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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
30 Mar 03 1242	Patient transferred to ICU from ER. Dressing to midline gastrostomy region CDI. (+) gastric secretions via inflated through NG tube. Vented in use per protocol. Dressing to (R) UQ CDI, dressing to (R) Ulnar region CDI. Vitals HR 119, 141/86, RR 23, SPO2 97% on 2 l/o O2. (b)(6)-2
1245 (b)(6)-2	Foley draining medium dark colored urine. Vitals Stable (b)(6)-2
30 Mar 03 1300	Resp Care Note: pt. on mech vent as ordered, all settings checked & set properly. All alarms set & working; Ambu bag @ bedside. BBS fairly decreased. Vent settings Vt 750 mL, SIMV, RR 12 peep 5 cm H2O, FIO2 2 L/min Bleed-in Ex. Vt 758 mL, PIP 35, Mean 12, SpO2 94% (b)(6)-2 SIVSIH
30 March 2003	Physician Note 40-50 Dragi 8th S/P laparotomy & [illegible] colon resection, not extenized. Pt preoperatively had resp arrest. O- on vent c O2 sats >95 Abdm - soft, tender on palp; ± B-S. Heart RR ± M Lungs - Coarse rhonchi heard throughout Ext - none well A- (1) S/P lap for GSW (2) COPD (3) [illegible] per order (b)(6)-2 WMD LTC

RELATIONSHIP TO SPONSOR | SPONSOR'S N (b)(6)-2 | SPONSOR'S ID NUMBER (SSN or Other)

LAST | FIRST (b)(6)-2

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY (b)(3)-1 | REC

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

(b)(6)-4

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 *(REV 5-99)*
Prescribed by GSA/ICMR FPMR (41 CFR) 101.11 203(b)(10)

MEDCOM - 6001

ACLU-RDI 1283 p.2

DATE	NOTES
30 mar 03	2100 PT sedated, (R) nare bleeding, (L) nare NG Tube
	To LIMS, placed @ 3rd tick mark, minimal drainage.
	PT intubated c̄ vent setting FIO2 21%, TV 750, peep 5
	rate 16, on AC. Partially compensated resp acidosis, c̄
	history of copd. Tube @ 22 @ the hub. Lung sounds
	course bilat A to B. PT HR Tachycardic @ 110-120, Hypotension
	Distal Pulses +3 upper & Lower Ext. Cap ref < 3 sec. Midline
	incision from sternum to groin, Dressing C D I. Gun shot wound
	To (L) side abdomin, Dressing C D I. Foley to Gravity draining
	QS. IV in (L) hand inf. LR 125/hr
	(b)(6)-2 Spc. LPN
30 mar 2130	350 cc via foley (b)(6)-2 Spc LPN
30 mar 2240	ABG drawn, compensated Resp Acidosis
	(b)(6)-2 Spc LPN
0100 30 mar	- suction PT minimal secretions (b)(6)-2 Spc LPN
31 mar 0240	- 500 cc via foley (b)(6)-2 Spc LPM
31 mar 0605	- urine via Foley 200 cc (b)(6)-2 Spc LPN
31 Mar 0750	Resp Care Note: pt. on mech vent as ordered, all settings checked
	+ set properly. All alarms set + working. Ambu @ bedside. BBS
	slightly course t/o. Admin 10 puffs Albuterol MDI. HR 111, RR
	15. SpO2 95-96%. Vent settings A/C RR 15, VT 750, Peep 5, FIO
	1 l/min bleed-in. Exhaled VT 748, PIP 36, Mean 13. (b)(6)-2 ALVS
0900	STABLE, VS WNL, SATS 95 c̄ VENTS CHANGES DONE OVERNIGHT
	STILL ON FULLY COMP. RESP. ACIDOSIS c̄ PCO2 AROUND 50 AND
	PO2 - 84%. LUNGS MILDLY COARSE THROUGHOUT, ↓BS, ABD DRESSING
	CHANGE DONE BY MD, HEALING WELL, NG TO (L) NARE TO INT. SUCT.
	POST HX OF COPD, DRESSING ON (R) FA C/D/I, GOOD PULSES, CAP
	REFILL < 4

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STANDARD FORM 509 (REV. 5-99) BAC

MEDCOM - 6002

DOD 13214

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
30 March 2003	
1445	S⊖ Pt 50-60 y.o Iraqi male c GSW, R forearm abdomen, S/P [b)(6)-2]
	X-ray of (R) forearm shows multiple metallic fragments throughout forearm. 2 fractures noted.
	Abdomen - soft, pain on deep palp; ± BS wound dressing not disturbed
	Heart - RR
	Lungs - diffuse coarse rhonchi on inspiration throughout
	Neck - supple
A-	(1) GSW abdomen S/P lap c resection of colon
	(2) Shrapnel injury to (R) forearm
	(3) Probable COPD
P-	IV Unasyn, fluids, treat COPD as best as possible
	Watch
	[b)(6)-2] to LTC

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

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

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

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

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

MEDCOM - 6003

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MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
31 March 2003 1235	Physician note 50ish Pt operated on 29 March 2003 for GSW to abdomen, S/P resection & reanastomis of colon at that date. Pt had episode of resp. arrest ? 2° to COPD. Now pt is on vent, c FiO2 21% c SpO2 @ 97% RR 13, pulse 114, BP 139/78. Lungs - coarse bronchi thruout in all lung fields Abdom - soft, very tender to minimal palp. BS absent. Ext. (R) forearm has fragment wound, ~ fracture. ~~ABGs on 30 March~~ (b)(6)- A - (1) GSW to Abdom - s/p resection & reanastomis ? early peritonitis (2) fragment wound to (R) forearm P - Cont as is: Recheck Abdom c xrays (b)(6)-2 MA LTC

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY		RECORDS MAINTAINED AT	

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

PROGRESS NOTES
Medical Record

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

MEDCOM - **6004**

DATE	NOTES
1300	CPAP trial done, PT RR ↑ 55 but held sats above 94,
	3 mg of MSO4, 2 mg Valium and 5 mg Vecuronium given IV
	per ↑ agitation
3/31/02 1326	Respiratory Care Note: pt. vent settings A/C RR 15, VT 750 mL, Peep 5
	cmH_2O, FIO_2 2 l/min bleed in. PIP 39 cmH_2O, mean 14 cmH_2O. HR
	111, SpO_2 95%. (b)(6)-2 [illegible]
1430	Stable, VS - see flow sheet, mostly ronchi on upper lobes bilaterally
	Unasyn 3G given IV, Zantac 50 see med sheet. (b)(6)-2
1600	PT extubated VS stable, venturi mask @ 40% sats
	at 96% P - 115 BP 155/82, RR 32, ronchi breath sounds
	clear upon deep suction by RT, mostly congested (b)(6)-2
1800	Unasyn 3 gm given IV, Heparin 5000 U SQ given as ordered
	Sats 95 P 110, VS stable see flow sheet still on VM 40%.
	Lungs course in upper lobes bilaterally all other fields clear ↓ B:
	good pulses x4. Dressing change done on (R) FA, still oozing (b)(6)-2

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
31 Mar 03	Respiratory Care Note: Vent settings, AC RR 15, Vt 750, Peep 5, FIO2 1%
10:15	Blood-In. Exh. Vt 760, PIP 36, SpO2 98%. Admin 10 puffs Albuterol
	MDI, HR 111, Sm white secretions. (b)(6)-2 91V3tt
1020	5 mg of Vecuronium given IV c 2 mg of Valium 20
	minutes before, stable Albut. tx given by RT, lungs
	still coarse, SATS at 98% no changes in Vent. settings.
1155	5 mg of Vecuronium given IV, plus 5 mg of Valium IV, see
	Vs flow sheet, (b)(6)-2
	SpO2 97
	RR 13
	HR 114
	139/7
31 Mar 2130	- PT A&O x3, Lung sounds course throughout, satting 93-96
	on 30% O2 via venturi mask. PT has very productive cough c
	Traces of blood, in sputum, Normal Sinus tachy, cap ref < 3sec
	all pulses +3, superficial shrapnel wound on ~~Lt~~ (R) forearm
	Dressing CDI, Gunshot wound to (L) upper Quad abdomin
	Dressing CDI, Midline incision, Dressing CDI, No bowel
	Sounds, abdomin distended, muscle strength weak, Foley to
	Gravity QS Dark concentrated.
31 Mar 03 2300	- LR 50/cc/hr TKO [illegible] (b)(6)-2 SPC LPN

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

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

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

(b)(6)-4

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101.1 1 203(b)(10)

MEDCOM - 6006

DATE	NOTES
1 APR 03 1340 Z	Patient c̄ ↓ Sats to 88% Dr Smith notified. ↑ FiO2 to 40% VM. 24 RRs CXR ordered New Abx orders noted. O2 Sats c̄ immediate ↑ to 91-92%
1429 Z.	UNASYN D/C, CHANGED TO ROCEPHIN 1GM c̄ NEW ORDER, FOLLOWED BY 50mg OF ZANTAC, AND 400mg OF CIPRO PIGGY BAG, CXR DONE PENDING RESULTS, NEB TX DONE BY R/T, STILL COARSE THROUGHOUT, ↓ AT THE BASES, ST c̄ GOOD DISTAL PULSES, STILL UTILIZING SECONDARY MUSCLES TO BREATH, WILL CONTINUE TO MONITOR ——— [redacted]
01 APR 03 1C:49	BP 159/84 P. 93 SpO2 91%
01 Apr 03 1905	PT A&OX3. PT Lung Sound Coarse. PT IV Fluids ↓ TO 200cc/HR. PT Has foley DRAIN clear yellow urine. PT HR in low 100's. Plan for PT TO be transferred to ICW 2.
/	[redacted]
1 Apr	Pt transferred from ICW #2 pt care w/ c̄ Δ in LOC did not follow commands c/o abd pain received MSO4 4mg IV x2 Pt on O2 concentrator range from 4-8 Lpm to maintain SpO2 of 92-97%. Will continue to monitor ——— [redacted] [illegible]
02 APR 03 0800	VS T98.7 AK BP 121/79 P 80 R 24 POX 96% O2 SpO2 [redacted] [illegible]
02 APR 03	s/p ex-lap c̄ colon resection 2° to GSW (surgery 29 MAR 03) afebrile VSS 47% (4L face mask) abx: Rocephin / Cipro / Clindamycin ? COPD H/H (01 APR) = 12/35 [redacted] Cont current tx, All IN, [illegible] Total [redacted]
1000 hrs	Dsg chg Abd given Morphine 2mg pr. SPC Rukker Andrea [illegible]
1451	Resp Care Note: pt admin 2.5mg c̄ 0.5mg Atrovent via HHN. BBS w/ tp slight I+E wheezes p̄ tx. Aeration Improved HR 98, 99 98. SpO2 on 6 lm 97%. Tol tx well. [redacted] [illegible] ———

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STANDARD FORM 509 (REV. 5-99) BACK

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MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
1 Apr 03 0830	Patient alert & aroused to stimuli. Venturi mask @ 6 LPM 100% @ 92% Bilateral lungs present to auscultation & ↑ rhonchi. + cough. Mild hypertension c prior hx. Dressing to midline abdomen. Secure & clean. Respirations moderately labored. Secondary dressing to (R) abdomen CDE. + distension, - fecal output. Unable to determine plates. Strong (R) FA present c 2cm wound & dressing which is CDE. Patient c/o thirst gave sips. Started Clevis pump & wean 1/0's. (b)(6)-2
0930	Patient midline incision/wound pink/beefy red c small amount of bloody. Wet to dry dressing performed. + purulent drainage noted. (b)(6)-2
0939	Lateral wound packed c wet/dry dsg. + drainage. (b)(6)-2
1315 2 Apr 03	Pat c/o incisional pain → MS 4-2 mg IVP for pain.
1 Apr 2003	Pt's O2 sat dec to 89%; NP Lungs - have diffuse inspiratory & exp. coarse rhonchi. Pt lethargic but arousable. Abdomen is soft, tender, ↓ BS (absent about) Δ antibiotics to Rocephin & Cipro, & Clindycin. Will notify surgeon's
	(b)(6)-2

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

(b)(6)-4

PROGRESS NOTES
Medical Record

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

MEDCOM - **6008**

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MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
4 APR 03 1100	PT recieved [redacted] via IV to (L) hand...
1105z	Pt placed on 2L O2 NC to keep O2 Sat 90% or better, Pt O2 Sat 91%. Levaquin 500mg PO Given.
1110z	Late Note for 1038z, Pt Dressing D clean W/D, no signs of infection.
4 Apr 03 1235	Nutrition – Patient has been NPO for 6 days will provide Clear liquids and monitor progress will advance as tolerated to Full Signed. (b)(6)-2 MAJ SP RD Nutrition Care
1246	93% SpO2 / 108 pulse
1311	VS WNL – 92% 2L O2 pulse, 98.3 temp, 138/76 BP, 24 RR, (b)(6)-2 WNL
1620	B/P 148/76 P 101 R 24 SAO2 95% T - 98.1 Pt Heplok flushed; Pt has wheezes in upper quadrents of (L/R) Lungs. Pt abdominal dressing needs changed. New dressing applied. Pt given Neb treatment. Pt refused to cooperate w/ treatment.
2200(Z)	Pt c/o pain, motions to (L) side abd, 2 vicodin P.O. given (b)(6)-2
15 Apr 03 0445	B/P 148/80, P-92, R-18, Temp-97.6. R/R/O x - 93% on 2L O2, HRR at 92 BPM. Wheezing noted upon expiration in L + R Lung anterior and posterior. NO IV access, Abdominal dressing soiled. Cap refill <3 - Pt has weakness in right arm. Aspirin not for AOL's – SPC (b)(6)-2 WNL
06 APR 03 0800z	Chem 7 & H/H drawn and sent to lab (b)(6)-2 2LNC/RA

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

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

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV 5.99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

MEDCOM - 6009

DATE	NOTES
4/5/03	GSW ABD S/P EX-LAP ē colectomy ī 1° Reanastomosis (3/29/03)
	COPD / S/P Ventilatory Failure
	VS: 148/80 92 18 97.6 93% 2ℓ
	C/O ABD PAIN ø FLATUS
	LUNGS: Diffuse inspiratory rales / exp coarse wheezy
	ABD: Midline incision (wound - granulating well)
	Distended ↓ BS but present
	Diffuse TTP mild
	Rectal: Brown Amount stool (guaiac)
	P) ① Clears (Cautiously) ③ Hold narcotics (1)
	② Supplemental O2 (b)(6)-2 (b)(6)-2
1615	B/P 158/82 P 104 R 24 SAO2 95% T 98.9 Pt took neb treatment Pt abdominal dressing needs changed — SPC (b)(6)-2
	Pt has decreased strength in (R) hand. Pt can feel and has good cap refill. → SPC (b)(6)-2
2340	Pt c/o Abdominal PN, Pt has decreased bowl sounds in all 4 quadrents. Pt stomach is distended. Consult ē Dr (b)(6)-2 a.m. for advise — SPC (b)(6)-2
0220	Pt recieved Neb Treatment ē saline and Atrivent — SRT (b)(6)-2
0600	LE Pt recieved Neb Treatment ī saline + Atrivent 2cc SRT (b)(6)-
4APR03	VITALS - TEMP 98.2, B/P 160/96 Pulse 96, SpO2 95%
0445	Resp 26 — SPC (b)(6)-2
1654	RR 32 100.9 TMP oral 92% SpO2 sup O2 HR 106 104/54.
	Pt recieve 650mg Tylnol PO for Pain ē fever — LPN, SGT
	Pt ā Bed Sat 2 Hyp X4 ē distended abd. Decreased strength in (R) hand =V to (L) Arm Good. (b)(6)-2 LPN, SGT

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STANDARD FORM 509 (REV. 5-99) BACK

MEDCOM - 6010

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
7Apr03 (b)(6)-2 / 2254	no vicodin, Tylenol #3 ī tab given for c/o pain (b)(6)-2 1LT/AN
2200	Pad 5485 pt is evac to Am. (b)(6)-2 LPN, SGT
2230	Pt given Albuterol/Atrivent NRB/Nebulizer @10L SPC (b)(6)-2
7Apr03/0300	B/P 138/68 P99 R24 T 98.7 SAO2 94%. Pt dressing
	looks okay Pt prepared for transport —— SPC (b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 *(REV 5-99)*
Prescribed by GSA/ICMR FPMR (41 CFR) 101.11 203(b)(10)

MEDCOM - 6011

AUTHORIZED FOR LOCAL REPRODUCTIO

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

07 Apr 03

(b)(3)-1

0117 S/p GSW to abdomen s/p Ex Lap colotomy & 1° anastomosis 2 this a.m. 03 abd & colectomy COPD. Denies SOB. Denies N/V. + flatus.

O: T = 99° SO_2 = 82-85%,
General alert
Lungs - diffuse coarse breath sounds
good air movement
Heart RRR @ mid
abdomen soft; slightly distended
BS; slightly tender
@ peritoneal wash incision-healthy
Ext + edema

A/P (1) S/P Ex Lap colotomy 1° anastomosis
- AAS
- NPO for now
(2) COPD
- albuterol/atrovent
- O2 prn keep sat > 90%

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | (b)(6)-2 | M_1 | SPONSOR'S ID NUMBER (SSN or Other)

DEPART /SERVICE | HOSPITAL OR MEDICAL FACILITY | (b)(6)-2 | MD

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

(b)(6)-4

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

PROGRESS NOTES
Medical Record

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

MEDCOM - 6012

AUTHORIZED FOR LOCAL REPRODUCTIO

MEDICAL RECORD (b)(3)-1 **S NOTES**

DATE	
	NKDA
1030	Arrived via letter from aerovac. S/P
RT IV:	GSW ē exploratory lap. Pulse ox 86% RA
0.5 Albuterol	Chart states possible hx of COPD, neb
	treatment given by RT, pt on 4L @ 28% O2
	via mask, pulse ox 1 to 91%, P100, T99.4
	118/80, RR 28, lungs sounds wheezes bilateral
	abdomen dressing changed by Dr. (b)(6)-2, pt
	denies pain @ this time (b)(6)-2
1100	given 5Mg MSO4 for C/O pain; IV site changed
	to (D)AC; LR wide open, pt C/O of thirst, Pt
	told thru interpreter that nes NPO; pulses equal
	all extremities; abdomen distended - minimal
	bowel sounds heard, heparin 5000 u given SQ;
	Zantac 50mg given IVPB
1230	5mg MSO4 given IVP for C/O pain; pt state
	NKDA thru interpreter; Abd X-ray complete,
	pt sat 90% on 4L @28% O2; pt states thru
	interpreter that he smokes 2 packs/day
1310	0.5 Albuterol & unit dose atrovent given tod
	pt via neb by RT (b)(6)-2 CRT/RD
1310	X-Ray Report shown to Dr. (b)(6)-2; Keep pt NPO (b)(6)-2

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

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

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

(b)(6)-4

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

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

MEDCOM - 6013

DATE	NOTES
420	P 104, O2 Sat 90% on 4L 28% O2 Vented [redacted]
	200cc dark urine, LR wide open
1642	Pt given albuterol/atrovent neb by RT, O2 sat 94%
	P 103; pt remains on 4L Mask @ 28%
1835	BP 143/104, P 105, T 101.0°, 90% on 4L Mask @ 28% O2
	RR 20; RT tx albuterol/atrovent @ 1800
1900	pt voided 300cc/hr dark urine [redacted] CPT [redacted]
	PO liquid 300cc orange drink & water

AUTHORIZED FOR LOCAL REPR.

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	**SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION** *(Sign each entry)*
02 APR 03 1600	VS T 98.1 BP 156/84 P 96 R 22
2 Apr 03	Resp Care Note pt admin 2.5mg Albuterol / 0.5mg Atrovent via HHN. BBS prior to tx [illegible] coarse, post tx no Δ. HR 99-100-100, RR 20, 22, 22. Tol tx well Ø adverse reaction to therapy. SpO2 96% on 4L NC
02 Apr 03 1900	Assessment Complete - IV (R) FA, HL (R) wrist (+) Rhonchi all lung fields - NC @ 4L - SpO2 95% Dsg (R) wrist c/d/i, leg med and Dsg - intact. Abd tight - distended. DP x 4 [illegible] Pt requesting water - [illegible] NPO - well [illegible] [illegible] (b)(6)-2
1835	IV infiltrated (R) wrist HL d/c'd - New IV (L) Hand (b)(6)-2
1900	New IV (R) upper arm
3 Apr 03 0830	Resp Care Note; pt admin 2.5mg Albuterol / 0.5mg Atrovent via Aerosol mask pt. BBS [illegible] slight I + E wheezes
03 APR 03 0830	V S T 99.7 BP 163/89 P 101 R 22 POX 96 SPC [illegible], [illegible]
3 Apr 03 0850	Nutrition - Patient NPO [illegible] since 29 Mar (5 days) (b)(6)-2 Dr. (b)(6)-2 ordered 10% Dextrose LR @ 125 ml/hr will provide 1020 kcal per day. Would recommend starting TF of Ensure at a drip rate to stimulate BS 5-7cc/hr. (b)(6)-2 MAJ SP RD

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

SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR

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

REGISTER NO. | WARD NO.

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

MEDCOM - 6015

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
03APR03	RT Notes: Pt received HHN via FM ē 0.5cc Albuterol
1120	UD Atrovent HR 97- O2 RR:24 BS exp wheezes +
	rhonchi throughout ō + p̄ tx. NPC. NAR - (b)(6)-2 91L
03APR03 1230	VS T 99.0 BP 129/90 P 100 R 22 POX 98 IV would not flush
	after receiving Rocephin; D/C'd IV Ⓡ Arm and tried Ⓛ Arm. Unsucc
	Did not receive Cipro. PT took (2) dumps, stool was brown
	semi soft/runny. SPC (b)(6)-2 91W MC ————
1500	was unable to give Clindamycin due to Ø IV Access
	Head Nurse notified. VS T 99.1 BP 140/80 P 100 R 22 POX 100
1530	Dsg chg of abdomen SPC (b)(6)-2 91W MC ————
1600	Restraints on both wrists. Pt refuses to keep O2 mask on face or
	Pox on finger. SPC (b)(6)-2 91W MC
1730	Foley - Drn 1200 cc DAU SPC (b)(6)-2 91W MC
	Nutrition - Patient continues on D10% @ 125cc hr, minimal
	bowel sounds - again recommend Drip TF of 5-7 cc Ensure per hour
	Ensure would stimulate gut motility. (b)(6)-2
4-4-03 0900	pt assessment complete he offers no c/o pain, his lungs have
	exp. wheezing throughout he has no c/o dyspnea or SOB, dressing on
	midline abd CDI dressing to Ⓑ flank CDI, IV fluids infusing @
	125/hr into Ⓛ hand IV started today. Foley D/C @ 0430. pulses present
	all ext Ⓒ periph edema, pt has simple mask ē O2 @ 4L sats 94% pt has
	hypoactive B/S abd large round + soft ———— (b)(6)-2 91W MC

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

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

4/4/03

MCW #1 Admit

POD #6 GSW ABD S/P Ex lap & colectomy & 1° REANAST

H/O COPD? O2 Requiring S/P Ventilatory Failure

T - 98° BP: 144/82 P - 106 81% SaO2 (RA)

LUNGS: RALES & COURSE WHEEZY (B)

CV: RRR S1 S2 ø S3

ABD: Protuberant ↓ BS

MIDLINE INCISION = granulating well

EXT: +2 (=PP MILD EDEMA

P) ① Supplemental O2

② Atrovent/Albuterol Neb Q6 NEED RT (NOTIFIED ALREADY

③ D/C IV Abx

④ Levaquin 500mg PO Q day X 5 days

⑤ Hep block IV

⑥ Cefaz 2gm IV push now

⑦ Regular Diet

⑧ Pain Control

⑨ Q day w/ NS dressing Δ's

(b)(6)-2

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

SPONSOR'S NAME | SSN/ID NO. | RELATIONSHIP TO SPONSOR

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

(b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE

Medical Record

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

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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
5apr03	Changes pts dressings, wet to dry @ 0645 [redacted]
5apr03 1112	put in heplock [redacted]
4/6/03 0655	[redacted] GSW ABD S/P EX-LAP x colectomy & 1° REPAIRS H/O COPD O2 DEPENDENT S/P VENTILATORY FAILURE C/O ABD PAIN VS: T- 98.2 169/96 96 SaO2 95% (2L) Resp 26 CV: RRR S1+2 LUNGS: COARSE INSP RHONCHI COARSE EXP WHEEZY (B) ABD: DISTENDED, BS PRESENT BUT HYPOACTIVE TTP RLQ > LLQ Ø FLATUS TODAY G/U: ⊕ DNR UOP YESTERDAY P) ① CONT CLEARS ② DIO LR @ 70cc/° ③ CHEM 7 / H/H TODAY ④ ATROVENT TID ⑤ OOB IN CHAIR BID ⑥ WOUND CARE [redacted]

STANDARD FORM 600 (REV. 6-97) BACK

'US GPO 2002 - 491-600/50618

MEDCOM - 6018

AUTHORIZED FOR LOCAL REPRODU

MEDICAL RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
4/4/03 1105Z	① ADMIT MCW #1
	② DX: GSW ABD S/P EXLAP & colectomy ? 1° REANASTOMOSIS (3/29/03)
	COPD? H/O ~~exacerbation~~ VENTILATORY Failure
	③ CONDITION: STABLE
	④ VITALS Q SHIFT
	⑤ DIET: Regular
	⑥ Heplock IV
	⑦ > LASIX 20mg IV NOW
(b)(6)-2	> Albuterol / Atrovent NEBS Q 6°
	> 2L NC O2
	> Levaquin 500mg po Q DAY
	> Tylenol 650mg Q 4° PRN
	> Vicodin ½-1 tabs Q 8° PRN
	⑧ W → D Dressing Δ's Q Day
	⑨
4/4/03 1230	D/C Regular
	Clear liquid Diet

(b)(6)-2

(b)(6)-2

(b)(6)-2

HOSPITAL OR MEDICAL FACILITY | SERVICE | RECORDS MAINTAINED AT

SPONSOR'S NAME | SSN/ID NO. | RELATIONSHIP TO SPONSOR

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

(b)(6)-4

(b)(3)-1

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

MEDCOM - 6019

DATE	SYMPTOMS, ~~DIAGNOSIS~~, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
4/5/03	ORDERS
0725Z	① Hold Narcotics for now (b)(6)-2
	② KUB (flat/upright)
4/6/03	① D10 LR @ 70cc/°
0500	② Chem 7 now (b)(6)-2
	③ H/H now
	④ ~~NPO ō now~~
	Cont Clears
	⑤ Ambulate TID

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