ADMISSION -- CODING INFORMATION

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

1. REPORTING MTF: (b)(3)-1 — LOCATION (State or Country Code): 7: I, 8: O

3. REGISTER NUMBER: (b)(6)-4

NAME (Last, First, Middle Initial): (b)(6)-4 (b)(6)-4

4. PAY GRADE

5. SEX

6. DATE OF BIRTH (Y Y Y Y M M D D)

7. AGE AT ADMISSION

8. RACE: Iraqi

9. ETHNIC BACKGROUND

RELIGION

10. LENGTH OF SERVICE

ETS

11. FMP: 9 9

12. SOCIAL SECURITY NUMBER: (b)(6)-4

ORGANIZATION (Active Duty Only)

13. MARITAL STATUS

HOUR OF ADMISSION: 2100

BRANCH / CORPS

14. FLYING STATUS

15. BENEFICIARY CATEGORY

16. ZIP CODE OF RESIDENCE

17. UNIT LOCATION (State or County Code)

18. MOS

19. TRAUMA

PREV. ADMISSION — YEAR — [X] NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: 72: D — [signature]

WARD: ICW3

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

21. TYPE OF DISPOSITION: Home

22. MTF TRANSFERRED TO

23. DATE OF DISPOSITION (Y Y M M D D): 0 3 0 5 0 6

24. CLINIC SVC - ADMITTING: A B A A

25. MTF TRANSFERRED FROM

26. DATE THIS ADMISSION (Y Y M M D D): 0 3 0 5 0 4

27. LOCATION OF OCCURRENCE (Battle Casualty Only)

28. MTF OF INITIAL ADMISSION

29. DATE INITIAL ADMISSION (Y Y M M D D)

FOR LOCAL USE

open R hip Fx GSW L leg, peroneal Nerve palsy

820.9
891.0
890.0
878.0
355.3
E99.2

ADMITTING OFFICER (Signature, as required): (b)(6)-2 (b)(6)-2 MC LTC, MC (b)(6)-2

SIGNATURE OF ADMITTING CLERK: (b)(6)-2 11010

DA FORM 2569, MAR 85 — EDITION OF MAY 79 IS OBSOLETE

MEDCOM - 5028

1 REPORTING MTF | 2 ...F LOCATION (State or Country Code)

1 2 3 4 5 6 | 7 8: I Z

(b)(3)-1

ADMISSION ... CODING INFORMATION

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

3 REGISTER NUMBER (b)(6)-4

NAME (Last, First, Middle Initial) (b)(6)-4 (b)(6)-4

4. PAY GRADE (16, 17): —

5. SEX (18): M

6 DATE OF BIRTH (Y Y Y Y M M D D) (19–26): 1 9 5 8 0 1 0 1

7. AGE AT ADMISSION (27, 28, 29): 45 Y

8. RACE (30): X

9. ETHNIC BACKGROUND (31): 9

RELIGION

10. LENGTH OF SERVICE (32, 33, 34): —

ETS

11. FMP (35, 36): 9 9

12. SOCIAL SECURITY NUMBER (37–45): (b)(6)-4

ORGANIZATION (Active Duty Only)

13. MARITAL STATUS (46): 2

HOUR OF ADMISSION: 2100

BRANCH / CORPS

14. FLYING STATUS (47, 48, 49): —

15. BENEFICIARY CATEGORY (50, 51, 52): K 9 7 nd

16. ZIP CODE OF RESIDENCE (53–61): 0 9 3 3 0 0 0 0 0

17. UNIT LOCATION (State or Country Code) (62, 63): —

18. MOS (64–70): —

19. TRAUMA (71):

PREV. ADMISSION YEAR: [X] NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION (72): 1

WARD: ICW 3

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION (73, 74): 0 5

22. MTF TRANSFERRED TO (75–80):

23. DATE OF DISPOSITION (Y Y M M D D) (81–86): 2003 0 5 0 6

24. CLINIC SVC - ADMITTING (87–90): A B A A

25. MTF TRANSFERRED FROM (91–96):

26. DATE THIS ADMISSION (Y Y M M D D) (97–102): 2003 0 5 0 4

27. LOCATION OF OCCURRENCE (Battle Casualty Only) (103, 104): I Z

28. MTF OF INITIAL ADMISSION (105–110):

29. DATE INITIAL ADMISSION (Y Y M M D D) (111–116):

FOR LOCAL USE

DX: 8209 open R Hip Fx GSW L leg, peroneal Nerve palsy
8901
8911
9110
3553
5990
E9912

Trauma 1 Inj 450

Px: 7935, 7965, 8622, 8659

ADMITTING OFFICER (Signature, as required) (b)(6)-2 (b)(6)-2 LTC, MC (b)(6)-2

SIGNATURE OF ADMITTING CLERK (b)(6)-2

EDITION OF MAY 79 IS OBSOLETE

MEDCOM - 5029

(b)(3)-1 | (b)(6)-4

Date of Admission: 4/ 8/2003

Date of Transfer:

Age:45 Gender: M

History:

Unknow Age Iraqi presented to (b)(3)-1 4 days s/p I&D of rt open hip fx and complex wounds of lt thigh and leg from
multiple GSW

Hospital Course:

Treated w/I&D of wounds and ORIG of hip fx. Partialsciatic nerve palsy. Treated w/ local wound care to left leg wounds. Recoved nicely. Fracture location has high failure rate and may require hemiarthroplasty as salvage operation later

All wounds closed delayed.

Diagnoses:

Open right hip hx, GSW lt thigh & leg, peroneal nerve palsy,

Surgeries/Treatment:

418103- I&D of all open wound, traction pin, ORIF rt hip fracture 4/10,

Recommendations:

ORIF rt hip fx, wound care/closure lt thigh and leg wounds. Low chance of fracture fixation success, will likely require hip prosthesis in the next Few months

Special Needs:

crutches for up to 3 months, ~~extended dressing changes to left thigh and leg up to 4 months~~

All wounds closed. Telfa dressing change to Left calf

Prognosis: Guarded

Physician: (b)(6)-2 L T Dept of Orthopedics 4/24/2003

MEDCOM - 5030

b)(3)-1 | (b)(6)-4

Date of Admission: 41812003
Date of Transfer:
Age:45 Gender: M

History:
Unknow Age Iraqi presented to (b)(3)-1 4 days s/p I&D of rt open hip fx and complex wounds of lt thigh and leg from
multiple GSW

Hospital Course:
Treated w/I&D of wounds and ORIG of hip fx. Partialsciaticnerve palsy. Treated w/ local wound care to left leg wounds. Recoved nicely. Fracture location has high failure rate and may require hemiarthroplasty as salvage operation later

Diaanoses:
Open right hip hx, GSW lt thigh & leg, peroneal nerve palsy,

Surgeries/Treatment:
418103- I&D of all open wound, traction pin, ORIF rt hip fracture 4/10,

Recommendations:
ORIF rt hip fx, wound carelclosure lt thigh and leg wounds. Low chance of fracture fixation success, will likely require hip prosthesis in the next few months

Special Needs:
~~crutches for up to 3 months, extended dressing changes to left thigh and leg up to 4 months~~

Prognosis: Guarded

Physician: (b)(6)-2 LT Dept of Orthopedics 4/24/2003

MEDCOM - 5031

(b)(3)-1

MEDICAL TREATMENT FACILITY

(b)(3)-1

LIFT OF OPPORTUNITY

NAME (LAST, FIRST, MIDDLE)				SOCIAL SECURITY NUMBER	
(b)(6)-4					
RANK/RATE	OFFICERS ONLY DESIG NOBC	ENLISTED NEC		BIRTH DATE	SEX
BRANCH OF SERVICE	NAMED AND ADDRESS OF PARENT MILITARY COMMAND			SHIP HOMEPORT	
UIC	BLOOD TYPE	RELIGIOUS PREFERENCE	MARITAL STATUS	IS SPOUSE ACTIVE DUTY	NUMBER OF DEPENDENTS
NAME OF NEXT OF KIN (NOK)				RELATIONSHIP OF NOK	
ADDRESS OF NOK				PHONE NUMBER OF NOK	

PRINTED NAME OF PATIENT RECEIVING FLIGHT TRAINING

SIGNATURE OF PATIENT

PRINTED NAME OF MEDHOLD COORDINATOR

SIGNATURE OF MEDHOLD COORDINATOR

(b)(6)-2 MD LT MC USNR

(b)(6)-2 MD

PRINTED NAME OF ATTENDING PHYISICIAN

SIGNATURE OF ATTENDING PHYSICIAN

MEDCOM - 5032

(b)(3)-1

Name: (b)(6)-4

CHCS Name (b)(6)-4

(b)(6)-4 Iraqi civilian

Prognosis: Guarded

Date of Admission: 41812003

Date of Transfer:

History:

Unknow Age Iraqi presented to (b)(3)-1 4 days slp I&D of rt open hip fx and complex wounds of lt thigh and leg from multiple GSW

Hospital Course:

Treated w/I&D of wounds and ORIf of hip fx. Partialsciaticnerve palsy resolving. Treated w/ local wound care to left leg wounds. Recoved nicely. Fracture location has high failure rate and may require hemiarthroplasty as salvage operation later,

Diagnoses:

Open right hip Fx; GSW lt thigh & leg, peroneal nerve palsy:

Surgeries/Treatmen

418103- I&D of all open wound, traction pin; ORIF rt hip fracture 4110;

Recommendations:

ORIF rt hip fx, wound carelclosure lt thigh and leg wounds. Low chance of fracture fixation success, will likely require hip prosthesis in the next few months

SpecialNeeds:

crutches for up to 3 months, may need hip prosthesis of femoral head resection if fx doesn't heal

Physician:

(b)(6)-2 CDR Dept of Orthopedics

5/3/2003

MEDCOM - 5033

USNS COMFORT (T-AH-20)

Perioperative Plan Of Care & Nursing Note

Patient Assessment For Surgery - Potential For Injury - **Outcome:** Patient is free from signs and symptoms of injury ☒ Yes ☐ No

Trauma# or Patient #

Diagnosis: (L) Thigh/Calf Wound **Planned Procedure:** I+D/Closure (L) Thigh/Calf Wound

Date: 4/25/03 Arrival Time: 0750 0740 Interviewer: LT (b)(6)-2

Side: ☐ N/A ☐ Right ☐ Left Age: 58 HT: WT:

From: ☐ CASREC ☐ ICU ☒ Ward ____ ☐ OTHER:

Transport Via: ☒ Gurney ☐ Litter ☐ Ambulated ☐ Wheelchair ☐ Other

Patient ID: ☐ Trauma card ☐ Verbal ☒ Chart ☐ Armband ☐ Other

Blood Ordered: ☒ N/A ☐ Yes ☐ Consent ☐ TIC #Units ☐ T/H #Units Comments:

Surgical/Anesthesia Consent Verified: ☒ Procedure ☐ Consent complete, dated, signed ☐ Emergent case; no consent, MD note — Indicated in Progress note

Preop Labs (HCG, etc): ☐ None ☒ Yes Test/Results:

Drug/Latex Allergies: ☐ NKDA Allergy/Reaction: Undetermined

Present On Admission: ☒ N/A ☐ Oxygen ☐ IV Site: #1 ____ #2 ____ ☐ Foley ☐ Endotrachial Tube ☐ Arterial Line Site: ____ ☐ Drain(s) ☐ Chest Tube(s) ☐ See RN Note # ____

Past Medical History: ☐ None known ☐ Smoker ppd/yrs ___/___ ☐ ETOH ☐ Asthma ☐ HTN ☐ CAD ☐ CBR exposure ☐ GERD

Past Surgical History: ☐ None known ☐ Yes List:

Cultural Needs Addressed: ☒ Yes ☐ No List: Interpreter available

Pre-Op Pain: ☐ No ☒ Yes Level ____ (0-10) Action Taken: Referred to Anesthesia Location/type:

Last PO Intake: (date/time) Solid: 4/24/03 Liquid: /

In Chart: ☐ H&P ☒ Yes ☐ No ☐ EKG ☒ Yes ☐ No ☐ CXR ☐ Yes ☐ No ☐ Other:

Skin Condition: ☒ Intact ☐ Other: Dressing to (L) Thigh/Calf

Limitations: ☐ N/A ☒ Language ☐ Mobility ☐ Other: Arabic only ☐ Auditory ☐ Visual ☐ Prosthesis

Personal Items: ☒ None ☐ Military gear ☐ Glasses ☐ Dentures ☐ Jewelry/wallet ☐ Other Disposition:

Potential For Anxiety – **Outcome:** Patent demonstrates knowledge of psychological responses to an invasive procedure ☐ Yes ☐ No

Mental/Emotional Status: ☒ Alert/Oriented ☐ Disoriented ☐ Anxious ☐ Appropriate for age ☐ Other ☒ Calm ☐ Sedated ☐ Unresponsive

Comfort Measures Implemented: ☐ Clear, concise explanations ☐ Communicated patient concerns to other staff members ☒ Remain with patient during induction

Pre-op Teaching Included: ☒ N/A due to patient condition ☐ Physical layout of OR ☐ Personnel present during procedure ☐ Environment (noise, temperature, etc.) ☐ Post-op expectation (PACU, drains, etc.)

Potential For Impaired Skin Integrity Related To Surgical Procedure – **Outcome:** Patient is injury free ☐ Yes ☐ No

Operative Position: ☒ Supine ☒ Prone ☐ Jackknife ☐ Lithotomy ☐ Other: ☐ Beach chair ☐ Sitting ☐ Lateral L I R

Positional Aids: ☒ Arms <90 Armboard: ☐ L ☐ R Tucked: ☐ L ☐ R ☐ Airplane ☐ Fracture Table ☐ Hand Table ☐ Stirrups ☐ Other: ☐ Axillary roll ☐ Gel Pad ☐ Leg Holder ☐ Tape ☐ Bean Bag ☐ Gel donut ☐ Pillows ☐ Wilson Frame Comments:

ESU # ____ Pad Site: (L) Thigh Pad Lot # 61277 Site Clear at end of case? ☐ No ☐ Yes If No, see RN note # ____ Bipolar: ___ Max Cut ___ Coag

DVT Prevention: SCD used ☒ No ☐ Yes Pressure: ___ ☐ Left ☐ Right Teds: ☐ No ☐ Yes Bair Hugger used: ☒ No ☐ Yes Other warming techniques:

☐ Arm ☐ Leg Tourniquet: # ____ ☐ Left ☐ Right ☐ webril applied Applied by: Applied by: Total Min: Total Min: Comments:

(b)(6)-4

Comments:

(b)(3)-1

Potential For Infection ... tcome: Appropriate Actions Taken to Prev... ection ☐ Yes ☐ No

Wound Classification: ☐ I ☒ II ☐ III ☐ IV

Shave Prep: ☐ Shave ☒ Clipper
Area: (L) Thigh By: (b)(6)-2

Skin Prep: ☐ Betadine Scrub ☒ Hibiclens ☐ Duraprep ☐ Other:

Solutions/Medications: ☒ Normal saline ☐ Sterile water ☐ Local ____ ☐ Antibiotics ____ ☐ Other: ____

Drains/Packing: ☒ None
☐ Foley FR: ____
☐ JP #1 Fr ___ Location: ____ #2 Fr ___ Location: ____
☐ Hemovac: Size ____ Location ____
☐ Chest tube: Location ____
Size ____ H20 Pressure: ____
☐ Packing: type/location: ____
☐ See RN Note # ____ for comments

Dressing: Location: ____

☐ ABD	☐ Cervical Collar	☐ Kling	☐ Sten-strips	☐ Benzoin
☒ Ace	☐ Coban	☐ Immobilizer	☐ Tape	☐ Mastisol
☐ Bias	☐ Drip Pad	☒ Plains	☐ Webril	☐ Bacitracin
☐ Band-Aid(s)	☐ Fluffs	☐ Sling	☐ Xeroform	
☐ Cast	☒ Kerlix	☐ Splint	☐ Other:	

Miscellaneous

Counts: (initials)
Scrub: ____ RN: ____

Correct?			
Sharps	☒ Yes	☐ No	☐ N/A
Sponges	☒ Yes	☐ No	☐ N/A
Instruments	☐ Yes	☐ No	☐ N/A

See RN note # ____ for additional comments

Xray: ☒ None ☐ Portable ☐ C-Arm ☐ Other:

Skin Integrity: ☒ Clear & Intact (other than incision)
Comments: ____
☐ See RN note # for additional comments.

Implants:
Item I Lot # / Exp Date:

See RN note # ___ for additional comments.

Discharge from Operating Room

Complications: ☒ None comments: ____
See RN note # ____ for additional comments

Transport From OR: ☒ Gurney w/ siderails up ☐ Litter w/ safety strap in place ☐ w/ Oxygen ☐ w/ Monitor ☐ Other:

Transferred To: ☒ PACU ☐ ICU ☐ Medivac ☐ Ward ____ ☐ Other

Report by: ☐ Anesthesia provider ☐ RN

Surgical Procedure Performed: I + D, Wound Closure (L) LE Wounds

RN Note: (number each note to corresponding area above)

Initial/Name Box: (please print)

(b)(6)-2
Primary OR RN Signature — Date 4/25/03

Relief OR RN Signature — Date/Time

2/2

AN...OTIC:
TIME GIVEN:
OTHER:

NNMC 6320/16 (05/91)
RECOVERY ROOM RECORD
NAVMED 6320/16 (REV. 11-77) S/N 0105-LF-206-3281

ALLERGIES

OPERATION PERFORMED	AGENTS AND TECHNICS OF ANESTHESIA

HOUR(S) 15 30 45 15 30 45 15 30 45

TEMPS: 220 200 180 160 140 120 100 80 60 40 20

RESP. RATE

NUMBERS FOR REMARKS

al
l:
to
tor
hm
art
v
cuff
e = .
t:

OXYGEN THERAPY

ROUTE	L/M	%	ON	OFF
MASK				
T-BAR				
VENTILAT.				

FLUID THERAPY

TYPE	5% D/RL	BLOOD	SALINE	OTHER
OPERATING ROOM				
RECOVERY ROOM				
TOTAL				

BLOOD LOSS IN OR: ______ CC

WARD PRE-OP BP / mmHg

TUBES: ☐ N/G ☐ FOLEY

IV IN (R) H c̄ 300 cc 18g
OF LR AT KVO cc/hr ~~ACW~~ TOW

IV IN (L) FA c̄ ~~500~~ cc 18g
OF ~~NS~~ AT ______ cc/hr TOW

ART. LINE IN

T-TUBES, HEMOVAC IN

ADMISSION	DISCHARGE
FROM MOR/SPEC. STUDY	TO WARD
DATE ______ HRS ______	DATE ______ HRS ______
DRESSINGS: LOCATIONS	
STATUS:	STATUS:
ENDOTRACHEAL TUBE – ORAL OR NASAL	
☐ YES ☐ NO	☐ YES ☐ NO
AIRWAY /BREATH SOUNDS	
☐ CLEAR ☐ PLAST AIRWAY ☐ OBSTRUCTS EASILY	STATUS:

	MOR	PACU	URINARY OUTPUT		DRAINAGE		
TIME							
CC							
TOTAL							
SP. GR							
S/A							

REMARKS *(AS NUMBERED)* AND PERTINENT PATIENT PROGRESS NOTES

1) ACW from MOR accompanied by

PMH:

Neuro:

Pain Yes/No Action:

CV: IV:

Other:

(CONT'D ON REVERSE)

POST-ANESTHESIA RECOVERY SCORE (ALDRETE SCORE)			A	D
Able to move 4 extremities voluntarily or on command	2	Activity		
Able to move 2 extremities voluntarily or on command	1			
Able to move 0 extremities voluntarily or on command	0			
Able to deep breathe and cough freely	2	Respiration		
Dyspnea or limited breathing	1			
Apneic	0			
BP±20% of preanesthetic level	2	Circulation		
BP±20-50% of preanesthetic level	1			
BP±50% of preanesthetic level	0			
Fully awake	2	Consciousness		
Arousable on calling	1			
Not responding	0			
Pink	2	Color		
Pale, dusky, blotchy, jaundiced, other	1			
Cyanotic	0			
		TOTALS		

NAUSEA AND VOMITING: ☐ NO ☐ YES → 1 2 3 4 5 6 TIMES

CAUDAL, SPINAL, OR EPIDURAL BLOCK
MOVEMENT PRESENT AT ______ HRS
SENSATION PRESENT AT ______ HRS

CONDITION ON TOW: ☐ GOOD ☐ FAIR ☐ POOR ☐ CRITICAL

RECOVERY:
☐ COMPLICATED
☐ UNEVENTFUL

PATIENT'S IDENTIFICATION:
(b)(6)-4

SIGNATURE OF RECEIVING AND RELEASING OFFICERS	ACW
	TOW

MEDCOM - 5036

NAVMED 6320/18 (BACK)

HOUR(S)	15	30	45	15	30	45	15	30	45	15	30	45	15
TEMPS: 220													
200													
180													
160													
140													
120													
100													
80													
60													
40													
20													
RESP. RATE													
NUMBERS FOR REMARKS													

Spinal Level:

EKG Rhythm

BP art

BP cuff

Pulse = •

Sat:

MEDICATIONS

TIME	DRUG	DOSE	ROUTE	NURSE

REMARKS (AS NUMBERED) AND PERTINENT PATIENT PROGRESS NOTES (CONT'D FROM FRONT)

(12) Nasal cannula at 2L Sat 99%. (13) Pt tolerating 2L O_2 98%. (b)(6)-2
(14) Unit 2 of blood being hung. 2152. (15) 2225 Blood finished.
(16) Blood warmer used for Both transfusions (17) Pt meets all criteria per [illegible], V/S stable (b)(6)-2 [illegible]

TOW Note: Neuro:

Pain: Yes/No Action:

Pulmonary:

CV: EKG Rhythm: IV:

Skin/Wound: Drainage Yes/No Color: Edema Yes/No

GI:

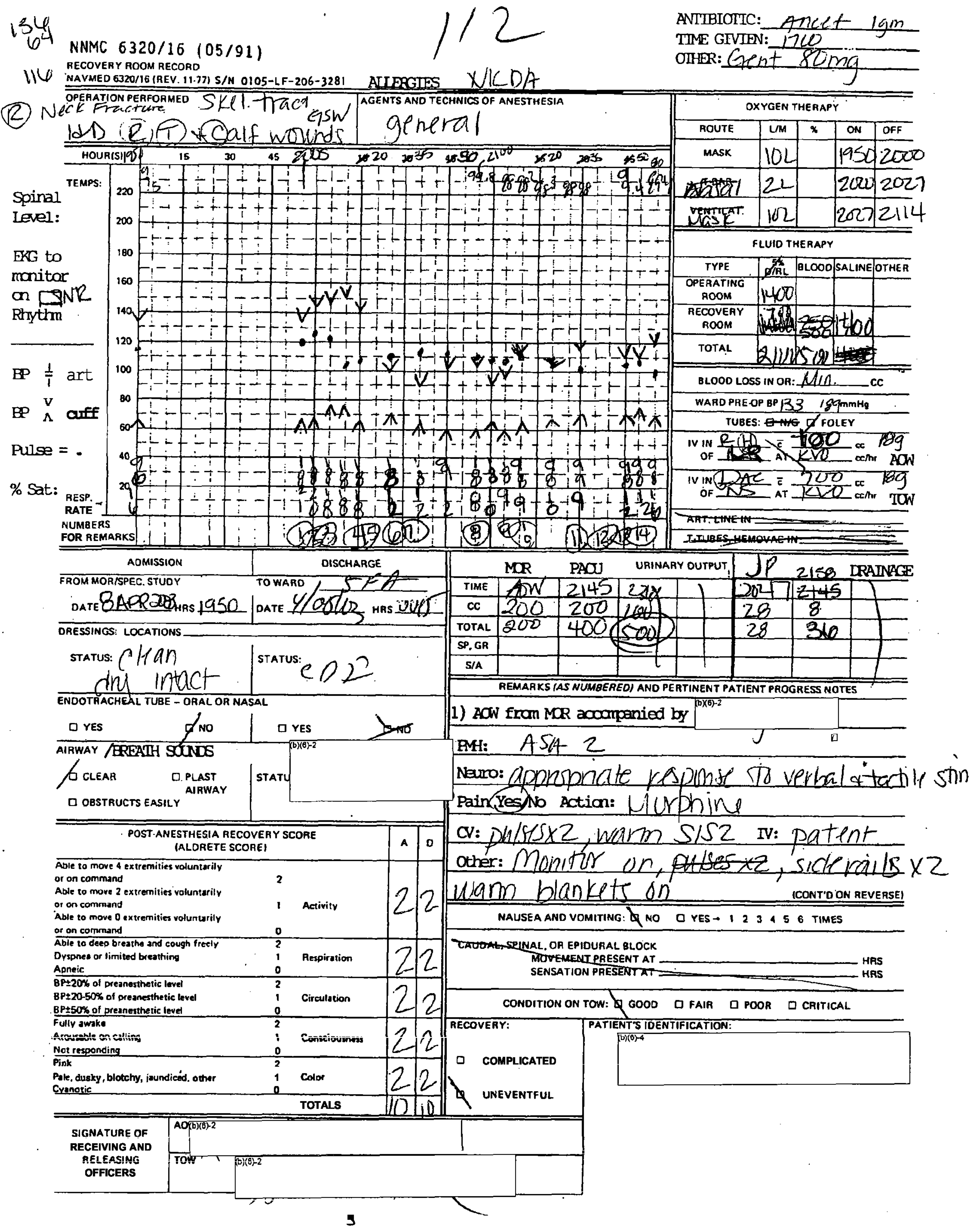
GU: Foley Yes/No Color of urine: Due to void:

Instructions/Interventions in PACU:

Report called to: By:

TOWed to: By:

MEDCOM - 5037



134 / 64 / 116 — 1/2

NNMC 6320/16 (05/91)
RECOVERY ROOM RECORD
NAVMED 6320/16 (REV. 11-77) S/N 0105-LF-206-3281

ALLERGIES: NKDA

ANTIBIOTIC: Ancef 1gm
TIME GIVEN: 1700
OTHER: Gent 80mg

OPERATION PERFORMED: (R) Neck Fracture; Skel. Traction; GSW I&D (R)(T) + calf wounds

AGENTS AND TECHNICS OF ANESTHESIA: general

Spinal Level:

EKG to monitor on ☐ SNR Rhythm

BP ┼ art
BP ∨∧ cuff
Pulse = •
% Sat:

HOUR(S) 1950 — 15 — 30 — 45 — 2005 — 2020 — 2035 — 2050 — 2100 — 2120 — 2135 — 2150

TEMPS: 220 / 200 / 180 / 160 / 140 / 120 / 100 / 80 / 60 / 40 / 20

RESP. RATE

NUMBERS FOR REMARKS: 1 2 3 4 5 6 7 8 9 10 11 12 13 14

OXYGEN THERAPY

ROUTE	L/M	%	ON	OFF
MASK	10L		1950	2000
Nasal	2L		2000	2027
Mask	10L		2027	2114

FLUID THERAPY

TYPE	5% D/RL	BLOOD	SALINE	OTHER
OPERATING ROOM	1400			
RECOVERY ROOM	[illegible]	500	400	
TOTAL	2[illegible]	500	[illegible]	

BLOOD LOSS IN OR: Min. cc
WARD PRE-OP BP 133/189 mmHg
TUBES: ~~N/G~~ ☑ FOLEY
IV IN R (H) OF LR ē 100 cc AT KVO cc/hr — 18g AOW
IV IN (L) LAC OF NS ē 700 cc AT KVO cc/hr — 18g TOW
~~ART. LINE IN~~
~~T-TUBES, HEMOVAC IN~~

ADMISSION
FROM MOR/SPEC. STUDY
DATE 8APR2003 HRS 1950

DISCHARGE
TO WARD SFA
DATE 4/08/03 HRS 2145

DRESSINGS: LOCATIONS
STATUS: clean dry intact
STATUS: c/d/i

ENDOTRACHEAL TUBE – ORAL OR NASAL
☐ YES ☑ NO
☐ YES ~~NO~~

AIRWAY / BREATH SOUNDS
☑ CLEAR ☐ PLAST AIRWAY
☐ OBSTRUCTS EASILY
STATUS (b)(6)-2

URINARY OUTPUT

	MOR	PACU		
TIME	AOW	2145	2200	
CC	200	200	100	
TOTAL	200	400	500	
SP. GR				
S/A				

DRAINAGE: JP

		2150
TIME	2047	2145
CC	28	8
TOTAL	28	36

REMARKS (AS NUMBERED) AND PERTINENT PATIENT PROGRESS NOTES

1) AOW from MOR accompanied by (b)(6)-2

PMH: ASA 2

Neuro: appropriate response to verbal & tactile stim

Pain (Yes)/No Action: Morphine

CV: pulses x2, warm S1S2 IV: patent

Other: Monitor on, ~~pulses x2~~, siderails x2 warm blankets on

(CONT'D ON REVERSE)

NAUSEA AND VOMITING: ☑ NO ☐ YES → 1 2 3 4 5 6 TIMES

~~CAUDAL, SPINAL, OR EPIDURAL BLOCK~~
MOVEMENT PRESENT AT ______ HRS
SENSATION PRESENT AT ______ HRS

CONDITION ON TOW: ☑ GOOD ☐ FAIR ☐ POOR ☐ CRITICAL

POST-ANESTHESIA RECOVERY SCORE (ALDRETE SCORE)

			A	D
Able to move 4 extremities voluntarily or on command	2	Activity	2	2
Able to move 2 extremities voluntarily or on command	1			
Able to move 0 extremities voluntarily or on command	0			
Able to deep breathe and cough freely	2	Respiration	2	2
Dyspnea or limited breathing	1			
Apneic	0			
BP±20% of preanesthetic level	2	Circulation	2	2
BP±20-50% of preanesthetic level	1			
BP±50% of preanesthetic level	0			
Fully awake	2	Consciousness	2	2
Arousable on calling	1			
Not responding	0			
Pink	2	Color	2	2
Pale, dusky, blotchy, jaundiced, other	1			
Cyanotic	0			
		TOTALS	10	10

RECOVERY:
☐ COMPLICATED
☑ UNEVENTFUL

PATIENT'S IDENTIFICATION: (b)(6)-4

SIGNATURE OF RECEIVING AND RELEASING OFFICERS
AOW (b)(6)-2
TOW (b)(6)-2

5

MEDCOM - 5038

NAVMED 6320/16 (BACK)

HOUR(S) 2209 15 20 30 35 45 50 15 20 30 35 45 50 15 30 45 15 30 45 15

TEMPS: 98.1 98.9 98.9

Spinal Level:

EKG Rhythm

BP art

BP cuff

Pulse =

% st:

REST. RATE

NUMBERS FOR REMARKS (15)

MEDICATIONS

TIME	DRUG	DOSE	ROUTE	NURSE
2011	Fentanyl	25mg	IV	(b)(6)-2
2020	Fentanyl	25 mg	IV	(b)(6)-2
2023	Demerol	25 mg	IV	(b)(6)-2

REMARKS (AS NUMBERED) AND PERTINENT PATIENT PROGRESS NOTES (CONT'D FROM FRONT)

(2) Fentanyl 25mg given for pain (3) Traction Dr. here. Pain seems relieved by meds. (4) Fentanyl for pain (5) Demerol for shivering (6) Face Mask 10L placed, sat 75% drop. (7) X-ray taken (7) Pt tolerating movement well, no longer shivering. (8) 1 unit of blood being hung up. (9) 4L nasal can. placed (10) tolerating 4L of O_2 sat 98%. (11) 2135 Unit 1 of blood finish

TOW Note: Neuro: appropriate verbal and tactile stimuli response

Pain: Yes/(No) Action:

Pulmonary: clear, O_2 @ 2L/NC /min O2 sat >95%

CV: warm, S1S2, pulses x2 EKG Rhythm: NSR IV: patent

Skin/Wound: clean dry drsg. Drainage Yes/(No) Color: Edema Yes/(No)

GI: oral cavity intact N/V

GU: Foley (Yes)/No Color of urine: yellow clear Due to void:

Instructions/Interventions in PACU: Transfused due to low H&H.

Report called to: (b)(6)-2 By: (b)(6)-2

TOWed to: 5 Fwd [illegible] By: (b)(6)-2

*U.S. Government Printing Office: 1991 — 504-109/20525 2-1

MEDCOM - 5039

ALLERGIES:

DATE ORD.	DATE RENEW	MEDICATIONS	TIME (HOURS TO BE GIVEN)	DATE OF ORDER	LABORATORY/DIAGNOSTIC TESTS EXAMINATIONS/ CONSULTATIONS	DATE SENT	DATE COMP
4-15		Percocet ii PO Q6°	06-12 18-24	4-15	Duplex of LE R/O DVT	X	
4-15		Colace 100mg PO BID	09-21				
~~4-15~~		~~Atrovent inh 2puffs Q~~ error (b)(6)-2		4-16	RPR, HIV, CBC, PT/INR		4/16
4/18		Lovenox 30 mg Sq bid	09, 21				
4/19		MVI 1 tab PO QD	0900	4/16	Gram stain	X	
4/19		FeSO4 325mg TID c meals	07, 12, 17	4/16	Wound culture	X	
4/23		Septra DS BID x 3 days	09, 21	4/16	Giemsa stain	X	
		For 6 doses		4/16	CBC c diff 4/17	X	
4/25		Septra DS i po bid x 24°		4/17	~~PT/INR~~ / CBC 4/18	X	
				4/19	CBC c [illegible] in AM	4/20	X
				4/19	X-ray AP / Lat		
					(R) wip 4/20		
				4/17	UA / C+S	X	4/26
4/23	4/25	Percocet i-ii PO q 4-6° PRN					
4-15		Atrovent inh 2 puffs Q2° PRN					
4-15		MSO4 6mg Q4° IV PRN					

ADDRESSOGRAPH

(b)(6)-4

MEDCOM - 5040

PATIENT PROFILE
NAVMED 6550/12 (5.801 S/N 0105-LF-206-5560

NKDA

√	ACTIVITY	DATE	√	BATH	DATE	DIET	DATE	√	VITAL SIGNS	FREQ	√	SPECIAL NOTES
	Bedrest			Bed bath		NPO			Temp			Dentures
	Bathroom Privileges			Shower					Pulse			Speech impediment
√	Up in chair			Tub		Reg	4-15		Resp			Language barrier
	Ambulate			Needs assistance		4/25			B/P			Prosthetic device
	Commode								Other			Visual impairment
	Needs assistance											Blind
	Restricted to unit											Contact lenses
	Hospital Privileges			ORAL HYGIENE	DATE							Glasses
	Other			Self		FEEDING	DATE		FLUIDS			Hearing defect
	OOB to chair with assistance	4/..		Needs assistance		Self			Forced to:			Other
				Special		Needs assistance			Restricted to:			
						Gavage			I & O			

DATE ORD.	DATE RENEW	TREATMENTS/SPECIAL NOTES	TIMES	DATE ORD.	DATE RENEW	TREATMENTS/SPECIAL NOTES	TIMES
4-15		Detrol - 1V (b)(6)-2		4-15	IVF	NS @100cc/hr	
4-15		NWB on Rt leg ↑ notes		4/17		Transfuse ↑ 4 PRBC	
4-15		Wound Vac - wet-to-dry on Ⓛ thigh + leg wounds		4/20		Consult PT - gait training / NWB Ⓡ LE	
4/25		please have pt sleep on stomach to help c̄ developing hip flexion contracture		4/23		LOO dmc	
				4/24		OR 4/25	
4/25		No pillows under knees		4/24		hold Lovenox	
4/25		remove post op dsg in 72° 28 Apr @ 1000		4/24		pt must sleep on stomach	
4/26		PT for hip extension rehab (called)					
4/24		make sure pt has enough Septra for discharge Fesol, colace, Percocet, Motrin					
				4-18		Condition - [illegible]	

ADDRESSOGRAPH

Level I

(b)(6)-4

DIAGNOSIS: s/p [illegible] Ⓛ leg + Ⓡ [illegible] sciatic [illegible]

AGE	HEIGHT	WEIGHT

PATIENT CLASSIFICATION: Stable

OP/SPECIAL PROCEDURES: [illegible] I + D 4/25

	DATE ON	DATE OFF
SI		
VSI		
RELIGIOUS RITES		

FINDINGS:

MEDCOM - 5041

NAVMED 6550/8 (REV. 4-74) S/N 0105-LF-216-5581

MEDICAL RECORD	MEDICATION ADMINISTRATION RECORD

SCHEDULED DRUGS — MONTH ______ 19 ____ DATES GIVEN

ORDER DATE	MEDICATION- DOSAGE- FREQUENCY ROUTE OF ADMINISTRATION	HOURS	4-15	4-16	4-17	4-18	4-19	4-20	4-21
4-15	Percocet II PO Q6°	0600	X	(b)(6)-2					
		1200	X						
	R= REFUSED	1800	(b)(6)-2						
		2400	(b)(6)-2						
4-15	Colace 100mg PO BID	0900							
		2100	(b)(6)-2						
4/18	Lovenox 30 mg sq bid	0900	(b)(6)-2						
		2100	X	X	X	(b)(6)-2			
4/19	MVI 1 tab PO QD	0900					(b)(6)-2		
4/19	FeSO4 325mg TID c̄ meals	0700					X	(b)(6)-2	
		1200					(b)(6)-2		
		1700							

INITIAL CODE

INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE
(b)(6)-2	(b)(6)-2	(b)(6)-2		(b)(6)-2	
(b)(6)-2	(b)(6)-2	(b)(6)-2		(b)(6)-2	
		(b)(6)-2		(b)(6)-2	
		(b)(6)-2		(b)(6)-2	BNS, NC

ADDRESSOGRAPH PLATE

(b)(6)-4

WARD NO.

Injection Site Code

① = Left Buttock ⑤ = Left Leg
② = Right Buttock ⑥ = Right Leg
③ = Left Deltoid ⑦ = Left Arm
④ = Right Deltoid ⑧ = Right Arm
= Abdomen

SINGLE DOSE, PRE- OP PRN & VARIABLE DOSE ORDERS SEE REVERSE

1 of 2

MEDCOM - 5042

MEDICATION ADMINISTRATION [illegible]RD (Back) S/N 0105-LF-216-5581

SINGLE ORDERS - PRE-OPERATIVE

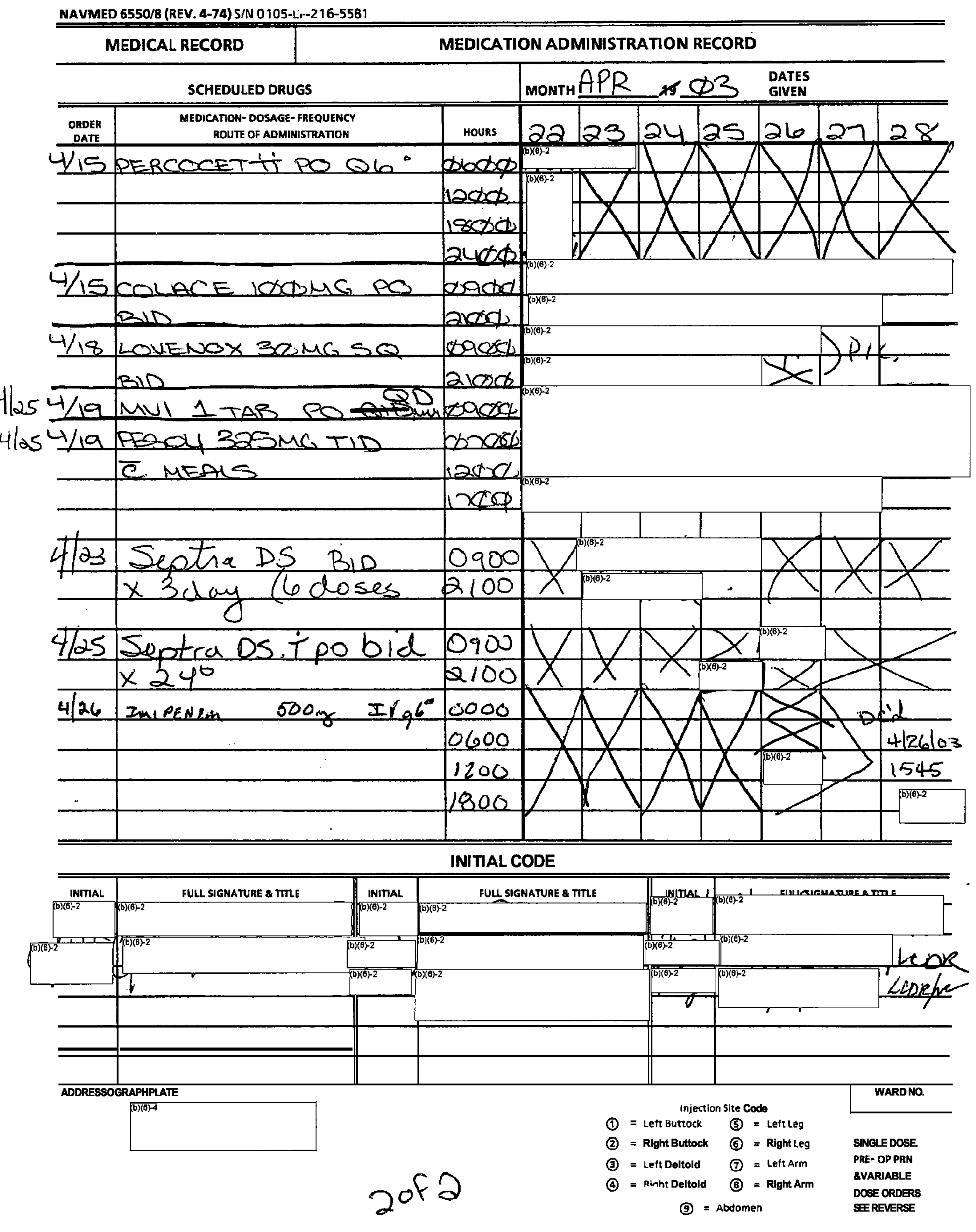
MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	GIVEN TIME	GIVEN INITIAL	MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	GIVEN TIME	GIVEN INITIAL
Coumadin 5mg PO NOW	16 Apr	1115	(b)(6)-2				

PRN AND VARIABLE DOSE MEDICATIONS

ORDER DATE	MEDICATION-DOSAGE FREQUENCY ROUTE OF ADMINISTRATION		DOSES GIVEN															
4-15	MSO4 6mg	DATE	4/15	4/16	16 Apr	16 Apr	16 Apr	18 Apr	19/4	4/21								
	Q4° IV PRN	TIME	1430	0249	0520	0930	1850	2035	0412	2230								
		DOSE	6mg	6mg	6mg	5mg	6mg	6mg	6	6mg								
		INIT.	(b)(6)-2															
4-15	Atrovent inh.	DATE																
	2 puffs Q2°	TIME																
	PRN	DOSE																
		INIT.																
		DATE																
		TIME																
		DOSE																
		INIT.																
		DATE																
		TIME																
		DOSE																
		INIT.																
		DATE																
		TIME																
		DOSE																
		INIT.																
		DATE																
		TIME																
		DOSE																
		INIT.																
		DATE																
		TIME																
		DOSE																
		INIT.																

MEDCOM - 5043

NAVMED 6550/8 (REV. 4-74) S/N 0105-LF-216-5581



MEDICAL RECORD	MEDICATION ADMINISTRATION RECORD

SCHEDULED DRUGS — MONTH APR ~~19~~ 03 — DATES GIVEN

ORDER DATE	MEDICATION- DOSAGE- FREQUENCY ROUTE OF ADMINISTRATION	HOURS	22	23	24	25	26	27	28
4/15	PERCOCET ÏÏ PO Q6°	0600	(b)(6)-2		X	X	X	X	X
		1200	(b)(6)-2	X	X	X	X	X	X
		1800		X	X	X	X	X	X
		2400		X	X	X	X	X	X
4/15	COLACE 100MG PO	0900	(b)(6)-2						
	BID	2100	(b)(6)-2						
4/18	LOVENOX 30MG SQ	0900	(b)(6)-2					D/C	
	BID	2100	(b)(6)-2				X		
4/25 4/19	MVI 1 TAB PO ~~BID~~ QD	0900	(b)(6)-2						
4/25 4/19	FESO4 325MG TID	0700							
	C̄ MEALS	1200							
		1700	(b)(6)-2						
4/23	Septra DS BID	0900	X	(b)(6)-2			X	X	X
	x 3day (6 doses	2100	X	(b)(6)-2					
4/25	Septra DS. Ï po bid	0900	X	X	X	X	(b)(6)-2	X	
	x 24°	2100	X	X	X	(b)(6)-2	X	X	
4/26	Imipenem 500mg IV q6°	0000	X	X	X	X	X		D/C'd
		0600	X	X	X	X	X		4/26/03
		1200	X	X	X	X	(b)(6)-2		1545
		1800	X	X	X	X	X		(b)(6)-2

INITIAL CODE

INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE
(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2
(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2 LCDR
		(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2 Ledeker

ADDRESSOGRAPHPLATE (b)(6)-4

WARD NO.

Injection Site Code
① = Left Buttock ⑤ = Left Leg
② = Right Buttock ⑥ = Right Leg
③ = Left Deltoid ⑦ = Left Arm
④ = Right Deltoid ⑧ = Right Arm
⑨ = Abdomen

SINGLE DOSE PRE- OP PRN &VARIABLE DOSE ORDERS SEE REVERSE

2 of 2

MEDCOM - 5044

MEDICATION ADMINISTRATIO' 'ORD (Back) S/N 0105-LF-216-5581

SINGLE ORDERS - PRE-OPERATIVE

MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	GIVEN TIME	GIVEN INITIAL	MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	GIVEN TIME	GIVEN INITIAL
TYLENOL 650 mg	4/25	2338	(b)(6)-2				
Benadryl 50 mg PO	4/27	0001					

PRN AND VARIABLE DOSE MEDICATIONS

ORDER DATE	MEDICATION-DOSAGE FREQUENCY ROUTE OF ADMINISTRATION		DOSES GIVEN															
4/23/03	PERCOCET I/II	DATE	4/28															
	PO q 4-6° PRN	TIME	0100															
		DOSE	2															
		INIT.	(b)(6)-2															
4/25	Percocet I-II	DATE	4/27	4/28	4/28													
	PO q 6° PRN	TIME	0410	0118	0440													
	PAIN	DOSE	II	II	II													
		INIT.	(b)(6)-2															
		DATE																
		TIME																
		DOSE																
		INIT.																
		DATE																
		TIME																
		DOSE																
		INIT.																
		DATE																
		TIME																
		DOSE																
		INIT.																
		DATE																
		TIME																
		DOSE																
		INIT.																
		DATE																
		TIME																
		DOSE																
		INIT.																

MEDCOM - 5045

b)(3)-1

Personal Data - Privacy Act of 1974 (PL 93-579)

PATIENT LAB INQUIRY

For: 20 Mar 03 - 19 Apr 03

Report requested by: (b)(6)-2

(b)(6)-4 (b)(6)-4 M/11d Reg #: (b)(6)-4

Ph: Military Unit: UNKNOWN

18 Apr 03 @ 0534 (Coll) PLASMA

Test	Result	Flag	Range	Units
PT.	20.4	H	(11.6- 14.4)	Seconds
INR	2.3			

Interpretations:
The current recommended therapeutic range for INR is 2.0-3.0 for all indications except prosthetic valves for which an INR 2.5-3.5 is recommended (Chest 108(4):231S-246S; 1995). It should be recognized that these are guidelines and adjustments may be required based on individual patient risk factors. The INR is not useful for the first 7-10 days of therapy.

18 Apr 03 @ 0534 (Coll) BLOOD

Test	Result	Flag	Range	Units
WBC	6.9		(4.8-10.8)	K/UL
RBC	2.9	L	(4.7-6.1)	1X10 6/UL
HCB.	8.6	L	(14.0-18.0)	g/dL
HCT.	25.8	L	(42-52)	%
MCV.	89.7		(80-94)	fL
MCH.	30.0		(27-32)	pg
MCHC.	33.5		(31-37)	g/dL
RDW.	13.6		(12-14)	%
PLT CNT	795	H	(150-450)	1x10 3/UL
Result Comment: NOTIFIED LT (b)(6)-2 @ 0711.KF				
MPV	7.4		(7.4-10.4)	FL
NEUT/100 WBC	66.6			%
NEUT%	4.6			1x10 3/UL
LYMPHS/100 WBC	22.3			%
LY#	1.5			1x10 3/UL
MONO/100 WBC	11.1			%
MO#	0.8			1x10 3/UL
EO#	<0.7			1x10 3/UL
BAS#.	<0.2			1x10 3/UL

L=Lo H=Hi *=Critical R=Resist S=Susc MS=Mod Susc I=Intermed
]=Uncert /A=Amended Comments= (O)rder, (I)nterpretations, (R)esult

b)(3)-1

Personal Data - Privacy Act of 1974 (PL 93-579)

PATIENT LAB INQUIRY

For: 12 Apr 03 - 13 Apr 03

Report requested by: (b)(6)-2

(b)(6)-4 (b)(6)-4 M/5d Reg #: (b)(6)-4

Ph: Military Unit: UNKNOWN

13 Apr 03 @ 0535 (Col 1) BLOOD

Test	Result	Flag	Range	Units
WBC	10.2		(4.8-10.8)	K/UL
RBC	2.8	L	(4.7-6.1)	1X10 6/UL
HCB	8.4	L	(14.0-18.0)	g/dL
HCT	25.2	L	(42-52)	%
MCV	90.1		(80-94)	fL
MCH	30.2		(27-32)	pg
MCHC	33.5		(31-37)	g/dL
RDW	13.6		(12-14)	%
PLT CNT	463	H	(150-450)	1x10 3/UL
MPV	7.8		(7.4-10.4)	FL

L=Lo H=Hi *=Critical Resist S=Susc MS=Mod Susc - ermed

MEDCOM - 5047

NAVMED 6550/8 (REV. 4-74) S/N 0105-LF-216-5581

MEDICAL RECORD	MEDICATION ADMINISTRATION RECORD

SCHEDULED DRUGS — MONTH Apr/May 19 2003 — DATES GIVEN

ORDER DATE	MEDICATION- DOSAGE- FREQUENCY ROUTE OF ADMINISTRATION	HOURS	4/28	4/29	4/30	5/1	5/2	5/3	5/4
4/28	Lovenox 30mg SQ BID	0900	X	(b)(6)-2					
		2100	(b)(6)-2						
4/19	MVI 1 Tab PO QD	0900	X	(b)(6)-2					
			X	X	X	X	X	X	X
4/19	FeSO4 325mg PO TID (crossed out)								
	ā Meals								
4/19	FeSO4 325mg PO TID	0700	X	(b)(6)-2					
	ā meals	1200	X						
		1700	(b)(6)-2						
4/15	Colace 100mg PO BID	0900	X	(b)(6)-2					
		2100	(b)(6)-2						

INITIAL CODE

INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE
(b)(6)-2	(b)(6)-2				

ADDRESSOGRAPH PLATE

(b)(6)-4

Injection Site Code

1 = Left Buttock
2 = Right Buttock
3 = Left Deltoid
4 = Right Deltoid
5 = Left Leg
6 = Right Leg
7 = Left Arm
8 = Right Arm
I = Abdomen

WARD NO. 5 FWD P

SINGLE DOSE. PRE- OP PRN &VARIABLE DOSE ORDERS SEE REVERSE

MEDCOM - 5048

MEDICATION ADMINISTRATION 'RD (Back) S/N 0105-LF-216-5581

SINGLE ORDERS - PRE-OPERATIVE

MEDICATION-DOSAGE ROUTE OF ADMINISTRATION	GIVEN			MEDICATION-DOSAGE ROUTE OF ADMINISTRATION	GIVEN		
	DATE	TIME	INITIAL		DATE	TIME	INITIAL

PRN AND VARIABLE DOSE MEDICATIONS

ORDER DATE	MEDICATION-DOSAGE FREQUENCY ROUTE OF ADMINISTRATION		DOSES GIVEN															
4/25	Percocet	DATE																
	i - ii PO	TIME																
	q6hr prn	DOSE																
	pain	INIT.																
4/28	Tylenol #3 ii	DATE	4/29	4/29	4/29	4/29	5/1	1 May	5/1	5/2	5/3	3 May	5/3	5/4				
	po q6° PRN	TIME	0211	0615	1420	2353	0311	1250	2311	5/2	0740	1310	2000	0815				
		DOSE	2	2	2	2	2	ii	2	2	2	ii	ii	ii				
		INIT.	(b)(6)-2															
	AMBIAN 25 mg	DATE	29 APR															
	PO QHS	TIME	2200															
		DOSE	25															
		INIT.	(b)(6)-2															
4/20	Meclizine 25 mg	DATE																
	PO QID PRN	TIME																
	motion sickness	DOSE																
		INIT.																
		DATE																
		TIME																
		DOSE																
		INIT.																
		DATE																
		TIME																
		DOSE																
		INIT.																
		DATE																
		TIME																
		DOSE																
		INIT.																

MEDCOM - 5049

ACLU-RDI 1259 p.22

DOD 12261

ANESTHESIA RECOR[D]

AMMC 279 (12/00)

Wt (kg) - 70 Ht (in) - Allergies - NKDA

Procedure: I+D (R) Thigh / (R) Calf, (R) Heal / [illegible]

Date: 9/18/3 | Anes. Start: 1845 | In Room: 1710 | (b)(6)-2 | LCDR/USN ANESTHESIA | Surg. Start: 1755 | Surg. End: 1930 | Anes. End: 1945 | Resident/SRNA | OR # 2 | Page 1 of 1 | See Page One

(b)(6)-2

Time	1715	30	45	1800	15	30	45	1900	15	30	45
O_2 L/M	8	1	1	1	1	1	1	1	1	8	
N_2O / Air L/M		1	1	1	1	1	1	1	X		
Vols Halo / Iso / Sevo / Des		1	1	1	1	1	.7	.7	X		
STP / Prop / Etomidate	120										
Sux / Cisatracurium	100										
Ro / Rapa / Vecuronium											
Lidocaine											
Neostigmine / Glyco											
Ephedrine / Neo											
Midazolam											
MSO_4 / Remi / Su / fentanyl	100										
Epid. Lido / Bupiv / Ropiv											
Morphine				2					2		
NS / LR			1000		1200			1400			
U/O			200								
EBL											

Totals: NS/LR 1400; U/O 200; EBL Minimal

Legend: ● = Pulse; ○ = Spont. Resp.; Ø = Asst. Resp.; ⓥ = Ventilator; X = MAP; Λ / V = NIBP; ⊥ / T = A-Line; I = Intubate; E = Extubate

(Vital signs graph, scale 40–180)

Hemocue - 7.5 @1815

PACU / ICU: Pulse - 116; BP 136/64; Temp - 97.5; RR 16; SaO_2 96; Comps - + / -

ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR
Es / Np / Or / Sk / Ax Temp									
% FiO_2	1.00	0.5	0.5	0.5	0.5	0.5	0.5	0.5	1.0
% SaO_2	100	100	100	98	100	99	100	100	100
$EtCO_2$		33	33	35	35	35	37	37	38
		0		0	0	0	0	0	0
TV		607	(V)	375	384	387	445	426	
PIP (cmH_2O)		24							
Resp. Rate		8		12	13	10	10	10	14

Checklist - ☒ O_2 ☒ Suction ☒ Machine ☐ Consent ☐ NPO

Monitors - ☒ SaO_2 ☒ ECG ☒ FiO_2 ☒ NIBP (L) / R arm ☒ $EtCO_2$ ☐ PCS / ES ☒ PNS ☐ PIP ☒ Temp ☒ Mass Spec ☐ Verbal ☐ TEE ☐ Fluid warmer ☐ Air Warm ☒ Foley ☐ FHT ☐ Pulm Art cath ☐ CVP IJ / SC / Fem L / R ☐ OG / NG L / R ☐ A-Line Rad / Fem L / R

Position - ☒ Pressure points padded ☒ Arms < 90° Supine Prone Lithotomy Sitting (Lateral) (L) / R

Drawn: Morphine 10 Used 10 Wasted 0 Witns
Drawn: Fentanyl 250 Used 175 Wasted 25 Witns [illegible]

IV - 18 Ga L / (R) Hand Wrist FA AC EJ

☐ Tourniquet ____ mmHg Times ____ ____

60 / 90 / 120 / 130 / 140 / 150 min - Surgeons informed

Antibiotics: Agent Ancef; mg 1GM; over 15 minutes; @ 1730

Gent 80mg 45" 1730-1815

Induction - (Monitors On) (Preoxygenated) (Smooth) Inhalation / (IV) (Cricoid Pressure) (Rapid Sequence) Mask ventilation easy (Y) / N

Intubation - Mac / (Mil) 2 Grade 1 view Tube Size 8 Attempts 1 (Oral) / Nasal L / R w/o (w/ Cuff) Stylet (Y) / N (Bil BS) (EtCO₂ x3) / CIN

Tube taped @ 23 cm @ (lips) / teeth / nares Trauma Y / (N) FOB / LW / Blind LMA # ____ DLT ____ Fr L / R

Maintenance - (Smooth) (Cuff checked) (Eyes taped) / lubed

Extubation - (Smooth) (Reversed) (SV) (VSS) (Full T4) (Head lift) / (Sustained tetanus) (Suctioned) (Awake) Deep

Disposition - PACU / (ICU) (SV) (VSS) (Awake) / sleepy Extubated / intubated

Patient Identification

(b)(6)-4

Prep: ☐ Sterile Technique ☐ Disposable kit ☐ Betadine prep x 3 ☐ Local infiltration ☐ Site ____ L / R ☐ Attempts ____

Blocks: ☐ Nerve Stim ____ mA ☐ Trans-arterial ☐ Dual cuff

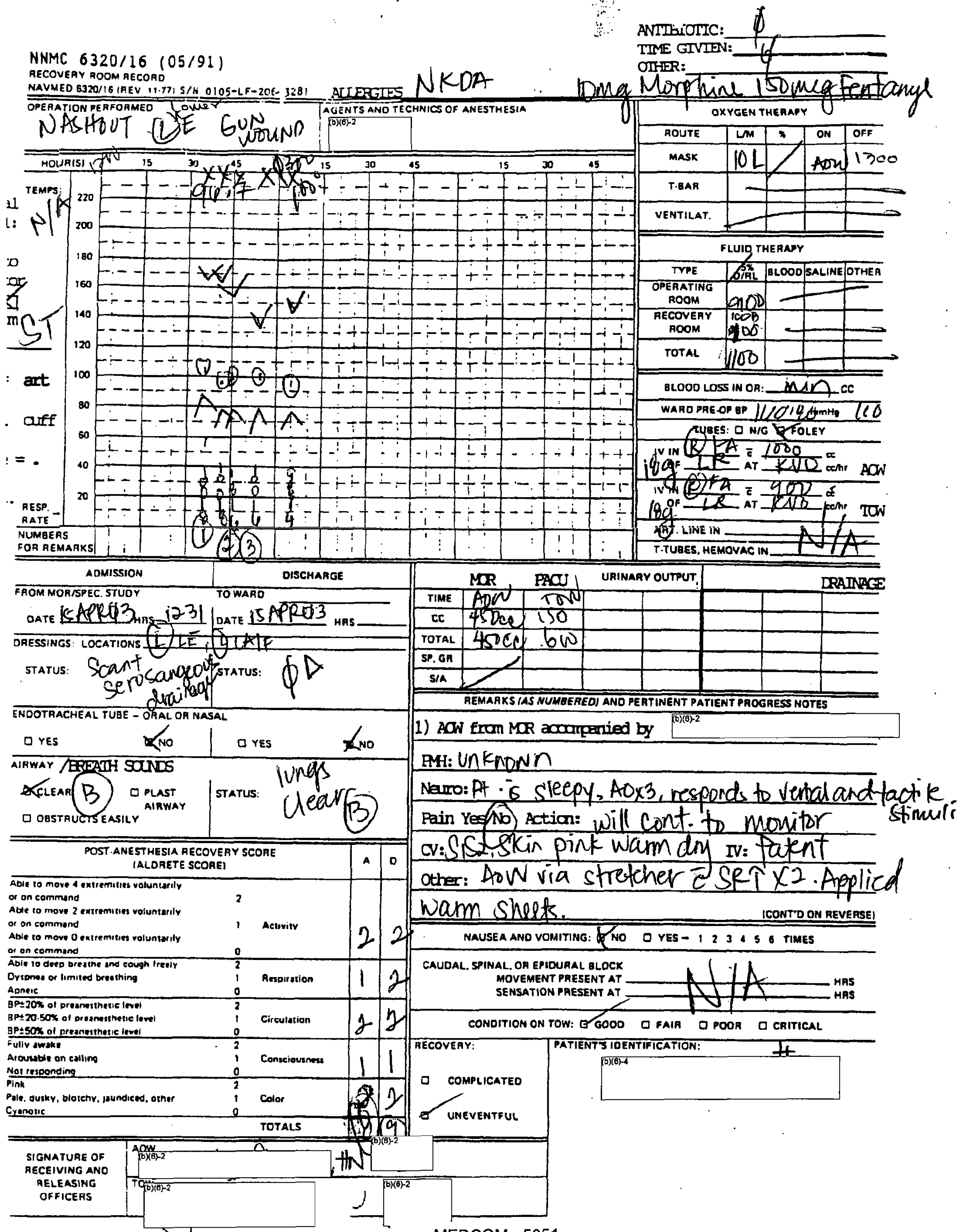
Regional: ☐ Spinal / Epidural ☐ Touhy / Whitacre / Quincke ☐ Needle guage ____ ☐ Sitting ☐ Lateral R / L ☐ LOR to Air / NS ☐ Paresthesia + / - ☐ Heme + / - ☐ CSF + / - ☐ Test dose ⊖ ☐ CSF ⊕ swi

Regional: ☐ Catheter out - tip intact ☐ Level ____

Lines: ☐ Seldinger Technique ☐ CVP manually transduced ☐ Cordis 9.5 / 8.5 Fr ☐ SLIC ☐ 2 / 3 - lumen

Comments / Drugs:

MEDCOM - 5050



ANTIBIOTIC: ∅
TIME GIVEN: ∅
OTHER: 10mg Morphine 150mcg Fentanyl

NNMC 6320/16 (05/91)
RECOVERY ROOM RECORD
NAVMED 6320/16 (REV 11-77) S/N 0105-LF-206-3281

ALLERGIES: NKDA

OPERATION PERFORMED: WASHOUT (L) LE GUN WOUND

AGENTS AND TECHNICS OF ANESTHESIA: (b)(6)-2

OXYGEN THERAPY				
ROUTE	L/M	%	ON	OFF
MASK	10 L	/	AOW	1700
T-BAR				
VENTILAT.				

FLUID THERAPY	5% D/RL	BLOOD	SALINE	OTHER
OPERATING ROOM	900			
RECOVERY ROOM	1000 / 900			
TOTAL	1100			

BLOOD LOSS IN OR: MIN cc
WARD PRE-OP BP 110/40 mmHg 100
TUBES: ☐ N/G ☐ FOLEY
IV IN (R) FA ē 1000 cc OF LR AT KVO cc/hr AOW 18g
IV IN (L) FA ē 900 cc OF LR AT KVO cc/hr TOW 18g
ART. LINE IN N/A
T-TUBES, HEMOVAC IN N/A

HOUR(S) 15 30 45 15 30 45 15 30 45
TEMPS: N/A
RESP. RATE
NUMBERS FOR REMARKS ① ② ③

ADMISSION	DISCHARGE
FROM MOR/SPEC. STUDY	TO WARD
DATE 15APR03 HRS 1231	DATE 15APR03 HRS
DRESSINGS: LOCATIONS (L) LE, (L) TALF	
STATUS: Scant serosanguous drainage	STATUS: ∅ Δ

ENDOTRACHEAL TUBE – ORAL OR NASAL
☐ YES ☒ NO | ☐ YES ☒ NO

AIRWAY / BREATH SOUNDS
☒ CLEAR (B) ☐ PLAST AIRWAY ☐ OBSTRUCTS EASILY
STATUS: lungs clear (B)

	MOR	PACU	URINARY OUTPUT			DRAINAGE		
TIME	AOW	TOW						
CC	450cc	150						
TOTAL	450cc	600						
SP. GR								
S/A								

REMARKS (AS NUMBERED) AND PERTINENT PATIENT PROGRESS NOTES
1) AOW from MOR accompanied by (b)(6)-2
PMH: UNKNOWN
Neuro: Pt ē sleepy, AOx3, responds to verbal and tactile stimuli
Pain Yes/(No) Action: will cont. to monitor
CV: SR, Skin pink warm dry IV: Patent
Other: AOW via stretcher ē SRT X2. Applied warm sheets.
(CONT'D ON REVERSE)

POST-ANESTHESIA RECOVERY SCORE (ALDRETE SCORE)			A	D
Able to move 4 extremities voluntarily or on command	2	Activity	2	2
Able to move 2 extremities voluntarily or on command	1			
Able to move 0 extremities voluntarily or on command	0			
Able to deep breathe and cough freely	2	Respiration	1	2
Dyspnea or limited breathing	1			
Apneic	0			
BP±20% of preanesthetic level	2	Circulation	2	2
BP±20-50% of preanesthetic level	1			
BP±50% of preanesthetic level	0			
Fully awake	2	Consciousness	1	1
Arousable on calling	1			
Not responding	0			
Pink	2	Color	2	2
Pale, dusky, blotchy, jaundiced, other	1			
Cyanotic	0			
		TOTALS	8	9

NAUSEA AND VOMITING: ☒ NO ☐ YES – 1 2 3 4 5 6 TIMES

CAUDAL, SPINAL, OR EPIDURAL BLOCK
MOVEMENT PRESENT AT N/A HRS
SENSATION PRESENT AT HRS

CONDITION ON TOW: ☒ GOOD ☐ FAIR ☐ POOR ☐ CRITICAL

RECOVERY: ☐ COMPLICATED ☒ UNEVENTFUL

PATIENT'S IDENTIFICATION: (b)(6)-4

SIGNATURE OF RECEIVING AND RELEASING OFFICERS
AOW (b)(6)-2 (b)(6)-2
TOW (b)(6)-2 (b)(6)-2

MEDCOM - 5051

NAVMED 6320/18 (BACK)

HOUR(S) 15 30 45 15 30 45 15 30 45 15 30 45 15

Spinal Level: N/A

EKG Rhythm: ST

BP art / BP cuff / Pulse / % Sat:

TEMPS: 220 200 180 160 140 120 100 80 60 40 20

RESP. RATE

NUMBERS FOR REMARKS

MEDICATIONS

TIME	DRUG	DOSE	ROUTE	NURSE
1253	MORPHINE	2mg	IV PUSH	Lt. (b)(6)-2
1304	MORPHINE	2mg	IV PUSH	Lt. (b)(6)-2

REMARKS (AS NUMBERED) AND PERTINENT PATIENT PROGRESS NOTES (CONT'D FROM FRONT)

(2) Pt. is resting comfortably and has Ø c/o any pain or discomfort. Will cont. to monitor. (KBW) (3) Pt. medicated for pain per doctor's order. Unable to assess pain level due to language. (KBW) (4) Pt. medicated for pain per doctor's order. (b)(6)-2

TOW Note: Neuro: Pt. is sleepy, Responds to verbal and tactile stimuli

Pain: Yes/No (No) Action: Pt. has Ø c/o pain. Will cont. to monitor

Pulmonary: lungs clear (B), SPO2 ≥ 95% on RA

CV: S1S2, Skin warm dry, color appropriate for ... EKG Rhythm: ST IV: Patent

Skin/Wound: DLE, Scant serosanguinous drainage Drainage Yes/No (Yes) Color: scant serous Edema Yes/No (No) Ø

GI: Pt. has Ø c/o n/v. Bowel sounds present x 4 quads. (b)(6)-2

GU: Foley Yes/No (No) (b)(6)-2 Color of urine: light yellow Due to void: 1831 N/A

Instructions/Interventions in PACU:

Report called to: ENS (b)(6)-2 By: (b)(6)-2 RN

TOWed to: SFP By: HM (b)(6)-2

MEDCOM - 5052

ANESTHESIA RECOR (b)(6)-2 Wt (kg) ~70 Ht (in) - .gies - NKDA

Procedure: GSW Washout LLE | LCDR NC USN | (b)(6)-2 | CRNA | Surgeon (b)(6)-2 | OR # 9 | See Page One

Date: 15Apr06 | Anes. Start 1135 | 1148 | Start 1200 | Surg. End 1218 | Anes. End 1230 | Resident/SRNA | Page 1 of 1

Time (12) 30 (13) 30 (14)

O_2 L/M	6-1	1	6
N_2O/Air L/M	1	1	0
Halo/Iso/Sevo/Des	.6	.5	0
STP/Prop./Etomidate	200		
Sux/Cistracurium	80		
Ro/Rapa/Vecuronium			
Lidocaine			
Neostigmine/Glyco			
Ephedrine/Neo			
MSO4 Midazolam		2-2	
MSO4/Remi/Su/Fentanyl	(150)		
Epid. Lido/Bupiv/Ropiv			
NS/LR		300	500
U/O			
EBL			

● = Pulse
○ = Spont. Resp.
∅ = Asst. Resp.
⊙ = Ventilator
X = MAP
Λ / V = NIBP
⊥ / T = A-Line
I = Intubate
E = Extubate

180 160 140 120 100 80 60 40

ø IV 18 started in Hold area

PACU / ICU
Pulse - 109
BP 168/88
Temp - 97.5
RR 18
SaO_2 - 100%
Comps - + 10

Sinus Arrh ECG	ST	ST	ST
Es/Np/Or/Sk/Ax Temp	axial		
% FiO_2	1.0	1.5	1.0
% SaO_2	100	100	100
$EtCO_2$	40	44	38
TV		400	390
PIP (cmH_2O)	⊗	0	0
Resp. Rate	14	17	18

Checklist – ☐ O_2 ☐ Suction ☐ Machine ☐ Consent ☐ NPO
Monitors – ☐ SaO_2 ☐ ECG ☐ FiO_2 ☐ NIBP L/R arm
☐ $EtCO_2$ ☐ PCS/ES ☐ PNS ☐ PIP ☐ Temp
☐ Mass Spec ☐ Verbal ☐ TEE ☐ Fluid warmer
☐ Air Warm ☐ Foley ☐ FHT ☐ Pulm Art cath
☐ CVP IJ/SC/Fem L/R ☐ OG/NG L/R
☐ A-Line Rad / Fem L/R
Position – ☐ Pressure points padded ☐ Arms < 90°
Supine Prone Lithotomy Sitting Lateral L/R
Drawn 10 Used 10 Wasted ∅ Witns
Drawn 250 Used 150 Wasted 100 Witns
IV - 18 Ga L/R Hand Wrist FA AC EJ
☐ Tourniquet _____ mmHg Times ___ ___
60/90/120/130/140/150 min - Surgeons informed

		Antibiotics
	Total	Agent -
900 ml	Total	mg -
450 ml	Total	over minutes
NIR	Total	@

Induction - Monitors On ✓ Preoxygenated ✓ Smooth ✓ Inhalation / IV Cricoid Pressure ✓ Rapid Sequence ✓ Mask ventilation easy Y / N

Intubation - Mac / Mil 3 Grade 1 view Tube Size 8.0 Attempts 1 Oral / Nasal L / R w/o w/ Cuff Stylet Y / N Bil BS / $EtCO_2$ x 3 / CIN

Tube taped @ 21 cm @ lips / teeth / nares Trauma Y / N FOB / LW / Blind LMA # ____ DLT ____ Fr L / R

Maintenance - Smooth Cuff checked ✓ Eyes taped / lubed

Extubation - Smooth ✓ Reversed ✓ SV VSS Full TV / Head lift / Sustained tetanus Suctioned ✓ Awake / Deep

Disposition - PACU / ICU SV VSS Awake / sleepy Extubated / intubated

Patient Identification

(b)(6)-4

Prep	Regional	Regional	Comments / Drugs:
☐ Sterile Technique	☐ Spinal / Epidural	☐ Catheter out - tip intact	
☐ Disposable kit	☐ Touhy / Whitacre / Quincke	☐ Level ______	
☐ Betadine prep x 3	☐ Needle guage ______	**Lines**	
☐ Local infiltration	☐ Sitting	☐ Seldinger Technique	
☐ Site ______ L/R	☐ Lateral R / L	☐ CVP manually transduced	
☐ Attempts ______	☐ LOR to Air / NS	☐ Cordis 9.5 / 8.5 Fr	
Blocks	☐ Paresthesia + / -	☐ SLIC	
☐ Nerve Stim ______ mA	☐ Heme + / -	☐ 2 / 3 - lumen	
☐ Trans-arterial	☐ CSF + / -		
☐ Dual cuff	☐ Test dose ⊖		
	☐ CSF ⊕ swirl		

MEDCOM - 5053

ANTIBIOTIC: Ancef 1gm
TIME GIVEN: 0845
OTHER:

NNMC 6320/16 (05/91)
RECOVERY ROOM RECORD
NAVMED 6320/16 (REV. 11-77) S/N 0105-LF-206-3281

ALLERGIES NKDA

OPERATION PERFORMED: I+D + closure (L) thigh + lower leg

AGENTS AND TECHNICS OF ANESTHESIA: 150 fent; General c LMA

Spinal Level: NA
EKG to monitor on [X] Rhythm ST
BP art / cuff
Pulse = •
% Sat:

TEMPS					
HOUR(S)	0900	15	30	45	1000
% Sat / Resp.	98 / 16	98 / 16	98 / 16	98 / 14	98 / 14
Numbers for remarks	1	2		3	4

OXYGEN THERAPY

ROUTE	L/M	%	ON	OFF
MASK	10L	X	AOW	1000
T-BAR				
VENTILAT.				

FLUID THERAPY

TYPE	5% D/RL	BLOOD	SALINE	OTHER
OPERATING ROOM	100			
RECOVERY ROOM	50			
TOTAL	150			

BLOOD LOSS IN OR: 25 cc
WARD PRE-OP BP 142/64 mmHg
TUBES: N/G FOLEY
IV IN (R) AC c 300 cc OF LR AT 150 cc/hr AOW
IV IN (R) AC c 250 cc OF LR AT 150 cc/hr TOW
ART. LINE IN
T-TUBES, HEMOVAC IN N/A

ADMISSION

FROM MOR/SPEC. STUDY DATE 4/25/02 HRS 0935

DISCHARGE

TO WARD 5FS DATE 4/25/02 HRS 1025

DRESSINGS: LOCATIONS (L) thigh + lower (L) E Ace wrap c kerlix

STATUS: C/D/I — STATUS: C/D/I

ENDOTRACHEAL TUBE – ORAL OR NASAL
☐ YES [X] NO — ☐ YES [X] NO

AIRWAY / BREATH SOUNDS
[X] CLEAR ☐ PLAST AIRWAY ☐ OBSTRUCTS EASILY
STATUS: Clear (B)

URINARY OUTPUT / DRAINAGE

	MOR	PACU
TIME	AOW	TOW
CC	N/M	N/M
TOTAL	Ø	Ø
SP. GR		
S/A		

REMARKS (AS NUMBERED) AND PERTINENT PATIENT PROGRESS NOTES

1) AOW from MOR accompanied by (b)(6)-2 (LCDR)
PMH: ASA II
Neuro: Sleepy but arrousable
Pain Yes (No) Action: Will monitor
CV: +/+ S1S2 HR 100's IV: Patent
Other: (1) AOW supine on gurney, warm sheets for ↓ temp.
(CONT'D ON REVERSE)

NAUSEA AND VOMITING: [X] NO ☐ YES → 1 2 3 4 5 6 TIMES

CAUDAL, SPINAL, OR EPIDURAL BLOCK: N/A
MOVEMENT PRESENT AT ____ HRS
SENSATION PRESENT AT ____ HRS

CONDITION ON TOW: [X] GOOD ☐ FAIR ☐ POOR ☐ CRITICAL

POST-ANESTHESIA RECOVERY SCORE (ALDRETE SCORE)

Criteria	Score	Category	A	D
Able to move 4 extremities voluntarily or on command	2	Activity	2	2
Able to move 2 extremities voluntarily or on command	1			
Able to move 0 extremities voluntarily or on command	0			
Able to deep breathe and cough freely	2	Respiration	2	2
Dyspnea or limited breathing	1			
Apneic	0			
BP±20% of preanesthetic level	2	Circulation	2	2
BP±20-50% of preanesthetic level	1			
BP±50% of preanesthetic level	0			
Fully awake	2	Consciousness	1	2
Arousable on calling	1			
Not responding	0			
Pink	2	Color	2	2
Pale, dusky, blotchy, jaundiced, other	1			
Cyanotic	0			
		TOTALS	9	10

RECOVERY: ☐ COMPLICATED [X] UNEVENTFUL

PATIENT'S IDENTIFICATION: 58 y.o 70 Kg (b)(6)-4

SIGNATURE OF RECEIVING AND RELEASING OFFICERS
AOW (b)(6)-2 HM (b)(6)-2 LCDR NC (b)(6)-2
TOW (b)(6)-2 HM (b)(6)-2 LCDR NC

MEDCOM - 5054

NAVMED 6320/18 (BACK)

HOUR(S)	15	30	45		15	30	45		15	30	45		15	30	45
TEMPS: 220															
200															
180															
160															
140															
120															
100															
80															
60															
40															
20															
RESP. RATE															
NUMBERS FOR REMARKS															

Spiral Level:

EKG Rhythm

BP ⊥ art

BP ^ cuff

Pulse = •

% Sat:

MEDICATIONS

TIME	DRUG	DOSE	ROUTE		NURSE
0955	Morphine	2mg	IVPush	(b)(6)-2	LCDR NC
0959	Morphine	2mg	IV Push		LCDR NC
1003	morphine	2mg	IVP		LCDR
1007	Morphine	2mg	IVPush		LCDR NC

REMARKS (AS NUMBERED) AND PERTINENT PATIENT PROGRESS NOTES (CONT'D FROM FRONT)

(2) Pt starting to wake up, slight shivering, c/o pain, medicated As ordered. [initials]
(3) Pt seems to be comfortable, resting c eyes closed [initials] (4) Pt meets D/c criteria for pacu, released by CDR (b)(6)-2 (b)(6)-2 (b)(6)-2

(4) TOW Note: Neuro: A&Ox3 MAE's, pt resting c eyes closed

Pain: Yes/(No) Action: medicated

Pulmonary: lungs clear O2 sats 100% on room Air

CV: +/+ S1 S2 HR 90's EKG Rhythm: SR IV: Patent

Skin/Wound: warm, dry, pink Drainage Yes/(No) Color: N/A Edema Yes/(No)

GI: Round, soft, s N/V

GU: Foley Yes/(No) Color of urine: N/A Due to void: 1530

Instructions/Interventions in PACU: Pt warmed to elevate temp, medicated for pain. [initials]

Report called to: LCDR (b)(6)-2 By: LCDR (b)(6)-2

TOWed to: 5FS By: LCDR (b)(6)-2, HN (b)(6)-2

MEDCOM - 5055

Pre / Post anesthetic Summary

NNMC 6320/279 (Dec-00)

Proposed Operation	Age	Weight (kg)	Height (in)	ASA Status	Allergies
ORIF (R) Hip (DHS)	50's (est)	70		1 (2) 3 4 5 E	NKAD

Chemistries	Hematology	Coags	Urinalysis / HCG	
133 / 105 / 21 / 95; 3 / 22 / 0.8	H/H - 8.9/26.1; Platelets - 231; WBCs - 7.1	PT -; INR -; PTT -	ф	NPO - 0300 Am sm piece of Apple; Teeth - Intact; Airway - MP I / (II) / III / IV; (FROM) 3 FB O, 3 FB HM

Respiratory
Cough: / Sputum: / Asthma: ф
COPD: / Recent URI: / TB: ф
Lung Exam: CTA
CXR:

HTN: / CAD: / MI: / CHF: / VHD: ф. EP 10
Arrythmias:
Exercise Tolerance: low RR no G/R/r
Cardiac Exam:
ECG: low RR - NO G/R/r

CNS / Skeletal
Seizure: / CVA: / LOC: / Neuro: ф
Muscle: / Skeletal: see below

Misc

Other
Hepatic: / Renal: / GI: ф
Endo:
Hem: ф
EtOH: / Tobacco: unknown

Previous Anesthetics: No problems

Current Medications: Ancef prior

Premedication: 6mg MSO4 0815 Am

Family Hx: unknown

Preoperative Diagnoses
1. fx (R) Hip
2. GSW (L) medial thigh
3. GSW (R) Buttock.
4. GSW Glans penis, penis and fx

Vitals	Pre-op	DOS
BP:		96/50
HR:		83
Resp:		16
Temp:		37
FHR:		

Evaluator Signature: (b)(6)-2 Date: 4/11/03 0815 Am

Day of Surgery
☑ Chart Reviewed / patient examined
☐ Risks / benefits / options discussed with patient
☐ Patient questions answered
☐ Patient / parent / guardian understands and accepts risks
☐ NPO after ______ liq., ______ clears, ______ solids
Plan: GETA

Staff MD / CRNA (b)(6)-2 CDR MC USN (b)(6)-2 Date & Time 4/11/03

Patient identification (b)(6)-4

~~Post-operative note~~
doing Well
☒ No apparent anesthetic complications
(b)(6)-2
Signat 4/ /03

MEDCOM - 5056

(b)(3)-1

Peri[redacted]erative Plan Of Care & Nursing No[redacted]

Patient Assessment For Surgery - Potential For Injury - Outcome: Patient is free from signs and symptoms of injury ☐ Yes ☐ No

Trauma# or Patient # (b)(6)-4

Diagnosis: SOFT TISSUE OPEN WOUND (L) x2 Planned Procedure: I&D (L) LEG

Side: ☐ N/A ☐ Right ☐ Left

Date: 15 Apr 03 Arrival Time: Interviewer: CPL (b)(6)-2

Age: HT: WT:

From: ☐ CASREC ☐ ICU ☒ Ward ☐ OTHER:

Transport Via: ☒ Gurney ☐ Litter ☐ Ambulated ☐ Wheelchair ☐ Other

Patient ID: ☐ Trauma card ☐ Verbal ☒ Chart ☐ Armband ☐ Other

Blood Ordered: ☒ N/A ☐ Yes ☐ Consent ☐ T/C #Units ☐ T/H #Units Comments:

Surgical/Anesthesia Consent Verified: ☐ Procedure ☐ Consent complete, dated, signed ☒ Emergent case; no consent, MD note

Preop Labs (HCG, etc): ☐ None ☐ Yes Test/Results: CBC - see chart

Drug/Latex Allergies: ☐ NKDA Allergy/Reaction: ?

Present On Admission: ☐ N/A ☐ Oxygen ☐ IV Site: #1 #2 ☒ Foley ☐ Endotrachial Tube ☐ Arterial Line Site: ☐ Drain(s) ☐ Chest Tube(s) ☐ See RN Note #

Past Medical History: ☒ None known ☐ Smoker ppd/yrs ___/___ ☐ ETOH ☐ Asthma ☐ HTN ☐ CAD ☐ GERD ☐ CBR exposure ☐ Other:

Past Surgical History: ☐ None known ☐ Yes List:

Cultural Needs Addressed: ☒ Yes ☐ No List:

Pre-Op Pain: ☐ No ☒ Yes Level 7 (0-10) Action Taken: Location/type:

Last PO Intake: (date/time) Solid ? Liquid: ?

In Chart: ☒ H&P ☒ Yes ☐ No ☐ EKG ☐ Yes ☐ No CXR ☐ Yes ☐ No ☐ Other:

Skin Condition: ☐ Intact ☒ Other: POSTERIOR SPLINT (L) LEG DRESSING x2 (L) THIGH + (L) CALF

Limitations: ☐ N/A ☒ Language ☒ Mobility ☐ Other: ☐ Auditory ☐ Visual ☐ Prosthesis

Personal Items: ☒ None ☐ Military gear ☐ Glasses ☐ Dentures ☐ Jewelry/wallet ☐ Other Disposition:

Potential For Anxiety – Outcome: Patent demonstrates knowledge of psychological responses to an invasive procedure ☐ Yes ☐ No

Mental/Emotional Status: ☒ Alert/Oriented ☐ Disoriented ☒ Anxious ☐ Appropriate for age ☐ Other ☐ Calm ☐ Sedated ☐ Unresponsive

Comfort Measures Implemented: ☐ Clear, concise explanations ☐ Communicated patient concerns to other staff members ☐ Remain with patient during induction

Pre-op Teaching Included: ☐ N/A due to patient condition ☐ Physical layout of OR ☐ Personnel present during procedure ☐ Environment (noise, temperature, etc.) ☐ Post-op expectation (PACU, drains, etc.)

Potential For Impaired Skin Integrity Related To Surgical Procedure – Outcome: Patient is injury free ☐ Yes ☐ No

Operative Position: ☒ Supine ☐ Prone ☐ Jackknife ☐ Lithotomy ☐ Other: ☐ Beach chair ☐ Sitting ☐ Lateral L / R

Positional Aids: ☒ Arms <90 Armboard ☒ L ☒ R Tucked: ☐ L ☐ R ☐ Airplane ☐ Fracture Table ☐ Hand Table ☐ Stirrups ☐ Other: ☐ Axillary roll ☐ Gel Pad ☐ Leg Holder ☐ Tape ☐ Bean Bag ☐ Gel donut ☐ Pillows ☐ Wilson Frame

Comments:

ESU # VALLEYLAB #9 Pad Site: U/A Pad Lot # 60277 Site Clear at end of case? ☐ No ☐ Yes If No, see RN note # Bipolar: ___ Max Cut 30 Coag 30

DVT Prevention: SCD used ☒ No ☐ Yes Pressure: ☐ Left ☐ Right Teds: ☒ No ☐ Yes Bair Hugger used: ☒ No ☐ Yes Other warming techniques:

Tourniquet: ☐ Arm ☐ Leg ☐ Left ☐ Right ☐ webril applied # N/A Applied by: Total Min: ↑ ↓ ↑ ↓

Comments:

(b)(6)-4

Comments:

Potential For Infect[illegible] – Outcome: Appropriate Actions Taken to [illegible]nt Infection ☐ Yes ☐ No

Wound Classification: ☐ I ☒ II ☐ III ☐ IV

Shave Prep: ☐ Shave ☐ Clipper
Area: N/A By: ____

Skin Prep: ☐ Betadine Scrub / PAINT
☐ Hibiclens
☐ Duraprep
☐ Other:

Solutions/Medications: ☒ Normal saline ☒ Sterile water ☐ Local ☐ Antibiotics ☐ Other:

Drains/Packing: ☒ None
☐ Foley FR:
☐ JP #1 Fr ___ Location: ___ #2 Fr ___ Location: ___
☐ Hemovac: Size ___ Location ___
☐ Chest tube: Location ___
Size ___ H20 Pressure: ___
☐ Packing: type/location: ___
☐ See RN Note # ___ for comments

Dressing: Location: ___
☐ ABD ☐ Cervical Collar ☐ Kling ☐ Steri-strips ☐ Benzoin
☒ Ace ☐ Coban ☐ Immobilizer ☐ Tape ☐ Mastisol
☐ Bias ☐ Drip Pad ☒ Plains ■ Webril ☐ Bacitracin
☐ Band-Aid(s) ☐ Fluffs ☐ Sling ☐ Xeroform
☐ Cast ☒ Kerlix ☐ Splint ☐ Other;

Miscellaneous

Counts: (initials)
Scrub: RN: Correct DEFFERED
Sharps ☐ Yes ☐ No ☐ N/A
Sponges ☐ Yes ☐ No ☐ N/A
Instruments ☐ Yes ☐ No ☐ N/A
See RN note # ___ for additional comments

Xray: ☒ None ☐ Portable ☐ C-Arm ☐ Other:

Skin Integrity:
☐ Clear & Intact (other than incision)
Comments: POSTERIOR SPLINT ON (L) LEG FOR FOOT DROP
☐ See RN note # ___ for additional comments.

Implants:
Item / Lot # / Exp Date:
N/A

See RN note # ___ for additional comments.

Discharge from Operating Room

Complications:
☒ None Comments: ___
See RN note # ___ for additional comments

Transport From OR:
☒ Gurney w/ siderails up
☐ Litter w/ safety strap in place
☐ w/ Oxygen
☐ w/ Monitor
☐ Other:

Transferred To:
☒ PACU
☐ ICU
☐ Medivac
☐ Ward ___
☐ Other

Report by:
☐ Anesthesia provider ☐ RN

Surgical Procedure Performed: I&D (L) THIGH WOUNDS

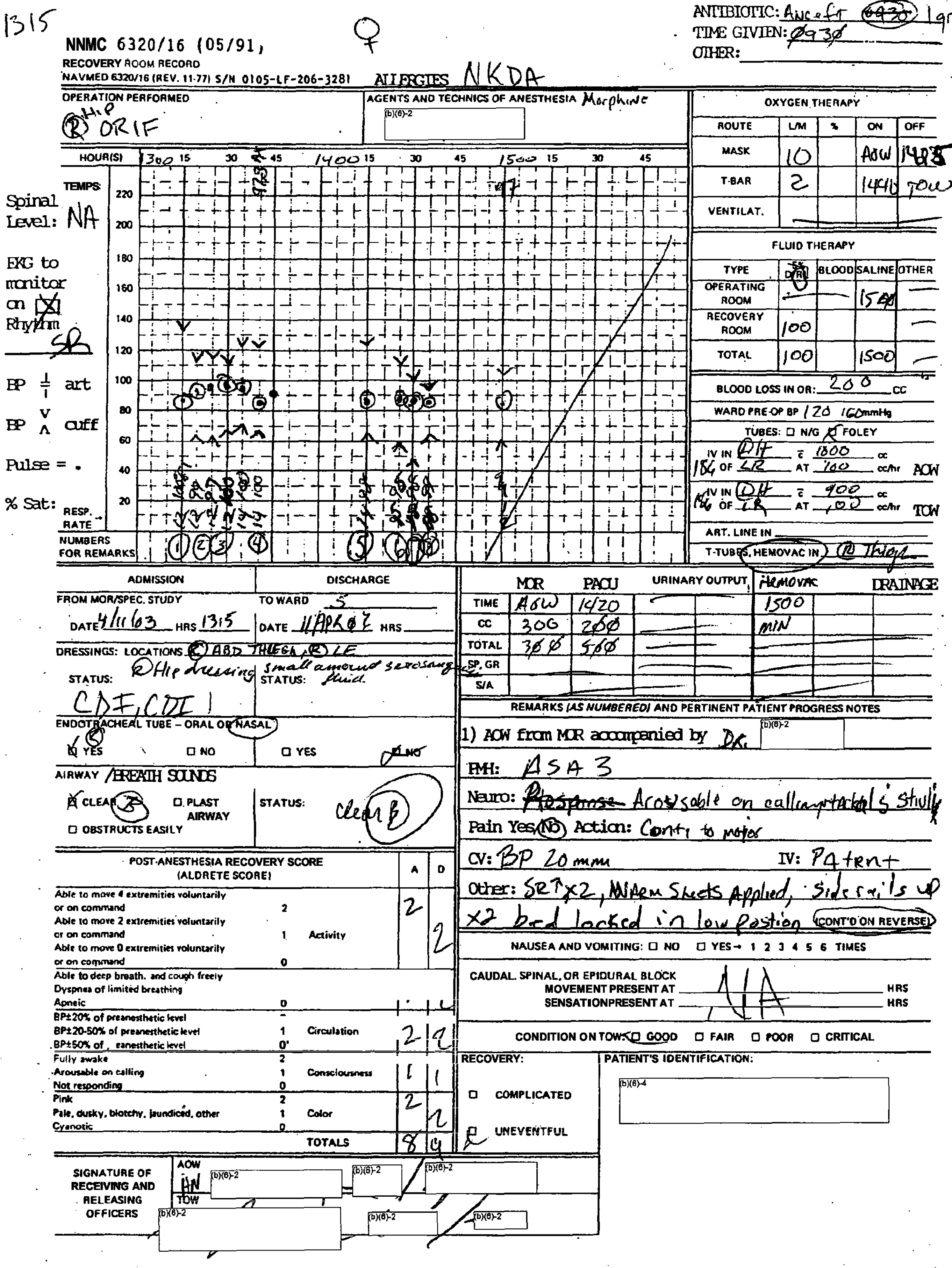
RN Note: (number each note to corresponding area above)

Initial/Name Box: (please print)

(b)(6)-2

Primary OR RN Signature ___ Date 15APR03

Relief OR RN Signature ___ Date/Time ___



1315

NNMC 6320/16 (05/91)

RECOVERY ROOM RECORD

NAVMED 6320/16 (REV. 11-77) S/N 0105-LF-206-3281

ALLERGIES NKDA

ANTIBIOTIC: Ancef 1gr
TIME GIVEN: 0930
OTHER:

OPERATION PERFORMED: (R) Hip ORIF

AGENTS AND TECHNICS OF ANESTHESIA: Morphine (b)(6)-2

Spinal Level: NA

EKG to monitor on [X] Rhythm SR

BP art / BP cuff / Pulse / % Sat

OXYGEN THERAPY

ROUTE	L/M	%	ON	OFF
MASK	10		AOW	1425
T-BAR	2		1440	TOW
VENTILAT.				

FLUID THERAPY

TYPE	D5RL	BLOOD	SALINE	OTHER
OPERATING ROOM	0		1500	
RECOVERY ROOM	100			
TOTAL	100		1500	

BLOOD LOSS IN OR: 200 CC

WARD PRE-OP BP 120/60 mmHg

TUBES: ☐ N/G ☒ FOLEY

IV IN (L) H c 1800 cc 18G OF LR AT 100 cc/hr AOW

IV IN (L) H c 900 cc 16G OF LR AT 100 cc/hr TOW

ART. LINE IN

T-TUBES, HEMOVAC IN (R) Thigh

ADMISSION — FROM MOR/SPEC. STUDY: DATE 4/11/03 HRS 1315

DISCHARGE — TO WARD 5 DATE 11APR03 HRS

	MOR	PACU	URINARY OUTPUT	HEMOVAC	DRAINAGE
TIME	AOW	1420		1500	
CC	300	200		MIN	
TOTAL	300	500			
SP. GR					
S/A					

DRESSINGS: LOCATIONS (R) ABD THIGH, (R) LE

STATUS: (R) Hip dressing CDI, CDI — STATUS: small amount serosang fluid.

ENDOTRACHEAL TUBE – ORAL OR NASAL: ☒ YES ☐ NO / ☐ YES ☒ NO

AIRWAY / BREATH SOUNDS: ☒ CLEAR ☐ PLAST AIRWAY ☐ OBSTRUCTS EASILY — STATUS: clear (B)

REMARKS (AS NUMBERED) AND PERTINENT PATIENT PROGRESS NOTES

1) AOW from MOR accompanied by Dr. (b)(6)-2

PMH: ASA 3

Neuro: Response Arousable on call, tactile stimuli

Pain Yes (No) Action: Cont. to monitor

CV: BP 20 mmHg — IV: Patent

Other: SRT x2, Warm sheets applied, side rails up x2 bed locked in low position (CONT'D ON REVERSE)

NAUSEA AND VOMITING: ☐ NO ☐ YES → 1 2 3 4 5 6 TIMES

CAUDAL, SPINAL, OR EPIDURAL BLOCK — MOVEMENT PRESENT AT ___ HRS; SENSATION PRESENT AT ___ HRS: NA

POST-ANESTHESIA RECOVERY SCORE (ALDRETE SCORE)

			A	D
Able to move 4 extremities voluntarily or on command	2	Activity	2	2
Able to move 2 extremities voluntarily or on command	1			
Able to move 0 extremities voluntarily or on command	0			
Able to deep breath, and cough freely				
Dyspnea of limited breathing				
Apneic	0			
BP±20% of preanesthetic level		Circulation	2	2
BP±20-50% of preanesthetic level	1			
BP±50% of preanesthetic level	0			
Fully awake	2	Consciousness	1	1
Arousable on calling	1			
Not responding	0			
Pink	2	Color	2	2
Pale, dusky, blotchy, jaundiced, other	1			
Cyanotic	0			
		TOTALS	8	9

CONDITION ON TOW: ☒ GOOD ☐ FAIR ☐ POOR ☐ CRITICAL

RECOVERY: ☐ COMPLICATED ☒ UNEVENTFUL

PATIENT'S IDENTIFICATION: (b)(6)-4

SIGNATURE OF RECEIVING AND RELEASING OFFICERS — AOW RN (b)(6)-2 (b)(6)-2 (b)(6)-2 — TOW (b)(6)-2 (b)(6)-2 (b)(6)-2

MEDCOM - 5059

NAVMED 6320/16 (BACK)

HOUR(S)	15	30	45	15	30	45	15	30	45	15	30	45	15

Spinal Level:

EKG Rhythm

BP art

BP cuff

Pulse =

% Sat:

TEMPS: 220 200 180 160 140 120 100 80 60 40 20

RESP. RATE

NUMBERS FOR REMARKS

MEDICATIONS

TIME	DRUG	DOSE	ROUTE	NURSE
1430	Morphine	2mg	IV Push	(b)(6)-2

REMARKS (AS NUMBERED) AND PERTINENT PATIENT PROGRESS NOTES (CONT'D FROM FRONT)

(2) Pt came in Intubated Anesthesia at bedside, Anesthesia extubated pt @ bedside pt tolerated procedure well (3) Nasal trumpet was placed by anesthesia. (4) X-Ray Tech c̄ Pt. X-ray taken During X-Ray Pt sutures broke and Bright Red draining 5) Dr (b)(6)-2 paged order given to hold pressure. DR. (b)(6)-2 AT BED SIDE Pressure Dressing applied to (6) Buttock Sit c̄ Sutters and ABD Dressings cont. monitor Dressing if saturated

TW Note: Neuro: Pt rest with eyes close arousal on call

Pain: Yes/No (No circled) Action:

Pulmonary: Lungs Clear Bilaterally Sat. well on 2 L of NC SAT > 97%

CV: S1, S2 EKG Rhythm: SR IV: PAtent

Skin/Wound: Warm Pink Drainage Yes/No (Yes circled) Color: Serosanguineous Edema Yes/No (Yes circled) (R) LE

GI: Bowel NO N/V

GU: Foley Yes/No (Yes circled) Color of urine: Dark Yellow Due to void: NA

Instructions/Interventions in PACU: NA

Report called to: ENS (b)(6)-2 By: (b)(6)-2

TWed to: 5 Forward By:

*U.S. Government Printing Office: 1991 — 504-100/20525 2-1

MEDCOM - 5060

(b)(6)-4

(b)(3)-1

TEST performed 1100

LABORATORY REQUEST FORM

FOR CHEMISTRY, SEROLOGY, AND COAGULATION, CHECK DESIRED TESTS.
FOR ALL OTHERS, CIRCLE DESIRED PANEL.

Check	CHEMISTRY	Result	URINALYSIS	Result	RBC MORPHOLOGY
	GLU		Spec Gravity		
	BUN		pH		
	CREAT		Leukocytes		
	NA		Nitrite		
	K		Protein		
	CL		Glucose		MICROBIOLOGY
	CO_2		Ketones		Culture Site:
	Phos		Urobilinogen		
	AST		Bilirubin		Results:
	ALT		Blood		
	LDH		Hemoglobin		
	TBIL		MICROSCOPIC		
	ALB				Sensitivity:
	CA				
	CHOL				
	TRIG				
	CK		HEMATOLOGY	6.4	
	TP		WBC	~~2.94~~	6.4 WBC
	MG		RBC	2.94	
	AMYL		HGB	8.2	
	LIPASE		HCT	25.8	MCH 27.9
			MCV	87.6	MCHC 31.8
	SEROLOGY		RDW	13.3	
	MONOSPOT		PLT	195	
			MPV	7.9	
	COAGULATION		DIFFERENTIAL		
	PT		NEUTRO		
	PTT		BAND		
			META		
	BLOOD GAS		MYELO		
	pH		PROMYELO		
	PCO_2		BLAST		
	PO_2		EOSINO		
	LACTATE		BASO		
	BICARBONATE		LYMPH		
	TOTAL CO_2		MONO		
	BASE EXCESS		NUCLEATED RBC		
	O_2 SAT				

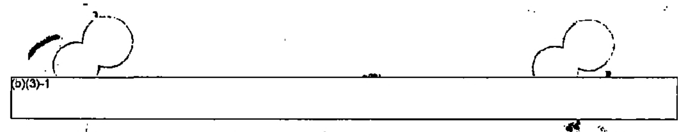
Patient Name: (b)(6)-4 Location: WARD 2

FMP/SSN: ____ Provider: CDR. (b)(6)-2

Patient ID: ____ ____ Date: 16 APR 03 1037

MEDCOM - 5061

FLTHOSPPNCLA6510/1 (1/03)



LABORATORY REQUEST FORM

FOR CHEMISTRY, SEROLOGY, AND COAGULATION, CHECK DESIRED TESTS.
FOR ALL OTHERS, CIRCLE DESIRED PANEL.

Check	CHEMISTRY	Result.	URINALYSIS		RBC MORPHOLOGY
	GLU		Spec Gravity		
	BUN		pH		
	CREAT		Leukocytes		
	NA		Nitrite		
	K		Protein		
	CL		Glucose		MICROBIOLOGY
	CO_2		Ketones		Culture Site:
	Phos		Urobilinogen		
	AST		Bilirubin		Results:
	ALT		Blood		
	LDH		Hemoglobin		
	TBIL		MICROSCOPIC		
	ALB				Sensitivity:
	CA		(b)(6)-4		
	CHOL				
	TRIG				
	CK		HEMATOLOGY		
	TP		WBC	10.5	MCH 27.5
	MG		RBC	3.78	MCHC 32.0
	AMYL		HGB	10.4	
	LIPASE		HCT	32.6	
			MCV	86.1	
	SEROLOGY		RDW	13.3	
	MONOSPOT		PLT	237	
			MPV	7.9	
	COAGULATION		DIFFERENTIAL		
	PT		NEUTRO		
	PTT		BAND		
			META		
	BLOOD GAS		MYELO		
	pH		PROMYELO		
	PCO_2		BLAST		
	PO_2		EOSINO		
	LACTATE		BASO		
	BICARBONATE		LYMPH		
	TOTAL CO_2		MONO		
	BASE EXCESS		NUCLEATED RBC		
	O_2 SAT				

Patient Name: (b)(6)-4 Location: WARD 2

FMP/SSN: Provider: CDR (b)(6)-2

Patient ID: Date: 04 APR 03

MEDCOM - 5062

FLTHOSPPNCLA 6510/1 (1/03)

(b)(6)-4

(b)(3)-1

LABORATORY REQUEST F(

FOR CHEMISTRY, SEROLOGY, AND COAGULATION, CHECK DESIRED TESTS.
FOR ALL OTHERS. CIRCLE DESIRED PANEL.

Check	CHEMISTRY	Result	URINALYSIS	Result	RBC MORPHOLOGY
	GLU		Spec Gravity		
	BUN		pH		
	CREAT		Leukocytes		
	NA		Nitrite		
	K		Protein		
	CL.		Glucose		MICROBIOLOGY
	CO_2		Ketones		Culture Site:
	Phos		Urobilinogen		
	AST		Bilirubin		Results:
	ALT		Blood		
	LDH		Hemoglobin		
	TBIL		MICROSCOPIC		
	ALB				Sensitivity:
	CA				
	CHOL				
	TRIG				
	CK		HEMATOLOGY		
	TP		WBC	7.2	
	MG		RBC	3.14	
	AMYL		HGB	9.0	
	LIPASE		HCT	27.3	
			MCV	86.9	
	SEROLOGY		RDW	13.6	
	MONOSPOT		PLT	194	
			MPV	7.5	
	COAGULATION		DIFFERENTIAL		
	PT		NEUTRO		
	PTT		BAND		
			META		
	BLOOD GAS		MYELO		
	pH		PROMYELO		
	PCO_2		BLAST		
	PO_2		EOSINO		
	LACTATE		BASO		
	BICARBONATE		LYMPH		
	TOTAL CO_2		MONO		
	BASE EXCESS		NUCLEATED RBC		
	O_2 SAT				

Patient Name: (b)(6)-4 Location: WARD 2

FMP/SSN: Provider: CDR (b)(6)-2

Patient ID: Date:

MEDCOM - 5063

FLTHOSPPNCLA 6510/1 (1/03)

(b)(6)-4

Fleet Hospital Operations and Training Command

CHCS QUICK ADMIT/PATINET TRACKIN FORM

Date: 4 APRIL 03

PATIENT NAME: (b)(6)-4		FMP/SSN: 20-
REGISTER NO:		ALGORITHM NO:
TRIAGE CATEGORY:	1-IMMEDIATE 3-DELAYED 5-EXPIRED	2-MINIMAL 4-EXPECTANT	GSW ↓ LEFT EXTREMITY

CHCS INTERWARD TRANSFER

TRANSFER FROM WARD	TO BED #	TRANSFER TO WARD
		WARD II

PATIENT S FINAL DISPOSITION

RETURNED TO DUTY'	MEDEVAC
MORGUE	OTHERS

MEDCOM - 5064

DOD 12276

ACLU-RDI 1259 p.37

Patient ID

Patient Profile

Fleet Hospital 3

Allergies	Vital Signs	Diet	Activity
Unknown	q 1 2 4 8 (12) Q Shift	Reg	Bed rest
	Call MD for:		Roll side to side
	HR > 120		
	SBP > 180 / < 90 DBP > 100		

	Vital Signs	Dressing Changes
	RR < ____ > ____	
	SpO2 ____	DSG Δ Q8° W → D Starting 05Apr03
	Temp > 101	
	UOP <	

IV Therapy		O2/Vent Settings	Misc
Fluid	Rate	O_2 ____ lpm	MSO4 5-10mg Q2-3h prn
~~LR~~	~~KVO~~	FiO2	Ancef 1g IV Q8°
Hep Loc		Mode	~~[illegible] Qd x3~~
		Rate	
		PEEP/PS	ICS Q1° while awake

Diagnosis
GSW x 2 BIL LE
R Femoral Neck Fx
c/w Penis

Condition
Stable
Foley to gravity.

Daily Labs/Xrays/Procedures	
CBC	Done

ONE TIME ORDERS

CBC 4/4
Port CXR.

MEDCOM - 5065

M.A.R.

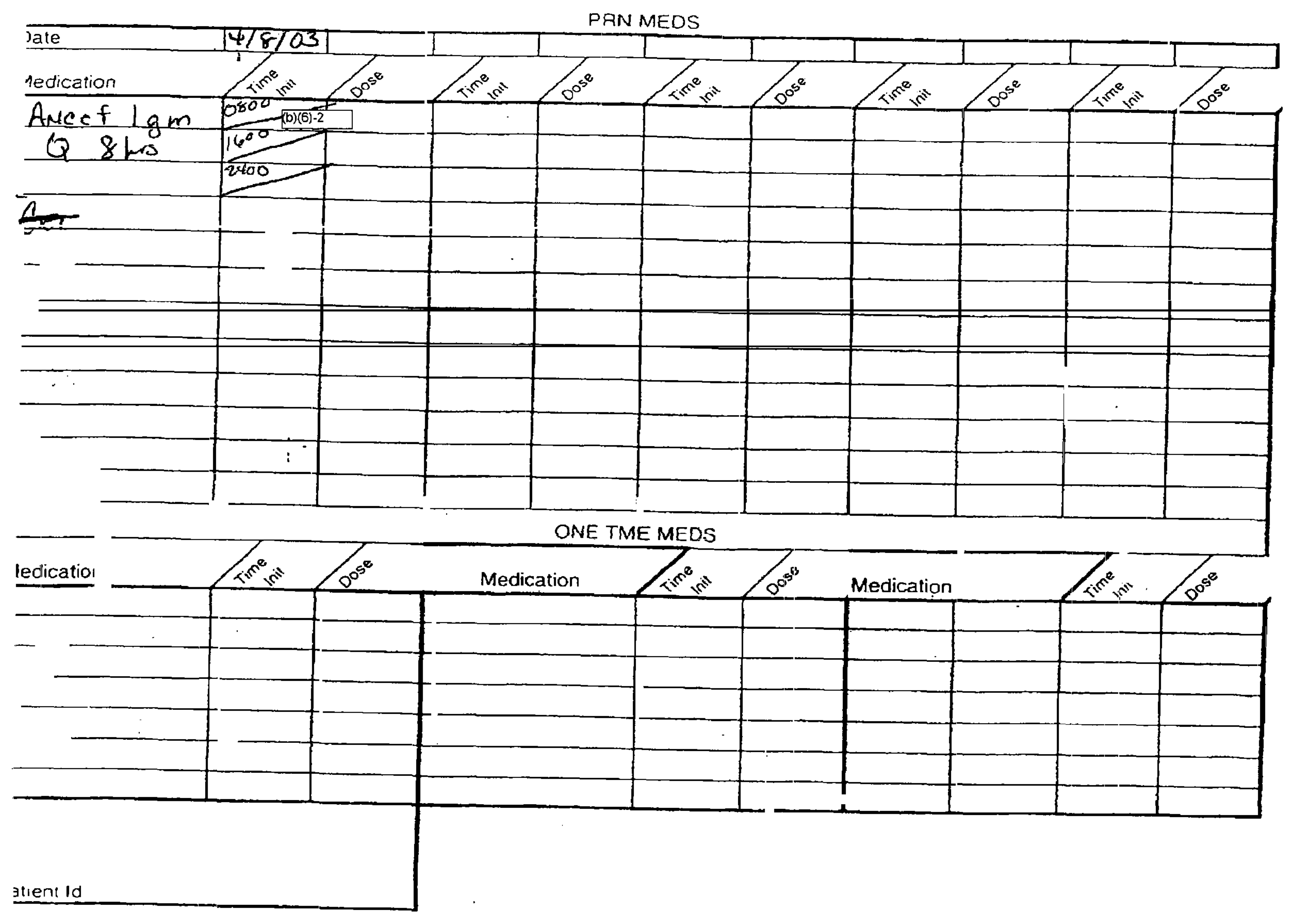
MEDICAL ADMINISTRATION RECORD

Date	4-8	4-9	4-10	4-11	4-12					
Medication	Time Init	Time Init	Time Init	Time Init	Time Init	Time Init	Time Init	Time Init	Time Init	Time Init
MSO4 5-10 mg Q2-5hrs										
Tylenol 3 1-2 Tabs po Q 4hs Prn										
MSO4 2-4mg IVPB Q 1° Prn	4mg RDG/ST									

(b)(6)-4

Patient Id

MEDCOM - 5066



PRN/ONE TIME MEDS

PRN MEDS

Date	4/8/03									
Medication	Time / Init	Dose	Time / Init	Dose	Time / Init	Dose	Time / Init	Dose	Time / Init	Dose
Ancef 1gm Q 8hrs	0800 (b)(6)-2									
	1600									
	2400									

ONE TME MEDS

Medication	Time / Init	Dose	Medication	Time / Init	Dose	Medication	Time / Init	Dose

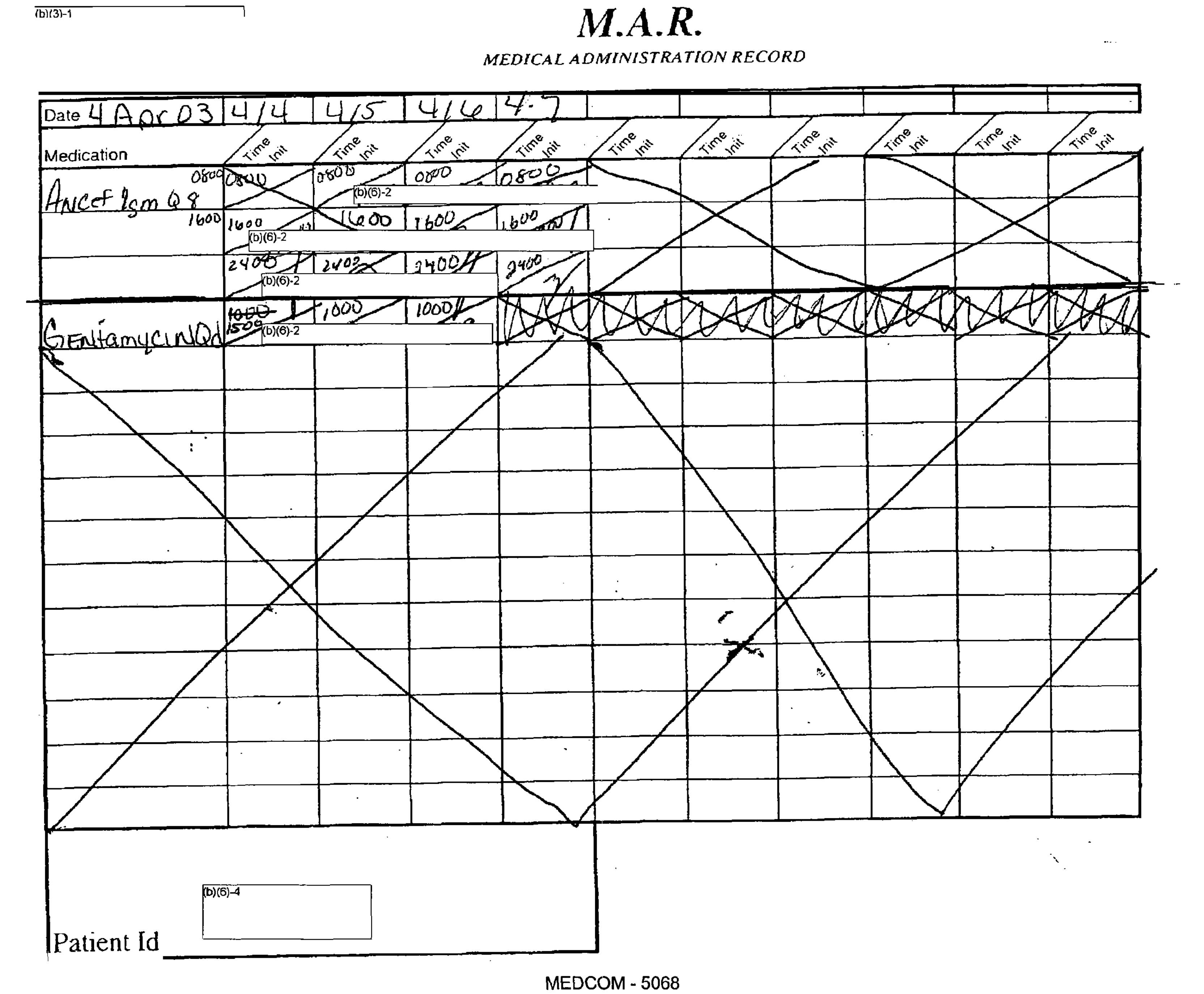
Patient Id

MEDCOM - 5067

(b)(3)-1

M.A.R.

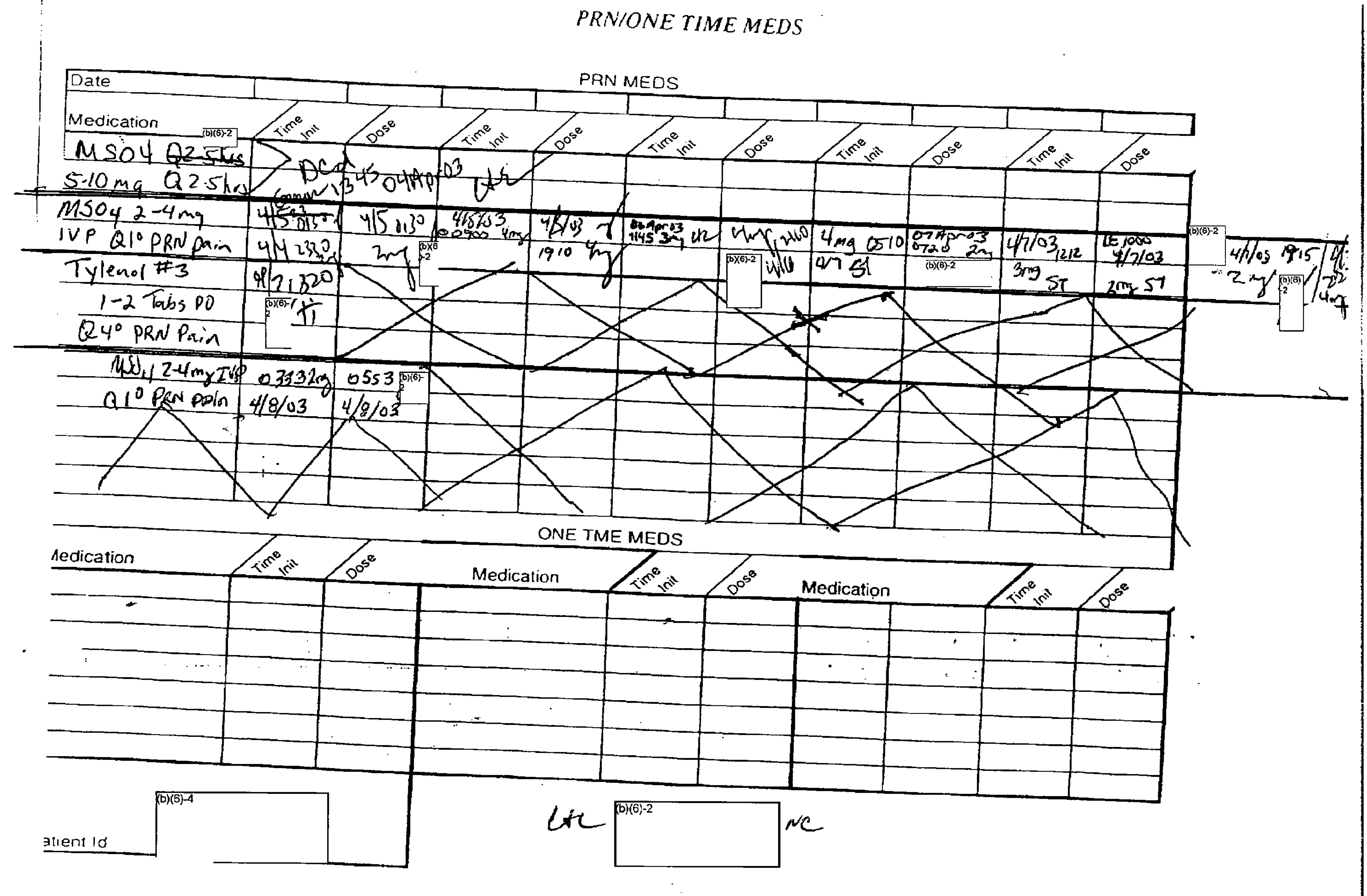
MEDICAL ADMINISTRATION RECORD



Date 4 Apr 03	4/4	4/5	4/6	4-7						
Medication	Time Init	Time Init	Time Init	Time Init	Time Init	Time Init	Time Init	Time Init	Time Init	Time Init
Ancef 1gm Q8 0800	0800	0800 (b)(6)-2	0800	0800						
1600	1600 (b)(6)-2	1600	1600	1600						
	2400 (b)(6)-2	2402	2400	2400						
Gentamycin QD	~~1000~~ 1500 (b)(6)-2	1000	1000							

Patient Id (b)(6)-4

MEDCOM - 5068



PRN/ONE TIME MEDS

PRN MEDS

Medication	Time / Init	Dose	Time / Init	Dose	Time / Init	Dose	Time / Init	Dose	Time / Init	Dose	Time / Init	Dose
MSO4 Q2.5hrs 5-10mg Q2.5hrs	DC'd 1345 04Apr03											
MSO4 2-4mg IVP Q1° PRN pain	4/5/03 0115	4/5 0130 2mg	4/5/03 0900 4mg	4/5/03 1910 4mg	06Apr03 1145 3mg	4mg 2400 4/6	4mg 0510 4/7	07Apr03 0720 2mg	4/7/03 1212 3mg	4/7/03 1000 2mg	4/7/03 1915 2mg	
Tylenol #3 1-2 Tabs PO Q4° PRN Pain	4/4 2330 / 4/8 2130											
MSO4 2-4mg IVP Q1° PRN pain	0333 2mg 4/8/03	0553 4/8/03										

ONE TIME MEDS

Medication	Time / Init	Dose	Medication	Time / Init	Dose	Medication	Time / Init	Dose

Patient Id (b)(6)-4

(b)(6)-2

MEDCOM - 5069

b)(3)-1 08 Ap (b)(6)-4 Page 1

Personal Data - Privacy Act of 1974 (PL 93-579)

PATIENT LAB INQUIRY

For: 29 Mar 03 - 08 Apr 03

Report requested by: (b)(6)-2

(b)(6)-4 (b)(6)-4 M/<1d Reg #: (b)(6)-4

Ph: Military Unit: UNKNOWN

08 Apr 03 @ 1436 (Coll) PLASMA

Test	Result	Flag	Range	Units
APTT	17.2	L	(23.8-35.5)	Seconds
PT	10.3	L	(11.6-14.4)	Seconds
INR	0.7			

Interpretations:
The current recommended therapeutic range for INR is 2.0-3.0 for all indications except prosthetic valves for which an INR 2.5-3.5 is recommended (Chest 108(4):231S-246S; 1995). It should be recognized that these are guidelines and adjustments may be required based on individual patient risk factors. The INR is not useful for the first 7-10 days of therapy.

08 Apr 03 @ 1436 (Coll) BLOOD

Test	Result	Flag	Range	Units
STAT WBC	8.6		(4.8-10.8)	K/UL
RBC	2.9	L	(4.7-6.1)	1X10 6/UL
HGB	8.5	L	(14.0-18.0)	g/dL
HCT	25.7	L	(42-52)	%
MCV	88.4		(80-94)	fL
MCH	29.1		(27-32)	pg
MCHC	32.9		(31-37)	g/dL
RDW	13.3		(12-14)	%
PLT CNT	244		(150-450)	1x10 3/UL
MPV	7.4		(7.4-10.4)	FL
BANDS/100 WBC	1			%
SEGS/100 WBC	76			%
L CD10	20			%
MONO%	3			%
PLT EST	NORMAL			
MORPHOLOGY	ABNORMAL			

Result Comment:
2+ BURR CELLS
1+ TARGET CELLS
SLIGHT POIKILOCYTOSIS

08 Apr 03 @ 1436 (Coll) SERUM

Test	Result	Flag	Range	Units
STAT NA+	134	L	(137-145)	mmol/L
K	3.6		(3.6-5.0)	mmol/L
CL-	104		(97-107)	mmol/L
CO2	24		(22-31)	mmol/L
BUN	19		(9-21)	mg/dL
GLUCOSE	85		(76-110)	mg/dL
CREAT	0.8		(0.8-1.5)	mg/dL

L=Lo H=Hi *=Critical esist S=Susc MS=Mod Susc I ermed

b)(3)-1 CASUALTY RECEIVING
-AL TREATMENT RECORD *(continued)*

RWAY nasal / oral Incubate nasal / oral ______ mm tube @ ______ cm teeth / nares
XYGEN (Room Air) Face Mask @ 12 L / min OTHER ______
JBES CHEST TUBE: size / site ______
N/G: guaiac neg/pos ______
(FOLEY:) dipstick blood neg / pos URINE DARK YELLOW, NON-AMBER

/ SITES	SIZE
R MID FOREARM	18G

V SOLUTION | AMT INFUSED
#1 2 mg MORPHINE | 2 mg
#2
#3
#4

BLOOD PRODUCTS | AMT INFUSED

TREATMENTS
1. Oxygen
2. Cricothyrotomy
3. Tracheotomy
4. IV Sites
5. Pressure Dressings
6. MAST
7. Apply Hemostat
8. Sutures
9. Tourniquet
10. (Bandage)
11. Splint
12. Cast
13. ______
14. ______

DRSG CHANGE
DRSG CHANGE

PERITONEAL LAVAGE
Comments ______

Results: (Circle one) POSITIVE NEGATIVE

OUTPUT
Chest Tube ______ cc
Gastric ______ cc
Foley 700 cc

TOTAL INTAKE ______ cc TOTAL OUTPUT ______ cc

MEDICATIONS	Dose	Route	Time	Initials	MEDICATIONS	Dose	Route	Time	Initials
Morphine	2 mg	IV	1415	(b)(6)-2					
Mefoxin									
Ancef									
Tet Tox									
Hypertet									

DATE	HOUR A.M.	HOUR P.M.	TRANSFERRED Time: ______ to OR ICU BURN ICU WARD: ______
		1545	PT TO RADIOLOGY FOR X-RAYS

☆ U. S. GPO: 1987-181-247/60056

MEDCOM - 5071 (Reverse)

Potential For Infectio– – (ome: Appropriate Actions Taken to Pre–nt tion ☑ Yes ☐ No

Wound Classification: ☐ I ☒ II ☐ III ☐ IV

Shave Prep: ☐ Shave ☐ Clipper
Area: ______ By: ______

Skin Prep: ☒ Betadine Scrub ☐ Hibiclens ☐ Duraprep ☐ Other: Bet Soln

Solutions/Medications: ☒ Normal saline ☐ Sterile water ☐ Local ☐ Antibiotics ☐ Other:

Drains/Packing: ☐ None
☐ Foley FR:
☐ JP #1 Fr 10 Location: (L) leg #2 Fr ___ Location: ______
☐ Hemovac: Size ____ Location ______
☐ Chest tube: Location ______
Size ______ H2O Pressure: ______
☐ Packing: type/location: ______
☐ See RN Note # ___ for comments

Dressing: Location: (L) + R LE
☐ ABD ☑ Ace ☐ Bias ☐ Band-Aid(s) ☐ Cast
☐ Cervical Collar ☐ Coban ☐ Drip Pad ☐ Fluffs ☒ Kerlix
☐ Kling ☐ Immobilizer ☑ Plains ☐ Sling ☐ Splint
☐ Steri-strips ☐ Tape ☑ Webril ☐ Xeroform ☐ Other:
☐ Benzoin ☐ Mastisol ☐ Bacitracin

Miscellaneous

Counts: (initials)
Scrub: ___ RN: [initials]

	Correct?		
Sharps	☑ Yes	☐ No	☐ N/A
Sponges	☑ Yes	☐ No	☐ N/A
Instruments	☐ Yes	☐ No	☐ N/A

See RN note # ___ for additional comments

Xray: ☑ None ☐ Portable ☐ C-Arm ☐ Other:

Skin Integrity: ☑ Clear & Intact (other than incision)
Comments: ______
☐ See RN note # ___ for additional comments.

Implants:
Item / Lot # / Exp Date:

See RN note # ___ for additional comments.

Discharge from Operating Room

Complications: ☑ None Comments: ______
See RN note # ___ for additional comments

Transport From OR: ☑ gurney w/ siderails up ☐ Litter w/ safety strap in place ☐ w/ Oxygen ☐ w/ Monitor ☐ Other:

Transferred To: ☑ PACU ☐ ICU ☐ Medivac ☐ Ward ___ ☐ Other
Report by: ☐ Anesthesia provider ☐ RN

Surgical Procedure Performed: I+D c̄ delayed 1° closure

RN Note: (number each note to corresponding area above)

Initial/Name Box: (please print)

(b)(6)-2 cem 4/8/03

Primary OR RN Signature Date

Relief OR RN Signature Date/Time

‾riOperative Plan Of Care & Nursi‾ Note

Patient Assessment For Surgery - Potential For Injury - Outcome: Patient is free from signs and symptoms of injury ☐ Yes ☐ No

Trauma# or Patient #

Diagnosis: (R) Buttocks Wound (L) thigh wound   Planned Procedure: I&D.   (b)(6)-2

Side: ☐ N/A ☒ Right ☒ Left

Date: 4/8/03 Arrival Time: Interviewer: LT   Age: HT: WT:

From:	Transport Via:	Patient ID:	Blood Ordered:	Surgical/Anesthesia Consent Verified:
☐ CASREC ☐ ICU ☐ Ward ____ ☐ OTHER:	☒ Gurney ☐ Litter ☐ Ambulated ☐ Wheelchair ☐ Other	☐ Trauma card ☐ Verbal ☒ Chart ☒ Armband ☐ Other	☒ N/A ☐ Yes ☐ Consent ☐ T/C #Units ____ ☐ T/H #Units ____ Comments:	☐ Procedure ☐ Consent complete, dated, signed ☒ Emergent case; no consent, MD note

Preop Labs (HCG, etc):	Drug/Latex Allergies:	Present On Admission:	Past Medical History:	Cultural Needs Addressed:
☐ None ☒ Yes Test/Results: ____	☐ NKDA Allergy/Reaction: Undetermined	☐ N/A ☐ Oxygen ■ IV Site: #1 ____ #2 ____ ☐ Foley ☐ Endotrachial Tube ☐ Arterial Line Site: ____ ☐ Drain(s) ____ ☐ Chest Tube(s) ____ ☐ See RN Note #	☐ None known ☐ Smoker ppd/yrs / ☐ ETOH ☐ Asthma ☐ HTN ☐ CAD ☐ **GERD** ☐ CBR exposure ☐ Other: Past Surgical History: ☐ None known ☐ Yes List: ____	☐ Yes ☐ No List: EPW Communicated thru interpreter - Arabic
Pre-Op Pain: ☐ No ☐ Yes Level ____ (0-10) Action Taken: ____ Location/type: ____				Last PO Intake: (date/time) Solid: 4/7/03 Liquid: 4/7/03

In Chart:	Skin Condition:	Limitations:	Personal Items:
☐ H&P ☐ Yes ☐ No ☐ EKG ☐ Yes ☐ No ☐ CXR ☐ Yes ☐ No ☐ Other: ____	☐ Intact ☐ Other: Dressing to (R) buttock, Wound to (L) thigh	☒ N/A ☐ Auditory ☒ Language ☐ Visual ☐ Mobility ☐ Prosthesis ☐ Other: Unable to communicate in English	☒ None ☒ Military gear ☐ Glasses ☐ Dentures ☐ Jewelry/wallet ☐ Other Disposition:

Potential For Anxiety – Outcome: Patent demonstrates knowledge of psychological responses to an invasive procedure ☐ Yes ☐ No

Mental/Emotional Status:	Comfort Measures Implemented:	Pre-op Teaching Included:
☐ Alert/Oriented ☐ Calm ☐ Disoriented ☐ Sedated ☐ Anxious.. ☐ Unresponsive ☐ Appropriate for age ☐ Other	☐ Clear, concise explanations ☐ Communicated patient concerns to other staff members ☐ Remain with patient during induction	☐ NIA due to patient condition ☐ Physical layout of OR ☐ Personnel present during procedure ☐ Environment (noise, temperature, etc.) ☐ Post-op expectation (PACU, drains, etc.)

Potential For Impaired Skin Integrity Related To Surgical Procedure – Outcome: Patient is injury free ☐ Yes ☐ No

Operative Position:	Positional Aids:				Comments:
☒ Supine 2nd ☐ Beach chair ☐ Prone ☐ Sitting ☐ Jackknife ☒ Lateral (L) R ☐ Lithotomy 1st Prone ☐ Other:	☐ Arms <90 Armboard: ☐ L ☐ R Tucked: ☐ L ☐ R	☒ Airplane ☐ Fracture Table ☐ Hand Table ☐ Stirrups ☐ Other:	☐ Axillary roll ☐ Gel Pad ☐ Leg Holder ☐ Tape	☐ Bean Bag ☐ Gel donut ☐ Pillows ☐ Wilson Frame	

ESU # 1 Pad Site: (R) Thigh Pad Lot # 66918 Site Clear at end of case? ☐ No ☐ Yes If No, see RN note # ____ Bipolar: ___ Max Cut___ Coag ___	**DVT Prevention:** SCD used ☒ No ☐ Yes Pressure: ___ ☐ Left ☐ Right Teds: ☐ No ☐ Yes **Bair Hugger used:** ☒ No ☐ Yes Other warming techniques:	**Tourniquet:** ☐ Arm ☐ Leg #____ ☐ Left ☐ Right ☐ webril applied ↑ ____ ↓ ____ ↑ ____ ↓ ____ Applied by: Total Min:	Comments:

(b)(6)-4

Comments:

MEDCOM - 5073

PeriOperative Plan Of Care & Nursing Note

Patient Assessment For Surgery - Potential For Injury - Outcome: Patient is free from signs and symptoms of injury ☒Yes ☐No

Trauma# or Patient #: (b)(6)-4
Diagnosis: ________
Planned Procedure: ORIF (R) Hip
(b)(6)-2
Side: ☐N/A ☒Right ☐Left
Date: 11 APR 03 Arrival Time: . Interviewer: LT. Age: HT:

From:	Transport Via:	Patient ID:	Blood Ordered:	Surgical/Anesthesia Consent Verified:
☐CASREC ☐ICU ☒Ward 5 FWD ☐OTHER:	☒Gurney ☐Litter ☐Ambulated ☐Wheelchair ☐Other	☐Trauma card ☐Verbal ☒Chart ☒Armband ☐Other	☒N/A ☐Yes ☐Consent ☐TIC #Units ____ ☐T/H #Units ____ Comments:	☐Procedure ☐Consent complete, dated, signed ☒Emergent case; no consent, MD note

Preop Labs (HCG, etc):	Drug/Latex Allergies:	Present On Admission:	Past Medical History:	Cultural Needs Addressed:
☐None ☒Yes 08APR03 Test/Results: HB 8.5 HCT 25.7 PLT 244	☒NKDA Allergy/Reaction: ____	☐N/A ☐Oxygen ☒IV Site: #1 (R) Forearm #2 ____ ☐Foley ☐Endotrachial Tube ☐Arterial Line Site: ☒Drain(s) JP (R) Hip ■ Chest Tube(s) ☐See RN Note #	☒None known ☐Smoker ppd/yrs / OETOH ☐Asthma ☐HTN ☐CAD ☐GERD ☐CBR exposure ☐other:	☒Yes ☐No List: PT PRIVACY RESPECTED

Pre-Op Pain: PT WAS MEDICATED @ 0815 ☐ ARRIVING IN HOLD AREA
☒No
☐Yes Level ____ (0-10)
Action Taken: ____
Location/type: ____

Past Surgical History:
☐None-known
☒Yes I+D (R) HIP
List: TRACTION PIN (R) LEG

Last PO Intake: (date/time)
Solid: > 5° AGO (PIGGY...)
Liquid:
ANES PROVIDER NOTIFIED

In Chart:	Skin Condition:	Limitations;	Personal Item:
H&P ☒Yes ☐No EKG ☐Yes ☐No CXR ☐Yes ☐No Other:	☐Intact ☐Other: MULTIPLE TRAUMATIC WOUNDS	☐N/A ☐Auditory ☐Language ☐Visual ☒Mobility ☐Prosthesis ☐Other:	☒None ☐Military gear ☐Glasses ☐Dentures ☐Jewelry/wallet ☐Other Disposition:

Potential For Anxiety – Outcome: Patent demonstrates knowledge of psychological responses to an invasive procedure ☒Yes ☐No

Mental/Emotional Status:	Comfort Measures Implemented:	Pre-op Teaching Included:
☐Alert/Oriented ☒Calm ☐Disoriented ☐Sedated ☐Anxious ☐Unresponsive ☐Appropriate for age ☐Other	☐Clear, concise explanations ■ Communicated patient concerns to other staff members ☒Remain with patient during induction	☒N/A due to patient condition / LANGUAGE BARRIER ☐Physical layout of OR, ☐Personnel present during procedure ☐Environment (noise, temperature, etc.) ☐Post-op expectation (PACU, drains, etc.)

Potential For Impaired Skin Integrity Related To Surgical Procedure – Outcome: Patient is injury free ☒Yes ☐No

Operative Position:	Positional Aids:	Comments:
☐Supine ☐Beach chair ☐Prone ☐Sitting ☐Jackknife ☐Lateral L I R ☐Lithotomy ☐Other:	☒Arms <90 ☐Airplane ☐Axillary roll ☐Bean Bag Armboard: ☒L ☒R ☐Fracture Table ☒Gel Pad ☐Gel donut ☐Hand Table ☐Leg Holder ☐Pillows Tucked: ☐L ☐R ☐Stirrups ☐Tape ☐Wilson Frame ☐Other:	

ESU # 10 Pad Site: (L) HIP Pad Lot # L1277/6/04 Site Clear at end of case? ☐No ☒Yes If No, see RN note # Bipolar: ___ Max Cut 30 Coag 30	DVT Prevention: SCD used ☒No ☐Yes Pressure: ___ ☐Left ☐Right Teds: ☐No ☐Yes Bair Hugger used: ☐No ☒Yes Other warming techniques:	Tourniquet: N/A ☐Arm ☐Leg #____ ☐Left ☐Right ☐webril applied Applied by: ↑ ____ ↓ ____ Total Min: T ↓	Comments:

(b)(6)-4

Comments: ____

Potential For Infection – Ou[illegible] e: Appropriate Actions Taken to Prevent Infe[illegible] n ☒Yes ☐No

'ound Classification:	Shave Prep:	[illegible] Prep:	Solutions/Me[illegible]:	
I ☒II ☐III ☐IV	☐Shave ☒Clipper	☒Betadine Scrub (b)(6)-2	☒Normal saline	☐Other,
	Area: (R) HIP By: DR	☐Hibiclens	☐Sterile Water	
	(b)(6)-2	☐Duraprep	☐Local	
		■ Other:	☐Antibiotics	

rains/Packing: ☐None
Foley FR: IJ PLACE UPON ARRIVAL TO OR
JP #1 Fr ___ Location: ______ #2 Fr ___ Location: ______
Hemovac: Size 1/8" Location (R) HIP
Chest tube: Location ______
Size ______ H20 Pressure: ______
Packing: type/location: ______
See RN Note # for comments

Dressing: Location: (R) HIP (L) LEG

☐ABD	☐Cervical Collar	☒Kling	☐Steri-strips	☐Benzoin
☒Ace	☐Coban	☐Immobilizer	☒Tape	☐Mastisol
☐Bias	☐Drip Pad	☒Plains	☐Webril	☐Bacitracin
☐Band-Aid(s)	☐Fluffs	☐Sling	☒~~Xeroform~~ (b)(6)-2	
☐Cast	☒Kerlix	☐Splint	☐Other:	

Miscellaneous

ounts: (initials)
rub: RN: (b)(6)-2

Correct?
Sharps ☐Yes ☐No ☐N/A
Sponges ☐Yes ☐No ☐N/A
~~Instruments ☐Yes ☐No ☐N/A~~

See RN note # ____ for additional comments

Xray:
☐None ☐Other:
☐Portable
☒C-Arm

Skin Integrity:
☐Clear & Intact (other than incision)
Comments: MULTIPLE TRAUMATIC WOUNDS
☐See RN note # ___ for additional comments.

nplants:
em / Lot # / Exp Date:
DHS IMPLANTS TR-245201 280.90 90mm 40°, 140 DHS 4 hole Long Barrel DHS Screw plate
LG FRAG SCREW: 4.5mm x 42mm x4 (214.042)
See RN note # for additional comments.

Discharge from Operating Room

omplications:
None Comments: ______
See RN note # for additional comments

Transport From OR:
☒gurney w/ siderails up
☐Litter w/ safety strap in place
☒w/ Oxygen
☐w/ Monitor
☐Other:

Transferred To:
☒PACU
☐ICU
☐Medivac
☐Ward
☐Other

Report by:
☒Anesthesia provider ☐RN

urgical Procedure Performed: ORIF (R) HIP, I+D (L) THIGH WOUND

N Note: (number each note to corresponding area above)

Initial/Name Box: (please print)
(b)(6)-2 (b)(6)-2
(b)(6)-2

(b)(6)-2 LTJG HARROS
Primary OR RN Signature Date
Relief OR RN Signature Date/Time

NKA

NAVMED 6550/8 (REV. 4-74) S/N 0105-LF-216-5581

MEDICAL RECORD | **MEDICATION ADMINISTRATION RECORD**

ORDER DATE	SCHEDULED DRUGS: MEDICATION- DOSAGE- FREQUENCY ROUTE OF ADMINISTRATION	HOURS	4/8	4/9	4/10	4/11	4/12	4/13	4/14
4/9	ANCEF 1g IV q 8hr x 48 hr	0800	X	(b)(6)-2	X	X	X	X	X
		1600	given @ PACU		X	X	X	X	X
		2400	(b)(6)-2	(b)(6)-2	X	X	X	X	X
4/9	LOVENOX 30 mg SQ BID	0800	X	(b)(6)-2	held		(b)(6)-2		D/C ō 1st dose
		1600	X		(b)(6)-2			X	
4/9	PERCOCET 1-2 TAB PO q 3° for	0200	X	(b)(6)-2			refused	refused	R
	moderate pain (around the	0500	X	(b)(6)-2	Held	Refused	refused		R
	clock) pt may refuse	0800	X	(b)(6)-2					
		1100	X	(b)(6)-2					held
	R = Refused	1400	X	(b)(6)-2				(b)(6)-2	
		1700	X	(b)(6)-2					
		2000	X	(b)(6)-2					
		2300	X	(b)(6)-2					
4/9	Ancef 1gm IVPB q 8° x 48	0800	X	X	(b)(6)-2		auto stop 4/11/03		
		1600	X	X	(b)(6)-2				
		2400	X	X	X				
4/11	Ancef 1GM IV Q8° x 48°	2300	X	X	X	(b)(6)-2			auto stop 4/13 @ 0800
		0700	X	X	X	X	(b)(6)-2		
		1500	X	X	X	X	(b)(6)-2		
4/11	Gentamycin 300mg IV x 48°	0800	X	X	X	X	(b)(6)-2		X
			X	X	X	X		X	X
4/11	Coumadin 5mg po q HS x 2 days		X	X	X	X	X	X	X
		2000	X	X	X	X	(b)(6)-2		X

INITIAL CODE

INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE
(b)(6)-2		(b)(6)-2		(b)(6)-2	
(b)(6)-2		(b)(6)-2		(b)(6)-2	
(b)(6)-2		(b)(6)-2			
		(b)(6)-2			
				(b)(6)-2	

ADDRESSOGRAPH PLATE

(b)(6)-4

2 of 2

Injection Site Code

1 = Left Buttock
2 = Right Buttock
3 = Left Deltoid
4 = Right Deltoid
5 = Left Leg
6 = Right Leg
7 = Left Arm
8 = Right Arm
9 = Abdomen

WARD NO.

SINGLE DOSE, PRE-OP PRN & VARIABLE DOSE ORDERS SEE REVERSE

MEDCOM - 5076

MEDICATION ADMINISTRATIOI ORD (Back) S/N 0105-LF-216-5581 N. A

SINGLE ORDERS - PRE-OPERATIVE

MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	TIME	INITIAL	MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	TIME	INITIAL

PRN AND VARIABLE DOSE MEDICATIONS

ORDER DATE	MEDICATION-DOSAGE FREQUENCY ROUTE OF ADMINISTRATION		DOSES GIVEN															
4/9	MSO4 6mg IM or	DATE	4/11	4/12	4/12	4/12	4/13	4/13	[illegible]	4/14	4/15	4/15						
4/11	IV q 4° PRN for	TIME	0815	1112	1750	0800	0800	2220	0415	0910	0917	0900						
	pain significant	DOSE	6mg	6mg	6+6	6mg	6mg	6mg	6mg	6mg	6mg	6mg						
		INIT.	(b)(6)-2															
4/9	PHENERGAN 25mg	DATE																
4/11	IM or IV q 4° PRN	TIME																
		DOSE																
		INIT.																
4/9	Tylenol 650 mg	DATE	4/12	4/13	4/15													
4/11	PO q 4° prn	TIME	1230	0730	1340													
		DOSE	ii	ii	ii													
		INIT.	(b)(6)-2															
4/9	MOM 30cc PO	DATE																
4/11	q 4° PRN	TIME																
		DOSE																
		INIT.																
4/9	BENADRYL 25mg	DATE	4/12															
4/11	PO q 4° PRN	TIME	2400															
	* UP TO 50mg PER	DOSE	50mg															
	WMO	INIT.	(b)(6)-2															
4/9	SURFAK 240mg	DATE																
4/11	PO BID PRN	TIME																
		DOSE																
		INIT.																
4/9	VALIUM 5mg PO	DATE	4/11															
4/11	q 12° PRN for	TIME	0630															
	muscle spasm in	DOSE	5mg															
	traction	INIT.	(b)(6)-2															

MEDCOM - 5077

NAVMED 6550/8 (REV. 4-74) S/N 0105-LF-216-5581

MEDICAL RECORD | **MEDICATION ADMINISTRATION RECORD**

SCHEDULED DRUGS			MONTH Apr ~~19~~ 2003						DATES GIVEN
ORDER DATE	MEDICATION- DOSAGE- FREQUENCY ROUTE OF ADMINISTRATION	HOURS	4/15	4/16	4/17	4/18	4/19	4/20	4/21
9 Apr	Percocet 1-2 Tab po Q3° for	0300	(b)(6)-2						
	moderate pain Pt may refuse	0600							
	R= refused	0900							
		1200							
		1500							
		1800							
		2100							
		2400							

INITIAL CODE

INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE
(b)(6)-2	ENS				

ADDRESSOGRAPH PLATE

(b)(6)-4

1 of 2

WARD NO.

Injection Site Code

① = Left Buttock
② = Right Buttock
③ = Left Deltoid
④ = Right Deltoid
⑤ = Left Leg
⑥ = Right Leg
⑦ = Left Arm
⑧ = Right Arm
⑨ = Abdomen

SINGLE DOSE. PRE- OP PRN & VARIABLE DOSE ORDERS SEE REVERSE

MEDCOM - 5078

(b)(3)-1

Personal Data - Privacy Act of 1974 (PL 93-579)
PATIENT LAB INQUIRY
For: 08 Apr 03 - 11 Apr 03

ort requested by: (b)(6)-2

(b)(6)-4 (b)(6)-4 M/3d Reg #: (b)(6)-4
Military Unit: UNKNOWN

SERUM

Apr 03 @ 1034 (Coll)

Test	Result	Flag	Range	Units
AT NA+	133	L	(137-145)	mmol/L
K	3.4	L	(3.6-5.0)	mmol/L
CL-	103		(97-107)	mmol/L
CO2	25		(22-31)	mmol/L

BLOOD

Apr 03 @ 1033 (Coll)

Test	Result	Flag	Range	Units
AT WBC	8.5		(4.8-10.8)	K/UL
RBC	3.0	L	(4.7-6.1)	1X10 6/UL
HGB	9.3	L	(14.0-18.0)	g/dL
HCT	26.7	L	(42-52)	%
MCV	88.5		(80-94)	fL
MCH	30.8		(27-32)	pg
MCHC	34.8		(31-37)	g/dL
RDW	13.6		(12-14)	%
PLT CNT	361		(150-450)	1x10 3/UL
MPV	8.1		(7.4-10.4)	FL
NEUT/100 WBC	74.1			%
NEUT%	6.3			1x10 3/UL
LYMPHS/100 WBC	18.3			%
LY#	1.6			1x10 3/UL
MONO/100 WBC	7.6			%
MO#	0.6			1x10 3/UL
EO#	<0.7			1x10 3/UL
BAS#	<0.2			1x10 3/UL

L=Lo H=Hi *=Critical Resist S=Susc MS=Mod Susc ermed

MEDCOM - 5079

Personal Data - Privacy Act of 1974 (PL 93-579)
Review Results

Report requested by: (b)(6)-2

(b)(6)-4 (b)(6)-4 M/15d Reg #: (b)(6)-4
Ph: Military Unit: UNKNOWN

23 Apr 03 @ 0824 (Coll) URINE

Test	Result	Flag	Reference	Units
COLOR.	YELLOW			
APPEARANCE.	HAZY			
SG.	1.010		(1.010-1.020)	

Interpretations:
Normal Range provided is for first morning void.

Test	Result	Flag	Reference	Units
PH.	6.0		(4.5-7.5)	
LEUKO EST	MODERATE	H	(NEGATIVE)	
NITRITE	NEG		(NEGATIVE)	
U PROT.	TRACE		(NEG)	MG/DL

Result Comment: SSA TEST PERFORMED WITH RESULT OF NEGATIVE

Test	Result	Flag	Reference	Units
UGLUCOSE.	NEG		(NEGATIVE)	mg/dL
U KETONES	NEG		(NEGATIVE)	mg/dL
UROBLGN	0.2		(0-1)	mg/dl
U BILI.	NEGATIVE		(NEGATIVE)	
U HGB	TRACE		(NEGATIVE)	
U WBC	50-100	H	(0-2)	/HPF
U RBC	1-3			
BACTERIA.	3+			/HPF

==
L=Lo H=Hi *=Critical R=Resist S=Susc MS=Mod Susc I=Intermed
[]=Uncert /A=Amended Comments= (O)rder, (I)nterpretations, (R)esult
==

*** End of Report ***

NNMC NEUROVASCULAR CHECK SHEET

DATE		TIME	2015	2028	2040	2105	2120	2140	2155	2215	2235	2250		
NEUROLOGICAL CHECK	EXTREMITY		(b)(6)-2											
	PAIN	ABSENT	(b)(6)-2											
		MINIMAL												
		MODERATE												
		SEVERE												
	SENSATION	NORMAL												
		NUMBNESS	(b)(6)-2											
		TINGLING												
		ABSENT												
	BLANCHING (N - Normal; S - Sluggish)				N	N	N	N	N	N	N	N		
	ACTIVE MOTOR FUNCTION	NORMAL												
		LIMITED												
		ABSENT	(b)(6)-2											
SIGNS OF COMPARTMENT SYNDROME		PAIN ON PASSIVE MOTION												
		PAIN UNRELIEVED BY ANALGESICS												
VASCULAR CHECK	COLOR	RED												
		PINK	(b)(6)-2											
		PALE												
		BLUE												
	SKIN TEMPERATURE	HOT												
		WARM	(b)(6)-2											
		COOL	(b)(6)-2		(b)(6)-2									
		COLD												
	PULSE	NORMAL	(b)(6)-2											
	SITE ® FOOT	WEAK			(b)(6)-2									
		ABSENT												
	EDEMA	NONE	(b)(6)-2		(b)(6)-2									
	SITE ® FOOT	SMALL												
		MODERATE												
		LARGE												

COMMENTS

INITIAL	SIGNATURE / TITLE	INITIAL	SIGNATURE / TITLE	INITIAL	SIGNATURE / TITLE
(b)(6)-2	HN				
(b)(6)-2	HN				

MEDCOM - 5081

PATIENT PROFILE
NAVMED 6550/12 (5-80) S/N 0105-LF-206-5560

NKDA

√	ACTIVITY	DATE	√	BATH	DATE	DIET	DATE	√	VITAL SIGNS	FREQ	√	SPECIAL NOTES
	Bedrest			Bed bath		NPO p̄ MN	4/14		Temp	Q4° x 24° then Q8° N/V checks c̄ vitals		Dentures
	Bathroom Privileges			Shower					Pulse			Speech impediment
	Up in chair			Tub					Resp			Language barrier
	Ambulate			Needs assistance					B/P			Prosthetic device
	Commode								Other			Visual impairment
	Needs assistance											Blind
	Restricted to unit											Contact lenses
	Hospital Privileges			ORAL HYGIENE	DATE							Glasses
	Other	4/10		Self		FEEDING	DATE		FLUIDS			Hearing defect
	NWB (R) leg			Needs assistance		Self			Forced to:			Other
				Special		Needs assistance			Restricted to:			
						Gavage	4/9		I & O x48°	Q8°		

DATE ORD.	DATE RENEW	TREATMENTS/SPECIAL NOTES	TIMES	DATE ORD.	DATE RENEW	TREATMENTS/SPECIAL NOTES	TIMES
4/9		TRANSFER EPW WARD		4/11		D5LR @ 100cc/Hr	
		DR (b)(6)-2 (ORTHO)					
[illegible]		[illegible]		4/11		Foley	
		[illegible]		4/11		Hemovac to suction	
		[illegible]					
[illegible]		[illegible]		4/14		Reposition Q2°	
		[illegible]	[illegible]			to prevent decub. ITIS	
4/11		CALL ORTHOTECH for casts, splints					
		traction or cast bivalving # 194		4/14		NPO p̄ MN ID in AM	
4/9		DRESSING Δ's Wet to DRY (C)				4/15	
		THIGH & LEG WOUNDS					
4/11		CALL ORTHO # 191 if excessive					
		drainage from pin sites					
4/11		If N/V change occur, call charge					
		Nurse/WARD M.O To assess & bivalve cast if present					
4/11		If UOP < 30 cc/hr, bolus 500 NS & assess					
		results Call Ward M.O. if no improvement					
4/11		O_2 if needed					
				4/14		(R) foot AFO to wear in	
4/11		Drsg Δ (L) thigh/leg				shoe (foot drop AFO)	
		wet to dry BID					

ADDRESSOGRAPH

(b)(6)-4

DIAGNOSIS
(R) OPEN HIP FX
COMPLEX WOUNDS (B) THIGH LEG

AGE	HEIGHT	WEIGHT

PATIENT CLASSIFICATION
STABLE

OP/SPECIAL PROCEDURES
S/P transfusion 2 units PRBC

	DATE ON	DATE OFF
SI		
VSI		
RELIGIOUS RITES		

FINDINGS:

MEDCOM - 5082

ALLERGIES:

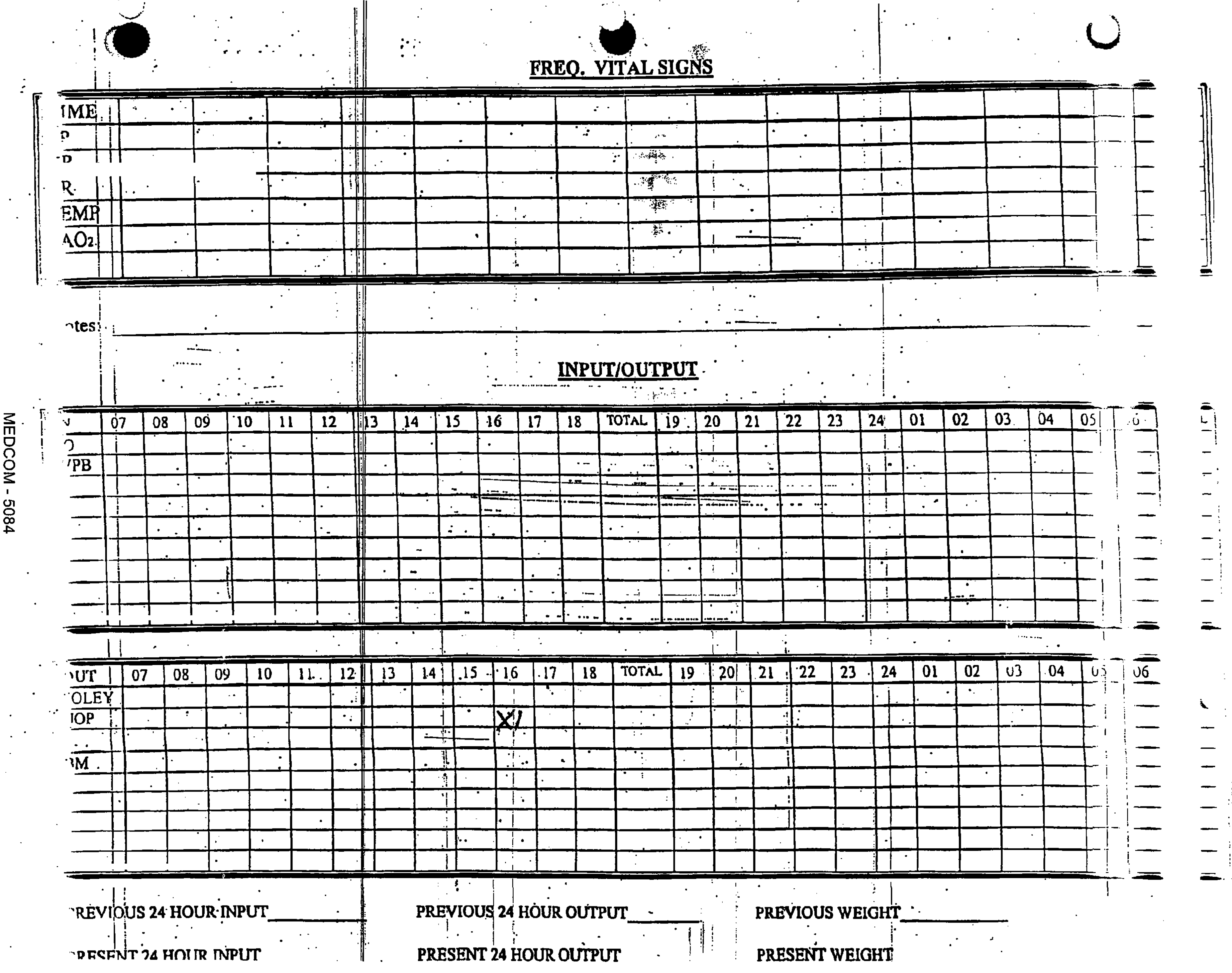
NONE KNOWN

DATE ORD.	DATE RENEW	MEDICATIONS	TIME (HOURS TO BE GIVEN)	DATE OF ORDER	LABORATORY/DIAGNOSTIC TESTS EXAMINATIONS/ CONSULTATIONS	DATE SENT	DATE COMP
4/9		Ancef ~~1g IV~~ q 8hr x 48hr	08-16-24	4/9	CBC, CHEM7 4/9 ☒		
4/9	P 0800 4/13	LOVENOX 30 mg SQ BID	08-16		CBC 4/10 ☒		
4/9		PERCOCET 1-2 TAB PO q3° (around the clock)	02-05-08 11-14-17		CBC 4/11 ☐		
		mod pain → pt may refuse	20-23	4/11	CHEM7, CBC 4/12 ☒		
4/11		Ancef 1GM Q 8° x 48°	07-15-23	4/11	CBC 4/13 ☒		
4/11		Gentamycin 300mg IV x 48°	0200	4/11	CBC 4/14		
4/12	P 4/13	COUMADIN 5mg PO QHS x 2d	2000	4/12	PT / INR 4/14		
4/9	4/	VALIUM 5 mg PO q 12° PRN					
4/9	4/11	SURFAK 240 mg PO BID PRN					
4/9	4/11	BENADRYL 25 mg PO q 4° PRN					
4/9	4/11	MOM 30 cc PO q 4° PRN					
4/9	4/11	TYLENOL 650 mg PO q 4° prn					
4/9	4/11	PHENERGAN 25 mg IM or IV q 4° PRN					
4/9	4/11	MSO4 6mg IM or IV q 4° PRN PAIN SIGNIFICANT					

ADDRESSOGRAPH

b)(6)-4

MEDCOM - 5083



FREQ. VITAL SIGNS

IME													
P													
P													
R													
EMP													
AO2													

otes:

INPUT/OUTPUT

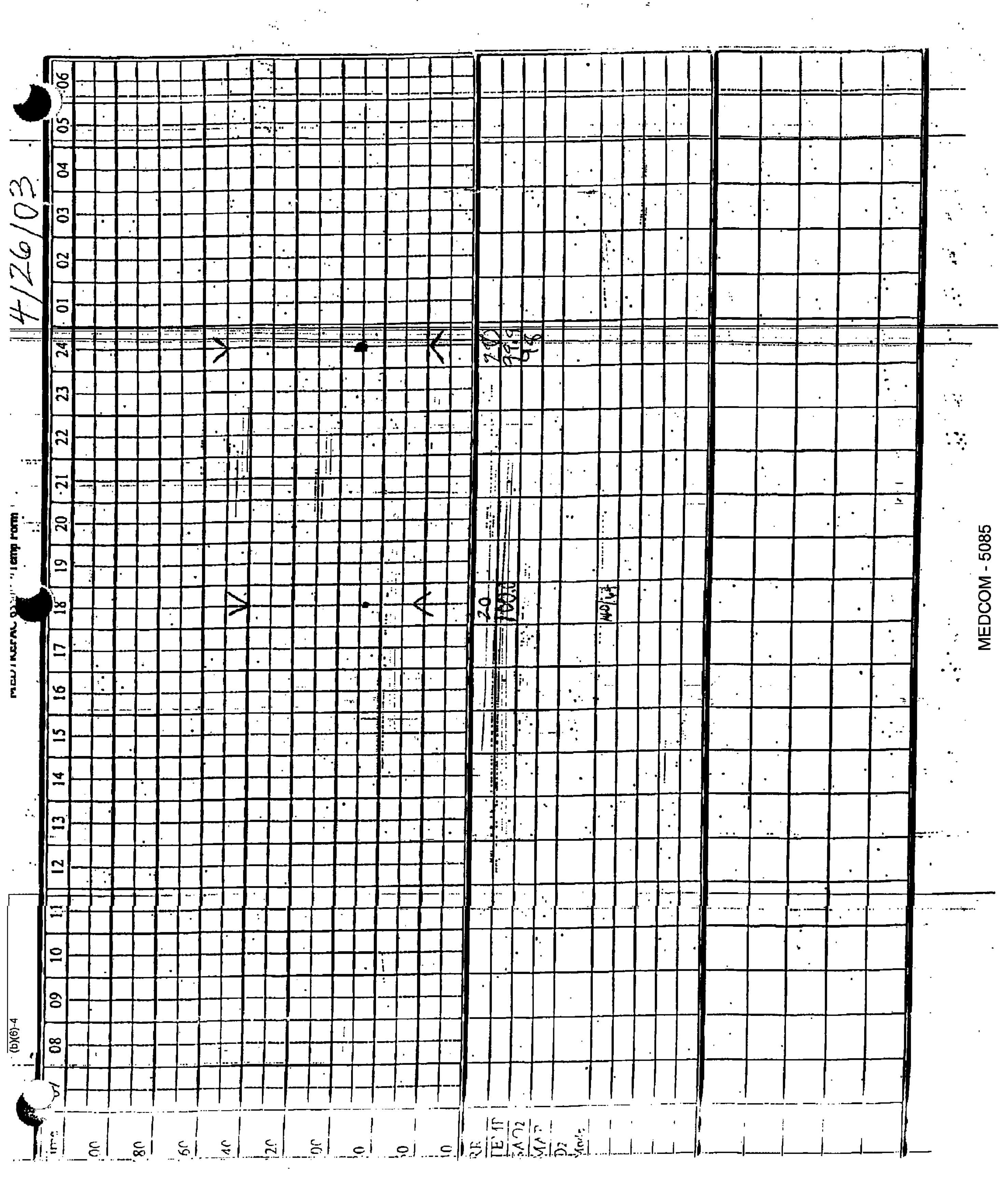
N	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06
O																									
VPB																									

UT	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06
OLEY																									
OP										X/															
BM																									

PREVIOUS 24 HOUR INPUT ______ PREVIOUS 24 HOUR OUTPUT ______ PREVIOUS WEIGHT ______

PRESENT 24 HOUR INPUT PRESENT 24 HOUR OUTPUT PRESENT WEIGHT

MEDCOM - 5084


4/26/03
MEDCOM - 5085

FREQ. VITAL SIGNS

IME														
P														
R														
R.														
EMP														
AO2														

otes: ____

INPUT/OUTPUT

N	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06
O																									
/PB																									

UT	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06
OLEY																									
IOP		600																							
RM																									

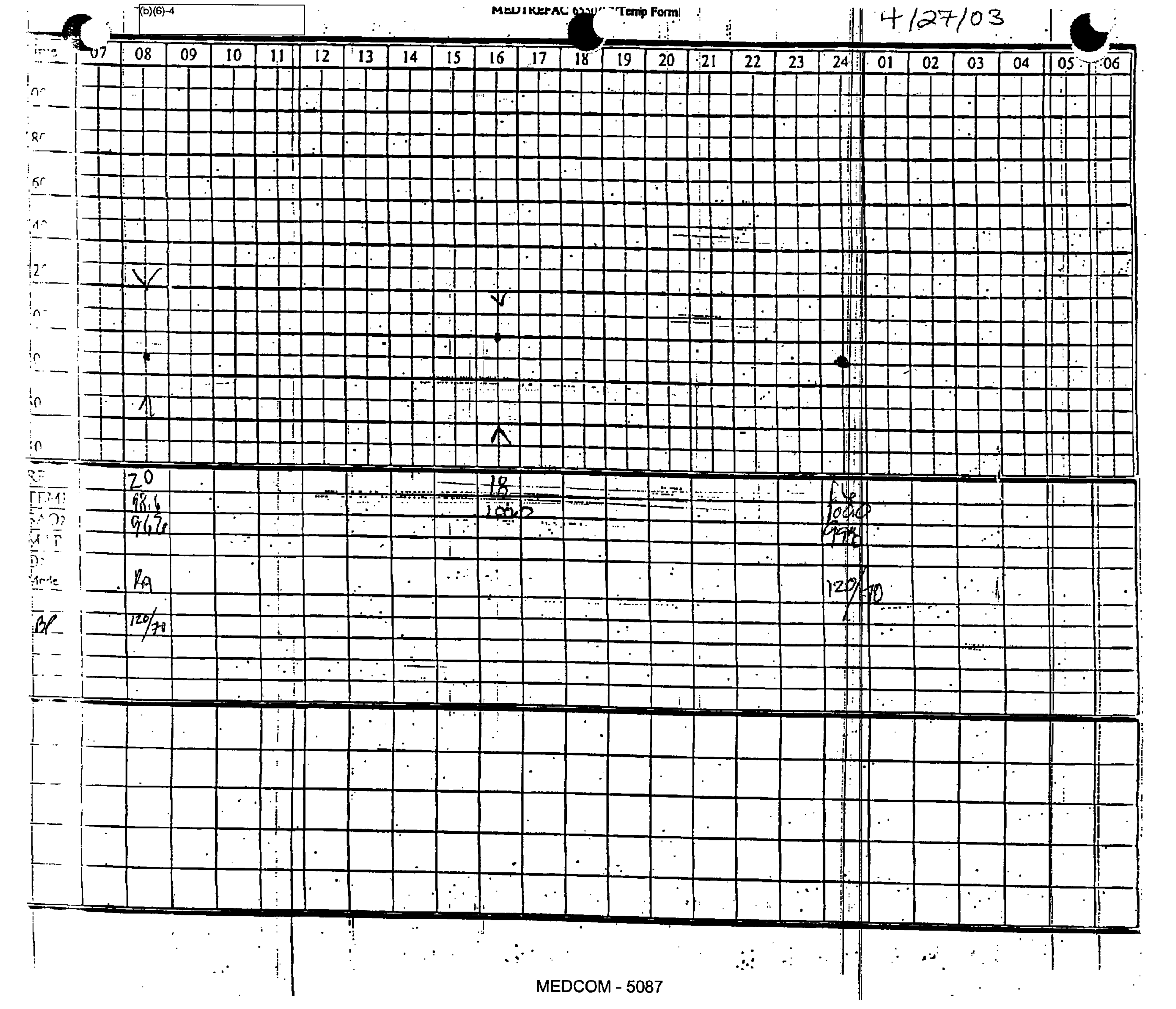
REVIOUS 24 HOUR INPUT ________ PREVIOUS 24 HOUR OUTPUT ________ PREVIOUS WEIGHT ________

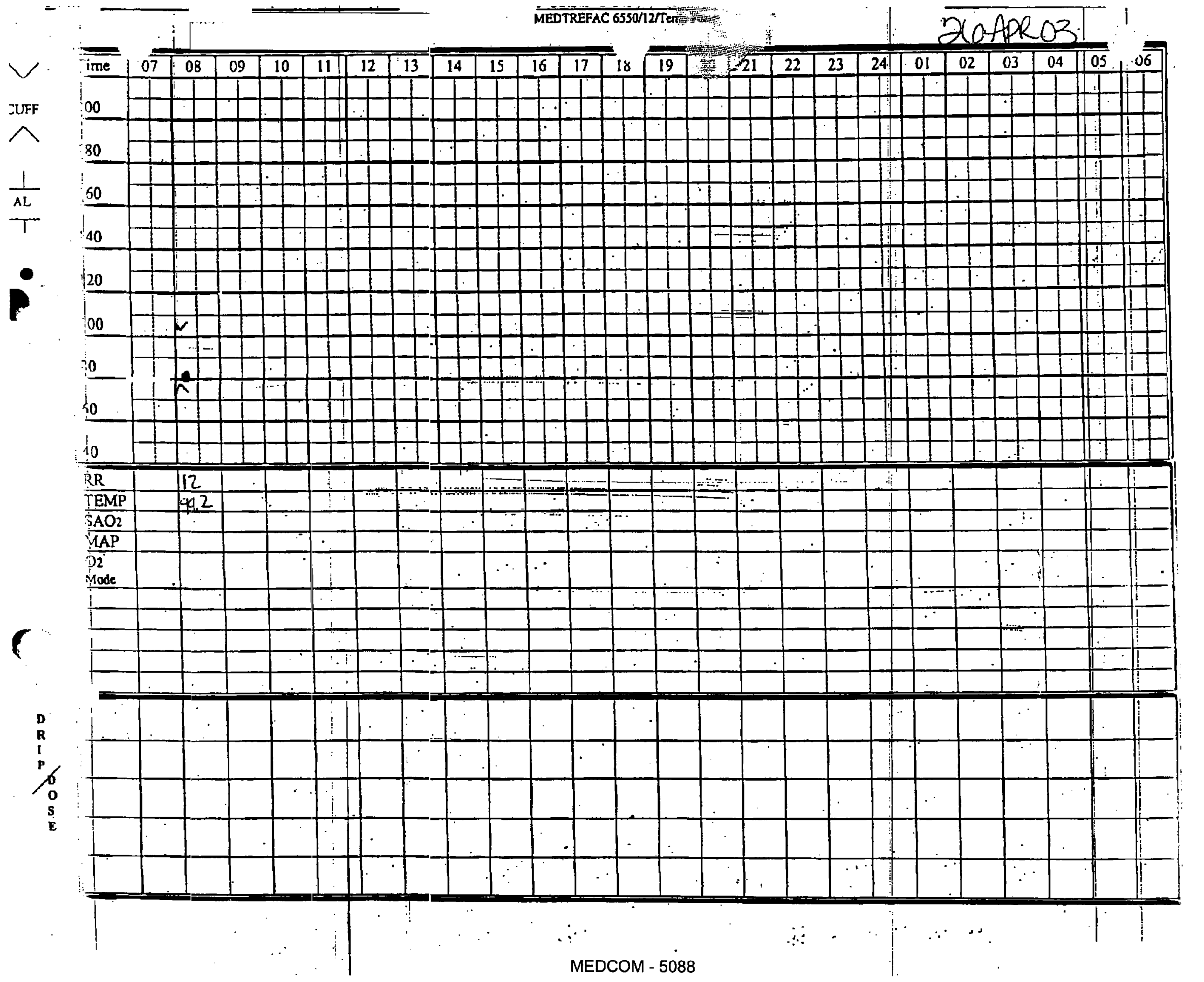
RESENT 24 HOUR INPUT PRESENT 24 HOUR OUTPUT PRESENT WEIGHT

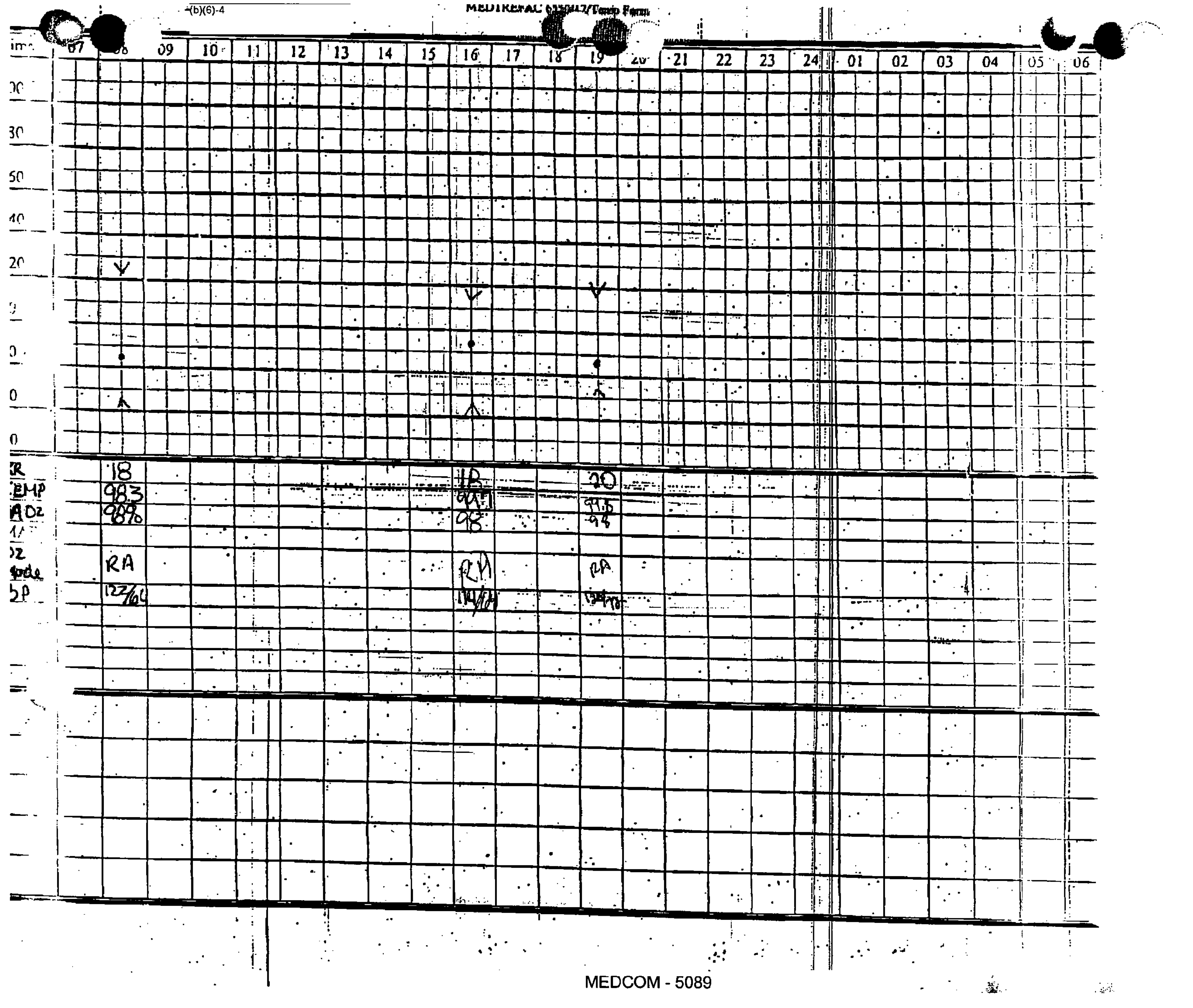
MEDCOM - 5086

ACLU-RDI 1259 p.59

DOD 12298


(b)(6)-4
MEDTREFAC [illegible] Temp Form
4/27/03
07 08 09 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 01 02 03 04 05 06
20
98.6
96%
RA
120/70
18
100.0
120/70
BP
MEDCOM - 5087


MEDTREFAC 6550/12/Terr
26APR03
Time 07 08 09 10 11 12 13 14 15 16 17 18 19 21 22 23 24 01 02 03 04 05 06
CUFF
AL
RR 12
TEMP
SAO2
MAP
O2
Mode
DRIP/DOSE
MEDCOM - 5088


MEDITREPAC
(b)(6)-4
07
08
09
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
01
02
03
04
05
06
18
983
98%
RA
122/64
20
RA
MEDCOM - 5089

FREQ. VITAL SIGNS

IME														
P														
R														
R														
EMP														
AO2														

otes:

INPUT/OUTPUT

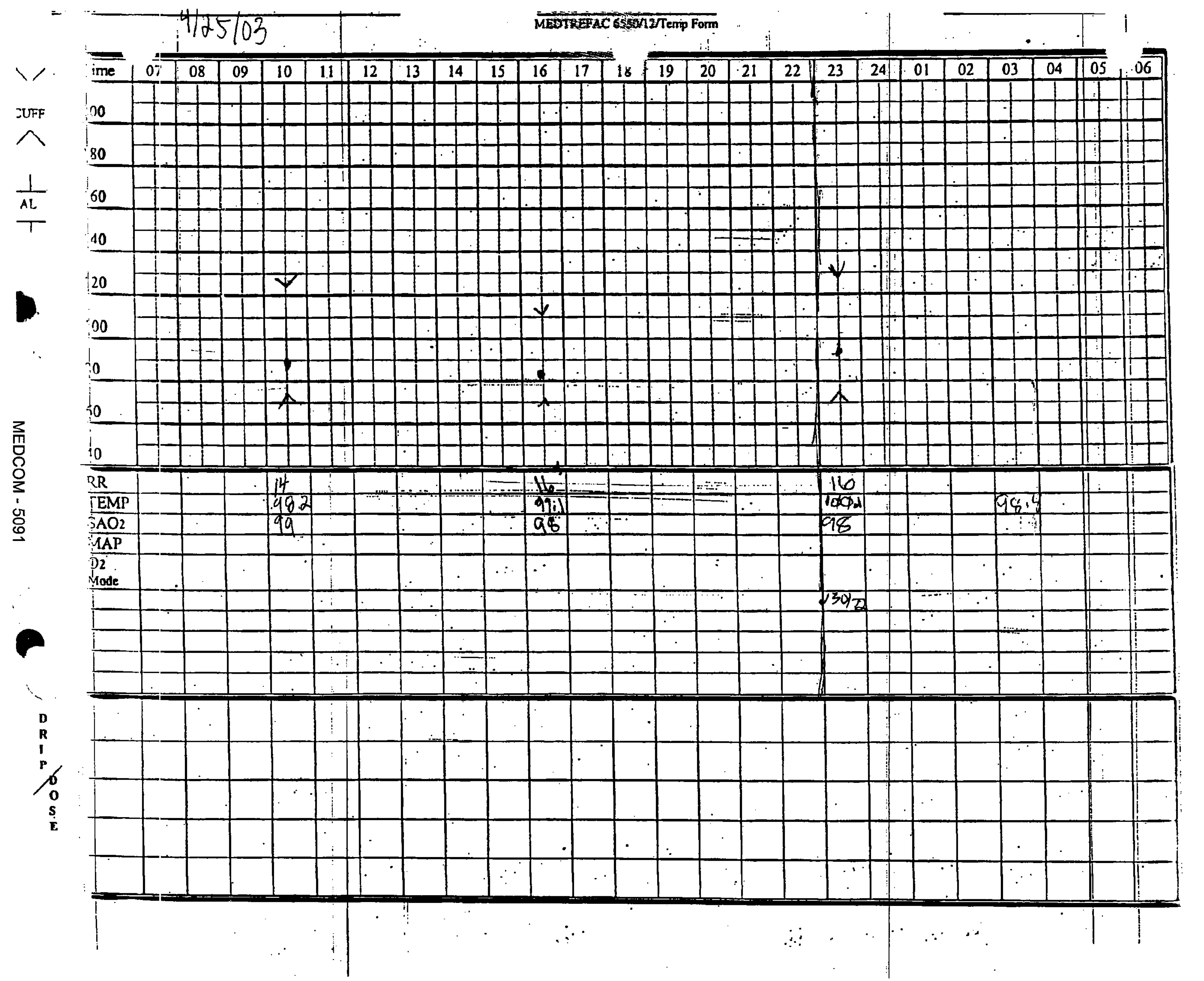
N	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	AL
O																										
VPB																										

UT	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06
OLEY																									
IOP										400	100			175			150								
M																									

REVIOUS 24 HOUR INPUT________ PREVIOUS 24 HOUR OUTPUT________ PREVIOUS WEIGHT________

RESENT 24 HOUR INPUT________ PRESENT 24 HOUR OUTPUT________ PRESENT WEIGHT________

MEDCOM - 5090



MEDTREFAC 6550/12/Temp Form

4/25/03

Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
RR				14						16							16							
TEMP				98.2						99.1							100.2				98.[illegible]			
SAO2				99						98							98							
MAP																								
O2																								
Mode																								
																	130/[illegible]							

CUFF AL DRIP/DOSE

MEDCOM - 5091

FREQ VITAL SIGNS

IME														
P														
R														
R														
EMP														
AO2														

otes:

INPUT/OUTPUT

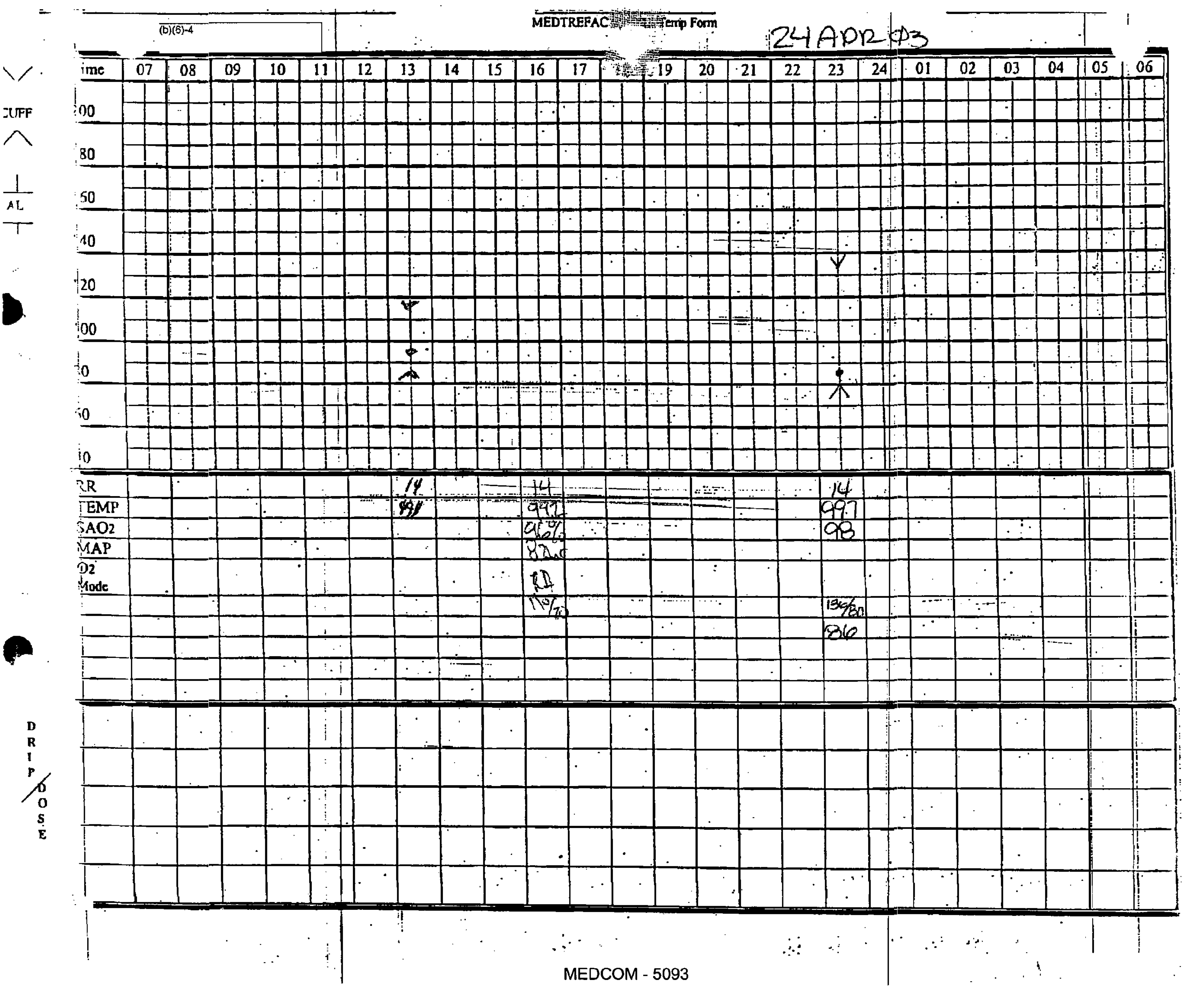
N	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	AL
O																										
PB																										

UT	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04
OLEY																							
OP									200									275					
M																							

REVIOUS 24 HOUR INPUT________ PREVIOUS 24 HOUR OUTPUT________ PREVIOUS WEIG________

RESENT 24 HOUR INPUT________ PRESENT 24 HOUR OUTPUT________ PRESENT WEIGI________

MEDCOM - 5092



MEDCOM - 5093

(b)(6)-4

MEDTREFAC 6550/12/Temp Form

Date: 23APR05

Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
200																								
180																								
160																								
140																								
120	√			V													V							
100																								
80	•			•													•							
60	Λ			Λ													Λ							
40																								

CUFF ∨ ∧ · AL ⊥ ⊤ · •

	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
RR	12			12						16							110							
TEMP	98.6			99.1						100.0							99.9							
SAO2										98%							98							
MAP										RA														
O2 Mode										128/74														
										102W							124/68							
																	88							

DRIP / DOSE

DOD 12307

FREQ. VITAL SIGNS

ME															
)															
R															
R															
EMP															
AO2															

otes: ____________________

INPUT/OUTPUT

	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
)																										
PB																										

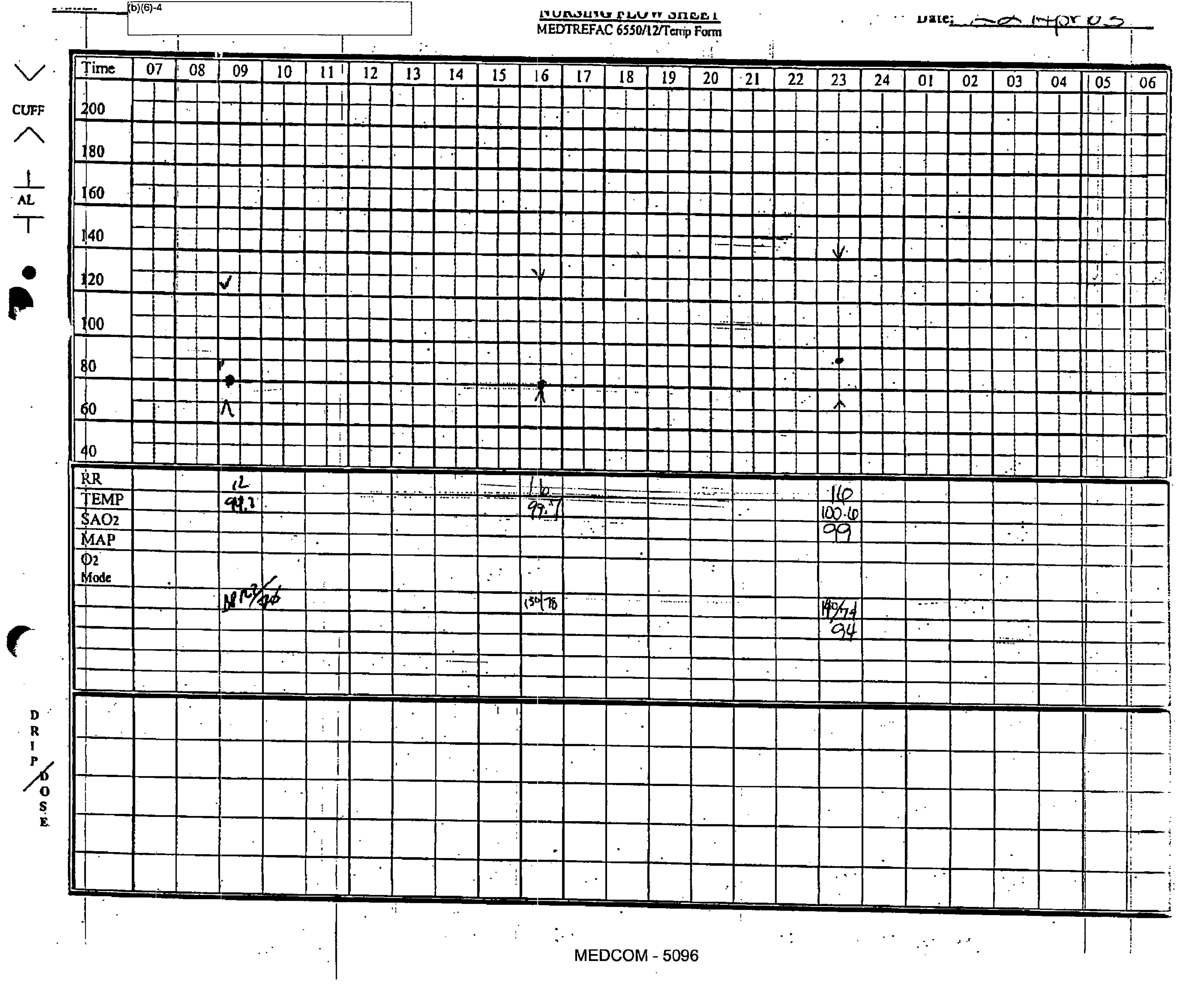
MEDCOM - 5095

UT	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	
OLEY																										
OP	400							185	180																	
M																										

REVIOUS 24 HOUR INPUT____________ PREVIOUS 24 HOUR OUTPUT________ PREVIOUS WEIGHT____________

RESENT 24 HOUR INPUT____________ PRESENT 24 HOUR OUTPUT________ PRESENT WEIGHT____________

ACLU-RDI 1259 p.68



(b)(6)-4

NURSING FLOW SHEET
MEDTREFAC 6550/12/Temp Form

Date: [illegible]

Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
200																								
180																								
160																								
140																								
120																								
100																								
80																								
60																								
40																								
RR			12							16							16							
TEMP			98.1							99.7							100.6							
SAO2																	99							
MAP																								
O2 Mode																								
			NBP 103/20							130/78							140/74 94							

CUFF
AL
DRIP / DOSE

MEDCOM - 5096

DOD 12309

FREQ. VITAL SIGNS

TIME															
BP															
HR															
RR															
TEMP															
SAO_2															

Notes:____

INPUT/OUTPUT

IN	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
PO																										
IVPB																										

MEDCOM - 5097

OUT	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
FOLEY																										
UOP						120											500									
						10[illegible]																				
BM																										

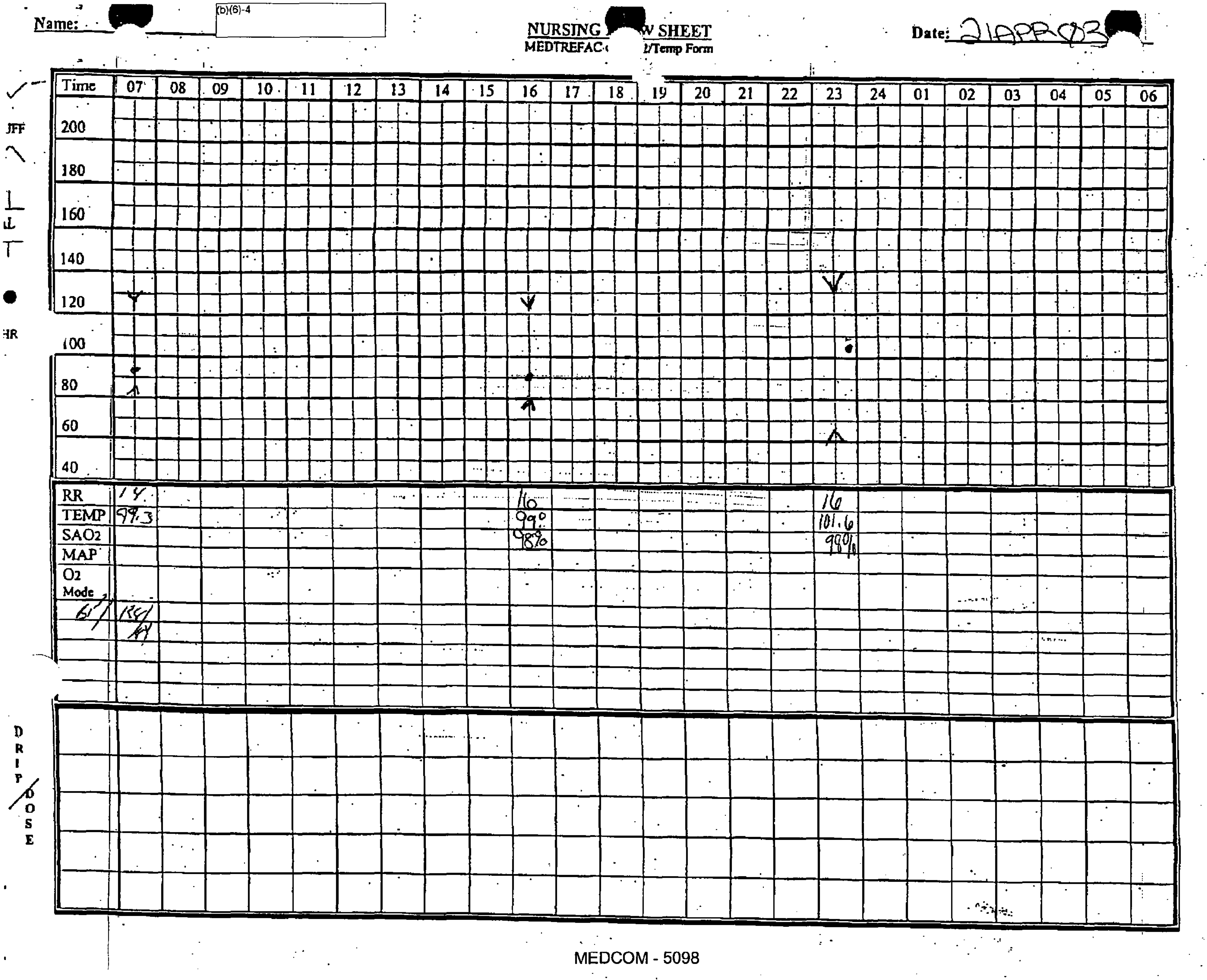
PREVIOUS 24 HOUR INPUT__________ **PREVIOUS 24 HOUR OUTPUT**__________ **PREVIOUS WEIGHT**__________

PRESENT 24 HOUR INPUT__________ **PRESENT 24 HOUR OUTPUT**__________ **PRESENT WEIGHT**__________

Name: (b)(6)-4

NURSING [redacted] W SHEET
MEDTREFAC [redacted] /Temp Form

Date: 21APR03



Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
RR	14									16							16							
TEMP	99.3									99.0							101.6							
SAO2										98%							98%							
MAP																								
O2 Mode																								
61/	134/44																							

Legend: ✓ JFF; ╲ ; ⊥ L ⊤ ; ● HR

DRIP / DOSE

MEDCOM - 5098

DOD 12311

FREQ. VITAL SIGNS

TIME															
BP															
HR															
RR															
TEMP															
SAO2															

Notes:____

INPUT/OUTPUT

IN	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
PO																										
IVPB																										

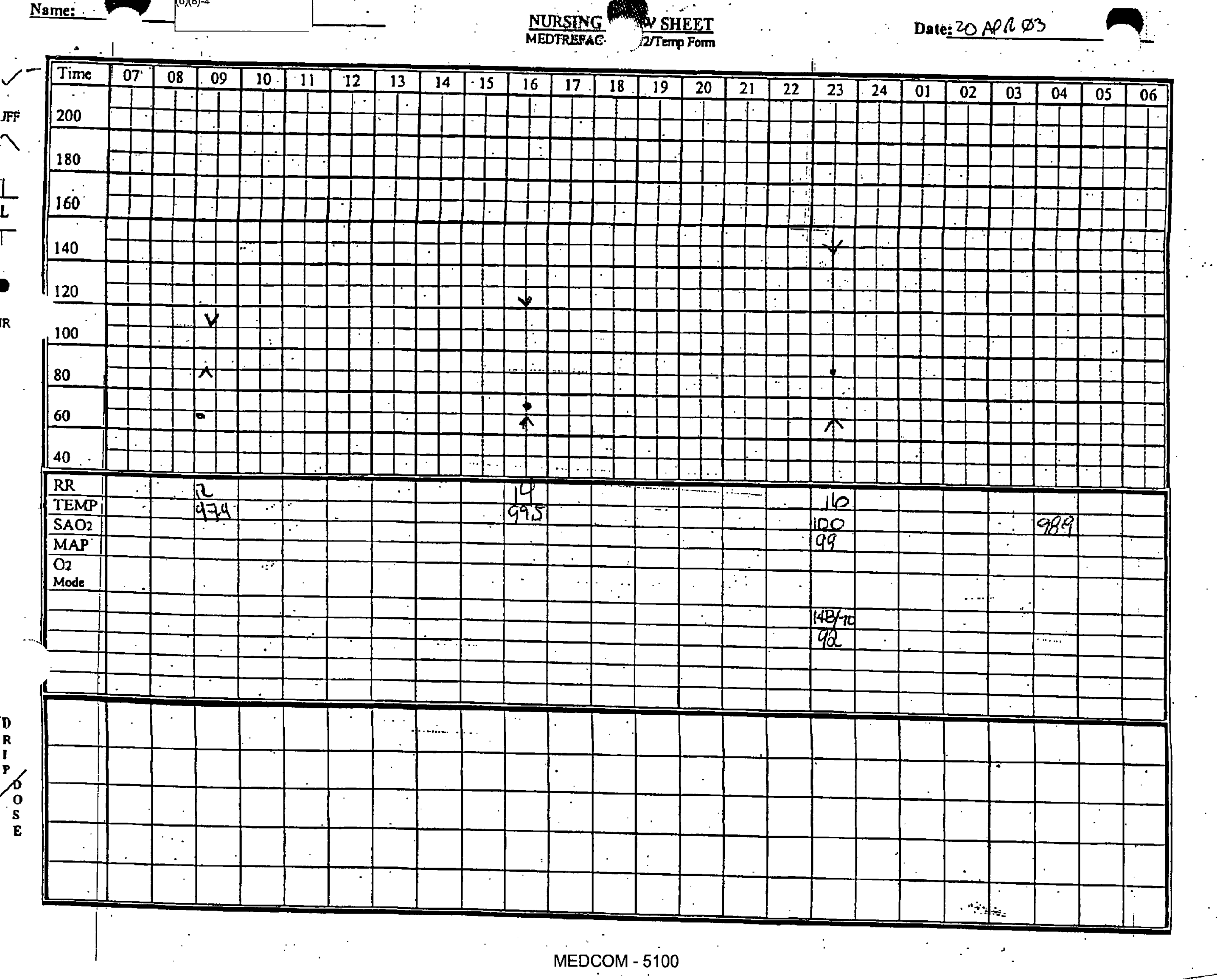
OUT	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOT/
FOLEY																										
UOP	285														600		400	100					325		100	
					500	300																				
BM																										

PREVIOUS 24 HOUR INPUT__________ PREVIOUS 24 HOUR OUTPUT__________ PREVIOUS WEIGHT__________

PRESENT. 24HOUR INPUT__________ PRESENT 24 HOUR OUTPUT__________ PRESENT WEIGHT__________

MEDCOM - 5099

ACLU-RDI 1259 p.72



Name: (b)(6)-4

NURSING ... V SHEET
MEDTREFAC ... 2/Temp Form

Date: 20 APR 03

Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
200																								
180																								
160																								
140																								
120																								
100																								
80																								
60																								
40																								
RR			12							14														
TEMP			97.9							99.5							16							
SAO2																	100					98.9		
MAP																	99							
O2 Mode																								
																	148/70							
																	92							

JFF

HR

DRIP/DOSE

MEDCOM - 5100

DOD 12313

FREQ. VITAL SIGNS

TIME															
BP															
HR															
RR															
TEMP															
SAO_2															

Notes:____

INPUT/OUTPUT

IN	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
PO																										
IVPB																										

OUT	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOT/
FOLEY					500																					
UOP							120													200				200		
BM						X																				

PREVIOUS 24 HOUR INPUT________ PREVIOUS 24 HOUR OUTPUT________ PREVIOUS WEIGHT________

PRESENT 24 HOUR INPUT________ PRESENT 24 HOUR OUTPUT________ PRESENT WEIGHT________

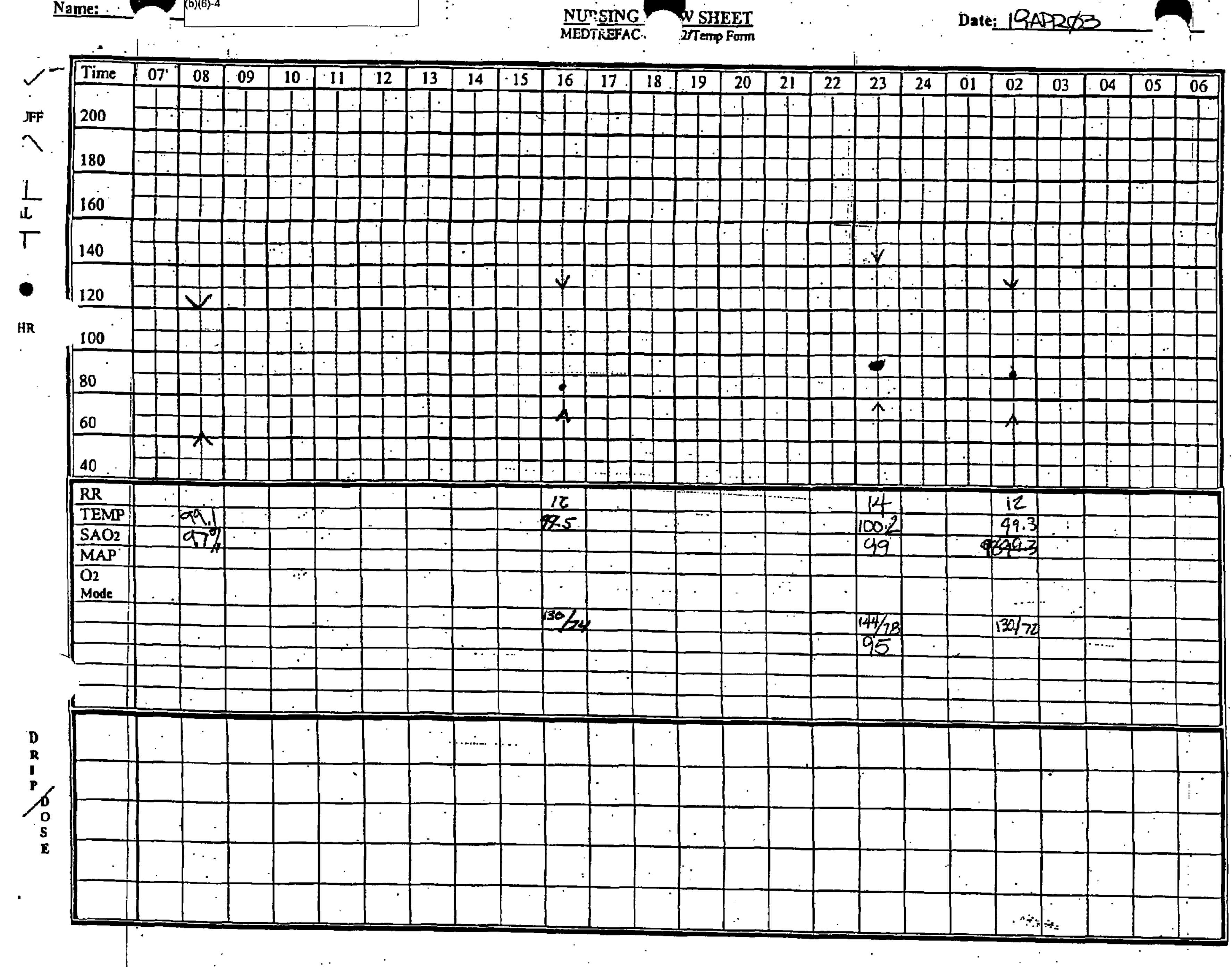
MEDCOM - 5101

ACLU-RDI 1259 p.74

Name: (b)(6)-4

NURSING [redacted] W SHEET
MEDTREFAC [redacted] 2/Temp Form

Date: 19APR03



Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
200																								
180																								
160																								
140																								
120																								
100																								
80																								
60																								
40																								
RR										12							14			12				
TEMP		99.1								99.5							100.2			99.3				
SAO2		97%															99			99.3				
MAP																								
O2 Mode																								
										130/74							144/78			130/72				
																	95							

Legend: ✓ = BP; ⌒ = [illegible]; ⊥ / ⊤ = [illegible]; ● = HR

DRIP / DOSE

MEDCOM - 5102

DOD 12314
ACLU-RDI 1259 p.75

DOD 12315

FREQ. VITAL SIGNS

TIME															
BP															
HR															
RR															
TEMP															
SAO_2															

Notes:

INPUT/OUTPUT

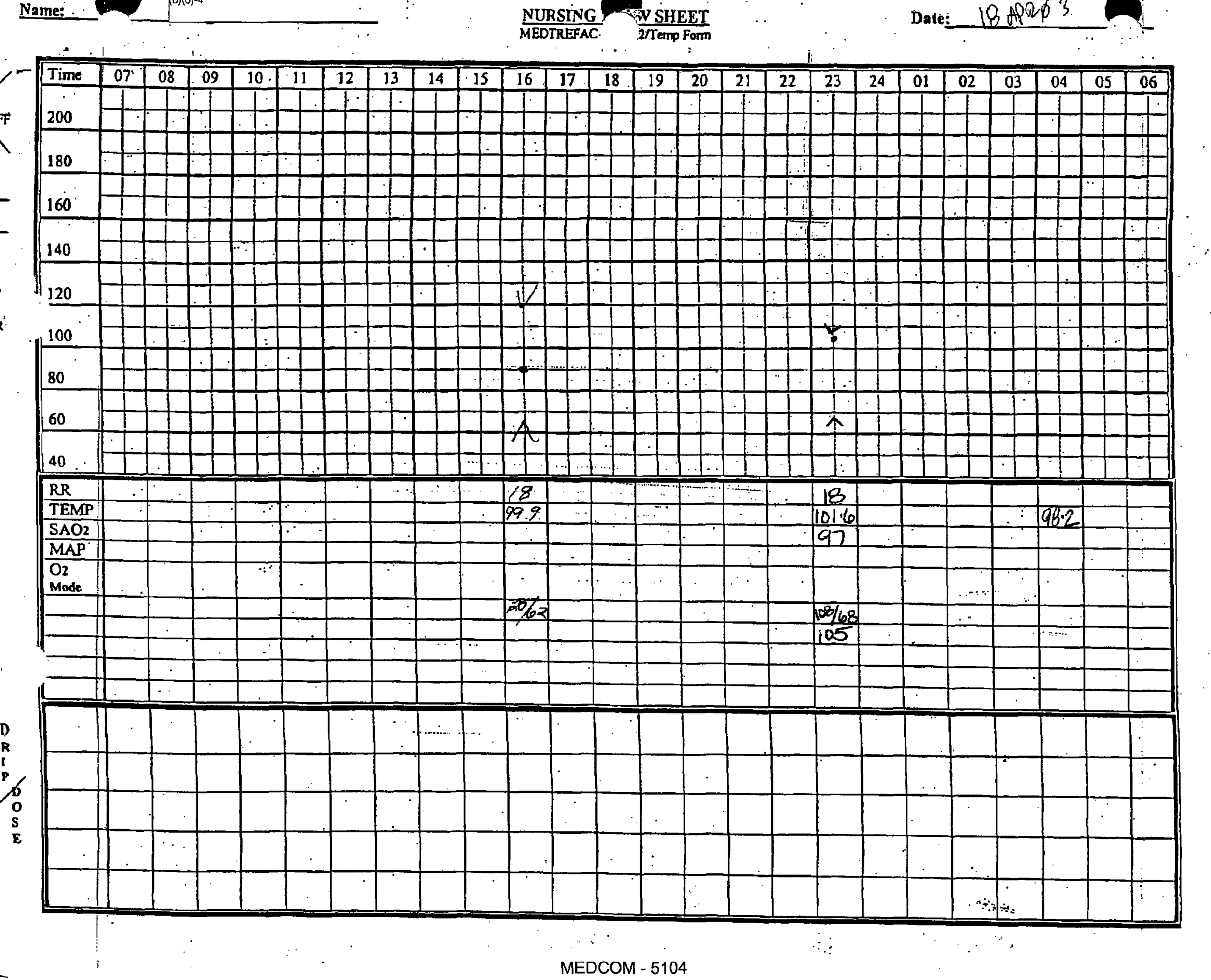
IN	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
PO																										
IVPB																										

MEDCOM - 5103

OUT	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOT/
FOLEY																	500				350			475		
UOP																										
BM																										

PREVIOUS 24 HOUR INPUT ____________ PREVIOUS 24 HOUR OUTPUT ________ PREVIOUS WEIGHT ____________

PRESENT 24 HOUR INPUT ____________ PRESENT 24 HOUR OUTPUT ________ PRESENT WEIGHT ____________



Name: (b)(6)-4

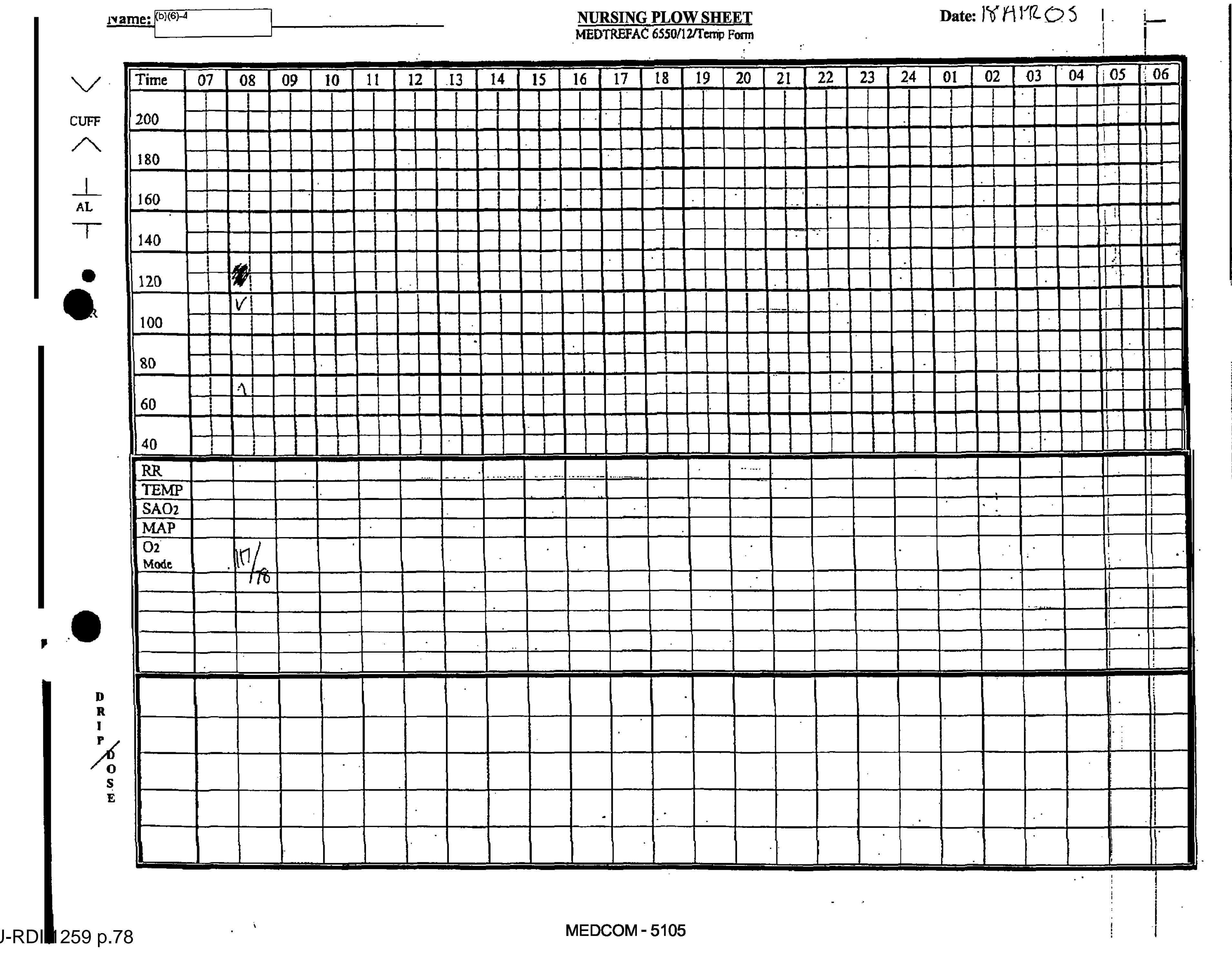
NURSING [redacted]W SHEET
MEDTREFAC 2/Temp Form

Date: 18 APR Ø 3

Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
200																								
180																								
160																								
140																								
120																								
100																								
80																								
60																								
40																								
RR										18							18							
TEMP										99.9							101.6					98.2		
SAO2																	97							
MAP																								
O2 Mode																								
										[illegible]/62							108/68							
																	105							

DRIP/DOSE

MEDCOM - 5104



Name: (b)(6)-4

NURSING FLOW SHEET
MEDTREFAC 6550/12/Temp Form

Date: 18 MAR 05

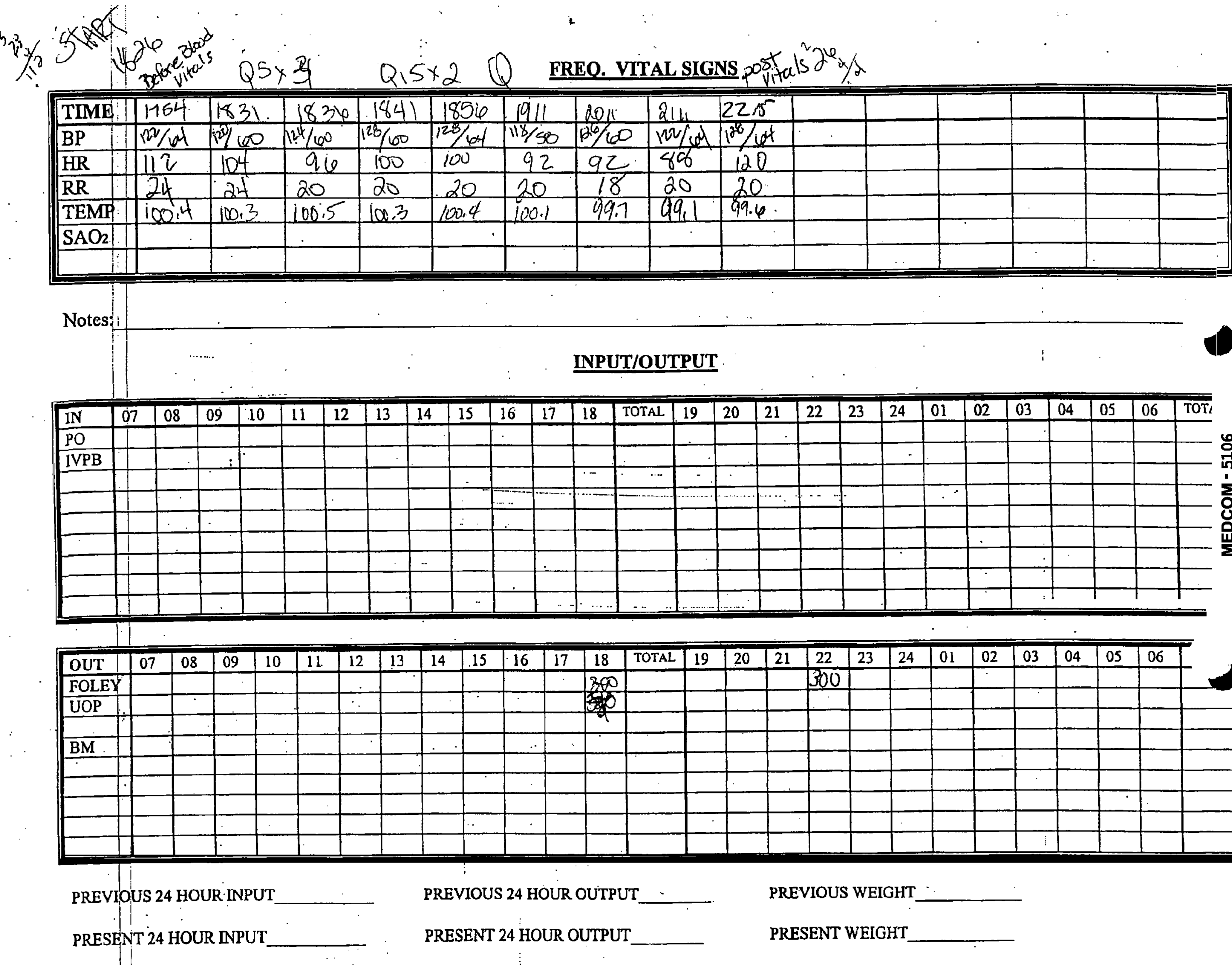
CUFF

AL

Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
200																								
180																								
160																								
140																								
120		V																						
100																								
80																								
60		^																						
40																								
RR																								
TEMP																								
SAO2																								
MAP																								
O2 Mode		117/78																						

DRIP/DOSE

MEDCOM - 5105



3/20/?? 112 START 1626 Before Blood vitals Q5x3 Q15x2 ⓠ

FREQ. VITAL SIGNS

post vitals 2nd ½

TIME	1764	1831	1836	1841	1856	1911	2011	2111	2215						
BP	122/64	122/60	124/60	128/60	128/64	118/58	126/60	122/64	128/64						
HR	112	104	96	100	100	92	92	88	120						
RR	24	24	20	20	20	20	18	20	20						
TEMP	100.4	100.3	100.5	100.3	100.4	100.1	99.7	99.1	99.6						
SAO2															

Notes:

INPUT/OUTPUT

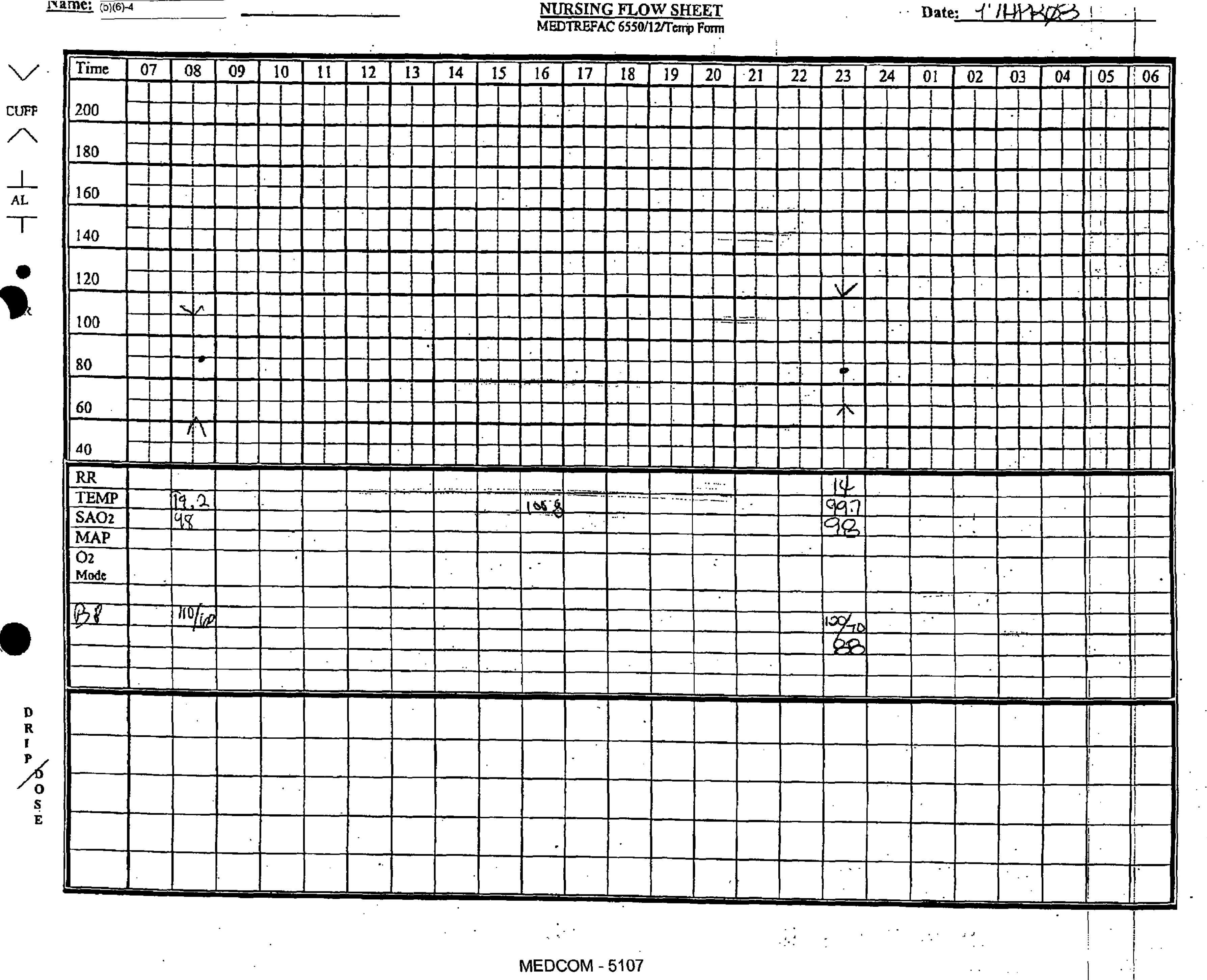
IN	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
PO																										
IVPB																										

OUT	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06
FOLEY												300					300								
UOP																									
BM																									

PREVIOUS 24 HOUR INPUT________ PREVIOUS 24 HOUR OUTPUT________ PREVIOUS WEIGHT________

PRESENT 24 HOUR INPUT________ PRESENT 24 HOUR OUTPUT________ PRESENT WEIGHT________

MEDCOM - 5106



Name: (b)(6)-4

NURSING FLOW SHEET
MEDTREFAC 6550/12/Temp Form

Date: [illegible]

Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
200																								
180																								
160																								
140																								
120																								
100																								
80																								
60																								
40																								
RR																	14							
TEMP		99.2								100.8							99.7							
SAO2		98															98							
MAP																								
O2 Mode																								
BP		110/60															120/70 88							

CUFF

AL

DRIP/DOSE

MEDCOM - 5107

DOD 12320

FREQ. VITAL SIGNS

TIME															
BP															
HR															
RR															
TEMP															
SAO2															

Notes: ____________________

INPUT/OUTPUT

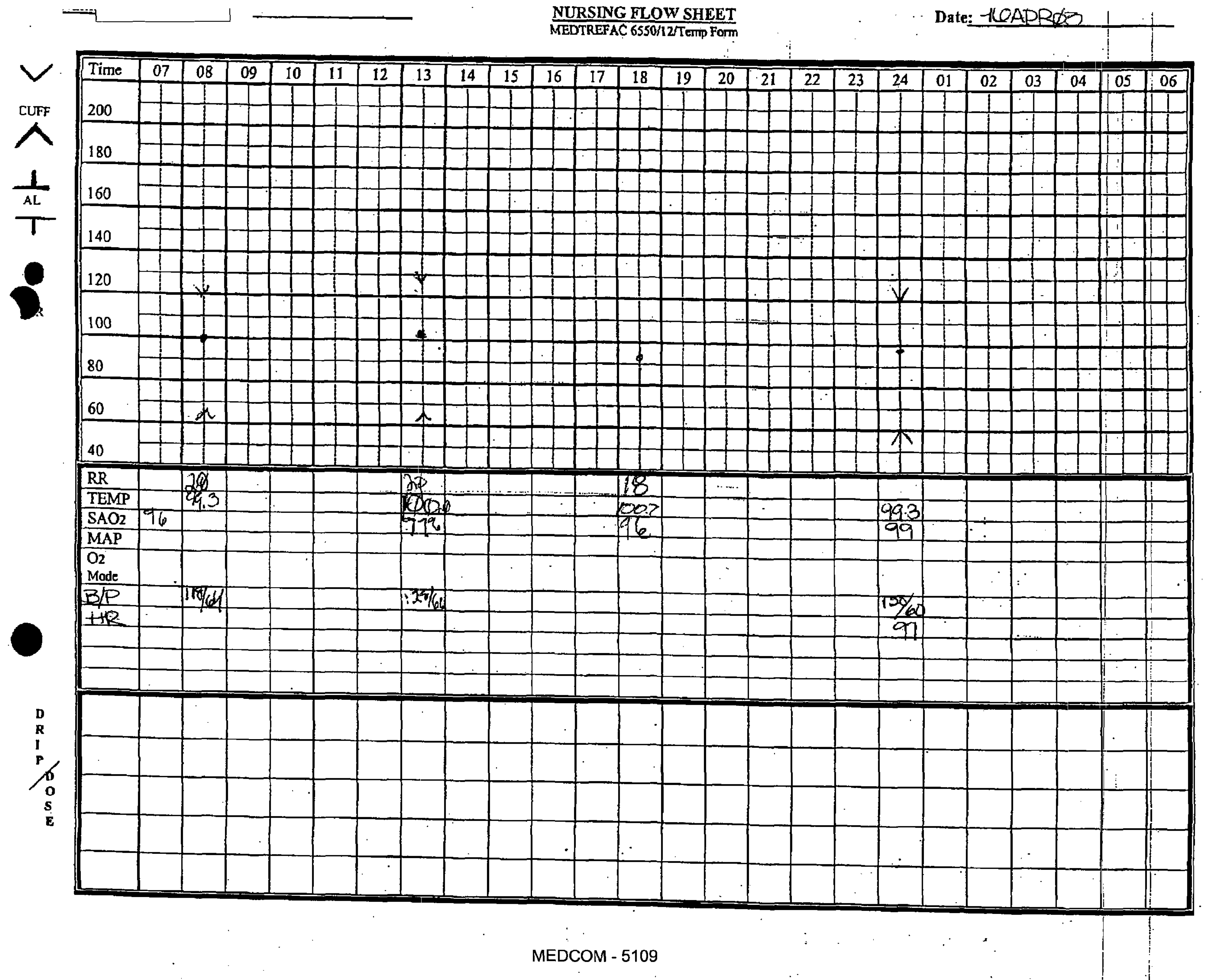
IN	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTA
PO																										
IVPB																										

MEDCOM - 5108

OUT	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	
FOLEY																			425							
UOP				240																						
BM																										

PREVIOUS 24 HOUR INPUT__________ PREVIOUS 24 HOUR OUTPUT__________ PREVIOUS WEIGHT__________

PRESENT 24 HOUR INPUT__________ PRESENT. 24 HOUR OUTPUT__________ PRESENT WEIGHT__________



NURSING FLOW SHEET
MEDTREFAC 6550/12/Temp Form

Date: 10APR03

Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
200																								
180																								
160																								
140																								
120																								
100																								
80																								
60																								
40																								
RR		20					20					18												
TEMP		99.3					100.0					100.7						99.3						
SAO2	96						97%					96						99						
MAP																								
O2 Mode																								
B/P		118/64					125/64											130/60						
HR																		97						

MEDCOM - 5109

FREQ. VITAL SIGNS

TIME															
BP															
HR															
RR															
TEMP															
SAO_2															

Notes:

INPUT/OUTPUT

IN	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTA
PO																										
IVPB																										

MEDCOM - 5110

OUT	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	
FOLEY												800						680								
UOP				575																					300	
BM																										

PREVIOUS 24 HOUR INPUT________ PREVIOUS 24 HOUR OUTPUT________ PREVIOUS WEIGHT________

PRESENT 24 HOUR INPUT________ PRESENT 24 HOUR OUTPUT________ PRESENT WEIGHT________

Name: (b)(6)-4

NURSING now SHEET
MEDTREFAC 6550/12/Temp Form

Date. 15APR03

Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
RR		12					14					16					16							
TEMP		99.9					100.4					101.5					101.7			100.7				
SAO2																	99			96				
MAP																								
O2 Mode																								
															132/64		154/70			129/60				
BP		148/77															107			102				

CUFF
AL
DRIP/DOSE

MEDCOM - 5111

DOD 12323

ACLU-RDI 1259 p.84

DOD 12324

FREQ. VITAL SIGNS

TIME															
BP															
HR															
RR															
TEMP															
SAO2															

Notes:

INPUT/OUTPUT

IN	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
PO																				500						
IVPB																										

OUT	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
FOLEY																										
UOP							1800cc									1500										
BM																										

PREVIOUS 24 HOUR INPUT__________ **PREVIOUS 24 HOUR OUTPUT**__________ **PREVIOUS WEIGHT**__________

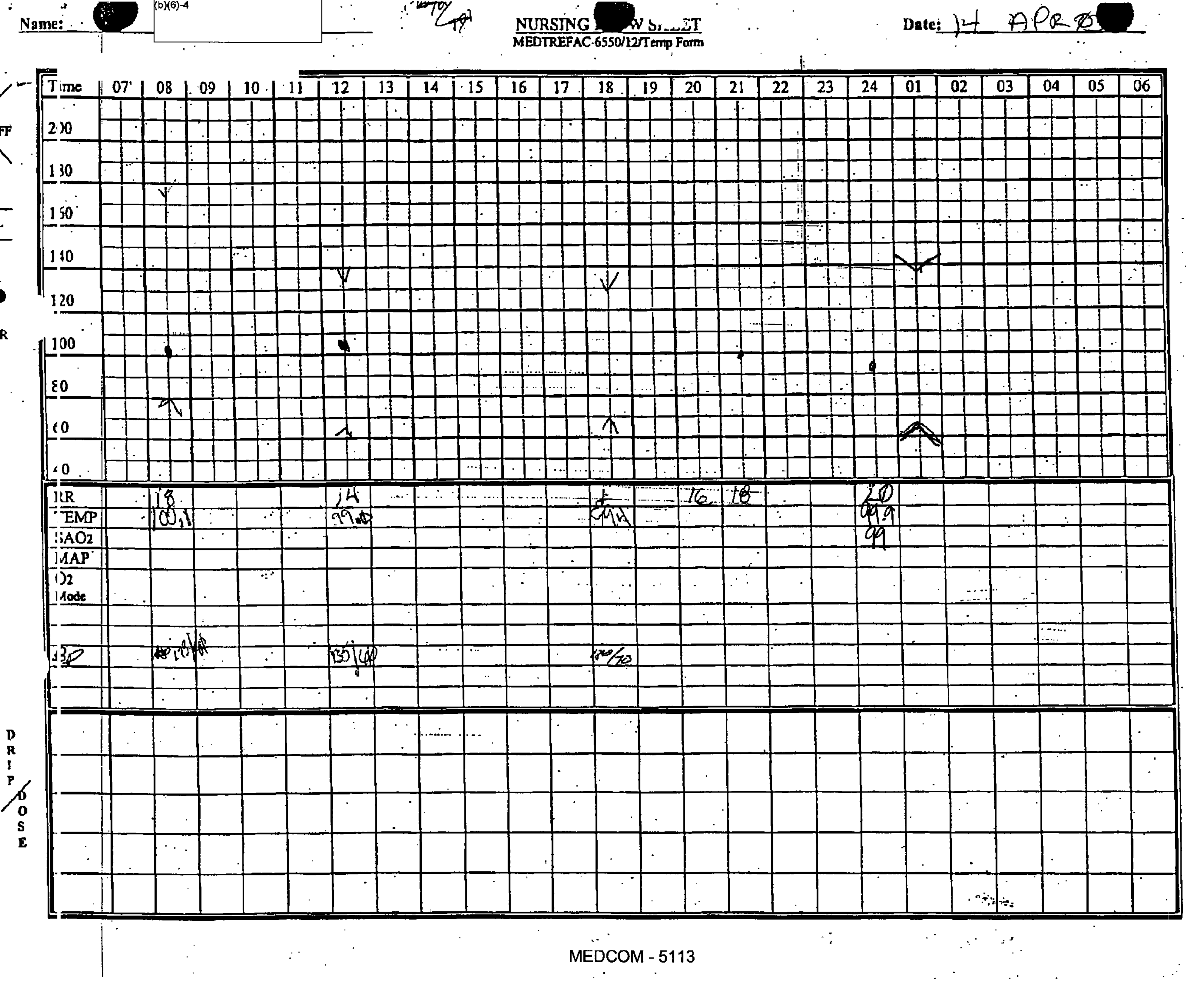
PRESENT 24 HOUR INPUT__________ **PRESENT 24 HOUR OUTPUT**__________ **PRESENT WEIGHT**__________

MEDCOM - 5112

Name: (b)(6)-4

NURSING [redacted] W SHEET
MEDTREFAC-6550/12/Temp Form

Date: 14 APR [redacted]



Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
RR		18				14						[illegible]		16	18			20						
TEMP		100.1				99.0						[illegible]						99.9						
SAO2																		99						
MAP																								
O2 Mode																								
BP		[illegible]				135/60						[illegible]/70												

Graph scale: 200, 180, 160, 140, 120, 100, 80, 60, 40

DRIP / DOSE

MEDCOM - 5113

FREQ. VITAL SIGNS

TIME															
BP															
HR															
RR															
TEMP															
SAO_2															

Notes:

INPUT/OUTPUT

IN	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
PO																										
IVPB																										

MEDCOM - 5114

OUT	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOT
FOLEY						1000											1000									
UOP																										
BM																										

PREVIOUS 24 HOUR INPUT__________ **PREVIOUS 24 HOUR OUTPUT**__________ **PREVIOUS WEIGHT**__________

PRESENT 24 HOUR INPUT__________ **PRESENT 24 HOUR OUTPUT**__________ **PRESENT WEIGHT**__________

Name: (b)(6)-4

NURSING [illegible] SHEET
MEDTREVAC [illegible] Temp Form

Date: 13 APR 03

Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
200																								
180																								
160																								
140																								
120																								
100																								
80																								
60																								
40																								
RR		24				22						26												
TEMP		101.2				99.3									99.2									
SAO2		97%																						
MAP																								
O2 Mode																								
BP		130/46				[illegible]								[illegible]/64										

DRIP/DOSE

MEDCOM - 5115

ACLU-RDI 1259 p.88

DOD 12327

DOD 12328

FREQ. VITAL SIGNS

TIME															
BP															
HR															
RR															
TEMP															
SAO_2															

Notes:____

INPUT/OUTPUT

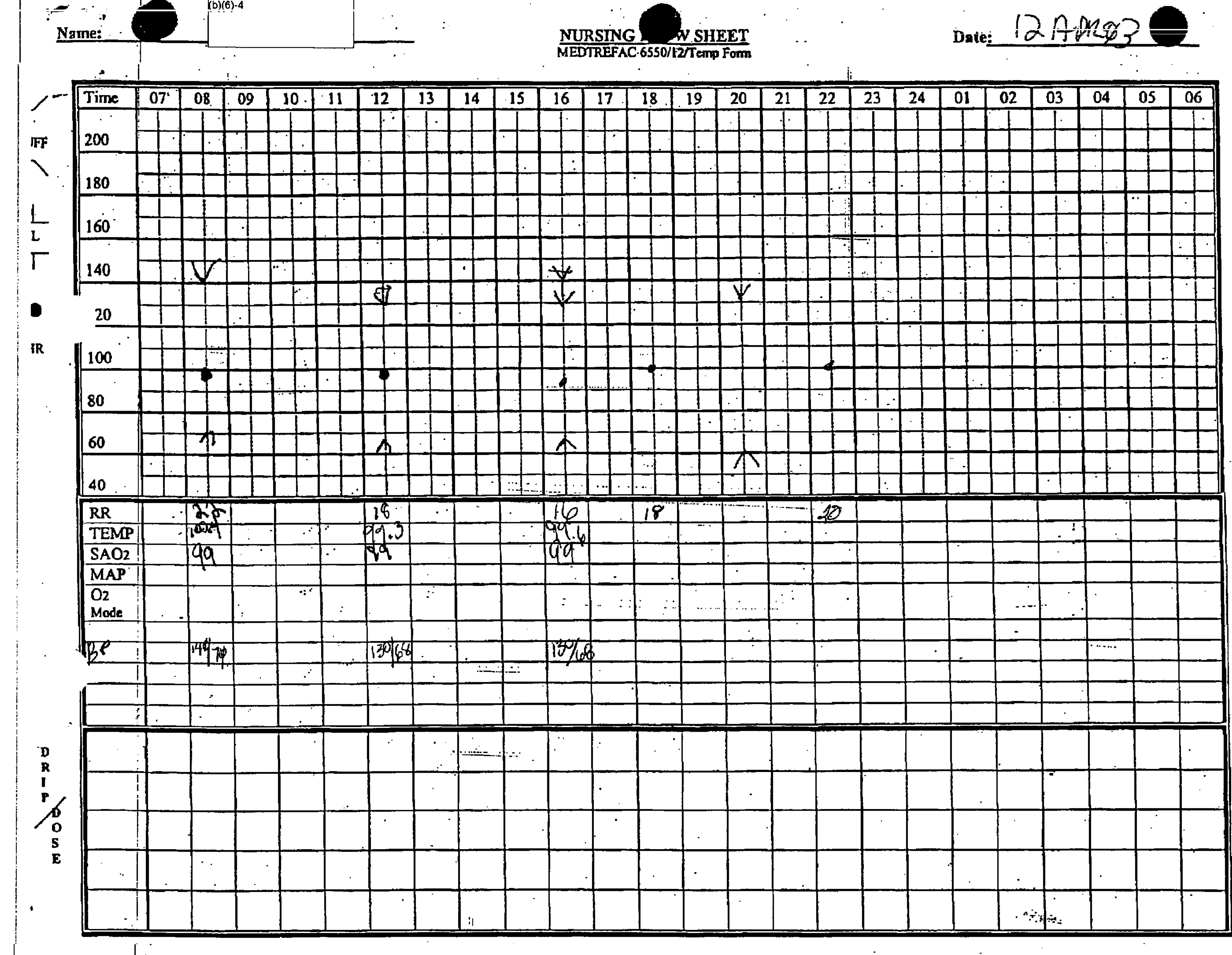
IN	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
PO																										
IVPB																										

MEDCOM - 5116

OUT	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTA'
FOLEY																										
UOP														800												
BM																										

PREVIOUS 24 HOUR INPUT__________ PREVIOUS 24 HOUR OUTPUT________ PREVIOUS WEIGHT__________

PRESENT.24 HOUR INPUT__________ PRESENT 24 HOUR OUTPUT________ PRESENT WEIGHT__________



Name: (b)(6)-4

NURSING [redacted]W SHEET
MEDTREFAC 6550/12/Temp Form

Date: 12 APR 03

Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
200																								
180																								
160																								
140																								
20																								
100																								
80																								
60																								
40																								
RR		28				16				16		18				20								
TEMP		[illegible]				99.3				99.6														
SAO2		99				99				99														
MAP																								
O2 Mode																								
BP		140/70				130/68				130/68														

DRIP / DOSE

FF
L
IR

MEDCOM - 5117

ACLU-RDI 1259 p.90

DOD 12329

DOD 12330

FREQ. VITAL SIGNS

TIME															
BP															
HR															
RR															
TEMP															
SAO_2															

Notes:

INPUT/OUTPUT

IN	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
PO																										
IVPB																										

MEDCOM - 5118

OUT	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTA
FOLEY																	100						400			
UOP																										
BM																										
Hemovac																	10									

PREVIOUS 24 HOUR INPUT________ PREVIOUS 24 HOUR OUTPUT________ PREVIOUS WEIGHT________

PRESENT 24 HOUR INPUT________ PRESENT 24 HOUR OUTPUT________ PRESENT WEIGHT________

Name: (b)(6)-4

NURSING [redacted]W SHEET

MEDTREFAC 6550/12/Temp Form

Date: 11APR03

Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
HR									92															
RR									14				16			16	18							[illegible]
TEMP									98.8			101.7	100.9			102.4	101.9							[illegible]
SAO2									96				96			97	22/30							
MAP																								
O2 Mode																								
B/P									132/80			132/72	118/68			132/60	122/60							112/[illegible]
		[illegible]																						

DRIP / DOSE

MEDCOM - 5119

DOD 12332

FREQ. VITAL SIGNS

TIME															
BP															
HR															
RR															
TEMP															
SAO_2															

Notes:

INPUT/OUTPUT

IN	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTA
PO																										
IVPB	200																									

MEDCOM - 5120

OUT	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
FOLEY														350												
UOP						400				120																
BM																										
JP																1Dcc										

PREVIOUS 24 HOUR INPUT________ **PREVIOUS 24 HOUR** OUTPUT________ **PREVIOUS WEIGHT**________

ACLU-RDI 1259 p.93

(b)(6)-4

10 April 2003

Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
200																								
180																								
160																								
140																								
120																								
100																								
80																								
60																								
40																								
RR		20					20				20													19
TEMP		98.7					98.3				[illegible]													99.3
SAO2		98									98													98
MAP																								
O2 Mode																								
BP		104/60					131/98 92																	RA 130/80

CUFF

AL

HR

DRIP/DOSE

ACLU-RDI 1259 p.94

DOD 12333

DOD 12334

FREQ. VITAL SIGNS

TIME															
BP															
HR															
RR															
TEMP															
SAO2															

Notes:

INPUT/OUTPUT

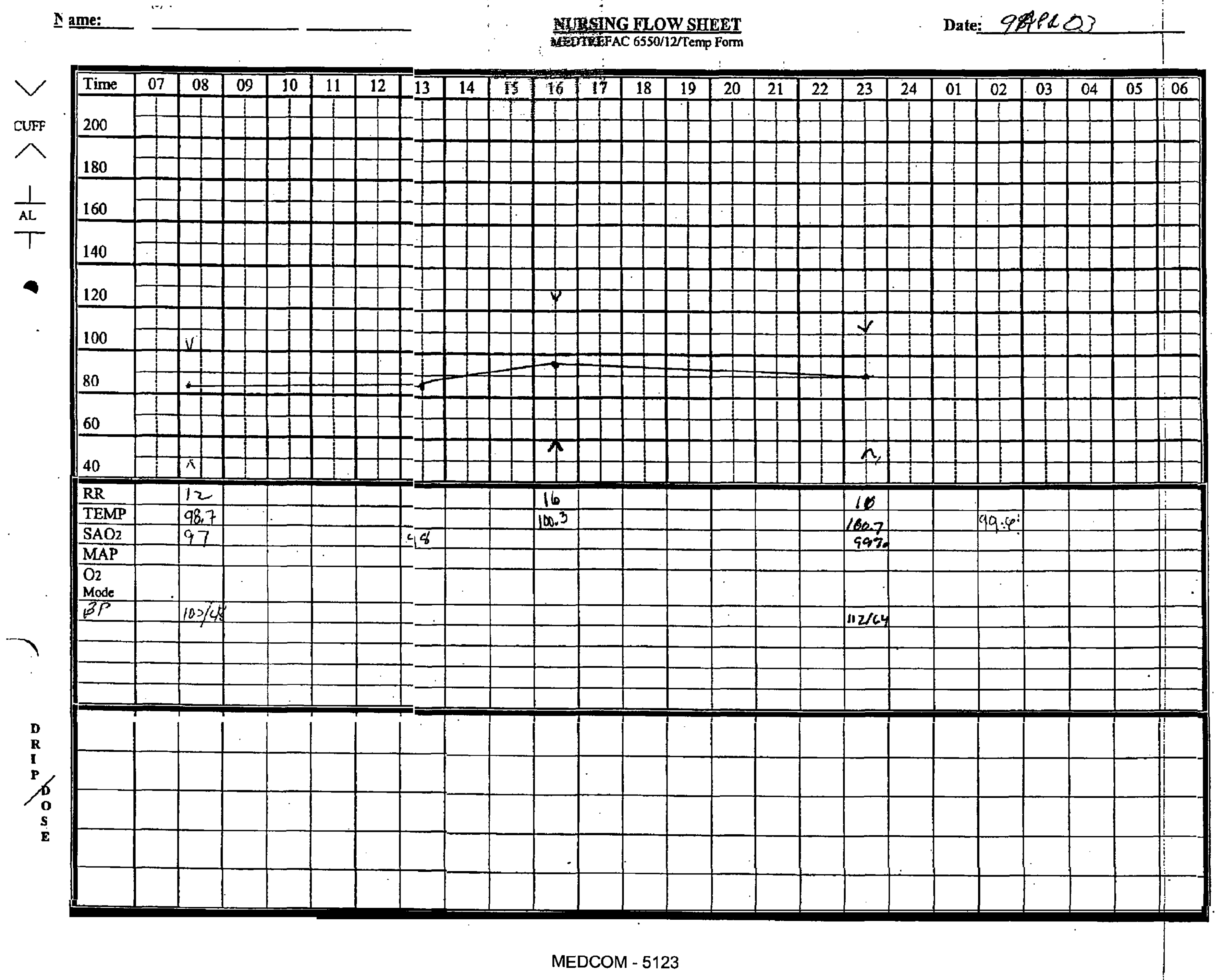
IN	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTA
PO																										
IVPB																										
IV								900					900		400											

MEDCOM - 5122

OUT	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	T
FOLEY			120					350					470													
UOP																										
BM																										
JP										30cc																

PREVIOUS 24 HOUR INPUT__________ PREVIOUS 24 HOUR OUTPUT__________ PREVIOUS WEIGHT__________

PRESENT 24 HOUR INPUT__________ PRESENT 24 HOUR OUTPUT__________ PRESENT WEIGHT__________



Name:

NURSING FLOW SHEET

MEDTREFAC 6550/12/Temp Form

Date: 9 APR 03

Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
RR		12								16							18							
TEMP		98.7								100.3							100.7			99.6				
SAO2		97					98										99%							
MAP																								
O2 Mode																								
BP		102/48															112/64							

MEDCOM - 5123

FREQ. VITAL SIGNS

TIME															
BP															
HR															
RR															
TEMP															
SAO_2															

Notes:

INPUT/OUTPUT

IN	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTA
PO																										
IVPB																									500	

MEDCOM - 5124

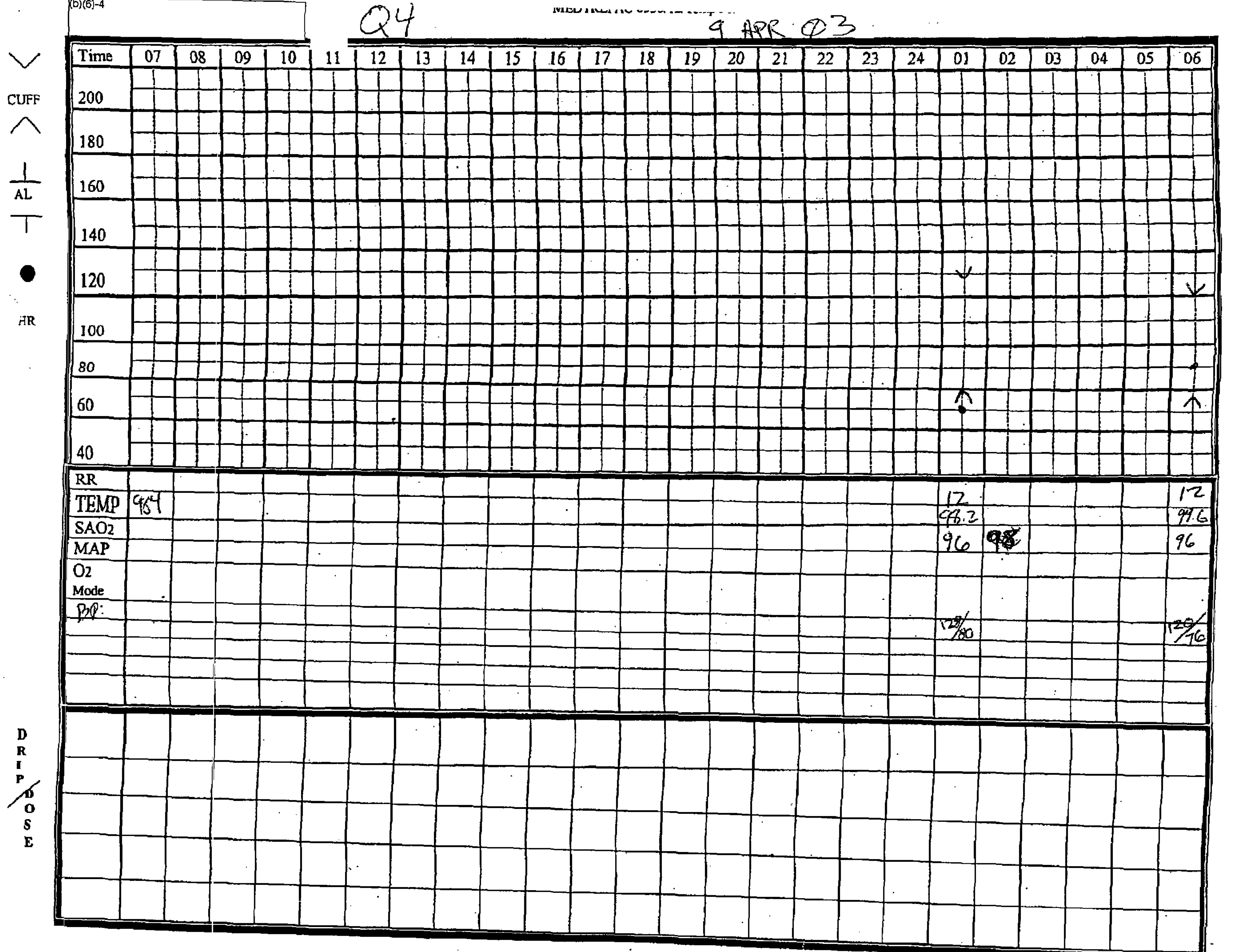
OUT	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TO...
FOLEY																										
UOP																										
BM																										

PREVIOUS **24 HOUR** INPUT__________ **PREVIOUS 24 HOUR OUTPUT**__________ **PREVIOUS WEIGHT**__________

PRESENT 24 HOUR OUTPUT PRESENT WEIGHT

(b)(6)-4

Q4 9 APR 03



Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
RR																			12					12
TEMP	98.4																		98.2					97.6
SAO2																			96	98				96
MAP																								
O2																								
Mode																								
BP:																			128/80					120/76

0700-1900	Time:	Signature:

NEUROLOGICAL

Level of Consciousness
Oriented to: Person ✓ Place ✓ Time ✓
Responds to: Verbal ✓ **Pain** ___ **Unresponsive**

Pupils R L
Size / Reaction: [ ] / [ ] [ ] / [ ]

Motor Strength S = Strong
Extremities: W = Weak
TR = Trace
A = Absent

	L	R
Upper	S	S
Lower	W	W

[ ] See Narrative

CARDIOVASCULAR

Pulses	R	L		R	L
Radial	+	+	Posterior Tibial	+	+
Femoral			Dorsalis Pedis	+	+

+ = Normal - = Weak 0 = Absent

Rhythm: ___ Ectopy: ___
Murmur: ___ Rub: ___ S1: ___ S2: ___
Neck Veins: ___
Edema: ___
[ ] See Narrative

RESPIRATORY

Breath Sounds: [✓] Clear [✓] Bilat
Location:
Crackles /Rales: ___ Dim: ___
Wheezes: ___ Absent: ___
Rhonchi: ___
Cough: Productive / Unproductive: N/A
Sputum: Color and Character: ___
Tubes: [ ] ET [ ] Trach
Size: ___ Location: ___
O2: [ ] Canula [ ] Mask
Chest Tubes: ___
[ ] See Narrative

GASTROINTESTINAL

Observation: Normal Exam
Auscultation: Normal Exam
Palpation: - Masses found
Stool: [ ] Incontinent [ ] Formed [ ] Soft
[ ] **Frequent** [ ] Liquid [ ] Hard
Diet:
Tubes / Bags / Suction / Drainage:
⊕ bowel sounds

See Narrative [ ] **NGT Placement**

GU

[x] Void **Urine: Color / Character**
Straw cloudy
Catheter: —
Other:
[ ] See Narrative

SKIN

Color / Turgur / Temperature / Moisture

Incisions / Dressings / Leisions / Dermal Ulcers
~~bilateral BLE~~ GSW x3 to b.lateral lower extremity
[ ] See Narrative - 7 wounds (open)

Narrative:

0710 Assumed care of Pt. Pt Alert and Oriented x 3, VSS No complaints voiced at this time. PERRLA Lungs CTA Abdominal EXAM Normal Pt recieved W-D Dressing x 3 and bacitracin and clean gauze to penis ~~shaft~~ head. Pt tolerated procedure well. (b)(6)-2

~~0830 Pt IV infiltrated. Ancef in R Hand IV infusing well Ancef here~~ (b)(6)-2

0800 Ancef infused (b)(6)-2

0905 Pt c/o pain Nurse notified (b)(6)-2

0910 Pt refused chow (b)(6)-2

0931 - Conan E Notes from ~~HM~~ HM3 (b)(6)-2 (b)(6)-2

0935 - Keep IV e KVO (b)(6)-2

1250 - Pt refused Chow or oral fluids IV remains to be removed once tolerating p.o will continue to monitor (b)(6)-2

1500 Rounds MBR ASLEEP AT THIS TIME IVF's infusing s̄ difficulty LR @ KVO in LFA no s/s of infiltration ~~pt voic~~ will continue to monitor this Pt (b)(6)-2

1507 Pt rolled on back from left side per MD order (reposition pt q2 hr)

1525 1600 Dressing Δ not done due to surgeon completing task earlier today (b)(6)-2

TE WARD - 24 HOUR FLOW SHEET

18:00	19:00	20:00	21:00	22:00	23:00	0:00	1:00	2:00	3:00	4:00	5:00	6:00
		148/92				136/86						
		24										
		(b)(6)-2 78				81 18						
		98.6										
						600						
				500					400		800	

200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20

Temp

glabellar tap or loud auditory stimulus

t glabellar tap or loud auditory stimulus

6 - No response to light glabellar tap or loud auditory stimulus

MEDCOM - 5127

FLTHOSPPNCLA 6320/1 (1/03)

ACLU-RDI 1259 p.100

DOD 12339

1900-0700	Time: 1900	Signature: (b)(6)-2

NEUROLOGICAL

Level of Consciousness
Oriented to: Person ✓ Place ✓ Time ✓
Responds to: Verbal ✓ Pain ___ Unresponsive ___

Pupils R L
Size / 3 / + 3 / +

Motor Strength S = Strong W = Weak TR = Trace A = Absent
Extremities:

	L	R
Upper	5	5
Lower	w	w

See Narrative

CARDIOVASCULAR

Pulses

	R	L
Radial	+	+
Femoral		

	R	L
Posterior Tibial	+	+
Dorsalis Pedis	+	+

+ = Normal - = Weak 0 = Absent

Rhythm: RRR Ectopy: (-)
Murmur: ___ Rub: ___ S1: ___ S2: ___
Neck Veins: ___
Edema: ___
See Narrative

RESPIRATORY

Breath Sounds: [✓] Clear [✓] Bilat
Location:
Crackles /Rales: ___ Dim: ___
Wheezes: ___ Absent: ___
Rhonchi: ___
Cough: Productive / Unproductive: ___
Sputum: Color and Character: ___
Tubes: ET Trach
Size: ___ Location: ___
O2: Canula Mask
Chest Tubes: ___
See Narrative

GASTROINTESTINAL

Observation: FLaT
Auscultation: BS x4 faint
Palpation: soft
Stool: Incontinent Formed Soft
Frequent Liquid Hard

Tubes / Bags / Suction / Drainage:
[illegible handwriting: "... abrasion / wound to groin, red / pink ... bacitracin / applied"]

See Narrative NGT Placement (b)(6)-2

GU

[X] Void Urine: Color / Character
YeLLow

Catheter:
Other:
See Narrative

SKIN

Color / Turgur / Temperature / Moisture

Incisions / Dressings / Leisions / Dermal Ulcers
GSW x 3 Lower extremity BiLaT

See Narrative

Narrative:

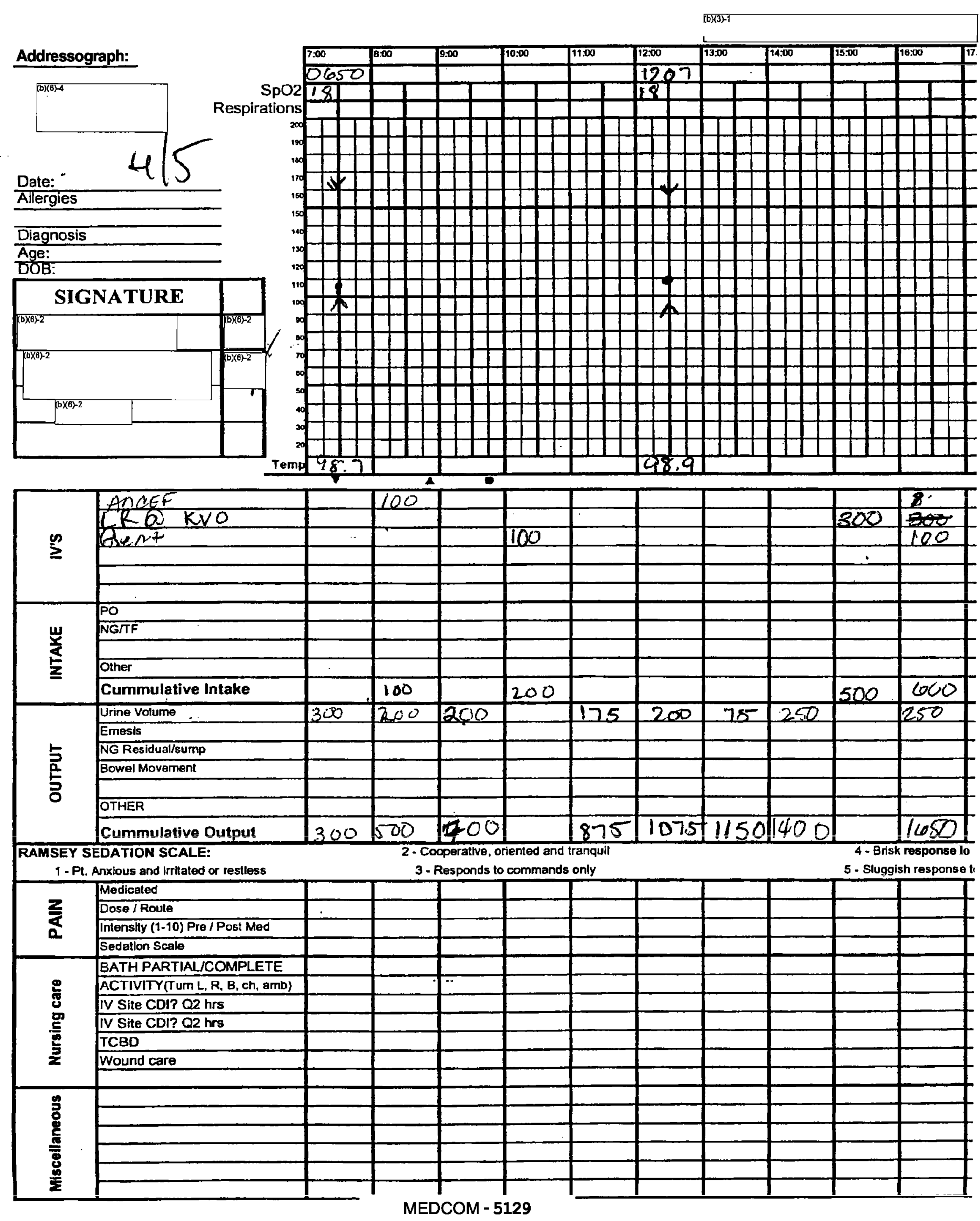
1900 assumed care of pt, see secondary assessment

1700 Concur c assessment of [illegible] as noted. Dressing to (R) upper [illegible] c [illegible] drainage, [illegible] (L) [illegible] dressing [illegible] drainage as well. [illegible] medication [illegible]
1930 [illegible] medication @ 1910 dressing [illegible] to [illegible], wounds pink c [illegible] purulent / serosanguinous drainage. Pt [illegible] @ [illegible] (b)(6)-2

MEDCOM - 5128

ACLU-RDI 1259 p.101

DOD 12340



(b)(3)-1

Addressograph:

(b)(6)-4

Date: 4/5

Allergies

Diagnosis

Age:

DOB:

SIGNATURE

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

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

(b)(6)-2

	7:00	8:00	9:00	10:00	11:00	12:00	13:00	14:00	15:00	16:00	17.
	0650					1207					
SpO2	18					18					
Respirations											
Temp	98.7					98.9					

		7:00	8:00	9:00	10:00	11:00	12:00	13:00	14:00	15:00	16:00
IV'S	Ancef		100								8.
	LR @ KVO									300	~~300~~
	Gent				100						100
INTAKE	PO										
	NG/TF										
	Other										
	Cummulative Intake		100		200					500	600
OUTPUT	Urine Volume	300	200	200		175	200	75	250		250
	Emesis										
	NG Residual/sump										
	Bowel Movement										
	OTHER										
	Cummulative Output	300	500	700		875	1075	1150	1400		1650

RAMSEY SEDATION SCALE:
1 - Pt. Anxious and irritated or restless
2 - Cooperative, oriented and tranquil
3 - Responds to commands only
4 - Brisk response lo
5 - Sluggish response t

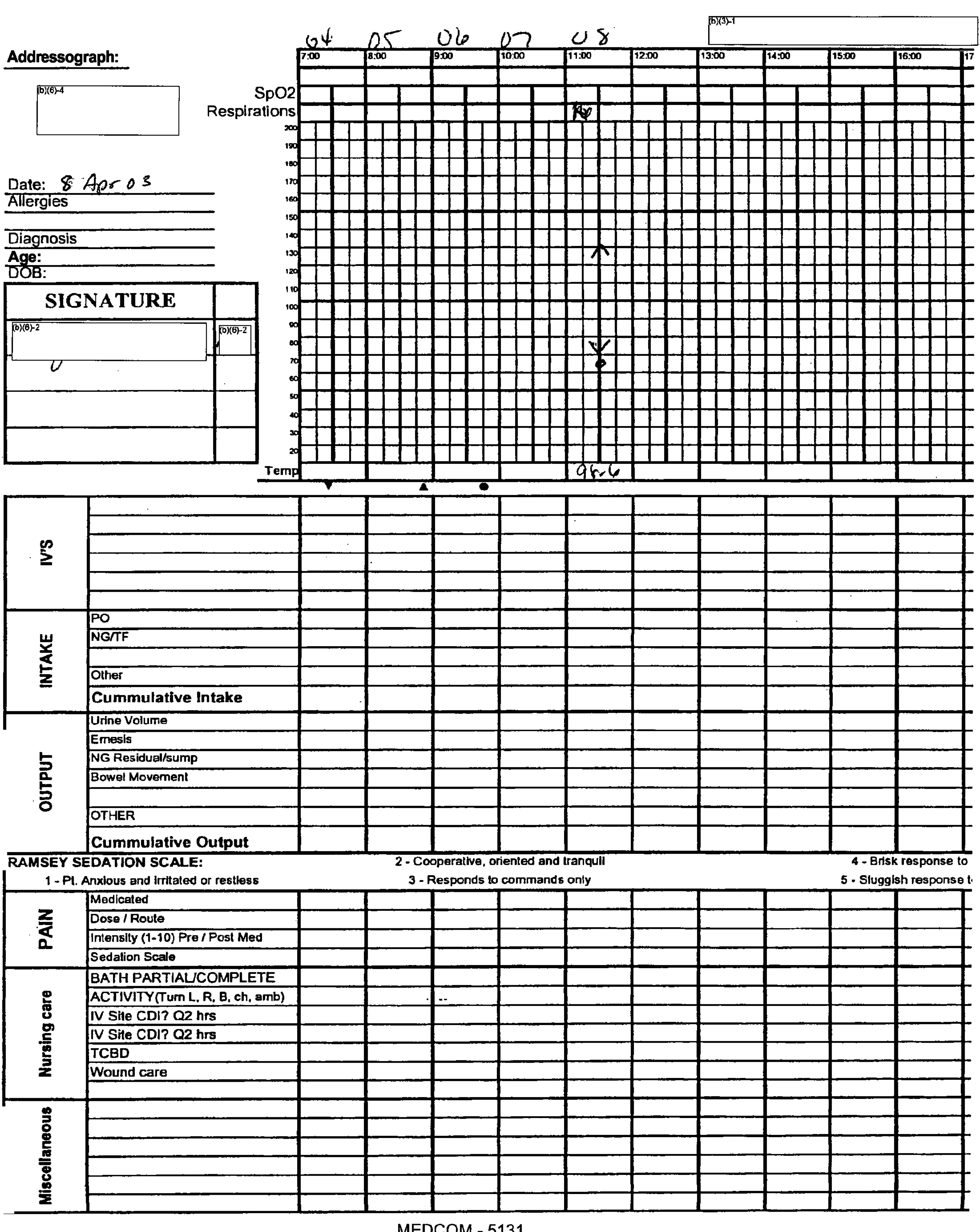
PAIN	Medicated
	Dose / Route
	Intensity (1-10) Pre / Post Med
	Sedation Scale
Nursing care	BATH PARTIAL/COMPLETE
	ACTIVITY(Turn L, R, B, ch, amb)
	IV Site CDI? Q2 hrs
	IV Site CDI? Q2 hrs
	TCBD
	Wound care
Miscellaneous	

MEDCOM - 5129

0700-1500

0700-1900 Time: Signature:	Shft A
NEUROLOGICAL	0830 Assumed care of pt ——— (b)(6)-2
Level of Consciousness	0841- Pt c/o pain. IV infiltrated. Attempted twice
Oriented to: Person ✓ Place ✓ Time ✓	in rt fore arm to flash vein blew. HN (b)(6)-2
Responds to: Verbal ✓ Pain ___ Unresponsive	attempted x 3 left arm good flash vein blew HM3
Pupils R L	(b)(6)-2 Attempt x 1 IV success fully. Morphine 4mg
Size / Reaction: _ / _ _ / _	pushed by HM3 (b)(6)-2 under nurse watch. Anxy
Motor Strength S = Strong W = Weak TR = Trace A = Absent — Upper: L S, R S; Lower: L S, R W	started. Will continue to monitor ——— (b)(6)-2
Extremities:	LATE ENTRY
See Narrative	0730 AM Assessment Pt A+O x 3 ⊕ steady
CARDIOVASCULAR	pulse cap refill > 3 sec in both fingers and
Pulses R L — Radial + +; Femoral; Posterior Tibial; Dorsalis Pedis + +	toes pt resting peacefully refused chow
+ = Normal - = Weak 0 = Absent	will continue to montor ——— (b)(6)-2
Rhythm: ___ Ectopy: ___	0905 PT TO BE D/C ——— (b)(6)-2
Murmur: ___ Rub: ___ S1: ___ S2: ___	0915 Pt left ward via gurney for
Neck Veins: ___	Medevac ——— (b)(6)-2
Edema: ___	
See Narrative	
RESPIRATORY	
Breath Sounds: ✓ Clear ✓ Bilat	
Location:	
Crackles /Rales: ___ Dim: ___	
Wheezes: ___ Absent: ___	
Rhonchi: ___	
Cough: Productive / Unproductive: ___	
Sputum: Color and Character: ___	
Tubes: ET Trach	
Size: ___ Location: ___	
O2: Canula Mask	
Chest Tubes: ___	
See Narrative	
GASTROINTESTINAL	
Observation: WNL	
Auscultation: WNL	
Palpation: WNL	
Stool: Incontinent Formed Soft Frequent Liquid Hard	
Diet: ___	
Tubes / Bags / Suction / Drainage: N/A	
See Narrative NGT Placement	
GU	
Void Urine: Color / Character	
Catheter: foley Dark amber	
Other:	
See Narrative	
SKIN	
Color / Turgur / Temperature / Moisture: Warm to touch normal color ⊝ moisture	
Incisions / Dressings / Leisions / Dermal Ulcers: W-D Dressing x 5 intact	
See Narrative	

MEDCOM - 5130



(b)(3)-1

Addressograph:

(b)(6)-4

Date: 8 Apr 03

Allergies

Diagnosis

Age:

DOB:

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

	04	05	06	07	08						
	7:00	8:00	9:00	10:00	11:00	12:00	13:00	14:00	15:00	16:00	17
SpO2											
Respirations					[illegible]						
200											
190											
180											
170											
160											
150											
140											
130					∧						
120											
110											
100											
90											
80					∨						
70					●						
60											
50											
40											
30											
20											
Temp					96.6						

▼ ▲ ●

		7:00	8:00	9:00	10:00	11:00	12:00	13:00	14:00	15:00	16:00
IV'S											
INTAKE	PO										
	NG/TF										
	Other										
	Cummulative Intake										
OUTPUT	Urine Volume										
	Emesis										
	NG Residual/sump										
	Bowel Movement										
	OTHER										
	Cummulative Output										

RAMSEY SEDATION SCALE:
1 - Pt. Anxious and irritated or restless
2 - Cooperative, oriented and tranquil
3 - Responds to commands only
4 - Brisk response to
5 - Sluggish response t

		7:00	8:00	9:00	10:00	11:00	12:00	13:00	14:00	15:00	16:00
PAIN	Medicated										
	Dose / Route										
	Intensity (1-10) Pre / Post Med										
	Sedation Scale										
Nursing care	BATH PARTIAL/COMPLETE										
	ACTIVITY(Turn L, R, B, ch, amb)										
	IV Site CDI? Q2 hrs										
	IV Site CDI? Q2 hrs										
	TCBD										
	Wound care										
Miscellaneous											

MEDCOM - 5131

0300-1500
Shift Δ

0700-1900 Time	Signature

NEUROLOGICAL

Level of Consciousness
Oriented to: Person ✓ Place ✓ Time ✓
Responds to: Verbal ✓ Pain ___ Unresponsive
Pupils R L
Size / Reaction: [ ]/[ ] [ ]/[ ]
Motor Strength Extremities: S = Strong W = Weak TR = Trace A = Absent

	L	R
Upper	S	S
Lower	S	W

[ ] See Narrative

CARDIOVASCULAR

Pulses

	R	L		R	L
Radial	+	+	Posterior Tibial	+	+
Femoral			Dorsalis Pedis	+	+

+ = Normal - = Weak 0 = Absent
Rhythm: ___ Ectopy: ___
Murmur: ___ Rub: ___ S1: ___ S2: ___
Neck Veins: ___
Edema: ___
[ ] See Narrative

RESPIRATORY

Breath Sounds: [✓] Clear [✓] Bilat
Location: CTA
Crackles /Rales: ___ Dim: ___
Wheezes: ___ Absent: ___
Rhonchi: ___
Cough: Productive / Unproductive: Ⓟ
Sputum: Color and Character: white thick
Tubes: [ ] ET [ ] Trach
Size: ___ Location: ___
O2: [ ] Canula [ ] Mask
Chest Tubes: ___
[ ] See Narrative

GASTROINTESTINAL

Observation: WNL
Auscultation: ⊕ Bowel sounds x 4
Palpation: Soft pain ⓒ palpation
Stool: [ ] Incontinent [ ] Formed [ ] Soft [ ] Frequent [ ] Liquid [ ] Hard
Diet: REG
Tubes / Bags / Suction / Drainage:
No Tubes etc
[ ] See Narrative [ ] NGT Placement

GU

[✓] Void Urine: Color / Character
Clear yellow ⊖ odor
Catheter: NA
Other:
[ ] See Narrative

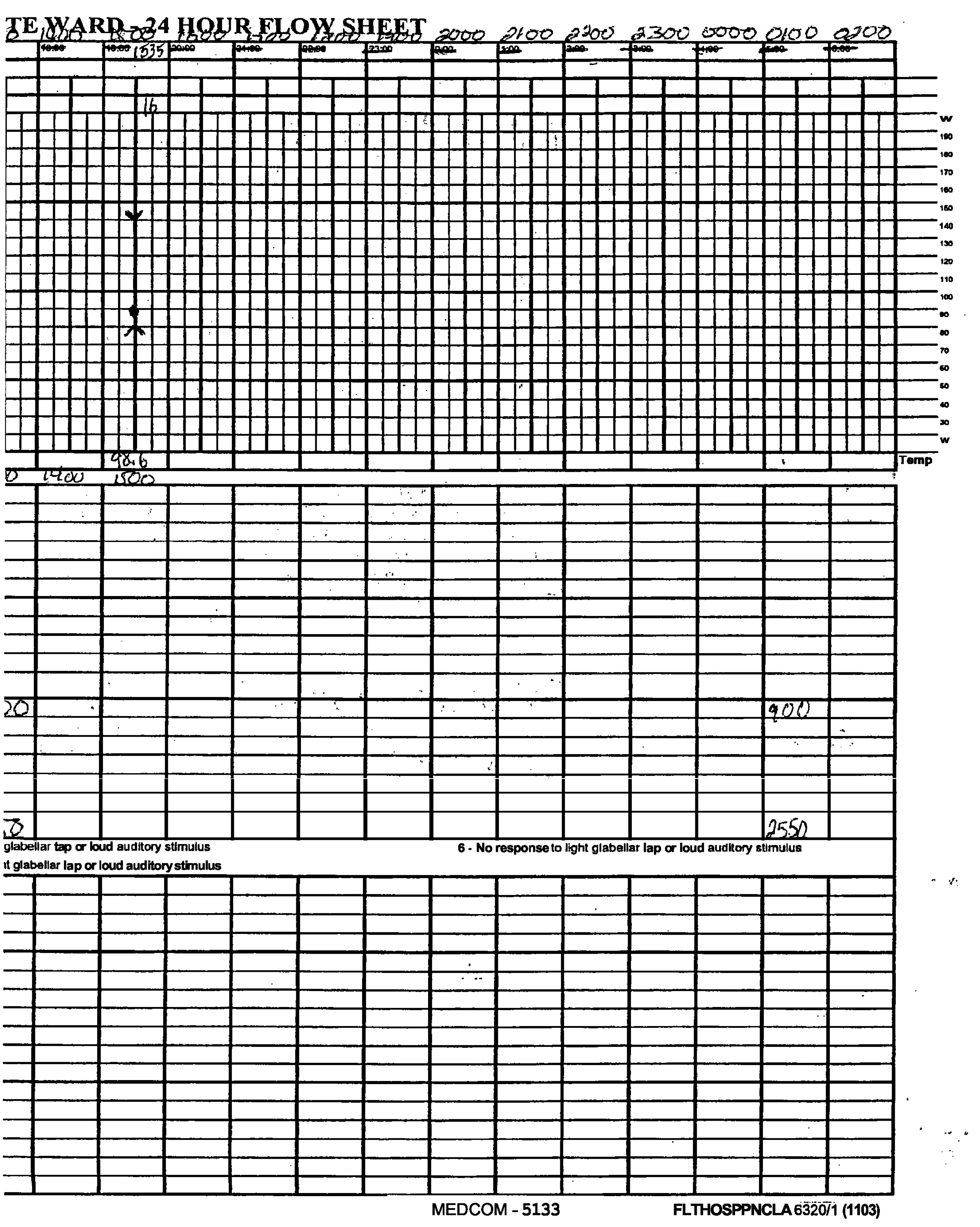
SKIN

Color / Turgur / Temperature / Moisture
WNL
Incisions / Dressings / Leisions / Dermal Ulcers
wounds x 7 Bacitracin to penis
Δ W-D dressing Bilat LE
[ ] See Narrative

Narrative:

0355- Assumed care of this pt. Pt resting comfortably. Will cont to monitor.
0720 Medicated ⓒ MSO4 2mg IVP for pt D/S to pain coverage ——— (b)(6)-2
0700 1st Am Assessment Pt A+O x3 PERRLA pupils @3 bilat pulse noted in radial, posterior tibial, and dorsalis pedis strong regular pulse. Lungs CTA Pt has cough producing thick white sputum. Abdominal exam within Normal limits except pt c/o pain/discomfort upon palpation of lower quads. Nurse informed Pt voids clear yellow urine ⊖ odor. Skin temp warm to touch ⊖ turgur No excess moisture noted on Pt wound. Dressed W-D And bacitracin applied to tip of penis. Pt voices No other complaints and nothing out of obvious is observed. All Am care provided. Oral care, clean bed linen AND Complete bed bath performed will continue to monitor ——— (b)(6)-2
0630 LE* DRSNG Δ W-D Dressing Δ TO 4 wounds ⊕ serosanguenous fluid ⊖ S/S infection Applied Bacitracin to tip of penis pt tolerated procedure well will continue to monitor ——— (b)(6)-2
0945 Pt ate 50% of beef stew ——— (b)(6)-2
1005 - pt medicated ⓒ 2mg [illegible] per pt request pt [illegible] ——— (b)(6)-2 [illegible] NC
1213 medicated ⓒ MSO4 3mg ——— (b)(6)-2 NC
1220 Pt rec'd foley catheter per Dr instructions. Immediate release of 800cc clear amber urine. Pt reports relief of pain from distention. ——— (b)(6)-2
1400 [illegible] (b)(6)-2

MEDCOM - 5132



TE WARD - 24 HOUR FLOW SHEET

0 1000 1800 1535 1600 1700 1800 1900 2000 2100 2200 2300 0000 0100 0200

16

98.6

Temp

0 1400 1500

20 900

0 2550

glabellar tap or loud auditory stimulus

6 - No response to light glabellar lap or loud auditory stimulus

t glabellar lap or loud auditory stimulus

MEDCOM - 5133 FLTHOSPPNCLA 6320/1 (1103)

1900-0700	Time	Signature

NEUROLOGICAL

Level of Consciousness
Oriented to: Person ✓ Place ✓ Time ✓
Responds to: Verbal ✓ Pain ___ Unresponsive ___
Pupils R L
Size / 3 / + 3 / 4
Motor Strength S = Strong W = Weak TR = Trace A = Absent
Extremities:

	L	R
Upper	W	W
Lower	W	TR

☐ See Narrative

CARDIOVASCULAR

Pulses	R	L		R	L
Radial	+	+	Posterior Tibial	+	+
Femoral	+	+	Dorsalis Pedis	+	+

+ = Normal - = Weak 0 = Absent
Rhythm: RRR Ectopy: Ø
Murmur: ___ Rub: ___ S1: ___ S2: ___
Neck Veins: ___
Edema: ___
☐ See Narrative

RESPIRATORY

Breath Sounds: ☑ Clear ☑ Bilat
Location:
Crackles /Rales: ___ Dim: ___
Wheezes: ___ Absent: ___
Rhonchi: ___
Cough: Productive / Unproductive: ___
Sputum: Color and Character: ___
Tubes: ☐ ET ☐ Trach
Size: ___ Location: ___
O2: ☐ Canula ☐ Mask
Chest Tubes: ___
☐ See Narrative

GASTROINTESTINAL

Observation: WNL
Auscultation: ⊕ BOWEL SOUNDS X4Q
Palpation: Ø DIFFICULTIES
Stool: ☐ Incontinent ☐ Formed ☐ Soft ☐ Frequent ☐ Liquid ☐ Hard
Tubes / Bags / Suction / Drainage:
☐ See Narrative ☐ NGT Placement

GU

☑ Void Urine: Color / Character
TEA COLOR / SLIGHTLY TURBID
Catheter: FOLEY → GRAV
Other:
☐ See Narrative

SKIN

Color / Turgur / Temperature / Moisture
WARM / DRY
Incisions / Dressings / Leisions / Dermal Ulcers
PENIS, (L) LE X2
☐ See Narrative

Narrative:

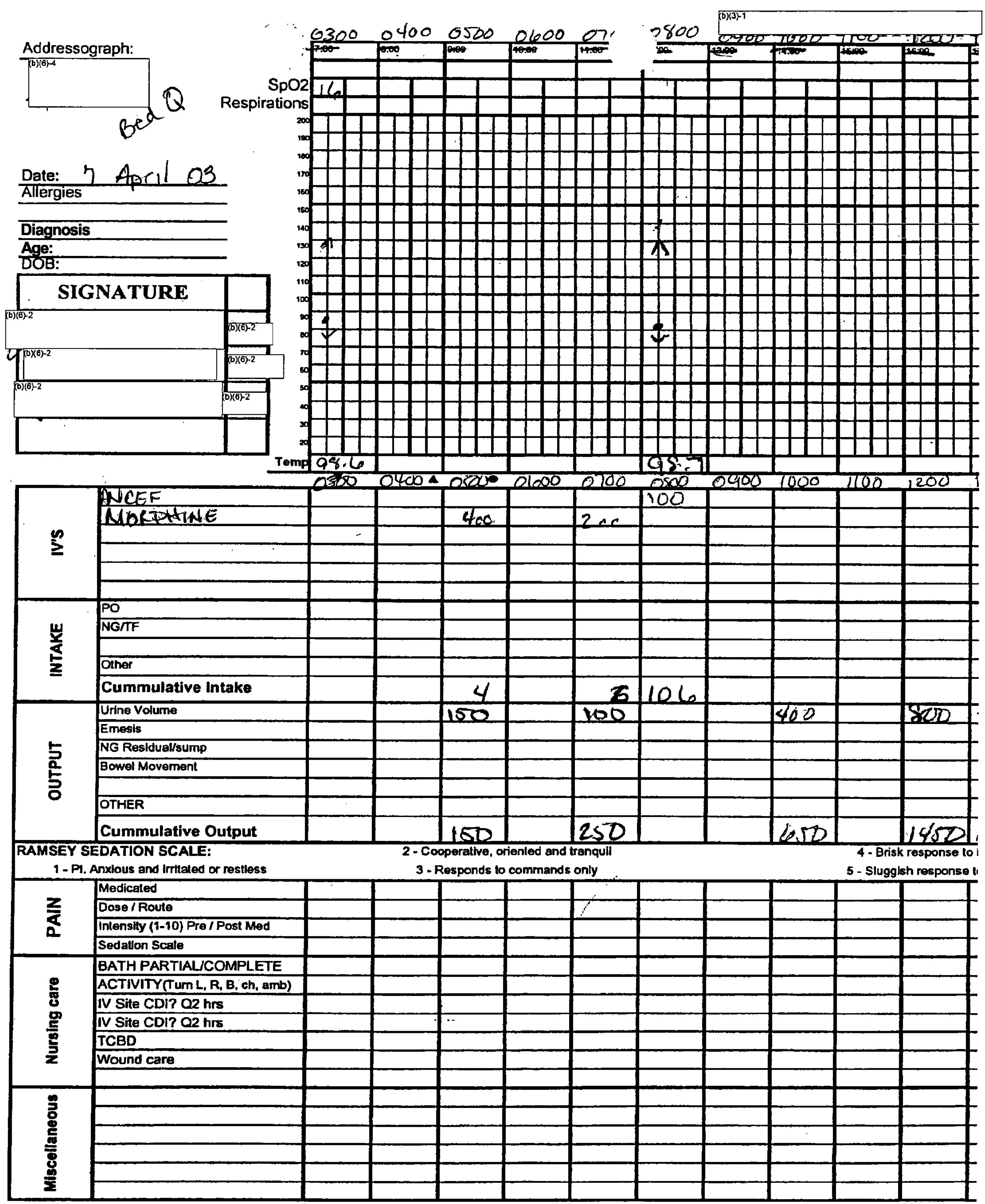
1915 - IV SITE C[illegible]GE FROM (L) FOREARM TO (R) WRIST. PT [illegible]LERATED Š COMPLAINT. PT RESTING COMFORTABLY. — HN (b)(6)-2

2210 - DRSG Δ @ (L) MED U LEG. REMOVED PACKING. Ø DRAINAGE, Ø EDEMA, Ø ERYTHEMA Ø PURULENT DRAINAGE Ø S/S INFECTION. PACKED Č DANKIN SOAKED GAUZE. COVERED Č CLEAN DRSG & KERLIX WRAP. DRSG Δ @ (L) LAT L LEG. REMOVED PACKING. Ø S/S INFECTION Ø DRAINAGE Ø EDEMA Ø PURULENT DRAINAGE (+) ERYTHEMA. PACKED Č DANKIN SOAKED GAUZE. COVERED Č CLEAN GAUZE & KERLIX WRAP. CARE TO WOUND @ TIP OF PENIS. BACITRACIN APPLIED TO WOUND. PT TOLERATED Š COMPLAINT. PT RESTING COMFORTABLY. — HN (b)(6)-2

0333 Pt medicated Č 2mg FS04 (b)(6)-2 will monitor — (b)(6)-2 UGS

0558 Pt requested pain meds given — (b)(6)-2 CT/CNA

MEDCOM - 5134



Addressograph: (b)(6)-4

Bed Q

Date: 7 April 03

Allergies

Diagnosis

Age:

DOB:

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

(b)(3)-1

	0300	0400	0500	0600	0700	0800	0900	1000	1100	1200
SpO2										
Respirations	16									
Temp	98.6					98.[illegible]				

		0300	0400	0500	0600	0700	0800	0900	1000	1100	1200
IV'S	ANCEF						100				
	MORPHINE			4cc		2cc					
INTAKE	PO										
	NG/TF										
	Other										
	Cummulative Intake			4		6	106				
OUTPUT	Urine Volume			150		100			400		800
	Emesis										
	NG Residual/sump										
	Bowel Movement										
	OTHER										
	Cummulative Output			150		250			650		1450

RAMSEY SEDATION SCALE:
1 - Pt. Anxious and irritated or restless
2 - Cooperative, oriented and tranquil
3 - Responds to commands only
4 - Brisk response to [illegible]
5 - Sluggish response t[illegible]

PAIN	Medicated										
	Dose / Route										
	Intensity (1-10) Pre / Post Med										
	Sedation Scale										
Nursing care	BATH PARTIAL/COMPLETE										
	ACTIVITY(Turn L, R, B, ch, amb)										
	IV Site CDI? Q2 hrs										
	IV Site CDI? Q2 hrs										
	TCBD										
	Wound care										
Miscellaneous											

MEDCOM - 5135

0700-1900	Time:	Signature:

NEUROLOGICAL

Level of Consciousness

Oriented to: Person ✓ Place ✓ Time ✓

Responds to: Verbal ✓ **Pain** ___ **Unresponsive**

Pupils R L

Size / Reaction: [ ]/[ ] [ ]/[ ]

Motor Strength S = Strong

Extremities: W = Weak; TR = Trace; A = Absent

	L	R
Upper	S	S
Lower	TR	TR

[ ] See Narrative

CARDIOVASCULAR

Pulses	R	L		R	L
Radial	+	+	Posterior Tibial		
Femoral			Dorsalis Pedis	+	+

+ = Normal - = weak 0 = Absent

Rhythm: ___ Ectopy: ___

Murmur: ___ Rub: ___ S1: ___ S2: ___

Neck Veins: ___

Edema: ___

[ ] See Narrative

RESPIRATORY

Breath Sounds: [✓] Clear [✓] Bilat

Location:

Crackles /Rales: ___ Dim: ___

Wheezes: ___ Absent ___

Rhonchi: ___

Cough: Productive / Unproductive: ___

Sputum: Color and Character: ___

Tubes: [ ] ET [ ] Trach

Size: ___ Location: ___

02: [ ] Canula [ ] Mask

Chest Tubes: ___

[ ] See Narrative

GASTROINTESTINAL

Observation: WNL

Auscultation: WNL

Palpation:

Stool: [ ] Incontinent [ ] Formed [ ] Soft [ ] Frequent [ ] Liquid [ ] Hard

Diet: ___

Tubes / Bags / Suction / Drainage:

[ ] See Narrative [ ] NGT Placement

GU

[ ] Void Urine: Color / Character

Catheter: ___

Other: ___

[ ] See Narrative

SKIN

Color / Turgur / Temperature / Moisture

GSW x 3 Bilat L E

Incisions / Dressings / Leisions / Dermal Ulcers

[ ] See Narrative

SHIFT A

0500 Assumed care of pt @ this time pt resting peacefully [illegible] rise and fall of chest [illegible] breath sounds. IVFs infusing LR @ KVO ē no difficulty will continue to monitor — (b)(6)-2

0530 Pt drank 40cc H2O — (b)(6)-2

0840 Pt ate 2 MRE crackers and apple jelly also drank 2 cups H2O No c/o pain (out of ordinary) or discomfort at this time. IV hep locked due to tolerating P.O. (b)(6)-2

1145 Medicated ē MSO4 3mg IVP for pain (b)(6)-2

1800 Dressing Δ's to All wounds BED LAT Linens Δ AM CARE performed Pt tolerated procedure well.

MEDCOM - 5136

1900-0700	Time:	Signature: (b)(6)-2

NEUROLOGICAL

Level of Consciousness
Oriented to: Person ✓ Place ✓ Time ___
Responds to: Verbal ✓ Pain ✓ Unresponsive ___

Pupils R L
Size / 3 / + 3 / +

Motor Strength Extremities: S = Strong, W = Weak, TR = Trace, A = Absent

	L	R
Upper	5	5
Lower	TR	TR

☐ See Narrative

CARDIOVASCULAR

Pulses	R	L
Radial	+	+
Femoral	+	+
Posterior Tibial	+	+
Dorsalis Pedis	+	+

+ = Normal - = Weak 0 = Absent

Rhythm: RRR Ectopy: Ø
Murmur: ___ Rub: ___ S1: ___ S2: ___
Neck Veins: ___
Edema: ___

☐ See Narrative

RESPIRATORY

Breath Sounds: ☑ Clear ☑ Bilat
Location:
Crackles /Rales: ___ Dim: ___
Wheezes: ___ Absent: ___
Rhonchi: ___
Cough: Productive / Unproductive: ___
Sputum: Color and Character: ___
Tubes: ☐ ET ☐ Trach
Size: ___ Location: ___
O2: ☐ Canula ☐ Mask
Chest Tubes: ___

☐ See Narrative

GASTROINTESTINAL

Observation: WNL
Auscultation: ⊕ BOWEL SOUNDS x 4Q
Palpation: SOFT
Stool: ☐ Incontinent ☐ Formed ☐ Soft ☐ Frequent ☐ Liquid ☐ Hard

Tubes / Bags / Suction / Drainage:

☐ See Narrative ☐ NGT Placement

GU

☐ Void Urine: Color / Character
NO VOID
Catheter:
Other:

☐ See Narrative

SKIN

Color / Turgur / Temperature / Moisture
DRY / WARM / WNL
Incisions / Dressings / Lesions / Dermal Ulcers
PENIS, (L) MED U LEG, (L) LAT L LEG

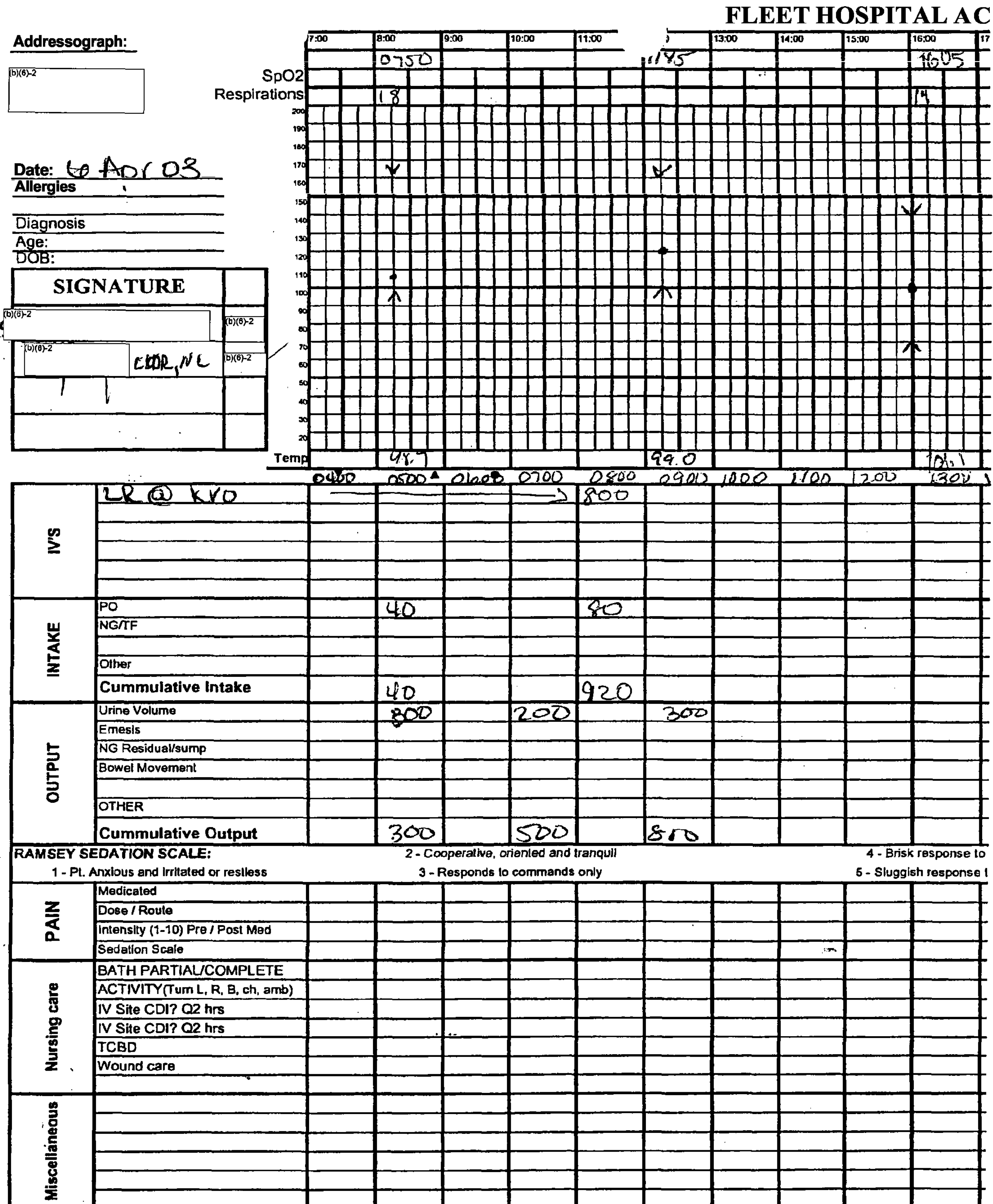
☐ See Narrative

1545 - SHIFT ASSUMED CARE OF PT. PT RESTING COMFORTABLY s̄ S/S COMPLAINT. ——— HN (b)(6)-2

2200 - DRSG Δ @ (L) MED U LEG. REMOVED PACKING, Ø DRAINAGE Ø EDEMA Ø S/S INFECTION Ø ERYTHEMA, Ø PURULENT DRAINAGE. PACKED c̄ DAGAN SOAKED GAUZE. COVERED c̄ CLEAN GAUZE + KERLIX WRAP. DRSG Δ @ (L) LAT L LEG. REMOVED PACKING. ⊕ SERROSENGUOUS DRAINAGE Ø EDEMA, Ø ERYTHEMA, Ø S/S INFECTION Ø PURULENT DRAINAGE. PACKED c̄ DAGAN SOAKED GAUZE, COVERED c̄ CLEAN DRSG + KERLIX WRAP. WOUND @ TIP OF PENIS, Ø DRAINAGE, Ø EDEMA, ⊕ ERYTHEMA, Ø S/S INFECTION, Ø PURULENT DRAINAGE. APPLIED BACITRACIN. PT TOLERATED s̄ COMPLAINT. PT RESTING COMFORTABLY. ——— HN (b)(6)-2

2214 Cova c̄ above pt pre Empty 4mg IVP ... Tolerated well ——— (b)(6)-2

MEDCOM - 5137



FLEET HOSPITAL AC

Addressograph:

(b)(6)-2

Date: 6 Apr 03

Allergies

Diagnosis

Age:

DOB:

SIGNATURE	
(b)(6)-2	(b)(6)-2
(b)(6)-2 CDR, NC	(b)(6)-2

	7:00	8:00	9:00	10:00	11:00		13:00	14:00	15:00	16:00
		0750				1145				1605
SpO2										
Respirations		18								14
Temp		98.7				99.0				101.1
	0400	0500	0600	0700	0800	0900	1000	1100	1200	1300
IV'S: LR @ KVO	→	→	→	→	800					
INTAKE: PO		40			80					
NG/TF										
Other										
Cummulative Intake		40			920					
OUTPUT: Urine Volume		300		200		300				
Emesis										
NG Residual/sump										
Bowel Movement										
OTHER										
Cummulative Output		300		500		800				

RAMSEY SEDATION SCALE:
1 - Pt. Anxious and irritated or restless
2 - Cooperative, oriented and tranquil
3 - Responds to commands only
4 - Brisk response to
5 - Sluggish response t

PAIN	
Medicated	
Dose / Route	
Intensity (1-10) Pre / Post Med	
Sedation Scale	

Nursing care	
BATH PARTIAL/COMPLETE	
ACTIVITY(Turn L, R, B, ch, amb)	
IV Site CDI? Q2 hrs	
IV Site CDI? Q2 hrs	
TCBD	
Wound care	

Miscellaneous

MEDCOM - 5138

0700-1900 | Time: [illegible] | Signature:

NEUROLOGICAL

Level of Consciousness
Oriented to: Person X Place X Time X
Responds to: Verbal X Pain ___ Unresponsive

Pupils R L
Size / Reaction: [ ]/[ ] [ ]/[ ]

Motor Strength S = Strong W = Weak TR = Trace A = Absent
Extremities:

	L	R
Upper	S	S
Lower	S	S

[ ] See Narrative

CARDIOVASCULAR

Pulses

	R	L		R	L
Radial	+	+	Posterior Tibial		
Femoral			Dorsalis Pedis	+	+

+ = Normal - = Weak 0 = Absent

Rhythm: ___ Ectopy: ___
Murmur: ___ Rub: ___ S1: S1 > S2: ___
Neck Veins: ___
Edema: (R) THIGH (L) LEG
[ ] See Narrative

RESPIRATORY

Breath Sounds: [X] Clear [ ] Bilat
Location:
Crackles /Rales: ___ Dim: ___
Wheezes: ___ Absent: ___
Rhonchi: ___
Cough: Productive / Unproductive: U
Sputum: Color and Character: ___
Tubes: [ ] ET [ ] Trach
Size: ___ Location: ___
O2: [ ] Canula [ ] Mask
Chest Tubes: ___
[ ] See Narrative

GASTROINTESTINAL

Observation: NORMAL
Auscultation: BOWEL SOUNDS PRESENT
Palpation: FIRM
Stool: [ ] Incontinent [ ] Formed [ ] Soft [ ] Frequent [ ] Liquid [ ] Hard
Diet:
Tubes / Bags / Suction / Drainage:
[ ] See Narrative [ ] NGT Placement

GU

[X] Void Urine: Color / Character
Catheter:
Other:
[ ] See Narrative

SKIN

Color / Turgur / Temperature / Moisture
NORMAL
Incisions / Dressings / Leisions / Dermal Ulcers
DRESSINGS ON (L)(R) LEGS.
[ ] See Narrative

Narrative:

0945 PT VITAL SIGNS TAKEN. PULSE: 112, B/P 162/102
RESPIRATIONS: 18, TEMP: 100.1. ——— (b)(6)-2
0950 PT IS A+OX3 AND RESPONDS TO VERBAL STIMULI. PT IS PERRLA AND HAS STRONG MOTOR SKILLS IN ALL FOUR EXTREMITIES. PT PULSES ARE NORMAL, S1 > S2, BREATH SOUNDS ARE CLEAR (c) COUGH. GI IS NORMAL WITH BOWEL SOUNDS PRESENT AND FIRM UPON PALPATION. NO VOID NOTED. SKIN IS NORMAL AND THERE ARE DRESSING ON (L) + (R) LEGS. ——— (b)(6)-2
1000 Concur c above note. Pt given MSO4 5mg IVP @ 0900 for MO exam. Pt To OR via gurney ——— (b)(6)-2 [illegible]
1330 Returned from OR via gurney (b)(6)-2 [illegible]
1345 mbr receiving LR @ 250cc/hr in L [illegible] No s/s of infection or infiltration to infusion site.
1450 MBR IV REPLACED DUE TO INFILTRATION
1500 GENT 400mg infusing in R HAND No S/S of infection or infiltration to infusion site. IVF's infusing well will continue to monitor. ——— (b)(6)-2
Concur c above note ——— (b)(6)-2 [illegible]

MEDCOM - 5139

TE WARD - 24 HOUR FLOW SHEET

18:00	19:00	20:00	21:00	22:00	23:00	0:00	1:00	2:00	3:00	4:00	5:00	6:00
		142/86				139/80				136/80		
		79				69				74		
		18				16				16		

200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20

18:00	19:00	20:00	21:00	22:00	23:00	0:00	1:00	2:00	3:00	4:00	5:00	6:00	
		99.1				98.8				98.1			Temp

150	150	150	150	150	150	150	150	150	150	150		
90												
			350				400			150		

glabellar tap or loud auditory stimulus

t glabellar tap or loud auditory stimulus

6 - No response to light glabellar tap or loud auditory stimulus

MEDCOM - 5140 FLTHOSPPNCLA 6320/1 (1/03)

1900-0700 Time 1700 Signat (b)(6)-2

NEUROLOGICAL

Level of Consciousness

Oriented to: Person ✓ Place ✓ Time ✓

Responds to: Verbal ✓ Pain ✓ Unresponsive ___

Pupils R L

Size / 2-3 / + 2-3 / +

Motor Strength S = Strong W = Weak TR = Trace A = Absent

Extremities:

	L	R
Upper	S	S
Lower	S	W

☐ See Narrative

CARDIOVASCULAR

Pulses	R	L		R	L
Radial	+	+	Posterior Tibial		
Femoral			Dorsalis Pedis	+	+

+ = Normal - = Weak 0 = Absent

Rhythm: RRR Ectopy: Φ

Murmur: ___ Rub: ___ S1: WNL S2: WNL

Neck Veins: ___

Edema: ___

☐ See Narrative

RESPIRATORY

Breath Sounds: ☒ Clear ☐ Bilat

Location:

Crackles /Rales: ___ Dim: ___

Wheezes: ___ Absent: ___

Rhonchi: ___

Cough: Productive / Unproductive: ___

Sputum: Color and Character: ___

Tubes: ☐ ET ☐ Trach

Size: ___ Location: ___

O2: ☐ Canula ☐ Mask

Chest Tubes: ___

☐ See Narrative

GASTROINTESTINAL

Observation: Normal

Auscultation: BS x4

Palpation:

Stool: ☐ Incontinent ☐ Formed ☐ Soft ☐ Frequent ☐ Liquid ☐ Hard

Tubes / Bags / Suction / Drainage: ~~Midline incision ē staples~~ Error

~~Abdominal C/D/I~~

☒ See Narrative ☐ NGT Placement

GU

☐ Void Urine: Color / Character

VOIDS

Catheter:

Other:

☐ See Narrative

SKIN

Color / Turgur / Temperature / Moisture

IV Ⓡ Hand

Incisions / Dressings / Leisions / Dermal Ulcers

Dress on Ⓛ Ⓡ Legs

☐ See Narrative

Narrative:

1700 Assumed care of PT. See secondary assessment (b)(6)-2

2000 IV changed to Ⓛ FA 18g. (b)(6)-2

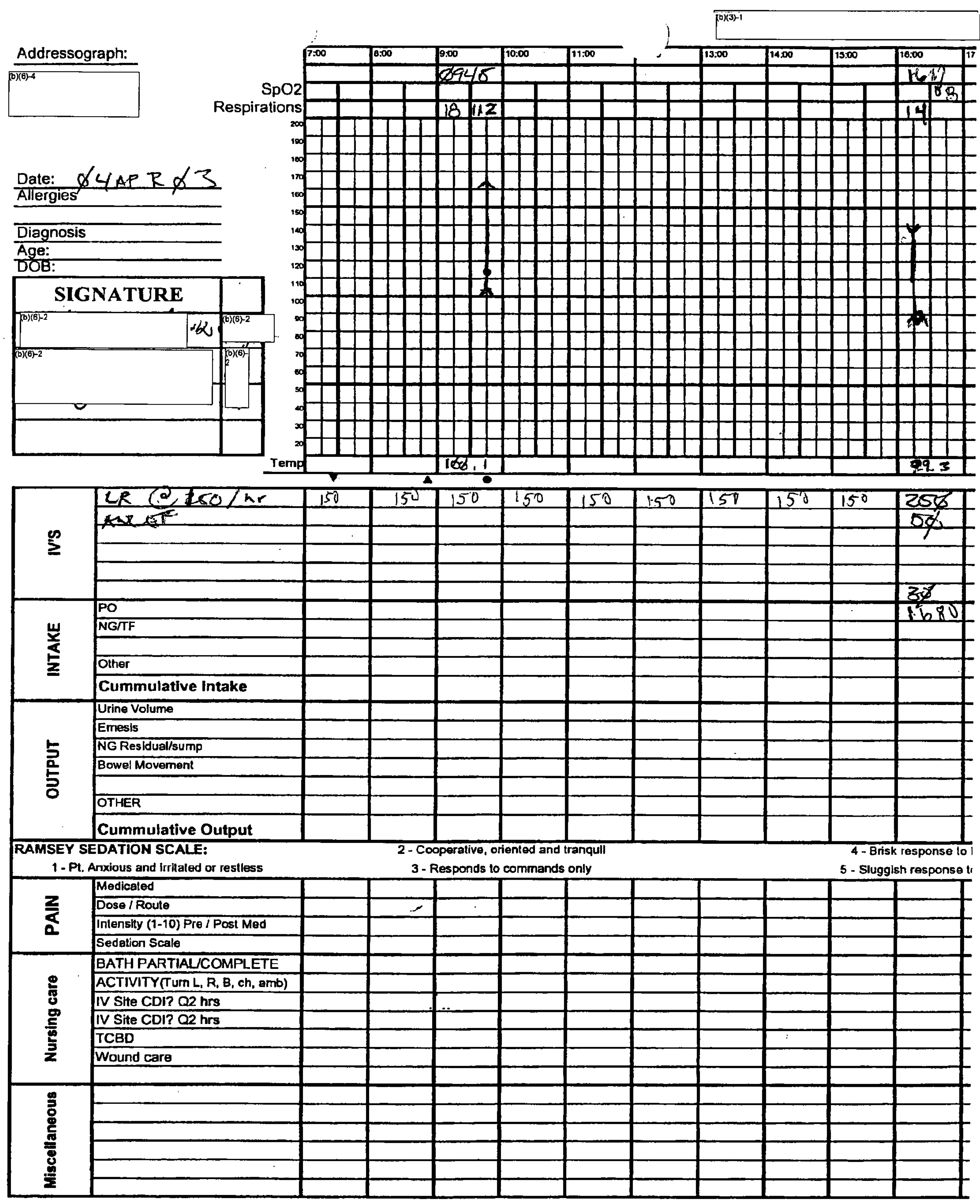
2200 Dressing Δ complete, new bag ER hung (b)(6)-2

2300 [illegible] assumed care @ 1700. Pt premedicated ē [illegible] IVP prior to dsg Δ, tolerated well. [illegible] dsg removed. [illegible] ē [illegible] drainage [illegible] to Ⓛ medial thigh [illegible]

0130 Pt c/o [illegible] pain, given [illegible] IVP (b)(6)-2

0415 No further Δ's to assessment. Pt remained primarily asleep s̄ c/o pain (b)(6)-2

MEDCOM - 5141



(b)(3)-1

Addressograph:

(b)(6)-4

Date: Ø4APRØ3
Allergies
Diagnosis
Age:
DOB:

SIGNATURE

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

	7:00	8:00	9:00	10:00	11:00		13:00	14:00	15:00	16:00	17
			Ø945							1610	
SpO2										98	
Respirations			18 / 12							14	
Temp			100.1							99.3	

IV'S											
	LR @ 150/hr	150	150	150	150	150	150	150	150	150	250
	[illegible]										5Ø
INTAKE	PO										3Ø
	NG/TF										1680
	Other										
	Cummulative Intake										
OUTPUT	Urine Volume										
	Emesis										
	NG Residual/sump										
	Bowel Movement										
	OTHER										
	Cummulative Output										

RAMSEY SEDATION SCALE:
1 - Pt. Anxious and irritated or restless
2 - Cooperative, oriented and tranquil
3 - Responds to commands only
4 - Brisk response to l
5 - Sluggish response t

PAIN	Medicated										
	Dose / Route										
	Intensity (1-10) Pre / Post Med										
	Sedation Scale										
Nursing care	BATH PARTIAL/COMPLETE										
	ACTIVITY(Turn L, R, B, ch, amb)										
	IV Site CDI? Q2 hrs										
	IV Site CDI? Q2 hrs										
	TCBD										
	Wound care										
Miscellaneous											

MEDCOM - 5142

Day Of Surgery
Vital Signs

(b)(6)-4

HOLDING AREA: Versed______mg IV Fentanyl 50 mcg IV Ancef/__________ ____gm IVPB

NAVHOSPPNCLA OVERPRINT (10-94) IV 16 / 18 / 20 ga in R / L Hnd / FA / AC (L) EJ

1050

WT 60 Kg **CLINICAL RECORD** ☒ Drugs / Equipment / O2 / Suction / Checked **ANESTHESIA**

	START	STOP
Anesthesia	1020	1147
Procedure	1112	1143

	1100	30	1200	30	1300	30	1400
AGENTS							
O2 L/MIN	4-2-1-1						
N2O Air L/Min							
DES / SEVO % (SEVO)	3-2.5-2						
(FEN) / SUF / ALF / REM	50						
PRO (PEN) / ETO	200						
(SUX) / MIVA / ATR	100						
NOR / PAV / ZEM / NIM							
MSO4		1 1					
MONITORS							
EKG	SR SR SR						
ET CO2	36 36 47						
FIO2	1.0						
SaO2%	100 100 100						
Temp. / S/A/R/E	36.6 37.2						
Urine ML							
EBL ML							

● = PULSE
O = SPONT RESP
⊘ = ASST RESP
⊗ = CNTRL RESP
⊕ = VENTILATOR
X CUFF BP
+ ART LINE
X = MAP
I = INTUBATE
R = REVERSAL
E = EXTUBATE

(Scale: 200, 180, 160, 140, 120, 100, 80, 60, 40, 20)

VENT		
Tidal Volume	400	490
Resp. Rate	8	8
Peak Pressure		
Vent Mode	8V	

Symbols for Remarks

FLUIDS		
Blood / Products		
IV (LR) / DSLR	500	700
IV		

POSITION

PRE-PROCEDURE

- ☑ Identified: ☑ ID Band ☐ Questioning
- ☑ Chart Reviewed ☐ Permit Signed
- ☐ NPO Since
- Pre-anesthetic State: ☑ Calm
- ☑ Awake ☐ Asleep
- ☐ Apprehensive ☐ Confused
- ☐ Uncooperative ☐ Unresponsive

PATIENT SAFETY

- ☑ Anes. Machine # 3 Checked
- ☑ Safety Belt On ☐ Axillary Roll
- ☑ Armboard Restraints ☐ Arms Tucked
- ☑ Pressure points checked and padded
- ☑ Eye Care: ☐ Ointment ☐ Saline
- ☑ Taped ☐ Pads ☐ Goggles

ANESTHETIC TECHNIQUE

- General: ☑ Pre-Oxygenation ☐ L.T.A.
- ☐ Rapid Sequences ☐ Cricoid Pressure
- ☑ Intravenous ☐ Inhalation
- ☐ Intramuscular ☐ Rectal
- Regional: ☐ Spinal ☐ Epidural
- ☐ Axillary ☐ Bier Block ☐ Ankle Block
- ☐ ________ ☐ Position______
- ☐ Prep________ ☐ Local________
- ☐ Needle
- ☐ Drug(s)________
- ☐ Dose________ ☐ Attempts x____
- ☐ Site________ ☐ Level
- ☐ Catheter________ ☐ See Remarks
- Other: ☐ M.A.C. ☐ ________

AIRWAY MANAGEMENT

- Intubation: ☑ Oral Tube size 7.0
- ☑ Stylet used ☐ Nasal ☑ Regular
- ☐ Magill's ☑ Direct ☐ RAE
- ☐ Fiber optic ☐ Blind ☑ Atraumatic
- ☑ Blade Mac 2 ☐ LMA
- ☑ Secured at 20 cm ☐ Dbl Lum
- ☑ Attempts x 1 ☑ ET CO2 present
- ☑ Breath sounds BILAT
- ☐ Uncuffed, leaks at______cm H2O
- ☑ Cuffed ☑ Min. occ. pres. ☑ Air ☐ NS
- Airway: ☐ Oral ☐ Nasal ☐ Difficult, see Remarks
- Circuit: ☑ Circle ☐ NRB
- ☐ Mask Case ☐ Nasal Cannula
- ☐ Via Tracheostomy ☐ Simple O2 mask

FLUID TOTALS

Crystalloid 700 EBL min
Blood______ Urine______

REMARKS

Smooth IV induction. Atraumatic intubation.

MONITORS AND EQUIPMENT

- ☐ Steth ☐ Precord ☐ Esoph ☐ Other
- ☑ Non-invasive B/P ☐ Left ☑ Right
- ☑ Continuous EKG ☐ V Lead EKG
- ☑ Pulse Oximeter ☑ Oxygen Sensor
- ☑ End Tidal CO2 ☐ Gas Analyzer
- ☑ Temp. ET ☐ Nerve Stimulator
- ☐ Warming Blanket ☐ Fluid Warmer
- ☐ Airway Humidifier ☐ Foley Catheter
- ☐ NG / OG Tube ☐ Art. Line______

EMERGENCE

Oral Suctioning ☐ Head Lift x 5 sec. ☐
Extubation: AWAKE ☐ ASLEEP ☐
TOF 4/4 with Sus Tet. ☐

RECOVERY

Location PACU	Time 1147
B/P 118/68	O2 Sat 100
P 100 R 16	T 97.7

- ☐ Awake ☑ Stable ☐ Nasal Oxygen
- ☑ Drowsy ☐ Unstable ☐ Mask Oxygen
- ☐ Somnolent ☐ Intubated ☐ T-piece Oxygen
- ☐ Unarousable ☐ Ventilator ☐ Oral/nasal airway

PACU NOTES

Parr____

NARCOTICS	(FENT) / SUF / REM	MS	MIDAZ
ISSUED	250	10	
USED	100		
WASTED	150		

PROCEDURE Debridements LEs & penis

SURGEON(S) (b)(6)-2

ANESTHESIA (b)(6)-2

PATIENT'S IDENTIFICATION (b)(6)-4 (b)(6)-4

(For typed or written entries give Name—last, first, middle, grade, date, hospital or medical facility.)

GEN
ANESTHESIA

DATE 4/4/03

Standard Form 517
Prescribed by GSA ICMR
FIRMR (41 CFR) 201-45 505
OCTOBER 1975 517-112

MEDCOM - 5143

ANESTHESIA RECORD

MNMC (12/00)

Procedure: Secondary closure of I+D thigh & flank wounds

Wt (kg) - | Ht (in) - | Allergies - NKDA

Anesthesia: (b)(6)-2 | Surgeon: (b)(6)-2

OR # 4 | Page 1 of 1 | See Page One

Date	Anes. Start	In Room	Surg. Start	Surg. End	Anes. End	Resident/SRNA
25APR2005	0800	0820	0842	0925	0935	

Time: 0815, 30, 0845, 0900, 0915, 0930, 0945, 1000, 1015

Agent				
O_2 L/M	6	1.5	1.5	1.5
N_2O / Air L/M		1.5	1.5	1.5
Halo / Iso / Sevo / Des	2.0	1.1	1.2	1.2
STP / Prop. / Etomidate	150 50 / 100		TOTAL - 300mg	
Sux / Cistracurium				
Ro / Rapa / Vecuronium				
Lidocaine	20			
Neostigmine / Glyco				
Ephedrine / Neo				
Midazolam				
MSO4 / Remi / Su / Fentanyl	50-50		50	
Epid. Lido / Bupiv / Ropiv				
0.9NACl -		4cc		700ml
NS / LR				
U/O			0 urine.	
EBL			25ml	

Checklist - ☑ O_2 ☐ Suction ☐ Machine ☐ Consent ☐ NPO

Monitors - ☑ SaO_2 ☑ ECG ☐ FiO_2 ☐ NIBP (L) R arm ☑ $EtCO_2$ ☐ PCS / ES ☐ PNS ☐ PIP ☐ Temp ☐ Mass Spec ☑ Verbal ☐ TEE ☐ Fluid warmer ☑ Air Warm ☐ Foley ☐ FHT ☐ Pulm Art cath ☐ CVP IJ / SC / Fem L / R ☐ OG / NG L / R ☐ A-Line Rad / Fem L / R

Position - ☐ Pressure points padded ☐ Arms < 90° — (Supine) Prone Lithotomy Sitting Lateral L / R

Split 100 mcg: Drawn 10 Used 1 Wasted 4 Witness (b)(6)-2

Drawn 250 Used 150 Wasted 100 Witness (b)(6)-2

IV # 18 Ga L / (R) Hand Wrist FA AC EJ

☐ Tourniquet ____ mmHg Times ____

60 / 90 / 120 / 130 / 140 / 150 min - Surgeons informed

Antibiotics — Agent Ancef; mg 1 Gm; over 20 minutes; @ 0845-0905

Vitals chart (180–40): pulse ~90–80, BP approx. 130/70 range.

PACU / ICU: Pulse - 109; BP 152/81; Temp - 95.5 Ax; R - 16; SaO_2 - 98; Comps - (-)

(1) To Room. Interpreter answered all question. Pt. understands surgery.

(2) Propofol 2nd Dosed to get LMA IN. Rigid jaw

Surgeon injected local Marcaine 0.25% plain. 10cc into wounds

ECG	SR	SR	SR	SR
Np / Or / Sk / Ax Temp		35.9	35.9	35.5
% FiO_2	100	54	54	50
% SaO_2	100	100	100	100
$EtCO_2$	37	42	40	34
(SR)			SR	SR
TV	400	350	317	321
PIP (cmH2O)		20	22	—
Resp. Rate	16	26	26	24

Induction - (Monitors On) (Preoxygenated) (Smooth) — Inhalation / IV — Cricoid Pressure — Rapid Sequence — Mask ventilation easy Y / N Board-leaks.

Intubation - Mac / Mil ____ Grade ____ view Tube Size ____ Attempts ____ Oral / Nasal L / R w/o w/ Cuff Stylet Y / N Bil BS / $EtCO_2$ x 3 / CIN

Tube taped @ ____ cm @ lips / teeth / nares — Trauma Y / N FOB / LW / Blind, LMA # 5 Classic — DLT ____ Fr L / R Cotton Airway.

Maintenance - (Smooth) (Cuff checked) (Eyes taped / lubed) Difficult to insert LMA - Rigid jaw s muscle Relaxation

Extubation (Smooth) LMA. Reversed SV VSS Full T4 / Head lift / Sustained tetanus Suctioned Awake / Deep

Disposition - (PACU) / ICU (SV VSS) (Awake) / sleepy Extubated / intubated

Prep — ☐ Sterile Technique ☐ Disposable kit ☐ Betadine prep x 3 ☐ Local infiltration ☐ Site ____ L / R ☐ Attempts ____

Blocks — ☐ Nerve Stim ____ mA ☐ Trans-arterial ☐ Dual cuff

Regional — ☐ Spinal / Epidural ☐ Touhy / Whitacre / Quincke ☐ Needle guage ____ ☐ Sitting ☐ Lateral R / L ☐ LOR to Air / NS ☐ Paresthesia + / - ☐ Heme + / - ☐ CSF + / - ☐ Test dose ⊖ ☐ CSF ⊕ swirl

Regional — ☐ Catheter out - tip intact ☐ Level ____

Lines — ☐ Seldinger Technique ☐ CVP manually transduced ☐ Cordis 9.5 / 8.5 Fr ☐ SLIC ☐ 2 / 3 - lumen

Comments / Drugs:

Patient Identification

(b)(6)-4

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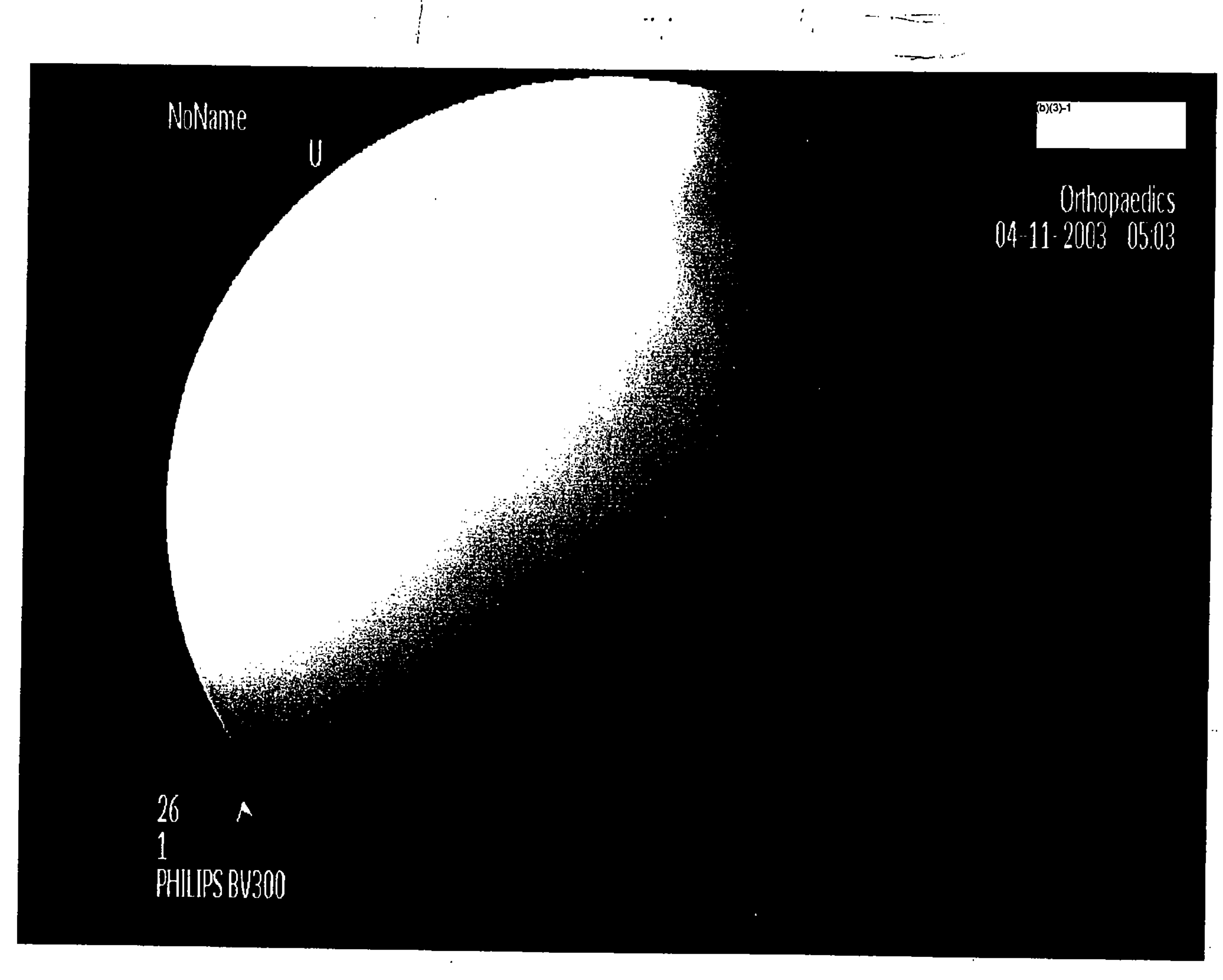

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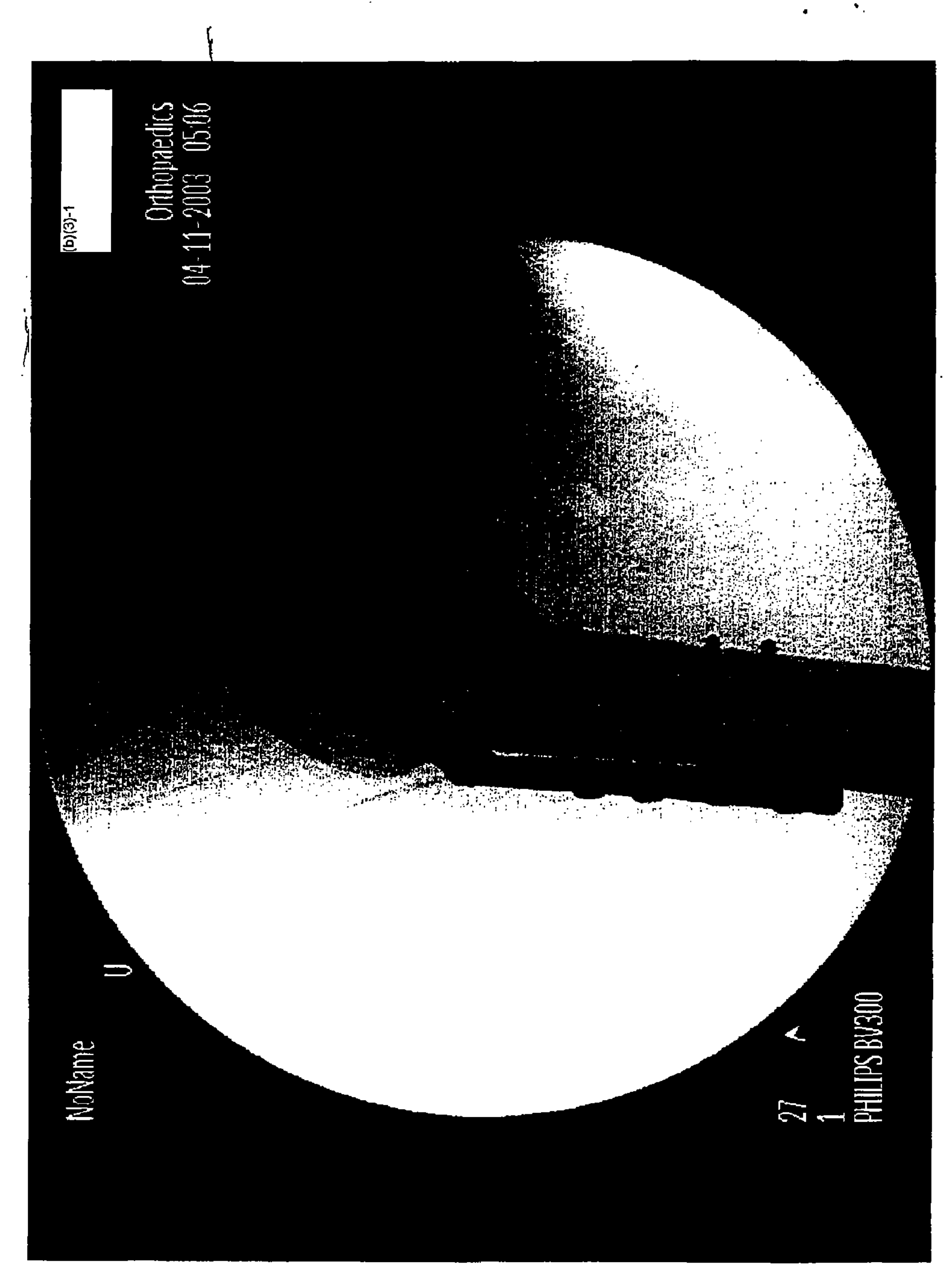

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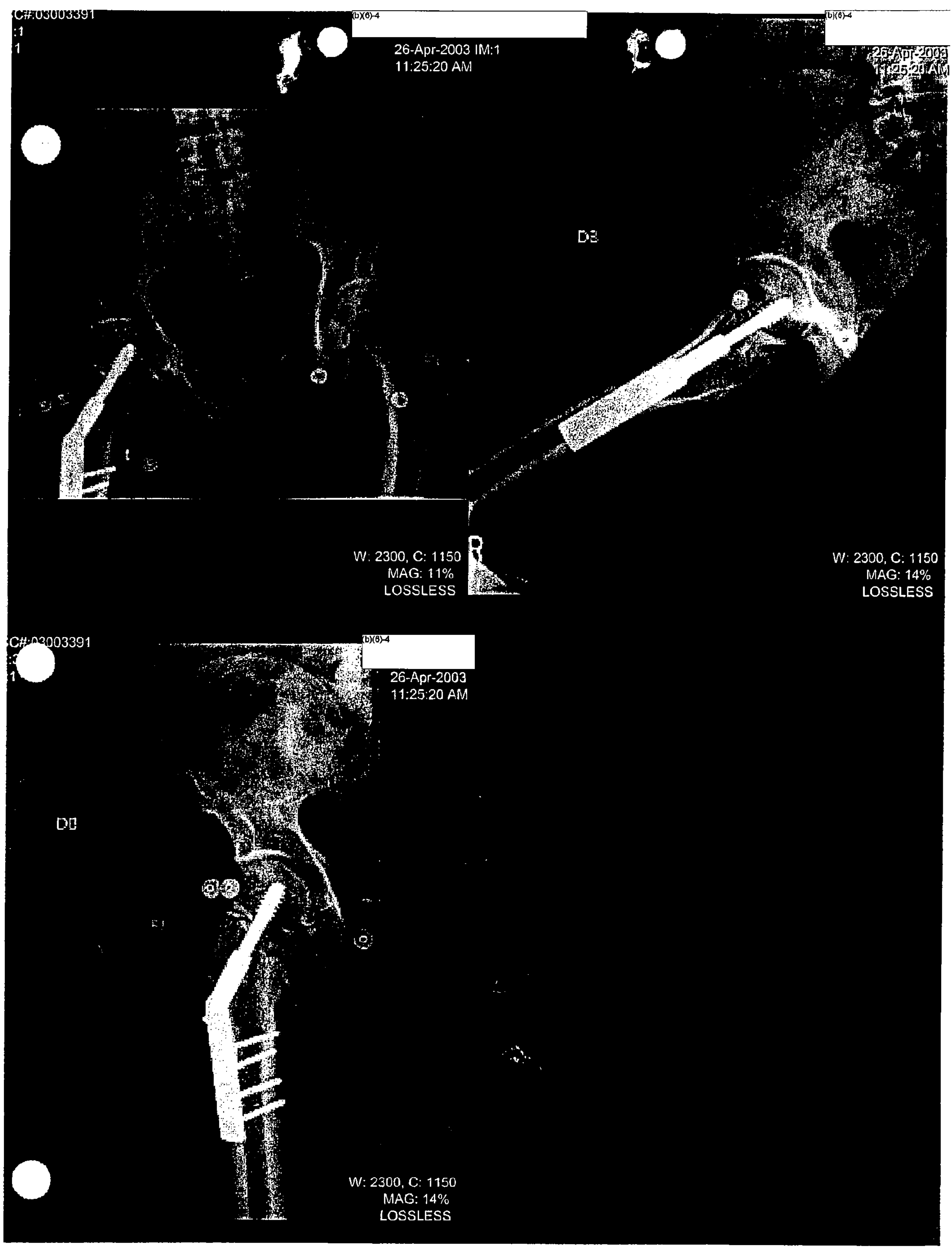

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