EPW / IRAQI UNKNOWNS INFORMATION

NAME: Unk

PSEUDO SSN: (b)(6)-4

CHCS NAME: (b)(6)-4

Home:Unk

DOB/AGE/YEAR:Unk

Capture site:Unk

MILITARY STATUS: Iraqi civilian

Rank:N/A

DIAGNOSIS: CHI with complications as listed above
Chest tube for complications arising after his trach

TREATMENT: Trach, G-tube, J-tube

RECOMMENDATIONS: 1. Keep head elevated. 2. Ventric to 0 cm. 3. Requiring hyperventilation, mannitol, propofol, narcs to control ICP.

Other names: NONE

(b)(3)-1

Name: ,

CHCS Name (b)(6)-4

(b)(6)-4 Iraqi civilian Date of Admission: 4/18/2003

Prognosis: Guarded Date of Transfer:

History:

8ish y/l IM in MVA. Treated at (b)(3)-1 Had a CHI and an intraparenchymal monitor was placed. However, he developed a SDH secondary to the monitor placement and required a crani for evacuation. That was evacuated and a ventriculostomy was placed.

Hospital Course:

ICP very labile and somewhat difficult to control. But gradually improved with mannitol, fentanyl, versed, intermittent vecuronium and thiopental. Ventric elevated to 7.5 cm on 4/25. Plan OR for replacement 4/27.(cancelled), CT repeat shows improvement, CT planned 4/29. D/C ventric and begin wean sedation.

Diagnoses:

CHI with complications as listed above; Chest tube for complications arising afle his trach; Ventriculostomyculture positive from 4/22 for gm positive cocci on 4/25. Started intrathecal vanc 4/25.

Surgeries/Treatmen

Trach, G-tube, J-tube; ex-lap 4/13 for ct finding of ? Air near Ligament of Treitz. Ct also noted R adrenal hematoma and fracture L kidney below pelvis. Ex-lap noted only duodenal hematoma (D4) and colonic serosal tear.;

Recommendations:

1. Keep head elevated. 2. Ventric to 0 cm. 3. Requiring hyperventilation, mannitol, propofol, narcs to control ICP. 4. +/- gastrostomy tube for feeds. 5. Wound care left flank. 6. Trach care and decannulation when appropriate.

SpecialNeeds:

Will need continued ICU care until ventriculostomyout and intracranial pressure issues resolved. Then will need several weeks of inpatient rehab.

Physician:

(b)(6)-2, LCDR Dept of Neurosurgery 5/3/2003

MEDCOM - 4892

free fibula flap + lateral dorsi flap
to rt. humerus (0900 -

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	S: S/P MVA, S/P Closed head injury & cranial S/P trach, S/P Chest tube, S/P VP ~~shunt~~ external ventriculostomy - now removed, S/P J tube S/P EXLAP for ⓛ Kidney & adrenal injury, duodenal hematoma - no purposeful movement, H/O TBI
	O: - S/P Omni - healed.
	- ⊕ tracheostomy - breathing on own
	abd - S/P EXLAP - well healed, NT, soft
	- J tube in place, small ⓛ hip wounds - healing.
	- mild sacral decub.
	- neck - supple
	- no movement of UE to pinch
	- no response to verbal cues
	- will blink if touch eye.
	- tolerates OG tube 5 gag.
	A/P: Severe head injury, post chemically induced head/pulmonary system.
	- will restart ABX but suspect will not survive.

(b)(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN of 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;	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)

MEDCOM - 4894

DATE	NOTES
04MAY03	DNR NOTE → pt c prob infected closed head injury despite broad spectrum ABX and prior heroic efforts at Yale. → Pt non-responsive to any stimulus except corneal response. → Oggig. → Pt has zero chance of survival in this location medical environment in both the acute and long term settings → After discussion with Dr (b)(6)-2 -DCCS have placed pt DNR as further medical care is futile. Will attempt to maintain current care (b)(6)-2 2400

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
4 May 03 2100	T 101 P 136 R 45 BP 127/95. Pt admited to Unit via emergency room. Pt a transfer from [b)(3)-1]. Pt not oriented to person, place or time. Midline incision that is healed. Oral gastric tube removed. Oral area suction. Trach area suctioned. Trach Care done. Foley Catheter draining amber urine. IV NS @ 80 cc/hr. Splints on lower legs bilaterally. Decub on (L) flank 2cm. Sacral decub Stage II. IV sites on (L) wrist and (R) wrist intact. IV infusing on (R) wrist. Tylenol PR given @ 2130
	[b)(6)-2] CPT, AN
2200	Unasyn 1.5 Gm IV. Zantac 20mg IVP. T 101.7 P 111 R 30 BP 124/80 SaO_2 = 100%. Hab obtained from (L) Arc on 1st attempt. FC clamped to obtain UA. [b)(6)-2] CPT, AN
2230	UA obtained and sent to lab. CBC results returned. Critical Value of Plt @ 1062. WBC 16.6 All other labs WNL. [b)(6)-2] CPT, AN
2300	T 99 (A). Pt repositioned to (R) side. Pillow between Knees. [b)(6)-2] CPT, AN

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME (LAST, FIRST, M.) | 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)

MEDCOM - **4896**

DATE	NOTES
1500 5 May 03	Assumed care of pt. Report from MAJ Velazquez Pt not alert. Resp reg and unlabored. LS Clear. Abd Soft and nontender. Healed midline incision. Trach intact. c O2 mask. Trach and oral Care Completed. large blood clot suctioned out of trach. IV site intact. Splint on L foot, switched to (R) foot. [redacted] [redacted] A
1600	Pt bathed, oral care, skin care. Pt repositioned to (L) side. Cath Care to foley. maint to void CPT AN
1800	Repositioned to (R) side. Suctioned. Δ Splint [redacted] CPT, AN
2000	Positioned on back. [redacted] CPT, AN
2200	Positioned on (R) side. [redacted] CPT, AN
2300	Trach Care to pt. [redacted] CPT, AN
0400 6 May 03	S/P craniotomy c trach, PT c incision from (L) side Forehead to right ear healing well. One staple in place. Pupils dilated, round & equal c accomodation to light ~~feeds~~ not tracking. Trach in place c 28% O2 SpO2 100%. Resp 20-30 CTA A to B Bilat. HR WNL, distal pulses +2 Bilat cap ref < 3 secs. B/S Active x 4, midline scar from previous surgery completely healed. Muscle tone weak, PT moves upper extremities to purpose, contracture To hands, Foot drop to feet Bilat, Foley to gravity draining O/S. Ulcer stage 2 dollar size in healing process on (R) buttocks, Stage 2 ulcer half dollar size on (L) hip. IV To Left forearm inf 5% elex in 0.45 NS @ 80/cc hr [redacted] SPC CPM

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
6 may 03	0030 - Turned PT to (R) side, applied Bacitracin to ulcers [redacted] SPC LPN
6 may 03	0100 - 180 cc urine clear yellow via Foley [redacted] SPC LPN
6 may 03	0400 - PT pulled IV cath. started 20G L hang inf 80cc/hr 5% Dextrose in 0.45 NS
6 may 03	1300 2.5 mg of VALIUM given, PT SEDATED, trach cleaned clean
6 May 1600	Initial assessment: No response to verbal stimuli responds to pain on trunk and upper extremities. Grimaces - does not localize. Pupils ERL (brisk) - 3mm. Eyes open - does not track or follow. O2 via trach collar - O2 sat 100% - BBS c exp. Rhonchi. $S_1 S_2$ - RRR/reg. Peripheral pulses palp all extr. Skin warm/dry - IV to LT hand patent, site WNL. Abd soft, flat. Active BS x4 quads - healed mid-line incision. Foley to gravity. Urine dk. yellow. Dressing to open wound LT thigh. Sacral decubitus open (to air) - Propped on LT side. A) - Non-responsive s/p craniotomy. P) turn q2°, suction trach prn meds as ordered [redacted] pupils
1700	trach suctioned of Mod. Amt blood tinged secretions, coughed up large clots. Air entry clear sats (100% [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.)*

[redacted]

REGISTER NO.	WARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FWMR (41 CFR) 201-9.202-1

MEDCOM - 4898

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1800	Imipenem not available from pharmacy. Dr [redacted] paged. [redacted]
6 May 03 2340	Pt s/p craniotomy scar from Forehead to (R) ear. Pupils equal round & react to light sluggishly. Trach in place c 40% o2, spo2 100%. Resp 20-25, CTA. No signs of dspnea. Midline scar from prior ex lap. B/S active x4. Normal Sinus Rythm c HR 60-80. PT has episodes which appear to be seizure activity. HR climbs to mid 100s during these episodes. All distal pulses +3 cap ref <3sec upper & lower ext. Foley to gravity draining Q/S. I V 20 G (L) hand inf 80 cc/hr D5 in 0.45 NS. Decubitus ulcer dollars size healing well stage II on (R) buttocks. Ulcer on (L) hip stage II healing well. Diet none [redacted] SPC LPN
7 May 03 0130	started 22 G IV in (R) Forearm [redacted] Spc LPN
7 May 03 0340	Did Trach care, suction PT mucus is blood tinged [redacted] Spc LPN
7 May 03 2330	PT has scar from Craniotomy Forehead to (R) ear. Pupils Dialated, equal round & react to light. PT unresponsive Trach in place. Resp CTA Spo2 100% on RA. B/S Active x4. Foley to gravity draining Q/S clear Yellow Muscle tone weak. PT moves upper ext independantly, P purpose. Lower ext flaccid. HR WNL all distal pulses +3 cap ref < 3 secs. PT has decub dollar size on (R) buttocks stage II healing well. Stage II decub on (L) hip healing well. IV to (L) hand 20 G inf 80 c/hr D5 NS. [redacted] Spc LPN

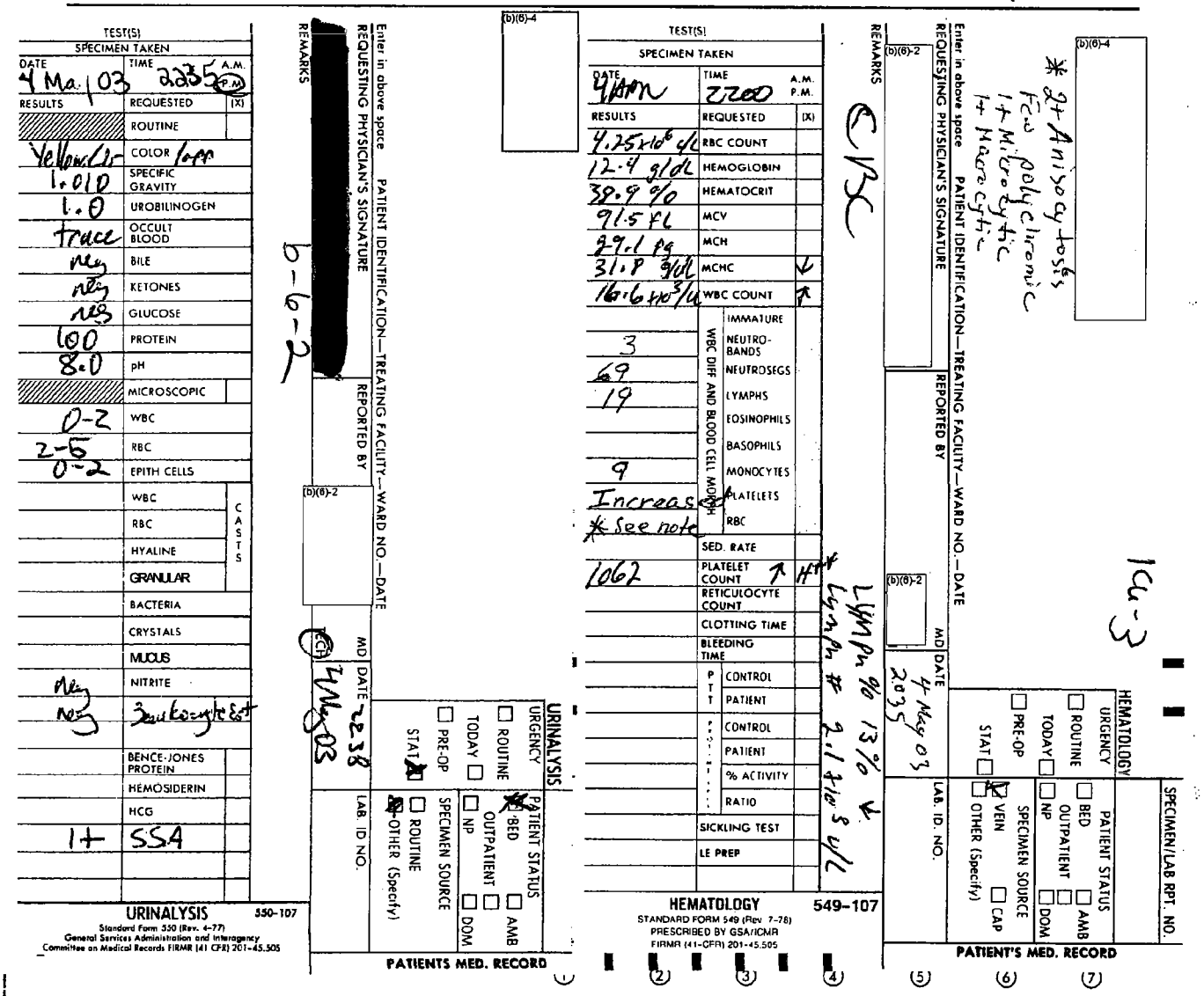
STANDARD FORM *600* (REV. 6-97) BACK

*U.S. GPO :2002 - 491-600/50618

MEDCOM - **4899**

STANDARD FORM 545 (rev. 10.75)
545-108

LABORATORY REPORT DISPLAY



TEST(S) SPECIMEN TAKEN — DATE 4 May 03 — TIME 2235 A.M. (P.M.)

RESULTS	REQUESTED	(X)
	ROUTINE	
Yellow/Lt	COLOR Lt yellow	
1.010	SPECIFIC GRAVITY	
1.0	UROBILINOGEN	
Trace	OCCULT BLOOD	
neg	BILE	
neg	KETONES	
neg	GLUCOSE	
100	PROTEIN	
8.0	pH	
	MICROSCOPIC	
0-2	WBC	
2-5	RBC	
0-2	EPITH CELLS	
	CASTS: WBC	
	CASTS: RBC	
	CASTS: HYALINE	
	CASTS: GRANULAR	
	BACTERIA	
	CRYSTALS	
	MUCUS	
neg	NITRITE	
neg	Bilirubin Est	
	BENCE-JONES PROTEIN	
	HEMOSIDERIN	
	HCG	
1+	SSA	

REMARKS: [redacted] b-6-2

Enter in above space — PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

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

REPORTED BY: [redacted] (b)(6)-2 MD

DATE: 4 May 03 — TIME: 2238

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

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

SPECIMEN SOURCE: ☒ ROUTINE ☐ OTHER (Specify)

LAB. ID. NO.

URINALYSIS 550-107
Standard Form 550 (Rev. 4-77)
General Services Administration and Interagency Committee on Medical Records FIRMR (41 CFR) 201-45.505

PATIENTS MED. RECORD

(b)(6)-4

TEST(S) SPECIMEN TAKEN — DATE 4 May 03 — TIME 2200 A.M. (P.M.)

RESULTS	REQUESTED	(X)
4.25 x10^6 c/c	RBC COUNT	
12.4 g/dl	HEMOGLOBIN	
38.9 %	HEMATOCRIT	
91.5 FL	MCV	
29.1 pg	MCH	
31.8 g/dl	MCHC	↓
16.6 H10^3/c	WBC COUNT	↑
	WBC DIFF AND BLOOD CELL MORPH: IMMATURE	
3	WBC DIFF AND BLOOD CELL MORPH: NEUTRO-BANDS	
69	WBC DIFF AND BLOOD CELL MORPH: NEUTROSEGS	
19	WBC DIFF AND BLOOD CELL MORPH: LYMPHS	
	WBC DIFF AND BLOOD CELL MORPH: EOSINOPHILS	
	WBC DIFF AND BLOOD CELL MORPH: BASOPHILS	
9	WBC DIFF AND BLOOD CELL MORPH: MONOCYTES	
Increas*	WBC DIFF AND BLOOD CELL MORPH: PLATELETS	
*See note	WBC DIFF AND BLOOD CELL MORPH: RBC	
	SED. RATE	
1062	PLATELET COUNT	↑ H*
	RETICULOCYTE COUNT	
	CLOTTING TIME	
	BLEEDING TIME	
	PTT CONTROL	
	PTT PATIENT	
	PROTHROMBIN TIME CONTROL	
	PROTHROMBIN TIME PATIENT	
	PROTHROMBIN TIME % ACTIVITY	
	PROTHROMBIN TIME RATIO	
	SICKLING TEST	
	LE PREP	

REMARKS: C BC

* Lymph % 13% ↓ Lymph # 2.1 x10^3 u/c

* 2+ Anisocytosis Few polychromic 1+ Microcytic 1+ Macrocytic

Enter in above space — PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

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

REPORTED BY: [redacted] (b)(6)-2 MD

DATE: 4 May 03 — TIME: 2035

HEMATOLOGY: URGENCY ☐ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT ☐

PATIENT STATUS: ☐ BED ☐ OUTPATIENT ☐ AMB ☐ 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

(b)(6)-4

1 2 3 4 5 6 7

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

(b)(6)-4

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

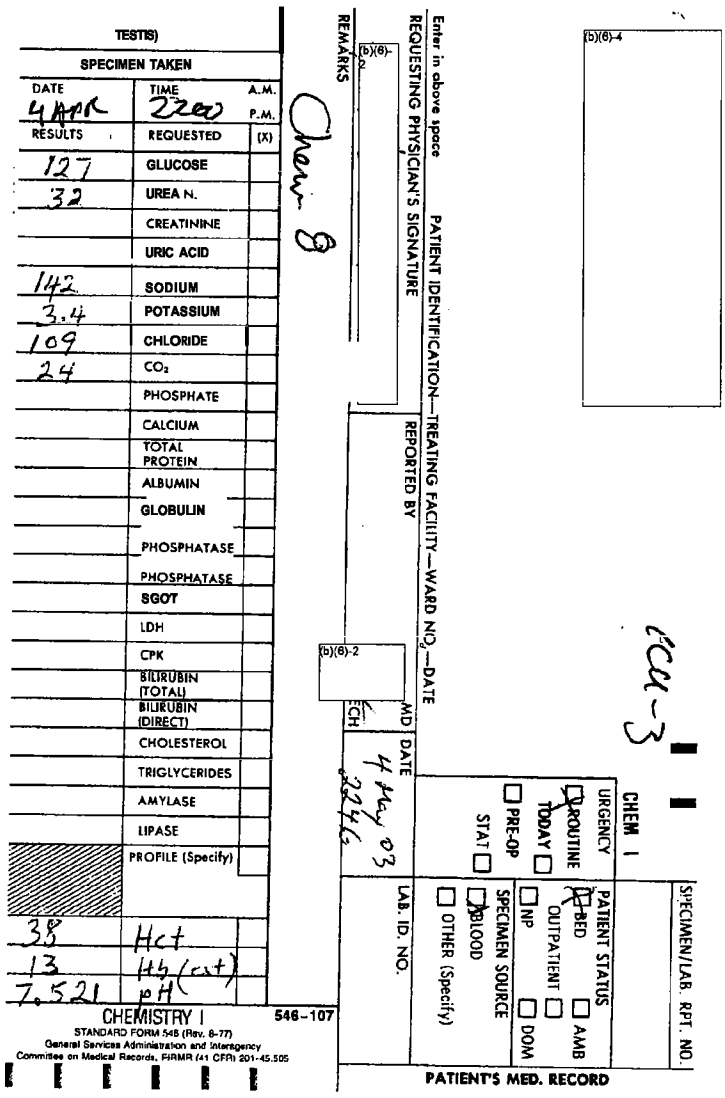
PRESCRIBE BY GSA/ICMR
FIRMR (41-CFR) 201-45.505

LABORATORY REPORT DISPLAY

MEDCOM - 4900

☆ U.S. GOVERNMENT PRINTING OFFICE PROG. 1752-2001/2002

CBC



TESTS)

SPECIMEN TAKEN

DATE 4 APR — TIME 2200 — A.M. / P.M.

RESULTS	REQUESTED	(X)
127	GLUCOSE	
32	UREA N.	
	CREATININE	
	URIC ACID	
142	SODIUM	
3.4	POTASSIUM	
109	CHLORIDE	
24	CO_2	
	PHOSPHATE	
	CALCIUM	
	TOTAL PROTEIN	
	ALBUMIN	
	GLOBULIN	
	PHOSPHATASE	
	PHOSPHATASE	
	SGOT	
	LDH	
	CPK	
	BILIRUBIN (TOTAL)	
	BILIRUBIN (DIRECT)	
	CHOLESTEROL	
	TRIGLYCERIDES	
	AMYLASE	
	LIPASE	
	PROFILE (Specify)	
38	Hct	
13	Hb (calc)	
7.521	pH	

CHEMISTRY I

546-107

STANDARD FORM 545 (Rev. 8-77)
General Services Administration and Interagency Committee on Medical Records. FIRMR (41 CFR) 201-45.505

REMARKS — Chem 8 — (b)(6)-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 — DATE 4 May 03 2246

ECH

(b)(6)-4

CBC-3

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

MEDCOM - 4901

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 ICU-3

(b)(6)-4

NURSING UNIT ICU-3 | ROOM NO. | BED NO.

DATE OF ORDER 4 MAY 03 | TIME OF ORDER ______ HOURS | LIST TIME ORDER NOTED AND SIGN

(b)(6)-2

1) Admit to ICU-3
2) Dx: S/P craniotomy
S/P trach
S/P EX LAP
3) Cond: serious
4) Vitals: monitor
5) activity - unable to ambulate will need Q 2 hr rolling.

(b)(6)-2

6) Nursing: ~~O2 tube to~~ ~~L~~ 5 ...
- SACRAL DECUB CARE
- trach care - Consult
- RESPIRATORY therapy
- D/C Q 6' tube
- foley to grav

(b)(6)-2

(b)(6)-2

(b)(6)-2 2230

7) IVF: D_5 1/2 NS IV at 80cc/H.

(b)(6)-2

8) Studies: CBC, UA, C Hem 1d

(b)(6)-2

9) Meds: ~~tylenol~~ and
Vancomycin 1gm IV Q6°
Unasyn 1.5 gm IV Q6°
Meropenem 500mg IVPB Q6°
Zantac 50mg IVPB Q8°

(b)(6)-2

Lactulose PO BID

(b)(6)-2

Phenobarb 40mg IV BID

(b)(6)-2

- if meds unavailable then don't give.

(b)(6)-2

10) DNR
11) tylenol 325mg PR Q6° ...
Valium ~~0.8~~ ...
0.04 - 0.2 mg/kg/dose, max 0.6 mg/kg/8hrs
q 2-4h PRN

(b)(6)-2

DA FORM 4256, 1 APR 79 | REPLACES EDITI... | MEDCOM - 4902 | ...E 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 SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER | TIME OF ORDER | DATE AND TIME ORDER WRITTEN AND SIGNATURE

5 May 03 | 0540

Adm via ~~PO Tylenol~~ IV 100 mg IV qd Dilantin. First dose now

V/O per Dr (b)(6)-2 (b)(6)-2

5 May 07 (b)(6)-2

08

NURSING UNIT | ROOM NO | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | DATE AND TIME ORDER WRITTEN AND SIGNATURE

5 May 03 | 1330

(1) Tylenol 650 mg PR X1 prn Fever

(b)(6)-2

CPT AN CRNA

02

5 May 1335 (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | DATE AND TIME ORDER WRITTEN AND SIGNATURE

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | DATE AND TIME ORDER WRITTEN AND SIGNATURE

NURSING UNIT | ROOM NO. | BED NO.

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

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MEDCOM - 4903

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 [redacted]	1)	DATE OF ORDER: 6 MAY 03 — TIME OF ORDER: 1830 HOURS Ng Stat swab & spot 30cc PO TID (b)(6)-2 [redacted]	7 ... 03 6 May (b)(6)-2 [redacted]
NURSING UNIT / ROOM NO. / BED NO.			
PATIENT IDENTIFICATION	1)	DATE OF ORDER: 6 MAY 03 — TIME OF ORDER: HOURS if empyema unabratable ~~transfer to treatment~~ ESR then hold. (b)(6)-2 [redacted]	KW 2130
NURSING UNIT / ROOM NO. / BED NO.			
PATIENT IDENTIFICATION	1)	DATE OF ORDER: 08 MAY 03 — TIME OF ORDER: (b)(6)-4 [redacted] HOURS transfer to [redacted] when available (b)(6)-2 [redacted]	8 May 03 (b)(6)-2 [redacted]
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.

☆ U S GOVERNMENT PRINTING OFFICE 1994-363-710
MEDCOM - 4904

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. 5 Yr. 63

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 10 11 12 13 14 15 16 17
5 May	[b)(6)-2]	Vitals: Monitor q 2°	07-15	[b)(6)-2]
			15-23	[b)(6)-2]
			23-07	
5 May 63	[b)(6)-2]	Activity - Unable to Ambulate Needs q 2 hr rolling	07-15	[b)(6)-2]
			15-23	[b)(6)-2]
			23-07	
5 May 63	[b)(6)-2]	Sacrum Decub care	07-15	[b)(6)-2]
			15-23	[b)(6)-2]
			23-07	
5 May	[b)(6)-2]	Trach Care - consult Resp therapy	07-15	[b)(6)-2]
			15-23	[b)(6)-2]
			23-07	[b)(6)-2]
		Foley to gravity	07-15	[b)(6)-2]
			15-23	[b)(6)-2]
			23-07	[b)(6)-2]
5 May	[b)(6)-2]	DNR	07-15	[b)(6)-2]
			15-23	[b)(6)-2]
			23-07	
6 May	[b)(6)-2]	Turn PT q 2hr while continuing to keep head of bed 30°	07	[b)(6)-2]
			09	
			11	[b)(6)-2]
			13	
			15	
			17	[b)(6)-2]
			19	
			21	
			23	

ALLERGIES: ☐ YES ☐ NO — Unk

PRIMARY DIAGNOSIS: S/P Craniotomy / Trach / Exp Lap.

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 — EDITION OF 1 DEC 77 MAY BE USED. — USAPA V1.00

MEDCOM - 4905

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo 5 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
5 May	(b)(6)-2	Admit ICU 3	5 May	Now	2030	(b)(6)-2
5 May	(b)(6)-2	Cond. Serious.	5 May	—	NOTED	
5 May	(b)(6)-2	D/C OG tube	5 May	Now	2100	
5		Studies: CBC, UA/ Chem 12	5 May	Now	2115	
8 May		I confer to 28th CSH when available	8 May	0920	Pending	
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					

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

USAPA V1.00

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. 5 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 4 5 6 7 8 9 10 11 12 13 14 15 16 17
5 May	(b)(6)-2	D5 1/2 NS @ 80cc/hr	07-15	/ (b)(6)-2
			15-23	(b)(6)-2
			23-07	
5 May	(b)(6)-2	Vancomycin 200mg IV q6°	04	/ (b)(6)-2
			10	/
			16	/ (b)(6)-2
			22	(b)(6)-2
5 May	(b)(6)-2	Unasyn 1.5 gr. IV q6°	05	/ (b)(6)-2
			11	/
			17	/ (b)(6)-2
			23	(b)(6)-2
5 May	(b)(6)-2	Imepenem 500 mg IVPB q6°	06	/ (b)(6)-2 Hold
			12	/
			18	/ (b)(6)-2
			24	(b)(6)-2
5 May	(b)(6)-2	Zantac 25mg IVPB q6°	03	/ (b)(6)-2
			09	/
			15	/
			21	(b)(6)-2
5 May	(b)(6)-2	Lacrilube OU BID	10	/ (b)(6)-2
			22	(b)(6)-2
5 May	(b)(6)-2	Phenobarb 40 mg IV BID	10	/ (b)(6)-2
			22	RN does not (b)(6)-2
5 May	(b)(6)-2	Dilantin 100mg qd IV	12	/ (b)(6)-2
6 May	(b)(6)-2	Mycostatin swish + spit 5cc PO TID	08	/ / (b)(6)-2
			14	/ / (b)(6)-2
			20	/ / (b)(6)-2

ALLERGIES: ☐ YES ☐ NO — Unk

PRIMARY DIAGNOSIS: S/P Craniotomy / trach / expl / Lap

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO — PAGE NO.

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	23	24	01	02	03	04	05	06

DA FORM 1 FEB 79 4678 — EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

MEDCOM - 4907

THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)

Verify by Initialing

Mo. 5 Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
5	(b)(6)-2	if Meds not Available - then don't give	5 May		NOTED	
5	(b)(6)-2	Dilantin First dose now 100mg IV	5 May	Now	1005	(b)(6)-2
6		If imipenem unavailable, then hold	6 may	now		

INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	TIME/DATE DISPENSED													
5 May	(b)(6)-2	Tylenol 325 mg PR q6° PRN	2115 4 may PR	1120 5 May PR 325	2000 5 May PR 325	1335 6 May PR 325	7 May 1500 325 PR									
				(b)(6)-2			(b)(6)-2									
5 May	(b)(6)-2	Tylenol 600 mg PRx PRN Fever	1345 5 may PR													
			(b)(6)-2													
6 may	(b)(6)-2	Valium .04 - .2 mg/kg/dose max .6 mg/kg/8hr 2-4 hr PRN		6 may 0400 2.5mg	6 may 1230 2.5mg	6 May 1840 2.5mg	7 May 0845 2.5mg	8 May 0815 2.5mg	5 May 1215 2mg							
				(b)(6)-2												

*U.S. GPO: 1996-454-110/95218

MEDCOM - 4908

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. ____ *Yr.* ____

VERIFY BY INITIALING | *INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION*

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	6	7	8	9	10	11	12	13	14	15	16	17	18	19
	-----	Continued	01	(b)(6)-2													
	-----		03														
	-----		05														
6 May03	(b)(6)-2	Foley care q d	08	(b)(6)-2													
5 May03		T meropenem 500 mg	06	/	/	○											
	-----	IVPB q 6°	12	|	|	(b)(6)-2											
	-----	~~(In 2nd drawer file cabinet~~	18	|	|												
	-----	~~Give to pharmacy in advance)~~	24	/	/												

ALLERGIES: ☐ YES ☐ NO | PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

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	23	24	01	02	03	04	05	06

DA FORM 1 FEB 79 **4678** EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

MEDCOM - 4909

MEDICAL RECORD - ICU FLOWSHEET

SECTION I - PATIENT ASSESSMENT DATA

PATIENT NAME: (b)(6)-4

DIAGNOSIS: CHI

DATE: 05/03/03

PATIENT ACUITY: HOSPITAL DAY: POST OP DAY:

	TIME:	0000	0100	0200	0300	0400	0500	0600	0700
VITAL SIGNS	BP ARTERIAL LINE							—	
	BP CUFF	130/74	133/81	123/78	123/80	146/90	125/80		122/70
	MAP	94	96	91	102	109	92		84
	TEMPERATURE								
	PULSE	98	101	110	100	97	93		92
	RESPIRATIONS	16	—	—	20	—	22		18
	PULSE OXIMETER	100	100	100	100	100	100		100
	CVP								
	PAIN (0 – 10)								
RESPIRATORY	OXYGEN (L/%)	80%	100	100	100	100	100	100	100
	O2 METHOD	Trach collar	TC	TC	TC	TC	TC	TC	TC
	VENT SETTINGS:								
	FIO2								
	MODE								
	TV								
	RATE								
	PEEP								
	PS								
	Respiratory Treatments								

Oxygen Method Key: NC = Nasal cannula NR = Non-rebreather FM = Face mask VM = Venturi mask V = Ventilator TC = Trach collar

Respiratory Treatment Key: HHN = Hand-held nebulizer MDI = Metered-dose inhaler CPT = Chest physiotherapy IS = Incentive spirometer

INTAKE		80	80	80	80	80	80	80	80
	PO	0	0	0	0	0	0	0	0
	TOTALS								640
OUTPUT	URINE								[illegible]
	STOOL	0	0	0	0	0	0	0	0
	TOTALS								200

(b)(6)-4

MEDICAL RECORD - ICU FLOWSHEET

SECTION I - PATIENT ASSESSMENT DATA

PATIENT NAME: **DATE:**

VITAL SIGNS	TIME:													
	BP ARTERIAL LINE													
	BP CUFF													
	MAP													
	TEMPERATURE													
	PULSE													
	RESPIRATIONS													
	PULSE OXIMETER													
	CVP													
	PAIN (0 - 10)													
RESPIRATORY	OXYGEN (L/%)													
	O2 METHOD													
	VENT SETTINGS:													
	FIO2													
	MODE													
	TV													
	RATE													
	PEEP													
	PS													
	Respirtory Treatments													

Oxygen Method Key: NC = Nasal cannula NR = Non-rebreather FM = Face mask VM = Venturi mask V = Ventilator TC = Trach collar
Respiratory Treatment Key: HHN = Hand-held nebulizer MDI = Metered-dose inhaler CPT = Chest physiotherapy IS = Incentive spirometer

INTAKE														
	PO													
	TOTALS													
OUTPUT	URINE													
	STOOL													
	TOTALS													

MEDICAL RECORD - ICU FLOWSHEET

SECTION I - PATIENT ASSESSMENT DATA

PATIENT NAME . DATE:

IV SITE ASSESSMENT:

LEGEND: WNL = NO REDNESS/SWELLING/OTHER S/S INFILTRATION/INFECTION
R – REDDENED P = PUFFY I = INFILTRATED CL = CENTRAL LINE

	LOCATION	CONDITION
IV SITE # 1	~~Rt Brachial PICC~~	(R) PIV
IV SITE # 2		(L) PIV
IV SITE # 3		

	TIME	INITIALS (b)(6)-2
IV PATENCY CHECKED	0:00	
IV SITE CARE PROVIDED		
IV TUBING CHANGED		

COMMENTS: Flushed ~~& Heparin~~ NO S/S of infiltration
D5½NS infusing (R) PIV

	LOCATION	CONDITION
IV SITE # 1		
IV SITE # 2		
IV SITE # 3		

	TIME	INITIALS
IV PATENCY CHECKED		
IV SITE CARE PROVIDED		
IV TUBING CHANGED		

COMMENTS:

AM STRIP

PM STRIP

SECTION III - SHIFT NOTES

(b)(6)-4

MEDICAL RECORD - ICU FLOW SHEET

SECTION II - PATIENT ASSESSMENT DATA - REVIEW OF SYSTEMS

PATIENT NAME: DATE:

	TIME: 0800 Sep 03 INITIALS:	TIME: INITIALS:
NEUROLOGICAL Alert and Oriented to time, place and name; Responds appropriately; Communication is adequate to express needs; Pupils equal and reactive to light.	Pupil react. ~~x~~, but PT does not track or follow any Commands	
CARDIOVASCULAR Age appropriate Rate, Rhythm, and Pulses; Capillary refill < 3 sec; No dependent edema, Nailbeds and mucous membranes pink. No calf tenderness. Prtraurc monitoring	ST ; No Ectopy 2+ pulses CRT ~~Refe~~ < 3sec Some Edema Noted Tobacco ~~Hand~~	
PULMONARY Respirations within normal limits for age; Breath sounds quiet and regular; Depth is regular; No dyrpnea; No cough: Suction; Secretions; Oxygen; ETT; Trach	-TRACH in place -PT Sat.y 100% on 02. Breathing Somewhat Laboried and Deep.	
C.I. Abdomen soft and non-distcnded; Bowel sounds active in all quadrants; No difficulty chewing or swallowing; No abdominal pain; Frequency and type of stool; No diarrhea; No constipation; No NN; NG Tube placement; Type of scorctions	-PT has Active BS. ~~-PT~~ No Bm TO Note.	
G.U. Voiding; Catheters; Urine clear yellow/amber No odor, discharge, frequency, urgency, nocturia	Foley Cath in place Draining Dark yellow urine. NO Discharge noted around meatus.	
MUSCULOSKELETAL: Normal muscle mass and dtvclopment Tor age; No dclormities; No assistive devices ncedcd: Normnl movement and lone; Normal active ROM without pain; No joint swelling, tenderness, weakness, or paresthesia	-PT Appearance FRAIL; Presores, ~~Cath~~ Does not follow Command. Moves only Arms.	
SKIN Color: warm; dry: intact; Turgor; No Wounds; lesions; rasher, Inflammation, ulcers, breaks in skin: No redness, blanching, irritation, over bony prominences; Mucous membranes moist: Wounds = location, condition, drainage, dressing	- mid line abdominal incision clsd. - Left wrist skin Breakdown Foam open 3in x 2in OTA - Left Buttock Break down OTA - Skin Dry But Warm to Touch.	
PAIN No complaints of pain/discomfort; Note Location; Duration; Intensity	UTA	
PSYCHOSOCIAL: Behavior is appropriate to the situation; Anxiety is controlled or mild and appropriate to the situation; Interacts appropriately with others	~~NO Family Present~~ No Sign of Anxiety.	

MEDICAL RECORD - ICU FLOWSHEET

SECTION I - PATIENT ASSESSMENT DATA

PATIENT NAME: (b)(6)-4 DATE: 6 May 03

DIAGNOSIS: PATIENT ACUITY: HOSPITAL DAY: POST OP DAY:

	TIME:	0700	0900	1100	1300	1500	1700	1900	2100	2300	0100	0300	0500
VITAL SIGNS	BP ARTERIAL LINE												
	BP CUFF	125/80	120/71	132/77	148/81	175/83	118/63	120/60	127/72	139/72	129/78	141/83	121/74
	MAP						77						
	TEMPERATURE	99.4 (A)	99.5 (A)	101.2 (O)	102.1 (T)	99.8	99.2 (A)	97.8 (A)	97.9 (A)	97.9 (A)	96.7 (A)	96.9 (A)	96.8 (A)
	PULSE	102	99	83	128	90	124	117	125	131	69	133	118
	RESPIRATIONS	31	27	36	33	22	36	24	24	24	18	38	33
	PULSE OXIMETER	100	100	100	100	100	100	100	100	100	100	100	100
	CVP				102.1 (A)								
	Temp				49								
	PAIN (0 – 10)												
RESPIRATORY	OXYGEN (L/%)												
	O2 METHOD												
	VENT SETTINGS:												
	FIO2												
	MODE												
	TV												
	RATE												
	PEEP												
	PS												
	Respiratory Treatments												

Oxygen Method Key: NC = Nasal cannula NR = Non-rebreather FM = Face mask VM = Venturi mask V = Ventilator TC = Trach collar
Respiratory Treatment Key: HHN = Hand-held nebulizer MDI = Metered-dose inhaler CPT = Chest physiotherapy IS = Incentive spirometer

														Shift
INTAKE	IV	150		50		550				640				640
	IV	~~50~~	50	50						200		~~50~~		200
	IV	~~100~~	50		50	50								Total 840
	PO				Total					840				
	TOTALS					1000								
OUTPUT	URINE													
	0700	220		100	100						180	200		140
	0810	200				50								160
														Total 680
	STOOL													
	TOTALS	420		100	100	50				840				

670

MEDICAL RECORD - ICU FLOWSHEET

SECTION I - PATIENT ASSESSMENT DATA

PATIENT NAME: (b)(6)-4 DATE: 5 03

IV SITE ASSESSMENT:

LEGEND: WNL = NO REDNESS/SWELLING/OTHER S/S INFILTRATION/INFECTION
R = REDDENED P = PUFFY I = INFILTRATED CL = CENTRAL LINE

LOCATION	CONDITION	LOCATION	CONDITION
IV SITE # 1 Lt forearm	Patent	IV SITE # 1	
IV SITE # 2 Rt forearm	Patent	IV SITE # 2	
IV SITE # 3		IV SITE # 3	

	TIME	INITIALS		TIME	INITIALS
IV PATENCY CHECKED	0800	AW	IV PATENCY CHECKED		
IV SITE CARE PROVIDED			IV SITE CARE PROVIDED		
IV TUBING CHANGED			IV TUBING CHANGED		

COMMENTS: Lt Rt forearm DIC @ 1915. Head wkl getting puffy

COMMENTS:

SECTION III - SHIFT NOTES

0700 – Initial assesment (see section II) Foley cath care performed. Positioned q 30°. Decubitus care performed - Lacrilube placed in lower lids. IV site Lt forearm patent Fluids x2. IV Right arm patent, Range of motion exercises. T @ 1100 101.2 325 mg Tylenol eidm PR. Retaken @ 1200 102.1. Consulted with Rpt (b)(6)-2 (anesthesia) who recommend cool compressers under armpits, on forehead and groin area. Recieving O2 4 l via trach. T retaken @ 1300, No changes. Tylenol 650 mg PR administered. Trach care done by resp. therapist. @ 1420 T 99.1 @ 1400, pt turned on Right side. Foot brace noted. Continue to monitor (b)(6)-2

MEDICAL RECORD - ICU FLOWS[illegible]T

SECTION II - PATIENT ASSESSMENT DATA - REVIEW OF SYSTEMS

PATIENT NAME: [redacted] DATE: 7 May 03

	TIME: / INITIALS:	TIME: / INITIALS:
NEUROLOGICAL Alert and Oriented to time, place and name; Responds appropriately; Communication is adequate to express needs; Pupils equal and reactive to light.	0700 EW Pupils equal and reactive to light	Pupils Dilated, equal, rand & react to Light & accomidation
CARDIOVASCULAR Age appropriate Rate, Rhythm, and Pulses; Capillary refill < 3 sec; No dependent edema. Nailbeds and mucous membranes pink. No calf lenderness. Pressure monitoring	0700 EW Regular rhythm Capillary refil < 2 sec Nailbeds and mucous membranes pink	8-9 years old 80-100 Bpm cap ref < 3 secs no signs of edema Distal pulses +2 Bilat
PULMONARY Respirations within normal limits for age; Breath sounds quiet and regular; Depth is regular; No dyspnea; No cough; Suction; Secretions: Oxygen: ETT; Trnch	0700 EW Normal respirations Trach in place No cough Suctioned x 1 Labored breathing; clear lung	Resp 20-30 Bpm, clear to ascultation, Trach @ 28% O2 via concentrator spo2 100%
G.I. Abdomen soft and non-distended; Bowel sounds active in all quadrants; No difficulty chewing or swallowing; No abdominal pain; Frequency and type of stool: No diarrhea; No constipntion; No NN; NG Tube placement; Type of secretions	0700 EW Abdomen soft No active bowel sounds noted - ∅ swallowing	B/S active x4
G.U. Voiding; Catheters; Urine clear yellow/amber No oder, discharge, frequency, urgency, nocturia	0700 EW Foley catheter in place Draining dark colored urine	Foley to Gravity draining Clear Yellow Q/S
MUSCULOSKELETAL: Normal muscle mass and development for age; No deformities; No assistive devices needed; Normal movement and tone; Normal active ROM without pain; No joint swelling, tenderness, weakness, or paresthesia	0700 EW unable to move by himself. ∅ deformities Left arm movement only	muscle tone weak, No Purpose full movement. Contractures in hands Bilat Foot drop Bilat
SKIN Color; warm; dry; Intact; Turgor; No Wounds; lesions; rashes, inflammation, ulcers, breaks in skin; No redness, blanching, irritation, over bony prominences; Mucous membranes moist; Wounds - location, condition, drainage, dressing	0700 EW Right hand edema +1 Dry skin Coccyx sacral wound Left upper thigh wound & size Multiple abd scars	skin TTR war dry ulcer stage 2 (R) buttocks ulcer to (L) hip stage 2 midline scar cervical scar
PAIN No complaints of pain/discomfort; Note Location; Duration; Intensity	0700 EW unable to assess	unable to assess
PSYCHOSOCIAL: Behavior is appropriate to the situation; Anxiety is controlled or mild and appropriate to the situation; Interacts appropriately with others	0700 EW unable to assess	unable to assess

MEDICAL RECORD - ICU FLOWSHEET

SECTION I - PATIENT ASSESSMENT DATA

PATIENT NAME: (b)(6)-4 DATE: 7 May 03

DIAGNOSIS: s/p Craniotomy PATIENT ACUITY: HOSPITAL DAY: POST OP DAY:

	TIME:	0700	0900	1100	1300	1500	1700	1900	2100	2300	0100	0300	0500	0700
VITAL SIGNS	BP ARTERIAL LINE	115/80	109/69	133/80	106/62	124/71	125							
	BP CUFF						123/77	121/94	110/85	128/84	134/101	138/97	138/90	103/76
	MAP													
	TEMPERATURE	97.5(A)	96.8(A)	99(A)	100(A)	99.1	98.7 AV	96.1 AV	98.3 AV	98.5 AV	97.4	98.0	98.2	
	PULSE	67	77	122	123	100	78	111	107	98	87	92	94	68
	RESPIRATIONS	18	19	38	39	31	21	22	24	18	26	22	21	16
	PULSE OXIMETER	100	100	100	100	100	100	100	100	100	100	100	100	100%
	CVP													
	PAIN (0 – 10)													
RESPIRATORY	OXYGEN (L/%)													
	O2 METHOD													
	VENT SETTINGS:													
	FIO2													
	MODE													
	TV													
	RATE													
	PEEP													
	PS													
	Respiratory Treatments													

Oxygen Method Key: NC = Nasal cannula NR = Non-rebreather FM = Face mask VM = Venturi mask V = Ventilator TC = Trach collar
Respiratory Treatment Key: HHN = Hand-held nebulizer MDI = Metered-dose inhaler CPT = Chest physiotherapy IS = Incentive spirometer

	TIME:		0900	1100	1200	1300	1500	1700	1900	2100	2300		Shift	
INTAKE	IV		150	50	150		500	160	160	160	160		IV	640
	IVPB						50/50			50			IVPB	300
													Total	940 in
	PO													
	TOTALS		150	200	350		750							
OUTPUT	URINE		100	120	120	190	220	70	280	300	145	200	300	90
												shift	Total	610 out
	STOOL													
	TOTALS		100	220	340	480	700	770	1050	1350	1495			

MEDICAL RECORD - ICU FLOWSHEET

SECTION I - PATIENT ASSESSMENT DATA

PATIENT SAME: (b)(6)-4 DATE: 6 May 03

IV SITE ASSESSMENT:

LEGEND: WNL = NO REDNESS/SWELLING/OTHER S/S INFILTRATION/INFECTION
R = REDDENED P = PUFFY I = INFILTRATED CL = CENTRAL LINE

	LOCATION	CONDITION
IV SITE # 1	Lt forearm	patent
IV SITE # 2		
IV SITE # 3		

	TIME	INITIALS
IV PATENCY CHECKED	0700	EW
IV SITE CARE PROVIDED	0800	EW
IV TUBING CHANGED	N/A	
COMMENTS:		

	LOCATION	CONDITIOT
IV SITE # 1		
IV SITE # 2		
IV SITE # 3		

	TIME	INITIALS
IV PATENCY CHECKED		
IV SITE CARE PROVIDED		
IV TUBING CHANGED		
COMMENTS:		

[AM STRIP

PM STRIP

SECTION III - SHIFT NOTES

0700 - Initial assessment see section II. Foley care performed. Cleaned under foreskin. Oral care performed. Lip gloss applied. Lotion applied to dry areas. Turned q 2°. Surgeon assessed pt. States does not want to start feedings. Dressing on Lt pelvic wound. Ø drainage. Dry & intact. Trach care performed @ 1120. Thick secretions removed while suctioning. (b)(6)-2 wfn

1230. 2.5 mg oic Valium given due to agitation, RR, HR and posturing. Possible seizure activity (redacted) b-6-2

1420. Suctioned via trach. Thick secretion removed. T-100.5 Tylenol 325 mg PR administered. (b)(6)-2 wfn

EDICAL RECORD - ICU FLOWSI

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II - PATIENT ASSESSMENT DATA - REVIEW ... STEMS

PATIENT NAME: (b)(6)-4

DATE: 6 May 03

	TIME: 0700 INITIALS: E	TIME: INITIALS:
NEUROLOGICAL Alert and Oriented to time, place and name; **Responds appropriately; Communication** is adequate to express needs; Pupils equal and reactive to light.	Non responsive Pupils dilated. Reacts to light.	PT Non resp. Pupils Dilated, Equal Round, react sluggishly
CARDIOVASCULAR Age appropriate **Rate**. Rhythm, **and** Pulses; **Capillary refill < 3 sec; No** dependent **edema.** Nailbeds and mucous **membranes pink.** No calftenderness. Pressure **monitoring**	Capillary refill < 2 sec. Edema Rt hand going down Nailbed + mucous membrane pink.	HR Fluctuates Dramaticly Distal pulses +3, cap ref <3sec skin TTR warm dry
PULMONARY **Respirations within normal Limits for age;** Breath sounds quiet and regular; Depth is **regular; No dyspnea;** No cough; **Suction;** Secretions; Oxygen; ETT: Trach	Trach in place Slight cough. Suctioned x 1 via trach O2 4 l Sat 100% Regular rhythm. Labored breathing	Resp 20-25, breath sands CTA Equal Bilat. Trach O2 40% SpO2 100%. Suction mucous blood tinged
G.I. Abdomen soft and **non-distended; Bowel sounds active** in **all** quadrants; No difficulty chewing or swallowing; No **abdominal** pain; Frequency and **type** of stool; ***No* diarrhea;** No **constipation;** No NN. **NG Tube placement;** Type of secretions	Abdomen soft. Non distinted Bowel sounds present	B/S Active x4 no Bowel movement, Diet None
G.U. Voiding; Catheters; Urine clear yellow/amber **No odor, discharge, frequency, urgency,** nocturia	Foley catheter in place Draining clear urine	Foley to Gravity draining Q/S Clear Yellow
MUSCULOSKELETAL: **Normal muscle mass** end **development** for nge: No **deformities;** S o **assistive devices** needed: **Normal movement** and tone; **Normal active ROM without pain;** No Joint **swelling,** tenderness, **weakness,** or paresthesia	Involuntary upper extremity movements. No movements upon command	PT moves upper extremities involuntarily. Lower ext Flaid muscle tone Weak,
SKIN Color; warm; dry; intact; **Turgor;** No Wounds; **lesions;** rashes, **inflammation,** ulcers. **breaks** lo skin; No **redness,** blanching, **irritation,** over **bony** prominences; Mucous membranes **moist;** Wounds – **location,** condition, **drainage, dressing**	Dry skin multiple areas Good skin turgor Sacral wound Dressing Left Flank(dry + intact)	Color TTR warm & dry Stage II decub on ⑤ buttocks ① hip in healing process
PAIN No complaints of **pain/discomfort;** - Note **Location; Duration; Intensity**	Unable to assess Patient non-responsive to stimuli	unable to assess
PSYCHOSOCIAL: Behavior **is appropriate** to the **situation;** Anxiety **is** controlled or mild and **appropriate to the situation; Interacts appropriately** with **others**	Unable to assess patient non-responsive	Unable to assess

MEDICAL RECORD - ICU FLOWSHEET

SECTION I - PATIENT ASSESSMENT DATA

PATIENT NAME: (b)(6)-4 DATE: 7 May 03

DIAGNOSIS: PATIENT ACUITY: HOSPITAL DAY: POST OP DAY:

	TIME:	0700	0900	1100	1300	1500	1700	1900	2100	2301	0100	0300	0500	0700
VITAL SIGNS	BP ARTERIAL LINE	103/76	94/44	105/73	121/79	119/78								
	BP CUFF						104/53	113/80	99/84	127/97	125/85	106/67	133/92	112/66
	MAP													
	TEMPERATURE	97.6(A)	98.4(A)	97.2(A)	99.4(A)	100.2(A)	99.1(A)	97.2(A)	98.3(A)	98.9(A)	98.5(A)	97.8	97.4	98.3
	PULSE	60	95	60	123	106	101	81	100	97	90	76	95	85
	RESPIRATIONS	15	25	17	35	38	27	16	18	22	23	16	20	22
	PULSE OXIMETER	100	100	100	106	100	99	106	100	100	100%	100%	100%	99%
	CVP													
	PAIN (0 - 10)													
RESPIRATORY	OXYGEN (L/%)	4 L					RA	RA	RA					
	O2 METHOD													
	VENT SETTINGS:													
	FIO2													
	MODE													
	TV													
	RATE													
	PEEP													
	PS													
	Respiratory Treatments													

Oxygen Method Key: NC = Nasal cannula NR = Non-rebreather FM = Face mask VM = Venturi mask V = Ventilator TC = Trach collar
Respiratory Treatment Key: HHN = Hand-held nebulizer MDI = Metered-dose inhaler CPT = Chest physiotherapy IS = Incentive spirometer

INTAKE	IV		50	50	50	50	50/50		50/100	50		[redacted]		650
	IV		50	250	[redacted]	325	160	160	160	160				200
													shift	850
	PO													
	TOTALS		100	400	450	825				1765				
OUTPUT	URINE													
			190	110	220	200	70	85	200	325		550	200	75
	STOOL												shift Total	
	TOTALS		190	200	420	620				1300				825

MEDCOM - 4920

MEDICAL RECORD - ICU FLOWSHEET

SECTION I - PATIENT ASSESSMENT DATA

PATIENT NAME: DATE:

IV SITE ASSESSMENT:

LEGEND: WNL = NO REDNESS/SWELLING/OTHER S/S INFILTRATION/INFECTION
R = REDDENED P = PUFFY I = INFILTRATED CL = CENTRAL LINE

	LOCATION	CONDITION		LOCATION	CONDITION
IV SITE # 1	LT forearm	patent	IV SITE # 1		
IV SITE # 2	Rt forearm	patent	IV SITE # 2		
IV SITE # 3			IV SITE # 3		

	TIME	INITIALS		TIME	INITIALS
IV PATENCY CHECKED	0700	cw	IV PATENCY CHECKED		
IV SITE CARE PROVIDED			IV SITE CARE PROVIDED		
IV TUBING CHANGED	N/A	cw	IV TUBING CHANGED		

COMMENTS:

COMMENTS:

AM STRIP

PM STRIP

SECTION III - SHIFT NOTES

0700 - Initial assessment see section II. Oral care given, Foley care given
Lip gloss applied. @ 0845, pt in taquicardic (> 130). 2.5 mg Valium administered
IV. ↓ Pulse 69. @ 1100 trach care provided, ∅ thick secretions.
@ 1200 lotion applied to upper and lower extremities. @ 1500 T↑ 100.2 (ax).
Adm Tylenol 325 mg. Continue to monitor temp. Cold cloth placed
on forehead. (b)(6)-2
1610 Pt Weaned to RA c̄ Trach-lar Dome. SpO2 97% on RA. (b)(6)-2
1620 - Initial assessment - Gnmacordopanstim. UE + Trunk only. PERRL Briskly.
4mm Resp. Regular per trach. O2 weaned off by RT SAT ≥97% BS CTA B/L.
Skin warm; cap refill <3 sec; Periph pulses palpable x4. Abd soft non-
tender. BS x 4 quads. foley to gravity. urine cl. yellow. Sacral decub.
c̄ pink tissue, on L side of Decub. IV to LT hand & RT
forearm A) Neuro deficit chids P) Supportive care. (b)(6)-2

MEDCOM - 4921

MEDICAL RECORD - ICU FLOW SHEET

PATIENT NAME: (b)(6)-4

SECTION II - PATIENT ASSESSMENT DATA - REVIEW OF SYSTEMS

DATE: 7 May 03

	TIME: 0700 INITIALS: EW	TIME: INITIALS:
NEUROLOGICAL Alert m d Oriented to time, place and name; Responds appropriately; Comrnunlcation Is adequate to express needs; Pupils equal and reactive to light.	Non-responsive Pupils non responsive/reactive to light Pupils dilated	
CARDIOVASCULAR Age appropriate Rate, Rhythm, and Pulses; Capillary refill < 3 sec; No dependent edema. Nailbeds and mucous membranes pink. No call tenderness. Pressure monitoring	Frequent Episodes of tachycardia >130 beats per minute Capillary refill < 3 sec Nailbeds pink	
PULMONARY Respirations within normal limits for age; Breath sounds quiet and regular: Depth is regular; No dyrpnea; No cough; Suction; Secretions; Oxygen; ETT; Trach	Breath sounds quiet labored breathing O2 4 L Trach in place	
G.I. Abdomen soft and non-distended; Bowel sounds active In all quadrants; No difficulty chewing or swallowing; No abdominal pain: Frequency and type of stool; No dfnrrhea; No constipation; No N/V; NC Tube placement; Type of secretions	Abdomen soft Non-distended No swallowing capability Ø BM	
G.U. Voiding; Catheters; Urine clear yellow/amber No odor, discharge, frequency, urgency, nocturia	Foley catheter in place Draining clear urine	
MUSCULOSKELETAL: Normal muscle mass and development for age: No deformities; No assistive dcvlccs needed; Normal movcmcnt and tone; Normal active ROM without pain; Na joint swelling, tenderness, weakness, or paresthesia	Rigid posture ROM with assistance	
SKIN Color; warm; dry: intact: Turgor; No Wounds: lesions; rashes, Inflammation, ulcers, breaks in skin; No redness, blanching, Irritation, over bony prominences; Mucous membranes moist; Wounds = location, condition, drainage, dressing	Dry skin upper/lower extremities Good skin turgor Sacral wound Small wound left pelvic area. Draining dry & intact	
PAIN No complaints of pain/discomfort; Note Location; Duration; Intensity	Unable to assess pt non-responsive	
PSYCHOSOCIAL: Behavior is appropriate to the situation; Anxiety is controlled or mild and appropriate lo the situation; Interacts appropriately with others	Unable to assess pt non-responsive	

MEDICAL RECORD - ICU FLOWSHEET

SECTION I - PATIENT ASSESSMENT DATA

PATIENT NAME: (b)(6)-4

DATE: 5 May 03

DIAGNOSIS: SP Craniotomy

PATIENT ACUITY: HOSPITAL DAY: POST OP DAY:

	TIME:	0700	0900	1100	1300	1500	1700	1900	2100	2300	0100	0300	0500
VITAL SIGNS	BP ARTERIAL LINE												
	BP CUFF	103/76	114/61	125/78	89/57	111/67							
	MAP												
	TEMPERATURE	99	98.7	97.2	96.6	98.1							
	PULSE	62	80	70	63	99							
	RESPIRATIONS	16	21	17	19	17							
	PULSE OXIMETER	100%	98	100	98	97							
	CVP												
	PAIN (0 – 10)												
RESPIRATORY	OXYGEN (L/%)												
	O2 METHOD												
	VENT SETTINGS:												
	FIO2												
	MODE												
	TV												
	RATE												
	PEEP												
	PS												
	Respiratory Treatments												

Oxygen Method Key: NC = Nasal cannula NR = Non-rebreather FM = Face mask VM = Venturi mask V = Ventilator TC = Trach collar
Respiratory Treatment Key: HHN = Hand-held nebulizer MDI = Metered-dose inhaler CPT = Chest physiotherapy IS = Incentive spirometer

	TIME:	0700	0900		1100	1300							
INTAKE	IV	640		350									
	IVPB	300	50	200									
	Total	940											
	PO												
	TOTALS		50	600									
OUTPUT	URINE		250	380	180	200							
	STOOL												
	TOTALS	410	250	630	710								

MEDICAL RECORD - ICU FLOWSHEET

SECTION I - PATIENT ASSESSMENT DATA

PATIENT NAME: DATE:

IV SITE ASSESSMENT:

LEGEND: WNL = NO REDNESS/SWELLING/OTHER S/S INFILTRATION/INFECTION
R = REDDENED P = PUFFY I = INFILTRATED CL = CENTRAL LINE

LOCATION	CONDITION	LOCATION	CONDITION
IV SITE # 1 Lt forearm	patent	IV SITE # 1	
IV SITE # 2		IV SITE # 2	
IV SITE # 3		IV SITE # 3	

	TIME	INITIALS		TIME	INITIALS
IV PATENCY CHECKED	0730	(b)(6)-2	IV PATENCY CHECKED		
IV SITE CARE PROVIDED			IV SITE CARE PROVIDED		
IV TUBING CHANGED			IV TUBING CHANGED		
COMMENTS:			COMMENTS:		

AM STRIP

PM STRIP

SECTION III - SHIFT NOTES

0730- Initial assessment ^ see Section II Pt non-responsive to stimuli. Resting on Rt side @ 0815 Pulse > 125. Adm Valium 2.5 mg @ 0915 Pulse 94 Turned q 2° Passive Rom performed on upper and lower extremities. Pulse > 150 @ 1215, Adm Valium 2.5 mg. @ 1330 Pulse <90. Civil affairs brought dad to pts bedside. Surgeon spoke with Father regarding pts condition. Foley care and ord care given. Lotion applied to upper and lower extremities. Vs Stable. Continue to monitor (b)(6)-2 RN

1500 Small quarter size red area noted on Rt pelvic bone.

MEDICAL RECORD - ICU FLOWSHEET

SECTION II - PATIENT ASSESSMENT DATA - REVIEW OF SYSTEMS

PATIENT NAME: DATE:

	TIME: 0730 INITIALS:	TIME: INITIALS:
NEUROLOGICAL Alert and Oriented to time, place and name; Responds appropriately; Communication is adequate to express needs; Pupils equal and reactive to light.	Non responsive. Non communicative. Pupils dilated Non-~~responsive~~ reactive to light	
CARDIOVASCULAR Age appropriate Rate, Rhythm, and Pulses; Capillary refill < 3 sec; No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness Pressure monitoring	Episodes of tachycardia (>130 beats) Capillary refill < 2 sec. No edemes	
PULMONARY Respirations within normal limits for age; Breath sounds quiet and regular; Depth is regular; No dyspnea; No cough; Suction: Secretions; Oxygen; ETT; Trach	Labored respirations Breath sounds clear Periodic cough Trach in place	
G.I. Abdomen soft and non-distended; Bowel sounds active in all quadrants; No difficulty chewing or swallowing; No abdominal pain; Frequency and type of stool; No diarrhea; No constipation; No N/V; NG Tube placement; Type of secretions	Abdomen soft. Non-distended Bowel sounds present Ø BM Unable to chew or swallow	
G.U. Voiding; Catheters; Urine clear yellow/amber No odor, discharge, frequency, urgency, nocturia	Foley catheter in place. Draining clear urine No odor.	
MUSCULOSKELETAL: Normal muscle mass and development for age; No deformities; No assistive devices needed; Normal movement and tone; Normal active ROM without pain; No joint swelling, tenderness, weakness, or paresthesia	Rigid posture at times Passive ROM	
SKIN Color; warm; dry; intact; Turgor; No Wounds; lesions; rashes, inflammation, ulcers, breaks in skin: No redness, blanching, irritation. over bony prominences; Mucous membranes moist; Wounds – location, condition, drainage, dressing	Good skin turgor Sacral wound with Bacitracin ointment Left pelvic wound = dressing (Dry & intact) Dry skin in multiple areas (mainly feet and hands)	
PAIN No complaints of pain/discomfort; Note Location; Duration; Intensity	Unable to assess. Non-responsive to pinching	
PSYCHOSOCIAL: Behavior is appropriate to the situation; Anxiety is controlled or mild and appropriate to the situation; Interacts appropriately with others	Unable to assess	