Allergies: Unknown

NAVMED 6550/8 (REV. 4-74) S/N 0105-LF-216-5581 PG 1 OF 2

MEDICAL RECORD | **MEDICATION ADMINISTRATION RECORD**

SCHEDULED DRUGS — MONTH APR 19 2003 — DATES GIVEN

ORDER DATE	MEDICATION- DOSAGE- FREQUENCY ROUTE OF ADMINISTRATION	HOURS	18	19	20	21	22	23	24
4/18	Zantac 50 mg IV Q8°	0600	X	(b)(6)-2	(b)(6)-2				
		1400	X		D/C		4/20		
		2200	(b)(6)-2						
4/18	Vitamin K 10 mg SQ QAM x 3	0900	X		(b)(6)-2		X	X	X
4/18	Flucinazole 400 mg po BID	0900	X						
		2100	X		(b)(6)-2				
4/18	Tobramycin 425 mg IVPB Q24°	2400	(b)(6)-2						
4/18	Tylenol		X	X	X	X	X	X	X
4/18	Rocephin 2 Gms Q8°	0600	X	(b)(6)-2					
		1400	X						
		2200	(b)(6)-2						
4/18	Nystatin Powder to rash BID (Creme)	0900	X						
		2100	(b)(6)-2			(b)(6)-2			
4/18	NAFCILLIN 2 gm IV. PB Q4°	0400	X						
		0800	X						
		1200	X						
		1600	X						
		2000	X						
		2400	(b)(6)-2						
4/20	albuterol / Atrovent neb CPT	0600			(b)(6)-2				
		1200							
		1800		Pt aware of	D/C				
		000							

INITIAL CODE

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

ADDRESSOGRAPH PLATE (b)(6)-4

(b)(6)-4

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

WARD NO. ICU #2

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

MEDCOM - 5400

allergies unknown

MEDICATION ADMINISTRATION RECORD 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

PRN AND VARIABLE DOSE MEDICATIONS

ORDER DATE	MEDICATION-DOSAGE FREQUENCY ROUTE OF ADMINISTRATION		DOSES GIVEN															
4/18	MSO4 2-6mg	DATE	4/19	4/20	4/21													
	IV Q1° prn	TIME	1340	1840	0450													
	pain	DOSE	2mg	2mg	6mg													
		INIT.	(b)(6)-2															
4/18	Tylenol 650mg	DATE																
	supp pr Q6h	TIME																
	prn Temp >101	DOSE																
		INIT.																
		DATE																
		TIME																
		DOSE																
		INIT.																
		DATE																
		TIME																
		DOSE																
		INIT.																
		DATE																
		TIME																
		DOSE																
		INIT.																
		DATE																
		TIME																
		DOSE																
		INIT.																
		DATE																
		TIME																
		DOSE																
		INIT.																

MEDCOM - 5401

PATIENT PROFILE

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

✓	ACTIVITY	DATE
	Bedrest	
	Bathroom Privileges	
	Up in chair	
	Ambulate	
	Commode	
	Needs assistance	
	Restricted to unit	
	Hospital Privileges	
	Other	
✓	Encourage OOB-chair	4/21

✓	BATH	DATE
	Bed bath	
	Shower	
	Tub	
	Needs assistance	

ORAL HYGIENE	DATE
Self	
Needs assistance	
Special	

DIET	DATE
NPO	
dl up may need help	4/21

FEEDING	DATE
Self	
Needs assistance	
Gavage	4/21

✓	VITAL SIGNS	FREQ
	Temp	
	Pulse	/ 95
	Resp	
	B/P	
	Other	
	Neurochecks	

FLUIDS	
Forced to:	
Restricted to:	
	&O

✓	SPECIAL NOTES
	Dentures
	Speech impediment
	Language barrier
	Prosthetic device
	Visual impairment
	Blind
	Contact lenses
	Glasses
	Hearing defect
	Other

DATE ORD.	DATE RENEW	TREATMENTS/SPECIAL NOTES	TIMES
4/21		Encourage OOB to chair PRN	
4/25		Foley d/c per MD order	
4/21		PT for ambulation	
4/22		Δ dsg to ® arm	
		Apply dry gauze over small skin defect. ø Iodoform ø packing to defect	
4/25		TEDs	
4/25		O2 via NC or FM to keep Sats ≥ 93%	

DATE ORD.	DATE RENEW	TREATMENTS/SPECIAL NOTES	TIMES
4/25		NS at 100 cc/hr x 24	0
		Medicine	
4/21		DIZ (b)(6)-2	

ADDRESSOGRAPH

(b)(6)-4

(b)(6)-4

DIAGNOSIS

4/21 Possible chest Contusion to chest GSW to ® LA & ® knee

AGE	HEIGHT	WEIGHT

PATIENT CLASSIFICATION

OP/SPECIAL PROCEDURES

FINDINGS:

	DATE ON	DATE OFF
SI		
VSI		
RELIGIOUS RITES		

[redacted]

RACK 1

MEDCOM - 5402

ALLERGIES:

DATE ORD.	DATE RENEW	MEDICATIONS	TIME (HOURS TO BE GIVEN)	DATE OF ORDER	LABORATORY/DIAGNOSTIC TESTS EXAMINATIONS/ CONSULTATIONS	DATE SENT	DATE COMP
4/21		Nafallin 2gram IVPB q6°	04-12-18-24				
4/21		Fluconazole 200mg po BID	09 21				
4/21		Lovenox 30mg po BID	09 21				
4/21		Lidex ointment to rash on back BID	09 21				
4/21		feso4 1 tab PO QD					
4/21		MVI 1 tab PO QD					
4/21		folic Acid 1 tab PO QD					
4/25		~~Imipenem~~ 500mg IV PB q8°	08-16-24				
4/25							
					Daily Labs		
					CBC, Chem 7, d/t, anti		

ADDRESSOGRAPH

MEDCOM - 5403

PATIENT PROFILE

NAVMED 6550112 (5-80) S/N 0105-LF-206-5560

√	ACTIVITY	DATE	√	BATH	DATE	DIET	DATE	√	VITAL SIGNS	FREQ	√	SPECIAL NOTES
✓	Bedrest	4/26		Bed bath		NPO			Temp	q		Dentures
	Bathroom Privileges			Shower		Regular Diet	4/28		Pulse	q	Q4°	Speech impediment
	Up in chair			Tub					Resp	q		Language barrier
	Ambulate			Needs assistance					B/P	q		Prosthetic device
	Commode			Foley Care					Other			Visual impairment
	Needs assistance								SAO2			Blind
	Restricted to unit								Neuro	Q4°		Contact lenses
	Hospital Privileges			**ORAL HYGIENE**	**DATE**							Glasses
	Other			Self		**FEEDING**	**DATE**		**FLUIDS**			Hearing defect
	OOB → chair	4/28		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
4/26		Isolation: Contact		4/27		IV: D/C HF → HL	
		Weight QD		4/28		SSRI; call Dr. (b)(6)-2	
4/26		TED's / SCD's				(pager #972) q6° c	
4/26		Foley to gravity				glucose results	
4/26		~~NG to LIS~~					
		~~Chest Tube to 20cm~~					
4/26		HOB ↑ ~~30°~~ 60°				O2:	
		C collar / Log Roll				Vent:	
4/26		Consult - Gen Surgery		4/26		Titrate SAO2 93-97% using NC/FM prn	
4/28		D/C NG/TF		4/26		Spirometry x 10/hr	
4/26		Call MD:					
		Temp > 101.5 or < 98				Protocols:	
		Hourly UOP < 0.5cc/kg				Electrolyte	
		MAP < 60 SBP > 200 DBP > 110				Other:	

ADDRESSOGRAPH	DIAGNOSIS	AGE	HEIGHT	WEIGHT
(b)(6)-4		PATIENT CLASSIFICATION		
(b)(3)-1	OP/SPECIAL PROCEDURES		DATE ON	DATE OFF
PERSONAL DATA PRIV ACT 1974		SI		
	FINDINGS:	VSI		
		RELIGIOUS RITES		

MEDCOM - 5404

ALLERGIES:

---

i-STAT EG7+

Pt [b)(6)-4]

Pt Name: [b)(6)-4]

Na_____150 mmol/L
_____3.9 mmol/L
TCO2_____21 mmol/L
iCa_____1.18 mmol/L
Hct_____28 %PCV
Hb*_____10 g/dL
*via Hct

At 37C
PH_____7.445
PCO2_____29.4 mmHg
PO2_____32 mmHg
HCO3_____20 mmol/L
BE,B_____-3 mmol/L
sO2*_____66 %
+calculated

At Patient Temp
PH_____7.412
PCO2_____32.3 mmHg
PO2_____38 mmHg

Patient Temp: 102.5F
FIO2_____: 30
Sample Type_: VEN

26APR03 16:56

Oper: [b)(6)-2]

Physician:_____

Ser# [b)(6)-4]
Ver: [b)(6)-2]

---

i-STAT G3+

Pt: [b)(6)-4]

Pt Name [b)(6)-4]

TCO2_____20 mmol/L

pH 37C
PH_____7.416
PCO2_____29.5 mmHg
PO2_____37 mmHg
HCO3_____19 mmol/L
BE,B_____-5 mmol/L
sO2*_____73 %
+calculated

Sample Type_: VEN

27APR03 06:04

Oper: [b)(6)-2]

Physician:_____

Ser# [b)(6)-4]
Ver: [b)(6)-2]

ICATIONS	TIME (HOURS TO BE GIVEN)	DATE OF ORDER	LABORATORY/DIAGNOSTIC TESTS EXAMINATIONS/ CONSULTATIONS	DATE SENT	DATE COMP
			Adm: CBC, Chem 7		
			Chem 20, ABG	Amylase	
			PT/PTT, T+C or	Lipase	
			T+H x 2 units		
		4/26	PCXR ☒		
		4/26	Pan culture	☒	
		4/26	CT - abd/pelvis	☒	
		4/26	Transfuse 2u PRBC	☒	☒
		4/26	Venous ABG & Blood	☒	
		4/27	dilantin level	☒	
		4/27	PT consult ☐	DI [b)(6)-2] to eval by PT	
		4/27			
		4/26	QAM: CBC, Chem 7		
			ABG, LFT's,		
			Amylase/Lipase		
			PT/PTT, Mg/Ca/PO4		
		4/27	Dilantin level		
		4/26	PCXR (outside		
			A [b)(6)-2]		
		4/	KR QAM		

PERSONAL DATA

MEDCOM - 5405 1

MEDICAL RECORD — PROGRESS NOTES

DATE

18APR03 Critical care (continued)

CXR - bilat alveolar infiltrates; metal in soft tissue in (L) m

(R) >> (L)

ETT and NG good position

CT head, C-spine (−)

(R) knee - metal, no fx

abd - NSBGP

A/P (1) post op resp failure - CXR c/w pneumonia as most likely etiology; blast injury less likely - temp curve has been ↓ - abx per orders; culture - low threshold to [illegible]

(2) Candida - fluconazole (no iv available) per NG - added gpc cellulitis coverage.

(3) line A-line

(4) wound care

(5) formal psych eval. hold propofol and reeval once settled in

([illegible]) hold drugs other than propofol c̄ CNS effects if possible.

(6) vent - wean support as tolerated

(Continue on reverse side)

REGIS (b)(6)-2 [redacted]

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

(b)(6)-4 [redacted]

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FPMR (41 CFR) 101-11.806-8
509-110

MEDCOM - 5406

PROGRESS NOTES

DATE	
	MD PN // Gen Surg.
4/19/03.	HD #2
1010	S: Stable overnight ↓ HR ↓ Temp.
	Extubated this AM: on O2 NC. propofol off
	now abx
	O: Tm: 101.4° (Admit) TN: 98 HR: 120-130's
	Gen: Awake & Alert / follows commands per RN
	c translator
	Wounds: (R) knee: ø fluctuance ø discharge
	(R) Arm: wash burns c intact ø erythem
	small defect: 1.5 cm x 1 cm
	repacked c iodoform // ø erythema
	A/P: Multiple problems but improved dramatically
	p admit. s/p Probable concussion; (R) knee GSW.
	(1) Extubated per ICU Team. On Abx c
	infection source is w/u - probable
	pneumonia. Primary management per ICU Team
	(2) Re: Soft tissue injury to (R) knee
	ø sx of infection. ø fx on films.
	follow / monitor.
	(3) Continue DSG Δ TID (R) Arm: ø sx
	of infection.
	(4) Will follow c you // 1ry management
	per ICU Team. ø surgical issues.
	Medical issues are main issue now.

(b)(6)-2

☆ U.S. GOVERNMENT PRINTING OFFICE: 1985-461-275/20017

MEDICAL RECORD	PROGRESS NOTES
DATE 4-18-03	Critical Care
	- 40ish y.o. ♂ Iraqi EPW transferred
	here from (b)(3)-1 after sustaining shrapnel wounds ? GSW (L) knee
	to (R) forearm and back/buttocks c̄ ? blast injury
	- debrided @ FST where tachycardic, febrile
	to 102° - covered c̄ Abx and transferred to
	(b)(3)-1 when he was able to wean off vent
	- low grade temps on series of Abx including
	Rocephin, gent, clinda, levofloxacin, Ancef
	Attempt @ weaning → tachypnea - never
	coherent (+) agitation - unable to do CT - transferred
	here.
	unknown PMH/allergies
	PE: WD/WN M c̄ ETT @ 23 cm @ lips
	NG and DHT in nares
	missing teeth and ext [illegible]
	BP- 110/75 R-18 GCS- 9T
	P- 126 sinus Sat-99 (30%, PEEP-5
	HEENT- as above TV-750 R-12 A/C)
	no lacerations, trauma, s/p [illegible] noted
	PERRL, ~ 4mm
	resists light in eye
	Coughs c̄ suctioning

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO. | WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR, FPMR (41 CFR) 101-11.806-8
509-110

MEDCOM - 5408

PROGRESS NOTES

DATE	
18APR03	Critical Care (continued)
	neck - supple ⊖ JVD, midline
	tracheal deviation or thyromegaly
	lungs - coarse rhonchi - clear somewhat
	c̄ aggressive suctioning - copious amounts
	of brown secretions and ? old
	clots
	card - RRR tachycardia
	abd - soft ⊖ HSM ⊕ BS, sl. ↓
	~~back - extension cordial rash c̄ satellite~~
	~~lesion extending from groin to back~~
	~~3-4 small excoriation over back~~
	ext - as above, large laceration (post op)
	c̄ sutures Ⓡ knee - small effusion (?)
	no erythema
	neuro - un purposeful but opens eyes
	and moves Ⓛ side to noxious stimuli
	some movement Ⓡ upper
	labs: 133 / 96 ⌐ 115
	4.2 / 29 ⌙ 12 / 0.9 LDH - 1861
	PO_4 - 5.3 CK - 827 AST/ALT - 72/57
	Mg - 2.2 GGT - 78
	PT/PTT - 15.7 / 22.7 11.3 > 10.9 / 32.1 plt - 352
	INR - 1.3

☆ U.S. GOVERNMENT PRINTING OFFICE: 1985-461-275/20017

MEDICAL RECORD	PROGRESS NOTES
DATE	
4.18.03	CT reviewed ~ no pathology revealed, no fract, heme, shift, masses. Currently no neurosurg issues. Rec normocarbia, ✓ for metabolic/toxic etiology. Trx & Disp w/ [redacted] (b)(6)-2 (b)(6)-2 MD-LCDR MC USNR

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO.

WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FIRMR 141 CFR) 201-45.505
509-111

MEDCOM - 5410

MEDICAL RECORD	PROGRESS NOTES

DATE	
	LAB Results / CXR / PLAIN Films
4/18/03	
1825	133 | 96 | 12 < 115
	4.2 | 29 | 0.9 CK: 857
	7.6 / 2.2 | 5.3 LDH: 1861
	Uric Acid 2.6 Alkφ: 98
	AST: 72 TB: 0.7
	ALT: 57 GGT: 78
	PTT: 22.7
	PT: 15.3 INR: 1.3
	11.3 > 10.9 / 32.1 < 352
1) Cont. vent	ICU team informed of
as per ICU	FOLLOW up: CK result
management.	CXR / KUB / (R) knee film.
2) Will	
consult	
ORTHO re:	KUB: shrapnel over sacrum
any further	nondilated small / large bowel suggestive
and recovery	of ileus. Bone / soft tissue NML
of (R) knee	C-spine: NML
	CXR: (B) airspace process (R>L) pneumonia vs.
	contusion; ?CHF component c̄ ↑ pulm veins.
	small (R) pleural effusion
	(R) knee: significant soft-tissue disruption
	Anteriorly above patella c̄ associated
	metallic foreign bodies φFx seen.

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO.

WARD NO.

PROGRESS NOTES

STANDARD FORM 509 (Rev. 1

Prescribed by GSA/ICMR,

FIRMR (41 CFR) 201-45.505

509-111

(b)(6)-2

MEDCOM - 5411

MEDICAL RECORD	PROGRESS NOTES

DATE	
	MD Admit NOTE
4/18/03. 1715	40's Iraqi man admitted from the field hospital s/p (R) knee GSW ?4/9/03 c̄ unresponsive status (intubated) since arrival to prior facility. Per note → incoherent speech // s/p I+D (R) GSW. Etiology of Head injury is unclear → ? concussion.
	Pt admitted intubated; unconscious; per notes pt. had been tried on T piece, but unable to be extubated. Pt prior on TF's, though has both Dobhoff TF + NGT in place. Pt also likely infected c̄ prior temps as high as 101.8 ∅ source.
	VS: 15 48 HR: 148 174/102 12 GCS: 3
	Gen: intubated // sedated. 101.4 rectal ∅ eye opening ∅ verbal response ∅ motor resp.
	PERRL;
	Heart: RRR's m Lungs: occ. rhonchi on Ant Auscultation
	Abd: soft / hypoactive BS
(R) forearm soft tissue defect? scabs → noninfected	Ext: (R) distal THIGH proximal to knee c̄ Sewn laceration ∅ pus stitches in place. Foley draining clear urine
	Genital: Exam c/w CANDIDA intertriginal Alimentro c̄

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO. | WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FIRMR (41 CFR) 201-45.505
509-111

MEDCOM - 5412

PROGRESS NOTES

DATE	
4/18/03 1715	local dissemination to involve dermatitis in BACK → ↑ down legs: some trunkal edema. A/P: Transfer to ICU. ① Neuro: unclear etiology of unresponsiveness = ? CONCUSSION CT SCAN need Hem: (-) r/o metabolic etiologies ② CV: Hyperdynamic still: TACHY cardia likely 2° to infection; stable BP's monitor. ③ Pulm: on vent Cadmit ABG: 7.41/42/90/26/ on 50% FiO2 √ CXR // GOAL: Extubation. ④ GI: Wean on TF's - √ UNB resume TF's if tol. GI proph. ⑤ GU: Good UO. Follow LABS. ⑥ HEM: Monitor Cyts. ⑦ ID: pancultured: source unknown Empiric Abx: Rocephin / TUBNA. Significant CANDIDA intertrigo → CANDIDA dermatitis → low BACK discomfort Would start systemic DIFLUCAN IV to cover for possible candidemia.

(b)(6)-2

(b)(6)-4

U.S. GOVERNMENT PRINTING OFFICE: 1990 262-081/20162 (11-77)

MEDCOM - 5413

MEDICAL RECORD | **PROGRESS NOTES**

DATE

4/19/03 ICU

* VTNS comfort d-2
* d.1 s/p extubation ("post op pneumonia")
* (R) knee wound
* skin rash - candida +/- bacterial cellulitis
* (R) arm S/T defect
* probable concussion

(meds)
Zantac
vit K
Fluconazole po d.1
tobramycin d.1
Rocephin d.1
Nafcillin d.1
Nystatin d.1

(PEX) Afeb Tm 100.4 on arrival 4/18 @ 1800
P-120 120/80 Awake, responsive, some verbal
moves all 4, sensation intact
Neck - ok
Lungs - poor air movement laterally + bases
RRR s m
~~Abd~~ NT
EXT (R) leg swollen / knee wound
(L) = nl
Skin small pustular rash groin
red flanks (B) (cellulitis ?)

(LABS)
12.8 \ (24) ↓ / 428

134 / 100 / 11 / 0.9
4.0 / 32 / (196)

Amyl 92
Lipase (645)
PT/PTT nl
"acetone (+)" (?)

(CXR)
(B) "pulm edema" resolved - small residual (R) pl. effusion

(imp) (1) seems stable but needs cont'd aggressive pulm toilet - problems listed above
(2) Anemia - STABLE FROM 21.00 4/18 ~~...~~
(3) ↑ lipase - re √ as try to feed / take sips po.

(b)(6)-2

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO. | WARD NO. R/CDR

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FIRMR (41 CFR) 201-45.505
509-111

MEDCOM - 5414

PROGRESS NOTES

DATE	
	MD PN : Gen Surg
4/20/03.	HD # 3
1300	S: continues stable overnight. moving all ext. ? (R) Arm pain stable p extubation. NPO and yesterday on RA c SATS: 97-100% O: TM: 99.6 TN: 99.6 Afebrile since admit on 4/18/03. 2781) 5450. Wounds all stable ϕ sign/ symptom of infection. (R) knee: sutures intact ϕ erythema ϕ pus (R) arm: small defect: intact. ϕ erythema A/P: HD # 3: Management in ICU (1) Pneumonia: continue abx. (2) Continue dvt Δ's BID. (3) When transfer out of ICU → to medicine c G.Surg. Consult (4) sutures (R) knee due out in another 7-10 days.

(b)(6)-2

MEDICAL RECORD	PROGRESS NOTES

DATE	
4/20/03	CCM * HD #3
	* bs: 4/19 (ext)
	Tm 100.8 I 2781 O 5450
Zantac 50 q8	HR 90-115 UO 60-90/h
vit K 10 q	Tc 99.6 HR-120 131/78 SpO2 98 on RA
QAM	
Fluconazole 400 po BID	(Labs) (14) 27/588 137/4.1 | 104/27 | 10/0.8 | 128 P-3.3 M-2.3
tobra 425 Q24°	(PEX) A+A but poorly follows
Rocephin 2g Q8°	commands - seems dazed.
Nystatin	Response to painful stim → dazed look c̄ much
Nafcillin 2g Q4	withdrawal - PRRL / conjug
ATS/AHV w/CPT	Lungs clear
MSO4 - prn	Abd soft N/T EXT: (B) heel decubs L>R • Knee WOUND OK
	skin erythematous cellulitis ~~[illegible]~~
	appearance 2/3 of back but sl improved
	on flank. Groin = seems better
	(I/P): # ↑ WBC but afebrile. Abx probably sufficient
	for cellulitis which does not seem worse
	# knee + arm S/T wounds OK per surgery -
	leave sutures another wk
	# concussion likely accounts for his neuro state
	# resp.: ∅ issues (CXR = nl)
	(Pl) • ~~Keep in ICU: for wound care / observation~~
	another 1-2 d Keep on side
	• DVT prophylax

(Continue on reverse side)

(b)(6)-2 [redacted]

MD/CDR

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

REGISTER NO.

(b)(6)-4 [redacted]

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FPMR (41 CFR) 101-11.806-8
509-110

MEDCOM - 5416

ACLU-RDI 1267 p.17

DOD 12628

PROGRESS NOTES

DATE

4/21/03

0905

ICU * HD # 3
* (R) knee + (R) arm soft tissue wounds
* skin rash flanks + back
* s/p probable concussion

fluconazole
tobramycin
rocephin
mystatin
nafcillin
Zantac
Lovenox prophyl.
~~tobramycin~~
mystatin

VSS/Afeb SpO2 96 on RA HR 114

PEX peculiar / stunned / dazed effect to me — however, was responding to translator + trying to move in bed using (3) arms earlier
Lungs ~ clear
Abd N/T
(R) knee wound (R) arm dressed
flank erythema ~ improved
groin rash improved.

labs + cultures 13.4 / 27 / 909 138 / 105 / 139 4.4 / 26 / 18/0.9

4/18 U/A 20-50 WBC bact + bacteria
4/18 Blood Cx → NO growth so far
4/18 LDH, CK + lipase all ↑ ; amylase ~ (not repeated)
TB 0.7 (wl)

Impression #(1) concussion / odd affect — clearly interacts differently to me, won't hold up arms, looks blankly but then responds to translator + moves on his own.
#(2) No distress / No resp issues — mild contusion or lung injury resolved
#(3) skin rash — ? fungal ? bacterial — would cont. nafcillin + fluconazole & d/c rocephin / tobramycin another day or two. All Rx was empiric based on diffuse erythematous / pustular rash suggestive of candida.
#(4) soft tissue injury — knee/arm — cont. f/u by surgeon.

(b)(6)-2

NMD/CDR

MEDICAL RECORD	PROGRESS NOTES
DATE	MD PN // Gen. Surgery
4/21/03. 1100	Ø iss wounds OK Ø erythema continue dry D's on (R) arm Primary Flu 6 ICU Team / once transfer to medicine for 1° care // sutures out in 1 WK. Ø surgical issues (b)(6)-2
4/22/03. 0930	MD PN // Gen Surg. Recovering well. Transferred to 4 FORWARD STARBOARD. Pt to work c patient Candida dermatitis rash improving. Transferred to Medicine: Dr. (b)(6)-2 d/w Dr Potts → Ø surgical issues – Will sign off – (R) Arm Ø functional packing needed: cover c dry gauze: minimal defect c Ø tracking. – (R) Knee: well healed remove sutures next week. – If questions, contact Dr. (b)(6)-2 (I will be returning to US) (b)(6)-2

(Continue on reverse side)

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

REGISTER NO | WARD NO

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR, FPMR (41 CFR) 101-11.806-8
509-110

PROGRESS NOTES

DATE	
22APR03	P.T. NOTE
0949	S: Pt seen by P.T. this AM. Upon arrival pt not talkative but stared at staff.
	O: Transfered pt from supine to EOB ~~PT~~ c mod-max assist x1, EOB to stand pivot to w/c c max assist x 2. PROM performed on all major joints of (B) UE & LE.
	A: Pt does give any participation, does not apply any weight on LE during transfers. Grimaced during (B) knee ROM.
	P: 1. will see pt QD.
	2. Perform ROM, Transfer exercises
	3. Progress to crutch training as mental status improves.
	(b)(6)-2
	~~Hot~~ (b)(6)-2
22APR03 1855	Medical Nutrition Tx:
	O: Per RN: ate dinner then vomited. Diet Rx: Regular
	Per RN- has tolerated ENSURE 5 vomiting.
	Dx: GSW to (R) knee. Wt = 70kg.
	Labs 21 APR03: Hgb/Hct 9.4↓/27.3↓
	A/P: Kcal needs: 30-35 kcal/kg/day = 2100-2450 kcal
	Protein needs: 1.5-2.0 g/kg/day = 105-140 g/day
	~~Recent~~ Hgb/Hct ↓- recommend offer Fe source c fruit juice to ↑ absorption. Recommend full liquid diet + ENSURE TID to ↑ PO intake c vomiting. RD to f/u q 2-3 days.
	(b)(6)-2 RD/LDA, RD (b)(6)-2 MPH, RD
	LT, MSC, USNR (b)(6)-2

STANDARD FORM 509 BACK (Rev. 11-77)

☆ U.S.G.P.O: 1984-0-421-526/124

MEDCOM - 5419

PROGRESS NOTES

DATE	
April 21 05	- Pt admitted to ICU intubated & vent
1335 hrs	c̄ possible chest contusion & pleural
	effusion - [illegible] next day normal &
	- extubated - off vent for 6 hrs -
	- GSW to R forearm [illegible]
	- GSW R knee [illegible] — clean
	- Central line in situ for IV [illegible]
	24 [illegible] — x 48 → [illegible]
	Possible head injury & cat scan -
	Does not respond appropriately always.
	- [illegible]
	may be [illegible] - ? - ? Drugs ? [illegible]
	- [illegible]
	on fluconazole 200mg [illegible] x 6 hrs
	- Cultures pending - [illegible]
	check [illegible] -
	- P - 1. Continue [illegible] 24 [illegible]
	2. Continue fluconazole 200mg [illegible]
	3. Encourage [illegible]
	4. [illegible]
	5. [illegible] to [illegible] -
	6 [illegible]
	(b)(6)-2
	(b)(6)-2

U.S. GOVERNMENT PRINTING OFFICE: 1985-461-275/2

STANDARD FORM 509 BACK (Rev. 11-77)

(b)(6)-4

MEDCOM - 5420

MEDICAL RECORD	PROGRESS NOTES
DATE	
April 22 03	Note Br a little short - NB trend
0905hr	- DJ having Q shift RPR -
	Continue tonic

(b)(6)-2

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FPMR (41 CFR) 101-11.806-8
509-110

MEDICAL RECORD	PROGRESS NOTES

DATE

23 APR 03 P.T. NOTE

Pt transferred from supine to EOB c max assist x1, EOB to w/c c max assist x2. PROM performed on (R) UE and LE. Pt just stares and does not talk nor moves. Cont. c transfer and ROM exercises. Staff encouraged to get pt OOB.

(b)(6)-2

PT TECHNICIAN

(b)(6)-2

23 Apr 03 Neurology

40's appearing Iraqi ♂ who came to us 4/18 c 1 wk Hx chest pain multiple trauma c flail injury & was probably intubated x at least 7 days at 2 prior hospital. He was never coherent, was febrile off & on since 18 April through multiple antibiotics - he always had trouble moving R arm. Head CT some ↓ sulcal markings (-) focal & lateral C spine ok (C3-T1 not seen) On 20 he was extubated successfully still isn't speaking to staff & would / can't walk -

Pt's Iraqi friends say he was

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO.

WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FIRMR (41 CFR) 201-45.505
509-111

MEDCOM - 5422

PROGRESS NOTES

DATE	
	~~(Say he's scared he told them he won't talk to us~~ from
	talking to them – nurses say he'll fear;
	squeeze their hands ok at times –
	~~##~~ T 101 now Neck supple
	MSE Hypervigilant not ~~or~~ stuporous –
	Follows some Arabic commands – won't speak uncooperative
	PERRL FOM1 = R ↓ VII (5l. pull?)
	corneal – ok Fog, tongue ok
	Motor ~~#~~ – ~~[illegible]~~ move all
	4, he has ~~[illegible]~~ 4/5 weak all 4 –
	R proximal arm 3/5 – Tone is ↓ R arm
	ok otherwise DTRs are +2 except
	+1 R arm Tres ↓↓ – Feels pain all 4 –
	(A) Poor exam ā uncooperative but
	this looks to me like diffuse axonal
	injury – could have some his deficits are stable from ICU ICU Neuropathy
	but ~~[illegible]~~ hasn't been tubed that long –
Fever –	Will repeat head CT & V (b)(6)-2
would	CT ~~of~~ cervical spine. If this is
w/u	ok needs PT nutrition & out of bed.
routinely	I don't see CNS infection at this point –
(including	If doesn't move along & fever persist may need LP –
central	The R arm could be brachial plexus but
line)	DAI more likely now – will have to settle out – (b)(6)-2

PROGRESS NOTES

DATE	
4-24-03	S. arrived on ward to assess pt, lying flat
0845	in bed, roommate attempting to feed pt egg.
	Pt diaphoretic, fever 103.8, pulse 140, RR
	52. - pulse ox 88 -
	Pt. put in chair upright and suctioned
	orally c̄ lg amts. Creamy sputum obtained
	Lungs - ↓ BS bases c̄ [illegible] / rhonchi
	+ lungs wet upper lung fields - pulse ox
	p̄ suction 97. O2 on 10L/NC, c̄ pulse
	ox's at 95-96%.
	Pt taken to xray for stat AP/LAT Chest.
0910	When lifted from chair to stool, pulse
	dizzy to feet, resp [illegible] visible, eyes
	rolled back c̄ loss of [illegible]. There was
	tremoring of arms & legs s̄ [illegible] tonic/clonic
	movements. Color became dusky/
	Pt layed onto floor & code blue called.
	(b)(6)-2 [redacted] FNRC

☆ U.S. GOVERNMENT PRINTING OFFICE : 1985 O - 461-275 (20166) STANDARD FORM 509 BACK (Rev. 11-77)

MEDCOM - 5424

MEDICAL RECORD	PROGRESS NOTES
DATE	

1115 120/84 → 84 ↓ normal

3

MI @ 2yrs ago age 39

120/80

↑ C P when feeling depressed

Feeling very depressed due to loss 2 3 sons. They were killed in front of him.

1125 not dizzy now

① HTN

② ↑ Lipids

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

PROGRESS NOTES

STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FIRMR 141 CFR) 201-45.505
509-111

MEDCOM - 5425

MEDICAL RECORD	PROGRESS NOTES
DATE	
4/24/03	Critical Care:
1350	- See prior notes for history
	transferred to ward 4/21 - no notes other
	than Surg - went to radiology this
	Am → found down c̄ loc, ~~...~~ /urine
	incontinence - woke up over ~20 min - bagged
	briefly and given amp D50 (BS before
	subsequently returned high) Probable
	blast injury c̄ ? CHI - CT head/neck
	negative on admission but no history
	of coherent behavior @ FH3 or here
	febrile on ward to 103° this Am
	Currently
	BP - 110/60 100.8 meds
	P - 126 R - 20 Nafcillin 2 q6°
	Sinus Sats 100% (3L) Fluconazole 200 bid
	PERRL, tracks objects / people lovenox 30 bid
	walking by lidex to back
	opens mouth ⊕ gag / cough FeSO4 tid
	but not strong MVI / folate
	neck - supple Ⓛ IJ in place
	(put in on admission) - site ok.
	Lungs - CTA
	Card - tachy, regular ⊖m

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO.

WARD NO. ICU

PROGRESS NOTES

STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FIRMR (41 CFR) 201-45.505

111

MEDCOM - 5426

PROGRESS NOTES

DATE

Critical care (continued)

abd - soft @ BS — CXR - during exp ↓ lung vol ow clear

back - rash less appears to be healing

ext - diffuse hyperreflexia — +4 both lower ext, stitches @ knee

neuro - CAO x 4 — will move both upper ext

Labs @ sputum - A-baumanii (sens - imipenem)

	1630 4/18	2151 4/18 (4/18)	4/19	4/20	4/21	0350 4/24	4/24
WBC	11.3	14.9	12.8	14	13.4	21.1	20.5
Hgb	10.9	9.0	8.6	9.2	9.4	11.3	10.4
Hct	32.1	25.4	24.0	27.1	27.3	32.6	30.2
plt	352	400	428	588	909	942	790

	4/18	4/19	4/20	4/21	4/24	4/24
Na	133	134	137	138	144	144
K+	4.2	4.0	4.1	4.4	4.2	5.9
Cl-	96	100	104	105	109	110
CO_2	29	32	27	26	23	15
Bun	12	11	10	18	43	51
creat	0.9	0.9	0.8	0.9	1.8	2.7
gluc.	115	196	128	139	199	290 (code)

☆ U.S. GOVERNMENT PRINTING OFFICE : 1985 O - 461-275 (20166)

MEDICAL RECORD	PROGRESS NOTES

DATE	
4/24/03	Critical Care (Contd)
1430	Labs (new)
	~~Af~~ (+)
	CK - 1538 143 / 110 / 56/23
	10.4 / 20.5 / 30.2 Mg - 3.3 4.4 / 22 \ 339
	790K. UA - 10 Pay - 7.7
	UA : 1.020 / 5.0 / 30 protein) alb - 3.1
	mod bili mod Hgb AST - 104 / ALT - 81
	5-10 WBC 1-3 RBC GGT - 139 ↑
	A - (1) prob Seizure in Radiology - etiology
	(Seizure disorder / CH / 2° to hypotension)
	not clear - hyperreflexic - new
	since admission (perhaps masked
	by propofol / sedation for vent)
	- CT head
	- EEG
	(2) Renal - Suspect pre renal etiology
	- hydrate
	- follow lytes creat
	(3) fever - d/c line (TLC - culture tip)
	d/c nafcillin ? LP - VCT
	imipenem (cover acinetobacter)
	Flumazenil

(Continued on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; ... al facility)

[redacted] (b)(6)-4

Culture blood urine

CXR clear

REGISTER NO. WARD NO. ICU

PROGRESS NOTES

STANDARD FORM 509 (Rev. 11-77)

Prescribed by GSA/ICMR,
FIR' 1) 201-45.505
-111

MEDCOM - 5428

PROGRESS NOTES

DATE

4/24/03 A/P (Continued)

1430 (4) Rash - Chronic fluconazole / Idep

(5) metabolic acidosis - resolving rapidly expect 2° to seizure

(6) ✓ wounds [redacted]

Capt/MC

Neurology

24 Apr 03 EEG = mild gen slow ~~5~~ focal findings or epileptiform activity — would go ahead & load ~~E~~ Dilantin to be careful — he is going off to pulm unknown — I think myoclonus is metabolic in origin & will improve — [redacted] CPT MC [redacted]

24Apr03 Critical Care:

- LP performed - opening pressure - 12 cm clear colorless fluid, ~5cc removed and sent in 3 tubes

tube 1 & 4 Cell Cnt, differential

tube 3 - gram stain culture

tube 2 - protein, glucose [redacted]

MEDICAL RECORD	PROGRESS NOTES

DATE	
25 Apr 03	ICU 02 POD ACI
1000	♂ blast CHI, (B) knee fx, ? Infection source c̄ ? Sz, s/p ACE
?	Event - hence, CA
↑ Imipen	Neuro - moves 4/4, clenches on LE, closes eyes to light
↑ Fluconazole	and resists lid opening, avoids dropped hand
Cidex	to face suggestive of malingering / factitious c̄ strength
PSRI	of clenches. Likely Sz yesterday, CSF neg/
Thiam	① Dilantin ② ✓ TSH, give B12, folate, thiamine
Folate	CV - MAP 70-80s HR 110-120s pulses 4/4 ⊕200
512 Img SQ	① HD stable c̄ good UO + perfusion
D5 ½NS @200	② wean [illegible] + 24° NS @100 cc/hr
	Pulm - lungs CTA secr 1/3 RA 98%
	① Resolving VAP - Pulm Toilet (OOB, nebs, CPT, ICS)
	GI - ⊕ BS ⊕ BM
152 / 170 / 37 / 212 ; 4.3 / 24 / 1.4	① Feed PO, pull NG, ~~[illegible]~~
16 / 8.7 / 7.36	FEN - lytes WNL d/c D5 + SSRI, ws to [illegible]
CSF n/i	Heme - stable
Slight [illegible]	ID - Tm 100³ WBC 16 improved
	VAP Acinetobacter - Imipenem S/S
⊕ Feed	line intn - 3° d/c
⊖ DVT, ⊖ GCT, ⊖ GI	Σ stable for floor to continue neuro evaluation

(b)(6)-2

(Continue on reverse side)

PATIENTS IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)*	REGISTER NO.	WARD NO.

)(6)-4

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-71)
Presc" , CSAICMR.
FIR! 201-45.505
-111

MEDCOM - 5430

MEDICAL RECORD	PROGRESS NOTES
DATE	

25 Apr 03 Neurology

Pt is now back in ICU for septic episode with a convulsive syncope. CT ECF & LP are ok (LP: Prot 45 | WBC)

His exam is still ↓ DTR strength & tone 3 extremities (R arm being worst) & ↑ tone & clonus L leg - but Toes ↓ & superficial reflexes ok - not very good [(b)(6)-2] cord lesion.

He is still uncooperative & I still think he can speak but won't -

(A) Puzzling. He either has closed head injury + sepsis ? unknown source (occult abcess ?) + uncooperation OR he has a central cord injury - C on-T spine

A rational approach would be to X Ray T + L spine (& get swimmers view to see C7 - T1) & if neg, Fix metabolic & infection issues & mobilize with help from other Iraqis (he has

(Continue on reverse side)

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

REGISTER NO. | WARD NO.

[b)(6)-4]

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR.
FIRP ') 201-45.505
-111

MEDCOM - 5431

PROGRESS NOTES

DATE	
	friends on ward)
	Would cover c̄ Dilantin
	despite ~~[illegible]~~ Non-epileptic EEG
	(b)(6)-2
	[illegible] spoke
	(b)(6)-2
26APR03	P.T. NOTE
	Pnt transferred from supine to EOB c̄ mod assist x2,
	EOB to stand pivoting to bedside chair c̄ mod
	assist x2. PROM performed on all joints of (B) UE and
	LE. Pnt (b)(6)-2 ~~sit~~ still doesn't talk nor move ind. Cont
	P.T. QD. —— (b)(6)-2
	HM - USN
	PT TECHNICIAN
	(b)(6)-2

MEDICAL RECORD	PROGRESS NOTES
4/26/03 DATE	ID consult
1215	40 y/o ♂ GSW (R) knee + head blast/closed injury ♂ residual neuro deficits. [redacted] coded + went to unit ♂ SZ + likely sepsis - blood (x) thus far. Pt stabilized + sent back to the ward. Febrile yesterday to 102°F ♀ ↑WBC. Asked to consult re: fevers, ↑WBC. Pt also ♂ hx "candida" rash + acinetobacter VAP.
O:	PMHx as above
	All: NKDA.
	HEENT: Ø thrush. Ø nodes
	Heart: RRR ♂ (m)
	Lungs: Harsh BS b/l bases. ↓BS + fine crackles bases.
	Abd: (+) NABS.
	Skin: Scaling resolving rash back + groin. Central line site (L) neck - mild TP mild erythema
	Ext: mild, stage I on heels
	Wounds (R) arm + (R) knee look ok.
	Meds
	Flucon 200qd 4/18-?
	Tobra 4/18-22
	CTX 4/18-22
	Nafcillin 4/18-24
	Nystatin 4/18
	Imp 4/24 —
	Iidex
	Inveral
	Zantac
	Dilantin
	nebs

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO.

WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FMR (41 CFR) 101-11.806-8
509-110

MEDCOM - 5433

PROGRESS NOTES

DATE

Labs

4/18 Acinetobacter baumanii Sputum - imp(S) only

4/24 urine NG

4/24 sputum - α-strep

E coli - amik, cefox, imp(S)

4/24 CSF - NG 1 WBC 1 RBC pro 20 P

4/24 Sputum - E coli

4/24 - Cath tip GNR x2, staph species.

Impressions:

40 y/o ♀ Closed head injury + GSW to (R) knee and arm. Subsequently ♀ Acinetobacter pneumonia. Now ♀ E coli pneumonia, line infection ♀ GNR + staph species. Line now out - needs 7d antibx.

Skin condition looks like resolving tinea, skin too dry, needs emollients. No evidence CNS infection

Rec: Imipenem for 8-12 more days.

Add vancomycin 1 gm q 8 hrs. for staph. for 5 days.

D/C Fluconazole - A to clotrimazole cream 1% tid

D/C Nystatin S/S - mouthwash.

D/C Tidex - will worsen fungal skin conditions

will follow ♀ you.

(b)(6)-2

(b)(6)-2

(b)(6)-2

(b)(6)-2

(b)(6)-2

DEOR, MC, USN
INFECTIOUS DISEASE

MEDICAL RECORD	PROGRESS NOTES

DATE	
4/26/03 1315	Internal Med HD #9
	Middle age Iraqi admitted to ICU on 18th, xfer from [redacted]
	3 s/p blast/shrapnel injury, intubated + sedated. He was extubated on HD #1
	Abn neuro findings – blank stare, inconsistent response to commands, non-focal exam. Xfer to floor HD #4 (Apr 21) Neuro consultant (Dr [redacted] found likely diffuse axonal injury –
EEG – diffuse slowing $\bar{c}$ focal sz epilept. actv.	Seizure in radiology HD #7 (Apr 24) so back to ICU. On admit there also ↑ creat 2.7, fever, WBC 21K. (+ Acineto ⊕ from 18th) Nafcillin Δ to ciprofloxacin, fluconaz contd. Back to Floor HD #8 (Apr 25) with Dilantin load. Continues to show altered mental status, clonus.
LP – nl pressure (WBC [illegible])	
micro – see [redacted] Dr note today.	Now on Floor, sitting in chair until appeared to become fatigued – when being helped back to bed desat to 70's. BP 110/.. pulse 120-140. 101^2, 130/90, pulse up to 130's $\bar{p}$ O_2 Fluid + Fluid bolus.

(Continue on reverse side)

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

REGISTER NO. | WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR, FPMR (41 CFR) 101-11.806-8
509-110

MEDCOM - 5435

PROGRESS NOTES

DATE	

Lungs sound coarse ~~ on R –
RT suctioned ~ 60 cc tan/beige
phlegm.

Lytes show Na 154 this am.

water deficit calc:

$$\left(\text{estimated current body water}\right)\left(\frac{Na}{140} - 1\right) = .5(80kg)\left(\frac{154}{140} - 1\right)$$

$$= 4\,L$$

Correction rate .5 mEq Na/°, need
14/.5 = 28° to infuse 4L free water = 140cc/°
1/2 NS boluses given for hypotension
+ tachycardia. Now will proceed
with 1/2NS 100cc/° (50cc/° free water)
+ D5W @ ~~100~~ 80 cc/°

(1920 – UOP >100/°, will ∆ to D5 ... (90cc/°)

A/P ① pneumonia clinically –
E coli 4/24. On Imip/
now Vanc. Good suction
today, will cont.

② polymicrobial cath tip cx of 4/24
incl GNR x2 + staph
Will add tobramycin 5mg/kg =
400 mg now + qD for ①+②

③ Hypernatremia as above. Free water

④ Renal – worsen ? tx IVs (b)(6)-2

(b)(6)-2

MEDICAL RECORD	PROGRESS NOTES

DATE	
26 Apr 03	Transfer Note
1700	Pt arrived in ICU c̄ Temp 102.5 +
	RA Spo2 ___ MAP 73, HR 127.
	Likely is febrile from infectious source (VAP,
	sacral/pelvic abscess, Abd abscess, ?).
	Recent negative CP + negative CT head. Manifests
	rechills + relapse type symptoms.
	Neuro — moves all 4, PERRLA, s/p SZ
	① Dilantin
	② Tx septic physiology
	CV — MAP 73 CVP 7-9 ⊕ Foley urine
	① HD stable c̄ mild mottling + Vspo2 66%
	during fever, will Tx fever + give 500cc
	bolus and re ✓ for Vspo2 > 75%
13) 8.8 / 632	Pulm - ✓ CXR sputum for Cx
15.1 / 124 / 24; 4.9 / 25 / 1.2	① Imipenem + Tobra + Pulm toilet
~~7.45 / 29~~	GI - ⊕ BS soft NT ① Zantac
7.4 / 32 / 66%	FEN - ↑Na → volume
	Heme - Tx anemia
	ID - sputum 24 Apr E coli Imipenem, Ceftriaxone
	sputum 18 Apr Acinetobacter Imipenem
	① Imipenem / Tobra
	② CT abd / pelvis + Sx look ③ Rpt Cx

(Continue on reverse side)

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

(b)(6)-4

REGISTER (b)(6)-2

Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-45.505

509-111

MEDCOM - 5437

ACLU-RDI 1267 p.38

DOD 12649

MEDICAL RECORD	PROGRESS NOTES
DATE 4-27-03	Critical care:
0950	- uneventful night since arrival - transf 1025
	on arrival CXR/CT shows new lower lobe
	pneumonia @ >> ⓛ - pros aspiration pna
	timing after Radiology event.
	meds:
110/70	CVP - 6-9. ½ NSS
110 sinus	I/O - 2350/2205 Invanz 3gm bid
R - 18-24	T - 99.8 Zantac 50mg°
Sat 96 (RA)	Vanc 1gm 12°
NG in place	Tobra 5mg/kg q24°
looks comfortable	Dilantin 100 tid
occ. q.h	albuterol/mucinex
lungs - ↓ bs, rhonchi bilat	Imipenem 500mg°
	10.0
Card - RRR	18.2 / 29.0
abd - soft active BS	4291C
Stage I breakdown over buttocks/coccyx.	147/120 124
Chest still persists	40/23 1.1/25
Skin as above - peeling in area of pressure	Amylase - 92
	7.42/29.5/37 Lipase - 423
	(renal) (Continue on reverse side)

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

(b)(6)-4

REGISTER NO.

WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FPMR (41 CFR) 101-11.806-8
509-110

(b)(3)-1

PERSONAL DATA PRIV ACT 1974

MEDCOM - 5438

PROGRESS NOTES

DATE	
4-27-03	Critical Care
	- CT reviewed
	CXR admission (R) lower lobe infiltrate
	(both on CT)
	A/P (1) Pneumonia - 2° to aspiration
	(most likely) r/o acinetobacter
	follow fevers, sputum, CXRs
	(2) Neuro - Chms/ms - etiology unclear
	needs further time to sort out
	long term prognosis
	- splint / per ortho
	(spine films ok) ⊖ Shrapnel
	in canal on CT - ✓ dilantin level.
	(3) Lytes - Na ↓ mg - ↑ D5 ½
	to 150 cc/hr / lungs will
	tolerate
	(4) Nutrition - Amylase/lipase - ok.
	Begin Osmolyte HN @
	20 - ↑ to target 75-80 cc/hr
	(b)(6)-2

MEDICAL RECORD	PROGRESS NOTES
DATE 27APR03	Medical Nutrition Tx: F/U:
1135	O: Osmolite HN @ 20cc/° - goal rate = 80cc/°.
	Labs 27APR03: 147/4.0/120/23/25/1.1/124 T amylase 92, lipase 423T.
	A/Ps: Osmolite HN @ 80cc/° = 2035kcal & 85g protein/day
	Kcal needs = 30-35 kcal/kg/day = 2100-2450kcal/day.
	Protein needs = ~~1g/kg~~ from 1.2-1.4 g/kg/day = 84-98 g/day
	Na, BUN, Glucose & lipase T. Recommend monitor labs &
	Osmolite HN @ 20 cc/° prior to T rate of Osmolite HN.
	RD to f/u in 2-3 days. (b)(6)-2 MPH, RD
	(b)(6)-2 MPH, RD
	LT, MSC, USNR (b)(6)-2
4/27/03	~~FED~~
1200	Tm 102.5, but less febrile, Sat (b)(6)-2
	Seems more comfortable than yesterday (b)(6)-2 appetite
	perking of arms & legs.
	~~HEART~~ RRR ⓜ
	Lungs: ~~ABS~~ BS bilat & BS ⓑ base ⓘ crackles
	Abd: ⓝ NABS
	Extrm: skin still dry/flaky.
↑	18.1 / 10 / 29 / <429 — 25 / 124 / 1.1
	4/24 blood NG — 4/24 CSF NG
	4/26 urine NG — 4/24 sputum E coli - amik ⑤ resx mmp
	4/26 blood NG
	4/24 Cath tip — ecoli ENT3+afl citrobacter

(b)(6)-4 (continue on reverse side)

last, first, middle | REGISTER NO. | WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FPMR (41 CFR) 101-11.806-8
509-110

(b)(3)-1 3:

PERSONAL DATA PRIV ACT 1974

MEDCOM - 5440

PROGRESS NOTES

DATE	
	ID (cont)
	CXR: RLL pneumonia
	CT: ∅ abscess abd.
	Imp: Probable asp. pneumonia + prior acinetobacter
Imp d3	pna
Tobra d1	Line sepsis – ecoli, CNS + acineto – line now out
Vanc d1	E coli is Tobra (R) amik (S) Tinea cruris/corporis
	Rec: cont vanco for line x 7 d total
	Imp x 14 d total
	D/C Tobra → amikacin 15 mg/kg/day.
	Clotrimazole bid – skin (b)(6)-2 [redacted]
	(b)(6)-2 LCDR, MC, USNR (UMO/SS) INFECTIOUS DISEASE SSN (b)(6)-2
4/28/03	Inf Dis.
0950	Pt afebrile overnight. BM x 1 today –
	no diarrhea. Still somnolent [illegible]
	twitching of ext.
O:	Tm Afeb.
	Heart: RRR ∅ (M)
	Lungs: Harsh BS (R)
Imp d4	Abd: ⊕ NABS
Amik d1	Skin: rash better – groin.
Vanc d2	WBC 12.8 / Hgb 9.7 / Hct 28.6 / Plt 405 ; Na 137 / Cl 109 / BUN 12 / K 3.5 / HCO3 33 / Cr 0.3 (cont)

MEDICAL RECORD	PROGRESS NOTES
DATE 4/28/03	Imp: Acinetobacter + E coli pneumonia E coli, Acinetobacter + Coag Neg Staph line infection Rec: Finish up 10 more d Impt Amik Vanco x 3-5 more d Keep glucose ↓ 200 to improve clearance of bacteria by PMNs (b)(6)-2 (b)(6)-2 (b)(6)-2

(Continue on reverse side)

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)* | REGISTER NO. | WARD NO.

(b)(6)-4

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FIRMR (41 CFR) 20145.505
509-111

MEDCOM - **5442**

MEDICAL RECORD	PROGRESS NOTES
DATE 28 Apr 03	ICU POD ACI
?	♂ GSW ACE + Sz + Aspirate Pneumonia
Current	Event ⊖
Zantac	Neuro - sedated / somnolent moves all 4
[illegible]	① no sedation / analgesia
Imipenem	② ? somnolence + shaky
Dilantin (on TF?)	CV - MAP 80 HR 100s pulses 4/4 (b)(6)-2 ≤ 100 (b)(6)-2
wacl res 2 to 60	① HD stable c̄ good perfusion
Amikacin	② D/C MF
Cefuroxime	Palm - RA ≥ 100% sec ? swallow Lg chest 4+
OSM 80	① Pulm Toilet (cob chi, 3° rib) + Abx
OS Y/S ≤ 150	GI - ⊕BS ⊕BM diarrhea
	① D/C TF + NG → ADAT
	FEN - qi... k, Zeal(i)
	Heme - stable
	ID - Tm 100.4 WBC 12 ↓
	UNP Ecoli → Imipenem / Amikacin
142 / 114 / 18; 3.7 / 24 / 0.9 (2.60)	
12 > 9 < 405	
Dilantin 10	(b)(6)-2

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO. | WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FIRMR (41 CFR) 201-45.505
509-111

(b)(6)-4

MEDCOM - 5443

PROGRESS NOTES

DATE	
4/29/03	IP
0900	Much better today. Tm 100.4
	Sometimes orients to others, but mostly somnolent + disoriented
O:	Afebrile
	HEENT: PERRL (N)
	Lungs: CTAB
Imp d5 d/c'd d2 vanc d3	Abd: +BS NABS
	Ext: Ø CCE
	↓ 11.3 \ 102 / 283 / 29.4 — 141 / 111 / 3.4 / 26 — 104 / 2.6 — *5
	Imp: Acinetobacter & coli; pna Acinetobacter, E coli, CNS line inf
	Rec: 9 more days Imp + Amik vanc d 3/7 for line inf. finish & moved.

(b)(6)-2

LCDR, MC, USNR (UMO/SS)
INFECTIOUS DISEASE
(b)(6)-2

MEDICAL RECORD	PROGRESS NOTES
DATE 28 Apr 03	ICU D 4 POD DOI
	GSW ACE + Aspirate pneumonia, Sz
Current	Events -
Zantac	Neuro - PERRLA, moves all 4, refused to eat
Vanco	spit out food in his mouth
Imipenem	no sedation/analgesia yet still sedated
Dilantin	shaking LE and fasciculus ... Will cath
3ncs	Dilantin and allow septic picture to clear
Amacin	CV - MAP 80 HR 80-100 pulses 4/4 even ...
Clotrimazol	HD stable c good perfusion + H2O. Currently
	relying on po for volume, but at current
	... rate c po will likely dehydrate
	R/A - CXR - clear lungs - ...
	RA → 100%
	pulm toilet (OOB chair, ...)
	GI - Reg diet Zantac ...
141 / 111 / 15 / 3.4 / 26 / 0.4 / 101	? diff → ...
11 / 10 / 38	FEN - lyte protocol
Dilantin 3	Heme - stable
	ID - Tm 100.5 WBC 11
	line intact - vanco 4/26
+ ...	VAP - ... - Imipenem 4/26, Amikacin 4/29
	May need to hydrate c Amikacin ...

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO.

(b)(6)-2

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-45.505
509-111

MEDCOM - 5445

PROGRESS NOTES

DATE	
29APR03	Medical Nutrition Tx's F/U's
1000	O: Diet Rx's Regular. ↓ PO intake today per RN.
	Observed - breakfast tray by ward kitchen - untouched.
	Labs 29APR03 141 / 3.4 / 111 / 20 / 15 / .8 / 104
	A/P's ↓ PO intake. Pt. trays kept by ward kitchen
	area when passed. If pt. refuses meal, offer
	2 cans ENSURE. Please record PO intake in nursing notes.
	Labs WNL ± K+↓ & Cl-↑ - will monitor.
	RD to f/u q 2-3 days. [redacted] MPH, RK
	(b)(6)-2 MPH, RD
	LT, MSC, USNR (b)(6)-2 (b)(6)-2

★U.S.GPO:1990-262-081/20173

STANDARD FORM 509 BACK (Rev. 11-77)

MEDCOM - **5446**

MEDICAL RECORD | **PROGRESS NOTES**

DATE	
14MAY03	Ward Medicine
0830	
Lovenox 30q12	T100 BP 110/80 P 110 RR 16 O2 sat 98%.
Zantac 50q8	
vanco 1g q12	All wound healing.
imipenem 500q6	Chest CTA
dilantin 200TID	CV RRR.
Probs	
GSW RLL	4/13 FSBG 104 110 114
pneumonia	phenytoin level 6.3 [illegible] 140 / 36.8
SZ disorder	[illegible] 32.3
acinetobacter	A/P
line infection.	1.) ID d/c 5/7 vanco ych for line infection
	d/c ? imipenem ~~for acinetobacter~~
	d/c amikacin for E. coli pna.
	2.) resp - cont albuterol
	3.) SZ - dilantin cont 200 TID - dilantin
	goal level 10-20.
	(b)(6)-2
	(b)(6)-2 (b)(6)-2

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility) | REGISTER NO. | WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FIRMR (41 CFR) 201-45.505
509-111

MEDCOM - 5447

PROGRESS NOTES

DATE	
5/1/03	Awake, conversational best he's been so far.
1030	C/O pain in his (R) leg.
O:	Afebrile VSS
	Heart: RRR
	Lungs: Hard BS (R) > (L)
	Abd: (+) NABS ø Mass
	Ext: (R) leg wound sites OK
	(R) central line - groin 6/c 9/6
	Imp: Line infection d 5/7 vanco
	pneumonia - klebsiella d 7/14 imp + amik.
	Rec: 7 more d of imp + amik
	2 more d vanco

(b)(6)-2

LCDR, MC, USNR (UMO/SS)
INFECTIOUS DISEASE
(b)(6)-2

MEDICAL RECORD	PROGRESS NOTES
DATE	
5/2/03	ID
1075	Afebrile.
	Pt does not believe he had pneumonia. Seems untrustworthy/ paranoid
O:	HEENT: RRR S (M)
	Lungs: CTAB
	Abd: NABS:
	lines OK, wound (R) leg ok
	Imp: line infection d/c, vanco for Staph.
	Pneumonia - Klebsiella very (R) day # 8/14 of imp + amik. Glycemic control good.
	Rec: cont Abx.
	(b)(6)-2 (b)(6)-2 MC, USNR (UMO/SS) INFECTIOUS DISEASE (b)(6)-2
2MAY03	Medical Nutrition Tx: F/U's
1115	S: Per trans - pt states has not from 4/30 - 5/2 ~ milk (ENSURE?) Hx/s
	O: Diet Rx: Regular: Per RN - pt eating 1/3 to 1/2 of meals + juice.
	Labs 2MAY: Hgb/Hct 10.6/31.1↓
	Glucose 5/1/03: 0600 = 96, 1200 = 98, 1600 = 101.
	A/P: Blood glucose levels WNL. Conflicting reports of PO intake. Recommend document PO intake in nursing notes for RD to assess. Hgb/Hct ↓, but slight improvement

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO. continued on back.

WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FPMR (41 CFR) 101-11.806-8
508-110

MEDCOM - 5449

PROGRESS NOTES

DATE	
2 MAY 03	Medical Nutrition Tx F/U
1115	since 24 APR03. If pt. refuses meal or eats < 1/2 of
	meal, offer ENSURE. RD to monitor PO intake via
	nursing notes + staff interview. RD to f/u q
	2-3 days. (b)(6)-2 [redacted] MPH, RD
	(b)(6)-2 [redacted] MPH, RD
	LT, MSC, USNR (b)(6)-2 [redacted]
2 MAY 03	Ward [illegible] (b)(6)-2 [redacted]
	S: ? [illegible]
	O: afebrile VS
	exam: [illegible]
	pheytoin 8.5
	K 3.5
	A/P Plan 1) cont abx at line [illegible] [illegible] [illegible]
	cont [illegible] [illegible] for
	2) SZ [illegible] - cont dilantin [illegible]
	(b)(6)-2 [redacted]

☆ U.S. GOVERNMENT PRINTING OFFICE: 1985-461-275/20017

STANDARD FORM 509 BACK (Rev. 11-77)

MEDCOM - 5450

MEDICAL RECORD | **PROGRESS NOTES**

DATE	
Ø2 May Ø3	P.T. Note
	Pnt seen this P.M. for ROM of (R) LE. Pnt c/o ↑ pain
	upon (R) Knee extension. AROM 10° – 120°. (I) c̄
	bed mobility. Will attemp to ambulate in the A.M.
	(b)(6)-2 HMC(FMF)
	P.T. Tech
6/3/03	ID
1026	Asleep - Coughs occasionally
	Afebrile -
	Heart: RRR s̄ (m) 7.4 \ 12.1 / 372 — 10 / 117 / 35.1 / 08
	Lungs: CTAB
	Abd: ⊕ NABS
	Imp: Line Infection day 7/7 vanco
	Pneumonia - aspiration d 9/14 for E coli +
	acinetobacter
	Rec: D/C vanco, D/C triple lumen (R) groin
	Continue imipenem + amikacin x 5 more days
	(b)(6)-2 (b)(6)-2
	LCDR, MC, USNR (UMO/SS) INFECTIOUS DISEASE (b)(6)-2
Ø3 May Ø3	P.T. Note - Pnt lying supine in gurney upon arrival. (I) c̄ bed
	mobility, Required Min. (A) x1 EOB to stand c̄ walker, ambulated 27ft
	c/o ↑ pain (R) LE. Pnt non-compliant c̄ sitting or lying supine positioning
	to prevent/correct (R) Knee Ext. contracture. (b)(6)-2 HMC(FMF)
	P.T. Tech

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO. | WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FIRMR 201-45.505
111

MEDCOM - 5451

PROGRESS NOTES — Respiratory NOTE

DATE	
26Apr03	RT Therapy note: Pt in low
	fowlers position on Partial rebreather mask.
(pre)	Sats 93% HR 10z Resp. 30. post → Sats 98%.
	HR 98/119 RR 32 BS → Coarse Rhonchi c̄ ↓ base RT
	To L To well CPT not given PT
	unable to tolerate. Continue nebs
	As ordered. Xray AP + Lat Shows Clear
	However PT B/S Sounds Course and wet in R Lobe.
	Continue nebs until Xray in A.M.
	(b)(6)-2 [redacted]
30APR03	RT NOTE: SVN c̄ UD Albuterol via ? given. BS (b)(6)-2 [redacted]
0905	Clear + ↓ Tlo. p̄- Ø A. Spo2 98% RA —
3MAY03	RT NOTE: SVN c̄ UD ALBUTEROL VIA MP IN SFP. (b)(6)-2 [redacted]
	BS Clear + ↓ Tlo p̄ Faint insp crackles RLL —

☆ U.S. GOVERNMENT PRINTING OFFICE : 1985 O - 461-275 (20166) STANDARD FORM 509 BACK (Rev. 11-77)

MEDCOM - 5452

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
4/18/03		1820	Admit from CasRec.
		1900	ASSUMED CARE OF PT. PT ON A/C Vent. RESTING FLAT ON BED. (b)(6)-2
		1905	20 mg. of Propofol given to Pt. I.V. push by RN. (b)(6)-2 (b)(6)-2
		2015	ASSESSMENT COMPLETED. NEURO: PT. RESPONSIVE TO PAIN STIMULI. PERLA + REACTIONS BOTH EYES. MOVES Ⓛ EXTREMITIES SPONTANEOUSLY Ⓡ EXTREMITIES EXTENDED. CARDIO: $S_1 S_2$, ST. c̄ B.P. 120's/80's + H.R. >120. Cap. refil x4 + Pulses x4. & equal. RESP PT. entubated ETT 8.5 25 cm @ Lip. Sats 100%. A/C MODE c̄ Peep of 5 FiO2 of 50%. P.S. of 10 + V.T. of 720. G.I.: +B.M. ABD. soft to TOUCH SOME BRUISING NOTED IN RLQ. N.G. TUBE IN Ⓡ NOSTRIL PLACEMENT CHECKED HOOKED UP TO SUCTION. FEEDING TUBE Ⓛ NOSTRIL ØT.F. @ THIS TIME. G.U.: FOLEY TO GRAVITY ≥100 cc/hr of clear yellow U/O. SKIN: Sutures NOTED TO Ⓡ ~~LEG~~ KNEE c̄ DRY BLOOD DRAINAGE NOTED. WARM SKIN TO TOUCH. TEMP @ 100.0°F AXILLARY. DRESSING UPPER ELBOW NOTED c̄ armboard Ø drainage. REDNESS TO Ⓛ + Ⓡ FLANK of THORSO. BRUISING ON Ⓛ FLANK c̄ swelling noted. RASH + DISCOLORATION TO back / lower back / inner thighs noted. M.O. AWARE. ~~Sw~~ SWELLING TO Ⓡ lower extremity +1. Slight swelling to hands + Ⓛ lower extremity. LINES: I.V. TO Ⓡ forearm Ⓛ arm, T.L.C on Ⓛ side of NECK Ø redness/swelling noted all lines flushable. Receiving propofol @ 30 cc/hr. (50 mcg/kl/hr.). RESPIRATION SOUNDS Equal + Clear to coarse equal chest expansion. NO ORDERS FROM M.O. given to RN @ THIS TIME.
		2040	FiO2 ↓ 30% by M.O. (b)(6)-2
		2050	Propofol ↑ to 60 mcg/k/min. (b)(6)-2
		2050	I.V. on Ⓛ arm removed. (b)(6)-2

Rate: 120's Rhythm: S.T.

P→R ≈ .12 QRS ≈ .12

P→P reg R→R reg

4/18/03

MEDCOM - 5453

NURSING NOTES
Standard Form 510
(Reverse)

CLINICAL RECORD — NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M	OBSERVATIONS (Include medication and treatment when indicated)
	2055		ARMBOARD REMOVED, SOFT RESTRAINT PLACED ON (L) upper extremity.
			Dressing on (R) forearm noted Ø drainage. (b)(6)-2
	2100		ORDERS RECEIVED BY M.O. TO RN. (b)(6)-2
	2130		A Line placed on (R) wrist by M.O. O'Neil, CLINE ZEROED. (b)(6)-2
	2320 ~~2330~~		VENT. SETTINGS Δ TO PSV BY R.T. Peep now 15, P.S. 20,
			FiO_2 30. (b)(6)-2
4/19	0035		PT REASSESSED. VENT MODE NOW ON PSV, PT. breath sounds
			clear — coarse sats @ 100%. PT NOW RESTING HEAD
			↑ 30° COMFORTABLY. MOVEMENT OF (L) EXTREMITIES
			SPONTANEOUSLY NOTED. U/O of >200cc/hr. STILL CLEAR.
			ROTATING PT IN BED Q2°. NG TUBE STILL CONNECTED TO
			SUCTION PT TOLERATING WELL. Ø RESPONSE TO PAINFUL
			STIMULI. NO OTHER Δ FROM INITIAL ASSESS. (b)(6)-2
	0300		PT AM CARE COMPLETED. NYSTATIN CREAM PLACED ON
			BACK + THIGHS FOR RASH. PT. TOLERATED WELL. (b)(6)-2
	0400		PT. REASSESSED. NO Δ FROM ~~INITIAL~~ ASSESSMENT DONE @ MIDNIGHT.
			PT. LABS OBTAINED. (b)(6)-2
	0525		DRESSING Δ TO (R) forearm, wound packed ~ IODOFORM PACKING
			STRIPS, DRY GAUZE placed on top. (b)(6)-2

Continue on reverse side

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

REGISTER NO. | WARD NO.

☆U.S. GOVERNMENT PRINTING OFFICE, 1986 O—491-248 (40045)

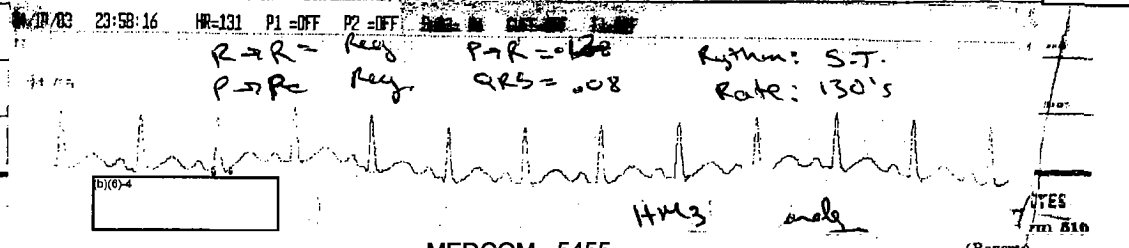
NURSING NOTES
Standard Form 510
PRESCRIBER BY GSA/ICMR
FIRMR (41 CFR) 201-45-505
510-110

(b)(6)-4

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
19APR03	—	1700	Dr. (b)(6)-2 notified of pt's rigor + rash to back. ID will be consulted (b)(6)-2 -JJ/NC
19APR03	—	1845	ID in to assess pt's rash (b)(6)-2 -RB/NC
4/19/03	—	1900	ASSUMED CARE OF PT. PT. RESTING COMFORTABLY IN BED, HOB ↑ 30°. PT. AWAKE + ORIENTED. (b)(6)-2
		1930	ASSESSMENT COMPLETE. NEURO: Perla reaction (+)/BRISK. PT AWAKE & and follows commands. MOVES All EXTREMITIES, constantly shakes LLE, M.D. aware. LIMITED MOVT TO RLE. SCD's ON @ 45 mm Hg. CARDIO. S1S2 ST. ē H.R. in 130's B.P. 140's/90's. SWELLING TO RLE ... SLIGHT ON HANDS. CAP REFILL <3 SECS X4, PULSES X4 all equal in strength. RESP: Equal/bilateral chest expansion, clear breath sounds breathing in the 30's. O2 Sats ≥95% breathing comfortably to R.A. G.I.: +B.S. ∅B.M. @ THIS TIME, ON CLEAR DIET. ABD. Soft to palpation. GU: Foley to gravity ½ of >200 c/hr. urine clear + yellow in color. Lines: T.L.C. to (L) side of neck ∅redness/swelling ē + Blood return, flushing good. Skin: Warm to touch pt. slightly sweating Temps = >100.00 & <101.0, axillary. STITCHES to (R) knee ē drainage noted. Dressings on (R) clavicle + (R) forearm intact ∅ drainage. Rash on back noted. Redness to both sides of Thorax noted, warm to touch. NO FLUIDS RUNNING @ THIS TIME. (b)(6)-2



(b)(6)-4

HM3 [illegible]

CLINICAL RECORD	NURSING NOTES (Sign all notes)	
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
4/19	0719		Assumed care of pt. of GSW @ knee. Trach on back. N: responds to pain, PERRL 3mm, GCS 6T, moves @ side extremities. CV: pulses x4, cap refill <3, S1S2 BP 130/70 HR 117 Resp: ON Vent CPAP/770/Peep15/FIO2.30/PS18 ETT 25@Lip Bilat Lung sounds CTA. RBS GT: BS x4 Hyperactive GU: FTG good output clear yellow @BM Skin: Wound to @ Knee, @ forearm @ shoulder, rest on back. Pressure blisters forming on both heels. Pillow placed to elevate off bed, but pt moves off. IV: D5 @ 125 ml/hr, propofol 60mcg/k/mn, @ IJ triple lumen A Line in @ wrist, 2 lg in @ forearm. (b)(6)-2
19 Apr	0730		SPT breathing trial done, pt tolerated well (b)(6)-2
19 Apr	0830		Pt extubated by RT, suction done, creamy chunky secretions noted, pt on humidyfier mask, O2 sat 100%. HOB elevated, will continue to monitor (b)(6)-2
19APR03	1100	—	Pt ↑ in ch. Pt does ø bear weight-lifted per staff. Tolerated well. ↑ 1° returned to bed (b)(6)-2
19APR03	—	1300	Pt on RA + tol well. Mild amt shakiness to @ LE. Pt much more alert (b)(6)-2 WJG/A
19APR03	—	1500	Pt occas agitated + shaky. 2mg IV80 given IVF's D/Cd, VSS no distress. Continue assessment (b)(6)-2 LJJG/A

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

REGISTER NO.

WARD NO.

(b)(6)-4

NURSING NOTES
Standard Form 510
*Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
510-110

MEDCOM - 5456

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
			RASH COVERING BACK + BUTTOCKS AREA.
			HN (b)(6)-2 1145 20/APR/03
		1600	PT OUT OF BED SITTING IN A WHEEL CHAIR PT TOLERATING WELL. WE ARE TRYING TO GET PATIENT TO EAT REGULAR DIET. PT WILL DRINK ENSURE + APPLE JUICE AND DOES WELL. PT WILL HOLD HIS OWN CUP IN (L) HAND ONLY. PT CLAIMS HE CANNOT FEEL (R) ARM.
			HN (b)(6)-2 1800
20/APR/03		1800	END OF SHIFT REPORT. PT IS NOW BACK IN BED RESTING AT THIS TIME. PT WAS OUT OF BED FOR 2 HOURS TOLERATED WELL. SAT IN WHEELCHAIR AND DRANK HIS COOL-AID HOLDING HIS OWN CUP. PT STARTED BECOMING AGGITATED AND STARTED SWEATING A LOT. PUT PT INTO BED AGAIN W/ HN (b)(6)-2 + PO. GLASS. NEURO: PT IS AWAKE AND ALERT HAD CONVERSATION W/ TRANSLATOR. PT KNOWS WHO HE IS AND WAS ASKING ABOUT FAMILY RESPONDS TO SIMPLE COMMANDS. CARDIO: PT IS ST W/ HR: 116. B/P: 127/90 MAP: 97. PT HAS STRONG PULSES IN ALL EXTREMITIES AND + CAPILLARY REFILL. PT IS S_1S_2. PT HAS HAD A LOW GRADE TEMP 98.3 HIGHEST TEMP 100.°. RESPIRATORY: PT IS ON ROOM AIR AND SATING AT 96% LUNGS ARE A LITTLE CORSE BUT IMPROVES WITH CHEST PT AND SUCTION. PT USUALLY COUGHS UP HIMSELF. GI: PT IS ON REGULAR DIET BUT DID NOT EAT DINNER. DRANK ENSURE AND JUICE INSTEAD. PT HAS + BOWEL SOUNDS IN ALL 4 QUADRENTS. GU: PT HAS FOLEY TO GRAVITY VOIDING CLEAR YELLOW URINE 80-100 CC/HR.

CLINICAL RECORD	NURSING NOTES

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
1/20/03		1130	ASSUMED CARE OF PT AT 1030 am. PT IS RESTING WITH HOB @ 35°. PT DOES NOT SHOW ANY SIGNS OF DISSTRESS. NEURO: PT IS AWAKE EYES OPEN. PUPILS ARE PERRLA. PT WILL FOLLOW SOME SIMPLE COMMANDS. DOES SPEAK IN HIS OWN LANGUAGE. PT DOES NOT SEEM TO BE ORIENTED AS TO PLACE OR TIME. CARDIO: PT IS ST HR: 148 B/P: 130/91 MAP: 103. PT IS S_1S_2. PT HAS A LOW GRADE TEMP OF 99.2 AT THIS TIME WILL CONTINUE TO MONITOR. PT HAS STRONG PULSES IN ALL 4 EXTREMITIES, GOOD CAPILLARY REFILL IN ALL 4 EXTREMITIES. NO EDEMA NOTED AT THIS TIME. RESPIRATORY: PT IS ON ROOM AIR SATING AT 98%. PT LUNGS ARE CORSE BUT IMPROVE WITH CHEST PT AND SUCKION IN SUCTION: THICK WHITE SS FLUID. LARGE AMOUNTS. PT OFTEN COUGHS IT UP ON HIS OWN. GI: PT IS ON A CLEAR LIQUID DIET AND SEEMS TO BE TOLERATING WELL. PT HAS + BOWEL SOUNDS IN ALL 4 QUADRENTS. HAD 1 SMALL BOWEL MOVEMENT VOIDED LIQUID ORANGE-BROWN STOOL. GU: PT HAS FOLEY TO GRAVITY VOIDING DARK YELLOW URINE 60-100 CC/HR. IV: PT HAS (L) SUBCLAVIAN TLC. NO FLUIDS AT THIS TIME. SKIN: PT HAS LARGE

Continue on reverse side

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

REGISTER NO.

WARD NO. ICU #2

U.S. GOVERNMENT PRINTING OFFICE : 1986 O—491-248 (40045)

NURSING NOTES
Standard Form 510
PRESCRIBED BY GSA/ICMR
FIRMR (41 CFR) 201-45-505
510-110

(b)(6)-4

NURSING NOTES

(Sign all notes)

DATE	HOUR AM.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
20APR03		2000	ENT: Pt. c rash across entire back, reddening blotches, rash extending to lateral (R)+(L) torso mild at this time, has sustained wound on (R) anterior thigh. Pt. SCD's removed by off going shift. Pt. resting in bed at this time VSS ——— HM3 (b)(6)-2 (b)(6)-2
20APR03		2015	VS to be taken q 2° as per RN LTJG (b)(6)-2 ——— HM3 (b)(6)-2
20APR03		2300	Pt. resting HR: 125-135 Sats 95% room air ——— HM3 (b)(6)-2
21APR03		0025	Pt. awake, laying on (R) side VSS, ST 122-135. shaking in (R) leg subsided. ——— HM3 (b)(6)-2
21APR03		0530	Pt. resting sats 98% VSS ST 133-135 beats per min ——— HM3 (b)(6)-2
21APR03		0555	Pt. turned over on back. HR down to 114-116, resting at this time ——— HM3 (b)(6)-2
21APR03		0845	Pt. awake laying in supine position VSS sats 97% ——— HM3 (b)(6)-2

★U S GPO 1880-0-281.782120262

MEDCOM - 5459

NURSING NOTES
Standard Form 510
(Reverse)

CLINICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
20/APR/03	Cont.		I.V: (L) SUBCLAVIAN TLC. ONLY USED FOR MEDS. FLUIDS: NO MAINTENCE FLUIDS SKIN: PT HAS A BAD RASH ON BACK + BUTTOCKS DR WANTS PT ON (R) OR (L) SIDE COMPLETLY AT ALL TIMES. PT HAS INCISION ON LOWR (R) LEG. SITE IS CLOSED WITH STICHES AND IS CLEAN + DRY. PT HAS A SMALL WOUND ON (R) FOREARM PACKED WITH PACKING STRIP + 4x4 ON TOP, ROLLER GAUZE TO HOLD IN PLACE.
			HN (b)(6)-2 1830 20/APR/03
20APR03	1840		Agree c above documentation by HN (b)(6)-2 Pt stable c vitals. Will con't to monitor (b)(6)-2 UJO/hr
20APR03	1930		Assume care of pt. Pt resting in semi fowlers position - HOB 45° Pt A&O x3, has generalized has bandage on (b)(6)-2 (R) forearm from wrist to elbow, pt moves arm, but does not flex fingers. Cap refill <3 secs x4 extremities (b)(6)-2 CV: Pt c ST, HR 145-148, pulses +, equal and bilateral in extremities x4. Resp: 24-32 breaths per min lung sounds coarse, equal rise & fall of chest. sats 99% on room air. GI: Bowel sounds active, abd s firmness or distention on palpation. Pt taking in food, meds PO. GU: Pt has foley cath, draining to gravity producing normal urine out put 80-100cc urine colour yellow/amber. Neuro: Pt A&O x 3 cap refills <3s pt has generalized continues twitching in (R) lower extremity

Continue on reverse side

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

(b)(6)-4

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

NURSING NOTES
Standard Form 510
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
510-110

CLINICAL RECORD | **NURSING NOTES** *(Sign all notes)*

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
21APR03	K	1630	Pt is alert, unable to determine if he understands questions. Drsg to (R) FA CDI, (R) thigh/knee sutures CDI. Ap. ueg, 2.5 coarse throughout. no dyspnea @ this time. WILL continue to monitor — (b)(6)-2 CDR
22APR03 0200			Assumed care of patient @ 0300 ERBA Vital signs stable, alert unable to determine mental status. (R) forearm dressing intact, (R) thigh/knee sutures intact. Foley to gravity draining clear amber urine. (L) triple lumen central line intact. patient demonstrating fine tremors, NO C/O pain nor discomfort @ this time — (b)(6)-2 CDR.
22APR03 0645			BP ↑ 120-140s/100-110, pulse 113-120 Temp 98.6 ERA, O2 SATS 95% CRA Dr. (b)(6)-2 notified, will observe for now — (b)(6)-2 CDR

Continue on reverse side

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

(b)(6)-4

REGISTER NO. | WARD NO.

NURSING NOTES
Standard Form 510
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
510-110

MEDCOM - 5461

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
4/21/03	0700		Assumed PT care. PT is resting in his bed, pt is alert and
			awake and is trying to speak. PT has a bandaged Ⓡ Forearm
			which he moves and flexes fingers slightly. PT has pulses
			in both upper extremities with normal heart beat clear
			lung sounds and pupils that are reactive to light and 2mm
			in diameter. Bowl sounds are active. PT moves both
			lower extremities and has pulses in all of them. PT has a
			rash on his back. Also pt has foley to gravity with clear
			yellow urine. ——— HN (b)(6)-2
21APR03	0850		Agree with above documentation by HN (b)(6)-2 Pt
			stable. TLC Ⓛ subclavian AL. Pt drinking fluids.
			Pt wakes & is interactive trying to communicate.
			Will con't to monitor ——— (b)(6)-2 [illegible]/NC
	1200		No Δ in above assessment ——— (b)(6)-2 [illegible]/NC
	1350		Report called to 4 Fwd S. Plan for pt transfer. Pt
			tolerated reg diet for lunch. VSS. ——— (b)(6)-2 [illegible]/NC
4/21/03			Pt received from ICU, sleepy but
			easily arousable. VSS, afebrile. Ⓛ IJ 2 [illegible]
			triple lumen intact. Incision to Ⓡ knee
			open to air clean dry. Dressing to Ⓡ UE
			clean dry & intact. MAEW. Stable
			Will continue to monitor. [illegible] to speak
			(b)(6)-2

★U.S.GPO:1990-0-281-782/20252

NURSING NOTES
Standard Form 510
(Reverse)

MEDCOM - 5462

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
4/22/03		1810	back into bed, VSS resting well. (b)(6)-2
4/24/03		1810	Concur with above assessment. (b)(6)-2
4/[illegible]/03		2330	ASSUMED CARE OF PT. PT VS ARE STABLE ALL DRSGS C,D,E, PT IS SLEEPING AND HAS NO C/O PAIN AT THIS TIME WILL CONTINUE TO MONITOR THROUGHOUT SHIFT (b)(6)-2 Pt called [illegible] noted; pt unable to sit up independently; pain noted to have call cords to [illegible] (b)(6)-2 NVC
23APR03		1600	ASSUMED PT CARE. V/S WNL. PT RESTING & SOCIALIZING IN BED. LUNG SOUNDS CTA. C&E BILATERALLY HEART SOUND RRR2, RRR, @BS. UNABLE TO VISUALIZE WOUNDS DUE TO DRESSINGS. (b)(6)-2 ACE BANDAGE @ (R) FOREARM WILL CONTINUE TO MONITOR (b)(6)-2
23 Apr 03		1610	Concur with above assessment. (b)(6)-2 BASINC Patient with flat affect. Strength decreased generally. R>L. Patient has not verbalized anything on this shift. Patient is also hesitant to follow commands. Will continue to monitor. (b)(6)-2 ENSINC

☆ U.S. GOVERNMENT PRINTING OFFICE : 1983 O - 421-526 (9201)

NURSING NOTES
Standard Form 610
(Reverse)

MEDCOM - 5463

CLINICAL RECORD	NURSING NOTES (Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
4/22/03		1200	Assumed pt care at 0730. Pt alert but unable to determine orientation. Pt OOB up to chair. Has productive cough c thick clear secretions. Appears unable to use RUE. Able to hold cup c left hand to drink c minimal assist. TLC to LUE, LLE, RLE. Pt ate 50% of meal c total assist and prompting for swallowing. Cont to have tremors mostly to LUE and occasionally LUE. Feet are mottled, will encourage elevate LE. Hair and upper body washed. Pt has small BM. Dry flaky skin noted to buttocks and lower back. Report given to 4FP and pt transferred via wheelchair. (b)(6)-2 LTC, RN
4/22/03		1810	Assumed PIT care. Lungs & heart clear to auscultate. Positive bowel sounds. T HR noted, 1176pm. PIT unresponsive to verbal stimuli. Neuro checks stable, PERRLA. Rt. arm dsg. dry & intact c edema x2. Rt. Knee GSW c edema x2, c/o redness or drainage. 1800 pt vomited while sitting up in W/C. PIT put

Continue on reverse side

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

REGISTER NO.

WARD NO.

NURSING NOTES
Standard Form 510
General Services Administration and Interagency Committee on Medical Records
FPMR 101-11.806-8—October 1975
510-109

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
23 Apr 2003			Pt care assumed @ 2300; Pt resting in pool of liquid brown & tool; tolerated bath well; HR 145 2200 yellow urine drained from foley Pt turned to side
2300			+ 102.1 will continue to monitor (b)(6)-2
0200			T. 100.3 will continue to monitor (b)(6)-2
0430			T 101.3 will continue to monitor
0640			T 101.9 Tylenol administered PR will continue to monitor (b)(6)-2

☆ U.S. GOVERNMENT PRINTING OFFICE : 1983 O - 421-526 (9201)

NURSING NOTES
Standard Form 610
(Reverse)

MEDCOM - 5465

CLINICAL RKORD			NURSING NOTES
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
24 Apr 03	0310		Pt's temp was taken @ this time ̄c noticing pt was shivering and sweating. Pt's temp was 103.1 F° axilary. Nurse was notified. 650 mg tylenol PR were given to pt. High temp work up was done. Pt's temp will be reassessed in 1/2°. ——
			(b)(6)-2

Continue on reverse side

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

REGISTER NO.

WARD NO.

NURSING NOTES
Standard Farm 510
General Services Administration and Interagency Committee on Medical Records
FPMR 101-11.806-8—October 1975
510-109

MEDCOM - 5466

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
4/24/03		1800	(Cont.) CV: ST; $S_1 S_2$ +2 pulses to all extremities; P.IV x2 (L)(R) AC. [illegible] Resp: LS/CL bilat dim bases SpO_2 100% on RA GI: NGT clamped BS hypo No flatus or BM GU: Foley to gravity draining adequate amt. of CL/yell urine. Integ: Rash to back - applying Lidex Bid Buttocks excoriated - keeping area clean & dry. Will continue to monitor VS/I&O q 1°. Will assess for pain/discomfort & turn pt. q 2°. Will notify physician of any Δ's in pt. condition (b)(6)-2
4/24/03		2130	PCXR to verify NGT placement. NGT is okay to use [illegible]
4/24/03		2200	Lumbar puncture performed by Dr. (b)(6)-2 20mg Propofol given. Pt. tolerated procedure well. CSF sent to lab (b)(6)-2
4/25/03		0000	Assessment unchanged (b)(6)-2
4/25/03	0725		Assumed care of pt. Neuro: Pupils (5) movement in all extremities, also in arms but stronger in legs, clonis in legs, bilat pulses (4) cap refill 3sec, color NFR. CV: $S_1 S_2$ ST 1teens to 120's. Pulm: productive cough c̄ secretions, pt swallows secretions. Lungs CBTA GI: NG tube hypoactive BS, Abd SNTND. GU: Foley draining ample amounts of clear yellow urine. Integ: Rash to back, GSW to (R) FA & (R) thigh. Devices (L) AC 20G Recieved from ER. (b)(6)-2 (b)(6)-2

CLINICAL RECORD	NURSING NOTES

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
4/25/03	1005		PT ADM from Radiology post code-blue. PT
			eyes open ⌀ verbal, not following commands, pupils 3mm
			(+)(S). PT ̄c fine tremors noted to (B) LE noted. O2 @ 10-15L/min
			via NRB. BS(+) CTA, RR-20-24, BP 90-110/50-70, pulses (+) x4.
			18G IV (R) AC ̄c LR infusing, HR 100-120 sinus tach, Temp 100.4 (A)
			GI BSx4 ̄c abdomen NT, ND, S. GU-foley draining clear yellow.
			M.D. @ bedside. (b)(6)-2
4/25/03	1030		Labs drawn, CXR done. IVF D/C'd NS @ 150cc/hr via
			TLC in (L) IJ. SCD placed on patient. PT more alert
			MAE's x4 spontaneously ̄c some fine tremors noted. (b)(6)-2
4/25/03	1100		NC @ 3-4L/min placed ̄c sats > 95. PT ̄c incision/staples
			to (R) thigh and ACE wrap to (R) FA noted. (b)(6)-2
4/25/03	1200		Neuro tech @ BS for EEG. (b)(6)-2
	1400		EEG done. (b)(6)-2
	1410		PT to CT scan (b)(6)-2
	1500		PT returned from CT. Placed in contact precautions
4/25	1600		CXR done, TLC with tip sent, LR bolus given
4/25	1700		NGT placed verified ̄c 10cc air (b)(6)-2
4/24	1900		Rec'd pt. in BED. Neuro: alert, does not follow commands, PERRLA, moves
			(L) side extremities, no movement on (R) side. Myoclonus to BLE

Continue on reverse side

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

(b)(6)-4

REGISTER NO.

WARD NO.

(b)(6)-4

NURSING NOTES
Standard Form 510
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
510-110

MEDCOM - 5468

4/25

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
4/25	0755		Pt resting s̄ complications or signs of discomfort. (b)(6)-2 HAS
4/25	0845		Pt recieved Lidex cream to Lower back & buttocks. (b)(6)-2
	1000		Pt resting s̄ signs of pain, pt tolerating ice chips. (b)(6)-2 HN
	1050		MD assessed pt for neuro status & function in extremities. (b)(6)-2 HN
	1100		Pt being TOW ~~to~~ about after orders are done. (b)(6)-2 HN
			Pt resting comfortably s̄ signs of pain. (b)(6)-2 HN
4/25	1600		PT in Low Fowler position c̄ NPC. attempted to induced sputum s̄ results PT instructed by interpreter to Cough. pt unable. Hb Oral suctioning and nebulizer per NP. Sats 97% HR 113 RR 18. post → B/S rhonchi c̄ ØΔ HR 128 RR 22 Sats 98%. (b)(6)-2 Continue nebs as Ordered.
4/25/03	1651		Albuterol / Mucomyst Tx given early / NP. Hold 1800 Tx to Resume by R.T. (b)(6)-2 (b)(6)-2

CLINICAL RECORD — NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS — Include medication and treatment when indicated
25 APR 03		1630	ASSUMED PT CARE. PT RESTING IN BED W/S WNL TEMP @ 102.1 CMDR (b)(6)-2 NOTIFIED. PT REPOSITIONED TO COUGH UP SECRETIONS @ BS. LUNG SOUNDS WEAK & DIMINISHED. HEART SOUNDS NSR. RRR. HEART RATE @ 122. (R) RADIAL WEAK. (R) DP LE WEAK & WEAK PULSE, WARM TO TOUCH. (+)3 SEC CAP REFILL NEURO CHECK BAD. PT STABLE WILL CONTINUE TO MONITOR. (b)(6)-2
		1630	Pt does not follow commands well. He is unresponsive to most verbal stimuli. Does withdraw to pain. Will continue to monitor lungs, neuro status. (b)(6)-2 ENS, NC
		1900	Pt to go to X-ray with 101.5 temp. CDR (b)(6)-2 told. Will give report to X-ray techs and send corpsman with pt. (b)(6)-2 ENS, MC

Continue on reverse side

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

REGISTER NO. | WARD NO.

☆ U.S. GOVERNMENT PRIMING OFFICE : 1986 0—491-248 (40045)

NURSING NOTES
Standard Form 510
PRESCRIBED BY GSA/ICMR
FIRMR (41 CFR) 201-45-505
510-110

CLINICAL RKORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
4/26/03		1900	assumed pt care, in process of Dr (b)(6)-2 putting NG tube in, placed after mult attempts, confirmed by auscultation and X Ray, placed in order to give CT contrast due to pt ↓ mental status - N- pt opens eyes only to painful stimuli, PERRLA 4mm, does not follow commands, lethargic, moving LLE spontaneously, clonus to BLE. Lungs - Clear Diminished, SpO2 95-98% on Room air thick frothy oral secretion suctioned upon prn toilet. CV - Stacy, S1, S2, CVP - 11, stable BP, ↑2 pulse x 4 ext, gen edema to all 4 ext. GI - +BS, S, NT, ND, NGT @ Nare NPO for CT scan of abd ± contrast. GU - foley to gravity drainage clear yellow urine. Skin - (R) LE incision s/p surgery several days ago, sutures intact, TEDS ± venodynes Lines - (R) Fem TLC ± .45 NS @ 100 cc/hr (L) wrist PIV. CTG (b)(6)-2
4/26/03		2340	Pt to CT scan CTG (b)(6)-2
4/27/03		0015	Pt returns from CT scan ± difficulty - CTG (b)(6)-2
4/27/03	0700		ASSUMED PT CARE @ 0645. PT laying IN BED ± HOB @ 45°. NEURO: EYES OPEN SPONTANEOUSLY, ⊕ MOVEMENT X 4 ± ↓ D. MOVEMENT TO RLE DUE TO (R) KNEE INCISION, ⊕ 3-STRENGTH X 3 ± ⊕ 2 TO RLE. PUPILS PERRLA ± 4mm PUPIL SIZE CV: ⊕ S1, S2, ↓3 CAP REFILL, ⊕ PULSES X 4, CVP 16

(For continuation see reverse side)

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

(b)(6)-4

REGISTER NO.

WARD NO. ICU 62

NURSING NOTES
Standard Form 510
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
510-110

MEDCOM - 5471

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
4/27	0700		CONT. FROM OTHER SIDE: NBP @ 104/76 c STC @ 110. PT HAS TODS + SCD'S, c MINIMAL SWELLING x 4. RESP: PT ON ROOM AIR c SATS @ 96%, R/R @ 20, LS COARSE BS Q SHIFT. PT DX c PNEMONIA. GI: NPO, c NGT @ (R) NARE TO SUCTION DRAINING LIME GREEN FLUID. BS ACTIVE x4, ØBM. GU: Foley DRAINING YELLOW URINE @ 100 cc/hr. SKIN: PT HAS TLC @ (R) FEMORAL, (L) 18 G IN HEPLOCKED IN (L) WRIST. PT has (R) knee INCISION c SUTURES. SITE looks good. Ø S/S INFECTION, SUTURES INTACT, Ø DRAINAGE NOTED @ THIS TIME. — HN3 (b)(6)-2 (b)(6)-2
4/27	0945		NOTED STAGE I DQ ON COCYX, APPLIED DUODERM TO SITE. — HN3 (b)(6)-2
4/27	1105		OSMOLITE HN TF STARTED @ 20 cc/hr. ↑ Q4° TO GOAL OF 80 cc/hr (b)(6)-2
4/27	1400		TF ADVANCED TO 40 cc/HR, Ø cc RESIDUAL AT THIS TIME. — HN3 (b)(6)-2
4/27	1530		D'D linen + performed mouth care c glycerin SWABS. — HN3 (b)(6)-2
4/27	1830		CHECKED TF RESIDUAL Ø cc NOTED @ THIS TIME. TF ADVANCED TO 60 cc/hr. — HN3 (b)(6)-2
4/27/03	1900		CONCUR c HN3 (b)(6)-2 (b)(6)-2 document
4/27/03		1910	Shift assessment: PT awake appears to be comfortable uncontrollable shakes. Neuro: PERRLA, pupil size 4 can obey commands but has trouble moving ext when asked. Cardio: S1S2, RS, cap refill <4 x4 ext. + edema +1 x4 ext. pulses x4 ext. Resp: RA, LS coarse, diminished in lower lobes. Coughing PT has Pneumonia. GI/GU: NPO + BS NG tube tube feeding Osmolite HN @ 60cc Foley to gravity yellow clear urine. Skin: Sutures (R) knee No signs of infection decubicus on coayx cover c duoderm ext x4 warm + dry. IV: TLC (R) Fem D5 1/2 NS cont (b)(6)-2

★U.S.GPO:1990-0-281-782/20252

NURSING NOTES
Standard Form 510
(Reverse)

CLINICAL RECORD	NURSING NOTES (Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
26APR03	0400		Pt was shown how to use I.S. After corpsman did it Pt did it. Pt then began to smile. Pt is resting @ this time. Will continue to monitor. — (b)(6)-2 HA
26APR03	0526		Pt incouraged to use I.S. Pt then coughed up clear, white spudum. — (b)(6)-2 HA
4/26/03	0555		Neb ē 4D Albuterol //ee Mucomyst x 15 min. B/S clear bilat Pre/post neb. CPT attempted, pt pushed hands away. Ø cough noted. Ø adverse effects noted. — (b)(6)-2 HM RT
4/26/03	0600		PT. GIVEN BED BATH @ 0300 AND GIVEN CHEST P.T. @ 0310. PT. GIVEN TYLENOL RECTALLY @ 0240. WILL CONTINUE TO MONITOR. — HN (b)(6)-2
4/26/03	0605		ASSUMED PT. CARE @ 2355. FOLEY DRAINING CLEAR YELLOW URINE. (R) THIGH STITCHES C/D/I Ø DRAINAGE, LL CAP REFILL; BLE APA WEAK, (+) PULSE, (+) SENSATION. DRY HEEL TO BOTH FOOT, APPLIED LOTION, PUT SOFT HEEL PAD APPLIED. WILL CONTINUE TO MONITOR. — HN (b)(6)-2

Continue on reverse side

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

REGISTER NO.

WARD NO.

(b)(6)-4

NURSING NOTES
Standard Form 510
General Services Administration and Interagency Committee on Medical Records
FPMR 101-11.806-8—October 1975
510-109

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
4/28/03	1630	(cont)	drink of Ensure c̄ shake of head. Assents to tea by nodding.
			(b)(6)-2 ENS/NC
4/28/03		19[illegible]	Assumed care, VS, CVP 10 Pt calm, relaxed
			Temp 100 orally, Tylenol given. Ø verbal, some mumbling
			Eyes PERRLA, CO. ABX/ST Ø ectopy noted, S1S2
			Lung sounds: noted clear c̄ [illegible] sats 99-100%
			RA. [illegible] in use, minimal, HR 100's, [illegible] to Ⓡ
			[illegible], flushes well Ø s/s infection ABX tx cont.
			Abd soft, ⊝ tender ⊕ BS ⊕ BM x1 loose brown.
			Ⓡ knee c̄ lg sutures c/d/i Ø s/s infection.
			⊕ pulses Cont to follow (b)(6)-2
4/28/03	add.	1950	Pt [illegible] to social area [illegible].
			Pt c̄ visible shaking noted to LE. Dr aware
			Ø seizures noted pupils ⊕ reactive Dilantin as
			ordered (b)(6)-2
4/29/03	0000		Assessment unchanged, NAD, cont to follow
			q ABX + resp Tx (b)(6)-2
4/29/03	0400		Assessment unchanged, NAD, cont to follow (b)(6)-2
4/29/03	0700		Assumed care of pt. Agree c̄ assessment from last night. Pt follows
			simple commands. Mumbles. Remains on RA; high 90s-100% sats
			Soft flat abd. BS x 4 quads. Foley to gravity. (b)(6)-2 ENS/NC
4/29/03		1420	Report called to ENS (b)(6)-2 (b)(6)-2 ENS/NC

CLINICAL RECORD — NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS — Include medication and treatment when indicated
4/28/03		1910	@ 150 cc/hr. HN [b)(6)-2]
	continue		
		1950	PT used incentive spirometer 2 deep breaths HN [b)(6)-2]
		2200	PT on (R) side. HN [b)(6)-2]
		2400	PT roll removed pt is now on back. HN [b)(6)-2]
		0544	PT am care given sheets Dsol HN [b)(6)-2]
4/28/03	0700	0700–1200	Assumed care of pt. [Neuro]: Sleeps comfortably. PEARL. Has been noted to sleep most of the time. [Resp]: RA, sat's 100%. Rhonchi throughout. = (B) chest rises. [CV]: NSR. $S_1 S_2$. Strong & equal pulses x4. Cap r. fill <3s. [GI]: NG c TF @ 80cc/hr. D/C'd by 11am as ordered. Pt. now on reg. diet. Large BM x1. [GU]: Foley to gravity. 100-200cc/hr. Clear, yellow urine. [Skin]: Wound to (R) knee: stitches. OTA. C+D+I. Ø drainage noted. Decub. on buttocks, covered c Tegaderm. [b)(6)-2] RN/BC
4/28/03		1500	Pt. c visible shaking of LE, (B). Dr's are aware. Pt. already on Dilantin. No seizure activity noted: Ø lip-smacking, Ø rhythmic movements of UE & LE. Pt. also noted to remain silent. Has not spoken once during shift, even when spoken to in Arabic. Neurosurgeon also aware of this issue [b)(6)-2] RN/BC
4/28/03		1630	Pt. OOB → chair c full assist. Pt. awake. Remains quiet. Denies (cont)

Continue on reverse side

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

REGISTER NO. | WARD NO.

NURSING NOTES
Standard Form 510
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
510-110

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
			sutures intact. Bilat heels boggy down evident L > R. Areas of redness ~~Breakdown~~ to back, hips & upper arms ~~to back hips but clear~~ but skin still intact. (R) femoral TLC to be flushed. Foley draining clear yellow urine. Lungs diminished bilat @ bases. IS used; respiratory in to do neb tx for pt. Will continue to monitor. (b)(6)-2 ENS NC
30APR03	2100		Assumed care of pt. pt V.S.S. except for T 100.4° per tylenol given. pt sheets changed and decubis ulcer on gluteus maximus debrided and new dressings placed. pt is in no apparent distress at this time. Will continue to monitor V.S. and pain managment. (b)(6)-2 ENS
1May03	0030		Care assumed @ 0700. Pt resting in bed. Translator page b/c pt ~~is~~ complaining but denying pain. Concerned about personal property per translator. Pt admits to be contacted by LT (b)(6)-2. Lungs slightly coarse @ bases but air transfer heard. IS used. (F)BS. Foley draining clear yellow urine. R femoral TLC dressing Δ'd 30Apr03 by ENS (b)(6)-2 Pedal pulses palpable bilat. Pt has marked tremors in RLE esp when moved. Bilat heel decubiti R > L. Pt feet elevated on two pillows. Will continue to monitor. DI (b)(6)-2 to be notified of heel & buttock decubiti if not ~~awake soon~~ notified previously (b)(6)-2
1MAY03		2352	ASSUMED CARE @ 1900. PT AOX3 FOLEY DRAWING CLEAR YELLOW URINE. VS WITHIN PARAMETERS. R FEMORAL TLC DRESSING CDI. PT FEET ELEVATED. NO COMPLAINTS. WILL CONTINUE TO MONITOR DURING SHIFT (b)(6)-2

☆ U.S. GOVERNMENT PRINTING OFFICE : 1983 O - 421-526 (2201)

NURSING NOTES
Standard Form 610
(Reverse)

MEDCOM - **5476**

CLINICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS — Include medication and treatment when indicated
29Apr03		1600	Transfer from ICU, received report from ENS Delcasal at 1410, arrived to ward 1450, VS: T=99.7, R=18, O_2=97% RA, BP=124/82, P=100, encouraged IS, (R) Knee sutures DTA intact no S/S infection, Circ check (R)LE WNL, Foley Cl Yel Urine
			Lungs R Cl Diminished / L Cl Diminished, HOB ↑ 72° — (b)(6)-2 ENS, RC
		1630	PT has rash on back and neck — (b)(6)-2 ENS, RC
		1830	Dr (b)(6)-2 paged, and is aware of rash, Temp 99.8, he will examine PT in am — (b)(6)-2 ENS, RC
			PT has skin breakdown on back, (R) Knee +2 edema, decub on sacral area, legs have tremors and MD is aware, patch of hair on scalp c exudate — (b)(6)-2 ENS
30Apr03	0240		Pt awoke + appears agitated. HOB @ 70°. VSS Pt had BM @ this time. Post cleanup, pt calm + resting. Foley drainage clear yellow urine Sacral area @ stage II clean covered c duoderm @ this time. (R) LE stitches intact open to air @ this time. Will continue to monitor — ENS (b)(6)-2 RC
30Apr03	0700		Assumed care @ 0700. Pt had bought of diarrhea - brown & odorless. Pt has stage 2 to 3 decubitus F.A surrounding breakdown to sacral area. Duoderm applied to sacral area & upper buttocks bilat. R thigh

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

REGISTER NO. | WARD NO.

(b)(6)-4

NURSING NOTES
Standard Form 510
General Services Administration and Interagency Committee on Medical Records
FPMR 101-11.806-8—October 1975
510-109

CLINICAL RECORD | **NURSING NOTES** (Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
5/2/03		1250	RT NOTE: SVN c UO Albuterol via MP in SFP. BS c- Clear thr L bibasilar. Strong NPC. VSS. (b)(6)-2
5/2/03		1330	Assumed care 1000 PT no c/o pain, GM case, A duoderm sacral area stage II ulcer cleaned c NS, TLC dsg intact, Lung 12 Cl Cl Dim Dim, (R) Knee sutures OTA intact, HOB↑ 22°, PT able to adjust self in bed, refused to stay off back, both feet elevated to keep heels off bed, blister on (R) heel (b)(6)-2
5/2/03		1810	SVN c UO Albuterol in MP in NFP. BS - Clear thr, Dbibasilar. Spo2 98% RA (b)(6)-2
5/2/03		2250	Pt. sleeping with complaint. VSS, UOP - 700 cc. (R) Knee sutures - clean, dry & intact. HOB↑ 72°. Cont. to monitor (b)(6)-2
5/3/03		1145	SVN c UO ALBUTEROL VIA MP IN WHEELCHAIR. BS - Clear thr NPC. I&O (b)(6)-2
			NPE (b)(6)-2 WC BS May 05

Continue on reverse side

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

REGISTER NO. | WARD NO.

NURSING NOTES
Standard Form 510
General Services Administration and Interagency Committee on Medical Records
FPMR 101-11.806-8—October 1975
510-109

CLINICAL RECORD	NURSING NOTES (Sign all notes)	
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medicotian and treatment when indicated
03 May 03		1540	Care assumed @ 0700. Pt resting in gurney. Per order pt to be moved to regular bed, have pt consult, & be OOB to chair TID. Pt had BM this AM. Foley draining clear dk yellow urine. Duoderm to buttocks D/d. Ø advancement in break down noted. Sacral area to approx center of buttocks covered. R hip has stage I breakdown. Covered c duoderm. Peripheral IV placed. R femoral IV to be D/C'd. Lungs CTA bilat. RLE thigh sutures intact. Circ/neuro WNL except pt has tremors with extensive movement of extremity. Pt is to see pt this PM. Currently resting. VS WNL. Will continue to monitor. (b)(6)-2 NB NC
04 May	1005		Care assumed @ 0700. Pt resting in bed. Lungs CTA bilat. VS WNL, chest expans symmetric. Ø N/V this am. R AC IV infiltrated. New site to be established & medication restarted. Foley draining clear yellow urine. R. femoral TLC removal site covered c gauze CDI. Femoral & pedal pulses palpable. Pt has movement & sensation to all extremities. Tremors noted in bilat LE. Sacral & buttock decubiti covered c duoderm. RLE thigh sutures intact. Pt to be trans today. (b)(6)-2 NB NC

Continue on reverse side

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

(b)(6)-4

REGISTER N O	WARD N O

NURSING NOTES
Standard Form 510
General Services Administration and Interagency Committee on Medical Records
FPMR 101-11.806-8—October 1975
510-109

MEDCOM - 5479