED BY GSA/ICMR
FIRMR (41-CFR) 201-45.505

Patus
ICU
b(6)-4

ALIGN ALL LABORATORY REPORTS ALONG THIS BASE LINE

INSTRUCTIONS: This form may be used to display laboratory reports as a flow sheet to be read as a progressive table. If so, a separate sheet should be used for each type of report form. When assorted report forms are mounted on the display sheet, both test names and results should always be visible.

SPACE BELOW: PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

FORMS DISPLAYED ON THIS SHEET ARE (Check one):

MOUNTED ON STRIPS 1 THROUGH 7
- CHEMISTRY I (SF 546)
- CHEMISTRY II (SF 547)
- CHEMISTRY III (SF 548)
- HEMATOLOGY (SF 549)
- URINALYSIS (SF 550)
- SEROLOGY (SF 551)
- SPINAL FLUID (SF 555)

MOUNTED ON STRIPS 1, 3, 5, AND 7
- PARASITOLOGY (SF 552)
- IMMUNOHEMATOLOGY (SF 556)
- ASSORTED FORMS
- OTHER (Specify)

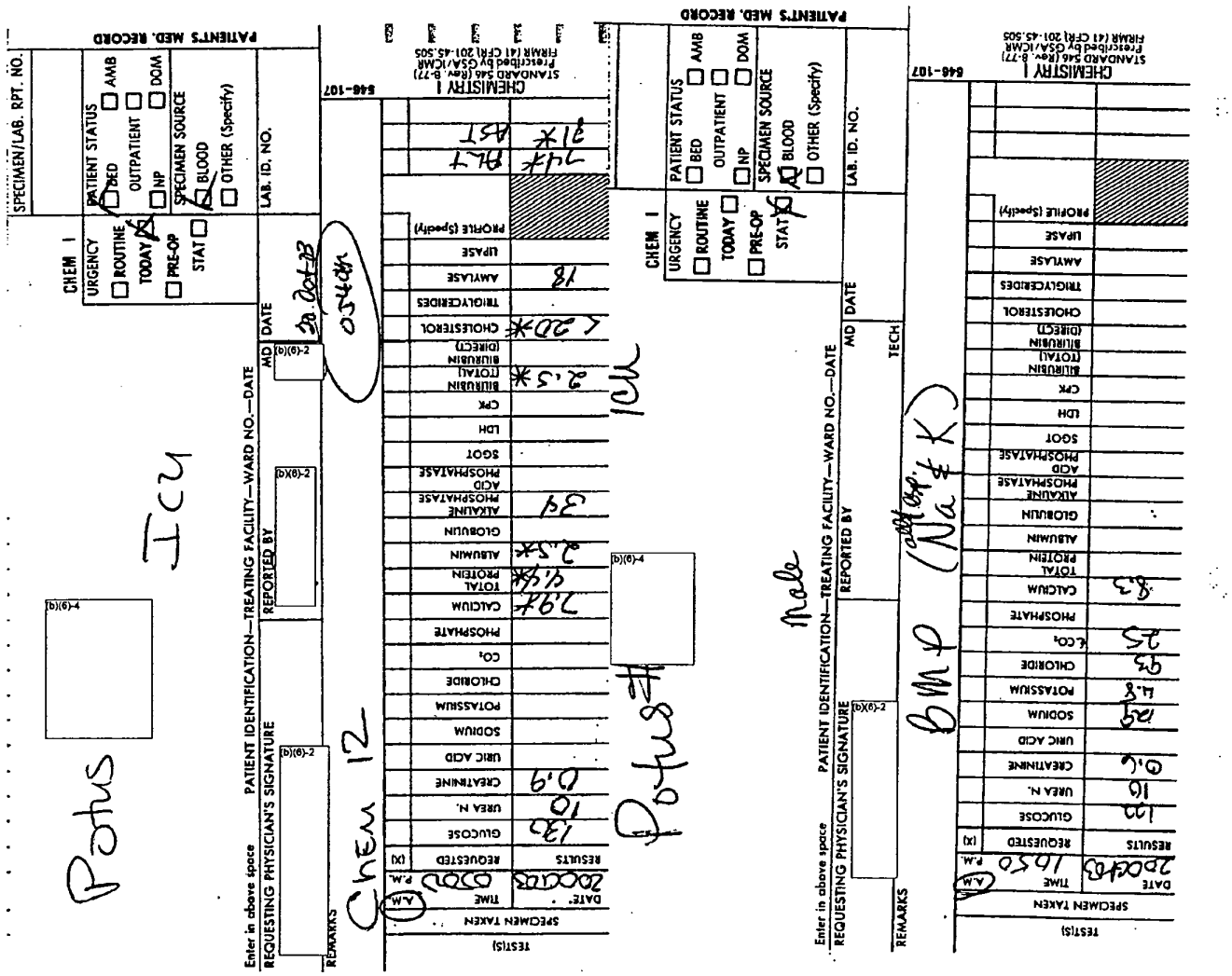
MOUNTED ON STRIPS 1, 4 AND 7
- MICROBIOLOGY I (SF 553)
- MICROBIOLOGY II (SF 554)
- MISCELLANEOUS (SF 557)
- ASSORTED FORMS

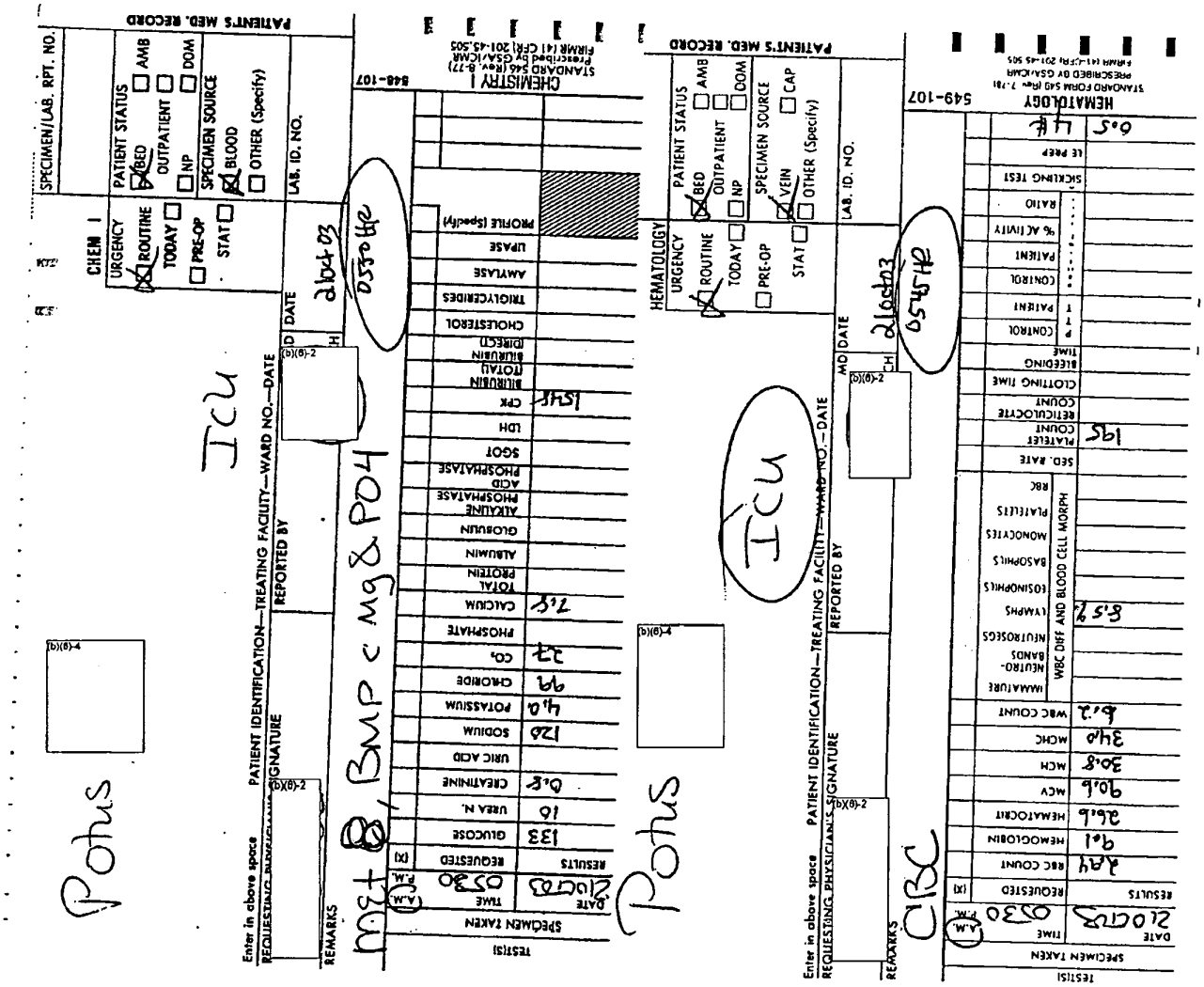
General Services Administration and Interagency Committee on Medical Records ICMR 201-45.505

LABORATORY REPORT DISPLAY

MEDCOM - 2479

☆ GPO—1991—304—610




PATIENT'S MED. RECORD
SPECIMEN/LAB. RPT. NO.
CHEM 1
URGENCY
ROUTINE
TODAY
PRE-OP
STAT
PATIENT STATUS
BED
AMB
OUTPATIENT
NP
DOM
SPECIMEN SOURCE
BLOOD
OTHER (Specify)
LAB. ID. NO.
DATE
ICU
Pohs
PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REPORTED BY
SIGNATURE
REMARKS
Enter in above space
REQUESTING PHYSICIAN'S
CHEMISTRY 1
848-107
TEST(S)
SPECIMEN TAKEN
RESULTS
REQUESTED
PROFILE (Specify)
UPASE
AMYLASE
TRIGLYCERIDES
CHOLESTEROL
BILIRUBIN DIRECT
BILIRUBIN TOTAL
CPK
LDH
SGOT
PHOSPHATASE ACID
PHOSPHATASE ALKALINE
GLOBULIN
ALBUMIN
TOTAL PROTEIN
CALCIUM
PHOSPHATE
CO2
CHLORIDE
POTASSIUM
SODIUM
URIC ACID
CREATININE
UREA N.
GLUCOSE
Bmp c Mg & PO4
HEMATOLOGY
549-107
PLATELET COUNT
WBC COUNT
RBC COUNT
HEMOGLOBIN
HEMATOCRIT
MCV
MCH
MCHC
WBC DIFF AND BLOOD CELL MORPH
CBC

DATE 10/22/03 | TIME 1040

Physician (b)(6)-2

Clinic/Ward/UCA ICU

☐ Clean Catch ☒ Catheterized

Urine Chemistry

Complete

Glu Neg pH 8.5
Bil Neg Pro 30
Ket small Uro Neg
SG 1.010 Nit Neg
Bldmod Leu Neg

LAB

☐ Routine
☐ Today
☒ STAT

Patient ID

POTUS

(b)(6)-4

UA

Color Amber
Appearance Clear
Clinitest
Acetest
Ictotest
SSA

Microscopic

Casts /LPF
Type
WBC 0-1 /HPF
RBC 0-1 /HPF
Crystals
Epi Cells /HPF
Type
Yeast
Trichomonas
Bacteria light
Mucous
Other

Reported By:

Clinical Data:

(b)(6)-2

Date: 22 Oct 03

Note: Micro exam only when abn. chem. found or upon special request.

Normal Values

Color: Straw, Yellow, Amber
Specific Gravity: 1.003-1.030
Urobilinogen: 0.1-1.0 EU/dl
pH: 4.6 — 8.0
WBC: 0—5/HPF
RBC: 0-3/HPF
Epi: 0—5/HPF
Others: Negative

DARNALL ARMY COMMUN
DEPARTMENT OF PA
FH MDA FORM 8 1

CHART COP

TEST(S)
SPECIMEN TAKEN
DATE 22 Oct 03 TIME 0415 A.M. P.M.
REQUESTED
RESULTS

Glu - 113
BUN - 9
CRE - 0.7
CK - 1201
Na - 121*
K - 3.9
Cl - 99
tCO2 - 24
Ca - 8.2

Met 6 Mg 8 K Bmp
Met lyte 8 Bmp
[redacted] (b)(6)(2)

REMARKS

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE (b)(6)-2

REPORTED BY (b)(6)-2

MD DATE 22 Oct 03

TECH

MISCELLANEOUS 557-107
STANDARD FORM 557 (Rev. 3-77)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45-505

Potus #

(b)(6)-4

ICU

MISC

URGENCY ☐ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT ☒

PATIENT STATUS ☒ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM

SPECIMEN SOURCE (Specify) Blood

LAB ID NO.

SPECIMEN/LAB RPT. NO

PATIENT'S MED. RECORD

Potus # (b)(6)-4

ICU

SPECIMEN/LAB RPT. NO

MISC

URGENCY ☐ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT ☒

PATIENT STATUS ☒ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM

SPECIMEN SOURCE (Specify) Blood

PATIENT'S MED. RECORD

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE (b)(6)-2

REPORTED BY (b)(6)-2

MD DATE 22 Oct 03

TECH

LAB ID NO.

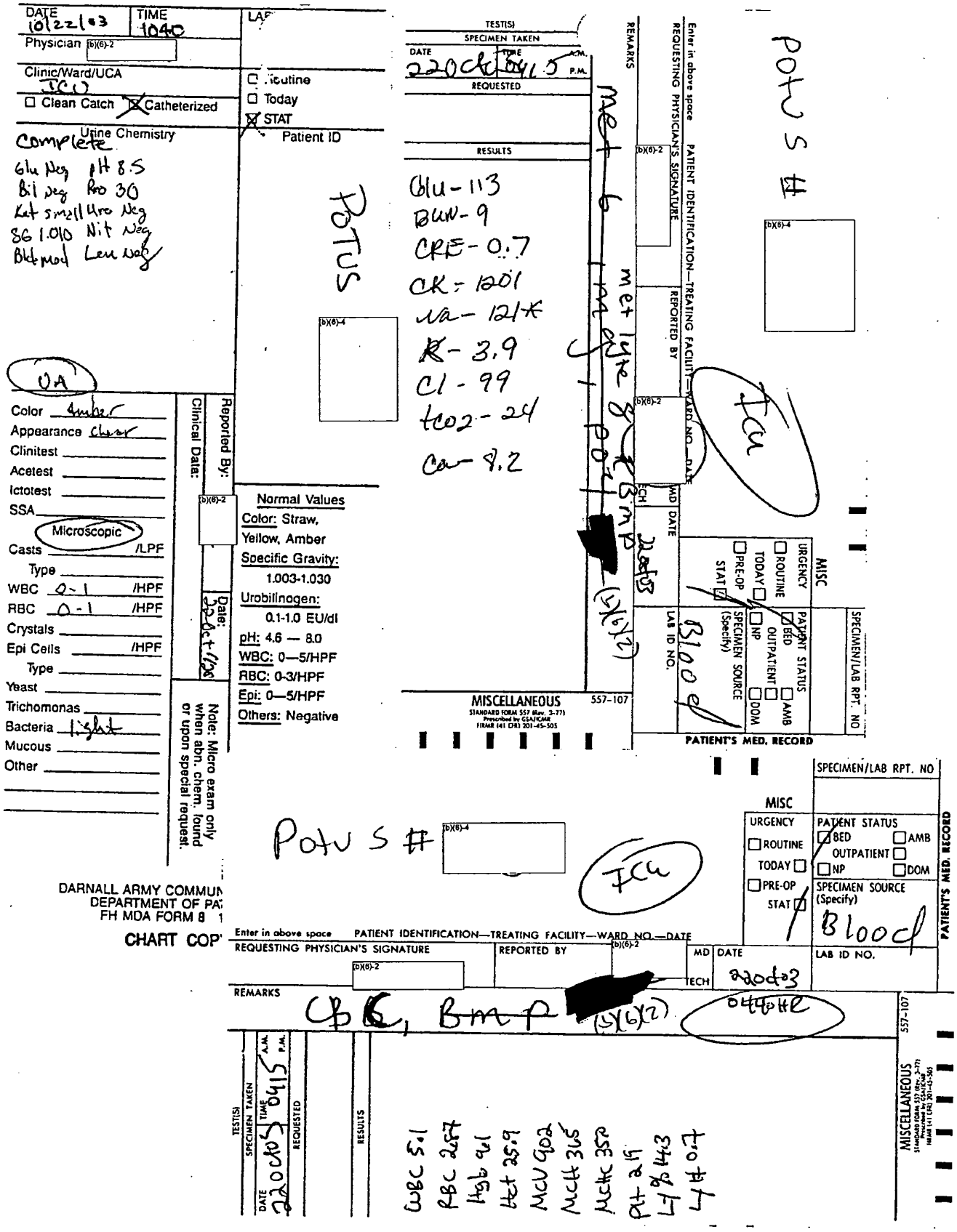
REMARKS

CBC, Bmp [redacted] (b)(6)(2) 0440HR

TEST(S)
SPECIMEN TAKEN
DATE 22 Oct 03 TIME 0415 A.M. P.M.
REQUESTED
RESULTS

WBC 5.1
RBC 2.87
Hgb 9.1
Hct 25.9
MCV 90.2
MCH 36.5
MCHC 35.0
Plt 219
Ly% 14.3
Ly# 0.7

MISCELLANEOUS 557-107
STANDARD FORM 557 (Rev. 3-77)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45-505



MEDCOM - 2482

TEST(S)

SPECIMEN TAKEN

DATE 23 Oct 03 TIME 0500 A.M. P.M.

REQUESTED

RESULTS

GLU - 117
BUN - 12
CRE - 1.0
CK - 618
K - 3.6
Cl - 99
+CO2 - 24
Ca - 7.9 *
Na - 136

BMP, mel Lyte 8

REMARKS (b)(6)-2

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE

REPORTED BY (b)(6)-2

MD (b)(6)-2

DATE 23 Oct 03

Potus (b)(6)-4

ICU

MISC

URGENCY ☑ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT

PATIENT STATUS ☑ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM

SPECIMEN SOURCE (Specify) Blood

LAB ID NO.

SPECIMEN/LAB RPT. NO

MISCELLANEOUS 557-107

STANDARD FORM 557 (Rev. 3-77) Prescribed by GSA/ICMR FIRMR (41 CFR) 201-45-505

PATIENT'S MED. RECORD

TEST(S)

SPECIMEN TAKEN

DATE 23 Oct 03 TIME 0500 A.M. P.M.

REQUESTED

RESULTS

WBC - 5.5
RBC - 2.49
Hgb - 8.4
Hct - 22.6
MCV - 90.8
MCH - 33.9
MCHC - 37.3
Plt - 219
Ly% - 14.3
Ly# - 0.8

CBC

REMARKS (b)(6)-2

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE

REPORTED BY (b)(6)-2

MD (b)(6)-2

DATE 23 Oct 03

Potus (b)(6)-4

ICU

MISC

URGENCY ☑ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT

PATIENT STATUS ☑ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM

SPECIMEN SOURCE (Specify) Blood

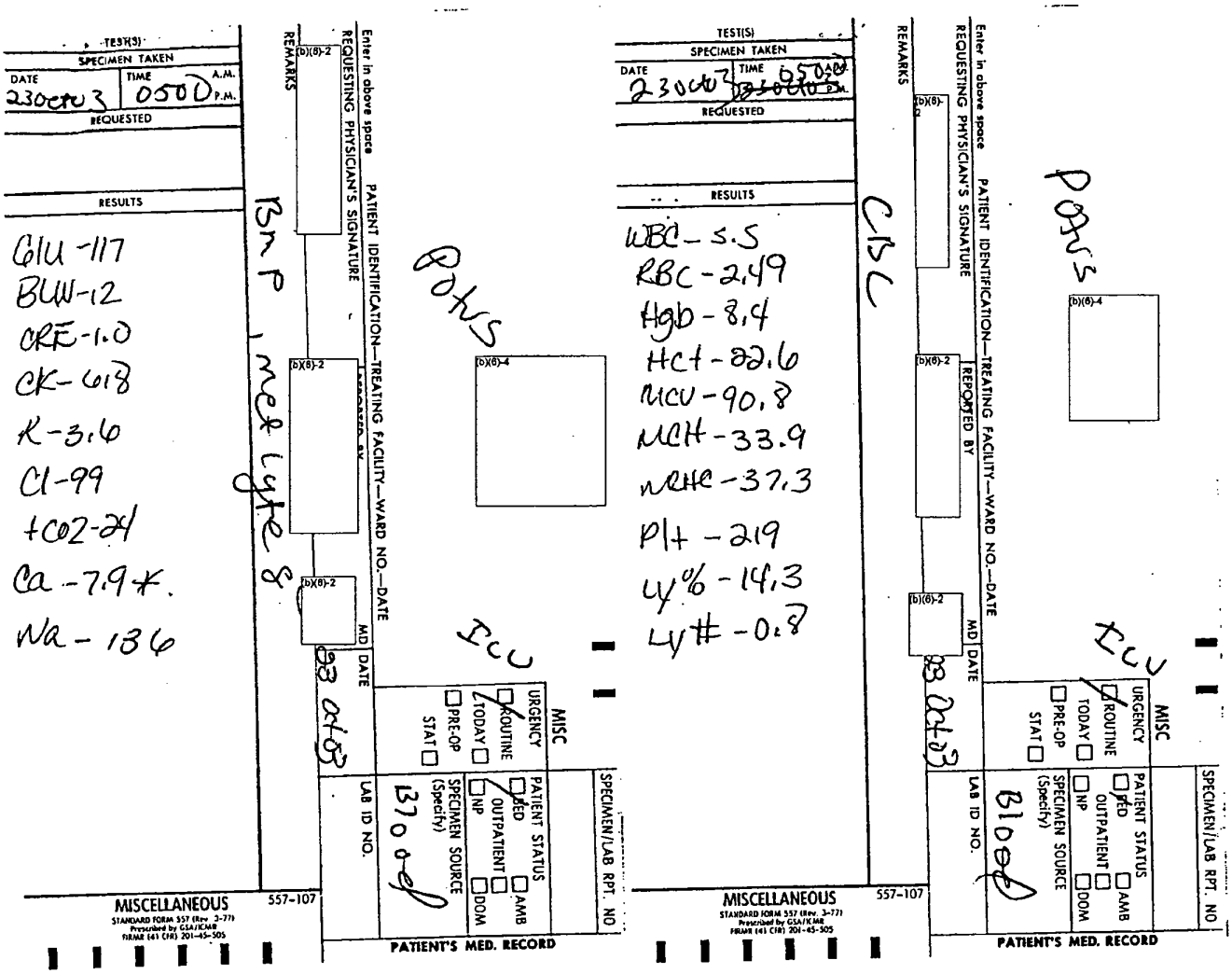
LAB ID NO.

SPECIMEN/LAB RPT. NO

MISCELLANEOUS 557-107

STANDARD FORM 557 (Rev. 3-77) Prescribed by GSA/ICMR FIRMR (41 CFR) 201-45-505

PATIENT'S MED. RECORD



MEDCOM - 2483

TEST(S)

SPECIMEN TAKEN

DATE 24Oct03 TIME 0442 A.M. P.M.

RESULTS	REQUESTED	(X)
2.99	RBC COUNT	
9.3	HEMOGLOBIN	
26.9	HEMATOCRIT	
90.0	MCV	
31.2	MCH	
34.6	MCHC	
6.3	WBC COUNT	
	WBC DIFF AND BLOOD CELL MORPH: IMMATURE	
	NEUTRO-BANDS	
	NEUTROSEGS	
22.7%	LYMPHS %	
	EOSINOPHILS	
	BASOPHILS	
	MONOCYTES	
328	PLATELETS	
	RBC	
	SED. RATE	
	PLATELET COUNT	
	RETICULOCYTE COUNT	
	CLOTTING TIME	
	BLEEDING TIME	
	PTT CONTROL	
	PTT PATIENT	
	CONTROL	
	PATIENT	
	% ACTIVITY	
	RATIO	
	SICKLING TEST	
	LE PREP	
1.4	L/H	

HEMATOLOGY 549-107

STANDARD FORM 546 (Rev. 7-78)
PRESCRIBED BY GSA/ICMR
FIRMR (41 CFR) 201-45.505

REMARKS

CBC

Enter in above space

REQUESTING PHYSICIAN'S SIGNATURE

Dr.

PATIENT IDENTIFICATION—TREATING FACILITY—WARD

REPORTED BY

(b)(6)-2

(b)(6)-2

MD DATE

ECH 24Oct03

05 10 HR

LAB. ID. NO.

HEMATOLOGY

URGENCY ☐ ROUTINE ☐ TODAY ☒ ☐ PRE-OP ☐ STAT

PATIENT STATUS ☒ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM

SPECIMEN SOURCE ☐ VEIN ☐ CAP ☐ OTHER (Specify)

SPECIMEN/LAB RPT. NO.

PATIENT'S MED. RECORD

Potus

(b)(6)-4

ICU

TEST(S)

SPECIMEN TAKEN

DATE 24Oct03 TIME 0442 A.M. P.M.

RESULTS	REQUESTED	(X)
112	GLUCOSE	
11	UREA N.	
0.7	CREATININE	X
	URIC ACID	
136	SODIUM	
4.0	POTASSIUM	
98	CHLORIDE	
22	CO_2	
NA	PHOSPHATE	X
8.1	CALCIUM	
	TOTAL PROTEIN	
	ALBUMIN	
	GLOBULIN	
	ALKALINE PHOSPHATASE	
	ACID PHOSPHATASE	
	SGOT	
	LDH	
	CPK	
	BILIRUBIN (TOTAL)	
	BILIRUBIN (DIRECT)	
	CHOLESTEROL	
	TRIGLYCERIDES	
	AMYLASE	
	LIPASE	
	PROFILE (Specify)	
NA	Mg	X

CHEMISTRY I 546-107

STANDARD 546 (Rev. 8-77)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505

REMARKS

MET 8 c̄ BMP

Enter in above space

REQUESTING PHYSICIAN'S SIGNATURE

Dr.

PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REPORTED BY

(b)(6)-2

(b)(6)-2

MD DATE

ECH 24Oct03

05 10 HR

LAB. ID. NO.

CHEM I

URGENCY ☐ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT ☒

PATIENT STATUS ☒ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM

SPECIMEN SOURCE ☒ BLOOD ☐ OTHER (Specify)

SPECIMEN/LAB. RPT. NO.

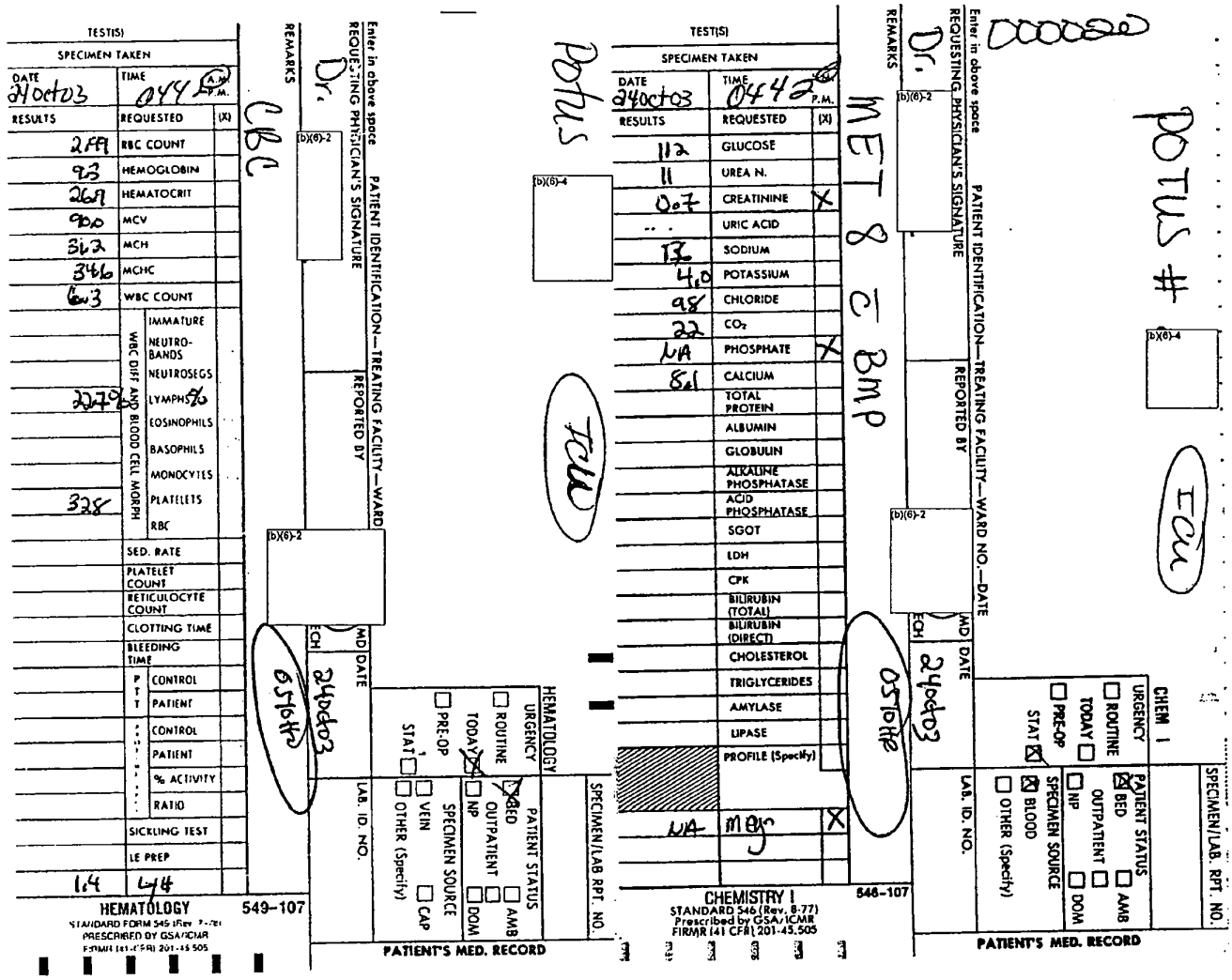
PATIENT'S MED. RECORD

000022

POTUS #

(b)(6)-4

ICU



MEDCOM - 2484

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI.	UNIT	DOB	RANK	SSN
Potus (b)(6)-4				

Physician:	Ward:	STAT / Routine	Specimen Date and Time:	Reported by:	Date and Time:
(b)(6)-2	ICU			(b)(6)-2 1745	25Oct03

Chemistry (I-STAT)					Chemistry (Piccolo Analyzer)				Hematology			
6+	7+	8+	Glu	Crea	Chem 12	MetLyte8	BMP	Liver	CBC	Malaria	H/H	

X	TEST	RESULT	REF. RANGE
	WBC		4.8-10.8 x10(3)/uL
	RBC		4.2-6.1 x10(6)/uL
	Hgb		12.0-18.0 g/dL
	Hct		35.0-60.0%
	MCV		80.0-99.0 fl
	MCH		27.0-31.0 pg
	MCHC		33.0-37.0 g/dL
	Plt		130-400 x10(3)/uL
	LY%		15.0-55.0%
	LY#		0.7-4.3 x10(3)/uL

Differential

Segs	38	Mono	9
Bands	19	Eos	5
Lymph	29	Baso	
Atyp Ly		Immature cells	
RBC Morph:			
Plt verify:			
Spun Crit			35-60%

Malaria Smear

Thin		No Plasmodium See
Thick		No Plasmodium See

Sed Rate

Sed Rate		1hr = 0-20 mm

Coagulation

PT		10-13 seconds
APTT		22.1-33.7 seconds
FDP		Negative
D-Dimer		Negative
Fibrinogen		200-400 mg/dL

Blood Bank

ABO/Rh		
T&C		
T&S		

REF. RANGE
3.3-5.5 g/dL
26-84 U/L
10-47 U/L
14-97 U/L
11-38 U/L
0.2-1.6 mg/dL
7-22 mg/dL
8.0-10.3 mg/dL
100-200 mg/dL
30-170 U/L
98-108 mmol/L
18-33 mmol/L
0.6-1.2 mg/dL
5-65 U/L
73-118 mg/dL
3.3-4.7 mmol/L
6.4-8.1 g/dL
128-145 mmol/L

...emistry

	Negative
	Negative
	Negative
	Negative
	Negative
	< 4.3 ng/mL
	< 0.19 ng/mL
	< 107 ng/mL

...iology

FecLeuk		Negative
Gram Stain		
WetPrep		Negative
KOH		No Fungal Elements
OccBld		Negative
O&P		No Ova/Parasite

HCG

Urine		Negative
Serum		Negative

Nitrite		Negative
Leuko		Negative

Urine Microscopic

WBC		Epi
RBC		Mucus
Bacteria		Yeast
Casts:		Spermatozoa
Crystals:		Amorph Sed
Other:		
Other:		

TEST(S)
SPECIMEN TAKEN

DATE	TIME	A.M. P.M.
25 Oct 03	1520	

RESULTS	REQUESTED	(X)
2.90	RBC COUNT	
8.8	HEMOGLOBIN	
26.0	HEMATOCRIT	
89.5	MCV	
30.5	MCH	
34.1	MCHC	
7.9	WBC COUNT	
	WBC DIFF AND BLOOD CELL MORPH: IMMATURE	
	NEUTRO-BANDS	
	NEUTROSEGS	
	LYMPHS	
	EOSINOPHILS	
	BASOPHILS	
	MONOCYTES	
	PLATELETS	
	RBC	
	SED. RATE	
394	PLATELET COUNT	
	RETICULOCYTE COUNT	
	CLOTTING TIME	
	BLEEDING TIME	
	PTT CONTROL	
	PTT PATIENT	
	PRT CONTROL	
	PRT PATIENT	
	% ACTIVITY	
	RATIO	
	SICKLING TEST	
17.0	LE PREP	
1.3	Ly#	

REMARKS

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE

REPORTED BY

TECH

MD

DATE

HEMATOLOGY URGENCY: ☐ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT ☒

LAB. ID. NO.

SPECIMEN SOURCE: ☐ VEIN ☐ CAP ☐ OTHER (Specify)

PATIENT STATUS: ☐ BED ☐ OUTPATIENT ☐ NP ☐ DOM ☐ AMB

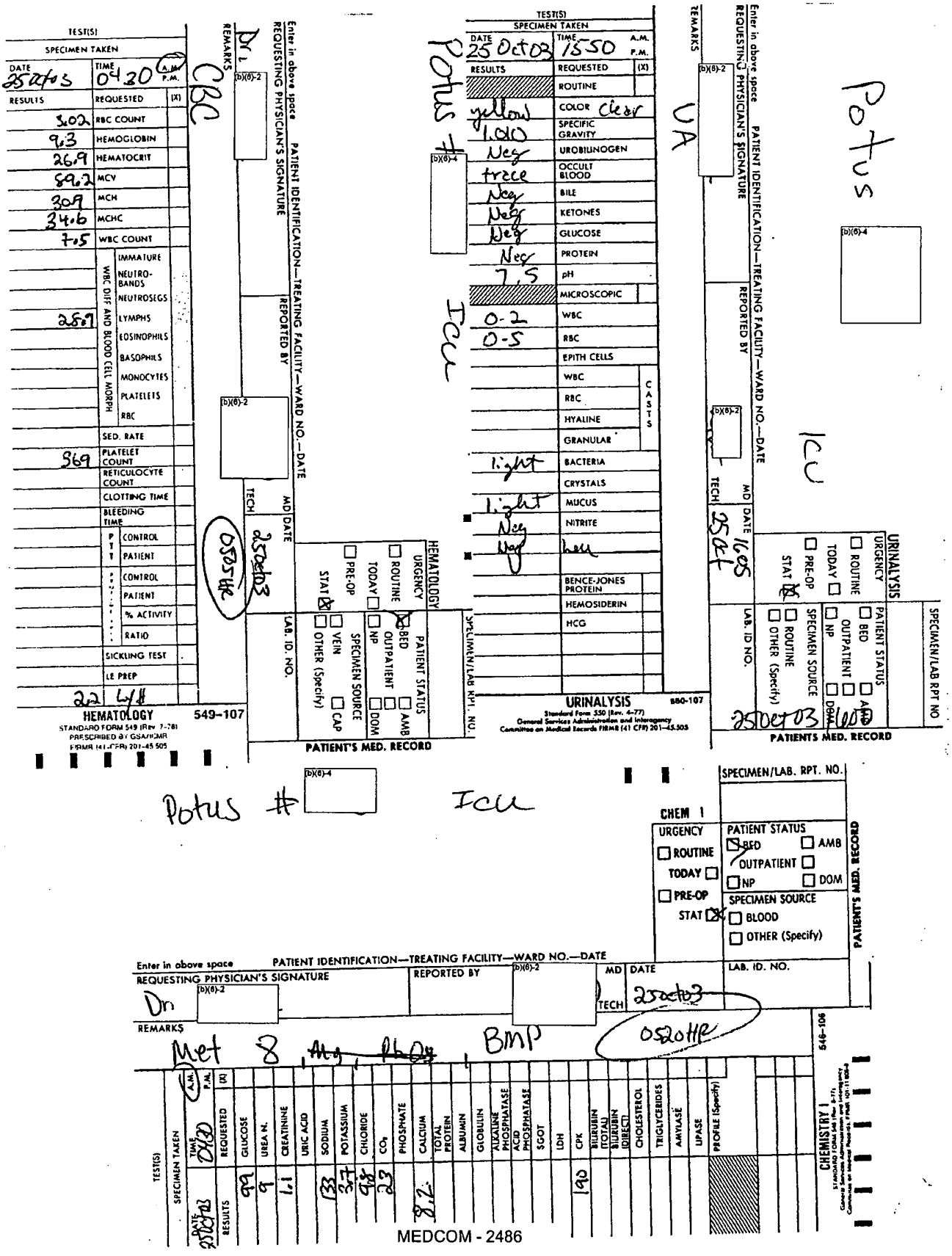
SPECIMEN/LAB RPT. NO.

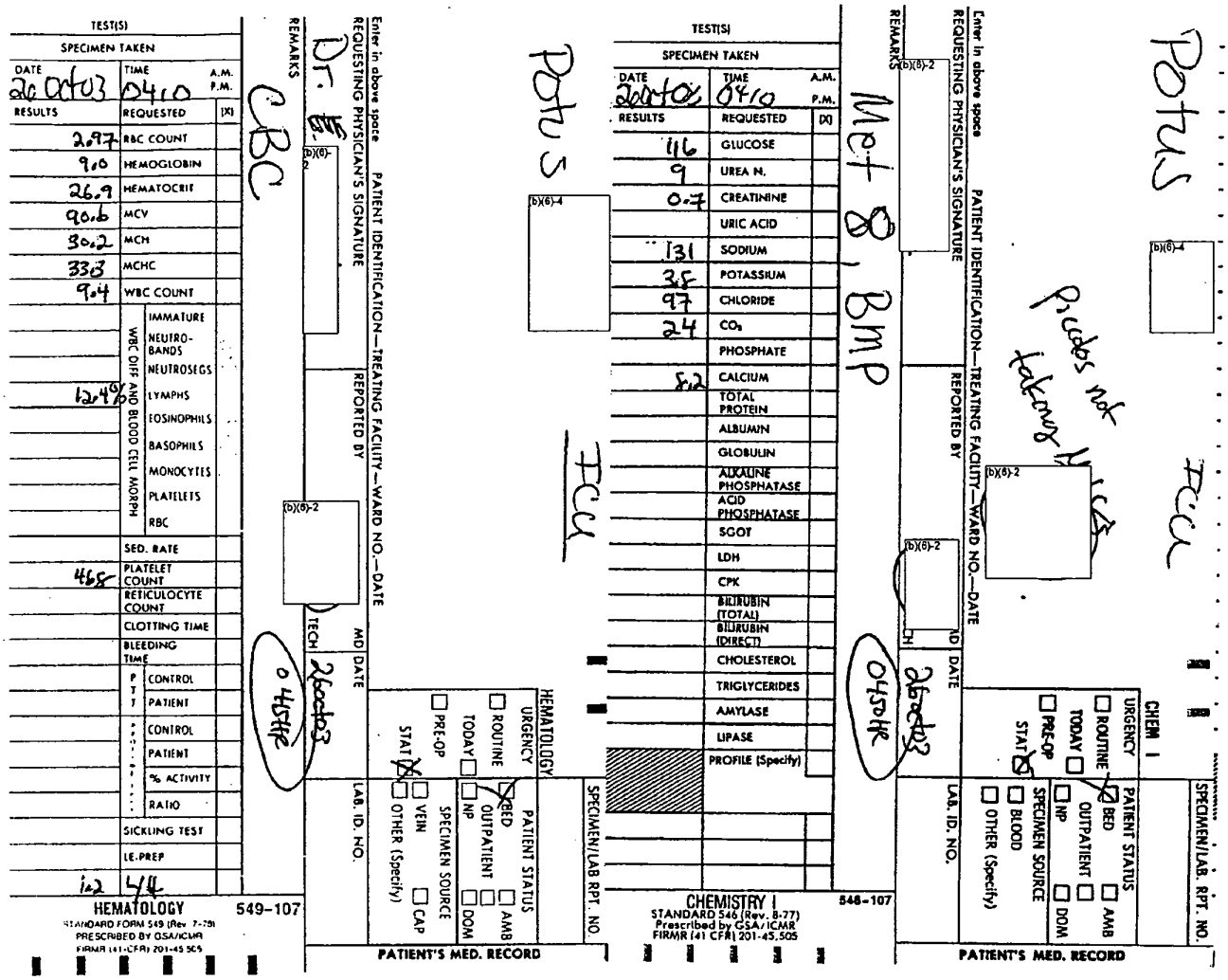
HEMATOLOGY 549-107
STANDARD FORM 549 (Rev 7-78)
PRESCRIBED BY GSA/ICMR
FIRMR (41-CFR) 201-45 505

CBC 25Oct03 1545

PHYSICIAN COPY

MEDCOM - 2485

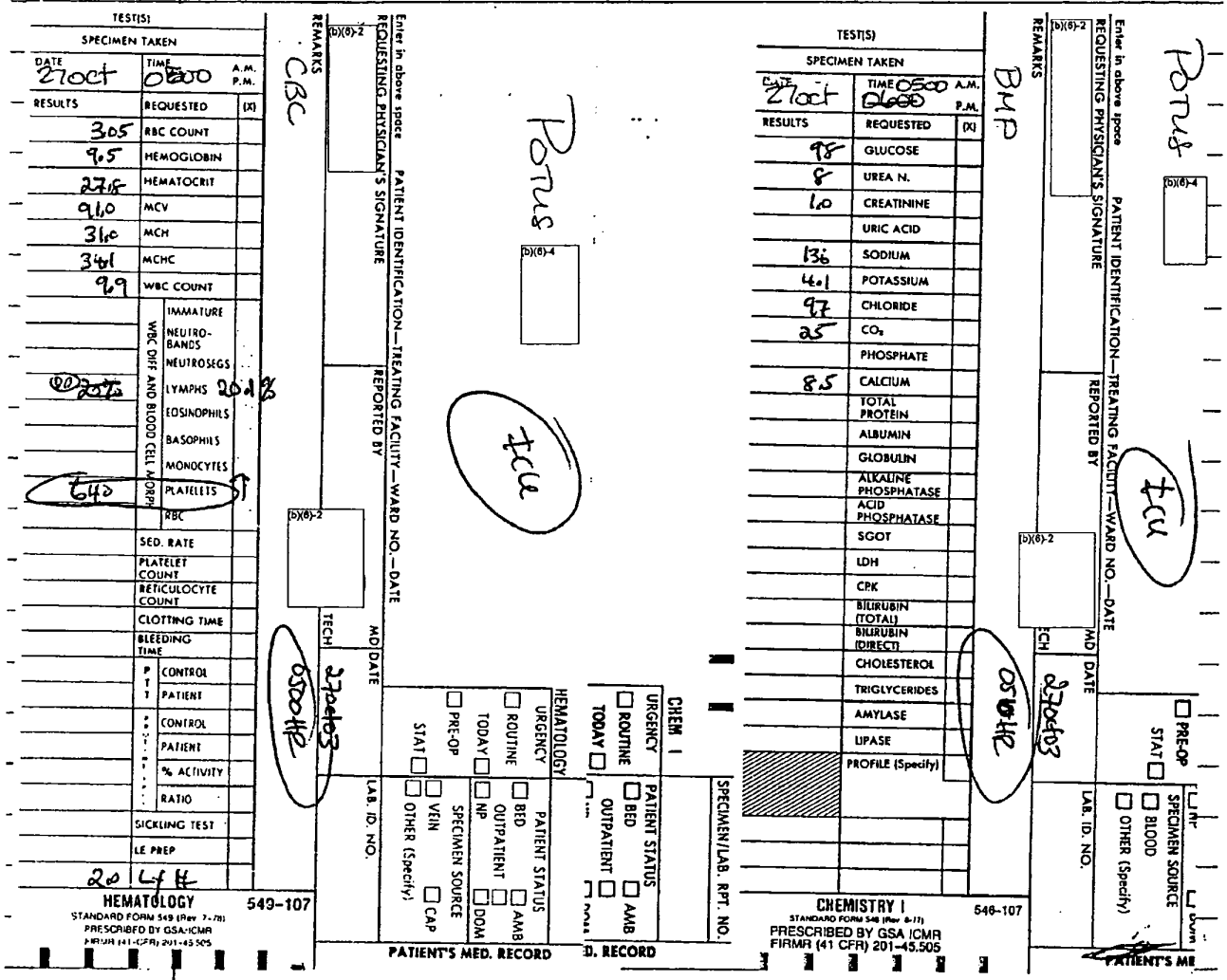

HEMATOLOGY
549-107
PATIENT'S MED. RECORD
URINALYSIS
PATIENTS MED. RECORD
Potus #
Icu
CHEM 1
PATIENT'S MED. RECORD
MEDCOM - 2486


HEMATOLOGY
549-107
CHEMISTRY I
548-107
CHEM I
PATIENT'S MED. RECORD
CBC
Pt's does not take any meds
Pt's
FCC
Met 8, BMP
FCC
Pt's
REMARKS
REQUESTING PHYSICIAN'S SIGNATURE
PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REPORTED BY
TECH
MD
DATE
LAB. ID. NO.
SPECIMEN/LAB RPT. NO.
HEMATOLOGY
CHEMISTRY
URGENCY
ROUTINE
TODAY
PRE-OP
STAT
PATIENT STATUS
BED
OUTPATIENT
NP
AMB
DOM
SPECIMEN SOURCE
BLOOD
VEIN
CAP
OTHER (Specify)
TEST(S)
SPECIMEN TAKEN
DATE
TIME
A.M.
P.M.
RESULTS
REQUESTED
RBC COUNT
HEMOGLOBIN
HEMATOCRIT
MCV
MCH
MCHC
WBC COUNT
WBC DIFF AND BLOOD CELL MORPH
IMMATURE
NEUTRO-BANDS
NEUTROSEGS
LYMPHS
EOSINOPHILS
BASOPHILS
MONOCYTES
PLATELETS
RBC
SED. RATE
PLATELET COUNT
RETICULOCYTE COUNT
CLOTTING TIME
BLEEDING TIME
PTT CONTROL
PTT PATIENT
% ACTIVITY
RATIO
SICKLING TEST
LE PREP
GLUCOSE
UREA N.
CREATININE
URIC ACID
SODIUM
POTASSIUM
CHLORIDE
CO2
PHOSPHATE
CALCIUM
TOTAL PROTEIN
ALBUMIN
GLOBULIN
ALKALINE PHOSPHATASE
ACID PHOSPHATASE
SGOT
LDH
CPK
BILIRUBIN (TOTAL)
BILIRUBIN (DIRECT)
CHOLESTEROL
TRIGLYCERIDES
AMYLASE
LIPASE
PROFILE (Specify)
STANDARD FORM 549 (Rev. 7-79)
PRESCRIBED BY GSA/ICMR
FIRMR (41 CFR) 201-45.505
STANDARD 546 (Rev. 8-77)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — **PROGRESS NOTES**

DATE | NOTES



RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		
PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)		REGISTER NO.	WARD NO.	

POTUS (b)(6)-4

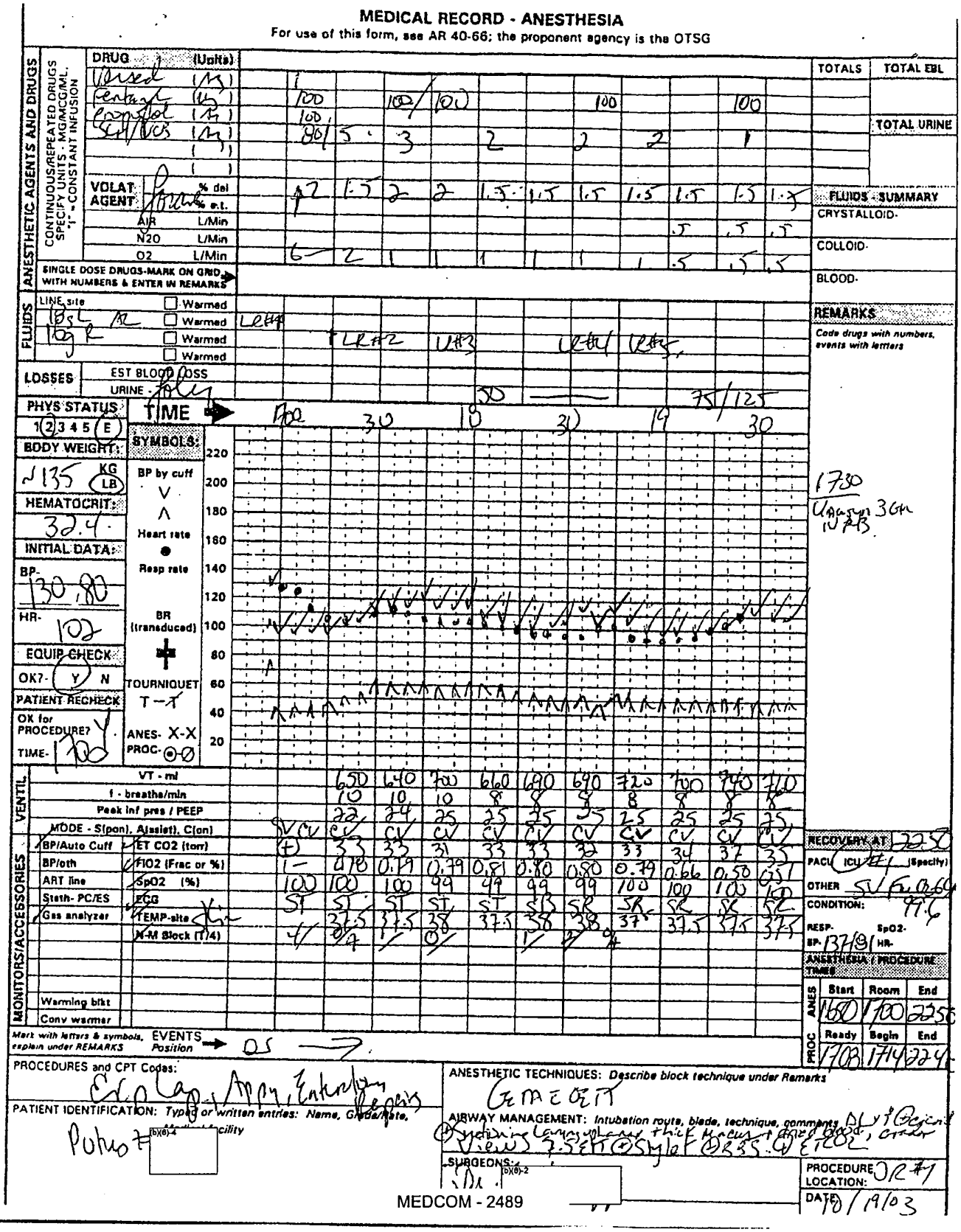
PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

MEDCOM - 2488

MEDICAL RECORD - ANESTHESIA

For use of this form, see AR 40-66; the proponent agency is the OTSG



MEDCOM - 2489

PREANESTHETIC SUMMARY

OPERATION PROPOSED	AGE	WEIGHT (LBS.)	SPECIAL INFORMATION
Explap-	~20	~135	

PHYSICAL STATUS: 1 (2) 3 4 5 6 7 E

URINALYSIS	HEMATOLOGY	BLOOD CHEMISTRY
NORMAL ..... ABNORMAL AND WHY?	HGB ..... RBC ..... HCT ..... OTHER 11.4 / 32.4	

RESPIRATORY SYSTEM (X-RAY, ASTHMA, OTHER PATHOLOGY)	CIRCULATORY SYSTEM BP ..... PULSE ..... ECG (IF PERTINENT)	CENTRAL NERVOUS SYSTEM (CEREBROVASCULAR, POLIO, NEUROLOGICAL)	OTHER SYSTEMS (ALLERGIES)
Unknown	127/77 109 101.3 Unknown	Unknown	Unknown Unknown

PREVIOUS ANESTHETICS AND COMPLICATIONS	PRESENT DRUG THERAPY; E.G., STEROIDS, TRANQUILIZERS
Unknown.	Unknown.

PREOPERATIVE DIAGNOSIS	PREMEDICATION

b)(6)-2 [redacted]

DATE 10/19/03

POSTANESTHETIC VISITS

RECORD ALL PERTINENT COMPLICATIONS

20 Oct 03/0745 Chart review completed. Transfused 2U PRBCs ≈ 0045 2° ↑HR ~140's. H&H prior 11.3/34.4. No apparent anesthetic sequela. VSS remain stable this AM. — [redacted] b)(6)-2 [redacted] CPT, [illegible]

b)(6)-4 [redacted]

#

*U.S. Government Printing Office: 1994 — 300-892/10029

MEDCOM - 2490

MEDICAL RECORD - ANESTHE

ıse of this form, see AR 40-66; the proponent a , the OTSG

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML, "1" = CONSTANT INFUSION

DRUG	(Units)
VOS	(MG) (D)
Morphine	(MG) ( ) ( ) ( ) ( )
VOLAT AGENT	% del % e.t.
AIR	L/Min
N2O	L/Min
O2	L/Min

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS

FLUIDS

LINE site	
18g L AC	☐ Warmed
16g R	☐ Warmed ☐ Warmed ☐ Warmed

LOSSES — EST BLOOD LOSS; URINE - 125/250

PHYS STATUS 1 (2) 3 4 5 (E)

BODY WEIGHT: N135 KG (LB)

HEMATOCRIT: 32.4

INITIAL DATA:

BP- 130/80

HR- 102

EQUIP CHECK

OK? Y N

PATENT

OK for PROCEDURE?

TIME-

SYMBOLS

BP by cuff V ^

Heart rate ●

Resp rate

BR (transduced)

TOURNIQUET T—T

ANES- X-X

PROC- ⊙-Ø

TIME 1145 20 30 21

220 200 180 160 140 120 100 80 60 40 20

VENTIL

VT - ml	770 730 830
f - breaths/min	8 8 8
Peak inf pres / PEEP	25/5 25/5 26/5
MODE - S(pon), A(assist), C(on)	CV CV CV

MONITORS/ACCESSORIES

✓	BP/Auto Cuff	ET CO2 (torr)	34	35	29	40 45
	BP/oth	FIO2 (Frac or %)	.51	.52	.71	.80 .7
	ART line	SpO2 (%)	100	100	100	100 100
	Steth- PC/ES	ECG	ST	ST	ST	
✓	Gas analyzer	TEMP-site Skr	36.5	37	37	
		N-M Block (T/4)				4/4
	Warming blkt					
	Conv warmer					

Mark with letters & symbols, explain under REMARKS — EVENTS Position → 0S →

TOTALS	TOTAL EBL
	200
	TOTAL URINE
	250

FLUIDS - SUMMARY

CRYSTALLOID- 3000

COLLOID-

BLOOD-

REMARKS

Code drugs with numbers, events with letters

2025 Neosynephrine 3cc Potassium O.Cm

2248 5U/cc

(+) Heat/Cold all extremities

(+) Head Lift x 5 sec

Extubated @ Suctioning oral pharynx.

TOICw SV.

RECOVERY AT

PACU ICU _____ (Specify)

OTHER _____

CONDITION:

RESP- SpO2-

BP- HR-

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES			
PROC	Ready	Begin	End

PROCEDURES and CPT Codes: Explap

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*

Pchus [b)(6)-4]

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*

[b)(6)-2]

[b)(6)-2]

PROCEDUR E

DATE 18/19/23

PAGE 2 OF 2

DA FORM 7389, FEB 1998 — MEDCOM - 2491 — COPY 2 - ANESTHESIA PROVIDER — USAPA V1.00

518-124

NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of _____ units)*
- [ ] CRYOPRECIPITATE *(Pool of _____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* _____

VOLUME REQUESTED *(If applicable)*: 1 Unit ML

REMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*

- [ ] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED: 19 OCT 03

DATE AND HOUR REQUIRED: 19 OCT 03 2350

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)*: (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE: S/p Schrapnel wounds s/p Ex lap

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER: (b)(6)-2 Error ? Incorrect spec, 91w2 42

DATE VERIFIED: (illegible)

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.: (b)(6)-4

TRANSFUSION NO.

PATIENT NO.

DONOR: ABO O; Rh NEG

RECIPIENT: ABO O; Rh POS

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
not performed	Comp

PREVIOUS RECORD CHECK:

- [X] RECORD
- [ ] NO RECORD

(b)(6)-2

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE: 20 Oct 03

REMARKS: Due to the critical condition of the below named patient the requesting physician named above is requesting immediate release of this blood product w/out complete testing and is accepting full responsibility of the administration of the transfusion.

SECTION III – RECORD OF TRANSFUSION

(b)(6)-2

AT (Hour): 0030

ON (Date): 20 October 2003

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

(b)(6)-2 Cpt AN

(b)(6)-2 spec, 91w2

PRE-TRANSFUSION

TEMP. 98.8 | PULSE 120 | BP 147/72

DATE OF TRANSFUSION: 20 OCT 03

TIME STARTED: 0045

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last name; Rank; hospital or medical facility)

Name/Rank: Potus

SSN #:

DOB:

Unit:

(b)(6)-4

POST-TRANSFUSION DATA

AMOUNT GIVEN: 1 Unit ML

TIME/DATE COMPLETED/INTERRUPTED: 0145 20 Oct 03

REACTION	TEMPERATURE	PULSE	BLOOD PRESSURE
[X] NONE [ ] SUSPECTED	99.1	120	138/42

If reaction is suspected—IMMEDIATELY:

1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION OF REACTION

- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER *(Specify)*

OTHER DIFFICULTIES *(Equipment, clots, etc.)*

- [X] NO
- [ ] YES *(Specify)*

(b)(6)-2 Cpt AN

Male

WARD: ICU

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 2492

Medical Record Copy

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

Potus # (b)(6)-4

DATE OF ORDER 10/19/03 TIME OF ORDER 1000 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) Admit to ICU S/p Scrapnel Wounds ? LOC (b)(6)-2

(2) Condition stable

(3) Vital q 2°

(4) Neuro q 1°

(5) Activity bed rest

NURSING UNIT | ROOM NO. | BED NO.

noted 9 WM6 (b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER

(6) IV; D5 1/2 NS @ 100 cc/hr HOURS

(7) Ancy 1 gram IVPB q 8°

(8) NOB @ 30 degrees

(9) Diet NPO

(10) CBC, BMP in Am

(b)(6)-2

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 10/19/03 TIME OF ORDER 1445 HOURS

(1) CBC @ 1500

(b)(6)-2

1530 [illegible]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 2493

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

Potus [redacted]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 19 Oct 03 TIME OF ORDER: 2100 ~~HOURS~~

LIST TIME ORDER NOTED AND SIGN

1. Admit to ICU
2. Dx: s/p Repair of Small & Lg Bowel Injury
3. Vitals: q 1°, I&O's
5. Act: Up to Chair q Shift beginning 20 Oct
6. Diet: NPO
7. O2 - Wean to Maint O2 Sat > 93%

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: TIME OF ORDER: _____ HOURS

8. Foley to Gravity
9. NG to Low Int Suction
10. IV: LR at 150cc/hr
11. Unasyn 3.0gm IVPB q 6°
12. Zantac 50mg IVPB q 8°
13. Morphine 2-8mg IVP q 1-2° prn
14. Phenergan 12.5mg IVP q 4° prn Nausea
15. If Able - Incentive Spir q 1° WA

noted 19Oct 214[redacted]

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: TIME OF ORDER: _____ HOURS

16. CBC, Chem-7 q am [redacted]

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 19 Oct 03 TIME OF ORDER: 2300 HOURS

1. Bolus i Liter LR Done [redacted]

noted 19Oct03 2305 [redacted]

DA FORM 1 APR 79 4256 REPLACE MEDCOM - 2494 MAY BE USED.

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

Potus [b)(6)-4]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
19 Oct 03	2350 HOURS	
(1) CBC NOW Done		
(2) Transfuse 2 units PRBC each over 1 hr		noted 20 Oct 03 0038

[b)(6)-2]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER	TIME OF ORDER
20 Oct 03	0920 HOURS
(1) Nutrition Consult	

[b)(6)-2]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER	TIME OF ORDER
20 Oct 03	1045 HOURS
(1) Met Lytes / BMP	
(2) Change IV to D5 1/2 NS c 20 meq KCl/l at 125 cc/hr	

noted ictm 10/20/03 1137

[b)(6)-2]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER	TIME OF ORDER
20 Oct 03	1241 HOURS
(1) Change A.M. Labs to CBC & BMP	
(2) Change IV to D5 NS c 20 meq KCl/l at 125cc/hr	
(3) ↓ Vitals to q 4°	
(4) Tylenol 650 mg PR q 6° prn Temp > 101°	

noted 5-K 10/20/03 1537

[b)(6)-2]

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 2495

CLINICAL RECORD - DOCTOR'S ORDERS
For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

POTUS # (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
20OCT03	1700 HOURS	

1. Tube feedings c osmalite HN 20cc/h, advance by 10cc/h q 6h as tolerated until target rate of 80cc/h when bowel fx
2. daily Net-6 Kred c Mg+ # PO4 (qAM)

(b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER
20OCT03	1740 HOURS

1. Ensure can be substituted if osmalite HN not available

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER
20 Oct 03	2103 HOURS

1. Hold Tube feeds for now
2. Cont IVF to LIS

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER
21OCT03	1000 HOURS

1. ice chips as tolerated (80, 9 shift)
2. ↓ IVrate to 75cc/h D5 NS c 20meq
3. encourage ambulation

(b)(6)-2

NURSING UNIT | RO | BED NO.

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 2496

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

POTUS# [redacted]

21 Oct 03 2018 [redacted] done 2030

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 21 Oct 03 — TIME OF ORDER: 2017 HOURS

LIST TIME ORDER NOTED AND SIGN

1. PCXR

[redacted]

PATIENT IDENTIFICATION

NOTED 1 Oct 2003 1025

NURSING UNIT	ROOM NO.	BED NO.
	[redacted]	

DATE OF ORDER: 22 Oct 03 — TIME OF ORDER: 1024 HOURS

1. N-T Suction q 4°
2. ↑ Maint IV to 100cc/hr.
3. UA to Lab Done
4. d/c Unasyn
5. Primaxin 500mg IV q 6°

[redacted]

PATIENT IDENTIFICATION

NOTED 22 Oct 03 1250

NURSING UNIT	ROOM NO.	BED NO.
		[redacted]

DATE OF ORDER: 22 Oct 03 — TIME OF ORDER: 1219 HOURS

1. d/c NG - done
2. d/c foley done 1200hrs.
3. Due to Void by 2000

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 22 Oct 03 — TIME OF ORDER: 2000 HOURS

1. clear liquids as tolerated

[redacted]

Noted 22 Oct 03 2005

[redacted]

24° Chart ✓ [redacted] 23 Oct 0001

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 2497

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

Potus # [redacted] (b)(6)-4

DATE OF ORDER: 22 Oct 03 — TIME OF ORDER: 2051 HOURS

① Mucomyst/Albuterol Nebs q 4°

[redacted] (b)(6)-2

LIST TIME ORDER NOTED AND SIGN

noted 22 Oct 03 2100 [redacted] (b)(6)-2

NURSING UNIT: ICU — ROOM NO.: 24° Chart ✓ — BED NO.: Ampere — 22 Oct 03 @ 2355

PATIENT IDENTIFICATION

POTUS # [redacted] (b)(6)-4

DATE OF ORDER: 23 Oct 03 — TIME OF ORDER: 0951 HOURS

① Dolcolax Supp PR Now and Repeat in 3°

② d/c Tylenol Suppository

③ Tylenol 650mg po q 4° prn Temp > 101°

④ NPO x̄ Meds.

[redacted] (b)(6)-2

noted (b)(6)-2 22 Oct

NURSING UNIT: ICU — ROOM NO. — BED NO.

PATIENT IDENTIFICATION

POTUS # [redacted] (b)(6)-4

DATE OF ORDER: 24 Oct 03 — TIME OF ORDER: 0900 HOURS

① clear liquid diet as tolerated

② ambulation AT LEAST Q.I.D.

[redacted] (b)(6)-2

noted 24 Oct 03

NURSING UNIT: ICU 24° — ROOM NO.: Chart ✓ — BED NO.: [redacted] (b)(6)-2 — 24 Oct 03 @ 2300

PATIENT IDENTIFICATION

POTUS # [redacted] (b)(6)-4

DATE OF ORDER — TIME OF ORDER — HOURS

NURSING UNIT: ICU — ROOM NO. — BED NO.

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 2498

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

Potus # (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	24 Oct 03	1418 HOURS	
1	Decrease Albuterol Nebs to q Shift		wtd 24Oct03 1420
2	↓ Maint IV to 50cc/hr		

(b)(6)-2

PATIENT IDENTIFICATION

Potus # (b)(6)-4

24Oct 1749 MS

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER
	24Oct03	1745 HOURS
1	Percocet 1-2 po q 4-6 prn	

(b)(6)-2

PATIENT IDENTIFICATION

Potus # (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

24° Chart ✓ Ambulate

	DATE OF ORDER	TIME OF ORDER
	24 Oct 03	2012 HOURS
1	Change Percocet to T po q 4° prn	
2	d/c Morphine	
3	CXR PA & Lat	

(b)(6)-2

24 Oct 03 @ 2300

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER
	24 Oct 03	2330 HOURS
1	d/c NT Suction	

(b)(6)-2

24Oct03 @2330

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 2499

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

Potus # [redacted]

25 Oct 03 1410 mj

DATE OF ORDER: 25 Oct 03 — TIME OF ORDER: 0945 HOURS — LIST TIME ORDER NOTED AND SIGN

1. ↑ diet to soft
2. ↑ diet as tolerated for dinner to regular
3. d/c Primaxin
4. Levaquin 500mg po bid

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

Potus # [redacted]

25 Oct 03 mj

DATE OF ORDER: 25 Oct 03 — TIME OF ORDER: 1516 HOURS

1. CBC, UA Stat
2. d/c Zantac
3. d/c Levaquin

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

Potus # [redacted]

25 Oct 03 1640 mj

DATE OF ORDER: 25 Oct 03 — TIME OF ORDER: 1634 HOURS

1. Levaquin 500mg po bid

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

24° chart ✓ complete cl [redacted] cp/m 25 Oct 03 @ 2330

PATIENT IDENTIFICATION

Potus # [redacted]

DATE OF ORDER: 26 Oct 03 — TIME OF ORDER: 1049 HOURS

1. Hep-Loch IV
2. Zantac 150mg po bid
3. Dulcolax Supp PR ✓ X 1 this a.m.
4. PA + Lat CXR

[redacted]

NURSING UNIT | ROOM | NO.

DA FORM 1 APR 79 4256 EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 2500

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION: Potus (b)(6)-4

DATE OF ORDER: 26 Oct 03 — TIME OF ORDER: 1330 HOURS — LIST TIME ORDER NOTED AND SIGN

① Colace 100mg po bid (b)(6)-2

NURSING UNIT: clast ✓ — ROOM NO.: 27oct023 (b)(6)-2

Noted by [illegible] 26 Oct 03 @ 1330

PATIENT IDENTIFICATION: Potus (b)(6)-4

DATE OF ORDER: 27 Oct 03 — TIME OF ORDER: 0930 HOURS

① Ambien 10mg gls pm insomnia
② ensure, 1 container b/w meals at least 1x/day (b)(6)-2

Noted 10/27/03 0930

NURSING UNIT: — ROOM NO.:

PATIENT IDENTIFICATION: Potus (b)(6)-4

DATE OF ORDER: 27 Oct 03 — TIME OF ORDER: 1030 HOURS

① d/c Daily CBC, RMP
② d/c Hip-lock (b)(6)-2

NURSING UNIT: — ROOM NO.: — BED NO.:

PATIENT IDENTIFICATION: Potus (b)(6)-4

DATE OF ORDER: 27 Oct 03 — TIME OF ORDER: 1200 HOURS

done 1230 (b)(6)-2

① d/c to MP's Custody (b)(6)-2

NURSING UNIT: — ROOM NO.: — BED NO.:

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 2501

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

MEDCOM Fr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 19 20 21 22
19Oct	(b)(6)-2	VS: q, 2°	D E N	(b)(6)-2
19Oct		Neuro ✓ q 1°	D E N	(b)(6)-2
19Oct		Activity: Bed Rest	D E N	(b)(6)-2
19Oct		HOB @ 30 degrees	D E N	(b)(6)-2
19Oct		Diet: NPO	D E N	(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: s/p scrapnel wounds

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION:

POTUS # (b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

MEDCOM - 2502

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON MEDICATION)			Mo ____ Yr ____	
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
19Oct	(b)(6)-2	Admit to ICU; S/P scrapral wounds; Dr Eastman	19 Oct	now	1050	(b)(6)-2
19Oct		Condition: Stable	19 Oct	now	1650	
19Oct		CBC, BMP in AM	20 Oct	0500		
19Oct		CBC @1500	19Oct	1600	(b)(6)-2	

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED

☆ U.S. GPO:1997-418-258/55257

MEDCOM - 2503

MAR

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. OCT Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 19	20	21	22
19 Oct	(b)(6)-2	IV D5½NS @ 100cc/hr	D	(b)(6)-2			
			E				
			N				
19 Oct	(b)(6)-2	Ancef 1G IVPB 98	03				D/C p̄ Surgery
			11	(b)(6)-2			
			19				

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P scrapnal wounds

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION:

POTUS # (b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

MEDCOM - 2504

MAR

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo. OCT Yr. 03

ATTEMPT BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 19 20 21 22 23 24 25 26 27
19OCT03	[redacted]	O_2 - wean to maintain	D	✓ [redacted]
		Sats >93%	E	✓
			N	[redacted]
19OCT03	[redacted]	IV - LR @ 150cc/hr	D	✓ [redacted] Discd 10/20/03
			E	✓
			N	[redacted]
19OCT03	[redacted]	Unasyn 3.0gm IVPB	05	✓ [redacted] Discd 10/22/03
		q6°	11	✓
			17	[redacted]
			23	[redacted]
19OCT03	[redacted]	Zantac 50mg IVPB	08	✓ [redacted] Stopped 25 Oct 03
		q8°	16	✓
			24	[redacted]
20 OCT03	[redacted]	D5½NS ē 20meq KCl	D	✓ Discd 10/21/03
		@125cc/h	E	✓
			N	✓
20OCT03	[redacted]	D5NSē 20meq/KCl	D	✓ [redacted] Discd 10/22/03
		@ 125cc/h	E	✓
21OCT	[redacted]	D5NSē 20KCl @ 75cc/h	N	✓
20 Oct 03	[redacted]	Tube Feeding ē Osmolite HN	D	✓ [redacted] Discd 10/20/03
		20cc/h ↑ by 10cc/h q 6° as	E	✓
		tolerated until target rate	N	✓
		of 80cc/h When bowel		
		Sound returns. May sub		
		ē Ensure if no Osmolite		
20OCT03	[redacted]	Hold Tube Feeds for now		[redacted]

ALLERGIES: ☐ YES ☐ NO — NKA

PRIMARY DIAGNOSIS: S/P Repair of small + lg bowel injury

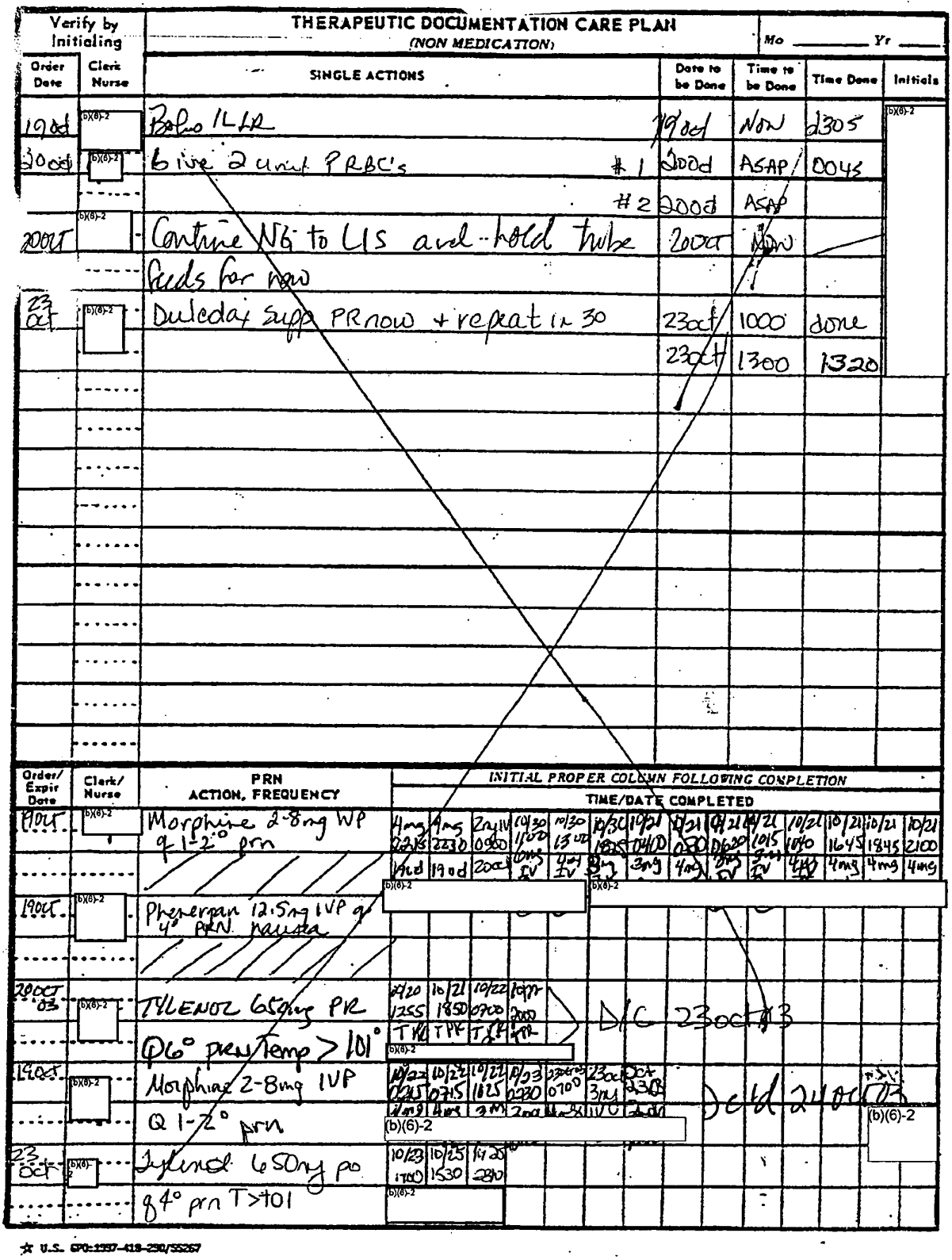
ADDITIONAL PAGES IN USE: ☒ YES ☐ NO — PAGE NO: 3

PATIENT IDENTIFICATION: Poles [redacted]

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

MEDCOM - 2505



Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON MEDICATION)				Mo _____ Yr _____
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
19 Oct	(b)(6)-2	Bolus ILLR	19 Oct	Now	2305	(b)(6)-2
20 Oct	(b)(6)-2	Give 2 unit PRBC's #1	20 Oct	ASAP	0045	
		#2	20 Oct	ASAP		
20 Oct	(b)(6)-2	Continue NG to LIS and hold tube feeds for now	20 Oct	Now		
23 Oct	(b)(6)-2	Duledax supp PR now + repeat in 30	23 Oct	1000	done	
			23 Oct	1300	1320	

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED												
19 Oct	(b)(6)-2	Morphine 2-8mg WP q 1-2° prn	4mg 2215 19 Oct	4mg 2230 19 Oct	2mg IV 0900 20 Oct	10/30 1100 10mg IV	10/30 1300 4mg IV	10/30 1825 3mg	10/21 0400 3mg	10/21 0800 4mg	10/21 0620 3mg IV	10/21 1015 3mg IV	10/21 1040 4mg	10/21 1645 4mg	10/21 1845 4mg	10/21 2100 4mg
19 Oct	(b)(6)-2	Phenergan 12.5mg IVP q 4° PRN nausea	(b)(6)-2					(b)(6)-2							
20 Oct 03	(b)(6)-2	TYLENOL 650mg PR Q6° prn Temp > 101°	10/20 1255 TPR	10/21 1850 TPR	10/22 0700 TPR	10/22 2000 TPR		D/C 23 Oct 03							
19 Oct	(b)(6)-2	Morphine 2-8mg IVP Q 1-2° prn	10/22 0215 4mg	10/22 0715 4mg	10/22 1825 3mg	10/23 0230 2mg	23 Oct 0700 4mg	23 Oct 3mg IV	Oct 2305 2mg						
23 Oct	(b)(6)-2	Tylenol 650mg po q 4° prn T>101	10/23 1700	10/25 1530	10/25 2310										

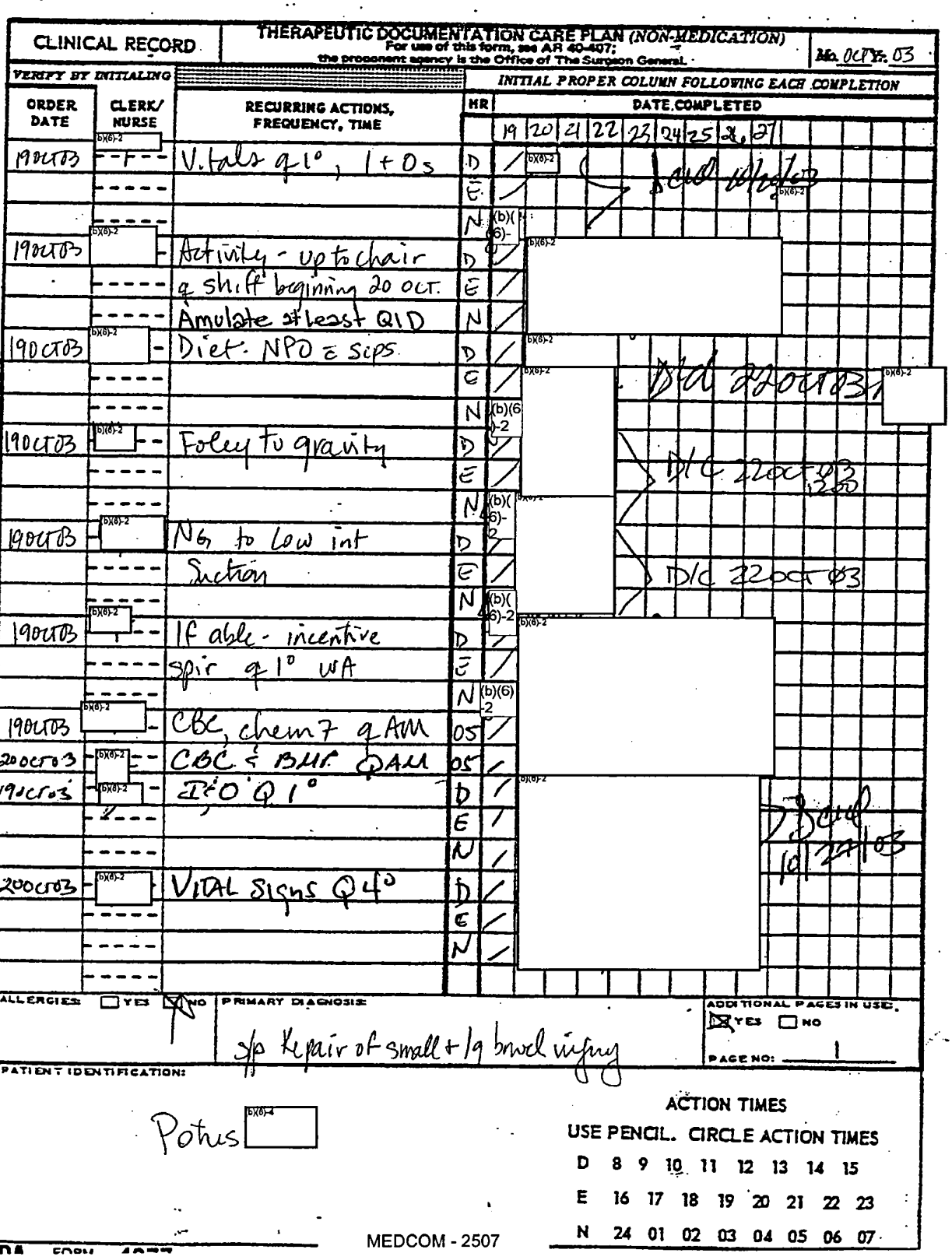
(b)(6)-2 (b)(6)-2 (b)(6)-2 (b)(6)-2 (b)(6)-2

D/C 23 Oct 03

D/C'd 24 Oct 03

☆ U.S. GPO:1997-418-290/55267

MEDCOM - 2506



CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. OCT Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 19	20	21	22	23	24	25	26	27
19OCT03	b(6)-2	Vitals q1°, 1+0s	D	/	b(6)-2							
			E	/								
			N	(b)(6)-2								
19OCT03	b(6)-2	Activity - up to chair	D	/	b(6)-2							
		q shift beginning 20 OCT.	E	/								
		Amulate at least QID	N	/								
19OCT03	b(6)-2	Diet: NPO c̄ sips	D	/	b(6)-2							
			E	/	b(6)-2							
			N	(b)(6)-2								
19OCT03	b(6)-2	Foley to gravity	D	/								
			E	/								
			N	(b)(6)-2	b(6)-2							
19OCT03	b(6)-2	NG to low int	D	/								
		Suction	E	/								
			N	(b)(6)-2								
19OCT03	b(6)-2	If able - incentive	D	/	b(6)-2							
		spir q1° WA	E	/								
			N	(b)(6)-2								
19OCT03	b(6)-2	CBC, chem 7 q AM	05	/								
20OCT03	b(6)-2	CBC & BMP QAM	05	/								
19OCT03	b(6)-2	I&O Q1°	D	/	b(6)-2							
			E	/								
			N	/								
20OCT03	b(6)-2	VITAL Signs Q4°	D	/								
			E	/								
			N	/								

D/C 10/20/03

D/C 22OCT03 b(6)-2

D/C 22OCT03 1200

D/C 22OCT03

D/C 10/27/03

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: s/p Repair of small + lg bowel injury

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO: 1

PATIENT IDENTIFICATION:

Potus b(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

MEDCOM - 2507

DA FORM 4077

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON MEDICATION)				Mo OCT Yr 03
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
19 OCT 03	(b)(6)-2	Admit to ICU	Noted			
20 OCT 03		MET LYTES / BMP	10/20	now	1050	(b)(6)-2
21 Oct	(b)(6)-2	Portable CXR	21 Oct	now	2030	
22 Oct		Due to void by 2000 hrs	22 Oct	2000		
24 OCT 03	(b)(6)-2	CXR Pa/lat	24 OCT	Now	2030	
25 Oct	(b)(6)-2	CBC, UA STAT	25 Oct	done	1545	
26 OCT		PA & LAT CXR	10/26	now	1105	

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED

☆ U.S. GPO:1997-418-290/55267

MEDCOM - 2508

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo. 10 Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 21	22	23	24	25	26	27
20Oct03	(b)(6)-2	Daily Met-6 panel c̄	05	(b)(6)-2						
		Mg i PO4 q AM								
10/21/03	(b)(6)-2	ICE CHIPS AS TOLERATED	D	(b)(6)-2						
		Q Shift	C	(b)(6)-2						
			N							
10/21/03	(b)(6)-2	ENCOURAGE AMBULATION	D	(b)(6)-2						
			E							
			N	(b)(6)-2						
10/22/03	(b)(6)-2	N-T SUCTION Q 4°	D	(b)(6)-2						
			C							
			N							
22OCT03	(b)(6)-2	Clear liquids as	B	(b)(6)-2						
		tolerated	L	(b)(6)-2						
			D							
23oct	(b)(6)-2	NPO x̄ meds	D	(b)(6)-2						
			E							
			N							
24oct03		Clear liquid diet as	D	(b)(6)-2						
		tolerated	E							
			N							
24oct03		Ambulate at least	D	(b)(6)-2						
		Q.ID	E							
			N							
25Oct	(b)(6)-2	↑ diet to soft, advance	B	(b)(6)-2						
		to regular as tolerated	L	(b)(6)-2						
			D							

DC'd 22OCT03 (b)(6)-2

DC'd 24OCT03

DC'd 24oct03 @ 2339 (b)(6)-2

D/C 23oct03

DC 24Oct03 0923

Ad 25Oct03 (b)(6)-2

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: S/P Repair of small & LRG bowel repair

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO: 2

PATIENT IDENTIFICATION:

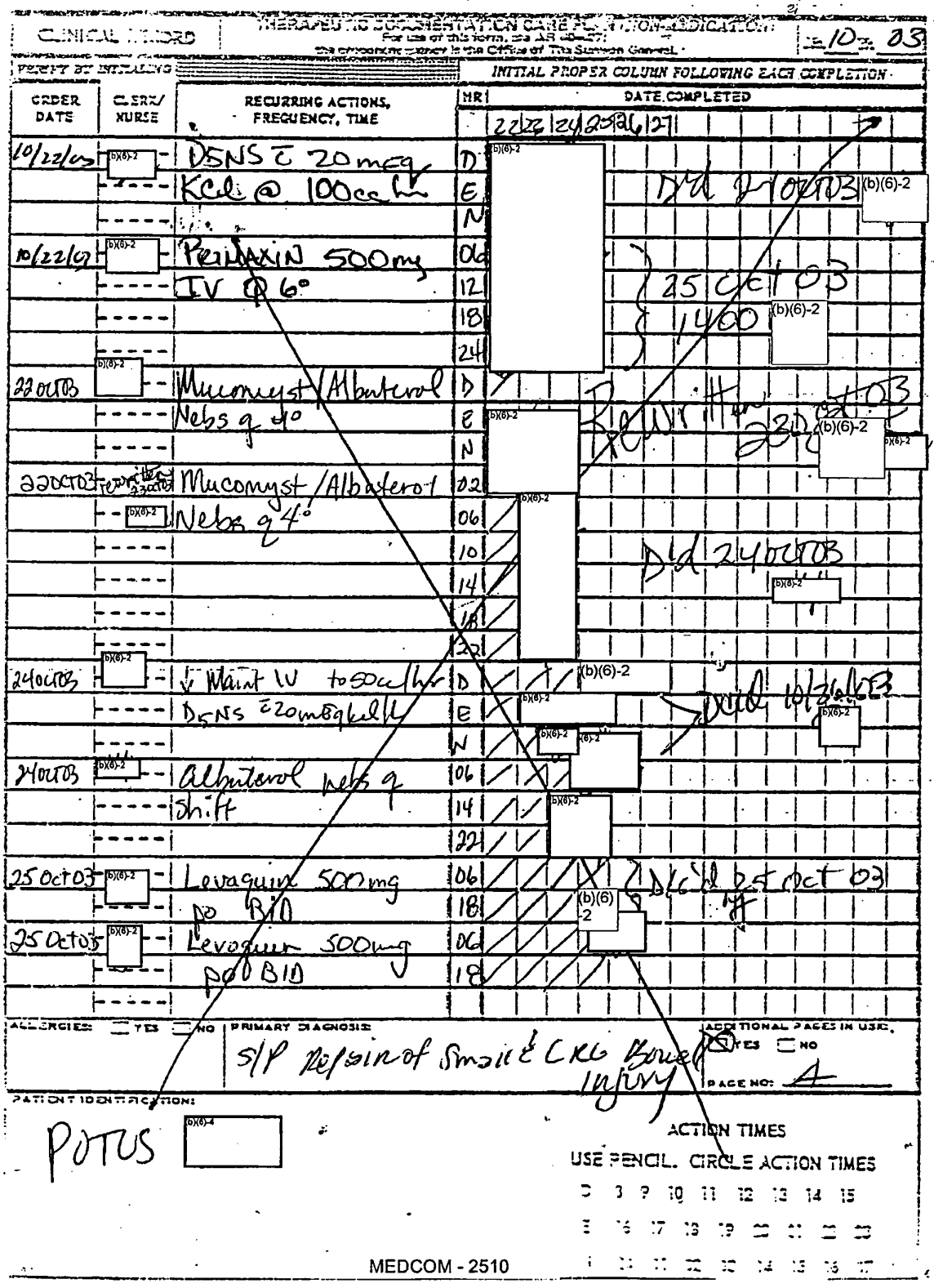
POTUS (b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	[illegible]	[illegible]	[illegible]	[illegible]

MEDCOM - 2509



CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE FLOW-MEDICATION
For use of this form, see AR 40-27; the proponent agency is the Office of The Surgeon General.

10 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 22 23 24 25 26 27
10/22/03	(b)(6)-2	D5NS c̄ 20 meq	D	(b)(6)-2
		KCl @ 100cc/hr	E	D'd 24 OCT 03 (b)(6)-2
			N	
10/22/03	(b)(6)-2	PRIMAXIN 500mg	06	
		IV Q 6°	12	25 Oct 03
			18	1400 (b)(6)-2
			24	
22 OCT 03	(b)(6)-2	Mucomyst/Albuterol	D	Rewritten 23 Oct 03
		Nebs q 4°	E	(b)(6)-2 (b)(6)-2 (b)(6)-2
			N	
22 OCT 03	rewritten 23 Oct 03	Mucomyst/Albuterol	02	
	(b)(6)-2	Nebs q 4°	06	(b)(6)-2
			10	D'd 24 OCT 03
			14	(b)(6)-2
			18	
			22	
24 OCT 03	(b)(6)-2	↓ Maint IV to 50cc/hr	D	(b)(6)-2
		D5NS c̄ 20 meq kcl/L	E	(b)(6)-2 D'd 10/26/03 (b)(6)-2
			N	(b)(6)-2 (b)(6)-2
24 OCT 03	(b)(6)-2	Albuterol nebs q	06	
		shift	14	(b)(6)-2
			22	
25 Oct 03	(b)(6)-2	Levaquin 500mg	06	D'd 25 Oct 03
		po BID	18	(b)(6)-2
25 Oct 03	(b)(6)-2	Levaquin 500mg	06	
		po BID	18	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P Repair of Small & LRG Bowel Injury

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO: 4

PATIENT IDENTIFICATION: POTUS (b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

D 8 9 10 11 12 13 14 15

E 16 17 18 19 20 21 22 23

1 2 3 4 5 6 7

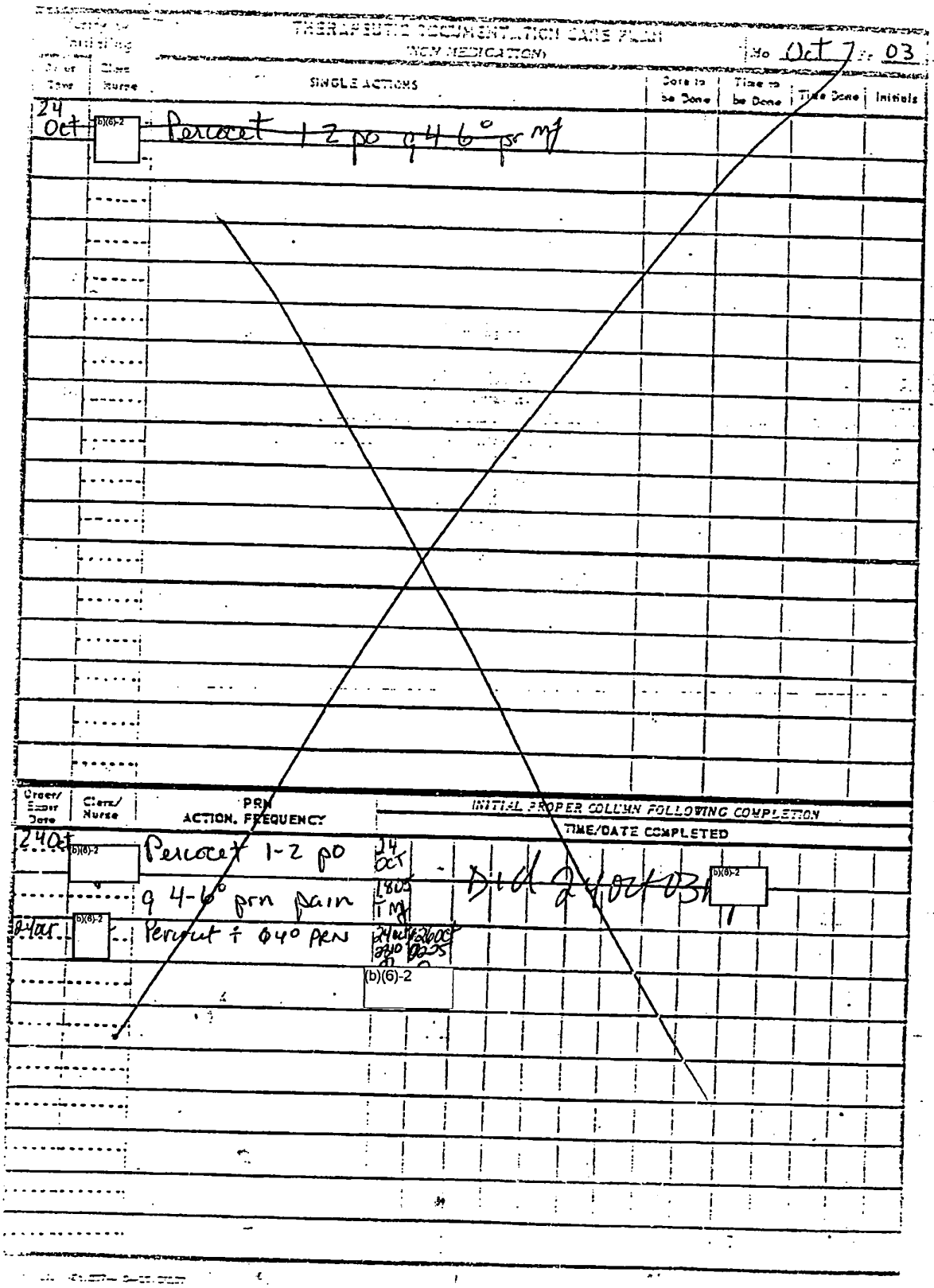
MEDCOM - 2510

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON MEDICATION)

No Oct 7 Pr 03

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
24 Oct	(b)(6)-2	~~Percocet 1-2 po q 4-6° pr mf~~				

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED	
24 Oct	(b)(6)-2	Percocet 1-2 po q 4-6° prn pain	24 Oct 1805 TMJ	Did 24 Oct 03 (b)(6)-2
24 Oct	(b)(6)-2	Percocet ÷ Φ4° PRN	24 Oct 2210 Φ 26 Oct 0225 (b)(6)-2	



MEDCOM - 2511

"M.A.R."

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)
For use of this form, see AR 40-407;
the proponent agency is the Office of The Surgeon General.

Jan 10 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 26	27
10/24/03	Recorded [redacted]	ALBUTEROL NEBS q	06	/ [redacted]	
		Shift	14	[redacted]	
			22	[redacted]	
10/24/03	Recorded [redacted]	LEVIQUIN 500mg PO	06	/ [redacted]	
		BID	18	[redacted]	
10/26/03	[redacted]	ZANTAC 150mg PO	10	[redacted]	
		BID	22		
10/26/03	[redacted]	HEPLOCK IV	D		
		(FLUSH Q Shift c̄ NS)	E		
			N		
26 Oct		Colace 100mg po	06		
	[redacted]	BID	18		

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: S/P Repair SML & Lrb bowel

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION:

POTUS [redacted]

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

D 8 9 10 11 12 13 14 15

E 16 17 18 19 20 21 22 23

MEDCOM - 2512

Verify by initiating

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON MEDICATION)

No. OCT Yr. 2005

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
10/26	(b)(6)-2	DULCOLAX Supp. Pr X 1 ~~[illegible]~~ this am	10/26	A.M.	1130	(b)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED
10/19	Recopied (b)(6)-2	PHENERGAN 125 mg	
		IV Q 4° PRN NAUSEA	
10/23	Recopie (b)(6)-2	Tylenol 650 mg PO	
		Q 4° PRN T > 101	
10/24	(b)(6)-2	Percocet T PO Q 4°	
		PRN	
10/27	(b)(6)-2	Ambien 10mg QHS	
		PRN INSOMNIA	

MEDCOM - 2513

CLINICAL RECORD — THERAPEUTIC SUPPLEMENTATION CARE PLAN/MEDICATION

For use of this form, see AR [illegible]; the proponent agency is the Office of The Surgeon General.

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 7/28/24
10/24	b)(6)-2	ENSURE 1 CONTAINER	10	
		BID MEALS AT LEAST	14	
		1X/day	18	

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: S/P Repair SMI & LRC Bowel

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

POTUS b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

0 3 9 10 11 12 13 14 15

[illegible] 16 17 18 19 20 21 22 23

[illegible] 24 01 02 03 04 05 06 07

MEDCOM - 2514

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-400; the proponent agency is The Office of The Surgeon General

REPORT TITLE: Unasyn 3gm 1730, NGT

POST ANESTHESIA CARE UNIT FLOWSHEET

OTSG APPROVED (Date): 17 Jan 80

PROCEDURE: Exp lap, appy enterotomy repair

PHYSICIAN: Dr [b)(6)-2]

ANESTHESIA BY: MAJ [b)(6)-2]

Gen Spinal MAC Axillary Local Bier Epidural Other

ALLERGIES: Unknown

AIRWAYS: Time DC'D

ETT Nasal Oral Trach

OXYGEN: Mask Nasal Face Blow-By Prongs Tent

Liter/min. %

ASA II History

Cardiac Rhythm

IV#1 LR@TKO Patent Infiltrated Site R FA Rate Gauge 16

IV#2 LR@ Patent Infiltrated Site 160 Rate Gauge 18 (1)AC

Time	B/P	P	R	O2SA	Temp	Act	Resp	Circ	LOC	Skin	PARS	COMMENTS	Neuro-Vascular
PRE-OP	130/80	102											Extr: L R Upper Lower Pulse DP PT RAD
PRE-OP	/												Blanche Pulse Warm Moves Y N
2100	137/81	117	18	100%	99.6	1	1	2	0	2	6		Blanche Pulse Warm Moves Y N
2105	141/76	114	16	100%		1	1	2	0	2	6		Blanche Pulse Warm Moves Y N
2110	149/78	113	16	100%		1	1	2	0	2	6		Blanche Pulse Warm Moves Y N
2125	170/77	115	18	100%		1	2	2	0	2	7		Blanche Pulse Warm Moves Y N
2140	147/77	119	19	100%		1	2	2	1	2	8		Blanche Pulse Warm Moves Y N
2155	134/80	123	19	99%		1	2	2	1	2	8		Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N
	/												Blanche Pulse Warm Moves Y N

POST ANESTHESIA RECOVERY SCORE "PARS"

Activity - General Anesthesia
2—Maintain head lift and open eyes
1—Unable to maintain head lift and open eyes
0—Unable to lift head and open eyes

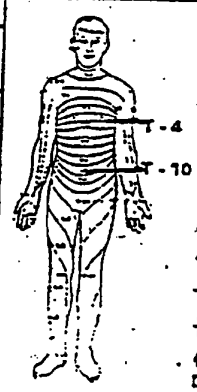
Activity - SAB or Subarachnoid Block
2—Moves all four extremities with control
1—Moves both upper extremities

Respirations
2—Spontaneous respiration; needs no support
1—Limited effort; needs artificial airway or jaw support
0—Needs ventilator; no spontaneous respiration

Circulation
2—BP 20% preanesthetic level
1—BP ~~20~~ - 50% preanesthetic level
0—BP 50% or more preanesthetic level

Level of Consciousness
2—Awake and alert; seldom dozes
1—Awakens when gently stimulated
0—Awakens only when vigorously stimulated

Skin
2—Normal skin color & temperature greater than 96°
1—Skin is pale, blotchy, dusky &/or temperature 95 - 96°
0—Cyanotic &/or temperature less than 95°



DRESSING:	Status	Location
Gauze		
Opsite		
Bandaid		
Steri-strips		
Collodian		
Peri-pad		
Coban		
Cotton Balls		
Ace Wrap		

TUBES AND DRAINS: Hemovac Foley NGT Chest Jackson-Pratt

(Continue on reverse)

PREPARED BY (Signature & Title): [b)(6)-2] UTAN

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: 19 OCT 03

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)

Pohus [b)(6)-4]

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTICS STUDIES

☐ TREATMENT

DA FORM 1 MAY 78 4700

FH MDA OP 132-11a (Rev) 1 Sep 99

MEDCOM - 2515

INTAKE			OUTPUT		
TIME	TYPE	AMT	TIME	TYPE	AMT
OR	LR	5000	OR	EBL	200
			OR	Urine	250
TOTAL			TOTAL		

PACU NURSING NOTES: NURSING CARE PROBLEM NO.'S IDENTIFIED. Refer to FH MDA OP 39

NURSING CARE PROBLEMS: 1. RESP; 2. CIRC; 3. ACT; 4. LOC; 5. TEMP; 6. PAIN; 7. SAFETY; 8. ANXIETY; 9. EDUC; 10. OTHER

2115 - Midline incision covered c̄ fluffs and foam tape. Multiple areas c̄ bandaids on chest. Hand (R) wrapped in kulis all disps CDI. Lugs clear in upper lobes. Rhonchi to bases (B). NGT placement verified now to LIS. Foley gravity draining dark yellow urine. [redacted] (b)(6)-2 KN

2130 - O_2 Mask removed sats 100% on RA [redacted] (b)(6)-2 KN

2205 - To ICU status. Remains unresponsive. (Cont to follow) [redacted] (b)(6)-2 CPT AN

MEDICATION RECEIVED IN PACU/ICU

MEDICATION GIVEN BY:	DRUG	DOSE	ROUTE	TIME	PAIN LEVEL	EFFECTIVENESS

DISPOSITION SUMMARY: Nursing Care Problems No.'s _____ Resolved; No.'s _____ Continue.
Patient was transferred from PACU/ICU recovery room via litter/crib with siderails raised, or held by parent in wheelchair.
Dressing status: CDI PAR Score 8 Safety Straps 4
Report given to N/A Remains in ICU Patient released by Anesthesia
Time out 2205 Nurse Signature: [redacted] (b)(6)-2 CPT AN

MEDCOM - 2516

ADMISSION AND CODING INFORMATION

For use of this form, see AR 40-400; the proponent agency is OTSG

1. REPORTING MTF	1 A; 2 (b)(3)-1; 3; 4; 5; 6
2. MTF LOCATION (State or Country Code.)	7 I; 8 Z
3. REGISTER NUMBER	9 (b)(6)-4; 10; 11; 12; 13; 14; 15
NAME (Last, First, Middle Initial)	Potos (b)(6)-4
4. PAY GRADE	16; 17
5. SEX	18 M
6. DATE OF BIRTH (Y Y Y Y M M D D)	19; 20; 21; 22; 23; 24; 25; 26
7. AGE AT ADMISSION	27; 28; 29
8. RACE	30
9. ETHNIC BACK-GROUND	31
RELIGION	
10. LENGTH OF SERVICE	32; 33; 34
ETS	
11. FMP	35 9; 36 8
12. SOCIAL SECURITY NUMBER	37; 38; 39; 40; 41; 42; 43; 44; 45 (b)(6)-4
ORGANIZATION (Active Duty Only)	
13. MARITAL STATUS	46
HOUR OF ADMISSION	1020
BRANCH / CORPS	
14. FLYING STATUS	47; 48; 49
15. BENEFICIARY CATEGORY	50 K; 51 7; 52 6
16. ZIP CODE OF RESIDENCE	53 0; 54 9; 55 3; 56 3; 57 4; 58; 59; 60; 61
17. UNIT LOCATION (State or Country Code)	62; 63
18. MOS	64; 65; 66; 67; 68; 69; 70
19. TRAUMA	71
PREV. ADMISSION	YEAR ☐ NO
20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	72 0
WARD	ICU
NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	
ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	
TELEPHONE NUMBER OF EMERGENCY ADDRESSEE	
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	(b)(3)-1 (b)(3)-1
21. TYPE OF DISPOSITION	73 0; 74 5
22. MTF TRANSFERRED TO	75; 76; 77; 78; 79; 80
23. DATE OF DISPOSITION (Y Y Y Y M M D D)	81 2; 82 0; 83 0; 84 3; 85 1; 86 0; 87 2; 88 7
24. CLINIC SVC - ADMITTING	89 A; 90 B; 91 A; 92 A
25. MTF TRANSFERRED FROM	93; 94; 95; 96; 97; 98
26. DATE THIS ADMISSION (Y Y Y Y M M D D)	99 0; 100 0; 101 0; 102 3; 103 1; 104 0; 105 1; 106 9
27. LOCATION OF OCCURRENCE (Battle Casualty Only)	107; 108
28. MTF OF INITIAL ADMISSION	109 A; 110 1; 111 9; 112 A; 113 1; 114
29. DATE INITIAL ADMISSION (Y Y Y Y M M D D)	115 2; 116 0; 117 0; 118 3; 119 1; 120 0; 121 1; 122 9
FOR LOCAL USE	

Dx: 86354, 86331, 86399, 8831, 8738, 89719, 2768, 490, 9584, 9110, 5180, 88000, 7806

Px: 4562, 4675, 4671, 8365, 4719, 5794, 966, 4502, 4503, 4602, 8622 X3

TRAUMA 9

INJURY 559

(b)(6)-2

SIGNATURE OF ADMITTING CLERK

MEDCOM - 2517

(b)(3)-1

INPATIENT TREATMENT RECORD COVER SHEET *(For Plate Imprinting)*

For use of this form, see AR 40-...

...nent agency is the Office of The Surgeon General.

PATIENT DATA ITEMS 1 - 30 (...

(b)(6)-4

(b)(6)-4

K78/20

LINE	LEGEND
1	REGISTER NO. - NAME - GRADE
2	SEX - AGE - RACE - RELIGION - LENGTH OF SVC - ETS - PREVIOUS ADMISSION
3	FMP - SSN - ORGANIZATION - WARD
4	FLY STAT - RATING/DESG - DEPT/BEN - BRANCH/CORPS - UIC/ZIP - TYPE CASE
5	SOURCE & AUTHORITY FOR ADMISSION - HOUR OF ADMISSION - CLINIC SVC
6	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
7	ADDRESS OF EMERGENCY ADDRESSEE - PHONE NO. - DATE OF THIS ADMISSION
8	NAME & LOCATION OF MEDICAL TREATMENT FACILITY DATE OF INITIAL ADMISSION

ADMISSION REMARKS

(b)(6)-4

(b)(6)-2

...TS OF WHOLE BLOOD/COMPONENT TRANSFUSED

25. TYPE DISPOSITION

D/C

(b)(6)-4

...OSITION

3 NOV 03

31. SELECTED ADMINISTRATIVE DATA

33. CAUSE OF INJURY

Gunshot Wound

☐ CHECK IF CONTINUED ON REVERSE

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

1) Grade III liver lac (R) lobe 998.2 ICD9, FY02
2) Total disruption (R) Kidney 780.55 ICD9, FY02
3) T_2 Paraplegia 344.1 ICD9 FY02
4) (L) thigh GSW @ fx 890.0 ICD9, FY02
5) Ex lap ō (R) nephrectomy / Repair liver lac 264.05, ICD9, FY02
6) Median sternotomy 736.3 ICD9, FY02

...TAL DAYS THIS FACILITY

...NT SICK | b. OTHER DAYS | c. CONV LV/COOP CARE DAYS | d. SUPPLEMENTAL CARE DAYS | e. BED DAYS | f. TOTAL SICK DAYS

☐ CHECK IF CONTINUED ON REVERSE

(b)(6)-2

c. CONV LV/COOP CARE DAYS | d. SUPPLEMENTAL CARE ... | ...BED ...

...CER

MEDCOM - 2518

Potu # (b)(6)-4 [redacted] (Detainee)

(b)(6)-4 [redacted]

PATIENT'S DEPOSIT RECORD
For use of this form, see AR 40-2; the proponent agency is the Office of The Surgeon General.

I have been informed that any funds or valuables in my possession while a patient in this hospital are retained at my own risk and that I may and should deposit same in the patient trust fund.

I do ☐ *do not* ☒ *wish to make a deposit at this time.*

(b)(6)-2 [redacted] LTL/An (EMT - RN)

Patient's signature (or witness's, if patient is unable to sign)

FUNDS & VALUABLES RECEIVED IN FULL *(Patient's or witness's signature and date)*

PATIENT'S IDENTIFICATION *(For plate imprint, typewriter or hand)*

FUNDS

DATE	DEPOSITS	WITHDRAWALS	BALANCE	SIGNATURE

VALUABLES

NUMBER	DESCRIPTION OF VALUABLES	DEPOSITS DATE	DEPOSITS SIGNATURE (Custodian)	WITHDRAWALS DATE	WITHDRAWALS SIGNATURE (Patient or intermediate individual)
001	Watch-1 (Black)	23Oct03	SPC (b)(6)-2 [redacted]		
002	Scans-1 (Black)	23Oct03	SPC		
003	Belt-1 (Black)	23Oct03	SPC		
004	Shoes-2 (Black)	23Oct03	SPC		
005	Socks-2 (Black)	23Oct03	SPC		

(b)(6)-2 [redacted]

DA FORM 1 DEC 77 3696 REPLACES EDITION OF 1 AUG 76, WHICH MAY BE USED. ★U.S.GPO:1991-0-301-988

MEDCOM - 2519

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

PERTINENT HISTORY, CHIEF COMPLAINT, AND CONDITION ON ADMISSION *(Enter date of admission)*

See SF 558
for complete H&P available
@ this time.

PHYSICAL EXAMINATION

PROGRESS *(Enter date of discharge and final diagnosis)*

(b)

(b)(6)-2

ATE	IDENTIFICATION NO.	ORGANIZATION
230CT03		
ve Name last, first, or medical facility)	REGISTER NO.	WARD NO.

Potus # (b)(6)-4

(b)(6)-4

MEDCOM - 2520

ABBREVIATED MEDICAL RECORD
Standard Form 539

GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
USAPPC V1.00

LAST NAME	FIRST NAME	MIDDLE IN	ID NUMBER

DATE	NOTES
10/3/03 1330	Surgery ~~PT~~ 5 hrs. tolerating diet, (+) BS/flatus Uss Agrb L-CTA, CXR-NOD CT-(L) rate 100cc CT (R) rate 250cc CV-RRR (S) Abl-mild distension, wound healing P/p S/p GSW to liver (R) Nephrectomy - stable D/c 2 CT continue (R) post tube ✓ CXR

(b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BAC
USAPA V1.0

MEDCOM - 2521

AUTHORIZED FOR LOCAL REPRODUCTION

-00-634-4176

CHRONOLOGICAL RECORD OF MEDICAL CARE

ICAL RECORD

SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)

DATE	
2 Oct 03 0730	Surgery Note 20's yo ♂ who attached fortified positive sustaining GSW to (L) chest and abd, (L) thigh. Presents hypotensive c̄ obvious paraplegia of low extr. CXR - wl. x̄ bullet fragment, Abd flm c̄ fx transverse process (L)2. To OR for emergent Exploration. [redacted] (b)(6)(2)
23 Oct 03 1130	Brief OP Note Prop, GSW to Abd/Chest Postop same (+) (1) Injury to (R) dome of liver (2) through and through injury To (R) Kidney (3) Large paraspinal defect/bone c̄ obvious transection spinal cord / bony defect Procedure, (1) Ex Lap (2) Median Sternotomy (3) Removal (R) Kidney (4) Repair laceration dome (R) side l c̄ omental pack

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	
		REGISTER NO.	WARD NO.

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)

CHRONOLOGICAL RECORD OF MEDICAL CA
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

MEDCOM - 2522

SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)

(b)(6)-2

(b)(6)-2

FPI, LEX. Printed on Recycled Paper

STANDARD FORM 600 (REV. 6-97) BACK

MEDCOM - 2523

NSN 7540-00-634-4178

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
23 Oct 03	0730: Arrived via ground to (b)(3)-1 Mosul, Iraq. Placed on monitors, clothing cut away, 100% O_2 @ spontaneous respirations RT and full medical staff at bedside. Ø IV access at this time (upon arrival)
0730	HR: 104 BP: Unable to obtain ox: Unable to obtain Md starting central line @ fem. Working on IV access
0735	HR: 94 BP: RR: ox: 99% IV 18G start @ AC 1000cc ↑
0740	HR: 87 BP: RR: ox: 95% 1000cc in, #2 IVF ↑
0743	Succinylcholine 100mg IVP/Anes; pt orally intubated, 22 cm @ teeth
	Blood ↑ uPRBC ↑ via @ Fem central line. labs drawn & sent.
	Foley placed – U/A sent
	CXR
0750	HR: 94 BP: 96/43 RR: Bagging 100% ox: 100% Versed 2mg IV, Vec 10mg IVP
	#2 of 2 PRBC ↑
0757	HR: 101 BP: 85/38 RR: Bagging 100% ox: 99% Dopamine started 5mcg/kg/min
0800	HR: 95 BP: 94/59 RR: Bagging 100% ox: 100% ↑ Dopa 10mcg/kg/min (26.3cc) Pr (b)(6)-2
	placed CT to @ CW – Pt prepared for surgery

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	Continued on Back

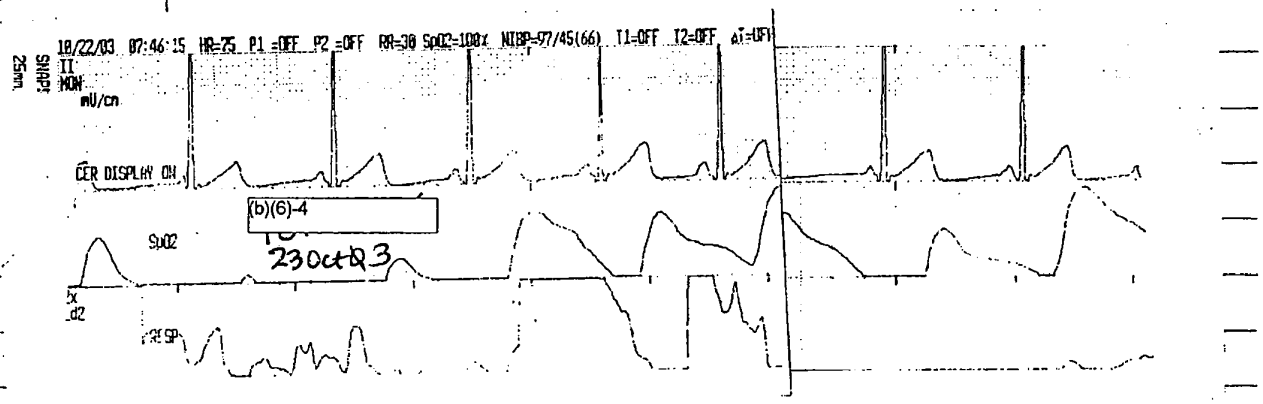
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* Iraqi EPW | REGISTER NO. (b)(6)-2 | WARD NO. N/A

POTUS # (b)(6)-4

MEDCOM - 2524

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
cont from front 23 Oct 03 0805	Pt transported to OR. Sent along with patient. Ancef + GM IVPB & Tetanus 0.5cc injection. — (b)(6)-2



3/327 HHC Scouts SPC Hopkins, Amari
Enemy drove off Interstate. Occupants exited car and begin to fire at Sniper teams located in OP. Snipers returned fire killing 2, Injuring 1, and 1 enemy escaped.

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | PROGRESS NOTES

DATE	23 Oct 03		NOTES
Unit #1	BP	T (AV)	P
Pre (1950)	104/65	96° (AV)	92
1955	127/81	96°	89
2000	135/44	96'	92
2005	123/45	96'	87
End #1 2015 ~~2020~~ My	134/73	96.3	91
Unit #2			
Pre 2025	142/58	96.3	91
2030	147/48	96.5	85
2035	150/82	96.8	90
2040	99/68	96.8	103
~~2055~~ ~~2100~~ My	109/77	96.8	98

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME (LAST, FIRST, MI) | SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade) | REGISTER NO. | WARD NO.

Potus (b)(6)-4

PROGRESS NOTES - Medical Record

STANDARD FORM 509 (REV 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

MEDCOM - 2526

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
10/24/03 1500	Surgery HD#1 POD#1
	Pt sedated, on vent, follows commands - upper extremities, No movement of lower ext
	Vss Agrb
	Resp Good ABL → 40%, PEEP 5 TV 800
	Sats 100% No acidosis
	CXR - clear
	CT - Ø airleak serous output
	CV - NSR/RRR
	Requiring Vasopressin / Dopamine
	Abd - ØBS, nondistended
	NG - minimal output
	Renal - good UOP I/O ≅ equal
	Agb 13.3 WBC 16.9 PLT 102
	CR 1.3
	ALKØ 40 ALT 243 AST 242 Tbili 3.3
	A/P L2 Paraplegia / liver lac / (R) Nephrectomy [redacted]
	(1) Continue supportive care Hemodyna (b)(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID (SSN or Other)
	LAST	FIRST	MI	

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)	REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

Potus (b)(6)-4

MEDCOM - 2527

DATE	NOTES
	(2) Maintain vent (2) present settings
	(3) Continue CT to suction @ 20cm
	(b)(6)-4 [redacted]

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STANDARD FORM 509 (REV 5-99) BACK

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540-00-634-4176

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
25 Oct 03	Surgery ND#2 POD#2
1400	Pt stable on Vent
	awake, alert
	Hemodynamics more stable
	Vss Aft
	L-CTA Sat 100% on 40% FIO
	CXR-clear CT ø airleak / ø effusion
	CV-RRR S(2)
	sternum-stable
	Abd-ØBS, soft nondistended
	Incision intact
	Renal - good UOP
	I/O (+)1600
	WBC 12.3 PLT 96
	CR 1.3 T Site 1.0 ALT 151 Alk Ø 42 Ast 120
	K 3.6
A/P	S/P GSW (R) Nephrectomy / diver repair
	T2 paraplegia
	(1) Vent to IMV Rate 8 - continue weaning
	(2) DIV to D5NS c̄ 20 kcal/l @ 125 cc/hr
	(3) Vasopressin weaned to off
	(4) Weaning

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
	Bypass		[redacted]
SPONSOR'S NAME	SSN/ID NO.	RELATI	

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or S[redacted] Date of Birth; Rank/Grade.)

(b)(6)-4

[redacted]

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

Potus (b)(6)-4

MEDCOM - 2529

Q

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
10/27/03	Pt extubated last PM, breathing comfortably
①900	No real Q's, ⊕ appetite
	Vss Afb
	L-ETA Sat 98% 2L NC
	CT ≈ 150 each 24hrs
	CXR - rotated small ⊖ effusion
	CV - RRR, NSR
	Wrnds leaking well
	Abd - BBS, nondistended
	K 3.1 WBC 6.7
	CR 1.2 Hgb 8.4
	S/O ⊖ 800
	A/P S/P GSW to Lwi (R) Nephrotomy
	① Clear liquids
	② D/C Alim
	③ Sub Q Expansion
	④ K replacement

(b)(6)-2

RELATIONSHIP TO SPONSOR | LAST | SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)* | REGISTER NO. | WARD NO.

Po hrs (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
11/3/03 0850	Surgery 24yo ♂ who presented in hypovolemic as well as spinal shock following 2 GSW to abdomen and (L) thigh. Upon eval was fluid resuscitated and started on pressors. PE revealed L2 paraplegia gross hematuria and an acute abdomen. He was taken to the OR for exploration. His injuries included a large stellate laceration to the (R) lobe of liver near the dome which required extensive mobilization of the liver → this was completed through a midline laparotomy/median sternotomy for adequate visualization. Pt also had a devitalized lacerated (R) kidney requiring nephrectomy. No bowel injury. A large bony defect of the posterior spine required removal of metallic fx and packing for control of hemorrhage along (R) psoas margin. Postoperatively the patient stabilized in 72 hours and has done well since that time. Chest tubes were removed over last 2-3 days, CXR clear. Pt has had return of bowel function, tolerating regular diet and is indicating

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)	REGISTER NO.	WARD NO.

Potus (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

MEDCOM - 2531

DATE	NOTES
	Sound training. Foley in place. No return of any neurologic function. By xray appears to be stable fx @ L2 c̄ intact ant/middle columns. Pt should have CT landeyer remain in place x 48 hrs. All surgical sites healing well. To be transferred to prevost marshall for questioning.

(b)(6)-2

FPI LEX Printed on Recycled Paper STANDARD FORM 509 (REV 5-99) BACK

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ACLU-RDI 1099 p.1316

DOD 006584

58-103 (See Instructions on Back of this Sheet) Og #1 of 2 NSN 7540-01-075-3786

EMERGENCY CARE AND TR... ...NT (Medical Record)

TREATMENT FACILITY (Stamp)

LOG NUMBER

ARRIVAL

DATE			TIME
DAY	MONTH	YR.	
3	OCT	03	0730

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☐ OTHER (Specify)

CURRENT MEDS. (tetanus immunization and other data): unknown

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES: unknown

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration)

SEX: M AGE: unk

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

VITAL SIGNS

TIME	0750		
P	96/43		
PULSE	94		
RESP.	30	SOE FLOWSHEET	
TEMP.	—		
T. (Child)	100% BVM		

CATEGORY (See reverse)

- [x] EMERGENT
- [ ] URGENT
- [ ] NON-URGENT

ORDERS	INITS.	TIME
1 & 2 BOLUS	MRM	0735/0740
2L NS OR LR		
MONITORS	MRM	0730
BC, T+C, UA	MRM	0743
NR, ABDO	MRM	0743
FOLEY	MRM	0743

ASSESSMENT/DIAGNOSIS

GSW, Thorax, abdomen

DISPOSITION (Check all that apply)

HOME | FULL DUTY

QUARTERS: 24 Hrs. | 48 Hrs. | 72 Hrs.

MODIFIED DUTY UNTIL: DAY | MONTH | YEAR

REFERRED TO (Indicate clinic)

EMERGENCY | TODAY

72 HOURS | ROUTINE

ADMIT. TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE

IMPROVED | UNCHANGED

DETERIORATED

TIME OF RELEASE:

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

TIME SEEN BY PROVIDER: ON ARRIVAL

Iraqi ♂ of unknown age brought to CSH via FLA in custody of [redacted] (SPC [redacted])
p̄ sustaining GSW to chest, Heimlich valve over chest wound, no IV access on arrival

"AMPLE" History unobtainable

A - patent, grunting respirations
B - Breath sounds, chest rise symmetric, tachypnic
C - Intermittent Thready peripheral pulses, active bleeding from (L) posterior thoracic chest wound
D - Moving upper extremities only; flaccid + unresponsive at lower extremities
E - Completely exposed, rolled and examined.

Succinocholine 100mg IV - 0743/MRM
Vecuronium 10mg IV 0750/MRM
Versed 2mg IV 0750/MRM
Dopamine g tt - 0757/MRM
Ancef T sm IV sent to OR/MRM
Tetanus

Ventilations assisted by BVM, 16 ga IV cath (L) FA, 8.5 F cordis placed (R) femoral vein by Dr. [redacted]

RSI c̄ 100mg succinylcholine, Intubated by MAT [redacted] c̄ 8.5 ET tube via DL

(L) chest tube Thoracostomy placed by Dr. [redacted]

2,500 cc crystalloid and 2 units Emergency release blood administered and transfered to OR

(CONTINUE ON SF 507, IF NEEDED)

PATIENT'S IDENTIFICATION (Mechanical imprint) OR WRITTEN ENTRIES GIVE: Name - last, first, middle; SSN; DOB, service status, name and relation of sponsor or next kin. (IMPORTANT: LIST FACILITY HOLDING TREATMENT RECORD).

(1 of 2)

Potus# [redacted]

[redacted]

[redacted] LTC, MC

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans)

PLXR - (L) Subcardiac missile fragment
Abdo - (L) paraspinal missile fragment, loss of psoas shadow

EMERGENCY CARE AND TREATMENT

STANDARD FORM 558 (Rev. 6-82)

MEDCOM - 2533

58-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp)

LOG NUMBER

ARRIVAL — DATE (DAY, MONTH, YR.) / TIME

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet)
☐ PRIVATE VEHICLE ☐ AMBULANCE ☐ OTHER (Specify)

CURRENT MEDS. (Tetanus immunization and other data)

HISTORY OBTAINED FROM ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration)

SEX

AGE

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

VITAL SIGNS

TIME			
P			
PULSE			
RESP.			
TEMP.			
WT. (Child)			

CATEGORY (See reverse)
☐ EMERGENT
☐ URGENT
☐ NON-URGENT

ORDERS	INITS.	TIME

ASSESSMENT/DIAGNOSIS
- SW Thorax and Abdomen

DISPOSITION (Check all that apply)
☐ HOME ☐ FULL DUTY
QUARTERS: ☐ 24 Hrs. ☐ 48 Hrs. ☐ 72 Hrs.
MODIFIED DUTY UNTIL: DAY / MONTH / YEAR
REFERRED TO (Indicate clinic)
☐ EMERGENCY ☐ TODAY
☐ 72 HOURS ☐ ROUTINE
ADMIT TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE
☐ IMPROVED ☐ UNCHANGED
☐ DETERIORATED
TIME OF RELEASE:

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

TIME SEEN BY PROVIDER

1 of 2

SEE PAGE

2° SURVEY -

GENERAL: minimally responsive
moving upper extremitys only, weakly

SKIN: Pale, cool, clammy

HEENT: No obvious injuries
os enucleated (old injury)
od pupil dilated, reactive

LUNGS: Tachypneic, grunting
chest rise, breath sounds symmetric
Penetrating wounds ① anterior paraxternal
② posterior-lateral thoracic

CV: Heart sounds distant

BACK: Penetrating wound ② posterior lateral only

ABDO: Rigid, tender

GU: nl ♂ EG ∅ trauma

RECTAL: ∅ blood; flaccid tone

EXTREM: ∅ obvious trauma,
2E's apparently unusable

NEURO: moving upper extremities only
initially, weak, purposful movements

18.2 / 13.8 / 414 / 40.1

134 | 100 | 318 | 1.9 | 16 | 4.3

UA - SG = 1.030 ∅ glucose ∅ ketone
(large blood) 0-5 WBC/HPF RBC

(CONTINUE (b)(6)-2

PATIENT'S IDENTIFICATION (Mechanical imprint)
OR WRITTEN ENTRIES GIVE: Name - last, first, middle; DOB, service status, name and relation of sponsor or kin. (IMPORTANT: LIST FACILITY HOLDING TREATMENT RECORD).

(b)(6)-2

LTR, USE

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans)

TO OR

(2 of 2)

IRAQI DETAINEE

(b)(6)-4

EMERGENCY CARE AND TREATMENT STANDARD FORM 558 (Rev. 6-82)
Prescribed by: GSA and MCM

MEDCOM - 2534

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	23 oct 03
DOS	23 oct 03
POD	DO8

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside		(b)(6)-2	
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On		N/A	
Call Light Within Reach		↓	
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 MAS (AN)	ICU	23 oct 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade; date; hospital or medical facility)*

POTUS (b)(6)-4

- ☐ HISTORY PHYSICAL
- ☐ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☐ OTHER *(Specify)*
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700 MEDCOM - 2535

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R												2		i					1				1	
	RADIAL L												2		1					1				1	
	DORSALIS PEDIS R												2		1					1				1	
	DORSALIS PEDIS L												2		1					1				1	
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale													1		1					1				1	
													3		4					4				3	
													8		8					8				8	
EDEMA													Ø		Ø					Ø				Ø	
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)													✓		✓					✓				✓	
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)													SR/AB		SR					SR				SR	
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)													✓		✓					✓				✓	
HYGIENE	BED BATH																								
	FOLEY CARE																								
	ORAL CARE																								
MOBILITY	BEDREST												✓		✓										
	~~BSC~~ LOGROLL												✓												
	DANGLE																							✓	
	CHAIR																								
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE														✓					✓					
	HOB 30 DEGREES																							✓	
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE																								
	PAIN SCALE (1-10)																✓							✓	
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended												✓		2					✓				2	
BOWEL SOUNDS (active all quads)													Ø		Ø					Ø				Ø	
NG / DOBHOFF PLACEMENT VERIFIED													✓		✓					✓				Ø	
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT													✓		✓					✓				✓	
VOIDING CLEAR, YELLOW URINE q.s.													✓		✓					✓				✓	
SKIN INTEGRITY	No Breakdown																								
Midline ABD	Surgical Wounds												✓		✓					✓				✓	
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1 ABD													✓		✓					✓				✓	
#2																									
#3																									

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
PIV 18ga	(R) hand	23Oct	CDI
TLC	(R) arm	23Oct	CDI – D/C'd 23 Oct 03
A-line	(L) radial	23Oct	CDI
Cordis	(L) groin	23 Oct 1800	CDI

(b)(6)-2

ACLU-RDI 1099 p.1320

DOD 006588

PUPIL SIZE		PUPILS	MOTOR FUNCTION	CHART CODES
1 mm	=	Equal	0 = No Movement	Present ✓
2 mm	R	Reactive	1 = Slight Flicker/ Trace of Contraction	
3 mm	NR	NonReactive	2 = Active (Gravity Eliminated)	Not Applicable /Absent (blank)
4 mm	L > R	Left Larger	3 = Active: against gravity, but not against resistance 4 = Active: Against Gravity and Resistance, not full strength	Refer to Nsg. Notes X
5 mm	R > L	Right Larger	5 = Full Strength against Examiners Resistance	No Change from Previous Assessment –

DATE: 23OCT03

TIME		0 1	0 2	0 3	0 4	0 5	0 6	0 7	0 8	0 9	1 0	1 1	1 2	1 3	1 4	1 5	1 6	1 7	1 8	1 9	2 0	2 1	2 2	2 3	2 4
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (2) To Pain (3) To Voice (1) Does Not Open													1		1				4	4				4	
B. BEST VERBAL RESPONSE (5) Oriented (2) Garbled (4) Confused (1) No Response (3) Inappropriate Verbal Response													T		T				T	T				T	
C. BEST MOTOR RESPONSE (6) Obeys Commands (3) Flexion to Pain (5) Localizes to Pain (2) Extension to Pain (4) Withdraw to Pain (1) No Response													1		1				6	6				6	
GLASCOW COMA SCALE (A+B+C)													2T		2T				10T	10T				10T	
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R												6+		7+				6+	6+				5+	
	L												N/A		N/A				N/A	N/A				N/A	
MOVEMENT (See Motor Function Scale at Top of Page)	RUE												Ø		Ø	1	3		3	3				3	
	LUE												Ø		Ø	1	3		3	3				3	
	RLE												Ø		Ø	Ø	Ø		Ø	Ø				Ø	
	LLE												Ø		Ø	Ø	Ø		Ø	Ø				Ø	
GRIP (S) Strong (W) Weak (-) absent	R												—												
	L												—						V	V				V	
RESPIRATIONS	REGULAR												V		V				E	E				E	
	IRREGULAR												E		e				N	N				e	
	UNLABORED												N		n				T	T				V	
	LABORED												T		t									X	
	SHALLOW																								
	RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL												5↓		5/1				5					5	
	LUL												5↓		5/1				5					5	
	RLL												5↓		5/1				5					5	
	LLL												5↓		5/1				5					5	
	BOTH BASES												1		1				1	1				1	
COUGH	NONE												✓		✓				✓	✓				✓	
	SPONTANEOUS																								
	PRODUCTIVE																								
	NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																									
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																									
VENTILATOR	Vt												700		700		800		800					800	
	FiO2												1.0		1.0		.6		.4					.4	
	RATE (SIMV/CMV)												✓		10		10		10					10	
	PEEP / CPAP												+5		5		5		5					5	
	PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE	NC (l/min)																								
	FM (l/min)																								
ETT = 8.5	NRBM (l/min)																								
	ETT 22 cm gums																								
ETT CARE / POSITION CHANGE																									
ETT / NT SUCTIONED																					-			RT	
INCENTIVE SPIROMETRY DONE																									
COUGH / DEEP BREATH																									
INITIALS													(b)(6)-2												

ACLU-RDI 1099 p.1321

DOD 006589

VITAL SIGNS

TIME	T	P	RR	BP	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200																	
0300																	
0400																	
0500																	
0600																	
0700																	
0800																	
0900																	
1000																	
1100																	
1200	35	81	10/10	~~136~~/50		134/59	78										
1300	35	81	10/10			136/59	78										
1400	90.9 (A)	77	12/10	95/52	100	100/50	63										
1500	91.3 A	81	10/10	100/64	98	100/53	66										
1600	92° A	93	10/10	123/67	100	120/70	88										
1700	93 (A)	100	16/10	118/64	100	126/66	84										
1800	94.8 (A)	99	15/10		100	69/44	58										
1900	95.6 (A)	99	10/10	115/65	100	120/65	79										
2000	96° (A)	89	16/10	127/81	100	128/70	86										
2100	96.8 (A)	81	16/10	123/86	100	114/75	89										
2200	97.8	97	12/10	114/75	100	136/76	89										
2300		90	10/10	93/-	100	93/53	64										
2400		76	10/10	132/77	100		100										

ACLU-RDI 1099 p.1322

DOD 006590

	INTAKE									OUTPUT						
	LR	Dopa	Vaso	PRBC	IVPB				Total	Urine	CT #1/#2	CT #3/#4	NGT		Total	COMMENTS
0100																
0200																
0300																
0400																
0500																
0600																
0700																
0800																
8 HR									8 HR.						8 HR	
0900																
~~1000~~ OR	OR 8500	Alb 100		OR 600						OR 200				EBL/OR 1000		
1100																
1200	150 150	7 7	15 15							400 400	#1 0 #2 20	#3 10	#4 350			
1300	150 300	7 14	15 30	401 401						250 650	#1 0 =0 45 65	340 = 50	#4 70 420			
1400	150 450	7 21	15 45	472 873	50 50					150 800	#1 0 40/105	40/90	125/545			
1500	150 600	7 28	15 60		100 150					225 1025	1 0/0 15/120	3 20/110	60/205			
1600	150 750	7 35	15 75		1000 1150					325 1350	0/0 15/135	15 125 20 625				
8 HR	750	35	75	873	1150				16 HR. 2883	1350	0 135	125 625		1000	16 HR. 3235	- 352
1700	150 150	7 7	20 20		1000 1000					350 350	0/0 20/20	20/20 80/80				
1800	150 300	9 16	30 50							200 550	See separate sheet attached					
1900	150 450	12 28	30 80							200 750						
2000	150 600	15 43	38 118	414 414						120 870						
2100	150 750	15 58	30 148	417 831	500 1500					200 1070			min.			
2200	150 900	15 73	30 178		50 1550					175 1245						
2300	150 1050	12 85	15 193							125 1370						
2400	150 1200	15 100	37.5 240.5							200 1570	0 170	105				
8 HR	1200	100	240.5	831	1550				24 HR. 3921.5	1570	0 305	130 880			24 HR 2985	

MEDCOM - 2539

6220

NSN 7540-00-634-4123

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
23 OCT 03 1300 hrs			Pt discharged from recovery status see flowsheet for details. Dr [redacted] (b)(6)-2 into see pt. #1 of 2 UR PRBCs ↑ HR/BP continue labile, ø titration of IV gtts required. CT dry contents moderate, UOP adequate (b)(6)-2
23 Oct 03		1730	Pt's BP ↓ to sys 70s → 80s ~1600. Vasopressin ↑ to .3u/min and 1 Liter RL given IVP. Received 4mg MSO4 and 2mg Versed @ 1515 and 1525. Pt's sys BP ↑ to >100 c̄ bolus + ↑ vasopressin. Dr. [redacted] (b)(6)-2 into see pt → ↑ vasopressin to .4u/min and ↑ dopamine to 9 ml/hr (3 mcg/kg/min) using 80 kg as estimated pt's weight. sys BP 110-120 @ this time. [redacted] (b)(6)-2 CJ AN
23 Oct 03		1930	↓↓ BP 60's/40's by A-line + cuff. (R) femoral cordis found completely out, hand/wrist restraints intact c̄ pt hands @ side. Minimal blood loss from cordis site, IV fluids running onto bed. Pressure held to (R) femoral site × 5 min, no hematoma noted. (L) femoral cordis inserted per Dr. [redacted] (b)(6)-2 s complications, good blood return. Vasopressin + dopamine titrated to ↑ sys BP >100. Pt was awake, responding and moving (B) arms while BP was in the 60's. Hands wrapped c̄ Kerlix to protect pt + prevent him from pulling out invasive lines. [redacted] (b)(6)-2 MAJ AN
23 Oct 03		2200	Recvd supine. USS. B/P in 150's. Eyes closed. Resp. per vent. Chest rises & falls equally bilat. Restraints intact. Assess completed. Vent settings TV 800. PEEP 5, F_1O_2 40%. Pulses barely palpable 2° Dopamine. Cont to monitor [redacted] (b)(6)-2 Cpt AN
23 Oct 03		2300	B/P ↓. ↑ Dopamine + Vasopressin p̄ MSO4. Continue to monitor. Pt asymp. c̄ ↓ in BP. [redacted] (b)(6)-2 Cpt AN

MEDCOM - 2540

Post tube Output - 23 Oct 03

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-400; the proponent agency is the Office of The Surgeon General.

REPORT TITLE: CONTINUED POST-ANESTHESIA CARE UNIT FLOW SHEET | OTSG APPROVED 17 Jan 80

	VITAL SIGNS						PAR SCORE							OTHER	
Time	B/P	P CT1	R CT2	O_2Sat CT3	T CT4	Act	Resp	Circ	LOC	Skin	PARS	Other	Neuro-Vascular	COMMENTS
~~PRE-OP~~	/												Extr: L R Upper Lower Pulse: DP PT RAD	
1700	/	0 0	20 20	20 20	80 80								Blanche Pulse Warm Moves Y N	
1800	/	0 0	20 40	15 35	30 130								Blanche Pulse Warm Moves Y N	
1900	/	0 0	40 80	40 75	40 170								Blanche Pulse Warm Moves Y N	
2000	/	0 0	50 130	10 85	30 200								Blanche Pulse Warm Moves Y N	
2100	/	0 0	20 150	0 85	20 220								Blanche Pulse Warm Moves Y N	
2200	/												Blanche Pulse Warm Moves Y N	
2300	/	0 0	80 190	80 105	35 255								Blanche Pulse Warm Moves Y N	
2400	/												Blanche Pulse Warm Moves Y N	
24 Oct 0100	/				75								Blanche Pulse Warm Moves Y N	
0200	/	0 0	30 30	30 20	75 75								Blanche Pulse Warm Moves Y N	
	/			

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	23 Oct 03
DOS	23 OCT 03
POD	1

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	6804.5
24 Hour Output	6772
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach	N/A	N/A	
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 , SPC, USAR	ICU	24 OCT 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade; date; hospital or medical facility)*

Potus (b)(6)-4

24 yo

☐ HISTORY PHYSICAL ☐ FLOWCHART

☐ OTHER EXAMINATION Or EVALUATION ☐ OTHER(Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700

MEDCOM - 2542

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R		/				/				/				/					/				/	
	RADIAL L		/				/				/				/					/				/	
	DORSALIS PEDIS R		/				/				/				X					X				/	
	DORSALIS PEDIS L		/				/				/				X					X				/	
SKIN (1) Dry (4) Cool (7) Jaundiced (2) Clammy (5) Flushed (8) Color Normal (3) Warm (6) Cyanotic (9) Pale			/				3				3				/					/				/	
			3				8				8				3					3				3	
			8												8					8				8	
EDEMA			Ø				Gen				Gen				X					gen				gen	
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)			✓				✓				✓				✓					✓				✓	
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)			SR				✓				✓				SR					SR				SR	
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)			✓				✓				✓				✓					✓				✓	
HYGIENE	BED BATH										✓														
	FOLEY CARE										✓														
	ORAL CARE										✓														
MOBILITY	BEDREST		✓								✓				✓					✓				✓	
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT																			✓	✓	✓			
	LEFT																								
	SUPINE		✓				✓				✓				✓								✓	✓	
	HOB 30 DEGREES																								
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE		✓																					✓	
	PAIN SCALE (1-10)																+		+		+				
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN (2) Soft & Flat (1) Distended			2				2				2				2					2				2	
BOWEL SOUNDS (active all quads)			Ø				⊖				⊖				X					⊖				Ø	
NG / DOBHOFF PLACEMENT VERIFIED			✓				✓								✓					✓				✓	
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT			✓				✓				✓				✓					✓				✓	
VOIDING CLEAR, YELLOW URINE q.s.							✓				✓				✓					✓					
SKIN INTEGRITY	No Breakdown						✓				✓									✓					
Iodine ABD	Surgical Wounds		✓								✓				✓					✓				✓	
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1 ABD			✓				✓				✓				✓					✓					
#2 CT Dressing																								✓	
#3																									

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
18G PIV	(R) hand	23Oct	Patent & s/sx of infection or infiltration 0600/100
TLC	(R) arm	23Oct	D/C'd 23Oct03
A-line	(L) radial	23Oct	Patent & s/sx of infection or infiltration 0600/10
Cordis	(L) groin	23Oct 1800	Patent & s/sx of infection or infiltration 0600/10
CT #1			PATENT & INTACT 0600/1000 / 1400/1700
CT #2			
CT #3			
CT #4			

(b)(6)-2

MEDCOM - 2543

PUPIL SIZE		PUPILS	MOTOR FUNCTION	CHART CODES
1 mm	=	Equal	0 = No Movement	Present ✓
2 mm	R	Reactive	1 = Slight Flicker/ Trace of Contraction	
3 mm	NR	NonReactive	2 = Active (Gravity Eliminated)	Not Applicable/Absent (blank)
4 mm	L > R	Left Larger	3 = Active: against gravity, but not against resistance 4 = Active: Against Gravity and Resistance, not full strength	Refer to Nsg. Notes X
5 mm	R > L	Right Larger	5 = Full Strength against Examiners Resistance	No Change from Previous Assessment –

DATE: 24 OCT. 03

| TIME | | |

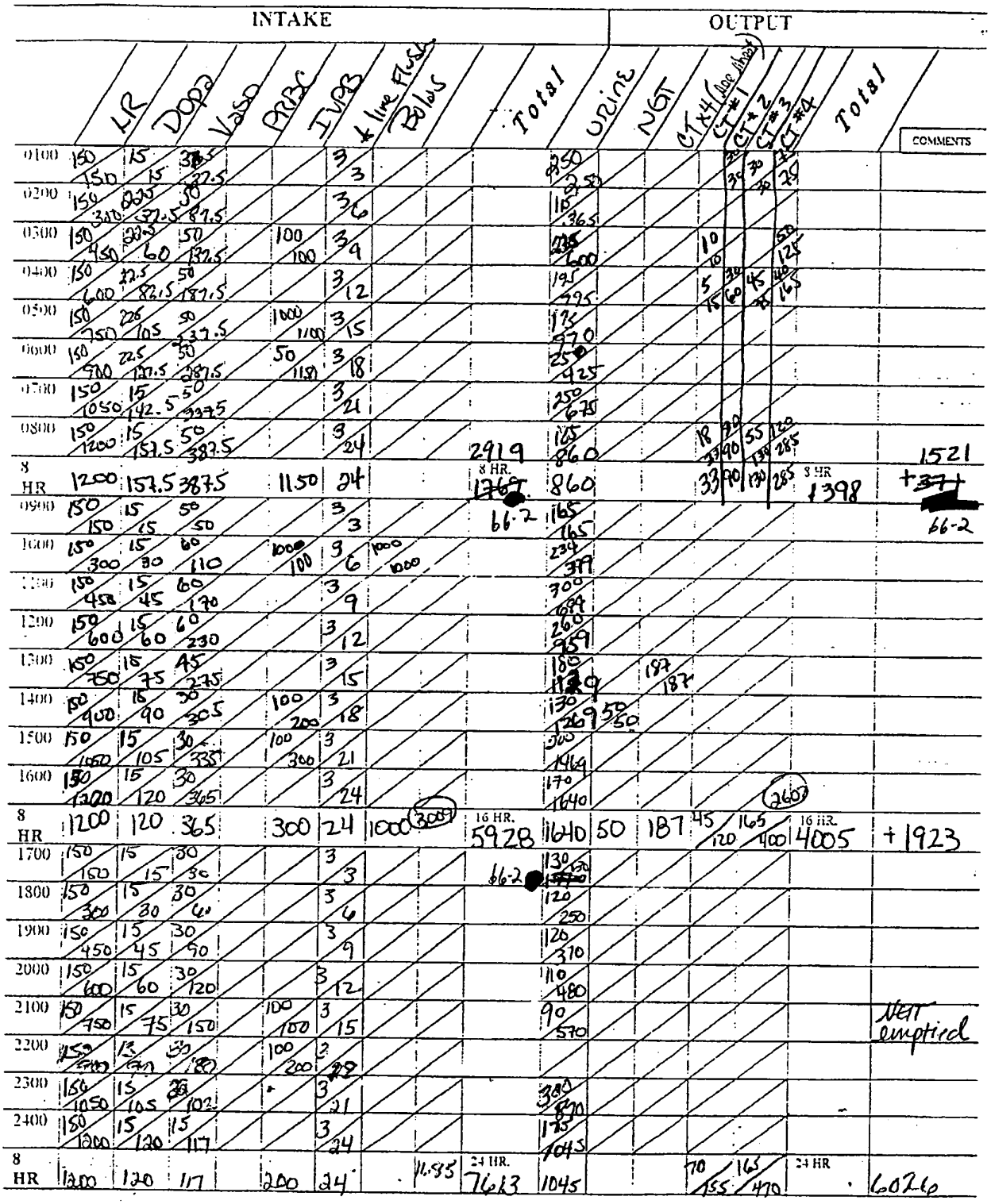
VITAL SIGNS

TIME	T	P	R	B.P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100		83	10/10	109/62	100	104/59	81										
0200	99.2	75	10/10	157/69	100	161/74	94										
0300		80	24/10	107/55	100	112/55	68										
0400		80	10/10	121/54	100	113/61	73										
0500																	
0600	98°(A)	76	17/10		100%	116/60	75										
0700	98°(A)	79	10/10		100%	114/61	76										
0800	99°(A)	78	10/10		100%	106/56	69										
0900	99°(A)	74	10/10		100%	110/58	73										
1000		74	10/10		100%	131/65	80										
1100	98°(A)	76	10/10		99%	131/62	80										
1200		81	10/10		95%	105/55	68										
1300	99°(A)	78	10/10		97%	115/55	70										
1400		81	10/10		100%	119/59	71										
1500	98.3°(A)	74	10/10		100%	117/55	69										
1600	98.2°(A)	73	10/10		99%	117/56	70										
1700		74	10/10		98%	122/56	73										
1800	98.4°(A)	73	10/10		100%	123/55	71										
1900	98°(A)	75	10/10		99	126/55	70										
2000	98°(A)	73	10/10		100	111/52	69										
2100	98.8(A)	75	10/10		100	145/53	72										
2200		73	10/10		99	152/56	76										
2300	98.1	76	10/10		100	164/72	76										
2400		80	10/10		100	169/58	74										

ACLU-RDI 1099 p.1329

DOD 006597

	INTAKE								OUTPUT								
	LR	Dopa	Vaso	PRBC	IVPB	+ line flush	Bolus	Total	Urine	NGT	CT x4 (line thread)	CT #1	CT #2	CT #3	CT #4	Total	COMMENTS
0100	150 / 150	15 / 15	37.5 / 37.5		3 / 3				250 / 250			30 / 30	30 / 30	75 / 75			
0200	150 / 300	22.5 / 37.5	50 / 87.5		3 / 6				115 / 365								
0300	150 / 450	22.5 / 60	50 / 137.5	100 / 100	3 / 9				235 / 600			10 / 10			50 / 125		
0400	150 / 600	22.5 / 82.5	50 / 187.5		3 / 12				195 / 795			5 / 15	30 / 60	45 / 75	40 / 165		
0500	150 / 750	22.5 / 105	50 / 237.5	1000 / 1100	3 / 15				175 / 970								
0600	150 / 900	22.5 / 127.5	50 / 287.5	50 / 1150	3 / 18				250 / 425								
0700	150 / 1050	15 / 142.5	50 / 337.5		3 / 21				250 / 675								
0800	150 / 1200	15 / 157.5	50 / 387.5		3 / 24			2919	185 / 860			18 / 33	30 / 90	55 / 130	120 / 285		
8 HR	1200	157.5	387.5	1150	24			8 HR. ~~1769~~ 66.2	860			33	90	130	285	8 HR 1398	1521 + ~~371~~ 66-2
0900	150 / 150	15 / 15	50 / 50		3 / 3				165 / 165								
1000	150 / 300	15 / 30	60 / 110	1000 / 100	3 / 6	1000 / 1000			234 / 399								
1100	150 / 450	15 / 45	60 / 170		3 / 9				300 / 699								
1200	150 / 600	15 / 60	60 / 230		3 / 12				260 / 959								
1300	150 / 750	15 / 75	45 / 275		3 / 15				180 / 1129		187 / 187						
1400	150 / 900	15 / 90	30 / 305	100 / 200	3 / 18				130 / 1269	50 / 50							
1500	150 / 1050	15 / 105	30 / 335	100 / 300	3 / 21				200 / 1469								
1600	150 / 1200	15 / 120	30 / 365		3 / 24				170 / 1640								
8 HR	1200	120	365	300	24	1000	3009	16 HR. 5928	1640	50	187	45 / 120	165 / 400	2607		16 HR. 4005	+ 1923
1700	150 / 150	15 / 15	30 / 30		3 / 3			66-2	130 / 150								
1800	150 / 300	15 / 30	30 / 60		3 / 6				120 / 250								
1900	150 / 450	15 / 45	30 / 90		3 / 9				120 / 370								
2000	150 / 600	15 / 60	30 / 120		3 / 12				110 / 480								
2100	150 / 750	15 / 75	30 / 150	100 / 100	3 / 15				90 / 570								NGT emptied
2200	150 / 900	15 / 90	30 / 180	100 / 200	3 / 18												
2300	150 / 1050	15 / 105	30 / 102		3 / 21				380 / 870								
2400	150 / 1200	15 / 120	15 / 117		3 / 24				175 / 1045								
8 HR	1200	120	117	200	24		11.85	24 HR. 7613	1045			70 / 155	165 / 470			24 HR	6026



MEDCOM - 2546

NSN 7540-00-634-4121

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
24 Oct 03	0100		Resting supine. Ø apparent distress. Cont to monitor. [redacted] cpt AN
24 Oct 03	0300		Agitated ⅋ assessment. B/P ↓ temp c̄ pump failure. Vasopression restarted ⅋ 5min + B/P is WNL. Cont. to monitor. [redacted] cpt AN
24 Oct 03	0500		Resting quietly. Ø Signs of distress. Cont to monitor. [redacted] cpt AN
24 Oct 03	0630		NAD VSS. LR @ 150 cc/hr. Dopamine @ 5mcg/Kg/min, & Vasopress 0.7 UN/Mn. CT's 1-4 patent c̄ serosanguinous drainage NGT TO LIWS. See flowsheet for assessment. [redacted] ICT, AN
24 Oct 03	0850		Informed Dr [redacted] of SBP ↓ to High 90's ↑ Vasopressin to 8u/min & began bolus of 1 Liter LR Will Continue to monitor. [redacted] ICT, AN
24 Oct 03	1190		VSS. NAD. (L) Femoral Dsg Δ'd. Dsg Applied to (L) ↓ back Wound. DRAINING Serosanguinos fluid. Pt follows COMMAND No movement of LE's. REORIENTED to PLACE & Condition [redacted] ICT, AN
24 Oct 03		1500	(R) hand/arm cold up to elbow, (+) pitting edema on ~~plantar~~ dorsal aspect of hand, (+) capillary refill. (R) hand 18G IV d/c'd d/t s/sx infiltration. No bleeding noted upon removal of IV. Pressure held to site for 1-2 minutes and small dsg applied. (B) radial pulses are weak difficult to find. Unable to palpate pedal pulses but cap refill on (B) toes < 3 sec, feet are cool. Chest, abd and chest tube dsgs Δ'd by Dr. [redacted] - dry and intact. All CT → suction c̄ bubbling in fluid chamber. Pt able to follow commands appropriately c̄ interpreter; Ø movement of lower extremities noted. Pt appears to be hypersensitive to touch, flinches to light touch @ ~ the level of the umbilicus. A few, distant bowel sounds were noted in LLQ and RLQ only. Small amt rhonchi noted during expiration in RLL and LLL of lungs. [redacted] MAT AN

MEDCOM - 2547

NSN 7540-00-634-4176

MEDICAL RECORD — AUTHORIZED FOR LOCAL REPRODUCTION

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
24 Oct 03 1930	(R) radial pulses weak, difficult to palpate. Unable to palpate (R) pedal pulses; (R) pedal pulses dopplerable, cap refill to (R) toes < 3 sec. Pt's head elevated ~ 20° and pt log rolled to (R) side. C/o abd pain per interpreter → 3mg MSO4 given, BP stable. Pt is cooperative and appropriate. Denies ability to move legs, denies touch sensation from pubis and below, remains hypersensitive to touch above level of umbilicus. (+) bowel sounds heard on auscultation. [b)(6)-2] MS AW
24 Oct 03 2015	ETT suctioned for minimal amt of blood drainage. (+) cough reflex. [b)(6)-2] MS AW
24 Oct 03 2300	Resp Asystole. VSS* in 120's. ↑ to 150's ↓ questioning. Vent settings unchanged. CT Dressings CDI, Opens eyes. Answers questions. Writes in both English & Arabic on clip board. Denies pain at this time. Pulses palpable c Doppler. Unable to move legs. Continue to monitor. [b)(6)-2] AW
25 Oct 03 0330	B/P remains ↑. Vasopressin to 0.7. Continue to monitor. [b)(6)-2] AW
25 Oct 03 2330	Vasopressin to 0.4 units per hour. Continue to monitor. VSS [b)(6)-2] AW
26 Oct 03 0030	B/P remains 140's. Vasopressin at 4 units. Continue to monitor. Vasopressin ↓ to 2 units. [b)(6)-2] Cpt AW

HOSPITAL OR MEDICAL FACILITY | STATUS | DEPART./SERVICE | RECORDS MAINTAINED AT

SPONSOR'S NAME | SSN/ID NO. | RELATIONSHIP TO SPONSOR

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.) | REGISTER NO. | WARD NO.

Potus # [b)(6)-4]

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
UMR (41 CFR) 201-9.202-1

MEDCOM - 2548

Chest tube Output c 10CT03

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-400; the proponent agency is the Office of The Surgeon General.

REPORT TITLE: CONTINUED POST-ANESTHESIA CARE UNIT FLOW SHEET

OTSG APPROVED 17 Jan 80

VITAL SIGNS						PAR SCORE						OTHER		
Time	B/P (CT#1)	P (CT#2)	R (CT#3)	O_2Sat (CT#4)	T	Act	Resp	Circ	LOC	Skin	PARS	Other	Neuro-Vascular	COMMENTS
PRE-OP	/												Extr: L R Upper Lower Pulse: DP PT RAD	
0100	10 / 80	30/20	30/30	75/95									Blanche Pulse Warm Moves Y N	
0200	10 / 90	30/80	30/30	50/125									Blanche Pulse Warm Moves Y N	
0500	5 / 15	35/60	45/95	40/165									Blanche Pulse Warm Moves Y N	
0700	18 / 33	30/90	50/130	120/165									Blanche Pulse Warm Moves Y N	
0300	12 / 45	30/120	30/160	115/400									Blanche Pulse Warm Moves Y N	
	/												Blanche Pulse Warm Moves Y N	
1500	0 / 45	5/125	5/165	0/400									Blanche Pulse Warm Moves Y N	
1600	/												Blanche Pulse Warm Moves Y N	
1700	/												Blanche Pulse Warm Moves Y N	
1800	10 / 55	10/135	0/165	15/445									Blanche Pulse Warm Moves Y N	
1900	5 / 60	20/155	0/165	30/445									Blanche Pulse Warm Moves Y N	
2000	8 /												Blanche Pulse Warm Moves Y N	
2100	10 / 70	0/155	0/165	25/470									Blanche Pulse Warm Moves Y N	
2200	/												Blanche Pulse Warm Moves Y N	

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	23 Oct
DOS	23 Oct
POD	2

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	7613
24 Hour Output	6026
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			N
Call Light Within Reach	N/A	/A	N
Side Rails Up			
Bed in Low Position			

PHYSICIAN'S Signature and Title	Department/Service/Clinic	DATE
(b)(6)-2 Col AN	ICU	25 Oct 08

PATIENT'S IDENTIFICATION *(Typed or written entries e.g., Name-last, first, Middle, grade/date; hospital or medical facility)*

Potus (b)(6)-4

- ☐ HISTORY PHYSICAL
- ☑ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☐ OTHER *(Specify)*
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

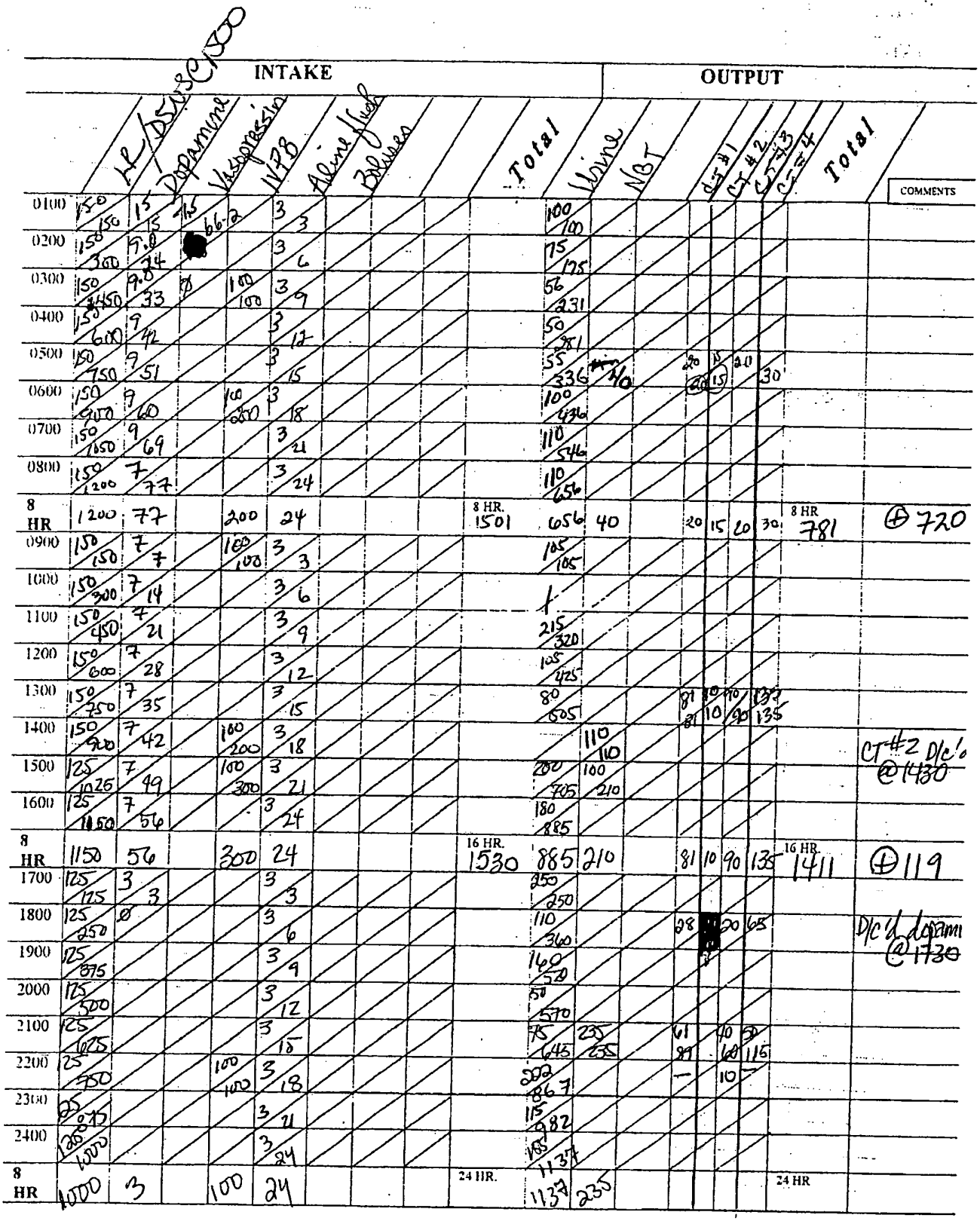
MEDCOM - 2550

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R		2				2					2			2				2					2	
	RADIAL L		2				2					2			2				2					2	
	DORSALIS PEDIS R		2				2					2			2				2					2	
	DORSALIS PEDIS L		2				2					2			2				2					2	
SKIN (1) Dry (4) Cool (7) Jaundiced (2) Clammy (5) Flushed (8) Color Normal (3) Warm (6) Cyanotic (9) Pale			1 3 8				1 3 8					1 3 8			1 3 8				1 3 8					1 3 8	
EDEMA			Gen				Gen					Gen			GEN				GEN					—	
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)			✓				✓					✓			S,S2 ✓				S,S2 ✓					✓	
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)			SR				✓					✓			✓				✓					✓	
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)															✓									✓	
HYGIENE	BED BATH									✓															
	FOLEY CARE		✓							✓															
	ORAL CARE									✓															
MOBILITY	BEDREST						✓					✓			✓				✓					✓	
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT		✓																	✓					
	LEFT																								
	SUPINE						✓					✓			✓									✓	
	HOB 30 DEGREES																		✓	✓				✓	
FALLS PROTOCOL INITIATED																				✓					
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE		✓				✓					✓			✓				✓					✓	
	PAIN SCALE (1-10)																								
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended		2				2					2			2				2					2	
BOWEL SOUNDS (active all quads)			Ø				Ø					Ø			abs.				abs						
NG / DOBHOFF PLACEMENT VERIFIED			✓				✓									✓									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT			✓				✓					✓			✓				✓						
VOIDING CLEAR, YELLOW URINE q.s.							✓					✓			✓				✓					✓	
SKIN INTEGRITY	No Breakdown									✓														✓	
mL Abd, [redacted]	Surgical Wounds		✓				✓					✓			✓				✓					✓	
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1 mL Abd			✓				✓					✓			✓				✓					✓	
#2 CT dressings			✓				✓					✓			✓				✓					✓	
#3 D'Hugn															✓				✓					✓	
#4 back																				✓					

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
A Line	(R) Radial	23 Oct	Patent /0600/1100/1400/e2300
Cordis	(L) femoral	23 Oct	Patent ± S/Sx of infection/inflammation/0600/
CT # 1			
CT # 2	D/C'd @ 1430		
CT # 3			patent + intact 0600/1100/1400/1800/2300

MEDCOM - 2551

	INTAKE									OUTPUT								
	LR/D5W SC1500	Dopamine	Vasopressin	IVPB	Aline/flush	Boluses			Total	Urine	NGT		CT #1	CT #2	CT #3	CT #4	Total	COMMENTS
0100	150/150	15/15	7.5	66.2	3/3					100/100								
0200	150/300	9.0/24	[illegible]		3/6					75/175								
0300	150/450	9.0/33	Ø	100/100	3/9					56/231								
0400	150/600	9/42			3/12					50/281								
0500	150/750	9/51			3/15					55/336	40		20/20	15/15	20	30		
0600	150/900	9/60		100/200	3/18					100/436								
0700	150/1050	9/69			3/21					110/546								
0800	150/1200	7/77			3/24					110/656								
8 HR	1200	77		200	24				8 HR. 1501	656	40		20	15	20	30	8 HR 781	⊕ 720
0900	150/150	7/7		100/100	3/3					105/105								
1000	150/300	7/14			3/6													
1100	150/450	7/21			3/9					215/320								
1200	150/600	7/28			3/12					105/425								
1300	150/750	7/35			3/15					80/505			81/81	10/10	90/90	135/135		
1400	150/900	7/42		100/200	3/18						110/110							CT #2 D/c'd @1430
1500	125/1025	7/49		100/300	3/21					200/705	100/210							
1600	125/1150	7/56			3/24					180/885								
8 HR	1150	56		300	24				16 HR. 1530	885	210		81	10	90	135	16 HR. 1411	⊕ 119
1700	125/125	3/3			3/3					250/250								
1800	125/250	Ø			3/6					110/360			28	[illegible]	20	65		D/c'd dopami @1730
1900	125/375				3/9					160/520								
2000	125/500				3/12					50/570								
2100	125/625				3/15					75/645	235/235		61/89	40/60	50/115			
2200	125/750			100/100	3/18					222/867			—	10	—			
2300	125/875				3/21					115/982								
2400	125/1000				3/24					155/1137								
8 HR	1000	3		100	24				24 HR.	1137	235						24 HR	



MEDCOM - 2552

NSN 7540-00-634-4123

MEDICAL RECORD			NURSING NOTE (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
25 Oct 03	0100		Vasopression to Off. Dopamine ↓ to 3ucgKg/min. VSS. SBP 130's-140's Continue to monitor. [redacted] pt AN
25 Oct 03	0200		SB/P remains >130. Dopamine at 3ucgs. MSO4 given for pain, at 0130. Currently resting c̄ distress. Pulses palpable at 2 p ↓ in Dopamine. Dressings CDI. Moves upper extremeties c̄ diff. Cont to monitor. [redacted] pt AN
25 Oct 03	0435		Blood drawn. Ø apparent distress. VSS. Cont to monitor. [redacted] pt AN
25 OCT 03	0630		NAD. VSS. LR @ 150cc hr. Dopamine 3 Mcg/Kg/min. Vasopression off. Follows Commands. [redacted] ILT, AN
25 OCT 03	0700		↓ Dopamine to 2.3 mcg/Kg/min Per Dr [redacted] SBP↑150's [redacted] ILT, AN
25 OCT 03	0745		Informed Dr [redacted] of Collevation between Invasive & NIBP. ~~IAB~~ SIBP ≥30 over SNIBP. Ordered to track NIBP. [redacted] ILT, AN
25 OCT 03	0935		Medicated c̄ MSO4 3mg IV & Versed 1mg IV for c/o pain and agitation. Bite block Δ'd. Drsg to back Δ'd. c̄ SS drainage (SATURATED) No skin breakdown noted. VSS. Tolerating ↓ vent RR to 8 [redacted] ILT, AN
		1400	Assumed care. NAD. Responds via headshake/writing on clip board. denies pain/discomfort. Dr [redacted] in to see pt. D/c'd ct #2, covered c̄ 4X4-CDI. Δ'd drsg to (L) thigh, D/c'd penrose, covered c̄ 4X4-CDI. Δ'd vent settings to SIMV.8. Pt somewhat uncomfortable c̄ Δ, but explained that it was to encourage him to take own breaths. Pt then calmed down. [redacted] ILT/AN
		1500	Administered 3mg MSO4 IV, 1mg Versed IV for pain/agitation [redacted] ILT/AN
		1645	Pt agitated, pointing towards mouth. Suctioned mouth and repositioned bite block & tube. Pt somewhat frustrated. Administered 3mg MSO4 & 1mg Versed IV. SpO2 100% Resp. 15. Will continue to monitor. [redacted] ILT/AN

MEDCOM - 2553

PUPIL SIZE		PUPILS	
1 mm	=	Equal	
2 mm	R	Reactive	
3 mm	NR	NonReactive	
4 mm	L > R	Left Larger	
5 mm	R > L	Right Larger	

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable /Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment –

DATE: 25 OCT 03

TIME		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open			4				4				4				4				4					4	
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response			E T T				1 T				1 T				1 T				1 T					1	
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response			6				6				6				6				6					6	
GLASCOW COMA SCALE (A+B+C)			11T				11T				11T				11T				15					11	
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R		4+				3+				3+				3+									3+	
	L		N/A				N/A				N/A				N/A									N/A	
MOVEMENT (See Motor Function Scale at Top of Page)	RUE		4				4				4				4				4					4	
	LUE		4				4				4				4				4					4	
	RLE		0				0				0				0				0					0	
	LLE		0				0				0				0				0					0	
GRIP (S) Strong (W) Weak (-) absent	R		W				W				W				W				W					W	
	L		W				W				W				W				W					W	
RESPIRATIONS	REGULAR		V				V				V				V				V					V	
	IRREGULAR																								
	UNLABORED		E				E				E				E				E					E	
	LABORED		N				N				N				N				N					N	
	SHALLOW		T				T				T				T				T					T	
	RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL		5				3				5				5				5					5	
	LUL		5				3				5				5				5					5	
	RLL		5				3				5				5				5					5	
	LLL		5				3				5				5				5					5	
	BOTH BASES						✓				✓														
COUGH	NONE		✓				✓				✓				✓				✓					✓	
	SPONTANEOUS																								
	PRODUCTIVE																								
	NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																									
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																									
VENTILATOR	Vt		800				800				800				800				800					800	
	FIO2		40				40				40				40				40					40	
~~A/C~~ ATC SIMV@1430	RATE (SIMV/CMV)		10				10				8				8				8					8	
	PEEP / CPAP		5				5				5				5				5					5	
	PRESS. SUPPORT		0				0				0				8				0					0	
OXYGEN DELIVERY DEVICE	NC (l/min)																								
	FM (l/min)																								
ETT # 8.5	NRBM (l/min)																								
	ETT 22 cm gums		✓				✓				✓				✓				✓					✓	
ETT CARE / POSITION CHANGE									✓		✓														
ETT / NT SUCTIONED									✓	✓						✓			✓						
INCENTIVE SPIROMETRY DONE																✓			✓					✓	
COUGH / DEEP BREATH																									
INITIALS		(b)(6)-2				(b)(6)-2					(b)(6)-2			(b)(6)-2		(b)(6)-2		(b)(6)-2						(b)(6)-2	

ACLU-RDI 1099 p.1338

DOD 006606

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100		81	19/10		100	135/48	65										
0200	99°	90	18/10		100	142/44	64										
0300		85	10/10		100	145/46	64										
0400		81	10/10		100	124/46	62										
0500	98.2	86	10/10		100	110/44	59										
0600	98.2 (A)	82	19/10		100	127/46	64										
0700		77	10/10		100%	148/58	66										
0800	97.8 (A)	86	9/8	99/41	100%	152/48	68										
0900	98.6 (A)	112	22/8	107/48	100%	162/58	85										
1000		84	8/8	103/39	100%	149/49	68										
1100	97.8 (A)	83	9/8	108/42	100%	142/52	70										
1200		83	10/8	110/45	100%	156/80	78										
1300	97.8 (A)	85	8/8	113/45	100%	163/50	70										
1400		100	14/8	111/49	100%		70										
1500	97.8 (A)	100	20/8	117/51	100%	177/56	75										
1600		96	9/8	109/45	100%	169/55	76										
1700	97.9 (A)	97	16/8	119/48	100	166/51	71										
1800		86	13/8	104/43	100	163/52	65										
1900	97.9 (A)	97	15/8	117/48	100	170/55	74										
2000		88	11/8	110/43	100	161/51	75										
2100	98.2 (A)	87	9/8	117/46	100	160/50	71										
2200	98.8 (A)	98	13/8	119/55	100	/	78										
2300	/	93	19/8	112/51	100	149/60	72										
2400	99.3	99	12/8	115/50	100	154/60	73										

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DOD 006607

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
25 Oct 03 1825	Pt requested "shorts" by writing on clipboard. Turned pt on (R) side. Placed shorts on, and Δ'd drsg to back. (saturated c̄ SS). Pt stated he was "comfortable" x̄ for "tube". Will continue to monitor [redacted] 00/AN
late entry 1730	D/C'd dopamine. [redacted] 00/AN
1905	Pt agitated, turning head from side to side. SaO2 100%, RR 32. Bagged pt for short times. Lung sounds rhonchus. Sxn - deep X3. Thick yellowish, blood tinged secretions noted. Also, oral sxn'd X 3 repositioned tube & block. ↑ HOB to 30° and put pt flat on back. Pt now appears to be resting comfortably p̄ lng versed IV. Also, applied ace bandages to BLE from knees & feet. Propped feet in flexed position c̄ blanket & egg crate pads. PROM done to BLE from hip down. VSS. afebrile. Will continue to monitor [redacted] 00/AN
25 Oct 03 2200	Assumed care of pt. [redacted] SPC, 9/wu
25 Oct 03 2300	Assessment complete, Ø c/o pain, CT to 20cm suction 6 x3, vent SIMV FiO2 40% Vt 800 Peep 5 Rate 8, NG to LIS DSNS c̄ 20KCL @ 125 to (L) cordis CDI, patent s̄ sx of infiltration, bandage intact to (L) thigh. conducted oral suctioning, pt tolerated well, moniters on, NAD, full assessment on DA form 4700. Egg crate padding below feet midline staple OTA CDI, CT bandages intact, foley tube attached to

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)*

REGISTER NO.

WARD NO. ICU

Potos # [redacted]

MEDCOM - 2556

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

DATE	NOTES
25OCT03 2300 (contin)	(R) thigh, B/p cuff to (R) LE, ACE bandaging to BLE, pulses present normal x 4, interpreter available — [redacted]
26OCT03	(0215) checked NGT placement — [redacted]
26OCT03 0350	Assessment complete pt Supine c̄ HOB elevated, conducted PROM exercise to BLE, pt tolerated well, (L) arm guarding lower abd pt c/o Ø pain @ this time, NGT to LIS, CT's to continuous 20cm suction Ø BS LS CTA. (R) lateral upper torso bandage CDI, CT bandages intact, OTA ML incision intact s̄ seepage, pt opens eyes spontaneously, responds to commands generalized non-pitting edema to BLE's, (R) hand more than (L) hand, ACE wrapping to BLE, cap refill <3sec. x 4 ext. ↑ Temp 99°, attempted cold damp cloth to skin, pt declined, indicates he's cold, will continue to monitor — [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK
USAPA V1.00

MEDCOM - 2557

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	23 OCT 03
DOS	23 OCT 03
POD	3

24 HOUR DATA	
24 Hour Balance	-893
24 Hour Intake	3972
24 Hour Output	4867
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2 [redacted] , SIWLIZ	(b)(6)-2 [redacted]
[redacted] ZAN	

Safety Checks	D	E	N
BVM at bedside	[redacted]		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach	N		N
Side Rails Up		A	A
Bed in Low Position			

PREPARED BY (Signature and Title) (b)(6)-2 [redacted] , SIWLIZ

Department/Service/Clinic: ICU

DATE: 26 OCT 03

PATIENT'S IDENTIFICATION (*For typed or written entries give: Name-last, first, Middle; grade:date; hospital or medical facility*)

Potus (b)(6)-4 [redacted]

- ☐ HISTORY/PHYSICAL
- ☒ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☐ OTHER(*Specify*)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 2558

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R			2				2				2			2				2				2		
	RADIAL L			2				2				2			2				2				2		
	DORSALIS PEDIS R			2				2				2			2				2				2		
	DORSALIS PEDIS L			2				2				2			2				2				2		
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale				3				†				3			3				3				3		
				3				3				3			3				3				3		
				8				8				8			8				8				8		
EDEMA				GEN				Gen				Gen			GEN				GEN				—		
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)				✓				✓				✓			✓				S1S2 ✓				✓		
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)				✓				✓				✓			✓				✓				✓		
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)				✓				✓							✓				✓				✓		
HYGIENE	BED BATH												✓												
	FOLEY CARE												✓												
	ORAL CARE												✓												
MOBILITY	BEDREST			✓				✓				✓			✓								✓		
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT																								
	LEFT																✓		✓				✓		
	SUPINE							✓				✓			✓										
	HOB 30 DEGREES			✓				✓				✓			✓		✓		✓				✓		
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE			PF								✓			✓				✓				PF		
	PAIN SCALE (1-10)						RA																		
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended			2				2				2			2				2				2		
BOWEL SOUNDS (active all quads)				Ø				Ø				Ø			abs				abs				Ø		
NG / DOBHOFF PLACEMENT VERIFIED 10/09/15				✓				✓							✓				✓						
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT				✓				✓				✓			✓				✓				✓		
VOIDING CLEAR, YELLOW URINE q.s.				✓				✓				✓			✓				✓				✓		
SKIN INTEGRITY	No Breakdown														✓				✓						
Midline OR incision	Surgical Wounds			✓				✓				✓			✓				✓				✓		
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1 Midline OR incision				✓				✓				✓			✓				✓				✓		
#2 GT grsg's				✓				✓				✓			✓				✓				✓		
#3 (L) thigh				✓				✓				✓			✓				✓				✓		
#4 back															✓				✓						

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
A-line	(L) Radial	23 OCT	Patent/0800/0700/1100/1400/1800/2200/0
Cordis	(L) SC Normal	23 OCT	Patent S SX of infiltration/0800/0700/1100/
CT #1	(L)	23 OCT	patent/intact/0800
CT #3	(R)	23 OCT	patent/intact/0800 /0700/1100/1400/ 18
CT #4	(R)	23 OCT	patent/intact/0800/ 1800 2200
Foley	Groin	23 OCT	patent intact/0800

ACLU-RDI 1099 p.1343

DOD 006611

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable /Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment –

DATE: 26 OCT 03

TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open			4				4				4			4				4				4		
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response			1				1				1 T			1 T				1 T				1		
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response			6				6				6			6				6				6		
GLASCOW COMA SCALE (A+B+C)			11				11				11T			11T				11T				11		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) R														3+				3+						
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) L			N/A											Ø				n/a Ø						
MOVEMENT (See Motor Function Scale at Top of Page) RUE			3				4				4			4				4				4		
MOVEMENT (See Motor Function Scale at Top of Page) LUE			4				4				4			4				4				4		
MOVEMENT (See Motor Function Scale at Top of Page) RLE			Ø				Ø				Ø			Ø				Ø				Ø		
MOVEMENT (See Motor Function Scale at Top of Page) LLE			Ø				Ø				Ø			Ø				Ø				Ø		
GRIP (S) Strong (W) Weak (-) absent R			W				W				W			W				W				W		
GRIP (S) Strong (W) Weak (-) absent L			W				W				W			W				W	✓			W		
RESPIRATIONS REGULAR			✓				V				V			V				T	✓					
RESPIRATIONS IRREGULAR																								
RESPIRATIONS UNLABORED			✓				E				E A T			E				E				✓		
RESPIRATIONS LABORED																		E				✓		
RESPIRATIONS SHALLOW							D							N				C				[redacted]		
RESPIRATIONS RETRACTIONS							T							T				E						
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished RUL			5				3				3			3				3	5			5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished LUL			5				3				3			3				3	5			5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished RLL			5				3				3			5				5	5			5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished LLL			5				3				3			5				5	5			5		
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished BOTH BASES			✓				✓				✓			✓				1	1			✓		
COUGH NONE			✓				✓				✓			✓				✓						
COUGH SPONTANEOUS																		✓				✓		
COUGH PRODUCTIVE																		✓				✓		
COUGH NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear			1				5											5				5		
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin			3				3											3				3		
VENTILATOR Vt			500				500				500			500				E						
VENTILATOR FIO2			40				40				40			40				X						
VENTILATOR RATE (SIMV)CMV)			8				5				6			6				T						
VENTILATOR PEEP / CPAP			5				5				5			5				U						
VENTILATOR PRESS. SUPPORT			Ø				Ø				Ø			Ø				R						
OXYGEN DELIVERY DEVICE NC (l/min)																		A						
OXYGEN DELIVERY DEVICE FM (l/min)																		T				RA		
OXYGEN DELIVERY DEVICE NRBM (l/min)																		E						
ETT # 85 ETT 22 cm gums													✓				✓	D						
ETT CARE / POSITION CHANGE			✓				✓								✓			1						
ETT / NT SUCTIONED			✓												✓			9						
INCENTIVE SPIROMETRY DONE																		1						
COUGH / DEEP BREATH																		5						
INITIALS		b(6)-2			b(6)-2						b(6)-2						b(6)-2							

MEDCOM - 2560

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100		105	15/8	106/54	100	136/62	76										
0200	99.4	96	15/8	106/49	100	157/63	70										
0300	95.6	82	11/8	103/48	100	157/63	68										
0400	99.0	89	11/8	114/48	100	149/54	72										
0500	99.2	85	2/8	114/51	100		73										
0600	99.6(A)	107	14/8	106/48	100%	159/57	79										
0700		99	10/8	91/37	100%	106/58	69										
0800	99.1(A)	92	11/8	104/50	100%	154/55	75										
0900		88	13/8	111/52	100%	149/57	71										
1000	99.4(A)	115	16/6	127/60	100%	157/70	98										
1100	99.4(A)	111	19/6	141/53	100%	N/A	DRAWING	BLOOD									
1200		100	19/6	126/54	100%	150/70	88										
1300	98.8(A)	107	15/6	122/66	100%	142/78	99										
1400	98.9(A)	89	19/6	132/68	100	133/73	91										
1500		81	19/6	137/68	100	139/76	91										
1600		112	16/6	130/75	100	157/95	96										turned to L
1700	99.0(A)	95	16/6	129/57	100	129/77	81										
1800		86	21	126/60	100	117/79	86									1740	T-piece, NAD
1900	99.7(A)	75	18	117/54	100	133/80	~~100~~ 78										
1915																	T-piece, AAO oriented. SR
2000		97	20	117/57	100	134/89	78										2L NC
2100		101	22	120/48	100	123/91	74										
2200																	
2242	100.8	86	22	109/47	96	109/90	70										
2300	100.9	88	24	112/54	94	116/88	71										RA 2L NC
2400	100.8	107	25	127/53	99	105/83	81										2L NC

	INTAKE									OUTPUT						
	DSNS	IVPB	Aline-flush	Polus					Total	Urine	NGT	CT #1	CT #3	CT #4	Total	COMMENTS
0100	125 / 125		3 / 3							130 / 130	175					
0200	125 / 250		3 / 6							80 / 210	175 / 175					
0300	125 / 375	100 / 100	3 / 9							70 / 280						
0400	125 / 500		3 / 12							100 / 380						
0500	125 / 625		3 / 15							90 / 470		5 / 5	20 / 20	15 / 15		
0600	125 / 750		3 / 18							110 / 580						
0700	125 / 875		3 / 21							105 / 685						
0800	125 / 1000	50 / 150	3 / 24	750 / 750						115 / 800						
8 HR	1000	150	24	750					8 HR. 1924	800	175	5	20	15	8 HR 1017	⊕ 909
0900	125 / 125		3 / 3							150 / 150						
1000	125 / 250	100 / 100	3 / 6							140 / 290						
1100	125 / 375		3 / 9							105 / 395						
1200	125 / 500		3 / 12							120 / 515						
1300	125 / 625		3 / 15							125 / 640	275 / 275	30 / 30	70 / 70	130 / 130		
1400	125 / 650	100 / 200	3 / 18							340 / 980						
1500	125 / 775	100 / 300	3 / 21							260 / 1240						
1600	125 / 900		3 / 24							190 / 1430						
8 HR	900	300	24						16 HR. 1224	1430	275	30	70	130	16 HR. 1935	⊖ 711
1700	125 / 125		3 / 3							240 / 240						
1800	125 / 250		3 / 6							200 / 440	175 / 175	45 / 45	25 / 25	65 / 65		
1900	125 / 375		3 / 9							250 / 690						
2000	75 / 450		3 / 12							190 / 880		15 / 60	0 / 25	10 / 75		
2100	75 / 525		3 / 15							250 / 1130						
2200	75 / 600	50 / 50	3 / 18							200 / 1330						
2300	75 / 675		3 / 21							115 / 1445		5 / 65	0 / 25	5 / 80		
2400	75 / 750		3 / 24							180 / 1625		30 / 85	20 / 45	80 / 160		
8 HR	750	50	24						24 HR. 824	1625		85	45	160	24 HR 1915	⊖ 1091

824 D/c'd

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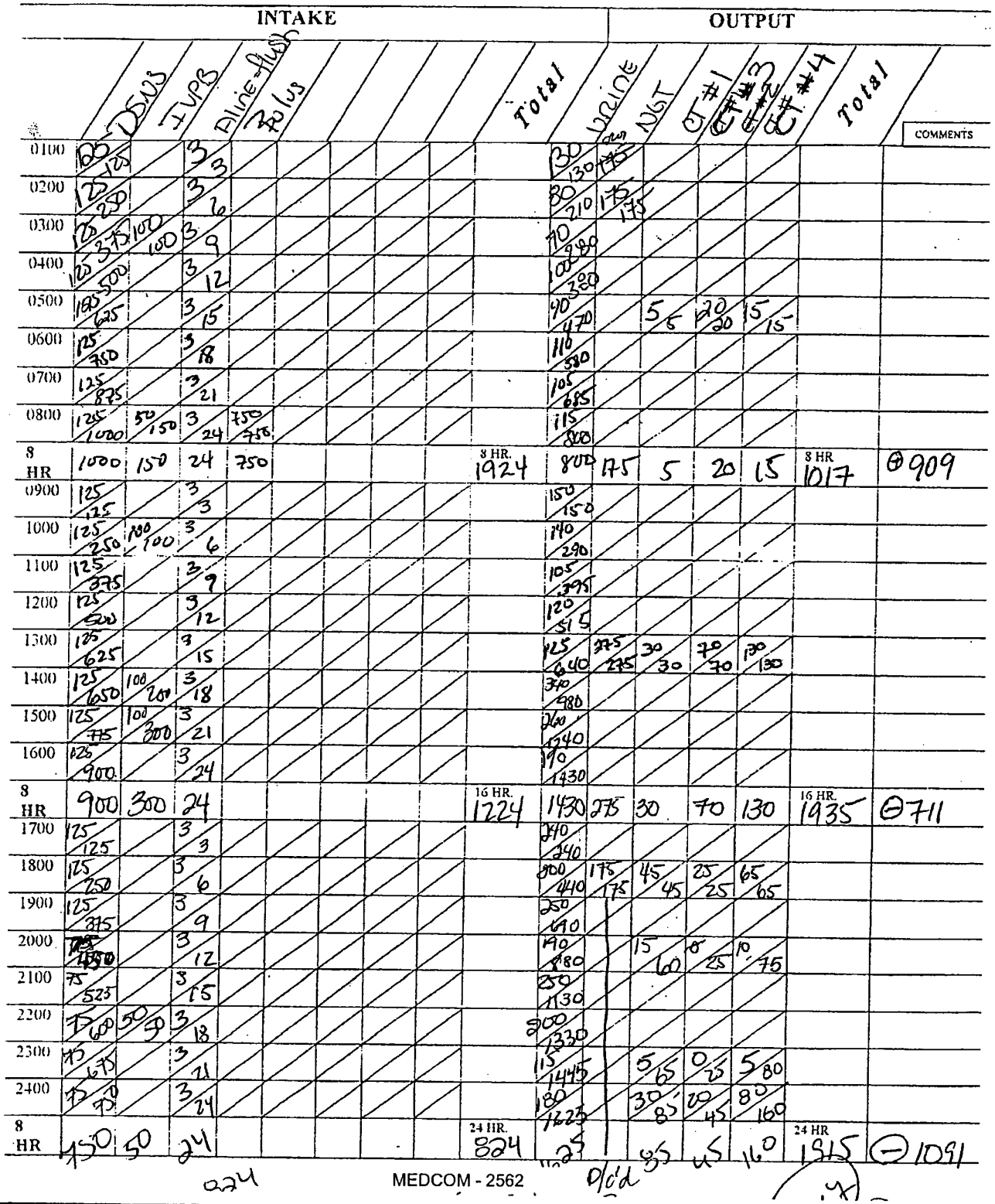

ACLU-RDI 1099 p.1346

DOD 006614

NSN 7540-00-634-4123

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
10/26/03	0645		Pt agitated. ATTEMPTED to pull out ETT. Crying motioning c̄ hand to pull ETT out. VSS. NAD MEDICATED c̄ MSO4 4mg & Versed 2mg IV. D5NS c̄ 20KCl @ 125cc hr. See flowsheet for Assessment. [redacted] LT,
10/26/03	0740		@ 0704 SBP↓ 90 NSR. Initiated LR bolus & Instilled 750cc. SBP back to > 100. A-line continues to not match NIBP. Will inform Dr [redacted] LT,
10/26/03		1300	Tolerating vent RR of 6. ABG shows retention of CO_2 d/T ↓ RR PH 7.40 PCO_2 49.7. Dr [redacted] AWARE. No Δ's to Vent Settings. Periodically medicated c̄ Versed & MSO4 for pain & agitation Control. [redacted] LT,
		1400	Assumed care. See flowsheet for details. Pt c/o "pain" in tire to abdomen. Administered 3mg MSO4 for pain [redacted]
		1600	Turned pt to (L) side to Δ drsg on back. Small amt. SS drainage noted. Chux underneath saturated c̄ serous fluid. Noted CT drsg leaking from (L) anterior chest. Δ'd drsg. Now CDI. While turning. CT #1, #3 & #4 put out significant amt SS fluid. Pt tolerated moderately well. Sxn'd x3 c̄ minimal results. Will continue to monitor [redacted]
		1640	Pt c/o discomfort around ETT. Administered MSO4 2mg IVP [redacted]
		1740	Vent removed, T-piece in place. Pt tolerating well initially on 40% O_2, SaO_2 - 100%, RR - 16-20. [redacted]
		1915	Extubated, pt able to cough. secretions suctioned 40% FM placed. SaO_2 remained 100%. Pt fully awake & able to breathe's distress. NEIT pulled at that time. Orders to ween O_2 to keep SaO_2 96% - ↓ to 2L/NC @ 1945, SaO_2 = 100%. VSS. Assisted pt c̄ oral care. Pt had many questions re: Surgery & explained that he was trying to get "revenge b/c an american soldier ruined his eye". Cont'd. [redacted]

MEDCOM - 2563

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
26Oct03 2000	Pt denies pain/discomfort. Will continue to monitor. ABG drawn @ 1955 — [redacted]
26OCT03 2200	Assumed care of pt, pt resting on (L) side c̄ HOB ↑ NAD, DSNS ~~Assumed~~ ~~care~~ c̄ 20KCL to (L) femoral cardis, resp regular deep unlabored, monitors on, CT's to continuous suction x3, denies pain @ this time — [redacted]
26OCT03 2250	Assessment complete, pt currently on RA, consult DAFORM 4700 for full assessment. Physician ordered CT x3 to water seal @ this time, will continue to monitor [redacted]
26Oct03 2320	turned pt to (R) side, tolerated c̄ difficulty (2330) A'd CT #1 drsg, pt c/o pain could not provide number RN on duty administered 3mg MS04 ~~2238~~ (2338) pt resting s̄ complaint — [redacted]
26Oct03	(2355) moistened pt's lips c̄ lemon swab — [redacted]
27OCT03	(0001) pt presents c̄ productive cough c̄ thick brown sputum — [redacted]
27Oct03	(0345) following assessment, pt presents c̄ productive cough c̄ thick yellow blood tinged sputum & diminished LS to (L) side of chest, PSO2 98% c̄ 32NC — [redacted]
27OCT03	(0440) ↓ O2 to 22NC — [redacted]
27OCT03	(0500) (P)CXR done — [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)*

REGISTER NO.	WARD NO.

POTUS # [redacted]

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

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DATE	NOTES
270CT03	(0515) nurse pt on his back, allowed to RINSE mouth & H_2O, pt spit H_2O out [redacted]
270CT03	(0540) RN on duty D/C (L) Radial A-line [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK
USAPA V1.00

MEDCOM - 2565

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	23 OCT 03
DOS	23 OCT 03
POD	4

24 HOUR DATA	
24 Hour Balance	+13
24 Hour Intake	3653
24 Hour Output	3640
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	(b)(6)-2

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		(b)(6)-2
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach	N		N
Side Rails Up	A		A
Bed in Low Position			

PREPARED BY (Signature and Title) (b)(6)-2 | Department/Service/Clinic: ICU | DATE: 27 OCT 03

PATIENT'S IDENTIFICATION (For typed or written entries give: Name-last, first, Middle; grade; date; hospital or medical facility)

Potus (b)(6)-4

(b)(6)-4

☐ HISTORY PHYSICAL ☒ FLOWCHART

☐ OTHER EXAMINATION Or EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700

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		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R			2				2				2			2				2		-		2		
	RADIAL L			2				2				2			2				2				2		
	DORSALIS PEDIS R			2				2				2			2				2				1		
	DORSALIS PEDIS L			2				2				2			2				2				2		
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale				1 3 8				1 3 8				1 3 8			1 3 8				1 3 8				1 3 8		
EDEMA				(S&D				Gen				Gen			Per				GEN				GEN		
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)				✓				✓ S1S2				✓ S1S2			S1S2 ✓				S1S2 ✓				✓		
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)				✓				✓				✓			✓				NSR ✓				✓		
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)				✓				D/C																	
HYGIENE	BED BATH																								
	FOLEY CARE																								
	ORAL CARE																								
MOBILITY	BEDREST			✓				✓				✓			✓				✓				✓		
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT			✓																		✓	✓		
	LEFT														✓										
	SUPINE							✓				✓			✓										
	HOB 30 DEGREES			✓				✓				✓			✓	✓			✓			✓	✓		
FALLS PROTOCOL INITIATED															✓	✓			✓			✓	✓		
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE			✓				✓				✓			✓				✓				*		
	PAIN SCALE (1-10)																						✓		
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended			2				2				2			2				2				2		
BOWEL SOUNDS (active all quads)				Ø				Hypo BS				Hyp			Hypo				hypo				✓		
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT				✓				✓				✓			✓				✓				✓		
VOIDING CLEAR, YELLOW URINE q.s.				✓				✓				✓			✓				✓				✓		
SKIN INTEGRITY	No Breakdown																								
ML OTA, DC	Surgical Wounds			✓				✓				✓			✓				✓				✓		
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1 Midline incision OTA				✓				✓				✓			✓				✓				✓		
#2 CT dsg's				✓				✓				✓			✓				✓				✓		
#3 (L) thigh				✓				✓				✓			✓				✓				✓		
#4 back															✓				✓						

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
A-line	(R) radial	23 OCT 03	Patent /0445 D/C C0540
Cordis	(L) femoral	23 OCT 03	CDT patent /0445 /0700 1100 1400 1800 2300
CT 1	(L)	23 OCT 03	patent/intact/0445/
CT 3	(R)	23 OCT 03	patent/intact /0445 AMD 1100 1400 1800 2300
CT 4	(R)	23 OCT 03	patent/intact /0445
foley	GROIN	23 OCT 03	patent/intact /0445

ACLU-RDI 1099 p.1351

DOD 006619

PUPIL SIZE		PUPILS	
1 mm	=	Equal	
2 mm	R	Reactive	
3 mm	NR	NonReactive	
4 mm	L > R	Left Larger	
5 mm	R > L	Right Larger	

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable/Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment –

DATE: 07 OCT. 03

TIME	0 1	0 2	0 3	0 4	0 5	0 6	0 7	0 8	0 9	1 0	1 1	1 2	1 3	1 4	1 5	1 6	1 7	1 8	1 9	2 0	2 1	2 2	2 3	2 4
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (2) To Pain (3) To Voice (1) Does Not Open		4					4				4			4					4				4	
B. BEST VERBAL RESPONSE (5) Oriented (2) Garbled (4) Confused (1) No Response (3) Inappropriate Verbal Response		5					5				5			5					5				5	
C. BEST MOTOR RESPONSE (6) Obeys Commands (3) Flexion to Pain (5) Localizes to Pain (2) Extension to Pain (4) Withdraw to Pain (1) No Response		6					6				4			6					4				6	
GLASGOW COMA SCALE (A+B+C)		15					15				15			15					15				15	
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) R														3+										
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) L																								
MOVEMENT (See Motor Function Scale at Top of Page) RUE		4					4				4			4					4				4	
MOVEMENT (See Motor Function Scale at Top of Page) LUE		4					4				4			4					4				4	
MOVEMENT (See Motor Function Scale at Top of Page) RLE		0					0				0			0					0				0	
MOVEMENT (See Motor Function Scale at Top of Page) LLE		0					0				0			0					0				0	
GRIP (S) Strong (W) Weak (-) absent R		W					W				W			W					W				W	
GRIP (S) Strong (W) Weak (-) absent L		W					W				W			W					W				W	
RESPIRATIONS REGULAR		✓					✓				✓			✓					✓					
RESPIRATIONS IRREGULAR																							✓	
RESPIRATIONS UNLABORED		✓					✓				✓			✓					✓				✓	
RESPIRATIONS LABORED																								
RESPIRATIONS SHALLOW																								
RESPIRATIONS RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished RUL		5					5/1				5/1			5					5				5	
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished LUL		1					5/1				5/1			5					5				1	
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished RLL		5					5/1				5/1			1					1				5	
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished LLL		1					5/1				5/1			1					1				5	
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished BOTH BASES		✓					5/1 ✓				5/1 ✓			1					1				✓	
COUGH NONE																								
COUGH SPONTANEOUS		✓					✓				✓			✓					✓				✓	
COUGH PRODUCTIVE		✓												✓										
COUGH NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear		2/3									4/5			4/5										
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin		3									3			3										
VENTILATOR Vt																								
VENTILATOR FiO2																								
VENTILATOR RATE (SIMV/CMV)																								
VENTILATOR PEEP / CPAP																								
VENTILATOR PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE NC (l/min)		2L					3L				3L			3L					3L				2L	
OXYGEN DELIVERY DEVICE FM (l/min)																								
ETT = _____ NRBM (l/min)																								
ETT = _____ ETT _____ cm gums																								
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED																								
INCENTIVE SPIROMETRY DONE																								
COUGH, DEEP BREATH																								
INITIALS		(b)(6)-2																						

ACLU-RDI 1099 p.1352

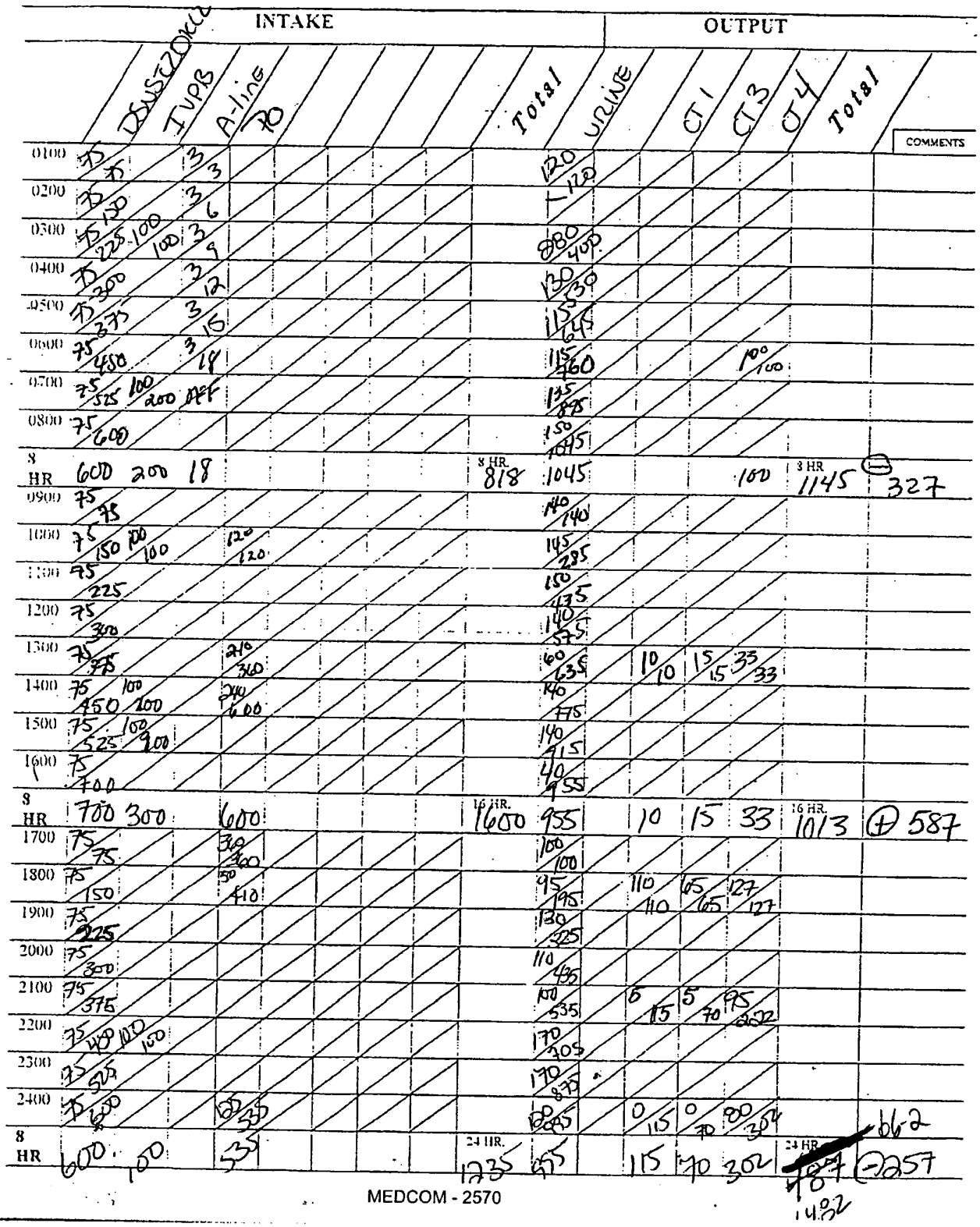
DOD 006620

VITAL SIGNS

TIME	T	P	R	BP	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100	100	103	25	111/51	97	82/62	74										
0200																	
0300	99	91	23	120/54	100	99/94	77				[6] [8]						
0400	/	88	24	120/54	98	103/81	78										
0500	100°	98	21	120/54	98	117/75	78										
0600		85	23	120/48	96												
0700	100	81	29	116/75	94%												
0800		94	28	115/59	100%												
0900	99 (a)	91	31	132/69	98												
1000		82	27	122/57	100												
1100		89	26	120/55	99												
1200	99 (a)	94	26	132/60	100%												
1300		78	30	100/56	100		76										3L/NC
1400		84	28	119/55	100		79										
1500	98.7 (a)	83	23	108/58	100		76										
1600		80	22	106/58	100		76										
1700		86	22	115/64	100		82										
1800		88	20	111/60	100		78										
1900	99 (a)	79	18	114/60	100		80										
2000		77	18	111/58	100		78										
2100		85	20	120/59	100		82										↓2L/NC
2200																	
2300	99.2	83	20	104/55	100		74										2L/NC
2400	/	92	20	110/57	100		79										2L/NC

ACLU-RDI 1099 p.1353

DOD 006621


INTAKE
OUTPUT
Dextrose
IVPB
A-line
PO
Total
Urine
CT 1
CT 3
CT 4
Total
COMMENTS
8 HR
16 HR
24 HR
MEDCOM - 2570

NSN 7540-00-634-4123

MEDICAL RECORD — NURSING NOTES (Sign all notes)			
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS — Include medication and treatment when indicated
10/27/13	0700		Resting quietly in NAD. ⊖ complaint of pain, N/V. VSS DSNS ē 20 KCal @ .75cc. A-line D/c'd by night shift DIT inability to blood draw ± not correlating ē NIBP. Pt speaks English well. Asked when he may be able to eat or drink H_2O. Explained d/t. Surgery may have to wait 1-2 days more. — (b)(6)-2 LCT, Rn.
10/27/13		1300	Tolerated approx. 360 cc CL diet ⊖ N/V. VSS NAD. Denies pain — (b)(6)-2 LCT, Rn
		1400	Assumed care. Pt resting comfortably in bed. Denies pain – c/o minimal discomfort around abd area. VSS, afebrile-VOP QS. See flowsheet for details. Will continue to monitor — (b)(6)-2
		1630	Foam to BLE. Replaced ace bandages from Thigh & feet. Propped heels off bed and propped feet in flexed position. Pt tolerated well. Sitting up @ 45°. Eating clear liquid diet – tolerating well. VSS. — (b)(6)-2
		2120	Pt c/o "all over pain" Tramisfied 1 50mg IVP. (b)(6)-2
27OCT13		2220	Assumed care of pt. pt resting on ⓡ side NAD breathing irregular unlabored, VCE2L — (b)(6)-2
		2315	Pt resting ⊼ distress VS WNL ē Low Grade fever pt O_2 @ 2L NC 100%, Administered SQ Heparin pt tolerated well CT bandages CDI, ML Incision ⊼ sx of infection, closed, CDI, ⓛ femoral cordis CDI running DSNS @ 75 cc/hr, faint pulse to ⓛ DP hypo active BS, ACE bandaging to BLE, Generalized non-pitting edema, MPCBS & interpreter available if needed, full assessment DA form 4700, will continue ē current POC — (b)(6)-2
28OCT13	0220		Provided pt ē PO potassium, pt tolerated 50% of dosage, refused rest remainder — (b)(6)-2
	0730		decreased pt O_2 to 1L NC sat 99-100% —

MEDCOM - 2571

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	23 OCT 03
DOS	23 OCT 03
POD	5

24 HOUR DATA	
24 Hour Balance	-980
24 Hour Intake	2775
24 Hour Output	3755
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside		(b)(6)-2	
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On		N/A	
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title) (b)(6)-2 Department/Service/Clinic: ICU DATE: 28 OCT 03

PATIENT'S IDENTIFICATION (*For typed or written entries give: Name-last, first, Middle; grade; date; hospital or medical facility*)

Potus (b)(6)-4

☐ HISTORY-PHYSICAL ☐ FLOWCHART

☐ OTHER EXAMINATION Or EVALUATION ☐ OTHER(*Specify*)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700

MEDCOM - 2572

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R			2				2					2		2				2				2		
	RADIAL L			2				2					2		2				2				2		
	DORSALIS PEDIS R			2				2					2		2				2				2		
	DORSALIS PEDIS L			2				2					2		2				2				2		
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale				1 3 8				1 3 8					1 3 8		1 3 8				1 3 8				1 3 8		
EDEMA				(-)				(-)					—		—				—						
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)				✓				✓					✓		SSR				SSR				R		
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)				✓				✓					✓		NSR				NSR				NSR		
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH												partial												
	FOLEY CARE																						✓		
	ORAL CARE																								
MOBILITY	BEDREST			✓				✓					✓		✓				✓				✓		
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT			✓											✓										
	LEFT								✓										✓				✓		
	SUPINE							✓					✓												✓
	HOB 30 DEGREES			✓				✓					✓		✓				✓				✓		
FALLS PROTOCOL INITIATED			N/A																						
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)			—																						
PAIN	PAIN FREE			✓				✓					✓		*				PF						✓
	PAIN SCALE (1-10)																								
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended			2				2					2		2				2						2
BOWEL SOUNDS (active all quads)				x4				x4					x4		x4				x4						✓
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT				✓				✓					✓		✓				✓						✓
VOIDING CLEAR, YELLOW URINE q.s.				✓				✓					✓												✓
SKIN INTEGRITY	No Breakdown																								
ML	Surgical Wounds			✓				✓					✓		✓				✓						✓
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1 ML OTA				✓				✓					✓		✓				✓						✓
#2 CT dsg				✓				✓					✓		✓				✓						✓
#3 (L) thigh				✓				✓					✓		✓				✓						✓
#4 back																									

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
CORDIS	(L) FEMORAL	23OCT03	CDT/e dsg
CT 1	(L)	23OCT03	} patent, intact /e dsg
CT 3	(R)	23OCT03	
CT 4	(R)	23OCT03	
foley	GROIN	23OCT03	patent e dsg

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PUPIL SIZE		PUPILS	
1 mm	=	Equal	
2 mm	R	Reactive	
3 mm	NR	NonReactive	
4 mm	L > R	Left Larger	
5 mm	R > L	Right Larger	

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker: Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable /Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment –

DATE: 28 OCT 03

TIME																								
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open			4			4			4	4			4			4								
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response			5			5			5	5			5			5								
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response			6			6			6	6			6			6								
GLASGOW COMA SCALE (A+B+C)			15			15			15	15			15			15								
PUPIL RESPONSE Size mm; React to Light (+) No Response (-)	R																							
	L																							
MOVEMENT (See Motor Function Scale at Top of Page)	RUE		4			4			4	4			4			4								
	LUE		4			4			4	4			4			4								
	RLE		0			0			0	0			0			0								
	LLE		0			0			0	0			0			0								
GRIP (S) Strong (W) Weak (A) absent	R		✓			5			5	5			5			5								
	L		W			5			5	5			5			5								
RESPIRATIONS	REGULAR		✓			✓			✓	✓			✓			✓								
	IRREGULAR																							
	UNLABORED		✓			✓			✓	✓			✓			✓								
	LABORED																							
	SHALLOW																							
	RETRACTIONS																							
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL		5			5			5	5			5			5								
	LUL		1			1			1	5			5			5								
	RLL		5			5			5	1			1			1								
	LLL		1			1			1	1			1			1								
	BOTH BASES		✓			✓			✓	1			1			1								
COUGH	NONE		✓			✓			✓															
	SPONTANEOUS								✓	✓			✓			✓								
	PRODUCTIVE								✓	✓			✓			✓								
	NONPRODUCTIVE																							
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear (6) Bloody																6			2					
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																								
VENTILATOR	Vt																							
	FiO2																							
	RATE-SIMV/CMV																							
	PEEP - CPAP																							
	PRESS. SUPPORT																							
OXYGEN DELIVERY DEVICE	NC (l/min)		RA			RA			RA	RA			RA			RA								
	FM (l/min)																							
ETT = _____	NRBM (l/min)																							
	ETT _____ cm gums																							
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED																								
INCENTIVE SPIROMETRY DONE																								
COUGH / DEEP BREATH																								
INITIALS			(b)(6)-2																					

ACLU-RDI 1099 p.1358

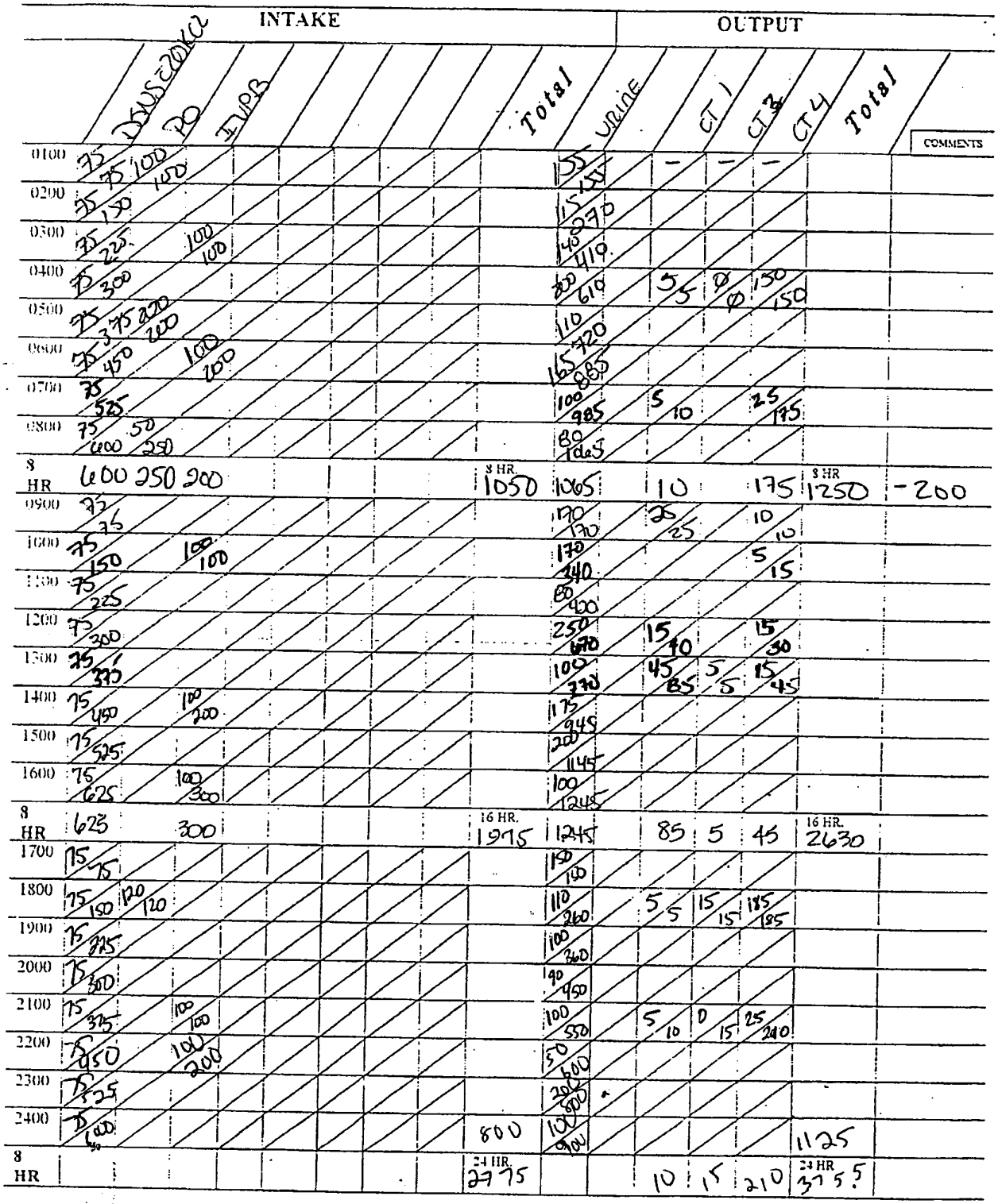
DOD 006626

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100	99⁵	88	18	118/65	99	/	89										2LNC
0200	/	79	18	105/56	100	/	75										1LNC
0300	994	95	20	110/56	97	/	77										RA
0400	/	82	18	113/60	94	/	80										RA
0500	/	86	22	115/61	99	/	82										RA
0600	/	73	20	111/55	97	/	75										RA
0700	995	77	18	115/59	98%		80										RA
0800		90	18	118/62	100%		84										RA
0900		78	18	114/55	99%		77										RA.
1000		75	16	113/57	96%		78										RA
1100		74	16	109/58	98%		78										RA
1200	993	74	16	117/59	95%		80										
1300		74	17	117/58	95%		80										
1400		78	20	118/59	96%		82										RA
1500	994	@81	20	129/66	97%		91										RA
1600		72	20	116/63	95%		82										RA
1700		71	18	114/63	95%		82										RA
1800		84	20	129/70	97%		93										RA
1900		78	20	115/60	96%		81										KA
2000	99¹	80	18	118/64	97%		85										K
2100		83	20	114/59	98%		80										RA
2200		85	18	124/60	99%		84										
2300	982	79	16	118/74	99%												
2400		84	18	127/66	99%		86										

ACLU-RDI 1099 p.1359

DOD 006627



	INTAKE					OUTPUT				
	D5NS+20KCl	PO	IVPB		Total	URINE	CT 1	CT 3	CT 4	Total
0100	75 75	100 100				155 155	–	–	–	
0200	75 150					115 270				
0300	75 225		100 100			149 419				
0400	75 300					200 619	5 5	0 0	150 150	
0500	75 375	220 200				110 720				
0600	75 450		100 200			165 885				
0700	75 525					100 985	5 10	25 175		
0800	75 600	50 250				80 1065				
8 HR	600	250	200		1050	8 HR 1065	10	175	8 HR 1250	-200
0900	75 75					170 170	20 25	10 10		
1000	75 150		100 100			170 340		5 15		
1100	75 225					60 400				
1200	75 300					250 670	15 10	15 30		
1300	75 375					100 770	45 85	5 5	15 45	
1400	75 450		100 200			175 945				
1500	75 525					200 1145				
1600	75 625		100 300			100 1245				
8 HR	625		300		16 HR. 1975	1245	85	5	45	16 HR. 2630
1700	75 75					150 150				
1800	75 150	120 120				110 260	5 5	15 15	185 185	
1900	75 775					100 360				
2000	75 500					90 450				
2100	75 575		100 100			100 550	5 10	0 15	25 240	
2200	75 650		100 200			50 600				
2300	75 725					200 800				
2400	75 800				800	100 900				1125
8 HR					24 HR. 2775		10	15	210	24 HR. 3755

MEDCOM - 2576

NSN 7540-00-634-4123

MEDICAL RECORD	NURSING NOTES (Sign all notes)	
DATE	HOUR A.M. / P.M.	OBSERVATIONS Include medication and treatment when indicated
28Oct03	0700	√ O_2 to RA [b(6)-2]
28Oct03	0530	(P)CXR conducted [b(6)-2]
	0600	received pt this AM; NAD; pt resting c eyes closed will cont to monitor [b(6)-2]
	0830	pt. states he is in pain; MSO4 3mg IVP given; assessment complete; NAD; VSS; will cont to monitor; [b(6)-2]
	1300	partial bed bath done; pt was moved into supine position from being on his (L) side dressing to back CDI; NAD, VSS [b(6)-2]
	1530	Dressing to coccis changed. Pt rolled to (R) side at his request. After roll, pt bed dropped @ HOB and pt c/o pain to dest. Medicated c 5mg MSO4 which helped relieve pain. Instructed importance of continuing to deep breathe. Pt questioned about Ramadan practices. Pt reports he is not following fasting practice [b(6)-2]
	1830	Pt consumed 15% of regular diet c any problems. Brushed teeth and washed face. cleaned lid of (L) eye [b(6)-2]
	2030	Pt reports he has more pain in back when he remains on (L) side than when he remains on right side. He is not having any difficulty breathing but is only able to raise 2 balls on Incentive Spirometer. Tires very easily. Pt Questioned about use of his legs again. Asked if it was forever that he won't be able to use them. [b(6)-2]
28Oct03	2200	Resting, @ S/S of resp. distress denied c/o pain. will continue to monitor pt [b(6)-2]

MEDCOM - 2577

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	23OCT03
DOS	29 OCT03
POD	

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside		(b)(6)-2	
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach		A	
Side Rails Up			
Bed in Low Position			

PHYSICIAN (Signature & Title)	Department/Service/Clinic	DATE
(b)(6)-2 CPN	ICU	29 OCT03

PATIENT'S IDENTIFICATION (*For typed or written entries give: Name-last, first, Middle; grade; date; hospital or medical facility*)

Potus # (b)(6)-4

- ☐ HISTORY/PHYSICAL
- ☐ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☐ OTHER(*Specify*)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700

MEDCOM - 2578

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R		2				2								2								2		
	RADIAL L		2				2								2								2		
	DORSALIS PEDIS R		2				2								2								2		
	DORSALIS PEDIS L		2				2								2								2		
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale			1 3 8				1 3 D								1 3 8								1 3 8		
EDEMA			WNL				BLE								FEN										
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)			R				✓								S1S2								R		
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)			NSR				NSR								✓								NSR		
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH		/						✓																
	FOLEY CARE								✓																
	ORAL CARE																						✓		
MOBILITY	BEDREST						✓	✓	✓						✓										
	BSC																						✓		
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT		/		✓		✓			✓				✓					✓						
	LEFT						✓		✓	✓	✓														
	SUPINE							✓				✓	✓												
	HOB 30 DEGREES						✓	✓	✓		✓		✓	✓	✓				✓						
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE		N												✓										
	PAIN SCALE (1-10)						8/10																		
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended		2												2								2		
BOWEL SOUNDS (active all quads)			/				✓								✓								✓		
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT			/				✓								✓								✓		
VOIDING CLEAR, YELLOW URINE q.s.			/				✓								✓								✓		
SKIN INTEGRITY	No Breakdown														✓										
Abd midline	Surgical Wounds		/				✓								✓								✓		
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1 ABD staples CDT			/				✓								✓										
#2 chest tubes CDT #1, 3, 4			/				✓								✓								✓		
#3 ABD dressing CDT			/				✓								✓								✓		
(L) thigh															✓										

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
central line	(L) fem	23 OCT 03	CDT
Foley			
22g	(L) FA	29 OCT 03	CDI

ACLU-RDI 1099 p.1363

DOD 006631

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable/Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment –

DATE: 29 OCT 03

TIME																								
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open		4				4								4									4	
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response		5				5								5									5	
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response		6				6								6									6	
GLASGOW COMA SCALE (A+B+C)		15				15								15									15	
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R	2+				2+								3+									2	
	L	2+				2+								N/A									2	
MOVEMENT (See Motor Function Scale at Top of Page)	RUE	4				4								4									4	
	LUE	4				4								4									4	
	RLE	0				0								0									0	
	LLE	0				0								0									0	
GRIP (5) Strong (3) Weak (1) Absent	R	4				5								5									5	
	L	4				5								5									5	
RESPIRATIONS	REGULAR	/				✓								✓									—	
	IRREGULAR																							
	UNLABORED	/				✓								✓									—	
	LABORED																							
	SHALLOW																							
	RETRACTIONS																							
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL	5				5								5									5	
	LUL	5				5								5									5	
	RLL	1				1								1									1	
	LLL	1				1								1									1	
	BOTH BASES	1				1								1									1	
COUGH	NONE	//																						
	SPONTANEOUS					✓								✓									✓	
	PRODUCTIVE					✓								✓									✓	
	NONPRODUCTIVE																							
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear		2				2								5									2	
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin														3										
VENTILATOR	Vt																							
	FiO2																							
	RATE (SIMV/CMV)																							
	PEEP - CPAP																							
	PRESS. SUPPORT																							
OXYGEN DELIVERY DEVICE	NC (l/min)																							
	FM (l/min)																							
ETT = _____	NRBM (l/min)																							
	ETT _____ cm gums																							
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED		/																						
INCENTIVE SPIROMETRY DONE						✓								✓									✓	
COUGH / DEEP BREATH		/				✓								✓									✓	
INITIALS		b(6)-2				b(6)-2								b(6)-2									b(6)-2	

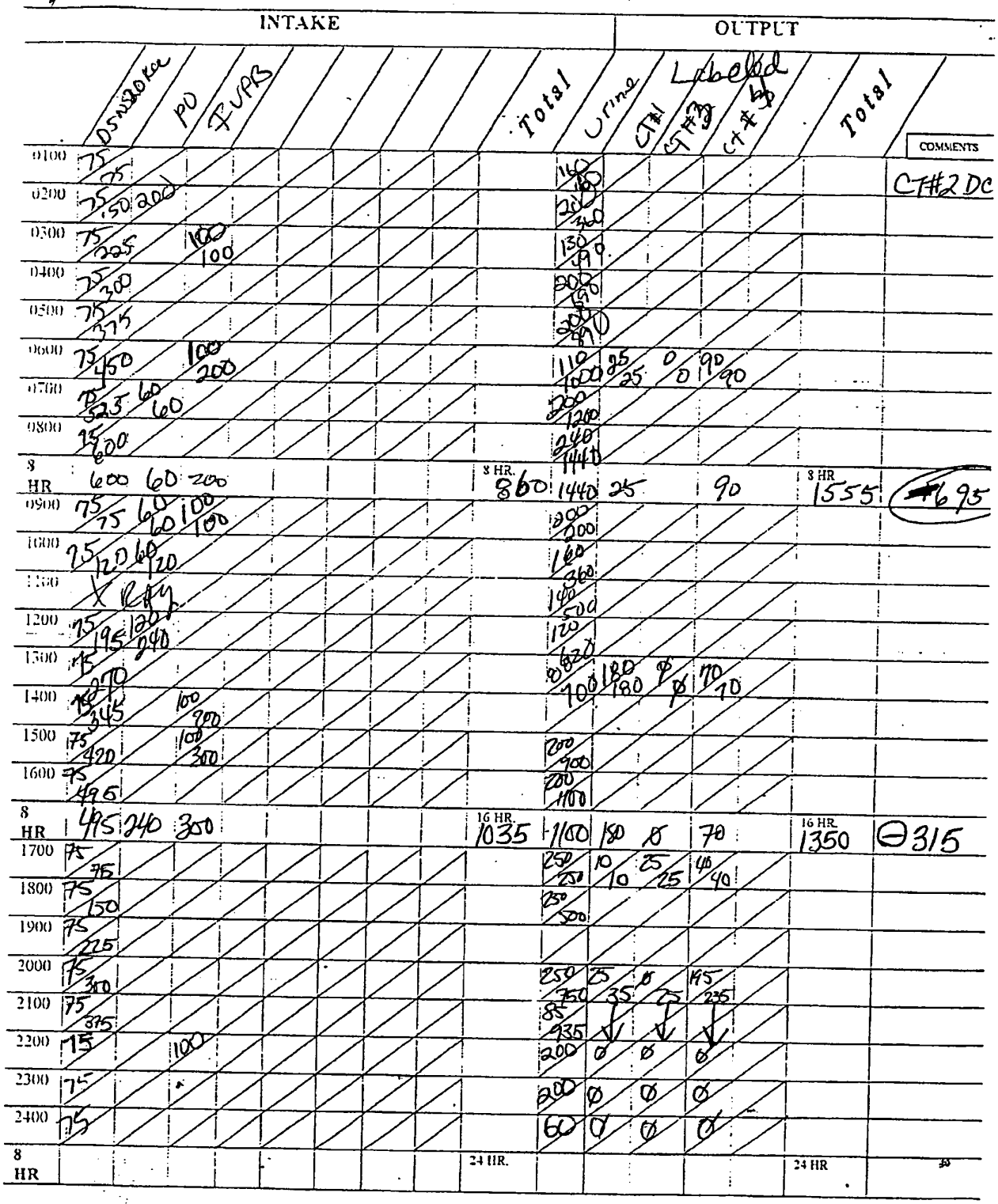
MEDCOM - 2580

VITAL SIGNS

TIME	T	P	R	BP	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100	96.3	87	16	119/59	97%		81										
0200		89	16	114/55	97%		80										
0300	98.5	86	18	121/61	98%		84										
0400		86	18	119/56	98%		82										
0500	98.7	85	18	116/62	97%		83										
0600		77	16	117/64	98%		85										(b)(6)-2
0700	99+	80	21	107/55	96%		76										
0800		80	17	119/66	98%		85										
0900	99+	91	24	114/61	96%		81										
1000																	
1100																	
1200	99+	89	20	113/61	96%		81										
1300		83	16	100/53	96%		71										
1400	98+	76	18	104/56	97%		74										
1500																	
1600																	
1700																	
1800	99+	96	22	124/64	98%		87										
1900																	
2000																	
2100																	
2200	99.6	95	20	109/57	95%		78										
2300																	
2400																	

ACLU-RDI 1099 p.1365

DOD 006633


INTAKE
OUTPUT
Dextrose
PO
IVPB
Total
Urine
CT#1
CT#3
CT#4
Labeled
Total
COMMENTS
CTH2 DC
8 HR
600 60 200
860
1440 25 90
1555
695
16 HR
495 240 350
1035
1100 180 0 70
1350
315
24 HR

MEDCOM - 2582

NSN 7540-00-634-4123

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
29 OCT 03	0300		- C/O pain to back 7/10, pain meds given (see MAR) will continue to monitor pt [redacted] (b)(6)-2
29 OCT 03	0630		Pt A&OX3, cooperative, requesting to be moved on to (L) side, severe pain when log-rolling pt. Lungs sounds clear (B) UL, significantly diminished in Lower Lobes, pulse ox 98% on Room air. Three chest tubes; labeled (#1) Chest tube located (L) lung, (#3) labeled chest tube located anterior (R) lung, (#4) labeled Chest tube posteriorly located (R) lung; all chest tubes to water seal c̄ drainage from #1 & #4 ~~ches~~ labelled chest tubes. (L) femoral central line patent & infusing maintenance NF c̄ difficulty. Urine catheter patent & draining into closed drainage system. (B) Ace bandages applied from calf to mid-foot in replaced of anti-embolis stockings. (L) eye socket sunken & no eyeball clearly seen. (L) ~~anterior~~ LERROR dressing CDI located in posterior chest. (L) upper chest near armpit dressing to wound CDI. (R) lateral chest dressing CDI. Pt taking po fluids c̄ difficulty. Ø acute distress noted. Will continue to monitor. [redacted] (b)(6)-2 LPN
29 OCT 03	10:30		Pt carried to X-ray for lumbar xray series accompanied by staff. Upon returned to ICU pt medicated c̄ Tylenol #3, 2 tabs per pin pain order ~~as~~ ORDER due to severe sternum pain. Will continue to monitor. [redacted] (b)(6)-2 LPN
		1400	Assumed care. Pt resting comfortably in bed. A&OX3, Denies pain. D'd dsg to L thigh. Noted mod. amt dried blood, some puss-like discharge. Flused c̄ sterile saline & expectorated wound. Covered c̄ sterile 4x4. [redacted] (b)(6)-2 WPN

MEDCOM - 2583

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
29Oct03 1515	Pt c/o (R) hand, middle finger pain. Noted swelling around 2nd joint. Dr Eastman aware. Small scab noted. Cleaned c̄ Soap + H_2O, then covered c̄ bacitracin & bandaid. Will cont. to monitor — (b)(6)-2 [redacted] 100/AN
1700	Pt denied dinner, but encouraged to eat something. Pt stated that he would eat fruit + tolerated all of 1 orange. Will continue to monitor — (b)(6)-2 [redacted] 100/AN
1830	Turned pt to (R) side, Δ'd drsg on mid-lower back. Noted small amt dried blood. Site c̄ some pus-like drainage + sm. amt bright red blood — (b)(6)-2 [redacted] 100/AN
1830	Δ'd drsg to (R) flank - sm. amt dried blood noted, left OTA — (b)(6)-2 [redacted] 100/AN
2100	While pt on (R) side, CT # 4 put out ~ 195 cc SS fluid. Will notify Dr (b)(6)-2 [redacted] — (b)(6)-2 [redacted] 100/AN
2200	resting comfortably will continue to monitor pt (b)(6)-2 [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)*

REGISTER NO.	WARD NO.

POTUS # (b)(6)-4 [redacted]

MEDCOM - 2584

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)

DATE	NOTES
	(b)(6)-2
30 Oct 03	~~[illegible]~~ Surgery Note
0930	Pt tolerating diet, no real Q's
	Uss Agents
	L-CTA sat good
	CT = 250 each side
	Ø airleak
	CXR-NOD
	CU-RRR
	old - NABS, soft nontender, Ø masses
	Incision-healing
	B/O = (-)1000
	Ø/p S/p GSW to liver/kidney
	T_2 Paraplegia
	(1) Continue CT
	(2) Supportive care
	(b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK
USAPA V1.00

MEDCOM - 2585

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	23 Oct 03
DOService	~~23 Oct 03~~ 30 Oct 03
POD	7

24 HOUR DATA	
24 Hour Balance	-115
24 Hour Intake	3140
24 Hour Output	3255
Weight on Admission	~~175~~
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside		(b)(6)-2	
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On		N/A	
Call Light Within Reach		N/A	
Side Rails Up		N/A	
Bed in Low Position		N/A	

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
	ICU	30 ~~Oct~~ Oct 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade;date; hospital or medical facility)*

Potus # (b)(6)-4

☐ HISTORY PHYSICAL ☐ FLOWCHART

☐ OTHER EXAMINATION Or EVALUATION ☐ OTHER(Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

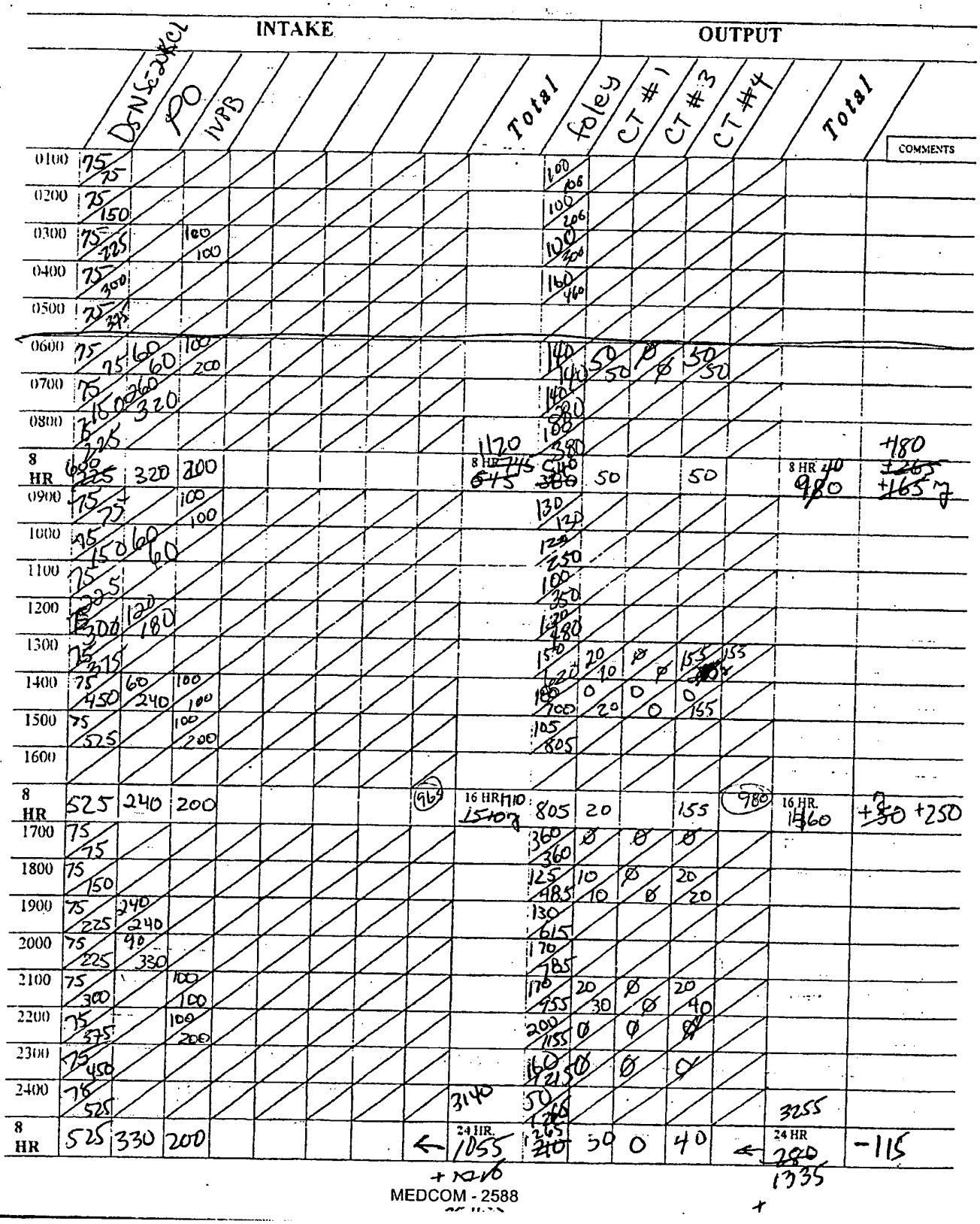
MEDCOM - 2586

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200		100	16	108/56	96%		73										
0300																	
0400																	
0500																	
0600	100	110	17	102/54	98%	—	74	—									KA
0700																	
0800																	
0900																	
1000	100	99	20	105/57	97%	—	72	—									RA
1100																	
1200																	
1300																	
1400	100	102	36	111/55	97		75										RA O_2
1500																	
1600																	
1700																	
1800	99.6	102	32	121/61	98		82										
1900																	RA O_2
2000																	
2100																	
2200	99.2	84	24	109/54	96%		75										
2300																	
2400																	

ACLU-RDI 1099 p.1371

DOD 006639


INTAKE
OUTPUT
D5NS-2KCl
PO
IVPB
Total
foley
CT #1
CT #3
CT #4
Total
COMMENTS
0100
0200
0300
0400
0500
0600
0700
0800
8 HR
0900
1000
1100
1200
1300
1400
1500
1600
8 HR
1700
1800
1900
2000
2100
2200
2300
2400
8 HR
8 HR
16 HR
24 HR
MEDCOM - 2588

NSN 7540-00-634-4123

MEDICAL RECORD — DATE	HOUR A.M.	HOUR P.M.	NURSING NOTES (Sign all notes) OBSERVATIONS Include medication and treatment when indicated
30Oct03	0200		resting comfortably, will continue to monitor pt [b(6)-2] PN
30Oct03	0615		Pt cooperative. Pt T max 100.4 and pt c/o chills. Lungs c (R) diminished lower lobes, (L) U Lobe c crackles, pt c/o severe substernal chest pain during use of I.S. & ~~Cough~~ cough deep, breathe. 3 Chest tubes labelled #1, #3, #4 all intact & at waterseal 20cm. (L) femoral central line intact & infusing Maintenance IV fluid & difficulty. Will continue to monitor [b(6)-2] SGT/LPN
30 Oct 03	1040hrs		(R) femoral introducer removed, manual pressure x 5 min, dsd applied. Tolerated c difficulty, [illegible]
30 Oct 03		1430	Pt alert and appears oriented x 3, cooperative. RR 36, unlabored, shallow. Lung CTA in all lobes, ↓↓ in bases. CT x 3 to waterseal. ACE bandages to lower legs, small - mod pedal edema, non-pitting. Cap refill brisk in all extremities. Pt denies sensation from just below umbilicus to feet. Unable to move legs. % mild back pain, denies need for pain med. [b(6)-2] MJ AN
30 Oct 03		1500	Pt able to lift 2 balls of IS x 6, C+DB → weak cough c loose secretions → swallowed, unable to expel. Pt instructed on rationale for IS and C+DB, states understanding, interpreter @ bedside. [b(6)-2] MJ AN
		1700	IS and C+DB done → small amt thick, yellow blood-tinged sputum; Lifted 2 balls x 9. [b(6)-2] MJ AN
		1800	No Δs in pedal edema noted since previous assessment. Mod. edema also noted to dorsal aspect of (R) hand, site of IV infiltration 4-5 days ago. (R) radial pulse 2+, brisk cap refill to (R) fingernail beds, Pt denies (R) hand pain. [b(6)-2] MJ AN

SEE NEXT PAGE - ATTACHED [redacted] b6-2

ACLU-RDI 1099 p.1373

DOD 006641

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
30 Oct 03 1910	Pt remains tachypneic c RR 32-36, resp. appear unlabored and shallow. Pt denies SOB, SpO_2 97-98% on RA. Dr. [b)(6)-2] informed of RR, PCXR taken. Pt c/o back pain, ii TC#3 given @ 1825. Will cont. to monitor. [b)(6)-2]
30 Oct 03 2100	Pt continued to c/o 8/10 back pain @ 1950, received order for MSO_4 2-8mg IVP q1° prn pain. 3mg MSO_4 IVP given @ 2000 c good relief, pain currently 2/10. (L) PIV Tubing d'd down to hub, IV site s S/Sx infection or infiltration; no pain @ IV site noted. IS done, pt able to lift 2 balls to top x10. C+DB done p IS → weak, non-productive, loose cough. RR remains 32-36, unlabored. Pt refused dinner x ate a pear, states he prefers fruits. Drinks fluids/water s difficulty. [b)(6)-2] MJ AF
30 Oct 03	2250- c/o pain to back 5/10, pain medication given (see MAR) will continue to monitor pt [b)(6)-2] CK
30 Oct 03	2330- denies c/o pain will cont. to monitor pt [b)(6)-2] CP

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		
PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)		REGISTER NO.		WARD NO.

Potus # [b)(6)-4]

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

MEDCOM - 2590

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	23 Oct 03
DOS	23 Oct 03
POD	8

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach	N	N	
Side Rails Up	A	A	
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2	ICU	31 Oct 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade; date; hospital or medical facility)*

Pot ws # (b)(6)-4

- ☐ HISTORY PHYSICAL
- ☐ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☐ OTHER *(Specify)*
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700

MEDCOM - 2591

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R		2							2					2								2		
	RADIAL L		2							2					2								2		
	DORSALIS PEDIS R		2							2					2								2		
	DORSALIS PEDIS L		2							2					2								2		
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale			1 3/8							1 3 8					1 3 8								1 3/8		
EDEMA			0												BEN								0		
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)			R							✓					SISZ ✓								R		
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)			NSR							✓					✓								NSR		
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH																						✓		
	FOLEY CARE		✓																						
	ORAL CARE																								
MOBILITY	BEDREST		✓							✓					✓								✓		
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT									✓															
	LEFT																								
	SUPINE														✓										
	HOB 30 DEGREES		✓							✓					✓								✓		
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)			✓																						
PAIN	PAIN FREE		✓												✓									✓	
	PAIN SCALE (1-10)																								
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended		2							2					2								2		
BOWEL SOUNDS (active all quads)			✓							Hyp					hyper								✓		
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT			✓							✓					✓								✓		
VOIDING CLEAR, YELLOW URINE q.s.			✓							✓					✓								✓		
SKIN INTEGRITY	No Breakdown														✓								✓		
	Surgical Wounds		✓							✓					✓										
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1 Incision ABD OTA (staples)			✓							✓					✓								✓		
#2 Chest tube site, CDI			✓							✓					✓								✓		
#3 ℄ L Back CDI			✓							✓					✓								✓		

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
20g	(L)FA	29Oct05	CDI /0900 /1400

MEDCOM - 2592

PUPIL SIZE		PUPILS	
1 mm	=	Equal	
2 mm	R	Reactive	
3 mm	NR	NonReactive	
4 mm	L > R	Left Larger	
5 mm	R > L	Right Larger	

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable/Absent (blank) –
Refer to Nsg. Notes X
No Change from Previous Assessment –

DATE: 31 Oct 03

TIME																								
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open		4						4				4								4				
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response		5						5				5								5				
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response		6						6				6								6				
GLASGOW COMA SCALE (A+B+C)		15						15				15								15				
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R	2+						2+				2+								2+				
	L	NR/+						NR/+				N/A								NA				
MOVEMENT (See Motor Function Scale at Top of Page)	RUE	4						4				4								4				
	LUE	4						4				4								4				
	RLE	0						0				0								0				
	LLE	0						0				0								0				
GRIP (5) Strong (4) Weak (3) absent	R	S						S				S								S				
	L	S						S				S								S				
RESPIRATIONS	REGULAR											✓												
	IRREGULAR																							
	UNLABORED	–						/				✓												
	LABORED																			✓				
	SHALLOW																							
	RETRACTIONS																							
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL	5						5/1				5/1								5				
	LUL	5						5/1				5/1								5				
	RLL	1						5/1				1								1				
	LLL	1						5/1				1								1				
	BOTH BASES	1						5/1				1								1				
COUGH	NONE																							
	SPONTANEOUS	/						/				✓								✓				
	PRODUCTIVE	/						/				✓								✓				
	NONPRODUCTIVE																							
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear		2						5												2				
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin		1						3												1				
VENTILATOR	Vt																							
	FiO2																							
	RATE (SIMV/CMV)																							
	PEEP / CPAP																							
	PRESS. SUPPORT																							
OXYGEN DELIVERY DEVICE	NC (l/min)																							
	FM (l/min)																							
ETT = _____	NRBM (l/min)																							
	ETT _____ cm gums																							
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED																								
INCENTIVE SPIROMETRY DONE		/																						
COUGH / DEEP BREATH		/										✓								✓				
INITIALS		(b)(6)-2						(b)(6)-2				(b)(6)-2								(b)(6)-2				

MEDCOM - 2593

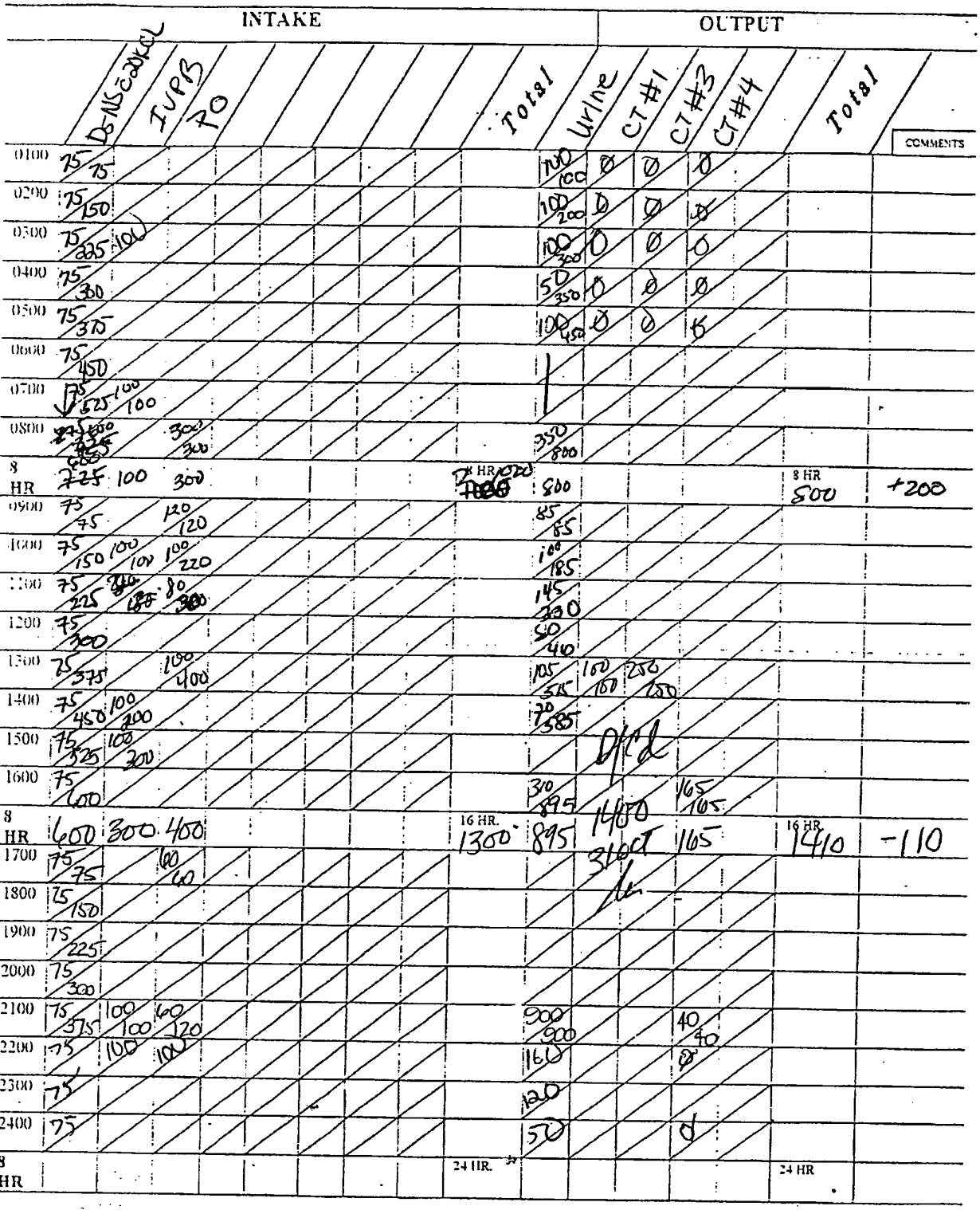
VITAL SIGNS

TIME	T	P	R	B.P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200	98.2	88	24	109/51	97%		68										
0300																	
0400																	
0500																	
0600																	
0700	100(A)	117	26	107/55	98												
0800																	
0900																	
1000																	
1100																	
1200																	
1300	99°	91	24	111/56	98%												
1400																	
1500																	
1600																	
1700																	
1800																	
1900																	
2000																	
2100	99°	105	22	116/60	97%												
2200																	
2300																	
2400																	

ACLU-RDI 1099 p.1378

DOD 006646

	INTAKE									OUTPUT					
	D5NS c 20KCL	IVPB	PO						Total	Urine	CT #1	CT #3	CT #4	Total	COMMENTS
0100	75 / 75									100 / 100	0	0	0		
0200	75 / 150									100 / 200	0	0	0		
0300	75 / 225	100								100 / 300	0	0	0		
0400	75 / 300									50 / 350	0	0	0		
0500	75 / 375									100 / 450	0	0	15		
0600	75 / 450														
0700	75 / 525	100 / 100													
0800	~~225~~ 600 / ~~225~~ 600		300 / 300							350 / 800					
8 HR	~~225~~ 600	100	300						8 HR ~~1000~~ 1020	800				8 HR 800	+200
0900	75 / 75		120 / 120							85 / 85					
1000	75 / 150	100 / 100	100 / 220							100 / 185					
1100	75 / 225	~~200~~ / ~~180~~	80 / ~~300~~							145 / 330					
1200	75 / 300									50 / 40					
1300	75 / 375		100 / 400							105 / 515	100 / 100	250 / 250			
1400	75 / 450	100 / 200								70 / 585					
1500	75 / 525	100 / 300									D/Cd				
1600	75 / 600									310 / 895			165 / 165		
8 HR	600	300	400						16 HR. 1300	895	1400		165	16 HR 1410	-110
1700	75 / 75		60 / 60								310CT				
1800	75 / 150														
1900	75 / 225														
2000	75 / 300														
2100	75 / 375	100 / 100	60 / 120							900 / 900			40 / 40		
2200	75	100	100							160			0		
2300	75									120					
2400	75									50			0		
8 HR									24 HR.					24 HR	



MEDCOM - 2595

MEDICAL RECORD

NSN 7540-00-634-4123

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
31Oct03	0200		- resting comfortably will cont. to monitor pt [redacted]
31OCT03	0800		Turned to (R) side. NAD Temp 100.3. Consumed 25% of Reg diet. [redacted]
31OCT03		1200	Consumed approx. 40% of Regular diet for lunch. Informed DR [redacted] of Pt C/O abd pain. No New orders given. [redacted]
		1400	Assumed care. DR [redacted] @ BS. Pulled CT's #1 & #3, 8 covered c̄ petroleum gauze, 4X4. DRsgs. CDI. Xray completed. Pt c/o moderate pain, but was pre-medicated c̄ T#3, MSO4. Will continue to monitor [redacted]
31OCT03	1830		Received report, assumed care. Pt turned to (L) side, states he is not currently in pain. Independent
31Oct03		2315	- C/O pain 7/10 to back, pain medication given (see MAR) will cont. to monitor pt [redacted]
31Oct03		2345	- resting comfortably will continue to monitor pt [redacted]

MEDCOM - 2596

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	23 Oct 03
DOS	23 Oct 03
POD	9

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside		(b)(6)-2	
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On		N/A	
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title)		Department/Service/Clinic	DATE
(b)(6)-2	CP	ICU	01 Nov 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade;date; hospital or medical facility)*

Potus (b)(6)-4

- ☐ HISTORY-PHYSICAL
- ☐ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☐ OTHER(*Specify*)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R		2					2					2		2								2		
	RADIAL L		2					2					2		2								2		
	DORSALIS PEDIS R		2					2					2		2								2		
	DORSALIS PEDIS L		2					2					2		2								2		
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale			1 3 8					1 3 8					1 3 8		1 3 8								1 3 8		
EDEMA			Gen					Gen					-		X								-		
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)			R					R					-		R								R		
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)			NSR					NSR					-		SR								✓		
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH												✓												
	FOLEY CARE		✓					✓															✓		
	ORAL CARE																								
MOBILITY	BEDREST		✓					✓					-		✓								✓		
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT														60										
	LEFT														✓										
	SUPINE							✓					✓		✓								✓		
	HOB 30 DEGREES		✓					✓					✓		✓										
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE		✓					*					*		Ø								✓		
	PAIN SCALE (1-10)																								
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN (2) Soft & Flat (1) Distended			2					2					2		2								2		
BOWEL SOUNDS (active all quads)			✓					x4					x4		✓								✓		
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT			✓					✓					-		✓								✓		
VOIDING CLEAR, YELLOW URINE q.s.			✓					✓					-		✓								✓		
SKIN INTEGRITY	No Breakdown																								
Sternum → Abd middle	Surgical Wounds		✓					✓					-		✓								✓		
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1 Incision OTAZ staples			✓					✓					-		✓								✓		
#2 CT site - Hu COT			✓					✓					-		✓								✓		
#3																									

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
IRG	L FA	29 Oct 03	COT

ACLU-RDI 1099 p.1382

DOD 006650

PUPIL SIZE	PUPILS	MOTOR FUNCTION	CHART CODES
1 mm	= Equal	0 = No Movement	Present ✓
2 mm	R Reactive	1 = Slight Flicker/ Trace of Contraction	
3 mm	NR NonReactive	2 = Active (Gravity Eliminated)	Not Applicable/Absent (blank)
4 mm	L > R Left Larger	3 = Active: against gravity, but not against resistance 4 = Active: Against Gravity and Resistance, not full strength	Refer to Nsg. Notes X
5 mm	R > L Right Larger	5 = Full Strength against Examiners Resistance	No Change from Previous Assessment –

DATE: 01 NOV 03

TIME	0 1	0 2	0 3	0 4	0 5	0 6	0 7	0 8	0 9	1 0	1 1	1 2	1 3	1 4	1 5	1 6	1 7	1 8	1 9	2 0	2 1	2 2	2 3	2 4
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (2) To Pain (3) To Voice (1) Does Not Open		4					4				–			4								4		
B. BEST VERBAL RESPONSE (5) Oriented (2) Garbled (4) Confused (1) No Response (3) Inappropriate Verbal Response		5					5				–			5								5		
C. BEST MOTOR RESPONSE (6) Obeys Commands (3) Flexion to Pain (5) Localizes to Pain (2) Extension to Pain (4) Withdraw to Pain (1) No Response		6					6				–			6								6		
GLASGOW COMA SCALE (A+B+C)		15					15				–			15								15		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) R		2+					2+				–			4+								3+		
L		NA					NA				–			N/A								NA		
MOVEMENT (See Motor Function Scale at Top of Page) RUE		4					4				–			5								5		
LUE		4					4				–			5								5		
RLE		0					0				–			0								0		
LLE		0					0				–			0								0		
GRIP (S) Strong (W) Weak (-) absent R		S					S				–			S								S		
L		S					S				–			S								S		
RESPIRATIONS REGULAR							✓				–			✓								✓		
IRREGULAR																								
UNLABORED		✓					✓				–			✓								✓		
LABORED																								
SHALLOW																								
RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished RUL		5					5				–			5								5		
LUL		5					5				–			5								5		
RLL		1					5				–			5								1		
LLL		1					5				–			5								1		
BOTH BASES							1				–											1		
COUGH NONE		✓									–	✓		✓										
SPONTANEOUS							✓															✓		
PRODUCTIVE							✓																	
NONPRODUCTIVE																						✓		
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear							3/2															2 Red		
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																								
VENTILATOR Vt							RA				RA											RA		
FiO2																								
RATE (SIMV/CMV)																								
PEEP / CPAP																								
PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE NC (l/min)																								
FM (l/min)																								
ETT = _____ NRBM (l/min)																								
ETT _____ cm gums																								
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED																								
INCENTIVE SPIROMETRY DONE		✓					✓							✓								✓		
COUGH / DEEP BREATH		✓					✓							✓								✓		
INITIALS		(b)(6)-2					(b)(6)-2				(b)(6)-2											(b)(6)-2		

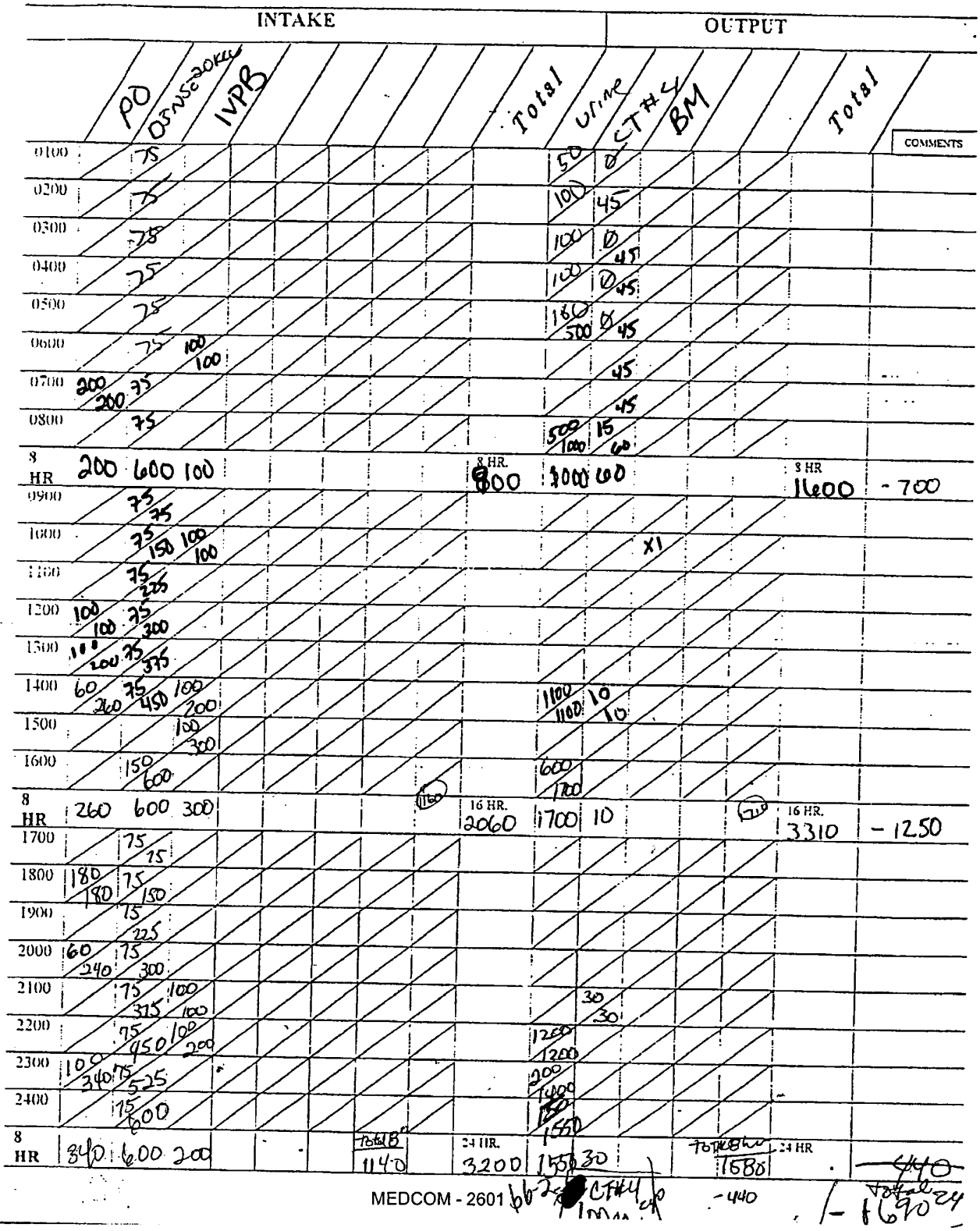
MEDCOM - 2599

VITAL SIGNS

TIME	T	P	R	B P	% SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200																	
0300																	
0400																	
0500	98.4	86	16	115/46	99%												
0600																	
0700																	
0800																	
0900																	
1000																	
1100																	
1200																	
1300																	
	99.3	88	16	102/49	94%		68										RA
1430	99@	83	20	108/50	95		72										RA
1500																	
1600																	
1700																	
1800																	
1900																	
2000																	
2100																	
2200	99.8	96	21	116/59	96%		79										RA
2300																	
2400																	

	INTAKE									OUTPUT							
	PO	0.5NS=20KCL	IVPB						Total	Urine	CT#4	BM				Total	COMMENTS
0100		75								50	Ø						
0200		75								100	45						
0300		75								100	Ø 45						
0400		75								100	Ø 45						
0500		75								180 500	Ø 45						
0600		75	100 100														
0700	200 200	75									45						
0800		75								500 1000	15 60						
8 HR	200	600	100						8 HR. 800	1000	60					8 HR 1600	-700
0900		75 75															
1000		75 150	100 100									X1					
1100		75 225															
1200	100 100	75 300															
1300	100 200	75 375															
1400	60 260	75 450	100 200							1100 1100	10 10						
1500			100 300														
1600		150 600								600 1700							
8 HR	260	600	300					1160	16 HR. 2060	1700	10				710	16 HR. 3310	-1250
1700		75 75															
1800	180 180	75 150															
1900		75 225															
2000	60 240	75 300															
2100		75 375	100 100								30 30						
2200		75 450	100 200							1200 1200							
2300	100 340	75 525								200 1400							
2400		75 600								150 1550							
8 HR	340	600	200				Total 8 1140		24 HR. 3200	1550	30			Total 8 1580		24 HR	~~-440~~

MEDCOM - 2601 66-2 CT#4 100 ... -440 Total 24 -1690



NSN 7540-00-634-4123

MEDICAL RECORD — NURSING NOTES (Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS — Include medication and treatment when indicated
01NOV03	0200		resting comfortably @ this time will cont. to monitor pt (b)(6)-2 (b)(6)-2 SN
	0915		pt. c/o gen. pain; ii T3 given; pt. requesting to shave his beard off; will cont to monitor (b)(6)-2
	1000		pt's beard shaved off; had a small BM of bile consistency; checked for rectum for impacted stool; there was stool → pt was disimpacted; NAD; pt. repositioned onto (L) side; will cont. to monitor (b)(6)-2
	1215		pt c/o pain gen. ii T3 given; stated he was not hungry + wanted food later; will cont. to monitor (b)(6)-2
1NOV03		1430	(L) pedal edema ↓ from 2days ago, non-pitting, cap refill brisk. (R) CT(#4) → WS ē fluid fluctuation. (L) FA IV ē D5NS +20KCl @ 75cc/hr, ∅ S/Sx infection or infiltration. ACE bandages to (B) LE. Pt appears alert, oriented x ∅ appropriate. (b)(6)-2 MJ AN
1NOV03		1500	Pt states he felt pressure on (B) feet when rolled on to back and feet propped against footboard. (b)(6)-2 MW AN
1NOV03		2110	ii TC#3 given @ 1710 for c/o (R) chest pain around (R) CT site. (R) CT ē 30cc serosang drainage this shift. Pt denies sensation below umbilicus on (R) side and ~ 2-3 inches below umbilicus on (L) side. Foot splints applied to prevent foot drop, remove splints for 1hr. q 4hrs to prevent pressure ulcers. Pt states relief of pain ē TC#3s. Ate ~½ dinner. (b)(6)-2 MJ AN
01NOV03		2200	Pt comfortable & cooperative, ∅ sign/symptoms of acute distress noted. CT#4 in (R) Anterior chest wall intact & draining into 20cm water seal. (B) LE ē calf-high splints. Will continued to monitor. (b)(6)-2 AN
01NOV03		2255	Medicated pt ē Tylenol ē Codeine ii po per prn order. (b)(6)-2 AN

MEDCOM - 2602

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	23 OCT 03
DOS	02 NOV 03
POD	10

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	(b)(6)-2

Safety Checks	D	E	N
BVM at bedside		(b)(6)-2	
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach		✓	
Side Rails Up		✓	
Bed in Low Position		✓	

PHYSICIAN (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 ANP	ICU	02 NOV 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade; date; hospital or medical facility)*

POTUS# (b)(6)-4

- ☐ HISTORY PHYSICAL
- ☐ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☐ OTHER *(Specify)*
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700

MEDCOM - 2603

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R							2							2								2		
	L							2							2								2		
	DORSALIS PEDIS R							2							2								2		
	L							2							2								2		
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale								1 3 8							1 3 8								1 3 8		
EDEMA								ccm							ccm										
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)								✓							Sbz								R		
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)								NSR							NSR								NSR		
SWAN GANZ CATHETER (Zeroed & calibrated)															0										
ARTERIAL LINE (zeroed & calibrated)															0										
HYGIENE	BED BATH											✓													
	FOLEY CARE											✓											✓		
	ORAL CARE																								
MOBILITY	BEDREST						✓								✓								✓		
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT																								
	LEFT									✓				✓			✓			✓		✓			
	SUPINE						✓				✓					✓									
	HOB 30 DEGREES						✓			✓	✓			✓		✓	✓			✓		✓			
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP13Z-26)																									
PAIN	PAIN FREE						✓							PF									✓		
	PAIN SCALE (1-10)						✓																		
PCA/PCEA IN USE (Refer to FHMDA OP13Z-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended						2							2								2			
BOWEL SOUNDS (active all quads)							X4							X4								✓			
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT							✓							✓								✓			
VOIDING CLEAR, YELLOW URINE q.s.							✓															✓			
SKIN INTEGRITY	No Breakdown																								
Sternum to Abd. Midline	Surgical Wounds						✓							✓								✓			
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1 Incision OTA c̄ Staples							✓							✓								✓			
#2 CT Site - #4 CDI							✓							✓								✓			
#3																									

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
20g	(L) FA	29 OCT 03	CDI

MEDCOM - 2604

PUPIL SIZE		PUPILS	
1 mm	=	Equal	
2 mm	R	Reactive	
3 mm	NR	NonReactive	
4 mm	L > R	Left Larger	
5 mm	R > L	Right Larger	

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable /Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment –

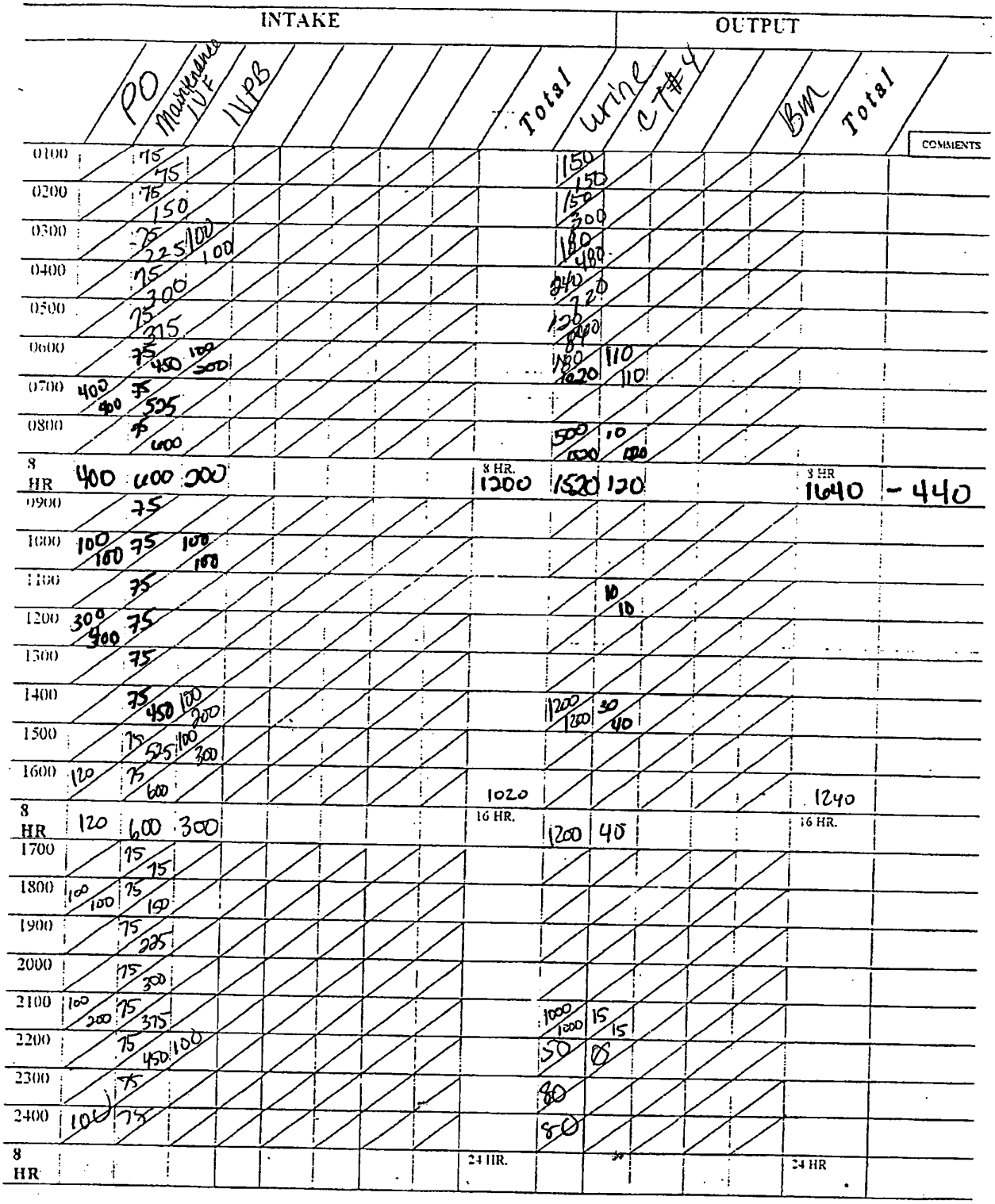
DATE: 02 NOV 03

TIME																								
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open							4						4									4		
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response							5						5									5		
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response							6						6									6		
GLASGOW COMA SCALE (A+B+C)							15						15									15		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R						3+						2+									2		
	L						+						–											
MOVEMENT (See Motor Function Scale at Top of Page)	RUE						4						4									4		
	LUE						4						4									4		
	RLE						0						0									0		
	LLE						0						0									0		
GRIP (S) Strong (W) Weak (-) absent	R						S						S									S		
	L						S						S									S		
RESPIRATIONS	REGULAR						✓						✓									✓		
	IRREGULAR																							
	UNLABORED						✓						✓									✓		
	LABORED																							
	SHALLOW																							
	RETRACTIONS																							
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL						5						5									5		
	LUL						5						5									5		
	RLL						5						5									1		
	LLL						5						5									1		
	BOTH BASES						1						1									1		
COUGH	NONE						✓						✓ bb-2									✓		
	SPONTANEOUS																							
	PRODUCTIVE												✓											
	NONPRODUCTIVE																							
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear (6) Bloody													6											
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																								
VENTILATOR	Vt						RA																	
	FiO2																							
	RATE (SIMV/CMV)																							
	PEEP / CPAP																							
	PRESS. SUPPORT																							
OXYGEN DELIVERY DEVICE	NC (l/min)																							
	FM (l/min)												RA											
ETT = _____	NRBM (l/min)																							
	ETT _____ cm gums																							
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED																								
INCENTIVE SPIROMETRY DONE							✓						✓									✓		
COUGH / DEEP BREATH							✓						✓									✓		
INITIALS							(b)(6)-2						(b)(6)-2									(b)(6)-2		

MEDCOM - 2605

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200																	
0300																	
0400																	
0500																	
0600																	
0700																	
0800	99.6	110	18	112/57	95%												
0900																	
1000																	
1100																	
1200																	
1300																	
1400																	
1500	99.3	94	20	103/55	95%				RA								
1600																	
1700																	
1800																	
1900																	
2000																	
2100																	
2200	98.9	67	16	106/59	99%				RA	7b							
2300																	
2400																	


INTAKE
OUTPUT
PO
Maintenance IVF
IVPB
Total
Urine
CT#4
BM
Total
COMMENTS
0100
0200
0300
0400
0500
0600
0700
0800
8 HR
8 HR.
1200
1520
120
8 HR
1640
-440
0900
1000
1100
1200
1300
1400
1500
1600
8 HR
1020
16 HR.
1240
16 HR.
1700
1800
1900
2000
2100
2200
2300
2400
8 HR
24 HR.
24 HR

MEDCOM - 2607

NSN 7540-00-634-4123

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
02 NOV 03	0545		Pt resting quietly c̄ any c/o discomfort or pain. CT, foley cath, & IV cath [redacted] all intact & patent. Will continue to monitor [redacted]
	0955		NAD; pt c/o pain medicated c̄ T3 & repositioned; ate 1/2 apple, box of raisens + 3 hard boiled eggs without difficult assessment complete; pt now resting c̄ eyes closed [redacted]
	1130		bed bath given to pt; hair washed; dressing to wound on (L) side of back Δ'd; dx to (L) thigh Δ'd; (L) inguinal area dressing taken off → pt has a blister formed from the tape; blister left open to air; pt has slight breakdown to (L) heel from splints; splints remain off until heel can dry; NAD; VSS; [redacted]
	1300		pt had 1 bite of hot dog + 1/4 hamburger bun states he is not very hungry will cont to monito [redacted]
		1415	Pt rolled to (L) side, at his request. Cough produced bloody sputum Pt c/o mild pain in back but requires no pain medicine Splints not on legs presently. Will replace splints @ 1500. Ensure padding stage 1 pressure ulcer (R) ~~outter~~ outer heel [redacted] LTAN
		1700	Pt medicated c̄ 3mg MSO_4 and tylenol #3 ~~#~~ tabs for pain in back. Rolled to (R) side @ pts request [redacted]
		2030	Pt rolled to (L) side, foot braces placed on feet (B) @ 1830. Pt (+) flates when rolled ⊘BM. Chest tube drainage serons marked @ 2030 for output. Foot of bed elevated @ pt request. [redacted]
		2100	Provost Marshall called about status of paralysis
	0001		c/o pain, pain med given (see MAR) will cont to monitor pt [redacted]

MEDCOM - 2608

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	23 Oct 03
DOS	
POD	

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside			
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 LPN	ICU	03 NOV 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, Middle; grade; date; hospital or medical facility)*

Potus # (b)(6)-4

- ☐ HISTORY PHYSICAL
- ☐ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☐ OTHER *(Specify)*
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700

MEDCOM - 2609

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R		2				2		2																
	L		2				2		2																
	DORSALIS PEDIS R		2				2		2																
	L		2				2		2																
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale			1 3 8				1 3 8		1 3 8																
EDEMA			0				~~0~~		0																
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)			R				R		R																
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)			NSR				NSR		NSR																
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH																								
	FOLEY CARE		✓																						
	ORAL CARE																								
MOBILITY	BEDREST		✓				✓		✓																
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE						✓		✓																
	HOB 30 DEGREES		✓				✓		✓																
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE		✓				✓		*																
	PAIN SCALE (1-10)																								
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended		2				2		2																
BOWEL SOUNDS (active all quads)			✓				x9		x4																
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT			✓				✓		✓																
VOIDING CLEAR, YELLOW URINE q.s.			✓				✓		✓																
SKIN INTEGRITY	No Breakdown																								
	Surgical Wounds		✓				✓		✓																
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1 Incision c̄ staples ABD OTA			✓				✓		staples removed																
#2 Old chest tube site #4 CDF			✓				✓		DC																
#3																									

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
20G	CFA	26Oct03	CDF

MEDCOM - 2610

PUPIL SIZE		PUPILS	MOTOR FUNCTION	CHART CODES
1 mm	=	Equal	0 = No Movement	Present ✓
2 mm	R	Reactive	1 = Slight Flicker/ Trace of Contraction	
3 mm	NR	NonReactive	2 = Active (Gravity Eliminated)	Not Applicable /Absent (blank)
4 mm	L > R	Left Larger	3 = Active: against gravity, but not against resistance 4 = Active: Against Gravity and Resistance, not full strength	Refer to Nsg. Notes X
5 mm	R > L	Right Larger	5 = Full Strength against Examiners Resistance	No Change from Previous Assessment –

DATE:

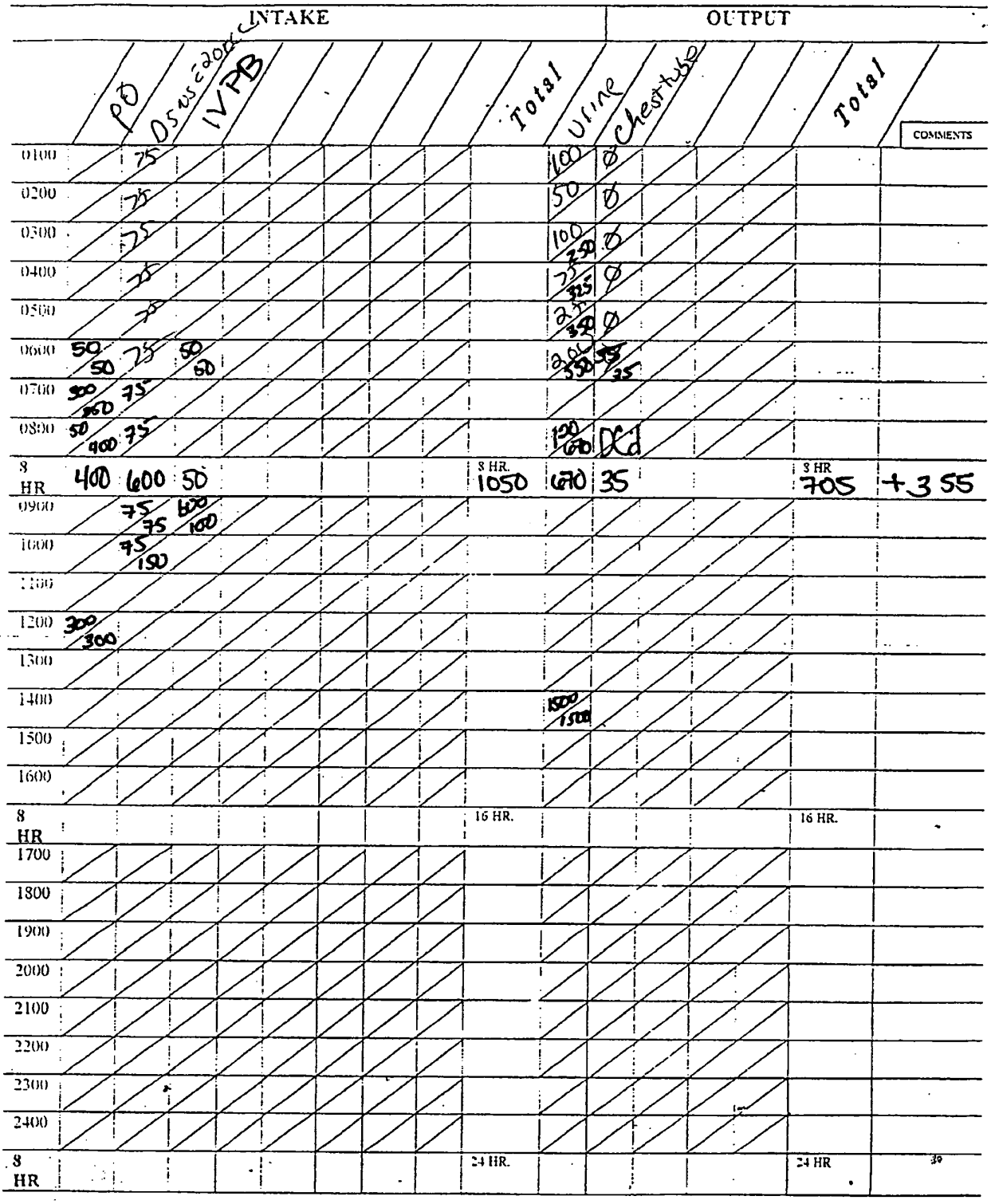
TIME		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open			4				4		4																
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response			5				5		5																
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response			6				6		6																
GLASGOW COMA SCALE (A+B+C)			15				15		15																
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R		2+				2+		2+																
	L		X				X		[illegible]																
MOVEMENT (See Motor Function Scale at Top of Page)	RUE		4				4		4																
	LUE		4				4		4																
	RLE		1				0		0																
	LLE		1				0		0																
GRIP (5) Strong (W) Weak (-) absent	R		5				5		5																
	L		5/				5		5																
RESPIRATIONS	REGULAR		/				/		✓																
	IRREGULAR																								
	UNLABORED																								
	LABORED																								
	SHALLOW																								
	RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL		5				5		5																
	LUL		5				5		5																
	RLL		1				1		1																
	LLL		1				1		1																
	BOTH BASES		/				1		1																
COUGH	NONE		/				✓		✓																
	SPONTANEOUS								✓																
	PRODUCTIVE								✓																
	NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear									2/3																
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin									3																
VENTILATOR	Vt						RA		RA																
	FiO2																								
	RATE (SIMV/CMV)																								
	PEEP / CPAP																								
	PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE	NC (l/min)																								
	FM (l/min)																								
ETT = _____	NRBM (l/min)																								
	ETT _____ cm gums																								
ETT CARE / POSITION CHANGE																									
ETT / NT SUCTIONED																									
INCENTIVE SPIROMETRY DONE																									
COUGH / DEEP BREATH			/				✓		✓																
INITIALS			(b)(6)-2				(b)(6)-2		(b)(6)-2																

MEDCOM - 2611

VITAL SIGNS

TIME	T	P	R	BP	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200																	
0300																	
0400																	
0500																	
0600	99°	94	16	112/59	91%												
0700																	
0800																	
0900																	
1000																	
1100																	
200																	
1300																	
1400																	
1500																	
1600																	
1700																	
1800																	
1900																	
2000																	
2100																	
2200																	
2300																	
2400																	

	INTAKE									OUTPUT					
	PO	D5 NS c̄ 20 cc	IVPB						Total	Urine	Chest tube			Total	COMMENTS
0100		75								100	Ø				
0200		75								50	Ø				
0300		75								100 / 250	Ø				
0400		75								75 / 325	Ø				
0500		75								25 / 350	Ø				
0600	50 / 50	75	50 / 50							200 / 550	35 / 35				
0700	300 / 350	75													
0800	50 / 400	75								120 / 670	DCd				
8 HR	400	600	50						8 HR. 1050	670	35			8 HR 705	+355
0900		75 / 75	600 / 100												
1000		75 / 150													
1100															
1200	300 / 300														
1300															
1400										1500 / 1500					
1500															
1600															
8 HR									16 HR.					16 HR.	
1700															
1800															
1900															
2000															
2100															
2200															
2300															
2400															
8 HR									24 HR.					24 HR	



MEDCOM - 2613

NSN 7540-00-634-4123

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
03 Nov 03	0200		-sleeping @ this time. Ø c/o pain, Ø s/s of resp. distress. will continue to monitor pt [redacted] cpt
	0600		received pt this AM; NAD; VSS; pt resting c eyes closed; will cont. to monitor [redacted]
	0800		Dr. [redacted] DC'd chest tube #4 without difficulty follow up CXR done; awaiting results; staples removed, without difficulty from mid-line incision left OTA; lung sounds good; SpO2 94% on RA. pt. now resting c eyes closed; will cont to monitor [redacted]
	1315		stitch (suture) removed from (L) thigh wound Clean, dry, sterile dressing applied. [redacted]
	1445		Pt clothed & ready. [redacted] signed out to MP Discharge instructions given to MP about Medications. drsg s&s, braces, paralysis. Extra supplies given to pt and MP. 2 Tylenol #3 given prior to D/C. [redacted]

MEDCOM - 2614

MEDICAL RECORD - PATIENT RELEASE / DISCHARGE INSTRUCTIONS

For use of this form, see MEDCOM Circular 40-5

DIRECTIONS: To be completed by attending provider and other staff at time of patient release following an outpatient procedure, extended care/treatment or discharge from an inpatient hospital stay.

SECTION I
TO BE COMPLETED BY PRIVILEGED PROVIDER

1. DATE OF PROCEDURE/ADMISSION: 23 Oct 03
2. ADMITTING/DIAGNOSIS: GSW to Abd, L2 Paraplegia
3. PERTINENT LAB, X-RAY, FINDINGS:
   Xray finding - fracture of L2 posterior column ō evidence of fragments in spinal canal
4. PROCEDURES, TREATMENT, HOSPITAL COURSE:
   Ex lap ō sternotomy Extension for repair of GSW to (R) Lobe of liver near dome, (R) Nephrectomy, debridement control of hemorrhage to (R) psoas/spinal area @ L2
5. FINAL DIAGNOSIS AND CONDITION AT DISCHARGE:
   GSW to Abd - Injury to Liver (R) lobe
   (R) Nephrectomy
   L2 Paraplegia
   GSW (L) thigh
6. ACTIVITY: as tolerated
7. DIET: Regular
8. MEDICATIONS:
   ☐ Medications have been prescribed for home use. See separate list and special instructions or see below.
   Dulculax 10mg po QD
   Colace 100mg po TID
   T3 1-2 po q 4-6° prn
9. INSTRUCTIONS (To Home Health Providers, Patient, etc):
   Leave CT bandages in place for 48hrs (11/5)
   Change Bandage (L) thigh PRN
   Foley to gravity
10. DISCHARGING PROVIDER
   (b)(6)-2 [redacted] (Signature)
   (b)(6)-2 [redacted] LTC MC USA (Printed or Stamped Name)

PATIENT IDENTIFICATION

Potus (b)(6)-4 [redacted]

SECTION II
TO BE COMPLETED BY OTHER STAFF, AS APPROPRIATE

1. DISPOSITIONED TO: ☐ HOME ☐ DUTY ☐ OTHER ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER
2. ACCOMPANIED BY: ☐ FAMILY ☐ FRIEND ☐ OTHER
3. PATIENT EDUCATION:
   Completed and patient prepared for home care. ☐ YES ☐ NO
   If no, explain:
   Patient ☐ states ☐ demonstrates understanding of home care needs.
   Printed educational materials provided:
4. Clinical outcomes met and post-discharge/release referrals made.
   ☐ YES ☐ NO If no, explain:
5. If transferred to another health care facility, report called to nurse.
   ☐ YES ☐ NO If no, explain:
6. NUTRITION CARE - Comments:
7. MEDICATIONS:
   Explained by: ☐ NURSE ☐ PHYSICIAN ☐ PHARMACIST
   Printed medication literature provided. ☐ YES ☐ NO
   Patient states understanding of prescribed medications. ☐ YES ☐ NO
8. EQUIPMENT/SUPPLIES PROVIDED:
   Keep braces on legs but take off occassionally to air out.
9. FOLLOW-UP APPOINTMENTS, POINT OF CONTACT & PHONE:
   ICU (b)(3)-1 [redacted]
10. FOR PROBLEMS OR EMERGENCY, CONTACT & PHONE:
11. COMPLETED BY:
   (b)(6)-2 [redacted] UTAN 3NOV03
   (Signature and Title) (Date and Time)

I HAVE RECEIVED A COPY OF AND UNDERSTAND THESE INSTRUCTIONS.

[redacted]

MEDCOM - 2615

MEDICAL RECORD	INTRAOPERATIVE DOCUMENT For use of this form, see AR 40-407, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Gurney BY [redacted]

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY CPT [redacted]

3. DATE 15/23/02 TIME PATIENT ARRIVED IN SUITE 0750

4. PATIENT IN ROOM TIME 2710 NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

☐ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☒ OTHER *(Specify)*

COMMENTS: Intubated

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted]	RELIEF SCRUB	
	SPC [redacted]		
ASSIGNED CIRCULATOR	CPT [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

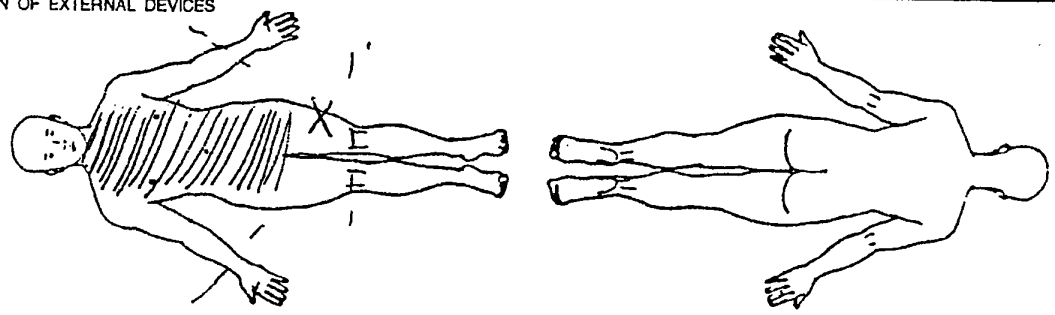
COMMENTS: none

8. SKIN PREPARATION

HAIR REMOVAL ☒ YES ☐ NO
DONE BY: ☒ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP
COMMENTS: none

PREP SOLUTION *(Specify)* Betn S&S
SITE Chest & abd. BY WHOM: CPT [redacted]
SITE: BY WHOM:
COMMENTS: none

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Strap --- Tourniquet

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No		C	C	SPC [redacted]	CPT [redacted]
Needle Sharp	☒ Yes ☐ No		C	C	SPC [redacted]	CPT
Instrument	☐ Yes ☒ No					
Other	☐ Yes ☒ No					

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

POTUS # [redacted]

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO

☒ ESU NO: 000434 50/50
GROUND PAD: BRAND Valley Lab
LOT NO: 69671 05/04

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

MEDCOM - 2616

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☒ NO ☐

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
Gelfm	1 sheet	FOP	Top	—	Dr. (b)(6)-2
Thrombin	20cc	TOP	Top	CPT (b)(6)-2	Dr.
Surgical	4X8	FOP	TOP	—	Dr.

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

NSS

OTHER ORDERS

	TIME	CARRIED OUT BY
(b)(6)-2		

PHYSICIAN'S SIGNA

15. X-RAY IN OPERATING ROOM YES ☒ NO ☒ IF YES, SITE

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 36 CT	2. 36 CT	3. 36 CT
SITE	1. Chest	2. Chest	3. Chest

18. DRESSING/IMMOBILIZATION (Specify)

abd's, 4x4's, tape

19. ADDITIONAL INFORMATION

Dr. (b)(6)-2
Dr.
Dr.

20. OPERATION(S) PERFORMED

Exp. lap & Sternotomy, Nephrectomy, liver OLL repair

21. PATIENT TRANSFERRED TO ICU TIME 1115 METHOD Gurney

22. REGISTERED NURSE SIGNATURE (b)(6)-2 CPT (b)(6)-2

REVERSE OF DA FORM 5179-1, O

*U.S. GPO: 1996-404-613/40449

MEDCOM - 2617

Ventilator Flow Sheet

Date	Time	Mode	V_T	Rate	FiO_2	PEEP	PIP	MAP	SpO_2	HR	BP	I:E	RT Init
23 Oct 03	1130	A/C	700	12	100	5	25	10	100	79	142/52	1:2.1	(b)(6)-2
23 Oct 03	1300	A/C	700	10	100	5	24	12	100	80	127/57	1:2.2	
23 Oct 03	1500	A/C	700	10	100	5	25	13	100	85	99/54	1:2.2	
23 Oct 03	1700	A/C	800	10	40	5	30	17	99	100	112/63	1:2.2	
	1900	A/C	800	10	40	5	26	12	100	100	145/72	1:2.2	
	2100	A/C	800	10	40	5	35	15	100	99	109/77	12:2	
	2300	A/C	800	10	40	5	27	17	100	99	98/51	12:21	
24 Oct 03	0100	A/C	800	10	40	5	28	18	100	99	134/77	12:21	
24 Oct 03	0300	A/C	800	10	40	5	32	17	100	98	126/80	12:1	
0	0500	A/C	800	10	40	5	27	14	100	88	157/80	12:21	
24 Oct 03	0900	A/C	800	10	40	5	23	10	100	98	160/57	1:2.2	
24 Oct 03	1100	A/C	800	10	40	5	25	11	100	72	133/59	1:2.2	
24 Oct 03	1300	A/C	800	10	40	5	24	10	97	75	114/55	1:2.2	(b)(6)-2
24 Oct 03	1500	A/C	800	10	40	5	23	10	99	69	115/54	1:2.2	
	1700	A/C	800	10	40	5	24	10	99	76	119/65	12:2	
	1900	A/C	800	10	40	5	27	12	98	76	123/8	12:2	
	2100	A/C	800	10	40	5	24	10	99	69	142/72	12:2	
	2300	A/C	800	10	40	5	35	12	98	75	63/66	12:2	
	2330	A/C	800	10	40	5	32	14	98	117	160/67	12:2	
25 Oct 03	0100	A/C	800	10	40	5	27	10	100	81	160/45	12:2	(b)(6)-2
25 Oct 03	0500	A/C	800	10	40	5	27	11	100	92	161/42	12:2	
25 Oct 03	0700	A/C	800	10	40	5	25	10	100	89	162/53	1:2.3	
25 Oct 03	0900	A/C	800	8	40	5	26	11	98	90	148/50	1:3.2	
25 Oct 03	1300	A/C	800	8	40	5	26	11	100	77	157/56	1:3.2	
25 Oct 03	1500	SIMV	800	8	40	5	29	11	100	86	174/51	1:1.6	
25 Oct 03	1700	SIMV	800	8	40	5	21	11	100	94	169/51	1:1.6	
	1900	SIMV	800	8	41	5	28	13	100	112	164/63	1:1.6	
	2100	SIMV	800	8	40	5	27	12	100	98	159/60	1:1.6	
	2300	SIMV	800	8	40	5	26	10	100	96	169/60	1:1.6	(b)(6)-2
	0100	SIMV	800	8	40	5	17	13	100	81	164/62	1:2	

VENT ADJ

POTUS (b)(6)-4

Date	Time	Vt	Rate	PEEP	PIP	MAP	SPO2	HR	BP	I:E	RT int
25 Oct 03	0800	800	8	5	27	10	100	92	139/62	1:2	(b)(6)-2
	0855	800	8	5	33	11	100	90	136/61	1:2.3	
26 Oct 03	0700	800	8	5	18	6	100	93	144/58	1:2	
26 Oct 03	0900	800	8	5	21	11	100	93	153/67	1:2	
26 Oct 03	1300	800	6	5	19	7	100	106	134/77	1:2.3	
26 Oct 03	1500	800	6	5	16	10	100	93	136/75	1:2.3	
26 Oct 03	1700	800	6	5	17	7	100	100	134/78	1:2.3	

(b)(6)-4

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE | SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*

Potus (b)(6)-4

MISC

SPECIMEN/LAB RPT. NO.

URGENCY: ☐ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT ☑

PATIENT STATUS: ☑ OR ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM

SPECIMEN SOURCE (Specify)

PATIENT'S MED. RECORD

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE | REPORTED BY (b)(6)-2 | MD | DATE 0853 | TECH 23Oct03 | LAB ID NO.

REMARKS: ABG

TEST(S) | SPECIMEN TAKEN | DATE 23Aug03 | TIME 0805 A.M. P.M. | REQUESTED | RESULTS

Na 137
K 5.2
TCO_2 22
iCa 0.98
pH 7.328
PCO_2 40.5
PO_2 390
HCO_3 21
BEcf -5
SO_2 106

MISCELLANEOUS 557-107

STANDARD FORM 557 (Rev. 3-77) Prescribed by GSA/ICMR FIRMR (41 CFR) 201-45-505

Potus (b)(6)-4

HEMATOLOGY

SPECIMEN/LAB RPT. NO.

URGENCY: ☐ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT ☑

PATIENT STATUS: ☐ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM

SPECIMEN SOURCE: ☑ VEIN ☐ CAP ☐ OTHER (Specify)

PATIENT'S MED. RECORD

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE (b)(6)-2 | REPORTED BY | MD | DATE 23Oct 0949 | TECH | LAB. ID. NO.

REMARKS: H+H

TEST(S) | SPECIMEN TAKEN | DATE 23Oct | TIME 0949 A.M. P.M. | REQUESTED (X) | RESULTS

RBC COUNT | HEMOGLOBIN 5.4 | HEMATOCRIT 15.1 | MCV | MCH | MCHC | WBC COUNT | IMMATURE | NEUTRO-BANDS | NEUTROSEGS | LYMPHS | EOSINOPHILS | BASOPHILS | MONOCYTES | PLATELETS | RBC | WBC DIFF AND BLOOD CELL MORPH | SED. RATE | PLATELET COUNT | RETICULOCYTE COUNT | CLOTTING TIME | SLEEDING TIME | CONTROL | PATIENT | CONTROL | PATIENT | % ACTIVITY | RATIO | SICKLING TEST | LE PREP

n entr. Grade.)

HEMATOLOGY 549-107

STANDARD FORM 549 (Rev. 7-78) PRESCRIBED BY GSA/ICMR FIRMR (41 CFR) 201-45-505

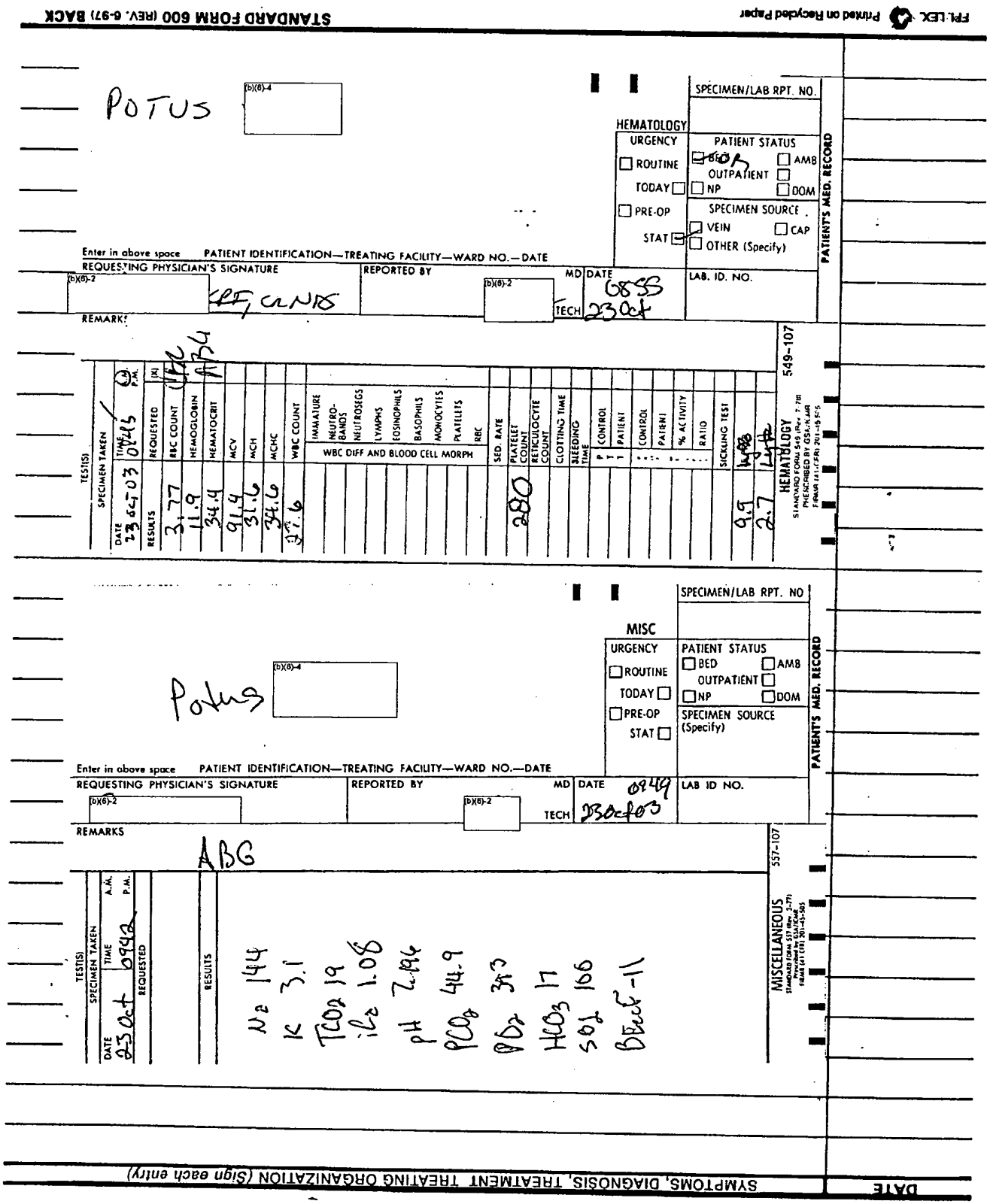
HOSPITAL OR MI ... AINED AT

SPONSOR'S NAM

PATIENT'S IDEN ... ARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

MEDCOM - 2620



POTUS

(b)(6)-4

HEMATOLOGY

SPECIMEN/LAB RPT. NO.

URGENCY: ☐ ROUTINE ☐ TODAY ☐ ☐ PRE-OP STAT ☐

PATIENT STATUS: ☐ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM

SPECIMEN SOURCE: ☐ VEIN ☐ CAP ☐ OTHER (Specify)

PATIENT'S MED. RECORD

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE: (b)(6)-2 CRF, CNRC

REPORTED BY: (b)(6)-2 MD TECH DATE: 0855 23 Oct

LAB. ID. NO.

REMARKS:

TESTS	SPECIMEN TAKEN DATE	TIME A.M. / P.M.	REQUESTED	RESULTS
WBC DIFF AND BLOOD CELL MORPH: IMMATURE				
NEUTRO-BANDS				
NEUTROSEGS				
LYMPHS				
EOSINOPHILS				
BASOPHILS				
MONOCYTES				
PLATELETS				
RBC				
SED. RATE				
PLATELET COUNT				280
RETICULOCYTE COUNT				
CLOTTING TIME				
BLEEDING TIME				
PT CONTROL				
PT PATIENT				
PTT CONTROL				
PTT PATIENT				
% ACTIVITY				
RATIO				
SICKLING TEST				
RBC COUNT	23 Oct 03	0845		3.77
HEMOGLOBIN				11.9
HEMATOCRIT				34.4
MCV				91.4
MCH				31.6
MCHC				34.6
WBC COUNT				9.6

549-107 HEMATOLOGY

STANDARD FORM 549 (Rev. 7-78) PRESCRIBED BY GSA/FMR FPMR (41 CFR) 201-45.5

POTUS

(b)(6)-4

MISC

SPECIMEN/LAB RPT. NO

URGENCY: ☐ ROUTINE ☐ TODAY ☐ ☐ PRE-OP STAT ☐

PATIENT STATUS: ☐ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM

SPECIMEN SOURCE (Specify)

PATIENT'S MED. RECORD

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE: (b)(6)-2

REPORTED BY: (b)(6)-2 MD TECH DATE: 0849 23 Oct 03

LAB ID NO.

REMARKS

ABG

TESTS	SPECIMEN TAKEN DATE	TIME A.M. / P.M.	REQUESTED	RESULTS
	23 Oct	0992		
Na				144
K				3.1
TCO2				19
iCa				1.08
pH				7.496
PCO2				44.9
PO2				343
HCO3				17
SO2				106
Base				-11

557-107 MISCELLANEOUS

STANDARD FORM 557 (Rev. 2-77) PRESCRIBED BY GSA/FMR FPMR (41 CFR) 201-45.505

SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry) DATE

MEDCOM - 2621

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE | SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*

POTUS [b)(6)-4]

SPECIMEN/LAB RPT. NO.

HEMATOLOGY

URGENCY: ☐ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT ☒

PATIENT STATUS: ☐ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM

SPECIMEN SOURCE: ☐ VEIN ☐ CAP ☒ OTHER (Specify)

PATIENT'S MED. RECORD

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE [b)(6)-2] | REPORTED BY [b)(6)-2] MD TECH | DATE 23Oct03 | LAB. ID. NO.

REMARKS

TEST(S)	SPECIMEN TAKEN	TIME	REQUESTED	RBC COUNT	HEMOGLOBIN	HEMATOCRIT	MCV	MCH	MCHC	WBC COUNT	IMMATURE	NEUTRO-BANDS	NEUTROSEGS	LYMPHS	EOSINOPHILS	BASOPHILS	MONOCYTES	PLATELETS	RBC	SED. RATE	PLATELET COUNT	RETICULOCYTE COUNT	CLOTTING TIME	SLEEDING TIME	CONTROL	PATIENT	CONTROL	PATIENT	% ACTIVITY	RATIO	SICKLING TEST	LE PREP
	DATE 23Oct	1042 A.M. P.M.			8.9	25.2																										

WBC DIFF AND BLOOD CELL MORPH

HEMATOLOGY 549-107 STANDARD FORM 549 (Rev. 7-78) PRESCRIBED BY GSA/ICMR FIRMR (41 CFR) 201-45 505

Potus [b)(6)-4]

SPECIMEN/LAB RPT. NO

MISC

URGENCY: ☐ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT ☒

PATIENT STATUS: ☒ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM

SPECIMEN SOURCE (Specify)

ICU

PATIENT'S MED. RECORD

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE [b)(6)-2] | REPORTED BY [b)(6)-2] MD TECH | DATE 23Oct03 | LAB ID NO.

REMARKS

FiO_2 - 100% T- 92 SaO_2 100%

TEST(S)	SPECIMEN TAKEN	TIME	REQUESTED	RESULTS
	DATE 23 Oct 03	1545 A.M. P.M.	ABG	Na - 143
				K - 4.6
				TCO2 - 17
				ica - 1.06
				HCO3 - 16
				BEcf - -12
				SO2 - 100
				PH - 7.240 @ px kard
				PCO2 - 35.2
				PO2 - 370

MISCELLANEOUS 557-107 STANDARD FORM 557 (Rev. 3-77) Prescribed by GSA/ICMR FIRMR (41 CFR) 201-45-505

HOSPITAL OR MEDI ... ED AT

SPONSOR'S NAME

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

REGISTER NO. | WARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

MEDCOM - 2622

STANDARD FORM 600 (REV. 6-97) BACK

FPI LEX Printed on Recycled Paper

SPECIMEN/LAB RPT. NO

MISC

Potus [b)(6)-4]

URGENCY: ☐ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT ☐

PATIENT STATUS: ☐ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM

SPECIMEN SOURCE (Specify)

PATIENT'S MED. RECORD

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE [b)(6)-2] | REPORTED BY [b)(6)-2] | MD | DATE 1053 | TECH 23 Oct | LAB ID NO.

REMARKS

TEST(S) | SPECIMEN TAKEN: DATE 23 Oct | TIME 1643 A.M. P.M. | REQUESTED: ABG | RESULTS: Na 144, K 4.0, TCO_2 19, iCa 1.02, pH 7.186, PCO_2 45.4, PO_2 396, HCO_3 17, BEcf 11, SO_2 100

MISCELLANEOUS 557-107

STANDARD FORM 557 (Rev. 3-77) PRESCRIBED BY GSA/ICMR FIRMR (41 CFR) 201-45.505

SPECIMEN/LAB RPT. NO.

HEMATOLOGY

Potus [b)(6)-4]

ICU

URGENCY: ☐ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT ☒

PATIENT STATUS: ☒ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM

SPECIMEN SOURCE: ☐ VEIN ☐ CAP ☐ OTHER (Specify)

PATIENT'S MED. RECORD

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE [b)(6)-2] | REPORTED BY [b)(6)-2] | MD | DATE 23 Oct 03 | TECH | LAB. ID. NO.

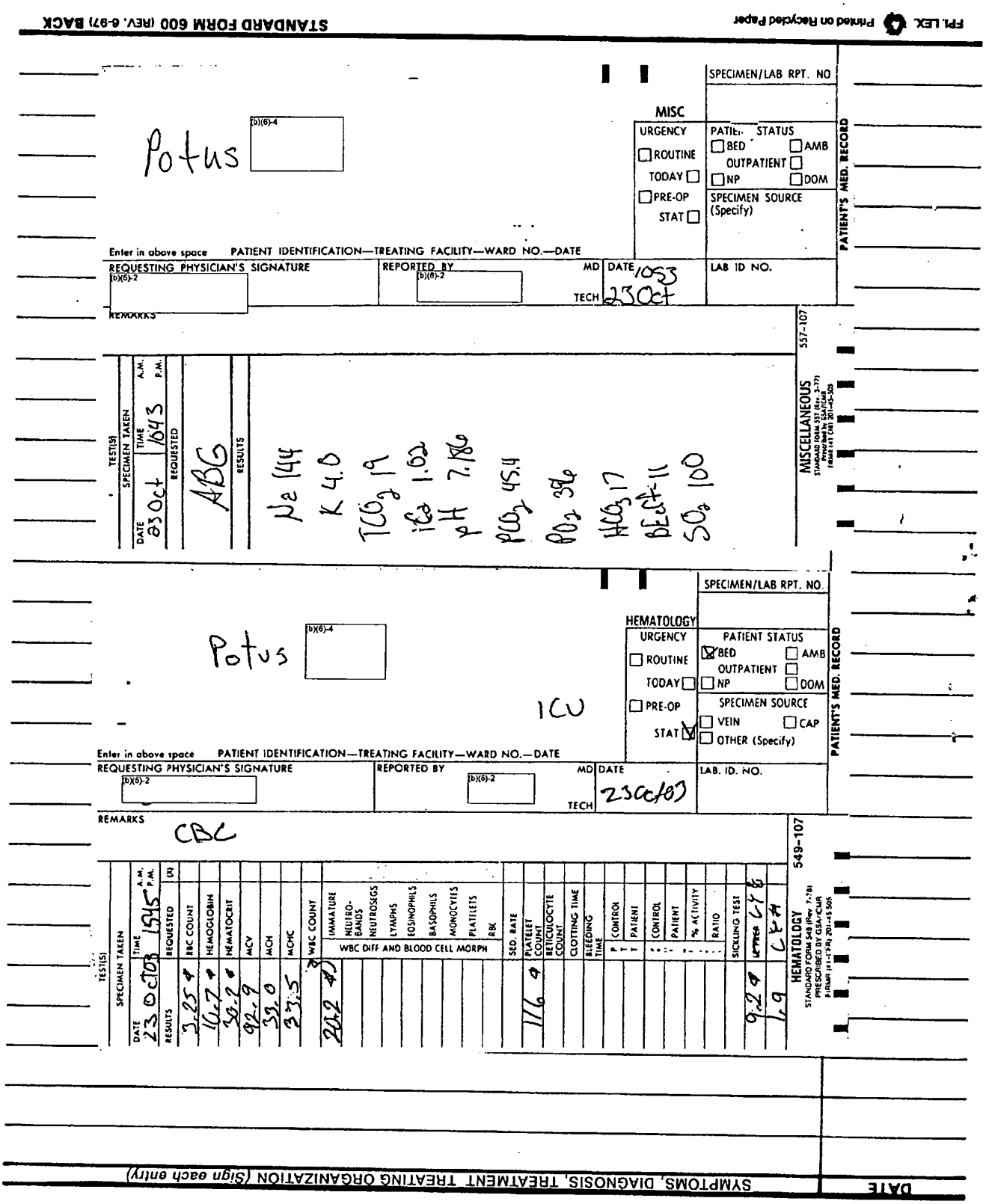
REMARKS CBC

TEST(S) | SPECIMEN TAKEN: DATE 23 Oct 03 | TIME 1545 A.M. P.M. | REQUESTED (X) | RESULTS: RBC COUNT 3.25 ♦, HEMOGLOBIN 16.7 ♦, HEMATOCRIT 30.2 ♦, MCV 92.9, MCH 33.0, MCHC 33.5, WBC COUNT 20.2 ♦, IMMATURE, NEUTRO-BANDS, NEUTROSEGS, LYMPHS, EOSINOPHILS, BASOPHILS, MONOCYTES, PLATELETS, RBC (WBC DIFF AND BLOOD CELL MORPH), SED. RATE, PLATELET COUNT 116 ♦, RETICULOCYTE COUNT, CLOTTING TIME, BLEEDING TIME, CONTROL, PATIENT, CONTROL, PATIENT, % ACTIVITY, RATIO, SICKLING TEST, LETTER CY 8, CY 4, 9.2 ♦, 1.9

HEMATOLOGY 549-107

STANDARD FORM 549 (Rev. 7-78) PRESCRIBED BY GSA/ICMR FIRMR (41 CFR) 201-45.505

SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry) | DATE



MEDCOM - 2623

TEST(S)
SPECIMEN TAKEN
DATE 23 Oct 03 TIME 1640 A.M. P.M.
REQUESTED
ABG
RESULTS

Na	142
K	4.7
TCO_2	19
iCa	1.05
pH	7.266
PCO_2	36.7
PO_2	274
HCO_3	17
BE ecf	-10
SO_2	100%

REMARKS
T- 92.6 (A)
FiO_2 0.6
VT- 800cc

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REQUESTING PHYSICIAN'S SIGNATURE
REPORTED BY
TECH MD DATE 23 Oct 03 1651
LAB ID NO.
MISC
URGENCY ☐ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT ☒
PATIENT STATUS ☐ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM
SPECIMEN SOURCE (Specify)
PATIENT'S MED. RECORD

Potus
ICU

MISCELLANEOUS 557-107
STANDARD FORM 557 (Rev. 3-77) Prescribed by GSA/ICMR FIRMR (41 CFR) 201-45-505

TEST(S)
SPECIMEN TAKEN
DATE 23 Oct 03 TIME 1755 A.M. P.M.
REQUESTED
ABG
RESULTS

Na	145
K	4.5
TCO_2	19
iCA	1.09
HCO_3	17
BE ecf	(-10)
SO_2	100%
ph	7.276
PCO_2	36.1
PO_2	237

REMARKS
FiO_2 40%
T- 93.8 (AX)

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REQUESTING PHYSICIAN'S SIGNATURE
REPORTED BY
MD DATE 23 Oct 03
LAB ID NO.
MISC
URGENCY ☐ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT ☐
PATIENT STATUS ☐ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM
SPECIMEN SOURCE (Specify)
SPECIMEN/LAB RPT. NO.
PATIENT'S MED. RECORD

Potus

MISCELLANEOUS 557-107
STANDARD FORM 557 (Rev. 3-77) Prescribed by GSA/ICMR FIRMR (41 CFR) 201-45-505

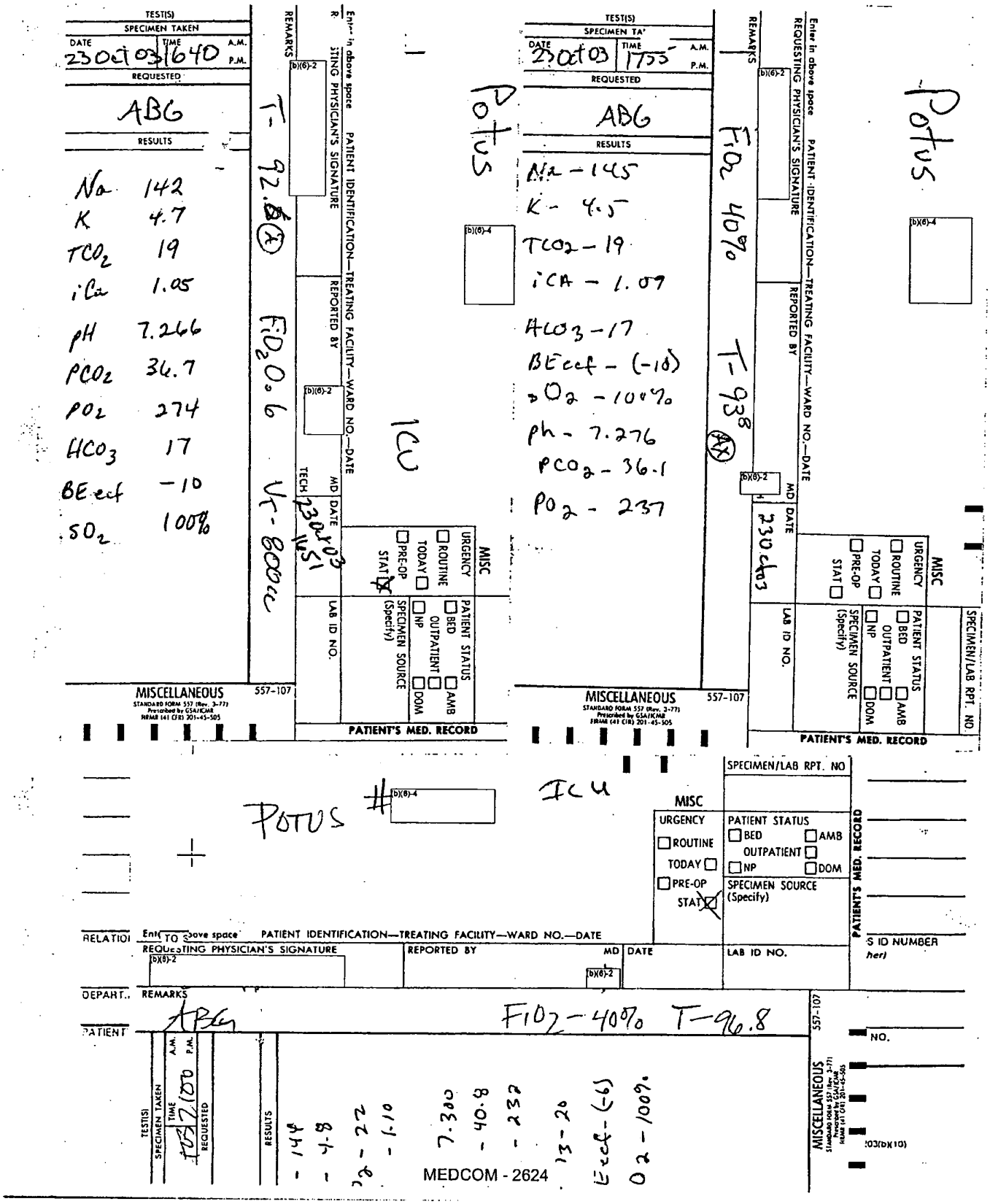
POTUS # ICU

SPECIMEN/LAB RPT. NO
MISC
URGENCY ☐ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT ☒
PATIENT STATUS ☐ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM
SPECIMEN SOURCE (Specify)
PATIENT'S MED. RECORD

RELATIO... Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REQUESTING PHYSICIAN'S SIGNATURE
REPORTED BY MD DATE
LAB ID NO.
...S ID NUMBER
DEPART... REMARKS
ABG
FiO_2 - 40% T-96.8
PATIENT
NO.
TEST(S) SPECIMEN TAKEN TIME A.M. P.M. 1700 REQUESTED
RESULTS
- 144
- 4.8
O_2 - 22
- 1.10
7.300
- 40.8
- 232
13 - 20
E ecf - (-6)
O_2 - 100%

MISCELLANEOUS 557-107
STANDARD FORM 557 (Rev. 3-77) Prescribed by GSA/ICMR FIRMR (41 CFR) 201-45-505

MEDCOM - 2624



21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI: POTUS# [b)(6)-4] | UNIT: EPW | DOB | RANK | SSN

Physician: [b)(6)-2] | Ward: EMT | X STAT / Routine | Specimen Date and Time: 23oct e 0740hr | Reported by: [b)(6)-2] | Date and Time: 23oct e 0815

Chemistry (I-STAT)

6+ (circled) 7+ 8+ Glu Crea (circled)

X	TEST	RESULT	REF. RANGE
	Na	134	128-145 mmol/L
	K	4.3	3.3-4.7 mmol/L
	Cl	100	98-108 mmol/L
	pH		7.35-7.45
	PCO2		35-45 mmHg
	PO2		80-90 mmHg
	TCO2		18-33 mmol/L
	HCO3		22-28 mmol/L
	sO2		95-99%
	BEecf		(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN	16	7-22 mg/dL
	Glu	318	73-118 mg/dL
	Creat	1.9	0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL
	Lactate		0.90-1.70 mmol/L

Chemistry (Piccolo Analyzer)

Chem 12 (circled) MetLyte8 BMP Liver

X	TEST	RESULT	REF. RANGE
	ALB	3.5	3.3-5.5 g/dL
	ALP	65	26-84 U/L
	ALT	126	10-47 U/L
	AMY	58	14-97 U/L
	AST	108	11-38 U/L
	Tbil	0.8	0.2-1.6 mg/dL
	BUN	13	7-22 mg/dL
	Ca	8.5	8.0-10.3 mg/dL
	Chol	131	100-200 mg/dL
	CK		30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat		0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein	6.7	6.4-8.1 g/dL
	Na		128-145 mmol/L

Hematology

CBC Malaria H/H

X	TEST	RESULT	REF. RANGE
	WBC	15.2	4.8-10.8 x10(3)/uL
	RBC	4.56	4.2-6.1 x10(6)/uL
	Hgb	13.8	12.0-18.0 g/dL
	Hct	40.1	35.0-60.0%
	MCV	88.1	80.0-99.0 fl
	MCH	30.3	27.0-31.0 pg
	MCHC	34.4	33.0-37.0 g/dL
	Plt	414	130-400 x10(3)/uL
	LY%	10.7	15.0-55.0%
	LY#	1.9	0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Immature cells

RBC Morph:

Plt verify:

Spun Crit | | 35-60%

Malaria Smear

Thin | | No Plasmodium Seer

Thick | | No Plasmodium Seer

Sed Rate

Sed Rate | | 1hr = 0-20 mm

Coagulation

PT		10-13 seconds
APTT		22.1-33.7 seconds
FDP		Negative
D-Dimer		Negative
Fibrinogen		200-400 mg/dL

Blood Bank

ABO/Rh | A | positive

T&C

T&S

Urinalysis

Color	yellow-cloudy	Straw/Yellow
Clarity	cloudy	Clear
Glucose	Neg	Negative
Bilirubin	Neg	Negative
Ketone	Neg	Negative
SG	1030	1.010-1.025
Blood	Large	Negative
pH	6.0	5.0-8.0
Protein	30	Negative-Trace
Urobili	0.2	Negative
Nitrite	Neg	Negative
Leuko	Neg	Negative

Urine Microscopic

WBC	0-5	Epi	RARE squamous
RBC	TNTC	Mucus	Modest
Bacteria (circled)	Moderate	Yeast	Neg
Casts:	non	Spermatozoa	Neg
Crystals:	non	Amorph Sed	Neg
Other:			

Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Negative
DOA		Negative
CK-MB		< 4.3 ng/mL
Troponin I		< 0.19 ng/mL
Myoglobin		< 107 ng/mL

Microbiology

Source:		
FecLeuk		Negative
Gram Stain		
WetPrep		Negative
KOH		No Fungal Elements
OccBld		Negative
O&P		No Ova/Parasite

HCG

Urine		Negative
Serum		Negative

Other: IStat 6/Cr/CBC, T... Ir...

MEDCOM - 2625

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI: POTUS (b)(6)-4 | UNIT | RANK | SSN

Physician: (b)(6)-2 | Ward: ICU | STAT / ~~Routine~~ | Date and Time: 10/23 1140 | Reported by: (b)(6)-2 | Date and Time: 1235 23Oct

Chemistry (i-STAT)

X	TEST	RESULT	REF. RANGE
	Na	143	128-145 mmol/L
	K	4.8	3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH	7.396	7.35-7.45
	PCO2	30.7	35-45 mmHg
	PO2	315	80-90 mmHg
	TCO2	21	18-33 mmol/L
	HCO3	20	22-28 mmol/L
	sO2	100	95-99%
	BEecf	-6	(-2) - (+3)
	AGap		8-16 mmol/L
	iCa	1.00	0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL

Urinalysis

Color		Straw/Yellow
Clarity		Clear
Glucose		Negative
Bilirubin		Negative
Ketone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative-Trace
Urobili		Negative
Nitrite		Negative
Leuko		Negative

Urine Microscopic

WBC		Epi	
RBC		Mucus	
Bacteria		Yeast	
Casts:			
Crystals:			
Other:			
Other:	ABG FIO2-100% T 33°C. CBC. Chem 12, PT/PTT		

Chemistry (Piccolo Analyzer)

X	TEST	RESULT	REF. RANGE
	ALB	1.9	3.3-5.5 g/dL
	ALP	29	26-84 U/L
	ALT	159	10-47 U/L
	AMY	45	14-97 U/L
	AST	160	11-38 U/L
	Tbil	0.8	0.2-1.6 mg/dL
	BUN	12	7-22 mg/dL
	Ca	6.3	8.0-10.3 mg/dL
	Chol	57	100-200 mg/dL
	CK		30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat	1.2	0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu	271	73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein	2.8	6.4-8.1 g/dL
	Na		128-145 mmol/L

Microbiology

Source:		
FecLeuk		Negative
Gram St		
WetPrep		Negative
KOH		No Fungal Elements
OccBld		Negative
O&P		No Ova/Parasite

Blood Bank

ABO/Rh		
T&C	A	pos
T&S		

HCG

Urine		Negative
Serum		Negative

Hematology

X	TEST	RESULT	REF. RANGE
	WBC	15.7	4.8-10.8 x10(3)/uL
	RBC	2.77	4.2-6.1 x10(6)/uL
	Hgb	9.3	12.0-18.0 g/dL
	Hct	26.0	35.0-60.0%
	MCV	93.7	80.0-99.0 fl
	MCH	33.6	27.0-31.0 pg
	MCHC	35.8	33.0-37.0 g/dL
	Plt	127	130-400 x10(3)/uL
	LY%	11.8	15.0-55.0%
	LY#	1.9	0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Imm
RBC Morph:	
Plt verify:	
Spun Crit	35-60%

Malaria Smear

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate

Sed Rate		1hr = 0-20 mm

Coagulation

PT	22.9	10-13 seconds
APTT	47.2	22.1-33.7 seconds
FDP		Negative

Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Negative

FORM BEARLAB 20 31 May 2003 MEDCOM - 2626

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI.	UNIT	DOB	RANK	SSN
Potus (b)(6)-4	ICU			

Physician:	Ward:		Specimen Date and Time:	Reported by:	Date and Time:
Dr. (b)(6)-2		Routine	24oct 0455 HR	(b)(6)-2	24oct03e 0725

Chemistry (I-STAT) — 6+ / 7+ / 8+ / Glu / Crea

X	TEST	RESULT	REF. RANGE
	Na	140	128-145 mmol/L
	K	4.7	3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH	7.404	7.35-7.45
	PCO2	39.0	35-45 mmHg
	PO2	227	80-90 mmHg
	TCO2	25	18-33 mmol/L
	HCO3	24	22-28 mmol/L
	sO2	100%	95-99%
	BEecf	0	(-2) - (+3)
	AGap		8-16 mmol/L
	iCa	1.10	0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL
	Lactate		0.90-1.70 mmol/L

Urinalysis

	Color		Straw/Yellow
	Clarity		Clear
	Glucose		Negative
	Bilirubin		Negative
	Ketone		Negative
	SG		1.010-1.025
	Blood		Negative
	pH		5.0-8.0
	Protein		Negative-Trace
	Urobili		Negative
	Nitrite		Negative
	Leuko		Negative

Urine Microscopic

	WBC		Epi
	RBC		Mucus
	Bacteria		Yeast
	Casts:		Spermatozoa
	Crystals:		Amorph Sed
	Other:		
	Other:		

Chemistry (Piccolo Analyzer) — Chem 12 / MetLyte8 / BMP / Liver

X	TEST	RESULT	REF. RANGE
	ALB	2.5#	3.3-5.5 g/dL
	ALP	40	26-84 U/L
	ALT	243#	10-47 U/L
	AMY	81	14-97 U/L
	AST	242#	11-38 U/L
	Tbil	3.3#	0.2-1.6 mg/dL
	BUN	15	7-22 mg/dL
	Ca	8.0	8.0-10.3 mg/dL
	Chol	144#	100-200 mg/dL
	CK		30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat	1.3#	0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu	149#	73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein	4.1#	6.4-8.1 g/dL
	Na		128-145 mmol/L

Misc. Chemistry

	Mono		Negative
	RPR		Negative
	HIV		Negative
	Meningitis		Negative
	DOA		Negative
	CK-MB		< 4.3 ng/mL
	Troponin I		< 0.19 ng/mL
	Myoglobin		< 107 ng/mL

Microbiology

	Source:		
	FecLeuk		Negative
	Gram Stain		
	WetPrep		Negative
	KOH		No Fungal Elements
	OccBld		Negative
	O&P		No Ova/Parasite

HCG

	Urine		Negative
	Serum		Negative

Hematology — CBC / Malaria / H/H

X	TEST	RESULT	REF. RANGE
	WBC	16.9	4.8-10.8 x10(3)/uL
	RBC	4.27	4.2-6.1 x10(6)/uL
	Hgb	13.3	12.0-18.0 g/dL
	Hct	38.6	35.0-60.0%
	MCV	90.6	80.0-99.0 fl
	MCH	31.2	27.0-31.0 pg
	MCHC	34.5	33.0-37.0 g/dL
	Plt	102	130-400 x10(3)/uL
	LY%	8.4	15.0-55.0%
	LY#	1.4	0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Immature cells

	RBC Morph:	
	Plt verify:	
	Spun Crit	35-60%

Malaria Smear

	Thin	No Plasmodium Seen
	Thick	No Plasmodium Seen

Sed Rate

	Sed Rate	1hr = 0-20 mm

Coagulation

	PT	10-13 seconds
	APTT	22.1-33.7 seconds
	FDP	Negative
	D-Dimer	Negative
	Fibrinogen	200-400 mg/dL

Blood Bank

	ABO/Rh	
	T&C	
	T&S	

MEDCOM - 2627

ABG, CBC, Chem 12, PT, PTT

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI.	UNIT	DOB	RANK	SSN
POTUS [b)(6)-4]		24 Jul		

Physician: [b)(6)-2]	Ward: ICU	STAT / Routine	Specimen Date and Time: 25 Mar 03	Reported by: [b)(6)-2]	Date and Time: 25 at 0532 Hr

Chemistry (i-STAT) — 6+ / 7+ / 8+ / Glu / Crea

X	TEST	RESULT	REF. RANGE
	Na	138	128-145 mmol/L
	K	3.6	3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH	7.521	7.35-7.45
	PCO2	35.2	35-45 mmHg
	PO2	245	80-90 mmHg
	TCO2	30	18-33 mmol/L
	HCO3	29	22-28 mmol/L
	sO2	100 %	95-99%
	BEecf	6	(-2) - (+3)
	AGap		8-16 mmol/L
	iCa	1.08	0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL
	Lactate		0.90-1.70 mmol/L

Urinalysis

	Color		Straw/Yellow
	Clarity		Clear
	Glucose		Negative
	Bilirubin		Negative
	Ketone		Negative
	SG		1.010-1.025
	Blood		Negative
	pH		5.0-8.0
	Protein		Negative-Trace
	Urobili		Negative
	Nitrite		Negative
	Leuko		Negative

Urine Microscopic

	WBC		Epi
	RBC		Mucus
	Bacteria		Yeast
	Casts:		Spermatozoa
	Crystals:		Amorph Sed
	Other:		
	Other:		

Chemistry (Piccolo Analyzer) — Chem 12 / MetLyte8 / BMP / Liver

X	TEST	RESULT	REF. RANGE
	ALB	1.8	3.3-5.5 g/dL
	ALP	42	26-84 U/L
	ALT	151	10-47 U/L
	AMY	46	14-97 U/L
	AST	122	11-38 U/L
	Tbil	1.0	0.2-1.6 mg/dL
	BUN	19	7-22 mg/dL
	Ca	7.5	8.0-10.3 mg/dL
	Chol	64	100-200 mg/dL
	CK	400	30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat	1.3	0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu	103	73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein	3.8	6.4-8.1 g/dL
	Na		128-145 mmol/L

Misc. Chemistry

	Mono		Negative
	RPR		Negative
	HIV		Negative
	Meningitis		Negative
	DOA		Negative
	CK-MB		< 4.3 ng/mL
	Troponin I		< 0.19 ng/mL
	Myoglobin		< 107 ng/mL

Microbiology

	Source:		
	FecLeuk		Negative
	Gram Stain		
	WetPrep		Negative
	KOH		No Fungal Elements
	OccBld		Negative
	O&P		No Ova/Parasite

HCG

	Urine		Negative
	Serum		Negative

Hematology — CBC / Malaria / H/H

X	TEST	RESULT	REF. RANGE
	WBC	12.3	4.8-10.8 x10(3)/uL
	RBC	3.01	4.2-6.1 x10(6)/uL
	Hgb	9.5	12.0-18.0 g/dL
	Hct	27.0	35.0-60.0%
	MCV	89.5	80.0-99.0 fl
	MCH	31.6	27.0-31.0 pg
	MCHC	35.4	33.0-37.0 g/dL
	Plt	96	130-400 x10(3)/uL
	LY%	10.9	15.0-55.0%
	LY#	1.3	0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Immature cells

RBC Morph:		
Plt verify:		
Spun Crit		35-60%

Malaria Smear

Thin		No Plasmodium See
Thick		No Plasmodium See

Sed Rate

Sed Rate		1hr = 0-20 mm

Coagulation

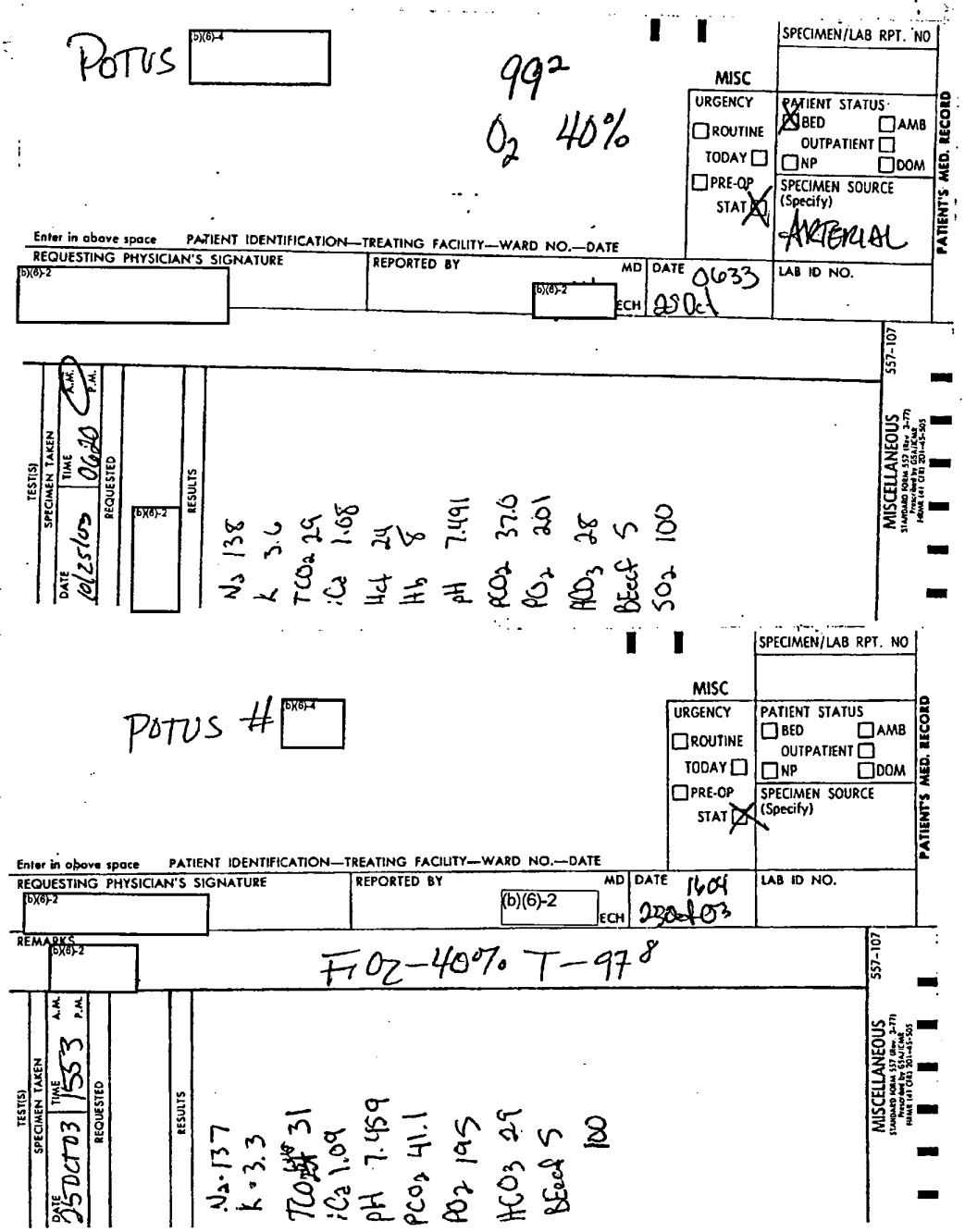
PT	13.4	10-13 seconds
APTT	33.4	22.1-33.7 seconds
FDP		Negative
D-Dimer		Negative
Fibrinogen		200-400 mg/dL

Blood Bank

ABO/Rh		
T&C		
T&S		

ACLU-RDI 1099 p.1412

DOD 006680


POTUS [b)(6)-4]
992
O2 40%
SPECIMEN/LAB RPT. NO
MISC
URGENCY
ROUTINE
TODAY
PRE-OP
STAT
PATIENT STATUS
BED
AMB
OUTPATIENT
NP
DOM
SPECIMEN SOURCE (Specify)
ARTERIAL
PATIENT'S MED. RECORD
Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REQUESTING PHYSICIAN'S SIGNATURE
REPORTED BY
MD
ECH
DATE 0633
LAB ID NO.
TEST(S)
SPECIMEN TAKEN
DATE 12/25/03
TIME 0620
A.M.
P.M.
REQUESTED
RESULTS
Na 138
K 3.6
TCO2 29
iCa 1.08
Hct 24
Hb 8
pH 7.491
PCO2 37.6
PO2 201
HCO3 28
Beecf 5
SO2 100
MISCELLANEOUS
557-107
POTUS # [b)(6)-4]
MISC
URGENCY
ROUTINE
TODAY
PRE-OP
STAT
PATIENT STATUS
BED
AMB
OUTPATIENT
NP
DOM
SPECIMEN SOURCE (Specify)
PATIENT'S MED. RECORD
Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REQUESTING PHYSICIAN'S SIGNATURE
REPORTED BY
MD
ECH
DATE 1604
LAB ID NO.
REMARKS
FIO2-40% T-97.8
TEST(S)
SPECIMEN TAKEN
DATE 25DEC03
TIME 1553
A.M.
P.M.
REQUESTED
RESULTS
Na 137
K 3.3
TCO2 31
iCa 1.09
pH 7.459
PCO2 41.1
PO2 195
HCO3 29
Beecf 5
100
MISCELLANEOUS
557-107

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE | SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*

Critical value for Hg reported to SGT [redacted] 66-2

POTUS # [redacted]

FCU

SPECIMEN/LAB RPT. NO

MISC

URGENCY: ☐ ROUTINE ☐ TODAY ☐ PRE-OP STAT ☒

PATIENT STATUS: ☐ BED ☐ AMB OUTPATIENT ☐ NP ☐ DOM

SPECIMEN SOURCE (Specify)

PATIENT'S MED. RECORD

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE [redacted] | REPORTED BY [redacted] | MD ECH | DATE 26oct03 | LAB ID NO.

REMARKS

ABG T-99° FiO2-40% 1905HR

TEST(S) | SPECIMEN TAKEN DATE 26Oct03 TIME 1859 A.M. P.M. | REQUESTED | RESULTS

Na 142
K 3.7
TCO2 34
ica 1.10
Hct 22%
Hb 7 C.V.
HCO3 33
BEef 10
SO2 100%
PH 7.500
PCO2 41.9
PO2 204
FIO2 40%
patient Temp 99.0

MISCELLANEOUS 557-107

STANDARD FORM 557 (Rev. 3-77) Prescribed by GSA/ICMR FIRMR (41 CFR) 201-45-505

POTUS [redacted]

ICU

Critical value on Hg reported to LT [redacted]

SPECIMEN/LAB RPT. NO

MISC

URGENCY: ☐ ROUTINE ☐ TODAY ☐ PRE-OP STAT ☒

PATIENT STATUS: ☐ BED ☐ AMB OUTPATIENT ☐ NP ☐ DOM

SPECIMEN SOURCE (Specify)

PATIENT'S MED. RECORD

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE [redacted] | REPORTED BY [redacted] | MD ECH | DATE 26oct03 | LAB ID NO.

REMARKS

ABG 2000HR T-99.7 FiO2-24/NC 28%

TEST(S) | SPECIMEN TAKEN DATE 26Oct03 TIME 2000 A.M. P.M. | REQUESTED | RESULTS

Extubation

Na 141
K 3.6
TCO2 33
ica 1.10
Hct 20%
Hb 7 C.V.
HCO3 32
BEef 9
SO2 100%
PH 7.45
PCO2 41.5
PO2 192
patient Temp 99.7
FIO2 25

MISCELLANEOUS 557-107

STANDARD FORM 557 (Rev. 3-77) Prescribed by GSA/ICMR FIRMR (41 CFR) 201-45-505

HOSPITAL OR MI ... AINED AT

SPONSOR'S NAM

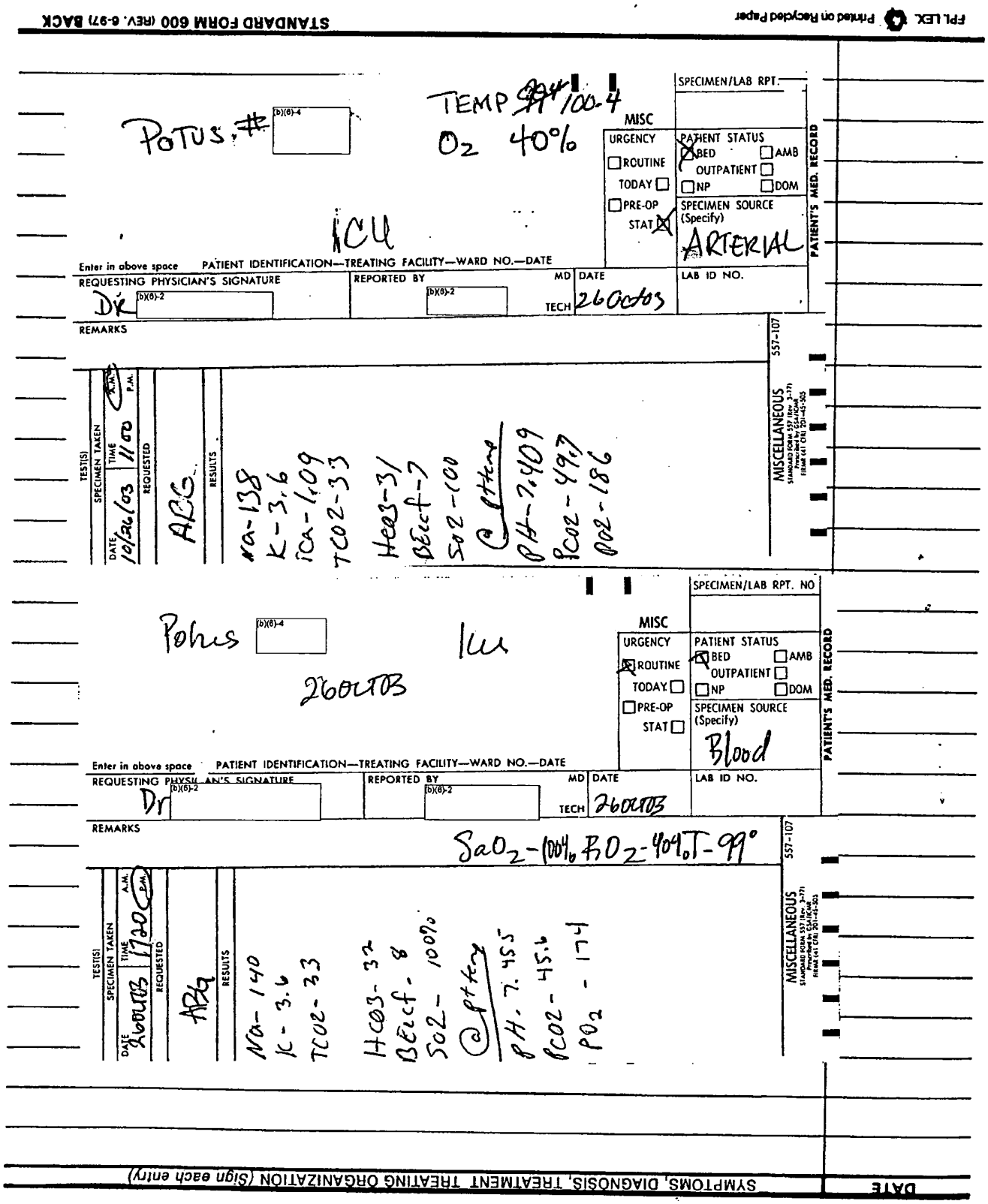
PATIENT'S IDEN... ARD NO.

Date of Birth; Rank/Grade.)

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

MEDCOM - 2630


STANDARD FORM 600 (REV. 6-97) BACK
FPL LEX Printed on Recycled Paper
POTUS #
(b)(6)-4
TEMP 99.4/100.4
O2 40%
ICU
SPECIMEN/LAB RPT.
MISC
URGENCY
ROUTINE
TODAY
PRE-OP
STAT
PATIENT STATUS
BED
AMB
OUTPATIENT
NP
DOM
SPECIMEN SOURCE (Specify)
ARTERIAL
PATIENT'S MED. RECORD
Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REQUESTING PHYSICIAN'S SIGNATURE
Dr
(b)(6)-2
REPORTED BY
MD
TECH
DATE
26OCT03
LAB ID NO.
REMARKS
557-107
MISCELLANEOUS
TEST(S)
SPECIMEN TAKEN
DATE
10/26/03
TIME
1100
A.M.
P.M.
REQUESTED
ABG
RESULTS
Na-138
K-3.6
iCa-1.09
TCO2-33
Hco3-31
Beef-7
So2-100
@ptty
pH-7.409
Pco2-49.7
Po2-186
SPECIMEN/LAB RPT. NO
Potus
ICU
26OCT03
SaO2-100% FiO2-40% T-99°
Blood
Na-140
K-3.6
TCO2-33
Hco3-32
Beef-8
So2-100%
@ptty
pH-7.455
Pco2-45.6
Po2-174
1120
SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
DATE

MEDCOM - 2631

ABG, CBC, Chem 12, PT/PTT

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI: Potus (b)(6)-4 | UNIT: — | DOB: — | RANK: — | SSN: —

Physician: (b)(6)-2 | Ward: ICU | [X] STAT / [ ] Routine | Specimen Date and Time: 260203 0425 | Reported by: (b)(6)-2 | Date and Tin: 26

Chemistry (i-STAT)

6+ 7+ 8+ Glu Crea

X	TEST	RESULT	REF. RANGE
	Na	138	128-145 mmol/L
	K	3.5	3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH	7.503	7.35-7.45
	PCO2	40.9	35-45 mmHg
	PO2	253	80-90 mmHg
	TCO2	33	18-33 mmol/L
	HCO3	32	22-28 mmol/L
	sO2	100%	95-99%
	BEecf	9	(-2) - (+3)
	AGap		8-16 mmol/L
	iCa	1.07	0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL
	Lactate		0.90-1.70 mmol/L

Urinalysis

Color		Straw/Yellow
Clarity		Clear
Glucose		Negative
Bilirubin		Negative
Ketone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative-Trace
Urobili		Negative
Nitrite		Negative
Leuko		Negative

Urine Microscopic

WBC		Epi	
RBC		Mucus	
Bacteria		Yeast	
Casts:		Spermatozoa	
Crystals:		Amorph Sed	
Other:			
Other:			

Chemistry (Piccolo Analyzer)

Chem 12 MetLyte8 BMP Liver

X	TEST	RESULT	REF. RANGE
	ALB	1.8 *	3.3-5.5 g/dL
	ALP	47	26-84 U/L
	ALT	135 *	10-47 U/L
	AMY	45	14-97 U/L
	AST	157 *	11-38 U/L
	Tbil	0.9	0.2-1.6 mg/dL
	BUN	14	7-22 mg/dL
	Ca	7.9 *	8.0-10.3 mg/dL
	Chol	75 *	100-200 mg/dL
	CK	L	30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat	1.4 *	0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu	122 *	73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein	4.3 *	6.4-8.1 g/dL
	Na		128-145 mmol/L

Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Negative
DOA		Negative
CK-MB		< 4.3 ng/mL
Troponin I		< 0.19 ng/mL
Myoglobin		< 107 ng/mL

Microbiology

Source:		
FecLeuk		Negative
Gram Stain		
WetPrep		Negative
KOH		No Fungal Elements
OccBld		Negative
O&P		No Ova/Parasite

HCG

Urine		Negative
Serum		Negative

Hematology

CBC Malaria H/H

X	TEST	RESULT	REF. RANG
	WBC	8.28	4.8-10.8 x10(3
	RBC	2.76	4.2-6.1 x10(6)
	Hgb	8.7	12.0-18.0 g/
	Hct	24.9	35.0-60.0%
	MCV	90.0	80.0-99.0 fl
	MCH	31.4	27.0-31.0 p
	MCHC	34.9	33.0-37.0 g/
	Plt	96	130-400 x10(3
	LY%	6.6	15.0-55.0%
	LY#	0.6	0.7-4.3 x10(3)

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Immature cells
RBC Morph:	
Plt verify:	
Spun Crit	35-60%

Malaria Smear

Thin		No Plasmodium S
Thick		No Plasmodium S

Sed Rate

Sed Rate		1hr = 0-20 mm

Coagulation

PT	12.3	10-13 seconds
APTT	31.0	22.1-33.7 seconc
FDP		Negative
D-Dimer		Negative
Fibrinogen		200-400 mg/dL

Blood Bank

ABO/Rh		
T&C		
T&S		

FORM BEARLAB 20 23 July 200[illegible] MEDCOM - 2632

critical value reported to [redacted] ICU, RN

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI.	UNIT	DOB	RANK	SSN
Potus [redacted]	—	—	—	—

Physician:	Ward:		Specimen Date and Time:	Reported by:	Date and Time:
[redacted]	ICU	X STAT	270003 0545	[redacted]	270603
		Routine			

Chemistry (i-STAT)

6+ / 7+ / 8+ / Glu / Crea

X	TEST	RESULT	REF. RANGE
	Na	142	128-145 mmol/L
	K	3.1	3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH	7.450	7.35-7.45
	PCO2	44.9	35-45 mmHg
	PO2	201	80-90 mmHg
	TCO2	32	18-33 mmol/L
	HCO3	31	22-28 mmol/L
	sO2	100	95-99%
	BEecf	7	(-2) - (+3)
	AGap		8-16 mmol/L
	iCa	1.09	0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL
	Lactate		0.90-1.70 mmol/L

Urinalysis

	Color		Straw/Yellow
	Clarity		Clear
	Glucose		Negative
	Bilirubin		Negative
	Ketone		Negative
	SG		1.010-1.025
	Blood		Negative
	pH		5.0-8.0
	Protein		Negative-Trace
	Urobili		Negative
	Nitrite		Negative
	Leuko		Negative

Urine Microscopic

	WBC		Epi
	RBC		Mucus
	Bacteria		Yeast
	Casts:		Spermatozoa
	Crystals:		Amorph Sed
	Other:		
	Other:	ABG ART	

Chemistry (Piccolo Analyzer)

Chem 12 / MetLyte8 / BMP / Liver

X	TEST	RESULT	REF. RANGE
	ALB	1.8 *	3.3-5.5 g/dL
	ALP	52	26-84 U/L
	ALT	108 *	10-47 U/L
	AMY	119 *	14-97 U/L
	AST	179 *	11-38 U/L
	Tbil	0.8	0.2-1.6 mg/dL
	BUN	9	7-22 mg/dL
	Ca	7.7 *	8.0-10.3 mg/dL
	Chol	88 *	100-200 mg/dL
	CK		30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat	1.2	0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu	189 *	73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein	4.6 *	6.4-8.1 g/dL
	Na		128-145 mmol/L

Misc. Chemistry

	Mono		Negative
	RPR		Negative
	HIV		Negative
	Meningitis		Negative
	DOA		Negative
	CK-MB		< 4.3 ng/mL
	Troponin I		< 0.19 ng/mL
	Myoglobin		< 107 ng/mL

Microbiology

	Source:		
	FecLeuk		Negative
	Gram Stain		
	WetPrep		Negative
	KOH		No Fungal Elements
	OccBld		Negative
	O&P		No Ova/Parasite

HCG

	Urine		Negative
	Serum		Negative

Hematology

CBC / Malaria / H/H

X	TEST	RESULT	REF. RANGE
	WBC	6.7	4.8-10.8 x10(3)/uL
	RBC	2.56	4.2-6.1 x10(6)/uL
	Hgb	8.4	12.0-18.0 g/dL
	Hct	23.4	35.0-60.0%
	MCV	91.2	80.0-99.0 fl
	MCH	32.9	27.0-31.0 pg
	MCHC	36.0	33.0-37.0 g/dL
	Plt	134	130-400 x10(3)/uL
	LY%	13.1	15.0-55.0%
	LY#	0.9	0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Immature cells

RBC Morph:		
Plt verify:		
Spun Crit		35-60%

Malaria Smear

Thin		No Plasmodium See
Thick		No Plasmodium See

Sed Rate

Sed Rate		1hr = 0-20 mm

Coagulation

PT	13.3 *	10-13 seconds
APTT	20.9 *	22.1-33.7 seconds
FDP		Negative
D-Dimer		Negative
Fibrinogen		200-400 mg/dL

Blood Bank

ABO/Rh		
T&C		
T&S		

MEDCOM - 2633 37° 7.89

Critical value Hgb Reported (b)(6)-2 @ 0

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI.	UNIT	DOB	RANK	SSN
Potus (b)(6)-4				

Physician:	Ward:			Reported by:	Date and Time:
(b)(6)-2	ICU	X STAT	Specimen Date and Time: 28 OCT 03 0420	(b)(6)-2	28 oct 03 0430
		Routine			

Chemistry (i-STAT)

6+ 7+ 8+ Glu Crea

X	TEST	RESULT	REF. RANGE
	Na	139	128-145 mmol/L
	K	4.5	3.3-4.7 mmol/L
	Cl	97	98-108 mmol/L
	pH	7.456	7.35-7.45
	PCO2	37.2	35-45 mmHg
	PO2	107	80-90 mmHg
	TCO2		18-33 mmol/L
	HCO3	26	22-28 mmol/L
	sO2	98 a/c	95-99%
	BEecf	2	(-2) - (+3)
	AGap		8-16 mmol/L
	iCa	1.04	0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL
	Lactate		0.90-1.70 mmol/L

Urinalysis

Color		Straw/Yellow
Clarity		Clear
Glucose		Negative
Bilirubin		Negative
Ketone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative-Trace
Urobili		Negative
Nitrite		Negative
Leuko		Negative

Urine Microscopic

WBC		Epi	
RBC		Mucus	
Bacteria		Yeast	
Casts:		Spermatozoa	
Crystals:		Amorph Sed	
Other:			
Other:			

Chemistry (Piccolo Analyzer)

Chem 12 MetLyte8 BMP Liver

X	TEST	RESULT	REF. RANGE
	ALB	1.7	3.3-5.5 g/dL
	ALP	54	26-84 U/L
	ALT	112	10-47 U/L
	AMY	127	14-97 U/L
	AST	152	11-38 U/L
	Tbil	0.9	0.2-1.6 mg/dL
	BUN	9	7-22 mg/dL
	Ca	7.5	8.0-10.3 mg/dL
	Chol	120	100-200 mg/dL
	CK		30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat	1.4	0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu	281	73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein	4.5	6.4-8.1 g/dL
	Na		128-145 mmol/L

Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Negative
DOA		Negative
CK-MB		< 4.3 ng/mL
Troponin I		< 0.19 ng/mL
Myoglobin		< 107 ng/mL

Microbiology

Source:		
FecLeuk		Negative
Gram Stain		
WetPrep		Negative
KOH		No Fungal Elements
OccBld		Negative
O&P		No Ova/Parasite

HCG

Urine		Negative
Serum		Negative

Hematology

CBC Malaria H/H

X	TEST	RESULT	REF. RANGE
	WBC	5.9	4.8-10.8 x10(3)/uL
	RBC	2.65	4.2-6.1 x10(6)/uL
	Hgb	8.3	12.0-18.0 g/dL
	Hct	24.2	35.0-60.0%
	MCV	91.5	80.0-99.0 fl
	MCH	31.2	27.0-31.0 pg
	MCHC	34.1	33.0-37.0 g/dL
	Plt	174	130-400 x10(3)/uL
	LY%	20.0	15.0-55.0%
	LY#	1.2	0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Immature cells
RBC Morph:	
Plt verify:	
Spun Crit	35-60%

Malaria Smear

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate

Sed Rate		1hr = 0-20 mm

Coagulation

PT	12.3	10-13 seconds
APTT	27.0	22.1-33.7 seconds
FDP		Negative
D-Dimer		Negative
Fibrinogen		200-400 mg/dL

Blood Bank

ABO/Rh		
T&C		
T&S		

ABG, CBC, Chem-10 or PTT

MEDCOM - 2634

FORM READ AR 30-33 July 2003

ACLU-RDI 1099 p.1418

DOD 006686

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES

Potus # [b)(6)-4]

SPECIMEN/LAB RPT. NO

MISC

URGENCY: ☐ ROUTINE ☐ TODAY ☐ ☐ PRE-OP ☐ STAT

PATIENT STATUS: ☐ BED ☐ AMB ☐ OUTPATIENT ☐ ☐ NP ☐ DOM

SPECIMEN SOURCE (Specify): Blood

PATIENT'S MED. RECORD

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE [b)(6)-2] REPORTED BY [b)(6)-2] MD [b)(6)-2] DATE 28 Oct 03 0458

LAB ID NO.

REMARKS

CBC, Chem 12, PT PTT

TEST(S) SPECIMEN TAKEN DATE 29 Oct 03 TIME 0415 A.M. P.M. REQUESTED RESULTS

AHB 1.8 *
ALP 75
ALT 107 *
AMX 114 *
AST 136 *
TBIL 1.1 PT-11.8
BUN 10 APTT-25.9
CA 7.8 *
CHOL 127
CRE 1.1
CLU 141 *
TP -5.1 *
WBC-6.5
KBC-2.99
Hgb-9.0
Hct-27.1
MCV-90.8
MCH-30.0
MCHC-33.1 Ly%-18.4
PLT-250 Lu#-1.2

MISCELLANEOUS 557-107

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)*

REGISTER NO.	WARD NO.

Potus # [b)(6)-4]

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/199
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(1

USAPA V1.0

MEDCOM - 2635

0845 HH 11.9/54.4
ABG pCO2 40.5 pO2 390
HCO3 26 BE -5
Na 137 K 5.2
iCA 0.31 ph 7.328

~~ASTAT~~	#	#	NA	K	CA	PH	PCO2	PO2		
1942	5.4	19.1	144	3.1	1.08	7.196	4 -	393	17	-11
43	8.9	25.2	144	4.0	1.02	7.186		396	17	-11

UNSTAT @ 0930

NGT 100 ML

MEDICAL RECORD - ANESTHESIA

For use of this form, see AR 40-66; the proponent agency is the OTSG

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML. "I" - CONSTANT INFUSION

DRUG (Units)													
VASOPRESSIN GTT (U/min)							0.3	0.3	0.3	0.5	0.2		0.2
VASOPRESSIN (U)							2	Fentanyl µg 50/50					
EPI GTT (mcg/min)							3	3	18				
EPI mg	10	1					0.5	0.3					
DOPAMINE µg/kg/min							15	20	20	20	10	5	5
NEO 40 µg/ml							30						
VOLAT AGENT (dial)													
% e.t.		1.0	0.4	0.3	0	0	0	0	0	0.2	0.3	0.4	0.4
UNASYN (mg)													
VECURONIUM (mg) IVPB											5		5
Versed (mg)													
O2 (L/Min)		2	2	2	2	2	2	2	2	2	2	2	2

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS

FLUIDS

LINE site	☐ Warmed												
CRYSTALLOID	☐ Warmed						1000	500	500	500			
	☐ Warmed												
Fentanyl µg	☐ Warmed						150						

LOSSES — EST BLOOD LOSS: 400 / URINE: 50 / 100 / 150 / 50 / 200

PHYS STATUS 1 2 3 4 5 (E)

BODY WEIGHT: 70 (KG) LB

HEMATOCRIT:

INITIAL DATA:

BP- 92/45

HR- 95

EQUIP CHECK: OK? (Y) N

PATIENT RECHECK: OK for PROCEDURE? TIME-

TIME 0800 0830 0900 0930 1000 1030 1100

SYMBOLS (ABC UNITS)

BP by cuff V ^ | Heart rate ● | Resp rate | BR (transduced) | TOURNIQUET T—T | ANES- X-X | PROC- ⊙-⊙

200 180 160 140 120 100 80 60 40 20

930 NGT → LTS
(E) RADIAL A-line placed
915 .5mg EPI
916 Bicarb
917 CV
951 .3mg EPI
1 AMP Mg in 250 cc (1 mg/cc) 900 18 gtt/min ctd
(R) hand

VENTIL

	0800	0830	0900	0930	1000	1030	1100	1130	1200	1230	1300	1330
VT - ml	670	690	730	660	680	670	700	690	680	690	710	690
f - breaths/min	10	8	7	7	7	8	7	7	7	7	6	6
Peak Inf pres / PEEP	20	19	19	18	18	19	19	19	19	19	21	21
MODE - S(pon), A(assist), C(on)	CV	CV	CV	CV	CV	CV	CV	CV	CV	CV	CV	CV

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	42	36	35	30	31	32	30	30	30	29	29	30
BP/oth	FIO2 (Frac or %)	.94	.94	.93	.94	.94	.94	.93	.93	.93	.93	.94	.94
ART line (R)RAD	SpO2 (%)	100	100	100	100	100	100	100	100	100	100	100	100
Steth- PC/ES	ECG	SR	SR	ST	ST	ST	ST	ST	ST	SR	SR	SR	SR
Gas analyzer	TEMP-site FHC/RN							33	33	33	33	33	33
	N-M Block (T/4)												
Warming blkt (L)FEET							41 C						
Conv warmer													

Mark with letters & symbols, explain under REMARKS — EVENTS Position → ARMS <90° / Head Padded / EYES TAPED FROM ENT

TOTALS — TOTAL EBL: 1000 — TOTAL URINE: 300

FLUIDS SUMMARY
CRYSTALLOID: 8508
COLLOID: 100 (25% ALBUMIN)
BLOOD: 2U PRBCs

REMARKS — Code drugs with numbers, events with letters

700 ml 25 µg

RECOVERY AT
PACU (CV) ____ (Specify)
OTHER ____
CONDITION:
RESP. SpO2
BP. HR.

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0808	0800	1132
PROC	Ready	Begin	End
	0805	0815	1105

PROCEDURES and CPT Codes: EXP. LAPAROTOMY / THORACOTOMY

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* GETA

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*

POTUS # (b)(6)-4

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* INTUBATED IN ENT; DL x 1, ATRAUMATIC

SURGEONS:

PROCEDURE LOCATION:

DATE:

MEDCOM - 2636

Cont'd. from Page 1

MEDICAL RECORD - ANESTHESIA

For use of this form, see AR 40-66; the proponent agency is the OTSG

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML, "I" = CONSTANT INFUSION

DRUG (Units)	
Vasopressin inf CI	0.2
Propofol µg/kg/min	3
( )	
Bcard 8-17/1 AHA	2
( )	
( )	
VOLAT AGENT	% dial / % e.t.
AIR	L/Min
N2O	L/Min
O2	L/Min 2

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS

FLUIDS

LINE site	☐ Warmed
	☐ Warmed
	☐ Warmed
	☐ Warmed

LOSSES — EST BLOOD LOSS / URINE

PHYS STATUS 1 2 3 4 5 E

BODY WEIGHT: KG / LB

HEMATOCRIT:

INITIAL DATA:

BP: ____/____

HR:

EQUIP CHECK

OK? Y N

PATIENT RECHECK

OK for PROCEDURE?

TIME:

TIME 11 : 30

SYMBOLS: BP by cuff V ^ — Heart rate ● — Resp rate — BR (transduced) + — TOURNIQUET T—T — ANES- X-X — PROC- ⊙-⊙

220 200 180 160 140 120 100 80 60 40 20

III

II

VENTIL

VT - ml	690
f - breaths/min	9
Peak inf pres / PEEP	28
MODE - S(pon), A(assist), C(on)	CV

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	35
BP/oth	FIO2 (Frac or %)	.5#
ART line	SpO2 (%)	100
Steth- PC/ES	ECG	JR
Gas analyzer	TEMP-INF	35
	N-M Block (T/4)	
Warming blkt		
Conv warmer		

Mark with letters & symbols, explain under REMARKS — EVENTS Position

TOTALS | **TOTAL EBL** | **TOTAL URINE**

FLUIDS SUMMARY

CRYSTALLOID-

COLLOID-

BLOOD-

REMARKS

Operation being performed Patient with Agitation

Drips Started

ICU TO ICU

VSA Overview

VSS 172/66 92 100%.

Report given Lieut Lafonte ICU Vasopressin D/C'd

Placed on Vent

Rate 15 TV 700 Peep 5 100% O_2

RECOVERY AT

PACU ICU _____ (Specify)

OTHER _____

CONDITION:

RESP- SpO2-

BP- HR-

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES			
PROC	Ready	Begin	End

PROCEDURES and CPT Codes:

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*

POTUS (b)(6)-4

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*

SURGEONS:

PROCEDURE LOCATION:

DATE:

MEDCOM - 2637

518-124

NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

- ☐ RED BLOOD CELLS
- ☐ FRESH FROZEN PLASMA
- ☐ PLATELETS *(Pool of _____ units)*
- ☐ CRYOPRECIPITATE *(Pool of _____ units)*
- ☐ Rh IMMUNE GLOBULIN
- ☐ OTHER *(Specify)* _____

VOLUME REQUESTED *(If applicable)*

_____ ML

REMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*

- ☐ TYPE AND SCREEN
- ☒ CROSSMATCH

DATE REQUESTED: 23 Oct 03

DATE AND HOUR REQUIRED: ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)*: (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE: S/P GSW Kidney/Liver

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER: [signature]

DATE VERIFIED

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.: (b)(6)-4

TRANSFUSION NO.

PATIENT NO.

TEST INTERPRETATION

ANTIBODY SCREEN: N/P

CROSSMATCH: Comp

PREVIOUS RECORD CHECK:

☐ RECORD ☐ NO RECORD

SIGNATURE OF PERSON PERFORMING TEST: (b)(6)-2

DONOR

ABO: A

Rh: POS

RECIPIENT

ABO: A

Rh: POS

☐ CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE

REMARKS: Due to the critical condition of the below named patient the above named physician requests the immediate release of this blood product w/o complete testing and is accepting full responsibility for the administration of this transfusion

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSP: (b)(6)-2

AT *(Hour)*: 2022 HR

ON *(Date)*: 23 Oct 03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER *(Signature)*: (b)(6)-2 MAJ AN

2nd VERIFIER *(Signature)*: (b)(6)-2 LTJG

PRE

TEMP.: 96.3 (AX) | PULSE: 91 | BP: 142/50

DATE OF TRANSFUSION: 23 Oct 03 | TIME STARTED: 2030

POST-TRANSFUSION DATA

AMOUNT GIVEN: 417 ML

TIME/DATE COMPLETED/INTERRUPTED: 2300 23 Oct 03 2055

REACTION: ☒ NONE ☐ SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
96.8 (AX)	98	109/77

If reaction is suspected—IMMEDIATELY:

1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION OF REACTION

☐ URTICARIA ☐ CHILL ☐ FEVER ☐ PAIN

☐ OTHER *(Specify)* N/A

OTHER DIFFICULTIES *(Equipment, clots, etc.)*

☒ NO ☐ YES *(Specify)*

SIGNATURE OF PERSON NOTING ABOVE: (b)(6)-2 MAJ AN

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle; grade; rank; rate; hospital or medical facility)

NAME/RANK:

SS #:

DOB:

UNIT:

Potus (b)(6)-4

SEX: M

WARD: ICU

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 2638

Medical Record Copy

518-124

NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

- ☐ RED BLOOD CELLS
- ☐ FRESH FROZEN PLASMA
- ☐ PLATELETS *(Pool of _____ units)*
- ☐ CRYOPRECIPITATE *(Pool of _____ units)*
- ☐ Rh IMMUNE GLOBULIN
- ☐ OTHER *(Specify)* _____

VOLUME REQUESTED *(If applicable)*

_____ ML

REMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*

- ☐ TYPE AND SCREEN
- ☒ CROSSMATCH

DATE REQUESTED: 23Oct03

DATE AND HOUR REQUIRED: ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)*: [b(6)-2]

DIAGNOSIS OR OPERATIVE PROCEDURE: S/P GSW Kidney/Liver

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER

DATE VERIFIED: On file

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.: [b(6)-4]

TRANSFUSION NO.

PATIENT NO.

DONOR: ABO A, Rh POS

RECIPIENT: ABO A, Rh POS

TEST INTERPRETATION

ANTIBODY SCREEN: N/S

CROSSMATCH: Comp

PREVIOUS RECORD CHECK: ☒ RECORD ☐ NO RECORD

SIGNATURE OF PERSON PERFORMING TEST: [b(6)-2]

☐ CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED — DATE

REMARKS: Due to the critical condition of the below named patient the above named physician requests the immediate release of this blood product w/o complete testing and is accepting full responsibility for the administration of this transfusion

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INS: [b(6)-2]

AT *(Hour)*: 1943 hrs — ON *(Date)*: 23Oct03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER *(Signature)*: [b(6)-2] MSAN

2nd VERIFIER *(Signature)*: [b(6)-2] USAN

PRE-TRANSFUSION TEMP. 96° (A) — PULSE 92 — BP 104/65

DATE OF TRANSFUSION: 23Oct03 — TIME STARTED: 1950

POST-TRANSFUSION DATA

AMOUNT GIVEN: 412 ML

TIME/DATE COMPLETED/INTERRUPTED: 2015

REACTION: ☒ NONE ☐ SUSPECTED

TEMPERATURE: 96.3 (A) — PULSE: 91 — BLOOD PRESSURE: 134/73

If reaction is suspected—IMMEDIATELY:

1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION OF REACTION

☐ URTICARIA ☐ CHILL ☐ FEVER ☐ PAIN

☐ OTHER *(Specify)* N/A

OTHER DIFFICULTIES *(Equipment, clots, etc.)*

☒ NO ☐ YES *(Specify)*

SIGNATURE OF PERSON NOTING ABOVE: [b(6)-2] MSAN

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle; grade; rank; rate; hospital or medical facility)

SEX: M — WARD: ICU

NAME/RANK: Potus [b(6)-4]

SS #:

DOB:

UNIT:

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 2639

Medical Record Copy

518-124 NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*
- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of _____ units)*
- [ ] CRYOPRECIPITATE *(Pool of _____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* _____

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*
- [ ] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED

DATE AND HOUR REQUIRED

REQUESTING PHYSICIAN *(Print)*
(b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE
Post Operative

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

VOLUME REQUESTED *(If applicable)*
Unit ML

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

SIGNATURE OF VERIFIER
Previous Clot

REMARKS:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:
RhIG TREATMENT? DATE GIVEN: _____
HEMOLYTIC DISEASE OF NEWBORN? _____

DATE VERIFIED
23 Oct 03

TIME VERIFIED
1155

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.
(b)(6)-4

TRANSFUSION NO.

PATIENT NO.

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
Not Performed	Ok

PREVIOUS RECORD CHECK:
- [X] RECORD
- [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST
(b)(6)-2

DONOR	RECIPIENT
ABO A	ABO A
Rh Pos	Rh Pos

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE

REMARKS: Due to the critical condition of the below named patient the requesting physician named above is requesting immediate release of this blood product w/out complete testing, and is accepting full responsibility of the administration of this transfusion.

SECTION III – RECORD OF TRANSFUSION

(b)(6)-2

AT (Hour) 1330 | ON (Date) 28 Oct 03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER *(Signature)*
(b)(6)-2 PC 91WMLL

2nd VERIFIER *(Signature)*

PRE-TRANSFUSION
TEMP. 33° C | PULSE 88 | BP 123/59

DATE OF TRANSFUSION
23 Oct 03

TIME STARTED
1336

POST-TRANSFUSION DATA

AMOUNT GIVEN	TIME/DATE COMPLETED/INTERRUPTED
401 ML	1455 23 Oct 03

REACTION	TEMPERATURE	PULSE	BLOOD PRESSURE
[X] NONE [ ] SUSPECTED	91.3 (A)	81	100/64

If reaction is suspected—IMMEDIATELY:
1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION OF REACTION
- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER *(Specify)* N/A

OTHER DIFFICULTIES *(Equipment, clots, etc.)*
- [X] NO
- [ ] YES *(Specify)*

SIGNATURE OF PERSON NOTING ABOVE
(b)(6)-2 MJ AN

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle; grade; rank; rate; hospital or medical facility)

Name/Rank: Potus
SSN:
DOB:
Unit:
(b)(6)-4

SEX M

WARD ICU

BLOOD OR BLOOD COMPONENT TRANSFUSION
Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 2640

Medical Record Copy

ACLU-RDI 1099 p.1424

DOD 006692

MEDICAL RECORD	BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*
- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of ____ units)*
- [ ] CRYOPRECIPITATE *(Pool of ____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* _____

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*
- [ ] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED 23 Oct 03

DATE AND HOUR REQUIRED ASAP

REQUESTING PHYSICIAN *(Print)* (b)(6)-2 [redacted]

DIAGNOSIS OR OPERATIVE PROCEDURE S/P Ex Lap

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

VOLUME REQUESTED *(If applicable)* _____ ML

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

SIGNATURE OF VERIFIER (b)(6)-2 [redacted] Previous Clot

REMARKS:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? ____

(b)(6)-2 [redacted] 23 Oct 03

T[redacted]FIED 0740

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. (b)(6)-4 [redacted]

TRANSFUSION NO.

PATIENT NO.

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
Not performed	OK

PREVIOUS RECORD CHECK: [X] RECORD [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST (b)(6)-2 [redacted]

DONOR	RECIPIENT
ABO A	ABO A
Rh Pos	Rh Pos

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED **DATE** 23 Oct 03

REMARKS: Due to the critical condition of the below named patient the requesting physician named above is requesting immediate release of this blood product w/out complete testing and is accepting full respo[illegible] of the administration of this transfusion.

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)* (b)(6)-2 [redacted]

AT *(Hour)* 1225 **ON** *(Date)* 23 Oct 03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER *(Signature)* (b)(6)-2 [redacted] MAT [illegible]

2nd VERIFIER *(Signature)* (b)(6)-2 [redacted] SGT/LPN

PRE-TRANSFUSION

TEMP. 33°C PULSE 78 BP 141/61

DATE OF TRANSFUSION 23 OCT 2003 **TIME STARTED** 12:30

POST-TRANSFUSION DATA

AMOUNT GIVEN 473 ML **TIME DATE COMPLETED INTERRUPTED** 1336 23 Oct 03

REACTION [✓] NONE [ ] SUSPECTED

If reaction is suspected – IMMEDIATELY:
1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION

[ ] URTICARIA [ ] CHILL [ ] FEVER [ ] PAIN

[ ] OTHER _____

OTHER DIFFICULTIES *(Equipment, clots, etc.)*

[✓] NO [ ] YES *(Specify)* _____

SIGNATURE OF PERSON NOTING ABOVE (b)(6)-2 [redacted] WMLE SPC

PATIENT IDENTIFICATION - USE EMBOSSER *(For typed or written entries give: NAME - Last, first, middle; rank/rate; hospital number and name of facility.)*

Potus (b)(6)-4 [redacted]

SEX M **WARD** ICU

BLOOD OR BLOOD COMPONENT TRANSFUSION STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

MEDICAL RECORD COPY

MEDCOM - 2641

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

Potus # (b)(6)-4

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
23OCT03	1120 HOURS	

(1) Admit to ICU (b)(6)-2
(2) Dx, S/p GSW to (R) Kidney/liver
(3) Condition critical
(4) Vitals, I/O's q1°
(5) Bedrest
(6) Log Roll
(7) CT to suction @ 20cm

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	
	HOURS	

(8) Diet NPO
(9) IV LR @ 150cc/hr
(10) Unasyn 3gms IVPB q6° 03-09-15-21
(11) Zantac 50mg IV q8° 06-14-22
(12) Morphine 2-8mg IV q1° prn
(13) Vasopressin 0.2 units/min
(14) Foley to gravity

NURSING UNIT | ROOM NO. | BED NO.

Noted 23OCT03 1335

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	
	HOURS	

(15) ABG, CBC, Chem-12 NOW PT/PTT
(16) CXR Portable ASAP (b)(6)-2
(17) Titrate Vasopressin to maintain SBP > 100
(18) Versed 1-2mg IV q1° prn

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER	TIME
23OCT03	112

(1) Dopamine 3μcg/kg/min, titrate to effect
(2) Vent orders: TV 700, rate 12/m, 100% O_2, 5 PEEP

NURSING UNIT | ROOM NO. | BED NO.

24° chart ✓ 2200 24OCT03 (b)(6)-2 Cpt AN

(b)(6)-2

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY

MEDCOM - 2642

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION: Potus (b)(6)-4

DATE OF ORDER: 10/23/03 TIME OF ORDER: 1240 HOURS

LIST TIME ORDER NOTED AND SIGN

1) 6 Rate on Vent to 10
2) Transfuse 2 units PRBC each over 1 hr

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO. (b)(6)-2

Granted 23 Oct 03 1333

PATIENT IDENTIFICATION

DATE OF ORDER: 10/23/03 TIME OF ORDER: 1515 HOURS

23 Oct 03 1530

1) Wean FIO2 to keep Sat > 92
2) ABG now
3) CBC now
4) NG to LIS

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 23 Oct 03 TIME OF ORDER: 1543 HOURS

23 Oct 03 1550

1) Bolus 1 Liter LR

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 23 Oct 03 TIME OF ORDER: 1559 HOURS

23 Oct 03 1600

1) Bolus 2nd Liter of LR

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1256

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CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

Potus (b)(6)-4

23 Oct 03 1610 (b)(6)-2

DATE OF ORDER 10/23/03 TIME OF ORDER 1600 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Hold 2nd L LR
2. Na Bicarb 2 Amps - done
3. ABG @ 1630
4. D Vent TV 800 (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

23 Oct 03 1700 (b)(6)-2

DATE OF ORDER 10/23/03 1700 HOURS

1. LR 1 liter 60 min
2. ABG @ 1800
3. ↓ FIO2 to 40

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

PATIENT IDENTIFICATION

23 Oct 03 1815 (b)(6)-2 done 1825 (b)(6)-2

DATE OF ORDER 10/23/03 TIME OF ORDER 1836 HOURS

1. Transfuse 2 units PRBC
2. 2 Amps Na Bicarb SVP
3. Calcium Chloride 1 amp - done

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER 10/23/03 TIME OF ORDER 2300 HOURS

1. ABG CBC Clem-12 in AM
2. Cxr Portable QAM

(b)(6)-2

(b)(6)-2

(b)(6)-2

23 Oct 03 2315

NURSING UNIT | ROOM NO. | BED NO.

24' Chart ✓ 2200 24 Oct 03 (b)(6)-2 Cpt AN

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

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CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
Potus (b)(6)-4	10/24/03	0508 HOURS	
	(1) Bolus 1 liter LR now		
		Done 0510 (b)(6)-2	
NURSING UNIT / ROOM NO. / BED NO.	(b)(6)-2		

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
Potus (b)(6)-4	10/24/03	0900 HOURS	
noted 24 Oct 03 (b)(6)-2	(1) Bolus 1l LR now (2) Dopamine @ 5mg/kg/min		
NURSING UNIT / ROOM NO. / BED NO.	(b)(6)-2		

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
Potus (b)(6)-4	10/24/03	1530 HOURS	
24 Oct 03 1600 (b)(6)-2	(1) Daily ABG CBC, Chem-72, PT/PTT Each AM (2) Daily Portable CXR R/O effusion		
NURSING UNIT / ROOM NO. / BED NO.			
24° chart ✓ 24 Oct 03 2200 (b)(6)-2	OPT AN (b)(6)-2		

PATIENT IDENTIFICATION	ORDER	OF ORDER	
Potus (b)(6)-4	10/25/03	0800 HOURS	
noted 10/25/03 0800 (b)(6)-2	(1) 6 Rate to 8 on Vent	Done 0800	
NURSING UNIT / ROOM NO. / BED NO.	(b)(6)-2		

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 2645

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION: POTUS # (b)(6)-4

DATE OF ORDER: 25 Oct 03 — TIME OF ORDER: 1415 HOURS — LIST TIME ORDER NOTED AND SIGN

(1) May sit HOB up to 45 degrees
(2) Δ Vent to SIMV RR (b)(6)-2 8 (E/A/LA)
(3) ABG @ 1600
(4) May turn side (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION: POTUS # (b)(6)-4

DATE OF ORDER: 25 Oct 03 — TIME OF ORDER: 1420 HOURS

(1) Wean dopamine to off
Keep [redacted] >100 (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION: POTUS # (b)(6)-4

DATE OF ORDER: 25 Oct 03 — TIME OF ORDER: 1430 HOURS

VO Dr (b)(6)-2 (b)(6)-2

(1) Δ fluids to DSNS + 20K @ 125 (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION: POTUS # 310

DATE OF ORDER: 26 Oct 03 — TIME OF ORDER: 0910 HOURS

(1) LIMV to L
(2) ABG @ 1100 (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

24° chart ✓ 28 Oct 03 2226 (b)(6)-2

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CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
POTUS # (b)(6)-4	10/26/03	1715 HOURS	
	ABG NOW		
NURSING UNIT: ICU / ROOM NO. / BED NO.			

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER
POTUS # (b)(6)-4	10/26/03	1901 HOURS
	① ABG NOW.	
NURSING UNIT: ICU / ROOM NO. / BED NO.		

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER
POTUS # (b)(6)-4	10/26/03	1930 HOURS
	① ABG @ 2000	
	② Wean FIO2 Keep Sat > 90%	
	③ D/C Versed	
	④ IV to 75cc/hr	
	⑤ D/C NGT	
NURSING UNIT: ICU / ROOM NO. / BED NO.		

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER
POTUS # (b)(6)-2	10/26/03	2280 HOURS
	CT to	
NURSING UNIT: ICU / ROOM NO.: 24 chart / BED NO. (b)(6)-2	CPT for 29 OCT 03 @ 2215	

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

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CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION: POTUS # (b)(6)-4

DATE OF ORDER: 10/27/03 TIME OF ORDER: 0900 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) Clear liquids
(2) Heparin 5000 units SQ q 12°
(3) Incentive Spirometry q 2° while awake
(4) ~~KCl~~ DPE

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION (b)(6)-2

DATE OF ORDER: 10/27/03 TIME OF ORDER: 10/27/03 HOURS

(1) Potassium liquid 20 meq q 8° x 3

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 10/28/03 TIME OF ORDER: 1110 HOURS

(1) Reg diet

(b)(6)-2

noted (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 10/29/03 TIME OF ORDER: 0930 HOURS

(1) Peripheral IV - Leptoch
(2) Tylenol #3 1-2 po q 4-6° prn
(3) Dulcolax 10 mg po QD 1st dose ASAP
(4) Colace 100 mg po TID
(5) D/C Daily lab work

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED (b)(6)-2

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CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION: POTUS # [redacted]

DATE OF ORDER: 29 Oct 03 — TIME OF ORDER: 1430 HOURS — LIST TIME ORDER NOTED AND SIGN

(1) Vitals q 4°

[redacted]

NURSING UNIT: ICU — ROOM NO. — BED NO.

PATIENT IDENTIFICATION: POTUS # [redacted]

DATE OF ORDER: 29 Oct 03 — TIME OF ORDER: 2200 HOURS

(1) D/C Heparin

[redacted]

NURSING UNIT: ICU — ROOM NO. — BED NO.

Chart V'ed [redacted] 29/oct03 @ 2200

PATIENT IDENTIFICATION: POTUS # [redacted]

DATE OF ORDER: 30 Oct 03 — TIME OF ORDER: 2000 HOURS

(1) Morphine 2-8mg IVP q 1° nrn main

[redacted]

NURSING UNIT: ICU — ROOM NO. — BED NO.

PATIENT IDENTIFICATION: POTUS # [redacted]

DATE OF ORDER: 10/31/03 — TIME OF ORDER: 1400 HOURS

(1) Portable CXR - ASAP S/P CT Removal

(1) Dulcolax 10mg Supp ½ PR now

NURSING UNIT: ICU — ROOM NO. — BED NO.

24° Chart [redacted] 2000 03 0020 [redacted]

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MA

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CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION: Potus # [redacted] (b)(6)-4

DATE OF ORDER: 31 Oct 03 | TIME OF ORDER: 1410 HOURS | LIST TIME ORDER NOTED AND SIGN

1/0 DR [redacted] (b)(6)-2 | [redacted] (b)(6)-2 | 1/0

1) Vitals Q8°

[redacted] (b)(6)-2

NURSING UNIT: ICU | ROOM NO.: 24 Chart | BED NO.: 2 Nov 03 @ 0020 [redacted] (b)(6)-2 CP/M

PATIENT IDENTIFICATION: Potus # [redacted] (b)(6)-4

DATE OF ORDER: 3 Nov 03 | TIME OF ORDER: 0850 HOURS

1) D/c Urasyn
2) Heplock IV
3) D/c Zantac
4) D/c S/O

[redacted] (b)(6)-2

done

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION | DATE OF ORDER | TIME OF ORDER

FOR: DCCS

02 2100 NOV 03

MSG [redacted] (b)(6)-2 - 5 81 - [redacted] (b)(3)-1

Called to let the DCCS know that the paperwork for the patient that got hit in the back and is paralysed will be ready tomorrow. He should also be EVAC out of here tomorrow. (they are working on a C-130).

NURSING: ICU

PATIENT

NURSING: ICU

ILT [redacted] (b)(6)-2

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

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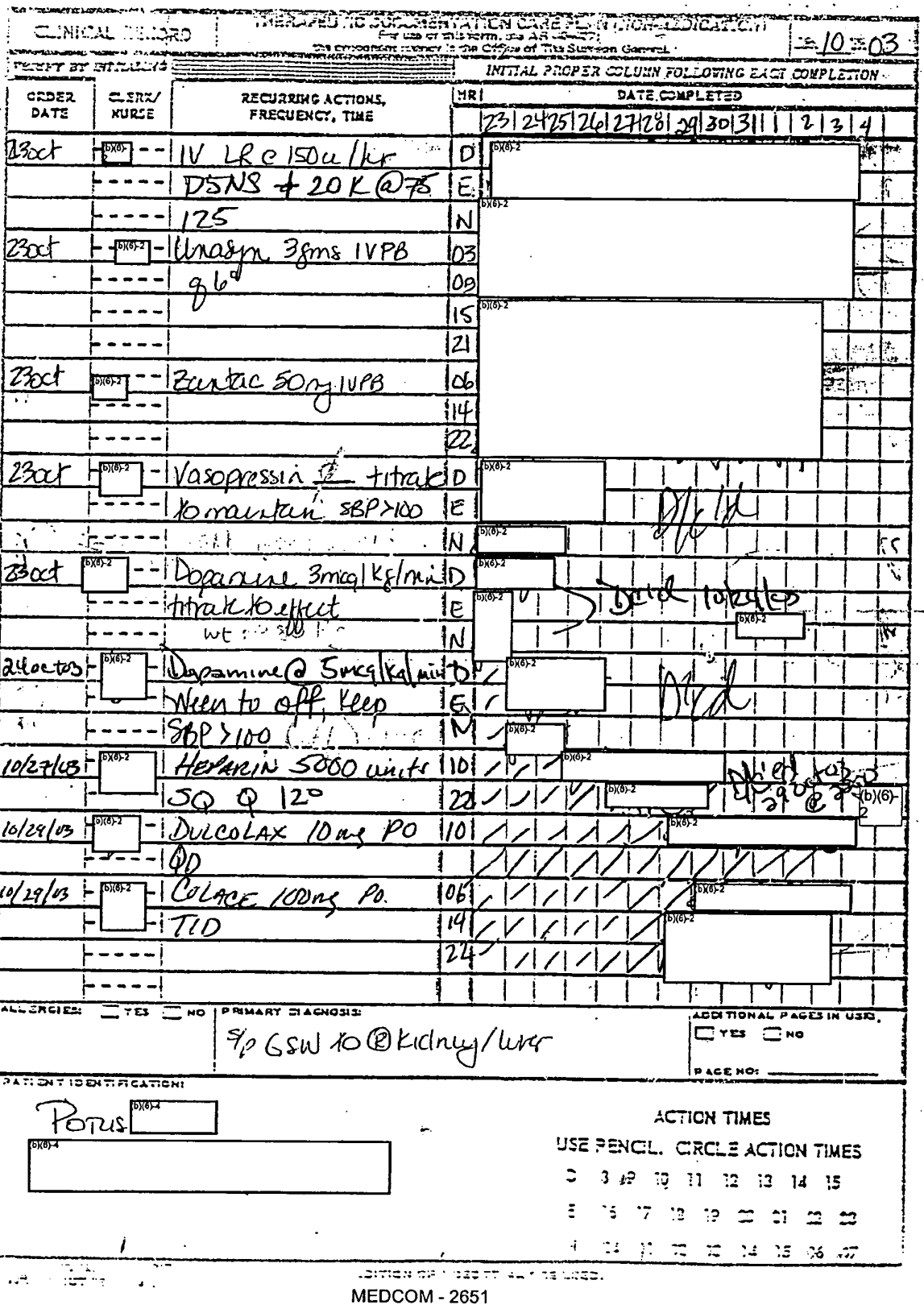


CLINICAL RECORD

THERAPEUTIC SUBSTANTIATION CARE PLAN/MEDICATION

For use of this form, see AR [illegible]; the proponent agency is the Office of The Surgeon General.

10/03

RECEIPT BY INITIALS

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 23 24 25 26 27 28 29 30 31 1 2 3 4
23oct	[b)(6)-]	IV LR @ 150 u/hr	D	[b)(6)-2]
		D5NS + 20K @ 75	E	
		125	N	[b)(6)-2]
23oct	[b)(6)-2]	Unasyn 3gms IVPB	03	
		q6°	09	
			15	[b)(6)-2]
			21	
23oct	[b)(6)-2]	Zantac 50mg IVPB	06	
			14	
			22	
23oct	[b)(6)-2]	Vasopressin titrate	D	[b)(6)-2]
		to maintain SBP >100	E	
			N	[b)(6)-2]
23oct	[b)(6)-2]	Dopamine 3mcg/kg/min	D	[b)(6)-2]
		titrate to effect	E	[b)(6)-2] [b)(6)-2]
		wt : [illegible]	N	
24oct03	[b)(6)-2]	Dopamine @ 5mcg/kg/min	D	[b)(6)-2]
		Wean to off, keep	E	
		SBP >100	M	[b)(6)-2]
10/27/03	[b)(6)-2]	Heparin 5000 units	10	[b)(6)-2]
		SQ Q 12°	22	[b)(6)-2] (b)(6)-2
10/29/03	[b)(6)-2]	Dulcolax 10mg PO	10	[b)(6)-2]
		QD		
10/29/03	[b)(6)-2]	Colace 100mg PO.	06	[b)(6)-2]
		TID	14	[b)(6)-2]
			24	

ALLERGIES: YES NO

PRIMARY DIAGNOSIS: S/P GSW to R kidney/liver

ADDITIONAL PAGES IN USE: YES NO

PAGE NO:

PATIENT IDENTIFICATION

POTUS [b)(6)-4]

[b)(6)-4]

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

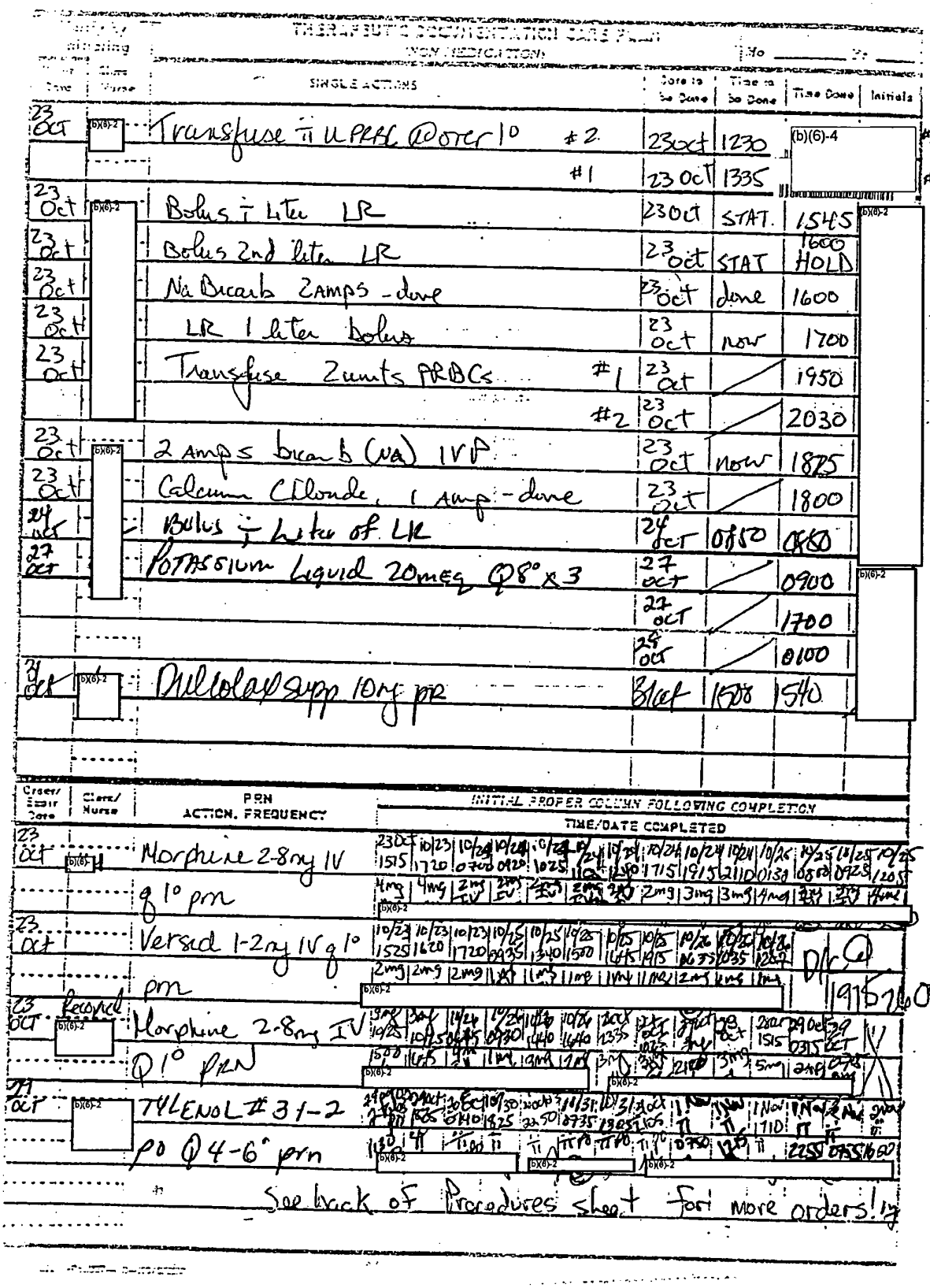
D 3 9 10 11 12 13 14 15

E 16 17 18 19 20 21 22 23

N [illegible]

[illegible]

MEDCOM - 2651



THERAPEUTIC DOCUMENTATION CARE PLAN
(NON MEDICATION)

Date	Clerk/Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
23 Oct	(b)(6)-2	Transfuse ⅔ U PRBC @ over 1° #2	23 Oct	1230	(b)(6)-4	#2
		#1	23 Oct	1335		#1
23 Oct	(b)(6)-2	Bolus ⅔ Liter LR	23 Oct	STAT.	1545	(b)(6)-2
23 Oct		Bolus 2nd liter LR	23 Oct	STAT	1600 HOLD	
23 Oct		Na Bicarb 2 Amps - done	23 Oct	done	1600	
23 Oct		LR 1 liter bolus	23 Oct	now	1700	
23 Oct		Transfuse 2 units PRBCs #1	23 Oct		1950	
		#2	23 Oct		2030	
23 Oct	(b)(6)-2	2 Amps bicarb (NA) IVP	23 Oct	now	1825	
23 Oct		Calcium Chloride, 1 Amp - done	23 Oct		1800	
24 Oct		Bolus ⅔ Liter of LR	24 Oct	0850	0850	
27 Oct		POTASSIUM Liquid 20 meq Q8° x 3	27 Oct		0900	(b)(6)-2
			27 Oct		1700	
			28 Oct		0100	
31 Oct	(b)(6)-2	Dulcolax supp 10 mg pr	31 Oct	1508	1540	

Order/Expir Date	Clerk/Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED
23 Oct	(b)(6)-4	Morphine 2-8 mg IV q 1° prn	23 Oct 1515 / 10/23 1720 / 10/24 0700 / 10/24 0920 / 10/24 1025 / 10/24 1100 / 10/24 1240 / 10/24 1715 / 10/24 1915 / 10/24 2110 / 10/25 0130 / 10/25 0850 / 10/25 0925 / 10/25 1205
			4 mg / 4 mg / 2 mg IV / 2 mg IV / 2 mg IV / 2 mg IV / 2 mg IV / 2 mg / 3 mg / 3 mg / 4 mg / 2 mg IV / 2 mg IV / 4 mg
23 Oct		Versed 1-2 mg IV q 1° prn	10/23 1525 / 10/23 1620 / 10/23 1720 / 10/25 0935 / 10/25 1340 / 10/25 1500 / 10/25 1645 / 10/25 1915 / 10/26 0635 / 10/26 1035 / 10/26 1207
			2 mg / 2 mg / 2 mg / 1 mg / 1 mg / 1 mg / 1 mg / 1 mg / 2 mg / 1 mg / 1 mg
23 Oct	Recorded (b)(6)-2	Morphine 2-8 mg IV Q 1° PRN	3 mg 10/25 / 3 mg 10/25 / 10/26 0645 / 10/26 0930 / 10/26 1440 / 10/26 1640 / 23 Oct 1335 / 23 Oct 1025 / 23 Oct 3 mg / 28 Oct 1515 / 29 Oct 0315 / 29 Oct
			1500 / 1645 / 4 mg / 1 mg / 3 mg / 2 mg / 3 mg / 3 mg / 2100 / 3 mg / 5 mg / 2 mg / 0750 mg
27 Oct	(b)(6)-2	TYLENOL #3 1-2 PO Q 4-6° prn	29 Oct 0105 / 29 Oct 1525 / 30 Oct 0140 / 10/30 1825 / 30 Oct 2250 / 10/31 0735 / 10/31 1305 / 31 Oct 1105 / 1 Nov 1100 / 1 Nov 1110 / 1 Nov 1110 / 2 Nov 2100
			1130 / 4 / 1100 / 1 / 1 / 1 PO / 1 PO / 1 PO / 0750 / 1215 / 1 / 2255 / 0755 / 1600

(b)(6)-2

D/C @ 1915 26 OCT 0

See back of Procedures sheet for more orders!

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Pg. 10 of 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 23 24 25 26 27 28 29 30 31 01 02 03
23 oct / 29 oct / 3 Nov	(b)(6)-2	Vitals I+O q4°	D	(b)(6)-2
		Q8°	E	
			N	
23 oct	(b)(6)-2	Bedrest - Log roll	D	
25 oct 03		May turn side to side,	E	
		↑ HOB to 45°	N	
23 oct	(b)(6)-2	CT to 20cm suction -	D	
26 oct 03	(b)(6)-2	Water seal	E	
			N	
23 oct	(b)(6)-2	Diet NPO	D	(b)(6)-2
			E	Dcd 10/27/03
			N	
23 oct	(b)(6)-2	Vent settings Mode SIMV	D	(b)(6)-2
		FiO2 0.4 Vt 800	E	W/c'd 26 oct 03 1915
		Peep Rate	N	(b)(6)-2 (b)(6)-2
23 oct	(b)(6)-2	Foley to gravity	D	(b)(6)-2
			E	
			N	
23 oct	(b)(6)-2	Wean FiO2 to keep	D	(b)(6)-2
		sats >92% 96%	E	(b)(6)-2
			N	
23 oct	(b)(6)-2	NG to LIS	D	
			E	(b)(6)-2 W/c'd 1915 26 oct 03 (b)(6)-2
			N	
23 oct	(b)(6)-2	to effusion CXR Portable QAM	05	(b)(6)-2
24 oct		Daily ABG, CBC, Chem-12,	05	(b)(6)-2 Dcd 10/29/03
		PT/PTT	X	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P GSW (R) Kidney/liver

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION:

Potus (b)(6)-4

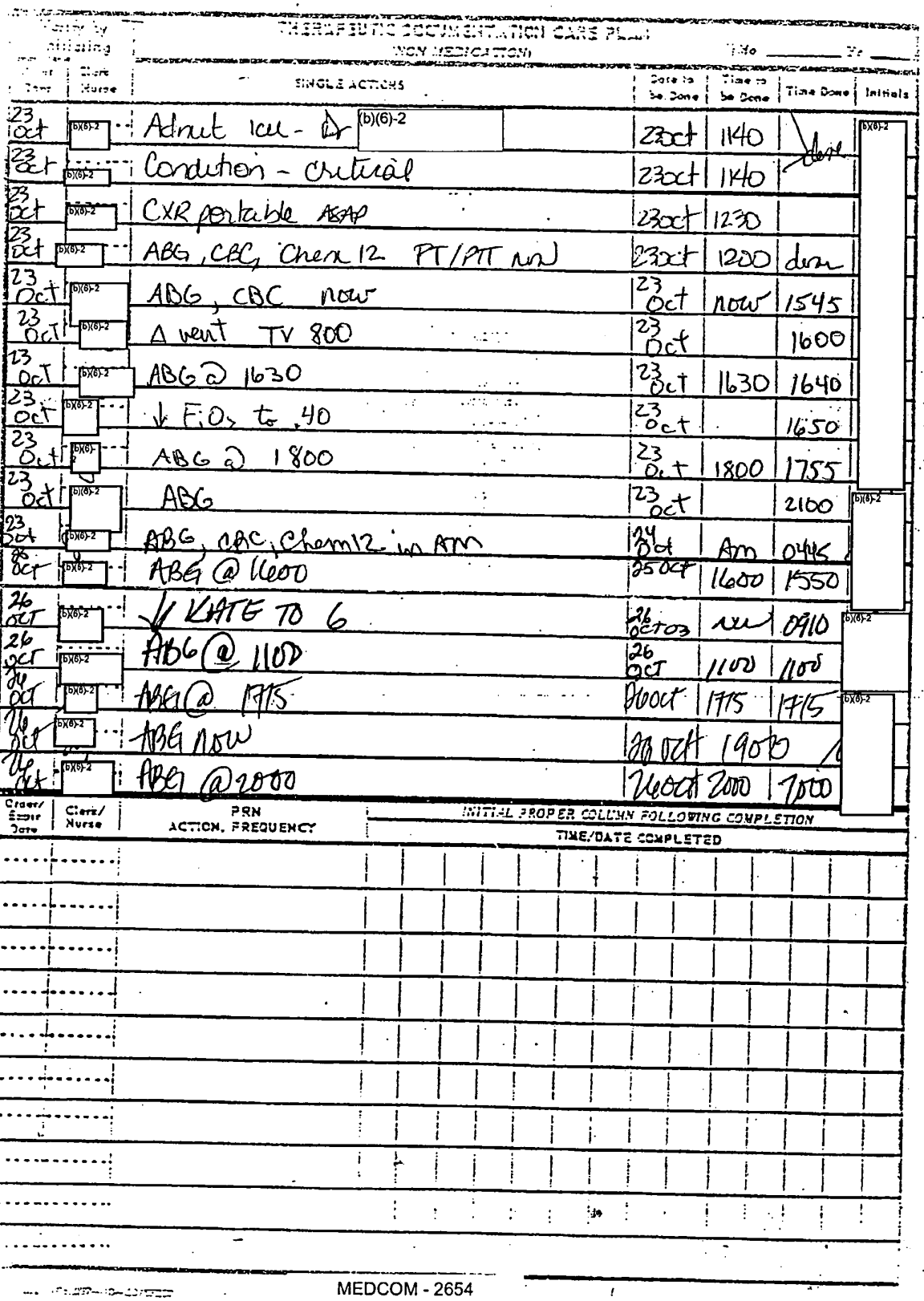
(b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

0	8	9	10	11	12	13	14	15
5	16	17	18	19	20	21	22	23
4	24	31	32	33	34	35	36	37

MEDCOM - 2653



THERAPEUTIC DOCUMENTATION CARE PLAN
(NON MEDICATION)

Order/ Enter Date	Clerk/ Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
23 Oct	(b)(6)-2	Admit ICU - Dr (b)(6)-2	23oct	1140		(b)(6)-2
23 Oct		Condition - Critical	23oct	1140		
23 Oct		CXR portable ASAP	23oct	1230		
23 Oct		ABG, CBC, Chem 12 PT/PTT now	23oct	1200	done	
23 Oct		ABG, CBC now	23 Oct	now	1545	
23 Oct		Δ vent TV 800	23 Oct		1600	
23 Oct		ABG @ 1630	23 Oct	1630	1640	
23 Oct		↓ FiO2 to .40	23 Oct		1650	
23 Oct		ABG @ 1800	23 Oct	1800	1755	
23 Oct		ABG	23 Oct		2100	(b)(6)-2
24 Oct		ABG, CBC, Chem 12 in AM	24 Oct	AM	0445	
25 Oct		ABG @ 1600	25 Oct	1600	1550	
26 OCT		↓ RATE TO 6	26 OCT 03	now	0910	(b)(6)-2
26 OCT		ABG @ 1100	26 OCT	1100	1100	
26 OCT		ABG @ 1715	26 OCT	1715	1715	(b)(6)-2
26 OCT		ABG now	26 OCT	1900		
26 OCT		ABG @ 2000	26 OCT	2000	2000	

Order/ Enter Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED

MEDCOM - 2654

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

No. 10 Dt. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 25 26 27 28 29 30 31 1 2 3 4
25Oct03	(b)(6)-2	N/O: Ace bandages to	D	✓ (b)(6)-2
		BLE	E	(b)(6)-2
			N	
25Oct03	(b)(6)-2	N/O: PROM to BLE	D	✓ (b)(6)-2
			E	(b)(6)-2
			N	
25Oct03	(b)(6)-2	N/O: Maintain flexion of	D	✓ (b)(6)-2
		feet to prevent foot	E	(b)(6)-2
		drop	N	(b)(6)-2
27Oct03	(b)(6)-2	CLEAR LIQUIDS D'd	D	✓ ✓ (b)(6)-2
28Oct03		Reg. Diet	E	✓ ✓
			N	✓ ✓ (b)(6)-2
27Oct03	(b)(6)-2	INCENTIVE SPIROMETER	D	✓ ✓ (b)(6)-2
		Q2° While awake	E	✓ ✓
			N	✓ ✓ (b)(6)-2
29Oct03	(b)(6)-2	PIV: HEPLOCK, flush	D	✓ ✓ ✓ ✓ (b)(6)-2
		Q Shift c 3-5cc NS	E	✓ ✓ ✓ ✓ (b)(6)-2
			N	✓ ✓ ✓ ✓ (b)(6)-2
1NOV03	(b)(6)-2	N/O: Foot splints to	02	✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ (b)(6)-2
		prevent foot drop. Remove	06	✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓
		Q4° for 1hr	10	✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓
			14	✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓
			18	✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓
			22	✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓

Dcd 11/1/03

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P GSW to (R) Kidney/liver

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION:

Potus # (b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	11	12	13	14	15	16	17

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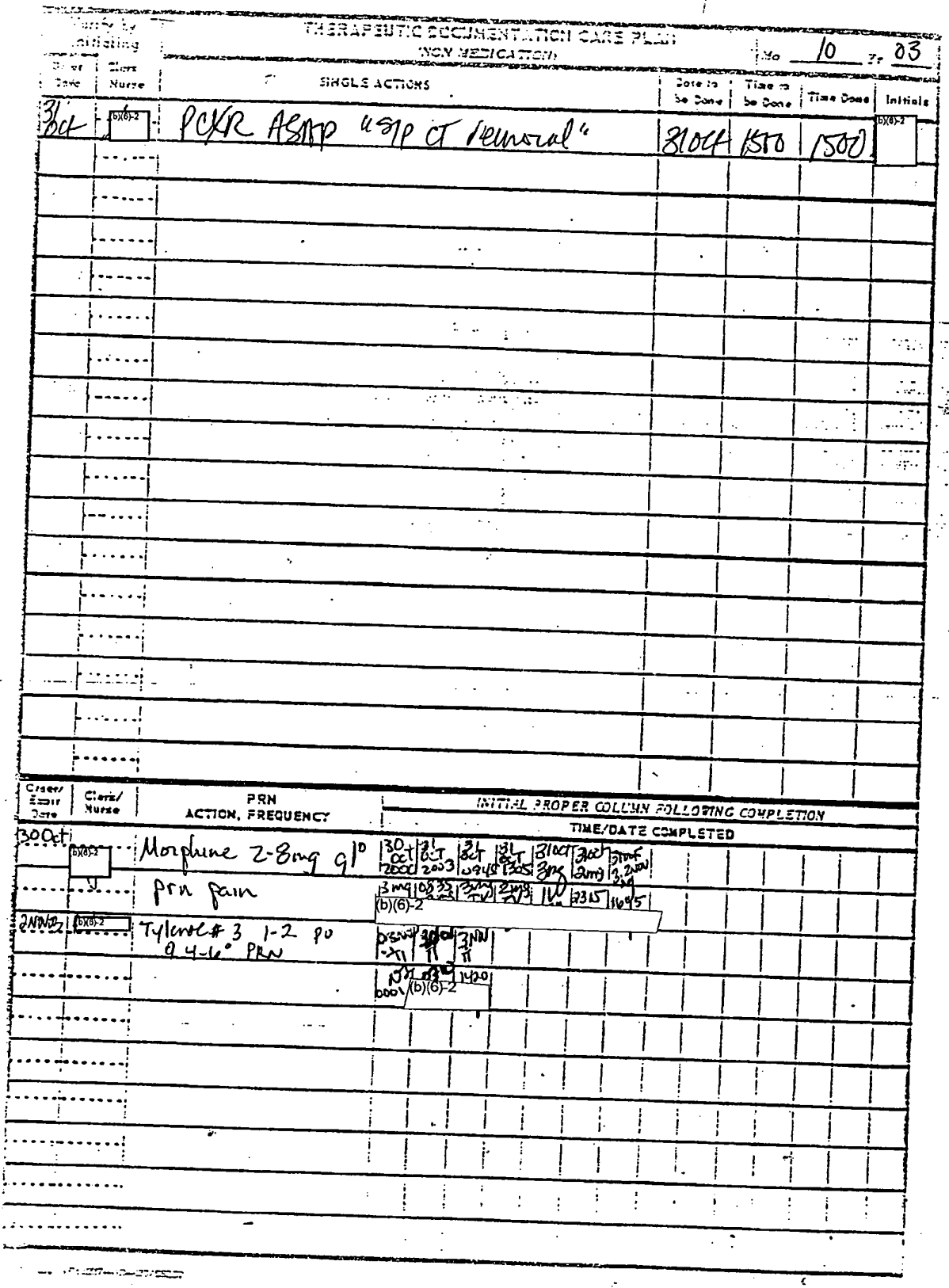
Verify by Initiating



THERAPEUTIC DOCUMENTATION CARE PLAN
(NON MEDICATION)

Mo 10 Yr 03

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
31 Oct	(b)(6)-2	PCXR ASAP "S/P CT removal"	31 Oct	1500	1500	(b)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED						
30 Oct	(b)(6)-2	Morphine 2-8mg q1°	30 Oct 2000	31 Oct 2003	31 Oct 0945	31 Oct 1305	31 Oct 3mg	31 Oct 2mg	31 Oct 3.2mg
		prn pain	3mg (b)(6)-2	0835	3mg TV	2mg TV	1V	2315	1645
2 Nov 03	(b)(6)-2	Tylenol #3 1-2 po q 4-6° PRN	0 SNN TT	30 Oct TT	3 NN TT				
			NS 0001 (b)(6)-2	0800	1420				

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-400; the proponent agency is The Office of The Surgeon General

REPORT TITLE: POST ANESTHESIA CARE UNIT FLOWSHEET

CTSG APPROVED (Date): 17 Jan 80

PROCEDURE: Ex lap/ [illegible]

PHYSICIAN:

ANESTHESIA BY:

(Gen) Spinal MAC Axillary
Local Bier Epidural Other

ALLERGIES:

AIRWAYS: Time DC'D

ETT Nasal Oral Trach

OXYGEN:

Mask Nasal Prongs Face Tent Blow-By

Liter/min. %

ASA History

Cardiac Rhythm

IV#1 Patent Infiltrated
Site Rate Gauge

IV#2 Patent Infiltrated
Site Rate Gauge

VITAL SIGNS						PARS SCORE						OTHER	
Time	B/P	P	R	O2SA	Temp	Act	Resp	Circ	LOC	Skin	PARS	COMMENTS	Neuro-Vascular
PRE-OP	/												Extr: L R Upper Lower Pulse DP PT Rad
PRE-OP	95/48	95	vent/intub		33								Blanche Warm Pulse Moves Y N
1140	91/46	71	"	"	33	0	0						Blanche Warm Pulse Moves Y N
1144	108/43	63	"	"									Blanche Warm Pulse Moves Y N
1150	112/46	81	"	"	33								Blanche Warm Pulse Moves Y N
1200	97/40	80	"	"									Blanche Warm Pulse Moves Y N
1215	156/54	88	"	"									Blanche Warm Pulse Moves Y N
1230	157/55	83	"	"	33								Blanche Warm Pulse Moves Y N
	Xfer	ICU	Stretcher										Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N

POST ANESTHESIA RECOVERY SCORE "PARS"

Activity - General Anesthesia
2—Maintain head lift and open eyes
1—Unable to maintain head lift and open eyes
0—Unable to lift head and open eyes

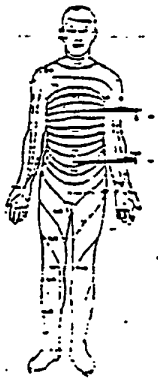
Activity - SAB or Subarachnoid Block
2—Moves all four extremities with control
1—Moves both upper extremities

Respirations
2—Spontaneous respiration; needs no support
1—Limited effort; needs artificial airway or jaw support
0—Needs ventilator; no spontaneous respiration

Circulation
2—BP 20% preanesthetic level
1—BP 20 - 50% preanesthetic level
0—BP 50% or more preanesthetic level

Level of Consciousness
2—Awake and alert; seldom dozes
1—Awakens when gently stimulated
0—Awakens only when vigorously stimulated

Skin
2—Normal skin color & temperature greater than 96°
1—Skin is pale, blotchy, dusky &/or temperature 95 - 96°
0—Cyanotic &/or temperature less than 95°



DRESSING:	Status	Location
Gauze		
Opsite		
Bandaid		
Steri-strips		
Collodian		
Pen-pad		
Coban		
Cotton Balls		
Ace Wrap		

TUBES AND DRAINS: Hemovac Chest Foley Jackson-Pratt NGT

(Continue on reverse)

PREPARED BY (Signature & Title): [b)(6)-2] MATAN

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: 23 OCT 03

PATIENT'S IDENTIFICATION (For typed or written entries give: Name-last, first, middle; grade; date; hospital or medical facility)

POTUS [b)(6)-4]

☐ HISTORY/PHYSICAL ☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)
☐ DIAGNOSTICS STUDIES
☐ TREATMENT

DA FORM 1 MAY 78 4700

FH MDA OP 132-11a, (Rev) 1 Sep 99

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- Unasyn 0900

INTAKE			OUTPUT		
TIME	TYPE	AMT	TIME	TYPE	AMT
OR	Crystal	8500	OR	EBL	1000
	25%	100	OR	Urine	200
	2U PRBC	600		NGT	100
TOTAL			TOTAL		

PACU NURSING NOTES: NURSING CARE PROBLEM NO.'S IDENTIFIED. Refer to FH MDA OP 39

NURSING CARE PROBLEMS: 1. RESP; 2. CIRC; 3. ACT; 4. LOC; 5. TEMP; 6. PAIN; 7. SAFETY; 8. ANXIETY; 9. EDUC; 10. OTHER

1140 hrs. Pt received from OR via litter, accompanied by anesthesia, surgeons. Unresponsive, Ⓡ pupil 6mm(+) brisk Ⓛ enucleation. Orally intubated. #8.5 22cm clip. A/C Rate 12 / FiO2 100% / Vt 700 / +5. Bilat breath sounds. CT x 4 to placed to suction. #4 c̄ immediate return of ≈ 250cc sanguinous liquid, Then ↓ rate. IV gtts titrated for BP. BP/HR labile, relatively stable profoundly hypothermic. Extremities flaccid (-) Babinski hindbanton 1300-> see ICU flowsheet for further details

(b)(6)-2

MEDICATION RECEIVED IN PACU/ICU

MEDICATION GIVEN BY:	DRUG	DOSE	ROUTE	TIME	PAIN LEVEL	EFFECTIVENESS

DISPOSITION SUMMARY: Nursing Care Problems No.'s_____ Resolved; No.'s_____ Continue.
Patient was transferred from PACU/ICU recovery room via litter/crib with siderails raised, or held by parent in wheelchair.
Dressing status:_____ PAR Score_____ Safety Strap_____
Report given to_____. Patient released by Anesthesia_____
Time out_____. Nurses Signature_____

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ADMISSION AND CODING INFORMATION

For use of this form, see AR 40-400; the proponent agency is OTSG

1. REPORTING MTF	1	2	3	4	5	6	2. MTF LOCATION (State or Country Code.) 7	8
	A	(b)(3)-1					I	Z

3. REGISTER NUMBER	9	10	11	12	13	14	15	NAME (Last, First, Middle Initial) Potus# (b)(6)-4 (Detainee)
	(b)(6)-4							

4. PAY GRADE	16	17	5. SEX	18				
				M				

6. DATE OF BIRTH (Y Y Y Y M M D D)	19	20	21	22	23	24	25	26	7. AGE AT ADMISSION	27	28	29	8. RACE	30

9. ETHNIC BACK-GROUND	31	RELIGION						

10. LENGTH OF SERVICE	32	33	34	ETS	11. FMP	35	36	12. SOCIAL SECURITY NUMBER	37	38	39	40	41	42	43	44	45
						9	8		(b)(6)-4								

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	46	HOUR OF ADMISSION	0810	BRANCH / CORPS			

14. FLYING STATUS	47	48	49	15. BENEFICIARY CATEGORY	50	51	52	16. ZIP CODE OF RESIDENCE	53	54	55	56	57	58	59	60	61
	N																

17. UNIT LOCATION (State or Country Code)	62	63	18. MOS	64	65	66	67	68	69	70	19. TRAUMA	71	PREV. ADMISSION YEAR		NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	72	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE					
	0		ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)					
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	(b)(3)-1	(b)(3)-1	Combat Support Hospital	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE				

21. TYPE OF DISPOSITION	73	74	22. MTF TRANSFERRED TO	75	76	77	78	79	80	23. DATE OF DISPOSITION (Y Y Y Y M M D D)	81	82	83	84	85	86	87	88
	0	5									2	0	0	3	1	1	0	3

24. CLINIC SVC - ADMITTING	89	90	91	92	25. MTF TRANSFERRED FROM	93	94	95	96	97	98	26. DATE THIS ADMISSION (Y Y Y Y M M D D)	99	100	101	102	103	104	105	106
	A	B	A	A		(b)(3)-1							2	0	0	3	1	0	2	3

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	107	108	28. MTF OF INITIAL ADMISSION	109	110	111	112	113	114	29. DATE INITIAL ADMISSION (Y Y Y Y M M D D)	115	116	117	118	119	120	121	122
				(b)(3)-1													

FOR LOCAL USE

DX: 86414
86612
8901
80630
8065
9222
3441
9584
82110
E9912

DX: 5061
8622
543
5551
8622X4
3409
9670

Trauma
9

Injury
569

ADMITTING O (b)(6)-2 (b)(6)-2 JRE OF ADMITTING CLERK

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