PROGRESS NOTES

DATE	
12APR03	Medical Nutrition Tx:
1400	O: Dx: GSW to abdomen Wt. ≅ 75kg.
	Ate Breakfast + lunch, RD offered ENSURE - pt accepted.
	Labs 10APR03: Hgb/Hct 12.0↓/37.2↓
	A/P: Kcal needs: 30-35kcal/kg/day = 2250-2625kcal/day.
	Protein needs: 1.5-2.0 g/kg/day = 112-150 g/day.
	Hgb/Hct ↓ - recommend MVI q day.
	Recommend Regular diet + snacks / ENSURE TID
	between meals. RD to f/u q 2-3 days.
	(b)(6)-2 MPH, RD
	(b)(6)-2 MPH, RD
	LT, MSC, USNR (b)(6)-2
15 Apr	~~H Sound~~
	Unclear if pt is eating or moving bowels 5-
	Abd remains distended but softer than
	a few days ago.
	Midline wound - clean granulated
	Will do colonoscopy and EGD (b)(6)-2
	Note - having watery diarrhea
	Will look for obstructing lesion, c dig (b)(6)-2

STANDARD FORM 509 BACK (Rev. 11-77)

☆ U.S.GPO:1984-0-421-526/124

MEDICAL RECORD	PROGRESS NOTES

DATE	
	~~CXR shows pneumonia~~
	Int Med
11 APR 03	Asked by gen surg to see pt for pneumonia
	Pt does not appear to be spontaneously
	coughing.
	On exam WBC (16.9)
	Lungs RLL rales
	CXR (B) LL infiltrate R > L 140/65 - 92 - 98.6
	Imp Pneumonia 95% Sat.
	Rx 1) Azithromycin 500 g po tonight
	2) then 250 g po q QD x 4 d
	(b)(6)-2 (b)(6)-2
12 Apr	Int med consult appreciated
1700	Review of films with radiology says pneumonia is
	s/p call.
	AXS ⊖ gas throughout colon -
	Add softies today. Non tender.
	Continuing to watch (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,
FPMR (41 CFR) 101-11.806-8
[illegible]09-110

MEDCOM - 5835

MEDICAL RECORD	PROGRESS NOTES
DATE	
14 Apr	No vital signs
1200	Not eating
	Abd soft but distended..
	Translator not currently available.
	Will get AAS

(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 - 5836

PROGRESS NOTES

DATE	
12 Apr 1990	12 days s/p x-lap for GSW to abdomen c̄ oversew of colostomy x2. Wound healing by 2° intention. Eating, stooling and passing flatus. OR note was significant for [illegible] of peritoneal and mesenteric nodules c/w metastatic or granulomatous disease.
	⊕ smoker
	Alert, cooperative, c/o weakness in right hand.
	PERRL EOM intact
	Oral cavity grossly s̄ lesions
	Neck supple s̄ adenopathy
	Lungs - ↓ BS bilat
	Abd - distended tympanitic,
	- midline wound clean, granulating
	- 2 cm wound to right of incision - clean.
	[illegible] s̄ masses
	Rectal - brown stool, no masses.
	Imp - s/p GSW to abdomen
	R/o met cancer; R/o TB.
	Plan - CXR - no obvious lesion
	KUB -
	CMP - alk P 352 K 3.8
	Feeding trial. If tolerated, discharge c̄ advice
	See Surg w/u (b)(6)-2
	WBC 17000 Hb 12.0 (b)(6)-2

U.S. GOVERNMENT PRINTING OFFICE: 1990 262-081/20182

STANDARD FORM 509 BACK (Rev. 11-77)

MEDICAL RECORD	PROGRESS NOTES

DATE	
	ICU
4-17-03/	ID 103 is s/p ex lap. for bile leak after laparot. for
1620	GSW in abdomen on Mar 29. Patient currently being
	treated for pneumonia and has developed post-operative hypox.
	requiring post-op mechanical ventilation.
Meds:	Neuro -> sedated for mechanical ventilation.
Meropenem	CV -> stable of good peripheral pulses.
Hep	Resp -> currently treated for presumed pneumonia. On
Zantac	PEEP 15 PS 12 CPAP
Morphine	-> will wean rapidly to extubation
Versed	GI -> post-op.
	FE -> urine output low -> will bolus w/ 2 liter LR now
Labs.	Overall -> stable but requiring PEEP to ↑ O_2 sat.
OK.	Mostly likely post-operative atelectasis -> will extubate
	ASAP.
	(b)(6)-2 (b)(6)-2
4/21/03	- Pt has abd distention & abd pain
1400	S/p Ex lap -
	- 2 drains in tact + central wound open.
	- Abd is tympanitic c̄ hypoactive BS's -
	mild by tender
	Bowel open x 2 [illegible] [illegible]

(Continue on reverse side)

PATIENTS 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, 806-8

509-110

MEDCOM - 5838

ACLU-RDI 1281 p.5

DOD 13050

PROGRESS NOTES

DATE	
	R/ chest clear.
	- A Acute Ileus [illegible] sub acute obstruction -
	P. 1. - Acute abd series
	x possible CT -
	2. Get surgical opinion (b)(6)-2
	DR (b)(6)-2 (b)(6)-2

STANDARD FORM 509 BACK (Rev. 11-77)

☆ U.S.GPO:1984-0-421-526/124

MEDCOM - 5839

PROGRESS NOTES

DATE	
17 Apr	Op note
1500	Ex lap c washout of bilious ascites. No active leak noted.
	Drains 2 JP, one in (R) gutter, 1 in Morrison's Pouch
	Opdine - Napurkowski
	GET
	EBL 200cc
	Pt tolerated procedure well, went to ICU
	because of hx of desat after prior surgery
	and desat during surgery (b)(6)-2 [redacted]
14 Apr	Afeb VSS, extubated last night O2 sat 90 on RA
0900	Urine output 50-70 cc/hr
	Lungs - junky
	Abd soft, dressing dry
	JPs draining ~200 cc serosanguinous fluid,
	no obvious succus or bile
	Na 133 K 5.1 Glu 130
	CXR
	Doing well, will transfer to ward, start sips
	of liquid (b)(6)-2 [redacted]

STANDARD FORM 509 BACK (Rev. 11-77)

☆ U.S.G.P.O.: 1986-491-248/20616

MEDCOM - 5840

MEDICAL RECORD	PROGRESS NOTES
DATE	
10 Apr 03 2000	As noted by DR (b)(6)-2 CT shows mild p/p collections of fluid in abdomen, suggestive of abscess. Aspiration of (R) gutter collection ⇒ bilious, succous material. CT showed no leak of contrast. GSW apparently hit colon in hepatic flexure (based on colonoscopy done yesterday) & could have injured liver or bile duct. Doubt ~~bowel inj~~ persistent bowel injury at this time as patient should be sicker. ERCP/HIDA unavailable Plan - ex lap, washout of abdomen, examine hepatic biliary tract, possible cholangiostomy & T-tube. will also get bx of those peritoneal nodules. (Path on colon bx ⇒ no tumor) will recheck labs, (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)

(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 - 5841

PROGRESS NOTES

DATE	
	Tmax 100³ P ~110
Apr	c/o diarrhea and irritation of Foley. Not
30	complaining of abdominal pain. No appetite,
	but apparently 2° fear of diarrhea
	No J-P drainage recorded past 24h. –
	Urine 500 cc yesterday pm, none recorded
	overnight
	Overall, appears to be doing well –
	Will D/C foley, check lab, try feeding, (b)(6)-2 [redacted]
	Stool c+s pending
	Pt seen this morning but chart not available
21 Apr	Pt. afeb, overall looking better
2130	less diarrhea
	Abd soft and midline wound clean.
	During day pt noted to be in some discomfort
	and to have some trouble breathing
	ABG and subsequent CT scan ⇒ reaccumulation of
	fluid over dome of liver. Mild abdominal collection
	less. No leakage of contrast. Contrast goes thru to
	gas filled colon
	Imp - recurrent/persistent Ⓡ subphrenic collection
	Plan - CT/US guided catheter placement and drainage (b)(6)-2 [redacted]

MEDICAL RECORD | **PROGRESS NOTES**

DATE	
17Apr 0600	Af AR 28-35 O2 sat ~ 95% ~ 2L Awake alert, appears to be complaining of foley lungs Abd distended/all but soft J-P drains currently empty but no output recorded since yesterday at 1000 No urine output recorded since 2300 yesterday. Abd wound reported as dry. Imp - ? No idea if pt has had anything po or passed any stool or flatus. Imp - appears to be doing well. (b)(6)-2 [redacted]
18APR03 1555	Medical Nutrition Tx: F/U: O: Ate lunch per RN. Labs 18APR03 Hgb/Hct 12.2↓/36.5↓ Meds: FeSO4, FolicAcid, MVI. Diet Rx: Regular A/P: Hgb/Hct ↓ - recommend offer MVI, FeSO4, folic acid c̄ fruit juice to ↑ absorption. PO intake fair. Recommend continue encourage PO intake c̄ Regular diet + snacks/ENSURE TID. RD to f/u q 2-3 days. (b)(6)-2 [redacted] MPH, RD (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]

(Continue on reverse side) LT, MSC, USNR (b)(6)-2 [redacted] MPH, RD

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 - 5843

MEDICAL RECORD | **PROGRESS NOTES**

DATE	
4/21/03 300	10 FR DRAIN PLACED IN BILOMA UNDER LOCAL ANESTHESIA. LARGE AMT PURULENT DRAINAGE - WILL NEED TO EMPTY DRAINAGE BAG FREQUENTLY. APPRECIATE CONSULT. WILL FOLLOW.
	(b)(6)-2 [redacted] (b)(6)-2 [redacted]
22 Apr 0730	Drained 600cc initially, 200cc next 4 hrs, 50cc past 4 hrs. Mostly fragrant bile. Gram stain showed no organisms, few WBC.
	Pt appears more comfortable today
	Afeb P 95-100
	Abd soft, non tender.
	Doing well
	(b)(6)-2 [redacted]
22 Apr 2115	Afeb VSS
	Good urine. Bilious drainage diminishing. Feels much better today. Eating, ambulatory and having normal bowel movements.

(Continue on reverse side)

REGISTER NO. | WARD NO.

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

(b)(6)-4 [redacted]

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

PROGRESS NOTES

DATE	
	Abd soft and nontender
	Growing gram neg rod from bile. As he has remained afeb, is looking so much better and has not been on any antibiotics, I would not start treatment at this time but continuing to watch closely
	(b)(6)-2
23 Apr 0945	Temp 100
	Eating + ambulating
	Continuing to do well,
	Midline wound clean
	(b)(6)-2
24 Apr	No change
	(b)(6)-2
25 Apr	Afeb VSS. Less perky today
	Minimal yellow clear draining
	Midline wound has pockets of necrotic tissue with mostly good granulation
	Subhepatic drain pulled.
	Doing well
	(b)(6)-2

U.S. GOVERNMENT PRINTING OFFICE: 1990 262-081/20182

MEDICAL RECORD	PROGRESS NOTES
DATE 22APR03	Medical Nutrition Tx: FLUi
1710	O: Eating dinner. Labs 21APR Hgb/Hct 9.6L/28.8L
	MCV/MCH 81.4 /27.1 Na^+ 132L glucose 133T
	Meds: Folic Acid, $FeSO_4$, MVI. Diet Rx: Regular.
	A/P: Hgb/Hct ↓ - recommend offer fruit juice c
	MVI & $FeSO_4$ to T absorption. Na^+ ↓ - decreased
	since 18APR03 - recommend offer ENSURE TID
	to provide additional 600 mg Na^+ q day.
	Glucose elevated, but normal lab since 18APR03.
	RD to f/u q 2-3 days. (b)(6)-2 MPH, RD
	(b)(6)-2 MPH, RD
	LT, MSC, USNR (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

MEDCOM - 5846

MEDICAL RECORD | **PROGRESS NOTES**

DATE	
5APR03 '23	Medical Nutrition TX S: Per translator: Appetite fair. Ate ½ of lunch + 1 apple. Wants juice. O: ∅ current labs. Diet Rx: Regular. A/P: PO intake good. Recommend continue encourage PO intake. RD to f/u q 3-5 days. (b)(6)-2 [redacted] MPH, RD (b)(6)-2 [redacted] MPH, RD LT, MSC, USNR (b)(6)-2 [redacted]
2? Apr 16??	Recorded drainage ?? in 24 hrs from JP; ~10?? in ?.1b ?? (since 0900). Suprahepatic drainage recorded as zero in 36 hrs; (b)(6)-2 [redacted] Both drains pulled.
27APR03 1440	Medical Nutrition TX: F/U S: Per translator: 4/26 - ate all 3 meals + apple + orange. 4/27 - ate breakfast + lunch + 1 apple + 1 orange. O: ∅ current labs. Diet Rx: Regular. A/P: PO intake good. Recommend continue to encourage PO intake. RD to f/u q 3-5 days. (b)(6)-2 [redacted] MPH, RD (b)(6)-2 [redacted] MPH, RD LT, MSC, USNR (b)(6)-2 [redacted]

(Continue on reverse side)

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

(b)(6)-4 [redacted]

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	
20 Apr	A ful
1300	Continues to eat and feel well
	Awaiting medical (b)(6)-2
21 Apr	Midline wound with 2 areas of necrosis,
	debrided at bedside. Otherwise good
	granulation
	Abd soft
	Doing well (b)(6)-2
1 MAY 03	Medical Nutrition Tx F/U:
1805	S: Per translator - ate all meals 4/30 + today.
	O: Diet Rx: Regular. ∅ current labs.
	A/P: PO intake good. Recommend continue to
	encourage PO intake. RD to f/u q 3-5 days.
	(b)(6)-2 MPH, RD
	(b)(6)-2 MPH, RD
	LT, MSC, USNR (b)(6)-2 (b)(6)-2

NURSING NOTES
(Sign all notes)

CLINICAL RECORD

HOUR A.M.	HOUR P.M.	OBSERVATIONS — Include medication and treatment when indicated
4/13		ASSUMED CARE OF Pt. Pt VS ARE STABLE. ABD DRESSING C.D.I, PT SLEEPING PEACEFULLY. WILL CONTINUE TO MONITOR PT. (b)(6)-2
03	0700	Assumed pt. care. Performed pt. assessment. No change since 0019. Pt now sleeping quietly. Will continue monitoring for any changes. (b)(6)-2
r 03	1100	Assumed care of pt. Patient resting in bed without complaint of pain. A&O x3. Cap refill <3 sec. PPPx4. Lungs CTAB. Some serosanguinus drainage noted on abdomen. BS hyperactive. Will continue to monitor. (b)(6)-2 EMS, we
APR 03	1900	Assesment Done. PT resting in bed. Complains of pain. Lung sound CTAB. Heart S1S2 RRR. (-) BS x4 some serosanginious drainage noted on abdomen dressing. DR notified. will monitor. PT dalored. (b)(6)-2
3 Apr 03	1900	Concur with above note. Will continue to monitor VS, pain. (b)(6)-2 EMS, we

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.

(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

MEDCOM - 5849

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
14 Apr 03		2300	Assumed Pt Assessment. Pt IV Site on (R) hand has NO S/Sx of infection + Lung Sounds diminished BS x4 Pt deg. upper abdomine CDI. Neuro ✓ + CAP Refilled Good. Pt is Sleeping Comfortably. (b)(6)-2 (b)(6)-2
14APR03	0800		Assumed care of Pt. Pt resting comfortably. VSS other than O2 at 91%. Will continue to monitor. Had pt. cough and deep breathe. O2 went up to 95-98%. (b)(6)-2

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

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

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
14 Apr 03		1530	Assumed care of patient. A&O. S1, S2, Lungs CTAB. Patient with limited inspiration do to guarding. Montgomery straps to abd. some drainage to middle of montgomery strap. Abd very distended but equal to yesterday. BS ⊕ but hypoactive, some what distant. Patient reports having loose stool when he eats. will continue to monitor VS, pain, bs, resp status. (b)(6)-2 ENS NC
15APR03		2315	Assumed Pt Care Pt H2 o3 ® Hand NO S/S of infect drs on upper abdominal was CDI. +BSx4Q cap Refill ≤ less than 2sec. Pt is sleeping comfortably —— H2 3 (b)(6)-2 (b)(6)-2
15APR03	0900		PT to Rad. VIA WC, corpmen, & escort (b)(6)-2
15 Apr 03		1630	Patient returned from EGD/colonoscopy. A&Ox3 S1, S2. Lungs CTAB. Patient coughing up some mucous. Abd. distended w/ montgomery strap in place. Some pain reported to abd. Patient passing gas, tolerating PO fluids. will continue to monitor VS, pain, bloating. —— (b)(6)-2 ENS, NC

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 - 5851

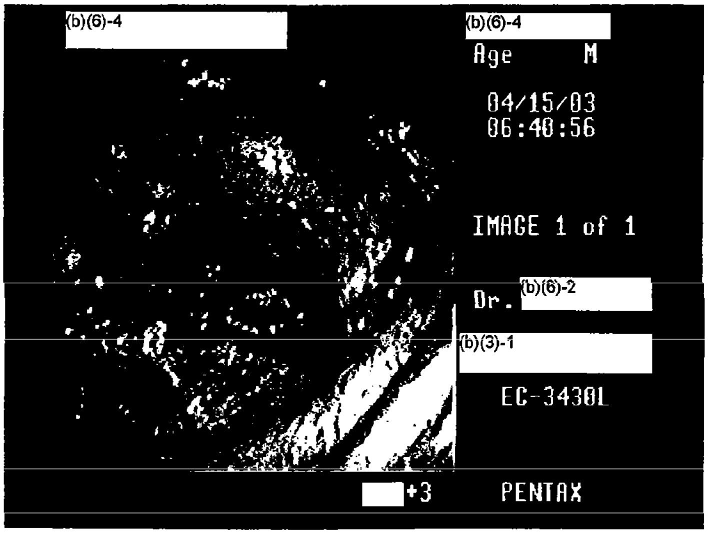
NURSING NOTES
(Sign all notes)

DATE	HOUR AM	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
16APR03		2300	Assumes Pt care. Pt drs on upper abdominal is CDI diminish BS Pt have no c/o pain resting comfortably —— (b)(6)-2 (b)(6)-2
16APR03	0930		Agree c̄ above assessment. Pt abd. distended, but soft. ØBM. Pt sipping contrast @ this time. Pt c/o nausea due to amount of contrast. Pt able to transfer from bed to WC with Ø assist. Will cont to monitor for pain/nausea (b)(6)-2
16APR03	1000		Pt to YueMed via WC for CT. (b)(6)-2
16Apr03		1530	Assumed care of patient. Patient resting in bed. Lungs CTAB, $S_1 S_2$, PPPx4. Abd soft distended. BS hypoactive. No N/V at this time. Patient reports loose stool, but none has been seen by staff. Will continue to monitor minimal drainage to montgomery strap. Does not appear to be new drainage (b)(6)-2
17APR03			Assumed Pt care. Pt drs on abdomen is CDI Pt is resting comfortably —— (b)(6)-2

PROGRESS NOTES

DATE	
4/16/03	Inf Med
1430	Pt had colonoscopy yest - Results on prior page - No clear cut ev of malignancy. He remains anorexic but quite distended - CT performed this AM - Numerous large areas of non enhancing fluid (liters) Pt was prepped + draped, anesthetized locally c̄ 1% xylocaine, then a 16 guage needle used to tap R LQ just superior to iliac crest 1 liter of bile-colored fluid was removed. Pt tolerated well + no complications were noted - I believe he may have an intraperitoneal bile leak, staining his ascitic fluid. I have sent fluid for cell count/diff, prot, alb, bili, cytology and cultures. Will review findings w/ Dr. (b)(6)-2 [redacted] (b)(6)-2 [redacted]

(b)(6)-2 [redacted]



MEDICAL RECORD	PROGRESS NOTES
DATE	
15 Apr	Op note
1430	EGD ⇒ normal
	Colonoscopy to cecum ⇒ no evidence of pseudomembranes or obstruction
	Edema and mass effect at site of surgical line in hepatic flexure.
	? Ca, ? reaction
	Will schedule CT scan to R/O partial small bowel obstruction, pancreatic lesion

(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 508 (Rev. 11-77)
Prescribed by GSA/ICMR,
FIRMR (41 CFRI 201-45 505

508-111

MEDCOM - 5854

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
1415	4/17/03		Received from OR c̄ stable VS, sedated, intubated (size 8.0 ETT measuring 22 @ the teeth; lungs c̄ crisp crackles and rhonchi sm amt tan fluid c̄ suctioning; ⊕ pupils PERRL, ⊖ abd sounds, NGT placement verified; palpable pulses all extremities, abd dsg c̄ JP X2 (charged) C/D/I; SCDs in place; plan is sedation c̄ possible wean and extubate this pm (b)(6)-2
4/17/03		1730	2nd Liter bolus done. (b)(6)-2
		1810	Lasix 10mg IVP 2° ↓ U.O. (b)(6)-2
		1830	Good U.O. result > 100cc (b)(6)-2
			Pt Extubated successfully (b)(6)-2
4/17/03		1900	ASSUMED CARE OF PT. RESTING SUPINE IN BED. FM 10L. PEARL A+O TO BEDSIDE ACTIVITY. EXLAP + WASHOUT. CTA UPPERS SLIGHT CRACKLES LOWERS. S_1 S_2 ST ⊕BS PULSES +4. FOLEY TO GRAVITY c̄ CLEAR AMBER URINE. DRSG TO MIDLINE TORSO C/D/I. VSS. WILL CONTINUE TO MONITOR. (b)(6)-2 RN/USA
4/18/03		0000	ASSESMENT COMPLETE. NO CHANGE FROM PREVIOUS ASSESMENT. NO SIGNIFICANT SIGNS OF PAIN. VSS. WILL CONTINUE TO MONITOR (b)(6)-2

CLINICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
4/18/03		0400	ASSESMENT COMPLETE. NO CHANGE FROM ABOVE. NO SIGNIFICANT
			S OF PAIN. VSS. WILL CONTINUE TO MONITOR. — (b)(6)-2 HN/USN
4/18/03		0000	Pt. states itching occassionally c no hives noted and
			daily cares completed w/ ↓ in Pt itching
			(b)(6)-2
18APR03		0000	Pt given Morphine occassionally for communicated
			Pt pain — (b)(6)-2
18APR03		0030	I agree w/ above assessment + care. — (b)(6)-2 RN

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 - 5856

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR ☑ P.M.	OBSERVATIONS Include medication and treatment when indicated
1415	4/17/03		Received from OR ē stable VS, sedated, intubated (size 8.0 ETT measuring 22 @ the teeth; lungs ē crisp crackles and rhonchi sm amt tan fluid ē suctioning; pupils PERRL, ⊝ abd sounds, NGT placement verified; palpable pulses all extremities, abd dsg ē JP X2 (charged) C/D/I; SCDs in place; plan is sedation ē possible wean and extubate this pm (b)(6)-2
4/17/03		1730	2nd Liter bolus done. (b)(6)-2
		1810	Lasix 10mg IVP 2° ↓ U.O. (b)(6)-2
		1830	Good U.O. result > 100cc
			Pt Extubated successfully
4/17/03		1900	ASSUMED CARE OF PT. RESTING SUPINE IN BED. FM 10L. PEARL A+O TO BEDSIDE ACTIVITY. EXLAP + WASHOUT. CTA UPPERS SLIGHT CRACKLES LOWERS. S_1 S_2 ST ⊕ BS PULSES +4. FOLEY TO GRAVITY ē CLEAR AMBER URINE. DRSG TO MIDLINE TORSO C/D/I. VSS. WILL CONTINUE TO MONITOR. (b)(6)-2 RN/US
4/18/03		0000	ASSESMENT COMPLETE. NO CHANGE FROM PREVIOUS ASSESMENT. NO SIGNIFICANT SIGNS OF PAIN. VSS. WILL CONTINUE TO MONITOR (b)(6)-2

★U.S.GPO:1990-0-281-782/20252

NURSING NOTES
Standard Form 510
(Reverse)

MEDCOM - 5857

CLINICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
4/18/03	0700		Assumed PT care. PT is resting supine in bed. PT's VS's are
			stable. PT has Foley to gravity with clear yellow urine. (b)(6)-2
			Dressing to Mid Torso. Pulses +4. ——— HN
4/18/03	0840		Heparin administered at 5000 usa ——— HN (b)(6)-2
4/18/03	1234		Performed dressing change on PT's Abdomen. Wound is
			aproximatly 10" long 2" wide has moderate amount of
			sero sanguinous drainage. PT tolerated dressing change with
			[illegible] well ——— HN (b)(6)-2
4/18/03	—	1305	Report called to ward nurse ——— (b)(6)-2
4/18/03		1930	PT transferred from 4 Forward Port.
			PT stable, assisted to bed, ambulatory
			Foley to gravity, draining amber
			colored urine. D5 ½ NS © 125. (b)(6)-2
			ABD dressing CDI. Will monitor ——— (b)(6)-2
~~18APR03~~	~~0000~~		~~ASSUMED PT CARE~~ (b)(6)-2
19APR03	0212		assumed care @ 2330. V/S stable. pt sat @ [illegible]
			O2 2L NC © ↑ sat >90. Pt. slightly agitated and
			pulling @ foley. [illegible]
			in chair. [illegible]
			[illegible]

Continue on reverse side (b)(6)-2

PATIENT'S IDENTIFICATION (*For typed or written entries give: Name—last, first, middle; grade;* **dare**; *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

MEDCOM - 5858

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
4/19/03		1500	Assumed pt care at 0700. Pt resting in bed.
			Pt on 3LNC, O2 Sat 92-95%. Alert and
			oriented, HRR, Lungs CTA(B), Abd distended,
			NT, large abd dsg Δ'd by wound care
			team, CDI. Foley draining dark yellow urine.
			Refused to eat lunch & Enc to drink ensure.
			Will cont to enc OOB to chair. (b)(6)-2 [redacted] LTJG, NC
4/19/03		1700	Assumed pt. care @ 1500. Pt resting in bed. Pt c̄
			foley cath. Abd. drsg. CDI. Pt. on nasal, set in
			4 L/min (SPO2 92%-95%). Pt c̄ D5 45% KCL 1000ml
			@ 125/hr. foley cath. draining dark yellow urine.
			Pt. complaining pain on his Abd. (notified the nurse)
			AOx3, HRR, Lungs is clear. VS taken BP 140/80, PR 111
			T. 96.9, R 30. Will cont. monitor ——— HN (b)(6)-2 [redacted]
		1730	Concurred c̄ above — (b)(6)-2 [redacted] ARB, NC
04/19/03	2330		Pt. sleeping @ this time. Pt. has Large dressing
			to ABD. Clean dry & intact. Pt. has a Foley
			cath. draining clear yellow urine. Lungs are
			Clear. Pt. has very high Resp. Pt. has ø c/o
			pain @ this time. Will continue to monitor (b)(6)-2 [redacted]
			Closely. ——— (b)(6)-2 [redacted]
04/20/03	0300		concur c̄ above ——— (b)(6)-2 [redacted] LCDR NC

★U.S. GPO: 1990-262-081/20136

NURSING NOTES
Standard Form 510
(Reverse)

MEDCOM - 5859

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
			me have. (b)(6)-2 RNS, RE
4/21/03		1400	Pt c/o abd pain, 7 to (2). Abd distended and TP. JP's to (R) Abd x2 draining minimal amt of serous fluid. Dr (b)(6)-2 in to assess pt. PE sent for AAS. CT c contrast also ordered. PE SOB due to distention bett sats WNL. (b)(6)-2 CEG, NC
04/21/03			Pt. went down for X-RAY today. Pt c/c ABD pain EARLIER. JP's draining scant amount of drainage. Pt. voiding without difficulty Pt. sleeping @ this time. will continue to monitor. (b)(6)-2
04/22/03	0100		Assummed pt. care @ 2330. Pt Lying in bed. Vs taken BP 132/78 PR 104 sto2 93, R 20, T 98.8. Lungs clear Abd distended, pulse good (2+ ea.) all Ea. Large abd. dsg. c a small amount of drainage. 2 JP drains c a small amount of serous fluid. Pt has a biloma drainage draining a large amount of purulent drainage (600 a emptied on 2300) Pt in nasal canula set in @ 2/min. Ø c/o pain at this time. Will cont. to monitor (b)(6)-2
	0230		Concurred c 0100 assessment (b)(6)-2 RNS, RE
04/22/03		1700	Pt. feeling much better today. Pt. has Ø c/o pain this time. VS stable Pt. eating & drinking good amounts,

CLINICAL RECORD			NURSING NOTES
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
20APR03	1235		Foley DC'd. Due to void @ 1835 — (b)(6)-2
20APR03			Pt. more comfortable today. Pt. has ∅ c/o
			pain. Pt HAD BM. today. RESTING most of the
			shift. Pt. still has ABD. DRESSING C.D.I. Pt.
			has. D5 ½ NS @ 125cc/hr. Pt. voiding spontaneous
			without difficulty. V/S STABLE. Will continue
			to monitor pt — (b)(6)-2
21APR03	0100		Assumed pt. care Ambulated pt. to bathroom, pt.
			tolerated well. Pt. abd. drsg intact c̄ small
			amount of drainage, c̄ 2 JP drains draining
			yellowish fluid. Pt has D5 ½ NS @ 125 cc/hr. No
			c/o pain at this time. Will cont. to monitor
			pt. care — (b)(6)-2
21APR03	0100		Administered O2 Nasal canula set in 3L/min.
			~~O2 Sat. 92=96%~~ error
			O2 Sat 92-96% — (b)(6)-2
	0300		Temp @ ∆ of shift 102°. 650mg
			Tylenol PR administered. T°@ 0130 =
			100.6 & currently 97.6°. Temp broken
			& diaphoretic, VSS. Will recheck in

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
510-110

MEDCOM - 5861

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
04/23/03		2000	Pt. Resting @ this time. Will continue to monitor pt. Pt. very ANXIOUS to go. (b)(6)-2
4/23/03		2400	Assumed pt. care. Pt c a biloma tube at (R) side of his chest. 2 JP drains (R) side of abd. c a small amount of serous fluid. Big drsg. on pt. abd., CDI. Lung is clear, Abd. slightly distended pt. is in good cond. No further changes. Will cont. to monitor pt. care (b)(6)-2 HN
	2430		Concurr active assessment (b)(6)-2
04/24/03		1600	Assumed pts care. pt. in good cheer @ this time. Pt. voiding good. pt. c/o little irritation to throat gave pt. water & it seemed to help. Pt. still has JP's draining small amounts of drainage. V/S are stable. Pt. drinking a lot. Will continue to monitor pt. (b)(6)-2
4/25/03	0000		Pt care assumed. Pt sleeping currently c in NAD. Mid incision covered c abd pads, continue dressing CDI. Biloma drain from RUQ c drainage. 2 JP's from RUQ drainage serous drainage. Fed distention to abd noted from previous nights. Dr (b)(5)-2 notified during 3/1 shift

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

NURSING NOTES
Standard Form 610
(Reverse)

CLINICAL RECORD | (b)(6)-2 | NURSING NOTES

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS (Include medication and treatment when indicated)
			CONT [redacted]
04/22/03		0900	of food + water. Pt. still has NBD. Dressing CDI. U/S stable @ this time. Pt has NO IV. site @ this time. Will reassess IV. site + Pt. + continue to monitor Pt. —— (b)(6)-2
04/23/03	2400		Assumed pt. care. Pt has a abd. drsg. c/d/i. 2" drains at the side of abd. draining small amount of serous fluid. Pt is draining tube at his chest side, draining a large amt. of purulent drainage. Temp. slightly high (100.4) O2 Sat 92% noted. No c/o pain at this time. Will cont. to monitor pt care —— (b)(6)-2
	0200		Concurred to above assessment. 3L O2 per NC to pt. Will monitor sats. 2 Tylenol tabs given for temp. Will recheck. —— (b)(6)-2 MD
04/23/03		2000	Assumed pt. care. Pt. very happy today Pt. has no c/o pain so far. Pt. had a BIG BM today confirmed by doctor. No changes to pt. Only issue is DOCTOR (b)(6)-2 Δ'd DRSG ON ABD. Continue on reverse side — CONT.

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

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

REGISTER NO.

WARD NO. 4 Med

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

MEDCOM - 5863

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
30 April 03		2045	Assumed pt care. Pt is Resting in the room. Pt did not c/o any pain or discomfort. Pt's dressing Δ was done to his mid line abdominal cavity. W-D dressing was performed. wound looks pink, no drainage was noted. Pt's V/S were WNL Pt will be monitor closely (b)(6)-2
30 APR 03	2100		Agree c above corpsman note & assessment (b)(6)-2
1 May 03	1937		Pt was lying on bed comfortably. Wound care was provided to pt. Pt's abdominal wound was repacked c a w/D dressing. wound looks pink and is in good shape. Pt didn't have any other amplaints. Pt will be monitor closely (b)(6)-2
01 May 03 @	2015		Pt had dsg's done; Agree c above corpsman noted assessment (b)(6)-2
02 May 03 @	0645		Assumed pt care @ this time no c/o's @ this time V/S nuero i/s wnl dressings to Abdomen CDI c no S/S of infection: pts bowl sounds active x4 quadrents. will continue to monitor (b)(6)-2
2 May 03 @	2030		Concur c above corpsman assessment. Continue to monitor. (b)(6)-2

*U.S. GOVERNMENT PRINTING OFFICE: 1985 0 – 461 –275 (20038)

NURSING NOTES
Standard Form 510
(Reverse)

MEDCOM - 5864

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
28APR03	0950		Assumed pt care @ 0730. Pt is resting with no complaints. VSS. will continue to monitor. —— (b)(6)-2
			Concur c above note. Abd dsg C/D/I & changed
	1100		by wound care team. no c/o pain noted.
			VS Q shift, eating well & ambulates c assistance.
			(b)(6)-2 [illegible]
28 April 03		2300	Pt is lying on bed. No c/o any pain or discomfort @ this time. Pt's wound on his abdomen is covered c gauze dressing CDI not drainage or s/s of infection was noted @ this time. —— (b)(6)-2
28APR03		2330	Pt's dsg D/C @ 2100. Site is beefy red. Agree c above corpsman note & assessment —— (b)(6)-2 [illegible]
29 APR 03 0850			assumed care of pt - Pt resting comfortably in bed. No complaints of pain. VSS, AF. Large tape and gauze dressing to midline abdomen, CDI. Will continue to monitor. —— (b)(6)-2 [illegible]
29 April 03		1930	Assumed pt care. Pt is lying on bed. Pt did not c/o pain or any other complications. Dressing change to midline abd ~~dressing~~ wound was done. Dressing now CDI. No other AS were noted or stated by Pt. @ this time. —— (b)(6)-2
29APR03		2300	Agree c above corpsman note & assessment —— (b)(6)-2 [illegible]

(b)(6)-4

*U.S. GOVERNMENT PRINTING OFFICE. 1985 0 – 461 –275 (20038)

NURSING NOTES
Standard Form 510
(Reverse)

MEDCOM - 5865

CLINICAL RECORD	NURSING NOTES *(Sign all notes)*

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
3 May 03	@	1950	Assumed pt care @ this time Pt has no c/os V/C nvero √s wm Will Continue to monitor ——— HN USN (b)(6)-2
03 May 03 @ 2030			Pt dsg is done. Wound pink/red c̄ yellow exudate. (b)(6)-2
			W-D dsg applied ——— ENS NC

Continue on reverse side

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

MEDCOM - 5866

CLINICAL RECORD		NURSING NOTES (*Sign all notes*)
DATE	**HOUR** A.M. P.M.	**OBSERVATIONS** Include medication and treatment when indicated
26APR03	2300	ASSUMED PT CARE. PT IS CURRENTLY RESTING COMFORTABLY. PT IS AAOX3 ØMSA'S, WDWN, VS NOTED + STABLE. HEART SOUNDS $S_1 S_2$ Ø GALLOPS, Ø MURMURS. LUNG SOUNDS CTA BILAT Ø WHEEZING, Ø RHONCHI. PT HAS DRSG ON MID ABDOMEN C/D/I. ALSO DRSG TO (R) FLANK C/D/I. PT HAS Ø COMPLAINTS AT THIS TIME. ALSO BOWEL SOUNDS PRESENT. WILL CONTINUE TO MONITOR + FOLLOW MD'S ORDERS —— HM3 (b)(6)-2
27APR03	0800	c assumed pt care @ 0715 pt is resting with Ø complaints. VSS. Lung sound cl (B). Mid-line abd dressing C/D/I. (R) flank dressing C/D/I. Will continue to monitor. —— (b)(6)-2
27APR03	2300	ASSUMED PT CARE. PT IS RESTING COMFORTABLY c̄ Ø COMPLAINTS. VS NOTED + STABLE. HEART SOUNDS $S_1 S_2$ Ø MURMURS, Ø GALLOPS. LUNG SOUNDS CTA BILAT. PT HAS MID-ABDOMEN DRESSING C/D/I. ALSO (R) FLANK DRSG C/D/I. WILL CONTINUE TO MONITOR + FOLLOW MD'S ORDERS — HM3 (b)(6)-2
	0325	Concurred c̄ above —— (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

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
4/25/03	0000		cont... Will reattempt to contact MO in AM. ——— (b)(6)-2 , CN3, NC
4/25/03		1830	ASSUMED PT CARE @ 1500. PT IS LYING ON BACK, RESTING BUT AROUSABLE, AOX3. VSS, COLD FEET, BUT ⊕ PULSE, CAP REFILL < 3 SECS. ABD SOFT, DRESSING HAS MIN AMOUNT ^serous OF DRAINAGE, 1 JP DRAIN. ~~DID BM TODAY @ 1700.~~ PT IS AMBULATORY W) MINIMUM ASSISTANCE, WENT TO BATHROOM FOR BM. Ø C/O PAIN @ THIS TIME. (b)(6)-2 ~~VSS~~ WILL CONTINUE TO MONITOR ——— (b)(6)-2
4/25/03		2015	Concur c̄ above note. ~~Pt~~ ~~nephrostomy~~ percutaneous tube also in place dmg yellow ~~urine~~ fluid. Drain care done, also to JP site & redressed. No c/o pain. Eating well ——— (b)(6)-2 LCDR
4.25-03		2400	Assumed care of pt. No complaint of pain. All drsg. on abd. CDI. JP drain Ⓡ side of abd. Intact draining small amount of serous fluid. Nephrostomy Intact & empty. VS taken BP 140/82, PR 96, SpO2 95% T 98.8, R 20. Lung clear, Abd. slightly distended. pulse good all ext. (<3 secs) cap refill. Pt. is in good cond. Will cont. to monitor (b)(6)-2
4/26/03		2110	Pt is alert. DR (b)(6)-2 in & removed percutaneous drain & JP drain. Sites both dressed. Pt did shower this pm & all wounds redressed. Pt tolerated well. Good appetite & voiding s̄ difficulty. No c/o pain noted ——— (b)(6)-2 LCDR

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

NURSING NOTES
standard Form 510
(Reverse)

MEDCOM - 5868

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
4/11/03	0600		Assumed care @ 2400. A&O x3. VSS. Dressings midline abd c/d/i. c/o of pain, MS04 given. Ambulated to BR earlier had BM. Pt resting comfortably at this time. Will continue to monitor. —— (b)(6)-2 ENS, NC
4/11/03	0900		Pt voiding dark, tea colored urine —— (b)(6)-2 SN, NC
4/12/03	0330		ASSUMED CARE OF PT. A/O x3. Δ IV SITE TO (A) HAND. ABD DRESSING C/D/I. PT C/O MINOR ABD PX. GIVEN PX MEDS WITH Ø FURTHER COMPLAINT. WILL CONTINUE TO MONITOR. (b)(6)-2 HN (b)(6)-2

★U.S. GOVERNMENT PRINTING OFFICE: 1985 0 – 461 –275 (20038)

NURSING NOTES
Standard Form 510
(Reverse)

MEDCOM - 5869

NURSING ADMISSION NOTE

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

DATE | HOURS A.M. | HOURS P.M. | OBSERVATIONS Include medication and treatment when indicated SERVICE:

ADMITTED TO: EFWD FROM: CasRec TIME ARRIVED: 1510 AGE: SEX: M

DX: s/p ex-lap for GSW DUE TO:

PAST MEDICAL HX: abd CA c mets to lungs

MEDICATIONS: surfak DISPOSITION:

ALLERGIES: VALUABLES: DISPOSITION:

VS: B/P 160/96 T: 99.1 P: 100 R: 26 HT: WT:

GENERAL APPEARANCE: elderly gentlemen in NAD

EENT: no drainage noted

NEUROLOGICAL: alert, attempts to communicate in Arabic & c sign language

RESPIRATORY: O2 2L O2sat 96%, wheezes and crackles in bases

CIRCULATORY: H=RRR

URINARY: voiding spontaneously

GI: abd. very distended, BS x 4 hypoactive, midline dsg. c gauze & tape, CDI

MUSCULO/SKELETAL: weakness to R hand, grip weak and unable to straighten wrist

SKIN INTEGRITY: no other skin breakdown noted

COPING: talking c reassurance

SUMMARY AND PLAN OF CARE: Will cont. to

girth. Encouraged coughing and deep breathing.

EMS (b)(6)-2

SIGNATURE: (b)(6)-2 DATE: 4/10 TIME: 1640

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-&October 1975
510-109

MEDCOM - 5870

(b)(6)-4

MEDICAL RECORD | **DOCTOR'S ORDERS** *(Sign all orders)*

DATE AND TIME START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
			5-Forward(s)		(b)(6)-2
10 Apr 03		✓	Admit to ward - s/p x-lap for GSW		
1400		✓	VS q4h		
		✓	IVF at 1.5		
		✓	Diet as desired		
		→	D5 1/4NS +20 mEq KCl/1.1L at 75 cc/hr		
		✓	Morphine sulfate 3-5 mg IV q3h prn pain		
		→	Sor Sak 1 po qd		
		✓	C-spine series done	(b)(6)-2	
		✓	Percocet 1-2 tab po q6h prn		
		✓	Nasal O2 2-3L/min nasal cannula		
				(b)(6)-2	
			NC 4/10/03	(b)(6)-2	
4/10/03			T.O. D/C NC	(b)(6)-2	(b)(6)-2
1900			X 1 UF To D5 1/2NS @ 20 KCL		(b)(6)-2
				(b)(6)-2 (b)(6)-2 (b)(6)-2	D/C NC
					(b)(6)-2
10 APR 03	1130	①	CXR in AM - ordered in CHCS	(b)(6)-2	(b)(6)-2
4/11/03	2150			(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)-2 NC @ 0630 | WARD NO.

4/11/03 24 chart verification COR (b)(6)-4

DOCTOR'S ORDERS

STANDARD FORM 508 (Rev. 10-75)
Prescribed by GSA and ICMR
FPMR 101-11. 806-8
508-110

MEDCOM - 5871

(b)(6)-4

Pre-flight checklist for medevac patients staged in CasRec

- ☐ Identification (ID/Band)
- ☐ Personal Effects – including hygiene and ADL supplies, ***valuables envelope***
- ☐ Medications – as derived from the discharge orders(___ day supply)
- ☐ Records (DC order, SF539 and Narrative Summary completed and signed, MAR updated)
- ☐ X-rays, CT scans, imaging studies –hardcopies
- ☐ Consumables (dressing change supplies, splints, O2/respiratory supplies, etc.)
- ☐ Flotation gear/hearing protection ???
- ☐ Handcuffs in place as appropriate

belongings
2.5 lbs.

1/2

PATIENT PROFILE

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

	ACTIVITY	DATE		BATH	DATE	DIET	DATE		VITAL SIGNS	FREQ		SPECIAL NOTES
	Bedrest			eed bath		NPO			Temp			Dentures
	Bathroom Privileges			Shower		As dc'd 4/20			Pulse			Speech Impediment
	Up In chair			Tub					Resp	q1°		Language barrier
✓	Ambulate	4/19		Needs assistance					B/P			Pronhotic device
	Commode								Other SATS			Visual Impairment
	Needs assistance											Blind
	Restricted to unit											Contact lenses
	Hospital Privileges			ORAL HYGIENE	DATE							Glasses
4/17 ✓	Other HOB ↑ 30°			Self		FEEDING	DATE		FLUIDS			Hearing defect
				Needs assistance		Self			Forced to:			Other
				Special		Needs assistance			Restricted to:			
						Gavage	4/19		I & O			

DATE ORD.	DATE RENEW	TREATMENTS/SPECIAL NOTES	TIMES	DATE ORD.	DATE RENEW	TREATMENTS/SPECIAL NOTES	TIMES
4/17		TEDS / SCDS			?	20G : RA	
4/18		incentive spirometer			4/20	16G : LA	
4/17		foley					
4/18		O2 at 2L NC O2 sat <90		4/18		D5 1/2 NS @ 125 cc/hr	
				4/19		Record urine output q 4°	
4/17		JP x2 - RECORD OUTPUT Q SHIFT (KEEP CHARGED)		4/19		Record output from JP q shift, record	
4/17		Δ MIDLINE DSG (saline) QD (W→D) @ 1000		4/20		Encourage Ambulation	
						PRN	
CALL MO FOR: T >101.5 or <98, HUOP < 0.5 cc/kg MAP <60 or SBP >200 or DBP >110						PROTOCOLS	

ADDRESSOGRAPH

(b)(6)-4

ICU2

(b)(6)-4

DIAGNOSIS

EXPLAP AND WASH-OUT 4/17
BILIOUS ASCITES

OP/SPECIAL PROCEDURES

ADMITTING MO:

(b)(6)-2

FINDINGS:

AGE	HEIGHT	WEIGHT
~50	64"	~70 KG

PATIENT CLASSIFICATION

	DATE ON	DATE OFF
SI	4/17	
VSI		
RELIGIOUS RITES		

Rack 33

MEDCOM - 5873

ALLERGIE

NKDA

DATE ORD.	DATE RENEW	MEDICATIONS	TIME (HOURS TO BE GIVEN)	DATE OF ORDER	LABORATORY/DIAGNOSTIC TESTS EXAMINATIONS/ CONSULTATIONS	DATE SENT	DATE COMP
4/18		Heparin 5000 u SQ BID	09-21	4/17	PCXR ☒		
4/18		Zantac 50 mg IV Q 8°		4/18	CBC, chem 7, mg Ca PO4 in AM	4/19	☒ 4/21
				4/21	AAS		
				4/21	U/S ABD		
				4/21	CT SCAN done		
4/18		Tylenol 650 mgs supp PR Q 6° prn temp > 102			ROUTINE LABS		
4/18		MSO4 2-6 mg IV Q 1° prn pain		QAM	CBC, chem 7		

ADDRESSOGRAPH

(b)(3)-1

Name: .

CHCS Name: (b)(6)-4

(b)(6)-4 Iraqi civilian

Prognosis: Good

Date of Admission: 411012003

Date of Transfer:

History:

GSW to abdomen. X-lap and oversew of small and large bowel injuries. Peritoneal implants suggestive of cancer or granulomatous disease noted. Transferred here, tolerating diet. **Hx** of COPD;

Hospital Course:

Poor appetite led to CT scan and above procedures. Once drained, eating and feeling well. Subhepatic drain pulled 25 Apr., Other drains pulled 27 Apr. Remains afebrile and eating well. 2 portions of midline wound are necrotic and may eventually break down causeing a hernia or dehiscence.

Diagnoses:

slp GSWto abdomen;; Bilious ascites;

Surgeries/Treatmen

EGD neg. Colonoscopy showed inflammation at GSW site, hepatic flexure.; X-lap(17Apr) for washout and drainage (JPx2; in right gutter and subhepatic region) of loculated bilous ascites. Dense adhesions precluding complete exam. No active leak or source of leak noted. No peritoneal nodules noted.; Percutaneous drain placement right subphrenic space for drainage of collection of bile.(21Ap).

Recommendations:

Local wound care to midline abdominal incision;

SpecialNeeds:

Physician:

b)(6)-2 LCDR Dept of General Surgery 5/3/2003

TRANSFER TO WARD ORD
(Circle appropriate order)

1. Admit to ward on DATE/TIME 18 Apr
2. **Admitting physician** (b)(6)-2
3. **Diagnosis:** Bilious ascites
4. **Procedures:** X-lap washout
5. **Condition:** (SD) **VSL** STABLE
6. **Allergies:** wl <,)A–
7. **Isolation:** (Standard) All paiients
   Contact MRSA, Viral hemorrhagic fevers
8. **Nursing:**
   Vital Signs (BP, Pulse, Temp,) every 4 hours
   Temp >101.5 or <98
   Call MD **Hourly Urine Output < 0.5 cc/kg**
   MAP < 60 or SBP >200 or DBP >110
   Weight QD
   ~~Neuro checks~~
   Teds/SCDS
   Foley to gravity
   ~~NG to LIS~~
   ~~Chest tube to -20cm H20 pleurovac~~
   Head of Bed elevated to 30 degrees
   ~~C-spine collar and lin~~
   Incentive Spirometry 10reps q
9. **Diet: NPO**
   (Clear liquids) – do not push
   Regular
   Advance as tolerated
10. **Activity:** Bed rest
    (Out of bed with assistance)
    Ad Lib
12. **IVF:** LR at ____cc/hr **or** D5 1/2 NS at 125 cc/hr. ~~Or Heparin Lock~~

(b)(6)-2

(b)(6)-2 4-18-03 1430

(b)(3)-1 , Dat Imission: 4/10/2003

CHCS Nan. (b)(6)-4 Date ansfer:

(b)(6)-4 EPW Age: Gender: M

History:
GSW to abdomen. X-lap and oversew of small and large bowel injuries. Peritoneal implants suggestive of cancer or granulomatous disease noted. Transferred here, tolerating diet. Hx of COPD;

Hospital Course:
Poor appetite led to CT scan and above procedures. Once drained, eating and feeling well.

Diaanoses:
s/p GSWto abdomen;, Bilious ascites,

Surgeries/Treatment:
EGD neg. Colonoscopy showed inflammation at GSW site, hepatic flexure. X-lap(17Apr) for washout and drainage of loculated bilous ascites. Dense adhesions precluding complete exam. No leak noted., Percutaneous drain placement right
subphrenic space for drainage of collection of bile.(21Ap).,

Recommendations:
Local wound care to midline abdominal incision; Drains out any day

Special Needs:

Prognosis: Good

Physician: (b)(6)-2 LCDR Dept of General Surgery 4/24/2003

(b)(3)-1

(b)(3)-1

Level II

4 F S

Lift of Opportunity Application

Last, First, & Middle Name: (b)(6)-4

Social Security/Pseudo SSN:

(b)(6)-4 (b)(6)-4

Name of escort accompanying applicant:

Rank/Rate	Service Branch	Civilian Status	Birth date	Gender	Religion
	EPW				

Complete Name & Address of Command/Unit

Homeport Location

Next of Kin's Name & Complete Address

Relationship of NOK

Next of Kin's Phone Number

Printed name & title of attending physician authorizing patient to return to duty or other specified location: (b)(6)-2

Signature of attending physician listed above: (b)(6)-2

*Attending physician's signature is **REQUIRED** in order to arrange transportation!*

Printed name of MED HOLD Coordinator (if applicable): _____

Signature of MED HOLD Coordinator listed above: _____

☺ *Patient Administration Use ONLY* ☺

N/A

Date chit received: _____

Initial the following once completed:

Date & Time of departure: _____

_____ PT discharged from CHCS

_____ Changes reflected on board and in the blue book

MEDCOM - 5878

11. Labs:

~~QAM~~ : (CBC) ~~Chem 7~~ ABG

LFTs Amylase/Lipase

PT/PTT (Mg/Ca/PO4)

13. Radiology: ______

14. Oxygen: 2 nasal canula for O_2 sat < 90

(b)(6)-2

15. Meds: Ancef 1gm IVPB Q8hrs x 6 doses total

Vancomycin 1gm IV Q12hrs (if PCN allergic) x 4 doses total

Mefoxin 1gm IV Q8hrs x 6 doses total

(Heparin 5000 units SQ BID)

Prilosec slurrey 40mg NG/po QD or (Zantac 50 mg IV q 8 hrs)

PRN: (Morphine sulfate 2-6mg IV Q 1hr prn pain)

'Ativan 1-2mg IV Q 1hr pm agitation

(Tylenol 650mg supp pr Q6hr prn Temp >101)

Benadryi 25 rng IV/P0 Q 4hrs PRN itch

Phenergan 12.5mg to 25mg P0/IV Q4hrs PRN nausea

Vistaril 12.5mg 25mg PO Q4hrs PRN nausea

16. MISC.

Change midline dressing qd, saline wet to dry

(b)(6)-2

(b)(6)-2

4-18-03

13. **Labs:**

On admission to ICU: CBC, Chem7, Chem 20, ABG, PT/PTT, Type/Cross **or** Type /Hold units

QAM : CBC	Chem 7	ABG (b)(6)-2
LFTs	Amylase/Lipase	
PT/PTT	Mg/Ca/PO4	

14. **Oxygen:** Titrate to SpO2 93-97% using nasal cannula, face mask prn (b)(6)-2

Ventilator protocol

15. **Meds:** Ancef 1gm IVPB Q8hrs x 6 doses

Vancomycin 1gm IV Q12hrs (if PCN allergic) x 4 doses

~~Mefoxin 1gm IV Q8hrs x 6 doses~~ (b)(6)-2

Heparin 5000 units SQ BID (b)(6)-2

Prilosec 40mg slurry NG/po QD or Zantac 50mg IV q 8 (b)(6)-2

PRN: ~~Morphine sulfate 2-6mg IV Q 1hr prn pain~~ see fasting order

Ativan 1-2mg IV Q 1hr prn agitation

Tylenol 650mg supp pr Q6hr prn Temp >101

Benadryl 25 mg IV/P0 Q 4hrs PRN itch

Phenergan 12.5mg to 25mg P0/IV Q4hrs PRN nausea

Vistaril 12.5mg 25mg PO Q4hrs PRN nausea

Jaled

16. **MISC.** J-P to bulb. Keep charged & record output q shift (b)(6)-2

Change midline dressing qd, u-TD (b)(6)-2

(b)(6)-2

(b)(6)-2

Protocols

Burn	Electrolyte
Insulin IV drip	Insulin Subcutaneous sliding scale
Heparin IV drip	Enteral Feeding

(b)(6)-4

ICU 2

(b)(6)-4

MEDCOM - 5880

ICU ADMISSION ORDER!:
(Circle appropriate order)

1. **Admit to ICU: Date/Time** 17 Apr
2. Admitting physician [redacted]
3. Diagnosis: Biliary ascites
4. Procedures: X-lap and washout
5. Condition: SL VSL
6. Allergies: [redacted]
7. **Isolation:** Standard — All patients
   - Airborne — Small pox, Measles, Varicella, Pulmonary tuberculosis, unknown.
   - Droplet — Pneumonic plague. Meningococcus, Influenza
   - Contact — MRSA, Viral hemorrhagic fevers

Vital S (BP, Pulse, Temp, SAO_2,) every hour
Call MD **Temp >101.5 or <98**
Hourly Urine Output < 0.5 cc/kg
MAP < 60 or SBP >200 or **DBP >110**

Neuro checks

Weight QD

Teds/SCDS

Foley to gravity

NG to LIS

Chest tube to -20cm H20 pleurovac

Head of Bed elevated to 30 degrees

C-spine collar and log roll

Incentive Spirometry 10reps QIhr

Faxed

9. **Diet:** NPO
   - Clear liquids
   - Regular
   - Advance as tolerated

10. **Activity:** Bed rest

11. ~~IVF: LR at~~ ~~cc/hr~~ or D5½NS at 125 cc/hr. HCK.
    ½NS at 125 cc/h

12. Radiology: CXR on admission and QAM (while Intubated)

ICU

[redacted]

MEDCOM - 5881

FREQ. VITAL SIGNS

TIME																		
BP																		
HR																		
RR																		
TEMP																		
SAO_2																		

Notes: _____

INPUT/OUTPUT

INPUT	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

MEDCOM - 5882

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																									300	
UOP					X1																					
BM					X1																					

PREVIOUS 24 HOUR INPUT_____ PREVIOUS 24 HOUR OUTPUT_____ PREVIOUS WEIGHT_____

PRESENT 24 HOUR INPUT_____ PRESENT 24 HOUR OUTPUT_____ PRESENT WEIGHT_____

DOD 13094

Name: (b)(6)-4

NURSING [illegible] SHEET
MEDTREFAC 65 [illegible] Temp Form

Date: 17 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		V																						
100																								
80		A																						
60																								
40																								
RR		22																						
TEMP		98.0																						
SAO2		89																						
MAP																								
O2 Mode																								
pulse		94																						

IFF / [illegible]

DRIP / DOSE

Name: (b)(6)-4

NURSING SHEET
MEDTREFAC 6550/12/Temp Form

Date: 18APR- 19APR

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	32	30	30	28	36	28	34	20										16		32			38	28
TEMP	100.1	100.6	99.2	99.4	97.5	100.8	100.1	99.1										99.4					97.9	99.1
SAO2	89	88	90	90	90	92	88											94%					95%	95%
MAP	91	85	70	87	85	92	90																	
O2 Mode	RA	RA	RA	RA	RA	RA	RA																RA	

JFF

HR

DRIP / DOSE

FREQ. VITAL SIGNS

TIME															
BP															
HR															
RR															
TEMP															
SAO2															

Notes:

INPUT/OUTPUT

I	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																										
R	150	150	150	D/C'd																						
Vanc		100																								
Foxin			100																							
Norm Sal				125	125	125																				
[illegible] Sulfa				100	~~100~~																					

MEDCOM - 5885

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	102	100	70	150	90	200	32											800								
UOP																										
BM																										
JP#1			60cc	40cc																						
JP#2			10cc	10cc																						

PREVIOUS 24 HOUR INPUT 2200 PREVIOUS 24 HOUR OUTPUT 1641 PREVIOUS WEIGHT ______

PRESENT 24 HOUR INPUT ______ PRESENT 24 HOUR OUTPUT ______ PRESENT WEIGHT ______

FREQ. VITAL SIGNS

TIME																	
BP																	
HR																	
RR																	
TEMP																	
SAO_2																	

Notes: _____

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	TOTAL
O											CAT															
VPB														1000						1000						

MEDCOM - 5886

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																							960			
UOP								150							700			800								
BM																										
JP1								5																	20	
JP2								5																	30	

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
MEDTREFAC 65 [illegible] Temp Form

Date: 19 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	32		33								30				20			20						
TEMP	97.4		98.1								96.9				99.2			100.3						
SAO2	92		94	95							95	96%	96%		95			95						
MAP												96O2	96O2											
O2 Mode																								

DRIP / DOSE

FREQ. VITAL SIGNS

TIME																	
BP																	
HR																	
RR																	
TEMP																	
SAO_2																	

Notes:

INPUT/OUTPUT

MEDCOM - 5888

	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
B																										

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		50																								
UOP		~~150~~						150		X1											250		160			
BM			X1					X1		X1																
JP1				100											200											
JP2															200											

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] SHEET
MEDTREAC-65 [redacted] 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		26							28								42				28		20	
TEMP		99.2							99.9								102.0-100.1				99.1	97.6	97.9	
SAO2		96							96								93%		95%	96%	99%	[illegible]	98%	
MAP																								
O2 Mode																								

DRIP / DOSE

MEDCOM - 5889

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
O											1000												120			
VPB										1000																

1922

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						300									800	150		520	280			1200	100		590	
BM			X1			X1																				
JP1									10					SAM									3			
JP2									5					SAM									5			
Bile Drain																		600cc				200cc				

PREVIOUS 24 HOUR INPUT_____ PREVIOUS 24 HOUR OUTPUT_____ PREVIOUS WEIGHT_____

PRESENT 24 HR INPUT_____ PRESENT 24 HOUR OUTPUT_____ PRESENT WEIGHT_____

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

NURSING [redacted] SHEET
MEDTREFAC 65[redacted] Temp Form

Date: 21 APR 93

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				26												30				28		
TEMP		98.7				98.2												98.8				99.8		
SAO2		96				95												95				96		
MAP																								
O2 Mode																								

IFF

DRIP / DOSE

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											120															
IVPB															500											

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	300			350																500		300		380		
BM																										
JP1				0												3cc										
JP3				0												SCANT										
#3	50			65																						

(b)(6)-2

PREVIOUS 24 HOUR INPUT_____ PREVIOUS 24 HOUR OUTPUT_____ PREVIOUS WEIGHT_____

PRESENT 24 HR INPUT_____ P _____

(b)(6)-2

NURSING [illegible] SHEET
MEDTREFAC-65[illegible]/Temp Form

Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03
200																					
180																					
160																					
140																					
120																					
100																					
80																					
60																					
40																					
RR		26								30								28			
TEMP		99.7								99.5				99.1				100.4			99.3
SAO2		97								97%								92			
MAP																		RA			
O2 Mode																					

IFF

DRIP / DOSE

FREQ. VITAL SIGNS

IMT																		
PD																		
ER																		
ER																		
EMT																		
AO7																		

Notes

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
											480			240												
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	TOTA
LE														(b)(6)-2												
OP																						200				
M												X														
JD1																	5cc									
JD2																	10cc									

PREVIOUS 24 HOUR INPUT_____ PREVIOUS 24 HOUR OUTPUT_____ PREVIOUS WEIGHT_____

PRESENT 24 HOUR INPUT_____ PR[redacted]_____

Name: (b)(6)-4

URSING [redacted] SHEET
EDTREFAC-65[redacted]/Temp Form

Apr 23

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																		29						
TEMP																		99.3						
SAO2																		97						
MAP																								
O2 Mode																								

IFF

DRIP / DOSE

FREQ. VITAL SIGNS

IM																	
P																	
R																	
R																	
EM																	
AO																	

Notes

INPUT/OUTPUT

MEDCOM - 5896

	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
										240																
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	TOTAL
OLE																										
OP	200																							700		
M																										
JP1																										
JP2																										
Drain																								0		

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] SHEET

MEDTREFAC-65[redacted] Temp Form

Date: [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
200																								
180																								
160																								
140																								
120																								
100																								
80																								
60																								
40																								
RR		22								24								22						
TEMP		99.3								97.1								98.8						
SAO2		94								99%								94%						
MAP																								
O2 Mode																								

IFF

DRIP

OSE

Name: (b)(6)-4

NURSING [redacted] SHEET
MEDTREFAC-65[redacted] Temp Form

Date: 15 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
FF / PULSE 200																								
180																								
160																								
140																								
120																								
IR 100																								
80																								
60																								
40																								
RR																	16							
TEMP																	98.6							
SAO2																	96							
MAP																	82							
O2 Mode																								
RA																								
																	136/80							
DRIP / DOSE																								

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																										

Pt Ambulates to BR

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	x1																									
												25														
BM																										

PREVIOUS 24 HOUR INPUT_____ PREVIOUS 24 HOUR OUTPUT_____ PREVIOUS WEIGHT_____

PRESENT 24 HOUR INPUT_____ PRESENT 24 HOUR OUTPUT_____ PRESENT WEIGHT_____

MEDCOM - 5899

DOD 13111

Name: (b)(6)-4

NURSING SHEET
MEDTREFAC-65 (Temp) Form

Date: 14APR03

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
JFF 200																								
180																								
160																								
140																								
120		✓																						
HR 100									✓															
80		^																						
60									^															
40																								
RR		20							20															
TEMP		98.8							97.8															
SAO2		99																						
MAP																								
O2 Mode																								
PULSE		99							90															
DRIP / DOSE																								

EDCOM - 5900

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	TOTAL
FOLEY																										
UOP		x1				125																				
BM		Ø																								

PREVIOUS 24 HOUR INPUT_____ **PREVIOUS 24 HOUR OUTPUT**_____ **PREVIOUS WEIGHT**_____

PRESENT 24 HOUR INPUT_____ **PRESENT 24 HOUR OUTPUT**_____ **PRESENT WEIGHT**_____

MEDCOM - 5901

Name: ____________________

NURSING [redacted] SHEET

MEDTREFAC [redacted] 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		v																						
100																								
80		^																						
60																								
40																								
RR		24								20														
TEMP		96.1								98.5														
SAO2		89								91														
MAP																								
O2 Mode																								
Pulse		101								108														

DRIP/DOSE

Name: (b)(6)-4

NURSING [redacted] SHEET
MEDTREFAC-65[redacted]/Temp Form

Date: 06 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																	16							
TEMP																	99.5							
SAO2																	96							
MAP																								
O2 Mode																								
BP																	111/65							

DOSE

Name: (b)(6)-4

NURSING FLOW SHEET
MEDTREFAC 6550/12/Temp Form

Q 4

Date: 12 APR 08

CUFF

AL

DRIP / DOSE

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				RO						12														
TEMP				97.7						98.0														
SAO2				96%			95			95%														
MAP																								
O2 Mode				RA			RA																	

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		240					240																			
IVPB	100	100	100	100	D/C																					

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																										
UOP			300				700							1900				150								
BM																										

PREVIOUS 24 HOUR INPUT_____ PREVIOUS 24 HOUR OUTPUT_____ PREVIOUS WEIGHT_____

PRESENT 24 HOUR INPUT_____ PRESENT 24 HOUR OUTPUT_____ PRESENT WEIGHT_____

MEDCOM - 5905

DOD 13117

Name: (b)(6)-4

NURSING [redacted] SHEET
MEDTREFAC-655[redacted]/Temp Form

Date: 19 Apr 05

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																		V						
140																								
120																								
100																		N						
80																		T						
60																								
40																		20						
RR																		995						
TEMP																		96						
SAO2																								
MAP																		135/90						
O2 Mode																								
RA																								

HR

DRIP / DOSE

MEDCOM - 5906

(b)(6)-2

Name:

NURSING FLOW SHEET
MEDTREFAC 6550/12/Temp Form

Date: 13APR03

CUFF

AL

DRIP / DOSE

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		o																						
80																		↑						
60		↑																						
40																								
RR		18																16						
TEMP		97.7																98.7						
SAO2																								
MAP																								
O2 Mode																								

Name: (b)(6)-4

NURSING FLOW SHEET
MEDTREFAC 6553/12/Temp Form

Date: 10 APR03

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
CUFF 200																								
180																								
AL 160									↓															
140																				↓				
120																								
100									•															
80																				↑				
60																								
40																								
RR									20											22				
TEMP									98.7											98.6				
SAO2									94											95				
MAP																								
O2 Mode									2LNC															
																				138/90				
DRIP/DOSE																								

Name: (b)(6)-4

NURSING [illegible] SHEET
MEDTREFAC 65[illegible] Temp Form

Date: 17 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																	16							
TEMP																	98.3							
SAO2																	88							
MAP																								
O2 Mode																								
BP																	116/70							

FF / [illegible] / IR

DRIP / DOSE

Name: (b)(6)-4

NURSING SHEET

MEDTREFAC 65 Temp Form

Date: 16APR03

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		16							16															
TEMP		98.1							98.6															
SAO2		89							93															
MAP																								
O2 Mode									10L/T															
PULSE		89							89															

JFF / T T T ● HD

DRIP / DOSE

MEDCOM - 5910

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						Ø																				

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						700																				
BM						Ø																				

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
MEDTREFAC-63[illegible] 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													V											
100		P																					V	
80		1																						
60													^										^	
40																								
RR		20											16										19	
TEMP		98.4											99.4											
SAO2																								
MAP																								
O2 Mode																								

DRIP / DOSE

Name: (b)(6)-4

NURSING [illegible] SHEET
MEDTREPAC [illegible] Temp Form

Date: 30 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		X											V											
100	*	●																						
80		O																						
60		△																						
40													A											
RR		19											16											
TEMP		999											99.0											
SAO2																								
MAP																								
O2 Mode																								

DRIP / DOSE

Name: (b)(6)-4

NURSING [redacted] SHEET
MEDTREFAC-65[redacted] Temp Form

Date: APR 24

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		V											V											
80													•											
60		^											^											
40																								
RR		20											20											
TEMP		98.8											99.5											
SAO2		99											97											
MAP																								
O2 Mode																								
BP		110/70											118/60											

DRIP / DOSE

NURSING SHEET
MEDTREFAC Temp Form

Date: 30 APR 03

(b)(6)-4

MEDCOM - 5915

Name: (b)(6)-4

NURSING [illegible] SHEET
MEDTREFAC-65[illegible]/Temp Form

Date: 27 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
200																							
180																							
160																							
140																							
120		↓								↓								↓					
100		•																•					
80																							
60		∧								∧								∧					
40																							
RR		16																18					
TEMP		99.4								98.4								99.6					
SAO2																		93%					
MAP																							
O2 Mode																							

DRIP / DOSE

Name: (b)(6)-4

NURSING ... SHEET
MEDTREFAC-65... /Temp Form

Date: 26 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		20															14							
TEMP		97.8							98.2								98.1							
SAO2		95															95%							
MAP																	—							
O2 Mode																	RA							

IFF

DRIP / DOSE

MEDCOM - 5917

FREQ. VITAL SIGNS

ME																	
MP																	
O2																	

es:

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
B									200		100	200				100										

T	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
LEY																										
P											300					200				400						

EVIOUS 24 HOUR INPUT_____ PREVIOUS 24 HOUR OUTPUT_____ PREVIOUS WEIGHT_____

ESENT 24 HOUR INPUT_____ PRESENT 24 HOUR OUTPUT_____ PRESENT WEIGHT_____

MEDCOM - 5918

DOD 13130

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

NURSING [redacted] SHEET
MEDTREFAC-65[redacted]/Temp Form

Date: 25 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			22							24								20				18		
TEMP			98.1							98.8								98.8				97.6		
SAO2			95															95				95		
MAP																								
O2 Mode																								

IFF

DRIP / DOSE

FREQ. VITAL SIGNS

E																											
P																											
2.																											

S:

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
															200										

	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
EY									100							150	100							500		
																	100							1000		

VIOUS 24 HOUR INPUT_____ PREVIOUS 24 HOUR OUTPUT_____ PREVIOUS WEIGHT_____

SENT 24 HOUR INPUT_____ PRESENT 24 HOUR OUTPUT_____ PRESENT WEIGHT_____

MEDCOM - 5920

ED 6550/8 (REV. 4-74) S/N 0105-Lt.216-5581

MEDICAL RECORD | **MEDICATION ADMINISTRATION RECORD**

SCHEDULED DRUGS — MONTH _____ 19 03 — DATES GIVEN

ORDER DATE	MEDICATION-DOSAGE-FREQUENCY ROUTE OF ADMINISTRATION	HOURS	4/10	4/11	4/12	4/13	4/14	4/15	4/16
4/10	Ampicillin 1 PO QID	0900	X	(b)(6)-2				DC 4/14/03	(b)(6)-2
4/11	~~Azithromycin 500 mg PO now (see back) then 250 mg po qd x 4 days~~								
4/11	Azithromycin 250 mg PO qd x 4 days	0900			(b)(6)-2		(b)(6)-2		X

INITIAL CODE

INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE
(b)(6)-2	(b)(6)-2 EMS, MC	(b)(6)-2	(b)(6)-2 (b)(6)-2		

(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

~~Rack #48~~ Rack #2 Rack #1

MEDCOM - 5921

MEDICATION ADMINISTRATION RECORD (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
4/11 Azithromycin 500	4/12	0320	(b)(6)-2				
mg po x 1 Now							
4/11 0.5 mL (H) Td							
once							
4/11 Dulcolax x1 Now po	4/12	0327	(b)(6)-2				

PRN AND VARIABLE DOSE MEDICATIONS

ORDER DATE	MEDICATION-DOSAGE FREQUENCY ROUTE OF ADMINISTRATION	DOSES GIVEN																
4/10	MSO4 3-5mg	DATE	4/10	4/11	4/12													
	IVP Q 30	TIME	2125	0250	0215													
	prn pain	DOSE	3mg	4mg	5													
		INIT.	(b)(6)-2															
4/10	Percocet	DATE	4/10	4/11	4/11	4/11	4/13											
	i-ii po	TIME	1620	0710	1210	2030	1220											
	Q3° prn	DOSE	1/ii	2	2	2	2											
		INIT.	(b)(6)-2															
4/12	Tylenol 650mg	DATE																
	PO q 4° PRN	TIME																
		DOSE																
		INIT.																
		DATE																
		TIME																
		DOSE																
		INIT.																
		DATE																
		TIME																
		DOSE																
		INIT.																
		DATE																
		TIME																
		DOSE																
		INIT.																
		DATE																
		TIME																
		DOSE																
		IN)-																

MEDCOM - 5922

G.P.O.: 1982-587-016/5409

ALLERGIES:

DATE ORD.	DATE RENEW	MEDICATIONS	TIME (HOURS TO BE GIVEN)	DATE OF ORDER	LABORATORY/DIAGNOSTIC TESTS EXAMINATIONS/ CONSULTATIONS	DATE SENT	DATE COMP
~~4/11~~		~~Azithromycin 500 mg po~~		4/10	C-Spine		4/10
				4/10	CXR in AM	4/11	
4/11		Azithromycin 250 mg	0900	4/11	~~AAS~~	4/11	
		po qd X 4 days		4/13	CBC, CMP in AM		
4/10		Surfak PO		~~4/15~~	~~RAI~~	4/15	
4/16		Heparin 5000U SQ BID	09/2100	4/15	Schedule CT of Abdomen w/contrast		
4/22		Tobramycin 320mg IVPB q d	1600	4/16	CBC, CMP Now		
4/22		Zantac 150 mg po BID	09-21	4/22	CT scan done 4/24	(b)(6)-2	
				4/22			
4/12		Tylenol 650 mg PO q4° PRN					
4/10		Phenergan 1-2 po q 3° prn					
4/10		MSO4 3-5 mg IVP q 3° prn					

ADDRESSOGRAPH

(b)(6)-4

MEDCOM 5923

PATIENT PROFILE

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

√	ACTIVITY	DATE	√	BATH	DATE	DIET	DATE	√	VITAL SIGNS	FREQ	√	SPECIAL NOTES
	Bedrest			Bed bath		NPO			Temp			Dentures
	Bathroom Privileges			Shower		4/20 DAT			Pulse	Q 4°		Speech impediment
	Up in chair			Tub		try yogurt			Resp			Language barrier
√	Ambulate ad lib			Needs assistance		Bread			B/P			Prosthetic device
	Commode					snacks in			Other 4/25			Visual impairment
	Needs assistance					between						Blind
	Restricted to unit											Contact lenses
	Hospital Privileges			ORAL HYGIENE	DATE							Glasses
	Other			Self		FEEDING	DATE		FLUIDS			Hearing defect
4/20	Aid + Encourage			Needs assistance		Self			Forced to:			Other
	Ambulation			Special		Needs assistance			Restricted to:			
						Gavage			I & O			

DATE ORD.	DATE RENEW	TREATMENTS/SPECIAL NOTES	TIMES	DATE ORD.	DATE RENEW	TREATMENTS/SPECIAL NOTES	TIMES
4/20		D/C Foley					
4/20		Record volume of all urine					
4/22		No IV access / Dc'd					
4/25		Dressing Δ BID					
4/25		LOO completed					
4/25		Dressing Supplies					
4/26		Pt may shower c̄ open wounds [illegible]					

Dr (b)(6)-2

ADDRESSOGRAPH

(b)(6)-4

(b)(6)-4

Rack 33

Rack # 5

DIAGNOSIS: S/P x-lap for GSW

AGE	HEIGHT	WEIGHT

PATIENT CLASSIFICATION

OP/SPECIAL PROCEDURES

FINDINGS:

	DATE ON	DATE OFF
SI		
VSI		
RELIGIOUS RITES		

MEDCOM - 5924

Standard Form 508

CLINICAL RECORD — DOCTOR'S ORDERS
(Sign all orders)

DATE AND TIME START	STOP	℞	DRUG ORDERS (Another brand of a generically equivalent product, identical in dosage form and content of active ingredient(s), may be administered UNLESS checked here)	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
20 Apr			May shower c̄ open abdomen		(b)(6)-2
1100			Redress after shower	(b)(6)-2	
			4/26/03 2115 (b)(6)-2	LCDR	
27	0115		24° ✓ complete	(b)(6)-2	[signature]
29APR03	0030		24° chart verification —	(b)(6)-2	EWS, NC
~~29APR03~~			~~Assumed care of pt. Pt resting comfortably in~~		
~~0850~~			~~bed. No c/o pain. VSS, AF. Large tape and~~		
			~~gauze dressing to midline abd — C/D/I.~~		
			~~Will continue to monitor.~~		(b)(6)-2
30APR03	0000		24° chart verification	(b)(6)-2	EWS, NC
01May03	0000		24° chart verification —	(b)(6)-2	[signature]
01MAY03	1500	(1)	Discharge to level II facility when available		
02May03 @	0015		24° chart verification —	(b)(6)-2	
				(b)(6)-2	EWS, NC
3May03 @	0015		— No New orders		(b)(6)-2
			— 24° chart verification		
04May03 @	0030		— 24° chart verification	(b)(6)-2	EWS, NC

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO. | WARD NO.

Facil #33

DOCTOR'S ORDERS
Standard Form 508
508-109

General Services Administration and
Interagency Committee on Medical Records
FPMR 101-11.806-8
October 1975

MEDCOM - 5925

508–112 7540–01–044–5515

MEDICAL RECORD

DOCTOR'S ORDERS

INSTRUCTIONS: Place form on firm surface; use pressure on ball point pen. Sign all orders.
Nurse: Remove one copy and send to Pharmacy after each order is written.

DATE AND TIME START	STOP	Rx	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
4/16/03	1420		① NPO p MN	(b)(6)-2	(b)(6)-2
			② CBC, CMP in AM		
			③ Heparin 5000 units SQ bid (if not already ordered)	(b)(6)-2	
Faxed 1340			→ 16 Apr 03 1430 Noted	(b)(6)-2 (b)(6)-2	
16 Apr 2000			EKG tonight done	(b)(6)-2	
			Do CBC and CMP now in stead of tomorrow	(b)(6)-2	
			D5 1/2 NS +20 mEq KCl/1,Kg @100/hr	(b)(6)-2 (b)(6)-2	
			4/16/03 Note	(b)(6)-2	
17 Apr 2003	0120		24° Chest Verification	(b)(6)-2	
17 Apr 1400			See ICU order sheet.	(b)(6)-2	
14 Apr 0730			Transfer to ward		
			D/C NG tube	(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

PACK #5 **MEDCOM - 5926** J. Pond

DOCTOR'S ORDERS
Medical Record
STANDARD FORM 508 (Rev. 3–94)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201–9.202–1

Standard Form 508

CLINICAL RECORD

DOCTOR'S ORDERS
(Sign all orders)

DATE AND TIME START	DATE AND TIME STOP	Rx	DRUG ORDERS (Another brand of a generically equivalent product, identical in dosage form and content of active ingredient(s): may be administered UNLESS checked here)	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
4.17.03 / 1515		⇨	Morphine 5mg - 10mg IV q5min PRN for pain	(b)(6)-2	(b)(6)-2
		→	Versed 1 to 5mg IV q5min PRN for anxiety.		
		→	PEEP to 10 cm H_2O.		
4-17-03 / 1540		→	PEEP to 15 cm H_2O		
4-17-03 / 1620			LR 1000 x 1 now please → done PCXR now		
4/17/03 / 1700			LR 1000cc x 1 now NC 04/17/03 @ 1800		
4/17/03 / 1800			Lasix 10mg IV x 1 Now CXR, NC 4/17/03 @ 1800		
4.17.03 / 1820			Change IVF to LR at 150 cc/hr.		
			12 VERIFICATION		

(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.

DOCTOR'S ORDERS
Standard Form 508
508-109

General Services Administration and Interagency Committee on Medical Records
FPMR 101-11.806-8
October 1975

MEDCOM - 5927

MEDICAL RECORD			DOCTOR'S ORDERS *(Sign all orders)*		
DATE AND TIME					
START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
11 Apr 1241			AAS now Noted (b)(6)-2 NC NAPR03 1330	(b)(6)-2	
11 Apr 1630			Dulcolax ī po now Cipro 500 mg po BID	(b)(6)-2	(b)(6)-2
11APR03	1900	(1)	0.5ml (H) Td once	(b)(6)-2 CDR/MC/USN (b)(6)-2 LCDR MC USN	(b)(6)-2
11 APR03 1915		(1) (2)	D/C CIPRO (discontinue) ZPAK (Azithromycin) 500mg PO now then 250mg QD x 4 days	TX (b)(6)-2	(b)(6)-2 (b)(6)-2 (b)(6)-2
12Apr03 @ 0030			24° chart verification	Noted (b)(6)-2	(b)(6)-2 / NC 4/12 @ 0134 (b)(6)-2
12 Apr 1708			Tylenol ~~gr X~~ 650mg po q4h prn pain (b)(6)-2	(b)(6)-2 12apr03	(b)(6)-2

FAXED 4/11

(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

(b)(6)-4 0410

24° chart verification 0240 13 April (b)(6)-2

REGISTER NO.

WARD NO.

DOCTOR'S ORDERS

STANDARD FORM 508 (Rev. 10-75)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45-505
508-112

MEDCOM - 5928

[redacted]

MEDICAL RECORD — DOCTOR'S ORDERS

(Sign all orders)

DATE AND TIME START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
20 Apr 1025			D/C Foley Record volume of all voiding Diet as desired with yogurt, bread AAd and ~~encourage~~ ambulation	(b)(6)-2	(b)(6)-2
4/20/03					(b)(6)-2
April 20 '03 1800hrs			CBC | TOMORROW CMP FeSO4 T tid Folic acid 1g QD Multivit T QD	(b)(6)-2 (b)(6)-2	
4/20 0245			24° ✓ complete	(b)(6)-2	RNS, NC
April 21 '03 1700hrs			ACUTE ABD SERIES - U/S ABDOMEN - SURGERY TO SEE (OR ORLINER)	(b)(6)-2	
noted		(b)(6)-2	[illegible], NC 4/21/03 1400		
21 Apr 0157			CT 9am - done	(b)(6)-2	

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade; rank; rate; hospital or medical facility)	REGISTER NO.	(b)(3)-1
(b)(6)-4 — Rack 33	DOCTOR'S ORDERS	

MEDCOM - 5929

STANDARD FORM 508 (Rev. 10-75)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45-505
508-112

RECORD

DOCTOR'S ORDERS
(Sign all orders)

START	Rx	DRUG ORDERS (Another brand of a generically equivalent product, identical in dosage form and content of active ingredient(s): may be administered UNLESS checked here)	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
18 APR 1000		2gm Magnesium Sulfate WPB x 1 Now	(b)(6)-2 done 1100	
		V.O. Dr (b)(6)-2 (b)(6)-2 CT (b)(6)-2 (b)(6)-2 CT		
			1445 4-18-03	
19APR03 @ 0211		VERIFIED		
			(b)(6)-2	
19 Apr 2031		Record urine output q4h	(b)(6)-2	
		Record output from J-P's q shift, record each one separately	(b)(6)-2	
		Assist in ambulation	(b)(6)-2	
		Record and notify	(b)(6)-2	
4/1 4/03 1000				
4/20 0300		chart verified (b)(6)-2	(b)(6)-2	
20 Apr 0920		Record J-P output q shift Record & if no output Record pulse and Temp q4h including nights Record urine output q4h x all shifts	(b)(6)-2	
4/20/03 1800		CBC, BMP, Mg++ now	(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. [redacted] NO.

(b)(6)-4

(b)(6)-2

DOCTOR'S ORDERS
Standard Form 508
508-109

General Services Administration and Interagency Committee on Medical Records
FPMR 101-11.806-8
October 1975

MEDCOM - 5930

MEDICAL RECORD **DOCTOR'S OR...**
(Sign all orders)

..., AND TIME ...T	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
faxed	4/22		0230 24° ✓ complete	(b)(6)-2	EWS, NC
4/22/03	4/22/03		T.O. DR (b)(6)-2 / (b)(6)-2		(b)(6)-2
1400	1400		Tobramycin 350mg IVPB qd		
	4/22/03 1400			(b)(6)-2	
22 Apr 0920			D/C Tobramycin	✓ (b)(6)-2	
			D/C IV	✓	
			Zantac 150 mg po bid	✓	
			(b)(6)-2		
			faxed to pharm 22APR02 2145		
			noted (b)(6)-2 LCDR NC	22APR02 2145	
4/23		0210	24° ✓ complete	(b)(6)-2	EWS NC
25 Apr 0600			Pulse + temp q4h		(b)(6)-2
			Aid and encourage ambulation		
			Give snacks in between meals		
			Change dressing BID (b)(6)-2		
			LOO		
			Needs dressings - no meds		
24APR03 0400			24hr Chart verification (b)(6)-2	(b)(6)-2	CDR (b)(6)-2

(Continue on reverse side)

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

(b)(6)-4

Rack 33

REGISTER NO.

WARD NO. (b)(3)-1

DOCTOR'S ORDERS

STANDARD FORM 508 (Rev. 10-75)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45-505
508-112

MEDCOM - **5931**

MEDICAL RECORD | **DOCTOR'S ORDERS** (Sign all orders)

DATE AND TIME START	DATE AND TIME STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
4/13/03	1935		① CBC + CMP in AM	(b)(6)-2	
4/13/03			(b)(6)-2 LCDR	(b)(6)-2 (b)(6)-2 CDR (b)(6)-2	
14 Apr 03	0225		24° Chest X-ray ordered	(b)(6)-2	
4/14/03	2050		① D/C Surfak (pt has diarrhea)	(b)(6)-2	
			(b)(6)-2	(b)(6)-2 CDR (b)(6)-2	
4/15/03	0315		24° Chest X-ray	(b)(6)-2	
15 Apr			Acute abdominal series ~~today~~ this morning	(b)(6)-2	
			~~Heart~~ NPO	(b)(6)-2	
			→ 15APR03 @ 0900	(b)(6)-2	NC
15 Apr 1430			Continue pre procedure orders.	(b)(6)-2	
			Clear liquid diet	(b)(6)-2	
			Scheduled CT of abdomen	(b)(6)-2	
			(b)(6)-2	(b)(6)-2	
			(b)(6)-2 4/15/03	(b)(6)-2 LCDR NC, USN	
4/16/03 0225			24° Chest X-ray	(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.

DOCTOR'S ORDERS

STANDARD FORM 508 (Rev. 10-75)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45-505
508-112

MEDCOM - 5932

NAVMED *655018* (REV. 4-74) S/N [illegible]-LF-216-5581

MEDICAL RECORD | **MEDICATION ADMINISTRATION RECORD**

SCHEDULED DRUGS — MONTH MAY 19~~20~~03 — DATES GIVEN

ORDER DATE	MEDICATION ROUTE OF ADMINISTR AGE-FR		2	3	4				
4/18	FeSO4 T tab PO TID	0700	(b)(6)-2						
		1100							
		1700							
4/18	FOLIC ACID T mg PO qd	0700							
4/18	MVI T tab PO qd	0700							
4/18	LOVENOX ~~30mg~~ SQ q 12h	0900							
		2100							
4/22	ZANTAC 150mg PO BID	0900							
		1700							

INITIAL CODE

INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE

(b)(6)-4

Injection Site Code

② = Right Buttock ⑤ = Right Leg

④ = Right Deltoid ⑧ = Right Arm

⑨ = Abdomen

SINGLE DOSE, PRE-OR PRN EXAMPLES

DOSE ORDERS SEE REVERSE

MEDCOM - 5933

MEDICATION ADMINISTRA RECORD (Back) S/N 0105-LF-216-5581

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					
4/10	PERCOCET	DATE	4/12	4/23	5/2	5/2	
	1-2 tabs PO	TIME	1800	1150	0715	2104	
	Q3° PRN	DOSE	2	2	2	2	
		INIT.	(b)(6)-2				
4/16	BENADRYL 25mg	DATE	4/12	4/23			
	PO Q4° PRN	TIME	1845	2430			
		DOSE	25	25			
		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 - 5934

Neurovascular/Neuromuscular Check (MEDTREFAC 6550/12/Temp Form)

	TIME	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04	05	06
	EYES OPEN	4		4				4																	
	VERBAL	2		2				5																	
	MOTOR	4		4				5																	
	TOTAL	10		10				14																	
	PUPIL REAC R/L	+ / +	/	+ / +	/	/	/	+ / +	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/
	PUPIL SIZE R/L	2 / 2	/	2 / 2	/	/	/	2 / 2	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/
LUE	COLOR	NFR		NFR				NFR																	
	PULSES	+		+				+																	
	CAP REFILL	L3		L3				L2																	
	MOVEMENT	+		+				+																	
	STRENGTH	2		3				3																	
RUE	COLOR	NFR		NFR				NFR																	
	PULSES	+		+				+																	
	CAP REFILL	L3		L3				L2																	
	MOVEMENT	+		+				+																	
	STENGTH	2		2				2																	
LLE	COLOR	NFR		NFR				NFR																	
	PULSES	+		+				+																	
	CAP REFILL	L3		L3				L2																	
	MOVEMENT	+		+				+																	
	STRENGTH	2		3				3																	
RLE	COLOR	NFR		NFR				NFR																	
	PULSES	+		+				+																	
	CAP REFILL	L3		L3				L2																	
	MOVEMENT	+		+				+																	
	STRENGTH	2		2-3				3																	

RESPONSE	1	2	3	4	5	6
EYES OPEN	Never	To Pain	To Sound	Spontaneously		
VERBAL	None	Incomprehensible	Inappropriate	Confused Conversa-	Oriented	
MOTOR	None	Extension	Flexion-Abnormal	Flexion-Withdrawal	Localizes Pain	Obeys Commands

LEGEND

Movement: + -
Strength: 0 - +5/5
P = Pronator Drift
FW = Flexion/Withdrawal
E = Extension
Fl = Flaccid
FA = Flexion Abnormal

Reflexes:
- = Absent
+ = Present

Pupil Reaction:
S = Sluggish
+ = Reactive
- = Nonreactive

PUPIL SIZE SCALE (MM)

SIZE

MEDCOM - 5935

(b)(6)-4

NURSING [redacted] SHEET
MEDTREFAC-65[redacted]/Temp Form

Date: Apr 20

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		18																						
TEMP		96.4																						
SAO2		99																						
MAP																								
O2 Mode																								

OFF

DRIP / DOSE

FREQ. VITAL SIGNS

TIME																
BP																
HR																
RR																
TEMP																
SAO_2																

Notes:

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	TOT
O																										
/PB																										

MEDCOM - 5937

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				200			300																			
UOP																	200									
BM																										

PREVIOUS 24 HOUR INPUT_____ PREVIOUS 24 HOUR OUTPUT_____ PREVIOUS WEIGHT_____

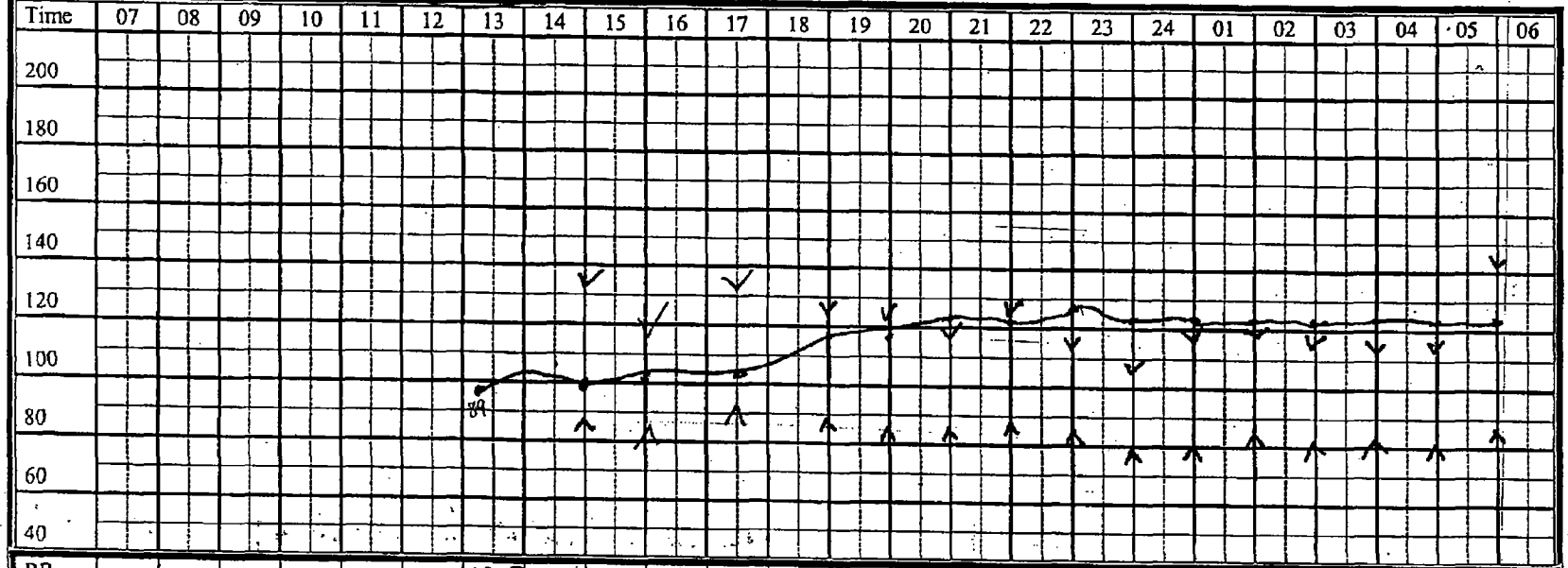
PRESENT 24 HOUR INPUT_____ PRESENT 24 HOUR OUTPUT_____ PRESENT WEIGHT_____

Name: (b)(6)-4

ADMISSION 1400

NURSING FLOW SHEET
MEDTREFAC 6550/12/Temp Form

Date: 17 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
RR							12			12	18		28	24	24	22	24	22	22	22	22	24	22	24
TEMP							99.3			98.3	—		—	98.4			96.2					97.2		100.6
SAO2							100%			100	100		96	96	97	94	97	96	97	96	97	96	97	98
MAP											103		97	92	96	97	97	91	92	92	92	91	97	97
O2 Mode							VENT			PSV	PSV		FM BL	FM BL	NC 1L	RA	NC 1L	NC 1L	NC 1L	NC 1L	RA	NC 1L	NC 1L	RA
Fi O2							50%			30%	30													
PSP										12	12													
PEEP										15	15													

DRIP / DOSE

FREQ. VITAL SIGNS

TIME	1400														
BP	150/86														
HR	98														
RR	12														
TEMP	97.3														
SAO2	100														

Notes: OR admission

(b)(6)-2

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												50	50						100							100
IVF							125	125	125	125	125	125	750	125	125	125	125	150	150	150	150	150	150	150	150	1200
FLUIDS	← from OR					→	2250 →						2250													
JP1							35 →					30	65											5 cc	20 cc	
JP2							5 →					60	65											10 cc	30 cc	
IV Fluids										1000	1000		2000		[illegible]											
NG flush															30											

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							50 →			30		25	105	70	50	50	35	35	35	45	40	50	50	36	70	59'
UOP							~~50~~ ph		*MD notified LAD UCP sel Bolus				400cc													
BM																										
EBL							200 →						200													
JP#1													805		∅										0	
JP#2													+736		30			50					30		30	140

PREVIOUS 24 HOUR INPUT 2200 PREVIOUS 24 HOUR OUTPUT 1641 PREVIOUS WEIGHT ____________

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

MEDCOM - 5939

TIME	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04	05	06
EYES OPEN										+				4				4				4		
VERBAL										ETT				1				1				1		
MOTOR										6				4				4				4		
TOTAL										RD				9				9				9		
PUPIL REAC R/L	/	/	/	/	/	/	/	/	/	+ +	/	/	/	+ +	/	/	/	+ +	/	/	/	+ +	/	/
PUPIL SIZE R/L	/	/	/	/	/	/	/	/	/	/	/	/	/	2 2	/	/	/	2 2	/	/	/	2 2	/	/
LUE COLOR														WNL				WNL				WNL		
PULSES														+2				+2				+2		
CAP REFILL														<3				<3				<3		
MOVEMENT														+				+				+		
STRENGTH																								
COLOR														WNL				WNL				WNL		
PULSES														+2				+2				+2		
CAP REFILL														<3				<3				<3		
MOVEMENT														+				+				+		
STENGTH																								
LLE COLOR														WNL				WNL				WNL		
PULSES														+2				+2				+2		
CAP REFILL														<3				<3				<3		
MOVEMENT														+				+				+		
STRENGTH																								
RLE COLOR														WNL				WNL				WNL		
PULSES														+2				+2				+2		
CAP REFILL														<3				<3				<3		
MOVEMENT														+				+				+		
STRENGTH																								

RESPONSE	1	2	3	4	5	6
EYES OPEN	Never	To Pain	To Sound	Spontaneously		
VERBAL	None	Incomprehensible	Inappropriate	Confused Conversa-	Oriented	1
MOTOR	None	Extension	Flexion-Abnormal	Flexion-Withdrawal	Localizes Pain	Obeys Commands

LEGEND

Movement: + -
Strength: 0 - +5/5
P = Pronator Drift
FW = Flexion/Withdrawal
E = Extension
FL = Flaccid
FA = Flexion Abnormal

Reflexes:
- = Absent
+ = Present

Pupil Reaction:
S = Sluggish
+ = Reactive
- = Nonreactive

PUPIL SIZE SCALE (MM)

SIZE

MEDCOM - 5940

NAVMED 655018 (REV. 4-74) S/N 010;. _.-216-5581 Recopied.

MEDICAL RECORD | **MEDICATION ADMINISTRATION RECORD**

SCHEDULED DRUGS — MONTH April 2000 — DATES GIVEN

ORDER DATE	MEDICATION-DOSAGE-FREQUENCY ROUTE OF ADMINISTRATION	HOURS	4/15	4/16	4/17	4/18	4/19	4/20
4/11	Azithromycin 250mg PO QD x 4 days	0900	(b)(6)-2	X	(b)(6)-2			
4/16	Heparin 5000U SQ BID	0900	X	X	(b)(6)-2			
		2100	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		

ADDRESSOGRAPH PLATE
(b)(6)-4

WARD NO.

Injection Site Code

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

SINGLE DOSE
PRE-OP PRN

SEE REVERSE

RAD [redacted] 91

MEDCOM - 5941

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

SINGLE ORDERS – PRE-OPERATIVE

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

PRN AND VARIABLE DOSE MEDICATIONS

ORDER DATE	MEDICATION-DOSAGE FREQUENCY ROUTE OF ADMINISTRATION	DOSES GIVEN	
4/10	MSO4 3-5 mg IVP q3° PRN pain	DATE	4/16
		TIME	0100
		DOSE	5mg
		INIT.	(b)(6)-2
4/10	Percocet 1-2 PO q3° PRN	DATE	4/16
		TIME	2100
		DOSE	2
		INIT.	(b)(6)-2
4/12	Tylenol 650 mg PO q4° PRN	DATE	
		TIME	
		DOSE	
		INIT.	
4/16	Benadryl 25mg PO q6° PRN	DATE	
		TIME	
		DOSE	
		INIT.	
4/16	Phenergan 25 IV/25mg PO PRN	DATE	
		TIME	
		DOSE	
		INIT.	
		DATE	
		TIME	
		DOSE	
		INIT.	
		DATE	
		TIME	
		DOSE	
		I	

★ G.P.O.: 1982-587-01615409

MEDCOM - 5942

(b)(3)-1

CP/RT Ventilator Check Off Sheet

Date	4/17/03											
Time	1430	1500	1540	1732								
Vent	760	760	760	760								
Mode	PSV	PSV	PSV	PSV								
VT set/actual												
VT spontaneous	400	477	388	455								
Rate set				1								
Rate total	11	19	18	24								
Peak flow	34	46	54	54								
Sensitivity	-2	-2	-2	-2								
Peep	10	12	15	15								
PIP	36	27	27	27								
~~Insp pause~~ PS	25	15	12	12								
~~Sigh volume~~ MV	5.30	8.54	8.28	9.31								
~~Sigh rate~~ MAP	19	15	19	19								
Sigh frequency				/								
Sigh PIP				/								
Fio2	.50	.30	.30	.3								
Waveform	DEC	DEC	DEC	/								
High PIP alarm	50	50	50	50								
Low PIP				/								
Low volume	200	200	200	20								
Det. delay				/								
Apneic period				20								
Low PEEP/CPAP				/								
High rate	35	35	35	35								
Volume check qS				/								
Temp/set				/								
Water level				/								
HME	NEW	OK	OK	OK								
PI/secretion check				/								
O2 sats	98%	97%	97%	97%								
Cuff Pressure	22			/								
Initials	(b)(6)-2											

Name/Signature	*Initials*	*Pt. Information/Addressograph*
(b)(6)-2	(b)(6)-2	(b)(6)-4

MEDCOM - 5943

Date	Time	
	1500	PT RECEIVED FROM OR S/P EX LAP. TRIED TO WEAN PS AND PEEP DOWN ONLY PARTIALLY SUCCESSFUL, FiO2 DOWN TO 30%. (b)(6)-2
		(b)(6)-2
	1550	CURRENT PLAN PLACE PATIENT ON PS 12 PEEP 5 FOR 2 HOURS THEN TRY TO WEAN. PT APPEARS TO BE TOLERATING VENT THERAPY AND APPEARS TO BE STABLE (b)(6)-2
	1500	LATE NOTE 8.0 mm OGTT PATENT AND SECURE AT (b)(6)-2 AT EQUAL BILAT LUNG SOUNDS & COARSE SOUNDS THROUGHOUT. SUCTION X 2 MOD AMOUNT (b)(6)-2
	1625	PT EXTUBATED, PLACED ON AEROSOL MASK & JET NEB AT FiO2 100%. PT HAS RHONCHI T/O, PT HAS WEAK COUGH. STILL SOMEWHAT SEDATED. WILL CONTINUE TO FOLLOW (b)(6)-2

LAB FLOW SHEET

b)(6)-4

PATIENT NAME

Date/Time	4/16	4/18													
CBC															
WBC (4.8-10.8) K/UL	13.4	21.1													
RBC (4.7-6.1) 1X10 6/UL	4.6	4.5													
HGB (14.0-18.0) g/Dl	12.5	12.2													
HCT (42-52) %	37.8	36.5													
PLT (150-450) 1x10 3/UL	827	917													
NEUT%	10.3	16.9													
CHEMISTRY															
NA+ (137-145) mmol/L	136	133													
K (3.6-5.0) mmol/L	3.9	5.1													
CL- (97-107) mmol/L	100	100													
CO2 (22-31) mmol/L	33	28													
BUN (9-21) mg/Dl	5	7													
GLUCOSE (76-110) mg/dL	122	138													
CREAT (0.8-1.5) mg/dL	0.4	0.8													
CA (8.8-10.4) mg/dL	8.5	8.2													
PHOSPHORUS (2.5-4.5) mg/dL	4.9	5.5													
URIC ACID (3.3-8.4) mg/dL	4.6														
PROTEIN TOTAL (6.3-8.3) g/dL	6.3														
ALBUMIN (3.5-5.0) g/dL	2.7														
AST (15-46) U/L	28														
LDH (313-618) U/L	698														
ALK PHOS (70-250) U/L	287														
TBILI (1.0-10.5) mg/dL	0.6														
GGT (8-78) U/L	164														
CK (0-203) U/L	42														
MG (1.7-2.2) mg/dL	2.0	1.3													
AMYLASE (30-110) U/L															
LIPASE (23-300) U/L															
ALT (11-66) U/L	37														
ABG															
pH															
pCO2															
pO2															
HCO3															
BE															
Sao2															
COAG															
APTT (23.8-35.5) Seconds															
PT (11.6-14.4) Seconds															
INR															
OTHER															

(b)(6)-4

MEDCOM - 5945

MEDICAL RECORD | **OPERATION REPORT**

PREOPERATIVE DIAGNOSIS

Intraabdominal Fluid Collection. GSW to both large and small bowel

SURGEON	FIRST ASSISTANT	SECOND ASSISTANT	
(b)(6)-2	(b)(6)-2		
ANESTHETIST	ANESTHETIC		TIME BEGAN 1151
LCDR (b)(6)-2	Gen		TIME ENDED 1405
SURGICAL NURSE	INSTRUMENT NURSE	TIME OPERATION BEGAN	TIME OPERATION COMPLETED
LTjg (b)(6)-2	HN (b)(6)-2 HM2 (b)(6)-2	1212	1350
OPERATIVE DIAGNOSES	DRAINS (Kind and number)		SPONGE COUNTVERIFIED
	JP 10 mm x2 to abdominal		Correct X2

SAA

MATERIAL FORWARDED TO LABORATORY FOR EXAMINATION

none

OPERATION PERFORMED

Ex lap and drainage of bilious ascites

DESCRIPTION OF OPERATION *(Type(s) of suture used, gross findings, etc.)*	MAJOR	MINOR	DATE OF OPERATION
	x		4/17/03

EBL 200 CC's IVLR_2000_cc's U/O 50 (foley)

Pt has multiple fluid collections on CT, bilious on aspiration, 2 weeks s/p x-lap and oversew of GSW to transverse colon. Prepped and draped in sterile fashion. Midline wound opened carefully with one small nick in liver. A fibrinous peel was found over the liver and this was entered and a liter of old bilious material was evacuated. Cultures were obtained yesterday so no new specimens were sent. This cavity was traced down theright gutter where the bowel and omentum were separated from the lateral abdominal wall and another cavity entered and evacuated. The bowel on the right side of the abdomen was covered by a bilious thick peel precluding safe identification of the space between loops of bowel. A similar cavity was encounteredin the pelvis. The bowel on the left side of the abdomen was healthy in appearance. Falciform ligament was divided. The gallbladder was identified and adhesions to the peel were divided until the porta hepatis could be identified as could the foramen of winslow. After copious irrigation, no fresh bilious or succus leakage could be noted. Some oozing of blood from peritoneal surfaces was encountered. The serosal/peritoneal nodules referred to in the original op note were not identified, 10mm JP was placed into Morrisons pouch and another into the right gutter. Both secured with nylon. At this point it was decided that further mobilization of the bowel to run it completely would probably lead to numerous enterotomies. Furthermore, the CT scan was done 12 hours after both upper and lower endoscopies carried out and no free air was noted. This suggested against a current hole in the bowel. Cholangiogram thru the GB was going to be done but the patient was in the wrong position to use the C-arm. Furthermore, it was decided that a PTHC could be done if bile was seen to be leaking from the drains. Fascia was closed with running #1 PDS and the wound packed. Patient was taken directly to the ICU for recovery, in satisfactory condition

SIGNATURE OF SURGEON		DATE
(b)(6)-2		4/17/03
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		OPERATION REPORT

STANDARD FORM 516 (REV. 9-77)
Prescribed by GSA and ICMR, FPMR 101-11.806-8

MEDCOM - 5946

(b)(3)-1

P[illegible]rative Plan Of Care & Nursing

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

Trauma# or Patient #

Diagnosis: Intra abdominal fluid collection **Planned Procedure:** ex-lap

Date: 4/17/03 Arrival Time: 1130 Interviewer: LT (b)(6)-2

Side: ☐ N/A ☐ Right ☐ Left 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:
☒
☐ Yes ☐ Consent
☐ TIC #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:

Drug/Latex Allergies:
☑ NKDA
Allergy/Reaction:

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

Past Medical History:
☑ None known
☐ Smoker ppd/yrs /
OETOH ☐ Asthma
☐ HTN ☐ CAD
☐ GERD ☐ CBR exposure
☐ Other:

Past Surgical History:
☐ None known
☑ Yes
List: See ob's chart

Cultural Needs Addressed;
☐ Yes ☑ No
List:

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

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

Chart:
[redacted]

EKG ☐ Yes ☐ No
CXR ☐ Yes ☐ No
Other:

Condition:
☑ Intact
☐ Other:

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

Personal Item
☑ 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 ☐ Calm
☐ Disoriented ☐ Sedated
☐ Anxious ☐ Unresponsive
☑ Appropriate for age
☐ Other

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 ☐ Beach chair
☐ Prone ☐ Sitting
☐ Jackknife ☐ Lateral L / R
☐ Lithotomy
☐ Other:

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

Comments:

ESU # 5
Pad Site: (R) thigh
Pad Lot # 61277
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: 45 ☐ Left ☐ Right
Teds: ☐ No ☑ Yes
Bair Hugger used: ☑ No ☐ Yes
Other warming techniques: Warm sheet

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

b)(6)-4

(b)(6)-4

Comment.:

(b)(3)-1 PeriOperative Plan Of Care & Nursing Note Page 1 of 2 (Rev 3/03)

MEDCOM - 5947

Potential For Infe | **)utcome:** Appropriate Actions Taken tc | **'nfection** ☒ Yes ☐ No

Wound Classification: ☐ I ☐ II ☑ III ☐ IV

Shave Prep: ☐ Shave ☐ Clipper
Area: _____ By: ____

Skin Prep:
☑ Betadine Scrub Spray
☐ Hibiclens
☐ Duraprep
☐ Other:

Solutions .cations:
☑ Normal saline
☐ Sterile water
☐ Local _____
☐ Antibiotics _____
☐ Other: _____

Drains/Packing: ☐ None
☑ Foley FR: 16
☐ JP #1 Fr 10 mm **Location:** Abd #2 Fr 10 mm Location: Abd
☐ Hemovac: Size ____ Location _____
☐ Chest tube: Location _____
Size _____ H2O 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?
HM [b)(6)-2] Sharps ☑ Yes ☐ No ☐ N/A
LTJG [b)(6)-2] 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: _____
☐ See RN note # ____ for additional comments.

Implants:
Item / Lot # / Exp Date: None
☐ See RN note # ____ for additional comments.

Discharge from Operating Room

Complications:
☐ None Comments: None
☐ 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 #2
☐ Medivac
☐ Ward ____
☐ Other

Report by:
☑ Anesthesia provider ☐ RN

Surgical Procedure Performed: Ex-Lap and drainage of ileus ascites.

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

Initial/Name Box: (please print)
[b)(6)-2] [b)(6)-2] LTJG _____
_____ _____ _____
_____ _____ _____

[b)(6)-2] LTJG 4/17/03
Primary OR RN Signature **Date**

[b)(6)-2]
Relief OR RN Signature **Date/Time**

Pre / Post-anesthetic Summary

NNMC 6320/279 (Dec-00)

Proposed Operation	Age	Weight (kg)	Height (in)	ASA Status	Allergies
Ex-lap	~50	~70	64"	1 (2) 3 4 5 E	NKDA

Chemistries

134	100	5
3.9	33	122
		04

TBo

Hematology
H/H - 12.5/37.8
Platelets - 827K
WBCs - 13.4

Coags
PT -
INR - 8Ø
PTT -

Urinalysis / HCG
Ø

NPO - ✓
Teeth - intact
Airway - MP I (II) / III / IV
FROM. 3 FB O. 3 FB HM

Respiratory
Cough:
Sputum:
Asthma:
COPD:
Recent URI: ~~Yes~~ No recent pneumonia
TB: ?

Lung Exam: distant

CXR: 4/11 patchy infiltrates (B) c/w pneumonia

CV
HTN:
CAD:
MI:
CHF:
VHD:
Arrythmias:
Exercise Tolerance:

Cardiac Exam:

ECG: 4/16 - NSR marked poor R wave progression QRS axis, poss. inf. infarct

CNS / Skeletal
Seizure:
CVA:
LOC:
Neuro:
Muscle:
Skeletal:

Misc
Ø

Other
Hepatic: Ø ?
Renal:
GI: s/p GSW to abd
Endo:
Heme: Ø?

EtOH:
Tobacco: ?

Previous Anesthetics:
29 Nov Ex-lap
15 Apr Colonoscopy + EGD } GA & probs

Current Medications:
Azithromycin

Premedication:
Ø

Family Hx:

Preoperative Diagnoses
(1) s/p Ex-lap for GSW to abdomen 29 Nov

Vitals	Pre-op	DOS
BP:	136/80	134/78
HR:	90	95
Resp:	18	18
Temp:		
FHR:		

Evaluator Signature | Date

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 signature: (b)(6)-2
Date & Time: 4/17/02 CRNA/LCDR/NC

Patient identification
(b)(6)-4

Post-operative note

☒ No apparent anesthetic complications

(b)(6)-2
Signature CRNA Date 4/17/02

MEDCOM - 5949

ANESTHESIA RECORD

MNMC 279(12/00)

Wt (kg) 70 | Ht (in) - 64 | Allergies - NKDA

Procedure	Anesthesiologist	Surgeon		OR # 3	See Page One
Ex-lap - drainage of bilious ascites	(b)(6)-2 [redacted]	(b)(6)-2 [redacted]	(b)(6)-2 [redacted]	Page 1 of ___	

Date	Anes. Start	In Room	Surg. Start	Surg. End	Anes. End	
4/17/03	1125	1151	1212	1350	1415	Ø

Time	1145	1200	30	1300	30	1400				
O₂ L/M	6 2	3	3	2	2	2	2	3	3	
N₂O / Air L/M	2	X								
Halo / Iso / Sevo / Des	1.0	1.1	1.1	1.1	1.1	1.1	1.1	1.1	0.7	
STP / Prop. / Etomidate	400									
Sux / Cistracurium	100									
Ro / Rapa / Vecuronium		10				6		4		
Lidocaine										
Neostigmine / Glyco										
Ephedrine / Neo										
Midazolam	3									2
MSO₄ / Remi / Su / Fentanyl	100	100-50		50		100		100		
Epid. Lido / Bupiv / Ropiv										
NS04										10
NS / LR									2000	
U/O									50	
EBL									200	

Checklist - ☑ O₂ ☑ Suction ☑ Machine ☑ Consent ☑ NPO

Monitors - ☑ SaO₂ ☑ ECG ☑ FiO₂ ☑ NIBP L/R arm ☑ EtCO₂ ☐ 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 5 Used 5 Wasted Ø Witns Ø

Drawn 500 Used 500 Wasted Ø Witns Ø

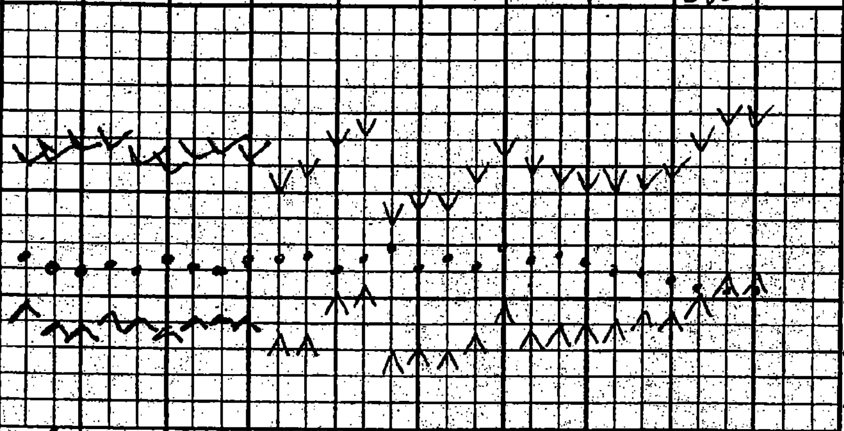
IV - 16 Ga L / R Hand Wrist FA AC EJ

☐ Tourniquet ___ mmHg Times ___

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

	Antibiotics
Total	Agent -
2250 Total	mg
50 Total	over minutes
200 Total	@

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



PACU / ICU
Pulse - 92
BP - 150/86
Temp - 97.3
RR - 12
SaO₂ - 100
Comps - + 1 C

1330 Suctioned ETT for mod. amt yellowish sputum
BS → insp + exp. wheezing / rhonchi in (B) all lobes.

1400 To ICU #2
VSS, O₂ via ETT 15L/min + monitors for transport

ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR
Es / Np / Or / Sk / Ax Temp		36.3	36.2	36.1	35.9	35.8	35.6	35.5	35.5
% FiO₂		1.0	1.0	1.00	1.00	1.00	1.00	1.00	1.00
% SaO₂		99	100	100	99	98	97	99	99
EtCO₂		44	41	40	39	37	36	36	36
	ØOØ	Ⓥ	Ø	Ⓥ	Ⓥ	Ⓥ	Ⓥ	Ⓥ	Ⓥ
TV	Ø	O	450	450	450	450	467	470	470
PIP (cmH₂O)			40	40	40	40	40	42	40
Resp. Rate			15	15	15	15	15	15	15

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

Intubation - Mac / Mil 3 Grade I view Tube Size 8.0 Attempts x1 Oral / Nasal L / R w/o / w/ Cuff Stylet Y / N Bil BS / EtCO₂ x 3 / CRN

Tube taped @ 23 cm @ lips / teeth / nares Trauma Y / N FOB / LW / Blind LMA # Ø DLT Ø Rt L T 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

Prep	Regional	Regional	Comments / Drugs:
☐ Sterile Technique	☐ Spinal / Epidural	☐ Catheter out - tip intact	
☐ Disposable kit	☐ Touhy / Whitacre / Quincke	☐ Level ___	
☐ Betadine prep x 2	☐ Needle guage ___	**Lines**	
☐ Local infiltration	☐ Skin	☐ 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 + / -		
☐ Deal cuff	☐ Test dose ⊖		
	☐ CSF ⊕ swirl		

Patient Identification

(b)(6)-4 [redacted]

(b)(6)-4 [redacted]

MEDCOM - 5950

NAVMED 6550/8 (REV. 4-74) S/N 0105- 5-5581

MEDICAL RECORD | **MEDICATION ADMINISTRATION RECORD**

SCHEDULED DRUGS — MONTH APRIL 19 2003 — DATES GIVEN

ORDER DATE	MEDICATION- DOSAGE- FREQUENCY ROUTE OF ADMINISTRATION	HOURS	4/17	4/18	4/19	4/20	4/21	4/22	4/23
4/17	MEFOXIN 1GM IV	0800	X	(b)(6)-2					
	Q8° X 6 DOSES	1600	1800 (b)(6)-2						
		2400							
4/17	HEPARIN 5,000 USQ BID	0900	X	(b)(6)-2					
		2100	(b)(6)-2						
4/17	ZANTAC 50MG IV	0800	X						
	Q8°	1600	(b)(6)-2						
		2400							

INITIAL CODE

INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE	INITIAL	(b)(6)-2
(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2 LCDR NC HN/USN	(b)(6)-2	

ADDRESSOGRAPH PLATE

(b)(6)-4

(b)(6)-4

Rack 33

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 - 5951

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

SINGLE ORDERS - PRE-OPERATIVE

MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	GIVEN TIME	INITIAL	MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	GIVEN TIME	INITIAL
MSO4 10MG/VERSED 2MG	4/17/03	1520	(b)(6)-2				
VERSED 2MG	4/17/03	1945					
Lasix 10mg IVP x 1	4/17	1810					
Mag Sulfate 2g IVB	4/18	1100		(b)(6)-2			

PRN AND VARIABLE DOSE MEDICATIONS

ORDER DATE	MEDICATION-DOSAGE FREQUENCY ROUTE OF ADMINISTRATION	DOSES GIVEN																
4/17	MSO4 5-10MG IV Q5MIN PRN PAIN	DATE	4/17	4/17	4/17	4/17	4/17	4/17										
		TIME	1745	2015	2345	0025	0300	0415										
		DOSE	5mg	2mg	3mg	3mg	3mg	4mg										
		INIT.	(b)(6)-2															
4/17	VERSED 1-5MG Q5MIN PRN ANXIETY	DATE	4/17	4/17	4/17	4/17												
		TIME	1622	1645	1740	1810												
		DOSE	2MG	2MG	2.5mg	3mg												
		INIT.	(b)(6)-2															
4/17/03	MSO4 2-4mg IV q1hr PRN pain	DATE	4/18															
		TIME	3mg															
		DOSE	120															
		INIT.	(b)(6)-2															
4/18	Tylenol 650mg Supp PR Q6° PRN temp > 102	DATE																
		TIME																
		DOSE																
		INIT.																
		DATE																
		TIME																
		DOSE																
		INIT.																
		DATE																
		TIME																
		DOSE																
		INIT.																
		DATE																
		TIME																
		DOSE																
		INIT.																

D/C'd

MEDCOM - 5952

(b)(3)-1

CASU/ RECEIVING

AL RECORD — ABBREVIATED MEDICAL RECORD

4/10/03 Time: 1310 arrived on board USNS Comfort

TRIAGE CATEGORY (Circle one): Immediate / Delayed / Minimal / Expectant

nsported by: (Circle one) Helo Boat Pier Other

(Circle one) LITTER AMBULATORY

iE: HEIGHT (ft' in"): Weight (lbs): ~75kg

STORY: 12 days s/p exp lap for GSW to abdomen, superficial GSW to (R) forearm. 3 CA to ABD / Metastatic CA.

LERGIES: unknown

URRENT MEDS: MSO4, Ativan, Valium

AST ILLNESSES: metastatic CA

AST MEAL: (Date) 4/10/03 (Time) AM

rents Preceding injury: transfer from (b)(3)-1 12 days s/p exp lap for GSW to ABD

TAL SIGNS	TIME	TEMP	PULSE	B/P	RESP RATE	GCS	CAP REFILL (pres/abs)
OMISSION	1310		102	165/83	26	15	+
ISCHARGE	1400	100'	98	160/80	26	15	+

upils: = OR ≠ (Circle one)

L reactive / sluggish / fixed (Circle one) — R reactive / sluggish / fixed (Circle one)

L ● ● ● ● R ● ● ● ●

Glasgow Coma Score (GCS)

		Points
A. Eye Opening		
	Spontaneous	4
	To voice	3
	To pain	4
	None	1
		(Total)
B. Verbal Responses		
	Oriented	5
	Confused	4
	Inappropriate words	3
	Incomprehensible words	2
	None	1
		Total "B"
C. Motor Responses		
	Obeys command	6
	Localize pain	5
	Withdraw (pain)	4
	Flexion (pain)	3
	Extension (pain)	2
	None	1
		Total "C"

15

Level of Consciousness (LOC) (Circle one)

A - Alert

V - Responds to Vocal Stimuli

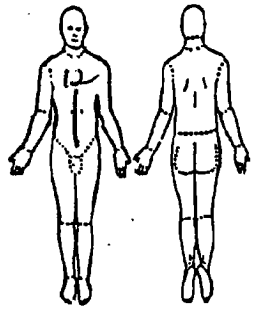
P - Responds to Painful Stimuli

U - Unresponsiveness

INJURIES

- Airway Obstruction: Yes / No
- Breath Sounds (+ / -)
- Hemorrhage
- Laceration
- Puncture
- Wound
- Trauma, Amputation
- Concussion
- Fracture
- Dislocation
- Burn
- dressing

BURN: 1° %; 2° %; 3° %



LAB

Hb/Hct

Lytes/BUN/Glue

ABG

UA

T&C units

XRAY

C-spine

CXR

Abdominal

IVP

Extremity

DIAGNOSIS:

(1) r/o metastatic CA

(2) 12 days post op ex lap for GSW to ABD

Continue on reverse side

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

(b)(6)-4

REGISTER NO.

WARD NO.

ABBREVIATED MEDICAL RE

STANDARD FORM 539

Prescribed by GSA/ICMR

FPMR (41 CFR) 201-45.505

S10-110

MEDCOM - 5953

(b)(3)-1

CASUALTY RECEIVING MEDICAL TREATMENT RECORD *(continued)*

WAY nasal / oral Incubate nasal ‖ oral _____ mm tube @ _____ cm teeth ‖ nares

YGEN Room Air Face Mask @ 12 L ‖ min OTHER _____

BES CHEST TUBE: size ‖ site _____

N/G: guaiac neg ‖ pos _____

FOLEY: dipstick blood neg ‖ pos _____

SITES	SIZE
LAC. a arrival ? gauge 20/cd	
L hand #20 1340 4/10/03	

SOLUTION	AMT INFUSED
1 Ø	
2	
3	
4	

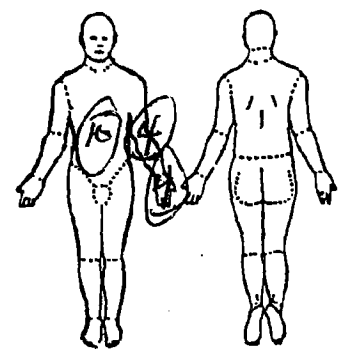
BLOOD PRODUCTS	AMT INFUSED

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

1a. _____

14. _____



PERITONEAL *LAVAGE*

Comments _____

Results: (Circle one) POSITIVE NEGATIVE

OUTPUT
Chest Tube _____ cc
Gastric _____ cc
Foley _____ cc

TOTAL INTAKE _____ cc TOTAL OUTPUT _____ cc

MEDICATIONS	Dose	Route	Time	Initials	MEDICATIONS	Dose	Route	Time	Initials
Morphine									
Mefoxin									
Ancef									
Tet Tox									
Hypertet									

DATE	HOUR A.M.	HOUR P.M.	TRANSFERRED Time: _____ to OR ICU BURN ICU WARD: _____
4/10/03	1310		Pt arrived in casper A+OX3 c complaint @ this time. O2 sats ↓ @ 80% on RA. O2 via NC started @ 2.5 l/min and sats ↑ to 95-96%. Dr (b)(6)-2 @ bedside (b)(6)-2
	1320		Dressing change done c sterile technique to abd wd to dry. Pt tolerated well (b)(6)-2
	1401		Pt transf'd to 5 FS, ENS Sproul, via RAD c HMescort (b)(6)-2

☆ U.S. GPO: 1987-181-247/60056

MEDCOM - 5954

(Reverse)

Personal Dat. Privacy Act of 1974 (PL 93-

PATIENT LAB INQUIRY

For: 21 Jan 03 - 01 May 03

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

(b)(6)-4 (b)(6)-4 M/21d Reg #: (b)(6)-4

Ph: Military Unit: UNKNOWN

21 Apr 03 @ 2226 (Coll) PERITONEAL F(ABDOMEN)

ASAP BF CULT: Final Report

Bacteriology Result:

thio growth day one. Gs: gram negative rods.notified dr. wright @ 1355.
xtn 4/22/03
many psuedomonas sp. Sens to amikacin, ciprofloxacin, imipenem, ceftazidime, ticarcillin
ID still pending.
Many Ps. Aeruginosa

21 Apr 03 @ 2226 (Coll) OTHER(ABDOMEN)

Order comment: RIGHT SUBPHRENIC FLUID COLLECTION

ASAP CRAM STA: Final Report

Cram Stain:

NO ORGANISMS NOTED. FEW PMNS. RARE MONOS.

21 Apr 03 @ 0555 (Coll) BLOOD

ASAP	WBC	14.5	H	(4.8-10.8)	K/UL
	RBC	3.5	L	(4.7-6.1)	1X10 6/UL
	HGB	9.6	L	(14.0-18.0)	g/dL
	HCT	28.8	L	(42-52)	%
	MCV	81.4		(80-94)	fL
	MCH	27.1		(27-32)	pg
	MCHC	33.3		(31-37)	g/dL
	RDW	16.1	H	(12-14)	%
	PLTCNT	553	H	(150-450)	1x10 3/UL
	MPV	8.5		(7.4-10.4)	FL
	NEUT/100 WBC	73.3			%
	NEUT%	10.6			1x10 3/UL
	LYMPHS/100 WBC	16.8			%
	LY#	2.4			1x10 3/UL
	MONO/100 WBC	9.9			%
	MO#	1.4			1x10 3/UL
	BAS#	<0.2			1x10 3/UL

21 Apr 03 @ 0555 (Coll) SERUM

ASAP	NA+	132	L	(137-145)	mmol/L
	K	4.0		(3.6-5.0)	mmol/L
	CL-	97		(97-107)	mmol/L
	CO2	28		(22-31)	mmol/L
	BUN	9		(9-21)	mg/dL

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

Persona Dat. Privacy Act of 1974 (PL 93-

PATIENT LAB INQUIRY

For: 21 Jan 03 - 01 May 03

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

(b)(6)-4 (b)(6)-4 M/21d Reg #: (b)(6)-4

Ph: Military Unit: UNKNOWN

21 Apr 03 @ 0555 (Coll)				SERUM
GLUCOSE	133	H	(76-110)	mg/dL
CREAT	0.6	L	(0.8-1.5)	mg/dL
20 Apr 03 @ 1521 (Coll)				BLOOD
WBC	16.5	H	(4.8-10.8)	K/U L
RBC	3.7	L	(4.7-6.1)	1X10 6/UL
HGB	10.0	L	(14.0-18.0)	g/dL
HCT	30.4	L	(42-52)	%
MCV	81.7		(80-94)	fL
MCH	26.9	L	(27-32)	pg
MCHC	32.9		(31-37)	g/dL
RDW	15.7	H	(12-14)	%
PLT CNT	526.0	H	(150-450)	1x10 3/UL
MPV	8.6		(7.4-10.4)	FL
NEUT/100 WBC	71			%
LYMPHS/100 WBC	19			%
MONO/100 WBC	9			%
EOS/100 WBC	1.0			%
PLT EST	HIGH			
MORPHOLOGY	NORMAL			
20 Apr 03 @ 1521 (Coll)				SERUM
M C	2.2		(1.7-2.2)	mg/dL
Interpretations:				
NA+	129	L	(137-145)	mmol/L
K	4.0		(3.6-5.0)	mmol/L
CL-	95	L	(97-107)	mmol/L
CO2	29		(22-31)	mmol/L
BUN	9		(9-21)	mg/dL
GLUCOSE	124	H	(76-110)	mg/dL
CREAT	0.6	L	(0.8-1.5)	mg/dL
18 Apr 03 @ 0505 (Coll)				BLOOD
STAT WBC	21.1	H	(4.8-10.8)	K/UL
RBC	4.5	L	(4.7-6.1)	1X10 6/UL
HGB	12.2	L	(14.0-18.0)	g/dL
HCT	36.5	L	(42-52)	%
MCV	82.2		(80-94)	fL
MCH	27.3		(27-32)	pg
MCHC	33.3		(31-37)	g/dL
RDW	16.1	H	(12-14)	%

L=Lo H=Hi *=Critical R=Resist S=Susc MS=Mod Susc I=Intermed
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Personal Dat, Privacy Act of 1974 (PL 93-)

PATIENT LAB INQUIRY

For: 21 Jan 03 - 01 May 03

Report requested by:

(b)(6)-4 (b)(6)-4 M/21d Reg #: (b)(6)-4

Ph: Military Unit: UNKNOWN

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18 Apr 03 @ 0505 (Coll)				BLOOD
PLT CNT	844	H	(150-450)	1x10 3/UL
Result Comment: NOTIFIED LT (b)(6)-2 @ 0630				
MPV	8.4		(7.4-10.4)	FL
NEUT/100 WBC	79.9			%
NEUT%	16.9			1x10 3/UL
LYMPHS/100 WBC	13.2			%
LY#	2.8			1x10 3/UL
MONO/100 WBC	6.9			%
MO#	1.5			1x10 3/UL
BAS#.	<0.2			1x10 3/UL
PLT EST	HIGH			
MORPHOLOGY	NORMAL			
18 Apr 03 @ 0505 (Coll)				SERUM
STATCA	8.2	L	(8.8-10.4)	mg/dL
PHOSPHORUS	5.5	H	(2.5-4.5)	mg/dL
MC	1.2	L*	(1.7-2.2)	mg/dL
Result Comment:				
VERIFIED BY REPEAT ANALYSIS.				
NOTIFIED TO HA (b)(6)-2 @0624				
Interpretations:				
NA+	133	L	(137-145)	mmol/L
K	5.1	H	(3.6-5 .0)	mmol/L
CL-	100		(97-107)	mmol/L
CO2	28		(22-31)	mmol/L
BUN	7	L	(9-21)	mg/dL
GLUCOSE	138	H	(76-110)	mg/dL
CREAT	0.8		(0.8-1.5)	mg/dL
16 Apr 03 @ 2129 (Coll)				SERUM
Order comment: PRE-OP				
NA+	136	L	(137-145)	mmol/L
K	3.9		(3.6-5.0)	mmol/L
CL-	100		(97-107)	mmol/L
CO2	33	H	(22-31)	mmol/L
BUN	5	L	(9-21)	mg/dL
GLUCOSE	122	H	(76-110)	mg/dL
CREAT	0.6	L	(0.8-1.5)	mg/dL
CA	8.5	L	(8.8-10.4)	mg/dL
PHOSPHORUS	4.9	H	(2.5-4.5)	mg/dL
URIC ACID	4.6		(3.3-8.4)	mg/dL

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L=Lo H=Hi *=Critical R=Resist S=Susc MS=Mod Susc I=Intermed

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Personal Dat Privacy Act of 1974 (PL 93-)

PATIENT LAB INQUIRY

For: 21 Jan 03 - 01 May 03

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

(b)(6)-4 (b)(6)-4 M/21d Reg #: (b)(6)-4

Ph: Military Unit: UNKNOWN

16 Apr 03 @ 2129 (Coll) SERUM

PROTEIN TOTAL	6.3		(6.3-8.3)	g/dL
ALBUMIN	2.7	L	(3.5-5.0)	g/dL
AST	28		(15-46)	U/L
ALT	37		(11-66)	U/L
LDH	694	H	(313-618)	U/L
ALK PHOS	287	H	(70-250)	U/L
TBILI	0.6	L	(1.0-10.5)	mg/dL
GGT	104	H	(8-78)	U/L
CK	42		(0-203)	U/L
MG	2.0		(1.7-2.2)	mg/dL

Interpretations:

16 Apr 03 @ 2129 (Coll) BLOOD

Order comment: PRE-OP

WBC	13.4	H	(4.8-10.8)	K/UL
RBC	4.6	L	(4.7-6.1)	1X10 6/UL
HGB	12.5	L	(14.0-18.0)	g/dL
HCT	37.8	L	(42-52)	%
MCV	83.1		(80-94)	fL
MCH	27.5		(27-32)	pg
MCHC	33.1		(31-37)	g/dL
RDW	15.9	H	(12-14)	%
PLT CNT	827	H	(150-450)	1x10 3/UL

Result Comment: NOTIFIED ENS (b)(6)-2 @ 2229.KF

MPV	7.9		(7.4-10.4)	FL
NEUT/100 WBC	46.7			%
NEUT#	6.3			1x10 3/UL
LYMPHS/100 WBC	38.3			%
LY#	5.1			1x10 3/UL
MONO/100 WBC	15.0			%
MO#	2.0			1x10 3/UL
BAS#	<0.2			1x10 3/UL

16 Apr 03 @ 1617 (Coll) BODY FLUID

WBC	135	MM3
RBC	1225	MM3
COLOR	BROWN	MM3
APPEARANCE	CLOUDY	
MN CELL	23	
PMN CELLS	77	MM3

L=Lo H=Hi *=Critical R=Resist S=Susc MS=Mod Susc I=Intermed
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Personal Dat Privacy Act of 1974 (PL 93-)

PATIENT LAB INQUIRY

For: 21 Jan 03 - 01 May 03

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

(b)(6)-4 (b)(6)-4 M/21d Reg #: (b)(6)-4

Ph: Military Unit: UNKNOWN

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16 Apr 03 @ 1357 (Coll) BLOOD(BLOOD)

BLD CULT: Final Report

Bacteriology Result:
AEROBIC AND ANAEROBIC VIAL NO GROWTH X 5 DAYS

16 Apr 03 @ 1354 (Coll) SERUM

PROTEIN TOTAL	3.2	L	(6.3-8.3)	g/dL

Order comment: ascites fluid

ALBUMIN	**1.1**	L	(3.5-5.0)	g/dL

Order comment: ascites

TBILI.	12.6	H	(1.0-10.5)	mg/dL

16 Apr 03 @ 1354 (Coll) CEREBROSPINA

Order comment: ascites fluid
Cancel comment: WRONG TEST ORDERED. ASCITES FLUID RECIEVED.
PROTEIN BF. . . . . LAB CANCELLED

16 Apr 03 @ 1354 (Coll) PERITONEUM

Cancel comment: UNABLE TO RESULT. TEST REORDERED. SJC.
BF CELL CNT . . . . . LAB CANCELLED

16 Apr 03 @ 1354 (Coll) PERITONEAL F(PERITONEUM)

BF CULT: Final Report

Bacteriology Result:
thio no growth after five days

16 Apr 03 @ 0000 (Coll) TISSUE(TISSUE)

TISSUE E

Microscopic Diagnosis:
A1: COLON
COLON, HEPATIC FLEXURE:
FRAGMENTS OF BENIGN COLONIC MUCOSA.

Staff Pathologist(s):
(b)(6)-2

Specimen(s):
[A] BIOPSY OF HEPATIC FLEXURE ...
1: COLON

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

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Personal Dat Privacy Act of 1974 (PL 93-)

PATIENT LAB INQUIRY

For: 21 Jan 03 - 01 May 03

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

(b)(6)-4)(6)-4 M/21d Req #: (b)(6)-4

Ph: Military Unit: UNKNOWN

16 Apr 03 @ 0000 (Coll) TISSUE(TISSUE)

Gross Description:
RECEIVED IN FORMALIN LABELED WITH THE PATIENT'S NAME (b)(6)-4 AND DESIGNATED BIOPSY OF HEPATIC FLEXURE, ARE MULTIPLE TAN SOFT TISSUE FRAGMENTS MEASURING UP TO 0.3 CM. M/1/NG.

Clinical History:
DIARRHEA 2 WEEKS S/P X-LAP FOR GSW WITH SUTURING OF COLON INJURY. METASTATIC PERITONEAL NODULES NOTED WITHOUT OBVIOUS PRIMARY.

Preoperative Diagnosis:
R/O CANCER

Operative Findings:
CANCER VS REACTION TO PRIOR INJURY.

Post Operative Diagnosis:
SAA

16 Apr 03 @ 0000 (Coll) NON GYN CYTO

Cancel comment: CORRECTION
CYTO N-CYN. . . . . DISCONTINUED

Modify comment: CORRECTION
CMO N-G

Microscopic Diagnosis:
A1: PERINEURIUM
ACCESSION ERROR. WRONG TOPOGRAPHY.
A2: PERITONEAL FLUID
NEGATIVE FOR MALIGNANCY.
ABUNDANT GRANULAR DEBRIS WITH MODERATE AMOUNT OF LYMPHOCYTES AND NEUTROPHILS. FEW SQUAMOUS CELLS, MACROPHAGES AND EOSINOPHILS ALSO NOTED.

Staff Pathologist(s): (b)(6)-2
Cytotechnologist(s): (b)(6)-2

Specimen(s):
[A] PERITONEAL FLUID
1: PERINEURIUM
2: PERITONEAL FLUID

Clinical History:

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L=Lo H=Hi *=Critical R=Resist S=Susc MS=Mod Susc I=Intermed
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Personal Dat Privacy Act of 1974 (PL 93-)
PATIENT LAB INQUIRY
For: 21 Jan 03 - 01 May 03
Report requested by: (b)(6)-2

(b)(6)-4 (b)(6)-4 M/21d Reg #: (b)(6)-4
Ph: Military Unit: UNKNOWN

16 Apr 03 @ 0000 (Coll) NON GYN CYTO
Clinical History: (Cont'd)
Pt s/p gsw abd, at surg noted to have peritoneal "studding" on CT has extensive ascites with enhancement

Preoperative Diagnosis:
ascites,r/o malignancy vs granulomatous dz

Operative Findings:
bilious ascites

Post Operative Diagnosis:
saa

15 Apr 03 @ 1515 (Coll) STOOL(FECES)
STOOL CU: Final Report
Bacteriology Result:
no salmonella or shigella noted

14 Apr 03 @ 0457 (Coll) BLOOD

WBC	14.8	H	(4.8-10.8)	K/UL
RBC	4.3	L	(4.7-6.1)	1X10 6/UL
HGB	11.9	L	(14.0-18.0)	g/dL
HCT	36.0	L	(42-52)	%
MCV	83.1		(80-94)	fL
MCH	27.4		(27-32)	pg
MCHC	33.0		(31-37)	g/dL
RDW	15.8	H	(12-14)	%
PLT CNT	836	H	(150-450)	1x10 3/UL

Result Comment:
Critical result verified by repeat analysis
Notified LT (b)(6)-2 on 4FP of result @ 0810 -- (b)(6)-2

MPV	8.4		(7.4-10.4)	FL
NEUT/100 WBC	64.7			%
NEUT%	9.6			1x10 3/UL
LYMPHS/100 WBC	23.8			%
LY#	3.5			1x10 3/UL
MONO/100 WBC	11.5			%
MO#	1.7			1x10 3/UL
PLT EST	HIGH			

Result Comment: MANUAL COUNT IS 855

L=Lo H=Hi *=Critical R=Resist S=Susc MS=Mod Susc I=Intermed
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Personal Dat Privacy Act of 1974 (PL 93-)

PATIENT LAB INQUIRY

For: 21 Jan 03 - 01 May 03

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

(b)(6)-4 (b)(6)-4 M/21d Reg #: (b)(6)-4

Ph: Military Unit: UNKNOWN

14 Apr 03 @ 0457 (Coll)				BLOOD
14 Apr 03 @ 0457 (Coll)				SERUM
NA+	136	L	(137-145)	mmol/L
K	4.1		(3.6-5.0)	mmol/L
CL-	100		(97-107)	mmol/L
CO2	30		(22-31)	mmol/L
BUN	8	L	(9-21)	mg/dL
GLUCOSE	110		(76-110)	mg/dL
CREAT	0.6	L	(0.8-1.5)	mg/dL
10 Apr 03 @ 1351 (Coll)				SERUM
STAT NA+	139		(137-145)	mmol/L
K	3.8		(3.6-5.0)	mmol/L
CL-	95	L	(97-107)	mmol/L
CO2	37	H	(22-31)	mmol/L
BUN	8	L	(9-21)	mg/dL
GLUCOSE	113	H	(76-110)	mg/dL
CREAT	0.6	L	(0.8-1.5)	mg/dL
CA	8.1	L	(8.8-10.4)	mg/dL
PHOSPHORUS	3.9		(2.5-4.5)	mg/dL
URIC ACID	3.5		(3.3-8.4)	mg/dL
PROTEIN TOTAL	6.9		(6.3-8.3)	g/dL
ALBUMIN	2.9	L	(3.5-5.0)	g/dL
AST	34		(15-46)	U/L
ALT	33		(11-66)	U/L
LDH	804	H	(313-618)	U/L
ALKPHOS	352	H	(70-250)	U/L
TBILI	1.0		(1.0-10.5)	mg/dL
GCT	151	H	(8-78)	U/L
CK	54		(0-203)	U/L
MG	2.3	H	(1.7-2.2)	mg/dL

Interpretations:

10 Apr 03 @ 1351 (Coll)				PLASMA
STAT APTT	21.2	L	(23.8-35.5)	Seconds
PT	13.6		(11.6-14.4)	Seconds
INR	**1.1**			

Interpretations:

The current recommended therapeutic range for INR is 2.0-3.0 for a11 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

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PATIENT LAB INQUIRY

For: 21 Jan 03 - 01May 03

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

(b)(6)-4 (b)(6)-4 M/21d Reg #: (b)(6)-4

Ph: Military Unit: UNKNOWN

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10 Apr 03 @ 1351 (Coll) PLASMA

Interpretations: (Cont'd)

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.

10 Apr 03 @ 1351 (Coll) BLOOD

STATWBC	16.9	H	(4.8-10.8)	K/UL
RBC	4.4	L	(4.7-6.1)	1X10 6/UL
HGB	12.0	L	(14.0-18.0)	g/dL
HCT	37.2	L	(42-52)	%
MCV	83.6		(80-94)	fL
MCH	27.0		(27-32)	pg
MCHC	32.3		(31-37)	g/dL
RDW	16.1	H	(12-14)	%
PLTCNT	629	H	(150-450)	1x10 3/UL
MPV	8.7		(7.4-10.4)	FL
NEUT/100 WBC	62			%
LYMPHS/100 WBC	27			%
MONO/100 WBC	7			%
EOS/100 WBC	4.0			%
PLT EST	HIGH			
ANISOCMOSIS	1+			

L=Lo H=Hi *=Critical R=Resist S=Susc MS=Mod Susc I=Intermed

[]=Uncert /A=Amended Comments= (O)rder, (I)nterpretations, (R)esult

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RADIOLOGIC EXAMINATION REPORT

Patient: (b)(6)-4 FMP/SSN: (b)(6)-4

(b)(3)-1 DIAGNOSTIC RADIOLOGY (b)(3)-1
Procedure: CHEST, PA
Requested by: (b)(6)-2
Ward/Clinic: WARD 4 FWD STBD (b)(3)-1
Exam Date: 21 Apr 2003@2236
Status: COMPLETE
Exam #: (b)(6)-4
Pregnant:

Reason for Order:
R/O PNEUMOTHORAX; S/P SUBPHRENIC DRAIN PLACEMENT

Order Comment:

Result Code: SEE RADIOLOGIST'S REPORT

Report:

CF several other recent prior cxr's. Progressive collapse RLL w/ possible pneumonia, appears worse on today's exam. Recommend PA and lateral viewsif feasible. ET and NG tubes DC'd. Mediastium normal.

Transcription Date/Time: 23 Apr 2003@0802

Interpreted by: (b)(6)-2 CDR,MC,USN
Supervised by:

Approved by: (b)(6)-2 CDR,MC,USN 23 Apr 2003@0807
Supervised by:

b)(6)-4 (b)(6)-4 10 Apr 2003 / MALE FOREIGN CIVILIAN
H: W:
Reg #: (b)(6)-4 Loc: CASREC MAIN Room-Bed:
Spon (b)(6)-4 Rank: D:
SF519-B Unit: RR:

RADIOLOGIC EXAMINATION REPORT

Patient: (b)(6)-4 FMP/SSN: (b)(6)-4

(b)(6)-4

DIAGNOSTIC RADIOLOGY (b)(3)-1

Procedure: ABDOMEN SERIES, ACUTE
Requested by: (b)(6)-2
Ward/Clinic: WARD 4 FWD STBD (b)(3)-1

Exam Date: 21 Apr 2003@1447
Status: COMPLETE
Exam #: (b)(6)-4
Pregnant:

Reason for Order:
R/O SUBACUTE OSTRUCTION/ILEUS
ABD DISTENSION

Order Comment:

Result Code: ABNORMALITY, ATTN. NEEDED

Report:

AAS cf AAS of 4/15/03.
Chest: Right hemidiaphragm again elevated.
A sliver of left sided subdiaphragmatic free air is noted on the current film. Question recent surgery to explain this. Otherwise consider other causes such.as perforation. Bibasilar atelectasis and low lung volumes also noted.

Drain over the right flank, new. Scattered small bowel air and a paucity of air in the colon- small bowel not dilated. Oval densities overlying the RUQ may represent pills in the gut.

Study otherwise negative.

Conclusion: Free subdiaphragmatic air. Bowel gas pattern suggesting ileus but not obstruction.

Transcription Date/Time: 21 Apr 2003@1722

Interpreted by: (b)(6)-2 CAPT,MC,USN
Supervised by:

Approved by: (b)(6)-2 CAPT,MC,USN 21 Apr 2003@1728
Supervised by:

FOREIGN CIVILIAN

Reg #: (b)(6)-4
SF519-B

pr 003 / MALE
Loc: CASREC MAIN
Spon: (b)(6)-4
Unit!

H: W:
Room-Bed:
Rank: D:
RR:

RADIOLOCIC EXAMINATION REPORT

Patient: (b)(6)-4 FMP/SSN: (b)(6)-4

(b)(6)-4 (b)(6)-4

Reg #: (b)(6)-4

SF519-B

10 Apr 2003 / MALE
Loc: CASREC MAIN
Spon: (b)(6)-4
Unit:

FOREIGN CIVILIAN
H: W:
Room-Bed:
Rank: D:
RR:

RADIOLOGIC EXAMINATION REPORT

Patient: (b)(6)-4 FMP/SSN: (b)(6)-4

(b)(3)-1 DIAGNOSTIC RADIOLOGY (b)(3)-1

Procedure: KUB
Requested by: (b)(6)-2
Ward/Clinic: CASREC MAIN

Exam Date: 10 Apr 2003@1313
Status: COMPLETE
Exam #: (b)(6)-4
pregnant:

Reason for Order:
POST OP

Order Comment:

Result Code: SEE RADIOLOGIST'S REPORT

Report:

Portable films of the abdomen are of limited diagnostic quality. No gross bowel dilatation or free gas is identified. Recommend in-dept films if feasible.

Transcription Date/Time: 10 Apr 2003@1411

Interpreted by: (b)(6)-2 CDR,MC,USN
Supervised by:

Approved by: (b)(6)-2 CDR,MC,USN 10 Apr 200301413
Supervised by:

b)(6)-4 (b)(6)-4 FOREIGN CIVILIAN

10 Apr 2003 / MALE
Reg #: (b)(6)-4 Loc: CASREC MAIN
Spon: (b)(6)-4
SF519-B Unit:

H: W:
Room-Bed:
Rank: D:
RR:

RADIOLOGIC EXAMINATION REPORT

Patient: (b)(6)-4 FMP/SSN: (b)(6)-4

(b)(3)-1

Procedure: PORTABLE, CHEST (AP ONLY)
Requested by: (b)(6)-2
Ward/Clinic: WARD 4 FWD PORT (b)(3)-1

DIAGNOSTIC RADIOLOGY (b)(3)-1
Exam Date: 17 Apr 2003@1703
Status: COMPLETE
Exam #: (b)(6)-4
Pregnant:

Reason for Order:
ETT PLACEMENT

Order Comment:

Result Code: SEE RADIOLOGIST'S REPORT

Report:

Compared with exam 15APR03. Interval intubation with tip in right mainstem bronchus - ward notified. NG tube noted with tip below film. Low lung volumes with atelectasis, less likely infiltrate. No pneumothorax. Remainder of exam is stable.

Transcription Date/Time: 17 Apr 2003@1712

Interpreted by: (b)(6)-2 MD LCDR, MC ,USN
Supervised by:

Approved by: (b)(6)-2 MD LCDR, MC ,USN 18 Apr 2003@1436
Supervised by:

(b)(6)-4 (b)(6)-4 FOREIGN CIVILIAN
10 Apr 2003 / MALE H: W:
Reg #: (b)(6)-4 Loc: CASREC MAIN Room-Bed:
Spon: (b)(6)-4 Rank: D:
SF519-B Unit: RR:

RADIOLOGIC EXAMINATION REPORT

Patient (b)(6)-4 FMP/SSN: b)(6)-4

b)(3)-1

Procedure: CT, ABDOMEN W/O
Requested by: (b)(6)-2
Ward/Clinic: WARD 4 FWD PORT (b)(3)-1

COMPUTED TOMOGRAPHY
Exam Date: 16 Apr 2003@0927
Status: COMPLETE
Exam #: (b)(6)-4
Pregnant:

Reason for Order:
ABDOMINAL DISTENTION

Order Comment:

Result Code: SEE RADIOLOGIST'S REPORT

Report:

1cm axial images thru the abdomen and pelvis after the uneventful administration of IV contrast.

The lung bases are remarkable for a small right effusion and bilateral atelectasis although the left base is suspicious for an infiltrate.

There are multiple intermediate density loculated fluid collections scattered through out the abdomen - which have enhancing rims, ranging in size from one to several cm's. The bulk of these collections are on the right.

The liver, spleen, pancreas, adrenal glands, kidneys, ureters, and bladder are normal. The prostate gland was not viusalized. The GI tract is normal except the asceding colon with is surrounded by these collections and is not well visualized. On a single image #25 there is a filling defect within the ascending colon of uncertain etiology. However, the bowel is unprepped. There is some wall thickening in this location. There are scattered less than 5mm mesenteric and para-aortic lymph nodes. No peritoneal studding or caking is seen on this exam. No free air is seen. Bones are remarkable only for a bridging osteophyte / partial fusion of the superior right sacroiliac joint.

Impression:

1. Left lower lobe infiltrate.

(b)(6)-4 (b)(6)-4 FOREIGN CIVILIAN
10 Apr 2003 / MALE H: W:
Reg #: (b)(6)-4 Loc: CASREC MAIN Room-Bed:
Spon: (b)(6)-4 Rank: D:
SF519-B Unit: RR:

RADIOLOCIC EXAMINATION REPORT

Patient: (b)(6)-4 FMP/SSN: (b)(6)-4

2. Multiple fluid collections may represent abcess. This finding di~cussed with Dr (b)(6)-2 at time of exam.

3. No definte evidence of intraperitonal neoplasm although the ascending colon is not well visualzed. The filling defect in the ascending colon could be stool. If concerned for a GI process, recommend barium enema or colonoscopy.

4. Right sacro-iliac joint finding likley degenerative in nature.

Transcription Date/Time: 16 Apr 2003@1100

Interpreted by: (b)(6)-2 MD LCDR, MC ,USN
Supervised by:

Approved by: (b)(6)-2 MD LCDR, MC ,USN 18 Apr 2003@1436
Supervised by:

(b)(6)-4 (b)(6)-4 FOREIGN CIVILIAN
10 Apr 2003 / MALE H: W:
Reg #: (b)(6)-4 Loc: CASREC MAIN Room-Bed:
Spon: (b)(6)-4 Rank: D:
SF519-B Unit: RR:

Personal Data - Privacy Act 4 (PL 93-579) Printed date: 01 May 2003@1556
Page: 1

RADIOLOGIC EXAMINATION REPORT

Patient: (b)(6)-4 FMP/SSN: (b)(6)-4

(b)(3)-1

DIAGNOSTIC RADIOLOGY (b)(3)-1

Procedure: ABDOMEN SERIES, ACUTE
Requested by: (b)(6)-2
Ward/Clinic: WARD 4 FWD PORT (b)(3)-1

Exam Date: 15 Apr 2003@0904
Status: COMPLETE
Exam #: (b)(6)-4
Pregnant:

Reason for Order:
DIARRHEA AND FAILURE TO EAT S/P EX LAP

Order Comment:

Result Code: SEE RADIOLOGIST'S REPORT

Report:

Minimal gas in abdomen. Gas in stomach. No dilated bowel. No free gas.
Bones normal. Right basal atelectasis.

Transcription Date/Time: 15 Apr 2003@0939

Interpreted by: (b)(6)-2 CDR,MC,USN
Supervised by:

Approved by: (b)(6)-2 CDR,MC,USN 15 Apr 2003@0940
Supervised by:

(b)(6)-4 (b)(6)-4

10 Apr 2003 / MALE
Loc: CASREC MAIN
Spon: (b)(6)-4
Unit:

FOREIGN CIVILIAN
H: W:
Room-Bed:
Rank: D:
RR:

Reg #: (b)(6)-4

SF519-B

MEDCOM - 5971

RADIOLOGIC EXAMINATION REPORT

Patient: (b)(6)-4 FMP/SSN: (b)(6)-4

(b)(3)-1

Procedure: C-SPINE (2)
Requested by: (b)(6)-2
Ward/Clinic: WARD 5 FWD STBD (b)(3)-1

DIAGNOSTIC RADIOLOGY (b)(3)-1
Exam Date: 12 Apr 2003@0827
Status: COMPLETE
Exam #: (b)(6)-4
Pregnant:

Reason for Order:
ADDITIONAL VIEW

Order Comment:

Result Code: SEE RADIOLOGIST'S REPORT

Report:

Three views were obtained. The vertebrae and alignment are normal. There is no evidence of fracture, subluxation, or other acute abnormality.

IMPRESSION: Normal Cervical Spine

Transcription Date/Time: 12 Apr 2003@1310

Interpreted by: (b)(6)-2 CDR,MC,USN
Supervised by:

Approved by: (b)(6)-2, CDR,MC,USN 12 Apr 2003@1849
Supervised by:

(b)(6)-4 (b)(6)-4

Reg #: (b)(6)-4

SF519-B

10 Apr 2003 / MALE
Loc: CASREC MAIN
Spon: (b)(6)-4
Unit:

FOREIGN CIVILIAN
H: W:
Room-Bed:
Rank: D:
RR:

RADIOLOGIC EXAMINATION REPORT

Patient: (b)(6)-4 FMP/SSN: (b)(6)-4

b)(3)-1 DIAGNOSTIC RADIOLOGY (b)(3)-1

Procedure: CHEST, AP (PORTABLE)
Requested by: (b)(6)-2
Ward/Clinic: CASREC MAIN

Exam Date: 10 Apr 2003@1317
Status: COMPLETE
Exam #: (b)(6)-4
Pregnant:

Reason for Order:
R/O INFILTRATES

Order Comment:

Result Code: SEE RADIOLOGIST'S REPORT

Report:

AP Portable view of chest shows motion artifact and low lung volumes. Apparaent increase lung in density is probably due to film technique.Repeat exam is recommended.

Transcription Date/Time: 10 Apr 2003@1404

Interpreted by: (b)(6)-2 CDR, MC, USN
Supervised by:

Approved by: (b)(6)-2 CDR, MC, USN 10 Apr 2003@1407
Supervised by:

(b)(6)-4 (b)(6)-4 FOREIGN CIVILIAN
10 Apr 2003 / MALE H: W:
Reg #: (b)(6)-4 Loc: CASREC MAIN Room-Bed:
Spon: (b)(6)-4 Rank: D:
SF519-B Unit: RR:

MEDCOM - 5973

RADIOLOGIC EXAMINATION REPORT

(b)(6)-4
(b)(3)-1
FMP/SSN: (b)(6)-4

CT ABD/PELVIS W/CONTRAST
by: (b)(6)-2 (b)(3)-1
ic: WARD 4 FWD STBD

COMPUTED TOMOGRAPHY
Exam Date: 21 Apr 2003@1720
Status: TRANSCRIBED
Exam #: (b)(6)-4
Pregnant:

r Order:
ON VS INTESTINAL LEAK VS REACCUMULATION OF BILOMA. PLEASE CONSIDER
OUS DRAINAGE OF ANY COLLECTIONS. HAS DRAINS IN RIGHT CUTTER AND
.C SPACE

nment:

ode: SEE RADIOLOGIST'S REPORT

JE: Axial CT images of abdomen and pelvis were acquired at 10mm
ıion. Intravenous and oral contrast were administered.

5: The current examination is compared to a similar study from 16
003. There is right basilar atelectasis and a right pleural effusion.
s re-accumulation of a large fluid collection over the dome of the
A drain is in a subhepatic location with marked decrease in the size
fluid collection it is draining. There is also a drain in the right
, Also smaller are several fluid collections in the mid-abdomen and
, A collection beneath the anterior abdominal wall has also decreased
e. The gallbladder is relatively decompressed with surrounding fluid
but less than on the previous study. The gallbladder and all of the
collections have enhancing walls, unchanged from the prior study. The
and spleen are normal in attenuation. Pancreas has a stable
'ance. The adrenal glands and kidneys are normal in appearance. The
/s enhance symmetrically and there is no evidence of hydronephrosis.
noted is a 3cm lobulated mass in the cecum which measures -59HU and
represent a lipoma. Small mesenteric and para-aortic lymph nodes are
nged and do not meet CT criteria far pathologic enlargement. Fluid is
ing the right colon. Midline abdominal incision from recent
ploration. No extravasation of gastrointestinal contrast media.

**********ATTENTION**********
* THIS REPORT IS PENDING APPROVAL BY RADIOLOGY AND *
* SHOULD NOT BE INTERPRETED AS THE FINAL REPORT. *
****

(b)(6)-4 (b)(6)-4
(b)(6)-4
19-B

10 Apr 2003 / MALE
Loc: CASREC MAIN
Spon: (b)(6)-4
Unit:

FOREIGN NATIONAL - POW/INTERN
H: W:
Room-Bed:
Rank: D:
RR:

MEDCOM - 5974

RADIOLOGIC EXAMINATION REPORT

Patient: (b)(6)-4 FMP/SSN: (b)(6)-4

IMPRESSION:

1. Interval placement of two drains, as above with decreasing size of all fluid collections except the collection over the dome of the liver which has increased in size; this collection is amenable to percutaneous drainage.

2. 3cm fat-containing cecal mass, as described above;

3. No evidence of extravasation of contast;

4. Post-operative changes.

Discussed with Dr. (b)(6)-2

Transcription Date/Time: 21 Apr 2003@2107

Interpreted by: (b)(6)-2 CDR,MC,USN
Supervised by:

Approved by:
Supervised by:

**********ATTENTION**********
* THIS REPORT IS PENDING APPROVAL BY RADIOLOGY AND *
* SHOULD NOT BE INTERPRETED AS THE FINAL REPORT. *
****

(b)(6)-4 (b)(6)-4 FOREIGN NATIONAL - POW/INTERN
10 Apr 2003 / MALE H: W:
Reg #: (b)(6)-4 Loc: Room-Bed:
Spon: b)(6)-4 Rank: D:
SF519-B Unit: RR:

RADIOLOGIC EXAMINATION REPORT

Patient: (b)(6)-4 FMP/SSN: (b)(6)-4

b)(3)-1

Procedure: CT, ABD/PELVIS W/CONTRAST
Requested by: (b)(6)-2
Ward/Clinic: WARD 4 FWD STBD (b)(3)-1

COMPUTED TOMOGRAPHY
Exam Date: 21 Apr 2003@1640
Status: COMPLETE
Exam # (b)(6)-4
Pregnant:

Reason for Order:
OBSTRUTION VS INTESTINAL LEAK VS REACCUMULATION OF BILOMA. PLEASE CONSIDER PERCUTANEOUS DRAINAGE OF ANY COLLECTIONS. HAS DRAINS IN RIGHT GUTTER AND SUBHEPATIC SPACE

Order Comment:

Result Code: SEE RADIOLOGIST'S REPORT

Report:

AAS cf AAS of 4/15/03.

Chest: Right hemidiaphragm again elevated. A sliver of left sided subdiaphragmatic free air is noted on the current film. Question recent prior surgery? Otherwise consider other causes of free intraabdominal air such as perforation. Bibasilar atelectasis and low lung volumes.

Drain over the right flank, new. Air collections scattered throughout the small bowel and gasless colon consistent with ileus but not suggesting obstrucion at this point. Oval densities over the left UQ most likely pill frags in the bowel.

Study otherwise negative.

Transcription Date/Time: 21 Apr 2003@1640

Interpreted by: (b)(6)-2 CAPT,MC,USN
Supervised by:

Approved by: (b)(6)-2 CAPT, MC, USN 21 Apr 2003@1648
Supervised by:

Amended Result Code: ABNORMALITY, ATTN. NEEDED

(b)(6)-4 (b)(6)-4 FOREIGN NATIONAL - POW/INTERN
10 Apr 2003 / MALE H: W:
Reg #: (b)(6)-4 Loc: CASREC MAIN Room-Bed:
Spon: (b)(6)-4 Rank: D:
SF519-B Unit: RR:

RADIOLOGIC EXAMINATION REPORT

Patient: (b)(6)-4 FMP/SSN: (b)(6)-4

Amended:
Though this exam was for CT of the abdomen/pelvis, the Acute Abdominal Series exam # (b)(6)-4 was inadvertantly dictated onto this CT report instead of the CT. The CT will be reported on a separate dictation after being re-ordered.

Transcribed Date/time: 21 Apr 2003@1715

Interpreted by: (b)(6)-2 CAPT,MC,USN
Supervised by:

Approved by: (b)(6)-2 CAPT,MC,USN 21 Apr 2003@1719
Supervised by:

(b)(6)-4 (b)(6)-4 FOREIGN NATIONAL - POW/INTERN

Reg #: (b)(6)-4 10 Apr 2003 / MALE H: W:
Loc: CASREC MAIN Room-Bed:
Spon: (b)(6)-4 Rank: D:
SF519-B Unit: RR:

b)(3)-1

Personal Data - Privacy Act of 1974 (PL 93-579)
PATIENT LAB INQUIRY 03
For: 14 Apr 03 - 17 Apr

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

(b)(6)-4 [redacted] M/7d Reg

Ph: Military Unit: UNKNOWN

16 Apr 03 @ 2129 (Coll) SERUM
Order comment: PRE-OP

NA+	136	L	(137-145)	mmol/L
K	3.9		(3.6-5.0)	mmol/L
CL-	100		(97-107)	mmol/L
CO2	33	H	(22-31)	mmol/L
BUN	5	L	(9-21)	mg/dL
GLUCOSE	122	H	(76-110)	mg/dL
CREAT	0.6	L	(0.8-1.5)	mg/dL
CA	8.5	L	(8.8-10.4)	mg/dL
PHOSPHORUS	4.9	H	(2.5-4.5)	mg/dL
URIC ACID	4.6		(3.3-8.4)	mg/dL
PROTEIN TOTAL	6.3		(6.3-8.3)	g/dL
ALBUMIN	2.7	L	(3.5-5.0)	g/dL
AST	28		(15 -46)	U/L
ALT	37		(11-66)	U/L
LDH	694	H	(313-618)	U/L
ALK PHOS	287	H	(70-250)	U/L
TBILI	0.6	L	(1.0-10.5)	mg/dL
GGT	104	H	(8-78)	U/L
CK	42		(0-203)	U/L
MG	2.0		(1.7-2.2)	mg/dL

Interpretations:

16 Apr 03 @ 2129 (Coll) BLOOD
Order comment: PRE-OP

WBC	13.4	H	(4.8-10.8)	K/UL
RBC	4.6	L	(4.7-6.1)	1X10 6/UL
HGB	12.5	L	(14.0-18.0)	g/dL
HCT	37.8	L	(42-52)	%
MCV	83.1		(80- 94)	fL
MCH	27.5		(27-32)	pg
MCHC	33.1		(31- 37)	g/dL
RDW	15.9	H	(12 -14)	%
PLTCNT	827	H	(150-450)	1x10 3/UL

Result Comment: NOTIFIED ENS (b)(6)-2 @ 2229 (b)(6)-2

MPV	7.9		(7.4-10.4)	FL
NEUT/100 WBC	46.7			%
NEUT%	6.3			1x10 3/UL
LYMPHS/100 WBC	38.3			%
LY#	5.1			1x10 3/UL
MONO/100 WBC	15.0			%

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

Personal Data - Privacy Act of 1974 (PL 93-579)
PATIENT LAB INQUIRY
For: 14 Apr 03 - 17 Apr 03

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

(b)(6)-4 (b)(6)-4 M/7d Reg #: (b)(6)-4
Ph: Military Unit: UNKNOWN

16 Apr 03 @ 2129 (Coll)				BLOOD
MO#	2.0			1x10 3/UL
BAS#	<0.2			1x10 3/UL
16 Apr 03 @ 1617 (Coll)				BODY FLUID
WBC	135			MM3
RBC	1225			MM3
COLOR	BROWN			MM3
APPEARANCE	CLOUDY			
MN CELL	23			
PMN CELLS	77			MM3
16 Apr 03 @ 1354 (Coll)				SERUM
PROTEIN TOTAL	3.2	L	(6.3-8.3)	g/dL
Order comment: ascites fluid				
ALBUMIN	1.1	L	(3.5-5.0)	g/dL
Order comment: ascites				
TBILI	12.6	H	(1.0-10.5)	mg/dL
15 Apr 03 @ 1515 (Coll)				STOOL(FECES)

STOOL CU: Final Report

Bacteriology Result:
no salmonella or shigella noted

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

ANTIBIOTIC: A—
TIME GIVEN:
OTHER: 10 versed / 550 meg fenny

NNMC 6320/16 (05/91)
RECOVERY ROOM RECORD

OPERATION PERFORMED	AGENTS AND TECHNICS OF ANESTHESIA
Flex Colonoscopy	Conscious Sedation

HOUR(S) 1400 15 30 45 2:150 15 30 45 15 30 45

TEMPS: 220 200 180 160 140 120 100 80 60 40 20
RESP. RATE
NUMBERS FOR REMARKS ① ② ③ ④ ⑤ ⑥

Spinal Level:
EKG to monitor on ☐ Rhythm SR-ST
BP ┴ art
BP v ∧ cuff
Pulse = •
% Sat:

OXYGEN THERAPY

RWTE	LM	8	ON	OFF
MASK	10		Arrival	1454
T-BAR				
VENTILAT.				

FLUID THERAPY

TYPE	5% D/RL	BLOOD	SALINE	OTHER
OPERATING ROOM	800			
RECOVERY ROOM	300			
TOTAL	1100			

BLOOD LOSS IN OR: 0 CC
WARD PRE-OP BP 136/80 mmHg
TUBES: ☐ N/G ☐ FOLEY
18g IV IN: RFA ē 300 cc
OF LR AT 300 cc/hr AOW
IV IN: RFA ē 1000 cc
18g OF LR AT KVO cc/hr TOW
ART. LINE IN
T-TUBES, HEMOVAC IN

ADMISSION	DISCHARGE
FROM MOR/SPEC. STUDY DATE 4/15 HRS 1448	TO WARD 4FS DATE 4/15 HRS 1545
DRESSINGS: LOCATIONS abd	
STATUS: CD : I	STATUS: CDI

	MOR	PACU	URINARY OUTPUT		DRAINAGE		
TIME	Arrival	1540	-				
CC	0	25					
TOTAL		25					
SP. GR							
S/A							

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

AIRWAY / BREATH SOUNDS
☑ CLEAR ☐ PLAST AIRWAY ☐ OBSTRUCTS EASILY | STATUS: CLEAR

REMARKS (AS NUMBERED) AND PERTINENT PATIENT PROGRESS NOTES

1) AOW from MOR accompanied by [redacted] (b)(6)-2
PMH: anorexia s/p GSW to abdomen [illegible]?
Neuro: Awake –
Pain (Yes)/No Action: abdominal
CV: S1 S2 ⊖ IV: patent
Other: [illegible] ↓ low portion. [illegible]
↑ x 2
(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

RECOVERY: ☐ COMPLICATED ☑ UNEVENTFUL

PATIENT'S IDENTIFICATION: [redacted] (b)(6)-4

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	

SIGNATURE OF RECEIVING AND RELEASING OFFICERS [redacted] (b)(6)-2
TOW [redacted] (b)(6)-2 [redacted] (b)(6)-2

MEDCOM - 5980

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)

(7) O2 d/c for O2 sat 92-94% on RA [illegible] (3) [illegible] in to speak to pt — gave instructions about (1) site dressing [illegible] (4) Pt requesting [illegible] to help him burp. BS ⊕ all quads. Abdomen distended. Tight but not hard. (b)(6)-2 (8) O2 d/c off [illegible] (6) Pt meets PACU discharge criteria — report called to [illegible] (b)(6)-2 4FS (b)(6)-2

TOW Note: Neuro: A&O x3

Pain: Yes/No (No circled) Action:

Pulmonary: LUNGS CLEAR TO AUSCULTATION

CV: S1 S2 EKG Rhythm: NSR IV: PATENT & INTACT

Skin/Wound: NO DRNG. SITE OVER ABD Drainage Yes/No (No circled) Color: Edema Yes/No (No circled)

GI: STOMACH DISTENDED NORMAL BOWEL SOUNDS

GU: Foley Yes/No (No circled) Color of urine: —0— Due to void: [illegible] @ 15:40 [illegible]

Instructions/Interventions in PACU: PT TOLD OF TOW. TOLD TO ASK FOR ASSISTANCE IN AMBULATION.

Report called to: [illegible] (b)(6)-2 By: (b)(6)-2 [illegible]

TOWed to: 4FS By: [illegible] (b)(6)-2 [illegible] (b)(6)-2

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

MEDCOM - 5981

508-111

NSN 7540-00-634-4121

MEDICAL RECORD | **DOCTOR'S ORDERS** (Sign all orders)

DATE AND TIME START	~~STOP~~	RX	DRUGORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
15APR05 1430			**ANESTHESIA PACU ORDERS**		
		(1)	Admit to PACU.		(b)(6)-2
		(2)	Allergies: NKDA		(b)(6)-2
		A (3.)	Vital signs per PACU protocol.		(b)(6)-2
		(4)	O2: ___FM @ 10LPM, ____% Blowby, ✓ NP @ 3 LPM.		
		(5.)	IVF: LR at 200 cc/hr		
		(6)	On ward: 02 @ **2-3** LPM **via** NC: YES (NO)		
		(7)	Pain medication:		
			~~Ketorolac ___ mg IV x1 dose (adults 30 mg max; peds consider 0.2-0.4 mg/kg)~~		
			MSO_4 2 mg IV q 6 min pm; max dose 12 **mg**		
			~~Fentanyl ___ mcg IV q ___ min prn; max dose ___ mcg~~		
			~~Percocet ___ tab(s) p.o. with sip of water~~		
			Other: Meperidine 25mg IV x1 PRN shivering		
		(8.)	Antiemetics:		
			Ondansetron 4 mg IVP, may repeat **x**1 in 15 min (0.1mg/kg; max 4 mg)		
			Metoclopramide ___ mg IV x1 (0.15 mg/kg; max 10 mg)		
			~~Droperidol ___ mg IV x 1 dose (0.01 mg/kg; max 0.625 mg) Must have baseline ECG available before administration.~~		
			Other		
			Clear liquids as tolerated: (YES) NO		
		(10.)	Notify Anesthesi (b)(3)-1 for airway issued, pain, nausea/vomiting not responsive to above orders or other patient problems/concerns per PACU protocol. (b)(6)-2		

(rev 3/2002) (OVER)

e on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: t, first. middle; grade; rank: rate: hospital or medical facility) | REGISTER NO. | WARD NO.

(b)(6)-4 (b)(6)-2

DOCTOR'S ORDERS
Medical Record

STANDARD FORM 508 (Rev. 3-94)
Prescribed by GSA.ICMR. FIRMR (41 CFR) 201-9.202-1

MEDCOM - **5982**

MEDICAL RECORD

DOCTOR'S CRDERS
(Sign all orders)

DATE AND TIME START	STOP	FIX	DRUGORDERS	OOCTOR S SIGNATURE	NURSE S SIGNATURE
15APR03 1430			**ANESTHESIA PACU ORDERS -- CONTINUED**		
		11.	Discharge patient from PACU per protocol: YES NO		(b)(6)-2
		12.	When epidural/spinal patients meet discharge criteria per PACU protocol, discharge to ward. On ward: bedrest pending full recovery of sensory and motor function; progress to ambulation with assistance.		
			FOR PACU KEEP PATIENTS ONLY		
		13.	Release patient from anesthesia care to KEEP status when patient meets anesthesia discharge criteria: YES NO		
			Notify anesthesia (1506) for airway management and: (circle if applicable)		
			a. Pain management		
			b. Fluid management		
			c. Other _____		
			TOW patient to ward in a.m. if patient meets discharge criteria: YES NO		
			Signature (b)(6)-2 (b)(6)-2 Beeper		
			(b)(6)-2 15Apr03		

STANDARD FORM 508 (Rev. 3-94) BAC

MEDCOM - 5983

Pre / Post-anesthetic Summary

NNMC 6320/279 (Dec-10)

Proposed Operation	Age	Weight (kg)	Height (in)	ASA Status	Allergies
Colonoscopy Esophagogastroduodenoscopy	~50	~70	5'4"	1 (2) 3 4 5 E	NKDA

Chemistries

Hematology
H / H -
Platelets -
WBCs -

Coags
PT -
INR -
PTT -

Urinalysis / HCG

NPO - ✓
Teeth - own Short neck Prominent teeth
Airway - MP I / II / III / IV
(FROM) ___ FB O, ___ FB HM

Respiratory
Cough:
Sputum:
Asthma:
COPD:
Recent URI:
TB:
Lung Exam: CTA (b)(6)-2
CXR:

CV
HTN:
CAD:
MI:
CHF:
VHD:
Arrythmias:
Exercise Tolerance:
Cardiac Exam: RRR
ECG:

CNS / Skeletal
Seizure:
CVA:
LOC:
Neuro:
Muscle:
Skeletal:
Misc

Other
Hepatic:
Renal:
GI:
Endo:
Heme:
EtOH:
Tobacco:

Mas Anesthetics:
29MAR03 ex lap (b)(6)-2

Current Medications:
Azithromycin 250mg PO QD

Premedication:

Family Hx:

Preoperative Diagnoses
~50y.o.♂ c Anorexia s/p GSW Abdomen. s/p ex lap
ASA II.
NAD.

Vitals	Pre-op	DOS
BP	136/80	
HR:	90	
Resp:	14	
Temp:	97°F	
~~PHR~~	OK 98	

Eval: (b)(6)-2 Signature Date 15APR03

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: GA.

Staff MD / CRNA signature (b)(6)-2 (b)(6)-2 Date & Time 15APR03 1330

Patient identification (b)(6)-4

Post-operative note

s/p GA for EGD + colonoscopy

☑ No apparent anesthetic complications

Signature (b)(6)-2 Date 16APR03

MEDCOM - 5984

ANESTHESIA RECOR

ANMC 4279(12/00)

Wt (kg) - 70 Ht (in) - ~54" Allergies NKDA

Procedure	Anesthe	Surgeon	OR #
EGD/Colonoscopy	(b)(6)-2	(b)(6)-2	3

Date	Anes. Start	In Room	Surg. Start	Surg. End	Anes. End	Resident/SRNA	Page
15APR03	1330	1350	1405	1443	1450		1 of 1

See Page One

Time 1400 1500 1600

O₂ L/M 3

N₂O / Air L/M

Vol% Halo / Iso / Sevo / Des

STP / Prop / Etomidate 20

Sux / Cisatracurium

Ro / Rapa / Vecuronium

Lidocaine

Neostigmine / Glyco

Ephedrine / Neo

Midazolam 10

MSO₄ / Remi / Sufentanyl 250

Epid. Lido / Bupiv / Ropiv

benzocaine 20% 2 sprays 3

NS / LR 1 400

U/O

EBL

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

180 160 140 120 100 80 60 40

PACU / ICU

Pulse - 10

BP - 146/91

Temp - 97.3

RR - 14

SaO₂ - 100%

Comps - + / -

ECG SR SR SR ST SR

Es / Np / Or / Sk / Ax Temp

% FiO₂ 3L 3L 3L 3L 3L

% SaO₂ 100 100 100 99 100

EtCO₂

TV

PIP (cmH₂O)

Resp. Rate

Checklist -
☑ O₂ ☑ Suction ☑ Machine ☑ Consent ☑ NPO

Monitors -
☑ SaO₂ ☑ ECG ☑ FiO₂ ☑ NIBP L / R arm
☑ EtCO₂ ☐ 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 ____ Used ____ Wasted ____ Witns ____
Drawn ____ Used ____ Wasted ____ Witns ____

IV - 20 Ga L R Hand Wrist FA AC EJ
☐ Tourniquet ____ mmHg Times I ____ I ____
60 / 90 / 120 / 130 / 140 / 150 min - Surgeons informed

		Antibiotics
	Total	Agent -
800cc	Total	ing -
No Foley	Total	over minutes
Minimal	Total	@

NC O2 3L an.
Monitors an.

To PACU Awake

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

Intubation - Mac / Mil ____ Grade ____ view Tube Size ____ Attempts ____ Oral / Nasal L / R w/o w/ Cuff Stylet Y / N Bil BS / EtCO₂ x 3 / CIN

Tube taped @ ____ 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

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

516-108 NSN 7540-00-634-4156

MEDICAL RECORD | Manual 3 Case #2 **OPERATION REPORT**

PREOPERATIVE DIAGNOSIS

R/O cancer

SURGEON	FIRST ASSISTANT	SECOND ASSISTANT	
Dr (b)(6)-2		Ø	
ANESTHETIST	**ANESTHETIC**		TIME BEGAN: 1435
(b)(6)-2	(b)(6)-2		TIME ENDED:
CIRCULATING NURSE	**SCRUB NURSE**	TIME OPERATION BEGAN	TIME OPERATION COMPLETED
(b)(6)-2 HN (b)(6)-2	HN (b)(6)-2	1412	1450

OPERATIVE DIAGNOSES

SAT

DRAINS *(Kind and number)* Ø

SPONGE COUNT VERIFIED (b)(6)-2 Corr.

MATERIAL FORWARDED TO LABORATORY FOR EXAMINATION

1) Dx of hepatic Flexure

1) Stool Culture for pathogens

OPERATION PERFORMED

1) Colonoscopy

2) EGD

DESCRIPTION OF OPERATION *(Type(s) of suture used, gross findings, etc.)*

Dr (b)(6)-2 - Consulted stm @ 1420

PROSTHETIC DEVICES *(Lot no.)* Ø

DATE OF OPERATION 4/16/03

Colonoscopy to cecum normal except for circumferential fullness & suture noted in area of hepatic flexure,

EGD to 3rd portion duodenum normal, including retroflex

No complications

SIGNATURE OF SURGEON (b)(6)-2

DATE 15 Apr 03

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

(b)(6)-4

REGISTER/I.D. NO.

WARD NO.

Dot (b)(6)-4

OPERATION REPORT
Medical Record

*U.S. GOVERNMENT PRINTING OFFICE: 1990-259-301

STANDARD FORM 516 (REV. 5-83)
Prescribed by GSA and ICMR, FPMR 101-11.806-8

MEDCOM - 5986

(b)(3)-1

P ' ative Plan Of Care & Nursing

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

Trauma# or Patient #

Diagnosis: R/O Cancer Planned Procedure: EGD, Colonoscopy

Date: 4/15/03 Arrival Time: 1300 Interviewer: (b)(6)-2 [illegible]

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

From: ☐ CAS/REC ☐ ICU ☑ Ward ___ 3 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 comp[lete], dated, signed ☐ Emergent case; no consent, MD note — N/A

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

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

Present On Admission: ☐ N/A ☐ Oxygen ☑ IV Site: #1 (R) forearm 20g #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:

Cultural Needs Addressed: ☐ Yes ☐ No List: N/A

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

Past Surgical History: ☐ None known ☐ Yes 65W→ ABD List: X- over sew bowel perforation

Last PO Intake: (date/time) Solid: 4/14/03 Liquid: 4/14/03

In Chart: ☑ H&P ☐ Yes ☐ No; ☐ EKG ☐ Yes ☐ No; ☐ CXR ☐ Yes ☐ No; ☐ Other: ___

Skin Condition: ☐ Intact ☑ Other: Sm wounds in lower Extremity, s/p ABD Surgery

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

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 — N/A

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

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.) — N/A

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 ABD ☐ Wilson Frame

Comments: ___

ESU # ___ Pad Site: ___ Pad Lot # ___ Site Clear at end of case? ☐ No ☐ Yes If No, see RN note # ___ Bipolar: ___ Max Cut ___ Coag ___ — N/A

DVT Prevention: SCD used ☐ No ☐ Yes Pressure: ___ ☐ Left ☐ Right Teds: ☐ No ☐ Yes **Bair Hugger used** ☐ No ☐ Yes Other warming techniques: — N/A

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

(b)(6)-4

(b)(6)-4

Comments:

Potential For Infe n **Outcome:** Appropriate Actions Taken tc Infection ☐ Yes ☐ No

Wound Classification: ☐I ☐II ☐III ☐IV

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

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

Solutions/Irrigations:
☐ Normal saline ☐ Other: _____
☐ Sterile water
☐ Local _____
☐ Antibiotics _____
NA

Drains/Packing: ☐ None
Foley FR. _____
JP #1 Fr ___ Location: _____ #2 Fr ___ Location: _____
Hemovac: Size ___ Location _____
Chest tube: Location _____ N/A
Size _____ H2O 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:**	

N/A

Miscellaneous

Counts: (initials)
Scrub: RN:
N/A
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
N/A

Skin Integrity:
☐ **Clear & Intact (other than incision)**
Comments: Skin
☐ **See RN note # f o r additional comments.**

Implants:
Item / **Lot # I Exp Date:** None

See RN note # ____ for additional comments.

Discharge from Operating Room

Complications:
None Comments: None.
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 Report by:
☐ ICU ☐ Anesthesia provider ☐ RN
☐ Medivac
☐ Ward ____
☐ Other ____

Surgical Procedure Performed: Colonoscopy, EGD A) Bx of Hepatic Lesion
1) Stool Specimen for Pathogens

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

Initial/Name Box: (please print)

(b)(6)-2

Signature Date 4/05/07

Relief OR RN Signature Date/Time

Personal Data - Privacy Act 1974 (PL 93-579) Printed date: 12 Apr 2003@1254
Page: 1

RADIOLOCIC EXAMINATION REPORT

Patient: (b)(6)-4 FMP/SSN: b)(6)-4

(b)(3)-1 DIAGNOSTIC RADIOLOGY (b)(3)-1

Procedure: CHEST- PA/LAT (NIPPLE MARKERS)
Requested by: (b)(6)-2
Ward/Clinic: WARD 5 FWD STBD (b)(3)-1

Exam Date: 11 Apr 2003@0948
Status: COMPLETE
Exam #: (b)(6)-4
Pregnant:

Reason for Order:
gsw R/O INFILTRATE

Order Comment:

Result Code: SEE RADIOLOGIST'S REPORT

Report:

PA and lat cxr cf port ap from 4/10 @ 1325:

Repeat film shows diffuse patchy infiltrates obscuring the heart obrders bilaterally c/w pneumonia, despite the increased lung volumes due to better inspiration. Atelectatic component also likely. No significant effusions noted on the lateral. Bones and soft tissues are unremarkable. Pulmonary vessels normal in size ruling out failure as cause for infiltrates.

Transcription Date/Time: 11 Apr 2003@1020

Interpreted by: (b)(6)-2 CAPT,MC,USN
Supervised by:

Approved by: (b)(6)-2 CAPT,MC,USN 11 Apr 2003@1025
Supervised by:

(b)(6)-4 (b)(6)-4 FOREIGN N VAL - POW/INTERN

10 Apr 200[illegible] MALE H: W:

Reg #: (b)(6)-4 Loc: CASREC MATN Room-Bed:

Spon: (b)(6)-4 Rank: D:

SF519-B Unit: RR:

Personal Data - Privacy Act 1974 (PL 93-579) Printed date: 12 Apr 2003@1254

Page: 1

RADIOLOCIC EXAMINATION REPORT

Patient: (b)(6)-4 FMP/SSN: (b)(6)-4

(b)(3)-1

DIAGNOSTIC RADIOLOGY

Procedure: ABDOMEN SERIES, ACUTE Exam Date: 11 Apr 2003@1457

Requested by: (b)(6)-2 Status: COMPLETE

Ward/Clinic: WARD 5 FWD STBD (b)(3)-1 Exam #: (b)(6)-4

Pregnant:

Reason for Order:
ABD MASS

Order Comment:

Result Code: SEE RADIOLOGIST'S REPORT

Report:

CXR shows low lung volumes but no gross abnormalities.
Abdomen films show large amount stool but no dilated large or small bowel, or free gas.
No abnormal calcifications. Bones normal.

Transcription Date/Time: 11 Apr 2003@1814

Interpreted by: (b)(6)-2 CDR,MC,USN
Supervised by:

Approved by: (b)(6)-2 CDR,MC,USN 11 Apr 2003@1816
Supervised by:

MEDCOM - 5990

04/16/2003 0?:1?:5? AM

Rx:
Dx:

BP:

Date:
Race:
Op:

Rate	92
PR	150
QRSD	92
QT	32?
QTc	407

--AXIS--

P	6
QRS	-63
T	25

. Normal sinus rhythm, rate 92 .... normal P axis, PV, rate & rhythm
Marked posterior QRS axis .... late V-lead transition
. Probable inferior infarct.......... 20's 2.3 F 3 ... to 240

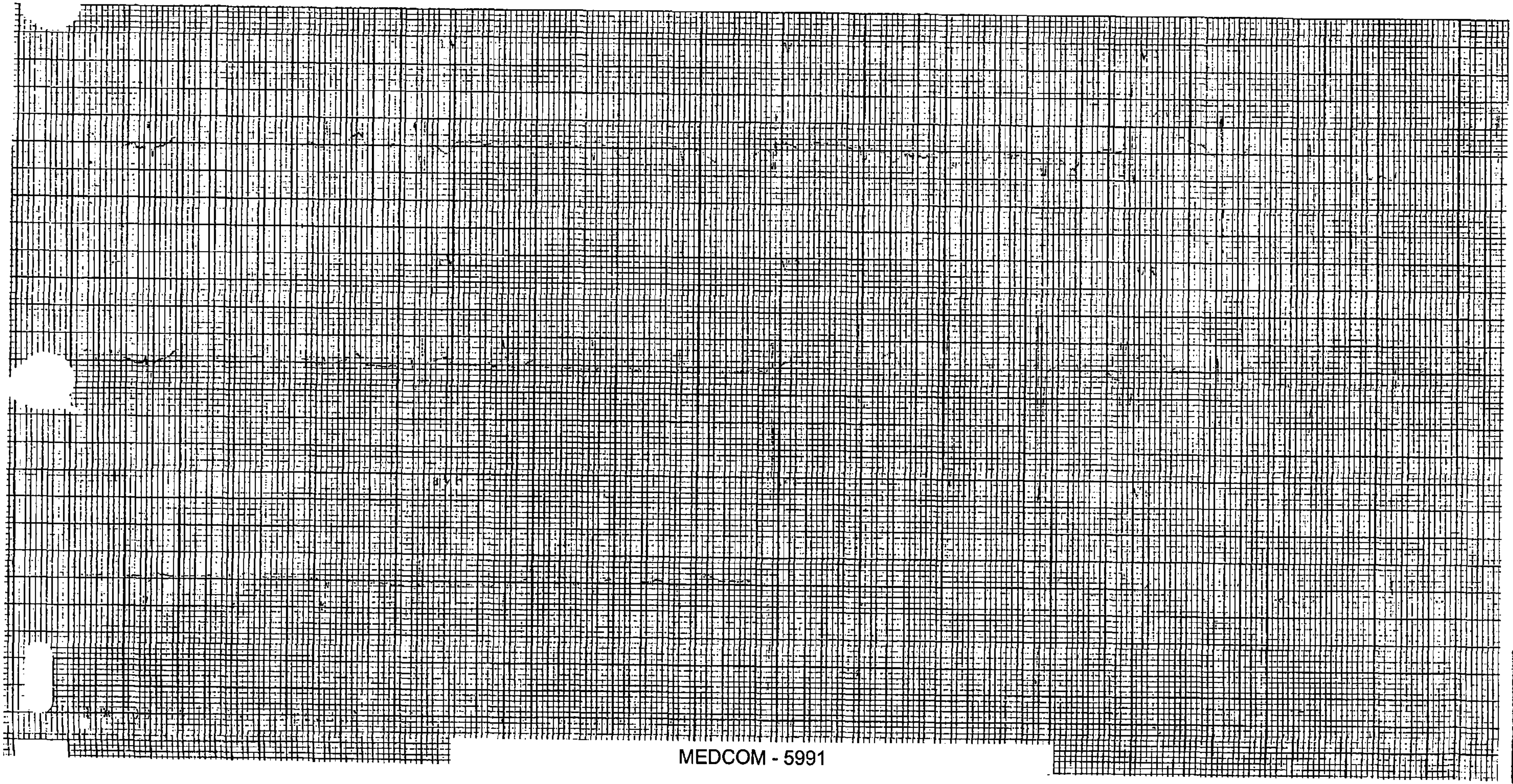
(b)(6)-4

AQUIRED @ 2050
16 APRIL 03

Requested by:

- ABNORMAL ECG -

PRELIMINARY-MD MUST REVIEW



MEDCOM - 5991

Name: (b)(6)-4

NURSING FLOW SHEET
MEDT 6550/12/Term

Date: 3N 03

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													∨											
100																								
80													• ∧											
60																								
40																								
RR													18											
TEMP													99.2											
SAO2																								
MAP																								
O2 Mode																								
DRIP/DOSE																								

Name: (b)(6)-4

NURSING [redacted] SHEET
[redacted]/Temp Form

Date: 02 May 13

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		V																						
80		01																						
60																								
40																								
RR		24											16											
TEMP		99.5											99.5											
SAO2																								
MAP																								
O2 Mode																								

DRIP / DOSE

RECOPY 4/25

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

MEDICAL RECORD | **MEDICATION ADMINISTRATION RECORD**

SCHEDULED DRUGS — MONTH _____ 19 2003 — DATES GIVEN

ORDER DATE	MEDICATION- DOSAGE- FREQUENCY ROUTE OF ADMINISTRATION	HOURS	25	26	27	28	29	30	1
4/18	FeSO4 1 tab PO TID	0700	(b)(6)-2				(b)(6)-2		
		1100							
		1700	(b)(6)-2		(b)(6)-2				
4/18	Folic Acid 1 mg PO qd	0700	(b)(6)-2						
4/19	MVI 1 tab PO qd	0700							
4/18	LOVENOX 30 MG SQ q12h	0900							
		2100							
4/22	ZANTAC 150 mg PO BID	0900	(b)(6)-2						
		1700							

INITIAL CODE

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

ADDRESSOGRAPH PLATE

(b)(6)-4

RACK # 33

RACK # 33

1 OF 1

MEDCOM - 5994

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.

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

MEDICATION ADMINISTRATION RECORD (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 650mg PO	5/4	0350	(b)(6)-2				

PRN AND VARIABLE DOSE MEDICATIONS

ORDER DATE	MEDICATION-DOSAGE FREQUENCY ROUTE OF ADMINISTRATION		DOSES GIVEN			
4/10	PERCOCET	DATE	4/29	4/23	5/2	5/2
	1-2 tabs PO	TIME	1800	1150	0735	2204
	Q3° PRN	DOSE	2	2	2	2
		INIT.	(b)(6)-2			
4/16	Benadryl 25mg	DATE	4/26	4/28		
	PO Q4° PRN	TIME	2045	2430		
		DOSE	25	25		
		INIT.	(b)(6)-2			

MEDCOM - 5995

NAVMED 6550/8 (REV. 4-74) S/N 0105-LF-2165581

MEDICAL RECORD | **MEDICATION ADMINISTRATION RECORD**

SCHEDULED DRUGS — MONTH MAY 29 30 03 — DATES GIVEN

ORDER DATE	MEDICATION-DOSAGE-FREQUENCY ROUTE OF ADMINISTRATION	HOURS	2	3	4				
4/18	FeSO4 1 tab PO TID	0700	(b)(6)-2		Refused				
		1100							
		1700							
4/18	FOLIC ACID 1 mg PO qd	0700			Refused				
4/18	MVI 1 tab PO qd	0700			Refused				
4/18	LOVENOX ~~30 mg~~ SQ q 12h	0900			(b)(6)-2				
		2100							
4/22	ZANTAC 150 mg PO BID	0400			(b)(6)-2				
		1700							

INITIAL CODE

INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE

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
⑨ = Abdomen

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

2 OF 2

MEDCOM - 5996

Received 4/18 AM

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

MEDICAL RECORD | **MEDICATION ADMINISTRATION RECORD**

SCHEDULED DRUGS — MONTH April 19 03 — DATES GIVEN

ORDER DATE	MEDICATION- DOSAGE- FREQUENCY ROUTE OF ADMINISTRATION	HOURS	18	19	20	21	22	23	24
4/18	Azithromycin 250mg po qday x4 days	0900	[b)(6)-2]	✓	✓	[b)(6)-2]			
			✓	✓	✓	✓	✓	✓	✓
4/18	Heparin 5000 u SQ BID	0900	X	[b)(6)-2]					
		2100	[b)(6)-2]						Give to Lovenox
4/18	FeSO4 1 tab po T.I.D.	0700	X	[b)(6)-2]					
		1100	X						
		1700	X						
4/18	Folic Acid 1mg po qd	0700	X						
4/18	MVI 1 tab po qd	0700	X						
4/17	METRONIDAZOLE 500MG IV Q8hr 6 Doses	0800	X	[b)(6)-2]					
		1600	X	[b)(6)-2]	X	D/C'd 6 doses			
		2400	[b)(6)-2]						
4/17	ZANTAC 50MG IV Q8°	0800	X	[b)(6)-2]					
		1600	X	[b)(6)-2]					DCD
		2400	[b)(6)-2]					[b)(6)-2]	
4/18	Lovenox 30 mg SQ q12h	0900	X	X	X	[b)(6)-2]			
		2100	X	X	[b)(6)-2]				
4/22	Tobramycin 350mg IVPB q8	1600	✓	✓	✓	✓	DCD	—	
			✓	✓	✓	✓	✓	✓	✓
4/22	Zantac 150 mg po BID	0900	X	X	X	X	X	[b)(6)-2]	
		1700	X	X	X	X	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] LCDR
					[b)(6)-2]

ADDRESSOGRAPHPLATE

[b)(6)-4]

WARD NO.

Injection Site Code

① = Lett Buttock ⑤ = Lett 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

rack #~~26~~

Rack 23

MEDCOM - 5997

MEDICATION ADMINISTRATION RECORD (Back) S/N 0105-LF-2165581

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																		
4/10	MSO4 3-5mg IVP q 3° prn pain	DATE	4/10																	
		TIME	0500																	
		DOSE	5mg																	
		INIT.	(b)(6)-2																	
4/10	Percocet 1-11 po q 3° prn	DATE	4/22	4/23																
		TIME	0145	2215																
		DOSE	1	2																
		INIT.	(b)(6)-2																	
4/12	Tylenol 650mg po q 4° PR	DATE																		
		TIME																		
		DOSE																		
		INIT.																		
4/10	Benadryl 25mg po q 4° prn	DATE	4/22																	
		TIME	0145																	
		DOSE	50mg																	
		INIT.	(b)(6)-2																	
4/16	Phenergan 25 IV prn	DATE																		
		TIME																		
		DOSE																		
		INIT.																		
		DATE																		
		TIME																		
		DOSE																		
		INIT.																		
		DATE																		
		TIME																		
		DOSE																		
		INIT.																		

b)(3)-1

CHCS Name: b)(6)-4

Date of Admission: 4/1012003

Date of Transfer:

(b)(6)-4 EPW

Age: Gender: M

History:
GSW to abdomen. X-lap and oversew of small and large bowel injuries. Peritoneal implants suggestive of cancer or granulomatous disease noted. Transferred here, tolerating diet. Hx of COPD;

Hospital Course:
Poor appetite led to CT scan and above procedures. Once drained, eating and feeling well.

Diaanoses:
s/p GSWto abdomen;, Bilious ascites,

Surgeries/Treatment:
EGD neg. Colonoscopy showed inflammation at GSW site, hepatic flexure. X-lap(17Apr) for washout and drainage of loculated bilous ascites. Dense adhesions precluding complete exam. No leak noted., Percutaneous drain placement right
subphrenic space for drainage of collection of bile.(21Ap).,

Recommendations:
Local wound care to midline abdominal incision; Drains out ~~any day~~

Special Needs:

Prognosis: Good

Physician: (b)(6)-2 LCDR Dept of General Surgery 4/24/2003