NSN 7540-01-165-7294 519-30

RADIOLOGIC CONSULTATION REQUEST/REPORT

(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography ***Examinations)***

EXAMINATION(S) REQUESTED	AGE / SEX	SSN *(Sponsor)*	WARD/CLINIC	REGISTER NO.
Portable KUB	FILM NO.			PREGNANT ☐ YES ☐ NO
	REQUESTED BY *(Print)*			TELEPHONE/PAGE NO.
	SIGNATURE OF REQUESTOR			DATE REQUESTED

SPECIFIC REASON(S) FOR REQUEST *(Complaints and findings)*

Distended abdomen; s/p GSW to abd c exploratory lap;

DATE OF EXAMINATION *(Month, day, year)*	DATE OF REPORT *(Month, day, year)*	DATE OF TRANSCRIPTION *(Month, day, year)*
7 Apr 03	7 Apr 03	

RADIOLOGIC REPORT

- markedly suboptimal exam 2° pt body habitus and portable technique
- Abdomen markedly distended and opaque, may reflect ascites
- Air seen within non-distended descending colon

(b)(6)-2

(b)(3)-1

PATIENT'S IDENTIFICATION *(For typed* **or** *written entries give: Name — last, first, middle, Medical Facility)*

(b)(6)-4

FOREIGN NATIONAL

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

MEDCOM - 6024 TION

STANDARD FORM 519-B (8-83 Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.806-8

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED. WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 07 April 03 — TIME OF ORDER: 1200 HOURS — LIST TIME ORDER NOTED AND SIGN

1. admit ICU-5
2. D(x) s/p Ex lap; mediastinum
3. vitals q 1hr
4. O_2 to keep SO_2 > ~~92%~~ 90%
5. notify MD abnormal vitals
6. IVF = D5NS @ 100cc/hr

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER — TIME OF ORDER — HOURS

7. NPO
8. Morphine 1-5mg IV q 1hr
9. I+O
10. albuterol/atrovent nebs q 1hr prn
11. Zantac 50mg IVPB q 8hrs
12. Heparin

(b)(6)-2

1230 7Apr

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER — TIME OF ORDER — HOURS

13. acute abdominal series r/o SBO

(b)(6)-2

(b)(6)-2 MD

(b)(3)-1

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 7 April 03 — TIME OF ORDER: 1452 HOURS

1) Clarify Heparin order — Heparin 5000u BID
2) Tylenol 650mg po prn
3) Clear liquid diet
4) Δ IVF to KVO 100cc/hr

7 1430

(b)(6)-2

7APR

(b)(6)-2

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

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CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD **DATE**, TIME AND SIGN EACH SET OF ORDERS. IF **PROBLEM ORIENTED** MEDICAL **RECORD** SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY **ARROW** BELOW.

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER 1440 HOURS | LIST TIME ORDER NOTED AND SIGN

(1) Δ Albuterol 2.5mg/3cc NSS to Albuterol 2.5mg/0.5mg Atrovent Q6

V.O. Dr. (b)(6)-2

03APR03/0535 (b)(6)-2

(6) Wean O2 & sat ≥ 80% (b)(6)-2 (b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER 03APR03/0840 HOURS

Δ IVF & D10LR @125/h (b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 4APR03 | TIME OF ORDER 0410 Z HOURS

(1) D/C Foley when

(2) Transfer to minimal care

P voiding (b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-4

(b)(3)-1

NURSING UNIT | ROOM NO. | BED NO.

ICU-2 | | I

DATE OF ORDER 4-4-03 | TIME OF ORDER | HOURS

(1) V/S V/S q 8 Per Dr (b)(6)-2 (b)(6)-2

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

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CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED. WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

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

NURSING UNIT / ROOM NO. / BED NO.

DATE OF ORDER: 30 March 2003 — TIME OF ORDER: 1445 HOURS

① Δ Versed to Valium 2-5mg IV q4h prn agitation

② Vanum 10mg IV q6 prn agitation

③

(b)(6)-2 [redacted]

LIST TIME ORDER NOTED AND SIGN: Noted (b)(6)-2 [redacted] 3 Mar

---

PATIENT IDENTIFICATION

NURSING UNIT / ROOM NO. / BED NO.

DATE OF ORDER: — TIME OF ORDER: 2030 HOURS

Δ Vanum ↑ 10mg IV q h prn

(b)(6)-2 [redacted]

LIST TIME ORDER NOTED AND SIGN: noted 30 Mar 03 (b)(6)-2 [redacted] CPS, RN

Chart ✓ 31 Mar 03 (b)(6)-2 [redacted]

PATIENT IDENTIFICATION

NURSING UNIT / ROOM NO. / BED NO.

DATE OF ORDER: Chart ✓ 31 Mar 03 2200 (b)(6)-2 [redacted] — TIME OF ORDER: HOURS

1 April 2003

Δ Dressing change wet to dry qd.

(b)(6)-2 [redacted]

LIST TIME ORDER NOTED AND SIGN: Noted (b)(6)-2 [redacted] 1 Apr

---

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

(b)(3)-1 [redacted]

NURSING UNIT: ICU-1 — ROOM NO. — BED NO. 1

DATE OF ORDER: 1 April 2003 — TIME OF ORDER: 1330Z HOURS — 1630 local

Give albuterol nebs q4h

D/C Imuran

① Rocephin 1gm IV qd ✓

② Cipro 400mg IV BID ✓

~~③ Flagyl~~ ③ Clindamycin 600mg IV tid ✓

④ PEEP ⑤ ↑ FiO2 ↑ tracking (b)(6)-2 [redacted] sat above 89%

⑤ CXR

LIST TIME ORDER NOTED AND SIGN: ✓ I stat & ✓ tonite @1800 (b)(6)-2 [redacted]

DA FORM 4256, 1 APR 79 — REPLACES EDITION OF 1 JUL 77, WHICH MAY BE [redacted]

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CLINICAL RECORD - DOCTOR'S ORDERS
For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED. WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION: (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	30 MAR 03 1125 HOURS	
1	Admit ICW I - Gen Surg / (b)(6)-2	
2	S/P Ex lap - Colon resection c	1° anastomosis
3	Stable	
4	VS q 2° I & O's	✓
5	NKDA	✓
6	Bedrest	✓
7	NG to LWS	✓
	PATIENT IDENTIFICATION	
	DATE OF ORDER / TIME OF ORDER	
8	Foley → gravity ____ HOURS	✓
9	Vent setting: SIMV Rate 12 TV 700	
	Peep 5 FiO2 - wean to keep > 93%	✓
10	NPO	✓
11	KVO @ 125 cc/hr	✓
12	MSO4 1-2 mg IV q 1-3° PRN pain	✓
13	Versed 1-2 mg IV q 1-2° PRN sedation	✓
14	Unasyn 3.0 gm IVPB q 6° - 1st now	✓
	PATIENT IDENTIFICATION	
	DATE OF ORDER / TIME OF ORDER	
15	Albuterol neb PRN HOURS	✓
16	Heparin 5000 u SQ q 12°	✓
17	Zantac 50 mg IVPB q 8°	✓
18	Notify MD for T > 102 P > 130 < 60	✓
	SBP > 170 < 110 UOP < 30 cc/hr for	✓
	2 consecutive hrs	✓
	(b)(6)-2	
	(b)(6)-2 MD	
	PATIENT IDENTIFICATION	
	DATE OF ORDER / TIME OF ORDER	
	30 MAR 03 1430 (b)(6)-2 HOURS MAJ, MC	
0	Bolus T Lact LR 1UF now. (b)(6)-2 1430 30 MAR 03	
	Verbal Order Dr (b)(6)-2 (b)(6)-2 (b)(6)-2	

NURSING UNIT | ROOM NO. | BED NO.

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

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CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo. Mar Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 30 31 / 2 3 4
30	(b)(6)-2	LR @ 125 cc/hr	07 15 19 23	(b)(6)-2 (b)(6)-2 DC 01-3-03
30	(b)(6)-2	Unasyn 3.0 gm IVPB q6° (first now)	06 12 18 24	(b)(6)-2 (b)(6)-2 Del 1 APR 03 1340 Z
30	(b)(6)-2	Heparin 5000u SQ q12° Z03 Z15	06 18	(b)(6)-2 (b)(6)-2
30	(b)(6)-2	Zantac 50 mg IVPB q8° Z03 Z11 Z19	06 14 22	(b)(6)-2 (b)(6)-2 (b)(6)-2
1 APR 03	(b)(6)-2	Rocephen 1 Gm IV qd Z11	14	(b)(6)-2
1 APR 03	(b)(6)-2	Ciprofloxacin 400mg IV BID Z03 Z15	03 15	(b)(6)-2 (b)(6)-2
1 APR 03	(b)(6)-2	Clindamycin 600 mg IV Z23 TID Z07 Z15	02 10 18	(b)(6)-2 (b)(6)-2 (b)(6)-2
01 APR 03	(b)(6)-2	T, titrate O2 to Keep Sats > 89%	02 10	(b)(6)-2 M
1 APR	(b)(6)-2	Albuterol Neb q 4°	03 07 11 15 19 23	(b)(6)-2 (b)(6)-2

ALLERGIES: ☐ YES ☑ NO — NKA

PRIMARY DIAGNOSIS: S/P Ex Lap - Colon resection ? GSW (R) Pit

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

PATIENT IDENTIFICATION: (b)(6)-4 (b)(3)-1

DISPENSING TIMES

USE PENCIL, CIRCLE MED TIMES

D	7	8	9	10	11	12	13	14	
E	15	16	17	18	19	20	21	22	
N	23	24	01	02	03	04	05	06	

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

MEDCOM - 6029

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo. MAR / APR Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
30	(b)(6)-2	MSO4 1-2MG IV q 1-2° PRN Pain	2MG 1230 / 2mg 1630 / 3MG / 30mg 1930 / 4mg / 3MG / ... / 2140 / 0210 ; (b)(6)-2
30		Versed 1-2mg IVq1-2° PRN sedation	1mg / 1.5mg 1335 / 2.0mg 1430 / 2.0mg / DC ; (b)(6)-2
30		Albuterol Nebs PRN	APR ; (b)(6)-2 ; 1230
30		Valium 2-5mg IV q4° PRN agitation	1700 2mg / 1830 3mg / 0330 5mg / 0900 2.5mg 31 Mar / 5mg 31 Mar / 2147 5mg / 1 APR / 5mg ; (b)(6)-2 ; 30 Apr ; 30 Mar
30		Vecuronium 10mg IVq60 PRN agitation	10mg 1VP / 1830 / 2330 10mg ; 2040 ; (b)(6)-2 ; 1515 ; DC
30		Vecuronium 10 mg IV qh prn	0330 10mg 30 Mar / 0400 30 Mar 10mg / 1330 30 Mar 10mg / 0530 30 Mar 10mg / 0345 31 Mar 10mg / 5mg 31 Mar 1 EV / DC / SP / Extubation / BJ
31		MSO4 1-2mg IV q 1-2° PRN Pain	1 APR / 4mg / 5mg / (b)(6)-2 / 2230

*U.S. GPO: 1998-454-110/95216

MEDCOM - 6030

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo. 3 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 30 31 1 2 3 4
30 MAR	(b)(6)-2	Vital Signs q2° c I/O's	07 19	(b)(6)-2
		Notify MD if T>102, P>120<60	19 07	(b)(6)-2 (b)(6)-2
		SBP >170 <110, MAP < 30 c/hr x2°		
30 MAR		Bedrest	07 19 19 07	(b)(6)-2
MAR 30		NG to LIWS	07 19 19 07	(b)(6)-2 (b)(6)-2 — D/C 31 MAR 03
30 MAR		Foley to Gravity	07 19 19 07	(b)(6)-2 (b)(6)-2 (b)(6)-2 — D/C'd 4/1/03
MAR 30		Vent: SIMV Rate 12 TV - 700 PEEP - 5	07 19 19 07	(b)(6)-2 (b)(6)-2 — D/C 31 MAR 03
MAR 30		FiO2 - wean to keep >92%	07 19 19 07	TH (b)(6)-2 D/C 31 MAR 03 JP
MAR 30		NPO for Diet	07 19 19 07	(b)(6)-2
31 MAR		Oxygen @ 2L/min via Trach collar	08	/ / (b)(6)-2
01 APR		Percussion & Postural Drainage (PRN)	07 19 19 07	/ / (b)(6)-2 / /

ALLERGIES: ☐ YES ☒ NO — NKA

PRIMARY DIAGNOSIS: S/P Ex Lap - Colon Resection c 10 anastomoses — 3 3 GSW (R) FA

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

PATIENT IDENTIFICATION:

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

DISPENSING TIMES

USE PFNCIL. CIRCLE MED TIMES

D 7 8 9 10 11 12 13 14

E 15 16 17 18 19 20 21 22

N 23 24 01 02 03 04 05 06

DA FORM 1 FEB 79 4678 — EDITI... F 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

MEDCOM - 6031

Verify by Initialing

...ERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. MAR Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
30 MAR 03	(b)(6)-2	Admit to ICU/ Gen Surgery (b)(6)-2	30	1150	1150	
		Condition Stable				
01 APR		CXR AP Portable	01 APR	Now	1345 Z	(b)(6)-2
01 APR		ISTAT & @ 1800 hr	01 APR	1800 (L)		

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED

US. GPO: 1998-454-110/95216

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo. 04 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 7 8
7Apr03	(b)(6)-2	Zantac 50mg IVPB	11	(b)(6)-2
		q8	19	
			03	
7Apr03		IVF @ 100cc/hr	07	(b)(6)-2
		LR	19	
7Apr03		NPO	07	N/C
			19	
7Apr03		Heparin 5000U bid	11 07	(b)(6)-2
			23	
7Apr03		Diet: Clear liquid	07	(b)(6)-2
			19	(b)(6)-2

ALLERGIES: ☐ YES ☐ NO — NKA

PRIMARY DIAGNOSIS: GSW to abd. E ex lap

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

D	7	8	9	10	11	12	13	14
E	15	16	17	18	19	20	21	22
N	23	24	01	02	03	04	05	06

DA FORM 4678, 1 FEB 79 — EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED. — USAPA V1.00

MEDCOM - 6033

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. Yr.

Order Date	Clerk/ Nurse	SINGLE ORDER PRE-OPERATIVES	Data to be Given	Time to be Given	Time Given	Initials
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
7 Apr	(b)(6)-2	Albuterol/Atrovent inhaler/Neb tx q 1hr prn	7 Apr 1030 / 7 Apr 1310 / 7 Apr 1640
....	.....		
7 Apr	(b)(6)-2	MS04 1-5 mg q 1hr prn	7 Apr 1100 5mg / 7 Apr 1230 5mg / 7 Apr 1845 2mg / 7 Apr 1995 3mg / 7 Apr 5mg / 8 Apr 0750
....			(b)(6)-2
....		Tylenol 650mg PO prn	7 Apr 650mg
.....			(b)(6)-2
.....			
.....			
....			
.....			
.....			
.....			
.....			

MEDCOM - 6034

USAPA V1.00

M RECORD - SUPLEMENTAL MEDI A

r use of this form, see AR 40-66; the propo... ...ncy is the Office of the Surgeon General

[redacted]

EPORT TITLE | OTSG APROVED (Date)

TRAUMA FLOWSHEET

INITIAL ASSESSMENT | ☐ IMMEDIATE ☐ DELAYED ☐ MINIMAL

ate: 30MAR08 Arrival Time: 1120 Sex: (M) F Age: _____ Wt: _____

llergies: _____ Tetanus Status: UTD Unknown

MP: Last Meal:

hief Complaint:

MH: | Medications:

reatments PTA:

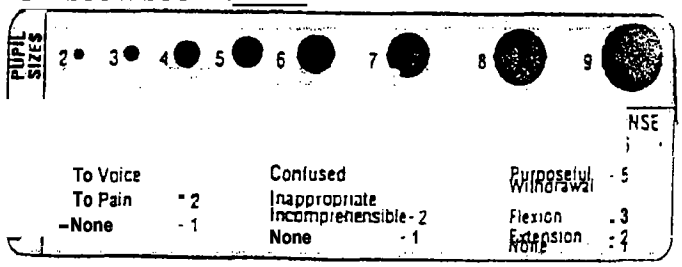
ITAL SIGNS: 1125 BP: 144/86 P: 113 RR: BVM TEMP: SAO2: 92

HEST
RAUMA ☐YES ☐NO
AIN ☐YES ☐NO
OB ☐YES ☐NO
UNG SOUNDS
R L
☐ ☐ CLEAR
☐ ☐ WHEEZES
☐ ☐ DECREASED
☐ ☐ ABSENT

SKIN
☐ WARM
☐ DRY
☐ PALE
☐ DUSKY
☐ MOIST

ABDOMEN
☐ SOFT
☐ DISTENDED
☐ TENDER
BOWEL SOUNDS
☐ YES ☐ NO
GUIAC TEST
☐ POS ☐ NEG

NEURO
PERRL ☐ YES ☐ NO R_____mm L_____mm
GLASCOW SCORE:_____



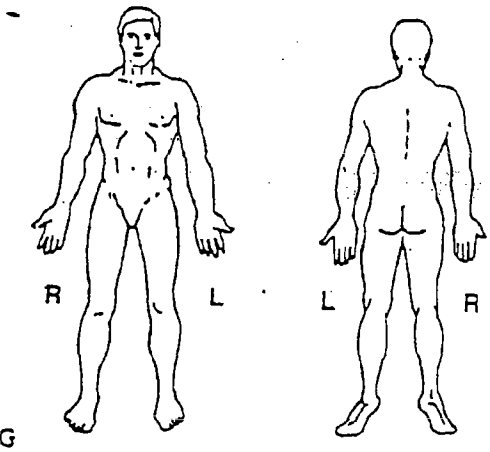
XTREMETIES
] DISTAL **PULSES**
] RT X 2 ☐LT X 2
MOVES EXTREMETIES X 4
NO EDEMA
NO DEFORMITIES

XCEPTIONS TO BOVE ARAMETERS:

REATMENTS:

SPLINTS:

2: LPM NC MASK ORAL AIRWAY
TT # MM NASAL AIRWAY
IONITOR ☐Y ☐N EKG ☐Y ☐N
IG TUBE #
OLEY: # DPL ☐ POS ☐ NEG
HEST TUBE ☐R ☐L CM H20



A = Abrasion
AP = Amputation
AV = Avulsion
B = Burn
C = Contusion
D = Deformity
E = Evisceration
OF = Open Fracture
CF = Closed Fracture
G = GSW (#Sites)
L = Laceration
PW = Puncture Wound
S = Stab Wound
O = Other

(Continue on reverse)

REPARED BY *(Signature & Title)* | DEPARTMENT/SERVICE/CLINIC (b)(3)-1 | DATE

ATIENT'S IDENTIFICATION *(For typed or written ntries give: Name - last; first; middle; grade; date; ospital or medical facility)*

(b)(6)-4

(b)(3)-1

☐ HISTORY/PHYSICAL ☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)
☐ DIAGNOSTIC STUDIES
☐ TREATMENT

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CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo.____ Yr.____

VERIFY BY INITIALING

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY
4-4-03	[redacted]	Δ IV Stats to Dwell
	-----	Heplock
4-4-03	[redacted]	VS q 8

4-4-03	[redacted]	Albuterol 2.5mg / 0.5mg atrovent
	-----	q6

4-4-03	-----	Levaquin 500mg QD po
4-4-03	-----	2L NC O2 keep O2 sat 90%

4/4/03	-----	Regular Diet

4/6/03	-----	D10 LR @ 70cc/hr

4/6/03	-----	Clear Liquid Diet

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

HR	DATE DISPENSED 4	5	6
07	[redacted]		
14	/		
22	/		
14	[redacted]		
22			
10	[redacted]		
16			
22			
04	[redacted]		
1100	[redacted]		
0400			
1600	[redacted]		
		D/C	
D	/ [redacted]		
N	/		
D	/ [redacted]		
N	/		

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO.

PATIENT IDENTIFICATION

[redacted]

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

D 7 8 9 10 11 12 13 14

E 15 16 17 18 19 20 21 22

N 23 24 01 02 03 04 05 06

NA, FORM 4878 EDITION OF 1 DE

MEDCOM - 6036

MEDICAL RECORD - ICU FLOWSHEET

SECTION I - PATIENT ASSESSMENT DATA

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

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

VITAL SIGNS	TIME:	1900	2000	21	22	23	24	01	02	03	04	05	06
	BP ARTERIAL LINE												
	BP CUFF	140/70				142/76				142/72			
	MAP												
	TEMPERATURE	100.4				98.1				99			
	PULSE	96				78				100			
	RESPIRATIONS	26				26				28			
	PULSE OXIMETER	87	97	90	92	92				92			
	CVP	before TX	after TX			TX done							
	PAIN (0 – 10)	7 pain								Abd discomfort 4			
			3 mg Morphine										
RESPIRATORY	OXYGEN (L/%)	4L	"	"	"	4L				4L			
	O2 METHOD	Mask	"	"	"	Mask				Mask			
	VENT SETTINGS:												
	FIO2												
	MODE												
	TV												
	RATE												
	PEEP												
	PS												
	Respiratory Treatments												

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

INTAKE	TIME:	1900	2000	2100	22	23	24	01	02	03	04	05	06
	IV	100	100/200	100/300	100/400	100/500	100/600	100/700	100/800	100/900	100/1000	100/1100	100/1200
	PO												
	TOTALS												
OUTPUT	URINE									175			150/325
	STOOL												
	TOTALS												

MEDICAL RECORD - ICU FLOWSHEET

SECTION I - PATIENT ASSESSMENT DATA

PATIENT NAME: (b)(6)-4 DATE: 9-7-03/9/8/03

VITAL SIGNS	TIME:	07	08	09	10	11	12	13	14	15	16	17	18	
	BP ARTERIAL LINE	140/88												
	BP CUFF													
	MAP													
	TEMPERATURE	98.0												
	PULSE	104												
	RESPIRATIONS	~~18~~ 20												
	PULSE OXIMETER	92%												
	CVP													
	PAIN (0 – 10)													
RESPIRATORY	OXYGEN (L/%)	4L												
	O2 METHOD	MASK												
	VENT SETTINGS:													
	FIO2													
	MODE													
	TV													
	RATE													
	PEEP													
	PS													
	Respiratory Treatments													

24 HOUR I & O: TOTAL IN _____
TOTAL OUT _____

INTAKE	TIME:	07	08	09	10	11	12	13	14					
	PO													
	TOTALS													
OUTPUT	URINE	400												
	STOOL													
	TOTALS													

MEDICAL RECORD - ICU FLOWSHEET

SECTION I - PATIENT ASSESSMENT DATA

PATIENT NAME: (b)(6)-4 DATE: 4-7-08

IV SITE ASSESSMENT:

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

	LOCATION	CONDITION
IV SITE # 1	(L) Ant Q.	wnl (positional)
IV SITE # 2		
IV SITE # 3		

	TIME	INITIALS
IV PATENCY CHECKED	1900	TAD
IV SITE CARE PROVIDED		
IV TUBING CHANGED		
COMMENTS:		

	LOCATION	CONDITION
IV SITE # 1	(R) AC	patent
IV SITE # 2		
IV SITE # 3		

	TIME	INITIALS
IV PATENCY CHECKED	0700	(b)(6)-2
IV SITE CARE PROVIDED		
IV TUBING CHANGED		
COMMENTS:		

AM STRIP

PM STRIP no Propaq

SECTION III - SHIFT NOTES

Pt c pain (b)(6)-2

Pt was given 3mg Morphine IVP (b)(6)-2

2000 Pt states no Abd pain but pressure or tightness (b)(6)-2

2100 Pt resting c eyes closed (b)(6)-2

2300 Heparin 5th Q to Abd 22G 5000u (b)(6)-2

0300 Pt to R discomfort to Abd but not pain. Pt waves hands out from Abd as if saying Abd is tight. Pt now responds to palpation of Abd as tender, but it is noted Abd is not firmer. (b)(6)-2

0310 Benadryl 25mg for rest (b)(6)-2

0315 M.D. on call ordered Benadryl for rest. MD was informed on status. (b)(6)-2

0430 Ambien 5mg P.O. one time now given for difficulty in sleeping (b)(6)-2

MEDICAL RECORD - ICU FLOWSHEET

SECTION II - PATIENT ASSESSMENT DATA - REVIEW OF SYSTEMS

PATIENT NAME: (b)(6)-4

DATE: 4-7-03 / 8APR03 0700

	TIME: 1930 INITIALS: 7AD	TIME: 0700 INITIALS: (b)(6)-2
NEUROLOGICAL Alert and Oriented to time, place and name; Responds appropriately; Communication is adequate to express needs; Pupils equal and reactive to light.	A+O x 3 PERRLA needs translator	A+Ox3 PERRLA needs translator
CARDIOVASCULAR Age appropriate Rate, Rhythm, and Pulses; Capillary refill < 3 sec; No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. Pressure monitoring	Heart - RRR Ø murmur Cap R. 3sec no edema,	RRR - S, S2 cap refill brisk 2-3sec. no edema
PULMONARY Respirations within normal limits for age; Breath sounds quiet and regular; Depth is regular; No dyspnea; No cough; Suction; Secretions; Oxygen; ETT; Trach	mild labor breathing Rhonchi & wheezing. B/L to lungs - SaO2 87 to 90	inspiratory wheezes this AM. RT doing tx. mild labored breathing. O2 mask 4L O2 Sats 92% this am
G.I. Abdomen soft and non-distended; Bowel sounds active in all quadrants; No difficulty chewing or swallowing; No abdominal pain; Frequency and type of stool; No diarrhea; No constipation; No NN; NG Tube placement; Type of secretions	Minimal Bowel sounds Non tender, soft Abd. mild Abd pain. No drainage to dressings.	Ø BS ascultated. MD aware. ABD distended + firm. ML ABD dsg - CDI - LLQ dsg CDI.
G.U. Voiding; Catheters; Urine clear yellow/amber No odor, discharge, frequency, urgency, nocturia	Dark amber urine minimal out put.	DN this am
MUSCULOSKELETAL: Normal muscle mass and development for age; No deformities; No assistive devices needed; Normal movement and tone; Normal active ROM without pain; No joint swelling, tenderness, weakness, or paresthesia	Full ROM to all extremities. = strength to Arms+legs no paresthesia	MAE 5 diff.
SKIN Color; warm; dry; intact; Turgor; No Wounds; lesions; rashes, inflammation, ulcers, breaks in skin; No redness, blanching, irritation, over bony prominences; Mucous membranes moist; Wounds - location, condition, drainage, dressing	Dry & Intact	Warm dry & intact
PAIN No complaints of pain/discomfort; Note Location; Duration; Intensity	mild pain to Abd.	mild pain to abd.
PSYCHOSOCIAL: Behavior is appropriate to the situation; Anxiety is controlled or mild and appropriate to the situation; Interacts appropriately with others		