b.6-2 All

PROGRESS NOTES

DATE	
27Jun03	1100 - Foley catheter pulled. [redacted]
1700	Assumed care of Pt @ 1300. VSS, A+O x 3. Penrose Drain putting out
	∅ to scant drainage to ABD pad. ∅ c/o pain. ∅ S/Sx
	of infection. (L) wrist PIV patent. ∅ IV assess
	WNL. Will Monitor [redacted]
27Jun03	Rec'd pt. @ 21:00. Awake + Alert in bed. Amb. to commode s difficulty
2017	Skin W/D. PERRLA ⊕ WNL. LCA Ⓑ. BS ⊕ x4. ⊕ PPP Ⓑ. Penrose patent
	scant amt. drainage blood tinged. ∅ c/o pain @ this time. Will
	cont. to mon. [redacted] 2LT/AN
28Jun03	General Surgery
0830	POD#3 S/P - [illegible] perineal abscess
	[illegible] area, tol. reg diet, ⊕ BM & flatus
	⊕ voiding spontaneously, ambulating well
	AFeb VSS
	Abd soft, NT ND
	perineum - no drainage from drain
	penrose ⊕ [illegible]
	Imp/Plan: [illegible] area
	- transfer to [illegible] hospital [illegible]
	[illegible]
	- if ∅ [illegible]
	[illegible] d/c home
	[redacted]

B6-2 All (except last)

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
28 Jun 03	Assumed care of pt @ 0500. Pt is awake and
	alert. VSS. Lungs CTA. Bowel sounds x 4 quads.
	Pt has transfer/d/c note. Pt will go to an
	Iraqi hospital. Transportation is being organized.
	Will continue to monitor ——— [redacted], SGT, AN
28Jun03	assumed care @1300 - VSS - pt. washed
1825	himself c̄ dinner - IV patent - pt. is
	awaiting transport to ~~ff~~ Iraqi hospital
	no c/o pain - dsg ~~@~~ perineum [redacted] R.AN
28Jun03	Rec'd pt @ 21:00. ~~Aa~~ Awake and Alert in bed. Skin PWD + CAB
22:06	PERRLA(B) WNL BS⊕x4 ⊕ PPP(B) PIV ∅ patent. D/C'd.
	Wound to perineum c̄ penrose intact. ∅ drainage noted.
	c/o "little" amt. of pain offered pain med. pt refused. will
	cont. to mon [redacted] RN/AN ———

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. ICW2

EPW # [redacted] B6-4

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

NSN 7540-00-634-4176 600-109

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
28 JUNE 03 0820	General Surgery - Transfer Summary DATE OF ADMISSION 25 JUNE 03 DATE OF TRANSFER 28 JUNE 03 DATE OF SURGERY 25 JUNE 03 HPI: APPROX 30 yo Iraqi civilian reported to have fallen from height 5-6 feet - receiving penetrating injury to perineum. Pt presented to EST - taken to OR - exam under anesthesia. Hemodynamically stable. Proctoscopy negative for rectal injury. Wound exploration no intraperitoneal injury. No bladder injury. Penrose drain placed in tract of wound. Foley cath placed - clear urine. Tract approx 10 cm deep Hospital course: Pt c̄ uncomplicated hospital stay. Tolerating regular diet. ⊕ BM ō blood in stool. Voiding spontaneously p̄ Foley removal. Ambulating well. No significant pain from wound. Minimal drainage. Plan: Remove - pick out - Penrose drain POD#5. Able to D/C c̄ f/u. [redacted] B6-2 Surgeon.

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

#[redacted]

B6-4

RECORDS MAINTAINED AT:

PATIENT'S NAME *(Last, First, Middle initial)*

SEX

RELATIONSHIP TO SPONSOR

STATUS

RANK/GRADE

SPONSOR'S NAME

ORGANIZATION

DEPART./SERVICE

SSN/IDENTIFICATION NO.

DATE OF BIRTH

CHRONOLOGICAL RECORD OF MEDICAL CARE

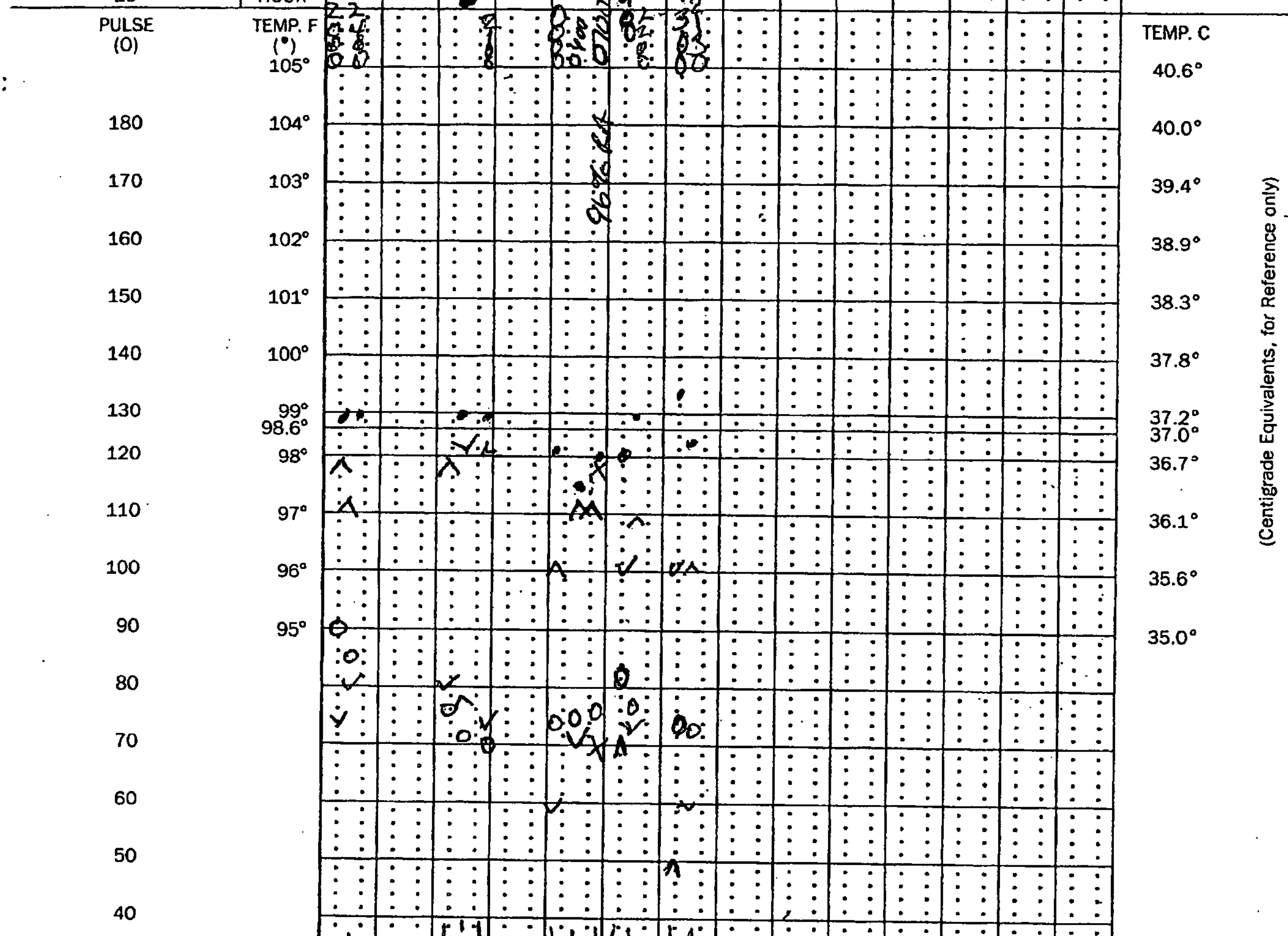
STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

MEDCOM - 12043

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY								
POST- DAY								
MONTH-YEAR	DAY	26 Jun	26 Jun	27	28	29	30	31
19	HOUR							



RESPIRATION RECORD	66	660	646 6b	62			
BLOOD PRESSURE	118/74	118/80	120/70 100/70	100/68			
P02	96	120/78	96/60				
HEIGHT: / WEIGHT →							

Record special data only when so ordered

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*

REGISTER NO.

WARD NO. ICW Z

STANDARD FORM 511 (REV. 7-95) **BACK**

#[redacted] B6-4

MEDCOM - 12044

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM MN HOURS
TO MN HOURS
TOTAL HOURS COVERED 24
DATE 6-26-03

INT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
0730	H_2O	240	240
1200	H_2O	120	360

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
MN	500	LR	250	08	475
		LR	225	05	700
05	500	LR	500		1200
10	50	cefotan	50		1250
1400	500	LR	500	2045	1750
2100	500	LR	250	MN	2000
2200	50	Cefotan	50	2230	2050

IRRIGATIONS (N/G, Bladder, etc.) Urine

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
04	C/U	1600	1600
12	C/U	1600	3200
08		500	3700
~~2045~~	700 C/U	1000	4700
2045	C/U	1200	5900

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl, Alb, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

#[redacted] b(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

MEDICINE GLASS (1 oz)	.30
SMALL FRUIT CUP	120
COFFEE CUP	160
LARGE COFFEE MUG	180
HALF PINT MILK	240
LARGE SOUP BOWL	240
LARGE WATER GLASS	240
PLASTIC OR PAPER JUICE CONTAINER	180

DD FORM 1 JAN 74 792 EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3630(TEMP) 1 JUL

*U.S.GPO:1998-404-613/30343

TWENTY-FOUR HOUR PATIE… INTAKE A… OUTPUT WORKSHEET

FRO… 0 H…
TO 2359 HOURS

TOTAL HOURS COVERED 24°

DATE 28Jun03

INT…

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
0700	oatmeal	1/2	
0700	applesauce	1/2	
0700	water	120	120cc

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL

Urine **IRRIGATIONS (N/G, Bladder, etc.)**

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0900	lt yellow urine	600cc	600 cc

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl, Alb, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

[redacted] b(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

MEDICINE GLASS *(1 oz)* .30	HALF PINT MILK 240
SMALL FRUIT CUP 120	LARGE SOUP BOWL......240
COFFEE CUP..............160	LARGE WATER GLASS..240
LARGE COFFEE MUG...180	PLASTIC OR PAPER JUICE CONTAINER...180

DD FORM 1 JAN 74 **792**

EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3030(TEMP) 1 JUL 7…

MEDCOM - 12046

*U.S.GPO:1996-404-613/30343

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

MN TO MN HOURS

TOTAL HOURS COVERED 24

DATE 6-27-03

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
MN	250	LR	150	01	150
	→ Hep Lock →				

IRRIGATIONS (N/G, Bladder, etc.) Urine

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
04	CYU	550	550
1000	Cyu	475	1020
1600	CYU	700	1720
2100	Cyu.	625	2345

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl. Alb, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

#[redacted] b(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

MEDICINE GLASS (1 oz)	30	HALF PINT MILK	240
SMALL FRUIT CUP	120	LARGE SOUP BOWL	240
COFFEE CUP	160	LARGE WATER GLASS	240
LARGE COFFEE MUG	180	PLASTIC OR PAPER JUICE CONTAINER	180

DD FORM 1 JAN 74 792

EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3630(TEMP) 1 JUL

MEDCOM - 12047

*U.S.GPO:1996-404-613/30343

TWENTY-FOUR HOUR PATIE… …TAKE AND OUTPUT WORKSHEET

FR… ____ HOURS
TO ____ HOURS
TOTAL HOURS COVERED
DATE

INT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
2000	500	LR	500	2040	500
2200	50	Cefotetan	50	2230	550

Output IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
2040	CVU	750cc	750cc

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl. Alb. P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

#[redacted] b(6)-4

INTAKE EQUIVALENTS (Serving levels cc)

MEDICINE GLASS (1 oz) .30	HALF PINT MILK 240
SMALL FRUIT CUP 120	LARGE SOUP BOWL.....240
COFFEE CUP.............160	LARGE WATER GLASS..240
LARGE COFFEE MUG...180	PLASTIC OR PAPER JUICE CONTAINER...180

DD FORM 1 JAN 74 792

EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3630(TEMP) 1 JUL 73 WHICH MAY BE USED.

MEDCOM - 12048

*U.S.GPO:1998-404-613/3034

b(6)-4

Ward/Section: ICW 2	R[redacted]NG PHYSICIAN: b(6)-2	RATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST [redacted] b(6)-4	DATE 25 JUN / TIME 1940	SSN/PSEUDO SSN: [redacted] [redacted]

b(6)-1

Hematology CBC

TEST	RESULT	REF. RANGE
WBC	15.7	4.8-10.8 x 10^3
RBC	4.17	4.7-6.1 x 10^9
Hgb	12.9	14-18 g/dl (M) 12-16 g/dl (F)
Hct	40.5	42-52% (M) 37-47% (F)
MCV	97.0	80-94 fl (M) 81-99 fl (F)
Plt	315	130-500 x 10^3 verified
Lymph %	10.4	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

[redacted]isc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Blood Bank Unit Crossmatch (YOU MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS: [redacted]

REPORTED BY: | **DATE:** | **LAB ID NO.:**

b(6)-2

MEDCOM - 12049

1CW2 b(6)-2

Ward/Section: ~~[illegible]~~	[redacted] PHYSICIAN:	**CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)
LAST, [redacted] b(6)-4	DATE 25Jun	TIME 1440
SSN/PSEUDO SSN: [redacted] b(6)-4		

(I-STAT)

TEST	RESULT	REF. RANGE
Na	141	138-146 mmol/L
K	3.3	3.5-4.9 mmol/L
Cl	105	98-109 mmol/L
pH	7.374	7.31-7.45
PCO2	45.9	35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2	28	23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3	27	22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf	2	(-2) – (+3) mmol/L
AnGap	12	10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN	11	8-26 mg/dl
GLU	123	70-105 mg/dl
Creat		0.[illegible]-1.5 mg/dl
Hct	34	38-51% PCV
Hgb	12	12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		Negative
Drug of Abuse		Negative
		Negative
		Negative
		Negative

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 u/l (M) 30-190 u/l (F)
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

REMARKS:		
REPORTED BY: [redacted]	**DATE:** 25June2003	**LAB ID NO.:**

MEDCOM - 12050

Dew#2 CBC

BPW# [redacted] b(6)-4 | [illegible] | 0315 |

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	13.4	4.8-10.8 x 10^3
RBC	4.23	4.7-6.1 x 10^9
Hgb	13.6	14-18 g/dl (M) 12-16 g/dl (F)
Hct	40.9	42-52% (M) 37-47% (F)
MCV	96.6	80-94 fl (M) 81-99 fl (F)
Plt	319	130-500 x 10^3 verified
Lymph %	19.5	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			
Spun Hematocrit		42-52% (M) 37-47% (F)	
Sed Rate			
Other			

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] **DATE:** **LAB ID NO.:**

b(6)-2

MEDCOM - 12051

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
[redacted] b(6)-4

NURSING UNIT: ICW 2
ROOM NO.:
BED NO.: 10

DATE OF ORDER: 25 June 03
TIME OF ORDER: 1840 HOURS
LIST TIME ORDER NOTED AND SIGN

1. Admit to ICW ✓
2. S/P penetrating injury to perineum ✓
3. Stable.
4. Stable
5. NKDA ✓
6. Vitals q 4° ē I/O's ✓

PATIENT IDENTIFICATION
[redacted] b(6)-4

NURSING UNIT: ICW 2
ROOM NO.:
BED NO.: 10

DATE OF ORDER
TIME OF ORDER ______ HOURS

7. Activity: ambulate ē assistance ✓
8. Diet: NPO ✓
9. IVF: LR @ 125cc/hr ✓
10. Meds: Cefotetan 2gm IV q 12° ✓
11. MSO4 1-6mg IV q 1° prn ✓
11. Labs: CBC in AM 26 June 03 ✓

PATIENT IDENTIFICATION
[redacted] b(6)-4

NURSING UNIT: ICW 2
ROOM NO.:
BED NO.: 10

DATE OF ORDER
TIME OF ORDER ______ HOURS

12. Nursing: ABD and perineum; Foley to gravity. ✓

b(6)-2 [redacted] MD
b(6)-2 [redacted] ICIAN 6-28-03 2330

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

NURSING UNIT: ICW2
ROOM NO.:
BED NO.: 3

DATE OF [redacted] RDER
26 June 03
0800 HOURS

~~D/C to Iraqi Hospital~~

CX [redacted] b(6)-2 265 MB

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

MEDCOM - 12052

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

#[redacted]

b(6)-4

NURSING UNIT: ICW 2
ROOM NO.:
BED NO.: 10

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

6-26-03 2130 VO. Dr. Dixon / LT Blanchard

① 650mg Tylenol PO x1 now [redacted] 2150

[redacted] b(6)-2

PATIENT IDENTIFICATION

#[redacted]

b(6)-4

NURSING UNIT: ICW 2
ROOM NO.:
BED NO.: 10

DATE OF ORDER: 26 JUNE 03
TIME OF ORDER: 2100 HOURS

① regular diet

② HL IV

③ D/C cefotetan after next dose

[redacted] b(6)-2

24° [redacted]

PATIENT IDENTIFICATION

#[redacted]

b(6)-4

NURSING UNIT: ICW 2
ROOM NO.:
BED NO.: 10

TO [illegible] 6-27-03 0010.

DATE OF ORDER: 27 June 03
TIME OF ORDER: 0020 HOURS

① D/C Foley

[redacted] b(6)-2

27 Jun 03 1050 b(6)-2 [redacted] 2400

24° [redacted] 0024/AN b(6)-2

PATIENT IDENTIFICATION

#[redacted]

b(6)-4

NURSING UNIT: ICW 2
ROOM NO.:
BED NO.: 10

DATE OF ORDER: 28 JUNE 03
TIME OF ORDER: 0050 HOURS

① TRANSFER TO IRAQI HOSPITAL WHEN MISSION BECOMES AVAILABLE. TRANSFER SUMMARY WRITTEN. NO MEDS NEEDED.

[redacted] b(6)-2 2000

b(6)-2 [redacted]

24° [redacted] 0050/AN

DA FORM 1 APR 79 **4256** REPLACES EDITION OF 1 JU[redacted]

MEDCOM - 12053

All b(6)-2 (except last)

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

Mo. ____ *Yr.* 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 25	26	27	28	29	30	31	
25	[redacted]	VS q̄ 4	4	/	[redacted]	[redacted]	[redacted]	/			
			8	/	[redacted]	[redacted]	[redacted]				
28	[redacted]	GS	12	/	[redacted]	[redacted]	[redacted]	/			
			16	/	[redacted]	[redacted]	[redacted]				
			20	[redacted]	[redacted]	[redacted]	[redacted]				
			24	[redacted]	[redacted]	[redacted]	[redacted]				
25	[redacted]	I & O's	6	/	[redacted]	[redacted]	[redacted]				DC'd 28 Jun
			14	/	[redacted]	[redacted]					
			21	[redacted]	[redacted]	[redacted]					
25	[redacted]	activity ambulate c̄ assist	6	/	[redacted]	[redacted]	[redacted]				
			14	/	[redacted]	[redacted]	[redacted]				
			21	[redacted]	[redacted]	[redacted]					
25	[redacted]	Diet: NPO	6	/	[redacted]	[redacted]					
			12	/	[redacted]	[redacted]					
			17	/	[redacted]	[redacted]					
25	[redacted]	foley to gravity	6	/	[redacted]	[redacted]					
			14	/	[redacted]	[redacted]	D/C				
			21	[redacted]	[redacted]	[redacted]					
25	[redacted]	abd pad to perineum	6	/	[redacted]	[redacted]	[redacted]				
			14	/	[redacted]	[redacted]					
			21	[redacted]	[redacted]	[redacted]					
26	[redacted]	Reg Diet	7	X	X	[redacted]	[redacted]				
			11	X	X	[redacted]	[redacted]				
			17	X	X	[redacted]	[redacted]				

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
S/P penetrating injury to perineum

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
PAGE NO: ________

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 EDITION OF 1 DEC 77 MAY BE USED. USAPA V1.00

MEDCOM - 12054

All b(6)-2

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Verify by Initialing

Mo 6 *Yr* 2003

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
25	[redacted]	admit ICW 2				[redacted]
25	[redacted]	Dx: S/P penetrating injury to perineum				[redacted]
25	[redacted]	Condition: stable				[redacted]
25	[redacted]	CBC in AM	26	04	04	[redacted]
27	[redacted]	D/C Foley	27	- done -		[redacted]
28	[redacted]	transfer to Iraqi hospital				
		when mission becomes avail.				
		- no meds needed				
		- transfer summary written				

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING COMPLETION* TIME/DATE COMPLETED

All b(6)-2 (except last)

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. 6 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 25	26	27	28	29	30	31
25	[redacted]	IV LR @ 125cc/hr	6	/	[redacted]					
			14	/	[redacted]					
			21	[redacted]	[redacted]					
25	[redacted]	Cefotan-2gm IV	10	/	[redacted]					
		q 12°	22	[redacted]	[redacted]		D/cd 6-26-03 2230			
6-26	[redacted]	HL IV	5	X	X	[redacted]	[redacted]			
			13	X	X	[redacted]	[redacted]	/C'd		
			21	X	X	[redacted]	[redacted]			

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS:

S/P penetrating injury to perineum

ADDITIONAL PAGES IN USE; ☐ YES ☐ NO

PAGE NO. ____________

PATIENT IDENTIFICATION:

[redacted]

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 - 12056

A11 b(6)-2

Verify by Initialing	**THERAPEUTIC DOCUMENTATION CARE PLAN** *(MEDICATIONS)*	*Mo.*______ *Yr.*______

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
626	[redacted]	650mg Tylenol PO x1 now	6-26	2130	2130	[redacted]
626	[redacted]	D/C cefotan p̄ next dose	6-26	2230	2230	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* TIME/DATE DISPENSED													
25	tO	MSO4 1-6mg IV	27 Jun 1100 4mg [redacted]													
		q 1° pen														

USAPA V1.00

MEDCOM - 12057

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF

1	2	3	4	5	6
A	1	1	D	1	▨

2. MTF LOCATION (State or Country Code.)

7	8
I	Z

3. REGISTER NUMBER (9–15): [redacted]

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

4. PAY GRADE (16, 17): EPW

5. SEX (18): M

6. DATE OF BIRTH (Y Y Y Y M M D D) (19–26): —

7. AGE AT ADMISSION (27–29): [redacted]

8. RACE (30): X

9. ETHNIC BACKGROUND (31): 9

RELIGION: MUSLIM

10. LENGTH OF SERVICE (32–34): —

ETS: —

11. FMP (35, 36): 9 9 b(6)-4

12. SOCIAL SECURITY NUMBER (37–45): [redacted]

ORGANIZATION (Active Duty Only): —

13. MARITAL STATUS (46): U

HOUR OF ADMISSION: 1930

BRANCH / CORPS: — b(6)-4

14. FLYING STATUS (47–49): —

15. BENEFICIARY CATEGORY

50	51	52
K	7	8

16. ZIP CODE OF RESIDENCE (53–61): —

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

18. MOS (64–70): —

19. TRAUMA (71): 1

PREV. ADMISSION YEAR: ☒ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION (72): 0

WARD: ICW2

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: —

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): —

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE: —

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted] b(2)-2

21. TYPE OF DISPOSITION (73, 74): ~~0~~ — 26

22. MTF TRANSFERRED TO (75–80):

23. DATE OF DISPOSITION (Y Y M M D D)

81	82	83	84	85	86
0	3	0	6	2	8

24. CLINIC SVC - ADMITTING (87–90):

25. MTF TRANSFERRED FROM (91–96):

26. DATE THIS ADMISSION (Y Y M M D D)

97	98	99	100	101	102
0	3	0	6	2	5

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

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

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

FOR LOCAL USE

DX: S/P penetrating wnd to perineum

Dx: 8796
E8880
E9208

b(6)-2 [redacted] Trauma

[redacted] 419 9

[redacted]

ADMITTING OFFICER (Sig

b(6)-2

DR. [redacted]

b(6)-2 [redacted]

DA FORM 2985

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

INPATIENT TREATMENT RECORD COVER SH

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

b(6)-4

1 REGISTER NUMBER: [redacted]

2 NAME (Last, First, MI): EPW [redacted] b(6)-4

3 GRADE: N/A

ADMISSION REMARKS

4 SEX: M

5 AGE: 28y

6 RACE: Z

7 RELIGION: unk b(6)-4

LENGTH OF SVC: N/A

9 ETS: N/A

10 PREVIOUS ADMISSION: No

11 FMP: 99

12 SSN: [redacted]

13 ORGANIZATION: N/A

14 WARD: CW2

15 FLYING STATUS: N/A

16 OSG:

BEN: K79

18 BRANCH/CORPS: N/A

19 UIC/ZIP:

20 TYPE CASE: B1

21 SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: Direct from ER

22 HOURS OF ADMISSION: 0212

23 CLINIC SERVICE: AEAA

24 NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: ——

25 TYPE DISPOSITION: 50

26 DATE OF DISPOSITION: 30 Jun 03

27a ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): ——

27b TELEPHONE NO.: ——

28 DATE OF THIS ADMISSION: 27 Jun 03

ADMITTING OFFICER: Dr. [redacted] b(6)-2

29 NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted] b(2)-2

30 DATE OF INITIAL ADMISSION:

32 UNITS COMPONENT TRANSFUSED:

31 SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33 CAUSE OF INJURY

34 DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

GSW Hip s/p I+D Ⓛ thigh

35. Total Days This Facility

a ABSENT SICK DAYS	b OTHER DAYS	c CONV. LV/COOP CARE DAYS	d SUPPLEMENTAL CARE DAYS	e BED DAYS	f TOTAL SICK DAYS
0	0	0	0	4	4

36. Total Days All Facilities

a ABSENT SICK DAYS	b OTHER DAYS	c CONV. LV/COOP CARE DAYS	d SUPPLEMENTAL CARE DAYS	e BED DAYS	f TOTAL SICK DAYS
0	0	0	0	4	4

SIGNATURE OF ATTENDING MEDICAL OFFICER: [redacted] Dr. [redacted]

SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER: for [redacted]

DA [redacted] EDITION OF 1

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

USAPPC V1.10

MEDCOM - 12059

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

PERTINENT HISTORY, CHIEF COMPLAINT, AND CONDITION ON ADMISSION *(Enter date of admission)*

28 y/o Iraqi EPW
cc: (L) Thy GSW
Shot (w) MP's 3hrs ago
Ø PMH
Ø meds
NKDA

PHYSICAL EXAMINATION

WDWNM NAD VSS AF
Mild Head wound Scalp
(L) Thy 7-10cm Long Deep wound
Bleeding medial (Lat HP

PROGRESS *(Enter date of discharge and final diagnosis)*

A) Left Hip GSW Non Bleeding
P) I&D w/ shot (L) Hip

[redacted] b(6)-2

SIGNATURE OF PHYS	DATE	IDENTIFICATION NO.	ORGANIZATION

PATIENT'S IDENTIFICA… ritten entries give Name last, first, … date; hospital or medical facility)

REGISTER NO.	WARD NO.

EPW [redacted] b(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
USAPPC V1.00

MEDICAL RECORD | **PROGRESS NOTES**

DATE	
28 JUN03	Assumed care of Pt @ 1300 upon transfer from ICU#3. VSS,
1530	A+O x3. Pain controlled c̄ PO percocet. Ⓛ Bicep PIV flushes well,
	IV ABX. Dsg to head CDI. Dsg to Ⓛ thigh/hip GSW intact.
	No new drainage, old dry bld drainage outlined. Wound
	elevated and iced. ⊕ sensation, palp. pulse, cap refil
	<3sec, mvt of toes Ⓛ foot. Ⓑ LS CTA, ⊕ BS x4 HR. b(6)-2 [redacted]
	O/W Assessment WNL. Will Monitor
2230	Assumed Pt care @ 2100. VSS, a+ox3, ∅ pain. Lung
	sounds CTA, pulses palpable x4, bs⊕ x4 quads. Dsg
	to head CDI, Dsg to Ⓛ thigh CDI, no drainage
	noted. Pt c̄ ⊕ ROM and sensation. Pt nps to OR in b(6)-2
	am. Will continue to monitor. [redacted] qiwmc
0030	IV infiltrated, restarted @ RFA. IV ABX running. [redacted] b(6)-2 qiwmc
29 June03 1000	Pt. in bed asleep easily aroused by verbal stimuli. Dressing
	to Ⓛ thigh saturated c̄ old blood. Pedal pulses in Ⓛ LE (+), sensation
	(+), cap refill <3sec. Pt. c/o HA x1, percocet given. Pt. c/o
	heartburn. Pt.'s been NPO since MN, awaiting washout in OR
	this AM. Lung sounds clear bilat, bowel sounds (+) x4 quads.
	All other assessment findings WNL. Pt. s̄ other complaints
	@ this time. IV HL in Ⓡ FA flushed well c̄ 3cc NS s̄ s/s of
	infection or infiltration. Will continue to monitor. [redacted] 1A
	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.

EPW [redacted] b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)
USAPPC V1.00

PROGRESS NOTES

DATE	
29 June 03 1330	Assumed pt care @1300 from previous shift. pt is NPO waiting to go to OR for washout. VSS. drsing to top of head C/d,i, 1" lac. c̄ 8 staples s̄ s/sx of infection noted, 4x4 gauze applied secured c̄ kerlix drsing. sore to Ⓡ side of nose healing s̄ diff. lung sounds CTA, abd soft BS⊕. Ⓛ hip drsing saturated c̄ old blood drainage, ⊖ new drainage noted pt able to wiggle toes. <3 sec cap refill, faint pulse noted. Ⓡ ext c̄ full ROM ⊕ pulse. BUE c̄ full ROM ⊕ pulses. HL to ⓇFA Ø s/sx of infection noted. pt complaining he wants to eat, ⊖ complaint of pain voiced @ this time. Will cont to monitor —— [redacted] 91WM6 SGT b(6)-2
29 June 03 1500	pt taken to OR via litter in stable condition —— b(6)-2 [redacted] 91WM6 SGT
29 June 03 1700	pt returned from OR via ICU 1 on litter in stable condition. VSS. drsing to head CDI. drsing to Ⓛ hip CDI. will cont to monitor —— b(6)-2 [redacted] 91WM6 SGT
29 June 03 1825	pt ate 100% dinner tray, tol po fluids well, IV fluid to be HL'd per orders. pt c/o pain given ii percocet per prn orders Will cont to monitor —— b(6)-2 [redacted] 91WM6 SGT
2245	Pt. care assumed @VSS. HR Reg, lungs CTA, ABD soft c̄ BS⊕ x4. Drsng to scalp CDI. Drsng to Ⓛ thigh CDI. Pt. has pulse 2⊕ Ⓛ ft c̄ Brisk cap refill, ⊕ROM, ⊕sensation. will cont to monitor. —— [redacted] b(6)-2
30 Jun 03 0600	Pt. in bed awake & alert. Wound to head approx. 2 inches in length, well approximated, s̄ s/s of infection. HL in ⓁFA flushed well c̄ 3cc NS s̄ s/s of infection. Lung sounds clear bilat. VSS. Dressing on Ⓛ leg CDI, weak pedal pulses, ROM(+) sensation(+). Pt. c/o reflux pain, possibly Will have pt. eat breakfast & monitor that pain. All other assessment findings

AUTHORIZED FOR LOCAL R

DICAL RECORD | PROGRESS NOTES

DATE | NOTES

b(6)-2

30Jun03 0600 WNL. Pt. s̄ other complaints @ this time. Will continue to monitor. [redacted]

1830 Assumed care of Pt @ 1300, VSS. A+O x 3. Pain controlled with percocet. Ⓛ thigh elevated/iced. Drsg/Ace WRAP CDI. Pt voiding <100cc Q hrs. Cathed pt c̄ 16F Foley cath, drained 600cc, clamped for 30min, unclamped drained 600cc for total of 1200cc CYU, left foley cath in place. Staples to top of head CDI. Pt c/o acid reflux, obtained order for Zantac. O/w Assessment WNL. Will cont to Monitor b(6)-2 [redacted]

2015. Pt. care assumed @ 2100. VSS. HR Reg. Lungs CTA, BS ⊕ x4. IV infusing to Ⓡ UE s̄ difficulty. IV site s̄ s/s infection. Drsg to Ⓛ thigh CDI. Pt has brisk cap refill to Ⓛ ft c̄ pedal pulse 2+, ⊕ ROM, ⊕ sensation. Will cont. to monitor. [redacted] b(6)-2 1LT AN

1July03 0530 Assume pt care @ 0500. pt Awake and Alert. VSS. C/O pain to Ⓛ thigh. Ⓛ thigh dsg CD+I. ⊕ sensation ⊕ movement below dsg. IV LR @ 100cc/hr to Ⓡ FA no s/s redness/infiltration. Foley to gravity draining CYU output, approx 400cc @ this time. NPO for surgery. HR reg. Lungs CTA Abd: soft BS x4 active. ii percocet (cont)

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

SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

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

EPW# [redacted] b(6)-4

FIRST NAME	MIDDLE INITIAL	ID NUMBER

NOTES

1July03 0530 ī sm sips of H_2O [illegible] pain. Will continue to monitor. ——— b(6)-2 [redacted] 91WM6

1July03 1020 pt returned from recovery. VSS. Dsg to Ⓛ thigh CD+I. Ⓛ LE elevated. no c/o pain. Will continue to monitor ← b(6)-2 [redacted] 91WM6

1040 pt c/o pain to Ⓛ thigh $\overset{\cdot\cdot}{\text{ii}}$ percocet adm — 91WM6

1245 1400cc CYU outputs this shift b(6)-2 91WM6

1July03 1430 assumed pt care @ 1300. pt sleeping easily aroused to verbal stimuli. VSS. Staples to top of head OTA. airway patent, lung sounds CTA, abd soft nontender BS⊕X4 quads. R ext c̄ full ROM ⊕ pulse. Ⓛ thigh dsing CDI, leg elevated ⊕ pulse. HL Ⓡ FA c̄ LR infusing s̄ diff. ∅ c/o pain voiced @ this time. Will cont to monitor ——— b(6)-2 [redacted] 91WM6

foley cath to gravity intact, draining s̄ diff - [redacted] 91WM6 b(6)-2

1JUL03 (2230) VSS. NAD. DSG to affected thigh D+I IVF as ordered, site s̄ redness or edema. Lungs CTA & = bilat. Pulses strong & =. BS⊕x4 Resting quietly @ present s̄ c/o. b(6)-2 [redacted] b(6)-2 [redacted]

1Jul03 2307 UOP 1000cc CYU ——— b(6)-2 ▷ PFC [redacted] 91W b(6)-2

2Jul03 0310 UOP 700cc CYU ———▷ PFC W

2JUL03 (0330) c/o pain in affected leg. Pt medicated as ordered c̄ Percocet $\overset{\cdot\cdot}{\text{ii}}$ PO. ——— [redacted]

2July03 0800 - Pt alert lying in bed. Voicing ∅ complaints. b(6)-2 VSS, lungs CTA, HR reg, BS⊕. Dsg intact to Ⓛ thigh. Pulse palpable. Pt able to wiggle toes. IV to Ⓛ arm infusing LR. Will cont to monitor ——— [redacted] 2Lt ANC

b(6)-2

AUTHORIZED FOR LOC

DICAL RECORD | PROGRESS NOTES

DATE	NOTES
2July03	1230 - Dsg Δ done to Ⓡ thigh. Old dsg c̄ large amount of old drainage. Incision c̄ sutures → intact Ø drainage noted. One small holes to Ⓛ of incision. Some red draining from site. New Dsg CDI. Gave percocet for pain. [redacted] b(6)-2
1445	Assumed care of Pt @ 1300. VSS. A+Ox3. Resting Comfortably pain controlled with PO percocet. Pt ambulated c̄ assistan Drsg Ⓛ thigh/ace wrap CDI ⊕ sensation, cap refil <3sec, ROM, palp. pulse RLE. o/a Ⓛ FA PIV patent c̄ LR @ 100 and IV ABX. o/a assess. WNL. Will Monitor & b(6)-2 [redacted]
02JUL03 21:31	Rec'd pt @ 21:00. Awake + alert in bed. Skin W/D. PERRLA ⊕ LCA Ⓑ BS ⊕ x4 ⊕ PPP Ⓑ. Ⓡ leg ↑ thigh, Ace wrap drsg C/D/I. Ⓡ foot ⊕ mobility, sensation, and <3 sec cap refill. Ⓡ foot cooler to touch than Ⓛ foot. 1+ faint pedal pulse Ⓡ foot. C/o pain ī Percocet given. Will cont to mon b(6)-2 [redacted] /AN
0050	Pt c/o pain Demerol and Phenergan given. Will mon
b(6)-2	[redacted] /AN b(6)-2
03:12	Pt c/o pain ii Percocet given [redacted] /AN
0330	Pt voided x2. 1st time in commode 100cc [redacted] b(6)-2 /AN

NSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | (SSN or Other

/SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

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

REGISTER NO. | WARD N

EPW [redacted]

b(6)-4

PROGRESS NOTES
Medical Record
STANDARD FORM 50

MEDCOM - 12065

AUTHORIZED FOR LOCAL REPRODUC

:AL RECORD | PROGRESS NOTES

'E	NOTES
3 Jul 1015	Assumed care of pt @ 0500. Pt is awake. VSS Lungs CTA. Bowel sounds x4 quads. OOB to br. Pt did personal hygiene. Pt is awaiting for Marines to pick him up. Pt can only leave with Marines. [redacted] LPN, SGT b(6)-2

IIP TO SPONSOR

SPONSOR'S NAME: LAST / FIRST / MI

SPONSOR'S ID NUMBER (SSN or Other)

RVICE

HOSPITAL OR MEDICAL FACILITY

RECORDS MAINTAINED AT

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

EPW [redacted] b(6)-4

REGISTER NO.

WARD NO

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV 5/1
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
27JUN03	b(6)-4
0300	Received from OR, EPW [redacted], S/P I + D Ⓛ thigh
VS: 118/75-	from GSW. Recovered fully @ 10 upon arrival.
104-21	Alert, able to verbalize needs. Foley draining clear
97-7	yellow urine, IVF LR @ 100 cc/hr set upon admission
	via dialaflow. Pt able to understand some basic
	English. Ⓛ thigh dressing c̄ bloody drainage noted.
	Orders noted as POC (plan of care). Monitor wound
	drainage + pain management. Pt denies pain @ this time
	Instructed to ask pain medicine as needed. Monitor
	pt closely. EPW protocol observed, MP @ bedside.
	b(6)-2 [redacted] Maj/AN
0430	Pt sound asleep @ this time. Vascular check normal
98.1-62-	cap refill < 3 seconds, able to move toes, pedal pulses ⊕.
22-108/57	T 98.7. NSR^{80s}, O_2 sat 100% b(6)-2 [redacted] Maj/AN
0500	Pt medicated c̄ Demerol 50 mg + Phenergan 25 mg IVP for c/o wound
	pain left thigh · b(6)-2 [redacted] Maj/AN
27Jun03 0530	Received pt who is sleeping quietly s̄ c/o complaints of pain.
	IVF infusing into Ⓛ AC site as ordered. Dressing to Ⓛ thigh
	intact w/ blood mark noted. V.S.S. Foley cath draining clear yellow
	urine. Will discuss w/ interpreter concerning expression of
	pain + nausea. RA w/ 100% sats. Cont. to monitor. b(6)-2 [redacted] TC/AN

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.

EPW [redacted] 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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
27 Jun 03 1000	Pt ate 3 slices of oranges + eggs. At this time, c/o ↑ pain in Ⓛ thigh, describing area by knee to drsg. Sik as a burning sensation. HR ↑ 120's. Demerol 50mg IV w/ Phenergan 25mg given. BP ↓ to 86/60. IVF open infusion of LR. ↑ c/o pain. B/P repeated 101/55. Demerol 50mg given (total 100mg). B/P 103/51 Will cont. to monitor. b(6)-2 [redacted] LTC/AN. b(6)-2 [redacted]
1030 27 Jun 03	Pt resting quietly. No c/o pain, V.S.S. Cont. to monitor. LTC/AN
b(6)-2 [redacted] ~~1030~~ 1305 27 Jun 03	Awake, comfortable, eating lunch + asking about another pt. Pt follows instruction to move leg out + in and extend/flex ankle. Drsg to head dry + intact. NV ✓ ⊕ w/ cap. refill < 3 sec. [redacted] b(6)-2
27 Jun 03 1600	Awaken p̄ resting w/ eyes closed. No request for pain meds. Eencouraged to move legs. Washed face + feet. Drsg. to Ⓛ thigh noted w/ blood, small amt. oozing [illegible] drsg. Drsg. enforced. b(6)-2 V.S.S. Cont. on RA c̄ sats > 96%. Cont. to monitor. [redacted] R/a
1800	Change of shift note: Pt awake, given dinner. Denies pain at this time, dressing D+I. NV ✓ WNL [redacted] Maj/AN
2200	Pt had dinner, taken p.o. liquid. s̄ difficulty. IV replaced b(6)-2 after 2200 Ancef. Flush + maintain patency of Ancef administration. Medicated c̄ Percocet ⅰ p.o. c̄ relief b(6)-2 [redacted] Maj/AN
0145	Medicated c̄ ⅰ Percocet p.o. for c/o pain Ⓛ thigh. Urinated clear yellow urine 125 cc. Pt went back to sleep b(6)-2 [redacted] Maj/
0400	Slept throughout the night s̄ any complaints. EPW protocol observed. Pt chained 2 points in bed [redacted] Maj/AN
0515	Given another Percocet ⅰ p.o. for c/o moderate pain b(6)-2 Voided 215 cc clear yellow urine. Ⓛ thigh dressing intact s̄ any additional drainage. b(6)-2 [redacted] Maj/AN
0500	Received report from previous shift. Pt has 2 point restraints. (-) c/o HA, pain @ this time. NV ✓ cont'd

STANDARD FORM 600 (REV. 6-97) **BACK**
*U.S. GPO: 2002 - 491-600/50618

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
28JUN03 0500	cont'd... completed. 1K Ⓛ AC IL and intact. Will cont. care. b(6)-2 [redacted] 1LTAN
0900	Pt c/o pain in head and leg. Gave percocet ī tab. Will cont. to assess pain level. b(6)-2 [redacted] 1LTAN
1150	Pt c/o pain in Ⓡ leg. Gave Demerol 50mg and phenergan 25mg. Will cont to assess pain level. b(6)-2 [redacted] 1LTAN
1250	Prepared pt for transfer. Gave report to 1Lt Mine [redacted] 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.

EPW [redacted] 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

MEDCOM - 12069

558-103

(See Instructions on Back of this Sheet)

NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY *(Stamp)*

LOG NUMBER

ARRIVAL			
DAY	MONTH	YR.	TIME
26	JUN	03	23:06

TRANSPORTATION TO HOSPITAL *(Attach care enroute sheet)*
☐ PRIVATE VEHICLE ☐ AMBULANCE
☑ OTHER *(Specify)* Medevac

CURRENT MEDS. *(tetanus immunization and other data)* 0 / 0

HISTORY OBTAINED FROM ☐ PATIENT ☐ OTHER *(Specify)*

ALLERGIES NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION *(City, State and ZIP Code)*

HOME TELE. NO. *(Inc. area code)*

CHIEF COMPLAINT(S) *(Include symptom(s), duration)* GSW to (L) thigh.

SEX M AGE 28

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER 2307

VITAL SIGNS			
TIME	2306	0005	
BP	111/64	117/72	
PULSE	~~88~~ 86	92	
RESP.	100% 18	16	
TEMP.	96.7	100% RA	
WT. (Child)	65 Kg		

CATEGORY *(See reverse)*
☐ EMERGENT
☒ URGENT
☐ NON-URGENT

ORDERS	INITS.	TIME
Tetanus Im .5ml	[redacted]	2311
1 GRAM Ancef IV		2311
5mg MSO4 IV		2312
5mg MSO4 IV		2350

b6-2

ASSESSMENT/DIAGNOSIS
① GSW (L) thigh
② Scalp Laceration Repaired

DISPOSITION *(Check all that apply)*
☐ HOME ☐ FULL DUTY
QUARTERS ☐ 24 Hrs. ☐ 48 Hrs. ☐ 72 Hrs.
MODIFIED DUTY UNTIL: DAY MONTH YEAR
REFERRED TO *(Indicate clinic)*
☐ EMERGENCY ☐ TODAY
☐ 72 HOURS ☐ ROUTINE
☒ ADMIT. TO HOSP. UNIT/SERVICE ICW #2

CONDITION UPON RELEASE
☒ IMPROVED ☐ UNCHANGED
☐ DETERIORATED 0

TIME OF RELEASE: 0010

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

Pt presents c̄ GSW c̄ (L) thigh. Also lac c̄ back of head. Pt smokes [illegible] drugs/ETOH

28 y/o ♂ EPW s/p opening fire on MP's, they fired back.
~ 3 hrs prior to arrival. pt driven here by the MP unit that shot him.

6: WD, WN, NAD A+O

H: (R) scalp lacerated ~ 3/4 inch [illegible]

N: [illegible]

L: CTA (B) [illegible]

B: [illegible]

Ext: [illegible]

PMH – 0
PSH – 0
(+) TOB

(L) Thigh – 0 shrapnel
Pelvis – NAD
CXR – WNL
Skull – 0 shrapnel

28.1 > 14 / 47 < 180

139 | 106 | 12 / 4.3 | 23 | 0.7 < 12

PT – 12
PTT – 21

CK – 388

A/P Scalp stapled / Ancef / dT / MSO4 given
Txf to O.R. c̄ [redacted]

b6-2

(CONTINUE ON SF 507, IF NEEDED)

PATIENT'S IDENTIFICATION *(Mechanical imprint)* FOR WRITTEN ENTRIES GIVE: *Name - last, first, middle; SSN; DOB, service status, name and relation of sponsor or next of kin. (IMPORTANT: LIST FACILITY HOLDING TREATMENT RECORD).*

SIGNATURE OF PROVIDER AND ID STAMP [redacted] 226T

INSTRUCTIONS TO PATIENT *(Include medications ordered, any limitations and follow-up plans)*

b(6)-2

EMERGENCY CARE AND TREATMENT

Medical Record Copy

MEDCOM - 12070

STANDARD FORM 558 (Rev. 6-82)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

FOR Use of this form, see AR 40-407; the proponent agency is The Office of the Surgeon General.

1. AGE:
HEIGHT:
WEIGHT:

2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication)
☒ NKDA ☐ PCN ☐ LATEX ☐ IODINE ☐ TAPE ☐ FOOD
REACTION:

3. PREVIOUS SURGERY [ ] NO [ ] YES (type):

4. PROPOSED SURGICAL PROCEDURE:

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition____________
Tobacco____ppd X____yrs. Body Piercing________ Diabetes (Y) (N) ROM_________ ASA/Motrin w/72 hrs (Y) (N)
ETOH__________ Implants________ Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS:

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ______Potential for anxiety related to: ______1) Surgical Procedure & Operating Room Environment ______2) Separation Anxiety (Child) ______3) Surgical Outcomes	o Pt. verbalizes any specific anxiety. o Pt. Exhibits relaxed body posture.	c Allow pt. to verbalize freely. c Explain OR environment and answer questions regarding surgery. c Offer comfort measures. (e.g., warm blanket, touch). c Explain all nursing procedures before they are done. c Remain with pt. whenever possible. c Maintain family interface. Parents to stay with pt.
B. AERATION ______Potential for respiratory dysfunction due to: ______1) Positioning ______2) Effects of Anesthesia ______3) Medical/Smoking History	o Pt. will be able to breathe without difficulty during immediate intraoperative phase .	c Offer to elevate head of litter or offer pillow. c Observe pt. while awaiting surgery for signs of distress. c Assist anesthesia during intubation and extubation.
C. INTEGUMENT ______Potential impairment of skin integrity due to: ______1) Intraoperative Immobility ______2) ESU Pad Placement ______3) Positional Aids ______4) Prosthesis ______5) Pooling of Prep Solutions	o Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened areas).	c Utilize pressure preventing devices on OR table and accessories. c Check for proper positioning and support to maintain good body alignment. o Pad pressure points. o Place ESU ground pad on non compromised skin surface area. o Keep prep fluids from pooling.

Emergency

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

Epo# [redacted] b(6)-4

VERIFICATIONS AT HOLDING AREA:
! ID/Allergy Band
! H & P
! NPO Since_____
! UHCG/LMP
! Dentures Removed
! Contacts Removed
! Jewelry Removed
! Body Pierce Removed
! Consent/Blood Transfusion Signed/Witnessed/Dated
! Surgical Site/Consent verified by Pt./Anesthesia/Surgeon
! Contact Precautions (Y) (N)
! Family/Friend:________________

DA FORM 5179, JUN 91 Previous editions are obsolete. USAPA V1.0

MEDCOM - 12071

L

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION _____ Potential for inadequate tissue perfusion due to: _____ 1) Intraoperative Mobility _____ 2) Positioning _____ 3) Existing Disease _____ 4) Safety Devices _____ 5) Hypothermia	o Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse.	o Check for support stockings or ace wraps. If none, check with doctors. o Check that safety straps are correctly applied. o Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. o Check that rings and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL E.1. _____ Potential impairment of mobility due to: _____ 1) Pain _____ 2) Intraoperative Hazards _____ 3) Prosthesis _____ 4) Positioning _____ 5) Transfer pt. to/from OR table E.2. _____ Potential discomfort due to: _____ 1) Length of Surgery _____ 2) Positioning _____ 3) Arthritis	o Pt. will be transferred to OR table without difficulty. o Pt. will not experience unnecessary physical discomfort.	o Have sufficient people available for transfer. o Insure proper body alignment. o Allow patient to lie in position of comfort while waiting for surgery. o Offer support (i.e., pillows, bath towels, etc.) for positioning.
F. SPECIAL SENSES F.1. _____ Diminished visual perception due to being: _____ 1) Pre-Medicated _____ 2) W/O Glasses F.2. _____ Potential for decreased communication due to: _____ 1) Diminished Hearing _____ 2) Language Barrier F.3. _____ Potential injury due to dentures: _____ 1) Upper _____ 4) Caps _____ 2) Lower _____ 5) Crowns _____ 3) Bridges	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR table. o Pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt. from _______ side. o Validate pt.'s understanding of verbal communication. o Verify removal of dentures.
G. OTHER PATIENT PROBLEMS/NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

10. OR NURSING INTERVENTIONS COMPLETED/ADDITIONAL INTRAOPERATIVE INTERVENTIONS NOTED.

b(6)-2 [redacted] CPT/AN 26 Jan 03 DATE

11. POSTOPERATIVE EVALUATION: SKIN INTEGRITY: Bovie Pad Site: ☐ Clean and Dry ☐ Red ☐ N/A

LEVEL OF CONSCIOUSNESS: ☐ A&O ☐ Drowsy ☐ Sleepy ☐ Intubated

LEVEL OF ACTIVITY: ☐ Moves All Extremities ☐ Moves Upper Extremities ☐ Transferred to litter with roller due to spinal

DRESSING DRY & INTACT: (Y) (N)

BREATHING EASY: (Y) (N)

12. PREOPERAT[redacted]PARED BY (Signature and Titl CPT/AN

DATE: 26 Jan 03 TIME: b(6)-2

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title)

DATE: TIME:

REVERSE OF FORM 5179, JUN 91 USAPA V1.0

MEDCOM - 12072

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

FOR Use of this form, see AR 40-407: the proponent agency is The Office of the Surgeon General.

1. AGE: 28

HEIGHT:

WEIGHT: 65 kg

2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication)

☒ NKDA ☐ PCN ☐ LATEX ☐ IODINE ☐ TAPE ☐ FOOD

REACTION:

3. PREVIOUS SURGERY [ ] NO [ ] YES (type):

4. PROPOSED SURGICAL PROCEDURE:

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition________

Tobacco ✓ ppd X___yrs. Body Piercing______ Diabetes (Y) (N) ROM______ ASA/Motrin w/72 hrs (Y) [✓ (N)]

ETOH______ Implants______ Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) [✓ (N)]

Glasses/Contact (Y) (N) Dentures Hypertension (Y) [✓ (N)] Herbal Medicines (Y) [✓ (N)] MEDS:

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL _____Potential for anxiety related to: _____1) Surgical Procedure & Operating Room Environment _____2) Separation Anxiety (Child) _____3) Surgical Outcomes	o Pt. verbalizes any specific anxiety. o Pt. Exhibits relaxed body posture.	o Allow pt. to verbalize freely. o Explain OR environment and answer questions regarding surgery. o Offer comfort measures. (e.g., warm blanket, touch). o Explain all nursing procedures before they are done. o Remain with pt. whenever possible. o Maintain family interface. Parents to stay with pt.
B. AERATION _____Potential for respiratory dysfunction due to: _____1) Positioning _____2) Effects of Anesthesia _____3) Medical/Smoking History	o Pt. will be able to breathe without difficulty during immediate intraoperative phase .	o Offer to elevate head of litter or offer pillow. o Observe pt. while awaiting surgery for signs of distress. o Assist anesthesia during intubation and extubation.
C. INTEGUMENT _____Potential impairment of skin integrity due to: _____1) Intraoperative Immobility _____2) ESU Pad Placement _____3) Positional Aids _____4) Prosthesis _____5) Pooling of Prep Solutions	o Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened areas).	o Utilize pressure preventing devices on OR table and accessories. o Check for proper positioning and support to maintain good body alignment. o Pad pressure points. o Place ESU ground pad on non compromised skin surface area. o Keep prep fluids from pooling.

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

EPW # [redacted] b(6)-4

VERIFICATIONS AT HOLDING AREA:

! ID/Allergy Band
! H & P
! NPO Since____
! UHCG/LMP
! Consent/Blood Transfusion Signed/Witnessed/Dated
! Surgical Site/Consent verified by Pt./Anesthesia/Surgeon
! Contact Precautions (Y) (N)
! Family/Friend:________

! Dentures Removed
! Contacts Removed
! Jewelry Removed
! Body Pierce Removed

DA FORM 5179, JUN 91 Previous editions are obsolete. USAPA V1.0

MEDCOM - 12073

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to: ____ 1) Intraoperative Mobility ✓ 2) Positioning ____ 3) Existing Disease ____ 4) Safety Devices ✓ 5) Hypothermia	o Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse.	o Check for support stockings or ace wraps. If none, check with doctors. o Check that safety straps are correctly applied. o Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. o. Check that rings and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to: ✓ 1) Pain ____ 2) Intraoperative Hazards ____ 3) Prosthesis ✓ 4) Positioning ____ 5) Transfer pt. to/from OR table E.2. ✓ Potential discomfort due to: ____ 1) Length of Surgery ✓ 2) Positioning ____ 3) Arthritis	o Pt. will be transferred to OR table without difficulty. o Pt. will not experience unnecessary physical discomfort.	o Have sufficient people available for transfer. o Insure proper body alignment. o Allow patient to lie in position of comfort while waiting for surgery. o Offer support (i.e., pillows, bath towels, etc.) for positioning.
F. SPECIAL SENSES F.1. ✓ Diminished visual perception due to being: ✓ 1) Pre-Medicated ____ 2) W/O Glasses F.2. ✓ Potential for decreased communication due to: ____ 1) Diminished Hearing ✓ 2) Language Barrier F.3. N/A Potential injury due to dentures: ____ 1) Upper ____ 2) Lower ____ 3) Bridges ____ 4) Caps ____ 5) Crowns	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR table. o Pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt. from ______ side. o Validate pt.'s understanding of verbal communication. o Verify removal of dentures.
G OTHER PATIENT PROBLEMS/NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

10. OR NURSING INTERVENTIONS COMPLETED/ADDITIONAL INTRAOPERATIVE INTERVENTIONS NOTED.

b(6)-2 [redacted] /MAJ AN 29 Jun 03 DATE

11. POSTOPERATIVE EVALUATION: SKIN INTEGRITY: Bovie Pad Site: ☑ Clean and Dry ☐ Red ☐ N/A DRESSING [✓ DRY] & INTACT: [✓ (Y)] (N)

LEVEL OF CONSCIOUSNESS: [redacted] ☑ Drowsy ☐ Sleepy ☐ Intubated BREATHING EASY: (Y) (N)

LEVEL OF ACTIVITY: ☑ Moves All Extremities ☐ Moves Upper Extremities

☐ Transferred to liter ~~with roller due to spinal~~ by OR Staff

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title)

b(6)-2 [redacted] MAJ AN

DATE: 29 Jun 03 TIME: 1450

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title)

b(6)-2 [redacted] MAJ AN

DATE: 29 Jun 03 TIME: 1601

REVERSE OF FORM 5179, JUN 91

USAPA V1.0

MEDCOM - 12074

b(6)-2 All (except last)

MEDICAL RECORD

INTRAOPER ve DOCUMENT

For use of this form, see AR 40-66, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: LITTER BY Anesthesia

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY 1LT [redacted]

3. DATE 1 Jul 03 TIME PATIENT ARRIVED IN SUITE 0805

4. PATIENT IN ROOM TIME 0805 NUMBER 1-1

5. PREOPERATIVE EMOTIONAL STATUS

☒ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS: NPO p̄ MN, NKDA

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted]	RELIEF SCRUB	
ASSIGNED CIRCULATOR	1LT [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)* Pt. supine on padded OR table. BUE on padded armboards <90°. Safety strap across mid abdomen.

☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

COMMENTS: Normal anatomic body alignment maintained.

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS: N/A

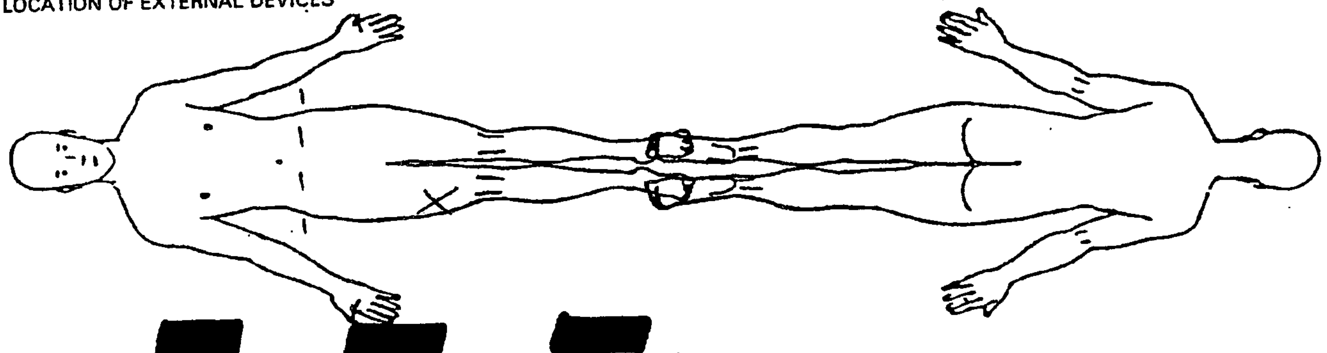
PREP SOLUTION *(Specify)* Betadine/ Betadine

SITE: Left thigh BY WHOM:

SITE: BY WHOM: 1LT [redacted]

COMMENTS: No pooling or adverse reaction

9. LOCATION OF EXTERNAL DEVICES



[redacted] [redacted] [redacted]

LEGEND X Ground Pad -- Safety Strap = = = Tourniquet

Initial: SPC [redacted]
1LT

C = Correct I = Incorrect

10. COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes	☐ No		C	C	SPC [redacted]	1LT [redacted]
Needle Sharp	☒ Yes	☐ No					
Instrument	☐ Yes	☒ No					
Other	☐ Yes	☒ No					

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

[redacted] b(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO

☒ ESU NO: #1 Cut 30 Coag 30

GROUND PAD: BRAND VL Rem Polyhesive II

LOT NO: 66226 Exp 2004-11

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES MEDCOM - 12075 HICH IS OBSOLETE. USAPA V1.01

13. PROSTHESIS, IMPLANTS ☐ YES ☒ NO IF YES NAME: ID NUMBER; MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☒

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

0.9 % NaCl- Q.S

b(6)-2

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE [redacted]

15. X-RAY IN OPERATING ROOM IF YES, SITE

YES ☐ NO ☒

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

TYPE/SIZE	1.	2.	3.
SITE	1.	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

Flufts, Kerlix, ACE

19. ADDITIONAL INFORMATION

Surgeon: Dr [redacted] b(6)-2

Anesthesia: MAJ [redacted]

b(6)-2

Pt. arrived in OR c̄ patent Foley cath.

DA5179 in chart

20. OPERATION(S) PERFORMED

I&D [illegible]gh wound

21. PATIENT TRANSFERRED TO ICU b(6)-2 TIME 0854 METHOD LITTER c̄ O2

22. REGISTERED NURSE SIGNATURE [redacted] RN

REVERSE OF DA FORM 5179-1, OCT 87

MEDCOM - 12076

USAPA V1.01

b(6)-2 All (except last)

MEDICAL RECORD | **INTRAOPE . DOCUMENT**

For use of this form, see AR 40-66, the pr. .t agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Litter BY CPT [redacted] / MAJ [redacted]

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE
D BY MAJ [redacted]

3. DATE 29 Jun 03 TIME PATIENT ARRIVED IN SUITE 1500

4. PATIENT IN ROOM
TIME 1500 NUMBER 1-2

5. PREOPERATIVE EMOTIONAL STATUS

☑ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS: Allergies:

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted]	RELIEF SCRUB	
ASSIGNED CIRCULATOR	MAJ [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

☑ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

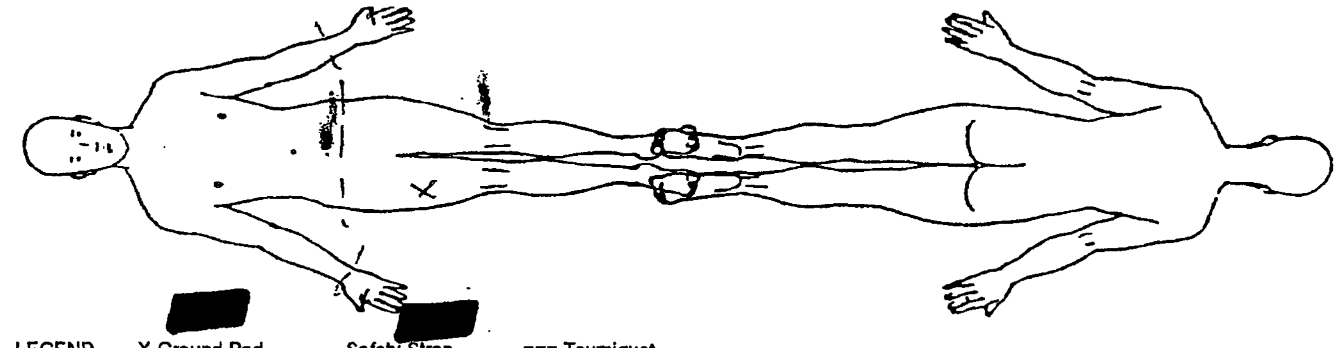
COMMENTS: 3L bag N.S. under Lt hip, both arms on padded armboards at < 90°

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☑ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR
☐ CLIP
COMMENTS:

PREP SOLUTION *(Specify)*
SITE: BY WHOM:
SITE: BY WHOM:
COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



[redacted]

[redacted]

LEGEND X Ground Pad -- Safety Strap === Tourniquet

10. COUNTS

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☑ Yes ☐ No		C	C	[redacted]	
Needle Sharp	☑ Yes ☐ No		C	C		MAJ [redacted]
Instrument	☐ Yes ☑ No				PFC	MAJ
Other	☐ Yes ☑ No				PFC	

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

EPW # [redacted]

12. ELECTROSURGERY DEVICE(S) (ESU) ☑ YES ☐ NO

☑ ESU NO: Valleylab #2
GROUND PAD: BRAND Valleylab
LOT NO: 65706 Exp 2004-11

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REF 'S DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLE USAPA V1.01

MEDCOM - 12077

13. PROSTHESIS, IMPLANTS ☐ YES ☒ NO IF YES NAME: ID NUMBER; MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☒

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S): N.S. x 7L.

OTHER ORDERS	TIME	CARRIED OUT BY
[redacted]		

PHYSICIAN'S SIGNATURE b(6)-2

15. X-RAY IN OPERATING ROOM IF YES, SITE
YES ☐ NO ☒

16. ORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 3/8" Penrose	2.	3.
SITE	1. Left thigh	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Fluffs
Kerlix, Ace

19. ADDITIONAL INFORMATION
WC
Surgeons: [redacted] b(6)-2 Anesthesia: CPT [redacted] b(6)-2 Anesthesia Type: GETA

Bovie Pad site intact pre-op ✓; post-op ✓ Bovie Settings: Coag/Cut 30/30

20. OPERATION(S) PERFORMED
I&D Left upper thigh wound

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU	1555	Litter

22. REGISTERED NURSE SIGNATURE [redacted] b(6)-2 at MAW AN 29 Ju 03

REVERSE OF DA FORM 5179-1, OCT 87 MEDCOM - 12078 USAPA V1.01

b(6)-2 All (except last)

MEDICAL RECORD | **INTRAOPE ~~~~~~ VE DOCUMENT**
For use of this form, see AR 40-66, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Litter BY Anes. Staff
2. PATIENT ID[redacted]D AND PROCEDURE VERIFIED BY [redacted] CPT/AN
3. DATE 26 Jun 03 TIME PATIENT ARRIVED IN SUITE EMT → OR
4. PATIENT IN ROOM TIME 0105 NUMBER FR

5. PREOPERATIVE EMOTIONAL STATUS

☑ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS: NKDA

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC. [redacted] (91D)	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT. [redacted] (66E) CPT. [redacted] (66E)	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

☐ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☑ LEFT SIDE UP ☐ RIGHT SIDE UP

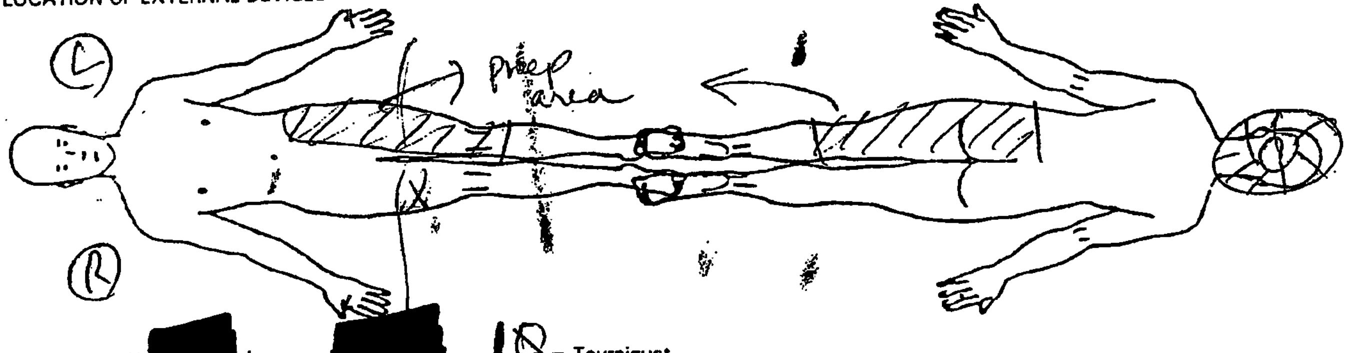
COMMENTS: Bean Bag utilized for (L) side up. pillow under (R) leg & (L) arm.

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☑ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP
COMMENTS: Ø

PREP SOLUTION *(Specify)* Betadine S/Sol
SITE: Lf. thigh & Hip BY WHOM: CPT. [redacted] AN
SITE: ~ BY WHOM: ~
COMMENTS: Ø poolings of sol.

9. LOCATION OF EXTERNAL DEVICES



LEGEND X [redacted]ad -- Su[redacted] ▯ = Tourniquet

10. COUNTS

		C = [redacted]rrect	I = Incorrect			
10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☑ Yes ☐ No	/	C	C	SPC [redacted]	CPT. [redacted]
Needle Sharp	☑ Yes ☐ No	/				
Instrument	☐ Yes ☑ No	/	/	/		
Other	☐ Yes ☑ No					

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

EPW # [redacted]

b(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☑ YES ☐ NO

☑ ESU NO: Valley Lab #2
GROUND PAD: BRAND poly hesive
LOT NO: 69652

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:
Coag 230
cut 230

DA FORM 5179-1, OCT 87 REPL S D MEDCOM - 12079 HICH IS OBSOL... USAPA V1.01

THESIS, IMPLANTS ☐ YES ☑ NO IF YES NAME: ID NUMBER; CTURER

MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☑

EDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S):

0.9% Nacl

b(6)-2

OTHER ORDERS	TIME	CARRIED OUT BY
16FR Foley inserted [redacted] in O.R	Intra-op	CPT [redacted]

PHYSICIAN'S SIGNATURE [redacted] b(6)-2

15. X-RAY IN OPERATING ROOM YES ☐ NO ☑ IF YES, SITE

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☑	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☑	NAME	NAME
CULTURE (C) YES ☐ NO ☑	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☑ NO ☐

TYPE/SIZE	1. 3/8" Penrose	2. Drain	3. Gauze
SITE	1. Lt. Thigh		3. Lt Thigh

18. DRESSING/IMMOBILIZATION *(Specify)*

4x8 Fluffs, ABD's Tape

19. ADDITIONAL INFORMATION

Surgeon: Dr [redacted] b(6)-2

Anes: Maj [redacted] (CRNA)

b(6)-2

20. OPERATION(S) PERFORMED

Lt. Thigh - I & D c̄ washout

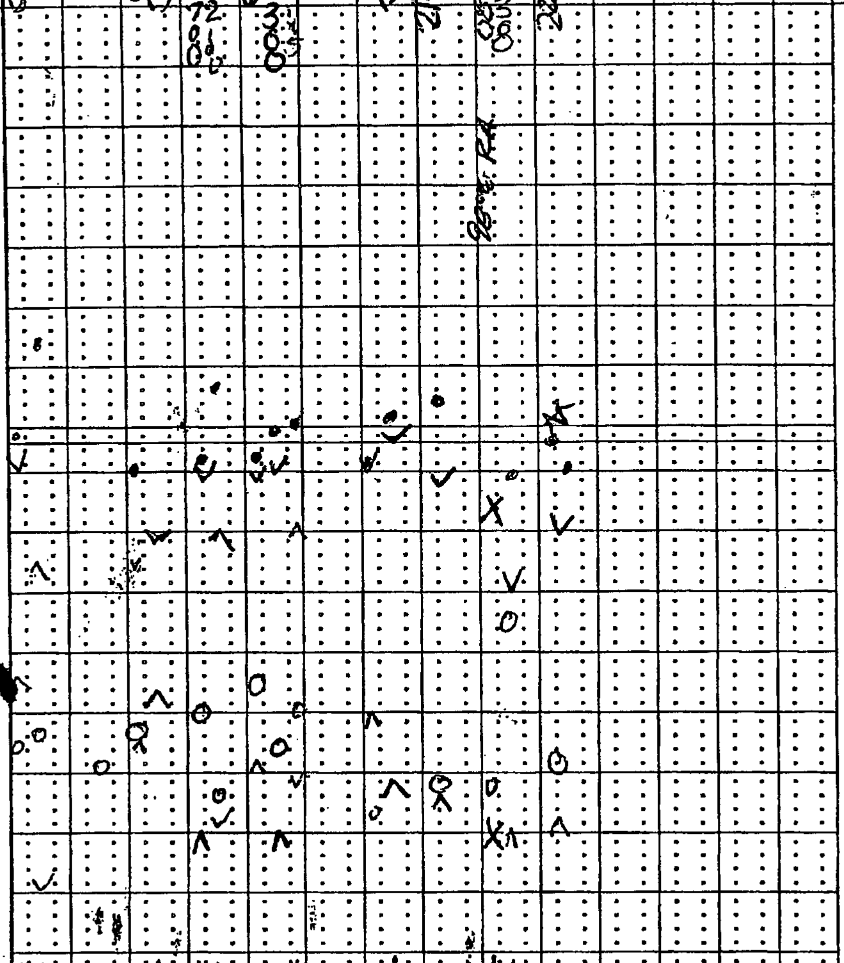
21. PATIENT TRANSFERRED TO ICU TIME see Anes Record. METHOD Litter

22. RE[redacted] CPT/AN

b(6)-2

REVERSE OF DA FORM 5179-1, OCT 87 MEDCOM - 12080 USAPA V1.01

MEDICAL RECORD		VITAL SIGNS RECORD						
HOSPITAL DAY								
POST-	DAY							
MONTH-YEAR	DAY	28	29	30	1	2	3	4
June ~~18~~ 2003	HOUR	13	0830 1720	0612 3 08	13 2140	0800 2250		



	28		29		30		1		2	
RESPIRATION RECORD	16 16		14	16 16	18		18 18	16	18 10	16
BLOOD PRESSURE	120/76		105/54	120/80	115/72 120/60		120/80 124/78	118/66	100/60	110/73
HEIGHT: / WEIGHT →										
	98%	94%	98%		97%		96% 98%	98%		98%

Record special data only when so ordered

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)

REGISTER NO.

WARD NO. ICW 2

STANDARD FORM 511 (REV. 7-95) BACK

GW [redacted] b(6)-4

Ward/Section: EMT

LAST, FIRST, MI

UESTING PHYSICIAN: [redacted]

b(6)-2

CHEMISTRY RESULT FORM

(Subject to the Privacy Act of 1974)

DATE 26Nov03

TIME 2325

SSN/PSEUDO SSN: # [redacted] b(6)-4

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		Negative
Drug of Abuse		Negative
		Negative
		Negative
		Negative

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU	123	73-118 mg/dl
BUN	12	7-22 mg/dl
CRE	0.7	0.6-1.2 mg/dl
CK	388	39-380 u/l (M) 30-190 u/l (F)
NA^+	139	128-145 mmol/l
K^+	4.3	3.3-4.7 mmol/l
CL^-	106	98-108 mmol/l
tCO_2	23	18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

REMARKS:

REPORTED BY: [redacted] b(6)-2

DATE: 26Nov03

LAB ID NO.:

Ward/Section: EMT	REQ [redacted]	PHYSICIAN:	**LABORATORY RESULT FORM** (Subject to the Privacy Act of
LAST, FIRST, MI. b(6)-2	DATE ~~26Jun03~~	TIME 2325	SSN/PSEUDO SSN # [redacted] b(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	25.7	4.8-10.8 x 10³
RBC	5.47	4.7-6.1 x 10⁹
Hgb	14.8	14-18 g/dl (M) 12-16 g/dl (F)
Hct	47.3	42-52% (M) 37-47% (F)
MCV	86.5	80-94 fl (M) 81-99 fl (F)
Plt	180	130-500 x 10³ verified
Lymph %	10.0	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF.
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF. RANGE
PT	12.3	9.8-13.6 secs
APTT	21.2	21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

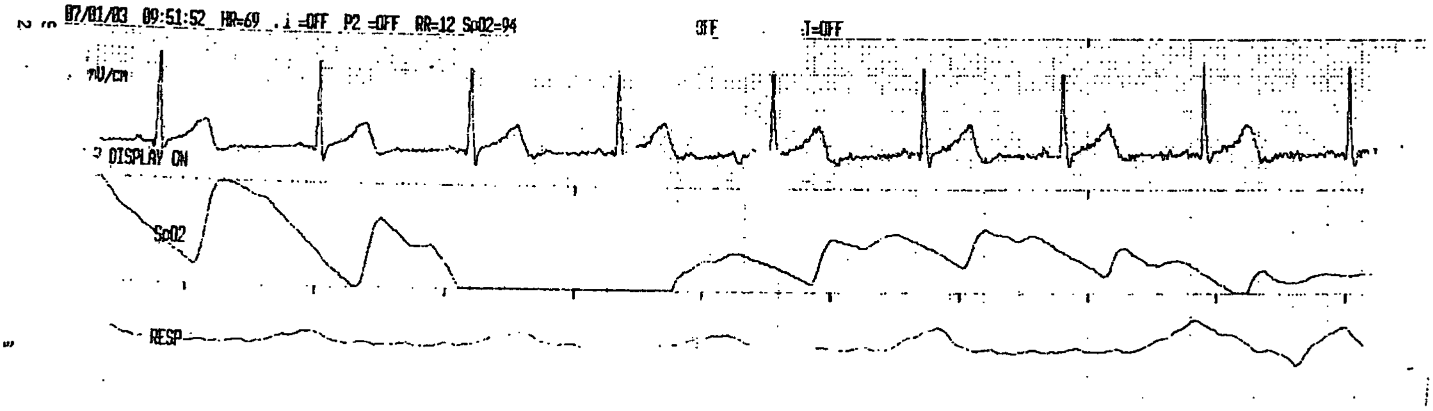
Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] b(6)-2 **DATE:** 26Jun03 **LAB ID NO.:**

MEDCOM - 12083


07/01/03 09:51:52 HR=69 . i =OFF P2 =OFF RR=12 SpO2=94
OFF
:T=OFF
mV/cm
DISPLAY ON
SpO2
RESP

MEDICAL RECORD ANESTHESIA

ANESTHETIC AGENTS AND DRUGS

CONTINUOUS / REPEATED DRUGS
SPECIFY UNITS – MG / MCG / ML.
" I "=CONSTANT INFUSION

DRUG	(Units)		TOTALS
versed	(mg)	2.5	2.5
mSO4	(mg)	2/2 2 2	8
propofol	(mg)	50	
	( )		
	( )		
	( )		
VOLAT AGENT I 50	% del	1.5 1.5 0.6X	
	% e.t.		
AIR	L/Min		
N2O	L/Min		
O2	L/Min	6 — 4 — 3 — 6	

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS &ENTER IN REMARKS ① ② ③

TOTAL EBL: min

TOTAL URINE: NM

FLUIDS

LINE site 20g RAC ☐ Warmed RL500↑ — /#2
☐ Warmed
☐ Warmed
☐ Warmed

LOSSES EST BLOOD LOSS
URINE –

FLUIDS – SUMMARY
CRYSTALLOID– 500
COLLOID– 0
BLOOD– 0

REMARKS–
Code drugs with numbers, events with letters
No Δ in pt status since last anesthetic. Plan general
① To room, SOC mons, smooth IV ind
② Zofran 4mg IV.
③ To recovery stable.

PHYS STATUS 1 [✓ 2] 3 4 5 E

BODY WEIGHT 65 [✓ KG] LB

HEMATOCRIT 47

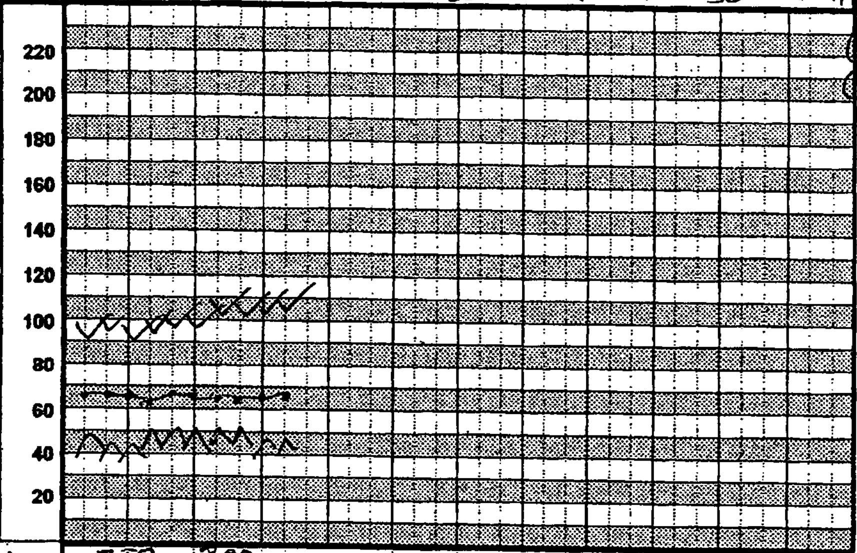
INITIAL DATA:
BP– 97/46
HR– 68

EQUIP CHECK
OK?– [✓ Y] N

PATIENT RECHECK
OK for PROCEDURE? y
TIME– 0755

TIME → 08 > 30 > 09 > 30 > 10 > 30 > 11

SYMBOLS:
BP by cuff V Λ
Heart rate ●
Resp rate
BP (transduced) ╪
TOURNIQUET T — ↗
ANES– X-X
PROC– ⊙ – Ø



VENTILATION

VT – ml	350	300
f – breaths/min	11	14
Peak inf pres / PEEP	—	—
MODE– S(pon), A(ssist), C(on)	S	S

MONITORS & ACCESSORIES

✓ BP/Auto Cuff	✓ ET CO2 (torr)	45	44
BP / oth	✓ FIO2 (Frac or %)	0.75	0.75
ART line	✓ SpO2 (%)	100	100
Steth- PC/ES	✓ ECG	SR	SR
Gas analyzer	TEMP- site available —		
	N-M Block (T/4)		
Warming blkt			
Conv warmer			

Mark with letters & symbols, explain under REMARKS **EVENTS**
Position —O— → →

RECOVERY AT
PACU [✓ ICU] ______ (Specify)
OTHER ______
CONDITION:
RESP– 26 SpO2– 100
BP– 104/55 HR– 62

ANESTHESIA / PROCEDURE TIME

	Start	Room	End
ANES	0755	0802	0900
	Ready	**Begin**	**End**
PROC	0807	0830	0845

PROCEDURES and CPT Codes
I&D Lt thigh

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*
GM

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*
Eyes taped, #9 OA placed, easy mask.

PATIENT IDENTIFICATION– *Typed or written entries: Name, Grade/Rate, Medical facility*

b(6)-4
[redacted] 28yo
ICW 2 NKDA

SURGEONS: [redacted] b(6)-2

AN[redacted] MAJ, CRNA

PROCEDURE LOCATION 1-1

DATE 7/1/03

PAGE 1 OF 1

ECORD – ANESTHESIA

b(6)-2 WAMC OP 576 REVISED
1 Jan 99

MEDCOM - 12085

*U.S. GPO: 2002-729-180/40137

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 28 DAYS MOS YRS
Sex [✓ MALE] ( ) FEMALE

ASA Physical State 1 [✓ 2] 3 4 5 [✓ E]
WT: 65 KG/LB HT: ______ IN.
ALLERGIES: NKDA

PROPOSED PROCEDURE: I&D washout Ⓛ leg
SURGICAL SERVICE: Ortho
NPO SINCE: 1300

HABITS:
TOBACCO: ⊕
ETOH: denies
DRUGS: ______

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) Ancef
( ) 5mg MSO4 2312
( ) 5mg MSO4 2350
( ) ______
( ) ______
( ) ______

PREMEDICATIONS:
None Yes (@ ______ Hrs) /CC
______ . ______ mg IV IM PO
______ . ______ mg IV IM PO
______ . ______ mg IV IM PO

LABORATORY STUDIES:
HB/HCT: ______ / ______
U/A: ______
OTHER: ______

25.7 > 14 / 47 < 180

139 | 106 | 12 / 4.3 | 23 | 0.7 < 123

PT-12
PTT-21

PREOPERATIVE PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:			
Hypertension	[✓ N]	Y	
Angina	[✓ N]	Y	
MI	[✓ N]	Y	
CVA	[✓ N]	Y	
Other	[✓ N]	Y	
Pulmonary System:			
Asthma	[✓ N]	Y	
Bronchitis/URI	[✓ N]	Y	
COPD	[✓ N]	Y	
Other	[✓ N]	Y	
Renal System:			
Acute/Chronic RF	[✓ N]	Y	
Gastrointestinal:			
Hepatitis	[✓ N]	Y	
Hiatal Hernia	[✓ N]	Y	
PUD/GERD	[✓ N]	Y	
Endocrine System:			
Diabetes	[✓ N]	Y	
Steriods	[✓ N]	Y	
Thyroid	[✓ N]	Y	
Neurological:			
Seizures	[✓ N]	Y	
Neuropathy	[✓ N]	Y	
Other	[✓ N]	Y	
Gynecological :			
Pregnancy	[✓ N]	Y	
Other Significant Hx:	N	Y	GSW Ⓛ thigh
	N	Y	Lac back of head
Familial HX	N	Y	

ASSESSMENT

PAST SURGICAL/ANESTHETIC
0

PHYSICAL EXAMINATION

BP 117/72 HR 92 R 16 T 96.7
Pain Scale 0-10 ______
HEENT - Teeth Intact
TM 3FB Trachea midline
TMJ/Neck ______
Oropharynx ______
Nares ______
CHEST: CTA
CARDIAC: RRR
EXTREMITIES:
dressing
IV Access: 18ga Ⓛ arm
Ulnar Filling: ______
BACK: ______
OTHER: ______

NPO Since 1300

ANESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ______ [✓ General]: Mask Intubation

Plan @ questions thru interpreter

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discussed wi[redacted]legal guardian. b(6)-2

The patie derstand and agrees. Questions answered.

Signed: ______ Date: 6/27/03 Time: 0100 Hrs

POST-ANESTHESIA EVALUATION AND NOTE (NON ASU)
{ } NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER

Signed: ______ Date: ______ Time: ______ Hrs

SEDATION KEY:

1. **MINIMAL** (Anxiolysis) Patient responds normally to verbal commands
2. **MODERATE** (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is not necessary.
3. **DEEP SEDATION/ANALGESIA.** Patient responds purposefully following repeated or painful stimulation. Airway assistance may

Patient Identification: (Ward) ______

EPW [redacted] b(6)-4

STHESIA PLAN OF CARE P…PROCEDURAL ASSESSMENT (Sedation/Anesthesia)

29 DAYS MOS [✓ YRS] Sex (✓) MALE ( ) FEMALE

ASA Physical State 1 [✓ 2] 3 4 5 E
WT: 65 [✓ KG]/LB HT: _____ IN.
ALLERGIES: NKDA

DSED PROCEDURE: (L) ~~Arm~~ I&D Thigh
ICAL SERVICE: ortho
INCE: p̄ MN

S:
ACCO: +
ETOH: ø
RUGS: ø

ENT MEDICATIONS:
dered as premed
Ancef 1gm Q8°

EDICATIONS:
Yes (@ _____ Hrs) /CC
… _____ mg IV IM PO
… _____ mg IV IM PO
… _____ mg IV IM PO

RATORY STUDIES:
T: _____/_____
R: _____

27 June 25.7 > 14 / 47 < 180

139 | 101 | 12 / 4.3 | 23 | 0.7 < 123

PT 12 | PTT 21

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:
Hypertension [✓ N] Y
Angina [✓ N] Y
MI [✓ N] Y
CVA [✓ N] Y
Other [✓ N] Y
Pulmonary System:
Asthma [✓ N] Y
Bronchitis/URI [✓ N] Y
COPD [✓ N] Y
Other [✓ N] Y
Renal System:
Acute/Chronic RF N Y
Gastrointestinal:
Hepatitis [✓ N] Y
Hiatal Hernia [✓ N] Y
PUD/GERD [✓ N] Y
Endocrine System:
Diabetes [✓ N] Y
Sterlods [✓ N] Y
Thyroid [✓ N] Y
Neurological:
Seizures [✓ N] Y
Neuropathy [✓ N] Y
Other [✓ N] Y
Gynecological :
Pregnancy N Y NA
Other Significant Hx:
N Y GSW (L) thigh
N Y Scalp LAC (BACK OF head)
Familial HX N [✓ Y]

ASSESSMENT
PAST SURGICAL/ANESTHETIC
I&D (L) thigh 5 days

PHYSICAL EXAMINATION
BP 120/80 HR 74 R 16 T 98.8
Pain Scale 0-10 _____
HEENT - Teeth Intact
Trachea midline
TMJ/Neck 3FB
Oropharynx grade 2
Nares _____
CHEST: CTA
CARDIAC: S1 S2 s̄ (m)
EXTREMITIES:
IV Access: 18G (L) Arm
Ulnar Filling: _____
BACK: _____
OTHER: _____

NPO Since p̄ MN

STHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): _____ { } General: Mask Intubation

No interpreter present / chart reviewed

IMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of [redacted] e been explained to a
sed with the patient/legal guardian. ua J, CRNA

tient/legal guardian seems to understand and agrees. Questions answered.
d: _____ Date: 29 Jun 03 Time: 1032 Hrs b(6)-2

ANESTHESIA EVALUATION AND NOTE (NON ASU)
APPARENT ANESTHETIC COMPLICATIONS { } OTHER

d: _____ Date: _____ Time: _____ Hrs

t Identification: (Ward) _____

#[redacted] (ICW2-ICU2)
b(6)-4

SEDATION KEY:
1. MINIMAL (Anxiolysis) Patient responds normally to verbal commands
2. MODERATE (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is no necessary.
3. DEEP SEDATION/ANALGESIA. Patient responds purposefully following repeated or painful stimulation. Airway assistance may

Iolacco NKDA

MEDICAL RECORD ANESTHESIA

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML, "I"=CONSTANT INFUSION

DRUG	Units		TOTALS
Midazolam	(mg)	2	2
Fentanyl	(mcg)	50 – 20	70
Propofol	(mg)	50 20[redacted] b6-2	50
	( )		
	( )		
	( )		
VOLAT. AGENT ISO	% del	2.0 2.0 2.0	
	% e.t.		
AIR	L/Min		
N2O	L/Min		
O2	L/Min	2 2 2 10	

TOTAL EBL 30

TOTAL URINE Ø

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS

FLUIDS

LINE site 18G (R) A ☒ Warmed LR #1 ——

☐ Warmed

☐ Warmed

☐ Warmed

LOSSES EST BLOOD LOSS 20

URINE – Ø

FLUIDS – SUMMARY

CRYSTALLOID– 300

COLLOID– Ø

BLOOD– Ø

PHYS STATUS 1 [✓ 2] 3 4 5 E

BODY WEIGHT 65 [✓ KG] LB

HEMATOCRIT 47

INITIAL DATA

BP – 120/86

HR – 74

EQUIP CHECK OK?– [✓ Y] N

PATIENT IDENTITY OK for PROCEDURE? JR

TIME– 1500

TIME → 1500 · 30 · 1600 · 30 · 1700

SYMBOLS:

BP by cuff V Λ

Heart rate ●

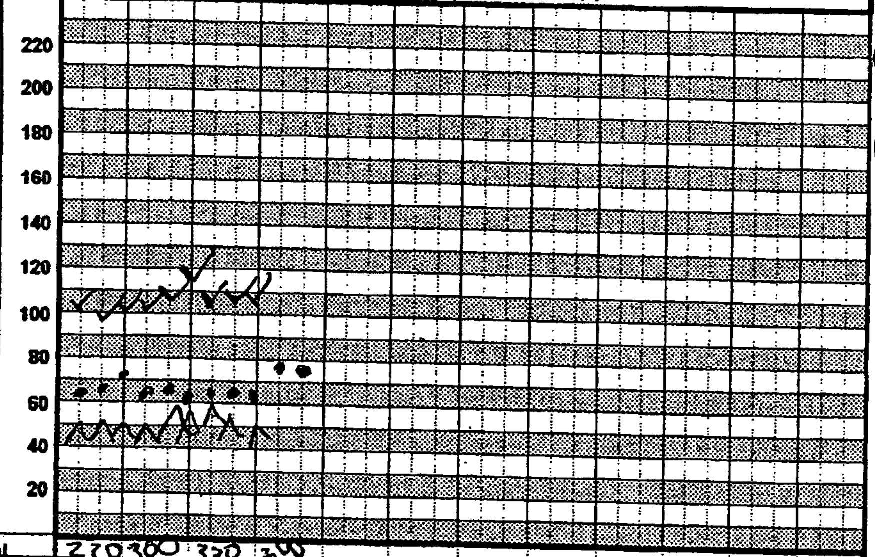
Resp rate

BP (transduced) ╧

TOURNIQUET T –

ANES– X-X

PROC ⊙ – Ø



VENTILATION	VT – ml	220	300	330	300
	f – breaths/min	10	14	7	11
	Peak inf pres / PEEP	—	—	—	
	MODE– S(pon), A(ssist), C(on)	S	S	S	S
✓ BP/Auto Cuff	✓ ET CO2 (torr)	50	49	52	44
✓ BP / oth	✓ FIO2 (Frac or %)	0.88	0.88	0.88	0.90
ART line	✓ SpO2 (%)	100	100	100	100
✓ Steth- PC/ES	✓ ECG	SR →		SR →	
Gas analyzer	TEMP- site	Available			
	N-M Block (T/4)				
		Room warmed → →			
✓ Warming blkt	✓	x1 Blanket x1 —			
Conv warmer					

Mark with letters & symbols, explain under REMARKS EVENTS ① ② ③ ④

Position → O—+

REMARKS–

Code drugs with numbers, events with letters

① Pre-op by b(6)-2 MAJ [redacted]

② Room monitor O2; Mask induct

③ 50 TV > 5ml/kg RR > 8 & < 30 BPM Oral airway remove

④ To litter to ICU I – Report to nurse

RECOVERY AT	1600
PACU [✓ ICU] I (Specify)	
OTHER T-97.1 Ax	
CONDITION: Stable asleep but responsive	
RESP- 20	SpO2- 99
BP- 98/52	HR- 62

ANESTHESIA / PROCEDURE TIME

	Start	Room	End
ANES	1500	1505	1605
	Ready	**Begin**	**End**
PROC	1515	1525	1543

PROCEDURES and CPT Codes

I+D (L) thigh GSW

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

GMA

AIRWAY MANAGEMENT: intubation route, blade, technique, comments

OP airway 9mm; chin support

PATIENT IDENTIFICATION– Typed or written entries: Name, Grade/Rate, Medical facility

EPW # [redacted] b(6)-4

b(6)-2 {

SURGEON [redacted]

ANESTHESIA [redacted] CRNA / CPT

MEDICAL [redacted] – ANESTHESIA

PROCEDURE LOCATION I

DATE 29 Jun 03

PAGE 1 OF 1

WRAMC OP 376 REVISED 1 Jan 99

PATIENT RECORD

MEDCOM - 12088

*U.S. GPO: 2002-729-180/40137

MEDICAL RECORD ANESTHESIA

ANESTHETIC AGENTS AND DRUGS

CONTINUOUS / REPEATED DRUGS
SPECIFY UNITS – MG / MCG / ML.
" | "=CONSTANT INFUSION

DRUG (Units)				
Versed (mg)	2.5			
Fent (µg)	150			50
Endo 50 Propofol (mg)	140			20
Succs (mg)	80			
Nimbex (mg)	6			
phenylephrine (µg)		100		
VOLAT AGENT % del				
% e.t.				
AIR L/Min				
N2O L/Min				
O2 L/Min	8	7		
SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS				Robinul x .2 mg

FLUIDS

LINE site				
NS ☐ Warmed	500			
LR ☐ Warmed				900
☐ Warmed				
☐ Warmed				

LOSSES

EST BLOOD LOSS				n
URINE –				700

TOTALS

TOTAL EBL: Min

TOTAL URINE: 700

FLUIDS – SUMMARY

CRYSTALLOID– 1300

COLLOID–

BLOOD–

PHYS STATUS
1 [✓ 2] 3 4 5 [✓ E]

BODY WEIGHT
65 [✓ KG] LB

HEMATOCRIT
47

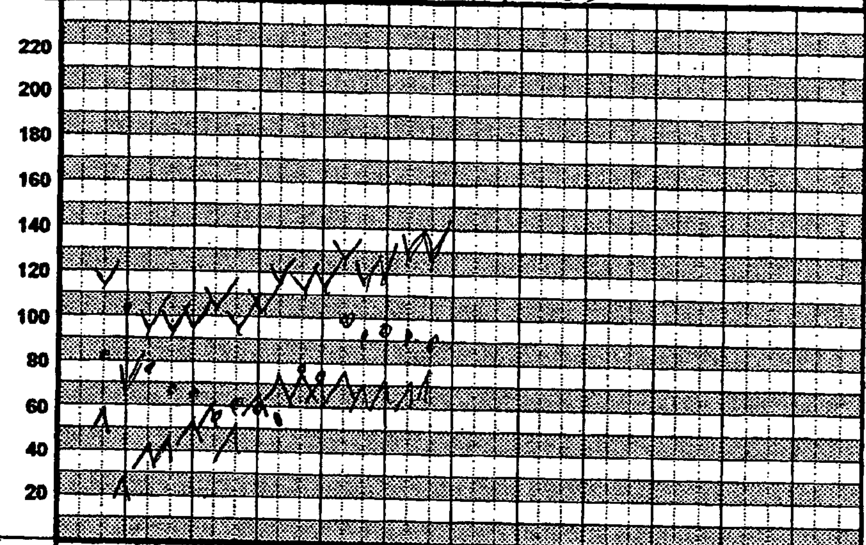
INITIAL DATA:
BP– 117/72
HR– 92

EQUIP CHECK
OK?– [✓ Y] N

PATIENT RECHECK
OK for PROCEDURE?
TIME– 0100

TIME → 01 X 30 X 02 X 30 X 03

SYMBOLS:
BP by cuff V Λ
Heart rate ●
Resp rate
BP (transduced)
TOURNIQUET T – X
ANES– X-X
PROC ⊙ – Ø



VENTILATION

VT – ml	1050	710	620	570	SV	
f – breaths/min	8	6	7	8	11	
Peak inf pres / PEEP	18	22	20	16		
MODE– S(pon), A(ssist), C(on)	SV	CV	CV	CV	CV	SV

MONITORS / ACCESSORIES

BP/Auto Cuff ✓	ET CO2 (torr)	30	28	29	30	35	44
BP / oth	FIO2 (Frac or %)	.56	.84	.85	.85	.81	.84
ART line	SpO2 (%)	100	100	100	100	100	100
Steth- PC/ES ✓	ECG	SR	SR	SR	SR	SR	SR
Gas analyzer ✓	TEMP- site	Available					
✓	N-M Block (T/4)	⊕ twitch –		4/4 5 sec tetany			
Warming blkt							
Conv warmer							

Mark with letters & symbols explain under REMARKS **EVENTS**
Position →

REMARKS–
Code drugs with numbers, events with letters

0105 pt ID, NPO in pre-op status. monitors applied
0110 IOI ⊕ Bilat BS–

0220 Spont Resp oral suction, purposeful movement extubated – had two episodes of croupy like cough. responded to pos pres assist vent. 3 puffs Albut not improved croupy sounds
. pt transferred to ward & report given

RECOVERY AT 0235
PACU ICU #3 (Specify)
OTHER
CONDITION: awake
RESP– 18 SpO2– 99
BP– 178/63 HR– 138

ANESTHESIA / PROCEDURE TIME

	Start	Room	End
ANES	0030	0105	0230

	Ready	Begin	End
PROC	0115	0140	0215

PROCEDURES and CPT Codes
washout Ⓔ thigh wound
I&D

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments 8.0 ETT placed one attempt c 3 MAC grade 2 view, secured at 23 cm teeth.

PATIENT IDENTIFICATION– Typed or written entries: Name, Grade/Rate, Medical facility

EPW [redacted] ICU-3

b(6)-2
SURGEONS: [redacted] b(6)2
ANESTHETISTS: [redacted] CRNA [redacted]
b(6)-2

PROCEDURE LOCATION 28th CSH

DATE 6/27/03

PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA
WAMC OP 376 REVISED
1 Jan 99
PATIENT RECORD
MEDCOM - 12089

*U.S. GPO: 2002-729-180/40137

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

[redacted] b(6)-4

EPW

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 27 Jun [illegible] TIME OF ORDER 0230 HOURS

LIST TIME ORDER NOTED AND SIGN

✓ [illegible]

✓ [illegible] Ⓛ Thigh GSW

✓ [illegible]

✓ [illegible]

✓ [illegible] Ad [illegible]

✓ [illegible] Ⓛ [illegible]

[illegible]

PATIENT IDENTIFICATION

EPW

[redacted] b(6)-4

DATE OF ORDER TIME OF ORDER

[illegible] HOURS

Vasc ✓ Q2° x 24

✓ [illegible]

✓ IVF LR @ 100cc/hr ✓

[illegible] ✓

✓ meds: Ancef 1 gm IV Q8°

✓ Demerol 50mg) IV Q3° prn

Phenergan 25mg

Noted [redacted] b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

EPW

[redacted] b(6)-4

DATE OF ORDER TIME OF ORDER

✓ Percocet [redacted] Q4 prn HOURS

b(6)-2

b(6)-2

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

EPW

[redacted] b(6)-4

DATE OF ORDER 27 Jun 03 TIME OF ORDER 1635 HOURS

V.O.

1. Demerol 50mg } IV q 3° prn
Phenergan 25mg

2. Δ dressing to Ⓛ thigh prn.

V.O. Dr. [redacted] / [redacted] LTC/AN

NURSING UNIT | ROOM NO. | BED NO.

2u ✓ [redacted] Maj/AN [redacted]

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

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

MEDCOM - 12090

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

EPW [redacted]

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 27 June 03

TIME OF ORDER 2020 HOURS

LIST TIME ORDER NOTED AND SIGN

V.O. Dr [redacted] per Dr [redacted]

b(6)-2

DC foley, notify MD if not urinate in 8°

b(6)-7

[redacted]

Maj [illegible]

[redacted]

b(6)-2

PATIENT IDENTIFICATION

EPW [redacted]

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 20 JUN 03

TIME OF ORDER 1605 HOURS

① I+O q2hrs, if UOP <80 ccs, leave in to gravity

② NPO after midnight

③ IV - LR at 100 cc/hr

④ Zantac 150 mg P.O.

[redacted]

b(6)-7

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER

TIME OF ORDER ______ HOURS

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER

TIME OF ORDER ______ HOURS

DA FORM 1 APR 79 4256

REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 12091

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

EPW
[redacted]

NURSING UNIT: ICW2
ROOM NO.: 24 VS
BED NO.: 2230

DATE OF ORDER: 28 Jun TIME OF ORDER: [illegible] HOURS

NPO p̄ MN

For washout 29 JUN 03

b(6)-2 [redacted]

28 Jun 03 [redacted]

LIST TIME ORDER NOTED AND SIGN: b(6)-2

PATIENT IDENTIFICATION

EPW
[redacted]

NURSING UNIT: ICW2
ROOM NO.:
BED NO.: 17

DATE OF ORDER: 29 June b(6)-2 1600 HOURS

Transfer PACU → ICW2

s/p ® Thigh I&D / DPC

Same

Continue Same Med / IV orders

PATIENT IDENTIFICATION

EPW
[redacted]

NURSING UNIT: ICW2
ROOM NO.:
BED NO.: 17

DATE OF ORDER: Resume TIME OF ORDER: DSD PRN HOURS

b(6)-2 [redacted]

b(6)-2
24 VS [redacted] 1LT AN 6.29.03 2245

noted b(6)-2 [redacted] 29 June 03 1705

PATIENT IDENTIFICATION

EPW
[redacted]

NURSING UNIT: ICW2
ROOM NO.:
BED NO.: 17

DATE OF ORDER: 1 JUL 03 TIME OF ORDER: 0830 HOURS

Transfer PACU → ICW2

s/p washout / DPC ✓

Same

Cont Med order ✓

DSD ↓ QD c̄ Ace wrap ✓

OK to D/C to EPW Camp 2/3 ...

b(6)-2 [redacted]

noted b(6)-7 [redacted] 1 July 03 1000

MEDCOM - 12092

ACLU-RDI 1592 p.52

NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
29Jun03	Ortho OP Note
	Preop Dx: (L) Thigh GSW
	Procedure: (L) Thigh washout / Delayed primary closure
	Surgeon: [redacted] b(6)-2
	EBL: min
	TT: ∅
	To PACU stable
	Drain Penrose plan to pull @ 48°
	Keep Ace wrap on @ All times
	[redacted] b(6)-2

MEDCOM - 12093

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
1 Jul 03	Ortho OP/EVAC NOTE
	28 yo EPW Iraqi Shot (R) leg
	Prep Dx (R) Quad T/T GSW
	c̄ Soft tissue Defect 1st to
	Procedure w/ washout / DPC
	Surgeon [redacted] b(6)-2
	EBL min
	TTL Ø
	Findings: Clean wound
	2° washout
	Closed Primarily
	Plan) Finish IV Abx tomorrow 2 Sx
	Δ to PO Abx and OK for D/C
	No Need for further operation
	[redacted] b(6)-2

RELATIONSHIP TO SPONSOR

SPONSOR'S NAME: LAST / FIRST

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.

[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

MEDCOM - 12094

MEDICAL RECORD

AUTHORIZED FOR LOCAL REPRODUCTION

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	Ortho Op Note
	Preop Dx Ⓛ Thigh GSW
	Postop Dx ī Same c̄
	SFA lac
	Surgeon: [redacted] b(6)-2
	EBL ≈ 400cc
	TOI ∅
	To PACU Stable
	Findings: SFA Artery ī Thigh [illegible]
	Torn off
	wound Debr 3L wash
	[illegible] Drain [illegible]

[redacted] 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.)*

[redacted] b(6)-4

REGISTER NO.

WARD NO.

21?

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1
USAPA V2.00

All b(6)-2 (except last)

CLINICAL RECORD | **THERAPEUTIC DOCUMENTATION CARE PLAN** *(NON-MEDICATION)*

For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo Xp *Yr.* 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	27	28	29	30	1	2	3	4						
27 June	[redacted]	Admit to ICU 3	05	[redacted]													
			17		done				[redacted]								
			X														
27 June	[redacted]	Condition: stable	05	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
			17	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]								
			X														
27 June	[redacted]	VS: per routine	05	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
			17	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
			X														
27 Jun	[redacted]	Activity: ad lib	05	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
			17	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]								
			X														
27 Jun	[redacted]	Foley to gravity	05	[redacted]	[redacted]		D/C 27JUN03										
			17	[redacted]													
27 Jun	[redacted]	Vascular √ q 2 hours x4	05	[redacted]	[redacted]	D/C											
			17	[redacted]													
27 Jun	[redacted]	Ice to left thigh c̄ elevation	05	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
			17	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]								
27 Jun	[redacted]	Adv. Reg. diet	05	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]								
			17	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]								
30	[redacted]	Foley to Gravity	5	/	/	/	/	[redacted]	[redacted]		DC'd						
			13	/	/	/	[redacted]	[redacted]	[redacted]								
			21	/	/	/	[redacted]	[redacted]	[redacted]								
1	[redacted]	DsgD QD c̄ ace wrap	10	/	/	/	/	[redacted]	[redacted]								

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW Hip s/p I+D Ⓛ thigh

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ____

PATIENT IDENTIFICATION:

EPW [redacted] b(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 EDITION OF 1 DEC 77 MAY BE USED. USAPA V1.00

MEDCOM - 12096

All b(6)-2

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo June *Yr* 2003

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
		~~Reinforce dressing~~ error				
27 June	[redacted]	DC foley, notify MD if not urinate in 8 hours	27 June	2020	done	[redacted]
28	[redacted]	TRANSFER TO ICW #2	28		1300	[redacted]
28	[redacted]	NPO p̄ MN for washout 29 JUN 03	28	2355	DONE	
30	[redacted]	ITC CATH, IF UOP > 500cc, leave in	30	1600	1600	[redacted]
30	[redacted]	NPO p̄ MN	30	2355	2400	[redacted]
1 July	[redacted]	transfer PACU → ICW 2	1 July			
1	[redacted]	s/p washout Ⓛ thigh	1 July	done		[redacted]
1	[redacted]	Continue med orders	1 July	0800		[redacted]
1	[redacted]	OK to DC to EPW camp 2 or 3 July	2003			

INITIAL PROPER COLUMN FOLLOWING COMPLETION

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	TIME/DATE COMPLETED
27 June	[redacted]	Reinforce dressing PRN	27 June 1600 [redacted] D/C 27 Jun 03
27 Jun	[redacted]	Δ' dressing to Ⓛ thigh prn.	
29 June	[redacted]	Reinforce dressing prn	

USAPA V1.00

MEDCOM - 12097

All b(6)-2 (except last)

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 06 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	27	28	29	30	1	2	3	4	5
27June03	[redacted]	IVF: LR 100cc hour	05	[redacted]		>	H.L					
		DC when tolerating PO	17									
		H.L flush after Ancef	X									
27June03	[redacted]	Ancef 1 gm IV	06	[redacted]								
		q8°	14									
			22	]								
			X									
27June	[redacted]	Demerol 50-100mg c̄	05	50/25	100/25	10						
		Phenergan 25 mg IV				on	back	(p.r.n)	[redacted]			
		q3 hours.										
28	[redacted]	H/L IV when tol PO	5	/	/	[redacted]		>	D/C			
			13	/	[redacted]							
			21	/	[redacted]							
30	[redacted]	IVF: LR@100cc/hr	5	/	/	/	/	[redacted]				
			13	/	/	/	[redacted]					
			21	/	/	/	[redacted]					
30	[redacted]	Zantac 150mg PO BID	10	/	/	/	/	[redacted]				
			22	/	/	/	[redacted]					

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW Hip s/p I+D Ⓛ Thigh

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ______

PATIENT IDENTIFICATION: EPW [redacted] 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 - 12098

All b(6)-2

Verify by Initialing	**THERAPEUTIC DOCUMENTATION CARE PLAN** *(MEDICATIONS)*	Mo. Jun 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													
27 Jun -----	[redacted] -----	Percocet $\overline{ii}$ p.o. q4° prn for pain	28 Jun 0900 [redacted]	28 Jun 1500 ii [redacted]	29 June 0030 ii tabs [redacted]	29 June 1215 ii tab [redacted]	29 June 1820 [redacted]	30 June 0700 ii PO [redacted]	30 June 0730 ii [redacted]	30 June 1400 ii [redacted]	[illegible] 2030 ii [redacted]		1 July [illegible] [redacted] 0609	1 July ii PO [redacted]	0530 Copied below	
27 Jun -----	[redacted] -----	Demerol 50mg } IV q3° Phenergan 25mg } p.r.n.	27 Jun 1330 50mg/25 [redacted]	28 Jun 1200 [illegible] [redacted]	29 Jun 0300 [illegible] [redacted]											
2 Jul -----	[redacted] -----	Percocet $\overline{ii}$ PO Q4° prn for pain	1 July 1010 ii PO [redacted]	1 July 1525 ii [redacted]	1 July 2124 ii [redacted]	2 Jul 0330 ii [redacted]	2 Jul 0830 ii [redacted]	2 Jul 1230 ii [redacted]	2 Jul 1900 ii [redacted]	3 Jul 0130 ii PO [redacted]	3 Jul 0311 ii PO [redacted]					
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															

USAPA V1.00

MEDCOM - 12099

MEDICAL RECORD-SUPPLEMENTAL MEDICAL

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE **Post-Anesthesia Care Unit (PACU) Flow Sheet**

OTSG APPROVED *(Date)*

Date: 27 JUN 03
Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
Time In: 0245
Allergies: NKDA OR Intake: Crystalloid 1300 Colloid —
Pre-op V/S: 117/72 OR Output: UOP 700 EBL Minimal
Procedures: I & D (L) thigh Wound
Meds/Times: 200 mcg Fentanyl 2.5 mg Versed 3 puffs Albuterol

Drains
Hemovac
NG
JP
T-tube
[✓ Foley]
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds History

Time
SaO2
FiO2
Methods
240
220
200
180
160
140
120
100
80
60
40
20
RR
T
Time
Pain (0-10)
LOS

Pacu Intake

Time	Solution	Amount	Site	By	Infused
0245	LR	150	(L) UE		700

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	122/76	118/75	
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	2	2	
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	2	2	
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	10	10	

Codes

AIRWAY
A = Ambu
BB = Blow-by
M = Mask
FT = Face Tent
RA = RoomAir
NC = Nasal Cannula

V/S
X = A-line BP
ˇ = Cuff BP
= Pulse

TEMP
S = Skin
O = Oral
A = Axillary
T = Tympanic
R = Rectal

LOS
C = Cervical
T = Thoracic
L = Lumbar
S = Sacral

Patient teaching done; Wound Care, Pain Management,
T, C, & DB,. Incentive Spirometer, Comfort Measures
Safety: SR up X 2. Falls Precautions. Privacy Maintained

(Continue on reverse)

PREPARED BY *(Signature & Title)* [redacted] ILT/AN

b(6)-2

DEPARTMENT/SERVICE/CLINIC ICW3

DATE 27JUN03

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

EPW [redacted] b(6)-4

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

DA FORM 4700, MAY 78 WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) Previous edition is obsolete
USAPPC V2.00

MEDCOM - 12100

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE Post-Anesthesia Care Unit (PACU) Flow Sheet

OTSG APPROVED *(Date)*

Date: 6/29
Time In: 1103
Allergies: NKDA
Pre-op V/S: 120/56 HR74
Procedures: [illegible] LAD Hern Repair
Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 300 Colloid
OR Output: UOP 30 EBL
Meds/Times: Toradol, [illegible]

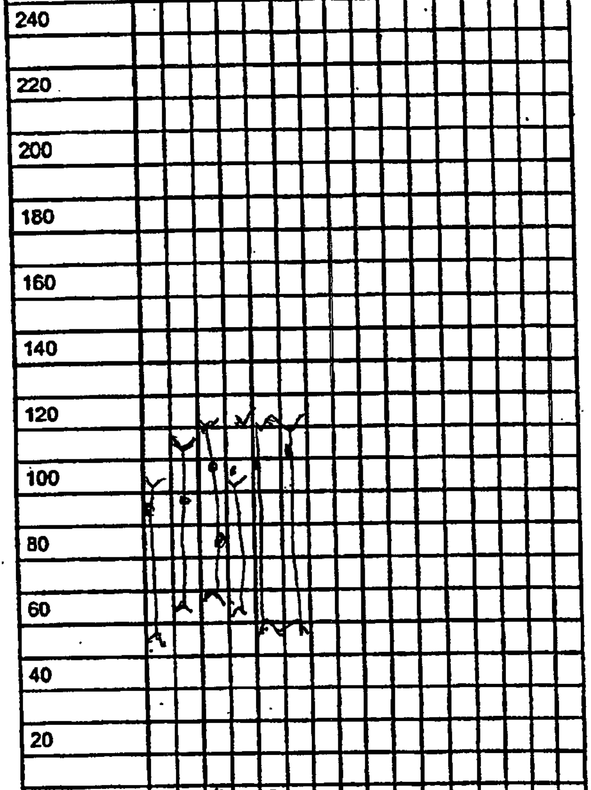
Drains
- Hemovac
- NG
- JP
- T-tube
- Foley
- TLS

Airway
- Nasal
- Oral
- ETT
- Trach
- Other

Pre Op Meds

History

Time	1600	1605	1610	1615	1645	1620
SaO2	100	100	100	100	100	96
FIO2	100	60	5	5	5	5
Methods	T/M	FM	FM	F	NC	RA



RR	10	14	16	11	12	14
T	97	97	98	98	98	

Time				
Pain (0-10)	6	4	0	0
LOS	[redacted]			

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays:

Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	1	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	2	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	2	2	2
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	10	12 ~~10~~	12

Codes

AIRWAY
A = Ambu
BB = Blow-by
M = Mask
FT = Face Tent
RA = RoomAir
NC = Nasal Cannula

V/S
X = A-line BP
^ = Cuff BP
= Pulse

TEMP
S = Skin
O = Oral
A = Axillary
T = Tympanic
R = Rectal

LOS
C = Cervical
T = Thoracic
L = Lumbar
S = Sacral

Patient teaching done; Wound Care, Pain Management,
T, C, & DB,. Incentive Spirometer, Comfort Measures
Safety: SR up X 2, Falls Precautions. Privacy Maintained

(Continue on reverse)

PREPARED BY: b(6)-2 [redacted] UMPri

DEPARTMENT/SERVICE/CLINIC: ICU I

DATE: 6/29/03

Name — last, first, middle; grade; date; hospital or medical facility)

EPW [redacted] b(6)-4

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

DA FORM 4700, MAY 78 WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) Previous edition is obsolete USAPPC V2.00

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By

NURSING NOTES

Pt left lcu I via litter accompanied by RN. axOx3. Pulse ox 96% RA. denies any pain. T-max 97.8. scalp and LE dry NT

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	LL	LL	+	+	+	W	NL
15'	⊕	+	+	+	+	W	NL
30'	⊕	+	+	+	+	W	NL
45'	⊕	+	+	+	+	W	NL
60'	⊕	+	+	+	+	W	NL
90'	[illegible]						
D/C							

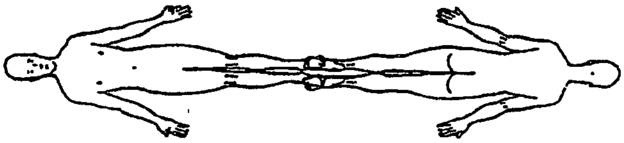
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

	Adm	15'	30'	45'	60'	90'	D/C
Fund. Height							
Lochia							
Peripad#							
Fund. Cond.							

DRESSINGS

Time	Location	Type	Drainage
Adm	Ⓛ thig.	Bulky	Ø
30'	✓	✓	✓
60'	✓	✓	✓
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

Discharge Criteria:
Date: **Time:** **PARS:**
BP: **T:** **HR:** **RR:** **Sa02:**
Pain Level at D/C (0-10):
Intake:________________ **Output:**________________
Additional Data:________________
Transferred To:________________
Report Given To:________________
Transferred Via: W/C Litter Gurney Ambulance
Transferred By:________________
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature:________________

WAMC OP 173-E

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

OTSG APPROVED *(Date)*

REPORT TITLE **Post-Anesthesia Care Unit (PACU) Flow Sheet**

Date: 01JUL03
Anesthesia Type (Circle)): [✓ General] Spinal Epidural IV Sedation Nerve Block
Time In: 9:08
Allergies: NKDA
OR Intake: Crystalloid LR Colloid
Pre-op V/S:
OR Output: UOP NM EBL minimal
Procedures: I&D (R) thigh
Meds/Times:

Drains
Hemovac
NG
JP
T-tube
[✓ Foley]
TCS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds

History

Time	900	905	910	915
SaO2	99	98		
FiO2				
Methods				
240				
220				
200				
180				
160				
140				
120				
100	v		v	v
		v		
80				
	•			•
60		•	•	
	^		^	^
40		^		
	•			
20				
RR	8	10	9	8
T	96			
Time				
Pain (0-10)				
LOS				

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays:

Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2		2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2		2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2		2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1		2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2		2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	[redacted] 2	NA	
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	[redacted] 9		10

Codes

AIRWAY
A = Ambu
BB = Blow-by
M = Mask
FT = Face Tent
RA = RoomAir
NC = Nasal Cannula

V/S
X = A-line BP
˅ = Cuff BP
• = Pulse

TEMP
S = Skin
O = Oral
A = Axillary
T = Tympanic
R = Rectal

LOS
C = Cervical
T = Thoracic
L = Lumbar
S = Sacral

Patient teaching done; Wound Care, Pain Management,
T, C, & DB,. Incentive Spirometer, Comfort Measures
Safety: SR up X 2, Falls Precautions. Privacy Maintained

(Continue on reverse)

PREPARED BY [redacted] b(6)-2

DEPARTMENT/SERVICE/CLINIC

DATE 01JUL03

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

[redacted] b(6)-4

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

DA FORM 4700, MAY 78 WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) Previous edition is obsolete USAPPC V2.00

All b(6)-2

MEDICATIONS						
Allergies:						
Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By

NURSING NOTES

Pt. from O.R. to ICU 1 for recovery. Responds to verbal c̄ painful stimuli. VSS. SpO2 100 RA. IV site (R) forearm infusing LR. Foley to gravity, yellow urine. I & D to (L) UE. Ace band-age around gauze. Ø obvious drain-age @ this time. +2 radial and pedal pulses. [redacted]

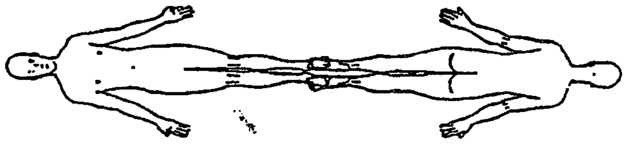
0955, VSS Ø distress noted. [redacted]

NEUROVASCULAR							
Time	Site (L)UE	Range Of Motion	Sensory	P	Cap Refill	T	Color NFR
Adm	(L)UE	+	+	P	B	C	[illegible]
15'	(L)UE	+	+	P	B	C	NFR
30'	(L)UE	+	+	P	B	C	NFR
45'							
60'							
90'							
D/C							

Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic, P = Pale, Pk = Pink
Capillary Refill: B = Brisk, S = Sluggish

C-SECTIONS							
	Adm	15'	30'	45'	60'	90'	D/C
Fund. Height							
Lochia							
Peripad#							
Fund. Cond.							

DRESSINGS			
Time	Location	Type	Drainage
Adm	(L)UE	Ace around gauze	Ø
30'			
60'			
D/C			



PACU OUTPUT			
Time	Source	Color/Appearance	Amount
0944	Foley	Yellow	425

CARDIAC RHYTHM			
Time	Rhythm	Symptomatic?	Rhythm Strip Run?
0951	NSR		Yes

WAMC OP 173-E

Discharge Criteria:
Date 01JUL03 **Time:** 9:51 **PARS:**
BP: 107/64 **T:** 96.8 **HR:** 63 **RR:** 9 **Sa02:** 98
Pain Level at D/C (0-10):
Intake: Ø **Output:** 425cc
Additional Data: None
Transferred To: ICU 2
Report Given To: SPC [redacted]
Transferred Via: W/C [✓ Litter] Gurney Ambulance
Transferred By: SGT [redacted]
Cleared IAW Recovery [redacted]
Charge Nurse Signatur [redacted]

PAGE 1

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

EPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

TIME	0600 INITIALS [redacted]	b(6)-2 INITIALS	INITIALS
PUPILS	PERRLA		PERRLA, Alert
SENSORIUM	Pt responds to verbal		Verbalizes need
	+ tactile stimuli		
RESPIRATORY PATTERN	Even + unlabored		Unlabored, BBS
BREATH SOUNDS	Clear bilateral		CTA, on RA
SECRETIONS	∅		SAO2 97%
	Pt on RA w/ Sats		no secretions
	@ 100%		
COLOR	Normal		Normal
INTEGRITY	GSW to (L) thigh. Drsg.		(L) thigh GSW S/P
	intact w/ blood noted + marked		debrided, dressing
LOCATION	(L) AC		(L) UE, LR @ KVO
CONDITION	IVF LR @ 100cc		increased to 100 cc/hr
	infusing into (L) AC		site intact
	site. s̄ S/S of		
	infection.		
ABDOMEN	Soft, non tender		Soft Nontender
BOWEL SOUNDS	(+) BS x 4 quads but		Hypoactive BS
	faint		
URINE:	Foley to gravity w/		Foley to gravity
COLOR/CLARITY	>50cc/hr. clear		draining clear yellow
	yellow urine draining		urine
CARDIAC RHYTHM	S1 S2 audible, ∅ S3 S4		NSR s̄ ectopy,
	NSR, reg. s̄ ectopy.		rate 80's, radial +
	HR 60-70's		pedal pulses strong
	(+) pedal pulse w/ cap.		palpable, NVI as
	refill < 3 sec. VSS		ordered cap refill <3 sec

LEGEND
Cr - Creatinine
F_iO_2 - Fraction of Inspired O_2
HCO_3 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
S/A - Fractional
SAT - Saturation
TRACH - Tracheostomy

(Continue on reverse)

EPAR b(6)-2 [redacted] Maj/AN

DEPARTMENT/SERVICE/CLINIC: ICU 2 west

DATE: 27JUN

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

EPW [redacted] b(6)-4

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

MEDCOM - 12105

27JUN	DX GSW Hip												HOSPITAL DAY				
TIME	0500	0600	07	08	09	10	11	12		13	14	15	16	17	18	19	20
Arterial Line																	
Cuff		109/56		107/59		84/40	Dener 106/55	110/57		115/64	100/53		104/54				99/54
emperature		98(A)		98.4(A)		99.4(A)		98.8(A)			99.1(A)		99(A)				99.5
lse		64		68		121		82		96	80		74				82
spiratory Rate		20		16		25		18		20	16		16				26
Sats		99%		100%		96%		99%		99	97		100				100
RA																	RA
Vascular ✓s		⊕	⊕	⊕	⊕	⊕	⊕	⊕		⊕	⊕	⊕	⊕	⊕		⊕	
Cap. refill		<3sec	<3sec	<3sec	<3sec	<3sec	<3sec	<3sec		<3sec	<3sec	<3sec	<3sec			<3sec	
TIME	05	06	07	08	09	10	11	12	8°T								
IVF	900	100	100	100	100	100	100	100	1500	100	100	100	100	100	100	100	100
Ancef		50									50						
PO															240		
OTALS																	
JRINE HOUR/TOTAL	275/275	125/400		100/500		150/650	50/700				575/1275		150/1325				285
sp gr																	
S/A																	
NG OUTPUT																	
pH																	
GUIAC																	
MESIS																	
TOOL																	

(800)

(100)

240

Foley out

(285)
+225
510

EPW [redacted] b(6)-4

1140
510
630

MEDCOM - 12106

PAG

ACUITY LEVEL CLASSIFICATION

	21	22	23	24	01	02	03	
			114/83				112/63	
			69				67	
			17				21	
			98				97	
			RA				RA	
								8° T
IVF	200	0	0	"				
Arcy	50							
							225/225	225

RESPIRATORY DATA

TIME		
MODE		
F_iO_2		
TV		
RATE		
PEEP		
ABG	pH	
	PCO_2	
	pO_2	
	HCO_3	
	SAT	
	BASE	

LABORATORY DATA

TIME	
GLUCOSE	
Na/K	
Cl/CO_2	
BUN/Cr	
WBC/PLATELET	
Hct/Hgb	

ACTIVITIES OF DAILY LIVING

TIME	1600
MOUTH CARE	
BATH	
SKIN CARE	KP
FOLEY CARE	
TRACH CARE	
ROM EXERCISES	KP

TURN

SUCTION

TIME

24° I&O TOTALS

wt Yesterday ____

wt Today 65 Kg

INTAKE

IV 900

po 240

1140

balance: +630

OUTPUT

Urine: 510

NURSE'S SIGNATURE

[redacted]

b(6)-2

KP.

b(6)-2

MEDCOM - 12107

PAGE

MEDICAL RECORD–SUPPLEMENTAL MEDICAL DATA
For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0515	INI[redacted] b(6)-2	INITIALS		INITIALS
NEURO	PUPILS	PERRLA				
	SENSORIUM	Alert, able to				
		follow simple				
		commands				
RESPIRATORY	RESPIRATORY PATTERN	RRR				
	BREATH SOUNDS	Clear throughout				
	SECRETIONS	Ø secretions noted				
		@ this time				
SKIN	COLOR	WNL for race				
	INTEGRITY	GSW (L) thigh, drsg D+I				
		Drsg to head D+I				
IV SITE	LOCATION	(L) AC S.L. Ø s/s of				
	CONDITION	infection				
GASTRO	ABDOMEN	soft and nondistended				
	BOWEL SOUNDS	BS(+) throughout				
GU	URINE:	uses urinal				
	COLOR/CLARITY					
CARDIOVASCULAR	CARDIAC RHYTHM	SR c̄ Ø s/s of ectopy				
		pulses palpable throughout				
		all ext. Cap. refill <3sec				

LEGEND

Cr - Creatinine
F_iO_2 - Fraction of inspired O_2
HCO_3 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
S/A - Fractional
SAT - Saturation
TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY *(Signature & Title)*	DEPARTMENT/SERVICE/CLINIC ICU 3 East	DATE 28 June 03

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

EPW [redacted] b(6)-4

☐ HISTORY/PHYSICAL
☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION
☐ OTHER *(Specif*
☐ DIAGNOSTIC STUDIES

MEDCOM - 12108

	DX													HOSPITAL DAY			
TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20
Arterial Line																	
Cuff		97/62				100/55		103/58									
mperature		99.4				98.5		99.0									
lse		70				67		93									
spiratory Rate		19				10		12									
NVV		⊕		⊕		⊕		⊕									
cap refil		<3sec		<3sec		<3sec		<3sec									
pedal pulse		⊕		⊕		⊕		⊕									
O2 sats		98%						96%									
[illegible]																	
[illegible]																	
TIME	05	06	07	08	09	10	11	12	8° T	13	14						
Ancef		50															
TALS																	
INE HOUR / TOTAL	140/140		175/315					275/590	590								
INE sp gr																	
INE S/A																	
IG OUTPUT																	
IG pH																	
IG GUIAC																	
ESIS																	
OL																	

EPW C.D [redacted] b(6)-4

PAGE

	21	22	23	24	01	02	03	~~04~~
BP								
T								
P								
R								
NV ✓								
cap refill								
pedal pulse								
								8° T

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA

	TIME								
	MODE								
	F_iO_2								
	TV								
	RATE								
	PEEP								
A	pH								
A	PCO_2								
B	pO_2								
B	HCO_3								
G	SAT								
G	BASE								

LABORATORY DATA

TIME								
GLUCOSE								
Na/K								
Cl/CO_2								
BUN/Cr								
WBC/PLATELET								
Hct/Hgb								

ACTIVITIES OF DAILY LIVING

				TURN	TIME			
TIME								
MOUTH CARE								
BATH								
SKIN CARE				SUCTION				
FOLEY CARE								
TRACH CARE								
ROM EXERCISES								

24° I&O TOTALS

wt Yesterday ________ wt Today ________

INTAKE OUTPUT

IV ________ Urine: ________

PO

NURSE'S SIGNATURE

[redacted]

b(6)-2

MEDCOM - 12110

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA
For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

TIME		INITIALS		INITIALS		INITIALS
PUPILS						
SENSORIUM						
RESPIRATORY PATTERN						
BREATH SOUNDS						
SECRETIONS						
COLOR						
INTEGRITY						
LOCATION						
CONDITION						
ABDOMEN						
BOWEL SOUNDS						
URINE:						
COLOR/CLARITY						
CARDIAC RHYTHM						

LEGEND

Cr - Creatinine	ICP - Intracranial Pressure	S/A - Fractional
F_iO_2 - Fraction of Inspired O_2	PCO_2 - Pressure of Arterial CO_2	SAT - Saturation
HCO_3 - Bicarbonate	PEEP - Positive End Expiratory Pressure	TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title) b(6)-2 [redacted] LTC/AN

DEPARTMENT/SERVICE/CLINIC ICU 2 west

DATE 6/28/03

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

EPW # [redacted] b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER *(Specify.*
☐ DIAGNOSTIC STUDIES

MEDCOM - 12111

	DX	HOSPITAL DAY
TIME		
Arterial Line		
Cuff		
emperature		
lse		
spiratory Rate		
Vascular V/s		
[illegible]		
[illegible]		
TIME	8°T	
LR		
OTALS		
URINE HOUR / TOTAL		
URINE sp gr		
URINE S/A		
NG OUTPUT		
NG pH		
NG GUIAC		
MESIS		
TOOL		

MEDCOM - 12112

PAG

ACUITY LEVEL CLASSIFICATION

8° T

RESPIRATORY DATA		TIME							
		MODE							
		F_iO_2							
		TV							
		RATE							
		PEEP							
	A	pH							
		PCO_2							
	B	pO_2							
		HCO_3							
		SAT							
	G	BASE							
LABORATORY DATA		TIME							
		GLUCOSE							
		Na/K							
		Cl/CO_2							
		BUN/Cr							
		WBC/PLATELET							
		Hct/Hgb							
ACTIVITIES OF DAILY LIVING		TIME				TURN	TIME		
		MOUTH CARE							
		BATH							
		SKIN CARE							
		FOLEY CARE				SUCTION			
		TRACH CARE							
		ROM EXERCISES							

24° I&O TOTALS

wt Yesterday ______ wt Today ______

INTAKE — IV ______ po

OUTPUT — Urine: ______

NURSE'S SIGNATURE

[redacted] T/hr KPo

b(6)-2

MEDCOM - 12113

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF

1	2	3	4	5	6
A	1	1	D	1	▨

2. MTF LOCATION *(State or Country Code.)*

7	8
I	Z

b(6)-4

3. REGISTER NUMBER 9 10 11 12 13 14 15 [redacted]

NAME *(Last, First, Middle Initial)* EPW [redacted] b(6)-4

4. PAY GRADE 16 17

5. SEX 18: M

6. DATE OF BIRTH *(YYYYMMDD)* 19 20 21 22 23 24 25 26

7. AGE AT ADMISSION 27 28 29: 2 8 y

8. RACE 30: Z

9. ETHNIC BACKGROUND 31: 9

RELIGION unk

10. LENGTH OF SERVICE 32 33 34

ETS N/A

11. FMP 35 36: ~~99~~ 20

12. SOCIAL SECURITY NUMBER 37 38 39 40 41 42 43 44 45 [redacted]

ORGANIZATION *(Active Duty Only)* N/A

13. MARITAL STATUS 46: u

HOUR OF ADMISSION 0212

BRANCH / CORPS N/A

14. FLYING STATUS 47 48 49

15. BENEFICIARY CATEGORY 50 51 52: K 7 8

16. ZIP CODE OF RESIDENCE 53 54 55 56 57 58 59 60 61

17. UNIT LOCATION *(State or Country Code)* 62 63

18. MOS 64 65 66 67 68 69 70

19. TRAUMA 71

PREV. ADMISSION YEAR ☒ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION 72: 0

WARD ICW2

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE *(Include ZIP Code)*

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] b(2)-2

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION

73	74
5	0

22. MTF TRANSFERRED TO 75 76 77 78 79 80

23. DATE OF DISPOSITION *(YYMMDD)*

81	82	83	84	85	86
0	3	0	6	3	0

24. CLINIC SVC - ADMITTING

87	88	89	90
A	E	A	A

25. MTF TRANSFERRED FROM 91 92 93 94 95 96

26. DATE THIS ADMISSION *(YYMMDD)*

97	98	99	100	101	102
0	3	0	6	2	7

27. LOCATION OF OCCURRENCE *(Battle Casualty Only)* 103 104

28. MTF OF INITIAL ADMISSION 105 106 107 108 109 110

29. DATE INITIAL ADMISSION *(YYMMDD)* 111 112 113 114 115 116

FOR LOCAL USE

Dx: GSW Hip s/p I+D ① thigh

Dx: 8900 Pr: 8628
9041 3888
E9912 8659 (2)
Inj Trauma
450 1

Dx: 8901
E9912
Pr: [illegible]
8659 (x2)
[illegible] [illegible]
1 450

ADMITTING OFFICER *(Si*[redacted]*s required)* Dr [redacted]

SIGNATURE OF ADMITTING CLERK [redacted] PFC, 91G10

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

MEDCOM 12114

INPATIENT TREATMENT RECORD COVE.

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

1 REGISTER NUMBER 0013649	2 NAME (Last, First, MI) UNK EPW		3 GRADE EPW	ADMISSION REMARKS
4 SEX M	5 AGE 45	6. RACE X	7 RELIGION MUSLIM	
8. LENGTH OF SVC —	9. ETS —	10 PREVIOUS ADMISSION NO		
11 FMP 99	12. SSN [redacted]	13. ORGANIZATION b(6)-4	14. WARD ICU3	
15 FLYING STATUS —	16. OSG —	17. BEN K78	18. BRANCH/CORPS —	19. UIC/ZIP —
20 TYPE CASE WIA				
21 SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION DIRECT FROM ER	22. HOURS OF ADMISSION 0045	23. CLINIC SERVICE AAAA		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE —	25. TYPE DISPOSITION D/C TO EPW CAMP	26. DATE OF DISPOSITION 28 JUN 03	ADMITTING OFFICER	
27a ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) —	27b TELEPHONE NO. —	28. DATE OF THIS ADMISSION 27 JUN 03		
29 NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted]	30. DATE OF INITIAL ADMISSION	32 UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED		

31

b(2)-2

☐ Check if Continued on Reverse

33 CAUSE OF INJURY

Pt. Shot by US SOLDIERS.

34 DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: GSW Ⓡ THIGH

890.0
E991.2

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	1	1

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS		f. TOTAL SICK DAYS
		[redacted]	[redacted]		

SIGNATURE OF ATTENDING MEDICAL OFFICER

DR [redacted]

DA FORM 3647, MAY 75 — USAPPC V1.10

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

b(6)-2

All b(6)-2 (except last)

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
27 JUN 0100	Patient received from EMT. Patient moved from stretcher to bed unassisted. LR@75cc/h via 18g Ⓛ AC. N Patient A&Ox3 Follows commands, speaks English. PERRLA. R Lungs clear c̄ bilat equal rise & fall of chest. RA c̄ SaO2 97%. Ø secretions. CV SR, S1/S2. Ø edema noted. Pulses +2 x 4. Cap Refill < 3 sec x4. GI Patient states Ø pain c̄ voiding. GU Abd flat, soft and nontender c̄ BS⊕x 4 quad. Skin Color normal for race. GSW to Ⓡ thigh ō drsg CDI. Line 18g Ⓛ AC, Ø s/s of infection noted, drsg CDI. VSS. Will monitor vital q4h. Patient states he is not currently in pain. Patient positions self for comfort. [redacted]T/AN
27 JUN 0500	Patient slept throughout night s̄ incidence. VSS@0500. Report given to dayshift; briefed on orders. [redacted]
27 JUNE 0531	Recieved report from Lt. [redacted] Pt. resting in bed c̄ eyes closed Ø distress Noted. IV site intact s̄ redness/swelling noted to site (Ⓛt AC) Bandage intact to Ⓡt leg. Will ~~be~~ continue to monitor for s/sx of distress. Sgt. [redacted]
0600	Drsg Δ done this AM. Ø edema Noted to GSW site. Ø c/o pain voiced @ present time, Will continue to monitor. Sg[redacted]

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.

EPW [redacted] 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

MEDCOM - 12116

All b(6)-2

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
0832	Resting in bed c̄ eyes opened. Denies Any PAin. Ø distress Noted. Will continue to Monitor. —— Sgt [redacted]
1011	Resting in bed s̄ distress. Ø complaints, Will cont. to monitor. —— Sgt [redacted]
1209	Resting in bed, Ø distress noted. Will continue to monitor. —— Sgt [redacted]
1356	Resting c̄ eyes closed. Ø distress noted. Will continue to monitor. —— Sgt [redacted]
1534	Sitting-up in bed s̄ distress. Ø complaints voiced At this time. Will continue to monitor. —— Sgt [redacted]
1800	Pt awake, given self bed bath, changed clothes. No complaints of pain @ this time. Dinner served. Interactive c̄ staff, speak and understand English. VSS [redacted] Maj AN
28JUN03 0500	Received report from night shift. Pt resting in bed quietly c̄ eyes closed. Ø s/s or c/o pain @ this time. Gave keflex per D/C order. 2 point restraints in place Ⓡ wrist, Ⓛ ankle. Will ✓ pulses Q1°. Ø needs expressed @ this time. SL Ⓛ AC. Will continue [redacted] 1LA
0700	Pt resting quietly c̄ eyes closed. Ø s/s of pain. Will continue care. —— [redacted] 1/AN
late entry 0600	Gave pt keflex i tablet 250mg OP med. [redacted] 1/AN
1200	Gave pt keflex 250mg i tab per Outpatient med written. —— [redacted] 1/AN
1240	Prepare pt for transfer to ICW2 via stretcher. Gave report to 1Lt [redacted] —— [redacted] N
1245	Received pt. from ICW3. VSS ——

STANDARD FORM 600 (REV. 6-97) BACK
*U.S. GPO: 2002 - 491-600/50618

NSN 7540-00-634-4176 All b(6)-2 (except last) AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	**CHRONOLOGICAL RECORD OF MEDICAL CARE**
DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
28 JUN 03	Pt ~~admitted~~ transferred to ICW #2 ~~via stretcher~~ ambulatory s/p GSW Ⓡ thigh.
1530	VSS. A+Ox3. Dsg applied to wound. Ø si/sx of infection, 4x4
	ĉ Kerlex wrap applied CDI. ⊕ sensation, palpable pulse, cap refill <3sec. Amb. ŝ assistance. D/C meds @ bedside. Patient
	demonstrates knowledge of prescribed orders. Guard escort
	to EPW camp. Will monitor ——— [redacted] /AN
2217	Pt care assumed @ 2100. VSS, alert and awake Ø %
	pain. Lung sounds CTA, pulses palpable x4, BS⊕ x 4
	quads. Abrasions ĉ Kerlix dsg on RLE CDI, ⊕ sensation
	and ROM, Ø swelling. Pt d/c to epw camp in AM,
	will continue to monitor. ——— [redacted] 91WM6
29 June 03 0830	Pt. awake & alert in bed. Wounds on Ⓡ leg are healing ĉ scabs ŝ
	s/s of infection. Dressing CDI. IV in Ⓛ AC removed per MD orders.
	Pt. without complaints @ this time. All other assessment findings
	WNL. Pt. awaiting evac to EPW camp. Will continue to
	monitor. ——— [redacted] /AN
29 June 03	assumed pt care @ 1300. pt AAOx3. VSS. lung sounds
1310	CTA, abd soft BS⊕ x4. BLE ĉ full rom ⊕ pulses. Ⓡ
	leg ĉ 2 wound sites, both sites healing ŝ S/Sx of infection
	drsng D/C'd ⊖ drainage noted. applied 4x4 gauze to
	each site secured ĉ tape. pt denies pain @ this time. pt
	has d/c orders. will cont to monitor ——— [redacted] 91WM6 SGT

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	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.

EPW [redacted]

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 - 12118

558-103 (See Instructions on Back of this Sheet. NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT [redacted] b(2)-2

LOG NUMBER

ARRIVAL				TRANSPORTATION TO HOSPITAL (Attach care enroute sheet)	CURRENT MEDS. (tetanus immunization and other data)
DAY	MONTH	YR.	TIME	☐ PRIVATE VEHICLE ☐ AMBULANCE	0
27	JUN	03	0005	☐ OTHER (Specify) AIR	

HISTORY OBTAINED FROM ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration) GSW Ethyl - Tob - 0

SEX M AGE 45

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER 0010

pO2 98%

VITAL SIGNS			
TIME	0005		
BP	130/95		
PULSE	105		
RESP.	18		
TEMP.	98.6		
WT. (Child)	75		

CATEGORY (See reverse)
- ☐ EMERGENT
- ☐ URGENT
- ☒ NON-URGENT

ORDERS	INITS.	TIME
CBC, Md18, UA	[redacted]	
® Femur X-Ray	[redacted]	0004
0.5 tetnus IM	[redacted]	0010
1 gm Ancef IV	[redacted]	0010

ASSESSMENT/DIAGNOSIS
GSW ® thigh

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

Ⓢ A 45 yo ♂ c̄ GSW to ® ~~Thigh~~ thigh.
Last meal 2 hrs ago. ethyl 0 tobacco 0.
Patient states "shot c̄ pistol." wound is through and through.
He was mediating a Fight and then shots started
O) ~~VSS~~ and he was hit with a Bullett.

b(6)-2
G: WD WN, NAD AAOx3
H: NCAT, PERRLA, EOMI, o/p ⊕, TM ⊕
N: ∅ meningismus
L: CTA ® ∅ w/r/rh
B: RRR ∅ M/R/G
Ext: NVI, FAROM All Joints ® Hips/knees/Ankles/ + Toes
Pt c̄ ~~Entrance~~ + Exit wound @ Post thigh

6.0 > 13.6 / 43.7 < 252

® Femur - ∅ Shrapnel
∅ Fx

27JUN03 0900
Addendum: Pt

Ⓐ/Ⓟ Ancef / dT / IVF / Dressed & cleaned
will be D/C'd tomorrow c̄ Keflex / wound percent.

DISPOSITION (Check all that apply)			
☐ HOME		☐ FULL DUTY	
QUARTERS			
☐ 24 Hrs.	☐ 48 Hrs.	☐ 72 Hrs.	
MODIFIED DUTY UNTIL:			
DAY	MONTH	YEAR	

REFERRED TO (Indicate clinic)
- ☐ EMERGENCY ☐ TODAY
- ☐ 72 HOURS ☐ ROUTINE

ADMIT. TO HOSP. UNIT/SERVICE ICU #3

CONDITION UPON RELEASE
- ☒ IMPROVED ☐ UNCHANGED
- ☐ DETERIORATED

TIME OF RELEASE: 0035

(CONTINUE ON SF 507, IF NEEDED)

PATIENT'S IDENTIFICATION (Mechanical imprint) FOR WRITTEN ENTRIES GIVE: Name - last, first, middle; SSN; DOB, service status, name and relation of sponsor or next of kin. (IMPORTANT: LIST FACILITY HOLDING TREATMENT RECORD)

[redacted] b(6)-4
14 Mar 1958
[redacted] b(6)-4

SIGNATURE OF PROVIDER AND ID STAMP
[redacted] 2265 [redacted]

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans) [redacted]
b(6)-2 b(6)-2

EMERGENCY CARE AND TREATMENT

STANDARD FORM 558 (Rev. 6-82)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

MEDCOM - 12119 Copy

AUTHORIZED FOR LOCAL R

DICAL RECORD | **PROGRESS NOTES**

DATE | Discharge Summary NOTES

27 June 0800 | 45 yo male c̄ GSW to Ⓡ thigh otherwise no other issues Given 1 dose of Ancef, afebrile, Wound dressing changed @ 0600, VSS, Pt being ~~ch~~ disch c̄ percocet, motrin & Keflex and crutches to EPW camp, VSS throughout hospital stay. Pt N/V intact throught course. Tol pos well. Has f/u c̄ camp medics

[redacted] b(6)-2

NSHIP TO SPONSOR

SPONSOR'S NAME

LAST

FIRST

MI

SPONSOR'S ID N (SSN or Other)

/SERVICE

HOSPITAL OR MEDICAL FACILITY

RECORDS MAINTAINED AT

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.

EPW # [redacted] b(6)-4

PROGRESS NOTES
Medical Record
STANDARD FORM 509 (F

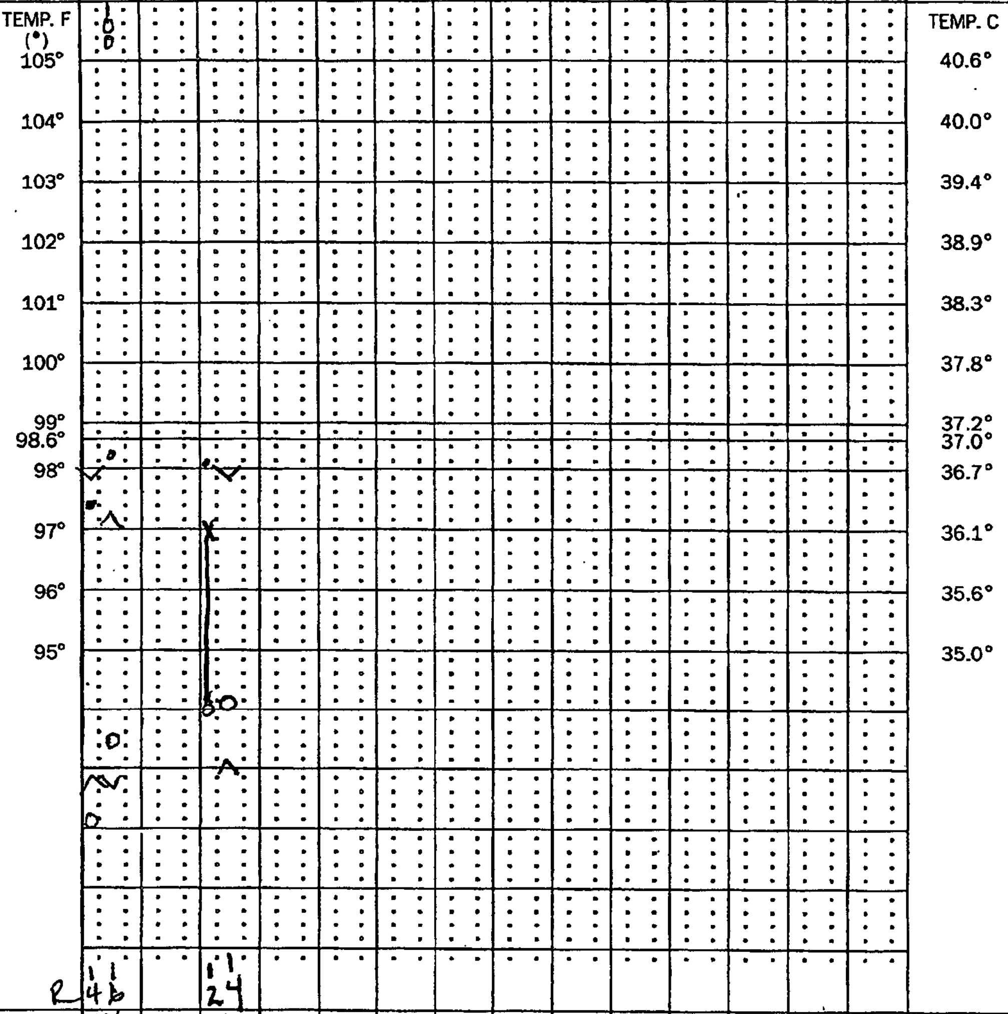
MEDCOM - 12120

27JUN PT'S NAME	0100	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	
	~~05~~	~~06~~	~~07~~	~~08~~	~~09~~	~~10~~	~~11~~	~~12~~	~~13~~	~~14~~	~~15~~	~~16~~	~~17~~	~~18~~	~~19~~	~~20~~	~~21~~	~~22~~	~~23~~	~~24~~	01	02	03	04
BP	130/80	16			108/87	104/80			107/69		111/66			[illegible]/68						126/79				
TEMP	98^{1}				98^{2}	96^{8}			97.9		98.5			99.1						98^{2}				
HR	87	74			71	70			90		83			85						84				
RR	18				18	20			18		20			20						20				
SA02	97	98			98	97			97		97			98						98				
O$_2$ Source	RA				RA	RA			RA		RA			RA						RA				
INPUT																								
PO																								
IV	75	75	75	75	75	75																		
NGT																								
IVPB						50																		
TOTAL	75	75	75	75	75	125																		
	75	150	225	300	375	500																		
OUTPUT																								
URINE										500						525						425		
NGT																								
STOOL																								
TOTAL																								
BALANCE																								

MEDCOM - 12121

EPW [redacted] b(6)-4

MEDICAL RECORD		VITAL SIGNS RECORD							
HOSPITAL DAY		1	2						
POST-	DAY								
MONTH-YEAR	DAY	28th	29						
June ~~18~~ 2003	HOUR	2	8						



RESPIRATION RECORD	R	16	24
BLOOD PRESSURE		118/68	110/72 118/72
HEIGHT:	WEIGHT →		
	SpO2	98%	98% 99%

Record special data only when so ordered

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*

REGISTER NO.

WARD NO.

STANDARD FORM 511 (REV. 7-95) **BACK**

EPW [redacted] b(6)-4

MEDCOM - 12122

Ward/Section: EM-1	REQ [redacted] PHYSICIAN: b(6)-2		**L. .ATORY RESULT FORM** (Subject to the Privacy Act
LAST, FIR [redacted] b(6)-4	DATE 27 JUN 03	TIME 0051	SSN [redacted] b(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
RBC		4.7-6.1 x 10^9
Hgb		14-18 g/dl (M) 12-16 g/dl (F)
Hct		42-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-500 x 10^3 verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			
Spun Hematocrit		42-52% (M) 37-47% (F)	
Sed Rate			
Other			

Urinalysis

TEST	RESULT	REF. RANGE
Color	yellow	N/A
App	clr	N/A
Glu	n	Negative
Bili	n	Negative
Ket	n	Negative
SG	1.030	N/A
Bld	lrg	Negative
pH	6.0	N/A
Prot	n	Negative
Urob	n	0.2-1.0
Nit	n	Negative
Leuk	n	Negative
HCG		Negative

Misc. Serology

TEST	RESULT	REF
RPR		Negat
Mono		Negat

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

25-50 RBC mucous light
1-5 WBC light bacter
~~amorphus sed~~

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS: [redacted] b(6)-2

REPORTED BY: | **DATE:** | **LAB ID NO.:**

MEDCOM - 12123

b(6)-2

Ward/Section: EMT	REQU Maj	[redacted]	LA ATORY RESULT FORM (Subject to the Privacy Act of
LAST, FIRST, MI.	DATE 27JUN	TIME 0015	SSN/PSEUDO SSN [redacted] b(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	6.0	4.8-10.8 x 10^3
RBC	5.05	4.7-6.1 x 10^9
Hgb	13.6	14-18 g/dl (M) 12-16 g/dl (F)
Hct	43.9	42-52% (M) 37-47% (F)
MCV	86.9	80-94 fl (M) 81-99 fl (F)
Plt	252	130-500 x 10^3 verified
Lymph %	32.3	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			
Spun Hematocrit		42-52% (M) 37-47% (F)	
Sed Rate			
Other			

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS: b(6)-2

REPORTED BY: [redacted] DATE: 6/26 LAB ID NO.:

[redacted]

b(6)-4

MEDCOM - 12124

b(6)-2

Ward/Section: EMT

LAST, FIRST, MI. 1MQJ

TESTING [redacted]

CHEMISTRY RESULT FORM
(Subject to the Privacy Act of 1974)

DATE 27JUN

TIME 0045

SSN/ [redacted] b(6)-4

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/l (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA⁺⁺		8.0-10.3mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU	95	73-118 mg/dl
BUN	9	7-22 mg/dl
CRE	1.1	0.6-1.2 mg/dl
CK	109	39-380 u/l (M) 30-190 u/l (F)
NA⁺	139	128-145 mmol/l
K⁺	4.6	3.3-4.7 mmol/l
CL⁻	106	98-108 mmol/l
tCO₂	25	18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA⁺⁺		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA⁺		128-145 mmol/l
K⁺		3.3-4.7 mmol/l
CL⁻		98-108 mmol/l
tCO₂		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA⁺		128-145 mmol/l
K⁺		3.3-4.7 mmol/l
CL⁻		98-108 mmol/l
tCO₂		18-33 mmol/l

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		Negative
Drug of Abuse		Negative
		Negative
		Negative
		Negative

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

[redacted] b(6)-4

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

[redacted] b(6)-4

NURSING UNIT: ICU3
ROOM NO.:
BED NO.: 9

PATIENT IDENTIFICATION

Noted 28 Jun 03 2200 [illegible] [redacted] b(6)-2

NURSING UNIT:
ROOM NO.:
BED NO.:

PATIENT IDENTIFICATION

NURSING UNIT:
ROOM NO.:
BED NO.:

PATIENT IDENTIFICATION

NURSING UNIT:
ROOM NO.: 24°/s
BED NO.: 2200

DATE OF ORDER: 27 June 03
TIME OF ORDER: 0050 HOURS

LIST TIME ORDER NOTED AND SIGN

✓ Admit to ICU #3
✓ Dx: GSW Ⓡ thigh
✓ Condition: Stable
✓ Vitals: per Routine
✓ All: NKDA ✓IVF: 75 cc/hr NS
meds: ✓1gm Ancef IV @ 0600 27 June 03
5mg MSO4 IV Q 4° prn pain

DATE OF ORDER:
TIME OF ORDER: HOURS

✓12.5 mg phenergan IV Q 4° with MSO4
Diet: Regular
Activity as tolerated
Nursing: change dressing in A.M.
(2) Fill prescription for Keflex / Percocet/motrin
(3) D/C IV @ 0630
(4) Return to EPW camp - Discharge @0800

DATE OF ORDER:
TIME OF ORDER: HOURS

(5) crutches to go with patient
TVF

[redacted] 2205

b(6)-2

DATE OF ORDER: 28 Jun
TIME OF ORDER: 1900 HOURS

D/C to EPW Campus
Have. [illegible] Ambulatory Mode

b(6)-2

28 Jun03 [redacted] [redacted] b(6-2

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

MEDCOM - 12126

All b(6)-2 (except last)

CLINICAL RECORD

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

Mo. JUN Yr. 2003

VERIFY BY INITIALING — *INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION*

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	26	27	28	01										
27 JUN	[redacted]	Condition Stable	05	/	[redacted]	[redacted]	[redacted]										
			17	[redacted]		[redacted]											
27 JUN	[redacted]	Vitals per Routine	05	/	[redacted]	[redacted]	[redacted]										
			17	[redacted]		[redacted]											
27 JUN	[redacted]	Diet Regular	05	/	[redacted]	[redacted]	[redacted]										
			17	[redacted]		[redacted]											
27 JUN		Activity as tolerated	05	/	[redacted]	[redacted]	[redacted]										
			17	[redacted]		[redacted]											

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS:
GSW Ⓡ Thigh

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
PAGE NO: ________

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 EDITION OF 1 DEC 77 MAY BE USED. USAPA V1.00

MEDCOM - 12127

All b(6)-2

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*	Mo JUN Yr 2003

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
27JUN	[redacted]	Admit to ICU3	27JUN	0100	0100	[redacted]
27JUN	[redacted]	Nursing to change dressing in AM	27JUN	0600	0600	[redacted]
27JUN	[redacted]	Fill prescriptions for Keflex, Percocet, Motrin	27JUN	0600	0600	[redacted]
27JUN	[redacted]	Return to EPW camp D/C @ 0800	27JUN	0800		
27JUN	[redacted]	Crutches to go c̄ patient	27JUN	0800		
28	[redacted]	Transfer ICW #2	28		1300	[redacted]
28	[redacted]	D/C to EPW camp when arrangement made				

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING COMPLETION* TIME/DATE COMPLETED

USAPA V1.00

MEDCOM - 12128

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. JUN *Yr.* 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 26	27	28												
27JUN	[redacted]	IVF 75cc/h NS	05		[redacted]			D/C @ 0630 27 JUN										
		D/C IV @ 0630 27JUN	17	[redacted]														
b(6)-2																		
27JUN	[redacted]	b(6)-2																

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS:

GSW Ⓡ Thigh

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____________

PATIENT IDENTIFICATION:

EPW [redacted] 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 - 12129

All b(6)-2

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*	*Mo.* JUN *Yr.* 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
27JUN	[redacted]	Ancef 1gm IV	0600	27JUN	27June 0600	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* TIME/DATE DISPENSED
27MAY	[redacted]	MSO4 5mg IV Q4° PRN PAIN give c̄ phenergan	
27MAY	[redacted]	Phenergan 12.5mg IV Q4° c̄ MSO4	

USAPA V1.00

MEDCOM - 12130

PAGE

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA
For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0515 INITIALS [redacted]	b(6)-2 INITIALS	INITIALS
NEURO	PUPILS	PERRLA		
	SENSORIUM	Alert, able to follow commands		
RESPIRATORY	RESPIRATORY PATTERN	RRR		
	BREATH SOUNDS	Clear throughout		
	SECRETIONS	Ø secretions @ this time		
SKIN	COLOR	WNL for race		
	INTEGRITY	GSW Ⓡ thigh, ~~dsg~~ ~~to head D+I~~ [redacted] dsg D+I	b(6)-2	
IV	LOCATION	Ⓛ AC Ø S/S of infection		
	CONDITION	S.L.		
	ABDOMEN	soft, nondistended		
	BOWEL SOUNDS	(+) throughout		
	URINE:	uses urinal		
	COLOR/CLARITY			
	CARDIAC RHYTHM	SR c̄ Ø S/S ectopy pulse palpable +2 in all ext.		

LEGEND
Cr - Creatinine
F_iO_2 - Fraction of Inspired O_2
HCO_3 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
S/A - Fractional
SAT - Saturation
TRACH - Tracheostomy

(Continue on reverse)

EPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC
ICU 2 west

DATE
28JUN03

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

EPW [redacted] b(6)-4

☐ HISTORY/PHYSICAL
☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION
☐ OTHER (Specif
☐ DIAGNOSTIC STUDIES

MEDCOM - 12131

PAG

DX

HOSPITAL DAY

TIME	05	06	07	08	09	10	11	12-		13	14	15	16	17	18	19	20
Arterial Line																	
Cuff		106/69				105/80		98/70									
mperature		98.6				96.7		96.4									
lse		83				81		83									
spiratory Rate		20				18		18									

TIME									8° T								

TALS

INE	HOUR / TOTAL	[illegible]		375 / 375														
	sp gr																	
	S/A																	
IG	OUTPUT																	
	pH																	
	GUIAC																	
ESIS																		
OL																		

							8° T

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA									
	TIME								
	MODE								
	F_iO_2								
	TV								
	RATE								
	PEEP								
A	pH								
A	PCO_2								
B	pO_2								
B	HCO_3								
G	SAT								
G	BASE								

LABORATORY DATA								
TIME								
GLUCOSE								
Na/K								
Cl/CO_2								
BUN/Cr								
WBC/PLATELET								
Hct/Hgb								

ACTIVITIES OF DAILY LIVING				
TIME				
MOUTH CARE				
BATH				
SKIN CARE				
FOLEY CARE				
TRACH CARE				
ROM EXERCISES				

	TIME			
TURN				
SUCTION				

24° I&O TOTALS

wt Yesterday ____ wt Today ____

INTAKE
IV ____
PO

OUTPUT
Urine: ____

NURSE'S SIGNATURE

[redacted]

b(6)-2

MEDCOM - 12133

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF (1–6): A 1 1 D i ▨

2. MTF LOCATION (7–8) *(State or Country Code.)*: I Z

3. REGISTER NUMBER (9–15): [redacted]

b(6)-4

NAME *(Last, First, Middle Initial)*: UNK EPW

4. PAY GRADE (16–17): EPW

5. SEX (18): M

6. DATE OF BIRTH *(Y Y Y Y M M D D)* (19–26): —

7. AGE AT ADMISSION (27–29): 4 5 Y

8. RACE (30): X

9. ETHNIC (31) **BACKGROUND**: 9

RELIGION: MUSLIM

10. LENGTH OF SERVICE (32–34): —

ETS: —

11. FMP (35–36): 9 9

12. SOCIAL SECURITY NUMBER (37–45): [redacted]

ORGANIZATION *(Active Duty Only)*: —

13. MARITAL STATUS (46): U

HOUR OF ADMISSION: 0045

BRANCH / CORPS: —

b(6)-4

14. FLYING STATUS (47–49): —

15. BENEFICIARY CATEGORY (50–52): K 7 8

16. ZIP CODE OF RESIDENCE (53–61): —

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

18. MOS (64–70): —

19. TRAUMA (71): |

PREV. ADMISSION YEAR ☐ ☒ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION (72): 0 b(2)-2

WARD: ICU3

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: —

ADDRESS OF EMERGENCY ADDRESSEE *(Include ZIP Code)*: —

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE: —

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted] b2-2

21. TYPE OF DISPOSITION (73–74): 0 5

22. MTF TRANSFERRED TO (75–80):

23. DATE OF DISPOSITION *(Y Y M M D D)* (81–86): 0 3 0 6 2 8

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

25. MTF TRANSFERRED FROM (91–96):

26. DATE THIS ADMISSION *(Y Y M M D D)* (97–102): 0 3 0 6 2 7

27. LOCATION OF OCCURRENCE *(Battle Casualty Only)* (103–104):

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

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

FOR LOCAL USE

DX: GSW (R) thigh

DX - 8900
E9912
T-1
I-450

ADMITTING OFFICER *(Signature, as requi* [redacted] MD

b(6)-2

DR [redacted]

b(6)-2

SIGNAT [redacted]

b(6)-2

MEDCOM - 12134

INPATIENT TREATMENT RECORD COVER SHEET

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

b(6)-4

1. REGISTER NUMBER [redacted]	2. NAME (Last, First, MI) EPW # [redacted] b(6)-4				3. GRADE EPW	ADMISSION REMARKS
4. SEX M	5. AGE 35y	6. RACE —	7. RELIGION —	[redacted] LENGTH OF SVC —	9. ETS —	10. PREVIOUS ADMISSION NO
11. FMP 99	12. SSN [redacted]		13. ORGANIZATION b(6)-4			14. WARD ICW#2
15. FLYING STATUS —	16. DSG —	BEN K78	18. BRANCH/CORPS —	19. UIC/ZIP —		20. TYPE CASE WIA
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct from ER			22. HOURS OF ADMISSION 1710	23. CLINIC SERVICE AEAA		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE UNK		25. TYPE DISPOSITION 21		26. DATE OF DISPOSITION 1 Jul 03		b(6)-2
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) UNK		27b. TELEPHONE NO. —		28. DATE OF THIS ADMISSION 27 June 03		ADMITTING OFFICER Dr. [redacted]
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] b(2)-2				30. DATE OF INITIAL ADMISSION		32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Dx: GSW and Thighs
to buttocks

956.0	27 Jun 03
890.1	86.28
877.1	29 Jun 03
	86.28
	86.59

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	3	3

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
	[redacted]				

SIGNATURE OF ATTENDING MEDICAL OFFICER [redacted] RECORDS OFFICER

Dr. [redacted]

DA FORM 3647, MAY [redacted] ...S OBSOLETE USAPPC V1.10

MEDCOM - 12202 b(6)-2

b(6)-2

INPATIENT TREATMENT RECORD COVER SHEET

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

b(6)-4

1. REGISTER NUMBER [redacted]
2. NAME (Last, First, MI) EPW# [redacted] [redacted]
3. GRADE
ADMISSION REMARKS
4. SEX M
374
6. RACE —
7. RELIGION —
8. LENGTH OF SVC b(6)-4
9. ETS b(6)-4
10. PREVIOUS ADMISSION NO
11. EMP 99
12. SSN b(6)-4 [redacted]
13. ORGANIZATION —
14. WARD ICW#2
15. FLYING STATUS —
16. RATING DSG —
17. DEPT./BEN K78
18. BRANCH/CORPS —
19. UIC/ZIP —
20. TYPE CASE WIA
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct from ER
22. HOURS OF ADMISSION 1575
23. CLINIC SERVICE AEAA
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE UNK
25. TYPE DISPOSITION 50
26. DATE OF DISPOSITION 27 June 03
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) UNK
27b. TELEPHONE NO. —
28. DATE OF THIS ADMISSION 27 June 03
ADMITTING OFFICER DR.
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] b(2)-2
30. DATE OF INITIAL ADMISSION
32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED
31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Dx: GSW bilateral thighs & Buttocks

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	1	1

36. Total Days All Facilities [redacted]

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

SIGNATURE OF ATTENDING [redacted] b(6)-2

MEDICAL RECORDS OFFICER [redacted] b(6)-2

MEDCOM - 1220 [redacted]

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

PERTINENT HISTORY, CHIEF COMPLAINT, AND CONDITION ON ADMISSION *(Enter date of admission)*

35 yo male c̄ GSW to b/l LE & BUTTOCKS
UNKNOWN CIRCUMSTANCE BROUGHT TODAY BY PST. NOW, PT
DOING WELL. PAIN CONTROLLED.

PMH: PSH: MEDS: ALL:

PHYSICAL EXAMINATION

GEN: AOx3, NAD
HEENT: WNL
LUNGS: CTA
CV: RRR s̄ M
ABD: SOFT, NT, ND ⊕BS
RECTAL: DEFERRED OR
PELVIS: STABLE

VASC:

9.6 > 12 / 34.7 < 246

NEURO: PT UNABLE TO SENSATION RIGHT LEG. ALSO UNABLE TO MOVE TOES & SENSATION ON RIGHT

PROGRESS *(Enter date of discharge and final diagnosis)*

Imp: GSW TO b/L LE & BUTTOCKS
Plan: TO OR FOR EXAM & WASHOUT
& EXAM UNDER ANESTHESIA

[redacted] b(6)-2

SIG N	DATE 22 JUN 03	IDENTIFICATION NO.	ORGANIZATION
FICATION *(For typed or written entries give Name last, first, middle; grade; date; hospital or medical facility)*		REGISTER NO.	WARD NO. ICW2

EPW

[redacted] b(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
USAPPC V1.00

MEDICAL RECORD | **PROGRESS NOTES**

DATE

27 JUN 03

10^{00} A (L)

OPERATIVE NOTE

DIAGNOSIS: s/p GSW Ⓑ Thighs / Ⓡ buttock (∅ fxs)

PROCEDURE: 1) Proctoscopy

2) I+D Ⓡ Buttock, FB Removal

3) I+D Ⓡ thigh, FB Removal, wound expl, tagged injured sciatic n

4) I+D Ⓛ Thigh

SURGEON: [redacted]

FINDINGS [redacted] ← b(2)-6 All

Anesth: G

Findings: ∅ rectal injury. High division of sciatic nerve c̄ disruption of lat trunk. Tagged.

FLUIDS: EBL: 100 cc

Comps: ∅

Rmks: Remove along tract of Ⓡ thigh through + through GSW.

Dispo: To ICU/Recovery stable, extubated.

b(2)-6

[redacted] MD

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

b(2)-4

[redacted]

33-10 IM

...RESS NOTES

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

NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
7JUN03	Surgery
	Pre.op Dx: GSW to Right ~~B~~ Thigh + Buttocks c̄
	Neurological deficit 2° to Sciatic Nerve injury +
	GSW to Left thigh
	Proc: Washout of ~~R~~ Wound - Sciatic Nerve Tagged
	Surg: [redacted] / [redacted]
	EBL: min b(6)-2
	Fluids: 1200 cc
	UO: 1600cc
	Complications: None
	Neurosurg eval in OR recommend waiting [illegible]
	to repair nerve
	Patient stable to RR
	[redacted] b(6)-2
9JUN03	Surg: Progress note POD#2
	Pt stable AFEB VSS
	Labs: CTA
	Gen: AAA
	Wounds: eval today & possible closure
	Imp: stable
	Plan: to OR today
	[redacted]

MEDICAL RECORD	PROGRESS NOTES

DATE

27june03 Rec'd pt from ICU 2 via litter, dx: GSW buttocks
2000 & thighs condition stable. VS BP 142/76, p84 temp 101.1
O2 sats 96% on RA. lung sounds CTA, abd soft
round nontender. BS⊕. ↓ext c̄ drsing to ↑ thighs
bilat Ⓡ side c̄ mod amount of bloody drainage noted
⊕ pulses bilat, Ⓛ side CDI. pt unable to move or
wiggle toes on Ⓡ side. ↑ Ext c̄ full ROM ⊕ pulses. IV
ⓁFA c̄ LR @ 100cc/hr, Ⓞ redness or edema. pt is NPO for
poss. surgery in AM. Drsing to buttocks CDI. MD [redacted]
aware of pts temp. Ⓞ med ordered. Ⓞ c/o pain @
voiced @ this time [redacted] 91wmc
-foley cath to gravity intact draining cl yellow b(6)-2
urine s̄ diff. will cont to monitor [redacted] 91wmc
28Jun03 Pt care assumed @ 2100. BP @ 178/86 @ 2100, pt c/o
0300 pain, 2mg MSO4 given for relief. At 0100 pt c̄ no pain,
BP 120/84. Lung sounds CTA, pulses palpable x4, BS⊕.
Dsg on Ⓛ Buttock CDI, Ⓡ side heavily saturated. Dsg
reinforced @ 0200. Pt c̄ ⊕ pulse, sensation and capillary
refill in lower extremeties. IV @ LFA [redacted] running LR @
100cc/hr. Pt to OR in AM, NPO right now. Will
continue to monitor. b(6)-2 [redacted] 91wmc
28 Jun03 1025- Pt alert, VSS, lungs CTA, HR reg, BS⊕. Dsg to
Ⓑ buttocks c̄ moderate drainage. Pulses ⊖ as strong bilat to
↑ + ↓ extremities. IV to Ⓛ forearm infusing LR @ 100cc. cont.

(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.

EPW # [redacted] b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)
USAPPC V1.00

All b(6)-2

PROGRESS NOTES

DATE	
	Gave MSO4 for pain. Pt sleeping comfortably. O/c
	to OR this Am —— [redacted] 2LtAN
28 Jun 03	assumed pt care @1300. pt sleeping, arouses to
1515	painful stimuli. VSS. lung sounds CTA, abd soft nontender
	nondistented BS⊕. drsing to Ⓡ upper thigh c̄ heavily saturated
	drainage, re-enforced. Ⓛ upper thigh drsing CDI, drsing to
	buttock area c̄ mod amt of drainage. ⊕ pulses to ↓ ext
	pt given 4mg MSO4 @1315 by Maj [redacted] for pain. HL
	to Ⓛ FA ⊖ s/sx of infection. BUE ō full rom ⊕ pulses. Will
	cont to monitor —— [redacted] 91WM6 SGT
28 Jun 03	pt states "no feeling in Ⓡ foot" pt struck ō a pin ⊕ feeling
1913	on bottom, side et toes, started feeling around heal area.
	drsing Δd to buttocks et thighs. Wound site to Ⓡ buttock
	3" long approx 4" deep, wound packed c̄ wet to dry kerlix
	covered by gauzes, 1/2" wound to L R Buttock packed c̄ wet to dry
	kerlix covered by gauze. Ⓡ thigh c̄ 1" wound packed c̄ wet to dry
	kerlix, Ⓛ thigh 1" wound packed covered c̄ gauze. ⊖ signs of infection
	all sites c̄ sm amt of bleeding. pt premedicated ō 4mg MSO4
	pt tol drsing Δ well. Will cont to monitor — [redacted] 91WM6 SGT
	- New IV started Ⓡ hand c̄ 18g x1 stick, HL Ⓛ FA dc'd intact s̄ diff
	—— [redacted] 91WM6 SGT

All b(6)-2 except last

AUTHORIZED FOR LOCAL R

:DICAL RECORD	PROGRESS NOTES

DATE	NOTES
29June03	0640 Assume pt care @ 0500. pt awake and alert. VSS, temp 99.1. pt NPO for surgery today. Dsg Δ's done to Ⓡ thigh and buttock. Old dsg saturated c̄ yellow drainage. Dsg Δ to Ⓡ inner thigh. New dsgs CD&I. HR reg. Lungs CTA BS x4 active. pt has no c/o pain @ this time. Will continue to monitor — [redacted]
29June03	HL to Ⓡ hand flushes well — [redacted]
1000	pt is unable to wiggle toes on Ⓛ foot, ⊖ sensation ⊖ babinski reflex. pt c/o pain ii percocet c̄ sip of H2O odn — [redacted]
29JUN03	OR NOTE
	Pre-op Dx: b/l thigh wounds & buttock wounds
	c̄ known sciatic nerve injury
	Proc: wash-out & closure of posterior wounds
	Surg: [redacted] / [redacted]
	Fluids: 600cc LR
	UO: NA Stable to RR
	EBL: min Ø complication
	Δ drain placed

[redacted]

INSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | SPONSOR'S ID N (SSN or Other)

/SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

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.

EPW # [redacted] b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (F

Prescribed by GSA/ICMR FPMR (41CFR) 101

MEDCOM - 12209

All b(6)-2 except first

EPW# [redacted] b(6)-4 | MIDDLE INITIAL | ID NUMBER

NOTES

29Jun03 returned from OR via litter in stable
2000 Condition - DTV @ 2400 - LR @ 100cc/hr
infusing into Ⓡ FA IV - dsg's x4 CDI, 3
on Ⓡ thigh/buttock, 1 on inner aspect of Ⓛ thigh -
JP x1 from Ⓡ buttock dsg c̄ 20cc bloody
drainage - tolerated water & an orange, given
ii Percocet PO and 2mg MSO4 IVP for pain @
1930 - ⊕ BS, lungs CTA Ⓑ, ⊕2 pedal pulses
Ⓑ, sensory deficit remains in Ⓡ foot, MD
aware - pt. awake and oriented [redacted]

30Jun03 Rec'd pt @ 21:00 29Jun03. Pt. sleeping, easily awakened.
0259 Alert. Skin W/D. VS WNL according to flowsheet. PERRLA ⊕
LCA Ⓑ. BS ⊕ x4. ⊕ PPP Ⓑ. Dsg to ↑ Ⓡ thigh C/D/I. JP drain intact
~~a e/o~~ err [redacted] Attempted to get pt. out of bed. Pt. refused and said
tomorrow he'll try. c/o pain x1 ii Percocet given. Will
cont to mon [redacted] SGT/AN

Addendum Pt. voided 300cc dk yellow urine c̄ strong odor [redacted] SGT/AN

30 Jun Assumed care of pt @ 0500. Pt [redacted] awake and
alert. HL in Ⓡ arm, patent and flushed. Pt received
percocet ii tabs @ 0500 for pain. Lung sounds CTA.
Bowel sounds x 4 quads. Will continue to monitor.
[redacted] SGT 91WM6

30Jun Dsg Δ'd @ 1000 hrs. Ø drainage. Ø s/s of infection.
[redacted] 91WM6, SGT

PREVIOUS EDITION IS USABLE

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
27-June-03	35 y.o. ♂ sustained mult. GSW's vs.
	Frag. wnds to both lower Ext.
	+ Buttocks. Pt A+O×3, c/o pain
	in Ⓡ leg.
B/P: 136/68	
P: 93	O. HEENT: WNL
R: 18	Chest: Symm. Resp. Exc.
	Lungs: equal BS Ⓑ
PMHx: ?	Heart: RRR
	Abd: Soft Ø tender, Ø trauma
PSHx: ?	Genit: WNL
	Rectal: NST, Ø gross Bld
allergies: ?	Pelvis: Stable.
	Buttocks: Wnds ×2 in Ⓡ Buttock
	lateral to anal verge.
	Ext: upper Ext: WNL
	Ⓡ leg: Entrance wnd medial post
	thigh, Exit wnd lat thigh.
	Distally Vasc. intact. ? decreased
	Sensation distally. Pt unwilling to
	fully straighten hip joint.

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.

Iraqi Male

[redacted]

b(6)-4

33 yo IM

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 - 12211

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	Ⓛ thigh; single wnd lat. thigh No exit seen. Distally NV intact c̄ full ROM, XRays; Retained frags in Buttocks + both thighs. No fx's seen. Dx; Mult. frag wnds ext. plan; ① to OR for rigid procto + washout/debridement. [redacted]

STANDARD FORM 600 (REV. 6-97) **BACK**

All b(6)-2 except last-

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
30Jun03	assumed care @ 1300 - VSS - medicated
1600	for pain in buttocks - 18g SL placed in
	Ⓡ AC, old site in Ⓡ FA tender to touch
	s̄ S/S infection - dsg intact on
	Ⓛ thigh & Ⓡ buttock/thigh x3. JP draining
	small amount — [redacted] AV
30Jun03	Pt care assumed @ 2100. VSS, a+ox3, Ø pain. HL @ RAC
2130	patent, IV ABX. Lung sounds CTA, pulses palpable x4,
	bs ⊕ x4 quads. Dsg on Ⓛ thigh CDI, Ⓡ buttock CDI. All
	dsg's on Ⓡ thigh CDI, JP site intact. Pt with ⊕ ROM, sensation
	and capillary refill in both lower extremeties. No complaints,
	will continue to monitor. [redacted] 91WM6 —
0400 1 July	25cc drained from JP tube [redacted] 91WM6
1 July 03	0700 - Pt alert lying in bed. Dsg to wounds
	intact. Will Δ later this shift. VSS, lungs CTA,
0500 98.8	HR reg, BS ⊕. Pulses strong & equal bilat to ↑ & ↓
80	extremities. HL to Ⓡ forearm infusing antibiotics.
16	Voicing Ø complaints at this time. Will cont
110/80	to monitor. — [redacted] 2LtAN
97%	

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. ICW2

EPW [redacted] 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

MEDCOM - 12213

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1Jul03	assumed care @ 1300 VSS - no c/o pain
1610	c̄ this time - pt. reported through interpreter
	that he was not eating because he does
	not want to have a BM due to the pain it
	may cause, through interpreter he stated
	understanding that he must eat to
	promote wound healing - Ⓡ buttock and
	thigh wound undressed by MD and left
	open to air, JP drain in place in Ⓡ buttock
	wound - pt. has dc orders for Iraqi hospital
	when transport [redacted] available - IV patent,
	abx continue —— [redacted] BAN

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	Ortho Evac Note
11/7/03	35 y/o Iraqi ♂ GSW Ⓟ post Thigh
	& Buttocks
	PreOp Dx: Ⓡ Thigh GSW
	PostOp Dx: Same c̄ Ⓛ Sciatic N. Inj
	Procedures: I&D, [illegible]
	Delayed 1° Closure
	Tagged Sciatic N. c̄
	Prolene for later Rep
	Surgeons: [redacted] b(6)-2
	Hosp Course: [redacted]
	Plan) Cont dsg wound
	DSG Δ BID D&D
	W&D if needed
	Neurosurg eval 6 weeks for
	Cable Graft repair Sciatic N.
	Pain per Med [illegible]
	b(6)-2 [redacted]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	[redacted] AINED 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.

[redacted] 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

MEDCOM - 12215

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1/12/03	TRANSFER NOTE
	PT c̄ MULTIPLE FRAGMENT & GSW TO
	POSTERIOR THIGH & BUTTOCK S/P
	WASHOUT & DEBRIDEMENT ON 2 OCCASSIONS
	& NOW c̄ LARGE POSTERIOR WOUNDS CLOSED -
	PT DOING WELL c/o FOOT NUMBNESS & DROP
	c/w SCIATIC INJURY MENTIONED AT SURGERY
	o/w s̄ COMPLAINT
	DIAGNOSIS: MULTIPLE WOUNDS
	RIGHT PARTIAL SCIATIC NERVE INJURY
	c̄ NEUROLOGICAL SEQUELA
	PLAN: MAY TRANSFER TO CIVILIAN HOSPITAL
	D/C DRAIN WHEN DRAINAGE LESS THAN 30cc/DAY
	REMOVE SUTURES IN 7-10 DAYS
	CONT bid WET TO DRY DRESSING AS
	UNTIL ANTERIOR WOUNDS HEALED
	CONTINUE ℞ 1-2 po q4° FOR PAIN
	b(6)-2 [redacted]

FPI. LEX. Printed on Recycled Paper

STANDARD FORM 600 (REV. 6-97) BACK

MEDCOM - 12216

AUTHORIZED FOR LOC

EDICAL RECORD | PROGRESS NOTES

DATE	NOTES
1 July 03 @2345	Pt sleeping, easily aroused. VSS. LCTA Ⓑ, ⊕ BS all quads, good peripheral pulses. HL to Ⓡ FA infusing ABX s̄ complications. Drsg intact on Ⓡ thigh & buttocks. ⊕ sensation & good cap refill in all extremities. Given ii Percocet for pain. Will con't to monitor — b(6)-2 [redacted] LPN SK
2 July 03 @0400	JP drained 7cc watery/bloody fluid c̄ small 4mm size clot noted. — [redacted] 91WM6 b(6)-2

NSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI | SPONSOR'S (SSN or Other

/SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record
STANDARD FORM 50

MEDCOM - 12217

558-103 *(See Instructions on Back of this Sheet)* NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY [redacted] b(2)-2

LOG NUMBER

ARRIVAL

DATE DAY	MONTH	YR.	TIME
27	JUN	03	1515

TRANSPORTATION TO H... *(Attach care enroute sheet)*
☐ PRIVATE VEHICLE ☐ AMBULANCE ☑ OTHER *(Specify)* Medevac

...DS. *(tetanus immunization and other data)* 0

HISTORY OBTAINED FROM ☑ PATIENT ☐ OTHER *(Specify)* via interpreter

ALLERGIES PCN

PATIENT'S HOME ADDRESS OR DUTY STATION *(City, State and ZIP Code)*

HOME TELE. NO. *(Inc. area code)*

CHIEF COMPLAINT(S) *(Include symptom(s), duration)* Fx's GSW → S/P Bilateral Thighs & Buttocks

SEX M AGE 35

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER

VITAL SIGNS

TIME	1515	1630	
BP	141/72	134/70	
PULSE	97	90	
RESP.	20	18	
TEMP.	100.1		
WT. (Child)	100kg	95%	

94%

CATEGORY *(See reverse)*
- ☐ EMERGENT
- ☐ URGENT
- ☑ NON-URGENT

ORDERS	INITS.	TIME
IVF'S	[redacted]	1515
CBC, Chem 12, Lytes		1530
CXR		1600

b6-2

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

35 yo Iraqi ♂ S/P GSW's to thighs & buttocks.

POC: ICU for recovery

ASSESSMENT/DIAGNOSIS
S/P GSW's to buttocks + thighs

DISPOSITION *(Check all that apply)*
☐ HOME ☐ FULL DUTY
QUARTERS ☐ 24 Hrs. ☐ 48 Hrs. ☐ 72 Hrs.
MODIFIED DUTY UNTIL: DAY MONTH YEAR
REFERRED TO *(Indicate clinic)*
☐ EMERGENCY ☐ TODAY ☐ 72 HOURS ☐ ROUTINE
ADMIT. TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE
☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

TIME OF RELEASE:

(CONTINUE ON SF 507, IF NEEDED)

PATIENT'S IDENTIFICATION *(Mechanical imprint)* FOR WRITTEN ENTRIES GIVE: *Name - last, first, middle; SSN; DOB, service status, name and relation of sponsor or next of kin. (IMPORTANT: LIST FACILITY HOLDING TREATMENT RECORD)*

[redacted]

b(6)-4

SIGNATURE OF PROVIDER AND ID STAMP

INSTRUCTIONS TO PATIENT *(Include medications ordered, any limitations and follow-up plans)*

EMERGENCY CARE AND TREATMENT

MEDCOM - 12218 PY

STANDARD FORM 558 (Rev. 6-82)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

FOR Use of this form, see AR 40-407; the proponent agency is The Office of the Surgeon General.

1. AGE: 33

HEIGHT:

WEIGHT: 100kg

2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication)
☐ NKDA ☒ PCN ☐ LATEX ☐ IODINE ☐ TAPE ☐ FOOD
REACTION:

3. PREVIOUS SURGERY [ ] NO [ ] YES (type):

b(6)2

4. PROPOSED SURGICAL PROCEDURE: [redacted] ~~Proctoscope~~ s/p GSW I&D of wounds

5. ADDITIONAL INFORMATION: (Previous surgical and medical history)
Skin Condition Multiple bruises & cuts
Tobacco 0 ppd X ___ yrs.
ETOH 0
Glasses/Contact (Y) [✓ (N)]
Body Piercing 0
Implants 0
Dentures 0
Diabetes (Y) [✓ (N)]
Respiratory Disease (Asthma/COPD) (Y) [✓ (N)]
Hypertension (Y) [✓ (N)]
ROM ↓
ASA/Motrin w/72 hrs (Y) [✓ (N)]
Anticoagulants (Y) [✓ (N)]
Herbal Medicines (Y) [✓ (N)]
MEDS:

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to: ✓ 1) Surgical Procedure & Operating Room Environment ___ 2) Separation Anxiety (Child) ✓ 3) Surgical Outcomes	✓ Pt. verbalizes any specific anxiety. ✓ Pt. Exhibits relaxed body posture.	✓ Allow pt. to verbalize freely. ✓ Explain OR environment and answer questions regarding surgery. ✓ Offer comfort measures. (e.g., warm blanket, touch). ✓ Explain all nursing procedures before they are done. ✓ Remain with pt. whenever possible. ✓ Maintain family interface. Parents to stay with pt.
B. AERATION ✓ Potential for respiratory dysfunction due to: ✓ 1) Positioning ✓ 2) Effects of Anesthesia ✓ 3) Medical/Smoking History	✓ Pt. will be able to breathe without difficulty during immediate intraoperative phase .	✓ Offer to elevate head of litter or offer pillow. ✓ Observe pt. while awaiting surgery for signs of distress. ✓ Assist anesthesia during intubation and extubation.
C. INTEGUMENT ✓ Potential impairment of skin integrity due to: ✓ 1) Intraoperative Immobility ✓ 2) ESU Pad Placement ✓ 3) Positional Aids ___ 4) Prosthesis ✓ 5) Pooling of Prep Solutions	✓ Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened areas).	✓ Utilize pressure preventing devices on OR table and accessories. ✓ Check for proper positioning and support to maintain good body alignment. ✓ Pad pressure points. ✓ Place ESU ground pad on non compromised skin surface area. ✓ Keep prep fluids from pooling.

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

[redacted] b(6)-4

VERIFICATIONS AT HOLDING AREA:
! ID/Allergy Band
! H & P
! NPO Since_____
! UHCG/LMP
! Consent/Blood Transfusion Signed/Witnessed/Dated
! Surgical Site/Consent verified by Pt./Anesthesia/Surgeon
! Contact Precautions (Y) (N)
! Family/Friend: 0
! Dentures Removed
! Contacts Removed
! Jewelry Removed
! Body Pierce Removed

DA FORM 5179, JUN 91 Previous editions are obsolete. USAPA V1.0

MEDCOM - 12219

A11 b(6)-2

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to: ✓ 1) Intraoperative Mobility ✓ 2) Positioning ✓ 3) Existing Disease ✓ 4) Safety Devices ✓ 5) Hypothermia	✓ Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse.	✓ Check for support stockings or ace wraps. If none, check with doctors. ✓ Check that safety straps are correctly applied. ✓ Offer pillow for under knees. ○ Place and take down legs from stirrups with slow bilateral motion. ✓ Check that rings and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to: ✓ 1) Pain ✓ 2) Intraoperative Hazards ____ 3) Prosthesis ✓ 4) Positioning ✓ 5) Transfer pt. to/from OR table E.2. ✓ Potential discomfort due to: ✓ 1) Length of Surgery ✓ 2) Positioning ____ 3) Arthritis	✓ Pt. will be transferred to OR table without difficulty. ✓ Pt. will not experience unnecessary physical discomfort.	✓ Have sufficient people available for transfer. ✓ Insure proper body alignment. ✓ Allow patient to lie in position of comfort while waiting for surgery. ✓ Offer support (i.e., pillows, bath towels, etc.) for positioning.
F. SPECIAL SENSES F.1. ✓ Diminished visual perception due to being: ✓ 1) Pre-Medicated ____ 2) W/O Glasses F.2. ✓ Potential for decreased communication due to: ____ 1) Diminished Hearing ✓ 2) Language Barrier F.3. ____ Potential injury due to dentures: ____ 1) Upper ____ 4) Caps ____ 2) Lower ____ 5) Crowns ____ 3) Bridges	✓ Pt. will be made aware of surroundings prior to anesthesia induction. ✓ Pt. will be transferred safely to OR table. ✓ Pt. will be able to understand instructions. ✓ Minimize danger of injury during intraop period.	✓ Introduce self. Keep pt. informed as to where he/she is and what is happening. ✓ Inform pt. in which direction to move and assist if necessary. ✓ Speak clearly and slowly. ✓ Address pt from either side. ✓ Validate pt.'s understanding of verbal communication. ✓ Verify removal of dentures.
G OTHER PATIENT PROBLEMS/NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

10. O [redacted] COMPLETE D/ADDITIONAL INTRAOPERATIVE INTERVENTION S NOTED.

RN 27 JUN 03 DATE

11. POSTOPERATIVE EVALUATION: SKIN INTEGRITY: Bovie Pad Site: ☒ Clean and Dry ☐ Red ☐ N/A DRESSING DRY & INTACT: [✓ (Y)] (N)

LEVEL OF CONSCIOUSNESS: ☐ A&O ☒ Drowsy ☐ Sleepy ☐ Intubated BREATHING EASY: [✓ (Y)] (N)

LEVEL OF ACTIVITY: ☒ Moves All Extremities ☐ Moves Upper Extremities ☐ Transferred to litter with roller due to spinal

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] RN

DATE: 27 JUN 03 TIME: 1700

13. POSTOPERATIVE [redacted] PREPARED BY (Signature and Title) [redacted]

DATE: 27 JUN 03 TIME: 1815

REVERSE OF FORM 5179, JUN 91 MEDCOM - 12220 USAPA V1.0

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

FOR Use of this form, see AR 40-407; the proponent agency is The Office of the Surgeon General.

1. AGE: 33 yrs.

HEIGHT:

WEIGHT:

2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication)
☐ NKDA ☒ PCN ☐ LATEX ☐ IODINE ☐ TAPE ☐ FOOD
REACTION:

3. PREVIOUS SURGERY [ ] NO [✓] YES (type):
I&D Rt Buttock & thigh

4. PROPOSED SURGICAL PROCEDURE:
Washout IDPC Thigh (R)

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition________
Tobacco____ppd X___yrs. Body Piercing________ Diabetes (Y) (N) ROM________ ASA/Motrin w/72 hrs (Y) [✓ (N)]
ETOH__________ Implants__________ Respiratory Disease (Asthma/COPD) (Y) [✓ (N)]/Anticoagulants (Y) [✓ (N)]
Glasses/Contact (Y) (N) Dentures Hypertension (Y) [✓ (N)] Herbal Medicines (Y) [✓ (N)] MEDS:

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to: ✓ 1) Surgical Procedure & Operating Room Environment ___ 2) Separation Anxiety (Child) ✓ 3) Surgical Outcomes	o Pt. verbalizes any specific anxiety. o Pt. Exhibits relaxed body posture.	o Allow pt. to verbalize freely. o Explain OR environment and answer questions regarding surgery. o Offer comfort measures. (e.g., warm blanket, touch). o Explain all nursing procedures before they are done. o Remain with pt. whenever possible. o Maintain family interface. Parents to stay with pt.
B. AERATION ✓ Potential for respiratory dysfunction due to: ___ 1) Positioning ✓ 2) Effects of Anesthesia ___ 3) Medical/Smoking History	o Pt. will be able to breathe without difficulty during immediate intraoperative phase.	o Offer to elevate head of litter or offer pillow. o Observe pt. while awaiting surgery for signs of distress. o Assist anesthesia during intubation and extubation.
C. INTEGUMENT ✓ Potential impairment of skin integrity due to: ___ 1) Intraoperative Immobility ✓ 2) ESU Pad Placement ___ 3) Positional Aids ___ 4) Prosthesis ✓ 5) Pooling of Prep Solutions	o Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened areas).	o Utilize pressure preventing devices on OR table and accessories. o Check for proper positioning and support to maintain good body alignment. o Pad pressure points. o Place ESU ground pad on non compromised skin surface area. o Keep prep fluids from pooling.

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

[redacted] - b(6)-4

VERIFICATIONS AT HOLDING AREA:

! ID/Allergy Band
! H & P
! NPO Since_____
! UHCG/LMP
! Consent/Blood Transfusion Signed/Witnessed/Dated
! Surgical Site/Consent verified by Pt./Anesthesia/Surgeon
! Contact Precautions (Y) (N)
! Family/Friend:__________

! Dentures Removed
! Contacts Removed
! Jewelry Removed
! Body Pierce Removed

DA FORM 5179, JUN 91 Previous editions are obsolete. USAPA V1.0

MEDCOM - 12221

A11 b(6)-2

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to: ✓ 1) Intraoperative Mobility ___ 2) Positioning ___ 3) Existing Disease ___ 4) Safety Devices ✓ 5) Hypothermia	o Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse.	o Check for support stockings or ace wraps. If none, check with doctors. o Check that safety straps are correctly applied. o Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. o Check that rings and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to: ✓ 1) Pain ✓ 2) Intraoperative Hazards ___ 3) Prosthesis ___ 4) Positioning ___ 5) Transfer pt. to/from OR table E.2. ✓ Potential discomfort due to: ✓ 1) Length of Surgery ✓ 2) Positioning ___ 3) Arthritis	o Pt. will be transferred to OR table without difficulty. o Pt. will not experience unnecessary physical discomfort.	o Have sufficient people available for transfer. o Insure proper body alignment. o Allow patient to lie in position of comfort while waiting for surgery. o Offer support (i.e.. pillows. bath towels. etc.) for positioning.
F. SPECIAL SENSES F.1. ✓ Diminished visual perception due to being: ✓ 1) Pre-Medicated ___ 2) W/O Glasses F.2. ✓ Potential for decreased communication due to: ___ 1) Diminished Hearing ✓ 2) Language Barrier F.3. NA Potential injury due to dentures: ___ 1) Upper ___ 2) Lower ___ 3) Bridges ___ 4) Caps ___ 5) Crowns	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR table. o Pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt. from ________ side. o Validate pt.'s understanding of verbal communication. o Verify removal of dentures.
G. OTHER PATIENT PROBLEMS/NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

10. OR NURSING INTERVENTIONS COMPLETED/ADDITIONAL INTRAOPERATIVE INTERVENTIONS NOTED.

[redacted] 29 Jun 03 DATE

11. POSTOPERATIVE EVALUATION: SKIN INTEGRITY: Bovie Pad Site: ☒ Clean and Dry ☐ Red ☐ N/A DRESSING DRY & INTACT: [✓ (Y)] (N)

LEVEL OF CONSCIOUSNESS: ☐ A&O ☒ Drowsy ☐ Sleepy ☐ Intubated

BREATHING EASY: [✓ (Y)] (N)

LEVEL OF ACTIVITY: ☒ Moves All Extremities ☐ Moves Upper Extremities ☐ Transferred to litter with roller due to spinal

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title)
[redacted] MAJ AN
DATE: 29 Jun 03 TIME: 1225

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted]
DATE: 29 Jun 03 TIME: 1740

REVERSE OF FORM 5179, JUN 91 MEDCOM - 12222 USAPA V1.0

MEDICAL RECORD | **INTRAOPER CUMENT**

For use of this form, see AR 40-407, the proponen cy is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA
BY

2. PATIENT IDENTIFIED [redacted] OCEDURE
VERIFIED BY

3. DATE 27 June 03
TIME PATIENT ARRIVED IN SUITE 0730

4. PATIENT IN ROOM
TIME 0745
NUMBER 60 b(6)-2

5. PREOPERATIVE EMOTIONAL STATUS

☒ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS: Interpreter present, All to PCN - Itching

6. NURSING PERSONNEL

ASSIGNED SCRUB	SSG [redacted] 91D b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	Cpt [redacted] / 66E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

☐ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE

LATERAL: ☐ LEFT SIDE UP ☒ RIGHT SIDE UP

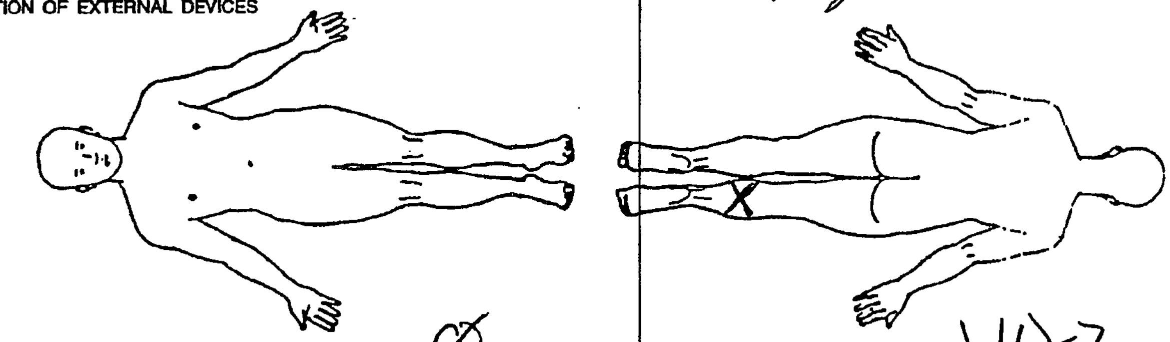
COMMENTS: Ax roll, Blankets padded

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR
☐ CLIP
COMMENTS:

PREP SOLUTION *(Specify)* Betadine
SITE: Buttocks Bilat BY WHOM: Cpt [redacted]
SITE: BY WHOM:
b(6)-2
COMMENTS: Spraying

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Strap === Tourniquet

b(6)-2

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☑ Yes ☐ No	C		C	[redacted]	[redacted]
Needle Sharp	☑ Yes ☐ No	C		C		
Instrument	☑ Yes ☐ No	C		C		
Other	☑ Yes ☐ No	C		C		

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

[redacted] b(6)-4

33 yo IM

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO

10/10

☐ ESU NO: F1043
GROUND PAD: BRAND Valleylab
LOT NO: 64289

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE.

MEDCOM - 12223

13. PROSTHESIS, IMPLANTS ☐ YE NO IF YES NAME: ID NU MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☒

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):
NSS - Pulse lavage - 8L

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM IF YES, SITE
YES ☐ NO ☒

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 5/8" Penrose	2. 1/4" Nu Gauze	3. 5/8" Penrose
SITE	1. Ⓡ thigh	2. Buttock;	3. Ⓛ thigh

18. DRESSING/IMMOBILIZATION *(Specify)*
Fluffs
Kerlix
Mastisol
[illegible]

19. ADDITIONAL INFORMATION
DR. [redacted] LTC
DR. LTC
DR Col
Anes - LTC - Gen
[redacted]
b(6)-2

Bullet Removed, Penrose placed
B/lat p̄ Lavage of 8 l.

20. OPERATION(S) PERFORMED
I & D Right lateral thigh & Buttock

21. PATIENT TRANSFERRED TO ICU TIME 1015 METHOD Litter

22. REGISTERED NURSE SIGNATURE [redacted] b(6)-2

VERSE OF DA FORM 5179-1, OCT 87 *U.S. Government Printing Office: 1995 — 388-733/23952

MEDCOM - 12224

MEDICAL RECORD INTRAOPERAT. OCUMENT

For use of this form, see AR 40-66, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: LITTER BY Anesthesia

2. PATIENT IDENTIFIED, [redacted] D PROCEDURE VERIFIED BY 1LT [redacted] b(6)-2

3. DATE 27 Jun 03 TIME PATIENT ARRIVED IN SUITE 1704

4. PATIENT IN ROOM TIME 1705 NUMBER 2-1

5. PREOPERATIVE EMOTIONAL STATUS

☒ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted] b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	1LT [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

☐ SUPINE ☐ LITHOTOMY ☒ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

COMMENTS: Normal anatomic body alignment maintained

8. SKIN PREPARATION

HAIR REMOVAL ☒ YES ☐ NO

DONE BY: ☒ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP

COMMENTS: No nicks or cuts

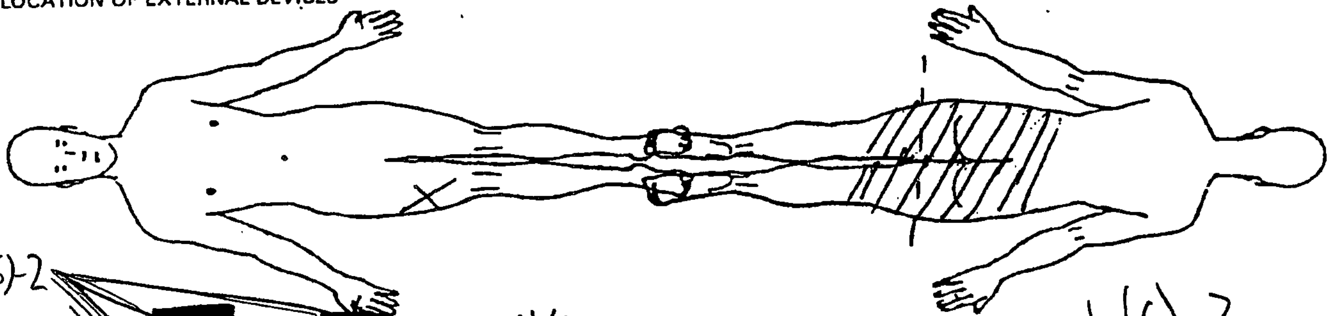
PREP SOLUTION *(Specify)* Betadine/Betadine

SITE: lower back to knees BY WHOM: 1LT [redacted]

SITE: BY WHOM: b(6)-2

COMMENTS: No pooling or adverse reaction

9. LOCATION OF EXTERNAL DEVICES



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

LEGEND X Ground Pad -- Safety Strap N/A === Tourniquet ☒1 - prep b(6)-2

Initial: PFC [redacted]
1LT [redacted]

10. COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
			C = Correct I = Incorrect				
Sponge	☒ Yes	☐ No		C	C	PFC [redacted]	1LT [redacted]
Needle Sharp	☒ Yes	☐ No					
Instrument	☐ Yes	☒ No					
Other	☐ Yes	☒ No					

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

[redacted] b(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO

☒ ESU NO: #3 cut 30 coag 30

GROUND PAD: BRAND VL REM Polyhesive

LOT NO: 69652 Exp 2005-03

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES L... MEDCOM - 12225 ICH IS OBSOLETE. USAPA V1.01

13. PROSTHESIS, IMPLANTS ☐ YES ☒ NO IF YES NAME: ID NUMBER; MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☐

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):
0.9% NaCl- Q.S.

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM IF YES, SITE
YES ☐ NO ☒

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. ~~Right thigh~~ kerlix	2.	3.
SITE	1. Right thigh	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
fluffs, Kerlix, ABD

19. ADDITIONAL INFORMATION
Surgeon: Dr. [redacted]
Anesthesia: MAJ [redacted]
} b(6)-2

b(6)-2 DA 5179 initiated

20. OPERATION(S) PERFORMED [redacted]
~~Proctoscope~~
I&D of wounds

21. PATIENT TRANSFERRED TO ICU TIME 1815 METHOD Litter c̄ O2

22. REGISTERED NURSE SIGNATURE [redacted] "17-N

REVERSE OF DA FORM 5179-1, OCT 87 USAPA V1.01

b(6)-2 MEDCOM - 12226

b(6)-2

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

For use of this form, see AR 40-66, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA: Litter BY CPT [redacted] /MAJ [redacted]

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY MAJ [redacted]

3. DATE 29 Jun 03
TIME PATIENT ARRIVED IN SUITE 1745

4. PATIENT IN ROOM
TIME 1745 NUMBER 1-2

5. PREOPERATIVE EMOTIONAL STATUS

☒ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted]	RELIEF SCRUB	
ASSIGNED CIRCULATOR	MAJ [redacted] CPT [redacted]	RELIEF CIRCULATOR	CPT [redacted] Ct

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

☐ SUPINE ☐ LITHOTOMY ☒ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

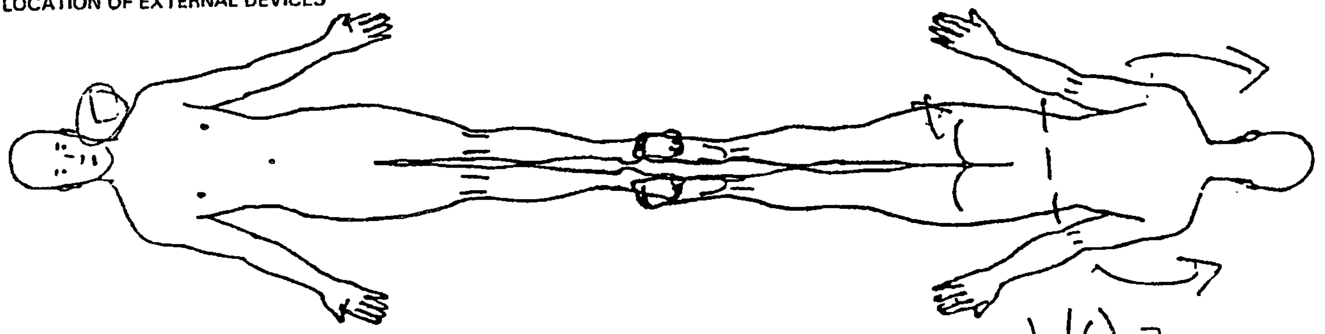
COMMENTS: Pillows under chest, pelvis, lower legs, head on foam donut

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☑ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR
☐ CLIP
COMMENTS:

PREP SOLUTION *(Specify)* Povidone scrub & solution
SITE: Rt buttock & thigh BY WHOM: CPT [redacted]
SITE: BY WHOM:
b(6)-2
COMMENTS: No pooling of solution

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad – Safety Strap = = = Tourniquet

b(6)-2

C = Correct I = Incorrect

10. COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes	☐ No		C	C	[redacted]	[redacted]
Needle Sharp	☒ Yes	☐ No					
Instrument	☐ Yes	☐ No					
Other	☐ Yes	☐ No					

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

#[redacted] b(6)-4

[redacted]

12. ELECTROSURGERY DEVICE(S) (ESU) ☑ YES ☐ NO

☒ ESU NO: Valleylab #2
GROUND PAD: BRAND Valleylab
LOT NO: 68936 Exp 2005-03

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

MEDCOM - 12227

DA FORM 5179-1, OCT 87 REPLACES D... ICH IS OBSOLETE. USAPA V1.01

13. PROSTHESIS, IMPLANTS ☐ YES ☒ NO IF YES NAME: ID NUMBER; MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☒

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

Nacl

OTHER ORDERS	TIME	CARRIED OUT BY
none		

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM IF YES, SITE

YES ☐ NO ☒

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. Drain JP Drain	2.	3.
SITE	1. Ⓡ thigh	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

Fluffs

Xe-form

19. ADDITIONAL INFORMATION

Surgeon: [redacted] [redacted] } b(6)-2

anes: CPT [redacted]

Bovie plate site

20. OPERATION(S) PERFORMED

Washout 1 DPC Ⓡ thigh

b(6)-2

21. PATIENT TRANSFERRED TO ICU 1

TIME see D47389

METHOD Litter

22. REGISTERED NURSE SIGNATURE [redacted] CPT AN [redacted]

REVE[redacted]7

USAPA V1.01

MEDCOM - 12228

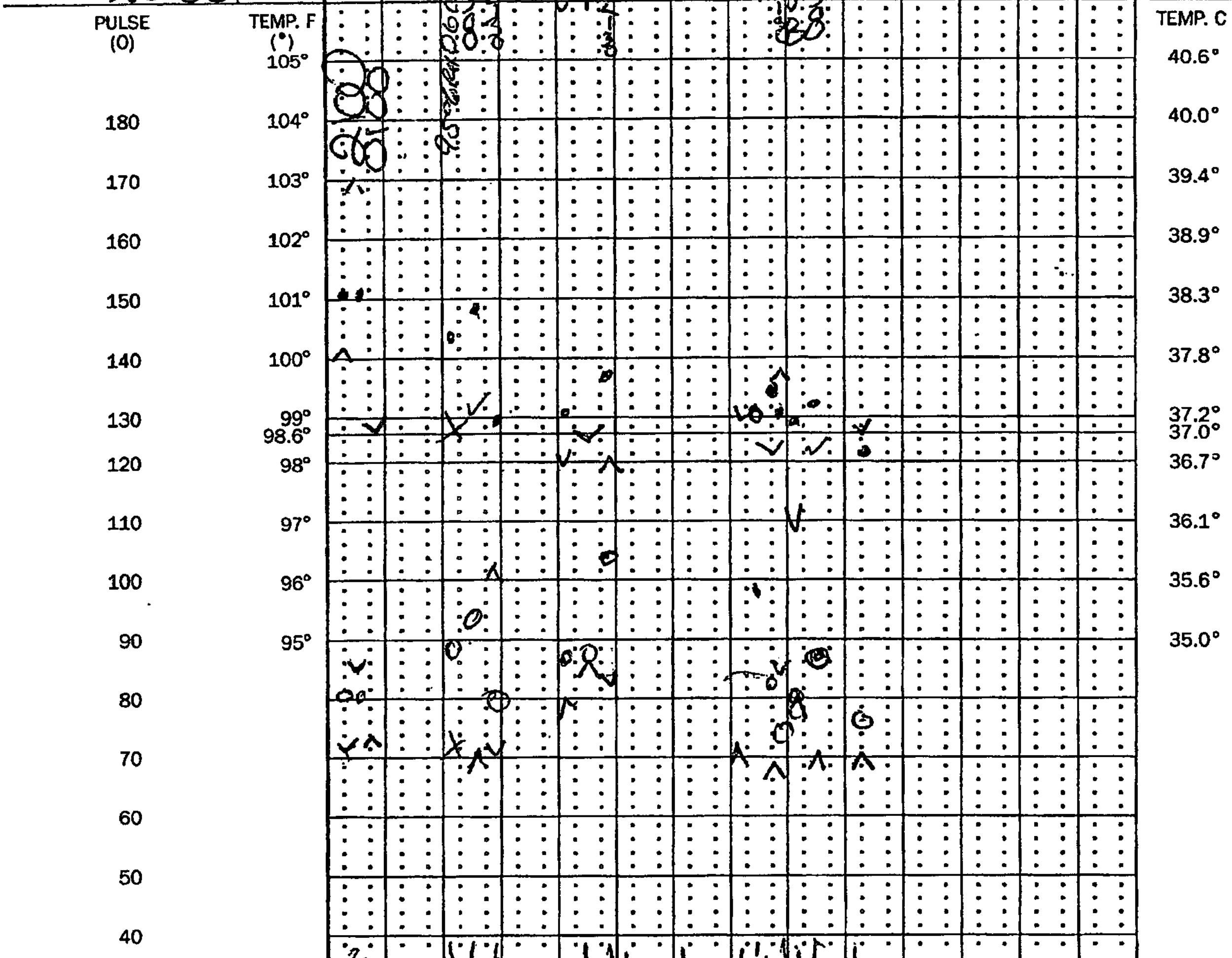
MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR June 2003



(Centigrade Equivalents, for Reference only)

DAY	27	28	29	30	1	3	4
HOUR		[illegible]	[illegible]	[illegible]	[illegible]		
RESPIRATION RECORD	20	18 16 18	14 16	16	16 16		
BLOOD PRESSURE	142/76 170/80 120/73	130/78	120/80 124/80	132/68	117/80 120/70 134/70		
HEIGHT: WEIGHT →				99% 98%	97% 98%		

Record special data only when so ordered

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*

REGISTER NO.

WARD NO. ICW2

STANDARD FORM 511 (REV. 7-95) **BACK**

~~EPW~~

CIV [redacted] b(6)-2

MEDCOM - 12229

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM 0[illegible] HOURS TO 052 HOURS

TOTAL HOURS COVERED 24

DATE 29 June

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
	NPO		

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL

~~IRRIGATIONS (N/G, Bladder,~~ etc.)

TIME	OUTPUT ~~TYPE~~	AMOUNT	ACCUMULATIVE TOTAL
1220	Dark Tea Colored Urine	475	

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl, Alb, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

[redacted]

b(6)-4

INTAKE EQUIVALENTS (Serving levels cc)

MEDICINE GLASS (1 oz) .30	HALF PINT MILK 240
SMALL FRUIT CUP 120	LARGE SOUP BOWL......240
COFFEE CUP..............160	LARGE WATER GLASS..240
LARGE COFFEE MUG...180	PLASTIC OR PAPER JUICE CONTAINER...180

DD FORM 1 JAN 74 792

EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3830(TEMP) 1 JUL 72

MEDCOM - 12230

*U.S.GPO:1998-404-613/30343

TWENTY-FOUR HOUR PATIENT . AKE AND OUTPUT WORKSHEET	FROI ___ HOURS TO ___ HOURS	TOTAL HOURS COVERED	DATE

INT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
12	H_2O	100	
18	Milk	240	340

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
2100	Cyu	700	700
0900	Cyu	1000	1700
0930	Foley pulled		
1000	Cyu	700	2400
1335	Cyu	750	3150
1700	Cyu	400	7550

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl. Alb. P. cells. etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

EPW # [redacted] b(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

MEDICINE GLASS (1 oz)	30
SMALL FRUIT CUP	120
COFFEE CUP	160
LARGE COFFEE MUG	180
HALF PINT MILK	240
LARGE SOUP BOWL	240
LARGE WATER GLASS	240
PLASTIC OR PAPER JUICE CONTAINER	180

DD FORM 1 JAN 74 792

EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3630(TEMP) 1 JU

*U.S.GPO:1996-404-613/30343

MEDCOM - 12231

TWENTY-FOUR HOUR PATIENT IN...E AND OUTPUT WORKSHEET	FROM 2 HOURS TO 0000 HOURS	TOTAL HOURS COVERED 24	DATE 30 Jun

INT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
0330	H_2O	200	200
0630	H_2O	200	400
1200	H_2O	120	520

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
06	50	ancef	50		50
14	50	ancef	100		100

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0300	dK yellow c strong odor	300	300
0700	dk yellow	280	580
0900	lt. yellow urine	600	1180
1355	lt. yellow urine	425	1605
1900	" "	400	2005
2214		400	2405

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl. Alb. P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

JP Drain ~~OTHER INTAKE~~

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0420	sanguinous	25	25
0904	bloody drainage	10	35
1925	bloody drainage	15cc	50cc

GRAND TOTAL INTAKE

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

EPW [redacted] b(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

MEDICINE GLASS (1 oz)	30	HALF PINT MILK	240
SMALL FRUIT CUP	120	LARGE SOUP BOWL	240
COFFEE CUP	160	LARGE WATER GLASS	240
LARGE COFFEE MUG	180	PLASTIC OR PAPER JUICE CONTAINER	180

DD FORM 1 JAN 74 792

EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3630(TEMP) 1 JUL 7- WHICH MAY BE USED.

*U.S.GPO:1996-404-613/30343

MEDCOM - 12232

TWENTY-FOUR HOUR PATIENT AKE AND OUTPUT WORKSHEET	FROM ... OURS TO 23.. HOURS	TOTAL HOURS COVERED	DATE
		24	30Jun03

INT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
0200	[illegible]	300cc	300cc
0030	H_2O	200	500

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL

JP Only

See Other Side

Urine ~~IRRIGATIONS (N/G, Bladder, etc.)~~

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0330	dk yellow c̄ strong odr	300cc	300cc
0700	dk yellow	280cc	580cc
0950	lt yellow urine	600cc	1480 cc
1355	" "	425cc	1700 cc

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl, Alb, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

JP Drain ~~OTHER INTAKE~~

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0420	sanguinous	25cc	25cc
0904	bloody drainage	10 cc	35 cc

GRAND TOTAL INTAKE

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

EPW # [redacted] b(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

MEDICINE GLASS *(1 oz)* .30	HALF PINT MILK 240
SMALL FRUIT CUP 120	LARGE SOUP BOWL.....240
COFFEE CUP..............160	LARGE WATER GLASS..240
LARGE COFFEE MUG...180	PLASTIC OR PAPER JUICE CONTAINER...180

DD FORM 1 JAN 74 792

EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3630(TEMP) 1 JUL

MEDCOM - 12233

*U.S.GPO:1998-404-613/30343

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM ______ HOURS
TO ______ HOURS

TOTAL HOURS COVERED

DATE 1 July 05

INT

ORAL

JP Output

TIME	TYPE	AMOUNT	ACCUM TOTAL
0400	Bloody fluid 1 July	25cc	25
1000	bloody fluid	15	40
1700	bloody fluid	25cc	75

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL

IRRIGATIONS (N/G, Bladder, etc.)

Urine

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
1250	Yellow urine	300cc	

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl. Alb, R. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

[illegible] [redacted] b(6)-4
CIV

INTAKE EQUIVALENTS (Serving levels cc)

MEDICINE GLASS (1 oz)	30	HALF PINT MILK	240
SMALL FRUIT CUP	120	LARGE SOUP BOWL	240
COFFEE CUP	160	LARGE WATER GLASS	240
LARGE COFFEE MUG	180	PLASTIC OR PAPER JUICE CONTAINER	180

DD FORM 1 JAN 74 792 ION OF 1 SEP 54 IS OBSOLETE. REPLACES ORM 3630(TEMP) 72 WHICH MAY BE USED.

*U.S.GPO:1998-404-613/30343

TWENTY-FOUR HOUR PATIENT INT. . AND OUTPUT WORKSHEET

FROM 0 OURS TO ______ HOURS	TOTAL HOURS COVERED		DATE 2July03

INT

JP OUTPUT ~~ORAL~~

TIME	TYPE	AMOUNT	ACCUM TOTAL
0400	bloody fluid.	7cc	7cc

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl. Alb, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

INTAKE EQUIVALENTS (Serving levels cc)

Item	cc	Item	cc
MEDICINE GLASS (1 oz)	30	HALF PINT MILK	240
SMALL FRUIT CUP	120	LARGE SOUP BOWL	240
COFFEE CUP	160	LARGE WATER GLASS	240
LARGE COFFEE MUG	180	PLASTIC OR PAPER JUICE CONTAINER	180

DD FORM 1 JAN 74 792

EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3030(TEMP) 1 JUL 72

MEDCOM - 12235

*U.S.GPO:1998-404-613/30343

EMT

[redacted] b(6)-2
21 Jun 03 1530

#[redacted] b(6)-4

(i-STAT)

TEST	RESULT	REF RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		[illegible]31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2)-(+3) mmol/L
AnGap		10-20 mmol/L
iCa		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.[illegible]-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin I		Negative
Drug of Abuse		Negative
		Negative
		Negative
		Negative

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB	3.0	3.5-5.5 g/dl
ALP	60	26-84 u/l
ALT	31	10-47 u/l
AMY	31	14-97 u/l
AST	55	11-38 u/l
TBIL	0.8	0.2-1.6 mg/dl
BUN	8	7-22 mg/dl
CA	8.1	8.0-10.3mg/dl
CHOL	112	100-200 mg/dl
CRE	0.9	0.6-1.2 mg/dl
GLU	107	73-118 mg/dl
TP	5.9	6.4-8.1 g/dl

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 u/l (M) 30-190 u/l (F)
NA		128-145 mmol/l
K		3.3-4.7 mmol/l
CL		98-108 mmol/l
tCO2		18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA		128-145 mmol/l
K		3.3-4.7 mmol/l
CL		98-108 mmol/l
tCO2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA	140	128-145 mmol/l
K	3.8	3.3-4.7 mmol/l
CL	105	98-108 mmol/l
tCO2	28	18-33 mmol/l

REMARKS:

REPORTED BY: [redacted] b(6)-2

DATE: 27 Jun 03

LAB ID NO.:

CBC

b(6)-2

Ward/Section: EMT	REQUES [redacted]		**LABORATORY RESULT FORM** (Subject to the Privacy Act of
LAST, FIRST, MI. # [redacted] b(6)-4	27Jun	TIME 1530	SSN/PSEUDO SSN

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	9.6	4.8-10.8 x 10^3
RBC	4.56	4.7-6.1 x 10^9
Hgb	12.2	14-18 g/dl (M) 12-16 g/dl (F)
Hct	39.7	42-52% (M) 37-47% (F)
MCV	87.0	80-94 fl (M) 81-99 fl (F)
Plt	246	130-500 x 10^3 verified
Lymph %	26.2	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted]

b(6)-2

DATE: 27 JUN 05

LAB ID NO.:

MEDCOM - 12237

0730 cefotetan 2gm IV

MEDICAL RECORD — ANESTHESIA

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML, "/" =CONSTANT INFUSION

DRUG	(Units)									
Fent	(cc)	2	1	2						
PPS	(mg)	200								
SUX	(mg)	100								
Vecu	(mg)				2	2	2	2	2	
	( )									
	( )									
VOLAT. AGENT Iso	% del		1.5	1.5	2	2	2	2	2	1.5 X
	% e.t.									
AIR	L/Min									
N2O	L/Min									
O2	L/Min	5	5	5	5	5	5	5	5	5

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS &ENTER IN REMARKS

FLUIDS

LINE site		
Ⓛ	☐ Warmed	1000 · 1200 — 1500 — 2000 — 2200 2300
Ⓡ	☐ Warmed	1000 — 1100 — 1400
	☐ Warmed	
	☐ Warmed	

LOSSES

EST BLOOD LOSS

URINE – 200 900

TIME → 0745 0800 15 ~~0815~~ 30 ~~30~~ 0900 X ~~0900~~ 30 X 1000

PHYS STATUS: (1) 2 3 4 5 E

BODY WEIGHT: 100 (KG) LB

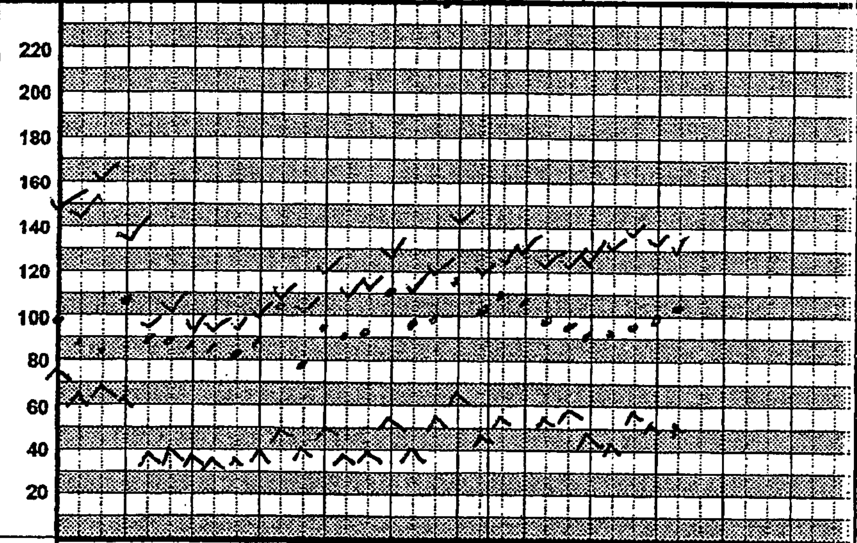
HEMATOCRIT:

INITIAL DATA: BP – 147/76 HR – 99

EQUIP CHECK: OK? – [✓ Y] N

PATIENT RECHECK: OK for PROCEDURE: yes TIME – 0730

SYMBOLS: BP by cuff V Λ; Heart rate ●; Resp rate; BP (transduced) ⊥ T; TOURNIQUET T – ✗; ANES– X-X; PROC ⊙ – Ø



VENTS

VT – ml									
f – breaths/min	23	25	35	25	30	32	24	24	24
Peak Inf pres / PEEP									
MODE– S(pon), A(ssist), C(on)	S	S	S	S	S	S	S	S	S

MONITORS / ACCESSORIES

☒ BP/Auto Cuff	☒ ET CO2 (torr)	48	50	44	57	53	51	52	48	45
BP / oth	☒ FIO2 (Frac or %)	.7	.7	.7	.7	.7	.7	.7	.7	.7
ART line	☒ SpO2 (%)	100	98	98	97	99	100	100	100	100
☒ Steth- PC/ES	☒ ECG	SR	SR	SR	ST	ST	SR	ST	SR	SR
Gas analyzer	TEMP- site									
	N-M Block (T/4)		4/4							
Warming blkt										
Conv warmer										

Mark with letters & symbols, explain under REMARKS EVENTS Position → ⊸ (L) lat – ⊸

TOTALS

TOTAL FEI: 100

TOTAL URINE: 900

FLUIDS SUMMARY:

CRYSTALLOID – 3700

COLLOID –

BLOOD –

REMARKS — *Code drugs with numbers, events with letters*

0730 – pt interviewed thru interpreter

0745 in OR

0800 – turned (L) lat. Ax roll in place, eyes + ears checked BS = BL.

0835 – turned supine

1010 – extubated

RECOVERY AT 1015

PACU (ICU) (Specify)

OTHER

CONDITION: Stable SV

RESP – 21 SpO2 – 100

BP – HR – 97

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0730	0745	1020
	Ready	**Begin**	**End**
PROC	0800	0835	1010

PROCEDURES and CPT Codes: EUA/procto, I&D of (R) thigh + (R) buttock (L) thigh wounds

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* GETA

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* Pre O2, RSI, class 2 view, [illegible] ETT, BS = BL, [illegible], BS = BL ETCO2 wx

PATIENT IDENTIFICATION– *Typed or written entries: Name, Grade/Rate, Medical facility*

[redacted]

b(6)-4

SURGEONS: [redacted]

ANESTHETIST: [redacted] b(6)-2

MEDICAL RECORD — ANESTHESIA

PROCEDURE LOCATION: OR

DATE: 27 JUN 03

PAGE 1 OF

b(6)-2 WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 12238

☆ U.S. GPO: 1999 – 528-336/10085

꞉STHESIA PLAN OF CARE PRE‚ ‚‚OCEDURAL ASSESSMENT (Sedation/A‚‚esthesia)

35 DAYS MOS YRS

Sex [✓ MALE] ( ) FEMALE

ASA Physical State 1 [✓ 2] 3 4 5 [✓ E]
WT: 100 [✓ KG]/LB HT: ____ IN.
ALLERGIES: PCN

POSED PROCEDURE: I@D Legwounds
GICAL SERVICE: Gen Surg
SINCE: 12hr

ITS:
BACCO: 0
ETOH: ____
DRUGS: ____

RENT MEDICATIONS:
ordered as premed

zofran Zantac
cefotan 2gms 0730
MS04

MEDICATIONS:
Yes (@ ____ Hrs) /CC
__ . ____ mg IV IM PO
__ . ____ mg IV IM PO
__ . ____ mg IV IM PO

ORATORY STUDIES:

ICT: ____ / ____

IER: ____

9.6 > 12.2 / 39.7 < 246

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:		
Hypertension	[✓ N] Y	
Angina	[✓ N] Y	
MI	[✓ N] Y	
CVA	[✓ N] Y	
Other	[✓ N] Y	
Pulmonary System:		
Asthma	[✓ N] Y	
Bronchitis/URI	[✓ N] Y	
COPD	[✓ N] Y	
Other	[✓ N] Y	
Renal System:		
Acute/Chronic RF	[✓ N] Y	
Gastrointestinal:		
Hepatitis	[✓ N] Y	
Hiatal Hernia	N Y	
PUD/GERD	N Y	
Endocrine System:		
Diabetes	[✓ N] Y	
Sleriods	[✓ N] Y	
Thyroid	[✓ N] Y	
Neurological:		
Seizures	[✓ N] Y	
Neuropathy	[✓ N] Y	
Other	[✓ N] Y	
Gynecological :		
Pregnancy	[✓ N] Y	
Other Significant Hx:		
	[✓ N] Y	GSW to thighs @ (R) buttocks
	[✓ N] Y	
Familial HX	[✓ N] Y	

ASSESSMENT

PAST SURGICAL/ANESTHETIC
wound exploration at FST today

PHYSICAL EXAMINATION
BP 134/70 HR 90 R 18 T 100.1
Pain Scale 0-10 ____
HEENT - Teeth ____
Trachea ____
TMJ/Neck ____
Oropharnyx ____
Nares ____
CHEST: ____
CARDIAC: ____
EXTREMITIES: ____
IV Access: ____
Ulnar Filling: ____
BACK: ____
OTHER: ____

NPO Since ____

ESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ____ [✓ General]: Mask Intubation
Information from previous FST pre-op

ORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to ussed with the patient/legal guardian.

b(6)-2

patient[redacted] and agrees. Questions answered.
ned: Date: 27 Jun 03 Time: 1640 Hrs

ST-ANESTHESIA EVALUATION AND NOTE (NON ASU)
NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER

ned: ____ Date: ____ Time: ____ Hrs

SEDATION KEY:

1. MINIMAL (Anxiolysis) Patient responds normally to verbal commands
2. MODERATE (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is n necessary.
3. DEEP SEDATION/ANALGESIA. Patient responds purposefully following repeated or painful stimulation. Airway assistance may

ent Identification: (Ward) ____

EPW [redacted] b(6)-4

MEDCOM - 12239

STHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

33 DAYS MOS YRS
Sex [✓ MALE] ( ) FEMALE

ASA Physical State 1 [✓ 2] 3 4 5 E
WT: 100 [✓ KG]/LB HT: ____ IN.
ALLERGIES: ~~NKDA~~ PCN

OSED PROCEDURE: (L) Thigh I&D / PPC
ICAL SERVICE: GS
INCE: p̄ MD

S:
ACCO: Ø
ETOH: Ø
RUGS:

ENT MEDICATIONS:
dered as premed
~~Zofran~~ Zantac
Cefotan 2Gms
MSO4

EDICATIONS:
fes (@ ____ Hrs) /CC
. ____ mg IV IM PO
. ____ mg IV IM PO
. ____ mg IV IM PO

RATORY STUDIES:
T: ____ / ____
R: ____

9.6 / 12.2 / 39.7 / 246

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:
Hypertension [✓ N] Y
Angina [✓ N] Y
MI [✓ N] Y
CVA [✓ N] Y
Other [✓ N] Y
Pulmonary System:
Asthma [✓ N] Y
Bronchitis/URI [✓ N] Y
COPD [✓ N] Y
Other [✓ N] Y
Renal System:
Acute/Chronic RF [✓ N] Y
Gastrointestinal:
Hepatitis [✓ N] Y
Hiatal Hernia [✓ N] Y
PUD/GERD [✓ N] Y
Endocrine System:
Diabetes [✓ N] Y
Steriods [✓ N] Y
Thyroid [✓ N] Y
Neurological:
Seizures [✓ N] Y
Neuropathy [✓ N] Y
Other [✓ N] Y
Gynecological :
Pregnancy N Y NA
Other Significant Hx:
N Y
N Y
Familial HX N [✓ Y] GSW B/lat thighs (R) buttocks

ASSESSMENT
PAST SURGICAL/ANESTHETIC
Wound Exp (FST) 27 June
I & D wounds 28 Jun

PHYSICAL EXAMINATION
BP 130/8 HR 88 R 16 T 99
Pain Scale 0-10 ____
HEENT - Teeth intact
Trachea midline
TMJ/Neck 3FB
Oropharnyx grade 2
Nares
CHEST: distant sounds / CTA
CARDIAC: S1S2 s̄ (m)
EXTREMITIES:
IV Access: 18GAC (L) hand
Ulnar Filling: ____
BACK: ____
OTHER: grade I view on previous Intubation

NPO Since p̄ MN

b(6)-2

THETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): { } ~~General~~: Mask Intubation
EPW (No interperter / [redacted], CRNA

MED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to a
sed with the patient/legal guardian.

tient/legal guardian seems to understand and agrees. Questions answered.
d: ____ Date: 29 Jun Time: 1030 Hrs

ANESTHESIA EVALUATION AND NOTE (NON ASU)
APPARENT ANESTHETIC COMPLICATIONS { } OTHER
d: ____ Date: ____ Time: ____ Hrs

SEDATION KEY:
1. MINIMAL (Anxiolysis) Patient responds normally to verbal commands
2. MODERATE (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is no necessary.
3. DEEP SEDATION/ANALGESIA. Patient responds purposefully following repeated or painful stimulation. Airway assistance may

t Identification: (Ward) ____
[redacted] (ICW$_2$ - ICU)
b(6)-4

MEDCOM - 12241

MEDICAL RECORD — ANESTHESIA

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML, " | "=CONSTANT INFUSION

DRUG	Units				
versed	(mg)	3			
Fent	(µg)	150	50		
lido	(mg)	50			
Succs	(mg)	100			
STP	(mg)	300			
MSO4	(mg)		5		
VOLAT AGENT Sevo	% del	2.0	2.0	2.5	X
	% e.t.				
AIR	L/Min				
N2O	L/Min				
O2	L/Min	8	2	2	10

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS

FLUIDS

LINE site 18g Ⓛ LR	☐ Warmed	500	1200
	☐ Warmed		
	☐ Warmed		
	☐ Warmed		

LOSSES

EST BLOOD LOSS — 18 min

URINE – 1800

TOTALS

TOTAL EBL: min

TOTAL URINE: 1800

FLUIDS – SUMMARY

CRYSTALLOID– 1200

COLLOID– 0

BLOOD– 0

REMARKS–

Code drugs with numbers, events with letters

1705 Pt interviewed in ER interpreter explained plan. To OR Monitors applied. 1715 IOI

1720 turned to prone pillows at ankles, hip chest, Face on Pillow nose, eyes ETT checked ⊕ Bilat BS. Shoulders supported.

1859 Returned to supine ⊕ bilat BS

1800 Reversal 5 mg Neostig, 18 mg Robinol.

1805 Spont Resp. oral suction. Purposeful movement extubation

transferred to ICU Report given

PHYS STATUS: 1 [✓ 2] 3 4 5 [✓ E]

BODY WEIGHT: 100 [✓ KG] LB

HEMATOCRIT: 39.7

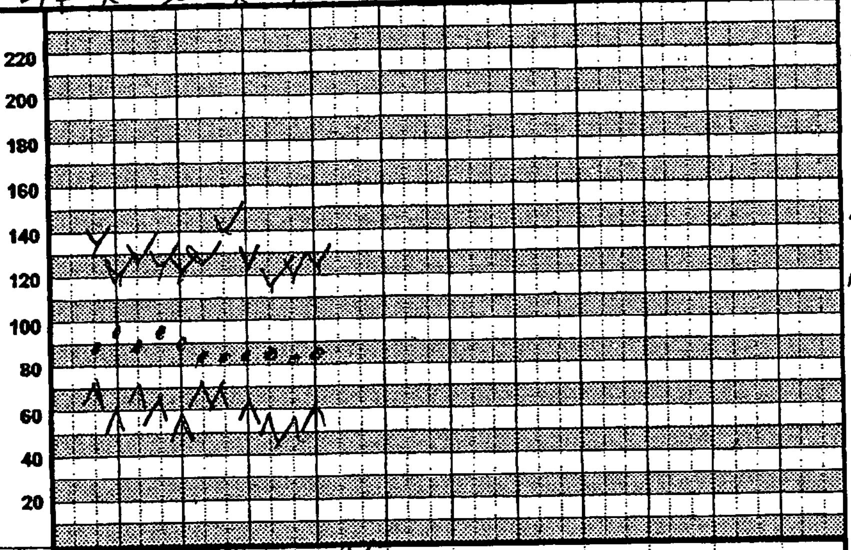
INITIAL DATA: BP – 133 / 72 HR – 90

EQUIP CHECK: OK? – [✓ Y] N

PATIENT RECHECK: OK for PROCEDURE? TIME– 1630

TIME → 17 X 30 X 18 X 30 X 19

SYMBOLS: BP by cuff ∨ ∧ Heart rate ● Resp rate BP (transduced) TOURNIQUET T — ANES— X-X PROC-⊙-Ø



VENTILATION

VT – ml		900	1000	1000	SV
f – breaths/min	10	10	10	10	
Peak inf pres / PEEP		27	27	27	
MODE– S(pon), A(ssist), C(on)	S→	CV	CV	CV	S

MONITORS

BP/Auto Cuff ✓	✓ ET CO2 (torr)	38	39	38	33	42
BP / oth	✓ FIO2 (Frac or %)		.55%	.55%	55	
ART line	✓ SpO2 (%)		100	100	100	
Steth- PC/ES ✓	✓ ECG		SR	SR	SR	
Gas analyzer ✓	✓ TEMP- site	Axillary				
	✓ N-M Block (T/4)		0/4			
Warming blkt						
Conv warmer						

Mark with letters & symbols, explain under REMARKS — EVENTS Position → 900 prone pillows

RECOVERY AT H20 1815

PACU ICU 2 (Specify)

OTHER

CONDITION:

RESP– 18 SpO2– 99.9

BP– 147/59 HR– 98

ANESTHESIA / PROCEDURE TIMES

ANES	Start	Room	End
	1625	1705	1820
PROC	Ready	Begin	End
	1715	1735	1755

PROCEDURES and CPT Codes
Washout GSW to Ⓡ Buttocks bilat thighs

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments #3 MAC, 8.0 ETT one attempt grade I view, secured at 24 cm teeth. ⊕ ETCO2 ⊕ bilat BS

PATIENT IDENTIFICATION— Typed or written entries: Name, Grade/Rate, Medical facility

EPW [redacted]
b(6)-4

SURGEONS: [redacted] b(6)-2 b(6)-2

AN [redacted] AJ CMA AN
b(6)-2

PROCEDURE LOCATION [redacted]

DATE 6/27/03 b(6)-2

PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED
1 Jan 99

MEDCOM - 12242

*U.S. GPO: 2002-729-180/40137

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 33 DAYS MOS [✓ YRS] **Sex** [✓ MALE] ( ) FEMALE

ASA Physical State 1 2 3 4 5 E
WT: 100 [✓ KG]/LB **HT:** _____ **IN.** 18[illegible]cm
ALLERGIES: PCN

PROPOSED PROCEDURE: I+D leg wounds.
SURGICAL SERVICE: G.S.
NPO SINCE: 12hr

HABITS:
TOBACCO: Ø
ETOH: ______
DRUGS: ______

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) Ø
( )
( )
( )
( )
( )

PREMEDICATIONS:
None Yes (@ ______ Hrs) /CC
______ . ______ mg IV IM PO
______ . ______ mg IV IM PO
______ . ______ mg IV IM PO

LABORATORY STUDIES:
HB/HCT: ______/______
U/A: ______
OTHER: ______

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:		
Hypertension	[✓ N] Y	
Angina	[✓ N] Y	
MI	[✓ N] Y	
CVA	[✓ N] Y	
Other	N Y	
Pulmonary System:		
Asthma	[✓ N] Y	
Bronchitis/URI	[✓ N] Y	
COPD	[✓ N] Y	
Other	N Y	
Renal System:		
Acute/Chronic RF	[✓ N] Y	
Gastrointestinal:		
Hepatitis	[✓ N] Y	
Hiatal Hernia	[✓ N] Y	
PUD/GERD	[✓ N] Y	
Endocrine System:		
Diabetes	[✓ N] Y	
Steriods	[✓ N] Y	
Thyroid	[✓ N] Y	
Neurological:		
Seizures	[✓ N] Y	
Neuropathy	[✓ N] Y	
Other	N Y	
Gynecological :		
Pregnancy	~~N~~ Y	
Other Significant Hx:		
	N Y	
	N Y	Ø
Familial HX	N Y	

ASSESSMENT
PAST SURGICAL/ANESTHETIC

PHYSICAL EXAMINATION
BP ___ HR ___ R ___ T ___
Pain Scale 0-10 ______
HEENT - Teeth intact
Trachea midline
TMJ/Neck ______
Oropharynx Cl 3
Nares ______
CHEST: ______
CARDIAC: ______
EXTREMITIES: ______
IV Access: gd
Ulnar Filling: ______
BACK: ______
OTHER: ______

NPO Since ______

ANESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ______ [✓] General: Mask [✓ Intubation]

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discussed with the patient/legal guardian.

b(6)-2

The patie[redacted]ems to understand and agrees. Questions answered.
Signed: ______ Date: 7 JUN 03 Time: 0730 Hrs

POST-ANESTHESIA EVALUATION AND NOTE (NON ASU)
{ } NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER

Signed: ______ Date: ______ Time: ______ Hrs

SEDATION KEY:

1. **MINIMAL** (Anxiolysis) Patient responds normally to verbal commands
2. **MODERATE** (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is not necessary.
3. **DEEP SEDATION/ANALGESIA.** Patient responds purposefully following repeated or painful stimulation. Airway assistance may be necessary.
4. **ANESTHESIA.** Patient does not respond to painful stimulation.

Patient Identification: (Ward) ______

Sa [redacted]

b(6)-4

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 33 DAYS MOS [✓ YRS] **Sex** [✓ MALE] ( ) FEMALE

PROPOSED PROCEDURE: I+D leg wounds.
SURGICAL SERVICE: G.S.
NPO SINCE: 12hr

ASA Physical State 1 2 3 4 5 E
WT: 100 [✓ KG]/LB **HT:** ____ **IN.** 18?cm
ALLERGIES: PCN

HABITS:
TOBACCO: 0
ETOH: ____
DRUGS: ____

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) 0
( )
( )
( )
( )
( )

PREMEDICATIONS:
None Yes (@ ____ Hrs) /CC
____ . ____ mg IV IM PO
____ . ____ mg IV IM PO
____ . ____ mg IV IM PO

LABORATORY STUDIES:
HB/HCT: ____ / ____
U/A: ____
OTHER: ____

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:
Hypertension [✓ N] Y
Angina [✓ N] Y
MI [✓ N] Y
CVA [✓ N] Y
Other N Y

Pulmonary System:
Asthma [✓ N] Y
Bronchitis/URI [✓ N] Y
COPD [✓ N] Y
Other N Y

Renal System:
Acute/Chronic RF [✓ N] Y

Gastrointestinal:
Hepatitis [✓ N] Y
Hiatal Hernia [✓ N] Y
PUD/GERD [✓ N] Y

Endocrine System:
Diabetes [✓ N] Y
Steriods [✓ N] Y
Thyroid [✓ N] Y

Neurological:
Seizures [✓ N] Y
Neuropathy [✓ N] Y
Other N Y

Gynecological :
~~Pregnancy N Y~~

Other Significant Hx:
N Y 0
N Y
Familial HX N Y

ASSESSMENT
PAST SURGICAL/ANESTHETIC

PHYSICAL EXAMINATION
BP ___ HR ___ R ___ T ___
Pain Scale 0-10 ____
HEENT - Teeth intact
Trachea midline
TMJ/Neck ____
Oropharynx Cl 3
Nares ____
CHEST: ____
CARDIAC: ____
EXTREMITIES: /
IV Access: gd
Ulnar Filling: /
BACK: ____
OTHER: ____

NPO Since ____

ANESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ____ [✓ General]: Mask/[✓ Intubation]

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discussed with the patient/legal guardian.

b(6)-2

The patie[redacted] seems to understand and agrees. Questions answered.
Signed: ____ Date: 7-12-03 Time: 0730 Hrs

POST-ANESTHESIA EVALUATION AND NOTE (NON ASU)
{ } NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER

Signed: ____ Date: ____ Time: ____ Hrs

SEDATION KEY:
1. **MINIMAL** (Anxiolysis) Patient responds normally to verbal commands
2. **MODERATE** (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is not necessary.
3. **DEEP SEDATION/ANALGESIA.** Patient responds purposefully following repeated or painful stimulation. Airway assistance may be necessary.
4. **ANESTHESIA.** Patient does not respond to painful stimulation.

Patient Identification: (Ward) ____

Sgt [redacted]

b(6)-4

C Form 2300 (Revised) 15 Mar 01 MCXC-DOS
MEDCOM - 12244
PATIENT RECORD COPY
Previous edition is obsolete
☆ U.S. GPO: 2002-729-283

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
EPW # [redacted]
b(6)-4

NURSING UNIT ICW 2
ROOM NO.
BED NO. 7

↓
DATE OF ORDER 15 May
TIME OF ORDER 1230 HOURS
LIST TIME ORDER NOTED AND SIGN

Ok to Txfr Iraqi Hospital

b(6)-2 [redacted]

noted 1330

PATIENT IDENTIFICATION
EPW # [redacted]
b(6)-4

NURSING UNIT ICW 2
ROOM NO.
BED NO. 7

DATE OF ORDER
TIME OF ORDER ______ HOURS

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

NURSING UNIT ICW 2
ROOM NO.
BED NO. 7

DATE OF ORDER
TIME OF ORDER ______ HOURS

PATIENT IDENTIFICATION
EPW # [redacted]
b(6)-4

NURSING UNIT ICW
ROOM NO.
BED NO. 7

DATE OF ORDER
TIME OF ORDER ______ HOURS

MEDCOM - 12245

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

'IENT IDENTIFICATION

EPW

[redacted]

b(6)-4

ISING UNIT 1CW2 | ROOM NO. | BED NO.

DATE OF ORDER 27 Jun 03 TIME OF ORDER 1710 HOURS | LIST TIME ORDER NOTED AN SIGN

~~1~~ Admit to ICW
~~2~~ NPO
~~3~~- IVF LR @ 100 cc/hr
~~4~~- VS per routine
~~5~~- I/O q shift
~~6~~- UP AD LIB
~~7~~- MSO4 1-2 mg q1° prn pain

IENT IDENTIFICATION

EPW

[redacted]

b(6)-4

DATE OF ORDER TIME OF ORDER ______ HOURS

~~8~~- Phenergan 25 mg IVPB q8° prn nausea
~~9~~- Heparin 5000 u SUB CUT q12°
~~10~~- Foley to Gravity

[redacted]

b(6)-2

:SING UNIT 1CW2 | ROOM NO. 24 VS 28 Jun03 0400 | BED NO.

IENT IDENTIFICATION

EPW

[redacted]

b(6)-4

DATE OF O[redacted] TIME OF ORDER

28 Jun 03 0815 HOURS

1- Regular Diet
2- Hep-lock IV
3- MSO4 1-4 mg q °
4- Wet Dressing Δ q shift

28 Jun 0900 b(6)-2

[redacted]

[redacted]

b(6)-2

SING UNIT 1CW2 | ROOM NO. | BED NO.

ENT IDENTIFICATION

EPW

[redacted]

b(6)-4

DATE OF ORDER T[redacted]

28 Jun 03 1700 HOURS

1- Percocet 1-2 po q4° prn pain
2- AC [illegible]

noted

[redacted]

b(6)-2

91WM6
28 Jun 03
1733

SING 1CW2 | ROOM NO. | BED NO.

MEDCOM - 12246

ACLU-RDI 1592 p.139

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

[redacted] b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

[redacted]

↓

DATE OF ORDER 28 Jun TIME OF ORDER 1900 HOURS

LIST TIME ORDER NOTED AND SIGN

NPO p̄ MN

for washout / DPC

28 Jun 03

2054

noted [redacted] b(6)-2

9100mg 28 June 03 1900

PATIENT IDENTIFICATION

EPW b(6)-2

[redacted] b(6)-4

DATE OF ORDER 29 Jun 03 TIME OF ORDER [redacted] HOURS

1. NPO

[redacted]

[redacted] 29 June 03 0640 hrs

b(6)-2

b(6)-2

NURSING UNIT ICW2 | ROOM NO. | BED NO. 7

PATIENT IDENTIFICATION

EPW

[redacted] b(6)-4

DATE OF ORDER 29 JUN 03 TIME OF ORDER ______ HOURS

1- ADMIT TO ICW

2- Clear Liquid Diet - May Advance

3- IVF LR @ 100cc/hr - Hep-lock when tolerating PO

4- VS per Routine

5- OOB c̄ assistance b(6)-2

6- I/O q shift

[redacted] 2030

NURSING UNIT ICW2 | ROOM NO. | BED NO. 7

PATIENT IDENTIFICATION

EPW

[redacted] b(6)-4

6/H/12

DATE OF ORDER TIME OF ORDER ______ HOURS

7- Percocet 1-2 PO q 3-4° prn pain

8- MSO4 1-2 mg q2° prn Breakthrough pain

9- Phenergan 25mg IVPB q 8° prn Nausea

10- Ancef 1gm q 8° IVPB

11- Heparin 5000 u SubQ q 12°

12- BID Dressing changes for anterior wounds only cut to [redacted]

NURSING UNIT ICW2 | ROOM NO. | BED NO. 7

DP / June [redacted] READ

DA FORM 1 APR 79 **4256** REPLACES [redacted] CH MAY BE USED.

b(6)-2

[redacted] b(6)-2

MEDCOM - 12247

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
EPW [redacted] b(6)-4

NURSING UNIT ICW2
ROOM NO. 24°/s 0000 1Jul03
BED NO. 7

↓

DATE OF ORDER 30Jun03
TIME OF ORDER 1600 HOURS
LIST TIME ORDER NOTED AND SIGN

① DC I/O's

② Continue to record JP output b(6)-2
per DS [redacted] chA
b(6)-2

nfb b(6)-2
[redacted]
1800

PATIENT IDENTIFICATION

NURSING UNIT
ROOM NO.
BED NO.

DATE OF ORDER
TIME OF ORDER HOURS

PATIENT IDENTIFICATION

NURSING UNIT
ROOM NO.
BED NO.

DATE OF ORDER
TIME OF ORDER HOURS

PATIENT IDENTIFICATION
EPW# [redacted] b(6)-4

NURSING UNIT ICW2
ROOM NO.
BED NO. 7

DATE OF ORDER
TIME OF ORDER HOURS

MEDCOM - 12248

All b(6)-2 except last

CLINICAL RECORD	**THERAPEUTIC DOCUMENTATION CARE PLAN** *(NON-MEDICATION)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	*Mo.* 6 *Yr.* 2003

VERIFY BY INITIALING — *INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION*

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED			
				27	28	29	
27	[redacted]	NPO	6	/	[redacted]	/	
			11	/		/	D/C 28Jun
			17	/		/	
27	[redacted]	VS PER Routine	5	/	[redacted]		
			13	[redacted]	[redacted]		
			21	[redacted]	[redacted]		
27	[redacted]	I + O's	5	/	[redacted]		
			13	[redacted]	[redacted]		
			21	[redacted]	[redacted]		
27	[redacted]	ACT: UP AD LIB	5	/	[redacted]		
			13	[redacted]	[redacted]		
			21	[redacted]	[redacted]		
27	[redacted]	Foley to Gravity	5	/	[redacted]	/	
			13	[redacted]		/	D/C 28Jun
			21	[redacted]		/	
28Jun	[redacted]	Regular diet	08	/	/	[redacted]	
			12	/	○	[redacted]	
			17	/	[redacted]	[redacted]	
28Jun	[redacted]	Dsg Δ's BID Wet → Dry	08	/	/	[redacted]	
			20	/	[redacted]	[redacted]	

ALLERGIES: ☒ YES ☐ NO

PCN

PRIMARY DIAGNOSIS: GSW buttocks & thighs

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ______

PATIENT IDENTIFICATION:

EPW [redacted] b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 EDITION OF 1 DEC 77 MAY BE USED. USAPA V1.00

MEDCOM - 12249

All b(6)-2

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo June *Yr* 2003

Verify by Initialing						
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
27	[redacted]	ADMIT TO ICW	27		1930	[redacted]
28	[redacted]	NPO p̄ MN for I+D washout	28	2400		[redacted]
29	[redacted]	NPO	29	now		

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING COMPLETION* TIME/DATE COMPLETED													

USAPA V1.00

MEDCOM - 12250

All b(6)-2 except last

CLINICAL RECORD

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

Mo. 6 *Yr.* 2003

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

VERIFY BY INITIALING

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 29	30	1	2	3	4	5
29	[redacted]	CL diet-adv as tol.	07	/	[redacted]	[redacted]				
			11	/	[redacted]	[redacted]				
			17	[redacted]	[redacted]	[redacted]				
			/							
29	[redacted]	VS per routine	06	/	[redacted]	[redacted]				
			14	[redacted]	[redacted]	[redacted]				
			22	[redacted]	[redacted]	[redacted]				
			/							
29	[redacted]	up c̄ assistance	06	/	[redacted]	[redacted]				
			14	[redacted]	[redacted]	[redacted]				
			22	[redacted]	[redacted]	[redacted]				
			/							
29	[redacted]	dressing changes BID for anterior wounds	08	/	[redacted]	[redacted]				
		only - wet to dry	20	[redacted]	[redacted]	[redacted]				
			/							
			/							
29	[redacted]	record JP output QS	06	[redacted]	[redacted]	[redacted]				
			14	[redacted]	[redacted]	[redacted]				
			20	[redacted]	[redacted]	[redacted]				
30	[redacted]	I/O q shift	05	/	[redacted]	D/C'd 30 Jun 03				
			13	/	[redacted]					
			21	[redacted]	[redacted]					

ALLERGIES: ☒ YES ☐ NO
PCN

PRIMARY DIAGNOSIS: S/P I&D thigh GSW Ⓡ

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
PAGE NO: ______

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

USAPA V1.00

DA FORM 4677, 1 OCT 78 EDITION OF 1 DEC 77 MAY BE USED.

MEDCOM - 12251

All b(6)-2

Verify Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*	*Mo* 6 *Yr* 2003

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
29	[redacted]	admit to FCW2	29	—		[redacted]
1	[redacted]	evac to Iraqi hospital				[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING COMPLETION* TIME/DATE COMPLETED													

USAPA V1.00

MEDCOM - 12252

All b(6)-2 except last

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. 06 *Yr* 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 27	28	24	30	1	2	3	4	5
27	[redacted]	IVP: LR@100cc/hr	5	/	[redacted]		/					
			13	[redacted]		/		D/C			28 Jun	
			21			/						
27	[redacted]	~~[illegible]~~ Heparin 5000u subcut Q12°	10	/	[redacted]							
			22	[redacted]								
27 Jun	[redacted]	HL: flush QS	05	/	[redacted]							
			13	/								
			21	/								

ALLERGIES: ☒ YES ☐ NO
PCN

PRIMARY DIAGNOSIS: GSW buttocks & thighs

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

PATIENT IDENTIFICATION:
EPW [redacted] 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 - 12253

All b(6)-2

Verify by Initialing	**THERAPEUTIC DOCUMENTATION CARE PLAN** *(MEDICATIONS)*	Mo. June 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			
27	[redacted]	MSO4 1-2mg Q1° prn pain	2mg 2230 IVP [redacted]	28 Jun 0530 2mg [redacted]	28 Jun 0300 2mg [redacted]	D'C 28 Jun
27	[redacted]	Phenergan 25mg IVP Q8° prn nausea				
28 VRn	[redacted]	MSO4 1-4 mg Q1° PRN	28 Jun 1020 4mg [redacted]	28 Jun 1345 4mg [redacted]		DC'd 28 June
28	[redacted]	Percocet i-ii po q4° prn pain	28 June 1735 [redacted]	28 June 0415 [redacted]	June 1000 2210 [redacted]	

USAPA V1.00

MEDCOM - 12254

ACLU-RDI 1592 p.147

All b(6)-2 except last

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. 6 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 29	30	1	2	3	4	5							
29	[redacted]	LR@100cc/hr - HL	06	/	[redacted]	[redacted]											
		When TOl PO	14	[redacted]	[redacted]	[redacted]											
		(HL 30 Jun 0630)	22	[redacted]	[redacted]	[redacted]											
			/														
29	[redacted]	ancef 1 gm q8°	06	/	[redacted]	[redacted]											
		IVPB	14	/	[redacted]	[redacted]											
			22	[redacted]	[redacted]	[redacted]											
			/														
29	[redacted]	Heparin 5000u	10	/	[redacted]	[redacted]											
		SQ q12°	22	[redacted]	[redacted]	[redacted]											

ALLERGIES: ☒ YES ☐ NO
PCN

PRIMARY DIAGNOSIS: S/P I&D GSW Ⓡ thigh

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

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

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 - 12255

A11 b(6)-2

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*	*Mo.* 6 *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													
29 2	[redacted]	Percocet 1-2 po q3-4° prn-pain	29 Jun ii [redacted] 1930	30 Jun 00:57 ii [redacted]	30 Jun 0800 ii [redacted]		30 Jun 1600 ii [redacted]	30 Jun 2000 ii [redacted]	30 Jun 2345 ii [redacted]	1 Jul 1630 ii [redacted]	1 Jul 2130 ii [redacted]					
-----	-----															
29 2	[redacted]	MSO4 1-2mg q2° prn-breakthrough pain	29 Jun 2mg [redacted] 1930	30 Jun 2mg 1030 [redacted]												
-----	-----															
29 13	[redacted]	Phenergan 25mg IVPB q8° prn-nausea														
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															

USAPA V1.00

MEDCOM - 12256

100Kg

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE **Post-Anesthesia Care Unit (PACU) Flow Sheet**

OTSG APPROVED *(Date)*

Date: 27 JUN
Time In: 1815
Allergies: NKA
Pre-op V/S: 133/72 HR 90
Procedures: Wash out GSW buttock & thighs

Anesthesia Type (Circle): [✓ General] Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 1200 LR Colloid
OR Output: UOP 1800 EBL minimal
Meds/Times:

3 versed
200mcg fent
50gMSO4

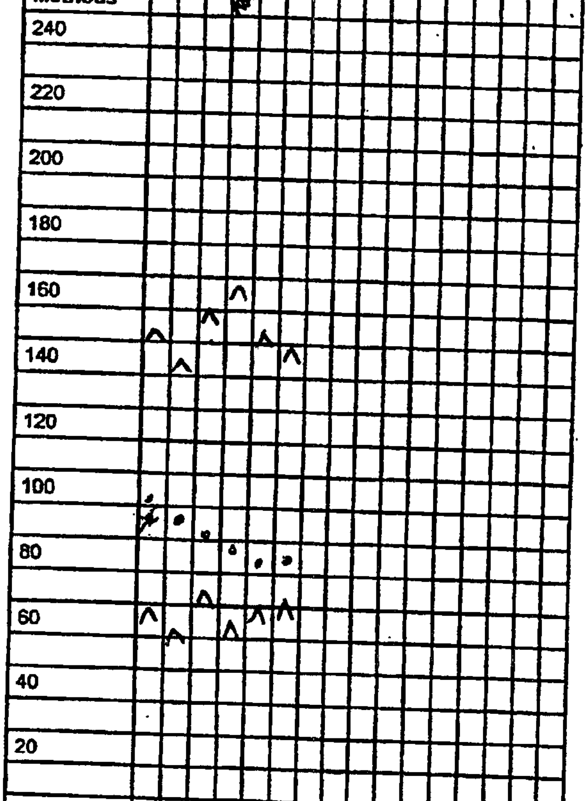
Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds

History

Time	1815	1822	1829	1845	1900	1935	[illegible]
SaO2	97	96	96	100	96	98	
FiO2	RA	RA	RA	10L	RA	RA	
Methods				[illegible]			



RR	18	20	14	16	18	18
T	99		100		100.3	100

Time	1815	1825	1900					
Pain (0-10)	0	0	0					
LOS								

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays:
Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	1	1
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	/	/	/
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	9	9	9

Codes

AIRWAY
A = Ambu
BB = Blow-by
M = Mask
FT = Face Tent
RA = RoomAir
NC = Nasal Cannula

V/S
X = A-line BP
˅ = Cuff BP
˄ = Pulse

TEMP
S = Skin
O = Oral
A = Axillary
T = Tympanic
R = Rectal

LOS
C = Cervical
T = Thoracic
L = Lumbar
S = Sacral

Patient teaching done: Wound Care, Pain Management,
T, C, & DB,. Incentive Spirometer, Comfort Measures
Safety: SR up X 2, Falls Precautions. Privacy Maintained

(Continue on reverse)

PREPARED BY *(Signature & Title)* [redacted] b(6)-2
SPC 91WM6

DEPARTMENT/SERVICE/CLINIC ICU2/PACU

DATE 27 JUN 03

entries give: *Name — last, ... medical facility)*

EPW
[redacted] b(6)-4
35 yo ♂

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

DA FORM 4700, MAY 78

WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN)

Previous edition is obsolete
USAPPC V2.00

MEDCOM - 12257

A11 b(6)-2

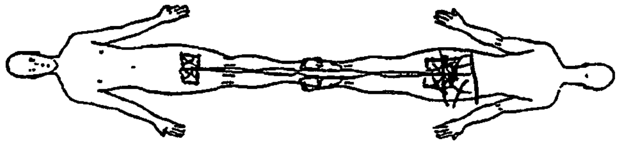
MEDICATIONS						
Allergies:						
Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By

NEUROVASCULAR							
Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm							
15'							
30'							
45'							
60'							
90'							
D/C							

Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic, P = Pale, Pk = Pink
Capillary Refill: B = Brisk, S = Sluggish

C-SECTIONS							
	Adm	15'	30'	45'	60'	90'	D/C
Fund. Height							
Lochia							
Peripad#							
Fund. Cond.							

DRESSINGS			
Time	Location	Type	Drainage
Adm	R+L inner thighs buttocks	6"x8" gauze	minimal
30'	"	"	minimal
60'	"	"	
D/C	"	"	



PACU OUTPUT			
Time	Source	Color/Appearance	Amount
1920	foley	Clear, Yellow	625

CARDIAC RHYTHM			
Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

1815 Pt arrived from OR via litter. lung Sounds clear bilaterally apex to base. RR equal + unlabored. O_2 Sat 96-99% RA. BS active x4 Quadrants. Radial + pedal pulses strong + equal to palpation. Cap Refill <3sec to all extremities. LR @ 100cc/hr to (L) forearm. No c/o pain. Alert to verbal stimuli. ———— SPC [redacted] 91WM6

1825 Pt placed on 10L Non-Rebreather for O_2 Sat of 88% RA. Will wean as tolerated SPC [redacted] 91W

1842 Dressings to pt buttocks + bilateral inner thighs. 6"x8" gauze c̄ tape. Drainage noted, minimal > (R) thigh.

1846 Pt removed from 10L Non-Rebreather, placed on RA. Maintained O_2 Sat @ 100% RA, RR 20. Will continue to monitor. SPC [redacted] 91WM

1919 Pt temp 101.3°. MD informed. SPC [redacted] 91WM

1925 Report given to ICW #2. SPC [redacted] 91W

1928 Pt able to wiggle toes on (L) extremity + able to move/bend (R) knee, ; pt not able to wiggle toes on (R) foot. - SPC [redacted] 91

Discharge Criteria:
Date: 27JUN03 Time: 1930 PARS: 9
BP: 139/62 T: 100.9 HR: 74 RR: 18 Sa02: 98% RA
Pain Level at D/C (0-10):
Intake: 200cc LR Output: 625cc
Additional Data: ~~NSA~~ temp 101.3 MD aware
Transferred To: ICW #2
Report Given To: 1LT [redacted]
Transferred Via: W/C [✓ Litter] Gurney Ambulance
Transferred By: SPC [redacted]
Cleared IAW Recovery Room SO [redacted]
Charge Nurse Signature: [redacted]

Name:
SSN:
DOB:
Unit:
Nationality:

HT:
WT: lb
WT: kg

DATE:
TIME:

Additional Orders/Charting:

Use Form [illegible]

1. Admit:	OR; ICU; Holding:
2. **Diagnosis:**	
3. Condition:	VSI SI Critical Guarded Stable
4. **Allergies:**	
5. **VS:** Q5-	15 min; Q1 hr; Q2 hrs; Q4 hrs; Q___ hrs; Notify MD for SBP: > ____ or < ___; DBP: > ___ or < ___; HR: > ____, < ____; RR: > ____, < ____; Temp: > _____
6. **IVF:** L	R @ _____ cc/hr; NS @ ______ cc/hr; Albumin @ ____ cc/hr; Hespan @ _____ cc/hr
7. Monitor:	Cardiac; Pulse Ox; Neuro Q ____ m/hr; A-line;
8. I&O: Q	1 hr; Q ____ hrs
9. Drains: N	G to Low or Cont suction; Foley to gravity
10. CT #1:	20 cm H2O suction, H2O seal; Heimlich
11. CT #2:	20 cm H2O suction, H2O seal; Heimlich
12. **LABS:**	ABG now & Q1 hr; Q2 hrs; Q ___ hrs; PRN Hct now & Q ___ hrs; Chem now & Q ___ hrs; UA
13. **BLOOD:**	T&S ____ units; T&C ____ units; Transfuse: ___ units PRBC or Whole Blood for Hct < ___ %
14. **Oxygen:**	2L NC; 4L NC; 5L FM; NRB _________; Keep Stats > 92%, > 95%
15. Diet: N	PO, Sips of H2O, Clear liq, Regular, Other ____
16. Activity:	Bed rest; BRP; Ward/Unit; Other ________
17. **MEDS:**	
Morphine	2, 4, or 6 mg IVP Q ____ min/hr prn Pain
Demerol	12.5 mg; 25 mg; 50-75 mg IVP prn Pain/chills
Zofran 2-	4 mg IVP Q ___ hrs prn Nausea
Zantac 5	0 mg IVPB Q 8 hrs
Abx: An	cef 1 gram in 100cc NS IVPB Q6-8 hrs
Abx: Ce	fotan 2 grams in 100cc NS IVPB Q12 hrs
Abx: Cli	ndamycin 600 or 900mg in 100cc NS IVPB
Abx: Pen	G 2 mil units in 100cc NS IVPB Q4-6 hrs
Abx: Ge	ntamicin 5 or 7 mg/kg/day IVBP over 30 min
18. **VENT:**	SIMV; TV: ____; RR: ___; Fio2: ___%; PEEP
ABG Q	___ hrs;
19. **Ortho:**	Wound Irrigation w/ NS; Batadine & Gauze Dsg
Soiled D	sg = Reinforce & notify MD; Splint; Cast
Neurova	scular checks Q ___ hrs; Distal Pulse/Circulation
Elevate	extremity above heart on blankets
20. X-Ray:	
21. **EVAC:**	Priority w/in 4-6 hrs; Routine w/in 24 hrs;

274th FST Doctors Orders +, by CPT [redacted] as of 29 Nov 2001

b(6)-2

DATE: 27 Jun 03
TIME: 1000 b(6)-4
Name: [redacted]
SSN: 33 yo IM
DOB:
Unit:
Nationality: Iraqi

HT:
WT: lb
WT: 100 kg

Additional Orders w/ Date & Time/Charting:

1. **Admit:** Recovery transfer to ICU ... Holding Company
2. **Diagnosis:** s/p GSW (R) Thigh / (R) Buttock.
3. **Condition:** VSI SI Critical Guarded [✓ Stable]
4. **Allergies:** PCN → Ceph ok.
5. **VS:** [✓ Q 1 hr]; Q 2 hrs; Q 4 hrs; Q 8 hrs.
Notify MD for SBP: >180 or <90; DBP: >100 <50;
HR: >120, <60; RR: >30, <10; Temp: > 101
6. **IVF:** IVF; [✓ LR] @ 100 cc/hr; NS @ ____ cc/hr;
7. **Monitor:** [✓ Cardiac]; [✓ Pulse Ox]; Neuro Checks Q ____ m/hr; A-line:
8. **I & Os:** [✓ Q1 hr]; Q ____ hrs
9. **Drains:** NG to Low/Cont suction; JP Drain; [✓ Foley] to gravity
10. **Chest Tube:** 20 cm H2O suction, H2O seal; Heimlich
11. **LABS:** ABG now & Q1 hr; Q2 hrs; Q ____ hrs; PRN
Hct now & Q ____ hrs; Chem now & Q ____ hrs; Urine Dip
12. **BLOOD:** T & S ____ units; T & C ____ units;
Transfuse: ____ units PRBC or Whole Blood for Hct < ____ %
13. **Oxygen:** 2L NC; [✓ 4L NC]; 5L FM; NRB; ________
Keep Stats > 92%, > 95%, ________
14. **VENT:** SIMV; TV: ____; RR: ____; Fio2: ____ %; PEEP: ____;
15. **Diet:** [✓ NPO]; Sips of H2O, Clear liquids, Regular, MRE,
16. **Activity:** [✓ Bed Rest]; BRP; HOB Up; Holding area/Unit; Other ____
17. **MEDS:** Morphine 2, 4, or 6 mg IVP Q 1° min/hr prn Pain
Demerol 12.5 mg; 25 mg; 50-75 mg IVP prn Pain/shivering
Toradol 15/30 mg IVP/IM Q 6 hrs/prn Pain (up to 5 days)
Percocet 1 -2 tabs or Tylenol III 1-2 tabs PO Q 6 hrs prn Pain
[✓ Zofran 2-4 mg] or Phenergan 12.5 – 25 mg IVP Q ____ hrs prn Nausea
[✓ Zantac 50 mg] IVPB Q 8 hrs
Vent Sedation: Diprivan / Propafol: 5–50 mcg/kg/min on a pump
Sedation: Versed (1mg/ml) 1mg slow IVP q2-3min up to 5mg b6-2
Abx: Ancef 1 gram in 100cc NS IVPB Q6-8 hrs
[✓ Abx: Cefotan] 2 grams in 100cc NS IVPB Q12 hrs (1st dose at 0730 [redacted]
Abx: Clindamycin 600 - 900mg 100cc NS IVPB over 30 minQ8 hrs
Abx: Gentamicin 5 or 7 mg/kg/day IVBP over 30 min Q day
Abx: Pen G 2 mil units in 100cc NS IVPB Q4-6 hrs
Abx: Unasyn 1.5 or 3 grams in 100cc NS IVPB Q 6 hrs

18. **Ortho:** Wound Irrigation w/ NS; Batadine & Gauze Dsg
Soiled Dsg = Reinforce & notify MD; Splint; Cast
[✓ Neurovascular checks] Q 1 hrs; [✓ Distal Pulse/Circulation]
Elevate extremity above heart on blankets
19. **Wound Care:** Wet to Dry Dsg Change NS Q ____ to ____
20. **BURNS:** IVF of LR: 4 cc/% BSA burn/kg = total 24 hr fluids;
Give ½ over 1st 8 hrs from Time of Burn; Clean Sterile dsg
21. **Head Injury:** Neuro checks (GCS) Q ____ min/hrs;
C-Spine: Clear/NOT Clear; Keep Head in midl[redacted]ion;
Mannitol (20%): 0.25/0.50/1 gm/kg IV
Notify MD for Mental Status c
20. **EVAC:** Priority [✓ w/in 4-6 hrs]
21. **Signature of Provider:** MD
274th FST Post-OP Orders, By CP

b(6)-2

MEDCOM - 12260

Initial Assessment:
Date 27 June 03 Time 0452

TH FORWARD SURGICAL TE

ICU____
OR____

NEUROLOGICAL ASSESSMENT

2 3 4 5 6 7 8 9

Pupil	Size	Reaction	Pupil	Size	Reaction
OD			OS		

Pupil Reaction: R - Reactive N - Non-Reactive

Level on Consciousness
☒ Awake ☐ Alert ☐ Drowsy
☐ Restlessness ☐ Lethargic
☐ Unconscious

Orientation:
☐ Time ☐ Place ☐ Person

Eyes Open:
☐ Spontaneous
☐ To Speech
☐ To Pain
☐ No Response

Best Verbal:
☒ Oriented & Converses
☐ Disoriented & Converses
☐ Inappropriate Words
☐ Incomprehensible Sound
☐ No Response

Best Motor:
☒ Obeys Commands
☐ Localizes Pain
☐ Extension
☐ No Response

Motor Ability & Strength:

	Strong	Weak	Absent
RA	5/5		
LA	5/5		
RL		4/5	
LL	5/5		

PSYCHOLOGICAL
☐ Calm ☐ Combative
☐ Cooperative ☒ Anxious

INTEGUMENTARY
Color:
☒ Normal
☐ Pale
☐ Flushed
☐ Cyanotic
☐ Jaundiced

Skin:
☒ Warm
☒ Dry
☐ Diaphoretic
☐ Cool
☐ Clammy

RESPIRATORY
☒ Unlabored ☐ Labored

Breath Sounds:
☒ Clear Bilaterally
☐ Absent R L
☐ Rales R L
☐ Wheezes R L

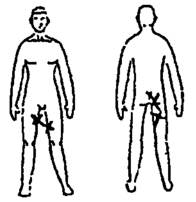
ABDOMINAL
☒ Soft ☐ Tender
☐ Rigid ☐ Non-Tender
☐ Distended ☐ Rebound

Bowel Sounds:
☐ Active ☐ Hypoactive
☐ Hyperactive ☐ Absent

CARDIOVASCULAR

Pulses	Right	Left
Brachial		
Radial		
Femoral		
Pedal		
Edema		

0-Absent + 2-Normal
- 1-Weak + 3-Bounding



Time	Temp	P	R	B/P	NURSING OBSERVATIONS/INTERVENTIONS
0510		93	18	130/68	Iraqi ♂ approx 36 y/o c GSW
0545		80	18	116/64	to upper (R) thigh, (R) buttcks cheek,
					& upper (L) thigh, Pt recieved
					16 gu IV in (R) arm & 18 gu
					IV in (L) arm - of LR.

Allergies

Time	IV	MEDICATIONS (dose/route site)
0502	4mg	Morphine [redacted] b(6)-2
~~05~~	~~1g~~	~~Ancef~~ Not given 2° possible allergies
0540	3mg	Morphine

INTAKE/OUTPUT	Time	IV	Urine	Chest	Gastric	Pertinent Lab Values
	Total:					

b(6)-4

[redacted]

33 y/o IM

ATLS WORKUP SHEET

DA FORM 4700 274th FST OP 1

MEDCOM - 12261

Remove Drain Ⓛ thigh
packed w/ gauze Ⓡ thigh

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE Post-Anesthesia Care Unit (PACU) Flow Sheet

OTSG APPROVED *(Date)*

Date: 27 Jun 03
Time In: 1015
Allergies: Penicillin
Pre-op V/S:
Procedures:
GSW Ⓛ thigh Ⓡ buttock

Anesthesia Type (Circle)): [✓ General] Spinal Epidural IV Sedation Nerve Block [redacted]
OR Intake: Crystalloid 3700 Colloid
OR Output: UOP 900 EBL 100
Meds/Times: 10mg MSO4

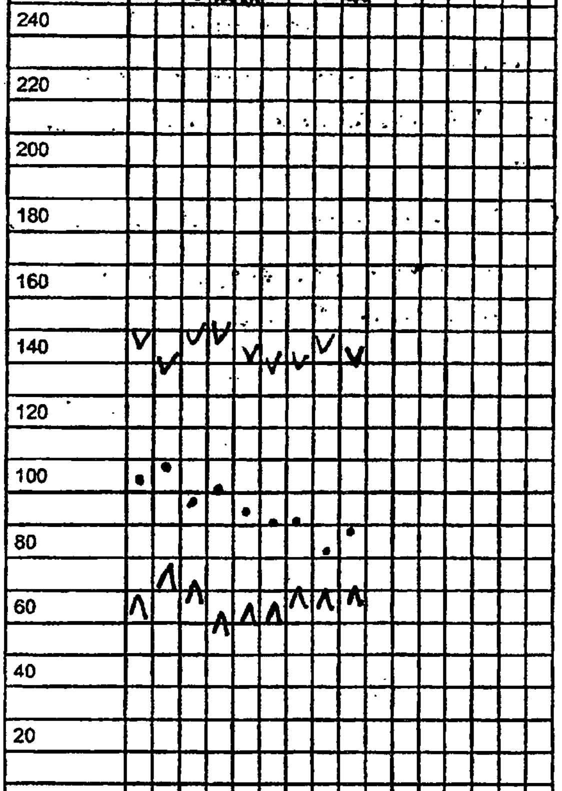
Drains
Hemovac
NG
JP
T-tube
[✓ Foley]
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds

History

Time	1015	1020	1025	1030	1045	1100	1115	1145	1215
SaO2	98	99	93	97	96	95	96	96	95
FiO2	3L	3L							
Methods	FM	FM	RA	RA	RA	RA	RA	RA	RA



RR	12	10	13	16	17	14	13	15	11
T									

Time								
Pain (0-10)								
LOS								

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1115	LR	150cc	Ⓛ Ⓛ		
1215	LR/NaCl	200cc	Ⓛ FA		

X-rays:

Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	2	2	
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	/	/	
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	10	10	

Codes

AIRWAY
A = Ambu
BB = Blow-by
M = Mask
FT = Face Tent
RA = RoomAir
NC = Nasal Cannula

V/S
X = A-line BP
˅ = Cuff BP
• = Pulse

TEMP
S = Skin
O = Oral
A = Axillary
T = Tympanic
R = Rectal

LOS
C = Cervical
T = Thoracic
L = Lumbar
S = Sacral

Patient teaching done; Wound Care, Pain Management.
T, C, & DB,. Incentive Spirometer, Comfort Measures
Safety: SR up X 2, Falls Precautions. Privacy Maintained

(Continue on reverse)

PREPARED BY *(Signature & Title)*

DEPARTMENT/SERVICE/CLINIC

DATE

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

Name — last,

[redacted] b(6)-4
37 y/o ♂

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

DA FORM 4700, MAY 78 WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) Previous edition is obsolete
USAPPC V2.00

[redacted]

A11 b(6)-2

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1046		MSO4 4mg	IVP			[redacted]
1219		MSO4 4mg	IVP			[redacted]

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	Foot		+	P	B	W	
15'	Foot		+	P	B	W	
30'	Foot		+	P	B	W	
45'	Foot		+	P	B	W	
60'	Foot		+	P	B	W	
90'							
D/C							

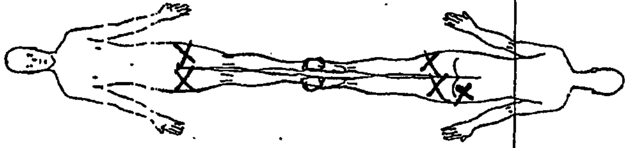
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent Color: C = Cyanotic, P = Pale, Pk = Pink
Capillary Refill: B = Brisk, S = Sluggish

C-SECTIONS

	Adm	15'	30'	45'	60'	90'	D/C
Fund. Height							
Lochia							
Peripad#							
Fund. Cond.							

DRESSINGS

Time	Location	Type	Drainage
Adm	Bilat Thigh	Gauze	CDI
30'	Bilat thigh	Gauze	CDI
60'	Ⓡ thigh	Ace wrap	red drainage
D/C	Bilat thigh	Gauze	CDI



PACU OUTPUT

Time	Source	Color/Appearance	Amount
1115	Foley	clear yellow	380 mL
1215	Foley	clear yellow	280 mL

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1015	NSR	N/A	
1045	NSR	N/A	

WAMC OP 173-E

NURSING NOTES

1015 - Pt arrived from OR via litter. Responsive to voice, LCTA all fields, respiratory effort even unlabored. Skin warm, dry, color wnl. IV running LR Ⓛ FA & Ⓡ AC. S_1 S_2 present cap refill < 2 sec. Bandages to bilateral thigh & Ⓛ buttock. Penrose drains bilateral thigh. Foley to gravity. Strong, active, movements all extremities. —— [redacted]

1016 - Strong palpable radial & pedal pulses bilat.

1115 - PMS present bilateral lower extremities skin warm dry —— [redacted]

1146 - Dressing reinforced Ⓡ thigh due to seepage - [redacted]

1156 - IV Ⓡ AC D/c'd, sluggish flow poor draw back. IV Ⓛ FA ↑ 1000 cc NaCl 0.9% — [redacted]

Discharge Criteria:

Date: **Time:** **PARS:**

BP: **T:** **HR:** **RR:** **SaO2:**

Pain Level at D/C (0-10):

Intake:______ **Output:**______

Additional Data:______

Transferred To:______

Report Given To:______

Transferred Via: W/C Litter Gurney Ambulance

Transferred By:______

Cleared IAW Recovery Room SOP B-3

Charge Nurse Signature:______

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE Post-Anesthesia Care Unit (PACU) Flow Sheet

OTSG APPROVED *(Date)*

Date: 29 June 03 Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
Time In: 1900
Allergies: NKA OR Intake: Crystalloid ________ Colloid ________
Pre-op V/S: ________ OR Output: UOP ________ EBL ________
Procedures: ________ Meds/Times: ________

Pre Op Meds History

Drains	Airway
Hemovac	Nasal
NG	Oral
JP	ETT
T-tube	Trach
Foley	Other
TLS	

Time	1900	1905	1910	1920	1930
SaO2	100	100	100	97	97
FiO2	4L	4L	4L	RA	RA
Methods	FM	FM	FM	/	
240					
220					
200					
180					
160					
140	v		v	V	
		V			V
120					
100	⊙	•		•	
80					
	^	^	^	^	^
60					
40					
20					
RR	12	8		9	7
T	[illegible]	[illegible]	100.9		100

Time					
Pain (0-10)					
LOS					

Patient teaching done; Wound Care, Pain Management,
T, C, & DB., Incentive Spirometer, Comfort Measures
Safety: SR up X 2, Falls Precautions. Privacy Maintained

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	1	1	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	2	2	2
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	10	11	12

Codes

AIRWAY
A = Ambu
BB = Blow-by
M = Mask
FT = Face Tent
RA = RoomAir
NC = Nasal Cannula

V/S
X = A-line BP
˅ = Cuff BP
⊙ = Pulse

TEMP
S = Skin
O = Oral
A = Axillary
T = Tympanic
R = Rectal

LOS
C = Cervical
T = Thoracic
L = Lumbar
S = Sacral

PREPARED BY *(Signature & Title)* [redacted] b(6)-2

DEPARTMENT/SERVICE/CLINIC ICU 1

(Continue on reverse)

DATE 29 JUN 03

PATIENT'S [redacted] *first, middle; grade; date; hospital or medical facility)* Name — last,

[redacted] b(6)-4

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

DA FORM 4700, MAY 78 WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN)

Previous edition is obsolete
USAPPC V2.00

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm							
15'							
30'							
45'							
60'							
90'							
D/C							

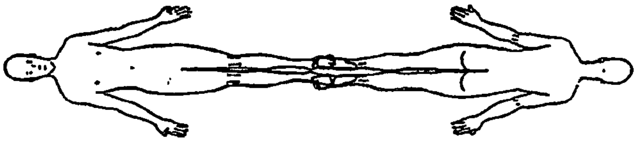
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic, P = Pale, Pk = Pink
Capillary Refill: B = Brisk, S = Sluggish

C-SECTIONS

	Adm	15'	30'	45'	60'	90'	D/C
Fund. Height							
Lochia							
Peripad#							
Fund. Cond.							

DRESSINGS

Time	Location	Type	Drainage
Adm			
30'	Ⓡ inner thigh buttock	guaze, tape	Ø
60'	Ⓛ thigh inner	guaze, tape	Ø
D/C	"	"	"



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1925	ST-117	—	—

WAMC OP 173-E

NURSING NOTES

Pt Brought To ICU 1 Via Litter For Recovery. Anesthesia @ Bs. O2 Sat 100% upon Arrival c̄ O2 @ 6L Non ReBreather [redacted]/RN

b(6)-2

Discharge Criteria:
Date: **Time:** **PARS:**
BP: **T:** **HR:** **RR:** **Sa02:**
Pain Level at D/C (0-10):
Intake:____________ **Output:**____________
Additional Data:____________
Transferred To:____________
Report Given To:____________
Transferred Via: W/C [✓ Litter] Gurney Ambulance
Transferred By:____________
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature:____________

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF

1	2	3	4	5	6
A	1	1	D	1	▨

2. MTF LOCATION *(State or Country Code.)*

7	8
I	Z

3. REGISTER NUMBER

9	10	11	12	13	14	15
[redacted]						

NAME *(Last, First, Middle Initial)*: EPW# [redacted] b(6)-4

4. PAY GRADE

16	17
EPW	

5. SEX

18
M

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

19	20	21	22	23	24	25	26

7. AGE AT ADMISSION

27	28	29
0	3	5

8. RACE

30
Z

9. ETHNIC BACKGROUND

31
Z

RELIGION: UNK

10. LENGTH OF SERVICE

32	33	34

ETS

11. FMP

35	36
9	9

12. SOCIAL SECURITY NUMBER

37	38	39	40	41	42	43	44	45
[redacted]								

ORGANIZATION *(Active Duty Only)*

13. MARITAL STATUS

46
Z

HOUR OF ADMISSION: 1710

BRANCH / CORPS: b(6)-4

14. FLYING STATUS

47	48	49

15. BENEFICIARY CATEGORY

50	51	52

16. ZIP CODE OF RESIDENCE

53	54	55	56	57	58	59	60	61

17. UNIT LOCATION *(State or Country Code)*

62	63

18. MOS

64	65	66	67	68	69	70

19. TRAUMA

71
9

PREV. ADMISSION

YEAR ☒ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION

72
0

WARD: ICW#2

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: UNK

ADDRESS OF EMERGENCY ADDRESSEE *(Include ZIP Code)*: UNK

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE: UNK

[redacted] b(2)-2

21. TYPE OF DISPOSITION

73	74
2	1

22. MTF TRANSFERRED TO

75	76	77	78	79	80

23. DATE OF DISPOSITION *(Y Y M M D D)*

81	82	83	84	85	86
6	3	0	7	0	7

24. CLINIC SVC - ADMITTING

87	88	89	90
A	E	A	A

25. MTF TRANSFERRED FROM

91	92	93	94	95	96

26. DATE THIS ADMISSION *(Y Y M M D D)*

97	98	99	100	101	102
0	3	0	6	2	7

27. LOCATION OF OCCURRENCE *(Battle Casualty Only)*

103	104

28. MTF OF INITIAL ADMISSION

105	106	107	108	109	110

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

111	112	113	114	115	116

FOR LOCAL USE

Dx: GSW to buttocks & Thighs

b(6)-2

[redacted]

Dx 8770
8900
9560
E9912 Trauma 9
Proc 860
8659
96
Inj 569
1A

ADMITTING OFFICER *(Signa*[redacted]: DR. [redacted]

SIGNATU[redacted]**TTING CLERK**: [redacted] b(6)-2

DA FORM 2985, MAR 90

MEDCOM - 12266

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF

1	2	3	4	5	6
A	1	1	D	1	▨

2. LOCATION (State or Country Code.)

7	8
I	Z

3. REGISTER NUMBER

9	10	11	12	13	14	15
[redacted]						

NAME (Last, First, Middle Initial) b(6)-4 EPW # b(6)-4 [redacted] [redacted]

4. PAY GRADE

16	17

EPW

5. SEX

18
M

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

19	20	21	22	23	24	25	26

7. AGE AT ADMISSION

27	28	29
0	3	7

8. RACE

30
Z

9. ETHNIC BACKGROUND

31
Z

RELIGION UNK

10. LENGTH OF SERVICE

32	33	34

ETS

11. FMP

35	36
9	9

12. SOCIAL SECURITY NUMBER

37	38	39	40	41	42	43	44	45
[redacted]								

ORGANIZATION (Active Duty Only)

13. MARITAL STATUS

46

HOUR OF ADMISSION 1373

BRANCH / CORPS b(6)-4

14. FLYING STATUS

47	48	49

15. BENEFICIARY CATEGORY

50	51	52

16. ZIP CODE OF RESIDENCE

53	54	55	56	57	58	59	60	61

17. UNIT LOCATION (State or Country Code)

62	63

18. MOS

64	65	66	67	68	69	70

19. TRAUMA

71

PREV. ADMISSION

YEAR ☐ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION

72
0

WARD ICU#2

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE UNK

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) UNK

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE UNK

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] b(2)-2

21. TYPE OF DISPOSITION

73	74
5	0

22. MTF TRANSFERRED TO

75	76	77	78	79	80

23. DATE OF DISPOSITION (Y Y M M D D)

81	82	83	84	85	86
0	3	0	6	2	7

24. CLINIC SVC - ADMITTING

87	88	89	90
A	E	A	A

25. MTF TRANSFERRED FROM

91	92	93	94	95	96

26. DATE THIS ADMISSION (Y Y M M D D)

97	98	99	100	101	102
0	3	0	6	2	7

27. LOCATION OF OCCURRENCE (Battle Casualty Only)

103	104

28. MTF OF INITIAL ADMISSION

105	106	107	108	109	110

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

111	112	~~113~~	~~114~~	~~115~~	~~116~~

FOR LOCAL USE

DX · GSW Bilateral thighs & Buttocks

Dx 8901 Trauma
8771 Inj 56

Proc 8605 x 3
4823

b(6)-2

[redacted]

ADMITTING OFFICER Dr. [redacted]

SIGNATURE OF ADMITTING CLERK [redacted] b(6)-2

DA FORM

MEDCOM - 12267

INPATIENT TREATMENT RECORD COVER S

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

[redacted]

1. REGISTER NUMBER [redacted]

2. NAME (Last, First, MI) EPW# [redacted] b(6)-4

3. GRADE EPW

4. SEX m

5. AGE 23y

6. RACE —

7. RELIGION —

8. LENGTH OF SVC —

9. ETS —

10. PREVIOUS ADMISSION NO

11. FMP 99

12. SSN [redacted]

13. ORGANIZATION —

14. WARD ICW1

15. FLYING STATUS —

16. RATING/DSG —

17. DEPT BED b(6)-4 K78

18. BRANCH/CORPS —

19. UIC/ZIP —

20. TYPE CASE NBI

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct from ER

22. HOURS OF ADMISSION 1534

23. CLINIC SERVICE ABAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE UNK

25. TYPE DISPOSITION 50

26. DATE OF DISPOSITION 26 July 03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) UNK

27b. TELEPHONE NO. —

28. DATE OF THIS ADMISSION 28 June 03

ADMISSION REMARKS

b(6)-2

ADMITTING OFFICER Dr [redacted]

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] b(2)-2

30. DATE OF INTIAL ADMISSION

32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Dx: S/P Colostomy / I&D Ⓛ FA

863.54
821.10
813.32
879.4
E922.9
958.8

78.53
79.62
86.28
86.59
54.62

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	[redacted]	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0		0	22	22

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	[redacted]	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
					—

SIGNATURE OF ATTENDING MEDICAL O [redacted] DR

MEDICAL RECORDS OFFICER

DA FORM

EDITION OF 1 AUG 78 IS OBSOLETE

USAPPC V1.10

b(6)-2

MEDCOM - 12268

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

PERTINENT HISTORY, CHIEF COMPLAINT, AND CONDITION ON ADMISSION *(Enter date of admission)*

23 yo Iraqi male states he was in taxi with a friend. His friend fired a weapon in the air. US Army returned fire. No firearm @ scene

All	PMH	PSH	TOB	Meds
Ø	Ø	ASS	Ø	Ø,

PHYSICAL EXAMINATION

NC AT   HR 88   117/57   99% SAT

Neck clr

Chest CBTA

Cor RRR 2+PP. Ⓛ Ulnar Abs a Ⓛ Ø

Abd Ⓛ flank wound @ iliac crest

Appears SQ tract.

Pelvis stable GU normal

rectal nl tone Hem⊖

ext thru & thru Ⓛ arm

GSW c soft tissue loss

ulnar nerve out median

compromise

Ⓡ knee GSW entrance wound

NVI

PROGRESS *(Enter date of discharge and final diagnosis)*

A/P GSW to Ⓛ Fore Arm, Ⓛ Flank Ⓡ Knee.

① CT Abd/pelvis

② to OR for Ⓛ Fore Arm I/D

b(6)-2

SIGN[redacted]	28JUN03	IDENTIFICATION NO.	ORGANIZATION
PATI[redacted]e Name last, first, grade, date; hospital or medical facility)		REGISTER NO.	WARD NO.

[redacted] b(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
USAPPC V1.00

NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
28JUN03	Surgery Brief op note
1830	indication GSW to Abd
	Procedure - Ex LAP, (L) colon Resection
	Descending colostomy with [illegible] pouch.
	Surgeon b(6)-2 [redacted] / [redacted] b(6)-2
	Anesth - GETA .
	Fluids 1700 LR UO 450
	EBL 50
	Findings ⓔ Through & through GSW to (L) colon
	@ Junction c̄ Sigmoid. Area Resected
	end Descending colostomy 'Hartman
	pouch.
	No ureteral/vascular injury.
	Comp None
	to ICU in good cond.
	[redacted] b(6)-2

AUTHORIZED FOR LOC

DICAL RECORD | PROGRESS NOTES

DATE | NOTES

1 July 03
0245
Pt transferred from ICU @ 2330, Pt had heart rate @125, c/o pain. 4mg MSO4 IVP given @0040. At 0100 pt had no c/o pain hr=95. Lung sounds CTA, BS⊕x4. Pt on 1-2L O2 via nasal cannula, sats>95%. Foley output CYU, insertion site CDI. Colostomy bag c̄ minimal output, site CDI. Pt with NG tube clamped, green residue in tube. Dsg on RLE, inner thigh CDI. Dsg's on Abd CDI; LUE dsg CDI, pt c̄ ⊕ sensation and rom. C/o slight irritation in throat. Will continue to monitor. SPC [redacted] 91WM6 b(6)-2

1 July 03
0715
MD Progress

POD # 3 Had I+D Ⓛ arm yesterday + t'fered to ICW

S/ No complaints. No nausea. Some pain in Ⓛ arm

O/ Afebrile HR 120's BP 126/78
Abd soft ND ⊕BS Ostomy pink ∅gas
Incision CDI JP pulled yesterday
6.9 > 28 <

A/ Doing well. Bowel function returning

P/ 1) PO pain meds
2) NGT pulled
3) Clear diet
4) D/C Cefotetan. Ancef for Fx
5) Clear diet
6) Transfer to Iraqi hospital if civilian status. If not will keep until tol reg diet + t'fer to EPW camp. b(6)-2
7) OK this per Dr [redacted]

NSHIP TO SPONSOR | SPONSOR'S NAME | LAST | FIRST | SPONSOR'S SSN or Other

SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED

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

REGISTER NO

[redacted] b(6)-4
EPW

PROGRESS NOTES
Medical Record
STANDARD FORM 50

AUTHORIZED FOR LOC

:DICAL RECORD | PROGRESS NOTES

DATE	NOTES
1 July03	0740 D/C Pt foley cath withdrew 9cc of normal saline ——— Spc [redacted] b(6)-2
1000	Assumed care of pt @ 0500. VSS. Pt is on 1L O2 NC - Sats are 98%. Lowered O2 to ½L - pt still sats @ 98%. Pt was given ~~to~~ percocet ii tabs @ 0710. Pt has LR. IV in Ⓡ arm. Ⓛ lower arm in cast. Elevated on pillow. Pt is now resting comfortably. ——— b(6)-2 [redacted] 91WM6, SGT
1Jul03 1845	assumed care @ 1300 - VSS - staples intact on abdomen, small amount of sero-sang. drainage near navel, colostomy Ø output, bag in place, stoma pink moist - bandage CDI on Ⓛ FA - pt. urinated 700cc @ 1600 - through interpreter pt. made aware that colostomy would remain for life, pt. stated understanding and disappointment - IV SL patent, abx continue - medicated for Ⓛ arm pain c̄ ii percocet PO - pt. tolerated tang, jello & H2O for dinner [redacted] b(6)-2

NSHIP TO SPONSOR	SPONSOR'S NAME LAST	FIRST	MI	SPONSOR'S (SSN or Other
/SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		
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.	

[redacted] b(6)-4

EPW

PROGRESS NOTES
Medical Record
STANDARD FORM 50

MEDCOM - 12272

AUTHORIZED FOR LOCAL RE

EDICAL RECORD	PROGRESS NOTES

DATE	NOTES
1 July @ 0030	Pt resting, easily aroused. BP 144/68; P: 92 R 20 O2 sat 97% RA. HOB ↑ to facilitate breathing. stoma: pink & moist, ∅ output to colostomy. Urinated 450cc yellow urine s̄ complication. hypoactive BS x4 quads. abd: ND, soft. incision site CDI. Will cont to monitor & support ——— [redacted] 91WM4 b(6)-2
2 Jul 03	Surgery No events noted. scheduled for OR washout of Ⓛ Arm today. VSS AFeb. wound - purulent drainage @ umbilicus staples removed and wound Dressed w→D Abd soft ND stoma viable Rep pink A/P Doing well D/C plan per ortho [redacted] b(6)-2

NSHIP TO SPONSOR | SPONS[redacted] | SPONSOR'S ID N (SSN or Other)
LAST | FIRST | MI

/SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

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.

EDW [redacted] b(6)-4

TCWZ

PROGRESS NOTES
Medical Record
STANDARD FORM 509

MEDCOM - 12273

All b(6)-2

MEDICAL RECORD | **PROGRESS NOTES**

DATE

7 Jul Assumed care of pt @ 0500. Pt resting quietly. O_2 sats were in the lower 80's. Pt was put on O_2 @ 1 lpm. Sats came up to 97%. Pt was up OOB ambulating and BR. Dr. [redacted] remove staples in the middle. Pt now has wet to dry dsg change twice a day. Pt is going to OR today.

[redacted] 91WM6, SGT

1500- Assumed care → PC @ 1300. VSS, A+O×3. Ø c/o pain. Ⓑ LS CTA. ⊕BS ⊕ ostomy c̄ Ø drainage NPO since MN, mid ABD incision staples OTA CDI, W → Ostomy CDI. Ⓛ UE dsg/ace CDI. Ⓡ wrist PIV HL, patent c̄ NABX. O/C to OR. O/W assess WNL. Will Monitor

[redacted]

Ortho PPN

Preop Dx: Ⓛ GSW arm Fx

[illegible] washout / DPC

[redacted]

EBL [illegible]

[illegible]

[illegible]

Wound clean & closed

[illegible]

(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.

[redacted]

NOTES

Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)
USAPPC V1.00

PROGRESS NOTES

DATE

1930 Pt returned from OR, ambulated s̄ assistance. JP suction bulb
draining lldy drainage. S/w no Δ [redacted]

b(6)-2

3Jul03 Surgery.
No events Afr. in Bag ⓟ stool
VSS Afeb
Abd ND soft NT stoma viable
wound - open midline clean

A/P Doing well
⓪ ext per ortho

b(6)-2

[redacted]

STANDARD FORM 509 (REV. 7-91) BACK
USAPPC V1.00

AUTHORIZED FOR LOCAL REPRODUC

:AL RECORD | PROGRESS NOTES

NOTES

2Jul03 Rec'd pt @ 21:00. Awake and alert. PERRLA ⊕. Skin W/D. LCAⒷ
22:06 BS⊕ x4 ⊕ PPPⒷ. Ⓛ arm ACE wrap dsg + cast in place C/D/I ([redacted] b6-2
able to move and feel fingers ↓ ROM to ~~Rt~~ fingers + thumb c/o
pain ĉ Percocet given. <3 sec. cap refill WNL to Ⓛ fingers.
3 July03 Assumed pt. care @ 0500: Pt. asleep. Awake easily
0630 on verbal command. A+O x 3. ⊕ PERRLA. Lungs CTA
⊕ Pulses x4. HL in Ⓡ AC patent. Colostomy bag intact
0600 98.2 staples to mid abd. ŝ s/s of infection. Ace wrap dsg +
95 cast to Ⓛ arm CDI. ⊕ Sensation in fingers ĉ decrease
16 132/80 ROM. JP drainage in Ⓛ arm ĉ small amount of
95% Reddish fluids. ∅ complaints @ this time. will
continue to monitor [redacted] b(6)-2 91W M6 —
0820 Dsg Δ Complete. ∅ signs of infection or foul odor
noted. b(6)-2 [redacted] 91W M6 —
3July03 assumed pt care @ [redacted]. pt resting quietly. VSS. lungs
1500 CTA, abd drsng CDI, staples intact OTA, colostomy bag
intact ∅ drainage noted. HL Ⓡ AC flushes well ∅ S/Sx
of redness/swelling. Ⓛ arm ĉ cast & ace wrap, drsng
CDI, fingers ĉ swelling ⊕ sensation ↓ ROM. JP tube intact
draining sm amt of reddish color drainage. B↓Ext ⊕ pulses
∅ c/o pain voiced. Will cont to monitor — [redacted] 91WM6 SGT

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

RVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

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

EPW [redacted] b(6)-4

PROGRESS NOTES
Medical Record

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

MEDCOM - 12276

All b(6)-2

ME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

ATE | NOTES

3Jul 03 2325 Received pt resting in bed. VSS, HOB ↑ 30°. LSCTAB, ABD SNT, BS⊕, Colostomy to RUQ, midline abd incision CTA, upper half w/ wet > dry drsg c/d/i. IV patent in Ⓡ ac, drsg Ⓛ UE c/d/i. medicated x1 for pain. Will cont to monitor [redacted] —

4 July03 1000 - Pt Alert lying in bed. VSS, HR regular, BS⊕x3. Colostomy intact s̄ stoma pink. Dsg Δ'd to incision on ABD. Opened s̄ S/s of infx. New HL to Ⓡ forearm. Ace wrap CDI to Ⓛ arm. Able to wiggle fingers, cap refill <3, ⊕ sensation. Continuing c̄ antibiotics. Medicated x1 c̄ percocet. Will cont to monitor — [redacted]

4July03 1325 assumed pt care @ 1300. pt awake et alert. VS: BP 130/74, P:95, R:18, temp: 98.5, O2 sats 95% on RA. lungs CTA abd BS⊕, colostomy intact, small amt of ~~dk~~ brown stool noted, drsg CDI. ↓ ext full ROM ⊕ pulses Ⓛ arm c̄ ace wrap drsg CDI. JP drain intact. Ⓡ FA c̄ HL Ø S/Sx of infection. Ø complaints voiced. Will cont to monitor. —— [redacted] 91WM6 SGT

4Jul03 21:53 Rec'd pt @ 21:00. Awake and alert in bed. VS WNL per flowsheet. Skin W/D. PERRLA⊕. PIV Ⓡ FA & patent new IV initiated to Ⓡ FA. Ⓛ arm c̄ ACE wrap dsg CDI. Able to move and feel fingers. Fingers warm to touch c̄ <3 sec cap refill. ML Abd incision c̄ staples intact and well approx. Colostomy draining liquid watery brown fluid. Ø c/o pain @ this time will cont to mon [redacted]

All b(6)-2

ME | FIRST NAME | MIDDLE INITIAL | ID NUMBER

ATE | NOTES

2330 pt c/o pain ii percocet given will mon [redacted] AN

5 Jul 03 Assumed pt. care @ 0800: Pt. awake A+Ox3. Lung CTA
0630: T 98.6 ⊕ Pulses, movement + good sensation in Ⓛ Fingers. ⊕ BS x4.
P 86 Colostomy bag intact. JP. drain c̄ red serous. HL Ⓡ FA
R 16 patent. Dsng c̄ ace wrap Ⓛ arm CDI. Denies
B/P 130/80 any c/o @ this time. [redacted] 9lai: RNb
SATS: 93%

1530 Assumed care of Pt @ 1300. VSS. A+Dx3. Ø c/o pain. Ⓡ FAPW
c̄ IV Abx patent. abd incision dsg CDI. Ostomy bag intact putting out
brown sticky feces. Ⓛ UE dsg CDI, JP draining sero sanguinous
fluid. ⊕ sensation, cap refill < 3sec, mvt of fingers Ⓛ hand. Ⓑ LS
CTA ⊕ BS. O/W assessment WNL [redacted]
5 Jul 03

2149 Pt. awake and alert in bed. PERRLA⊕. Skin W/D. LCA Ⓑ
BS⊕x4. ⊕ PPP Ⓑ. HL to Ⓡ FA intact and patent. Colostomy
in place draining dk brown stool. Stoma beefy red in
color. ML ABD incision c̄ staples intact well approx.
DSG to incision C/D/I. Ⓛ arm ACE wrap dsg C/D/I
Ⓛ arm ↑ c̄ ice. Able to move and feel fingers. Fingers
warm to touch c̄ ⊕ < 3sec. cap refill. Ø c/o pain
will cont. to mon [redacted] AN

6 Jul 03
0800 pt. awake & alert in bed. JP drain D/c'd by MD, cast applied
to Ⓛ UE. Colostomy draining dark brown liquid stool, stoma pink
& moist. VSS. Dressing to ABD Δ'd, wound s̄ s/s of infection.
IV in Ⓡ FA flushed well c̄ 3cc NS s̄ s/s of infection or infiltration.
HR Reg, lung sounds clear bilat. Pt. s̄ complaints @ this time.
All other assessment findings WNL. Will continue to monitor [redacted]

MEDCOM - 12278

AUTHORIZED FOR LOCAL REPRODUC

:AL RECORD | PROGRESS NOTES

E	NOTES
5 M03	Surgery
	No events Stoma Functional
	VSS AFeb
	Abd Benign
	Wound healing.
	A/P Doing well plan per ortho for Ⓛ
	Arm wound
	[redacted] b(6)-2

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

RVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO | WARD NO

EPW # [redacted] b(6)-4

PROGRESS NOTES
Medical Record

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

MEDCOM - 12279

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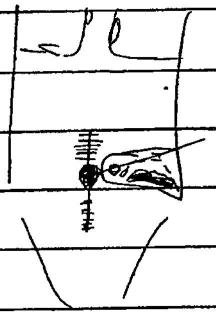
MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES b(2)-2
6 July 03	EPW c̄ Ⓛ Colostomy returned from [redacted] today.
	He has fever of 101° and open (dehisced) wound midline to Ⓡ of Colostomy
	Colostomy bag c̄ gas + stool. Stoma pink.
	101² oral 122/90
	P 120 regular



Tunnels slightly, cephalad

Ⓛ Cast

A/P ① Colostomy / functioning ② SIRS

② Fever ? Etiology ? Tachycardia 120 Likely Fever + Dehydration. R/o Early Sepsis

① Open Abd wound. We are concerned that Pt. will not be able to keep this wound clean. He will live in the dirt and sleep on the ground. I feel there is a risk of fecal contamination.

② Consult 581st ? Pt hold

③ c/w Percocet, Keflex

Note: Pt had (2) Percocet @ 2023 hrs b(6)-2

[redacted]

CPT, [illegible]

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.

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/199
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USAPA V1.

MEDCOM - 12280

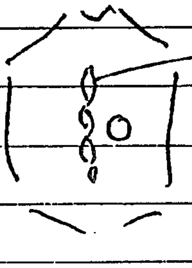
All b(6)-2

.TE NOTES

6JUL03 1430 Assumed care of Pt. @ 1300 VSS. A+Ox3. Ø c/o pain.
Ⓛ UE cast CDI ⊕ sensation, cap refil <3sec. MVT
Ⓛ hand. Ostomy Bag draining dark brown liquid stool.
MID ABD incision approximated well. half of staples removed
steri strips applied. W→D dsg to abd wound Δ'D,
Ø si/sx of infection. Ⓑ LS CTA. ⊕ BS. TOL PO Reg/halal
DIET. Ø/w assessment war. Will cont
to monitor [redacted]

1530 Removed rest of staples. D/C IV Ⓡ FA d/t leaking &
pain. Ø si/sx of infection. New 18G started Ⓟ FA [redacted]
well.

6JUL03 Surgery
Pt returns from [redacted] with wound
separation an "concern for cleanliness".
VS: 87 123/63 98.6
ex—



10.6 >—< 9?6
36

A/P, wound separation
Readmit for wound c[redacted]

All b(6)-2

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ICAL RECORD | PROGRESS NOTES

ATE	NOTES
6Jul03	Pt readmitted for dx of wound separation via EMT
2223	stretcher - Awake and alert. able to amb from stretcher
	to bed s̄ difficulty. Skin W/D. PERRLA ⊕. LCA Ⓑ.
	BS ⊕ x4. Colostomy bag Δ'd. ML ABD incision c̄
	WSD dsg C/D/I Cast to Ⓛ arm C/D/I able to
	move and feel fingers. ⊕ <3 sec cap refill. Warm
	to touch. C/o ⊗ pain @ this time will cont to mon.
0103	C/o pain ii Percocet given will mon [redacted] /A
7 July 03	1100 - Pt alert out of bed X1. VSS, lungs CTA,
	BS ⊕. Cast to Ⓛ arm, able to wiggle fingers,
	⊕ sensation, warm to touch. Dsg Δ'd to
0600 97.6	abd. incision, site s̄ s/s of infx. Colostomy
72 12	intact. 2 dsg applied to ↓ extremities for
120/80	minor wounds. Medicated x1 c̄ percocet
95%	for pain. Tolerated breakfast & lunch
	Will cont. to monitor —— [redacted]
1900	Assumed care of Pt @ 1300. VSS. A+Ox3. Ø c/o pain. Ⓛ UE cast CDI ⊕
	sensation, mot cap refil <3 sec Ⓛ hand - MID ABD INCISION W→D Δ done
	Ø s/sx infection. Ostomy bag intact ⊘ drainage in bag. O/w [redacted]
	Assessment WNL. Will Cont to Monitor —

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PROGRESS NOTES
Medical Record

STANDARD FORM 509
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All b(6)-2

.TE	NOTES
7 Jul 03	Assumed pt. care @ 2100. Pt. OOB & sitting up in chair. A+Ox3. Lungs CTA. Hypo active BSx4. Colostomy bag intact and empty. dsng to mid abd. CDI. Dsng c̄ ace wrap on Ⓛ arm CDI. ⊕ sensation and movement in Ⓛ fingers. Denies any discomfort @ this time — [redacted] 91WM6
8 J-ly 03	0910 - Pt alert lying in bed. Dsg Δd to abd. Incision opened c̄ Ø s/s of infx noted. Colostomy bag Δ'd. Cast to Ⓛ arm. ⊕ sensation in fingers. Pain to small finger.
0640 97.4 64 12 112/74 96%	Gave percocet for pain. VSS, lungs CTA, BS⊕ x 3. Pulses ⊕. Will cont. to monitor — [redacted]
8 July 03 1400	assumed pt care @ 1300. pt resting quietly. VSS. lungs CTA, abd colostomy bag intact BS present. ↓ext ⊕ pulses. Ⓛ arm c̄ cast ⊕ movement. ⊕ IV RAC infusing s̄ diff. Ⓘ s/sx of infiltration. Ⓘ complaints voiced @ this time. Will cont to monitor [redacted] 91WM6
2145	Pt. care assumed @ 2100. VSS. HR Reg, Lungs CTA, BS ⊕ x4. Colostomy bag intact draining soft brown stool. Midline ABD dsng CDI. Ⓛ UE ↑ on blanket. Cast CDI. Ⓛ hand has brisk cap refill c̄ ⊕ ROM digits, ⊕ sensation. Will cont. to monitor. Pt ↑ to BR to void s̄ ambulated length of ward x6. — [redacted] 1LT AN

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.TE NOTES

Ortho Evac Note

6Jul03

23 yo Iraqi ♂

GSW (R) Forearm

Prep Dx: (R) GSW Ulna Fx

Ulnar Neuropathy

Loss muscle Belly Ulnar Com

Comp Syndrome

Loss Ulnar Artery

procedures: Multiple I&D

IM Steinman pin Ulna

c̄ Segmental Defect

Delayed 1° Closure wounds

Hospital Course Benign

D/C Meds: Keflex 250 QID

Percocet prn pain

Motrin 800 TID

b(6)-1 [redacted]

P/) Suture Removal 2wks

LAE x 6wks

Then consider for

Bone Graft to

Defect

[redacted] b(6)-2

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CAL RECORD | PROGRESS NOTES

	NOTES
11 July 03	0800 Pt alert lying in bed. VSS, lungs CTA, HR regular, BS⊕ x 3 Colostomy intact. Dsg to incision midline abd CDI. HL Ⓡ forearm patent. Did not eat breakfast this AM. Cast to Ⓛ arm, able to wiggle fingers, ⊕ sensation, warm to touch. Voicing ∅ complaints at this time. Will cont to monitor ——— b(6)-2 [redacted] AN
0600 96.4 55 14 120/78 96%	
1730	Assumed care of pt @ 1300. VSS. A+Ox3. ∅ c/o pain. Ⓑ LS CTA, Abd wound to suction/dsg CDI. Ostomy bag producing formed brown stools. Ⓛ UE cast CDI, ⊕ sensation, mot fingers, cap refil <3 sec. Elevated Ⓛ UE. HL Ⓡ AC HL Ⓛ IVARX O/W assessment WNL Will Monitor [redacted]
2200	Pt. care assumed @ 2100. Pt. c/o ABD pain. b(6)-2 Percocet given. HR Reg, lungs CTA, BS ⊖ X4. ABD wound drsng CDI, JP to suction draining rust brown fluid. colostomy intact, passing soft formed stool. cast to Ⓛ UE CDI. CSMTS Ⓛ hand WNL - UTA pulse 2° cast - Will cont to moniter. ——— [redacted] AN. b(6)-2

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EPW # [redacted] b(6)-4

PROGRESS NOTES
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STANDARD FORM 509
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All b(6)-2

TE	NOTES
7-12-03 0100	colostomy bag leaking @ edges p̄ being emptied. colostomy bag Δ'd. sm. open area to skin approx. 1cm in length noted under old colostomy bag. Tissue pink s̄ drainage. Sterile 2x2 applied to open area. ——— [redacted] LT/AN
0345	< 20cc out per ABD drain, brown mucous-like fluid [redacted]
12 July 03	1100 - Pt alert lying in bed. VSS, lungs CTA, HR reg, BS⊕ x 3. Cast to Ⓛ arm, able to wiggle fingers, ⊕ sensation, warm to touch. Colostomy intact. Dsg to suction intact to midline abd. Gave percocet for pain. Will cont to monitor ——— [redacted] 2Lt
1700	Assumed care of patient @ 1300. VSS. A+O x3. ø c/o pain. ABD dsg CDI. Ostomy bag ~~[illegible] formed [illegible]~~ intact ø stool. Cast Ⓛ arm CDI, ⊕ sensation mvt, cap refill < 3 sec Ⓛ hand. TOL REG DIET. Ⓛ AC PIV HL c̄ IV ABX patent. O/W Assessment WNL. Will monitor [redacted]
2145	Pt. care assumed @ 2100. HR reg, lungs CTA, patient using IS while awake c̄ good results. BS ⊕ x4. ostomy pink s̄ drainage today. Colostomy bag intact. ML ABD drsng CDI. will cont. to monitor ——— [redacted]
2230	ML ABD drsng Δ'd. Wound is beefy red in color c̄ ø purulent drainage. W→D drsng done ——— [redacted]
0130	- Pt c/o nausea → phenergan given IVP [redacted]

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
13 July 03	1200 - Pt alert lying in bed. VSS throughout
	shift. Lungs CTA, BS ⊕ x 3. Began having
	loose stool in colostomy around noon
0720 97.5	today. Pt has been c/o stomach cramping
79	most of shift. Had forceful vomiting x 1
108/72 97%	around 1100. MD was informed. New
	HL started in Ⓡ wrist for antibiotics.
	DSD D'd to abd, CDI. Will cont to
	monitor ———— b(6)-2 [redacted]
1420	assumed care of Pt @ 1300. VSS. A+O x3 Ⓑ LS CTA, ⊕ BS
	ostomy bag draining c̄ loose [redacted] brown stools. Abd drsg CDI Ⓛ UE cast
	CDI. ⊕ sensation/cap refill b(6)-2 <3sec/mvt Ⓛ fingers. Ø c/o pain. b(6)-2
	O/W assessment WNL. Will monitor — [redacted]
13 JUL 03	Rec'd c/o pt @ 21:00. Pt awoke and alert in bed; Restraints x 2̄
21:57	Ⓡ wrist Ⓛ ankle. PERRLA ⊕ Skin W/D. LCA Ⓑ. ⊕ BS x 4. C/O
	epigastric pain ii maalox tab given. c/o pain to old PIV
	site Ⓡ AC. Heat pack applied for 15 min. New PIV @ Ⓡ FA
	patent. cast to Ⓛ Arm C/D/I ⊕ sensation to fingers. ⊕ ROM.
	⊕ <3 sec cap refill to fingers. ⊕ PPP Ⓑ. Colostomy intact c̄ ⊕
	brown stool draining to bag. ML ABD dsg C/D/I. Wound
	to Ⓡ outer aspect of thigh healing and scabbing over. DSD to

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EPW # [redacted] b(6)-4

REGISTER NO.

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PROGRESS NOTES
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STANDARD FORM 509 (REV. 5/1999)
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USAPA V1.00

All b(6)-2

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	to Ⓛ side of lower back. c/o pain in abd ~~&~~ Error [redacted] from gas.
	will cont to mon [redacted] 2LT/AN ——
13 Jun 03	ABD Dressing change done. Wound appears wet, red.
	No foul odor a color noted. W→D dressing c̄ 4x4
	covering wound. Changed s̄ difficulty. [redacted]
14 July 03	0800 - Pt alert lying in bed. VSS, Lungs [redacted], HR reg,
	BS⊕, Colostomy intact emptying loose stool
	into bag. LR @ 75"/ into Ⓡ wrist. DSG
	to abd incision. Voicing Ø complaints at this
	time. Will cont to monitor [redacted]
1500.	Assumed care of pt @ 1300. VSS. A+O x3. Ø c/o pain. ABD
	DRSG CDI. Ostomy Bag draining loose brown stools; Cast Ⓛ UE CDI
	⊕ sensation/cap refill <3 sec lmvt fingers Ⓛ hand. LR @ 75cc/hr c̄ IV ABX via
	Ⓡ wrist IV. O/w Assessment WNL. Will Monitor [redacted]
2300.	Pt. care assumed @ 2100. HR Reg, Lungs CTA, BS ⊕ x4. VSS
	MC ABD dsng Δ'd; CDI. ostomy pink, draining soft brown
	semi-liquid stool. colostomy bag CDI. cast to Ⓛ UE
	intact c̄ neuro checks WNL. Pt given ii percocet
	for pain. will cont. to monitor —— [redacted]
15 Jul	Assumed care of pt @ 0500. Pt asleep. VSS Lungs
	CTA. Dsg on abd. dry and intact. Ostomy bag on
	Ⓛ side of abd. - intact. Pt awaiting OR. Will continue
	to monitor. —— [redacted], LPN, SGT
1200	Pt R/T from OR. VSS, Pt awake [redacted] LPN, SGT
~~15 Jul~~	[redacted]

STANDARD FORM 509 (REV. 5/1999) BACK
USAPA V1.00

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
15 Jul 02	Brief op note
	indication open clean laparotomy wound
	Procedure DPC
	Surgeon [redacted] b(6)-2
	Anest GETA
	wound closed c̄ interrupted Mattress
	sutures
	to ward in good cond.
	[redacted] b(6)-2
16 Jul 02	Surgery
	No events
	VSS Afeb
	wound - Iodoform Gauze pulled
	Dressed
	A/P Doing well
	cont wound care
	b(6)-2 [redacted]

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[redacted] b(6)-4

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PROGRESS NOTES
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STANDARD FORM 509 (REV. 5/1999)
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DICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
15 July 1300	- Assumed care of PT. PT is alert lying in bed. PT responds to verbal stimuli. PT c/o pain to Abdomen. PT received 2 tabs Percocet P.O. for pain. Abdominal dressing is CDI. No s/s of infection c̄ brown stool, loose draining. PT urinated 800cc of urine and now feels much better. Lung sounds are clear bilateral. Abdomen is soft + Tender. PT has Good Pulse motor function on All extremity. Skin is warm + Dry. PT has 75cc/hr LR on Ⓡ hand. Site is Dry + INTACT. PT is now resting comfortably in bed. Will continue to monitor. SGT [redacted] LPN b(6)-2
15 July	- PT is sleeping in bed no c/o pain from Abdomen. Will continue to monitor [redacted]. LPN b(6)-2
15 July 03	2325 Assume pt care @ 2100. pt Awake and Alert. VSS. Cast to LUE CD+I ⊕ movement ⊕ sensation to fingers. Abd dsg. D+I Red drainage to gauze. Colostomy bag intact c̄ brown soft stool. LR @ 75cc/hr to Ⓡ wrist no s/s redness/infiltration. No c/o pain @ this time Will continue to monitor [redacted] 3LUMC b(6)-2

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WARD NO.

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (RE
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All b(6)-2

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
16 Jul	Assumed care of pt @ 0500. Pt asleep. COB 7
	BR. VSS. Lungs CTA. Bowel sounds ✓ 4 quads.
	Cast on Ⓛ arm. Bandage down middle of abdomen.
	Dry and intact. Colostomy bag on Ⓛ side of abd.
	Pt was given 650 mg of Tylenol @ 0900 for
	pain — [redacted] LPN, SGT
1700	Assumed care of Pt @ 1800. VSS. A+O x3. Ø c/o pain.
	ABD incision CDI. Ostomy Bag patent/intact Ⓡ wrist
	PIV LR @ 75cc/hr c̄ IVABX patent. Ⓛ UE cast CDI,
	⊕ sensation, cap refill <3 sec, mvt fingers Ⓛ hand.
	⊕ BS Ⓑ LS CTA HRR. O/W assessment WNL
	Will monitor — [redacted]
16 JUL 03	Rec'd c/o pt @ 21:00. Awake and alert in bed. Restraints
21:34	x2 Ⓡ + Ⓛ ankles. Circ la ⊕ WNL. Skin color WNL. LCA Ⓑ
	error [redacted] ~~BS ⊕ x4~~ ML ABD error [redacted] ~~→A~~ DSG C/D/I. Colostomy c̄ scant amt
	stool draining. ⊕ PPP Ⓑ BS hypoactive x4. c/o pain x1 650mg
	Tylenol given. PIV Ⓡ FA c̄ patent new IV initiated.
	Cast to Ⓛ arm C/D/I. ⊕ sensation ⊕ <3 sec cap refill. Will
	cont to mon [redacted] 2LT/AN
0428	c/o nausea. 12.5mg Phenergan given 2LT/AN
17 Jul	Assumed care of pt @ 0500. Pt awake and
	alert. VSS. Lungs CTA. Bowel sounds ✓ 4
	quads. Abd. soft and tender. Pt ~~awaiting~~ [redacted]
	~~may leave~~ [redacted] ~~tomorrow tomorrow. Ø c/o pain~~
	discomfort — [redacted] LPN-SGT

All b(6)-2 except last

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IEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
17 July03	assumed pt care @ 1300. VSS. lungs CTA, abd soft
1430	BS⊕, colostomy bag intact. ↓ ext ē full ROM ⊕ pulse.
	Ⓛ arm ē cast ⊕ movement ⊕ sensation. <3 sec cap refill.
	Ⓡ arm ē full ROM ⊕ pulse. IV Ⓛ AC infusing LR @ 75cc/hr.
	s̄ diff. Ø c/o pain voiced @ this time. Will cont to
	monitor ——— [redacted] 91WM6 -
18Jul03	Rec'd c/o pt @ 21:00. VS WNL per flow sheet. Restraints
00:08	x2 Ⓡ and Ⓛ ankles. Awake and alert in bed. Skin color WNL
	PERLA⊕ WNL. ICA⊕ Ⓡ AC PIV patent ē 75cc/hr LR infusing
	Ⓛ arm cast C/D/I. Digits ē ⊕ ROM x̄ thumb and forefinger. ⊕
	sensation ⊕ <3 sec cap refill. BS⊕ x4. ML DSG C/D/I.
	Colostomy intact. Stoma beefy red in color. ⊕ flatus ⊕ brown
	loose stool. c/o pain x1 to ML ABD. ii Percocet given. Ø
	c/o N/V @ this time. Will cont to mon. [redacted] /AN
2nd [redacted] ~~0258~~	~~c/o pain @ ML ABD inc. ii Percocet given Will mon~~
	[redacted] 2D/AW ———
18 Jul	[redacted] ssumed care of pt @ 0520. Pt asleep. Bandage
	intact and dry. Ostomy bag intact. VSS. Lungs
	CTA. Bowel sounds ✓ 4 quads. Ø c/o pain/
	discomfort. Will continue to monitor. ——— [redacted] SGT

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#[redacted] b(6)-4

PROGRESS NOTES
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STANDARD FORM 509 (R
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MEDCOM - 12292

All b(6)-2

	FIRST NAME	MIDDLE INITIAL	ID NUMBER

TE	NOTES
18Jul03	assumed care @1300 - VSS - no c/o pain
1650	@ this time - SL patent in Ⓡ AC - neuro
	✓'s WNL in Ⓛ fingers - abd dsg intact -
	colostomy putting out liquid reddish-brown
	stool and gas, bag intact - pt. not willing
	to get out of bed to ambulate - tol.
	regular diet for Lu[redacted] - I/O QS —
	—— CR, AN
18Jul03	Rec'd c/o pt @ 21:00 VS WNL per flow sheet. Restraints
23:17	x2. Ⓡ wrist Ⓛ ankle. LCA Ⓑ BS ⊕ x4. ML DSG to ABD C/D/I.
	Colostomy LUQ c̄ sm. amt. formed stool draining.
	Cast to Ⓛ arm C/D/I. ⊕ sensation to digits ⊕ ROM ⊕
	<3 sec cap refill. PIVHL to Ⓡ AC patent. c/o pain
	x1 ii Tylenol given will cont to mon [redacted] AN
19 Jul	Assumed care of pt @ 0700. VSS. Lungs CTA
	Incision down mid-abdomen. Bandage dry
	and intact. Colostomy bag changed. ∅ c/o
	pain/discomfort —— [redacted] LPN, SGT
19Jul03	assumed care of pt. @1300 - VSS - no c/o
1630	pain @ this time - LR @ 75 cc/hr infusing
	into Ⓡ AC IV site patent - Ⓛ arm cast intact,
	Ⓛ finger cap refill <2 sec, pt can wiggle
	fingers, ⊕ sensation x5 fingers - ⊕ BS in
	Ⓛ upper quad, stoma pi[redacted], liquid green
	stool output ——

All b(6)-2 except last

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:AL RECORD | PROGRESS NOTES

NOTES

19Jul03 2045 pt. ambulated on ward x 15 minutes s̄ assistance - medicated c̄ 650mg tylenol PO for abd pain - pt. encouraged to exercise Ⓛ fingers to improve mobility [redacted]

19July03 2150 Assume pt care @ 2100. pt awake and alert. no c/o pain @ this time. VSS - HR reg. Lungs CTA. Abd ~~[illegible]~~ midline dsg CD+I. Colostomy bag intact to ⓁUQ draining brown watery stool. BS x 3. Cast to LUE CD+I ⊕ movement ⊕ sensation to fingers. LR @ 75cc/hr to Ⓡ AC infusing s̄ s/s infiltration/redness. Will continue to monitor [redacted]

1100 - Pt vomited X1. Gave Phenergan - [redacted]

20July03 1000 - Pt alert ambulating x1 this AM. VSS, lungs CTA, BS⊕. Colostomy intact. Dsg Ø to closed incision midline abd. Cast to Ⓛ Arm, ⊕ sensation, able to wiggle fingers, Skin warm to touch. IV to Ⓡ AC. Will cont to monitor [redacted]

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EPW [redacted] b(6)-4

PROGRESS NOTES
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STANDARD FORM 509
Prescribed by GSA/ICMR FPMR (41 CFR) 101

MEDCOM - 12294

All b(6)-2

TE	NOTES
20Jul03	assumed care @1300 - VSS - pt. sleeping
1330	@ present, easy to awaken - Stoma pink -
	LR @ 75cc/hr infusing into Ⓡ AC IV - neuro
	v's WNL in Ⓛ fingers - abd incision c̄ sutures
	intact, open to air, no drng - noted - no c/o
	pain or nausea @ this time [redacted]
20JUL03	Rec'd c/o pt @ 21:00. VS WNL per flowsheet. Restraints
23:23	x2 to Ⓡ/Ⓛ ankles. Awake and alert in bed. PERRLA⊕WNL
	Skin w/D/LCAⒷ. BS⊕x4. ML inc. OTA C/D/I. Ostomy
	draining brown stool, scant amt. Stoma beefy red in
	color. Cast to Ⓛ arm C/D/I. ⊕ sensation ⊕ ROM ⊕ <3sec
	cap refill to digits. Encouraged and instructed pt. to
	perform ~~passing~~ passive and active ROM to Ⓛ fingers
	~~ø~~ c/o pain @ this time. Will cont. to mon [redacted]
21 July	Assumed care of pt @ 0500. Pt awake and
	alert. VSS. Lungs CTA. Stiches down abd. in-
	tact and dry. Colostomy bag changed @
	0600. Ø c/o pain / discomfort — [redacted] LPN SG.

MEDCOM - 12295

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DICAL RECORD | **PROGRESS NOTES**

TE	NOTES
27 July 03 1430	Pt stable. AAOx3. Lungs CTA bilat, Ø resp distress. NSR. Abd soft, non-tender, bowel sounds active x4 quads. Ostomy emptied and cleaned. Formed brown stool. Ø complaints b6-2 [redacted]
28 Jul 03 1700	pt. d/c'd to EPW camp, hands restrained - pt. had colostomy supplies and xrays & d/c summary - escorted to helicopter by mP —— [redacted]

b(6)-2

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

	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO. ICW2

[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV
Prescribed by GSA/ICMR FPMR

MEDCOM - 12296

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
30Jun04	Ortho op note
	Preop Dx: (L) GSW forearm
	Procedure Repeat I&D (L) 9L lavage
	IM 1/8" Steinmann pin
	Fixation Ulna
	Partial Closure wound
	Surg: [redacted] b(6)-2
	EBL: 250cc
	TT: 0
	To PACU Stable
	Finding - Still contaminated wound
	Debrided unable to fully
	cover Bone - elected for
	IM Steinmann Pin Fixation
	Plan: Repeat I&D full Closure
	48°
	[redacted] 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.

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

MEDCOM - 12297

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
29JUN03 (0600)	pt A/O; VSS; distal pulses palpable; no s/s of hemorrhage;
	assessment completed; ——— [redacted]
0730	pt OOB to c̄ difficulty; tolerating movement well; no
	change in VS ——— [redacted] b(6)-2
29JUN03	MD Note
0831	POD #1 s/p Exlap, (L) partial colectomy + Hartman's procedure
	+ I+D (L) forearm by ortho.
	S/ No complaints this am.
	O/ T 98.2 HR low 100s BP 104/64 RR 19 97% 2L NC
	UO 50-200 cc/hr JP 40 cc since surgery
	A+O x3
	Lungs CTAB 11.4 > 11.4 / 36.6 < 342 131 | 102 | 10 / 4.6 | 26 | 0.9 < 13
	RR nl S1+S2
	Abd soft, ND, mildly TTP no BS
	Ostomy pink Ø gas in bag
	Dressing CDI
	(R) LE GSW wound Ø erythema
	A/ Doing well POD #1. No issues
	P/ 1) OOB today, ambulate 4) Continue Abx
	2) Keep NPO for now 5) Transfer to ward late
	3) Ortho plan to I+D (L) arm tomorrow. today or tomorrow.

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RE
		b(6)-2	[redacted]
SPONSOR'S NAME	**SSN/ID NO.**	**RELATIONSHIP TO SPONSOR**	WO MC USA

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.

[redacted] 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

MEDCOM - 12298

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
30 Jun 03	(0750) JP pulled intact; pt premedicated c̄ MSO4 4mg
	IV; new dsg intact c̄ staples; pt c/o some
	[illegible]; will Ambulate + return to bed @ 1000; pt told
	by interpreter POC + reasons for OOB/amb/MPD +IS — pt
	verbalized understanding of instructions. — [redacted]
30 JUN 03	MD Progress b(6)-2
0842	POD #2 s/p Exlap, partial colectomy, colostomy + Hartman's
	S/ No complaints. No nausea/emesis No flatus.
	O/ Afebrile VS normal O_2 sat 99% 2LNC
	UO 50-150 cc/hr JP 14 cc/24°
	Abd soft ND ⊕BS
	Incision CDI
	Lungs CTA
	A/ Doing well, Return of bowel function
	P/ Clamp NGT
	To OR today to I+D Ⓛ arm b(6)-2
	Ambulate [redacted]
	Adv diet after OR today.
	WRAMC USA
0950	pt Ambulated x 15m c̄ assist; returned to bed; ostomy bag
	changed s̄ difficulty no drainage noted; 2mg MSO4 for
	pain before procedure; pt resting; VSS — [redacted]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
			b(6)-2 [redacted]

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.

EPW [redacted] 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

MEDCOM - 12299

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
30 JUN 1400	pt may go to OR today; was OOB today x 4°; Ambulated 15m; using IS q1°; no change in assessment status; —— [redacted]
1600	pt repts pain to LUE; OMM↑, MSO4 4mg for pain; wasted 10mg Demerol accidentally opened for 353 but not used. → b(6)-2 witnessed by my atr —— [redacted]
1 July 03	Assumed care of pt @ 0500. Pt is awake. Dr. [redacted] came in.- Removed pt's bandage from his abdomen. She said there was no need to bandage wound again. Pt has staples going down his midsection. Colostomy bag was changed due to pt wound weeping blood. It looked as though feces might get into the wound. Two 2x2's were placed on incision to absorb discharge. Pt was medicated twice with percocet @ 0710 and 1220. Pt is now sleeping. —— [redacted], 91WM6, SGT —— 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. ICW2

[redacted] 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

MEDCOM - 12300

AUTHORIZED FOR LOCAL RI

DICAL RECORD	PROGRESS NOTES

DATE	NOTES
	Ortho Op Note
	PreOp Dx: (L) Forearm GSW Fx
	PostOp Dx: Same, Midshaft ulna Defect
	Ulnar A/N laceration/Defect
	Volar Forearm muscle Defect
	Med N. / Rad Art (P)
	c̄ contus
	Procedure: I&D/washout / Prophylac
	Fasciotomie
	Surgeon: [redacted] b(6)-2
	EBL c̄ 300cc
	TT Ø
	TO PACU Stable
	Plan) Repeat washout 3-5 days
	ORIF c̄ plate/screws w/
	wound closure
	b(6)-2
	[redacted]

NSHIP TO SPONSOR

SPONSOR'S NAME

LAST

FIRST

MI

SPONSOR'S ID N (SSN or Other)

SERVICE

HOSPITAL OR MEDICAL FACILITY

RECORDS MAINTAINED AT

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.

[redacted] b(6)-4

PROGRESS NOTES
Medical Record
STANDARD FORM 509 (F
Prescribed by GSA/ICMR FPMR (41 CFR) 101

NSN 7540-00-634-4176 AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
9Jul03	Surgery
	No events
	VSS Afeb
	wound good ~~&~~ granulation x̄
	in deepest part of wound
	A/p wound separation.
	Plan W-D for 2 more days then
	to OR for closure.
	[redacted]
	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.

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

All b(6)-2 except last

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
9 July 03	0735 Assume pt care @ 0500. Pt asleep easy to awake. VSS. HR regular Lungs CTA throughout. Abd soft. colostomy bag intact BS active x3. ⊖ BS under colostomy. Dsg Δ'd area pink no s/s infection Dsg Δ'd to Ⓛ side and behind Ⓡ knee. No drainage no signs of infection noted. Ⓛ arm cast CD+I. ⊕ sensation ⊕ movement to fingers. Pt amb s̄ difficulty. LR @ 150cc/hr to Ⓡ FA no s/o redness or infiltration $\frac{60}{T1}$ percocet for pain. Will continue to monitor [redacted]
	1235 New colostomy bag placed. draining soft formed brown stool. [redacted]
1430	Assumed care of Pt @ 1300. VSS. A+O x3. Ødo pain. LR @ 150 via Ⓡ FA PIV. Ⓛ UE Cast CDI ⊕ sensation, mvt, cap refil < 3sec Ⓛ fingers. Ⓑ lungs CTA, ⊕ BS, Ostomy bag draining [illegible] ~~brown formed stools.~~ [illegible] MID ABD incision drsg CDI. O/W Assessment WNL. Will Monitor [redacted]
2130	Pt. care assumed @ 2100. Pt. alert & compliant c̄ care. HR Reg, lungs CTA, ABD c̄ BS ⊕ x4. ABD drsng CDI. Colostomy bag intact. Ostomy pink, passing soft formed stool. Cast to Ⓛ arm CDI. Ⓛ Arm ↑. Ø pain, brisk cap refill c̄ ⊕ sensation, ⊕ ROM. Pt. c/o pain to IV site. Ø swelling, Ø erythema, Ø leaking, flushes well. Will cont. to monitor [redacted]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED A[redacted]
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: ([redacted] written entries; give: Name - last, first, middle; ID No or SSN; Sex; D[redacted] Rank/Grade.)

REGISTER NO.

WARD NO.

Ew [redacted] 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

MEDCOM - 12303

All b(6)-2

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10July03	0600 Assume care @ 0500. Pt awake and alert. VSS. HL to Ⓡ FA no s/s redness/inflamation c̄ flush. No c/o pain @ this time. HR reg. Lungs CTA. Abd soft. Midline dsg CD+I. Colostomy bag intact. Site pink draining soft brown stool. LUE cast CD+I. ⊕ movement ⊕ sensation cap refill < 3sec to fingers. pt amb s̄ difficulty. Will continue to monitor — [redacted] lwmp
	0915 Abd wound dsg to suction, continuous 125mmHg x3 days — [redacted] 5lwmp
10July03 1410	assumed pt care @ 1300. pt awake et alert. VSS lungs CTA, abd drsng CDI c̄ intermittent suction. Colostomy bag intact. BLE c̄ full ROM ⊕ pulses. LUE c̄ cast ⊕ movement of fingers, < 3 sec cap refill. Ø c/o pain voiced @ this time. Will cont to monitor — [redacted] 9lwmp
2015	5cc reddish thin drainage emptied from suction Ø complaints voiced — [redacted] 9lwxl
10JUL03 21:26	Rec'd c/o pt @ 21:00. Awake and alert in bed. VS WNL per flowsheet. Restraints x2 Ⓡ+Ⓛ ankles. PERRLA ⊕ WNL. Skin color WNL. LCA Ⓑ. BS ⊕ x4. MLABD dsg C/D/I to suction. Colostomy intact c̄ scant amt. stool draining. Ⓛ arm cast C/D/I. Pt able to move and feel fingers. Fingers warm to touch c̄ <3sec cap refill. ⊕ PPP Ⓑ. c/o pain x1 ii Percocet given. Ø further complaints @ this time. Will cont. to mon. [redacted] 2LT/AN —
0140	Pt spitting in bedpan for most of shift. @ this time vomitted x1. ii tabs maalox and 25 mg Phenergan given IVP. Pt sleeping @ 0207. Will cont. to mon [redacted] LT/AN —

FPI. LEX. Printed on Recycled Paper

STANDARD FORM 600 (REV. 6-97) BACK

MEDCOM - 12304

558-103 *(See Instructions on Back of this Sheet)* NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY *(Stamp)* [redacted] b(2)-2

LOG NUMBER

ARRIVAL

DATE DAY	MONTH	YR.	TIME
6	28	03	0520

TRANSPORTATION TO HOSPITAL *(Attach care enroute sheet)*
☐ PRIVATE VEHICLE ☐ AMBULANCE ☑ OTHER *(Specify)* Medevac

CURRENT MEDS. (Tetanus immunization and other data) MSO4

HISTORY OBTAINED FROM ☑ PATIENT ☐ OTHER *(Specify)*

ALLERGIES NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION *(City, State and ZIP Code)*

HOME TELE. NO. *(Inc. area code)*

CHIEF COMPLAINT(S) *(Include symptom(s), duration)* GSW Ⓛ arm

SEX ♂ AGE 23

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER 0520

VITAL SIGNS

TIME	1200	1215	1230
BP	117/57	123/63	121/66
PULSE	80	91	94
RESP.	20	20	18
TEMP.	—		
WT. (Child)	73kg		

CATEGORY *(See reverse)*
☐ EMERGENT
☑ URGENT
☐ NON-URGENT

b6-2

ORDERS	INITS.	TIME
abs CBC Chem7 lytes	[redacted]	1200
UA PTT's UA		1200
2L NS Bolus		1200
xR OFA ⓑ knee		1200
fentanyl		1205
		1215

ASSESSMENT/DIAGNOSIS
Ct 1230
① Ⓛ arm GSW
② Abd GSW stable

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

ABC intact
buttock surgery last year

S: GSW abd/arm approx [illegible] PTA.

Pt states he was [illegible] shot while in Taxi.

NMO

1° A: OP/NP clear/pt [illegible] speech clear/[illegible]
B: CTA ⓑ = [illegible]
C: ⊕ 2 pulses ⓑ x4 ext =
D: GCS 15
E: Abd ⊕ GSW Ⓛ flank x2 laterally
Foley placed clear 200cc yellow urine

2° ~~Head~~: OP/NP clear / neck supple, NT
PERRL [illegible] ~~Head~~ atraumatic
Chest [illegible]
CV: [illegible]
Abd: [illegible] ⊕ [illegible] ↓ BS
[illegible]
Ext: Ⓛ [illegible] Ⓛ open forearm fx
⊕ rad pulses / [illegible] fingers x5
[illegible] defecit

CXR: CXR [illegible]

A/P: stable, [illegible]

[redacted] b(6)-2

b(6)-2 [redacted]

DISPOSITION *(Check all that apply)*
☐ HOME ☐ FULL DUTY
QUARTERS ☐ 24 Hrs. ☐ 48 Hrs. ☐ 72 Hrs.
MODIFIED DUTY UNTIL: DAY MONTH YEAR
REFERRED TO *(Indicate clinic)*
☐ EMERGENCY ☐ TODAY ☐ 72 HOURS ☐ ROUTINE
ADMIT. TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE
☒ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

TIME OF RELEASE:

(CONTINUE ON SF 507, IF NEEDED)

PATIENT'S IDENTIFICATION *(Mechanical imprint)* FOR WRITTEN ENTRIES GIVE: *Name - last, first, middle; SSN; DOB, service status, name and relation of sponsor or next of kin. (IMPORTANT: LIST FACILITY HOLDING TREATMENT RECORD).*

[redacted] b(6)-4

SIGNATURE OF PROVIDER AND ID STAMP

INSTRUCTIONS TO PATIENT *(Include medications ordered and follow-up plans)*

EMERGENCY CARE AND TREATMENT **STANDARD FORM 558** (Rev. 6-82) Prescribed by GSA and ICMR FIRMR (41 CFR) 201-45.505

MEDCOM - 12305 Copy

b(2)-2

NSN 7540-01-075-3786

MEDICAL RECORD	**EMERGENCY CARE AND TREATMENT** *(Patient)*	LOG NUMBER	TREATMENT FACILITY CMT [redacted]
		RECORDS MAINTAINED AT	

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY

STATE

ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)* 6 July 03

TIME 2215

TRANSPORTATION TO FACILITY Medevac

SEX ♂

AGE 19

DUTY/LOCAL PHONE: AREA CODE · NUMBER

HOME PHONE: AREA CODE · NUMBER

MILITARY STATUS

ITEM	YES	NO	N/A
PRP			
FLYING STATUS			

MEDICAL HISTORY OBTAINED FROM

THIRD PARTY INSURANCE

ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2568 IN CHART		

NAME OF INSURANCE COMPANY

CURRENT MEDICATIONS

ALLERGIES NKDA

INJURY OR OCCUPATIONAL ILLNESS

ITEM	YES	NO	WHEN *(Date)*
IS THIS AN INJURY?			WHERE
INJURY/SAFETY FORMS			

HOW

EMERGENCY ROOM VISIT

DATE LAST VISIT

24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT

COMPLETED INTITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT Multiple GSW, exceeds Cad acute Abd. Cast on (L) arm colostomy bag

CATEGORY OF TREATMENT

☐ EMERGENT

☐ URGENT

☐ NON-URGENT

TIME

INITIALS

VITAL SIGNS

TIME 2215					
BP 123/63					
PULSE 157					
RESP 20					
TEMP 98.6					
~~WT~~ SpO2 97					

LAB ORDERS

	[✓ CBC] DIFF		ABG	PT/PTT		BHCG/URINE/BLOOD/QUANT
	URINE C&S		UA MSCC/CATH			CHEM:
	BLOOD C&S X					

X-RAY ORDERS

	CXR PA & LAT/PORTABLE		C-SPINE
	ACUTE ABDOMEN		LS SPINE
	SINUS		HEAD CT
	ANKLE R/L		

ORDERS

☑ PULSE OX 95 ☒ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE

DISPOSITION ☐ HOME ☐ FULL DUTY

MODIFIED DUTY UNTIL

DISPOSITION QUARTERS /OFF DUTY ☐ 24 HRS. ☐ 48 HRS. ☐ 78 HRS.

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ TO

WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

PATIENT'S IDENTIFICATION *(For typed or written entries, give: Name -- last, first, middle; ID no. (SSN or other); hospital or medical facility)*

[redacted]

b(6)-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

STANDARD FORM 558 (REV. 9-96)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.203(b)(10)
USAPA V1.00

MEDCOM - 12306

[redacted] b(6)-4 Date: MON - [illegible] 30 JUNE

PATIENT ASSESSMENT

TIME: 0600 SIGNATURE: [redacted] b6-2

SKIN AND MUCOUS MEMBRANES

Skin : [✓ Loose] / Tight / Diaphoretic / Shiny / Dry

Skin : Temperature WI

Color: Pale / Cyanotic / Jaundiced NFR

Mucous Membranes: [✓ Moist] / Dry / Cracked

Skin Breakdown: [✓ None] Location: Size:

NEUROLOGICAL

[✓ Loc] / Alert / Lethargic / Unresponsive X 3 GCS: 15

Orientated / Disoriented Pupils: 3R

Extremity Movement: Full / [✓ Limited] / None

CARDIOVASCULAR

Pulse (0 - 4): Radials 2+ Pedals 2+

Capillary Refill: <3 Seconds Homan's Sign

Jugular Venous Distension NA Edema

Heart Sounds S1S2

Rhythm SR PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			▨	▨
Site				
Solution				

Chest Pain

RESPIRATORY

Chest Expansion / [✓ Symmetrical] / Asymmetrical

Respiration / [✓ No Distress] / SOB / Labored / Use of Access Muscles

Breathing Patterns: Normal

Cough: Productive / [✓ Nonproductive] / None

Sputum: Color / Amount / Consistency / Odor White

Chest Drainage System Gravity: Suction cm:

Air Leak No Yes Crepitus

Character of Drainage:

Trachea / Midline / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
rackles	NA	
heezes		
iminished		
bsent		

GASTROINTESTINAL

bdomen: [✓ Soft] / Firm / Hard / Distended cm Girth

owel Sounds: [✓ Normal] / Hyperactive / Hypoactive / Absent

ressings:

G Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

G Drainage: Color Character

be Feeding: Day No: Strength: Rate: Aspirate:

ool: Character None in bag

ains: JP D/C

GENITOURINARY

ne Color: yellow Character: clear

iding: [✓ Continent] / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

HER: 30 JUN 03

PATIENT ASSESSMENT

b(6)-2

TIME: 1700 SIGNATURE: [redacted]

SKIN AND MUCOUS MEMBRANES

Skin : [✓ Loose] / Tight / Diaphoretic / Shiny / Dry

Skin : Temperature 98.6

Color: Pale / Cyanotic / Jaundiced normal for race

Mucous Membranes: [✓ Moist] / Dry / Cracked

Skin Breakdown: [✓ None] Location: Size:

NEUROLOGICAL

[✓ Loc] / [✓ Alert] / Lethargic / Unresponsive GCS:

[✓ Orientated] / Disoriented Pupils: 3mm

Extremity Movement: Full / [✓ Limited] / None

CARDIOVASCULAR

Pulse (0 - 4): 4 Radials 2+ Pedals 2+

Capillary Refill: <3 Seconds Homan's Sign

Jugular Venous Distension NA Edema

Heart Sounds S1, S2

Rhythm SR PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			▨	▨
Site				
Solution				

Chest Pain

RESPIRATORY

Chest Expansion / [✓ Symmetrical] / Asymmetrical

Respiration / [✓ No Distress] / SOB / Labored / Use of Access Muscles

Breathing Patterns:

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor

Chest Drainage System Gravity: Suction cm:

Air Leak No Yes Crepitus

Character of Drainage:

Trachea / Midline / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: [✓ Soft] / Firm / Hard / Distended tender cm Girth

Bowel Sounds: Normal / Hyperactive / [✓ Hypoactive] / Absent

Dressings:

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate.

Stool: Character none in bag

Drains:

GENITOURINARY

Urine Color: yellow Character: clear

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

30 June 03

MEDCOM - 12307
II

b(6)-2

2140 3 Jun 03 - pt received from OR.

VSS → [redacted] 110, 146/88, 98 on 42 FM, 17, Temp: .

[N] reactive to stimuli; eyes - pupils 2mm; s/p sss from anesthesia however makes purposeful movements; [CV] S1/S2;

(P) pulses (3+) x4; <3 sec cap refill; [R] CTA upper Apex, although (L) diminished 105 sedation breath sounds; needle excursion ETT; (+) productive cough w/ dark sputum.

[GI/GU] adequate UO (see I+O); hypoactive bowel sounds. NGT clamp.

[MSK] (L) UE w/ Sully drg (-) drainage noted

[Plan] Anticipate transfer to ICW #2.

[redacted] 1LtAN

b(6)-2

DAte ~~28 Jun~~

28 June

PATIENT ASSESSMENT

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin : Loose / Tight / Diaphoretic / Shiny / Dry

Skin : Temperature – warm to touch

Color: Pale / Cyanotic / Jaundiced normal for race (–) cyanosis

Mucous Membranes: [✓ Moist] / Dry / Cracked

Skin Breakdown: None Location: [illegible] Size:

NEUROLOGICAL

Loc / [✓ Alert] / [✓ Lethargic] / Unresponsive GCS: 15

Orientated / Disoriented Pupils: 1mm [illegible] [illegible]

Extremity Movement: Full / [✓ Limited] / None

CARDIOVASCULAR

Pulse (0 - 4): +3 × 4 Radials posit... Pedals pos + me

Capillary Refill: brisk Seconds <3 Homan's Sign

Jugular Venous Distension (–) Edema (–)

Heart Sounds S1/S2 ST

Rhythm sinus tach PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			▨	▨
Site			(L) hand #18	(L) AC #16
Solution			LR	

Chest Pain

RESPIRATORY

Chest Expansion / [✓ Symmetrical] / Asymmetrical

Respiration / [✓ No Distress] / SOB / Labored / Use of Access Muscles

Breathing Patterns: [illegible]

Cough: Productive / Nonproductive / [✓ None]

Sputum: Color / Amount / Consistency / Odor NA

Chest Drainage System Gravity: N/A Suction cm:

Air Leak No Yes Crepitus

Character of Drainage:

Trachea / [✓ Midline] / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles	CTA bilat	
Wheezes		
Diminished		92% 4 sats
Absent		[illegible]

GASTROINTESTINAL

Abdomen: [✓ Soft] / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / [✓ Absent]

Dressings: Midline – C/D/I, [illegible] intact

NG Tube: [✓ Clamped]/Inter. Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Ø Character

Tube Feeding: Day No: Strength: Rate: Aspirate:

Stool: Character NDD

Drains: JP to midline [illegible]

GENITOURINARY

Urine Color: clear yellow Character: –clots to [illegible]

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER: restraints bilat

PATIENT ASSESSMENT

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin : Loose / Tight / Diaphoretic / Shiny / Dry

Skin : Temperature

Color: Pale / Cyanotic / Jaundiced

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils:

Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radials Pedals

Capillary Refill: Seconds Homan's Sign

Jugular Venous Distension Edema

Heart Sounds

Rhythm PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			▨	▨
Site				
Solution				

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

Respiration / No Distress / SOB / Labored / Use of Access Muscles

Breathing Patterns:

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor

Chest Drainage System Gravity: Suction cm:

Air Leak No Yes Crepitus

Character of Drainage:

Trachea / Midline / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings:

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate:

Stool: Character

Drains:

GENITOURINARY

Urine Color: Character:

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

MEDCOM - 12309

Skin: ① two fragment wounds,
size 1/2 dime to Ⓛ hip
draining serosang - med. amount;
pressure dsg applied
② 1/2 dime size frag wound
draining small amount of
serosang from Ⓡ distal
thigh - lateral aspect.
- bulky dsg to Ⓛ PA - c/d/i
N] groggy from anesthesia; responsive
to painful stimuli; makes
purposeful movements (attempts to
take off oxygen mask) with
UEs

b(6)-4 #[redacted]

Date: 29 Jun 03

PATIENT ASSESSMENT

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin : [✓ Loose] / Tight / Diaphoretic / Shiny / [✓ Dry]

Skin : Temperature WNL

Color: Pale / Cyanotic / Jaundiced NFR

Mucous Membranes: [✓ Moist] / Dry / Cracked

Skin Breakdown: [✓ None] Location: Size:

NEUROLOGICAL

Loc / [✓ Alert] / Lethargic / Unresponsive FL GCS: 15

Orientated / Disoriented Pupils: 3R

Extremity Movement: Full / [✓ Limited] / None

CARDIOVASCULAR

Pulse (0 - 4): 2+ Radials 2+ Pedals

Capillary Refill: <3 Seconds Homan's Sign

Jugular Venous Distension 0 Edema 0

Heart Sounds S1 S2

Rhythm SR PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			▨	▨
Site				
Solution				

Chest Pain

RESPIRATORY

Chest Expansion / [✓ Symmetrical] / Asymmetrical

Respiration / [✓ No Distress] / SOB / Labored / Use of Access Muscles

Breathing Patterns: regular

Cough: Productive / Nonproductive / [✓ None]

Sputum: Color / Amount / Consistency / Odor

Chest Drainage System Gravity: Suction cm:

Air Leak No Yes Crepitus

Character of Drainage:

Trachea / Midline / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds CTA	Anterior/Location	Posterior/Location
Crackles		
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen [✓ Soft] / Firm / Hard / Distended cm Girth

Bowel Sounds: [✓ ~~Normal~~] / Hyperactive / [✓ Hypoactive] / Absent

Dressings:

NG Tube: Clamped / [✓ Inter. Suction] / Cont. Suction/Dependent Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate:

Stool: Character

Drains: JP

GENITOURINARY

Urine Color: Yellow Character: clear

Voiding: Continent / Incontinent / [redacted]

EMOTIONAL[redacted]

THER[redacted]

24 Jun

b(6)-2

MEDCOM - 12311

PATIENT ASSESSMENT

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin : Loose / Tight / Diaphoretic / Shiny / [✓ Dry] / ⊘ turgor

Skin : Temperature - warm [redacted]

Color: Pale / Cyanotic / Jaundiced NFR b(6)-2

Mucous Membranes: [✓ Moist] / Dry / Cracked

Skin Breakdown: ~~None Location: Size:~~ see sick

NEUROLOGICAL

Loc / [✓ Alert] / Lethargic / Unresponsive GCS: 15

Orientated / [✓ Disoriented] Pupils: 2R

Extremity Movement: Full / Limited / None — see sick

CARDIOVASCULAR

Pulse (0 - 4): 3+-4 Radials 3+ Pedals 3+

Capillary Refill: <3 Seconds Homan's Sign

Jugular Venous Distension 0 Edema 0

Heart Sounds S1 + S2 ST

Rhythm ST PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			▨	▨
Site				
Solution				

Chest Pain

RESPIRATORY

Chest Expansion / [✓ Symmetrical] / Asymmetrical

Respiration / [✓ No Distress] / SOB / Labored / Use of Access Muscles CTA

Breathing Patterns:

Cough: [✓ Productive] / Nonproductive / None small amount [illegible]

Sputum: [✓ Color] / Amount / Consistency / Odor brown small, speckled

Chest Drainage System Gravity: [illegible] Suction cm:

Air Leak No Yes Crepitus

Character of Drainage:

Trachea / [✓ Midline] / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles	CTA s.bt	
Wheezes		
Diminished		sats 96 2L on
Absent		

GASTROINTESTINAL

Abdomen [✓ Soft] / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / [✓ Hypoactive] / Absent

Dressings: [illegible]

NG Tube: Clamped / [✓ Inter. Suction] / Cont. Suction/Dependent Drainage [illegible]

NG Drainage: Color Green Character

Tube Feeding: Day No: Strength: Rate: Aspirate:

Stool: Character

Drains:

GENITOURINARY

Urine Color: yellow Character: clear

Voiding: Continent / Incontinent / [✓ Foley] Catheter

EMOTIONAL/PSYCHOSOCIAL

see sick

[redacted]
b(6)-4

SC NTPG

29JUNE 03 1750:

[SKIN] (L) FLANK DSG - SMALL AMOUNT
SEROSANG c̄ SIZE = [illegible] x2;
(R) HIP DSG = SMALL AMOUNT
SEROSANG, ½ DIME SIZE = ~~[illegible]~~ [redacted] b6-2
[illegible] WOUND

[MSK] ULE to sling c̄ (+) [illegible];
OOB to chair x1

[PAIN] MSO4 / Tramadol given as ordered.

Cefotetan

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

FOR Use of this form, see AR 40-407; the proponent agency is The Office of the Surgeon General.

1. AGE: 24

HEIGHT:

WEIGHT: 80 kg

2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication)
☒ NKDA ☐ PCN ☐ LATEX ☐ IODINE ☐ TAPE ☐ FOOD
REACTION:

3. PREVIOUS SURGERY [ ] NO [✓] YES (type):
Exp Lap c̄ colostomy, I&D Lt forearm

4. PROPOSED SURGICAL PROCEDURE:
I&D Lt forearm

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition____
Tobacco ✓ ppd X___yrs. Body Piercing____ Diabetes (Y) (N) ROM____ ASA/Motrin w/72 hrs (Y) (N)
ETOH ✓ Implants____ Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS: Cefotetan, Torado Ancef

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to: ✓ 1) Surgical Procedure & Operating Room Environment ___ 2) Separation Anxiety (Child) ✓ 3) Surgical Outcomes	ø Pt. verbalizes any specific anxiety. ø Pt. Exhibits relaxed body posture.	ø Allow pt. to verbalize freely. ø Explain OR environment and answer questions regarding surgery. ø Offer comfort measures. (e.g., warm blanket, touch). ø Explain all nursing procedures before they are done. ø Remain with pt. whenever possible. ø Maintain family interface. Parents to stay with pt.
B. AERATION ✓ Potential for respiratory dysfunction due to: ✓ 1) Positioning ✓ 2) Effects of Anesthesia ✓ 3) Medical/Smoking History	ø Pt. will be able to breathe without difficulty during immediate intraoperative phase.	ø Offer to elevate head of litter or offer pillow. ø Observe pt. while awaiting surgery for signs of distress. ø Assist anesthesia during intubation and extubation.
C. INTEGUMENT ✓ Potential impairment of skin integrity due to: ✓ 1) Intraoperative Immobility ✓ 2) ESU Pad Placement ___ 3) Positional Aids ___ 4) Prosthesis ✓ 5) Pooling of Prep Solutions	ø Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened areas).	ø Utilize pressure preventing devices on OR table and accessories. ø Check for proper positioning and support to maintain good body alignment. ø Pad pressure points. ø Place ESU ground pad on non compromised skin surface area. ø Keep prep fluids from pooling.

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

#[redacted] b(6)-4

VERIFICATIONS AT HOLDING AREA:
! ID/Allergy Band
! H & P
! NPO Since MN
! UHCG/LMP
! Dentures Removed
! Contacts Removed
! Jewelry Removed
! Body Pierce Removed
! Consent/Blood Transfusion Signed/Witnessed/Dated
! Surgical Site/Consent verified by Pt./Anesthesia/Surgeon
! Contact Precautions (Y) [✓ (N)]
! Family/Friend: ø

DA FORM 5179, JUN 91 Previous editions are obsolete USAPA V1.0
MEDCOM - 12313

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to: ✓ 1) Intraoperative Mobility ___ 2) Positioning ___ 3) Existing Disease ___ 4) Safety Devices ✓ 5) Hypothermia	ø Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse.	ø Check for support stockings or ace wraps. If none, check with doctors. ø Check that safety straps are correctly applied. ø Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. ø Check that rings and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to: ✓ 1) Pain ✓ 2) Intraoperative Hazards ___ 3) Prosthesis ___ 4) Positioning ___ 5) Transfer pt. to/from OR table E.2. ✓ Potential discomfort due to: ✓ 1) Length of Surgery ✓ 2) Positioning ___ 3) Arthritis	ø Pt. will be transferred to OR table without difficulty. ø Pt. will not experience unnecessary physical discomfort.	ø Have sufficient people available for transfer. ø Insure proper body alignment. ø Allow patient to lie in position of comfort while waiting for surgery. ø Offer support (i.e., pillows, bath towels, etc.) for positioning.
F. SPECIAL SENSES F.1. ✓ Diminished visual perception due to being: ✓ 1) Pre-Medicated ___ 2) W/O Glasses F.2. ✓ Potential for decreased communication due to: ___ 1) Diminished Hearing ✓ 2) Language Barrier F.3. N/A Potential injury due to dentures: ___ 1) Upper ___ 4) Caps ___ 2) Lower ___ 5) Crowns ___ 3) Bridges	ø Pt. will be made aware of surroundings prior to anesthesia induction. ø Pt. will be transferred safely to OR table. ø Pt. will be able to understand instructions. ø Minimize danger of injury during intraop period.	ø Introduce self. Keep pt. informed as to where he/she is and what is happening. ø Inform pt. in which direction to move and assist if necessary. ø Speak clearly and slowly. o Address pt from either side. ø Validate pt.'s understanding of verbal communication. ø Verify removal of dentures.
G OTHER PATIENT PROBLEMS/NEEDS. Or continuation of above problems/needs. b(6)-2	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

10. O[redacted]S COMPLETE D/ADDITIONAL INTRAOPERATIVE INTERVENTION S NOTED.

17 RN   2 Jul 03 DATE

11. POSTOPERATIVE EVALUATION: SKIN INTEGRITY: Bovie Pad Site: ☐ Clean and Dry ☐ Red ☐ N/A DRESSING DRY & INTACT: (Y) (N)
LEVEL OF CONSCIOUSNESS: ☐ A&O ☐ Drowsy ☐ Sleepy ☐ Intubated BREATHING EASY: (Y) (N)
LEVEL OF ACTIVITY: ☐ Moves All Extremities ☐ Moves Upper Extremities
☐ Transferred to litter with roller due to spinal

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title)
[redacted] MAJ AN
DATE: 2 Jul 03 TIME: 1515

13. POSTOPERATIVE [redacted] RED BY (Signature and Title) [redacted]
DATE: 2 Jul 03 TIME: b(6)-2

REVERSE OF FORM 5179, JUN 91 b(6)-2 MEDCOM - 12314 USAPA V1.0

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

FOR Use of this form, see AR 40-407; the proponent agency is The Office of the Surgeon General.

1. AGE: ?
HEIGHT: ?
WEIGHT: ?

2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication)
☐ NKDA ☐ PCN ☐ LATEX ☐ IODINE ☐ TAPE ☐ FOOD
REACTION:

3. PREVIOUS SURGERY [ ] NO [ ] YES (type):

4. PROPOSED SURGICAL PROCEDURE:
Ex-Lap / (L) Forearm I&D

Unable to assess due to Emergency KEW

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition____
Tobacco____ppd X___yrs. Body Piercing____ Diabetes (Y) (N) ROM____ ASA/Motrin w/72 hrs (Y) (N)
ETOH____ Implants____ Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures____ Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS:

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL X Potential for anxiety related to: X 1) Surgical Procedure & Operating Room Environment ___ 2) Separation Anxiety (Child) X 3) Surgical Outcomes	o Pt. verbalizes any specific anxiety. o Pt. Exhibits relaxed body posture.	o Allow pt. to verbalize freely. o Explain OR environment and answer questions regarding surgery. o Offer comfort measures. (e.g., warm blanket, touch). o Explain all nursing procedures before they are done. o Remain with pt. whenever possible. o Maintain family interface. Parents to stay with pt.
B. AERATION X Potential for respiratory dysfunction due to: X 1) Positioning X 2) Effects of Anesthesia ___ 3) Medical/Smoking History	o Pt. will be able to breathe without difficulty during immediate intraoperative phase.	o Offer to elevate head of litter or offer pillow. o Observe pt. while awaiting surgery for signs of distress. o Assist anesthesia during intubation and extubation.
C. INTEGUMENT X Potential impairment of skin integrity due to: X 1) Intraoperative Immobility X 2) ESU Pad Placement X 3) Positional Aids ___ 4) Prosthesis X 5) Pooling of Prep Solutions	o Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened areas).	o Utilize pressure preventing devices on OR table and accessories. o Check for proper positioning and support to maintain good body alignment. o Pad pressure points. o Place ESU ground pad on non compromised skin surface area. o Keep prep fluids from pooling.

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

EPW #[redacted] b(6)-4

VERIFICATIONS AT HOLDING AREA
! ID/Allergy Band ! Dentures Removed
! H & P ! Contacts Removed
! NPO Since_____ ! Jewelry Removed
! UHCG/LMP ! Body Pierce Removed
! Consent/Blood Transfusion Signed/Witnessed/Dated
! Surgical Site/Consent verified by Pt./Anesthesia/Surgeon
! Contact Precautions (Y) (N)
! Family/Friend:__________

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MEDCOM - 12315

6. PATIENT PROBLEMS AND NEEDS	PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION __X__ Potential for inadequate tissue perfusion due to: __X__ 1) Intraoperative Mobility __X__ 2) Positioning ____ 3) Existing Disease __X__ 4) Safety Devices __X__ 5) Hypothermia	o Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse.	o Check for support stockings or ace wraps. If none, check with doctors. o Check that safety straps are correctly applied. o Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. o Check that rings and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL E.1. __X__ Potential impairment of mobility due to: __X__ 1) Pain __X__ 2) Intraoperative Hazards ____ 3) Prosthesis __X__ 4) Positioning __X__ 5) Transfer pt. to/from OR table E.2. __X__ Potential discomfort due to: __X__ 1) Length of Surgery __X__ 2) Positioning ____ 3) Arthritis	o Pt. will be transferred to OR table without difficulty. o Pt. will not experience unnecessary physical discomfort.	o Have sufficient people available for transfer. o Insure proper body alignment. o Allow patient to lie in position of comfort while waiting for surgery. o Offer support (i.e., pillows, bath towels, etc.) for positioning.
F. SPECIAL SENSES F.1. ____ Diminished visual perception due to being: ____ 1) Pre-Medicated ____ 2) W/O Glasses F.2. ____ Potential for decreased communication due to: ____ 1) Diminished Hearing ____ 2) Language Barrier F.3. ____ Potential injury due to dentures: ____ 1) Upper ____ 4) Caps ____ 2) Lower ____ 5) Crowns ____ 3) Bridges	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR table. o Pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt. from ________ side. o Validate pt.'s understanding of verbal communication. o Verify removal of dentures.
G OTHER PATIENT PROBLEMS/NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

10. OR NURSING INTERVENTIONS COMPLETED/ADDITIONAL INTRAOPERATIVE INTERVENTIONS NOTED.

[redacted] b(6)-2 28 JUN 03 DATE

11. POSTOPERATIVE EVALUATION: SKIN INTEGRITY: Bovie Pad Site: _X_ Clean and Dry ☐ Red ☐ N/A DRESSING DRY & INTACT: [✓ (Y)] (N)

LEVEL OF CONSCIOUSNESS: ☐ A&O ☐ Drowsy ☒ Sleepy ☐ Intubated

BREATHING EASY. [✓ (Y)] (N)

LEVEL OF ACTIVITY: ☒ Moves All Extremities ☐ Moves Upper Extremities ☐ Transferred to litter with roller due to spinal

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] b(6)-2

DATE: 28 June 03 TIME: 1235

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] b(6)-2

DATE: 28 June 03 TIME: 1715

REVERSE OF FORM 5179, JUN 91 MEDCOM - 12316 USAPA V1.0

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

FOR Use of this form, see AR 40-407; the proponent agency is The Office of the Surgeon General.

1. AGE: 23

HEIGHT:

WEIGHT:

2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication)
☒ NKDA ☐ PCN ☐ LATEX ☐ IODINE ☐ TAPE ☐ FOOD
REACTION:

3. PREVIOUS SURGERY [ ] NO [X] YES (type):
I&D Left arm & ex lap

4. PROPOSED SURGICAL PROCEDURE:
ORIF ulna

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition intact x wound sites
Tobacco Ø ppd X___yrs. Body Piercing________ Diabetes (Y) (N) ROM ↓ ASA/Motrin w/72 hrs (Y) (N)
ETOH Ø Implants________ Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) [✓ (N)] Dentures Hypertension (Y) (N) Herbal Medicines (Y) [✓ (N)] MEDS: Toradol, cefotan MSO4 prn

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to: ✓ 1) Surgical Procedure & Operating Room Environment ___ 2) Separation Anxiety (Child) ✓ 3) Surgical Outcomes	✓ Pt. verbalizes any specific anxiety. ✓ Pt. Exhibits relaxed body posture.	✓ Allow pt. to verbalize freely. ✓ Explain OR environment and answer questions regarding surgery. ✓ Offer comfort measures: (e.g., warm blanket, touch). ✓ Explain all nursing procedures before they are done. ✓ Remain with pt. whenever possible. ✓ Maintain family interface. Parents to stay with pt.
B. AERATION ✓ Potential for respiratory dysfunction due to: ✓ 1) Positioning ✓ 2) Effects of Anesthesia ✓ 3) Medical/Smoking History	✓ Pt. will be able to breathe without difficulty during immediate intraoperative phase.	✓ Offer to elevate head of litter or offer pillow. ✓ Observe pt. while awaiting surgery for signs of distress. ✓ Assist anesthesia during intubation and extubation.
C. INTEGUMENT ✓ Potential impairment of skin integrity due to: ✓ 1) Intraoperative Immobility ✓ 2) ESU Pad Placement ✓ 3) Positional Aids ___ 4) Prosthesis ✓ 5) Pooling of Prep Solutions	✓ Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened areas).	✓ Utilize pressure preventing devices on OR table and accessories. ✓ Check for proper positioning and support to maintain good body alignment. ✓ Pad pressure points. ✓ Place ESU ground pad on non compromised skin surface area. ✓ Keep prep fluids from pooling.

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

[redacted] b(6)-4

VERIFICATIONS AT HOLDING AREA:
! ID/Allergy Band
! H & P
! NPO Since MN
! UHCG/LMP
! Consent/Blood Transfusion Signed/Witnessed/Dated
! Surgical Site/Consent verified by Pt./Anesthesia/Surgeon
! Contact Precautions (Y) [✓ (N)]
! Family/Friend: Ø
! Dentures Removed
! Contacts Removed
! Jewelry Removed
! Body Pierce Removed

DA FORM 5179, JUN 91 Previous editions are obsolete. MEDCOM - 12317 USAPA V1.0

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to: ✓ 1) Intraoperative Mobility ✓ 2) Positioning ✓ 3) Existing Disease ✓ 4) Safety Devices ✓ 5) Hypothermia	✓ Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse.	✓ Check for support stockings or ace wraps. If none, check with doctors. ✓ Check that safety straps are correctly applied. ✓ Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. ✓. Check that rings and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to: ✓ 1) Pain ✓ 2) Intraoperative Hazards ___ 3) Prosthesis ✓ 4) Positioning ✓ 5) Transfer pt. to/from OR table E.2. ✓ Potential discomfort due to: ✓ 1) Length of Surgery ✓ 2) Positioning ___ 3) Arthritis	✓ Pt. will be transferred to OR table without difficulty. ✓ Pt. will not experience unnecessary physical discomfort.	✓ Have sufficient people available for transfer. ✓ Insure proper body alignment. ✓ Allow patient to lie in position of comfort while waiting for surgery. ✓ Offer support (i.e., pillows, bath towels, etc.) for positioning.
F. SPECIAL SENSES F.1. ✓ Diminished visual perception due to being: ✓ 1) Pre-Medicated ___ 2) W/O Glasses F.2. ✓ Potential for decreased communication due to: ___ 1) Diminished Hearing ✓ 2) Language Barrier F.3. ___ Potential injury due to dentures: ___ 1) Upper ___ 2) Lower ___ 3) Bridges ___ 4) Caps ___ 5) Crowns	✓ Pt. will be made aware of surroundings prior to anesthesia induction. ✓ Pt. will be transferred safely to OR table. ✓ Pt. will be able to understand instructions. ✓ Minimize danger of injury during intraop period.	✓ Introduce self. Keep pt. informed as to where he/she is and what is happening. ✓ Inform pt. in which direction to move and assist if necessary. ✓ Speak clearly and slowly. ✓ Address pt. from ELHUR side. ✓ Validate pt.'s understanding of verbal communication. ✓ Verify removal of dentures.
G OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

10. OR NURSING INTERVENTIONS COMPLETED/ADDITIONAL INTRAOPERATIVE INTERVENTIONS NOTED.

[redacted] 1LT/AN b(6)-2 30 JUN 03 DATE

11. POSTOPERATIVE EVALUATION: SKIN INTEGRITY: Bovie Pad Site: ☐ Clean and Dry ☐ Red ☐ N/A

LEVEL OF CONSCIOUSNESS: ☐ A&O ☐ Drowsy ☐ Sleepy ☐ Intubated

LEVEL OF ACTIVITY: ☐ Moves All Extremities ☐ Moves Upper Extremities ☐ Transferred to liter with roller due to spinal

DRESSING DRY & INTACT (Y) (N)

BREATHING EASY: (Y) (N)

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] 1LT/AN

DATE: 30 JUN 03 TIME: 0914

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title)

DATE: TIME:

REVERSE OF FORM 5179, JUN 91 MEDCOM - 12318 USAPA V1.0

All b(6)-2 except last

MEDICAL RECORD — **INTRAOPER[illegible]OCUMENT**

For use of this form, see AR 40-66, the prop[illegible] agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATIN[illegible] VIA Litter BY Anesthesia

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY Anesthesia

3. DATE 28 June 03 TIME PATIENT ARRIVED IN SUITE 1255

4. PATIENT IN ROOM TIME 1255 NUMBER 2 [illegible] #4

5. PREOPERATIVE EMOTIONAL STATUS

☐ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☒ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS: ~~Allergies:~~ [redacted] Pt sedated.

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted]	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted]	RELIEF CIRCULATOR	MAJ [redacted] 1145-1230

7. POSITION AND POSITIONAL AIDS *(Specify)* Pt in proper body alignment. Arms on arm boards ie <90°. Tourniquet placed on left upper arm by D[redacted] Tourniquet isolated

☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

COMMENTS: From prep c̄ 1015 U-drape.

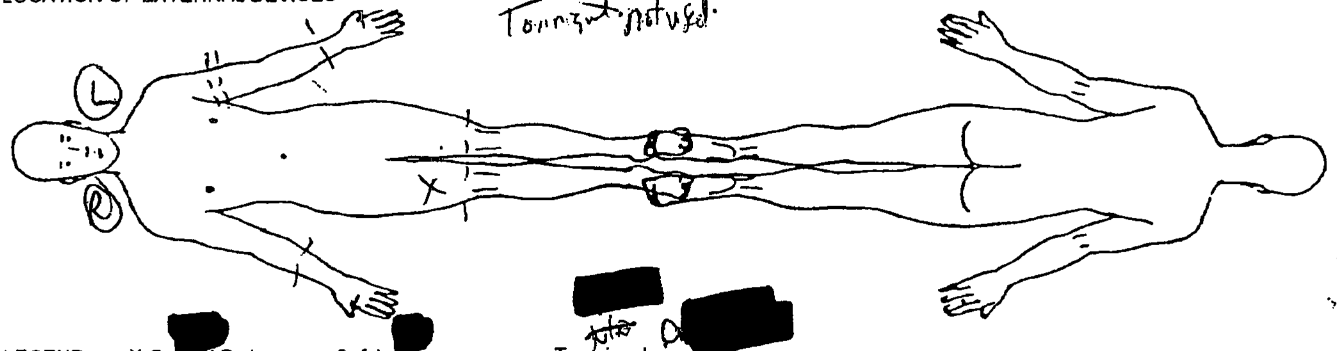
8. SKIN PREPARATION

HAIR REMOVAL ☒ YES ☐ NO
DONE BY: ☒ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP
COMMENTS: no nicks noticed - shaved ABD - MAJ [redacted]

PREP SOLUTION *(Specify)* Betadine Scrub / Paint
SITE: ABD BY WHOM: MAJ [redacted]
SITE: left arm BY WHOM: CPT [redacted]
COMMENTS: no pooling noted

9. LOCATION OF EXTERNAL DEVICES

Tourniquet noted.



LEGEND X Gr[redacted]nd Pad -- Safety [redacted]trap === Tourniquet [redacted] ~~[illegible]~~ D[redacted]

C = Correct I = Incorrect Initial count - SPC [redacted] / CPT [redacted]

10. COUNTS			First count Other**	~~First~~ Closing Count [illegible]	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes	☐ No	C	C	C	[redacted] SPC	[redacted] CPT
Needle Sharp	☒ Yes	☐ No	C	C	C		
Instrument	☒ Yes	☐ No	C	C			
Other	☐ Yes	☒ No					

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

EPW # [redacted] b(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO

☒ ESU NO: 000450
GROUND PAD: BRAND Valleylab
LOT NO: 69652

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES [illegible] WHICH IS OBSOLETE. USAPA V1.01

MEDCOM - 12319

13. PROSTHESIS, IMPLANTS ☐ YES ☒ NO IF YES NAME: ID NUMBER; MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☒

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S): 0.9% NS

OTHER ORDERS	TIME	CARRIED OUT BY
[redacted]		

PHYSICIAN'S SIGNATURE b(6)-2

15. X-RAY IN OPERATING ROOM IF YES, SITE
YES ☐ NO ☒

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE/SIZE	10mm JP		
SITE	ABD		

18. DRESSING/IMMOBILIZATION *(Specify)*
4x8-ABD
Fluffs, webril, splint, webril, ace - left arm

19. ADDITIONAL INFORMATION
WC IV
Surgeons: [illegible]/[illegible]/[illegible] Anesthesia: CPT [redacted] Anesthesia Type: General
b(6)-2

Bovie Pad site intact pre-op CDI; post-op CDI Bovie Settings: Coag/Cut 30/30

20. OPERATION(S) PERFORMED
#1 Exploratory Laparotomy c̄ small bowel resection & colostomy / #2 I&D left forearm

21. PATIENT TRANSFERRED TO ICU #1 TIME 1710 METHOD Litter

22. REGISTERED NURSE SIGNATURE K– [redacted] b(6)-2

REVERSE OF DA FORM 5179-1, OCT 87

USAPA V1.01

MEDCOM - 12320

All b(6)-2 except last

MEDICAL RECORD

INTRAOPER…VE DOCUMENT

For use of this form, see AR 40-66, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: Litter BY: Anes. Staff
2. PATIENT [redacted] PROCEDURE VERIFIED BY [redacted] CPT/Ans
3. DATE: 30 June 2003 TIME PATIENT ARRIVED IN SUITE: ICU → OR
4. PATIENT TIME: 1909 NUMBER: 2-4

5. PREOPERATIVE EMOTIONAL STATUS

☑ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS: MCDA, NPO PMN

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] ORT	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT. [redacted] 66E)	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

☑ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

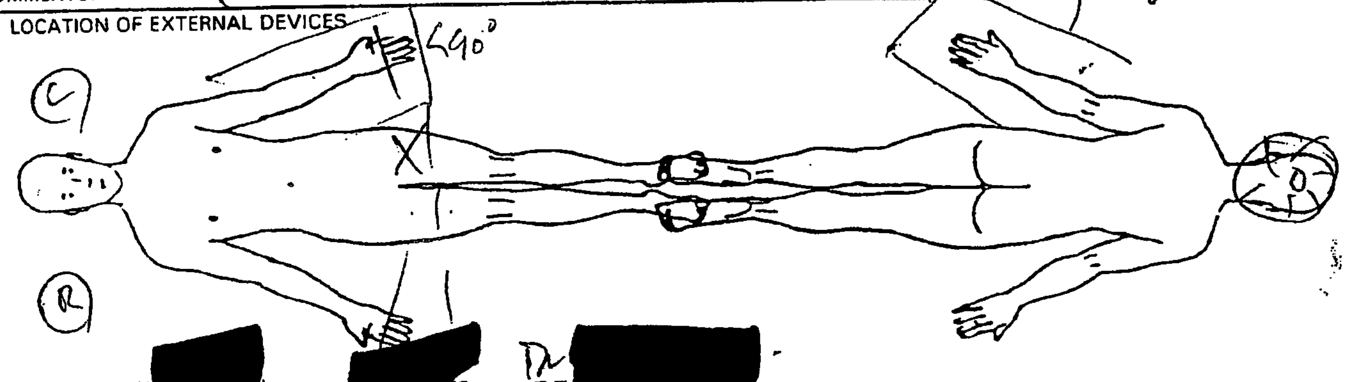
COMMENTS: Two armboard used to Lt arm

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☑ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP
COMMENTS: Ø

PREP SOLUTION *(Specify)*: Betadine s/sol
SITE: Lt. arm BY WHOM: Maj [redacted]
SITE: ~ BY WHOM: ~
COMMENTS: Ø Poolings of sol.

9. LOCATION OF EXTERNAL DEVICES



LEGEND X [redacted] -- [redacted] ap == [redacted]

10. COUNTS

C = Correct I = Incorrect

10. COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☑ Yes	☐ No	/	C	C	SPC [redacted]	CPT [redacted]
Needle Sharp	☑ Yes	☐ No	/				
Instrument	☐ Yes	☑ No	/	/	/		
Other	☐ Yes	☑ No	/				

11. PATIENT IDENTIFICATION

(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)

[redacted] b(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☑ YES ☐ NO

☑ ESU NO: Valley Lab 4
GROUND PAD: BRAND: Polyhesive
LOT NO: 68936
☐ ESU NO:
GROUND PAD: BRAND:
LOT NO:
☐ BIPOLAR NO:
Coag: 30 Cut: 30

MEDCOM - 12321

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.01

13. PROSTHESIS, IMPLANTS ☑ YES ☐ NO IF YES NAME: ID NUMBER; MANUFACTURER

K-wire 1/8" x 1 Lot # 0617102.

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☑

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S):
0.9% NaCl pulse lavage

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE [redacted] b(6)-2

15. X-RAY IN OPERATING ROOM YES ☑ NO ☐ ARM IF YES, SITE Ⓛ arm

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☑	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☑	NAME	NAME
CULTURE (C) YES ☐ NO ☑	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☐ NO ☑

TYPE/SIZE	1. Cerlix Packing	2.	3.
SITE	Ⓛ Ulna.	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Hutts
Kerlix
Ace & splint.

19. ADDITIONAL INFORMATION

Surgeon: Dr [redacted] b(6)-2
Anes: Maj [redacted]

20. OPERATION(S) PERFORMED

Lt. arm washout, ORIF.

21. PATIENT TRANSFERRED TO ICU TIME See Anes Record METHOD Litter

22. REGIS[redacted] CPT/AN

b(6)-2

All b(6)-2 except last

MEDICAL RECORD | **INTRAOPERA. _DOCUMENT**
For use of this form, see AR 40-66, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: Litter BY MAJ [redacted] /MAJ [illegible]
2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY 1LT [redacted]
3. DATE 2 Jul 03 TIME PATIENT ARRIVED IN SUITE 1525
4. PATIENT IN ROOM TIME 1525 NUMBER 2-1

5. PREOPERATIVE EMOTIONAL STATUS

☒ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS: NPO p MN. NKDA

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted]	RELIEF SCRUB	
ASSIGNED CIRCULATOR	MAJ [redacted] 1LT [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

☑ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

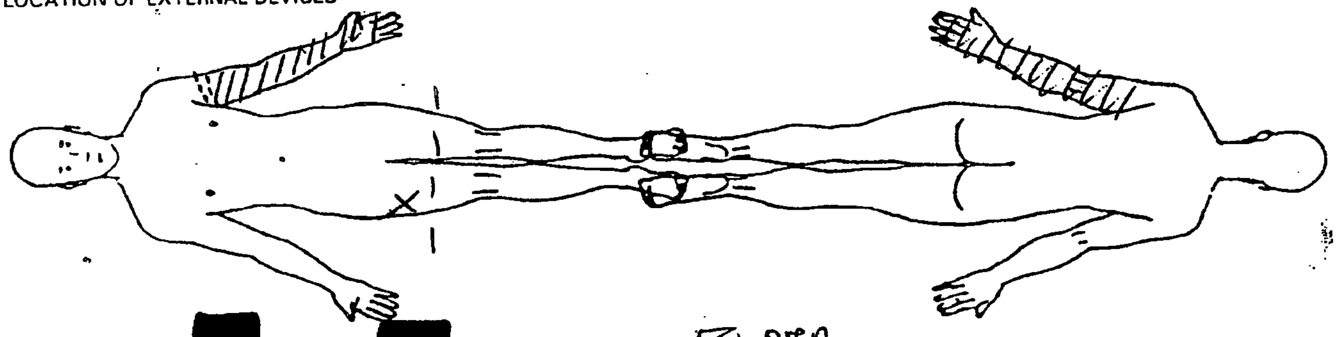
COMMENTS:

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP
COMMENTS: N/A

PREP SOLUTION *(Specify)* Povidone scrub & solution
SITE: Left arm BY WHOM: 1LT
SITE: BY WHOM:
COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



[redacted] [redacted]

LEGEND X Ground Pad -- Safety Strap === Tourniquet ▨ prep

Initial: SPC [redacted] 1LT

10. COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☑ Yes	☐ No		C	C	SPC [redacted]	1LT [redacted]
Needle Sharp	☑ Yes	☐ No					
Instrument	☐ Yes	☑ No					
Other	☐ Yes	☑ No					

C = Correct I = Incorrect

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

[redacted] b(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☑ YES ☐ NO

☑ ESU NO: Valley lab # 3 cut 30 coag 30
GROUND PAD: BRAND Valleylab
LOT NO: 65716 Exp 2004-11

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 MEDCOM - 12323 REPLACES DA FORM 5179-1 (TEST), DEC 84, WHICH IS OBSOLETE. USAPA V1.01

13. PROSTHESIS, IMPLANTS ☐ ☒ NO IF YES NAME: ID NUM MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☐

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S): N.S.

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE [redacted] b(6)-2

15. X-RAY IN OPERATING ROOM IF YES, SITE

YES ☐ NO ☒

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 10mm J-P drain	2.	3.
SITE	1. LFA	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

Flufts, Kerlix, webril splint, ACE

19. ADDITIONAL INFORMATION

Surgeon Dr [redacted] b(6)-2

Anes: MAJ [redacted]

DA 5179 In Chart

20. OPERATION(S) PERFORMED

I&D Lt forearm

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU 2	See DA3389	Litter

22. REGISTERED NURSE SIGNATURE [redacted]

REVERSE OF DA FORM 5179-1, OCT 87 USAPA V1.0

b(6)-2

MEDCOM - 12324

MEDICAL RECORD

INTRAOPERA . E DOCUMENT

For use of this form, see AR 40-66, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Litter BY Anesthesia

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY [redacted] CPT/AN

3. DATE 15 JUL 03 TIME PATIENT ARRIVED IN SUITE 1036

4. PATIENT IN [redacted] b(6)-4 TIME 1036 NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

☐ CALM ☒ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SGT [redacted] b(6)-4	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

COMMENTS: Proper body alignment

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

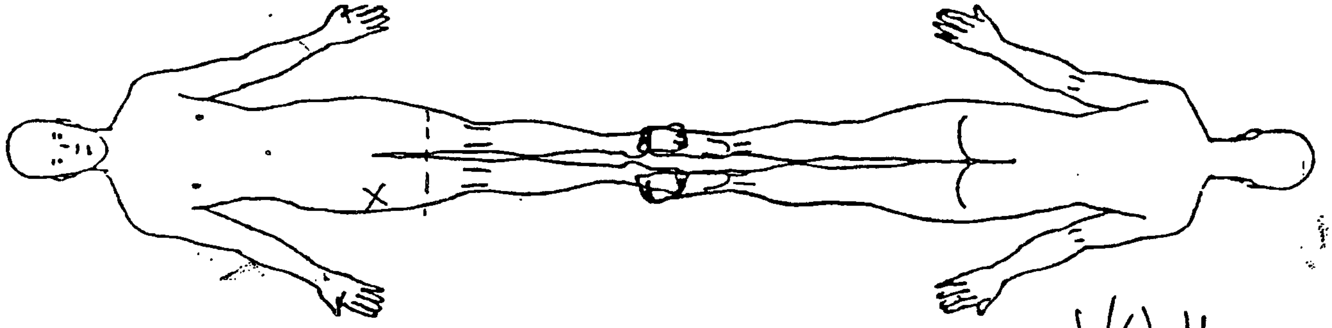
PREP SOLUTION *(Specify)* Hibiclens/NS

SITE: Abd. BY WHOM: [redacted]

SITE: BY WHOM:

COMMENTS: No pooling of fluids

9. LOCATION OF EXTERNAL DEVICES



b(6)-4

LEGEND X Ground Pad --- Safety Strap = = = Tourniquet

C = Correct I = Incorrect Initial C [redacted]

10. COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes	☐ No					
Needle Sharp	☒ Yes	☐ No					
Instrument	☐ Yes	☒ No					
Other	☐ Yes	☒ No					

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

#[redacted] b(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☐ YES ☐ NO

☐ ESU NO: FOE000450

GROUND PAD: BRAND Valleylab

LOT NO: 68936

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

MEDCOM - 12325

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.01

13. PROSTHESIS, IMPLANTS ☐ YES ☒ NO IF YES NAME: ID NUMBER; MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☒

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

0.9% NS

OTHER ORDERS	TIME	CARRIED OUT BY
NONE		

PHYS[redacted] b(6)-2

15. X[redacted] IF YES, SITE

YES ☐ NO ☒

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 1/2" Iodoform	2.	3.
SITE	1. abdomen	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

4X8 Opsite

Ta[redacted] b(6)-2

19. ADDITIONAL INFORMATION

Surgeon: [redacted]

Anesthesia: [redacted]

b(6)-2

20. OPERATION(S) PERFORMED

DPC Open Abd. Wound

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICW2 Recover in ICU 2	1130	Litter w/anesthesia

22. REGISTERE[redacted] CPT/AN

b(6)-2

REVERSE OF DA USAPA V1.01

MEDCOM - 12326

MEDICAL RECORD

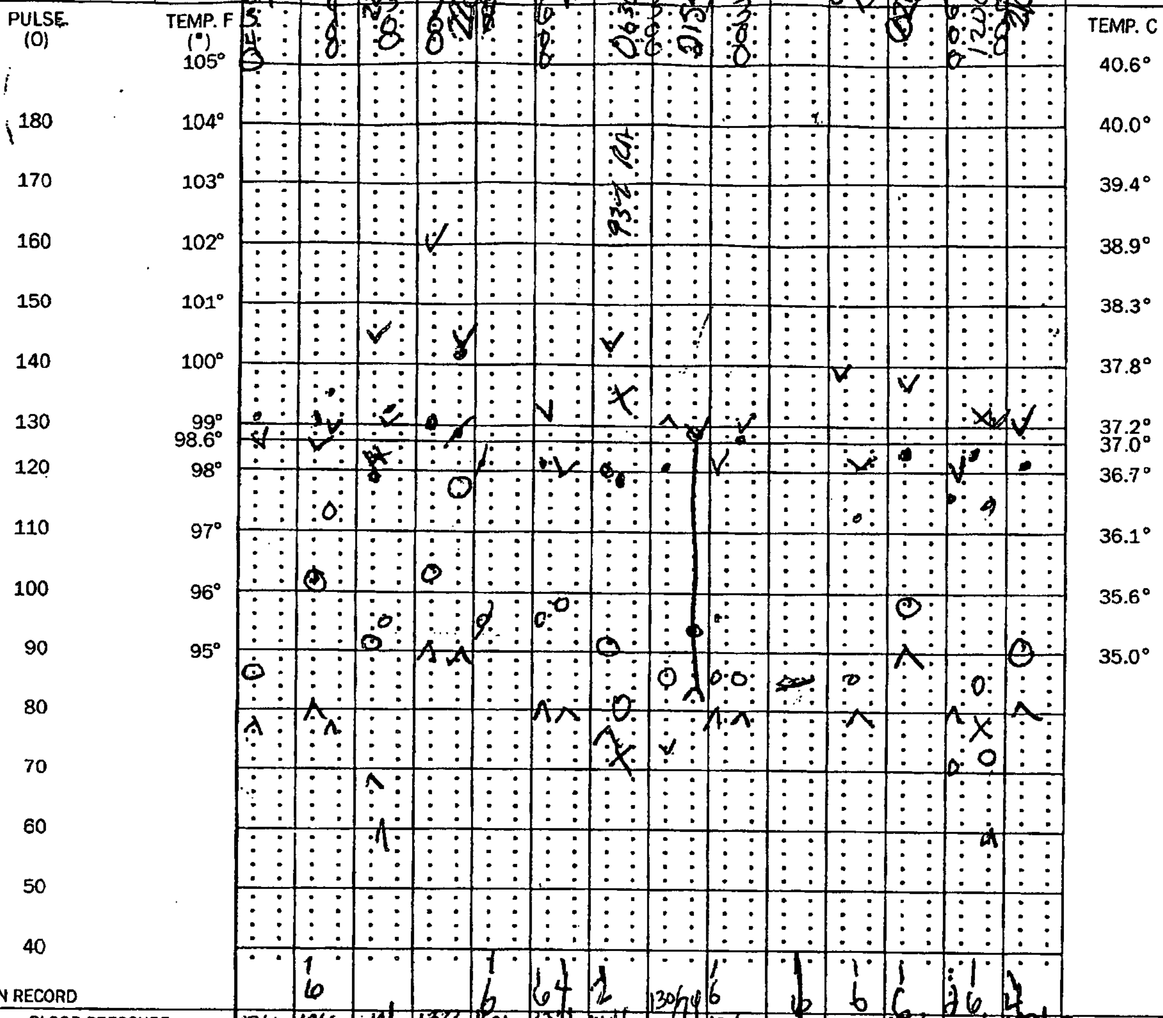
VITAL SIGN ECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR July '19 DAY: Jun 30, 1, 2, 3, 4, 5, 6, 7

HOUR: 2100, 1800, 0830, 1800, 0630, 1800, 0630, 2155, 1300, 0813, 1800, 0600, 1200, 1800



RESPIRATION RECORD: 16, 16, 16, 12, 16, 16, 16, 16, 16, 12

Record special data only when so ordered

BLOOD PRESSURE: 124/78, 126/80, 144/78, 132/70, 160/90, 132/70, 144/76, 130/74, 129/80, 130/70, 129/80, 128/82

SPO2 R: 98, 98%, 130/60, 144/90, 128/80, 130/78, 129/80, 130/60

16, 95, 97%, 98%, 97%, 93%, 80/60

HEIGHT: WEIGHT →: 124/78, 97 RA, 94%, 95%, 96%

94%, 81%, 97%, 93%, 98%, 96%, 94%

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*

REGISTER NO.

WARD NO. ICW2

STANDARD FORM 511 (REV. 7-95) BACK

[redacted] b(6)-4

MEDCOM - 12327

ACLU-RDI 1592 p.220

511-119

NSN 7540-00-634-4124

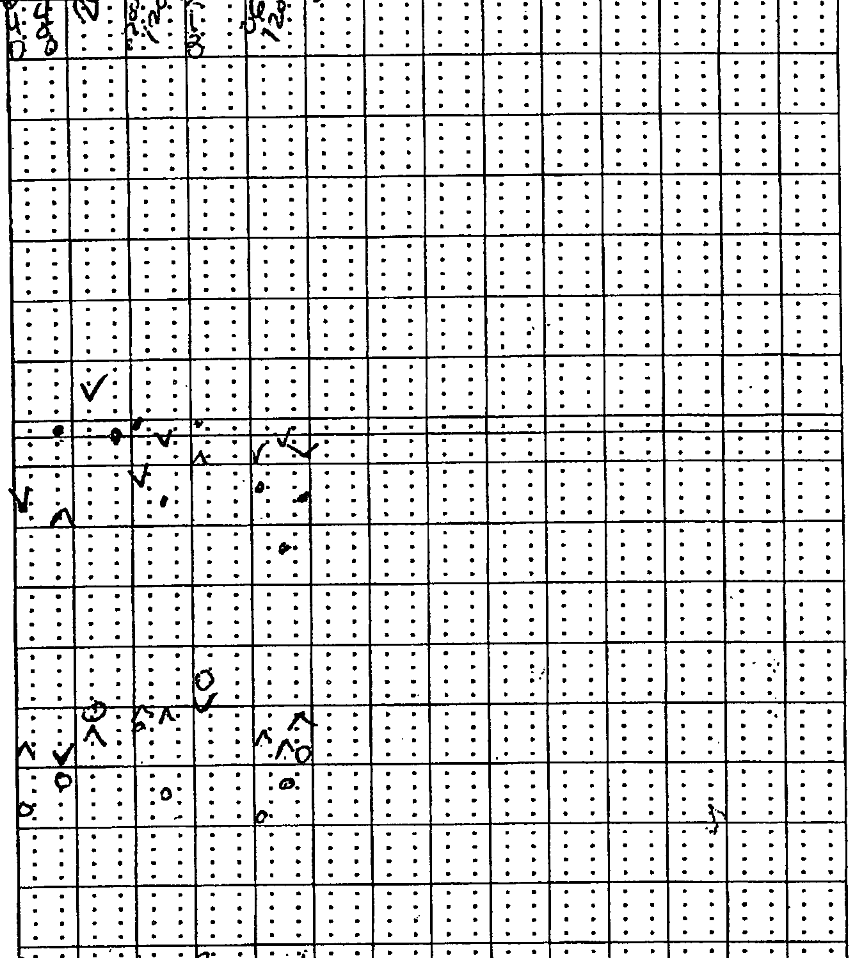
MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY							
POST- DAY							
MONTH-YEAR / DAY	8	9	10	11	12	13	14
19 / HOUR	[illegible]	[illegible]	[illegible]				

PULSE (O)	TEMP. F (•)	TEMP. C
	105°	40.6°
180	104°	40.0°
170	103°	39.4°
160	102°	38.9°
150	101°	38.3°
140	100°	37.8°
130	99°	37.2°
	98.6°	37.0°
120	98°	36.7°
110	97°	36.1°
100	96°	35.6°
90	95°	35.0°
80		
70		
60		
50		
40		

(Centigrade Equivalents, for Reference only)



RESPIRATION RECORD	2	16	18	20	18	16
BLOOD PRESSURE	112/64	131/[illegible]	124/80		100/76	
	112/68		124/80		122/78	
HEIGHT: / WEIGHT →						
	96%	95%				

Record special data only when so ordered

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*

REGISTER NO.

WARD NO.

[redacted] b(6)-4

VITAL SIGNS RECORDS

Medical Record

STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 12328

511-119

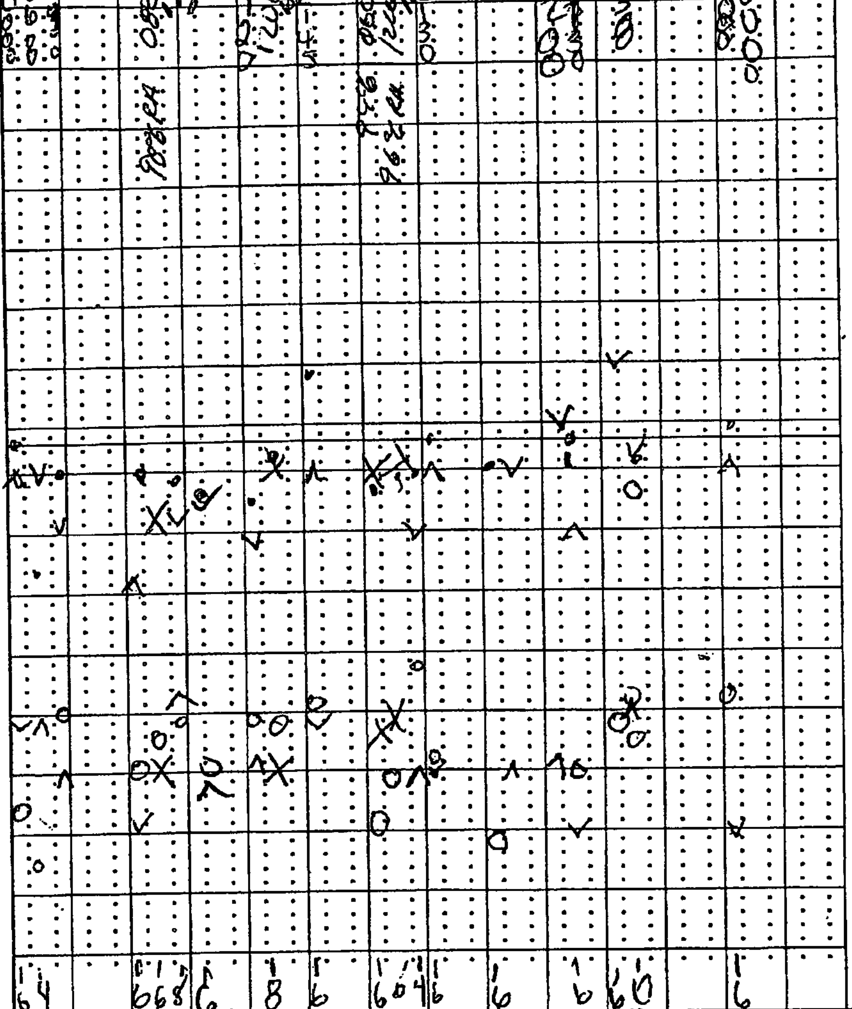
NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY
POST- DAY
MONTH-YEAR July 2003

DAY	11	12	13	14	15	16	17
HOUR	[illegible]	0800 1248	0800 1200 1345	0800 1200 1330	1200	1300	0800 2000



	11	12	13	14	15	16	17
RESPIRATION RECORD	16 14	16 16 18 16	18 16	16 10 14 16	16 16	16 10	16
BLOOD PRESSURE	120/70 110/70	112/84	114/[illegible] 108/72	108/70	120/70 130/72	130/80 128/80	
HEIGHT: WEIGHT →							
	96% 95%	96% 98%	97%	93%	98% 98%	94%	

Record special data only when so ordered

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*

REGISTER NO.

WARD NO.

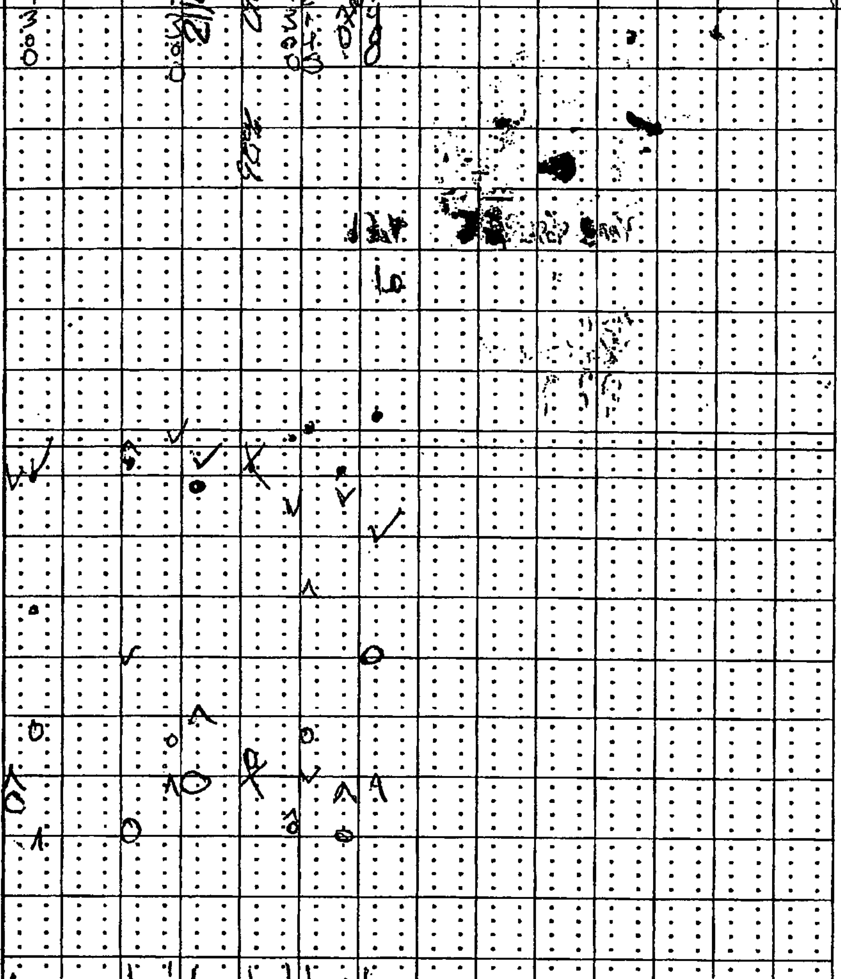
#[redacted] b(6)-4

VITAL SIGNS RECORDS
Medical Record

STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 12329

MEDICAL RECORD	VITAL SIGNS RECORD						
HOSPITAL DAY							
POST- DAY	18	19	2021	21	22	23	24
MONTH-YEAR July DAY							
19 2003 HOUR	1	14	0800 12	1			
	380	2114	0340 05	08			



	18		19		20		21	
RESPIRATION RECORD	16		18	14	16	16	16	16
BLOOD PRESSURE	120/70 120/70		128/70	122/82	114/64	114/60	110/70	
HEIGHT: WEIGHT →	95%		96% BPM			95		

Record special data only when so ordered

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)

REGISTER NO.

WARD NO. TCW 2

STANDARD FORM 511 (REV. 7-95) BACK

[redacted] b(6)-4

MEDCOM - 12330

Date 28JUNE 03 Bed # 5

Patient's Name: EDW [redacted] B(6)-4

Time	05	06	07	08	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
BP														153/93	137/85	139/90	137/92	138/89	133/82					
TEMP															99.1									
HR														110	114	110	111	112	109					
RR														16	16	15	14	13	14					
SAO2														98	99	98	97	96	97					
FIO2														10LFM	10LFM	2LNC	2LNC	2LNC	2LNC					
INPUT																								
PO																								
IV														100	125	125	125	125	125					
NGT														clam	LIWS									
Running Total															225	350	375	500	625					
TURN Q 2																								
TOTAL																								
OUTPUT																								
URINE														200	125	140	130	150	75					
NGT																								
STOOL																								
JP														30										
TOTAL														230	355	495	625	775	850					
BALANCE																								
Initials														[redacted]	[redacted]	[redacted]	[redacted]	[redacted]						

b(6)-2

MEDCOM - 12331

EMT
[redacted] b(6)-4

28 Jun

(i-STAT)

TEST	*RESULT*	*REF. RANGE*
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.35-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) [illegible] (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2)-(+3) mmol/L
AnGap		10-20 mmol/L
iCa		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.6-1.3 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	*RESULT*	*REF. RANGE*
Troponin I		Negative
Drug of Abuse		Negative
		Negative
		Negative
		Negative

(Piccolo) Chemistry 12

TEST	*RESULT*	*REF. RANGE*
ALB	3.3	3.5-5.5 g/dl
ALP	57	26-84 u/l
ALT	34	10-47 u/l
AMY	33	14-97 u/l
AST	32	11-38 u/l
TBIL	0.6	0.2-1.6 mg/dl
BUN	11	7-22 mg/dl
CA++	8.0	8.0-10.3 mg/dl
CHOL	98	100-200 mg/dl
CRE	1.0	0.6-1.2 mg/dl
GLU	125	73-118 mg/dl
TP	5.6	6.4-8.1 g/dl

~~(Piccolo) Metlyte 8~~

TEST	*RESULT*	*REF. RANGE*
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 u/l (M) 30-190 u/l (F)
NA+		128-145 mmol/l
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
tCO2		18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	*RESULT*	*REF. RANGE*
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA++		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA+		128-145 mmol/l
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
tCO2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	*RESULT*	*REF. RANGE*
ALB		3.3-5.5 g/dl
ALP		20-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	*RESULT*	*REF. RANGE*
NA+	130	128-145 mmol/l
K+	4.3	3.3-4.7 mmol/l
CL-	108	98-108 mmol/l
tCO2	23	18-33 mmol/l

REMARKS:

REPORTED BY:	**DATE:**	**LAB ID NO.:**
[redacted] b(6)-2	28 Jun	

B(6)-2

Ward/Section: EMT	REQU	G PH [redacted]	**L RATORY RESULT FORM** (Subjec the Privacy Act of
LAST, FIRST, M [redacted] B(6)-4		26 JUN 03	TIME 1200
SSN [redacted] b(6)-4			

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	17.2	4.8-10.8 x 10³
RBC	4.13	4.7-6.1 x 10⁹
Hgb	12.1	14-18 g/dl (M) 12-16 g/dl (F)
Hct	38.0	42-52% (M) 37-47% (F)
MCV	91.9	80-94 fl (M) 81-99 fl (F)
Plt	405	130-500 x 10³ verified
Lymph %	10.2	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis

TEST	RESULT	REF. RANGE
Color	Yellow	N/A
App	clear	N/A
Glu	Neg	Negative
Bili	Neg	Negative
Ket	Neg	Negative
SG	1.020	N/A
Bld	Neg	Negative
pH	6.0	N/A
Prot	Neg	Negative
Urob	0.2	0.2-1.0
Nit	Neg	Negative
Leuk	Neg	Negative
HCG		Negative

Misc Serology

TEST	RESULT	REF
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

CSF

Cell Count			
Directigen		Negative	

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

(Coagulation Studies)

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH
[redacted] b(6)-4		
PT = 12.1		
PTT = 22.9		

REMARKS:

REPORTED BY: | **DATE:** | **LAB ID NO.:**

MEDCOM - 12333

Ward/Section: ICU #1

EQUESTING PHYSICIAN: [redacted] b(6)-2

LABORATORY RESULT F
(Subject to the Privacy Act of 1

LAST, FIRST, MI. EPW # [redacted] b(6)-4

DATE 4/29/03

TIME 0400

SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	11.4	4.8-10.8 x 10^3
RBC	3.95	4.7-6.1 x 10^9
Hgb	11.4	14-18 g/dl (M) 12-16 g/dl (F)
Hct	36.6	42-52% (M) 37-47% (F)
MCV	92.6	80-94 fl (M) 81-99 fl (F)
Plt	342	130-500 x 10^3 verified
Lymph %	12.0	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			
Spun Hematocrit		42-52% (M) 37-47% (F)	
Sed Rate			
Other			

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc Serology

TEST	RESULT	REF
RPR		Negati
Mono		Negati

Microbiology

Source		
Gram Stain		
Occ Bld		Neg
H. pylori		Neg
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinaly

Blood Bank

MUST SUBMIT SF 518 V
EVERY UNIT REQUES

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Blood Bank Unit Crossmatch
(MUST SUBMIT SF 518 WITH EVERY UNIT OF BLO
REQUESTED)

UNIT	TYPE	CROSSMA

REMARKS: CBC

REPORTED BY: b(6)-2 [redacted]

DATE: 29Apr03

LAB ID NO.:

MEDCOM - 12334

ection: ICU#1 | REQ | NG PHYSICIAN: [redacted] b(6)-2

RATORY RESULT FORM
(Subject to the Privacy Ac

FIRST, MI. EPW [redacted] b(6)-4 | DATE 6/30/03 | TIME 0400 | SSN/PSEUDO SSN

(Hematology) CBC

T	RESULT	REF. RANGE
	8.8	4.8-10.8 x 10⁹
	3.06	4.7-6.1 x 10⁹
	9.1	14-18 g/dl (M) 12-16 g/dl (F)
	28.1	42-52% (M) 37-47% (F)
	91.6	80-94 fl (M) 81-99 fl (F)
	311	130-500 x 10⁹ verified
%	16.4	20.5-51.1%

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

Misc. Serology

TEST	RESULT	RE
RPR		Negative
Mono		

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

matology) Manual Differential

		Mono	
		Eos	
		Baso	
		Imm	

crit		42-52% (M) 37-47% (F)
e		

Microscopic Urinalysis

CSF

Cell Count			
Directigen		Negative	

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

(Coagulation Studies

	RESULT	REF. RANGE
		9.8-13.6 secs
		21-34 secs
r		<20 ug/ml
		<10 ug/ml

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

RKS:

RTED BY: [redacted] | DATE: 30Jun03 | LAB ID NO.:

b(6)-2

MEDCOM - 12335

Ward Section: ICU#1	REQUEST. PHYSICIAN: [redacted] b(6)-2			**CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)
LAST, FIRST, MI EPW [redacted] b(6)-4		DATE 6/30	TIME 0400	SSN/PSEUDO SSN:

(i-STAT)

TEST	*RESULT*	*REF. RANGE*
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.35-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2)-(+3) mmol/L
AnGap		10-20 mmol/L
iCa		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	*RESULT*	*REF. RANGE*
Troponin I		Negative
Drug of Abuse		Negative
		Negative
		Negative
		Negative

(Piccolo) Chemistry 12

TEST	*RESULT*	*REF. RANGE*
ALB		3.5-5.5 g/dl
ALP		20-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA++		8.0-10.3mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

(Piccolo) Meltyte 8

TEST	*RESULT*	*REF. RANGE*
GLU	118	73-118 mg/dl
BUN	10	7-22 mg/dl
CRE	0.8	0.6-1.2 mg/dl
CK	1369	39-380 u/l (M) 30-190 u/l (F)
NA+	116	128-145 mmol/l
K+	4.4	3.3-4.7 mmol/l
CL	101	98-108 mmol/l
tCO2	30	18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	*RESULT*	*REF. RANGE*
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA+		128-145 mmol/l
K+		3.3-4.7 mmol/l
CL		98-108 mmol/l
tCO2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	*RESULT*	*REF. RANGE*
ALB		3.3-5.5 g/dl
ALP		20-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	*RESULT*	*REF. RANGE*
NA		128-145 mmol/l
K+		3.3-4.7 mmol/l
CL		98-108 mmol/l
tCO2		18-33 mmol/l

REMARKS:

REPORTED BY: [redacted]	**DATE:** 30Jun03	**LAB ID NO.:**

b(6)-2

Ward Section ICW 2	RE[redacted]NG PHYSICIAN: b(6)-2	**LAB[illegible]RY RESULT FORM** (Sub[illegible] to the Privacy Act of 1974)
LAST, FIRST, MI EPW [redacted] b(6)-4	DATE 0400	TIME 1 July
		SSN/PSEUDO SSN

(Hematology) CBC

TEST	RESULT	REF RANGE
WBC	6.8	4.8-10.8 x 10³
RBC	3.07	4.7-6.1 x 10⁶
Hgb	9.0	14-18 g/dl (M) 12-16 g/dl (F)
Hct	28.3	42-52% (M) 37-47% (F)
MCV	92.1	80-94 fl (M) 81-99 fl (F)
Plt	404	130-500 x 10³ verified
Lymph %	20.3	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		< 20 ug/ml
FDP		< 10 ug/ml

Blood Bank Unit Crossmatch
(MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS: Also Hct [illegible] (calculation)

REPORTED BY: [redacted]	**DATE:** 01 Jul 03	**LAB ID NO.:**

b(6)-2

MEDCOM - 12337

Ward/Section: EmT	ESTING Dr. [redacted] b(6)-2		**LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)
LAST, FIRST, MI.		DATE 6Jul03	TIME 2215
			[redacted] DO SSN: b(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	10.6	4.8-10.8 x 10^3
RBC	3.91	4.7-6.1 x 10^9
Hgb	11.4	14-18 g/dl (M) 12-16 g/dl (F)
Hct	36.2	42-52% (M) 37-47% (F)
MCV	92.4	80-94 fl (M) 81-99 fl (F)
Plt	966	130-500 x 10^3 verified
Lymph %	18.7	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

Spun ematocrit		42-52% (M) 37-47% (F)
d Rate		
er		

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

T	RESULT	REF. RANGE
		9.8-13.6 secs
	\	21-34 secs
		<20 ug/ml
		<10 ug/ml

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

RKS:

D BY: [redacted] b(6)-2

DATE: 6Jul03

LAB ID NO.:

MEDCOM - 12338

MEDICAL RECORD - ANESTHESI.

For ‿ of this form, see AR 40-66; the proponent agenc‿ ‿ne OTSG

NKDA

Procedure verified

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML. "I" = CONSTANT INFUSION

DRUG (Units)			
Lido (MG)	50		
Fentanyl (UG)	250		
Propofol (MG)	200		
Sux (MG)	100		
( )			
( )			
VOLAT AGENT 150 % del		3.0	2.0 X
% e.t.			
AIR L/Min			
~~N2O~~ L/Min			
O2 L/Min	6	2	2

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS → ↓ induction

FLUIDS

LINE site #20 (R) PA ☑ Warmed LR ↑ ——————

☐ Warmed

☐ Warmed

☐ Warmed

LOSSES EST BLOOD LOSS

URINE -

TOTALS	
TOTAL EBL	min
TOTAL URINE	—

FLUIDS SUMMARY

CRYSTALLOID- LR - 700

COLLOID-

BLOOD-

REMARKS

Code drugs with numbers, events with lettters

1030 - Meto 10 - Preop done - Chart red IV in place

1045 In room - monitors on Induction & intubation

1130 - Opened eyes - extubated to ICU 2 for recovery

66-2

[redacted]

ICU 2

PHYS STATUS 1 [✓ 2] 3 4 5 E

BODY WEIGHT: 80 [✓ KG] LB

HEMATOCRIT:

INITIAL DATA: BP- 105/55

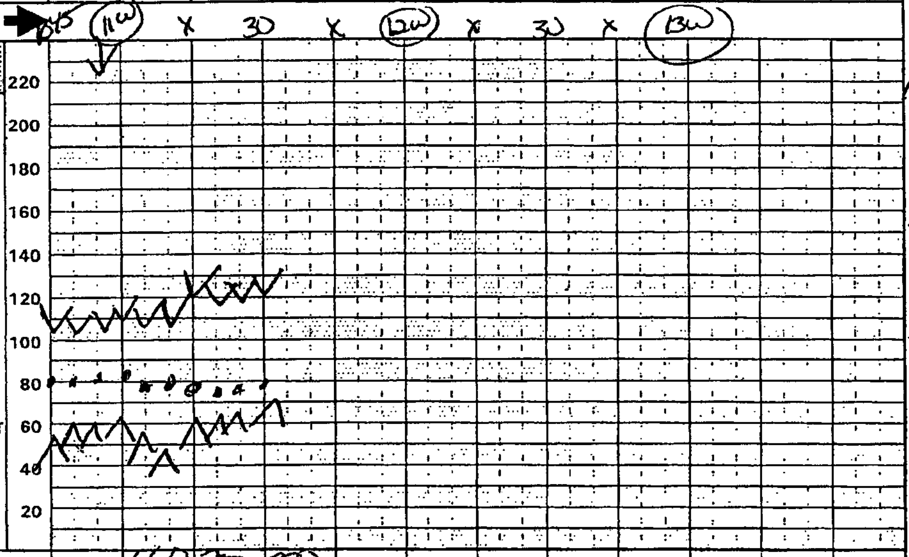
HR- 85

EQUIP CHECK OK?- [✓ Y] N

PATIENT RECHECK OK for PROCEDURE? (+) TIME- 1030

SYMBOLS: BP by cuff V Λ; Heart rate ●; Resp rate; BR (transduced) ╪; TOURNIQUET T—T; ANES- X-X; PROC- ⊙-Ø

TIME → 1015 (11w) x 30 x (12w) x 30 x (13w)



VENTIL

VT - ml		660	350	330
f - breaths/min		8	17	20
Peak inf pres / PEEP		23		
MODE - S(pon), A(ssist), C(on)	SV	CV	SV	SV

MONITORS/ACCESSORIES

✓ BP/Auto Cuff	✓ ET CO2 (torr)		37	37	36
BP/oth	✓ FIO2 (Frac or %)	1.0	1.0	1.0	
ART line	✓ SpO2 (%)	100	100	100	
Steth- PC/ES	✓ ECG	NS	NS	NS	
✓ Gas analyzer CO2	✓ TEMP-site		available ————		
	N-M Block (T/4)		4/4 5"		
✓ Warming blkt	Blanket on legs/head wrap				
Conv warmer					

Mark with letters & symbols, explain under REMARKS EVENTS Position → Sup arms < 90° abducted & padded

RECOVERY AT PACU [✓ ICU] ____ (Specify)

OTHER Stable

CONDITION: 66-2

RESP- 23 SpO2- 96%

BP- 117/67 HR- 99

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1030	1045	1140
	Ready	**Begin**	**End**
PROC	1055	1100	1125

PROCEDURES and CPT Codes: DPC Abd wound

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* GETA - Oral ETT, taped 22 cm teeth @ #3 MAC. Eyes taped. Soft bite block.

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* DL x 1 ē preox. Gr I view ē s. cricoid pressure ETT easily passed. Atraumatic. Teeth OK

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*

[redacted] b(6)-4

ICW 2

SURGEONS: [redacted] b(6)-2

ANESTHET [redacted]

PROCEDURE LOCATION: 2

DATE: 15 Jul 03

PAGE 1 OF 1

DA FORM 7389, FEB 1998 MEDCOM - 1233 ... PATIENT'S MEDICAL RECORD USAPA V1.00

MEDICAL RECORD **ANESTHESIA**

ANESTHETIC AGENTS AND DRUGS

CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML. * | "=CONSTANT INFUSION

DRUG	(Units)	
Fentanyl	(cc)	(5) 3
Lidocaine	(mg)	100
Propofol	(mg)	150 50
Sux	(mg)	80
Vec.	(mg)	6
	( )	
VOLAT AGENT Forane	% del	2.0 2.5 X
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	8 — 2 — 2 — 2 - 8

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS ▶ VERSED 3mg IV

FLUIDS

LINE site LR, ☐ Warmed — 500 LR

☐ Warmed

☐ Warmed

☐ Warmed

LOSSES	
EST BLOOD LOSS	— 50
URINE –	— 200 —

TOTALS	
TOTAL EBL	50
TOTAL URINE	200

FLUIDS – SUMMARY

CRYSTALLOID– 1500

COLLOID– 0

BLOOD– 0

REMARKS–

Code drugs with numbers, events with letters

suction of via ETT

Reversed c̄ 5mg Neostigmine 1mg Robinul T4 c̄ sustain

Toradol 30mg 2100

PHYS STATUS: 1 [✓ 2] 3 4 5 E

BODY WEIGHT: 80 [✓ KG] LB

HEMATOCRIT: 9/28

INITIAL DATA:

BP – 118/67

HR – 99

EQUIP CHECK: OK?– [✓ Y] N

PATIENT RECHECK

OK for PROCEDURE– OK

TIME– 1940

TIME ➡ 2000 x 30 x 2100 x

SYMBOLS:

BP by cuff V Λ

Heart rate ●

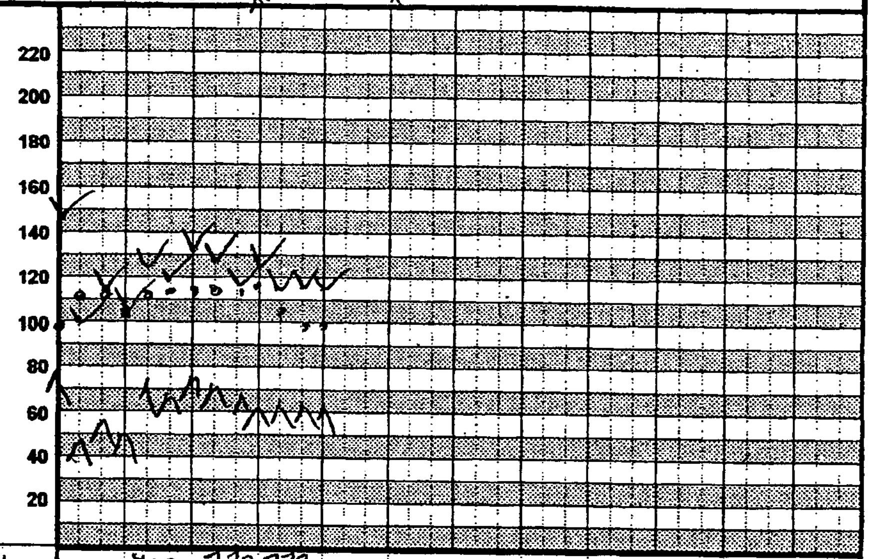
Resp rate

BP (transduced) ╪

TOURNIQUET T—T

ANES— X-X

PROC ⊙—Ø



VT – ml		700	780	770
f – breaths/min	10	10	8	8
Peak inf pres / PEEP	23	25	25	25
MODE– S(pon), A(ssist), C(on)	S	C	C	C
✓ BP/Auto Cuff ✓ ET CO2 (torr)	54	46	30	33
BP / oth ✓ FIO2 (Frac or %)	.91	.91	.91	.91
ART line ✓ SpO2 (%)	100	100	100	100
Steth- PC/ES ✓ ECG	ST	ST	ST	ST
Gas analyzer ✓ TEMP- site PO		98'		
✓ N-M Block (T/4)			4/4	3/4
Warming blkt				
Conv warmer				

Mark with letters & symbols, explain under REMARKS EVENTS

Position ⟶ [illegible]

RECOVERY AT 124 #/

PACU ICU ________ (Specify)

OTHER ________ 98

CONDITION:

RESP– 10 SpO2–

BP– 134/85 HR– 121

ANESTHESIA / PROCEDURE TIME

	Start	Room	End
ANES	1940	1950	2130
	Ready	**Begin**	**End**
PROC	2005	2020	2115

PROCEDURES and CPT Codes

I+D (R) forearm

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

GETA

Tube taped 23 cm

Eyes taped

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*

SIVI, DL Mac 3 VI, atraumatic, Cuff ↑, BS=BS

PATIENT IDENTIFICATION– *Typed or written entries: Name, Grade/Rate, Medical facility*

[redacted] EPW

b(6)-4

SURGEONS: Dr [redacted] b(6)-2

ANESTHETIST [redacted] MAT, CRNA

PROCEDURE LOCATION # 2

DATE 30 Jun 03

PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED
1 Jan 99

MEDCOM - 12340

*U.S. GPO: 2002-729-180/40137

MEDICAL RECORD ANESTHESIA

ANESTHETIC AGENTS AND DRUGS

CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML. "I"=CONSTANT INFUSION

DRUG (Units)					
Norcuron (ml)	2	1.5			
Fentanyl ( )	50				
( )					
( )					
( )					
( )					
VOLAT AGENT Forane % del	1.5 – 1.5 – 1.5 X				
% e.t.					
AIR L/Min					
N2O L/Min					
[✓ O2] L/Min	2 — 2 — 2 — 2 – 8				
SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS					

FLUIDS

LINE site 18G (R) hand ☐ Warmed	~~400~~ ~~1000~~ 400 — 500
18G (R) ARm ☐ Warmed	1000 — 1200 — 1300
☐ Warmed	
☐ Warmed	

LOSSES

EST BLOOD LOSS	50/100 50/150 50/200
URINE – Foley	50/500

PHYS STATUS: 1 [✓ 2] 3 4 5 [✓ E]

BODY WEIGHT: 80 KG LB

HEMATOCRIT: 12/38

INITIAL DATA:

BP –

HR –

EQUIP CHECK

OK? [✓ Y] N

PATIENT CONSENT

OK for PROCEDURE?

TIME–

TIME → 1600 15 x 30 x 1700 x 30

SYMBOLS:

BP by cuff ∨ ∧

Heart rate ●

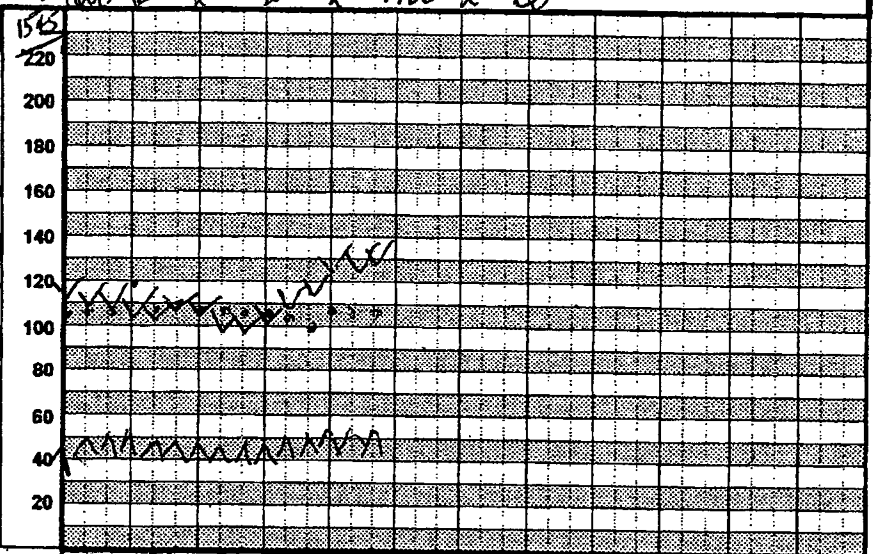
Resp rate

BP (transduced)

TOURNIQUET T – ✗

ANES– X-X

PROC-⊙-Ø



VENT

VT – ml	830	830	810	830	320
f – breaths/min	10	10	10	10	11
Peak inf pres / PEEP	23	23	23	23	
MODE– S(pon), A(ssist), C(on)	C	C	C	C	S

MONITORS / ACCESSORIES

✓ BP/Auto Cuff	✓ ET CO2 (torr)	34	33	34	33	51
BP / oth	✓ FIO2 (Frac or %)	.77	.77	.77	.77	.77
ART line	✓ SpO2 (%)	100	100	100	100	99
Steth- PC/ES	✓ ECG	ST	ST	ST	ST	ST
Gas analyzer	TEMP- site NO	99.3				
	✓ N-M Block (T/4)	4/4			4/4 c Sustained	
Warming blkt						
Conv warmer						

Mark with letters & symbols, explain under REMARKS

EVENTS

Position → ~~ ←

TOTALS

TOTAL EBL

TOTAL URINE

FLUIDS – SUMMARY

CRYSTALLOID– See pg 1

COLLOID–

BLOOD–

REMARKS–

Code drugs with numbers, events with letters

1550: Dr [redacted] starts op-procedure on (L) Forearm

1640: b(6)-2 REVERSED c 5mg Neostigmine + 1.0 Robinul T4 c Sustained

RECOVERY AT

PACU ICU_____ (Specify)

OTHER_____

CONDITION:

RESP– SpO2–

BP– HR– See pg 1

ANESTHESIA / PROCEDURE TIME

ANES	Start	Room	End
PROC	Ready	Begin	End

See pg 1

PROCEDURES and CPT Codes

I&D (L) Forearm – Fasciotomy

Ex. Lap – Partial Colon Resection

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

SEE PG #1

b(6)-2

PATIENT IDENTIFICATION– Typed or written entries: Name, Grade/Rate, Medical facility

EPW # [redacted] b(6)-4

SURGEONS: [redacted] / [redacted] / [redacted]

ANESTH [redacted] b(6)2

PROCEDURE LOCATION OR #2

DATE 28 Jun 03

PAGE 2 OF 2

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 12341

*U.S. GPO: 2002-729-180/40137

EMT → ICU₂ for RR * If ICU admit → ICU 1 for RR) in to ICW 1

(4 liters crystalloid in EMT)

MEDICAL RECORD ANESTHESIA

DRUG	(Units)					
Fentanyl	(mcg)	100	100	50	100	
Propofol	( )	100				
Lidocaine	( )	50				
SCH	(mg)	140				
Vecuronium	(mg)	8	2	3	4	3	1
MSO4	( )	5	5	5	2	

VOLAT AGENT ISO % del 1.6 – 1.6 1.8 1.5 – 1.5 – 1.6 1.8 – 1.6 – 1.8

% e.t.

AIR L/Min

N2O L/Min

O2 L/Min 10 – 2 – 2 2 – 2 – 2 – 2 – 2 – 2 – 2 –

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS
1525 4mg Zofran IV
1530 – 30mg Toradol IV

FLUIDS

LINE site		
18g (R) Hand	☐ Warmed	LR 300↑ ——— > 1100 XLR ——— KVO > 1400
18g (R) Arm	☐ Warmed	LR 900↑ ——— X/1000
	☐ Warmed	
	☐ Warmed	

LOSSES
EST BLOOD LOSS 50
URINE – Foley 200cc (in EMT) 400 50/450

TOTALS
TOTAL EBL 200
TOTAL URINE 500

FLUIDS – SUMMARY
CRYSTALLOID – 1800
COLLOID – 0
BLOOD –

REMARKS –
Code drugs with numbers, events with letters

1245 Pt id in EMT. To OR via litter.

1255 In room, (+)O2 (+) monitors. Smooth IV induction. OG placed, Stomach Sxn.

1317 Incision Ex Lap

1325 Bank Scan available for Brk. Report Received

1335 OGT Δ to NGT (R) nare

1420 1gm Ancef IVPB

1515: [redacted] relieves b(6)-2

PHYS STATUS 1 [✓ 2] 3 4 5 [✓ E]

BODY WEIGHT 80 KG LB

HEMATOCRIT 12/38

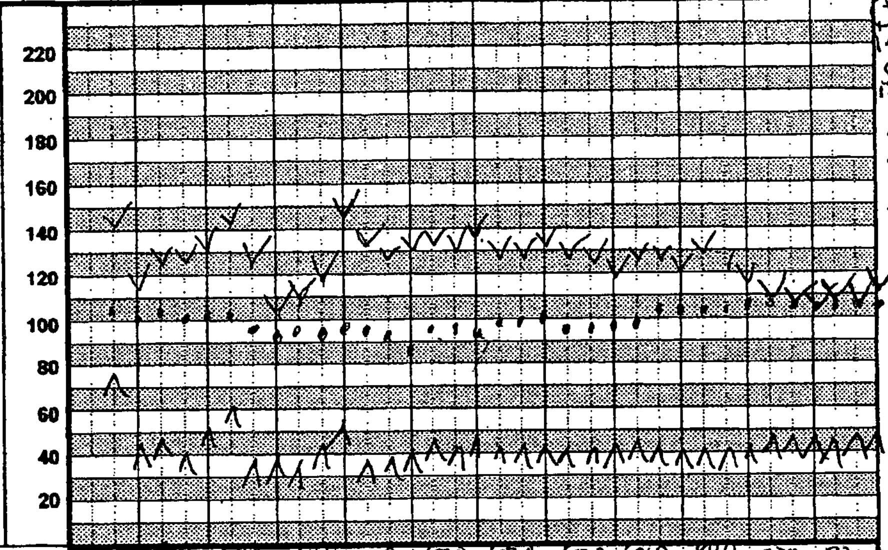
INITIAL DATA
BP – 141/75
HR – 101

EQUIP CHECK
OK? – ✓ N

PATIENT RECHECK
OK for PROCEDURE? Okay
TIME – 1230

TIME → 1245 1300 15 30 45 1400 X 30 X 1500 X 30 X

SYMBOLS:
BP by cuff V Λ
Heart rate ●
Resp rate
BP (transduced)
TOURNIQUET T – X
ANES – X-X
PROC ⊙ – Ø



VT – ml	–	810	840	840	830	820	830	830	840	840	830	836
f – breaths/min	20	10	10	10	10	9	9	10	10	10	10	10
Peak inf pres / PEEP	–	24	24	24	23	23	23	23	22	23	23	23
MODE – S(pon), A(ssist), C(on)	S	C	C	C	C	C	C	C	C	C	C	C
X ET CO2 (torr)	(+)	36	35	32	33	31	34	35	34	35	34	35
X FIO2 (Frac or %)	.76	.76	.76	.76	.76	.78	.78	.78	.78	.81	.77	.77
X SpO2 (%)	100	100	100	100	100	100	100	100	100	100	100	100
X ECG	ST	ST	ST	SR	SR	SR	SR	SR	SR	SR	SR	ST
X TEMP- site Available												
X N-M Block (T/4)		4/4	0/4		4/4	0/4	4/4	1/4		3/4		

X BP/Auto Cuff
X BP / oth
ART line
Steth- PC/ES
Gas analyzer
Warming blkt
Conv warmer

PP padded, Eyes Taped, Soft bite block placed, Arms ∠ 90°

Mark with letters & symbols, explain under REMARKS
EVENTS
Position —— ⊙ ——→ ——→ ——→ ——→ ——→

RECOVERY AT ECG #1
PACU ICU ____ (Specify)
OTHER SaO2 99
CONDITION: 10L/F
RESP – 16 SpO2 – 99
BP – 134/79 HR – 100

ANESTHESIA / PROCEDURE TIME

	Start	Room	End
ANES	1245	1255	1720
	Ready	Begin	End
PROC	1303	1317	1650

PROCEDURES and CPT Codes I & D (L) Forearm
Ex. Lap partial Colon Resection

ANESTHETIC TECHNIQUES: Describe block technique under Remarks GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments RSI & Cricoid pressure. DL x 1 attempt c̄ # 8 ETT, mac 3. (+) BBS (+) ETCO2. Secured @ 21 cm teeth. Atraumatic

PATIENT IDENTIFICATION – Typed or written entries: Name, Grade/Rate, Medical facility

EPW # [redacted] b(6)-4

SURGEONS: [redacted] [redacted] [redacted]

CPT / CRNA

MEDICAL RECORD

PROCEDURE LOCATION OR #2

DATE 28 Jun 03

PAGE 1 OF 2

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 12342

b(6)-2

*U.S. GPO: 2002-729-180/40137

Smoker

ANESTHESIA PLAN OF CARE PRE-PROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 24 DAYS MOS [✓ YRS]   Sex [✓ MALE] ( ) FEMALE

ASA Physical State 1 [✓ 2] 3 4 5 E
WT: 80 [✓ KG]/LB HT: ______ IN.
ALLERGIES: NKDA

PROPOSED PROCEDURE: [redacted] DPC Abdom wound
SURGICAL SERVICE: General Surgery b(6)-2
NPO SINCE: Midnight 14 Jul 03

HABITS:
TOBACCO: +
ETOH: +
DRUGS: −

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) Ancef 6°
( )
( )
( )
( )
( )
( )

PREMEDICATIONS:
None Yes (@ ______ Hrs) /CC
______ . ______ mg IV IM PO
______ . ______ mg IV IM PO
______ . ______ mg IV IM PO

LABORATORY STUDIES:
HB/HCT: ______ / ______
U/A: ______
OTHER: ______
6 July 03
10.6 / 11.4 / 966
36.2

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:
- Hypertension [✓ N] Y
- Angina [✓ N] Y
- MI [✓ N] Y
- CVA [✓ N] Y
- Other [✓ N] Y

Pulmonary System:
- Asthma [✓ N] Y
- Bronchitis/URI [✓ N] Y
- COPD [✓ N] Y
- Other [✓ N] Y

Renal System:
- Acute/Chronic RF [✓ N] Y

Gastrointestinal:
- Hepatitis [✓ N] Y
- Hiatal Hernia [✓ N] Y
- PUD/GERD [✓ N] Y

Endocrine System:
- Diabetes [✓ N] Y
- Steroids [✓ N] Y
- Thyroid [✓ N] Y

Neurological:
- Seizures [✓ N] Y
- Neuropathy [✓ N] Y
- Other [✓ N] Y

Gynecological :
- Pregnancy [✓ N] Y

Other Significant Hx:
- [✓ N] Y GSW to (L)
- N Y abdominal
- Familial HX N Y GSW (L) arm

ASSESSMENT

PAST SURGICAL/ANESTHETIC
mult GA's
D/C
no anesth compl
no fx hx

PHYSICAL EXAMINATION
BP 108/70 HR 70 R ___ T ___
Pain Scale 0-10 ___
HEENT - Teeth intact
Trachea midline
(TM)J/Neck FROM
Oropharynx Cl 2, 3fb TM
Nares OK
CHEST: BBS/CTA
CARDIAC: S1S2 (R)
EXTREMITIES:
IV Access: #20 (R) wrist
Ulnar Filling: OK
BACK: OK
OTHER: ______

NPO Since MN 14 Jul 03

ANESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ______ {✓} General: Mask [✓ Intubation]

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discussed with the [✓ patient]/legal guardian. used interpreter

The [✓ patient]/legal o[redacted]rees. Questions answered.
Signed: [redacted] Date: 15 Jul 03 Time: 0800 Hrs
b(6)-2

POST-ANESTHESIA EVALUATION AND NOTE (NON ASU)
{ } NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER

Signed: ______ Date: ______ Time: ______ Hrs

SEDATION KEY:
1. **MINIMAL** (Anxiolysis) Patient responds normally to verbal commands
2. **MODERATE** (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is not necessary.
3. **DEEP SEDATION/ANALGESIA.** Patient responds purposefully following repeated or painful stimulation. Airway assistance may be necessary.
4. **ANESTHESIA.** Patient does not respond to painful stimulation.

Patient Identification: (Ward) ______

[redacted] b(6)-4
Q-DAY
ICW2

WAMC Form 2300 (Revised) 15 Mar 01 MCXC-DOS

MEDCOM - 12343

Previous edition is obsolete
☆ U.S. GPO: 2002-729-283

STHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

24 DAYS MOS [✓ YRS]   Sex ( ) MALE ( ) FEMALE

ASA Physical State 1 [✓ 2] 3 4 5 E
WT: 80 [✓ KG]/LB HT: ____ IN.
ALLERGIES: NKDA

POSED PROCEDURE: I&D (L) arm + Ex lap
GICAL SERVICE: Ortho + General
SINCE: last night; water [illegible]

ITS:
BACCO: yes
ETOH: yes
DRUGS: 0

RENT MEDICATIONS:
ordered as premed

0

MEDICATIONS:
e Yes (@ ______ Hrs) /CC
___ . ______ mg IV IM PO
___ . ______ mg IV IM PO
___ . ______ mg IV IM PO

ORATORY STUDIES:

ICT: ______/______

ER:

17.2 > 12.1 / 38.0 < 405

130 | 108
4.3 | 23

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:		
Hypertension	[✓ N] Y	
Angina	[✓ N] Y	
MI	[✓ N] Y	
CVA	[✓ N] Y	
Other	[✓ N] Y	
Pulmonary System:		
Asthma	[✓ N] Y	
Bronchitis/URI	[✓ N] Y	
COPD	[✓ N] Y	
Other	[✓ N] Y	
Renal System:		
Acute/Chronic RF	[✓ N] Y	
Gastrointestinal:		
Hepatitis	[✓ N] Y	
Hiatal Hernia	[✓ N] Y	
PUD/GERD	[✓ N] Y	
Endocrine System:		
Diabetes	[✓ N] Y	
Steriods	[✓ N] Y	
Thyroid	[✓ N] Y	
Neurological:		
Seizures	[✓ N] Y	
Neuropathy	[✓ N] Y	
Other	[✓ N] Y	
Gynecological :		
Pregnancy	N Y	N/A
Other Significant Hx:	[✓ N] Y	GSW to (L)
	N Y	lateral abdomen
Familial HX	N Y	+ GSW (L) FA

ASSESSMENT

PAST SURGICAL/ANESTHETIC

0

PHYSICAL EXAMINATION

BP ___ HR ___ R ___ T ___
Pain Scale 0-10 ______
HEENT - Teeth intact
Trachea midline
TMJ/Neck FROM
Oropharynx MP 2
Nares ______
CHEST: CTA (B)
CARDIAC: RRR (-) m
EXTREMITIES:
IV Access: 18G (R) A
Ulnar Filling: ______
BACK: ______
OTHER: ______

NPO Since ______

ESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ______ [✓ { } General:] Mask [✓ Intubation]

ORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to ussed with the patient/legal guardian.

b(6)-2

pa[redacted]tand and agrees. Questions answered.
ne CRNA/CPT Date: 28 Jun 02 Time: 1246 Hrs

ST[redacted]EVALUATION AND NOTE (NON ASU)
N APPARENT ANESTHETIC COMPLICATIONS { } OTHER

ned: ______________ Date: ________ Time: ______ Hrs

SEDATION KEY:

1. MINIMAL (Anxiolysis) Patient responds normally to verbal commands
2. MODERATE (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is n necessary.
3. DEEP SEDATION/ANALGESIA. Patient responds purposefully following repeated or painful stimulation. Airway assistance may

ent Identification: (Ward) ______________

EPW# [redacted] b(6)-4

MEDCOM - 12344

⑦

ANESTHESIA PLAN O E PREPROCEDURAL ASSESSMENT (Sed. Anesthesia)

Age 24 DAYS MOS [✓ YRS] Sex ( ) MALE ( ) FEMALE

PROPOSED PROCEDURE: I&D Darm-
SURGICAL SERVICE: Ortho
NPO SINCE: MN

ASA Physical State 1 [✓ 2] 3 4 5 E
WT: 80 [✓ KG]/LB HT: ____ IN.
ALLERGIES: NKDA

HABITS:
TOBACCO: yes
ETOH: yes
DRUGS: ____

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) cefotetan 2 gm
( ) MSO4
( )
( )
( )
( )

PREMEDICATIONS:
None Yes (@ ____ Hrs) /CC
____ . ____ mg IV IM PO
____ . ____ mg IV IM PO
____ . ____ mg IV IM PO

LABORATORY STUDIES:
HB/HCT: ____ / ____
U/A: ____
OTHER: ____

8.8 > 9.1 / 28.1 < 311

116 | 101 | 10 / 4.4 | 30 | .8 < 118

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:			
Hypertension	[✓ N]	Y	
Angina	[✓ N]	Y	
MI	[✓ N]	Y	
CVA	[✓ N]	Y	
Other	[✓ N]	Y	
Pulmonary System:			
Asthma	[✓ N]	Y	
Bronchitis/URI	[✓ N]	Y	
COPD	[✓ N]	Y	
Other	[✓ N]	Y	
Renal System:			
Acute/Chronic RF	[✓ N]	Y	
Gastrointestinal:			
Hepatitis	[✓ N]	Y	
Hiatal Hernia	[✓ N]	Y	
PUD/GERD	[✓ N]	Y	
Endocrine System:			
Diabetes	[✓ N]	Y	
Steriods	[✓ N]	Y	
Thyroid	[✓ N]	Y	
Neurological:			
Seizures	[✓ N]	Y	
Neuropathy	[✓ N]	Y	
Other	[✓ N]	Y	
Gynecological :			
Pregnancy	N	Y	N/A
Other Significant Hx:			
	N	Y	GSW to Ⓛ
	N	Y	abdomen and
Familial HX	N	Y	GSW to Ⓛ arm

ASSESSMENT
PAST SURGICAL/ANESTHETIC

PHYSICAL EXAMINATION
BP 118/67 HR 99 R 18 T 98.7
Pain Scale 0-10 ____
HEENT - Teeth ____
Trachea Intact
MP2 TMJ/Neck Midline
Oropharynx ____
Nares ____
CHEST: CTA
CARDIAC: RRR
EXTREMITIES: ____
IV Access: ____
Ulnar Filling: ____
BACK: ____
OTHER: ____

NPO Since ____

ANESTHETIC PLAN: ( ) LOCAL ( ) MAC ( ) Regional (Specify): ____ [✓ General]: Mask [✓ Intubation]

Chart Reviewed -

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discussed with the patient/legal guardian. b(6)-2

The patien[redacted]ees. Questions answered.
Signed: Date: 6/30/03 Time: 1110 Hrs

POST-ANESTHESIA EVALUATION AND NOTE (NON ASU)
( ) NO APPARENT ANESTHETIC COMPLICATIONS ( ) OTHER

Signed: ____ Date: ____ Time: ____ Hrs

SEDATION KEY:

1. MINIMAL (Anxiolysis) Patient responds normally to verbal commands
2. MODERATE (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is not necessary.
3. DEEP SEDATION/ANALGESIA. Patient responds purposefully following repeated or painful stimulation. Airway assistance may be necessary.
4. ANESTHESIA. Patient does not respond to painful stimulation.

Patient Identification: (Ward) ICW / Rec ICU /

EPW [redacted]
b(6)-4

WAMC Form 2300 (Revised) 15 Mar 01 MCXC-DOS

Previous edition is obsolete
☆ U.S. GPO 2002-729-285

PATIENT RECORD COPY

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

IENT IDENTIFICATION

EPW
[redacted] b(6)-4
ICU#1

ISING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 28 June 03
TIME OF ORDER 1534 HOURS
LIST TIME ORDER NOTED AN SIGN

(1) Admit ICU 1
(2) Dx s/p Exlap, colectomy, end colostomy + I+D (L) forearm
(3) Condition good
(4) VS q 1hr including SaO2 + UO
(5) Call MD for Hr <50 >120 SBP>160 <90 DBP>90 <60 RR >30 <10 UO <30cc/hr T>100.4

IENT IDENTIFICATION

b(6)-2
[redacted]

28JUN03
2230HRS

SING UNIT | NO.

DATE OF ORDER
TIME OF ORDER HOURS

(6) All NKDA
(7) Act ~~adt~~ [redacted] b(6)-2
(8) Diet NPO
(9) IVF LR@125 cc/hr
(10) MSO4 1-4 mg IV q 1 hr prn pain
(11) Toradol 30 mg IV q 6 hrs x 6 doses then D/C
(12) Cefotetan 2 mg IV q 8 hrs. First dose ~~when~~ now.

b(6)-2
[redacted]

IENT IDENTIFIC

DATE OF ORDER
TIME OF ORDER HOURS

b(6)-2

(13) NGT to LIWS
(14) Foley to gravity
(15) CBC Chem 8 qAM
(16) Ortho Dr [redacted] Surg Dr [redacted] or [redacted]

MC USA

SING UNIT | ROOM NO. | BED NO.

ENT IDENTIFICATION

DATE OF ORDER 28 Jun
TIME OF ORDER 1700 HOURS

Gentamycin 500 mg IV x1 now
ICU/Ethan DUB

29 June 03
[redacted]

SING UNIT | ROOM NO. | BED NO.

b(6)-2

MEDCOM - 12346

CLINICAL RECORD - DOCTOR'S ORDERS

DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS [illegible]
TEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW [illegible]

ENT IDENTIFICATION

EPW # [redacted]
b(6)-4

SING UNIT: ICU#1
ROOM NO:
BED NO: 5

DATE OF ORDER: 29 Jun 03
TIME OF ORDER: 0717

① Activity OOB to chair today & walk c̄ assistance
② IS 10 x q 1hr while awake
③ Wean O_2 to keep sats > 96%

b(6)-2 [redacted]
29 Jun
[redacted] 0923
b(6)-2

ENT IDENTIFICATION

SING UNIT:
ROOM NO:
BED NO:

DATE OF ORDER: 30 Jun 03
TIME OF ORDER: 0708

① NGT clamped
② NPO for surgery. After surgery may have sips of clears

[redacted]
30 Jun
0740
[redacted] MAJ MC USA
b(6)-2

ENT IDENTIFICATION

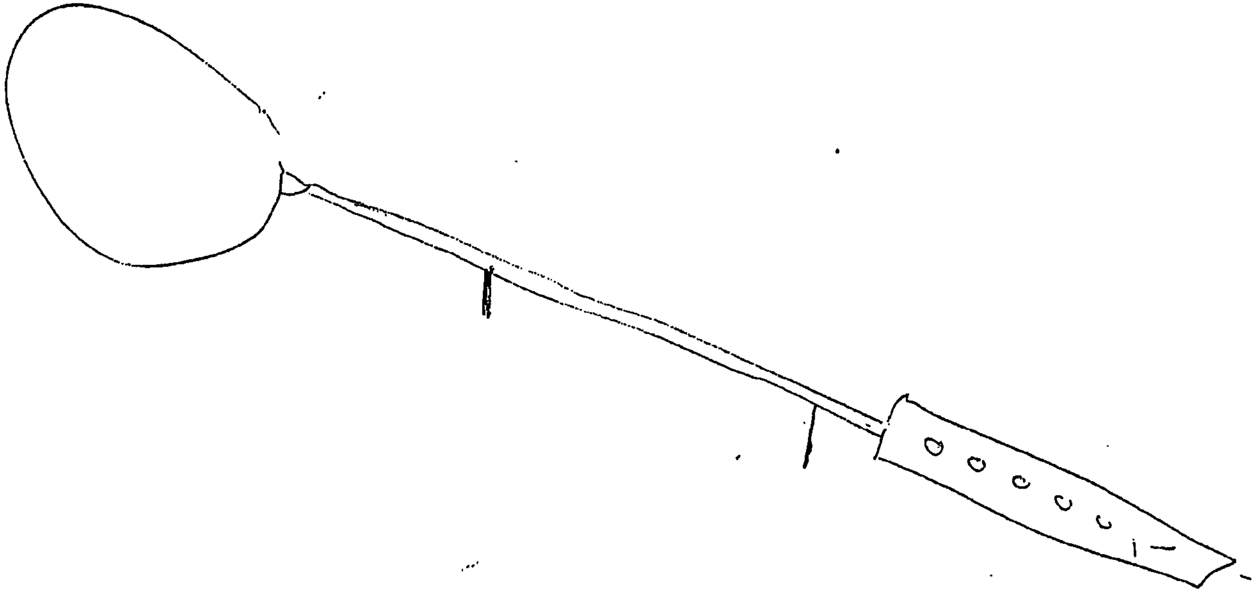
SING UNIT:
ROOM NO.
BED NO.

DATE OF ORDER:
TIME OF ORDER:

ENT IDENTIFICATION

SING UNIT:
ROOM NO.
BED NO.

DATE OF ORDER:
TIME OF ORDER:



CLINICAL RECORD - DOCTOR'S ORDERS

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

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

[redacted] b(6)-4

NURSING UNIT: ICW 2
ROOM NO.:
BED NO.: [redacted]

Noted 08:03 30Jun03

DATE OF ORDER: 30 Jun 03 TIME OF ORDER: 2115 HOURS

LIST TIME ORDER NOTED AND SIGN

Transfer ICU → ICW2 ✓
S/P washout / [illegible] [illegible]
Stable ✓
US per routine ✓
Diet: Adv. [illegible] ✓
Continue Surg prep order and meds ✓

PATIENT IDENTIFICATION

[redacted]

~~ICW~~ b(6)-4

NURSING UNIT: ICW 2
ROOM NO.:
BED NO.:

b(6)-2 [illegible]

DATE OF ORDER TIME OF ORDER HOURS

Adv Diet Clears ✓
Clamp NGT ✓
IV: [illegible] TKO ✓
[illegible] ✓
[illegible] AD/Left Fore Arm [illegible] ✓
24° Done [redacted] b(6)-2 [illegible]

PATIENT IDENTIFICATION

[redacted] b(6)-4

NURSING UNIT: ICW2
ROOM NO.: 24 V/s
BED NO.: 0800

DATE OF ORDER: 30Jun03 23:30 [redacted] HOURS

V.O.
I+Os q shift ✓
CBC in AM only 1 JUL 03 ✓
D/C q AM CBC ✓

noted 23:40 30Jun03

1 July 03 [redacted] b(6)-2

PATIENT IDENTIFICATION

CDW
[redacted] b(6)-4

NURSING UNIT: ICW2
ROOM NO.:
BED NO.: 10

DATE OF ORDER: 1JULY03 HOURS

1) D/C cefotetan ✓
2) Ancef 1gm IV q 8 hrs ✓
3) D/C'd NGT ✓
4) Diet Clears / Liquids
5) D/C Foley. Due to void p̄ 6 hrs. ✓
6) Percocet 1-2 tab po q 4-6 hrs prn pain
7) OOB to chair + Ambulate Ⓠ shift

[redacted] b(6)-2

[redacted] b(6)-2

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

MEDCOM - 12349

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 [redacted] b(6)-4

DATE OF ORDER [redacted] TIME OF ORDER 2230 HOURS

LIST TIME ORDER NOTED AND SIGN [redacted] 0800 29 J b(6)-2

NPO p MN

for [illegible] 2 day

[redacted]

NURSING UNIT ICW 2 ROOM NO. BED NO. 10

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

DATE OF ORDER 2 Jul 03 TIME OF ORD[redacted] 1000 HOURS

[redacted] 1145 JS

① D midline dressing w-?D BID

② Pt may Ambulate TID

[redacted] b(6)-2

NURSING UNIT ICW 2 ROOM NO. BED NO. 10

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

DATE OF ORDER 2 Jul 03 TIME OF ORDER 1530 HOURS

~~NPO~~ Closure wound

Cont all prev orders

[illegible]

JP to Bulb suction [redacted]

NURSING UNIT ICW 2 ROOM NO. [redacted] BED NO. 10

b(6)-2 2 Jul [illegible]

PATIENT IDENT[redacted] EPW [redacted] b(6)-4

DATE OF ORDER 15 Jul 03 TIME O[redacted]

Resume previous orders b(6)-2

NURSING UNIT ICW 2 ROOM NO. BED NO. 10

MEDCOM - 12350

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

IDENTIFICATION
EPN
[redacted] b(6)-4

UNIT: 1CW2
ROOM NO.
BED NO.

DATE OF ORDER: 6 May 03
TIME OF ORDER: 1000 HOURS

✓ D/C to EPW Camp
if OK c Gen Surgery

[redacted] b(6)-2

LIST TIME ORDER NOTED AND SIGN.

IDENTIFICATION

DATE OF ORDER
TIME
HOURS

① Admit to ICW ✓
② Dx wound separation ✓
③ Cond stable ✓
④ Vitals Routine (Q4° with I&O) ✓
⑤ All NKDA ✓
⑥ Act OOB Ad lib ✓
Nurse colostomy care ✓

UNIT
ROOM NO.
BED NO.

IDENTIFICATION

DATE OF ORDER
TIME OF ORDER
HOURS

Wet to Dry Dressing to
Mid line wound BID ✓
Regular Diet ✓
IVF LR @ 150 ✓
meds
Percocet I-II tabs PO Q4°-6° PRN Pain ✓
Tylenol 650 mg PO Q6° PRN Pain ✓

Noted
[redacted]
b6-2

UNIT
ROOM NO.
BED NO.

IDENTIFICATION

DATE OF ORDER
TIME OF ORDER

Noted
0800 2JU
[redacted]
b(6)-2
0300 7 Jul 03

[redacted]
b(6)-2

04, 10, 16, 22 → gm Ancef IV Q6° ✓ 04° ✓ done
b(6)-2

UNIT
ROOM NO.
BED NO

MEDCOM - 12351

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

IDENTIFICATION

EPW
# [redacted] b(6)-4

UNIT: 1CW2
ROOM NO.
BED NO.

DATE OF ORDER: 7Jul03
TIME OF ORDER: 0700 HOURS
ORDER NOTED AND SIGN

① D/C I/O
② Q6° vital signs
b(6)-2
[redacted] b(6)-2
[illegible] b(6)-2 [redacted]
b(6)-2 [redacted]
[illegible] 8Jul 03 0020 [redacted]
27 US G B[illegible] IN/AN 7-8-03 2300.

IDENTIFICATION

EPW
# [redacted] b(6)-4

UNIT: 1CW2
ROOM NO.
BED NO.

DATE OF ORDER
TIME OF ORDER
HOURS

9JUL03 1630
① D/C IVF
V.O. [redacted] b(6)-2
[redacted]
b(6)-2 b(6)-2

IDENTIFICATION

EPW
# [redacted] b(6)-4

UNIT: 1CW2
ROOM NO.
BED NO.

DATE OF ORDER: 10Jul03
TIME OF ORDER: 0940 HOURS

① JP to continuous 125mmHg suction.

b(6)-2
[redacted]

noted 10July 1000 Gt

IDENTIFICATION

UNIT
ROOM NO.
BED NO.

DATE OF ORDER: 11Jun03
TIME OF ORDER: 0141 HOURS

V.O.
Maalox 2-4 tabs PO TID PRN
Phenergan 25mg IVP q6° PRN
Nausea/vomiting
2240 [redacted] b(6)-2 /AN
b(6)-2 /AN

noted 0141 11Jun03 [redacted] b(6)-2 /AN

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

[redacted]

b(6)-4

DATE OF ORDER 12 Jul 03 TIME OF ORDER 1600 HOURS

LIST T ORDE NOTED SIGN

① D/c suction

② wet to Dry Dressing BID to Abd

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

b(6)-2 Noted [redacted]

NURSING UNIT	ROOM NO.	BED NO.

2130 VS [redacted]

PATIENT IDENTIFICATION

[redacted]

b(6)-4

DATE OF ORDER 13 JUL 03 TIME OF ORDER 1645 HOURS ~~7~~ 2240'

① NPO p MN

LR @ 75cc/hr @ 2400

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

b(6)-2 [redacted]

NURSING UNIT	ROOM NO.	BED NO.
		24° ✓

[redacted]

PATIENT IDENTIFICATION

[redacted]

b(6)-4

DATE OF ORDER 14 JUL 03 TIME OF ORDER 1030 HOURS

19 July [redacted]

① Reg Diet

NPO p MN for OR on 15 [redacted]

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

NURSING UNIT	ROOM NO.	BED NO.

21° VS [redacted] 7-14-03 2250

b(6)-2

PATIENT IDENTIFICATION

[redacted]

b(6)-4

DATE OF ORDER TIME OF ORDER 1100 HOURS

18 July 1230 [redacted] b(6)-2

① 15 Jul 03

Resume previous order c̄

No dressing Δ's

b(6)-2 [redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICW2	24V°	10

[redacted] 20 July 03 0105

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

MEDCOM - 12353

CLINICAL RECORD - DOCTOR'S ORDERS

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

[illegible] RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM [illegible] WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW

PATIENT IDENTIFICATION

[redacted] b(6)-4

NURSING UNIT: ICW 2

ROOM NO:

BED NO: 6

DATE OF ORDER: 2ta 21Ju03

TIME OF ORDER:

① D/c to EPW CAMP. whe- Available

b6-2

[redacted] 0721

PATIENT IDENTIFICATION

NURSING UNIT:

ROOM NO.

BED NO.

DATE OF ORDER

TIME OF ORDER

HOURS

PATIENT IDENTIFICATION

NURSING UNIT:

ROOM NO.

BED NO.

DATE OF ORDER

TIME OF ORDER

PATIENT IDENTIFICATION

NURSING UNIT:

ROOM NO.

BED NO

DATE OF ORDER

TIME OF ORDER

MEDCOM - 12354

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

[redacted] b(6)-4

NURSING UNIT ICW2 **ROOM NO.** **BED NO.** 9

DATE OF ORDER 26Jul03 **TIME OF ORDER** 1900 **HOURS**

LIST TIME ORDER NOTED AND SIGN

Admit : ICW#2
dx: ulnar fx s/p suture removal
condition - stable
VS - none
diet Regular
Activity - ad lib [redacted]

b(6)-2

PATIENT IDENTIFICATION

EPW

[redacted] b(6)-4

NURSING UNIT ICW2 **ROOM NO.** **BED NO.** 9

DATE OF ORDER **TIME OF ORDER** [redacted] **HOURS**

[redacted] b(6)-2

noted

[redacted] b(6)-2

2000

PATIENT IDENTIFICATION

EPW

[redacted] b(6)-4

NURSING UNIT ICW2 **ROOM NO.** **BED NO.** 9

DATE OF ORDER 26Jul **TIME OF ORDER** 21:08 **HOURS**

b(6)-2

V.O. From Dr. [redacted] to
LT [redacted] b(6)-2
D/C Pt to EPW camp
when available escort.
Dr [redacted] [redacted]
b(6)-2

b(6)-2

noted
21:08 b(6)-2
[redacted]

PATIENT IDENTIFICATION

NURSING UNIT **ROOM NO.** **BED NO.**

DATE OF ORDER **TIME OF ORDER** **HOURS**

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

MEDCOM - 12355

All b(6)-2 except last

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	*Mo.* Jun *Yr.* 2003

VERIFY BY INITIALING — *INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION*

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 28 29 30	
28 JUN	[redacted]	VS q1hr INcluding SaO2 + UO	05 17	[redacted]	D/C'd DC See next Sheet
28 JUN	[redacted]	I+O's (uo) q1hr	05 17	[redacted]	Rewritten See next Sheet
28 JUN	[redacted]	Call MD FoR HR<50 >120, SBP>160<90, DBP>90<60, RR>30 <10, UO <30cc/HR, T>100.4	05 17	[redacted]	See rewritten Green Sheet
28 JUN	[redacted]	Activity: ~~Bed Rest~~ OOB to chair/Amb c̄ Assist	05 17	[redacted]	See rewritten Green Sheet
28 JUN	[redacted]	Diet: NPO	05 17	[redacted]	Δ'd
28 JUN	[redacted]	NGT to ~~LIWS~~ Clamped	05 17	[redacted]	See rewritten Green Sheet
28 JUN	[redacted]	Foley to Gravity	05 17	[redacted]	See rewritten Green Sheet
28 JUN	[redacted]	CBC + MetLyte 8 q AM	05 17	[redacted]	D/C'd Em QAM
28 JUN	[redacted]	Ice/Elevate Ⓛ UE	05 17	[redacted]	Rewritten See next Sheet

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS:
Dx S/P Exp lap Colectomy, End colostomy, I+D Ⓛ Forearm

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO
PAGE NO: 1

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 MEDCOM - 12356 USED. USAPA V1.00

All b(6)-2

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo June *Yr* 2003

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
28JUN	[redacted]	ADMIT ICU 1	28JUN	Done		[redacted]
28JUN	[redacted]	CONDITION Good	28Jun	Done		[redacted]
30Jun	[redacted]	Transfer from ICU -> ICW 2	30Jun	Done		[redacted]
30Jun	[redacted]	S/P washout / Impending ulnar repair	30Jun	Done		[redacted]
30Jun	[redacted]	Stable condition	30Jun	Done		[redacted]
30Jun	[redacted]	Continue same preop orders and	30Jun	Done		[redacted]
		meds				
30Jun	[redacted]	X-Ray ~~AB~~ AP/Lat Forearm in AM	01Jul	AM ⇒	See rewritten Green sheet	

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING COMPLETION*													
			TIME/DATE COMPLETED													

USAPA V1.00

MEDCOM - 12357

All b(6)-2 except last

CLINICAL RECORD

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

Mo. 6 *Yr.* 2003

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

VERIFY BY INITIALING ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 29	30
29JUN	[redacted]	IS: 10 q1° WA.	05	[redacted]	[redacted]
			17	[redacted]	[redacted]
29Jun	[redacted]	Wear O2 Keep	05	[redacted]	[redacted]
		Sats >96%.	17	[redacted]	[redacted]
30Jun	[redacted]	VS Per routine	05	/	/
			13	/	/
			21	/	
30Jun	[redacted]	Advance diet to clears	05	/	/
			13	/	/
			21	/	/
30Jun	[redacted]	Clamp NGT	05	/	/
			13	/	/
			21	/	
30Jun	[redacted]	TCO/elevate Ⓛ UE	05	/	/
			13	/	/
			21	/	
30Jun	[redacted]	I+O's UOq ~~thr~~ [illegible] shift	05		
			13		
			21		
30Jun	[redacted]				

See rewritten Green Sheet

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
s/p Colectmy / I+D Ⓛ FA.

ADDITIONAL PAGES IN USE:
☐ YES ☐ NO

PAGE NO: 2

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78   MEDCOM - 12358   USED.   USAPA V1.00

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*			*Mo* ______ *Yr* 2003	
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
30JUN	[redacted]	CBC in AM 1JUL03	01JUL	0400		
	-----	b(6)-2				

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING COMPLETION* TIME/DATE COMPLETED													
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USAPA V1.00

MEDCOM - 12359

All b(6)-2 except last

CLINICAL RECORD | **THERAPEUTIC DOCUMENTATION CARE PLAN** *(NON-MEDICATION)*
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.
Mo. ____ *Yr.* 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	30	01	02	03	4	5	6	7	8	9	10	11	12	13
30 Jun	[redacted]	VS: Per Routine	05	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
			13	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
			21	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]								
30 Jun	[redacted]	Diet: ~~Adv to clears~~	07	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
		REG (2 JUL 03 [redacted])	12	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
			17	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
30 Jun	[redacted]	IS: 10 q 1° while	05	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
		awake	13	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
			21	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]								
30 Jun	[redacted]	Clamp NG tube	05	/				DC'd @ 0700									
			13	/				1 July				[redacted]					
			21	[redacted]													
30 Jun	[redacted]	Ice/Elevate Ⓛ UE	05	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
			13	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
			21	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]								
30 Jun	[redacted]	Wear O2 Keep Sats	05	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
		>96%.	13	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
			21	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]								
30 Jun	[redacted]	I+O's q Shift	05	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
			13	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
			21	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]								
30 Jun	[redacted]	NGT clamped	05	/													
			13	/													
			21	/													
30 Jun	[redacted]	Foley to Gravity	05	/				DC'd @ 0700									
			13	/				1 July				[redacted]					
			21	[redacted]													

ALLERGIES: ☒ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
S/P Colectomy T+D Ⓛ FA

ADDITIONAL PAGES IN USE: ☐ YES ☒ NO
PAGE NO: 31

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 EDITION OF 1 DEC 77 MAY BE USED. USAPA V1.00
MEDCOM - 12360

All b(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*	*Mo* ____ *Yr* 2003			
Order Date	**Clerk Nurse**	**SINGLE ACTIONS**	**Date to be Done**	**Time to be Done**	**Time Done**	**Initials**
30Jun	[redacted]	X-ray LAT/AP	1Jul	AM		
30Jun	[redacted]	CBC in AM	1Jul	0400 ~~AM~~	0400	[redacted]
1Jul	[redacted]	NPO p̄ mn / OR in am	2Jul	mn	0800	[redacted]
2	[redacted]	s/p Closure Wound	2		1800	[redacted]
2	[redacted]	Cont Previous Orders	2		1800	[redacted]
6Jly	[redacted]	D/C to EPW Camp if OK c̄ Gen Surgery	6Jly	ASAP		

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING COMPLETION* TIME/DATE COMPLETED													

USAPA V1.00

MEDCOM - 12361

All b(6)-2 except last

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)

For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo. JUN Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 28 29 30 1 2 3 4 5 6 7 8 9 10 11
28JUN	[redacted]	IVF: LR@ 125cc/HR	05 17	[redacted] see below
28JUN	[redacted]	Toradol 30 mg IV Q6 hrs x 6 doses Then D/C	06 12 18 24	[redacted]
28JUN	[redacted]	Cefotetan 2 mg IV Q8 hrs	06 14 22	[redacted] DC'd 1 July 0800 [redacted]
30Jun	[redacted]	IVF TKO	05 13 21	[redacted] 1 Jul 03 [redacted]
1 July	[redacted]	Ancef 1 gm IV q 8 hrs	06 14 22	[redacted] SEE A1530 PAGE

ALLERGIES: ☐ YES ☒ NO

~~AF~~ NKDA

PRIMARY DIAGNOSIS: Dx s/p Exp Lap, Colectomy, End Colostomy + I+D (L) ForeArm

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION:

[redacted] b(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 EDITION OF 1 DEC 77 MAY BE USED. USAPA V1.00

MEDCOM - 12362

a All b(6)-2

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo ______ *Yr* ______

Verify by Initialing: Order Date	Verify by Initialing: Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
28 JUN	[redacted]	Cefotetan 2mg (First Dose Now)	28 JUN	1910	1950	[redacted]
28 JUN		Gentamycin 500 mg IV x 1 Now	28 JUN	1845	19:0	[redacted]

INITIAL PROPER COLUMN FOLLOWING COMPLETION

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	TIME/DATE COMPLETED														
28 JUN	[redacted]	MSO4 1-4 Mg IV q1hr PRN Pain	29 Jun 0120 4mg IV [redacted]	29 Jun 0800 4mg [redacted]	29 Jun 0915 [redacted]	29 Jun H[illegible] 2mg [redacted]	3mg 6/29 w [redacted]	2mg 0700 6/30 [redacted] IV	30 Jun 4mg 0630 [redacted]	30 Jun 4mg 0730 [redacted]	30 JUN 4mg 16[redacted]	[redacted]	4mg 0040 1 July [redacted]	4mg 0818 2 Jul [redacted]	4mg IV 5 Jul 0043 [redacted]	4mg IV 0530 0537 [redacted]	4mg IV 1 July 0930 [redacted]
		~~Toradol 30mg IV Q6 hrs x 6~~															
1 July	[redacted]	Percocet 1-2 tabs q 4-6 hr prn	1 July 2210 11	1 Jul 112	1 Jul BnS 1845	3 Jul 0855 [redacted]	3 July 1805 [redacted]	3 Jul 2037 [redacted]	4 Jul 0900 [redacted]	4 July 0830 [redacted]	4 Jul 2330 [redacted]	5 Jul 2000 [redacted]					

USAPA V1.00

MEDCOM - 12363

All b(6)-2 except last

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)

For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo. JUN Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	28	29	30	1	2	3	4	5	6	7	8	9	10	11
28JUN	[redacted]	IVF: LR@ 125cc/HR	05 17	[redacted]							See below						
28JUN	[redacted]	Toradol 30 mg IV Q6 hrs x 6 doses Then D/C	06 12 18 24	[redacted]													
28JUN	[redacted]	Cefotetan 2 mg IV Q8 hrs	06 14 22	[redacted]							DC'd 1 July 0700			[redacted]			
30Jun	[redacted]	IVF TVO	05 13 21			[redacted]				1 Jul 03 [redacted]							
1 July	[redacted]	Ancef 1 gm IV q 8 hrs	06 14 22					[redacted]						SEE A 2ND PAGE			

ALLERGIES: ☐ YES ☒ NO

~~AT~~ NKDA

PRIMARY DIAGNOSIS: Dx S/P Exp Lap, Colectomy, End Colostomy + I+D (L) ForeArm

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION:

[redacted]

b(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78

EDITION OF 1 DEC 77 MAY BE USED.

USAPA V1.00

MEDCOM - 12364

All b(6)-2 except last

CLINICAL RECORD

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

Mo. 6 *Yr.* 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	30	01	02	03	4	5	6	7	8	9	10			
30Jun	[redacted]	Activity: Sng OOB>	05	/	[redacted]												
		Chair, Amb c̄ assist	13	/	[redacted]												
			21	[redacted]													
30Jun	[redacted]	Call MD for HR<50	05	/	[redacted]												
		>120, SBP <90 >150	13	/	[redacted]												
		DBP<60 >90, RR>30	21	[redacted]													
		<10, UO <30cc															
		T- >100.4															
2Jul	[redacted]	Δ middle dsg, wet	08	/	[redacted]												
		to dry BID	20	/	/	[redacted]											
2 Jul	[redacted]	Pt may ambulate TID	05	/	[redacted]		[redacted]										
			13	/	/	[redacted]											
			21	/	/	[redacted]											
2Jul	[redacted]	JP to Bulb suction	5	/	/	/	[redacted]										
			13	/	/	[redacted]						D/C'D					
			21	/	/	[redacted]											

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
S/P Colectomy/T+D @ FA

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

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 EDITION OF 1 DEC 77 MAY BE USED. USAPA V1.00
MEDCOM - 12365

All b(6)-2 except last

the proponent agency is the Office of The Surgeon General. MO. YR 2003

RIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED
				21
6 Jul	[redacted]	OOB ad lib	05	[redacted]
			13	
			21	
6 Jul	[redacted]	Ostomy care	05	[redacted]
			13	
			21	
6 Jul	[redacted]	Regular diet	06	[redacted]
			12	[redacted]
			17	
6 Jul	[redacted]	VS q 6	06	
			12	
			18	
			24	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Wound Separation

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ____

PATIENT IDENTIFICATION:

#[redacted] b(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIME

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 — EDITION OF 1 DEC 77 MAY BE USED. — USA

MEDCOM - 12366

All b(6)-2 except last

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

Mo. ____ *Yr.* 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	07	8	9	10	11	12	13	14	15	16	17	18	19	20
6 Jul	[redacted]	VS Q4°	02	[redacted]													
			06														
			10				D/C				7 July						
			14														
			18														
			22														
6 Jul	[redacted]	I + O's	05	[redacted]			D/C			7 July							
			13														
			21														
6 Jul	[redacted]	OOB → ~~Chair~~ Ex room ad lib	05	[redacted]													
			13	[redacted]													
			21	[redacted]													
6 Jul	[redacted]	Colostomy care	05	[redacted]													
			13	[redacted]													
			21	[redacted]													
6 Jul	[redacted]	W→D dsg midline wound BID	08	[redacted]	[redacted]	[redacted]		see new sheet									
			20	[redacted]													
6 Jul	[redacted]	Reg diet	07	[redacted]													
			12	[redacted]													
			17	[redacted]													
6 Jul	[redacted]	VS Q6	06	[redacted]													
			12	[redacted]													
			18	[redacted]													
			24	[redacted]													

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
Wound Separation

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

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 | EDITION OF 1 DEC 77 MAY BE USED. | USAPA V1.00
MEDCOM - 12367

All b(6)-2

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo July *Yr* 2003

Verify by Initialing						
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
13	[redacted]	NPO p̄ MN	13	2355		[redacted]
13	[redacted]	NPO p MN (15 July)	15	0001	0001	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION													
			TIME/DATE COMPLETED													

USAPA V1.00

MEDCOM - 12368

All b(6)-2 except last

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

Mo. July *Yr.* 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	10	11	12	13	14	15	
10 July	[redacted]	JP to continuous	06	[redacted]						
		125mmHg suction.	14					D/C 12 July		
			22							
12	[redacted]	W→D dsg BID	10	[redacted]	/	[redacted]			D/C 15 July 03 [redacted]	
		to ABD	22	/	/					

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
Wound Separation

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
PAGE NO: ______

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 | EDITION OF 1 DEC 77 MAY BE USED. | USAPA V1.00

MEDCOM - 12369

All b(6)-2 except last

the proponent agency is the Office of The Surgeon General.

MO. 7 YR2003

RIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 26	27	28
26	[redacted]	activity-ad lib	05	/		
			13	[redacted]		
			21			
			/			
26	[redacted]	diet: regular	~~09~~	/		
			12	/	[redacted]	
			17	/		
			/			
26	[redacted]	VS-none	05	/		
			13	[redacted]		
			21			

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Boarde —ulnar fx/ s/p suture removal

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ____

PATIENT IDENTIFICATION:

EPW [redacted] b(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIME

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78

EDITION OF 1 DEC 77 MAY BE USED.

USA

MEDCOM - 12370

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*	*Mo* 7 *Yr* 2003			
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
26	[redacted]	Condition: stable				
	-----	admit ICW #2				
26	[redacted]	D/C pt. to EPW Camp when	ASAP			
	-----	available escort				

	-----					

b(6)-2

Order/ Expir Date		PRN ACTION, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING COMPLETION* TIME/DATE COMPLETED													
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															
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MEDCOM - 12371

All b(6)-2 except last

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. Jul *Yr.* 03

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

ORDER DATE	CLERK/NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 14	15	16	17	18	19	20	21	22
6 July	[redacted]	LR @75cc/hr @	08	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[illegible]
			14	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		
			22	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		
13 July	[redacted]	Ancef 1gm IV Q6 04	08	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
		10	14	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		
		16	20	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		[redacted]
		22	02	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS:

Wound separation

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____________

PATIENT IDENTIFICATION:

EPW # [redacted] 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 - 12372

All b(6)-2

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*	Mo. 7 Yr. 03

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

INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	TIME/DATE DISPENSED													
16 July	[redacted]	Percocet i-ii tabs PO q4-6 PRN pain	15 July 1700 II [redacted]	15 July II 1320 [redacted]	15 July II 2045 [redacted]	16 July 0345 II PO [redacted]	17 July 0010 II PO [redacted]	17 Jul 2242 II PO [redacted]	18 July 0525 II PO [redacted]	19 July 2250 II [redacted]						
16 July	[redacted]	Tylenol 650mg po Q6° PRN pain	16 July 0900 650mg [redacted]	16 Jul 01:54 650 mg PO [redacted]	18 Jul 975mg [redacted] 1900 (+)	18 Jul 2045 II PO [redacted]	18 Jul 2040 [redacted] II									
21 July	[redacted]	Maalox 2-4 tabs po TID PRN														
17 July	[redacted]	Phenergan 25mg IVP q6° PRN for nausea ī vomiting	17 Jul 1907 12.5mg IV [redacted]	20 July 1112 [redacted]												

USAPA V1.00

MEDCOM - 12373

All b(6)-2 except last

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.* 7 *Yr.* 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY [redacted]	HR	6	[redacted]	8	9	10	11	12	13	14	15	16	17	18	19
Orig [redacted] ~~10 03~~	[redacted]	~~IVF LR@ 150cc/hr~~ D/C	05	/	[redacted]												
10 JUL		HL	13	/													
			21	Em													
Orig [redacted] ~~07 JUL~~	[redacted]	1gm Ancef IV	04	/													
		Q6°	10	/													
			16	/													
			22	/													
13	[redacted]	Start LR@ 75cc/hr	5	/								/	[redacted]				
		@ 2400 13JUL03	13	/								/					
			21	/								[redacted]					
		Ancef 1gm IV	08	/	/	/	/	/	/	/	/	[redacted]					
		Q6	14	/	/	/	/	/	/	/	/						
			20	/	/	/	/	/	/	/	/						
			02	/	/	/	/	/	/	/	/						

Rewritten

Rewritten

Rewritten

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
Wound Separation

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

PATIENT IDENTIFICATION:
EPW
[redacted] 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 - 12374

All b(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*			*Mo.* ____ *Yr.* ____	
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													
6 Jul	[redacted]	Percocet i - ii tabs	2 Jul 0105 ii PO	3 Jul 0300 ii	7 Jul 1230 ii	8 Jul 0140 ii	9 July 0235 ii PO	10 July 0400 ii PO	10 July 1630 ii PO	11 Jul ii PO	10 Jul 21:35 ii PO	11 July 1245 ii PO	11 July 2200 ii PO	12 July 0630 ii	12 Jul 2200 ii	13 Jul 03:20 ii PO
		PO Q4° - Q6° PRN	[redacted]		[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
		Pain														
6 Jul	[redacted]	Tylenol 650mg														
		PO Q6° PRN pain														
11 Jul	[redacted]	Maalox 2-4 tabs	0141 11 Jul ii PO	2000 ii PO												
		PO TID PRN	[redacted]	[redacted] 13 Jul												
11 Jul	[redacted]	Phenergan 25mg IVP	0741 11 Jul 25mg IVP	3 July 0115 25mg IVP	13 Jul 1130											
		q6° PRN for Nausea	[redacted]	[redacted]	[redacted]											
		and Vomiting														

USAPA V1.00

MEDCOM - 12375

TWENTY-FOUR HOUR PATIENT INTAK AND OUTPUT WORKSHEET

FROM ____ HRS TO ______ HOURS

TOTAL HOURS COVERED

DATE

INT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
0800	Juice	120cc	120cc
0800	Water	60cc	180cc
1600	Jello	120	300
	tang	200	500
	H_2O	100	600

Lactated Rig. INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
0450	500cc	LR TKO	500	900	500
0900	500cc	LR	500	~~1400~~ 1200	1000
14	50	ancef	50		1050

urine ~~IRRIGATIONS (N/G~~ [✓ Bladder], etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
1600	urine	700	700

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl, Alb, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

EPW [redacted] b(6)-4

INTAKE EQUIVALENTS (Serving levels cc)

MEDICINE GLASS (1 oz) .30	HALF PINT MILK 240
SMALL FRUIT CUP 120	LARGE SOUP BOWL.....240
COFFEE CUP.............160	LARGE WATER GLASS..240
LARGE COFFEE MUG...180	PLASTIC OR PAPER JUICE CONTAINER...180

DD FORM 1 JAN 74 792

EDITION OF 1 SEP 71 IS OBSOLETE. REPLACES DA FORM 3630 (TEMP) 1 JUL 72

MEDCOM - 12376

*U.S.GPO:1996-404-613/30343

b(6)-4

[redacted] 29Jun Fcq#7

PAGI

DATE	DX												HOSPITAL DAY			

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15
BP Arterial Line	[illegible]/	137/	141/	125/	127/	133/	124/	132/		104/	110/	129/	122/	124/	131/	125/	126/
BP Cuff	51	88	77	80	99	86	82	79		64	61	85	70	70	72	73	69
Temperature	98.8				99.4		98.2								99.2		
Pulse	135	115	99	97	96	106	103	105		104	101	78	97	94	97	113	99
Respiratory Rate	13	19	14	14	16	16	17	17		19	19	19	15	16	18	16	16
SAO2	100	98	99	98	99	100	95%	97%		97%	97%	97%	97%	97%	97%	99	99
O2 source	2L NC	2 NC	2L NC	2L NC	2L NC	2L NC	2L NC	2L		2L	2L	2L	2L	2L	2L	2L	2L
pain																	
intervention																	
TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15
IVP	125	125	125	125	125	125	100	200	850	100	100	100	100	100	100	100	100
										50						50	
									b6-2								
									[redacted]								
TOTALS		250		500	625	750			850								
URINE HOUR / TOTAL	125/125	100/225	75/300	100/400	75/475	50/525	100/625	200/825	825	100/100	100/200	50/250	200/450	100/550	100/650	100/750	100/850
URINE sp gr																	
URINE S/A																	
NG OUTPUT																	
NG pH																	
NG GUIAC																	
EMESIS																	
STOOL																	
DRAINS JP					10			0	10			4					
DRAINS																	
DRAINS									0								
TOTALS									835								804

500
100

900

MEDCOM - 12377

[redacted] b(6)-4

29 Jun 03

PAG

OP DAY

	16	17	18	19	20	21	22	23	
	117/72	124/62	132/66	135/72	173/80	128/73	125/60	132/71	
	108	102	105	97	85	92	90	89	
	23	17	25	19	24	18	18	17	
	98%	98%	96	96	96	98	98	99	
	2L	2L	2L	2L	2L	2L	2L	2L	
			OOB to chair				98.6 Ax		
	16	17	18	19	20	21	22	23	8° T
CR	125	125	125	125	125	125	125	125	
ABX						50			
UOP	100/100	100/200	[illegible]/300	50/350	100/450	200/650	230/912	250/1150	

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA

	TIME	
	MODE	
	F_iO_2	
	TV	
	RATE	
	PEEP	
ABG	pH	
	PCO_2	
	pO_2	
	HCO_3	
	SAT	
	BASE	

LABORATORY DATA

TIME	04
GLUCOSE	130
Na/K	131/4.6
Cl/CO_2	102/23
BUN/Cr	10/0.4
WBC/PLATELET	11.4/342
Hct/Hgb	30/11

ACTIVITIES OF DAILY LIVING

TIME	
MOUTH CARE	
BATH	
SKIN CARE	
FOLEY CARE	
TRACH CARE	
ROM EXERCISES	

TURN

SUCTION

TIME

24° I&O TOTALS

wt Yesterday ______ wt Today ______

INTAKE

IV ______

po ______

TOTAL ______

OUTPUT

Urine: ______

TOTAL ______

NURSE'S SIGNATURE

MEDCOM - 12378

TWENTY-FOUR HOUR PATIEN .A E AND OUTPUT WORKSHEET

FR 5 HOURS
TO 0029 HOURS

TOTAL HOURS COVERED: 24

INT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
0800	Milk	250	250
1800	milk	250	500
1800	H2O	50	550

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
0600	50	ANCEF	50	0630	50
1415	50	Ancef	50	1445	100
2200	50	Ancef	50		150

JP ~~IRRIGATIONS~~ (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0845	Red serosang fluid	20	20
0800	Red serous fluid	20	40
2025	Red serosang fluid	20	60cc
0300	serosang.	20	80cc

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl, Alb, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

INTAKE EQUIVALENTS *(Serving levels cc)*

MEDICINE GLASS (1 oz)	30	HALF PINT MILK	240
SMALL FRUIT CUP	120	LARGE SOUP BOWL	240
COFFEE CUP	160	LARGE WATER GLASS	240
LARGE COFFEE MUG	180	PLASTIC OR PAPER JUICE CONTAINER	180

DD FORM 1 JAN 74 792

EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3630(TEMP)

MEDCOM - 12379

*U.S.GPO:1998-404-613/3034

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM ____ HOURS
TO ________ HOURS
TOTAL HOURS COVERED
DATE 2JUL03

INTAKE

~~ORAL~~ JP Drain

TIME	TYPE	AMOUNT	ACCUM TOTAL
1930	Bldy	30	30

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL

IRRIGATIONS *(N/G, Bladder, etc.)*

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT *(i.e. Bl. Alb. P. cells, etc.)*	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

EPW [redacted] b(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

MEDICINE GLASS *(1 oz)*	.30
SMALL FRUIT CUP	.120
COFFEE CUP	.160
LARGE COFFEE MUG	.180
HALF PINT MILK	.240
LARGE SOUP BOWL	.240
LARGE WATER GLASS	.240
PLASTIC OR PAPER JUICE CONTAINER	.180

DD FORM 1 JAN 74 792 EDITION OF 1 FEB 71 IS OBSOLETE. REPLACES DA FORM 3630(TEMP) 1 JUL 7 MEDCOM - 12380 *U.S.GPO:1996-404-613/30343

TWENTY-FOUR HOUR PATIENT INTA... AND OUTPUT WORKSHEET

FROM [illegible] HOURS
TO 2000 HOURS
TOTAL HOURS COVERED 24
DATE 5Oct03

INT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
0610	50cc	Ancef	50cc	0650	50cc
1400	100	Ancef	100		150
2000	100	Ancef	100		250

JP ~~IRRIGATIONS~~ (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0200	Red fluid	10cc	10cc
2100	Red fluid	10	20cc

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl. Alb. P. cells. etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

EPW [redacted] b(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

MEDICINE GLASS *(1 oz)*	.30
SMALL FRUIT CUP	120
COFFEE CUP	160
LARGE COFFEE MUG	180
HALF PINT MILK	240
LARGE SOUP BOWL	240
LARGE WATER GLASS	240
PLASTIC OR PAPER JUICE CONTAINER	180

MEDCOM - 12381

DD FORM 1 JAN 74 792

EDITIO... 1 JUL 72 WHICH MAY BE USED.

REPLACES DA FORM 3830(TEMP)

TWENTY-FOUR HOUR PATIENT ...AKE AND OUTPUT WORKSHEET	FRO. ___ OURS TO ___ HOURS	TOTAL HOURS COVERED	DATE 4 Jul

INT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
08	milk + 2	480	
1000	H2O	100	580
1700	milk	240	820

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
06	100	Ancef	100	0630	100
14	100	ancef	100	1430	200
22	100	ancef	100	2330	300

JP ~~IRRIGATIONS (N/G,~~ Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
09	red	15 "	15
2000	red	10cc	25cc

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl. Alb, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

#[redacted]

b(6)-4

INTAKE EQUIVALENTS (*Serving levels cc*)

MEDICINE GLASS (*1 oz*) .30	HALF PINT MILK 240
SMALL FRUIT CUP 120	LARGE SOUP BOWL.....240
COFFEE CUP..............160	LARGE WATER GLASS..240
LARGE COFFEE MUG...180	PLASTIC OR PAPER JUICE CONTAINER...180

DD FORM 1 JAN 74 792

EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3630(TEMP) 1 JUL 72 WHICH MAY BE USED.

*U.S.GPO:1998-404-613/30343

MEDCOM - 12382

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM ____ HOURS TO 05 HOURS	TOTAL HOURS COVERED 24	DATE 6July	

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL

JP ~~IRRIGATIONS~~ (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0400	Red bloody fluid	7cc	7cc
	JP Removed		
	6 July 03		
	0930		

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl. Alb. P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

EPW # [redacted] b(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

MEDICINE GLASS *(1 oz)*	30	HALF PINT MILK	240
SMALL FRUIT CUP	120	LARGE SOUP BOWL	240
COFFEE CUP	160	LARGE WATER GLASS	240
LARGE COFFEE MUG	180	PLASTIC OR PAPER JUICE CONTAINER	180

DD FORM 1 JAN 74 792

EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3830(TEMP) 1 JUL 72 WHICH MAY BE USED.

*U.S.GPO:1996-404-613/30343

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA
For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

b(6)-2

OTSG APPROVED *(Date)*
DA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	1445 INITIALS [redacted]	1730 INITIALS [redacted]	INITIALS
NEURO	PUPILS	unequal, Ⓛ eye reactive	OS 2mm sluggish	
	SENSORIUM	to light sluggish. Pt	OD irregular 4mm &	
		opens eyes to voice and	Reaction. Opens OU to	
		moves all ext. Will be	voices follows sound c̄	
		sedated c̄ propofol & fentanyl	move head; MAE's purpose	
RESPIRATORY	RESPIRATORY PATTERN	RRR, equal chest rise	Vent: FIO 50%, rate	
	BREATH SOUNDS	Clear throughout	12, PEEP 5, TV 750.	
	SECRETIONS	Ø noted @ this time.	BS CTAB c̄ ↓↓ Ⓛ lobes.	
			Bilat symmetrical	
			Chest expansion.	
			SATS 100%.	
SKIN	COLOR	WNL for race	Membranes pink. Neck	
	INTEGRITY	drsg on mouth and head	& mandible c̄ acc/	
		OH & sanguinous fluid on Ⓛ	cheek press. Band wrap	
IV SITE	LOCATION	Ⓡ AC + Ⓛ AC c̄ LR infusing	g. PIV 18g Ⓡ AC	
	CONDITION	Ⓛ radial A-line	Saline lock; PIV Ⓛ AC	
		Ø S/S of infection noted	18g infuse LR 150, Propofol	
			14mcg, Fent 25mcg, Ⓡ	
			RADIAL Aline. Lines patent	
			s̄ S/Sx infiltration	
GASTRO	ABDOMEN	soft and nondistended	Obese, round, soft.	
	BOWEL SOUNDS	BS in all quadrants	hypoactive BS in (4)	
			Quads. NPO maintained	
GU	URINE:	foley to gravity drainage	#16F Foley cath intact	
	COLOR/CLARITY	clear yellow urine	Secure to Ⓛ thigh.	
			Cl. yellow urine (>30/hr)	
CARDIOVASCULAR	CARDIAC RHYTHM	SR c̄ Ø ectopy, HR 80-90	SS s̄ ectopy. HR	
		pulses palpable +2	80s - 100s. HTN A-	
		wrists, +1 dorsalis pedis,	Line B/P 170s/60-70s.	
		tibialis pulses doppler. Pt	PP +2 density & post	
		Obese. Edema to face	Tib doppler +2 dens, M	

LEGEND
Cr - Creatinine
F_iO_2 - Fraction of Inspired O_2
HCO_3 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
S/A - Fractional
SAT - Saturation
TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY
b(6)-2 [redacted]

DEPARTMENT/SERVICE/CLINIC
ICU 3

DATE
28 Jan 03

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

[redacted] b(6)-4

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

DA FORM 1 MAY 78 **4700**
Proponent: Dept of Nurs

MEDCOM - 12384

WMC OP 375 (Redesignated)
1 Apr 90 (HSXC-NU)

PAGE 2 OF 4

DATE 28 Jun03	DX											HOSPITAL DAY					
TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20
BP Arterial Line											137/64	137/65	144/70	165/75	173/74	112/65	
BP Cuff															140/63	146/63	
Temperature											98^3		98^9	98^9	X	X	
Pulse											83	81	93	85	102	86	
Respiratory Rate											14	14	27	16	16	25	
MAP											90	91	112	107	94	86	
SaO2											100	100	100	100	100	99	
O2 Source											Vent	Vent	vent	vent	SIMV	Simv	
pain																	
intervention																	

TIME	05	06	07	08	09	10	11	12	8° T	13	14	15	16	17	18	19	20	8° T
LR											3000 OR	125	125	125	125	125	125	3750
Propofol												5.0	5.4	7.[illegible]	7.6	8.0	8.0	41.6
Fentanyl												5.0	5.0	5.0	5.8	5^0	7^0	42
TOTALS																		3833.6

URINE	HOUR / TOTAL											OR 300 / 300	60 / 360	35 / 395	35 / 430	105 / 535	55 / 590	40 / 630	630
	sp gr																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS	JP											EBL 150		35				70	255
TOTALS																			

MEDCOM - 12385

PAGE 3 OF 4

POST-OP DAY

VITAL SIGNS									
	21	22	23	00	01	02	03	04	
	153/98	116/60	125/61	116/59	93/50	106/56	114/58		
	141/79	114/56	X	119/62	X	X	X		
T	X	101^6	X	X	100^4	99^7	X	X	
P	105	94	91	93	93	87	82	86	
RR	26	11	10	12	12	12	12	24	
MAP	121	81	84	79	69	76	78		
Sat	100	100	100	100	100	100	100	100	
	Simv	SIMV	Simv	Simv	Simv	Simv	Simv	Simv	
			[illegible]						

INTAKE									
	21	22	23	00	01	02	03	04	8° T
	125	125	125	125	125	125	125	125	1000
	10	15	15	15	15	15	15	15	115
	7°	7°	7°	7°	7°	7°	7°	7°	56
									1171

OUTPUT									
	45/45	30/75	30/105	30/135	30/165	26/191	30/221	26/247	247

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA				
TIME	1445	1513	1832	
MODE	SIMV			
F_iO_2	50			
TV	750			
RATE	14			
PEEP	5			
ABG pH		7.443	7.461	
ABG PCO_2		30.7	31.1	
ABG pO_2		91	126	
ABG HCO_3		21	22	
ABG SAT		98	99	
ABG BASE		-3	-2	

LABORATORY DATA		
TIME	1513	
GLUCOSE	127	
Na/K	134/4.4	
Cl/CO_2	112/20	
BUN/Cr	14/0.6	
WBC/PLATELET	16.4/384	
Hct/Hgb	34.1/10.7	
CK	352	

ACTIVITIES OF DAILY LIVING		
TIME		
MOUTH CARE		
BATH		
SKIN CARE		
FOLEY CARE		
TRACH CARE		
ROM EXERCISES		

TURN / SUCTION	TIME
TURN	1730
	1930
	2100
	2330
SUCTION	2100
	0100

24° I&O TOTALS

wt Yesterday ______
wt Today b(6)-2

INTAKE
IV 5004.6
po 0
TOTAL 5004.6

OUTPUT
Urine: 577
TOTAL

BALANCE 4127.6

NURSE'S SIGNATURE	INITIALS
[redacted]	AIR

MEDCOM - 12386

PAG

NEUROLOGICAL ASSESSMENT

HOURS	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
SPONTANEOUSLY 4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4
TO SPEECH 3																								
TO PAIN 2																								
NO EYE OPENING 1																								
ORIENTED 5																								
CONFUSED 4																								
VERBALIZES 3																								
VOCALIZES 2																								
NO VOCALIZATION 1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
OBEYS COMMANDS 6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6
LOCALIZES PAIN 5																								
FLEXION WITHDRAWAL 4																								
ABNORMAL FLEXION 3																								
EXTENSION TO PAIN 2																								
NO MOTOR RESPONSE 1																								
NORMAL POWER	L/R	L/R	L/R	L/R	L/R	L/R	L/R	L/R	L/R	L/R	L/R	L/R	L/R	L/R	L/R	L/R	L/R	L/R	L/R	L/R	L/R	L/R	L/R	L/R
MILD WEAKNESS																								
SEVERE WEAKNESS																								
ABNORMAL FLEXION																								
ABNORMAL EXTENSION																								
NO RESPONSE																								
NORMAL POWER	L/R	L/R	L/R	L/R	L/R	L/R	L/R	L/R	L/R	L/R	L/R	L/R	L/R	L/R	L/R	L/R	L/R	L/R	L/R	L/R	L/R	L/R		
MILD WEAKNESS																								
SEVERE WEAKNESS																								
ABNORMAL FLEXION																								
ABNORMAL EXTENSION																								
NO RESPONSE																								
HT SIZE	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4
REACTION	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
FT SIZE	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
REACTION	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
ALE	● 2 ● 3 ● 4 ● 5 ● 6 ● 7 mm																							
L PERFUSION URE ·																								

LEC

C C by sw

T Trac
S Slur
D Dys
R Rec
E Exp

R R
L L

Record separa there differe betwe two sid

++ I
+ S
- I Res

+ Inta
- Abn

VASCULAR ASSESSMENT

HOURS		05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
Radial	R	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++
	L	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++
Pedal	R	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++
	L	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++	++		++
Post tibial	R	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
	L	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+

LEGE
++ Nc
+ W
- Al
D Do

CIV [redacted] b(6)-4

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

b(6)-2

OTSG APPROVED *(Date)* DA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0500 INITIALS [redacted]	2000 INITIALS [redacted]	INITIALS
NEURO	PUPILS		R pupil elongated due to [illegible] segment L pupil ~~equal~~ reactive to light	
	SENSORIUM	Alert, open eyes spontaneously to voice. Sedated c̄ propofol and fentanyl	moves all extremities [illegible] sedated c̄ propofol, pain control c̄ fentanyl	
RESPIRATORY	RESPIRATORY PATTERN	RRR, equal chest rise	reg. + clear ETTube 26cm R nare	
	BREATH SOUNDS	ETT @ 26cm Ⓡ nare SIMV,	SIMV 40% peep 5 TV 750	
	SECRETIONS	peep 5, TV 750, FiO2 50%, RR 12. ∅ secretions noted @ this time	rate 4 ∅ secretions breath on own are shallow	
SKIN	COLOR	WNL for race	Sharing to face s/p GSW	
	INTEGRITY	GSW Ⓛ mandible/jaw. Dsg D/I	to L mandible dressing c̄ serosanguinous drag on L side	
IV SITE	LOCATION	Ⓛ radial A-line, Ⓛ AC,	L + R AC PMB Gauze.	
	CONDITION	Ⓡ AC c̄ ∅ S/S of infection. Ⓛ AC-propofol, LR, fentanyl infusing Ⓡ AC - S.L.	L Radial A line c̄ positive waveform	
GASTRO	ABDOMEN	soft nondistended	soft nondistended	
	BOWEL SOUNDS	BS(+) in all quads. hypoactive	BS(+)	
GU	URINE:	foley to gravity draining	yellow urine clear in adequate	
	COLOR/CLARITY	dark yellow urine	amounts via foley to gravity	
CARDIOVASCULAR	CARDIAC RHYTHM	SR c̄ ∅ ectopy noted. Edema to Ⓛ side face, pulses +2 throughout c̄ tibialis +1	NSR s̄ ectopy noted facial edema pulses palpable x 4 extremities	

LEGEND

Cr - Creatinine
FiO2 - Fraction of Inspired O2
HCO3 - Bicarbonate
ICP - Intracranial Pressure
PCO2 - Pressure of Arterial CO2
PEEP - Positive End Expiratory Pressure
S/A - Fractional
SAT - Saturation
TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY *(Signature & Title)* [redacted] b(6)-2 91WM6

DEPARTMENT/SERVICE/CLINIC ICU 3

DATE 29 Jun 03

[redacted] *written entries give: Name—last, first, middle; grade; date; hospital or medical facility)*

[redacted] b(6)-4

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

DA FORM 1 MAY 78 4700
Proponent: Dept of Nurs

MEDCOM - 12388

WAMC OP 375 (Redesignated)
1 Apr 90 (HSXC-NU)

DATE	DX	HOSPITAL DAY

VITAL SIGNS

TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
BP Arterial Line	125/62	119/60	123/61	141/55	144/65	114/57	139/66	138/61		134/55	108/60	112/55	112/54	123/59	137/65	143/73	122/67	
BP Cuff																		
Temperature	99^{0}	98^{7}	98^{4}	98^{1}	97^{9}	97^{9}	97^{4}	98^{7}		98^{0}	99^{2}	99^{6}	99^{1}	99^{7}	99^{6}	99.2	99.7	
Pulse	89	81	81	80	82	80	80	80		90	92	90	90	92	94	91	88	
Respiratory Rate	12	25	12	12	36	12	31	25		[illegible]	24	20	20	24	19	19	17	
MODE	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV		SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	
SAT	100	100	100	100	100	100	100	100		99	98	96	98	97	96	94	95	
MAP(Aline)	87	82	85	74	100	80	95	91		89	90	77	76	84	92	103	86	
pain																		
intervention																		

INTAKE

TIME	05	06	07	08	09	10	11	12	8°T	13	14	15	16	17	18	19	20	8°T
LR	125	125	125	125	125	125	125	125	900	125	125	125	125	125	125	125	129	
Propofol	15	15	15	15	15	15	15	15	120	18.9	16.2	16.2	16.2	16.2	19	13	12	
Fentanyl	7^{0}	7	7^{0}	7.0	7.0	7.0	7.0	7.0	56	7^{0}	8^{0}	8^{0}	8.0	8.0	10	10	10	
Bolus					500				500									
TOTALS																		

OUTPUT

Foley URINE	HOUR / TOTAL	30/30	45/75	27/102	26/128	42/170	32/202	32/234	44/278	278	42/320	46/366	65/431	38/469	52/521	70/591	70	55	
	SP GR																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS	JP		20						15	35				15					
TOTALS																			

MEDCOM - 12389

POST-OP DAY

VITAL SIGNS

21	22	23	00	01	02	03	04	
	110/61	105/66	72/69					
				142/70		126/55	135/57	
	99.7				99.5			
	92	88	84	90		88	93	
	16	15	14	14		13	13	
	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	
	99	98	100	100		100	100	
		82	70	95		83	88	

INTAKE

21	22	23	00	01	02	03	04	8°T
125	125	125	125	125	125	125	125	
12	12	12						
10	10	10	10	10	10	10	~~10~~ 6	

OUTPUT

40	50	110	60	100	100			

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA

TIME	0500	1200
MODE	SIMV	SIMV
F_iO_2	50	40
TV	750	750
RATE	12	4
PEEP	5	5
ABG pH		7.354
ABG PCO_2		40.3
ABG pO_2		76
ABG HCO_3		24
ABG SAT		94
ABG BASE		-2

LABORATORY DATA

TIME	0500
GLUCOSE	135
Na/K	132/4.3
Cl/CO_2	107/22
BUN/Cr	12/0.8
WBC/PLATELET	12.2/331
Hct/Hgb	31.2/9.5
RBC	3.7
MCV	84.2
lymph	21.6

ACTIVITIES OF DAILY LIVING

TIME	
MOUTH CARE	
BATH	
SKIN CARE	
FOLEY CARE	
TRACH CARE	
ROM EXERCISES	

TURN

SUCTION

TIME

24° I&O TOTALS

wt Yesterday ________

wt Today b(6)-2

INTAKE

IV ________

po ________

TOTAL ________

OUTPUT

Urine: ________

TOTAL ________

BALANCE ________

NURSE'S SIGNATURE	INITIALS
[redacted]	[redacted]

CIV [redacted] MEDCOM - 12390
b(6)-4

DATE MON 30JUN03 | DX S/P colostomy j GSW | HOSPITAL DAY 3

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15
BP Arterial Line	124	129	117	131	135	134	126	101		122	133	118	135	128	135	134	139
BP Cuff	49	63	67	71	76	68	69	42		73	75	67	75	72	74	74	74
Temperature					98.9							98.7		~~[illegible]~~			
Pulse	92	89	97	85	105	92	111	99		99	101	99	98	89	85	99	100
Respiratory Rate	18	16	20	17	14	15	17	20		21	16	18	14	15	16	18	17
SAO2	98	98	99	99	96	97	94	100		100	100	96	96	99	99	98%	100
source	2LNC	2LNC	2LNC	2L	2L	2L	2L	2L		2L	2L	2L	2L	2L	2L	2L	2L
pain																	
intervention																	

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	
LR	125	125	125	125	125	125	125	125	100	125	125	125	125	125	125	125	125	1000
Ampo							100		100							100		300
TOTALS	125	250	375	500	625	750			1000 1000									1300
URINE HOUR / TOTAL	125/125	125/250	75/325	150/475	150/625	150/775	100/875	100/975	975	50/50	100/150	100/250	100/350	200/550	150/700	100/800	200/1000	
URINE sp gr																		
URINE S/A																		
NG OUTPUT															300	300		
NG pH																		
NG GUIAC																		
EMESIS																		
~~STOOL~~ JP									10	DC								
DRAINS																		
TOTALS									985									1300

MEDCOM - 12391

PAGI

OF DAY

	16	17	18	19	20	21	22	23	
	131	134	121/73						
Cuff	74	73	121/73	139/73		Vitals			
Temp		97	98.6						
Pulse	99	100	91	90					
Resp	97%	100%	100%	98		See Remarks			
	2L	2L	2L	2L	W/R				
	NC	NC	NC	NC					
			20	18					

	16	17	18	19	20	21	22	23	8° T
CK	125	125	125	125					
	150/150	100/250	275/525						
NGT		200							

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA									
TIME									
MODE									
F_iO_2									
TV									
RATE									
PEEP									
ABG pH									
PCO_2									
pO_2									
HCO_3									
SAT									
BASE									

LABORATORY DATA								
TIME								
GLUCOSE								
Na/K								
Cl/CO_2								
BUN/Cr								
WBC/PLATELET								
Hct/Hgb								

ACTIVITIES OF DAILY LIVING				TURN SUCTION				
TIME					TIME			
MOUTH CARE								
BATH								
SKIN CARE								
FOLEY CARE								
TRACH CARE								
ROM EXERCISES								

24° I&O TOTALS

wt Yesterday ________ wt Today ________

INTAKE

IV ________

po ________

____

TOTAL ________

OUTPUT

Urine: ________

____

____

TOTAL ________

BALANCE ________

NURSE'S SIGNATURE

MEDCOM - 12392

All b(6)-2

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

OTSG APPROVED *(Date)*

REPORT TITLE **Post-Anesthesia Care Unit (PACU) Flow Sheet**

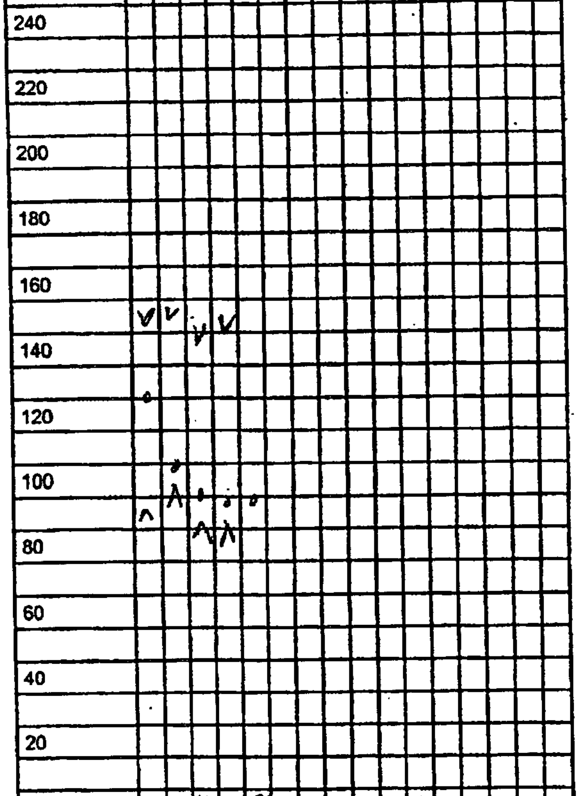
Date: 30 Jun 03
Time In: ~~2145~~ 2145
Allergies: NKDA
Pre-op V/S:
Procedures: I&D [illegible]
Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 1500 ~~Colloid~~ LR
OR Output: UOP 200 EBL 50
Meds/Times:

Drains		Airway
Hemovac	1	Nasal
[✓ NG]		Oral
JP		ETT
T-tube		Trach
[✓ Foley]		Other
TLS		

Pre Op Meds

History

Time	2145	2155	2205	2210	2220											
SaO2	94	100	100	90	98											
FiO2																
Methods																



RR	31	16	19	13	17											
T		98.8														

Time								
Pain (0-10)								
LOS								

Patient teaching done; Wound Care, Pain Management,
T, C, & DB,. Incentive Spirometer, Comfort Measures
Safety: SR up X 2, Falls Precautions. Privacy Maintained

Pacu Intake

Time	Solution	Amount	Site	By	Infused
2145	LR	KVO			

X-rays:

Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C	Codes
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2			**AIRWAY** A = Ambu BB = Blow-by M = Mask FT = Face Tent RA = RoomAir NC = Nasal Cannula
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2			
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2			**V/S** X = A-line BP ˅ = Cuff BP ˄ = Pulse
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1			**TEMP** S = Skin O = Oral A = Axillary T = Tympanic R = Rectal
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2			
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	2			**LOS** C = Cervical T = Thoracic L = Lumbar S = Sacral
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	11			

(Continue on reverse)

PREPARED BY *(Signature & Title)* [redacted] 1LT AN

DEPARTMENT/SERVICE/CLINIC ICU #1

DATE 30 Jun 03

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

[redacted]

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

DA FORM 4700, MAY 78 WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) Previous edition is obsolete USAPPC V2.00

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm			x4		<3	w	NBR
15'			x4		<3	w	NBR
30'							
45'							
60'							
90'							
D/C							

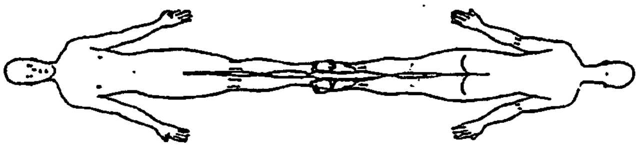
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent Color: C = Cyanotic, P = Pale, Pk = Pink Capillary Refill: B = Brisk, S = Sluggish

C-SECTIONS

	Adm	15'	30'	45'	60'	90'	D/C
Fund. Height							
Lochia							
Peripad#							
Fund. Cond.							

DRESSINGS

Time	Location	Type	Drainage
Adm	VCR	intact	∅
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

-see [illegible] data assessment for initial rec. assmt.

2220: (N) NOA; ⊕ sensation; pt has purposeful movements; still groggy from anesthesia; (R) ↑ RR; [illegible] setting. Sats 98% 2L NC; (CV) NSR-ST; ⊕ cap refill; GI - total U/O of 30cc in [illegible] for recovery.

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

Transferred to ICW-2 at 2235

[illegible] — [redacted] [illegible]

b(6)-2

Discharge Criteria:
Date: **Time:** **PARS:**
BP: **T:** **HR:** **RR:** **SaO2:**
Pain Level at D/C (0-10):
Intake:_______________ **Output:**_______________
Additional Data:_______________
Transferred To:_______________
Report Given To:_______________
Transferred Via: W/C Litter Gurney Ambulance
Transferred By:_______________
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature:_______________

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

OTSG APPROVED *(Date)*

REPORT TITLE **Post-Anesthesia Care Unit (PACU) Flow Sheet**

Date: 2 Jul 02
Time In: 1615
Allergies: NKDA
Pre-op V/S: 127/59 / 85
Procedures: I+d (L) UE

Anesthesia Type (Circle)): [✓ General] Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 800 Colloid
OR Output: UOP 0 EBL minimal
Meds/Times:

Versed 2mg
Fent 250mcg

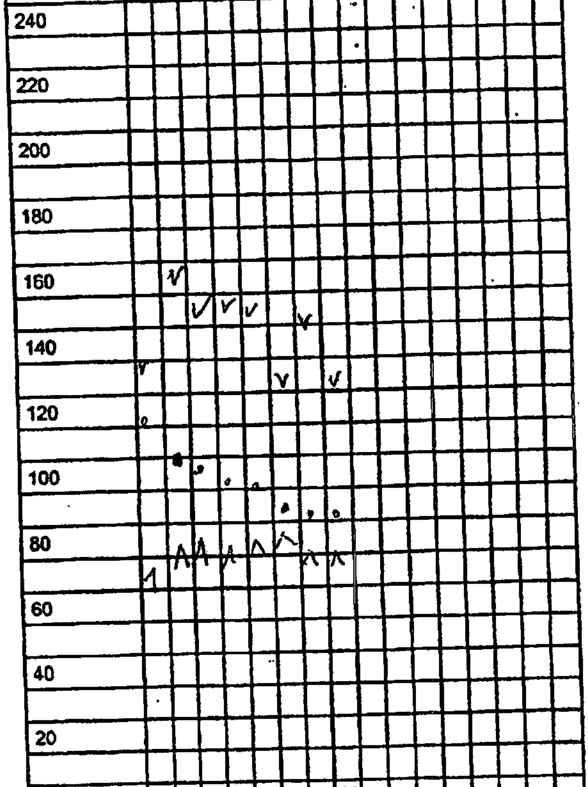
Drains: Hemovac, NG, [✓ JP], T-tube, Foley, TLS

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds

History

Time	1620	1625	1630	1635	1640	1645	1700	1715	1730
SaO2	98	99	99	99	98	98	99		
FiO2	21	21	21	21	22	21	21		
Methods									



RR	19	19	20	18	18	17	18	17	
T	98.3							98.9	

Time								
Pain (0-10)	2/10	–	–					
LOS								

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays:

Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	1	1	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	2	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	~~2~~	/	/
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	9	9	10

Codes

AIRWAY
A = Ambu
BB = Blow-by
M = Mask
FT = Face Tent
RA = RoomAir
NC = Nasal Cannula

V/S
X = A-line BP
* = Cuff BP
= Pulse

TEMP
S = Skin
O = Oral
A = Axillary
T = Tympanic
R = Rectal

LOS
C = Cervical
T = Thoracic
L = Lumbar
S = Sacral

Patient teaching done; Wound Care, Pain Management.
T, C, & DB., Incentive Spirometer, Comfort Measures
Safety: SR up X 2, Falls Precautions. Privacy Maintained

(Continue on reverse)

PREPARED BY [redacted] LPN. b(6)-2

DEPARTMENT/SERVICE/CLINIC ICU 2

DATE x 25 Jly 03

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

EPW # [redacted] b(6)-4

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

DA FORM 4700, MAY 78 WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) Previous edition is obsolete USAPPC V2.00

All b(6)-2

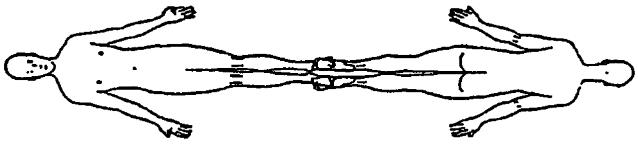
MEDICATIONS						
Allergies:						
Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
		0				

NEUROVASCULAR							
Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	ⓁArm	+	+	P	B	W	PK
15'	ⓁArm	+	+	P	B	W	PK
30'	ⓁArm	+	+	P	B	W	PK
45'	ⓁARM	+	+	P	B	W	PK
60'	ⓁARM	+	+	P	B	W	PK
90'	ⓁArm						
D/C	ⓁArm	"	"	"	"	"	"

Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic, P = Pale, Pk = Pink
Capillary Refill: B = Brisk, S = Sluggish

C-SECTIONS	Adm	15'	30'	45'	60'	90'	D/C
Fund. Height							
Lochia							
Peripad#							
Fund. Cond.							

DRESSINGS			
Time	Location	Type	Drainage
Adm	Left Arm	Ace	0
30'	Left Arm	Ace	0
60'	Left Arm	Ace	0
D/C	" "	"	0



PACU OUTPUT			
Time	Source	Color/Appearance	Amount
		0	

CARDIAC RHYTHM			
Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

Pt admitted @ 1645. VSS, Alert, responsive, Follows Commands. Pt placed on 2L O2 NC Sats - 98-99%. Pt c̄ Acewrap & splint to Ⓛ forearm. Drsg C/D/I. JP Drain in place, draining red fluid. Neurochecks to extremity WNL. Pt can wiggle extremities. Extremity warm to touch. Cap refill < 2 sec. Pt c/o ~~pain~~ minimal pain.

[redacted] LPN

Discharge Criteria:
Date: 2 July 03 **Time:** 1720 **PARS:** 10
BP: 137/85 **T:** 98.9 **HR:** 62 **RR:** 18 **Sa02:** 98
Pain Level at D/C (0-10):
Intake: 0 **Output:** 0
Additional Data:
Transferred To: ICW [redacted]
Report Given To: Sgt
Transferred Via [redacted] **Gurney Ambulance**
Transferred By:
Cleared IAW Re
Charge Nurse S

MEDCOM - 12396

ACLU-RDI 1592 p.289

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

OTSG APPROVED *(Date)*

REPORT TITLE Post-Anesthesia Care Unit (PACU) Flow Sheet

July 10.
closure

Date: 15Jul03
Anesthesia Type (Circle): [✓ General] Spinal Epidural IV Sedation Nerve Block
Time In: 1130
Allergies: NKDA
OR Intake: Crystalloid 700 Colloid
Pre-op V/S:
OR Output: UOP 0 EBL minimal
Procedures: Abdominal closure
Meds/Times:

Drains		Airway
Hemovac	(	Nasal
NG	(	Oral
JP		ETT
T-tube		Trach
Foley		Other
TLS		

Pre Op Meds

History

17/07

Time	1130	1140	1145	1200	1215	1220
SaO2	97	98	97	97	98	
FiO2	RA	RA	RA	RA	RA	
Methods						
240						
220						
200						
180						
160						
140						
120	V		V			
		V		Y	V	
100	•					
80		•	•	•		
					•	
60	Λ		Λ		Λ	
		Λ		Λ		
40						
20						
RR	~~20~~	14	17	12	13	
T	97				98	

Time				
Pain (0-10)				
LOS				

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays:

Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	2	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable; not radial (0) Carotid only reliable pulse	2	2	2
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	12	12	12

Codes

AIRWAY
A = Ambu
BB = Blow-by
M = Mask
FT = Face Tent
RA = RoomAir
NC = Nasal Cannula

V/S
X = A-line BP
˅ = Cuff BP
˄ = Pulse

TEMP
S = Skin
O = Oral
A = Axillary
T = Tympanic
R = Rectal

LOS
C = Cervical
T = Thoracic
L = Lumbar
S = Sacral

Patient teaching done: Wound Care, Pain Management, T, C, & DB., Incentive Spirometer, Comfort Measures
Safety: SR up X 2, Falls Precautions, Privacy Maintained

(Continue on reverse)

PREPARED BY *(Signature & Title)* [redacted]

b(6)-2

DEPARTMENT/SERVICE/CLINIC ICU2

DATE 15Jul03

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

#[redacted]

b(6)-4

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

DA FORM 4700, MAY 78 WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) Previous edition is obsolete USAPPC V2.00

All b(6)-2

MEDICATIONS						
Allergies:						
Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	ⒹArM	⊕	⊕	P	B	W	PK
15'							
30'							
45'							
60'							
90'							
D/C							

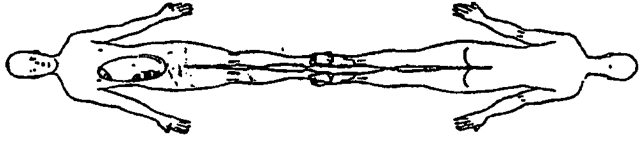
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent Color: C = Cyanotic, P = Pale, Pk = Pink Capillary Refill: B = Brisk, S = Sluggish

C-SECTIONS

	Adm	15'	30'	45'	60'	90'	D/C
Fund. Height							
Lochia		N/A					
Peripad#							
Fund. Cond.							

DRESSINGS

Time	Location	Type	Drainage
Adm	Abdominal	gauze	small amt
30'	Abdominal	gauze	small amt serous
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount
			[illegible]

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

Pt received on unit s/p abdominal closure. A+O x3 c̄ sats 96-100% on room air. lungs CTA bilaterally Abdominal drsg c̄ small amt of serous drainage noted. ⊕BS x4 quads. Will continue to monitor [redacted]

Discharge Criteria:
Date: 5 Jun 03 Time: PARS:
BP: 117/5 T: HR: RR: 20 Sa02: 96%
Pain Level at D/C (0-10): --
Intake: ∅ Output: ∅
Additional Data:
Transferred To: ICW 2
Report Given To:
Transferred Via: W/C [✓ Litter] Gurney Ambulance
Transferred By: CPT [redacted]
Cleared IAW Recovery Room SOP B-3 [redacted]
Charge Nurse Signature

MEDCOM - 12398

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE Post-Anesthesia Care Unit (PACU) Flow Sheet

OTSG APPROVED *(Date)*

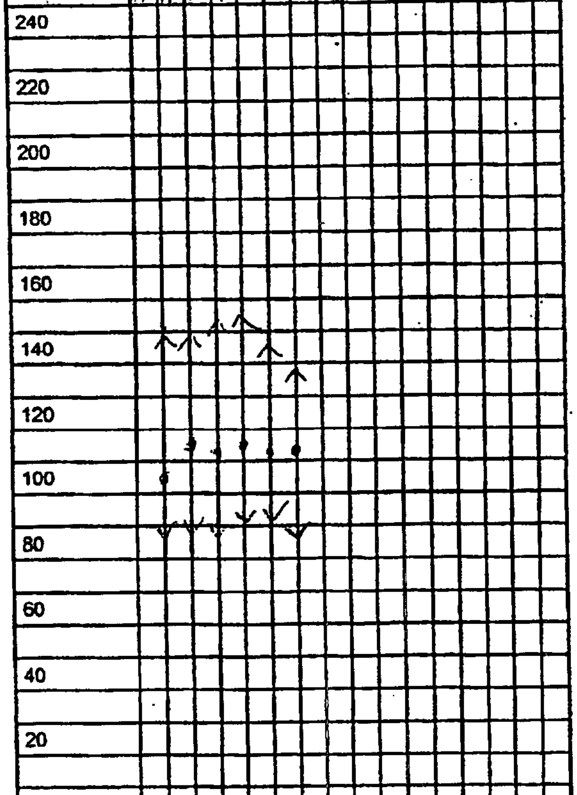
Date: 28 June 03 Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
Time In: 1730
Allergies: NKDA OR Intake: Crystalloid 1400 Colloid
Pre-op V/S: OR Output: UOP EBL
Procedures: ~~[illegible]~~ Meds/Times: ~~Ancef 1gm 1420~~

Drains: Hemovac [✓ NG] [✓ JP] T-tube [✓ Foley] TLS

Airway: [✓ Nasal] Oral ETT Trach Other

Pre Op Meds History

Time	1730	1735	1740	1745	1750	1800
SaO2	100	100	100	100	100	100
FiO2	10L	10L	10L	10L	10L	10L
Methods	FM	FM	FM	FM	FM	FM



RR			
T			
Time			
Pain (0-10)	0	0	0
LOS	[illegible]	[illegible]	[illegible]

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1750	LR				
	LR				

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	1	1	
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	1	1	
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	1	
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse			
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	7	7	

Codes

AIRWAY
A = Ambu
BB = Blow-by
M = Mask
FT = Face Tent
RA = RoomAir
NC = Nasal Cannula

V/S
X = A-line BP
^ = Cuff BP
= Pulse

TEMP
S = Skin
O = Oral
A = Axillary
T = Tympanic
R = Rectal

LOS
C = Cervical
T = Thoracic
L = Lumbar
S = Sacral

Patient teaching done: Wound Care, Pain Management,
T, C, & DB., Incentive Spirometer, Comfort Measures
Safety: SR up X 2, Falls Precautions. Privacy Maintained

(Continue on reverse)

PREPARED BY *(Signature & Title)* b(6)-2 [redacted] CAT/AN

DEPARTMENT/SERVICE/CLINIC ICU #1

DATE 28 June 03

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

EPW [redacted] b(6)-4

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

DA FORM 4700, MAY 78 WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) Previous edition is obsolete USAPPC V2.00

MEDICATIONS

Allergies: NKDA

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
				8		

See green white sheet

PK Adm Rcd

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm							
15'	(L) h	unable to assess		+	< 3sec	W/D	Normal
30'	(L) hand	unable to assess		+	< 3sec	W/D	Nor
45'							
60'							
90'							
D/C							

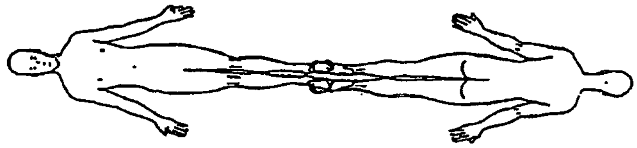
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent Color: C = Cyanotic, P = Pale, Pk = Pink Capillary Refill: B = Brisk, S = Sluggish

C-SECTIONS

	Adm	15'	30'	45'	60'	90'	D/C
Fund. Height			N/A				
Lochia							
Peripad#							
Fund. Cond.							

DRESSINGS

Time	Location	Type	Drainage
Adm	(L) ARM	splint Ace wrap	
30'	(L) ARM	splint Ace wrap	
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount
1500	JP	Woody	30
1800	Foley	Clear yellow	200

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1730	ST 100's		NO

WAMC OP 173-E

NURSING NOTES

pt Arrived @ 1230 - VSS. O2 Applied. transferred to unit bed. Assessment done see ICU Assessment sheet. nasal trumpet in place. pt very sedated at this time does not follow instructions. will continue to monitor [redacted] CPT/AN

b(6)-2

Discharge Criteria:

Date: **Time:** **PARS:**

BP: **T:** **HR:** **RR:** **Sa02:**

Pain Level at D/C (0-10):

Intake: **Output:**

Additional Data:

Transferred To:

Report Given To:

Transferred Via: W/C Litter Gurney Ambulance

Transferred By:

Cleared IAW Recovery Room SOP B-3

Charge Nurse Signature:

b(6)-4

1. LAST NAME [redacted]

SS

RANK/GRADE EPW

☒ MALE / HOMME
☐ FEMALE / FEMME

SPECIALTY CODE / GPM

RELIGION / RELIGION

2. UNIT / UNITÉ

FORCE / ÉLÉMENT

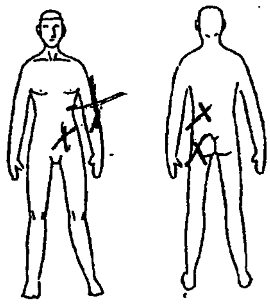
NATIONALITY / NATIONALITÉ

A/T	AF/A	N/M	MC/M
☐	BC / BC	☐	NBI / BNC

☐ DISEASE / MALADIE ☐ PSYCH / PSYCH

3. INJURY / BLESSURE

FRONT / DEVANT BACK / ARRIÈRE



☐ AIRWAY / TRACHÉE
☐ HEAD / TÊTE
☒ WOUND / BLESSURE
☐ NECK/BACK INJURY / BLESSURE AU COU/AU DOS
☐ BURN / BRÛLURE
☐ AMPUTATION / AMPUTATION
☐ STRESS / TENSION
☐ OTHER *(Specify)* / AUTRE *(Spécifier)*

2030 HRS
Recieved 2 Tablets
~~Percocet PO.~~

4. LEVEL OF CONSCIOUSNESS / NIVEAU DE CONSCIENCE

☐ ALERT / ALERTE
☐ VERBAL RESPONSE / RÉPONSE VERBALE
☐ PAIN RESPONSE / RÉPONSE À LA DOULEUR
☐ UNRESPONSIVE / SANS RÉPONSE

5. PULSE / POULS

TIME / HEURE

6. TOURNIQUET / GARROT ☐ NO / NON ☐ YES / OUI

TIME / HEURE

7. MORPHINE / MORPHINE ☐ NO / NON ☐ YES / OUI

DOSE / DOSE

TIME / HEURE

8. IV / IV

TIME / HEURE

9. TREATMENT / OBSERVATIONS / CURRENT MEDICATION / ALLERGIES / NBC (ANTIDOTE)
TRAITEMENT / OBSERVATIONS / PRESENTE MEDICATION / ALLERGIES / ANTIDOTES

6 Jul 03
mutiple GSW, exceeds care,
also needs Surg. Eval, for
Acute Abd.
T 101.4 Rectal
BP 122/98
P 102

10. DISPOSITION / DISPOSITION

☐ RETURNED TO DUTY / RETOUR À L'UNITÉ
☐ EVACUATED / EVACUÉ
☐ DECEASED / DÉCÉDÉ

TIME / HEURE

DATE/DATE (YYMMDD)

11. PROVIDER / UNIT / OFFICIER MÉDICALE / UNITÉ

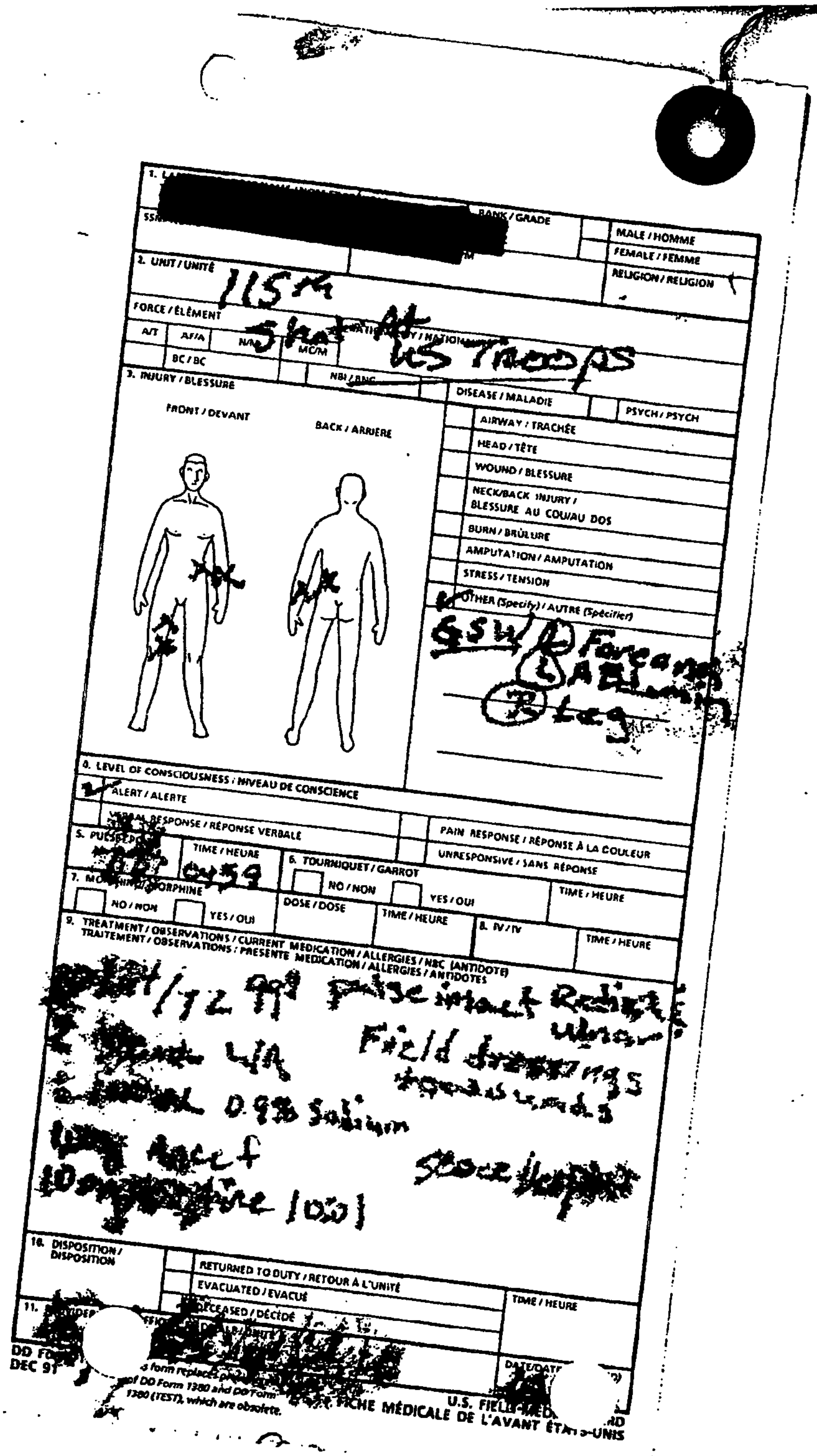
DD Form 1380,
DEC 91

This form replaces previous editions of DD Form 1380 and DD Form

U.S. FI
FICHE MÉDICALE DE L'

MEDCOM - 12401

:49



1. [redacted]

SSN [redacted]

RANK / GRADE

☐ MALE / HOMME

☐ FEMALE / FEMME

RELIGION / RELIGION

2. UNIT / UNITÉ 115th

FORCE / ÉLÉMENT

A/T AF/A N/M MC/M BC/BC

NATIONALITY / NATIONALITÉ

Shot At US TROOPS

NBI / BNC

3. INJURY / BLESSURE

FRONT / DEVANT

BACK / ARRIÈRE

☐ DISEASE / MALADIE

☐ PSYCH / PSYCH

☐ AIRWAY / TRACHÉE

☐ HEAD / TÊTE

☐ WOUND / BLESSURE

☐ NECK/BACK INJURY / BLESSURE AU COU/AU DOS

☐ BURN / BRÛLURE

☐ AMPUTATION / AMPUTATION

☐ STRESS / TENSION

☑ OTHER (Specify) / AUTRE (Spécifier)

GSW (R) Forearm
(L) A[illegible]
(R) Leg

4. LEVEL OF CONSCIOUSNESS / NIVEAU DE CONSCIENCE

☑ ALERT / ALERTE

☐ VERBAL RESPONSE / RÉPONSE VERBALE

☐ PAIN RESPONSE / RÉPONSE À LA COULEUR

☐ UNRESPONSIVE / SANS RÉPONSE

5. PULSE/POULS [illegible] TIME / HEURE 0459

6. TOURNIQUET / GARROT ☐ NO / NON ☐ YES / OUI TIME / HEURE

7. MORPHINE / MORPHINE ☐ NO / NON ☐ YES / OUI DOSE / DOSE TIME / HEURE

8. IV / IV TIME / HEURE

9. TREATMENT / OBSERVATIONS / CURRENT MEDICATION / ALLERGIES / NBC (ANTIDOTE)
TRAITEMENT / OBSERVATIONS / PRESENTE MEDICATION / ALLERGIES / ANTIDOTES

[illegible] /72 99 pulse intact Radial Ulnar
[illegible] 4A Field dressings
[illegible] 0.9% Sodium [illegible] to wounds
[illegible] Ancef [illegible]
[illegible] 1001

10. DISPOSITION / DISPOSITION

☐ RETURNED TO DUTY / RETOUR À L'UNITÉ

☐ EVACUATED / ÉVACUÉ

☐ DECEASED / DÉCÉDÉ

TIME / HEURE

11. PROVIDER / [illegible] DATE / [illegible]

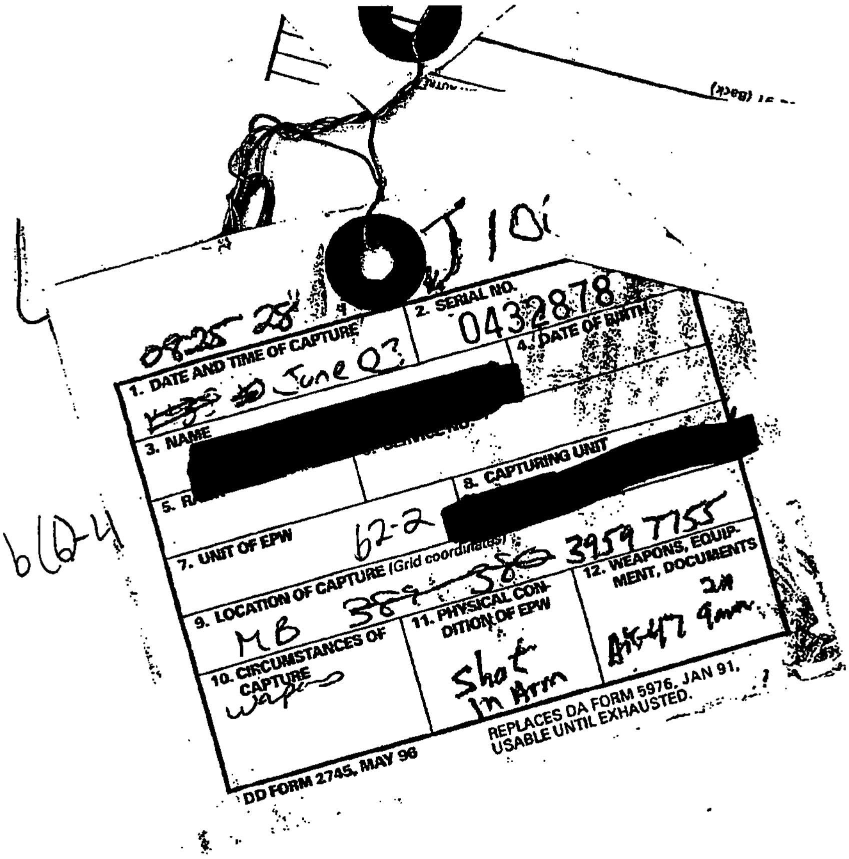
DATE/DATE [illegible]

DD Form 1380
DEC 91

This form replaces [illegible] of DD Form 1380 and DD Form 1380 (TEST), which are obsolete.

U.S. FIELD MEDICAL CARD
FICHE MÉDICALE DE L'AVANT ÉTATS-UNIS

MEDCOM - 12402



J10

b(2)-4

1. DATE AND TIME OF CAPTURE
0825 28
~~[illegible]~~ June 03

2. SERIAL NO.
0432878

4. DATE OF BIRTH

3. NAME
[redacted]

5. RANK

6. SERVICE NO.

7. UNIT OF EPW
62-2 [redacted]

8. CAPTURING UNIT
[redacted]

9. LOCATION OF CAPTURE (Grid coordinates)
MB ~~389~~ ~~380~~ 3959 7755

10. CIRCUMSTANCES OF CAPTURE
Weapons

11. PHYSICAL CONDITION OF EPW
Shot in Arm

12. WEAPONS, EQUIPMENT, DOCUMENTS
2M
AK47 9mm

DD FORM 2745, MAY 96

REPLACES DA FORM 5976, JAN 91, USABLE UNTIL EXHAUSTED.

ADMISSIO CODING INFORMATION

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

1. REPORTING MTF

1	2	3	4	5	6
A	1	1	D	1	▨

2. OCATION *(State or Country Code.)* IZ

3. REGISTER NUMBER (9–15) [redacted]

b6-4

NAME *(Last, First, Middle Initial)* EPW# [redacted] b(6)-4

4. PAY GRADE (16, 17) EPW

5. SEX (18) M

6. DATE OF BIRTH *(YYYYMMDD)*

19	20	21	22	23	24	25	26
0	0	1	3				

7. AGE AT ADMISSION

27	28	29
0	2	3

8. RACE (30) Z

9. ETHNIC BACKGROUND (31) Z

RELIGION UNK

10. LENGTH OF SERVICE (32, 33, 34)

ETS

11. FMP

35	36
9	9

12. SOCIAL SECURITY NUMBER (37–45) [redacted]

ORGANIZATION *(Active Duty Only)*

13. MARITAL STATUS (46)

HOUR OF ADMISSION

BRANCH / CORPS

14. FLYING STATUS (47, 48, 49)

15. BENEFICIARY CATEGORY (50, 51, 52)

16. ZIP CODE OF RESIDENCE (53–61)

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

18. MOS (64–70)

19. TRAUMA (71) 9

PREV. ADMISSION YEAR ☒ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION (72) 0 b(2)-2

WARD ICU1

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE UNK

ADDRESS OF EMERGENCY ADDRESSEE *(Include ZIP Code)* UNK

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE UNK

NAME A [redacted]

21. TYPE OF DISPOSITION

73	74
5	0

22. MTF TRANSFERRED TO (75–80)

23. DATE OF DISPOSITION *(YYMMDD)*

81	82	83	84	85	86
0	3	0	7	2	6

24. CLINIC SVC - ADMITTING

87	88	89	90
A	B	A	A

25. MTF TRANSFERRED FROM (91–96)

26. DATE THIS ADMISSION *(YYMMDD)*

97	98	99	100	101	102
0	3	0	6	2	8

27. LOCATION OF OCCURRENCE *(Battle Casualty Only)* (103, 104)

28. MTF OF INITIAL ADMISSION (105–110)

29. DATE INITIAL ADMISSION *(YYMMDD)* (111–116)

FOR LOCAL USE

DR. S/P Colectomy / IED (L) FA

T: 1

Inj: 450

Dx: 81290 [illegible] 8910 E9912

PR: 5421 [illegible] 4610

[redacted]

ADMITTING OFFICER *(Signature, as required)* Dr [redacted]

[redacted] **F ADMITTING CLERK** b(6)-2

DA FO [redacted]

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

MEDCOM - 12404

INPATIENT TREATMENT RECORD COVER SHEET

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

1 REGISTER NUMBER: 0013676

2 NAME (Last, First, MI): EPW # [redacted] b(6)-4

3 GRADE: —

4 SEX: M

5 AGE: 33Y

6 RACE: Iraqi

7 RELIGION: b(6)-4

8 COMPONENT/SVC: —

9 ETS: —

10 PREVIOUS ADMISSION: NO

11 FMP: ~~99~~ 20

12 SSN: [redacted]

13 ORGANIZATION: —

14 WARD: ICU3

15 FLYING STATUS: —

16 BSG: —

17 DEPT BCN: K78a

18 BRANCH/CORPS: —

19 UIC/ZIP: —

20 TYPE CASE: VSI

21 SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: Direct from ER

22 HOURS OF ADMISSION: 1455

23 CLINIC SERVICE: Burns

24 NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: —

25 TYPE DISPOSITION: Dc to CIV Facility

26 DATE OF DISPOSITION: 2003 June 29

27a ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): —

27b TELEPHONE NO: —

28 DATE OF THIS ADMISSION: 2003 June 28

29 NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted] b(2)-2

30 DATE OF INITIAL ADMISSION:

ADMISSION REMARKS:

ADMITTING OFFICER: b(6)-2 [redacted]

33 COMPONENT TRANSFERRED:

☐ Check if Continued on Reverse

33 CAUSE OF INJURY

34 DIAGNOSES, OPERATIONS AND SPECIAL PROCEDURES

Dx → 2° Burns ≈ 14% of Body

943.25
943.29
945.29
948.10
E923.8

86.22

35. Total Days This Facility

a ABSENT SICK DAYS	b OTHER DAYS	c CONV. LV/COOP CARE DAYS	d SUPPLEMENTAL CARE DAYS	e BED DAYS	f TOTAL SICK DAYS
0	0	0	0	1	1

36. Total Days All Facilities

a ABSENT SICK DAYS	b OTHER DAYS	c CONV. LV/COOP CARE DAYS	d SUPPLEMENTAL CARE DAYS	e BED DAYS	f TOTAL SICK DAYS

SIGNATURE [redacted] b(6)-2

[redacted] SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER [redacted] SPC b(6)-2

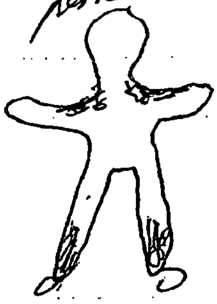
DA FOR[redacted] EDITION OF 1 AUG 78 IS OBSOLETE USAPPC V1.00

MEDICAL RECORD	**ABBREVIATED MEDICAL RECORD**

PERTINENT HISTORY, CHIEF COMPLAINT, AND CONDITION ON ADMISSION *(Enter date of admission)*

33yo Iraqi male admitted burns 2° ammunition explosion.
transferred to [redacted] for further treatment
b(2)-2

anterior



Pulse [illegible] Nerve present
ℓ P P

PHYSICAL EXAMINATION

130/62 - 104 - 18 - 99.?
Neuro oriented
Chest -> Ⓛ CW Ⓡ ant partial thickness burn
Chest CTA BL
CV RRR
ABD soft NT

Lower ext - partial thickness, [illegible]
ankle area full thickness burns below knees b/l
[illegible] once

Ext R/L upper arms chest area partial thickness burns

PROGRESS *(Enter date of discharge and final diagnosis)*

Burns: 20% TBSA partial thickness c̄ 4-5% full thickness ext burns

Plan: resuscitate c̄ IVF
Foley
Dress wounds - dressings

SIGNATURE OF PHYSICIAN	DATE	IDENTIFICATION NO.	ORGANIZATION

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

[redacted] b(6)-4

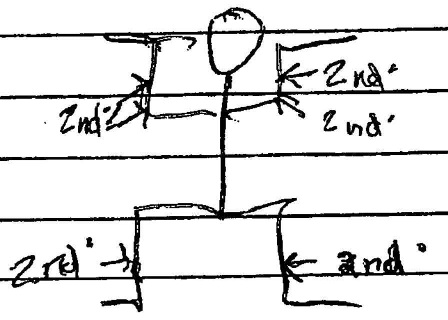
ABBREVIATED MEDICAL RECORD
Standard Form 539

GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
USAPPC V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
28 June 03	30 to 40 y/o male c̄ 2nd° Burns to
	elbows and forearms and to both ears.
1218	1222 ~~122~~ IV changed to NS 1000ml 14Ga.
BP: 113/38	Burn dressings changed out on lower legs and
P: 112	arms
SPO2: 94	
A: NKDA	Tylenol given at 14:06 hrs 975 mg. PO.
Meds: Migraine pills	



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.

[redacted] b(6)-4

[redacted]

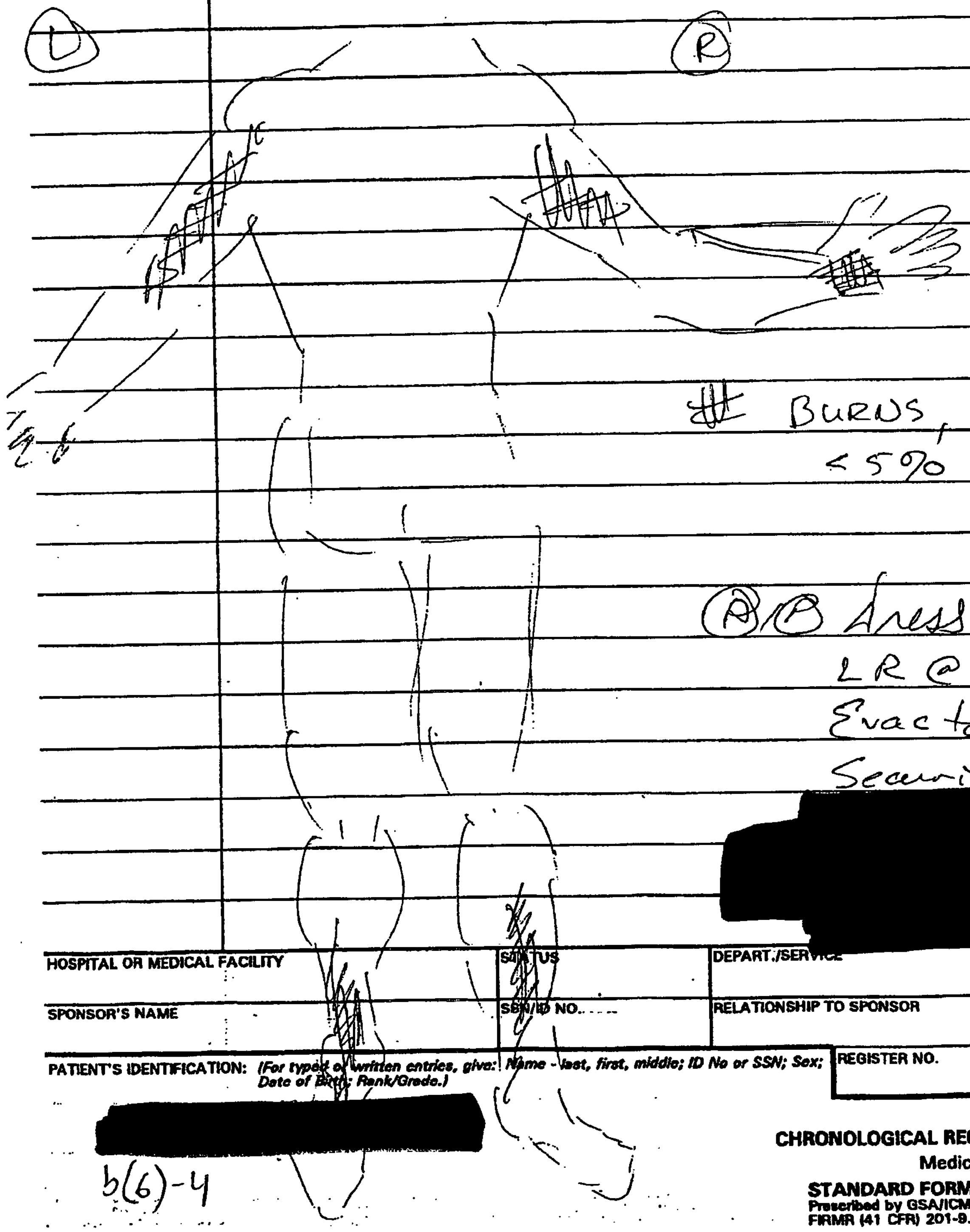
b(6)-4

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
28JUN03	~35-40 y/o Iraqi, was in bunker c̄ ammunition. Cigarette triggered explosion. Awake, alert, Ø signs of smoke inhalation.



BURNS, 2°
<5%

Ⓐ/Ⓑ dress wounds
LR @ 150ml/°
Evac to [redacted] b(2)-2
Security
[redacted] b(6)-2
MAJ, MC

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.

[redacted]

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

Lt [redacted] b(6)-2
PC [redacted]

558-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT [redacted] b(6)-2

LOG NUMBER

ARRIVAL DATE: DAY / MONTH / YR.	28 / June / 03
TIME	1455
TRANSPORTATION TO HOSPITAL (Attach care enroute sheet)	☐ PRIVATE VEHICLE ☐ AMBULANCE ☐ OTHER (Specify) B,RC
CURRENT MEDS. (tetanus immunization and other data)	None
HISTORY OBTAINED FROM	☒ PATIENT ☐ OTHER (Specify)
ALLERGIES	NKDA
PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)	
HOME TELE. NO. (Inc. area code)	
CHIEF COMPLAINT(S) (Include symptom(s), duration)	BURNS
SEX	33
AGE	M
POSSIBLE THIRD PARTY PAYER?	☒ YES ☐ NO
TIME SEEN BY PROVIDER	

VITAL SIGNS

TIME	1654	1710
BP	[illegible]	[illegible]
PULSE	107	104
RESP.	18	18
TEMP.	99.7	
WT. (Child)	80 kg	

CATEGORY (See reverse)
☐ EMERGENT
☐ URGENT
☒ NON-URGENT b6-2

ORDERS	INITS.	TIME
~~Chem 10~~ CBC	[redacted]	1700
Met Panel	[redacted]	1700
[illegible]	[redacted]	1700
Td [illegible]	[redacted]	1700
~~[illegible]~~	[redacted]	~~1700~~
4mg MSO4 IV	[redacted]	1750

ASSESSMENT/DIAGNOSIS
14% burn

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

33 y/o ♂ c/o Burns to the feet, arms, face etc.
Bilaterally 3rd° burns to ~~Ball~~ Back of calf, Back of upper arm and Ⓡ side of mandible.

Staff: Flash burns to arms/legs [illegible] @ 2 1000 hrs.
ø SOB/cough/ [illegible] [illegible] x Ⓛ ear.

O: A&Ox [illegible] [illegible] distress. VSS
HEENT: [illegible] clear/ [illegible] neck: supple w/ Ⓛ ear ⊕ 2° burns
Resp: CTA Ⓑ
CV: [illegible] ø m/r/g
Abd: soft NT
Skin ⊕ 2° burns back of legs/arms Ⓑ (10%) ear, feet 4% = 14%

A/P ① 2° burn 14% stable
→ Burn unit

DISPOSITION (Check all that apply)
☐ HOME ☐ FULL DUTY
QUARTERS ☐ 24 Hrs. ☐ 48 Hrs. ☐ 72 Hrs.
MODIFIED DUTY UNTIL: DAY MONTH YEAR
REFERRED TO (Indicate clinic)
☐ EMERGENCY ☐ TODAY
☐ 72 HOURS ☐ ROUTINE
ADMIT. TO HOSP. UNIT/SERVICE ICU3

CONDITION UPON RELEASE
[✓ IMPROVED] ☐ UNCHANGED
☐ DETERIORATED
TIME OF RELEASE:

(CONTINUE ON SF 507, IF NEEDED)

SIGNATURE OF PROVIDER AND ID STAMP [redacted] b(6)-2

INSTRUCTIONS TO PATIENT (Include medications and follow-up plans)

PATIENT'S IDENTIFICATION (Mechanical imprint)
FOR WRITTEN ENTRIES GIVE: Name - last, first, middle; SSN; DOB, service status, name and relation of sponsor or next of kin. (IMPORTANT: LIST FACILITY HOLDING TREATMENT RECORD).

[redacted] b(6)-4

[redacted] b(6)-2

EMERGENCY CARE AND TREATMENT
MEDCOM - 12409 opy

STANDARD FORM 558 (Rev. 6-82)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

NURSING NOTES
(Sign all notes)

DATE	HOUR		OBSERVATIONS Include medication and treatment when indicated
	A.M.	P.M.	
28 June03		2300	PT Transfered to ICU#3 from EMT @ 1800
			via litter. Dx 2° burns to 14% BSA. All
			burned areas were cleaned and dressed.
			Foley catheter inserted @ 2200hrs.
			PT vital signs stable, SaO_2 98 % on b(6)-2
		b(6)-2	room air [redacted] [illegible] SPC
	0230	[redacted]	pt sleeping comfortably in bed. Ø c/o pain
			or discomfort. will continue to monitor [redacted]
29 Jun 03	0627		Nursing: See ICU Flow Sheet for nursing assessment
			Pt prepared for Evac to Baghdad Hospital.
			All dressings reinforced. Pt given 3mg MSO4 IV
			for c/o pain. IV Heplocked. [redacted] [illegible]
			b(6)-2

STANDARD FORM 510 (REV. 7-91) BACK

rd/Section Emt	:E	TING PHYSICIAN:		MISTRY RESULT FORM Subject to the Privacy Act of 1974
ST FIRST, MI [redacted] b(6)-4		DATE [redacted]	TIME 1655	SSN/PSEUDO SSN

(i-STAT)

EST	RESULT	REF. RANGE
ı		138-146 mmol/L
		3 5-4 9 mmol/L
		98-109 mmol/L
ı		7 31-7 45
'O2		35-45 mmHg (art) 41-51 mmHg (ven)
)2		80-105 mmHg (art) N/A (ven)
'O2		23-27 mmol/L (art) 24-29 mmol/L (ven)
CO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
)2		95-98%
Eecf		(-2) – (+3) mmol/L
nGap		10-20 mmol/L
a		1 12-1 32 mmol/L
UN		8-26 mg/dl
LU		70-105 mg/dl
reat		0 7-1.5 mg/dl
ct		38-51% PCV
gb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
roponin-i		
Drug of Abuse		

(P[redacted]

TEST	[redacted]	E b(6)-2
ALB	Void	3 5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA⁺⁺		8.0-10.3mg/dl
CHOL		100-200 mg/dl
CRE		0 6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU	100	73-118 mg/dl
BUN	7	7-22 mg/dl
CRE	0.8	0 6-1 2 mg/dl
CK	677	39-380 u/l (M) 30-190 u/l (F)
NA⁺	139	128-145 mmol/l
K⁺	4.3	3 3-4 7 mmol/l
CL⁻	108	98-108 mmol/l
tCO₂	22	18-33 mmol/l

(Piccolo) Metabolic Basic

TEST	RESULT	
GLU	100	[illegible]
BUN	7	[illegible]
CA⁺⁺	~~0.8~~	[illegible]
CRE		[illegible]
NA⁺		[illegible]
K		[illegible]
CL⁻		[illegible]
tCO₂		[illegible]

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RAN
ALB		3 3-5 5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0 2-1 6 mg/dl
GGT		5-65 u/l
TP		6 4-8 1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RAN
NA⁺		128-145 mmo
K⁺		3 3-4 7 mmo
CL⁻		98-108 mmo
tCO₂		18-33 mmo

REMARKS:

REPORTED BY: [redacted] b(6)-2	DATE: 28 Jun 03	LAB ID NO.:

MEDCOM - 12411

b(6)-4

Ward/Section: EMT E ING PHYSICIAN:

A TORY RESULT FORM

(Subject to the Privacy Act of 1974)

LAST, FIRST, MI. [redacted]

DATE 28 June

TIME 1655

SSN/PSEUDO SSN: [redacted]

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	19.6	4.8-10.8 x 10^3
RBC	5.94	4.7-6.1 x 10^9
Hgb	16.4	14-18 g/dl (M) 12-16 g/dl (F)
Hct	53.6	42-52% (M) 37-47% (F)
MCV	90.3	80-94 fl (M) 81-99 fl (F)
Plt	354	130-500 x 10^3 verified
Lymph %	15.2	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted]

DATE: 28 Jun 03

LAB ID NO.:

b(6)-2

MEDCOM - 12412

/

ard Section: ICU 3	R [redacted] S PHYSICIAN: b(6)-2	**CH[illegible] RESULT FORM** (Subject to the Privacy Act of 1974)
AST, FIRST, MI CIV [redacted] b(6)-4	DATE 29June03	TIME 0330
		SSN/PSEUDO SSN:

(i-STAT)

TEST	*RESULT*	*REF. RANGE*
a		138-146 mmol/L
		3.5-4.9 mmol/L
l		98-109 mmol/L
H		7.31-7.45
CO2		35-45 mmHg (art) 41-51 mmHg (ven)
O2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
CO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
O2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
a		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dL

(Piccolo) Chemistry 12

TEST	*RESULT*	*REF. RANGE*
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

(Piccolo) Metlyte 8

TEST	*RESULT*	*REF. RANGE*
GLU	91	73-118 mg/dl
BUN	7	7-22 mg/dl
CRE	1.0	0.6-1.2 mg/dl
CK	913	39-380 u/l (M) 30-190 u/l (F)
NA^+	134	128-145 mmol/l
K^+	4.3	3.3-4.7 mmol/l
CL^-	106	98-108 mmol/l
tCO_2	24	18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	*RESULT*	*REF. RANGE*
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	*RESULT*	*REF. RANGE*
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	*RESULT*	*REF. RANGE*
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

Misc. Chemistry

TEST	*RESULT*	*REF. RANGE*
Troponin-I		Negative
Drug of Abuse		Negative
		Negative
		Negative
		Negative

REMARKS:

b(6)-2

REPORTED BY: [redacted]	**DATE:** 29Jun03	**LAB ID NO.:**

MEDCOM - 12413

ICU ⊃ [redacted] b(6)-2

CIV [redacted] b(6)-4 29 June03 0330 [redacted] b(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	13.4	4.8-10.8 x 10³
RBC	5.61	4.7-6.1 x 10⁹
	15.8	14-18 g/dl (M) 12-16 g/dl (F)
ict	50.7	42-52% (M) 37-47% (F)
	90.3	80-94 fl (M) 81-99 fl (F)
	291.	130-500 x 10³ verified
ymph %	23.6	20.5-51.1%

(Hematology) Manual Differential

egs		Mono	
ands		Eos	
ymph		Baso	
		Imm	
BC ymph			
ematocrit		42-52% (M) 37-47% (F)	
ed Rate			
ther			

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RA
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WIT
EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF. RANGE
T		9.8-13.6 secs
PTT		21-34 secs
dimer	-	<20 ug/ml
DP		<10 ug/ml

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

EMARKS:

EPORTED BY: DATE: LAB ID NO

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

IENT IDENTIFICATION

[redacted]

b(6)-4

SING UNIT | ROOM NO. | BED NO.

IENT IDENTIFICATION

[redacted]

b(6)-4

SING UNIT | ROOM NO. | BED NO.

IENT IDENTIFICATION

SING UNIT | ROOM NO. | BED NO.

IENT IDENTIFICATION

SING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 28 Jun 03 TIME OF ORDER 1730 HOURS

LIST TIME ORDER NOTED AND SIGN

① Admit ICU
② Dx 2° burns ~ 14%
③ Stable
④ NKDA
⑤ Vitals per protocol
⑥ Bedrest
⑦ Nursing dressing Δs per burn protocol

1815 [redacted] b(6)-2

DATE OF ORDER TIME OF ORDER HOURS

⑧ Regular diet
⑨ IV bolus ī L NS then 150 cc/hr
⑩ MSO4 4mg IV upon arrival then per Surgeon on call
~~⑪ Call Surgeon on call~~

Thanks! [redacted]

Done in [redacted] 0730 b(6)-2

DATE OF ORDER 28 JUN 03 TIME OF ORDER 1810 HOURS

① MSO4 1-15 mg IV for initial dressing ē assessment
② MSO4 1-10 mg IV q 1° PRN
~~③ [illegible]~~
③ Foley cath [redacted] b(6)-2 [redacted]
care ... if < 50cc/hr
U.O.

DATE OF ORDER TIME OF ORDER HOURS

④ CBC, Chem 7 in AM

b(6)-2

2140 [redacted] 4/AN 6552 29 Jun 03

MEDCOM - 12415

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

ATIENT IDENTIFICATION

b(6)-4 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

↓

DATE OF ORDER 28 JUNE 03

TIME OF ORDER 0630 HOURS

LIST TIME ORDER NOTED AND SIGN

① TRANSFER TO CIVILIAN HOSP.

[redacted]

b(6)-2

Noted b(6)-2 [redacted] 29 Jun 03 0637

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER

TIME OF ORDER ______ HOURS

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER

TIME OF ORDER ______ HOURS

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER

TIME OF ORDER ______ HOURS

REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

DA FORM 1 APR 79 4256

MEDCOM - 12416

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
29 June 03	Surgery Transfer Note
0830	Date of Admission 28 June 03
	Date of Transfer 29 June 03
[illegible]	Dx: 20% TBSA partial thickness flash burns
[illegible]	Hosp Course: 33 yo ♂ sustained burns to shoulders
NSAIDs	& upper arms posteriorly & posterior lower legs B/L
Silvadene	total body surface area approx 20%. Pt resuscitated
[illegible]	c̄ IV fluid overnight. Foley catheter placed [illegible]
ALL NKDA	Burns debrided & dressed c̄ Silvadene. No
	complications
	[redacted] 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.

[redacted] 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

All b(6)-2 except last

CLINICAL RECORD

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

Mo. June Yr. 2003

VERIFY BY INITIALING — *INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION*

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 28	29
6/28	[redacted]	Stable	05	/	[redacted]
			17	[redacted]	
6/28	[redacted]	Vitals per protocol	05	/	[redacted]
			17	[redacted]	
6/28	[redacted]	Bedrest	05	/	[redacted]
			17	[redacted]	
6/28	[redacted]	Nursing dressing Δ's	05	/	[redacted]
		per burn protocol (bid)	17	[redacted]	
6/28	[redacted]	Reg. diet	05	/	[redacted]
			17	[redacted]	
6/28	[redacted]	Foley cath	05	/	[redacted]
			17	[redacted]	
6/28	[redacted]	call MD if uo	05	/	[redacted]
		< 50cc/°	17	[redacted]	

ALLERGIES: ☐ YES ☐ NO
NKA

PRIMARY DIAGNOSIS: 2° burn ≈ 14%

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

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 EDITION OF 1 DEC 77 MAY BE USED. USAPA V1.00

MEDCOM - 12418

All b(6)-2

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo Jun *Yr* 2003

Verify by Initialing						
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
6/28	[redacted]	Admit to ICU 3	6/28		Done 1730	[redacted]
6/28	[redacted]	CBC Chem 7 in am	6/29	04	0330	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING COMPLETION* TIME/DATE COMPLETED

USAPA V1.00

MEDCOM - 12419

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. 6 *Yr.* 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 28	29												
6/28	[redacted]	IVF NS @ 150 cc/hr	05	/	[redacted]	b(6)-2											
		b(6)-2	17	[redacted]	b(6)-2												

ALLERGIES: ☐ YES ☐ NO

NKA

PRIMARY DIAGNOSIS:

2° burn ≈ 14%

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ______

PATIENT IDENTIFICATION:

[redacted] 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 - 12420

All b(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*			Mo.______ Yr. ______	
Order Date	**Clerk/ Nurse**	**SINGLE ORDER, PRE-OPERATIVES**	**Date to be Given**	**Time to be Given**	**Time Given**	**Initials**
6/28	[redacted]	IV bolus ī LNS then 150cc/°	6/28	done		[redacted]
6/28	[redacted]	MSO4 4mg IV upon arrival then	6/28	Done in ER		[redacted]
		per surgeon on call.				
~~6/28~~	[redacted]	~~MSO4 1-15mg IV q 1° prn~~				
6/28	[redacted]	MSO4 1-15mg IV for initial	6/28	done		[redacted]
		dressing + debridement				

Order/ Expir Date	**Clerk/ Nurse**	**PRN MEDICATION, DOSE, FREQUENCY**	***INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION*** **TIME/DATE DISPENSED**
6/28	[redacted]	MSO4 1-10mg IV	8 Jun 03
		q 1° prn	3mg 0622
			[redacted]

USAPA V1.00

MEDCOM - 12421

PAGE 1 OF 4

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA
For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
DA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	2000	INITIALS		INITIALS		INITIALS
NEURO	PUPILS	PERL bilat	[redacted]	b(6)-2			
	SENSORIUM	moves all extremities					
		x4					
RESPIRATORY	RESPIRATORY PATTERN	regular					
	BREATH SOUNDS	clear all fields					
	SECRETIONS	Ø					
SKIN	COLOR	brown to black bilat					
	INTEGRITY	upper arm R hand					
		bilat calf + foot					
IV SITE	LOCATION	heplock 18G L hand					
	CONDITION	18G PIV R wrist					
		patent & intact					
GASTRO	ABDOMEN	soft non tender					
	BOWEL SOUNDS	present x 4 quads					
		tolerating po s difficulty					
GU	URINE: COLOR/CLARITY	clear yellow via					
		foley to gravity drg					
CARDIOVASCULAR	CARDIAC RHYTHM	S1S2					

LEGEND

Cr - Creatinine	ICP - Intracranial Pressure	S/A - Fractional
F_IO_2 - Fraction of Inspired O_2	PCO_2 - Pressure of Arterial CO_2	SAT - Saturation
HCO_3 - Bicarbonate	PEEP - Positive End Expiratory Pressure	TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title) [redacted] b(6)-2

DEPARTMENT/SERVICE/CLINIC ICU 3

DATE 28 Jan 2003

PATIENT'S IDENT[redacted]ive: Name—last, first, middle: grade, [redacted]

[redacted] b(6)-4

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

DA FORM 1 MAY 78 **4700**
Proponent: Dept of Nurs

WAMC OP 375 (Redesignated)
1 Apr 90 (HSXC-NU)

MEDCOM - 12422

DATE		DX													HOSPITAL DAY				
VITAL SIGNS	TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
	BP Arterial Line															113 58			
	BP Cuff																		
	Temperature																		
	Pulse															112			
	Respiratory Rate															20			
	pain intervention																		
INTAKE	TIME	05	06	07	08	09	10	11	12	8°T	13	14	15	16	17	18	19	20	8°T
	IVF															150	150	150	
	TOTALS																		
OUTPUT	URINE HOUR / TOTAL																		
	URINE sp gr																		
	URINE S/A																		
	NG OUTPUT																		
	NG pH																		
	NG GUIAC																		
	EMESIS																		
	STOOL																		
	DRAINS																		
	DRAINS																		
	DRAINS																		
	TOTALS																		

MEDCOM - 12423

PAGE 3 OF 4

POST-OP DAY

VITAL SIGNS									
	21	22	23	00	01	02	03	04	/
		120/51							
						110/62			
		81				84			
		18				16			
		98				100			
						RA			

INTAKE									
	21	22	23	00	01	02	03	04	8° T
	150	150	150	150	150	150	150	150	

OUTPUT									
	/	700	150/850	/	/	400/1250	/	350	

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA										
	TIME									
	MODE									
	F_iO_2									
	TV									
	RATE									
	PEEP									
ABG	pH									
	PCO_2									
	pO_2									
	HCO_3									
	SAT									
	BASE									

LABORATORY DATA									
TIME									
GLUCOSE									
Na/K	/	/	/	/	/	/	/	/	/
Cl/CO_2	/	/	/	/	/	/	/	/	/
BUN/Cr	/	/	/	/	/	/	/	/	/
WBC/PLATELET	/	/	/	/	/	/	/	/	/
Hct/Hgb	/	/	/	/	/	/	/	/	/

ACTIVITIES OF DAILY LIVING			
TIME			
MOUTH CARE			
BATH			
SKIN CARE			
FOLEY CARE			
TRACH CARE			
ROM EXERCISES			

	TIME				
TURN					
SUCTION					

24° I&O TOTALS

wt Yesterday ________ wt Today ________

INTAKE
IV ________
po ________
TOTAL 1650

OUTPUT
Urine: ________
____
TOTAL 1600

BALANCE ________

NURSE'S SIGNATURE	INITIALS
SPC [redacted]	
b(6)-2	

MEDCOM - 12424

All b(6)-2 except last

PAGE 1 OF 4

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA
For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
DA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0523 INITIALS [redacted]	INITIALS	INITIALS
NEURO	PUPILS	PERRLA		
	SENSORIUM	A+O x 3		
RESPIRATORY	RESPIRATORY PATTERN	Regular + Unlabored		
	BREATH SOUNDS	CTA		
	SECRETIONS	None		
		Airway Patent		
SKIN	COLOR	Normal for Race		
	INTEGRITY	14% TBSA burn,		
		dressings c/d/I		
IV SITE	LOCATION	Ⓡ Hand + Ⓛ Hand		
	CONDITION	Ø S/S of infection		
GASTRO	ABDOMEN	Soft + Nontender		
	BOWEL SOUNDS	~~Active~~ Hypoactive BS		
		Ø N/V		
GU	URINE:			
	COLOR/CLARITY	Clear, Yellow		
		Foley to Gravity		
CARDIOVASCULAR	CARDIAC RHYTHM	NSR, Ø ectopy		
		CV = S_1S_2		
		Strong pulses palpated		
		in all extremities		
		Cap Refill < 3 secs		

LEGEND
Cr - Creatinine
F_iO_2 - Fraction of Inspired O_2
HCO_3 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
S/A - Fractional
SAT - Saturation
TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY *(Signature & Title)* [redacted] /SW

DEPARTMENT/SERVICE/CLINIC: ICU 3

DATE: 29 Jun 03

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

[redacted] b(6)-4

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

DA FORM 1 MAY 78 4700
Proponent: Dept of Nurs

WAMC OP 375 (Redesignated)
1 Apr 90 (HSXC-NU)

MEDCOM - 12425

DATE

DX.

HOSPITAL DAY

VITAL SIGNS

TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
BP Arterial Line																		
BP Cuff	117/61	159/62																
Temperature		97.4																
Pulse	96	96																
Respiratory Rate	12	16																
SaO2	95	99																
O2 Meth	RA	RA																
pain intervention																		

INTAKE

TIME	05	06	07	08	09	10	11	12	8°T	13	14	15	16	17	18	19	20	8°T
NS	160	150																
PO																		
TOTALS																		

OUTPUT

		05	06	07	08	09	10	11	12	8°T	13	14	15	16	17	18	19	20	8°T
URINE	HOUR / TOTAL	50	60	80															
	sp gr																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS																			

POST-OP DAY

VITAL SIGNS

21	22	23	00	01	02	03	04	

INTAKE

21	22	23	00	01	02	03	04	8° T

OUTPUT

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA

	TIME	
	MODE	
	F_iO_2	
	TV	
	RATE	
	PEEP	
A	pH	
	PCO_2	
	pO_2	
B	HCO_3	
	SAT	
G	BASE	

LABORATORY DATA

TIME	0330
GLUCOSE	91
Na/K	134/4.3
Cl/CO_2	106/24
BUN/Cr	7/1.0
WBC/PLATELET	134/281
Hct/Hgb	50.7/15.1

ACTIVITIES DAILY LIVING

TIME	
MOUTH CARE	
BATH	
SKIN CARE	
FOLEY CARE	
TRACH CARE	
ROM EXERCISES	

TURN

SUCTION

TIME

24° I&O TOTALS

wt Yesterday ______ wt Today ______

INTAKE
IV ______
po. ______
______
TOTAL ______

OUTPUT
Urine: ______
______
______
TOTAL ______

BALANCE ______

NURSE'S SIGNATURE	INITIALS
[redacted]	
b(6)-2	

MEDCOM - 12427

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF

1	2	3	4	5	6
A	1	A	D	1	▨

2. MTF LOCATION *(State or Country Code.)*

7	8
I	Z

3. REGISTER NUMBER (9–15) [redacted]

NAME *(Last, First, Middle Initial)* EPW #[redacted] b(6)-4

4. PAY GRADE (16, 17)

5. SEX (18) M

6. DATE OF BIRTH *(Y Y Y Y M M D D)* (19–26)

7. AGE AT ADMISSION

27	28	29
3	5	Y

8. RACE (30) Z

9. ETHNIC BACKGROUND (31) 9

RELIGION

10. LENGTH OF SERVICE (32, 33, 34)

ETS

11. FMP

35	36
9	9

12. SOCIAL SECURITY NUMBER (37–45) [redacted]

ORGANIZATION *(Active Duty Only)*

13. MARITAL STATUS (46) U

HOUR OF ADMISSION 1455

BRANCH / CORPS

14. FLYING STATUS (47, 48, 49)

15. BENEFICIARY CATEGORY

50	51	52
K	7	9

16. ZIP CODE OF RESIDENCE (53–61)

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

18. MOS (64–70)

19. TRAUMA (71) 9

PREV. ADMISSION YEAR ☒ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION (72) 0

WARD ICU3

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE *(Include ZIP Code)*

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] b(2)-2

21. TYPE OF DISPOSITION

73	74
2	6

D/C to CIV Acute care facility

22. MTF TRANSFERRED TO (75–80)

23. DATE OF DISPOSITION *(Y Y M M D D)*

81	82	83	84	85	86
0	3	0	6	2	9

24. CLINIC SVC - ADMITTING

87	88	89	90
A	B	M	A

Burns

25. MTF TRANSFERRED FROM (91–96)

26. DATE THIS ADMISSION *(Y Y M M D D)*

97	98	99	100	101	102
0	3	0	6	2	8

27. LOCATION OF OCCURRENCE *(Battle Casualty Only)* (103, 104)

28. MTF OF INITIAL ADMISSION (105–110)

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

FOR LOCAL USE

DX → 14 percent body burns (2°)

b(6)-2

ADMITTING OFFICER *(Signature, as required)* [redacted]

SIGNATURE OF ADMITTING CLERK b(6)-2 [redacted] SPC

DA FORM 2985, MAR 90

INPATIENT TREATMENT RECORD CO SHEET

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

1 REGISTER NUMBER
[redacted]

2 NAME (Last, First, MI)
EPW # [redacted] b(6)-4

3 GRADE
—

ADMISSION REMARKS

4 SEX: M
5 AGE: 50Y
6 RACE: Iraqi
7 RELIGION: b(6)-4
8 LENGTH OF SVC: —
9 ETS: —
10 PREVIOUS ADMISSION: NO

11 FMP: ~~9~~ 20
12 SSN: [redacted]
13 ORGANIZATION: —
14 WARD: ICU3

15 RATING STATUS: —
16 RATING DSG: —
17 DEPT RLN: K78
18 BRANCH/CORPS
19 UIC/ZIP: —
20 TYPE CASE: VSI

21 SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: Direct from ER
22 HOURS OF ADMISSION: 1700
23 CLINIC SERVICE: Burns

24 NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: —
25 TYPE DISPOSITION: TRNFR to CIV FACILITY
26 DATE OF DISPOSITION: 2003 June 29

27a ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): —
27b TELEPHONE NO: —
28 DATE OF THIS ADMISSION: 2003 June 28

ADMITTING OFFICER b(6)-2
[redacted]

29 NAME AND LOCATION OF MEDICAL TREATMENT FACILITY b(2)-2
[redacted]

30 DATE OF INITIAL ADMISSION

32 COMPONENT TRANSFERRED

☐ Check if Continued on Reverse

33 CAUSE OF INJURY

34 DIAGNOSES, OPERATIONS AND SPECIAL PROCEDURES

Dx → 13 percent 2° Burns to Body

946.2
948.10
E993

86.28

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	1	1

36. Total Days All Facilities

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

[redacted] OFFICER [redacted]

for SIGNATURE [redacted] SPC

DA FO[redacted]

EDITION OF 1 AUG 76 IS OBSOLETE

USAPPC V1.10

b(6)-2

MEDCOM - 12429

INPATIENT TREATMENT RECORD CO SHEET

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

1 REGISTER NUMBER: [redacted]

2 NAME (Last, First, MI): EPW # [redacted] b(6)-4

3 GRADE: —

ADMISSION REMARKS

4 SEX: M | 5 AGE: 50Y | 6 RACE: Iraqi | 7 RELIGION: — b(6)-4 | 8 LENGTH OF SVC: — | 9 ETS: — | 10 PREVIOUS ADMISSION: NO

11 FMP: ~~9~~20 | 12 SSN: [redacted] | 13 ORGANIZATION: — | 14 WARD: ICU3

15 FLYING STATUS: — | 16 RATING USG: — | 17 DEPT BEN: K78 | 18 BRANCH/CORPS | 19 UIC/ZIP: — | 20 TYPE CASE: VSI

21 SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: Direct from ER

22 HOUR OF ADMISSION: 1700

23 CLINIC SERVICE: Burns

24 NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: —

25 TYPE DISPOSITION: TRNFR TO CIV FACILITY

26 DATE OF DISPOSITION: 2003 June 29

27a ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): —

27b TELEPHONE NO: —

28 DATE OF THIS ADMISSION: 2003 June 28

ADMITTING OFFICER: b(6)-2 [redacted]

29 NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: b(2)-2 [redacted]

30 DATE OF INITIAL ADMISSION

32 COMPONENT TRANSFERRED

☐ Check if Continued on Reverse

33 CAUSE OF DEATH

34 DIAGNOSES, OPERATIONS AND SPECIAL PROCEDURES

Dx → 13 percent 2° Burns to Body

946.2
948.10
E993

86.28

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV LV/CONP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	1	1

36. Total Days All Facilities

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV LV/CONP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

[redacted] [redacted] for SIGNATURE [redacted] SPC

DA FOR[redacted] EDITION OF 1 AUG 78 IS OBSOLETE USAPPC V1.00

b(6)-2

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

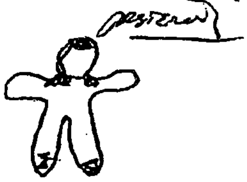
PERTINENT HISTORY, CHIEF COMPLAINT, AND CONDITION ON ADMISSION *(Enter date of admission)*

[illegible] 50 y/o Iraqi male [illegible] burns 2° to [illegible] explosion in bunker. Burns to B/C [illegible] ext/feet, [illegible] & shoulders posteriorly/[illegible]

Pulses [illegible] Neuro intact

[redacted]

b(6)-2



PHYSICAL EXAMINATION

146/61 - 110 - 24 upon presentation now 114/68 - 88 - 20 - 98

84 kg Heart RRR, lungs [illegible] partial thickness burns [illegible]

Chest [illegible] Ext - upper arms & forearms partial thickness

[illegible] lower ext & knees/ankles partial thickness

Abd soft NT

PROGRESS *(Enter date of discharge and final diagnosis)*

Imp/plan: Partial thickness burns - [illegible]

- [illegible] - [illegible]
- Debride & dress wounds
- pain control.

b(6)-2

SIGN[redacted]ed or written entries give Name last, first, middle; grade; date; hospital or medical facility)

DATE 28 JUL 03

IDENTIFICATION NO.

ORGANIZATION

REGISTER NO.

WARD NO.

[redacted]

b(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
USAPPC V1.00

MEDCOM - 12431

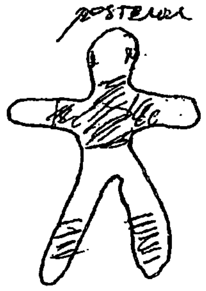
MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

PERTINENT HISTORY, CHIEF COMPLAINT, AND CONDITION ON ADMISSION *(Enter date of admission)*

Approx 40 yo Iraqi male suffered partial thickness burns to back, posterior lower extremities & upper arms 2° UXO encountered while gathering wood.

Assessed hemodynamically stable

Airway ✓
[illegible] ✓
Neuro ✓
NKDA



PHYSICAL EXAMINATION

Vitals 98.1 BP 145/80 HR 105 SaO2 100% in ER   X-ray [illegible]

HEENT NCAT PERRL [illegible]

[illegible] B/L blistered

Neck: [illegible] partial - superficial burns to neck post.

Back: partial thickness burns - extending [illegible] to buttocks

Lower extrem partial thickness, Lt ↓ knee Ⓡ deep partial/full thickness burns × one digit

Chest CTA B/L

Abd soft NT

Ⓛ [illegible]

PROGRESS *(Enter date of discharge and final diagnosis)*

Imp: 30-35% partial thickness - some possibly full thickness [illegible]
Blast burn from UXO

Plan: resuscitate
Foley cath
wound debridement

[redacted] b(6)-2

SIG[redacted]	DATE	IDENTIFICATION NO.	ORGANIZATION
MD	28 MAR 03		

PA[redacted]CATION *(For typed or written entries give Name last, first, middle; grade; date; hospital or medical facility)*

REGISTER NO.	WARD NO.

[redacted] b(6)-4

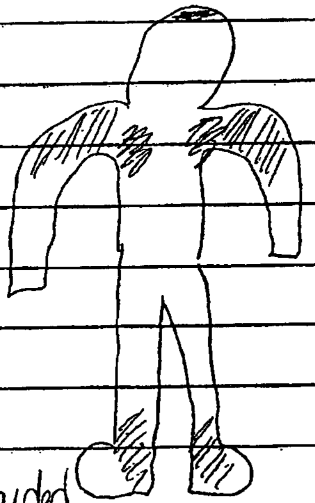
ABBREVIATED MEDICAL RECORD
Standard Form 539

GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
USAPPC V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
28 June 03	ER Note
14:40	Iraqi male sustained burn p̄ explosion
	in ammunition bunker
	Ø PMH ⊕ c/o pain at burn sites
PE:	BP 141/61 p-110 r-24 sat 95%
	HEENT - large blister c̄ fluid on top of
	head
	Lungs - clear
	CVR - Reg
	Abd - soft
	Ext - ~15% 2° burns
	bilat shoulder area + post.
	upper arms, bilat ankles
	+ bottom of feet
A/P	15% TBSA 2° burns
	- wounds cleansed c̄ NS + debrided
	- Silvadene + bandages applied
	- MS 6mg IV given for pain
	[redacted] b(6)-2
	PT MC



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.

[redacted] 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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
28Jun03	ARRIVES 1437 IV R HAND
	BURNS FROM BLAST IN BUNKER
1439	BP: 141/61 P: 110 R: 24 SPO2 95%
	2° BURNS ON TO TOP OF HEAD AND BACK, BOTH FEET
1442	IV Ⓛ HAND
1444	BURNS DÉBRIDED
	15% 2° BURNS
1450	6 mg MS JP
1450	SILVADINE APPLIED TO BURNS
1455	P: 109 BP: R: 20 SPO2 95%

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.

[redacted] 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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
29 JUNE 03	Transfer Summary - Surgery
0640	Date of Admission: 23 June 03
	Date of Transfer: 29 June 03
Allergies:	Dx: 15% TBSA partial thickness burn
NKA/	Approx 50 y/o ♂ sustained [illegible] burns from
Meds:	ammunition explosion to top of head, posterior
Silvadene/	shoulders c̄ [illegible] (L > R). The burns
[illegible]	partial thickness. He resuscitated ICU,
	Foley cath placed to monitor [illegible] He
	hemodynamically stable. The burns dressed
	c̄ Silvadene [illegible] debridement.
	Transfer for cont wound care.
	[redacted] 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.

[redacted] 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

MEDCOM - 12435

ICU3

558-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp) [redacted] b(2)-2

LOG NUMBER

ARRIVAL				TRANSPORTATION TO HOSPITAL (Attach care enroute sheet)	CURRENT MEDS. (tetanus immunization and other data)
DAY	MONTH	YR.	TIME	☐ PRIVATE VEHICLE ☐ AMBULANCE	0
28	JUNE	03	1657	☒ OTHER (Specify) Medivac	

HISTORY OBTAINED FROM ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration) BURNS back, hands, feet, calves

SEX M

AGE

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER 1655

SpO2 96

VITAL SIGNS			
TIME	1657		
BP	141/68		
PULSE	88		
RESP.	20		
TEMP.	98.8		
WT. (Child)	84kg		

CATEGORY (See reverse)
- EMERGENT
- URGENT
- NON-URGENT

ORDERS	INITS.	TIME
.5 Tetanus	[redacted]	1713
[illegible]		
~~[illegible]~~		

b(6)-2

ASSESSMENT/DIAGNOSIS
13% 2° burns

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

M.d 40s ♂ s/p flash powder burns this am @ 1000 at this am, denies F/C/SOB/CP/eye involvement.

Seen by American provider

[illegible]

OS A&O×4 in no distress

HEENT OP/np clear/moist mm PO ~~neck~~ supple NO
eyes clear

Chest CTA(B)

CV: RRR no m/r/g

Abd soft NT

5/5 strength UE/LE (B) gait NL

Skin: (+)(B) shoulder 2° burns 5%
top of head 2° burn — 1%
(B) lower calves/feet — 5%
(B) hands — 2%
} 13%

A/P 13% burns 2°

→ Admit

b(6)-2

DISPOSITION (Check all that apply)	
HOME	FULL DUTY
QUARTERS	
24 Hrs. 48 Hrs. 72 Hrs.	
MODIFIED DUTY UNTIL:	
DAY MONTH YEAR	
REFERRED TO (Indicate clinic)	
EMERGENCY	TODAY
72 HOURS	ROUTINE
ADMIT. TO HOSP. UNIT/SERVICE	
CONDITION UPON RELEASE	
☑ IMPROVED	☐ UNCHANGED
☐ DETERIORATED	
TIME OF RELEASE:	

(CONTINUE ON SF 507, IF NEEDED)

SIGNATURE OF PROVIDER AND ID STAMP [redacted]

PATIENT'S IDENTIFICATION (Mechanical imprint) FOR WRITTEN ENTRIES GIVE: Name - last, first, middle; SSN; DOB, service status, name and relation of sponsor or next of kin. (IMPORTANT: LIST FACILITY HOLDING TREATMENT RECORD).

[redacted] b(6)-4 →

INSTRUCTIONS TO PATIENT (Include medications and follow-up plans)

MEDCOM - 12436 TREATMENT
Medical Record Copy

STANDARD FORM 558 (Rev. 6-82)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

All b(6)-2

510-112 NSN 7540-00-634-4123

MEDICAL RECORD

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
28 June 03		2143	PT admitted to ICU3 @ 1800hrs Dx 2°
			burns 15% BSA. —— SPC [redacted]
28 Jun 03		2300	Dressing change due to burns. Tolerated procedure
			ē difficulty care continued as ordered —— [redacted]
29 June 03	0530	~~0530~~	pt VSS. pt report received From Spc [redacted] no problems
			@ present will continue to monitor → [redacted]
	0655		pt transferred to Baghdad see Dr's progress notes for
			details —— [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)

REGISTER NO.

WARD NO.

NURSING NOTES

Medical Record

STANDARD FORM 510 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 12437

ICU3

[redacted] b(6)-4 [redacted] b(6)-2 29Jun03 | 0330 [redacted] b(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	10.2	4.8-10.8 x 10'
RBC	5.99	4.7-6.1 x 10'
	17.1	14-18 g/dl (M) 12-16 g/dl (F)
	55.0	42-52% (M) 37-47% (F)
	91.7	80-94 fl (M) 81-99 fl (F)
	245.	130-500 x 10' verified
ymph %	14.9	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
ands		Eos	
ymph		Baso	
		Imm	

ematocrit		42-52% (M) 37-47% (F)
ed Rate		
ther		

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

Misc. Serology

TEST	RESULT	REF. R
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negati
H. pylori		Negati
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WI EVERY UNIT REQUESTE

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF. RANGE
T		9.8-13.6 secs
PTT		21-34 secs
dimer		<20 ug/ml
DP		<10 ug/ml

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATC

EMARKS:

EPORTED BY: [redacted]

b(6)-2

DATE: 6 29

LAB ID NO.:

MEDCOM - 12438

Ward/Section: ICU3

REQU[illegible]ING PHYSICIAN: Dr [redacted] b(6)-2

CHEMISTRY RESULT FORM
(Subject to the Privacy Act of 1974)

AST, FIRST, MI [redacted] b(6)-4

DATE 29 Jun 03

TIME 0330

SSN/PSEUDO SSN: [redacted] b(6)-4

EC8+ (i-STAT)

TEST	RESULT	REF. RANGE
Na	129	138-146 mmol/L
K	>9.0	3.5-4.9 mmol/L
l	114	98-109 mmol/L
H		7.31-7.45
CO2		35-45 mmHg (art) 41-51 mmHg (ven)
O2		80-105 mmHg (art) N/A (ven)
TCO2	24	23-27 mmol/L (art) 24-29 mmol/L (ven)
CO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
O2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
a		1.12-1.32 mmol/L
BUN	26	8-26 mg/dl
GLU	98	70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct	51	38-51% PCV
Hgb	17	12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		Negative
Drug of Abuse		Negative
		Negative
		Negative
		Negative

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 u/l (M) 30-190 u/l (F)
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

REMARKS:

REPORTED BY: [redacted] b(6)-2

DATE:

LAB ID NO.:

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

IENT IDENTIFICATION

[redacted]

b(6)-4

SING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 28 Jun 03
TIME OF ORDER: 1900 HOURS
LIST TIME ORDER NOTED AND SIGN

① Admit ICU 3
② Dx 13% 2° burns
③ Stable
④ NKDA
⑤ Vitals per protocol
⑥ Bedrest
⑦ Dressing BS per protocol

1820 [redacted]

b(6)-2

IENT IDENTIFICATION

[redacted]

b(6)-4

SING UNIT | ROOM NO. | BED NO.

DATE OF ORDER:
TIME OF ORDER: HOURS

⑧ IV bolus ī LRS then 150cc/h
⑨ MSO4 4mg IV upon arrival

Thanks! [redacted] 0800

b(6)-2

IENT IDENTIFICATION

SING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 28 JUNE 03
TIME OF ORDER: 1825 HOURS

① MSO4 2-10mg IV q1° PRN
wound care & pain control
② Foley catheter - call MD if <30 cc/h
③ CBC, Ch [redacted] ō AM

[redacted] MS

b(6)-2

1850 [redacted]

b(6)-2

IENT IDENTIFICATION

DATE OF ORDER: 29 JUNE 03
TIME OF ORDER: 0645 HOURS

① d/c to [illegible] hospital

[redacted]

[redacted]

b(6)-2

SING UNIT | ROOM NO. | BED NO.

MEDCOM - 12440

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)

For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo. ____ *Yr.* 2003

VERIFY BY INITIALING — *INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION*

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 28	29	
6/28	[redacted]	Stable	05	/	[redacted]	
			17	[redacted]	[redacted]	
6/28	[redacted]	vitals per protocol	05	/	[redacted]	
			17	[redacted]	[redacted]	(b)(6)-2
6/28	[redacted]	Bedrest	05	/	[redacted]	
			17	[redacted]	[redacted]	
6/28	[redacted]	Dressing Δ's per protocol (bid)	05	/	[redacted]	
			17	[redacted]	[redacted]	
6/28	[redacted]	Foley cath	05	/	[redacted]	
			17	[redacted]	[redacted]	
6/28	[redacted]	Call MD if uo <50cc/°	05	/	[redacted]	
			17	[redacted]		

ALLERGIES: ☐ YES ☑ NO

NKA

PRIMARY DIAGNOSIS: 13% 2° burn

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ____

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 USED. MEDCOM - 12441 USAPA V1.00

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo ______ *Yr* 2003

Verify by Initialing						
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
6/28	[redacted]	Admit to ICU-3	6/28		1800	[redacted] (b)(6)-2
6/28	[redacted]	CBC, Chem 7 in am	6/29			

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION													
			TIME/DATE COMPLETED													

USAPA V1.00

MEDCOM - 12442

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 — *INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION*

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED		
				28	29	
6/28	[redacted]	NS.e 150cc/°	05	/ [redacted]		(b)(6)-2
			17	[redacted]		(b)(6)-2

ALLERGIES: ☐ YES ☒ NO

NKA

PRIMARY DIAGNOSIS:

Dx: 13% 2° burn

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ________

PATIENT IDENTIFICATION:

#[redacted](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 - 12443

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo.____ Yr.____			
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
6/28	[redacted]	IV bolus ī L NS then 150cc/°	6/28			[redacted]
6/28	[redacted]	MSO4 4 mg IV upon arrival	6/28			[redacted]

(b)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED
6/28	[redacted]	MSO4 2-10mg IV	
		q 1° prn wound	
		care & pain control	

MEDICAL RECORD–SUPPLEMENTAL MEDICAL DATA
For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET (b)(6)(2)

OTSG APPROVED *(Date)*
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	29 June 03 TIME	0600 INITIALS [redacted]	INITIALS	2100 INITIALS [redacted]
NEURO	PUPILS	PERRLA		
	SENSORIUM	A&O x3		
		purposeful movement x4		
		Follows commands		
RESPIRATORY	RESPIRATORY PATTERN	RR - 18 SpO2 - 97%		
	BREATH SOUNDS	on RA		
	SECRETIONS	Lung Sound CTA (B)		
SKIN	COLOR	Normal For Race		
	INTEGRITY	15% BSA Burns		15% BSA Burns
IV SITE	LOCATION	18g to (L) wrist		
	CONDITION	infusing NS @ 150cc/hr		
		c̄ No s/s of infection		
		or infiltration		
GASTRO	ABDOMEN	Soft flat non distended/		
	BOWEL SOUNDS	nontender		
		Normoactive bowel		
		Sound x4		
GU	URINE:	clear/yellow Q5		
	COLOR/CLARITY	urine voiding via		Clear/yellow
		Foley		
CARDIOVASCULAR	CARDIAC RHYTHM	HR - 80 BP - 130/80		
		NSR		
		Cap Refill ≤3 x4		
		Peripheral pulses x4		

LEGEND

Cr - Creatinine	ICP - Intracranial Pressure	S/A - Fractional
F_iO_2 - Fraction of Inspired O_2	PCO_2 - Pressure of Arterial CO_2	SAT - Saturation
HCO_3 - Bicarbonate	PEEP - Positive End Expiratory Pressure	TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY *(Signature & Title)*

DEPARTMENT/SERVICE/CLINIC
ICU 3

DATE
29 June 03

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

#[redacted] (b)(6)-4

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

DA FORM 1 MAY 78 **4700**
Proponent: Dept of Nurs

MEDCOM - 12445

WAMC OP 375 (Redesignated)
1 Apr 90 (HSXC-NU)

DATE

DX

HOSPITAL DAY

VITAL SIGNS	TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
	BP Arterial Line																		
	BP Cuff		130/50																
	Temperature		100.7																
	Pulse		80																
	Respiratory Rate		18																
	SPO2		97%																
	~~RA~~ Method		RA																
	[illegible]																		

INTAKE	TIME	05	06	07	08	09	10	11	12	8° T	13	14	15	16	17	18	19	20	8° T
	TOTALS																		

OUTPUT																				
	URINE	HOUR / TOTAL																	200	
		sp gr																		
		S/A																		
	NG	OUTPUT																		
		pH																		
		GUIAC																		
	EMESIS																			
	STOOL																			
	DRAINS																			
	TOTALS																			

MEDCOM - 12446

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	2300 INITIALS [redacted]	(b)(6)-2 INITIALS	INITIALS
NEURO	PUPILS	PERL		
	SENSORIUM	moving all extremities		
		pulses palpable x4 ext		
RESPIRATORY	RESPIRATORY PATTERN	reg		
	BREATH SOUNDS	clear in all lobes		
	SECRETIONS	Ø		
SKIN	COLOR	Burn to scalp, bilat back		
	INTEGRITY	[illegible], bilat lower legs		
		+ feet		
IV SITE	LOCATION	16G L arm		
	CONDITION	patent + intact		
GASTRO	ABDOMEN	soft non tender		
	BOWEL SOUNDS	present x 4 quads		
		tolerating po		
GU	URINE:	Clear yellow via		
	COLOR/CLARITY	foley cath to gravity drain		
CARDIOVASCULAR	CARDIAC RHYTHM	S1S2 regular		
		NSR		

LEGEND
Cr - Creatinine
F_iO_2 - Fraction of inspired O_2
HCO_3 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
S/A - Fractional
SAT - Saturation
TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY *(Signature & Title)* (b)(6)-2 [redacted]

DEPARTMENT/SERVICE/CLINIC ICU 3

DATE 28 Jun 2003

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

[redacted] (b)(6)-4

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

DA FORM 1 MAY 78 **4700**
Proponent: Dept of Nurs

MEDCOM - 12447

WAMC OP 375 (Redesignated)
1 Apr 90 (HSXC-NU)

DATE

DX

HOSPITAL DAY

VITAL SIGNS	TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
	BP Arterial Line																139		
	BP Cuff																64		
	Temperature																		
	Pulse																82		
	Respiratory Rate																17		
	O2 Sat																97		
	[illegible] intervention																		
INTAKE	TIME	05	06	07	08	09	10	11	12	8°T	13	14	15	16	17	18	19	20	8°T
	IVF																150	150	
	TOTALS																		
OUTPUT	URINE HOUR / TOTAL																		
	URINE sp gr																		
	URINE S/A																		
	NG OUTPUT																		
	NG pH																		
	NG GUIAC																		
	EMESIS																		
	STOOL																		
	DRAINS																		
	DRAINS																		
	DRAINS																		
	TOTALS																		

MEDCOM - 12448

POST-OP DAY

VITAL SIGNS	21	22	23	00	01	02	03	04	
		141							
		59			120/51			121/41	
					98.9			99°	
		65			73			80	
		12			21			15	
		100			98			98	

INTAKE	21	22	23	00	01	02	03	04	8° T
	150	150	150	150	150	150	150	150	

100	120	100	110	90	100	150	110	

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA		TIME									
		MODE									
		F_iO_2									
		TV									
		RATE									
		PEEP									
	ABG	pH									
		PCO_2									
		pO_2									
		HCO_3									
		SAT									
		BASE									

LABORATORY DATA	TIME									
	GLUCOSE									
	Na/K									
	Cl/CO_2									
	BUN/Cr									
	WBC/PLATELET									
	Hct/Hgb									

ACTIVITIES OF DAILY LIVING	TIME				TIME					
	MOUTH CARE				TURN					
	BATH									
	SKIN CARE									
	FOLEY CARE				SUCTION					
	TRACH CARE									
	ROM EXERCISES									

24° I&O TOTALS

wt Yesterday ________ wt Today ________

INTAKE

IV ________

po ________

TOTAL ________

OUTPUT

Urine: ________

____

____

TOTAL ________

BALANCE ________

NURSE'S SIGNATURE	INITIALS
[redacted]	[redacted]
(b)(6)-2	

b(6)-2

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF — 1 2 3 4 5 6 — [redacted]

2. M [illegible]CATION (State or Country Code.) — 7 8 — I Z

3. REGISTER NUMBER — 9 10 11 12 13 14 15 — [redacted]

NAME (Last, First, Middle Initial) — EPW # [redacted] (b)(6)-4

4. PAY GRADE — 16 17 — —

5. SEX — 18 — M

6. DATE OF BIRTH (YYYYMMDD) — 19 20 21 22 23 24 25 26 — —

7. AGE AT ADMISSION — 27 28 29 — 5 0 Y

8. RACE — 30 — Z

9. ETHNIC BACKGROUND — 31 — 9

RELIGION — —

10. LENGTH OF SERVICE — 32 33 34 — —

ETS — —

11. FMP — 35 36 — 9 9

12. SOCIAL SECURITY NUMBER — 37 38 39 40 41 42 43 44 45 — [redacted]

ORGANIZATION (Active Duty Only) — —

13. MARITAL STATUS — 46 — U

HOUR OF ADMISSION — 1657

BRANCH / CORPS (b)(6)-4 — —

14. FLYING STATUS — 47 48 49 — —

15. BENEFICIARY CATEGORY — 50 51 52 — K 7 9

16. ZIP CODE OF RESIDENCE — 53 54 55 56 57 58 59 60 61 — —

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

18. MOS — 64 65 66 67 68 69 70 — —

19. TRAUMA — 71 — 9

PREV. ADMISSION — YEAR — ☒ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION — 72 — 0

WARD — ICU3

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY — [redacted] (b)(2)-2

21. TYPE OF DISPOSITION — 73 74 — 2 6 — TRNSFR to CIV Acute Care Facility

22. MTF TRANSFERRED TO — 75 76 77 78 79 80

23. DATE OF DISPOSITION (YYMMDD) — 81 82 83 84 85 86 — 0 3 0 6 2 9

24. CLINIC SVC - ADMITTING — 87 88 89 90 — A B M A — Burns

25. MTF TRANSFERRED FROM — 91 92 93 94 95 96

26. DATE THIS ADMISSION (YYMMDD) — 97 98 99 100 101 102 — 0 3 0 6 2 8

27. LOCATION OF OCCURRENCE (Battle Casualty Only) — 103 104

28. MTF OF INITIAL ADMISSION — 105 106 107 108 109 110

29. DATE INITIAL ADMISSION (YYMMDD) — 111 112 113 114 115 116

FOR LOCAL USE

DX-7 13 percent 2° Burns to Body

Dx 94120
94325
[redacted]
94522
94810
Trauma 9
Inj 759

ADMITTING OFFICER (Signature, as required)

SIGNATURE OF ADMITTING CLERK — [redacted] SPC

(b)(6)-2

MEDCOM - 12450

b(a)-2

INPATIENT TREATMENT RECORD COVER SHEET

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

[redacted]

NAME (Last, First, MI) EPW # [redacted] (b)(6)-4

3 GRADE —

RELIGION

M — IRAQI (b)(6)-4

10 CTS —

10 PREVIOUS ADMISSION NO

13 ORGANIZATION —

14 WARD Jeu3

AGE 99

[redacted]

BRANCH/CORPS —

19 UIC/ZIP —

20 TYPE CASE VSI

15 FLYING STATUS —

DSG —

K79

21 SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION

Direct from ER

22 HOURS OF ADMISSION 1900

23 CLINIC SERVICE Burns

24 NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE —

25 TYPE DISPOSITION D/c to CW care facility

26 DATE OF DISPOSITION 2003 June 29

27a ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) —

27b TELEPHONE NO —

28 DATE OF THIS ADMISSION 2003 June 28

30 DATE OF INITIAL ADMISSION

ADMISSION REMARKS

ARMY LINE OFFICER (b)(6)-2

[redacted]

32 UNITS OF WHOLE BLOOD COMPONENT TRANSFUSED

[redacted] (b)(2)-2

Check if Continued on Reverse

33 CAUSE OF INJURY

34 DIAGNOSES, OPERATIONS AND SPECIAL PROCEDURES

DX → 23% Burns to body; 2°

35. Total Days This Facility

a ABSENT SICK DAYS	b OTHER DAYS	c CONV LV/COOP CARE DAYS	d SUPPLEMENTAL CARE DAYS	e BED DAYS	f TOTAL SICK DAYS
0	0	0	0	1	1

36. Total Days All Facilities

a	b OTHER DAYS	c CONV. LV/COOP CARE DAYS	d SUPPLEMENTAL CARE DAYS	e BED DAYS	f TOTAL SICK DAYS
[redacted]					

[redacted] SPC

DA FOR

(b)(6)-2

EDITION OF 1 AUG 78 IS OBSOLETE

USAPPC V1

MEDCOM - 12451

AUTHORIZED FOR LOCAL RI

:DICAL RECORD	PROGRESS NOTES

DATE	NOTES
28 Jun03 1918 (b)(6)-2	Nursing: Pt admitted to ICU 3 for burn to back, legs, upper arms + hands, back of neck, and tip of ears. 192 [redacted] ~~Pt debrea~~ Debridement of burns completed per protocol. Posterior portion of legs white surrounded by pink/red tissues. Blisters noted on toes and legs. No pain felt while [redacted] 1927 ~~debreed~~ debreeding back of Ⓡ leg (white area). Pt felt some pain during debridement of white tissue on ~~to~~ [redacted] 1930 Ⓛ back of Ⓛ leg. Silvadene cream applied. Blisters noted on posterior portion Ⓑ upper extremeties from shoulder to elbow. Blisters also noted on ~~both hanc~~ [redacted] 1933 on anterior portion of hands + fingers. Debridement completed, skin pink/red on arms + hands. Silvadene cream applied. Pink skin noted from neck to superior portion of buttocks. Minimal burn noted to neck. Silvadene cream applied and burn pad turned into vest to cover back. External meatus of Ⓑ ears debreeded. Sulfamylon cream applied. Pt received 20mg total Morphine during ~~debreedement~~ [redacted] 1940 Debridement. Respirations regular + unlabored. Airway patent. VSS. SaO_2 95% on RA. Pt voided 200cc clear urine per urinal. (Cont'd)

NSHIP TO SPONSOR

SPONSOR'S NAME: LAST / FIRST / MI

SPONSOR'S ID N (SSN [redacted]

/SERVICE

HOSPITAL OR MEDICAL FACILITY

RECORDS MAINTAINED AT (b)(6)-2

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 (F

ST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
28 Jun 03 1918	Nursing Cont'd: Strong pulses palpated in all extremities. Cap refill <3 secs. Pt resting quietly in bed. Report given to Haj [redacted] —— [redacted] CPT/AN (b)(6)-2

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	**CHRONOLOGICAL RECORD OF MEDICAL CARE**
DATE	**SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION** *(Sign each entry)*
29 June 03	Surgery Transfer Summary
0635	Date of Adm: 28 June 03
	Date of Transfer: 29 June 03
[illegible]	Hospital Course & HPI: 30% TBSA partial thickness burns
[illegible]	? to flash. Pt is 46 y/o ♂ sustained flash burns to
[illegible]	posterior neck, ears, upper extremities, lower [illegible]
Silvadene	& B/L [illegible] [illegible]. He has partial thickness
Bacitracin	[illegible] [illegible] [illegible] ? [illegible] full thickness or deep partial
[illegible]	thickness burns. [illegible] [illegible] [illegible]
[illegible]	[illegible] [illegible] [illegible] [illegible]
	[illegible]. Burns dressed with Silvadene
	& Bacitracin to [illegible] [illegible] [illegible]

[redacted] (b)(6)-2

[illegible]

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.

[redacted] (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

558-103

(See Instructions on Back of this Sheet)

NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp) [redacted] (b)(2)-2

LOG NUMBER /

ARRIVAL
DATE: DAY 28 MONTH Jun YR. 03 TIME 1700

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet)
☐ PRIVATE VEHICLE ☐ AMBULANCE ☑ OTHER (Specify) Medevac

CURRENT MEDS. (tetanus immunization and other data) ∅ Seasonal allergy shots

HISTORY OBTAINED FROM ☑ PATIENT ☐ OTHER (Specify)

ALLERGIES NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration) Burns

SEX ♂ AGE 31

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER

VITAL SIGNS			
TIME	1700		
BP	136/64		
PULSE	99		
RESP.	14		
TEMP.			
WT. (Child)	85 kg		

CATEGORY (See reverse)
☐ EMERGENT
☒ URGENT
☐ NON-URGENT

ORDERS	INITS.	TIME
IV bolus LR		1700
CBC / lytes BUN Cr		
Td .5 cc IM		1705

ASSESSMENT/DIAGNOSIS
23% burns to body

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

26 ♂ s/p burns from flash powder burns while getting wood @ ~1800 today. Seen by

PMH
Seasonal allergy

O: A&O x4 in mod distress. VS as above
HEENT: PERRL clear/pat nares, neck supple
eyes clear
Chest: CTA(B) taking full breaths symmetrically
CVS: RRR ø m/r/g
Abd: obese, soft, NT
Ext: grossly NC, 5/5 strength w/ (B)
Skin: (L) 2° burns entire back – 13%
(B) post arms 2° burns – 4% (B) hands circumferential 2% = 23%
(B) post calf burns 4%

A/P Stable 23% burns to body/ext
→ Admit burn unit

DISPOSITION (Check all that apply)
☐ HOME ☐ FULL DUTY
QUARTERS ☐ 24 Hrs. ☐ 48 Hrs. ☐ 72 Hrs.
MODIFIED DUTY UNTIL: DAY MONTH YEAR
REFERRED TO (Indicate clinic)
☐ EMERGENCY ☐ TODAY
☐ 72 HOURS ☐ ROUTINE
ADMIT. TO HOSP. UNIT/SERVICE ICU3

CONDITION UPON RELEASE
☐ IMPROVED ☐ UNCHANGED
☐ DETERIORATED

TIME OF RELEASE:

(CONTINUE ON SF 507, IF NEEDE[redacted]

SIGNATURE OF PROVIDER AND ID STAMP (b)(6)-2

INSTRUCTIONS TO PATIENT (Include medicati[redacted] any limitations and follow-up plans)

PATIENT'S IDENTIFICATION (Mechanical imprint)
FOR WRITTEN ENTRIES GIVE: Name - last, first, middle; SSN; DOB, service status, name and relation of sponsor or next of kin. (IMPORTANT: LIST FACILITY HOLDING TREATMENT RECORD).

[redacted] (b)(6)-4

EMERGENCY CARE AND TREATMENT

STANDARD FORM 558 (Rev. 6-82)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

MEDCOM - 12455 Copy

NURSING NOTES
(Sign all notes)

DATE	HOUR		OBSERVATIONS Include medication and treatment when indicated
	A.M.	P.M.	
28 June 03		2300	PT transfered to ICU#3 from EMT via litter. @1815
			Dx - 1° & 2° burns to 23% BSA. All burned areas
			cleaned and dressings applied. Foley cath
			placed 2215 hrs. PT vital signs stable, SaO2
			100% on RA ——— [redacted] (b)(6)-2 SPC 91WM6
	0245		pt sleeping at this time. Adequate urine
			output. VSS. No s/s of pain or discomfort at
			this time. Will continue to monitor [redacted] 91WM6 (b)(6)
	0515		Report given to SPC [redacted] ——— (b)(6)
	0520		Received report and care of pt. from previous shift
			pt. in bed resting awake & alert all VSS w/l
			Cont to monitor ——— [redacted] (b)(6)-2

STANDARD FORM 510 (REV. 7-91) BACK

MEDCOM - 12456

rd/Section EMT [redacted] (b)(6)-2

MISTRY RESULT FORM
(Subject to the Privacy Act of 1974)

ST FIRST, M[redacted] #[redacted] (b)(6)-4 [redacted] DATE 28Jun03 TIME 0710 SS[redacted]

(i-S[redacted]

EST	RESULT	REF. RANGE
		138-146 mmol/L
		3.5-4.9 mmol/L
		98-109 mmol/L
		7.31-7.45
O2		35-45 mmHg (art) 41-51 mmHg (ven)
O2		80-105 mmHg (art) N/A (ven)
O2		23-27 mmol/L (art) 24-29 mmol/L (ven)
CO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
O2		95-98%
ecf		(-2) - (+3) mmol/L
nGap		10-20 mmol/L
a		1.12-1.32 mmol/L
UN		8-26 mg/dl
LU		70-105 mg/dl
reat		0.7-1.5 mg/dl
ct		38-51% PCV
gb		12-17 g/dl

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB	1.9	3.5-5.5 g/dl
ALP	37	26-84 u/l
ALT	22	10-47 u/l
AMY	19	14-97 u/l
AST	29	11-38 u/l
TBIL	0.6	0.2-1.6 mg/dl
BUN	5	7-22 mg/dl
CA++	5.1	8.0-10.3mg/dl
CHOL	118	100-200 mg/dl
CRE	0.8	0.6-1.2 mg/dl
GLU	125	73-118 mg/dl
TP	3.8	6.4-8.1 g/dl

(Piccolo) Metabolic (b)(6)-4

TEST	RESULT	REF. RANGE
GLU		
BUN		
CA		
CRE		
NA+		
K		
CL		98-
tCO2		

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RAN
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 u/l (M) 30-190 u/l (F)
NA+		128-145 mmol/l
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
tCO2		18-33 mmol/l

Misc. Chemistry

TEST	RESULT	REF. RANGE
roponin-i		
rug of buse		

(Piccolo) Electrolyte

TEST	RESULT	REF. RAN
NA+	152	128-145 mmo
K+	2.7	3.3-4.7 mmo
CL-	114	98-108 mmo
tCO2	17	18-33 mmo

REMARKS:

REPORTED BY: [redacted] (b)(6)-2 | DATE: 28 Jun03 | LAB ID NO.:

(b)(6)-2

Ward Section: 2MT	[redacted]	**LA TORY RESULT FORM** (Subject to the Privacy Act of 1974)
LAST, FIRS [redacted] (b)(6)-4	[redacted] 28Jun03	TIME 1710 [redacted] (b)(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	24.4	4.8-10.8 x 10^3
RBC	5.91	4.7-6.1 x 10^6
Hgb	16.8	14-18 g/dl (M) 12-16 g/dl (F)
Hct	54.5	42-52% (M) 37-47% (F)
MCV	92.3	80-94 fl (M) 81-99 fl (F)
Plt	402	130-500 x 10^3 verified
Lymph %	10.6	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis

TEST	RESULT	REF. RANGE
Color	Yell	N/A
App	Clear	N/A
Glu	Neg	Negative
Bili	Neg	Negative
Ket	Neg	Negative
SG	1.010	N/A
Bld	Neg	Negative
pH	6.0	N/A
Prot	Neg	Negative
Urob	0.2	0.2-1.0
Nit	Neg	Negative
Leuk	Neg	Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED [redacted]	**DATE:** 28Jun03	**LAB ID NO.:**

(b)(6)-2

Seg-69 35.4

Band-20

Lymph-5

A Lymph-5

mono-1

1+ Toxic granules

Normocytic/normochrom:

Platelet increased

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

IENT IDENTIFICATION

[redacted] b)(6)-4

SING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 28 Jun 03 TIME OF ORDER 1715 HOURS

LIST TIME ORDER NOTED AND SIGN

① Admit ICU 3
② Dx 23% burns
③ Condition stable
④ NKDA
⑤ Vitals per protocol
⑥ Bed rest — 1755
⑦ Dressing Δs per burns — Kpa

IENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

⑧ Regular diet
⑨ IV bolus c̄ LR NS then 150cc/°
⑬ MSO4 4mg upon arrival to ICU
then per surgery on call
⑪ Call Surgeon on call for further orders

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

SING UNIT | ROOM NO. | BED NO.

IENT IDENTIFICATION

DATE OF ORDER 28 JUNE 03 1805 HOURS

① AFTER LR BOLUS
INCREASE IVF TO 200 cc/° x 8°
THEN ↓ to 150cc/°
② MSO4 2-10mg IV q 1° PRN
dressing Δs & pain control
③ SILVADENE TO ALL WOUNDS
c̄ SULFAMYLON TO EARS

SING UNIT | ROOM NO. | BED NO.

IENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

④ MSO4 10mg IV x1 DOSE DURING THAT DRESSING Δ
Thank you [redacted] (b)(6)-2

⑤ FOLEY CATHETER
⑥ CALL MD FOR UO < 50cc/°

[redacted] (b)(6)-2

SING UNIT | ROOM NO. | BED NO.

⑦ CBC/CHEM 7 in AM

MEDCOM - 12460

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	*Mo.* ____ *Yr.* 2003

VERIFY BY INITIALING — *INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION*

)(6)-2

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 28	29	
28 Jun	[redacted]	Condition stable	05	[redacted]	[redacted]	
			17	[redacted]	[redacted]	
28 Jun	[redacted]	Vitals per protocol	05	[redacted]	[redacted]	
			17	[redacted]	[redacted]	
28 Jun	[redacted]	Bedrest	05	[redacted]	[redacted]	
			17	[redacted]		
28 Jun	[redacted]	Dressing Δ's per burn	05	[redacted]		(b)(6)-2
		(bid)	17	[redacted]	[redacted]	
28 Jun	[redacted]	Reg. diet	05	[redacted]	[redacted]	
			17	[redacted]		
28 Jun	[redacted]	Silverdene to all wounds	05	[redacted]		
		& sulfamycon to ears	17	[redacted]		
		(bid)	/			
28 Jun	[redacted]	Foley Cath	05	/	[redacted]	
			17	[redacted]	[redacted]	
28 Jun	[redacted]	Call MD for uo	05	[redacted]	[redacted]	
		< 50cc/°	17	[redacted]		

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS:

23% burn

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ____________

PATIENT IDENTIFICATION:

#[redacted](b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 EDITION OF 1 DEC 77 MAY BE USED. USAPA V1.00

MEDCOM - 12461

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Verified by Initialing

Mo ______ *Yr* 2003

	Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials	
b)(6)-2	28 Jun	[redacted]	Admit to ICU 3	28Jun		0715 Done	[redacted]	(b)(6)-2

	Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED
b)(6)-2	28Jun	[redacted]	Call Surgeon on	
			call for further	
			orders.	
b)(6)-2	28Jun	[redacted]	Call MD for	
			uo < 50cc/hr.	

USAPA V1.00

MEDCOM - 12462

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

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

b)(6)-2

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED				
				28	28 [redacted]			
28 Jun	[redacted]	IV bolus ī L NS then 150cc/°	05	/	[redacted]	)(6)	-2	
			17					

ALLERGIES: ☐ YES ☐ NO

N KDA

PRIMARY DIAGNOSIS:

23% burn

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ________

PATIENT IDENTIFICATION:

[redacted])(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 - 12463

A11 (b)(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*	*Mo.* ______ *Yr.* ______			
Order Date	**Clerk/ Nurse**	**SINGLE ORDER, PRE-OPERATIVES**	**Date to be Given**	**Time to be Given**	**Time Given**	**Initials**
28 Jun	[redacted]	IV bolus ī L NS	28 Jun			
28 Jun	[redacted]	MSO4 4mg upon arrival then per	28 Jun		Done	
		Surgeon on call				
28 Jun	[redacted]	After ī liter bolus, ↑ IVF to	6/28			
		200cc/° x 8° then ↓ to 150cc/°				
28 Jun	[redacted]	MSO4 10mg IV x ī done during dressing	6/28			
		Δ'				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* TIME/DATE DISPENSED
6/28	[redacted]	MSO4 2-10mg IV	29 Jun 0451
		q 1° prn dressing	II IV
		Δ's + pain control	[redacted]

USAPA V1.00

MEDCOM - 12464

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	2100	INITIALS [redacted]	(b)(6)-2	INITIALS		INITIALS
NEURO	PUPILS	PERL					
	SENSORIUM	moving all extremities					
		x4 pulses palpable					
		appropriate response					
		to pain					
RESPIRATORY	RESPIRATORY PATTERN	reg					
	BREATH SOUNDS	clear to all fields					
	SECRETIONS	Ø secretion					
SKIN	COLOR	burns to back, bilat					
	INTEGRITY	hand, upper arm, calf					
		of both legs 1,2,3° burn					
IV SITE	LOCATION	R wrist 18G PN					
	CONDITION	patent & intact					
		s̄ sign of infection					
GASTRO	ABDOMEN	soft non tender					
	BOWEL SOUNDS	present					
		Tolerating po s̄ difficulty					
GU	URINE:	clear yellow					
	COLOR/CLARITY	via foley cath to					
		gravity drain					
CARDIOVASCULAR	CARDIAC RHYTHM	S1S2 SR@ST					
		regular s̄ ectopy					
		Ø edema					

LEGEND
Cr - Creatinine
F_iO_2 - Fraction of Inspired O_2
HCO_3 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
S/A - Fractional
SAT - Saturation
TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY *(Signature & Title)*
(b)(6)-2 [redacted]

DEPARTMENT/SERVICE/CLINIC
ICU 3

DATE
28 Jan 2003

PATIENT'S IDENTIFICATION [redacted] —last, first, middle; grade; date; hospital or medical facility)

[redacted] (b)(6)-4

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

DA FORM 1 MAY 78 4700
Proponent: Dept of Nurs

WAMC OP 375 (Redesignated)
1 Apr 90 (HSXC-NU)

DATE	DX	HOSPITAL DAY

		05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
VITAL SIGNS	TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
	BP Arterial Line															134 58			
	BP Cuff																		
	Temperature																		
	Pulse															108			
	Respiratory Rate															18			
	O2 Sat															97			
	pain																		
	intervention																		
INTAKE	TIME	05	06	07	08	09	10	11	12	8°T	13	14	15	16	17	18	19	20	8°T
	IVF															150	150	150	
	PO																		
	TOTALS																		
OUTPUT	URINE HOUR / TOTAL															200			
	URINE sp gr																		
	URINE S/A																		
	NG OUTPUT																		
	NG pH																		
	NG GUIAC																		
	EMESIS																		
	STOOL																		
	DRAINS																		
	DRAINS																		
	DRAINS																		
	TOTALS																		

POST-OP DAY

VITAL SIGNS

24	22	23	00	04	02	03	04	
					122/73			
	102				107			
	22				20			
	97				96			
					RA			

INTAKE

21	22	23	00	01	02	03	04	8° T
150	150	150	150	150	150	150	150	
					200			

OUTPUT

900/1100	/	120/1220	/	/	300/1520	/	100/	1620

ACUITY LEVEL CLASSIFICATION

RESPIRATORY / RESP DATA

TIME	
MODE	
F_iO_2	
TV	
RATE	
PEEP	
ABG pH	
ABG PCO_2	
ABG pO_2	
ABG HCO_3	
ABG SAT	
ABG BASE	

LABORATORY / DATA

TIME	
GLUCOSE	
Na/K	
Cl/CO_2	
BUN/Cr	
WBC/PLATELET	
Hct/Hgb	

ACTIVITIES OF DAILY LIVING

TIME	
MOUTH CARE	
BATH	
SKIN CARE	
FOLEY CARE	
TRACH CARE	
ROM EXERCISES	

TURN — TIME

SUCTION

24° I&O TOTALS

wt Yesterday ______ wt Today ______

INTAKE
IV 1650
po 200
TOTAL 1850

OUTPUT
Urine: ______
TOTAL 1620

BALANCE______

NURSE'S SIGNATURE	INITIALS
[redacted] (b)(6)-2	[redacted] (b)(6)-2

MEDCOM - 12467

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA
For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA Appr 8 Mar 89

INI[redacted]IFT ASSESSMENT

	TIME	0600	INITIALS	(b)(6)-2	INITIALS		INITIALS
NEURO	PUPILS	3mm PERRL Brisk					
	SENSORIUM	Awake + Alert Move					
		all extremities ē					
		purposeful movement					
RESPIRATORY	RESPIRATORY PATTERN	Regular Pattern, Bilat.					
	BREATH SOUNDS	equal rise + fall, CTA					
	SECRETIONS	bilat Ø secretions					
		SaO2-95% RA					
SKIN	COLOR	1° + 2° Burns 23% TBSA					
	INTEGRITY						
I.V. SITE	LOCATION	20ga I.V. to (R) wrist					
	CONDITION	NS infusing @ 150cc/hr					
		Site CDI Ø s/s					
		erythema					
GASTRO	ABDOMEN	+ BS x 4 quads					
	BOWEL SOUNDS	Soft Non tender					
		Ø distention					
GU	URINE:	Clear yellow foley					
	COLOR/CLARITY	to gravity					
CARDIOVASCULAR	CARDIAC RHYTHM	S1S2 Audible HR 106					
		Pulses +2 x 4 extremities					

LEGEND

Cr - Creatinine	ICP - Intracranial Pressure	S/A - Fractional
F_iO_2 - Fraction of Inspired O_2	PCO_2 - Pressure of Arterial CO_2	SAT - Saturation
HCO_3 - Bicarbonate	PEEP - Positive End Expiratory Pressure	TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY *(Signature & Title)*

DEPARTMENT/SERVICE/CLINIC
ICU 3

DATE
23Jun03

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

[redacted] (b)(6)-4

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

DA FORM 1 MAY 78 4700
Proponent: Dept of Nurs

WAMC OP 375 (Redesignated)
1 Apr 90 (HSXC-NU)

PAGE 2 OF 4

DATE

DX

HOSPITAL DAY

VITAL SIGNS	**TIME**	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
	BP Arterial Line																		
	BP Cuff	132/81	177/72																
	Temperature		96.7																
	Pulse	108	104																
	Respiratory Rate	20	22																
	SaO2	95	96																
	Method O2	RA	RA																
	pain intensity																		

INTAKE	**TIME**	05	06	07	08	09	10	11	12	8°T	13	14	15	16	17	18	19	20	8°T
	NS	150	150																
	TOTALS																		

OUTPUT	**URINE**	**HOUR / TOTAL**		40																
		SP GR																		
		S/A																		
	NG	**OUTPUT**																		
		pH																		
		GUIAC																		
	EMESIS																			
	STOOL																			
	DRAINS																			
	TOTALS																			

MEDCOM - 12469

PAGE 3 OF 4

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS									
	21	22	23	00	04	02	03	04	

INTAKE									
	21	22	23	00	04	02	03	04	8°T

OUTPUT

RESPIRATORY DATA		
	TIME	
	MODE	
	F_iO_2	
	TV	
	RATE	
	PEEP	
ABG	pH	
	PCO_2	
	pO_2	
	HCO_3	
	SAT	
	BASE	

LABORATORY DATA	
TIME	
GLUCOSE	
Na/K	
Cl/CO_2	
BUN/Cr	
WBC/PLATELET	
Hct/Hgb	

ACTIVITIES OF DAILY LIVING		TURN
TIME		TIME
MOUTH CARE		
BATH		
SKIN CARE		SUCTION
FOLEY CARE		
TRACH CARE		
ROM EXERCISES		

24° I&O TOTALS

[redacted] URE

(b)(6)-2

wt Yesterday ______ wt Today ______

INTAKE
IV ______
po ______
TOTAL ______

OUTPUT
Urine: ______
TOTAL ______

BALANCE ______

MEDCOM - 12470

(b)(6)-2

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF						**2. MTF LOCATION**		*(State or Country Code.)*
1	2	3	4	5	6	7	8	
[redacted]						I	Z	

3. REGISTER NUMBER

9	10	11	12	13	14	15
[redacted]						

NAME *(Last, First, Middle Initial)* EPW # [redacted] (b)(6)-4

4. PAY GRADE

16	17
—	—

5. SEX

18

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

19	20	21	22	23	24	25	26
—	—	—	—	—	—	—	—

7. AGE AT ADMISSION

27	28	29
—	—	—

8. RACE

30
Z

9. ETHNIC BACKGROUND

31
9

RELIGION —

10. LENGTH OF SERVICE

32	33	34
—	—	—

ETS —

11. FMP

35	36
9	9

12. SOCIAL SECURITY NUMBER

37	38	39	40	41	42	43	44	45
[redacted]								

ORGANIZATION *(Active Duty Only)* —

13. MARITAL STATUS

46
U

HOUR OF ADMISSION 1900

BRANCH / CORPS (b)(6)-4 —

14. FLYING STATUS

47	48	49
—	—	—

15. BENEFICIARY CATEGORY Enemy POW

50	51	52
K	7	9

16. ZIP CODE OF RESIDENCE

53	54	55	56	57	58	59	60	61
—	—	—	—	—	—	—	—	—

17. UNIT LOCATION *(State or Country Code)*

62	63
—	—

18. MOS

64	65	66	67	68	69	70
—	—	—	—	—	—	—

19. TRAUMA

71
9

PREV. ADMISSION YEAR ☒ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION

72
0

WARD ICU 3

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE unk

ADDRESS OF EMERGENCY ADDRESSEE *(Include ZIP Code)* unk

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE unk

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] (b)(2)-2

21. TYPE OF DISPOSITION D/C to CIV Acute Care Facility

73	74
2	6

22. MTF TRANSFERRED TO

75	76	77	78	79	80

23. DATE OF DISPOSITION *(Y Y M M D D)*

81	82	83	84	85	86
0	3	0	6	2	9

24. CLINIC SVC - ADMITTING

87	88	89	90

25. MTF TRANSFERRED FROM

91	92	93	94	95	96

26. DATE THIS ADMISSION *(Y Y M M D D)*

97	98	99	100	101	102
0	3	0	6	2	8

27. LOCATION OF OCCURRENCE *(Battle Casualty Only)*

103	104

28. MTF OF INITIAL ADMISSION

105	106	107	108	109	110

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

111	112	113	114	115	116

FOR LOCAL USE

DX ⇒ 23 percent burns to body ; 2°

DX: 94224
94323
94420
94524
94820
E892
Px: 8622

Trauma
9

Injury
759

ADMITTING OFFICER *(Signature, as required)* [redacted] (b)(6)-2

SIGNATURE OF ADMITTING CLERK [redacted] SPC (b)(6)-2

DA FORM 2985, MAR 90

MEDCOM - 12471

INPATIENT TREATMENT RECORD COV ET

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

EPW

[redacted]

2. NAME (Last, First, MI) [redacted] (b)(6)-4

3. GRADE N/A

4. M

5. 28y

6. RACE Z

7. RELIGION N/A

8. SVC N/A

9. ETS N/A

10. PREVIOUS ADMISSION No

11. FMP (b)(2)-2 99

12. SSN (b)(6)-4 [redacted]

13. ORGANIZATION N/A

14. WARD ICU2

15. FLYING STATUS N/A

16. DSG

17. DEPT./BEN K91 ~~K79~~

18. BRANCH/CORPS N/A

19. UIC/ZIP

20. TYPE CASE NBI

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct from E.R.

22. HOURS OF ADMISSION 1954

23. CLINIC SERVICE ABPA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE —

25. TYPE DISPOSITION 50

26. DATE OF DISPOSITION 3 Jul 03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) —

27b. TELEPHONE NO. —

28. DATE OF THIS ADMISSION 1 Jul 03

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] (b)(2)-2

30. DATE OF INTIAL ADMISSION

ADMISSION REMARKS

ADMITTING OFFICER (b)(6)-2 [redacted]

32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED

31.

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Head Laceration/Trauma

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	3	3

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	3	3

SIGNATURE OF ATTENDING [redacted] (b)(6)-2 [redacted]

SIGNATURE OF [redacted] RECORDS OFFICER (b)(6)-2

DA FORM 3647 [redacted] EDITION OF 1 AUG 78 IS [redacted]

USAPPC V1 10

MEDCOM - 12472

MEDICAL RECORD — **ABBREVIATED MEDICAL RECORD**

PERTINENT HISTORY, CHIEF COMPLAINT AND CONDITION ON ADMISSION (Enter date of admission)

See 558

PHYSICAL EXAMINATION

PROGRESS (Enter date of discharge and final diagnosis)

Head Laceration
2°
trauma

SIGNATURE OF PHYSICIAN [redacted]

DATE 1 Jul 03

IDENTIFICATION NO

ORGANIZATION

PATIENT'S IDENTIFICATION [redacted] ...itten entries give: Name - last, first, ... date, hospital or medical facility)

)(6)-2

[redacted] (b)(6)-4

REGISTER NO.

WARD NO.

ABBREVIATED MEDICAL RECORD
Standard Form 600
GENERAL SERVICES ADMINISTRATION AND INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975

AUTHORIZED FOR LOCAL REPRODUC

:AL RECORD | **PROGRESS NOTES**

TE	NOTES
1 July 03	Admitted from EMT to ICU #2 via litter. Alert, verbal
2300	[redacted] pt applied wrist restraints. Eyes: PERRL @ 2mm. (R) eye
	sclera ē slight redness noted. Lung sound clear bil. BS present
	in all 4 quads. (L) lateral head laceration ē staples. Top
	of head laceration ē staples noted. C/o (R) knee being
	sore. Scrapes noted to back. No drainage noted or active
	bleeding noted to back or head lacerations. (L) HL AC s̄ s/s
	of infection or infiltration noted. Will monitor. [redacted]
2355	Applied bacitracin to lacerations on head. Pt resting in (b)(6)-
	bed. Wrist restraints ~~still~~ [redacted] intact. Will monitor [redacted]
2300	Late entry. Versed 2.5mg IVP given. Will monitor
2 July 03	#2 Facial trauma, head lac, Back contusions.
	ø c/o [illegible] Transfer to ward when possible 2 to EPW Cage.
	[redacted] (b)(6)-2
2 July 03	Nursing assessment - Pt A&O x3, VSS, Head ē 2 Lacerations
11:19	closed ē staples to air. Minimal drainage noted, without s/s of
	infection. Eyes Perrla. Heart Sounds S_1 S_2 present, Lung
	Sounds clear bilaterally. + BS x 4 quadrants. Pt ē contusions
	to (L) side of neck, (L) Arm & Back. IV HL 18g in (L) AC
	patent & without s/s of infection. Pt non-combative at this
	time wrist restraints in place. Will continue to Monitor. [redacted]

SHIP TO SPONSOR	SPONSOR'S NAME LAST	FIRST	MI	SPONSOR'S ID NUMBE (ISSN or Other)
				(b)(6)-2

SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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.

7 [redacted] (b)(6)-4

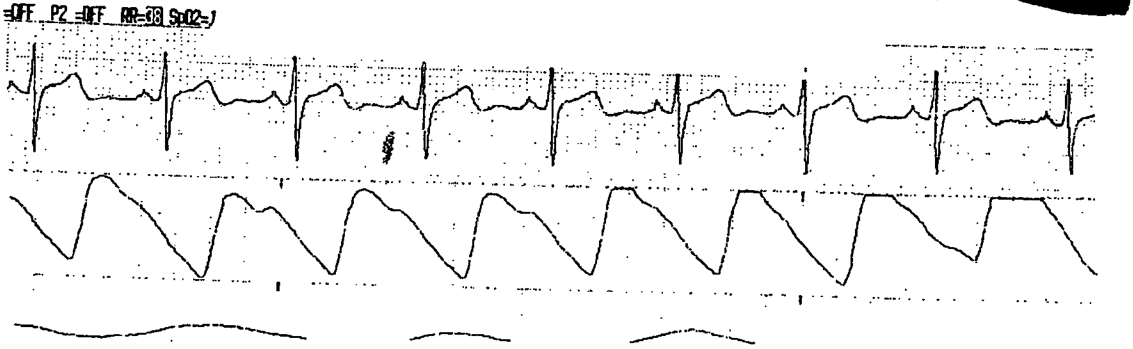
PROGRESS NOTES
Medical Record
STANDARD FORM 509 (REV. 5
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203

MEDCOM - 12474

A11 (b)(6)-2

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
2 July 03 1700	Assumed care of pt p̄ Dayshift report given. Alert/oriented. No c/o pain @ present time. IV (L) AC HL s̄ S/S of infection of infiltration noted. Flushes s̄ difficulty. [illegible] @ 3m. Lung sounds clear bil, BS ⊕ in all 4 quads. Pedal pulses present bil. Radial pulse present bil. NSR s̄ ectopy. Will Monitor. Laceration on head open to air c̄ stapes. No active bleeding noted. No drainage noted. [redacted]
1900	Pt voided spont. approx 175cc clear yellow urine. [redacted]



DATE	NOTES
2321	Applied triple antibiotic ointment to lacerations to head. Lacerations open to air c̄ staples. No active bleeding or drainage noted. [redacted]
3 Jul 03 0013	DC'd HL 14G (L) AC. Cath intact. Applied 2x2 pressure [redacted] Secured c̄ tape. [redacted]

STANDARD FORM 509 (REV. 5/1999) BAC
USAPA V1

AUTHORIZED FOR LOCAL REPRODU

CAL RECORD | PROGRESS NOTES

TE	D/C & Transfer Summary NOTES
2 July	28 yo [illegible] Iraqi s/p physical attacks p̄ [redacted]
	attacking US soldiers c̄ bayonet, by report. Brought in
	in restraints 2° Head Lac/trauma, reported LOC & Back
	trauma. CT & plain films = WNL ØFx.
	Wounds - cleansed & closed c̄ staples.
	No issues p̄ admission.
	Ⓐ Head trauma & Laceration. Back Trauma.
	Ⓟ - evac to EPW camp for processing
	removal of staples July 10th.
	[redacted] / [redacted] (b)(6)-2
	MAJ MC

SHIP TO SPONSOR	SPONSOR'S NAME LAST	FIRST	MI	SPONSOR'S ID NUMBE (SSN or Other)

SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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.

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODU

CAL RECORD | PROGRESS NOTES

TE	NOTES
3 Jul 03 0830	Nursing Notes - Pt A&O x3, VSS, No Δ's from previous shift. Pt c̄ staples to air Ⓛ forehead, & Ⓡ top of head. No S/S of infection. Pt c/o pain in his back & neck. 800mg Motrin given/MD orders. Pt tolerates reg diet w/o complaint. —— [redacted] 91WM6 —— (b)(6)-2
3 Jul 03 11:00	~~[illegible]~~ Pt pending DC. No Δ's. Pt c/o pain ø Δ on shift. 800 Motrin given @ 0800, T^3 given @ 1000.

SHIP TO SPONSOR	SPONSOR'S NAME LAST	FIRST	MI	SPONSOR'S ID NUMBE (SSN or Other)

SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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.
[redacted] (b)(6)-4		

PROGRESS NOTES
Medical Record

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

558-103 *(See Instructions on Back of this Sh* NSN 7540-01-075-378

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY: EMT

LOG NUMBER:

ARRIVAL — DATE: DAY 1 MONTH JULY YR 03 — TIME 1954

TRANSPORTATION TO HOSPITAL *(Attach care enroute sheet)*: ☐ PRIVATE VEHICLE ☐ AMBULANCE ☒ OTHER *(Specify)* MP'S

CURRENT MEDS. *(tetanus immunization and other data)*: ∅

HISTORY OBTAINED FROM: ☒ PATIENT ☐ OTHER *(Specify)*

ALLERGIES: Penicillin

PATIENT'S HOME ADDRESS OR DUTY STATION *(City, State and ZIP Code)*:

HOME TELE. NO. *(Inc. area code)*:

CHIEF COMPLAINT(S) *(Include symptom(s), duration)*: Head Injury

SEX: M AGE: 28

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER:

VITAL SIGNS

TIME	1905	2227	
BP	129/98	134/78	
PULSE	98	75	
RESP.	22	16 100%	
TEMP.		97.9	
WT. (Child)	70 Kg		

CATEGORY *(See reverse)*

☐ EMERGENT
☐ URGENT
☒ NON-URGENT

ORDERS	UNITS.	TIME
Thefa/Sliz	[redacted]	2013
X-ray Skull Series		2013
T&S CBC		2013
V/S q1hr		
IVS	[redacted]	2013
Ancef 1g IV		2013

ASSESSMENT/DIAGNOSIS: Head trauma ĉ ∅ 62 concentration.

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

28 yo Iraqi ♂ s/p Physical restraints by MPs p̄ jesturing & attacking ĉ bayonet. Reported LOC by MP's & pt. c/o Face pain. Back pain.

Ⓞ VSS; A&Ox3 Ambulates
♡ - RRR
Lys = CTA Ⓑ
ABD - NDNTBS
FAST U/S Neg.
Ext = ∅ Lac / edema / FROM

Head - Eomi
3 Head lac's.
swelling pain over Ⓡ eye.
Nose Not displaced TTP
Blood in nostrils.

Pupils / ∅
15 Mg / ∅
Bx / ∅

Skull film
? no obvious Fx

17 ✕ 16 / 447 / 54

ORDERS
Tetanus IM .5 2010
Morphine .5 2015
3mg Versed 201
MS04 3mg 2040
2mg Versed 2040
2mg Morphine 2100
[redacted]

Procedure: wounds cleaned closed ĉ staples.

DISPOSITION *(Check all that apply)*

☐ HOME ☐ FULL DUTY

QUARTERS: ☐ 24 Hrs. ☐ 48 Hrs. ☐ 72 Hrs.

MODIFIED DUTY UNTIL: DAY MONTH YEAR

REFERRED TO *(Indicate clinic)*:

☐ EMERGENCY ☐ TODAY
☐ 72 HOURS ☐ ROUTINE

ADMIT. TO HOSP. UNIT/SERVICE: ICU

CONDITION UPON RELEASE: ☒ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

TIME OF RELEASE:

(CONTINUE ON SF 507, IF NEEDED)

PATIENT'S IDENTIFICATION *(Mechanical imprint)* FOR WRITTEN ENTRIES GIVE: *Name - last, first, middle; SSN; DOB, service status, name and relation of sponsor or next of kin. (IMPORTANT: LIST FACILITY HOLDING TREATMENT RECORD).*

[redacted] (b)(6)-4

SIGNATURE OF PROVIDER AND ID STAMP [redacted] (b)(6)-2

INSTRUCTIONS TO PATIENT ... ordered, any limitations and follow-up plans)

[redacted] (b)(6)-2

EMERGENCY CARE AND TREATMENT — STANDARD FORM 558 (Rev. 6-8
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

MEDCOM - 12478 Copy

EPW # [redacted] 1 July 03

(b)(6)-4

Time	05	06	07	08	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
BP																			119/62					
TEMP																			988A					
HR																			79					
RR																			19					
SAO2																			94					
FIO2																			RA					
INP																								
PO																								
I																								
NG																								
TURN Q 2																								
TOTAL																								
OUTPUT																								
URINE																								
NGT																								
S OL																								
TO																								
B CE																								

[redacted] (b)(6)-4

Patient's Name: ENW H [redacted] (b)(6)-4 2 July 03

Time	05	06	07	08	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
BP				120/[illegible]				130/86		/				132/92										
TEMP				98.4 T				98.5		/				99.1 A										
HR				80				75		/				81										
RR				20				18		/				28										
SAO2								97		/				100										
FIO2				RA				RA		/				RA										
UT				200				/		/														
P				/				/		/				100						60				
I								/		/														
NG				/				/		/														360
TURN Q 2	self turns			S				self		Self														
TOTAL				200				/		/														
OUTPUT																								
URINE			400	525				/		500					175									1600
NGT																								
STOOL	0	0	0	0	x1			/		/														
			400	525	—			/		/														
TO			400	925				/		/														
B. CE					~~x1~~			/		/														
stool					x1																			

MEDCOM - 12480

(b)(6)-4 [redacted]

[redacted] Name: EPW 3 July 03

Time	05	06	07	08	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
BP	[illegible]	138/82																						
TEMP		97.9																						
HR		72																						
RR		26																						
SAO2		97																						
FIO2		RA																						
PUT		/																						
PO		/																						
I		/																						
NG.		/																						
TURN Q 2		self																						
TOTAL		/																						
OUTPUT		/																						
URINE		/	350																					
NGT		/																						
STOOL		/																						
TO		/																						
B. CE		/																						

Ward/Section: EMT

OU[redacted]CIAN: (b)(6)-2

HE[illegible]AISTRY RESULT FORM
(Subject to the Privacy Act of 1974)

LAS[redacted] (b)(6)-4

DATE 1JULY03

TIME 2015

SSN[redacted] (b)(6)-4

(I-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		Negative
Drug of Abuse		Negative
		Negative
		Negative
		Negative

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA++		8.0-10.3mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU	138	73-118 mg/dl
BUN	11	7-22 mg/dl
CRE	0.7	0.6-1.2 mg/dl
CK	284	39-380 u/l (M) 30-190 u/l (F)
NA+	138	128-145 mmol/l
K+	3.9	3.3-4.7 mmol/l
CL-	105	98-108 mmol/l
tCO2	23	18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA++		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA+		128-145 mmol/l
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
tCO2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA+		128-145 mmol/l
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
tCO2		18-33 mmol/l

REMARKS:

REPORTED BY: [redacted] (b)(6)-2

DATE: 01Jul03

LAB ID NO.:

MEDCOM - 12482

LAB·RATORY RESULT FORM
(Subject to the Privacy Act of 1974)

d/Section: EMT

ESTING PHYSICIAN: [redacted] (b)(6)-2

ST, FIRST, M [redacted] b)(6)-4

DATE 4JUL03

TIME 2015

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

(Hematology)

EST	RESULT	REF. RANGE
WBC	17.9	4.8-10.8 x 10^3
RB	6.17	4.7-6.1 x 10^9
Hgb	16.5	14-18 g/dl (M) 12-16 g/dl (F)
Hct	54.2	42-52% (M) 37-47% (F)
MCV	87.8	80-94 fl (M) 81-99 fl (F)
PLT	447	130-500 x 10^3 verified
ph %	16.9	20.5-51.1%

Hematology) Manual Differential

s		Mono	
ds		Eos	
ph		Baso	
p		Imm	
ph			

n atocrit		42-52% (M) 37-47% (F)
Rate		
er		

Coagulation Studies

ST	RESULT	REF. RANGE
		9.8-13.6 secs
T		21-34 secs
imer		<20 ug/ml
		<10 ug/ml

(Urinalysis)

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

MARKS: [redacted] (b)(6)-2

PORTED B [redacted] DATE: LAB ID NO.:

MEDCOM - 12483

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

ATIENT IDE[redacted]ICATION

[redacted] (b)(6)-4

URSING UNIT | ROOM NO. | BED NO.

ATIENT IDENTIFICATION

[redacted] (b)(6)-4

URSING UNIT | ROOM NO. | BED NO.

ATIENT IDENTIFICATION

[redacted] (b)(6)-4

URSING UNIT | ROOM NO. | BED NO.

ATIENT IDENTIFICATION

URSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 1 Jul 03 TIME OF ORDER ______ HOURS | LIST TI ORDE NOTED A SIGN

✓ Admit = ICW
✓ Dx = Head Lac / Trauma
✓ Cond: stable EPW Agressive
✓ VS = q shift
✓ All = PCN
✓ Act = Restraints c̄ BRP
✓ Nursing = Wound care

DATE OF ORDER TIME OF ORDER HOURS

✓ Diet = NPO until 2 July AM Reg
✓ IV = HL/Saline Lock
✓ Labs = 0
✓ Specials = On call for Head CT [illegible] [redacted]
✓ Meds = MSO4 2-5mg IVP q2° PRN pain
✓ Versed 2-4mg IVP q2° PRN aggitation.
✓ Keflex 250mg i po QID
✓ Transfer to ICW when bed is av[redacted] / wynr

DATE OF ORDER Noted [redacted] 2349 HOURS (b)(6)-2
24°CC @ 1240 [redacted] c̄ noted S[redacted]

July 2 1045

✓ Motrin 800mg i po q8° PRN pain.
✓ Transfer to ICW, Same above orders
✓ D/c Versed ; D/c IV
✓ D/c MSO4
✓ T#3 ii po q4° PRN pain.
✓ D/c to EPW CAMP when ready [redacted]

DATE OF ORDER Noted [redacted] Orders noted
24°CC @ 2340 2 July 03 Orders noted S[redacted] HOURS
(b)(6)-2

CLINICAL RECORD

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

Mo. ____ *Yr.* 2003

VERIFY BY INITIALING — *INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION*

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 1	2	3											
1 July 03	[redacted]	VS q Shift	05	/	[redacted]	[redacted]											
			17	[redacted]	[redacted]												
b)(6)-2 1 July 03	[redacted]	Act: restraints c BRP	05	[redacted]	[redacted]	[redacted]		(b)(6)-2									
			17	[redacted]	[redacted]												
1 July 03	[redacted]	Nursing: wound care	05	[redacted]	[redacted]	[redacted]											
			17	[redacted]	[redacted]												
1 July 03	[redacted]	NPO until 2 July AM	05	[redacted]	[redacted]	[redacted]											
		then Reg diet	1	[redacted]	[redacted]												

ALLERGIES: ☑ YES ☐ NO
PCN

PRIMARY DIAGNOSIS: Head lac/trauma

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
PAGE NO: ______

PATIENT IDENTIFICATION:
~~Head lac/trauma~~ err

(b)(6)-4 [redacted]

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 EDITION OF 1 DEC 77 MAY BE USED. USAPA V1.00

MEDCOM - 12485

THERAPEUTIC DOCUMENTATION CARE PLAN

(NON-MEDICATION)

Mo ______ *Yr* 2003

(b)(6)-2

(b)(6)-

Verify by Initialing: Order Date	Verify by Initialing: Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
1Jul03	[redacted]	Admit ICU #2	1Jul03	2300	2300	[redacted]
1Jul03		Cond is Stable EPW aggressive	1Jul03	2300	2300	
2Jul03		Transfer to BCW when available	[illegible]			
2Jul03	[redacted]	DC to EPW Camp when ready				
2Jul03		DC IV				

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													

USAPA V1.00

MEDCOM - 12486

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

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

(b)(6)-2

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED													
				1	2	3											
1 July 03	[redacted]	Keflex 250mg i po QID	06	/ [redacted]	[redacted]	[redacted]											
			12	/ [redacted]													
			18	/ [redacted]			(b)(6)-2										
			24	[redacted]													
1 July 03	[redacted]	IV HL/Saline Lock	05	/			DCd										
		Ⓛ ~~Ac~~ JR ~~466~~ 14G.	17	[redacted]													

ALLERGIES: ☑ YES ☐ NO

PCN

PRIMARY DIAGNOSIS: head lac/trauma

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

PATIENT IDENTIFICATION:

#[redacted] 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 - 12487

(b)(6)-2

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*					*Mo.* ______ *Yr.* ______
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													
			1 July 03													
1 July 03	[redacted]	Versed 2-4mg IVP q 2°	2300 2.5mg [redacted]	pc	d											
- - - - -	- - - - -	prn assitation														
1 July	[redacted]	MSO4 2-5mg IVP		pcd												
- - - - -	- - - - -	q 2° prn pain														
2 July 03	[redacted]	Motrin 800mg i po q 8°	3 Jul 03 08 [redacted]													
- - - - -	- - - - -	prn pain														
3 July 03	[redacted]	Tylenol #3 ii po q 4°	3 1600 [redacted]													
- - - - -	- - - - -	prn pain	[redacted]													
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															

USAPA V1.00

MEDCOM - 12488

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF

1	2	3	4	5	6
A	1	1	D	1	▨

2. MTF LOCATION *(State or Country Code.)*

7	8
I	Z

3. REGISTER NUMBER (9–15) [redacted]

NAME *(Last, First, Middle Initial)* IPW [redacted] (b)(6)-4

4. PAY GRADE (16, 17)

5. SEX (18): M

6. DATE OF BIRTH *(Y Y Y Y M M D D)* (19–26)

7. AGE AT ADMISSION (27–29): 2 8 y

8. RACE (30): Z

9. ETHNIC BACKGROUND (31): 9

RELIGION unk

10. LENGTH OF SERVICE (32–34)

ETS NA

11. FMP (35, 36): ~~9 9~~ 20

12. SOCIAL SECURITY NUMBER (37–45) [redacted]

ORGANIZATION *(Active Duty Only)* N/A

13. MARITAL STATUS (46): u

HOUR OF ADMISSION 1954

BRANCH / CORPS (b)(6)-4 N/A

14. FLYING STATUS (47–49)

15. BENEFICIARY CATEGORY (50–52): ~~K 7 9~~ ~~K91~~ K78

16. ZIP CODE OF RESIDENCE (53–61)

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

18. MOS (64–70)

19. TRAUMA (71): 9

PREV. ADMISSION YEAR ☐ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION (72): 0

WARD ICU 2

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE *(Include ZIP Code)*

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

NAME AND [redacted] **MEDICAL TREATMENT FACILITY** (b)(2)-2

21. TYPE OF DISPOSITION (73, 74): ~~5 0~~ 1 0

22. MTF TRANSFERRED TO (75–80)

23. DATE OF DISPOSITION *(Y Y M M D D)*

81	82	83	84	85	86
0	3	0	7	0	3

24. CLINIC SVC - ADMITTING

87	88	89	90
A	B	P	A

25. MTF TRANSFERRED FROM (91–96)

26. DATE THIS ADMISSION *(Y Y M M D D)*

97	98	99	100	101	102
0	3	0	7	0	1

27. LOCATION OF OCCURRENCE *(Battle Casualty Only)* (103, 104)

28. MTF OF INITIAL ADMISSION (105–110)

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

FOR LOCAL USE

Dx: Head Laceration / Trauma

Trauma 9 Inj 979

Dx: 8505[illegible]1
959[illegible]1
E995

ADMITTING OFFICER *(Signature, as required)* [redacted]

SIGNATURE OF ADMITTING CLERK [redacted] [redacted] PFC, 91G10

DA FORM 2985, MAR 90 [redacted]

(b)(6)-2

MEDCOM - 12489

INPATIENT TREATMENT RECORD COVER SHEET

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

(b)(6)-4

1. REGISTER NUMBER [redacted]

2. NAME (Last, [redacted] EPW # [redacted] (b)(6)-4

3. GRADE EPW

4. SEX [redacted] AGE M 27

6. RACE —

7. RELIGION —

8. LENGTH OF SVC —

9. ETS —

10. PREVIOUS ADMISSION NO

11. EMP 99

12. SSN [redacted]

13. ORGANIZATION (b)(6)-4

14. WARD ICU

15. FLYING STATUS —

16. DSG —

17. DEPT./BEN K78

18. BRANCH/CORPS —

19. UIC/ZIP —

20. TYPE CASE WIA

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct from ER

22. HOURS OF ADMISSION 2320

23. CLINIC SERVICE AEAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE UNK

25. TYPE DISPOSITION ~~50~~ 24

26. DATE OF DISPOSITION 6 Aug 03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) UNK

27b. TELEPHONE NO. UNK

28. DATE OF THIS ADMISSION 1 July 03

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

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] (b)(2)-2

30. DATE OF INITIAL ADMISSION

32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED

ADMISSION REMARKS

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Dx: GSW to Ⓡ Leg (foot), Ⓡ thumb

35. **Total Days This Facility**

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	1 mth 5 days	1 mth / 5 days

36. **Total Days All Facilites**

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
	[redacted]		[redacted]		

SIGNATURE OF ATTENDING MED[redacted] Dr [redacted]

[redacted] ICAL RECORDS OFFICER

DA FORM 3647, MAY 7[redacted] MEDCOM 12490 TE (b)(6)-2

(b)(6)-2

USAPPC V1.10

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

PERTINENT HISTORY, CHIEF COMPLAINT, AND CONDITION ON ADMISSION *(Enter date of admission)*

27 Y/O IRAQI EPW BROUGHT TO FST FORWARD.
GSW TO (R) LEG 11 DAYS AGO. IN LLE.
C/O PAIN. ALSO (R) THUMB PAD TIP AVULSION.

NO HX [illegible]

∅ MEDS

NKDA 1 PPD

UA/WNL →
CK-97
135 | 101 | 9 / 81
3.7 | 25 | 0.7

PHYSICAL EXAMINATION

IN NAD
HEENT - AT/NC
CHEST - SUTURE (L) CHEST WALL
ABD - BENIGN
EXT - (R) THUMB TIP AVULSION, WELL HEALED
(R) LEG IN CAST

PROGRESS *(Enter date of discharge and final diagnosis)*

(P) I+D IN AM

[redacted]

(b)(6)-2

SIG [redacted]	DATE 13 MAY 03	IDENTIFICATION NO.	ORGANIZATION
P [redacted] or typed or written entries give Name last, first, middle; grade; date; hospital or medical facility)		REGISTER NO.	WARD NO.

[redacted] [redacted]

(b)(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539
GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL
RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
539-108

MEDCOM - 12491

117

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
11 July 03	Ⓢ Pt c/o Ⓡ ankle GSW, says he's received no
2040	antibiotics or care in 10 days. GSW happened 14 days
BP: 122/80	ago. Pt says he can feel bones moving under cast.
P: 96	
T: 99.4	Ⓞ Ⓡ leg cast, stab wound Ⓛ hand.
Osat: 98%	
R: 24	

LOC I
EPW Camp

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)*

[redacted] (b)(6)-4

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record
STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.0

510-112

NSN 7540-00-634-4123

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
7-1-03	2330		Rpt recieved, Patient transfered + ~~settled~~ into bed, Pt A+Ox3,
			Respirations unlabored, Skin CDI, except (R) hand GSW +
			(R) Leg GSW, Cast on (R) Leg, Abd Soft, Non-Tender, Cap
			refill <3sec, IV LR @ 125 cc/hr (L) AC PIV, IV dressing
			CDI, No-Redness [redacted] Pt scheduled for Surgery in
			AM, NPO [redacted] /AN (b)(6)-2
	0810		pt A/O; VSS; wheezing to auscultation; ø s/s
			of respiratory distress; SaO2 >95%; minimal
			cough; piv patent RLE to leg cast; thumb
			wrapped
		(1000)	came in to see pt; pt A/O; no Δ in status
		(1200)	MSO4 for pain to LE
7/2/03		1700	Received pt resting in bed. VSS. Not going to OR today
			ate 75% of dinner. No c/o pain at this time.
			Right toes are black, day shift said docs are
			aware. Right thumb still bandaged [redacted] No
			other issues at this time (b)(6)-2
			0200 - Pt VSS. No c/o pain. Sleeping
7-3-03		0600	Assumed pt care from SG [redacted] pt sleeping @
			change of shift & all VSS. LR infusing @ 125cc/hr
			pt remains NPO d/t scheduled surgery for I/D
			per night shift [redacted] [illegible]
			(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.
EPW # [redacted] (b)(6)-4		

NURSING NOTES
Medical Record

STANDARD FORM 510 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-

MEDCOM - 12493

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
			approx 1800
7.3.03/1600			Pt returned from OR after I&D of (R) thumb
			& (R) leg fx. No complications during surgery.
			All VSS SpO2 93-96% on RA pain mgd well
			c̄ MSO4 IVP & percocet. Dressings C/D/I
			Tolerating clears @ this time [redacted] /LTRN
03 Jul 03 1830			Assessment done ∅ significant Δs from day
			shift. Pt. tol dinner well RLE ↑ for comfort ⇒ cast
			C,D,+I. toes warm/discolored as noted earlier - Staff
			aware (R) thumb dsg C.D.I. HOB ↑ Care plan reinforced
			pain meds side effects, act. level diet. D/c planning,
			P.T./rehab; needs reinforcement. VSS/Afeb. [redacted]
03 Jul 03 2000			Pt. tol po well - drinking milk(s). IV HL &
			(R) D/C'd. Medicated PRN c̄ effect relief
			[redacted] /LPN
04 July 03 0430			Pt. slept most of night. Medicated PRN - (+) results
			tol. po well / VSS & Afeb. [redacted] /LPN
			(b)(6)-2

[redacted]

STANDARD FORM 510 (REV. 7-91) BAC

*U.S. Government Printing Office: 1995 - 404-763/20065

N 7540-00-634-4176 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
30NOV03	Ortho Op Note
	Pre-Op Dx ① Grade III B open Ⓡ
	tib-fib fracture ~ old
	② Traumatic amputation Ⓡ thumb tip
	Post-Op Dx - Same
	Procedure ① I+D Ⓡ leg
	② I+D DPL Ⓡ thumb tip
	Surgeon - [redacted]
	Asst - none EBL 100 : SDD 4x
	Findings - Grade III B open Ⓡ
	tib-fib fracture, unstable.
	Bits of bone, loose, in wound.
	Removed. Thumb tip with
	retained nail fragment, needed
	end of distal phalanx rongeured
	back.
	Plan - Repeat I+D in 48-72 hours,
	consider X-fix vs early
	[redacted]b)(6)-2

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

RECORDS MAINTAINED AT:

PATIENT'S NAME *(Last, First, Middle initial)*

SEX

RELATIONSHIP TO SPONSOR

STATUS

RANK/GRADE

SPONSOR'S NAME

ORGANIZATION

DEPART./SERVICE

SSN/IDENTIFICATION NO.

DATE OF BIRTH

MEDCOM - 12495 F MEDICAL CARE **STANDARD FORM 600** (REV. 5-84)
Prescribed by GSA and ICMR

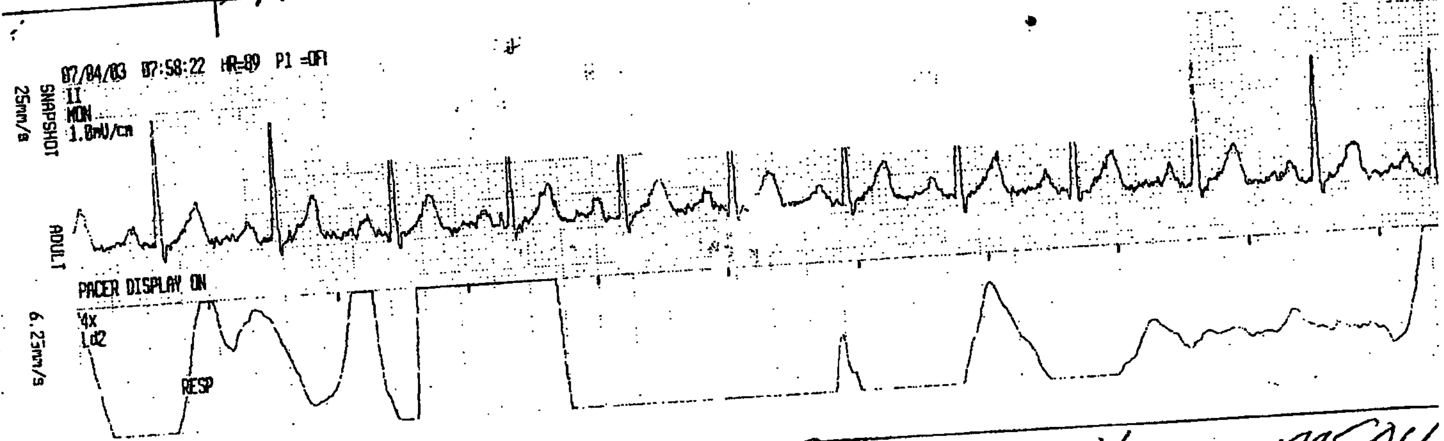
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
6 Jul 03	Ortho Op Note:
	Pre Op Dx: Gustilo IIIB open (R)
	tib-fib fracture s/p GSW
	Post Op Dx: Same
	Procedure: Ex-fix (R) ankle
	I+D (R) ankle
	Surgeon: [redacted] (b)(6)-2
	EBL: min
	Fluids: 700 LR
	Findings - fixed with delta frame construct
	with through calcaneal pin. Position
	acceptable, about 5° excessive valgus.
	Still some purulence from posterior
	wound.
	Plan: IV abx, repeat I+D 8 or 9 Jul
	[redacted]
	(b)(6)-2
	[illegible]
	COL MC

AUTHORIZED FOR LOCAL REPRODUCTION

CHRONOLOGICAL RECORD OF MEDICAL CARE

EDICAL RECORD	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
DATE	
7/4/03	0500 Assumed care. Report given. Pt AAOx3. See ICU-I flowsheet [redacted]
	for initial assessment

(b)(6)-2



7/4/03	0730 c/o pain (R) leg. 4mg MSO4
	IVP.
	0800 Pt ate breakfast s̄ difficulty.
	0840 Dr Granger @ bedside. Orders
	received. [redacted] (b)(6)-2
	0900 Sign placed over bed NPO p̄
	MN. Noted on green sheet. [redacted]
	1000 5mg MSO4 IVP given c/o leg pain
	1330 Pt use wet ones to wash
	body. Neurovascular remains intact.
	1430 VSS. No distress noted @ this time

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	
		REGISTER NO.	WARD NO.

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

EPW [redacted] (b)(6)-4

11 Jul 03

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 - 12497

All (b)(6)-4 except where noted.

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
4 July 03	Received pt from Op[redacted] VSS. C/o pain 5mg MSO4 given. Pt
	assessment done. Pt c/o itching. Gave 50 mg Benadryl IV per Sg
	doctors orders. Pt resting now. Will continue to monitor.
	0200 - Pt sleeping. C/o pain 5mg MSO4 given —— S[redacted]
	0400 - Pt sleeping. Tried to have BM but couldn't. No
	other issues at this time —— SSG [redacted] (b)(6)-2
	(b)(6)-2
05 July 03	Rc'd pt from [redacted]. VSS Afebrile, pt sleeping. [redacted]
	0630 Pt attempted to make bowel movement Ø
	0800 Prepare patient for OR [redacted]
	0900 DC IV (L) HC, site red + infused, start (R) Amp 20 G [redacted]
	1600 Pt no C/o pain, still awaiting to go to OR[redacted]
4 July 03 1700	Assumed care @ 1700. VSS - pt sitting up in bed eating
	dinner. ~~Ass~~ Assessment done. will continue to monitor.
	[redacted] CPT/AN
6 July 03	Recovery, Ex fix (R) ankle Gen ET, 700 LR, UBL-m, Ø UOP, 250m Fent 10mg MSO4
	0815 BP 134/67 P 102, RR 15, T 95.3 Sats 99%
	0820 146/87 105 13 97%
	0825 143/86 98 14 98%
	0840 149/83 93 12 98.1
	0855 144/71 96 14
	0920 136/81 98 10

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.

[redacted] (b)(6)-4

MEDCOM - 12498

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

All (b)(6)-2 except where noted.

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
6 July 03	0815 Pt back from OR, Brown/Black hardened digits in
	right foot, External fixator placed to Ⓡ ankle
	no c/o pain at this time, pt can move toes on
	command.
6 July 03	Assumed care. VSS - Assessment done. see
1720	Assessment sheet. 5mg MSO4 given for
	pain. will continue to monitor [redacted] CPT/AN
0001	VSS pt remains stable. Assessment
7 July 03	unchanged from earlier. pt c̄ min
	complaints of pain x 2 since shift
	Δ. wiggles toes and has + dorsalis
	pedis pulse b/l Lower extremities.
	A-febrile will continue to monitor.
	[redacted] CPT/AN
7 July	Assumed care, No changes from 6 July will [redacted]
0600	to monitor assessment in flow sheet VSS A-
1600	Pt remains stable nothing different from prior Shift
1600	Pt discharged to EPW Camp, escorted by MP. Discharge planning,
	X-rays, & medications in possession. [redacted]

OSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
PONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

ATIENT'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.

EPW # [redacted] (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

MEDCOM - 12499

(b)(6)-2 except where noted.

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
7 July	1700 · Received pt resting in bed. No c/o pain. Ate [redacted]
	100% of dinner. VSS. No other issues at this time — Sgt
	1800 - Pt given basin & soap pt gave himself a [redacted]
	bed bath. Pt now smells good — Sgt [redacted]
	0200 - Pt's IV's are infiltrated. Removed [redacted]
	both & placed another 18G in L Hand - Sgt
	0400 - Pt VSS. No c/o pain. Resting in bed — Sgt [redacted]
	0420 - Pt vomiting up yellow fluid — Sgt [redacted]
8 July	0530 Received report from Sgt [redacted], Pt resting
	quietly in bed. Sleeping s̄ s/s distress. Assessment
	performed see ICU-1 flowsheet. New IV started
	(L) forearm 22g. (R) hand IV removed, nonpatent fluids
	would not run. — [redacted]
	0800 Pt up to Bedside commode - defecated a
	moderate amt of stool. Pt now up in chair. Will
	continue to monitor — [redacted]
	0920 Pt received ii Percocet c̄ 3mg MSO4 for control
	of pain — [redacted]
	1100 - Pt's (R) [redacted] ex-fix, old DRSG removed, site cleansed c̄
	1/2 peroxide/1/2 sterile saline, Pedal pulse palpable, necroses
	noted on toes of pt. Dr informed. medicated c̄ 6mg
	MSO4 while DRSG Δ performed. Pt tolerated well - [redacted]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MA
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.

[redacted] (b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

MEDCOM - 12500

STANDARD FORM 600 (REV. 6-97)
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MEDICAL RECORD | **PROGRESS NOTES** | AUTHORIZED FOR LOCAL REPRODUCTION

DATE	NOTES
8 July 03	1220 Pt. ate 75% of lunch tray. Pt back to bed, resting quietly — [redacted]
	1540 Pt resting ̄s co pain — [redacted]
9 July 03 @	1866 Rpt recieved Physical assessment completed + recorded on Flowsheet, [redacted] CPT/AN —
0340 ~~03~~ 9 July 03	Pt. had UOP of 570CC — [redacted]
0419 9 July 03.	Pt had UOP of 300CC — [redacted]
9 Jul 03 0845	Ortho Op Note.
	Pre Op Dx - Open distal (L) tibia fracture
	Post Op Dx - Same
	Procedure: I+D, [illegible] wound
	Surgeon: [redacted] b6-2
	Anes - [illegible]
	[illegible] - [illegible] [illegible]
	Findings: Wound clean. [illegible] [illegible]
	Plan: [illegible] [illegible] to [illegible] dressing change.

[redacted]

LATIONSHIP TO SPONSOR | SPONSOR'S NAME LAST | FIRST | BER

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

ENT'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. ICU I

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

MEDCOM - 12501

(b)(6)-2 except where noted

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
EPW [redacted] (b)(6)-4			

DATE	NOTES
9 July 03	RC'd Pt lying in bed sleeping. No c/o pain @ this time VS q 4°, status unchanged, condition stable, will cont to monitor, prep for HP in OR this AM. [redacted]
	1600. Pt OOB this shift tolerated very well moved 80% by himself. Pt seems to be Hallucinating x 2 episodes since returning from OR this AM. MAJ Greenly aware + will contact DR. NO other issues NO c/o pain at this time
1930 09 JUL 03	USS - PT was Halucinating yelling for his mother stated that he saw his mother walk out of ward. Haldol 5mg IV given. Resting quietly @ present time. Refused to eat dinner. Drank 100cc of H2O. Restraints to UE in place and secure. will continue to monitor. —SGT [redacted]
0200 ~~09~~ 10 Jul	Ø further hallucinations noted. Resting quietly c̄ eyes closed. IV of LR TKO. Is patent Ø s/s of infiltration USS. will continue to monitor. —SG [redacted]
0430 10 JUL 03	USS - Resting quietly c̄ eyes closed. Ø hallucinations noted. Restraints to UE in place and secure. —S [redacted]
10 July 03	Pt USS. Afebrile throughout shift. No c/o pain, pt OOB @ 1430 to bedside commode [redacted] 1 BM Ⓜ solid stool.
1530	R'd Dsg + did pin care to Ⓡ Ankle x-fix. No c/o pain no issues @ this time
1700	Pt received from Sgt [redacted] VSS. Assist pt OOB to BSC changed dressings, did pin care, pt back in bed [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK
USAPA V1.0C

EPI [redacted] (b)(6)-4

MEDCOM - 12502

All (b)(6)-2 except where noted.

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10 July 1700	Received pt resting in bed. No c/o pain VSS. A+O x3.
	Assessment done. No issues at this time — [redacted] LPN
	2015 - Pt OOB to chair. Tolerated fine. Dressings changed
	and pin care done. Pins look clean. Pt c/o dizziness and
	SOB, took vitals - VSS. Pt reassured, dizziness + SOB
	went away — [redacted] PN
	2050 - Pt liner changed. Pt put back in bed [redacted] LPN
	0200 - No changes in assessment. VSS. No c/o pain
	Sleeping through night — [redacted] PN
	0400 - Pt still sleeping. No c/o pain — [redacted]
11 July	0500 Received report from [redacted] Pt, resting quietly
	in bed. No c/o pain, VSS, AOx3. Assessment performed.
	Will continue to monitor — [redacted]
	0900 Pt. out of bed, sitting in chair, Tolerating well
	no c/o pain — [redacted]
11 July 03	Received pt from [redacted] No c/o pain Assessment
1700	done. Got pt OOB to chair. Changed dressings, did
	pin care. All pins are clean. — [redacted] LPN
2000	Pt. OOB to BSC. One bowel movement — [redacted]
2400	Pt sleeping VSS. No c/o pain — [redacted]
0400	Pt slept through the night. No c/o pain — [redacted]
☆	Changed IV site at 2200 — [redacted]

HOSPITAL OR MEDICAL FACILITY | STATUS | DEPART./SERVICE | RECOR[redacted]

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.

[redacted] (b)(6)-4

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

MEDCOM - 12503

All (b)(6)-2 except where noted

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
12/Jul/03/	0500 Assumed care. Report given
	See ICU-2 flow sheet for initial
	Assessment —— [redacted]
	0630 OOB to chair ē min Assistance
	needed. —— [redacted]
	0850 Rtn back to bed, ē assist
	1130 AM care given. Linens Δed
	1355 Drsg Δed. Area cleansed
	tolerated well. —— [redacted]
	1530 formed brown stool / in [illegible]
	chair —— [redacted]
13 July 03	0600 Received report. Pt resting quietly in
	bed, no c/o pain. VSS. Spoke ē MD about IV antibiotic
	Gentamycin 400mg x 2 weeks. Will continue to monitor.
	—— [redacted]
	0810 Pt. c/o pain in Ⓡ LL area, ṫṫ Tylenol given,
	Pt. up to side of bed, eating. Will continue
	to monitor —— [redacted]
	0830 Pt. ate 100% of breakfast tray —— [redacted]
	1230 Pt ate 75% of dinner tray, Pin care provided.
	Cleansed ē ½ peroxide/½ sterile water Left open to air.
	Ⓡ thumb cleaned & redressed —— [redacted]

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.

12/Jul/03 [redacted] (b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
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MEDCOM - 12504

(b)(6)(2)

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
14 July 03	pt remains stable. VSS. Resting well s̄ complaint.
0100	tol dinner and performed pin care himself.
	p̄ instruction from SPC [redacted] pt demonstrated
	proper tecnique and tol procedure well. Ø
	c/o pain. will continue to monitor. [redacted] CPT/AN
0130	Assessment unchanged from earlier. (R) Lower
	extremity 2+ pulses DP + PT. can wiggle toes
	and has good sensation. will continue to
	monitor. [redacted] CPT/AN

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.

EPW
[redacted] (b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
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MEDCOM - 12505

All (b)(6)-2 except where noted

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
14Jul03 0730	Rec'd pt lying in bed, Report given from CPT [redacted] Pt
	stable VSS/A see flow sheet for assessment. [redacted]
0800	Pt ate all of meal, NO c/o pain. Pins show NO S/S
	infection. Will continue to monitor [redacted]
0900	Pt OOB ambulating w/crutches for approx 15
	minutes, tolerated very well.
1300	Pin care/wound care c mostly pt assist. NO S/S
	of infection [redacted]
1400	Pt OOB to chair
1600	Pt Back to Bed [redacted]
1800 14Jul03	VSS - Alert x3 - Ø c/o pain or discomfort @ present.
	TOL reg diet. Ate 100% of supper. sitting up in bed @ present
	Sgt [redacted] 91C20
1745 14Jul03	Pin care done to Ⓡ lower extremity. Ø Reddness or drainage.
	cleansed c sterile H_2O_2. OA to back of Ⓡ foot dress wet today.
	small amt of bloody drainage noted. covered c 2x2. Percocet ii PO
	given @ 1900 for c/o Ⓡ leg pain. sitting up in chair @
	present time. Sgt [redacted] 91C20
0400 15Jul03	VSS - Ø c/o pain or discomfort @ present time. Rested
	quietly all noc. Sgt [redacted] 91C20
15Jul03 0800	Assumed care of pt. coherent/cooperative. Ext. Fix. to Ⓡ lower
	leg intact. ⊕ pedal pulses of both extremities. Dsg to Ⓡ lower leg CDI,

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* [redacted] *Name - last, first, middle; ID No or SSN; Sex;*

REGISTER NO. | WARD NO.

[redacted]

(b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
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MEDCOM - 12506

All (b)(6)-2 except where noted

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	wet to dry. Ø c/o pn @ this time. Pt. sitting up in bed, Ø distress noted. [redacted]
JUL 0900	Pt. c/o Ⓡ lower leg pn. Ī percocet po given. Will continue to monitor [redacted]
15 JUL 1130	Pt. tolerated lunch well. 30 min. later OOB to chair c̄ Ⓡ extremity elevated. Ø c/o pn. [redacted]
15 JUL 1430	Pt. ambulated c̄ crutches for approx. 10 min. Currently resting quietly in bed. Will continue to monitor. [redacted]
15 JUL 1700	Pt. had x1 BM via bedside commode. Pt. eating dinner. Ø c/o pn. Will brief oncoming shift. [redacted]
15 JUL 03 2020	pt. transferred from ICW1 to ICW2 @ ~ 1845 ambulatory c̄ crutches in stable condition - VSS - no c/o pain - Ⓡ ankle ex fix intact, dsg CDI on inner aspect of Ⓡ ankle, stitches intact on lower Ⓡ shin - lungs CTA Ⓑ - ⊕ BS - ⊕ 2 peripheral pulses x 4 extremeties - Ⓡ toes 2nd 3rd & 5th c̄ healing burns - pt. did own pin-care c̄ 1/2 strength H_2O_2 - medicated for pain c̄ 650 mg tylenol PO - ⊕ IV access [redacted] R+AN

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.)*

EPW # [redacted] (b)(6)-4

REGISTER NO.

WARD NO. ~~ICW1~~ ICW2

CHRONOLOGICAL RECORD OF MEDICAL CARE

Medical Record

STANDARD FORM 600 (REV. 6-97)
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MEDCOM - 12507

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:AL RECORD | PROGRESS NOTES

:E | NOTES

16Jul03 22:25 Rec'd c/o pt @ 21:00. Awake and alert in bed. Restraints x2 Ⓡ wrist Ⓛ Ankle. Perrla ⊕ WNL. Skin color WNL. LCA Ⓑ BS ⊕ x4. ⊕ PPP Ⓑ. Ⓡ ↓ ext. ex fix in place. pin sites Ø sxs infection. Ⓡ foot ⊕ ROM ⊕ sensation ⊕ PP ⊕ <3sec cap. refill. Skin to Ⓡ foot remains dry cracking black in some areas on toes. C/o pain x1. ii Percocet given. Will cont. to mon [redacted] AN

0640 Pt. care assumed @ 0500. Pt. febrile @ 100.4. Pt tach @ 110, diaphoretic. 650mg Tylenol given PO. HR c̄ S_1, S_2. Lungs CTA, BS ⊕ x4. Ex-fix to Ⓡ ankle intact. Pinsites CTA, Ø drainage noted. Ⓡ leg ↑. Ⓡ ft skin dry, cracking in places, toenails black. Pulse 2+, toes warm. will cont. to monitor. [redacted] RN

17Jul03 1335 assumed care @1300 - VSS - no c/o pain @ this time - neuro ✓'s WNL for Ⓡ foot - pin sites for Ⓡ ankle ex fix s̄ s/s infection, dsg CDI on inner aspect of Ⓡ ankle - [redacted]

17JUL03 22:18 Rec'd c/o pt @ 21:00. VS WNL Per flow sheet. Awake and alert in bed. Perrla ⊕ WNL. Skin color WNL. LCA Ⓑ. BS ⊕ x4 ⊕ PPP Ⓑ. Ⓡ ↓ ext. ex. fix in place. Pin sites and sutures Ø sxs infection. ⊕ sensation ⊕ ROM ⊕ <3sec cap refill to digits.

:SHIP TO SPONSOR	SPONSOR'S NAME LAST	FIRST	MI	SPONSOR'S ID (SSN or Other)
SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		

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.

EPW [redacted] (b)(6)-4

PROGRESS NOTES
Medical Record
STANDARD FORM 509
Prescribed by GSA/ICMR FPMR (41CFR) 101

(b)(6)-2

TI NOTES

15JUL08 2045 Rec'd c/o pt @ 21:00. VS WNL per flowsheet. Skin color WNL PERRLA⊕WNL. LCAⒷ. BS⊕x4. ⊕PPPⒷ. Ⓡ ext. fix to ankle intact. ø s&s infection @ pin site. Sutures intact. DSD C/D/I. c/o pain x1. i Percocet given. Will cont to mon [redacted]

0530 Pt. care assumed @ 0500. Pt. c/o pain to ⓇLE. i Percocet given P.O. HR Reg, lungs CTA. BS⊕x4. Ⓡ ex fix to ankle intact. Pinsites OTA, s̄ s/s infection. Drsng to Ⓡ ft C/D, will Δ c̄ pin-care. Ⓡ ft c̄ pedal pulse 2+, ⊕ROM, ⊕sensation metatarsals. Cap refill to Ⓡ ft < 3sec. Toenails Ⓡ ft thickened, black in color, c̄ skin peeling dorsal surface Ⓡ ft. Will cont. to moniter. [redacted]

0640 Pt. assisted c̄ pincare using 50% H_2O_2/50% SW. ø drainage noted @ pinsites. Ⓡ ft soaked & cleaned and lotion applied. Dsng to Ⓡ ankle Δ'd & is CDI. Will cont to monitor

1020 Pt OOB → chair, restrained [redacted]

1345 Assumed care of Pt @ 1300. VSS. A+Ox3. Pain controlled c̄ po tylenol. Ⓑ BS CTA ⊕BSx4. Ⓡ LE EX-FIX CDI. ⊕sensation palpable pulse, cap refil <3sec, mvt toes Ⓡ foot. Drsg to Ⓡ lower calf CDI. O/W assessment WNL. Will cont. to monitor [redacted]

All (b)(6)-2 except where noted

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IEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
cont'd.	c/o feeling cold and was shivering. Temp 99.0. c/o pain
	ii Percocet given
0700	. Pt. care assumed @ 0500. Pt. sleeping, arouses to
	verbal stimuli. Pt. febrile @ 100.9. 650mg Tylenol
	given PO. VS otherwise stable. HR Reg. lungs CTA, BS⊕x4
	skin hot to touch. Ex-fix to Ⓡ ankle intact. pin sites
	CTA, s̄ drainage. Ⓡ ft slightly edematous c̄ ⊕ warm,
	⊕ sensation toes c̄ pulse 2+. Skin to rt ft. peeling,
	dry. Will cont. to monitor. —— [redacted]
1400	Assumed care of Pt @ 1300. VSS. A+Ox3. Ø c/o pain.
	Ⓛ LE EXFIX intact. lower Ⓛ calf dsg CDI. ⊕ palpable
	pulse, mvt of toes, cap refil <3sec Sensation. Pin care
	done on pt with H_2O_2. O/W assessment WNL. [redacted]
	[redacted] for [redacted]
18 Jul 23:06	Rec'd c/o pt @ 21:00. VS WNL per flow sheet Restraints
	x2 Ⓡ wrist Ⓛ ankle skin color WNL. LCA Ⓑ. BS⊕x4 ⊕PPPⒷ
	Ⓡ l.ext. ex fix to ankle intact. pins s̄ sxs infection.
	DSD applied to sutures C/D/I. Top of foot and toes remain
	Pink and black to 2nd toe. Able to move digits. ⊕ sensation
	⊕ <3sec blanching to skin on digits c/o pain to top
	of foot. ii Tylenol given. Will cont to mon [redacted]

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SPONSOR'S NAME
LAST
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RVICE
HOSPITAL OR MEDICAL FACILITY
RECORDS MAINTAINED AT

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

#[redacted] (b)(6)-4

REGISTER NO.
WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (R
Prescribed by GSA/ICMR FPMR (41 CFR) 101-1

(b)(6)-2

	FIRST NAME	MIDDLE INITIAL	ID NUMBER

TE	NOTES
7·19·03 0730	Pt care assumed @ 0500. VSS. HR Reg, lungs CTA, BS ⊕ x4. Ø pain. Ex-fix to Ⓡ ankle intact. Pin sites OTA s̄ s/s infection. Ⓡ ft c̄ pulse 2+, ⊕ sensation, ⊕ ROM, cap refill <3 sec. Will cont to moniter. [redacted]
1330	Assumed care Pt @ 1300. VSS. A+O x3. Ø c/o pain. Ⓡ ankle EX FIX CDI. Dsg to lower Ⓡ leg CDI. ⊕ sensation, cap refil <3 sec, mvt toes Ⓡ foot. Pt does [illegible] Ø si/sx of infection. O/W assessment WNL. Will cont. Monitor [redacted]
19 July 03	2155 Assume pt care @ 2100. pt awake and alert. OOB to chair c̄ Ⓡ leg elevated. VSS. HR reg Lungs CTA. Abd soft non tender non distended BSx4. Ⓡ thumb stitches intact no signs of infection OTA. Ⓡ LE ex-fix intact dsg CD+I. pt c/o pain to top and bottom of foot. Will give pain meds as ordered. [redacted]
20 July 03	0800 - Pt alert sitting up upright in bed eating breakfast. VSS, lungs CTA, BS⊕. Ext fix intact to Ⓡ leg. Ⓡ foot c̄ edema. Pulse ⊕, able to wiggle toes. Skin warm to touch. Will cont to monitor [redacted]
1320	Assumed care of Pt @ 1300. VSS. A+O x3. Ø c/o pain. Ⓛ LE ankle EX FIX CDI. Ø si/sx infection @ pin site. ⊕ palapable pulse, cap refil <3 sec, mvt toes, sensation. Ⓡ foot ⊕ edema to foot O/W assess WNL. Will Monitor [redacted]

(b)(6)-2

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
21 JUL 03 0042	Rec'd c/o pt @ 21:00. VS WNL per flowsheet. Restraints x2 (L) ankle (R) wrist. PERRLA (+) WNL. LOC(B). BS(+)x4. (+)PPP(B) c/o pain x2 to (R) ↓ ext. ii Tylenol given s̄ relief. i percocet given for pain. (R) ↓ ext ex fix intact. (R) foot to mid-calf warm to touch and warmer than superior to ex-fix. (R) foot darker in color than (L) foot. Skin and toenails remain thich and black and pink. ~~white~~ circ (+) sensation (+) ROM (+) <3 sec. cap refill. Ex fix pins s̄ sxs infection. Will cont. to mon [redacted] 2LT/AN
0900	Pt. care assumed @ 0500. VSS. HR Reg, lungs CTA, BS(+)x4. Ex-Fix to (R) LE intact. Pin sites s̄ s/s infection. (R) foot edematous, warm to palpation. Pulse 2+. (+) sensation, (+) Rom. Will cont. to monitor. [redacted] CPT/AN
1325	assumed care @ 1300. VSS. A+O x3. Ø c/o pain (R) LE EX FIX CDI, pins OTA Ø si/sx of infection, (+) palpable pulse, cap refil <3 sec, mvt toes, sensation (R) foot. [redacted] on crutches s̄ assistance. Ø IV Acces. (+) 1 Edema (L) foot O/all assessment WNL. Will monitor [redacted]
21 July 2125	Pt care assumed @ 2100. Pt awake and alert s̄ c/o pain, Lung sounds CTA, pulses palpable x4, bs(+)x4 quads, Ex fix on r/e intact, insertion site is clean c̄ no drainage, Pt c̄ (+) pulse and sensation in (R) foot. RUE c̄ (+) pulse and sensation, wound c̄ sutures on (R) thumb CDI. Will continue to monitor. [redacted] 9lum
22 July 03	0610 Assume pt care @ 0500. Pt Awake and Alert. c/o pain to (R) Foot. Will give meds as ordered. VSS. HR reg. Lungs CTA. Abd soft BSx4 (cont) [redacted]

All (b)(6)-2 except where noted

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
22July03	0610 (cont) Ex-Fix to Ⓡ LE intact. Sm dsg CD+I ⊕ pulse ⊕ movement below ex-fix. Will continue to monitor —— [redacted] lkMc
22Jul03 2030	assumed care @1300 - VSS - medicated c̄ 650mg tylenol PO c̄ good results @1700 - neuro checks WNL in Ⓡ foot, pt. removed dsg on Ⓡ ankle, wound dry and healing - pt. to do pin care —— [redacted] n, A
22Jul03 23:03	Rec'd c/o pt @21:00. VS WNL per flowsheet. Restraints x2 Ⓡ wrist Ⓛ ankle. PERRLA ⊕ WNL. Skin color WNL LCA Ⓑ. ⊕ BS x4. Ⓡ thumb sutures intact. Ⓡ ↓ ext. ex-fix intact. Pin sites s̄ s/s infection. Sutures OTA. Ⓡ foot remains slightly darker in appearance than Ⓛ foot ⊕ PPP Ⓑ. c/o pain x1 650mg Tylenol given. Will cont to mon. [redacted] RN
23Jul	Assumed care of pt @ 0500. Pt was asleep. VSS. Lungs CTA. Bowel sounds x4 quads. Ext. fix on Ⓡ leg. Pins intact. Pt did his own pin care. ∅ c/o pain/discomfort - [redacted] SGT

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. 1 CW2

EPW

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

All (b)(6)-2 except where noted

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
23 July 03 1400	Assumed pt care @ 1300. VSS. pt awake & alert. Lungs CTA, abd soft nontender. BS ⊕ x4 quads. Ⓡ leg c̄ ext fix, OTA Ø S/Sx of infection noted, ⊕ pulse Ⓛ leg c̄ full ROM ⊕ pulse. BUE c̄ full ROM ⊕ pulses. Ø IV access noted. Ø c/o pain/discomfort voiced @ this time. Will cont to monitor – [redacted]
23 Jul 03 23:03	Rec'd c/o pt @ 21:00. Restraints x2 Ⓡ wrist Ⓛ Ankle, VS WNL per flow sheet. Awake/alert in bed. Perrla [illegible]. Skin C/D/I LCA(B). BS ⊕ x4. Ⓡ ex. fix. intact. pins s̄ s/s infection @ insertion site. Ⓡ foot +1 edema c̄ pitting. digits remain black 1st and 2nd toes. Suture to Ⓡ thumb intact c/o pain x1 ii tylenol given. Will cont. to mon [redacted] DLT/AN
24 July 03	0545 pt care assumed @ 0500. pt Awake and Alert. VSS. HR reg. Lungs CTA. Abd soft BS x4 RLE ex-fix intact. ⊕ movement ⊕ sensation below pins. Suture to Ⓡ thumb intact. No c/o pain @ this time. Will continue to monitor [redacted]
24 Jul 03 1510	Assumed care @ 1300 – VSS – medicated c̄ 650mg tylenol PO for pain – ⊕ 2 pedal pulse ⊕ movement & sensation in Ⓡ toes – [redacted]

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. 5CW2

#[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
24Jul03	Rec'd c/o pt @ 21:00. VS WNL per flowsheet. Restraints x2
2320	Ⓡ wrist Ⓛ ankle. Skin W/D. LCA Ⓑ BS⊕ x4. ⊕ PPP Ⓑ. Ⓡ LE
	ex fix in place s̄ sxs infection @ pin sites. c/o pain x1
	ī Tylenol ī Percocet given will cont. to mon[redacted]
25July03	1120 - Pt alert sitting upright in bed c̄ Ⓡ leg
	elevated. Ext fix intact to Ⓡ leg. Tylenol given
	for pain. VSS, lungs CTA, HR reg, BS⊕. ~~Will~~ err [redacted]
	Pulses ⊖ & strong bilat to ↑ & ↓ extremities. Able
	to wiggle Ⓡ ft toes, ⊕ sensation, le[illegible]
	to touch. Will cont to monitor - [redacted]
25Jul03	assumed care @ 1330 - VSS - medicated c̄
1830	650 mg tylenol PO @ 1800 c̄ good results - neuro
	V'S WNL in Ⓡ foot, foot becomes dark purple
	when pt. stands c̄ crutches, ⊕2 pedal pulse
	@ all times - pt. did own pin care, demonstrated
	correct technique ~~and~~ - [redacted] RN
25Jul03	Rec'd c/o pt. @ 21:00. Restraints x 2 Ⓡ wrist/Ⓛ ankle. VS WNL
22:04	per flow sheet. Pt. awake and alert in bed. Skin W/D. PERRLA ⊕.
	LCA Ⓑ BS⊕ x4. ⊕ PPP Ⓑ. Ⓡ thumb sutures intact. ø sxs infection.
	Ⓡ ↓ ext. ex-fix intact pin sites s̄ sxs infection. Digits ⊕ ROM,
	⊕ sensation, ⊕ < 3sec cap refill. c/o pain x1 to bottom of foot. ī
	tylenol ī Percocet given. Will cont. to mon[redacted] /AW

All (b)(6)-2 except where noted

MEDICAL RECORD | **PROGRESS NOTES**

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NOTES

26 July03 0521- Pt alert this am sitting upright in bed. VSS, lungs CTA, HR reg, BS⊕. Ext fix intact to Ⓡ lower leg. Some edema noted to foot. Able to wiggle toes, ⊕ sensation, pulse ⊕, skin warm to touch. Voicing ⊘ complaints at this time. Will cont to monitor —— [redacted]

16Jul03 1420 assumed care @ 1300 - VSS - no c/o pain @ this time - pt. clipping toe nails - wound on Ⓡ leg healed, edges closed, ⊕ 2 pedal pulse in Ⓡ toes, pt. has ⊕ cap ref. & ⊕ sensation in Ⓡ toes — [redacted]

26Jul03 21:55 Rec'd c/o pt @ 21:00. Restraints x 2 Ⓛ wrist/Ⓛ ankle. VS WNL per flowsheet. Pt awake and alert in bed. Skin W/D. PERRLA ⊕ WNL. LCA Ⓑ. BS⊕ x 4. ⊕ PPP Ⓑ. Skin color to Ⓡ foot remains discolored compared to mid-calf skin color. Ⓡ ex-fix in place. pinsites C/D s̄ sxs infection. sutures intact to wounds on inner and outter aspect of Ⓡ ankle ⊕ ROM/limited ⊕ sensation ⊕ cap refill to Ⓡ foot digits ⊕ & pitting edema +1 Ⓡ foot/Ankle ⊘ c/o pain @ this time will cont. to mon. [redacted] AJ/AN —— b(6)-2

Addendum Sutures to Ⓡ thumb C/D/I ⊘ s/s infection will mo[redacted] /AN

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

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. TEWZ

b(6)-4

E.P [redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509

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MEDCOM - 12516

MEDICAL RECORD | **PROGRESS NOTES**

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NOTES

27July03 0630 Pt. awake & alert sitting up in bed eating breakfast. HR Regular, Lung sounds clear bilat, bowel sounds (+) x 4 quads. Ⓡ LE elevated on folded blanket, pedal pulse palpable, (+) sensation. Skin below Ⓡ ankle reddened c̄ mild edema, cap refill unable to assess due to fungus on toenails, sutures on dorsal side of Ⓡ foot intact s̄ s/s of infection. Pt. s̄ complaints @ this time. All other assessment findings WNL. Pt. s̄ IV access. Will continue to monitor. [redacted] /AN

27Jul03 1625 assumed care @ 1300 - VSS - neuro V'S WNL in Ⓡ foot, wounds healed - Tylenol #3 ordered for pain, percocet will no longer be used as pt. reports it is not effective for pain - no c/o pain @ this time [redacted] AN

27Jul03 2349 Rec'd c/o pt @ 21:20. Restraints x2 Ⓛ wrist Ⓛ ankle VS WNL per flow sheet. Awake and alert in bed. Skin W/D. ICA Ⓑ. BS ⊕ x4. ⊕ PPP Ⓑ Ⓡ LE c̄ ex. fix intact. pin insertion sites s̄ s/s infection. Sutures to outter and inner aspect of ankle C/D/I OTA. Sutures to Ⓡ thumb OTA s̄ s/s infection c/o pain x 1 i Percocet and i Tylenol given. Will mo[redacted] 2320/AN

0017 ~~c/o pain~~ Error [redacted]

SPONSOR'S NAME LAST	FIRST	MI	SPONSOR'S ID NUMBER

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 ICW2

PROGRESS NOTES
Medical Record

STANDARD FORM 509
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MEDCOM - 12517

All (b)(6)-2 except where noted

NSN 7540-00-634-4176

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
28July03 0900	Pt. asleep in bed easily aroused by verbal stimuli. No IV access. HR Regular, Lung sounds clear bilat, bowel sounds (+) x 4 quads. (R) LE ↑ on folded blanket, insertion sites from ext. fix s̄ s/s of infection, (R) foot c̄ small amt. of swelling & erythoma, unable to assess cap refill due to nail fungus, foot warm to touch (+) sensation, limited ROM. Pt s̄ complaints @ this time. All other assessment findings WNL. Will continue to monitor. [redacted] 1AN
28Jul03 1845	assumed care @ 1300 - VSS - medicated c̄ ii T#3 PO @ 1430 for pain, no further c/o pain - pt. now stating T#3 does not help his pain as he is laughing and joking c̄ his brother - neuro V'S WNL in (R) foot - pt. did own pin care c̄ H_2O_2/saline mix [redacted] CR, AN
2330 28Jun03	Pt care assumed @ 2100, VSS, c/o pain @ 2230, 325 tylenol, ī percocet given. Lungs CTA, pulses (+) x4, BS (+). RLE c̄ exfix (+) sensation and capillary refill, pins clean and intact. [redacted] foot c̄ swelling, and erythema, more so when ambulating. Pt ambulated x30 minutes. No complaints, continue to monitor. [redacted]
29July03	0610 Assume pt care @ 0500. pt awake and alert. No c/o pain or discomfort. VSS. RLE ex-fix intact. (+) sensation. limited movement, elevated @ this time (cont) [redacted]

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. ICW

EPW= [redacted] (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

MEDCOM - 12518

(b)(6)-2

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
29Jul03	0610 Sutures to thumb intact. Will cont to monitor —— [redacted]
	1400 Pt stable at this time. AAO×3. PERRLA. Lung CTA bilat, ∅ resp distress. NSR. Abd soft, non tender, bowel sounds active ×4 quads. Ⓡ LE ex-fix intact, pin sites CDI. Pt perform pin care by himself c̄ supervision. Ⓡ foot c̄ strong pulse and brisk cap refill. Ⓡ foot c̄ discoloration ∅ complaint of pain. —— [redacted] LT/AN
29 JUL 03 21:57.	Rec'd c/o pt @ 21:00. Restraints x 2 Ⓡ wrist Ⓛ ankle. VS WNL per flowsheet. Awake and alert in bed. PERRLA ⊕ WNL. ICA Ⓑ. BS ⊕ ×4. ⊕ PPP Ⓑ. Ⓡ ex-fix in place. Pin insertion sites ⊝ s/s infection. ⊕ ROM ⊕ <3 sec cap refill ⊕ sensation to digits. Foot up to ankle discolored. Sutures to entrance and exit wound C/D/I OTA. Ⓡ thumb sutures [redacted] A. ⊝ c/o pain @ this time. Will cont to mon [redacted] AN
30July03 0600	Pt. asleep in bed easily aroused by verbal stimuli. VSS. HR Regular. Lung sounds clear bilat, bowel sounds (+) x4 quads. Ⓡ LE ↑ on folded blanket. Ext fix insertion sites s̄ s/s of infection, Ⓡ foot from ankle down c̄ erythema, ↑ temp, mild swelling, (+) sensation, (+) pedal pulse, unable to assess cap refill due to toe fungus. Pt. c/o pain, will give i Percocet. All other assessment findings WNL. Pt s̄ other complaints @ this time. Will continue to monitor. —— [redacted]
30;	

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MEDICAL RECORD | PROGRESS NOTE ~~CHRONOLOGICAL RECORD OF MEDICAL CARE~~

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
30Jul03 1320	assumed care @1300 – VSS – no c/o pain @ this time – neuro V'S WNL in (R) foot, foot remains discolored slightly [redacted] Sites s̄ S/S infection —
30Jul03 23:43	Rec'd c/o pt @ 21:00. Restraints x2 (L) wrist (L) ankle. VS WNL per flowsheet. Awake and alert in bed. Skin W/D PERRLA (+) WNL. LCA (B). HR reg APEM WNL. BS (+) x4. (+) PP (B). Sutures to (L) thumb remain OTA s̄ s/s infection. (R) ext ex-fix intact. Pin sites open to air s̄ s/s infection. Sutures to entrance and exit wound on (R) ankle OTA s̄ s/s infection c/o pain x1 T Percocet given. Will cont to mon [redacted]
310510 July 03	Nursing Assessment: Assumed care of pt. Airway intact, breathing even and unlabored, LS clear to all fields (B). Abd soft, nontender, s̄ distention, BS (+) x4. Voids spontaneously. FROM and neurovascularly intact to (B) UE and LLE. ROM to ankle of RLE limited 2° ex fix. Otherwise, RLE has FROM and neurovascularly intact. Pin sites to (R) LE are CDI and open to air. Ø IV access. — [redacted]
31 July 03 1300	- Received PT Alert resting in bed. (–) c/o pain or discomfort. Lung sounds are clear Bilateral. BSx4. PT has (+) ROM to (R) ex-fix leg. Cap Ref 2 secs. Skin is Dry & warm. Pin site is clear of infection and open to Air. Sutures to entrance & exit wound on (R) Ankle remain clear of S/S of infection. Will cont to monitor. [redacted]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	[redacted] RDS 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. ICW2

FPW # [redacted] (b)(6)-4

PROGRESS NOTE ~~CHRONOLOGICAL RECORD OF MEDICAL CARE~~

Medical Record

STANDARD FORM 600 (REV. 6-97)
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MEDCOM - 12520

(b)(6)-2

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
31 Jul 03 23:25	Rec'd c/o pt @ 21:00. Restraints x2 (R) wrist (L) ankle. VS WNL per flow sheet. Awake and alert in bed. Skin W/D. LCA(B). BS(+)x4. (+)PP(B) (R) thumb sutures OTA ø s/s infection (L)LE ex-fix intact. Pin sites ø s/s infection. Wounds to ankle c̄ sutures OTA ø s/s infection. (+)ROM (+)<3sec cap refill (+) sensation to digits (R) foot ø c/o pain @ this time will cont. to mon. [redacted] BLT/AN
1 Aug 03 0700	Assumed pt. care @ 0500. VSS. A+Ox3. Lungs CTA. (+) BS x4. (R) thumb sutures intact. Ex-Fix to (R) leg intact, (+) sensation + movement below site. ø Complaints @ this time [redacted]
1400	Pt stable. AAOx3. PERRLA. Lungs CTA bilat, ø resp distress. NSR. Abd soft, non-tender. Bowel sounds active x4 quads. Brisk cap refill and strong pulses x 4 extremities. Sutures to (R) thumb open to air, CDI. (R) LE ex-fix intact. pin sites CDI. ø Complaints [redacted] /AN
01 Aug 03	Rec'd c/o patient @ 21:00. Pt c̄ restraints x2 (L) wrist (R) ankle VS WNL per flowsheet. pt. awake and alert. Voicing concerns about (R) leg amputation to interpretter. Concerns addressed. Skin W/D. PERRLA(+)WNL. LCA(B). BS(+)x4 (+)PP(B). HR reg S1S2. Sutures to (R) thumb OTA ø s/s infection. (L)LE ex-fix in place. Sutures to wounds @ inner and outter aspects of ankle OTA ø s/s infection: Pin sites OTA ø s/s infection. (+)ROM (+)<3sec cap refill (+) sensation to (L) foot digits. ø c/o pain @ this time will cont. to mon. [redacted] /AN

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MEDCOM - 12521

All (b)(6)-2 except where noted.

NSN 7540-00-634-4176 600-108

HEALTH RECORD PROGRESS NOTES ~~CHRONOLOGICAL RECORD OF MEDICAL CARE~~

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
2 August 03 0830	Pt. VSS. HR Regular, Lung sounds clear bilat, bowel sounds ⊕ x4 quad Pt. s̄ IV access. Insertion sites of Ⓡ LE ext fix s̄ s/s of infection, leg ↑ on folded blanket. Skin on Ⓡ LE from ankle down to toes c̄ erythem ↑ temp, pedal pulse palpable, ⊕ sensation, limited ROM. Pt. s̄ complaints @ this time. All other assessment findings WNL. Will continue to monitor. —— [redacted] /A
2 Aug 03 1900	assumed care @ 1300, VSS - no c/o pain @ this time - pt. did own pin care, sites s̄ s/s infection - 2 sutures removed from Ⓡ thumb, site intact - 3 sutures removed from incision on Ⓡ lower shin, wound healed, edges remain closed - pt. applied lotion to Ⓑ feet 2° to dry skin —— [redacted]s WNL to Ⓡ foot, 1st & 2nd toenails black, redness remains on 1, 2, 3 & 5th toes —— [redacted] R.A
error 2 ~~Ju~~ Aug 03 02:22	Rec'd c/o pt. @ 21:00. VS WNL per flow sheet. Restraints x2 Ⓡ wrist Ⓛ ankle. Awake and alert in bed. PERRLA ⊕ WNL. LCA Ⓑ HRR S_1S_2 BS ⊕ x4 Ⓡ thumb s̄ s/s infection. Ⓡ LE ex-fix intact. Pin sites OTA s̄ s/s infection. Wounds to ankle s̄ s/s infection. Ⓡ foot remains slightly darker in color than rest of leg. ⊕ sensation ⊕ ROM ⊕ <3 sec cap refill to Ⓡ foot digits c/o pain x1 ī tylenol given. will cont. to mon. [redacted] /RN

PATIENT'S IDENTIFICATION *(Use this space for Mechan[redacted] Imprint)*

RECORDS MAINTAINED AT:

ICW2

PATIENT'S NAME *(Last, First, Middle initial)*		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME		ORGANIZATION
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

EPW
[redacted] (b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
MEDCOM - 12522

STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

(b)(6)-2

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
2Aug03 2235	Tylenol ī offered to pt. for pain management. Pt. refused tylenol stated "521". Pt. received nothing [redacted]
3Aug03 0226	Pt. c/o pain x2 ïï Tylenol given. Pt. accepted pain med. s̄ difficulty [redacted] 2LT/AN
3Aug03 0630	Pt. asleep in bed easily aroused by verbal stimuli. HR Regular, lungsounds clear bilat, bowel sounds (+) x4 quads. Ext fix to Ⓡ LE intact ↑ on folded blanket, insertion sites s̄ s/s of infection. On Ⓡ foot from ankle down skin is red, slightly swollen & very warm to the touch. Pt. s̄ complaints @ this time. No IV access. All other assessm findings WNL. Will continue to monitor. —— [redacted] /AN
1110	Pt. c/o pain, ïï tylenol given —— Ct
3 Aug 03 1300	~Received PT Alert + sitting in bed c̄ ⊖ c/o pain or discomfort. VSS. Breath sounds clear B. bilateral. BS x4. PT has ⊕ ROM to Ⓡ ex-fix. leg. Cap ref +2 seconds. ⊖ s/s of infection noted. Skin is warm + dry. PT has ⊖ IV access. Will cont to monitor PT. ——
2139	Pt. care assumed @ 2100. VSS HR Reg, lungs CTA, BS ⊕ x4. Ex-fix Ⓡ LE intact. Pinsites s̄ s/s infection. Ⓡ ft c̄ ⊕ sensation, ⊕ ROM, pulse 2+. Will cont. to monitor. —— [redacted] LT/AN
4Aug03 0600	Pt. VSS. HR Regular, lungsounds clear bilat, bowel sounds (+) x4 quads. Ext fix to Ⓡ LE intact, insertion sites s̄ s/s of infection. Ⓡ foot from ankle down skin is red, slightly swollen & very warm to the touch, pedal pulse palpable, limited ROM in digits. Pt. s̄ complaints @ this time. All other assessment findings WNL. Will continue to monitor. —— [redacted] 2LT/AN
4Aug03 2100	VSS. no c/o pain — neuro √s WNL in Ⓡ foot —— [redacted] , AN

*U.S. Government Printing Office: 1996 - 404-763/40001

STANDARD FORM 600 BACK (REV. 5-84)

All (b)(6)-2 except where noted

NSN 7540-00-634-4176 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
04Aug03	Rec'd c/o pt @ 21:00 Restraints x2 Ⓡ wrist Ⓛ ankle.
2357	VS WNL per flowsheet. Awake and alert in bed. Skin WD.
	PERRLA ⊕ WNL. LCA ⊕. HRRS, Sa. BS ⊕ x4. Ⓡ LE exfix in place
	pinsites s̄ s/s infection. ⊕ ROM ⊕ sensation ⊕ PPP Ⓡ ⊕ <3sec
	cap refill to Ⓡ digits c/o pain x1 ii Tylenol given will cont.
	to mon. [redacted] RN/AD
5AUG03	0515 Assume pt care @ 0500. pt sleeping easy to awake. No
	c/o pain. VSS. HR reg Lungs CTA Abd soft non tender BS x4
	RLE ex-fix intact. ⊕ movement ⊕ pulse ⊕ sensation below
	ex-fix. Elevated @ this time. Will continue to monitor [redacted]
5Aug03	assumed care @ 1300 - VSS - pt. wants to
2020	return to EPW camp - Xray of Ⓡ ankle done
	as requested, pt. to have exfix removed
	and cast placed in next few days - pt. has
	cut on Ⓛ foot due to trip on the way to
	xray suite - medicated for pain c̄ tylenol
	200 @ ~1930, good relief [redacted]
5Aug03	Pt care assumed @ 2100. VSS, c/o pain in R BKA.
2205	Lung sounds CTA, pulses + x4, bs ⊕. Dsg on R BKA
	CDI. Pt ambulated x 10 minutes this shift. Pt npo c̄
	surgery in am, to return to epw camp in 48 hrs. Will
	continue to monitor. [redacted]

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

SS EPW

[redacted]

[redacted]

(b)(6)-4

RECORDS MAINTAINED AT:			
PATIENT'S NAME *(Last, First, Middle initial)*			SEX
RELATIONSHIP TO SPONSOR	STATUS		RANK/GRADE
SPONSOR'S NAME		ORGANIZATION	
DEPART./SERVICE	SSN/IDENTIFICATION NO.		DATE OF BIRTH

CHRONOLOGICAL RECORD OF MEDICAL CARE

MEDCOM - 12524

STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
6 August03 0600	Pt. awake c̄ alert in bed. New I.V placed in Ⓡ FA for surgery this AM for removal c̄ casting of ext fix. Pt.'s been NPO since MN. HR Regular, lungsounds clear bilat, bowel sounds ⊕ x 4 quads. Insertion sites to Ⓡ LE ext. fix s̄ s/s of infection, pedal pulse palpable, limited ROM in digits, erythema noted from ankle down. Pt. s̄ complaints @ this time. All other assessment findings WNL. Will continue to monitor. [redacted] b(6)-2
1130	Pt. back from OR via litter. VSS
1200	IV D/c'd.
6Aug03 1400	Pt stable at this time. AAOx3. PERRLA. Lungs CTA bilat, ∅ resp distress. NSR. Abd soft, non-tender, bowel sounds active x 4 quad. Strong pulses and brisk cap refill x 4 extremities. Cast from toes to groin on Ⓡ leg. ∅ complaints. Ambulated on crutches c̄ PT today. b(6)-2 [redacted]
6Aug03 2140	Pt care assumed @ 2100. VSS, alert and awake, c̄ c/o pain @ heel on r/e. Lung sounds CTA, pulses ⊕ x4, [illegible] x4. Cast on r/e CDI, ⊕ cap refill and able to wiggle toes. Pt to be discharged in AM, summary and orders written. b(6)-2 [redacted]
7Aug03	0525 Assume pt care @ 0500. Awake and Alert. c/o pain mostly located @ Ⓡ knee. ~~and to~~ error Cast to RLE intact. ⊕ movement ⊕ sensation to toes. VSS. HR reg Lungs CTA Abd soft BSx4. Percocet for pain. Plan for discharge today. [redacted] b(6)-2

NSN 7540-00-634-4176 600-108

HEALTH RECORD progress ~~CHRONOLOGICAL RECORD OF MEDICAL CARE~~ notes

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
7Aug03 1340	assumed care @ 1300 - USS - no c/o pain @ this time - <2 sec cap. refill in Ⓡ toes, pt. can wiggle Ⓡ toes, cast intact thigh to toes - pt. awaiting transport to EPW camp b(6)-2 [redacted]
7AUG03 1600	Discharged to EPW Camp. Escorted by MP. Discharge summary x-rays & medications in possession. [redacted] b(6)-2

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

EPW

b(6)-4

[redacted]

RECORDS MAINTAINED AT: ▶			
PATIENT'S NAME *(Last, First, Middle initial)*			SEX
RELATIONSHIP TO SPONSOR	STATUS		RANK/GRADE
SPONSOR'S NAME		ORGANIZATION	
DEPART./SERVICE	SSN/IDENTIFICATION NO.		DATE OF BIRTH

CHRONOLOGICAL RECORD OF MEDICAL CARE

MEDCOM - 12526

STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

PATIENT ASSESSMENT Sgt [redacted] b(6)-2

TIME: 1700 SIGNATURE: [redacted]

SKIN AND MUCOUS MEMBRANES

Skin : Loose / Tight / Diaphoretic / Shiny / [✓ Dry]

Skin : Temperature warm

Color: [✓ Pale] / Cyanotic / Jaundiced NFR

Mucous Membranes: [✓ Moist] / Dry / Cracked

Skin Breakdown: [✓ None] Location: Size:

NEUROLOGICAL

Loc / [✓ Alert] / Lethargic / Unresponsive GCS:

[✓ Orientated] / Disoriented Pupils:

Extremity Movement: Full / [✓ Limited] / None cast on right leg

CARDIOVASCULAR

Pulse (0 - 4): +2 Radials +2 Pedals unable to assess

Capillary Refill: <2 Seconds Homan's Sign ↓ Ø

Jugular Venous Distension Ø Edema Ø cast

Heart Sounds S1S2

Rhythm NSR PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			▨	▨
Site			Rt FA	NS @125cc/hr
Solution				

Chest Pain Ø

RESPIRATORY

Chest Expansion / [✓ Symmetrical] / Asymmetrical

Respiration / [✓ No Distress] / SOB / Labored / Use of Access Muscles

Breathing Patterns: even

Cough: Productive / Nonproductive / [✓ None]

Sputum: Color / Amount / Consistency / Odor

Chest Drainage System Gravity: Suction cm:

Air Leak No Yes Crepitus

Character of Drainage:

Trachea / [✓ Midline] / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes	CTA-B	
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: [✓ Soft] / Firm / Hard / Distended cm Girth

Bowel Sounds: [✓ Normal] / Hyperactive / Hypoactive / Absent

Dressings: RLE cast C,D+I

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate:

Stool: Character

Drains:

GENITOURINARY

Urine Color: clear yellow Character:

Voiding: [✓ Continent] / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER: dsg to R thumb C,D,+I

7.3.03 PATIENT ASSESSMENT b(6)-2

TIME: 0530 SIGNATURE: [redacted]

SKIN AND MUCOUS MEMBRANES

Skin : Loose / Tight / Diaphoretic / Shiny / [✓ Dry]

Skin : Temperature warm

Color: Pale / Cyanotic / Jaundiced appropriate for race.

Mucous Membranes: [✓ Moist] / Dry / Cracked

Skin Breakdown: [✓ None] Location: Size:

NEUROLOGICAL

Loc / [✓ Alert] / Lethargic / Unresponsive GCS: 15

[✓ Orientated] / Disoriented Pupils: 3mm brisk

Extremity Movement: Full / [✓ Limited] / None RLE Cast moves toes

CARDIOVASCULAR

Pulse (0 - 4): Radials +2 Pedals Ⓛ pedal +2

Capillary Refill: <3 Seconds Homan's Sign Ø UTA Ⓡ pedal

Jugular Venous Distension Ø Edema Ø

Heart Sounds S1S2

Rhythm NSR S ectopy PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			▨	▨
Site			RFA	
Solution			LR	

Chest Pain Ø

RESPIRATORY

Chest Expansion / [✓ Symmetrical] / Asymmetrical

Respiration / [✓ No Distress] / SOB / Labored / Use of Access Muscles

Breathing Patterns: even

Cough: Productive / Nonproductive / [✓ None]

Sputum: Color / Amount / Consistency / Odor Ø

Chest Drainage System Gravity: Suction cm:

Air Leak No Yes Crepitus

Character of Drainage:

Trachea / [✓ Midline] / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes	CTA	Bilat
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: [✓ Soft] / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / [✓ Hypoactive] / Absent

Dressings: RLE C/D/I

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate

Stool: Character

Drains: NPO denies N/V/D.

GENITOURINARY

Urine Color: amber Character: clear

Voiding: Continent / urinal Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER: C/D/I dressing RLE

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03 Jul 03

EPW # [redacted] b(6)-4

MEDCOM - 12527

Date 4/[illegible]

b(6)-2

PATIENT ASSESSMENT

ME: 4/[illegible] SIGNATURE [redacted]

SKIN AND MUCOUS MEMBRANES

: Loose / Tight / Diaphoretic / Shiny / [✓ Dry]
: Temperature 99.6
: Pale / Cyanotic / Jaundiced WNL
us Membranes: ~~Moist~~ / [✓ Dry] / Cracked
Breakdown: [✓ None] Location: Size:

NEUROLOGICAL

[✓ Alert] / Lethargic / Unresponsive GCS:
[✓ tated] / Disoriented Pupils:
nity Movement: Full / [✓ Limited] / None (R) leg cast

CARDIOVASCULAR

(0 - 4): +2 Radials +2 Pedals
ry Refill: <2 Seconds Homan's Sign
r Venous Distension Ø Edema Ø
Sounds RSR
n PRI: QRS:

ar Catheter	Central	Arterial	Peripheral 1	Peripheral 2
rms			▨	▨
			(R) AC 20	
n				

Pain

RESPIRATORY

xpansion [✓ Symmetrical] / Asymmetrical
[✓ tion / No Distress] / SOB / Labored / Use of Access Muscles
g Patterns: REG
Productive / Nonproductive / [✓ None]
: Color / Amount / Consistency / Odor Ø
rainage System Gravity: Ø Suction cm:
No Ø Yes Ø Crepitus Ø
er of Drainage: Ø
/ Midline / Deviated (R) / Deviated (L) Ø
Airway Size: Type: Position:

th Sounds	Anterior/Location	Posterior/Location
	ESS. CTA	
:		
ed		

GASTROINTESTINAL

: [✓ Soft] / ~~Firm~~ / Hard / Distended cm Girth
unds: [✓ Normal] / Hyperactive / Hypoactive / Absent
:
Clamped/Inter. Suction/Cont. Suction/Dependent Drainage
age: Color Ø Character Ø
ding: Day No: Strength: Rate: Aspirate:
aracter

GENITOURINARY

Color: Character:
Continent / Incontinent / [✓ Catheter]

EMOTIONAL/PSYCHOSOCIAL

Appropriate

EPW [redacted]

PATIENT ASSESSMENT

TIME: 1150 SIGNATURE: [redacted]

SKIN AND MUCOUS MEMBRANES

Skin : Loose / Tight / Diaphoretic / Shiny / [✓ Dry]
Skin : Temperature warm
Color: Pale / Cyanotic / Jaundiced NFR
Mucous Membranes: [✓ Moist] / Dry / Cracked
Skin Breakdown: [✓ None] Location: Size:

NEUROLOGICAL

[✓ Loc / Alert] / Lethargic / Unresponsive GCS:
[✓ Orientated] / Disoriented Pupils:
Extremity Movement: Full / [✓ Limited] / None Cast on L leg

CARDIOVASCULAR

Pulse (0 - 4): +2 Radials +2 Pedals
Capillary Refill: <3 Seconds Homan's Sign
Jugular Venous Distension Ø Edema Ø
Heart Sounds S1S2
Rhythm NSR PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			▨	▨
Site			LAC HL	
Solution				

Chest Pain

RESPIRATORY

Chest Expansion / [✓ Symmetrical] / Asymmetrical
Respiration / [✓ No Distress] / SOB / Labored / Use of Access Muscles
Breathing Patterns:
Cough: Productive / Nonproductive / [✓ None]
Sputum: Color / Amount / Consistency / Odor
Chest Drainage System Gravity: Suction cm:
Air Leak No Yes Crepitus
Character of Drainage:
Trachea / [✓ Midline] / Deviated (R) / Deviated (L)
Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles	CTA B	
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: [✓ Soft] / Firm / Hard / Distended cm Girth
Bowel Sounds: [✓ Normal] / Hyperactive / Hypoactive / Absent
Dressings:
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage
NG Drainage: Color Character
Tube Feeding: Day No: Strength: Rate: Aspirate:
Stool: Character
Drains:

GENITOURINARY

Urine Color: yellow Character:
Voiding: [✓ Continent] / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

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

MEDCOM - 12528

3 M1   DAte 5-8-0-

PATIENT ASSESSMENT

E: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Loose / Tight / Diaphoretic / Shiny / Dry
Temperature 96.5
Pale / Cyanotic / Jaundiced
: Membranes: Moist / Dry / Cracked
eakdown: [✓ None] Location: Size:

NEUROLOGICAL

ert / Lethargic / Unresponsive GCS:
ed / Disoriented Pupils:
y Movement: Full [✓ Limited] None R HAND Cast

CARDIOVASCULAR

) - 4): ✓ Radials --- Pedals
Refill: <3 Seconds Homan's Sign
Venous Distension Ø Edema Ø
ounds S1S2

PRI: QRS:

Catheter	Central	Arterial	Peripheral 1	Peripheral 2
ns			▨	▨
			R HAND	
			20 g HL	

in

RESPIRATORY

ansion / [✓ Symmetrical] / Asymmetrical
n / [✓ No Distress] / SOB / Labored / Use of Access Muscles
Patterns:
roductive / Nonproductive / [✓ None]
Color / Amount / Consistency / Odor
nage System Gravity: Suction cm:
No Yes Crepitus
of Drainage:
[✓ Midline] / Deviated (R) / Deviated (L)
rway Size: Type: Position:

Sounds	Anterior/Location	Posterior/Location
	CTA B	

GASTROINTESTINAL

[✓ Soft] / Firm / Hard / Distended cm Girth
ds: Normal / Hyperactive / [✓ Hypoactive] / Absent

lamped/Inter. Suction/Cont. Suction/Dependent Drainage
e: Color yellow Character clear
g: Day No: Strength: Rate: Aspirate:
acter

GENITOURINARY

lor: Character:
ntinent / Incontinent / Catheter

PATIENT ASSESSMENT b(6)-2

TIME: 1730 SIGNATURE: [redacted] /AW

SKIN AND MUCOUS MEMBRANES

Skin : Loose / Tight / Diaphoretic / Shiny / Dry
Skin : Temperature 97.8
Color: Pale / Cyanotic / Jaundiced Normal for Race
Mucous Membranes: [✓ Moist] / Dry / Cracked
Skin Breakdown: None Location: d/t to (R) leg and (R) thumb

NEUROLOGICAL

Loc [✓ Alert] / Lethargic / Unresponsive GCS:
[✓ Orientated] / Disoriented Pupils:
Extremity Movement: [✓ Full] / [✓ Limited] / None upper and (L) lower (R) Leg splint

CARDIOVASCULAR

Pulse (0 - 4): 2+ Radials (R) No Pedals (L) 2+
Capillary Refill: < 3 Seconds Homan's Sign
~~Jugular Venous Distension~~ Edema Ø edema
Heart Sounds S1 S2 present
Rhythm S Rhythm ~~PRI: QRS:~~

Vascular Catheter	Central	Arterial	Peripheral 1	Peripher
Waveforms			▨	▨
Site			(R) hand	
Solution			20g HL	

Chest Pain

RESPIRATORY

Chest Expansion / [✓ Symmetrical] / Asymmetrical
Respiration / [✓ No Distress] / SOB / Labored / Use of Access Muscles
Breathing Patterns: even + unlabored
Cough: Productive / Nonproductive / [✓ None]
Sputum: Color / Amount / Consistency / Odor none
~~Chest Drainage System Gravity:~~ ~~Suction cm:~~ [redacted]
~~Air Leak No Yes Crepitus~~
Character of Drainage: none noted
Trachea / Midline / Deviated (R) / Deviated (L)
Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles	CTA bilat	
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: [✓ Soft] / Firm / Hard / Distended cm Girth
Bowel Sounds: [✓ Normal] / Hyperactive / Hypoactive / Absent
Dressings: (R) thumb + (R) Lower extremity
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage
NG Drainage: Color yellow Character clear d/c'd
~~Tube Feeding: Day No: Strength: Rate: Aspirate~~
~~Stool: Character~~
~~Drains:~~

GENITOURINARY

~~Urine Color:~~ ~~Character:~~
~~Voiding: Continent /~~ Incontinent /

c8K

EPW [redacted] b(6)-4

MEDCOM - 12529

b(6)-2

DATE: 6 July PATIENT ASSESSMENT

TIME: 1720 SIGNATURE: [redacted]

SKIN AND MUCOUS MEMBRANES

Skin: Loose / [✓ Tight] / Diaphoretic / Shiny / [✓ Dry]

Skin: Temperature 98°

Color: Pale / Cyanotic / Jaundiced Normal for Race

Mucous Membranes: [✓ Moist] / Dry / Cracked

Skin Breakdown: None Location: dsg to (R) leg & (R) thumb

NEUROLOGICAL c̄ X-Fix

Loc / [✓ Alert] / Lethargic / Unresponsive GCS:

[✓ Orientated] / Disoriented Pupils: 3mm Perrla

Extremity Movement: [✓ Full] / [✓ Limited] / None upper lower (R)

CARDIOVASCULAR

Pulse (0 - 4): 2+ Radials 2 Pedals (L) 2+

Capillary Refill: Seconds Homan's Sign

Jugular Venous Distension Edema Ø edema

Heart Sounds S1 S2 present

Rhythm SR 80 to ST 100s ~~PRI: QRS:~~

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			▨	▨
Site			(R) hand	
Solution			NS @ 100cc/hr	

Chest Pain

RESPIRATORY

Chest Expansion / [✓ Symmetrical] / Asymmetrical

Respiration / [✓ No Distress] / SOB / Labored / Use of Access Muscles

Breathing Patterns: even and unlabored

Cough: Productive / Nonproductive / [✓ None]

Sputum: ~~Color / Amount / Consistency / Odor~~ none

~~Chest Drainage System Gravity: Suction cm:~~ see

~~Air Leak No Yes Crepitus~~

Character of Drainage: none noted

Trachea / Midline / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles	CTA bilat	
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: [✓ Soft] / Firm / Hard / Distended cm Girth

Bowel Sounds: [✓ Normal] / Hyperactive / Hypoactive / Absent

Dressings: (R) thumb & (R) leg

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color yellow Character clear urine

~~Tube Feeding: Day No: Strength: Rate: Aspirate:~~

~~Stool: Character~~ bedside

Drains: urinal

GENITOURINARY

Urine Color: Character: see above

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER: VSS will continue to monitor

[redacted]

EPW [redacted]

b(6)-4

PATIENT ASSESSMENT

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / [✓ Dry]

Skin: Temperature 98-0

Color: Pale / Cyanotic / Jaundiced Nl = R

Mucous Membranes: [✓ Moist] / Dry / Cracked

Skin Breakdown: [✓ None] Location: Size:

NEUROLOGICAL

Loc / [✓ Alert] / Lethargic / Unresponsive GCS:

[✓ Orientated] / Disoriented Pupils:

Extremity Movement: Full / [✓ Limited] / None EXFIX (R) Ankle

CARDIOVASCULAR

Pulse (0 - 4): 2 Radials 2 Pedals 2

Capillary Refill: Seconds Homan's Sign

Jugular Venous Distension Ø Edema Ø

Heart Sounds S1S2 Ausc.

Rhythm PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			▨	▨
Site			(R) HAND	
Solution			NS HL	

Chest Pain Ø

RESPIRATORY

Chest Expansion / [✓ Symmetrical] / Asymmetrical

Respiration / [✓ No Distress] / SOB / Labored / Use of Access Muscles

Breathing Patterns: = & unlabored

Cough: Productive / Nonproductive / [✓ None]

Sputum: Color / Amount / Consistency / Odor None

Chest Drainage System Gravity: Ø Suction cm:

Air Leak No Yes Crepitus

Character of Drainage: — None

Trachea / [✓ Midline] / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Ø Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes	CTA (B)	
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: [✓ Soft] / Firm / Hard / Distended ND cm Girth

Bowel Sounds: Normal / Hyperactive / [✓ Hypoactive] / Absent

Dressings: (R) thumb (R) leg

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Ø Character

Tube Feeding: Day No: Strength: Rate: Aspirate

Stool: Character Ø

Drains:

GENITOURINARY

Urine Color: yellow Character: Clear

Voiding: [✓ Continent] / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER: VSS Afebrile

MEDCOM - 12530

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

FOR Use of this form, see AR 40-407: the proponent agency is The Office of the Surgeon General.

1. AGE: 27
HEIGHT:
WEIGHT:

2. KNOWN ALLERGIC SENSITIVITIES (e.g.. Iodine, Tape, Medication)
☒ NKDA ☐ PCN ☐ LATEX ☐ IODINE ☐ TAPE ☐ FOOD
REACTION:

3. PREVIOUS SURGERY [ ] NO [ ] YES (type):

4. PROPOSED SURGICAL PROCEDURE: S/P GSW Ⓡ leg. x Chest wound.

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition____
Tobacco____ppd X___yrs. Body Piercing Ø Diabetes (Y) [✓ (N)] ROM____ ASA/Motrin w/72 hrs (Y) [✓ (N)]
ETOH Ø Implants Ø Respiratory Disease (Asthma/COPD) (Y) [✓ (N)] Anticoagulants (Y) [✓ (N)]
Glasses/Contact (Y) [✓ (N)] Dentures Ø Hypertension (Y) [✓ (N)] Herbal Medicines (Y) [✓ (N)] MEDS: Ancef, MSO4, Percocet

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to: ✓ 1) Surgical Procedure & Operating Room Environment ___ 2) Separation Anxiety (Child) ✓ 3) Surgical Outcomes	✓ Pt. verbalizes any specific anxiety. ✓ Pt. Exhibits relaxed body posture.	✓ Allow pt. to verbalize freely. ✓ Explain OR environment and answer questions regarding surgery. ✓ Offer comfort measures. (e.g.. warm blanket, touch). ✓ Explain all nursing procedures before they are done. ✓ Remain with pt. whenever possible. ✓ Maintain family interface. Parents to stay with pt.
B. AERATION ✓ Potential for respiratory dysfunction due to: ✓ 1) Positioning ✓ 2) Effects of Anesthesia ✓ 3) Medical/Smoking History	✓ Pt. will be able to breathe without difficulty during immediate intraoperative phase.	✓ Offer to elevate head of litter or offer pillow. ✓ Observe pt. while awaiting surgery for signs of distress. ✓ Assist anesthesia during intubation and extubation.
C. INTEGUMENT ✓ Potential impairment of skin integrity due to: ✓ 1) Intraoperative Immobility ✓ 2) ESU Pad Placement ✓ 3) Positional Aids ___ 4) Prosthesis ✓ 5) Pooling of Prep Solutions	✓ Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened areas).	✓ Utilize pressure preventing devices on OR table and accessories. ✓ Check for proper positioning and support to maintain good body alignment. ✓ Pad pressure points. ✓ Place ESU ground pad on non compromised skin surface area. ✓ Keep prep fluids from pooling.

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

[redacted]

b(6)-4

VERIFICATIONS AT HOLDING AREA:
! ID/Allergy Band ! Dentures Removed
! H & P ! Contacts Removed
! NPO Since MN ! Jewelry Removed
! UHCG/LMP ! Body Pierce Removed
! Consent/Blood Transfusion Signed/Witnessed/Dated
! Surgical Site/Consent verified by Pt./Anesthesia/Surgeon
! Contact Precautions (Y) (N)
! Family/Friend: Ø

DA FORM 5179, JUN 91 Previous editions are obsolete USAPA V1.0
MEDCOM - 12531

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to: ✓ 1) Intraoperative Mobility ✓ 2) Positioning ✓ 3) Existing Disease ✓ 4) Safety Devices ✓ 5) Hypothermia	✓ Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse.	✓ Check for support stockings or ace wraps. If none, check with doctors. ✓ Check that safety straps are correctly applied. ✓ Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. ✓ o. Check that rings and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to: ✓ 1) Pain ✓ 2) Intraoperative Hazards ___ 3) Prosthesis ✓ 4) Positioning ✓ 5) Transfer pt. to/from OR table E.2. ✓ Potential discomfort due to: ✓ 1) Length of Surgery ✓ 2) Positioning ___ 3) Arthritis	✓ Pt. will be transferred to OR table without difficulty. ✓ Pt. will not experience unnecessary physical discomfort.	✓ Have sufficient people available for transfer. ✓ Insure proper body alignment. ✓ Allow patient to lie in position of comfort while waiting for surgery. ✓ Offer support (i.e., pillows, bath towels, etc.) for positioning.
F. SPECIAL SENSES F.1. ✓ Diminished visual perception due to being: ✓ 1) Pre-Medicated ___ 2) W/O Glasses F.2. ✓ Potential for decreased communication due to: ___ 1) Diminished Hearing ✓ 2) Language Barrier F.3. ___ Potential injury due to dentures: ___ 1) Upper ___ 4) Caps ___ 2) Lower ___ 5) Crowns ___ 3) Bridges	✓ Pt. will be made aware of surroundings prior to anesthesia induction. ✓ Pt. will be transferred safely to OR table. ✓ Pt. will be able to understand instructions. ✓ Minimize danger of injury during intraop period.	✓ Introduce self. Keep pt. informed as to where he/she is and what is happening. ✓ Inform pt. in which direction to move and assist if necessary. ✓ Speak clearly and slowly. ✓ Address pt from either side. ✓ Validate pt.'s understanding of verbal communication. ✓ Verify removal of dentures.
G OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	**OTHER PATIENT GOALS AND EXPECTED OUTCOMES.** Or continuation of above goals and outcomes.	**OTHER NURSING INTERVENTIONS** Or continuation of above interventions

10. OR NURSING INTERVENTIONS COMPLETED/ADDITIONAL INTRAOPERATIVE INTERVENTIONS NOTED.

[redacted] CPT AN b(6)-2 3 July 03 DATE

11. POSTOPERATIVE EVALUATION: SKIN INTEGRITY: Bovie Pad Site: ☒ Clean and Dry ☐ Red ☐ N/A DRESSING DRY & INTACT: [✓ (Y)] (N)

LEVEL OF CONSCIOUSNESS: ☐ A&O ☒ Drowsy ☐ Sleepy ☐ Intubated BREATHING EASY: [✓ (Y)] (N)

LEVEL OF ACTIVITY: ☒ Moves All Extremities ☐ Moves Upper Extremities ☐ Transferred to litter with roller due to spinal

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] b(6)-2

DATE: 2 Jul 03 TIME: 0955

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title) Steff[redacted] CPT AN

DATE: 3 July 03 TIME: 1324

REVERSE OF FORM 5179, JUN 91 MEDCOM - 12532 USAPA V1.0

MEDICAL RECORD

INTRAOP. IVE DOCUMENT

For use of this form, see AR 40-66, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: Litter BY Anesthesia	2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY CPT [redacted] b(6)-2
3. DATE 3 July 03 TIME PATIENT ARRIVED IN SUITE 1205	4. PATIENT IN ROOM TIME 1205 NUMBER 1-1 17

5. PREOPERATIVE EMOTIONAL STATUS

☒ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS:
NPO p̄ MN, NKDA

6. NURSING PERSONNEL

ASSIGNED SCRUB	Pfc [redacted] b(6)-2	RELIEF SCRUB	b(6)-2
ASSIGNED CIRCULATOR	CPT [redacted]	RELIEF CIRCULATOR	CPT [redacted] 1240-1310 1LT [redacted] (1300)

7. POSITION AND POSITIONAL AIDS *(Specify)*

☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

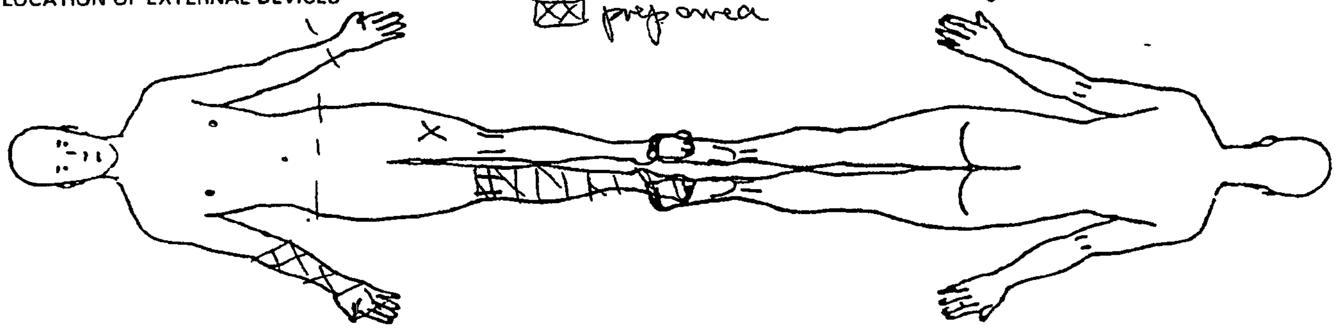
COMMENTS: proper body alignment maintained, 2 armboards used for Ⓡ arm positioning position approved by surgeon + anesthesia

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO DONE BY: ☐ OR ☐ NURSING UNIT METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP COMMENTS:	PREP SOLUTION *(Specify)* Beta/Beta b(6)-2 SITE Ⓡ arm to elbow BY WHOM: CPT [redacted] SITE Ⓡ Leg to knee BY WHOM: CPT COMMENTS: no pooling or skin reaction noted

9. LOCATION OF EXTERNAL DEVICES

☒☒ prep area



LEGEND X Ground Pa[redacted] -- Safety Strap[redacted] = = = Tourniquet

10. COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
			C = Correct	I = Incorrect		b(6)-2	
Sponge	☐ Yes	☐ No		C	C	PFC [redacted]	1LT [redacted]
Needle Sharp	☐ Yes	☐ No					
Instrument	☐ Yes	☐ No					
Other	☐ Yes	☐ No					

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

# [redacted]
ICU-1 b(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☐ YES ☐ NO

☐ ESU NO: Valleylab Force 2 # 4
GROUND PAD: BRAND Valleylab Rem Polyhesive II
LOT NO: 65706 2004-11

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

MEDCOM - 12533

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.01

13. PROSTHESIS, IMPLANTS ☐ YES ☒ NO IF YES NAME: ID NUMBER; MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☒

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO. TYPE(S):
0.9 NaCl

OTHER ORDERS	TIME	CARRIED OUT BY
none		

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM IF YES, SITE
YES ☐ NO ☐

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☐	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☐	NAME	NAME
CULTURE (C) YES ☐ NO ☐	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. Iodoform Gauze	2.	3.
SITE	1. Left ankle	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Fluffs Ⓡ thumb –
Kerlix Xeroform
Acewrap 2x2
tubegauze

19. ADDITIONAL INFORMATION

Surgeon: [redacted]
b(6)-2
Anesthesia: [redacted]

20. OPERATION(S) PERFORMED

I&D Right ankle & Ⓡ thumb

21. PATIENT TRANSFERRED TO ICU-1 b(6)-2

TIME Sep DA7389

METHOD Litter c̄ safety [illegible]

22. REGISTERED NURSE SIGNATURE
Steff[redacted] DTHN

MEDICAL RECORD

INTRAOP. IVE DOCUMENT

For use of this form, see AR 40-66, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: litter BY OR staff

2. PATIENT IDEN [redacted] D AND PROCEDURE VERIFIED BY b(6)-2

3. DATE 6 Jul 03 TIME PATIENT ARRIVED IN SUITE —

4. PATIENT IN ROOM TIME 0600 NUMBER 2-1

5. PREOPERATIVE EMOTIONAL STATUS

☒ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS: NAD p̄ MN

6. NURSING PERSONNEL

ASSIGNED SCRUB	Spc [redacted] 91D b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	My [redacted] 66E	RELIEF CIRCULATOR	1LT [redacted] 66E (0715)

7. POSITION AND POSITIONAL AIDS *(Specify)* Pt placed on OR bed. arms on arm boards < 90° strapped

☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

COMMENTS: Strap across midline. Warm blanket used.

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR

☐ CLIP

COMMENTS:

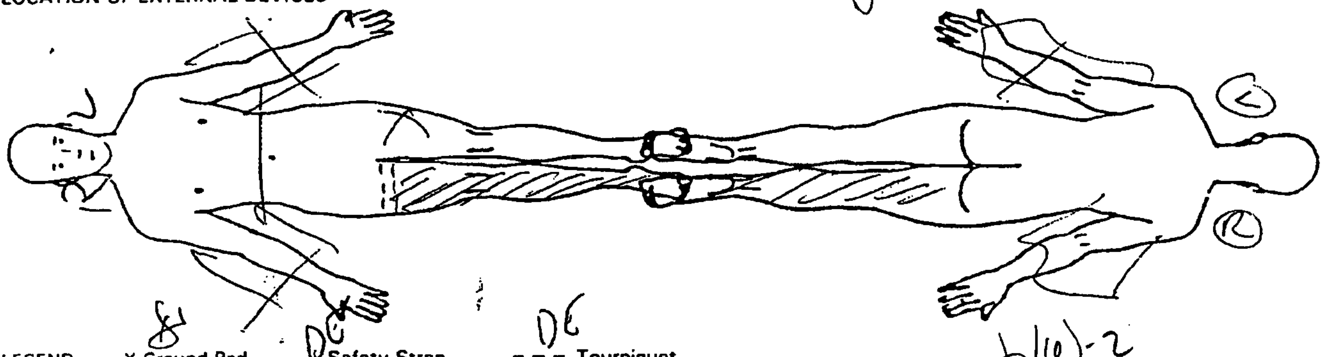
PREP SOLUTION *(Specify)* Betadine/Betadine

SITE: Right leg BY WHOM:

SITE: BY WHOM: DELACRUZ AN

COMMENTS: Ø pooling of solution noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad DC Safety Strap DC = = = Tourniquet

b(6)-2

10. COUNTS		C = Correct I = Incorrect Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR [redacted]
Sponge	☒ Yes ☐ No		C	C	[redacted]	1LT [redacted]
Needle Sharp	☒ Yes ☐ No					
Instrument	☐ Yes ☒ No					
Other	☐ Yes ☒ No					

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

# [redacted]

b(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO 30/30

☒ ESU NO: VL#

GROUND PAD: BRAND VL Rem Poly II

LOT NO: 65704

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

MEDCOM - 12535

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.01

13. PROSTHESIS, IMPLANTS ☒ YES ☐ NO IF YES NAME: ID NUMBER; MANUFACTURER

Stryker Howmedica
Hoffman II Load # 0618701

5018-6-180 x 2
5023-5-150 x 2

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☒

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO. TYPE(S):
0.9% NaCl

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGN [redacted] b(6)-2

15. X-RAY IN OP
YES ☒ NO ☐
IF YES, SITE
C-Arm of Rt ankle

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

TYPE/SIZE	1.	2.	3.
SITE	1.	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Xeroform
Fluffs
Kerlix
ACE

19. ADDITIONAL INFORMATION

Chery
Albertson

geta

DA 5179 In Chart.

20. OPERATION(S) PERFORMED

External fixator application to Rt tibia

21. PATIENT TRANSFERRED TO ICU 1 b(6)-2 TIME 0809 METHOD litter c̄ O_2

22. REGISTERED NURSE SIGNAT [redacted]

REVERSE OF DA FORM 5179-1, OCT 8 USAPA V1.01

MEDICAL RECORD | **INTRAOF … E DOCUMENT**

For use of this form, see AR 40-66, th… .ent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA BY litter

2. PATIENT ID[redacted]RECORD REVIEWED AND PROCEDURE VERIFIED BY CPT/AN b(6)-2

3. DATE 6 AUG 03 TIME PATIENT ARRIVED IN SUITE 0908

4. PATIENT IN ROOM TIME 0908 NUMBER 2-1

5. PREOPERATIVE EMOTIONAL STATUS

☒ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS: Allergies:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SSG [redacted] b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

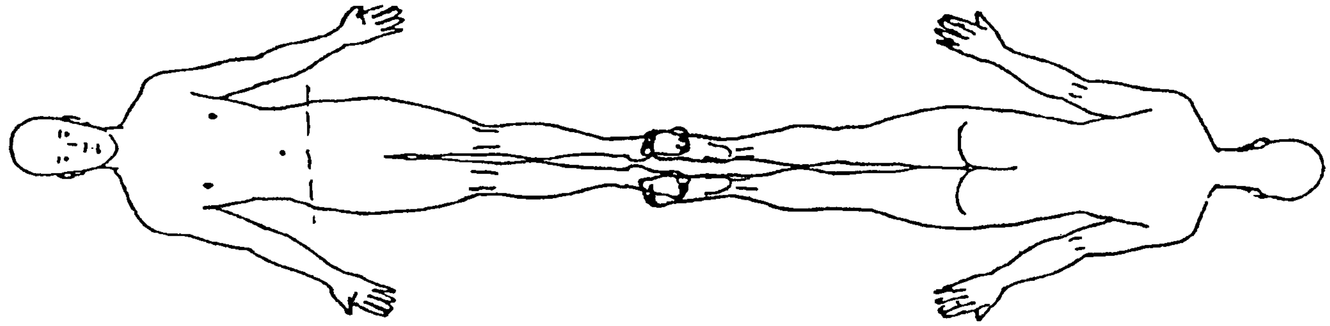
COMMENTS: Proper body alignment maintained

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR
☐ CLIP
COMMENTS:

PREP SOLUTION *(Specify)* Betadine prep sticks
SITE: Ⓡ lower Leg BY WHOM: Meyer
SITE: BY WHOM:
COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad – Safety Strap === Tourniquet

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☐ Yes ☒ No					
Needle Sharp	☐ Yes ☒ No					
Instrument	☐ Yes ☒ No					
Other	☐ Yes ☒ No					

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

#[redacted]

b(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☐ YES ☒ NO

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:
☐ ESU NO:
GROUND PAD: BRAND
LOT NO:
☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES E… MEDCOM - 12537 …H IS OBSOLETE. USAPA V1.01

13. PROSTHESIS, IMPLANTS ☐ YES ☒ NO IF YES NAME: ID NUMBER; MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☒

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☐ YES ☒ NO, TYPE(S):

OTHER ORDERS	TIME	CARRIED OUT BY
None		

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM
YES ☒ NO ☐ IF YES, SITE C-Arm – Rt. lower Leg

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

TYPE/SIZE	1.	2.	3.
SITE	1.	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
2x2
Kerlix
Webril
Fiberglass cast

19. ADDITIONAL INFORMATION
WC
Surgeons: [redacted] b6-2
Anesthesia: Albritton
Anesthesia Type: Sedation

Bovie Pad site intact pre-op —; post-op — Bovie Settings: Coag/Cut
Tourniquet Site intact pre-op_____: post-op_____
Tourniquet Time: Up____ Down_____

20. OPERATION(S) PERFORMED
Removal of Ex-fix Rt. lower Leg
Application of Rt-Long Leg Cast

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU 2	1110	Litter

22. REGISTER [redacted] PT/AN

REVERSE OF DA FORM 5179-1, OCT USAPA V1.01

b(6)-2 MEDCOM - 12538

MEDICAL RECORD | **INTRAOPE ATIVE DOCUMENT**

For use of this form, see AR 40-66, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: litter BY Anesthesia

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY CPT [redacted] b(6)-2

3. DATE 9 July 03 TIME PATIENT ARRIVED IN SUITE 0823

4. PATIENT IN ROOM TIME 0823 NUMBER 2113

5. PREOPERATIVE EMOTIONAL STATUS

☒ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS: no changes from previous 5179 nkda s/p I+D Ⓡ ankle +Ⓡ thumb

6. NURSING PERSONNEL

ASSIGNED SCRUB	SP[redacted] b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT[redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

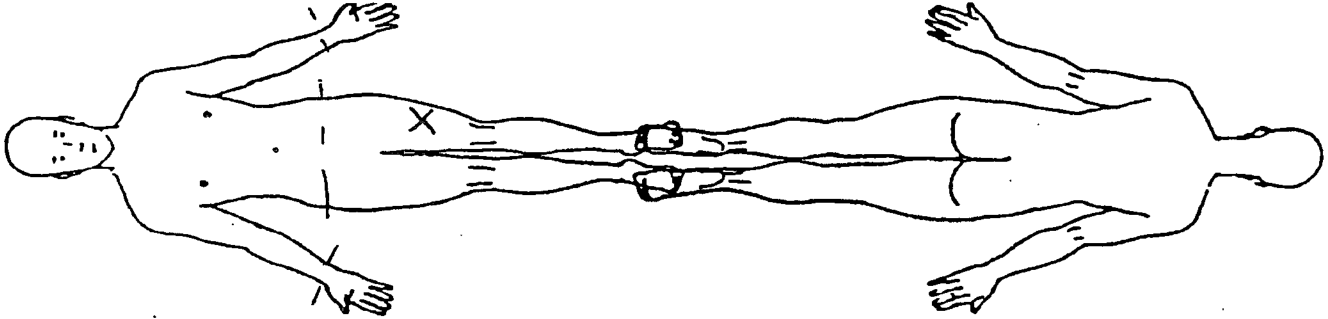
COMMENTS: proper body alignment maintained, arms on padded armboards at less than 90°, position approved by surgeon + anesthesia

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR
☐ CLIP
COMMENTS:

PREP SOLUTION *(Specify)* ~~Betal Beta~~
SITE: Ⓡ BY WHOM [redacted]
SITE: N/A BY WHOM:
b(6)-2
COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad [redacted] - Safety Strap [redacted] = = = Tourniquet

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☐ Yes ☐ No					
Needle Sharp	☐ Yes ☐ No					
Instrument	☐ Yes ☐ No					
Other	☐ Yes ☐ No					

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

[redacted] b(6)-4
ICW-1

12. ELECTROSURGERY DEVICE(S) (ESU) ☐ YES ☒ NO

☐ ESU NO: Valleylab Force 2 #2
GROUND PAD: BRAND Valleylab Rampolyhesive II
LOT NO: 65706 2004-11

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

MEDCOM - 12539

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.01

13. PROSTHESIS, IMPLANTS ☐ YES ☒ NO IF YES NAME: ID NUMBER; MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☒

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):
0.9% NaCl

OTHER ORDERS	TIME	CARRIED OUT BY
none		

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM IF YES, SITE
YES ☐ NO ☒

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☐	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☐	NAME	NAME
CULTURE (C) YES ☐ NO ☐	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

TYPE/SIZE	1.	2.	3.
SITE	1.	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Fluffs
Kerlix
Acewrap

19. ADDITIONAL INFORMATION
Surgeon: [redacted]
Anesthesia: [redacted] b(6)-2

20. OPERATION(S) PERFORMED
I+D Ⓡ ankle / foot, Dressing Δ

21. PATIENT TRANSFERRED TO
ICU-1 b(6)-2

TIME See DA7389

METHOD Litter

22. [redacted] NURSE SIGNATURE
CPT, AN

REVERSE OF DA FORM 5179-1, OCT 8

USAPA V1.01

MEDCOM - 12540

511-119 NSN 7540-00-634-4124

MEDICAL RECORD

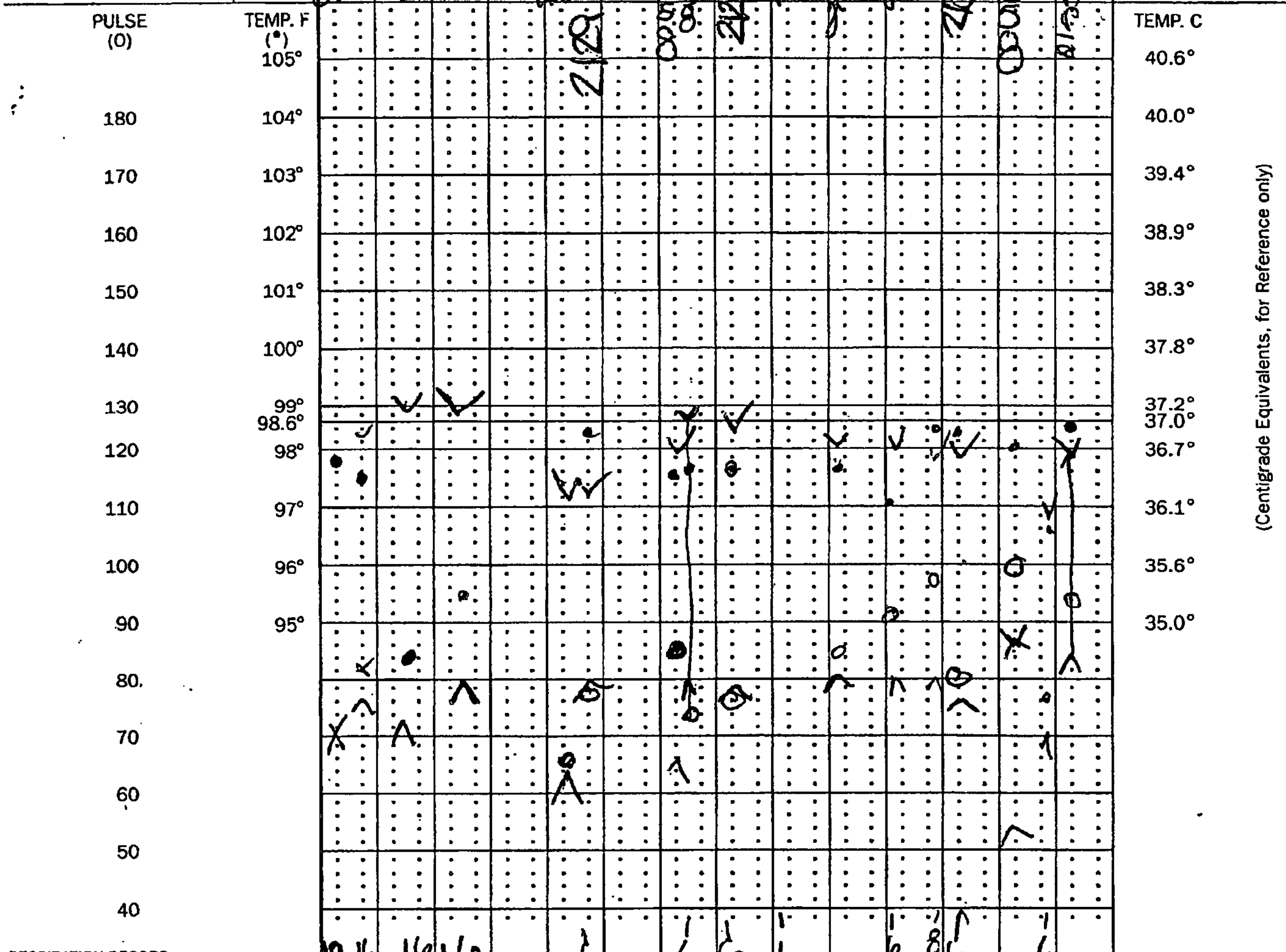
VITAL SIGNS RECORD

HOSPITAL DAY: 7-2-03

POST- DAY

MONTH-YEAR DAY: 01/01 22 23 24 25

19 HOUR: 0400 0900 2.0?1 1600 2100 0000 0800 2214 ? ? 2134 0500 0800 0135



RESPIRATION RECORD: 18 16 16 16 16 16 16 16 16 18 16 16

Record special data only when so ordered

BLOOD PRESSURE: 97.8 97.7 120/ 80/ 126/78 120/70 119/70 118/76 88/54 110/80 100/70 116/80 98%

HEIGHT: WEIGHT →

SpO2: 97/96 95% RA 95% RA 93% RA 98/99% 97% 98% 99% 98%

IN: 500 800 550

out: 800 700 500

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*

REGISTER NO.

WARD NO. ICW2

EPW [redacted] b(6)-4

VITAL SIGNS RECORDS

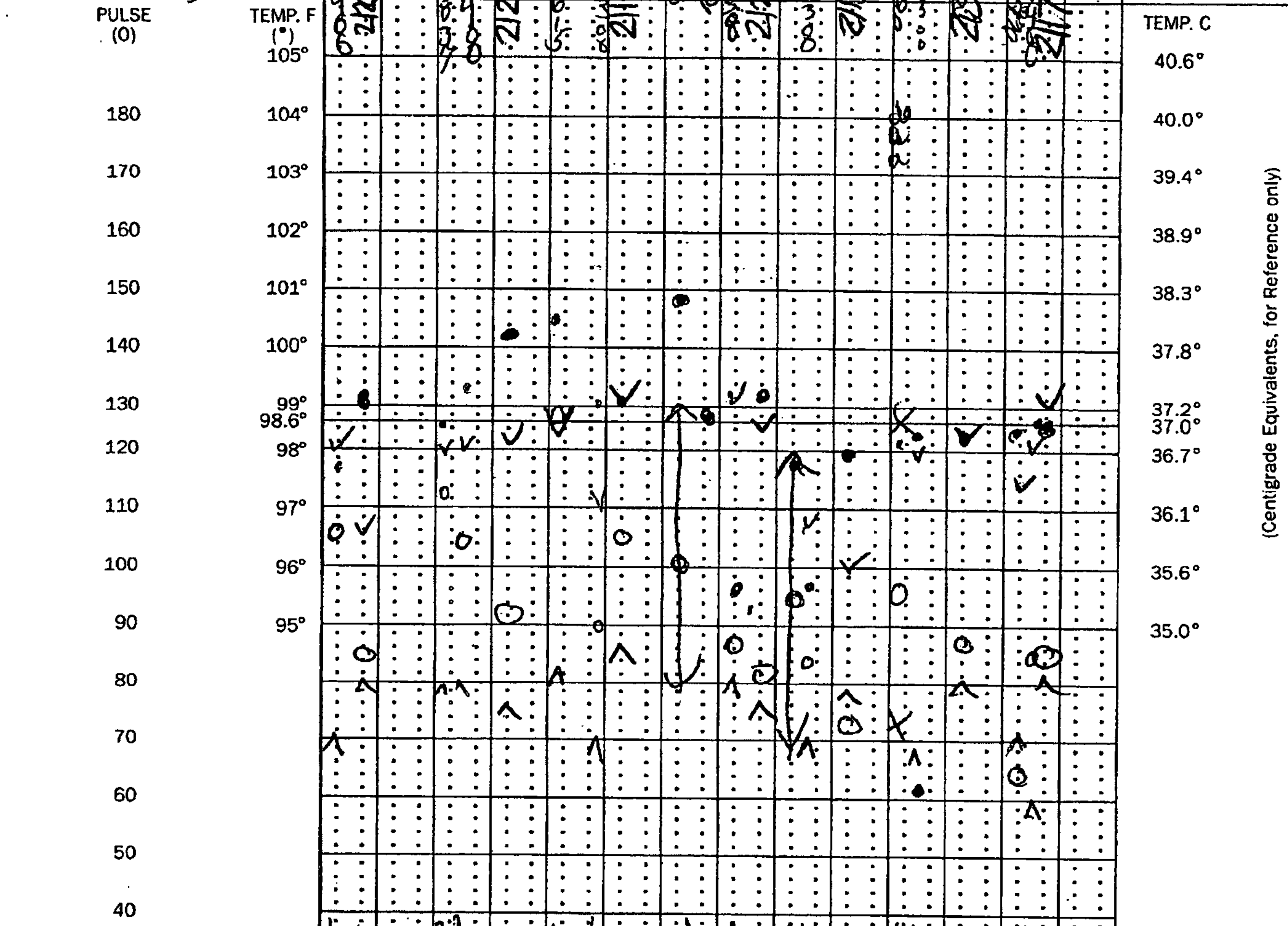
Medical Record

STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 12541

MEDICAL RECORD | VITAL SIGNS RECORD

HOSPITAL DAY	~~10~~						
POST- DAY	10						
MONTH-YEAR July DAY	15	16	17	18	19	20	21
19 2003 HOUR	0906 2100	0847 0800 2121	0615 1008 2111	[illegible] 2124	0713 2115	0815 2355	[illegible] 2117



	15	16	17	18	19	20	21
RESPIRATION RECORD	16 18	18 16	16 18	16 16	14 16	18 16	16 16
BLOOD PRESSURE	120/70 108/80	118/78 120/80 124/76	124/82 134/86	108/80 130/80 130/[illegible] 124/72	126/80 108/70 100/78	118/68 102/80	114/70 120/60 130/82
HEIGHT: WEIGHT →							
	99%	98% 98%	98 98%	99% 98%	98% 97%	99% 98%	98/99%

Record special data only when so ordered

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*

REGISTER NO.

WARD NO. ICW Z

STANDARD FORM 511 (REV. 7-95) **BACK**

EPW [redacted] b(6)-4

MEDCOM - 12542

Date [redacted] b(6)-4 Bed # 2

Patient's Name: 3 July

Time	05	06	07	08	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
		104/51				107/62						97/56												
BP																								
TEMP		96.5										98.7										119/73		
HR		102				108						60										96.3		
RR		13				12																61		
SAO2																						14		
FIO2																						98		
																						RA		
INPUT																								
PO																								
IV PB					100																			
NGT																								
TURN Q 2																								
TOTAL																								
OUTPUT		200			450	300																		
URINE																								
NGT																						400		
STOOL																								
TOTAL																								
BALANCE																								
Initials																								

500 NS
ΦUO
long [illegible] PAGE OF R.S [illegible]

DATE	DX													HOSPITAL DAY					
TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	16	17
BP Arterial Line																			
BP Cuff			112/65				111/64			116/73	117/64	116/63	135/71		131/73	124/70	114/62	118/59	
Temperature							98.7								97.5				
Pulse			65				57			58	57	57	65		97	~~93~~ 70	71	88	90
Respiratory Rate			12				12			14	12	14	14		12	8	16	9	26
			96				96			96	96	96	97		95	94	93	93	93
			RA				RA			RA	RA	RA	RA		RA	RA	RA	RA	RA
pain																			
intervention																			

INTAKE																			
TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	~~16~~	17
LR	125/1000	125/1125	125/1250	125/1375	125	125	125	125		125	125	125	125		125	125	125	125	125
ABT							50												100
TOTALS																		16	17

OUTPUT																				
URINE	HOUR / TOTAL			600			500 / 1100				525			600					[illegible]	[illegible]
	sp gr																			
	S/A																			
NG	OUTPUT																			
	pH																			
	GUIAC																			
EMESIS																				
STOOL																				
DRAINS																				
TOTALS																				

AY

17	18	19	20	21	22	23	
	125/66				110/88		
		99.1			98.5		
	72				68		
	19				14		
	96%				94%		
	RA				RA		
			66'2				

17	18	19	20	[redacted]	[redacted]	23	8°T
125	125/250	125/375	~~125/500~~	~~125/625~~	~~125/750~~	~~125/875~~	500
	300	300	240	240		240	1320
			milk	milk		milk	

PO

50
40
680
6
1320

		450		400			956

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA

TIME	
MODE	
F_iO_2	
TV	
RATE	
PEEP	
ABG pH	
ABG PCO_2	
ABG pO_2	
ABG HCO_3	
ABG SAT	
ABG BASE	

LABORATORY DATA

TIME	
GLUCOSE	
Na/K	
Cl/CO₂	
BUN/Cr	
WBC/PLATELET	
Hct/Hgb	

ACTIVITIES OF DAILY LIVING

TIME	
MOUTH CARE	
BATH	
SKIN CARE	
FOLEY CARE	
TRACH CARE	
ROM EXERCISES	

TURN

SUCTION

TIME

24° I&O TOTALS

wt Yesterday ______ wt Today ______

INTAKE
IV ______
po ______
______
TOTAL ______

OUTPUT
Urine: ______
______
______
TOTAL ______

BALANCE

[redacted] NATURE

b(6)-2

PAGE 3 OF 4

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS									
	16	17	18	19	20	21	22	23	
BP	F	[illegible]							
T	97.8	97.7							
P	69	69							
R									
SpO₂	98	98							

INTAKE									
	16	17	18	19	20	21	22	23	8° T
		900							

RESPIRATORY DATA										
	TIME									
	MODE									
	F_iO_2									
	TV									
	RATE									
	PEEP									
ABG	pH									
	PCO_2									
	pO_2									
	HCO_3									
	SAT									
	BASE									

LABORATORY DATA									
TIME									
GLUCOSE									
Na/K									
Cl/CO_2									
BUN/Cr									
WBC/PLATELET									
Hct/Hgb									

ACTIVITIES OF DAILY LIVING				
TIME				
MOUTH CARE				
BATH				
SKIN CARE				
FOLEY CARE				
TRACH CARE				
ROM EXERCISES				

	TIME					
TURN						
SUCTION						

24° I&O TOTALS

wt Yesterday ________ wt Today ________

INTAKE
IV ________
po ________
____
TOTAL ________

OUTPUT
Urine: ________
____
____
TOTAL ________

BALANCE ________

NURSE'S SIGNATURE	INITIALS

4Jul03

Date 04Jul 03 Bed # [redacted] 2L

Patient's Name EPW [redacted]

b(6)-4

Time	05	06	07	08	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
BP	125/70	106/81	134/62	137/77	120/64	123/71	122/66	125/73	115/69	124/71	116/69	120/73			112/69			100/76		112/59		109/65		109/63
TEMP																			98.5					
HR	[illegible]	72	62	84	69	79	81	78	70	77	85	81			82			72		74		76		78
RR	14	12	25	27	16	15	17	18	12	24	27	20			20			18		16		16		18
SAO2	94	93	96	95	98	99	95	94	95	93	96	95			96			94		97		96		96
FIO2	[illegible]														RA			RA		RA		RA		RA
INPUT																								
PO				330								450	1230											
IV		50				100				50	~~150~~		330											
~~VCT~~																								
TURN Q 2																								
													990											
TOTAL																								
OUTPUT															400		400		400					
URINE	100				600				400			500	730							700				
NGT																								
STOOL																								
TOTAL																								
BALANCE																								
Initials																								

b(6)-4

Bed#2 EPW [redacted] Date 04 Jul

PATIENT ASSESSMENT

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin : Loose / Tight / Diaphoretic / Shiny / Dry

Skin : Temperature

Color: Pale / Cyanotic / Jaundiced

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils:

Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radials Pedals

Capillary Refill: Seconds Homan's Sign

Jugular Venous Distension Edema

Heart Sounds

Rhythm PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			▨	▨
Site				
Solution				

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

Respiration / No Distress / SOB / Labored / Use of Access Muscles

Breathing Patterns:

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor

Chest Drainage System Gravity: Suction cm:

Air Leak No Yes Crepitus

Character of Drainage:

Trachea / Midline / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings:

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate:

Stool: Character

Drains:

GENITOURINARY

Urine Color: Character:

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

PATIENT ASSESSMENT

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin : Loose / Tight / Diaphoretic / Shiny / Dry

Skin : Temperature

Color: Pale / Cyanotic / Jaundiced

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils:

Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radials Pedals

Capillary Refill: Seconds Homan's Sign

Jugular Venous Distension Edema

Heart Sounds

Rhythm PRI: QRS:

Vascular Catheter Central Arterial Peripheral 1 Peripheral 2

Waveforms

Site

Solution

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

Respiration / No Distress / SOB / Labored / Use of Access Muscles

Breathing Patterns:

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor

Chest Drainage System Gravity: Suction cm:

Air Leak No Yes Crepitus

Character of Drainage:

Trachea / Midline / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds Anterior/Location Posterior/Location

Crackles

Wheezes

Diminished

Absent

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings:

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate:

Stool: Character

Drains:

GENITOURINARY

Urine Color: Character:

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

EPW [redacted] b(6)-4

MEDCOM - 12548

Date 7 July [redacted] b(6)-4 Bed # 2

Patient's Name:

Time	05	06	07	08	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
BP																123/66				118/64				110/60
TEMP																								
HR																75				81				68
RR																14				16				14
SAO2																96%				95%				96%
FIO2																RA				RA				RA
INPUT																								
PO													240											
IV																		100						
NGT																								
TURN Q 2																								
TOTAL																								
																~~400~~								
OUTPUT																400						400		
URINE																								
NGT																								
STOOL																								
TOTAL																								
BALANCE																								
Initials																								

MEDCOM - 12549

b(6)-2

DATE:

PATIENT ASSESSMENT

TIME: 1700 SIGNATURE: [redacted]

SKIN AND MUCOUS MEMBRANES

Skin : Loose / Tight / Diaphoretic / Shiny / [✓ Dry]

Skin : Temperature warm

Color: Pale / Cyanotic / Jaundiced NFR

Mucous Membranes: [✓ Moist] / Dry / Cracked

Skin Breakdown: [✓ None] / Location: Size:

NEUROLOGICAL

Loc / [✓ Alert] / Lethargic / Unresponsive GCS:

[✓ Orientated] / Disoriented Pupils:

Extremity Movement: Full / [✓ Limited] / None Cast & ext fix on right leg

CARDIOVASCULAR

Pulse (0 - 4): +2 Radials +1 Pedals 0

Capillary Refill: <3 Seconds Homan's Sign

Jugular Venous Distension 0 Edema 0

Heart Sounds S1 S2

Rhythm NSR PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			▨	▨
Site			L Hand HL	
Solution			LAC HL	

Chest Pain

RESPIRATORY

Chest Expansion / [✓ Symmetrical] / Asymmetrical

Respiration / [✓ No Distress] / SOB / Labored / Use of Access Muscles

Breathing Patterns:

Cough: Productive / Nonproductive / [✓ None]

Sputum: Color / Amount / Consistency / Odor

Chest Drainage System Gravity: Suction cm:

Air Leak No Yes Crepitus

Character of Drainage:

Trachea [✓ Midline] / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles	CTA-B	
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: [✓ Soft] / Firm / Hard / Distended cm Girth

Bowel Sounds: [✓ Normal] / Hyperactive / Hypoactive / Absent

Dressings: none

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate:

Stool: Character

Drains:

GENITOURINARY

Urine Color: yellow Character: Clear.

Voiding: [✓ Continent] / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

---

b(6)-4 [redacted]

PATIENT ESSMENT

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin : Loose / Tight / Diaphoretic / Shiny / Dry

Skin : Temperature

Color: Pale / Cyanotic / Jaundiced

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils:

Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radials Pedals

Capillary Refill: Seconds Homan's Sign

Jugular Venous Distension Edema

Heart Sounds

Rhythm PRI: QRS

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			▨	▨
Site				
Solution				

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

Respiration / No Distress / SOB / Labored / Use of Access Muscles

Breathing Patterns:

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor

Chest Drainage System Gravity: Suction cm.

Air Leak No Yes Crepitus

Character of Drainage:

Trachea / Midline / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings:

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate

Stool: Character

Drains:

GENITOURINARY

Urine Color: Character:

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

MEDCOM - 12550

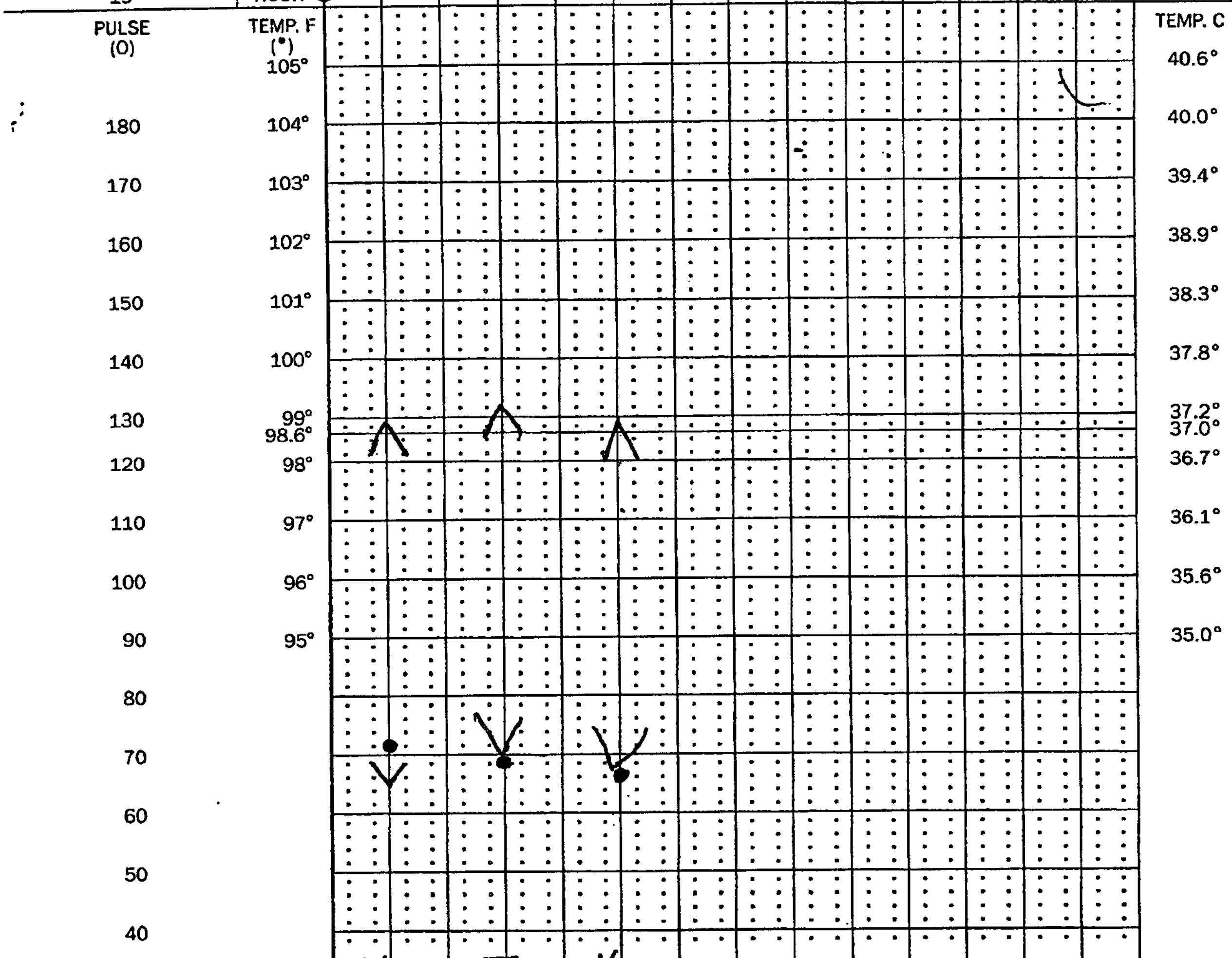
511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY			
POST- DAY	7/8/03		
MONTH-YEAR	DAY		2400	0100
19	HOUR	2000		



RESPIRATION RECORD 16 17 16

Record special data only when so ordered

BLOOD PRESSURE

HEIGHT: WEIGHT →

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*

REGISTER NO.

WARD NO.

[redacted]

b(6)-4

VITAL SIGNS RECORDS

Medical Record

STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 12551

	7/9					7/10						7/11					
	08	12	16	20	24	04	08	12	16	20	24	04	08	HOSPITAL DAY 12	16	20	24
TIME	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
BP Arterial Line	122/	127/	129/				129/		125/80	112/	119/	114/					
BP Cuff	90	69	64				69			71	46	65	118/65	125/70	115/75		
Temperature	99.0	98.4	99.0				98.9			98.0			98.2	98.4			
Pulse	68	77	82				87		72	91	67	72	90	90	85		
Respiratory Rate	20	20	22				18		20	18	14	16	16	20	20		
SpO2	97%	98%	99%				98%		98%	98	99	98	97	98	98		
Source	RA	RA	RA	RA			RA		RA	RA	RA	RA	RA	RA			
pain																	
intensity	08	12	16	20	24	04	08	12	16	20	24	04	08	12	16	20	24
INTAKE **TIME**	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
PO	250	150	200				100	200	200				100				
IV (X4)	125	125	HL				HL	HL	HL			1	HL				
IVPB	200	100					200	100					100				
													100				

		08	12	16	20	24	04	08	12	16	20	24	04	08	12	16	20	24
TOTALS																		
URINE	**HOUR / TOTAL**	425	400	475				425	350	250				250				
	sp gr																	
	S/A																	
NG	**OUTPUT**																	
	pH																	
	GUIAC																	
EMESIS																		
STOOL										X1								
DRAINS																		

MEDCOM - 12552

in OR 7/hr

70mg Ketamine
2.5 versed
150 mic fent

400cc LR
MVBL

		P	R	Spoz	
0848	128/70	70	18	97%	T 98.8
0855	119/59	67	19	97%	
0900	122/66	70	16	95%	
[illegible]	121/61	70	9	98%	

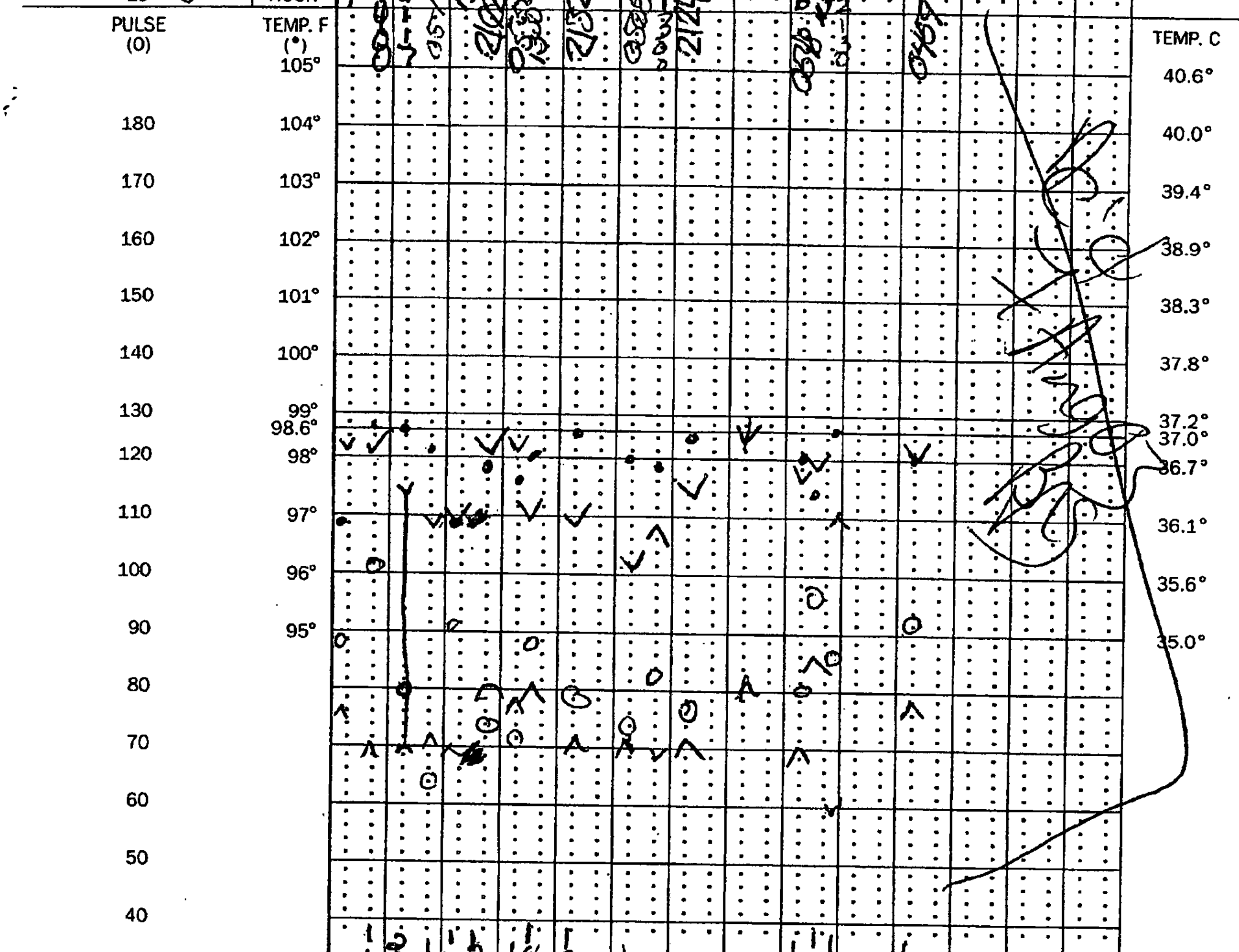
[redacted]

[redacted]

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY							
POST- DAY							
MONTH-YEAR Aug/03 DAY	2-3	3-4	4-5	5	6	7	8
19 HOUR	7 [illegible]	[illegible] 2100 0530	2152 0800 1324 2124		0800 [illegible]	0400	



RESPIRATION RECORD	16 20 16 16 18	18 16	16		16 18 16	16	
BLOOD PRESSURE	122/86 114/70 108/70 132/98	108/72 107/72 114/72			116/70	120/78	
	90/62 108/72 124/80 119/80	108/62			118/86		
HEIGHT: WEIGHT →					98		
O2 Sats →	97% 98 97% 97	98% 98 98%			98	98	
	98 97% 97%						

Record special data only when so ordered

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*

REGISTER NO.

WARD NO. 1CW2

STANDARD FORM 511 (REV. 7-95) **BACK**

EPW
#[redacted]
b(6)-4

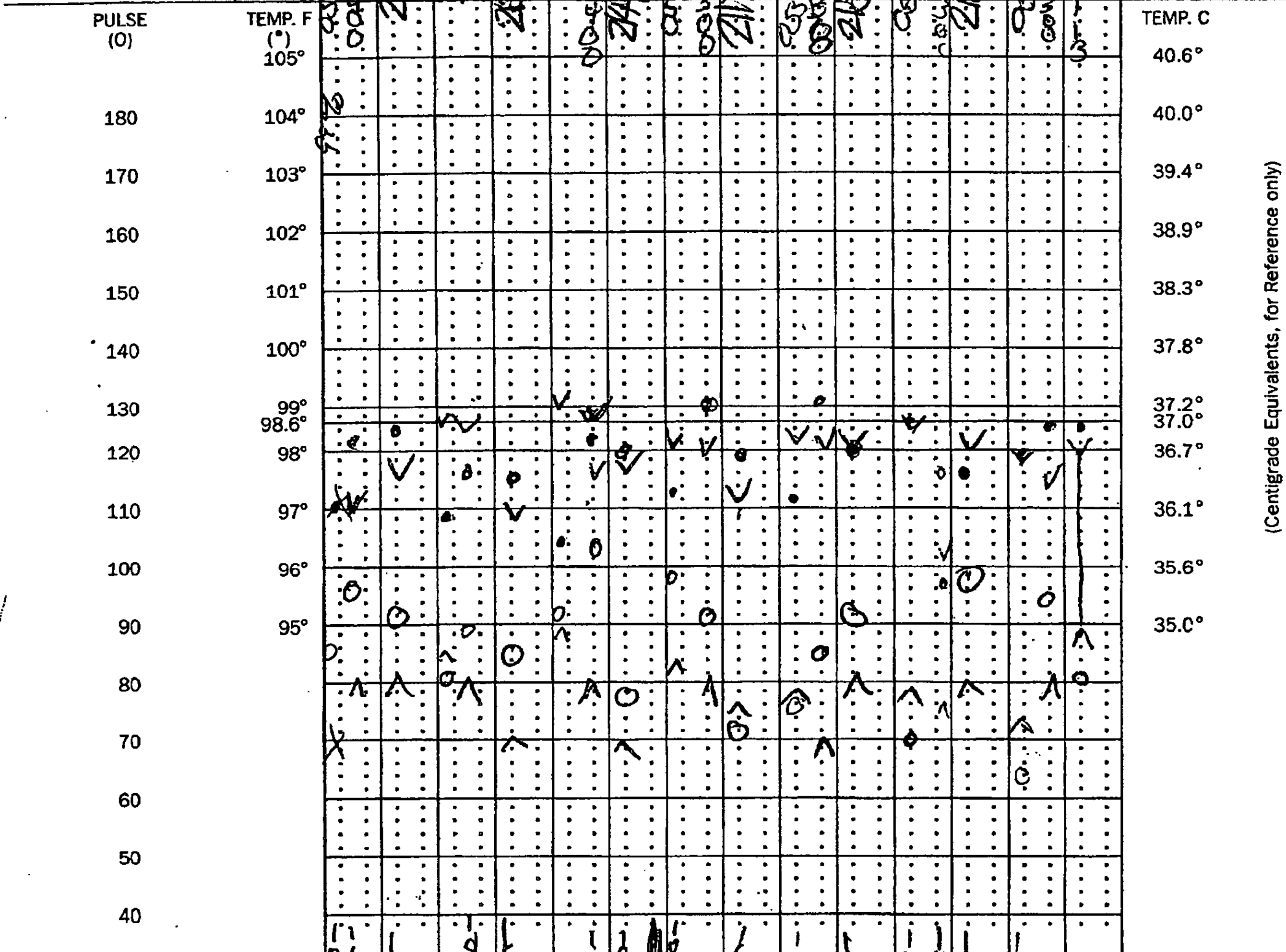
MEDCOM - 12554

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY							
POST- DAY							August
MONTH-YEAR	DAY	26	27	28	29	30	31	1
19	HOUR	[illegible] 2115	0713 2100	1040 2117	0800 2117	0555 2100	0820 2200	0830 [illegible]



RESPIRATION RECORD	36	16	18	16	10	16	18	16	16	16	16	14	16	16
BLOOD PRESSURE	110/50	116/80	124/85 / 124/80	128/70	130/86 / 110/80	116/70	120/84 / 130/80	124/70	127/70 / 120/70	120/80	122/78 / 102/76	120/80	118/74 / 116/80	
HEIGHT:	WEIGHT →	97%	99% / 98%	98%	97%	97%		97%	98	99%	98/	97%	98/	98/

Record special data only when so ordered

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*

REGISTER NO.

WARD NO.

EPW [redacted] b(6)-4

VITAL SIGNS RECORDS

Medical Record

STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 12555

b(6)-2

Ward/Section: BMT

REQUESTING PHYSICIAN: [redacted]

ISTRY RESULT FORM
(Subject to the Privacy Act of 1974)

LAST, FIRST [redacted] b(6)-4

DATE: 1July03

TIME: 2300

SSN/P [redacted] SSN: b(6)-4

(i-STAT)			(Piccolo) Chemistry 12		
TEST	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*
Na		138-146 mmol/L	ALB		3.5-5.5 g/dl
K		3.5-4.9 mmol/L	ALP		26-84 u/l
Cl		98-109 mmol/L	ALT		10-47 u/l
pH		7.31-7.45	AMY		14-97 u/l
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)	AST		11-38 u/l
PO2		80-105 mmHg (art) N/A (ven)	TBIL		0.2-1.6 mg/dl
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)	BUN		7-22 mg/dl
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)	CA^{++}		8.0-10.3mg/dl
sO2		95-98%	CHOL		100-200 mg/dl
BEecf		(-2) - (+3) mmol/L	CRE		0.6-1.2 mg/dl
AnGap		10-20 mmol/L	GLU		73-118 mg/dl
Ca		1.12-1.32 mmol/L	TP		6.4-8.1 g/dl
BUN		8-26 mg/dl			
GLU		70-105 mg/dl			
Creat		0.7-1.5 mg/dl			
Hct		38-51% PCV			
Hgb		12-17 g/dl			

~~(Piccolo) Metlyte 8~~

TEST	*RESULT*	*REF. RANGE*
GLU	81	73-118 mg/dl
BUN	9	7-22 mg/dl
CRE	0.7	0.6-1.2 mg/dl
CK	97	39-380 u/l (M) 30-190 u/l (F)
NA^+	135	128-145 mmol/l
K^+	3.7	3.3-4.7 mmol/l
CL^-	101	98-108 mmol/l
tCO_2	25	18-33 mmol/l

Misc. Chemistry

TEST	*RESULT*	*REF. RANGE*
Troponin-I		Negative
Drug of Abuse		Negative
		Negative
		Negative
		Negative

(Piccolo) Metabolic Panel

TEST	*RESULT*	*REF. RANGE*
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	*RESULT*	*REF. RANGE*
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	*RESULT*	*REF. RANGE*
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

REMARKS:

b(6)-2

REPORTED BY: [redacted]

DATE: 01Jul03

LAB ID NO.:

MEDCOM - 12556

9 July | T | 6 Jul | 7 July PAGE 2 C

DX | HOSPITAL DAY

TIME	20	24	04	08	12	16	20	24	04	08	12	16	20	24	04	08	12	16
Arterial Line Cuff	106/66	94/58	107/101	136/67	127/68	130/78	144/85	132/73	119/71	117/62	119/67	114/61						
mperature	98.1	98.3	97.6	95.3	99.2		97.8	97.6	97.5	98.0	97.7	99.7						
lse	59	51	62	102	77	100	89	75	65	57	79	83						
spiratory Rate	16	14	14	15	12	20	16	16	14	11	14	13						
Sat	97	96	96	99	98		96	96	97	95	98	98						

79
102
15.3

TIME

OTALS

URINE	HOUR / TOTAL	500/600	500/1000		1000/1600	450 400/2200		1100/3600	350/4950	600 ~~5550~~ 5550	1150 600	780	220						
	SP GR																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
MESIS																			
TOOL																			
RAINS																			
OTALS																			

EP [redacted]

b(6)-2

b(6)-2

Ward/Section: BMT	REQUESTING PHYSICIAN: [redacted]	**ISTRY RESULT FORM** (Subject to the Privacy Act of 1974)
LAST, FI [redacted]	DATE 15Jul03	TIME 2000
		SSN/PSEUDO SSN: [redacted]

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

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		Negative
Drug of Abuse		Negative
		Negative
		Negative
		Negative

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU	81	73-118 mg/dl
BUN	9	7-22 mg/dl
CRE	0.7	0.6-1.2 mg/dl
CK	97	39-380 u/l (M) 30-190 u/l (F)
NA^{+}	135	128-145 mmol/l
K^{+}	3.7	3.3-4.7 mmol/l
CL^{-}	101	98-108 mmol/l
tCO_2	25	18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^{+}		128-145 mmol/l
K^{+}		3.3-4.7 mmol/l
CL^{-}		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA^{+}		128-145 mmol/l
K^{+}		3.3-4.7 mmol/l
CL^{-}		98-108 mmol/l
tCO_2		18-33 mmol/l

REMARKS:

REPORTED BY: [redacted]	**DATE:** 01Jul03	**LAB ID NO.:**

b(6)-2

b(6)-2

d/Section: ENT

JESTING [redacted]

LABORATORY RESULT FORM
(Subject to the Privacy Act of 1974)

ST, FIRST, MI [redacted] b(6)-4

DATE 1Jul03

TIME 1300

SSN/PSEUDO SSN: [redacted] b(6)-4

(Hematology) CBC

EST	RESULT	REF. RANGE
C		4.8-10.8 x 10^3
		4.7-6.1 x 10^9
		14-18 g/dl (M) 12-16 g/dl (F)
		42-52% (M) 37-47% (F)
V		80-94 fl (M) 81-99 fl (F)
		130-500 x 10^3 verified
ıph %		20.5-51.1%

Hematology) Manual Differential

s		Mono	
ds		Eos	
ıph		Baso	
p		Imm	
ph			

n ıatocrit		42-52% (M) 37-47% (F)
Rate		
er		

Urinalysis

TEST	RESULT	REF. RANGE
Color	yel	N/A
App	hazy	N/A
Glu	n	Negative
Bili	n	Negative
Ket	n	Negative
SG	1.020	N/A
Bld	n	Negative
pH	5.0	N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

Coagulation Studies

EST	RESULT	REF. RANGE
		9.8-13.6 secs
ΓT		21-34 secs
imer		<20 ug/ml
		<10 ug/ml

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

MARKS:

PORTED BY: [redacted] b(6)-2

DATE:

LAB ID NO.:

MEDCOM - 12559

MEDICAL RECORD ANESTHESIA

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML. " | "=CONSTANT INFUSION

DRUG	(Units)		TOTALS
versed	(mg)	2.5	2.5
MSO4	(mg)	4 2/4	10
propofol	(mg)	150	
phenergan	(mg)	12.5	
	(mg)		
	( )		
VOLAT AGENT Iso	% del	1.5 1.5 2.5–2.0–2.5 0.8 x	
	% e.t.		
AIR	L/Min		
N2O	L/Min		
O2	L/Min	6–2–2 – 2 – 2 – 2 2 – 6	
SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS		①② ③	

TOTAL EBL: min

TOTAL URINE: NM

FLUIDS — LINE site 20g LFA ☐ Warmed 600 1' — 500

☐ Warmed

☐ Warmed

☐ Warmed

FLUIDS – SUMMARY

CRYSTALLOID– 500

COLLOID– 0

BLOOD– 0

LOSSES — EST BLOOD LOSS

URINE –

REMARKS–

Code drugs with numbers, events with letters

Pt & chart ✓. OK to proceed.

① To room, SOC monitors, pre O2.

② Smooth IV indx

③ To recovery stable.

PHYS STATUS 1 [✓ 2] 3 4 5 E

BODY WEIGHT 70 [✓ KG] LB

HEMATOCRIT —

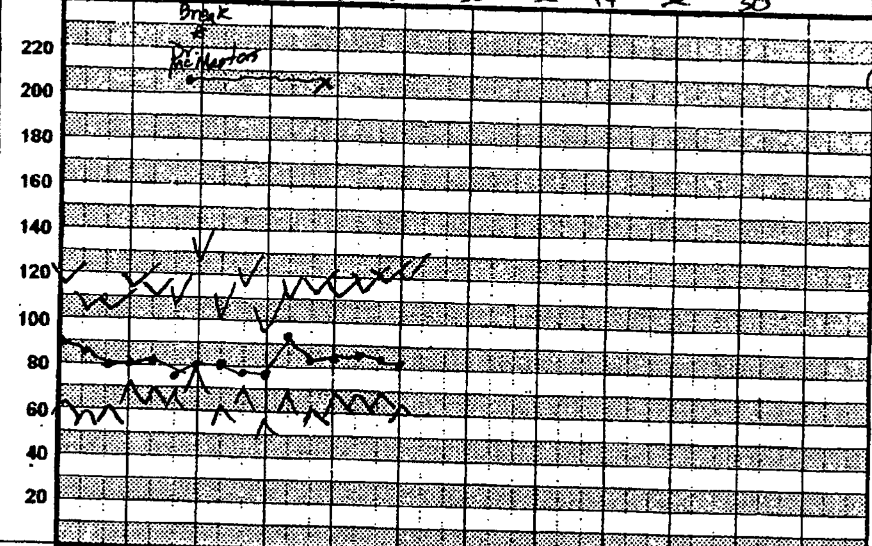
INITIAL DATA
BP – 117/63
HR – 90

EQUIP CHECK OK? – [✓ Y] N

PATIENT RECHECK OK for PROCEDURE? Y
TIME – 1130

TIME → 12 x 30 x 13 x 30 x 14 x 30

SYMBOLS:
BP by cuff V Λ
Heart rate ●
Resp rate
BP (transduced)
TOURNIQUET T – X
ANES – X-X
PROC ⊙ – ∅



VT – ml	280	250	310	460	480
f – breaths/min	26	20	10	15	16
Peak inf pres / PEEP					
MODE– S(pon), A(ssist), C(on)	S	S	S	S	S
✓ ET CO2 (torr)	36	35	42	39	40
✓ FiO2 (Frac or %)	0.7	0.7	.7	.7	0.7
✓ SpO2 (%)	99	99	99	100	100
✓ ECG	SR	SR	SR	SR	SR
TEMP- site	available				
N-M Block (T/4)					

MONITORS / ACCESSORIES
✓ BP/Auto Cuff
BP / oth
ART line
Steth- PC/ES
Gas analyzer
Warming blkt
Conv warmer

RECOVERY AT 1325
PACU [✓ ICU] (Specify)
OTHER 995
CONDITION:
RESP– 16 SpO2– 95
BP– 131/72 HR– 98

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1350	1200	1330
	Ready	**Begin**	**End**
PROC	1205	1230	1320

Mark with letters & symbols, explain under REMARKS EVENTS
Position → O—I——⇒

PROCEDURES and CPT Codes
① I&D Rt thumb
② I&D Rt ankle

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*
GM

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*
Eyes taped, #90A placed, easy mask

PATIENT IDENTIFICATION– *Typed or written entries: Name, Grade/Rate, Medical facility*
b(6)-4

EPW # [redacted]
27 yrs old
NKDA

SURGEON [redacted]

[redacted] MAS, CRNA

PROCEDURE LOCATION 1-1

7/3/03

MEDCOM - 12560

GSW Ⓡ ankle + stab Ⓛ and several do
Tobacco gr >10

NKDA

MEDICAL RECORD ANESTHESIA

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML, "I" ="CONSTANT INFUSION

DRUG	Units		TOTALS
Fentanyl	(mcg)	<200> 50	250
MSO4	(mg)	<5> 2 1 1/1	10
Lidocaine	(mg)	50	
Propofol	(mg)	150	
Sux	(mg)	80	
VCB	(mg)	5 2	
VOLAT AGENT: Iso	% del	1.5 1.5↓1.0 1.3 1.2 1.0 X	
	% e.t.		
AIR	L/Min		
N2O	L/Min		
O2	L/Min	10 2 2 2 2 2 2 4	
SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS &ENTER IN REMARKS		③ ④	

TOTAL EBL: min

TOTAL URINE: 0

FLUIDS – SUMMARY
CRYSTALLOID– 700
COLLOID– 0
BLOOD– 0

FLUIDS

LINE site		
16G Ⓛ A	☒ Warmed	LR#1 — 100 — /200
20G Ⓡ AC	☐ Warmed	NS(500) — 400–500/Saline locked
	☐ Warmed	
Ancef 1gm	☐ Warmed	IVPB →

LOSSES EST BLOOD LOSS
URINE –

PHYS STATUS 1 [✓ 2] 3 4 5 E

BODY WEIGHT 70 [✓ KG] LB

HEMATOCRIT —

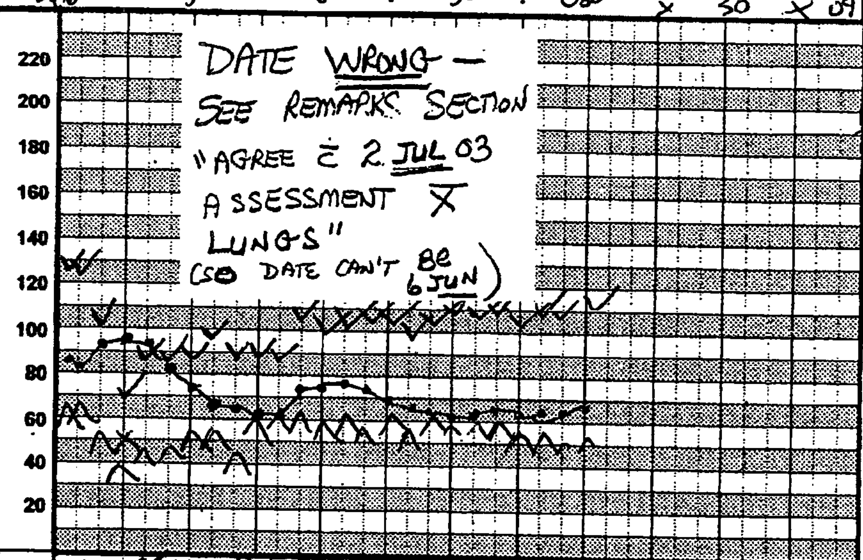
INITIAL DATA
BP – 107/61
HR– 62

EQUIP CHECK OK?– [✓ Y] N

PATIENT RECHECK OK for PROCEDURE? Jc
TIME– 0550

SYMBOLS:
BP by cuff ∨ ∧
Heart rate ●
Resp rate
BP (transduced)
TOURNIQUET T – ✗
ANES– X-X
PROC ⊙ – Ø

TIME → 0600 . 30 . 0700 . 30 . 0800 × 30 × 09



DATE WRONG – SEE REMARKS SECTION "AGREE ō 2 JUL 03 ASSESSMENT X̄ LUNGS" (SO DATE CAN'T BE 6 JUN)

VT – ml	+	660	700	690	690	420	380	420	450
f – breaths/min	–	10	7	7	7	8	10	10	10
Peak inf pres / PEEP	—	20	20	21	21	—	—	—	—
MODE– S(pon), A(ssist), C(on)	S	C	C	C	C	S	S	S	S
✓ ET CO2 (torr)	45	33	35	33	33	46	42	43	
✓ FiO2 (Frac or %)	0.71	0.71	0.71	0.71	0.70	0.88	0.89	0.89	
✓ SpO2 (%)	100	100	100	100	100	100	100	100	
✓ ECG	SR	SR	SR	SR	SR	SR	SR	SR	
✓ TEMP- site Nasal	—	97.2	—	—	—	—	—	—	
✓ N-M Block (T/4)	0/4	4/4	3/4	4/4	4/4 +fade c tet	4/4 c sust tetany			
✓ BS	+	—							
✓ Warming blkt	Wool Blanket → x1 → → →								
Conv warmer									

✓ BP/Auto Cuff
✓ BP / oth
ART line
Steth- PC/ES
Gas analyzer

Mark with letters & symbols, explain under REMARKS
EVENTS ① ②
Position — 0-1 → →

REMARKS– Code drugs with numbers, events with letters
① Review of system Agree ō 2 Jul 03 assessment X̄ lungs ~~(B) Stated pre-op.~~
② Room, monitors, O2, Induced, eyelid taped
③ Relief [redacted]
④ Soft 30 f NA placed. Pt extub deep s̄ diff: recovery stable

RECOVERY AT
PACU [✓ ICU] ______ (Specify)
OTHER 95.3 ax
CONDITION:
RESP– 24 SpO2– 97%
BP– 136/67 HR– 110

ANESTHESIA / PROCEDURE TIME

ANES	Start	Room	End
	0550	0600	0815
PROC	Ready	Begin	End
	0608	0639	0800

PROCEDURES and CPT Codes
I+D + ExFix Ⓡ Ankle

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
DLx1 MAC 3 Grade 1 view: 21 cm @ lip 8.0 OETT styletted 10 ml air to cuff; +BBS + Sust ETCO2

PATIENT IDENTIFICATION– Typed or written entries: Name, Grade/Rate, Medical facility
EPW # [redacted]
b(W)-4

SURGEONS: [redacted] b(W)-2
ANES [redacted] MAJ / CRNA

PROCEDURE LOCATION 2
DATE 6 Jun 03
PAGE 1 **OF** 1

[redacted] MEDICAL RECORD – ANESTHESIA
WAMC OP 376 REVISED
1 Jan 99
MEDCOM - 12561
*U.S. GPO: 2002-729-180/40137

SMOKER
27/m

MEDICAL RECORD - ANESTI

… ıse of this form, see AR 40-66; the proponent y is the OTSG

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML, "I" = CONSTANT INFUSION

DRUG	**(Units)**			
MIDAZ	(mg)	5		
FENT	(mcg)	50 100/100		
PROPOFOL	(mg)	30	TTE →	
	( )			
	( )			
	( )			
VOLAT AGENT	% del			
	% e.t.			
AIR	L/Min			
N2O	L/Min			
MASK O2	L/Min	8 →		

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS →

FLUIDS

LINE site (L) A	☐ Warmed	NS →
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOSSES
EST BLOOD LOSS
URINE -

TOTALS	
TOTAL EBL	MIN
TOTAL URINE	NA

FLUIDS - SUMMARY
CRYSTALLOID- NS 400
COLLOID-
BLOOD-

REMARKS
Code drugs with numbers, events with lettters
0955 Pre Op EVAL
REVIEW → NO Δ
IV → (L) A

10⁰⁴ OR #2 MONITORS ↑
O₂/MASK

PHYS STATUS
1 [✓ 2] 3 4 5 E

BODY WEIGHT:
70 [✓ KG] LB

HEMATOCRIT:

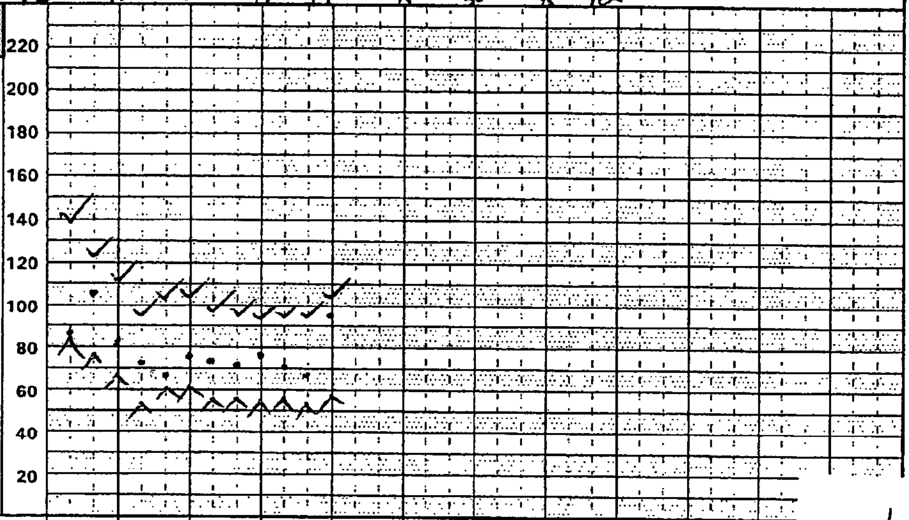
INITIAL DATA:
BP- 139/84
HR- 86

EQUIP CHECK
[✓ OK?] Y N

PATIENT RECHECK
[✓ OK for PROCEDURE?]
TIME-

TIME → 10⁰⁰ 15 30 45 11⁰⁰ 15 30 45 12 Noon

SYMBOLS:
BP by cuff ∨ ∧
Heart rate ●
Resp rate
BR (transduced)
TOURNIQUET T—T
ANES- X-X
PROC- ⊙-Ø



6 AUG

VENTIL

VT - ml					
f - breaths/min	16 8	8	10 12		
Peak inf pres / PEEP					
MODE - S(pon), A(ssist), C(on)	S S	S	S	S	

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)					
BP/oth	FIO2 (Frac or %)	>.21	>.21	>.21	>.21	
ART line	SpO2 (%)	99	99	99	99	
Steth- PC/ES	ECG	SR	SR	SR	SR	
Gas analyzer	TEMP-site	AVAIL →				
	N-M Block (T/4)					
Warming blkt						
Conv warmer						

(Specify)
LE
98
95
EDURE

ANES	Start		End
	0955	10⁰⁴	11¹⁵
PROC	Ready	Begin	End
	10¹⁰	10¹⁵	11⁰⁰

Mark with letters & symbols, explain under REMARKS EVENTS →
Position → O—I

PROCEDURES and CPT Codes:
EX FIX REMOVAL & CAST

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*
LA c̄ SED TTE = TITRATE TO EFFECT

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*
#[redacted]
b(6)-4

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*
NATURAL → O₂ MASK

SURGEONS [redacted] b(6)-2

ANESTHETI[redacted]

PROCEDURE LOCATION: OR #2 28CSH

DATE: 06 AUG 03

PAGE 1 OF 1

DA FORM 7389, FEB 1998 MEDCOM - 12562 COPY 1 - PATIENT'S MEDICAL RECORD USAPA V1.00

Tobacco

NKDA

MEDICAL RECORD — ANESTHESIA

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML, "( )" = CONSTANT INFUSION

DRUG (Units)					TOTALS
Ketamine (mg)	10	<40> 10	10		70
Midazolam (mg)	1	1.5			2.5
Fentanyl (mcg)	<50>	50	50		150
( )					
( )					
( )					
VOLAT. AGENT % del					
% e.t.					
AIR L/Min					
N2O L/Min					
O2 SFM L/Min	10	10	10	X	

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS

FLUIDS

LINE site PIV Ⓡ A ☒ Warmed LR – #1

Ancef 1gm ☐ Warmed IVPB →

☐ Warmed

☐ Warmed

LOSSES EST BLOOD LOSS

URINE –

TOTAL EBL: MIN

TOTAL URINE: Ø

FLUIDS – SUMMARY

CRYSTALLOID – 400

COLLOID – Ø

BLOOD – Ø

REMARKS – Code drugs with numbers, events with letters

① Pre-op assessment + Review of Systems agree c̄ S[illegible] pre-[illegible]

② Room, monitor, O2 Sedation TTE

③ Moved self to litter + to ICU 1

④ Report to RN. Moved self to bed

PHYS STATUS: 1 [✓ 2] 3 4 5 E

BODY WEIGHT: 70 [✓ KG] LB

HEMATOCRIT: —

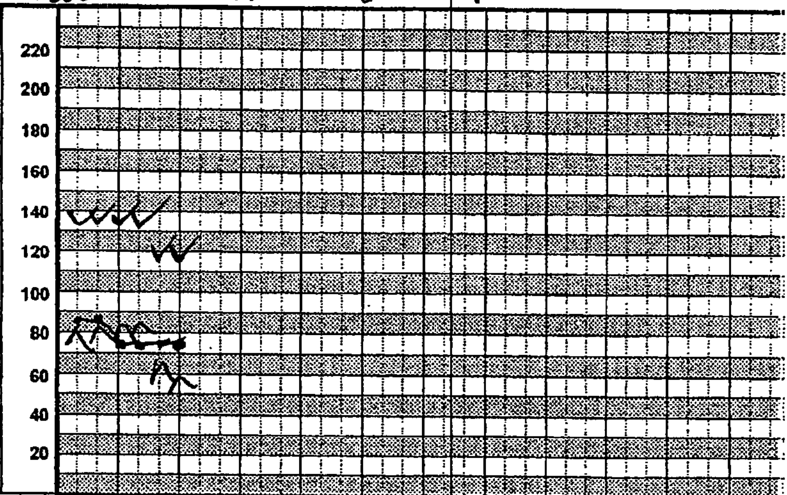
INITIAL DATA: BP – 130/70 HR – 68

EQUIP CHECK: OK? – [✓ Y] N

PATIENT RECHECK: OK for PROCEDURE? TIME – 0800 JR

TIME → 0815 · · 0900 · 30 · 1000

SYMBOLS: BP by cuff ∨ ∧; Heart rate ●; Resp rate; BP (transduced); TOURNIQUET T – ✗; ANES – X-X; PROC ⊙ – Ø



VENT

VT – ml	+	+	+
f – breaths/min	20	20	20
Peak insp pres / PEEP	—	—	
MODE – S(pon), A(ssist), C(on)	S	S	S

MONITORS / ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	+	+	
BP / oth	FIO2 (Frac or %)	7.21	7.21	7.21
ART line	SpO2 (%)	100	100	
Steth- PC/ES	ECG	SR →		
Gas analyzer	TEMP- site	Available		
	N-M Block (T/4)			
Warming blkt	– X 1 wool blanket			
Conv warmer				

Mark with letters & symbols, explain under REMARKS EVENTS ① ② ③ ④ Position →

RECOVERY AT 0850

PACU (ICU) 1 (Specify)

OTHER T – 98.8

CONDITION: stable, awake

RESP – 20 SpO2 – 96%

BP – 128/70 HR – 79

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0810	0815	0858
	Ready	**Begin**	**End**
PROC	0820	0825	0845

PROCEDURES and CPT Codes

I+D Ⓡ tibia

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

MAC c̄ Sedation

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

Natural + SFM

PATIENT IDENTIFICATION – Typed or written entries: Name, Grade/Rate, Medical facility

EPW # [redacted]

b(6)-4

SURGEONS / [redacted] CRNA / – ANESTHESIA

PROCEDURE LOCATION 1

DATE 9 July 03

PAGE 1 OF 1

OP 376 REVISED 1 Jan 99

PATIENT RECO[redacted]

b(6)-2

☆ U.S. GPO: 1999 – 528-336/10085

MEDCOM - 12563

ANESTHESIA PLAN OF CAR. . REPROCEDURAL ASSESSMENT (Seo...on/Anesthesia)

Age 27 DAYS MOS [✓ YRS]

Sex (X) MALE ( ) ~~FEMALE~~

ASA Physical State 1 [✓ 2] 3 4 5 E
WT: 70 KG/LB HT: _____ IN.
ALLERGIES: NKDA

PROPOSED PROCEDURE: I&D ANKLE & THUMB
SURGICAL SERVICE:
NPO SINCE:

HABITS:
TOBACCO: SMOKER
ETOH: 0
DRUGS:

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) MSO4
( ) PERCOCET
( )
( ) ANCEF -06
( ) GENT - 1000

PREMEDICATIONS:
None Yes (@ ______ Hrs) /CC
______ . ______ mg IV IM PO
______ . ______ mg IV IM PO
______ . ______ mg IV IM PO

LABORATORY STUDIES:
HB/HCT: ______ / ______
U/A:
OTHER:

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:
Hypertension [✓ N] Y
Angina [✓ N] Y
MI [✓ N] Y
CVA [✓ N] Y
Other [✓ N] Y
DENIED

Pulmonary System:
Asthma N Y GSW (L) THORAX
Bronchitis/URI N Y OLD WD UNDETERMINED
COPD N Y
Other N Y

Renal System:
Acute/Chronic RF [✓ N] Y

Gastrointestinal:
Hepatitis [✓ N] Y
Hiatal Hernia [✓ N] Y
PUD/GERD [✓ N] Y

Endocrine System:
Diabetes [✓ N] Y
Steriods [✓ N] Y
Thyroid [✓ N] Y

Neurological:
Seizures [✓ N] Y
Neuropathy [✓ N] Y
Other [✓ N] Y

Gynecological :
Pregnancy [✓ N] Y
DENIED

Other Significant Hx:
N Y 134 H/o PELVIC Fx
N Y
Familial HX N Y

ASSESSMENT
PAST SURGICAL/ANESTHETIC
Ø

9 Jly 03

PHYSICAL EXAMINATION
BP 130/70 HR 68 RR 16 T: — JPL
Pain Scale 0-10
HEENT - Teeth
Trachea
TMJ/Neck 3+
Oropharynx MP2 / TMD:
Nares
CHEST: CTA JPL
CARDIAC: S1 S2 JPL
EXTREMITIES:
IV Access: (L) AC 20G
Ulnar Filling:
BACK:
OTHER:

NPO Since MN 9 Jly 03

ANESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ______ {✓} General: Mask [✓ Intubation]

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discussed with [redacted] al guardian. b(6)-2

The patient/leg [redacted] rstand and agrees. Questions answered.

Signed: [redacted] Date: 05 JUL 03 Time: 0800 Hrs

POST-ANESTHESIA EVALUATION AND NOTE (NON ASU)
{ } NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER

Signed: ______ Date: ______ Time: ______ Hrs

7 Jly 03 07

[redacted]

MAJ CRNA

SEDATION KEY:
1. **MINIMAL** (Anxiolysis) Patient responds normally to verbal commands
2. **MODERATE** (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is not necessary.
3. **DEEP SEDATION/ANALGESIA.** Patient responds purposefully following repeated or painful stimulation. Airway assistance may

Patient Identification: (Ward)

[redacted]

b(6)-4

ICU, → ICU,

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 27 DAYS MOS [✓ YRS]   Sex [✓ MALE] ( ) ~~FEMALE~~

PROPOSED PROCEDURE: Remove Ex Fix & Cast
SURGICAL SERVICE: ORTHO
NPO SINCE:

ASA Physical State 1 [✓ 2] 3 4 5 E
WT: 70 [✓ KG]/LB HT: ____ IN.
ALLERGIES: NKDA

HABITS:
TOBACCO: Smoker
ETOH:
DRUGS:

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) PRN/PAIN
( ) Tylenol
( ) Percocet
( )
( )
( )

PREMEDICATIONS:
None Yes (@ ______ Hrs) /CC
______ . ______ mg IV IM PO
______ . ______ mg IV IM PO
______ . ______ mg IV IM PO

LABORATORY STUDIES:
HB/HCT: ______ / ______
U/A:
OTHER:

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:			
Hypertension	[✓ N]	Y	
Angina	[✓ N]	Y	
MI	[✓ N]	Y	
CVA	[✓ N]	Y	
Other	N	Y	
Pulmonary System:			
Asthma	N	Y	GSW (L) Thorax
Bronchitis/URI	N	Y	Old wd undetermined
COPD	N	Y	
Other	N	Y	
Renal System:			
Acute/Chronic RF	[✓ N]	Y	
Gastrointestinal:			
Hepatitis	N	Y	
Hiatal Hernia	[✓ N]	Y	
PUD/GERD	[✓ N]	Y	
Endocrine System:			
Diabetes	[✓ N]	Y	
Steriods	[✓ N]	Y	
Thyroid	[✓ N]	Y	
Neurological:			
Seizures	[✓ N]	Y	
Neuropathy	[✓ N]	Y	
Other	[✓ N]	Y	
Gynecological :			
Pregnancy	N	Y	
Other Significant Hx:			
	N	Y	Pelvic Fx X 13yrs ago
	N	Y	
Familial HX	N	Y	

ASSESSMENT
PAST SURGICAL/ANESTHETIC
Surgs Multiple
No Anes Probs

PHYSICAL EXAMINATION
BP ___ HR ___ R ___ T ___
Pain Scale 0-10 ______
HEENT - Teeth
Trachea
TMJ/Neck 3+ TMD
Oropharnyx MP2
Nares
CHEST: CTA
CARDIAC: S1 S2
EXTREMITIES:
IV Access: (R) A
Ulnar Filling:
BACK:
OTHER:

NPO Since MN

ANESTHETIC PLAN: [✓ LOCAL] [✓ MAC]   { } Regional (Specify): ______   { } General: Mask Intubation

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discussed with the patient/legal guardian.

b(6)-2

The patient/[redacted] and agrees. Questions answered.
Signed: Date: 06 Aug 03 Time: 0940 Hrs

POST-ANESTHESIA EVALUATION AND NOTE (NON ASU)
{ } NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER

Signed: ______ Date: ______ Time: ______ Hrs

Patient Identification: (Ward) ______

#[redacted]   ICW2/ICU2

b(6)-4

SEDATION KEY:
1. **MINIMAL** (Anxiolysis) Patient responds normally to verbal commands
2. **MODERATE** (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is not necessary.
3. **DEEP SEDATION/ANALGESIA.** Patient responds purposefully following repeated or painful stimulation. Airway assistance may be necessary.
4. **ANESTHESIA.** Patient does not respond to painful stimulation.

WAMC Form 2300 (Revised) 15 Mar 01 MCXC-DOS   MEDCOM - 12565
PATIENT RECORD COPY
Previous edition is obsolete
☆ U.S. GPO: 2002-729-283

ANESTHESIA PLAN OF CA REPROCEDURAL ASSESSMENT (Se   on/Anesthesia)

Age 27 DAYS MOS [✓ YRS]   Sex [✓ MALE] ( ) FEMALE

PROPOSED PROCEDURE: I&D Ⓡ thumb + Ⓡ ankle
SURGICAL SERVICE: ORTHO
NPO SINCE: 2240

ASA Physical State 1 [✓ 2] 3 4 5 E
WT: 70 [✓ KG] LB HT: ____ IN.
ALLERGIES: NKDA

HABITS:
TOBACCO: yes
ETOH:
DRUGS:

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) ∅
( )
( ) Ancef 1gm IVPB q8°
( )
( )
( )

PREMEDICATIONS:
None Yes (@ ______ Hrs) /CC
______ · ______ mg IV IM PO
______ · ______ mg IV IM PO
______ · ______ mg IV IM PO

LABORATORY STUDIES:
HB/HCT: ______/______
U/A:
OTHER:

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:
Hypertension N Y Denies
Angina N Y
MI N Y
CVA N Y
Other N Y
Pulmonary System:
Asthma N Y GSW Ⓛ thorax
Bronchitis/URI N Y old wound undetermined
COPD N Y Denies else
Other N Y pulm closed
Renal System:
Acute/Chronic RF N Y
Gastrointestinal:
Hepatitis N Y
Hiatal Hernia N Y
PUD/GERD N Y
Endocrine System:
Diabetes N Y
Steriods N Y
Thyroid N Y
Neurological:
Seizures N Y
Neuropathy N Y
Other N Y
Gynecological :
Pregnancy N Y N/A
Other Significant Hx:
N Y
N Y
Familial HX [✓ N] Y None

Ⓡ ankle GSW & stab Ⓛ hand
10 days ago

ASSESSMENT

PAST SURGICAL/ANESTHETIC
∅ Denies

PHYSICAL EXAMINATION
BP 128/ HR 82 R 16 T - SaO_2 95%
Pain Scale 0-10
HEENT - Teeth intact
Trachea midline
TMJ/Neck FROM
Oropharynx MP 2° TMD 3
Nares
CHEST: Exp. wheezing
CARDIAC: RRR ⓢ ⓜ
EXTREMITIES:
IV Access:
Ulnar Filling:
BACK:
OTHER: 6/6/03 Lungs CTAB

NPO Since 2240

ANESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ______ {✓} General: [✓ Mask or Intubation]

Interpreter present

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discussed with the patient/legal guardian.

b(6)-2

[redacted] CRNA/MAJ 6 July 03   107/61 97.6 62 14 96%

The understand and agrees. Questions answered.

CRNA/MAJ   Date: 7 July 03   Time: 0756 Hrs

POST-ANESTHESIA EVALUATION AND NOTE (NON ASU)
{ } NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER

Signed: ______ Date: ______ Time: ______ Hrs

SEDATION KEY:

1. MINIMAL (Anxiolysis) Patient responds normally to verbal commands
2. MODERATE (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is not necessary.
3. DEEP SEDATION/ANALGESIA. Patient responds purposefully following repeated or painful stimulation. Airway assistance may

Patient Identification: (Ward) ICW 1

EPW # [redacted]

b(6)-4

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

ATIENT IDENTIFICATION

b(6)-4

[redacted]

[illegible]

URSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 1 JUN 03 TIME OF ORDER 2320 HOURS

LIST TI ORDEF NOTED A SIGN

[illegible]

① Admit to ICU-1

② Dx - GSW to Ⓡ thigh, Ⓡ foot [redacted]

③ Condition fair

④ VS - routine b(6)-2 [redacted]

⑤ Bed rest

⑥ Regular diet, NPO [redacted]

ATIENT IDENTIFICATION

b(6)-4

[redacted]

DATE OF ORDER TIME OF ORDER HOURS

⑦ IV - LR at 125 cc/hr

⑧ Ancef 1 gram IVPB q 8 hrs

⑨ MSO4 2-6 mg IVP q 2 hrs prn

⑩ Tylenol 650 mg P.O. q 4 hrs prn

⑪ Percocet, 1-2 tabs P.O. q 4-6 hrs prn

⑫ To OR in AM

b(6)-2 [redacted]

URSING UNIT | ROOM NO. | BED NO.

ATIENT IDENTIFICATION

DATE OF ORDER 4 Jun 03 TIME OF ORDER 1730 HOURS

1 Benadryl IV 50mg XT Now.

V.O. DR [redacted]

URSING UNIT | ROOM NO. | BED NO.

2140 [redacted]

ATIENT IDENTIFICATION

b(6)-2 HOURS

URSING UNIT | ROOM NO. | BED NO.

MEDCOM - 12567

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.

PATIENT IDENTIFICATION
b(6)-4
[redacted]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION
b(6)-4
[redacted]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 3 JULY 03 TIME OF ORDER 1340 HOURS

LIST TIME ORDER NOTED AND SIGN: 1355 [redacted]

① S/P I+D Ⓡ LEG INCISION
Ⓡ THUMB TIP AMPUTATION
② CONDITION: STABLE
③ VS: ROUTINE b(6)-2
④ BED REST, OOB TO CHAIR, T
⑤ ELEVATE Ⓡ FOOT

DATE OF ORDER TIME OF ORDER HOURS

⑥ REGULAR DIET
⑦ IV: LR AT 125cc/hr, HEP
LOCK WHEN TOLERATING
PO WELL
⑧ PERCOCET 1-2 TABS P.O. Q 4-6 HRS
PRN
⑨ TYLENOL 650mg P.O. Q 4 HRS PRN
⑩ MSO4 2-6 mg IVP Q 2 HRS PRN

DATE OF ORDER TIME OF ORDER HOURS

⑪ ANCEF 1 GM IVPB Q 8 HRS
⑫ GENTAMYCIN 400 mg ~~P.O.~~ IV Q 24 HRS
Pe [redacted]
b(6)-2

DATE OF ORDER 3 JULY 03 TIME OF ORDER 1705 HOURS

① TRANSFER TO WARD WHEN
BED AVAILABLE [redacted]

4/4/03/0830 [redacted]
② NPO p MN scheduled [illegible]
U.O.R. [redacted]
b(6)-2
[illegible] @1650

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

MEDCOM - 12568

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

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 4 Jun 03
TIME OF ORDER: 0845 HOURS
LIST TIME ORDER NOTED AND SIGN

NPO p̄ MN
for I&D 5 Jun 03

b(6)-2 [redacted]

PATIENT IDENTIFICATION

b(6)-4

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 6 Jun 03
TIME OF ORDER: 0805 HOURS

① Resume previous orders
② s/p ex-fix and I&D (R) ankle
③ Bedrest – strict
④ VS – routine
⑤ OOB to chair TID
⑥ Elevate (R) foot

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER
TIME OF ORDER
HOURS

⑦ Regular diet
⑧ IV LR at 125cc/hr. Hep lock when taking P.O. well

b(6)-2 [redacted]

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 9 Jun 03
TIME OF ORDER: 0845 HOURS

① Resume previous orders
② Transfer to ICW
③ Regular diet
④ IV LR at 125cc/hr. Hep lock when taking P.O. well
⑤ Daily wet to dry dressing changes and pin care

[redacted]

b(6)-2

DA FORM 1 APR 79 4256

REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 12569

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

ATIENT IDENTIFICATION

b(6)-4 [redacted]

b(6)-2 [redacted]

URSING UNIT | ROOM NO. | NO.

9Jul03 1700

DATE OF ORDER 9 Jul TIME OF ORDER 1720 HOURS

LIST ORD NOTED SIG

1) HalDoL 5 Mg IV PRN
Q6° For Agitation b(6)-2

V.O. DR [redacted] MAJ/AN

ATIENT IDENTIFICATION

DATE OF ORDER 7/13/03 TIME OF ORDER 1500 HOURS

1) DC IV meds, Ancef & Gentamycin
2) DC IV
3) Start Cipro 500mg PO X BID

b(6)-2

V.O. Dr [redacted] MAJ/AN

[redacted] b(6)-2

URSING UNIT | ROOM NO. | BED NO.

b(6)-2

24° ✓ done [redacted] AN

ATIENT IDENTIFICATION

E P W b(6)-4

[redacted]

DATE OF ORDER 7/27/03 TIME OF ORDER 1620 HOURS

① Tylenol #3 1-2 PO. Q 4-6 hrs
PRN b(6)-2

[redacted] noted 1620

URSING UNIT | ROOM NO. | BED NO.

ICW2

24° ✓ 2315 28 July 03 [redacted]

ATIENT IDENTIFICATION

[redacted]

b(6)-4

DATE OF ORDER TIME OF ORDER

29 July 03 2300 HOURS

① Benadryl 50mg ↑ po qhs prn
[illegible]

[redacted]

b(6)-2

29 Jul 03 [redacted]

b(6)-2

URSING UNIT | ROOM NO. | BED NO.

b(6)-2

24° ✓ done [redacted] AN

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
EPW b(6)-4
[redacted]

NURSING UNIT: ICW2
ROOM NO.: 24°VS
BED NO.: 11

DATE OF ORDER: 5Aug03
TIME OF ORDER: 2100 HOURS
LIST TIME ORDER NOTED AND SIGN

① NPO p̄ MN
② to OR 6Aug per Dr [redacted]
Taken [redacted]

noted [redacted] 2100 b(6)-2

2200 05 Aug03 [redacted]

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

NURSING UNIT: ICW2
ROOM NO.: 24°VS
BED NO.: 2200

DATE OF ORDER: 6 AUG 03
TIME OF ORDER: 1100 HOURS

noted [redacted] 1100 6/8

① RESUME PREVIOUS ORDERS
② REGULAR DIET
③ IV LR AT 125cc/hr, D/C IV WHEN TAKING P.O. WELL
④ UP ON CRUTCHES WITH P.T. TODAY
⑤ TO EPW GROUP IN AM

[redacted]
b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT
ROOM NO.
BED NO.

DATE OF ORDER
TIME OF ORDER
[redacted]
b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT
ROOM NO.
BED NO.

DATE OF ORDER
TIME OF ORDER _______ HOURS

DA FORM 1 APR 79 4256 REPLACES MEDCOM - 12571 MAY BE USED.

b(6)-2

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

Mo. ____ *Yr.* 2003

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

ORDER DATE	CLERK/ NURSE	b(6)-2 RECURRING ACTIONS, FREQUENCY, TIME	HR	1	2	3	4	5	6	7	8	9	10	11	12	13	14
7-1-03	[redacted]	VS - routine	05	/	[redacted]												
			17	/													
[redacted]																	
7-3-03	[redacted]	Regular Diet	05		/	[redacted]											
			17	/	/												
7-3-03	[redacted]	Bedrest, OOB TC	05	/	/												
		TID	17	/													
6 Jul	[redacted]	Resume Previous Orders		/													
7/9	[redacted]	Daily wet to dry Dsg	05	/	/	/	/	/	/	/	/	[redacted]				[redacted]	
		Δ's PRN PIN care	17	/	/	/	/	/	/	/	/	[redacted]				[redacted]	

D/C'd 7 AUG 03 1[illegible]30 hrs

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW (R) leg - (R) hand

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ____

PATIENT IDENTIFICATION: b(6)-4

EPW # [redacted]

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 EDITION OF 1 DEC 77 MAY BE USED. USAPA V1.00

MEDCOM - 12572

b(6)-2 All

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo ______ *Yr* 2003

Verify by Initialing Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
7-1-03	[redacted]	Admit to ICU-1	7-1-03	2320	2320	[redacted]
7-1-03	[redacted]	Dx - GSW to (R) Leg, (R) Hand	7-1-02	2320	2320	
7-1-03	[redacted]	Condition - Fair	7-1-02	2320	2320	
7/4	[redacted]	NPO p̄ MN scheduled for I&D in AM	7/5/03	AM		done
7/9	[redacted]	Transfer ICW	7/9	Am		

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													

USAPA V1.00

MEDCOM - 12573

b(6)-2

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

Mo. Jul *Yr.* 2003

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 15	16	17	18	19	20	21	22	23	24	25	26	27	28
7-1-03	[redacted]	VS-routine	05	[redacted]													
			17	[redacted]													
7-1-03	[redacted]	Regular Diet	08	[redacted]													
			17	[redacted]													
7-3-03	[redacted]	Bedrest, OOBTC	08	[redacted]													
		TID.	17	[redacted]													
7-8-03	[redacted]	Daily wet to dry Dsg A's prn	08	[redacted]													
		prn care BID	17	[redacted]													
7-6-03	[redacted]	Elevate Ⓡ Foot	05	[redacted]													
			17	[redacted]													

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW-Ⓡleg-Ⓡhand

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ____

PATIENT IDENTIFICATION:

EPW# [redacted]

b(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78

MEDCOM - 12574

JSED.

USAPA V1.00

b(6)-2 All

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo 7 Yr 2003

Verify by Initialing: Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
7-1-03	[redacted]	Admit to ICU-1	7-1-03	2320	2320	[redacted]
7-1-03	[redacted]	DX-GSW to Ⓡ leg, Ⓡ hand;	7-1-03	2320	2320	[redacted]
7-1-03	[redacted]	Condition-Fair	7-1-03	2320	2320	[redacted]
7-4-03	[redacted]	NPO p̄ MN scheduled for I c̄ D in AM	7-5-03	AM		
~~7-9-03~~	[redacted]	~~Transfer to ICW~~ CE			done	
7-9-03	[redacted]	Transfer to ICW	7-9-03	AM	done	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED

USAPA V1.00

MEDCOM - 12575

b(6)-2 All

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 — *INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION*

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 1	2	3	4	5	6	7	8	9	10	11	12	13	14
7-1-03	[redacted]	IV LR @ 125 cc/hr	05	/	[redacted]			D/C'd 03 Jul 03									
			19	[redacted]													
			22	[redacted]													
7-1-03	[redacted]	Ancef 1 gram IVPB Q8°	06	/	[redacted]												
			14	/	[redacted]												
			22	[redacted]													
7.3.03	[redacted]	Gentamycin 400mg IV QD	10	/	/	[redacted]											
7.3.03		LR 125cc/hr, HL when tolerating PO well.	05	/	/	[redacted]											
		HL @ 2006 7.3.03	17	/	[redacted]												
		flush HL q shift.															
7/13/03	[redacted]	Cipro 500mg BID	10	/	/	/	/	/	/	/	/	/	/	/	/	/	[redacted]
			22	/	/	/	/	/	/	/	/	/	/	/	/	[redacted]	

DC'd AUG 03 1600 hr

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW (R) hand (R) leg

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ______

PATIENT IDENTIFICATION:

EPW [redacted]

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 — MEDCOM - 12576 — ED UNTIL EXHAUSTED. — USAPA V1.00

b(6)-2 All

Verify by Initialing		**THERAPEUTIC DOCUMENTATION CARE PLAN** *(MEDICATIONS)*	Mo.		Yr.	
Order Date	**Clerk/ Nurse**	**SINGLE ORDER, PRE-OPERATIVES**	**Date to be Given**	**Time to be Given**	**Time Given**	**Initials**
7-1-03	[redacted]	~~TO OR IN AM~~ wrong sheet	7-1-03	2330	2330	[redacted]
7/4	[redacted]	50mg Benadryl IV for itching	7/4	1800	1800	[redacted]
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					

Order/ Expir Date	**Clerk/ Nurse**	**PRN MEDICATION, DOSE, FREQUENCY**	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* TIME/DATE DISPENSED													
7-1-0 [redacted]	[redacted]	MSO4 2-6mg IVP Q2hr	2Jul03 4mg 0030	2Jul 5mg 0630	2Jul 5mg 1200	2Jul 5mg 1520	2July 5mg 1910 [redacted]	2July 8mg 2145 [redacted]	7.3 4mg 1100 TB	7.3 6mg 1630	7.3 4mg 1930	7.3 4mg 2030	7.3 4mg 2315	7.4 6mg 0100	7.4 6mg 0506	7/4 6mg 0800
7-1-03	[redacted]	Tylenol 650mg PO	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]			[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
- - - - -	- - - - -	Q4hr PRN														
7-1-03	[redacted]	Percocet 1-2 tabs PO Q4-6 hrs PRN	7.3 II 0830 TB	7.3 2 1920	7/4 II 2[illegible]	7/6 II 0140	7/6 II 009	7July II 0605	7/7 II 1630	7/8 II 0900 CB	7-14 II 1800 [redacted]	7-15 II 0900				
7-1-0 [redacted]	[redacted]	T		[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
7/4/03	[redacted]	MSO4 2-6mg IVP Q2 hr	7/4 5mg [illegible] 1000	7/4 5mg [illegible] 1500	7/4 4mg [illegible] 1720 8 July 3mg CB 0820	7/4 4mg 2040 [redacted] 8 July 6mg 1150 [redacted]	7/5 4mg 0030 [redacted] 8 July 1mg WS [redacted]	7/5 5mg 1215 [redacted]	7/5 6mg 1500 [redacted]	7/6 6mg 0850 [redacted]	7/6 4mg 0940 [redacted]	7/6 5mg 1450 [redacted]	7/6 5mg 1300 [redacted]	6July 5mg 1720 [redacted]	6July 5mg 2130 [redacted]	7July 5mg 0650 TB
- - - - -	- - - - -															
- - - - -	- - - - -															
9Jul	[redacted]	HalDoL 5mg IV PRN	1700 9Jul I Mtt E⊕													
- - - - -	- - - - -	Q6° for Agitation														
- - - - -	- - - - -															
- - - - -	- - - - -															

see below [redacted]

USAPA V1.00

MEDCOM - 12577

b(6)-2

recopied

the proponent agency is the Office of The Surgeon General.

MO 7 YR 2003

RIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	29	30	31	1	2	3	4	5	6	7	8	9	10
1	[redacted]	VS-routine	05	[redacted]										D/c'd		
			13											7AUG03		
			21											1600		
			/											Am		
1	[redacted]	regulardiet	05	[redacted]										D/c'd		
			13											7AUG03		
			21											1600		
			/											Am		
3	[redacted]	bedrest - OOB to chair TID	05	[redacted]										D/c'd		
6		elevate (R) foot	13											7AUG03		
			21											1600		
			/											Am		
4	[redacted]	dir care BID	08	[redacted]										ex fix		
		dailyw-D dsgD - D/c'd	1											removed		

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: GSW (R) thumb (R) foot ex fix

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ____

PATIENT IDENTIFICATION:

~~EdW~~ BSS [redacted]

b(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIME

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 MEDCOM - 12578 USED. USA

[illegible]

b(6)-2 All

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo 7 *Yr* 2003

Verify by Initialing

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
5	[redacted]	NPO p̄ MN	6			
5	[redacted]	O/C to OR in AM	6	O/C		
6Aug	[redacted]	D/C to EPW camp in AM	7Aug	AM	1600	[redacted]
6Aug	[redacted]	Up on crutches c̄ PT today	6Aug	AM	1630	[redacted]

Order/ Expir Date		PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED

b(6)-2

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. Jul Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED													
				15	16	17	18	19	20	21	22	23	24	25	26	27	28
7-13-03	[redacted]	Cipro 500mg BID	10	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
b(6)-2			22	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW Ⓡ hand Ⓡ leg

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

PATIENT IDENTIFICATION:

EPW # [redacted]

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 - 12580

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*			Mo. Jul	Yr. 2003
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
7-4-03	[redacted]	50mg Benadryl IV for itching	7-4-03	1800	1800	[redacted] Transcrib

[illegible]-2 A11

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED
7-1-03	[redacted] [redacted]	Tylenol 650 mg PO Q4hr prn	1330 [illegible] 17 July 17Jul 1810 ii PO 18Jul [illegible] 19Jul 1400 ii PO 20 July 1000 20Jul 2201 ii PO 22Jul 1715 22Jul 0956 ii PO 23 July 1935 ii [redacted] 25Jul 03 1810 [illegible]
7-1-03	[redacted]	Percocet 1-2 tabs PO Q4-6hrs prn	15Jul [illegible] 15Jul [illegible] tab 16Jul 0530 16Jul 22:20 ii PO 17July 2020 17Jul 02:17 ii PO 18Jul 1030 ii PO 19Jul [illegible] 19July 2100 19Jul 2300 20Jul 00:25 ii PO [redacted] [redacted] [redacted]
7-1-03	[redacted]	Percocet 1-2 tabs PO Q4-6hrs PRN	7/21 1151 21 Jul 2300 22July 0930 ii PO 22July 0945 ii PO 23Jul 03:36 ii PO 23Jul 2210 ii PO 24Jul 03:28 ii PO 24Jul 0930 ii PO [redacted] copied
23Jul	[redacted]	Tylenol 650mg PO Q4° PRN	23Jul 0818 ii PO 24July 0705 ii PO 24Jul 08:56 ii PO 25Jul 2011 ii PO 26Jul 650mg PO 26Jul 03:20 ii PO [redacted] copied
27 Jul	[redacted]	Tylenol #3 1-2 tabs PO q4-6hrs	27Jul 1615 27Jul 2030 28July 1000 ii PO 28 July 1430 ii PO [redacted] copied

USAPA V1.00

MEDCOM - 12581

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*			*Mo.* 8 *Yr.* 03	
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					

b(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION.* TIME/DATE DISPENSED
7/1/03	[redacted]	tylenol 650mg po Q4hr PRN	Ī 2300 28Jul III 0021 30Jul 30Jul 1340 III [illegible] 0005 Ī PO 3Aug 1110 IIPO 4Aug 1120 IIPO 4Aug 2046 IIPO 4Aug 1930 IIPO [redacted] DC 4Aug03 [redacted]
7/1/03	[redacted]	Percocet 1-2 tabs po q4-6' PRN	Ī 2300 28Jul II 1245 29Jul Ī 2000 29Jul 30Jul 0658 Ī PO 30Jul 2351 Ī PO 31Jul 0304 Ī PO 31Jul 0730 II PO 3Aug 1500 II 3Aug 1515 II 3Aug 2330 II 5Aug 0730 II 5Aug 2002 II 6Aug 1310 7Aug 0520 II PO KW [redacted] [redacted]
27July	[redacted]	tylenol #3 1-2 tabs po q4-6' PRN	27July II PO 0810 [redacted]
30Jul	[redacted]	Benadryl 50mg Ī PO qHS sleep	30Jul 0105 Ī PO [redacted]

FPW # [redacted] MEDCOM - 12582

b(6)-4

USAPA V1.00

b(6)-2

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. Jly Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	August DATE DISPENSED													
				29	30	31	1	2	3	4	5	6	7	8	9	10	11
28Jly03	[redacted]	Cipro 500mg BID po	10	[redacted]										D/C'd			
			22	[redacted]										7Aug	1600		
6Aug03	[redacted]	IV LR @125cc/hr: D/C	04				IV										
		IV when tolerating po well	14				D/C'd										
			22					6Aug	1200								

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW Ⓡ hand Ⓡ leg

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ______

PATIENT IDENTIFICATION:

EPW
[redacted]

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

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE **Post-Anesthesia Care Unit (PACU) Flow Sheet**

OTSG APPROVED *(Date)*

Date:
Time In: 0845
Allergies: NKDA
Pre-op V/S:
Procedures: I&D DSgA
(R) Ankle

Anesthesia Type (Circle)): General Spinal Epidural [✓ IV Sedation] Nerve Block
OR Intake: Crystalloid 400 cc LR Colloid
OR Output: UOP EBL min
Meds/Times: 70mg Ketamine
2.5 Versed iv, 60 Fent

Drains
- Hemovac
- NG
- JP
- T-tube
- Foley
- TLS

Airway
- Nasal
- Oral
- ETT
- Trach
- Other

Pre Op Meds

History

Time	0845	0855	0900	0915	0930	0945										
SaO2	97	97	95	98	97	9?										
FiO2																
Methods	RA	RA	RA	RA		RA										
240																
220																
200																
180																
160																
140																
	V				V											
120			^	V												
		^			^	V										
100																
80																
	R															
60		V	V		^	^										
				^												
40																
20																
RR	17	19	16	9	16	13										
T A	98.5				98.4											

Time								
Pain (0-10)								
LOS								

Pacu Intake

Time	Solution	Amount	Site	By	Infused
0845	LR	500	(R) FA	OR	500
0945	LR	125	(R) FA	ICU t	125

X-rays:

Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2^	2	
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	1	
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	N/A	N/A	
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	9	9	

Codes

AIRWAY
A = Ambu
BB = Blow-by
M = Mask
FT = Face Tent
RA = RoomAir
NC = Nasal Cannula

V/S
X = A-line BP
ˆ = Cuff BP
= Pulse

TEMP
S = Skin
O = Oral
A = Axillary
T = Tympanic
R = Rectal

LOS
C = Cervical
T = Thoracic
L = Lumbar
S = Sacral

Patient teaching done: Wound Care, Pain Management,
T, C, & DB,. Incentive Spirometer, Comfort Measures Blanket (elevation)
Safety: SR up X 2, Falls Precautions. Privacy Maintained

(Continue on reverse)

PREPARED BY *(Signature & Title)*

DEPARTMENT/SERVICE/CLINIC

DATE

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

Name – last,

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

DA FORM 4700, MAY 78 **WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN)** **Previous edition is obsolete**

USAPPC V2.00

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	(R) Leg	Partial	+	P		W	
15'							
30'							
45'							
60'							
90'							
D/C							

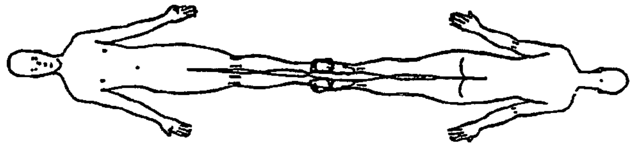
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

	Adm	15'	30'	45'	60'	90'	D/C
Fund. Height							
Lochia							
Peripad#							
Fund. Cond.							

DRESSINGS

Time	Location	Type	Drainage
Adm	(R) Ankle	Ace wrap/Ex Fix	0
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount
1000	[illegible].	yellow, CLR	600

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

~~1891U (R) Forearm; S/P I&D (R) Ankle~~, LR125 KO

1000 S/P I&D (R) Ankle

Cond stable

Neuro: Pt ~~can~~ can move toes & bear min weight to (R) Ankle,

Card: PP x2 R Ankle, cap refill unable to assess

IV site (R) FA. LR infusing 125cc/hr via Dial a flow.

VOP through bedside Comode & urinal

Discharge Criteria:
Date: 7/9 **Time:** **PARS:**
BP: **T:** **HR:** **RR:** **Sa02:**
Pain Level at D/C (0-10):
Intake:__________ **Output:**__________
Additional Data:
Transferred To:
Report Given To:
Transferred Via: W/C Litter Gurney Ambulance
Transferred By:
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature:

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	0615 TIME	0615	INITIALS [redacted] b(6)-2	INITIALS
NEURO	PUPILS	PERRLA. 3mm.		1835 PERRLA 3mm
	SENSORIUM			A+Ox3, Cooperative
RESPIRATORY	RESPIRATORY PATTERN	no distress, (B) equal		Unlabored CTA (B)
	BREATH SOUNDS	chest rise/fall.		
	SECRETIONS	clear CS to aus.		
		BPM 12-18.		
SKIN	COLOR	normal for race		W D
	INTEGRITY	(R) LE, ex fix in place,		(R) LE - ExFixator in place
		Skin of toes - necrosis, hard & black		
IV SITE	LOCATION	(R) hand, site		(R) hand - ⊖ S/Sx inf
	CONDITION	$\bar{s}$ S/S infect/		
		infiltration -		
		0730 new IV started		
		(R) forearm		
GASTRO	ABDOMEN	+ BS x4 quads		+ BS x4
	BOWEL SOUNDS	NT, ND.		NonTender, Soft
GU	URINE:			
	COLOR/CLARITY			
CARDIOVASCULAR	CARDIAC RHYTHM	S1, S2, SB -		$S_1 S_2$ SR-SB
		60-65 BPM		

LEGEND			
	Cr - Creatinine	ICP - Intracranial Pressure	S/A - Fractional
	F_1O_2 - Fraction of Inspired O_2	PCO_2 - Pressure of Arterial CO_2	SAT - Saturation
	HCO_3 - Bicarbonate	PEEP - Positive End Expiratory Pressure	TRACH - Tracheostomy

b(6)-2

(Continue on reverse)

[redacted] 91WM6	DEPARTMENT/SERVICE/CLINIC ICU 2 west	DATE 8 July 03

[redacted] ve: Name—last, first, middle; grade; date; hospital or medical facility)

[redacted]

b(6)-4

☐ HISTORY/PHYSICAL
☐ OTHER EXAMINATION OR EVALUATION
☐ DIAGNOSTIC STUDIES
☐ TREATMENT
☐ FLOW CHAR
☐ OTHER *(Spe*

DA FORM 1 MAY 78 **4700**
Proponent: Dept of Nurs

MEDCOM - 12586

WAMC OP 375 (Redesignated)
1 Apr 90 (HSXC-NU)

PA

DX [illegible]

HOSPITAL DAY

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15
P Arterial Line																	
P Cuff							130/85					120/80				118/90	
emperature							97.9					97.5				98.2	
ulse							65					72				68	
espiratory Rate							16					20				16	
[illegible]																	
[illegible]																	

TIME		24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15
IVPB								100					100				100	300
T																		
OTALS																		
JRINE	HOUR / TOTAL										200/500					275/475		400/875
	sp gr																	
	S/A																	
NG	OUTPUT																	
	pH																	
	GUIAC																	
MESIS																		
TOOL											med amt.							

PA

BP
Temp
Pulse
RR
O2

17	18	19	20	21	22	23	
			126/				
			64				
			~~96~~				
			72				
			16				
			98%				
			RA				

IV
PO

17	18	19	20	21	22	23	8°T
		275/275					

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA

TIME								
MODE								
F_iO_2								
TV								
RATE								
PEEP								
ABG pH								
PCO_2								
pO_2								
HCO_3								
SAT								
BASE								

LABORATORY DATA

TIME								
GLUCOSE								
Na/K								
Cl/CO_2								
BUN/Cr								
WBC/PLATELET								
Hct/Hgb								

ACTIVITIES OF DAILY LIVING

TIME			
MOUTH CARE			
BATH			
SKIN CARE			
FOLEY CARE			
TRACH CARE			
ROM EXERCISES			

	TIME			
TURN				
SUCTION				

24° I&O TOTALS

wt Yesterday ________
wt Today ________

INTAKE
IV ________

OUTPUT
Urine: ________

NURSE'S SIGNATURE

MEDCOM - 12588

Fo ICAL RECORD—SUPPLEMENTAL ME DA
see AR 40-66; the proponent agency is the C The General

REPORT TITLE
INTENSIVE CA E NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

NEURO	1700 TIME	1 INITIALS	10 July [illegible] INITIALS [redacted]	July 1700 INITIALS [redacted]
	PUPILS	3 m	PERRL R (B) 3m	Perrla 3mm
	SENSORIUM	Alert - when spoken	AAOx3	A+Ox3
		TO Person & place?		
				b(6)-2
RESPIRATORY	RESPIRATORY PATTERN	Reg even	even unlabored	even unlabored
	BREATH SOUNDS	CTA BiL	CTA-(B)	CTA-B
	SECRETIONS	0	∅	none
			SpO2 97-99%	
SKIN	COLOR	Normal for Race	NFR	NFR
	INTEGRITY	(R) foot injury Toes dark	dry intact	dry/intact,
				cast on right leg
IV SITE	LOCATION	(R) FA is patent	(L) FA patent	LFA
	CONDITION	0 s/s infiltration	HL ∅ s/s inf	HL
GASTRO	ABDOMEN	Soft NonTender	Soft NT & ND	soft, nontender
	BOWEL SOUNDS	BS (+) x4 Quads	(+) BS x4	+BS x 4 qds
GU	URINE.	Clear yellow	clear - dark	urinal
	COLOR/CLARITY	uses urinal cont.	yellow	clear, yellow
CARDIOVASCULAR	CARDIAC RHYTHM	NSR	S_1S_2 [illegible]	S_1S_2
				NSR
			B/P	+2 pulses radial/pedal
			∅	<3sec cap refill

LEGEND
Cr - Creatinine
F_iO_2 - Fraction of Inspired O_2
HCO_3 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
S/A - Fractional
SAT - Saturation
TRACH - Tracheostomy

b(6)-2

(Continue on reverse)

[redacted]/1620

DEPARTMENT/SERVICE/CLINIC
ICU 2 east

DATE
09Jul03

tten entries give: Name—last, first, middle; grade; date; hospital or medi l facility)

EPW [redacted]

b(6)-4

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

DA FORM 1 MAY 78 4700
Proponent Dept of Nurs

WAMC OP 375 (Redesignated)
1 Apr 90 (HSXC-NU)

ICAL RECORD—SUPPLEMENTAL MEDICAL DATA
rm. see AR 40-66, the proponent agency is the Office

.TSG APPROVED (Date)
OA Appr 8 Mar 89

REPORT TITLE
INTENSIVE URSING FLOW SHEET

INITIAL SHIFT ASSESSMENT

	TIME	1700	INITIALS [redacted]	0500	INITIALS [redacted]		INITIALS
NEURO	PUPILS	Perrla 3mm		PERRLA [illegible]			
	SENSORIUM	A+O×3		[illegible]			
		limited ROM		[illegible]			
				[illegible]			
				[illegible]			
RESPIRATORY	RESPIRATORY PATTERN	even, unlabored.		[illegible]			
	BREATH SOUNDS	CTA-B		[illegible]			
	SECRETIONS	none		[illegible]			
				[illegible]			
				[illegible]			
SKIN	COLOR	NFR		SKIN W&D			
	INTEGRITY	dry, intact		[illegible]			
I.V. SITE	LOCATION	R hand		(B) hand [illegible]			
	CONDITION	c/d/i patent		[illegible] patent			
				[illegible] well			
GASTRO	ABDOMEN	soft, nondistended		[illegible] soft [illegible]			
	BOWEL SOUNDS	+BS x 4 quads		+ BS x4			
GU	URINE COLOR/CLARITY	clear yellow		[illegible] AMBER			
		uses urinal		[illegible] URINAL			
CARDIOVASCULAR	CARDIAC RHYTHM	S1S2		RSR [illegible]			
		NSR		[illegible] beats			
		+2 pulses pedal/		[illegible] (B)			
		radial		lower leg			
		<3 sec capillary					

LEGEND
Cr - Creatinine
FiO2 - Fraction of Inspired O2
HCO3 - Bicarbonate
ICP - Intracranial Pressure
PCO2 - Pressure of Arterial CO2
PEEP - Positive End Expiratory Pressure
SA - Fractional
Sat - Saturation
TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC
ICU 2 [illegible]

DATE

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

[redacted]

b(6)-4

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

DA FORM 1 MAY 78 4700
Proponent: Dept of Nurs

WAMC OP 375 (Redesignated)
1 Apr 90 (HSXC-NU)

DATE | DX | HOSPITAL DAY | PAGE 2 OF 4

VITAL SIGNS	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial Line																		
BP Cuff	112/68				106/64					121/73				134/66				
Temperature	98.2				98.1													
Pulse	79				74					84				76				
Respiratory Rate	14				14					18				18				
	98				96					96				99				
	RA				RA					RA				RA				

INTAKE	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
[illegible]							50		50	320		100			360	100		720 950
TOTALS									50									950

OUTPUT		24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
URINE	HOUR / TOTAL	400				400 120							[illegible]				300		920
	Sp.gr																		
	S/A																		
NG	Output																		
	pH																		
	Guiac																		
EMESIS																			
STOOL															X1				
DRAINS																			
TOTALS																			

MEDCOM - 12591

PAGE 3 OF 4

POST-OP DAY

V	16	17	18	19	20	21	22	23	
BP I					118/71				
Temp T									
HR A					85				
RR					14				
L					98				
O2					RA				
S									
I									
G									
N									
S									

	16	17	18	19	20	21	22	23	8° T
I									
N									
T									
A									
K									
E									
					410				
O									
U									
T									
P									
U									
T									

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA									
TIME									
MODE									
F_iO_2									
TV									
RATE									
PEEP									
A pH									
A PCO_2									
B pO_2									
B HCO_3									
G SAT									
G BASE									

LABORATORY DATA									
TIME									
GLUCOSE									
Na/K									
Cl/CO_2									
BUN/Cr									
WBC/PLATELET									
Hct/Hgb									

ACTIVITIES OF DAILY LIVING											
TIME				TURN	TIME						
MOUTH CARE											
BATH											
SKIN CARE											
FOLEY CARE				SUCTION							
TRACH CARE											
ROM EXERCISES											

24° I&O TOTALS

wt Yesterday ________ wt Today ________

INTAKE		OUTPUT	
IV	________	Urine:	________
PO	________		________
	________		________
TOTAL	________	TOTAL	________

BALANCE________

NURSE'S SIGNATURE	INITIALS

MEDCOM - 12592

MEDICAL RECORD—SUPPLEMENTAL MED AT
form, see AR 40-66; the proponent agency is the O neral

REPORT TITLE
INTENSI are URSING FLOW SHEET b(6)-2

OTSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0600	INIT [redacted]	1800	INITIALS [redacted]		INITIALS
NEURO	PUPILS	3mm Perr		3mm Perll			
	SENSORIUM	Pt. AOx3, no c/o		A+Ox3			
		pain.		MAE x 4			
				RLE Toes only			
RESPIRATORY	RESPIRATORY PATTERN	unlabored, even		even + unlabored			
	BREATH SOUNDS	Ⓑ, CTA		CTA bilat			
	SECRETIONS	Ø		Ø noted			
SKIN	COLOR	warm c̄ dry		warm + dry			
	INTEGRITY	intact		Intact			
IV SITE	LOCATION	Ⓡ FA, EDT,		D/C			
	CONDITION	no s/s of infl/infil					
				NO IV			
				fluids			
GASTRO	ABDOMEN	Soft, NT, ND.		soft nontender			
	BOWEL SOUNDS	BS x 4 quads		BS x 4 quads			
				will start tubefeeds			
GU	URINE:	warm yellow,		yellow			
	COLOR/CLARITY	via urinal		/clear			
CARDIOVASCULAR	CARDIAC RHYTHM	S1S2 70-80's		S1S2			
				70-80's			

LEGEND
Cr - Creatinine
F_iO_2 - Fraction of Inspired O_2
HCO_3 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
S/A - Fractional
SAT - Saturation
TRACH - Tracheostomy

(Continue on reverse)

[redacted]
P irst, middle; grade; date; hospital or medical facility

DEPARTMENT/SERVICE/CLINIC: ICU 2 west

DATE: 13 July 03

b(6)-2

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

DA FORM 1 MAY 78 4700
Proponent: Dept of Nurs

WAMC OP 375 (Redesignated)
1 Apr 90 (HSXC-NU)

MEDCOM - 12593

PAGE 2 OF 4

DATE

DX

HOSPITAL DAY

VITAL SIGNS	TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
	BP Arterial Line							120/84							118/79				
	BP Cuff																		
	Temperature							98											
	Pulse							76							80				
	Respiratory Rate							20							18				
	SpO2							98							99				
								RA											
INTAKE	TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	TOTALS																		
OUTPUT	URINE HOUR / TOTAL				350			350							300				-
	URINE Sp Gr																		
	URINE Sm																		
	NG Output																		
	NG pH																		
	NG Guaiac																		
	EMESIS																		
	STOOL																		
	DRAINS																		
	DRAINS																		
	DRAINS																		
	TOTALS																		

PAGE 3 OF 3

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

	16	17	18	19	20	21	22	23	
BP	115/75		120/78				115/75		
T									
P	97		82				73		
R	16		16				20		
SpO2	99		100%				98		
							RA		

	16	17	18	19	20	21	22	23	8°T
PO									
			400/300					350/140	

TIME								
MODE								
F_IO_2								
TV								
RATE								
PEEP								
A pH								
A PCO_2								
B pO_2								
B HCO_3								
SAT								
G BASE								

TIME								
GLUCOSE								
Na/K								
Cl/CO2								
BUN/Cr								
WBC/PLATELET								
Hct/Hgb								

TIME			
MOUTH CARE			
BATH			
SKIN CARE			
FOLEY CARE			
TRACH CARE			
ROM EXERCISES			

TURN

SUCTION

TIME

24° I&O TOTALS

wt Yesterday ______ wt Today ______

INTAKE

IV ______

po ______

TOTAL ______

OUTPUT

Urine: ______

TOTAL ______

BALANCE ______

NURSE'S SIGNATURE	INITIALS

MEDCOM - 12595

ACLU-RDI 1592 p.488

…ICAL RECORD—SUPPLEMENTAL …

For use … see AR 40-66; the proponent agency is …

… DATA … The Surg…

REPORT TITLE

INTEN… CARE N…RSING FLOW SHEET

b(6)-2

…G APPROVED (Date)

CA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0600	INITIALS	1800	[redacted]		INITIALS
NEURO	PUPILS	5mm PEARLA		Pearla 3 mm			
	SENSORIUM	Can move all		Alert x 3			
		4 extremities					
RESPIRATORY	RESPIRATORY PATTERN	even unlabored		Reg even			
	BREATH SOUNDS	CTA B		CTA B/L			
	SECRETIONS	Ø		Ø			
		RR 14					
		SpO2 98%					
SKIN	COLOR	NFR		Normal for Race			
	INTEGRITY	Dry		warm dry			
IV SITE	LOCATION	Ø		Ø			
	CONDITION	Ø		Ø			
GASTRO	ABDOMEN	hypo x 4		BS⊕ x 4 quads			
	BOWEL SOUNDS			soft NT			
		Firm ND-T					
GU	URINE	via urinal		clear yellow			
	COLOR/CLARITY	yellow clear		via urinal			
CARDIOVASCULAR	CARDIAC RHYTHM	S1 S2 ausc		S1 S2			
				NSR			
		PP x4/x4					

LEGEND
Cr - Creatinine
FiO2 - Fraction of Inspired O2
HCO3 - Bicarbonate
ICP - Intracranial Pressure
PCO2 - Pressure of Arterial CO2
PEEP - Positive End Expiratory Pressure
%A - Fractional
SAT - Saturation
TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC: ICU 2nd

DATE

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

EPW [redacted]

b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 1 MAY 78 4700
Proponent: Dept of Nurs

WAMC OP 375 (Redesignated)
1 Apr 90 (HSXC-NU)

MEDICAL RECORD—SUPPLEMENTAL M

For use of t

. see AR 40-66; the proponent agency is thi

DATA

The Su

REPORT TITLE

INTEN CARE ING FLOW SHEET

SG APPROVED (Date)

OA Appr 8 Mar 89

15 Jul 03

INITIAL ASSESSMENT

	TIME	0500	INITIALS [redacted]	INITIALS		INITIALS
NEURO	PUPILS	PERRLA				
	SENSORIUM	A/O x3, follows all				
		commands	b(6)-2			
RESPIRATORY	RESPIRATORY PATTERN	even, unlabored				
	BREATH SOUNDS	CTA (B)				
	SECRETIONS	0				
SKIN	COLOR	NFR				
	INTEGRITY	warm & dry, intact				
IV SITE	LOCATION					
	CONDITION					
GASTRO	ABDOMEN	soft ND/NT				
	BOWEL SOUNDS	x4 hyperactive				
GU	URINE:	via urinal				
	COLOR/CLARITY	drk yellow s				
		sediment				
CARDIOVASCULAR	CARDIAC RHYTHM	NSR				
		S1S2 auscultated				

LEGEND	Cr - Creatinine F_iO_2 - Fraction of Inspired O_2 HCO_3 - Bicarbonate	ICP - Intracranial Pressure PCO_2 - Pressure of Arterial CO_2 PEEP - Positive End Expiratory Pressure	SA - Fractional SAT - Saturation TRACH - Tracheostomy

(Continue on reverse)

[redacted] b(6)-2

es give: Name—last, first, middle; grade; date; hospital or medical facility)

EPW-[redacted]

b(6)-4

DEPARTMENT/SERVICE/CLINIC ICU 2nd

DATE 15 Jul 03

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

DA FORM 1 MAY 78 **4700**
Proponent: Dept of Nurs

WAMC OP 375 (Redesignated) 1 Apr 90 (HSXC-NU)

MEDCOM - 12597

129/17

PAGE 2 OF 4

DATE

DX

HOSPITAL DAY

VITAL SIGNS	TIME		24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
	BP Arterial Line						128					120/				118/				
	BP Cuff						82					/54				/68				
	Temperature						98.2					98.6				97.8				
	Pulse						91					72				82				
	Respiratory Rate						12					14				14				
	O2						97					98				97				
	RA/O2						RA					RA				RA				
INTAKE	TIME		24	01	02	03	04	05	06	07	8° T	08	09	10	11	12	13	14	15	8° T
												80				300				
	TOTALS																			
OUTPUT	URINE	HOUR / TOTAL										225				625				
		sp gr																		
		S/A																		
	NG	Output																		
		pH																		
		Guaiac																		
	EMESIS																			
	STOOL																			
	DRAINS																			
	TOTALS																			

POST-OP DAY

V	16	17	18	19	20	21	22	23	
I	128								
B/P –	80		122/82						
Tp T	96.9		98						
A	86		83						
R L	18		16						
SAO2	97		98						
	[illegible]		RA						
S									
I									
G									
N									
S									

	16	17	18	19	20	21	22	23	8° T
I	[illegible]								
N									
T									
A									
K									
E									
	0								
O									
U									
T									
P									
U									
T									

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA		TIME									
		MODE									
		F_iO_2									
		TV									
		RATE									
		PEEP									
	A	pH									
		PCO_2									
	B	pO_2									
		HCO_3									
		SAT									
	G	BASE									

LABORATORY DATA	TIME									
	GLUCOSE									
	Na/K									
	Cl/CO_2									
	BUN/Cr									
	WBC/PLATELET									
	Hct/Hgb									

ACTIVITIES DAILY LIVING	TIME				TURN	TIME				
	MOUTH CARE									
	BATH									
	SKIN CARE									
	FOLEY CARE				SUCTION					
	TRACH CARE									
	ROM EXERCISES									

24° I&O TOTALS

wt Yesterday ____ wt Today ____

INTAKE OUTPUT

IV ____ Urine: ____

PO ____

TOTAL ____ TOTAL ____

BALANCE ____

NURSE'S SIGNATURE	INITIALS

DATE [redacted] DX [redacted]

AL DAY [redacted] PAGE 2 OF 4

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial Line							134/81											
BP Cuff																		
Temperature																		
Pulse							79											
Respiratory Rate							14											
							97											
							84											

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
TOTALS																		

OUTPUT

URINE	HOUR / TOTAL					400	1100 [illegible]			1510							450 450		450
	sp gr																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUAIAC																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS										1510									450

MEDCOM - 12600

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

PAGE 3 OF 4

VITAL SIGNS

	16	17	18	19	20	21	22	23	
		116/							
		65							
		80							
		13							
		91							
		98							

	16	17	18	19	20	21	22	23	8°T

TIME									
MODE									
F_iO_2									
TV									
RATE									
PEEP									
A pH									
PCO_2									
B pO_2									
HCO_3									
SAT									
G BASE									

LABORATORY

TIME									
GLUCOSE									
Na/K									
Cl/CO_2									
BUN/Cr									
WBC/PLATELET									
Hct/Hgb									

ACTIVITIES OF DAILY LIVING

TIME			
MOUTH CARE			
BATH			
SKIN CARE			
FOLEY CARE			
TRACH CARE			
ROM EXERCISES			

	TIME				
TURN					
SUCTION					

24° I&O TOTALS

wt Yesterday ________ wt Today ________

INTAKE OUTPUT

IV ________ Urine: ________

PO ________ ________

________ ________

TOTAL ________ TOTAL ________

BALANCE ________

NURSE'S SIGNATURE	INITIALS

MEDCOM - 12601

~DICAL RECORD—SUPPLEMENTAL M~ ~CAL ~

~e ~ ~e AR 40-66; the proponent agency is ~ of ~ on General

REPORT TITLE

INTENSIVE ~RE NU~ ~ING FLOW SHEET

OTSG APPROVED *(Date)*
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	1910	INITIALS [redacted]	b(6)-2	INITIALS		INITIALS
NEURO	PUPILS	3mm					
	SENSORIUM	A+O×3					
RESPIRATORY	RESPIRATORY PATTERN	unlabored					
	BREATH SOUNDS	CTA B					
	SECRETIONS	⊖					
SKIN	COLOR	W, D					
	INTEGRITY	Intact					
IV SITE	LOCATION	Ⓡ FA - ⊖ s/sx inf					
	CONDITION						
		Dressing Ⓡ Thumb — CDI					
		Ⓛ Ankle - CDI					
GASTRO	ABDOMEN	Soft Non-Tender					
	BOWEL SOUNDS	BS'x4					
GU	URINE:						
	COLOR/CLARITY	Yellow, Clear					
CARDIOVASCULAR	CARDIAC RHYTHM	NSR					

LEGEND	Cr - Creatinine F_iO_2 - Fraction of inspired O_2 HCO_3 - Bicarbonate	ICP - Intracranial Pressure PCO_2 - Pressure of Arterial CO_2 PEEP - Positive End Expiratory Pressure

S/A - Fractional
SAT - Saturation
TRACH - Tracheostomy

b(6)-2

(Continue on reverse)

PREP [redacted] Cpt/AN

DEPARTMENT/SERVICE/CLINIC ~~[illegible] 2 East~~ ICU I

DATE

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

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

PAGE 2 OF 4

DATE 0 21 03	DX	HOSPITAL DAY

	TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
VITAL SIGNS	BP Arterial Line																			
	BP Cuff																			
	Temperature																			
	Pulse																			
	Respiratory Rate																			
	[illegible]																			
	[illegible]																			

	TIME	24	01	02	03	04	05	06	07	8° T	08	09	10	11	12	13	14	15	8° T
INTAKE	Ancef IV																		
	TOTALS																		
OUTPUT	URINE HOUR / TOTAL			700															
	URINE sp gr																		
	URINE S/A																		
	NG OUTPUT																		
	NG pH																		
	NG GUIAC																		
	EMESIS																		
	STOOL																		
	DRAINS																		
	TOTALS																		

MEDCOM - 12603

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23	
					134/				
					67				
					98.2				
					98				
					16				
					97%				
					RA				

	16	17	18	19	20	21	22	23	8°T
					600			350	950

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA		TIME									
		MODE									
		F_iO_2									
		TV									
		RATE									
		PEEP									
	A	pH									
		PCO_2									
		pO_2									
	B	HCO_3									
		SAT									
	G	BASE									

LABORATORY DATA	TIME									
	GLUCOSE									
	Na/K									
	Cl/CO$_2$									
	BUN/Cr									
	WBC/PLATELET									
	Hct/Hgb									

ACTIVITIES OF DAILY LIVING	TIME				TURN / SUCTION	TIME				
	MOUTH CARE									
	BATH									
	SKIN CARE									
	FOLEY CARE									
	TRACH CARE									
	ROM EXERCISES									

24° I&O TOTALS

wt Yesterday ________ wt Today ________

INTAKE

IV ________

po ________

____

TOTAL ________

OUTPUT

Urine: ________

____

____

TOTAL ________

BALANCE ________

NURSE'S SIGNATURE	INITIALS

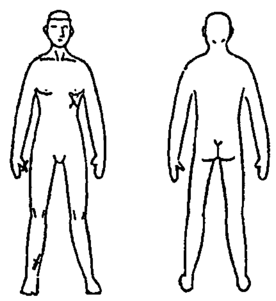
MEDCOM - 12604

b(6)-1

[redacted] NOM ET PRÉNOM	RANK / GRADE		MALE / HOMME
			FEMALE / FEMME
SSN / NUMÉRO MATRICULE	SPECIALTY CODE / GPM		RELIGION / RELIGION
2. UNIT / UNITÉ			
FORCE / ÉLÉMENT	NATIONALITY / NATIONALITÉ		
A/T · AF/A · N/M · MC/M			
BC / BC	NBI / BNC	DISEASE / MALADIE	PSYCH / PSYCH

3. INJURY / BLESSURE

FRONT / DEVANT BACK / ARRIÈRE



☐	AIRWAY / TRACHÉE
☐	HEAD / TÊTE
✓	WOUND / BLESSURE
☐	NECK/BACK INJURY / BLESSURE AU COU/AU DOS
☐	BURN / BRÛLURE
✓	AMPUTATION / AMPUTATION
☐	STRESS / TENSION
✓	OTHER (Specify) / AUTRE (Spécifier)

[illegible]-wound
Ⓡ thumb amputation
② [illegible]

1 JUL 03
to
28th CSH

4. LEVEL OF CONSCIOUSNESS / NIVEAU DE CONSCIENCE

✓	ALERT / ALERTE		PAIN
	VERBAL RESPONSE / REPONSE VERBALE		UNR

5. PULSE / POULS TIME / HEURE

6. TOURNIQUET / GARROT ☐ NO / NON ☐ YES /

7. MORPHINE / MORPHINE ☒ NO / NON ☒ YES / OUI DOSE / DOSE TIME / HEURE

9. TREATMENT / OBSERVATIONS / CURRENT MEDICATION / ALLERGIES / NBC
TRAITEMENT / OBSERVATIONS / PRESENTE MEDICATION / ALLERGIES / AN

· Dressing Ⓡ hand
- IV initiated @ 2135
2L (LR)
- [illegible] initiated @ 2135 1g.
- Morphine 2201

10. DISPOSITION / DISPOSITION ☐ RETURNED TO DUTY / RETOUR À L'UNITÉ ☐ EVACUATED / EVACUÉ ☐ DECEASED / DÉCÉDÉ

TIME / HEURE b(6)-2

11. PROVIDER / UNIT / OFFICIER MÉDICALE / UNITÉ [redacted]

DATE/DATE (YYMMDD) 00306 01

DD Form 1380, DEC 91 *This form replaces previous editions of DD Form 1380 and DD Form 1380 (TEST), which are obsolete.*

U.S. FIELD MEDICAL CARD
FICHE MÉDICALE DE L'AVANT ÉTATS-UNIS

MEDCOM - 12605

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12. REASSESSMENT / REASSESSMENT

DATE / DATE (YYMMDD) 20030601		TIME OF ARRIVAL / HEURE D'ARRIVÉE		
TIME / HEURE 2:30	[illegible]			
BP / PS [illegible]	T: 98			
PULSE / POULS [illegible]				
RESP / RESP 20				

DATE / TIME
DATE / HEURE

13. CLINICAL COMMENTS / DIAGNOSIS
INFORMATION MÉDICALE / DIAGNOSTIQUES

14. ORDERS / ANTIBIOTICS (Specify) / TETANUS / IV FLUIDS
DIRECTIVES MÉDICALES / ANTIBIOTIQUES (Spécifier) / TÉTANOS / IV FLUIDE

15. PROVIDER / OFFICIER MÉDICALE DATE/DATE (YYMMDD)

16. DISPOSITION / DISPOSITION ☐ RETURNED TO DUTY / RETOUR À L'UNITÉ ☐ EVACUATED / EVACUÉ ☐ DECEASED / DÉCÉDÉ TIME / HEURE

17. RELIGIOUS SERVICES / SERVICES RELIGIEUX ☐ BAPTISM / BAPTISE ☐ ANOINTING / ONCTION ☐ CONFESSION / CONFESSION ☐ PRAYER / PRIÈRE ☐ COMMUNION / COMMUNION ☐ OTHER / AUTRE

CHAPLAIN / CHAPELAIN

DD Form 1380, DEC 91 (Back)

ADMISSION ...D CODING INFORMATION

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

1. REPORTING MTF

1	2	3	4	5	6
A	1	1	D	1	▨

2. M... ...ATION *(State or Country Code.)*

7	8
I	Z

3. REGISTER NUMBER (9–15): [redacted]

NAME *(Last, First, Middle Initial)*: EPW # [redacted] b(6)-4

4. PAY GRADE (16, 17): EPW

5. SEX (18): M

6. DATE OF BIRTH *(YYYYMMDD)*

19	20	21	22	23	24	25	26
Z	Z	Z	Z	Z	Z	Z	Z

7. AGE AT ADMISSION

27	28	29
2	7	Y

8. RACE (30): X

9. ETHNIC BACKGROUND (31): 9

RELIGION: UNK

10. LENGTH OF SERVICE (32–34): —

ETS: —

11. FMP

35	36
9	9

12. SOCIAL SECURITY NUMBER (37–45): [redacted]

ORGANIZATION *(Active Duty Only)*: —

13. MARITAL STATUS (46): Z

HOUR OF ADMISSION: 2320

BRANCH / CORPS: b(6)-4 —

14. FLYING STATUS (47–49): —

15. BENEFICIARY CATEGORY

50	51	52
K	7	8

16. ZIP CODE OF RESIDENCE

53	54	55	56	57	58	59	60	61
Z	Z	Z	Z	Z				

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

18. MOS (64–70): —

19. TRAUMA (71): 1

PREV. ADMISSION YEAR: ☒ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION (72): 0

WARD: ICU 1

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: UNK

ADDRESS OF EMERGENCY ADDRESSEE *(Include ZIP Code)*: UNK

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted] b(2)-2

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE: UNK

21. TYPE OF DISPOSITION

73	74
5	0

22. MTF TRANSFERRED TO (75–80):

23. DATE OF DISPOSITION *(YYMMDD)*

81	82	83	84	85	86
0	3	0	7	1	3

24. CLINIC SVC - ADMITTING

87	88	89	90
A	E	A	A

25. MTF TRANSFERRED FROM (91–96):

26. DATE THIS ADMISSION *(YYMMDD)*

97	98	99	100	101	102
0	3	0	7	0	1

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

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

29. DATE INITIAL ADMISSION *(YYMMDD)* (111–116):

FOR LOCAL USE

GSW (R) hand (R) leg

Dx: 8221 ~~E9112~~ 882 E9112 [redacted]

~~8302~~ [redacted]

Px: ~~8821~~ 8628

b(6)-2

ADMITTING OFFICER [redacted]

SIGNATURE OF ADMITTING CLERK [redacted]

DA FORM 2985, MAR ...

MEDCOM - 12606

INPATIENT TREATMENT RECORD COVER SH

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

b(6)-4

1. REGISTER NUMBER [redacted]
2. NAME (Last, First, MI) EPW [redacted]
3. GRADE N/A
4. SEX M
5. AGE 32y
6. RACE Z
7. RELIGION unk
8. LENGTH OF SVC N/A
9. ETS N/A
10. PREVIOUS ADMISSION No
11. FMP 99
12. SSN [redacted]
13. ORGANIZATION N/A
14. WARD ICW
15. FLYING STATUS N/A
16. DSG BEN K79
18. BRANCH/CORPS N/A
19. UIC/ZIP
20. TYPE CASE WIA
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct from ER
22. HOURS OF ADMISSION 2323
23. CLINIC SERVICE AEAA
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE ———
25. TYPE DISPOSITION 50
26. DATE OF DISPOSITION 14 July 03
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) ———
27b. TELEPHONE NO. ———
28. DATE OF THIS ADMISSION 01 July 03
ADMITTING OFFICER D [redacted] b(6)-2
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] b(2)-2
30. DATE OF INITIAL ADMISSION
31. S
32. UNITS COMPONENT TRANSFUSED

ADMISSION REMARKS

33. CAUSE OF INJURY ☐ Check if Continued on Reverse

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

S/P GSW Ⓛ hand + Ⓡ foot
S/P I+D Ⓛ hand + Ⓡ foot

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	15	15

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	15	15

[redacted] D [redacted]

SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER For [redacted]

DA F

EDITION OF 1 AUG 78 IS OBSOLETE

USAPPC V1 10

b(6)-2

MEDCOM - 12607

MEDICAL RECORD | ABBREVIATED MEDICAL RECORD

PERTINENT HISTORY, CHIEF COMPLAINT, AND CONDITION ON ADMISSION *(Enter date of admission)*

32 yo ~~middle age~~ Iraqi male who is brought to the CSH from the EPW camp c̄ 6 day old GSW to leg/hand now c̄ evidence of infection. c/o pain c̄ hand [illegible]

PMHx: 0 PSHx: 0 NKDA meds: 0 tob: 0

PHYSICAL EXAMINATION

130/61 P56 R12 T98'

WDWN ♂ NAD

Eyes clear

HEENT PERRL [illegible]

Abd soft NTND

Nl Ext genitalia

leg: ① Straight good ROM, (R) foot c̄ puncture wound over metatarsal

Arms: left webbing between pinkie and ring fingers c̄ purulent wound

no induration

PROGRESS *(Enter date of discharge and final diagnosis)*

Dx: ① puncture wound (R) foot

② Infected wound (L) pinky finger

- to OR for washout and [illegible]
- Ancef [illegible]

SI [redacted]

DATE 7 JUL 03 | IDENTIFICATION NO. | ORGANIZATION

PATI [redacted] ION (For typed or written entries give Name last, first, middle; grade; date; hospital or medical facility)

REGISTER NO. | WARD NO.

b(6)-2

ABBREVIATED MEDICAL RECORD
Standard Form 539
GENERAL SERVICES ADMINISTRATION AND INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
539-106

117

MEDICAL RECORD | AUTHORIZED FOR LOC

PROGRESS NOTES

DATE	NOTES
02Jul03 0600	Received report from outgoing Shift. VSS NAD A+O×3 denies discomfort. LS - slight wheeze c̄ exhalation cleared c̄ cough. R-16 even unlabored BS active ×4 ⊖ DTN ⊖ Rigidity, NT. Skin - IV Ⓡ FA NSS 100cc/hr patent Ⓛ hand between 4th-5th fingers in webbing ⊕ laceration c̄ dried blood ⊕ serous drg. Cleaned c̄ Betadine Soap, bacitracin, non stick gauze, Kerlex wrap tolerated well cap refill brisk pulses present ×4 [redacted] Skin warm to touch NVI, Ⓛ leg, ~~posterior~~ splinted c̄ ace wrap, Pt able to move toes cap refil +1, toes warm to touch. NPO since midnight pend surgery for Ⓛ leg today. Will cont to monitor SGT WAGROVES 91WM
02Jul03 0015	late entry PT in soft Restraints of both wrists as per protocol. - speaks English denies discomfort SGT [redacted] b(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME LAST	FIRST	MI	SPONSOR ISSN or O
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

EPW [redacted] b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM
Prescribed by GSA/ICMR FPMR 141CFR

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

LAST NA[redacted]	FIRST NAME	MIDDLE INITIAL	ID NUMBER
#			#[redacted]

DATE	NOTES
2 FEB 03 1800	Received pt from offgoing nurse. Alert awake and oriented. MAE x 4. ⊕ sensation to all extremities. ø c/o pain @ this time. Room air O2SATS 98%. Equal chest expansion. Ⓑ CTA. Sinus brady ø ectopy. PPP x 3 unable to asses Ⓡ LE due dsg to the area. Afebrile. Active BS x 4. Abd flat soft non-tender. Voiding without difficulty. Will keep monitoring. [redacted] b(6)-2
0532 2[redacted]03	Assumed care of pt, VS 120/80-97.5-48-16-SpO2 96% on RA, Pt Alert, verbal can move all extremities, lungs CTA ③, equal rise and fall of chest. CV - S1 S2 present, S. brady, pulses x 4 extremities, LR @ 100/hr infusing in Ⓡ forearm, ~~IV site~~ c/d/i, ~~ABD~~ - ND, NT, BS x 4, voids clear yellow urine about 200cc. NV intact x 4 extremities. Ⓡ leg cast + dressing c/d/i. ② hand wx dressing Δ'd - wx color is pink to white no drainage noted. Wet to dry dressing applied to wx, Pt awaiting O.R. for Ⓡ leg I+D today. [redacted] b(6)-2

STANDARD FORM 509 (REV. 5/1999)
USAI

MEDCOM - 12610

LAST NAME | FIRST NAME | M. INITIAL | ID NUMBER

DATE | NOTES

3 JULY 03
1100
Ortho Op Note [redacted] b(6)-2
Pre Op Dx [redacted] GSW (R) FOOT
Old GSW (L) 5F, hand
Post Op Dx - Same
Procedure: I+D (R) foot
I+D (L) hand
Surgeon: [redacted] b(6)-2
EBL - min
IVF: ~~LR 65~~ NS 800 cc
Findings - No frank pus. Some gross contamination - sand in (R) foot, No collection further abscess wound down to extensor tendons.
Wounds packed with NU-GAUZE
Plan: Repeat I+D in 48 hours,
Then DPC of hand

b(6)-2 [redacted]

03 July 03
1900
Received pt. @ 1700. Neuro: A+O x 3. Pupils equal & reactive. Resp: equal rise & fall of chest. Lungs CTA throughout. SpO2 97% RA. CV: HR regular Ø murmers. 2+ pulses (R) hand, (L) foot. Cap refill brisk x4. GI: abd. soft, flat, non-tender. (+) BS x4. GU: able to spont. void 400cc clear yellow urine. Skin: (L) hand bandage & wrapped c̄ ACE. (+) CSM - able to move fingers. Pinky finger on (L) hand very tender. Pt. withdrew hand c̄ light touch of that finger. (R) foot wrapped c̄ ACE. (+) CSM. Lines: PIV HL (R) FA

b(6)-2 [redacted] 1LT/AN

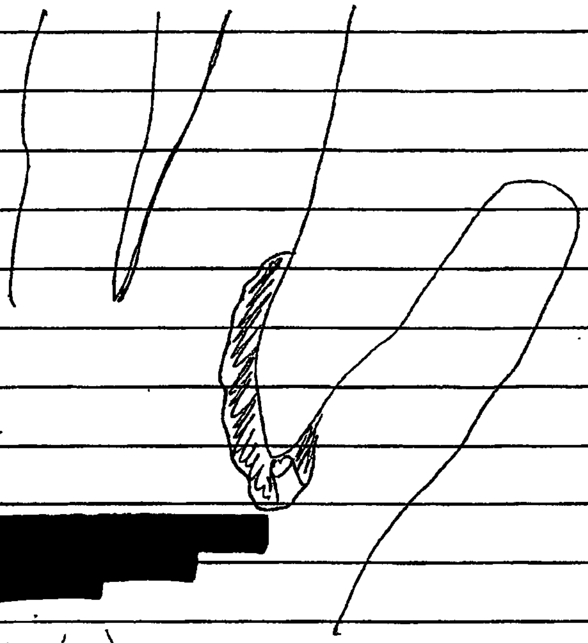
STANDARD FORM 509 (REV. 6/1999) BACK
USAPA V1.00

b(6)-4

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES** [redacted]

DATE	NOTES
1July03	Iraqi CI arrived tonight c/o Ⓡ foot, Ⓛ hand pain Small Caliber GSW Entry dorsum Ⓡ foot c̄ Exit Plantar aspect ⊕ TTP Pulses 2/4 DP, PT foot warm 110/72 60 96% Sat RR12 Ⓛ hand c̄ Avulsion and ? joint space Entry between 4th, 5th Phalange
	A/P ① GSW Ⓡ foot ② Avulsion ? GSW grazing injury to Ⓛ MCP 4, 5 ① S&I 1st ② Clean / Bandage ③



[redacted]

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.

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10
USAPA V1.0

MEDCOM - 12612

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES b(6)-2 AM
05 July 03 0030	PIV to Ⓡ FA reddened & leaking @ the site when flushed c̄ NS. IV dc'd & new IV placed Ⓡ FA c̄ 20g. Ancef 1gm IVPB infusing into site s̄ difficulty. —— [redacted]
05 July 03 0415	Pt. slept through the night c̄ minimal c/o. VSS. NV ✓ intact to Ⓛ hand & Ⓡ foot. Will cont. to monitor. —— [redacted]
05 July 03 1700	Pt. A&O x3. Lungs CTA. VSS. Ⓛ hand & Ⓡ foot wrapped c̄ kerlix & ACE wrap. NV ✓ intact to both. 2+ pulses x3 cap refill brisk x4. Pt. denies pain. —— [redacted]
05 July 03 1900	Pt. transfered to ICW 2. Able to walk to ICW 2 c̄ use of one crutch. NWB to Ⓡ LE. —— [redacted]
1930	Assumed care of Pt upon transfer @ 1900. A+O x3. HL Ⓡ UE patent. Ⓡ LE dsg/ace CDI ⊕ cap refil <3 sec mvt, sensation Ⓡ Foot. Ⓛ UE dsg CDI. ⊕ mvt, cap refil <3 sec. Ⓛ hand – Ø c/o pain. Ⓑ LS CTA. ⊕ BS x4. Ø c/o Assessment WNL. Will monitor. [redacted]
5 Jul 03 2200	Rec'd pt @ 21:00. Awake and alert in bed. VS WNL per flow sheet. PERRLA ⊕. LCA Ⓑ. BS ⊕ x4. ⊕ PPP Ⓑ. PIV/HL Ⓡ FA intact patent. ACE wrap DSG to Ⓛ hand CDI. ACE wrap cast to Ⓡ foot CDI. Pt able to move and feel Ⓛ fingers and Ⓡ ~~ob~~ toes. Each are warm to touch c̄ good <3 sec. cap refill. ø complaints @ this time. Will cont. to mon [redacted]
0200	C/o dizziness and nausea. 12.5 mg Phenergan given will cont. to mon. [redacted]
0300	Pt sleeping ø further c/o nausea. Will mon.
b(6)-2	[redacted]

STANDARD FORM 509 (REV. 5/1999) BACK
USAPA V1.00

ELW [redacted] b(6)-4

MEDCOM - 12613

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
04 July 03 0350	Pt. able to sleep through the night until 0330. Woke up c/o pain in Ⓛ hand. Medicated him c̄ Percocet ii PO. Cont. to have neurovascular √ intact in Ⓛ hand & Ⓡ foot. VSS through the night. Will cont. to monitor. b(6)-2 [redacted] [illegible]
04 Jul 03 0600	Received report from outgoing shift VSS NAD Pt. resting ō eyes closed easily roused A+O x3 PERRLA EOMI color good LS CTA equal bilat BS active x4 ⊖ DTN ⊖ Rigidity NT, Cap refill brisk Skin warm, dry Drg Ⓛ hand CDI, able to move fingers, color good pinky sore to move minimal edema. Ⓡ leg drg CDI able to move toes, color good, good cap refil warm to touch minimal edema. denies pain at this time. will cont to monitor SGT [redacted] /WM6 b(6)-2
04 July 03 1800	Pt. doing well today. Neuro: A&O×3, PERLA Resp: Lungs CTA throughout CV: HRR ∅ murmur 2+ pulses ×3 cap refill brisk. GI: ⊕ BM earlier today. C/o abd. pain, pt. feels he needs another BM. ⊕ BS x4. GU: sport. void c̄ clear yellow urine. Skin: Ⓛ hand wrapped c̄ kerlix & Ace - C/D/I. ⊕ CSM. Ⓡ Foot wrapped c̄ kerlix & ACE - C/D/I. ⊕ CSM Able to wiggle fingers & toes. Lines: HL to Ⓡ AC. [redacted] [illegible]

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.

EPW # [redacted]

b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

MEDCOM - 12614

NOTES

6 Jul 03 0840 Pt. assessment Complete: VSS. Alert & oriented x3. ⊕ PERRLA. Lungs CTA. ⊕ Pulses x4. ⊕ BS x4. Drsng to Ⓛ hand + Ⓡ foot CDI. ⊕ movement & ⊕ sensation to Ⓛ fingers + Ⓡ toes. s/o pain when both extremities is touch. Cap refill <3 sec. s/o dizziness. HL Ⓡ FA patent to flush. Will continue to monitor [redacted]

1030 NPO p̄ lunch for washout today. [redacted] 9Lw MB [redacted]

1900. Assumed care of Pt @ 1300. VSS. A-O x3. Ø c/o pain, PIV patent HLC IV Abx. NPO since 1200. Ⓛ UE drsg ace CDI ⊕ sensation, mvt of fingers, cap refil <3 sec Ⓛ hand. Ⓡ LE drsg/ace CDI ⊕ sensation, cap refil <3 sec. mvt toes Ⓛ foot. Q(W) [redacted] LWN.

6 Jul 03 2115 ~~2100~~ ~~22:35~~ [redacted] Pt. returned from OR @ 2130. VS WNL per ~~OR~~ ICU flow sheet. PERRLA ⊕. LCA Ⓑ. BS ⊕ x4. ⊕ PPP Ⓑ. PIV HL Ⓡ FA patent. tolerating PO. Ⓛ Hand Ace wrap Dsg ~~CDI~~. able to move and feel fingers; warm ~~to tou~~ touch c̄ <3sec cap refill. Ø c/o pain or dizziness @ this time Ø c/o n/v. Will cont. to mon. Ⓡ Foot ACE wrap dsg C/D/I. Able to move and feel toes warm to touch c̄ <3sec cap refill. Will cont to mon. [redacted] /AN

22:35 C/O pain ii Percocet given Will mon. [redacted] /AN

7 July 03 0900 - Pt alert tolerated breakfast this AM. VSS. lungs CTA, BS⊕. Dsg to Ⓛ arm CDI. Able to wiggle fingers, ⊕ sensation, warm to touch. Dsg to Ⓡ L extremity. ⊕ sensation, warm to touch. Voicing Ø complaint at this time will cont to monitor [redacted] /AN

1600 97.5
54
12
90/53
98%

6 Jul - 2 AN

AUTHORIZED FOR LOCAL RE

DICAL RECORD | PROGRESS NOTES

DATE	NOTES
6Jly03	Ortho OP/Evac Note
	72 y/o Iraqi EPW
	Preop Dx: (R) Foot GSW (R) Hand GSW
	Procedure Repeat Washout/I&D
	Surgeon: [redacted] b(6)-2
	EBL:
	TO PACU stable
	Findings: (R) Foot plantar Abscess Improved [illegible] c̄ [illegible] (R) SF P1 Lac → DPC
	Plan) Repeat Washout (R) Foot 48°
	b(6)-2 [redacted]

SHIP TO SPONSOR | SPONSOR'S NAME LAST | FIRST | 'S ID N Other

SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS

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

EPW [redacted] b(6)-4

TE NOTES

3 Jul 03 assumed care @ 1300 - VSS - no c/o pain @
1615 this time - SL patent - dsgs intact
and clean on Ⓛ hand and Ⓡ foot - pt. can
wiggle Ⓛ fingers & Ⓡ toes, <2 sec cap.
refill in the same - pt. hops to BR
on Ⓛ foot —— [redacted] AN
2200. Pt. care assumed @ 2100. VSS. Pt. c/o mild discomfort
Ⓛ little finger. HR reg, Lungs CTA, ABD soft BS ⊕ x4.
Drsng to Ⓛ LE CDI. UTA pulse 2° drsng. ⊕ sensation,
⊕ ROM digits c̄ Brisk cap refill. Drsng to Ⓡ LE CDI.
UTA pulse 2° drsng. ⊕ sensation toes, ⊕ ROM, cap
refill < 3 sec. Will cont. to monitor —— [redacted] AN
9 July 03 0555 Assume pt care @ 0500. Pt asleep
easy to awake. VSS. HL to Ⓡ hand flushes
well. HR reg Lungs CTA. Abd soft BS x4. Dsg
c̄ ace wrap LUE to hand and wrist. CD+I ⊕ movement
⊕ sensation to fingers. Ⓡ LE dsg and ace wrap CD+I
⊕ movement ⊕ sensation to toes cap refill <3 sec. No
c/o pain. Will continue to monitor. —— [redacted] mmp
1000 pt NPO for I+D @ 1400 [redacted] mmp
9 July 03 assumed pt care @ 1300. VSS assessment findings
1330 WNL. pt off to OR in stable condition [redacted] mmp

b(6)-2 AN

AUTHORIZED FOR LOCAL REPRO

ICAL RECORD | **PROGRESS NOTES**

ATE	NOTES
7 Jul 03 1710	assumed care @ 1300 - VSS - SL patent - no c/o pain @ this time - Kerlix and Ace wrap dressings CDI on Ⓛ hand & Ⓡ foot - pt. can wiggle Ⓛ fingers & Ⓡ toes, < 2 sec cap. refill in Ⓛ fingers & Ⓡ toes tol. regular diet - ambulated to BR and had BM —— b(6)-2 [redacted] CR, AN
7 Jul 03 2200	Assumed pt. care @ 2000: Pt. A+O x 3. ⊕ BS x4. lungs CTA - Drsg c̄ Ace wrap on Ⓛ hand and Ⓡ foot CDI - ⊕ sensation and movement in toes + fingers. HL Ⓡ FA patent to flush. c/o dizziness. Will continue to monitor - [redacted] 91WM6 b(6)-2
8 Jul 03	0933 - Pt alert lying in bed. VSS, lungs CTA; ⊕ BS x4: Dsg to Ⓛ hand + Ⓡ ft CDI. HL to Ⓡ wrist patent. Voicing no complaints
0700 96.5 57 14 100/60 96%	Will cont to monitor —— [redacted] 2Lt AN b(6)-2

IONSHIP TO SPONSOR

SPONSOR'S NAME

LAST

FIRST

MI

SPONSOR'S ID (SSN or Other)

T./SERVICE

HOSPITAL OR MEDICAL FACILITY

RECORDS MAINTAINED AT

T'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. CCW 2

EPW [redacted]

b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509
Prescribed by GSA/ICMR FPMR (41CFR) 101-

MEDCOM - 12618

4 July03 pt returned from ICU2 in stable condition. VSS. drsng
1630 to Ⓡ foot & Ⓛ nd CDI. will cont to itor – [redacted] 91WM6

2200 Pt. care assumed @ 2100 - VSS. Pt. c/o dizziness,
Ø N/V. HR Reg, Lungs CTA, BS ⊕ x4. Drsng to Ⓛ hand
CDI, brisk cap refill c̄ ⊕ sensation, ⊕ ROM. Drsng
to Ⓡ ft CDI, brisk cap refill c̄ ⊕ sensation, ⊕ ROM.
will cont. to monitor. b(6)-2 [redacted]

10 July03 0620 Assume pt care @ 0500. pt asleep ~~easy~~ easy [redacted] LPN
to awake. VSS. LR @ 125cc/hr to Ⓛ FA - no s/s
0500 96.2 redness/infiltration will HL p̄ breakfast. HR reg. Lungs
56
14 CTA. BS x4 abd soft. no tenderness on palpation. Ⓛ
106/64
96% hand dsg and ace wrap CD+I. ⊕ movement ⊕ sensation
to fingers. Ⓡ foot dsg and ace wrap CD+I ⊕ movement
⊕ sensation to toes. No c/o pain. will continue to
monitor b(6)2 [redacted] 91WM6

10Jul03 assumed care @ 1300 - VSS - Ⓡ foot dsg Δ'd,
1645 4x4 gauze over wound packing, Kerlix, ace wrap
CDI - SL patent Ⓛ FA - no c/o pain - c/o
nausea but no vomiting - tolerated
regular diet b(6)-2 [redacted]

030 Pt care assumed @ 2100 VSS, no c/o pain @ [illegible] time. Lung
July03 sounds CTA, BS ⊕ x4. Dsg on Ⓡ ft cdi, ⊕ sensation and
cap refill. HL @ LFA flushes well, will continue to monitor.
b(6)-2 [redacted] 91WM6

00 96.3 Assumed care of pt @ 0500. Pt asleep. VSS
62
16 Lungs CTA. Abd. soft and tender. Bowel sounds
100/66
96% x4 quads. Dsg to Ⓡ ft. ⊕ sensation and cap
refill less than 3 sec. Ø c/o pain/discomfort.
b(6)-2 [redacted] LPN, SGT

AUTHORIZED FOR LOCAL RE

EDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
9 Jun 03	Ortho Op Note
	Pre-Op Dx – ① ABSCESS Ⓡ FOOT
	② LACERATION Ⓛ SF
	Post Op Dx – Same
	Procedure – ① I+D Ⓡ FOOT
	② Ⓛ SFT
	Surgeon [redacted]
	[illegible]
	Anesthesia · MASK
	Findings – Ⓡ foot Abscess
	getting smaller. Packed loosely
	with 1/2" NU GAUZE. Ⓛ SF healing
	some slight pus. Sutures opened
	irrigated NU-GAUZE
	Plan: IV ABX. Dressing changes
	daily.
	[redacted]

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

SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

EPW# [redacted] b(6)-4

	FIRST	MIDDLE INITIAL
	LTW [redacted]	

MEDCOM - 12620

TE | NOTES

12 Jul Assumed care of pt @ 0500. Pt asleep. VSS.
Pt went to OR @ 0730. RT @ 0845. VSS.
Lungs CTA. Abd soft and tender. Bowel sounds
x 4 quads. Pt had I+O. Ø c/o pain/discomfort.
Will continue to monitor. —— [redacted] 91WM6, SGT

1630 Assumed care of Pt @ 1300. VSS. A+Ox3. Ⓡ UE PIV HL
c IVABX patent. Ⓛ hand drsg CDI ⊕ sensation, mvt, cap refil < 3 sec, +
Ⓡ LE Drsg CDI ⊕ sensation, mvt, cap refil <3 sec Ⓛ foot. Ø c/o
pain. O/w assessment WNL Will Monitor —— [redacted]

2030 Pt care assumed @ 2100. Pt. c/o dizziness c̄ nausea.
12.5mg phenergan given IV. IV site flushes easily (Ⓡ hand)
and is s̄ s/s infection or infiltration. HR Reg, Lungs CTA,
BS ⊕ x4. Drsg to Ⓡ ft CDI. Toes to Ⓡ ft ⊕ sensation, ⊕
ROM, ⊕ pain to 2nd & third toes. Drsg to Ⓛ UE CDI. ⊕ ROM,
⊕ sensation, Ø pain digits Ⓛ hand. Brisk cap refill x 4
extremities. Will cont. to monitor. —— [redacted]

13 Jul 03 0515: Assumed pt care @ 0500: Pt resting, awakened
easily. VSS. A+O x 3. HL in Ⓡ FA. Denies
any discomfort @ this time. Will continue to
monitor —— [redacted] 91W M6 ——

1430 Assumed care of pt @ 1300. A+Ox3. Ø c/o pain. ⊕ LS CTA
⊕ BS x4. Ⓛ hand drsg CDI ⊕ sensation, cap refil ≤3 sec, mvt of
fingers. Ⓡ LE drsg/ace CDI ⊕ sensation, cap refil ≤3 sec
mvt toes. patent Ⓛ FA PIV HL c̄ IV ABX. O/w assess
WNL Will monitor —— [redacted]

b(6)-2 All

AUTHORIZED FOR LOCAL REPR

:AL RECORD | PROGRESS NOTES

NOTES

11 JUN03 1355 : Assumed care PE @ 1300 VSS. A+O x3
C/O slight pain in (L) pinkey, ring finger. Drsg to (L) hand CDI, ⊕ sensation, cap refil<3sec, mvt fingers. Drsg (R) Foot CDI ⊕ sensation, cap refil<3 sec, mvt toes. C/W assessment WNL. Will Monitor [redacted] b(w)-2

2300 Pt care assumed @ 2100. VSS. HR Reg, RTAV
Lungs CTA BS ⊕ x4. Drsg to (L) UE CDI c̄ brisk cap refill, ⊕ ROM, ⊕ sensation. Drsg to (R) UE CDI c̄ ⊕ sensation, ⊕ ROM, brisk cap refill. Ø pain @ this time. Will cont. to moniter. —— [redacted]
b(w)-2

12 JUN 0820 Ortho Op Note
Pre-Op Dx: (1) (L) foot abscess
(2) (R) hand abscess
Post-Op Dx: Same
Procedure: I+D (L) foot
I+D (R) hand
Surgeon: [redacted] b(w)-2
Findings: Foot abscess, continue to drain
Loose pus in hand [redacted] b(w)-2

SHIP TO SPONSOR | SPONSOR'S NAME LAST | FIRST | MI | SPONSOR'S ID (SSN or Other)

SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

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.

EPW # [redacted]
b(w)-2

PROGRESS NOTES
Medical Record
STANDARD FORM 509
Prescribed by GSA/ICMR FPMR (41 CFR) 101

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
25 Jul	Assumed care of pt @ 0800. Pt asleep. VSS.
	Lungs CTA. Bowel sounds x 4 quads. Ø c/o pain/
	discomfort. Pt has dc orders. Awaiting trans-
	portation. —— b(6)-2 [redacted] LPN-86T
15 Jul 03	assumed care @ 1500 - VSS - dsg CDI
1500	on (L) hand and (R) foot - reflex @ bedside
	as pt. is awaiting dc to EPW camp - b(6)-2
	pt. will leave c̄ crutches. [redacted]
15 Jul 03	pt had hands bound, meds in pocket c̄
1600	ID # tag attached, escorted to helicopter
	(MP escort for transport to EPW)
	camp —— [redacted]
	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. ICW 2

[redacted]

b(6)-2

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
13 JUL 03 21:32	Rec'd c/o pt. @21:00. Awake and alert in bed. Restraints x2Ⓑ wrist and ankle. Skin W/D. PERRLA ⊕ WNL. LCA Ⓑ. BS ⊕ x4. ⊕PPP Ⓑ. Ⓛ Hand ⊕ ROM ⊕ sensation ⊕ <3sec. cap refill. c/o 3/10 pain to ~~X~~ 2nd [redacted] 3rd and 4th fingers. Ⓡ foot ⊕ sensation ⊕ ROM ⊕ <3 sec cap refill. & error [redacted] Kerlix dsg to Ⓛ Hand C/D/I. ACE wrap dsg to Ⓡ foot C/D/I. c/o 5/10 pain to Ⓡ foot ii Percocet given. Will cont to mon [redacted] 2LT/AN
14 July 03 0830 0630 96.6 P 54 RR 14 BP 116/74 Sats 96%	New IV started in Ⓡ hand. HR regular, lung sounds clear bilat, bowel sounds (+) x4 quads. Bandage to Ⓛ hand CDI, (+) sensation in digits, full ROM, cap refill <3sec. Ⓡ foot dressing CDI, (+) sensation, limited ROM in digits, cap refill <3sec. VSS. Pt s̄ complaints @ this time. All other assessment findings WNL. Will continue to monitor. [redacted] 2LT/AN
14 Jul 03 1930	assumed care @1300 – VSS – SL removed – pt. started on PO Keflex 350mg QID – DC orders written, DC summary in chart, prescription to pharmacy – Ⓡ foot dsg Δ'd, packing removed and dry dsg. placed on foot, 2 sutures in place around wound on foot – no c/o pain – Ⓛ hand dsg intact [redacted]
2120	Pt. care assumed @ 2100. Pt. resting quietly. HR Reg, Lungs CTA, BS ⊕ x4. Drsng to Ⓛ hand, Ⓡ ft CDI. Neuro checks Ⓛ hand, Ⓡ ft WNL. ⌀ IV access ⌀ pain @ this time. Will cont to monitor. [redacted]
	b(6)-2 A11

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

MEDCOM - 12624

NSN 7540-00-634-4176

600-108

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	Transfer + D/C Note 28th CSH
14 Nov 03 1615	32 y/o Iraqi male who sustained fragment wounds to (R) foot + (L) hand. Originally treated in Iraqi hospital, then sent to [redacted] b2-2 from EPW camp. ♂ on admission had abscess plantar surface of (R) foot and (L) RF-SF webspace. Multiple I+D's and wound packing and closure, with improvement.
	Plan: D/C to EPW camp. Crutches, WBAT on (R). Dry dressing changes. Keflex 250 QID x 10 days
	[redacted]
	b(6)-2

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

[redacted]

b(6)-4

D [redacted]

RECORDS MAINTAINED AT:

PATIENT'S NAME *(Last, First, Middle initial)*

SEX

RELATIONSHIP TO SPONSOR

STATUS

RANK/GRADE

SPONSOR'S NAME

ORGANIZATION

DEPART./SERVICE

SSN/IDENTIFICATION NO.

DATE OF BIRTH

CHRONOLOGICAL RECORD OF MEDICAL CARE

MEDCOM - 12625

STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

-103

(See Instructions on Back of this Sheet)

NSN 7540-01-075-378

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp): EMT

LOG NUMBER:

ARRIVAL

DATE DAY	DATE MONTH	DATE YR.	TIME
1	JULY	03	2350

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☒ OTHER (Specify)

CURRENT MEDS. (tetanus immunization and other data): Ø

HISTORY OBTAINED FROM: ☒ PATIENT ☐ OTHER (Specify)

ALLERGIES: NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code):

HOME TELE. NO. (Inc. area code):

CHIEF COMPLAINT(S) (Include symptom(s), duration): GSW Ⓡ Foot

SEX: M

AGE:

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ ~~NO~~

TIME SEEN BY PROVIDER: 2310

027.96

VITAL SIGNS

TIME	2300		
BP	130/61		
PULSE	56		
RESP.	12		
TEMP.	98.1		
WT. (Child)			

CATEGORY (See reverse)

☐ EMERGENT
☐ URGENT
☒ NON-URGENT 2

ORDERS	INITS.	TIME
1 gm Ancef IV	[redacted]	
5 mg MSO4 IV	[redacted]	2120
CBC, Metlyte	[redacted]	2115
PT, PTT T&S	[redacted]	2115
Ⓡ Foot Ⓛ Hand	[redacted]	2125
TENS Blu's.	[redacted]	2115

ASSESSMENT/DIAGNOSIS:

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

Prior to administration,
PT CAS card stated 1 gm Ancef/5 mg

Ø iraqi

32 yo ♂ who came for EPW camp 6 days after a GSW to his foot and hand

Here for wound care

See H&P

Admit for wound care

Order
25 mg IV 2120
Tet. 5 mg 2326

Ⓡ Foot
(-)

Ⓛ Hand
(-)

7.2 / 12.3 / 274 / 35.7

CC
PT/PTT
T&S

[redacted]

b(6)-2

Ⓐ/Ⓒ

DISPOSITION (Check all that apply)

☐ HOME ☐ FULL DUTY

QUARTERS: ☐ 24 Hrs. ☐ 48 Hrs. ☐ 72 Hrs.

MODIFIED DUTY UNTIL: DAY / MONTH / YEAR

REFERRED TO (Indicate clinic):

☐ EMERGENCY ☐ TODAY
☐ 72 HOURS ☐ ROUTINE

ADMIT. TO HOSP. UNIT/SERVICE: ICU2

CONDITION UPON RELEASE

☐ IMPROVED ☐ UNCHANGED
☐ DETERIORATED

TIME OF RELEASE:

(CONTINUE ON SF 507; IF NEEDED)

PATIENT'S IDENTIFICATION (Mechanical imprint)
FOR WRITTEN ENTRIES GIVE: Name - last, first, middle; SSN; DOB, service status, name and relation of sponsor or next of kin. (IMPORTANT: LIST FACILITY HOLDING TREATMENT RECORD).

[redacted]

b(6)-4

SI[redacted] b(6)-2

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans)

EMERGENCY CARE AND TREATMENT

MEDCOM - 12626

STANDARD FORM 558 (Rev. 6-82)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

MEDICAL RECORD

PREOPERATIVE/POSTOPE IVE NURSING DOCUMENT

FOR Use of this form, see AR 40-407; the proponent agency is The Office of the Surgeon General.

1. AGE: 32

HEIGHT:

WEIGHT:

2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication)
☒ NKDA ☐ PCN ☐ LATEX ☐ IODINE ☐ TAPE ☐ FOOD
REACTION:

3. PREVIOUS SURGERY [X] NO [ ] YES (type):

4. PROPOSED SURGICAL PROCEDURE:
Rt Foot I&D, Pinning ?

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition WNL
Tobacco 0 ppd X ___ yrs. Body Piercing 0 Diabetes (Y) [✓ (N)] ROM WNL ASA/Motrin w/72 hrs (Y) [✓ (N)]
ETOH 0 Implants 0 Respiratory Disease (Asthma/COPD) (Y) [✓ (N)] Anticoagulants (Y) [✓ (N)]
Glasses/Contact (Y) [✓ (N)] Dentures 0 Hypertension (Y) [✓ (N)] Herbal Medicines (Y) (N) MEDS: MSO4, Ancef

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to: ✓ 1) Surgical Procedure & Operating Room Environment ___ 2) Separation Anxiety (Child) ✓ 3) Surgical Outcomes	ø Pt. verbalizes any specific anxiety. ø Pt. Exhibits relaxed body posture.	ø Allow pt. to verbalize freely. ø Explain OR environment and answer questions regarding surgery. ø Offer comfort measures. (e.g.. warm blanket, touch). ø Explain all nursing procedures before they are done. ø Remain with pt. whenever possible. ø Maintain family interface. Parents to stay with pt.
B. AERATION ✓ Potential for respiratory dysfunction due to: ✓ 1) Positioning ✓ 2) Effects of Anesthesia ✓ 3) Medical/Smoking History	ø Pt. will be able to breathe without difficulty during immediate intraoperative phase.	ø Offer to elevate head of litter or offer pillow. ø Observe pt. while awaiting surgery for signs of distress. ø Assist anesthesia during intubation and extubation.
C. INTEGUMENT ✓ Potential impairment of skin integrity due to: ✓ 1) Intraoperative Immobility ✓ 2) ESU Pad Placement ✓ 3) Positional Aids ___ 4) Prosthesis ✓ 5) Pooling of Prep Solutions	ø Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened areas).	ø Utilize pressure preventing devices on OR table and accessories. ø Check for proper positioning and support to maintain good body alignment. ø Pad pressure points. ø Place ESU ground pad on non compromised skin surface area. ø Keep prep fluids from pooling.

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

[redacted]

b(6)-4

VERIFICATIONS AT HOLDING AREA:
! ID/Allergy Band ! Dentures Removed
! H & P ! Contacts Removed
! NPO Since MN ! Jewelry Removed
! UHCG/LMP ! Body Pierce Removed
! Consent/Blood Transfusion Signed/Witnessed/Dated
! Surgical Site/Consent verified by Pt./Anesthesia/Surgeon
! Contact Precautions (Y) (N)
! Family/Friend: ___

DA FORM 5179, JUN 91 Previous editions are obsolete. USAPA V1.0

MEDCOM - 12627

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to: ✓ 1) Intraoperative Mobility ✓ 2) Positioning ✓ 3) Existing Disease ✓ 4) Safety Devices ✓ 5) Hypothermia	✓ Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse.	✓ Check for support stockings or ace wraps. If none, check with doctors. ✓ Check that safety straps are correctly applied. ✓ Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. ✓ Check that rings and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to: ✓ 1) Pain ✓ 2) Intraoperative Hazards ____ 3) Prosthesis ✓ 4) Positioning ✓ 5) Transfer pt. to/from OR table E.2. ✓ Potential discomfort due to: ✓ 1) Length of Surgery ✓ 2) Positioning ____ 3) Arthritis	✓ Pt. will be transferred to OR table without difficulty. ✓ Pt. will not experience unnecessary physical discomfort.	✓ Have sufficient people available for transfer. ✓ Insure proper body alignment. ✓ Allow patient to lie in position of comfort while waiting for surgery. ✓ Offer support (i.e., pillows, bath towels, etc.) for positioning.
F. SPECIAL SENSES F.1. ✓ Diminished visual perception due to being: ✓ 1) Pre-Medicated ____ 2) W/O Glasses F.2. ✓ Potential for decreased communication due to: ____ 1) Diminished Hearing ✓ 2) Language Barrier F.3. ____ Potential injury due to dentures: ____ 1) Upper ____ 2) Lower ____ 3) Bridges ____ 4) Caps ____ 5) Crowns	✓ Pt. will be made aware of surroundings prior to anesthesia induction. ✓ Pt. will be transferred safely to OR table. ✓ Pt. will be able to understand instructions. ✓ Minimize danger of injury during intraop period.	✓ Introduce self. Keep pt. informed as to where he/she is and what is happening. ✓ Inform pt. in which direction to move and assist if necessary. ✓ Speak clearly and slowly. ✓ Address pt from either side. ✓ Validate pt.'s understanding of verbal communication. ✓ Verify removal of dentures.
G OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

10. OR NURSING INTERVENTIONS COMPLETED/ADDITIONAL INTRAOPERATIVE INTERVENTIONS NOTED.

[redacted] b(6)-2 CPT/AN

3 July 03 DATE

11. POSTOPERATIVE EVALUATION: SKIN INTEGRITY: Bovie Pad Site: ☐ Clean and Dry ☐ Red ☐ N/A DRESSING DRY & INTACT: [✓ (Y)] (N)

LEVEL OF CONSCIOUSNESS: ☐ A&O ☑ Drowsy ☐ Sleepy ☐ Intubated

BREATHING EASY: [✓ (Y)] (N)

LEVEL OF ACTIVITY: ☐ Moves All Extremities ☐ Moves Upper Extremities ☐ Transferred to litter with roller due to spinal

12. PREOPERATIVE [redacted] PREPARED BY (Signature and Title) b(6)-2 RN

DATE: 3 Jul 03 TIME: 0840

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] CPT/AN

DATE: 3 July 03 TIME: b(6)-2

REVERSE OF FORM 5179, JUN 91

MEDCOM - 12628

USAPA V1.0

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

FOR Use of this form, see AR 40-407; the proponent agency is The Office of the Surgeon General.

1. AGE: 32

HEIGHT:

WEIGHT: 60 kg

2. KNOWN ALLERGIC SENSITIVITIES (e.g.. Iodine, Tape, Medication)
☒ NKDA ☐ PCN ☐ LATEX ☐ IODINE ☐ TAPE ☐ FOOD
REACTION:

3. PREVIOUS SURGERY [ ] NO [☒] YES (type):
error [redacted] ~~Ⓡ fa~~ Ⓛ foot Ⓡ foot I+D

4. PROPOSED SURGICAL PROCEDURE:
Ⓡ Ⓛ foot / ~~Ⓡ~~ Ⓛ hand washout

see H+P

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition wound Ⓡ foot / Ⓛ hand
Tobacco____ppd X____yrs. Body Piercing Ø Diabetes (Y) [✓ N] ROM________ ASA/Motrin w/72 hrs (Y) [✓ N]
ETOH Ø Implants Ø Respiratory Disease (Asthma/COPD) (Y) [✓ N] Anticoagulants (Y) [✓ N]
Glasses/Contact (Y) [✓ N] Dentures Ø Hypertension (Y) [✓ N] Herbal Medicines (Y) (N) MEDS: Ancef, Cipro

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to: ✓ 1) Surgical Procedure & Operating Room Environment ____ 2) Separation Anxiety (Child) ✓ 3) Surgical Outcomes	☐ Pt. verbalizes any specific anxiety. ☐ Pt. Exhibits relaxed body posture.	☐ Allow pt. to verbalize freely. ☐ Explain OR environment and answer questions regarding surgery. ☐ Offer comfort measures. (e.g.. warm blanket, touch). ☐ Explain all nursing procedures before they are done. ☐ Remain with pt. whenever possible. ☐ Maintain family interface. Parents to stay with pt.
B. AERATION ✓ Potential for respiratory dysfunction due to: ✓ 1) Positioning ✓ 2) Effects of Anesthesia ____ 3) Medical/Smoking History	☑ Pt. will be able to breathe without difficulty during immediate intraoperative phase.	☐ Offer to elevate head of litter or offer pillow. ☐ Observe pt. while awaiting surgery for signs of distress. ☐ Assist anesthesia during intubation and extubation.
C. INTEGUMENT ✓ Potential impairment of skin integrity due to: ✓ 1) Intraoperative Immobility ✓ 2) ESU Pad Placement ✓ 3) Positional Aids ____ 4) Prosthesis ✓ 5) Pooling of Prep Solutions	☑ Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened areas).	☐ Utilize pressure preventing devices on OR table and accessories. ☐ Check for proper positioning and support to maintain good body alignment. ☐ Pad pressure points. ☐ Place ESU ground pad on non compromised skin surface area. ☐ Keep prep fluids from pooling.

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

#[redacted] b(6)-4
ICW-2

VERIFICATIONS AT HOLDING AREA:
! ID/Allergy Band ! Dentures Removed
! H & P ! Contacts Removed
! NPO Since noon ! Jewelry Removed
! UHCG/LMP ! Body Pierce Removed
! Consent/Blood Transfusion Signed/Witnessed/Dated
! Surgical Site/Consent verified by Pt./Anesthesia/Surgeon
! Contact Precautions (Y) [✓ N]
! Family/Friend: Ø

DA FORM 5179, JUN 91 Previous editions are obsolete. USAPA V1.0

MEDCOM - 12629

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to: ✓ 1) Intraoperative Mobility ✓ 2) Positioning ___ 3) Existing Disease ✓ 4) Safety Devices ✓ 5) Hypothermia	✓ Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse.	○ Check for support stockings or ace wraps. If none, check with doctors. ✓ Check that safety straps are correctly applied. ○ Offer pillow for under knees. ○ Place and take down legs from stirrups with slow bilateral motion. ✓. Check that rings and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to: ___ 1) Pain ✓ 2) Intraoperative Hazards ___ 3) Prosthesis ✓ 4) Positioning ✓ 5) Transfer pt. to/from OR table E.2. ✓ Potential discomfort due to: ✓ 1) Length of Surgery ✓ 2) Positioning ___ 3) Arthritis	o Pt. will be transferred to OR table without difficulty. o Pt. will not experience unnecessary physical discomfort.	o Have sufficient people available for transfer. o Insure proper body alignment. o Allow patient to lie in position of comfort while waiting for surgery. o Offer support (i.e., pillows, bath towels, etc.) for positioning.
F. SPECIAL SENSES F.1. ✓ Diminished visual perception due to being: ✓ 1) Pre-Medicated ___ 2) W/O Glasses F.2. ✓ Potential for decreased communication due to: ___ 1) Diminished Hearing ✓ 2) Language Barrier F.3. ___ Potential injury due to dentures: ___ 1) Upper ___ 4) Caps ___ 2) Lower ___ 5) Crowns ___ 3) Bridges	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR table. o Pt. will be able to understand instructions. o Minimize danger of injury during intraop period. Iraqi national	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt from either side. o Validate pt.'s understanding of verbal communication. o Verify removal of dentures.
G OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

10. OR NURSING INTERVENTIONS COMPLETED/ADDITIONAL INTRAOPERATIVE INTERVENTIONS NOTED.

[redacted] b(6)-2

6 July 03 DATE

11. POSTOPERATIVE EVALUATION: SKIN INTEGRITY: Bovie Pad Site: ☒ Clean and Dry ☐ Red ☐ N/A DRESSING DRY & INTACT: [✓ Y] (N)

LEVEL OF CONSCIOUSNESS: ☐ A&O ☒ Drowsy ☐ Sleepy ☐ Intubated BREATHING EASY: [✓ Y] (N)

LEVEL OF ACTIVITY: ☒ Moves All Extremities ☐ Moves Upper Extremities ☐ Transferred to litter with roller due to spinal

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] PT/AN b(6)-2

DATE: 6 July 03 TIME: 1545

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted]

DATE: 6 July 03 TIME: 2035 b(6)-2

REVERSE OF FORM 5179, JUN 91 MEDCOM - 12630 USAPA V1.0

MEDICAL RECORD — **INTRAOPER... DOCUMENT** b(6)-2

For use of this form, see AR 40-66, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Litter BY Amb. Staff

2. PATIENT ID[redacted]WED AND PROCEDURE VERIFIED BY [redacted] CPT/AN

3. DATE 9 July 2003 TIME PATIENT ARRIVED IN SUITE ICW → OR

4. PATIENT IN ROOM TIME 1345. NUMBER 2-1/4

5. PREOPERATIVE EMOTIONAL STATUS

☑ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS: NKDA, NPOP MN.

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] ORT b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

☑ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

COMMENTS: (B) arm to padded arm board <90°.

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☑ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS: Ø

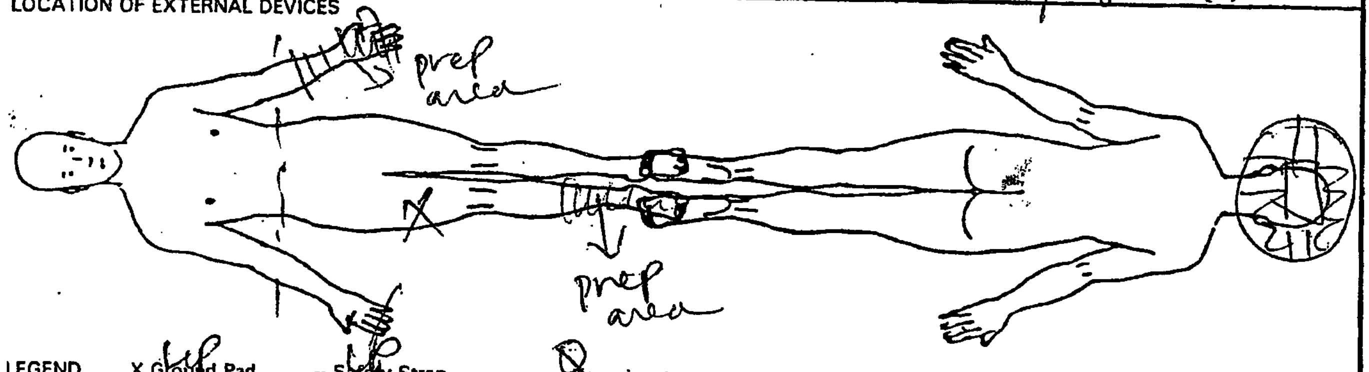
PREP SOLUTION *(Specify)* Betadine S/Sol

SITE: (R) foot BY WHOM: CPT. [redacted]

SITE: (L) hand BY WHOM:

COMMENTS: Ø poolings of sol. b(6)-2

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad Up -- Safety Strap Up = = = Tourniquet Ø

10. COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
			C = Correct I = Incorrect			b(6)-2	
Sponge	☑ Yes	☐ No	/	C	C	SPC [redacted]	CPT [redacted]
Needle Sharp	☑ Yes	☐ No					
Instrument	☐ Yes	☑ No		/	/		
Other	☐ Yes	☑ No					

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

GPW [redacted]

b(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☑ YES ☐ NO

☑ ESU NO: Valley Lab

GROUND PAD: BRAND Polyhesive II

LOT NO: 65706

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

Coag: 30, Cut: 30,

DA FORM 5179-1, OCT 87 REPLACES DA ... H IS OBSOLETE. MEDCOM - 12631 USAPA V1.01

13. PROSTHESIS, IMPLANTS ☐ YES ☑ NO IF YES NAME: ID NUMBER; MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☑

MEDICATIONS, SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S):

0.9% Nacl

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM IF YES, SITE

YES ☐ NO ☑

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☑	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☑	NAME	NAME
CULTURE (C) YES ☐ NO ☑	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☑ NO ☐

	1.	2.	3.
TYPE/SIZE	1/4" NU Gauze		
SITE	Rt foot &	(Lt) hand	

18. DRESSING/IMMOBILIZATION *(Specify)*

fluffs
Kerlix
Ace & Tape

19. ADDITIONAL INFORMATION

Surgeon: [redacted] b(6)-2
Anes: Maj [redacted] (CRNA)

20. OPERATION(S) PERFORMED

(Rt) foot I&D and (Lt) hand I&D

21. PATIENT TRANSFERRED TO b(6)-2 ICU

TIME See Anes Record

METHOD Litter

22. REGISTERED NURSE SIGNATURE [redacted] CPT/AN

MEDICAL RECORD — **INTRAOPERA… DOCUMENT**

For use of this form, see AR 40-66, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Litter BY Anesthesia

2. PATIENT IDENTIFIE… RECORD REVIEWED AND PROCEDURE VERIFIED BY CPT [redacted] b(6)-2

3. DATE 6 July 03 TIME PATIENT ARRIVED IN SUITE 1940

4. PATIENT IN ROOM TIME 1940 NUMBER 2

5. PREOPERATIVE EMOTIONAL STATUS

☐ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS:
NPO p̄ 1200, NKDA

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)* Pt in proper body alignment. Arms on armboards c̄ <90°. Left armboard doubled as an armtable.

☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

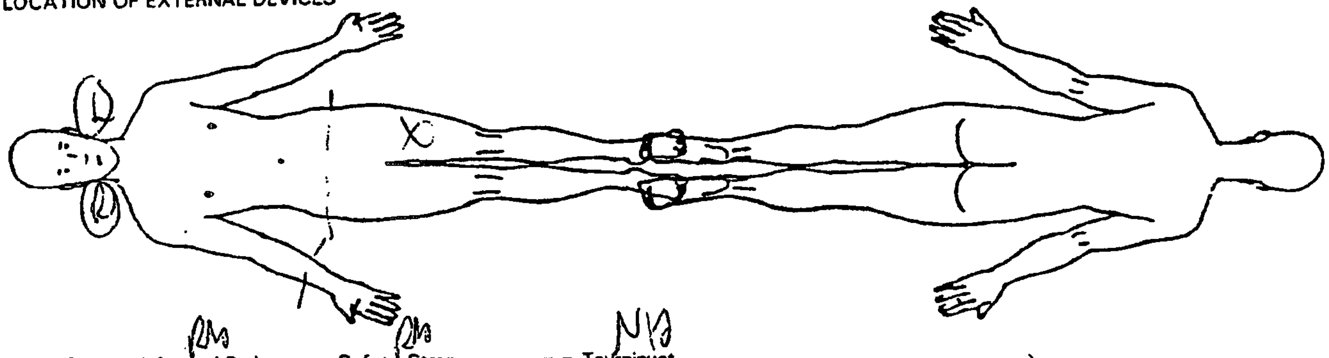
COMMENTS:

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR
☐ CLIP
COMMENTS:

PREP SOLUTION *(Specify)* Beta Beta
SITE: Right leg knee ⇒ down BY WHOM: [redacted]
SITE: Left Arm BY WHOM: [redacted]
COMMENTS: no pooling noted b(6)-2

9. LOCATION OF EXTERNAL DEVICES



RM RM NA

LEGEND X Ground Pad – Safety Strap = = = Tourniquet

b(6)-2

Initial,		C = Correct I = Incorrect				
10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No	/	C	C	SPC [redacted]	CPT [redacted]
Needle Sharp	☒ Yes ☐ No	/				
Instrument	☐ Yes ☐ No	/	/	/	/	/
Other	☐ Yes ☐ No					

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

# [redacted] b(6)-4
ICW-2

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO

☒ ESU NO: # 000950
GROUND PAD: BRAND VL
LOT NO: G5706

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES MEDCOM - 12633 …ICH IS OBSOLETE. USAPA V1.01

13. PROSTHESIS, IMPLANTS ☐ YES ☒ NO IF YES NAME: ID NUMBER; MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☒

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):
0.9% Nacl - Q.S.

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM IF YES, SITE
YES ☐ NO ☒

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☐	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☐	NAME	NAME
CULTURE (C) YES ☐ NO ☐	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 1/2" Iodoform Guaze	2.	3.
SITE	1. Right Foot	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Fluffs, kerlix, ace - right foot & left hand

19. ADDITIONAL INFORMATION

Surgeon: Dr [redacted] b(6)-2
Anesthesia: MAJ [redacted] CRNA

DA 5179 In Chart

20. OPERATION(S) PERFORMED
I&D Right foot c̄ packing / I&D left hand c̄ delayed primary closure

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU-1 b(6)-2	see DA7389	Litter

22. REGISTERED NURSE SIGNATURE [redacted]

REVERSE OF DA FORM 5179-1, OCT 87 MEDCOM - 12634 USAPA V1.01

MEDICAL RECORD | **INTRAOPERAT... DOCUMENT**
For use of this form, see AR 40-66, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Litter BY Ames' staff
2. PATIENT IDEN[redacted]ND PROCEDURE VERIFIED BY [redacted] CPT/An
3. DATE 7 July 03 TIME PATIENT ARRIVED IN SUITE 1CU2-20R
4. PATIENT IN ROOM TIME b(6)-2 NUMBER 1-1/2

5. PREOPERATIVE EMOTIONAL STATUS

☑ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS: NKDA. NPO p MN.

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted] (D) b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] (66E)	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

☑ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

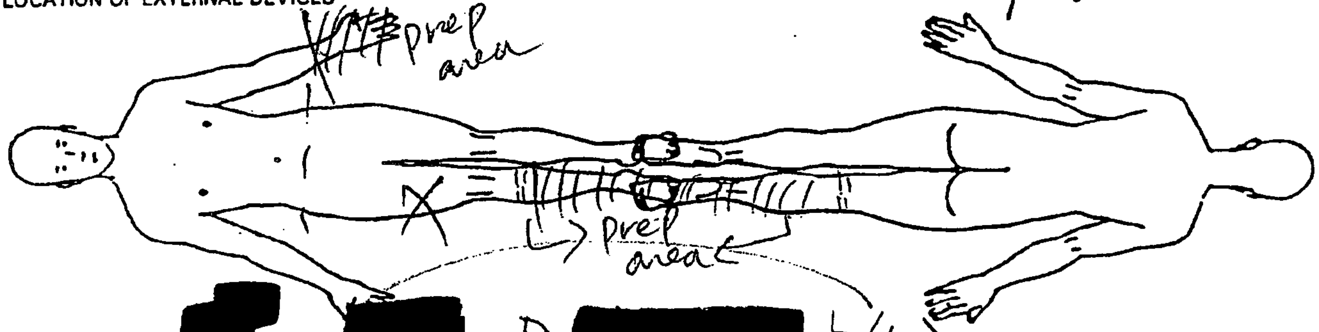
COMMENTS:

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☑ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP
COMMENTS: ∅

PREP SOLUTION *(Specify)* Betadine S/Sol.
SITE: (L) hand BY WHOM:
SITE: (Rt) Foot BY WHOM:
COMMENTS: ∅ Poolings of Sol.

9. LOCATION OF EXTERNAL DEVICES



LEGEND [redacted] X Gro[redacted]d -- Sa[redacted]trap Dr[redacted] === Tourniquet b(6)-2

10. COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
			C = Correct I = Incorrect				
Sponge	☑ Yes	☐ No	/	C	C	PFC [redacted]	CPT [redacted]
Needle Sharp	☑ Yes	☐ No					
Instrument	☐ Yes	☑ No			C		
Other	☐ Yes	☑ No					

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

[redacted] b(6)-4
EPW

12. ELECTROSURGERY DEVICE(S) (ESU) ☑ YES ☐ NO

☑ ESU NO: #1 Valley Lab
GROUND PAD: BRAND polyhesive II
LOT NO: 69652
☐ ESU NO:
GROUND PAD: BRAND
LOT NO:
☐ BIPOLAR NO:
Coag: 30 Cut: 30

DA FORM 5179-1, OCT 87 REPLACES MEDCOM - 12635 IICH IS OBSOLETE. USAPA V1.01

13. PROSTHESIS, IMPLANTS ☐ YES ☑ NO IF YES NAME: ID NUMBER; MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☑

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S):
0.9%NaCl

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM IF YES, SITE
YES ☐ NO ☑

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☑	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☑	NAME	NAME
CULTURE (C) YES ☐ NO ☑	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☑ NO ☐

	1.	2.	3.
TYPE/SIZE	1/4" NU Gauze	1/2" NU Gauze	
SITE	Rt foot	Lt 5th finger wd	

18. DRESSING/IMMOBILIZATION *(Specify)*
fluffs.
Kerlix
Ace

19. ADDITIONAL INFORMATION

Surgeon: Dr. [redacted] b(6)-4
Anes: CPT [redacted] (CRNA)

20. OPERATION(S) PERFORMED

Rt Foot [illegible]&D and Lt - hand I&D.

21. PATIENT TRANSFERRED TO b(6)-21 CW2 TIME See Anes Record METHOD Litter

22. REGISTER[redacted] CPT/AN

REVERSE OF DA FORM 5179-1, OCT 87 MEDCOM - 12636 USAPA V1.01

MEDICAL RECORD | **INTRAOPERA DOCUMENT**

For use of this form, see AR 40-66, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: Litter BY: Amo Staff

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED: [redacted] CPT/AN

3. DATE: 12 July 03

TIME PATIENT ARRIVED IN SUITE:

4. PATIENT IN ROOM TIME: 0800 b(6)-2 NUMBER: 1-8

5. PREOPERATIVE EMOTIONAL STATUS

☑ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS: NKDA, NPO p MN.

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted] ORT b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT. [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

☑ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

COMMENTS:

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☑ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* [redacted]

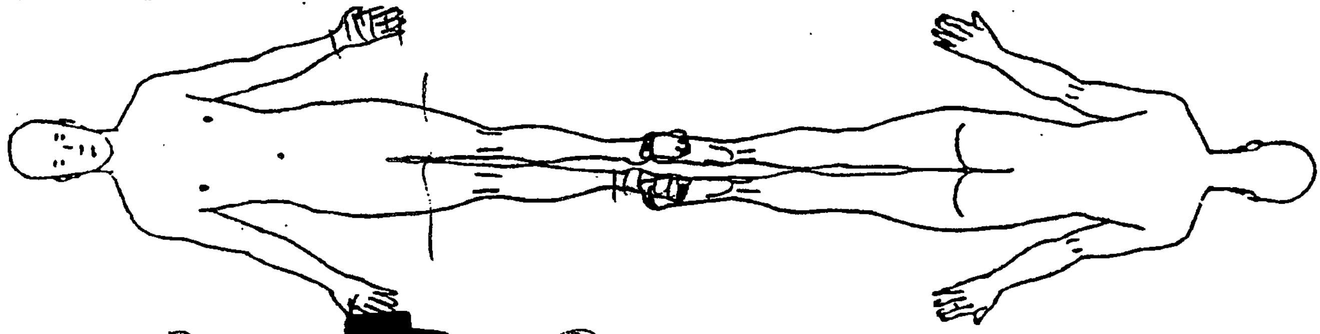
SITE: Rt foot BY WHOM: Dr [redacted]

SITE: Lt hand BY WHOM:

b(6)-2

COMMENTS: Ø pooling

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- S[redacted] ≡ = = Tourniquet

C = Correct I = Incorrect

b(6)-2

10. COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☑ Yes	☐ No	/	C	C	PFC [redacted]	CPT [redacted]
Needle Sharp	☐ Yes	☐ No					
Instrument	☐ Yes	☑ No					
Other	☐ Yes	☑ No					

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

EPW # [redacted].

b(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☐ YES ☑ NO

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES MEDCOM - 12637 HICH IS OBSOLETE. USAPA V1.01

13. PROSTHESIS, IMPLANTS ☐ YES ☑ NO IF YES NAME: ID NUMBER; MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☑

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S):
0.9% NS

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM IF YES, SITE
YES ☐ NO ☑

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☑	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☑	NAME	NAME
CULTURE (C) YES ☐ NO ☑	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☐ NO ☑

TYPE/SIZE	1.	2.	3.
SITE	1.	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
fluffs Ace.
2x2
Kerlix Tape

19. ADDITIONAL INFORMATION
Dr [redacted] b(6)-2
Maj [redacted]

20. OPERATION(S) PERFORMED
Rt foot I&D & Ⓛ hand washout

21. PATIENT TRANSFERRED TO ICU^2 b(6)-2 TIME See Anes Record METHOD Litter

22. REGIST [redacted] DI/AN

REVERSE OF DA FORM 5179-1, OCT 87 MEDCOM - 12638 USAPA V1.01

J-3,

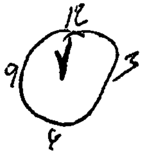
Date 04 July 03 [redacted] Bed # 2

Patient's Name: EPW # [redacted]

Time	05	06	07	08	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
BP	118/78													118/78										110/78
TEMP	99.1													99.3										97.9
HR	64													107										61
RR	18													20										14
SAO2	94													96										97
FIO2	RA													RA										RA
INPUT																								
PO		250		180				250			250													
IV																				100				
NGT																								
TURN Q 2																								
TOTAL																								
OUTPUT																								
URINE			550		350			400			350					400			300					300
NGT																								
STOOL											X·1													
TOTAL			550		900			1300			1650					2050			2350					2650
BALANCE																								
Initials																								

b(6)-1 [redacted] 3 Jun 03

Time	05	06	07	08	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
					O																			
BP	120/80								120/68				122/82						115/80					
TEMP	97.5								98.2				99.1						98.0					
HR	48				R				108				104						101					
RR	16								14				18						20					
SAO2	96%								96				97						95					
FIO2	RA								RA				RA						RA					
	NPO	NPO	NPO						240															
Iv	100	100	100	100	500	100																		
NGT																								
IVPB																				50				
TURN Q 2																								
								1300 240 1340	1340															
TOTAL																								
OUTPUT							750					650												
URINE	275	200												400					400					
NGT																								
STOOL																								
TOTAL BALANCE	275	475					1225		1225			1875		2275					2075					



MEDCOM - 12640

05July03 Bed #2

Patient's Name: EPW #[redacted] ~~[illegible]~~

Time	05	06	07	08	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
BP		110/76												100/60										
TEMP		97.6												97.9										
HR		74												65										
RR		16												16										
SAO2		100												99										
FIO2		RA												RA										
INPUT		0																						
PO		100		240		240	~~[illegible]~~		100															
IV		0																						
NGT		N/A																						
DB				100						100														
TURN Q 2	N/A VT moves himself																							
												800												
TOTAL				340		640				[illegible]		[illegible]												
OUTPUT																								
URINE		300			375					350		300												
NGT																								
STOOL				X1																				
TOTAL		300			675					35		1500												
BALANCE																								
Initials																								

MEDCOM - 12641

[illegible]

# [redacted] 2 JUL 03

Time	~~05~~	06	07	08	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
	0600																							
BP	104		98/61	105/70					~~108/68~~					105/65				110/60				105/55		
TEMP	984		97^4	98					97^4					97^3								97^8		
HR	46		63	48					52					50				48				45		
RR	16		14	16					16					18				20				22		
SA	97		97	95					96					97				98				98		
2	RA		RA	RA										NA				NA				NA		
	~~100~~	~~100~~	~~100~~	~~100~~	~~100~~	~~100~~	~~100~~	~~100~~	~~100~~															
INPUT	NS	NS	NS	NS	NS	NS	NS	NS	NS															
PO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO											
IV (LR 100)	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
NGT	0		0																					
IVPB	0		0	50								50								50				
TURN Q 2	-																							
																				150				
													1400	1500	1600	1700	1800	1900	2000	2150	2250	2350	2450	2550
TOTAL	100		200	350					950				1850											
OUTPUT	0		0																					
IE				125					350							200			250				375	275
L																							1400	1475
TOTAL				125					~~475~~				475			675			1025					
BALANCE	0		0																					

IN 2550

OUT 1475

MEDCOM - 12642

Patient's Name: #[redacted] 5-13-0 ~~1~~ 8412 - 28[illegible]

Time	05	06	07	08	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
BP																				105/61	94/53	94/55	93/52	
TEMP																				96.5				
HR																				48	48	45	50	50
RR																				18	16	18	20	18
SAO2																				97	98	96	97	98
FIO2																				RA	RA	RA	RA	RA
T																								
IV																				100	100	100	100	100
NGT																				50				
IVPB																								
TURN Q 2																								
																				150	100	100	100	100
TOTAL																				150	250	350	450	550
OUTPUT																								
URINE																							150	
NGT																								
STOOL																								
TOTAL																							150	
BALANCE																								

IN 550

OUT 150

MEDCOM - 12643

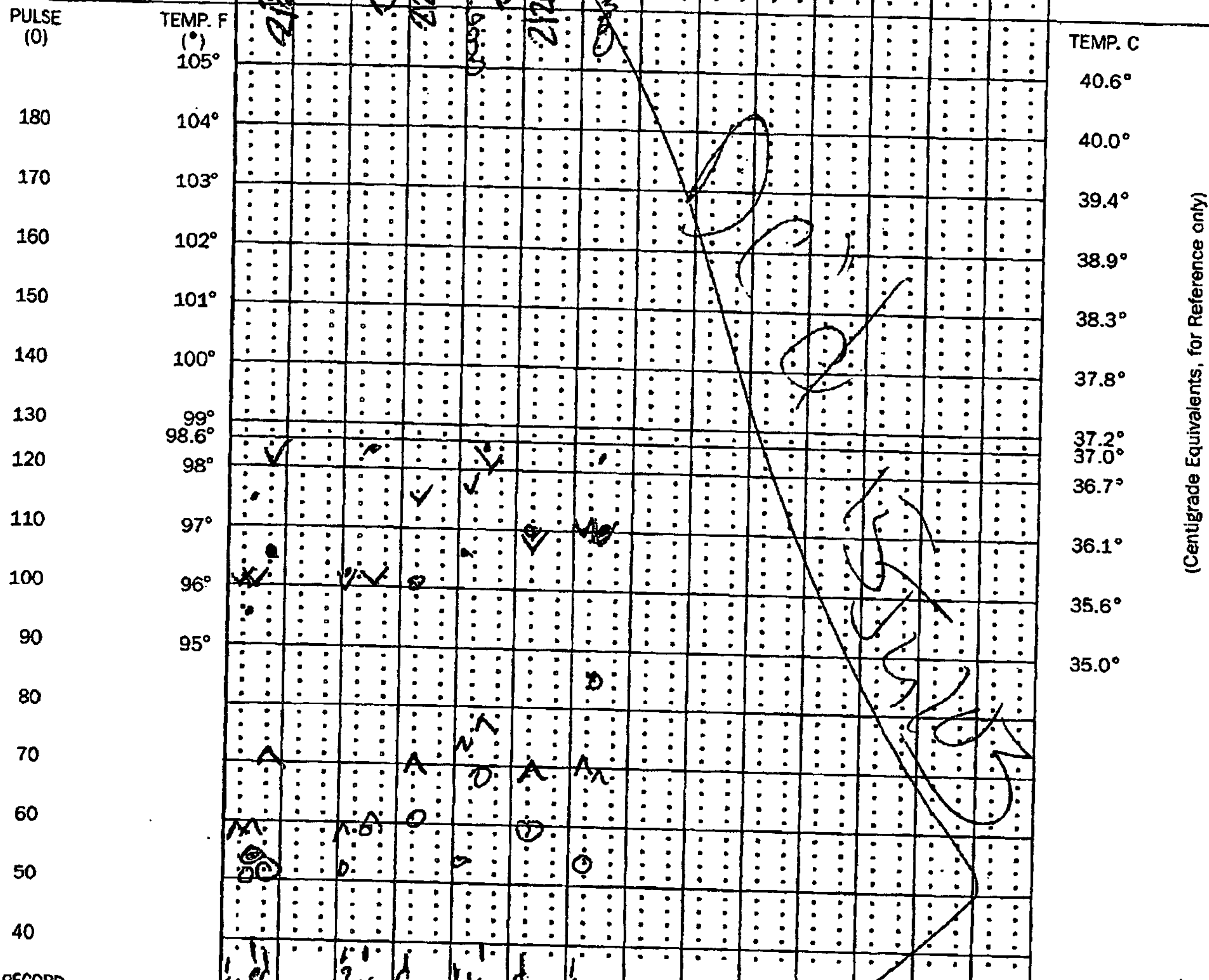
MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR DAY	12	13	14	15
19 HOUR	2126	13 2022	0300 2126	3



RESPIRATION RECORD	16	24	16	16	16	10
BLOOD PRESSURE	[illegible] [illegible] [illegible]	100/60 114/62	114/72	116/74 139/78	108/70	118/70 118/70
HEIGHT: WEIGHT →	97% 97% 96%	96% 97%	98%	96% 97%	98%	95%

Record special data only when so ordered

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*

#[redacted]

b(6)-4

REGISTER NO.

WARD NO. ICW2

STANDARD FORM 511 (REV. 7-95) **BACK**

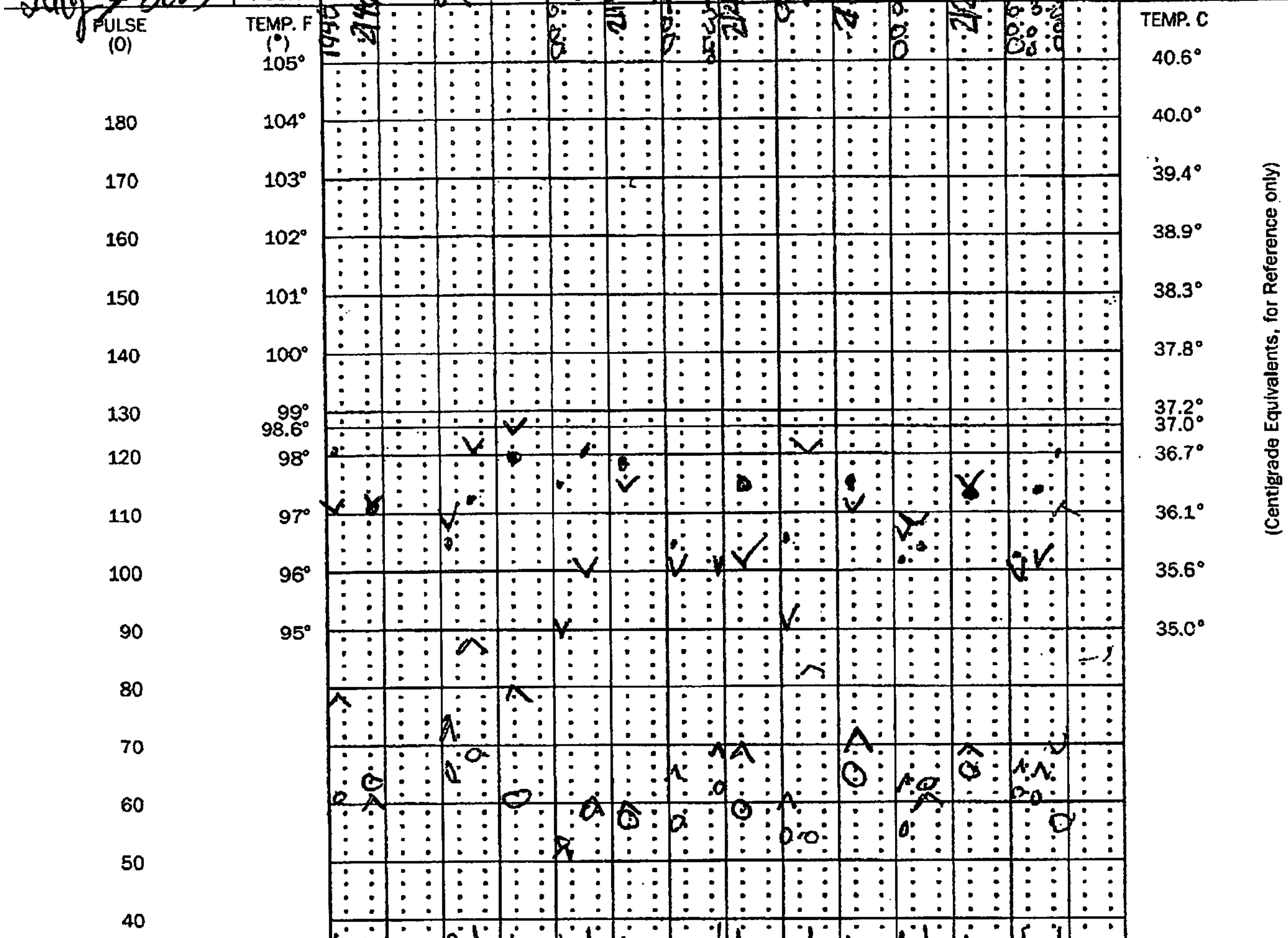
MEDCOM - 12644

511-119 NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY								
POST- DAY								
MONTH-YEAR	DAY	5	6	7	8	9	10	11
July 19 2003	HOUR	1930 2140	0830	0830 2130	2130	2130	0930 2130	0830



RESPIRATION RECORD	R 24		20 14	16	16 14	12	14	16 18		14	18	14 12	16	16 16		
BLOOD PRESSURE	119/78 117/62		103/74 120/80	124/60	99/52 101/60	114/60	110/64	102/70	109/80	110/72	106/64 108/62	114/70	104/66 108/68		
HEIGHT: / WEIGHT →															
SpO2	95% 97%		97% 97%	95%	98% 95%	98%	96%	95%	96%	98%	96% 97%	98%	96%		

Data only when so ordered

IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*

REGISTER NO.

WARD NO. ICW 2

2PW [redacted] b(6)-4

VITAL SIGNS RECORDS

Medical Record

STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 12645

b(6)-2

Ward/Section: EMT	JEST [redacted] Dr. [redacted]	**CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. EPW	DATE 17Jul03	TIME 2145
		[redacted] SSN: [redacted] b(6)-4

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		Negative
Drug of Abuse		Negative
		Negative
		Negative
		Negative

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU	88	73-118 mg/dl
BUN	15	7-22 mg/dl
CRE	0.7	0.6-1.2 mg/dl
CK	761	39-380 u/l (M) 30-190 u/l (F)
NA^+	142	128-145 mmol/l
K^+	4.4	3.3-4.7 mmol/l
CL^-	105	98-108 mmol/l
tCO_2	24	18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

REMARKS:

REPORTED BY: [redacted]	**DATE:** 07Jul03	**LAB ID NO.:**

b(6)-2

MEDCOM - 12646

PT PTT

12.2 / 22.4

b(6)-2

d/Section: EMT	REQUESTING PHYSICIAN: Dr [redacted]	**LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)

T, FIRST, MI.	DATE (JULY 8)	TIME 2315	SSN/ SSN: [redacted] b(6)-4

(Hematology) CBC			Urinalysis			Misc. Serology		
EST	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*
C	7.2	4.8-10.8 x 10³	Color	yellow	N/A	RPR		Negative
C	4.56	4.7-6.1 x 10⁹	App	clear	N/A	Mono		Negative
)	12.3	14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	**Microbiology**		
	39.7	42-52% (M) 37-47% (F)	Bili		Negative	Source		
V	87.0	80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
	274	130-500 x 10³ verified	SG		N/A	Occ Bld		Negative
ph %	26.0	20.5-51.1%	Bld		Negative	H. pylori		Negative

Hematology) Manual Differential				Urinalysis (cont.)				
				pH		N/A	Micro Parasites	
s		Mono		Prot		Negative	Malaria	
ds		Eos		Urob		0.2-1.0	O & P	
ph		Baso		Nit		Negative	Other	
p		Imm		Leuk		Negative	**Microscopic Urinalysis**	
C ph				HCG		Negative		

			CSF			Blood Bank
n atocrit		42-52% (M) 37-47% (F)				
Rate			Cell Count			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED
er			Directigen		Negative	ABO/Rh

Coagulation Studies			Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)		
ST	*RESULT*	*REF. RANGE*	*UNIT*	*TYPE*	*CROSSMATCH*
		9.8-13.6 secs			
T		21-34 secs			
imer		<20 ug/ml			
		<10 ug/ml			

MARKS:

PORTED BY: | DATE: | LAB ID NO.:

MEDCOM - 12648

ACLU-RDI 1592 p.541

Tobacco

NKDA

MEDICAL RECORD ANESTHESIA

ANESTHETIC AGENTS AND FLUIDS — CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML; " | "=CONSTANT INFUSION

DRUG	(Units)			TOTALS
fentanyl	(mg)	50 (200)		250
Lidocaine	(mg)	40		40
Propofol	(mg)	150	50	200
Sux	(mg)	80		80
	(mg)			
	( )			
INHAL AGENT: ISO	% del	1.5 1.5 1.5 X		
	% e.t.			
AIR	L/Min			
N2O	L/Min			
O2	L/Min	10 2 2 2 10		

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS

TOTAL IN: MFL

TOTAL URINE: 0

FLUIDS – SUMMARY

CRYSTALLOID– 300

COLLOID– 0

BLOOD– 0

FLUIDS

LINE site		
20G (R) A	☒ Warmed	LR D/C'd X
18G (R) AC	☒ Warmed	LR #1
	☐ Warmed	
	☐ Warmed	

LOSSES: EST BLOOD LOSS

URINE –

PHYS STATUS: 1 [✓ 2] 3 4 5 E

BODY WEIGHT: 75 [✓ KG] LB

HEMATOCRIT: —

INITIAL DATA: BP – 108/74 HR – 70

EQUIP CHECK: OK? – [✓ Y] N

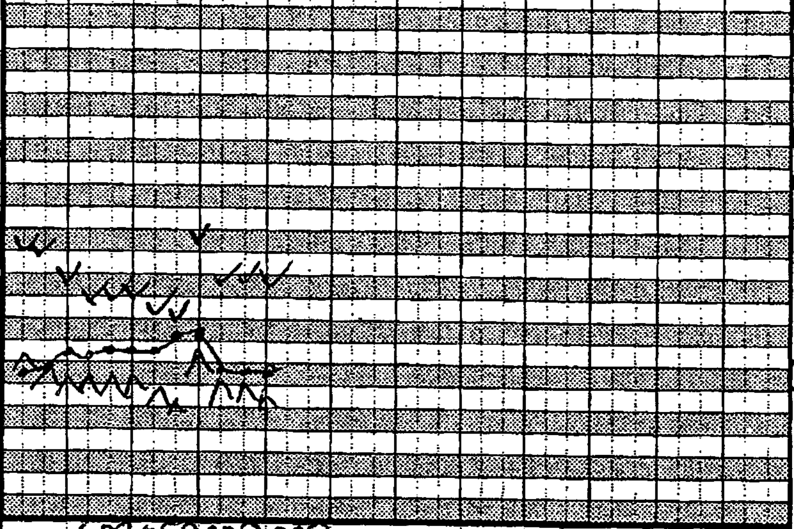
PATIENT SIGNED: OK for PROCEDURE? JSW TIME– 1915

TIME → 1930 · 2000 · 30 · 2100 · 30 · 2200

SYMBOLS:

- BP by cuff: V / Λ
- Heart rate: ●
- Resp rate
- BP (transduced)
- TOURNIQUET T – ✗
- ANES– X-X
- PROC ⊙ – Ø

220 200 180 160 140 120 100 80 60 40 20



VT – ml	—	600	650	330	300
f – breaths/min	—	10	6	9	9
Peak inf pres / PEEP	—	20	20	—	
MODE– S(pon), A(ssist), C(on)	S	C	C	S	S

MONITORS: ✓ BP/Auto Cuff; ✓ BP / oth; ART line; Steth- PC/ES; Gas analyzer; ✓ Warming blkt; Conv warmer

✓ ET CO2 (torr)	50	35	31	61	55
✓ FIO2 (Frac or %)	0.89	0.89	0.89	0.89	0.89
✓ SpO2 (%)	100	100	100	100	100
✓ ECG	SR	SR	SR	SR	
TEMP- site	Unavailable ——				
N-M Block (T/4)					
BS	X1 ——				
✓	x1 wool blanket ——>				

Mark with letters & symbols, explain under REMARKS EVENTS ① ② ③ ④ ⑤

Position →

REMARKS–

Code drugs with numbers, events with letters

① Pre-op assessment noted, NPO status & explained to pt to go to OR

② Room, monitors, O2, induced, eyelids taped, see airway management

③ Zofran 4mg IV

④ TV > 4ml/kg; RR > 8 & < 30 BPM. Of suctioned; Responsive! Extubated s̄ complications

⑤ To litter & TO ICU. Report to RN.

RECOVERY AT 2030

PACU (ICU) 1 (Specify)

OTHER T 97.2

CONDITION: Stable/awake

RESP– 20 SpO2– 99

BP– 128/72 HR– 76

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1925	1935	2040

	Ready	Begin	End
PROC	1945	2055	2025

PROCEDURES and CPT Codes

I&D (R) foot + (L) hand

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

GETA

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* Grade I view

DL x1 MAC 4 8.0 styletted OETT 22cm @ lip + BBS, + bilat rise + ETCO2

PATIENT IDENTIFICATION– *Typed or written entries: Name, Grade/Rate, Medical facility*

EPW # [redacted]

b(6)-2

b(6)-4

SURGEONS [redacted]

[redacted] CRNA

MAJ – ANESTHESIA

PROCEDURE LOCATION 2

DATE 6 July 03

PAGE 1 OF 1

WAMC OP 376 REVISED
1 Jan 99

MEDCOM - 12649

*U.S. GPO: 2002-729-180/40137

NKDA

MEDICAL RECORD **ANESTHESIA**

ANESTHETIC AGENTS AND DRUGS

CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML. ° | "=CONSTANT INFUSION

DRUG (Units)		TOTALS
Midazolam (mg)	2.5	2.5
Fentanyl (mcg)	50 25	75
Ketamine (mg)	10 – 10	20
Propofol (mg)	50 – 50	100
( )		
( )		

VOLAT. AGENTS Iso % del 1.5 1.5 X

% e.t.

AIR L/Min

N2O L/Min

O2 L/Min 10 2 2 10

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS

TOTAL EBL: min

TOTAL URINE: 0

FLUIDS

LINE site 20G (R) A ☐ Warmed 0/c'd

16G (L) Arm ☒ Warmed LR #1 —

☐ Warmed

☐ Warmed

LOSSES EST BLOOD LOSS

URINE –

FLUID SUMMARY

CRYSTALLOID– 300

COLLOID– 0

BLOOD– 0

REMARKS

Code drugs with numbers, events with letters

① Pre-op review of systems. Lungs – CV – Airway – NPO – confirmed since a

Glycopyrrolate 0.2mg

② Room, monitors O2 Sedation TTE

③ Zofran 4mg IV for c/o N+V

④ A, A, responsive removed Nasal airway himself. To litter + to ICU Report to nurse

PHYS STATUS [✓ 1] 2 3 4 5 E

BODY WEIGHT 70 [✓ KG] LB

HEMATOCRIT 9 July 03 39.7

INITIAL DATA: BP– 90/60 HR– 55

EQUIP CHECK OK?– [✓ Y] N

PATIENT RECHECK OK for PROCEDURE? ✓ [illegible] TIME– 1330

TIME → 1345 1400 . 30 . 1500

SYMBOLS:

BP by cuff ∨ ∧

Heart rate ●

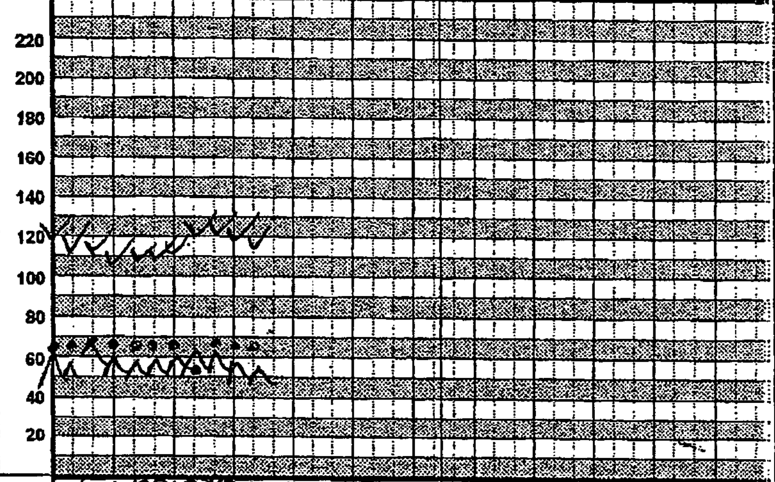
Resp rate

BP (transduced)

TOURNIQUET T – ✗

ANES– X-X

PROC-⊙-Ø



VENT.

VT – ml	⊥	400	330	600
f – breaths/min	=	18	12	12
Peak Inf pres / PEEP	=	–	–	–
✓ MODE– S(pon), A(ssist), C(on)	S	S	S	S

MONITORS / ACCESSORIES

✓ BP/Auto Cuff	✓ ET CO2 (torr)	+	45	49	50
✓ BP / oth	✓ FIO2 (Frac or %)	0.71	0.71	0.71	0.71
ART line	✓ SpO2 (%)	100	100	100	100
Steth- PC/ES	✓ ECG SR	SR →			→
Gas analyzer	✓ TEMP- site AU	Axillary →			
	N-M Block (T/4)				
	BS	+ —			
✓ Warming blkt	✓ x1	→			→
Conv warmer					

Mark with letters & symbols, explain under REMARKS EVENTS ①② ③ ④

Position →

RECOVERY AT 1450

PACU [✓ ICU 2] (Specify)

OTHER T-95.4

CONDITION: Stable, arousable

RESP– 20's SpO2– 96

BP– 124/80 HR– 63

ANESTHESIA / PROCEDURE TIMES

ANES.	Start 1330	Room 1345	End 1455
PROC.	Ready 1400	Begin 1418	End 1440

PROCEDURES and CPT Codes

I + D (R) foot [redacted] 66-2 + (L) hand-finger

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

MAC

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*

OA 9mm; [illegible] airway 7FR; head tilt, chin lift

PATIENT IDENTIFICATION – *Typed or written entries: Name, Grade/Rate, Medical facility*

FPW # [redacted]

b(6)-4

SURGEONS [redacted] b(6)-?

[redacted] CRNA

MAJ

PROCEDURE LOCATION 2

DATE 9 July 03

PAGE 1 OF 1

MEDICAL RE[redacted]NESTHESIA

WAMC OP 376 REVISED Jan 99

PATIENT RECO[redacted]

☆ U.S. GPO: 1999 – 528-336/10085

MEDCOM - 12650

7/12/03: No Δ in pt status
sir prior anesthetics.
Pla :A. New preop deferred.

MEDICAL RECORD — ANESTHESIA

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML, " | "=CONSTANT INFUSION

DRUG	(Units)			TOTALS
Versed	(mg)	2.5		2.5
MSO4	(mg)	4	2	6
Propofol	(mg)		100	
	( )			
	( )			
	( )			
VOLAT AGENT Haloth	% del	2.0 X		
	% e.t.			
AIR	L/Min			
N2O	L/Min			
O2	L/Min			

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS ▶ ① ② ③

FLUIDS

LINE site			
20g LFA	☐ Warmed	RL DC'd	
18g RFA	☐ Warmed	————	200
	☐ Warmed		
	☐ Warmed		

LOSSES — EST BLOOD LOSS / URINE –

TOTAL EBL: min

TOTAL URINE: 0

FLUIDS SUMMARY

CRYSTALLOID– 200
COLLOID– 0
BLOOD– 0

REMARKS– *Code drugs with numbers, events with letters*

① To room, SOC monitors, preO2
② Smooth IV induction
③ To recovery stable.

PHYS STATUS: [✓ 1] 2 3 4 5 E

BODY WEIGHT: 60 [✓ KG] LB

HEMATOCRIT: —

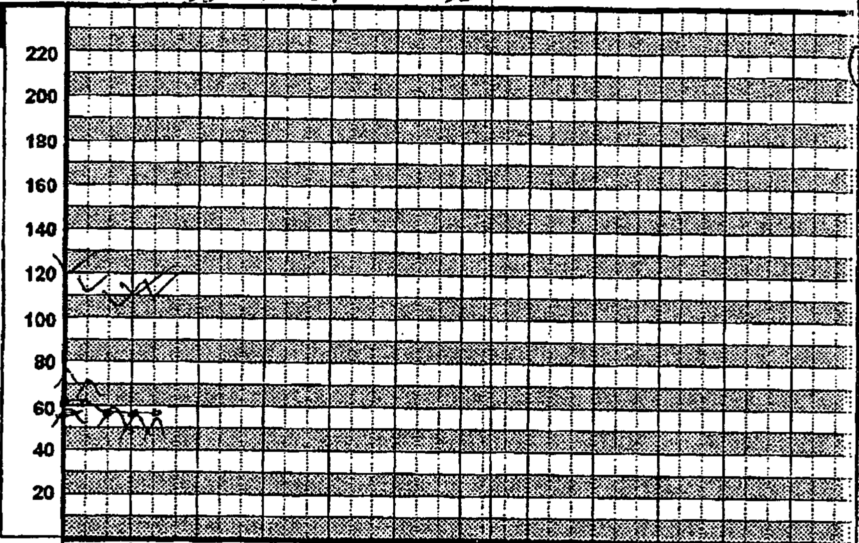
INITIAL DATA: BP – 120/71 HR– 58

EQUIP CHECK: OK?– [✓ Y] N

PATIENT RECHECK: OK for PROCEDURE? Y TIME– 0705

TIME ➡ 08 × 30 × 09 × 30

SYMBOLS: BP by cuff ∨ ∧; Heart rate ●; Resp rate; BP (transduced) ╪; TOURNIQUET T –; ANES– X-X; PROC– ⊙ – Ø



VENTIL

VT – ml		
f – breaths/min	16	14
Peak inf pres / PEEP		
MODE– S(pon), A(ssist), C(on)	S	S

MONITORS / ACCESSORIES

✓ BP/Auto Cuff	✓ ET CO2 (torr)	36	36
BP / oth	✓ FIO2 (Frac or %)	0.9	0.9
ART line	✓ SpO2 (%)	100	100
Steth- PC/ES	✓ ECG	SB	SB
Gas analyzer	TEMP- site		
	N-M Block (T/4)		
Warming blkt			
Conv warmer			

Mark with letters & symbols, explain under REMARKS EVENTS *Position* ⟶ O—

RECOVERY AT
PACU [✓ ICU] 1 (Specify)
OTHER 2
CONDITION: 96
RESP– SpO2– 98
BP– 95/61 HR– 62

ANES PROCEDURE TIMES

	Start	Room	End
ANES	0750	0800	0830

	Ready	Begin	End
PROC	0802	0807	0815

PROCEDURES and CPT Codes
Washout lt hand & Rt foot

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*
GM

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*
Eyes taped, #9OA, easy mask.

PATIENT IDENTIFICATION— *Typed or written entries: Name, Grade/Rate, Medical facility*
EPW # [redacted]
32 yo b(6)-4

SURGEONS: [redacted] b(6)-2

ANESTHETISTS: [redacted] MAJ, CRNA

PROCEDURE LOCATION 1-1

DATE 7/12/03

PAGE 1 OF 1

RD – ANESTHESIA
WAMC OP 570 REVISED
1 Jan 99

MEDCOM - 12651

☆ U.S. GPO: 1999 – 528-336/10085

ANESTHESIA PLAN OF CARE PR...ROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 32 DAYS MOS [✓ YRS]
Sex ( ) MALE ( ) FEMALE

PROPOSED PROCEDURE: (R) pinning foot
SURGICAL SERVICE: Ortho
NPO SINCE: MN

ASA Physical State [✓ 1] 2 3 4 5 E
WT: 70 [✓ KG] LB HT: ____ IN.
ALLERGIES: NKDA

HABITS:
TOBACCO: 0
ETOH: 0
DRUGS: ____

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) Ancef 1g IV q8°
( )
( )
( )
( )
( )

PREMEDICATIONS:
None Yes (@ ____ Hrs) /CC
____ - ____ mg IV IM PO
____ - ____ mg IV IM PO
____ - ____ mg IV IM PO

LABORATORY STUDIES:
HB/HCT: 12.3 / 39.7
U/A:
OTHER:

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:			
Hypertension	N	Y	Denies
Angina	N	Y	
MI	N	Y	
CVA	N	Y	
Other	N	Y	
Pulmonary System:			
Asthma	N	Y	
Bronchitis/URI	N	Y	
COPD	N	Y	
Other	N	Y	
Renal System:			
Acute/Chronic RF	N	Y	
Gastrointestinal:			
Hepatitis	N	Y	
Hiatal Hernia	N	Y	
PUD/GERD	N	Y	
Endocrine System:			
Diabetes	N	Y	
Steriods	N	Y	
Thyroid	N	Y	
Neurological:			
Seizures	N	Y	
Neuropathy	N	Y	
Other	N	Y	
Gynecological:			
Pregnancy	N	Y	N/A
Other Significant Hx:			
	N	Y	
	N	Y	
Familial HX	N	Y	

① GSW (R) foot ② Infected wound ③ Pinky finger

ASSESSMENT
PAST SURGICAL/ANESTHETIC
0

PHYSICAL EXAMINATION
BP 130/61 HR 56 R 12 T 98.1
Pain Scale 0-10 ____
HEENT - Teeth intact · Cavity (R) lower molar
Trachea Midline
TMJ/Neck FROM; Pain (R) neck
Oropharynx MP1
Nares patent
CHEST: CTA (B)
CARDIAC: RRR (-) R
EXTREMITIES:
IV Access: (R) FA 18G PIV
Ulnar Filling:
BACK:
OTHER:

NPO Since MN

ANESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ____ [✓ General]: [✓ Mask Intubation]

Speaks little English. Discussed to OR for surgery. Pt understands

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discussed with the patient/legal guardian.

b(6)-2

The patient/legal guardian seems to understand and agrees. Questions answered.
Signed: [redacted] CRNA/MAJ Date: 2 July 03 Time: 0815 Hrs

POST-A HESIA EVAL ND NOTE (NON ASU)
{ } NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER

Signed: ________ Date: ______ Time: ______ Hrs

Patient Identification: (Ward) ________

EPW# [redacted] b(6)-4

SEDATION KEY:

1. MINIMAL (Anxiolysis) Patient responds normally to verbal commands
2. MODERATE (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is not necessary.
3. DEEP SEDATION/ANALGESIA. Patient responds purposefully following repeated or painful stimulation. Airway assistance may

MEDCOM - 12652

ME…AL RECORD ANESTHESIA

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML. "I" = CONSTANT INFUSION

DRUG	(Units)		TOTALS
MSO4	( )	10 – 10	20
fentanyl	( )	50	50
propofol	( )	150	150
	( )		
	( )		
	( )		
VOLAT AGENT ISO	% del	x/1.5/2.0/1.5/2.0/0	
	% e.t.		
AIR	L/Min		
N2O	L/Min		
O2	L/Min	5/3/4/4/4/0	

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS ▶

TOTAL EBL MIN

TOTAL URINE 0

FLUIDS – SUMMARY

CRYSTALLOID– 800

COLLOID– 0

BLOOD– 0

FLUIDS

LINE site 18g (R) FA

☐ Warmed	<900+>	
☐ Warmed	NS 1 —— 800	
☐ Warmed		
☐ Warmed		

LOSSES EST BLOOD LOSS

URINE –

REMARKS–

Code drugs with numbers, events with letters

0950 PT ID, CHART REVIEWED, Ø Δ from preop 2400.

1003 RM, O2, monitors

1100 OOR TO ICU 2

1110 RPT TO SGT [redacted]

PHYS STATUS [✓ 1] 2 3 4 5 E

BODY WEIGHT 60 [✓ KG] LB

HEMATOCRIT

INITIAL DATA

BP – 124/70

HR– 88

EQUIP CHECK OK?– [✓ Y] N

PATIENT RECHECK OK for PROCEDURE? Y

TIME– 1008

TIME ➡ 1015 1030 Ø 1100

SYMBOLS:

BP by cuff V Λ

Heart rate ●

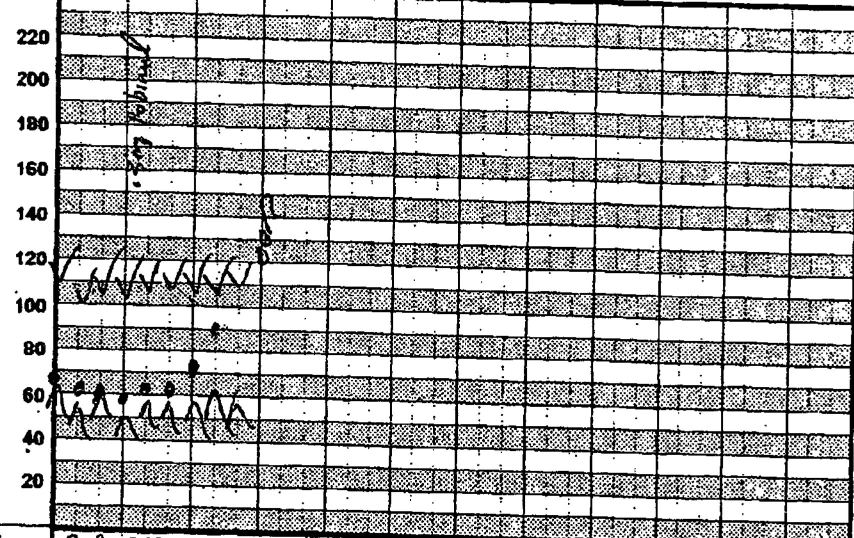
Resp rate

BP (transduced) ⊥ T

TOURNIQUET T – T̸

ANES– X-X

PROC ⊙ – Ø



VENTILATION

VT – ml	300	210	210
f – breaths/min	12	12	14
Peak inf pres / PEEP	/	/	/
MODE– S(pon), A(ssist), C(on)	S	S	S

MONITORS AND EQUIPMENT

BP/Auto Cuff	X	ET CO2 (torr)	44	53	50
BP / oth	X	FIO2 (Frac or %)	.76	.76	.76
ART line	X	SpO2 (%)	100	100	100
Steth- PC/ES	X	ECG	SR	SR	SR
Gas analyzer	X	TEMP- site	Axial		
	X	N-M Block (T/4)			
Warming blkt					
Conv warmer					

Mark with letters & symbols, explain under REMARKS

EVENTS *Position* ⟶ 0—

RECOVERY AT 1109

PACU ICU ________ (Specify)

OTHER ________

CONDITION: stable

RESP- 14 SpO2- 97

BP- 177/10 HR- 94

ANESTHESIA / PROCEDURE TIMES

ANES	Start	Room	End
	0950	1003	1115
PROC	Ready	Begin	End
	1010	1029	1059

PROCEDURES and CPT Codes

I & D Ankle

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

GA c̄ mask

PATIENT IDENTIFICATION– *Typed or written entries: Name, Grade/Rate, Medical facility*

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*

OA in place – mask

[redacted]

DIW-4

[redacted] DIW-2

CPT CRNA

PROCEDURE LOCATION OR 1

MEDCOM - 12653

THESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

32 DAYS MOS YRS   Sex [✓ MALE] ( ) FEMALE

OSED PROCEDURE: I+D (R) Foot + (L) hand   GSW (R) FOOT
ICAL SERVICE: ORTHO
INCE: 1200 N002

ASA Physical State [✓ 1] 2 3 4 5 E
WT: 60 [✓ KG]/LB HT: _____ IN.
ALLERGIES: NKDA

S:
ACCO: Ø
ETOH:
RUGS:

ENT MEDICATIONS:
dered as premed

EDICATIONS:
Yes (@ ______ Hrs) /CC
______ mg IV IM PO
______ mg IV IM PO
______ mg IV IM PO

RATORY STUDIES:
T: 12.3 / 39.7
R:

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:
- Hypertension N Y
- Angina N Y
- MI N Y
- CVA N Y
- Other N Y

Pulmonary System:
- Asthma N Y
- Bronchitis/URI N Y
- COPD N Y
- Other N Y

Renal System:
- Acute/Chronic RF N Y

Gastrointestinal:
- Hepatitis N Y
- Hiatal Hernia N Y
- PUD/GERD N Y

Endocrine System:
- Diabetes N Y
- Steriods N Y
- Thyroid N Y

Neurological:
- Seizures N Y
- Neuropathy N Y
- Other N Y

Gynecological :
- Pregnancy N Y

Other Significant Hx:
- N Y
- N Y

Familial HX N Y

Ø

ASSESSMENT

PAST SURGICAL/ANESTHETIC

Ø

PHYSICAL EXAMINATION

BP 108/79 HR 78 R 20 T 97   6 July 03
Pain Scale 0-10
HEENT - Teeth intact
Trachea midline
TMJ/Neck FROM
Oropharynx MP1
Nares Patent
CHEST: ~~St. [illegible] CTA~~ CTA (B)
CARDIAC: S1 S2 66.2 RRR ⊖ (R)
EXTREMITIES:
IV Access: 18g RUE / 20G (L) FA
Ulnar Filling:
BACK:
OTHER:

NPO Since 1200

THETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ________ ☒ General: Mask [✓ Intubation]

MED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to a [redacted] legal guardian. CRNA/MAJ 6 July 03

b(6)-2

tient/legal guardian/seems to understand and agrees. Questions answered. 1921

[redacted] CPT CRNA Date: 3 JUL 03 Time: 1000 Hrs

ANESTHESI[redacted]N AND NOTE (NON ASU)
APPARENT ANESTHETIC COMPLICATIONS { } OTHER

: ________ Date: ______ Time: _____ Hrs

SEDATION KEY:

1. **MINIMAL** (Anxiolysis) Patient responds normally to verbal commands
2. **MODERATE** (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is not necessary.
3. **DEEP SEDATION/ANALGESIA.** Patient responds purposefully following repeated or painful stimulation. Airway assistance may

t Identification: (Ward) ________

[redacted]

b(6)-4

MEDCOM - 12654

[redacted] [redacted] AUTHORIZED FOR LOCAL RI

EDICAL RECORD	PROGRESS NOTES

DATE	NOTES
9 Jan 03	Ortho Op Note
	Pre Op Dx — ① abscess Ⓡ foot
	② abscess Ⓛ SF
	Post Op Dx — Same
	Procedure — ① I+D Ⓡ foot
	② I+D Ⓛ SF
	Surgeon — [redacted] b(6)-2
	EBL ~ min
	Anesthesia — MASK
	Findings — Ⓡ foot chronic abscess getting smaller. Packed loosely with 1/2" NU gauze. Ⓛ SF had some slight pus. Sutures opened irrigated w-gauze
	Plan — IV abx. Dressing changes daily.
	b(6)-2 [redacted]

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

SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

EPW# [redacted]

b(6)-4

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

ATIENT IDENTIFICATION

[redacted]

b(6)-4

URSING UNIT: ICU 2 | ROOM NO. | BED NO.

ATIENT IDENTIFICATION

b(6)-2

Noted [redacted] 12 Jul 03 0030

URSING UNIT | ROOM NO. | BED NO.

ATIENT IDENTIFICATION

URSING UNIT | ROOM NO. | BED NO.

ATIENT IDENTIFICATION

URSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 2323 TIME OF ORDER 1 Jul 03 HOURS | LIST TI ORDEF NOTED A SIGN

Admit to ward
Dx s/p GSW to hand / foot
Condition stable
Diet NPO after midnight
IVF LRC 100 cc/h
Ancef 1gm q 8° IV
Normal EPW precaution.

DATE OF ORDER TIME OF ORDER HOURS

Meds:
MSO4 2-5mg IVP q 3° PRN
phenergan 12.5mg IVP q 6° PRN nausea
Ambien 10mg PO q HS PRN
Splint to (R) leg.
Bring to (L) hand
to OR in AM
Dr [redacted]

DATE OF ORDER

NKDA

b(6)-4

HOURS

LTC MC

DATE OF ORDER TIME OF ORDER HOURS

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
EPW
[redacted]
b(6)-4

DATE OF ORDER 3 JULY 03 TIME OF ORDER 1100 HOURS
LIST TIME ORDER NOTED AND SIGN

① RESUME PREVIOUS ORDERS
② S/P I+D (R) FOOT + (L) LEG ✓
③ CONDITION FAIR
④ VS ROUTINE
⑤ UP AD LIB, NWB ON (R)
⑥ REGULAR DIET ✓

[redacted]
7/3/03
540

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

Done ⑦ IV LR AT 125 CC/HR. HEP LOCK WHEN TOLERATE P.O. WELL ✓
Done ⑧ ADD CIPROFLOXACIN 500 MG P.O. BID.

b(6)-2 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

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

DATE OF ORDER 3 July TIME OF ORDER HOURS
D/C MSO4
Percocet i-ii po q4-6° PRN pain
Saline lock IV

b(6)-2
[redacted]
7/3/03

[redacted] / [redacted]

NURSING UNIT | ROOM NO. | BED NO.

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

DATE OF ORDER 5 July 03 TIME OF ORDER HOURS
24° chart ✓ done 04 July 03 @ 0340 mz
Transfer to KW2
Resume Previous orders.

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

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JU[redacted] WHICH MAY BE USED.

MEDCOM - 12657

ACLU-RDI 1592 p.550

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

[redacted]

b(6)-4

b(6)-2 noted [redacted] 1040

DATE OF ORDER 6 Jul 03 **TIME OF ORDER** 0900 **HOURS**

LIST TIME ORDER NOTED AND SIGN

NPO

✓ for warrant today

[redacted] b(6)-2

NURSING UNIT ICW2 **ROOM NO.** **BED NO.**

PATIENT IDENTIFICATION

noted 21:15 [redacted]

DATE OF ORDER 6 Jul 03 **TIME** [redacted] 2000 **HOURS**

Transfer PACU → ICW2

S/P D&D (R) Foot / (L) Hand

[illegible]

Adv Rx Diet

HLIV when tol PO

Resume [illegible] meds

NURSING UNIT **ROOM NO.** **BED NO.**

24° V/S done [redacted]

PATIENT IDENTIFICATION

24° V/S 07 [redacted] ICTAN 7-8-03 2300 [redacted] b(6)-2

DATE **TIME OF ORDER**

[redacted]

b(6)-4

9 Jul 03 1000

NPO NOW

NURSING UNIT **ROOM NO.** **BED NO.**

PATIENT IDENTIFICATION

[redacted]

b(6)-4

DATE OF ORDER 9 July 03 **TIME OF ORDER** 1430 **HOURS**

1. Resume previous orders ✓
2. Regular diet ✓
3. IV LR at 125cc/hr HLOC when taking PO well. ✓
4. S/P I&D (R) foot ✓
5. TO ICU → ICW2 ✓
6. Daily dry dressing change [redacted]

NURSING UNIT **ROOM NO.** [redacted] **BED NO.**

24° V/S [redacted] + 10 [illegible] 0000.

noted [redacted] [illegible] 0030

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

MEDCOM - 12658

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.

b(6)-2

PATIENT IDENTIFICATION

b(6)-4

[redacted]

DATE OF ORDER 12 JAN 03 TIME OF ORDER 0820 HOURS

LIST T ORDE NOTED SIGN [redacted]

1. Resume previous orders
2. S/P I+D (R) foot (L) hand
3. Regular diet
4. IV: LR at 125cc/hr
5. Daily dry dressing changes
6. Hep lock IV when taking PO well

NURSING UNIT ICW 2 ROOM NO. BED NO. 11

PATIENT IDENTIFICATION

24°VS [redacted]

[redacted]

b(6)-4

TIME OF ORDER 14 JAN 2345 HOURS [redacted]

b(6)-2

b(6)-2

NURSING UNIT ICW 2 ROOM NO. BED NO. 11

PATIENT IDENTIFICATION

b(6)-4

[redacted]

DATE OF ORDER 12 JAN 03 TIME OF ORDER 1610 HOURS

b(6)-2 [redacted]

1. D/C IV
2. D/C cultures
3. Keflex 250 mg ⊕ 10 P.O.
4. May D/C to EPW camp

1800

b(6)-2

NURSING UNIT ICW 2 ROOM NO. BED NO. 11

PATIENT IDENTIFICATION

24°VS [redacted] 14 JAN [redacted]

b(6)-4

[redacted]

DATE [redacted] 14.03 TIME OF ORDER 2350 HOURS

NURSING UNIT ICW 2 ROOM NO. BED NO. 11

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

MEDCOM - 12659

b(6)-2

Green Sheet

the proponent agency is the Office of The Surgeon General.

MO. 7 YR 2003

RIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED												
				15	16	17	18									
3	[redacted]	VS routine	05	[redacted]												
			13	[redacted]												
			21													
			/													
3	[redacted]	regular diet	07	[redacted]												
			12	[redacted]												
			17	[redacted]												
			/	[redacted]												
6	[redacted]	up ad lib - NWB (L) leg	05	[redacted]												
			13	[redacted]												
			21													
			/													
9	[redacted]	dry dsg AQD	18	[redacted]												

DC'd 15 Jul 03

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS:
S/P GSW to hand & foot
S/P I&D (L) hand/(R) foot

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ______

PATIENT IDENTIFICATION:

EPW [redacted] b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIME

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78

EDITION OF 1 DEC 77 MAY BE USED.

USA

MEDCOM - 12660

b(6)-8

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	*Mo.* Jul *Yr.* 2003

VERIFY BY INITIALING — *INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION*

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 1	2	3	4	5	6	7	8	9	10	11	12	13	14
2 Jul	[redacted]	Condition: Stable	05	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
	[redacted]		17	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
2 Jul	[redacted]	Diet: NPO after	05	/	[redacted]	[redacted]	→ D/c'd 03Jul03										
	[redacted]	Midnight	17	/	[redacted]	[redacted]	[redacted]	1100 SGT WAG[illegible]									
2 Jul	[redacted]	Normal EPW pre-	05	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
		cautions	17	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
2 Jul	[redacted]	Splint to Ⓡ leg	05	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		Δ'd p̄				
			17	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]						
2 Jul	[redacted]	Dressing to Ⓛ hand	05	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]			Surgery			
			17	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]			[illegible]			
03 Jul	[redacted]	VS Routine	03	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
			18	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
03 Jul	[redacted]	Regular diet	08	/	/	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
			12	/	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
			18	/	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
03 Jul	[redacted]	~~up OOB at tb N~~ [redacted]	05	/	/	/			D/C'd								
		~~ON Ⓡ leg~~ [redacted]	12	/	/												
6	[redacted]	up ad-lib-NWB	05	/	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
		on Ⓡ leg.	17	✓	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
9 July	[redacted]	~~ORtho dressing~~ error Δ	18	✓	✓	/	/	/	/	/	/	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
		dry dsg Δ QD															

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS: S/P I+D Ⓛ Hand Ⓡ Foot
~~S/P GSW to hand / Ⓡ Foot~~ [illegible]

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
PAGE NO: ____________

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 EDITION OF 1 DEC 77 MAY BE USED. USAPA V1.00

Verify by Initialing		**THERAPEUTIC DOCUMENTATION CARE PLAN** *(NON-MEDICATION)*	Mo July Yr 2003			
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
1 Jun	[redacted]	Admit to WARD	1 Jun	dn		[redacted]
1 Jun	[redacted]	To OR in AM	2 Jun	IN AM		
3/7	[redacted]	Resume previous orders s/p I&D	3/7/03	3/7		
		Ⓡ foot Ⓛ hand condition stable.				
5	[redacted]	Transfer to ICW2, Resume Previous Orders	5		1900	[redacted]
6 Jul	[redacted]	NPO ṗ lunch for washout today	6 Jul	ṗ 1200		[redacted]
6 Jul	[redacted]	Transfer PACU → ICW2	6 Jul	done	→	[redacted]
6 Jul	[redacted]	Cond: Stable	6 Jul	done	→	[redacted]
6 Jul	[redacted]	Resume preop meds	6 Jul	done	→	[redacted]
14	[redacted]	may DC to EPW camp	14	ASAP		
	[redacted]					
		b(6)-2 All				

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING COMPLETION* TIME/DATE COMPLETED

USAPA V1.00

MEDCOM - 12662

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. 7 *Yr.* 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 15	16	17	18	19
1 Jul	[redacted]	ancef 1gm q8°	08			DC'd 14 Jul 03		
		IVPB	16					
			24					
3	[redacted]	Cipro 500mg PO BID	08	[redacted]				
			20					
3	[redacted]	SL-flush QS	05	[redacted]		DC'd 14 Jul 03		
			17					
14	[redacted]	eflex 250mg PO	06	[redacted]		DC'd		
		QID	12	[redacted]				
			18	[redacted]				
		b(6)-2	24	[redacted]		15 Jul 03		

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS:
S/P GSW Ⓛ hand/Ⓡ foot
S/P IED Ⓛ hand/Ⓡ foot

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ______

PATIENT IDENTIFICATION:
EPW [redacted]
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 - 12663

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*	*Mo.* 7 *Yr.* 03

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

b(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* TIME/DATE DISPENSED													
1 Jul	[redacted]	Phenergan 12.5mg														
		IVP q6° prn-nausea														
1	[redacted]	Ambien 10mg PO														
		qhs-prn														
3	[redacted]	Percocet i-ii PO														
		q4-6° prn-pain														

USAPA V1.00

MEDCOM - 12664

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

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. July *Yr.* 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 1	2	3	4	5	6	7	8	9	10	11	12	13	14
1 Jun	[redacted]	IVF: LR @ 100 cc/	08	/	[redacted]	/	> D/ced					03 Jul 03					
			17	/	[redacted]							1 SGT	[redacted]				
1 Jul	[redacted]	Ancef 1 gm q 8°	08	/	[redacted]												
		IV	16	/	[redacted]												
			24	[redacted]													
03 Jul	[redacted]	Cipro 500mg	08	/	/	/	[redacted]										
		PO BID.	20	/	/	[redacted]											
03 Jul	[redacted]	(HL) when taking	05	/	[redacted]				> D/C'd								
		PO well	17	[illegible]	[redacted]												
03 Jul	[redacted]	IV LR @ 125 cc/hr. (Hep)	05	/	/	[redacted]											
	[redacted]	(Loc) when tolerating	17	/	/	[redacted]											
		PO. well	/														
			/														
14	[redacted]	Keflex 250mg PO	06														
		QID	12														
			18														
			24													[redacted]	

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
~~S/P GSW TO ARMS (R) FOOT~~ Δ'd
S/P I+D (L) Hand (R) Foot

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

PATIENT IDENTIFICATION:
2W
#[redacted]
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 - 12665

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*			Mo. Jul Yr. 03	

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to ✓ be Given	Time Given	Initials
7/3/03	[redacted]	# Saline Loc IV	7/3/03	Now	1600 03 Jul 03	[redacted]

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

Order/ Expir Date	Clerk/	PRN MEDICATION, DOSE, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* TIME/DATE DISPENSED							
2 Jul	[redacted]	MSO4 3-5 mg IVP Q 3° prn	02 Jul 03 0300 4mg IVP [redacted]	02 Jul 1300 4mg IV [redacted]	02 Jul 1730 4mg IV	2 Jul 2200 4mg [redacted]	3 Jul 1200 [redacted]		DC'd 03 Jul 03 1600	
2 Jul	[redacted]	Phenergan 12.5 mg IVP q 6° prn nausea	03 Jul 0300 12.5 IVP [redacted]	2 Jul 2400 12.5 IVP [illegible] [redacted]	[illegible] 2300 12.5 IV [redacted]	[illegible] [redacted]				
1 Jul	[redacted]	Ambien 10 mg PO Q HS prn								
3 Jul	[redacted]	Percocet i - ii PO q 4-6° PRN pain	03 Jul 1600 i PO [redacted]	4 Jul 03 0330 ii [redacted]	4 Jul 03 [illegible] ii	[illegible] 03 ii PO [redacted]	7 Jul 2355 ii [redacted]	8 Jul 0100 ii PO	[illegible] 0144 ii PO [redacted]	
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USAPA V1.00

MEDCOM - 12666

95.4

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE **Post-Anesthesia Care Unit (PACU) Flow Sheet** ICW 2

OTSG APPROVED *(Date)*

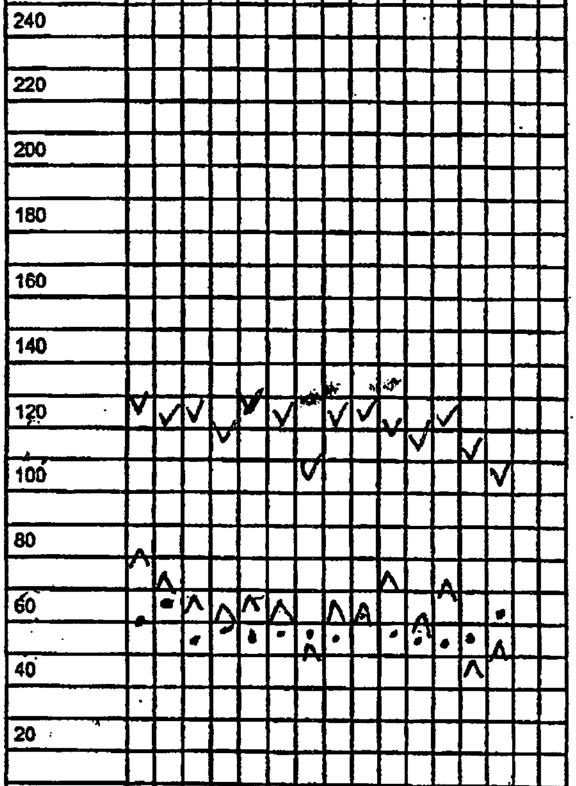
Date: 09 Jul 03
Time In: 1453 9 JUL 03
Allergies: None Known
Pre-op V/S: 90/60
Procedures: I & D wrist wound
Anesthesia Type (Circle): [✓ General] Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 300 Colloid ____
OR Output: UOP 0 EBL min
Meds/Times: none given
90/60

Pre Op Meds 1455 — 1600
History

Drains
~~Hemovac~~
~~NG~~
~~JP~~
~~T-tube~~
~~Foley~~
PCS

Airway
~~Nasal~~
~~Oral~~
~~ETT~~
~~Trach~~
~~Other~~

Time	1453	1456	1501	1506	1511	1516	1521	1525	1531	1536	1540	1545	1551	1556	1600	
SaO2																
FIO2																
Methods																



RR	22	14	14	14	15	14	15	16	18	14	17	12	12	20		
T	95.4								95.8		97.2					

Time								
Pain (0-10)								
LOS								

Patient teaching done; Wound Care, Pain Management,
T, C, & DB., Incentive Spirometer, Comfort Measures
Safety: SR up X 2, Falls Precautions. Privacy Maintained

Pacu Intake

Time	Solution	Amount	Site	By	Infused
7/9/1453	LR	KVO	L hand	[redacted]	

X-rays:
Labs:

Post-Anesthesia Recovery score

Criteria	ADM 1453	30' 1427	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	1	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	[illegible]	2
Circulation (Peds <5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	/	/	/
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	9	9	10

Codes

AIRWAY
A = Ambu
BB = Blow-by
M = Mask
FT = Face Tent
RA = RoomAir
NC = Nasal Cannula

V/S
X = A-line BP
* = Cuff BP
= Pulse

TEMP
S = Skin
O = Oral
A = Axillary
T = Tympanic
R = Rectal

LOS
C = Cervical
T = Thoracic
L = Lumbar
S = Sacral

(Continue on reverse)

PREPARED BY *(Signature & Title)* [redacted] RN b(6)-2
DEPARTMENT/SERVICE/CLINIC ICW 2
DATE 9 JUL 03

[redacted] TIFICATION *(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)*

EPW [redacted] 32 y/o 70 kg
b(6)-4
Dx, GSW (R) foot infection (L) finger

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

DA FORM 4700, MAY 78 WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) Previous edition is obsolete
USAPPC V2.00

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
9 Mar 03	5-6	Ø meds [illegible] refused				[redacted]
made reference and referred to ICW 2						[redacted]

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	Hand	MOE	normal	c	<3 sec	warm	NTA
15'	Toe						
30'							
45'							
60'	Same as previous						
90'	Transferred to ICW 2 BED (11)						
D/C							

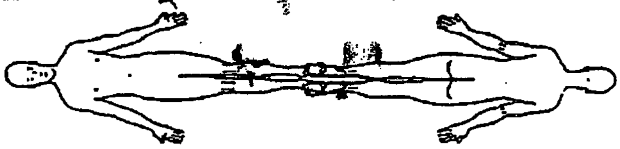
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent Color: C = Cyanotic, Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

	Adm	15'	30'	45'	60'	90'	D/C
Fund. Height							
Lochia							
Peripad#							
Fund. Cond.							

DRESSINGS

Time	Location	Type	Drainage
Adm	(L) Hand (R) Foot	[illegible]	Ø
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount
1605	NONE	NONE	Ø

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1503-1605	SR/SB	ectopy	Continuous

WAMC OP 173-E

NURSING NOTES

received pt @ 1453 VS recorded and taking [illegible] drsg on (L) hand (R) foot and MOE [illegible] <3 cap refill unable to palpate pulse on (R) [illegible] due to drsg good cap refill < 3 sec good feeling in (L) foot and (R) foot moves all [redacted] [illegible]

♂ 32 y/o EPW 3[illegible]
@1605 gave report to Sgt [redacted]

Neuro: Alert oriented PERRLA = 3-4mm MOE drsg on (L) hand and (R) foot Ø pain medication given c/o discomfort when received med. pain level 5-6 on 10 point scale refused medication reference to [illegible] RR: 10-25 CTA bilaterally GU normal [illegible] [illegible] CTA [illegible] Ø [illegible] [redacted]

D(L)-2 AM

Discharge Criteria: 10 on scale
Date: 9 Mar 03 Time: 1605 PARS:
BP: 103/54 T: 97.2 F HR: 72 RR: 25 Sa02: 100%
Pain Level at D/C (0-10): (5-6) Ø pain med request
Intake: Ø Output: Ø
Additional Data: Drg on (L) hand (R) foot
Transferred To: ICW 2 Bed # 11
Report Given To: SGT [redacted]
Transferred Via: W/C, [✓ Litter] Gurney Ambulance
Transferred [redacted] [redacted]
Cleared IA[redacted] SOP 8-3
Charge Nurse Signature: [redacted]

MEDCOM - 12668

120/71 58

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE Post-Anesthesia Care Unit (PACU) Flow Sheet

OTSG APPROVED *(Date)*

Date: 7-12-03

Time In: 0805

Allergies: NKDA

Pre-op V/S: 120/71

Procedures: S/P I&D [illegible]

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block

OR Intake: Crystalloid 200 LR Colloid

OR Output: UOP Ø EBL Ø

Meds/Times: 2.5 mg Versed [illegible]

Pre Op Meds: N/A

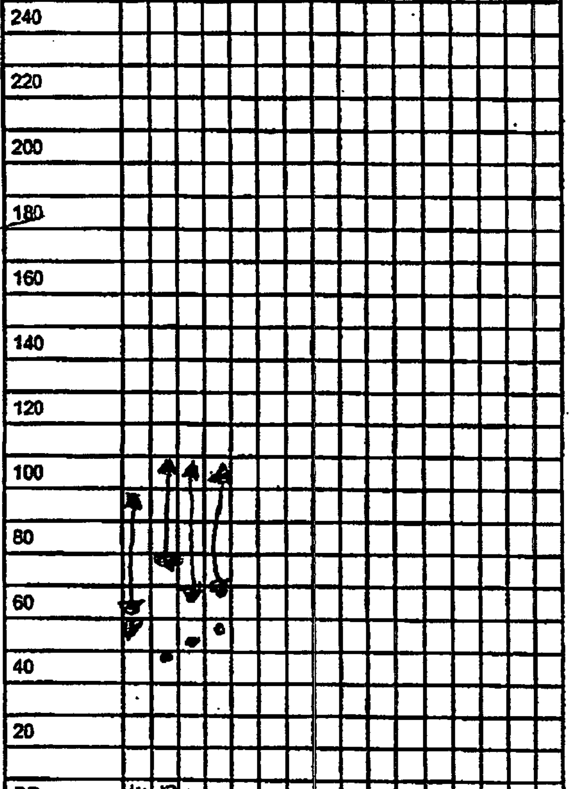
History

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

59
95/61
97%
14
96.2
105/70
48
12
100%
108/69
53
10
100
107/72
57
20
100%
E
69

Time	[illegible]	[illegible]	[illegible]	[illegible]	
SaO2	97	99	100	100	
FIO2	BN	RA	RA	RA	
Methods					
RR	14	12	10	20	
T	96.7			96.8	



Time	0820	0835
Pain (0-10)	Ø	Ø
LOS		

Pacu Intake					
Time	Solution	Amount	Site	By	Infused

X-rays:

Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	~~2~~ 2		
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2		
Blood Pressure (2) SBP +/- 20 of Pre-op (1) SBP +/- 20-50 of Pre-op (0) SBP +/- 50 of Pre-op	2		
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	2		
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2		
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse			
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	10		

Codes

AIRWAY
A = Ambu
BB = Blow-by
M = Mask
FT = Face Tent
RA = RoomAir
NC = Nasal Cannula

V/S
X = A-line BP
˅ = Cuff BP
• = Pulse

TEMP
S = Skin
O = Oral
A = Axillary
T = Tympanic
R = Rectal

LOS
C = Cervical
T = Thoracic
L = Lumbar
S = Sacral

Patient teaching done: Wound Care, Pain Management,

T, C, & DB., Incentive Spirometer, Comfort Measures

Safety: SR up X 2, Falls Precautions, Privacy Maintained

(Continue on reverse)

PREPARED BY *(Signature &* [redacted] b(6)-2 1LT [illegible] BSN

DEPARTMENT/SERVICE/CLINIC

DATE 7-12-03

PATIENT'S IDE[redacted]es give: *Name - last, first, middle; grade; date; hospital or medical facility)*

[redacted] b(6)-4 [illegible] ICW 2

☐ HISTORY/PHYSICAL

☐ OTHER EXAMINATION OR EVALUATION

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

☐ FLOW CHART

☐ OTHER *(Specify)*

DA FORM 4700, MAY 78 WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) Previous edition is obsolete USAPPC V2.00

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm							
15'							
30'							
45'							
60'							
90'							
D/C							

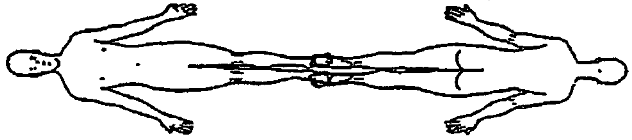
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic, P = Pale, Pk = Pink
Capillary Refill: B = Brisk, S = Sluggish

C-SECTIONS

	Adm	15'	30'	45'	60'	90'	D/C
Fund. Height							
Lochia							
Peripad#							
Fund. Cond.							

DRESSINGS

Time	Location R wrist	Type Kerlix & Coban	Drainage ø
Adm	@hand	Kerlix	ø
30'			ø
60'			
D/C			ø



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
0830	SB NSR	̄s ectopy	

WAMC OP 173-E

NURSING NOTES

Pt arrived via litter, [illegible] USS @ time of xfr from OR. Pt on BX SpO2 97-99%. Pt cooperative ø follows all commands, able to move all extrem

N [illegible] reactive pupils 3mm sluggish

CV SB NSR ̄s ectopy, ø JVD, +2 pulses radial & pedal bilat, all extrem warm, cap refill <3secs.

Resp CTA bilat, breathes even & unlabored on RA @ SpO2 100%, ø cough.

GI abd soft nontender, ~~absent~~ BS denies N/V/D.

GU ø Foley, ø UO.

Lines R wrist PIV.

Discharge Criteria:
Date: 7/12 Time: 0855 PARS: 10
BP: 107/72 T: 96.9 HR: 50 RR: 12 SaO2: 100
Pain Level at D/C (0-10): ø
Intake: ø Output: ø
Additional Data:
Transferred To: ICW [redacted]
Report Given To: Sgt [redacted]
Transferred Via: W/C [✓ Litter] Gurney Ambulance
Transferred By: 1LT [redacted] ICW-2
Cleared IAW Recovery Room [redacted]
Charge Nurse Signature: [redacted]

MEDCOM - 12670

Post-Anesthesia Care Unit (PACU) Flow Sheet

Date: 03 Jul 03
Time In: 1118
Allergies: NKDA
Pre-op V/S: 124/70 88
Procedures: I&D of (R) FT (R) hand
Anesthesia Type (Circle): [✓ General] Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 800 Colloid
OR Output: UOP 0 EBL 0
Meds/Times: Morphine 10mg

Drains: Hemovac, NG, JP, T-tube, Foley, TLS [illegible]

Airway: [✓ Nasal] Oral ETT Trach Other

Pre Op Meds

History

Time	1116	1118	1120	1125	1140	1145	1150									
SaO2	96	96	92	95	96	98	97									
FiO2																
Methods																
240																
220																
200																
180																
160																
140																
		^														
120	^		^	^	^	^										
100																
	•	•														
80			•	•	•											
	v	v	v	v	v	v •										
60																
40																
20																
RR	14	12	10	14	14	16										
T	96.8		96.5													

Time					
Pain (0-10)					
LOS					

OR [redacted] Intake

Time	Solution	Amount	Site	By	Infused
1115	LR	800cc	R FA	OR	800

X-rays:

Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	/	/	/
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	9	10	10

Codes

AIRWAY
A = Ambu
BB = Blow-by
M = Mask
FT = Face Tent
RA = RoomAir
NC = Nasal Cannula

V/S
X = A-line BP
^ = Cuff BP
• = Pulse

TEMP
S = Skin
O = Oral
A = Axillary
T = Tympanic
R = Rectal

LOS
C = Cervical
T = Thoracic
L = Lumbar
S = Sacral

Patient teaching done: Wound Care, Pain Management, T, C, & DB, Incentive Spirometer, Comfort Measures
Safety: SR up X 2, Falls Precautions, Privacy Maintained

(Continue on reverse)

PREPARED BY (Signature & Title)
SGT [redacted] b(6)-4

DEPARTMENT/SERVICE/CLINIC
ICU 2

DATE
03 Jul 03

PATIENT'S IDEN[redacted] Name — last, first, middle; grade; date; hospital or medical facility)
EPW [redacted]
b(6)-4

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

DA FORM 4700, MAY 78 WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) Previous edition is obsolete
USAPPC V2.00

MEDICATIONS						
Allergies: NKDA						
Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	R Leg	F	NVI	+	b	96.8	PK
15'	"	F	NVI	+	b	96.2	PK
30'	"	F	NVI	+	b	97.2	PK
45'	"	F	NVI	+	b	–	PK
60'	"						
~~90'~~	~~"~~						
D/C	"						

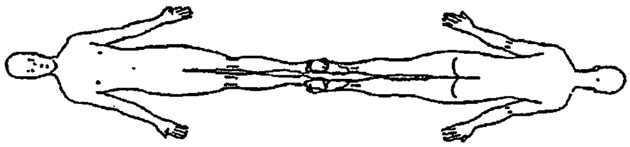
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

	Adm	15'	30'	45'	60'	90'	D/C
Fund. Height	N/A						
Lochia							
Peripad#							
Fund. Cond.							

DRESSINGS

Time	Location	Type	Drainage
Adm	(R) Ft + (L) hand	Kerlex/ace	Ø Ø
30'	" "	" "	Ø Ø
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

NURSING NOTES

31 y.o EPW transfered via
litter from OR to ICU 2 for ID
+ (R) Ft + (L) hand. VS 137/80 p 91 R 14
SaO2 96% RA. Color pK aroused
c̄ verbal + touch stimuli R-even
unlabored NAD nasal airway (L)
nare. pulses present Cap refil
brisk skin warm dry.
IV (R) FA 18G 100cc/hr NSS
patent (R) Ft Drg CDI Cap refil
brisk toes warm to touch.
(L) hand drg CDI from NVI
cap refil brisk will cont to
monitor SGT [redacted] 91WM6 –
1150 pt c/o inability to void had
attempted to dry x 10 MIN (+) DTN
over syphis - in out cath 850cc
clear yellow urine pt stated relief
SGT [redacted] 91WM6 b(6)-2
1210 - VSS NAD LS CTA
Stated feeling hurting Drg CDI
X 2 SGT [redacted] 91WM6 —
b(6)-2

b(6)-2

Discharge Criteria:
Date: 03 Jul 03 Time: 1210 PARS:
BP: 122/72 T: 98.2 HR: 74 RR: 14 Sa02: 96% RA
Pain Level at D/C (0-10): Ø
Intake: NPO (125cc NSS) Output: 750cc
Additional Data: Ø
Transferred To: Remained @ ICU 2
Report Given To: N/A
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: N/A

MEDCOM - 12672

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE Post-Anesthesia Care Unit (PACU) Flow Sheet

OTSG APPROVED *(Date)*

Date: 1-6-03 Anesthesia Type (Circle)): [✓ General] Spinal Epidural IV Sedation Nerve Block
Time In: 0800
Allergies: NKDA OR Intake: Crystalloid 300 Colloid
14Kg Pre-op V/S: 108/74-70 OR Output: UOP EBL 0
Procedures: I+D (R) Foot/(L) Hand Meds/Times:

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds b

History

Time	[illegible]	[illegible]	[illegible]														
SaO2	99	96	98														
FiO2	[illegible]																
Methods																	
240																	
220																	
200																	
180																	
160																	
140																	
	✓		✓														
120		✓															
100																	
80																	
	^	^	^														
60																	
40																	
20																	
RR	20	16	20														
T	98																

Time								
Pain (0-10)								
LOS								

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	2	2	
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	2	2	
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	12	12	12

Codes

AIRWAY
A = Ambu
BB = Blow-by
M = Mask
FT = Face Tent
RA = RoomAir
NC = Nasal Cannula

V/S
X = A-line BP
˅ = Cuff BP
= Pulse

TEMP
S = Skin
O = Oral
A = Axillary
T = Tympanic
R = Rectal

LOS
C = Cervical
T = Thoracic
L = Lumbar
S = Sacral

Patient teaching done; Wound Care, Pain Management,
T, C, & DB., Incentive Spirometer, Comfort Measures
Safety: SR up X 2, Falls Precautions, Privacy Maintained

(Continue on reverse)

PREPARED [redacted] b(6)-2

DEPARTMENT/SERVICE/CLINIC

DATE

PATIENT [redacted] written entries give: *first, middle; grade; date; hospital or medical facility)* *Name — last,*

#[redacted]

ICW-2 b(6)-4

☐ HISTORY/PHYSICAL
☐ OTHER EXAMINATION OR EVALUATION
☐ DIAGNOSTIC STUDIES
☐ TREATMENT

☐ FLOW CHART
☐ OTHER *(Specify)*

DA FORM 4700, MAY 78 WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) Previous edition is obsolete

USAPPC V2.00

MEDCOM - 12673

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	R Foot						
15'							
30'							
45'							
60'							
90'							
D/C							

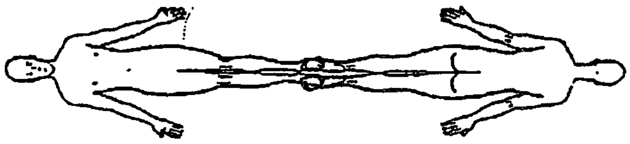
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic, P = Pale, Pk = Pink
Capillary Refill: B = Brisk, S = Sluggish

C-SECTIONS

	Adm	15'	30'	45'	60'	90'	D/C
Fund. Height							
Lochia							
Peripad#							
Fund. Cond.							

DRESSINGS

Time	Location	Type	Drainage
Adm			
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

2046 - Rpt from CRNA [redacted]

2117 - Rpt Given to LT [redacted]

b(6)-2

Discharge Criteria:

Date: **Time:** **PARS:**

BP: **T:** **HR:** **RR:** **Sa02:**

Pain Level at D/C (0-10):

Intake:________________ **Output:**____________

Additional Data:____________________

Transferred To:____________________

Report Given To:____________________

Transferred Via: W/C Litter Gurney Ambulance

Transferred By:____________________

Cleared IAW Recovery Room SOP B-3

Charge Nurse Signature: ________________

b(6)-2

1. L[redacted] RANK/GRADE | MALE/HOMME | FEMALE/FEMME

SSN/NU CIALTY CODE/GPM | RELIGION/RE

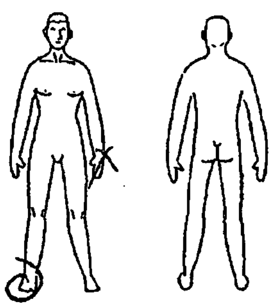
2. UNIT/U

FORCE/ÉLÉMENT | NATIONALITY/NATIONALITÉ

A/T | AF/A | N/M | MC/M | BC/BC | NBI/BNC | DISEASE/MALADIE | PSYCH/PSYCH

3. INJURY/BLESSURE

FRONT/DEVANT BACK/ARRIÈRE



AIRWAY/TRACHÉE
HEAD/TÊTE
WOUND/BLESSURE
NECK/BACK INJURY/ BLESSURE AU COU/AU DOS
BURN/BRÛLURE
AMPUTATION/AMPUTATION
STRESS/TENSION
OTHER (Specify)/AUTRE (Spécifier)

GSW (R) Foot, L HAND avulsion

EVEL OF CONSCIOUSNESS/NIVEAU DE CONSCIENCE

ALERT/ALERTE | PAIN RESPONSE/RÉPONSE À LA DOULEUR
VERBAL RESPONSE/RÉPONSE VERBALE | UNRESPONSIVE/SANS RÉPONSE

ULSE/POULS | TIME/HEURE | 6. TOURNIQUET/GARROT ☐ NO/NON ☐ YES/OUI | TIME/HEURE

ORPHINE/MORPHINE ☐ NO/NON ☒ YES/OUI | DOSE/DOSE 10mg | TIME/HEURE 2215 | 8. IV/IV | TIME/HEURE

TREATMENT/OBSERVATIONS/CURRENT MEDICATION/ALLERGIES/NBC (ANTIDOTE)
TRAITEMENT/OBSERVATIONS/PRÉSENTE MÉDICATION/ALLERGIES/ANTIDOTES

I.V 18GA (L)AC 0.9% Sodium @2145

1 Gram Ancef @ 2150

Bag #2 LR @ 2205

10. DISPOSITION/DISPOSITION ☐ RETURNED TO DUTY/RETOUR À L'UNITÉ ☐ EVACUATED/ÉVACUÉ ☐ DECEASED/DÉCÉDÉ | TIME/HEURE

11. PROVIDER/UNIT/OFFICIER MÉDICALE/UNITÉ | DATE/DATE (YYMMDD)

DD Form 1380, DEC 91 *This form replaces previous editions of DD Form 1380 and DD Form 1380 (TEST), which are obsolete.*

U.S. FIELD MEDICAL CARD
FICHE MÉDICALE DE L'AVANT ÉTATS-UNIS

MEDCOM - 12675

---

12. REASSESSMENT/RÉASSESSMENT

DATE/DATE (YYMMDD) 1 Jul 03	TIME OF ARRIVAL/HEURE D'ARRIVÉE			
TIME/HEURE 2200				
BP/PS 122/78				
PULSE/POULS 73				
RESP/RESP 20				

DATE/TIME DATE/HEURE

13. CLINICAL COMMENTS/DIAGNOSIS
INFORMATION MÉDICALE/DIAGNOSTIQUES

14. ORDERS/ANTIBIOTICS (Specify)/TETANUS/IV FLUIDS
DIRECTIVES MÉDICALES/ANTIBIOTIQUES (Spécifier)/TÉTANOS/IV FLUIDE

15. PROVIDER/OFFICIER MÉDICALE | DATE/DATE (YYMMDD)

16. DISPOSITION/DISPOSITION ☐ RETURNED TO DUTY/RETOUR À L'UNITÉ ☐ EVACUATED/ÉVACUÉ ☐ DECEASED/DÉCÉDÉ | TIME/HEURE

ICES/EUX ☐ BAPTISM/BAPTISÉ ☐ ANOINTING/ONCTION ☐ CONFESSION/CONFESSION ☐ PRAYER/PRIÈRE ☐ COMMUNION/COMMU ☐ OTHER/AUTRE

CHAPLAIN/CHAPELAIN

ADMISSION A ODING INFORMATION

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

1. REPORTING MTF / **TF LOCATION** *(State or Country Code.)*

1	2	3	4	5	6	/	8
A	1	1	D	1	▨	1	Z

3. REGISTER NUMBER

9	10	11	12	13	14	15
[redacted]						

NAME *(~~Last, First,~~ Middle Initial)* EPW [redacted] b(6)-4

4. PAY GRADE

16	17

5. SEX

18
M

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

19	20	21	22	23	24	25	26
1	9	7	1	0	1	0	1

7. AGE AT ADMISSION

27	28	29
3	2	y

8. RACE

30
Z

9. ETHNIC BACKGROUND

31
9

RELIGION unk

10. LENGTH OF SERVICE

32	33	34

ETS N/A

11. FMP

35	36
9	9

12. SOCIAL SECURITY NUMBER

37	38	39	40	41	42	43	44	45
[redacted]								

ORGANIZATION *(Active Duty Only)* N/A

13. MARITAL STATUS

46
U

HOUR OF ADMISSION 2323

BRANCH / CORPS N/A b(6)-4

14. FLYING STATUS

47	48	49

15. BENEFICIARY CATEGORY

50	51	52
K	7	9

16. ZIP CODE OF RESIDENCE

53	54	55	56	57	58	59	60	61

17. UNIT LOCATION *(State or Country Code)*

62	63

18. MOS

64	65	66	67	68	69	70

19. TRAUMA

71

PREV. ADMISSION YEAR ☒ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION

72
0

WARD ICU2

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE *(Include ZIP Code)*

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] b2-2

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION

73	74
5	0

22. MTF TRANSFERRED TO

75	76	77	78	79	80

23. DATE OF DISPOSITION *(Y Y M M D D)*

81	82	83	84	85	86
0	3	0	7	1	4

24. CLINIC SVC - ADMITTING

87	88	89	90
A	E	A	A

25. MTF TRANSFERRED FROM

91	92	93	94	95	96

26. DATE THIS ADMISSION *(Y Y M M D D)*

97	98	99	100	101	102
0	3	0	7	0	1

27. LOCATION OF OCCURRENCE *(Battle Casualty Only)*

103	104

28. MTF OF INITIAL ADMISSION

105	106	107	108	109	110

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

111	112	113	114	115	116

FOR LOCAL USE

Dx: S/p GSW to Ⓛ hand + Ⓡ foot
S/p I&D Ⓛ hand + Ⓡ foot

Injury Trauma
450 1

Dx: 9583
6827
V5849
E9440

Pr: 8604

[redacted]

ADM [redacted] **uired)** R LTR
Dr. [redacted]

SIGNATURE OF ADMITTING CLERK [redacted] PFC, 91610

DA F [redacted]

b(6)-2

MEDCOM - 12676

INPATIENT TREATMENT RECORD COVER SHEET

Fr f this form, see AR 40-400; the proponent a s OTSG

1. REGIS [redacted]	2. N First MI EPW# [redacted] b(6)-4	3. GRADE EPW	ADMISSION REMARKS

4. SEX M	5. AGE 27	6. RACE —	7. RELIGION —	8. LENGTH OF SVC —	9. ETS —	10. PREVIOUS ADMISSION NO	

11. FMP 99	12. SSN [redacted]	13. ORGANIZATION —	14. WARD ICU3

15. FLYING STATUS —	16. RATING/ DSG —	17. DEPT./ BEN K78	18. BRANCH/CORPS b(6)-4	19. UIC/ZIP —	20. TYPE CASE WIA

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct from ER	22. HOURS OF ADMISSION 2330	23. CLINIC SERVICE AEAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE UNK	25. TYPE DISPOSITION 50	26. DATE OF DISPOSITION 6 Aug 03	b(6)-2

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) UNK	27b. TELEPHONE NO. UNK	28. DATE OF THIS ADMISSION 13 July 03	ADMITTING OFFICER DR [redacted]

29. [redacted] b(2)-2	30. DATE OF INITIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. [redacted]

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Dx: GSW to (R) tibia exfix, GSW to (L) hand

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	26	26

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

SIGNATURE OF ATTENDING MEDICAL OFFICER DR [redacted] [redacted]

[redacted] MEDICAL RECORDS OFFICER

DA F

EDITION OF 1 AUG 78 IS OBSOLETE

USAPPC V1.10

b(6)-2

MEDCOM - 12677

INPATIENT TREATMENT RECORD COVER SHEET

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

[redacted]	2. NAME (Last, First [redacted] EPW#[redacted]		3. GRADE EPW	ADMISSION REMARKS
4. M / AGE 27	6. —	7. RELIGION —	LENGTH OF SVC —	9. ETS —
				10. PREVIOUS ADMISSION No
11. FMP 99	12. SSN [redacted]	13. ORGANIZATION b(6)-4		14. WARD ICU3
15. FLYING STATUS —	16. RATING/DSG —	17. BEN K78	18. BRANCH/CORPS —	19. UIC/ZIP —	20. TYPE CASE WIA
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct from ER	22. HOURS OF ADMISSION 2330	23. CLINIC SERVICE AEAA		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE Unk	25. TYPE DISPOSITION 50	26. DATE OF DISPOSITION 13 July 03	b(6)-2	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) UNK	27b. TELEPHONE NO. Unk	28. DATE OF THIS ADMISSION 02 Jul 03	ADMITTING OFFICER DR [redacted]	
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] b(2)-2		30. DATE OF INITIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED	

31. SELECTED ADMINISTRATIVE DATA [redacted]

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Dx: GSW to (R) Tibia ext-fix, GSW to (L) hand

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	12	12

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
	b(6)-2	[redacted]			

SIGNATURE OF ATTENDING [redacted]
DR [redacted]

SIGN[redacted]R MEDICAL RECORDS OFFICER

MEDCOM - 12678 [redacted]

DA FORM [redacted]

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

PERTINENT HISTORY, CHIEF COMPLAINT, AND CONDITION ON ADMISSION *(Enter date of admission)*

24 y/o ♂ s/p GSW to (L) hand and (R) leg ~ x20 days ago. Has (L) ~~[illegible]~~ hypothenar eminence injury and (R) tib x-fix

Ø meds

Ø [illegible]

NKDA

PHYSICAL EXAMINATION

NAD

AT/NC Heart

[illegible] ~ [illegible]

Ext ~ (L) hand ~ [illegible] (L) [illegible] with wound over hypothenar eminence

(R) tibia ~ large, swollen, open wound with [illegible] [illegible] fixator.

PROGRESS *(Enter date of discharge and final diagnosis)*

(P) I+D in OR.

b(6)-2

SIGNATURE OF PH [redacted]	DATE 1 JUN 03	IDENTIFICATION NO.	ORGANIZATION
PATIENT'S IDENTIFICATION *(For typed or written entries give Name last, first, middle; grade; date; hospital or medical facility)*		REGISTER NO.	WARD NO.

[redacted] [redacted]

b(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
USAPPC V1.00

b(6)-4

[redacted]

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
1 July 03	
	Ⓢ PT ♂ ē Ⓡ Tibia Fixation ⓒ Ⓛ hand GSW
Pulse 95	PT in hospital 6 days out 10 days w/o treatment
BP 118/62	no meds/antibiotics. PT states he can feel foot
RR 18	pn scale 8/10. A+O x 3.
Temp 99.3	
	Ⓞ 6inch avulsion Ⓡ tibia, 2 sutures.
	3inch GSW Ⓡ fibia, entry 2 sutures
	⊕ edema, ⊕ weeping D/C green pus ⊕ infection.
meds	Tissue and Bone visible gangelia Ⓡ toes
none.	⊖ Pulse dorsal pedis
	Ⓛ hand GSW 2 inches 3 sutures. cap refill 3sec.
	radial pulse present,
	Pt Cannot extend the 5th Distal phalange
	Ⓐ GSW, left hand right leg
	Ⓟ 1. I.V. Lactated Ringer's
	2. Povidine Scrub, Hydrogen Peroxide Cleaning
	3. Tylenol 3 P.O. (2) 2030 hrs
	4 External Fixator was cleaned
	5 Wet → Dry One
	6 581st → CSH

b(6)-2

[redacted]

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.

[redacted]

b(6)-4

PROGRESS NOTES
Medical Record
STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

MEDCOM - 12680

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
Jul KT 2 Aug 2003 @ 0100	Admission - Pt is 27 y/o EPW male. S/P GSW to Ⓡ Tibia c̄ external fixator and GSW to Ⓛ hand c̄ dressing. Admitted to ICU #3 via EMT. Vital signs upon arrival stable. IV access in Ⓡ forearm 18g Cath c̄ LR @ 125 cc/hr. Pt restrained at 2 points, Ⓛ arm and Ⓡ leg. Scheduled for OR later in AM. Pt currently NPO. Will continue to monitor. b(6)-2 [redacted] SPC 91WM6
@ 0200	Pt c/o inability to urinate. Upon assessment pt's bladder was firm upon palpation. 16 fr. foley cath placed which yeilded 1100 cc of clear yellow urine. Pt communicated cath produced relief. Will continue to monitor. [redacted] 91WM6 SPC
@ 0412	PT c/o pain to RLE @ external fixator 4 mg MSO4 given. Will continue to monitor [redacted] 91WM6 SPC
@ 0500	Report given to LTC [redacted] Pt VSS afebrile. [redacted] SPC 91WM6
2 Jul 03 0600	Received pt this am w/ plan for OR. V.[redacted]. Pt resting quietly. See initial assessment note. Ⓡ LE w/ external fixator. Cap. refill + pulse to Ⓡ foot palpable but faint (<3 secs.). Ⓡ noted to have blacken areas to toes. Area of 1" by 3" on top of Ⓡ foot looks like a blood vessels but

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.

EPW [redacted]

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

MEDCOM - 12681

#1

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	hardened. Quarter-size skin break down on outer lateral aspect of Ⓡ foot. Ⓡ foot appears to have been burned in area of skin break down. Cont. to monitor. Pain management. – [redacted] LTC/AN
2Jul03 1600	Pt continues to be NPO. Awaiting OR for Ⓡ tibia Fx. MSO4 IV given as ordered. Pt concerned w/ brother who came in w/him. Plan: IVF, OR, Pain management. – [redacted] LTC/AN b(6)-2
3Jul03 0515	Received report and care of pt. from night shift. Pt resting in bed ⊘ s/s of pain/discomfort. Pt currently NPO awaiting to go to OR. VSS will cont to monitor – b(6)-2 [redacted] LPN
1000	Pt continues to be NPO awaiting OR. Pt resting comfortably. ⊘ s/s pain discomfort will cont to monitor [redacted] LPN b(6)-2
3Jul03	ORTHO OP NOTE Pre Op Dx: ① Open Grade III B Ⓡ tibia fx. ② Open Ⓛ 5th MC Fx Post Op Dx: Same Procedure: ① I+D Ⓡ LE ② I+D Ⓛ Hand Surgeon: [redacted] b(6)-2 EBL – 50 3Jul03 0900 hr Findings – large through + through GSW with large 8cm tibial defect, dead bone + muscle [illegible] above Plan: BKA. b(6)-2 [redacted]

STANDARD FORM 600 (REV. 6-97) **BACK**
*U.S. GPO: 2002 - 491-600/50618

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1530	Pt rcvd 90[redacted], 20mg MSO4, 50mg Benadryl, 2.5mg Versed UOP 200cc, PT now resting in bed & s/s of pain/discomfort.
1700	Report & care of pt
1700	Received report from day shift. Pt appears to be resting comfortably in bed. Foley draining to gravity, urine clear & yellow. External Fixator to (R) Lower Extremity. Dressing C/D/I will continue to monitor [redacted]
2100	Pt appears to be sleeping comfortably VSS, continue pain management will continue to monitor [redacted] SPC, 91WM
0100	Pt appears to be sleeping comfortably, continue pain management. VSS will continue to monitor [redacted] SPC, 91WM6
0500	Gave report to day shift [redacted] SPC, 91W
0515	Received report and care of patient from previous shift. pt sleeping and shows Ø s/s of pain/discomfort will cont to monitor [redacted] LPN
0900	Pt resting in bed & C/O pain/discomfort VSS will cont to monitor [redacted] LPN
1030	Pt C/O pain to (R) Lower extremity. Pt given 2 tabs

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	b(6)-2

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

All

REGISTER NO.	WARD NO.

EPW # [redacted]

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

#2

b(6)-2 All

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
	percocet for pain. will cont to monitor – [redacted] RN
1430	Pt resting in bed & c/o pain/discomfort. Pt
	consumed 1/3 lunch and drank 1/2 [redacted] VSS
	will cont to monitor ———
1700	Pt received 2 tabs percocet for pain. Pt resting in
	bed. Report and care of pt. given to on[redacted]
	shift ———
1730	Report recieved from spc. [redacted] pt VSS
	will continue to monitor. ——— [redacted] 91WM6
2400	pt sleeping in bed. VSS ——— [redacted] 91WM6
5 Jul 03	Received report from previous nurse. VSS will continue
0600	to monitor. ~~~ [redacted]
0800	Dr [redacted] in c̄ interpreter to discuss plan
	of care: amputation, risks, benefits and alternatives [redacted]
1000	pt's brother from ICU here to talk to him.
1730	Report recieved from SPC [redacted] VSS,
	surgery rescheduled for tomorrow. pt
	ate dinner, will be NPO @ midnight. Will
	continue to monitor ——— [redacted] 91WM6
2400	pt VSS afebrile. NPO for surgery in AM. Will
	continue to monitor ——— [redacted] 91WM6
0500	Report given to PFC [redacted] 91WM6
0535	pt Report Recieved From spc [redacted] VSS no problems @ presen
	pt awaiting procedure will continue to monitor – [redacted], PFC 91W
1200	pt resting in bed complains of pain in (R) LE Pt medicated per doctors
	orders ——— [redacted]

FPI. LEX. Printed on Recycled Paper

STANDARD FORM 600 (REV. 6-97) BACK

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
7 JUL 03	Surgery Pt POD#1 BKA - LEFT open 2° to concerns of infection. CNS: Awake Alert CV: RRR HR 80s BP 124/70 Lungs: CTA 95% RA Wound: Dressing Clean, Dry + intact Labs: 11.9 > 11/35 < 876 Rx: Stable POD#1 Plan to OR tomorrow to close stump NPO p̄ midnight Hep-lock IV [redacted] b(6)-2
9 JUL 03	Surgery Pt POD#1 closure of right BKA stump. Pt c̄ Nausea + emesis this AM ⊝ fever CNS: Awake + Alert CV: HR <100 BP 131/55 17.8 / 27.3 — 116 Lungs: CTA 95% RA EXT: ⊘ infiltrates ABD: soft, nontender ⊝ BS Stump: pain controlled Imp: POD# ↑ WBC + fever unknown etiology Plan: NO Levaquin - foley out Monitor [redacted] b(6)-2

U.S. Government Printing Office: 1995 — 387-722/20035

STANDARD FORM 600 BACK (REV. 5-84)

MEDCOM - 12685

b(6)-2 All unless
marked otherwist

NSN 7540-00-634-4176 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
6 July 03	Pt back to ICU 3 from OR. S/P Ⓡ BKA.
1945	Recovery performed in ICU 3. see Pacu form for
	detials. Pt A+O x 3 moves all four extremities.
	Dressing to Ⓡ leg c̄ ace wrap. 0 drainage
	at surgical site. IV LR @ 50 cc/hr. Fentanyl
	@ 175 mcg/hr for pain. Will continue to
	monitor. —— [redacted] 91WM6
2200	pt resting in bed. VSS, afe[redacted]ile. c/o
	pain to surgical site will notify MD [redacted] 91WM6
2300	Order for Versed obtained from Dr [redacted]
7	4 mg given. Will continue to monitor —— [redacted] 91WM6
0200	pt resting comfortably. VSS Fentany[redacted] dripp at
	150 mcg/hr. —— [redacted] 91WM6
0755	pt Report Recieved From Spc [redacted] VSS pt resting calmly
	in bed @ this time no [redacted] problems noted @ present will continue
	to moniter —— [redacted] PFC 91WM6 ——

PATIENT'S ~~IDENTIFICATION~~ *(Use this space for Mechanical Imprint)*

EPW # [redacted]

b(6)-4

RECORDS MAINTAINED AT: ▶

PATIENT'S NAME *(Last, First, Middle initial)*		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME		ORGANIZATION
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

CHRONOLOGICAL RECORD OF ME ARE **STANDARD FORM 600** (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

MEDCOM - 12686

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | ~~CHRONOLOGICAL RECORD OF MEDICAL CARE~~

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
7Jul03 @ 1715	Recieved report from off-going shift. Pt awake in bed. A+O×3. Pt c̄ Fentanyl drip @ 150 mcg/hr. Pt states still has pain from time to time. Pt given 2.5 mg Versed for agitation/phantom pain. Pt's tegament hang. VSS. Pt's Ⓡ LE elevated on pillow. Drsg on stump CDI. Will continue to monitor [redacted] LPN
2100	Pt resting quietly. No c/o pain @ this time. Interpreter in to see pt and explained to pt that he is to be NPO p̄ MN for OR tomorrow. VSS. Will continue to monitor. [redacted] LPN
0100	Pt NPO since MN for OR in AM. LR started @ 100 cc/hr as per MD's orders. Pt's VSS. Pt given 2.5 mg Versed and Fentanyl ↑ to 175 mcg/hr. Pt c̄ adequate pain control @ this time. Will continue to monitor [redacted] LPN
0430	Pt rested mostly throughout night. Pt had periods of worse pain @ times. Pt on 175 mcg Fentanyl/hr – 150 mcg/hr Fentanyl throughout night. Pt given 50-100 mcg bolus's a few times for worsening pain. Pt given Versed ×3, 2.5 mg for agitation. Pt NPO since MN and LR @ 100 cc/hr started @ MN as well. Pt's VS remained stable throughout the night c̄ QS urine output. Will pass report to day shift. [redacted] LPN
@ 0500	Recieved report from spc [redacted] pt resting quietly in bed @ this time awaiting OR for procedure [redacted]
@ 1120	Pt back from OR New orders written and transcribed [illegible] pt doing well no problems @ present will continue to monitor
@	[redacted] [illegible]

b(6)-2 ↑ All

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.

EPW [redacted] 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

b(6)-2 A11

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
28 Jul, 03	pt ↑ temp to 103.4 pt given tylenol will recheck Temp in
@ 1425	1° and monitor for further complications none @ present
	will continue to monitor —— [redacted] PFC 91W
8 July @ 1730	Report recieved from PFC [redacted] pt VSS
	will continue to monitor. —— [redacted] 91WM6
@ 2000	pt temp ↑ 101.1 Tylenol 650 given [redacted] 91WM6
@ 2400	pt resting in bed. VSS —— [redacted]
@ 0400	pt sleeping, AM labs drawn, VSS Fentanyl gtt @
	175 mcg/hr —— [redacted]
09 Jul	
0500	Received report + assumed care of Pt. VSS,
	Pt lying in bed + appears to be resting comfortably
	@ this time. Will continue to Monitor. —— [redacted] 91W
0800	Pt lying in bed sleeping + Appears to be resting
	comfortably @ this time. Will continue to Monitor. [redacted] 91WM6
0805	Fentanyl ↓ from 125mcg to 150mcg, Pt lying in bed c̄ Ø new
	complaints. Will continue to Monitor. —— [redacted] 91W
1000	Fentanyl ↓ From 150 mcg to 100 mcg. Pt lying in bed + appears
	to be resting comfortably @ this time. Will continue to
	Monitor. —— [redacted] 91WM6
1200	Pt received 1 liter LR bolus for low urine output. Will
	continue to Monitor. —— [redacted] 91WM
1300	Fentanyl ↓ From 100 mcg to 50mcg. Will continue to monitor.
	—— [redacted] 91WM6
1330	Pt Complaining of pain, Medicated c̄ 2mg MSO4. Will continue
	to monitor. —— [redacted] 91WM6

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STANDARD FORM 600 (REV. 6-97) BACK

MEDCOM - 12688

09 Jul

NOTES b(6)-2 A11

1530 Pt urinated, 1075 cc clr yellow urine obtained. UA sent to lab. Pt now lying in bed + appears to be resting comfortably, will continue to monitor. — [redacted] 91WMG

1200 Report given to Nightshift. — [redacted] 91WMG

1730 Report recieved from SPC [redacted] Pt VSS, afebrile Fentanyl drip @ 50 mcg/hr. NS @ 50cc/hr. Will continue to monitor — [redacted] b(6)-2 91WMG

1900 Fentanyl drip D/C'D — [redacted] 91WMG

2200 Pt resting comfortably in bed. VSS temp 100.3 will continue to monitor. — [redacted]

0300 pt sleeping 0 c/o pain @ this time [redacted]

10 July 0500 Received report + assumed care of pt. VSS, Pt lying in bed sleeping + appears to be resting comfortably @ this time. Will continue to monitor. — [redacted] 91WMG

0700 Pt sitting ↑ in bed eating breakfast c̄ 0 Ntd complaints @ this time. — [redacted] 91WMG

0900 1 Liter LR bolus given per order. Pt appears to be resting comfortably. Will monitor. — [redacted] 91WMG

1045 Pt lying in bed sleeping c̄ covers pulled over head. Appears to be resting comfortably @ this time. — [redacted] 91WMG

SHIP TO SPONSOR
SPONSOR'S NAME
LAST
FIRST
MI
SPONSOR'S ID (SSN or Other,
ERVICE
HOSPITAL OR MEDICAL FACILITY
RECORDS MAINTAINED AT
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

[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509
Prescribed by GSA/ICMR FPMR (41CFR) 101

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:AL RECORD | **PROGRESS NOTES**

E	NOTES
10 July	b(6)-2 All ↓
1100	Pt complaining of pain, medicated c̄ 2 tabs Percocet. Will continue to monitor. —— [redacted] 91WM6
1300	Pt lying in bed sleeping + appears to be resting comfortably @ this time. Will continue to monitor. —— [redacted] 91WM6
1700	Gave report to Nightshift.
10 July	(1700) Pt care Report Recieved from S [redacted] Pt awake, alert, oriented s̄ acute episodes voiced/noted. —— [redacted] 91WM6
10 July	(2120) Percocet tab ii Po given for c/o Stump discomfort @ distal end & at anterior knee. Pt Quiet p̄ care. [redacted] 91wm
10 July 03	(0330) Percocet tab ii Po given for c/o Stump discomfort. Quiet p̄ care. [redacted] 91wm
11 July 03	(0430) Pt Remain asleep s̄ acute Episode noted —— [redacted] 91WM6
11 July	(0500) Pt Care Report given to SPC [redacted] Pt Resting quietly s̄ acute Episodes noted. —— [redacted] 91WM6
11 July 03	@ 0620 pt report recieved From SSg [redacted] VSS Assessment complete WNL See pt Flowsheet pt resting quietly in bed pt C/o pain medicated (cont)

SHIP TO SPONSOR	SPONSOR'S NAME LAST	FIRST	MI	SPONSOR'S ID NUMBE (SSN or Other)

SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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.

#[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

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

ME | FIRST NAME | MIDDLE INITIAL | ID NUMBER

ATE | NOTES

b(6)-2 A1

11July03 (cont) per doctors orders no other problem noted @ present will continue to monitor —— [redacted] FC 91WM6

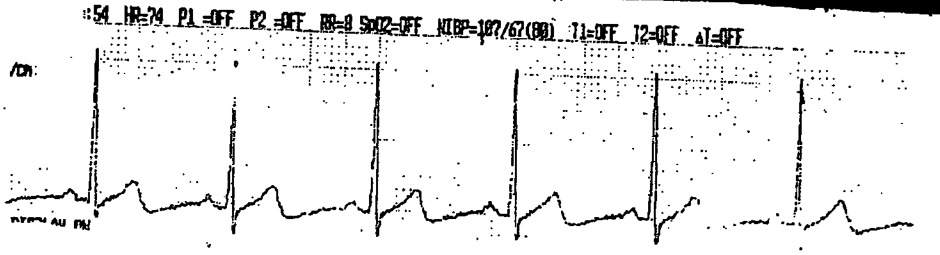
11July03 @1130 pt cast removed c̄ c/o pain medicated per doctors orders pt rested after procedure pt up out of bed to comode c̄ little assistance will continue to monitor —— [redacted] PFC 91WM6

11July03@ 1310 pt taken to OR. For procedure will continue to monitor upon return —— [redacted] PFC 91WM6

b(6)-2

11July03@ 1520 pt returned [redacted] from OR @ 1415 new orders written pt VSS x̄ Temp of 100.7 ~~with~~ pt complains of pain medicated per doctors orders no other problems noted @ present will continue to monitor —— [redacted] PFC 91WM6

11July03 (1700) Pt care Report Recieved from ~~SPC~~. PFC
b(6)-2 [redacted] Pt s/p surgical procedure, s̄ acute Episode noted / Reported. —— [redacted] 91WM6


:54 HR=74 P1=OFF P2=OFF RR=8 SpO2=OFF NIBP=107/67(80) T1=OFF T2=OFF ΔT=OFF
/cm:

11July03 (2000) Initial dose of vancomycin 500mg IVPB given per Dr order s̄ incident. Fentanyl drip on hold during Antibiotic infusion. Pt resting quiet @ present. —— [redacted] 91WM6

11July03 (2130) 15mg fentanyl IVP given by Maj.
b(6)-2 [redacted] 2° to break thru discomfort. Quiet c̄ care. Initial dose of Flagyl 250mg IVP given per dr order. s̄ incident. —— [redacted] 91WM6

b(6)-2

EPW [redacted]

b(6)-4

MEDCOM - 12691

ACLU-RDI 1592 p.584

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
10 Jul 03	SURGERY PROGRESS
	PT STABLE POD #2 PAIN WELL CONTROLLED
	VSS / AFEB
	LUNGS CTA
	ABD: SOFT, NT, ND ⊕BS
	CAST IN PLACE
	LABS 136 / 3.9 (101 / 25 (6 / .4 < 114 14.9 > / 26 < 468
	Imp: STABLE
	PLAN: TRANSFER TO ICW
	SEE ORDERS [redacted]
	b(6)-2
11 Jul 03	SURGERY OP NOTE
	PRE-OP DX: INFECTED STUMP
	POST-OP DX: INFECTED STUMP & NECROTIC BONES
	PROC: I&D + WASH-OUT
	F/U/O: 600cc LR STABLE TO ICW
	EBL: MIN WOUND [redacted]
	UO: NA SEE b(6)-2
	COMPLICATION: 0

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.

[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

b(6)-2 All
unless noted otherwise

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:AL RECORD

PROGRESS NOTES

NOTES

11 Jul 03 (2200) Fentanyl drip removed s̄ incident. Pt given Routine med of IVP toradol 30mg by Ma [redacted]. VSS. Afebrile. Stump dressing intact s̄ new drainage noted. — PIV (R) FA patent s̄ S/Sx infiltration. Pt repositioned. Independent movement c̄ verbal instruction. Stump ↑ on blanket rolls. — [redacted] 91WM6

11 Jul (2315) Pt care report given to SPC [redacted] Pt Rest. quietly s̄ acute Episode noted. — [redacted] 91WM6

12 Jul 0010 Pt resting quietly in bed. A+Ox 3 but drowsy. Pt NPO p̄ MN For OR in AM. Pt expresses no needs @ this time. Will continue to monitor. — [redacted]

12 Jul 03 0230 Pt continue to c/o (R) stump pain, increased Fentanyl drip to 150mcg/hr, voiding spontaneously 950cc each time. Gave MSO4 3mg in addition to the ↑ rate of Fentanyl. Monitor effect titrate Fentanyl drip as needed to maintain comfort [redacted]

0430 Pt c/o pain off and on throughout night. Pt's Fentanyl drip titrated to effect. Pt has been NPO p̄ MN for OR today. Pt supposed to go to OR @ 0530 for wound/stump debridement and washing. Ace wrap on stump CDI. No more drainage noted since beginning o' shift. Pt given 0400 dose of Toradol by Maj [redacted] @ 0345. Will pass report to incoming shift. — [redacted] LPN

SHIP TO SPONSOR

SPONSOR'S NAME

LAST	FIRST	MI	(SSN or Other)

SERVICE

HOSPITAL OR MEDICAL FACILITY

RECORDS MAINTAINED AT

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.

EPW
[redacted]
b(6)-4

PROGRESS NOTES
Medical Record

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

MEDCOM - 12693

ME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

ATE	NOTES
12 July 03 0500	Recieved report from Spc. [redacted] Pt. resting c̄ eyes closed, easily arroused. ∅ distress noted. Resp 14. Will continue to monitor. Sgt [redacted]
0523	Resting in bed c̄ eyes ~~closed~~ open opened. VSS stable. ∅ complaints voiced. Drsg noted to (L) ~~stump~~ amp amputated leg c̄ moderated amounted of old drainaged noted to drsg. Will continue to monitor. Sgt [redacted]
0542	Anest^hetis here to pre-medicate pt. for OR procedure. [redacted]
	SUMMARY OP-NOTE
	PRE-OP DX: INFECTED (R) BKA STUMP
	PROC: DRESSING Δ WASHOUT
	SURG: [redacted]
	COMPLICATIONS: ∅
	EBL: 200cc
	IVFS: 200cc b(6)-2 All
	UO: NA
	DRAINS: NONE
	STABLE TO PCU
	REPORT PROCEDURES IN A.M
	[redacted]
0650	Return from OR. s̄ distress. BP 103/66 Pulse 79 RR 11 SpO2 100%. O2 c̄ 6L/50%. Recieved 2mg versed, 70 of Propofol 20mg of MSO4. Stump dressed. Will monitor. Sgt [redacted]

b(6)-2 A(1)
unless noted dif.

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
12 July 03	Stump drsg reinforced @ this time. —— [redacted]
0710	B/P 108/74, HR 61, RR 13, SpO2 100%. ——
@0900 12Jul03	IV restarted in Ⓛ forearm with a 20G catheter. Antibiotic +
	LR infusing s̄ difficulties. Pt voices ∅ c/o c̄ this time. [redacted] LTC/AN
1108	Pt. resting quietly s̄ distress. ∅ complaints voiced At present time,
	will cont. to monitor. —— [redacted]
1309	C/o Stump pain. Percocet Tab ii po given for c/o pain. Will
	continue to monitor. —— Sgt. [redacted]
1348	continue to c/o stump pain. MS04 4mg IV given for [illegible] min.
	Will continue to monitor. —— [redacted]
1514	Resting in bed s̄ complaints. Will continue to monitor.
	[redacted]
1535	C/o Stump pain @ present time. MS04 4mg IV given for
	pain. Will continue to monitor. —— [redacted]
1611	∅ complaint voiced @ present time. Will continue
	monitor. —— [redacted]
1730	Report recieved from SGT [redacted] pt VSS.
	LR @ 125 into Ⓛ arm IV. Wash out done in OR
	today to Ⓡ stump. pt resting quietly [redacted] 91WM6

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)

EPW # [redacted]
b(6)-4

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

b(6)-2
A11

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
12JUL03 2130	Pt sleeping comfortably in bed. UOP adequate will continue to monitor —— [redacted] 91WM6 SPC
0200	Pt resting quietly in bed. VSS afebrile will continue to monitor —— [redacted] 91WM6 SPC
0450	pt sleeping in bed. VSS, afebrile. AM labs drawn. WBC 6.7, RBC 2.85, Hgb 7.7, Hct 25.2 pt for OR this am. No significant changes in condition during night shift. [redacted] 91WM6 SPC
0552	Receive report from Spc. [redacted] ∅ complaints. ∅ distress noted @ present time. Will monitor. —— Bgl [redacted]
0643	C/O ~~[illegible]~~ [redacted] abd. pain. Attempt x1 to go to bedside toilet unable @ time. Will monitor pt. for distress. SpO2 100%. HR 74. —— [redacted]
0737	C/O stump pain. MSO4 4mg IV given for C/O pain —— Bg [redacted]
0900	Return from OR. Condition remain stable. Received 250mcg Fent., 2.5mg versed & 10mg of Propofol. C/O stump pain 4mg of MSO4 IV given for C/O. Will monitor — [redacted]
0924	Percocet Tab ii po given for C/O stump pain. Fent ↑ to 25mcg/hr. Will continue to monitor. —— [redacted]
0946	Medicated per MD order via LtCol [redacted] Will monitor. B/P 118/67 HR 79 RR 8 SpO2 91. ∅ distress noted condition stable. —— [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK
USAPA V1.00

b(6)-2 All
unless otherwise noted

NSN 7540-00-634-4176 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
13 July 03 0949	Pt. resting c̄ eyes closed. RR 6 SpO_2 95% HR 66. Ø complaints. Ø distress. Will continue to monitor. —— Sgt [redacted]
1100	Pt. resting quietly s̄ complaints. B/P 117/67 RR 9 SpO_2 99 HR 71. Will continue to monitor. —— Sgt [redacted]
1149	C/o pain Percocet Tab ii po given for complaint. Sgt [redacted]
1220	Continue to c/o pain. MSO_4 4mg given IV for c/o pain. Will monitor. —— Sgt [redacted]
1254	Resting c̄ eyes closed. Easily aroused. Will continue to monitor. Sgt [redacted]
1401	Pt. up to bedside toilet washing self. Ø distress. Ø complaints voiced. Will continue to monitor. —— Sgt [redacted]
1435	C/o stump pain. MSO_4 4mg IV given for complaint. Sgt [redacted]
1600	Lying in bed c̄ eyes opened. Ø distress noted. Ø complaints voiced. Will continue to monitor. [redacted]
1650	C/o stump pain MSO_4 4mg IV given for complaint. Will continue to monitor. Sgt [redacted]
1730	Report recieved from SGT [redacted] pt VSS IV Fluids LR @ 125 cc/hr. Fentanyl drip @ 100 mcg/hr pt interacts well with staff. Will continue to monitor. [redacted] 91WM6

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

EPW # [redacted]
b(6)-4

RECORDS MAINTAINED AT:

PATIENT'S NAME *(Last, First, Middle initial)*
SEX
RELATIONSHIP TO SPONSOR
STATUS
RANK/GRADE
SPONSOR'S NAME
ORGANIZATION
DEPART./SERVICE
SSN/IDENTIFICATION NO.
DATE OF BIRTH

CHRONOLOGICAL RECORD OF MEDICAL CARE
MEDCOM - 12697

STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
3JUly03 2300	pt sleeping at this time. VSS stable. Ø c/o pain @ this time. Will continue to monitor [redacted] 91WM6
@0120	pt had an episode of nausea and vomited approx. 200cc fluid. pt stated nausea passed after emisis. Will continue to monitor [redacted] 91wm
@0300	pt AM labs drawn. Hgb 7.0, Hct 22.6 Dr. [redacted] notified. pt cross matched for 2 units PRBC's. [redacted] 91W M6 SPC
@0500	pt VSS, currently sleeping On call for OR today [redacted] 91W M6 SPC
0530 14July03	Recieved report from Spc [redacted] Pt. alert & responsive this am. c/o pain to stump, 2mg MSO4 IV given for complaint. Drainage noted to ace wrap on stump. Pt. NPO this am for OR procedure. H&H low. Typed & screened for PRBC. Will monitor pt. for S/Sx of distress. Sgt [redacted]
0800	Resting in bed c̄ eyes closed. Ø complaints voiced @ present time. Ø distress noted. Will monitor for S/Sx of distress. Sgt [redacted]
0846	c/o stump pain 4mg MSO4 IV given as Rx. Will continue to monitor. Sgt [redacted]
0950	MSO4 4mg IV given for c/o stump pain. Will continue to monitor. Sgt [redacted]
1104	Resting c̄ eyes closed. Ø distress noted. Resp 17. Will continue to monitor for S/Sx of distress. Sgt [redacted]
1334	Resting c̄ eyes closed. RR 22. Ø distress noted @ present time. Will continue to monitor. Sgt [redacted]
1604	Resting in bed s̄ complaints @ present time. Will continue to monitor for S/Sx of distress. Sgt [redacted]

*U.S. Government Printing Office: 1995 — 387-722/20035

b(6)-2 All

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
13 Jul 03	Procedure Note
	Pre Dx: Infected BKA
	Post Dx - Same
	Procedure - Washout BKA Stump
	Surgeon [redacted] b(6)-2
	Anes: Gen
	Findings Pus in sac (R) proximal
	wound looks pretty good.
	No devitalized tissue
	Cultures ø
	To the [illegible]
	[redacted] 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.)*

[redacted] b(6)-4

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
USAPA V2.00

NSN 7540-00-63

DICAL RECORD

NURSING N

(Sign all no

TE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated.
14 July	03	1800	Received report from ongoing shift. Pt scheduled to OR remain NPO, pt aware. Fentanyl drip in progress titrate to effect, appear comfortable in bed. [redacted] VSS, BP↓ Map 70. LR @ 125 cc/hr. H+H 7/22.0 MD made aware from previous shift. Continue POC as planned.
			[redacted] Maj / AN

b(6)-2

b(6)-2

See next Page

(Continue on reverse side)

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

NURSING NOTES
Medical Record

[redacted] b(6)-4

MEDCOM - 12700

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
14 JUL 03	OP NOTE
	PRE-OP DX: INFECTED Ⓡ BKA STUMP
	POST-OP DX: SAME
	PROCEDURE: DEBRIDEMENT OF KNEE + WASH-OUT OF STUMP
	SURGEON: [redacted] b(6)-2
	ANESTH: GETA
	EBL: MINIMAL
	FLUIDS: b(6)-2
	UO: NA
	STABLE TO ICU [redacted]
14 July 03	Post-procedural note
1945	Returned from the OR s/p washout, pt drowsy but easily
	aroused. Minimal EBL, received MSO4 20mg c̄ Propofol 200 mg
	c̄ induction anesthetics. PICC line placement Ⓛ AC dressed c̄
	opsite on arrival. Resume previous orders as noted. VS: 98.7
	90-13-100/51-99% RA. Resting comfortably in bed. [redacted] mg/hr
2045	IVF transferred to Ⓛ AC PICC line. Fentanyl @ 100 mcg/hr, LR@125.
	Drip started today in the OR ——— [redacted] mg/hr

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) [redacted]

REGISTER NO.

WARD NO.

EPW [redacted]

b(6)-4

PROGRESS NOTES
Medical Record
STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
15 July 03	Pt slept most of the night, on Fentanyl 100 mcg/hr.
0400	Pain well controlled. PICC line intact ē LRC 125 cc/hr
	VSS ——— [redacted]
0430	Fentanyl decreased to 50 mcg/hr to awaken pt, needed
	to void. NPO p̄ MN to OR this AM ——— [redacted]
0545	Received report From Nightshift + Assumed care of Pt.
	VSS, will contine to Monitor. ——— [redacted] AIWMG
0615	See Assessment sheet For Assessment — [redacted] AIWMG
0630	Pt ↑ OOB to BSC ——— [redacted] AIWMG
0730	Pt Picked up For OR. ——— [redacted] AIWMG
15 JUL 03	OR NOTES
	PRE-OP DX: INFECTED (R) BKA STUMP ē PROGRESSIVE
	NECROSIS OF RIGHT PRE-PATELLAR SKIN
	PROC: WASHOUT + DEBRIDEMENT - CLOSED SKIN OVER
	PATELLA
	SURG: [redacted]
	EBL: 200cc b(6)-2 AR
	FLUID: 200cc HESPAN 400cc LR
	UO: NA
	complications: Ø
	STABLE TO ICW
	[redacted]
1000	Pt Lying in bed ē Ø Ntd C/o ~~pain @ this time~~ Complaints
	@ this time. Pain being controlled. ——— [redacted]
1200	Preparing for blood transfusion. ——— [redacted] AIWMG

STANDARD FORM 509 (REV. 5/1999) BACK
USAPA V1.00

MEDCOM - 12702

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
15 Jul 03 1215	First unit PRBC's started @ this time. Blood verified + Pre-transfusion vitals obtained. Will monitor. [redacted] 91WM6 b(6)-2

Time	1210	1215	1220	1225	1230	1235	1250	1305	1320
BP	97/50	100/44	101/48	94/54	104/58	105/55			
Temp	98.5	98.5	98.5	98.3	98.5	98.4	98.1		
HR	88	69	62	63	59	65	70		
RR	15	16	16	14	14	13	14		
SAO2	99%	99%	99%	98%	99%	99%	100%		

1330	First unit complete. [redacted] 91WM6
1345	Pre-transfusion vitals taken + blood verified. Starting Second unit. [redacted] 91WM6 b(6)-2

Time	1345	1355	1400	1405	1420	1435	1450	1520
BP	121/53	103/53		95/56	102/55	110/51	109/61	108/65
Temp	98.5	97.8	97.9	98.0	98.1	97.9	97.6	97.8
HR	88	69		62	60	70	77	75
RR	14	15	16	16	18	16	16	14
SAO2	100%	100%	100%	99%	98%	95%	99%	99%

1530	Second unit complete, VSS, 0 Reaction Ntd. Will Continue to monitor. [redacted] 91WM6 b(6)-2

RELATIONSHIP TO SPONSOR

SPONSOR'S NAME: LAST / FIRST / MI

SPONSOR'S ID NUMBER (SSN or Other)

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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)*

[redacted] b(6)-4

REGISTER NO

WARD NO

PROGRESS NOTES
Medical Record

STANDARD FORM 509
Prescribed by GSA/ICMR FPMR

b(6)-2 AR

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
11 July 03 0707	Pt. resting in bed c̄ eyes closed. Easily aroused. Ø distress noted. Will continue to monitor. Sgt [redacted]
0817	To OR. Sgt
0957	Return from OR. B/P 117/71 Resp 6 SpO_2 100% on 6L O_2 HR 80. Pt. received general anesthetic. Will continue to monitor pt. Sgt [redacted]
1026	Pt. resting in bed c̄ eyes closed. Easily aroused. Ø complications/distress noted @ present time. Will continue to monitor pt Sgt [redacted]
1054	Pt. resting in bed s̄ complaints @ present time (E) un(E) Engaging on conversation c̄ PFC [redacted] Ø distress noted SpO_2 100% on R/A. Will monitor. [redacted]
1100	Received orders to transfer to ICW 2 EPR ward. Sgt [redacted]
1118	C/o stump pain 4mg MSO_4 IV given for complaint. Will continue to monitor. Sgt [redacted]
1124	VS; HR 104 SpO_2 100 RR 8 B/P 123/80 Temp 98.8. Condition remain stable. Sgt [redacted]

MEDCOM - 12704

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
	b(6)-2 KH
15 Jul 03 1630	Pt sitting up in bed interacting c̄ staff & appears to be in a cheery mood. VSS, H&H ↑ following transfusion, see lab sheet for results. Will continue care. [redacted] 91WM6
1700	Received report from day shift. [redacted] 91WM6
2200	Pt appears to be resting comfortably in bed VSS, Will continue to monitor. [redacted]
0200	Pt resting comfortabl in bed. Will continue to monitor. [redacted] SPC, 91WM6
0430	Drew am labs. [redacted] SPC, 91WM6
0500	Gave report to day shift. [redacted]
0517	Told to not place Foley by Maj [redacted] Reported to day shift (SGT [redacted] SPC, 91WM6
0550 16 July 03	Received Report from SPC [redacted] F/C held off via Shift charge nurse (Major [redacted] night shift) & distress noted this am. ∅ complaints voiced @ present time. Pt. resting in bed c̄ eyes closed. Will continue to monitor for any s/s of distress. — Sgt [redacted]
0613	C/O Stump pain. 2mg MSO4 IV given for complaint. Will continue to monitor. — Sgt [redacted]

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

# [redacted]

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PROGRESS NOTES
Medical Record

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	**SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION** *(Sign each entry)*
0 Jul/03	Surgery OP NOTE
	PREOP DX: NON-HEALING GSW TO RLE ō
	SUBSTANTIAL BONE LOSS & INFECTION
	PROC: RIGHT BKA
	SURG: [redacted] / [redacted]
	EBL: 150cc.
	FLUIDS: 1L LR.
	UO: 250cc.
	Complications: Ø
	Comment: WOUND ~~Loosley~~ loosely APPROXIMATED
	DRAINS: PENROSE
	STABLE TO ICU - will RECLOSE in 48 hours
	[redacted] b(6)-2
10 Aug 03	Brief op note
	Preop Dx Infected BKA Postop Dx Same
	Proc: [illegible] debride
	Surgeon [redacted] b(6)-2 / Anes [redacted] b(6)-2
	[illegible]
	[illegible] complications. [illegible]
	TO [illegible] [redacted] b(6)-2

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

SPONSOR'S NAME | RELATIONSHIP TO SPONSOR

PATIENT'S IDENTIFICATION: *(For typed or w... ...le; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* | REGISTER NO. | WARD NO.

EPW # [redacted]
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

#3

MEDCOM - 12706

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
8 JUL 03	Surgery op Note
	Pre-op Dx: Open BKA
	Proc: Revise + Close stump + washout
	Surg: [redacted] b(6)-2
	EBL: 50cc
	Fluids 1300cc LR
	UO: 350cc UO
	Complications: 0
	JP 10 mm in stump
	Stable to Recovery/ICU [redacted]
	b(6)-2

STANDARD FORM 600 (REV. 6-97) **BACK**
*U.S. GPO: 2002 - 491-600/50618

CAL RECORD

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PROGRESS NOTES

NOTES

7-16-03 1238 Pt. tx to ICW #2 from ICU#3 via litter. Pt. crying out in pain. 2mg MSO4 given IVP. PICC line to Ⓛ AC CDI, flushes well, positional. LR @ 100cc/h. HL to Ⓡ wrist intact. HR Reg. Scattered insp wheezes. ABD soft c̄ BS ⊕ x4. Ⓡ stump drsng CDI, ↑ on pillow. Will cont to moniter. [redacted]

7-16-03 1308 - Received PT in bed c/o pain to Ⓡ stump. PT VSS. Lung sounds Are clear Bilateral. Skin is warm + Dry. Good PMS on upper extremities + Ⓛ leg. BS x4 Ⓡ stump Dressing is dry + intact. PT was given ii Percocet TABS @ 1300 for pain. LR @ 100cc/hr to Ⓛ wrist running well ō no s/s infection. heplock Ⓡ wrist CDI. HR Reg. ABD soft soft c̄ BS x4. Will continue to monitor for pain. [redacted]

16 July - PT will be NPO after midnight. [redacted] b(6)-2

16 July 1955 - PICC line was D/C ō tip intact. [redacted]

17July03 0050 Pt. awake & alert in bed. Pt c̄ continues c/o pain for the past 3 hours despite medication administration, now comfortable s̄ complaints. HR Regular, lung sounds clear bilat, bowel sounds (+) x4 quads. Ⓡ BKA dressing slowly becoming saturated c̄ bld, reinforced DSG c̄ additional ace wrap. HL to Ⓡ wrist flushed well c̄ 3cc NS s̄ s/s of infection.

SHIP TO SPONSOR

SPONSOR'S NAME

LAST

FIRST

MI

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REGISTER NO

WARD NO ICW2

EPW# [redacted]

b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509
Prescribed by GSA/ICMR FPMR (41 CFR) 101

TE | NOTES

17July03 0050 Ⓡ LE ↑ @ 30° c̄ rolled blanket underneath. All other assessment findings WNL. Will continue to monitor drainage from Ⓡ LE. Pt NPO for I c̄ D this AM. [redacted] /AN

0010 Pt. care assumed @ 2100. VSS. Pt. c/o pain Ⓡ LE. 4mg MSO4 given IVP. Ⓡ wrist HL intact, flushed. 0 s/s infection. HR Reg, lungs CTA, BS ⊕ x4. Ⓡ stump ↑, drsg Dry c̄ intact. Will cont. to moniter. Pt NPO for surgery [redacted] /AN.

17JUL03 0930 c/o pain in Ⓡ leg. Pt medicated as ordered c̄ 4mg MSO4. IV. S.L. flushed easily, site s̄ redness or edema. Resting quietly @ present. [redacted]

17Jul03 Brief Op Note
Preop Dx - Infected Ⓡ BKA
Postop: [illegible] Ⓡ BKA
Surgeon [redacted]
Anes
Findings [illegible] [illegible] [illegible]
[illegible] [illegible] [illegible]
Cleaned up area [illegible] Seen
by Orange ortho
[illegible] b(6)-2 AN
[redacted]

IEDICAL RECORD | **PROGRESS NOTES**

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DATE	NOTES
17Jul03 1800	assumed care @ 1300 - pt. returned from surgery @ 1600 - VSS - S/P BKA Ⓡ washout - Ⓡ FA IV SL'd p̄ pt. tol. regular diet for dinner - lungs CTA Ⓑ - ⊕ BS - no UO since surgery, DTV by 2300 - pt. NPO p̄ MN for washout in AM - labs ordered in AM - pt. c/o small amount of pain in Ⓡ LE, will continue to monitor - dsg on Ⓡ BKA CDI and stump elevated on pillow [redacted] RN b(6)-2
18July03 0000	Pt. asleep in bed s̄ complaints @ this time. Ⓡ BKA ↑ @ 30° on folded blanket. DSG to Ⓡ BKA CDI. HR Regular, lung sounds clear bilat, bowel sounds ⊕ x 4 quads. HL in Ⓡ FA s̄ s/s of infection. Pt. to be NPO since MN for washout this AM. VSS. All other assessment findings WNL. Will continue to monitor. [redacted] RN
0700	Pt. care assumed @ 0500. VSS. HR Reg, LS CTA bilat. BS ⊕ x4. HL to Ⓡ FA flushed s̄ diff, s̄ s/s infection. PT NPO for surgery. Ø pain @ this time. Ⓡ BKA ↑ c̄ drsng CDI. Will cont. to monitor. [redacted] RN b(6)-2

IP TO SPONSOR

SPONSOR'S NAME: LAST | FIRST | MI

SPONSOR'S ID NUMBER (SSN or Other)

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EPW [redacted]

b(6)-4

REGISTER NO.

WARD NO. ICW

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (R
Prescribed by GSA/ICMR FPMR (41 CFR) 101-1

FIRST NAME	MIDDLE INITIAL	ID NUMBER

TE

NOTES

18 Jul 03 Brief Op Note
Preop Dx - Infected Ⓡ BKA
Postop Dx - Wound Contaminated
Procedure - Ⓡ BKA washout and closure
Surgeon [redacted]
Complications Ø

[redacted]

1100 Pt back from RR via litter. VSS, Ø pain. LR @ 125 cc/hr to Ⓛ wrist HL. HR Reg, lungs CTA, BS ⊕ x4, ABD flat, firm. Ⓡ stump drsng CDI, ↑ on blankets. JP draining bright red bloody drainage. Pt resting quietly. Will cont to monitor. [redacted]

1900 Assumed care of Pt @ 1300. VSS. A+O x3. Pain controlled with PO Percocet - Amb. ̅s assistance on crutches. Ⓡ BKA Drsg / ACE. JP drain 30cc bloody drainage. HL PIV Ⓡ FA 1 VABX. O/W Assess. WNL. Will Monitor [redacted]

19 Jul 03 0035 Rec'd c/o pt @ 21:00. ~~Asleep in~~ in bed. Awakened easily. VS WNL per flow sheet. Restraints x2 Ⓡ wrist Ⓛ ankle. LCA Ⓑ. BS ⊕ hypoactive x4, ⊕ PPP Ⓑ ~~x~~ Ⓡ BKA stump ACE wrap D/I/C/D/I. Ø c/o pain @ this time. Will cont. to mon. [redacted]

b(6)-2 ARL

MEDCOM - 12711

b(6)-2 AM

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
7-19-03	0705: Pt. care assumed @ 0500. VSS. Pt. given i Percocet for pain @ 0600. Pt. assisted to BR on crutches for BM. HR Reg, lungs CTA, BS ⊕ x4. Ⓡ LE stump ↑. Dsng CDI. HL to Ⓡ AC intact s̄ s/s infection. [redacted]
1300	Assumed Care of Pt @ 1300. VSS. A+O x3. Pain controlled c̄ percocet. Ⓡ BKA Dsg/ace CDI c̄ JP Drain c̄ sml amount bloody drainage. Ⓡ PA SL c̄ IV ABX. O/W Assessment WNL. will Monitor [redacted]
2100	Pt returning from BR on crutches had syncopal episode. Staff caught Pt. Placed in Bed. VS O₂SAT 98% pulse 140. Rested for 3 min. VSS. BP: 104/70 P: 110 R: 26 O₂SAT: 98% Pt A+O x3. Resting. Rel will monitor [redacted]
2101	Duoderm applied to 2° Skin Ulcer Lower Back [redacted]
19 July 03	2210 Assume pt care @ 2100. pt Asleep easy to awake. Alert Skin pale warm and dry to touch. VSS. HL to Ⓡ AC no s/s redness/infiltration c̄ flush. HR reg lungs CTA. Abd soft flat BS x4. Ⓡ BKA Dsg CD+I JP drain draining sm amt bloody drainage. Duoderm to lower back CD+I. Will continue to monitor [redacted]
20 July 03	0820- Pt alert lying in bed. VSS, lungs CTA, HR reg, BS ⊕. Pulses ⊕ + strong x3. Ace wrap to Ⓡ BKA, CDI. HL to Ⓡ AC. Voiding & [illegible]. Will cont. to monitor. JP draining small amount of red fluid [redacted]

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USAPA V1.00

[redacted] b(6)-4

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MEDICAL RECORD	PROGRESS NOTES
DATE	**NOTES**
20JUL03 1330	Assumed care Pt @ 1300. VSS. A&O x3. ⊘ c/o pain. Ⓑ LS CTA ⊕ BS x4 HRR; Ⓡ BKA drsg CDI. JP draining serous fluid. Ⓡ AC HL ī IV access patent. O/W assessment WNL. NPO for OR. Will monitor [redacted]
1332	Duoderm to sacral skin ulcer CDI — [redacted]
1500	Ortho Op Note
	Dx s/p Ⓡ BKA b(6)-2 Arl
	Px Dsg Δ
	Surgeon [redacted]
	Anes MAC
	Findings wound dry, healing well [redacted] MAJ [redacted]
1630	Pt returned from OR. VSS. A&O x3. Ⓑ LS CTA ⊕ BS x4. Stump drsg CDI. Will monitor [redacted]
1915	D/C IV Ⓡ AC infiltrated, catheter intact. New 18G PIV started Ⓛ FA - patent [redacted]
21Jul03 0050	Rec'd pt care @ 21:00. VS WNL per flowsheet. Awake and alert in bed. ICA Ⓑ. BS ⊕ x4. ⊕ PPP ⊕ ROM stump. ⊕ Skin W/D. c/o pain x2 ii Percocet given. Will cont to monitor [redacted]

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

b(6)-4

PROGRESS NOTES
Medical Record

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USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
	#376		

DATE	NOTES
7-21-03	0642. Pt. care assumed @ 0500. VSS. Pt. c/o pain Ⓡ BKA. ī percocet given. HL to Ⓛ FA flushe s̄ diff. HR Reg, lungs CTA Bilat, ABD soft c̄ BS ⊕x4. Ⓡ BKA ↑, dsng CDI. Will cont. to moniter. b(6)-2 [redacted] UT,
1900	Assumed care of Pt @ 1300. VSS. A+Ox3. Pain controlled c̄ percocet. Ⓡ BKA drsg/ace wrap CDI. Ⓛ FA PIV patent c̄ IV ABx. D/W assessment c̄ w/c. will Monitor b(6)-2 [redacted]
	ccor
22 July 03 0145	Pt. asleep in bed. Pt. c̄ c/o pain @ 0030, medicated c̄ ii percocet. HR Regular, lung sounds clear bilat, bowel sounds (+) x 4 quads. Ⓡ BKA ↑ on folded blanket. HL in Ⓛ FA flushed well c̄ 3cc NS s̄ s/s of infection. DSG to Ⓡ BKA CDI. Pt s̄ complaints @ this time. Will continue to monitor [redacted] b(6)-2
22 July	0615 Assume pt care @ 0500. pt Awake and Alert. VSS. no c/o pain or discomfort @ this time. HR reg Lungs CTA. Abd soft BSx4. Ⓡ BKA DSG CD+I. HL to Ⓛ FA no s/s redness/infiltration c̄ flush will continue to monitor b(6)-2 [redacted] 91WMP.
22 Jul 03 1700	assumed care @ 1300 - VSS - SL patent - dsg intact on Ⓡ BKA - medicated for pain c̄ ii Percocet PO c̄ good results - pt. able to ambulate c̄ crutches s̄ difficulty - MD to remove dsg today [redacted] CR, AN

STANDARD FORM 509 (REV. 5/1999) BACK
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b(6)-2

#[redacted]
b(6)-4

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MEDICAL RECORD | **PROGRESS NOTES** | AUTHORIZED FOR LOCAL REPRODUCTION

b(6)-2

DATE	NOTES
22Jul03 2045	assumed care @1300 - VSS - medicated c̄ ii Percocet PO @1615 c̄ good results - binder - remains in place on decubitus on bottom [redacted]
22JUL03 22:45	Rec'd c/o pt @ ~~22~~ error [redacted] 21:00. VS WNL per flowsheet. Restraint x1 Ⓛ wrist. Pt awake and alert. Skin color WNL. PERRLA ⊕WNL. LCAⒷ. HR WNL/Reg. BS⊕x4. Ⓡ↓ BKA ACE wrap intact. ∅ c/o pain @ this time will cont to mon [redacted] RN
23 Jul	Assumed care of pt @ 0500. Pt asleep. VSS. Lungs CTA. Bowel sounds x 4 quads. Pt woke up constipated. Pt was given warm milk to drink. Pt was able to use BR 2 hours later. Pt is now asleep again. Pt has ∅ c/o pain/discomfort @ this time. Will continue to monitor. [redacted] LPN, SGT
23July03 1405	assumed pt care @ 1300. pt lying in bed refused lunch tray. VSS. lungs CTA, abd soft BS⊕ x4 quads Ⓡ BKA drsng CDI. Ⓛ leg c̄ full ROM ⊕ pulse. BUE c̄ full ROM ⊕ pulses. HL Ⓡ FA ∅ S/SX of infection noted. ∅ c/o pain/discomfort. Will cont to monitor. [redacted] 91WM6

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

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[redacted]

b(6)-4

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23Jul03

NOTES

23:42 Rec'd c/o pt @21:00. Restraints x1 (L) wrist. VS WNL per flowsheet. Pt sleeping in bed/easily awakened. Skin W/D. PERRLA (+) WNL LCAB. BS(+)x4. HL patent (R) F/A. (R)(R)(B). (R) BKA ACE wrap dsg C/D/I. no c/o's. Will cont. to mon [redacted] 2L AN

b(6)-2

24July03 0535 Assumed pt care @ 0500. pt Awake and Alert. VSS. HR reg Lungs CTA. Abd soft no c/o tenderness on palpation BS x4. (R) BKA ace wrap intact pt NPO for OR today. No c/o pain. HL to (R) FA no s/s redness/infiltration c̄ flush. Will continue to Monitor

b(6)-2 [redacted] SMMG

24Jul03 1500 assumed care @1300 - VSS - pt. 0/c for OR, NPO since midnight, LR @100cc/hr started due to >12° NPO - pt. has no c/o pain @ this time

b(6)-2 [redacted] CR AN

7/24/03 [illegible] OP [illegible]

[illegible] Dx (R) BKA [illegible]

[illegible] [illegible] b(6)2 [illegible]

Surg [redacted] [illegible]

[illegible]

[illegible]

SPONSOR'S NAME FIRST MI SPONSOR'S ID NUMBER (SSN or Other)

HOSPITAL OR MEDICAL FACILITY [redacted] RECORDS MAINTAINED AT

b(6)-2

... give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade

WARD NO. ICW2

EPW [redacted]

b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509

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PROGRESS NOTES

DATE | NOTES b(6)-2 All

sutures ø exudate noted @ this time c/o pain. ī Percocet given.
HL Ⓡ FA ø patent. New IV placed. Will cont. to mon.
[redacted] 2LT/AN

26July03 0515 Assume pt care @ 0500. Pt awake and alert. no c/o pain or discomfort @ this time. VSS. HR reg Lungs CTA. Abd soft BS×4 Ⓡ BKA Cast CD+I Ⓡ Knee stitches intact. Area around stitches red and tender. No IV site @ this time. Will cont. to monitor. —— [redacted]

26Jul03 2000 assumed care @1800 - VSS - sutures intact, area remains discolored, tender to touch - medicated for pain c̄ ī Percocet PO - dsg CDI on Ⓡ BKA —— [redacted]

26Jul03 21:51 Rec'd c/o pt @ 21:00. Restraints ×1 Ⓛ wrist. VS WNL per flow sheet. Pt awake and alert in bed. Perrla ⊕ WNL. LOA Ⓑ BS⊕×4. ⊕PP Ⓑ. Ⓡ BKA DSG C/D/I. Sutures to patella, OTA c̄ ⊖ S×S infection ⊕ redness ⊕ edema ø pitting around sutures ø c/o pain @ this time. Will cont. to mon. [redacted] 2LT/AN

27July03 0630 Pt. awake & alert sitting up in bed eating breakfast. HR Reg, lung sounds clear bilat, bowel sounds (+) x4 quads. Pt. c/o pain; ī Percocet given @ 0735. Ⓡ BKA DSG CDI. Sutures to Ⓡ knee intact, skin surrounding

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

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REGISTER NO. | WARD NO. ICW2

EPW [redacted]

b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (R

MEDCOM - 12717

DATE	NOTES
24Jul03	assumed care when pt. returned
2000	from surgery - dsg intact, sutures
	open to air, intact, no drainage noted -
	IV SL'd pt. tol. regular diet - pt.
	given scheduled elavil and ii percocet
	PO for pain - cuader [illegible] intact. -
	Sacral decubitus ulcer - [redacted] CR/AN
24Jul03	Rec'd c/o pt. @21:00. Restraints ~~x2~~ error x1 Ⓡ wrist. VS WNL
23:01	per flowsheet. Skin W/D. LCA Ⓑ. PIV HL to Ⓡ FA
	patent/intact. Ⓡ BKA c̄ dsc C/D/I. sutures to patella
	C/D/I. Sxs infection ⊕ redness ⊕ swelling. ∅ c/o pain
	@ this time. will cont. to mon. [redacted] 2LT/AN
25Jul03	0713 - Pt alert ate 75% of breakfast. VSS, lungs CTA,
	HR reg, BS⊕, Ⓡ BKA c̄ dsg CDI. Sutures to
	patella intact. HL to Ⓡ forearm → patent,
	Voicing ∅ complaints at this time. Will cont.
	to monitor [redacted] 2LT/AN
25Jul03	assumed care @ 1330 - VSS - SL patent -
1400	dsg CDI on Ⓡ BKA, Sutures intact, area
	around sutures appears ecymotic, purple
	in color - no c/o pain @ this time -
	[redacted] CR/AN
25Jul03	pt. had 2 loose BM this shift - medicated
1830	x i for pain in knee Ⓡ - [redacted] CR/AN
25Jul03	Rec'd c/o pt. @21:00. Restraints x1 Ⓡ wrist. VS WNL per flowsheet. Pt.
21:51	awake and alert in bed. PERRLA ⊕. Skin W/D LCA Ⓑ. BS ⊕ x4. ⊕ PP Ⓑ Ⓡ BKA
	dsg C/D/I. sutures to patella intact c̄ ⊕ sxs infection ⊕ redness around

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NOTES

27July03 0630 sutures c̄ erythema noted, skin warm to the touch. Pt s̄ IV access. All other assessment findings WNL. Pt s̄ other complaints @ this time. Will continue to monitor. —— [redacted] 2LT/AN

27Jul03 1415 assumed care @ 1300 - VSS - no c/o pain @ this time - dsg CDI on Ⓡ BKA, sutures intact, area c̄ reddish erythema noted, tender and warm to touch - [redacted] CR/AN

27Jul03 2324 Rec'd c/o pt @ 21:20. Restraints x2 Ⓡ wrist. VS WNL per flowsheet. Pt sleeping in bed easily awakened. Skin W/D, LCAⒷ, BS⊕ x4 ⊕ PPⒷ, sutures to Ⓡ knee C/D/I area around sutures ⊕ s/s infection ⊕ redness. DSG to Ⓡ leg C/D/I. s̄ c/o pain @ this time will cont. to mon. [redacted] 2LT/AN

28July03 0900 Pt. awake & alert in bed. s̄ complaints. VSS. Pt. s̄ IV access. HR Reg., lung sounds clear bilat, bowel sounds (+) x4 quads. DSG to Ⓡ BKA CDI, sutures to knee intact: erythema noted on surrounding skin & warm to touch. Pt. c/o pain @ 0730, i Percocet given. All other assessment findings WNL. Will continue to monitor. —— [redacted] 2LT/AN

28Jul03 1900 assumed care @ 1300 - VSS - medicated for Ⓡ knee pain c̄ i Percocet PO @ 1855 - dsg CDI on Ⓡ leg, sutures intact, redness diminishing @ suture site - encouraged pt. to do PROM on Ⓡ knee

SPONSOR'S NAME

LAST	FIRST	MI	SPONSOR'S ID NUMBER (SSN or other)

HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

... last is written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade

REGISTER NO.

WARD NO. I EW

EPW [redacted]

b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509
Prescribed by GSA/ICMR ...

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | ~~CHRONOLOGICAL RECORD OF MEDICAL CARE~~

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
28Jul03	pt. demonstrated understanding of PROM
con't.	ambulated to BR c̄ crutches, had BM — [redacted]
2330	Pt care assumed @ 2100. VSS, alert and awake, ī percocet b(6)-2
28July03	given for pain @ 2300. Lungs CTA, BS⊕ x4. Sutures OTA on
	Ⓡ BKA intact. Slight erythema noted on knee. Pt ambulated,
	Stopped due to dizziness, had to be carried back to bed.
	Performed ROM x30 minutes and massaged muscles, understands
	need for rom. Continue to monitor. [redacted] glume b(6)-2
29July03	0550 Assume pt care @ 0500. pt awake and
	alert. VSS. HR reg Lungs CTA. Abd soft BSx4. Ⓡ BKA
	stitches intact OTA, redness noted. Skin breakdown
	to lower back, OTA pt encouraged to lay on side.
	No c/o pain or discomfort @ this time, will
	encourage ROM and amb. c̄ crutches. —— [redacted]
	1400 Pt stable at this time. AAOx3. PERRLA
	Lungs CTA bilat, ⌀ resp distress. NSR. Abd
	soft, non-tender, bowel sounds active
	x4 quads. Strong pulse, brisk cap refill
	and good strength to bilat upper extremity
	and Ⓛ leg. Sutures to Ⓡ knee c CDI, site
	reddened. Sutures to stump CDI. Pt exercising
	Ⓡ knee. Ø complaints —— [redacted]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT b(6)-2
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. 1CW2

EPW# [redacted]

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

MEDCOM - 12720

b(6)-2 All

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1630 29 July 03	Every other suture removed from suture line on stump. Site C/D/I, wound healing well, good approximation of wound edges. Granuloma above suture line on stump draining serosanguinous fld. ∅ complaints. —— [redacted] /AN
29 JUL 03 01:48	Rec'd c/o pt @ 21:00. Restraints x1 Ⓛ wrist. Pt VS WNL per flow sheet. Awake and alert in bed. Doing ROM exercises to Ⓡ leg/stump. Perrla ⊕ WNL. LCA Ⓑ. ⊕ BS x4 ⊕ PP Ⓑ. HR Reg. Ⓡ stump @ patella sutures intact C/D. ⊕ sxs infection ⊕ redness ⊕ tenderness ⊕ ↑ warmth noted around sutures. Sutures @ stump C/D/I. DSD c̄ scant amt yellow drainage noted. a d/s @ this time will cont to mon [redacted]
30 July 03 0530	Pt. asleep in bed easily aroused by verbal stimuli. HR Reg, lung sounds clear bilat, bowel sounds ⊕ x 4 quads. Sutures intact on Ⓡ knee c̄ amputation site, erythema surrounding sutures on Ⓡ knee c̄ ↑ temp. Pt. VSS. Pt. s̄ IV access. Pt. s̄ complaints @ this time. All other assessment findings WNL. Will continue to monitor. —— [redacted] LT/AN
30 Jul 03 1930	Assumed care @ 1300 - VSS - medicated ⊕ for pain c̄ i Percocet @ 1400 c̄ good results, no c/o pain @ this time - Sutures to be removed 31 Jul and if wound stays closed pt. will go to EPW camp - pt. wrapped stump c̄ Kerlix to prevent sutures from rubbing on sheet - wound covered c̄ 2x2, small amt serosang drainage noted - —— [redacted] CR/AN

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | PROGRESS NOTE ~~CHRONOLOGICAL RECORD OF MEDICAL CARE~~

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
30 Jul 03 2307	Rec'd c/o pt @ 21:00. Restraints x 1 Ⓛ wrist. VS WNL per flowsheet. Awake and alert in bed. Skin WNL W/D PERRLA ⊕ WNL. LCA Ⓑ. HR reg S1S2 WNL. BS ⊕ x4. ⊕ PPB c/o pain x1 ī Percocet given. Sutures to stump OTA. Will cont. to mon. [redacted] /AO b(6)-2
310550 July 03	Nursing Assessment: Assumed pt. care. Airway intact, breathing even and unlabored, LS clear to all fields Ⓑ. Abd soft, nontender, ī distention. Voids spontaneously. FROM to all extremities, and neurovascularly intact. Stump to Ⓡ LE, drsg CDI. Ø IV access. [redacted]
311000 July 03	Nursing: Sutures removed from stump and knee per orders of physician. Upon removal of sutures from knee, pt bent knee and wound reopened. Conferred c̄ Dr. [redacted] 2- Dr. [redacted] not available. Steristrips c̄ benzoine applied per Dr [redacted] suggestion [redacted]
31 July 03 1305	- Assumed pt care. Breath sounds are clear bilateral. VSS. BS x4. Abdomen soft. Pt has ⊕ ROM to upper extremity + Ⓛ leg. Pt has ⊖ c/o pain currently. Stump to Ⓡ LE is dry + intact c̄ steri strips to the knee. Pt exhibits no discomfort from stump and is resting in bed. Will cont to monitor. [redacted]
31 Jul 03 23:15	Rec'd c/o pt @ 21:00. Restraints x2 1 Ⓡ wrist. Awake and alert in bed. Skin W/D. PERRLA ⊕ WNL. LCA Ⓑ. BS ⊕ x4. ⊕ PPB Ⓡ BKA steristrips intact. ⊖ c/o pain @ this time. Will cont. to mon. [redacted] /AO

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. 1CW2

EPW # [redacted]

b(6)-4

PROGRESS NOTE ~~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 - 12722

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1 Aug 03	0650: Assumed pt. care @ 0500. Pt. awake A+O x3. lungs CTA. + Pulses. ⊕ BS x4. sterile strips on Ⓡ knee Denies any complaint of discomfort. [redacted]
1400	Pt stable at this time A+O x3 PERRLA. Lungs CTA bilat, Ø resp distress. NSR. Abd soft, non-tender, bowel sounds active x4 quads. Brisk cap refill and strong pulses to bilat UE and Ⓛ leg. Ⓡ stump c̄ steri strips open to air. Suture line CDI. Pt exercising Ⓡ knee. Ø complaints —— [redacted] /KY
01Aug03 21:31	Rec'd c/o pt @ 21:00. Restraints x1 Ⓛ wrist. VS WNL per flow sheet. Sleeping in bed easily awakened. Skin WNL W/D. PERRLA ⊕ WNL. LCAB HRRs, S2 WNL. BS ⊕ x4. ⊕ PP ⊕. Ⓡ BKA c̄ kerlix dsg C/D/I. Stump soft and warm to touch. Ø apparent s/s infection. c/o pain x1 ÷ Percocet given. Will cont to mon. [redacted] 2LT/AN ——
2August03 0915	. HR Regular, lung sounds clear bilat, bowel sounds (+) x4 qu Pt. s̄ IV access. Am care completed. Pt. removed sterile strips on his Ⓡ knee, wound is open c̄ patellar tendon visible. Skin around wound is red c̄ ↑ temp. MD notified. Sterile strips reapplied & 4x4 applied. Pt. c̄ limited ROM of knee. All other assessment findings WNL. Pt s̄ complaints @ this time. Will continue to monitor. —— [redacted] 1LT/AN
2Aug03 1900	assumed care @ 1300 - VSS - medicated for c/o pain c̄ (650 mg tylenol) PO @ 1430 c̄ good results - Ⓡ knee dsg Δ'd, 2x2 wet dsg done, skin open, patellar tendon visible, area around wound remains red, small skin tear above & below wound —— [redacted] CN, A

FPI. LEX. Printed on Recycled Paper

600 (REV. 6-97) BACK

MEDCOM - 12723

b(6)-2 All

b(6)-2 A71

NSN 7540-00-634-4176 600-108

HEALTH RECORD PROGRESS NOTES ~~CHRONOLOGICAL RECORD OF MEDICAL CARE~~

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
4Aug03	assumed care @1300 - VSS - medicated for
1900	pain @1500 c̄ 650mg tylenol PO c̄ good
	results - dsg Δ'd on Ⓡ Knee, wound edges
	red, ~2x2in opening c̄ patellar tendon visible,
	w→d dsg applied, Kerlix placed - pt ambulated
	to BR c̄ crutches, had BM - [redacted]
4Aug03	Rec'd pt @ 21:00. Restraints x2 Ⓡ wrist Ⓛ ankle. VS WNL per
23:48	flow sheet. Pt. awake and alert requesting pain med. ii
	Tylenol given. Pt refused tylenol. [illegible] Skin W/D.
	LCA Ⓑ. HRR S1 S2. BS x4. ⊕PP Ⓑ. @ 23:54 pt. decided to take ii
	Tylenol Ⓡ stump kerlix dsg C/D/I. ∅ further complaints
	will mon. [redacted]
5Aug03	0535 Assume pt care @ 0500. Asleep easy to
	arise. No c/o pain or discomfort @ this time. VSS.
	HR reg Lungs CTA Abd soft BS x4. Ⓡ BKA dsg
	CD+I. Will continue to monitor [redacted]
5Aug03	assumed care @1300 - VSS - dsg Δ'd twice
2030	this shift - o/c to OR in AM, NPO p̄ MN
	for Surgery 6Aug03, pt aware of plan -
	medicated c̄ tylenol ii PO @1400 c̄ good
	results [redacted] b(6)

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

ICW2

EPW #[redacted]

b(6)-4

RECORDS MAINTAINED AT:

PATIENT'S NAME *(Last, First, Middle initial)*

SEX

RELATIONSHIP TO SPONSOR

STATUS

RANK/GRADE

SPONSOR'S NAME

ORGANIZATION

DEPART./SERVICE

SSN/IDENTIFICATION NO.

DATE OF BIRTH

CHRONOLOGICAL RECORD OF MEDICAL CARE

STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

MEDCOM - 12724

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
2 Aug 03 21:45	Rec'd c/o pt. @ 21:00. Restraints x2 Ⓡ wrist Ⓛ ankle. VS WNL per flowsheet. Pt. awake and alert in bed. Voicing concerns to interpretter that he wants to "receive care in an Iraqi Hospital because the doctor scared him when stated he was to have an AKA". Dr. [redacted] aware of pt's feelings. PERRLA ⊕ WNL. LOA ③. HRR S1S2. BS⊕x4. Ⓡ stump wrapped c̄ Kerlix dsg C/D/I. ⊕PP Ⓑ. c/o pain x1 ii Tylenol given. Will cont to mon [redacted])AU
0305 10 Aug 03	NURSING ASSESSMENT: Assumed care of pt. Airway intact, breathing even and unlabored, LS clear to all fields. Abd soft, nontender, s̄ distention. BS⊕x4. Voids spontaneously. FROM and neurovascularly intact to all extremities. Ⓡ LE stump, suture line intact c̄ scabs to all suture sites. Kerlix gauze to Ⓡ knee, CDI. ∅ IV access. [redacted]
2 AUG 03 1300	- PT IS resting in bed c̄ ⊖ c/o pain or discomfort. VSS. Heart. Breath sounds bilateral. BS x4. Ⓡ stump wrapped + is CDI. Skin is warm + Dry c̄ ⊖ s/s of infection. Will cont to monitor PT. [redacted]
2130	Pt. care assumed @ 2100. VSS. Pt. c/o pain Ⓡ LE @ stump. ii Percocet given. HR Reg, lungs CTA, BS⊕x4. Dsg to Ⓡ stump CDI. Will cont. to monitor. [redacted]
4 Aug 03 0600	Pt. VSS. No IV access. HR Regular, lung sounds clear bilat, bowel sounds (+) x4 quads. DSG to Ⓡ BKA CDI, limited ROM. Pt. s̄ complaints @ this time. All other assessment findings WNL. Will continue to monitor. [redacted] 2LT/AN
0830	W→D DSG Δ'd to Ⓡ knee. Patellar tendon clearly visible through half dollar size wound. Edges of wound are red & temp is ↑. No drainage noted. [redacted]
	b(6)-2 All

*U.S. Government Printing Office: 1996 - 404-763/40001

STANDARD FORM 600 BACK (REV. 5-84)

NSN 7540-00-634-4176 600-109

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
5 Aug 03	Pt care assumed @ 2100. VSS, alert and awake
2240	s̄ c/o pain after 650 mg tylenol @ 2000. Lung
	sounds CTA, pulses ⊕ x4, BS ⊕ x4. Exfix on Ⓡ LE CDI,
	pt c̄ ⊕ ROM, sensation in LE. Pt to have exfix
	dc/d tomorrow, expected to return to epw camp
	on 7 Aug 03. Will continue to monitor. [redacted] 91WM6
6 August 03	Pt. awake & alert in bed. New IV placed in Ⓛ FA for surgery this AM.
0600	Pt. .s been NPO since MN. HR Regular, lung sounds clear bilat,
	bowel sounds (+) x4 quads. DSG to Ⓡ BKA CDI, limited ROM to
	Ⓡ knee. Pt. s̄ complaints @ this time. All other assessment
	findings WNL. Will continue to monitor. ——— [redacted] LT/AN
6 Aug 03	Brief op note
	Pre op Dx - Open [illegible] wound
	Post op Dx - Same
	Procedure - Advancement-flap Closure of [illegible]
b(6)-2	wound placement of [illegible]
A[illegible]	[illegible]
	Surg [redacted] Assist Capt Cl.[illegible]
	Anes GET
	Findings - Debrided wound and Advanced
	V flap with good full thick Closure
	Compl ∅

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

EPW

[illegible]

[redacted]

b(6)-4

RECORDS MAINTAINED AT: [redacted]

PATIENT'S NAME [redacted]		SEX
RELATIONSHIP TO SPONSOR		RANK/GRADE
SPONSOR'S NAME		ORGANIZATION
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

CHRONOLOGICAL RECORD OF MEDICAL CARE

MEDCOM - 12726

STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
06 Aug 03	Pt. back from OR. Vital stable [redacted]
1130	Pt. c̄ cast to Ⓡ leg s̄ complaints @ this time.
06Aug03	Pt stable at this time. AAOx3. PERRLA. Lungs
1400	CTA bilat, Ø resp distress. NSR. Abd soft
	non-tender, bowel sounds active x 4
	Quads. Strong pulses and brisk cap
	refill x 3 extremities. Cast TO Ⓡ BKA
	CDI. [redacted] 1LT/AN
8/30	Pt care assumed @ 2100. Temp @ 100.6, pulse @ 122,
	650 mg tylenol given. Pt alert and awake, no c/o pain
	at this time. Lung sounds CTA, bsx4. Osg on
	Ⓡ BKA cdi. Pt c̄ discharge summary and orders on 7Aug,
	will continue to monitor. [redacted] 9U/MC
7Aug03	0530 Assume pt care @ 0500. Awake and Alert
	c/o pain to Ⓡ BKA. percocet given. Cast to Ⓡ BKA intact
	VSS x̄ temp 99.4 HR reg Lungs CTA Abd soft BSx4.
	plan for Discharge today. HL to Ⓛ FA ⊕ flush s̄ s/s
	redness/infiltration. will continue to monitor. [redacted] BIWM
7Aug03	assumed care @ 1300 – VSS – medicated c̄
1350	ii Tylenol PO for c/o pain [redacted] ~ 1330, pt.
	Sleeping @ present – cast intact on Ⓡ BKA –
	pt. awaiting transport to EPW camp [redacted]
	b(6)-2 All

*U.S. Government Printing Office: 1996 - 404-783/40001

STANDARD FORM 600 BACK (REV. 5-84)

MEDCOM - 12727

558-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TRE. .TMENT
(Medical Record)

TREATMENT FACILITY (Stamp): EMT

LOG NUMBER:

ARRIVAL

DATE: DAY	MONTH	YR.	TIME
1	JUL	03	2255

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet)
☐ PRIVATE VEHICLE ☐ AMBULANCE
☒ OTHER (Specify) Medevac

CURRENT MEDS. (tetanus immunization and other data): None

HISTORY OBTAINED FROM ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES: NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code):

HOME TELE. NO. (Inc. area code):

CHIEF COMPLAINT(S) (Include symptom(s), duration):

SEX: ♂ AGE: 24

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER:

VITAL SIGNS

TIME	2255		
BP	103/61		
PULSE	79		
RESP.	18		
TEMP.	98.2		
WT. (Child)	150		

CATEGORY (See reverse)
X EMERGENT
URGENT
NON-URGENT

ORDERS	INITS.	TIME
~~[illegible]~~ XRY		
CBC Met Pane	[redacted]	2300
	b6-2	

ASSESSMENT/DIAGNOSIS
(R) X-Fix / (L) hypothenar sutures

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

(R) Tib X-Fix & (L) hypothenar tendon repair ~ 20-25 days ago in Iraqi hosp. presents for follow-up care. PMHx

(O) X-Fx (R) tib open wound.
(L) hypothenar F/q.ed c̄ sutures.

b(6)-2

DISPOSITION (Check all that apply)
HOME | FULL DUTY
QUARTERS: 24 Hrs. | 48 Hrs. | 72 Hrs.
MODIFIED DUTY UNTIL: DAY | MONTH | YEAR
REFERRED TO (Indicate clinic):
EMERGENCY | TODAY
72 HOURS | ROUTINE
ADMIT. TO HOSP. UNIT/SERVICE: ORTHO.

CONDITION UPON RELEASE
IMPROVED | UNCHANGED
DETERIORATED

TIME OF RELEASE:

(CONTINUE ON SF 507, IF NEEDED)

[redacted]

PATIENT'S IDENTIFICATION (Mechanical imprint) FOR WRITTEN ENTRIES GIVE: Name - last, first, middle; SSN; DOB, service status, name and relation of sponsor or next of kin. (IMPORTANT: LIST FACILITY HOLDING TREATMENT RECORD).

4 [redacted] b(6)-4

SIGNATURE OF PROVIDER AND ID STAMP

INSTRUCTIONS TO PATIENT (Include medications, any limitations and follow-up plans)

EMERGENCY CARE AND TREATMENT

MEDCOM - 12728 PPY

STANDARD FORM 558 (Rev. 6-82)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

FOR Use of this form, see AR 40-407; the proponent agency is The Office of the Surgeon General.

1. AGE: 27

HEIGHT:

WEIGHT:

2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication)
☒ NKDA ☐ PCN ☐ LATEX ☐ IODINE ☐ TAPE ☐ FOOD
REACTION:

3. PREVIOUS SURGERY [ ] NO [X] YES (type):
Ext. Fix RLE

4. PROPOSED SURGICAL PROCEDURE: s/p GSW (L) hand x (R) tibia

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition intact ̄x wound sites
Tobacco____ppd X___yrs. Body Piercing ø Diabetes (Y) [✓ (N)] ROM ↓ ASA/Motrin w/72 hrs (Y) [✓ (N)]
ETOH ø Implants ø Respiratory Disease (Asthma/COPD) (Y) [✓ (N)] Anticoagulants (Y) [✓ (N)]
Glasses/Contact (Y) [✓ (N)] Dentures ø Hypertension (Y) [✓ (N)] Herbal Medicines (Y) [✓ (N)] MEDS: Ancef, morph

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to: ✓ 1) Surgical Procedure & Operating Room Environment ___ 2) Separation Anxiety (Child) ✓ 3) Surgical Outcomes	ø Pt. verbalizes any specific anxiety. ø Pt. Exhibits relaxed body posture.	ø Allow pt. to verbalize freely. ø Explain OR environment and answer questions regarding surgery. ø Offer comfort measures. (e.g., warm blanket, touch). ø Explain all nursing procedures before they are done. ø Remain with pt. whenever possible. ø Maintain family interface. Parents to stay with pt.
B. AERATION ✓ Potential for respiratory dysfunction due to: ✓ 1) Positioning ✓ 2) Effects of Anesthesia ✓ 3) Medical/Smoking History	ø Pt. will be able to breathe without difficulty during immediate intraoperative phase.	ø Offer to elevate head of litter or offer pillow. ø Observe pt. while awaiting surgery for signs of distress. ø Assist anesthesia during intubation and extubation.
C. INTEGUMENT ✓ Potential impairment of skin integrity due to: ✓ 1) Intraoperative Immobility ✓ 2) ESU Pad Placement ✓ 3) Positional Aids ___ 4) Prosthesis ✓ 5) Pooling of Prep Solutions	ø Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened areas).	ø Utilize pressure preventing devices on OR table and accessories. ø Check for proper positioning and support to maintain good body alignment. ø Pad pressure points. ø Place ESU ground pad on non compromised skin surface area. ø Keep prep fluids from pooling.

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

[redacted] b(6)-4

[redacted] b(6)-2

VERIFICATIONS AT HOLDING AREA:
! ID/Allergy Band ! Dentures Removed
! H & P ! Contacts Removed
! NPO Since MN ! Jewelry Removed
! UHCG/LMP ! Body Pierce Removed
! Consent/Blood Transfusion Signed/Witnessed/Dated
! Surgical Site/Consent verified by Pt./Anesthesia/Surgeon
! Contact Precautions (Y) [✓ (N)]
! Family/Friend: ø

DA FORM 5179, JUN 91 Previous editions are obsolete. USAPA V1.0

MEDCOM - 12729

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to: ✓ 1) Intraoperative Mobility ✓ 2) Positioning ✓ 3) Existing Disease ✓ 4) Safety Devices ✓ 5) Hypothermia	✓ Pt. will exhibit signs of adequate tissue perfusion (e.g.. color, warmth, pedal pulse.	✓ Check for support stockings or ace wraps. If none, check with doctors. ✓ Check that safety straps are correctly applied. ✓ Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. ✓ Check that rings and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to: ✓ 1) Pain ✓ 2) Intraoperative Hazards ✓ 3) Prosthesis ___ 4) Positioning ✓ 5) Transfer pt. to/from OR table E.2. ✓ Potential discomfort due to: ✓ 1) Length of Surgery ✓ 2) Positioning ~~✓ 3) Arthritis~~ KN	✓ Pt. will be transferred to OR table without difficulty. ✓ Pt. will not experience unnecessary physical discomfort.	✓ Have sufficient people available for transfer. ✓ Insure proper body alignment. ✓ Allow patient to lie in position of comfort while waiting for surgery. ✓ Offer support (i.e.. pillows, bath towels, etc.) for positioning.
F. SPECIAL SENSES F.1. ✓ Diminished visual perception due to being: ✓ 1) Pre-Medicated ___ 2) W/O Glasses F.2. ✓ Potential for decreased communication due to: ___ 1) Diminished Hearing ✓ 2) Language Barrier F.3. ___ Potential injury due to dentures: ___ 1) Upper ___ 4) Caps ___ 2) Lower ___ 5) Crowns ___ 3) Bridges	✓ Pt. will be made aware of surroundings prior to anesthesia induction. ✓ Pt. will be transferred safely to OR table. ✓ Pt. will be able to understand instructions. ✓ Minimize danger of injury during intraop period.	✓ Introduce self. Keep pt. informed as to where he/she is and what is happening. ✓ Inform pt. in which direction to move and assist if necessary. ✓ Speak clearly and slowly. ✓ Address pt. from either side. ✓ Validate pt.'s understanding of verbal communication. ✓ Verify removal of dentures.
G. OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs. /	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes. /	OTHER NURSING INTERVENTIONS Or continuation of above interventions /

10. OR NURSING INTERVENTIONS COMPLETED/ADDITIONAL INTRAOPERATIVE INTERVENTIONS NOTED.

[redacted] b(6)-2 CPT/AN 3 July 03 DATE

11. POSTOPERATIVE EVALUATION: SKIN INTEGRITY: Bovie Pad Site: ☒ Clean and Dry ☐ Red ☐ N/A DRESSING DRY & INTACT: [✓ Y] N

LEVEL OF CONSCIOUSNESS: ☐ A&O ☐ Drowsy ☒ Sleepy ☐ Intubated

LEVEL OF ACTIVITY: ☐ Moves All Extremities ☒ Moves Upper Extremities ☐ Transferred to litter with roller due to spinal

BREATHING EASY: [✓ Y] N

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] b(6)-2

DATE: 2 Jul 03 TIME: 1000

13. POSTOPERATIVE [redacted] PREPARED BY (Signature and Title) CPT/AN

DATE: 3 July 03 TIME: 1500 b(6)-2

REVERSE OF FORM 5179, JUN 91

MEDCOM - 12730 USAPA V1.0

MEDICAL RECORD | **PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT**

FOR Use of this form, see AR 40-407; the proponent agency is The Office of the Surgeon General.

1. AGE: 27

HEIGHT:

WEIGHT:

2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication)
☒ NKDA ☐ PCN ☐ LATEX ☐ IODINE ☐ TAPE ☐ FOOD
REACTION:

3. PREVIOUS SURGERY [ ] NO [X] YES (type):
ExFix (R) Tibia, I+D (R) Tibia

4. PROPOSED SURGICAL PROCEDURE:
(R) Tibia I+D -vs- BKA

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition (R) LL + foot necrotic

see H+P

Tobacco___ppd X___yrs. Body Piercing ø Diabetes (Y) [✓ N] ROM_____ ASA/Motrin w/72 hrs (Y) [✓ N]

ETOH ø Implants ø Respiratory Disease (Asthma/COPD) (Y) [✓ N] Anticoagulants (Y) [✓ N]

Glasses/Contact (Y) [✓ N] Dentures ø Hypertension (Y) [✓ N] Herbal Medicines (Y) [✓ N] MEDS:

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to: ✓ 1) Surgical Procedure & Operating Room Environment ___ 2) Separation Anxiety (Child) ✓ 3) Surgical Outcomes	q Pt. verbalizes any specific anxiety. q Pt. Exhibits relaxed body posture.	q Allow pt. to verbalize freely. q Explain OR environment and answer questions regarding surgery. q Offer comfort measures. (e.g., warm blanket, touch). q Explain all nursing procedures before they are done. q Remain with pt. whenever possible. q Maintain family interface. Parents to stay with pt.
B. AERATION ✓ Potential for respiratory dysfunction due to: ✓ 1) Positioning ✓ 2) Effects of Anesthesia ___ 3) Medical/Smoking History	✓ Pt. will be able to breathe without difficulty during immediate intraoperative phase.	q Offer to elevate head of litter or offer pillow. q Observe pt. while awaiting surgery for signs of distress. q Assist anesthesia during intubation and extubation.
C. INTEGUMENT ✓ Potential impairment of skin integrity due to: ✓ 1) Intraoperative Immobility ✓ 2) ESU Pad Placement ✓ 3) Positional Aids ___ 4) Prosthesis ✓ 5) Pooling of Prep Solutions	✓ Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened areas).	o Utilize pressure preventing devices on OR table and accessories. o Check for proper positioning and support to maintain good body alignment. o Pad pressure points. o Place ESU ground pad on non compromised skin surface area. o Keep prep fluids from pooling.

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

# [redacted] b(u)-2

ICU-3

VERIFICATIONS AT HOLDING AREA:

! ID/Allergy Band ! Dentures Removed
! H & P ! Contacts Removed
! NPO Since noon ! Jewelry Removed
! UHCG/LMP ! Body Pierce Removed
! Consent/Blood Transfusion Signed/Witnessed/Dated
! Surgical Site/Consent verified by Pt./Anesthesia/Surgeon
! Contact Precautions (Y) [✓ N]
! Family/Friend: ø

DA FORM 5179, JUN 91 Previous editions are obsolete. USAPA V1.0

MEDCOM - 12731

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to: ✓ 1) Intraoperative Mobility ✓ 2) Positioning ____ 3) Existing Disease ✓ 4) Safety Devices ✓ 5) Hypothermia	✓ o Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse.	o Check for support stockings or ace wraps. If none, check with doctors. ✓ o Check that safety straps are correctly applied. o Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. ✓ o Check that rings and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL E.1. ____ Potential impairment of mobility due to: ____ 1) Pain ✓ 2) Intraoperative Hazards ____ 3) Prosthesis ✓ 4) Positioning ✓ 5) Transfer pt. to/from OR table E.2. ✓ Potential discomfort due to: ✓ 1) Length of Surgery ✓ 2) Positioning ____ 3) Arthritis	✓ o Pt. will be transferred to OR table without difficulty. ✓ o Pt. will not experience unnecessary physical discomfort.	✓ o Have sufficient people available for transfer. ✓ o Insure proper body alignment. ✓ o Allow patient to lie in position of comfort while waiting for surgery. ✓ o Offer support (i.e., pillows, bath towels, etc.) for positioning.
F. SPECIAL SENSES F.1. ✓ Diminished visual perception due to being: ✓ 1) Pre-Medicated ____ 2) W/O Glasses F.2. ✓ Potential for decreased communication due to: ____ 1) Diminished Hearing ✓ 2) Language Barrier F.3. ____ Potential injury due to dentures: ____ 1) Upper ____ 4) Caps ____ 2) Lower ____ 5) Crowns ____ 3) Bridges	✓ o Pt. will be made aware of surroundings prior to anesthesia induction. ✓ o Pt. will be transferred safely to OR table. ✓ o Pt. will be able to understand instructions. ✓ o Minimize danger of injury during intraop period. Iraqi national	✓ o Introduce self. Keep pt. informed as to where he/she is and what is happening. ✓ o Inform pt. in which direction to move and assist if necessary. ✓ o Speak clearly and slowly. ✓ o Address pt. from either side. ✓ o Validate pt.'s understanding of verbal communication. o Verify removal of dentures.
G. OTHER PATIENT PROBLEMS/NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

10. OR NURSING INTERVENTIONS COMPLETED/ADDITIONAL INTRAOPERATIVE INTERVENTIONS NOTED.

[redacted] b(6)-2 6 July 03 DATE

11. POSTOPERATIVE EVALUATION: SKIN INTEGRITY: Bovie Pad Site: ☒ Clean and Dry ☐ Red ☐ N/A DRESSING DRY & INTACT: [✓ (Y)] (N)
LEVEL OF CONSCIOUSNESS: ☐ A&O ☒ Drowsy ☐ Sleepy ☐ Intubated
LEVEL OF ACTIVITY: ☐ Moves All Extremities ☒ Moves Upper Extremities BREATHING EASY: [✓ (Y)] (N) b(6)-2
☐ Transferred to litter with roller due to spinal

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] CPT/AN b(6)-2
DATE: 6 July 03 TIME: 1530

13. POSTOPERATIVE EVALUATION BY (Signature and Title) [redacted] CPT/AN
DATE: 6 July 03 TIME: 1940

REVERSE OF FORM 5179, JUN 91

MEDCOM - 12732 USAPA V1.0

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

FOR Use of this form, see AR 40-407; the proponent agency is The Office of the Surgeon General.

1. AGE: 25

HEIGHT: /

WEIGHT: 65 kg

2. KNOWN ALLERGIC SENSITIVITIES (e.g.. Iodine, Tape, Medication)
☒ NKDA ☐ PCN ☐ LATEX ☐ IODINE ☐ TAPE ☐ FOOD
REACTION:

3. PREVIOUS SURGERY [ ] NO [☒] YES (type):
GSW (R) Tibi [illegible] (R) [illegible] s/p [illegible]

4. PROPOSED SURGICAL PROCEDURE:
I&D amputated (R) leg

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition______
Tobacco___ppd X___yrs. Body Piercing______ Diabetes (Y) (N) ROM______ ASA/Motrin w/72 hrs (Y) (N)
ETOH______ Implants______ Respiratory Disease (Asthma COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures______ Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS:

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to: ✓ 1) Surgical Procedure & Operating Room Environment ✓ 2) Separation Anxiety (Child) ✓ 3) Surgical Outcomes	o Pt. verbalizes any specific anxiety. o Pt. Exhibits relaxed body posture.	o Allow pt. to verbalize freely. o Explain OR environment and answer questions regarding surgery. o Offer comfort measures. (e.g.. warm blanket. touch). o Explain all nursing procedures before they are done. o Remain with pt. whenever possible. o Maintain family interface. Parents to stay with pt.
B. AERATION ✓ Potential for respiratory dysfunction due to: ✓ 1) Positioning ✓ 2) Effects of Anesthesia ✓ 3) Medical/Smoking History	o Pt. will be able to breathe without difficulty during immediate intraoperative phase .	o Offer to elevate head of litter or offer pillow. o Observe pt. while awaiting surgery for signs of distress. o Assist anesthesia during intubation and extubation.
C. INTEGUMENT ✓ Potential impairment of skin integrity due to: ✓ 1) Intraoperative Immobility ✓ 2) ESU Pad Placement ✓ 3) Positional Aids ✓ 4) Prosthesis ✓ 5) Pooling of Prep Solutions	o Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened areas).	o Utilize pressure preventing devices on OR table and accessories. o Check for proper positioning and support to maintain good body alignment. o Pad pressure points. o Place ESU ground pad on non compromised skin surface area. o Keep prep fluids from pooling.

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

[redacted]

blcd-4

VERIFICATIONS AT HOLDING AREA:
! ID/Allergy Band ! Dentures Removed
! H & P ! Contacts Removed
! NPO Since____ ! Jewelry Removed
! UHCG/LMP ! Body Pierce Removed
! Consent/Blood Transfusion Signed/Witnessed/Dated
! Surgical Site/Consent verified by Pt./Anesthesia/Surgeon
! Contact Precautions (Y) (N)
! Family/Friend:______

DA FORM 5179, JUN 91 Previous editions are obsolete. USAPA V1.0

MEDCOM - 12733

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION XO Potential for inadequate tissue perfusion due to: XO 1) Intraoperative Mobility XO 2) Positioning XO 3) Existing Disease XO 4) Safety Devices XO 5) Hypothermia	o Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse.	o Check for support stockings or ace wraps. If none, check with doctors. o Check that safety straps are correctly applied. o Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. o. Check that rings and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL E.1. XO Potential impairment of mobility due to: XO 1) Pain XO 2) Intraoperative Hazards XO 3) Prosthesis XO 4) Positioning XO 5) Transfer pt. to/from OR table E.2. XO Potential discomfort due to: XO 1) Length of Surgery XO 2) Positioning XO 3) Arthritis	o Pt. will be transferred to OR table without difficulty. o Pt. will not experience unnecessary physical discomfort.	o Have sufficient people available for transfer. o Insure proper body alignment. o Allow patient to lie in position of comfort while waiting for surgery. o Offer support (i.e., pillows, bath towels, etc.) for positioning.
F. SPECIAL SENSES F.1. ______ Diminished visual perception due to being: ______ 1) Pre-Medicated ______ 2) W/O Glasses F.2. XO Potential for decreased communication due to: ______ 1) Diminished Hearing XO 2) Language Barrier F.3. ______ Potential injury due to dentures: ______ 1) Upper ______ 4) Caps ______ 2) Lower ______ 5) Crowns ______ 3) Bridges	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR table. o Pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt. from ________ side. o Validate pt.'s understanding of verbal communication. o Verify removal of dentures.
G OTHER PATIENT PROBLEMS/NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

10. OR NURSING INTERVENTIONS COMPLETED/ADDITIONAL INTRAOPERATIVE INTERVENTIONS NOTED.

[redacted] b(6)-2 12 July 03 DATE

11. POSTOPERATIVE EVALUATION: SKIN INTEGRITY: Bovie Pad Site: ☒ Clean and Dry ☐ Red ☐ N/A

LEVEL OF CONSCIOUSNESS: ☐ A&O ☐ Drowsy ☒ Sleepy ☐ Intubated

LEVEL OF ACTIVITY: ☒ Moves All Extremities ☐ Moves Upper Extremities ☐ Transferred to litter with roller due to spinal

DRESSING DRY & INTACT: [✓ (Y)] (N)

BREATHING EASY: [✓ (Y)] (N)

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] b(6)-2

DATE: 12 July 03 TIME: 0650

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] b(6)-2

DATE: 0656 TIME: 12 July 03

REVERSE OF FORM 5179, JUN 91

MEDCOM - 12734 USAPA V1.0

MEDICAL RECORD - INTRAOPERAT DOCUMENT

For use of this form, see AR 40-66, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA: [illegible] BY Anesthesia

2. PATIENT IDENTIFI[redacted] PROCEDURE
VERIFIED BY CPT b(6)-2

3. DATE 3 July 03
TIME PATIENT ARRIVED IN SUITE 1955

4. PATIENT IN ROOM
TIME 1955
NUMBER 1-1 8

5. PREOPERATIVE EMOTIONAL STATUS

☒ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted] b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

COMMENTS: proper body alignment maintained, 2 armboards used for positioning of left arm, position approved by surgeon + anesthesia

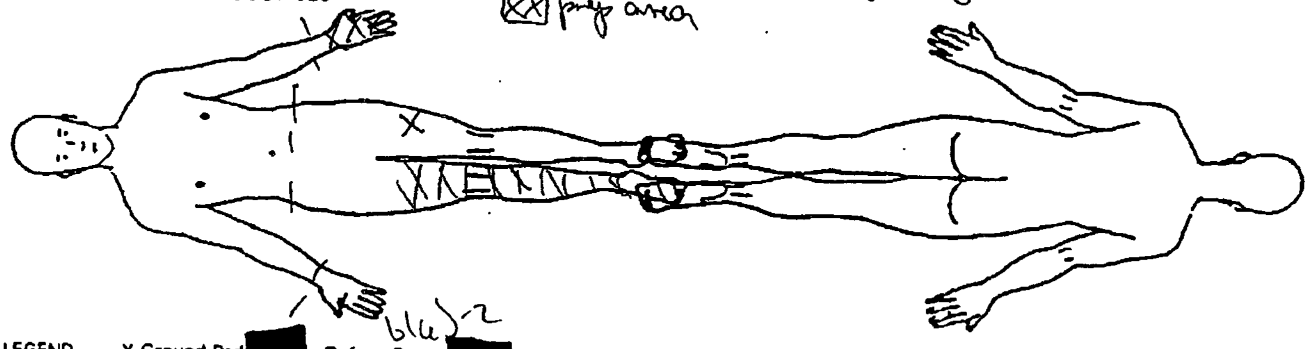
8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR
☐ CLIP
COMMENTS:

PREP SOLUTION *(Specify)* Beta|Beta
SITE: (R) Leg to 3 in above knee BY WHOM: [redacted]
SITE: (L) hand BY WHOM:
b(6)-2
COMMENTS: no peeling or skin removed

9. LOCATION OF EXTERNAL DEVICES

☒☒ prep area



b(6)-2

LEGEND X Ground Pad [redacted] - Safety Strap [redacted] = = = Tourniquet

10. COUNTS

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☐ Yes ☐ No					
Needle Sharp	☐ Yes ☐ No					
Instrument	☐ Yes ☐ No					
Other	☐ Yes ☐ No					

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

[redacted] b(6)-4
ICU #3

12. ELECTROSURGERY DEVICE(S) (ESU) ☐ YES ☐ NO

☐ ESU NO: Valleylab Force 2 ~~#Z4~~ #4
GROUND PAD: BRAND Valleylab Rem Polyhesive II
LOT NO: 69652 2005-04
☐ ESU NO:
GROUND PAD: BRAND
LOT NO:
☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES D MEDCOM - 12735 CH IS OBSOLETE. USAPA V1.01

13. PROSTHESIS, IMPLANTS ☐ YES ☒ NO IF YES NAME: ID NUMBER; MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☒

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):
0.9% Nacl

OTHER ORDERS	TIME	CARRIED OUT BY
none		

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM IF YES, SITE
YES ☐ NO ☒

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 16 F FIC	2.	3.
SITE	1. Bladder	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Fluffs
Kerlix
Acewrap

19. ADDITIONAL INFORMATION
Surgeon: [redacted]
Anesthesia: [redacted] b (6)-2

- FIC in place upon arrival to OR

20. OPERATION(S) PERFORMED
I+D Ⓡ tibia fx + I+D Ⓛ hand

21. PATIENT TRANSFERRED TO
ICU- b(6)-2

TIME See DA7389

METHOD
Liter c Safety

[redacted] NURSE SIGNATURE

REVERSE 87

MEDCOM - 12736

USAPA V1.01

MEDICAL RECORD — **INTRAOPERAT OCUMENT**

For use of this form, see AR 40-66, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: Litter BY: Anesthesia

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY: CPT [redacted] b(6)-2

3. DATE: 6 July 03

TIME PATIENT ARRIVED IN SUITE: 1735

4. PATIENT IN ROOM TIME: 1735 NUMBER: 1-1 | 6

5. PREOPERATIVE EMOTIONAL STATUS

☒ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] b(6)-2 PFC [redacted] (out @ 1835)	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] Maj [redacted] out @ 1845)	RELIEF CIRCULATOR	CPT [redacted] (1910-EOC)

7. POSITION AND POSITIONAL A *(Specify)*

☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

COMMENTS: proper body alignment maintained; arms on padded armboards at less than 90°; position approved by surgeon + anesthesia

8. SKIN PREPARATION

b(6)-2

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

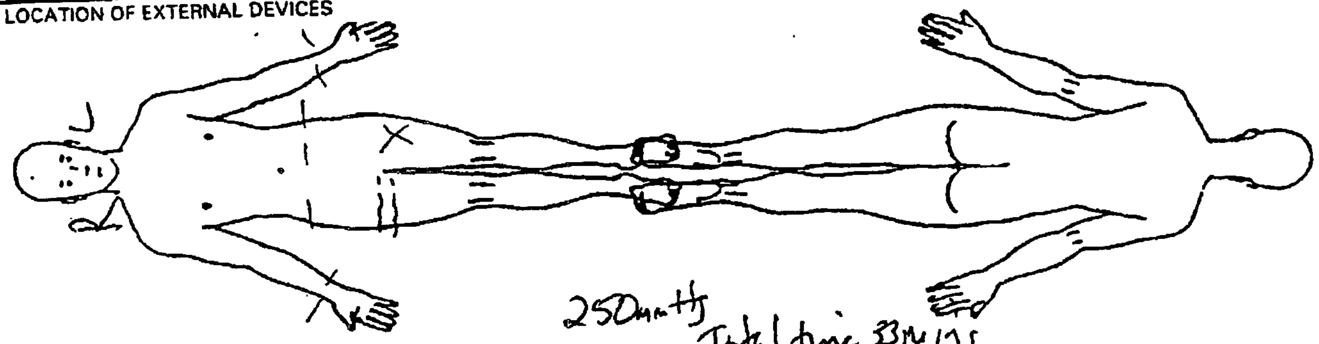
PREP SOLUTION *(Specify)* Beta | Beta

SITE: Ⓡ Leg BY WHOM: [redacted]

SITE: BY WHOM:

COMMENTS: no pooling or skin reaction noted

9. LOCATION OF EXTERNAL DEVICES



250mmHg

Total time 33mins

LEGEND X Ground Pad SM — Safety Strap SM = = = Tourniquet

b(6)-2

10. COUNTS

C = Correct I = Incorrect

10. COUNTS			Other**	First Closing Count.	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes	☐ No	C	C	C	[redacted]	[redacted]
Needle Sharp	☒ Yes	☐ No					
Instrument	☐ Yes	☐ No					
Other	☐ Yes	☐ No					

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

#[redacted]

ICU-3

b(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO

☒ ESU NO: Valleylab Force #2 # 4

GROUND PAD: BRAND Valleylab Rem Polyhesive II

LOT NO: 69652 2005-04

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES I CH IS OBSOLETE. USAPA V1.01

MEDCOM - 12737

13. PROSTHESIS, IMPLANTS ☐ YES ☒ NO IF YES NAME: ID NUMBER; MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☒

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):
0.9% NaCl

OTHER ORDERS	TIME	CARRIED OUT BY
none		

PHYSICIAN'S SIGNATURE [redacted] b(6)-2

15. X-RAY IN OPERAT
YES ☐ NO ☒ IF YES, SITE

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☐	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☐	NAME	NAME
CULTURE (C) YES ☐ NO ☐	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE/SIZE	16F FIC	3/8 in Penrose	
SITE	Bladder	Ⓡ leg	

18. DRESSING/IMMOBILIZATION *(Specify)*
Fluffs
Kerlix
Acewrap

19. ADDITIONAL INFORMATION
Surgeon: [redacted]
Anesthesia: [redacted] b(6)-2

- FIC in place prior to arrival to OR

20. OPERATION(S) PERFORMED
Ⓡ BKA, Dressing Δ Ⓛ hand

21. PATIENT TRANSFERRED TO ICU 3 b(6)-2
TIME See DA7389 1940
METHOD litter

22. REGISTERED NURSE SIGNATURE [redacted] CPT AN [redacted]

b(6)-2

MEDICAL RECORD — **INTRAOPERAT DOCUMENT**
For use of this form, see AR 40-66, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: Litter BY Anesthesia
2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY 1LT [redacted] b(6)-2
3. DATE 8 JUL 03 TIME PATIENT ARRIVED IN SUITE 0815
4. PATIENT IN ROOM TIME 0815 NUMBER 2-1

5. PREOPERATIVE EMOTIONAL STATUS

☒ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS: NPO p̄ MN, NKDA

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted] b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	1LT [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)* Supine on padded OR table. BUE on padded armboards <90°.

☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

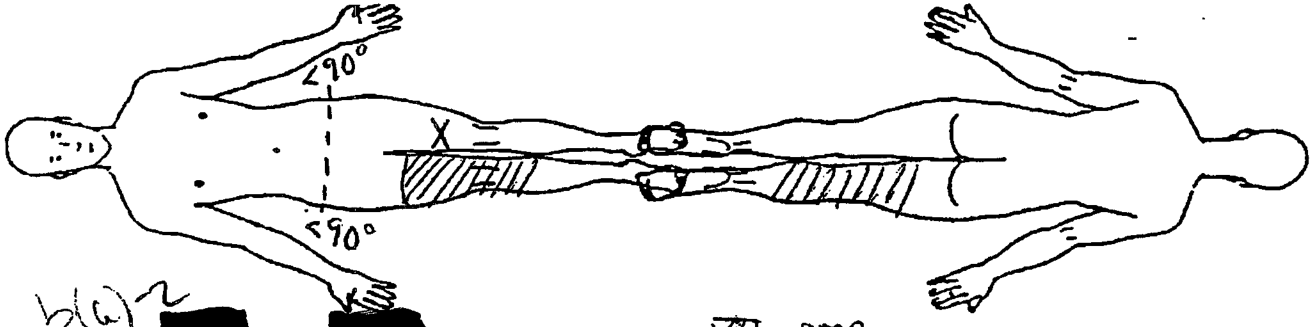
COMMENTS: Normal anatomic body alignment maintained

8. SKIN PREPARATION

HAIR REMOVAL ☒ YES ☐ NO Dr. Nessen
DONE BY: ☒ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☒ RAZOR
☐ CLIP (R) BKA stump
COMMENTS: No nicks or cuts

PREP SOLUTION *(Specify)* Betadine/Betadine
SITE: Right leg BY WHOM:
SITE: BY WHOM: 1LT [redacted]
COMMENTS: No pooling or adverse reaction

9. LOCATION OF EXTERNAL DEVICES



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

LEGEND X Ground Pad -- Safety Strap === Tourniquet ▨ - prep

b(6)-2

Initial: PFC [redacted] 1LT

10. COUNTS		C = Correct I = Incorrect Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No	/	C	C	PFC [redacted]	1LT [redacted]
Needle Sharp	☒ Yes ☐ No	/				
Instrument	☐ Yes ☒ No		/	/		
Other	☐ Yes ☒ No					

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

# [redacted]

b(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO

☒ ESU NO: # 000450 cut 30 coag 30
GROUND PAD: BRAND VL REM Polyhesive II
LOT NO: 657016 Exp 2004-11

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES L... ...ICH IS OBSOLETE. MEDCOM - 12739 USAPA V1.01

13. PROSTHESIS, IMPLANTS ☐ YES ☒ NO IF YES NAME: ID NUMBER; MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☐

MEDICATIONS, SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
N/A					

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):
0.9% NaCl - Q.S.

OTHER ORDERS	TIME	CARRIED OUT BY
N/A		

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM IF YES, SITE
YES ☐ NO ☒

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. #10 J-P drain	2.	3.
SITE	1. Right BKA Stump	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Fluffs
Kerlix
ACE

19. ADDITIONAL INFORMATION
Surgeon: Dr [redacted] Dr. [redacted]
Anesthesia: MAJ [redacted] b(6)-2

GETA

Pt. arrived in OR c̄ patent Foley cath.
DA 5179 in Chart

20. OPERATION(S) PERFORMED
Revision x wash-out RBKA

21. PATIENT TRANSFERRED TO ICU 3 TIME 1006 METHOD LITTER c̄ O2

22. REGISTERED NURSE SIGNATURE b(6)-2 [redacted] RN

REVERSE OF DA FORM 5179-1, OCT 87 USAPA V1.01

MEDCOM - 12740

MEDICAL RECORD — **INTRAOPERA OCUMENT**

For use of this form, see AR 40-66, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Litter BY OR Staff

2. PATIENT I[redacted]WED AND PROCEDURE VERIFIED BY b(6)-2

3. DATE 11 Jul 03 TIME PATIENT ARRIVED IN SUITE 1310

4. PATIENT IN [redacted] TIME 1310 NUMBER 1-1

5. PREOPERATIVE EMOTIONAL STATUS

☒ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	Spc [redacted] b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	Maj [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

COMMENTS: arms extended on armboards ∠90° bilaterally

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Beta/Beta

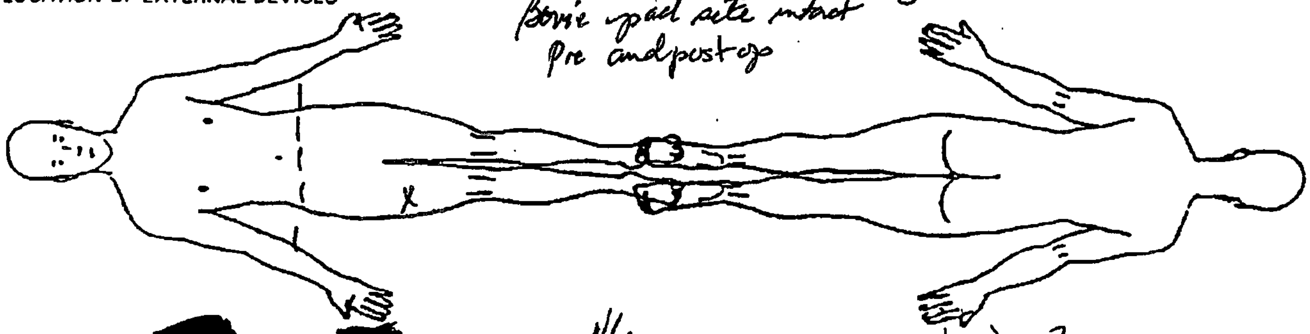
SITE: Rt leg BY WHOM: Maj [redacted]

SITE: BY WHOM: b(6)-2

COMMENTS: ∅ pooling

9. LOCATION OF EXTERNAL DEVICES

Bovie pad site intact Pre and post op



LEGEND X Gro[redacted]d -- S[redacted]Strap = = = Tourniquet N/A

b(6)-2

10. COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
			C = Correct I = Incorrect		Initial:	[redacted]	[redacted]
Sponge	☑ Yes	☐ No	/	C	C	[redacted]	[redacted]
Needle Sharp	☑ Yes	☐ No	/	C	C		
Instrument	☐ Yes	☑ No	/	/	/		
Other	☐ Yes	☑ No	/	/	/		

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

#[redacted]

b(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO

Cut 30 Coag 30

☐ ESU NO: Valleylab

GROUND PAD: BRAND Valleylab

LOT NO: 65706

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA ... H IS OBSOLETE. USAPA V1.01

MEDCOM - 12741

13. PROSTHESIS, IMPLANTS ☐ YES ☒ NO IF YES NAME: ID NUMBER; MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☒

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

NS

OTHER ORDERS	TIME	CARRIED OUT BY
None		

PHYSICIAN'S SIGNATURE [redacted] b(6)-2

15. X-RAY IN OPERATING R IF YES, SITE

YES ☐ NO ☒

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

TYPE/SIZE	1.	2.	3.
SITE	1.	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

Fluffs
Kerlix

19. ADDITIONAL INFORMATION

WC II

surgeon: [redacted] b(6)-2

Anesthesia: [redacted]

20. OPERATION(S) PERFORMED

I&D Rt stump

21. PATIENT TRANSFERRED TO ICU3 b(6)-2 TIME 1414 METHOD litter

22. RE [redacted] MAJ AN

REVERS [redacted] A FORM 5179-1, OCT 87 USAPA V1.01

MEDCOM - 12742

ACLU-RDI 1592 p.635

MEDICAL RECORD – **INTRAOPERAT OCUMENT**

For use of this form, see AR 40-66, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: Gurney BY OR personnel

2. PATIENT IDENTIFIED, RECO[redacted]D AND PROCEDURE VERIFIED BY Cpt [redacted] b(6)-2

3. DATE 12 Apr.03 TIME PATIENT ARRIVED IN SUITE 0555

4. PATIENT IN ROOM TIME 0600 NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

☒ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	Spc. [redacted] b(6)-2	RELIEF SCRUB	b(6)-2
ASSIGNED CIRCULATOR	Cpt. [redacted]	RELIEF CIRCULATOR	LTC [redacted]

7. POSITION AND POSITIONAL AIDS *(Specify)*

☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

COMMENTS:

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

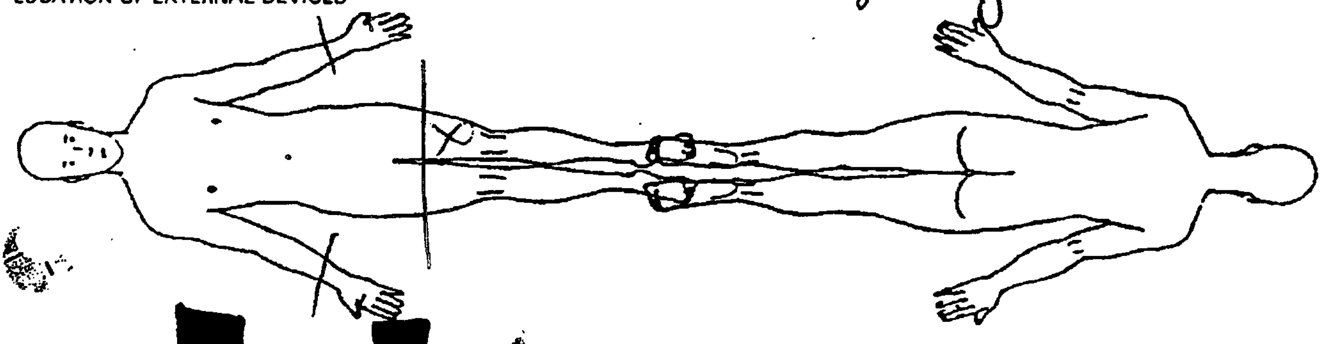
PREP SOLUTION *(Specify)* Betadine soap/scrub

SITE: BY WHOM:

SITE: (R) stump + thigh BY WHOM: Ltc [redacted]

COMMENTS: No pooling b(6)-2

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Grou[redacted]ad -- Saf[redacted]trap ▨== Tourniquet

10. COUNTS

b(6)-2

10. COUNTS			C = Correct I = Incorrect Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes	☐ No	/	C	C	Spc [redacted]	Cpt [redacted]
Needle Sharp	☒ Yes	☐ No	/				
Instrument	☐ Yes	☒ No	/	/	/	/ / /	/ /
Other	☐ Yes	☒ No	/	/	/	/ / /	/ /

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

[redacted]

b(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO

☒ ESU NO: 1

GROUND PAD: BRAND valleylab

LOT NO: 657[illegible]

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

cut: 30 coag: 30

DA FORM 5179-1, OCT 87 REPLACES D... MEDCOM - 12743 ...CH IS OBSOLETE. USAPA V1.01

13. PROSTHESIS, IMPLANTS ☐ YES ☒ NO IF YES NAME: ID NUMBER; MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☒ NO ☐

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

0.9% NaCl

OTHER ORDERS	TIME	CARRIED OUT BY
[redacted]		

PHYSICIAN'S SIGNATURE b(6)-2

15. X-RAY IN OPERATING ROOM IF YES, SITE

YES ☐ NO ☒

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

TYPE/SIZE	1.	2.	3.
SITE	1.	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

Kerlix, Fluff, 4x8, DG

19. ADDITIONAL INFORMATION

Anesthesia - OR Vietas, RNA

Surgeon - Dr [redacted]

b(6)-2

20. OPERATION(S) PERFORMED

I+D Lt. amputation stump/ leg

21. PATIENT TRANSFERRED TO ICU #3 b(6)-2 TIME 06-13 METHOD via litter

[redacted] LTC, AN. [redacted]

[redacted] OF DA FORM 5179-1, OC [redacted] USAPA V1.01

b(6)-2

MEDCOM - 12744

MEDICAL RECORD | **INTRAOPERATIV_ .OCUMENT**
For use of this form, see AR 40-66, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: Litter BY Anesthesia

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY 1LT [redacted] b(6)-2

3. DATE 13 July 03 TIME PATIENT ARRIVED IN SUITE 0755

4. PATIENT IN ROOM TIME 0755 NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

☒ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS:
NPO p̄ MN. NKDA

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted] 91D b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	1LT [redacted] 66E CPT [redacted] 66E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL [redacted] - supine on padded OR table BUE on padded armboards <90° Safety strap across mid-abdomen.

☐ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

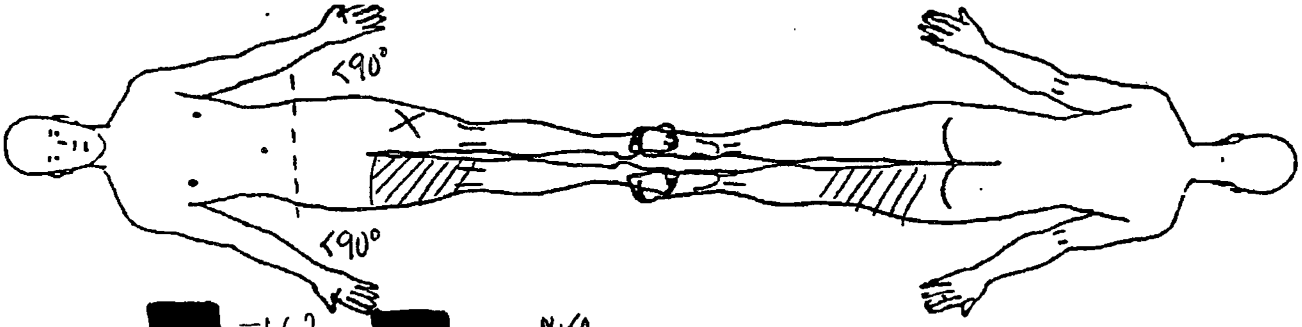
COMMENTS: Normal anatomic body alignment maintained.

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR
☐ CLIP
COMMENTS: N/A

PREP SOLUTION *(Specify)* Betadine/Betadine
SITE: Right leg BY WHOM: CPT [redacted]
SITE: BY WHOM:
COMMENTS: No pooling or adverse reaction b(6)-2

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad [redacted] b6-2 -- Safety [redacted] N/A === Tourniquet

Initial: PFC 1LT [redacted]

C = Correct I = Incorrect

b(6)-2

10. COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes	☐ No		C	C	PFC [redacted]	1LT [redacted]
Needle Sharp	☒ Yes	☐ No					
Instrument	☐ Yes	☒ No					
Other	☐ Yes	☒ No					

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

[redacted]
b(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO

☒ ESU NO: # 4 Cut 30 Coag 30
GROUND PAD: BRAND VL REM Polyhesive II
LOT NO: 68936 Exp 2005-03

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA ... WHICH IS OBSOLETE. MEDCOM - 12745 USAPA V1.01

13. PROSTHESIS, IMPLANTS ☐ YES ☒ NO IF YES NAME: ID NUMBER; MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☒ NO ☐

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
Hibiclens Lot 3721H Exp 05/04	Q.S.	intra-op	local application	mfr. Regent Med	Dr [redacted]
					b(6)-2

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):
0.9% NaCl Q.S.

OTHER ORDERS	TIME	CARRIED OUT BY
N/A		

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM IF YES, SITE
YES ☐ NO ☒

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. Fluff packing c̄ Betadine / NaCl soln.	2.	3.
SITE	1. Right BKA Stump	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Fluffs
Kerlix
ACE

19. ADDITIONAL INFORMATION
Surgeon: Dr [redacted]
Anesthesia: MAS [redacted] & MAS [redacted]
b(6)-2

DA 5179 InChart

20. OPERATION(S) PERFORMED
Wash-out Right BKA stump

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU		LITTER c̄ O2

22. REGISTERED NURSE SIGNATURE [redacted] 7AN b(6)-2

REVERSE OF DA FORM 5179-1, OCT 87

USAPA V1.01

MEDCOM - 12746

MEDICAL RECORD — **INTRAOPERAT DOCUMENT**
For use of this form, see AR 40-66, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: litter BY anesthesia	2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY [redacted] b(6)-2
3. DATE 14 JUL 03 TIME PATIENT ARRIVED IN SUITE 1835	4. PATIENT IN ROOM [redacted] TIME 1835 NUMBER

5. PREOPERATIVE EMOTIONAL STATUS

☒ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SGT [redacted] b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

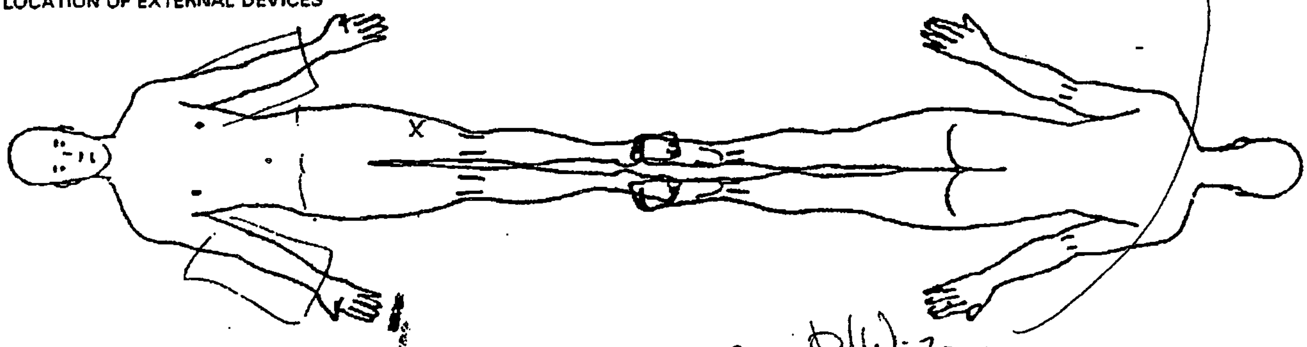
COMMENTS: in proper body alignment

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR
☐ CLIP
COMMENTS:

PREP SOLUTION *(Specify)* Betadine scrub/sol'n
SITE: Ⓡ BKA stump BY WHOM:
SITE: BY WHOM: [redacted]
COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Strap = = = Tourniquet

b(6)-2

10. COUNTS		C = Correct I = Incorrect Other**	First Closing Count	Final Closing Count	Initial [redacted] SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No			C	[redacted]	[redacted]
Needle Sharp	☒ Yes ☐ No			C	[redacted]	[redacted]
Instrument	☐ Yes ☒ No					
Other	☐ Yes ☒ No					

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

#[redacted]

b(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO

☒ ESU NO: 4
GROUND PAD: BRAND Valleylab
LOT NO: #68936

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA MEDCOM - 12747 CH IS OBSOLETE. USAPA V1.01

13. PROSTHESIS, IMPLANTS ☐ YES ☒ NO IF YES NAME: ID NUMBER; MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☒

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

0.9% NS

OTHER ORDERS	TIME	CARRIED OUT BY
None		

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM IF YES, SITE

YES ☐ NO ☒

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

TYPE/SIZE	1.	2.	3.
SITE	1.	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

Fluffs
ABD
Kerlix
Ace

19. ADDITIONAL INFORMATION

Surgeon: [redacted]

Anesthesia: [redacted]

20. OPERATION(S) PERFORMED

I:D Ⓡ BKA stump

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICW 3	1925	Litter w/anesthesia

22. REGIS [redacted] SIGNATURE CPT 10N

REVERSE OF DA OCT 87

(b)(6)-2

MEDCOM - 12748 USAPA V1.01

MEDICAL RECORD | **INTRAOPERATI DOCUMENT**
For use of this form, see AR 40-66, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Gurney BY OR/Anesth.

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY LTC [redacted] b(6)-2

3. DATE 15 Jul. 03 TIME PATIENT ARRIVED IN SUITE 0659

4. PATIENT IN ROOM
TIME 0700 NUMBER 1-1 4

5. PREOPERATIVE EMOTIONAL STATUS

☒ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	Spc. [redacted] b(6)-2	RELIEF SCRUB	Pfc [redacted] b(6)-2
ASSIGNED CIRCULATOR	LTC [redacted]	RELIEF CIRCULATOR	CPT [redacted] 0715-EOC

7. POSITION AND POSITIONAL AIDS *(Specify)*

☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

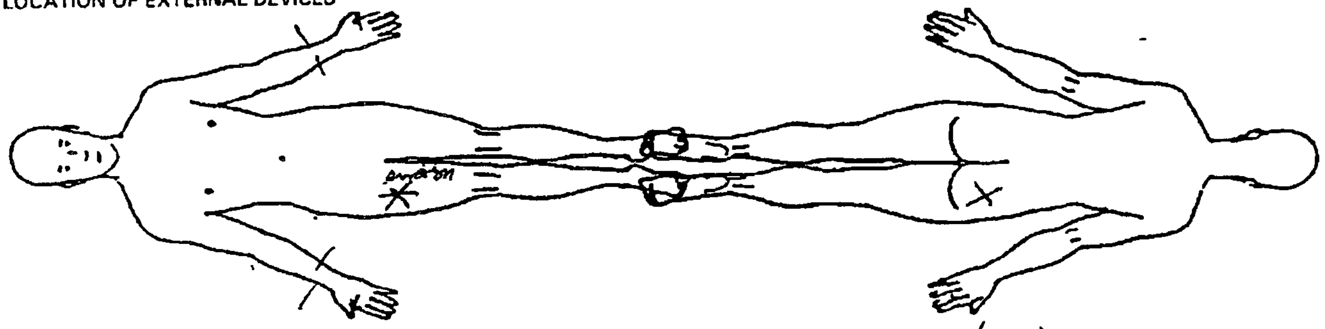
COMMENTS: proper body alignment maintained

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP
COMMENTS:

PREP SOLUTION *(Specify)* Betadine Soap/Sol
SITE Ⓡ Leg (BKA) BY WHOM [redacted]
SITE: BY WHOM: b(6)-2
COMMENTS: no pooling or skin reaction noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Strap = = = Tourniquet

b(6)-2

C = Correct I = Incorrect

10. COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes	☐ No		C	C	[redacted]	[redacted]
Needle Sharp	☒ Yes	☐ No					
Instrument	☐ Yes	☐ No					
Other	☐ Yes	☐ No					

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

[redacted]

b(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO

☒ ESU NO: Valleylab Force 2 #4
GROUND PAD: BRAND VL Rem Polyhesive II
LOT NO: 68936 2005-03

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES I MEDCOM - 12749 ICH IS OBSOLETE. USAPA V1.01

13. PROSTHESIS, IMPLANTS ☐ YES ☒ NO IF YES NAME: ID NUMBER; MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☒

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):
0.9% Nacl

OTHER ORDERS	TIME	CARRIED OUT BY
none [redacted]		

PHYSICIAN'S SIGNATURE [redacted] b(6)-2

15. X-RAY IN OPERATING ROOM IF YES, SITE
YES ☐ NO ☒

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

TYPE/SIZE	1.	2.	3.
SITE	1.	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Fluffs ABD
Kerlix
Acewraps

19. ADDITIONAL INFORMATION
Surgeon: [redacted]
Anesthesia: [redacted] b6-2

- see previous DA 5179 for pre-op assessment and NsgDx → no Δ's

20. OPERATION(S) PERFORMED
I+D Right BKA
close knee wound (R)

21. PATIENT TRANSFERRED TO ICU-3
TIME see DA 7389
METHOD litter

22. REGISTERED NURSE SIGNATURE [redacted] CPT 1-W b(6)-2

REVERSE OF DA FORM 5179-1, OCT 87 USAPA V1.01

MEDCOM - 12750

b(6)-2

MEDICAL RECORD — INTRAOPERAT DOCUMENT

For use of this form, see AR 40-66, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Litter BY O-R Staff

2. PATIENT I[redacted] PROCEDURE VERIFIED BY [redacted] CPT/AN

3. DATE 17 Jul 03 TIME PATIENT ARRIVED IN SUITE ICU → OR

4. PATIENT IN ROOM TIME 0820 NUMBER 2-1/1

5. PREOPERATIVE EMOTIONAL STATUS

☑ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS: NKDA. NPO p̄ MN.

6. NURSING PERSONNEL

ASSIGNED SCRUB	SGT. [redacted] (1st FST) b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT. [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

☑ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

COMMENTS: Ⓑ arm to padded arm board <90°

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☑ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

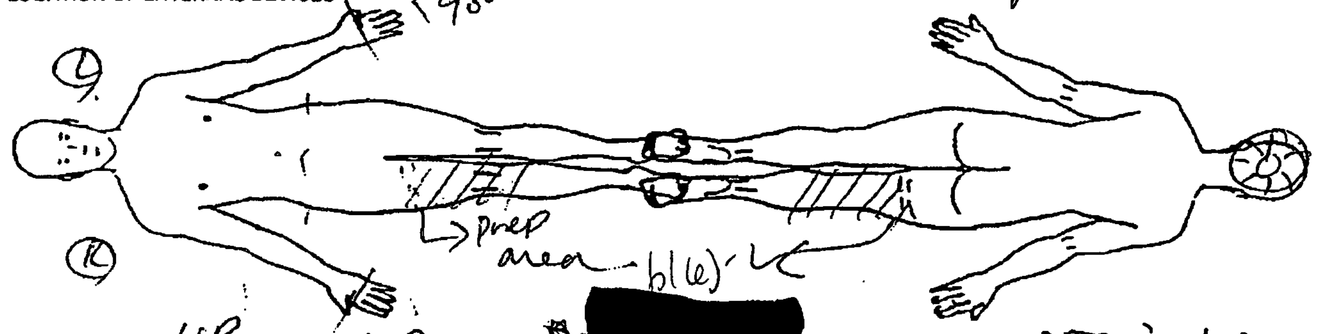
PREP SOLUTION *(Specify)* Betadine S/Sol

SITE: Rt BKA to thigh BY WHOM:

SITE: BY WHOM: ~

COMMENTS: Ⓡ poslinop

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad UP -- Safety Strap UP === Tourniquet [redacted] 275 mmHg 25 minutes

b(6)-2

10. COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
			C = Correct I = Incorrect				
Sponge	☑ Yes	☐ No	/	C	C	SGT [redacted]	CPT. [redacted]
Needle Sharp	☑ Yes	☐ No	/				
Instrument	☐ Yes	☑ No	/	/	/	/	/
Other	☐ Yes	☑ No					

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

EPW # [redacted]

b(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☑ YES ☐ NO

☑ ESU NO: Valley Lab

GROUND PAD: BRAND Polyhesive II

LOT NO: 65706

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO: [redacted] / Cut 30

b(6)-2

DA FORM 5179-1, OCT 87 REPLACES D, MEDCOM - 12751 CH IS OBSOLETE. USAPA V1.01

13. PROSTHESIS, IMPLANTS ☐ YES ☑ NO IF YES NAME: ID NUMBER; MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☑

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S):

0.9% NaCl

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM IF YES, SITE
YES ☐ NO ☑

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☑	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☑	NAME	NAME
CULTURE (C) YES ☐ NO ☑	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☑ NO ☐

TYPE/SIZE	1. Kerlix fluff		3.
SITE	1. (Rt) Knee	2.	3.

18. DRESSING/IMMOBILIZATION (Specify)

fluffs ABD's
Kerlix
Ace.

19. ADDITIONAL INFORMATION

Dr. [redacted] / Dr. [redacted]
CPT. [redacted] (CRNA) b(6)-2

20. OPERATION(S) PERFORMED

(Rt). BKA Revision, washout & debridement

21. PATIENT TRANSFERRED TO b(6)2 ICU TIME See Anes. Record METHOD Litter

22. [redacted] CPT/AN

REVERSE OF DA FORM 5179-1, OCT

USAPA V1.01

MEDCOM - 12752

MEDICAL RECORD | **INTRAOPERATI... DOCUMENT**
For use of this form, see AR 40-66, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: LITTER BY Anesthesia

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY 1LT [redacted] b(6)-2

3. DATE 17 JUL 03 TIME PATIENT ARRIVED IN SUITE 1134

4. PATIENT IN ROOM TIME 1134 NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

☒ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS:
NPO p̄ MN, NKDA

6. NURSING PERSONNEL

ASSIGNED SCRUB	SGT [redacted] 91D b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	1LT [redacted] 66E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)* Pt. supine on padded OR table. BUE on padded arm boards <90°

☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

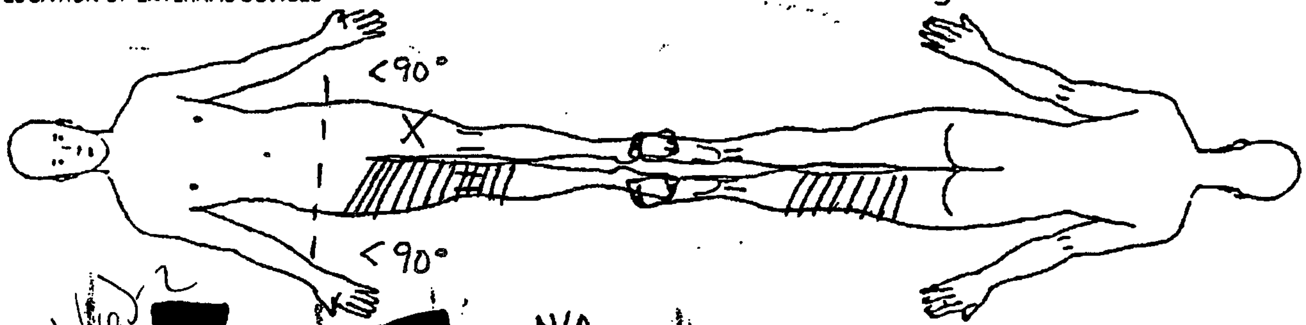
COMMENTS: Normal anatomic body alignment maintained

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR
☐ CLIP
COMMENTS: N/A

PREP SOLUTION *(Specify)* Betadine/Betadine
SITE: Right leg BY WHOM: 1LT [redacted]
SITE: BY WHOM:
Hibiclens scrub intra-op by Dr. [redacted]
COMMENTS: No pooling or adverse reaction

9. LOCATION OF EXTERNAL DEVICES



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

LEGEND X Ground Pad -- Safe[redacted]trap N/A === Tourniquet ▨ - prep

Initial: SGT
1LT [redacted]

C = Correct I = Incorrect

10. COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB b(6)-2	CIRCULATOR
Sponge	☒ Yes	☐ No		C	C	SGT [redacted]	1LT [redacted]
Needle Sharp	☒ Yes	☐ No					
Instrument	☐ Yes	☒ No					
Other	☐ Yes	☒ No					

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

EPW # [redacted]

b(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO

☒ ESU NO: #4. CUT 30 COAG 30
GROUND PAD: BRAND VL REM PolyHesive II
LOT NO:

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA ... CH IS OBSOLETE. MEDCOM - 12753 USAPA V1.01

13. PROSTHESIS, IMPLANTS ☐ YES ☐ NO IF YES NAME: ID NUMBER; MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☐

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):
0.9 % NaCl - Q.S

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM IF YES, SITE
YES ☐ NO ☒

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. Kerlix fluffs c̄ Dakins Soln.	2.	3.
SITE	1. Right BKA stump	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Fluffs
Kerlix
ACE

19. ADDITIONAL INFORMATION
SURGEON : Dr. [redacted]
ANESTHESIA : MAJ [redacted] b(6)-2

DA 5179 In Chart

20. OPERATION(S) PERFORMED
Wash-out BKA stump

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU 2	1438	LITTER c̄ O2

22. REGISTERED NURSE SIGNATURE b(6)-2 [redacted] T/AN

REVERSE OF DA FORM 5179-1, OCT 87 USAPA V1.01

MEDCOM - 12754

MEDICAL RECORD — **INTRAOPERAT DOCUMENT**

For use of this form, see AR 40-66, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA: litter BY Anesthesia

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE
VERIFIED BY CPT [redacted] b(6)-2

3. DATE 18 July 03
TIME PATIENT ARRIVED IN SUITE 0730

4. PATIENT IN ROOM
TIME 0730 NUMBER I-1 1

5. PREOPERATIVE EMOTIONAL STATUS

☒ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS: See previous DA 5179 for pre-op assessment + Nsg. dx -> no Δ's

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted] SSG [redacted]	RELIEF SCRUB	
ASSIGNED CIRCULATOR	1LT [redacted] b(6)-2 CPT [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL [redacted]

☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

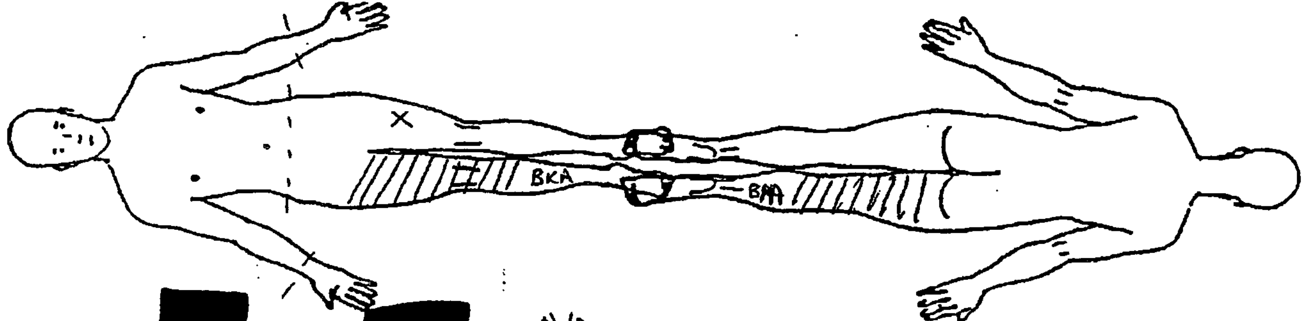
COMMENTS: correct body alignment maintained, arms on padded arm boards at less than 90°, position approved by surgeon + anesthesia

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR
☐ CLIP
COMMENTS: N/A

PREP SOLUTION *(Specify)* Betadine / Betadine
SITE: Right leg BY WHOM: CPT [redacted]
SITE: Right leg Hibiclens scrub in bag BY WHOM: Dr. [redacted] b(6)-2
COMMENTS: No pooling or adverse reaction

9. LOCATION OF EXTERNAL DEVICES



[redacted] [redacted]

LEGEND X Ground Pad -- Safety Strap === Tourniquet N/A

Initial: PFC Nedd
1LT Malachi

10. COUNTS

C = Correct I = Incorrect

		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No		C	C	[redacted]	[redacted]
Needle Sharp	☒ Yes ☐ No					
Instrument	☐ Yes ☒ No					
Other	☐ Yes ☒ No					

b(6)-2

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

# [redacted]
ICW-2 b(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO

☒ ESU NO: #4 cut 30 coag 30
GROUND PAD: BRAND VL REM Polyhesive II
LOT NO: 68936 Exp 2005-11

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FO... WHICH IS OBSOLETE. MEDCOM - 12755 USAPA

13. PROSTHESIS, IMPLANTS ☐ YES ☒ NO IF YES NAME: ID NUMBER; MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☒

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):
0.9% NaCl

OTHER ORDERS	TIME	CARRIED OUT BY
none		

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM IF YES, SITE
YES ☐ NO ☒

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☐	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☐	NAME	NAME
CULTURE (C) YES ☐ NO ☐	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 10mm JP	2.	3.
SITE	1. Ⓡ BKA Stump	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Fluffs Xeroform
Kerlix
Acewrap

19. ADDITIONAL INFORMATION
Surgeon [redacted]
Anesthesia: [redacted] b(6)-2

DA 5179 In Chart

20. OPERATION(S) PERFORMED
I+D Ⓡ BKA + closure of wound

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU-2 b(6)-2	See JA7389	litter

22. REGISTERED NURSE SIGNATURE
[redacted] CPT/AN [redacted]

REVERSE OF DA FORM 5179-1, OCT 87 USAPA V1.01

MEDCOM - 12756

MEDICAL RECORD | **INTRAOPERATI DOCUMENT**
For use of this form, see AR 40-66, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: Litter BY Anesthesia

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY CPT [redacted] b(6)-2

3. DATE 20 July 03 TIME PATIENT ARRIVED IN SUITE 1445

4. PATIENT IN ROOM TIME 1445 NUMBER 1-

5. PREOPERATIVE EMOTIONAL STATUS

☒ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	Pfc [redacted] b(6)2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

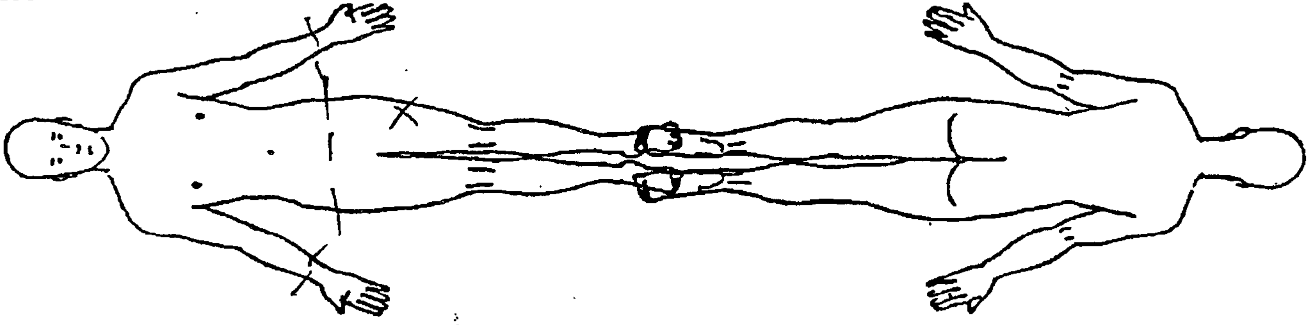
COMMENTS: proper body alignment maintained

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR
☐ CLIP
COMMENTS:

PREP SOLUTION *(Specify)* N/A
SITE: BY WHOM:
SITE: BY WHOM:
COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad[redacted] - Safety Strap[redacted] = = = Tourniquet

C = Correct I = Incorrect

10. COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☐ Yes	☐ No					
Needle Sharp	☐ Yes	☐ No					
Instrument	☐ Yes	☐ No					
Other	☐ Yes	☐ No					

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

#[redacted]
ICW-2 b(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☐ YES ☒ NO

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:
☐ ESU NO:
GROUND PAD: BRAND
LOT NO:
☐ BIPOLAR NO:

MEDCOM - 12757

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.01

13. PROSTHESIS, IMPLANTS ☐ YES ☒ NO IF YES NAME; ID NUMBER; MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☒

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

0.9% NaCl

OTHER ORDERS	TIME	CARRIED OUT BY
None		

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM IF YES, SITE

YES ☐ NO ☒

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☐	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☐	NAME	NAME
CULTURE (C) YES ☐ NO ☐	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

TYPE/SIZE	1.	2.	3.
SITE	1.	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

Fluffs Xeroform

Kerlix

Acewrap

19. ADDITIONAL INFORMATION

- DA 5179 on chart

Surgeon: [redacted]

Anesthesia: [redacted] b(6)-2 All

20. OPERATION([redacted] PERFORMED

~~I+I~~ error Drsg Δ. Ⓡ BKA

21. PATIENT TRANSFERRED TO ICU 2

TIME See DA7389

METHOD Litter

22. REGISTERED NURSE SIGNATURE

[redacted] CPT/AN

REVE[redacted] T 87

MEDCOM - 12758

USAPA V1.01

MEDICAL RECORD | **INTRAOPERA OCUMENT**

For use of this form, see AR 40-66, the propone ncy is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Gurney BY Anesth.

2. PATIENT IDENTIFIED, RE [redacted] AND PROCEDURE
VERIFIED BY LTC [redacted] b(6)-2

3. DATE 24 Jul. 03 TIME PATIENT ARRIVED IN SUITE 1515

4. PATIENT IN ROOM
TIME 1515 NUMBER 2

5. PREOPERATIVE EMOTIONAL STATUS

☒ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS: Allergies:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SSG [redacted] b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	Cpt [redacted] LTC [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL [redacted]

☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

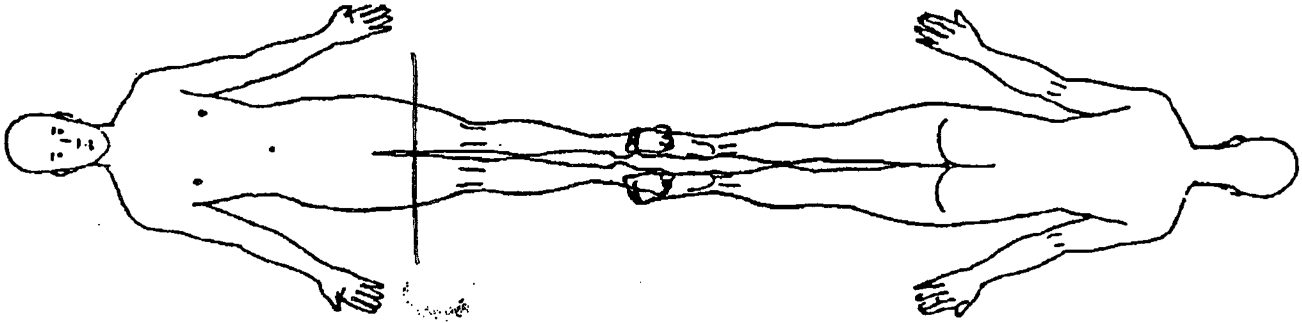
COMMENTS:

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR
☐ CLIP
COMMENTS:

PREP SOLUTION *(Specify)* N/A
SITE: BY WHOM:
SITE: BY WHOM:
COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad --- Safety Strap === Tourniquet

10. COUNTS		C = Correct I = Incorrect Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☐ Yes ☒ No					
Needle Sharp	☐ Yes ☒ No					
Instrument	☐ Yes ☒ No					
Other	☐ Yes ☒ No					

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

[redacted]
b(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☐ YES ☒ NO

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:
☐ ESU NO:
GROUND PAD: BRAND
LOT NO:
☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 R CES DA FORM 5179-1 (TEST) DEC 83 WHICH IS OBS USAPA V1.01

MEDCOM - 12759

13. PROSTHESIS, IMPLANTS ☐ YES ☒ NO IF YES NAME: ID NUMBER, MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☒

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S)

0.9% NaCl-

OTHER ORDERS	TIME	CARRIED OUT BY
none		

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM IF YES, SITE

YES ☐ NO ☒

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

TYPE/SIZE	1.	2.	3.
SITE	1.	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

ABD

7 Fluffs

Kerlix

Acewrap

19. ADDITIONAL INFORMATION

WC

Surgeons: [redacted] Anesthesia: Cpt [redacted] CRNA Anesthesia Type:

Cpt [redacted]

b(6)-2

-DA 5179 on chart, Ø Δ's

Bovie Pad site intact pre-op NA ; post-op NA Bovie Settings: Coag/Cut

Tourniquet Site intact pre-op NA ; post-op NA

Tourniquet Time: Up NA Down NA

20. OPERATION(S) PERFORMED

Ⓡ BKA Dressing Change under anesthesia

21. PATIENT TRANSFERRED TO ICU2

TIME See DA 7389

METHOD Via Gurney

22 [redacted] TC, AN [redacted] CPT/AN

REVERSE OF DA FORM [illegible], OCT

MEDCOM - 12760

USAPA V1.01

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

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

For use of this form, see AR 40-66, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA: [illegible] BY Anesthesia

2. PATIENT IDENTIFIED, [redacted] AND PROCEDURE
VERIFIED BY 1LT

3. DATE 6 Aug03
TIME PATIENT ARRIVED IN SUITE 0800

4. PATIENT IN ROOM
TIME 0800 NUMBER b(6)-2

5. PREOPERATIVE EMOTIONAL STATUS

☐ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS:
NPO p̄ MN, NKDA

6. NURSING PERSONNEL

ASSIGNED SCRUB	SGT [redacted] 91D b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	1LT [redacted] 66E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)* Pt. supine on padded OR table, BUE on padded armboards < 90°

☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

COMMENTS: Normal anatomic body alignment maintained

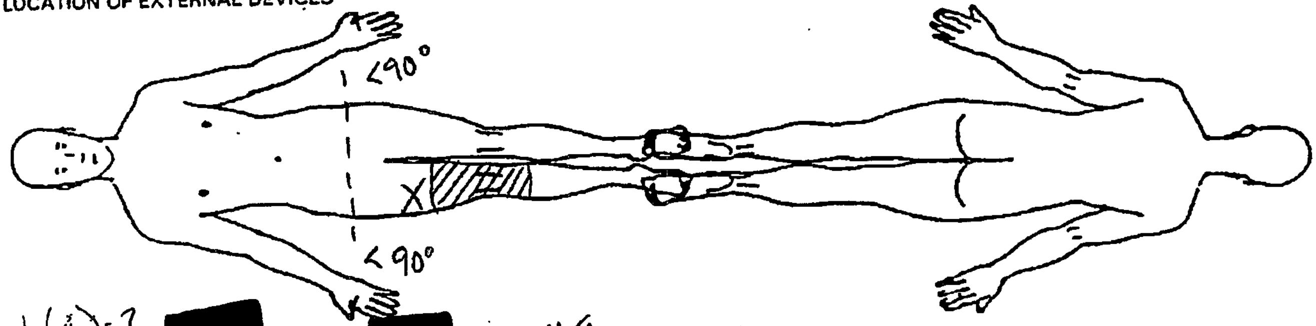
b(6)-2

8. SKIN PREPARATION

HAIR REMOVAL ☒ YES ☐ NO 1LT [redacted] b(6)-2
DONE BY: ☒ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☒ RAZOR
☐ CLIP Right leg
COMMENTS: No nicks or cuts noted

PREP SOLUTION *(Specify)* Betadine / Betadine
SITE: Right leg BY WHOM: 1LT [redacted]
SITE: BY WHOM:
COMMENTS: No pooling or adverse reaction

9. LOCATION OF EXTERNAL DEVICES



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

LEGEND X Ground Pad -- Safety Strap N/A === Tourniquet ▨ - PTCP

Initial: SGT [redacted]
1LT

C = Correct I = Incorrect

10. COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB b(6)-2	CIRCULATOR b(6)-2
Sponge	☒ Yes	☐ No		C	C	SGT [redacted]	1LT [redacted]
Needle Sharp	☒ Yes	☐ No					
Instrument	☐ Yes	☒ No					
Other	☐ Yes	☒ No					

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

# [redacted]
b(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☑ YES ☐ NO

☒ ESU NO: 4 cut 30 coag 30
GROUND PAD: BRAND VL REM PolyHesive II
LOT NO: 68936 Exp 2005-03

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES MEDCOM - 12761 HICH IS OBSOLETE. USAPA V1.01

13. PROSTHESIS, IMPLANTS ☐ YES ☒ NO IF YES NAME: ID NUMBER; MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☐

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
N/A					

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):
0.9% NaCl - Q.S.

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'[redacted] b(6)-2

15. X-RAY I
YES ☐ NO ☒
IF YES, SITE

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

TYPE/SIZE	1.	2.	3.
SITE	1.	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Keroform, fluff, kerlix webril, cast

19. ADDITIONAL INFORMATION
Surgeon: Dr. [redacted]
Anesthesia: CPT [redacted] b(6)-2

DA 5179 in Chart

20. OPERATION(S) PERFORMED
Closure Ⓡ knee wound

21. PATIENT TRANSFERRED TO ICU3 b(6)-2
TIME See DA7389
METHOD Litter

22. REGISTERED NURSE SIGNATURE [redacted] S/RN

REVERSE OF DA FORM 5179-1, OCT 87 USAPA V1.01

MEDCOM - 12762

PATIENT ASSES NT

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin . Loose / Tight / Diaphoretic / Shiny / Dry
Skin : Temperature
Color Pale / Cyanotic / Jaundiced
Mucous Membranes: Moist / Dry / Cracked
Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:
Orientated / Disoriented Pupils:
Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radials Pedals
Capillary Refill: Seconds Homan's Sign
Jugular Venous Distension Edema
Heart Sounds
Rhythm PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			▨	▨
Site				
Solution				

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical
Respiration / No Distress / SOB / Labored / Use of Access Muscles
Breathing Patterns:
Cough: Productive / Nonproductive / None
Sputum: Color / Amount / Consistency / Odor
Chest Drainage System Gravity: Suction cm:
Air Leak No Yes Crepitus
Character of Drainage:
Trachea / Midline / Deviated (R) / Deviated (L)
Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth
Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent
Dressings:
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage
NG Drainage: Color Character
Tube Feeding: Day No: Strength: Rate: Aspirate:
Stool Character
Drains.

GENITOURINARY

Urine Color: Character:
Voiding. Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER

NT ASSESSMENT

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin : Loose / Tight / Diaphoretic / Shiny / Dry
Skin : Temperature
Color: Pale / Cyanotic / Jaundiced
Mucous Membranes: Moist / Dry / Cracked
Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:
Orientated / Disoriented Pupils:
Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radials Pedals
Capillary Refill: Seconds Homan's Sign
Jugular Venous Distension Edema
Heart Sounds
Rhythm PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Periphera. 2
Waveforms			▨	▨
Site				
Solution				

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical
Respiration / No Distress / SOB / Labored / Use of Access Muscles
Breathing Patterns:
Cough: Productive / Nonproductive / None
Sputum: Color / Amount / Consistency / Odor
Chest Drainage System Gravity: Suction cm:
Air Leak No Yes Crepitus
Character of Drainage:
Trachea / Midline / Deviated (R) / Deviated (L)
Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth
Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent
Dressings:
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage
NG Drainage: Color Character
Tube Feeding: Day No: Strength: Rate: Aspirate
Stool: Character
Drains:

GENITOURINARY

Urine Color: Character:
Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

MEDCOM - 12763

PT'S NAME:

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
BP				111/66									110/68				115/70				111/67			
TEMP				96.3									98.5				98.2				98.4			
HR				77									69				72				70			
RR				12									18				22				18			
SA02				100%									100%				98%				98%			
method				NRB																				
INPUT	~~125~~			~~125~~																				
PO	NPO	NPO	NPO	~~NPO~~ NC																				
IV	125	125	400	125																				
NGT																								
Fent	50			250																				
TAL																								
TPUT															1000					850				
URINE		450																						
NGT																								
STOOL																								
TOTAL																								
ALANCE																								

MEDCOM - 12764

PATIENT ASS' ENT

ME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Loose / Tight / Diaphoretic / Shiny / [✓ Dry]

Temperature Warm

: Pale / Cyanotic / Jaundiced Normal for Race

ous Membranes: [✓ Mois] / Dry / Cracked

Breakdown: None Location: Size:

NEUROLOGICAL

[✓ Alert] / Lethargic / Unresponsive GCS:

[✓ ntated] / Disoriented Pupils: 3mm

emity Movement: Full / Limited / None

CARDIOVASCULAR

e (0 - 4): Radials +2 Pedals (L) +2 (R) +1

llary Refill: Seconds >3 Homan's Sign

lar Venous Distension Ø Edema

t Sounds S1 S2

hm RRR PRI: QRS:

ular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
eforms			▨	▨
tion				

st Pain

RESPIRATORY

st Expansion / [✓ Symmetrical] / Asymmetrical

piration / [✓ No Distress] / SOB / Labored / Use of Access Muscles

thing Patterns: Reg Rate Rythm

gh: Productive / Nonproductive / [✓ None]

um: Color / Amount / Consistency / Odor NONE

st Drainage System Gravity: N/A Suction cm:

Leak No Yes Crepitus

racter of Drainage:

hea / [✓ Midline] / Deviated (R) / Deviated (L)

icial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
ckles	CTA	Bilat
eezes		
nished		
ent		

GASTROINTESTINAL

omen [✓ Soft] / Firm / Hard / Distended [illegible] cm Girth

el Sounds: [✓ Normal] / Hyperactive / Hypoactive / Absent

ssings: (R) Lower Extremity (L) Hand

Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

Drainage: Color N/A Character

e Feeding: Day No: Strength: Rate: Aspirate:

ol: Character

ns.

GENITOURINARY

e Color: yellow Character: Clear

ding: Continent / Incontinent / [✓ Catheter]

EMOTIONAL/PSYCHOSOCIAL

Pt resting in bed Ø S/S of pain or discomfort

HER.

ENT ASSESSMENT b(6)-2

TIME: 2000 SIGNATUR [redacted]

SKIN AND MUCOU MBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / [✓ Dry]

Skin: Temperature Warm

Color: Pale / Cyanotic / Jaundiced Normal to race

Mucous Membranes: [✓ Moist] / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / [✓ Alert] / Lethargic / Unresponsive GCS:

[✓ Oriented] / Disoriented Pupils: 3mm

Extremity Movement: [✓ Full] / Limited / None X RLE

CARDIOVASCULAR

Pulse (0 - 4): Radials +2 Pedals (L) +2 (R) +1

Capillary Refill: Seconds < 3 Homan's Sign

Jugular Venous Distension Ø Edema Ø

Heart Sounds S1, S2 Ø ectopy

Rhythm RRR PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Pe
Waveforms			▨	▨
Site				
Solution				

Chest Pain

RESPIRATORY

Chest Expansion / [✓ Symmetrical] / Asymmetrical

Respiration / [✓ No Distress] / SOB / Labored / Use of Access Mu

Breathing Patterns: RRR

Cough: Productive / Nonproductive / [✓ None]

Sputum: Color / Amount / Consistency / Odor None

Chest Drainage System Gravity: Suction cm.

Air Leak No Yes Crepitus

Character of Drainage:

Trachea / [✓ Midline] / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/
Crackles	CTA	
Wheezes	Bilat	
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: [✓ Soft] / Firm / Hard / Distended cm Girl

Bowel Sounds: [✓ Normal] / Hyperactive / Hypoactive / Absent

Dressings: RLE & L' hand

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: As

Stool: Character

Drains:

GENITOURINARY

Urine Color: yellow Character: clear

Voiding: Continent / Incontinent / [✓ Cathete]

EMOTIONAL/PSYCHOSOCIAL

OTHER:

MEDCOM - 12765

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05
BP			117/57										109/58				110/54				111/51				
Temp			98.1										97.9				98.1				98.1				
HR			83										76				82				83				
RR			21										18				17				18				
SAO2			96										96				95				96				
INPUT														400			240			480					
PO																									
IV																									
NG-t																									
TOTAL																									
Output													100	250	50	150	50	200	275	100	50	50	125		
urine																									
NGT																									
stool																									
TOTAL																									
.Nce																									

PATIENT ASS [redacted] ENT b(6)-2

TIME: 0547 SIGNATURE: [redacted]

SKIN AND MUCOUS MEMBRANES

Skin : [✓ Loose] / Tight / Diaphoretic / Shiny / Dry

Skin : Temperature 98.5

Color: Pale / Cyanotic / Jaundiced normal for race

Mucous Membranes: [✓ Moist] / Dry / Cracked

Skin Breakdown: None Location: buttocks Size: Quarter Size

NEUROLOGICAL

Loc / [✓ Alert] / Lethargic / Unresponsive GCS:

[✓ Orientated] / Disoriented Pupils: PERL

Extremity Movement: Full / [✓ Limited] / None amputated (Rt) leg

CARDIOVASCULAR

Pulse (0 - 4): + Radials + Pedals (Lt) foot

Capillary Refill good Seconds <3 Homan's Sign

Jugular Venous Distension Edema 0

Heart Sounds normal

Rhythm normal PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			▨	▨
Site			picc line to	(Rt) arm
Solution			[illegible]	

Chest Pain [illegible]

RESPIRATORY

Chest Expansion / [✓ Symmetrical] / Asymmetrical

Respiration / [✓ No Distress] / SOB / Labored / Use of Access Muscles

Breathing Patterns: normal

Cough: Productive / Nonproductive / [✓ None]

Sputum: Color / Amount / Consistency / Odor 0

Chest Drainage System Gravity: Suction cm:

Air Leak No Yes Crepitus

Character of Drainage:

Trachea / [✓ Midline] / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes	CTA	
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: [✓ Soft] / Firm / Hard / Distended cm Girth

Bowel Sounds: [✓ Normal] / Hyperactive / Hypoactive / Absent

Dressings:

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate:

Stool: Character 0

Drains.

GENITOURINARY

Urine Color: yellow Character: clear

Voiding: [✓ Continent] / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

ENT ASSESSMENT

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin : Loose / Tight / Diaphoretic / Shiny / Dry

Skin : Temperature

Color: Pale / Cyanotic / Jaundiced

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils:

Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radials Pedals

Capillary Refill: Seconds Homan's Sign

Jugular Venous Distension Edema

Heart Sounds

Rhythm PRI: QRS:

Vascular Catheter Central Arterial Peripheral 1 Peripheral 2

Waveforms

Site

Solution

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

Respiration / No Distress / SOB / Labored / Use of Access Muscles

Breathing Patterns:

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor

Chest Drainage System Gravity: Suction cm.

Air Leak No Yes Crepitus

Character of Drainage:

Trachea / Midline / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds Anterior/Location Posterior/Location

Crackles

Wheezes

Diminished

Absent

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings:

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate

Stool: Character

Drains:

GENITOURINARY

Urine Color: Character:

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

b(6)-4

FPW #[redacted] MEDCOM - 12767 [illegible] 16, 2003

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
BP	108/56				Returned from OR 0907	119/71	115/70																	
Temp	98.5					97.8	98.1																	
HR	75					80	80																	
RR	10					6	8																	
SAO2	97					100	100																	
O2						6L	R/A																	
INPUT																								
PO																								
LR IV	125	125	125			125	125																	
NGt																								
IVPB		50	100	TO OR																				
Fent	15	15	15																					
TOTAL																								
Output																								
urine		825					775																	
NGt																								
Stool																								
TOTAL																								
BALANCE																								

MEDCOM - 12768

July 16, 2003

FPW # [redacted] (6)

b(6)-4

[redacted]

13July03

b(6)-2 All

PATIENT ASSESSMENT

TIME 0545 SIGNATURE [redacted]

SKIN AND MUCOUS MEMBRANES

Skin : [✓ Loose] / Tight / Diaphoretic / Shiny / Dry
Skin : Temperature warm to touch - 98.6
Color Pale / Cyanotic / Jaundiced normal for race
Mucous Membranes: [✓ Moist] / Dry / Cracked
Skin Breakdown: [✓ None] Location: Size:

NEUROLOGICAL

Loc / [✓ Alert] / Lethargic / Unresponsive GCS:
[✓ Orientated] / Disoriented Pupils:
Extremity Movement: Full [✓ Limited] None amputated (R) leg

CARDIOVASCULAR

Pulse (0 - 4): + Radials + Pedals ([illegible])
Capillary Refill good Seconds Homan's Sign
Jugular Venous Distension Edema 0
Heart Sounds normal
Rhythm normal PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			▨	▨
Site			(R) arm	
Solution			LR@125ml/hr	

Chest Pain

RESPIRATORY

Chest Expansion / [✓ Symmetrical] / Asymmetrical
Respiration / [✓ No Distress] / SOB / Labored / Use of Access Muscles
Breathing Patterns: normal
Cough: [✓ Productive] / Nonproductive / None
Sputum: Color / Amount / Consistency / Odor ~~clear~~ (thick white
Chest Drainage System Gravity: Suction cm:
Air Leak No Yes Crepitus
Character of Drainage:
Trachea / [✓ Midline] / Deviated (R) / Deviated (L)
Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles (VA)	to Rt lobe	
Wheezes ~~CTA~~		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: [✓ Soft] / Firm / Hard / Distended cm Girth
Bowel Sounds: [✓ Normal] / Hyperactive / Hypoactive / Absent
Dressings:
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage
NG Drainage: Color Character
Tube Feeding: Day No: Strength: Rate: Aspirate:
Stool. Character
Drains

GENITOURINARY

Urine Color: yellow Character:
Voiding [✓ Continent] Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER pain management

ENT ASSESSMENT

TIME: 2000 SIGNATURE [redacted]

SKIN AND MUCOUS MEMBRANES

Skin : [✓ Loose] / Tight / Diaphoretic / Shiny / [✓ Dry]
Skin : Temperature Warm
Color: Pale / Cyanotic / Jaundiced Normal to Race
Mucous Membranes: [✓ Moist] / Dry / Cracked
Skin Breakdown: [✓ None] Location: Size:

NEUROLOGICAL

Loc / [✓ Alert] / Lethargic / Unresponsive GCS:
[✓ Orientated] / Disoriented Pupils:
Extremity Movement: [✓ Full] Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radials +2 Pedals +2
Capillary Refill: Seconds < 3 Homan's Sign (-)
Jugular Venous Distension 0 Edema. 0
Heart Sounds S1 S2 No Ectopy
Rhythm Sinus Rhythm PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			▨	▨
Site			(L) arm	
Solution			LR@125ml/hr	

Chest Pain 0

RESPIRATORY

Chest Expansion / [✓ Symmetrical] / Asymmetrical
Respiration / [✓ No Distress] / SOB / Labored / Use of Access Muscles
Breathing Patterns: RRR
Cough: Productive / Nonproductive / [✓ None]
Sputum: Color / Amount / Consistency / Odor
Chest Drainage System Gravity: 0 Suction cm.
Air Leak No Yes Crepitus
Character of Drainage: -
Trachea / [✓ Midline] / Deviated (R) / Deviated (L)
Artificial Airway Size: 0 Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles	CTA	
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: [✓ Soft] Firm / Hard / Distended cm Girth
Bowel Sounds: [✓ Normal] Hyperactive / Hypoactive / Absent
Dressings: Drsg to (R) stump CDI
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage
NG Drainage: Color Character
Tube Feeding: Day No: Strength: Rate: Aspirate
Stool: Character
Drains: 0

GENITOURINARY

Urine Color: yellow Character: Clear
Voiding: [✓ Continent] / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

MEDCOM - 12769

b(6)-2

13 July 03

PT'S NAME [redacted]

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
BP	108/59		112/63	TO OR/RETURN	130/79	117/61			94/69	85/48		92/48	92/48	95/48				100/59				105/54		
TEMP	98.6		98.7		94.9					97.7		97.7									98.2			
HR	70		82		126	108			77	88		69	69	67				83				63		
RR	12		10		18	10			9	8		8	8	8				11				13		
SA02	99		100		99	98			99	100		98	98	100				98				97		
														RA				RA				RA		
INPUT																								
PO																								
IV	125	125	125		125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125
NGT		50	100		25	25	25	25	25	25	25	25	25	25	10	10	10	10	10	10	8	7	7	
ent																		200						
VPB																								
TAL												1375 225 1600												
TPUT																								
URINE		500					1000													1000				
NGT																								
STOOL																								
												1500												
TOTAL																								
BALANCE																								

1500

5

MEDCOM - 12770

PATIENT ASSF^S' ^NT

b(6)-2

TIME: 0530 SIGNATURE [redacted]

SKIN AND MUCOUS MEMBRANES

Skin : [✓ Loose] / Tight / Diaphoretic / Shiny / Dry

Skin . Temperature 99°

Color. Pale / Cyanotic / Jaundiced normal for race

Mucous Membranes: [✓ Moist] / Dry / Cracked

Skin Breakdown: [✓ None] Location: Size:

NEUROLOGICAL

Loc / [✓ Alert] / Lethargic / Unresponsive GCS:

[✓ Orientated] / Disoriented Pupils: PERL

Extremity Movement: Full / [✓ Limited] / None Amputated Ⓡ leg

CARDIOVASCULAR

Pulse (0 - 4): + Radials + Pedals Ⓛ foot

Capillary Refill: good Seconds <3 Homan's Sign

Jugular Venous Distension Edema 0

Heart Sounds Normal

Rhythm Regular PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			▨	▨
Site			Ⓡ arm	Ⓛ arm
Solution				LR @ 125 cc/h [illegible]

Chest Pain

RESPIRATORY

Chest Expansion / [✓ Symmetrical] / Asymmetrical

Respiration / [✓ No Distress] / SOB / Labored / Use of Access Muscles

Breathing Patterns: normal

Cough: [✓ Productive] / [✓ Nonproductive] / None rare wht/clear

Sputum: [✓ Color] / Amount / Consistency / Odor clear, scant, thin,

Chest Drainage System Gravity: Suction cm:

Air Leak No Yes Crepitus

Character of Drainage:

Trachea / [✓ Midline] / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles	↓ Ⓡ lobe	
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: [✓ Soft] / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / [✓ Hypoactive] / Absent

Dressings:

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate:

Stool: Character

Drains

GENITOURINARY

Urine Color: yellow Character:

Voiding: [✓ Continent] Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER: Drsg to Ⓡ stump.

ENT ASSESSMENT

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin : Loose / Tight / Diaphoretic / Shiny / [✓ Dry]

Skin : Temperature warm

Color: [✓ Pale] / Cyanotic / Jaundiced

Mucous Membranes: Moist / [✓ Dry] / Cracked

Skin Breakdown: [✓ None] Location: Size:

NEUROLOGICAL

Loc / Alert / [✓ Lethargic] / Unresponsive easily aroused

[✓ Orientated] / Disoriented Pupils:

Extremity Movement: [✓ Full] / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radials (+) Pedals (+)

Capillary Refill: <3 Seconds Homan's Sign

Jugular Venous Distension 0 Edema 0

Heart Sounds S_1S_2 NSR 68-70

Rhythm NSR PRI: [illegible] QRS:

Vascular Catheter	Central	Arterial	[✓ Peripheral]	Peripheral 2
Waveforms			▨	▨
Site				
Solution				

Chest Pain 0

RESPIRATORY

Chest Expansion / [✓ Symmetrical] / Asymmetrical

Respiration / [✓ No Distress] / SOB / Labored / Use of Access Muscles

Breathing Patterns: regular non labored

Cough: Productive / Nonproductive / [✓ None]

Sputum: Color / Amount / Consistency / Odor 0

Chest Drainage System Gravity: 0 Suction cm.

Air Leak ~~No~~ Yes Crepitus

~~Character of Drainage:~~

Trachea / [✓ Midline] / Deviated (R) / Deviated (L)

~~Artificial Airway Size: Type:~~ Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes		
Diminished	↓ lower lobe	
Absent		

GASTROINTESTINAL

Abdomen: [✓ Soft] / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / [✓ Hypoactive] / Absent

Dressings: Ⓡ stump

~~NG Tube: Clamped/Inter.~~ Suction/Cont. Suction/Dependent Drainage

~~NG Drainage: Color~~ Character

~~Tube Feeding: Day No:~~ Strength: Rate: Aspirate

Stool: Character

~~Drains:~~

GENITOURINARY

Urine Color: yellow Character:

Voiding: [✓ Continent] Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

Cooperative, verbalizes need

OTHER:

MEDCOM - 12771

b(6)-4

PT'S NAME EPW [redacted] 14 July 03

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
BP	112/70				112/68				[illegible]			118/70		97/53	100/51	104/54	103/50			96/49				107/56
TEMP	99.0				99.1				98.5			99.7		99.6	98.7					98.3				99.0
HR	79				86				100			88		88	92	83	105	59	67	64			70	68
RR	16				19				12			19		28	23	16	10	13	10	13			13	14
SA02	100				99				99			98		98	98	97	100	99	99	98			99	99
Mode	R/A				R/A				R/A			R/A		RA	RA	RA	RA	RA	RA	RA			RA	RA
INPUT																								
PO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	Post-op									
LR IV	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125
NGT																								
IVPB		50		100						50														
TAL																								
TPUT																								
URINE	775			500			875			470						125								
NGT																								
STOOL																								
TOTAL																								
BALANCE																								

3000

2745

Balance +255

3000
2745
255

MEDCOM - 12772

PATIENT ASSESSMENT [redacted] b(6)-2

TIME: 0500 SIGNATURE 3of [redacted]

SKIN AND MUCOUS MEMBRANES

Skin : [✓ Loose] / Tight / Diaphoretic / Shiny / Dry

Skin : Temperature warm & dry to touch

Color. Pale / Cyanotic / Jaundiced normal for Race

Mucous Membranes: [✓ Moist] / Dry / Cracked

Skin Breakdown: [✓ None] Location: Size:

NEUROLOGICAL

Loc / [✓ Alert] / Lethargic / Unresponsive GCS:

[✓ Orientated] / Disoriented Pupils: PERL 3+

Extremity Movement: Full / [✓ Limited] / None Amputated (R) leg

CARDIOVASCULAR

Pulse (0 - 4): Radials (B) + Pedals (Lt) +

Capillary Refill: Good Seconds Homan's Sign

Jugular Venous Distension N/A Edema N/A

Heart Sounds normal

Rhythm T6-normal PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			▨	▨
Site			Rt. arm	H. arm
Solution			LR@125cc/hr	LR@125cc/hr Infiltrated

Chest Pain 0

RESPIRATORY

Chest Expansion / [✓ Symmetrical] / Asymmetrical

Respiration / [✓ No Distress] / SOB / Labored / Use of Access Muscles

Breathing Patterns: normal-14

Cough: Productive / Nonproductive / [✓ None]

Sputum: Color / Amount / Consistency / Odor 0

Chest Drainage System Gravity: N/A Suction cm:

Air Leak No Yes Crepitus

Character of Drainage:

Trachea / [✓ Midline] / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes	CTA	
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: [✓ Soft] / Firm / Hard / Distended cm Girth

Bowel Sounds: [✓ Normal] / Hyperactive / Hypoactive / Absent

Dressings:

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate:

Stool: Character

Drains

GENITOURINARY

Urine Color: Character:

Voiding: [✓ Continent] / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

ATIENT ASSE

TIME: SIGNATURE

SKIN AND MUCOUS M

Skin : [✓ Loose] / Tight / Diaphoretic / Shiny

Skin : Temperature Warm

Color: Pale / Cyanotic / Jaundiced Norm

Mucous Membranes: [✓ Moist] / Dry / Cracked

Skin Breakdown: [✓ None] Location:

NEUROLOGICAL

Loc / [✓ Alert] / Lethargic / Unresponsive GCS:

[✓ Orientated] / Disoriented Pupils:

Extremity Movement: [✓ Full] / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radials +2 Pedals +2

Capillary Refill: Seconds <3 Homan's Sign ⊖

Jugular Venous Distension 0 Edema 0

Heart Sounds S1 S2 No ectopy

Rhythm Sinus Rhythm PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripher
Waveforms			▨	▨
Site			(L) arm	
Solution			LR@125cc/hr	

Chest Pain 0

RESPIRATORY

Chest Expansion / [✓ Symmetrical] / Asymmetrical

Respiration / [✓ No Distress] / SOB / Labored / Use of Access Muscles

Breathing Patterns: RRR

Cough: Productive / Nonproductive / [✓ None]

Sputum: Color / Amount / Consistency / Odor

Chest Drainage System Gravity: 0 Suction cm.

Air Leak No Yes Crepitus

Character of Drainage: -

Trachea / Midline / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Locat
Crackles	CTA	
Wheezes		
Diminished	Bilat	
Absent		

GASTROINTESTINAL

Abdomen: [✓ Soft] / Firm / Hard / Distended cm Girth

Bowel Sounds: [✓ Normal] / Hyperactive / Hypoactive / Absent

Dressings: Drsg to (R) stump C/D/I

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drain

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate

Stool: Character

Drains:

GENITOURINARY

Urine Color: yellow Character: Clear

Voiding: [✓ Continent] / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

MEDCOM - 12773

12 July 03

b(6)-4th [redacted]

		06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
			96.8		99 (a)				98.3			98.5								97.2				98.1
			81		88				117			86				86				70				73
			5		16				10			18				19				19				16
			100		98				100			100				99				100				100
	0656		108/74		97/55				99/55			99/55				110/51				97/49				114/64
INPUT																								
PO	NPO	NPO				360	360	360		120						60			100					
IV	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125
NG-t																								
IVPB			50		100				50									150						
Fent	15	15	–	–	–	–	–	–	–															
TOTAL													3055											
Output																								
urine							800		800	1025			750				675				600			
NGT																								
Stool																								
TOTAL													2625											
BAlance													+ 750 3375											

TO OR Returned from OR

IN 6

OUT 7

MEDCOM - 12774

[redacted]

12 July 03

b(6)-4

PATIENT ASS SMENT

TIME: SIGNATU

SKIN AND MUCOUS MEMBRANES

Skin . [✓ Loose] / Tight / Diaphoretic / Shiny / Dry
Skin : Temperature 99.3 Axillary
Color Pale / Cyanotic / Jaundiced Normal for Race
Mucous Membranes [✓ Moist] / Dry / Cracked
Skin Breakdown: [✓ None] Location: Size:

NEUROLOGICAL

Loc [✓ Alert] / Lethargic / Unresponsive GCS:
[✓ Orientated] / Disoriented Pupils:
Extremity Movement: [✓ Full] / Limited / None x̄ Right Lower Extremity

CARDIOVASCULAR

Pulse (0 - 4): Radials +3 x 2 --- Pedals +3 x 1 (L)
Capillary Refill: ≤ 3 sec Seconds Homan's Sign neg
Jugular Venous Distension None Edema none
Heart Sounds S₁S₂ CTA
Rhythm NSR @ 79 BPM PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			▨	▨
Site			(R) arm	
Solution			LR @ 50cc/hr	

Chest Pain

RESPIRATORY

Chest Expansion [✓ Symmetrical] / Asymmetrical
Respiration [✓ No Distress] / SOB / Labored / Use of Access Muscles
Breathing Patterns: Reg @ 24
Cough: Productive / Nonproductive / [✓ None]
Sputum: Color / Amount / Consistency / Odor None
Chest Drainage System Gravity: Suction cm:
Air Leak No Yes Crepitus
Character of Drainage:
Trachea / [✓ Midline] / Deviated (R) / Deviated (L)
Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes	CTA	CTA
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: [✓ Soft] / Firm / Hard / Distended non tender cm Girth
Bowel Sounds: [✓ Normal] / Hyperactive / Hypoactive / Absent
Dressings: CDI
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage
NG Drainage: Color Character
Tube Feeding: Day No: Strength: Rate: Aspirate:
Stool: Character
Drains JP

GENITOURINARY

Urine Color: Character:
Voiding: [✓ Continent] / external Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

ATIENT ASSESSMENT

b(6)-2 91wmb

TIME: 1700 SIGNATURE: [redacted]

SKIN AND MUCOUS MEMBRANES

Skin : Loose / [✓ Tight] / Diaphoretic / Shiny / Dry
Skin : Temperature Warm
Color: Pale / Cyanotic / Jaundiced Membranes pink
Mucous Membranes: [✓ Moist] / Dry / Cracked
Skin Breakdown: [✓ None] Location: Size:

NEUROLOGICAL

Loc [✓ Alert] / Lethargic / Unresponsive GCS:
[✓ Orientated] / Disoriented Pupils:
Extremity Movement: [✓ Full] / Limited / None

CARDIOVASCULAR

(L) Doppler
Pulse (0 - 4): Palp Radials + 3 Pedals (R) [illegible]
Capillary Refill: < 3 Seconds Homan's Sign
Jugular Venous Distension Ø Edema
Heart Sounds S₁S₂
Rhythm SR HR 80's PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Periphera
Waveforms			▨	▨
Site			(R) FA	
Solution			LR 150"	

Chest Pain Denies

RESPIRATORY

Chest Expansion [✓ Symmetrical] / Asymmetrical
Respiration [✓ No Distress] / SOB / Labored / Use of Access Muscles
Breathing Patterns: Regular RR 20's
Cough: [✓ Productive] / Nonproductive / [✓ None] Aw c̄ CDB
Sputum: Color / Amount / Consistency / Odor White
Chest Drainage System Gravity: Ø Suction cm.
Air Leak No Yes Crepitus
Character of Drainage: -
Trachea / [✓ Midline] / Deviated (R) / Deviated (L)
Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Locatio
Crackles		
Wheezes	CTA	Bilat
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: [✓ Soft] / Firm / Hard / Distended cm Girth
Bowel Sounds: Normal / [✓ Hyperactive] / Hypoactive / Absent
Dressings: (L) BKA c̄ Ace wrap
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Draina
NG Drainage: Color Character
Tube Feeding: Day No: Strength: Rate: Aspirate
Stool: Character
Drains: Ø

GENITOURINARY

Urine Color: yellow Character: dark
Voiding: [✓ Continent] / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

NO C/O discomfort @ present

OTHER:

11 July 03

MEDCOM - 12775

b(6)-2 # [redacted]

	05	06	07	08	09	10	11	12	13	14	15	16	17	*18	19	20	21	*22	23	24	01	*02	05	04
Temp	99.3			97.9			98.5					101.3		986				99		98.7		99.2		99.4
HR	79			73			91					106		80	73	89		73		86		90		83
RR	24			16			15					15		13	13	21		21		19		16		14
SAO2	97%			98%			99%					99%		98				99		97		99		99
BP	104/52			101/52			104/57					124/73		107/67	103/62	104/59		101/62		107/61		119/71		105/61
INPUT																								
PO				NPO →																				
IV	50	50	50	50	50	50	50	50				650	125	125	125	125	125	125	125	150	150	150	150	150:27
NGt								400				1050												
Fent														20	20	20	X	20	20	15	15	15	15	15 = 17:
IVPB																100	100							20
TOTAL	50	100	150	200	250	300	350	400				1050	1175											input 3100 total
Output																								
urine						500												950				950		output 2400. l
NGT																								
stool						⊕																		
TOTAL																								
Balance																								1925

— Pt to OR for Surgery —

— Pt returned from OR See OR Flow Sheet

— See PACU Sheet for Post OP Vitals (

b(6)-4 # [redacted] 11 July 03

PATIENT ASSESSMENT

TIME: SIGNATU

SKIN AND MUCOUS MEMBRANES

Skin: [✓ Loose] / Tight / Diaphoretic / Shiny / Dry
Skin: Temperature Warm
Color Pale / Cyanotic / Jaundiced NFR
Mucous Membranes: [✓ Moist] / Dry / Cracked
Skin Breakdown: [✓ None] Location: Size:

NEUROLOGICAL

Loc / [✓ Alert] / Lethargic / Unresponsive GCS:
[✓ Orientated] / Disoriented Pupils: PERRL
Extremity Movement: [✓ Full] / Limited / None Ⓡ BKA

CARDIOVASCULAR

Pulse (0 - 4): Radials +3 Pedals + 0
Capillary Refill: brisk Seconds Homan's Sign
Jugular Venous Distension 0 Edema 0 Ntd
Heart Sounds S1, S2
Rhythm PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			▨	▨
Site				
Solution				

Chest Pain

RESPIRATORY

Chest Expansion / [✓ Symmetrical] / Asymmetrical
Respiration / [✓ No Distress] / SOB / Labored / Use of Access Muscles
Breathing Patterns: Reg. R+R
Cough: Productive / Nonproductive / [✓ None]
Sputum: Color / Amount / Consistency / Odor
Chest Drainage System Gravity: Suction cm:
Air Leak No Yes Crepitus
Character of Drainage:
Trachea / [✓ Midline] / Deviated (R) / Deviated (L)
Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles	CTA	
Wheezes		
Diminished	bilat	
Absent		

GASTROINTESTINAL

Abdomen: [✓ Soft] / Firm / Hard / Distended cm Girth
Bowel Sounds: [✓ Normal] / Hyperactive / Hypoactive / Absent
Dressings: Cast to Ⓡ LE Stump
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage
NG Drainage: Color Character
Tube Feeding: Day No: Strength: Rate: Aspirate:
Stool. Character No BM
Drains. JP to Ⓡ LE

GENITOURINARY

Urine Color: Clr Yellow Character:
Voiding: [✓ Continent] / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

ATIENT ASSESSMENT

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry
Skin: Temperature
Color: Pale / Cyanotic / Jaundiced
Mucous Membranes: Moist / Dry / Cracked
Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:
Orientated / Disoriented Pupils:
Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radials Pedals
Capillary Refill: Seconds Homan's Sign
Jugular Venous Distension Edema
Heart Sounds
Rhythm PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Periphera
Waveforms			▨	▨
Site				
Solution				

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical
Respiration / No Distress / SOB / Labored / Use of Access Muscles
Breathing Patterns:
Cough: Productive / Nonproductive / None
Sputum: Color / Amount / Consistency / Odor
Chest Drainage System Gravity: Suction cm:
Air Leak No Yes Crepitus
Character of Drainage:
Trachea / Midline / Deviated (R) / Deviated (L)
Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Locati
Crackles		
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth
Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent
Dressings:
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Draina
NG Drainage: Color Character
Tube Feeding: Day No: Strength: Rate: Aspirate
Stool: Character
Drains:

GENITOURINARY

Urine Color: Character:
Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

MEDCOM - 12777

[redacted] J-3 D 10 July

		06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
Temp		97.7		97.2		98.2		98.3		98.6	995						1015		1009	X			992	
HR		71		68		72		91		93	71									80				
RR		16		14		16		16		18	23									20				
SAO2		98%		98%		97%		98%		97%	97									100				
BP		91/50		83/48		93/53		96/58		92/50	99/50								99/55	X				
INPUT																								
PO		450			400	240				240					200		100						100	
IV	50	125	50	50	1000	25.	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	
NGT																								
IVPB		100				100				50														
TOTAL																								
Output																								
urine					1050					925							950							
NGT																								
stool																								
TOTAL																								
Balance																								
IS		✓									X		X		X		X		X					

IV 2275

PO 1730

Urine 2925

1080

PATIENT ASSESSMENT

b(6)-2

TIME: 0630 SIGNATU [redacted]

SKIN AND MUCOUS MEMBRANES

Skin: [✓ Loose] / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature Warm

Color: Pale / Cyanotic / Jaundiced NFR

Mucous Membranes: [✓ Moist] / Dry / Cracked

Skin Breakdown: [✓ None] Location: Size:

NEUROLOGICAL

Loc [✓ Alert] / Lethargic / Unresponsive GCS:

[✓ Orientated] / Disoriented Pupils:

Extremity Movement: [✓ Full] / Limited / None (R) BKA

CARDIOVASCULAR

Pulse (0 - 4): Radials +3 Pedals +2

Capillary Refill: brisk Seconds Homan's Sign

Jugular Venous Distension 0 Edema 0 Ntd

Heart Sounds S1, S2

Rhythm PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			▨	▨
Site				
Solution				

Chest Pain 0

RESPIRATORY

Chest Expansion [✓ Symmetrical] / Asymmetrical

Respiration [✓ No Distress] / SOB / Labored / Use of Access Muscles

Breathing Patterns: Reg. R+R

Cough: Productive / Nonproductive / [✓ None]

Sputum: Color / Amount / Consistency / Odor

Chest Drainage System Gravity: Suction cm:

Air Leak No Yes Crepitus

Character of Drainage:

Trachea [✓ Midline] / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles	CTA bilat	
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: [✓ Soft] / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / [✓ Hypoactive] / Absent

Dressings: ~~No~~ Cast to (R) stump

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate:

Stool: Character

Drains: JP to (R) leg

GENITOURINARY

Urine Color: Character:

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

PATIENT ASSESSMENT

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin: [✓ Loose] / Tight / Diaphoretic / Shiny / [✓ Dry]

Skin: Temperature Warm

Color: Pale / Cyanotic / Jaundiced NFR

Mucous Membranes: [✓ Moist] / Dry / Cracked

Skin Breakdown: [✓ None] Location: Size:

NEUROLOGICAL

Loc / [✓ Alert] / Lethargic / Unresponsive GCS:

[✓ Orientated] / Disoriented Pupils: Perrla

Extremity Movement: [✓ Full] / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radials +2 Pedals +2

Capillary Refill: Seconds < 3 Homan's Sign

Jugular Venous Distension 0 Edema 0

Heart Sounds

Rhythm PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Periphera
Waveforms			▨	▨
Site			Warm	
Solution			LR @ 50cc/hr	

Chest Pain

RESPIRATORY

Chest Expansion / [✓ Symmetrical] / Asymmetrical

Respiration / [✓ No Distress] / SOB / Labored / Use of Access Muscles

Breathing Patterns: RRR

Cough: Productive / Nonproductive / [✓ None]

Sputum: Color / Amount / Consistency / Odor

Chest Drainage System Gravity: 0 Suction cm.

Air Leak No Yes Crepitus

Character of Drainage: -

Trachea / [✓ Midline] / Deviated (R) / Deviated (L)

Artificial Airway Size: 0 Type: Position:

Breath Sounds	Anterior/Location	Posterior/Locati
Crackles	CTA Bilat	
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings: Cast to Stump

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Draina

NG Drainage: Color Character.

Tube Feeding: Day No: Strength: Rate: Aspirate

Stool: Character 0

Drains: JP Drain to (R) leg

GENITOURINARY

Urine Color: yellow Character: Clear

Voiding: [✓ Continent] / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

09 JUL 03

[redacted] b(6)-4

MEDCOM - 12779

EPW [redacted] b(6)-

9 July 03

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
Temp		100.3	100.0	100.7		101.8		100.9		99.5		98.6		99.4				100.3		99.5		99.0		99.1
HR		102		96		106		100		76		84		83		86		94		87		83		80
RR		16		14		16		16		17		16		18		16		16		16		16		18
SAO2		98%		98%		96%		97%		98%		98%		98%		98%		97%		98		98		98%
BP		94/50		98/50		107/55		98/55		122/39				90/50		99/44		96/51		100/60		95/61		94/49
INPUT																								50
PO		240		480																				
LR IV	50	50	50	50	50	50	5	100	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	
NG+ Fent	12.5	12.5	12.5	15	15	10	10	10	5	5								200						
IVPB			50			100																		
TOTAL																								
Output											1075				800									
urine																								
NGT																								
stool											45cc													
JP																								
TOTAL																								
BAlance																								

b(6)-2

PATIENT ASSESSMENT

TIME: 8 July 07 SIGNATURE: [redacted]

SKIN AND MUCOUS MEMBRANES

Skin : [✓ Loose] / Tight / Diaphoretic / Shiny / Dry
Skin : Temperature warm 100.6
Color. Pale / Cyanotic / Jaundiced Normal for Race
Mucous Membranes: [✓ Moist] / Dry / Cracked
Skin Breakdown: [✓ None] Location: Size:

NEUROLOGICAL

Loc / [✓ Alert] / Lethargic / Unresponsive GCS:
[✓ Oriented] / Disoriented Pupils:
Extremity Movement: [✓ Full] / Limited / None ✗ RLE Amputation

CARDIOVASCULAR

Pulse (0 - 4): Radials +4 Pedals +1 in (L)
Capillary Refill: ≤3 Seconds Homan's Sign
Jugular Venous Distension none Edema None
Heart Sounds S1 S2
Rhythm NSR 88 bpm PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site			(R) arm	
Solution			LR @ 100	

Chest Pain

RESPIRATORY

Chest Expansion / [✓ Symmetrical] / Asymmetrical
Respiration / [✓ No Distress] / SOB / Labored / Use of Access Muscles
Breathing Patterns: 14
Cough: Productive / Nonproductive / [✓ None]
Sputum: Color / Amount / Consistency / Odor
Chest Drainage System Gravity: Suction cm:
Air Leak No Yes Crepitus
Character of Drainage:
Trachea / [✓ Midline] / Deviated (R) / Deviated (L)
Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes	CTA	CTA
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: [✓ Soft] / Firm / Hard / Distended cm Girth
Bowel Sounds: [✓ Normal] / Hyperactive / Hypoactive / Absent
Dressings: CDI
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage
NG Drainage: Color Character
Tube Feeding: Day No: Strength: Rate: Aspirate:
Stool: Character
Drains

GENITOURINARY

Urine Color: Clear Yellow Character: CS
Voiding. Continent / Foley Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

ENT ASSESSMENT

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin : Loose / Tight / Diaphoretic / Shiny / [✓ Dry]
Skin : Temperature Warm
Color: Pale / Cyanotic / Jaundiced Normal for Race
Mucous Membranes: [✓ Moist] / Dry / Cracked
Skin Breakdown: [✓ None] Location: Size:

NEUROLOGICAL

Loc / [✓ Alert] / Lethargic / Unresponsive GCS:
[✓ Oriented] / Disoriented Pupils:
Extremity Movement: [✓ Full] / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radials +2 Pedals X1 +2
Capillary Refill: Seconds 3 Homan's Sign
Jugular Venous Distension 0 Edema 0
Heart Sounds S1 S2
Rhythm PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site			(R) Arm	
Solution			LR @ 50	

Chest Pain 0

RESPIRATORY

Chest Expansion / [✓ Symmetrical] / Asymmetrical
Respiration / [✓ No Distress] / SOB / Labored / Use of Access Muscles
Breathing Patterns: RRR 16 BPM
Cough: Productive / Nonproductive / [✓ None]
Sputum: Color / Amount / Consistency / Odor 0
Chest Drainage System Gravity: 0 Suction cm
Air Leak No Yes Crepitus
Character of Drainage:
Trachea / Midline / Deviated (R) / Deviated (L)
Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes	CTA	CTA
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: [✓ Soft] / Firm / Hard / Distended cm Girth
Bowel Sounds: [✓ Normal] / Hyperactive / Hypoactive / Absent
Dressings: CDI
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage
NG Drainage: Color Character
Tube Feeding: Day No: Strength: Rate: Aspirate
Stool: Character
Drains:

GENITOURINARY

Urine Color: yellow Character: clear
Voiding: Continent / Incontinent / [✓ Catheter]

EMOTIONAL/PSYCHOSOCIAL

OTHER:

MEDCOM - 12781

PTS NAME:

85-0103

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
BP	98/60					105/52		[illegible]/63		127/79		118/62		120/72		117/68		109/61		106/55		101/61		97/5
TEMP	100.6					99.3		99.8		103.4	104.3	102.3		100.5		100.6								
HR	89	See OR FlowSheet				101		101		136		110		105		110		111		111		99		103
RR	12					24		12		16		14		16		18		18		18		14		16
SA02	94					100		98		96		96		97		97		96		97		99		99
						RA		RA		RA		RA		RA		RA		RA		RA		RA		RA
INPUT																								
PO	0					0																		
IV	117.5	117.5				168	168	68	68	118	68	68	70	70	70	70	70	170	110	70	70	80	70	70
NGT						~~100~~																		
TOTAL	117.5																							
OUTPUT																								
URINE	0					300		200		300			300							1000				
NGT																								
STOOL																								
TOTAL						300		500		800			1100											
BALANCE																								

MEDCOM - 12782

EPW [redacted] b(6)-4

b(6)-2

PATIENT ASSESSMENT

TIME: 0600 SIGNATURE: [redacted] LTC/L

SKIN AND MUCOUS MEMBRANES

Skin : [✓ Loose] / Tight / Diaphoretic / Shiny [✓ / Dry]

Skin : Temperature warm 98.8

Color. Pale / Cyanotic / Jaundiced Normal for Race

Mucous Membranes: [✓ Moist] Dry / Cracked

Skin Breakdown: [✓ None] Location: Size:

NEUROLOGICAL

Loc [✓ Alert] / Lethargic / Unresponsive GCS:

[✓ Orientated] / Disoriented Pupils: PERRLA

Extremity Movement: [✓ Full] Limited / None x̄ RLE Amputation

CARDIOVASCULAR

Pulse (0 - 4): <3sc. Radials RT ⊕ --- Pedals Ⓛ ⊕

Capillary Refill: ≤3 Seconds Homan's Sign 0

Jugular Venous Distension NO Edema NO

Heart Sounds S1S2

Rhythm NSR 71 PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms	N/A		▨	▨
Site			Ⓡ arm	
Solution			LR @ 50cc/hr	

Chest Pain None

RESPIRATORY

Chest Expansion / [✓ Symmetrical] / Asymmetrical

Respiration / [✓ No Distress] / SOB / Labored / Use of Access Muscles

Breathing Patterns: R

Cough: Productive / Nonproductive / [✓ None]

Sputum: Color / Amount / Consistency / Odor Non productive

Chest Drainage System Gravity: N/A Suction cm:

Air Leak No Yes --Crepitus

Character of Drainage:

Trachea [✓ Midline] / Deviated (R) / Deviated (L)

Artificial Airway Size: RA Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles	Clear bilateral	
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: [✓ Soft] / Firm / Hard / Distended cm Girth

Bowel Sounds: [✓ Normal] / Hyperactive / Hypoactive / Absent

Dressings: CDI

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage N/A

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate:

Stool: Character 0

Drains 0

GENITOURINARY

Urine Color: Yellow Character: Clear s̄ Sediment

Voiding. [✓ Continent] / Foley Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

ENT ASSESSMENT

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin : [✓ Loose] / Tight / Diaphoretic / Shiny / [✓ Dry]

Skin : Temperature WNL

Color: Pale / Cyanotic / Jaundiced WNL

Mucous Membranes: [✓ Moist] / Dry / Cracked

Skin Breakdown: [✓ None] Location: Size:

NEUROLOGICAL

Loc / [✓ Alert] / Lethargic / Unresponsive GCS:

[✓ Orientated] / Disoriented Pupils: 3mm

Extremity Movement: Full / [✓ Limited] / None Ⓡ BKA

CARDIOVASCULAR

Pulse (0 - 4): +3 Radials +3 Pedals +3

Capillary Refill: < Seconds 3 Homan's Sign (-)

Jugular Venous Distension (-) Edema -0

Heart Sounds S1S2

Rhythm SR PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			▨	▨
Site			Ⓡ Arm PIV	
Solution			Fentanyl	

Chest Pain

RESPIRATORY

Chest Expansion / [✓ Symmetrical] / Asymmetrical

Respiration / [✓ No Distress] / SOB / Labored / Use of Access Muscles

Breathing Patterns: WNL

Cough: Productive / Nonproductive / [✓ None]

Sputum: Color / Amount / Consistency / Odor

Chest Drainage System Gravity: Suction cm:

Air Leak No Yes Crepitus

Character of Drainage:

Trachea / [✓ Midline] / Deviated (R) / Deviated (L)

Artificial Airway Size: — Type: — Position: —

Breath Sounds	Anterior/Location	Posterior/Location
Crackles	CTA x all lung fields	
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: [✓ Soft] / Firm / Hard / Distended cm Girth

Bowel Sounds: [✓ Normal] / Hyperactive / Hypoactive / Absent

Dressings: —

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate

Stool: Character None this shift

Drains: —

GENITOURINARY

Urine Color: Amber Character: Clear

Voiding: [✓ Continent] / Foley Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

MEDCOM - 12783

0 EPW [redacted] b(6)-4 7 July 03

PT'S NAME

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
									↓		↓		↓		↓		↓		↓		↓		↓	
BP	12/77		109/71		116/67		122/71		116/65	106/65	100/60		98/57		97/59		108/68		103/64		107/69		102/65	
TEMP	96.8		98.7		100^{3}(a)		101^{4}(a)		101^{2}(a)	101^{8}(a)	99^{2}(a)		97^{8}		98.1		99.8		98.7		99.2		100.8	
HR	71		71		74		84		97	102	86		68	S	83		93		89		96	~~85~~	83	
RR	12		11		13		14		15	16	18		16		12		18		17		19		10	
SA02	99		97		96		95		96	95	98		98		93		97		95%		96%		95	
	RA		RA		RA		RA		RA	RA	RA		RA		RA		RA		RA		RA		RA	
							Tylenol			Tylenol														
INPUT														400		350		200		100	NPO			
PO																								
IV/TK	50	50	50	50	50	50	50	Heplock																
NGT																								
Fentanyl	30	30	30	30	30	30	30	20	30	↓20	30	30	30	30	30	30	30	30	30	130	130	130	130	130
IVPB		100	100					100		100														
					800																			
TOTAL	80	260	440	~~500~~	~~600~~	880	960 12	1080	1110 12	1230	1260	1290	1320	1830	1860	1890	1920	1950	1980	2110	2240	2370	2500	2630
													* 480 1800											1600
OUTPUT																								
URINE	0	0	0	900	100		400	625	650	375		350	350											
NGT																								
STOOL																								
																								5350
TOTAL				900	1000		1400	2025	2475	~~275~~ 3050 375/4		3400	3750											
F CE																								

2675
375
3050

PATIENT ASSESSMENT

EPW [redacted] b(6)-4
6 JU/03

TIME: SIGNATU.

SKIN AND MUCOUS MEMBRANES

Skin : [✓ Loose] Tight / Diaphoretic / Shiny / Dry WNL
Skin : Temperature warm
Color. Pale / Cyanotic / Jaundiced Normal For RAce
Mucous Membranes: [✓ Moist] / Dry / Cracked
Skin Breakdown: [✓ None] Location: Size:

NEUROLOGICAL

Loc / [✓ Alert] / Lethargic / Unresponsive GCS:
[✓ Orientated] / Disoriented Pupils:
Extremity Movement: Full / [✓ Limited] / None x RLE

CARDIOVASCULAR

Pulse (0 - 4): 52 Radials ++ Pedals +
Capillary Refill: ≤3sec Seconds Homan's Sign
Jugular Venous Distension None Edema None
Heart Sounds S_1 S_2
Rhythm NSR PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			▨	▨
Site			Ⓡ ARM	
Solution			Heplocked	

Chest Pain

RESPIRATORY

Chest Expansion / [✓ Symmetrical] / Asymmetrical
Respiration [✓ / No Distress] / SOB / Labored / Use of Access Muscles
Breathing Patterns: Reg
Cough: Productive / Nonproductive / [✓ None]
Sputum: Color / Amount / Consistency / Odor
Chest Drainage System Gravity: Suction cm:
Air Leak No Yes Crepitus
Character of Drainage:
Trachea / [✓ Midline] / Deviated (R) / Deviated (L)
Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes	CTA	CTA
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: [✓ Soft] Firm / Hard / Distended cm Girth
Bowel Sounds: [✓ Normal] / Hyperactive / Hypoactive / Absent
Dressings: CDI to R leg
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage
NG Drainage: Color Character
Tube Feeding: Day No: Strength: Rate: Aspirate:
Stool: Character
Drains

GENITOURINARY

Urine Color: Character:
Voiding. [✓ Continent] / urinal Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER.

ATIENT ASSESSMENT b(6)-2

TIME: 2100 SIGNATU[redacted]MBRANES

Skin : Loose / Tight / Diaphoretic / Shiny / [✓ Dry]
Skin : Temperature Warm
Color: Pale / Cyanotic / Jaundiced Normal for race
Mucous Membranes: [✓ Moist] / Dry / Cracked
Skin Breakdown: [✓ None] Location: Size:

NEUROLOGICAL

Loc / [✓ Alert] / Lethargic / Unresponsive GCS:
[✓ Orientated] / Disoriented Pupils:
Extremity Movement: [✓ Full] Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radials +2 Pedals +2
Capillary Refill: Seconds <3 Homan's Sign
Jugular Venous Distension 0 Edema 0
Heart Sounds S_1 S_2
Rhythm NSR PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripher
Waveforms			▨	▨
Site			Ⓡ arm	
Solution			LR@50cc	

Chest Pain 0

RESPIRATORY

Chest Expansion / [✓ Symmetrical] / Asymmetrical
Respiration [✓ / No Distress] / SOB / Labored / Use of Access Muscles
Breathing Patterns: RRR
Cough: Productive / Nonproductive / [✓ None]
Sputum: Color / Amount / Consistency / Odor
Chest Drainage System Gravity: 0 Suction cm
Air Leak No Yes Crepitus
Character of Drainage:
Trachea [✓ / Midline] / Deviated (R) / Deviated (L)
Artificial Airway Size: 0 Type: Position:

Breath Sounds	Anterior/Location	Posterior/Locati
Crackles	Clear Bilat	
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: [✓ Soft] / Firm / Hard / Distended cm Girth
Bowel Sounds: [✓ Normal] / Hyperactive / Hypoactive / Absent
Dressings: Ⓡ Leg Bulky drsg c̄ ace wr
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drain
NG Drainage: Color Character
Tube Feeding: Day No: Strength: Rate: Aspirate
Stool: Character
Drains:

GENITOURINARY

Urine Color: yellow Character: Clear
Voiding: Continent / Incontinent / [✓ Catheter]

EMOTIONAL/PSYCHOSOCIAL

OTHER:

MEDCOM - 12785

PTS NAME EPW [redacted] Date 6 Jul 03

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	
BP	110/60				106/57				113/58				105/54				135/72	118/71	119/75	126/82	125/78	125/75	118/74	124/76	
TEMP	98.1				97.7				97.9				98.3				99.1	/	98.5						
HR	52				56				55				57				69	79	95	105	82	72	67	71	
RR	18				17				18				18				12	9	11	23	10	12	12	12	
SA02	96				97%				97%				97%				99	95	96	100	97	94	96	95	
					RA				RA				RA	IN	OR		RA	RA	RA	RA	RA	RA	RA	RA	
INPUT																									
PO	NPO															50	50	30	50	50	50	50	50	80	450
IV UR					100					NQ															
NGT																20	30	35	30	30	30	30	30	30	265
[illegible]																									
TOTAL																									
OUTPUT																									
URINE	200	400	100	200	200	0/200	600	200	5/200	0/200	5/200	700/900	900	900		200	100	100	100	100	200	100	100	200	2
NGT																									
STOOL																									
TOTAL																									
E[illegible]CE																									

210
55
265

EPW [redacted] b(6)-4 8 JULY 03

PATIENT ASS

ME: 0600 SIGNATURE [redacted] b(6)-2

SKIN AND MUCOUS ME

[✓ Loose] / Tight / Diaphoretic / Shiny / Dry

: Temperature warm

: Pale / Cyanotic / Jaundiced

ous Membranes: [✓ Moist] / Dry / Cracked

Breakdown: [✓ None] Location: Size:

NEUROLOGICAL

[✓ Alert] / Lethargic / Unresponsive GCS: 15

[✓ ntated] / Disoriented Pupils: PERRLA

emity Movement: Full / [✓ Limited] / None

CARDIOVASCULAR

e (0 - 4): Radials +2 Pedals

llary Refill: <3sec Seconds Homan's Sign

lar Venous Distension Edema Ø

t Sounds S1 S2

hm Reg PRI: QRS:

ular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
eforms			▨	▨
			(L) AC	
tion				

st Pain

RESPIRATORY

st Expansion / [✓ Symmetrical] / Asymmetrical

piration / [✓ No Distress] / SOB / Labored / Use of Access Muscles

thing Patterns:

gh: Productive / [✓ Nonproductive] / None

um: Color / Amount / Consistency / Odor

st Drainage System Gravity: ND Suction cm:

Leak [✓ No] Yes Crepitus

racter of Drainage:

hea / [✓ Midline] / Deviated (R) / Deviated (L)

icial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
ckles	CTA Bilaterally	
eezes		
nished		
ent		

GASTROINTESTINAL

omen: [✓ Soft] / Firm / Hard / Distended NDD cm Girth

el Sounds: [✓ Normal] / Hyperactive / Hypoactive / Absent

ssings:

Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

Drainage: Color Character

e Feeding: Day No: Strength: Rate: Aspirate:

ol: Character

ns

GENITOURINARY

e Color: light yellow Character: Clear

ding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

interacts c̄ staff & gestures / via interpreter

HER:

TIENT ASSESSMENT b(6)-2

TIME: 20-- SIGNATURE [redacted]

SKIN AND MUCOUS MBRANES

Skin : Loose / Tight / Diaphoretic / Shiny / [✓ Dry]

Skin : Temperature Warm

Color: Pale / Cyanotic / Jaundiced Normal to Race

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: [✓ None] Location: Size:

NEUROLOGICAL

Loc / [✓ Alert] / Lethargic / Unresponsive GCS:

[✓ Orientated] / Disoriented Pupils: 3mm

Extremity Movement: [✓ Full] / Limited / None ↓ RLE

CARDIOVASCULAR

Pulse (0 - 4): Radials +2 Pedals +2

Capillary Refill: Seconds <3 Homan's Sign

Jugular Venous Distension Ø Edema Ø

Heart Sounds S1 S2 Ø ectopy

Rhythm PRI: QRS:

Vascular Catheter	Central	Arterial	[✓ Peripheral 1]	Pe
Waveforms			▨	▨
Site			(R) upper arm	
Solution				

Chest Pain

RESPIRATORY

Chest Expansion / [✓ Symmetrical] / Asymmetrical

Respiration / [✓ No Distress] / SOB / Labored / Use of Access Mu

Breathing Patterns: RRR

Cough: Productive / Nonproductive / [✓ None]

Sputum: Color / Amount / Consistency / Odor Ø

Chest Drainage System Gravity: Suction cm:

Air Leak No Yes Crepitus

Character of Drainage:

Trachea / [✓ Midline] / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/
Crackles	CTA	
Wheezes	Bilat	
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: [✓ Soft] / Firm / Hard / Distended cm Gir

Bowel Sounds: [✓ Normal] / Hyperactive / Hypoactive / Absent

Dressings: RLE - kerlex & ACE wrap

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: As

Stool: Character Ø

Drains:

GENITOURINARY

Urine Color: yellow Character: Clear

Voiding: Continent / Incontinent / [✓ Catheter]

EMOTIONAL/PSYCHOSOCIAL

OTHER:

MEDCOM - 12787

EPW [redacted] b(3)-4 5 July 03

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	0
BP	10/65							170/						120/66						15/90			
Temp	98.4							97.8						98						98			
HR	55							58						60						62			
RR	17							18						18						16			
SAO2	97							94						95						96			
								RA						RA						RA			
INPUT																		10					
PO																							
IV																		106					
NGt																							
TOTAL																							
Output																							
urine	300														200			300					
NGt																							
stool																							
TOTAL																							
Nce																							

3 July 03 b(6)-2

PATIENT ASSES [redacted]

TIME: 0600 SIGNATUR

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / [✓ Dry]
Skin: Temperature warm
Color: Pale / Cyanotic / Jaundiced Normal for Race
Mucous Membranes: [✓ Moist] / Dry / Cracked
Skin Breakdown: [✓ None] Location: Size:

NEUROLOGICAL

Loc [✓ Alert] / Lethargic / Unresponsive GCS:
[✓ Orientated] / Disoriented Pupils: 3mm PERRL
Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0-4): Radials +2 Pedals +2
Capillary Refill: Seconds >3 Homan's Sign
Jugular Venous Distension Ø Edema Ø
Heart Sounds S,S2
Rhythm PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site				
Solution				

Chest Pain Ø

RESPIRATORY

Chest Expansion / [✓ Symmetrical] / Asymmetrical
Respiration / [✓ No Distress] / SOB / Labored / Use of Access Muscles
Breathing Patterns: Reg. Rate Rythm
Cough: Productive / Nonproductive / [✓ None]
Sputum: Color / Amount / Consistency / Odor Ø
Chest Drainage System Gravity: Suction cm:
Air Leak No Yes Crepitus
Character of Drainage:
Trachea / [✓ Midline] / Deviated (R) / Deviated (L)
Artificial Airway Size: N/A Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles	CTA	
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: [✓ Soft] / Firm / Hard / Distended Ø distention cm Girth
Bowel Sounds: [✓ Normal] / Hyperactive / Hypoactive / Absent
Dressings: ORIF (B) Lower Ext.
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage
NG Drainage: Color N/A Character
Tube Feeding: Day No: Strength: Rate: Aspirate:
Stool: Character None
Drains:

GENITOURINARY

Urine Color: yellow Character: Clear
Voiding: Continent / Incontinent / Catheter [illegible]

EMOTIONAL/PSYCHOSOCIAL

Resting in bed Ø S/S of [illegible]
OTHER: discomfort

MEDCOM - 12789

PATIENT ASSESSMENT

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / [✓ Dry]
Skin: Temperature warm
Color: Pale / Cyanotic / Jaundiced NFR
Mucous Membranes: [✓ Moist] / Dry / Cracked
Skin Breakdown: [✓ None] Location: Size:

NEUROLOGICAL

Loc / [✓ Alert] / Lethargic / Unresponsive GCS:
[✓ Orientated] / Disoriented Pupils: PERRL 3mm
Extremity Movement: Full / [✓ Limited] / None (R)LE c̄ External Fix

CARDIOVASCULAR

Pulse (0-4): Radials +2 Pedals +2
Capillary Refill: Seconds <3 sec Homan's Sign
Jugular Venous Distension None Edema
Heart Sounds S S
Rhythm RR + Rhythm PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site			HL to	
Solution			(R) FA	

Chest Pain

RESPIRATORY

Chest Expansion / [✓ Symmetrical] / Asymmetrical
Respiration / [✓ No Distress] / SOB / Labored / Use of Access Muscles
Breathing Patterns: RR + Rhythm
Cough: Productive / Nonproductive / [✓ None]
Sputum: Color / Amount / Consistency / Odor None
Chest Drainage System Gravity: N/A Suction cm:
Air Leak No Yes Crepitus
Character of Drainage:
Trachea / Midline / Deviated (R) / Deviated (L)
Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles	CTA Bilat	
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: [✓ Soft] / Firm / Hard / Distended cm Girth
Bowel Sounds: [✓ Normal] / Hyperactive / Hypoactive / Absent
Dressings: ORIF (R) LE
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage
NG Drainage: Color Character
Tube Feeding: Day No: Strength: Rate: Aspirate:
Stool: Character NONE
Drains:

GENITOURINARY

Urine Color: Clear Yellow Character:
Voiding: Continent / Incontinent / [✓ Catheter] 18 [illegible]

EMOTIONAL/PSYCHOSOCIAL

Appears to be resting peacefully
[illegible] c̄ (R)LE elevated

PT'S NAME:

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
BP		114/60						115/63						135/71					110/51					
TEMP		98.6						98.3						98.7					98.5					
HR		65						70						69					62					
RR		20						77						14					16					
SA02		97						76						98					97					
INPUT																								
PO				250		200			580							240								
IV				50						50														
NGT																								
TOTAL																								
OUTPUT																								
URINE						700			600			900						700					300	
NGT																								
STOOL																								
TOTAL																								
BALANCE																								

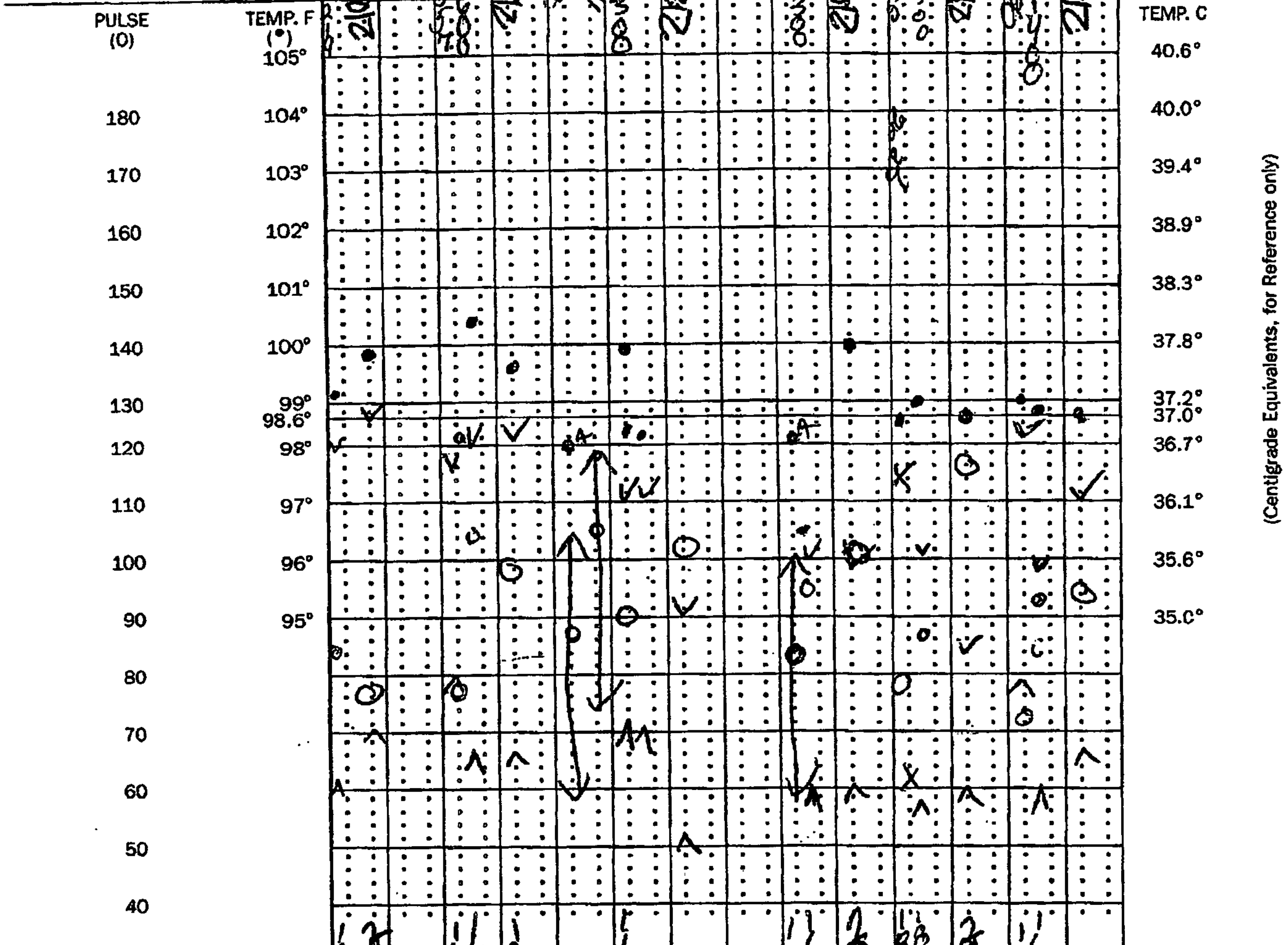
MEDCOM - 12790

511-119 NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY							
POST- DAY							
MONTH-YEAR / DAY	16	17	18		19	20	21
19 / HOUR	2100	2100	2100	2100	2100	2100	2100



RESPIRATION RECORD 6 4 16 18 16 14 20 18 20 16

Record special data only when so ordered

BLOOD PRESSURE 118/64 124/70 110/78 120/66 124/60 104/60 118/74 110/60 98/52 100/60 98/60 102/58 84/60 98/60 110/60

HEIGHT: WEIGHT ⟶ 98/ 100%

02 sat 98% 99% 95% 96% 97% 99% 100% 98% 99% 97% 99% 99%

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*

REGISTER NO.

WARD NO. ICW 2

[redacted]

b(6)-4

VITAL SIGNS RECORDS

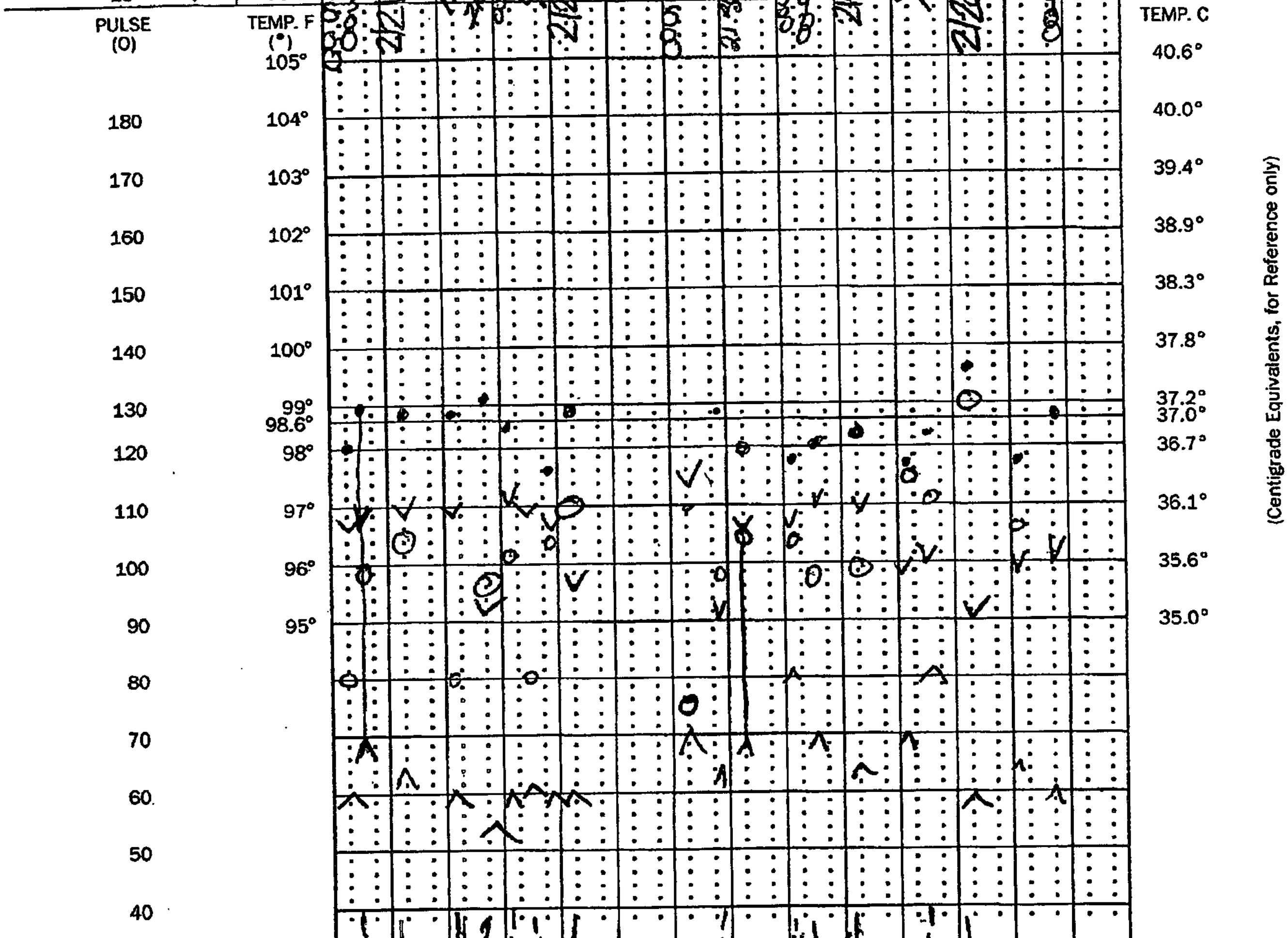
Medical Record

511 (REV. 7-95)
VICMR, FIRMR (41 CFR) 201-9.202-1

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY								
POST- DAY								
MONTH-YEAR July	DAY	22	23 24		25	26	27	28
19	HOUR	0300 2122	0300 2122	2122	0558 2122	0300 2122	0600 2122	9 0800



RESPIRATION RECORD	16	16	18	16	18	16	16	16	14	16	16		
BLOOD PRESSURE	100/60 108/70	108/64	108/70 [illegible]	110/60 108/62 104/70	94/60	116/70 90/64	104/82 110/70	108/64	98/70 104/62	104/58	99/65 100/60		
HEIGHT:	WEIGHT → 98%	98%	98% 98%	99%	99% 99%	98%	98%		99%	98% 100%	99%	99%	

Record special data only when so ordered

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*

REGISTER NO.

WARD NO. ICW2

STANDARD FORM 511 (REV. 7-95) BACK

X [redacted]
b(6)-4

MEDCOM - 12792

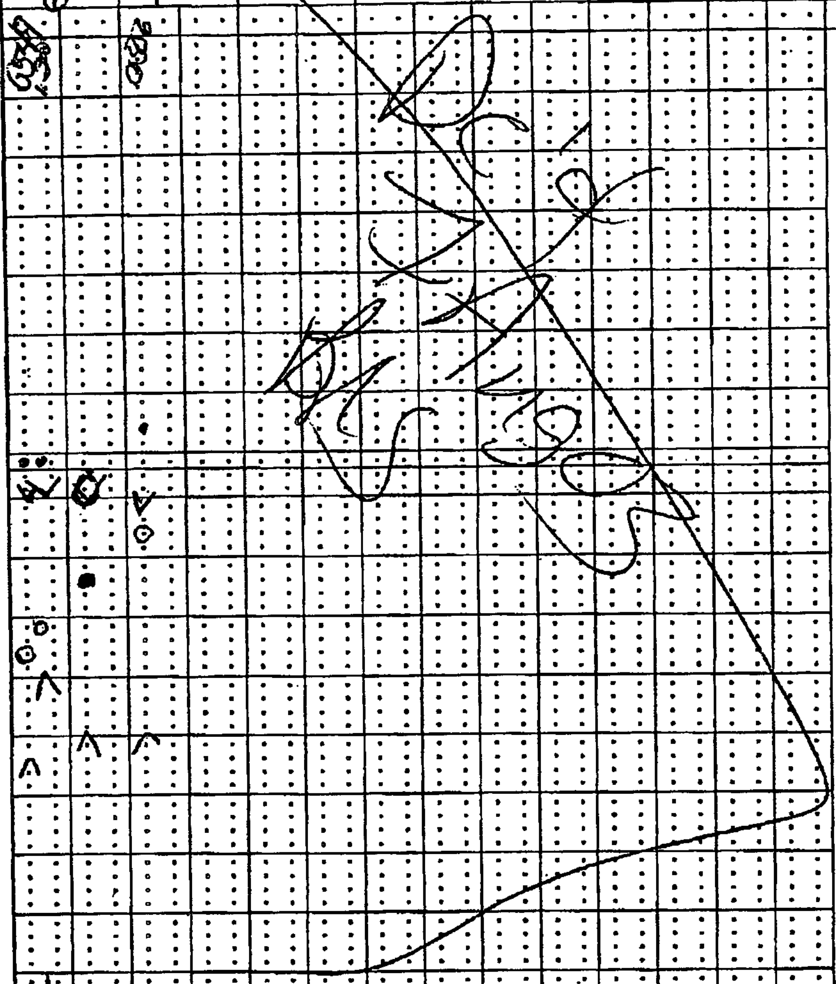
119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY		
POST- DAY		
MONTH-YEAR August DAY	6	7
19 HOUR	[illegible]	[illegible]



RESPIRATION RECORD 8 1

Record special data only when so ordered

BLOOD PRESSURE	120/[illegible] 120/90	[illegible]/60	118/80
HEIGHT: WEIGHT → DAY	98		
	98%	98% 98%	98

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*

REGISTER NO.

WARD NO. ICW

[redacted]

b(6)-4

VITAL SIGNS RECORDS

Medical Record

STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDICAL RECORD

VITAL SIGNS RECORD

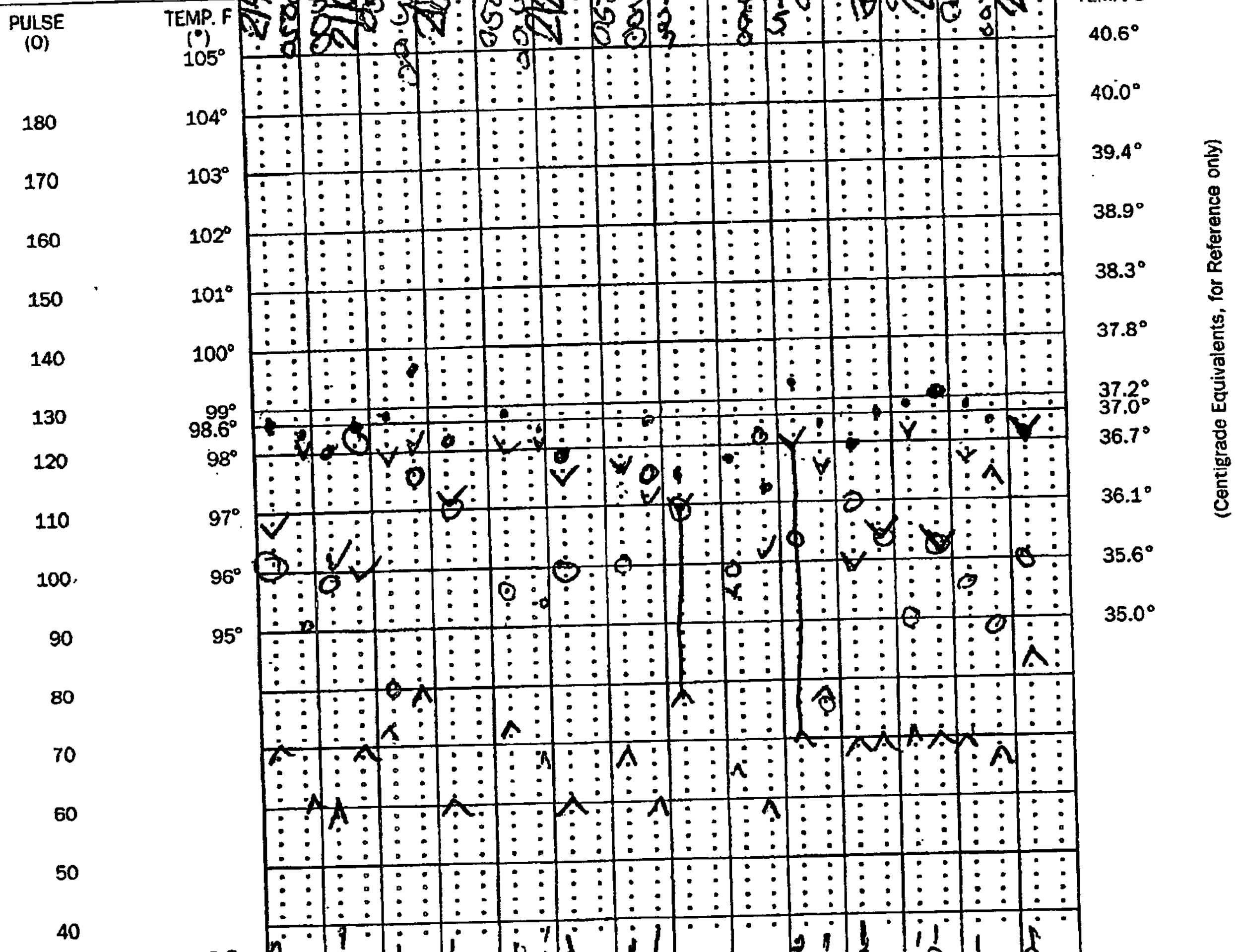
HOSPITAL DAY

POST- DAY

MONTH-YEAR July 05 DAY 29 30 31 August 1 2 3 4 5 ~~9~~-5

19 HOUR [illegible]

PULSE (0) TEMP. F (°) TEMP. C



RESPIRATION RECORD RR 16 16 16 16 16 16 18 16 16 20 18 18 20 16 18

BLOOD PRESSURE 108/70 100/60 118/74 112/80 129/74 114/60 114/80 110/70 95/65 98/70 132/72 114/90 120/81

[illegible] 120/76 110/60 100/60 114/58 [illegible] 102/70 [illegible]

HEIGHT: WEIGHT → 98 99/ 100% 97/ 99% 99% 98% 98% 99 99 100%

99% 99% 99% 99 98 100% 99%

Record special data only when so ordered

PATIENT'S IDENTIFICATION (*For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility*)

REGISTER NO.

WARD NO. ICW2

EPW# [redacted]

blk 3-4

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET	FROM [illegible] HOURS TO 0359 HOURS	TOTAL HOURS COVERED 24°	DATE 19Jul

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE *(Include Medications)*	AMOUNT RECD	TIME COMPL	ACCUM TOTAL

JP Drain ~~IRRIGATIONS~~ *(N/G, Bladder, etc.)*

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0430	Bloody drainage	10cc	10cc
2400	"	20 cc	30cc
0800	light red	6.5	36.5cc

D/C

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT *(i.e. Bl. Alb, P. cells, etc.)*	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

USAPPC V1.00

MEDCOM - 12795

OUTPUT

URINE						~~NASOGASTRIC~~ JP Drain			
TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	TYPE	ACCUM TOTAL
					18JUL03	2030	30cc	Bloody	30

CHEST						EMESIS			
TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS					OTHER OUTPUT			
TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	TYPE	ACCUM TOTAL
					GRAND TOTAL OUTPUT			

REMARKS

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

EPW

[redacted]

b(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

MEDICINE GLASS *(1 oz)*	30	HALF PINT MILK	240
SMALL FRUIT CUP	120	LARGE SOUP BOWL	240
COFFEE CUP	150	LARGE WATER GLASS	240
LARGE COFFEE MUG	180	PLASTIC OR PAPER JUICE CONTAINER	180

DD FORM 792, JAN 74

EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3630(TEMP)
1 JUL 72 WHICH MAY BE USED.

USAPPC V1.00

b(6)-4

ISTRY RESULT FORM
(Subject to the Privacy Act of 1974)

Ward/Section: EMT

STING PHYSICIAN: [redacted] b(6) 2

LAST, FIRST, MI: [redacted]

DATE: 1JUN-03

TIME: 2300

SSN/PSEUDO SSN: [redacted] b(6)-4

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		Negative
Drug of Abuse		Negative
		Negative
		Negative
		Negative

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB	2.9	3.5-5.5 g/dl
ALP	74	26-84 u/l
ALT	24	10-47 u/l
AMY	77	14-97 u/l
AST	24	11-38 u/l
TBIL	0.7	0.2-1.6 mg/dl
BUN	8	7-22 mg/dl
CA++	8.6	8.0-10.3mg/dl
CHOL	132	100-200 mg/dl
CRE	0.8	0.6-1.2 mg/dl
GLU	83	73-118 mg/dl
TP	6.2	6.4-8.1 g/dl

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU	81	73-118 mg/dl
BUN	9	7-22 mg/dl
CRE	0.5	0.6-1.2 mg/dl
CK	131	39-380 u/l (M) 30-190 u/l (F)
NA+	131	128-145 mmol/l
K+	4.1	3.3-4.7 mmol/l
CL-	105	98-108 mmol/l
tCO2	23	18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA++		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA+		128-145 mmol/l
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
tCO2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB	~~2.9~~	3.3-5.5 g/dl
ALP	~~74~~	26-84 u/l
ALT	~~24~~	10-47 u/l
AMY	~~77~~	14-97 u/l
AST	~~24~~	11-38 u/l
TBIL	~~0.7~~	0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA+		128-145 mmol/l
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
tCO2		18-33 mmol/l

REMARKS:

REPORTED BY: [redacted]

DATE: 21 Jun 03

LAB ID NO.:

b(6)-2

d/Section: EMT	RE [redacted] G PHYSICIAN: b(6)-2	RATORY RESULT FORM (Subject to the Privacy Act of 1974)
T, FIRST MI [redacted] b(6)-4	DATE 1JUL03	TIME 2300
SSN/PSEUDO SSN: [redacted] b(6)-4		

Hematology (CBC)

EST	RESULT	REF. RANGE
WBC	9.0	4.8-10.8 x 10^3
RBC	3.88	4.7-6.1 x 10^9
Hgb	11.1	14-18 g/dl (M) 12-16 g/dl (F)
Hct	35.1	42-52% (M) 37-47% (F)
MCV	90.2	80-94 fl (M) 81-99 fl (F)
Plt	210	130-500 x 10^3 verified
Lymph %	36.3	20.5-51.1%

Hematology Manual Differential

s		Mono	
ds		Eos	
ph		Baso	
p		Imm	
ph			

atocrit		42-52% (M) 37-47% (F)
Rate		
er		

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

EST	RESULT	REF. RANGE
		9.8-13.6 secs
T		21-34 secs
imer		<20 ug/ml
		<10 ug/ml

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

MARKS:

PORTED BY: [redacted] b(6)-2

DATE: [redacted] b(6)-4

LAB ID NO.:

MEDCOM - 12798

ICU 3 b(6)-4 Dr [redacted] b(6)-2 # [redacted] b(6)-4

EPW [redacted]

7 July | 0405

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	11.9	4.8-10.8 x 10^3
BC	3.90	4.7-6.1 x 10^9
	11.1	14-18 g/dl (M) 12-16 g/dl (F)
	35.2	42-52% (M) 37-47% (F)
	90.3	80-94 fl (M) 81-99 fl (F)
	576	130-500 x 10^3 verified
ymph %	19.7	20.5-51.1%

(Hematology) Manual Differential

egs		Mono	
ands		Eos	
ymph		Baso	
		Imm	

ematocrit		42-52% (M) 37-47% (F)
ed Rate		
ther		

Coagulation Studies

TEST	RESULT	REF. RANGE
		9.8-13.6 secs
PTT		21-34 secs
dimer		<20 ug/ml
DP		<10 ug/ml

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATC

Misc. Serology

TEST	RESULT	REF. R
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negati
H. pylori		Negati
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WI EVERY UNIT REQUESTE

ABO/Rh

EMARKS:

EPORTED BY:	DATE:	LAB ID NO.:

[redacted] b(6)-2

MEDCOM - 12799

b(6)-2

Ward/Section: ICU3	ING PHYSICIAN: [redacted]	ORY RESULT FORM o the Privacy Act of 1974)
LAST, FIRST, MI b(6)-4 [redacted]	DATE 8 Jul TIME 0500	SSN/PSEUDO SSN: [redacted] b(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	14.5	4.8-10.8 x 10³
RBC	4.03	4.7-6.1 x 10⁶
Hgb	11.1	14-18 g/dl (M) 12-16 g/dl (F)
Hct	36.3	42-52% (M) 37-47% (F)
MCV	90.3	80-94 fl (M) 81-99 fl (F)
Plt	482	130-500 x 10³ verified
Lymph %	19.7	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] **DATE:** **LAB ID NO.:**

b(6)-2

MEDCOM - 12800

Chemistry Only

Ward/Section: 1CU3	REQUESTING PHYSICIAN: [redacted] b(6)-2	**CHEMISTRY RESULT FO** (Subject to the Privacy Act of 197
LAST, FIRST, MI. b(6)-4 [redacted]	DATE 8Jul03 / TIME 0325	SSN/PSEUDO SSN: [redacted] b(6)-4

i-STAT

TEST	RESULT	REF. RANGE
	Chem 7	
Na	133	138-146 mmol/L
K	4.9	3.5-4.9 mmol/L
Cl	97	98-109 mmol/L
H	7.478	7.31-7.45
CO2	40.8	35-45 mmHg (art) 41-51 mmHg (ven)
O2		80-105 mmHg (art) N/A (ven)
CO2	33	23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3	~~32~~	22-26 mmol/L (art) 23-28 mmol/L (ven)
O2		95-98%
BEecf		(-2) – (+3) mmol/L
nGap		10-20 mmol/L
a		1.12-1.32 mmol/L
UN	4	8-26 mg/dl
LU	105	70-105 mg/dl
reat		0.7-1.5 mg/dl
ct		38-51% PCV
gb		12-17 g/dl

Misc Chemistry

TEST	RESULT	REF. RANGE
oponin-I		
rug of buse		

(Piccolo) Chem [illegible]

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

[illegible]

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 u/l (M) 30-190 u/l (F)
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RA
GLU		73-118 mg/d
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/
CRE		0.6-1.2 mg/d
NA^+		128-145 mm
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmo
tCO_2		18-33 mmol/

(Piccolo) [illegible]

TEST	RESULT	REF. RAN
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RAN
NA^+		128-145 mmo
K^+		3.3-4.7 mmol/
CL^-		98-108 mmol/
tCO_2		18-33 mmol/l

EMARKS:

28 8Jul03

LABORATORY RESULT FORM
(Subject to the Privacy Act of 1974)

Ward/Section: ICU 3

REQUESTING PHYSICIAN: [redacted] b(6)-2

LAST, FIRST, MI: EPW [redacted] b(6)-4

DATE: 9 Jul 4

TIME: 0400

SSN/PSEUDO SSN: [redacted] b(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	17.8	4.8-10.8 x 10³
RBC	3.06	4.7-6.1 x 10⁹
Hgb	8.3	14-18 g/dl (M) 12-16 g/dl (F)
Hct	27.3	42-52% (M) 37-47% (F)
MCV	91.0	80-94 fl (M) 81-99 fl (F)
Plt	416	130-500 x 10³ verified
Lymph %	16.4	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			
Spun Hematocrit		42-52% (M) 37-47% (F)	
Sed Rate			
Other			

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS: [redacted] b(6)-2

REPORTED BY:

DATE:

LAB ID NO.:

MEDCOM - 12802

Ward/Section: ICU-3	REQUESTING PHYSICIAN: [redacted] b(6)-2	**LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. #[redacted] b(6)-4	DATE 09JUL	TIME 1525	SSN/PSEUDO: #[redacted] b(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
RBC		4.7-6.1 x 10^9
Hgb		14-18 g/dl (M) 12-16 g/dl (F)
Hct		42-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-500 x 10^3 verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

[✓ Urinalysis]

TEST	RESULT	REF. RANGE
Color	Yellow	N/A
App	Clear	N/A
Glu	Neg	Negative
Bili	Neg	Negative
Ket	Neg	Negative
SG	1005	N/A
Bld	Neg	Negative
pH	6.5	N/A
Prot	Neg	Negative
Urob	0.2	0.2-1.0
Nit	Neg	Negative
Leuk	Neg	Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted]	**DATE:** 9 Jul 03	**LAB ID NO.:**

b(6)-2

MEDCOM - 12803

b(6)-4

Ward/Section: ICU 3	REQUESTING PHYSICIAN: [redacted] b(6)-2	**LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted]	DATE 10Jul4	TIME 0335
SSN/PSEUDO SSN: [redacted] b(6)-4		

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10³
RBC		4.7-6.1 x 10⁹
Hgb		14-18 g/dl (M) 12-16 g/dl (F)
Hct		42-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-500 x 10³ verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Blood Bank Unit Crossmatch
(MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

REMARKS:

MEDCOM - 12804

Chemistry Only

Ward/Section: ICU 3

REQUESTING PHYSICIAN: [redacted] b(6)-2

CHEMISTRY RESULT FORM
(Subject to the Privacy Act of 1974)

LAST, FIRST, MI. [redacted] b(6)-4

DATE 10 Jul 4

TIME 0335

SSN/PSEUDO SSN: [redacted] b(6)-4

i-STAT

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

[illegible]

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA⁺⁺		8.0-10.3mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

[illegible]

TEST	RESULT	REF. RANGE
GLU	114	73-118 mg/dl
BUN	6	7-22 mg/dl
CRE	0.4	0.6-1.2 mg/dl
CK	952	39-380 u/l (M) 30-190 u/l (F)
NA⁺	136	128-145 mmol/l
K⁺	3.9	3.3-4.7 mmol/l
CL⁻	101	98-108 mmol/l
tCO₂	28	18-33 mmol/l

(Basic Metabolic Panel)

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA⁺⁺		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA⁺		128-145 mmol/l
K⁺		3.3-4.7 mmol/l
CL⁻		98-108 mmol/l
tCO₂		18-33 mmol/l

[illegible]

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

[illegible]

TEST	RESULT	REF. RANGE
NA⁺		128-145 mmol/l
K⁺		3.3-4.7 mmol/l
CL⁻		98-108 mmol/l
tCO₂		18-33 mmol/l

REMARKS:

b(6)-2

Ward/Section: ICU3	REQUESTING PHYSICIAN: [redacted]	**LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. b(6)-4 # [redacted]	DATE 10Jul03	TIME 1035	SSN/PSEUDO SSN:

[✓ (Hematology) CBC]

TEST	*RESULT*	*REF. RANGE*
WBC		4.8-10.8 x 10^3
RBC		4.7-6.1 x 10^9
Hgb		14-18 g/dl (M) 12-16 g/dl (F)
Hct		42-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-500 x 10^3 verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis

TEST	*RESULT*	*REF. RANGE*
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	*RESULT*	*REF. RANGE*
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

TEST	*RESULT*	*REF. RANGE*
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	*TYPE*	*CROSSMATCH*

REMARKS:

Ward/Section: ICU3	REQUESTING PHYSICIAN:	**LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. H [redacted] b(6)-4	DATE 11 Jul	TIME 0330
SSN/PSEUDO SSN:		

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	11.1	4.8-10.8 x 10^3
RBC		4.7-6.1 x 10^9
Hgb		14-18 g/dl (M) 12-16 g/dl (F)
Hct		42-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-500 x 10^3 verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			
Spun Hematocrit		42-52% (M) 37-47% (F)	
Sed Rate			
Other			

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

REMARKS:

MEDCOM - 12807

Ward/Section: ICU3	RE [redacted] ING PHYSICIAN: b(6)-2		LA TORY RESULT FORM (Su .. to the Privacy Act of 1974)
LAST, FIRST, MI. b(6)-4 EPW [redacted]	DATE 0400	TIME 12Jul	SSN/PSEUDO SSN: EPW [redacted] b(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
RBC		4.7-6.1 x 10^6
Hgb		14-18 g/dl (M) 12-16 g/dl (F)
Hct		42-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-500 x 10^3 verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	**DATE:**	**LAB ID NO.:**

MEDCOM - 12808

b(6)-2

Ward/Section: ICU #3	RE [redacted] ING PHYSICIAN: b(6)-2		LA TORY RESULT FORM (Su . to the Privacy Act of 1974)
LAST, FIRST, MI [redacted]	DATE 13Jul4	TIME 0330	SSN/PSEUDO SSN: [redacted] b(6)-4

(Hematology) CBC		
TEST	*RESULT*	*REF. RANGE*
WBC		4.8-10.8 x 10^3
RBC		4.7-6.1 x 10^6
Hgb		14-18 g/dl (M) 12-16 g/dl (F)
Hct		42-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-500 x 10^3 verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential			
Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis		
TEST	*RESULT*	*REF. RANGE*
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

CSF		
Cell Count		
Directigen		Negative

Misc. Serology		
TEST	*RESULT*	*REF. RANGE*
RPR		Negative
Mono		Negative

Microbiology		
Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

Blood Bank	
MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED	
ABO/Rh	

Coagulation Studies		
TEST	*RESULT*	*REF. RANGE*
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)		
UNIT	*TYPE*	*CROSSMATCH*

REMARKS:

REPORTED BY: [redacted]	**DATE:**	**LAB ID NO.:**

b(6)-2

MEDCOM - 12809

ICU 3

b(6)-4

EPW [redacted]

b(6)-2

Dr [redacted] 14 July 0230

b(6)-4

[redacted]

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	8.6	4.8-10.8 x 10³
EC	2.55	4.7-6.1 x 10⁹
	7.0	14-18 g/dl (M) 12-16 g/dl (F)
	22.6	42-52% (M) 37-47% (F)
	88.6	80-94 fl (M) 81-99 fl (F)
	611	130-500 x 10³ verified
ymph %	25.6	20.5-51.1%

(Hematology) Manual Differential

egs		Mono	
ands		Eos	
mph		Baso	
		Imm	
ymph			

ematocrit		42-52% (M) 37-47% (F)
ed Rate		
ther		

Coagulation Studies

TEST	RESULT	REF. RANGE
		9.8-13.6 secs
PTT		21-34 secs
dimer		<20 ug/ml
DP		<10 ug/ml

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc Serology

TEST	RESULT	REF. RA
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

EMARKS:

EPORTED BY: [redacted] DATE: LAB ID NO

b(6)-2

MEDCOM - 12810

Chemistry Only

CHEMISTRY RESULT FORM
(Subject to the Privacy Act of 1974)

Ward/Section: ICU 3

REQUESTING PHYSICIAN: [redacted] b(6)-2

LAST, FIRST, MI: EPW [redacted]

b(6)-

DATE: 7/15/03

TIME: 0330

SSN/PSEUDO SSN:

i-STAT [illegible]

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) ~ (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

[illegible]

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

[illegible]

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 u/l (M) 30-190 u/l (F)
NA$^+$		128-145 mmol/l
K$^+$		3.3-4.7 mmol/l
CL$^-$		98-108 mmol/l
tCO$_2$		18-33 mmol/l

[illegible] Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA$^+$		128-145 mmol/l
K$^+$		3.3-4.7 mmol/l
CL$^-$		98-108 mmol/l
tCO$_2$		18-33 mmol/l

[illegible]

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

[illegible]

TEST	RESULT	REF. RANGE
NA$^+$		128-145 mmol/l
K$^+$		3.3-4.7 mmol/l
CL$^-$		98-108 mmol/l
tCO$_2$		18-33 mmol/l

REMARKS:

[redacted] 15 Jul 03

b(6)-2

MEDCOM - 12811

b(6)-2

Ward/Section: ICU 3	R STING PHYSICIAN: [redacted]	LA ATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. b(6)-4 EPW [redacted]	DATE 7/15/03	TIME 0330
SSN/PSEUDO SSN [redacted] b(6)-4		

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10³
RBC		4.7-6.1 x 10⁶
Hgb		14-18 g/dl (M) 12-16 g/dl (F)
Hct		42-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-500 x 10³ verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted]	**DATE:**	**LAB ID NO.:**

b(6)-2

MEDCOM - 12812

b(6)-2

Ward/Section: ICU-3	R. STIN[redacted]CIAN: DR [redacted]	**LA...RATORY RESULT FORM** (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. b(6)-4 # [redacted]	DATE 15 Jul	TIME 1610
SSN/PSEUDO SSN: # [redacted] b(6)-4		

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
RBC		4.7-6.1 x 10^6
Hgb		14-18 g/dl (M) 12-16 g/dl (F)
Hct		42-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-500 x 10^3 verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			
Spun Hematocrit		42-52% (M) 37-47% (F)	
Sed Rate			
Other			

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Blood Bank Unit Crossmatch
(MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted]	**DATE:** 15 Jul/03	**LAB ID NO.:**

b(6)-2

MEDCOM - 12813

ACLU-RDI 1592 p.706

b(6)-2

Ward/Section: ICU 3	REQ [redacted] NG PHYSICIAN:		**LABO. JRY RESULT FORM** (Subject to the Privacy Act of 1974)
LAST, FIRST, MI [redacted] b(6)-4	DATE 16 Jul 0	TIME 0430	SSN/PSEUDO SSN: [redacted] b(6)-4

) CBC

TEST	*RESULT*	*REF. RANGE*
WBC		4.8-10.8 x 10^3
RBC,		4.7-6.1 x 10^9
Hgb		14-18 g/dl (M) 12-16 g/dl (F)
Hct		42-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-500 x 10^3 verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Coagulation Studies

TEST	*RESULT*	*REF. RANGE*
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Urinalysis

TEST	*RESULT*	*REF. RANGE*
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Blood Bank Unit Crossmatch
(MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	*TYPE*	*CROSSMATCH*

Misc. Serology

TEST	*RESULT*	*REF. RANGE*
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

REMARKS:

REPORTED BY: [redacted]	**DATE:** 16 Jul/03	**LAB ID NO.:**

b(6)-2

MEDCOM - 12814

Ward Section: ICW2	REQU	S PHYSICIAN:	**CHEM RY RESULT FORM** (Subject to the Privacy Act of 1974)
AST, FIRST, MI EPW #[redacted] b(6)-4	DATE 18Aug03	TIME 0355	SSN/PSEUDO SSN:

(i-STAT)

TEST	*RESULT*	*REF RANGE*
Na	133	138-146 mmol/L
K	4.2	3.5-4.9 mmol/L
Cl	100	98-109 mmol/L
pH		7.35-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2)-(+3) mmol/L
AnGap		10-20 mmol/L
iCa		1.12-1.32 mmol/L
BUN	6	8-26 mg/dl
GLU	147	70-105 mg/dl
Crea		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	*RESULT*	*REF. RANGE*
Troponin-I		Negative
Drug of Abuse		Negative
		Negative
		Negative
		Negative

(Piccolo) Chemistry 12

TEST	*RESULT*	*REF. RANGE*
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA++		8.0-10.3mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

(Piccolo) Metlyte 8

TEST	*RESULT*	*REF. RANGE*
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 u/l (M) 30-190 u/l (F)
NA+		128-145 mmol/l
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
tCO2		18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	*RESULT*	*REF. RANGE*
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA++		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA+		128-145 mmol/l
K+		3.3-4.7 mmol/l
Cl		98-108 mmol/l
tCO2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	*RESULT*	*REF. RANGE*
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	*RESULT*	*REF. RANGE*
NA+		128-145 mmol/l
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
tCO2		18-33 mmol/l

REMARKS:

REPORTED BY: [redacted]	**DATE:**	**LAB ID NO.:**

b(6)-2 18Aug03

ICW2 b(6)-4 [redacted] 2LT /AN

EPW# [redacted] b(6)-4

18JUly03 [redacted]

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
RBC		4.7-6.1 x 10^6
Hgb		14-18 g/dl (M) 12-16 g/dl (F)
Hct		42-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		150-500 x 10^3 verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		10 ug/ml

Blood Bank Unit Crossmatch
(MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] **DATE:** 18Jul03 **LAB ID NO:**

b(6)-2

MEDCOM - 12816

b(6)-2

Ward/Section: ICW2

REQUESTING PHYSICIAN: [redacted]

LABORATORY RESULT FORM
(Subject to the Privacy Act of 1974)

LAST, FIRST, MI. EPW# [redacted] b(6)-4

4Aug03

TIME

SSN/PSEUDO SSN: 0376

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
RBC		4.7-6.1 x 10^9
Hgb		14-18 g/dl (M) 12-16 g/dl (F)
Hct		42-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-500 x 10^3 verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Blood Bank Unit Crossmatch
(MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:

DATE:

LAB ID NO.:

MEDCOM - 12817

MEDICAL RECORD — ANESTHESIA

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML, "I" = CONSTANT INFUSION

DRUG	(Units)		TOTALS
NSO4	(mg)	10 – 10	20
Benadryl	(mg)	50	50.
Versed	(mg)	2.5	2.5
Propofol	(mg)	50	50
	( )		
Robinul	(mg)	.2	.2
VOLAT AGENT ISO	% del	x/1.5/1.5/1.5/1.5/.8/.4/x	
	% e.t.		
AIR	L/Min		
N2O	L/Min		
O2	L/Min	8/3/3/3/4/4/4/8	

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS

TOTAL EBL: <100

TOTAL URINE: 200

FLUIDS – SUMMARY

CRYSTALLOID– 900 LR

COLLOID– 0

BLOOD– 0

FLUIDS

LINE site		
	☐ Warmed	
18g RUE	☐ Warmed	LR ——— 800 – 100
	☐ Warmed	
	☐ Warmed	

LOSSES

EST BLOOD LOSS

URINE – Foley indwelling 200

PHYS STATUS: [✓ 1] 2 3 4 5 E

BODY WEIGHT: 65 [✓ KG] LB

HEMATOCRIT:

INITIAL DATA

BP – 93/52

HR – 100

EQUIP CHECK

OK? – [✓ Y] N

OK for PROCEDURE? Y

TIME – 1357

TIME → 1345 1400 ✗ 1430 ✗ 1500

SYMBOLS:

BP by cuff V Λ

Heart rate ●

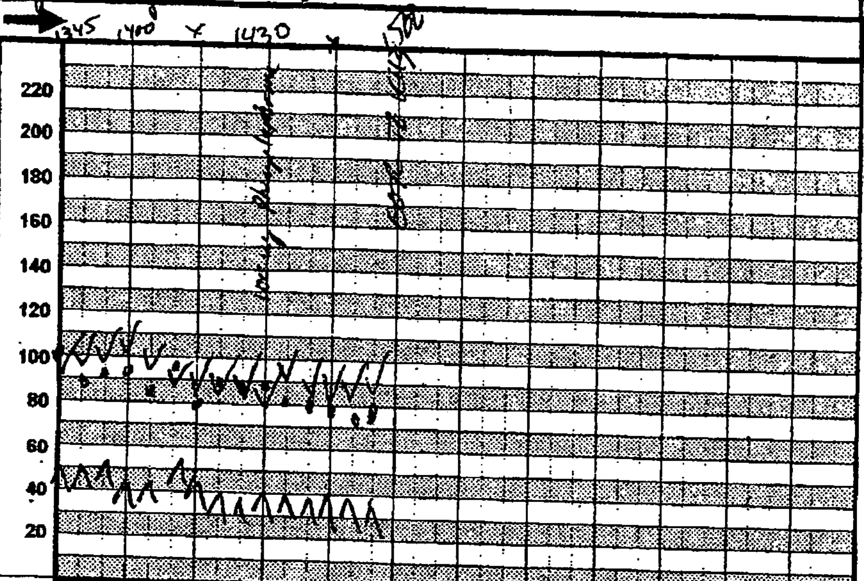
Resp rate

BP (transduced)

TOURNIQUET T – ✗

ANES – X-X

PROC ⊙ – Ø



	1345				
VT – ml	710	790	370	280	530
f – breaths/min	16	16	16	16	14
Peak inf pres / PEEP	/	/	/	/	/
✓ MODE– S(pon), A(ssist), C(on)	S	S	S	S	S
✓ ET CO2 (torr)	41	38	39	39	40
✓ FIO2 (Frac or %)	.75	.75	.75	.75	.40
✓ SpO2 (%)	100	100	100	100	100
✓ ECG	SR	SR	SR	SR	SR
✓ TEMP- site	Axil				
✓ N-M Block (T/4)					

✓ BP/Auto Cuff

BP / oth

ART line

Steth- PC/ES

Gas analyzer

Warming blkt

Conv warmer

Mark with letters & symbols, or plain under REMARKS

EVENTS

Position → 0–

REMARKS–

Code drugs with numbers, events with letters

1340 PT ID, Ø CHANGE FROM PREOP Hx

1350 RM. O2, MON.

1359 TOTS

1508 RPT TO SPC [redacted]

RECOVERY AT 1504

PACU ICU ________ (Specify)

OTHER ________

CONDITION: STABLE

RESP– SpO2–

BP– HR–

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1340	1350	1510

	Ready	Begin	End
PROC	1359	1428	1452

PROCEDURES and CPT Codes

EXT FIX ADJUSTMENT

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

GA – mask

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

Mask ̄c NA

SURGEONS: [redacted]

[redacted] LT CRNA

PROCEDURE LOCATION OR 1

3 JUL 03

PATIENT IDENTIFICATION– Typed or written entries: Name, Grade/Rate, Medical facility

[redacted]

b(6)-4

b(6)-2

MEDCOM - 12818

NKA
PIV/Foley

MEDICAL RECORD ANESTHESIA

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML. • "I"=CONSTANT INFUSION

DRUG	Units		TOTALS
Versed	(mg)	2.5	
Fentanyl	(cc)	1 2 1 1	25 mg 250 mcg
Lido/Propofol	(mg)	20/130 20	
Sux	(mg)	90	
Phenergan	(mg)	12.5	
MSO4	( )	5 5	
VOLAT AGENT: Iso	% del	X 1 – .8 – 1 — 1.5 – 2 — 2 – 1.5 0.X	
	% e.t.		
AIR	L/Min		
N2O	L/Min		
O2	L/Min	6 – 2 – 2 – 2 – 2 – 2 – 2 8	

TOTAL EBL: 150
TOTAL URINE: 250

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS

FLUIDS
LINE site RA 18g ☐ Warmed — 400 – 700 – 800 900 1000 NS LR →
☐ Warmed
☐ Warmed
☐ Warmed

LOSSES
EST BLOOD LOSS 250/250
URINE – 150/150

FLUIDS – SUMMARY
CRYSTALLOID – LR /NS 1000
COLLOID – Ø
BLOOD – Ø

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 65 [✓ KG] LB

HEMATOCRIT:

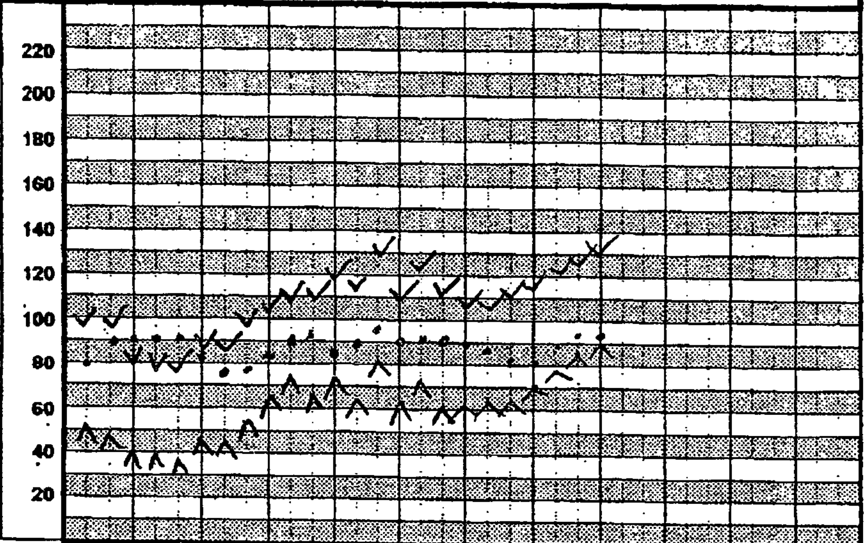
INITIAL DATA:
BP – 94/153
HR – 96 77%

EQUIP CHECK
OK? – [✓ Y] N

PATIENT RECHECK
OK for PROCEDURE Y
TIME – 1730

TIME → 1745 1800 x 30 x 19 x 30 x 20

SYMBOLS:
BP by cuff V Λ
Heart rate ●
Resp rate
BP (transduced)
TOURNIQUET T – X
ANES – X-X
PROC ⊙ – Ø



REMARKS – Code drugs with numbers, events with letters

Preop PIV ✓ NPO since 1200 agrees to GA for R leg surgery cooperative to OR On monitors Stable IV Induction ExFix d/c prep/drape 1937 Suction, Agreed to E

RLK T @ 250 mmHg
↑ @ 1812
↓ @ 1845
33 min T.T.

VENTILATION

VT – ml		640	640	660	650	660	560	
f – breaths/min		8	7	7	7	8	6 12	12
Peak inf pres / PEEP		18	18	18	18	17	16	
MODE – S(pon), A(ssist), C(on)	S	C	C	C	C	C	C S	S

MONITORS / ACCESSORIES

✓ BP/Auto Cuff	✓ ET CO2 (torr)	+	31	32	32	33	32	39	34
BP / oth	✓ FIO2 (Frac or %)	.9	.88	.87	.89	.88	.88	.88	.88
ART line	✓ SpO2 (%)	100	100	100	100	100	100	100	100
Steth- PC/ES	✓ ECG	SR	SR	SR	SR	SR	SR	SR	SR
Gas analyzer	✓ TEMP- site P.O.		36.5	36.1	36.9	36.9	37.1	36.9°C	X
	✓ N-M Block (T/4)	4	0	4					
Warming blkt									
Conv warmer									

Report to MAJ [redacted]

Mark with letters & symbols, explain under REMARKS
EVENTS
Position → (sup)

RECOVERY AT
PACU [✓ ICU 3] (Specify)
OTHER
CONDITION: STABLE
RESP – 16 Room Air SpO2 – 99
BP – 127/84 HR – 103

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1725	1735	1945
	Ready	**Begin**	**End**
PROC	1742	1754	1935

PROCEDURES and CPT Codes
Rt BKA

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GA: eyes taped, DLx1, grd I view, 3 MAC, 8.0 ETT
BBS = B, +ETCO2, taped @ 24 cm GBB.
AIRWAY MANAGEMENT: intubation route, blade, technique, comments

PATIENT IDENTIFICATION – Typed or written entries: Name, Grade/Rate, Medical facility
#[redacted]
ICU #3
b(6)-4

[redacted]

ANESTHETIST: [redacted] LTC CRNA
b(6)-2

PROCEDURE LOCATION OR 1
6 JUL 03
1 of 1

MEDCOM - 12819

MEDICAL RECORD — ANESTHESIA

ANESTHETIC AGENTS AND DRUGS

CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML, " I "=CONSTANT INFUSION

DRUG	(Units)									TOTALS
Versed	(mg)	5								5mg
Fent	(µg)	50	50	50	25 25		25	25		250µg
Propofol	(mg)	150					50			
Lido	(mg)	25					25			
MSO4	( )		5		5					10mg
	( )									
INHALAT AGENT Forane	% del	1.5	2.0		1.5	1	X			
	% e.t.									
AIR	L/Min									
N2O	L/Min									
O2	L/Min	8	2	2	2	3	9			

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS ▶

TOTAL EBL: 150

TOTAL URINE: 350

FLUIDS

LINE site LR	☐ Warmed	500	800	1300
	☐ Warmed			
	☐ Warmed			
	☐ Warmed			

FLUIDS – SUMMARY

CRYSTALLOID– 1300

COLLOID– 0

BLOOD– 0

LOSSES		
EST BLOOD LOSS	100	150
URINE –	300	350

PHYS STATUS: 1 [✓ 2] 3 4 5 E

TIME ▶ X 30 X 09 X 30 X 10

BODY WEIGHT: 65 [✓ KG] LB

HEMATOCRIT: 35.2

INITIAL DATA:

BP – 120/69

HR – 124

EQUIP CHECK

OK?– [✓ Y] N

PATIENT IDENTIFIED

OK for PROCEDURE?

TIME– 0730

SYMBOLS:

BP by cuff V Λ

Heart rate ●

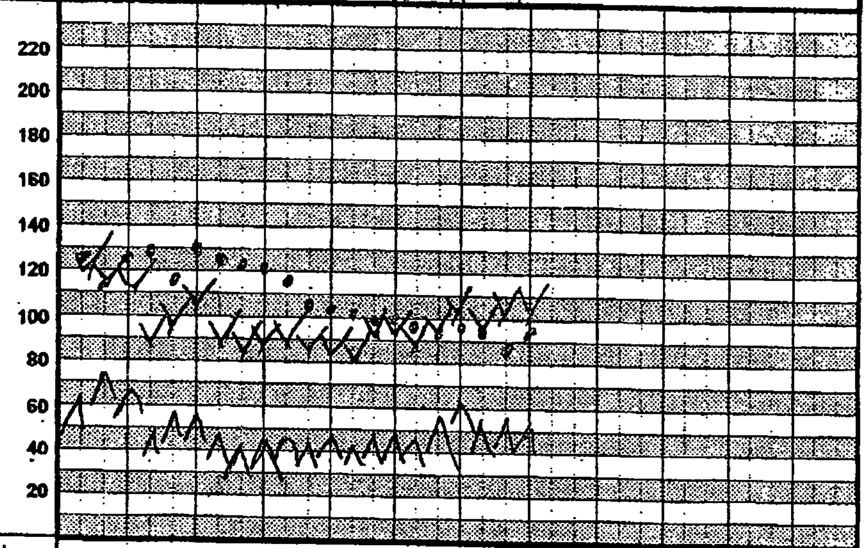
Resp rate

BP (transduced) ╧ ╤

TOURNIQUET T – ~~T~~

ANES– X-X

PROC– ⊙–Ø



REMARKS–

Code drugs with numbers, events with letters

0815 in OR monitors applied

0820 Induct #4 LMA placed ⊕ bilat BS ⊕ ETCO2

1005 Spont Resp ⊕ swallow, LMA out transfered to ICU stable report given.

VENTILATION

VT – ml								
f – breaths/min	12	10	6	12	6	9	9	7
Peak insp pres / PEEP								
MODE– S(pon), A(ssist), C(on)	SV AV SV	SV	AV	SV	SV	SV		

MONITORS

✓ BP/Auto Cuff	✓ ET CO2 (torr)	48	47	46	39	37	41	
BP / oth	✓ FIO2 (Frac or %)	93 92	91	91	91	91	92	
ART line	✓ SpO2 (%)	99 98	95	100	100	100	100	
Steth- PC/ES	✓ ECG	ST ST	ST	ST	ST	ST	ST	
Gas analyzer	✓ TEMP- site	Available						
	N-M Block (T/4)							
Warming blkt								
Conv warmer								

RECOVERY AT 1010

PACU ICU ICU3 (Specify)

OTHER ______

CONDITION: RA

RESP– 12 SpO2– 94%

BP– 115/85 HR– 118

ANESTHESIA / PROCEDURE TIME

	Start	Room	End
ANES	0715	0815	1020
	Ready	Begin	End
PROC	0820	0836	~~1000~~ 0955

Mark with letters & symbols, explain under REMARKS **EVENTS**

Position ⟶ supine

PROCEDURES and CPT Codes

(L) BKA Revision c washout

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

Gen Anes #4 LMA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments #4 LMA placed one attempt ⊕ ETCO2 ⊕ bilat BS

PATIENT IDENTIFICATION– Typed or written entries: Name, Grade/Rate, Medical facility

[redacted] ICU3 ICU3

b(6)-4

SURGEON [redacted]

MAJ. CRNA 7/8/03

b(6)-2

PROCEDURE LOCATION OR 2

28 TMCSH

MEDCOM - 12820

MEDICAL RECORD - ANESTHESIA

8 For us his form, see AR 40-66; the proponent agency OTSG

ANESTHETIC AGENTS AND DRUGS

CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML, "I" = CONSTANT INFUSION

DRUG (Units)	20			9	TOTALS	TOTAL EBL
Versed (mg)	2.5				2.5	10
Fent (mg)	.50	50 50 50			250	
Propofol ( )	180					

TOTAL URINE: Un

VOLAT AGENT: Forane % del 1.20 — 1 — X

% e.t.

AIR L/Min

N2O L/Min

O2 L/Min 4

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS

FLUIDS

LINE site LR start 700 ☐ Warmed

☐ Warmed

☐ Warmed

☐ Warmed

FLUIDS SUMMARY

CRYSTALLOID- 1500 c/c

COLLOID-

BLOOD-

LOSSES

EST BLOOD LOSS

URINE -

PHYS STATUS

1 [✓ 2] 3 4 5 E

BODY WEIGHT: 105 [✓ KG] LB

HEMATOCRIT: 25

INITIAL DATA:

BP- 118/69

HR- 87

EQUIP CHECK

OK?- [✓ Y] N

PATIENT RECHECK

OK for PROCEDURE?

TIME- 0730

TIME → 8 20

SYMBOLS:

BP by cuff V Λ

Heart rate ●

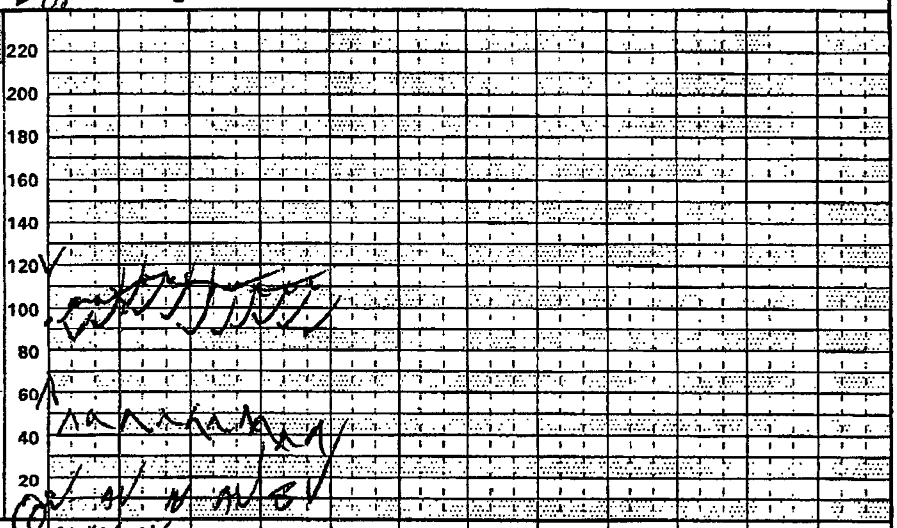
Resp rate

BR (transduced)

TOURNIQUET T—T

ANES- X-X

PROC- ⊙-Ø



REMARKS

Code drugs with numbers, events with letters

① Tum[illegible] — [illegible]

② [illegible] 1cy

[illegible]

O2 [illegible]

VENTIL

VT - ml: SV AV SV

f - breaths/min

Peak inf pres / PEEP

MODE - S(pon), A(ssist), C(on)

MONITORS/ACCESSORIES

✓ BP/Auto Cuff

BP/oth

ART line

Steth- PC/ES

✓ Gas analyzer

✓ ET CO2 (torr)

✓ FIO2 (Frac or %)

✓ SpO2 (%)

✓ ECG

✓ TEMP-site Axilla

N-M Block (T/4)

Warming blkt

Conv warmer

Mark with letters & symbols, explain under REMARKS EVENTS Position → [illegible]

RECOVERY AT:

PACU ICU S (Specify)

OTHER

CONDITION:

RESP- SpO2-

BP- HR- 107

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0715	0755	0855
	Ready	**Begin**	**End**
PROC	0805	810	845

PROCEDURES and CPT Codes:

I&D Ⓡ Leg Amp

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

#4LMA

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* #4LMA

Placed one attempt ⊕ETCO2⊕ Bilat BS b2-2

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*

#[redacted] b(6)-4

SURGEONS: [redacted] b(6)-2

ANESTHETIST: [redacted] [redacted] CRNA [redacted] [illegible]

PROCEDURE LOCATION: [redacted]

DATE: 7/13/03

PAGE 1 OF 1

MEDICAL RECORD **ANESTHESIA**

CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML. "("=CONSTANT INFUSION

DRUG	(Units)					
phenergan	(mg)	12.5			12.5	
Morphine	(mg)	4/2	4/4	6		
propofol	(mg)	150				
	( )					
	( )					
	( )					
VOLAT. AGENT Isc	% del	2.0	1.5	1.5	1.0X	
	% e.t.					
AIR	L/Min					
N2O	L/Min					
O2	L/Min	6—2—2—2—2—6				

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS: ① ② ③

LINE site 20g RFA ☐ Warmed RL 800↑———— 500–1000

☐ Warmed

☐ Warmed

☐ Warmed

LOSSES: EST BLOOD LOSS

URINE –

TOTALS: 20 min

TOTAL URINE: None

FLUIDS – SUMMARY

CRYSTALLOID– 600

COLLOID– 0

BLOOD– 0

REMARKS– Code drugs with numbers, event with letters

① To room, SOC mons applied, pre O2.

② Smooth IV ind

③ Pt to recovery stable. Report to nsg staff.

ASA STATUS: (2) 3 4 5 E

BODY WEIGHT: 65 (KG) LB

HEMATOCRIT: 26

INITIAL DATA: 103/59, HR-102

EQUIP CHECK: K? (Y) N

PATIENT RECHECK for PROCEDURE? ✓

TIME → 13 30 14 30 15 30

SYMBOLS:

BP by cuff ∨ ∧

Heart rate •

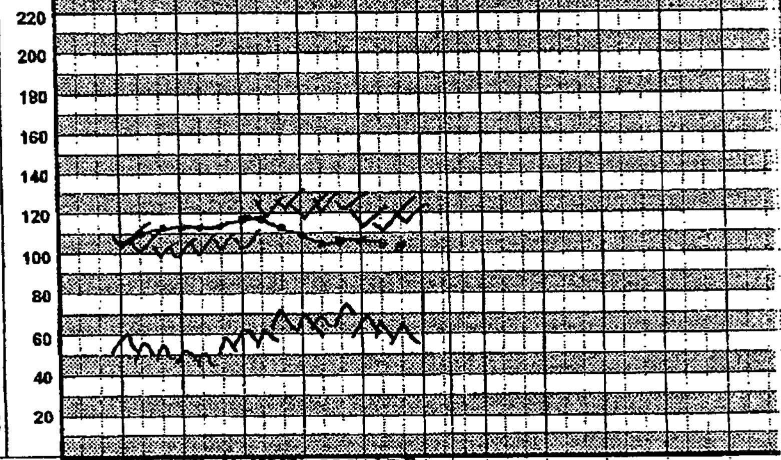
Resp rate

BP (transduced)

TOURNIQUET T – ✗

ANES– X-X

PROC-⊙-0



VT – ml		450	400	410	500	470	
f – breaths/min		28	34	28	24	26	
Peak insp pres / PEEP		—	—	—	—	—	
MODE– S(pon)/A(ssist), C(on)	S	S	S	S	S	S	
✓ BP/Auto Cuff	✓ ET CO2 (torr)	30	30	36	32	34	
BP / oth	✓ FIO2 (Frac or %)	0.8	0.8	0.8	0.8	0.8	
ART line	✓ SpO2 (%)	ST	ST	ST	ST	ST	ST
Steth- PC/ES	✓ ECG	100	100	100	100	100	100
Gas analyzer	TEMP- site available						
	N-M Block (T/4)						
Warming blkt							
Conv warmer							

Mark with letters & symbols, explain under REMARKS EVENTS

Position → O—| ——→ ——→

RECOVERY AT PACU (ICU) 3 (Specify)

OTHER

CONDITION:

RESP- 16 SpO2- 98

BP- 127/79 HR- 105

ANES/SURGICAL PROCEDURE TIME

	Start	Room	End
ANES	1300	1310	1425
	Ready	Begin	End
PROC	1315	1325	1410

PROCEDURES and CPT Codes: Debride/Washout Rt BKA Stump

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: Gen Mask

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: Eyes taped, #9 OA placed, easy mask

PATIENT IDENTIFICATION– Typed or written entries: Name, Grade/Rate, Medical facility

b(6)-4

EPW [redacted]

24 yo ♂

NKDA

IW3

SURGEON [redacted]

[redacted] MAJ CRNA

RECORD – ANESTHESIA

WAM[redacted] REVISED 1 Jan 99

b(6)-2

PATIENT RECORD

PROCEDURE LOCATION 1-1

DATE 7/11/03

PAGE 1 OF 1

☆ U.S. GPO: 1999 – 528-338/10

MEDCOM - 12822

ICU 3

Dravene case

MEDICAL RECORD — ANESTHESIA

ANESTHETIC AGENTS AND DRUGS
CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML. * [*]=CONSTANT INFUSION

DRUG	ROUTE		TOTALS
Propofol	(mg)	<70>	70
MSO4 <10>	(mg)	<10> <5> <5>	30
Lidocaine	(mg)	50	5
VC3cc	(mg)	2	2
	( )		
	( )		
VOLAT AGENT Hal	% del	1.3 1.6 X	
	% e.t.		
AIR	L/Min		
N2O	L/Min		
O2	L/Min	10 – 2 – 10	

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS ▶

TOTAL EBL: min

TOTAL URINE: N/A

FLUIDS SUMMARY
CRYSTALLOID– 200
COLLOID– 0
BLOOD– 0

FLUIDS
LINE site 14 (R)
☐ Warmed
☐ Warmed LR ——— 200
☐ Warmed
☐ Warmed

LOSSES
EST BLOOD LOSS
URINE – Not measured

PHYS STATUS: 1 [✓ 2] 3 4 5 E

TIME → 0600 15 30 45

BODY WEIGHT: 65 [✓ KG] LB

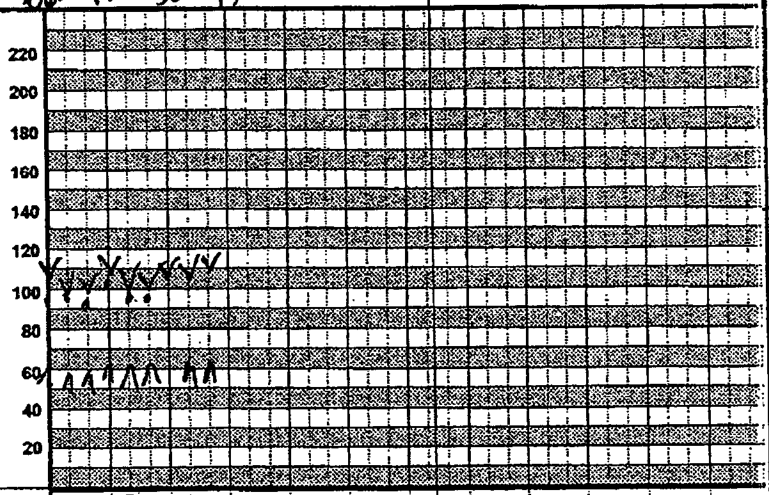
HEMATOCRIT: 7.4/24

INITIAL DATA:
BP– 106,56
HR– 75

EQUIP CHECK: OK?– [✓ Y] N

PATIENT RECHECK: OK for PROCEDURE Okay
TIME– 0530

SYMBOLS:
BP by cuff V Λ
Heart rate ●
Resp rate
BP (transduced) ╧╤
TOURNIQUET T — ↗
ANES– X-X
PROC-⊙-Ø



REMARKS–
Code drugs with numbers, events with letters!

0535 Arrived to ICU 3. Given 10mg MSO4 titrated. To OR via litter – pt moved self.

0600 In room. ⊕ monitors, ⊕ O2, smooth IV/inhalation induction. Arms < 90° on armboards.

0616 Procedure started

0640 Procedure complete. To ICU 3 in stable condition, Report to RNs

VENTIL			
VT – ml	–	–	–
f – breaths/min	24	30	24
Peak insp pres / PEEP	–	–	–
MODE– S(pon), A(ssist), C(on)	S	S	S

MONITORS / ACCESSORIES

☒ BP/Auto Cuff	☒ ET CO2 (torr)	31	28	30
BP / oth	☒ FIO2 (Frac or %)	>.21	>.21	>.21
ART line	☒ SpO2 (%)	100	100	100
Steth- PC/ES	☒ ECG	SR	ST	SR
Gas analyzer	☒ TEMP- site Skin			
	N-M Block (T/4)			
Warming blkt				
Conv warmer		Pt padded, eyes ears nose free of pressure		

Mark with letters & symbols, explain under REMARKS
EVENTS
Position → 0 →

RECOVERY AT 0645
PACU ICU 3 (Specify)
OTHER
CONDITION: Stable
RESP– 12 SpO2– 100
BP– 103/66 HR– 98

ANES / PROCEDURE TIMES

ANES	Start 0535	Room 0600	End 0648
PROC	Ready 0608	Begin 0616	End 0640

PROCEDURES and CPT Codes
Washout (R) BKA stump

ANESTHETIC TECHNIQUES: Describe block technique under Remarks GA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
Anesthesia mask, oral airway, Eyes taped.

PATIENT IDENTIFICATION– Typed or written entries: Name, Grade/Rate, Medical facility

ICU 3
EPW # [redacted] b(6)-4
NKDA 24 yo ♂

SURGEONS [redacted] b(6)-2

ANESTHETIST [redacted]

PROCEDURE LOCATION OR 1
DATE 12 Jul 03
PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA
WAMC OP 376 REVISED
1 Jan 99

PATIENT RECORD

☆ U.S. GPO: 1999 – 628-336/10085

6 Changes from 13 Jul 03 8.6/22.6 Procedure verified

Pre-op done 13 Jul 03

MEDICAL RECORD - ANESTHESIA

For u... ..is form, see AR 40-66; the proponent agency i... ..OTSG

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML, "I" = CONSTANT INFUSION

DRUG (Units)					TOTALS
lidocaine (MG)	30				30
Propofol (MG)	200				200
Sux (MG)	100				100
MSO4 (MG)	<10>	<10>			20
( )					
( )					
VOLAT AGENT 150 % del		1.5	1.5	1.5 X	
% e.t.					
AIR L/Min					
~~N2O~~ L/Min					
O2 L/Min	6 -	2 -	2 -	2	10

TOTAL EBL: MIN

TOTAL URINE: 0

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS → ↓ induction & intubation

FLUIDS

LINE site #18 (R) A/C ☐ Warmed LR ——

☐ Warmed

☐ Warmed

☐ Warmed

LOSSES

EST BLOOD LOSS

URINE -

FLUIDS SUMMARY

CRYSTALLOID- LR - 800

COLLOID- 0

BLOOD- 0

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 70 (KG) LB

HEMATOCRIT: 22

INITIAL DATA: BP- 118/70 /

HR- 88

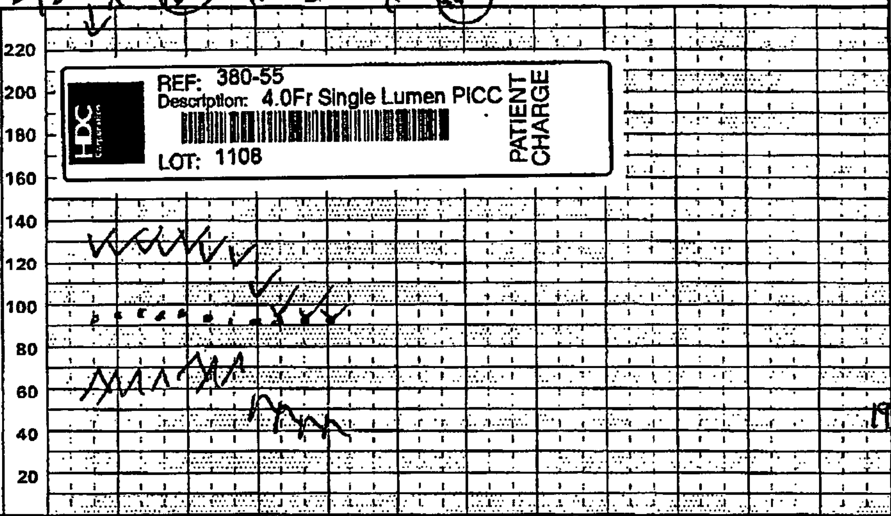
EQUIP CHECK OK?- [✓ Y] N

PATIENT RECHECK OK for PROCEDURE? (+)

TIME- 1700

TIME → 1800 X (1820) X 30 X (1900)

SYMBOLS: BP by cuff V Λ; Heart rate ●; Resp rate ○; BR (transduced); TOURNIQUET T—T; ANES- X-X; PROC- ⊙-Ø



REF: 380-55
Description: 4.0Fr Single Lumen PICC
LOT: 1108
HDC Corporation
PATIENT CHARGE

VENTIL

VT - ml		650	290	300
f - breaths/min		10	30	20
Peak inf pres / PEEP		17		
MODE - S(pon), A(ssist), C(on)	DV	CV	SV	S

MONITORS/ACCESSORIES

✓ BP/Auto Cuff	✓ ET CO2 (torr)		32	32	
BP/oth	✓ FIO2 (Frac or %)	1.0	1.0	1.0	0.86
ART line	✓ SpO2 (%)	100	100	100	100
Steth- PC/ES	✓ ECG	NS	NS	NS	SR
Gas analyzer	✓ TEMP-site	Skin		35 ——	
	N-M Block (T/4)				
✓ Warming blkt	head wrap ——				
Conv warmer					

Mark with letters & symbols, explain under REMARKS EVENTS → Position a - arms < 90° abducted & padded

REMARKS
Code drugs with numbers, events with letters

1800 - A meta chart reviewed IV in place

1840 - In room - monitors on - Induction intubation took over for care PICC line placed using aseptic technique advanced to 50cm - 10cm mark; dressing + Blood return

1950 P suctioned RR>8+<30BPM TV>4mL/KG Extubated s̄ complications TO ICU-3 Report

RECOVERY AT 1927

PACU ICU 3 (Specify)

OTHER T 36 Ax

CONDITION: Stable

RESP- 20 SpO2- 98

BP 94/47 HR- 115

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1800	1840	1940
	Ready	Begin	End
PROC	1850	1900	1915

PROCEDURES and CPT Codes: I+D (R) BKA stump.

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* # 8.0 ETT-LSI. #2 Miller, taped 21cm teeth. OGT L c̄ ⊕ return Eyes taped. OGT L c̄ ⊕ return

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* DL c̄ T p̄ preox. GR I view. ETT easily passed BSS+ / ETCO2 + Atraumatic

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*

[redacted]

b(6)-4

SURGEON: [redacted] b(6)-2

ANES [redacted]

PROCEDURE # LOCATION:

DATE: 14 Jul 03

PAGE 1 of 1

DA FORM 7389, FEB 1998 MEDCOM - 12824 COPY ... PATIENT'S M... RECORD USAPA V1.00

ACLU-RDI 1592 p.717

MEDICAL RECORD - ANESTHESIA

For us is form, see AR 40-66; the proponent agency i JTSG

ANESTHETIC AGENTS AND DRUGS – CONTINUOUS/REPEATED DRUGS - SPECIFY UNITS - MG/MCG/ML. "I" = CONSTANT INFUSION

DRUG (Units)						TOTALS
Fentanyl (mcg)	<250>					250
MSO4 (mg)	10		<10>			20
Propofol (mg)	150					
Neosynephrine (mcg)			100	100		
Zofran (mg)				4		
( )						
VOLAT AGENT Sevo % del	2.0	3.5	2.0	3.0	2.0 X	
% e.t.						
AIR L/Min						
N2O L/Min						
O2 L/Min	10	2	2	2	2 - 10	

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS → X Hespan 500 ——

TOTAL EBL: 200cc

TOTAL URINE: NA

FLUIDS - SUMMARY

CRYSTALLOID- 400

COLLOID- 200

BLOOD- 0

FLUIDS

LINE site 16 (R) AC ☐ Warmed LR ——

(L) AC ☐ Warmed

☐ Warmed

☐ Warmed

LOSSES

EST BLOOD LOSS

URINE - Not measured

PHYS STATUS

1 2 3 4 5 E

BODY WEIGHT: 70 [✓ KG] LB

HEMATOCRIT: 22

INITIAL DATA:

BP- /

HR- 90

EQUIP CHECK

OK?- [✓ Y] N

PATIENT RECHECK

OK for PROCEDURE?

TIME- 0650

TIME → 0700 · 30 · 0800 15

SYMBOLS:

BP by cuff V Λ

Heart rate ●

Resp rate

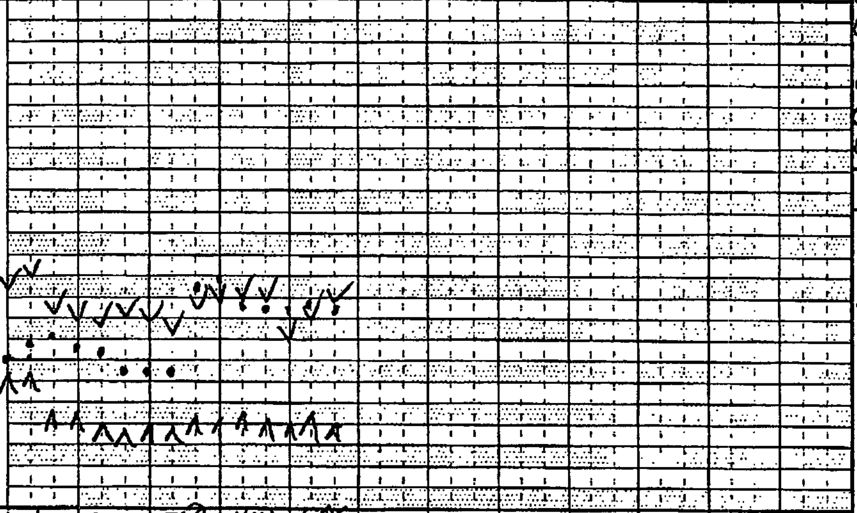
BR (transduced) ✚

TOURNIQUET T—T

ANES- X-X

PROC- ⊙-Ø

220 200 180 160 140 120 100 80 60 40 20



REMARKS

Code drugs with numbers, events with letters

0650- Pre-op review of systems; NPO verified; Lungs CTA (B) w RRR ⊝ m

0700 Room, monitors O2 mask

0715 Chris Watters CRNA to relieve.

0810 To ICU 3 4 in stable condition, to ICU 3 c mask O2. Report to RN

VENTIL

VT - ml	+	600	560	410	600
f - breaths/min	—	10	10	14	15
Peak inf pres / PEEP	—	—	—	—	—
MODE - S(pon), A(ssist), C(on)	S	S	S	S	S

MONITORS/ACCESSORIES

✓ BP/Auto Cuff	✓ ET CO2 (torr)	40	35	37	31	35
✓ BP/oth	✓ FIO2 (Frac or %)	0.83	0.83	.83	.83	.83
ART line	✓ SpO2 (%)	100	100	100	100	100
Steth- PC/ES	✓ ECG	SR ——	→	——	ST	SR
Gas analyzer	✓ TEMP-site	Axilla 36.5 Skin 34				
	N-M Block (T/4)					
✓ Warming blkt	✓ x1 Blanket ——	→	——	→		
Conv warmer						

Mark with letters & symbols, explain under REMARKS EVENTS → Position O— ——→ ——→

RECOVERY AT 0815

PACU ICU 3 (Specify)

OTHER

CONDITION: Stable

RESP- 16 SpO2- 100

BP- 111/66 HR- 71

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0645	0700	0820
	Ready	**Begin**	**End**
PROC	0710	0723	0805

PROCEDURES and CPT Codes: I&D (R) BKA

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* GMA

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*

[redacted]

b(6)-4

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* Natural c chin lift

SURGEONS: [redacted] b(6)-2

[redacted] CRNA/MAJ

PROCEDURE LOCATION: 1

DATE: 15 July 03

PAGE 1 OF

DA FORM 7389, FEB 1998

MEDCOM - 12825 [redacted] T'S MEDICAL RECORD USAPA V1.00

ACLU-RDI 1592 p.718

ICU3

MEDICAL RECORD - ANESTHESIA

For u. .his form, see AR 40-66; the proponent agency . OTSG

Drawer Case

ANESTHETIC AGENTS AND DRUGS

CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML, "I" = CONSTANT INFUSION

DRUG (Units)							TOTALS
Lidocaine (mg)	50						50
Versed (mg)	<5>						5
Mscr (mg)	<10>	<10>	<10>				30
Propofol (mg)	140						
( )							
( )							
VOLAT AGENT Halothane % del		1.3 –	1.8 –	1.5	1.0	X	
% e.t.							
AIR L/Min							
N2O L/Min							
(O2) L/Min	10 –	2 –	2 –	2 –	2 –	10	

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS →

TOTAL EBL: 100

TOTAL URINE: N/A

FLUIDS

LINE/site (L) AC PICC

☐ Warmed							
☐ Warmed	(500cc)	ℓ ———				(500)	
☐ Warmed							
☐ Warmed							

FLUIDS SUMMARY

CRYSTALLOID- 500

COLLOID- Ø

BLOOD- Ø

LOSSES

EST BLOOD LOSS

URINE - Not measured

PHYS STATUS 1 (2) 3 4 5 E

BODY WEIGHT: 65 KG LB

HEMATOCRIT: 8/24

INITIAL DATA:

BP- ____/____

HR-

EQUIP CHECK

OK?- [✓ Y] N

PATIENT RECHECK

OK for PROCEDURE? Okay

TIME- 0815

TIME → 0815 30 45 0900 15 30 45

SYMBOLS:

BP by cuff V Λ

Heart rate ●

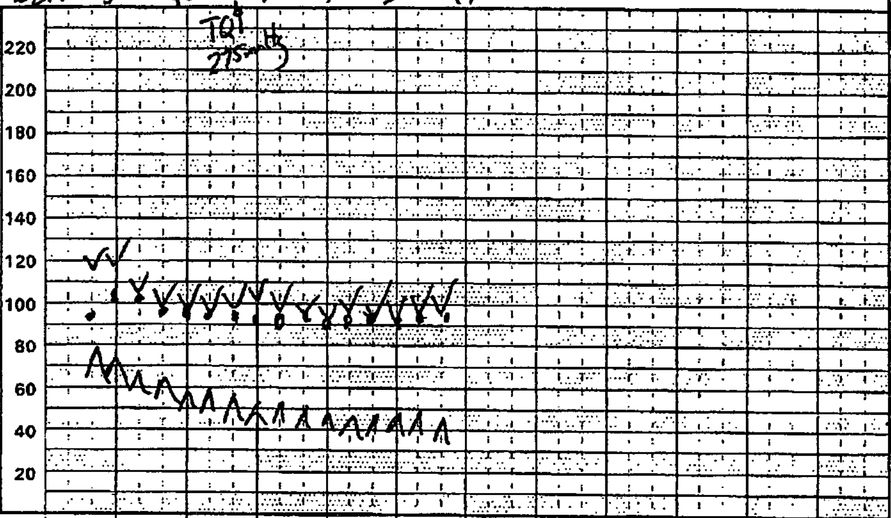
Resp rate

BR (transduced) ╪

TOURNIQUET T—T̸

ANES- X-X

PROC- ⊙-Ø



VENTIL

VT - ml	—	—	—	—	—	—
f - breaths/min	20	22	16	18	18	16
Peak inf pres / PEEP	—	—	—	—	—	—
MODE - S(pon), A(ssist), C(on)	S	S	S	S	S	S

MONITORS/ACCESSORIES

☒ BP/Auto Cuff	☒	ET CO2 (torr)	(+)	48	43	45	4	
BP/oth	☒	FIO2 (Frac or %)	.91	.91	.91	.91	.91	.91
ART line	☒	SpO2 (%)	100	100	100	100	100	100
Steth- PC/ES	☒	ECG	SR	ST	SR	SR	SR	SR
Gas analyzer	☒	TEMP-site skin						
		N-M Block (T/4)						
Warming blkt								
Conv warmer								

Mark with letters & symbols, explain under REMARKS EVENTS Position → Sup ——→ ——→ ——→

REMARKS

Code drugs with numbers, events with letters.

0810 Pt. i/n ICU3. To OR via litter.
0820 In room, + monitors, + O2. Smooth IV induction. Pt padded, eyes taped, arms < 90°
0846 Procedure started
0840 LMA out s̄ diff. Oral Airway, WT placed. Pt vent easily.
0845 To ICU3 c̄ mask O2, stable, Report to RN

RECOVERY AT 0945

PACU ICU 3 (Specify)

OTHER ____

CONDITION: Stable

RESP- 18 SpO2- 100

BP- 117/71 HR- 93

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0810	0820	0855
	Ready	**Begin**	**End**
PROC	0835	0846	0910

PROCEDURES and CPT Codes: I&D (R) BKA

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* GA

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*

EPW [redacted]

b(6)-4

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* #4 LMA inserted x 1 attempt s̄ difficulty, + BBS + ETCO2. Soft bite

SURGEON: [redacted]

ANESTHETIST: [redacted]

b(6)-2

PROCEDURE LOCATION: OR 2

DATE: 16 Jul 03

PAGE 1 OF 1

DA FORM 7389, FEB 1998

MEDCOM - 12826

COPY 1 - PATIENT'S MEDICAL RECORD

USAPA V1.00

see previous

WKDA

pre-op GAS

MEDICAL RECORD - ANESTHES

For us ‍.is form, see AR 40-66; the proponent agency . ‍JTSG

procedure verified

ANESTHETIC AGENTS AND DRUGS

CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML, "I" = CONSTANT INFUSION

DRUG (Units)					TOTALS
Lidocaine (Mg)	30				
Propofol (Mg)	200				
MSO4 (Mg)	<10>	<10> <10>	<10>		40mg
( )					
( )					
( )					
VOLAT AGENT 5O % del		2.0	1.5	1.25 X	
% e.t.					
AIR L/Min					
N2O L/Min					
O2 L/Min	6 - 2 - 2 - 2 - 6				

TOTAL EBL —

TOTAL URINE —

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS → ↓ induction

FLUIDS SUMMARY

CRYSTALLOID- LR - 600

COLLOID- —

BLOOD- —

FLUIDS

LINE site #20 (B) PIA ☐ Warmed — LR ↑

☐ Warmed

☐ Warmed

☐ Warmed

LOSSES

EST BLOOD LOSS

URINE -

PHYS STATUS 1 [✓ 2] 3 4 5 E

BODY WEIGHT: 65 [✓ KG] LB

HEMATOCRIT: 24.6

INITIAL DATA:

BP- 108/56

HR- 75

EQUIP CHECK OK?- [✓ Y] N

PATIENT RECHECK OK for PROCEDURE? (+)

TIME- 1315

TIME → 1330 x (1400) x 30 x (1500) x 30 x (1600)

SYMBOLS:

BP by cuff V Λ

Heart rate ●

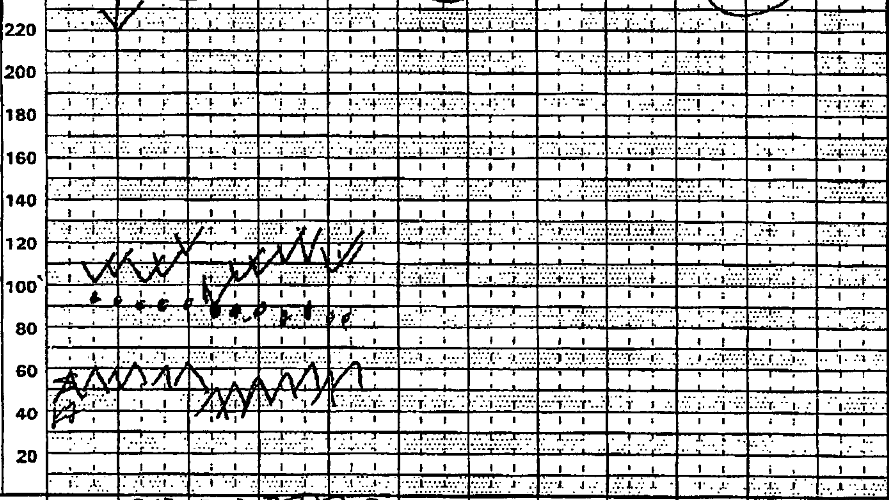
Resp rate

BR (transduced) ╪

TOURNIQUET T—T

ANES- X-X

PROC- ⊙-Ø



VENTIL

VT - ml		200	220	350	320
f - breaths/min	20	23	23	21	21
Peak Inf pres / PEEP					
MODE - S(pon), A(ssist), C(on)	SV	SV	SV	SV	SV

MONITORS/ACCESSORIES

~~BP/Auto Cuff~~	~~ET CO2~~ (torr)		35	35	35	36
BP/oth	~~FIO2~~ (Frac or %)	1.0	1.0	1.0	1.0	1.0
ART line	~~SpO2~~ (%)	100	100	100	100	100
Steth- PC/ES	~~ECG~~	NS	NS	NSR	NS	NS
~~Gas analyzer~~ CO2	~~TEMP~~-site	axillary				
	N-M Block (T/4)					
~~Warming blkt~~		wool blanket				
Conv warmer						

Mark with letters & symbols, explain under REMARKS EVENTS → Position ↗ — arms < 90° abducted c padded

REMARKS

Code drugs with numbers, events with lettters

1330 Met
10 IV in place
Chart red
Pre op done
1340 In room —
monitors on
induction

1335 Awake
LMA D/C'd
TO ICU
for recovery

ICU 2

RECOVERY AT:

PACU [✓ ICU] (Specify)

OTHER SAS

CONDITION: 35

RESP- 12 SpO2- 97%

BP- 108/66 HR- 116

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1330	1345	1425
	Ready	**Begin**	**End**
PROC	1350	1353	1421

PROCEDURES and CPT Codes: D c D (R) stump

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* General LMA

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* #4, 20 cc air inflated into cuff. Taped in place c soft bite block. Eyes taped. Preoxygenation. LMA #4 inserted. x1 attempt. Atraumatic

PATIENT IDENTIFICATION: *Typed or written entries: ~~Name~~, Grade/Rate, Medical facility*

#[redacted] ICW-2

6(W)-4

SURGEONS [redacted] 3(W)-2

ANESTHETIST [redacted]

PROCEDURE LOCATION: 4/1

DATE: 17 Jul 03

PAGE 1 OF 1

DA FORM 7389, FEB 1998

MEDCOM - 12827

COPY 1 - PATIENT'S MEDICAL RECORD

USAPA V1.00

MEDICAL RECORD - ANESTHESIA

For u… …is form, see AR 40-66; the proponent agency i… OTSG

Drawarz Case

ANESTHETIC AGENTS AND DRUGS

CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML, "I" = CONSTANT INFUSION

DRUG (Units)							TOTALS
Versed (mg)	3						3
Fentanyl (mcg)							
MSO4 (mg)	10	10		10			30
Propofol (mg)	30						
( )							
( )							
VOLAT AGENT Halothane % del	1.5	1.1	1.3	1.0	X		
% e.t.							
AIR L/Min							
N2O L/Min							
O2 L/Min	10	2	2	2	2	10	

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS

TOTAL EBL: 100cc

TOTAL URINE: w/14

FLUIDS

LINE site		
20g (R) wrist	☐ Warmed	WS —— (400) —— (700)
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

FLUIDS SUMMARY

CRYSTALLOID- WS 700cc

COLLOID- 0

BLOOD- 0

LOSSES

EST BLOOD LOSS: 50

URINE - Not measured

REMARKS

Code drugs with numbers, events with letters

7/18/03 No Δ in pt status since prior workup. Plan GA.

0720 Held in ICW 2. To OR on litter.

0730 In room, ⊕ monitors, ⊕ O2. Smooth inhalation induction c̄ drawer. All padded, eyes, ears, nose free of pressure

0855 Procedure complete. To ICW 2 c̄ mask O2 stable awake Report to RN

PHYS STATUS: 1 [✓ 2] 3 4 5 E

BODY WEIGHT: 65 [✓ KG] LB

HEMATOCRIT: 24.6%

INITIAL DATA: BP- 104/60 HR- 114

EQUIP CHECK OK?- [✓ Y] N

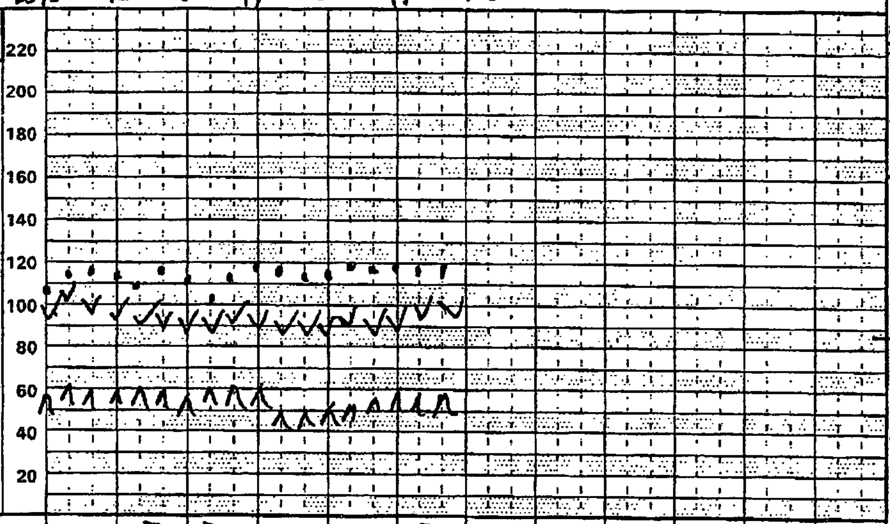
PATIENT RECHECK OK for PROCEDURE? Okay TIME- 0715

Smoker

NKDA

TIME → 0730 45 0800 15 30 45 0900

SYMBOLS: BP by cuff ∨ ∧ Heart rate ● Resp rate BR (transduced) TOURNIQUET T—T ANES- X-X PROC- ⊙-Ø



VENTIL

VT - ml	—	—	—	—	—	—
f - breaths/min	18	30	31	30	24	24
Peak inf pres / PEEP	—	—	—	—	—	—
MODE - S(pon), A(ssist), C(on)	S	S	S	S	S	S

MONITORS/ACCESSORIES

✓ BP/Auto Cuff	✓ ET CO2 (torr)	⊕	32	33	34	36	36
BP/oth	✓ FIO2 (Frac or %)	>.21	>.21	>.21	>.21	>.21	>.21
ART line	✓ SpO2 (%)	100	100	100	100	100	100
Steth- PC/ES	✓ ECG	ST	ST	ST	ST	ST	ST
Gas analyzer	✓ TEMP-site Skin				96°		
	N-M Block (T/4)						
Warming blkt							
Conv warmer							

Mark with letters & symbols, explain under REMARKS EVENTS *Position* → a —→ —→ —→

RECOVERY AT: 0900

PACU [✓ ICU] 2 (Specify)

OTHER

CONDITION: Stable

RESP- 24 SpO2- 100

BP- 99/71 HR- 102

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0720	0730	0905
	Ready	Begin	End
PROC	0740	0758	0855

PROCEDURES and CPT Codes: I+D (R) BKA - Closure Stump

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* GA

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*

EPW # [redacted]
24 yo ♂ b(6)-4
ICW 2

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* Anesthesia Mask, oral airway, Nasal Trumpet. Eyes taped,

SURGEONS: [redacted]

ANESTHETISTS: [redacted] b(6)-2

PROCEDURE LOCATION:

DATE: 7/18/03

PAGE 1 OF 1

DA FORM 7389, FEB 1998 MEDCOM - 12828 COPY 1 - PATIENT'S MEDICAL RECORD USAPA V1.00

Ⓡ BKA drsg Δ vs AKA   eneral Anes.   MVC I B3CTM, HRRR ØM S2, 5Ø6 100/60

ASA II Tdi Hx I:D, drg Δ NKA   last surg 18 Jul

MEDICAL RECORD - ANESTHESIA

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

S: Gent 1800 F. lowil Forty 0800 ⓓ-Mgt   Precceft [illegible]

DRUG (Units)				TOTALS	TOTAL EBL
promethazine (mg)	25			25	Ø
morphine (mg)	<10>	4/2	4	20	
propofol (mg)		140			TOTAL URINE
( )					N/A
( )					
( )					

CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML. "I" = CONSTANT INFUSION

ANESTHETIC AGENTS AND DRUGS

VOLAT AGENT				
ISO % del		1.5	X	
% e.t.				
AIR L/Min				
N2O L/Min				
O2 L/Min		6 - 2 - 2	X	
SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS		① ②	③	

FLUIDS

LINE site 18g RAC ☐ Warmed	NS	—— 400
☐ Warmed		
☐ Warmed		
☐ Warmed		

LOSSES

EST BLOOD LOSS

URINE -

FLUIDS - SUMMARY

CRYSTALLOID- 400

COLLOID- Ø

BLOOD- Ø

REMARKS

Code drugs with numbers, events with letters

Pt & chart ✓. Labs ✓. OK to proceed c̄ GA.

① To room, SOC monitors on, pre O2.

② Smooth IV induction.

③ To recovery stable. Report given.

PHYS STATUS: 1 [✓ 2] 3 4 5 E

BODY WEIGHT: 65 [✓ KG] LB

HEMATOCRIT: 13 Jul 26.9

INITIAL DATA:

BP- 91/58

HR- 107

EQUIP CHECK: OK?- [✓ Y] N

PATIENT RECHECK: OK for PROCEDURE? Y

TIME- 1430

TIME → 30 x 15 x 30 x 16 x 30

SYMBOLS:

BP by cuff V Λ

Heart rate ●

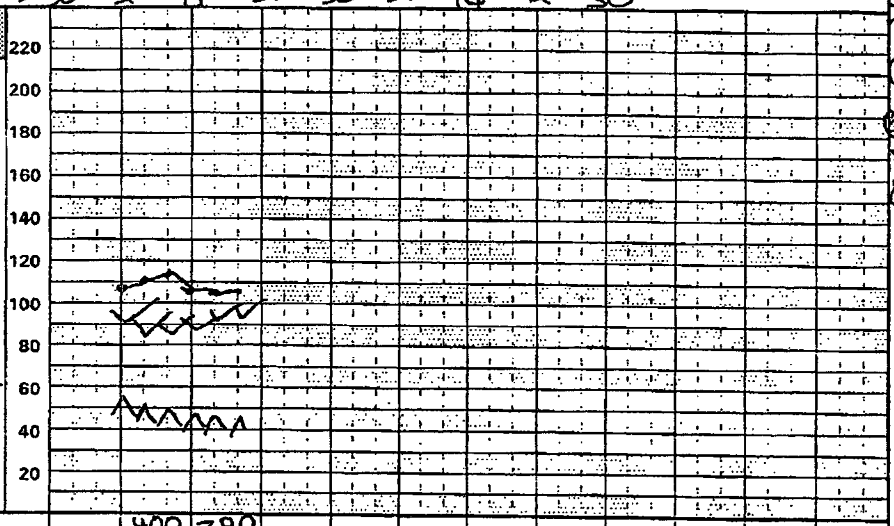
Resp rate

BR (transduced)

TOURNIQUET T—T

ANES- X-X

PROC- ⊙-Ø



VENTIL

VT - ml	400	390	
f - breaths/min	26	20	
Peak inf pres / PEEP	—	—	
MODE - S(pon), A(ssist), C(on)	S	S	

MONITORS/ACCESSORIES

✓ BP/Auto Cuff	✓ ET CO2 (torr)	34	32	
BP/oth	✓ FIO2 (Frac or %)	0.8	0.8	
ART line	✓ SpO2 (%)	100	100	
Steth- PC/ES	✓ ECG	ST	ST	
Gas analyzer	TEMP-site available			
	N-M Block (T/4)			
Warming blkt				
Conv warmer				

Mark with letters & symbols, explain under REMARKS EVENTS Position → O —— 1 ——→

RECOVERY AT 1512

PACU [✓ ICU] (Specify)

OTHER 99°

CONDITION:

RESP. 21 SpO2- 100

BP- 92/59 HR- 106

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1430	1445	1520
	Ready	Begin	End
PROC	1450	1455	1510

PROCEDURES and CPT Codes:
EUA, remove JP, dssg Δ R+ BKA stump

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*
General mask.

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*
# [redacted] AKA FREDDY
b(6)-4 ICW 2

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*
Eyes taped, 30F NA placed, easy mask

SURG [redacted] b(6)-2, MAJ, CRNA

PROCEDURE LOCATION: 1-1

DATE: 7/20/03

PAGE 1 OF 1

DA FORM 7389, FEB 1998   MEDCOM - 12829 [redacted] PATIENT'S MEDICAL RECORD   USAPA V1.00

Smoller NKDA

MEDICAL RECORD - ANESTHESIA

For . s form, see AR 40-66; the proponent agency ·TSG

ANESTHETIC AGENTS AND DRUGS

CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML, "I" = CONSTANT INFUSION

DRUG (Units)								TOTALS
Versed (mg)	2-2							4mg
MSO4 (mg)	10	4	6	55				30mg
propofol (mg)	5050							100mg
( )								
( )								
( )								
VOLAT AGENT halothane del	.54 1	.75	.75	.75	.75	.5X		
% e.t.								
AIR L/Min								
N2O L/Min								
O2 L/Min	4-6	4	4	4	6	6	6	

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS

TOTAL EBL: 60cc

TOTAL URINE: 0

FLUIDS

LINE site								
☐ Warmed								
IV LR ☐ Warmed	—	—	400	—	—	—	600	
☐ Warmed								
☐ Warmed								

FLUIDS - SUMMARY

CRYSTALLOID- 600cc

COLLOID-

BLOOD-

LOSSES

EST BLOOD LOSS

URINE -

REMARKS

Code drugs with numbers, events with letters

SD'd pt in SCU 2
① Inhalation incision induction c halothane tolerated well
② OETT placed per Surgeon
0906 end of Casting
③ To SCU 3 on Rm air 99% Responds to Name
Report to Cpt Rayski RN
VS Stable.

PHYS STATUS: 1 [✓ 2] 3 4 5 E

BODY WEIGHT: 65 KG [✓ LB]

HEMATOCRIT: 28.9

INITIAL DATA:

BP- 113/79

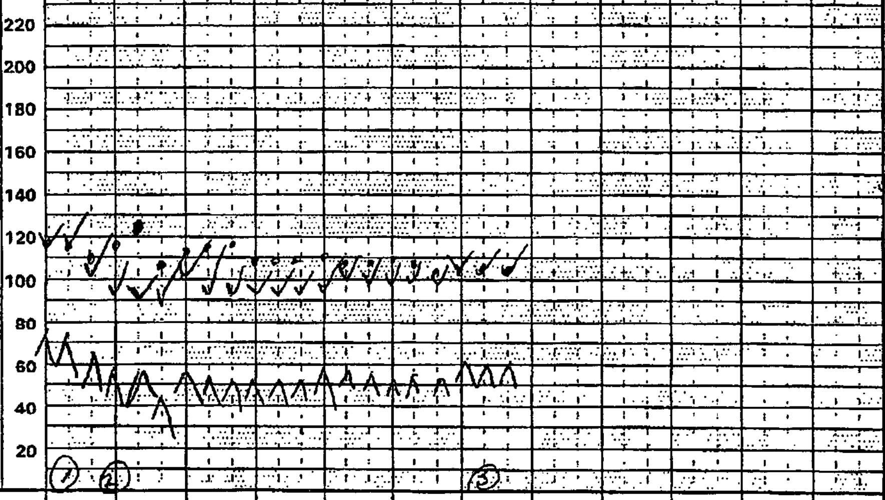
HR- 118

EQUIP CHECK
OK?- [✓ Y] N

PATIENT RECHECK
OK for PROCEDURE? Y
TIME- 0730

TIME → 0800 . 30 . 0900 930

SYMBOLS:
BP by cuff V Λ
Heart rate ●
Resp rate
BR (transduced) ✝
TOURNIQUET T — T
ANES- X-X
PROC- ⊙-Ø



VENTIL

VT - ml							
f - breaths/min	32	36	22	22	22	22	22
Peak inf pres / PEEP							
MODE - S(pon), A(ssist), C(on)	S	A	S	S	S	S	S

MONITORS/ACCESSORIES

✓ BP/Auto Cuff	✓ ET CO2 (torr)	42	43	45	42	45	45	45
BP/oth	✓ FIO2 (Frac or %)	.85	.85	.85	.85	.85	.85	.85
ART line	✓ SpO2 (%)	100	100	100	100	100	100	100
✓ Steth- [✓ PC] /ES	✓ ECG	ST	ST	ST	ST	ST	ST	ST
Gas analyzer	✓ TEMP-site Skin	34	34	34	34	34	34	34
	N-M Block (T/4)							
Warming blkt								
Conv warmer								

Mark with letters & symbols, explain under REMARKS EVENTS Position → ⌐ Bilat arms <90°

RECOVERY AT 0945

PACU ICU 3 (Specify)

OTHER ________

CONDITION: Stable

RESP- 22 SpO2- 99

BP- 113/69 HR- 111

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	~~0800~~ 0750	0800	0945

	Ready	Begin	End
PROC	0818	0827	0927

PROCEDURES and CPT Codes: (R) Stump closure with flap advancement

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*
GA

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*

[redacted] b(6)-4

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*
MASK induction, oral airway → OETT 8.0 @22 cm +/= BBS + +ETCO2

SURGEONS: [redacted] b(6)-2

ANESTHETISTS: [redacted]

PROCEDURE LOCATION: OR1

DATE: 06 Aug 03

PAGE 1 OF 1

DA FORM 7389, FEB 1998 COPY 1 - PATIENT'S MEDICAL RECORD USAPA V1.00

MEDCOM - 12830

ːSTHESIA PLAN OF CARE PRE.. ..OCEDURAL ASSESSMENT (Sedation/A...sthesia)

24 DAYS MOS [✓ YRS] Sex [✓ MALE] ( ) FEMALE

POSED PROCEDURE: I&D (R) TIB & ExFix

GICAL SERVICE: ______

SINCE: ______

ASA Physical State [✓ 1] 2 3 4 5 E

WT: 65 [✓ KG]/LB HT: 66? IN.

ALLERGIES: NKDA

ITS: SMOKER

BACCO: ______

ETOH: ______

DRUGS: ______

RENT MEDICATIONS:

ordered as premed

______

MEDICATIONS:

ː Yes (@ ______ Hrs) /CC

__ . ______ mg IV IM PO

__ . ______ mg IV IM PO

__ . ______ mg IV IM PO

ORATORY STUDIES:

H/H

HCT: 11.1 , 35.1

IER: ______

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:

Hypertension [✓ N] Y

Angina [✓ N] Y

MI [✓ N] Y

CVA [✓ N] Y

Other [✓ N] Y

Pulmonary System:

Asthma N Y IN/EX WHEEZES

Bronchitis/URI N Y

COPD N Y (B)

Other N Y

Renal System:

Acute/Chronic RF [✓ N] Y

Gastrointestinal:

Hepatitis [✓ N] Y

Hiatal Hernia [✓ N] Y

PUD/GERD [✓ N] Y

Endocrine System:

Diabetes [✓ N] Y

Steriods [✓ N] Y

Thyroid [✓ N] Y

Neurological:

Seizures [✓ N] Y

Neuropathy [✓ N] Y

Other [✓ N] Y

Gynecological :

Pregnancy N Y

Other Significant Hx:

N Y

N Y

Familial HX N Y

ASSESSMENT

PAST SURGICAL/ANESTHETIC

I&D MULTIPLE

PHYSICAL EXAMINATION

BP 111/51 HR 83 R 20 T ___

Pain Scale 0-10 ______

HEENT - Teeth WNL

Trachea ______

TMJ/Neck 3+

Oropharnyx MP-2

Nares ______

CHEST: IN & EX WHEEZES

CARDIAC: S1 S2

EXTREMITIES:

IV Access: (R) FA

Ulnar Filling: ______

BACK: ______

OTHER: ______

NPO Since YESTERDAY

ESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ______ {✓} General: Mask [✓ Intubation]

ORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to ːussed with [redacted]dian. b(6)-2

patient[redacted]and and agrees. Questions answered.

ːed: [redacted] Date: 03 JUL 03 Time: 0720 Hrs

ːT-ANESTHESIA EVALUATION AND NOTE (NON ASU)

NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER

ːed: ______ Date: ______ Time: ______ Hrs

ent Identification: (Ward) ______

~~EPW #~~ [redacted]

~~Stays in ICU-1~~

~~Rec, in ICU-2~~

EPW # [redacted]

b(6)-4

SEDATION KEY:

1. MINIMAL (Anxiolysis) Patient responds normally to verbal commands
2. MODERATE (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is n necessary.
3. DEEP SEDATION/ANALGESIA. Patient responds purposefully following repeated or painful stimulation. Airway assistance may

MEDCOM - 12831

ANESTHESIA PLAN OF CARE PRE ...CEDURAL ASSESSMENT (Sedation/A...sthesia)

Age 21 DAYS MOS YRS

Sex (X) MALE ( ) FEMALE

PROPOSED PROCEDURE: BKA, (R) leg s/p ex fix
SURGICAL SERVICE: ORTHO/GS
NPO SINCE: 1200

ASA Physical State [✓ 1] 2 3 4 5 E
WT: 65 [✓ KG]/LB HT: 66 IN.
ALLERGIES: 0

HABITS:
TOBACCO: ✓
ETOH:
DRUGS:

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) Ancef
( ) MSO4
( ) Percocet
( )
( )
( )

PREMEDICATIONS:
None Yes (@ ______ Hrs) /CC
______ . ______ mg IV IM PO
______ . ______ mg IV IM PO
______ . ______ mg IV IM PO

LABORATORY STUDIES:
HB/HCT: ______ / ______
U/A:
OTHER:

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:		
Hypertension	N Y	0
Angina	N Y	
MI	N Y	
CVA	N Y	
Other	N Y	
Pulmonary System:		
Asthma	N Y	0
Bronchitis/URI	N Y	
COPD	N Y	
Other	N Y	
Renal System:		
Acute/Chronic RF	N Y	0
Gastrointestinal:		
Hepatitis	N Y	
Hiatal Hernia	N Y	
PUD/GERD	N Y	
Endocrine System:		
Diabetes	N Y	0
Steriods	N Y	
Thyroid	N Y	
Neurological:		
Seizures	N Y	
Neuropathy	N Y	
Other	N Y	
Gynecological :		
Pregnancy	N Y	0
Other Significant Hx:		
	N Y	
	N Y	
Familial HX	N Y	

ASSESSMENT

PAST SURGICAL/ANESTHETIC
s/p ex fix

PHYSICAL EXAMINATION
BP 103/54 HR 57 R 17 T 98.3
Pain Scale 0-10 ______ 97% on RA
HEENT - Teeth OK
Trachea
TMJ/Neck MP Cl II
Oropharynx 3FB MO 3F
Nares
CHEST: CTA = B
CARDIAC: RRR
EXTREMITIES:
IV Access: RA PIV 18g
Ulnar Filling:
BACK:
OTHER:

NPO Since

ANESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ______ {X} General: Mask Intubation

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discussed with the patient/legal guardian.

b(6)-2

The patient/[redacted] seems to understand and agrees. Questions answered.

Signed: [redacted] -TC CRNA Date: 6 Jul 03 Time: 1720 Hrs

POST-ANESTHESIA EVALUATION AND NOTE (NON ASU)
{ } NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER

Signed: ______ Date: ______ Time: ______ Hrs

SEDATION KEY:
1. **MINIMAL** (Anxiolysis) Patient responds normally to verbal commands
2. **MODERATE** (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is not necessary.
3. **DEEP SEDATION/ANALGESIA.** Patient responds purposefully following repeated or painful stimulation. Airway assistance may

Patient Identification: (Ward) ______

[redacted]

ICU #3

b(6)-4

MEDCOM - 12832

THESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

24 DAYS MOS YRS

Sex ( ) MALE ( ) FEMALE

OSED PROCEDURE: BKA (L) leg

ICAL SERVICE: Ortho/GS

NCE: MAJ

ASA Physical State 1 [✓ 2] 3 4 5 E

WT: 65 KG/LB HT: 66 IN.

ALLERGIES: NKDA

S:

ACCO: (+)

ETOH: 0

RUGS: 0

ENT MEDICATIONS:

dered as premed

Ancef

Tagamet

Fent IV

Versed

EDICATIONS:

Yes (@ ______ Hrs) /CC

_. ______ mg IV IM PO

_. ______ mg IV IM PO

_. ______ mg IV IM PO

RATORY STUDIES:

T: ______ / ______

R: ______

133 | 97 | 4 < 105

4.9 | 40.8

11.9 > 11.1 / 35.2 < 576

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:

Hypertension	[✓ N]	Y	See pre-op
Angina	[✓ N]	Y	6 July
MI	[✓ N]	Y	
CVA	[✓ N]	Y	
Other	[✓ N]	Y	
Pulmonary System:			
Asthma	[✓ N]	Y	
Bronchitis/URI	[✓ N]	Y	
COPD	[✓ N]	Y	
Other	[✓ N]	Y	
Renal System:			
Acute/Chronic RF	[✓ N]	Y	
Gastrointestinal:			
Hepatitis	[✓ N]	Y	
Hiatal Hernia	[✓ N]	Y	
PUD/GERD	[✓ N]	Y	
Endocrine System:			
Diabetes	[✓ N]	Y	
Steriods	[✓ N]	Y	
Thyroid	[✓ N]	Y	
Neurological:			
Seizures	[✓ N]	Y	
Neuropathy	[✓ N]	Y	
Other	[✓ N]	Y	
Gynecological :			
Pregnancy	[✓ N]	Y	
Other Significant Hx:			
	[✓ N]	Y	
	[✓ N]	Y	
Familial HX	[✓ N]	Y	

ASSESSMENT
PAST SURGICAL/ANESTHETIC

S/P ex Fx

PHYSICAL EXAMINATION

BP 145/60 HR 89 R 12 T 100.6

Pain Scale 0-10 ______

HEENT - Teeth Poor Dentition -

Trachea MP-2 3FB oral

TMJ/Neck TM 3FB

Oropharnyx ______

Nares ______

CHEST: RRR

CARDIAC: CTA

EXTREMITIES:

IV Access: ______

Ulnar Filling: ______

BACK: ______

OTHER: ______

NPO Since ______

THETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ______ [✓ General]: Mask Intubation

MED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to a sed with the patient/legal guardian.

b(6)-2

[redacted] tand and agrees. Questions answered.

Date: 7/8/03 Time: 0730 Hrs

ANESTHESIA EVALUATION AND NOTE (NON ASU)

APPARENT ANESTHETIC COMPLICATIONS { } OTHER

d: ______ Date: ______ Time: ______ Hrs

t Identification: (Ward) ______

SEDATION KEY:

1. MINIMAL (Anxiolysis) Patient responds normally to verbal commands
2. MODERATE (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is no necessary.
3. DEEP SEDATION/ANALGESIA. Patient responds purposefully following repeated or painful stimulation. Airway assistance may

MEDCOM - 12833

ANESTHESIA PLAN OF CARE   PROCEDURAL ASSESSMENT [illegible]   [illegible]

Age 24 DAYS MOS [✓ YRS]   Sex [✓ MALE] ( ) FEMALE

PROPOSED PROCEDURE: Washout   s/p GSW Rt tibia & Lt hand
SURGICAL SERVICE: Surgery
NPO SINCE: 0700

ASA Physical State 1 [✓ 2] 4 5 E
WT: 65 [✓ KG] LB HT: ____ IN.
ALLERGIES: NKDA

HABITS:
TOBACCO: (+)
ETOH: 0
DRUGS: 0

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) LR 50cc/Hr
( ) Levaquin 500 q AM
( ) Colace 100mg BID
( ) ____
( ) ____
( ) ____

PREMEDICATIONS:
None Yes (@ ____ Hrs) /CC
____ - ____ mg IV IM PO
____ - ____ mg IV IM PO
____ - ____ mg IV IM PO

LABORATORY STUDIES:
HB/HCT: ____/____
U/A: ____
OTHER: ____

11.1 > 8.3 / 26.2 < 525

130 | 101 | 6 / 3.9 | 28 | 0.4 < 114

1310

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW
Cardiovascular:
Hypertension N Y
Angina N Y
MI N Y
CVA N Y
Other N Y
Pulmonary System:
Asthma N Y
Bronchitis/URI N Y
COPD N Y
Other N Y
Renal System:
Acute/Chronic RF N Y
Gastrointestinal:
Hepatitis N Y
Hiatal Hernia N Y
PUD/GERD N Y
Endocrine System:
Diabetes N Y
Steriods N Y
Thyroid N Y
Neurological:
Seizures N Y
Neuropathy N Y
Other N Y
Gynecological :
Pregnancy N Y
Other Significant Hx:
N Y
N Y
Familial HX N Y

all neg

ASSESSMENT
PAST SURGICAL/ANESTHETIC
Rt BKA 6 July
Revision 8 July
Ex Fix 2 June?

multiple easy intub.

PHYSICAL EXAMINATION
104/59 HR 90 R 15 T 98.5
Pain Scale 0-10 sleeping
HEENT - Teeth poor
Trachea ML
TMJ/Neck FROM
Oropharynx MP2
Nares N/A
CHEST: CTAB
CARDIAC: RRR
EXTREMITIES:
IV Access: RFA 20g
Ulnar Filling: N/A
BACK: N/A
OTHER: N/A

NPO Since 0700

ANESTHETIC PLAN: ( ) LOCAL ( ) MAC ( ) Regional (Specify): ____ [✓ General]: [✓ Mask] Intubation GETA backup

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to / discussed [redacted] b(6)-2 ...grees. Questions answered.
Date: 7/11/03 Time: 1230 Hrs

POST-
( ) NO APPARENT ANESTHETIC COMPLICATIONS ( ) OTHER
Signed: ____ Date: ____ Time: ____ Hrs

No Δ in [illegible] 7.4/58
X 7.4/23.9
for 7/12/03.
[redacted] CPT CAMA
b(6)-2

SEDATION KEY:
1. MINIMAL (Anxiolysis) Patient responds normally to verbal commands
2. MODERATE (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is not necessary.
3. DEEP SEDATION/ANALGESIA. Patient responds purposefully following repeated or painful stimulation. Airway assistance may

Patient Identification: (Ward) ICU 3

EPW # [redacted] b(6)-4

Plan for 1300 since pt ate bkft.

MEDCOM - 12834

ANESTHESIA PLAN OF CARE: PROCEDURAL ASSESSMENT

Age 24 DAYS MOS YRS

Sex [✓ MALE] ( ) FEMALE

ASA Physical State 1 [✓ 2] 3 4 5 E
WT: 65 KG/LB HT: ____ IN
ALLERGIES: NKDA

PROPOSED PROCEDURE: (R) Amputated Leg I&D s/p GSW R+ Tibia & Lt Hand
SURGICAL SERVICE: Gen Surg
NPO SINCE: MN

HABITS:
TOBACCO: (4)
ETOH: 0
DRUGS: 0

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) Vanco
( ) Levo
( ) Flagle
( ) Fen: Heparin
( ) Toradol
( ) Benl

PREMEDICATIONS:
None Yes (@ ______ Hrs) /CC
______ . ______ mg IV IM PO
______ . ______ mg IV IM PO
______ . ______ mg IV IM PO

LABORATORY STUDIES:

HB/HCT: ________ / ________
U/A: ________
OTHER: ________

6.7 > 7.7 / 25 < 594

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:
Hypertension N Y
Angina N Y
MI N Y
CVA N Y
Other N Y
Pulmonary System:
Asthma N Y
Bronchitis/URI N Y
COPD N Y
Other N Y
Renal System:
Acute/Chronic RF N Y
Gastrointestinal:
Hepatitis N Y
Hiatal Hernia N Y
PUD/GERD N Y
Endocrine System:
Diabetes N Y
Steriods N Y
Thyroid N Y
Neurological:
Seizures N Y
Neuropathy N Y
Other N Y
Gynecological:
Pregnancy N Y
Other Significant Hx:
N Y
N Y
Familial HX N Y

Neg
See PO
7/11/03

ASSESSMENT

PAST SURGICAL/ANESTHETIC
R BKA 6 July
Revision 8 July
Ex Fix 7 June

PHYSICAL EXAMINATION

BP 109/59 P 70 R 12 ° 98.6 ax
Pain Scale 0-10 ______
HEENT - Teeth Front upper mov Orbit Intact
Trachea M.P. Midline
TMJ/Neck 3FB TM
Oropharynx 3FB oral opening
Nares ______
CHEST: CTA B base
CARDIAC: RRR
EXTREMITIES:

IV Access: ______
Ulnar Filling: ______

BACK: ______

OTHER: ______

NPO Since ______

ANESTHETIC PLAN: ( ) LOCAL ( ) MAC ( ) Regional (Specify): ______ [✓ General]: Mask Intubation

Procedure pt understands via talk with Interpreter

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to discussed wit[redacted] legal guardian. b(6)-2

The p n and agrees. Questions answered.
Signed: Date: 7/12/03 Time: 0730 Hrs

POST-AN EVALUATION AND NOTE (NON ASU)
( ) NO APPARENT ANESTHETIC COMPLICATIONS ( ) OTHER

Signed: ______ Date: ______ Time: ______ Hrs

Patient Identification: (Ward) ICU3 - ICU3

EPW

[redacted]

b(6)-4

SEDATION KEY:

1. MINIMAL (Anxiolysis) Patient responds normally to verbal commands
2. MODERATE (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is not necessary.
3. DEEP SEDATION/ANALGESIA Patient responds purposefully following repeated or painful stimulation. Airway assistance may

MEDCOM - 12835

3Kc **NESTHESIA PLAN OF CARE P. OCEDURAL ASSESSMENT**

ge ___ DAYS MOS YRS Sex ( ) MALE ( ) FEMALE

ROPOSED PROCEDURE: (L) BKA washout
URGICAL SERVICE: Gen Surg
PO SINCE: MN

ASA Physical State 1 [✓ 2] 3 4 5 E
WT: 65 KG/LB HT: ____ IN.
ALLERGIES: NKDA

ABITS:
TOBACCO: (+)
ETOH: 0
DRUGS: 0

URRENT MEDICATIONS:
! = ordered as premed
! Vanco
! Levoquin
! Heparin
! Fent
! MSO4
!

REMEDICATIONS:
one Yes (@ ____ Hrs) /CC
____ . ____ mg IV IM PO
____ . ____ mg IV IM PO
____ . ____ mg IV IM PO

ABORATORY STUDIES:
B/HCT: ____ / ____
/A:
THER:

6.7 > 7.7/24.6 < 684

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:			
Hypertension	[✓ N]	Y	
Angina	[✓ N]	Y	
MI	[✓ N]	Y	
CVA	[✓ N]	Y	
Other	N	Y	
Pulmonary System:			
Asthma	[✓ N]	Y	
Broncnitis/URI	[✓ N]	Y	
COPD	[✓ N]	Y	
Other	[✓ N]	Y	
Renal System:			
Acute/Chronic RF	[✓ N]	Y	
Gastrointestinal:			
Hepatitis	[✓ N]	Y	
Hiatal Hernia	[✓ N]	Y	
PUD/GERD	[✓ N]	Y	
Endocrine System:			
Diabetes	[✓ N]	Y	
Steriods	[✓ N]	Y	
Thyroid	[✓ N]	Y	
Neurological:			
Seizures	[✓ N]	Y	
Neuropathy	[✓ N]	Y	
Other	[✓ N]	Y	
Gynecological :			
Pregnancy	N	Y	
Other Significant Hx:			
	N	Y	(L) BKA
	N	Y	2u PRBC's
Familial HX	N	Y	15 Jul

ASSESSMENT
PAST SURG/CAL/ANESTHETIC
S/P ex fix –

PHYSICAL EXAMINATION
BP 108/56 HR 71 RR 12 T 98.5
Pain Scale 0-10 ____
HEENT - Teeth Poor dentition
Trachea MP 2 3FB Oral
Thd/Neck midline
Oropharnyx ____
Nares ____
CHEST:
CARDIAC:
EXTREMITIES:
IV Access:
Ulnar Filling:
BACK:
OTHER:

NPO Since MN

ANESTHETIC PLAN: ( ) LOCAL ( ) MAC ( ) Regional (Specify): ____ [✓ ( )] General: Mask intubation

NFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discussed with the patient/legal guardian. b(6)-2

The p [redacted] stand and agrees. Questions answered.
Signe [redacted] Date: 7/16/03 Time: 0800 Hrs

OST-ANESTHESIA EVALUATION AND NOTE (NON ASU)
) NO APPARENT ANESTHETIC COMPLICATIONS ( ) OTHER

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward) ____

[redacted]

b(6)-4

SEDATION KEY:
1. MINIMAL (Anxiolysis) Patient responds normally to verbal commands
2. MODERATE (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is not necessary.
3. DEEP SEDATION/ANALGESIA. Patient responds purposefully following repeated or painful stimulation. Airway assistance may

MEDCOM - 12836

37K

NESTHESIA PLAN OF CARE P: OCEDURAL ASSESSMENT (Sedation, Analgesia)

ge ___ DAYS MOS YRS

Sex ( ) MALE ( ) FEMALE

ASA Physical State 1 [✓ 2] 3 4 5 E
WT: 65 KG/LB HT: _____ IN
ALLERGIES: NKDA

ROPOSED PROCEDURE: (L) BKA workout
URGICAL SERVICE: Gen Surg
PO SINCE: MN

ABITS:
TOBACCO: (+)
ETOH: Ø
DRUGS: Ø

URRENT MEDICATIONS:
= ordered as premed
Vanco
Levoquin
Heparin
Fent
MSO4

REMEDICATIONS:
one Yes (@ _____ Hrs) /CC
_____ . _____ mg IV IM PO
_____ . _____ mg IV IM PO
_____ . _____ mg IV IM PO

ABORATORY STUDIES:
B/HCT: _____ / _____
VA:
THER:

$6.7 \rangle \frac{7.7}{24.6} \langle 684$

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:
Hypertension [✓ N] Y
Angina [✓ N] Y
MI [✓ N] Y
CVA [✓ N] Y
Other [✓ N] Y

Pulmonary System:
Asthma [✓ N] Y
Broncitis/URI [✓ N] Y
COPD [✓ N] Y
Other [✓ N] Y

Renal System:
Acute/Chronic RF [✓ N] Y

Gastrointestinal:
Hepatitis [✓ N] Y
Hiatal Hernia [✓ N] Y
PUD/GERD [✓ N] Y

Endocrine System:
Diabetes [✓ N] Y
Steriods [✓ N] Y
Thyroid [✓ N] Y

Neurological:
Seizures [✓ N] Y
Neuropathy [✓ N] Y
Other [✓ N] Y

Gynecological :
Pregnancy N Y

Other Significant Hx:
N Y (L) BKA
N Y 34 YRBL'S
Familial HX N Y 15 Jul

ASSESSMENT
PAST SURGICAL/ANESTHETIC
S/P ex Fx –

PHYSICAL EXAMINATION
BP 108/86 HR 77 R 10 T 98.5
Pain Scale 0-10 _____
HEENT - Teeth Poor dentition
Trachea MP 2 3FB Oval
TMJ/Neck midline
Oropharynx _____
Nares _____
CHEST: _____
CARDIAC: _____
EXTREMITIES: _____
IV Access: _____
Ulnar Filling: _____
BACK: _____
OTHER: _____

NPO Since MN

ANESTHETIC PLAN: ( ) LOCAL ( ) MAC ( ) Regional (Specify): _____ [✓ General]: Mask Intubation

NFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discussed with the patient/legal guardian.

The pa[redacted]erstand and agrees. Questions answered.

b(6)-2

Sig Date: 7/16/03 Time: 0800 Hrs

OST-ANESTHESIA EVALUATION AND NOTE (NON ASU)
( ) NO APPARENT ANESTHETIC COMPLICATIONS ( ) OTHER

Signed: _____ Date: _____ Time: _____ Hrs

Patient Identification: (Ward) _____

[redacted]

b(6)-4

SEDATION KEY:
1. MINIMAL (Anxiolysis) Patient responds normally to verbal commands
2. MODERATE (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is not necessary.
3. DEEP SEDATION/ANALGESIA Patient responds purposefully following repeated or painful stimulation. Airway assistance may

MEDCOM - 12837

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

☒ RED BLOOD CELLS

☐ FRESH FROZEN PLASMA

☐ PLATELETS *(Pool of ____ units)*

☐ CRYOPRECIPITATE *(Pool of ____ units)*

☐ Rh IMMUNE GLOBULIN

☐ OTHER *(Specify)* ____

VOLUME REQUESTED *(If applicable)* ____ ML

REMARKS: 1 UNit

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*

☐ TYPE AND SCREEN

☒ CROSSMATCH

DATE REQUESTED: 15 JUL 03

DATE AND HOUR REQUIRED: NOW

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: ____

HEMOLYTIC DISEASE OF NEWBORN? ____

REQUESTING PHYSICIAN *(Print)*: DR [redacted] b(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE: S/P (R) BKA

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER: [redacted] b(6)-2

DATE VERIFIED: 15 JUL 03

TIME VERIFIED: 1050

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. b(6)-4 [redacted]

TRANSFUSION NO.

PATIENT NO.

DONOR ABO Rh: A pos

RECIPIENT ABO Rh: A pos

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	Comp

PREVIOUS RECORD CHECK: ☒ RECORD ☐ NO RECORD

SIGNATURE OF PERSON PERFORMING TEST: [redacted]

☐ CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED [redacted] 03 b(6)-2

REMARKS: EXP: 15 JULY 03

SECTION III – RECORD OF TRANSFUSION

PRE-[redacted]SION DATA

INSPECTED AND [redacted] b(6)-2

AT *(Hour)* 1149 ON *(Date)* 15Jul03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER *(Signature)*: [redacted] LTC/AN b(6)-2

2nd VERIFIER *(Signature)*: [redacted] 91WM6

TEMP. 98.5 PULSE 88 BP ~~116/~~ 97/137/50

DATE OF TRANSFUSION: 15 JUL 03

TIME STARTED: 1210

POST-TRANSFUSION DATA

AMOUNT GIVEN: 1 Unit ML

TIME DATE COMPLETED: 1330 15 JUL 03 INTERRUPTED

REACTION: ☒ NONE ☐ SUSPECTED

If reaction is suspected – IMMEDIATELY:

1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION

☐ URTICARIA ☐ CHILL ☐ FEVER ☐ PAIN

☐ OTHER ____

OTHER DIFFICULTIES *(Equipment, clots, etc.)*

☒ NO ☐ YES *(Specify)* ____

SIGNATURE OF PERSON NOTING ABOVE: [redacted] b(6)-2

PATIENT IDENTIFICATION - USE EMBOSSER *(For typed or written entries give: NAME - Last, first, middle; rank/rate; hospital number and name of facility.)*

Male WARD ICU-3

[redacted]

b(6)-4

BLOOD OR BLOOD COMPONENT TRANSFUSION
STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

MEDCOM - 12838

MEDICAL RECORD COPY

MEDICAL RECORD | **BLOOD OR BLOOD COMPONENT TRANSFUSION**

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

☒ RED BLOOD CELLS
☐ FRESH FROZEN PLASMA
☐ PLATELETS *(Pool of _____ units)*
☐ CRYOPRECIPITATE *(Pool of _____ units)*
☐ Rh IMMUNE GLOBULIN
☐ OTHER *(Specify)* __________

VOLUME REQUESTED *(If applicable)* __________ ML

REMARKS: 1 Unit

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*

☐ TYPE AND SCREEN
☒ CROSSMATCH

DATE REQUESTED 15 Jul 03

DATE AND HOUR REQUIRED NOW

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:
RhIG TREATMENT? DATE GIVEN: ______
HEMOLYTIC DISEASE OF NEWBORN? ______

REQUESTING PHYSICIAN *(Print)* DR [redacted] b(6)-2

DIAGNOSIS/OPERATIVE PROCEDURE s/p Ⓡ BKA

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER [redacted] b(6)-2

15 Jul 03

TIME VERIFIED 1050

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. b(6)-4 [redacted]

TRANSFUSION NO.

PATIENT NO.

DONOR ABO Rh A pos

RECIPIENT ABO Rh A pos

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	Comp

☐ CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

REMARKS: Exp: 15 JUL03

PREVIOUS RECORD CHECK: ☐ RECORD ☒ NO RECORD

SIGNATURE OF PERSON PERFORMING TEST [redacted] b(6)-2

DATE 15 Jul 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND [redacted] b(6)-2

A[redacted] 318 ON *(Date)* 15 July 03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER *(Signature)* [redacted] b(6)-2

2nd VERIFIER *(Signature)* [redacted] 91WM6 b(6)-2

PRE-TRANSFUSION TEMP. 98.5 PULSE 88 BP 121/53

DATE OF TRANSFUSION 15 Jul 03

TIME STARTED 1540

POST-TRANSFUSION DATA

AMOUNT GIVEN 1 Unit ML

TIME DATE COMPLETED INTERRUPTED 1520

REACTION ☒ NONE ☐ SUSPECTED

If reaction is suspected – IMMEDIATELY:
1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION

☐ URTICARIA ☐ CHILL ☐ FEVER ☐ PAIN
☐ OTHER __________

OTHER DIFFICULTIES *(Equipment, clots, etc.)*
☒ NO ☐ YES *(Specify)* __________

SIGNATURE OF PERSON NOTING ABOVE [redacted]

PATIENT IDENTIFICATION - USE EMBOSSER *(For typed or written entries give: NAME - Last, first, middle; rank/rate; hospital number and name of facility.)*

SEX Male

WARD ICU-3

[redacted]

b(6)-4

BLOOD OR BLOOD COMPONENT TRANSFUSION
STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

MEDCOM - 12839

MEDICAL RECORD COPY

INSTRUCTIONS FOR NON SELF-EXPLANATORY ITEMS

SECTION I – REQUISITION

Component Requested

"Other (Specify)" – List any whole blood or blood product not on menu, i.e., washed RBC's, deglycerolized RBC's, etc.

"Volume Requested (If applicable)" – Use only when different from standard amount, i.e., exchange transfusion 50 ml.

"Known Antibody Formation/Transfusion Reaction" – Check Medical Records. Annotate N/A if appropriate.

"If Patient is Female, Is There History Of" – Check medical records. Annotate N/A if appropriate.

SECTION II – PRE-TRANSFUSION TESTING

"Transfusion Number/Patient Number" – List either based on local procedures.

"Previous Record Check" – Current tests should be compared with prior records for ABO and Rh type, difficulty in blood typing, clinically significant unexpected antibodies, and severe adverse reactions.

"Test Interpretation" – Use the following standard notations. "NEG" or "POS" for antibody screen block. "COMPAT" or "INCOMPAT" for crossmatch block.

SECTION III – RECORD OF TRANSFUSION

"Pre-Transfusion Data"

"Inspected and Issued by ______________ (Signature) at ________ (Hour) on __________ (Date)."

This statement is to be completed by the issuing laboratory person once he/she has inspected the blood immediately before issue from the laboratory. The blood must not be abnormal in color or appearance or expired, and if any of these conditions exist the blood will not be used for transfusion.

"Signature" blank must contain the signature, as opposed to name, of issuing laboratory person.

"Hour" and "Date" are as of actual issue.

The issuing laboratory person will secure this form to the blood bag by string, rubberband, or tie knotted to the tag and the blood container before issuing the blood.

"Post-Transfusion Data" – Completed by transfusionist.

"Amount Given ______ ml" – Visual approximation.

"Reaction Description" – Circle appropriate reaction or describe "other" on separate sheet and attach to SF 518.

"Other Difficulties" – Circle item or describe on separate sheet and attach to SF 518.

STANDARD FORM 518 BACK (REV. 8-86)

MEDCOM - 12840

All b(6)-2 unless otherwise noted

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

ATIENT IDENTIFICATION
b(6)-4
[redacted]

URSING UNIT | ROOM NO. | BED NO.

ATIENT IDENTIFICATION

URSING UNIT | ROOM NO. | BED NO.

ATIENT IDENTIFICATION
b(6)-4
[redacted]

URSING UNIT: ICU3 | ROOM NO. | BED NO.

24° chart check 0100 03 July 03 [redacted] 1LT/AN

ENT IDENTIFICATION

URSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 1 JUL 03
TIME OF ORDER: 2330 HOURS
LIST TIME ORDER NOTED AND SIGN

① Admit to ICU-3
② S/P GSW (R) tibia, (L) wrist
③ Condition - fair
④ VS - routine
⑤ Bed rest
⑥ Regular diet, NPO after midnight

DATE OF ORDER
TIME OF ORDER HOURS

⑦ IV - LR at 125 cc/hr
⑧ Ancef 1 gram IVPB Q 8 hrs
⑨ MSO4 2-6 mg IVP Q 2 hrs prn
⑩ Tylenol 650 mg P.O. or P.R. Q 4 hrs prn
⑪ Percocet 1-2 tabs P.O. Q 4-6 hrs prn
⑫ To OR in AM [redacted]

Chart ✓ 2 Jul 03 053

DATE OF ORDER: 2 JUL 03
TIME OF ORDER: 1830 [redacted] HOURS

① Surgery on 3 Jul. NPO p̄ MN tonight
Regular diet tonight.
V.O. DR [redacted] LT/AN

DATE OF ORDER: 3 JUL 03
TIME OF ORDER: 1500 HOURS

① Resume previous orders
② Regular diet
③ IV - LR at 125 cc/hr, hep lock when taking P.O. well
④ MSO4 2-6 mg IVP Q 2 hrs prn
⑤ Transfer to ward when bed [redacted] available

Noted 3 July 03 [redacted]

24° ✓ [redacted] CPT/AN 6 Jul 03 [redacted] 0702

MEDCOM - 12841 [redacted]

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

TIENT IDENTIFICATION

EPW #[redacted]

b(6)-4

DATE OF ORDER 6 Jul 03

TIME OF ORDER ______ HOURS

LIST TIME ORDER NOTED AND SIGN

- ✓ 1- Admit to ICU3
- ✓ 2- Clear Liquid Diet - Advance as tolerated
- ✓ 3- Bed-Rest Elevate R LE ō ~~*~~ pillow under knee
- ✓ 4- LR @ 50 cc/hr
- ✓ 5- Foley to Gravity

b(6)-2 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

EPW #[redacted]

DATE OF ORDER

TIME OF ORDER ______ HOURS

- ✓ 6- VS per Routine
- ✓ 7- Fentanyl 100 mcg/hr titrate for pain control
- ✓ 8- Phenergan 25mg IVPB q6° prn nausea
- ✓ 9. Ancef 1gm q8° IVPB
- 10- ~~Zantac 50~~ Tagamet 300mg IVPB q6°
- 11- Call for increasing pain

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

EPW #[redacted]

DATE OF ORDER

TIME OF ORDER ______ HOURS

in STUMP - Concerns for Hematoma

12. CBC in AM

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

b(6)-4

EPW #[redacted]

DATE OF ORDER 6Jun

TIME OF ORDER [illegible] HOURS

b(6)-7

Versed 2-5mg IV prn

Don [redacted]

b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

[redacted]

DA FORM 1 APR 79 **4256**

REPLACES EDITION OF 1 JUL 77, [redacted] BE USED.

MEDCOM - 12842

b(6)-2 All unless otherwise noted

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

ATIENT IDENTIFICATION

b(6)-4

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 7 Jul 03

TIME OF ORDER ______ HOURS

LIST TIME ORDER NOTED AND SIGN

1- NPO p midnight

2- Start IV LR @ 100cc/hr @ midnight - hep-lock until K/200

[redacted]

24° ✓ done [redacted] /0100 8 Jul 03

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 8 Jul 03

TIME OF ORDER ______ HOURS

- ☒ 1- Admit to ICU
- ☒ 2- Clear Liquid Diet - Advanced as tolerated
- ☒ 3. Bed-Rest
- ☒ 4- LR @ 50cc/hr
- ☒ 5- VS per routine
- ☒ 6- Fentanyl 100mcg/hr titrate for pain control

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER

TIME OF ORDER ______ HOURS

- ☒ 7- Vancomycin 500mg IVPB q [illegible]
- ☒ 8- Zantac 50mg IVPB q 8°
- ☒ 9- Call for increasing pain
- ☒ 10- CBC in AM
- ☒ 11- Phenergan 25mg IVPB q6° prn Nausea
- ☒ 12- Foley to gravity
- ☒ 13- IS 10 min q°

1021 [redacted]

8 Jul 03

PATIENT IDENTIFICATION

DATE OF ORDER

TIME OF ORDER ______ HOURS

- ☒ 14- Heparin 5000 u SC q 12°

[redacted]

10 Jul 03

0757

NURSING UNIT

24° ✓ [redacted]

REP ... EDITION OF 1 JUL 77, WHICH MAY BE USED.

DA FORM 4256 1 APR 79

MEDCOM - 12843

b(6)-2 All
unless otherwise noted

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

EPW [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 08Mar TIME OF ORDER 1900 HOURS

LIST TIME ORDER NOTED AND SIGN

MSO4 2-10mg IV Q2° prn

Tylenol 650mg PO Q4° prn

Percocet ii PO Q3° prn

D/C foley

[redacted]

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 9 Mar 03 TIME OF [redacted]

1- CXR this A.M.

2- [illegible] 800 mg po q A.M.

3- Colace 100 mg po bid

4- UA

5- ~~DC~~ [illegible]: Times off

6- Toradol 30 mg q6° IVPB

7 MOM 2 tsp q4° until BM

Ntd by SFC [redacted]
09Jul @0800

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER [redacted]

9 MAR 03

1- IV Bolus LR 1 Liter

2 CBC + CHEM 7 in A.M.

noted
[illegible]
Jul 03

[redacted]

24° / Chart / [redacted] 10 Jul 03 0800

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

TIME OF ORDER

10 MAR 03 HOURS

1- Transfer to ICW 8- Act per PT

2- VS per routine cont

3- I/O q shift

4- Percocet 1-2 po q4° prn pain

5- Colace 100mg po bid

6- Toradol 30mg IVPB q6°

[illegible] 5000u SC q12°

Ntd
18 July 1718
SPC [redacted]

[redacted]

b(6)-2 All unless otherwise noted

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]

ICU-3

DATE OF ORDER 10 Jul 03

TIME OF ORDER ________ HOURS

LIST TIME ORDER NOTED AND SIGN

9- Vancomycin 800 mg po bid — Ntd by

10 Levaquin 500 mg po qd — SK [redacted] 1718 Jul 11

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 10 Jul 03

TIME OF ORDER 1615 HOURS

1- DC Vanco — Ntd by

2 - DC Heparin — SK [redacted]

3 - DC Zantac — 1718

4 - DC Torado [redacted]

NURSING UNIT | ROOM NO. | BED NO.

2° / Arrive [illegible] [illegible] 0200 12 July

PATIENT IDENTIFICATION

DATE OF ORDER 11 Jul 03

TIME OF ORDER 1415 HOURS

1- Admit to ICU 3

2. IVF LR @ 125 cc/hr

3- Regular diet

4. Percocet 1-2 po q4° prn pain

5 - Vancomycin 800 mg IVPB q12°

6 - Levaquin 500 mg po qd

7- Flagyl 250 mg IVPB tid

Noted by [redacted] 11 Jul 03

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER

TIME OF ORDER ________ HOURS

8 - CBC q AM

9. Up c̄ assistance

10- Heparin 5000 u q12° SC

11- NPO p̄ midnight

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

24 V [redacted]

MEDCOM - 12845 July 02

b(6)-2 All unless
otherwise noted

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]

DATE OF ORDER

TIME OF ORDER ______ HOURS

LIST TIME ORDER NOTED AND SIGN

Toradol 30mg IV q 6°.
MS04 1-4mg IVP q hr. PRN
breakthrough pain.
VO: Dr [redacted]
Fen [redacted]

AW

NURSING UNIT | ROOM NO. | BED NO.

24 [redacted] 0245 12 Ju [redacted]

[redacted]

PATIENT IDENTIFICATION

b(6)-4

[redacted]

DATE OF ORDER 12 Jul 03

[redacted] ORDER ______ HOURS

Continued previous orders

noted [redacted]
80
13 July 03

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

b(6)-4

[redacted]

DATE OF ORDER 13 July 03

TIME OF ORDER ______ HOURS

1) Resume previous orders

noted [redacted]
0911
13 July 03

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

b(6)-4

[redacted]

DATE OF ORDER 13 Jul 03

TIME OF ORDER 0930 HOURS

1- Fentanyl 100ug IVP PRN

Transcribed
13 July 03
29

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

24 [redacted] 13 Jul 03 1830

DA FORM 4256

MEDCOM - 12846

REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

b(6)-2 All unless otherwise noted

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 ICU 3

[redacted]

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 14 JUL 03

TIME OF ORDER ______ HOURS

LIST TIME ORDER NOTED AND SIGN

1- Resume previous orders

2- NPO p̄ midnight

3- To OR in AM

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 15 JUL 03

TIME OF ORDER ______ HOURS

1- Foley to gravity

2- Transfuse 2u PRBC

3- CBC p̄ transfusion

4- Regular diet

5- Resume previous orders

6- NPO p̄ midnight → to OR in AM

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 15 JUL 03

TIME OF ORDER ______ HOURS

NPO after MN

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 15 JUL 03

TIME OF ORDER 2228 HOURS

DC Foley

[redacted]

NPO after MN

[redacted]

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77

MEDCOM - 12847

b(6)-2 All unless otherwise noted

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
#[redacted]
b(6)-4

NURSING UNIT: ICU3
ROOM NO.:
BED NO.: 2

↓

DATE OF ORDER: 14 July 03
TIME OF ORDER: 0635 HOURS

① MOM 2 tsp Q4° until BM occur.
V.O. Dr.[redacted]/Sgt[redacted]

LIST TIME ORDER NOTED AND SIGN: Transcribed 14 July 03 0635 Sgt[redacted]

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

NURSING UNIT: ICU3
ROOM NO.:
BED NO.: 2

DATE OF ORDER: 14 Jul 03
TIME OF ORDER: 1000 HOURS

V.O. Crutches for ambulation bid + prn.
From. Dr.[redacted] LTC/AN

noted [redacted] 1008 14 July 03

PATIENT IDENTIFICATION

NURSING UNIT:
ROOM NO.:
BED NO.:

DATE OF ORDER:
TIME OF ORDER: ______ HOURS

PATIENT IDENTIFICATION

NURSING UNIT:
ROOM NO.:
BED NO.:

DATE OF ORDER:
TIME OF ORDER: ______ HOURS

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

MEDCOM - 12848

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]

ICW2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 16 Jul 03 TIME OF ORDER ______ HOURS

LIST TIME ORDER NOTED AND SIGN

✓ 1) To ICU then EPW ward - ICW 2

✓ 2) Dx: S/P R BKA Washout

✓ 3) Condition stable

✓ 4) Vitals Q1hr x4 then Q8° when transf to ICW

16 Jul 03 1245

b(6)-2

[redacted]

PATIENT IDENTIFICATION

b(6)-4

[redacted]

DATE OF ORDER TIME OF ORDER ______ HOURS

✓ 5) Activity OOB to chair

✓ 6) Diet [illegible] as tolerated And [illegible]

✓ 7) IV LR at 100cc/hr heplock when taking PO well

8) MEDS

NURSING UNIT 18 ROOM NO. BED NO.

08/16/24

- Gentamycin 300mg IV QD

✓ - Ancef 1gm IV Q8°

PATIENT IDENTIFICATION

b(6)-4

[redacted]

DATE OF ORDER TIME OF ORDER ______ HOURS

- MSO4 1-4 mg IV q1-2° prn

or

- Percocet 1-2 PO Q4° prn

✓ Elavil 25mg PO TID

NURSING UNIT | ROOM NO. | BED NO.

✓ 9) - [illegible] for warmth and tenderness.

PATIENT IDENTIFICATION

b(6)-4

[redacted]

DATE OF ORDER TIME OF ORDER ______ HOURS

✓ 10) Call MD T>101.5, SBP>180 [illegible] UOP <30/hr.

b(6)-2

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

24° chart ✓ done 17 July @0030 [illegible]

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

MEDCOM - 12849

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

PATIENT IDENTIFICATION

EPW [redacted]

b(6)-4

NURSING UNIT	ROOM NO	BED NO.
ICW2		15

DATE OF ORDER 17 Jul 03 TIME OF ORDER ______ HOURS

1) To ICW2 the ICW2 wh meets recovy crit
2) Dx S/P (R) BKA washout
3) Vitals per RR until then Q8°
4) Activity OOB to chair when alert & Awake

PATIENT IDENTIFICATION

EPW [redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICW2		15

DATE OF ORDER TIME OF ORDER HOURS

5) Diet NPO until fully Awake then regular
6) NPO after MN
7) IVF at 100cc/hr heplock when taking PO well
8) Labs CBC, Electrolytes in AM

[redacted]

PATIENT IDENTIFICATION

EPW [redacted]

b(6)-4

NURSING UNIT	ROOM NO	BED NO.
ICW2		15

DATE OF ORDER TIME OF ORDER ______ HOURS b(6)-2

9) MEDS
Gentamycin 300mg IV Q [redacted]
Fortaz 2g IV Q8°
MSO4 1-10 IV Q1-2°
or
Percocet 1 PO Q4 prn

PATIENT IDENTIFICATION

EPW [redacted]

NURSING UNIT	ROOM NO	BED NO.
ICW2		15

DATE OF ORDER TIME OF ORDER

Zofran 4mg IV Q6° prn HOURS

10) Call MD T > 101.5, SBP > 180 < 90
no void 8° postop.
11) Elavil 25 po TID

b(6)-2 [redacted]

DA FORM 4256 24° chart check [redacted] WHICH 2LT/AN 18 July 0200

MEDCOM - 12850

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

PATIENT IDENTIFICATION

b(6)-4

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

[redacted]

7/18/03 Noted [redacted]

b(6)

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

1) [illegible] ICW2 ([illegible])
2) Dx s/p [illegible]
3) Vital [illegible] q8°
4) Activ OOB to [illegible]
5) Diet [illegible] awake

DATE OF ORDER | TIME OF ORDER | HOURS

6) IV at 125cc/h
heplock when taking po
7) Meds
[illegible] 350mg IV q d
Fortaz 2gm IV q8°
MSO4 I-II IV q3-4° prn
or
Percocet II po q4° prn

DATE OF ORDER | TIME OF ORDER | HOURS

Elavil 25mg po TID
8) Neuro [illegible] q8°
9) Call MD T>101.5, [illegible] >110
<90, etc.

[redacted] /RN

DATE OF ORDER | TIME OF ORDER | HOURS

19 Jul 03
NPO after MN

b(6)

noted [redacted]
19 July 03 2100

[redacted]

24° done [redacted] 20 July 03 0120

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

[redacted]

NURSING UNIT 1CW2 | ROOM NO. | BED NO. 12

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

1 - s/p Dig Δ Ⓡ BKA

- Resume prior orders

- reg diet

[redacted]

b(6)-2

[redacted]

noted [redacted]

24° v/done [redacted] AW

PATIENT IDENTIFICATION

b(6)-4

[redacted]

NURSING UNIT 1CW2 | ROOM NO. | BED NO.

DATE OF ORDER [redacted] HOURS

7-21-03 V.O. Dr. [redacted] / LT [redacted]

① Δ Elavil to 75mg QD po

[redacted]

24° chart ✓ 22 Jul 03 0345 [redacted] AW

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT ICW2 | ROOM NO. | BED NO. 12

DATE OF ORDER 22 Jul 03 TIME OF ORDER 02:43 HOURS

VO

Ⓟ MOM 1 dose x1 now

noted 0243 22 Jul 03

Dr. [redacted]

b(6)-2

24° v/done [redacted] AW

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT ICW 2 | ROOM NO. | BED NO. 12

DATE OF ORDER 23 Jul 03 TIME OF ORDER HOURS

1) NPO after MN

b(6)-2

[redacted]

noted [redacted]

DA FORM 1 APR 79 **4256**

REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

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

EPW [redacted] b(6)-4

NURSING UNIT: ICW2
ROOM NO.:
BED NO.: 12

DATE OF ORDER: 24 Jul 03
TIME OF ORDER: HOURS
LIST TIME ORDER NOTED AND SIGN

1) To RR then ICW2
2) Dx S/P Drsg Δ
3) V.S. per [illegible] then Q 8°
4) Activity OOB to chair
5) Diet) Regular when Alert and awake

PATIENT IDENTIFICATION

EPW [redacted] b(6)-4

NURSING UNIT: ICW2
ROOM NO.:
BED NO.: 12

DATE OF ORDER:
TIME OF ORDER: HOURS

6) IV hep lock when tolerating po well b(6)-2 [redacted]
7) MEDS
Percocet ii po Q 4° prn
Elavil 25 mg po TID
levoflox 500 po QD

PATIENT IDENTIFICATION

EPW [redacted] b(6)-4

NURSING UNIT: ICW2
ROOM NO.:
BED NO.: 12

DATE OF ORDER:
TIME OF ORDER: HOURS

8) Contact MD if T > 101.5 SBP > 180
<90, UOP <30cc [illegible] 8°
[illegible]

b(6)-2 [redacted]

PATIENT IDENTIFICATION

EPW b(6)-4 [redacted]

NURSING UNIT: ICW2
ROOM NO.:
BED NO.: 12

DATE OF ORDER: 24 Jul 03
TIME OF ORDER: 1900 HOURS

Elavil 75 mg [redacted]

b(6)-2 [redacted]

[redacted]

[redacted]

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

MEDCOM - 12853

CLINICAL RECORD - DOCTOR'S ORDERS

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

[illegible] SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED [illegible] IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

#[redacted]

b(6)-4

NURSING UNIT: ICW2 | ROOM NO.: | BED NO.: 12

DATE OF ORDER | TIME OF ORDER 29 July

V.O. per Dr [redacted] to LT Walker to remove q other suture of lower suture line on (L) leg:

b(6)-2

[redacted] LT/AN

done

noted [redacted] 1320

24° ✓ done [redacted] CPT/AN

PATIENT IDENTIFICATION

EPW

[redacted]

NURSING UNIT: ~~ICW2~~ | ROOM NO.: | BED NO.: ~~12~~

DATE OF ORDER 31 July 03 | TIME OF ORDER 0840 HOURS

① Maalox 30cc PO q 4-6 hrs prn

② DC stitches to stump ē knee. No Steri strips

V.O. Dr [redacted] /AN

b(6)-2

NOTED

24° ✓ done [redacted]

PATIENT IDENTIFICATION

NURSING UNIT: ICW2 | ROOM NO.: | BED NO.: 12

DATE OF ORDER 2 Aug 03 | TIME OF ORDER HOURS

TID wet to dry 2x2

[redacted]

b(6)-2

noted 2 Aug 03 0930 [redacted]

b(6)-2

PATIENT IDENTIFICATION

EPW

#[redacted]

b(6)-4

NURSING UNIT: ICW2 | ROOM NO.: | BED NO.: 12

DATE OF ORDER 2 Aug 03 | TIME OF ORDER 1000 HOURS

VO from Dr [redacted] to LT [redacted]

① Tylenol 650mg q 4-6° PRN for pain

b(6)-7

[redacted] CPT/AN

24° ✓ done [redacted] [redacted] /AN

MEDCOM - 12854

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
EPW [redacted]

NURSING UNIT: ICW2
ROOM NO.: [illegible]
BED NO.: 12

DATE OF ORDER: 5Aug03
TIME OF ORDER: 2030 HOURS

LIST TIME ORDER NOTED AND SIGN

① NPO p MN — [redacted] noted
② D/C foley in AM — [illegible]
Per Dr [redacted] taken off [redacted] b(6)-2
5 Aug03 [redacted]

PATIENT IDENTIFICATION
[redacted]
b(6)-4

NURSING UNIT: ICW2
ROOM NO.:
BED NO.:

DATE OF ORDER: 6Aug03
TIME OF ORDER: HOURS

1) [illegible] ICW 2
2) Dx S/P Advancement Flap / [illegible] (R) BKA
3) VS per RN routine then q8°
4) Activity Ad lib
5) Diet Advance as tol
6) IV at 125cc/h [illegible] when tolg po well

PATIENT IDENTIFICATION

DATE OF ORDER
TIME OF ORDER HOURS

noted 6Aug03 1200 [redacted]

7) NSD'S
MSO4 2-4mg IV q1°prn
or
Percocet 1 po q4°
Elavil 75mg po TID
8) Call MD T>101.5, SBP>180 [illegible]
[redacted]

NURSING UNIT:
ROOM NO.:
BED NO.:

PATIENT IDENTIFICATION

DATE OF ORDER [redacted] HOURS
b(6)-2

9) Valium 5mg po TID
[redacted]

b(6)-2S

6Aug03 1220
① ELAVIL 75MG P.O. BID
② VALIUM 5MG P.O. TID PRN [redacted]

NURSING UNIT:
ROOM NO.:
BED NO.: [redacted]

DA FORM 1 APR 79 4256 REPL MEDCOM - 12855 ICH MAY BE USED.

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

EPW # [redacted]

Noted [redacted] 6 Aug 03

b(6)-2

DATE OF ORDER 6 Aug 03

TIME OF ORDER ________ HOURS

LIST TIME ORDER NOTED AND SIGN

D/C c̄ AM

[redacted]

b(6)-2

[redacted]

NURSING UNIT

ROOM NO.

BED NO.

24°/s 2200 6 Aug 03

PATIENT IDENTIFICATION

DATE OF [redacted]

TIME OF ORDER ________ HOURS

NURSING UNIT

ROOM NO.

BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER

TIME OF ORDER ________ HOURS

NURSING UNIT

ROOM NO.

BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER

TIME OF ORDER ________ HOURS

038

NURSING UNIT

ROOM NO.

BED NO.

DA FORM 1 APR 79 4256

REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

☆ U.S. GO

MEDCOM - 12856

710

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

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. JUL Yr. 2003

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 1	2	3	4	5	6	7
1July03	[redacted]	VS Routine	5	/	[redacted]					
			17	/						
1July03	[redacted]	Regular diet	5	/	[redacted]					
	[redacted]		17	/						
1Jul03	[redacted]	Condition: Fair	05	/	[redacted]					
			17	/						

DC 7/6/03

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P GSW Ⓡ Tibia & Ⓛ Hand

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ______

PATIENT IDENTIFICATION:

EPW [redacted] b(6)-4

[redacted]

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 MEDCOM - 12857 USED. USAPA V1.00

b(6)-2

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo July *Yr* 2003

Verify by Initialing						
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
1July	[redacted]	Admit to ICU 3			0100	[redacted]
1July	[redacted]	Dx S/P GSW Ⓡ Tibia, Ⓛ Hand				[redacted]
1July	[redacted]	Condition - Fair				[redacted]
1July	[redacted]	NPO past midnight	1Jul	2400	Don	[redacted]
1July	[redacted]	TO OR in A.M.	2Jul	O/C		
2JUL	[redacted]					
3July	[redacted]	Transfer to Ward when bed available	3July			

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													

USAPA V1.00

MEDCOM - 12858

b(6)-2A11

CLINICAL RECORD | **THERAPEUTIC DOCUMENTATION CARE PLAN** *(NON-MEDICATION)*
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.
Mo. 7 *Yr.* 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED
				6 7 8 9 10 11
6 Jul 03	[redacted]	Clear liquid diet -	06	[redacted]
		advance as tolerated	14	[redacted] order Δ'd
			22	[redacted]
	[redacted]		X	[redacted]
6 Jul 03	[redacted]	Bedrest Elevate ~~RHE~~ RLE	05	/ [redacted]
		c̄ pillow under knee	17	/ [redacted] order Δ'd
	[redacted]		X	
6 Jul 03	[redacted]	Foley to gravity	05	/ [redacted]
			17	[redacted] / D/C 8 Jul KP
			X	
6 Jul 03	[redacted]	VS per routine	05	/ [redacted]
			17	[redacted]
	[redacted]		X	
6 Jul 03	[redacted]	CBC in AM	04	[redacted] / / [redacted]
			X	
6 Jul	[redacted]	Call for increasing	05	/ [redacted]
		pain in stump -	17	[redacted]
		concern for hematoma	X	/ / / / / / / / / / / / / /
7 Jul	[redacted]	Encourage active 82°	05	[redacted]
		Rom (abductor of RLE)	07	/ [redacted]
8 Jul 03	[redacted]	IS 10 times Q hr	05	/ / [redacted]
			17	/ / [redacted]
10 Jul 03	[redacted]	I+O's Q shift	05	/ / / /
			17	/ / / [redacted]

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW Ⓡ Tibia & Ⓛ Hand s/p Ⓡ BKA

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ____________

PATIENT IDENTIFICATION:

EPW [redacted]

b(6) 4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 MEDCOM - 12859 USED. USAPA V1.00

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo ______ *Yr* 2003

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
6Jul03	[redacted]	Admit to ICU				
7Jul	[redacted]	NPO p̄ MN	7Jul	2400	Done	[redacted]
8Jul03	[redacted]	CBC in AM	9Jul03	0400	0400	[redacted]
8Jul03	[redacted]	D/C Foley	8Jul03			[redacted]
09Jul	[redacted]	CXR this AM	09Jul	NOW	0730	[redacted]
09Jul	[redacted]	UA	09Jul	NOW		
9Jul	[redacted]	CBC + Chem7 in AM	10Jul	0400		
09Jul	[redacted]	IV Bolus 1 Liter LR	09Jul	NOW	1200	[redacted]
10Jul	[redacted]	TRANSfer to ICW	10Jul	ASAP		

D/W-Z All

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED
03Jul	[redacted]	Call for increasing pain to the stump	

USAPA V1.00

MEDCOM - 12860

b(6)-2A11

CLINICAL RECORD | **THERAPEUTIC DOCUMENTATION CARE PLAN** *(NON-MEDICATION)*
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.
Mo. ____ *Yr.* 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 11	12	13	14	15	16	17	18	19	20	21		
11 July 03	[redacted]	Admit to ICU 3	05	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]						
11 July 03	[redacted]	Regular diet	07	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]						
			12	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
			18	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
11 July 03	[redacted]	CBC q AM	04	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]						
11 July 03	[redacted]	Up c̄ Assistance	05	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
			17	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
11 July 03	[redacted]	NPO p̄ Midnight	2400	/	[redacted]	[redacted]	[redacted]	[redacted]								
14 Jul 03	[redacted]	Crutches bid + prn	05	/	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]						
			17	/	/	/	[redacted]	[redacted]	[redacted]							

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Ⓡ BKA S/P Walkout

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ____

PATIENT IDENTIFICATION:

EPW

#[redacted]

b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 EDITION OF 1 FEB 77 MAY BE USED. USAPA V1.00

MEDCOM - 12861

Verify by Initialing		**THERAPEUTIC DOCUMENTATION CARE PLAN** *(NON-MEDICATION)*				*Mo* ______ *Yr* 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
14 Jul	[redacted]	Resume previous orders	14 July	noted		[redacted]
14 Jul	[redacted]	TO OR in AM - NPO p̄ MN	14 July	2400		
	-----	Transfuse 2u PRBC	15 Jul			[redacted]
	-----	NPO p̄ Midnight	15 Jul			
	-----	CBC after Transfussion	15 Jul			[redacted]

	-----					

b(6)-2 All

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING COMPLETION* TIME/DATE COMPLETED													
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USAPA V1.00

MEDCOM - 12862

blue. 2 AM

the proponent agency is the Office of The Surgeon General. MO. 7 YR. 2003

RIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	16	17	18	19	20	21	22	23	24	25	26	27
4 July	[redacted]	Vital Signs routine	05	[redacted]	[redacted]	[redacted]	[redacted]								
17		call MD T>101.5, SBP>180<90	13	[redacted]	[redacted]	[redacted]									
			21	[redacted]	[redacted]	[redacted]									
14 July	[redacted]	Act: OOB to chair	05	/	[redacted]	[redacted]	[redacted]								
17			13	/	[redacted]	[redacted]									
			21	[redacted]	[redacted]	[redacted]									
14 July	[redacted]	Diet: Regular	07	/	[redacted]	[redacted]									
17		(when alert/awake)	12	/	[redacted]	[redacted]									
			17	[redacted]	[redacted]										

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

S/P Ⓡ BKA Washout

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ______

PATIENT IDENTIFICATION:

#[redacted] b(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIME

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 MEDCOM - 12863 E USED. USA

Verify by Initialing						
THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*				*Mo* July	*Yr* 2003	
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
16 July	[redacted]	transfer to ICW II : Cond stable	16	— done —		[redacted]
16 July	[redacted]	NPO p̄ MN for washout (17 July)	17	0000	—	[redacted]
17	[redacted]	Call MD if no void 8° postop	17	2300	[illegible]	[redacted]
17	[redacted]	to ICW2 then ICW2 when meets			1545	[redacted]
		recovery criteria	17		~~1605~~	
17	[redacted]	NPO p̄ midnight	18	0001		[redacted]
17	[redacted]	CBC, electrolytes in AM	18	04	0400	[redacted]

b(6)-2 All

Order/ Expir Date		PRN ACTION, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING COMPLETION* TIME/DATE COMPLETED
16 July	[redacted]	Call MD for	
		T > 101^{5}, SBP > 180	
		< 90, UOP < 30/hr	

MEDCOM - 12864

b(6)-2 All

the proponent agency is the Office of The Surgeon General.

MO. 7 YR. 2003

RIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	August → DATE COMPLETED 31	1	2	3	4	5	6	7	8	9	10	11	12
18 July	[redacted]	Vitals Q 8°	06	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	DC'd 7 Aug 03				
			14	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]					
			22	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]					
18 July	[redacted]	Act: OOB → chair	06	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]					
			14	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]					
			22	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]					
18 July	[redacted]	Diet: Regular	07	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]					
			11	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]					
			17	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]					
2 Aug 03	[redacted]	2x2 W→D. DSG Δ to	08	/	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	D/C'd				
		(R) knee TID	14	/	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	pt. c̄ cast				
			20	/	/	☐	[redacted]	[redacted]	[redacted]	[redacted]	/					

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P (R) BKA closure

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ____

PATIENT IDENTIFICATION:

EPW # [redacted] b(6)-4

ICW2

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIME

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 MEDCOM - 12865 IE USED. USA

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*			Mo 7 Yr 2003	
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
5	[redacted]	NPO p̄ MN	6	24	24	[redacted]
5	[redacted]	O/C to OR	6	O/C	—	
6	[redacted]	D/C to EPW camp in am	7	ASAP	103	

	-----					

b(6)-2 All

Order/ Expir Date		PRN ACTION, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING COMPLETION* TIME/DATE COMPLETED
10 July	[redacted]	Contact MD T>101.5,	
-----	-----	SBP >180, <90	
-----	-----		
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MEDCOM - 12866

b(6)-2

the proponent agency is the Office of The Surgeon General.

Mo. 7 YR. 2003

FY BY INITIALING			INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION													
ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED												
				18	19	20	21	22	23	24	25	26	27	28	29	30
7-8	[redacted]	Vitals Q8°	5	[redacted]												
24			13													
			21													
7-18	[redacted]	Act. OOB → chair	5	[redacted]												
24			13													
			21													
7-18	[redacted]	Diet Reg when	7	[redacted]												
24		alert & awake	11													
			17													
7-18	[redacted]	Record JP output	5	[redacted]		> JP D/C'D										
		Q8°	13													
			21													
7-18	[redacted]	Contact MD T>101.5,	5	[redacted]												
		SBP >180, <90.	13													
			21													

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: S/P BKA close

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION:

#[redacted]

b(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIME

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 MEDCOM - 12867 E USED. USA

D(e)-2

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo 7 *Yr* 2003

Verify by Initialing: Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
7-18	[redacted]	To ICW # 2	7-18	1100	1100	[redacted]
7-19	[redacted]	NPO p̄ MN	7-19	2400	2400	[redacted]
19	[redacted]	Resume Previous Orders	20	Done		[redacted]
23	-----	NPO p̄ MN	24	2400	2400	[redacted]
31	[redacted]	DC stiches to stump 3 knee. Ø skin strips	31	Today		[redacted]

Order/ Expir Date		PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED
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-----	-----		
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MEDCOM - 12868

b(6)-2 All

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.* 7 *Yr.* 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 1	2	3	4	5	6	7
1 July 03	[redacted]	Ancef 1 Gram IVPB Q8	6	/	[redacted]					
			14	/	[redacted]					
			22	[redacted]			[redacted]		[redacted]	
1 July 03	[redacted]	IVLR @ 125 cc/hr 05	05	[redacted]				HL		
			17	[redacted]						
3 July 03	[redacted]	Heplock IV when tol. P.O.	05	/	/	/	[redacted]			
			17	/	/	[redacted]				

D/C 7/6/03

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P GSW Ⓡ Tibia, Ⓛ Hand

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____________

PATIENT IDENTIFICATION:

EPW [redacted] b(6)-4

[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

DA FORM 4678, 1 FEB 79 — MEDCOM - 12869 — ...SED UNTIL EXHAUSTED. — USAPA V1.00

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*	*Mo.* JUL *Yr.* 03

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

b(6)-2 A11

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY		*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* TIME/DATE DISPENSED													
1Jul/y03	[redacted]	MSO4 2-6 mg IVP	D T	2Jul 0412	2Jul 1100	2Jul 1500	2JUL 1735	2JUL 2230	03JUL 0030	03JUL 0230	3Jul 1801	3Jul 2049	4Jul 1800	5 Jul	5 Jul	5JUL 1800	5JUL 1845
		Q2hrs Prn	D I	4mg IVP	4mg IVP	4mg [redacted]	4mg [redacted]	4mg [redacted]	3mg [redacted]	3mg [redacted]	3mg [redacted]	2mg [redacted]	4mg [redacted]	1000 2mg [redacted]	400 3mg [redacted]	3mg [redacted]	3mg [redacted]
			E	[redacted]	(+)	[redacted]										④	⑧
1Jul/y03	[redacted]	Tylenol 650 mg PO															
		or PR Q4hrs prn															
1Jul/y03	[redacted]	Percocet 1-2 tabs		2JUL 1930	3Jul 1807	3Jul 2300	4Jul 1032	4Jul 1634	4July 2030	5Jul 1230							
		PO Q4-6hrs Prn		[illegible] [redacted]	[illegible] [redacted]	ii [redacted]	2 tabs [redacted]	2 tabs [redacted]	II [redacted]	ii [redacted]							
05JUL	[redacted]	MSO4 2-6mg IVP	D T	05JUL 2125	06JUL 0231	06JUL 0680	06JUL 1130	6Jul 1600									
		Q2H PRN	D I	3mg [redacted]	6mg [redacted]	6mg [redacted]	6mg [redacted]	[illegible] IVP [redacted]									
			E			[illegible]	Ⓓ										

USAPA V1.00

MEDCOM - 12870

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

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.* 7 *Yr.* 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 6	7	8	9	10	11	
6 Jul 03	[redacted]	LR @ 50cc/hr	05	/	[redacted]		D/c			7 Jul [illegible]
			17	/						
			X							
6 Jul 03	[redacted]	Fentanyl 100mcg/hr	06	/	[redacted]					D/C'D
		titrate for pain control	14							
			22							
6 Jul 03	[redacted]	Ancef 1 gm q8°	06	/	[redacted]					DC'd 7/08/03
		IVPB	14	/						
			22	/						
6 Jul 03	[redacted]	Tagamet 300mg	06	/	[redacted]					DC'd 7/08/03
		IVPB q6°	12	/						
			18	/						
			24	/						
8 Jul 03	[redacted]	LR @ 50 cc/hr	05	/	/	[redacted]				Orders Δ'd
			17	/	/					
8 Jul 03	[redacted]	Vancomycin 500mg	10	/	/	[redacted]				D/C'd
		IVPB Q12°	22	/	/					
8 Jul 03	[redacted]	Zantac 50mg IVPB	06	/	/	[redacted]				D/C'd
		Q8°	14	/	/					
			22	/						
8 Jul 03	[redacted]	Heparin 5000u SC	10	/	/	[redacted]				D/C'd
		Q12°	22	/	/					
9 Jul 03	[redacted]	LevaQuin 500mg QAM	10	/	/	[redacted]				Times Δ'd
		PO								
9 Jul 03	[redacted]	Colace 100mg PO	10	/	/	[redacted]				D/C
		BID	22	/	/					

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW Ⓡ Tibia & Ⓛ Hand S/P Ⓡ BKA

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

PATIENT IDENTIFICATION:

EPW [redacted]

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 ...SED UNTIL EXHAUSTED. USAPA V1.00

MEDCOM - 12871

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*	*Mo.*_____ *Yr.*_____

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
7Jul	[redacted]	Start IV LR @ 100cc/hr @	Done		[redacted]	
		midnight - Heplock until then.				
9Jul	[redacted]	IV bolus LR 1L	9July	done	1145	[redacted]
		b(6)-2 AH				
		b(6)-2				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* TIME/DATE DISPENSED													
9Jul	[redacted]	Phenergan 25mg IVPB q6° prn nausea	09Jul 0730 25mg [redacted]	9Jul 1900 25mg												
		b(6)-2														
6Jul	[redacted]	Versed 2-5 mg IVP Prn	6Jul 2226 4mg [redacted]	7Jul 0400 4mg	7July 0650 2mg	7Jul 0928 2.5mg	7Jul 1255 2.5mg	7Jul 1800 2.5mg [redacted]	7Jul 2100 2.5mg [redacted]	8Jul 0030 2.5mg [redacted]	8July 0600 4mg [redacted]	8Jul 1140 4mg [redacted]	8July 1430 4mg 2mg	8July 1700 4mg [redacted]	8Jul 2220 2.5 [redacted]	9July 0905 5mg [redacted]
		b(6)-2														
9July	[redacted]	MSO4 2-10mg IVP Q2 PRN	8Jul 930 2 [redacted]	9Jul 2110	8Jul 2226	8Jul 2400 6mg	8Jul 0300 6mg	9Jul 0615 4mg IVP	09Jul 1330 2mg [redacted]	9Jul 1530 3mg	10Jul 0130 4mg [redacted]	10Jul 0400 4mg	10Jul 1410 2mg	11July 0838 5mg	11July 0906 5mg	11July 1105 5mg
8July	[redacted]	Percocet II PO Q3h PRN	8Jul 1930 II PO [redacted]	09Jul 0800 2tabs [redacted]	09Jul 1100 2tab	09Jul 1400 2tabs	09Jul 1700 2tabs	10Jul 0930 II PO	10Jul 0650 2tab	10Jul 1100 2tab	10Jul 1400 2tab	D/C				
		b(6)-2														
8July	[redacted]	Tylenol 650mg PO q4 PRN	[redacted]	8Jul 1900	9Jul											

USAPA V1.00

MEDCOM - 12872

b(6)-2A1

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 — *INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION*

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 09	10	11	12	13									
9 Jul 03	[redacted]	Toradol 30 mg IVP	06	[redacted]	[redacted]												
		96°	12	[redacted]		D/C'd											
			18	n													
			24	n													
09 Jul	[redacted]	Titrate Fentanyl	05			D/C'd											
		to OFF	17	n													

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

PATIENT IDENTIFICATION:

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 MEDCOM - 12873 ED UNTIL EXHAUSTED. USAPA V1.00

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*				*Mo.* ______ *Yr.* ______
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
	-----					

	-----	b(6)-2 A11				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* TIME/DATE DISPENSED													
9Jul03	[redacted]	MOM 2 tsp q4°	09Jul 1100	09Jul 1500	9Jul 1900	9Jul 2300	9Jul 0500	9Jul 1000	10 Jul	10 Jul						
-----	-----	until BM	10cc [redacted]	10cc [redacted]	10cc [redacted]	10cc [redacted]	10cc [redacted]	10cc [redacted]	2100 [redacted]	0535 [redacted]						
-----	-----	Percocet 1-2 tabs	10 Jul 05 @0650													
-----	-----	Q4° PRN Pain	[redacted]													
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															

USAPA V1.00

MEDCOM - 12874

b(6)-2

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: July *Yr.* 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	11	12	13	14	15	16	17	18	19	20	21			
11 July 03	[redacted]	IVF LR @ 125cc/hr	05	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
			17	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
11 July 03	[redacted]	Vancomycin 500mg IVPB	08	X	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
		q 12°	20	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
11 July 03	[redacted]	Levoquin 500mg po QD	15	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
11 July 03	[redacted]	Flagyl 250mg IVPB tid	06	X	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
			14	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
			22	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
11 July 03	[redacted]	Heparin 5000u q12° SC	10	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
			22	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
11 July 03	[redacted]	Toradol 30mg IV q6°	16	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
			22	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
			04	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
			10	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
11 July 03	[redacted]	Fentanyl drip 100mcg/hr	05	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
		& titrated	17	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
14 July 03	[redacted]	MOM 2 tsp Q4° until	04	/	/	/	[redacted]	[redacted]	[redacted]	[redacted]							
		BM occur	08	/	/	/	[redacted]	[redacted]	[redacted]	[redacted]							
			12	/	/	/	[redacted]	[redacted]									
			16	/	/	/	[redacted]										
			20	/	/	/	[redacted]	[redacted]	[redacted]								
			24	/	/	/	[redacted]	[redacted]	[redacted]								

b(6)-2

DC'd 15 Jul 03
2240

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: I+D Ⓡ BKA S/P Washout

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ______

PATIENT IDENTIFICATION:

EPW
#[redacted]
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

MEDCOM - 12875

;ED UNTIL EXHAUSTED.

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo. JU		
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time
13July 0935	[redacted]	Fentanyl 100mg IVP NOW	13July NOW	0935	0935

b(6)-2 ARL

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY		INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
11 July 08	[redacted]	Percocet 1-2 po q 4°	D	11Jul	12Jul	12July	12Jul	13July	13 July	13 July	15Jul	15Jul	15Jul	16Jul	16Jul		
			T	1525	1445	1307	2040	0925	1149		0900	1300	1700	1134	2005		
			D	ii		ii	ii	ii	i	1955	2 tab	2 tab	2 tab	2 tab	2 tab		
		PRN For Pain	I	[redacted]	[redacted]												
		MS04 1-4mg IVP q hr	D	11Jul	12Jul	12 July	12 July	12 July	12Jul 2035	13Jul 0240	13July 0736	13July 0909	13July 1000	13July 1220	13July 1434	13July 1647	14July 0500
			T	1600	0245	1340	1535	1442	4mg	4mg	4mg	4mg	2mg	4mg	4mg	4mg	2mg
		PRN breakthrough	D	3mg	3mg	4mg	4mg	2mg									
		Pain	I	KMO	[redacted]												
rewritten 14July	[redacted]	MS04 1-4mg IVP q hr	D	14July	14July	14Jul	15Jul	16Jul	14July	14July							
			T	0824	0450	1355	0850	0500	0612	1119							
		prn breakthrough pain	D	4mg	4mg	2mg	4mg	4mg	2mg	4mg							
			I	[redacted]													

USAPA V1.00

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. 7 *Yr.* 03

ERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	16	17	18	19	20	21	22	23	24	25	26	27	28	29
16 July 17 Jul	[redacted]	Gentamycin 300mg IV QD	18	[redacted]													
16 July	[redacted]	Ancef 1gm IV Q8	08 16 24	[redacted]				DC'd 17 Jul 03									
16 July 17	[redacted]	IV LR @ 100cc/h HL when tol PO	05 13 21	[redacted]													
16 July 17	[redacted]	Elavil 25 mg PO TID	8 16 24	[redacted]													
17	[redacted]	Fortaz 2gm IVPB q8°	08 16 24	I/ [redacted] /													

b(6)-2 AH

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P Ⓡ BKA Washout

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ______

PATIENT IDENTIFICATION:

[redacted] 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 MEDCOM - 12877 SED UNTIL EXHAUSTED. USAPA V1.00

		be Given	be Given

b(6)-2 All

er/ ir e	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED												
16/17 July	[redacted]	MSO4 I - 4 mg IV Q1-2 hr PRN	7-16 1220 2mg IV [redacted]	7/16 2000 4mg	16 July 2400 2mg IV	17 July 0115 2mg IV	17 July 0001 4mg IV [redacted]	17 Jul 0930 4mg [redacted]	17 July 4mg 1133 IV [redacted]	/	17 Jul 2030 [redacted]				
16/17 July	[redacted]	Percocet I-II PO Q4 PRN	7-16 II 1506	7/16 II 2005	16 July 2400 II po	17 July 0350 II po	18 July 0340 II po	15 July II 1620	20 July 1558						
		[redacted]													
17	[redacted]	Zofran 4mg IV q6° prn nausea													

USAPA V1.

b(6)-2 A11

CLINICAL RECORD

THERAPEUTIC DOCUMENTATIO… …DICATIONS)
For use of this form, se…
the proponent agency is the Office of … …on General.

Mo. 7 Yr. 03

INITIAL PROF… …UMN FOLLOWING EACH ADMINISTRATIO…

…ERIFY BY INITIALING

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 18 19 20 21 22 23 24
7-18	[redacted]	LR @ 125cc/hr (HL) when tol PO	5 13 21	[redacted] DC'd
7-18	[redacted]	Gentamycin 350mg IV QD	18	[redacted]
7-18	[redacted]	Fortaz 2gm IV Q8°	08 16 24	[redacted] [redacted]
7-18	[redacted]	Elavil 25mg PO TID	08 16 24	[redacted]
221	[redacted]	Elavil 75mg PO QD	08	[redacted] D'd See below [redacted]
24	[redacted]	elavil 25mg PO TID	06 14 22	/ / / D/C See below [redacted]
24	[redacted]	levofloxin 500mg PO QD	20	[redacted]
24	[redacted]	elavil 75mg PO BID	08 20	/ [redacted]

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: S/P BKA close

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ______

PATIENT IDENTIFICATION:

#[redacted]

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

MEDCOM - 12879

b(6)-2 A11

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

			be Given	be Given		
22Jul	[redacted]	MOM PO x 1dose [illegible] ~~PO~~ [redacted] now	now	2214	2214	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED									
7 18	[redacted]	MSO4 i - iv IV Q 2-4° PRN or Percocet ii PO Q4° PRN pain.	72 0800 4mg IV ABS	18 July 2100 ii PO [redacted]	19 July 0508 ii	19 July 2350 ii PO [redacted]	20 Jul 0407 ii PO [redacted]	21 July 0608 i PO	21 July 1915 i po	22 July 0030 ii po [redacted]	22 July 0730 ii PO [redacted]	22 Jul 1615 BAS ii (t)
22 Jul 24 Jul 27	[redacted]	Percocet ii PO Q4° PRN pain	23 Jul 0131 i PO [redacted]	24 Jul 0425 ii PO	24 Jul 2000 ii PO							
-----	-----											
-----	-----											
-----	-----											
-----	-----											
-----	-----											

USAPA V1.00

MEDCOM - 12880

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Verify by Initialing

Mo. 7 Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....	b(6)-2 AM				
	.....					

INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	TIME/DATE DISPENSED													
18 Jly	[redacted]	MSO4 i–ii IVP														
.....	.....	Q2-4° PRN														
18 July	[redacted]	Percocet ii PO Q4°	25Jul 1830 i PO	25Jul 2148 i PO	26Jul 0920 i PO	26Jul 1150 ii PO	26Jul i PO BDS 1950	27Jul 08:18 i PO	27Jul 0853 i PO	27Jul 0135 i PO	27Jul 1630 i PO BDS	28Jul 0148 i PO	28Jul 0730 i PO	28Jul 1900 i PO BDS	i 0830	i 0826
.....	.....	PRN pain	[redacted]					[redacted]								
.....	.....															
July	[redacted]	Percocet i–ii PO Q4°	29Jul 1600 i	29Jul 2000 ii	30Jul 0130 i	30Jul 1400 i PO BDS (+)	30Jul 23:14 i PO	31Jul 0730 ii PO	31Jul 1200 i PO	31Jul 1755 ii	1Aug 0730 ii PO	~~1Aug 1020 ii PO~~	2Aug 1130 ii PO	3Aug 2127 ii	5Aug 0705 ii PO	6Aug 1840 ii
.....	.....	PRN pain	[redacted]				[redacted]									
.....	.....															
31	[redacted]	Maalox 30cc PO q4-6hrs prn	31Jul 0845													
.....	.....		30cc [redacted]													
3Aug	[redacted]	Tylenol 650mg q4-6°	3Aug ii PO	1045 3Aug ii PO [redacted]	3Aug 2015 ii PO	2Aug 0755 ii PO	4Aug 0930 ii PO	4Aug 1500 ii PO BDS	4Aug 0845 ii PO	4Aug 0554 ii PO	4Aug 1400 ii PO	5Aug 0800 650mg	6Aug 1610	6Aug 1900	7Aug 1330	
.....	.....	PRN pain	(+)	1430 (+)	[redacted]				[redacted]			[redacted]				
6Aug	[redacted]	Valium 5mg po TID PRN										[redacted]				

USAPA V1.00

MEDCOM - 12881

b(6)-2 A11

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. 06 *Yr.* 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	25	26	27	28	29	30	31	1	2	3	4	5	6	7
24 July	[redacted]	Levofloxin 500mg PO QD	20	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
24 July	[redacted]	Elavil 75 mg PO BID	08	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
			20	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
6Aug03	[redacted]	IV: LR @ 125cc/hr (HL) when tolerating po	06														
			14														
			22														SP
6Aug03	[redacted]	Valium 5mg po TID	06	✓													
			14			D/C'd 6Aug03 1215											
			22														

DC

DC 8/7/0

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: S/p BKA close

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ______

PATIENT IDENTIFICATION:

EPW [redacted] 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 - 12882

PAGE 1 OF 4

MEDICAL RECORD–SUPPLEMENTAL MEDICAL DATA
For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
DA Appr 8 Mar 89

INITIAL [redacted] ASSESSMENT

NEURO	TIME	0130	INITIALS [redacted] b(6)-2		INITIALS		INITIALS
	PUPILS	Perrla					
	SENSORIUM	Pt A+Ox3					
		Moves alle extremities					
		x RLE has ↓ ROM					
		r/t ex fix.					
RESPIRATORY	RESPIRATORY PATTERN	RAR					
	BREATH SOUNDS	Clear bilat					
	SECRETIONS	0 cough					
		0 SOB					
		SaO2					
SKIN	COLOR	Normal to Race					
	INTEGRITY	intact x Ⓛ Hand &					
		Ⓡ LE (ex fix)					
IV SITE	LOCATION	Ⓡ AC 20g					
	CONDITION	Flushes c̄ no					
		difficulty.					
		LR @ 125 cc/hr					
GASTRO	ABDOMEN	BS active x 4 quads					
	BOWEL SOUNDS	0 distention or					
		tenderness upon					
		palpation					
GU	URINE:	Foley cath (16fr) placed					
	COLOR/CLARITY	@ 0200 d/t distention					
		1100 cc out clear yellow					
CARDIOVASCULAR	CARDIAC RHYTHM	Sinus Brady 54-57					
		S1S2 present 0 ectopy					
		Edema to RLE 3+					
		Pulses present					
		x 4 extremities					

LEGEND

Cr - Creatinine	ICP - Intracranial Pressure	SA - Fractional
F_iO_2 - Fraction of inspired O_2	PCO_2 - Pressure of Arterial CO_2	SAT - Saturation
HCO_3 - Bicarbonate	PEEP - Positive End Expiratory Pressure	TRACH - Tracheostomy

b(6)-2

(Continue on reverse)

PREPARED BY *(Signature & Title)*
[redacted]

DEPARTMENT/SERVICE/CLINIC
ICU 3

DATE 2 July 03 ~~2 Aug 03~~

[redacted] e—last, first, middle; grade; date; (Hospital or medical facility)

EPW [redacted]

b(6)-4

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

DA FORM 1 MAY 78 4700
Proponent Dept of Nurs

MEDCOM - 12883

WAMC OP 375 (Redesignated)
1 Apr 90 (HSXC-NU)

DATE	DX	HOSPITAL DAY

VITAL SIGNS

TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
BP Arterial Line																		
BP Cuff																		
Temperature																		
Pulse																		
Respiratory Rate																		
pain																		
intervention																		

INTAKE

TIME	05	06	07	08	09	10	11	12	8° T	13	14	15	16	17	18	19	20	8° T
LR																		
PO																		
TOTALS																		

OUTPUT

URINE	HOUR / TOTAL																	
	10 gr																	
	S/A																	
NG	OUTPUT																	
	pH																	
	GUIAC																	
EMESIS																		
STOOL																		
DRAINS																		
TOTALS																		

MEDCOM - 12884

Admission

POST-OP DAY

VITAL SIGNS	21	22	23	00	01	02	03	04	
					106/66				
					97.9				
					54				
					18				
					100				
					RA				

INTAKE	21	22	23	00	01	02	03	04	8° T
					125	125	125	125	

Foley Cath placed

OUTPUT									
	/	/	/	/	/	1100/1100	/	350/1450	

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA									
TIME									
MODE									
F_iO_2									
TV									
RATE									
PEEP									
ABG pH									
ABG PCO_2									
ABG pO_2									
ABG HCO_3									
ABG SAT									
ABG BASE									

LABORATORY DATA									
TIME									
GLUCOSE									
Na/K	/	/	/	/	/	/	/	/	/
Cl/CO_2	/	/	/	/	/	/	/	/	/
BUN/Cr	/	/	/	/	/	/	/	/	/
WBC/PLATELET	/	/	/	/	/	/	/	/	/
Hct/Hgb	/	/	/	/	/	/	/	/	/

ACTIVITIES OF DAILY LIVING					
TIME					
MOUTH CARE					
BATH					
SKIN CARE					
FOLEY CARE					
TRACH CARE					
ROM EXERCISES					

	TIME					
TURN						
SUCTION						

24° I&O TOTALS

wt Yesterday ______ wt Today ______

INTAKE

IV 500

po ______

TOTAL ______

OUTPUT

Urine: 1450

TOTAL 1450

BALANCE ______

NURSE'S SIGNATURE	INITIALS
SPC [redacted] WMG	[redacted]
b(6)-2	

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

b(6)-2

OTSG APPROVED *(Date)*
DA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0600 INITIALS [redacted]	INITIALS	1830 INITIALS [redacted]
NEURO	PUPILS	PERRLA		PERRLA 3mm brisk
	SENSORIUM	awakes easily. Follows		Able to move extremities
		non-verbal commands.		c̄ ext fixator on RLE.
		∅ deficits x̄ unable to		Follows simple commands
		flex Ⓛ pinky finger.		able to communicate pain
RESPIRATORY	RESPIRATORY PATTERN	Equal + unlabored		symmetrical rise & fall of
	BREATH SOUNDS	Clear bilateral. ON		chest, BS clear Ⓑ
	SECRETIONS	RA w/ Sats >99%.		∅ secretions
		∅ secretions.		RR 18, SaO2 97% on RA
SKIN	COLOR	Normal for race. Mucous membranes pink.		
	INTEGRITY	intact x̄ 1"x3" blood-like		Normal for race
		blister (hard) on Ⓡ foot w/ quarter-size skin breakdown		intact
IV SITE	LOCATION	Ⓡ forearm (20G)		
	CONDITION	LR @ 125cc/hr infusing		20G Ⓡ FA, ∅ S/S infection
		into Ⓡ forearm s̄ problems		LR @ 125cc dial-a-flow
		∅ s/s of infection.		
		Dressing to site Δ'd this		
		am.		
GASTRO	ABDOMEN	flat, non-distended.		
	BOWEL SOUNDS	⊕ BS x 4 quads.		flat, soft, nontender
		NPO for OR today.		BS ⊕ x 4 quads
				NPO for surgery this
GU	URINE:			pm
	COLOR/CLARITY	clear yellow s̄ sediments		Foley to gravity
		adequate hourly output		clear yellow urine
CARDIOVASCULAR	CARDIAC RHYTHM	S1S2 ∅ dysrhythmia.		
		V.S.S Cap. refill to Ⓡ		SR, S1/S2
		leg <3sec. but pedal		∅ edema
		pulse faint but palpable.		pulses 2+ Ⓑ UE/LE
				cap refill < 3sec Ⓑ UE/LE

LEGEND

Cr - Creatinine	ICP - Intracranial Pressure	S/A - Fractional
F_IO_2 - Fraction of inspired O_2	PCO_2 - Pressure of Arterial CO_2	SAT - Saturation
HCO_3 - Bicarbonate	PEEP - Positive End Expiratory Pressure	TRACH - Tracheostomy

PREPARED BY *(Signature & Title)*

(Continue on reverse)

DEPARTMENT/SERVICE/CLINIC: ICU 3

DATE: 2 July 03

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

EPW [redacted] b(6)-4

[redacted]

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

DA FORM 1 MAY 78 **4700**
Proponent: Dept of Nurs

MEDCOM - 12886

WAMC OP 375 (Redesignated)
1 Apr 90 (HSXC-NU)

DATE 02JUL03
DX
HOSPITAL DAY

VITAL SIGNS

TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
BP Arterial Line																		
BP Cuff	123/79	109/91		109/74		115/65	117/64	114/58			102/64		101/59		114/60		106/68	
Temperature	97.1	97		97.7		98		98.2			99.2		99.2		98.8			
Pulse	66	64		62		68	66	74			78		74		60		78	
Respiratory Rate	17	18		18		16	20	18			18		20		18		18	
SaO2	99	99		97%		97%	98%	99%			96		97%		97		98	
O2 Meth	RA	RA		RA		RA	RA	RA			RA		RA		RA		RA	
							↓ pain med given											
pain intervention																		

INTAKE

TIME	05	06	07	08	09	10	11	12	8° T	13	14	15	16	17	18	19	20	8° T
LR	125	125	125	125	125	125	125	125	1000	125	125	125	125	125	125	125	125	1000
PO	NPO																	
IVPB		50							50		50							50
TOTALS									1050									1050

OUTPUT

		05	06	07	08	09	10	11	12	8° T	13	14	15	16	17	18	19	20	8° T
URINE	HOUR / TOTAL		275 / 275		125 / 400		125 / 525		250 / 775			150 / 925		100 / 1025		150 / 1175		200 / 1375	1375
	sp gr																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS																			

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS

24	22	23	00	01	02	03	04	/
	110/70							
	68							
	16							
	97							
	RA							

INTAKE

21	22	23	00	01	02	03	04	8° T
125	125	125	125	125	125			
	50							50

OUTPUT

1 /	150/1525	/	250/1775	/	/	/	/	

RESPIRATORY DATA

TIME									
MODE									
F_iO_2									
TV									
RATE									
PEEP									
A B G pH									
PCO_2									
pO_2									
HCO_3									
SAT									
BASE									

LABORATORY DATA

TIME									
GLUCOSE									
Na/K	/	/	/	/	/	/	/	/	/
Cl/CO_2	/	/	/	/	/	/	/	/	/
BUN/Cr	/	/	/	/	/	/	/	/	/
WBC/PLATELET	/	/	/	/	/	/	/	/	/
Hct/Hgb	/	/	/	/	/	/	/	/	/

ACTIVITIES OF DAILY LIVING

TIME	1100		
MOUTH CARE	Kpo		
BATH			
SKIN CARE			
FOLEY CARE	Kpo		
TRACH CARE			
ROM EXERCISES			

TURN

SUCTION

TIME

24° I&O TOTALS

wt Yesterday ________ wt Today ________

INTAKE

IV ________

po ________

TOTAL ________

OUTPUT

Urine: ________

TOTAL ________

BALANCE ________

NURSE'S SIGNATURE	INITIALS
[redacted] FC/AN	[redacted]
[redacted] LT/AN	
b(6)-2 All	

MEDCOM - 12888

ACLU-RDI 1592 p.781

PAGE

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA
For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

TIME	0630 INITIALS [redacted]	b(6)-2 INITIALS	INITIALS
PUPILS	PERRL		3mm PERRL
SENSORIUM	Pt alert to touch + Voice Stimuli. Follows Simple commands		A+O x3 follows simple commands
RESPIRATORY PATTERN	Reg R+R		Reg Rhythm
BREATH SOUNDS	CTA bilat		CTA Bilat
SECRETIONS	Ø Ntd secretions Ø Ntd diff breathing equal rise + fall		symetrical rise + fall of chest.
COLOR	Pale		Pale Redness
INTEGRITY			to Ⓡ butt cheek.
LOCATION	Ⓛ AC Pic LR @125		Ⓛ AC Pic c̄ LR
CONDITION	Fent @ 15cc		@ 125cc/hr fent @ 15cc/hr IV to Ⓛ FA Ⓟ + flush.
ABDOMEN	Soft, Non tender, Non		Soft non tender
BOWEL SOUNDS	distended		non distended ⓅBS x4 good
URINE: COLOR/CLARITY	Clr Yellow to urinal @ bedside in adequate Amounts.		pt voiding spontaneously via urinal, clear yellow
CARDIAC RHYTHM	Ø Ntd ectopy. Radial Pulses @ +2 + Ⓛ Pedal @ +2 c̄ brisk cap refill to all		SSz, Ⓟ Rad pulses Ⓟ Pedal pulses, < 3sec cap refill.

LEGEND
Cr - Creatinine
F_iO_2 - Fraction of
HCO_3 - Bicarbonat

STATE FARM INSURANCE

Vanc ~~2000~~
Hepain ~~2200~~
~~Toradol 2200~~ DC'd · 0400
MoM 2000, 2400

b(6)-2

(Signature & Title) [redacted] 91WM6
(For typed or written entries give: dle; grade; date; hospital or medical facility)

se)

P

ART

pecify)

NPO p̄ Mid
CBC 2AM

[redacted]
b(6)-4

CAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General

REPORT TITLE Post-Anesthesia Care Unit (PACU) Flow Sheet

OTSG APPROVED (Date)

Date: 6 July 03
Time In: 1942
Allergies: NKDA
Pre-op V/S:
Procedures: Ⓡ BKA

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid ______ Colloid ______
OR Output: UOP 250 EBL 150
Meds/Times:

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds

History

Time	1945	1950	1955	2010	2025	2040										
SaO2	99	97	98	98	100	99										
FiO2																
Methods	RA	RA	RA	RA	RA	RA										
240																
220																
200																
180																
160																
140																
					^	^										
120	^	^	^	^												
100	•	•														
			•	•												
80	v	v	v		v	v										
				v		•										
60					•											
40																
20																
RR	20	16	14	21	10	21										
T		98.8		98												

Time								
Pain (0-10)								
LOS								

Patient teaching done; Wound Care, Pain Management,
T, C, & DB,. Incentive Spirometer, Comfort Measures
Safety: SR up X 2, Falls Precautions. Privacy Maintained

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays:

Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	2	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	2	2	2
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	12	12	12

Codes

AIRWAY
A = Ambu
BB = Blow-by
M = Mask
FT = Face Tent
RA = RoomAir
NC = Nasal Cannula

V/S
X = A-line BP
ˇ = Cuff BP
• = Pulse

TEMP
S = Skin
O = Oral
A = Axillary
T = Tympanic
R = Rectal

LOS
C = Cervical
T = Thoracic
L = Lumbar
S = Sacral

(Continue on reverse)

PREPARED BY (Si[redacted] b(6)-2
SPC

DEPARTMENT/SERVICE/CLINIC
ICU 3

DATE
6 July 03

PATIENT[redacted] typed or written entries give: Name —last, first,:mid[redacted]grade; date; hospital or medical facility)

EPW [redacted] b(6)-4

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

MEDCOM - 12890

b(6)-2

MEDICATIONS

ergies:

me	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
2015		Fentanyl 150mcg IVP				[redacted]

NEUROVASCULAR

ime	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
m							
:							

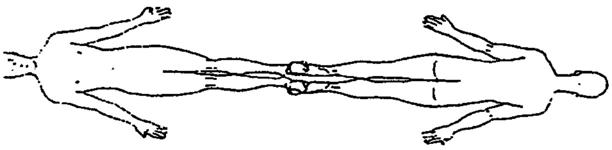
ovement/Sensation: + = present, - = absent Temp: C = Cool, = Warm Pulses: P = Palpable, D = Doppler, A = Absent olor: C = Cyanotic, pillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

	Adm	15'	30'	45'	60'	90'	D/C
nd. Height							
chia							
ripad#							
nd. Cond.							

DRESSINGS

Time	Location	Type	Drainage
m/1950	Ⓡ Leg	Drsg c̄ Ace wrap	0
:			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

NURSING NOTES

pt transfered to ICU3 from OR s/p Ⓡ BKA. pt A+O x3, VSS, SAO2 98% on room air. LR @ 50cc/hr to IV in Ⓡ upper arm. Moves all extremities. Fentanyl 150mcg IVP given for c/o pain. Will continue to monitor [redacted]

b(6)-2

Discharge Criteria:

Date: **Time:** **PARS:**

BP: **T:** **HR:** **RR:** **Sa02:**

Pain Level at D/C (0-10):

Intake:________ **Output:**________

Additional Data:

Transferred To:

Report Given To:

Transferred Via: W/C Litter Gurney Ambula

Transferred By:

MEDCOM - 12891

.ICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General

REPORT TITLE Post-Anesthesia Care Unit (PACU) Flow Sheet

OTSG APPROVED (Date)

Date:
Time In:
Allergies:
Pre-op V/S:
Procedures: debridement Ⓡ leg

Anesthesia Type (Circle)): [✓ General] Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 600 Colloid
OR Output: UOP 0 EBL min
Meds/Times: 20mg MSO4 25mg Phenergan

Drains
- Hemovac
- NG
- JP
- T-tube
- Foley
- TLS

Airway
- Nasal
- [✓ Oral]
- ETT
- Trach
- Other

Pre Op Meds 5x3 ·15

History

Time	1420	[illegible]	1435	1445	1500	1515	1530									
SaO2	98	96	96	98	99	99	96									
FiO2																
Methods	RA	RA	RA	RA	RA	RA	RA									
240																
220																
200																
180																
160																
140																
	∨	∨														
120			∨	∨	∨	∨	∨									
100	•	•	•	•	•	•	•									
80				∧												
	∧	∧	∧		∧	∧	∧									
60																
40																
20																
HR -	103	104	103	103	104	107	100									
RR -	21	14	17	20	17	14	14									
T -	100.8	100.1	100.4	100.7	101.4	100.7	100.9									

Time								
Pain (0-10)								
LOS								

Patient teaching done: Wound Care, Pain Management.
T, C, & DB,. Incentive Spirometer, Comfort Measures
Safety: SR up X 2, Falls Precautions. Privacy Maintained

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays:

Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C	Codes
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities				AIRWAY A = Ambu BB = Blow-by M = Mask FT = Face Tent RA = RoomAir NC = Nasal Cannula V/S X = A-line BP ˇ = Cuff BP • = Pulse TEMP S = Skin O = Oral A = Axillary T = Tympanic R = Rectal LOS C = Cervical T = Thoracic L = Lumbar S = Sacral
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea				
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op				
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain				
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic				
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse				
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.				

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC

DATE

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

Name — last,

b(6)-4

#[redacted]

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

MEDCOM - 12892

.CAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General

REPORT TITLE **Post-Anesthesia Care Unit (PACU) Flow Sheet**

OTSG APPROVED *(Date)*

Date: 15 Jul
Time In: 0825
Allergies: ______
Pre-op V/S: ______
Procedures: ______

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 400 Colloid ______
OR Output: UOP ______ EBL 200cc
Meds/Times: 250 Fent 20 MSO4 4 zofran

Drains	Airway
Hemovac	Nasal
NG	Oral
JP	ETT
T-tube	Trach
Foley	Other
TLS	

Pre Op Meds

History

Time	0825	0830	0835	0840	0855	0910	0940									
SaO2	100	100	100	100	98	100	99									
FiO2																
Methods	NRB	NRB	NRB	NRB	RA	RA	RA									
240																
220																
200																
180																
160																
140																
120			Λ	Λ	Λ											
	Λ	Λ				Λ										
100																
80	•	Λ	•		Λ	•	•									
		•	Λ	Λ		Λ										
60	Λ															
40																
20																
RR	12	18	16													
T	96.3															

Time									Patient teaching done; Wound Care, Pain Management.
Pain (0-10)									T, C, & DB,. Incentive Spirometer, Comfort Measures
LOS									Safety: SR up X 2, Falls Precautions. Privacy Maintained

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: ______ Labs: ______

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2		
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2		
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2		
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	2		
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2		
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	\	\	\
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	10		

Codes

AIRWAY
A = Ambu
BB = Blow-by
M = Mask
FT = Face Tent
RA = RoomAir
NC = Nasal Cannula

V/S
X = A-line BP
ˇ = Cuff BP
= Pulse

TEMP
S = Skin
O = Oral
A = Axillary
T = Tympanic
R = Rectal

LOS
C = Cervical
T = Thoracic
L = Lumbar
S = Sacral

Continue on reverse

PREPARED BY *(Signature & Title)* b(6)-2
[redacted] 91WM6

DEPARTMENT/SERVICE/CLINIC

DATE

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

[redacted]
b(6)-4

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

MEDCOM - 12893

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE **Post-Anesthesia Care Unit (PACU) Flow Sheet**

OTSG APPROVED *(Date)*

Date: 16 July 03
Time In: 0957
Allergies: NKA
Pre-op V/S:
Procedures: I&D Ⓡ BKA

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 500 Colloid 0
OR Output: UOP N/A EBL 100
Meds/Times:

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds

History

Time	0957	1012	1021	1035	1057											
SaO2	100	100	100	100	97											
FiO2																
Methods																
240																
220																
200																
180																
160																
140																
120																
100																
80																
60																
40																
HR	82	68	76	74	63											
BP	11[illegible]	[illegible]	[illegible]	[illegible]	[illegible]											
RR	6	16	8	9	5											
T	[illegible]	[illegible]	[illegible]	[illegible]	98											

Time								
Pain (0-10)	0	0	0					
LOS								

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays:

Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities		2	
Airway [✓ (2) Cough, Deep breath] (1) Dyspnea, limited breathing (0) Apnea		2	
Blood Pressure [✓ (2) SBP =/- 20 of Pre-op] (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op		2	
Consciousness [✓ (2) Fully Awake, audible crying] (1) Arousable to verbal or pain		2	
Color [✓ (2) Baseline color & appearance] (1) pale, mottled, jaundiced (0) Cyanotic		2	
Circulation (Peds < 5 Years) [✓ (2) radial Pulse Palpable] (1) Axillary palpable, not radial (0) Carotid only reliable pulse			
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.			

Codes

AIRWAY
A = Ambu
BB = Blow-by
M = Mask
FT = Face Tent
RA = RoomAir
NC = Nasal Cannula

V/S
X = A-line BP
[✓ • = Cuff BP]
= Pulse

TEMP
S = Skin
O = Oral
[✓ A = Axillary]
T = Tympanic
R = Rectal

LOS
C = Cervical
T = Thoracic
L = Lumbar
S = Sacral

Patient teaching done: Wound Care, Pain Management.
T, C, & DB., Incentive Spirometer, Comfort Measures
Safety: SR up X 2, Falls Precautions. Privacy Maintained

(Continue on reverse)

PREPARED BY *(Signature & Title)*

DEPARTMENT/SERVICE/CLINIC
ICU3

DATE
16 July 03

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

EPW #[redacted] b(6)-4

July 16, 2003

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

DA FORM 4700, MAY 78 WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) Previous edition is obsolete
USAPPC V2.00

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

OTSG APPROVED (Date)

REPORT TITLE **Post-Anesthesia Care Unit (PACU) Flow Sheet**

Date: 17 July 03
Time In: 1440
Allergies: NKDA
Pre-op V/S: 108/54 75
Procedures: Ⓡ BKA Stump washout

Anesthesia Type (Circle)): [✓ General] Spinal Epidural IV Sedation Nerve Block LMA 40 mso4
OR Intake: Crystalloid 600 Colloid Ø
OR Output: UOP Ø EBL 10
Meds/Times: Ø

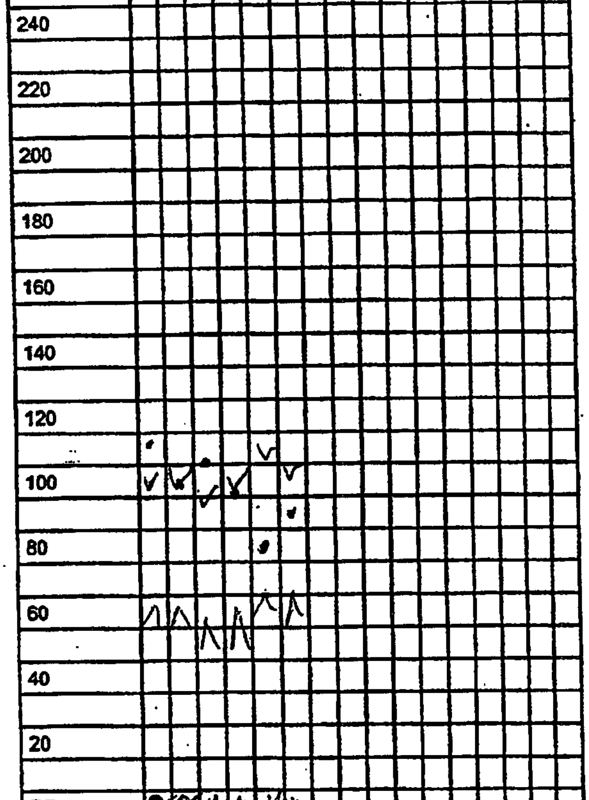
Drains
~~Hemovac~~
~~NG~~
~~JP~~
~~T-tube~~
~~Foley~~
TLS

Airway
~~Nasal~~
~~Oral~~
~~ETT~~
~~Trach~~
~~Other~~

Pre Op Meds

History

Time	1445	1450	1505	1515	1530	1545
SaO2	96	98	97	99	98	97
FiO2	RA	RA	RA	RA	RA	RA
Methods						



RR	[illegible]	[illegible]	14	16	14	16
T	99.2					99

Time								
Pain (0-10)								
LOS								

Patient teaching done: Wound Care, Pain Management.
T, C, & DB., Incentive Spirometer, Comfort Measures
Safety: SR up X 2, Falls Precautions, Privacy Maintained

Pacu Intake

Time	Solution	Amount	Site	By	Infused
		Ø			

X-rays:

Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	/	/	/
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	9	10	10

Codes

AIRWAY
A = Ambu
BB = Blow-by
M = Mask
FT = Face Tent
RA = RoomAir
NC = Nasal Cannula

V/S
X = A-line BP
˅ = Cuff BP
˄ = Pulse

TEMP
S = Skin
O = Oral
A = Axillary
T = Tympanic
R = Rectal

LOS
C = Cervical
T = Thoracic
L = Lumbar
S = Sacral

(Continue on reverse)

PRE[redacted] b(6)-2 LPN.

DEPARTMENT/SERVICE/CLINIC ICU # 2

DATE 17 July 03

[redacted] entries give: Name — last, [redacted] middle; grade; date; hospital or medical facility)

[redacted]

b(6)-4

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

DA FORM 4700, MAY 78 WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) Previous edition is obsolete USAPPC V2.00

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	RLE	+	+	Amput	B	W	PK
15'	RLE	+	+	Amput	B	W	PK
30'	RLE	+	+	Amput	B	W	PK
45'	RLE	+	+	Amput	B	W	PK
60'	RLE	+	+	Amput	B	W	PK
90'							
D/C	RLE	+	+	Amput	B	W	PK

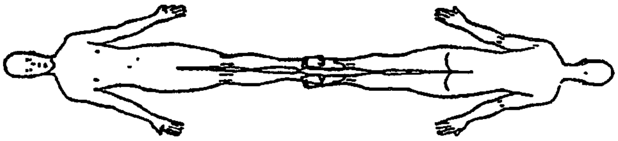
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic, P = Pale, Pk = Pink
Capillary Refill: B = Brisk, S = Sluggish

C-SECTIONS

	Adm	15'	30'	45'	60'	90'	D/C
Fund. Height							
Lochia							
Peripad#							
Fund. Cond.							

DRESSINGS

Time	Location	Type	Drainage
Adm	RLE	ACE	0
30'	"	"	"
60'	"	"	"
D/C	"	"	"



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

1445 Pt alert, verbal, follows commands on arrival from OR. Pt Sat 96% on RA - Pt able to Cough & Deep Breath. Drsg to RLE C/D/I. 15:38 - Pt alert, verbal, USS. Pt Sat 98% on RA. Pt able to Cough & deep breath. Drsg to RLE C/D/I. [redacted] LPN

b(6)-2

Discharge Criteria:
Date: 17 Jul 02 Time: PARS: 10
BP: 108/70 T: 99.1 HR: 95 RR: 16 Sa02: 99
Pain Level at D/C (0-10): 0
Intake: 0 Output: 0
Additional Data: 0
Transferred To: ICW #2
Report Given To: Cpt. [redacted]
Transferred Via: W/C [✓ Litter] Gurney Ambulance
Transferred By: SPC [redacted]
Cleared IAW Recovery Room SOP B-3 b(6)-2
Charge Nurse Signature:

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE **Post-Anesthesia Care Unit (PACU) Flow Sheet**

OTSG APPROVED *(Date)*

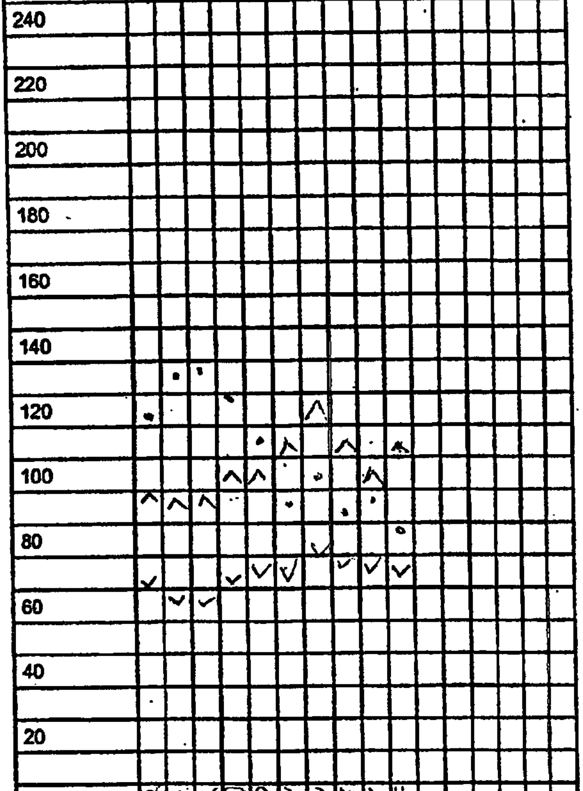
Date: 18 Jul 03 Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
Time In: 0900
Allergies: NKDA OR Intake: Crystalloid 700 Colloid
Pre-op V/S: 134/60 118 OR Output: UOP EBL 100
Procedures: closure flap Meds/Times:

Drains
Hemovac
NG
[✓ JP]
T-tube
Foley
TLS

~~Airway~~
[✓ Nasal]
[✓ Oral]
ETT
Trach
Other

Pre Op Meds History

Time	0900	0905	0910	0915	0920	0930	0945	1000	1015	1030					
SaO2	100	100	100	100	100	100	100	100	100	100					
FIO2	8L	8L	8L	8L	8L	8L	8L	0	0	0					
Methods	M	M	M	M	M	M	M	RA	RA	RA					



RR	12	13	13	20	13	14	14	16	16	16					
T	96.7		97.2			98.7		98.7							

Time	0	0	0					
Pain (0-10)								
LOS								

Patient teaching done: Wound Care, Pain Management.
T, C, & DB.. Incentive Spirometer, Comfort Measures
Safety: SR up X 2, Falls Precautions. Privacy Maintained

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays:
Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	1	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	1	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	1	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	1	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	/	/	/
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	6	9	10

Codes

AIRWAY
A = Ambu
BB = Blow-by
M = Mask
FT = Face Tent
RA = RoomAir
NC = Nasal Cannula

V/S
X = A-line BP
˄ = Cuff BP
= Pulse

TEMP
S = Skin
O = Oral
A = Axillary
T = Tympanic
R = Rectal

LOS
C = Cervical
T = Thoracic
L = Lumbar
S = Sacral

(Continue on reverse)

b(6)-2

PREPARED BY *(Signa*[redacted] SGT [redacted] 91WM6

DEPARTMENT/SERVICE/CLINIC ICU 2

DATE 18 Jul 03

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

EPW # [redacted] b(6)-4
244.08
ICU 2

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

DA FORM 4700, MAY 78 WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) Previous edition is obsolete USAPPC V2.00

b(6)-2 All

MEDICATIONS

Allergies: NKDA

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
		Ø				

NEUROVASCULAR

Time	Site Ⓛ leg arms	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	[illegible]	+	+	P	S	97⁶	P
15'		+	+	P	S		P
30'	✓	+	+	P	B	98²	pk
45'		+	+	P	B		pk
60'		+	+	P	B	98⁴	pk
90'							
D/C	✓	+	+	P	B	97⁸	pk

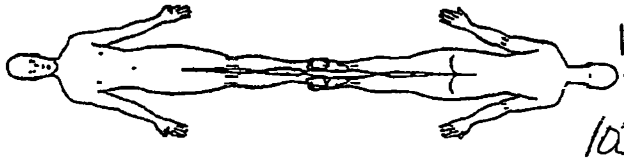
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent Color: C = Cyanotic, Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

	Adm	15'	30'	45'	60'	90'	D/C
Fund. Height			N/A				
Lochia							
Peripad#							
Fund. Cond.							

DRESSINGS

Time	Location	Type	Drainage
Adm 0900	Ⓡ BKA	bulky/ace	Ø
30' 0930	Ⓡ BKA	" "	Ø
60' 1002	Ⓡ BKA	" "	Ø
D/C 1030	Ⓡ BKA	" "	Ø



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Sinus Rhythm	Symptomatic?	Rhythm Strip Run?
0900	tachy	no	NO
1030	NSR	N/A	NO.

WAMC OP 173-E

NURSING NOTES

24 y.o EPW ♂ transported via
litter from OR to ICU 2 s/p
I+D Ⓡ BKA - closure stump.
Received report from Anesthesiologist
PT VS 99/71 P127 R12 SaO2 100%
8L via venturi mask. LS -
CTA shallow - opens eyes to
painful stimuli color pale,
nasal trumpet, J-tube in place Ⓛ nare
PARS scale 6. IV 20 Ⓡ FH
flush running TKO patent.
Drg - bulky c̄ ace wrap CDI
JP to suction approx 3cc bloody
drg. ABD ⊝ DTN ⊝ Rigidity NT
will cont to monitor SGT [redacted]
0935 - eyes open VSS SaO2 100% 8L
⊕ gag reflex - pt indicating to take
out J-tube - removed after pt
followed deep breathing + cough request
+ demonstrated NVI color pink
tolerated well Ø emesis or aspirate
noted. Will cont to monitor [redacted]
nasal trumpet Ⓛ nare remains
SGT [redacted] /AN/MC
1030 Transport via litter to ICU 2. VSS NAD SaO2 100
drg CDI. A+Ox3 Denies c̄ pain SGT [redacted]
JP drain

Discharge Criteria:
Date: 18Jul03 Time: 1030 PARS: 10
BP: 110/76 T: 98² HR: 88 RR: 16 Sa02: 100 RA
Pain Level at D/C (0-10): Ø
Intake: 150cc Output: Ø
Additional Data: None
Transferred To: ICW 2
Report Given To:
Transferred Via: W/C [✓ Litter] Gurney Ambulance
Transferred By: SGT [redacted]
Cleared IAW Recovery Room SOP
Charge Nurse Signature:

18Jul03 1043 Concur c̄ above assessment - Ready for transfer
MAJ/AN [redacted] b(6)-2

MEDCOM - 12898

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE **Post-Anesthesia Care Unit (PACU) Flow Sheet**

OTSG APPROVED *(Date)*

Date: ______

Anesthesia Type (Circle) [✓ General] Spinal Epidural IV Sedation Nerve Block

Time In: 1520

Allergies: NKDA

OR Intake: Crystalloid 400 Colloid ______

25 Rnt
22 Morph

Pre-op V/S: 91/58 107

OR Output: UOP ______ EBL 0

Procedures: exam under Anesthesia, JP Removed

Meds/Times: ______

1513 – 1613

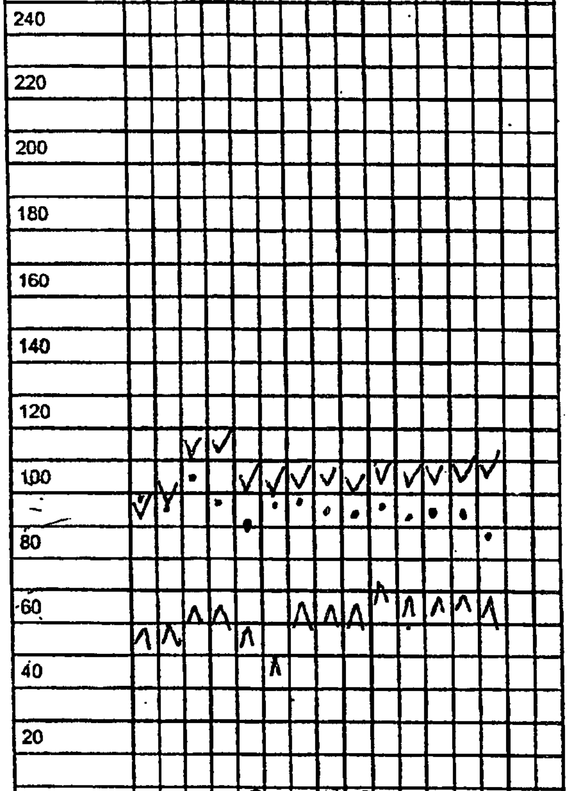
Pre Op Meds

History

Drains
- Hemovac
- NG
- JP
- T-tube
- Foley
- TLS

Airway
- Nasal
- Oral
- ETT
- Trach
- Other

Time	1510	1513	1520	1525	1530	1536	1540	1545	1550	1555	1600	1605	1610	1615		
SaO2	100	100	100	100	100	100	100	98	99	99	99	99	99	99		
FIO2	100	—	—		RA	—	—	—	—	—	RA	RA	RA	RA		
Methods	F	M	—	—	RA											



RR	16	24	14	22	13	28	21	16	20	12	17	19	20	18		
T	99	[illegible]					98									

Time									
Pain (0-10)	0								
LOS									

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: ______ Labs: ______

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	1	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	1	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	/	/	/
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	8	9	10

Codes

AIRWAY
A = Ambu
BB = Blow-by
M = Mask
FT = Face Tent
RA = RoomAir
NC = Nasal Cannula

V/S
X = A-line BP
˅ = Cuff BP
• = Pulse

TEMP
S = Skin
O = Oral
A = Axillary
T = Tympanic
R = Rectal

LOS
C = Cervical
T = Thoracic
L = Lumbar
S = Sacral

Patient teaching done; Wound Care, Pain Management.
T, C, & DB,. Incentive Spirometer, Comfort Measures
Safety: SR up X 2, Falls Precautions. Privacy Maintained

(Continue on reverse)

[redacted] *Title)* b(6)-2
9 lCuMr

DEPARTMENT/SERVICE/CLINIC ICU 2 PACU

DATE 20 JUL 03

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

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

4f [redacted]
b(6)-4

MEDCOM - 12899

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1540	5	Percocet	PO	5	[illegible]	[redacted]

NURSING NOTES

received [illegible] pain [illegible] gave
percocet @ 1540hrs [illegible]
[illegible] [redacted] [illegible]

b(6)-2

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm		MAE	Intact	98	<3	99	NFP
15'				99	<3		NFP
30'				106	<3		NFP
45'				99	<3		NFP
60'		MAE	Intact	98	<3	98.8	NFP
90'							
D/C							

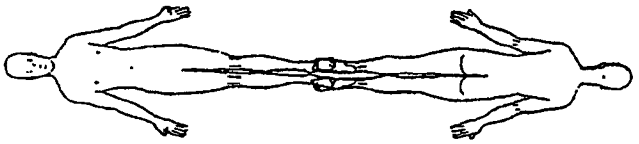
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic, P = Pale, Pk = Pink
Capillary Refill: B = Brisk, S = Sluggish

C-SECTIONS

	Adm	15'	30'	45'	60'	90'	D/C
Fund. Height							
Lochia							
Peripad#							
Fund. Cond.							

DRESSINGS

Time	Location	Type	Drainage
Adm	(R) leg	Ace cover gauze	∅
30'			∅
60'			∅
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1513	SR	∅ ectopy	Continuous
1615	SR	∅ ectopy	Continuous

Discharge Criteria: 1615
Date: 10 [illegible] Time: [illegible] PARS: 10
BP: 101/67 T: 98.8 HR: 93 RR: 19 Sa02: 99
Pain Level at D/C (0-10):
Intake: 600cc [illegible] Output: ∅
Additional Data: 1615
Transferred To: ICW2 [illegible]
Report Given To:
Transferred Via: W/C [✓ Litter] Gurney Ambulance
Transferre[redacted] 91WM6

b(6)-2

MEDCOM - 12900

97^{8}

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE **Post-Anesthesia Care Unit (PACU) Flow Sheet**

OTSG APPROVED *(Date)*

Date: 24Jul03
Time In: 1540
Allergies: NKDA
Pre-op V/S: 93/77 101
Procedures: Dsg Δ

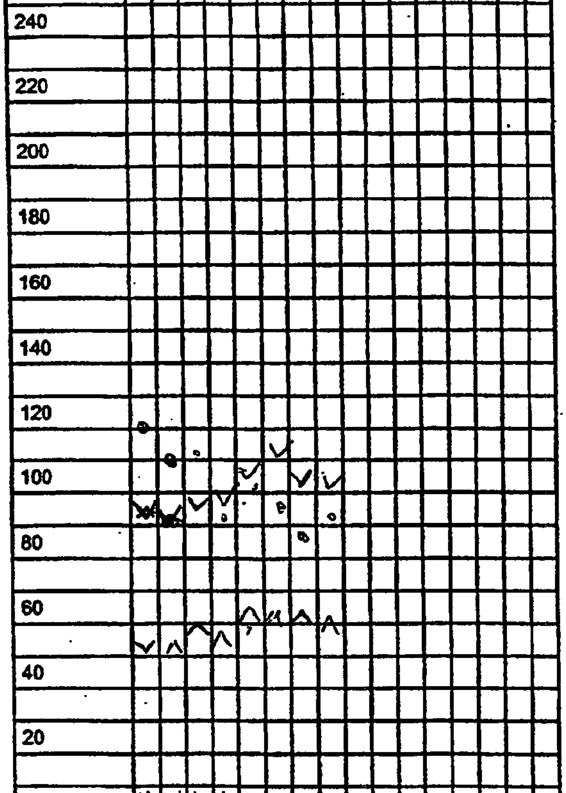
Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
10 morph
Halothan-
OR Intake: Crystalloid 300 Colloid
OR Output: UOP 0 EBL min-
Meds/Times:

Drains
Hemovac
~~[illegible]~~
JP
T-tube
Foley
S
None

Airway
[✓ Nasal]
Oral
ETT
Trach
Other

Pre Op Meds History

Time	1540	1545	1550	1555	1600	1615	1630
SaO2							
FIO2							
Methods							



RR	16	14	16	18	22	20	21
T	97^{8}						

Time								
Pain (0-10)								
LOS								

Patient teaching done; Wound Care, Pain Management,
T, C, & DB,. Incentive Spirometer, Comfort Measures
Safety: SR up X 2, Falls Precautions. Privacy Maintained

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1640	LR	250	(L) FA	CR	—

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	1	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	/	/	/
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	8	10	10

Codes

AIRWAY
A = Ambu
BB = Blow-by
M = Mask
FT = Face Tent
RA = RoomAir
NC = Nasal Cannula

V/S
X = A-line BP
˅ = Cuff BP
• = Pulse

TEMP
S = Skin
O = Oral
A = Axillary
T = Tympanic
R = Rectal

LOS
C = Cervical
T = Thoracic
L = Lumbar
S = Sacral

(Continue on reverse)

b(6)-7

PREPARED BY SGT [redacted] 91WM6

DEPARTMENT/SERVICE/CLINIC ICU 2

DATE 24Jul03

PATIENT'S ID[redacted] *first, middle; grade; date; hospital or medical facility)* Name —last,

[redacted]

b(6)-4

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

DA FORM 4700, MAY 78 WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) Previous edition is obsolete
USAPPC V2.00

MEDCOM - 12901

b(6)-2 A11

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
		NONE				

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	ⓇBKA	+	+	P	B	W	PK
15'	ⓇBKA	(NP)	+	P	B	W	PK
30'	ⓇBKA	+(Q X10)	+	P	B	W	PK
45'	ⓇBKA	〃	+	P	B	W	PK
60'	RBKA	〃	+	P	B	W	PK
90'							
D/C	RBKA	〃	+	P	B	W	PK

Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent

Color: C = Cyanotic, P = Pale, Pk = Pink

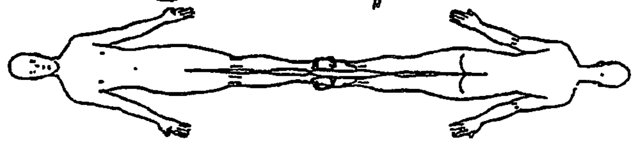
Capillary Refill: B = Brisk, S = Sluggish

C-SECTIONS

	Adm	15'	30'	45'	60'	90'	D/C
Fund. Height		N/A					
Lochia							
Peripad#							
Fund. Cond.							

DRESSINGS

Time	Location	Type	Drainage
Adm	ⓇBKA	bulky/ace	Ø
30'	ⓇBKA	bulky/ace	
60'	ⓇBKA	bulky/ace	
D/C	ⓇBKA	bulky/ace	



PACU OUTPUT

Time	Source	Color/Appearance	Amount
	NONE		

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
		unremarkable	

WAMC OP 173-E

NURSING NOTES

EPW ♂ transferred via litter from
OR S/P Drg Δ & washout of ⓇBKA.
pt resting c̄ eyes closed j-tube &
nasal trumpet present. VS 94/57 T
P 120 R 16 SaO2 100% 10L Face Mask
color good capfill brisk. easily
roused Ø c/o pain. Drg Ⓡ
BKA bulky c̄ ace CDI. LS CTA
will cont to monitor SGT [redacted]
1550 pt eyes open states/
gestures to take nasal & oral
airway out. airways removed
tolerated well VSS NAD will cont
to monitor. SGT [redacted] MM
1555 O2 removed pt A+O X3
SaO2 99% RA SGT [redacted]
1640 - VS 98/56 T 97^{8} HR 81
R 22 SaO2 99% RA pt A+O X3
NAD Remain unlabored. received
250cc LR. Drg ⓇBKA CDI
color PK. Ø c/o pain.
to be transported via litter
to ICU 2 SGT [redacted]

Discharge Criteria:
Date: 04 Jul 03 **Time:** 1640 **PARS:** 10
BP: 98/56 **T:** 97^{8} **HR:** 81 **RR:** 22 **Sa02:** 99 RA
Pain Level at D/C (0-10): 0
Intake: **Output:** Ø
Additional Data: None
Transferred To: ICU 2 [redacted]
Report Given To: LT [redacted]
Transferred Via: W/C [redacted] Ambulance
Transferred By: SGT [redacted] LPN
Cleared IAW Recove[redacted]
Charge Nurse Signa[redacted] /AN

MEDCOM - 12902

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE **Post-Anesthesia Care Unit (PACU) Flow Sheet**

OTSG APPROVED *(Date)*

Date: 6 Aug 03
Time In: 0949
Allergies: None
Pre-op V/S: 113/74, 113
Procedures: Skin Closure, Flap Advancement, Casting

Anesthesia Type (Circle): [✓ General] Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 600 Colloid
OR Output: UOP 0 EBL 60
Meds/Times: Halothane, Morphine 30mg Versed 4 mg

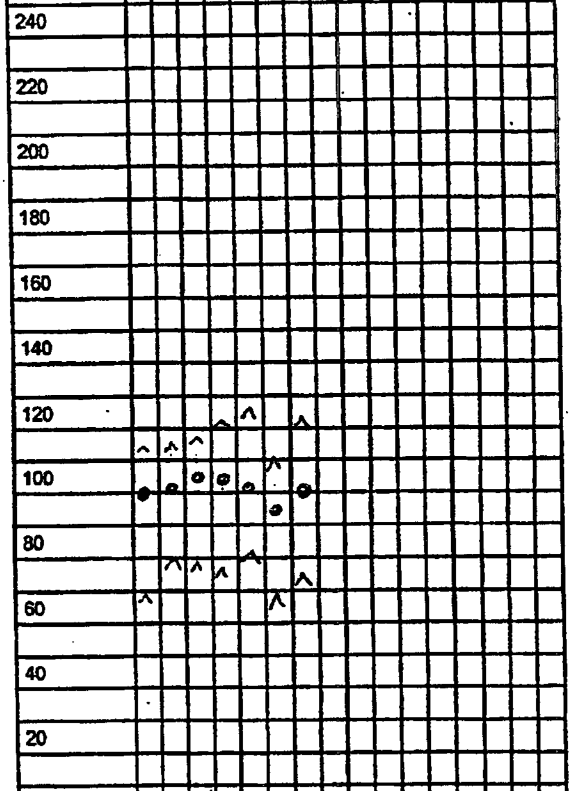
Pre Op Meds

History

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other natural

Time	0949	0955	1000	1005	1020	1035	1110								
SaO2	96	100	100	100	97	100	92								
FiO2	RA	RA	RA	RA	RA	RA	RA								
Methods															



RR	10	9	14	10	11	14									
T	95				98										

Time									
Pain (0-10)									
LOS									

Patient teaching done; Wound Care, Pain Management,
T, C, & DB,. Incentive Spirometer, Comfort Measures
Safety: SR up X 2, Falls Precautions. Privacy Maintained

Pacu Intake

Time	Solution	Amount	Site	By	Infused
0949	LR	400	(L) FA	[redacted]	40cc

X-rays:

Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	1	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP +/- 20 of Pre-op (1) SBP +/- 20-50 of Pre-op (0) SBP +/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	/	/	/
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	8	10	10

Codes

AIRWAY
A = Ambu
BB = Blow-by
M = Mask
FT = Face Tent
RA = RoomAir
NC = Nasal Cannula

V/S
X = A-line BP
˄ = Cuff BP
● = Pulse

TEMP
S = Skin
O = Oral
A = Axillary
T = Tympanic
R = Rectal

LOS
C = Cervical
T = Thoracic
L = Lumbar
S = Sacral

(Continue on reverse)

PREPARED BY [redacted] /AW b(6)

DEPARTMENT/SERVICE/CLINIC ICU 3

DATE 6 Aug 03

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

[redacted] b(6)-4

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

DA FORM 4700, MAY 78 WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) Previous edition is obsolete USAPPC V2.00

MEDCOM - 12903

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P Femoral	Cap Refill	T	Color
Adm	(R) BKA	+	/	+	/	W	PK
15'	(R) BKA	+	/	+	/	W	PK
30'	(R) BKA	+	/	+	/	W	PK
45'	(R) BKA	+	/	+	/	W	PK
60'	(R) BKA	+	/	+	/	W	PK
90'							
D/C	(R) BKA	+	/	+	/	W	PK

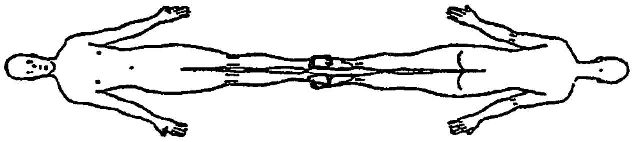
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic, P = Pale, Pk = Pink
Capillary Refill: B = Brisk, S = Sluggish

C-SECTIONS

	Adm	15'	30'	45'	60'	90'	D/C
Fund. Height							
Lochia							
Peripad#							
Fund. Cond.							

DRESSINGS

Time	Location	Type	Drainage
Adm	(R) BKA	Cast	None
30'	(R) BKA	Cast	None
60'	(R) BKA	Cast	None
D/C	(R) BKA	Cast	None



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

0955 - Pt arrived from OR via litter. Pt in stable condition. Sats 100% on RA. [illegible] 0955 Cast on (R) stump intact, Ø drainage noted. [redacted]

b(6)-2

Discharge Criteria:
Date: 6 Aug 03 **Time:** 1110 **PARS:** 10
BP: 122/75 **T:** 96° **HR:** 100 **RR:** 14 **Sa02:** 97
Pain Level at D/C (0-10): None
Intake: 280 **Output:** Ø
Additional Data:
Transferred To: ICW 3 [redacted]
Report Given To: LT [redacted]
Transferred Via: W/C [✓ Litter] Gurney Ambulance
Transferred By: Cpt [redacted]
Cleared IAW Recovery Room [redacted]
Charge Nurse Signatur[redacted]

b(6)-2

1. LAST NAME, FIRST NAME / NOM ET PRÉNOM K-10-100

RANK / GRADE

☐ MALE / HOMME
☐ FEMALE / FEMME

SSN / NUMÉRO MATRICULE

SPECIALTY CODE / GPM

RELIGION / RELIGION

2. UNIT / UNITÉ

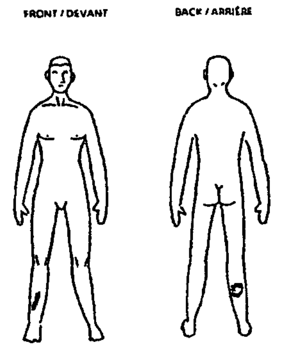
FORCE / ÉLÉMENT

NATIONALITY / NATIONALITÉ

☐ A/T ☐ AF/A ☐ N/M ☐ MC/M

☐ BC / BC ☐ NBI / BNC ☐ DISEASE / MALADIE ☐ PSYCH / PSYCH

3. INJURY / BLESSURE



☐ AIRWAY - TRACHÉE
☐ HEAD / TÊTE
☐ WOUND / BLESSURE
☐ NECK/BACK INJURY / BLESSURE AU COU/AU DOS
☐ BURN / BRÛLURE
☐ AMPUTATION / AMPUTATION
☐ STRESS / TENSION
☒ OTHER (*Specify*) / AUTRE (*Spécifier*)

GSW Ⓡ leg

4. LEVEL OF CONSCIOUSNESS / NIVEAU DE CONSCIENCE

☒ ALERT / ALERTE
☐ VERBAL RESPONSE / RÉPONSE VERBALE
☐ PAIN RESPONSE / RÉPONSE À LA DOULEUR
☐ UNRESPONSIVE / SANS RÉPONSE

5. PULSE / POULS

TIME / HEURE

6. TOURNIQUET / GARROT ☐ NO / NON ☐ YES / OUI

TIME / HEURE

7. MORPHINE / MORPHINE 220 ☐ NO / NON ☒ YES / OUI

DOSE / DOSE

TIME / HEURE

8. IV / IV

TIME / HEURE

9. TREATMENT / OBSERVATIONS / CURRENT MEDICATION / ALLERGIES / NBC (ANTIDOTE)
TRAITEMENT / OBSERVATIONS / PRESENTE MEDICATION / ALLERGIES / ANTIDOTES

- IV initiated
- 1g Ancef 2135
- Morphine 2205

10. DISPOSITION / DISPOSITION

☐ RETURNED TO DUTY / RETOUR À L'UNITÉ
☐ EVACUATED / EVACUÉ
☐ DECEASED / DÉCÉDÉ

TIME / HEURE

11. PROVIDER / UNIT / OFFICIER MÉDICALE / UNITÉ

DATE/DATE (YYMMDD)

DD Form 1380, DEC 91

This form replaces previous editions of DD Form 1380 and DD Form 1380 (TEST), which are obsolete.

U.S. FIELD MEDICAL CARD
FICHE MÉDICALE DE L'AVANT ÉTATS-UNIS

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF

1	2	3	4	5	6
A	1	1	D	1	▨

2. MTF LOCATION *(State or Country Code.)*

7	8
I	D

3. REGISTER NUMBER (9–15) [redacted]

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

EPW # [redacted]

4. PAY GRADE (16, 17) EPW

5. SEX (18) M

6. DATE OF BIRTH *(Y Y Y Y M M D D)* (19–26)

7. AGE AT ADMISSION

27	28	29
0	2	7

8. RACE (30) Z

9. ETHNIC BACKGROUND (31) Z

RELIGION

10. LENGTH OF SERVICE (32–34)

ETS

11. FMP

35	36
9	9

12. SOCIAL SECURITY NUMBER (37–45) [redacted]

ORGANIZATION *(Active Duty Only)*

13. MARITAL STATUS (46) Z

HOUR OF ADMISSION 2330

BRANCH / CORPS b(6)-4

14. FLYING STATUS (47–49)

15. BENEFICIARY CATEGORY

50	51	52
K	7	8

16. ZIP CODE OF RESIDENCE (53–61)

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

18. MOS (64–70)

19. TRAUMA (71) 9

PREV. ADMISSION YEAR ☒ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION (72) 0

WARD ICU #3

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE unk

ADDRESS OF EMERGENCY ADDRESSEE *(Include ZIP Code)* unk

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE unk

(2)-2 [redacted]

21. TYPE OF DISPOSITION

73	74
5	0

22. MTF TRANSFERRED TO (75–80)

23. DATE OF DISPOSITION *(Y Y M M D D)*

81	82	83	84	85	86
0	3	0	7	1	3

24. CLINIC SVC - ADMITTING

87	88	89	90
A	E	A	A

25. MTF TRANSFERRED FROM (91–96)

26. DATE THIS ADMISSION *(Y Y M M D D)*

97	98	99	100	101	102
0	3	0	7	0	2

27. LOCATION OF OCCURRENCE *(Battle Casualty Only)* (103, 104)

28. MTF OF INITIAL ADMISSION (105–110)

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

FOR LOCAL USE

Dx: GSW to (R) tibia ext fx, GSW to (L) hand

b(6)-2

[redacted]

ADMITTING OFFICER *(Signature, as re*[redacted]

DR-[redacted]

SIGNATURE OF ADMITTING CLERK [redacted]

DA FORM 2985, MAR 89 USAPPCV1.0

MEDCOM - 12906

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF (1–6): A 1 1 B 1
2. MTF LOCATION (State or Country Code.) (7–8): T Z

3. REGISTER NUMBER (9–15): [redacted]

NAME (Last, First, Middle Initial): EPW # [redacted] b(6)-4

4. PAY GRADE (16–17): EPW
5. SEX (18): M

6. DATE OF BIRTH (YYYYMMDD) (19–26):
7. AGE AT ADMISSION (27–29): 0 2 7
8. RACE (30): Z
9. ETHNIC BACKGROUND (31): Z
RELIGION: unk

10. LENGTH OF SERVICE (32–34):
ETS:
11. FMP (35–36): 9 9
12. SOCIAL SECURITY NUMBER (37–45):

ORGANIZATION (Active Duty Only):
13. MARITAL STATUS (46): Z
HOUR OF ADMISSION: 2330
BRANCH / CORPS:

14. FLYING STATUS (47–49):
15. BENEFICIARY CATEGORY (50–52): K 7 8
16. ZIP CODE OF RESIDENCE (53–61):

17. UNIT LOCATION (State or Country Code) (62–63):
18. MOS (64–70):
19. TRAUMA (71): X
PREV. ADMISSION YEAR:
9 NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION (72): 0 b(2)-2
WARD: ICU3
NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: unk
ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): unk
TELEPHONE NUMBER OF EMERGENCY ADDRESSEE: unk

[redacted]

21. TYPE OF DISPOSITION (73–74): 5 0
22. (75–80):
23. DATE OF DISPOSITION (YYMMDD) (81–86): 0 3 0 8 0 6

24. CLINIC SVC - ADMITTING (87–90): A E A A
25. MTF TRANSFERRED FROM (91–96):
26. DATE THIS ADMISSION (YYMMDD) (97–102): 0 3 0 7 1 3

27. LOCATION OF OCCURRENCE (Battle Casualty Only) (103–104):
28. MTF OF INITIAL ADMISSION (105–110):
29. DATE INITIAL ADMISSION (YYMMDD) (111–116):

FOR LOCAL USE

DX: GSW to R tibia exfix, GSW to L hand

Dx: 8912
8822
8913

Px 7916 (X2)
8162

[redacted]

ADMITTING OFFICER (Signature, as required)

DR [redacted]

SIGNATURE OF ADMITTING CLERK

DA FORM 2985, MAR 89

b(6)-2

USAPPCV1.0

MEDCOM - 12907

INPATIENT TREATMENT RECORD COVER SH

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

1 REGISTER NUMBER: 0013740
2. NAME (Last, First, MI): EPW [redacted]
3. GRADE: N/A
ADMISSION REMARKS:
4. SEX: M
5. AGE: 28y
6. RACE: Z
7 RELIGION: unk b(6)-4
8. [redacted] N/A
9. ETS: N/A
10. PREVIOUS ADMISSION: NO
11 FMP: 99
12. SSN: [redacted]
13. ORGANIZATION: N/A
14. WARD: ICU1
15 FLYING STATUS: N/A
16. DSG:
17. BEN: K79 K78
18 BRANCH/CORPS: N/A
19. UIC/ZIP:
20 TYPE CASE: NBi
21 SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: Direct from E.R.
22. HOURS OF ADMISSION: 1950
23. CLINIC SERVICE: AEAA
24 NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: ——
25. TYPE DISPOSITION: 50
26 DATE OF DISPOSITION: 3 Jul 03
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): ——
27b. TELEPHONE NO.: ——
28 DATE OF THIS ADMISSION: 2 Jul 03
ADMITTING OFFICER: b(6)-2 Dr. [redacted]
29 NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted] b(2)-2
30 DATE OF INTIAL ADMISSION:
32. UNITS COMP[redacted] TRANSFUSED
31

☐ Check if Continued on Reverse

33 CAUSE OF INJURY

34 DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Ⓛ clavicle fx

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	2	2

36. Total Days All Facilites

a. ABSENT SICK DAYS	[redacted]	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	[redacted]	0	0	2	2

[redacted] Dr. [redacted]

SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER [redacted]

EDITION OF 1 A

USAPPC V1 10

b(6)-2

MEDCOM - 12908

ACLU-RDI 1592 p.801

2 July 03 S: Tried to rush the gate @ BIAP prison 4 days ago. arrived ~~here~~ @ Abu Ghraib yesterday. Multiple bruises Ⓡ face Ⓡ ribs & Ⓛ shoulder area with obvious clavicle deformity. Had an Xray at BIAP c̄ 581st arrived with only a sling on the Ⓛ arm

O: ecchymosis & abrasions Ⓡ periorbital. ecchymosis & deformity Ⓛ shoulder. [illegible] ecchymosis Ⓡ ant lower ribs.

PERRL
VFROM
intact EOMs
erythema
sclera Ⓡ

A: Ⓡ periorbital contusion/Abrasion.

Ⓛ Clavicle fx clinically ✓

Ⓡ Rib fx clinically ✓

Ⓡ Subchorionic Hemorrhage

P: ① Figure 8 sling placed

② Wounds cleansed

③ Send for evaluation ortho f/clavicle fx.

[redacted]

MAJ MC
BN Surgeon

[redacted]

b(6)-2 AM

NS ASSESSMENT

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
2020	2020 02 JUL 03: Pt received. VSS: 130/75; 16;
02 JUL 03	52; 99% on RA. Has NS @ KVO to (L) FA; ⊖ s/s of infiltration/
	inflammation. Pt is restrained per CSH protocol. [RESP]
	CTA b/lat [CV] S1, S2; HR reg. currently 72; <3sec cap refill.
	[GI/GU] NT/ND; ⊕ BS ⊕ flatus; U/O without difficulty.
	[NM] Clavicle tender; (R) eye has ⊕ echymosis / ~~Skoog~~ drainage
	[Pain] perc. Q6 PRN; meets VS; anticipate transfer to Cu comp in am.
	[redacted] 1LT AN b(6)-2
	McMenamin
	MEDS: Percocet at 2100. ii for pain; instructed patient
	in use of artificial tears; patient demonstrated proper tech
	for medication.
	Intake & outputs
	2100
	U/O - 300
	IV - KVO to (R) FA

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.

EPW [redacted] 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

MEDCOM - 12910

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
0830 July 3, 2003	Pt. tolerated breakfast well. A+OX3. Pt. resting well @ this time. Ø c/o pain. fig. 8 splint still intact. will cont. to monitor —— [redacted] b(6)-2
7/4/03 0900	D/C Summary Pt [illegible] in ER for Ⓛ clavicle fx. Admitted 2° transportation issue - will d/c c̄ 8 of 8 slg + [illegible] [redacted] 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.

EPW [redacted] b(6)-4

ICU#

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 - 12911

558-103 *(See Instructions on Back of this Sheet)* b(6)-2 NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREA[redacted]

LOG NUMBER

ARRIVAL DATE: DAY 02 MONTH 07 YR. 03 TIME 1545	TRANSPORTATION TO HOSPITAL *(Attach care enroute sheet)* ☐ PRIVATE VEHICLE ☐ AMBULANCE ☑ OTHER *(Specify)*	CURRENT MEDS. *(Tetanus immunization and other data)* ∅	HISTORY OBTAINED FROM ☑ PATIENT ☐ OTHER *(Specify)* ALLERGIES NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION *(City, State and ZIP Code)*

HOME TELE. NO. *(Inc. area code)*

CHIEF COMPLAINT(S) *(Include symptom(s), duration)* Clavicle Injury

SEX M AGE 28

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER 16:00

VITAL SIGNS			
TIME	1546		
BP	124/85		
PULSE	97		
RESP.	14		
TEMP.	98.8		
WT. *(Child)*			

CATEGORY *(See reverse)*
- EMERGENT
- URGENT
- ✓ NON-URGENT

ORDERS	INITS.	TIME
X-ray clavicle	[redacted]	
Spec		
CBC PT, [illegible]		
SIV, [illegible] IV		1645

ASSESSMENT/DIAGNOSIS

Ⓛ clavicle Fx

DISPOSITION *(Check all that apply)*

HOME ☐ FULL DUTY

QUARTERS ☐ 24 Hrs. ☐ 48 Hrs. ☐ 72 Hrs.

MODIFIED DUTY UNTIL: DAY MONTH YEAR

REFERRED TO *(Indicate clinic)*

☐ EMERGENCY ☐ TODAY ☐ 72 HOURS ☐ ROUTINE

ADMIT. TO HOSP. UNIT/SERVICE ICU-1

CONDITION UPON RELEASE ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

TIME OF RELEASE: 19:30

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

S: 28 y.o. EPW brought in s/p altercation
at prison c̄ multiple ~~abs~~ abrasions, suspected clavicle &
rl FX, ⊕ conjunctival hemorrhage. Via interpreter, pt
reports pain Ⓛ ~~clavicle~~ clavicle

O: VSS afebrile HEENT ⊕ [illegible] conjunctival hemorrhage, s̄ orbital ecchy.
Gen: thin 28 y.o. ♂ c̄ multiple abrasions, ⊕ mild distress
2° pain from clavicle Fx (pt pointing to clavicle)
Chest: ⊕ edema, ecchymosis over Ⓛ clavicle c̄ marked TTP
CTA Ⓑ RRR
Abd: soft, ND, ⊕ mild epigastric tenderness
Back: ⊕ multiple contusions/abrasions

X-RAY
⊕ Ⓛ clavicle Fx
∅ pneumothorax

A: i) Ⓛ clavicle Fx
ii) multiple contusions

P: i) Percocet 1-2 tabs, q 6° po
ii) Continue Figure 8 splint
iii) will admit 2° transportation issues

(CONTINUE ON SF 507, IF NEEDED)

PATIENT'S IDENTIFICATION *(Mechanical imprint)* FOR WRITTEN ENTRIES GIVE: *Name - last, first, middle; SSN; DOB, service status, name and relation of sponsor or next of kin. (IMPORTANT: LIST FACILITY HOLDING TREATMENT RECORD).*

#[redacted]
b(6)-4

SIGNATURE OF PROVIDER AND ID STAMP [redacted] POWERS MD

INSTR[redacted]ENT *(Include medications ordered, any limitations and follow-up plans)*

b(6)-2

EMERGENCY CARE AND TREATMENT
MEDCOM - 12912 Copy

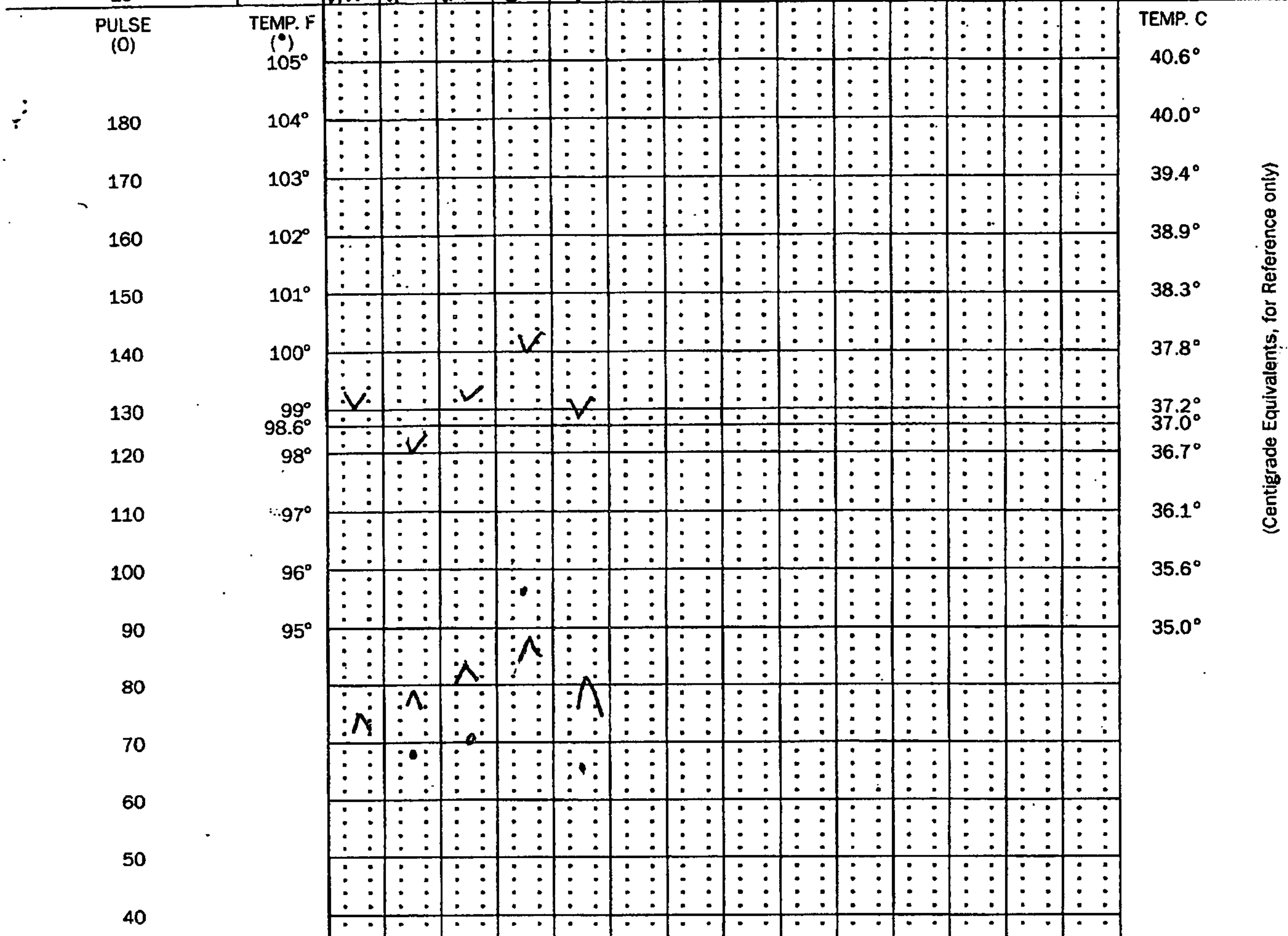
STANDARD FORM 558 (Rev. 8-8?)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

511-119 NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY					
POST- DAY	02Jul03				
MONTH-YEAR / DAY					
19 / HOUR	2000	2030	2100	2200	2400



RESPIRATION RECORD RR	16	16	16	16	16
BLOOD PRESSURE					
	RA	RA	RA	RA	RA
SAO2	100	100	100	98	98
HEIGHT: WEIGHT ⟶					
IVF	125	125	KVO	KVO	
OUTPUT			300	600	400
Percocet			5/1		
Temp					95.9 ax

Record special data only when so ordered

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*

Ern [redacted]

b(6)-4

REGISTER NO.

WARD NO. ICU#1

VITAL SIGNS RECORDS

Medical Record

STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 12913

Ward/Section: EMT	QU TING PHYSICIAN:	C ST. RESULT FORM .1 to th Privacy Act of 1974)

LAST, FIRST, MI: EPW [redacted] b(6)-4	DATE 2 Jul	TIME 1630	SSN/PSEUDO SSN:

(I-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		Negative
Drug of Abuse		Negative
		Negative
		Negative
		Negative

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU	97	73-118 mg/dl
BUN	8	7-22 mg/dl
CRE	0.5	0.6-1.2 mg/dl
CK	3065	39-380 u/l (M) 30-190 u/l (F)
NA^{+}	136	128-145 mmol/l
K^{+}	4.1	3.3-4.7 mmol/l
CL^{-}	108	98-108 mmol/l
tCO_2	22	18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^{+}		128-145 mmol/l
K^{+}		3.3-4.7 mmol/l
CL^{-}		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA^{+}		128-145 mmol/l
K^{+}		3.3-4.7 mmol/l
CL^{-}		98-108 mmol/l
tCO_2		18-33 mmol/l

REMARKS:

REPORTED BY: [redacted]	DATE: 2 Jul	LAB ID NO.:

b(6)-2

MEDCOM - 12914

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

[redacted]

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER

TIME OF ORDER 19:50 HOURS

LIST TIME ORDER NOTED AND SIGN

7/2 Admit to ICU-1

Diagnosis: Ⓛ clavicle Fx

Condition Good

Vitals q shift

Allergies: NKDA

Activity: Bedrest c̄ bathroom priv.

Nursing ① Continue Figure 8 splint

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER

TIME OF ORDER 19:30 HOURS

7/2 Diet: Regular

IV: KVO

Meds: i) 2 tabs Percocet q 6 PRN pain

ii) 2 mg morphine q 2 for breakthrough pain

LABS: NONE

Additional: Please transfer when available bed

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER

TIME OF ORDER ______ HOURS

in ICW

[redacted] MD

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 3 Jly 03

TIME OF ORDER 0900 HOURS

① D/C old ERW convert c̄

Figure of 8 sling ⓁUE

Noted

@0900

[redacted]

b(6)-2

MEDCOM - 12915

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	*Mo.* ____ *Yr.* 2003

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED													
				2	3	4											
7/2/03	[redacted]	VITALS Q SHIFT	05	/	[redacted]												
			17	[redacted]													
7/2/03	[redacted]	ACT: BR c̄ BRP	05	/	[redacted]												
			17	[redacted]													
7/2/03	[redacted]	NSG: CONTINUE FIG 8 SLING	05	/	[redacted]												
			17	[redacted]													
7/2/03	[redacted]	DIET: REG	05	/	[redacted]												
			17	[redacted]													
		b(6)-2															

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS:

Ⓛ CLAVICLE FX

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ________

PATIENT IDENTIFICATION:

[redacted]

b(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78

EDITION OF 1 DEC 77 MAY BE USED.

MEDCOM - 12916

USAPA V1.00

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo ______ *Yr* 2003

Verify by Initialing Order Date	Verify by Initialing Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
7/2	[redacted]	ADMIT TO ICU 1	7/2/03	now	2230	[redacted]
7/2		COND : GOOD	7/2/03	NOW	2230	[redacted]
7/31		D/C EPW comp c̄ figure of 8	31 July 03			
		sling Ⓛ UE				
		D(W)-2 All				

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING COMPLETION* TIME/DATE COMPLETED
7/2/03	[redacted]	Transfer to ICW upon bed availability	

USAPA V1.00

MEDCOM - 12917

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 | *INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION*

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED													
				2	3												
3/2/03	[redacted]	IV: KVO	5	[redacted]													
		— b(6)-2 —	17														

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
(L) clavicle Fx

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

PATIENT IDENTIFICATION:
[redacted]
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 - 12918

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*			Mo.______ Yr.______	
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													
7/2/03	[redacted]	Percocet 2 TABS Q6° PRN PAIN	T1 [illegible] 2400 7-2-03													
7/2/03	[redacted]	MSO4 2mg Q°2 For Break through pain														
		b(6)-2														

USAPA V1.00

MEDCOM - 12919

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0545	IN[redacted] b(6)-2		INITIALS		INITIALS
NEURO	PUPILS	PERRLA					
	SENSORIUM	a+ox3 Pt follows					
		commands well					
RESPIRATORY	RESPIRATORY PATTERN	reg, even, unlabored					
	BREATH SOUNDS	CTA					
	SECRETIONS	0					
SKIN	COLOR	normal for race					
	INTEGRITY						
IV SITE	LOCATION	(R) FA					
	CONDITION	clean dry intact					
GASTRO	ABDOMEN	B, soft, nontender					
	BOWEL SOUNDS	BS x4					
GU	URINE:	cloudy yellow					
	COLOR/CLARITY	Pt. urinating					
		on own					
CARDIOVASCULAR	CARDIAC RHYTHM	normal sinus rhythm					

LEGEND	Cr - Creatinine	ICP - Intracranial Pressure	S/A - Fractional
	F_iO_2 - Fraction of Inspired O_2	PCO_2 - Pressure of Arterial CO_2	SAT - Saturation
	HCO_3 - Bicarbonate	PEEP - Positive End Expiratory Pressure	TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY *(Signature & Title)*
[redacted]

DEPARTMENT/SERVICE/CLINIC
ICU 2 west

DATE

yped or written entries give: Name—last, first, ospital or medical facility)

b(6)2

☐ HISTORY/PHYSICAL
☐ OTHER EXAMINATION OR EVALUATION
☐ DIAGNOSTIC STUDIES
☐ TREATMENT
☐ FLOW CHAR
☐ OTHER *(Spe*

DA FORM 1 MAY 78 4700
Proponent: Dept of Nurs

MEDCOM - 12920

WAMC OP 375 (Redesignated)
1 Apr 90 (HSXC-NU)

PA

DX

HOSPITAL DAY

TIME	24	01	02	03	04	05	06	07	/	08	09	10	11	12	13	14	15
P Arterial Line																	
P Cuff	124/[illegible]						122/82										
emperature							98.6										
ulse							72										
espiratory Rate							16										
pain																	
saturation																	
TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15
PO										300							
OTALS																	
JRINE HOUR / TOTAL							550		550								
JRINE sp gr																	
JRINE S/A																	
NG OUTPUT																	
NG pH																	
NG GUIAC																	
MESIS																	
TOOL																	

MEDCOM - 12921

PA.

ACUITY LEVEL CLASSIFICATION

17	18	19	20	21	22	23	
17	18	19	20	21	22	23	8°T

RESPIRATORY DATA

TIME								
MODE								
F_iO_2								
TV								
RATE								
PEEP								
A B G pH								
A B G PCO_2								
A B G pO_2								
A B G HCO_3								
A B G SAT								
A B G BASE								

LABORATORY DATA

TIME								
GLUCOSE								
Na/K								
Cl/CO_2								
BUN/Cr								
WBC/PLATELET								
Hct/Hgb								

ACTIVITIES OF DAILY LIVING

TIME			
MOUTH CARE			
BATH			
SKIN CARE			
FOLEY CARE			
TRACH CARE			
ROM EXERCISES			

TURN TIME			
SUCTION			

24° I&O TOTALS

wt Yesterday ______ wt Today ______

INTAKE

IV ______

OUTPUT

Urine: ______

NURSE'S SIGNATURE

MEDCOM - 12922

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF

1	2	3	4	5	6
A	1	1	D	1	▨

2. LOCATION *(State or Country Code.)*

7	8
I	Z

3. REGISTER NUMBER

9	10	11	12	13	14	15
[redacted]						

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

EPW [redacted]

4. PAY GRADE

16	17

5. SEX

18
m

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

19	20	21	22	23	24	25	26

7. AGE AT ADMISSION

27	28	29
2	8	y

8. RACE

30
Z

9. ETHNIC BACKGROUND

31
9

RELIGION unk.

10. LENGTH OF SERVICE

32	33	34

ETS N/A

11. FMP

35	36
9	9

12. SOCIAL SECURITY NUMBER

37	38	39	40	41	42	43	44	45
[redacted]								

ORGANIZATION *(Active Duty Only)* N/A

13. MARITAL STATUS

46
u

HOUR OF ADMISSION 1950

BRANCH / CORPS b(6)-4 N/A

14. FLYING STATUS

47	48	49

15. BENEFICIARY CATEGORY

50	51	52
K	7	8

16. ZIP CODE OF RESIDENCE

53	54	55	56	57	58	59	60	61

17. UNIT LOCATION *(State or Country Code)*

62	63

18. MOS

64	65	66	67	68	69	70

19. TRAUMA

71
9

PREV. ADMISSION

YEAR

☒ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION

72
0

WARD ICU1

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE *(Include ZIP Code)*

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted]

21. TYPE OF DISPOSITION b(2)-2

73	74
5	0

22. MTF TRANSFERRED TO

75	76	77	78	79	80

23. DATE OF DISPOSITION *(Y Y M M D D)*

81	82	83	84	85	86
0	3	0	7	0	3

24. CLINIC SVC - ADMITTING

87	88	89	90
A	E	A	A

25. MTF TRANSFERRED FROM

91	92	93	94	95	96

26. DATE THIS ADMISSION *(Y Y M M D D)*

97	98	99	100	101	102
0	3	0	7	0	2

27. LOCATION OF OCCURRENCE *(Battle Casualty Only)*

103	104

28. MTF OF INITIAL ADMISSION

105	106	107	108	109	110

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

111	112	113	114	115	116

FOR LOCAL USE

Dx: (L) clavicle fx

Dx: 81000
9248
9221
9222
92300
92303
92310
92311
E9174

[redacted] b(6)-2

Dr. [redacted]

SIGNATURE OF ADMITTING CLERK

[redacted] PFC, 91G10

DA [redacted]

MEDCOM - 12923

INPATIENT TREATMENT RECORD COVER

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

1. REGISTER NUMBER [redacted]

2. NAME (Last, First, MI) EPW [redacted] b(4)-4

3. GRADE N/A

ADMISSION REMARKS

4. SEX m

5. 21y

6. Z

7. RELIGION N/A

8. LENGTH OF SVC N/A

9. ETS N/A

10. PREVIOUS ADMISSION No

11. FMP ~~20~~ 20 99

12. SSN [redacted]

13. ORGANIZATION N/A

14. WARD ICU3

15. FLYING STATUS N/A

16. RATING/DSG

17. DEPT GEN ~~K79~~ K78

18. BRANCH/CORPS N/A

19. UIC/ZIP

20. TYPE CASE NBI

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct from E.R.

22. HOURS OF ADMISSION 1811

23. CLINIC SERVICE AEAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE —

25. TYPE DISPOSITION 50

26. DATE OF DISPOSITION 3 Jul 03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) —

27b. TELEPHONE NO. —

28. DATE OF THIS ADMISSION 2 Jul 03

ADMITTING OFFICER Dr. [redacted] b(6)-2

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] b(2)-2

30. DATE OF INITIAL ADMISSION

32. UNITS COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Re-eval for cast

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	2	2

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
[redacted]	[redacted]	0	0	2	2

SIGNATURE [redacted]

SIGNATURE OF PAD OR MEDICAL [redacted]

DA FORM [redacted] ITION OF 1 AUG 76 IS OBSOLETE

USAPPC V1.10

b(6)-2

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
3Jul03 c0600	Received pt who is resting quietly. Assessment complete. See unit abbreviated assessment form. Pt awaiting return to camp. Plan: Cont. to monitor for discomfort. Pt denies pain @ present time. — [redacted] RC/AN —
1041	Pt. resting in bed c̄ eyes closed. 0 distress noted. 0 complaint(s) voiced @present time. Wi[redacted] to monitor pt. for s/sx of distress. — [redacted]
1641	EPW transferred back to EPW Camp. Escorted via (MP) Spc. [redacted] — [redacted]
	b(6)-2 AM

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.)*

EPW [redacted]

b(6)-4

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 - 12925

NSN 7540-01-075-3786

MEDICAL RECORD	**EMERGENCY CARE AND TREATMENT** *(Patient)*	LOG NUMBER	TREATMENT FACILITY EMT
		RECORDS MAINTAINED AT	

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS EPW

CITY

STATE

ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)* 2 July 03

TIME 1811

TRANSPORTATION TO FACILITY

SEX M

AGE 21

DUTY/LOCAL PHONE: AREA CODE / NUMBER

HOME PHONE: AREA CODE / NUMBER

MILITARY STATUS

ITEM	YES	NO	N/A
PRP			
FLYING STATUS			

MEDICAL HISTORY OBTAINED FROM

THIRD PARTY INSURANCE

ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2568 IN CHART		

NAME OF INSURANCE COMPANY

CURRENT MEDICATIONS 0

ALLERGIES NKDA

INJURY OR OCCUPATIONAL ILLNESS

ITEM	YES	NO
IS THIS AN INJURY?		
INJURY/SAFETY FORMS		

WHEN *(Date)*

WHERE

HOW

EMERGENCY ROOM VISIT

DATE LAST VISIT

24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT

COMPLETED INTITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT Ⓡ Leg GSW

CATEGORY OF TREATMENT

☐ EMERGENT

☐ URGENT

☒ NON-URGENT

TIME 1811

b(6)-2 IN[redacted]

VITAL SIGNS

TIME	1815				
BP	110/78				
PULSE	93				
RESP	16				
TEMP	99.3				
WT	57Kg				

LAB ORDERS

CBC/DIFF	AB	PT/PTT	BHCG/URINE/BLOOD/QUANT
URINE C&S	UA MSCC/CATH		CHEM:
BLOOD C&S X			

X-RAY ORDERS

CXR PA & LAT/PORTABLE	C-SPINE
ACUTE ABDOMEN	LS SPINE
SINUS	HEAD CT
ANKLE R/L	

ORDERS

☑ PULSE OX 98%

☐ MONITOR

☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE

DISPOSITION

☐ HOME ☐ FULL DUTY

MODIFIED DUTY UNTIL

DISPOSITION QUARTERS /OFF DUTY

☐ 24 HRS. ☐ 48 HRS. ☐ 78 HRS.

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE

☐ IMPROVED ☐ UNCHANGED

☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ TO

WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

PATIENT'S IDENTIFICATION *(For typed or written entries, give: Name -- last, first, middle; ID no. (SSN or other); hospital or medical facility)*

EPW [redacted]

b(6)-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

STANDARD FORM 558 (REV. 9-96)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.203(b)(10)
USAPA V1.00

NSN 7540-01-075-3786

MEDICAL RECORD	**EMERGENCY CARE AND TREATMENT** *(Doctor)*	TIME SEEN BY PROVIDER

TEST RESULTS

CBC	WBC	SMAC	ABG/PULSE OX	RADIOLOGY	Check if read by radiologist ☐
	H/H		SUP 02	PH	PO2
	PLT		PCO2	SAT	OTHER
PT			U/A	DIP	
APTT	BHCG	ETOH	GLU	MICRO	

RESULTS
Ⓡ leg – ⊕ Healing Fx
⊕ [illegible] improved

EKG INTERPRETATION

PROVIDER HISTORY/PHYSICAL
21 y/o ē cast on Ⓡ leg x 48 days because of GSW.
PN - 0/10

EP w/ Pt sent here only for Reevaluation of Bone Healing By X-ray + Removal of 48 day old CAST, Pt ē no other complaint or problems.

G, WD, WN NAD, AAOx3
Ext: good ROM Ankle/toes. ⊕ open wound, Healing well.

Discussed ē [illegible]

Ⓐ/Ⓟ Long leg cast ē window for wound care / RTD

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP
[redacted]

DIAGNOSIS
Ⓡ Tibia Fracture

CODES
b(6)-2

PATIENT'S IDENTIFICATION *(For typed or written entries, give: Name – last, first, middle; ID no. (SSN or other); hospital or medical facility)*
[redacted] b(6)-4

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

STANDARD FORM 558 (REV. 9-96)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.203(b)(10)
USAPA V1.00

b(6)-7

PATIENT AS MENT

TIME: 2015 SIGNATUR [redacted]

SKIN AND MUCOUS

Skin : [✓ Loose] / Tight / Diaphoretic / Shiny / [✓ Dry]
Skin : Temperature warm
Color: Pale / Cyanotic / Jaundiced Normal to Race
Mucous Membranes: [✓ Moist] / Dry / Cracked
Skin Breakdown: [✓ None] Location: Size:

NEUROLOGICAL

Loc / [✓ Alert] / Lethargic / Unresponsive GCS:
[✓ Orientated] / Disoriented Pupils: Perrla
Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): 3 Radials ++ Pedals ++
Capillary Refill: < Seconds 3 Homan's Sign ⊖
Jugular Venous Distension ⊖ Edema ⊖
Heart Sounds $S_1 S_2$ Ø ectopy
Rhythm RRR PRI: — QRS: —

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			▨	▨
Site				
Solution				

Chest Pain Ø

RESPIRATORY

Chest Expansion / [✓ Symmetrical] / Asymmetrical
Respiration / [✓ No Distress] / SOB / Labored / Use of Access Muscles
Breathing Patterns:
Cough: Productive / Nonproductive / [✓ None]
Sputum: Color / Amount / Consistency / Odor
Chest Drainage System Gravity: — Suction cm: —
Air Leak No Yes Crepitus
Character of Drainage:
Trachea [✓ Midline] / Deviated (R) / Deviated (L)
Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth
Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent
Dressings:
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage
NG Drainage: Color Character
Tube Feeding: Day No: Strength: Rate: Aspirate:
Stool: Character
Drains:

GENITOURINARY

Urine Color: yellow Character: clear
Voiding: [✓ Continent] / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

ATIENT ASSESSMENT

TIME: 0600 SIGNATURE [redacted]

SKIN AND MUCOUS MEMBRANES

Skin : Loose / Tight / Diaphoretic / Shiny [✓ Dry] intact
Skin : Temperature warm to touch
Color: Pale / Cyanotic / Jaundiced normal for race
Mucous Membranes [✓ Moist] Dry / Cracked
Skin Breakdown: [✓ None] Location: Size:

NEUROLOGICAL

Loc [✓ Alert] Lethargic / Unresponsive GCS:
[✓ Orientated] / Disoriented Pupils: Reactive
Extremity Movement: [✓ Full] Limited / None x̄ Ⓡ leg w/ cast

CARDIOVASCULAR

Pulse (0 - 4): Radials ++ Pedals ++ x̄ Ⓡ leg. Cas
Capillary Refill: < 3 Seconds Ⓡ toes Homan's Sign Ø
Jugular Venous Distension Ø Edema Ø
Heart Sounds $S_1 S_2$ on monitor
Rhythm Reg. PRI: NL QRS: NL

Vascular Catheter N/A	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			▨	▨
Site	N/A			
Solution				

Chest Pain Ø

RESPIRATORY

Chest Expansion [✓ Symmetrical] / Asymmetrical unlabored
Respiration [✓ No Distress] / SOB / Labored / Use of Access Muscles
Breathing Patterns: even + regular
Cough: Productive / Nonproductive [✓ None]
Sputum: Color / Amount / Consistency / Odor N.NC
Chest Drainage System Gravity: N/A Suction cm:
Air Leak No Yes Crepitus
Character of Drainage:
Trachea [✓ Midline] / Deviated (R) / Deviated (L)
Artificial Airway Size: N/A Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: [✓ Soft] Firm / Hard / Distended cm Girth
Bowel Sounds: [✓ Normal] / Hyperactive / Hypoactive / Absent
Dressings: N/A
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage
NG Drainage: Color N/A Character
Tube Feeding: Day No: Strength: Rate: Aspirate
Stool: Character
Drains:

GENITOURINARY

Urine Color: Character: Has not voided c̄ time of assessment.
Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

Speaks English. Cast to Ⓡ leg intact. Denies any discomfort. Wishes to Sleep.

OTHER:

EPW [redacted] b(6)-4   2 July 03

PT'S NAME:

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	0
BP																113/56							
TEMP																98.6							
HR																61							
RR																18							
SA02																99							
INPUT																							
PO																240							
IV																							
NGT																							
TOTAL																							
OUTPUT																							
URINE																			200				
NGT																							
STOOL																							
AL																							
ICE																							

EAW [redacted] b(6)-4

3 July 03

	05	06	07	08	9	10	11	12	13	14
HR	65	~~60~~ 62 94				88				
RR		18				18				
SA02		99%								
B/p		65/55				112/70				
Temp.		98(A)				97.7				
INPUT										
PO										
IV										
NGT										
AL										
OUTPUT										
URINE						650				
NGT										
STOOL										
TOTAL										
BALANCE										

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

[redacted]

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 2 July 03
TIME OF ORDER: 1940 HOURS

LIST TIME ORDER NOTED AND SIGN

Admit ICU #7 (EPW)
DX: (R) Tibia Fracture - old
Condition: stable
Vitals per routine
All: NKDA
Meds: Ciprofloxacin 500 mg p.o. QD given 2000
Diet: Regular

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER
TIME OF ORDER ______ HOURS

Activity - as tolerated
Plan: RTD to EPW camp in Am
- D/C patient @ 0700 03 July 03.
- Send pt back with his ciprofloxacin

b(6)-2 [redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER
TIME ______ HOURS

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER
TIME OF ORDER ______ HOURS

MEDCOM - 12931

EPW [redacted]

b(6)-4

1. LAST NAME, [redacted] NOM ET PRÉNOM | RANK / GRADE | ☐ MALE / HOMME | ☐ FEMALE / FEMME

[redacted] MATRICULE | SPECIALTY CODE / GPM | RELIGION / RELIGION

2. UNIT / UNITÉ

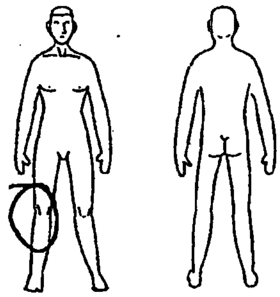
FORCE / ÉLÉMENT: A/T | AF/A | N/M | MC/M

NATIONALITY / NATIONALITÉ

☐ BC / BC ☐ NBI / BNC ☐ DISEASE / MALADIE ☐ PSYCH / PSYCH

3. INJURY / BLESSURE

FRONT / DEVANT — BACK / ARRIÈRE



☐ AIRWAY / TRACHÉE
☐ HEAD / TÊTE
☐ WOUND / BLESSURE
☐ NECK/BACK INJURY / BLESSURE AU COU/AU DOS
☐ BURN / BRÛLURE
☐ AMPUTATION / AMPUTATION
☐ STRESS / TENSION
☒ OTHER (Specify) / AUTRE (Spécifier)

GSW cast more
the 1mon.

4. LEVEL OF CONSCIOUSNESS / NIVEAU DE CONSCIENCE
☐ ALERT / ALERTE ☐ PAIN RESPONSE / RÉPONSE À LA DOULEUR
☐ VERBAL RESPONSE / RÉPONSE VERBALE ☐ UNRESPONSIVE / SANS RÉPONSE

5. PULSE / POULS | TIME / HEURE | 6. TOURNIQUET / GARROT ☐ NO / NON ☐ YES / OUI | TIME / HEURE

7. MORPHINE / MORPHINE ☐ NO / NON ☐ YES / OUI | DOSE / DOSE | TIME / HEURE | 8. IV / IV | TIME / HEURE

9. TREATMENT / OBSERVATIONS / CURRENT MEDICATION / ALLERGIES / NBC (ANTIDOTE)
TRAITEMENT / OBSERVATIONS / PRESENTE MEDICATION / ALLERGIES / ANTIDOTES

10. DISPOSITION / DISPOSITION
☐ RETURNED TO DUTY / RETOUR À L'UNITÉ
☐ EVACUATED / EVACUÉ
☐ DECEASED / DÉCÉDÉ
TIME / HEURE

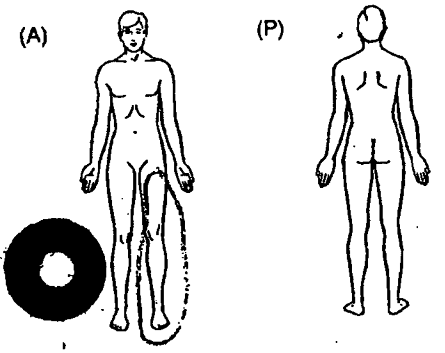
11. PROVIDER / UNIT / OFFICIER MÉDICALE / UNITÉ | DATE/DATE (YYMMDD)

DD Form 1380, DEC 91 — *This form replaces previous editions of DD Form 1380 and DD Form 1380 (TEST), which are obsolete.*

U.S. FIELD MEDICAL CARD
FICHE MÉDICALE DE L'AVANT ÉTATS-UNIS

D[illegible]E/[illegible]ED M171[illegible]01

Mass Casualty Incident Tag
©Eastern PA EMS Council - 1997



TIME	1546
AGE	SEX
LUNGS	
PULSE	82
RESP.	
B.P.	129/73

A | V | P | U

Patient Name (if known) 1 7316

Notes/Treatment Reeval for cast x 48days
X-ray to check healing of bone
Small amount of Callus-Healing
Slowly.

MEDCOM - 12932

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF						2. LOCATION (State or Country Code.)	
1	2	3	4	5	6	7	8
A	1	1	D	1	▨	I	Z

3. REGISTER NUMBER (9–15): [redacted]

NAME (Last, First, Middle Initial): EPW [redacted] b(6)-4

4. PAY GRADE (16–17): .

5. SEX (18): M

6. DATE OF BIRTH (YYYYMMDD)								7. AGE AT ADMISSION			8. RACE	9. ETHNIC BACKGROUND
19	20	21	22	23	24	25	26	27	28	29	30	31
1	9	8	2	0	1	0	1	2	1	y	Z	9

RELIGION: N/A

10. LENGTH OF SERVICE (32–34):

ETS: unk

11. FMP (35–36): 9 9

12. SOCIAL SECURITY NUMBER (37–45): [redacted]

ORGANIZATION (Active Duty Only): Unk

13. MARITAL STATUS (46): u

HOUR OF ADMISSION: 1811

BRANCH / CORPS: N/A b(6)-4

14. FLYING STATUS (47–49):

15. BENEFICIARY CATEGORY (50–52): K 7 8

16. ZIP CODE OF RESIDENCE (53–61):

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

18. MOS (64–70):

19. TRAUMA (71):

PREV. ADMISSION YEAR: ☒ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION (72): 0

WARD: ICU3

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE.

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] b(2)-2

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION (73–74): 5 0

22. MTF TRANSFERRED TO (75–80):

23. DATE OF DISPOSITION (YYMMDD)					
81	82	83	84	85	86
0	3	0	7	0	3

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

25. MTF TRANSFERRED FROM (91–96):

26. DATE THIS ADMISSION (YYMMDD)					
97	98	99	100	101	102
0	3	0	7	0	2

27. LOCATION OF OCCURRENCE (Battle Casualty Only) (103–104):

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

29. DATE INITIAL ADMISSION (YYMMDD) (111–116):

FOR LOCAL USE

Dx: Re-eval for cast

V54.89
Dx: 823.80

V54.16

V53.7

ADMITTING OFFICER (Sig [redacted] b(6)-2
MAJ Hilliard

SIGNATURE OF ADMITTING CLERK
[redacted] PFC, 91W10

DA FORM 2985, MAR 90

MEDCOM - 12933

INPATIENT TREATMENT RECORD COVER SHEET

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

1. [redacted]
2. NAME (Last, First, MI) EPW [redacted] b(6)-4
3. GRADE N/A

ADMISSION REMARKS

4. SEX M
5. AGE 30y
6. RACE Z
7. RELIGION unk
8. [redacted] N/A
9. ETS N/A
10. PREVIOUS ADMISSION No
11. FMP 99
12. SSN [redacted]
13. ORGANIZATION N/A
14. WARD ICU2
15. FLYING STATUS N/A
16. RATING/DSG
17. DEPT/BEN K78
18. BRANCH/CORPS N/A
19. UIC/ZIP
20. TYPE CASE WIA
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct from ER
22. HOURS OF ADMISSION 0915
23. CLINIC SERVICE ABAA
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
25. TYPE DISPOSITION 50
26. DATE OF DISPOSITION 6 Jul 03
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
27b. TELEPHONE NO.
28. DATE OF THIS ADMISSION 3 Jul 03

ADMITTING OFFICER b(6)-2 Dr. [redacted]

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] b(2)-2
30. DATE OF INITIAL ADMISSION
32. UNITS OF [redacted] COMPONENT TRANSFUSED
31. SE[redacted]

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

GSW Chest s/p

875.0

E991.2

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	4	4

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0 b(6)-2	0	4	4

SIGNATURE OF ATTENDING MEDICAL OFFICER [redacted] Dr. [redacted]

SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER For [redacted]

DA FORM 3647, MAY 79

MEDCOM - 12934

USAPPC V1.10

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

PERTINENT HISTORY, CHIEF COMPLAINT, AND CONDITION ON ADMISSION *(Enter date of admission)*

30 yo Iraqi male standing in field when firefight between Iraqi civ and US soldier broke out. Wt in chest by errant fire

NKDA PMH PSH meds
0 0 0

PHYSICAL EXAMINATION

VS 84 131/61 96

NCAT
Neck clr clinically
chest (R) post lat mid chest penetrating wnd with surrounding crepts

Abd
Rigid ⊕ Guarding
TTP in epigastrium ? (R)UQ
Gu wnl
rectal nl tone Heme ⊖
ext ⊖ cce 2+PD.

CXR - Hemo pneumo thorax Fragment medi[illegible]

PROGRESS *(Enter date of discharge and final diagnosis)*

A/P GSW to chest lat below the nipple line with Abd tenderness.
WF
to OR for ex LAP R/O intraperitoneal injury.

[redacted] b(6)-2

S	DATE 3Jul03	IDENTIFICATION NO.	ORGANIZATION
PATI ...itten entries give Name last, first, middle; grade; date; hospital or medical facility)		REGISTER NO.	WARD NO.

#[redacted]

b(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
USAPPC V1.00

MEDCOM - 12935

MEDICAL RECORD | **PROGRESS NOTES**

DATE	
1017 4 JUN 03	pt ↑ out of bed X4 hours attempted cough and deep breaths pt noncompliant in regard to coughing suctioned X3 small amount of yellow to brown - explained rationale for need for cough deep breath and use of IS will attempt q1° if ∅ results will suction again in 4 hours MSO_4 4mg last dose @ 0900 hr improvement noted in pt temp ↓ from TMAX of 100.5 °F oral to present temp of 98.3 °F oral @ present pt resting in bed FM @ 4L sats 94-96% range attempted NC but sats of pt in 80s sats ↑ adequately and general appearance ē good cap refill ē FM @ present
	b(6)-2 [redacted]
1607 4 JUN 03	pt ↑ OOB to chair aggressive pulmonary toilet care given ē IS and cough deep breathing FM 4L sats between 95-97% while ↑ requires 4L while in bed resting able to maintain sats ē 2L but unable to use NC for the
	b(6)-7 [redacted]
1700	Assumed care of dayshift report given. Alert, verbal. PERRL @ 2mm. Nasal airway Ⓛ nare. O2 @ 2L/Min per face Mask. Skin color appropriate for race. Ⓛ AC LR @ 100cc/hr s̄ S/S of infection or infiltration. Ⓡ AC HL s̄ S/S of infection or infiltration. Flushes well. Lung sounds ronchi noted bil. ⊖ BS noted in all 4 quads. ABD DSG Mod amt light drainage noted

(Continue on reverse side)

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

[redacted]

b(6)-4

REGISTER NO. | WARD NO.

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

b(6)2 All

PROGRESS NOTES

DATE

On DSG. ABD soft nondistended. Chest tube DSG ⓒ
Small amt dried bloody drainage noted on DSG. Chest
tube to 20cm H2O suction. IS used approx
@10 X'S. Pedal pulses present bil. Radial pulses
present bil. Foley clear amber urine noted to
bedside foley bag. Will Monitor Sgt [redacted]

1815 C/o pain @ ABD. MSO4 5mg given IV for pain Will
Monitor — Sgt [redacted]

1925 T 100.5 A Tylenol 650mg po given. Will
Monitor — Sgt [redacted]

2025 T 100.5 A Will cont to Monitor. I/S used
approx 15 X'S Will Monitor — Sgt [redacted]

2125 MSO4 1mg given for Midline pain. Will Monitor [redacted]

2135 Suction pt after pt coughed up sputum. Small
amt blood tinged sputum noted. Will Monitor
IS used approx @5 X'S. — Sgt [redacted]

2000 Late entry pt pulled out Nasal airway [redacted]

2140 RT (SGT [redacted] Δ'd Face Mask to NC. O2 @ 3L/Min
per NC. SPO2 @ 96%. Will Monitor. Sgt [redacted]

0042 C/o pain on Midline. Give MSO4 1mg IV [redacted]
Will Monitor — Sgt [redacted]

0112 SPO2 ↓ 88%. NC taken off. Reapplied Face mask
SPO2 ↑ 95%. Will Monitor. Pt resting in bed. No
c/o pain @ present time — Sgt [redacted]

0500 Resting in bed @ present time — Sgt [redacted]

[redacted]

b(6)-4

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
1800 5Jul03	episode of desat due to poor pain management and assessment & NSO3 given and assessed using 1-10 point scale hourly and prior to assess need for pain management med. — 1-10 in English 1-10 in Arabic ? question and point method @ 1500 assessed of ? HR facial expression otherwise pt expresses 10 out of 10 signed out med reassessed by Charge Nurse in conference reassessment before giving and pt said ? pain @ present held did not give — @ 1800 reassessed pain ? chart ? pain expressed no pain medication given.
1800 5Jul03	attempted to suction as ordered pt batt [redacted] declined to allow to suction. b(a)-2
5July03 1700	Assumed care of pt ? dayshift report given. Alert, verbal. PERRL @ 3mm. O2 @ 4L/per face mask. Skin warm & dry to touch. Color: Appropriate for race. Ⓛ AC IV s̄ S/S of infection or infiltration noted. LR @ 100cc/hr via Ⓛ IV. Ⓡ AC ~~HL~~ s̄ S/S of infection or infiltration noted Ⓡ AC Flushes well. Lung sounds rhonchi noted bil. even rise & fall bil chest. Midline ABD incision c̄ staples open to air. No active bleeding noted or drainage noted. ABD: BS noted in all 4 quads. Pedal pulses present

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.

[redacted]

b(a)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

D(u)-2A11

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
5 July 03 (Cont) 1700	Bil. Radial pulses present bil. Ⓡ inner heel area old blister area noted healing. Bottom of feet Ⓡ several scab areas noted. Ⓛ Bottom of foot 1 scab area noted. Ⓡ lateral chest area 10x8cm CDI. IS used several x5. Will Monitor ——— Sgt [redacted]
5 Jun 03 2012	~~Attemp~~ NT suction tried on pt pt not cooperate NT suction Not Done Pt was able to cough some secretions ups. Pt placed back on 4 LPM SpO2 93% ——— SGT [redacted] LT
2030	↓ O2 2L per face mask SPO2 @ 96% Will Monitor ——— Sgt [redacted]
2113	SPO2 @ 96% Will Monitor. Pt resting in bed @ this time ——— Sgt [redacted]
2400	Pt not suction. Pt don't want suctioned. Pt coughing up sputum @ x5. Will cont to monitor Sgt [redacted]
0200	Pt void [redacted] 200cc dark amber urine. Will Monitor ——— Sgt [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK
USAPA V1.00

[redacted] b(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
384			

b(6)-2 Art

DATE	NOTES
6 July 03	Assumed care of pt ō dayshift report given by Sgt
1700	[redacted] Alert, verbal. PERRL @ 2 mm. Lung sounds
	ronchi noted bil. Ⓡ lateral chest area DSG C/D/I. BS ⊕
	in all 4 quads. ABD incision c̄ staples C/D/I & open
	to air. No drainage or active bleeding noted. No S/S of
	infection noted. Pedal pulses present bil. Radial
	pulses present bil. Ⓡ foot (bottom of foot) scab areas
	noted. No active bleeding or drainage noted. Open to
	air. Will monitor pt. — Sgt [redacted]
	LR @ 100cc/hr via Ⓡ AC IV. No S/S of infection or
	infiltration noted. Will monitor — Sgt [redacted]
1910	Pt has coughed up sputum several times — Sgt [redacted]
2000	Pt has coughed c̄ sputum several times — Sgt [redacted]
0000	Pt has productive c̄ sputum several times Sgt [redacted]
7 Jul 03.	pt alert oriented 3mm PERRLA — CV SR RR — rhonchi bilaterally
0622	deep breathing done c̄ productive cough brown to yellowish in color
	c/o taking small amount of food w/ [illegible] of stool —
	pt voids in urinal c̄ [illegible] problem. (R) IV infiltrated
	D/C'd started (L) anterior forearm. 18G [illegible] [illegible] infusing
	100cc/° LR. [redacted]
1700	Assumed care of pt ō dayshift report given by Sgt
	[redacted] — Sgt [redacted]
1755	Alert, verbal, oriented x3. PERRL @ 2 mm. Lung sounds
7 July 03	clear bil. BS present in all 4 quads. ABD incision
	c̄ staples C/D/I. No drainage or active bleeding noted.
	Ⓡ lat. chest DSG C/D/I. Pedal pulse present bil.
	Radial pulses present bil. LR @ 100cc/hr via Ⓛ FA IV

STANDARD FORM 509 (REV. 5/1999) BACK
USAPA V1.00

[redacted]

b(6)-4

MEDCOM - 12940

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
0700 6 JUL 03	Neuro: alert and oriented MAE sensation throughout
	CV: SR s̄ ectopy bilateral BV ALG x L.
	RR: Rhonchus in upper lobes diminished in bases - improvement
	on respiratory depth - symmetrically rhythmic bilateral
	even regular good productive cough c̄ brown to yellow sputum
	GI: tolerated clear liquids advance to regular for
	breakfast hypoactive BS x4 quadrants
	GU: voiding spontaneously in urinal dark yellow/clear
	Skin: midline staples on abd - Drg over old CT site clean
	dry and intact. - Cleaned genital area care area
	feet unable to remove fragments from feet [redacted]
0900 6 JUL 03	pt ↑ ambulated c̄ assist sats O2 on RA 92-94%
	cough deep breathing c̄ productive cough [redacted]
1200 6 JUL 03	pt ↑ ambulatory tolerated well. Continued [redacted] deep breathing
	and pt has productive cough coughing up yellow to brown
	secretions [redacted]
1400 6 JUL 03	able to wean off O2 to room air - enough to [illegible] and
	[illegible] of [illegible] pt resting comfortably in bed @
	present [redacted]
1600 6 JUL 03	pt FS ambulation scheduled 6x a day and productive cough
	lungs still Rhonchus but soft ↑ O2 sats 98% RA [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME LAST	FIRST	SPONSOR'S ID NUMBER (SSN or Other)
		[redacted]	b(6)-2 A1

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.

[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
1755 (cont)	Ⓛ FA (inner) IV s̄ S/S of infection or infiltration noted.
7 July 03	Will monitor. ——— Sgt [redacted]
1830	Pt voided 300cc clear yellow urine — Sgt [redacted]
2150	C/o pain in ABD pain! Give ii percocet po. Will
	Monitor ——— Sgt [redacted]
2300	Resting in bed @ present time. Will Monitor S [redacted]
	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. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

AUTHORIZED FOR LOCA

DICAL RECORD | **PROGRESS NOTES**

DATE | NOTES

Brief op note

Indication - Acute Abdomen with GSW to chest
below nipples

Procedure - exploratory laparotomy

Surgeon [redacted]

Anesth: GETA

Fluid: 300 LR 600 Hespan

UO

EBL min

Findings Negative ex LAP. No Liver ? Diaphragm

comp None

to ICU good condition

[redacted]

b(6)-2

INSHIP TO SPONSOR

SPONSOR'S NAME

LAST

FIRST

MI

SPONSOR'S I (SSN or Other)

/SERVICE

HOSPITAL OR MEDICAL FACILITY

RECORDS MAINTAINED AT

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

REGISTER NO.

WARD NC

[redacted]

b(6)-4

PROGRESS NOTES
Medical Record
STANDARD FORM 50

NSN 7540-01-075-3786

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT
(Patient)

LOG NUMBER

TREATMENT FACILITY

RECORDS MAINTAINED AT [redacted] b(2)-2

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY

STATE

ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)* 3 July 03

TIME 0615

TRANSPORTATION TO FACILITY medevac

SEX M

AGE 30

DUTY/LOCAL PHONE: AREA CODE / NUMBER

HOME PHONE: AREA CODE / NUMBER

MILITARY STATUS ITEM	YES	NO	N/A
PRP			
FLYING STATUS			

MEDICAL HISTORY OBTAINED FROM

THIRD PARTY INSURANCE ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2568 IN CHART		

NAME OF INSURANCE COMPANY

CURRENT MEDICATIONS Ø

ALLERGIES NKDA

INJURY OR OCCUPATIONAL ILLNESS

ITEM	YES	NO	WHEN *(Date)*
IS THIS AN INJURY?			WHERE
INJURY/SAFETY FORMS			

HOW

EMERGENCY ROOM VISIT

DATE LAST VISIT

24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT

COMPLETED INTITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT GSW

ø surgeries
ø med hx

CATEGORY OF TREATMENT

☒ EMERGENT

☐ URGENT

☐ NON-URGENT

TIME 06 23

INITIALS b(u) [redacted]

VITAL SIGNS

TIME	0623	0698	0715	0740
BP	137/76	131/64	137/70	131/61
PULSE	104	81 SR	85 SR	85 SR
RESP	25	18	18	14
TEMP	99.5			
WT		100% NRB	100% NRB	100% NRB

LAB ORDERS

X [redacted] ~~C/DIFF~~	ABG	X [redacted] PTT		BHCG/URINE/BLOOD/QUANT
URINE C&S	UA MSCC/~~CATH~~			CHEM: Mcl B/Chem 12
BLOOD C&S X				

X-RAY ORDERS

✓	CXR PA & LAT/PORTABLE	C-SPINE
	ACUTE ABDOMEN	LS SPINE
	SINUS	HEAD CT
	ANKLE R/L	

ORDERS

☒ PULSE OX 100%

☐ MONITOR

☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
0630	10 mg morphine	[redacted]	[redacted]	0630	
0680	chest x-ray			0680	
0710	5mg MSO4				
0710	50mg Pentothal				

DISPOSITION

☐ HOME ☐ FULL DUTY

MODIFIED DUTY UNTIL

DISPOSITION QUARTERS /OFF DUTY

☐ 24 HRS. ☐ 48 HRS. ☐ 78 HRS.

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

0724 100mg - Pentothal
0730 100mg - Pentothal
0740 50mg Pentothal

CONDITION UPON RELEASE

☐ IMPROVED ☐ UNCHANGED

☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ TO

WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

PATIENT'S IDENTIFICATION *(For typed or written entries, give: Name -- last, first, middle; ID no. (SSN or other); hospital or medical facility)*

EPW

[redacted]

b(a)-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

STANDARD FORM 558 (REV. 9-96)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.203(b)(10)
USAPA V1.00

NSN 7540-01-075-3786

MEDICAL RECORD	**EMERGENCY CARE AND TREATMENT** *(Doctor)*	TIME SEEN BY PROVIDER

TEST RESULTS

CBC	WBC	SMAC		ABG/PULSE OX			RADIOLOGY / Check if read by radiologist ☐
	H/H			SUP 02	PH	P02	RESULTS
	PLT			PCO2	SAT	OTHER	
PT				U/A	DIP		EKG INTERPRETATION
APTT		BHCG	ETOH	GLU	MICRO		

PROVIDER HISTORY/PHYSICAL

0635 - Foley 16 FR to gravity J output 300cc yellow urine. [redacted]
In field - two large bore IV's infusing NS c̄ difficulty. 1gr Ancef given IV 10mg MSO4 IM. chest valve in place. Pt on arrival A+O. c/o pain to upper rt chest [redacted] midaxillary. NSR per monitor. Lungs CTA Ⓑ. Good color.
0725 - Chest tube placed under conscious sedation - Tolerated well. VSS during & p̄ procedure. 142/49, 88 SR, 14, 100%. MRB

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP

DIAGNOSIS

CODES

PATIENT'S IDENTIFICATION *(For typed or written entries, give: Name – last, first, middle; ID no. (SSN or other); hospital or medical facility)*

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

STANDARD FORM 558 (REV. 9-96)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.203(b)(10)
USAPA V1.00

MEDCOM - 12945

MEDICAL RECORD

PREOPERATIVE/POSTOPER...VE NURSING DOCUMENT

FOR Use of this form, see AR 40-407; the proponent agency is The Office of the Surgeon General.

1. AGE:

HEIGHT:

WEIGHT:

2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication)
☑ NKDA ☐ PCN ☐ LATEX ☐ IODINE ☐ TAPE ☐ FOOD
REACTION:

3. PREVIOUS SURGERY [ ] NO [ ] YES (type):

4. PROPOSED SURGICAL PROCEDURE:

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition______
Tobacco____ppd X___yrs. Body Piercing______ Diabetes (Y) (N) ROM______ ASA/Motrin w/72 hrs (Y) (N)
ETOH______ Implants______ Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS:

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ____Potential for anxiety related to: ____1) Surgical Procedure & Operating Room Environment ____2) Separation Anxiety (Child) ____3) Surgical Outcomes	o Pt. verbalizes any specific anxiety. o Pt. Exhibits relaxed body posture. Emergency	c Allow pt. to verbalize freely. c Explain OR environment and answer questions regarding surgery. c Offer comfort measures. (e.g., warm blanket, touch). c Explain all nursing procedures before they are done. c Remain with pt. whenever possible. c Maintain family interface. Parents to stay with pt.
B. AERATION ____Potential for respiratory dysfunction due to: ____1) Positioning ____2) Effects of Anesthesia ____3) Medical/Smoking History	o Pt. will be able to breathe without difficulty during immediate intraoperative phase.	c Offer to elevate head of litter or offer pillow. c Observe pt. while awaiting surgery for signs of distress. c Assist anesthesia during intubation and extubation.
C. INTEGUMENT ____Potential impairment of skin integrity due to: ____1) Intraoperative Immobility ____2) ESU Pad Placement ____3) Positional Aids ____4) Prosthesis ____5) Pooling of Prep Solutions	o Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened areas).	c Utilize pressure preventing devices on OR table and accessories. o Check for proper positioning and support to maintain good body alignment. o Pad pressure points. o Place ESU ground pad on non compromised skin surface area. o Keep prep fluids from pooling.

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

Bpw # [redacted]

VERIFICATIONS AT HOLDING AREA:
! ID/Allergy Band ! Dentures Removed
! H & P ! Contacts Removed
! NPO Since____ ! Jewelry Removed
! UHCG/LMP ! Body Pierce Removed
! Consent/Blood Transfusion Signed/Witnessed/Dated
! Surgical Site/Consent verified by Pt/Anesthesia/Surgeon
! Contact Precautions (Y) (N)
! Family/Friend:______

DA FORM 5179, JUN 91 Previous editions are obsolete. USAPA V1.0
MEDCOM - 12946

6. PATIENT PROBLEMS AND NEEDS	PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ______Potential for inadequate tissue perfusion due to: ______1) Intraoperative Mobility ______2) Positioning ______3) Existing Disease ______4) Safety Devices ______5) Hypothermia	o Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse.	o Check for support stockings or ace wraps. If none, check with doctors. o Check that safety straps are correctly applied. o Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. o. Check that rings and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL E.1.______Potential impairment of mobility due to: ______1) Pain ______2) Intraoperative Hazards ______3) Prosthesis ______4) Positioning ______5) Transfer pt. to/from OR table E.2.______Potential discomfort due to: ______1) Length of Surgery ______2) Positioning ______3) Arthritis	o Pt. will be transferred to OR table without difficulty. o Pt. will not experience unnecessary physical discomfort. Emergency	o Have sufficient people available for transfer. o Insure proper body alignment. o Allow patient to lie in position of comfort while waiting for surgery. o Offer support (i.e.: pillows, bath towels, etc.) for positioning.
F. SPECIAL SENSES F.1.______Diminished visual perception due to being: ______1) Pre-Medicated ______2) W/O Glasses F.2.______Potential for decreased communication due to: ______1) Diminished Hearing ______2) Language Barrier F.3.______Potential injury due to dentures: ______1) Upper ______4) Caps ______2) Lower ______5) Crowns ______3) Bridges	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR table. o Pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt. from ______ side. o Validate pt.'s understanding of verbal communication. o Verify removal of dentures.
G OTHER PATIENT PROBLEMS/NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

10. OR NU[redacted]OMPLETE D/ADDITIONAL INTRAOPERATIVE INTERVENTION S NOTED.

[redacted] 3 July 03 DATE

11. POSTOPERATIVE EVALUATION: SKIN INTEGRITY: Bovie Pad Site: ☐ Clean and Dry ☐ Red ☐ N/A DRESSING DRY & INTACT: (Y) (N)

LEVEL OF CONSCIOUSNESS: ☐ A&O ☐ Drowsy ☐ Sleepy ☐ Intubated BREATHING EASY: (Y) (N)

LEVEL OF ACTIVITY: ☐ Moves All Extremities ☐ Moves Upper Extremities ☐ Transferred to litter with roller due to spinal

12. PREOPERA[redacted]PREPARED BY (Signature and Tit[redacted]

DATE: 3 July 03 TIME: 0800

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title)

DATE: TIME:

REVERSE OF FORM 5179, JUN 91 MEDCOM - 12947 USAPA V1.0

MEDICAL RECORD | **INTRAOPERA DOCUMENT** b(6)-2

For use of this form, see AR 40-66, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: Litter b(6)-2 BY [redacted] Staff

2. PATIE [redacted] ROCEDURE VERIFIED BY

3. DATE: 3 July 03 TIME PATIENT ARRIVED IN SUITE: EMT → OR

4. PATIENT IN ROOM TIME: 0803 NUMBER: 1-1/1

5. PREOPERATIVE EMOTIONAL STATUS

☐ CALM ☑ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS: NKDA

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted] (91D) b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] (66E)	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

☑ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

COMMENTS: Bil arm to Padded Armboard <90°. Body alignment maintained.

8. SKIN PREPARATION

HAIR REMOVAL: ☑ YES ☐ NO

DONE BY: ☑ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☑ RAZOR ☐ CLIP

COMMENTS: Ø

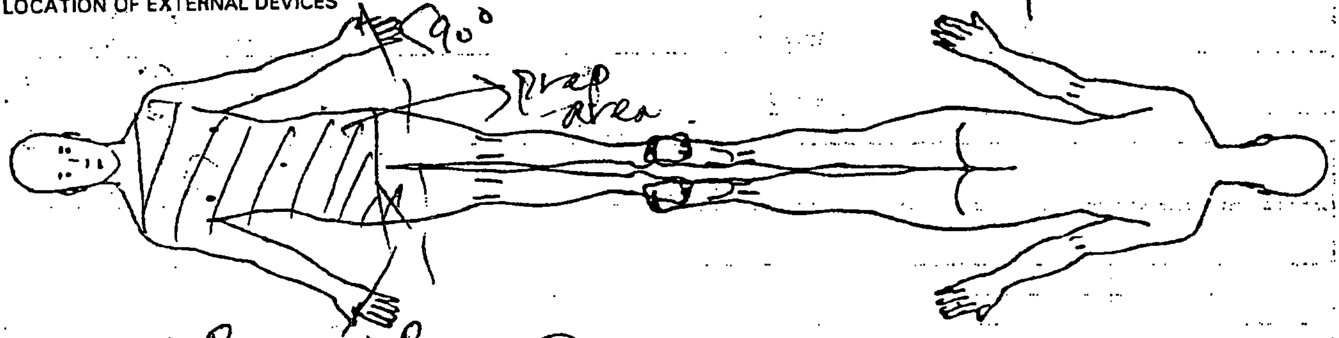
PREP SOLUTION *(Specify)*: Betadine s/sol

SITE: Abd → BY WHOM: CPT [redacted]

SITE: Chest → BY WHOM:

COMMENTS: Ø pooling of sol b(6)-2

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Strap == X Tourniquet

10. COUNTS

C = Correct I = Incorrect

			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☑ Yes	☐ No	C	C	C	PFC [redacted]	CPT [redacted]
Needle Sharp	☑ Yes	☐ No					
Instrument	☑ Yes	☐ No					
Other	☐ Yes	☐ No					

b(6)-2

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

EPW [redacted]

b(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☑ YES ☐ NO

☑ ESU NO: Valley Lab

GROUND PAD: BRAND Valleylab

LOT NO: 65706

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO: Coag: 30 Cut 30

MEDCOM - 12948

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.01

13. PROSTHESIS, IMPLANTS ☐ YES ☑ NO IF YES NAME: ID NUMBER; MANUFACTURER

14: MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☑

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S):

0.9% Nacl

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM IF YES, SITE

YES ☐ NO ☑

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☑	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☑	NAME	NAME
CULTURE (C) YES ☐ NO ☑	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☐ NO ☑

TYPE/SIZE	1.	2.	3.
SITE	1.	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

4X8

Tape

19. ADDITIONAL INFORMATION

b(6)-2

Surgeon: Dr [redacted]

Anes: CPT. [redacted] (CRNA)

20. OPERATION(S) PERFORMED

Ex Lap c Dressing chest tube.

21. PATIENT TRANSFERRED TO ICU TIME See Anes Record METHOD Litter c O2

22. R[redacted] CPT/AN

REVERSE OF DA FORM 5179-1, OCT 1

b(6)-2

MEDCOM - 12949 USAPA V1.01

Dx 30 y/o GSW ~ Chest

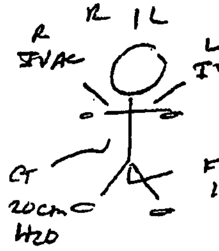
70 kg estimated wt.

1700 (Neuro) Alert/oriented — Said he'd some MSO4 20 mg this shift
- Toradol order but not available
- Added — Percocet PO

(CV) - SR - ST c̄ ectopy/ PVC b. AC LR@100cc/° TMAX 100⁵

Date 4 JUL 03 b(3)-1 Bed # 8

Patient's Name: F [redacted]



LABS

(Piccolo) Metlyte 8

Glucose 113 mg/dl

BUN 8

Cre 0.6

CK 254 U/L

Na 131 mmol/L

K 4.2 mmol/L

Cl 99 mmol/L

tCO2 24 mmol/L

Hematology

WBC 9.1 (x10³)

RBC 4.51 (x10⁹)

Hgb 12.4

Hct 39.7 %

MCV 88

Plt 187 (x10³)

Lymph 11.4 %

Time	05	06	07	08	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
(RR) (CT) ↑CX	2°																							
(GI) BP	150/77	129/77	132/81	122/91	125/71	124/68	134/94	128/73	130/96	131/73	119/72	127/75	118/68	133/76	126/69	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
(GU) TEMP.		100° Ax		100⁵		98²	Ax				99³		99²	100⁴	100⁵	100⁴	100⁴	100⁹	100³	100⁷	100⁹	100³	99⁴	99³
HR	88	99	119	123	110	99	93	89	88	128	110	103	96	105	96	115	103	101	91	93	104	99	96	87
RR	18	22	35	36	24	19	19	20	22	44	25	25	18	20	26	24	25	38	23	19	20	26	21	25
SAO2	98	94	92		96	94	97	96	96	93	95	96	96	94	95	96	96	97	95	95	95	94	92	94
FIO2	4L	4L	10L	10L	12L	8L 4L	2L	2L	2L	4L	4L	4L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L
Source	FM	FM	NRM	NRM	FM	FM	FM	FM	FM	FM	FM	FM	FM	FM	FM	FM	FM	NC	NC	NC	FM	FM	FM	FM
↑ Chair (C)			(↑C)	(↑C)	(↑C)	(↑C)	Bed	Bed	Bed	(↑C)	(↑C)	(↑C)	Bed	Bed										
INPUT																								
PO	NPO												NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO
IV (LR)	150	150	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
NGT																								
MSO4	0530 3mg				4mg		2mg (pt stated)			6mg		5mg												
TURN Q 2			(↑C)	(↑C)	(↑C)	(↑C)	Bd	—	—	(↑C)	—	(↑C)	Bed											
Total MSO4/shift		—	—	—	7	—	9	—	—	15	—	20	20	5mg										
TOTAL	150	300	400	500	600	700	800	900	1000	1,100	1200	1,300	1,420											2520
OUTPUT																								
URINE	100	100	100	50	62	62	50	60	60	60	50	50	50	~~500~~ 50	50	55	50	150	50	50		185	55	75
NGT																								
STOOL																								
TOTAL	100	200	300	350	412	474	524	584	644	704	754	804	854											1554
BALANCE							+276																	
CT / 1°	0	7	7	7	7	7	10	—	—	10	—	—	10	0	2	0	0	0	0	0	0	0	0	2
Total in bottle	655	Average 50 →				690	700	→		710	→		720											
Total shift CT	→												65cc											
Initials	[redacted]																							

MEDCOM - 12950

Tmax 101.1 F ax

Patient's Name: [redacted]

Time	05	06	07	08	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
BP	123/96	121/71	127/69	128/70	133/81	134/97	147/84	135/81	150/98	119/58	119/63	91/65	126/61	103/61	100/54	119/51	105/68	123/66	105/65	117/67	106/68	114/60	119/65	118/61
TEMP	98.4				99.3	99.5					101.5 F				98.8A		97.9A	97.3A	97.9A	97.9A		98.7A		
HR	86	82	76	80	92	98	110	112	100	98	98	93	104	75	89	73	80	85	79	75	82	80	75	104
RR	14	15	18	29	24	31	28	26	24	22	18	10	16	23	21	14	24	23	15	15	12	20	14	23
SAO2	93	96	95	93	93	93	94	96	85	98	97	95	92	94	92	96	95	96	95	98	94	96	100	93
FIO2	FM2	FM2	2L	2L ↑10		10L	10L	10L 16		15L	10	6	4L	4L	4L	4L	2L	2L	2L	2L	2L	2L	2L	2L
Method	FM	FM	FM	FM	FM	FM	FM	FM	NRM	NRM	FM	FM	FM	FM	FM	FM	FM	FM	FM	FM	FM	FM	FM	FM
INPUT	PO ———									(120) ———			(120)											
PO	NPO	NPO	———						Clear ↑ Advance as tolerated					60		180		240		240				
IV LR	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	
~~NGT~~ MSO4				3+3			7	4 → 1310																
TURN Q 2	Bed	Bed	Bed	Bed	(↑C)	(↑C)	(↑C)	Bed	BED	BED	BED	BED	BED											
TOTAL	100	200	300	400	500	600	700	800	900	1000	1100	1320	1420 2440											(3401)
													(1660)											
OUTPUT																						800		
URINE	60	60	60	60	60	60 Seal)	60	60	60	60	60	60	120											
~~NGT~~ CT	—	—	—	—	—	H2O	30					D/C (PC)												
STOOL	0	0										1630												
CT Total	-						(790)																	
TOTAL	60	120	180	240	300	360	450	510	570	630	690	750	870											
BALANCE		+80									+570													(1070)
Initials																								

02B 3 am

Patient's Name: [redacted] b(6)-4

Time	05	06	07	08	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
BP	124/63	112/61	108/59	110/60	111/65	117/65	117/62	119/61	118/59	112/50	91/47	103/54	118/66	128/65	108/60	102/54	119/63	[illegible]	108/61	128/68	107/[illegible]	112/70	128/[illegible]	123/70
TEMP	98.7				98.3				99.2	97.7	98.4				99.2 A	97.7 A			98.2 A			97.5		
HR	86	72	79	80	94	94	85	89	83	86	80	81	94	94	78	81	80	83	78	77	88	103	79	105
RR	22	14	28	26	22	23	15	18	34	21	20	24	29	25	14	24	15	15	20	18	16	21	22	22
SAO2	97	97	93	92	92	95	93	92	93	92	94	93	98 94	91	99	94	94	96	96	98	94	93	90	99
FIO2	2L	2L	RA	RA	RA	2L	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA
method	Fm	Fm	—	—	—	Fm	—																	
↑A (Ambulating)					↑A			↑A					↑A											
INPUT																								
PO		120	—	120	—	500	60				240			240						60				
IV LR	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	
~~NGT~~ Percocet		ii					ii							ii Perc						ii Percs				
TURN Q 2	Self																							
Pain assess 1-10 scale	0	0	0	0	0	0	0	0	0	0	0	0	0											
Sub ~~total~~						840					340													
TOTAL	100	200	300	400	500	1340	1,500	1600	1700	1800	2,140	2,240												3640
OUTPUT																								
URINE	0	0	0	0	0	0	0	0	0	375	0	0				~~[illegible]~~ 2225								
NGT —																								
STOOL	0	0	0	0	0	0	0	0	0	0	0	0												
BS	+	+	+	+	+	+	+	+	+	+	+	+												
TOTAL										375														
BALANCE		+200			+500	+1,340				+1,425	+1,765	1,865												~~[illegible]~~ 2090
Initials																								

a.m. Care given
WASHED
ORAL CARE DONE

Worked on bathroom[illegible]
C/o pain in (R) side of
foot. Wash [illegible]

a.m care given

Need D/C IV or extend

Date 7 July 03 Bed # 8

Patient's Name 384

VS q4° Δ @ 0500hrs +

Time	05	06	07	08	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
BP	[illegible]	120/63	119/73	118/63				100/57				116/60		128/70				120/61				139/71		
TEMP	97.5° Ax							99.1° Ax				99.5° Ax		99°A				99°A				98.7°A		
HR	103	68	73	77				83				92		91				78				71		
RR	20	12	18	22				19				22		20				24				18		
SAO2	96	98	96	95				96%				96		96				95				95		
FIO2	RA	RA	RA	RA				RA						RA				RA				RA		
INPUT																								
PO		30		500				500																
IV	100	100	100	—	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
NGT																								
TURN Q 2																								
Sub-Totals	100	130	100	500	100	100	100	600	100	100	100	100	100											
TOTAL	100	230	330	830	930	1,030	1,130	1730	1,830	1930	1,930	2,030	2,130											3230
OUTPUT																								
URINE	—	—	—	300	-	350	—	380				300			300									
NGT																								
STOOL	—	—	—	[illegible]	—	—	—	—	—	—	—													
TOTAL				300		650		1,000				1,300												1600
BALANCE																								
Initials																								

going on yellow Day

Patient's Name: 8 Jan 05 4 [redacted] b(6)

Time	05	06	07	08	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
BP																								
TEMP																								
HR																								
RR																								
SAO2																								
FIO2																								
INPUT																								
PO																								
IV	100																							
NGT																								
TURN Q 2																								
TOTAL																								
OUTPUT	500																							
URINE																								
NGT																								
STOOL																								
TOTAL																								
BALANCE																								
Initials																								

Vard/Section:	R. NG PHYSICIAN:	RATORY RESULT FORM (Subject to the Privacy Act of 1974)
.AST, FIRST, MI.	DATE 3Jul03	TIME 0635
SSN/PSEUDO SSN: [redacted] b(6)-4		

(Hematology) CBC		
TEST	*RESULT*	*REF. RANGE*
VBC	23.0	4.8-10.8 x 10³
RBC	4.58	4.7-6.1 x 10⁹
Igb	12.9	14-18 g/dl (M) 12-16 g/dl (F)
Ict	40.4	42-52% (M) 37-47% (F)
ACV	88.2	80-94 fl (M) 81-99 fl (F)
Plt	206	130-500 x 10³ verified
.ymph %	—	20.5-51.1%

(Hematology) Manual Differential			
Segs	59	Mono	4
Bands	26	Eos	
.ymph	9	Baso	
Atyp	2	Imm	
RBC Morph	Hypochromic 1+ Anisocytosis 1+ Platelet adequate Vacuoles 1+ Dohle bodie 1+		

Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis		
TEST	*RESULT*	*REF. RANGE*
Color	Yellow	N/A
App	Clear	N/A
Glu	Neg	Negative
Bili	Neg	Negative
Ket	Neg	Negative
SG	1.030	N/A
Bld	Trace Hemolyzed	Negative
pH	5.0	N/A
Prot	30 Small	Negative
Urob	0.2	0.2-1.0
Nit	Neg	Negative
Leuk	NA	Negative
HCG		Negative

CSF		
Cell Count		
Directigen		Negative

Misc. Serology		
TEST	*RESULT*	*REF. RANGE*
RPR		Negative
Mono		Negative

Microbiology		
Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

WBC-20-30 Mucous Large
RBC-20-30 Bacti-Trace
SSA-Small
gran & Hyaline Casts -1-3

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies		
TEST	*RESULT*	*REF. RANGE*
PT	12.1	9.8-13.6 secs
APTT	20.4	21-34 secs
D-dimer		<20 ug/ml
FDP		<10 ug/ml

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	*TYPE*	*CROSSMATCH*

REMARKS:

REPORTED BY: [redacted]	**DATE:** 3Jul03	**LAB ID NO.:**

b(6)-2

b(6)-2

Ward Section: EMT

[redacted]SICIAN:

ISTRY RESULT FORM
(Subject to the Privacy Act of 1974)

LAST, FIRST [redacted] b(6)-2

DATE 30Jul03 | TIME 0626 | SSN [redacted] b(6)-1

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/l (art) 24-29 mmol/l (ven)
HCO3		22-26 mmol/l (art) 23-28 mmol/l (ven)
sO2		95-98%
BEecf		(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
iCa		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		Negative
Drug of Abuse		Negative
		Negative
		Negative
		Negative

(Piccolo) Chemistry 12

TEST	RESULT	REF RANGE
ALB	4.0	3.5-5.5 g/dl
ALP	67	26-84 u/l
ALT	23	10-47 u/l
AMY	34	14-97 u/l
AST	28	11-38 u/l
TBIL	0.7	0.2-1.6 mg/dl
BUN	11	7-22 mg/dl
CA++	8.4	8.0-10.3 mg/dl
CHOL	84	100-200 mg/dl
CRE	0.9	0.6-1.2 mg/dl
GLU	159	73-118 mg/dl
TP	7.1	6.4-8.1 g/dl

(Piccolo) Metlyte 8

TEST	RESULT	REF RANGE
GLU	155	73-118 mg/dl
BUN	11	7-22 mg/dl
CRE	0.6	0.6-1.2 mg/dl
CK	361	39-380 u/l (M) 30-190 u/l (F)
NA+	141	128-145 mmol/l
K+	4.0	3.3-4.7 mmol/l
CL-	109	98-108 mmol/l
tCO2	23	18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA		128-145 mmol/l
K		3.3-4.7 mmol/l
Cl		98-108 mmol/l
tCO2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dl
ALP		20-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA		128-145 mmol/l
K		3.3-4.7 mmol/l
CL		98-108 mmol/l
tCO2		18-33 mmol/l

REMARKS:

REPORTED BY: [redacted] b(6)-2

DATE: 3Jul03

LAB ID NO.:

Ward/Section: ICU 2	REQ. Dr. [redacted] b(6)-2	**RATORY RESULT FORM** (Subject to the Privacy Act of
LAST [redacted] #[redacted] b(6)-4	DATE 4JUL03	TIME 0430
		SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	9.1	4.8-10.8 x 10^3
RBC	4.51	4.7-6.1 x 10^9
Hgb	12.4	14-18 g/dl (M) 12-16 g/dl (F)
Hct	39.7	42-52% (M) 37-47% (F)
MCV	88.0	80-94 fl (M) 81-99 fl (F)
Plt	187	130-500 x 10^3 verified
Lymph %	11.4	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			
Spun Hematocrit		42-52% (M) 37-47% (F)	
Sed Rate			
Other			

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] b(6)-2 **DATE:** 4Jul03 **LAB ID NO.:**

MEDCOM - 12957

ICU 2 b(6)-4
[redacted]   Sr. [redacted]   4/8/2 03   0430

(i-STAT)

TEST	RESULT	REF RANGE
Na		135-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-48 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) [illegible] (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		[illegible] mmol/L
AnGap		10-20 mmol/L
iCa		1.12-1.32 mmol/L
BUN		8-26 mg/dl
Glu		[illegible] mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF RANGE
Troponin I		Negative
Drug of Abuse		Negative
		Negative
		Negative
		Negative

(Piccolo) Chemistry 12

TEST	RESULT	REF RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 U/L
ALT		10-47 U/L
AMY		14-97 U/L
AST		11-38 U/L
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA		8.0-10.3 mg/dl
CHOL		100-300 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

(Piccolo) Metlyte 8

TEST	RESULT	REF RANGE
GLU	113	73-118 mg/dl
BUN	8	7-22 mg/dl
CRE	0.6	0.6-1.2 mg/dl
CK	2541	39-380 U/L (M) 30-190 U/L (F)
NA	131	128-145 mmol/L
K	4.2	3.5-4.7 mmol/L
Cl	99	98-108 mmol/L
tCO2	24	18-33 mmol/L

(Piccolo) Metabolic

TEST	RESULT	RE
GLU		73-1
BUN		
CA		8.0-1
CRE		0.6-1
NA		128-
K		3.6-
Cl		98-1
tCO2		18-3

(Piccolo) Liver Pane

TEST	RESULT	RE
ALB		3.5
ALP		26-84
ALT		10-47
AMY		14-9
AST		11-38
TBIL		0.2-
GGT		5-65
TP		6.4-8

(Piccolo) Electroly

TEST	RESULT	RE
NA		128-1
K		3.6-
Cl		98-10
tCO2		18-3

REMARKS:

REPORTED BY: b(6)-2 [redacted]

DATE: 4 5 4/03

LAB ID NO.:

MEDICAL RECORD ANESTHESIA

ANESTHETIC AGENTS AND DRUGS

CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML, "I" = CONSTANT INFUSION

DRUG (Units)					
Propofol ( )	150				
Lidocaine ( )	100				
succinylcholine ( )	100				
Fentanyl ( )	100	50	50	50	
Vecuronium ( )		5	3		
( )					
VOLAT AGENT 150 % del / % e.t.	0 / 1.5 / 1.5 / .8 / .4 / 0				
AIR L/Min					
N2O L/Min					
O2 L/Min	8 / 1 / 1 / 1 / 1 / 1 / 5				
SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS					

FLUIDS

LINE site		
	☐ Warmed	HESPAN 500
18g ① AC	☐ Warmed	ⓁⓇ – 500 – #3 –
18g ② AC	☐ Warmed	#2 ——— LR4 –
	☐ Warmed	

LOSSES

EST BLOOD LOSS		
URINE –	400	100

TOTALS	
TOTAL EBL	<100
TOTAL URINE	500

FLUIDS – SUMMARY

CRYSTALLOID– 2300

COLLOID– 500

BLOOD– 0

PHYS STATUS: [✓ 1] 2 3 4 5 / [✓ E]

BODY WEIGHT: 70 [✓ KG] LB

HEMATOCRIT:

INITIAL DATA:

BP – 151/94

HR – 96

EQUIP CHECK

OK? – Y N

PATIENT IDENTIFIED

OK for PROCEDURE?

TIME–

TIME → 0800 ✗ 0830 ⊗ 0900

SYMBOLS:

BP by cuff ∨ ∧

Heart rate ●

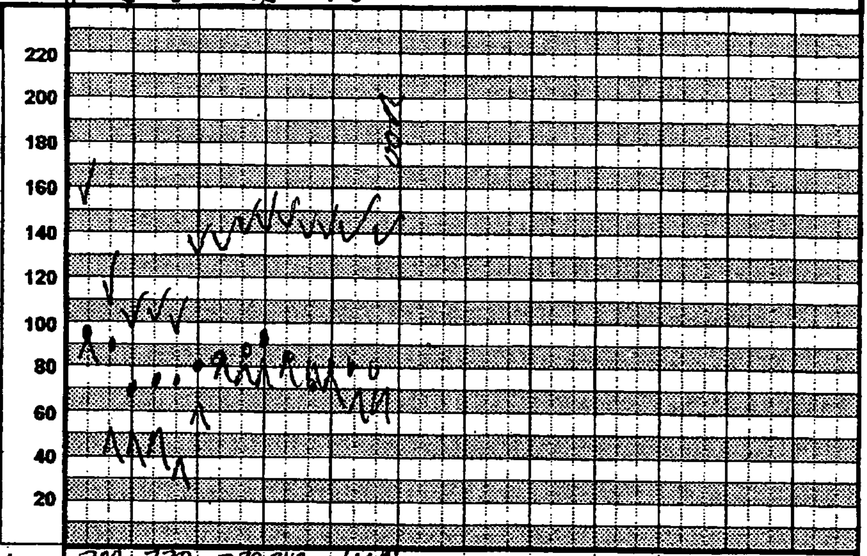
Resp rate

BP (transduced) ╪

TOURNIQUET T – ↗

ANES – X-X

PROC – ⊙ – Ø



REMARKS –

Code drugs with numbers, events with letters

0748 PT ID, PREOP FORM 2400 COMPLETE.

0803 Rm, O2, mon.

0810 RSI/C

0846 5 mg Neostigmine .8 mg Robinul TOF

VENTILATION

VT – ml	700	720	720	740	400
f – breaths/min	8	10	10	4	10
Peak inf pres / PEEP	22	22	22	23	<
MODE – S(pon), A(ssist), C(on)	S-C–	C	C	C	S

MONITORS AND EQUIPMENT

BP/Auto Cuff ☒	ET CO2 (torr)	49	41	36	42	37
BP / oth ☒	FIO2 (Frac or %)	.80	.78	.78	.74	.80
ART line ☒	SpO2 (%)	100	100	100	100	100
Steth- PC/ES ☒	ECG	SR	SR	SR	SR	SR
Gas analyzer ☒	TEMP- site	Axial				
☒	N-M Block (T/4)	4/4 - 0/4 - 4/4 - 3/4 - 4/4 –				
Warming blkt						
Conv warmer						

Mark with letters & symbols, explain under REMARKS EVENTS

Position → 0—

RECOVERY AT 0914

PACU [✓ ICU] ________ (Specify)

OTHER ________

CONDITION: Stable

RESP- 10 SpO2- 96

BP- 146/87 HR- 79

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0748	0813	0930
PROC.	Ready	Begin	End
	0813	0827	0900

PROCEDURES and CPT Codes

EX LAP

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments DL x 2, success c̄ 4.0 MAC. grade II view #8.0 ETT TO 22 @ teeth, ⊕BBS ⊕ETCO2

b(6)-2

PATIENT IDENTIFICATION – Typed or written entries: Name, Grade/Rate, Medical facility

#[redacted]

b(6)-4

SURGEON [redacted]

ANES [redacted] CPT CRNA

PROCEDURE LOCATION

DATE 3 JUL 03

PAGE 1 OF

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 12959

U.S. GPO: 2002-729-180/40

;THESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

30 DAYS MOS YRS

Sex (X) MALE ( ) FEMALE

ASA Physical State [✓ 1] 2 3 4 5 [✓ E]
WT: 70 [✓ KG] LB HT: ____ IN.
ALLERGIES: NKDA

OSED PROCEDURE: GX LAP GSW MID Ⓡ AXILLARY
ICAL SERVICE: GEN
INCE: Unknown

S:
ACCO: 0
ETOH: 0
RUGS: 0

ENT MEDICATIONS:
dered as premed

0

EDICATIONS:
Yes (@ ______ Hrs) /CC
. ______ mg IV IM PO
. ______ mg IV IM PO
. ______ mg IV IM PO

RATORY STUDIES:

T: ________/________
R: ________

141 | 109 | 11 / 155
4.0 | 23 | 1.6

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:		
Hypertension	N Y	
Angina	N Y	
MI	N Y	
CVA	N Y	
Other	N Y	
Pulmonary System:		
Asthma	N Y	0
Bronchitis/URI	N Y	
COPD	N Y	
Other	N Y	
Renal System:		
Acute/Chronic RF	N Y	
Gastrointestinal:		
Hepatitis	N Y	
Hiatal Hernia	N Y	
PUD/GERD	N Y	
Endocrine System:		
Diabetes	N Y	
Steriods	N Y	
Thyroid	N Y	
Neurological:		
Seizures	N Y	
Neuropathy	N Y	
Other	N Y	
Gynecological :		
Pregnancy	N Y	
Other Significant Hx:		
	N Y	
	N Y	
Familial HX	N Y	

ASSESSMENT
PAST SURGICAL/ANESTHETIC

0

PHYSICAL EXAMINATION
BP 134/61 HR 84 R ___ T ___
Pain Scale 0-10 ______
HEENT - Teeth Intact
Trachea Midline
TMJ/Neck FROM
Oropharnyx MP II
Nares ______
CHEST: CTA
CARDIAC: $S_1 S_2$
EXTREMITIES:
IV Access: 2 Lg BORE Ⓛ + Ⓡ AC
Ulnar Filling: ______
BACK: ______
OTHER: CHEST TUBE / FOLEY

NPO Since ______

;THETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ______ [✓ X] General: Mask [✓ Intubation]

;MED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to a ;sed with the patient/legal guardian.

b(a)-2

tient/le[redacted]s to understand and agrees. Questions answered.
d: [redacted] CPT CRNA Date: 3 JUL 03 Time: 0750 Hrs

-ANESTH[redacted]N AND NOTE (NON ASU)
) APPARENT ANESTHETIC COMPLICATIONS { } OTHER

d: ______________ Date: ________ Time: ______ Hrs

t Identification: (Ward) ______________

SEDATION KEY:

1. **MINIMAL** (Anxiolysis) Patient responds normally to verbal commands
2. **MODERATE** (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is no necessary.
3. **DEEP SEDATION/ANALGESIA.** Patient responds purposefully following repeated or painful stimulation. Airway assistance may

#[redacted]

b(a)-4

MEDCOM - 12960

3 5 6 9 10 11 12 13 14 15 16 17 18 19

*U.S. GPO:1992-316-809/40017

am (P) ICU2

-165-7294

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

TION(S) REQUESTED

CXRay (Portable)

AGE 31 SEX M SSN [redacted]

WARD/CLINIC ICU 2

REGISTER NO.

FILM NO.

PREGNANT ☐ YES ☐ N

RE[redacted] b(6)-2

TELEPHONE/PAGE

SIGNATURE OF REQUESTOR

DATE REQUESTED

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

EXAMINATION *(Month, day, year)*

DATE OF REPORT *(Month, day, year)*

DATE OF TRANSCRIPTION *(Month, day, year)*

GIC REPORT

'S IDENTIFICATION *(For typed or written entries give: ast, first, middle, Medical Facility)*

[redacted] b(6)-4
ICU 2 Bed 8

LOCATION OF MEDICAL RECORDS

MEDCOM - 12961

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

[redacted]

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 3Jul03 TIME OF ORDER 0915 HOURS

LIST TIME ORDER NOTED AND SIGN: b(6)-2 [redacted] 3Jul03 0915

① Admit to ICU

S/p GSW to chest

cond stable

Vitals Q1° c̄ I/O

All NKDA

Act Bedrest

Nurse CT to 20cm H2O suction

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER ______ HOURS

Foley to grav

Diet NPO

IVF LR @ 150 cc/hr

meds

✓ MSO4 1-10 mg Q1° PRN pain

Ancef 1gm IV Q8° x 3 doses

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER ______ HOURS

CBC, Medlyte 8 in Am.

CXR now - and [redacted]

NURSING UNIT | ROOM NO. | BED NO.

b(6)-2

PATIENT IDENTIFICATION

[redacted]

b(6)-2

DATE OF ORDER ✓ 3Jul03 TIME OF ORDER 1630 HOURS

✓ Tylenol 650mg PO Q4° PRN pain

✓ D/C NGT

✓ Incentive spirometry [redacted]

b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

MEDCOM - 12962

ACLU-RDI 1592 p.855

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

TIENT IDENTIFICATION

b(6)-4

[redacted]

[redacted]

DATE OF ORDER 4JUL03 TIME OF ORDER 0700 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) OOB

(2) Agressive Pulm toilet. Nursing retn Q4 as necessary.

(3) ↓IVF to 100 cc/hr

[redacted]

IRSING UNIT | ROOM NO | BED

TIENT IDENTIFICATION

b(6)-2

[redacted]

DATE OF ORDER 4July03 TIME OF ORDER 1315 HOURS

b(6)-2

A/1

(1) Toradol 15mg IV Q6° x2days

[redacted]

IRSING UNIT | ROOM NO. | BED

TIENT IDENTIFICATION

[redacted]

DATE OF ORDER 4Jul03 TIME OF ORDER 1700 HOURS

(1) Percocet I-II tab po Q4° PRN Pain

[redacted]

IRSING UNIT | ROOM NO. | BED NO.

4JUL03 @ 0229 Orders Noted 4July03 [redacted]

TIENT IDENTIFICATION

[redacted]

DATE OF ORDER 5Jul03 TIME OF ORDER 0605 HOURS

(1) CXR now

[redacted]

138

IRSING UNIT | ROOM NO. | BED NO.

A FORM 1 APR 79 4256

REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED

☆ U.S. GOVERNMENT PRINTING OFFICE: 1994 - 363-710

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

NT IDENTIFICATION [redacted] b(6)-4 [redacted] b(6)-2

NG UNIT | ROOM NO. | BED

DATE OF ORDER 5Jul03 TIME OF ORDER 1030 HOURS

LIST TIME ORDER NOTED AND SIGN

① CT to water seal

② CXR @1600

[redacted]

NT IDENTIFICATION [redacted] b(6)-2 [redacted]

NG UNIT | ROOM NO. | BED

DATE OF ORDER 5Jul03 TIME OF ORDER 1370 HOURS b(6)-2

① CXR NOW (Done)

② Δ CT dressing QD

③ NT suction Q4° x 48 hrs

④ Percocet T1 tab PO Q4° x 24 - Round the clock [redacted]

NT IDENTIFICATION [redacted] b(6)-4 [redacted] b(6)-2

NG UNIT | ROOM NO. | BED

DATE OF ORDER TIME OF ORDER 5 July 03 HOURS

1. Clear liquids diet advance as tolerated V.O. [redacted] 91W77th

[illegible] [redacted]

2. DIC [redacted]

V.O. [redacted] [redacted]

b(6)-2

24°CC @ 2128 Orders noted 5 July 03 [redacted]

NT IDENTIFICATION [redacted]

NG UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER 0800 HOURS

1. NT suction q 4° x 48° held if pt has productive cough V.O. Dr [redacted] b(6)-2

[redacted] 91W77th

2. pt OOB & ambulate may take pt off monitor during ambulation if sats ≥ 90% and S/Sx of Respiratory distress

V.O. Dr [redacted] [redacted] [redacted] @ 1945 b(6)-2

MEDCOM - 12964

Orders noted 6 July 03 [redacted]

ACLU-RDI 1592 p.857

[redacted]

b(6)-4

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

IENT IDENTIFICATION

[redacted]

SING UNIT | ROOM NO | BED N

[redacted]

DATE OF ORDER | TIME OF ORDER 0800 HOURS 7 July 03 | LIST TIM ORDER NOTED AND SIGN

1. VS q 4° Vic. O[redacted]

given 1 & [redacted] Luma

b(6)-2

b(6)-2

24°CC@ 0001 Orders noted Sg[redacted]ly03

b(6)-2

IENT IDENTIFICATION

[redacted]

SING UNIT | ROOM NO | BED NO

DATE OF ORDER | TIME OF ORDER HOURS

ENT IDENTIFICATION

b(6)-4

[redacted]

SING UNIT | ROOM NO | BED NO

DATE OF ORDER | TIME OF ORDER HOURS

ENT IDENTIFICATION

b(6)-4

[redacted]

SING UNIT | ROOM NO | BED NO

DATE OF ORDER | TIME OF ORDER HOURS

b(6)-2 b(6)-2 A11

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

Mo. July Yr. 2003

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	3	4	5	6	7	8	9	10	11	12	13	14	15	16
[redacted]																	
3JULY03	[redacted]	Act: BR	05	[redacted]		No @ 0700 hrs 4July03											
			17														
3JULY03	[redacted]	Chest tube to 20cm [redacted]	05	[redacted]													
3JULY03	[redacted]	Diet NPO	06	[redacted]													
[redacted]																	
3JULY03	[redacted]	Incentive Spirometer	05	[redacted]													
			17														
4JULY03	[redacted]	OOB	05	[redacted]													
			17														
4JULY03	[redacted]	Aggressive pulmonary toilet	05	X [redacted]													
			17														
[redacted]																	
5JUL	[redacted]	NT suction q 4° x 48°	04	X	X	X	O	O									
			08	X	X	X	O	O									
			12	X	X	[redacted]	O	O									
			16	X	X	[redacted]											
			20	X	[redacted]												
			24	X	[redacted]												
5JULY03	[redacted]	Δ CT dressing QD	[redacted]														
5JULY03	[redacted]	Clear Liquids diet advance as tolerated	06	/	/	/	[redacted]										
			12	/	/	[redacted]											
			18	/	/	[redacted]											

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS: S/p GSW chest

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO
PAGE NO: 1

PATIENT IDENTIFICATION: [redacted]

b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 EDITION OF 1 DEC 77 MAY BE USED. USAPA V1.00

MEDCOM - 12966

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*	Mo July 7 Yr 2003			
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
3/7	[redacted]	Admit to ICU s/p GSW to chest	3/7/03	done		[redacted]
	-----	condition stable	3/7/03			
3/7	[redacted]	CBC Medlyte 8-Am Done	4/7/03	4/7	4/7/03	[redacted]
3/7	[redacted]	CXR Now ~~and in Am~~	3/7/03	Now	1252	XRAY [redacted] No Good
3/7	[redacted]	CXR IN AM	4/7/03	4/7/03	4/7/03	XRAY [redacted]
3/7	[redacted]	D/C NGT	3/9/03	3/9/03	1630	[redacted]

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

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING COMPLETION* TIME/DATE COMPLETED													
9 Jul 03	[redacted]	Nasal pharyngeal suction if necessary Q 4°	T 1	1000 9/10												
-----	-----		m z	Suct (+)												
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															

USAPA V1.00

MEDCOM - 12967

(b)(6)-2

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

Mo. July *Yr.* 2003

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

ORDER DATE	CLERK/ [redacted]	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 6	7	8	9	10	11	12	13	14	15	16	17	18	19
6 JUL 03	[redacted]	NT suction q 4° x 48°	04	[redacted]	[redacted]	X											X
		PRN, if pt. has productive	08	[redacted]	[redacted]												X
		cough	12	[redacted]	[redacted]	X											X
			16	[redacted]	[redacted]	X											X
			20	[redacted]	[redacted]												X
	[redacted]		24	[redacted]	[redacted]	X											X
6 JUL 03		pt OOB to ambulate	04	[redacted]	[redacted]												
		may take pt off	08	[redacted]	[redacted]												
		monitor during	12	[redacted]	[redacted]												
		ambulation if sats	16	[redacted]	[redacted]												
		↑ 90% and s̄ S/S of	20	[redacted]	[redacted]												
	[redacted]	Respiratory distress	24	[redacted]	[redacted]												
7 Jul 03		VS q 4°	05	[redacted]	[redacted]												
			1	[redacted]	[redacted]												

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
S/P GSW Chest

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO
PAGE NO: 2

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

RM 4677, 1 OCT 78 EDITION OF 1 DEC 77 MAY BE USED. USAPA V1.00
MEDCOM - 12968

b(6)-2 AM

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. July Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 3	4	5	6	7	8	9	10	11	12	13	14	15	16
3/7/03	[redacted]	Ancef 1 gm IV Q 8°	06	[illegible]	X												
		X3 doses	14	[redacted]	X												
			22	[redacted]	X												
3/7/03	[redacted]	IVF LR @ 150cc/hr	0	[redacted]	[redacted]	Δ [illegible] 4 July 03											
			17	[redacted]													
4/7/03	[redacted]	IVF LR @ 100cc/°	05	X	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]								
			17	X	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]								
4/7/03	[redacted]	Toradol 15 mg IV Q 6°	6	X	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	unavailable @ pharmacy							
		x 2 days	12	X	X												
			18	X	[redacted]	[redacted]	[redacted]	[redacted]									
			24	X	[redacted]	[redacted]	[redacted]	[redacted]									
5 July 03	[redacted]	Percocet ii tabs P.O.	6	X	X	X	[redacted]	[redacted]	X								X
		Q 8° x24 around the	12	X	X	[redacted]	[redacted]	[redacted]	X								X
		clock	18	X	X	[redacted]	[redacted]	X	X								X
			24	X	X	[redacted]	[redacted]	X	X								X

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
(R)
S/P GSW to Chest

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

PATIENT IDENTIFICATION:

[redacted]

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

78, 1 FEB 79 EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

MEDCOM - 12969

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*				Mo. JULY Yr. 03
Order Date	**Clerk/ Nurse**	**SINGLE ORDER, PRE-OPERATIVES**	**Date to be Given**	**Time to be Given**	**Time Given**	**Initials**

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

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY		*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* TIME/DATE DISPENSED												
3 JULY 03	[redacted]	MSO4 1-10mg IVP	T I	1400 [redacted]	1600 [redacted]	1745 [redacted]	1450 [redacted]	2025 [redacted]	2130 [redacted]	2245 [redacted]	0630 [redacted]	0300 4mg	0530 3mg	0700 [redacted]	0900 [redacted]	1115 [redacted]
-----	[redacted]	q1° p.r.n pain	M E	3mg (+)	3mg (+)	3mg 3gu	3mg 3gu	4mg 3gm	5mg 3gu	3mg 3gu	4mg [redacted]	4mg [redacted]	4mg [redacted]	4mg [redacted]	4mg [redacted]	2mg [redacted]
3 JUL 4 03	[redacted]	Tylenol 650 mg po. for pain q4°	T I	1630 JTP	4July 1800											
-----	-----		M E	650 (/)	[redacted]											
3 JUL 4 03	[redacted]	MSO4 1-10mg IVP	T I	1405 JTP	1600 JTP	1815 6mg IV	2125 7mg IV	0042 7mg WO	0800 [redacted]	1100 [redacted]	1230 [redacted]	1330 [redacted]				
-----	-----	q1° p.r.n pain	M E	6mg (+)	5mg (+)	[redacted]	[redacted]	[redacted]	(+)	2mg (+)	4 •	2 (+)				
4 Jul 03	[redacted]	Percocet i-ii tabs po	T I	6July03 1800	7July03 2100											
-----	-----	q4° for pain	M E	[redacted]	[redacted]											
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															

Relwn't 45mg [redacted]

USAPA V1.00

MEDCOM - 12970

PAGE 1 OF 4

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

b(6)-2

OTSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME		INITIALS [redacted]	1730	INITIALS [redacted]		INITIALS
NEURO	PUPILS	Conformed Language		PERL e 2mm Brisk			
	SENSORIUM	intact		INTACT. MAE x 4.			
	1-10mg prn	MOE		c/o PAIN. Alert awake.			
	mSO4	Eyes PERRLA — 2mm					
	3mg [illegible] 14-1800	E pin point					
RESPIRATORY	RESPIRATORY PATTERN	shallow guarded		Shallow breathing			
	BREATH SOUNDS	diminished		clear but ↓ @ bases (B)			
	SECRETIONS	∅		∅			
	CT 20cm H2O	390 marked drainage		(R) CT TO 20cm H2O			
	@ 1700hrs	560		suction with bloody			
	Total out	170cc		drainage.			
SKIN	COLOR	NFR		Normal for race.			
	INTEGRITY	feet calloused		Intact. Dressing to			
		CT - ABD MIDLINE		(R) CT & MIDLINE ABD area.			
IV SITE	LOCATION	AC bilateral		AC (B)			
	CONDITION	R 18 L 14		(R) 18g (L) 14g			
		patent c̄ s/s of		patent ∅ signs or			
		problem		symptoms of infil-			
				tration.			
GASTRO	ABDOMEN	firm		Flat tender to touch			
	BOWEL SOUNDS	∅ bowel sounds		Absent BS x 4			
		present		quadrants			
GU	URINE:	FC/BSF		Foley catheter to			
	COLOR/CLARITY	Yellow Clear		gravity drain with			
				clear yellow urine.			
CARDIOVASCULAR	CARDIAC RHYTHM	SR		SR ∅ ectopy S1S2			
				PPP x 4. Afebrile.			
				Will continue to			
				monitor for any			
				changes. [redacted]			

LEGEND

Cr - Creatinine
F_iO_2 - Fraction of Inspired O_2
HCO_3 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
S/A - Fractional
SAT - Saturation
TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title) [redacted] 9/WM6.

DEPARTMENT/SERVICE/CLINIC ICU 2nd

DATE 3 Jul 03

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

b(6)-2

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

DA FORM 1 MAY 78 4700
Proponent Dept of Nurs

MEDCOM - 12971

WAMC OP 375 (Redesignated)
1 Apr 90 (HSXC-NU)

(D) GSW 3/7/03 – exp lap to and – Chest
30 y/o ♂ (EPW) [redacted] 70 kg estimated body [redacted]
Admitted 0915 q1° VS Act. BR CT 20cm H2O

*a.m. labs
CBC – medlyte 8
Procedure CXR

140

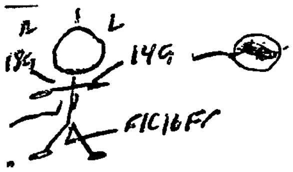
PAGE 2 OF 4

DATE | DX: exp lap to and, s GSW | 14 ST | HOSPITAL DAY

TIME	05	06	07	08	09	10	11	12	13	13	14	15	16	17	18	19	20	22
BP Arterial Line																		
BP Cuff					92/85	148/87	134/77	134/96	/	142/76	140/81	135/77	132/75	143/85	128/73	135/80	140/74	
Temperature					95³			98¹	[illegible]	98⁵		100⁵	100²	100				
Pulse					90	76	76	86		88	100	99	99	94	91	94	88	
Respiratory Rate					22	13	18	17		18	35	28	25	20	19	31	23	
FiO2					100%	100%	6L	4L		4L	2L	2L	2L	2L	2L	2L	2L	
SATS					99	97	98	98		97	96	96	96	96	96	97	97	
method					NRM	NRM	NC	NC		NC	NC	NC	NC	NC	NC	NC	NC	
Δ position q2°					B	B	L	L		B	B	R	R	B				
pain																		
intervention																		

TIME	05	06	07	08	09	10	11	12	13 8°T	13	14	15	16	17	18	19	20	22 8°T
IV LR					150	150	150	150		150	150	150	150	150	150	150	150	
IVBP																		
Ancef x 3doses					① –	50					50							
MSO4 1-10mg IV q1°										MSO4	0³ cc	MSO4	0³ cc					
Diet NPO					NPO	NPO	NPO	NPO		NPO	NPO	NPO	NPO	NPO	NPO	NPO	—	
Sub totals					150	200	150	150	650	150	250	150	150	150	150	150	150	
TOTALS					150	350	500	650		800	1050	1200	1350	1500	1650	1800	1950	

		05	06	07	08	09	10	11	12	13	13	14	15	16	17	18	19	20	22
URINE	HOUR / TOTAL	/	/	/	/	346	361	366	351		75	75	200	100	75	150	200	150	
	sp gr																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS	CT	(mark on admit)			390	20	20	20	10		15	15	0	20	30	10	10	10	
	total in bottle																	590	
						386	386	386	360	[illegible]	75	75	200	120	105				
TOTALS						20	992	1698	1518	[illegible]	1593	1668	1868	1988	2093				



[redacted] [redacted]

POST-OP DAY

VITAL SIGNS

21	22	23	24	01	02	03	04	
137/72	134/95	134/85	143/88	135/78	128/82	133/80	135/81	
			100.1			99.8		
82	82	95	90	92	91	94	87	
19	19	14	22	30	21	23	23	
2L	2L	2L	4L	8L	8L	6L	6L	
98	95	95	95	88	97	96	97	
NC	NC	NC	NC	NRB	NRB	RBT	RBT	

INTAKE

21	22	23	24	01	02	03	04	8° T
150	150	150	150	150	150	150	150	
	/86							
150	250	150	150	150	150	150	150	
2100	2350	2500	2650	2800	2950	3100	3250	

OUTPUT

150/~~2600~~	100	100	100	150	175	300	150/450	
10	5	5	10	10	20	0	5	
600	605	610	620	630	650	650	655	655

ACUITY LEVEL CLASSIFICATION

RESPIRATORY STATUS

	TIME									
	MODE									
	F_iO_2									
	TV									
	RATE									
	PEEP									
A	pH									
	PCO_2									
	pO_2									
B	HCO_3									
	SAT									
G	BASE									

LABORATORY DATA

a.m lab TIME									
GLUCOSE									
Na/K									
Cl/CO$_2$									
BUN/Cr									
WBC/PLATELET									
Hct/Hgb									

ACTIVITIES OF DAILY LIVING

TIME					TIME				
MOUTH CARE				TURN					
BATH									
SKIN CARE									
FOLEY CARE				SUCTION					
TRACH CARE									
ROM EXERCISES									

24° I&O TOTALS

wt Yesterday ________ wt Today ________

INTAKE

IV ________

po ________

____

TOTAL ________

OUTPUT

Urine: ________

____

____

TOTAL ________

BALANCE ________

NURSE'S SIGNATURE | **INITIALS**

[redacted]

b(6)-2

MEDCOM - 12973

mso4 3mg

NEUROLOGICAL ASSESSMENT

				HOURS	0900	1000	1100	1200	1400	1500
COMA SCALE	EYES OPEN	SPONTANEOUSLY	4							
		TO SPEECH	3		3	3	3	3		
		TO PAIN	2							
		NO EYE OPENING	1							
	BEST VERBAL RESPONSE	ORIENTED	5							
		CONFUSED	4		4	4	4	4		
		VERBALIZES	3							
		VOCALIZES	2							
		NO VOCALIZATION	1							
	BEST MOTOR RESPONSE	OBEYS COMMANDS	6		6	6	6	6		
		LOCALIZES PAIN	5							
		FLEXION WITHDRAWAL	4							
		ABNORMAL FLEXION	3							
		EXTENSION TO PAIN	2							
		NO MOTOR RESPONSE	1							
LIMB MOVEMENT	ARMS	NORMAL POWER								
		MILD WEAKNESS			✓ RL	✓ RL	✓ RL	✓ RL		
		SEVERE WEAKNESS								
		ABNORMAL FLEXION								
		ABNORMAL EXTENSION								
		NO RESPONSE								
	LEGS	NORMAL POWER								
		MILD WEAKNESS			✓ RL	✓ RL	✓ RL	✓ RL		
		SEVERE WEAKNESS								
		ABNORMAL FLEXION								
		ABNORMAL EXTENSION								
		NO RESPONSE								
PUPILS	RIGHT	SIZE			2	2	2	2		
		REACTION			+	+	+	+		
	LEFT	SIZE			2	2	2	2		
		REACTION			+	+	+	+		
PUPIL SCALE		● 2 ● 3 ● 4 ● 5 ● 6 ● 7 mm								
ICP										
CEREBRAL PERFUSION PRESSURE										

LEGEND

C Closed by swelling

T Trach/Endo
S Slurring
D Dysphasia
R Receptive
E Expressive

R Right
L Left

Record separately if there is a difference between the two sides.

++ Brisk
+ Slow
- No Response

+ Intact
- Abnormal

VASCULAR ASSESSMENT

HOURS		
	R L	
	R L	
	R L	
	R L	
	R L	

LEGEND

++ Normal
+ Weak
- Absent
D Doppler
R Right
L Left

MEDCOM - 12974

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE Post-Anesthesia Care Unit (PACU) Flow Sheet GSW
ASA IE

OTSG APPROVED (Date)

30 y/o
70 kg

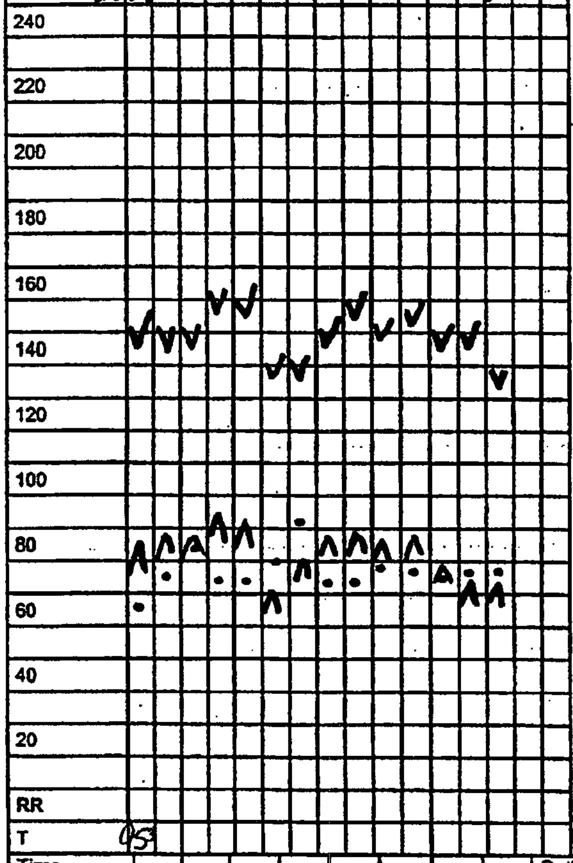
Date: 3Jul03 Anesthesia Type (Circle)): General Spinal Epidural fent 250mcg
Time In: 0915 IV Sedation Nerve Block MSO4 EMT-15mg
Allergies: None known OR Intake: Crystalloid 2300 Colloid Hespan 500
Pre-op V/S: 151/94, 96 OR Output: UOP 500 EBL <100
Procedures: expl lap-tomid Meds/Times:
s Axilla (R)
R 18G (L) AC
~~IV Bilateral~~ AC 18 14

Drains
Hemovac
NG
JP
T-tube
Foley — 16 Fr.
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds History

Time	0915	0920	0925	0930	0935	0940	0945	0950	0955	1000	1005	1010	1015	1020		
SaO2	98	92	96	98	98	98	99	98	98	99	99	99	99	98		
FiO2 NRM	[illegible]	96														
Methods	[illegible]															



T 98

Time								
Pain (0-10)	No	fully	2	wake		(Awake)		
LOS								

Patient teaching done; Wound Care, Pain Management,
T, C, & DB,. Incentive Spirometer, Comfort Measures
Safety: SR up X 2, Falls Precautions. Privacy Maintained

Pacu Intake

Time	Solution	Amount	Site	By	Infused
	LR	150cc			

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	1	1	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	1	1
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	/	/	/
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	8	8	9

Codes

AIRWAY
A = Ambu
BB = Blow-by
M = Mask
FT = Face Tent
RA = RoomAir
NC = Nasal Cannula

V/S
X = A-line BP
˅ = Cuff BP
• = Pulse

TEMP
S = Skin
O = Oral
A = Axillary
T = Tympanic
R = Rectal

LOS
C = Cervical
T = Thoracic
L = Lumbar
S = Sacral

(Continue on reverse)

[redacted] 91WM6

(For typed or written entries give: Name — last, [redacted] grade; date; hospital or medical facility)

-b)(6)2 / 384)

DEPARTMENT/SERVICE/CLINIC ICU 2

DATE 3Jul03

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

DA FORM 4700, MAY 78 WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) Previous edition is obsolete
USAPPC V2.00

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	Head	MOE	intact	+4	<3		NFR
15'		MOE		↑↓	<3		NFR
30'		MOE		Smm	<3		NFR
45'		MOE		Sm	<3		NFR
60'	[illegible]	MOE		m	<3		NFR
90'	D/C'd						
D/C							

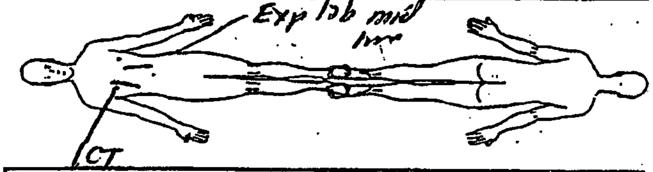
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

	Adm	15'	30'	45'	60'	90'	D/C
Fund. Height							
Lochia							
Peripad#							
Fund. Cond.							

DRESSINGS X2 mid [illegible]

Time	Location	Type	Drainage
Adm	Reinforced	Telfa dry/[illegible]	charge Nurse
30'			
60'	Marked on	Dressing	
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
0916	SR	SR [illegible]	Continuous

WAMC OP 173-E

NURSING NOTES

Discharge Criteria:
Date: **Time:** **PARS:**
BP: **T:** **HR:** **RR:** **Sa02:**
Pain Level at D/C (0-10):
Intake:__________ **Output:**__________
Additional Data:__________
Transferred To:__________
Report Given To:__________
Transferred Via: W/C Litter Gurney Ambulance
Transferred By:__________
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature:__________

O(

1. LAST NAME, FIRST NAME / NOM ET PRÉNOM

RANK / GRADE

☒ MALE / HOMME
☐ FEMALE / FEMME

SSN / NUMÉRO MATRICULE

SPECIALTY CODE / GPM

RELIGION / RELIGION

2. UNIT / UNITÉ

FORCE / ÉLÉMENT

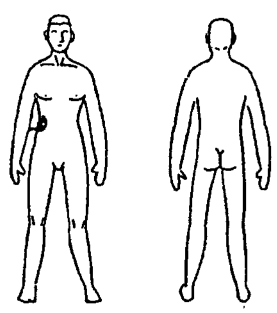
A/T | AF/A | N/M | MC/M

NATIONALITY / NATIONALITÉ Iraqi civilian

BC / BC ☐ NBI / BNC ☐ DISEASE / MALADIE ☐ PSYCH / PSYCH

3. INJURY / BLESSURE

FRONT / DEVANT BACK / ARRIÈRE



☐ AIRWAY / TRACHÉE
☐ HEAD / TÊTE
☒ WOUND / BLESSURE
☐ NECK/BACK INJURY / BLESSURE AU COU/AU DOS
☐ BURN / BRÛLURE
☐ AMPUTATION / AMPUTATION
☐ STRESS / TENSION
☐ OTHER (Specify) / AUTRE (Spécifier)

4. LEVEL OF CONSCIOUSNESS / NIVEAU DE CONSCIENCE

☒ ALERT / ALERTE
☐ VERBAL RESPONSE / RÉPONSE VERBALE
☐ PAIN RESPONSE / RÉPONSE À LA DOULEUR
☐ UNRESPONSIVE / SANS RÉPONSE

5. PULSE / POULS 96 TIME / HEURE 0500

6. TOURNIQUET / GARROT ☒ NO / NON ☐ YES / OUI TIME / HEURE

7. MORPHINE / MORPHINE ☐ NO / NON ☒ YES / OUI 10mg DOSE / DOSE ~~[illegible]~~ 10 TIME / HEURE 0508

8. IV / IV Bilat TIME / HEURE 0500

9. TREATMENT OBSERVATIONS / CURRENT MEDICATION / ALLERGIES / NBC (ANTIDOTE)
TRAITEMENT / OBSERVATIONS - PRESENTE MEDICATION / ALLERGIES / ANTIDOTES

[illegible] chest tube Bilateral IV (saline [illegible])
O_2
Ancef 1g, 10 Morphine
Asherman chest valve

10. DISPOSITION / DISPOSITION ☐ RETURNED TO DUTY / RETOUR À L'UNITÉ
[redacted] ACUÉ
TIME / HEURE

11. P [redacted] AS MC
DATE/DATE (YYMMDD)

DD Fo[redacted]
DEC 9 [redacted] Form 1380 and DD Form 1380 (TEST), which are obsolete.

U.S. FIELD MEDICAL CARD
FICHE MÉDICALE DE L'AVANT ÉTATS-UNIS

b(6) - 2

12. REASSESSMENT / RÉASSESSMENT

DATE / DATE (YYMMDD)

TIME OF ARRIVAL / HEURE D'ARRIVÉE

TIME / HEURE	0505	0514		
BP / PS	130/72	142/94		
PULSE / POULS		90		
RESP / RESP				

DATE / TIME
DATE / HEURE

13. CLINICAL COMMENTS / DIAGNOSIS
INFORMATION MÉDICALE / DIAGNOSTIQUES

0514; No exit wound

Decreased breath sounds on right

14. ORDERS / ANTIBIOTICS (Specify) / TETANUS / IV FLUIDS
DIRECTIVES MÉDICALES / ANTIBIOTIQUES (Spécifier) / TÉTANOS / IV FLUIDE

b(6)-2

[redacted] MAJ

DATE/DATE (YYMMDD) 03/4/03

16. DISP
DISPO

TO DUTY / RETOUR À L'UNITÉ

/ EVACUÉ

DECEASED / DÉCÉDÉ

TIME / HEURE 0520

17. RELIGIOUS SERVICES / SERVICES RELIGIEUX

☐ BAPTISM / BAPTISÉ
☐ ANOINTING / ONCTION
☐ CONFESSION / CONFESSION
☐ PRAYER / PRIÈRE
☐ COMMUNION / COMMUNION
☐ OTHER / AUTRE

CHAPLAIN / CHAPELAIN

DD Form 1380, DEC 91 (Back)

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF / **2. LOCATION** (State or Country Code.)

1	2	3	4	5	6	7	8
A	1	1	D	1	▨	I	Z

3. REGISTER NUMBER

9	10	11	12	13	14	15
[redacted]						

NAME (Last, First, Middle Initial): EPW [redacted] b(6)-4

4. PAY GRADE

16	17

5. SEX

18
m

6. DATE OF BIRTH (YYYYMMDD)

19	20	21	22	23	24	25	26

7. AGE AT ADMISSION

27	28	29
3	0	y

8. RACE

30
Z

9. ETHNIC BACKGROUND

31
9

RELIGION: unk

10. LENGTH OF SERVICE

32	33	34

ETS: N/A

11. FMP

35	36
9	9

12. SOCIAL SECURITY NUMBER

37	38	39	40	41	42	43	44	45
[redacted]								

ORGANIZATION (Active Duty Only): N/A

13. MARITAL STATUS

46
u

HOUR OF ADMISSION: 0915

BRANCH / CORPS: N/A

14. FLYING STATUS

47	48	49

15. BENEFICIARY CATEGORY

50	51	52
K	7	8

16. ZIP CODE OF RESIDENCE

53	54	55	56	57	58	59	60	61

17. UNIT LOCATION (State or Country Code)

62	63

18. MOS

64	65	66	67	68	69	70

19. TRAUMA

71

PREV. ADMISSION YEAR ☒ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION

72
0

WARD: ICU2

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted] b(2)-2

21. TYPE OF DISPOSITION

73	74
5	0

22. MTF TRANSFERRED TO

75	76	77	78	79	80

23. DATE OF DISPOSITION (YYMMDD)

81	82	83	84	85	86
0	3	0	7	0	6

24. CLINIC SVC - ADMITTING

87	88	89	90
A	B	A	A

25. MTF TRANSFERRED FROM

91	92	93	94	95	96

26. DATE THIS ADMISSION (YYMMDD)

97	98	99	100	101	102
0	3	0	7	0	3

27. LOCATION OF OCCURRENCE (Battle Casualty Only)

103	104

28. MTF OF INITIAL ADMISSION

105	106	107	108	109	110

29. DATE INITIAL ADMISSION (YYMMDD)

111	112	113	114	115	116

FOR LOCAL USE

Dx: S/P GSW chest

Dx 875.0 E991.2 Proc: 54.11

860.5 54.11
E991.2

Inj Trauma
450 1

b(6)-2 [redacted]

ADMITTING OFFICER [redacted]

SIGNATURE OF ADMITTING CLERK b(6)-2

Dr. [redacted] PFC, 91G10

DA FORM 2985, MAR 90

MEDCOM - 12979

INPATIENT TREATMENT RECORD COVER SHEET

F of this form, see AR 40-400; the proponent ager TSG

b(6)-4

1 REGISTER NUMBER [redacted]	2. NAM irst, MI) HVD EPW # [redacted]			3. GRADE EPW	ADMISSION REMARKS
4 SEX M	5. AGE 47	6. RACE Iraqi	7. RELIGION — b(6)-4	8. LENGTH OF SVC —	9. ETS —
10. PREVIOUS ADMISSION NO					
11. FMP 99	12. SSN [redacted]		13. ORGANIZATION —		14. WARD ICU 3
15. FLYING STATUS —	16. DSG —	17. BEN K78	18. BRANCH/CORPS —	19. UIC/ZIP —	20. TYPE CASE WIA
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct from ER			22. HOURS OF ADMISSION 0929	23. CLINIC SERVICE ABMA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE unk		25. TYPE DISPOSITION 03	26. DATE OF DISPOSITION 17 OCT03		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) unk		27b. TELEPHONE NO. unk	28. DATE OF THIS ADMISSION 3July03	ADMITTING OFFICER DR. b(6)-2 [redacted]	
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] b(2)-2			30. DATE OF INITIAL ADMISSION	32. OF WHOLE BLOOD/ COMPONENT TRANSFUSED	

SELECTED ADMINISTRATIVE DATA

☐ Check If Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: STSG

	Proc.	Dx:
	86.22	946.3
	93.57	946.2
	38.93	948.10
	86.69	453.8
	86.09	038.9
	86.63	998.89
	39.98	E825.1
	86.28	E924.8
	86.59	E958.8
	84.02	

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	3.5 mths	3.5 mths

Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

SIGNATURE OF ATTENDING MEDICAL [redacted]

[redacted] MEDICAL RECORDS OFFICER b(6)-2

FORM 3647, MA [redacted] EDITION OF [redacted] OBSOLETE

USAPPC V1.10

b(6)-2

MEDCOM - 12980

INPATIENT TREATMENT RECORD COVER SHEET

For use of this form, see AR 40-400; the proponent ager TSG

1 [redacted]	2. [redacted] ast, First, MI)					3. GRADE NA	ADMISSION REMARKS
4 M	5 UNK	6 UNK	7 UNK	8 NA	9 NA	10. PREVIOUS ADMISSION NO	
11 FMP 99	12 SSN [redacted]	13. ORGANIZATION NA b(6)-4				14. WARD ICW1	
15. FLYING STATUS NA	16. DSG	17. DEPT./BEN NA	18. BRANCH/CORPS NA	19. UIC/ZIP		20. TYPE CASE NBI	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct From Emt				22. HOURS OF ADMISSION 1000	23. CLINIC SERVICE ABAA		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE UNK			25. TYPE DISPOSITION 24		26. DATE OF DISPOSITION 10/16/03		
27a ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) UNK			27b. TELEPHONE NO. UNK		28 DATE OF THIS ADMISSION 9/6/03		ADMITTING OFFICER b(6)-2 Dr [redacted]
29 NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] b(2)-2					30. DATE OF INTIAL ADMISSION 9/6/03		32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

SKIN GRAFT HEELS
CLOSURE BUTTOCK WOUND

35. Total Days This Facility

a ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	22	22

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	2	2

SIGNATURE OF AT[redacted] [redacted]	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER [redacted]

DA FORM [redacted] EDITION OF 1 AUG 78 IS OBSOLETE [redacted] USAPPC V1.10

b(6)-2

MEDCOM - 12981

MEDICAL RECORD	**ABBREVIATED MEDICAL RECORD**

PERTINENT HISTORY, CHIEF COMPLAINT, AND CONDITION ON ADMISSION *(Enter date of admission)*

47 yo ~~[illegible]~~ 1331 male states he was picked up by American soldiers 0200 2JUL03 he states he was stripped down and placed in HUMVEE. The hot metal in the Humvee caused his burns. Also He develope Ⓛ leg swelling at home 12 days Ago → to some theater Asset (medical) treated & transferred here.

NKDA PMH Asthma med Proventil PSH Ø ROS neg

PHYSICAL EXAMINATION

NCAT A&O×3

Neck cl

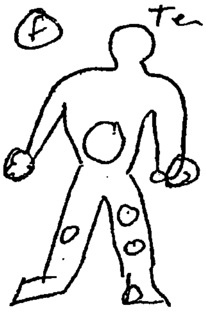
Chest CBTA

Car RRR 2+ PP in All ext

Abd NABS ND soft NT

GU WNL

ext Ⓛ leg swollen and ⊕ Tender to palpation



~10% BSA Deep second Degree Burn.

PROGRESS *(Enter date of discharge and final diagnosis)*

A/P ① DVT c̄ phlegmasia → Lovenox 90mg SQ BID

② Burn → dressing Δ, IVF,

b(6)-2

[redacted]	DATE 3JUL03	IDENTIFICATION NO.	ORGANIZATION
PAT… d or written entries give Name last, first, … rade; date; hospital or medical facility)		REGISTER NO.	WARD NO.

[redacted]

b(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
USAPPC V1 00

32 4/6

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	47 y/o ♂ presents c̄ SOB & wheezing.
02Jul03	States thru interpreter he is in pain due
0400	to burns on body. Prior to arrival @ our
BP 115/76	facility pt received 6 puffs of Ventolin.
P 128	Pt placed on O2 sat ↑ 98%. ↓ wheezing.
R 48	Course breath sounds. Pulse 140. Alert & oriented X3.
T 98.6	Burns/wounds as follows –
Osat: 92	—— Right leg mid thigh approx 9 X 3.5 area,
	Knee abrasion & 2X4 area to lower leg. Heel
	skin 99% off & was removed. Area was circular
	hard black skin approx 2X3. Right hand palm black
NKDA	—— Left leg mid thigh approx 5X6 area, 2X2 area
	to Knee. Heel skin 99% off - removed. Area was
Asthma	3X3 circular hard skin/black. Ⓛ hand with
Ventolin	peeling skin.
TIME 0515	—— Buttocks burned area - not treated.
T: 98.4	Request evaluation of wounds & pain
P: 105	management [redacted]
SpO2: 99	@ 0548 10mg Morphine Admin IM 91W3P SGT
B/P: 110/73	@ 0620 4mg MSO4 IV
	b(6)-2
Resp: 20	

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.

HVD [redacted]

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

MEDCOM - 12983

b(6)-4

ME [redacted] | FIRST NAME | MIDDLE INITIAL | ID NUMBER

ATE	NOTES
13 JUL 2000	Patient up to bedside commode c̄ minimal assistance. Sat on BSC for approximately 1 hour. Had semiformed dark brown stool. - Patient assisted back to bed. [redacted] /AN
2200	T100^{4}. Patient sleeping. [redacted] LT/AN
14 JUL 0000	Patient sleeping VSS [redacted] LT/AN
0100	Patient awake complaining of pain. MSO4 4mg given. [redacted] /AN
0200	T101^{5}. Tylenol 650mg PO given. will monitor. [redacted] /AN
0400	T98^{8}. VSS. [redacted] /AN
0500	Report given to nurse. [redacted] LT/AN
0530	Received report + assumed care of Pt. T-99.2, VSS, will monitor. [redacted] 91WMA
0800-0930	dressing Δ started @ 0800, Pt medicated τ̄ Ketamine, Fentanyl, + Versed. Pt tolerated well. Old dressings removed + burns cleaned c̄ hibiclense + rinsed thoroughly c̄ bulky dressings applied. Finished change @ 0930, will continue to monitor. [redacted] 91WMG
1200	Pt lying in bed sleep + appears to be resting comfortably @ this time. VSS, will continue to Monitor. [redacted] 91WMG
1400	Pt remains asleep. VSS T. 101.9 Received Tylenol @ 1230 for Temp. Will cont to monitor for Δs [redacted] SFC
1500	Patient OOB to chair. Remains in stable condition. Conts to complain of pain when moving. Difficulty standing. Bil edema to + extrem [redacted] ace wraps c̄ dsg intact. Will cont c̄ care. [redacted] SFC
1700	Report given to Nightshift. [redacted] 91WMG.

b(6)-2 AN

ME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

ATE	NOTES
15JUL	Brief op Note
	indication Full thickness Burns
	Surgery Burn wound debridement
	and STSG
	Surgeon [redacted] b(6)-2
	Anest GETA
	Fluids - EBL 450 2u PRBC
	Procedure - Debridement of all wounds
	STSG Donors - Abd, (R) thigh, (L) calf
	Applications - Abd (B) thigh
	Vac to Abd
	No comp. [redacted]
16JUL	Surgery
Lovenox	No events POD # 1 STSG b(6)-2
Feeding	VSS Tm 100.6 HR 110's UO ~80 cc/h
Albumin	Chest CBTA
	Abd - ND soft Dressing sucked Down.
	NABS.
	8.7 >—< 329 29
	A/P Doing well will ✓ STSG @ Day #3.
	stopped Abx for Pneumonia [redacted]

b(6)-2

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES b(2)-2
16 OCT 03	DISCHARGE NOTE [redacted]

LTC [redacted] MD

DOA 3 JUL 03 b(6)-2

DOD 17 OCT 03

HOSPITAL COURSE: Patient transfered from southern medical facility with multiple burns in conjunction with swelling of (L) leg suggestive of a Deep venous thrombosis. Initially patient treated with Silvadene based wound care and anticoagulation. Eventually he was taken to the operating room multiple times to complete skin grafting of his arms, abd, thighs and legs. Finally, he required excision of two large eschars of his bilateral heels. These were treated after appropriate granulation development with full thickness grafts from his buttock. Unfortunately his course was complicated by the right buttock hematoma and need of drainage and open wound care. This was subsequently closed leaving a moderate wound continuing with dressing changes now. His (R) hand required amputation of his finger.

(Cont)

STANDARD FORM 509 (REV. 5/1999) BACK
USAPA V1.00

Final diagnosi

① DVT (R) calf
② multiple scald burns to arms, abd, thighs, fee and legs
③ buttock hematomi
④ Amputation (R) hand-finger/thumb

Plan Con't dressing changes
Percocet 1-2 PO q4° PRN pain
F/u as needed.

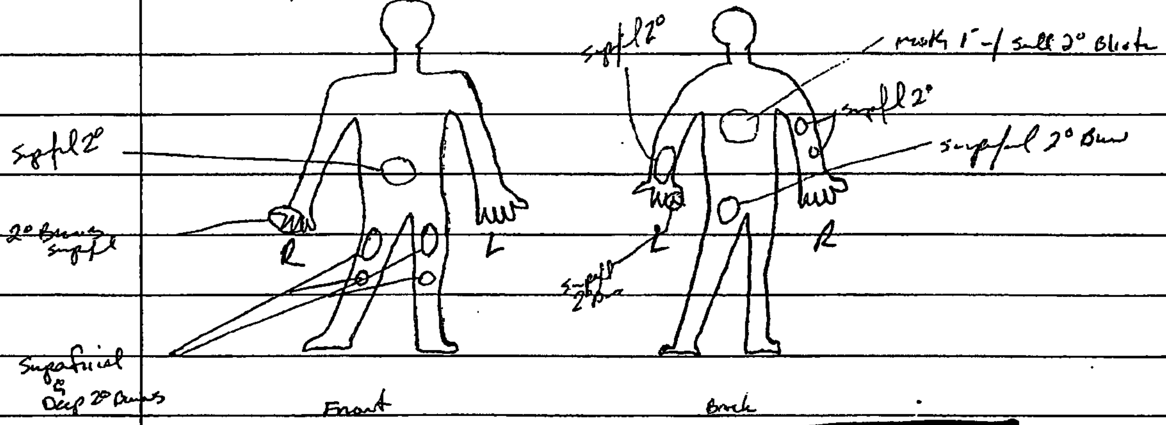
[redacted] b(6)-2
RUTCM

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
02 July 03	S) 47 y/o HVD brought to Aid Station by 115th MP. PT speaks English. He states
0600	he was captured at 0030 this AM and placed in a vehicle that got very Hot on the
PMHx	drive over here causing his burns. He states he was not exposed to Flames.
Asthma ØDM ØMI	He states he has no difficulty Breathing. He states he had no burns on his body
ØHCD	before he was placed in the truck. Ø Hx of poor wound healing
PSHx	O) A&A in Mild/moderate distress
Ø	Vitals, see next page - mild Tachy otherwise wnl
NKDA	HEENT: Ø Burns Ø Singed Hair Ø carbon deposits in oropharynx/nasal phar
MEDS Albuterol MDI	Lungs CTA Ⓑ c/o Rales, rare wheezing that clears
	Heart RRR ØMRG
FHx (+) TOB 3 ppd	Abd - NABS Ø peritoneal signs
(+) ETOH last drink 2 weeks	Ext - MAEW ØCCE pulses x 2 Ⓑ x 4 Ext.
	Skin - Ø circumferential Burns



ONE [redacted] b(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DE[redacted]	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.

HVD# [redacted] b(6)-2

[redacted]

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
02 July 03	(A/P) pt has primarily superficial 2° Burns w/ 2 small areas of Deep 2° Burns
	on (B) Thighs (Ant), Total BSA Burned is ~10%
	Patient might require skin grafts to thighs but will observe for a few days
	See - orders [redacted]
	Need to Report to CID CPT MC
02 July 03 0800	CID notified & will be here at 1800 for dressing Δ. D(u)-2AM
	[redacted]
02 July 03 0830	Pt admitted Pt Hold. 2 18g A (R) AC & (L) FA Sodium
	Chloride 9%. Tylenol 650mg & Aciphex given. Blood
	Test drawn. Foley draining dark yellow urine.
	Dressing Δ done @ 0600 to both arms, Thigh, knee
	& Bottom of feet & abdominal area. [redacted]
1010	MSO4 2mg given for pain
10 58	BP-125/77 P-79 SpO_2-93 R-24 T-98.4
13:00	pt. given 600mg Tylenol po
15:00	BP-125/77 P-77 SpO_2-95 R-20 T-98.6
19:44	BP 109/69 P-86 SpO_2-93 R-24 T-99.6. pt. given 650mg Tylenol
	pd [redacted]
23 06	BP-113/74 P-98 SpO_2-94 R-24 T-101
3 Jul 03 3 06	BP-116/69 P98 SpO_2-94 R-20 T-101
308	Pt. given 650mg Tylenol po
0545	Pt given 2mg MSO4 before dressing change [redacted]
	pain except finger @ this time
600	Dressing change hands, feet, both legs, both arms-
	abdomen, lower back buttox.
700	BP 135/77 P-104 SpO_2 89 R-28 T-100.8 pt. giv. 650mg Tylenol po [redacted]

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NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
3 JUL 03 8:00	pt. given unasyn 3g IV [redacted]
0801	20mg Aciphex PO given [redacted] SPC 91WM6
	b(6)-2
	Transfer Note
Ø3 July Ø3 0830	S) patient states that he is cold & is shaking. states pain & swelling in (L) leg.
	O) vitals this AM 135/77. P=104 SaO2=89%, RR=28 Tc=100.8 Tmax 101
	Gen patient w/ rigorous chills A&A in mild distress, breathing comfortably & speaking in
	full sentences
	HEENT: Ø JVD
	Lungs mostly clear to auscultation w/ (B) lower field [illegible]/Exp wheeze good BS (B)
	Heart mild Tachy Regular rhythm Ø m/r/g
	Abd mild LUQ TTP over lower Ribs 2° to Being Hit in This area, NABS Ø peritoneal signs
	Ø Spleen palpated Ø Hepatic pain on palpation
	GU: Foley w/ good UOP ~50cc/hr
	Ext LLE is Edematous & has pain in medial posterior Aspect of thigh (+) Homans
	Skin see detailed ~~[illegible]~~ of drawing of Burns. Blisters now present due to [illegible]
	deep 2° Burns to (B) Thighs Improve but will probably Require grafting
	Labs 130 | 104 | 13 / 4.0 | [illegible] | 1.0 < 94 4/14 17/50 WBC = 13.2
	A/P 1) ~10% BSA Burns mostly superficial 2° Burns but 2 deep 2° Burns which will most
	likely require grafting & wound care although wounds continue to Improve
	2) Sepsis/Bacteremia: patient did not Receive Unasyn as ordered due to Nursing overlooking
	order. unable to get Blood Culture, unasyn 3.0g given this AM will Require
	close monitoring in ICU setting

over

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 - 12990

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
03 July cont	3) probable DVT. w/ Positive Homans & contralateral Edema. will need Doppler US & Anticoagulation
	4) Transfer to 28th CASH [redacted] b(6)-2
	5) CID investigation ongoing!

STANDARD FORM 600 (REV. 6-97) **BACK**

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:AL RECORD | PROGRESS NOTES

E

Received report from previous nurse, pt resting [redacted]

10 Jul comfortably. VSS will continue to monitor [redacted] WT/AN

0500

10 Jul 0600 Pt to OR accompanied by anesthesia [redacted] WT/AN

0830 Pt back from OR. VSS sats low 90's placed on NRB [redacted]
Sats ↑ 97%, will wean O2 as tolerated. [redacted] WT/AN

1200 Pt in RA 97%, 2U PRBC transfused, will draw post transfusion CBC, Pt encouraged IS q1° X 10 (3 Balls), Central line dressing changed, Foley care done, Barrier cream applied, TF restated @ 50 cc/hr [redacted] WT/AN

1400 TF stopped, Pt c/o abdominal fullness, Denies urgency for BM. BS active X 4 quad, Pt drank glass [redacted] through straw, VSS will continue to monitor [redacted] WT/AN

1600 20 mg lasix IVP given [redacted] WT/AN

b(6)-2 AN

SHIP TO SPONSOR | SPONSOR'S NAME | SPONSOR'S ID NUMBE (SSN or Other)

LAST | FIRST | MI

SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

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

REGISTER NO. | WARD ICU3

PROGRESS NOTES
Medical Record

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

[redacted]

b(6)-4

b(6)-4

ME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
[redacted]			

ATE	NOTES
12JUL 2330	Changed Abd drsg. Reapplied Silvadene and Burn dressing. Did foley care. —— [redacted] 1LT/AN
13JUL 0100	Patient sleeping in bed. VSS. Will continue to monitor. —— [redacted] 1LT/AN
0300	Patient restless. States pain to abd. Give MSO4. Will monitor. —— [redacted] 1LT/AN
0500.	Patient resting in bed c̄ HOB ↑. Alert. Lungs CTA x̄ inspiratory wheezes that clear c̄ neb tx. ST, generalized edema to BLE. BS ↓, NGT clamped @ 0000 13JUL, Ø BM this shift. Foley to gravity draining light yellow, clear urine s̄ sediment. Drsg to burns CDI. BLE elastic wrap. VSS. Report given to nurse. —— [redacted] 1LT/AN
0500	Received report from previous shift. Pt awake c̄ Ø s/s of pain / discomfort. LR infusing @ 50cc/h. TF on hold due to scheduled surgery today. NPO since 0200 x̄ meds c̄ sips of H2O. Will cont. care. —— [redacted] 1LT/AN
0600	Flushed Ⓡ IJ central line c̄ 3cc heparin. Explained POC for the day. Pt acknowledges understanding. Will cont. care —— [redacted] 1LT/AN
0730	Pt requesting to go to bathroom. Moved pt to BSC c̄ assistance. Pt appears to have more strength than previously. Pt able to move Ⓡ leg and stand up straight c̄ support. Pt had one watery diarrheal episode. Cleaned pt and prepared pt for OR. Placed pt on stretcher c̄ anesthesia. Accompanied pt to OR for drsg Δ [redacted] 1LT/AN

b(6)-2

MEDCOM - 12993

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:AL RECORD | PROGRESS NOTES

NOTES

12 July 03 0100 Pt took dressing off completely Ⓛ arm. Verbalize wanting to clean it himself but unable to do it. Cleaned wound redressed c̄ Silvadene, pt c/o pain, refuse to do the other arm. Pt is not scheduled for dressing change until AM under conscious sedation. Made NPO p̄ MN. Pt c̄ intermittent disorientation at night. —— [redacted] AN b(6)-2 AN

0400 Slept from 0200 to 0400 non-interrupted. Hiccups resolving, no hiccups noted throughout the night. Thorazine converted to p.o. last dose @ 2000. VSS, foley c̄ 5 amber colored urine [redacted] /n

12 Jul 03 1000 Received report from previous nurse @ 0500 pt. sleeping comfortably. Bilateral insp. wheeze, .5cc/3cc NS albuterol neb given → CTA bilaterally. Conscious sedation for dressing change: 100 mg Ketamine, 250 mg fentanyl, 8 mg versed, 50 mcg/hr fentanyl patch intact, tolerated well, ace wrap to Ⓛ leg. TF restarted @ 50 cc/hr, BS active x 4 quads, tolerating sips of water, 96% on RA, Bacitracin to meatus, no c/o at this time. will continue to monitor [redacted] LT/AN.

1100 addendum to previous entry: 0.2 mg robinul given prior to conscious sedation [redacted] LT/AN

12 JUL 1200 Reported received. Patient in bed c̄ HOB ↑ — [redacted] /AN

1830 Assessment completed. — [redacted] LT/AN

2000 Patient resting in bed. — [redacted] LT/AN

SHIP TO SPONSOR	SPONSOR'S NAME LAST [redacted]	FIRST	MI	SPONSOR'S ID NUMBER (SSN or Other)

SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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. ICU 3

EPW [redacted]

b(6)-4

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUC

:AL RECORD | PROGRESS NOTES

E | NOTES

13JUL03 0900 Received pt from OR via stretcher. Pt on O_2 4L via FM. O_2 sats 100%. Transferred pt to bed. Pt appears to be disoriented. Oriented pt. Will cont. care [redacted]

1030 Pt c/o pain in stomach and Ⓛ arm wounds Gave MSO_4 III mg IVP. Pt appears to be more calm. Resting quietly. Started TF @ 75cc/hr and gave pt. sips of water. Will cont. care [redacted]

1200 Pt resting quietly. Pt requesting to talk to family. Attempted to get home phone number c̄ Ø success. Ø needs expressed @ this time. Δ'd central line drsg using sterile technique. Will cont. care. [redacted]

1400 Pt completed IS 10x throughout the day. Pt resting quietly. Will cont care. [redacted]

1600 Pt temp 101^3. Dr. [redacted] notified. Gave tylenol 650 mg po. Will cont to assess temp. [redacted]

1700 Gave report to night shift. [redacted]

1700 Received report from nurse. [redacted]

1730 Assessment completed. [redacted]

1900 T 100^3, will monitor. Resting in bed. [redacted]

SHIP TO SPONSOR | SPONSOR'S NAME | | | SP[redacted] (ISSN or Other)
LAST | FIRST | MI | b(6)-2 AN

SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

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.

[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

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

All b(6)-2 unless noted differently

MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
15 July	(1730) MSO4 5mg IVP given by MAJ Neumen for c/o surgical discomfort. Resting s̄ [redacted] distress s̄ c/o. —— [redacted] 91WM6
15 July 03	(2200) PO med + IVPB vancomycin given per Rx. TL IJ remains patent. Site s̄ adverse s/sx. Retain PO intake —— [redacted] 91WM6
16 July 03	(2400) Resting s̄ acute episode noted. —— [redacted] 91WM6
16 July 03	(0400) Initial assessment unchanged. Blood specimen from distal port (R) TL IJ. sent to lab for CBC + met 8. No adverse effects noted from procedure [redacted] 91WM6 —— [redacted] 91WM6
16 July	(0515) Dobhoff Jevity feed turned off in prep for pt conscious sedation procedure for drsg Δ. Pt care report given to CPT [redacted]. Pt awake c/o "gas". HOB ↑ + pt turned for position Δ. VSS [redacted] 91WM6
16JUL03 0630	NN: PHYSICAL ASSESSMENT COMPLETED SEE FLOWSHEET. WOUNDS: BILAT UPPER EXT DRESSINGS CDI c̄ KERLEX AND ACE WRAP ON (L) ARM. →

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)

[redacted]

b(6)-4

REGISTER NO | WARD NO

PROGRESS NOTES
Medical Record
STANDARD FORM 509
Prescribed by GSA/ICMR FIRMR

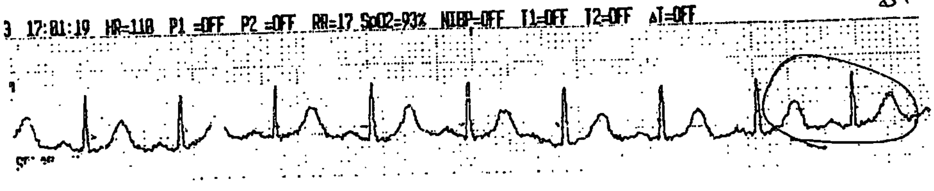
LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
15 July 03 @ 0620	pt assessment complete WNL see DA Form 4700 op 375 for details VSS report recieved From SSG Wright pt resting comfortably in bed @ this time. IV LR @ 50 cc/hr infusing via Alaris Pump to triple-lumen ® IJ. dobhoFF on hold For OR. procedure Dressing CDI pt shows no signs of acute distress @ present will continue to monitor per doctors orders —— [redacted] PFC 9/wm6
@1440	pt resting quietly @ this time VSS Jevity @ 128cc/hr LR @ 50 pt taken to or for dressing Δ grafting with ⊕ results no problems @ present will continue to monitor [redacted] [illegible]
@1515	pt VSS c̄ temp of 101.5 tylenol given per doctors orders will recheck temp in 30° —— b(6)2 [redacted] PFC [illegible]
~~@1615~~ 15 July (1700)	Pt Care Report Recieved from PFC [redacted] Pt resting supine in Bed c̄ HOB low fowlers. Pt c̄ No Acute distress voiced/noted. Pt Requesting staff assistance to contact "Brother". Abdomen firm, obese c̄ ⊕ hypoactive BS in (4) Quads. Postop graft site of ventral abd area covered c̄ STSG dressing (occlusive) to 125mmHg suction via PDA. suction machine. Serosang drainage noted. BLE pedal pulses dopplerable c̄ ⊕ density digits warm, mobile c̄ brisk cap refill. Bilat Anterior thigh donor sites c̄ staples intact to secure mesh dressing. Sites edematous but pink. Ace wrap intact to LLE. —— [redacted] JMG b(6)-2

RATE 110

PR .16

QRS .04



3 17:01:19 HR=110 P1 =OFF P2 =OFF RR=17 SpO2=93% NIBP=OFF T1=OFF T2=OFF ΔT=OFF

MEDCOM - 12997

MEDICAL RECORD | PROGRESS NOTES

DATE | NOTES

17 July 03 Dressing to the hands changed. Medicated c̄ MSO4 10mg
2030 c̄ Versed 5mg IV. Pt remained awake, continue to c/o pain
even after dressing change. Monitor pain once rested
from dressing change. ——→ [redacted] Maj / AN

2200 Pt observed to be asleep @ this time. b(6)-2
2400 Pt awaken c/o pain on the graft & donor site, request
to turn off vac. Explained suction & rationale for using
did not understand but agreed. Gave MSO4 5mg for pain.
UO continue to be adequate & becoming clearer from the [redacted] Maj/AN
early output. No other significant issues ——

0215 Pt had ↑ small amt. of mucousy stool dressing to the buttocks
changed c̄ Silvadene, site c̄ adequate vascularization
0300 Medicated c̄ MSO4 5mg IVP for c/o buttocks wound and
leg pain —— [redacted] /AN

b(6)-2

0700 NN PT RESTING QUIETLY IN BED VSS NSR A-FEBRILE.
UOP > 60mL/HR. TF OFF FOR DRESSING Δ. — [redacted]
1030 NN DRESSING Δ; PT TOLERATED DRESSING Δ WELL c̄ SEDATION
PROVIDED BY NURSING STAFF. ABD GRAFT SITE WOUND-VAC Δ'd
APPLIED 4X4 MOISTENED c̄ SILVAMYLON SOLUTION AND MONT STRAPS
APPLIED. PULSES INTACT X4 EXT. VSS. WILL CONT TO MON [redacted]

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME LAST | FIRST

DEPT./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.

[redacted] b(6)-4

ICU-3

[redacted] b(2)-2

PROGRESS NOTES
Medical Record
STANDARD FORM 509

MEDCOM - 12998

AUTHORIZED FOR LOCAL REPRODUC

:AL RECORD	PROGRESS NOTES
E	NOTES
13Jul03	Surgery
	No events over night
	VSS AFeb (Base HR 105-110) UO >200cc/h
	~~Exam~~
	Neuro - AxO today
	Chest CTA
	Abd Benign
	Wounds - All burns will Require more Debridement
	~~will Pla Deb~~
	A/P Doing well. systemically Better c̄
	good dressings, and improved mental
	status will plan Debridement & Graft
	Wed or tomorrow or Tues.
	[redacted]
	b(6)-2

SHIP TO SPONSOR	SPONSOR'S NAME LAST	FIRST	MI	SPONSOR'S ID NUMBE (SSN or Other)

SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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.

[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
18 July 03	Received report from ongoing shift. Wound vac off
1800	Abd dressing enforced c̄ Montgomery strap. TLC, Ⓡ SC
	intact, LR @ 50cc/hr. Dobhoff @ 128 cc/hr ↑ from last shift.
	Abd distended but pt denies abdominal cramps. BS Ⓟ.
	Foley intact draining clear yellow urine, scrotum c̄ edema
	Beginning T101.1. Monitor ↑ temp this shift. Otherwise VSS.
	Pt in bed sleeping but easily aroused — [redacted] Maj/AN
2330	Dressing changed to UE, pt given MSO4 10mg, Versed 5mg c̄ Fentanyl
	100 mcg before + during dressing change. Pt continue to scream
	during dressing change + stop when procedure is over. May b(6)-2
	recommend changing dressing once a day to include hands or
	to administer conscious sedation if dressing is warranted.
	b(6)-2 [redacted] Maj/AN
0300	Pt awoken from sleep p̄ dressing change earlier. Had ↑ brownish
	blood tinged stool (? from wound vs bowels) moderate amt. TF turned
	off @ 0200. Pt continue to c/o pain to graft sites — [redacted] Maj/AN
19 JUL 03	NN: PT HAD BM VIA BEDPAN. BM WAS MED SOFT, BROWN. VSS
0700	FEBRILE 101.8 TYLENOL GIVEN PRN, IS UTILIZED, WILL CONT TO
	MONITOR — b(6)-2 [redacted] CPT/AN
0730	NN: PHYSICAL ASSESSMENT COMPLETE. NEURO: A/O X3 PLEAS/COOP
	FOLLOWS COMMANDS MAE X4 GENERALIZED WEAKNESS NOTED.

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.

[redacted] b(6)-4

[redacted]

b(2)-2

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)

MEDCOM - 13000

DATE	NOTES
0730	VN CONT'D: PUL: LUNG SOUND CLEAR BILAT APEX, DIMINISHED Ⓡ BASE
	CRACKLES Ⓡ BASE. USES IS WELL. CV: $S_1 S_2$ NOTED SR/ST 90-110'S c̄
	NO ECTOPY NOTED. PULSES $\overset{+3\ +3}{+2\ +2}$. GI: BS ⊕ X4 QUAD SOFT TENDER TO
	TOUCH. DOBHOFF TF NASAL OFF FOR CONSCIOUS SEDATION/DRESSING Δ.
	LAST BM 19JUL03 ~~THU~~ AM. GU: FOLEY TO GRAVITY DRAINING CLEAR YELLOW
	URINE > 60ML/HR. Ⓡ TLC INFUSING LR @ 50ML/HR. NO S/S OF INFILTRATION
	OR INFECTION. WOUNDS: BILAT UE DRESSING CDI, ABD GRAFT SITE DRESSING
	MOIST AND INTACT, ABD DONOR SITE DRY AND INTACT. BILAT THIGH DRESSING
	CLEAN MOIST AND INTACT, BILAT LE DRESSING CDI. BACK DRESSING INTACT.
	PT RESTING QUIETLY IN BED PAIN CONTROLLED c̄ MSO4, WILL CONT TMM — [redacted]
19Jul03	Surgery POD#4 STSG
0830	~~Tm to~~ No events
CR	Tm 101.3 | 98.6 HR 90's-110 BP 110's/60's
fentanyl	uo 90-200 cc/hr. SAT 99% RA.
Lovenox	Chest CTA
Albumin	Abd Benign
	Wounds Ready for grafting
	9.1 > 30.6 < 959 132 | 101 / 14 ; 4.2 | 25 \ 119
	A/P Doing well will plan Additional STSG
	to knees Ⓡ calf & Ⓛ Arm. tomorrow.
	NPO p̄ mn
	T&S

STANDARD FORM 509 (REV. 5/13)

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
18Jul03.	Surgery POD #3 STSG
IVF	No events
Ketamine	Tm 100.9/100.2 HR 90's. UO 90-150 cc/h
Fentanyl	Chest CBM
Versed	Abd Benign
Lovenox	wound, - excellent take of Abd wound. 88-90%
Albuterol	inconclusive take on (B) thigh wounds but would graft stuck but not as pink
	7.5 > 29.6 < 886 133 ~~[illegible]~~ | 102 | 13 < 141 / 4.2 | 26
	A/P Doing well will cover grafts for 2 Additional Days. and Assess final take will plan further grafting on Sunday
	[redacted]
	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

[redacted]

b(6)-4

PROGRESS NOTES
Medical Record
STANDARD FORM 509 (REV 5-1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)

MEDCOM - 13002

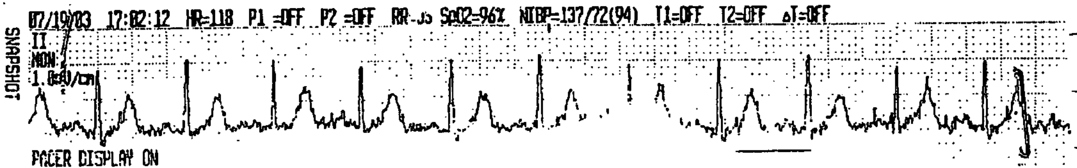
AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE | NOTES

19 JUL 03 NN 1645 — NN: PT C/O BEING COLD AND BEGAN SHIVERING. COVERED PT ē BLANKET AND CHECKED TEMP VIA AUXILLA. TEMP WAS 102.0°F. ADMINISTERED TYLENOL 650mg PO PRN PER MD ORDER AND HAD PT UTILIZE IS. PT HAD UNEVENTFUL DAY OTHERWISE. Δ'D ADD SKIN GRAFT DRESSING AND APPLIED SILVADENE CREAM PER MD. WILL CONT TO MONITOR ——— b(6)-2 [redacted] CRN

19 July (1700) Pt CARE REPORT RECIEVED FROM CPT [redacted].


07/19/03 17:02:12 HR=118 P1 =OFF P2 =OFF RR-- SpO2=96% NIBP=137/72(94) T1=OFF T2=OFF ΔT=OFF
SNAPSHOT
II
MON
1.0mV/cm
PACER DISPLAY ON

19 July (1700) NEURO: Awake, Alert, ORIENTED person, place, time, event At present. Requires OCCASSIONAL REORIENTATION, Place, time + Event. Cooperative/pleasant. PERRLA 2mm ⊕. MAE ē purpose. Active ē turning/Repositioning. Pulmonary: 4L N/C on ē SATS ↑90's. D/C 4L TO RA. SATS maintained At ↑90s. No S/Sx dyspnea. BS [redacted] ē ↓↓ Bases. + occ. Rhonchi. MDI ii puff Albuterol dose given by CPT [redacted]. Pt USES incentive spirometer ē correct demo./Some Prodding.

19 July (2000) SKIN: Skin CARE done per RX. b(6) [redacted] 91WM6

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

[redacted] b(6)-4

ICU 3

[redacted]

b(2)-2

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)

MEDCOM - 13003

DATE	NOTES
19 July (2000) cont	Skin wounds Ⓡ Arm + hand c̄ less Reaction to discomfort than Ⓛ arm + hand. NO sedation/ analgesia for Bilat UE. 5mg IVP MSO4 given by LT Frazier for BLE dressing Δ/ wound care. Pt Quiet s̄ distress p̄ care. Peri care c̄ scrotum erythemic c̄ yellowish matter unable to wash off. Foley care done s̄ event. [redacted] 91WM6
19 July 03	(2000) PIV 18g to Ⓡ anterior forearm placed s̄ incident by SPC Jenkins 91WM6. Ⓡ IJ TL D/CD s̄ incident. CATH Removed c̄ tip intact. — [redacted] 91WM6
19 July 03	(2330) Jevity Ⓣ Dobhoff feed turned off in prep for OR/NPO status in AM. Dobhoff flushed easily + clamped. [redacted] 91WM6
20 July 03	(0315) Tylenol 650mg PO given for Ax temp 101.7. Pt resting quietly p̄ care. [redacted] 91WM6
20 July 03	(03:30) Blood Specimen to lab from Ⓛ ~~FA~~ lateral AC venipuncture for CBC/met 8 [redacted] 91WM
20 July 03	(0510) Pt care Report given to SPC [redacted] Pt awake, alert c̄ episode of Continual asking "What am I doing" Causing need to reorient to Surroundings. Pt Consolable. — [redacted] 91W
0510	Received report + assumed care OF Pt. — [redacted] 91W
0640	Pt Lying in bed sleeping + appears to be resting comfortably @ this time. Assessment complete, VSS. Will Monitor. — [redacted] 91WM
	b(6)-2 All

STANDARD FORM 509 (REV. 5/1999) BACK
USAPA

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
07AUG03 0911	Sitting up by BS in chair. Ø complications noted @ present time. Will continue to monitor. Sgt [redacted]
1222	Pt. back to bed @ present time. Ø complaints voiced. Will continue to monitor. Sgt [redacted]
1417	Resting in bed c̄ eyes opened. Ø distress noted. Will continue to monitor. Sgt [redacted]
1625	Up to chair after BM/urination. MD @ BS. Ø distress noted. Will continue to monitor. Sgt [redacted]
07aug03 1900	pt report recieved @ 1800 by Sgt [redacted] No problems noted @ present will continue to monitor [redacted] PFC 91W
@ 1930	pt VSS pt upto commode to void pt back to bed began to cry for unexplained reasons pt calmed and in bed @ present pt assessment complete see flow sheet No signs of acute distress noted @ present will continue to monitor [redacted] PFC 91W
@ 2145	pt VSS remain stable no Δs in condition pt resting calmly in bed @ present will continue to monitor [redacted] PFC 91W
@ 0200	pt VSS pt dressing to head CDI No problems noted U/A results pending will continue to monitor [redacted] PFC 91W
@ 0525	pt VSS no problems noted @ present will continue to monitor [redacted] PFC 91W
8Aug 0600	Received report + assumed care of Pt. VSS. Will continue to monitor. [redacted] 91WMG
0700	Pt ate almost all of breakfast. Ø ntd distress @ this time. VSS, will monitor. [redacted] 91WMG
1015	Pt ↑ to BSC to void. Appears to be in pain Attempting to urinate. [redacted] 91WMG

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MEDICAL RECORD | **PROGRESS NOTES**

b(6)-2

DATE	NOTES
06 Aug 03 1400	Resting quietly in bed. Ø distress noted. Will contin[redacted] to monitor. [redacted]
1600	Resting in bed c̄ eyes opened. Ø distress no[redacted] present time. Will continue to monitor. [redacted]
1702	F/C D/C'ed per MD'S order. [redacted]
1800.	Report received from ~~CPT~~ [redacted] Sgt- [redacted]. Pt resting in bed quietly. [redacted]
2200.	Pt 1st void 275cc. Drsgs Δ'd to (B) heels. Wounds c̄ beefy red lining, yellow thick tissue inside wounds. Silvadene reapplied and wounds redressed [redacted]
0200.	Pt sleeping in bed. Will cont. to monitor [redacted]
0618 07 Aug 03	Recieved Report from LT [redacted]. Pt resting in bed c̄ eyes opened. Ø distress noted. Ø complaints voiced. Will contin[redacted] to monitor. [redacted]
0644	Percocet Tab ii po for drsg Δ pre-med. Will monitor. [redacted]
0730	Drsg Δ started. 4mg MSO4 given for pain. Will monitor throughout procedure. 0836 Drsg Δ completed. Pt up to BS toilet. Will monitor any S/Sx of distre[redacted]

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.

EPW [redacted]

b(6)-4

PROGRESS NOTES
Medical Record
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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
08 Aug 03 1050	Pt back into bed from BSC c̄ Ø Ntd distress. Voided 450cc clr yellow urine. Pt lying back in bed + appears to be resting comfortably @ this time. Will monitor. [redacted] 91WM6
1300	Pt lying in bed + appears to be resting comfortably @ this time. VSS, will continue to monitor. [redacted] 91WM6
1400-1500	Dressing Δ's performed. Old dressings removed + sites cleaned + rinsed thoroughly. Silvidine applied c̄ bulky dressings. Pt tolerated well. Will continue to monitor. [redacted] 91WM6
1510	Pt to chair after drsng Δ complete. [redacted] 91WM
1630	Pt back to bed @ this time, Ø Ntd complaints. Will continue to monitor. [redacted] 91WM6
08 Aug 03	(1800) Pt care Report Recieved from SPC [redacted] Pt Awake, oriented person, place, event. Cooperative & pleasant s̄ Acute Episode noted/Reported. [redacted]
08 Aug 03	(1900) Fed pt 25-30%. Reg diet c̄ Ø Resistance. Refused Ensure Supplement. Rest in p̄ Care. [redacted] 91WM6
08 Aug 03	(2300) Remains awake, Calm s̄ acute Episode [redacted] 91WM6

RELATIONSHIP TO SPONSOR

SPONSOR'S NAME: LAST | FIRST b(6)-2 A-11 | 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)*

[redacted]

b(6)-4

REGISTER NO.

WARD NO. ICW-3

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
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MEDCOM - 13007

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
09 Aug 03	(0045) MSO4 6mg IVP via PIV 20g to (R) FA by LT [redacted] Pt c̄ ↑ agitation/c/o discomfort p̄ application of Silvadene to B/L Heels. Ambien 10mg po @ 0100 for insomnia given per Rx. Pt resting p̄ care. [redacted] 91WM6
09 Aug 03	(0440) Pt Awake, Alert, Scratching wound on (R) Buttock. (R) Hand (thumb) Bleeding (drsg off.) Pt ↑ agitation, noted disorientation combative. NOTED (R) PIV infiltrated. PIV D/C. Site firm, erythemic s̄ exudate. Pulses palp. CAP Refill <3 Sec. (R) Hand wound redressed c̄ ASSIST. (2) Staff 2° pt combative, Shouting. PIV NOT Restarted Will arrange for day shift nursing to Clarify need for continued PIV access. per Charge Nurse Maj. [redacted]. Pt quiet p̄ care but appears disorie[redacted] Napping @ intervals. [redacted] 91WM6
09 Aug 03	(0545) Pt Care Report given to Sg[redacted] Pt asleep s̄ acute episode @ present. [redacted] 91WM6
09 Aug 03 0600	Received report from Sgt [redacted]. Pt. condition remain stable. B/P 112/65 RR 18 HR 97 Temp 97?. IV out @ present time. Will inform MD [redacted] when rounds are made. Bandage on hands Δ'ed @ 0530 due to wound drainage. Pt. c/o itch, a while. MD to be notified. Will monitor. [redacted]

b(6)-2 All

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
10 aug 03	pt VSS pt transferred to bed #1 s̄ problem pt is calm/comperative
@ 0025	@ present resting quietly in bed pt shows No s/s of acute distress @
	present will continue to monitor throughout Night – [redacted] PFC 91W/M6
10 Aug 03	Receive report from PFC [redacted] Pt. condition remain stable.
0624	Pt. resting in bed c̄ eyes opened c/o being cold. Extra blanket
	placed over pt. No futher complaints. Will continue to [redacted]
	monitor. Sgt
10 Aug 03	Surgery
0800	No complaints tol Po well
	VSS Afeb.
	ex Areas of open wound
	Ⓡ knee, L knee, Ⓡ thumb, Ⓛ palm Ⓑ heels
	will discuss c̄ ortho concerning coverage
	of these areas.
	[redacted]
0943	Percocet tab ii p.o. given @ 0730 for drsg Δ. Drsg Δ
	complete. Pt. up to chair @ present. Will [redacted]
	continue to monitor. Sgt
1221	Pt. continue to sit up in chair. s̄ distress noted.
	Ø complaints voiced. Will continue to monitor. [redacted]
1406	Resting in bed c̄ eyes closed. Ø distress noted. Will
	Continue to monitor
1702	Ø distress noted. Will monitor. Sgt [redacted]
	b(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK
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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
09 Aug 03 1020	Drsg Δ started @ 0800 c̄ MD @ BS. Percocet Tab ii po for pain and Benadryl 25mg po given for itching. Pt. tolerated procedure s̄ complaints. 0945. Drsg Δ completed c̄ Eucerin cream applied to donor sites. Pt. up to Ⓑ chair @ present time. Consumed 70% of breakfast. Morning medication issued as Rx. Will continue to monitor. [redacted]
1023	Pt. c/o sleepiness. Sleepiness caused via medication. Pt placed back in bed due to drowsiness. [redacted]
1145	Resting quietly in bed c̄ eyes closed. Ø Resp. distress noted @ present time. RR 20. Will continue to monitor for S/S of distress. [redacted]
1420	Resting in bed s̄ distress. Will continue to monitor for S/S of distress. [redacted]
1630	Resting in bed c̄ eyes closed. Ø distress noted. Will continue to monitor. [redacted]
09 Aug 03 @1910	pt report recieved from Cpt [redacted] b(6)-2 pt VSS Assessment Complete and WNL pt resting quielty @present No signs of acute distress b(6)-2 noted @ present will continue to monitor througout Night → [redacted] PFC 91WM6

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

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[redacted]

b(6)-4

MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
22AUG03	Surgery
	Feels well
	temp 101 Hrs Afternoon
	wound heels look good Ⓛ ī some poss
	fungal element.
	A/P Doing well Apply silvadene to Ⓛ Heel
	Send UA
	[redacted]
	b(6)-2
23 AUG03	Surgery
	Feels well No complaint
	Tm 101 98.9 HR Am VSS
	Heels ready for Full thickness SSG
	A/P to OR in AM Ortho to take distal Ⓡ
	thumb phalanx off. will give Cipro for Febrile
	UTI (UA ⊕).
	[redacted]
	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

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[redacted]

b(6)-4

MEDCOM - 13011

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
23AUG03	(1020) Assumed care of pt c̄ 0700 p̄ report from night shift. Pt alert, speaking some English. ∅ C/o pain. VSS. Drsgs to legs, arms, hands, chest and back CDI. Ace wraps to feet CDI. Pt able to move all extremities. Skin warm to touch. Pt eating small amount of reg. diet. Pt started on po cipro. Labs drawn and sent to lab this am. Restraint on Ⓛ wrist. Pt resting quietly on Ⓛ side c̄ this time. Will continue to monitor. [redacted] RN
24aug03 1122	Received pt resting in bed, VSS, NPO. Alert and oriented, speaks small amt English. ∅ c/o pain. Drgs to legs, arms, hands, chest and back intact, dry. Hands warm to touch, feet warm to touch. Restraint in place. LSC/AB after medicating w/ ii puffs albuterol. HRR, BS ⊕ x4, abd SNT. ∅ BM so far this shift. Am meds held due to pt going to OR today. Will cont to monitor [redacted]
24AUG03 1940	VSS. AO. Flush colored appearance. ⊕ pulses. DSG's CDI to burns. ∅ c/o pain @ this time. Heels elevated and rotated per routine to prevent decubiti breakdown. NPO p̄ MN for grafting & amputation. LSCLAB. ∅ c/o pain or N/V/D. Resting comfortably. [redacted] RN
25aug03 1110	Received pt in stable condition, VSS, AOx3, NPO for OR. No c/o pain, amb x1 this am, dsgs c/d/i, IV patent + intact, no remarkable findings [redacted]

STANDARD FO (REV. 5/1999) BAC

USAPA V1.0

MEDCOM - 13012

b(6)-2 A11

PROGRESS NOTES

DATE	
27 aug cont's (1920)	intact. Cpt. [redacted] spoke c̄ MD about getting a central line put in. MD gave verbal orders to D/C IV, percocet for pain. (L) Knee drum site cleaned & silvadine applied, wrapped c̄ Kerlix: O2 on by NC @ 2L O² sat now 98%. resp. even & unlabored. drsg to buttocks: ∅ bleeding noted thru drsg. will cont to mon — [redacted] 91WM6
27 aug @2200	* Lovenox given per MD orders. Pt resting ∅ distress noted. VSS. O2 2L NC on. will cont to mon — [redacted] 91WM6
	@2300 – I concur c̄ above assessments – [redacted]
28 aug 03 @0015	Pt emesis x2, (about 100 cc total) clear fluid. will cont to monitor — [redacted] 91WM6
28 aug @0515	Total urine output this shift was 620cc of amber urine. ∅ c/o pain unless touched. does not want any pain meds. will cont to mon — [redacted] 91WM6
28 Aug 1000	VSS Alert & oriented. Anesthesia ~~[illegible]~~ started IV to (R) FH x 1 attempt [illegible] c̄ 10cc [illegible] AM care done. Drsg changed to [illegible]. [illegible] to STSG sites with [illegible] as ordered. [illegible] Bilateral heels intact and to continue [illegible] [illegible]. Voiding clear yellow urine. Tolerating regular diet. HOB ↑30 will continue to [illegible]. Restraints removed and reapplied. will check restraints [illegible]

STANDARD F [redacted]

b(6)-2
A11

MEDICAL RECORD | PROGRESS NOTES

DATE	
27AUG03 1200	(Continued) Heels elevated to clear off bed- to prevent pressure. Will obtain PRBC from Lab and administer as ordered.
27AUG03 ~~1250~~ 1235 1330	Started Blood transfusion @ 1250. VSS @ this time. Rechecked VS @ ~~13~~ 1305 VS remain stable. Per translator Pt denied chills pain or urticaria. Transfusion continues. Vit K 10mg given SQ as ordered. Will continue to monitor closely. b(6) [redacted]
27AUG03 1800	Transfusion complete
27aug @1900	Pt a&ox3, VS: 104/72 R:20 O2 sat 94% P:90 p̄ taking report from day shift. HRRR, lungs CTA(B), productive cough. (+)BS x4 qds. abd is soft, non-tender, burn site on abd open to air. +2 & equal pulses. HCT 30.4 p̄ PRBC transfusion. PT/PTT not done per MD verbal order. MD instructed to give the 2200 dose of lovenox today. Will cont to mon b(6)-2 [redacted] 91W M6 SPC
27aug@ 1920	Pt stated that he was having difficulty breathing. O2 2L NC put on. O2 sat @ 97% p̄ O2. R:22 & even, lungs CTA(B), IV site to (L) bicep area infiltrated, IV D/C'd. catheter (cont)

(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.

H

[redacted]

b(6)-4

PROGRESS NOTES

Medical Record

STANDARD FORM 509 (REV. 7-91)
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PROGRESS NOTES

DATE

29 aug @0550 Pt had soft, brown BM. Pt O2 sat @ 89% p̄ taking some deep breaths & c/s went back ↑ to 97% resp even & unlabored. Pt voided 800cc cyu this shift. IVF LR @ 100 to Ⓡ Arm infusing s̄ s/sx infection/infiltration. Will cont to mon — b(6)-2 [redacted] 91WM6

0550- Eucerin cream applied to healed graft sites. Silvadene c̄ Kerlix applied to open sites. ∅ bleeding noted to buttocks. New drsgs applied to extr. (thighs) & knee). BUN is low: 4) Will cont to monitor — b(6)-2 [redacted] 91WM6

29AUG03 (1115) Assumed care of pt @ 0600 p̄ report from night shift. Pt alert, speaking English. VSS lungs CTA Ⓑ ⊕BS x4 quads. O2 sat 98% on RA. Pt medicated c̄ ii Percs this am for pain c̄ good relief. Pt medicated c̄ 25mg Phenergan IV for nausea this am c̄ good relief. Drsgs to Ⓡ and Ⓛ knees and shins Δd this am. Silvadene applied to sites. moisturizin cream applied to healing graft sites and covered c̄ gauze. Pt medicated c̄ 6mg MSO4 prior to drsg Δs and tol procedure well. Drsg to Ⓡ thumb Δd. Sutures to thumb CDI. ∅ s/sx infection. IVFs infusing into IV in Ⓡ wrist s̄ s/sx infection/infiltration. JP to cont. wall suction @ 125 intact to bilat. heels. Drsgs to heels intact. Pt able to move toes. Cap. refill <3 secs. ⊕ pedal pulses equal bilat. Pt tol sm. amount of reg diet. 2-point restraints in

MEDICAL RECORD | PROGRESS NOTES

DATE	
28Aug	Pt A/Ox3, VSS, HRRR, lungs CTA Ⓑ, ⊕BS x4 quads.
@ 1945	drsg to buttocks c̄ Ø active bleeding noted
	drsg to hands CDI, drsgs to heels c̄ JP to
	wall suction @ 125. Sites to Ⓛ knee cleaned,
	silvadene & Kerlix applied. HOB ↑ 30°. O^2 sat
	@ 97% RA. Ø c/o pain unless touched. Healing
	burn sites open to air. circulation assessed
	+2 pulses, brisk cap refill. 2 pt restraints
	on. Will check circulation frequently. LR @ 100
	infusing to Ⓡ arm s̄ S/Sx infection/infiltration
	Will cont to monitor — [redacted] 91WM6
28Aug03	1955: I concur c̄ above assessment. b(6)-2 [redacted]
28Aug03	Drsg to buttock c̄ Ø bleeding noted. IVF infusing
@2110	circulation assessed. Will cont to monitor —
	b(6)- [redacted] 91WM6 —
@0001	c/o slight pain to Ⓛ extr. ii Percocet given. Will
	monitor for relief b(6)-2 [redacted] 91WM6
@0230	: Orders rewritten on new green & white sht.
	Will let day shift know to clarify orders
	with MD in AM. Pt resting @ this time c̄
	Ø distress noted — [redacted] 91WM6
	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. ICW 1

#[redacted] EPW)

b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
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USAPPC V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
17Sep03 0650	CDI. Drsg to Ⓑ LE CDI. Skin graft areas on Ⓑ LE warm Dry. No s/s of infection noted. Will continue to monitor. —— [redacted] 91WM6
	(1700) I concur c̄ above assessment. —— [redacted]
17 Sep.03 1945	Pt resting in bed, A+Ox3, VSS, LS CTA Ⓑ, ⊕ BS x4, pt ambulated, ∅ c/o pain, heat compress applied to LLE, abd soft flat nontender, dsg's on heels Ⓑ CDI, dsg's on buttocks Δ'd [redacted] where blood tinged, wounds appear ∅ s/sx of infex, dsg on Ⓛ Knee CDI, proper circulation + skin integrity on pts of restraint. —— [redacted] 91W
18Sep03	Pt Awake A&O LS CTA Ⓑ ⊕BS [redacted] ads. S_1 S_2 present. Drsg to Ⓑ LE CDI. Drsg to Ⓡ hand ~~DDI~~ CDI. VSS Denies pain at this time. —— [redacted] 91WM6
18 Sep.03 1840	Pt resting in bed, A+Ox3, VSS, LS [redacted] TA Ⓑ, ⊕ BS x4, dsg's to Ⓛ Knee, heels Ⓑ CDI, ambulates c̄ steady gait, voiding s̄ complications, abd soft flat nontender, ∅ c/o pain @ this time, proper circulation + skin integrity on pts of restraint. [redacted] 91W
19Sep03 [illegible]	Received resting in bed, VSS, AxO3 [redacted] speaking: Drsgs changed: Ⓛ knee w/ silvadene & gauze, ∅ open area, ∅ pus. bilateral butt cheeks w/ gauze, kerlix and [illegible]. Bilat. heels w/ petroleum gauze & kerlix wrap. c/o [illegible] @ this time. SIGS. amb independently

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blw-2 AU

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
16SEP03	(1135) Assumed care of pt @ 0600 p̄ report from night shift. Pt alert, speaking some English. VSS. Pain controlled c̄ Percs/TID motrin. Drsgs to heels, Ⓛ knee, and bilat buttocks Δd this am. Vaseline gauze applied to heels p̄ Bacitracin applied. Silvadene cream applied to Ⓛ knee. Pt applying moisturin to healing graft sites. Pt tol. reg diet well. Voiding s̄ difficulty. Will continue to monitor. [redacted] AW
	(1305) Pt amb to BR s̄ difficulty. Amb in hallway @ this time - gait steady. 0 assistance needed. Will cont. to monitor. [redacted] AW
16 Sep03 1830	Pt resting in bed, VSS, A+O x3, LS CTA Ⓑ, ⊕ BS x4, S1 S2 present, 0 c/o pain, dsg's to Ⓛ knee, heels x2 CDI, dsg's buttocks CDI, pt ambulates s̄ assistance, voiding s̄ complication. [redacted] 91WM6
1835	Proper Circulation + skin integrity a/t pts of restraint. [redacted] 9W
	b(6)-2 [redacted]
17Sep03 0650	Pt Awake A&O Denies pain at this time LS CTA Ⓑ S1 S2 present ⊕ BS x4 quads. Drsg to Ⓡ finger

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.

#[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES DLW-2 AM
21 Sept 03 ~~0800~~	0700 Alert & Oriented VSS Lungs clear. BS ⊕ x4 quad. Abd soft non-distended. Up ~~OOB~~ ad lib to BR. Drsg Bld to bilateral heels and Ⓛ Knee. [illegible] cream applied to STSG. No pain or discomfort voiced or noted [redacted] LTN
21 SEP 03 2108	VSS. Ambulated x1 for 45 min. s̄ difficulty. AO. Dsg's to heels and buttock CDI. Some serosanguinous drainage to Ⓛ & Ⓡ buttock but intact. Applied cream to burned areas by self. Head is shaved. [redacted].
22Sept03	1300 - assumed care of patient @ 0800 - assessment completed. PERRLA, Lungs CTA Ⓑ, resp even-unlabored, NSR, Abd soft nontender, ambulating to latrine, W→D Drsng Δ to Ⓛ knee + Drsng Δ to Ⓛ + Ⓡ Buttock wounds. Drsng to Ⓑ heels. Petrogauze applied. ⊖ s/s of infection. Pt. did not want to perform personal hygiene. Pt. stated he will do it this pm. Pt. currently downstairs talking to CID. [redacted]
22Sep03@1915	Assumed care @ 1800; VSS, pt A&Ox3, ⊕ CMS, NV intact; ⊖ C/o pain or discomfort @ this time; pt OOB to amb in hall x1 for 30 min; dsgs to heels CDI, minimal drainage noted; dsg to buttocks bilat CDI; eucerin cream applied to healing graft sites; restraints in place, ⊕ circulation, ⊖ skin breakdown; cont to monitor [redacted]

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MEDICAL RECORD | **PROGRESS NOTES**

b(6)-2 All

DATE	NOTES
cont 19Sept03 1351	applies light pressure to heels w/ exc: ⊕BM. OOBx: amb to BR. Ø other remarkable assessments noted. Ø c/o pain @ this time. Will cont to monitor. [redacted]
20Sep03 0300	Assumed care @ 1800; All VSS, A&Ox3 speaking both English & arabic; ⊕CMS, NV intact; dsg to Ⓛ Knee Δ'd c̄ silvadene, eucerin cream applied to healing sites, all other dsgs CDI; pt ↑ amb in hall x1 c̄ difficulty; ØΔ's in assess [redacted] restraints in place, ⊕ circulation, Ⓞ skin breakdown cont to mon
20Sep03	0800 – VSS. Alert & Oriented OOB to BR to shower. Dressing to Buttocks & Ⓛ Knee Bilateral heels reapplied p̄ shower a/Keep Clean. Peripheral pulses palpable ⊕ BS ⊕ X4 quadrant. Will contin [redacted] of Care 2C7 Ax
20SEP03 2125	VSS. AO. OOB to ambulate on own x1 for 30 min. Tolerated well. WTD DSG Δ'd to Ⓛ knee and DSG Δ'd to Ⓛ & Ⓡ buttock wounds. Serous drainage - moderate amount to Ⓡ buttock. Ø foul odor or overt bleeding. Pt. self medicated c̄ lotion to burn areas; ⊕ pulses to extremities. [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME LAST	FIRST	MI	SPONSOR'S ID NUMBER (SSN or Other)
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PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)

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C#[redacted] b(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

b(6)-2 All

DATE	NOTES
24SEP03 2224	VSS. AO. Skin intact to all extremities. Pt. applied Eucerin/lotion to skin. DSG placed on (L) knee. All other systems intact & WNL. Heel DSG's CDI. [redacted]
25Sept 0700	Received pt resting in bed, VSS, A+Ox3, speaks english fairly well. Pt is able to apply eucerin cream to healed graft areas independently. Drsg Δ'd to b/lat heels w/ vaseline gauze and (L) knee w/ W→D. ø c/o pain thus far this shift. Restraints in place per EPW protocal, ø skin breakdown or circulation issues noted ø other remarkable assessments @ this time. Will cont to monitor pt. [redacted]
25 SEP03 2211	VSS. AO. Ambulated [redacted] for 45° on ward. Applied cream to wounds by self. Heel DSG's intact. (+) pulses. OTA wounds pink & moist. (+) pulses to BLE. Left (L) knee wound OTA. [redacted]
26Sept 0700	Received pt resting in this AM, VSS, OOB and amb. A+Ox3, speaks english well. Self applies eucerin cream to healed graft sites. Bilateral heel drsgs changed w/ vaseline gauze, bilateral buttock drs Δ'd green drainage noted and foul odor noted to buttock wounds. Amb on in hallways. ø c/o pain this shift, ø other remarkable assessments @ this time. Restraints on per EPW protocal, ø skin breakdown or circulation issues noted. Will cont to monitor pt. [redacted]

#[redacted]

b(6)-4

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
23 Sep 03 0730	— Assumed care of pt. A&O x3. VSS c/o pain to thumb and Ⓛ knee. Scheduled motrin 800mg administered c̄ relief. Dressing to bilat [redacted] ~~complete~~. heels vasaline dressing to keep graft moist. Ⓡ knee kerlix wrapped. Lungs clear HRRR Active BS. Bulky dressing to bilat buttocks, Ø s/s of infection Will cont to monitor b(6)-2 [redacted]
23sep03@1915	Assumed care @ 1800; VSS, pt A&OX3 speaking english & arabic, Ø c/o pain or discomfort @ this time; amb x2 for 20 min each time; bilat heel dsg Δ'd - CDI; Eucerin cream; Silvaden cream applied accordingly; Ø Δ in assessment; restraints in place, ⊖ skin break ↓; ⊕ circulation; will cont to monitor; b(6)-2 [redacted]
24 Sep 03 0700	— Assumed care of pt. awake alert and oriented X3. VSS Ø c/o pain or discomfort @ this time. Lungs CTA HRRR Active BS x 4 quads. Urinating QS per urinal and ambulates to the BR s̄ difficulty. Dressing Δ to bilat heels able to apply pressure. Ø active bleeding noted. Small amounts of drainage. Dressing to bilat buttocks. Δ CDI. Sylvadene cream and moisturizing cream applied to graft sites. Will cont to monitor b(6)-2 [redacted]
	(1135) I concur c̄ above assessment. [redacted]

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#[redacted] b(6)-4		KW#1

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DATE	NOTES
27Sep03@0300	Assumed care @ 1800; All VSS, pt A&Ox3 speaking arabic & english; ⊕ CMS, NV intact throughout; dsg to heels Δ'd c̄ petroleum gauze wrapped c̄ Kerlix-CDI, ⊖ active bleeding; dsg to buttocks bilat Δ'd c̄ W→D c̄ Daken Sol, scant amt of drng on old dsg; amb in hall for 20 min, ⊖ BM this shift, voiding QS c̄ difficulty; restraints in place; ⊕ circulation ⊖ skin breakdown; cont to monitor [redacted] b(6)-2
	(0310) Ⓛ knee OTA, silvadene cream applied, Eucerin - self application PRN [redacted]
27 Sept 03 0900	VSS A&O. Peripheral pulses palpable +2. Dsg to Buttocks changed using Dakens Sol as ordered. Ⓑ Heel dsg D&I. Pt reminded of 1400 hr Appt c̄ CIA. OOB → BR for AM care. Denies pain/discomfort @ this time. Pt applied Eucerin cream to all healed graft sites except back which was applied by staff. Will continue plan of care [redacted] 2LT
27 Sept 03 1400	Pt left c̄ CIA ~~[illegible]~~ dressed appropriate for weather. Ø pain/distress noted or voiced b(6)-2 [redacted] 2LT A
27Sep03@ 2245	Assumed care @ 1800; All VSS, pt A&Ox3, NV intact, pain controlled c̄ perc. pt ↑ amb

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME LAST	FIRST	MI	SPONSOR'S ID NUMBER (SSN or Other)
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# [redacted]
b(6)-4

MEDCOM - 13023

b(6)-2 All

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	(cont) in hall x for 10 min s̄ difficulty; dsg to (B) buttocks Δ'd W→D c̄ Daken's solution, ⊖ s/sx infection; (B) heel dsgs Δ'd c̄ petroleum gauze, ⊖ s/sx infection; Silvadene cream applied to (L) knee OTA, healing well, self-application of Eucerin cream; restraints in place, ⊕ circ. ⊖ skin breakdown; cont to monitor. b(6)-2 [redacted]
~~28~~	
28 Sept03 0800	VSS. A&O OOB to BR for AM care. Dsg'd to Buttocks changed as ordered. Small Amt of bleeding from (R) Buttocks wound upon removing old dsg. Pt applied Eucerin cream to healed graft sites. needed assist c̄ graft sites on back. No acute care needed at this time b(6)-2 [redacted] I A
28 Sept03 1340	Per Dr [redacted] Removed staples from heels. Grafts tissue remain intact. Vaseline gauze dsg applied to cleaned heels with Normal NS. Pt Tolerated well
28 Sep.03 1830	Pt A+D x3, VSS, LS CTA (B), ⊕ BS x4, abd soft flat nontender, voiding w/o difficulties, dsgs to heels + buttocks CDI, ø c/o pain @ this time, OOB to BR and ambulated s̄ complications good circulation, ø skin break↓ on pts of restraint [redacted] aw b(6)-2 [redacted]
29SEP03	(1400) Assumed care of pt @ 0600 p̄ report from night shift. Pt alert, speaking English. VSS. Pain controlled c̄ TID

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
30SEP03 (1505)	(cont) 1-point restraint in place s̄ s/sx complications. Will continue to monitor. ——— b(6)-2 [redacted] RN
(2000)	Pt a/o, VSS, LCTAB, HRRR ⊕BSx4 qds, drsg to Ⓑ heels CDI Eucerin cream applied to healed graft sites. drsg to buttocks CDI. ambulated in hallway s̄ difficulty voiding cyu via urinal. c/o some pain to Ⓡ hand but denies needing any pain meds. 1 pt restraint in place ⊕ circulation. Will monitor b(6)-2 [redacted]
(2330)	2 percocet tabs given for pain c̄ relief noted. Will monitor ——— b(6)-2 [redacted] GIWM6 SPC
01OCT03	(1715) Assumed care of pt @ 0600. Pt alert, speaking Arabic. VSS. Pain controlled c̄ Percs. Drsg to heels and buttocks Δd this am. Pt tol reg diet well. Voiding s̄ diff. 1-point restraint in place s̄ s/sx complications. Will cont. to monitor. b(6)-2 [redacted] RN
1OCT03 1830	Pt A+Ox3, VSS, LS CTA Ⓑ, ⊕ BSx4, denies pain, dsg's to heels + buttocks CDI, voiding well, ø s/sx of poor circulation or skin breakdown on pts of restraint. ——— b(6)-2 [redacted] GIW
1OCt03	2100 - pt. ambulates in hal[redacted] difficulty, +2 restraints on in bed; continue to monitor. ——— b(6)-2 [redacted] LT/AN
2OCT03 1430	received pt resting in bed, VSS, A+Ox3, arabic speaking, and speaks english well. Pt self applied eucerin cream to healed sites. Bilateral heel drsg Δ'd w/ vaseline gauze + [illegible] buttock drsg Δ w/ Dakins WTD. ↓ green, foul odored

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
29SEP03	(cont) motrin. Drsgs to heels Δd. Skin graft sites
(1400)	intact. Bacitracin applied to heels, covered c̄ vaseline
	gauze and Kerlex. Wet → dry drsgs on buttocks Δd
	as ordered. Pt applying moisturin cream to healed
	skin graft sites. Pt amb s̄ difficulty. Tol. reg diet
	well. Voiding s̄ difficulty. 1 point restraint in place s̄
	s/sx complications. Will cont. to monitor b(6)-2 [redacted] DAW
29 Sep 03	Pt AtOx3, VSS, OOB to ambulate, LS CTA Ⓑ, ⊕ BS x4
1830	peripheral pulses equal bilat, abd soft flat non
	tender, applied Eucerin cream to graft sites,
	dsg's heels Ⓑ CDI, dsg's on buttocks CDI,
	pt ambulates w/o complications, voiding well,
	Ø s/sx of poor circulation or skin integrity on
	pts of restraint. ——— b(6)-2 [redacted]
29 Sep 03	2100 – I concur c̄ above assessment. – [redacted]
30SEP03	(1505) Assumed care of pt [illegible] p̄ report from night shif
	Pt alert, speaking English. VSS. Pain controlled c̄ Percs
	motrin. Drsgs to heels Δd. Bacitracin applied to heels
	and covered c̄ vaseline gauze and Kerlex. Drsgs to
	buttocks Δd, wet → dry. Pt tol. well. Pt amb in hallway
	s̄ difficulty. Pt tol. reg diet well. Voiding s̄ difficulty.

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

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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.

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#[redacted]
b(6)-4

MEDCOM - 13026

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
3 Oct 03 @ 2115	Assumed care @ 1800; All VSS, pt A&O x3, ↑ amb in hall x2 for 45 min each, tol well; pain controlled c̄ percs x1; dsgs to (B) heels CDI, ⊖ drainage; dsgs to (B) buttocks Δ'd c̄ Daken's solution; ↓ing green drainage on old bandage; Restraint in place ⊕ circulation, ⊖ ~~drainage~~ [redacted] skin break down; ∅ significant Δ's in assessment; Cont to monitor [redacted]
4 Oct 03 0900	VSS. Alert & Oriented. Denies pain or discomfort @ this time. Dsg to heels dry & intact. Dsg to Buttock Dry & intact. Pt resting in bed c̄ eye closed. Will change Dsg later this shift. No acute care needed @ this time [redacted] LT A
	Assumed care @ 1800; All VSS, pt A&O, ↑ amb in hall x1 for 60 min; ~~pain~~ perc for pain; dsgs to (B) heels Δ'd c̄ petroleum gauze - CDI; dsg to (B) buttocks Δ'd c̄ Daken's solution, ∅ Δs; Restraint in place; ⊕ circ. ⊖ skin breakdown, cont to monitor [redacted]
05 Oct 03 0900	VSS alert & Orient. Pt spoke c̄ Dr [redacted] about going ~~Ab~~ to EPW Camp. Pt denies pain & discomfort @ this time. Dsg to heels & buttocks Dsd as order. Graft to heels intact without drainage ~~edge~~ edges are well approximated. Buttock wound with granulation tissue present. ∅ c/o pain or discomfort @ this time. Will continue care as planned. [redacted] 2LT
	b(6)-2 All

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
[illegible]	drainage. OOB & amb in hallways [illegible], tol po SVgs. Pt has restraints on per EPW protocol ē ∅ skin breakdown is noted. ∅ other remarkable assessments @ this time, will cont to monitor pt [redacted]
2oct03@2400	Assumed care @ 1800; All VSS, pt A&Ox3 speaking both english ē arabic; pt ↑ to amb in hall X1 for 30 min; Ⓑ heel dsg s CDI; Ⓑ buttock dsg s Δd, very minimal drainage on old dsg - CDI; pain controlled ē percs; Restraints in place ⊕ circulation, ⊖ skin break ↓; cont to monitor [redacted]
3oct03@[illegible]	Received pt resting in bed, VSS, tol po, AXOX3. Speaks arabic and good english. OOB + amb in halls. Pt self applies Eucerin cream to healed graft [redacted] sites, dsgs to bilat feet Δ'd w/ petroleum gauze, minimal serous drainage noted, no staples noted or loose edges. Dsgs to bilateral buttock Δ'd, serosang/sang. drainage noted and green slimy foul odored drainage noted on old dsgs, Dakin's solution used. Restraints per EPW protocol, ∅ breakdown noted. Pt conts to have small decub on Ⓡ ankle. Restraints per EPW protocol [redacted]

RELATIONSHIP TO SPONSOR

SPONSOR'S NAME

LAST | FIRST | MI

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

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b(6)-2 All

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
5OCT.03 1900	Pt awake, A+O x3, VSS, OOB to ambulate, denies pain, dsg's on heels CDI, dsg's on buttocks CDI LS CTA Ⓑ, ⊕ BSx4, abd soft flat nontender, voiding s̄ difficulty, continues to apply cream to graft sites, Ø s/sx of poor circulation or skin breakdown on pt of restraint. b(6)-2 [redacted] 91W
Ø6OCTØ3	(1545) Assumed care of pt @ ΦΦΦΦ p̄ report from night shift. Pt alert, speaking English. VSS. Φ c/o pain. Pt amb in hallway @ this time. Drsgs to heels Δd - Φ s/sx infection @ graft sites. Drsgs to buttocks Δd c̄ Dakins soln - wet → dry. Pt applying moisturin cream to healed graft sites. Pt tol. reg diet well. Voiding s̄ difficulty. 1 point restraint in place while in bed. Will continue to monitor. b(6)-2 [redacted] 91W
6OCT.03 1930	Pt A+O x3, VSS, OOB to ambulate, dsg's on heels Δ'd, applied vaseline gauze and covered c̄ kerlix, ambulates s̄ diff, voiding well, applied moisturin cream to healing graft sites, NPO p̄ MN to OR in AM, pain controlled c̄ percs, 1 pt restraint c̄ good circulation + Ø skin breakdown. [redacted] 91W

b(6)-2

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME LAST | FIRST

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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.

[redacted]

b(6)-4

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MEDCOM - 13029

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
07OCT03	(1600) Assumed care of pt @ 0600 p̄ report from night
	shift. Pt alert, speaking Arabic. VSS. 0 c/o pain. Pt
	NPO this am for surgery today. 20g IV started in
	Ⓛ forearm. IVF infusing s̄ s/sx infiltration. CBC,
	Chem 7 sent to lab. Pt amb s̄ difficulty. Pt to
	OR this pm @ 1315 for surgery via gurney in
	stable condition b(6)-2 [redacted] AN)
	(1750) Pt tx back to ward p̄ surgery in stable cond.
	medicated c̄ MSO4 lomg IVP for pain. Pt resting
	on Ⓡ side. Drsgs to buttocks intact c̄ small
	amount sero-sang drainage noted. monitoring.
	b(6)-2 [redacted] AN
07 OCT. 03	Pt asleep, easily aroused, VSS, LS CTA Ⓑ,
1900	⊕ BS x4, medicated for pain c̄ ii percs, tol PO
	well, HL IV, voiding well c/y urine, dsg to
	heels Δ'd, wounds healing properly, dsg on
	buttocks have small amount of sero-sang drainage,
	1 pt restraint in place, ø s/sx of [redacted] poor circ-
	ulation or skin ~~integri~~ breakd
	b(6)-2
08OCT03	(1535) Assumed care of pt @ 0600 p̄ report from night
	shift. Pt alert, speaking Arabic. VSS. Pain controlled
	c̄ Percs. Drsgs to Ⓑ buttock and Ⓑ heels Δd.
	Sutures to buttocks CDI c̄ small amount sero-sang
	drainage noted. SL in Ⓛ forearm flushes well s̄ s/sx
	infiltration/infection. Tol reg diet well. Voiding s̄
	difficulty. 1 point restraint in place s̄ s/sx ~~of~~ [redacted]

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
	Brief op note
7 OCT 03	Procedure close buttock wound
	Surgn Dr [redacted]
	Fluids 8 0 cc
	EBL min
	Anes / spn q 8°
	Complict 0 [redacted]
	b(6)-2

RELATIONSHIP TO SPONSOR

SPONSOR'S NAME: LAST | FIRST | MI

SPONSOR'S ID NUMBER *(SSN or Other)*

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PROGRESS NOTES
Medical Record

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES b(6)-2 A11
08OCT03 (1535)	(cont) complications. Will continue to monitor. [redacted] w/AD
8Oct03	1900= VSS, Ø c/o pain @ this time, A+OX3, Speaks English well to communicate, Dsg to Buttocks CDI, monitoring for drainage, Dsg's to (B) heel CDI, pt. gets OOB & ambulates s̄ assistance, X1 restraint when in bed, ⊖ skin breakdown, scattered wounds to (B) LE'S, Fentanyl patch on (L) upper arm intact, IV HL to (L) FA flushed and patent, continuing IV Ancef. POC: Wound management, pain control. Will continue to monitor. [redacted] 1/AN
8 Oct03	2100= IV restarted to (L) FA, IV that was in (L) FA infiltrated - D/C'd intact, continuing IV Ancef. [redacted] 1/AN
9Oct03 0900	VSS alert & oriented c/o pain to (R) Buttock wound noted 10/10. Percocet 2 tabs given PO @ 0730. @0845 still c/o pain 10/10 MSO4 6mg IVP given and effective. Lungs clear Bilateral. Abd soft non-distended BS (+) x4 quad. Repositioned on side with pillows to ↓ pressure to buttocks. (L) FA IV saline lock [redacted] (continued)

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME LAST	FIRST	MI	SPONSOR'S ID NUMBER
				[redacted]

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)*

[redacted]

b(6)-4

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LAST NAME | FIRST NAME | MIDDLE INITIAL | ID NUMBER

DATE | NOTES

(Continued)

09Oct03 0500 Patent & intact. Resting with eyes closed. Will continue care as planned. [redacted] LTK

9Oct03 1940 VSS. AO. ESC+AB. Used nebulizer albuterol x2 before ambulating. DSG's to buttock CDI. Ambulated x1 on ward for 15 min, used BR, and then c/o light headedness and placed back in bed. Stable. Rested comfortably. [redacted]

10Oct03 Progress

b(6)-2 All

PT stable AFeb

Wound (R) skin edges separation ø purulent DC

(L) wound healing

A/P: Wounds healing

Plan: cont current management

[redacted]

10OCT03 (1240) Assumed care of pt @ 0600 p̄ report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c̄ Percs. Drsgs to heels Δd this am. Skin graft sites healing well. Drsg to (R) buttock Δd. Sutures to (R) buttock intact c̄ small amount of seperation. Sutures to (L) buttock CDI, left open to air per MD order. SL in (L) forearm flushes well s̄ s/sx infection/infiltration. Tol. reg diet well. Voiding s̄ difficulty. 1-point restraint in place s̄ s/sx complications. Will cont. to monitor. [redacted]

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
11Oct03	2100 = (B) Buttock Dsg's Δ'd, scant serosanguineous drainage noted, sutures intact —— [redacted] /AN
12Oct03	2045: VSS, ø c/o pain, A+O×3, OOB ē ambulates s̄ difficulty, Dsg's to (B) Buttocks CDI, heel wounds open to air ē ø drainage - healing well, IV 20G to (L) FA patent, ×1 restraint s̄ skin breakdown, ø other remarkable findings, continue to monitor. —— [redacted] /TW
13Oct03 0950	Received pt resting in bed, VSS, tol PO, appetite poor. Pt c/o upset stomach and diarrhea. ø BM thus far this shift. Enc PO intake of fluids for replacement of nightshift diarrhea output and to ↑ BP (see VS sheet). Dsgs to buttock D. Pt self applied eucerin to healed graft sites. Wounds OTA. Amb indep. Restraints per EPW protocol ø breakdown noted. Will cont to monitor [redacted]
13Oct03	1930: VSS, c/o ø pain, ø diarrheal episodes, (B) buttock dsg's CDI, applies eucerin cream to leg wounds himself, OOB ē ambulates s̄ difficulty, H/L IV to (L) FA patent, ×2 restraints when in bed s̄ skin breakdown noted, ø other remarkable findings. Will continue to monitor. —— [redacted] /TW
	b(6)-2 All

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
10/11/03 0040	135. AO. Resting in bed comfortably. Refused to wash early on shift. DSG's to Ⓡ & Ⓛ buttox intact s̄ drainage. Non-productive cough c̄ continued use of albuterol inhaler x1. [illegible] Med c/o pain 5/10 to buttox and provided [illegible]. b(6)-2 [redacted]
11 Oct 03 0700	- Assumed care of pt. A+O x3. C/O pain medicated c̄ percocet II tabs for relief. Wounds to bilat buttock dressings changed CDI minimal bleeding. Encouraged Q2° position change to sides to prevent putting pressure of wound. Will cont to monitor b(6)-2 [redacted]
	(1710) I concur c̄ above assessment. [redacted]
11 OCT 03	2000: VSS, ∅ c/o pain, ambulating in hall s̄ difficulty, x1 BM tonight in BR, Dsg's to Buttocks CDI - reinforce/Δ PRN. Pt. turns Q1°-2° to keep pressure off gluteal areas. IV H/L to Ⓛ FA flushed + patent. Heel wounds healing well - open to air on initial assessment but dressing c̄ Kerlex prior to walking in hall CDI. ∅ other remarkable findings. Continue to monitor. x 2 restraints ⊖ skin breakdown. [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME LAST	FIRST	MI	SPONSOR'S ID N[redacted] (SSN or Other) b(6)-2
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. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

#[redacted]
b(6)-4

MEDCOM - 13035

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
12Oct03	Progress note
	Patient continues to heal adequately
	(R) buttock c̄ small wound separation.
	(L) WNL
	Plan: Con't local wound care
	[redacted]
	b(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK
USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
14 oct 03 0700	-Assumed care of pt A+O x3. VSS. c/o pain to wounds bilat buttocks. Medicated c̄ tylenol #3 ĪĪ tabs for pain relief. DSG change Ø active bleeding noted. Wounds healing Ø s/s of infection. Afebrile - Lungs clear non productive cough. Inhaler albuterol @ bedside PRN use SOB - Ø complaints @ this time. Will [redacted] to monitor b(6)-2
14 OCT 03 2132	VSS, AO. Ø c/o pain @ this time. Δ's to DSG's on buttox s̄ difficulty. 2 cm area of dehiscence to Ⓡ buttox c̄ Ø s/s of infection or active bleeding. ⊕ pulses and <3 SEC CAP. Burns to body intact s̄ s/s infection. Eucerin cream applied to areas by patient and assistance to bilateral heels. Tolerated well. BS ⊕ x4. Ambulated on ward x1 for 1½ hours s̄ difficulty. [redacted] b(6)-2
15 oct 03 0700	-Assumed care of pt. A+O x3. VSS. Dressing Δ this morning bilateral buttocks. sutures removed. Minimal bleeding / serous drainage to dressing Ø active bleeding noted. Encouraged q2° position change from side to side to keep pressure of gluteous. Lungs CTA. HCRR Active BS. Ambulates to BR. Will cont to monitor b(6)-2 [redacted]
	(1300) I concur c̄ above assessment. [redacted]
15 OCT 03 2100	VSS. AO. ⊕ pulses. Hel grafts intact to BLE. DSG's Δ'd to Ⓡ & Ⓛ Buttox - Ⓡ buttox pink c̄ 2cm dehisced region, Ⓛ buttox c̄ 1cm x2 dehisced region Ø purulent drainage or overt bleeding, Ø s/s infection. Pt. applied moist[redacted] cream by self. Resting in bed comfortably [redacted] b(6)-2

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
16 OCT 03 @ 0700	Assumed care of pt. A&O x3, V.S.S. Pt. has no C/O pain. Pt. applies cream to effected areas; cream @ bedside. All other assessments WNL. DSNG to buttocks Δ'd last night. DSNG is CDI. EPW restraint protocol used. No skin breakdown noted around restraints. —— [redacted] 2LT, AN
16 OCT @ 1000	Pt. OOB ambulating in hallway. Pt. refused to do AM care. —— [redacted] 2LT, AN
16 OCT 03 2340	VSS. AO. LSCTAB. HRR. ⊕ pulses in all extremities. BS ⊕ x4. DSG Δ'd performed to bilateral buttocks. ∅ s/s infection. Ambulates well on ward s̄ difficulty for 30 min. Applied moisture cream to wounds and butt cheeks. Cont to monitor. [redacted]
17 OCT 03 0200	- Assumed care of pt. A+O x3 VSS ∅ c/o pain or discomfort @ this time. Ok for discharge to EPW camp. Buttocks dsg's changed ∅ s/s of infection

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. ICW #4

#[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

MEDCOM - 13038

NSN 7540-00-634-4176 AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
3 July 03	Cont: Silvadene applied. Afebrile, VSS, O_2 off sat
23	>95%, nasal trumpet removed. Medicated c̄ Percocet
	II mg P.O. prior to dressing change. Pt went to
	sleep afterwards. UO still not consistent closely
	monitored ___ b(6)-2 [redacted] /AN
0300	UO averaging 20cc/hr for 2 hours, Notified
	Dr Dixon. Pt received total of 2000cc + increased
	IVF to 200cc/hr @ 2130. Ordered 20 mg Lasix
	IVP + was given at this time [redacted] /AN
0400	Incidental Nursing Note: b(6)-2 [redacted]
	Attempted to draw blood three times but unsuccessful.
	Pt has generalized edema on both arms, uses fine needles,
	IV site also unsuccessful. Baseline CBC $8.7 > \frac{12.0}{38.5} < 29.0$. Need
	central or other means if q day blood draw is warranted.
	Post Lasix administration:
	Baseline UO averaging 20cc/hr. Post Lasix administration
	urine output from 0300-0400 up to 600cc of straw colored
	urine. Pt c/o thirst, drank two cups of water. Continue
	to monitor UO + edema. b(6)-2 [redacted] Maj/AN
1030	Dressing changed, Silvadene to burn areas, medicated
4 July	c̄ 6 mg MSO4 & 2 mg Versed, tolerated well. Sat pt up
	on side of bed for dressing change on buttocks & linen change

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.

[redacted] [redacted]

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1030	continuation: Pt tolerated well. Pt ate 40% of
	breakfast & milk (240cc). b(6)-2 Dr [redacted] aware of 3° burn
	& K of 5.2. will continue to monitor & encourage PO intake
4 July 03	Surgery
Lovenox	No events overnight
Levaquin	VSS Afeb UO brisk following lasix
Proventil	wound - clean
	Chest CTA
	CXR low volume but clear.
	LABS
	110 | 101 < 9 / 94 ; 9.0 > 44 < 327
	5.2 | 25 | 1.0
	Doing well cont Dressing Δ's Plan
	excision & grafting Sunday. b(6)-2
	[redacted]
	b(6)-2
1900	Nursing Note:
1930	Received report @ 1730. pt stable, in bed. Pain well
	managed c̄ Percocet ii p.o. IVF LR @ 200cc/hr. Urine output
	average 30-40 cc/hr. MD made aware, otherwise VSS.
	Pt A & O x3. Up to BSC, had i soft BM. Bed bath
2030	done afterwards. Medicated c̄ Percocet ii p.o. prior to
	dressing change. —— [redacted] Maj / AN
	b(6)-2

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STANDARD FORM 600 (REV. 6-97) BACK

MEDCOM - 13040

NSN 7540-00-634-4176

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
3 Jul 03	Nursing: Pt admitted from ER for DVT Ⓛ LE and
1245	Burns. ~~A+[redacted]meter~~ 1245 A+O×3, understands some english.
	Airway patent, respirations regular & unlabored.
	Sats 97% on 2LNC. Nursing staff starting Debridement
	will administer pain medication as ordered.
	Infusing LR @ 150cc/hr via IV in Ⓛ FA. Pulses
	in all extremeties weak but palpable. DVT to
	LLE. Leg swollen c̄ palpable pulse. Foley to gravity.
	Draining clear, yellow urine. Will continue to
	monitor. [redacted] /Av
	b6-2
3 Jul 03	Nursing: Debridement completed. ~~Burn noted on~~ [redacted] 1433
1430	Patches of 2nd degree burn noted on Ⓡ palm up to
	armpit. Skin pink, ⊕ pain. 2° burn noted on Ⓛ palm
	up to wrist. Skin pink and bleeding. White/yellow
	~~areas of tissue~~ [redacted] 1443 no tissue noted on abdomen and
	Ⓡ+Ⓛ thigh. Skin red c̄ black areas noted on Ⓑ heel.
	Skin red on buttocks. Silvadene cream applied
	to burn areas and wrapped c̄ Kerlex. Pt did not
	tolerate procedure. Pt very agitated and fighting
	staff during debridement. Total of 20mg MSO4 IV
	and 10mg Versed IV used for pain and sedation.
	Pt resting quietly. Easily arousable. Respirations unlabored.

HOSPITAL OR MEDICAL FACILITY	~~STATUS~~	DEPART./SERVICE	RECORDS MAINT[redacted]
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	/Av b6-2

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.

[redacted] b6-4

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
3 Jul 03	Nursing: ~~General~~ [redacted] ~~Surgeons n.~~ 1545 Pt diaphoretic, T-99.5,
1545	pt lethargic but arousable. Respirations tachypneic
	and labored. Sats 89-90% on 6L NC. Pt switched to
	50% Ventimask. Sats 92%. Expiratory wheezing c̄
	Rhonchi noted in Ⓑ upper lobes. HR ↑ 130-140s. General
	Surgeons notified. ABG + EKG done. Nasal trumpet
	inserted in Ⓡ nare. 0.2 mg of Narcan IV administered.
	Neb treatment given by RT. Pt more comfortable
	p̄ treatments. Sats 90-92% on Venti Mask (50%),
	RR 16, HR 122. Respirations regular + unlabored.
	UOP <20cc/hr. Pt given 500 cc NS bolus. Will
	continue to monitor. —— [redacted] b6-2
3 Jul 03	Nursing: UOP-10cc, pt given another 500cc NS
1656	bolus per Dr. [redacted] b6-2 b6-2 [redacted]
3 Jul 03	Received report from outgoing shift. Pt on FM 50%, sat 89-90%
1800	drowsy but arousable. Speak + or understand English. gave
	albuterol puffs x2. Burn dressing to arms & legs intact.
	Edema to UE + LE. Ⓛ LE > Ⓡ LE. Pt is monitored for possible
	DVT. See flow sheets for pertinent info → [redacted]
1830	UO still decreased, given another bolus of LR 500 (1500 today) b6-2
	Monitor urine output, notify MD if still an issue [redacted] b6-2
2130	Increased IVF rate from 150cc-200cc, urine output from 35-50cc
	O_2 sat up to 100% c̄ VM@50%. titrated O_2 ↓ to NC 2L/min sat
	remained in the upper 90s, lungs c̄ crackles upper lobe c̄ mild
	wheezing, ↓ BS lower lobe. Pt observed to be asleep but
	arousable. In no apparent distress. Ⓛ LE elevated. [redacted] b6-2
2300	Dressing changed to hands/arms, LE & back c̄ debridement
	Burn surfaces on the arms & legs appear ~~[illegible]~~ whitish,

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MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
31 Mar	Progress Note
	Ø complaints
	VSS afebrile
	wounds Eschar on heels (fingers loosing)
	(+) necrotic tissue (B) knees
	loss of graft med (L) thigh
	Hand graft looks good
	Plan: needs further debridement
	to OR in AM

[redacted]

b6-2

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.

[redacted]

b6-4

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
2300	Pt is observed to be asleep @ this time UO increasing.
	Will monitor closely. Afebrile, sat 91-99% (positional)
	Pain well managed by MSO4 6mg during dressing
	changes ——— b6-2 [redacted] Maj / AN
0400	Pt slept throughout the night. Received nebs treatment
	@ this time c̄ albuterol puffs x4, breathing unlabored
	maintaining sat >90% in RA, prone positional. T99.9 @
	this hour. Pain and comfort well controlled c̄ p.o. + IV manage-
	ment. ——— b6-2 [redacted] Maj / AN
5Jul03	Surgery
0700	No events overnight Foley pos(trans)
	VSS AFeb.
	Chest CTA
	CV RRR 2HPP
	Abd NABS soft ND
	wound to be dressed
	A/P 10% BSA Burn and (L) DVT
	Doing well much improved mental
	status Needs to eat or will Require
	DHT. Pt may Ambulate [redacted] b6-2

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

H/C [redacted] b6-4

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
5 Jul 03	Pt doing well after dressing change, medicated c̄
1030	MSO4 16 mg & Versed 5 mg but pt still in great pain
	may require conscious sedation next time, Pt up out of
	bed & stood for 15 min for dressing change on back &
	buttocks. (L) AC PIV infiltrated → D/C'ed, catheter intact,
	will continue to monitor b6-2 [redacted] 1LT/AN
1700	Received report from RN. b6-2 [redacted] 1LT/AN
1800	Assessment completed. b6-2 [redacted] 1LT/AN
2100	Drsg changed started. Premedicated c̄ MSO4 5mg,
	Versed 3mg. Given total MSO4 of 20mg, Versed
	10mg. Patient did not tolerate any scrubbing; would
	withdrawn. Recommend conscious sedation for
	debridement of multiple burn sites. VS remained b6-2
	stable throughout drsg Δ. Drsg Δ compled 2240. [redacted]
6 JULY 03 0100	Patient sleeping VSS b6-2 [redacted] 1LT/AN
0300	Patient sleeping. VSS. Awakened for T&C blood drawn.
	Arterial blood drawn from (R) radial stick. [redacted] b6-2 1LT/A
0500	Report given to RN. b6-2 [redacted] 1LT/AN
6 July 03 0500	Received report from previous shift. Pt resting
	quietly c̄ eyes closed. Peripheral IV intact. O_2
	sats 96% on RA. Bilat. ↓ ext. elevated on half
	donuts. Noted scrotal edema. Scrotum elevated.
	Pt is edematous. Will ambulate. CXray complete
	Ø labs drawn this a.m. Type and cross 2units
	PRBC prepared by previous shift. Concern about
	pain control during drsg Δ. Suggest conscious
	sedation. Will discuss with MD. Will cont.
	care. b6-2 [redacted] 1LT/AN

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	**SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION** *(Sign each entry)*
6Jul03	Surgery. Op Note
1205	Indication Burn wound
	procedure excision of Burn
	Surgeons [redacted] b6-2
	Anest GETA
	Finding Large Burns on Abd/Thighs/Ant Knees
	excised to viable tissue with Dressing.
	Comp None
	Dispo to ICU 3 in good cond
	[redacted] b6-2
6 Jul 03	Pt resting s̄ any complaints, has not requested any need
2200	for pain. Foley draining qs yellow urine. No acute issues.
	Dressing to the abdomen draining bloody drain. Will change
	dressing & continue to monitor ——— b6-2 [redacted] Maj AN
2330	Medicated c̄ MSO4 4 mg IVP for c/o wound pain b6-2 [redacted] Maj/AN
0200	Pt is observed to be asleep. VSS. UE/LE elevated. b6-2
	Scrotal edema noted, elevated on a towel → [redacted] Maj AN
0400	Pt up to the BSC c̄ assistance, put out large amt of
	soft/loose stool. Received total of 7 mg MSO4 prior to OOB
	& upon return to bed. Max T 100.2 @ this time. Foley ↓

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REGISTER NO.

WARD NO.

[redacted] b6-4

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
7 Jul 03	Continuation:
0400	UO from 50 to 30 cc/hr. Pls continue to monitor UO report if continue to decrease. b6-2 [redacted]
0500	Rcvd report + care of pt from previous shift. pt sleeping in bed Ø S/S of pain/discomfort VSS will cont to monitor b6-2 [redacted] LPN
0800	Pt awake resting in bed VSS will cont to monitor b6-2 [redacted] LPN
1200	Dsg Δ's complete tol well. Conscious sedation tol well. Wounds appear beefy red to pink c̄ some eschar remaining. Wet to dry Δ's on Abd. and bilat. thighs. Silvadene applied to feet bilat., buttocks, arms & hands bilat, and back. VSS throughout will cont to monitor b6-2 [redacted] LPN
1500	Pt consumed 2 cans of Ensure Plus and told he needs to eat and drink his ensure or the other option will be to place a dobhoff tube. Pt understands options that were explained to him VSS will cont to monitor b6-2 [redacted]
1700	Report and care of pt given to oncoming shift b6-2 [redacted] LPN
1730	Received report from outgoing shift. patient appear drowsy but easily aroused. IVF LR @ 100 thru the SC triple lumen cath Foley intact draining tea colored urine. Dressing intact, instructed to change grafted area c̄ W-D dressing. Pt to have Ensure as tolerated + encourage p.o. food intake b6-2 [redacted]

STANDARD FORM 600 (REV. 6-97) BACK
*U.S. GPO: 2002 - 491-600/50618

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
6JUL03 0630	Pt resting quietly. Discussed POC c̄ pt. Gave RT tx. Pt remains NPO status Will do daily hygiene care —— b6-2 [redacted]
1015	Prep pt. for OR. Pt left for OR via litter. [redacted]
1200	Completed drsg Δ in OR. Cleaned bilat ↑ext c̄ hibiclens and rinsed c̄ NS. Covered burns c̄ silvadene and gauze. Wrapped wounds c̄ kerlex. —— b6-2 [redacted]
1200	Cleaned buttocks and back wounds c̄ hibiclens and rinsed c̄ NS. Applied silvadene and covered c̄ gauze. —— b6-2 [redacted]
1240	Received pt from OR. Pt has bilat ↓ ext wrapped c̄ ace wraps. Bilat ↓ ext and stomach are wet → dry drsgs. Montgomery straps present on stomach/abd region. Pt awaken easily by verbal response. Pt able to swallow water. Gave RT tx. O_2 sats low 90s. Will cont. care. [redacted]
1240	Pt on 5L O_2 via NC due to anesthesia from OR. —— b6-2 [redacted]
1255	Noted Ⓡ jugular central line placed by anesthesia in OR. ∅ S/S of infection. Will secure c̄ tape b6-2 [redacted]
1330	Pt c/o pain in arms and legs. Gave MSO4 ii mg IVP. Will cont contd...

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

[redacted] b6-4

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

MEDCOM - 13048

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
6 JUL 02 1350	to assess pain level. —— b6-2 [redacted]
1420	Reinforced drsg on bilat ↑ ext due to weeping wounds
	will cont. care. —— b6-2 [redacted]
1600	Pt resting quietly c̄ eyes closed. Appears to be in 0
	pain, LR @ 100cc/hr infusing. Will cont. care. [redacted]
1700	Gave report to night shift. —— b6-2 [redacted]
1800	Received report from dayaing shift. Pt alert, able to verbalize
	needs. IV LR @ 100 thru (R) SC triple lumen. VSS, T 100.0
	dressing intact. Brief pt regarding plan of care. — b6-2 [redacted]

see next page
7/7/03

STANDARD FORM 600 (REV. 6-97) **BACK**
*U.S. GPO: 2002 - 491-600/50818

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
08 July 03	Premedicated c̄ MSO4 6 mg c̄ Versed 2.5 mg for
0000	dressing change to the abdomen and upper legs (thighs)
	Wound s/p debridement 6 July. Wound clean applied
	W-D dressing. Given additional MSO4 4 mg and Versed 2.5 mg
	during the procedure at approx 2300. Pt continue to c/o
	pain, gave Percocet ii p.o. and MSO4 2 mg. Pt.
	is observed to be asleep, RR 11-12 even, SAO2 98% RA.
	——— [redacted] Maj/AN
0400	CBC, Met 8, T + C ii sent. Pt slept c̄ intermittent wakefulness
	for c/o generalized wound pain received a total of MSO4
	10 mg from 0000 - 0400 given three increments. Pt.
	is observed to be asleep. Just received 4 mg MSO4 @
	0350. Afebrile, VSS ——— [redacted] Maj/AN
0500	Rcvd report & care of pt from previous shift. VSS ——— [redacted]
8 JUL 03	Surgery WD # 5 POD # 2
	No events not taking PO well
	VSS AFeb UO increasing
	Chest CBTA
	cor RRR [illegible]
	Wounds - Granulation beginning on exam 5 sites.
	6 > 30 < 474 134 | 98 / 7 104
	5.8 | 20 0.7 over →

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 - 13050

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
8Jul03	Surgery (cont) A/P 10% Burn mostly full thickness plan grafting in the next couple of days DVT - Resolving ~~edema~~ swelling. [redacted] b6-2
0730	Pt resting comfortably in bed. VSS pt shows s/s of pain/discomfort will cont. to monitor b6-2 [redacted]
0930	Dsg. Δ's complete tol well c̄ conscious sedation wounds appear beefy red to pink, some eschar remains. Wet to dry dsg. to Abdomen + upper legs. Silvadene applied to lower legs, hands, arms, buttocks + back. VSS throughout will cont to monitor b6-2 [redacted] LPN
1015	Dobhoff tube placed and placement verified by X-RAY. b6-2 [redacted] LPN
1215	Pt sleeping in bed x̄ s/s of pain or discomfort. VSS will cont to monitor b6-2 [redacted] LPN
1330	Pt given Percocet 2 tabs for pain will ambulate in 30 minutes VSS will cont to monitor b6-2 [redacted] LPN
1630	Pt OOBTC for 2 1/2 hrs. Pt now back in bed. Pt VSS throughout will cont to monitor b6-2 [redacted] LPN
1700	Care of pt and report given to oncoming shift VSS. b6-2 [redacted] LPN
~~2000~~	error [illegible] ~~pt complaining of abdominal pain + hiccups [illegible]~~ stopping hiccups b6-2 [redacted]

STANDARD FORM 600 (REV. 6-97) BACK
*U.S. GPO: 2002 - 491-600/50618

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1050	7.7 〉 28 〈 674 129 / 3.7 | 96 / 28 〈 10 / 0.9
	A/P s/p Burn excision Again to viable tissue
	Necrotic Areas removed
	On Abx for possible cellulitis Vanc/Gentamycin
	DVT on Lovenox
	[redacted] b6-2
10/20/03	Brief op Note
	indication Full thickness Burns
	~~surg~~ Procedure Repeat Burn excision
	Surgeon [redacted]
	Anest [redacted] b6-2
	LR - 1100 UO - 175
	PRBC - 2u EBL 450
	Findings Previous Burns excised to SUB Q
	tissue. Necrotic tissue Debrided.
	Ⓛ Arm Debrided.
	Comp None.
	[redacted] b6-2

NSN 7540-00-634-4176

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MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
9 Jul 03	Surgery
	No events overnight
	Tm 101.6 99. now HR 100's
	Gen Chest CTA [illegible]
	Abd ND NT
	Wounds Ⓡ knee & Ⓛ thigh Region
	more Debridement
	? cellulitis around Ⓛ [illegible] leg wound
	A/P ? burn cellulitis
	Add Vanc
	↓IVF due to Goal @ TF
	Plan Op Debridement on Mon
	[redacted] b6-2
10 Jul 03	Surgery
	Tm HR BP
	Chest CTA
	cor RRR 2+PP
	Abd Quite BS
	Wounds - Debrided to Viable tissue today.
	Over →

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)
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MEDCOM - 13053

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
20 Jul 03	OR staff here to pick up pt for procedure. VSS.
0745	—————— [redacted] b6-2
20Jul03	Surgery op Note
	Indication Burn
	Procedure STSG from Back to Ⓛ ForeArm/Hand,
	Ⓑ Ant knees, Ⓡ Lateral Lower Leg, SACRAL AREA
	Surgeons - [redacted] b6-2
	Anesth [redacted] b6-2
	Fluids -
	Procedure as Above. VAC to most sites
	Comp None.
	to ICW U 3 stable
	[redacted] b6-2
	28CSH
	MD FACS
1215	Pt returned from OR. Pt awake + alert to voice
	+ pain stimuli. Pt had EBL of 50cc, UOP of 100cc,
	Received 2000ml LR, 1000 mcg fentanyl, +5mg Versed. Will
	Monitor. —————— [redacted] b6-2

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.

[redacted] b6-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
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MEDCOM - 13054

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

20 JUL 03 Recovery VS below —— [redacted] 91WM6
b6-2

Time	1220	1225	1230	1245	1300	1315	1330
BP	126/77	126/76	125/75	147/79	127/72	134/72	131/69
HR	92	94	98	103	109	108	107
RR	24	26	26	36	34	26	22
Temp	94.2	94.2	94.3	94.6	96.4	97.4	98.2
SAO2	95%	95%	95%	94%	94%	94%	93%
Method	RA	RA	RA	RA	RA	RA	RA

1330 Pt currently stable, VSS, Lying in bed looking around ward. Will continue c̄ plan of care. —— b6-2 [redacted] 91WM6

1515 Pt temp ↑ to 100.8, medicated c̄ 650mg tylenol. Will continue to monitor. —— b6-2 [redacted] 91WM6

1620 Pt lying in bed on Ⓡ side. VSS, No issues @ this time. Temp ↓ to 100.8, Will continue to monitor. b6-2 [redacted] 91WM6

20 July 03 (1800) PT care Report Recieved from SPC [redacted] b6-2 Pt c̄ Resting awake in bed s̄ acute episode reported or noted. Wound VAC to Ⓛ leg, abd + Ⓛ arm on a continuous 125mmHg suction. PIV 18g to Ⓡ FA s̄ s/sx infiltration c̄ LR 100° via dialaflow. Dressings to graft sites (Ⓛ arm, abd, BLE) intact, clean, dry. Back drsg intact, clean + dry. Sacrum drsg intact clean + dry. —— b6-2 [redacted] 91WM6

20 July (1840 + 2400) Tmo. lim TAL c̄ Po for loose Brown Stool. Resting p̄ care. Refused Cl. liq diet. —— [redacted] 91WM6
b6-2

STANDARD FORM 600 (REV. 6-97) BACK

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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
21 July 03 1130	Dsg Δs complete Pt tol well. Dsg's to Skingrafts
	on buttocks, Ⓛ arm + hand + Bilat. Lower extremities
	intact. Dsg's to Donor sites on back + leg intact
	VSS throughout conscious sedation. will cont to
	monitor ——— b6-2 [redacted] LPN
1330	Pt resting in bed Ø C/O pain or discomfort VSS, will
	cont to monitor ——— b6-2 [redacted] LPN
1600	Pt awake in bed. Ø C/O pain or discomfort VSS
22 July (1800)	will cont. to monitor ——— b6-2 [redacted] LPN
	Pt CARE REPORT RECEIVED from SPC [redacted] b6-2
	Pt awake, alert, oriented to person only.
	NO Acute Episode noted / Reported. b6-2 [redacted] 91W
22 July 03	(1900) Immodium tab i given po for loose
	Stool by brown. Pt s̄ adverse effects.
	——— b6-2 [redacted] 91WM6
22 July 03	(2200/2400) Albuterol inhaler + IS exercise
	administered per Rx. Pt remains awake
	for this shift. ——— b6-2 [redacted] 91WM6
23 July	(0300) Remains awake s̄ acute episodes.
	——— b6-2 [redacted] 91WM6
23 July	(0600) Blood Specimen for CBC, ~~[illegible]~~ & Sent to lab.
	Pt s̄ adverse effect noted from procedure.
	——— [redacted] 91WM6
23 July	(0600) Pt care report given to SGT [redacted] b6 Pt
	Still awake s̄ acute episode noted. [redacted] b6-2 91WM6

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MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
22July03	Rcvd report + care of patient VSS pt sleeping ȼ s/s
0600	of pain or discomfort will cont to monitor — b6-2 [redacted] LP
0830	PT DC'd own dobhoff tube. PT scheduled to restart
	tube feeds tomorrow 23July03, VSS pt resting
	comfortably in bed will cont to monitor — b6-2 [redacted] LP
22Jul03	Surgery
Lovenox	No complaints POD#2 from STSG to Ⓛ Arm
Albuterol	Ⓑ knees and Buttocks
Sebutron	Tm 99.8 90-100 HR BP 110's/60's UO 50-80 cc/hr
	AxO
	Chest CTA
	Wounds Dressed
	Labs. 135 | 101 | 10 ⟨ 96 ; 4.4 | 21 | 0.9 ; 7.0 ⟩ 29.8 ⟨ 917
	A/P Doing well. will Remove VAC on STSG to-
	morrow.
	[redacted] b6-2

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.

[redacted] b6-4

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
23 July 13 1545	Unable to flush pt's IV. New IV Started 20g needle cather inserted in (L) AC. Site flushes well. Ø infiltration noted to area. Will continue to monitor pt. b6-2 [redacted]
1708	Pt. resting in bed quietly s̄ distress. Ø complaints voiced @ present time. Will continue to monitor. b6-2 [redacted]
1630	pt report received @ 1800 by SGT [redacted] b6-2 pt Lying calmly in bed No problems @ present will continue to monitor b6-2 [redacted] PFC [illegible]
2300	pt remains awake pt medicated due to BM Pad Δ. pt VSS No signs of acute distress noted @ present will continue to monitor througout night b6-2 [redacted] PFC [illegible]
@0300	pt resting Calmly in bed No problems @ present VSS pt shows no signs of acute distress @ present will Continue to monitor b6-2 [redacted] PFC [illegible]
@0555	pt resting calmly in bed condition & vital signs stable pt has Ø complaints of pain @ this time graft site moistened througout night no problems noted no S/S of acute distress noted @ this time will continue to monitor b6-2 [redacted] PFC [illegible]
@0610	pt report given to Spc [redacted] VSS no problems @ present b6-2 [redacted] PFC [illegible]
0630	Received report and care of pt from previous shift. Pt awake in bed Ø c/o pain or discomfort. VSS will Cont to monitor b6-2 [redacted] LPN
0830	Pt sleeping in bed Ø s/s of pain or discomfort Dsg intact will cont to monitor b6-2 [redacted] LPN
1130	Pt awake in bed VSS Ø c/o pain or discomfort. will [redacted] ~~comfort~~ continue to monitor b6-2 [redacted] LPN
1330	Pt sleeping in bed VSS Ø s/s of pain or discomfort will cont to monitor b6-2 [redacted] LPN
1630	Pt Dsg Δ's complete Pt received 250 mcg Fentanyl Pt tol well. Graft sites healing well wounds appear pink to beefy red VSS. will cont to monitor [redacted] LPN

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
23 July 03 0715	Received report from Sgt [redacted] b6-2 @ 0700. Pt. sitting up in bed c̄ eyes opened. Ø complaints voiced Ø distress noted @ present time. LR @ 100cc/hr. IV patent to (R) arm s̄ redness/swelling noted to area. Drsg noted to (B) legs & (L) hand, also noted to abd. region. Pt has F/C to gravity @ BS. Will continue to monitor. b6-2 Sgt. [redacted]
0819	Pt. resting in bed c̄ eyes open s̄ discomfort noted @ present time. Will continue to monitor for s/sx of distress. Sgt [redacted] b6-2
0953	Sutures removed from graft site in front. Pt. tolerated procedure well. VS: BP 105/69 RR 19 SpO2 95% HR 101. Drsg Δed done as per M.D. Pt. resting comfortable in bed after drsg Δed completed. Ø distress noted. Will continue to monitor b6-2 Sgt [redacted]
1225	Temp 100.4 Tylenol tab ii po. given for fever. — Sgt [redacted]
1306	Temp 98.2. Rest in bed c̄ eyes opened. Ø distress noted. b6-2 Will continue to monitor. b6-2 Sgt [redacted]
1348	Pt. restless, appears confused @ present time. Removing bandages as soon as staff walks away from bed. Rambling on and on in Arabic when translated Pt. would like to thank the staff. Will continue to monitor. b6-2 Sgt [redacted]

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.

[redacted] b6-4

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
25 July	(0600) Pt care Report given to LT [redacted]. b6-2
	Pt awake c̄ no acute distress. b6-2 — [redacted] 91WM6
25 July 0600	Received report from previous shift. Pt resting
	comfortably c̄ eyes closed. Intermittent sleep.
	LR infusing @ 100cc/h via dial-a-flow. Drsgs
	intact. Viewed labs. Will report abnormal
	results to Dr [redacted] b6-2. Will con't care [redacted]
0800	Completed drsg Δ. Covered donor site on back c̄ b6-2
	burn pad. Washed burn sites c̄ hibiclens x̄ back
	Ⓡ thigh and rinsed c̄ NS. Placed silvadene
	on Ⓡ heel and Ⓛ heel, Ⓡ upper thigh, bilat hands,
	upper back, Ⓛ thigh. Placed xeroform gauze on
	bilat knees, buttocks and covered c̄ sulfamylon
	soln. Wrapped Ⓛ leg c̄ splint and ace bandage.
	Need to get splint made for Ⓛ leg. Will contact
	PT. Gave total 225mcg fentanyl throughout
	drsg Δ. Wasted 25mcg fentanyl witnessed by Sgt
b6-2	[redacted] Completed foley care and bed bath.
	Pt tolerated drsg Δ well. Pt lifted own leg and
	turned self. Δ'd linen and placed two burn pads.
	Turned pt on Ⓡ side. Pt resting quietly c̄ eyes
	closed @ this time. Will cont. care. — b6-2 [redacted]
1000	Pt resting in bed at this time. Pt has ø complaints
	of pain or discomfort VSS will cont. to monitor —
	b6-2 [redacted]
1200	IV in Ⓛ FA infiltrated. D/C'd IV. Will restart IV.
	b6-2 [redacted]
1300	Pt UO < 30cc. Attempting to restart IV. [redacted]

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STANDARD FORM 600 (REV. 6-97) BACK

b6-2

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
24 July (1800)	Pt CARE Report Recieved from SPC [redacted] b6-2. Pt
	Awake, Alert s̄ noted/Reported Acute episodes
	b6-2 [redacted] 91WM6
24 July 03 (2000)	Ambien 5mg PO given for rest.
	Pt 90 being tired but noted ↑ agitation:
	pulling at lines, dressings & Blankets. PO intake
	of ## glasses of juice, 1 jello cup & 1/2 glass
	H_2O Readily taken s̄ noted dyspagia, N/V. Resting
	awake p̄ care. b6-2 [redacted] 91WM6
24 July 03	(2200) Pt dangling @ Bedside @ own Self
	Repositioning. Placed in Chair @ Bedside.
	Resting awake s̄ distress noted. b6-2 [redacted] 91W
24 July 03	(2300) Assisted Back to Bed. Amb c̄ slow
	maneuvers. Needs Reminding to Rotate feet.
	Assisted by (2) staff members. Siderails ↑ x2.
	HOB [illegible]. PIV (L) upper arm patent/intact
	s̄ S/Sx infiltration. Dressing intact to UE/LE,
	ABD + [redacted] ~~DC~~ Buttocks b6-2 [redacted] 91W
25 July	(0300) Incontinent of large Soft Brown Stool.
	Buttock wound cleaned/Redressed c̄ Vaseline
	Gauze + Sulfamylon Solution. (L) leg immobilizer
	Removed 2° ↑ soiling. Pt resting quiet p̄ care.
	[redacted] 91W b6-2

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[redacted] b6-4

REGISTER NO.

WARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
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MEDCOM - 13061

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
25 July 03	(2100) Assisted back to Bed c̄ (2) staff member
	Transfers c̄ partial weight bearing & poor Rotatix
	of feet. HOB ↑ low fowlers. Ambien 10mg Po given
	per Rx. Resting Awake s̄ distress noted. PIV 20g
	to (L) wrist s̄ s/sx infiltration. Foley draining b6-2
	cloudy yellow urine (U.O. > 30ml/hr.) — [redacted] 91WM6
25 July 03	(2300) Pt Remains Awake. Noted yawning.
	Frequently. — b6-2 [redacted] 91WM6
26 July 03	(0100) Pt c̄ snoring Respirations. Asleep s̄ noted
	distress. — b6-2 [redacted] 91WM6
26 July 03	(0300) Pt Remains Asleep s̄ acute episode.
	noted. — b6-2 [redacted] 91WM6
26 July 03	Pt care Report given to LT [redacted] b6-2 Pt awake
	s̄ acute episode. — [redacted] 97WM6 b6-2

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MEDCOM - 13062

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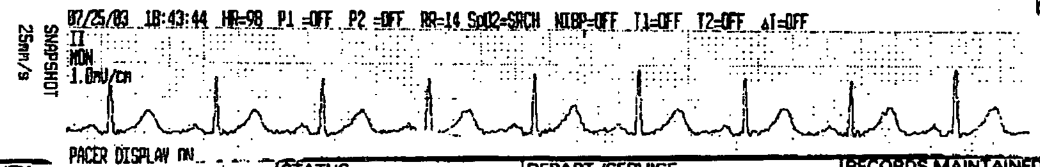
MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
25 JUL 03 1450	Restarted IV 20 gauge Ⓡ wrist. LR infusing @ 100cc/h. Will cont to monitor UO. Will cont. care. b6-2 [redacted] 10TAW
1500	Pt UO <20cc/°. Informed Dr b6-2 [redacted]. 1L NS bolus verbal order. Will cont to monitor U.O. b6-2 [redacted]
1600	Pt walked from bed to chair ō minimal assistance. Pt wincing in pain. Gave 4mg MSO4 @ 1645. NS bolus infusing. Ring linen. Ø needs from pt. Will cont. care b6-2 [redacted]
1700	Pt sitting in chair & tolerating well. Pt ate 6 bites of dinner and refused the rest. Explained to pt if not eat will give dophoff tube. Will cont. care. b6-2 [redacted]
1840	Gave report to night shift. Ø BM throughout day. UO ≈ 38 p̄ bolus. ≈ 300cc bolus still to infuse. b6-2 [redacted]
25 July (1900)	Pt care report Recieved from LT [redacted]. b6-2 Pt Awake s̄ noted Acute Episode. Oriented only to Person. Co-operative. Sitting in Chair AC Bedside. [redacted] 91W b6-2


07/25/03 18:43:44 HR=98 P1 =OFF P2 =OFF RR=14 SpO2=SRCH NIBP=OFF T1=OFF T2=OFF ΔT=OFF
SNAPSHOT
25mm/s
II
MON
1.0mV/cm
PACER DISPLAY ON

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.

#[redacted] b6-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
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MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
27JUL03	Progress Note
	Patient s̄ specific complaints today
	HR 91 RR 14 97% SAO_2 RA 136 | 103 | 7 < 98 / 4.6 | 22 | 1.0
meds	UOP 7855
Albuterol 2 puffs	Tmax 100' 9.5 > 9.7 / 31.7 < 990
q6°	wounds nicely dressed
Lovenox 90 mg SQ	Ø central line
BID	A: Progressing well
*Fentanyl patch	Plan DCS to q[illegible]°
	Δ LOS to three weeks [redacted] b6-2

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.)*

[redacted] b6-4

REGISTER NO.

WARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
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MEDCOM - 13064

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
29 July 03	Recieved report from Ssg [redacted] b6-2. Pt. resting in bed c̄ eyes closed.
0711	Ø distress noted. Ø complaints voiced. VSS. LR @ 100cc/hr. IV site
	patent. Will continue to monitor ——— b6-2 Sgt [redacted]
0800	Percocet Tab ii po for dsg Δ. Tolerated procedure well. Ø distress
	noted @ time. Pt. up to chair for breakfast p̄ dsg Δ. Consumed 50%
	of morning meal. Drank 360cc of fluids c̄ meal. Up to chair-
	bedside toilet for BM p̄ breakfast. Will continue to monitor.
	——— b6-2 Sgt. [redacted]
1044	Pt. remain sitting in chair s̄ discomfort. Will continue to monitor.-
	——— b6-2 Sgt. [redacted]
1147	Pt. back to bed s̄ difficulty. Will continue to monitor.-
	——— b6-2 Sgt [redacted]
1226	Pt. consumed 50% of meal. ——— b6-2 Sgt [redacted]
1418	Resting in bed c̄ eyes closed. Ø distress noted. Will cont.
	to monitor. ——— Sgt [redacted]
1753.	Up to BS toilet. Ø distress noted. Will continue to b6-2
	monitor. ——— Sgt. [redacted] b6-2
1800	Received report from day shift, pt resting
	comfortably in bed. [redacted] b6-2 SPC, 91WM6 —
1900	Pt IV DC'd due to leaking. Spoke to
	MD, Dr [redacted] b6-2 would like pt Output monitored
	through night [redacted] SPC 91WM6 —
2300	Pt resting comfortably in bed. VSS. Will b6-2
	continue to monitor. b6-2 [redacted] SPC, 91WM6 —
30 Jul 03	pt c̄ OOB to Bedside commode, small BM (formed).
2400	Will continue to monitor. b6-2 [redacted] SPC, 91WM6 —
0400	Pt resting comfortably in bed. Will continue
	to monitor [redacted] SPC, 91WM6 —

b6-2

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
28 July	1000 received report from previous nurse @ 0600; Pt resting
	comfortably in bed. IS x 10 (3kdlr), Dressing changed c̄
	2 percocet, Silvadene to burn and donor sites, petrolatum gauze c̄
	sulfamylon soaked gauze on graft areas, Ace wrap c̄ splint on Ⓓ
	leg. Pt stood up for dressing change on back and butt,
	Sat on chair for breakfast ate 20% c̄ 1 can ensure.
	foley care done, arm care done, VSS afebrile, will monitor [illegible]
1700	Pt walked the length of ward x2 mostly on his own c̄
	minimal assist, Sitting up on chair, ate 25% of dinner, 1 can
	ensure, VSS, tolerated well, Ø c/o will monitor [redacted] b6-2 [illegible]
28 July 03	(1800) Pt care Report Received from LT [redacted] b6-2
	Pt up in chair s̄ Acute Episode noted / Reported.
	b6-2 [redacted] 91WM6
28 July	(2120) Back to Bed c̄ assist of (2) Staffs.
	Slow, unsteady gait c̄ posture leaning forward.
	Positioned on Ⓛ Side. b6-2 [redacted] 91WM6
29 July	(0100) Continues sleeping @ 1.5 - 2.0 hr in-
	tervals s̄ acute Episode. b6-2 [redacted] 91WM6
29 July	(0600) Pt care report given to b6 [redacted]. Pt Resting
	Asleep s̄ acute episode noted. [redacted] 91WM6 b6-2

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.

[redacted] b6-4

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

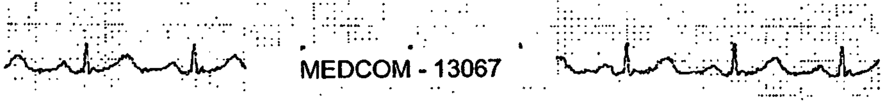
MEDCOM - 13066

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
31July 03 0630	Report recieved from night shift nurse. pt VSS, Ø IV access, foley cath in place draining clear yellow urine. Will continue to monitor. [redacted] 91WM6
0730	pt ~~pre~~ medicated for drsg Δ c̄ percocet II tabs PO —— [redacted] b6-2 b6-2
0930	Pt's dressings Δ'd. Xeroform on back trimmed. Dr. [redacted] b6-2 present during drsg Δ to evaluate wounds. pt for OR tomorrow in AM [redacted] 91WM6
1200	pt VSS, asleep in bed @ this time. Consumed 50% of lunch. —— [redacted] 91WM6
1400	pt out of bed, sitting in chair. —— [redacted] 91WM6
1756	pt currently sleeping. VSS. Consumed 40% of dinner. —— [redacted] 91WM6
~~1800 30J~~	(31July 1800) Pt CARE Report Recieved from Maj [redacted] b6-2 / SPC [redacted] b6-2. Pt resting in Bed awake s̄ acute episode noted/Reported. [redacted] 91WM6 b6-2
31July03	(1900) Skin Assessment unRemarkable for wounds to Bilat Hands, ABD, Back, Buttock & BLE (thighs, LE). Pt Request Ø Analgesia. Denies discomfort. All wound dressed per Rx. —— b6-2 [redacted] 91WM6
31July03	(2030) PIV 20g CATH STARTED TO Ⓛ upper Anterior Arm by LT [redacted] b6-2. Previous attempts to Bilat FA unsuccessful by SSG [redacted] b6-2 / SPC [redacted] b6-2 NS @ 100° per dial-A-flow. Site intact c̄ opsite dressing. —— b6-2 [redacted] 91WM6
01July03	(0315) To BSC, per Request "my stomach". No acute distress noted @ present. —— [redacted] 91WM6

FPI. LEX. Printed on 7) BACK

b6-2

17:57:48 HR=97 P1 =OFF P2 =OFF RR=18 SpO2=83% NIBP=OFF T1=OFF T2=OFF ΔT=OFF



MEDCOM - 13067

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (*Sign each entry*)
30 July 03 0630	Recieved report from SPC [redacted]. b6-2 pt VSS
	∅ IV access, foley cath in place. Will b6-2
	continue to monitor. —— SPC [redacted] b6 91WM6
0830	Drsg changes done. Pre medicated c̄ b6-2
	percocet ii tabs. —— [redacted] 91WM6
1200	Foley cath D/c'd —— [redacted] b6-2 91WM6
Correction	Last note, wrong pt —— [redacted] 91WM6 b6-2
1200	pt sleeping @ this time. VSS, afebrile
	UOP adequate. Will continue to monitor —— [redacted] b6-2
1600	VSS, no Δ in condition —— [redacted] b6-2
~~30Jul03~~	~~Received report from of going shift. Pt appearse~~
[redacted] ~~1800~~	~~to be resting comfortably in bed. VSS. PICC to Ⓛ FA~~
	~~⊕ Flush to both ports~~ [redacted] b6-2
30Jul03.	
1910.	Pt up sitting in chair. Pt transferred c̄ minimal
	assist —— [redacted]
2010.	Pt had small soft brown BM. Pt back to b6-2
31Jul03.	bed —— b6-2 [redacted]
0130.	Pt continues to appear restless in bed. Ambien
	5mg PO given to help pt sleep —— b6-2 [redacted]
0548	Pt resting quietly in bed s̄ complaint. VSS —— [redacted]
	b6-2

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.

Pt EPW [redacted] b6-4

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

MEDCOM - 13068

NSN 7540-00-634-4176 AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
01Aug03	(0600) Pt Remains hemodynamically stable. NPO status intact for pending surgical procedure. Eve dose of Lovenox held. Pt Care Report given to SPC [redacted] b6-2. Pt asleep s̄ Acute Episode. — [redacted] 91WM6
0630	Report recieved from night shift nurse. pt VSS, No significant changes in pt condition over night. IV 18g L AC LR @ 100cc/hr. — [redacted] b6-2 91WM6
0730	pt leaving for OR at this time — [redacted] 91WM6
1030	pt back from OR. VSS will initiate recovery procedures — [redacted] b6-2
1200	pt sleeping at this time. VSS, afebrile Ø c/o pain at this time — [redacted] b6-2 91WM6
1230	pt medicated c̄ Percocet II tabs for c/o pain — [redacted] b6-2
1500	pt asleep @ this time. VSS [redacted] b6-2
1Aug03	(1800) Pt Care report from SPC [redacted]. Pt s̄ acute Episode noted/Reported. b6-2 [redacted] b6-2 91WM6
2Aug03	(0600) Pt Care report given to SPC [redacted]. Pt night uneventful. BSC c̄ 1 small Brown formed BM b6-2 C0015. 0055 Ambien + Percocet given. — [redacted] b6-2 91WM6

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.

[redacted] b6-4

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
2 Aug 03 0630	Recieved report from SSG [redacted] b6-2 pt
	VSS, no significant Δ in condition over
	night. b6-2 [redacted] 91WM6
0800	pt to Xray [redacted]
0900	IV in pt's Ⓛ ac infiltrated during b6-2 trip to
	X-ray new IV started in Ⓛ wrist [redacted] b6-2
0930	Drsg Δs done at this time. b6-2 [redacted]
1200	VSS, pt asleep at this tim[redacted]. Ø new c/o
	pain b6-2 [redacted]
02 Aug 03	(1800) Pt CARE Report Recieved from SPC [redacted] b6-2
	Pt awake, alert, oriented to person, c̄ easy Re-
	orientation to place/event. No acute episode
	noted/Reported. b6-2 [redacted] 91WM6
02 Aug 03	(2100) BiLAT heel dressing Δ per Rx in progress.
	Medicated c̄ total 6mg IVP MSO4 for procedure.
	Tolerated care c̄ ↑↑ crying out/withdrawing.
	esp. c̄ Ⓛ foot (Ⓡ lateral ~~edge~~ edge + heel). Wound
	edges erythemic @ Ⓡ edge. Quiet s̄ care.
	b6-2 [redacted] 91WM6
02 Aug 03	(2200) c/o "Stomach Not good", "gas". Pt denies
	need to defecate. No flatulence noted. BS active,
	ABD Soft, nontender x 4 quads. b6-2 [redacted] 91WM6
03 Aug 03	(0050) Ambien 10mg PO for noted wakefulness c̄
	Restlessness. Pt Quiet p̄ care. [redacted] b6-2 91W
03 Aug	(0600) PT Care report given to Cpt [redacted] SC'. Pt
	Resting s̄ acute Episode [redacted] 91WM6
	b6-2

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STANDARD FORM 600 (REV. 6-97) BACK

NSN 7540-00-634-4176 AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (*Sign each entry*)
1 Aug 03	Brief op note
	Procedure: ① Debridement (B) fingers
	② Debridement R heel Eschar
	Dr Jeg
	GETA
	EBL min.
	Ø complicn
	Findg purulent drainage (R heel.
	[redacted] b6-2

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.

[redacted] b6-4

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

MEDCOM - 13071

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
04Aug03	Progress note
	Patient comfortable
Med	Afebrile
Lovenox	UO 1500
Paxil	wounds healing
Fentanyl patch	Ø : Dsg OK
MSO4 PRN	Cont + c̄ current plan [redacted] b6-2
04Aug03 0919	Drsg Δ completed. Pt. was premedicated c̄ Percocet tab ii po. Tolerated procedure well. Will continue to monitor. b6-2 [redacted]
1048	Pt. resting in bed c̄ eyes closed. RR16 HR86. Ø distress noted Will continue to monitor. b6-2 [redacted]
1202	Resting c̄ eyes closed. Easy to arouse. Ø distress noted RR18 HR82. Will continue to monitor. b6-2 [redacted]
1403	Resting in bed c̄ eyes opened. Ø distress noted Will monitor. b6-2 [redacted]
1712	Pt. lying in bed c̄ eyes opened. Will cont. to monitor. b6-2 [redacted]
1800	Pt care report received from SGT [redacted] b6-2. Pt awake alert, oriented s̄ acute episode. [redacted] b6-2 1Lt
2100	Dressing Δ to Bilat heels completed per Rx. Pt c̄ ↑↑ c/o discomfort throughout procedure. Premed c̄ 10mg IV MSO4 By LT [redacted] b6-2 ii percocet given @ 2200 & Ambien 10mg @ 2230. Pt continue c̄ c/o discomfort

STANDARD FORM 60[redacted] 1Lt b6-2

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NSN 7540-00-634-4176 AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
02AUG03	Pt. resting in bed s̄ complaints. Consumed ½ cans of
0741	ensure c̄ coca added for flavoring. Consumed 30% of
	breakfast @ that time. Will continue to encourage
	fluid intake for Calories. b6-2 [redacted]
0757	Percocet Tab ii po for pre-medication for dsg Δ.
	b6-2 Sgt. [redacted]
1042	Dsg change completed. Ø distress noted.
	Will continue to monitor. b6-2 Sgt [redacted]
1244	Resting in bed s̄ distress. Will continue
	to monitor. b6-2 Sgt. [redacted]
1346	Resting in bed c̄ eyes opened. Ø distress noted. Will
	continue to monitor. Sgt. [redacted]
1554	Up to ICW I due to AC problems. Ø b6-2
	distress noted. b6-2 Sgt. [redacted]
1738	IV pulled out. New one placed to Ⓡ inner
	arm. Ø redness/swelling noted to area. Will
	Continue to monitor. b6-2 Sgt. [redacted]
[redacted] ~~0800~~ 0630	Gave report to SGT [redacted] b6-2 [redacted]
04Aug03	Recieved report from Spc [redacted] b6-2. Pt. resting in
0600	bed s̄ complaints. Ø distress noted. Condition Remain
	Stable @ present time. Will continue to monitor.
	Sgt [redacted]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT b6-2
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.

#[redacted] b6-4

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

MEDCOM - 13073

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
5 Aug 03 1800	Gave report to night shift. [redacted] b6-2
1820	Received report from day shift. Pt resting in bed c̄ no
	c/o pain. VSS. [redacted] b6-2
(2100)	Pt's VSS, ∅ c/o pain, resting in bed. [redacted] b6-2
(2300)	Pt's VSS, ∅ c/o pain. Pt sleeping in bed. will
	continue to monitor. [redacted] b6-2
06Aug03	(0100) Pt sleeping in bed VSS q urine to foley drs
	clear yellow no c/o pain. [redacted] b6-2
	(0300) Pt had formed BM, VSS, ∅ c/o pain. will
	continue to monitor [redacted] b6-2
	(0500) VSS, Pt sleeping in bed, no c/o pain.
	will continue to monitor. [redacted]
	(0600) Gave report to day shift. [redacted] b6-2
06Aug03	Received report from Spc. [redacted] b6-2. Pt resting in bed c̄ eyes
0600	opened s̄ complaints. ∅ distress noted @ present time. Vital
	Signs stable; B/P 109/68 HR 81 RR 18. Will continue to monitor.
	Sgt [redacted] b6-2
0700	Pt. consumed 50% of breakfast. Drank ensure.
	Sgt [redacted]
0745	Percocet tab ii given po for pre-medication for drsg Δ. b6-2
	Sgt [redacted]
0800	Drsg Δ start. Dr. [redacted] b6-2 @ BS. Pt tolerated procedure b6-2
	well. 0840 Drsg Δ completed. Pt up to BS toilet. Will
	continue to monitor. b6-2 Sgt [redacted]
1025	Pt. back to bed @ present time. Up talking c̄ PAD personnel.
	∅ distress noted. Will continue to monitor. b6-2 Sgt [redacted]
1225	Consumed 60% of lunch s̄ difficulty. Will ~~contin~~
	continue to monitor. Sgt [redacted]

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STANDARD FORM 600 (REV. 6-97) BACK

b6-2

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
2400 4 Aug 03	Pt asleep s̄ acute Episode noted! — b6-2 [redacted] 91Wm
5 Aug 03 (0600)	Pt care rept given to LT [redacted]. Pt awake, calm, pleasant. Bilat heels/BLE ↑ on pillow supports. — b6-2 [redacted] 91Wm6
5 Aug 03 0600	Received report from previous shift. Pt awake c̄ 0 % pain/discomfort. LR infusing. 0 needs expressed. Will cont. care. — b6-2 [redacted] 1LT/AN
0700	Pt ate 45% of breakfast c̄ minimal assistance. Encourage pt to eat more food and drink more ensure. Will cont. care. — b6-2 [redacted] 1LT/AN
1200	Completed drsg Δ's. Washed burn wounds & graft sites c̄ hibiclens. Rinsed c̄ NS. Applied silvaden wrapped c̄ kerlex & burn drsgs. Wrapped Ⓛ leg c̄ ace bandage. Gave total MSO4 4 mg IVP. Pt tol. well. Δ'd linens. Pt to BSC. Bilat heels appear necrotic. Will inform Dr. for possible OR to debride/clean wound. Will cont. care. — b6-2 [redacted] 1LT/AN
1400	Pt resting quietly c̄ eyes closed. 0 % pain, discomfort. Will cont. care. — b6-2 [redacted] 1LT/AN
1600	Pt awake in bed. 0 needs expressed. Will cont. care. — [redacted] 1LT/AN

HOSPITAL OR MEDICAL FACILITY

STATUS

DEPART./SERVICE

RECORDS MAINTAINED AT b6-2

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.

[redacted] b6-4

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

MEDCOM - 13075

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10 Aug 03 @ 2250	pt report received from Sgt [redacted] b6-2 pt VSS Assessment Complete
	pt resting quietly @ this time no problems @ present dressings remain
	CDI will continue to monitor throughout night for acute Δs
	b6-2 [redacted]
11 Aug 03 @ 0500	pt slept comfortably throughout night no problems noted @ present
	and pt has Ø complaint at this time VSS will continue to monitor
	b6-2 [redacted]
11 Aug 03	Nursing: VSS. Ø distress noted. Pt ate 60% of
0844	breakfast. Dressings C/D/I. Resting quietly @
	this time. Ø complaints voiced @ this time.
	b6-2 [redacted]
11 Aug 03	Nursing: Dressing Δ completed. Pt received ī tabs
1349	Percocet prior to ~~begin~~ DM1345 dressing Δ. Pt tolerated
	procedure well and able to assist staff during
	dressing Δ. Graft and donor sites healing well
	except for graft site on Ⓛ knee. Pus noted on
	Ⓛ knee. Silvadene cream applied to Ⓛ knee, Ⓑ heels
	and small segments of grafts that are not healing as
	well. Eucerin 1352 cream applied healed graft +
	donor sites. Pt resting quietly @ this time s̄
	complaint. [redacted]
	b6-2

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.

[redacted] b6-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
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FIRMR (41 CFR) 201-9.202-1
USAPA V2.00

MEDCOM - 13076

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
12Aug03 @2335	pt Assessment Complete VSS pt condition s̄ Δ's pt is resting quietly in bed with Ø complaints @ this time pt shows no signs of acute distress @ present will continue to monitor throughout night [redacted] PFC
13Aug03 0628	Recieved report from night shift nurse. Pt resting in bed c̄ eyes opened. Ø distress noted. Ø complaints voiced @ present time. Will continue to monitor. Sgt. [redacted]
0740	Percocet Tab ii p.o. for pre-med before drsg Δ. b6-2 Sgt [redacted] b6-2
0943	Drsg Δ complete @ this time. Pt tolerated procedure well. Resting in bed @ present time c̄ eyes opened. Ø complaints. Will continue to monitor. Sgt [redacted] b6-2
	Surgery No complaints VSS Afeb Wounds healing. No Labs A/P cont Dressing Δ's [redacted] b6-2
1137	Pt resting in bed c̄ eyes closed. Ø distress noted. RR 11 b6-2 Will continue to monitor. Sgt [redacted]
1317	Lying in bed c̄ eyes closed. Ø distress noted. Will Monitor. Sgt [redacted]

b6-2

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
11 Aug 03	Nursing: Pt resting quietly s̄ complaints.
1726	Dressings C/D/I. VSS. b6-2 [redacted] 2LT/AN
1800	Received report, Patient resting in bed. [redacted] 1LT/AN
1850	Assessment completed. VSS. ∅ Complaints. [redacted] 1LT/AN
2100	Patient sleeping. b6-2 [redacted] 1LT/AN
2300	Drsg change to feed. Premedicated c̄ Percocet ii tabs.
	Small amount of yellowish drainage on heels Ⓑ [redacted] 1LT/AN
12 AUG 03 0100	Patient sleeping. b6-2 [redacted] 1LT/AN
0430	Labs drawn/sent to lab. [redacted] 1LT/AN
0500	Fentanyl patch changed. b6-2 [redacted] 1LT/AN
0600	Recieved report from Lt [redacted] b6-2. ∅ distress noted. Will
	monitor. b6-2 Sgt [redacted]
0730	Percocet Tab ii p.o. given for pre-med. Drsg Δ.
	b6-2 Sgt [redacted]
0930	Drsg Δ completed @ present time. ∅ distress
	noted. Will monitor b6-2 Sgt [redacted]
1105	Resting in bed c̄ eyes closed. ∅ distress noted @
	present time. Leap 10+ever. Will monitor. b6-2 Sgt [redacted]
1402	Resting c̄ eyes closed. ∅ distress noted @ present
	time. Will continue to monitor b6-2 Sgt [redacted]
1617	Resting quietly in bed s̄ distress. Will continue
	to monitor Sgt [redacted]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
			b6-2
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.)*

[redacted] b6-4

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

USAPA V2.00

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
2230	Dressing Δ complete. Pt tolerated procedure well. Will continue to monitor. [redacted] b6-2 SPC, 91WM6
13Aug03 0300	Pt resting comfortably in bed Will continue to monitor. [redacted] b6-2 SPC 91WM6
15Aug03 0609	Received report from SPC [redacted] b6-2 Pt sitting up in bed eating breakfast s̄ distress. Ø complaint(s) voiced @ present time. Will continue to monitor. b6-2 Sgt [redacted]
0615	MD in this morning to make rounds. New orders noted @ present time. Sgt [redacted] b6-2
0633	Premedicated c̄ percocet for drsg Δ. Will monitor. b6-2 Sgt [redacted]
0800	Drsg Δ completed @ present time. Pt tolerated procedure well. Will continue to monitor b6-2 Sgt [redacted]
1000	Resting in bed s̄ distress. Will continue to monitor. b6-2 Sgt [redacted]
1213	Sitting up in bed talking c̄ staff. Ø complaints voiced @ present time. Will continue to monitor. b6-2 Sgt [redacted]
1415	Resting in bed c̄ eyes closed. Ø distress noted. b6-2 Sgt [redacted] Will monitor.
1617	Resting in bed on Rt side. Ø complaints voiced. Will continue to monitor. b6-2 Sgt [redacted]
1830	Received report from outgoing shift. Pt resting in bed. Plan: Continue c̄ POC and dressing change to the bed tonight [redacted] Maj/AN b6-2

STANDARD FORM 600 (REV. 6-97) BACK

USAPA V2.00

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
13 Aug 03	Resting c̄ eyes closed. Ø distress noted. b6-2
1528	Will continue to monitor. Sgt [redacted]
1745	Sitting up in bed eating dinner s̄ distress. Will
	monitor. Sgt. [redacted] b6-2
14 AUG 03	Received report from night shift. Pt awake
0600	in bed c̄ Ø complaints @ this time. VSS. Will
	cont. care. [redacted] b6-2
1015	Gave percocet ii tabs for drsg Δ. Δ'd drsgs
	by washing wounds c̄ hibiclens and rinsing
	c̄ NS. Applied silvadene and wrapped wounds
	in burn drsgs. Ace wrapped (L) LE. Pt tol.
	drsg Δ well. Will cont care. b6-2 [redacted] 1LT AN
1230	Pt resting quietly c̄ eyes closed. Ø needs expressed.
	Will cont care. [redacted] 1LT AN b6-2
1700	Ø needs expressed @ this time. Pt resting quietly.
	Ate 60% dinner. Will cont care. b6-2 [redacted] 1LT AN
1800	Gave report to next shift. b6-2 [redacted] 1LT AN
1800	Received report from 1LT [redacted] Pt resting comfortably
	in bed, VSS, Dressings C/D/I. Will continue
	to monitor. [redacted], SPC, 91WM6 b6-2
2130	Pre medicated c̄ II tabs percocet for Dressing
	Δ. [redacted] b6-2 SPC, 91WM6

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.

EPW [redacted] b6-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1
USAPA V2.00

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
16 Aug 03	Received report From Nightshift + assumed
0600	care of Pt. VSS, Ø Ntd distress @ this time. Will
	monitor. ——— b6-2 [redacted] 91WM6
0800	Pt lying in bed sleeping + appears to be resting
	Comfortably @ this time. Will monitor. —— [redacted] 91WM6
1050	Pt to OR for heel debridement. b6-2 —— [redacted] 91WM6
1145	Pt back From OR, see recovery sheet — [redacted] 91WM6
1215	Pt medicated c̄ 2tabs Percocet for drsng Δ. Will b6-2
	monitor. ——— b6-2 [redacted] 91WM6
150-1330 NC ~~1225~~	DRsng Δ's performed @ this time. Old dressings removed
	+ sites cleaned c̄ hibiclens + rinsed thouroughly.
	Silvidine applied to sites + bulky dressings. Pt b6-2
	tolerated well, Will monitor. ——— [redacted] 91WM6
1600	Pt complaining of heel pain, medicated c̄ 2 tabs percocet.
	Will continue to monitor. ——— b6-2 [redacted] 91WM6
16 Aug 03 1800	pt report recieved from Sp [redacted] b6-2 No problems noted @ this time will
	continue to moniter ——— b6-2 [redacted] PFC Sam
@2100	pt c/o pain medicated as per doctors orders no problems @ present will
	continue to moniter ——— b6-2 [redacted] PFC Sam
@2305	pt VSS no problems @ present pt remains calm resting in bed @
	this time will continue to moniter ——— b6-2 [redacted] PFC Sam
@0005	pt dressing Δ'd s̄ complication medicated as per doctors orders
	pt resting quietly @ this time will continue to moniter — PFC [redacted] b6-2
17 Aug 03	Received report from PFC [redacted] b6-2. rest in bed
0700	c̄ eyes opened. Ø distress noted. Bandage to
	(B) feet, leg + hands IV site to (L) AC s̄ infiltrati
	Ø complaints voiced. USS Will monitor. ———
	[redacted] b6-2

STANDARD FORM 600 (REV. 6-9[redacted]

USAPA V2 00

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
15 Aug 03	Dressing changed earlier, applied Silvadene ē 4x4
2300	gauze. Wound have whitish/cheesy like appearance.
	Needed debridement. Spoke to MD. about debriding it.
	MD will debride in AM. Pt placed on NPO status
	after MN. Pt made aware ——— [redacted] Maj/AN b6-2
0300	Up the bedside commode, c/o abdominal cramps. Had
	one hard stools in large amt. Voiding spontaneously
	s̄ problem. VSS, afebrile. Remained NPO for heel
	debridement today ——— [redacted] b6-2 Maj/AN
0430	Draw blood, able to draw enough amount for
	chem 8, CBC deferred @ this time previous H+H 11.4/36.1
	from Wednesday, no active bleeding noted to necessitate
	needing CBC. Will notify physician. Pt [redacted] b6-2 remain
	NPO
16 Aug ~~0600~~	OP Note
1100	Indication heel wounds
	Surgeon [redacted] b6-2
	Anest GETA
	Findings heel necrotic tissue debrided & Dressed.
	to ICU ē good cond.
	[redacted] b6-2

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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.

[redacted] b6-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
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USAPA V2.00

MEDCOM - 13082

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17 AUG 03	Surgery
	No complaints heel debridement
	yesterday
	VSS AFeb.
	cont dressing D's.
	will plan full thickness skin graft to heels
	when good granulation.
	[redacted] b6-2
17 Aug 03	Drsg Δ completed @ present time. Pre med.
1032	c̄ Percocet Tab ii p.o. @ 0820. ø complaints
	voiced. ø distress noted. Tolerated drsg Δ
	well. —— Sgt [redacted] b6-2
1324	Up to BS toilet s̄ complication. C/o being ~~tired~~ restrained
	to bed. ø complaints of pain voiced. Will
	Continue to monitor. —— Sgt [redacted] b6-2
1623	Lying in bed on back. ø complaints voiced. Will
	continue to monitor. —— Sgt [redacted]
~~1758~~	~~Percocet Tab ii po. for pain.~~ error [redacted] Sgt [redacted] b6-2
17 Aug 03 @ 1828	pt report recieved @ 1800 From Sgt [redacted] b6-2 pt resting quietly @ this time
	ø complaint no signs of acute distress noted @ present will continue
	to monitor throughout Night —— [redacted] b6-2 PFC 91WM6

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.

EPW [redacted]

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
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MEDCOM - 13083

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17 Aug 03 @ 1730	pt VSS Assessment complete pt doing well no complaints @ this time will continue to monitor —— [redacted] b6-2 RC
17 Aug 03 0715	Nursing: VSS, see ICU flow sheet for nursing assessment. Exp. wheezing auscultated in upper + middle lobes. Pt denies any respiratory distress. Pt using Albuterol inhaler s̄ difficulty. Sats 96% on RA. [redacted] b6-2
17 Aug 03 1510	Nursing: Dressing Δ completed. Pt received Percocet 2 tabs prior to dressing Δ. ~~Burn~~ RK 1511. Grafts healing well except for Ⓛ knee. Purulent yellow drainage noted on Ⓛ knee extending to ~~tendons~~ [redacted] 1517 - possible bone. Wet to dry dressing done on Ⓑ heels. Heels red to pink. Pt tolerated procedure well. —— [redacted] b6-2
17 Aug 03 1800	Received report from off going shift, Pt has dressings to Ⓑ UE, BLE, ABD, Back. C/D/I Will continue to monitor. [redacted] b6-2 SPC, 91WM6
2200	Pt resting comfortably in bed VSS. Will continue to monitor. [redacted] SPC, 91WM6 — b6-2
19 Aug 03 0100	Pt resting comfortably in bed. VSS Will continue to monitor. [redacted] SPC 91WM6
0600	Reported off to on coming shift. b6-2 [redacted]
0600	Received report + assumed care of pt. VSS, Pt stable. Pt lying in bed sleeping + appears to be resting comfortably @ this time. Will monitor. —— [redacted] 91WM6
0820	Pt awake, sitting ↑ in bed eating breakfast c̄ Ø ntd complaints @ this time. Will continue to monitor. — [redacted] b6-2 91WM6
1300	Pt up in chair @ side of bed to eat lunch. Ø ntd complaints. Ø signs of distress, Will continue to monitor. —— [redacted] 91WM6

b6-2

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
20 Aug 03 1518	Nursing: Dressing Δ completed. Pt tolerated procedure [redacted] 1515 well. Pt assisted to clean and rinse hands. Purulent drainage noted on (L) knee. Silvadene cream applied to graft + donor sites on arms legs, abdomen, and back. Wet to dry dressing Δ ~~done to~~ [redacted] 1520 done to (B) heels. Pt premedicated c̄ Percocet 2 tabs PO. Pt ambulated up and down unit. Pt sitting up in chair eating lunch. b6-2 [redacted]
20Aug03 2100.	Drsg Δ complete to (B) heels. Heels are pink c̄ some yellow exudate. Saline soaked gauze placed and wound redressed — b6-2 [redacted]
23 AUG 03 2032	VSS. AO. DSG's CDI on all extremities. (+) pulses to all extremities and warm to touch. CR ≤ 2 seconds. Patient more flesh toned in face. Rotating in bed per routine turning. Denies pain @ this time. NPO p̄ MN. b6-2 [redacted]
25Aug03 @2100	Drsg Δ's completed to burn sites. IVF infusing to (R) AC s̄ complication. VSS, +2 pulses, Drsg Δ to heels. no c/o pain or discomfort. Will cont to mon — b6-2 [redacted] 91WM6 [redacted]
25aug@ 2130	Pt repositioned, meds given. Will cont to monitor — [redacted] 91WM6 SPC b6-2

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
19 Aug 03 1515	Pt pre-medicated c̄ 2 tabs Percocet for dressing Δ. Will monitor.
	Plan to start dressing Δ in 30 mins. b6-2 [redacted]
1610-1715	Dressing changes performed. Old dressings removed, sites
	cleaned c̄ hibiclens + rinsed thouroughly. W/T/D to heels,
	other sites covered c̄ silvidine + bulky drsngs. Tolerated
	Drsng Δ well. Will continue to monitor. b6-2 [redacted]
1840	Nightshift Nurse finaly ready for report, Reported OFF.
	b6-2 [redacted]
1840	~~Dayshift finally ready~~ Error ~~to~~ give ~~report~~ Report received from
	day shift [redacted] b6-2
2005	Percocet 2 tabs PO given in preparation for
	drsg Δ to heels. [redacted] b6-2
2040	Drsg Δ'd to Ⓑ heels. Heels appear beefy red c̄ some
	areas of yellow exudate noted. W to D drsg as
	ordered b6-2 [redacted]
0050	Pt up @ BS voiding. Pt voided clear dark yellow
	urine. Pt c/o difficulty urinating @ times, but
	denies burning. Will notify MD in am. b6-2 [redacted]
20 Aug 03 0911	Nursing: VSS, sats 95% on RA. Pt denies any difficulty
	breathing. Inspiratory / Expiratory wheezing auscultated
	in Ⓑ upper + middle lobes. Dressings c/d/i. No
	complaints voiced. [redacted] b6-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
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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. ICU-3

#[redacted] b6-4

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

USAPA V2.00

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
21AUG03	(1605) Pt admitted to unit via litter in stable condition. Pt A/O speaking some English. ⌀ C/o pain. VSS. Lungs CTA(B). ⊕ BS x4 quads. Drsgs CDI. Ace wraps to feet intact. Pt positioned on Ⓡ side @ this time. Pt restrained to bed c̄ wrist restraints. Pt resting quietly @ this time. Will continue to monitor. [redacted] b6-2
21 AUG03 2300	VSS. A/O. DSG's to Abdomen & arms CDI as well as to back. Denies pain @ this time. IS performed x10 c̄ difficulty. ⊕ pulses. Flushed color to skin. Resting comfortably. [redacted] b6-2
22AUG03	(1345) Assumed care of pt @ 0700 p̄ report from night shift. Pt alert speaking some English. Drsg on abdomen Δd this am - silvadene cream applied to wound site. Drsgs on arms and back CDI. Ace wraps on feet CDI. Feet elevated on blankets. Temp @ 1300-100.7 Pt C/o chills. Pt medicated c̄ ii Tylenol. Will recheck temp in 1°. ⌀ C/o pain. 2-point restraints in place. Pt resting quietly @ this time. Will cont. to monitor. b6-2 [redacted] (1440) Drsgs to heels Δd. Silvadene applied to Ⓛ heel. Heels elevated off of bed. Pt denies need for pain meds. Dr. [redacted] aware of pt's fever. Will send UA c̄ next void. Monitoring. [redacted] b6-2
22AUG03 2005	Elevated T @ 101.9 and provided 2 tylenol. A/O. Denies pain @ this time. DSG's CDI. LSCtAB. S1, S2. ⊕ pulses. Reinforced IS use q1-2° to reduce fever. Resting comfortably in bed. Somewhat pale color / flushed. [redacted] b6-2

STANDARD FORM 600 (REV. 6-97) BACK
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MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
20AUG03	SURGERY
	VSS AFEB
	NO SIGNIFICANT CHANGES
	WNDS: CDI
	CV: RRR
	Rp: SMB13
	PLAN: TO BAGHDAD TOMORROW [redacted]
	b6-2
21 Aug 03 0904	Nursing: VSS. Sats 96% on RA. Denies any SOB. Respirations regular + unlabored. Dressing Δ completed. Pt given Percocet ii tabs prior to dressing Δ. Pt tolerated procedure well. Pt assisted in cleaning arms and thigh. Purulent drainage noted on Ⓛ knee. Silvadene cream applied to graft and donor sites. Wet to dry dressings done on Ⓡ heel. Fentanyl patch Δ'd. Pt given scheduled dose of Atarax and Colace. Pt prepared for transport to Baghdad hospital. Pt to be transferred via litter. [redacted]
	b6-2

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[redacted] b6-4

REGISTER NO.

WARD NO.

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MEDCOM - 13088

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
26AUG03 1145hr	VSS Alert & Oriented. Medicated c̄ Mo[redacted] MSO4 5mg IVP upon arrival to floor from PACU via litter. O2SAT 96% ~~Resp~~ [redacted] ~~18/min~~. Resp 18/min even and unlabored. Lower extremities elevated to keep heels clear of bed. Continuous suction on as ordered. Lungs clear. BS (+) x4 quadrants. Pedal pulses palpable bilateral. Capillary refill < 3 sec to toes bilaterally. Will continue to monitor comfort level. Restraints reapplied will check restraints frequently. Will heplock IV to (L) AC which is patent & intact. [redacted] b6-2 7274
26AUG03 1830	Pt. resting, easily aroused. Resp (18) even & unlabored. O2 Sat 96%. VSS, c/o pain 5mg MSO4 given c̄ obvious relief. Site to heels c̄ continuous suction as ordered. Legs elevated slightly c̄ heels off bed in air. Drsg c̄ xeroform to lower extr. burn site to abdomen c̄ no drg noted. IV site to (L) AC patent s̄ s/sx infection/infiltration. Pt voiding dyu adequately. Encourage PO fluids. Will cont to mon. [redacted]

HOSPITAL OR MEDICAL FACILITY | STATUS | DEPART./SERVICE | [redacted]

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.

[redacted] b6-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
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MEDCOM - 13089

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
27 aug 03 @ 0025	Site of skin graft removal (buttocks) began bleeding. Hematoma present. sutures intact c̄ active bleeding noted. Pressure applied. MD notified. (Dr [redacted]). MD came to BS. Pt saturated 2 dressings & linen. MD cut one suture & packed site c̄ iodiform, then applied pressure dressing. VS were taken BP 120/75 P: 120 R 22 O2 Sat 83. LR [redacted] started into ② FA s̄ complication. CBC c̄ C&T x2 units to be done after bolus. O2 by NC applied. 2L. new orders given: O2 by NC 2L PRN, notify MD if HCT<28, HR>100, or if pt continues to saturate dressing. Will monitor drsg frequently cont to mon —— [redacted] 91WM6
27 aug @ 0130	Pt VS taken: 118/68 R:20 P:89 O2 Sat 95 resp even & unlabored. ∅ distress noted. Pt may go back to OR in AM? Will cont to mon — [redacted] 91WM6
27 aug 03: @ 0215	Pt suture site to buttocks began bleeding. Saturated dressings again c̄ small amt of pooling. O2 by NC 2L on. BP 108/73 R:20 P: 101 O2 Sat 94%. resp even & unlabored. MD notified. Dressings reinforced. MD came to bedside. soaked gauze in lidocaine c̄ epi & packed the site. LR @ 125cc/hr infusing per orders

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
27AUG0	VSS. NPO O/C for OR. A & Oriented.
0800	Lungs clear (B) O2SAT 98% on 2l NC. Peripheral
	pulses palpable. Reinforce buttock drsg and
	change linen soiled ē blood @ 0600. Ø
	soiling of blood on sheet @ this time. Suction
	@ 125 continuous to Bilateral heels. Lower
	extremity elevated to keep heels clear of
	bed. (L) FA IV patent & intact infusing
	LR @ 125cc/hr. Will continue to monitor
	[redacted] 2LT AN
	b6-2
27AUG03	OR NOTE
	PRE-OP DX: LEFT BUTTOCK HEMATOMA / BLEEDING
	POST-OP DX: SAME
	PROCEDURE: CONTROL OF BLEEDING & WASH-OUT / CLOSURE
	SURG: [redacted] / [redacted]
	EBL: 50cc b6-2
	FLUID: 1 UNIT PRBC 500cc LR
	COMPLICATIONS: Ø
	STABLE TO RR [redacted] b6-2
27AUG03	Received Pt from PACU Alert & Oriented
1200	VSS ~~Drg~~ [redacted] Drsg to (L) buttocks dry & intact
	Lungs clear. Abd soft non distended.
	BS (+) x4 quadrant. (L) upper arm IV patent
	& intact infusing LR @ 125cc/hr. O2SAT 98%
	on Room air. Bilateral heel drains connected
	to suction 125mmHg continuously. ~~Heels eleva~~

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(continued)

[redacted] 2LT AN

b6-2

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DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
27Aug03	given. CBC done @0230 HCT: 38.3, another
cont'd (0215)	CBC due @ 0600. now NPO for OR in
	AM. for washout & resuture of site.
	Will monitor graft sites closely —
	b6-2 [redacted] 91WM6
27Aug03	VS: 112/70 R:18 P:89 O2sat 95%. O2 @ 2L by
@0320	NC. Will monitor closely — [redacted] 91WM6
27Aug03	b6-2
@0445	Reinforced drsg to buttocks. Drsg's sat
	urated. SpO2 95% HR 104. labs drawn.
	(CBC). O2 by NC@2L. Pt voided 300cc cyu.
	800cc total output this shift. R:16
	even & unlabored. circulation assessed.
	brisk cap refill, + +2 pulses to extr. 2pt
	restraints on. LR @ 125 s̄ complication/infiltr
	Will cont to monitor [redacted] b6-2 91WM6, SPC
27Aug@	HCT now 31.1 (dropped 7 pts) 38.3 this
0600	am @0215. Will notify MD & oncoming shift
	[redacted] 91WM6
	b6-2

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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.

EPW # [redacted] b6-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
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NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
29NOV03	Surgery
	Pt stable / Afeb
	Lungs: CTA
	CV: RRR
	Abd: soft, NT, ND, +BS
	Wounds: Healing well
	Imp: stable
	Cont current management
	[redacted]
	b6-2

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.

[redacted] b6-4

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	(cont) place ø S&x complications c̄ circulation/skin
	breakV. Will continue to monitor. [redacted]
	b6-2
29AUG03	Surgery
	POD 4/3 Doing well s̄ complaint
	VSS/Afeb
	Lungs: CTA
	CV: RRR
	Wounds: Dressings Clean Dry + Intact
	Burns Healing well
	Rp: Stable
	Plan: Cont. current management [redacted] b6-2
29AUG03	Pt resting in bed, AtOx3, VSS, LS CTA Ⓑ, ⊕
2000	BS x4, SAT 96% w/o O2, S1 S2 present, ø/o pain
	@ this time, ø c/o nausea, Dsg to LE x2 CDI,
	wound appear to be healing properly c̄ ø s/sx of
	infex, Dsg to hands Ⓑ CDI, IV Ⓡ wrist patent
	infusing LR @ 100cc/hr, wall suction in place ø
	drainage noted, Dsg to heel Ⓑ intact, able to
	ambulate, able to move toes, peripheral pulses

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.
#[redacted] b6-4		

CHRONOLOGICAL RECORD OF MEDICAL CARE
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MEDCOM - 13094

DATE	[redacted]MPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
Cont.	[redacted]act. palpable, proper circulation + skin integrity on pts. of restraint. [redacted] 91WM6
	[redacted]
0200	Dsg's Δ'd. b6-2 [redacted] 91WM6
30AUG03	(1025) Assumed care of pt @ 0800 p̄ report from night shift. Pt sleeping, but easily aroused. VSS. Tol small amount of breakfast. Hct 24.8 this am Dr. [redacted] b6-2 notified. 1st unit PRBC started @ 1020 into IV in Ⓡ forearm. ϕ S/Sx adverse rxn @ this time. See SF511 for VS. Will cont. to monitor. b6-2 [redacted]
	(1245) 1st unit PRBC completed. ϕ adv. rxn noted. VSS. New 18g IV started in Ⓡ ankle d/t IV in Ⓡ forearm infiltrating during infusion. NS infusing s̄ S/Sx infiltration. monitoring. b6-2 [redacted]
	(1320) 2nd unit PRBCs started @ 1310. ϕ S/Sx adverse rxn @ this time. See SF511 for VS monitoring. b6-2 [redacted]
	(1640) 2nd unit PRBCs finished @ 1515. ϕ adverse rxn noted. LR restarted @ 100cc/hr via dial a flow p̄ completion of PRBCs. ϕ S/Sx infiltration of IV site. Drsgs to ⒷLE Δd. Silvadene cream applied to Ⓑ knees and Ⓡ shin. moisturin cream applied to healing skin graft sites. Drsgs to Ⓑ buttocks removed this pm. Sutures intact-open to air. Small amount of sero sang drainage noted on ch' Drsgs to heels intact. JP to heels to wall suction-cont. @ 125. Pt started on FeSO4. T reg diet well. Voiding s̄ difficulty. 2 · poir

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
30 Aug 03	Surgery
	PT STABLE / AFEB TOLERATING PO
	LUNGS: CTA
	CV: RRR HCT = 24.8
	ABD: SOFT, NT, ND ⊕BS
	Rp: STABLE
	PLAN: W.U. TRANSFUSE 2u PRBCS [redacted] b6-2
2 Sep 03	~~September~~ Surgery
	No complaints
	VSS Afeb.
	Heel grafts – Ⓡ ~80% take
	Ⓛ ~60% take c̄ some ? [illegible]
	A/P Doing well cont Bedrest.
	[redacted] b6-2

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.

[redacted] b6-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
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MEDCOM - 13096

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
30AUG03	(cont) restraints in place. - ∅ S/Sx complications c̄
	circulation/skin breakdown. Will continue to monitor.
	b6-2 [redacted]
30AUG 03	Pt resting in bed, HOB 45°, LS CTA Ⓑ, ⊕ BS x4,
1950	S1 S2 present, VSS, IV Ⓡ foot patent infusing
	LR @ 100cc/hr, ∅ c/o pain @ this time, drsgs
	LE x2 CDI, dsgs to UE x2 CDI, proper circu-
	lation + skin integrity on pts of restraint. [redacted]
	b6-2 [redacted] b6-2
31aug03 [illegible]	Received pt resting in bed. VSS, A+OX3.
	Dressing Δ'd by MD ∅ heels bilaterally
MD	States that dressing Δ's are BID on
	heels w/ vaseline gauze and kerlex
	wrap + to cont heel protection.
	pt other drsgs Δ'ed ā C/D/I. pt
	buttock incisions OTA, ∅ drainage
	noted and small 2x2 drsg noted
	on sacral area. IV patent & intact
	on Ⓡ foot. HOB↑ and heels off bed.
	~~No~~ Ⓡ thumb w/ sutures c/d/i with
	∅ drainage noted. Will cont to monitor
	pt. [redacted]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
	b6-2		

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.
#[redacted] b6-4		

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
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MEDCOM - 13097

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
31 Aug @ 2300	Assumed care @ 1800; VSS, pt A&OX3 speaking some english; Ø c/o pain or discomfort @ this time; S1 S2; LS CTA Ⓑ; ⊕ BS x4; pt voiding QS clear, yellow urine, Ø BM this shift; all dsgs Δd; eucerin, silvadene, & petroleum gauze applied to those ordered areas; dsgs CDI; sutures to Ⓡ thumb CDI, well approximated; incisions to buttocks OTA, Ø drng noted; HOB↑, heels off bed on pads; restraints in place, circulation & skin integrity intact; cont to monitor [redacted]
01 Sept 1830	Received pt resting in bed. VSS, A+OX3, Drsg Δ'd done per orders; Ⓛ knee appears to have yellow substance in the middle of wound, Ø odor noted. BS hyperactive. Loose stools x2 on this shift. Sutures Ⓡ thumb c/d/i. SVGS, HOB↑ heels on relief pads/doughnuts. Restraint in place per EPW protocol, good skin circulation + integrity noted. [redacted] b6-2
1 Sep. 03 1830	Pt awake in bed, A+Ox3, VSS, LS CTA Ⓑ, ⊕ BS x4, Dsg's hand Ⓑ CDI, Dsg's on LE Ⓑ CDI, IV Ⓡ foot patent infusing LR @ 100cc/hr c/o stomache ache + cramping q̄ pt ate meal, HOB 45°, proper circulation + skin integrity on 2 pts of restraint. [redacted] b6-2 91WM6
2030	Stomache ache controlled c̄ 12.5mg phenergan, will cont. to monitor. [redacted] 91WM6 b6-2
	Concur c̄ above assessment. [redacted]

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DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
3Sept03 0700	integrity and extremity circulation frequently. b6-2 [redacted]
3 Sep. 03 1815	Pt A+O x3, resting in bed, VSS, wheezing noted Ⓑ, SAT 95%, encouraged use of IS, hyperactive BS x4, dsgs LE x2 CDI, sutures on Ⓡ thumb intact, Ø c/o pain @ this time, IV Ⓡ foot patent infusing LR 100 cc/hr, voiding c/y urine, peripheral pulses +2. [redacted] b6-2 91WM6
1900	Assessed for proper circulation + skin integrity on pts of restraint. [redacted] 91WM6 b6-2
4 Sept 03 0900	VSS A&O. Lungs clear Bilat. Properly uses Incentive spirometer c̄ 900-1200 cc/sec. Non-productive cough. O2 SAT 95% RA. BS+ x4 quad. Consumed regular diet for breakfast Ø c/o N/V. Ⓡ hand c̄ sutures intact. Ø drainage or swelling noted to Ⓡ thumb suture line. Ⓡ lower leg IV patent & intact without redness, swelling or pain. Infusing LR @ 100 cc/hr. Heels graft site with staples intact. Eucerin cream applied to all STSG sites except to Ⓛ knee which already cream was applied. Sutures intact to buttock incision Ø drainage or swelling noted. Voiding clear yellow urine. 1200 ~~Assist~~ Restraints: removed & reapplied. Skin intact underneath restraints. Will check restraints skin integrity & circulation to extremities frequently [redacted] b6-2 ZC7
4Sep03 @ 1945	Assumed care @ 1800; VSS, pt A&O X3 speaking both English & arabic;

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
2 Sep 03 0900	VSS Alert & Oriented. IV LR @ 100cc/hr to Ⓡ lower leg patent & intact. Lungs clear. BS Ⓟ x4 quads. Peripheral pulses palpable +2. Dsg dry and intact. Voiding clear yellow urine. Consumed regular diet. Repositioned in bed Q2hrs & prn for comfort. [redacted] b6-2
2 Sep 03 1730	Pt AtOx3, VSS, LS CTA Ⓑ, ⊕ BS x4, c/o pain on stomach, medicated c̄ 2 percocets, dsg's on LE x2 CDI, dsg's on hands x2 CDI, IV Ⓡ Foot intact infusing LR @ 100cc/hr, LE x2 resting on round blue pillows, HOB 30°, encouraged use of IS, voiding c/y urine, proper circulation + skin integrity on pts. of restraint. [redacted] b6-2
2200	Dsgs Δ'd and vaseline gauze applied to heals. [redacted] b6-2
3 Sept 03 0730	VSS Alert & Oriented. Ⓡ lower leg IV intact and patent infusing LR @ 100cc/hr. Dsg to STSG dry & intact. Voiding clear yellow urine. Lungs clear. BS Ⓟ 4 quads. Peripheral pulses palpable +2. Resting, consumed regular diet. [illegible] under restraints [illegible] checked restraints, skin

HOSPITAL OR MEDICAL FACILITY:

STATUS:

DEPART./SERVICE: (Continue)

RECORDS MAINTAINED AT: [redacted]

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.:

[redacted] b6-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
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MEDCOM - 13100

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
05SEP03	(cont) breakdown/circulation. Will continue to monitor.
5 Sep. 03	b6-2 [redacted] WO/AW
1830	Pt resting in bed, A+Ox3, VSS, LS CTA Ⓑ,
	⊕ BS x4, S1 S2 present, peripheral pulses equal Ⓑ,
	∅ c/o pain @ this time, c/o diahrea x2, dsg's to
	heels CDT, sutures on Ⓡ thumb intact ∅ s/sx of
	infex, IV Ⓡ foot patent infusing LR @ 100 cc/hr, dsg
	Ⓛ knee CDI, voiding c/y urine, proper circulation
	+ skin integrity on pts of restraint b6-2 [redacted] 91WM6
06SEP03	(1400) Assumed care of pt @ 0600 p̄ report from night shift.
	Pt alert, speaking some Arabic, some English. VSS. Pain
	controlled c̄ Percs. Dsgs to heels Δd this am. Bacitracin
	applied to heels prior to vaseline gauze and Kerlex.
	Dsg to Ⓛ knee Δd - silvadene applied to wound.
	moisturin cream applied to healing graft sites. Staples
	on heels intact. Sutures to Ⓡ thumb CDI. Sutures
	to bilat. buttock c̄ small amount sero sang drainage
	intact. IVFs infusing into IV in Ⓡ ankle s̄ s/sx infection,
	infiltration. Pt tol reg diet well. Voiding s̄ difficulty.
	Pt ↑ to chair @ this time - tol. well. AM care
	done by pt. Pt able to move toes. ⊕ sensation.
	Restraint on when in bed - ∅ s/sx complications c̄ b6-2
	skin breakdown/circulation. Will cont to monitor [redacted]

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	(cont) $S_1 S_2$, ⊕ pulses x4, LS CTA Ⓑ; ⊕ BS x 4, pt voiding QS, clear, yellow urine; BM x1 this shift; dsg to Ⓡ thumb Δ'd c̄ sutures intact & well approximated ⊖ drng or edema; dsg to Ⓛ knee Δd c̄ minimal and sanguinous drng noted; dsg to heels CDI, ⊖ drainage; PIV to Ⓡ LE patent & infusing LR @ 190 cc/hr s̄ s/sx infection/infiltratcation; Eucerin cream applied to all applicable areas, silvadene to Ⓛ knee; Sutures to buttocks incision bilat intact, sutures well approximated ⊖ drng or edema noted; restraints in place, circulation & skin integrity intact; cont to monitor ——— b6-2 [redacted]
05SEP03	(1315) Assumed care of pt @ 0800 p̄ report from night shift. Pt alert, speaking some English. VSS Ø c/o pain @ this time. Pt tol reg. diet well. Voiding s̄ difficulty. Dsg to Ⓛ knee Δd this am. Silvadene cream applied to wound. Dsgs to bilat heels Δd, c̄ vaseline gauze, covered c̄ Kerlex. Silvadene cream applied to Ⓛ heel. Staples to skin grafts on heels intact. moisturin cream applied to healing skin graft sites. Dsg to Ⓡ thumb Δd - sutures intact - Ø s/sx infection. Sutures to bilat buttock CDI - open to air. Pt able to move toes s̄ difficulty. ⊕ sensation in heels. cap refill <3secs. IVF infusing into IV in Ⓛ ankle s̄ s/sx infection/infiltration Restraint in place s̄ s/sx complications of skin

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.

[redacted] b6-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
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MEDCOM - 13102

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
6 Sep. 03	Pt lying in bed, AtOX3, VSS, LS CTA (B),
1845	(+) BS x4, S1 S2 present, skin warm + dry, cap.
	ref. <3sec, peripheral pulses +2, c/o some
	pain on buttocks, dsgs on heels c̄ some
	bloody drainage noted, dsg on (L) knee CDI,
	IV (R) foot intact infusing LR @ 100 cc/hr.
	assessed for proper circulation + skin integrity
	on pts of restraint. —— b6-2 [redacted] 91WM6
	—————— [redacted]
2000	Pt had a BM this PM, Dsgs on heels
	Δ'd c̄ vaseline gauze + kerlix wrapped
	around heels. —— b6-2 [redacted] 91WM6
0630	Pt had BM, formed. —— [redacted] 91WM6
7Sept03 1000	Received pt in stable condition, VSS, A&OX3,
	sleeping intermittently. LSCTA(B) BS(+)4 ABD S/NT,
	HRR, pulses strong + equal bilat. Dsg Δ's
	done, currently c/d/i, old dsgs w/ dry bloody
	drainage on heels. Silvadene cream applied
	to (L) knee. IV to (R) foot patent, infusing IVF w/o
	apparent complication. Restraint to RE w/
	kerlix underneath, skin integrity + circulation
	intact. ∅ BM this shift. [redacted]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE b6-2	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

[redacted]

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

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WARD NO.

#[redacted] b6-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
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MEDCOM - 13103

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
7Sep03@1845	Assumed care @1800; USS, pt A&Ox3 speaking both arabic & english; S1S2,
	(+) pulses x4; LS CTA(B); (+) BS x4, pt voiding QS, clear yellow urine; BM x1, soft
	semiformed brown stool; All dsg CDI; dsg to (L) knee Δ'd ē silvadene applied;
	eucerin cream applied to all open burns; PIV to (R) foot patent & infusing
	LR @ 100cc/hr s̄ s/sx infection/infiltration; 2-point restraints in place
	circulation & skin integrity intact; cont to monitor [redacted] b6-2
8SEP03 0130	Pt. c/o upset stomach and provided 20cc of
	Maalox Antacid. [redacted]
	b6-2
	Surgery
8Sept	No complaint
	USS AFeb
	wound - (L) FTSG Donor site ē
	SQ hematoma ē some oozing.
	Pressure bandage Applied.
	A/P Doing well
	Plan walky burrow [redacted] b6-2
8Sept03	Received pt this am in stable condition, USS, A&Ox3
	speaks minor english. Drsgs Δ'd, eucerin applied.
	to all wounds, vaseline gauze + kerlex to heels
	bilaterally. Wet to dry Drsg to (L) knee w/ kerlex.
	IV d/c'ed, Foley d/c'ed. Sutures removed this
	afternoon by MD on buttock (L). (L) buttocks
	suture line oozing from hematoma, pressure dsg
	applied to buttocks by MD. CCDTC notified MD [redacted]

b6-2

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
9Sep03 1200	VSS. Alert & Oriented. OOB ambulate around in room. Tolerated well. STSG sites to (L) buttocks c̄ bleeding upon ambulating. Pressure dsg applied bleeding stop. Lungs clear, BS (+) x4 quad. abd ; nondistended. Voiding clear yellow urine in urinal. Ace wraps in place to heels upon ambulating. ~~ATB~~ Monitor applied to STSG sites. Restraints removed and reapplied. Skin intact under restraints. Will continue to monitor. [redacted] b6-2 2LT
9Sept03	1420. (R) Buttock graft area opened c̄ oozing blood. pressure dsg applied. Dr [redacted] b6-2 informed ∅ new orders. Will continue to monitor. [redacted] b6-2 2LT AN
9Sep.03 1845	Pt A+Ox3, VSS, resting in bed, LS CTA (B), (+) BS x4, abd soft flat nontender, pressure dsg to buttocks CDI, dsg's on heels x2 CDI, ∅ c/o pain @ this time, voiding clear yellow urine to urinal, HOB 30°, dsg (L) Knee CDI, assessed for proper circulation + skin breakdown on pts of restraint. b6-2 [redacted] 91WM6
2045	Pt OOB to ambulate, (R) foot sensitive in area where pt had IV, ambulated 10 steps and sat on chair, medicated for pain prior to ambulation. [redacted] b6-2 91WM6

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
cont 08Sep03 1613	pt c/o stomach trouble. pt feels he has diarrhea, BM's
	are soft but formed, ø stools this shift. Comfeel
	placed on Ⓡ ankle area and pt educated. to
	keep moving extremity to different positions +
	keep pressure off ankle area ⇒ Stage II decub. Restraint
	x1 on Ⓡ wrist ø skin breakdown or impaired
	circulation noted. ø other remarkable assessments
	noted. Will cont to monitor. [redacted] b6-2 RN
8sep03 @ 1930	Assumed care @ 1800; A&Ox3, c/o pain, perc ii given c̄ good relief; S1 S2,
	LS CTA Ⓑ; ⊕ BS x4, ⊖ BM this shift; all dsgs C/D/I, dsg to Ⓛ knee Δ'd; No
	remarkable assessment findings; 1-point restraint in place, ⊖ skin
	breakdown, circulation intact; cont to monitor b6-2 [redacted]
	[redacted]
9Sep03	Surgery
0820	No complaints
	VSS AFeb.
	Heels - Good overall take. Now 2wks post op
	Ⓛ FTSG Donor ↓ Hemorrhg.
	A/P Doing well Allow Ambulation
	b6-2
	[redacted]

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.

EPW # [redacted] b6-4

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10Sept03 0815	A&O VSS. OOB ambulating. Tolerated well. Drsg changed to heels, (L) knee & buttocks as ordered. Lungs clear. BS (+) x4 quadrants. Peripheral pulses palpable +2. Warm compress applied to (R) foot. IV Abx as ordered. [illegible] noted. Pt c/o pain in (L) foot near [illegible] Restraints removed & reapplied Ø [illegible] [redacted] the Skin intact under restraints b6-2 [redacted]
10Sep.03 1845	Pt resting in bed, A+Ox3, VSS, LS CTA(B), (+) BSx4, peripheral pulses +2, voiding c/y urine, dsg's on heels x2 CDI, pressure dsg on buttocks CDI, Ø c/o pain @ this time, Ø skin breakdown + proper circulation on pts of restraint. b6-2 [redacted] 91WM6 [redacted]
11Sept03 0900	Assume care of Pt. VSS, A+Ox3. Changed dressing on arm, no sign of infection. Little drainage around buttocks. Can walk c̄ help. Dsg's on heels x2. Ø c/o pain.. Cont. to monitor Pt. [redacted] b6-2
11 Sept 03 0950	Concur c̄ above. Lungs CTA(B) WNL. Will assist c̄ ambulation. Circulation & skin integrity checked throughout shift to 2 pt restraint extremities. Intact. [redacted] nurs b6-2

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.

[redacted] b6-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

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MEDCOM - 13107

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
11sep03	Surgery
	NO events
	USS Ares
	wounds Healing No new issues.
	Ap Pt must Ambulate and
	be out of Bed !
	[redacted] b6-2
11 Sept 03	Asst MD c̄ assessing wounds & changing dsgs. Pt
1100	up to chair. Will ambulate p̄ lunch — [redacted] b6-2
11Sep03@2230	Assumed care @ 1800; USS; pt A&OX3, ⊕ movement & sensation, NV intact; ⊕ pulses X4;
	LSCTA Ⓑ; ⊕ BSX4, pt voiding QS, c/y urine, ⊖ BM this shift; dsg to Ⓛ knee Δ'd; all
	other Δs CDI s̄ drainage; Eucerin cream applied to all open burn sites; pt ↑ to
	amb in hall X1 c̄ minimal assistance from walker; medicated X1 c̄ perc 5 c̄
	good relief; restraints in place; ⊕ circ. & skin integrity; cont to monitor — [redacted]
12 Sep 03	Assumed care of pt. A+O x 3 sitting up in bed
0700 -	eating Breakfast. c/o pain to feet. bilat skin graft.
	wound care this AM. Lungs CTA HRRR S1 S2 present
	Active BS x4 quads. Encourge ambulation this AM
	c̄ walker. Will cont to monitor — b6-2 [redacted] 91WM6
12 Sep 03	- c/o pain medicated c̄ percocet ii tabs for relief. Will
1300	cont to monitor — b6-2 [redacted]

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
13sep@0130	Assumed care @ 1900; VSS, A&Ox3, (-) C/o pain, NV intact - (+) CMS; (+) pulses x4
	LSCTA (B); (+) BSx4, pt voiding QS, c/y urine; (-) BM thus far; pt ↑ amb in hall x1 for
	~~30~~ 15min c̄ min assistance from walker & s̄ complications, pt was in NAD (-) SOB,
	(-) c/o dizziness during amb; dsg to (L) knee Δ'd, all other dsgs CDI c̄ min. amt
	drainage noted; Eucerin cream applied to healing burn sites; 2-point restraints in
	place; (+) circulation & skin integrity; cont to moni. toc ——— b6-2 [redacted]
13 sep 03	— Pt resting in bed @ this time c/o pain to (R) calf
@ 0700	skin graft. VSS. Warm compresses ordered per MD to apply.
	Dressings Δ to bilat heels and buttock. Sylvadene cream
	applied to wounds Ambulation encouraged. Lungs CTA HRRR
	Active BS Will cont to monitor ——— b6-2 [redacted] ...m
	(1040) I concur c̄ above assessment [redacted]
13SEP03	VSS, AO. Speaking fair english and arabic @ times.
2025	DSG's to (B) heels, (L) & (R) buttocks clean, (L) knee
	intact and dry. (+) pulses to all extremities.
	Voiding light amber urine, quantity sufficient.
	Able to ambulate c̄ minimal assistance. (L) and (R)
	buttock remains blue/purple in color and @ stage
	I [illegible] for skin breakdown. Tolerated PO
	meal & fluids well. Fentanyl 50mcg patch placed to
	(L) shoulder ——— [redacted] b6-2

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.

[redacted] b6-4

6
12
18
24

CHRONOLOGICAL RECORD OF MEDICAL CARE
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MEDCOM - 13109

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
14 Sep 03 0700	- Assumed care of pt. A+O x3. VSS c/o pain to skin graft bilat feet medicated c̄ percocet ii tabs for relief. Dressing Δ's to feet and buttock complete silvadone cream and moisturin applied to skin graft. Pt instructed to ambulate more apply pressure to heels. and exercise ROM Will cont to monitor ——— [redacted] b6-2
14Sep03 @ 2330	Assumed care @ 1800 p̄ receiving report from day shift; VSS, A&O X3; c/o pain, medicated c̄ ii perc c̄ good relief; dsg to buttocks Δ'd; all other dsgs CDI; Eucerin cream applied to open sites; pt amb in hall X1 for 20 min c̄ min assistance from walker; Ø complications during amb; IS encouraged q1°; ROM completed; restraints x2 applied; ⊖ skin break ↓; ⊕ circulation; cont to monitor —— b6-2 [redacted]
15SEP03	(1630) Assumed care of pt @ 0600 p̄ report from night shift. Pt alert, speaking Arabic and some English. VSS. Pain controlled c̄ Percs. Dsgs to heels, Ⓛ knee, and buttocks Δd this am. Ø S/Sx infection @ wound sites. Pt applied moisturin to healing graft sites. Pt tol. reg diet well. Voiding s̄ difficulty. 2 point restraints in place s̄ S/Sx complications. Will cont. to monitor. —— b6-4 [redacted]
	(1640) Pt OOB to amb in hallway. Gait steady. Pt tol. well. Monitoring. —— b6-2 [redacted]
15 Sep. 03 1830	Pt resting in bed, VSS, A+Ox3, Ø c/o pain @ this time, Dsg's to heels, Ⓛ Knee + buttocks CDI, LS CTA Ⓑ, ⊕ BS x4, voiding w/o complications, 2 pt restraint c̄ proper circulation + Ø skin break down. —— b6-2 [redacted] 91W

FPI. LEX. Printed on Recycled Paper

STANDARD FORM 600 (REV. 6-97) BACK

MEDCOM - 13110

62-2

NSN 7540-01-075-3786

MEDICAL RECORD	**EMERGENCY CARE AND TREATMENT** *(Patient)*	LOG NUMBER	TRE[redacted]ILITY CSA
		RECORDS MAINTAINED AT	

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)* 3 July 03 | TIME 929

TRANSPORTATION TO FACILITY Airevac

SEX M

AGE 47

DUTY/LOCAL PHONE: AREA CODE | NUMBER

HOME PHONE: AREA CODE | NUMBER

MILITARY STATUS ITEM	YES	NO	N/A
PRP			
FLYING STATUS			

MEDICAL HISTORY OBTAINED FROM

THIRD PARTY INSURANCE ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2568 IN CHART		

NAME OF INSURANCE COMPANY

CURRENT MEDICATIONS
iraqi meds?
ventolin

ALLERGIES
Ø

INJURY OR OCCUPATIONAL ILLNESS ITEM	YES	NO	WHEN *(Date)*
IS THIS AN INJURY?			WHERE
INJURY/SAFETY FORMS			

HOW

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT UTD | COMPLETED INTITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT burns smoke +

CATEGORY OF TREATMENT

☐ EMERGENT

☐ URGENT

☑ NON-URGENT

TIME 0930

INITIALS RD

VITAL SIGNS	89	95			
TIME	930	1025			
BP	113/71	126/79			
PULSE	120	121			
RESP	16	16			
TEMP	104.2	103.0			
WT	95 kg				

LAB ORDERS

✓	CBC/DIFF	ABG	✓	PT/PTT	BHCG/URINE/BLOOD/QUANT
✓	URINE C&S ✓	UA MSCC/CATH	✓		CHEM: 12 lyte
	BLOOD C&S X				

X-RAY ORDERS

✓	CXR PA & LAT/PORTABLE	C-SPINE
	ACUTE ABDOMEN	LS SPINE
	SINUS	HEAD CT
	ANKLE R/L	

ORDERS

☑ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
1005	Lovenox 90mg SQ	[redacted]	[redacted]	1005	
1020	Levaquin 500mg IV			1020	
1023	1 gm Tylenol PO		66-2	1023	

DISPOSITION ☐ HOME ☐ FULL DUTY

DISPOSITION QUARTERS /OFF DUTY ☐ 24 HRS. ☐ 48 HRS. ☐ 78 HRS.

MODIFIED DUTY UNTIL

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

PATIENT'S IDENTIFICATION *(For typed or written entries, give: Name -- last, first, middle; ID no. (SSN or other); hospital or medical facility)*

EPW 000-00-[redacted] 66-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

STANDARD FORM 558 (REV. 9-96)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.203(b)(10)
USAPA V1.00

MEDCOM - 13111

NSN 7540-01-075-3786

MEDICAL RECORD	**EMERGENCY CARE AND TREATMENT** *(Doctor)*	TIME SEEN BY PROVIDER

TEST RESULTS

CBC	WBC	SMAC		ABG/PULSE OX			RADIOLOGY — Check if read by radiologist ☐
	H/H			SUP 02	PH	PO2	RESULTS
	PLT			PCO2	SAT	OTHER	
PT				U/A	DIP		EKG INTERPRETATION
APTT		BHCG	ETOH	GLU	MICRO		

PROVIDER HISTORY/PHYSICAL

(S)

PMhx
ashma
PShx Ø

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP

DIAGNOSIS

CODES

PATIENT'S IDENTIFICATION *(For typed or written entries, give: Name – last, first, middle; ID no. (SSN or other); hospital or medical facility)*

EPW 000-00-0[redacted] b6-4

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

STANDARD FORM 558 (REV. 9-96)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.203(b)(10)
USAPA V1.00

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
09Jul03. cont.	1015		sedation for pain management. Versed 6mg IV, fentanyl 250mcg, ~~ø~~ Ketamine 90mg and 0.2mg Robinol given. VSS. Pt on NRB for ~~se~~ during sedation. SaO2 100%. WTD dressing for abdomen. Silvadene applied to all other areas. Will continue to monitor. b6-2 [redacted]
		1110.	Lasix 10mg IVP given as ordered - [redacted]
		1115.	Pt refused to eat lunch. Will try again later —— b6-2 [redacted]
		1300.	SpO2 ↓ to 89-90%. Continue working IS and gave MDI as ordered. SpO2 remains decreased. Pt up to chair c̄ 4 assist. Pt medicated c̄ 2mg MSO4. b6-2 [redacted]
		1310	SpO2 ↑ to 96%-97% Will continue to monitor [redacted]
		1345.	Percocet 2 tabs PO given for c/o pain to Burns —— b6-2 [redacted]
		1350	Type and cross drawn from distal port of CVC and sent to lab —— b6-2 [redacted]
		1600.	Pt back to bed c̄ ~~minimal assist~~ [redacted] 2 person assist. Pt is unsteady on feet, however used more of own body strength for mvmt. Pt turned to Ⓡ side. Will continue to monitor. — b6-2 [redacted]
9 July 03		2100	pt complains of hiccups + abd pain given meds and H2O/soda c̄ some relief
		2200	Continued

510-112 NSN 7540-00-634-4123

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR		OBSERVATIONS Include medication and treatment when indicated
	A.M.	P.M.	
8 July 03	...	2000	Received report from ongoing shift, pt just got back
2000			to bed, alert, verbalized wanting to rest. Dobhoff in
			place TF Jevity @ 125cc/hr. IVF LR @ 125 to
			SCCL. T 99.3, VSS on monitor, foley draining >30cc/hr
			Tea colored urine. Continue plan of care – b6-2 [redacted]
2230-			Premedicated c̄ MSO4 8mg c̄ Versed 5mg 30' prior to dressing
2300			change. Then gave additional MSO4 2mg c̄ 2.5mg Versed
			plus Percocet ii p.o. for continued c/o pain during dressing
			change. Pt groaning & screaming during the procedure but
			started to calm down once dressing completed VSS.
2330			Pt is observed to be asleep. TF resumed @ 125cc/hr
			residual ✓ <30cc. Monitor abdominal distention.
			Gave Mylanta 30cc ~~p/o~~ for c/o indigestion. b6-2 [redacted] Maj/AN
0100			Pt awaken shortly but went back to sleep. Appears
			comfortable. Foley draining minimal amt. <50cc/hr. Continue
			to monitor. Notify MD @ this time b6-2 [redacted] Maj/AN
0400			Dobhoff halfway out. Removed and pushed
			back in place. Tube feeding on hold for
			now until placement is confirmed by X-ray.
			Request read. No significant incident
			this shift. VSS —— b6-2 [redacted], Maj/AN
1015.			Drsg Δ complete to burn areas. Most burns 3° Dr
			[redacted] @ BS to assess wounds. Conscious
			b6-2

(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.

EPW 0[redacted] b6-4

NURSING NOTES
Medical Record

STANDARD FORM 510 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR- 201-9.202-1

MEDCOM - 13114

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
11 JULY 03		0500	cont'd... TF on hold due to conscious sedation for drsg Δ. Will cont. care. — b6-2 [redacted] [illegible]
		0600	Pt UO <30cc. Will cont to monitor and inform MD. — b6-2 [redacted] [illegible]
		0700	Pt completed IS x 10 breaths while awake. Pt did IS well. Plan to complete Drsg Δ and ambulate pt. Pt temp 101°. Will cont to monitor temp. Pt also has hiccups. Will discuss pt care c̄ Dr. [redacted]. b6-2 [redacted] [illegible]
		0930	Completed drsg Δ. Washed all burn wounds c̄ hibiclens and rinsed c̄ sterile water. Applied silvadene and covered c̄ burn drsgs. Wrapped ext wounds in kerlex. Wrapped abd burn wound c̄ abd binder. Ace wrapped bilat ↓ ext. Pulses present. Cap. refill <3 sec. Gave pt bed bath simultaneously. Pt put under conscious sedation. Fentanyl 250mcg, ketamine 100mcg, versed 7mg, and robinol 0.2mg given. Pt on nonrebreather c̄ 10L O2 @ time of sedation. O2 sats 100%. Δ'd pt bed sheets and elevated Ⓛ ↓ ext and scrotum. Completed foley care. Noted erythemia around border of most burn wounds. Dr. [redacted] aware. Will cont. care — b6-2 — [redacted] [illegible]
		1040	Dr. [redacted] in to see pt. Aware of condi

b6-2

*U.S. Government Printing Office: 1995 - 404-763/20065

STANDARD FORM 510 (REV. 7-91) BACK

MEDCOM - 13115

510-112 NSN 7540-00-634-4123

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
10 June 03		1815	Received report from ongoing shift. Pt awake; had debridement of the wound today. TF on hold for now for dressing change under conscious sedation. Received total of PRBC 4 units today (2u OR, 2u ICU3). Afebrile
		0820	H + H 129) 10.6 / 37.5 (537. Continue c̄ POC —— [redacted] Maj/AN
		2020	Pt remain NPO for conscious sedation. Anesthesia notified. Pt informed of the upcoming procedure. Anticipatory anxiety noted but otherwise understand necessity of dressing change tonight —— b6-2 [redacted] Maj/AN
		2230	Complete dressing change done c̄ the pt conscious sedation: Versed 10mg, MSO4 10mg, Fentanyl 150 mcg + Ketamine 100mg throughout the procedure. Pt. ~~[illegible]~~ error tolerated procedure well, drowsy but easily aroused. Wound fully debrided today, had areas of heavy bleeding, pressure applied.
		0330	Slept throughout the night c̄ intermittent wakefulness due to hiccups. VSS T max 99.7. No significant events @ night. NPO @ 0300 (TF) on hold for dressing change conscious sedation b6-2 [redacted] Maj/AN
		0400	Lab results: 9.2 > 9.7 / 30.5 < 5.39, > 129 / 3.9 < 95, BUN 13 Creat .7
11 July 03		[illegible]	Received report from previous shift. Pt awake and in bed in chair mode. LR infusing in (R) IJ central line. Pt hiccuping. [illegible] cont ⇒

(Continue on reverse side)

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

[redacted] b6-4

REGISTER NO.

WARD NO.

NURSING NOTES
Medical Record

STANDARD FORM 510 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 13116

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
11 July 03	1040		UO, temp, and hiccups ~~Md~~ [redacted] new orders given and completed. Started TF @ 50cc/h. Pt resting quietly @ this time. Plan to ambulate @ ≈1400. —— b6-2 [redacted]
	1200		Pt resting quietly. Ø needs expressed @ this time. —— b6-2 [redacted]
	1310		Gave pt thorazine for hiccups IM Ⓛ deltoid. Attempted to place NGT x iii. Will assess affects of thorazine ā attempting to place NGT to assess if NGT is necessary. Will cont. care. —— b6-2 [redacted]
	1515		Pt walked around bed to chair c̄ assist. Pt dragged feet and stood tall. Pt currently in chair. Stopped TF. Will restart when place pt in bed. Pt tol walk well c̄ lots of encouragement. Will cont. care. —— b6-2 [redacted]
	1650		PT assisted self into getting into bed. PT lifted both lower ext c̄ minimal assist into bed. PT O_2 sat remained in 90s. Elevated Ⓑ LE and scrotum. Pt appears to be free of pain @ this time. Gave pt encouragement for doing a great job. Gave report to night shift. b6-2 [redacted]
	1650		Pt sat in chair ≈2 hours and tol. somewhat well. O_2 sats 94%-97%. —— b6-2 [redacted]

MEDCOM - 13117

NURSING NOTES
(Sign all notes)

DATE 2003	HOUR		OBSERVATIONS Include medication and treatment when indicated
	A.M.	P.M.	
11 July 03		1700 1800	Received report from ongoing shift. Pt observed up on the chair. Returned to bed @ the beginning of the shift c̄ 4 people assisting. pt able to move LE slowly & upper arms. Alert, able to verbalize needs. Wanting to rest, refuse to eat dinner. TF off, reconnected @ 1800. Denies need for pain medicine @ this time. VSS, T 100.5 - 107 - 12 - 94% RA, BP 125/64. In no apparent distress. IVF @ 50cc/hr (LR) Foley @ 30cc amber colored urine. Monitor & continue c̄ POC. ——— b6-2 [redacted] Maj / AN
11 July 03		2100	Pt OOB to BSC c̄ assistance (2 people), able to assist c̄ difficulty but trying. Had ↑ moderate amt of stool, received MOM half an hour ago. Returned to bed maneuvering self c̄ assist. Pt asked to rest, request to remove abd binder, I replaced c̄ ace/kerlix to hold dressing. Pt feel more comfortable, dressing c̄ some drainage, reinforced & rewrapped. Denies need for pain medicine when asked. T. 100.5, already on [illegible] antibiotic — b6-2 [redacted] Maj / AN
11 July 03		2300	Pt awaken c/o generalized pain specifically back pain, pt repositioned in bed, gave MSO4 5mg IV at this time. Continue to monitor pain level. b6-2 [redacted] Maj / AN
11 July 03		2400	Pt awaken, asked to sit up in bed. Checked dressing, drainage noted, ⊕ foul smell, applied Silvadene to exposed areas on the thigh & buttocks, reapplied dressing. T 100.3 Verbalized pain relief from MSO4. b6-2 [redacted] Maj / AN
12 July 03	1	0030	Hold TF for conscious sedation in AM —— [redacted] Maj b6-2

EPW [redacted] b6-4

MEDCOM - 13118

NSN 7540-00-63

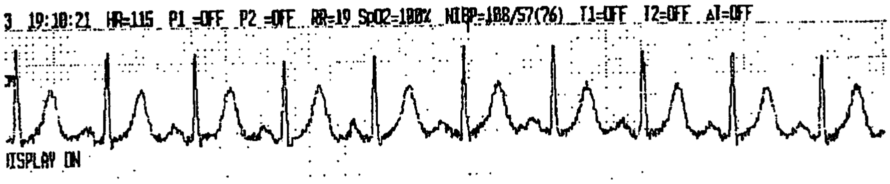
DICAL RECORD

NURSING
(Sign all n

TE | HOUR A.M. | P.M.

OBSERVATIONS
Include medication and treatment when indicated

14 July (1700) Pt CARE Report Recieved from SPC [redacted] b6-2
Pt Sitting in Chair: Awake, Alert, Co-Oper-
ative. Occassional moaning. Responds
appropriately to verbal commands/Requests.
No Acute Episodes noted/Reported. [redacted] 91WM
b6-2


3 19:10:21 HR=115 P1 =OFF P2 =OFF RR=19 SpO2=100% NIBP=188/57(76) T1=OFF T2=OFF AT=OFF
DISPLAY ON

14 July 03 (1745) Pt Refused solids for meal. Readily
drank 100% milk, & Retained. Continuous
Dobhoff feed of Jevity (+) via pump @ 101ml/hr
on s̄ adverse effect noted. (+) hyperactive
BS in (4) Quads. b6-2 [redacted] 91WM6

14 July 03 (1830) Assisted back to Bed c̄ (2) Staff @
Bedside. Noted ↑ Attempt to do transfer
c̄ ↓ passive assist. Supports partial weight
c̄ stooped posture. ↑ crying out c̄ movement.
Quiet when Resting. Crying out sporatically
& when asked to Raise hand or call STAFF
by name. Able to ↓ ? incident of Acute
distress. States "Sisic" When need Assist.
b6-2 [redacted] 91WM6

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

[redacted] b6-4

NURSING NOTES
Medical Record

MEDCOM - 13119

14 June (1900) Inquiring about plan of care. "How long to stay here". Pt Resting Quietly p̄ Review Pending Surgical procedure + Recovery c̄ him.

b6-2 [redacted] 91WM6

14 June 03 (2000) MDI Albuterol given per Rx. BS c̄ Occ End Exp wheezes/rhales in Base esp. Ⓛ c̄ ↓↓ move in Ⓡ Base.

[redacted] 91WM6 b6-2

14 June (2300) To BSC for loose low brown stool. No adverse effects noted. [redacted] 91W

15 June (0130) Tylenol tab 2 lessons PO for fever 101^2

b6-2 [redacted] 91WM6

b6-2

15 June (0500) PT Care Report given to PFC [redacted]. PT Awake, alert, oriented s̄ Acute Episode noted. NPO for Conscious Sedation Procedure.

[redacted] 91WM

b6-2

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
17 Jul 03 0130			weaned pt off NC to RA. SaO2 @ 95%
			pt sleeping in bed will con't to monitor [redacted]
0200			stopped tube feeding. pt is NPO for conscious b6-2
			sedation this A.M. will cont to monitor [redacted]
17 Jul 03			Received report from SPC [redacted] b6-2 Pt resting
0500			in bed on back. Drsgs intact to all wounds.
			SPO2 92-93%. Incentive spirometry used. SPO2
			↑ to 98% with use. Will monitor b6-2 [redacted]
0840			Drsg Δ complete to burn areas. LT [redacted] @ BS
			for conscious sedation. Fentanyl 275mcg, Ketamine
			100mg, versed 8mg and 2mg MSO4 IVP along
			with .2mg Robinol. Ⓡ heel appears black, wound
			to Ⓡ knee beefy red c̄ active bleeding and some
			white areas. Ⓛ knee also beefy red c̄ active
			bleeding and white patchy areas. Wounds
			all appear beefy red c̄ some areas containing
			white full thickness areas. Ace wrap to Ⓛ
			leg. Large drsg intact to abd to suction. Ⓡ
			thigh donor site appears weepy, heat lamp
			applied. Graft site drsgs on Ⓡ upper thigh
			intact and moist. [redacted]
0900			Pt refused to use IS. b6-2 [redacted]
1015			Pt shaved and mouth care complete. [redacted]
1800			Received report from ongoing shift. Pt awake no c/o
			of pain @ this time. Graft site in the abdomen hook up
			to suction. Dressing intact c̄ some drainage noted left hand.
			T 100.4. See flow sheet for other pertinent info b6-2 [redacted] /An

*U.S. Government Printing Office: 1995 - 404-763/20065

STANDARD FORM 510 (REV. 7-91)

MEDCOM - 13121

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
16JUL03			NN CONT'D: BILAT LOWER EXT DRESSING CDI c̄ KERLEX AND
0630			ACE WRAP ON Ⓛ LEG. CAP REFILL < 2 SECS X 4 EXT. ABD DRESSIN
			INTACT c̄ GAUZE AND PLASTIC WRAP TO CONT SXN VIA JP
			DRAINS X 2. BILAT ANTERIOR THIGH DRESSING INTACT c̄ GAUZE
			WHICH ARE MOIST. DOBHOFF TF NASAL STOPPED FOR CONSCIOUS
			SEDATION DURING DRESSING Δ's FLUSHED c̄ STERILE H_2O. PT
			RESTING QUIETLY IN BED PAIN CONTROLLED c̄ MSO4. WILL CONT
			TO MONITOR ——— [redacted] CRN
16JUL03			b6-2
1230			NN: DRESSING Δ DONE PT TOLERATED WELL c̄
			CONSCIOUS SEDATION GIVEN BY ANESTHESIA SERVICES.
			PULSE: BILAT RAD +3 BILAT DP +2. EDEMA NOTED ON
			Ⓛ LE AND TRUNK. RESTARTED TF @ 100 mL/HR
			VSS. WILL CONT TO MONITOR ——— [redacted] b6-2 CRN
1730			recieved pt's report from day shift. pt resting in
			bed s̄ any complaints will cont to monitor — b6 [redacted]
2000			pt oob to bedside comode. pt had light brown
			loose stool. pt tolerated ambulating c̄ assistance.
			pt now sitting up in bed on Ⓛ side. will
			cont to monitor ——— b6 [redacted]
2100			Dressing Δ started. Changed Ⓛ arm + Ⓡ arm + hand.
			Ⓛ foot ~~and thigh~~ [redacted] Ⓡ foot and knee. moistened
			graft Ⓡ + Ⓛ thigh. pt tolerated dressing change
			c̄ 200mcg of Fentanyl + 8 mg Versed. pt S_aO^2 to
			87-89% put on 3L NC. pt now resting in bed.
			will cont to monitor ——— b6 [redacted]

[redacted] b6-4
ICU-3
[redacted] b2-2

MEDCOM - 13122

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
21 July	(0330)		PIV 18g to (R) FA c̄ S/Sx Infiltration,
			No Flow / Flash. Edema @ Site. Restart
			18g PIV to (R) lateral wrist s̄ incident.
			b6-2 [redacted] 91WM6
21 July	(0500)		5mg IVP MSO4 Given by MAJ.
			Neumein 2° c/o "Man" to (L) Hand.
			Continues c/o discomfort p̄ analgesia.
			Hand c̄ ↑ swelling noted. Hand ↑ on
			Blanket Roll. b6-2 [redacted] 91WM6
21 July	(0600)		Pt care Report to SPC [redacted] b6-2
			Awake s̄ noted distress. b6-2 [redacted] 91WM6
21 Jul 03	0600		Received report + Assumed care of Pt. VSS,
			Pt Appears to be resting well @ this time. Will
			Monitor. [redacted] MD b6-2 b6-2 [redacted] 91WM6
	0745		Pt Lying in bed sleeping c̄ 0 Ntd distress + Appears
			to be resting comfortably @ this time. Will continue to
			Monitor. b6-2 [redacted] 91WM6
	0840		Pt Complaining of Pain, Medicated c̄ 6mg MSO4. Will
			continue to Monitor. b6-2 [redacted] 91WM6
	0945	-1045	Dressing Changes Performed. Ace wrap + splints
			removed from Legs, dressings removed from old graft
			sites + old donorsite. Areas Cleaned c̄ hibiclens +
			rinsed thoroughly. Silvidine + bulky dressings Applied +
			Ace wrap re-applied. Old dressings removed from
			(R) arm + Abd. Areas Cleaned c̄ Hibiclens + rinsed
			thoroughly c̄ Silvidine + bulky dressings Applied.

Continued →

DATE	HOUR A.M.	P.M.	OBSERVATIONS Include medication and treatment when indicated
21 Jul 03	0945-	1045	Pt tolerated well c̄ Minimal Sedation. Will Continue to Monitor. b6-2 [redacted] 91WM6
	1245		Pt Lying in bed + appears to be in cheery mood. VSS, Ø Ntd distress @ this time, Will continue to Monitor. b6-2 [redacted] 91WM6
	1415		Pt Lying in bed + appears to be resting comfortably @ this time. VSS, UOP good. Will continue to Monitor. b6-2 [redacted] 91WM6
	1620		Pt Lying in bed sleeping + appears to be resting Comfortably @ this time. Will continue to Monitor. b6-2 [redacted] 91WMe
21 Jul	21 ~~1800~~	1800	Pt appearse to be resting comfortably in bed VSS. Dobhoff to R nare, no TF. JP drain to Ⓡ arm ABD, ↓ⓇLE, draining serous sanguinous fluid IV to ⓇFA c̄ LR @ 125 cc/hr. will continue to monitor b6-2 [redacted], SPC, 91WM6
21 Jul		2000	Pt resting comfortably in bed Repositioned onto Ⓡ side. Dressings C/D/I VSS, will continue to monitor. b6-2 [redacted], SPC, 91WM6
21 Jul		2200	Pt resting in bed, turned on Ⓛ side VSS Will continue to monitor. b6-2 [redacted]
22 Jul		0001	Pt resting comfortably in bed, VSS Will continue to monitor b6-2 [redacted]
22 Jul		0200	Turned pt on Ⓡ side, VSS. Will continue to monitor. b6-2 [redacted]

MEDCOM - 13124

ACLU-RDI 1592 p.1017

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
27July	(0600)		Pt care Report given to LT [redacted] b6-2 to Pt c̄. No acute episode noted. Awake, alert, oriented only to person. [redacted] 91WM6
		0600	Report received from Sr SSG [redacted] Pt laying in bed on Ⓡ side s̄ complaints. b6-2 [redacted]
		0700.	Pt turned to Ⓛ side ———
		0850.	Pt ate couple of bites of [redacted] and drank 1 can ensure plus ——— b6-2 [redacted]
		1115.	Drsg change complete. 150mcg of fentanyl IVP given for Δ. Pt tolerated well. Wounds redressed as ordered. Pt up to chair following procedure. Pt drank 1 can Ensure Plus and water. Pt refusing lunch tray.
27Jul03		1800	Pt resting comfortably in bed. Dressings C/D/I. IV to Ⓛ FA c̄ NS @ 100cc/hr. VSS. will continue to monitor [redacted], SPC, 91WM6 ——— b6-2
27Jul03		2200	Pt appears to be resting comfortably in bed. Moistened dressing to Ⓡ calf. VSS. b6-2 will continue to monitor, [redacted], 91WM6
28Jul03		0200	Pt appears to be resting comfortably in bed. VSS. Will continue to monitor. b6-2 [redacted]
28Jul03		0500	Replaced pt Fent patch. Patch located in Ⓡ upper back. VSS. will continue to monitor, [redacted] b6-2, SPC, 91WM6 ———
28Jul03		0600	Gave report to day shift. [redacted] ——— b6-2

*U.S. Government Printing Office: 1995 - 404-763/20065

STANDARD FORM 510 (REV. 7-91) BACK

510-112

NSN 7540-00-634-4123

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
26 Jul 03	0600		Received report from previous nurse. Pt sleeping
			comfortably VSS no c/o @ time, will continue to
			monitor [redacted] b6-2
26 Jul	0900		Dressing changed. Silvadene to arms, legs & abdomen,
			back and sacrum, sulfamylon solution to graft site,
			petrolatum dressing to graft site. Pt laying down his
			side p̄ dressing change. Medicated c̄ 225 mcg of
			fentanyl, Tolerated procedure well, VSS, will
			continue to monitor. b6-2 [redacted]
1630 26 Jul 03			AM care done, Pt shaved; teeth brushed, Pt had
			BM using BSC. Walked to dirty utility sink
			to wash hair & tolerated well, 2 cans of
			ensure given since 0600, Pt taking adequate
			PO water intake, VSS. will continue to monitor [redacted]
1700 26 Jul 03			Pt ate 50% of dinner - tolerated well [redacted] b6-2
26 July 03 (1800)			Pt care. Report Received from LT [redacted]
			Pt asleep s̄ acute episode noted.
			b6-2 [redacted]
26 July (2200)			Continue to sleep @ intervals of 1.5 hr
			@ a time. No acute episode noted.
			BM x1 on commode. Positive formed
			Brown stool. b6-2 [redacted]
27 July (0200)			No acute episode. [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)*	REGISTER NO.	WARD NO.
[redacted] b6-4		

NURSING NOTES
Medical Record

STANDARD FORM 510 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 13126

[redacted] 66-4 8 Jul 03

PATIENT ASSESSMENT

ME 1000 SIGNATURE: [redacted] 66-2

SKIN AND MUCOUS MEMBRANES

[✓ Loose] / Tight / Diaphoretic / Shiny / [✓ Dry]

Temperature warm

Pale / Cyanotic / Jaundiced normal for race

ous Membranes [✓ Moist] / Dry / Cracked dressings to burn area

Breakdown [✓ None] Location: Size:

NEUROLOGICAL

[✓ Alert] / Lethargic / Unresponsive GCS: 15

[✓ ...ntated] / Disoriented Pupils: confused

emity Movement: Full / [✓ Limited] / None

CARDIOVASCULAR

(0 - 4) Radials +2 Pedals +2

llary Refill Seconds <3 sec Homan's Sign

ular Venous Distension Edema

Sounds S1S2

thm reg PRI: QRS:

ular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
aforms				
			(R) FA 0 s/s 1)	
tion			nfxn	

Pain

RESPIRATORY

Expansion [✓ Symmetrical] / Asymmetrical

ation [✓ No Distress] / SOB / Labored / Use of Access Muscles

thing Patterns: even & unlabored

Productive / Nonproductive / [✓ None]

um Color / Amount / Consistency / Odor

Drainage System Gravity: Suction cm:

Leak No Yes Crepitus

of Drainage:

[✓ Midline] / Deviated (R) / Deviated (L)

cial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
ckles	CTA bilaterally	
ezes		
nished		
ent		

GASTROINTESTINAL

omen [✓ Soft] / Firm / Hard / Distended NT/ND cm Girth

el Sounds: [✓ Normal] / Hyperactive / Hypoactive / Absent

ssings:

Tube Clamped/Inter Suction/Cont. Suction/Dependent Drainage

Drainage Color Character

e Feeding Day No: Strength: Rate: Aspirate:

Character

ns:

GENITOURINARY

Color light yellow Character: clear

ing Continent / Incontinent / [✓ Catheter] foley

PATIENT ASSESSMENT

66-2

TIME: 1800 SIGNATURE: [redacted]

SKIN AND MUCOUS MEMBRANES

Skin: Loose / [✓ Tight] / Diaphoretic / Shiny / Dry

Skin: Temperature Warm to touch

Color: Pale / Cyanotic / Jaundiced membranes pink

Mucous Membranes [✓ Moist] / Dry / Cracked

Skin Breakdown: None Location: See SF 600 Size:

NEUROLOGICAL

Loc [✓ Alert] / Lethargic / Unresponsive GCS

[✓ Orientated] / ~~Disoriented Pupils:~~ T person place only

Extremity Movement: Full / [✓ Limited] / None 2° dressings

CARDIOVASCULAR

Pulse (0 - 4): Palp Radials +3 Palp Pedals +3

Capillary Refill: <3 Seconds Homan's Sign

Jugular Venous Distension Ø Edema

Heart Sounds S1S2

Rhythm Regular ST PRI: QRS

Vascular Catheter	Central	Arterial	Peripheral 1	Per
Waveforms				
Site			20 (L)	
Solution			[illegible]	

Chest Pain Ø

RESPIRATORY

Chest Expansion [✓ Symmetrical] / Asymmetrical

Respiration [✓ No Distress] / SOB / Labored / Use of Access Mus

Breathing Patterns: Regular RA SATS 90S

Cough: Productive / Nonproductive / [✓ None]

Sputum: Color / Amount / Consistency / Odor Ø

Chest Drainage System Gravity: Ø Suction cm

Air Leak Ø No Yes Crepitus

Character of Drainage: Ø

Trachea [✓ Midline] / Deviated (R) / Deviated (L)

Artificial Airway Size: Ø Type: Position.

Breath Sounds	Anterior/Location	Posterior.L
Crackles		
Wheezes		
Diminished	Bilat in Base	
Absent		

GASTROINTESTINAL

Abdomen [✓ Soft] / Firm / Hard / Distended cm Girth

Bowel Sounds [✓ Normal] / Hyperactive / Hypoactive / Absent

Dressings: See SF 600

NG Tube: Clamped/Inter. Suction/Cont Suction/Dependent D Ø

NG Drainage: Color Ø Character

Tube Feeding: Day No: Ø Strength: Rate: Asp

Stool: Character Ø

Drains: Foley 16F c̄

GENITOURINARY

Urine Color: yellow Character Concentrated

Voiding: Continent

MEDCOM - 13127

PATIENT ASSESSMENT 29 July 03

ME: 0600 SIGNATURE: Sgt. [redacted] b6-2

SKIN AND MUCOUS MEMBRANES

[✓ Loose] / Tight / Diaphoretic / Shiny / Dry

Temperature 98.4

r. Pale / Cyanotic / Jaundiced normal for race

ous Membranes: [✓ Moist] / Dry / Cracked

Breakdown: [✓ None] Location: Size:

NEUROLOGICAL

[✓ Alert] / Lethargic / Unresponsive GCS:

[✓ ntated] / Disoriented Pupils: PERL

emity Movement: Full / [✓ Limited] / None DSG to hands + legs

CARDIOVASCULAR

e (0 - 4): + Radials + Pedals

llary Refill: Seconds Homan's Sign

ular Venous Distension N/A Edema Ø

rt Sounds normal

thm 96 PRI: QRS:

cular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
eforms			▨	▨
			IV to (Rt)	
ion	LR @ 100cc/hr		↓ Arm	

st Pain

RESPIRATORY

t Expansion / [✓ Symmetrical] / Asymmetrical

ration / [✓ ~~No Distress~~] / SOB / Labored / Use of Access Muscles

thing Patterns: 24

gh: [✓ Productive] / Nonproductive / None

tum: Color / Amount / Consistency / Odor

t Drainage System Gravity: Suction cm:

Leak No Yes Crepitus

acter of Drainage:

chea [✓ Midline] / Deviated (R) / Deviated (L)

icial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
kles CTA		
ezes		
nished		
ent		

GASTROINTESTINAL

omen [✓ Soft] / Firm / Hard / Distended cm Girth

el Sounds: [✓ Normal] / Hyperactive / Hypoactive / Absent

ssings DSG to hands + legs/feet

Tube Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

Drainage: Color Character

e Feeding: Day No: Strength: Rate: Aspirate:

l Character Ø

ns

GENITOURINARY

e Color yellow Character:

ding Continent / [✓ Incontinent] / Catheter F/C

PATIENT ASSESSMENT

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin : [✓ Loose] / Tight / Diaphoretic / Shiny / Dry

Skin : Temperature Warm

Color: Pale / Cyanotic / Jaundiced Normal for Race

Mucous Membranes: [✓ Moist] / Dry / Cracked

Skin Breakdown: [✓ None] Location: Size:

NEUROLOGICAL

Loc / [✓ Alert] / Lethargic / Unresponsive GCS:

[✓ Orientated] / Disoriented Pupils:

Extremity Movement: Full / [✓ Limited] / None Splints to BLE

CARDIOVASCULAR

Pulse (0 - 4): +2 Radials +2 Pedals

Capillary Refill: < 3 Seconds Ø Homan's Sign

Jugular Venous Distension Edema

Heart Sounds S1 S2

Rhythm RR+R PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Pe
Waveforms			▨	▨
Site				
Solution				

Chest Pain

RESPIRATORY

Chest Expansion / [✓ Symmetrical] / Asymmetrical

Respiration / [✓ No Distress] / SOB / Labored / Use of Access Mus

Breathing Patterns: RR+R

Cough: Productive / Nonproductive / [✓ None]

Sputum: Color / Amount / Consistency / Odor

Chest Drainage System Gravity: Suction cm

Air Leak No Yes Crepitus

Character of Drainage:

Trachea / Midline / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position.

Breath Sounds	Anterior/Location	Posterior/L
Crackles	CTA Bilat	
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: [✓ Soft] / Firm / Hard / Distended cm Girth

Bowel Sounds: [✓ Normal] / Hyperactive / Hypoactive / Absent

Dressings: C D I to hand + legs

NG Tube: Clamped/Inter. Suction/Cont Suction/Dependent D

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Asp

Stool: Character None @ this time

Drains:

GENITOURINARY

Urine Color: yellow Character clear.

Voiding: Continen

foley draining to gravity. 29 July

[redacted] b6-4

MEDCOM - 13128

~~26~~ 27 July 03

#[redacted]

PATIENT ASSESSMENT

ME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Loose / Tight / Diaphoretic / Shiny / [✓ Dry]

Temperature warm.

Pale / Cyanotic / Jaundiced

ous Membranes: Moist / [✓ Dry] / Cracked

Breakdown: [✓ None] Location: Size:

NEUROLOGICAL

[✓ Alert] / Lethargic / Unresponsive GCS:

ntated / Disoriented UTA Pupils: Splint to (L) leg.

emity Movement: Full / [✓ Limited] / None

CARDIOVASCULAR

(0 - 4) +3 Radials +2 Pedals

illary Refill <2 Seconds Homan's Sign

ular Venous Distension Edema Ø

Sounds S1-S2. Rate 70's.

thm NSR PRI: QRS:

cular Catheter	Central	Arterial	[✓ Peripheral 1]	Peripheral 2
eforms			▨	▨
		(R) FA	20G c̄	LR @ 110
tion		Inserted	26	July 03

t Pain

RESPIRATORY

Expansion / [✓ Symmetrical] / Asymmetrical

ation / [✓ No Distress] / SOB / Labored / Use of Access Muscles

hing Patterns: SpO2 98% on RA

gh: Productive / Nonproductive / [✓ None]

um: Color / Amount / Consistency / Odor

Drainage System Gravity: Suction cm:

Leak No Yes Crepitus

racter of Drainage:

chea [✓ Midline] / Deviated (R) / Deviated (L)

cial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
kles		
ezes	clear bilat	
nished		
ent		

GASTROINTESTINAL

omen: [✓ Soft] / Firm / Hard / Distended cm Girth

el Sounds: [✓ Normal] / Hyperactive / Hypoactive / Absent

ssings to burn areas on body.

Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

Drainage: Color Character

e Feeding: Day No: Strength: Rate: Aspirate:

ol Character

ns

GENITOURINARY

e Color: Foley to gravity drn clear yellow urine

ding Continent / Incontinent /

EPW ~~#[illegible]~~

PATIENT ASSESSMENT

66-45

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin : Loose / Tight / Diaphoretic / Shiny / [✓ Dry]

Skin : Temperature Warm

Color: Pale / Cyanotic / Jaundiced WFR

Mucous Membranes: Moist / [✓ Dry] / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / [✓ Alert] / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils: UTA

Extremity Movement: Full / [✓ Limited] / None Splint to (L) leg

CARDIOVASCULAR

Pulse (0 - 4): +3 Radials +2 Pedals

Capillary Refill: <3 Seconds (−) Homan's Sign

Jugular Venous Distension Edema

Heart Sounds S1, S2

Rhythm NSR PRI: QRS

Vascular Catheter	Central	Arterial	Peripheral 1	Pe
Waveforms			▨	▨
Site		(R) FA	[illegible]	
Solution		@	100 cc/hr	

Chest Pain

RESPIRATORY

Chest Expansion / [✓ Symmetrical] / Asymmetrical

Respiration / [✓ No Distress] / SOB / Labored / Use of Access Mus

Breathing Patterns: RR+R

Cough: Productive / Nonproductive / [✓ None]

Sputum: Color / Amount / Consistency / Odor

Chest Drainage System Gravity: Suction cm

Air Leak No Yes Crepitus

Character of Drainage:

Trachea / [✓ Midline] / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position.

Breath Sounds	Anterior/Location	Posterior/L
Crackles		
Wheezes	CTA B/lat	
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: [✓ Soft] / Firm / Hard / Distended cm Girth

Bowel Sounds: [✓ Normal] / Hyperactive / Hypoactive / Absent

Dressings: C/D/I

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent D

NG Drainage: Color dark Character yellow

Tube Feeding: Day No: Strength: Rate: Asp

Stool: Character

Drains:

GENITOURINARY

Urine Color: Character:

foley to gravity

MEDCOM - 13129

66-4

PATIENT ASSESSMENT

ME [redacted] SIGNATURE: [redacted] 66-2

SKIN AND MUCOUS MEMBRANES

[✓ Loose] / Tight / Diaphoretic / Shiny / [✓ Dry]
Temperature warm
r Pale / Cyanotic / Jaundiced normal for race
ous Membranes [✓ Moist] / Dry / Cracked
Breakdown: [✓ None] Location: Size:

NEUROLOGICAL

[✓ Alert] / Lethargic / Unresponsive GCS: 15
[✓ ntated] / Disoriented Pupils: PERRLA
emity Movement: Full / [✓ Limited] / None

CARDIOVASCULAR

e (0 - 4). Radials +2 ... Pedals +2
llary Refill <3sec Seconds Homan's Sign
ular Venous Distension Edema
rt Sounds S1S2
thm ST PRI: QRS:

ular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
eforms			▨	▨
			(R) wrist	
tion				

st Pain

RESPIRATORY

t Expansion [✓ Symmetrical] / Asymmetrical
ration [✓ No Distress] / SOB / Labored / Use of Access Muscles
thing Patterns: even unlabored
gh: Productive / Nonproductive / [✓ None]
tum: Color / Amount / Consistency / Odor
st Drainage System Gravity: Suction cm:
Leak No Yes Crepitus
racter of Drainage:
chea [✓ Midline] / Deviated (R) / Deviated (L)
icial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
ckles	CTA bilaterally	
ezes		
inished	↓ x LLO gl	
ent		

GASTROINTESTINAL

omen: [✓ Soft] / Firm / Hard / Distended cm Girth
el Sounds [✓ Normal] / Hyperactive / Hypoactive / Absent
ssings
Tube Clamped/Inter Suction/Cont. Suction/Dependent Drainage
Drainage: Color Character
e Feeding: Day No: Strength: Rate: Aspirate:
ol Character
ns

GENITOURINARY

e Color: clear yellow Character:
ding Continent / Incontinent / Catheter

PATIENT ASSESSMENT

66-2

TIME: 1600 SIGNATURE [redacted]

SKIN AND MUCOUS MEMBRANES

Skin : Loose / [✓ Tight] / Diaphoretic / Shiny / Dry
Skin : Temperature Warm to touch
Color: Pale / Cyanotic / Jaundiced membranes pink
Mucous Membranes: [✓ Moist] / Dry / Cracked
Skin Breakdown: None Location: See SF ~~Size~~ 600

NEUROLOGICAL

Loc / [✓ Alert] / Lethargic / Unresponsive GCS:
Orientated / [✓ Disoriented] Pupils: 3mm R
Extremity Movement: Full / [✓ Limited] / None

CARDIOVASCULAR

Pulse (0 - 4): Palp Radials +3 Palp Pedals +3
Capillary Refill: < 3 Seconds Homan's Sign
Jugular Venous Distension Ø Edema
Heart Sounds S1 S2
Rhythm ST HR ↓100's. PRI: QRS

Vascular Catheter	Central	Arterial	Peripheral 1	Per
Waveforms			▨	▨
Site			20g (R)	
Solution			WRIST	

Chest Pain Ø

RESPIRATORY

Chest Expansion [✓ Symmetrical] / Asymmetrical
Respiration [✓ No Distress] / SOB / Labored / Use of Access Mus
Breathing Patterns: Regular c̄ ↓↓ Bases
Cough: Productive / Nonproductive / [✓ None]
Sputum: Color / Amount / Consistency / Odor Ø
Chest Drainage System Gravity: Ø Suction cm
Air Leak No Yes Crepitus
Character of Drainage:
Trachea [✓ Midline] / Deviated (R) / Deviated (L)
Artificial Airway Size: Ø Type: Position.

Breath Sounds	Anterior/Location	Posterior/L
Crackles		
Wheezes		
Diminished	Bilat	Bilat
Absent		

GASTROINTESTINAL

Abdomen: [✓ Soft] / Firm / Hard / Distended cm Girth
Bowel Sounds: [✓ Normal] / Hyperactive / Hypoactive / Absent
Dressings: See SF 600
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent D
NG Drainage: Color Ø Character
Tube Feeding: Day No: Ø Strength: Rate: Asp
Stool: Character loose Brown
Drains: Foley 16 F.

GENITOURINARY

Urine Color: yellow Character: Cloudy
Voiding: Continent /

H [redacted] 66-4
26 July 03

MEDCOM - 13130

ASSESSMENT b6-2 b6-2

TIME: 0600 SIGNATU [redacted]

SKIN AND MUCOUS MEMBRANES

Skin : [✓ Loose] / Tight / Diaphoretic / [✓ Shiny] / Dry
Skin : Temperature 97.7 normal
Color: Pale / Cyanotic / Jaundiced normal for race
Mucous Membranes: [✓ Moist] / Dry / Cracked
Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc [✓ Alert] / Lethargic / Unresponsive GCS:
[✓ Orientated] / Disoriented Pupils: PERL
Extremity Movement: Full / [✓ Limited] / None Burns to ↑+↓ extremities

CARDIOVASCULAR

Pulse (0 - 4): + Radials + Pedals
Capillary Refill: Good Seconds Homan's Sign
Jugular Venous Distension N/A Edema to (L) feet
Heart Sounds normal
Rhythm normal PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			▨	▨
Site			Rt innerarm	
Solution			LR @ 100cc/hr	

Chest Pain Ø

RESPIRATORY

Chest Expansion [✓ Symmetrical] / Asymmetrical
Respiration [✓ No Distress] / SOB / Labored / Use of Access Muscles
Breathing Patterns: normal
Cough: Productive / Nonproductive / [✓ None]
Sputum: Color / Amount / Consistency / Odor N/A
Chest Drainage System Gravity: Suction cm:
Air Leak No Yes Crepitus
Character of Drainage:
Trachea [✓ Midline] / Deviated (R) / Deviated (L)
Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes	CTA	
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: [✓ Soft] / Firm / Hard / Distended cm Girth
Bowel Sounds: [✓ Normal] / Hyperactive / Hypoactive / Absent
Dressings: To abdomen, back, U & L extremities
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage
NG Drainage: Color Character
Tube Feeding: Day No: Strength: Rate: Aspirate:
Stool: Character Ø
Drains: Ø

GENITOURINARY

Urine Color: pale yellow Character:
Voiding: Continent / [✓ Incontinent] Catheter NO

EMOTIONAL/PSYCHOSOCIAL

OTHER:

TIME: 1800 SIGNATURE: [redacted]

SKIN AND MUCOUS MEMBRANES

Skin : Loose / [✓ Tight] / Diaphoretic / Shiny / Dry
Skin : Temperature warm to touch
Color: Pale / Cyanotic / Jaundiced Membranes Pink.
Mucous Membranes: [✓ Moist] / Dry / Cracked
Skin Breakdown: None Location: SEE S ~~Size~~: 600
SEE SW

NEUROLOGICAL

Loc [✓ Alert] / Lethargic / Unresponsive GCS:
[✓ Orientated] / Disoriented Pupils:
Extremity Movement: Full / [✓ Limited] / None 2° BLE/UE. wounds

CARDIOVASCULAR

Pulse (0 - 4): Palp Radials +3 Palp Pedals +3
Capillary Refill: < 3 Seconds Homan's Sign
Jugular Venous Distension Ø Edema
Heart Sounds S_1 S_2
Rhythm Regular PRI: QRS:

Vascular Catheter Ø	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			▨	▨
Site			PIV 20g	
Solution LR	100°		(R) wrist	

Chest Pain Denies

RESPIRATORY

Chest Expansion [✓ Symmetrical] / Asymmetrical
Respiration [✓ No Distress] / SOB / Labored / Use of Access Muscles
Breathing Patterns: Regular RA SATS Mid 90's
Cough: Productive / Nonproductive / [✓ None]
Sputum: Color / Amount / Consistency / Odor Ø
Chest Drainage System Gravity: Ø Suction cm:
Air Leak Ø No Yes Crepitus
Character of Drainage: Ø
Trachea [✓ Midline] / Deviated (R) / Deviated (L)
Artificial Airway Size: Ø Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes		
Diminished B/lat	Bases	Bases
Absent		

GASTROINTESTINAL

Abdomen: [✓ Soft] / Firm / Hard / Distended cm Girth
Bowel Sounds: [✓ Normal] / Hyperactive / Hypoactive / Absent
Dressings: SEE SF600 for wound ASSessment
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage Ø
NG Drainage: Color Ø Character
Tube Feeding: Day No: Ø Strength: Rate: Aspirate
Stool: Character Ø
Drains: Ø

GENITOURINARY

Urine Color: YEllow Character: clear
Voiding: Continent / Incontinent / [✓ Catheter]

EMOTIONAL/PSYCHOSOCIAL

Oriented, person place, event
Cooperative / Pleasant

OTHER:

[redacted] 04Aug03
b6-4

ASSESSMENT b6-2

TIME: 0645 SIGNATU.. [redacted] b6-2

SKIN AND MUCOUS MEMBRANES

Skin : [✓ Loose] / Tight / Diaphoretic / Shiny / [✓ Dry]
Skin : Temperature Warm
Color: Pale / Cyanotic / Jaundiced Normal to Pink
Mucous Membranes: [✓ Moist] / Dry / Cracked
Skin Breakdown: None Location: Burn Areas Size:

NEUROLOGICAL

Loc / [✓ Alert] / Lethargic / Unresponsive GCS:
[✓ Orientated] / Disoriented Pupils:
Extremity Movement: [✓ Full] / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radials +2 --- Pedals +2
Capillary Refill: Seconds <3sec Homan's Sign
Jugular Venous Distension 0 Edema (L) Foot
Heart Sounds /
Rhythm PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			▨	▨
Site			(R) AC	
Solution			LR@100	

Chest Pain

RESPIRATORY

Chest Expansion / [✓ Symmetrical] / Asymmetrical
Respiration / [✓ No Distress] / SOB / Labored / Use of Access Muscles
Breathing Patterns: ARR
Cough: Productive / Nonproductive / [✓ None]
Sputum: Color / Amount / Consistency / Odor
Chest Drainage System Gravity: 0 Suction cm:
Air Leak No Yes -- Crepitus
Character of Drainage:
Trachea / Midline / Deviated (R) / Deviated (L)
Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles	CTA	CTA
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen [✓ Soft] / Firm / Hard / Distended cm Girth
Bowel Sounds: [✓ Normal] / Hyperactive / Hypoactive / Absent
Dressings: Dressings to be Δ'd in OR
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage
NG Drainage: Color Character
Tube Feeding: Day No: Strength: Rate: Aspirate:
Stool: Character 0
Drains: ---

GENITOURINARY

Urine Color: yellow Character: Clear
Voiding: Continent / Incontinent / [✓ Catheter]

EMOTIONAL/PSYCHOSOCIAL

OTHER:

TIME: 18[illegible] SIGNATURE: [redacted] b6-2

SKIN AND MUCOUS MEMBRANES

Skin : Loose / [✓ Tight] / Diaphoretic / Shiny / Dry
Skin : Temperature Warm to Touch
Color: Pale / Cyanotic / Jaundiced Membranes Pink
Mucous Membranes: [✓ Moist] / Dry / Cracked
Skin Breakdown: [✓ None] Location: Size:

NEUROLOGICAL

Loc / [✓ Alert] / Lethargic / Unresponsive GCS:
[✓ Orientated] / Disoriented Pupils:
Extremity Movement: Full / [✓ Limited] / None 2° BLE Wounds

CARDIOVASCULAR

Pulse (0 - 4): Palp Radials +3 Palp Pedals +3
Capillary Refill: <3 Seconds Homan's Sign neg
Jugular Venous Distension 0 Edema
Heart Sounds S S
Rhythm Regular PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			▨	▨
Site			20g PIV (L) AC	
Solution	R 100°			

Chest Pain Denies

RESPIRATORY

Chest Expansion / [✓ Symmetrical] / Asymmetrical
Respiration / [✓ No Distress] / SOB / Labored / Use of Access Muscles
Breathing Patterns: Reg.
Cough: Productive / Nonproductive / [✓ None]
Sputum: Color / Amount / Consistency / Odor 0
Chest Drainage System Gravity: 0 Suction cm:
Air Leak No Yes Crepitus
Character of Drainage: 0
Trachea / [✓ Midline] / Deviated (R) / Deviated (L)
Artificial Airway Size: Type: 0 Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes		
Diminished	Bilat	Bilat
Absent		

GASTROINTESTINAL

Abdomen [✓ Soft] / Firm / Hard / Distended cm Girth
Bowel Sounds [✓ Normal] / Hyperactive / Hypoactive / Absent
Dressings: See DF600 for Skin Assess
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage
NG Drainage: Color 0 Character
Tube Feeding: Day No: 0 Strength: Rate: Aspirate
Stool: Character 0
Drains: 0

GENITOURINARY

Urine Color: yellow Character: Clear
Voiding: ~~Continent~~ / Incontinent / [✓ Catheter]

EMOTIONAL/PSYCHOSOCIAL

OTHER:

01 Aug 03 b6-4

[redacted]

PAGE

ACUITY LEVEL CLASSIFICATION

22	23	00	01	02	03	04	

RESPIRATORY DATA			TIME
	MODE		
	F_iO_2		
	TV		
	RATE		
	PEEP		
	A	pH	
		PCO_2	
		pO_2	
	B	HCO_3	
		SAT	
	G	BASE	

22	23	00	01	02	03	04	8°

LABORATORY DATA	TIME
	GLUCOSE
	Na/K
	Cl/CO$_2$
	BUN/Cr
	WBC/PLATELET
	Hct/Hgb

ACTIVITIES DAILY LIVING	TIME	TURN	TIME
	MOUTH CARE		
	BATH		
	SKIN CARE		
	FOLEY CARE	SUCTION	
	TRACH CARE		
	ROM EXERCISES		

24° I&O TOTALS		NURSE'S SIGNATURE
wt Yesterday ______	wt Today ______	
INTAKE	OUTPUT	
IV ______	Urine: ______	
po ______	______	

MEDCOM - 13133

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
BP			109/63				129/69				119/68					109/59				135/60				X
TEMP	X		98.2				98.5				98.7				97.4									
HR	85	86	98				97				96					108				96				87
RR	14	11	14				11				10					10				12				11
SA02	93	96	96				97				100					98				97				98
INPUT																								
PO															240			200		100				
NS IV	100	100	100		~~200~~		100	100	100	100	100	100	100											
NGT																								
LR														100	100	100	100	100	100	100	100	100	100	100
TOTAL																								
OUTPUT																								
URINE					200		200				300		100											500
NGT																								
STOOL																								
TOTAL																								
BALANCE																								

IN OR

OR

IV 2100 Urine

PO

Balance

01Aug03

#[redacted] b6-4

ASSESSMENT 66-2

TIME: 0607 SIGNATU. [redacted] 66-2

SKIN AND MUCOUS MEMBRANES

Skin : [✓ Loose] / Tight / Diaphoretic / Shiny / [✓ Dry]

Skin : Temperature Warm

Color: Pale / Cyanotic / Jaundiced Normal to race

Mucous Membranes: [✓ Moist] / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / [✓ Alert] / Lethargic / Unresponsive GCS:

[✓ Orientated] / Disoriented Pupils: 3mm Perrla

Extremity Movement: [✓ Full] / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radials -- Pedals

Capillary Refill: Seconds < 3 Homan's Sign 0

Jugular Venous Distension 0 Edema

Heart Sounds S_1 S_2 No ectopy

Rhythm NSR PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			▨	▨
Site				
Solution				

Chest Pain 0

RESPIRATORY

Chest Expansion / [✓ Symmetrical] / Asymmetrical

Respiration / [✓ No Distress] / SOB / Labored / Use of Access Muscles

Breathing Patterns: RRR

Cough: Productive / Nonproductive / [✓ None]

Sputum: Color / Amount / Consistency / Odor None

Chest Drainage System Gravity: 0 Suction cm:

Air Leak No Yes -- Crepitus

Character of Drainage:

Trachea / [✓ Midline] / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles	CTA	CTA
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: [✓ Soft] / Firm / Hard / Distended cm Girth

Bowel Sounds: [✓ Normal] / Hyperactive / Hypoactive / Absent

Dressings:

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate:

Stool: Character

Drains: --

GENITOURINARY

Urine Color: yellow Character: Clear

Voiding: Continent / Incontinent / Catheter Foley

EMOTIONAL/PSYCHOSOCIAL

OTHER:

TIME: 18 SIGNATURE: [redacted]

SKIN AND MUCOUS MEMBRANES

Skin : Loose / Tight / Diaphoretic / Shiny / [✓ Dry]

Skin : Temperature Warm.

Color: Pale / Cyanotic / Jaundiced Normal for Race.

Mucous Membranes: [✓ Moist] / Dry / Cracked

Skin Breakdown: [✓ None] Location: Size:

NEUROLOGICAL

Loc / [✓ Alert] / Lethargic / Unresponsive GCS:

[✓ Orientated] / Disoriented Pupils:

Extremity Movement: [✓ Full] / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): +2 Radials +2 Pedals

Capillary Refill: < 2 Seconds Homan's Sign

Jugular Venous Distension Edema 0

Heart Sounds S1-S2.

Rhythm Sinus tach. Rate 100's QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms	0		▨	▨
Site				
Solution				

Chest Pain

RESPIRATORY

Chest Expansion / [✓ Symmetrical] / Asymmetrical

Respiration / [✓ No Distress] / SOB / Labored / Use of Access Muscles

Breathing Patterns: Regular

Cough: Productive / Nonproductive / [✓ None]

Sputum: Color / Amount / Consistency / Odor

Chest Drainage System Gravity: Suction cm:

Air Leak No Yes Crepitus

Character of Drainage: -

Trachea / [✓ Midline] / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles	CTA	
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: [✓ Soft] / Firm / Hard / Distended cm Girth

Bowel Sounds: [✓ Normal] / Hyperactive / Hypoactive / Absent

Dressings: Burn areas, D/d in AM.

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate

Stool: Character

Drains:

GENITOURINARY

Urine Color: Clear dark Character: yellow urine.

Voiding: Continent / Incontinent / 0 Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER: 0

30 Jul 03 pt: EPW [redacted] 66-4

MEDCOM - 13135

PATIENT ASSESS~~ENT

TIME: SIGNATURE.

SKIN AND MUCOUS MEMBRANES

Skin. Loose / Tight / Diaphoretic / Shiny / [✓ Dry]
Skin: Temperature Warm to touch
Color: Pale / Cyanotic / Jaundiced Normal for Race
Mucous Membranes: [✓ Moist] / Dry / Cracked
Skin Breakdown: [✓ None] Location: Size:

NEUROLOGICAL

Loc / [✓ Alert] / Lethargic / Unresponsive GCS:
[✓ Oriented] / Disoriented Pupils:
Extremity Movement. Full / [✓ Limited] / None 10% Burns

CARDIOVASCULAR

Pulse (0 - 4): Radials +2 Pedals +2
Capillary Refill: Seconds >3 Homan's Sign
Jugular Venous Distension Ø Edema
Heart Sounds S_1S_2
Rhythm RRR PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			▨	▨
Site	TLC Neck			
Solution	LR@100cc/hr			

Chest Pain Ø

RESPIRATORY

Chest Expansion / [✓ Symmetrical] / Asymmetrical
Respiration / [✓ No Distress] / SOB / Labored / Use of Access Muscles
Breathing Patterns: RRR
Cough: Productive / Nonproductive / [✓ None]
Sputum: Color / Amount / Consistency / Odor Ø
Chest Drainage System Gravity: Ø Suction cm:
Air Leak No Yes Crepitus
Character of Drainage: NA
Trachea / [✓ Midline] / Deviated (R) / Deviated (L)
Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles	CTA Bilat	
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: [✓ Soft] / Firm / Hard / Distended cm Girth
Bowel Sounds: [✓ Normal] / Hyperactive / Hypoactive / Absent
Dressings: Abd, Bilat hands, Bilat legs, buttocks, Back
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage
NG Drainage: Color N/A Character
Tube Feeding: Day No: Strength: Rate: Aspirate:
Stool Character
Drains. Ø

GENITOURINARY

Urine Color. Clear Character: yellow
Voiding. Continent / Incontinent / [✓ Catheter] Gravity

EMOTIONAL/PSYCHOSOCIAL

Pt resting comfortably Ø S/S of pain/distress

OTHER:

~~TIENT ASSESSMENT

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry 30-40% burn
Skin: Temperature warm & dry
Color: Pale / Cyanotic / Jaundiced WNL for race
Mucous Membranes: [✓ Moist] / Dry / Cracked
Skin Breakdown: None Location: arms/LE Size: buttocks back

NEUROLOGICAL

Loc / [✓ Alert] / Lethargic / Unresponsive GCS: —
[✓ Oriented] / Disoriented Pupils: PERRLA
Extremity Movement: Full / [✓ Limited] / None due to pain

CARDIOVASCULAR

Pulse (0 - 4): Radials (+) Pedals (+) faint
Capillary Refill: <3 sec Seconds — Homan's Sign —
Jugular Venous Distension Ø Edema hands/LE
Heart Sounds S_1S_2, ST 100's
Rhythm NSR [illegible] PRI: — QRS. —

Vascular Catheter	[✓ Central]	Arterial	Peripheral 1	Peripheral 2
Waveforms			▨	▨
Site				
Solution				

Chest Pain Ø

RESPIRATORY

Chest Expansion / [✓ Symmetrical] / Asymmetrical
Respiration / [✓ No Distress] / SOB / Labored / Use of Access Muscles
Breathing Patterns: unlabored even, NAD
Cough: Productive / Nonproductive / [✓ None]
Sputum: Color / Amount / Consistency / Odor —
Chest Drainage System Gravity: Ø Suction cm
Air Leak Ø No Yes Crepitus
Character of Drainage: —
Trachea / [✓ Midline] / Deviated (R) / Deviated (L)
Artificial Airway Size: Ø Type: Ø Position.

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes	X occasional exp wheeze	
Diminished	X 2 pack/day smoker	
Absent		

GASTROINTESTINAL

Abdomen: [✓ Soft] / Firm / Hard / Distended cm Girth
Bowel Sounds: [✓ Normal] / Hyperactive / Hypoactive / Absent
Dressings: hands, LE, buttocks, back
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage
~~NG Drainage~~: Color — Character —
~~Tube Feeding~~: Day No: Strength: Rate: Aspirate
Stool: Character soft large last BM 7/6/03
Drains: —

GENITOURINARY

Urine foley Color: tea Character: clear
~~Voiding: Continent / Incontinent / Catheter~~

EMOTIONAL/PSYCHOSOCIAL

Cooperative, somber, verbalize needs.

OTHER:

ASSESSMENT

TIME: 0900 SIGNATU. [redacted] b6-2

SKIN AND MUCOUS MEMBRANES

Skin : [✓ Loose] / Tight / Diaphoretic / Shiny / [✓ Dry]
Skin : Temperature Warm
Color: Pale / Cyanotic / Jaundiced Normal to Race
Mucous Membranes: [✓ Moist] / Dry / Cracked
Skin Breakdown: None Location: Burn Sites Size:

NEUROLOGICAL

Loc / [✓ Alert] / Lethargic / Unresponsive GCS:
[✓ Orientated] / Disoriented Pupils:
Extremity Movement: [✓ Full] / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radials +2 Pedals +2
Capillary Refill: Seconds <3 Homan's Sign
Jugular Venous Distension 0 Edema (L) Foot
Heart Sounds S_1 S_2
Rhythm NSR PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			▨	▨
Site			(R) wrist	
Solution			LR@100	

Chest Pain

RESPIRATORY

Chest Expansion / [✓ Symmetrical] / Asymmetrical
Respiration / [✓ No Distress] / SOB / Labored / Use of Access Muscles
Breathing Patterns: RRR
Cough: Productive / Nonproductive / [✓ None]
Sputum: Color / Amount / Consistency / Odor
Chest Drainage System Gravity: 0 Suction cm:
Air Leak No Yes -- Crepitus
Character of Drainage:
Trachea / [✓ Midline] / Deviated (R) / Deviated (L)
Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles	CTA	CTA
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: [✓ Soft] / Firm / Hard / Distended cm Girth
Bowel Sounds: [✓ Normal] / Hyperactive / Hypoactive / Absent
Dressings: Drsgs Δ'd CDI
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage
NG Drainage: Color Character
Tube Feeding: Day No: Strength: Rate: Aspirate:
Stool: Character 0
Drains: 0

GENITOURINARY

Urine Color: yellow Character: Clear
Voiding: Continent / Incontinent / [✓ Catheter] Foley

EMOTIONAL/PSYCHOSOCIAL

OTHER:

TIME: 1800 SIGNATURE: [redacted] b6-2

SKIN AND MUCOUS MEMBRANES

Skin : Loose / [✓ Tight] / Diaphoretic / Shiny / Dry
Skin : Temperature WARM TO TOUCH
Color: Pale / Cyanotic / Jaundiced Membranes pink
Mucous Membranes: [✓ Moist] / Dry / Cracked
Skin Breakdown: [✓ None] Location: Size:

NEUROLOGICAL

Loc / [✓ Alert] / Lethargic / Unresponsive GCS:
[✓ Orientated] / Disoriented Pupils:
Extremity Movement: Full / [✓ Limited] / None 2° BLE WOUNDS

CARDIOVASCULAR

Pulse (0 - 4): Palp Radials +3 Palp Pedals +3
Capillary Refill: < 3 Seconds Homan's Sign
Jugular Venous Distension 0 Edema
Heart Sounds S_1 S_2
Rhythm PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			▨	▨
Site			20g PIV	
Solution LR			(R) wrist	

Chest Pain Denies

RESPIRATORY

Chest Expansion / [✓ Symmetrical] / Asymmetrical
Respiration / [✓ No Distress] / SOB / Labored / Use of Access Muscles
Breathing Patterns: Regular
Cough: Productive / Nonproductive / [✓ None]
Sputum: Color / Amount / Consistency / Odor 0
Chest Drainage System Gravity: 0 Suction cm:
Air Leak 0 No Yes Crepitus
Character of Drainage: 0
Trachea / [✓ Midline] / Deviated (R) / Deviated (L)
Artificial Airway Size: 0 Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes		
Diminished	Bases Bilat	Bases Bilat
Absent		

GASTROINTESTINAL

Abdomen: [✓ Soft] / Firm / Hard / Distended cm Girth
Bowel Sounds: [✓ Normal] / Hyperactive / Hypoactive / Absent
Dressings: See SF 600 for Skin assess.
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage 0
NG Drainage: Color 0 Character
Tube Feeding: Day No: 0 Strength: Rate: Aspirate
Stool: Character 0
Drains: 0

GENITOURINARY

Urine Color: yellow Character: Concentrated
Voiding: Continent / Incontinent / [✓ Catheter]

EMOTIONAL/PSYCHOSOCIAL

Cooperative, pleasant. Oriented to person, place. Reorient to
OTHER: time + event easily.

02Aug03

[redacted] b6-4

11/1/03

TIME: 0840 SIGNA[redacted] b6-2

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / [✓ Dry]

Skin: Temperature Warm

Color: Pale / Cyanotic / Jaundiced Normal for Race

Mucous Membranes: Moist / [✓ Dry] / Cracked

Skin Breakdown: None Location: Burns arms, legs, Abdomen, Back Size:

NEUROLOGICAL

LOC: [✓ Alert] / Lethargic / Unresponsive GCS:

[✓ Oriented] / Disoriented Pupils: PERRLA

Extremity Movement: Full / Limited / None Active

CARDIOVASCULAR

Pulse (0-4): Radials +3 Pedals +3

Capillary Refill Seconds <3 Homan's Sign

Jugular Venous Distension Ø Edema BLE

Heart Sounds CV=S1S2

Rhythm SR PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site				
Solution				

Chest Pain

RESPIRATORY

Chest Expansion: [✓ Symmetrical] / Asymmetrical

Respiration: [✓ No Distress] / SOB / Labored / Use of Access. Muscles

Breathing Patterns: Regular, Unlabored

Cough: Productive / Nonproductive / None None

Sputum: Color / Amount / Consistency / Odor

Chest Drainage System Gravity: Suction cm:

Air Leak No Yes Crepitus

Character of Drainage:

Trachea: Midline / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes	CTA	
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: [✓ Soft] / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / [✓ Hypoactive] / Absent

Dressings: C/D/I

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate:

Stool: Character

Drains:

GENITOURINARY

Urine Color: Not yet voided Character:

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

Calm, cooperative

OTHER:

PATIENT ASSESSMENT b6-2

TIME: SIGNATURE:[redacted] CT/A

SKIN AND MUCOUS MEMBRANES

Skin: [✓ Loose] / Tight / Diaphoretic / Shiny / [✓ Dry]

Skin: Temperature Warm

Color: Pale / Cyanotic / Jaundiced Normal for Race

Mucous Membranes: [✓ Moist] / Dry / Cracked

Skin Breakdown: None Location: Burns Drsg CDI

NEUROLOGICAL

LOC: [✓ Alert] / Lethargic / Unresponsive GCS:

[✓ Oriented] / Disoriented Pupils: PERRLA 3mm brisk

Extremity Movement: [✓ Full] / Limited / None Weak

CARDIOVASCULAR

Pulse (0-4): +2 Radials +2 Pedals

Capillary Refill: <3 Seconds — Homan's Sign

Jugular Venous Distension Edema

Heart Sounds S1/S2

Rhythm NSR PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripher
Waveforms				
Site				
Solution				

Chest Pain

RESPIRATORY

Chest Expansion: [✓ Symmetrical] / Asymmetrical

Respiration: [✓ No Distress] / SOB / Labored / Use of Access. Muscles

Breathing Pattern: RRR

Cough: Productive / Nonproductive / [✓ None]

Sputum: Color / Amount / Consistency / Odor

Chest Drainage System Gravity: Suction cm:

Air Leak No Yes Crepitus

Character of Drainage:

Trachea: Midline / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Loca
Crackles	CTA (B)	
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: [✓ Soft] / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / [✓ Hypoactive] / Absent

Dressings: ARMS, LEGS, ABD, BACK BURN DRSG CDI

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drain

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate

Stool: Character

Drains:

GENITOURINARY

Urine Color: Spontaneously Character:

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

Cooperative, Follows Simple Commands

OTHER:

MEDCOM - 13138

66-4

ICU Flowsheet **Patient Name:** [redacted]

Date: 11 / AUG / 2003

Vital Signs	24	01	02	03	04	05	06	07	08	09	10	11		12	13	14	15	16	17	18	19	20	21	22	23	
Temperature	98.4	→	98.1						97^{2}					97^{7}				97^{7}			98^{0}					
Pulses	83		83						81					80				82			84					
B/P > A-Line																										
MAAP		→																								
B/P > Cuff	122/64		122/67						100/78					112/74				122/68			120/60					
Respirations	14		14						16					17				16			16					
Sa002	98%		98%						95					96				97			96					
	RA	→	RA						RA					RA				RA			RA					

Intake	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
IVF:																										
PO Intake											240	60		60					237							
O.R.R. IN																										
Totals																										

Output	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
Urine Hourly																		250								
NG Tube																										
Drains #1																										
#2																										
#3																										
Emesis																										
Stool																										
O.R.R. OUT																										
Totals																										

24 hour input	
24 hour output	
24 hour balance	

#[redacted] 66-4

11 Aug 03

PATIENT ASSESSMENT

TIME: SIGNATURE

SKIN AND MUCOUS MEMBRANES

Skin Loose / Tight / Diaphoretic / Shiny / [✓ Dry]

Skin : Temperature Warm to touch

Color Pale / Cyanotic / Jaundiced Normal for Race

Mucous Membranes: [✓ Moist] / Dry / Cracked

Skin Breakdown: [✓ None] Location: Size:

NEUROLOGICAL

Loc / [✓ Alert] / Lethargic / Unresponsive GCS:

[✓ Orientated] / Disoriented Pupils:

Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radials +2 Pedals +2

Capillary Refill: Seconds Homan's Sign

Jugular Venous Distension Ø Edema Scrotal, Bilat legs

Heart Sounds S, S2

Rhythm PRI: QRS:

Vascular Catheter	[✓ Central]	Arterial	Peripheral 1	Peripheral 2
Waveforms	Ⓡ		▨	▨
Site	Brach			
Solution	LR @ 150cc/hr			

Chest Pain Ø

RESPIRATORY

Chest Expansion / [✓ Symmetrical] / Asymmetrical

Respiration / [✓ No Distress] / SOB / Labored / Use of Access Muscles

Breathing Patterns: RRR

Cough. Productive / Nonproductive / [✓ None]

Sputum: Color / Amount / Consistency / Odor Ø

Chest Drainage System Gravity: Suction cm:

Air Leak No Yes Crepitus

Character of Drainage:

Trachea / [✓ Midline] / Deviated (R) / Deviated (L)

Artificial Airway Size: NA Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes	wheezes throughout	
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: [✓ Soft] / Firm / Hard / Distended cm Girth

Bowel Sounds: [✓ Normal] / Hyperactive / Hypoactive / Absent

Dressings: Legs, Arms, Hands, Abd, buttock, back

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Ø Character

Tube Feeding: Day No: Ø Strength: Rate: Aspirate:

Stool. Character

Drains Ø

GENITOURINARY

Urine Color: Yellow Character: Clear

Voiding Continent / Incontinent / [✓ Catheter] gravity

EMOTIONAL/PSYCHOSOCIAL

Pt resting comfortably in bed Ø c/o pain, discomfort

OTHER

T JT ASSESSMENT

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin : Loose / Tight / Diaphoretic / Shiny / [✓ Dry]

Skin : Temperature warm dry to touch

Color: Pale / Cyanotic / Jaundiced WNL for race

Mucous Membranes: [✓ Moist] / Dry / Cracked

Skin Breakdown: None Location: 10-20% burn Size: hands arms legs

NEUROLOGICAL

Loc / [✓ Alert] / Lethargic / Unresponsive GCS:

[✓ Orientated] / Disoriented Pupils:

Extremity Movement: [✓ Full] / [✓ Limited] / None due to pain

CARDIOVASCULAR

Pulse (0 - 4): Radials (+) Pedals (+)

Capillary Refill: <3 sec Seconds Homan's Sign (−)

Jugular Venous Distension — Edema hands Ⓛ leg, feet

Heart Sounds S, S2

Rhythm ST 110 PRI: — QRS:

Vascular Catheter	[✓ Central]	Arterial	Peripheral 1	Peripheral 2
Waveforms			▨	▨
Site				
Solution				

Chest Pain (−)

RESPIRATORY

Chest Expansion / [✓ Symmetrical] / Asymmetrical

Respiration / [✓ No Distress] / SOB / Labored / Use of Access Muscles

Breathing Patterns: BBS regular unlabored

Cough: Productive / Nonproductive / [✓ None]

Sputum: Color / Amount / Consistency / Odor ——

Chest Drainage System Gravity: NA Suction cm NA

~~Air Leak No Yes~~ Crepitus

Character of Drainage: (−)

Trachea / [✓ Midline] / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position.

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes	✓	
Diminished	✓ throughout	
Absent		

GASTROINTESTINAL

Abdomen: [✓ Soft] / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / [✓ Hypoactive] / Absent

Dressings: hands, LE, buttocks, abd, back

~~NG Tube:~~ Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

~~NG Drainage~~: Color Character

Tube Feeding: Day No: 1 Strength: Rate: 125 Aspirate

Stool: Character (−)

~~Drains:~~

GENITOURINARY

Urine foley Color: amber Character: clear

~~Voiding: Continent / Incontinent / Catheter~~

EMOTIONAL/PSYCHOSOCIAL

Low tolerance for pain, requiring maximum MSO4 10mg during dressing Δ. Alert, cooperative

OTHER: Comfort returns after procedure.

25 July 03
[redacted]
b6-4

0635 PATIENT ASSESSMENT

b6-2

b6-4

ME: [redacted] SIGNATURE: [redacted] LT/AN

SKIN AND MUCOUS MEMBRANES

[✓ Loose] / Tight / Diaphoretic / Shiny / Dry
Temperature WARM
r Pale / Cyanotic / Jaundiced WNL for Race
ous Membranes: [✓ Moist] / Dry / Cracked
Breakdown: [✓ None] Location: ——— Size: ———

NEUROLOGICAL

Alert / Lethargic / Unresponsive confused GCS: ———
nated / [✓ Disoriented] Pupils: 3# brisk
emity Movement: [✓ Full] / Limited / None

CARDIOVASCULAR

s (0 - 4) 2 Radials 2 Pedals
llary Refill <3 Seconds Homan's Sign (—)
ular Venous Distension ——— Edema pitting BLE +3
rt Sounds S,S2
thm ST PRI: ——— QRS: ———

cular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
eforms	—	—	▨	▨
Site	—	—	L upper arm	
Soln			LR @ 100cc/h	

st Pain 0

RESPIRATORY

st Expansion / [✓ Symmetrical] / Asymmetrical
piration / [✓ No Distress] / SOB / Labored / Use of Access Muscles
thing Patterns:
gh: Productive / Nonproductive / [✓ None]
tum Color / Amount / Consistency / Odor N/A
st Drainage System Gravity: ——— Suction cm: ———
Leak No Yes Crepitus ———
racter of Drainage: ———
hea [✓ Midline] / Deviated (R) / Deviated (L)
icial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
ckles		
eezes	Diminished bilat & bases	
inished		
ent		

GASTROINTESTINAL

omen [✓ Soft] / Firm / Hard / Distended ——— cm Girth
el Sounds [✓ Normal] / Hyperactive / Hypoactive / Absent
ssings: BLE, BUE, buttocks, back, stomach intact & dry
~~Tube: Clamped/Inter.~~ Suction/Cont. ~~Suction/Dependent Drainage~~
Drainage: Color ——— Character ———
e Feeding: Day No: ——— Strength: ——— Rate: ——— Aspirate: ———
l Character 0 @ this time
ns ———

GENITOURINARY

e Color: DARK YELLOW Character: 0 sediment
nd Continent / [✓ Incontinent] / [✓ Catheter]

PATIENT ASSESSMENT

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin : Loose / [✓ Tight] / Diaphoretic / Shiny / Dry
Skin : Temperature Warm to Touch
Color: Pale / Cyanotic / Jaundiced membranes pink,
Mucous Membranes [✓ Moist] / Dry / Cracked
Skin Breakdown: None Location: SEE SF ~~Size:~~ 600

NEUROLOGICAL

Loc / [✓ Alert] / Lethargic / Unresponsive GCS:
Orientated / [✓ Disoriented] Pupils:
Extremity Movement: Full / [✓ Limited] / None

CARDIOVASCULAR

Pulse (0 - 4): Palp Radials +3 Palp Pedals +3
Capillary Refill: Seconds Homan's Sign
Jugular Venous Distension 0 Edema
Heart Sounds S1 S2 ST c̄ HR ↓ 100's
Rhythm Regular PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Per
Waveforms			▨	▨
Site			20g (R)	
Solution			WRIST	

Chest Pain 0

RESPIRATORY

Chest Expansion / [✓ Symmetrical] / Asymmetrical
Respiration / [✓ No Distress] / SOB / Labored / Use of Access Mus
Breathing Patterns: Regular c̄ ↓↓ Bases
Cough: Productive / Nonproductive / [✓ None]
Sputum: Color / Amount / Consistency / Odor 0
Chest Drainage System Gravity: 0 Suction cm
Air Leak No Yes Crepitus
Character of Drainage: -
Trachea / [✓ Midline] / Deviated (R) / Deviated (L)
Artificial Airway Size: 0 Type: Position.

Breath Sounds	Anterior/Location	Posterior/L
Crackles		
Wheezes		
Diminished	Bilat Bases	—
Absent		

GASTROINTESTINAL

Abdomen: [✓ Soft] / Firm / Hard / Distended cm Girth
Bowel Sounds [✓ Normal] / ~~Hyperactive / Hypoactive~~ / Absent b6-2
Dressings: SEE [redacted] SF 600
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent D
NG Drainage: Color 0 Character
Tube Feeding: Day No: 0 Strength: Rate: Asp
Stool: Character Loose Brown
Drains: Foley 16 F

GENITOURINARY

Urine Color: yellow Character: Cloudy
Voiding: Continent /

MEDCOM - 13141

MEDICAL RECORD	**PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT** For use of this form, see AR 40-407; the proponent agency is The Office of the Surgeon General.

1. AGE: HEIGHT: WEIGHT: See H+P

2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): NKDA

3. PREVIOUS SURGERY ☐ NO ☒ YES (type): See H+P

4. PROPOSED SURGICAL PROCEDURE: Full Thickness Skin Graft

5. ADDITIONAL INFORMATION: See H+P for additional information

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to Traumatic injury; language barrier; family separation; surgical environment	☑ Pt. verbalizes any specific anxiety. ☑ Pt. exhibits relaxed body posture.	☑ Allow pt. to verbalize freely. ☑ Explain OR environment and answer questions regarding surgery. ☑ Offer comfort measures, (e.g., warm blanket, touch) ☑ Explain all nursing procedures before they are done. ☑ Remain with pt. whenever possible. ☑ Maintain family interface.
B. AERATION ✓ Potential for respiratory dysfunction due to sedation; positioning; injury; previous medical condition	☑ PT. will be able to breathe without difficulty during immediate intra-operative phase.	☑ Offer to elevate head of litter or offer pillow. ☑ Observe pt. while awaiting surgery for signs of distress ☑ Assist anesthesia during intubation and extubation
C. INTEGUMENT ✓ Potential impairment of skin integuity due to bovie pad; poistion; fluid shift	☑ PT. will not exhibit signs of impairment of skin integrity (e.g., reddened areas.	☑ Utilize pressure preventing devices on OR table and accessories. ☑ Check for proper positioning and support to maintain good body alignment. ☑ Pad pressure points. ☑ Place ESU ground pad on non compromised skin surface area. ○ Keep prep fluids from pooling.

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

EPW # [redacted] b6-4

DA FORM 5179, JUN 91 Previoius editions are obsolete. USAPA V1.0

MEDCOM - 13142

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to anesthesia; traumatic injury; position; previous surgery	o✓ Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse).	o✓ Check for support stockings or ace wraps. If none, check with doctors. o✓ Check that safety straps are correctly applied. o Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. o Check that rings have been removed.
E. NEUROMUSCULAR CONTROL ✓ E.1. ✓ Potential impairment of mobility due to sedation; pain; injury E.2. ____ Potential discomfort due to injury; pain	o✓ Pt. will be transferred to OR table without difficulty. o✓ Pt. will not experience unnecessary physical discomfort.	o✓ Have sufficient people available for transfer. o✓ Insure proper body alignment. o✓ Allow patient to lie in position of comfort while waiting for surgery. o✓ Offer support (i.e., pillows, bathtowels, etc.) for positioning.
F. NEUROMUSCULAR CONTROL F.1. ✓ Disminished visual perception due to being injury ; sedation ✓ F.2. ✓ Potential for decreased communictaion due to language barrier; sedation; pain; injury F.3. Potential injury due to dentures. ✓ NA	o✓ Pt. will be made aware of surroundings prior to anesthesia induction. o✓ Pt. will be transferred safely to OR table. o✓ Pt. will be able to understand instructions. o Minimize danger of injury during intraop period. ✓	o✓ Introduce self. Keep pt. informed as to where he/she is and what is happening. o✓ Inform pt. in which direction to move and assist if necessary. o✓ Speak clearly and slowly. o✓ Address pt. from Either side. o✓ Validate pt.'s understanding of verbal communications. ~~o Verify removal of dentures.~~ NA
G. OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS. Or continuation of above interventions.

10. OR NURS[redacted]D/ADDITIONAL INTEROPERATIVE INTERVENTIONS NOTED.
CPT/AN 26 Aug 03 DATE

11. PO[redacted]OPERATIVE EVALU[redacted]ON: b6-2

12. PREOPERTIVE [redacted] b6-2
(Signature and Title) [redacted] CPT/AN
DATE: 26 Aug 03 TIME: 0925

13. PREOPERTIVE EVALUATION PR[redacted] b6-2
BY (Signature and Title [redacted] CPT/AN
DATE: 26 Aug 03 TIME: 1030

REVERSE OF DA FORM 5179, JUN 91 USAPA V1.0

MEDCOM - 13143

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

For use of this form, see AR 40-66; the proponent agency is The Office of the Surgeon General.

1. AGE: / HEIGHT: / WEIGHT: unknown

2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): NKDA

3. PREVIOUS SURGERY [ ] NO [X] YES (type): SEE H+P

4. PROPOSED SURGICAL PROCEDURE: Burn Debridement of Both Hands/Feet Dsg Change

5. ADDITIONAL INFORMATION: Last PO: p̄ MN Medical Hx: see H+P Implants: Ø Medications: Ancef
Jewelry removed: [✓ yes]/no Family waiting: yes/[✓ no]

NPO p̄ MN

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to traumatic injury; language barrier; family separation; surgical environment	☑ Pt. verbalizes any specific anxiety. ☑ Pt. exhibits relaxed body posture.	☑ Allow pt. to verbalize freely. ☑ Explain OR environment and answer questions regarding surgery. ○ Offer comfort measures, (e.g., warm blanket, touch) ☑ Explain all nursing procedures before they are done. ○ Remain with pt. whenever possible. ☑ Maintain family interface.
B. AERATION ✓ Potential for respiratory dysfunction due to sedation; positioning; injury	☑ PT. will be able to breathe without difficulty during immediate intra-operative phase.	☑ Offer to elevate head of litter or offer pillow. ☑ Observe pt. while awaiting surgery for signs of distress ☑ Assist anesthesia during intubation and extubation
C. INTEGUMENT ✓ Potential impairment of skin integuity due to bovie pad; position; fluid shift	☑ PT. will not exhibit signs of impairment of skin integrity (e.g., reddened areas.	☑ Utilize pressure preventing devices on OR table and accessories. ☑ Check for proper positioning and support to maintain good body alignment. ☑ Pad pressure points. ○ Place ESU ground pad on non compromised skin surface area. ○ Keep prep fluids from pooling.

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

#[redacted]-EPW
ICU-13 b6-4

DA FORM 5179, JUN 91 Previoius editions are obsolete. USAPA V1.01

MEDCOM - 13144

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ___ Potential for inadequate tissue perfusion due to anesthesia; traumatic injury; position; shock; previous surgery	o Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse).	o Check for support stockings or ace wraps: If none, check with doctors. o Check that safety straps are correctly applied. o Offer pillow for under knees. ~~o Place and take down legs from stirrups with slow bilateral motion.~~ o Check that rings have been removed.
E. NEUROMUSCULAR CONTROL E.1. ___ Potential impairment of mobility due to sedation; pain; injury E.2. ___ Potential discomfort due to injury; pain	o Pt. will be transferred to OR table without difficulty. o Pt. will not experience unnecessary physical discomfort.	o Have sufficient people available for transfer. o Insure proper body alignment. o Allow patient to lie in position of comfort while waiting for surgery. o Offer support (i.e., pillows, bathtowels, etc.) for positioning.
F. NEUROMUSCULAR CONTROL F.1. ___ Disminished visual perception due to being injury; sedation; F.2. ___ Potential for decreased communictaion due to language barrier; sedation F.3. Potential injury due to dentures. ___ NA	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR table. o Pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt. from Either side. o Validate pt.'s understanding of verbal communications. o Verify removal of dentures.
G. OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS. Or continuation of above interventions.

10. OR [redacted] ADDITIONAL INTEROPERATIVE INTERVENTIONS NOTED.

[redacted] CPT/AN 1 Aug 03 DATE

11. POSTOP [redacted] TIVE EVALUATION: b6-2

12. PREOP [redacted] BY CPT/AN
(Signature and T [redacted] b6-2
DATE: 1 Aug 03 TIME: 0835

13. PREO [redacted] BY (Sign [redacted] CPT/AN
DATE 1 Aug 03 TIME: 1015 b6-2

REVERSE OF DA FORM 5179, JUN 91 USAPA V1.01

MEDICAL RECORD

PREOPERATIVE/POSTOPE...TI_ NURSING DOCUMENT

FOR Use of this form. see AR 40-407: the proponent agency is The Office of the Surgeon General.

1. AGE:

HEIGHT:

WEIGHT:

2. KNOWN ALLERGIC SENSITIVITIES (e.g.. Iodine, Tape, Medication)
☐ NKDA ☐ PCN ☐ LATEX ☐ IODINE ☐ TAPE ☐ FOOD
REACTION:

3. PREVIOUS SURGERY [ ] NO [ ] YES (type):

4. PROPOSED SURGICAL PROCEDURE: DRESSING Δ

See H+P

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition________
Tobacco____ppd X___yrs. Body Piercing________ Diabetes (Y) (N) ROM________ ASA/Motrin w/72 hrs (Y) (N)
ETOH________ Implants________ Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS:

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL __✓__ Potential for anxiety related to: ____ 1) Surgical Procedure & Operating Room Environment ____ 2) ~~Separation Anxiety (Child)~~ 4 ____ 3) Surgical Outcomes	✓ o Pt. verbalizes any specific anxiety. ✓ o Pt. Exhibits relaxed body posture.	✓ o Allow pt. to verbalize freely. ✓ o Explain OR environment and answer questions regarding surgery. ✓ o Offer comfort measures. (e.g.. warm blanket. touch). ✓ o Explain all nursing procedures before they are done. ✓ o Remain with pt. whenever possible. o Maintain family interface. Parents to stay with pt.
B. AERATION __✓__ Potential for respiratory dysfunction due to: ____ 1) Positioning ____ 2) Effects of Anesthesia ____ 3) Medical/Smoking History	✓ o Pt. will be able to breathe without difficulty during immediate intraoperative phase .	✓ o Offer to elevate head of litter or offer pillow. ✓ o Observe pt. while awaiting surgery for signs of distress. ✓ o Assist anesthesia during intubation and extubation.
C. INTEGUMENT __✓__ Potential impairment of skin integrity due to: ____ 1) Intraoperative Immobility ____ 2) ESU Pad Placement ____ 3) Positional Aids ____ 4) Prosthesis ____ 5) Pooling of Prep Solutions	✓ o Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened areas).	✓ o Utilize pressure preventing devices on OR table and accessories. ✓ o Check for proper positioning and support to maintain good body alignment. o Pad pressure points. ✓ o Place ESU ground pad on non compromised skin surface area. ✓ o Keep prep fluids from pooling.

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

# [redacted] 66-4

66-2

VERIFICATIONS AT HOLDING AREA:
[redacted] /Allergy Band
& P
! NPO Since 0 Hr
! ~~UHCG/LM~~ [redacted]
[redacted] nsent/Blood Transfusion
[redacted] ed/Witnessed/Dated
[redacted] rgical Site/Consent verified by
/Anesthesia/Surgeon
[redacted] Contact Precautions (Y) [✓ (N)]
! Family/Friend: NMs

[redacted] tures Removed
ntacts Removed
ewelry Removed
Body Pierce Removed

USAPA V1.0

DA FORM 5179, JUN 91 Previous editions are obsolete.

MEDCOM - 13146

6. PATIENT PROBLEMS AND NEEDS	PATIENT GOALS AND EXPECTED OUTCOMES	OR NURSING INTERVENTIONS
D. CIRCULATION: ✓ Potential for inadequate tissue perfusion due to: ____ 1) Intraoperative Mobility ____ 2) Positioning ____ 3) Existing Disease ____ 4) Safety Devices ____ 5) Hypothermia	✓ o Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse.	✓ o Check for support stockings or ace wraps. If none, check with doctors. ✓ o Check that safety straps are correctly applied. ~~o Offer pillow for under knees~~ o ~~Place and take down legs from stirrups with~~ slow bilateral motion. ✓ o Check that rings and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL ✓ E.1. ✓ Potential impairment of mobility due to: ____ 1) Pain ____ 2) Intraoperative Hazards ____ 3) Prosthesis ____ 4) Positioning ____ 5) Transfer pt. to/from OR table E.2. ____ Potential discomfort due to: ____ 1) Length of Surgery ____ 2) Positioning ____ 3) Arthritis	✓ o Pt. will be transferred to OR table without difficulty. ✓ o Pt. will not experience unnecessary physical discomfort.	✓ o Have sufficient people available for transfer. o Insure proper body alignment. ✓ o Allow patient to lie in position of comfort while waiting for surgery. ✓ o Offer support (i.e., pillows, bath towels, etc.) for positioning.
F. SPECIAL SENSES F.1. ✓ Diminished visual perception due to being: ____ 1) Pre-Medicated ____ 2) W/O Glasses F.2. ✓ Potential for decreased communication due to: ____ 1) Diminished Hearing ____ 2) Language Barrier F.3. ____ Potential injury due to dentures: ____ 1) Upper ____ 4) Caps ____ 2) Lower ____ 5) Crowns ____ 3) Bridges	✓ o Pt. will be made aware of surroundings prior to anesthesia induction. ✓ o Pt. will be transferred safely to OR table. o Pt. will be able to understand instructions. ✓ o Minimize danger of injury during intraop period.	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. ✓ o Speak clearly and slowly. o Address pt. from [illegible] side o Validate pt.'s understanding of verbal communication. ✓ o Verify removal of dentures.
G. OTHER PATIENT PROBLEMS/NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

b6

10. OR NU[redacted]ERVENTIONS C[redacted]PLETE ☒ ADDITIONAL INTRAOPERATIVE INTERVENTION S NOTED.

[redacted] CPT/AN 13 Jul 03 DATE

11. PO[redacted]OPERATIVE EVA[redacted]UATION: SKIN INTEGRITY: Bovie Pad Site: ☐ Clean and Dry ☐ Red ☒ N/A DRESSING DRY & INTACT: [✓ (Y)] (N)
LEVEL OF CONSCIOUSNESS: ☐ A&O ☒ Drowsy ☐ Sleepy ☐ Intubated BREATHING EASY [✓ (Y)] (N)
LEVEL OF ACTIVITY: [redacted] Moves All Ex[redacted]ities ☐ Moves Upper Extremities
[redacted]nsferred to litter with roller due to spinal

12. PREOPER[redacted]ARED BY (Signature and [redacted] CPT/AN
DATE: 13 Jul 03 TIME: [redacted] 0910

b6

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title)
DATE: 13 Jul 03 TIME: 0910

REVERSE OF FORM 5179, JUN 91 MEDCOM - 13147 USAPA V1.0

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

FOR Use of this form, see AR 40-407; the proponent agency is The Office of the Surgeon General.

1. AGE: 48
HEIGHT:
WEIGHT:

2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication)
☒ NKDA ☐ PCN ☐ LATEX ☐ IODINE ☐ TAPE ☐ FOOD
REACTION:

3. PREVIOUS SURGERY [X] NO [ ] YES (type):

4. PROPOSED SURGICAL PROCEDURE:
Wound Excision + grafting

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition ______
Tobacco ____ ppd X ____ yrs.
ETOH ______
Glasses/Contact (Y) (N)
Body Piercing ______
Implants ______
Dentures ______
Diabetes (Y) (N)
Respiratory Disease [✓ (Asthma/COPD)] [✓ (Y)] (N)
Hypertension (Y) (N)
ROM ______
Herbal Medicines (Y) (N)
ASA/Motrin w/72 hrs (Y) (N)
Anticoagulants (Y) (N)
MEDS:

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to: ✓ ✓ 1) Surgical Procedure & Operating Room Environment ____ 2) Separation Anxiety (Child) ✓ 3) Surgical Outcomes	Pt. verbalizes any specific anxiety. Pt. Exhibits relaxed body posture.	Allow pt. to verbalize freely. Explain OR environment and answer questions regarding surgery. Offer comfort measures. (e.g., warm blanket, touch). Explain all nursing procedures before they are done. Remain with pt. whenever possible. Maintain family interface. Parents to stay with pt.
B. AERATION ✓ Potential for respiratory dysfunction due to: ✓ 1) Positioning ✓ 2) Effects of Anesthesia ____ 3) Medical/Smoking History	✓ Pt. will be able to breathe without difficulty during immediate intraoperative phase.	Offer to elevate head of litter or offer pillow. Observe pt. while awaiting surgery for signs of distress. Assist anesthesia during intubation and extubation.
C. INTEGUMENT ✓ Potential impairment of skin integrity due to: ✓ 1) Intraoperative Immobility ✓ 2) ESU Pad Placement ✓ 3) Positional Aids ____ 4) Prosthesis ✓ 5) Pooling of Prep Solutions	✓ Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened areas).	Utilize pressure preventing devices on OR table and accessories. Check for proper positioning and support to maintain good body alignment. Pad pressure points. Place ESU ground pad on non compromised skin surface area. Keep prep fluids from pooling.

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

[redacted] 66-4
ICU; 3

VERIFICATIONS AT HOLDING AREA:
! ID/Allergy Band
! H & P
! NPO Since Midnight
! UHCG/LMP
! Dentures Removed
! Contacts Removed
! Jewelry Removed
! Body Pierce Removed
! Consent/Blood Transfusion Signed/Witnessed/Dated
! Surgical Site/Consent verified by Pt./Anesthesia/Surgeon
! Contact Precautions (Y) [✓ (N)]
! Family/Friend: ______

USAPA V1.0

DA FORM 5179, JUN 91 Previous editions are obsolete.

MEDCOM - 13148

6. PATIENT PROBLEMS AND NEEDS	PATIENT GOALS AND EXPECTED OUTCOMES	OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to: ___ 1) Intraoperative Mobility ✓ 2) Positioning ___ 3) Existing Disease ✓ 4) Safety Devices ✓ 5) Hypothermia	✓ Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse.	o Check for support stockings or ace wraps. If none, check with doctors. ✓ Check that safety straps are correctly applied. o Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. ✓ Check that rings and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to: ✓ 1) Pain ✓ 2) Intraoperative Hazards ___ 3) Prosthesis ✓ 4) Positioning ✓ 5) Transfer pt. to/from OR table E.2. ___ Potential discomfort due to: ✓ 1) Length of Surgery ✓ 2) Positioning ~~✓ 3) Arthritis~~	o Pt. will be transferred to OR table without difficulty. o Pt. will not experience unnecessary physical discomfort.	o Have sufficient people available for transfer. o Insure proper body alignment. o Allow patient to lie in position of comfort while waiting for surgery. o Offer support (i.e., pillows, bath towels, etc.) for positioning.
F. SPECIAL SENSES F.1. ✓ Diminished visual perception due to being: ✓ 1) Pre-Medicated ___ 2) W/O Glasses F.2. ✓ Potential for decreased communication due to. ___ 1) Diminished Hearing ✓ 2) Language Barrier F.3. ___ Potential injury due to dentures: ___ 1) Upper ___ 2) Lower ___ 3) Bridges ___ 4) Caps ___ 5) Crowns	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR table. o Pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt. from either side o Validate pt.'s understanding of verbal communication. o Verify removal of dentures.
G. OTHER PATIENT PROBLEMS/NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

10. OR NURSING INTERVENTIONS COMPLETED/ADDITIONAL INTRAOPERATIVE INTERVENTIONS NOTED.

[redacted] CPT/AN b6-2 6 July 03 DATE

11. POSTOPERATIVE EVALUATION: SKIN INTEGRITY: Bovie Pad Site: ☒ Clean and Dry ☐ Red ☐ N/A DRESSING DRY & INTACT: [✓ (Y)] (N)

LEVEL OF CONSCIOUSNESS: ☐ A&O ☒ Drowsy ☐ Sleepy ☐ Intubated

BREATHING EASY [✓ (Y)] (N)

LEVEL OF ACTIVITY: ☐ Moves All Extremities ☒ Moves Upper Extremities ☐ Transferred to litter with roller due to spinal

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] CPT/AN b6-2

DATE: 6 July 03 TIME: 0740

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] CPT/AN b6-2

DATE: 6 July 03 TIME: 1240

MEDICAL RECORD | **INTRAOPER. Ɛ DOCUMENT**

For use of this form, see AR 40-66, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: Litter BY Anesthesia

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY 1LT [redacted] b6-2

3. DATE 20 JUL 03

TIME PATIENT ARRIVED IN SUITE 0750

4. PATIENT IN ROOM TIME 0752 NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

☐ CALM ☒ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS: Multiple burns
NPO p̄ MN, NKDA Foley cath

b6-2 6. NURSING PERSONNEL

ASSIGNED SCRUB	SSG [redacted] 91D	RELIEF SCRUB	
ASSIGNED CIRCULATOR	1LT [redacted] b6-2 66E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)* #1 Pt prone on padded OR table. Pillows under chest and legs. Genitals free from impingement.

☐ SUPINE ☐ LITHOTOMY ☒ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP.

#2 Pt. Supine - BUE <90°

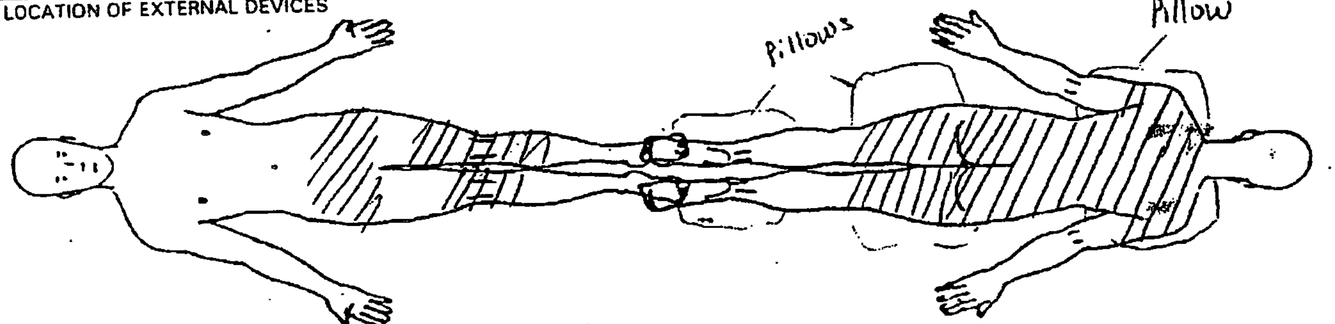
COMMENTS: Normal anatomic body alignment maintained.

8. SKIN PREPARATION b6-2

HAIR REMOVAL ☒ YES ☐ NO Buttocks
DONE BY: ☒ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☒ RAZOR By Dr. [redacted]
☐ CLIP
COMMENTS: No nicks or cuts noted.

PREP SOLUTION *(Specify)* Hibiclens
SITE: Back of thighs - BY WHOM: 1LT [redacted]
SITE: to neck BY WHOM:
COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



LEGEND X [redacted]round Pad --[redacted]y Strap = = = Tourniquet N/A ▨ - prep

Initial: SSG [redacted]
1LT b6-2

10. COUNTS			C = Correct I = Incorrect				
			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes	☐ No					
Needle Sharp	☒ Yes	☐ No					
Instrument	☐ Yes	☒ No					
Other	☐ Yes	☒ No					

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

[redacted] b6-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO

☒ ESU NO: 000450 CUT 30 COAG 30
GROUND PAD: BRAND VL Rem Polyhesive II
LOT NO: 65706 2004-11

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 — REPLACES DA MEDCOM - 13150 ꟻH IS OBSOLETE. USAPA V1.01

13. PROSTHESIS, IMPLANTS ☐ YES ☒ NO IF YES NAME: ID NUMBER; MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☒ NO ☐

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
NaCl c̄ Epi 1:100,000 Lot 2047 Exp Jul-04 American Regent	Q.S.	intra-op	local application	CPT [redacted]	Dr. [redacted]
Mineral Oil Lot 857101 NOV 03	Q.S	intra-op	local application	[redacted]	Dr. [redacted]
					b6-2

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):
0.9% NaCl · Q.S.

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM IF YES, SITE
YES ☐ NO ☒

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 10mm J-P drain	2. 10mm J-P drain	3. 10mm J-P drain
SITE	1. Buttocks wound	2. Left Arm wound	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
STSG site: Xeroform fluffs, ABD ~~+ Ioban~~
Buttocks/sacrum: xeroform, Ioban
BLE - Xeroform, Kerlix splint ACE
LUE - Xeroform, Kerlix, splint ACE

19. ADDITIONAL INFORMATION
Surgeon: Dr. [redacted], Dr. [redacted]
Anesthesia: MAJ [redacted]
b6-2

DA 5179 in Chart

20. OPERATION(S) PERFORMED
Debridement of burns
STSG
Dressing Δ

21. PATIENT TRANSFERRED TO ICU 3 TIME 1200 METHOD LITTER c̄ O2

22. REGISTERED NURSE SIGNATURE [redacted] RN
b6-2

REVERSE OF DA FORM 5179-1, OCT 87 MEDCOM - 13151 USAPA V1.01

MEDICAL RECORD | **INTRAOPER DOCUMENT**

For use of this form, see AR 40-66, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA litter BY OR staff

2. PATIENT IDEN[redacted] AND PROCEDURE VERIFIED BY [redacted]

3. DATE 15 Jul 03

TIME PATIENT ARRIVED IN SUITE —

4. PATIENT IN ROOM TIME 06:57 NUMBER 2-1

b6-2

5. PREOPERATIVE EMOTIONAL STATUS

☐ CALM ☒ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS: dobb 4066 o26 @ 0200

6. NURSING PERSONNEL

ASSIGNED SCRUB	SGT [redacted] : (1st HST)	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT. [redacted]	RELIEF CIRCULATOR	

b6-2

7. POSITION AND POSITIONAL AIDS *(Specify)*

☑ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

COMMENTS:

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☑ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Hibiclens sol.

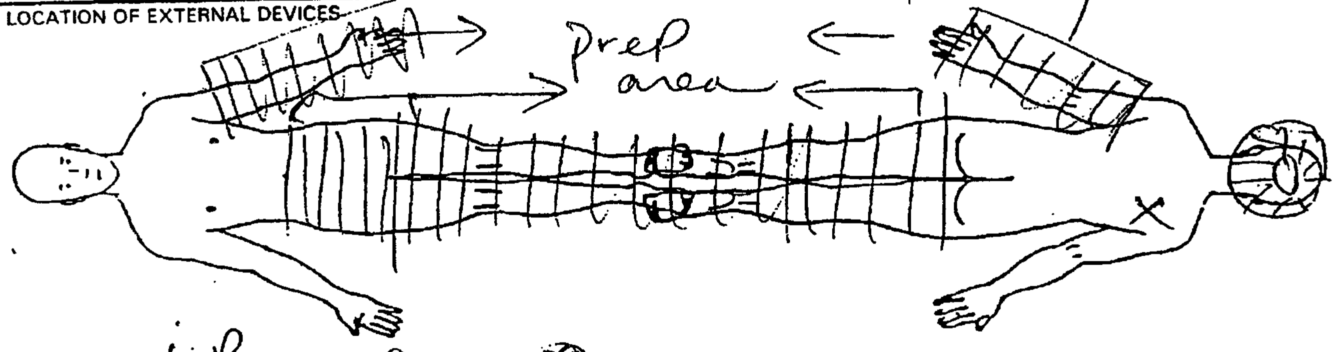
SITE: (B) leg BY WHOM: Dr [redacted]

SITE: (L) arm BY WHOM: CPT. [redacted]

COMMENTS: ø pooling

b6-2

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Strap = = Tourniquet

up

10. COUNTS			C = Correct I = Incorrect Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☑ Yes	☐ No		C	C	SGT [redacted]	CPT. [redacted]
Needle Sharp	☑ Yes	☐ No					
Instrument	☐ Yes	☑ No					
Other	☐ Yes	☐ No					

b6-2 b6-2

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

#[redacted] b6-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☑ YES ☐ NO

☑ ESU NO: Valley Lab

GROUND PAD: BRAND polyhesive II

LOT NO: 68936

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

Coag: 30 / Cut: 30

DA FORM 5179-1, OCT 87 REPLACES D MEDCOM - 13152 CH IS OBSOLETE. USAPA V

13. PROSTHESIS, IMPLANTS	☐ YES ☑ NO	IF YES NAME: ID NUMBER; MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) ☑ YES ☐ NO

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
1:1000 epi with 1L NS	Q.S	intraop	topical use	CPT. [redacted]	Dr. [redacted]
Mineral oil	Q.S	"	"	[redacted]	b6-2 "
c Silvadene 1%	Q.S	"	"	[redacted]	"

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S):

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM — YES ☐ NO ☑ — IF YES, SITE

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☑	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☑	NAME	NAME
CULTURE (C) YES ☐ NO ☑	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☐ NO ☑

	1.	2.	3.
TYPE/SIZE			
SITE			

18. DRESSING/IMMOBILIZATION *(Specify)*

Xeroform · Ioban.
fluffs,
Kerlix
Ace & Spandage.

19. ADDITIONAL INFORMATION

Dr. [redacted] ([redacted]
Maj [redacted] (CRNA)
b6-2

20. OPERATION(S) PERFORMED

Ⓑ leg & Ⓛ arm Burn Wd Excision c̄ Debridement, skin graft to Burn Wd; Abd.

21. PATIENT TRANSFERRED TO ICU	TIME See Anes Record	METHOD Litter

22. REGISTERED NURSE SIGNATURE [redacted] c [redacted]

b6-2 b6-2

REVERSE OF DA [redacted] *5179-1, OCT 87* MEDCOM - 13153 USAPA V1.01

MEDICAL RECORD | **INTRAOPERA DOCUMENT**
For use of this form, see AR 40-66, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA: litter BY: anesthesia (Cherry)

2. PATIENT IDENT[redacted]D PROCEDURE
VERIFIED BY [redacted] CPT/AN

3. DATE 26 Aug 03
TIME PATIENT ARRIVED IN SUITE 0835

4. PATIENT IN ROOM
TIME 0835 b6-2 / NUMBER 2-1

5. PREOPERATIVE EMOTIONAL STATUS
☐ CALM ☒ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*
COMMENTS:

6. NURSING PERSONNEL

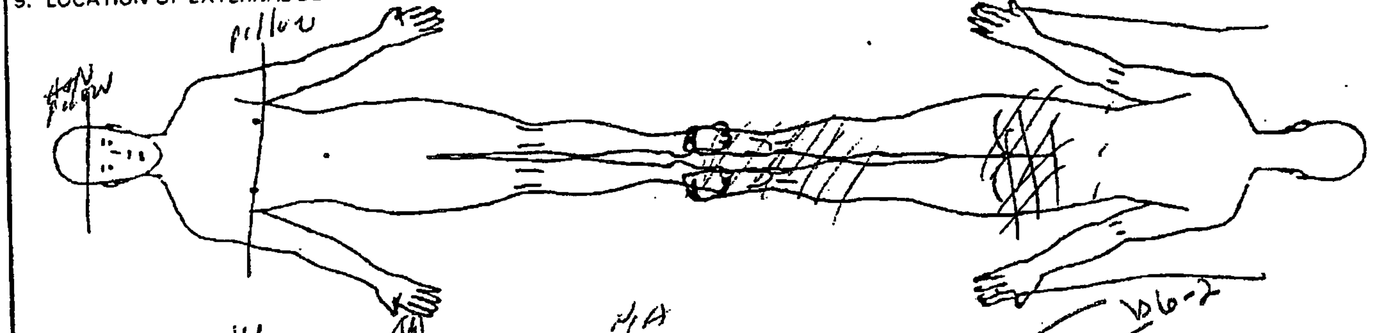
ASSIGNED SCRUB	SPC [redacted], ORT b6-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] AN b6-2	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)* Pt transferred to OR table anatomically aligned for surgical procedure c̄ pillow under chest, knees, H+N pillow under head (B) arms on padded
☐ SUPINE ☐ LITHOTOMY ☒ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP
arm boards less 90°
COMMENTS:

8. SKIN PREPARATION
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP
COMMENTS:

PREP SOLUTION *(Specify)* Beta / Beta
SITE: (B) legs calf & feet BY WHOM: CPT [redacted]
SITE: Buttock BY WHOM: MAJ [redacted] b6-2
COMMENTS: Ø pooling of solution noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Strap === Tourniquet
W (M) NA

10. COUNTS
C = Correct I = Incorrect
initial CPT [redacted] / SPC [redacted]

10. COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☑ Yes	☐ No	C	C	C	SPC [redacted]	CPT [redacted] b6-2
Needle Sharp	☑ Yes	☐ No	C	C	C		
Instrument	☐ Yes	☑ No					
Other	☐ Yes	☑ No					

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*
EPW # [redacted] b6-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☑ YES ☐ NO 30/30
☑ ESU NO: 40S R8B 10239S
GROUND PAD: BRAND Valley lab
LOT NO: 68936
☐ ESU NO:
GROUND PAD: BRAND
LOT NO:
☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES D MEDCOM - 13154 CH IS OBSOLETE. USAPA V1.01

13. PROSTHESIS, IMPLANTS ☐ YES ☒ NO IF YES NAME: ID NUMBER; MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☐

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S): 0.9% NACl
1:1000 Epi c̄ 300 cc NACl
(30 cc)

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM IF YES, SITE
YES ☐ NO ☒

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☑ NO ☐

TYPE/SIZE	1. JP x 2 10mm	2.	3.
SITE	1. Both ankles	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Fluffs
Kerlix
4x8
Xeroform

19. ADDITIONAL INFORMATION
Surgeons Anesthesia
[redacted] [redacted]
b6-2

20. OPERATION(S) PERFORMED
Split Thickness Skin Graft to Ⓑ heels
Ⓛ Thumb partial Amputation

21. PATIENT TRANSFERRED TO RACU | TIME 1030 | METHOD Litter c̄ O2

22. REGISTERED NURSE SIGNATURE [redacted] CPT/AN
b6-2

REVERSE OF DA FORM 5179-1, OCT 87 MEDCOM - 13155 USAPA V1.01

MEDICAL RECORD — **INTRAOPER[illegible] DOCUMENT**

For use of this form, see AR 40-66, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: Litter BY Anesthesia	2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY CPT [redacted] -b6-2
3. DATE 6 July 03 — TIME PATIENT ARRIVED IN SUITE 1015	4. PATIENT IN ROOM TIME 1015 — NUMBER H 1.6

5. PREOPERATIVE EMOTIONAL STATUS

☒ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] -b6-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] b6-2	RELIEF CIRCULATOR	b6-2 MAJ [redacted] (1125-1150)

7. POSITION AND POSITIONAL AIDS *(Specify)*

☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

COMMENTS: proper body alignment maintained, pillow under legs, arms on padded armboards at less than 90°, position approved by surgeon + anesthesia

8. SKIN PREPARATION

HAIR REMOVAL ☒ YES ☐ NO Dr. [redacted] b6-2

DONE BY: ☒ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP

COMMENTS: no nicks or cuts noted

PREP SOLUTION *(Specify)* Beta / Beta

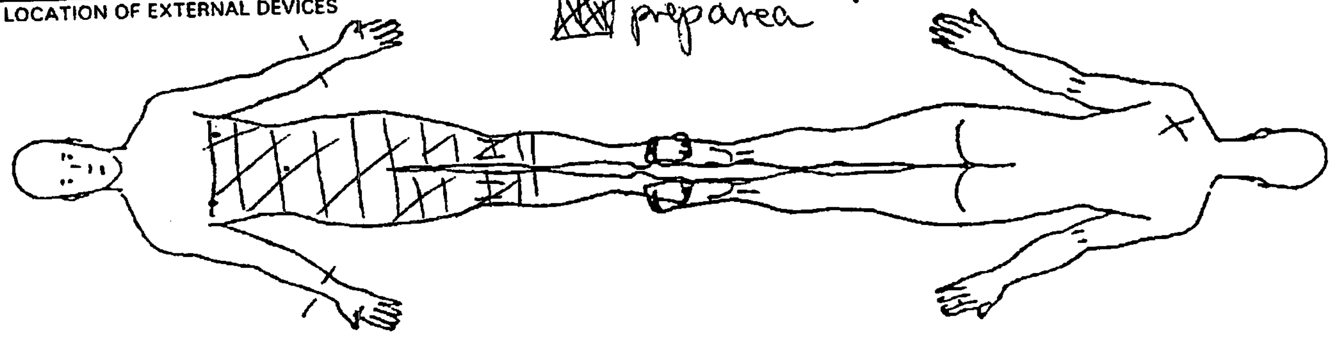
SITE: Abdomen to nipples BY WHOM: [redacted]

SITE: B/L thighs to 2 in below knees BY WHOM:

COMMENTS: no pooling or skin reaction noted

9. LOCATION OF EXTERNAL DEVICES

▨ prep area



LEGEND X Ground Pa[redacted] -- Safety Strap[redacted] = = = Tourniquet

C = Correct I = Incorrect

10. COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☐ Yes	☑ No					
Needle Sharp	☐ Yes	☑ No					
Instrument	☐ Yes	☑ No					
Other	☐ Yes	☑ No					

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

#[redacted] - b6-4

ICU-3

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO

☒ ESU NO: Valleylab Force 2 #4

GROUND PAD: BRAND Valleylab Rem Polyhesive II

LOT NO: 65706 2004-11

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 — REPLACES D[illegible]CH IS OBSOLETE. — MEDCOM - 13156 — USAPA V1.01

13. PROSTHESIS, IMPLANTS ☐ YES ☒ NO IF YES NAME: ID NUMBER; MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☒

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO. TYPE(S):
0.9% NaCl
0.9% NaCl c̄ Epi 1:100,000

OTHER ORDERS	TIME	CARRIED OUT BY
none		

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM IF YES, SITE
YES ☐ NO ☒

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☐	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☐	NAME	NAME
CULTURE (C) YES ☐ NO ☐	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 16F FIC	2.	3.
SITE	1. Bladder	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Fluffs ABD
Kerlix
Acewrap

19. ADDITIONAL INFORMATION

Surgeon: [redacted], [redacted]
Anesthesia: [redacted] b6-2

- FIC in place prior to arrival to OR

20. OPERATION(S) PERFORMED
Burn Debridement (thighs, knees b/l, abdomen)
Dressing Δ feet + hands

21. PATIENT TRANSFERRED TO ICU-3 b6-2 | TIME see DA7389 | METHOD litter

22. REGISTERED NURSE SIGNATURE [redacted]

REVERSE OF DA FORM 5179-1, OCT 87 MEDCOM - 13157 USAPA V1.01

MEDICAL RECORD — **INTRAOPERA . DOCUMENT**
For use of this form, see AR 40-66, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: litter BY: OR staff
2. PATIENT IDENTI[redacted] RECORD REVIEWED AND PROCEDURE VERIFIED BY: CPT[illegible]
3. DATE: 10 Jul 03
TIME PATIENT ARRIVED IN SUITE: 0610
4. PATIENT IN ROOM TIME: 0610 b6-2 NUMBER: 1-1

5. PREOPERATIVE EMOTIONAL STATUS

☐ CALM ☒ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS:

b6-2

6. NURSING PERSONNEL

ASSIGNED SCRUB	Sgt [redacted] 91D	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] 66E CPT [redacted] b6-2	RELIEF CIRCULATOR	MAJ [redacted] (CTJ- b6-2

7. POSITION AND POSITIONAL AIDS *(Specify)* Pt in proper body alignment. Arms on armboards <90°. Support to left hip.

☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

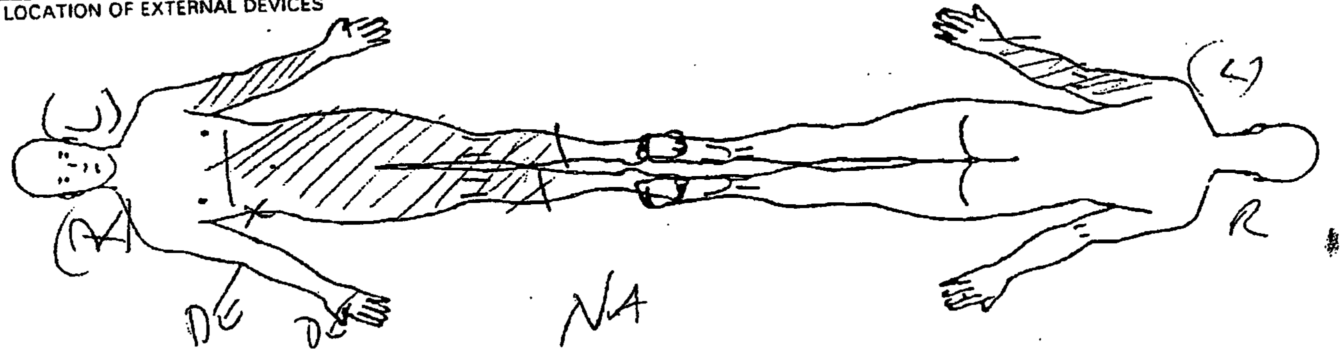
COMMENTS:

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP
COMMENTS:

PREP SOLUTION *(Specify)* H. biclens
SITE: left arm 1000, Left leg, BY WHOM: CPT [redacted] / CPT [redacted]
SITE: Right leg BY WHOM:
COMMENTS: ∅ pooling of solution noted.

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Strap = = = Tourniquet

10. COUNTS

C = Correct I = Incorrect

10. COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☑ Yes	☐ No					
Needle Sharp	☑ Yes	☐ No					
Instrument	☐ Yes	☐ No					
Other	☐ Yes	☐ No					

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

#[redacted] -b6-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO 30/30

☐ ESU NO: VL #1
GROUND PAD: BRAND VL Rem Poly II
LOT NO: 65706

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA MEDCOM - 13158 CH IS OBSOLETE. USAPA V1.01

13. PROSTHESIS, IMPLANTS ☐ YES ☒ NO IF YES NAME: ID NUMBER; MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☐

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☑ YES ☐ NO. TYPE(S):
Warm 0.9% NaCl c̄ Epinephrine 1:100,000

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE [redacted]

15. X-RAY IN OPERATING ROOM YES ☐ NO ☒ IF YES, SITE

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

TYPE/SIZE	1.	2.	3.
SITE	1.	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

19. ADDITIONAL INFORMATION

[redacted] b6-2

20. OPERATION(S) PERFORMED

Wound Debridement Ⓛ Ⓡ LE Abdomen
Ⓛ Arm

21. PATIENT TRANSFERRED TO ICU 3 TIME METHOD litter

22. REGISTERED NURSE SIGNATURE [redacted]

b6-2

REVERSE OF DA FORM 5179-1, OCT 87 MEDCOM - 13159 USAPA V1.01

MEDICAL RECORD | **INTRAOPER. DOCUMENT**

For use of this form, see AR 40-66, the propon[redacted]ency is the off[redacted]he Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: [redacted] litter BY Anesthesia

2. PATIENT IDENT[redacted]D, RECORD R[redacted]ED AND PROCEDURE VERIFIED BY [redacted] (CPT/An)

3. DATE 13 Jul 03 TIME PATIENT ARRIVED IN SUITE b6-2

4. PATIENT IN ROOM TIME b6-2 NUMBER

5. PREOPERATIVE EMOTIONAL STATUS

☐ CALM ☒ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SGT [redacted] b6-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] b6-2 An	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)* Pt transferred to OR table, anatomically aligned for surgical procedure c̄ pad under head

☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

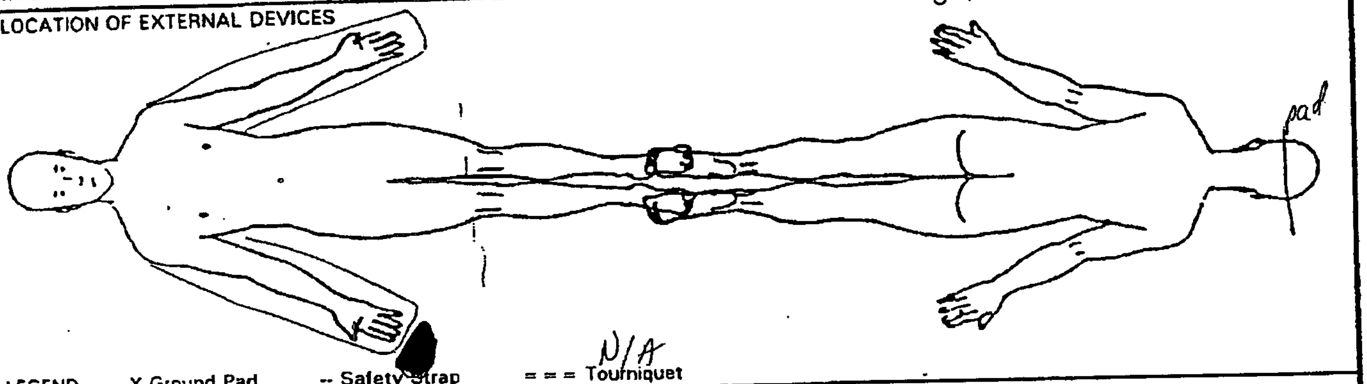
COMMENTS:

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP
COMMENTS:

PREP SOLUTION *(Specify)* Hibiclens BY WHOM: [redacted] b6-2
SITE: Entire Body BY WHOM: 1LT PFC [redacted]
SITE:
COMMENTS: Ø pooling of solution noted

9. LOCATION OF EXTERNAL DEVICES



[redacted]

LEGEND X Ground Pad -- Safety Strap === Tourniquet N/A

10. COUNTS

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☐ Yes ☐ No					
Needle Sharp	☐ Yes ☐ No					
Instrument	☐ Yes ☐ No					
Other	☐ Yes ☐ No					

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

[redacted] b6-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☐ YES ☒ NO

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES I[illegible]ICH IS OBSOLETE. MEDCOM - 13160 USAPA V1.01

13. PROSTHESIS, IMPLANTS ☐ YES ☒ NO IF YES NAME: ID NUMBER; MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☒

MEDICATIONS. SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S): 0.9% nacl

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNA[redacted] b6-2

15. X-RAY IN I IF YES, SITE
YES ☐ NO ☒

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☑	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☑	NAME	NAME
CULTURE (C) YES ☐ NO ☑	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☐ NO ☐

TYPE/SIZE	1.	2.	3.
SITE	1.	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Burn Blankets
Silvadene Cream
Fluff

19. ADDITIONAL INFORMATION
Surgeon [redacted]
Anesthesia [redacted]
b6-2

20. OPERATION(S) PERFORMED
Dressing Change

21. PATIENT TRANSFERRED TO ICU-3 [redacted] b6-2 TIME 0914 METHOD Litter

22. REGISTERED NURSE SIGNATURE CPT/AN

REVERSE OF DA FORM 5179-1, OCT 87 MEDCOM - 13161 USAPA V1.01

MEDICAL RECORD **INTRAOPER :D JMENT**

For use of this form, see AR 40-66, the pro agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA litter BY Anesthesia

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE
VERIFIED BY [redacted] CPT/AN
b6-2

3. DATE 1 Aug 03
TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM
TIME
NUMBER

5. PREOPERATIVE EMOTIONAL STATUS

☐ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS: Allergies: NKDA

6. NURSING PERSONNEL

ASSIGNED SCRUB	~~SSG Fr~~ SPC [redacted] b6-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] AN b6-2	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)* pt transferred to OR table, anatomically aligned for surgical procedure c̄ (B) arms on padded arm board less 90°

☑ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

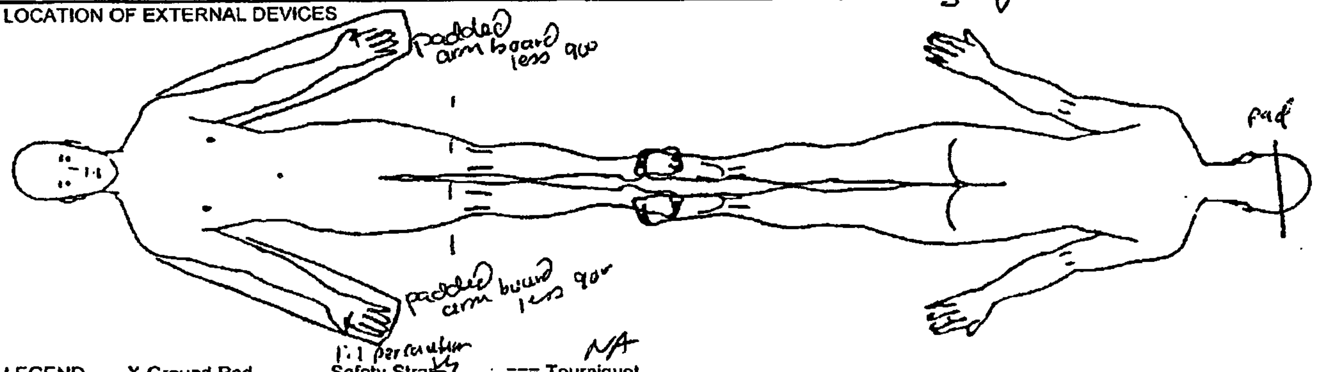
COMMENTS:

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR
☐ CLIP
COMMENTS:

PREP SOLUTION *(Specify)* Hibiclens
SITE: (B) Hands BY WHOM: CPT [redacted], AN
SITE: (B) Feet BY WHOM:
b6-2
COMMENTS: Ø Pooling of solution noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Strap 1:1 percaution === Tourniquet NA

10. COUNTS (C = Correct I = Incorrect)

			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☐ Yes	☐ No					
Needle Sharp	☐ Yes	☐ No					
Instrument	☐ Yes	☐ No					
Other	☐ Yes	☐ No					

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

#[redacted]-EPW
} b6-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☐ YES ☒ NO

☐ ESU NO: ____
GROUND PAD: BRAND ____
LOT NO: ____
☐ ESU NO: ____
GROUND PAD: BRAND ____
LOT NO: ____
☐ BIPOLAR NO: ____

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.01

MEDCOM - 13162

13. PROSTHESIS, IMPLANTS ☐ YES ☒ NO IF YES NAME: ID NUMBER; MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☒

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

0.9-1 NaCl

OTHER ORDERS	TIME	CARRIED OUT BY
Foley 16Fr changed in OR.		

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM IF YES, SITE

YES ☐ NO ☒

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

TYPE/SIZE	1.	2.	3.
SITE	1.	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

Fluffs
Kerlix
ABD pad

19. ADDITIONAL INFORMATION
WC
Surgeons: [redacted] b6-2 Anesthesia: STAS-CRNA General Anesthesia Type: General

Bovie Pad site intact pre-op N/A; post-op N/A Bovie Settings: Coag/Cut
Tourniquet Site intact pre-op N/A: post-op N/A
Tourniquet Time: Up N/A Down N/A

20. OPERATION(S) PERFORMED

Burn Debridement (B) Hands ~~[illegible]~~/Feet

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU	1015	Litter

22. REGISTERED NURSE SIGNATURE [redacted] b6-2 CPT/AN

REVERSE OF DA FORM 5179-1, OCT 87 MEDCOM - 13163 USAPA V1.01

MEDICAL RECORD **INTRAOPER/ D JMENT**

For use of this form, see AR 40-66, the prop. .gency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Gurney BY Anesth

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY LTC [redacted] b6-2

3. DATE 16 Aug 03 TIME PATIENT ARRIVED IN SUITE 1055

4. PATIENT IN ROOM TIME 1055 NUMB[redacted] 1

5. PREOPERATIVE EMOTIONAL STATUS

☒ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS: Allergies:

6. NURSING PERSONNEL

ASSIGNED SCRUB	~~PFC~~ [redacted] Sgt [redacted] b6-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	LTC [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

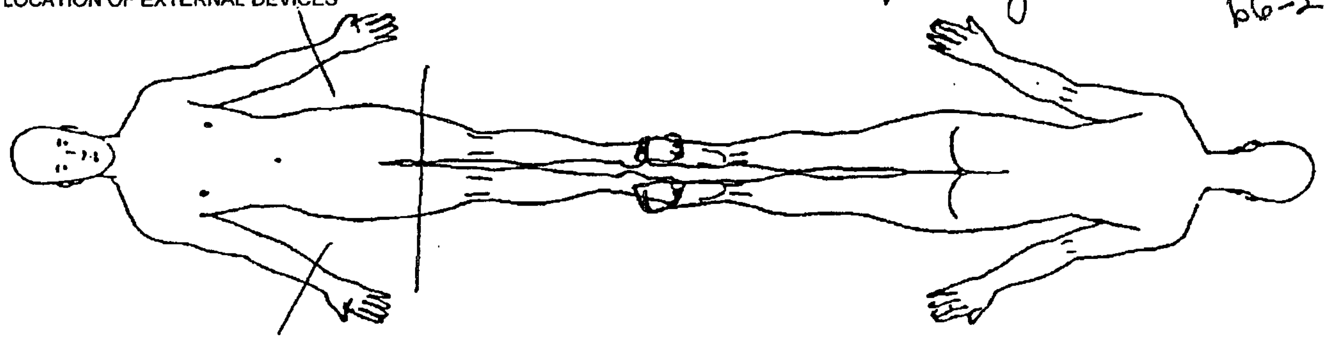
COMMENTS:

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR
☐ CLIP
COMMENTS:

PREP SOLUTION *(Specify)* Betadine soap/sol.
SITE: (R) ↓ leg BY WHOM: LTC [redacted]
SITE (Lt) ↓ leg BY WHOM: MAJ [redacted]
COMMENTS: No pooling noted
b6-2

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Strap === Tourniquet

10. COUNTS — C = Correct I = Incorrect

10. COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes	☐ No	✓	C	C	~~PFC~~ [redacted] b6-2	LTC [redacted] b6-2
Needle Sharp	☒ Yes	☐ No	✓	C	C	Sgt. [redacted]	
Instrument	☐ Yes	☒ No					
Other	☐ Yes	☒ No					

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

#[redacted] b6-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☐ YES ☒ NO

☒ ESU NO: Valleylab Force 2
GROUND PAD: BRAND REM Polyhesive II
LOT NO: 68936
☐ ESU NO:
GROUND PAD: BRAND
LOT NO:
☐ BIPOLAR NO:
cut: 30 coag: 30

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.01

MEDCOM - 13164

ACLU-RDI 1592 p.1057

13. PROSTHESIS, IMPLANTS ☐ YES ☒ NO IF YES NAME: ID NUMBER; MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☒

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

0.9% NaCl

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATU[redacted] b6-2

15. X-RAY IN OPERA ROOM IF YES, SITE
YES ☐ NO ☒

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

TYPE/SIZE	1.	2.	3.
SITE	1.	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
fluffs
kerlix
ACE

19. ADDITIONAL INFORMATION [redacted] b6-2
WC
Surgeons: Dr. [redacted] b6-2 Anesthesia: LTC [redacted] b6-2 esthesia Type: ~~GETA~~ [redacted]

Bovie Pad site intact pre-op clear; post-op clear Bovie Settings: Coag/Cut 30/30

20. OPERATION(S) PERFORMED

Bil. heel debriedment

21. PATIENT TRANSFERRED TO ICU 3 TIME 1140 METHOD via Gurney

22. RE[redacted], LTC, AN

REVERSE OF DA FORM 5179-1, OCT 87 b6-2 MEDCOM - 13165 USAPA V1.01

MEDICAL RECORD INTRAOPER/ D IMENT

For use of this form, see AR 40-66, the prop .gene; ...e office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM (MAJ [redacted])
VIA Wheeled litter BY Anesthesia

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY CPT [redacted] b6-2

3. DATE 27AUG03 TIME PATIENT ARRIVED IN SUITE 1000 b6-2

4. PATIENT IN ROOM TIME 1000 NUMBER Rm 2 bed/ case 1

5. PREOPERATIVE EMOTIONAL STATUS

☒ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS: Allergies: NKA

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] 91D b6-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] RN b6-2	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)* Pt intubated on stretcher - pt log rolled onto padded OR bed maintaining correct body alignment, Arms in superman position on padded armboards.

☐ SUPINE ☐ LITHOTOMY ☒ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

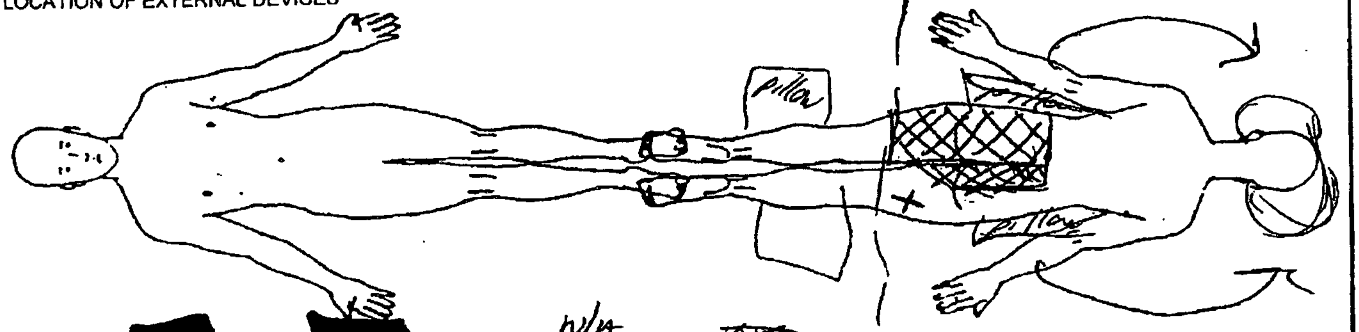
COMMENTS: pillow under chest + hips, pillow under shins, toes hanging freely. face on foam doughnut.

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR
☐ CLIP
COMMENTS:

PREP SOLUTION *(Specify)* Beta/Beta
SITE: Ⓛ Buttock (as below) BY WHOM:
SITE: BY WHOM:
COMMENTS: no pooling of solutions noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND X [redacted] Ground Pad [redacted] – Safety Strap === Tourniquet N/A ▨ -prep

10. COUNTS		C = Correct I = Incorrect					
			Initial ~~Other~~	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes	☐ No	C		C	SPC [redacted]	CPT [redacted]
Needle Sharp	☒ Yes	☐ No	C		C	b6-2	
Instrument	☐ Yes	☒ No					
Other	☐ Yes	☒ No					

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

ISN [redacted] [redacted]

b6-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO

☒ ESU NO: R8E 105305
GROUND PAD: BRAND Valleylab Polyhesive II REM
LOT NO: 68936 / 2005-03

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.01

MEDCOM - 13166

13. PROSTHESIS, IMPLANTS ☐ YES ☒ NO IF YES NAME: ID NUMBER; MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) ☐ YES ☒ NO

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

QS: 0.9% Nacl.

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE [redacted] b6-2

15. X-RAY IN OPERATING ROOM IF YES, SITE
YES ☐ NO ☒

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (F/S) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

TYPE/SIZE	1.	2.	3.
SITE	1.	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

4x8 plain sponges + Silk Tape

19. ADDITIONAL INFORMATION
WC/11
Surgeons: Dr [redacted]
Dr [redacted] b6-2
Anesthesia: Mas [redacted] CRNA b6-2
Anesthesia Type: GEN/ENDO

Bovie Pad site intact pre-op CI; post-op CI Bovie Settings: Coag/Cut 30/30 Blend 1-
Tourniquet Site intact pre-op N/A post-op
Tourniquet Time: Up N/A Down – correct body alignment maintained throughout roll ~~back~~ ~~to~~ wheeled litter.

DA 5179 completed previously

20. OPERATION(S) PERFORMED

wash out + closure Ⓛ Buttock

21. PATIENT TRANSFERRED TO ICU3/PACU	TIME 1115	METHOD Wheeled litter

22. REGISTERED NURSE SIGNATURE [redacted]

b6-2

MEDICAL RECORD

INTRAOPERATIVE D UMENT

For use of this form, see AR 40-407, the pro gency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATIN M
VIA Litter BY anesthesia

2. PATIENT IDENTI [redacted] ECORD REVIEWED AND PROCEDURE VERIFIED BY CPT/AN
\ b6-2

3. DATE 7 Oct 03
TIME PATIENT ARRIVED IN SUITE 1554

4. PATIENT IN ROOM TIME 1554
NUMBER

5. PREOPERATIVE EMOTIONAL STATUS

☒ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SGT [redacted] b6-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

☐ SUPINE ☐ LITHOTOMY ☒ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

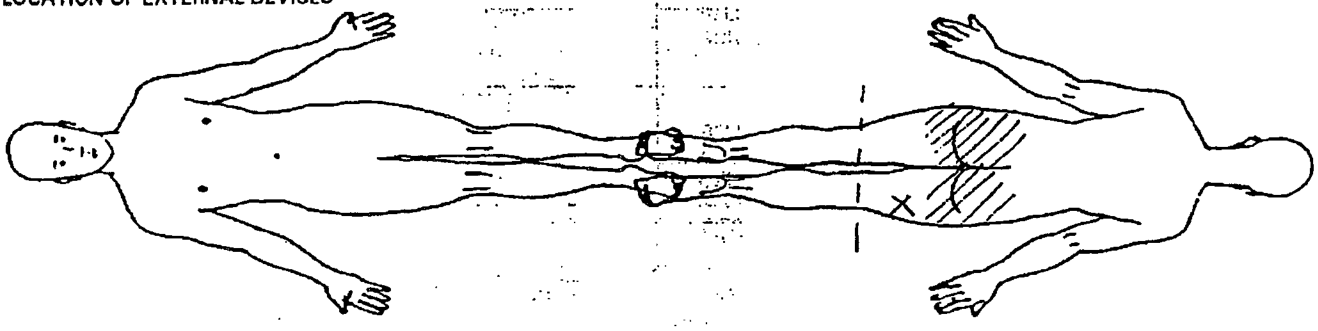
COMMENTS: Proper body alignment maintained. Pillow under chest, lower legs. Padding under knees. Arms at sides

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR
☐ CLIP
COMMENTS:

PREP SOLUTION *(Specify)* Betadine scrub/sol'n
SITE: Bilat. buttocks BY WHOM: [redacted]
SITE: BY WHOM: [redacted]
COMMENTS: No pooling of fluids

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad – Safety Strap = = = Tourniquet

		C = Correct I = Incorrect		Initial C	[redacted]		
10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB		CIRCULATOR
Sponge	☒ Yes	☐ No			C	[redacted] b6-2	[redacted]
Needle Sharp	☒ Yes	☐ No					
Instrument	☐ Yes	☒ No					
Other	☐ Yes	☒ No					

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

#[redacted] b6-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO

☒ ESU NO: R88102393 30/30
GROUND PAD: BRAND Valleylab REM
LOT NO: 70011
☐ ESU NO:
GROUND PAD: BRAND
LOT NO:
☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.00

MEDCOM - 13168

13. PROSTHESIS, IMPLANTS ☐ YES ☐ NO IF YES NAME: ID NUMBER; FACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☒

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

0.9% NS

OTHER ORDERS	TIME	CARRIED OUT BY

PH[redacted] 66-2 [redacted]

15. [redacted] ROOM IF YES, SITE

YES ☐ NO ☒

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

TYPE/SIZE	1.	2.	3.
SITE	1.	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

4x8
Tape

19. ADDITIONAL INFORMATION

Surg: [redacted] - 66-2
Anesth: [redacted] CRNA
Anesth: General

20. OPERATION(S) PERFORMED

Closure of buttocks wounds

21. PATIENT TRANSFERRED TO PACU TIME 1702 1[illegible]02 METHOD Litter

22. REGISTERED NURSE SIGNATURE [redacted] 66-2 CPT/AN

EPW #0 [redacted] b6-4 7 July 03

PT'S NAME

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	
BP	113/61	129/64	117/62	117/59	1	114/60	138/73	106/65	103/70	112/63	108/60	108/59	100/58			100/51				98/51					
TEMP																									
HR	101	102	102	105	102	104	120	124	109	109	117	114	107	109	111	105	104			99	100	99	96	94	
RR	12	11	14	14	14	14	20	24	20	22	18	22	18	13	18	15	16			10	10	10	12	7	
SA02	97	96	96	97	96	96	97	96	96	94	93	95	96	94	94	94	95			95	96	96	97	96	
	RA	RA	RA	RA		RA	4LM	4L	RA	RA	RA	RA	RA	RA	RA	RA	RA			RA	RA	RA	RA	RA	
IN IT								237			380					300			150						987
PO																									2400
LR IV	100	100	106	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	
NGT																									3387
TOTAL																									
OUTPUT																									
URINE	35	35	35	35	100	50	50	50	50	50	80	60	80	60	70	60	90	50	60	60	125	120	270	90	1885
NGT																									
STOOL																									
TOTAL																									
																								+	1502	
B E																									

MEDCOM - 13170

PT'S NAME #O[redacted] 66-4 8 July 03

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
BP	102/46		115/65	136/78	126/66	126/78	118/61	123/61	99/52	104/59					105/61	101/61	113/63	120/63	123/68	120/64	125/64	113/61	113/63	112/60
TEMP	97.8		98.9			99.2			101.3	101.6	101.3	99.4		99.3						99.5			98.9	
HR	94	95	100	109	113	121	116	115	114	118	128	117		99	105	109	111	112	108	110	107	105	107	
RR	11	11	16	16	18	18	18	18	16	21	15	14		18	17	21	18	17	20	14	14	19	17	13
SA02	97	96	97	100	96	97	95	96	98	95	50	97		96	96	93	96	94	92	91	92	93	94	97
	RA	RA	RA	NRB	RA	RA	RA	RA	RA	RA	RA	RA		RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA
INPUT																								2400
PO	NPO																							
LR IV	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
NGT																								
IVPB				50	50	100																		2050
Dobhoff						100	100	100	125	125	125	125	125	125	125	125	125	D	125	125	125	125	125	off
Residual																	750	<30						
TOTAL																								
																								1605
OUTPUT																								
URINE	170	90	200	35	35	100	60	75	75	100	50	60		60	20	50	70	100	35	25	30	25	40	80
NGT				50																				
STOOL																								
TOTAL																								
BALANCE																								

Balance: +2845
−200
+2645

MEDCOM - 13171

[redacted] 166-4 EPW 0[redacted] 9 July 03

	05	05	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02
BP	124/64																					
Temp																						
HR	105																					
RR	16																					
SAO2	97																					
	RA																					
INPUT																						
PO																						
LR IV	100																					
~~TEI~~																						
TOTAL																						
Output																						
urine																						
NGT																						
stool																						
TOTAL																						
Balance																						

MEDCOM - 13172

MEDCOM - 13173

PATIENT ASSESSMENT

TIME: 0800 SIGNATURE: [redacted] b6-2 CAPT

SKIN AND MUCOUS MEMBRANES

Skin. Loose / Tight / Diaphoretic / Shiny / Dry CDI
Skin. Temperature WARM
Color. Pale / Cyanotic / Jaundiced PINK
Mucous Membranes: [✓ Moist] / Dry / Cracked
Skin Breakdown: [✓ None] Location: Size:

NEUROLOGICAL

Loc / [✓ Alert] / Lethargic / Unresponsive ORIENT X3 GCS: 15
[✓ Orientated] / Disoriented Pupils: 3-4mm BILAT
Extremity Movement: Full / [✓ Limited] / None

CARDIOVASCULAR

Pulse (0 - 4): Radials +3 BILAT Pedals +3 BILAT
Capillary Refill: < 2 SEC Seconds Homan's Sign NEG
Jugular Venous Distension NONE Edema +3 (L) UE/LE/TRUNK
Heart Sounds S1 S2 NOTED
Rhythm NSR/ST 90-110'S PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms	—	—		
Site	(R) IJ			
Solution	LR			

Chest Pain NONE

RESPIRATORY

Chest Expansion / [✓ Symmetrical] / Asymmetrical REG
Respiration / [✓ No Distress] / SOB / Labored / Use of Access Muscles
Breathing Patterns:
Cough: Productive / [✓ Nonproductive] / None
Sputum: Color / Amount / Consistency / Odor
Chest Drainage System Gravity: — Suction cm: —
Air Leak — No — Yes — Crepitus —
Character of Drainage: —
Trachea / [✓ Midline] / Deviated (R) / Deviated (L)
Artificial Airway Size: — Type: — Position: —

Breath Sounds	Anterior/Location	Posterior/Location
Crackles	~~BILAT BASES~~	BILAT BASES
Wheezes		
Diminished	BILAT BASE	
Absent		

GASTROINTESTINAL

Abdomen: [✓ Soft] / Firm / Hard / Distended cm Girth
Bowel Sounds: Normal / Hyperactive / [✓ Hypoactive] / Absent
Dressings: CLEAN/INTACT MOIST Ē SILVADENE SOL
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage
NG Drainage. Color — Character —
Tube Feeding: Day No: — Strength: JEVITY Rate: Aspirate:
Stool Character
Drains NONE

GENITOURINARY

Urine Color: YELLOW Character: CLEAR
Voiding. Continent / Incontinent / [✓ Catheter]

EMOTIONAL/PSYCHOSOCIAL

OTHER: SEE NOTE

PATIENT ASSESSMENT

TIME: 1800 SIGNATURE: [redacted] b6-2

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / [✓ Dry] 30-35% burns
Skin: Temperature warm
Color: Pale / Cyanotic / Jaundiced Normal
Mucous Membranes: [✓ Moist] / Dry / Cracked
Skin Breakdown: None Location: arms, abd, LE Size: graft site abd & thigh

NEUROLOGICAL

Loc / [✓ Alert] / Lethargic / Unresponsive GCS:
[✓ Orientated] / Disoriented Pupils:
Extremity Movement: [✓ Full] / [✓ Limited] / None due to pain LE arms (R)

CARDIOVASCULAR

Pulse (0 - 4): Radials [✓ 4] Pedals
Capillary Refill: < 3 Seconds Homan's Sign
Jugular Venous Distension Edema feet, LE L>R
Heart Sounds ST 104's, ø ectopy, S1 S2
Rhythm ST PRI: ~~QRS:~~

~~Vascular Catheter~~	~~Central~~	~~Arterial~~	~~Peripheral 1~~	~~Peripheral 2~~
Waveforms				
Site				
Solution				

~~Chest Pain~~ ø

RESPIRATORY

Chest Expansion / [✓ Symmetrical] / Asymmetrical
Respiration / [✓ No Distress] / SOB / Labored / Use of Access Muscles
Breathing Patterns: unlabored, even
Cough: Productive / Nonproductive / [✓ None]
Sputum: Color / Amount / Consistency / Odor none
~~Chest Drainage System Gravity:~~ Suction cm.
~~Air Leak No Yes Crepitus~~
~~Character of Drainage:~~
~~Trachea~~ / [✓ Midline] / Deviated (R) / Deviated (L)
Artificial Airway Size: ~~Type: Position:~~

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes	expiratory	
Diminished	throughout	
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / [✓ Distended] cm Girth
Bowel Sounds: [✓ Normal] / Hyperactive / Hypoactive / Absent
Dressings: arms, abd, thigh, feet
~~NG Tube: Clamped~~/Inter. Suction/Cont. Suction/Dependent Drainage
~~NG Drainage: Color~~ Character
Tube Feeding: Day No: Strength: FS Rate: 128 Aspirate ø
Stool: Character mucousy light color
~~Drains~~:

GENITOURINARY

Urine Color: foley, Character yellow
~~Voiding: Continent / Incontinent / Catheter~~

EMOTIONAL/PSYCHOSOCIAL

intermittent confusion due to narcotics + anesthesia (sedation) otherwise cooperative

OTHER: Low tolerance for pain during dressing changes

MEDCOM 13173

ACLU-RDI 1592 p.1066

PT'S NAME

18 July 03

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
BP	109/59	105/54	107/54	104/61	135/84	124/76	129/70	135/77	125/71	129/69	111/64	114/59	116/62	114/62	114/56	115/59		112/63	116/58	114/58				
TEMP	100.2					100.0				99.8				101.1							100.2			99.9
HR	101	98	94	106	114	110	88	88	104	108	102	104	104	103	102	105	103	102	105	107	102	↓	98	100
RR	10	14	16	20	20	16	16	16	14	16	18	16	20	20	20	18	18	19	20	18	~~102~~	↓	20	20
SA02	92	94	95%	99%	96%	96%	97%	98%	97	97	96	94	98%	94	97	93	94	95	96	94	95	0	94	95
O2 MODE	RA	RA	RA	RA	RA		RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA		RA	RA
INPUT																								
PO																								
IV	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50
~~NGT~~	0					100	100	110	110	120	128	128	128	128	128	128	128	128	128	128	128	128	0	0
TOTAL												1396												
OUTPUT																								
URINE	80	170	8	250		120		80	80	110		120	100	100	100	160	125	125	125	125	140	120	120	
NGT																								
STOOL																								
TOTAL	80	250		500		620		700	780	890		1010												
NCE																								

pt # [redacted]
8.0 ETT b6-4
24 @ teeth

28TH COMBAT SUPPORT HOSPITAL VENTILATOR FLOW SHEET

DATE	TIME	MODE	RATE	VOLUME	FI02	PEEP	PIP	total PT RATE	HR	SO2	BP	Ph	Pco2	Po2	BE	HCO3	SaO2	REMARKS	INT
19 July	1400	SIMV	13	800	40	8	37	13	115	100	121/65								[redacted]
19 JUL	1830	SIMV	13	800	60	8	35	13	131	99	134/70								[redacted]
19 JUL	2000	SIMV	13	800	60	8	37	13	119	99	109/55							Alb/Atro + lavag + sx	[redacted]
19 JUL	2150	SIMV	13	800	60	8	39	13	112	100	125/61								[redacted]
20 Jul	0144	Simv	13	800	60	8	38	0	106	94	101/44								[redacted]
20 Jul	0345	Simv	13	800	60	8	36	0	106	100	104/45	7.516	42	69	11	34	95%	Alb/Atro lavag Sx	[redacted]
20 Jul	0601	Simv	13	800	60	8	39	0	111	98	113/57								[redacted]
20 Jul	0818	Simv	13	800	60	8	40	0	108	97	100/52							Alb/Atro lavage	[redacted]
20 Jul	1200	SIMV	13	800	60	8	39	0	112	99	131/72							Alb/Atro/lavage	[redacted]
20 July	1400	SIMV	13	800	60	8	37	0	125	99	143/81								[redacted]
20 July	1600	SIMV	13	800	60	8	33	30	125	99	135/85							Alb/Atro/lavage	[redacted]
20 JUL	1800	SIMV	13	800	60	8	33	13	103	99	104/49							Alb/Muco/Sx/lavage	[redacted]
20 JUL	2000	SIMV	13	800	60	8	36	13	108	98	111/60								[redacted]
20 JUL	2200	SIMV	13	800	60	8	36	13	104	100	97/57								[redacted]
20 JUL	2345	SIMV	13	800	60	8	39	13	93	100	86/45								[redacted]
21 Jul	0235	Simv	13	800	60	8	38	13	95	98	104/35								[redacted]
21 Jul	0427	Simv	13	800	60	8	43	0	99	99	104/55							~~Alb/lavage~~/Sx	[redacted]
21 Jul	0554	Simv	13	800	60	8	40	0	97	99	103/52							Alb/muco/ss/lavage	[redacted]
21 Jul	0750	Simv	13	800	60	8	40	0	117	99	1							Suction by Doc	[redacted]
21 July	1200	SIMV	13	800	40	8	36	13	99	100	123/65							Alb/muco/Sx/lavage	[redacted]
21 July	1400	SIMV	13	800	40	8	35	15	103	100	110/54								[redacted]
21 July	1630	SIMV	13	800	40	8	67	20	112	100	119/63								[redacted]
21 JUL	1725	SIMV	13	800	50	8	38	28	123	99	136/71								[redacted]
21 JUL	1945	SIMV	13	800	50	8	38	13	105	100	110/60							Alb/muco/CPT/Sx	[redacted]
21 JUL	2155	SIMV	13	800	50	8	36	13	104	100	110/58								[redacted]
22 JUL	0012	SIMV	13	800	50	8	37	13	97	100	108/60								[redacted]
22 Jul	0157	Simv	13	800	50	8	37	13	94	100	102/52								[redacted]
22 Jul	0420	SIMV	13	800	50	8	36	13	101	100	—								[redacted]
22 Jul	0555	Simv	13	800	50	8	40	13	104	100	116/61							Alb/muc/Suction	[redacted]
22	0803	Simv	13	800	50	8	40	13	114	100	90/41							BS coarse	[redacted]
22 July	1000	SIMV	13	800	35%	5	37	28	109	100	112/56								[redacted]
22 July	1215	SIMV	13	800	35	5	40	13	104	100	137/108								[redacted]
22 July	1600	SIMV	11	800	36	5	29	13	121	100	105/60								[redacted]
22 JUL	1710	SIMV	11	800	45	5	27	15	121	100	109/57								[redacted]
22 JUL	1820	SIMV	11	800	45	5	30	28	114	100	123/67							Alb/muc Sx/BS c	[redacted]

all b6-2

MEDCOM - 13175

[redacted] 19 July 03
66-4

19 June 03

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
BP	111/59	104/56	114/64	114/66	135/84	127/73	139/70	125/64	118/70	111/63	111/77	112/61	137/72	94/52	X	X		101/50	99/49	104/53	111/62	105/57	118/57	11/53
TEMP	99.9	101.8		98.6				98.8					102.0	102²	X	X	99⁴	X	X		100⁴	101⁷	X	X
PR	161	106	102	98	100	108	104	106	100	98	102	104	114	112	103	99	98	101	101	100	102	101	105	98
RR	25	16	18	16	20	20	20	16	16	14	14	16	24	23	20	29	21	18	19	20	19	19	15	14
SAO2	94	95	96	99%	97%	96%	97%	98%	97%	96%	95%	98%	97%	98	98	94	100	100	99	93	95	94	96 93	94
	RA	M	M	M	M	M	M	M	M	M	M	M	4LNC	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA
PUT																								
PO	Ø														100									
IV	50	50	50	50	50	50	50	250	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50
NGT	Ø					100	110	110	120	120	128	128	128	128	128	128	128	128	128	Ø	Ø	Ø	Ø	Ø
																				Tuezeo OFF				
TOTAL																								
OUTPUT																								
URINE	90	120	100	170	240	70		230	130	160	120	80	100	100	100	100	200	100	160	100	150	200	200	
NGT																							3060	
STOOL			X T																			+		
TOTAL																								
BALANCE																								

MEDCOM - 13176

IV 1200 URINE
PO 1812
3012
BALANCE

x Sn. 1[illegible]

28TH COMBAT SUPPORT HOSPITAL VENTILATOR FLOW SHEET [redacted]

b6-4

DATE	TIME	MODE	RATE	VOLUME	FI02	PEEP	PIP	total PT RATE	HR	SO2	BP	Ph	Pco2	Po2	BE	HCO3	SaO2	REMARKS	INT
~~23JUL~~	~~0020~~	~~SIMV~~	~~12~~	~~850~~	~~50%~~	~~5~~	~~28~~	~~12~~	~~98~~	~~100~~	~~134/72~~								[redacted]
23JUL	0021	SIMV	11	800	.45%	5	29	11	105	98	96/51								[redacted]
0222	23Jul	Simv	11	800	45	5	31	11	102	100	108/54								[redacted]
23Jul	0440	Simv	11	800	45	5	38	24	123	100	122/62	7.602	34.8	59	13	34	94%	Nurse gave tx [illegible]	[redacted]
23Jul	0636	Simv	11	800	↑55	5	28	22	110	100	98/52								[redacted]
23Jul	0803	Simv	11	800	55	5	27	11	67	100	104/56								[redacted]
23Jul	1000	SIMV	12	800	55	5	29	20	109	100	111/59								[redacted]
23Jul	1400	SIMV	12	800	55	5	29	12	122	99	97/52								[redacted]
23Jul	1605	SIMV	14	800	55	5	37	19	114	100	96/57								[redacted]
23JUL	1755	SIMV	14	800	55	5	34	22	106	100	108/64								[redacted]
23JUL	2010	SIMV	14	800	55	5	35	14	104	100	105/53								[redacted]
23JUL	2115	SIMV	14	800	50	5	36	14	103	100	115/60								[redacted]
24JUL	0020	SIMV	14	820	50	5	40	14	103	100	137/71							Sx mucous plug	[redacted]
24Jul	0200	Simv	14	800	50	5	36	14	104	99	94/49								[redacted]
24Jul	0417	Simv	14	800	50	5	40	18	104	98	58/47								[redacted]
24Jul	0637	Simv	14	800	50	5	38	14	96	99	87/45								[redacted]
24Jul	1000	SIMV	14	800	100	5	36	14	112	100	97/48								[redacted]
24Jul	1200	Simv	14	800	50	5	39	15	102	96	—								[redacted]
24Jul	1400	Simv	14	800	50	5	38	14	115	98	—								[redacted]
24Jul	1630	Simv	14	800	50	5	37	14	102	98	123/58								[redacted]
24JUL	1735	SIMV	15	800	50	5	36	15	114	98	139/58								[redacted]
24JUL	1950	SIMV	14	800	50	5	35	14	106	98	164/53							So, neb, CPT	[redacted]
24JUL	2125	SIMV	14	800	50	5	33	14	119	96	108/55								[redacted]
25JUL	0020	SIMV	14	800	45	5	34	14	104	100	133/64								[redacted]
25Jul	0137	Simv	14	800	45	5	34	14	106	98	102/62								[redacted]
25Jul	0407	SIMV	14	800	45	5	34	15	106	98	106/57							Sx, CPT	[redacted]
25Jul	0559	SIMV	14	800	45	5	36	14	103	99	123/60							BS coarse	[redacted]
25Jul	0746	Simv	14	800	45	5	34	14	103	98	122/63								[redacted]
25Jul	1000	Simv	14	800	50	5	33	15	116	100	124/63								[redacted]
25Jul	1200	Simv	14	800	50	5	32	14	102	100	119/56								[redacted]
25JUL	1814	SIMV	14	800	50	5	39	24	112	97	107/62								[redacted]
25JUL	1915	SIMV	14	800	50	5	36	14	107	97	97/46								[redacted]
25JUL	2150	SIMV	14	800	50	5	40	24	102	98	100/48								[redacted]
25JUL	2344	SIMV	14	800	50	5	37	24	112	96	101/49								[redacted]
26Jul	0155	Simv	14	800	50	5	40	14	120	98	94/44								[redacted]
26Jul	0404	Simv	14	800	50	5	42	14	89	98	69/45								
26Jul	0547	Simv	14	800	50	5	38	14	88	100	107/46								

ax b6-2

MEDCOM - 13177

#386

24 July 03

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
BP	113/61	112/61	119/64	118/62	108/61	112/67	120/64	128/81	117/65	112/63	110/60	127/70	117/65		124/63	121/65	113/67	117/61	115/68		117/63	103/62		114/74
TEMP	99.1	99.2						98.8				99.0			993	X	X	X	X	X	X	X	X	993
HR	106	111	102	101	93	89	91	93	94	94	96	96	92	94	100	108	104		103	112	97	108	163	102
RR	21	26	13	17	19	20		38	18	20	21	22	21	18	20	33	16		21	21	25	31	28	24
SA02	96%	96%	96%	96	97	98	97	96	97	97	95	96	97	97	97	93	96		93	98	95	94	93	93
	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA
INPUT																								
PO																525	120		50					
IV	100	100	100	100	100	100	100	100	100	100	100	100	—	—	↑	100	100	100	100	100	100	100	100	100
NGT																								
																Ambien	Awake	Awake	Awake	Sleep				
TOTAL																								
OUTPUT																								
URINE	35	70	100	75	90	70	120	126	60	50	50	90	90	100	85	50	60	140	65	60	80	—	140	—
NGT																								
STOOL																							Lg Loose Brown	
TOTAL																								
BALANCE																								

MEDCOM - 13178

IV 2100
PO 695
2795

URINE 1830

Balance 965

	05	06	07	08	09	10	11	12	13	14	15	16
BP			119/60	94/70	109/78	95/65	118/64	116/72	118/70	110/82	103/64	108/65
TEMP			99.5	98.5	98.5	98.7				99°	99.3	99.0
HR	109	97	98		116	97	96	110	107	130	94	100
RR	23	29	24	29	29	25	27	23	15	30	18	16
SA02	94	98	94	96	96	95	94	92	76	95	96	97
MODE	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA
INPUT												
PO			100									360
LR IV	100	160	100	100	100	100	100	100	—	—	100	100
NGT												
BOLUS												1000
TOTAL	100	200	400	500	600	700	800	900	900	900	1000	2360
OUTPUT												
Foley URINE	40	28	60	30	30	45	140	75	20	20	28	36
NGT												
STOOL												
TOTAL	40	68	128	158	188	233	373	448	468	488	516	552
BALANCE												

	17	18	19	20	21	22	23	24	01	02	03	04
BP		117/65	X	X	101/63	106/68	114/73	X	115/55	114/77	118/57	116/61
TEMP	97.7	97.7	X	X				X	X	X	X	X
HR	100	101	99	96	91	118	105	104	99	104	101	93
RR	20	20	29	19	22	41	30	28	19	31	21	20
SA02	97	97	97	96	99	96	98	96	95	94	98	93
MODE	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA
INPUT												
PO	120	Dw	495									
LR IV	~~100~~ Dw	~~100~~	100	100	100	100	100	100	100	100	100	100
NGT												
BOLUS		↑										
TOTAL	2480											
OUTPUT												
Foley URINE	38	—	—	65	60	—	140	65	100	115	160	100
NGT												
STOOL												
TOTAL	590											
BALANCE												

MEDCOM - 13179

IV Urine

PO Balance

#[redacted] 6604

25 July 03

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
BP	123/64	121/66		~~105~~	116/64	108/63	120/78	117/70		106/67		115/67		113/58	95/58	105/69	111/55	119/55				102/67		
TEMP	F99	X				97				98					100	X	X	998						
HR	95	96			106	95	91	94		104		101		102	110	93	98	84				100		
RR	23	21			18	23	19	17				18		20	20	28	30	26				24		
SA02	93	97			95	95	97	96		97%		96		97	98	98	97	97				97		
MODE	RA	RA			RA	RA	RA	RA		RA		RA		RA	RA	RA	RA	RA				RA		
INPUT																								
PO																								
IV	100	100			100	100	100	100	100	100	100	100	100	100	100	110	100	100	100	100	100	100	100	100
NGT																								
TOTAL																								
UTPUT																								
URINE	—	200				300	40	60				350		40				65		200		200	500	200
NGT																								
STOOL																								
OTAL																								
BALANCE																								

MEDCOM - 13180

IV 2200
PO 240
2440

Urine
1855
(SRC Balanced.

26 July 03
H [redacted] 66-4

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
BP	X	X	91/57					101/60				111/63				115/68			111/64				118/69	
TEMP								977				984				987			987				984	
HR	91	97	91					103				101				110			101				110	
RR	10	12	14					20				20				18			22				22	
SA02	98	97	97%					97%				94%				97%			96%				96%	
MODE	RA	RA	RA					RA				RA				RA			RA				RA	
INPUT																								
PO				140				300																
LR IV	100	100	100	100	100	100	100	100	100	100	100	100		100	100	100	100	100	100	100	100	100	100	100
NGT																								
TOTAL																								
OUTPUT																								
URINE			130					300				250				250			275				275	
NGT																								
STOOL									1 brown soft															
TOTAL																								
BALANCE																								

MEDCOM - 13181

27 July # [redacted] b6-4

BP					120/73					107/63				103/71						X				
TEMP					97.1					98-					98.3									
HR					100					97				107						100				
RR					18					20				18						20				
SA02					95					97				98						97				
					RA					RA				RA						RA				
INPUT																								
PO					360																			
IV																								
NGT																								
AL																								
UTPUT																								
URINE		200		200		200				480				280							250			
NGT																								
STOOL																								
TAL																								
LANCE																								

MEDCOM - 13182

EPW [redacted] 28 Jul 03

66-4

IV 0

PO 360

urine

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
	103/57	110/63				115/73				102/66					110/68				108/53				11/67	
TEMP	98.6	98.9				96.8				98.4					98.5				98.3				99	
HR	86	96				106				93					101				97				103	
RR	13	24				17				13					20				14				14	
SA02	98	99				95				97					98%				97%				98%	
INPUT																								
PO				360	120			120		120		357												
ER IV	100	100	100	100	100	100	100	100	100	100	100	100	100		250									
NGT																			~~60~~	~~60~~	~~60~~	~~60~~	~~60~~	~~60~~
												1300												
												~~1557~~												
AL													2857											
UTPUT																								
URINE	145	140			140			80		200		140				200		275		275		150		200
NGT																								
STOOL				0																				
TAL													845											
LANCE																								

MEDCOM - 13183

29 July 03

[redacted] 66-4

[illegible]	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
TEMP																				99°				98°
HR			107				83				85				88					95				94
RP.			17				18				11				19					16				16
SA02			99				99				98				100%					96%				97%
BP			103/62				112/50				101/54				106/75					109/62				112/66
															RA					RA				RA
INPUT																								
PO			300				600																	
IV																								
NGT																								
TAL																								
OUTPUT																								
URINE			200				50				300					200				150				
NGT																								
STOOL																								
TOTAL																								
BALANCE																								

MEDCOM - 13184

pt: EPW [redacted] b6-4

30 Jul 03

DOD-026097

				08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
BP				115/60			107/71				104/73			131/63	[illegible]			X	~~116/57~~					
TEMP				98.6							97.3				98.2									97.6
HR				105			95				99				102			88	~~88~~					
RR				20			10				14				36			13	~~13~~					
SA02				98			96				95				96			97	~~94~~					
O2 source				RA			RA				RA				RA			RA	RA					
																			[redacted]	66-2				
INPUT																								
PO																							240	
NS IV																↑	50	100	100	100	100	100	100	100
NGT																								
OTAL																								
OUTPUT																								
URINE				200			200				220					120								
NGT																								
STOOL																								
TOTAL																								
BALANCE																								

MEDCOM - 13185

[redacted] 66-4

31Jul03

MEDCOM - 13186

ASSESSMENT 9[illegible]46 b6-2

TIME: 10 SIGNATURE: [redacted] b6-2

SKIN AND MUCOUS MEMBRANES

Skin : [✓ Loose] / Tight / Diaphoretic / Shiny / [✓ Dry]
Skin : Temperature Warm
Color: Pale / Cyanotic / Jaundiced Normal to Race
Mucous Membranes: [✓ Moist] / Dry / Cracked
Skin Breakdown: None Location: Burn Sites Size:

NEUROLOGICAL

Loc / [✓ Alert] / Lethargic / Unresponsive GCS:
[✓ Oriented] / Disoriented Pupils:
Extremity Movement: [✓ Full] / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radials +2 Pedals +2
Capillary Refill: Seconds <3sec Homan's Sign
Jugular Venous Distension Ø Edema
Heart Sounds $S_1 S_2$
Rhythm NSR PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			▨	▨
Site				
Solution				

Chest Pain

RESPIRATORY

Chest Expansion / [✓ Symmetrical] / Asymmetrical
Respiration / [✓ No Distress] / SOB / Labored / Use of Access Muscles
Breathing Patterns: RRR
Cough: Productive / Nonproductive / [✓ None]
Sputum: Color / Amount / Consistency / Odor
Chest Drainage System Gravity: Suction cm:
Air Leak No Yes Crepitus
Character of Drainage:
Trachea / [✓ Midline] / Deviated (R) / Deviated (L)
Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles	CTA	CTA
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: [✓ Soft] / Firm / Hard / Distended cm Girth
Bowel Sounds: [✓ Normal] / Hyperactive / Hypoactive / Absent
Dressings: Drsgs D/I CDI
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage
NG Drainage: Color Character
Tube Feeding: Day No: Strength: Rate: Aspirate:
Stool: Character
Drains: Ø

GENITOURINARY

Urine Color: yellow Character: Clear
Voiding: Continent / Incontinent / [✓ Catheter] Foley

EMOTIONAL/PSYCHOSOCIAL

OTHER:

TIME: 1900 SIGNATURE: [redacted]

SKIN AND MUCOUS MEMBRANES

Skin : Loose / [✓ Tight] / Diaphoretic / Shiny / Dry
Skin : Temperature Warm to touch
Color: Pale / Cyanotic / Jaundiced Membranes pink
Mucous Membranes: [✓ Moist] / Dry / Cracked
Skin Breakdown: [✓ None] Location: See SF600 for Skin Assess

NEUROLOGICAL

Loc / [✓ Alert] / Lethargic / Unresponsive GCS:
[✓ Oriented] / Disoriented Pupils:
Extremity Movement: Full / [✓ Limited] / None 2° BLE wounds

CARDIOVASCULAR

Pulse (0 - 4): Palp Radials +3 Palp Pedals +3
Capillary Refill: <3 Seconds Homan's Sign Neg
Jugular Venous Distension Ø Edema
Heart Sounds S_1, S_2
Rhythm SR HR 80-90s PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			▨	▨
Site			Ø	Ø
Solution			Ø	Ø

Chest Pain Denies

RESPIRATORY

Chest Expansion / [✓ Symmetrical] / Asymmetrical
Respiration / [✓ No Distress] / SOB / Labored / Use of Access Muscles
Breathing Patterns: Regular
Cough: Productive / Nonproductive / [✓ None]
Sputum: Color / Amount / Consistency / Odor Ø
Chest Drainage System Gravity: Ø Suction cm:
Air Leak No Ø Yes Crepitus
Character of Drainage: Ø
Trachea / [✓ Midline] / Deviated (R) / Deviated (L)
Artificial Airway Size: Type: Ø Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes		
Diminished	Bilat	Bilat
Absent		

GASTROINTESTINAL

Abdomen: [✓ Soft] / Firm / Hard / Distended cm Girth
Bowel Sounds: [✓ Normal] / Hyperactive / Hypoactive / Absent
Dressings: See SF600 for Wound Assess
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage Ø
NG Drainage: Color Ø Character
Tube Feeding: Day No: Ø Strength: Rate: Aspirate
Stool: Character Ø
Drains: Foley

GENITOURINARY

Urine Color: yellow Character: Clear
Voiding: Continent / Incontinent / [✓ Catheter]

EMOTIONAL/PSYCHOSOCIAL

Pleasant, calm

OTHER:

#319[illegible]03 # [redacted] b6-4

13186

MEDCOM - 1919 66-2

PATIENT ASSESSMENT

TIME: 0045 SIGNATURE: [redacted]

SKIN AND MUCOUS MEMBRANES

Skin: [✓ Loose] / Tight / Diaphoretic / Shiny / Dry
Skin: Temperature 97.+ warm to touch
Color: Pale / Cyanotic / Jaundiced normal for race
Mucous Membranes: Moist / Dry / [✓ Cracked]
Skin Breakdown: [✓ None] Location: Size:
2° to hands, feet [illegible]

NEUROLOGICAL

LOC / [✓ Alert] / Lethargic / Unresponsive GCS:
[✓ Oriented] / Disoriented Pupils:
Extremity Movement: Full / [✓ Limited] / None Burns to hand, feet, [illegible]

CARDIOVASCULAR

[illegible]
Pulse (0 - 4): + Radials + Pedals feet
Capillary Refill: + Seconds Homan's Sign
Jugular Venous Distension 0 Edema to left feet
Heart Sounds normal
Rhythm normal PRI QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site				
Solution			0	

Chest Pain 0

RESPIRATORY

Chest Expansion / [✓ Symmetrical] / Asymmetrical
Respiration [✓ No Distress] / SOB / Labored / Use of Access Muscles
Breathing Patterns: normal
Cough: Productive / [✓ Nonproductive] / None
Sputum: Color / Amount / Consistency / Odor N/A
Chest Drainage System Gravity: Suction cm:
Air Leak No Yes Crepitus
Character of Drainage:
Trachea [✓ Midline] / Deviated (R) / Deviated (L)
Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles	CTA	
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen [✓ Soft] / Firm / Hard / Distended cm Girth
Bowel Sounds: [✓ Normal] / Hyperactive / Hypoactive / Absent
Drainage:
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage
NG Drainage: Color Character
Tube Feeding: Day No: Strength: Rate: Aspirate:
Stool: Character
Drains:

GENITOURINARY

Urine Color: Character:
Voiding: [✓ Continent] / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin: [✓ Loose] / Tight / Diaphoretic / Shiny / [✓ Dry]
Skin: Temperature 97.9 warm
Color: Pale / Cyanotic / Jaundiced Normal for race
Mucous Membranes: [✓ Moist] / Dry / Cracked moist
Skin Breakdown: [✓ None] Location: Burn to hands & feet Size: Dressing C/D/I

NEUROLOGICAL

LOC / [✓ Alert] / Lethargic / Unresponsive GCS:
[✓ Oriented] / Disoriented Pupils PERRL
Extremity Movement: Full / [✓ Limited] / None slightly weak

CARDIOVASCULAR

Pulse (0 - 4): 92-HR Radials (+)(+) Pedals (+)(+)
Capillary Refill: ≤3 Seconds Homan's Sign
Jugular Venous Distension 0 Edema to (L) foot
Heart Sounds
Rhythm NSR PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral
Waveforms				
Site			0	
Solution				

Chest Pain None

RESPIRATORY

Chest Expansion / [✓ Symmetrical] / Asymmetrical
Respiration / [✓ No Distress] / SOB / Labored / Use of Access Muscles
Breathing Patterns: Normal
Cough: Productive / Nonproductive / [✓ None]
Sputum: Color / Amount / Consistency / Odor None
Chest Drainage System Gravity: Suction cm:
Air Leak NO Yes Crepitus
Character of Drainage:
Trachea / [✓ Midline] / Deviated (R) / Deviated (L)
Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles	CTA (B)	
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen / [✓ Soft] / Firm / Hard / Distended cm Girth
Bowel Sounds [✓ Normal] / Hyperactive / Hypoactive / Absent
Drainage: C/D
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drain
NG Drainage: Color Character
Tube Feeding: Day No: Strength: Rate: Aspirate
Stool: Character N/A @ present
Drains:

GENITOURINARY

Urine Color: Character:
Voiding: [✓ Continent] / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

Calm Helpful

OTHER:

13187

66-2
[redacted] 034903

ICU Flowsheet

Patient Name: # 386

Date: 03/AUG/ 2003

Viital Signs	24	01	02	03	04	05	06	07	08	09	10	11		12	13	14	15	16	17	18	19	20	21	22	23	
Temmperature								98.7			97.2					97.6				97.9				97.3		
Pulsse	85	87	101	95	95	86	92	101			95					97				96				92		
B/P A-Line	-																									
MARP																										
B/P Cuff						115/63	113/65	105/65			106/61					109/63				109/60				110/62		
Resspirations	12	12	13	12	11	8	15	9			15					13				11	14			18		
S02	97	97	97	95	96	95	96	97%			98					99				100	100			100%		

ntake	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
IV LR	100	100	100	100	100	100	100	100	100	100	100	100		100	100	100	100	100	100	100	100	100	100	100	100	
) intake																										
.RR. IN																										
Totals																										

(Output	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
Urrine Hourly				350	550/900	100/1000		125/1125			250/1175					[illegible]/1250		200/1450	125/1575	75/1650	150	128	85	200	175	
NG Tube																										
is #1																										
#2																										
#3																										
Emnesis																										
Stoool										1																
O.RR. OUT																										
Totals																										

24 hour input	
24 hour output	
24 hour balance	

MEDCOM - 13188

[illegible]
#[redacted] 66-4

VSQ4°

ICU Flowsheet

Patient Name:

Date: / / 2003

Vital Signs	24	01	02	03	04	05	06	07	08	09	10	11		12	13	14	15	16	17	18	19	20	21	22	23	
Temperature										986										986						
Pulse						88				102					100				94				94			
B/P A-Line	–																									
MAP															108/39				116/60							
B/P Cuff										114/65																
Respirations						12				18					11				12				15			
SaO2						98				98					96				97%				98			

Intake	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
IVF: LR						150	100	100	100		100	100	600	100	100	100	100	100	100	100	100	100	100	100	100	1200
PO Intake																				240		100				340
.RR. IN																										
Totals																										1540

Output	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
Urine Hourly										460			460		200				400	150				300		1050
NG Tube																										
s #1																										
#2																										
#3																										
Emesis																										
Stool																										
O.RR. OUT																										
Totals																										

24 hour input	2140
24 hour output	1510
24 hour balance	630

MEDCOM - 13189

ICU Flowsheet **Patient Name:** 386 **Date:** 04 / AUG / 2003

Vitital Signs	24	01	02	03	04	05	06	07	08	09	10	11		12	13	14	15	16	17	18	19	20	21	22	23	
Temmperature			97^{7}				99^{1}				96^{8}					[illegible]										
Pulsse			84				88				87					[illegible]									98		
B/P ' A-Line	-		108/				113/65				102/60					111/64											
MARP			/51																								
B/P ' Cuff																											
Resspirations			14				10				10					12									30		
S '2			99%				100				96					98									99		

ıtake	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
IVF							100	100	100	100	100	100	600	100	100	100	100	100	100	100	100	100	100	100	100	
																			1200							
)) intake								712	120/832	120/952			952	237/1189			120/1309		1309		340					
RR. IN																										
' Totals																										

(Output	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
Urinne Hourly	62	100	50	58	68		75/75	100/176	100/275				275	225/500	75/575	150/725	100/825		825							
NG ' Tube																										
s #1																										
#2																										
#3																										
Emnesis																										
Stoool																										
O.RR. OUT																										
' Totals																										

24 hour input	
24 hour output	
24 hour balance	

MEDCOM - 13190

[redacted] b6-4

MEDCOM - 13191

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
BP	109/66	129/71				119/72				109/63				107/62				120/71				104/75		
TEMP	98^8	98^8				97^9				97.9				98^2				98^1				97^5		
HR	81	95				85				89				84				80				71		
RR	18	15				12				17				16				15						
SA02	98	95								94				95				95				96%		
INPUT																								
PO			357					240		120														
IV	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
NGT													1200											
													1917									IN	2117	
TOTAL																								
OUTPUT																								
URINE	150		175		100		75			200			150					275 1st void				out	1125	
NGT														850										
STOOL																								
TOTAL																								
BALANCE																								

06AUG03

[redacted] b6-4

[redacted] 66-4 06AUG03

MEDCOM - 13192

[redacted] 66-2

TIME: 1700 SIGNATU. [redacted]

SKIN AND MUCOUS MEMBRANES

Skin : [✓ Loose] / Tight / Diaphoretic / [✓ Shiny] / Dry

Skin : Temperature 98.6

Color: Pale / Cyanotic / Jaundiced normal for race

Mucous Membranes: [✓ Moist] / Dry / Cracked

Skin Breakdown: [✓ None] Location: Size:

NEUROLOGICAL

Loc / [✓ Alert] / Lethargic / Unresponsive GCS:

[✓ Orientated] / Disoriented Pupils:

Extremity Movement: Full / [✓ Limited] / None Burn to hands, legs, feet, abd, back

CARDIOVASCULAR

Pulse (0 - 4): >4 Radials -- >4 Pedals

Capillary Refill: good Seconds Homan's Sign

Jugular Venous Distension - Edema -to (B) feet

Heart Sounds normal ;95

Rhythm normal PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site			(R) inner arm	
Solution			NS@100cc/hr	

Chest Pain N/A

RESPIRATORY

Chest Expansion / [✓ Symmetrical] / Asymmetrical

Respiration / [✓ No Distress] / SOB / Labored / Use of Access Muscles

Breathing Patterns: 15 normal

Cough: Productive / Nonproductive / [✓ None]

Sputum: Color / Amount / Consistency / Odor N/A

Chest Drainage System Gravity: Suction cm:

Air Leak No Yes -- Crepitus

Character of Drainage:

Trachea / [✓ Midline] / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes	CTA	
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: [✓ Soft] / Firm / Hard / Distended cm Girth

Bowel Sounds: [✓ Normal] / Hyperactive / Hypoactive / Absent

Dressings: Drsg to abd, feet, back, legs + hands

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate:

Stool: Character

Drains: N/A

GENITOURINARY

Urine Color: yellow Character:

Voiding: [✓ Continent] / Incontinent / Catheter -NO

EMOTIONAL/PSYCHOSOCIAL

OTHER:

ENT ASSESSMENT 66-2

TIME: 1830. SIGNATURE: [redacted]

SKIN AND MUCOUS MEMBRANES

Skin : Loose / Tight / Diaphoretic / Shiny / [✓ Dry]

Skin : Temperature Warm

Color: Pale / Cyanotic / Jaundiced

Mucous Membranes: [✓ Moist] / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / [✓ Alert] / Lethargic / Unresponsive GCS:

[✓ Orientated] / Disoriented Pupils:

Extremity Movement: Full / [✓ Limited] / None

CARDIOVASCULAR

Pulse (0 - 4): +2 Radials Pedals

Capillary Refill: <2 Seconds Homan's Sign

Jugular Venous Distension Edema

Heart Sounds S1 - S2.

Rhythm Reg. PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site	(R) FA	18 @	100cc/h	
Solution				

Chest Pain

RESPIRATORY

Chest Expansion / [✓ Symmetrical] / Asymmetrical

Respiration / [✓ No Distress] / SOB / Labored / Use of Access Muscles

Breathing Patterns: Regular

Cough: Productive / Nonproductive / [✓ None]

Sputum: Color / Amount / Consistency / Odor

Chest Drainage System Gravity: Suction cm

Air Leak No Yes Crepitus

Character of Drainage: -

Trachea / [✓ Midline] / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes	Clear Bilat.	
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: [✓ Soft] / Firm / Hard / Distended cm Girth

Bowel Sounds: [✓ Normal] / Hyperactive / Hypoactive / Absent

Dressings: Burn areas, grafts

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate

Stool: Character

Drains:

GENITOURINARY

Urine Color: Due to void Character:

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

13192

ICU Flowsheet **Patient Name:** EPW [redacted] -b6-4 **Date:** 07 AUG / 2003

Viiital Signs	24	01	02	03	04	05	06	07	08	09	10	11		12	13	14	15	16	17	18	19	20	21	22	23	
Tenmperature						97.5	97.1				97.6					97.5				98.5				98.3		
Pulsse						83	81				90					90				92				88		
B/P ³ A-Line																										
MAAP																										
B/P ³ Cuff						114/67	114/70				128/79					117/68				116/68				109/64		
Resspirations						10	12				12					12				12				12		
Sa002						94	94				96					95				96%				94%		
																				RA				RA		

'ntake	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
Iv. - LR						100	100	100	100	100	100	100		100	100	100				100	100	100	100	100	100	
PO) intake							357		120/97							477/954										
O.RR. IN																										
' Totals																										

(Output	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
Uririne Hourly						350/350			125/375									x1		x1				350		
NG) Tube																										
'ns #1																										
#2																										
#3																										
Emnesis																										
Stoool																			1							
O.RR. OUT																										
' Totals																										

24 hour input	
24 hour output	
24 hour balance	

MEDCOM - 13193

MEDCOM - 13194 i03

66-2

...IENT ASSESSMENT

TIME: 0600 SIGNATU... [redacted]

SKIN AND MUCOUS MEMBRANES

Skin : [✓ Loose] / Tight / Diaphoretic / [✓ Shiny] / Dry

Skin : Temperature 97.5

Color: Pale / Cyanotic / Jaundiced normal for race

Mucous Membranes: [✓ Moist] / Dry / Cracked

Skin Breakdown: [✓ None] Location: Size:

NEUROLOGICAL

Loc / [✓ Alert] / Lethargic / Unresponsive GCS:

[✓ Orientated] / Disoriented Pupils:

Extremity Movement: Full / [✓ Limited] / None Burns to feet, legs, abd, back + hands

CARDIOVASCULAR

Pulse (0 - 4): 74 Radials → 4 Pedals

Capillary Refill: good Seconds Homan's Sign

Jugular Venous Distension 0 Edema (Rt) feet

Heart Sounds S3 normal.

Rhythm normal PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			▨	▨
Site			Rt inner	arm
Solution			LR @ 100cc	/hr

Chest Pain 0

RESPIRATORY

Chest Expansion / [✓ Symmetrical] / Asymmetrical

Respiration / [✓ No Distress] / SOB / Labored / Use of Access Muscles

Breathing Patterns: normal

Cough: Productive / [✓ Nonproductive] / None

Sputum: Color / Amount / Consistency / Odor N/A

Chest Drainage System Gravity: Suction cm:

Air Leak No Yes Crepitus

Character of Drainage:

Trachea [✓ Midline] / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes	CTA	
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: [✓ Soft] / Firm / Hard / Distended cm Girth

Bowel Sounds: [✓ Normal] / Hyperactive / Hypoactive / Absent

Dressings: feet, legs, abd, back + hands

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate:

Stool: Character

Drains:

GENITOURINARY

Urine Color dark yellow Character:

Voiding: [✓ Continent] / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin : [✓ Loose] / Tight / Diaphoretic / Shiny [✓ Dry]

Skin : Temperature - 98.5

Color: Pale / Cyanotic / Jaundiced Normal For Race

Mucous Membranes: [✓ Moist] / Dry / Cracked

Skin Breakdown: [✓ None] Location: Burns Size: Arms, legs, feet, [illegible]

NEUROLOGICAL

Loc / [✓ Alert] / Lethargic / Unresponsive GCS:

[✓ Orientated] / Disoriented Pupils: PERRL

Extremity Movement: [✓ Full] / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): 92 Radials +4 Pedals +4

Capillary Refill: ≤3 Seconds Homan's Sign

Jugular Venous Distension 0 Edema 0 minimal

Heart Sounds NSR Reg

Rhythm NSR PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			▨	▨
Site			(L) inner Arm	
Solution			LR @ 100cc/hr	

Chest Pain 0

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

Respiration / [✓ No Distress] / SOB / Labored / Use of Access Muscles

Breathing Patterns: 12 BPM 96% SPO2 RA

Cough: Productive / Nonproductive / [✓ None]

Sputum: Color / Amount / Consistency / Odor N/A

Chest Drainage System Gravity: Suction cm:

Air Leak No Yes Crepitus

Character of Drainage:

Trachea / [✓ Midline] / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes	CTA(B)	
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: [✓ Soft] / Firm / Hard / Distended cm Girth

Bowel Sounds: [✓ Normal] / Hyperactive / Hypoactive / Absent

Dressings: Feet legs Arm Abd, back CDI

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate

Stool: Character

Drains:

GENITOURINARY

Urine Color: Dark Yellow Character: Clear

Voiding: [✓ Continent] bedside urinal Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

helpful cooperative

Sad

OTHER:

EPW [redacted] 66-4

07 AUG 03

13194

V 66-41

ICU Flowsheet **Patient Name:** # [redacted] ~~[illegible]~~ **Date:** 9 8 / Aug / 2003

Vital Signs	24	01	02	03	04	05	06	07	08	09	10	11		12	13	14	15	16	17	18	19	20	21	22	23		
Temperature			X				97.5				97.7					98.2				97.9				98.3			
Pulse			89				85				97					91				92				88			94
B/P A-Line			X																								
MAP			X																								
B/P Cuff			X				117/68				112/65					[illegible]				117/63				113/70			
Respirations			26				12				18					18				16				16			16
SaO2			X								99									96%				96%			98
			X																	RA				RA			RA

Intake	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
IVF: LR	100	100	100						D/C'ed																	
PO Intake																										
O.R. IN																										
Totals																										

Output	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
Urine Hourly			400 / 400													[illegible]								375		
NG Tube																										
Drains #1																										
#2																										
#3																										
Emesis																										
Stool																										
O.R. OUT																										
Totals																										

24 hour input	
24 hour output	
24 hour balance	

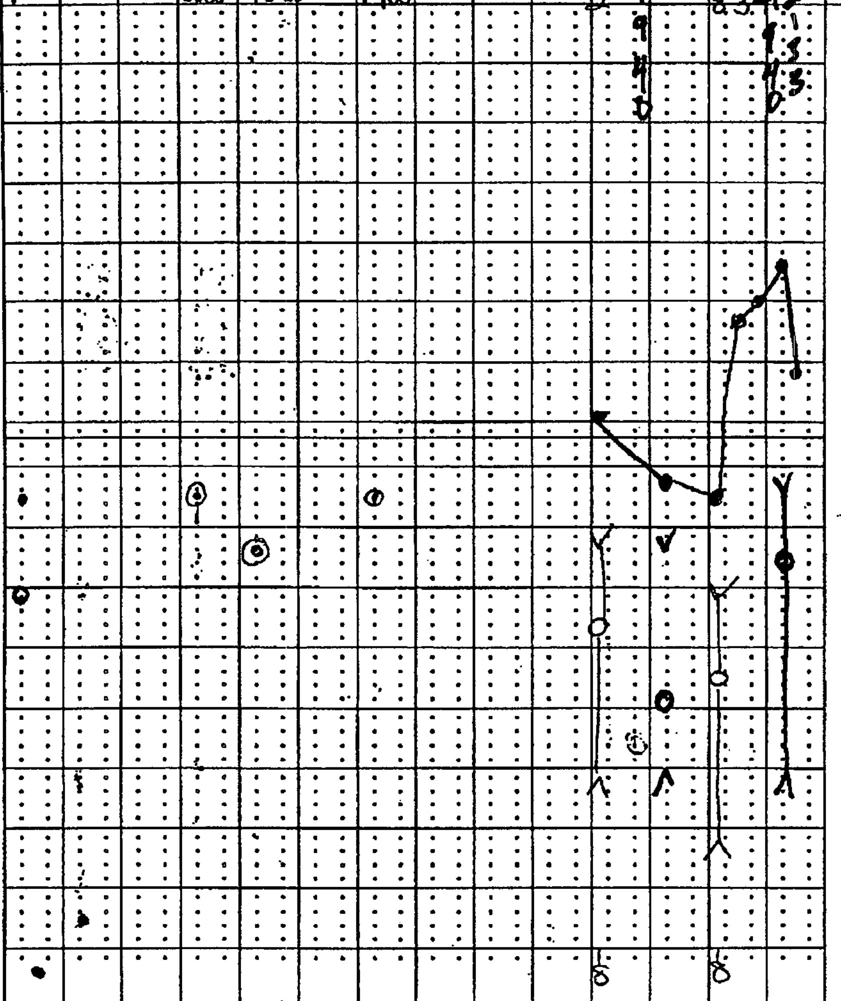
MEDCOM - 13196

1-119 NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY											1		2	
POST- DAY											~~20~~			
MONTH-YEAR AUG / DAY	12			0600					1800		21AUG03		22AUG03	
19 2003 / HOUR	4			0600	1003		1400				5	1940	835	1140 12 133



RESPIRATION RECORD											8		8	
BLOOD PRESSURE				118/70	114/68		116/68				107/68	108/70	98/57	111/69
HR				91	76		85					81		105
RR				12	10		10							1014
HEIGHT: / WEIGHT →												979		157
SAO2	99			96	96		95				97%(RA)	98%	96%(RA)	
source	RA			RA	RA		RA							
Out put	250				300									

Record special data only when so ordered

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital of medical facility)*

REGISTER NO.

WARD NO. ICU3

[redacted] 66-4

VITAL SIGNS RECORDS

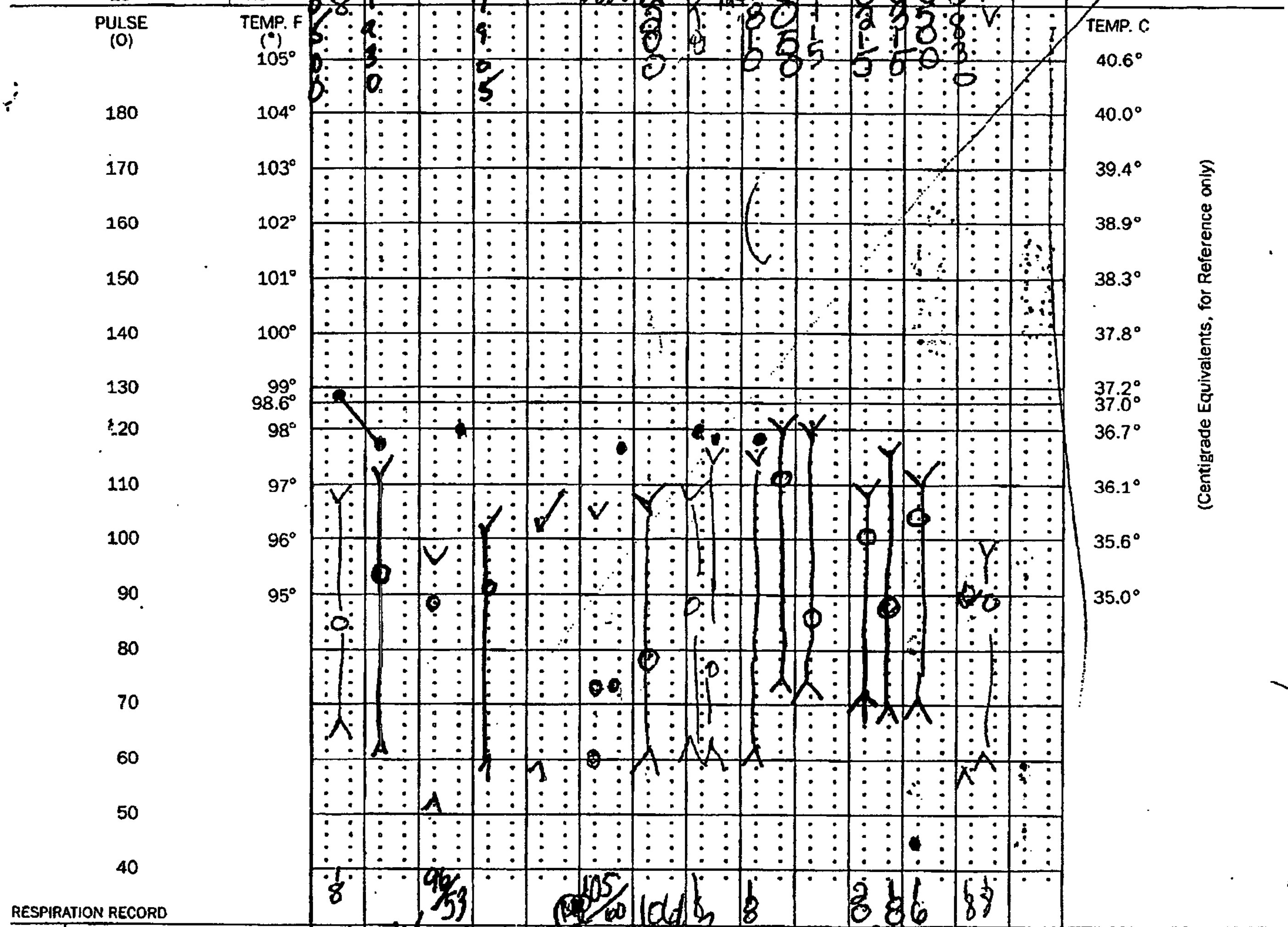
Medical Record

STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

13196

MEDCOM - 13197

MEDICAL RECORD	VITAL SIGNS RECORD
HOSPITAL DAY	23AUG03 24AUG03
POST- DAY	
MONTH-YEAR DAY	23AUG03 24AUG03 25AUG03 25/26 Aug 26 27 27th 27th
19 HOUR	0800 1930 1905 0840 2200 1200 1800 0015 2215 2350 2350 0800



RESPIRATION RECORD 18 96/53 105/60 104/62 18 20 18 16 18

Record special data only when so ordered	
BLOOD PRESSURE	107/67 111/65 P 88 104/60 (74) 100/73 110/71
	100% T 97.3 98 108/64 116/70 86/58
	97.4 97.0 97/64 97/61
HEIGHT: WEIGHT →	94 O2 97 97% SpO2 94 93% 95%
O2 sat 97% (RA)	96% ~ 96% 94%
	O2 by NC @ 2L

ENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*

REGISTER NO.

WARD NO.

STANDARD FORM 511 (REV. 7-95) BACK

1-1

[redacted]

66-4

13197

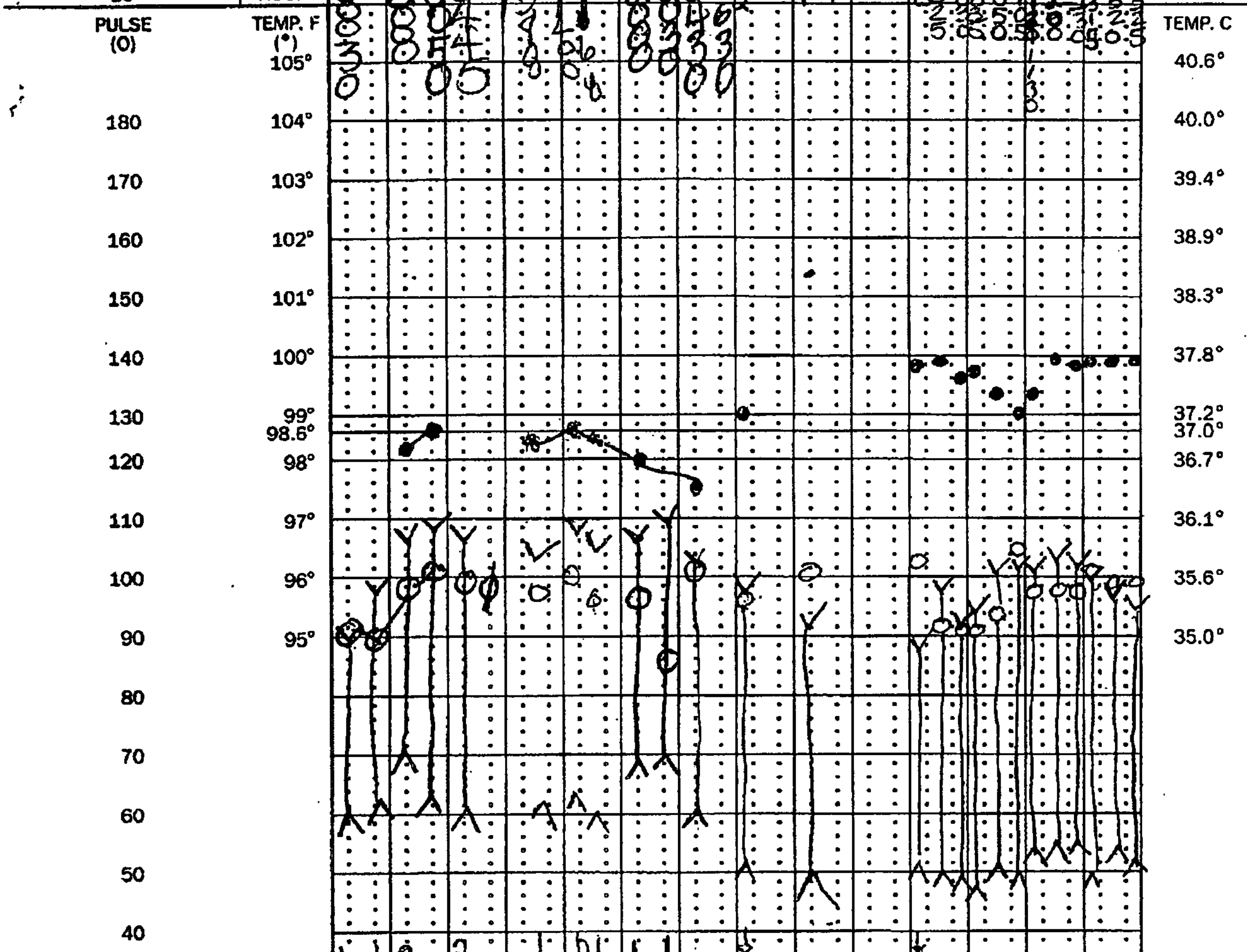
MEDCOM - 13198

511-119 NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY	
POST- DAY	
MONTH-YEAR DAY	27Aug 28th/ 28th/28th 29Aug 29AUG 30AUG05 30
19 HOUR	0830 2000 / 2145 0805 2330 [illegible] 19 [illegible]



RESPIRATION RECORD 18 18 20 20 18 18 16 18 18 18

BLOOD PRESSURE	106/72 108/68 106/61 9 106/68 109/69 97/52 97/52 97/50 101/4 101/4 87/52 97/50 92/49 99/47 101/51 102/50 101/54 103/55 102/55 97/50 97/54 95/52
HEIGHT:	WEIGHT →
(O2 Sat)	97% 98 97 98% 97 (RA) 95% 98 (RA)
	O2 by NC @ 2L 99% 97%
	O2 NC 2L

Record special data only when so ordered

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*

REGISTER NO.

WARD NO.

(99% @ 0050)

[redacted] b6-4

VITAL SIGNS RECORDS

Medical Record

STANDARD FORM 51[illegible]
Prescribed [illegible]

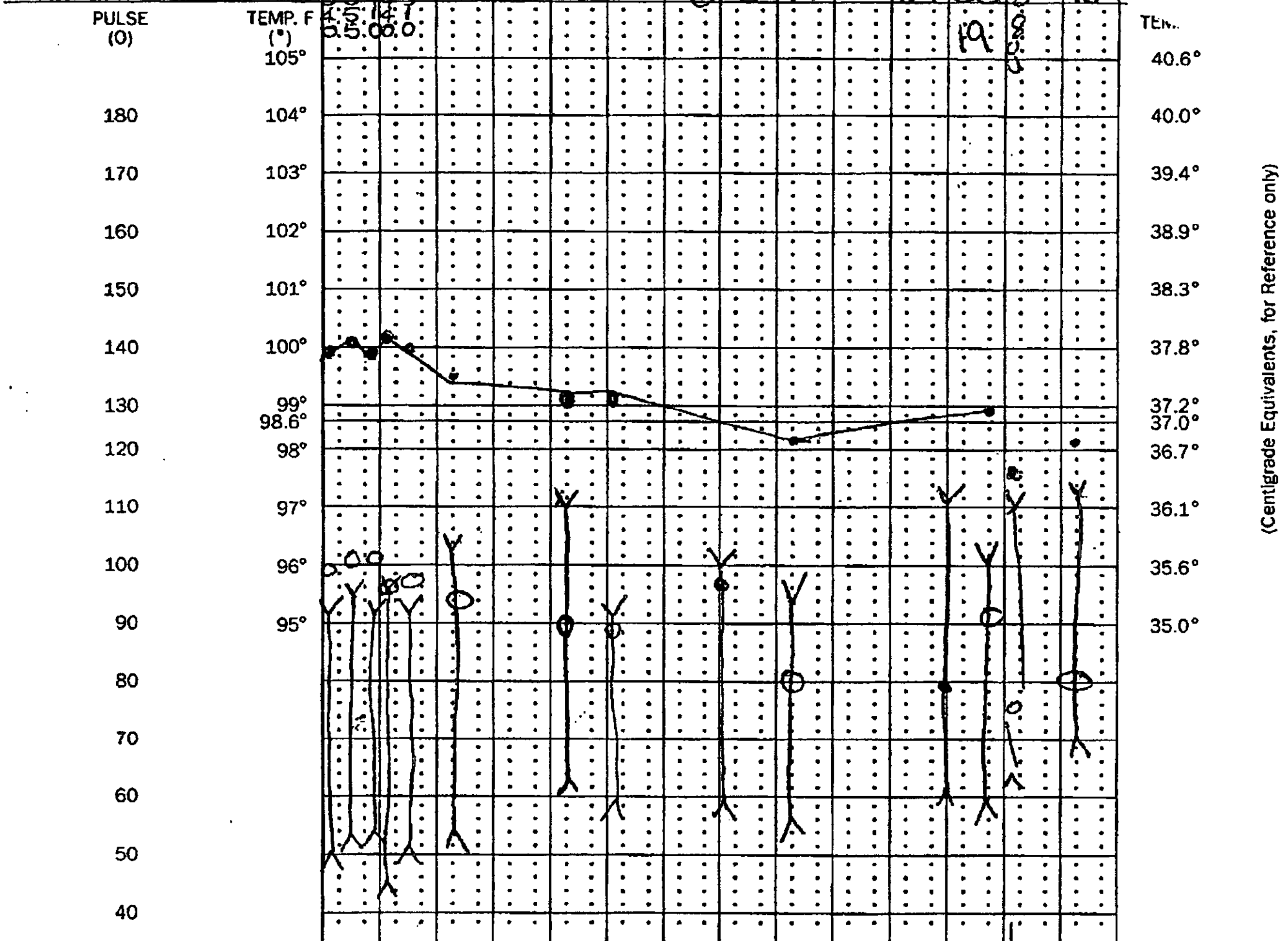
13198

MEDICAL RECORD

VITAL SIGNS RE

(REV. 7-95) by USA/ICMR, FIRMR (41 CFR) 201-9.202-1

HOSPITAL DAY								
POST- DAY								
MONTH-YEAR / DAY	30AUG03	30	31AUG	1Sept	1 Sep.	2Sept		
19 / HOUR	1 1 1 1 1 3 3 4 4 5 4 5 1 4 7 5 5 0 0 0	19	0800	0800	19	0700 19	0800	18



16

RESPIRATION RECORD

RESPIRATION				16						18	
BLOOD PRESSURE	92/50	95/45	103/54	111/60	92/57	103/59	94/56	119/61	101/59	110/64	93/70
	94/53	92/52	94	90		97	81	79	92		81
	92/54		99.5	99.1		96.5	98.2	97.5	98.9		98.2
HEIGHT: / WEIGHT →									96%		
			95%	96%		93%	98%		93%	97%	95%
				96%					R-14		

Record special data only when so ordered

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*

REGISTER NO.

WARD NO.

#0[redacted] 66-4

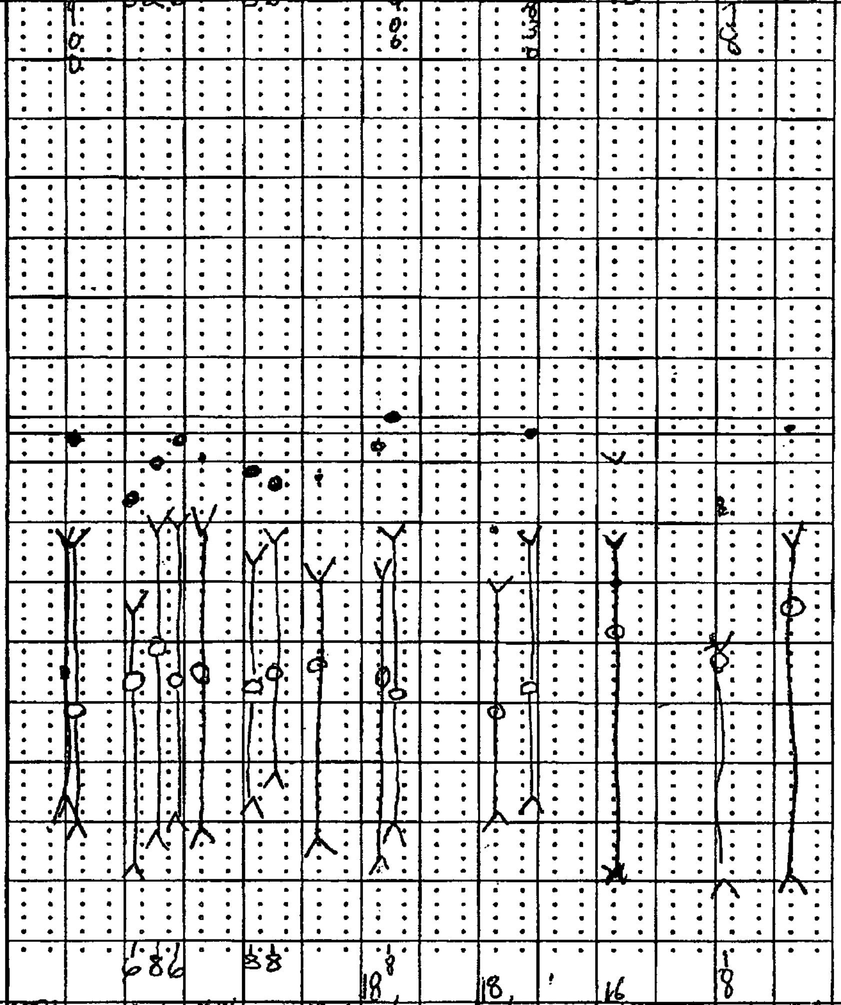
STANDARD FORM 511 (REV. 7-95) BACK

13199

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY														
POST- DAY	4Sept													
MONTH-YEAR DAY	0715		05SEP03		06SEP03		7Sept		8Sept		9Sept03		10 Sep	
19 HOUR		1400	826	18	810	18	0906		08	1830	18		0 78	18



RESPIRATION RECORD			686		88		18 18		18		16		18	
BLOOD PRESSURE	108/64		95/53	108/59	109/64	106/57	107/54		98/62		106/60		84/49	106/52
	85	100/60	98/58	85	109/68	86	107/60		106/64		T 98.6			96
	97.1		109/61	98.1		97.7					H 92			98.8
HEIGHT: WEIGHT →	95% RA													
	16-R		97%(RA)	95%	94%(RA)						94%		94%	96%
			94%(RA)		95%(RA)	96%	94% RA		94% RA					
			99%(RA)				95% RA		96% RA					

Record special data only when so ordered

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)

REGISTER NO.

WARD NO.

[redacted] b6-4

VITAL SIGNS RECORDS

Medical Record

STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

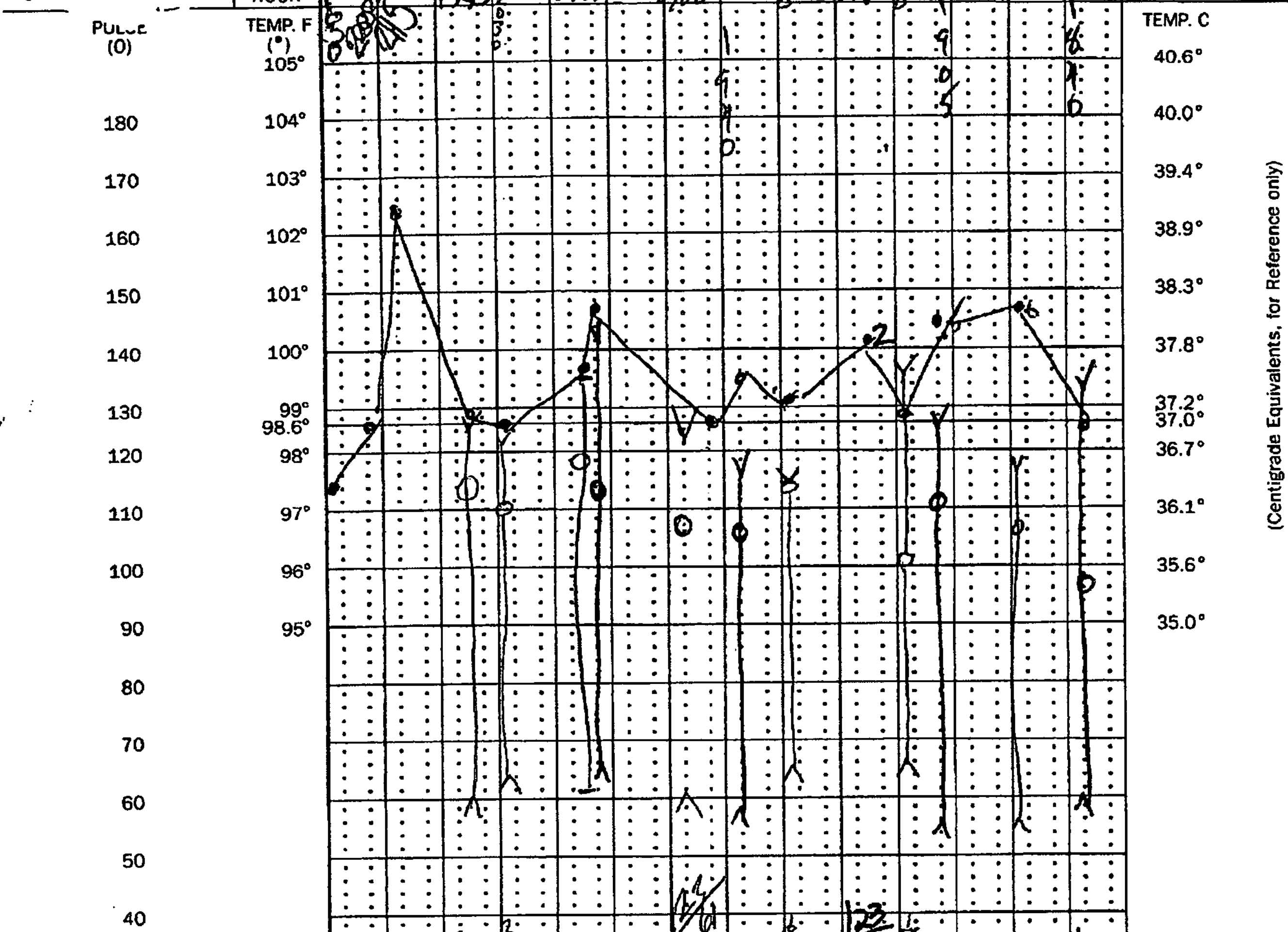
13200

MEDCOM - 13201

NSN 7540-00-634-4124

VITAL SIGNS RECORD

DAY	10	12 sep	13 Sep	14 Sept	15 SEP	16 SEP	17 SEP 03
HOUR	1	1330 2030	0100	1900 1940	8 1945	8 1905	1640



RESPIRATION RECORD		20 20	20	14/61 (P) 107	18 123/44	18	14 19
BLOOD PRESSURE		125/60 127/64	135/61		118/59 117/65	139/60 121/56	117/56 128/56
Record special data only when so ordered		H 114 T 98.8 95% RA 136RA	H 139 T 99.6 95% RA 143/64 121 100.8 96%	T 98.7 98%	101 99.6 98' 97% (RA) (P) 100 (R) 16 (O2) 96% RA	111 100.5 97.1 R 98% (RA)	107 110 107.1 99.7 95 95 123/60 99

HEIGHT: | WEIGHT →

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*

REGISTER NO.

WARD NO.

C724

VITAL SIGNS RECORDS

Medical Record

STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

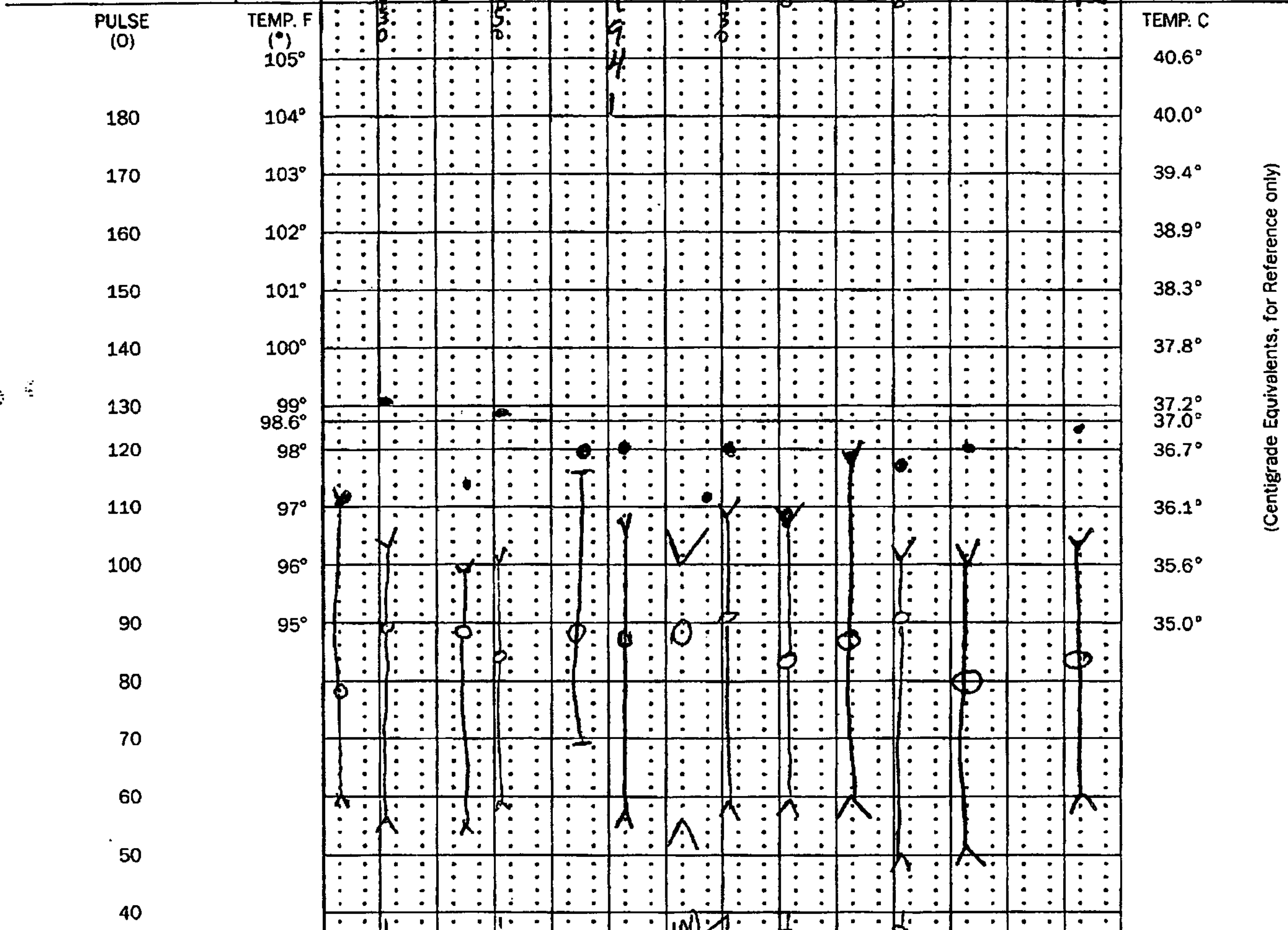
13201

MEDCOM - 13202

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY														
POST- DAY														
MONTH-YEAR / DAY	11 Sep 03		12 Sep		13 Sep		14 Sept		15 SEP 03		16 SEP 03		17 Sep	
19 / HOUR		1330	0700	1530	0700	1941		1136	8	18	8	18		18



RESPIRATION RECORD	98%	18	18	18	18		100/56	18	18		18		16	
BLOOD PRESSURE	111/40	103/56	98/55	101/59	116/69	106/56	P88	106/58	107/59	117/60	110/50	108/52	93/47	108/60
	T97.6		H88		H 89	88	P97			87		80	55	84
	P78		T97.4		T98.0	98.1				97.4		98	97.8	98.4
HEIGHT: / WEIGHT →	R18		97%		98%	96% RA							95	
O2 Sat		98% RA	RA	99% RA	RA		93%	96% RA	97 (RA)	98%	97 (RA)	98%		96%

Record special data only when so ordered

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*

REGISTER NO.

WARD NO.

STANDARD FORM 511 (REV. 7-95) **BACK**

[redacted] 66-4

13202

MEDICAL RECORD

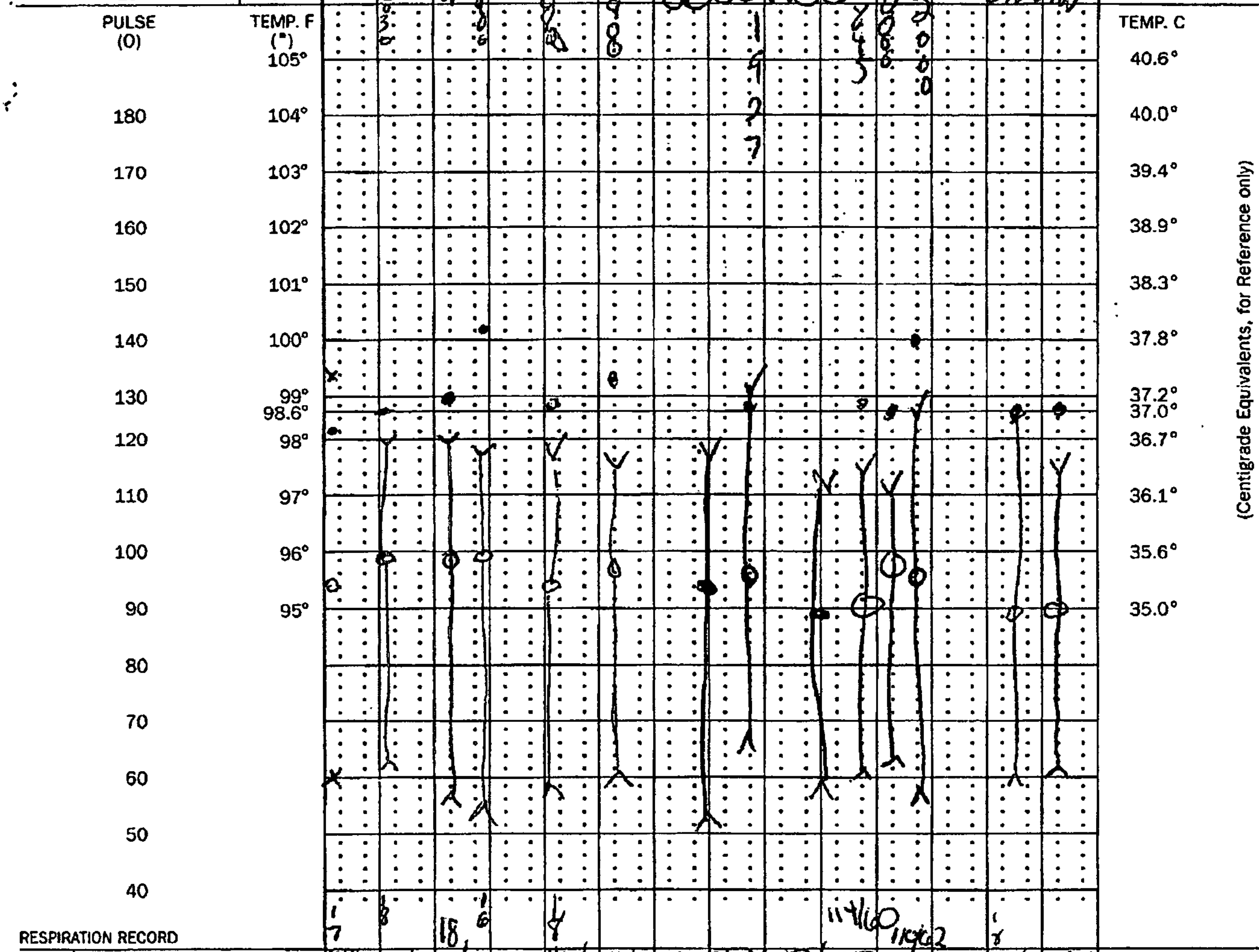
VITAL SIGNS RECORD

HOSPITAL DAY

POST-OP 1 DAY

MONTH-YEAR Sep 03 DAY 18 19 20 21 22 23 24

19 HOUR 0830 1130 0700 1800



RESPIRATION RECORD

Record special data only when so ordered

BLOOD PRESSURE 132/80 118/63 119/57 116/64 116/60 117/[illegible] 112/58 114/60 119/62 124/60 114/62

99 P 99 88 90 99 115 90

96 R 114/55 R 18 16 16 16 T 98 98.4

HEIGHT: WEIGHT → 98 [illegible] 97 RA T 97.7 98.4 98.6 97.6 98.5

SPO2: 99% RA 96% RA 97% 09% [illegible] 96 RA 97% RA

120/56

139/66 98.7 96

100°

96 RA 96%

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*

REGISTER NO.

WARD NO.

STANDARD FORM 511 (REV. 7-95) **BACK**

EPW

0 [redacted] 66-4

13203

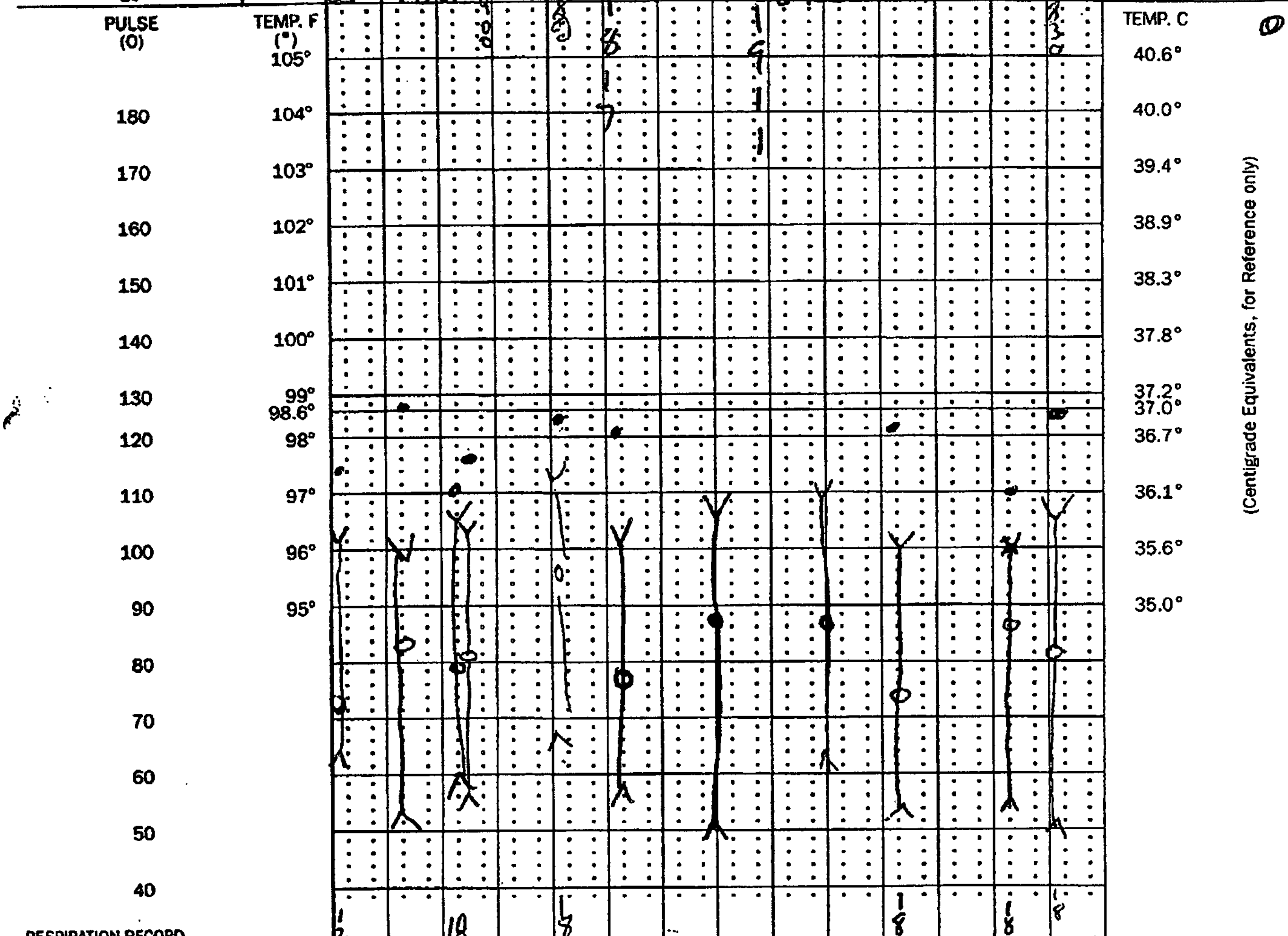
511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY							
POST- DAY							
MONTH-YEAR Sep 03 DAY	18	19	20 Sept	21 Sept	22 Sept	22 Sept	23 Sept 03
19 HOUR	2 18	07 1900	0830	0845 1911	0916	1809	1830



RESPIRATION RECORD 12 18 18 18 18 18

Record special data only when so ordered

BLOOD PRESSURE 102/64 98/54 105/60 113/65 100/51 104/108 100/53 95/55 95/53 105/62

71 83 103/56 102/65 P 84 87 74 T97.4 T97.4

97.3 98.7 79 R 18 R-18 H88 H88

HEIGHT: WEIGHT 0745 93% 95% 96% RA 96% 66 T 97.4 T-97.0 98.1

96% RA 97 97% RA 95% 97.9 96% 95% RA

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*

REGISTER NO.

WARD NO.

[redacted] b6-4

VITAL SIGNS RECORDS

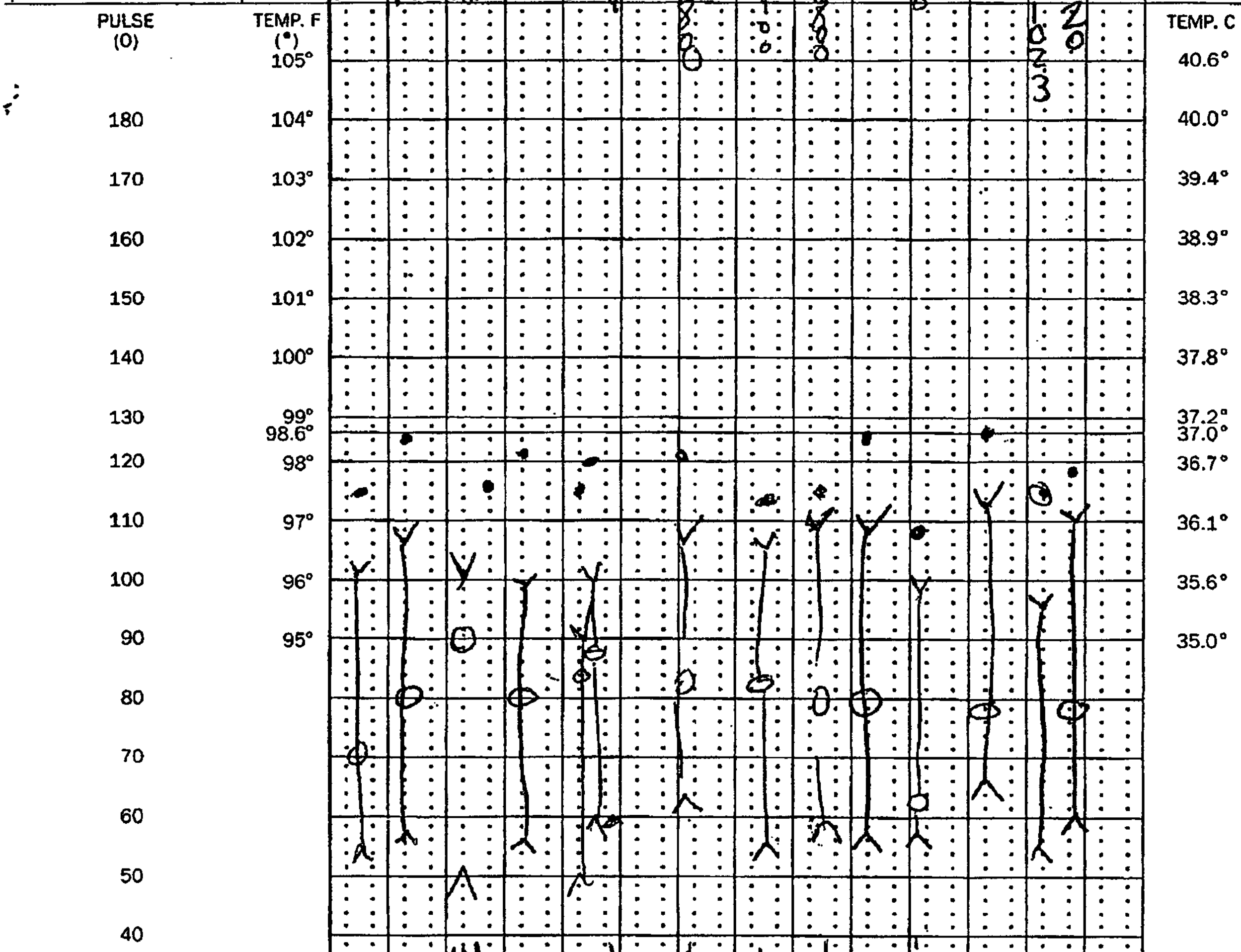
Medical Record

STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

13204

MEDICAL RECORD | **VITAL SIGNS RECORD**

HOSPITAL DAY							
POST- DAY	24 Sep	25 Sept	26 SEP	27 SEP	28 SEP		
MONTH-YEAR DAY						29SEP03	3[illegible]SEP04
19 HOUR	0700 1920	0800 1300	08 1[illegible]	0800 1100	0800	08	1023 20



RESPIRATION RECORD	16	16	101/52	16	16	18		18	18	14		16		
BLOOD PRESSURE	101/55	103/57	P	97/56	90/50					108/57	108/57	113/66	90/55	
	H 70	80	P 91	80	100/60			105/55		80		78		
	T 97.5	98.5	T 97.6						96	98.5		98.6	110/60	
HEIGHT: WEIGHT →	97%	97%					97%	96% RA						
O2 Sat	RA		>90%		93%						96% RA	96%	96%	
			94	96	96% RA					95%			RA	
													96% (RA)	

Record special data only when so ordered

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*

REGISTER NO.

WARD NO.

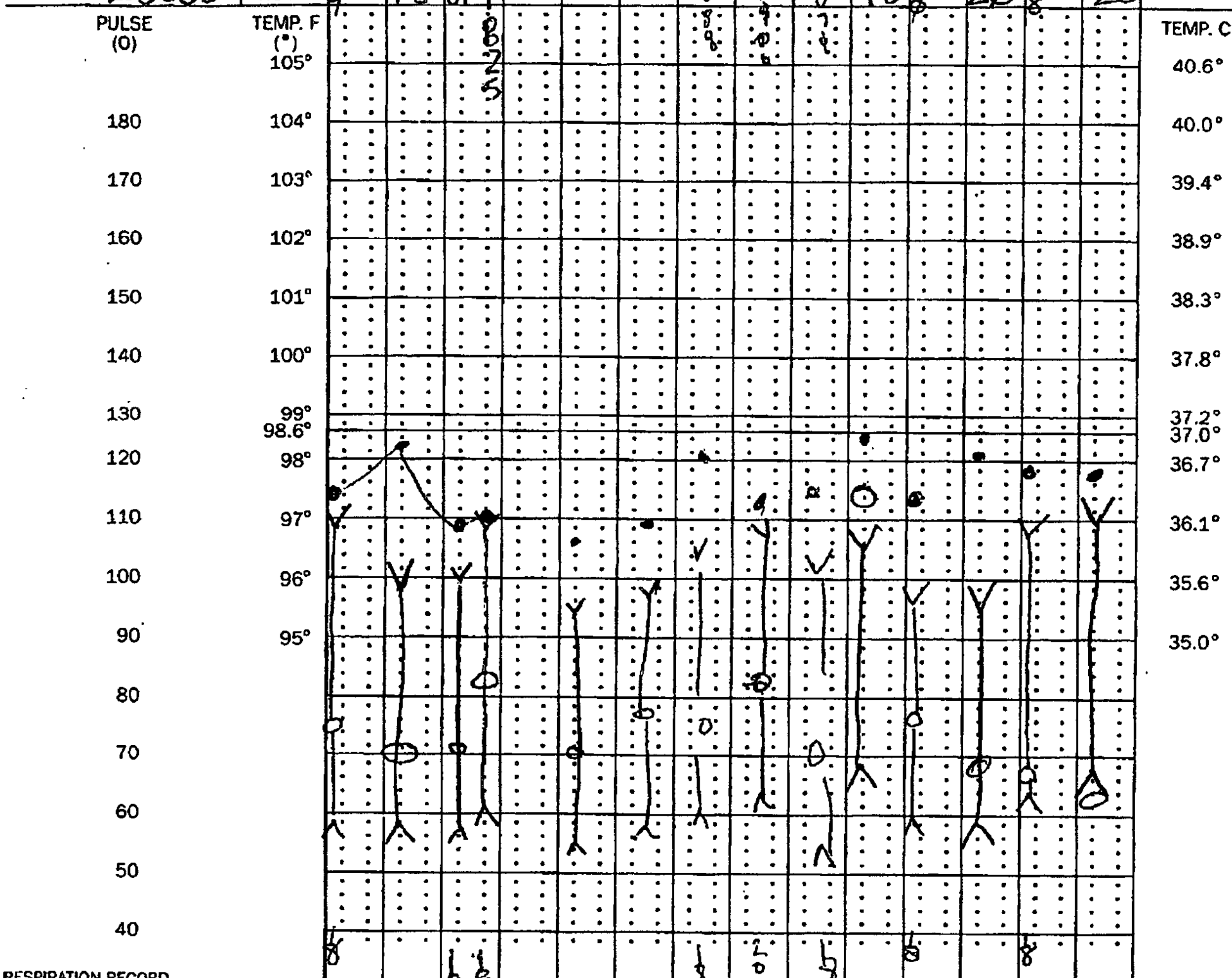
STANDARD FORM 511 (REV. 7-95) **BACK**

#[redacted] 66-4

13205

MEDCOM - 13206

MEDICAL RECORD		VITAL SIGNS RECORD													
HOSPITAL DAY															
POST-	DAY														
MONTH-YEAR OCT	DAY	01		2 OCT		3 Oct 03		4 Oct		5 Oct		6 OCT 03		07 OCT 03	
~~19~~ 2003	HOUR	9	18	09 1825				089	1906	079	18	10	20	08	20



RESPIRATION RECORD	18		18 18				18	20	18		18		18	
BLOOD PRESSURE	108/58	98/58	99/57		95/55					105/68	94/60	105/59	107/64	110/67
		70	108/61		99/67	97/57		109/64		115		68		63
		98^{3}			HR70					98^{9}		98^{2}		97^{8}
HEIGHT: WEIGHT →														
O2 Sat	95(RA)	98%	97%		96%	97%RA	97%	97%RA	98	97%	95(RA)	98%	95(RA)	95%
			LN											
			96% RA											

Record special data only when so ordered

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*

REGISTER NO.

WARD NO.

STANDARD FORM 511 (REV. 7-95) **BACK**

#[redacted] 66-4

13206

NSN 7540-00-634-4124

-119

MEDICAL RECORD

VITAL SIGNS RECORD

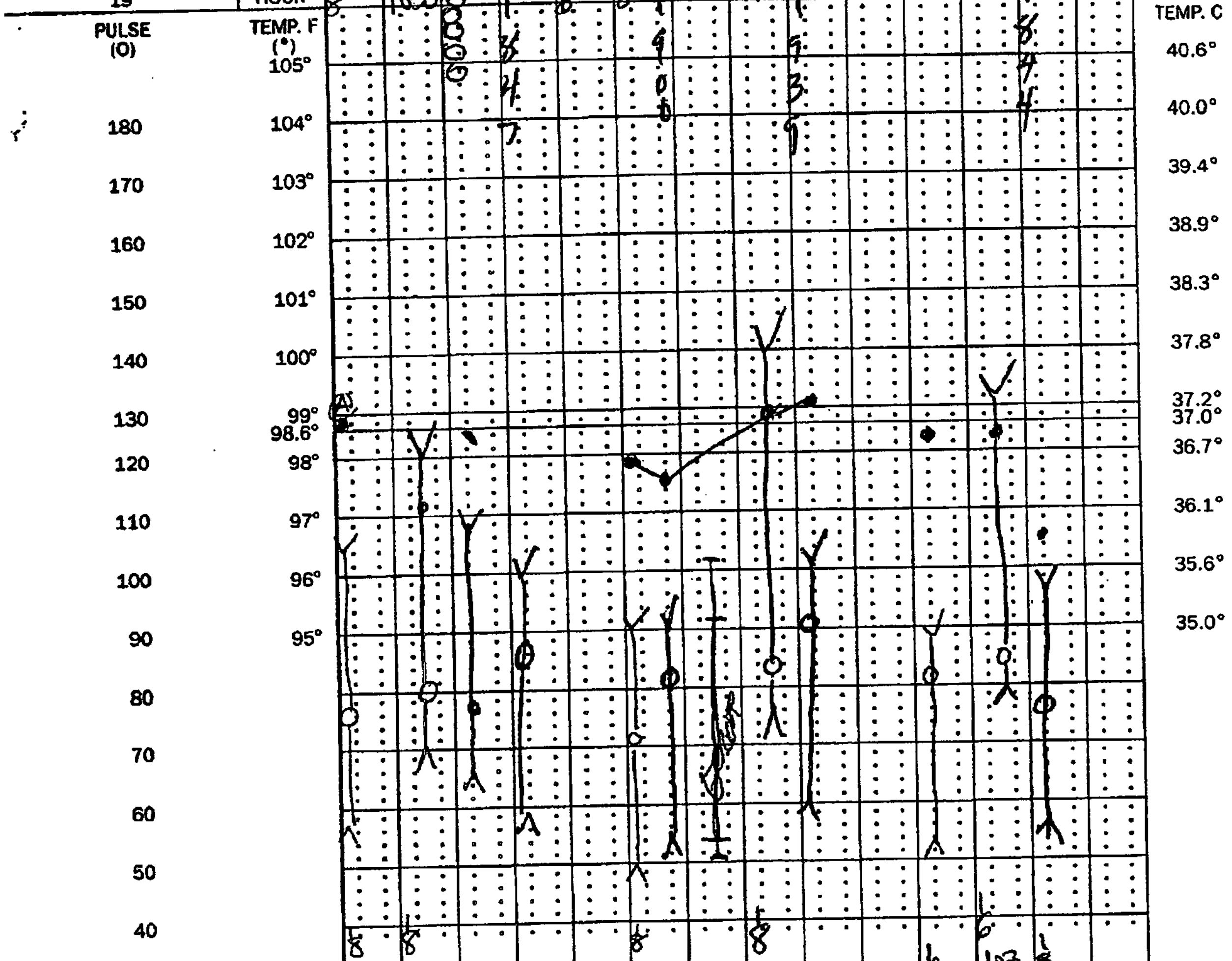
HOSPITAL DAY

POST- DAY

MONTH-YEAR 19

DAY: 07OCT03 | 9Oct | 10 Oct | 11 OCT 03 | 12 oct | 13 oct | 14 Oct 03

HOUR: 8 | 1830 | 0800 | 1834 | 08 | 8 | 1910 | 0700 | 1900 | 1930 | 08 | 1830 | 1844



RESPIRATION RECORD: 18 | 18 | 18 | 18 | 18 | 16 | 18

BLOOD PRESSURE: 104/57 | 103/67 | 117/65 | 100/68 | 90/50 | 92/51 | 111/62 | 103/61 | 88/53 | 103/64 | 102/57 | 96/56

85 | 83 | 92 | T 97.1 | 77

98.3 | 97.7 | 96.1 | H 78 | 96

99.1 | 99.2 | 95% RA

HEIGHT: WEIGHT →

O2 Sat: 96%(RA) | O2 95% RA | 90 90 RA | 93%(RA) | 98% O2 95% RA | 98% RA | O2 98% RA | 95% O2

Record special data only when so ordered

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*

REGISTER NO.

WARD NO.

#[redacted] b6-4

VITAL SIGNS RECORDS

Medical Record

STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

13207

MEDCOM - 13208

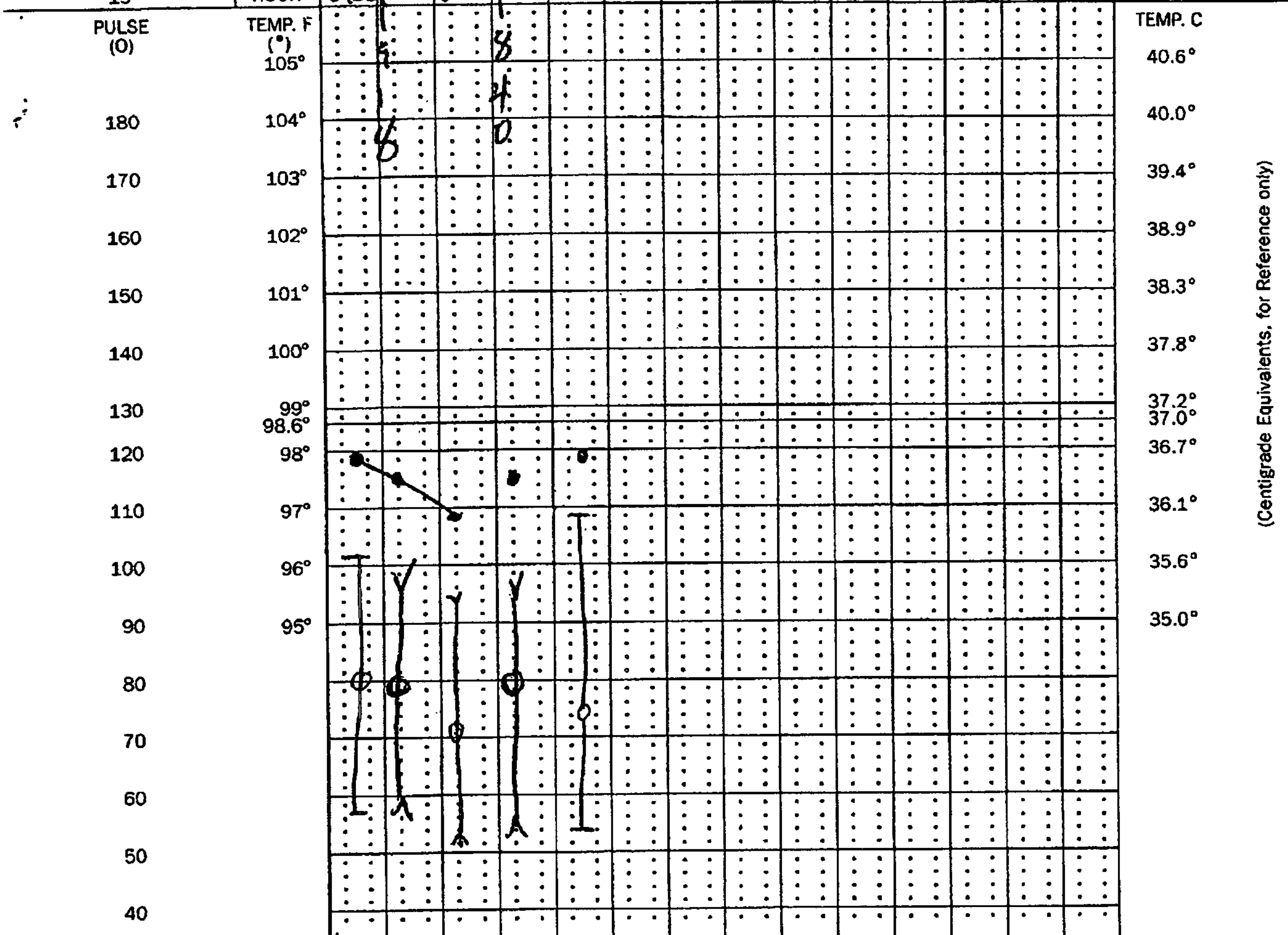
511–119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY			
POST- DAY			
MONTH-YEAR / DAY	15 oct	16 oct	17 oct
19 / HOUR	0700	08	0700



RESPIRATION RECORD	18					
BLOOD PRESSURE	102/57	58/60	99/53	76/55	109/64
	H 80	80	T 96.8	80	70
	T 98	97.4	H 72	97.5	97.9
HEIGHT: / WEIGHT →	98%				97%
	RA	98%	96%	96%	RA

Record special data only when so ordered

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*

REGISTER NO.

WARD NO.

VITAL SIGNS RECORDS

Medical Record

STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

#[redacted] b6-4

13208

Ward/Section: Emt	REQUESTING PHYSICIAN:	**LA RA RY RESULT FORM** l to the Privacy Act of 1974)
LAST, FIRST, MI [redacted] b6-4	DATE 3 Jul 03 / TIME 538	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	8.7	4.8-10.8 x 10^3
RBC	4.03	4.7-6.1 x 10^9
Hgb	12.0	14-18 g/dl (M) 12-16 g/dl (F)
Hct	38.5	42-52% (M) 37-47% (F)
MCV	95.6	80-94 fl (M) 81-99 fl (F)
Plt	290	130-500 x 10^3 verified
Lymph %	.24.2	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis

TEST	RESULT	REF. RANGE
Color	yellow	N/A
App	cloudy	N/A
Glu	Neg	Negative
Bili	Neg	Negative
Ket	80	Negative
SG	1.030	N/A
Bld	LRG	Negative
pH	5.0	N/A
Prot	Neg	Negative
Urob	0.2	0.2-1.0
Nit	Neg	Negative
Leuk	N/T	Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

TNTC RBC
occ WBC
mod EPI-CELL
2+ mucous

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

Coagulation Studies

TEST	RESULT	REF. RANGE
PT	14.1	9.8-13.6 secs
APTT	30.1	21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] b6-2	**DATE:** 3 Jul 03	**LAB ID NO.:**

MEDCOM - 13209

Ward/Section: EMT	'ESTING PHYSICIAN:	**CH 'RY RESULT FORM** (Su the Privacy Act of 1974)
LAST, FIRST, MI [redacted] b6-2	DATE 3Jul03	TIME 938
		SSN/PSEUDO SSN:

(i-STAT)

TEST	*RESULT*	*REF. RANGE*
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/l (art) 24-29 mmol/l (ven)
HCO3		22-26 mmol/l (art) 23-28 mmol/l (ven)
sO2		95-98%
BEecf		(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

(Piccolo) Chemistry 12

TEST	*RESULT*	*REF. RANGE*
ALB	1.5	3.5-5.5 g/dl
ALP	53	26-84 u/l
ALT	39	10-47 u/l
AMY	19	14-97 u/l
AST	36	11-38 u/l
TBIL	0.4	0.2-1.6 mg/dl
BUN	8	7-22 mg/dl
CA^{++}	7.2	8.0-10.3mg/dl
CHOL	115	100-200 mg/dl
CRE	1.0	0.6-1.2 mg/dl
GLU	87	73-118 mg/dl
TP	4.6	6.4-8.1 g/dl

(Piccolo) Metabolic Panel

TEST	*RESULT*	*REF. RANGE*
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	*RESULT*	*REF. RANGE*
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Metlyte 8

TEST	*RESULT*	*REF. RANGE*
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 u/l (M) 30-190 u/l (F)
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

Misc. Chemistry

TEST	*RESULT*	*REF. RANGE*
Troponin-I		Negative
Drug of Abuse		Negative
		Negative
		Negative
		Negative

(Piccolo) Electrolyte

TEST	*RESULT*	*REF. RANGE*
NA^+	138	128-145 mmol/l
K^+	4.4	3.3-4.7 mmol/l
CL^-	110	98-108 mmol/l
tCO_2	13	18-33 mmol/l

REMARKS:

REPORTED BY: [redacted]	**DATE:** 3 Jul 03	**LAB ID NO.:**

b6-2

MEDCOM - 13210

ard Section ICU 3	REQ	PHYSICIAN:	**CHEM Y RESULT FORM** (Subject to the Privacy Act of 1974)
AST, FIRST, MI # [redacted] b6-4	DATE: 4Jul03	TIME 0400	SSN/PSEUDO SSN.

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
		3.5-4.9 mmol/L
l		98-109 mmol/L
H		7.31-7.45
CO2		35-45 mmHg (art) 41-51 mmHg (ven)
O2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
O2		95-98%
BEecf		(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
a		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		Negative
Drug of Abuse		Negative
		Negative
		Negative
		Negative

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA++		8.0-10.3 mg/dl
CHOL		100-300 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU	94	73-118 mg/dl
BUN	8	7-22 mg/dl
CRE	1.0	0.6-1.2 mg/dl
~~CK~~		39-380 u/l (M) 30-190 u/l (F)
NA+	110	128-145 mmol/l
K+	5.2	3.3-4.7 mmol/l
CL	101	98-108 mmol/l
tCO2	25	18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA++		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA+		128-145 mmol/l
K+		3.3-4.7 mmol/l
CL		98-108 mmol/l
tCO2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA		128-145 mmol/l
K+		3.3-4.7 mmol/l
CL		98-108 mmol/l
tCO2		18-33 mmol/l

REMARKS:

REPORTED BY: [redacted]	**DATE:** 4Jul03	**LAB ID NO.:**

b6-2

MEDCOM - 13211

Ward/Section: ICU 3	R[redacted]TING PHYSICIAN: b6-2	**L ATORY RESULT FORM** (S ct to the Privacy Act of 1974)
LAST, FIRST, MI. # [redacted] b6-4	DATE 4 Jul 03	TIME 0400	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	*RESULT*	*REF. RANGE*
WBC	9.0	4.8-10.8 x 10^3
RBC	4.61	4.7-6.1 x 10^6
Hgb	13.6	14-18 g/dl (M) 12-16 g/dl (F)
Hct	44.5	42-52% (M) 37-47% (F)
MCV	96.7	80-94 fl (M) 81-99 fl (F)
Plt	327	130-500 x 10^3 verified
Lymph %	20.7	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Coagulation Studies

TEST	*RESULT*	*REF. RANGE*
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Urinalysis

TEST	*RESULT*	*REF. RANGE*
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	*RESULT*	*REF. RANGE*
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	*TYPE*	*CROSSMATCH*

REMARKS:

REPORTED BY: [redacted]	**DATE:** 4 30 03	**LAB ID NO.:**

b6-2

MEDCOM - 13212

ICU 3

[redacted] b6-4

5JUN08 0648

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	7.0	4.8-10.8 x 10³
RBC	3.88	4.7-6.1 x 10⁶
[illegible]	11.9	14-18 g/dl (M) 12-16 g/dl (F)
[illegible]	37.2	42-52% (M) 37-47% (F)
[illegible]	95.8	80-94 fl (M) 81-99 fl (F)
[illegible]	324	130-500 x 10³ verified
ymph %	33.3	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
ands		Eos	
ymph		Baso	
[illegible]		Imm	
[illegible]			

crit		42-52% (M) 37-47% (F)
d Rate		
ther		

(Urinalysis)

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. R
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negati
H. pylori		Negati
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WI
EVERY UNIT REQUESTE

ABO/Rh

Coagulation Studies

TEST	RESULT	REF. RANGE
T		9.8-13.6 secs
PTT		21-34 secs
dimer		<20 ug/ml
DP		<10 ug/ml

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATC

EMARKS:

EPORTED BY: [redacted] b6-2

DATE: 5Jun0[illegible]

LAB ID NO.:

MEDCOM - 13213

Chemistry Only

Section: ICU3	REQUESTING PHYSICIAN:	**CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)
, FIRST, MI. [redacted] b6-4	DATE 5 JUL 03	TIME 0640
SSN/PSEUDO SSN:		

(i-STAT)

T	RESULT	REF. RANGE
		138-146 mmol/L
		3.5-4.9 mmol/L
		98-109 mmol/L
		7.31-7.45
		35-45 mmHg (art) 41-51 mmHg (ven)
		80-105 mmHg (art) N/A (ven)
		23-27 mmol/L (art) 24-29 mmol/L (ven)
		22-26 mmol/L (art) 23-28 mmol/L (ven)
		95-98%
		(-2) – (+3) mmol/L
		10-20 mmol/L
		1.12-1.32 mmol/L
		8-26 mg/dl
		70-105 mg/dl
		0.7-1.5 mg/dl
		38-51% PCV
		12-17 g/dl

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

(Piccolo) MetLyte 8

TEST	RESULT	REF. RANGE
GLU	102	73-118 mg/dl
BUN		7-22 mg/dl
CRE	0.9	0.6-1.2 mg/dl
CK	410	39-380 u/l (M) 30-190 u/l (F)
NA^+	<110	128-145 mmol/l
K^+	4.1	3.3-4.7 mmol/l
CL^-	100	98-108 mmol/l
tCO_2	27	18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

Misc. Chemistry

T	RESULT	REF. RANGE

(Piccolo) Electrolytes

TEST	RESULT	REF. RANGE
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

ARKS:

RTED BY: [redacted] b6-2

DATE: 5 JUL 03

LAB ID NO.:

MEDCOM - 13214

Chemistry Only

CHEMISTRY RESULT FORM
(Subject to the Privacy Act of 1974)

[illegible]: ICU 3	REQUESTING PHYSICIAN: [redacted] b6-2			
LAST, FIRST, MI: #0 [redacted] b6-4		DATE [illegible]/03	TIME 0400	SSN/PSEUDO SSN: [illegible]

(i-STAT)

TEST	RESULT	REF. RANGE
		138-146 mmol/L
		3.5-4.9 mmol/L
		98-109 mmol/L
		7.31-7.45
		35-45 mmHg (art) 41-51 mmHg (ven)
		30-105 mmHg (art) N/A (ven)
		23-27 mmol/L (art) 24-29 mmol/L (ven)
		22-26 mmol/L (art) 23-28 mmol/L (ven)
		95-98%
		(-2)-(+3) mmol/L
		10-20 mmol/L
		1.12-1.32 mmol/L
		8-26 mg/dl
		70-105 mg/dl
		0.7-1.5 mg/dl
		38-51% PCV
		12-17 g/dl

(Piccolo) [illegible]

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dl
ALP		25-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA++		8.0-10.3 mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

(Piccolo) [illegible]

TEST	RESULT	REF. RANGE
GLU	99	73-118 mg/dl
BUN	9	7-22 mg/dl
CRE	0.6	0.6-1.2 mg/dl
~~CK~~	114	39-380 u/l (M) 30-190 u/l (F)
NA+	115	128-145 mmol/l
K+	3.6	3.3-4.7 mmol/l
CL-	93	98-108 mmol/l
tCO2	27	18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA++		[illegible]
CRE		[illegible]
NA+		128-145 mmol/l
K+		3.3-4.7 mmol/l
CL		98-108 mmol/l
tCO2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dl
ALP		[illegible]
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(i-STAT) Chemistry

TEST	RESULT	REF. RANGE

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA		128-145 mmol/l
K		3.3-4.7 mmol/l
CL		98-108 mmol/l
tCO2		18-33 mmol/l

REMARKS:

TESTED BY: [redacted] DATE: [illegible] LAB ID NO.:

7 Jul 03

b6-4

MEDCOM - 13215

Ward/Section: ICU 3	TESTING PHYSICIAN: [redacted] 66-2	**ORATORY RESULT FORM** (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. #EPW 0[redacted] 66-4	DATE 7/7/03	TIME 0400	SSN/PSEUDO SSN:

(Hematology) CBC			**Urinalysis**			**Misc. Serology**		
TEST	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*
WBC	6.0	4.8-10.8 x 10^3	Color		N/A	RPR		Negative
RBC	3.45	4.7-6.1 x 10^9	App		N/A	Mono		Negative
Hgb	10.4	14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	**Microbiology**		
Hct	32.8	42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV	94.8	80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
Plt	424	130-500 x 10^3 verified	SG		N/A	Occ Bld		Negative
Lymph %	.436	20.5-51.1%	Bld		Negative	H. pylori		Negative
(Hematology) Manual Differential			pH		N/A	Micro Parasites		

Segs		Mono		Prot		Negative	Malaria	
Bands		Eos		Urob		0.2-1.0	O & P	
Lymph		Baso		Nit		Negative	Other	
Atyp		Imm		Leuk		Negative	**Microscopic Urinalysis**	
RBC Morph				HCG		Negative		

Spun Hematocrit		42-52% (M) 37-47% (F)	**CSF**			**Blood Bank**
Sed Rate			Cell Count			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED
Other			Directigen		Negative	ABO/Rh

Coagulation Studies			**Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)**		
TEST	*RESULT*	*REF. RANGE*	*UNIT*	*TYPE*	*CROSSMATCH*
PT		9.8-13.6 secs			
APTT		21-34 secs			
D dimer		<20 ug/ml			
FDP		<10 ug/ml			

REMARKS: 66-2

REPORTED BY: [redacted]	**DATE:** 0-7-7/03	**LAB ID NO.:**

MEDCOM - 13216

Ward/Section: ICU 3

REQUESTING PHYSICIAN: [redacted] b6-2

LABORATORY RESULT FORM
(Subject to the Privacy Act of 1974)

LAST, FIRST, MI: # [redacted] b6-4

DATE: 08 July 03

TIME: 0330

SSN/PSEUDO SSN: EPW 0 [redacted] b6-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	6.1	4.8-10.8 x 10^3
RBC	3.14	4.7-6.1 x 10^6
Hgb	9.3	14-18 g/dl (M) 12-16 g/dl (F)
Hct	30.1	42-52% (M) 37-47% (F)
MCV	95.6	80-94 fl (M) 81-99 fl (F)
Plt	474	130-500 x 10^3 verified
Lymph %	40.8	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh:

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Blood Bank Unit Crossmatch
(MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS: Also - ACT (activated clotting time)

REPORTED BY: [redacted] b6-2

DATE:

LAB ID NO.:

MEDCOM - 13217

Ward/Section: ICU 3

REC NG PHYSICIAN: [redacted] 66-2

CHE RY RESULT FORM
(Subject to the Privacy Act of 1974)

LAST, FIRST, MI: EPW #0 [redacted] 66-4

DATE: 8 Jul 03

TIME: 0330

SSN/PSEUDO: EPW 0 [redacted] 66-4

(i-STAT)

TEST	*RESULT*	*REF. RANGE*
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	*RESULT*	*REF. RANGE*
Troponin-I		Negative
Drug of Abuse		Negative
		Negative
		Negative
		Negative

(Piccolo) Chemistry 12

TEST	*RESULT*	*REF. RANGE*
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA++		8.0-10.3mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

(Piccolo) Metlyte 8

TEST	*RESULT*	*REF. RANGE*
GLU	104	73-118 mg/dl
BUN	7	7-22 mg/dl
CRE	0.7	0.6-1.2 mg/dl
CK	95	39-380 u/l (M) 30-190 u/l (F)
NA+	134	128-145 mmol/l
K+	3.8	3.3-4.7 mmol/l
CL-	98	98-108 mmol/l
tCO2	26	18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	*RESULT*	*REF. RANGE*
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA++		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA+		128-145 mmol/l
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
tCO2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	*RESULT*	*REF. RANGE*
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	*RESULT*	*REF. RANGE*
NA+		128-145 mmol/l
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
tCO2		18-33 mmol/l

REMARKS:

66-2

REPORTED BY: [redacted]

DATE:

LAB ID NO.:

MEDCOM - 13218

ICU#3 #0 86

#0 [redacted] b6-4

12/19/03 | 0402 |

(Hematology) CBC

TEST	RESULT	REF. RANGE
[illegible]	(6.4) 7.4	4.8-10.8 x 10^3
[illegible]	(3.4) 3.21	4.7-6.1 x 10^6
[illegible]	(9.3) 9.5	14-18 g/dl (M) 12-16 g/dl (F)
[illegible]	(30.1) 31.0	42-52% (M) 37-47% (F)
[illegible]	(95.6) 96.6	80-94 fl (M) 81-99 fl (F)
[illegible]	(474) 603	130-400 x 10^3 verified
[illegible]	(40.8) 39.2	20.5-51.1%

(Hematology) Manual Differential

[illegible]		Mono	
[illegible]		Eos	
[illegible]		Baso	
		Imm	
[illegible]		42-52% (M) 37-47% (F)	
[illegible]			
[illegible]			

Coagulation Studies

TEST	RESULT	REF. RANGE
		9.8-13.6 secs
		21-34 secs
[illegible]		<20 ug/ml
		<10 ug/ml

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc Serology

TEST	RESULT	REF. RA
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WIT EVERY UNIT REQUESTED

ABO/Rh

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] | DATE: | LAB ID NO

b6-2

MEDCOM - 13219

1113 #0[redacted] b6-4

Chemistry Only

rd/Section: Ward ICU3	REQUESTING PHYSICIAN: [redacted] b6-2	**CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)
ST, FIRST, MI. #0[redacted] b6-4	DATE 7/9/03	TIME 0400
SSN/PSEUDO SSN:		

( ) STAT

EST	RESULT	REF. RANGE
		138-146 mmol/L
		3.5-4.9 mmol/L
		98-109 mmol/L
		7.31-7.45
O2		35-45 mmHg (art) 41-51 mmHg (ven)
2		80-105 mmHg (art) N/A (ven)
'O2		23-27 mmol/L (art) 24-29 mmol/L (ven)
O3		22-26 mmol/L (art) 23-28 mmol/L (ven)
2		95-98%
ecf		(-2) – (+3) mmol/L
Gap		10-20 mmol/L
		1.12-1.32 mmol/L
IN		8-26 mg/dl
U		70-105 mg/dl
ar		0.7-1.5 mg/dl
t		38-51% PCV
b		12-17 g/dl

Misc Chemistry

EST	RESULT	REF. RANGE
ponin-I		
ig of use		

(Piccolo) Chemistry 13

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA⁺⁺		8.0-10.3mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

[illegible]

TEST	RESULT	REF. RANGE
GLU (104)	137	73-118 mg/dl
BUN (7)	11	7-22 mg/dl
CRE (0.7)	0.5	0.6-1.2 mg/dl
CK (95)	74	39-380 u/l (M) 30-190 u/l (F)
NA⁺ (134)	~~1~~ 132	128-145 mmol/l
K⁺ (3.8)	4.0	3.3-4.7 mmol/l
CL⁻ (98)	97	98-108 mmol/l
tCO₂ (26)	27	18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA⁺⁺		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA⁺		128-145 mmol/l
K⁺		3.3-4.7 mmol/l
CL⁻		98-108 mmol/l
tCO₂		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA⁺		128-145 mmol/l
K⁺		3.3-4.7 mmol/l
CL⁻		98-108 mmol/l
tCO₂		18-33 mmol/l

MARKS: [redacted] b6-2

MEDCOM - 13220

post xfsn CBC
2U PRBC OR, 2U PRBC - ICU 3

Ward/Section: ICU 3	REQUESTING PHYS Dr [redacted] 66-2	**LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] 66-4	[redacted]E	TIME
		SSN/PSEUDO SSN:

```
ID: 000[redacted]   66-4        10-07-03
WB                                14:42
                                Patient
                                 Limits
WBC   12.9 H  x10^3/uL         4.5  10.5
RBC   3.71 L  x10^6/uL        4.00  6.00
Hgb   10.5 L  g/dL            11.0  18.0
Hct   34.5 L  %               35.0  60.0
MCV   93.2    fL              80.0  99.9
MCH   28.6    pg              27.0  31.0
MCHC  30.7 L  g/dL            33.0  37.0
Plt   537. H  x10^3/uL        150.  450.
LY%   16.6 *L %               20.5  51.1
LY#    2.1 *  x10^3/uL         1.2   3.4
```

l
S
B:
Ly
At
RB
Mo:

Urinalysis		
TEST	*RESULT*	*REF. RANGE*
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
CG		Negative

Misc. Serology		
TEST	*RESULT*	*REF. RANGE*
RPR		Negative
Mono		Negative

Microbiology		
Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

CSF		
Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies		
TEST	*RESULT*	*REF. RANGE*
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Blood Bank Unit Crossmatch
(MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	*TYPE*	*CROSSMATCH*

REMARKS:

MEDCOM - 13221

Ward/Section: ICU 3	REQUES[redacted]: b6-2	**LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. #[redacted] b6-4	DATE 10 July 2003	TIME 0350	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESU
l	
L	
Se	
Ba	
Lyı	
Atyı	
RBC Morp	
Spun Hemat	
Sed Rat	
Other	

```
ID: 00[redacted]   b6-4          10-07-03
WB                                  03:51
                              Patient
                               Limits
WBC    7.7    x10^3/uL         4.5  10.5
RBC   2.92 L  x10^6/uL        4.00  6.00
Hgb    8.7 L  g/dL            11.0  18.0
Hct   28.2 L  %               35.0  60.0
MCV   96.6    fL              80.0  99.9
MCH   29.7    pg              27.0  31.0
MCHC  30.7 L  g/dL            33.0  37.0
Plt   642.  H x10^3/uL        150.  450.
LY%   33.3    %               20.5  51.1
LY#    2.6    x10^3/uL         1.2   3.4
```

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
rot		Negative
rob		0.2-1.0
it		Negative
uk		Negative
G		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS: [redacted] 10 July 03

b6-2

MEDCOM - 13222

Ward Section: ICU 3

REQ.

G PHYSICIAN: [redacted] b6-2

CHE. . RY RESULT FORM

(Subject to the Privacy Act of 1974)

LAST, FIRST, MI [redacted] b6-4

DATE 10Jul03

TIME 0350

SSN/PSEUDO SSN:

(i-ST

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/l
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		Negative
Drug of Abuse		Negative
		Negative
		Negative
		Negative

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA⁺⁺		8.0-10.3 mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU	122	73-118 mg/dl
BUN	10	7-22 mg/dl
CRE	0.9	0.6-1.2 mg/dl
CK	88	39-380 u/l (M) 30-190 u/l (F)
NA⁺	129	128-145 mmol/l
K⁺	3.9	3.3-4.7 mmol/l
CL⁻	96	98-108 mmol/l
tCO₂	28	18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA⁺⁺		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA⁺		128-145 mmol/l
K⁺		3.3-4.7 mmol/l
CL		98-108 mmol/l
tCO₂		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA		128-145 mmol/l
K⁺		3.3-4.7 mmol/l
CL⁻		98-108 mmol/l
tCO₂		18-33 mmol/l

REMARKS:

REPORTED BY: [redacted] b6-2

DATE: 10Jul03

LAB ID NO.:

MEDCOM - 13223

LABORATORY RESULT FORM
(Subject to the Privacy Act of 1974)

Ward/Section: 1113

REQUESTING PHYSICIAN: [redacted] b6-2

LAST, FIRST, MI. b6-4 [redacted]

DATE 11 July

TIME 0445

SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	9.2	4.8-10.8 x 10^3
RBC	3.29	4.7-6.1 x 10^6
Hgb	9.7	14-18 g/dl (M) 12-16 g/dl (F)
Hct	30.5	42-52% (M) 37-47% (F)
MCV	92.7	80-94 fl (M) 81-99 fl (F)
Plt	539	130-500 x 10^3 verified
Lymph %	26.8	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

Blood Bank Unit Crossmatch
(MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

Chemistry Only

CHEMISTRY RESULT FORM
(Subject to the Privacy Act of 1974)

Ward/Section: ICU3

REQUESTING PHYSICIAN: [redacted] b6-2

LAST, FIRST, MI. [redacted] b6-4

DATE 11 Jul 4

TIME 0445

SSN/PSEUDO SSN:

i-STAT

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

(Piccolo) [illegible]

TEST	RESULT	REF. RANGE
GLU	148	73-118 mg/dl
BUN	13	7-22 mg/dl
CRE	0.7	0.6-1.2 mg/dl
CK	115	39-380 u/l (M) 30-190 u/l (F)
NA^+	129	128-145 mmol/l
K^+	3.9	3.3-4.7 mmol/l
CL^-	95	98-108 mmol/l
tCO_2	28	18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

REMARKS:

MEDCOM - 13225

Chemistry Only

Ward/Section: ICU3

REQUESTING PHYSICIAN: [redacted] 66-2

CHEMISTRY RESULT FORM
(Subject to the Privacy Act of 1974)

LAST, FIRST, MI. [redacted] 66-4

DATE 11 Jul 4

TIME 0445

SSN/PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Crea		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA⁺⁺		8.0-10.3mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

[illegible]

TEST	RESULT	REF. RANGE
GLU	148	73-118 mg/dl
BUN	13	7-22 mg/dl
CRE	0.7	0.6-1.2 mg/dl
CK	115	39-380 u/l (M) 30-190 u/l (F)
NA⁺	129	128-145 mmol/l
K⁺	3.9	3.3-4.7 mmol/l
CL⁻	95	98-108 mmol/l
tCO₂	28	18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA⁺⁺		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA⁺		128-145 mmol/l
K⁺		3.3-4.7 mmol/l
CL⁻		98-108 mmol/l
tCO₂		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolytes

TEST	RESULT	REF. RANGE
NA⁺		128-145 mmol/l
K⁺		3.3-4.7 mmol/l
CL⁻		98-108 mmol/l
tCO₂		18-33 mmol/l

REMARKS:

MEDCOM - 13226

ICU 3 EPW [redacted] b6-4 12 July 03 0400

(Hematology) CBC

TEST	RESULT	REF. RANGE
		4.8-10.8 x 10^3
		4.7-6.1 x 10^6
		14-18 g/dl (M) 12-16 g/dl (F)
		42-52% (M) 37-47% (F)
		80-94 fl (M) 81-99 fl (F)
		130-500 x 10^3 verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

		Mor

[redacted] b6-4

```
ID: 00[redacted]                  12-07-03
ZB:                                  03:33
                                   Patient
                                    Limits
WBC     7.2    x10^3/uL       4.5   10.5
RBC    3.06 L  x10^6/uL      4.00   6.00
Hgb     9.0 L  g/dL          11.0   18.0
Hct    28.4 L  %             35.0   60.0
MCV    93.0    fL            80.0   99.9
MCH    29.4    pg            27.0   31.0
MCHC   31.7 L  g/dL          33.0   37.0
Plt    583.  H x10^3/uL      150.   450.
LY%    32.4    %             20.5   51.1
LY#     2.3    x10^3/uL       1.2    3.4
```

b6-4

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
		0.2-1.0
		Negative
		Negative
		Negative

Misc Serology

TEST	RESULT	REF. R
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negati
H. pylori		Negati
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

CSF

tigen		Negative

Blood Bank

MUST SUBMIT SF 518 WIT EVERY UNIT REQUESTE

ABO/Rh

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATC

TEST	R	
		21-34 secs
dimer		<250 ng ml
		<10 ug ml

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

MEDCOM - 13227

Chemistry Only

/Section: ICU 3	REQUESTING PHYSICIAN:	**CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)

, FIRST, MI. 0[redacted] 66-4	DATE 12Jul03	TIME 0400	SSN/PSEUDO SSN: 0[redacted] 66-4

(i-STAT)

ST	RESULT	REF. RANGE
		138-146 mmol/L
		3.5-4.9 mmol/L
		98-109 mmol/L
		7.31-7.45
2		35-45 mmHg (art) 41-51 mmHg (ven)
		80-105 mmHg (art) N/A (ven)
2		23-27 mmol/L (art) 24-29 mmol/L (ven)
3		22-26 mmol/L (art) 23-28 mmol/L (ven)
		95-98%
f		(-2) - (+3) mmol/L
ap		10-20 mmol/L
		1.12-1.32 mmol/L
		8-26 mg/dl
		70-105 mg/dl
		0.7-1.5 mg/dl
		38-51% PCV
		12-17 g/dl

Misc Chemistry

T	RESULT	REF. RANGE
in-1		
of e		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

(Piccolo) MetLyte

TEST	RESULT	REF. RANGE
GLU	125	73-118 mg/dl
BUN	11	7-22 mg/dl
CRE	0.9	0.6-1.2 mg/dl
CK	137	39-380 u/l (M) 30-190 u/l (F)
NA^+	128	128-145 mmol/l
K^+	3.5	3.3-4.7 mmol/l
CL^-	95	98-108 mmol/l
tCO_2	29	18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

ARKS:

[redacted] 66-2
12Jul03

MEDCOM - 13228

0200-0800 off } 8° off
0800-1000 drsg Δ }

112
16) 1800
16
20
16
40
48

1000
800
550
250

Ward/Section: ICU3	R[redacted]ICIAN: b6-2	L ORY RESULT FORM (S ect to the Privacy Act of 1974)

LAST, FIRST, MI. [redacted] b6-4	DATE 13JUL	TIME 0335	SSN/PSEUDO SSN:

b6-4

```
ID: 000[redacted]                    13-07-03
WB                                  04:00
                                 Patient
                                  Limits
WBC    6.7    x10^3/uL     4.5  10.5
RBC   2.99 L  x10^6/uL    4.00  6.00
Hgb    6.7 L  g/dL        11.0  18.0
Hct   26.2 L  %           35.0  60.0
MCV   94.3    fL          80.0  99.9
MCH   29.2    pg          27.0  31.0
MCHC  30.9 L  g/dL        33.0  37.0
Plt   674.  H x10^3/uL    150.  450.
LY%   29.3    %           20.5  51.1
LY#    2.0    x10^3/uL     1.2   3.4
```

CBC

REF. RANGE
.8-10.8 x 10³
.7-6.1 x 10⁹
4-18 g/dl (M) 2-16 g/dl (F)
2-52% (M) 7-47% (F)
0-94 fl (M) 1-99 fl (F)
30-500 x 10³ erified
0.5-51.1%

Differential

o	

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted]	**DATE:** 13Jul03	**LAB ID NO.:**

b6-2

MEDCOM - 13230

Ward/Section: ICU3	REQ...	...ING PHYSICIAN: [redacted] b6-2	...HEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] b6-4	DATE 13JUL	TIME 0335	SSN/PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

```
======= PICCOLO =======
13/07/03           04:12
REFERENCE RANGE:     MALE
PATIENT #: [redacted] b6-4
GENERAL CHEMISTRY 12
DISC LOT #:       3082AA4
OPER #: 678     DR #: 000
SERIAL #:      0000100697
.........................
ALB   1.5*  3.3-5.5   G/DL
ALP   109*  26-84     U/L
ALT   137*  10-47     U/L
AMY    91   14-97     U/L
AST   141*  11-38     U/L
TBIL  0.6   0.2-1.6  MG/DL
BUN   ***   7-22     MG/DL
CA++  7.4*  8.0-10.3 MG/DL
CHOL  136   100-200  MG/DL
CRE   1.0   0.6-1.2  MG/DL
GLU   126*  73-118   MG/DL
TP    4.8*  6.4-8.1   G/DL

INST QC: OK    CHEM QC: OK
HEM 0 ,  LIP 0 ,  ICT 0
```

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA++		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA+		128-145 mmol/l
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
tCO$_2$		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		Negative
Drug of Abuse		Negative
		Negative
		Negative
		Negative

		A)
		)
		ol/l
K		...ol/l
CL-		98-108 mmol/l
tCO$_2$		18-33 mmol/l
BUN	7	

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA+	132	128-145 mmol/l
K+	3.2	3.3-4.7 mmol/l
CL-	97	98-108 mmol/l
tCO$_2$	31	18-33 mmol/l

REMARKS:

REPORTED BY: [redacted]	**DATE:**	**LAB ID NO.:**

b6-2

MEDCOM - 13231

555 70 1481

555 1841 7250 909
1484
1481

Chemistry Only

CHEMISTRY RESULT FORM
(Subject to the Privacy Act of 1974)

Ward/Section: ICU3

REQUESTING PHYSICIAN: [redacted] b6-2

LAST, FIRST, MI. [redacted] b6-4

DATE 14JUL

TIME 0300

SSN/PSEUDO SSN:

i-STAT

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Crear		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

REMARKS: [redacted] 14Jul03 b6-2

Piccolo Chemistry

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l

```
======= PICCOLO =======
14/07/03                03:08
REFERENCE RANGE:         MALE
PATIENT #: [redacted]  b6-4
METLYTE 8
DISC LOT #:           3141A44
OPER #: 678         DR #: 000
SERIAL #:          0000100676
.............................
GLU   102   73-113   MG/DL
BUN     7   7-22     MG/DL
CRE   0.6   0.6-1.2  MG/DL
CK     84   39-380     U/L
NA+   ♦♦♦   128-145  MMOL/L
K+    3.6   3.3-4.7  MMOL/L
CL-    98   38-108   MMOL/L
tCO2   25   18-33    MMOL/L

INST QC: OK     CHEM QC: OK
HEM 0 ,  LIP 0 ,  ICT 0
```

Na 133mm/L

Piccolo Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
A^{++}		8.0-10.3 mg/dl
RE		0.6-1.2 mg/dl
A^{+}		128-145 mmol/l
$^{+}$		3.3-4.7 mmol/l
L^{-}		98-108 mmol/l
CO$_2$		18-33 mmol/l

Piccolo Liver Panel Plus

TEST	RESULT	REF. RANGE
LB		3.3-5.5 g/dl
LP		26-84 u/l
LT		10-47 u/l
MY		14-97 u/l
ST		11-38 u/l
BIL		0.2-1.6 mg/dl
GT		5-65 u/l
P		6.4-8.1 g/dl

Piccolo Electrolyte

TEST	RESULT	REF. RANGE
A^{+}		128-145 mmol/l
$^{+}$		3.3-4.7 mmol/l
L^{-}		98-108 mmol/l
CO$_2$		18-33 mmol/l

MEDCOM - 13233

RATORY RESULT FORM
(Subject to the Privacy Act of 1974)

Ward/Section: ICU3
TESTING PHYSICIAN: [redacted] b6-2
LAST, FIRST, MI. [redacted] b6-4
DATE 14JUL
TIME 0300
SSN/PSEUDO SSN:

```
ID: 000[redacted] b6-4
WB
                          14-07-03
                             03:13
                           Patient
                            Limits
WBC    6.0    x10^3/uL    4.5  10.5
RBC    2.95 L x10^6/uL    4.00 6.00
Hgb    8.7 L  g/dL        11.0 18.0
Hct    27.8 L %           35.0 60.0
MCV    94.4   fL          80.0 99.9
MCH    29.4   Pg          27.0 31.0
MCHC   31.1 L g/dL        33.0 37.0
Plt    752. H x10^3/uL    150. 450.
LY%    32.1   %           20.5 51.1
LY#    2.6    x10^3/uL    1.2  3.4
```

(Hematology) CBC

TEST	RESULT	REF. RANGE
		4.8-10.8 x 10^3
		4.7-6.1 x 10^9
		14-18 g/dl (M) 12-16 g/dl (F)
		42-52% (M) 37-47% (F)
		80-94 fl (M) 81-99 fl (F)
		130-500 x 10^3 verified
		20.5-51.1%

al Differential

Mono	
Eos	
Baso	
Imm	

		42-52% (M) 37-47% (F)
Other		

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: **DATE:** **LAB ID NO.:**

MEDCOM - 13234

b6-4

```
ID: 00[redacted]                     15-07-03
WB                                      03:44
                                      Patient
                                       Limits
WBC    7.3     x10^3/uL     4.5  10.5
RBC    2.97 L  x10^6/uL     4.00  6.00
Hgb    8.6 L   g/dL        11.0  18.0
Hct   26.5 L   %           35.0  60.0
MCV   96.1     fL           80.0  99.9
MCH   29.1     pg          27.0  31.0
MCHC  30.3 L   g/dL        33.0  37.0
Plt   909.   H x10^3/uL    150.  450.
LY%   26.0     %            20.5  51.1
LY#    1.9     x10^3/uL     1.2   3.4
```

```
-------------------------------
i-STAT EC8+

Pt. [redacted]
Pt Name:___________

Glu________118 mg/dL
BUN_________11 mg/dL
Na_________139 mmol/L
K__________4.1 mmol/L
Cl__________97 mmol/L
TCO2________31 mmol/L
AnGap________9 mmol/L
Hct_________25 %PCV
Hb*__________9 g/dL
  *via Hct
pH_______7.414
PCO2______46.4 mmHg
HCO3________30 mmol/L
BEecf________5 mmol/L

Sample Type_

  15JUL03     03:44

Oper: 1676

Physician:____________

Cart# 40763
Ver: JAMS0464
     CLEW A08

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```

Ward/Section: / 3

.STING [redacted] b6-2

L. A1ORY RESULT FORM
(Su.,ject to the Privacy Act of 1974)

DATE	TIME	SSN/PSEUDO SSN:
15 July 03	0915	

[redacted] b6-4

15-0?45
09127
Patient
Limits

[illegible]	[illegible]	x10^3/uL	4.5	10.5
[illegible]	[illegible]	x10^6/uL	4.?0	6.00
[illegible]	[illegible]	g/dL	11.0	18.0
[illegible]	[illegible]	%	35.0	60.0
[illegible]	[illegible]	fL	80.0	99.9
[illegible]	[illegible]	pg	27.0	31.0
[illegible]	[illegible]	g/dL	33.0	37.0
[illegible]	[illegible]	x10^3/uL	150.	450.
[illegible]	[illegible]	%	20.5	51.1
[illegible]	[illegible]	x10^3/uL	1.2	3.4

CBC

REF. RANGE
4.8-10.8 x 10³
4.7-6 1 x 10⁶
14-18 g/dl (M) 12-16 g/dl (F)
42-52% (M) 37-47% (F)
80-94 fl (M) 81-99 fl (F)
130-500 x 10³ verified
20.5-51.1%

al Differential

ono	
s	
iso	
m	
Morph	

Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
[redacted]	15 JUL 03	

b6-2

[redacted] b6-4

MEDCOM - 13236

Ward/Section: ICU3	REC	NG PHYSICIAN: [redacted] b6-4	LAB((Sub) … RESULT FORM the Privacy Act of 1974)
LAST, FIRST, MI. H [redacted]	DATE 16 July	TIME 0410	SSN/PSEUDO SSN:

(Hematology) CBC

~~TEST~~	~~RESULT~~	~~REF. RANGE~~
~~WBC~~		4.8-10.8 x 10³
RBC		

```
ID: 0X[redacted]   b6-4          16-07-03
WB                                  04:24
                                 Patient
                                  Limits
WBC    8.3     x10^3/uL     4.5   10.5
RBC    3.12 L  x10^6/uL     4.00  6.00
Hgb    9.1 L   g/dL        11.0  18.0
Hct   29.3 L   %           35.0  60.0
MCV   93.7     fL          80.0  99.9
MCH   29.3     pg          27.0  31.0
MCHC  31.2 L   g/dL        32.0  37.0
Plt   829.  H  x10^3/uL   150.   450.
LY%   26.4     %           20.5  51.1
LY#    2.2     x10^3/uL     1.2   3.4
```

Other	

b6-4 Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	**DATE:**	**LAB ID NO.:**

1643

i-STAT EC8+

Pt: [redacted] b6-4

Pt Name:____________

Glu__________176 mg/dL
BUN__________11 mg/dL
Na__________132 mmol/L
K__________4.1 mmol/L
Cl__________96 mmol/L
TCO2________38 mmol/L
AnGap________0 mmol/L
Hct__________23 %PCV
Hb*__________8 g/dL
[illegible]
PH_______7.449
PCO2_______41.6 mmHg
HCO3__________[illegible] mmol/L
BEecf________[illegible] mmol/L

Sample Type_

16JUL03 04:28

Oper. [redacted] b6-2

Physician:____________

Ser# 40763
Ver# JAMS046A
CLEW A93

REQU PHYSICIAN [redacted] b6-? | CHEM Y RESULT FORM (Subjec to the Privacy Act of 1974)

[redacted] b6-4 | DATE: 16 Jul | TIME: 0410 | SSN/PSEUDO SSN:

	(Piccolo) Chemistry 12			(Piccolo) Metabolic Panel		
RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
10 mmol/L	ALB		3.5-5.5 g/dl	GLU		73-118 mg/dl
) mmol/l	ALP		26-84 u/l	BUN		7-22 mg/dl
9 mmol/L	ALT		10-47 u/l	CA^{++}		8.0-10.3 mg/dl
.45	AMY		14-97 u/l	CRE		0.6-1.2 mg/dl
mmHg (art) mmHg (ven)	AST		11-38 u/l	NA$^+$		128-145 mmol/l
5 mmHg (art) (ven)	TBIL		0.2-1.6 mg/dl	K$^+$		3.3-4.7 mmol/l
mmol/l (art) mmol/l (ven)	BUN		7-22 mg/dl	CL$^-$		98-108 mmol/l
mmol/l (art) mmol/l (ven)	CA^{++}		8.0-10.3mg/dl	tCO$_2$		18-33 mmol/l
8%	CHOL		100-200 mg/dl	(Piccolo) Liver Panel Plus		
(-3) mEq/L	CRE		0.6-1.2 mg/dl	TEST	RESULT	REF. RANGE
30 mmol/L	GLU		73-118 mg/dl	ALB		3.3-5.5 g/dl
5-132 mmol/L	TP		6.4-8.1 g/dl	ALP		26-84 u/l
5 mg/dl	(Piccolo) Metlyte 8			ALT		10-47 u/l
105 mg/dl	TEST	RESULT	REF. RANGE	AMY		14-97 u/l
-1.5 mg/dl	GLU		73-118 mg/dl	AST		11-38 u/l
51% PCV	BUN		7-22 mg/dl	TBIL		0.2-1.6 mg/dl
-17 g/dl	CRE		0.6-1.2 mg/dl	GGT		5-65 u/l
iry	CK		39-380 u/l (M) 30-190 u/l (F)	TP		6.4-8.1 g/dl
EF. RANGE	NA$^+$		128-145 mmol/l	(Piccolo) Electrolyte		
egative	K$^+$		3.3-4.7 mmol/l	TEST	RESULT	REF. RANGE
legative	CL$^-$		98-108 mmol/l	NA		128-145 mmol/l
legative	tCO$_2$		18-33 mmol/l	K$^+$		3.3-4.7 mmol/l
Negative				CL$^-$		98-108 mmol/l
Negative				tCO$_2$		18-33 mmol/l

REMARKS:

REPORTED BY: [redacted] b6-2

DATE:

LAB ID NO.:

MEDCOM - 13238

Ward/Section: ICU3

REQ:

IG PHYSICIAN: [redacted] b6-2

CHE. RY RESULT FORM

(Subj... the Privacy Act of 1974)

LAST, FIRST, MI: [redacted] b6-4

DATE: ,

TIME: 45

SSN/PSEUDO SSN: [redacted] b6-4

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		Negative
Drug of Abuse		Negative
		Negative
		Negative
		Negative

G

B

Cl

Ck

NA

K

CL

ICO

i-STAT EC8+

Pt: [redacted] b6-4

Pt Name:____________

Glu__(176)__112 mg/dL

BUN__(11)___15 mg/dL

Na__(132)__130 mmol/L

K__(4.1)__4.1 mmol/L

Cl__(98)___100 mmol/L

TCO2_________30 mmol/L

AnGap(10)_____ mmol/L

Hct_________24 %PCV

Hb*__________8 g/dL

*via Hct

pH_______7.423

PCO2______43.2 mmHg

HCO3________28 mmol/L

BEecf________4 mmol/L

Sample Type_:

17JUL03 03:53

Oper: [redacted] b6-2

Physician:_____________

Ser# 40763

Ver: JAMS046A
CLEW A93

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA⁺⁺		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA⁺		128-145 mmol/l
K⁺		3.3-4.7 mmol/l
CL⁻		98-108 mmol/l
CO_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
LB		3.3-5.5 g/dl
P		26-84 u/l
T		10-47 u/l
IY		14-97 u/l
T		11-38 u/l
L		0.2-1.6 mg/dl
T		5-65 u/l
		6.4-8.1 g/dl

(Piccolo) Electrolyte

T	RESULT	REF. RANGE
		128-145 mmol/l
		3.3-4.7 mmol/l
		98-108 mmol/l
		18-33 mmol/l

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
[redacted] b6-2	17Jul03	

Ward/Section: ICW3	REQ	~~G~~ PHYSICIAN: Dr [redacted] b6-2	**LAB~~ORATORY~~ RESULT FORM** (Subj~~ect to~~ the Privacy Act of 1974)
LAST, FIRST, MI.	DATE 17Jul03	TIME 0348	SSN/PSEUDO SSN: [redacted] b6-4

```
ID: [redacted]   b6-4
                              17-07-03
                                 03:55
                               Patient
WBC   8.0     x10^3/uL 8.3      Limits
RBC   3.10 L  x10^6/uL 3.12   4.5  10.5
Hgb   9.1 L   g/dL  9.1     4.00  6.00
Hct   28.5 L  %     29.3    11.0  16.0
MCV   94.9    fL    93.1    35.0  60.0
MCH   29.3    pg    29.3    80.0  99.9
MCHC  30.9 L  g/dL  31.2    27.0  31.0
Plt   900. H  x10^3/uL 829  33.0  37.0
LY%   37.7    %     20.1    150.  450.
LY#   3.0           20.5  51.1
              x10^3/uL  1.2   3.4
                1.2
```

Spun Hematocrit		42-5.. (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Blood Bank Unit Crossmatch
(MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted]	**DATE:**	**LAB ID NO.:**

b6-4

```
i-STAT EC8+

Pt:[redacted]  66-4

Pt Name:____________

Glu________141 mg/dL
BUN_________13 mg/dL
Na_________133 mmol/L
K__________4.2 mmol/L
Cl_________102 mmol/L
TCO2________26 mmol/L
AnGap_______11 mmol/L
Hct_________28 %PCV
Hb*_________10 g/dL
  *via Hct
pH_______7.402
PCO2______39.2 mm
HCO3________24 mmol/L
BEecf________0 mmol/L

Sample Type_:

 18JUL03     03:49

Oper:[redacted]  66-2

Physician:_____________

Ser# 42011
Ver: JAMS046A
     CLEW A93
```

RE	NG PHYSICIAN [redacted] 66-2	**LAB Y RESULT FORM** (Subj. o the Privacy Act of 1974)	
	DATE 7/18/03	TIME 0330	SSN/PSEUDO SSN:

C	Urinalysis			Misc. Serology		
F. RANGE	*TEST*	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*
10.8 x 10^3	Color		N/A	RPR		Negative
6 1 x 10^6	App		N/A	Mono		Negative
8 g/dl (M) 6 g/dl (F)	Glu		Negative	**Microbiology**		
2% (M) 7% (F)	Bili		Negative	Source		
4 fl (M) 9 fl (F)	Ket		Negative	Gram Stain		
500 x 10^3 ied	SG		N/A	Occ Bld		Negative
-51.1%	Bld		Negative	H. pylori		Negative
ifferential	pH		N/A	Micro Parasites		
	Prot		Negative	Malaria		
	Urob		0.2-1.0	O & P		
	Nit		Negative	Other		
	Leuk		Negative	**Microscopic Urinalysis**		
	HCG		Negative			

	CSF			Blood Bank	
2% (M) 17% (F)				**MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED**	
	Cell Count			ABO/Rh	
	Directigen		Negative		

lies			**Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)**		
		RANGE	*UNIT*	*TYPE*	*CROSSMATCH*
PT		9.8-13.6 secs			
APTT		21-34 secs			
D dimer		<20 ug/ml			
FDP		<10 ug/ml			

REMARKS:

REPORTED BY:	**DATE:**	**LAB ID NO.:**

rgl 18Jul03

Ward/Section: ICU 3

RE TING PHYS [redacted] b6-2

LAST, FIRST, MI. EPW [redacted] b6-4

(i-STAT)			(Pic
TEST	*RESULT*	*REF. RANGE*	*TEST*
Na		138-146 mmol/L	ALB
K		3.5-4.9 mmol/L	ALP
Cl		98-109 mmol/L	ALT
pH		7.31-7.45	AMY
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)	AST
PO2		80-105 mmHg (art) N/A (ven)	TBIL
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)	BUN
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)	CA⁺⁺
sO2		95-98%	CHOL
BEecf		(-2) – (+3) mmol/L	CRE
AnGap		10-20 mmol/L	GLU
Ca		1.12-1.32 mmol/L	TP
BUN		8-26 mg/dl	
GLU		70-105 mg/dl	*TES*
Creat		0.7-1.5 mg/dl	GLU
Hct		38-51% PCV	BUN
Hgb		12-17 g/dl	CRE

Misc. Chemistry			
TEST	*RESULT*	*REF. RANGE*	CK
			NA⁺
Troponin-I			K⁺
Drug of Abuse			CL⁻
			tCO₂

CL⁻		98-108 mmol/l
tCO₂		18-33 mmol/l

```
i-STAT EC8+

Pt: [redacted] b6-4
Pt Name:____________

Glu________119 mg/dL
BUN_________14 mg/dL
Na_________132 mmol/L
K__________4.2 mmol/L
Cl_________101 mmol/L
TCO2________25 mmol/L
AnGap_______11 mmol/L
Hct_________30 %PCV
Hb*_________10 g/dL
  *via Hct
PH_______7.403
PCO2______38.5 mmHg
HCO3________24 mmol/L
BEecf_______-1 mmol/L

Sample Type_:

 19JUL03      04:31

Oper: [redacted] b6-2

Physician:______________

Ser# 42011
Ver: JAMS046A
     CLEW A93
```

```
i-STAT CREA

Pt: 386
Pt Name:____________

Crea_______0.9 mg/dL

Sample Type_:

 19JUL03      ?-?32

Oper: 13

Physician:______________

Ser# [illegible]
Ver: JAMS046A
     CLEW A93
```

B		3.3-5.5 g/dl
P		26-84 u/l
.T		10-47 u/l
MY		14-97 u/l
ST		11-38 u/l
BIL		0.2-1.6 mg/dl
GT		5-65 u/l
P		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	*RESULT*	*REF. RANGE*
NA⁺		128-145 mmol/l
K⁺		3.3-4.7 mmol/l
CL⁻		98-108 mmol/l
tCO₂		18-33 mmol/l

REMARKS:

REPORTED BY: [redacted] b6-2

DATE: 19 Jul 03

LAB ID NO.:

Ward/Section: Icu 3	REQ	ING PHYSICIAN: b6-2	LAB RESULT FORM (Sub to the Privacy Act of 1974)
LAST, FIRST, MI. EPW [redacted] b6-4	DATE 7/18/03	TIME 0400	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE

b6-4

```
ID [redacted]              17-07-03
                              04:06
                            Patient
                             Limits
WBC   8.1     x10^3/uL     4.5  10.5
RBC   3.25 L  x10^6/uL     4.00 6.00
HGB   9.5 L   g/dL         11.0 18.0
HCT   26.5 L  %            35.0 60.0
MCV   78.9    fL           80.0 99.9
MCH   29.2    pg           27.0 31.0
MCHC  31.0 L  g/dL         33.0 37.0
PLT   [illegible] H x10^3/uL 150. 450.
LY%   26.0    %            20.5 51.1
LY#   [illegible] x10^3/uL  1.2  3.4
```

RBC Morph		
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted]	**DATE:** 19 Jul 03	**LAB ID NO.:**

b6-2

Ward/Section: 1Ux3	RE TING PHYSICIAN: [redacted] 66-2		**.EMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. # [redacted] 66-4	DATE 20Jul	TIME 0330	SSN/PSEUDO

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

(I

TEST
ALB
ALP
ALT
AMY
AST
TBIL
BUN
CA⁺⁺
CHOL
CRE
GLU
TP

```
i-STAT CREA

Pt: [redacted] 66-2
Pt Name:___________

Crea_______0.9 mg/dL

Sample Type_:

 20JUL03      04:10

Oper: [redacted] 66-2

Physician:______________

Ser# 42011
Ver: JAMS046A
     CLEW A93
```

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 u/l (M) 30-190 u/l (F)
NA⁺		128-145 mmol/l
K⁺		3.3-4.7 mmol/l
CL⁻		98-108 mmol/l
tCO_2		18-33 mmol/l

ALT
AMY
AST
TBIL
GGT
TP

(Pi

ST

```
i-STAT EC8+

Pt: [redacted] 66-4
Pt Name:___________

Glu_________17 mg/dL
BUN__________14 mg/dL
Na__________ 32 mmol/L
K___________4.3 mmol/L
Cl______        mmol/L
TCO2____       , mmol/L
AnGap_________9 mmol/L
Hct__________29 %PCV
Hb*__________10 g/dL
   *via Hct
pH_______7.459
PCO2______34.5 mmHg
HCO3_________24 mmol/L
BEecf_________1 mmol/L

Sample Type_:

 20JUL03      04:10

Oper: [redacted]

Physician:_______________

Ser# 40763
Ver: JAMS046A
     CLEW A93
```

(P.

TEST		
NA⁺		128-145 mmol/l
K⁺		3.3-4.7 mmol/l
CL⁻		98-108 mmol/l
tCO_2		18-33 mmol/l

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

REMARKS:

REPORTED BY: [redacted] 66-2	**DATE:** 20Jul03	**LAB ID NO.:**

MEDCOM - 13244

Ward/Section: 1Ux3	REC	[redacted]HYSICIAN: b6-2	LAB... RESULT FORM (Subj... the Privacy Act of 1974)
LAST, FIRST, MI. # [redacted]	DATE 20July	TIME 0330	SSN/PSEUDO SSN.

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
RBC		4.7-6.1 x 10^6

```
ID [redacted]   b6-4   20-07-03
                           03:46
                         Patient
                          Limits
WBC   5.7    x10³/uL    4.8  10.8
RBC   3.74 L x10⁶/uL   4.70  6.10
Hgb   9.5 L  g/dL      11.0  16.0
Hct   31.1 L %         35.0  46.0
MCV   83.2   fL        80.0  99.9
MCH   29.3   pg        27.0  31.0
MCHC  31.4 L g/dL      33.0  37.0
PLT   857. H x10³/uL   150.  450.
LYM   37.1   %         20.5  51.1
MXD   2.1    x10³/uL    1.2   3.4
```

Morph		
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

b6-4 Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted]	**DATE:** 20July03	**LAB ID NO.:**

b6-2

MEDCOM - 13245

Ward/Section: ICU3

REC [redacted] NG PHYSICIAN: b6-2

LAB ONLY RESULT FORM
(Subj o the Privacy Act of 1974)

LAST, FIRST, MI. # [redacted] b6-4

DATE 21 July

TIME 0330

SSN/PSEUDO SSN.

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	8.1	4.8-10.8 x 10^3
RBC	2.98	4.7-6.1 x 10^6
Hgb	8.7	14-18 g/dl (M) 12-16 g/dl (F)
Hct	28.0	42-52% (M) 37-47% (F)
MCV	93.9	80-94 fl (M) 81-99 fl (F)
Plt	887	130-500 x 10^3 verified
Lymph %	33.7	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			
Spun Hematocrit		42-52% (M) 37-47% (F)	
Sed Rate			
Other			

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Blood Bank Unit Crossmatch
(MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted]

DATE: 21Jul03

LAB ID NO.:

b6-2

Ward/Section: ICu3

R STING PHYSICIAN: [redacted] b6-2

HEMISTRY RESULT FORM

(Subject to the Privacy Act of 1974)

LAST. FIRST, MI. # [redacted] b6-4

DATE 21July

TIME 0330

SSN/PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
AI T		
A		
A		
T		
B		
C		
C		
C		
G		
Tl		
G		
Bl		
Cl		
Cl		
N,		
K'		
Cl		
tC		

```
======== PICCOLO ========
21/07/03                05:19
REFERENCE RANGE:         MALE
PATIENT #: [redacted] b6-4
METLYTE 8
DISC LOT #:           3152AA4
OPER #: 013        DR #: 000
SERIAL #:          0000100684
.............................
GLU     94   73-118    MG/DL
BUN     10   7-22      MG/DL
CRE    1.0   0.6-1.2   MG/DL
CK      88   39-380      U/L
NA+    ***   128-145   MMOL/L
K+     4.5   3.3-4.7   MMOL/L
CL-    100   98-108    MMOL/L
tCO2    23   18-33     MMOL/L

INST QC: OK    CHEM QC: OK
HEM 2+,  LIP 0 ,  ICT 0
```

Na 134

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^{+}		128-145 mmol/l
K^{+}		3.3-4.7 mmol/l
CL^{-}		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA^{+}		128-145 mmol/l
K^{+}		3.3-4.7 mmol/l
CL^{-}		98-108 mmol/l
tCO_2		18-33 mmol/l

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

REMARKS:

REPORTED BY: [redacted] b6-2

DATE: 21July03

LAB ID NO.:

MEDCOM - 13247

Ward/Section: ICU 3	REQUESTING PHYSICIAN: [redacted] 66-2	**LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. 66-4 [redacted]	DATE 223.l	TIME	SSN/PSEUDO SSN: [redacted] 66-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	7.0	4.8-10.8 x 10^3
RBC	3.19	4.7-6.1 x 10^9
Hgb	9.2	14-18 g/dl (M) 12-16 g/dl (F)
Hct	27.8	42-52% (M) 37-47% (F)
MCV	93.4	80-94 fl (M) 81-99 fl (F)
Plt	917	130-500 x 10^3 verified
Lymph %	36.8	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			
Spun Hematocrit		42-52% (M) 37-47% (F)	
Sed Rate			
Other			

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Blood Bank Unit Crossmatch
(MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] 66-2	**DATE:** 223a/03	**LAB ID NO.:**

MEDCOM - 13248

b6-2

Ward/Section: ICU3	UESTING PHYSICIAN: [redacted]	MISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI [redacted] b6-4	DATE 22 Jul	TIME
SSN/P[redacted] SSN: b6-4		

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/l
Cl		98-109 mmol/l
pH		7.31-7.45
PCO2		35-45 mmHg (41-51 mmHg (ve
PO2		80-105 mmHg (a N/A (ven)
TCO2		23-27 mmol/L (a 24-29 mmol/L (v
HCO3		22-26 mmol/L (a 23-28 mmol/L (v
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol.
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		[illegible]

```
======= PICCOLO =======
22/07/03                  05:18
REFERENCE RANGE:           MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #.             3152AA4
OPER #:              DR #: 000
SERIAL #             0000100684
...............................
GLU    [illegible]  [illegible]  MG/DL
BUN    10     7-22      MG/DL
CRE    0.9    0.5-1.2   MG/DL
[illegible]  74  39-380  U/L
[illegible]  [illegible]  128-145  MMOL/L
K+     [illegible].4  3.3-4.7  MMOL/L
CL     101    98-108    MMOL/L
tCO2   21     18-33     MMOL/L

INST QC: OK     CHEM QC: [illegible]
HEM 0 ,  LIP 0 ,  ICT 0
```

b6-4

Na 135 mmol/L

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
CO_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
LB		3.3-5.5 g/dl
LP		26-84 u/l
LT		10-47 u/l
MY		14-97 u/l
ST		11-38 u/l
BIL		0.2-1.6 mg/dl
GT		5-65 u/l
P		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
A^+		128-145 mmol/l
$^+$		3.3-4.7 mmol/l
L^-		98-108 mmol/l
O_2		18-33 mmol/l

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

REMARKS:

REPORTED BY: [redacted]	DATE: 22 Jul 03	LAB ID NO.:

b6-2

Ward/Section: ICU 3 | QUESTING PHYSICIAN: [redacted] b6-2 | MISTRY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. # [redacted] b6-4 | DATE 25July | TIME 0430 | SSN/PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE

```
======= PICCOLO =======
25/07/03              04:32
REFERENCE RANGE:       MALE
PATIENT #: [redacted] b6-4
METLYTE 8
DISC LOT #:         3152AA4
OPER #: 678      DR #: 000
SERIAL #:        0000100676
.........................
GLU    102   73-118   MG/DL
BUN     10   7-22     MG/DL
CRE    1.1   0.6-1.2  MG/DL
CK     141   39-380     U/L
NA+    ♦♦♦   128-145  MMOL/L
K+     4.5   3.3-4.7  MMOL/L
CL-     99   98-108   MMOL/L
tCO2    22   18-33    MMOL/L

INST QC: OK    CHEM QC: OK
HEM 0 ,  LIP 0 ,  ICT 0
```

Na-134

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
LU		73-118 mg/dl
UN		7-22 mg/dl
A^{++}		8.0-10.3 mg/dl
RE		0.6-1.2 mg/dl
A^{+}		128-145 mmol/l
		3.3-4.7 mmol/l
		98-108 mmol/l
O_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
B		3.3-5.5 g/dl
P		26-84 u/l
T		10-47 u/l
MY		14-97 u/l
T		11-38 u/l
IL		0.2-1.6 mg/dl
T		5-65 u/l
		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
+		128-145 mmol/l
		3.3-4.7 mmol/l
		98-108 mmol/l
O_2		18-33 mmol/l

REMARKS:

REPORTED BY: [redacted] b6-2 | **DATE:** 25Jul03 | **LAB ID NO.:**

LABORATORY RESULT FORM
(Subject to the Privacy Act of 1974)

Ward/Section: ICU3	REQUESTING PHYSICIAN: [redacted] b6-2			
LAST, FIRST, MI. # [redacted] b6-4		DATE 25 July	TIME 0420	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	9.1	4.8-10.8 x 10³
RBC	3.53	4.7-6.1 x 10⁹
Hgb	10.3	14-18 g/dl (M) 12-16 g/dl (F)
Hct	33.1	42-52% (M) 37-47% (F)
MCV	93.7	80-94 fl (M) 81-99 fl (F)
Plt	1016	130-500 x 10³ verified
Lymph %	32.5	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			
Spun Hematocrit		42-52% (M) 37-47% (F)	
Sed Rate			
Other			

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted]	**DATE:** 25 July 03	**LAB ID NO.:**

b6-2

MEDCOM - 13251

Ward/Section: ICU 3	REQUESTING PHYSICIAN: [redacted] b6-2	**LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. # [redacted] b6-4	DATE 27 Jul	TIME 0 45 0350	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE

```
                    b6-4
ID: 000[redacted]                  27-07-03
WB                                   04:56
                                  Patient
                                   Limits
WBC   9.5     x10^3/uL     4.5  10.5
RBC   3.34 L  x10^6/uL     4.00  6.00
Hgb   9.7 L   g/dL        11.0  18.0
Hct   31.7 L  %           35.0  60.0
MCV   94.9    fL          80.0  99.9
MCH   29.0    pg          27.0  31.0
MCHC  30.6 L  g/dL        33.0  37.0
Plt   990.  H x10^3/uL   150.  450.
LY%   36.8  * %           20.5  51.1
LY#    3.5 *H x10^3/uL     1.2   3.4
```

Lymph		Baso	
Atyp		Imm	
RBC Morph			

Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Blood Bank Unit Crossmatch
(MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted]	**DATE:** 27 Jul 03	**LAB ID NO.:**

b6-2

MEDCOM - 13252

Ward/Section: ICu3

.QUESTING PHYSICIAN: [redacted] b6-2

MISTRY RESULT FORM
(Subject to the Privacy Act of 1974)

LAST, FIRST, MI. # [redacted] b6-4

DATE 27Jul

TIME 03~~33~~45

SSN/PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE

```
:::::::: PICCOLO ::::::::
27/07/03              04:55
REFERENCE RANGE:       MALE
PATIENT #: [redacted] b6-4
METLYTE 8
DISC LOT #:         3152AA4
OPER #: 678      DR #: 000
SERIAL #:        0000100684
...........................
GLU     98   73-118   MG/DL
BUN      7   7-22     MG/DL.
CRE    1.0   0.6-1.2  MG/DL.
CK     124   39-380     U/L
NA+    ♦♦♦   128-145  MMOL/L
K+     4.6   3.3-4.7  MMOL/L
CL-    103   98-108   MMOL/L
tCO2    22   18-33    MMOL/L

INST QC: OK    CHEM QC: OK
HEM 0 , LIP 0 , ICT 0
```

Na-136

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
U		73-118 mg/dl
N		7-22 mg/dl
++		8.0-10.3 mg/dl
E		0.6-1.2 mg/dl
+		128-145 mmol/l
		3.3-4.7 mmol/l
		98-108 mmol/l
$_2$		18-33 mmol/l

(Piccolo) Liver Panel Plus

EST	RESULT	REF. RANGE
B		3.3-5.5 g/dl
P		26-84 u/l
T		10-47 u/l
Y		14-97 u/l
T		11-38 u/l
IL		0.2-1.6 mg/dl
T		5-65 u/l
		6.4-8.1 g/dl

(Piccolo) Electrolyte

EST	RESULT	REF. RANGE
+		128-145 mmol/l
		3.3-4.7 mmol/l
		98-108 mmol/l
$_2$		18-33 mmol/l

REMARKS:

REPORTED BY: [redacted] b6-2

DATE: 27Jul03

LAB ID NO.:

MEDCOM - 13253

Ward/Section: ICU3	REQUESTING PHYSICIAN: Dr [redacted] b6-2	**LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. [redacted] b6-4	DATE 29 July	TIME 21.30	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
		4.8-10.8 x 10³
		M)
		F)
		)
		4)
		')
		10³
		1%
		erential

ID: 00[redacted] b6-4
WB

```
                          29-07-03
                             07:16
                           Patient
                            Limits
WBC    7.9    x10^3/uL     4.5  10.5
RBC    3.42 L x10^6/uL     4.00 6.00
Hgb   10.0 L  g/dL        11.0  18.0
Hct   32.5 L  %           35.0  60.0
MCV   95.0    fL          80.0  99.9
MCH   29.4    pg          27.0  31.0
MCHC  31.0 L  g/dL        33.0  37.0
Plt 1014. +H  x10^3/uL   150.   450.
LY%   48.5 *  %           20.5  51.1
LY#    3.8 *H x10^3/uL     1.2   3.4
```

Atyp		Imm	
RBC Morph			
Spun Hematocrit		42-52% (M) 37-47% (F)	
Sed Rate			
Other			

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Blood Bank Unit Crossmatch
(MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted]	**DATE:** 29 Jul 03	**LAB ID NO.:**

b6-2

MEDCOM - 13254

Ward/Section: CU3	QUESTING PHYSICIAN: [redacted] b6-2	**MISTRY RESULT FORM** (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] b6-4	DATE 29Jul | TIME 0638	SSN/PSEUDO SSN:

(i-STAT)

TEST	*RESULT*	*REF. RANGE*
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	*RESULT*	*REF. RANGE*
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

```
======== PICCOLO ========
29/07/03              06:52
REFERENCE RANGE:       MALE
PATIENT #: [redacted] b6-4
METLYTE 8
DISC LOT #:         3152AA4
OPER #: 210      DR #: 000
SERIAL #:        0000100676
..............................
GLU     92   73-118   MG/DL
BUN      7   7-22     MG/DL
CRE    1.2   0.6-1.2  MG/DL
CK      58   39-380     U/L
NA+    131   128-145  MMOL/L
K+     4.3   3.3-4.7  MMOL/L
CL-     99   98-108   MMOL/L
tCO2    23   18-33    MMOL/L

INST QC: OK    CHEM QC: OK
HEM 0 ,  LIP 0 ,  ICT 0
```

(Piccolo) Metabolic Panel

EST	*RESULT*	*REF. RANGE*
U		73-118 mg/dl
N		7-22 mg/dl
++		8.0-10.3 mg/dl
E		0.6-1.2 mg/dl
+		128-145 mmol/l
		3.3-4.7 mmol/l
-		98-108 mmol/l
$_2$		18-33 mmol/l

(Piccolo) Liver Panel Plus

EST	*RESULT*	*REF. RANGE*
B		3.3-5.5 g/dl
P		26-84 u/l
T		10-47 u/l
Y		14-97 u/l
T		11-38 u/l
IL		0.2-1.6 mg/dl
T		5-65 u/l
		6.4-8.1 g/dl

(Piccolo) Electrolyte

EST	*RESULT*	*REF. RANGE*
+		128-145 mmol/l
		3.3-4.7 mmol/l
		98-108 mmol/l
$_2$		18-33 mmol/l

REMARKS:

REPORTED BY: [redacted]	**DATE:** 29Jul03	**LAB ID NO.:**

b6-2

Ward/Section: ICU3	REQUESTING PHYSICIAN: [redacted] b6-2	**CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. H [redacted] b6-4	DATE 2 Aug	TIME 0530	SSN/PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (ar 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE

```
======= PICCOLO =======
02/08/03              06:19
REFFRENCE RANGE:       MALE
PATIENT #: [redacted] b6-4
METLYTE 8
DISC LOT #:         3152AA4
OPER #: 269      DR #: 000
SERIAL #:        0000100494
..........................
GLU     92   73-118   MG/DL
BUN      8   7-22     MG/DL
CRE    0.9   0.6-1.2  MG/DL
CK     30*   39-380     U/L
NA+    134   128-145  MMOL/L
K+     4.5   3.3-4.7  MMOL/L
CL-    103   98-108   MMOL/L
tCO2    23   18-33    MMOL/L

INST QC: OK    CHEM QC: OK
HEM 0 ,  LIP 1+,  ICT 0
```

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^{+}		128-145 mmol/l
K^{+}		3.3-4.7 mmol/l
CL^{-}		98-108 mmol/l
tCO$_2$		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA^{+}		128-145 mmol/l
$^{+}$		3.3-4.7 mmol/l
L^{-}		98-108 mmol/l
tCO$_2$		18-33 mmol/l

REMARKS:

REPORTED BY: [redacted]	**DATE:** 2Aug03	**LAB ID NO.:**

b6-2

MEDCOM - 13256

Ward/Section: ICU3	REQUESTING PHYSICIAN: [redacted] b6-2	**LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. [redacted] b6-4	DATE 2Aug	TIME 0550	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	~~RESULT~~	REF. RANGE
		.8-10.8 x 10^3
		.7-6.1 x 10^9
		4-18 g/dl (M) 2-16 g/dl (F)
		2-52% (M) 7-47% (F)
		i0-94 fl (M) i1-99 fl (F)
		.30-500 x 10^3 /erified
		20.5-51.1%

l Differential

no	
o	
n	

b6-4

```
ID: 000[redacted]                02-08-03
WB                                  07:59
                                  Patient
                                   Limits
WBC    3.9 *  x10^3/uL     4.5  10.5
RBC   3.70 L  x10^6/uL    4.00  6.00
Hgb   10.6 L  g/dL        11.0  18.0
Hct   35.1    %           35.0  60.0
MCV   94.8    fL          80.0  99.9
MCH   28.7    pg          27.0  31.0
MCHC  30.3 L  g/dL        33.0  37.0
Plt  764.  H  x10^3/uL    150.  450.
LY%  44.5  *  %           20.5  51.1
LY#    4.0 #H x10^3/uL     1.2   3.4
```

Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Blood Bank Unit Crossmatch
(MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted]	**DATE:** 2AUG03	**LAB ID NO.:**

b6-2

MEDCOM - 13257

Ward/Section: 1CU 3	REQUES[redacted]IAN: b6-2	**LABORATORY RESULT FORM** **(Subject to the Privacy Act of 1974)**

LAST, FIRST, MI. [redacted] b6-4	DATE 8/5/03	TIME 0400	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		
RBC		
Hgb		
Hct		
M(		
P(		
L:		
Atyp		
RBC Morph		
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

```
ID: 00[redacted]  b6-4
WB
                              05-08-03
                                 04:04
                               Patient
WBC   7.0    x10^3/uL          Limits
RBC   3.66 L x10^6/uL        4.5   10.5
Hgb  10.5 L  g/dL           4.00   6.00
Hct  34.4 L  %              11.0   18.0
MCV  94.1    fL             35.0   60.0
MCH  28.6    pg             80.0   99.9
MCHC 30.5 L  g/dL           27.0   31.0
Plt  593. H  x10^3/uL       33.0   37.0
LY%  56.0 HH %              150.   450.
LY#   3.9 HH x10^3/uL       20.5   51.1
                             1.2    3.4
```

Urinalysis

TEST	RESULT	REF. RANGE
lor		N/A
p		N/A
1		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Blood Bank Unit Crossmatch
(MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] b6-2	**DATE:** 5 Aug 03	**LAB ID NO.:**

Ward/Section: ICU 3	REQUESTING PHYSICIAN: [redacted] b6-2	**CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] b6-4	DATE 8/5/03 TIME 0920	SSN/PSEUDO SSN:

(i-STAT)

TEST	*RESULT*	*REF. RANGE*
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	*RESULT*	*REF. RANGE*
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	*RESULT*	*REF. RANGE*
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

(Piccolo) Metlyte 8

TEST	*RESULT*	*REF. RANGE*
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 u/l (M) 30-190 u/l (F)
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	*RESULT*	*REF. RANGE*
tCO_2		18-33 mmol/l

```
.:::::: PICCOLO :::::::
05/03/03                04:04
REFERENCE RANGE:         MALE
PATIENT #: [redacted]  b6-4
METLYTE 8
DISC LOT #:           3151AA4
OPER #: 013         DR #: 000
SERIAL #:          0000100684
.........................
GLU     92   73-118   MG/DL
BUN      7   7-22     MG/DL
CRE    1.0   0.6-1.2  MG/DL
CK      39   39-380     U/L
NA+    130   128-145  MMOL
K+     4.4   3.3-4.7  MMOL
CL-    103   98-108   MMOL
tCO2    21   18-33    MMOL

INST QC: OK      CHEM QC: OK
HEM 0 ,  LIP 0 ,  ICT 0
```

REMARKS:

REPORTED BY: [redacted] b6-2	**DATE:** 5Aug03	**LAB ID NO.:**

Ward/Section: ICU3	REQUESTING PHYSICIAN:	**CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. # [redacted] b6-4	DATE 9 Aug	TIME 0520 04[illegible]	SSN/PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 u/l (M) 30-190 u/l (F)
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE

```
======== PICCOLO ========
09/08/03                05:28
REFERENCE RANGE:         MALE
PATIENT #: [redacted]  b6-4
METLYTE 8
DISC LOT #:           3141AA4
OPER #: 013         DR #: 000
SERIAL #:          0000100676
.........................
GLU      92   73-118    MG/DL
BUN       7   7-22      MG/DL
CRE     0.7   0.6-1.2   MG/DL
CK       44   39-380      U/L
NA+     131   128-145  MMOL/L
K+      4.4   3.3-4.7  MMOL/L
CL-     103   98-108   MMOL/L
tCO2     22   18-33    MMOL/L

INST QC: OK    CHEM QC: OK
HEM 2+,  LIP 0 ,  ICT 0
```

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

REMARKS:

REPORTED BY: [redacted] b6-2	**DATE:** 9Aug03	**LAB ID NO.:**

Ward/Section: ICU3	REQUESTING PHYSICIAN:	**LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. H [redacted] b6-4	DATE 9 Aug	TIME ~~0445~~ 0530	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE

```
ID: CC[redacted]                    09-08-03
#P                                     05:36
                                   Patient
                                    Limits
WBC    7.7    x10^3/uL      4.5   10.5
RBC    4.10   x10^6/uL      4.00  6.00
Hgb    11.9   g/dL          11.0  18.0
Hct    35.2   %             35.0  60.0
MCV    95.3   fL            80.0  99.9
MCH    29.0   pg            27.0  31.0
MCHC   31.1 L g/dL          33.0  37.0
PLT    461  H x10^3/uL      130.  450.
LY%    64.7 H %             20.5  51.1
LY#     5.0 + x10^3/uL       1.2   3.4
```

b6-4

Atyp		Imm	
RBC Morph			

Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Blood Bank Unit Crossmatch
(MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted]	**DATE:** 9Aug03	**LAB ID NO.:**

b6-2

MEDCOM - 13261

b6-2

Ward/Section: ICU3	REQUESTING PHYSICIAN: [redacted]	**CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] b6-4	DATE 12 AUG TIME 0430	SSN/PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat	1.0	0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA++		8.0-10.3 mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

(Piccolo) Metabolic Panel

i-STAT EC8+

pt: [redacted]

pt Name:____________

```
Glu__________85 mg/dL
BUN__________8 mg/dL
Na_________138 mmol/L
K__________4.0 mmol/L
Cl_________105 mmol/L
TCO2________29 mmol/L
AnGap________9 mmol/L
Hct_________38 %PCV
Hb*_________13 g/dL
  *via Hct
pH_______7.414
PCO2______42.9 mmHg
HCO3________27 mmol/L
BEecf________3 mmol/L
```

Sample Type_: oral 0

12AUG03 04:37

Oper: [redacted] b6-2

Physician:______________

Ser# 42011

Ver: JAMS046A
CLEW A93

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 u/l (M) 30-190 u/l (F)
NA+		128-145 mmol/l
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
tCO2		18-33 mmol/l

REMARKS: Chem 7

REPORTED BY: [redacted] b6-2	**DATE:** 12AUG03	**LAB ID NO.:**

MEDCOM - 13262

Ward/Section: ICU3	REQUESTING PHYSICIAN: [redacted] b6-2		**LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] b6-4	DATE 12AUG	TIME 0430	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
W		
R		
H		
H		
M		
Pl		
L		
S		
B		
L		
A		
RBC Morph		
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

b6-4

```
ID: [redacted]                        12-08-03
                                         04:35
                                       Patient
                                         units
WBC    7.0      x10^3/uL      4.5   10.5
RBC    3.87 L   x10^6/uL      4.00  6.00
Hgb    11.4     g/dL          11.0  18.0
Hct    36.1     %             35.0  60.0
MCV    93.4     fL            80.0  99.9
MCH    29.5     pg            27.0  31.0
MCHC   31.6 L   g/dL          33.0  37.0
PLT    434.     x10^3/uL      150.  450.
LY%    53.5 H   %             25.5  51.1
LY#    3.8 H    x10^3/uL       .2   3.4
```

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted]	**DATE:** 12AUG03	**LAB ID NO.:**

b6-2

MEDCOM - 13263

Ward/Section: ICU 3	REQUESTING PHYSICIAN: [redacted] b6-2	**CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] b6-4	DATE (8/16) · TIME 0400	SSN/PSEUDO SSN: 386

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALE		
ALP		
ALT		
AM		
AST		
TBI		
BUN		
CA+		
CHC		
CRE		
GLU		
TP		

TE		
GLU		
BUN		
CRE		
CK		
NA+		
K+		
CL-		
tCO2		

```
======= PICCOLO =======
16/08/03            04:43
REFERENCE RANGE:      MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #:         3151AA4
OPER #: 678      DR #: 000
SERIAL #:        0000100676
..........................
GLU    86    73-118   MG/DL
BUN     6*   7-22     MG/DL
CRE   0.9    0.6-1.2  MG/DL
CK     49    39-380   U/L
NA+   127*   128-145  MMOL/L
K+    5.4*   3.3-4.7  MMOL/L
CL-    99    98-108   MMOL/L
tCO2   19    18-33    MMOL/L

INST QC: OK    CHEM QC: OK
HEM 3+,  LIP 1+,  ICT 0
```

b6-4

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
		73-118 mg/dl
		7-22 mg/dl
		8.0-10.3 mg/dl
		0.6-1.2 mg/dl
		128-145 mmol/l
		3.3-4.7 mmol/l
		98-108 mmol/l
		18-33 mmol/l

lo) Liver Panel Plus

RESULT	REF. RANGE
	3.3-5.5 g/dl
	26-84 u/l
	10-47 u/l
	14-97 u/l
	11-38 u/l
	0.2-1.6 mg/dl
	5-65 u/l
	6.4-8.1 g/dl

ccolo) Electrolyte

RESULT	REF. RANGE
	128-145 mmol/l
	3.3-4.7 mmol/l
	98-108 mmol/l
	18-33 mmol/l

REMARKS:

REPORTED BY: [redacted]	**DATE:** 16Aug03	**LAB ID NO.:**

b6-2

MEDCOM - 13264

Ward/Section: ICU-3	REQUESTING PHYSICIAN: [redacted] b6-2	**LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. #[redacted] b6-4	DATE 16 Aug	TIME 0825
SSN/PSEUDO SSN: #386		

(Hematology) CBC

TEST	~~RESULT~~	~~REF. RANGE~~
WBC		4.9 [illegible]
RBC	[illegible]	[illegible]
H[illegible]	[redacted] b6-4	[illegible]
H[illegible]	[illegible]	[illegible]
M[illegible]	[illegible]	[illegible]
Pl[illegible]	[illegible]	[illegible]
Ly[illegible]	[illegible]	[illegible]
([illegible]	[illegible]	[illegible]
Seg	[illegible]	[illegible]
Ban		
Lym		
Atyp		Imm
RBC Morph		
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] b6-2	**DATE:** 16 Aug 03	**LAB ID NO.:**

MEDCOM - 13265

Ward/Section: KW#1	REQUESTING PHYSICIAN: [redacted] b6-2	**LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. #P[redacted] b6-4	DATE 22AUG03 / TIME 1530	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	*RESULT*	*REF. RANGE*
WBC		4.8-10.8 x 10'
RBC		4.7-6.1 x 10⁹
Hgb		14-18 g/dl (M) 12-16 g/dl (F)
Hct		42-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-500 x 10³ verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis

TEST	*RESULT*	*REF. RANGE*
Color	Amber	N/A
App	cloudy	N/A
Glu	NeG	Negative
Bili	NeG	Negative
Ket	Small	Negative
SG	1.030	N/A
Bld	Trace	Negative
pH	6.0	N/A
Prot	30	Negative
Urob	0.2	0.2-1.0
Nit	POS	Negative
Leuk	NeG	Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	*RESULT*	*REF. RANGE*
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

SSA - Trace
wbc - many
rbc - 25-50
Epi - 1-5

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

TEST	*RESULT*	*REF. RANGE*
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	*TYPE*	*CROSSMATCH*

REMARKS:

REPORTED BY: [redacted]	**DATE:** 22Aug03	**LAB ID NO.:**

b6-2

MEDCOM - 13266

Ward/Section: ICW-H	REQUESTING PHYSICIAN: [redacted] b6-2	**LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. [redacted] b6-4	DATE 23AUG03	TIME 0730	SSN/PSEUDO SSN:

CBC

```
ID: [redacted]      b6-4
WB                          08-22-03
                               23:46
                             Patient
                              Limits
 WBC    9.9     x10^3/uL    4.5  10.5
 RBC    4.35    x10^6/uL    4.00 6.00
 Hgb   12.7     g/dL       11.0  18.0
 Hct   39.9     %          35.0  60.0
 MCV   91.8     fL         80.0  99.9
 MCH   29.2     pg         27.0  31.0
 MCHC  31.8 L   g/dL       33.0  37.0
 Plt  447.      x10^3/uL  150.  450.
 LY%  25.9  *   %          20.5  51.1
 LY#    2.6 *   x10^3/uL    1.2   3.4
```

atial

Urinalysis

TEST	*RESULT*	*REF. RANGE*
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

Misc. Serology

TEST	*RESULT*	*REF. RANGE*
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites	/	
Malaria		
O & P		
Other		

Microscopic Urinalysis

Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

Coagulation Studies

TEST	*RESULT*	*REF. RANGE*
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Blood Bank Unit Crossmatch
(MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	*TYPE*	*CROSSMATCH*

REMARKS:

REPORTED BY: [redacted]	**DATE:** 8-23-03	**LAB ID NO.:**

b6-2

MEDCOM - 13267

Ward/Section:	REQUESTING PHYSICIAN:	**CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)

LAST, FIRST, MI.	DATE	TIME	SSN/PSEUDO SSN:

(i-STAT)			(Piccolo) Chemistry 12			(Piccolo) Metabolic Panel		
TEST	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*
		..0-146 mmol/L						

```
i-STAT CREA

Pt: [redacted]  b6-4
Pt Name:______________

Crea_______1.1 mg/dL

Cl__________[illegible]
TCO2________28 mmol/L
AnGap_______7 mmol/L
Hct_________42 %PCV
Hb*_________14 g/dL
  *via Hct
PH_______7.484
PCO2______36.1 mmHg
HCO3________27 mmol/L
BEecf______4 mmol/L

Sample Type_:

23AUG03      08:14

Oper: [redacted]  b6-2

Physician:______________

Ser# 42015
er: JAMS046A
   CLEW A93
```

```
======= PICCOLO =======
23/08/03            07:43
REFERENCE RANGE:     MALE
PATIENT #: [redacted]  b6-4
METLYTE 8
DISC LOT #:        3152AA4
OPER #: 034      DR #: 000
SERIAL #:       0000100684
..........................
GLU   102   73-118   MG/DL
BUN   ♦♦♦   7-22     MG/DL
CRE   ♦♦♦   0.6-1.2  MG/DL
CK     34*  39-380     U/L
~~NA+   123~~   128-145  MMOL/L
K+    4.5   3.3-4.7  MMOL/L
CL-    99   98-108   MMOL/L
tCO2   20   18-33    MMOL/L

INST QC: OK    CHEM QC: OK
HEM 2+,  LIP 0 ,  ICT 0
```

TEST	*RESULT*	*REF. RANGE*
LU		73-118 mg/dl
UN		7-22 mg/dl
A++		8.0-10.3 mg/dl
RE		0.6-1.2 mg/dl
IA+		128-145 mmol/l
+		3.3-4.7 mmol/l
L-		98-108 mmol/l
CO2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	*RESULT*	*REF. RANGE*
LB		3.3-5.5 g/dl
LP		26-84 u/l
LT		10-47 u/l
MY		14-97 u/l
ST		11-38 u/l
BIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	*RESULT*	*REF. RANGE*
NA+		128-145 mmol/l
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
tCO2		18-33 mmol/l

RE

REPORTED BY:	**DATE:**	**LAB ID NO.:**

MEDCOM - 13268

Ward/Section: ICW1	REQUESTING PHYSICIAN:	**LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)

LAST, FIRST, MI: # [redacted] 66-4	DATE 26Aug	TIME @ 0600	SSN/PSEUDO SSN: # [redacted] 66-4

(Hematology) CBC

TEST	RESULT	REF. RANGE

26 Aug 03 @ 0600

ID: 00 [redacted] 66-4
WB

WBC	7.0	x10^3/uL
RBC	4.04	x10^6/uL
Hgb	11.5	g/dL
Hct	37.0	%
MCV	91.6	L
MCH	28.5	
MCHC	31.1 L	
Plt	498.	
LY%	64.4	
LY#	4.5	

Sed Rate		
Other		

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh		

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Blood Bank Unit Crossmatch
(MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	**DATE:**	**LAB ID NO.:**

MEDCOM - 13269

Ward/Section: ICW 1	REQUESTING PHYSICIAN:	**CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. epw #[redacted] 66-4	DATE 26Aug@	TIME 0000	SSN/PSEUDO SSN: epw #[redacted] 66-4

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 u/l (M) 30-190 u/l (F)
NA^+		128-145 mmol
K^+		3.3-4.7 mmol/l
CL		98-108 mmol/
tCO_2		18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE

```
======= PICCOLO =======
26/08/03              06:38
REFERENCE RANGE:        MALE
PATIENT #:  0[redacted]  66-4
METLYTE 8
DISC LOT #:          3152AA4
OPER #: 034        DR #: 000
SERIAL #:         0000100494
..........................
GLU      87   73-118   MG/DL
BUN       5*  7-22     MG/DL
CRE     1.0   0.6-1.2  MG/DL
CK       22*  39-380     U/L
NA+     128   128-145  MMOL/L
K+      4.4   3.3-4.7  MMOL/L
CL-     100   98-108   MMOL/L
tCO2     23   18-33    MMOL/L

INST QC: OK    CHEM QC: OK
HEM 0 ,  LIP 0 ,  ICT 0
```

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

REMARKS:

REPORTED BY:	**DATE:**	**LAB ID NO.:**

chem 8

Ward/Section: ICW 1	REQUESTING PHYSICIAN: [redacted] b6-2	**LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. # [redacted] b6-4	DATE 27Aug	TIME 0240	SSN/PSEUDO SSN # [redacted]

(Hematology) CBC

TEST	RESULT	REF. RANGE
W		
R		
H		
H		
M		
P		
I		

27aug03
@0245

```
ID: 000[redacted]              08-2-03
WB                b6-4           18:
                               Patient
                                Limits
WBC   11.4 H  x10^3/uL     4.5  10.5
RBC   4.14    x10^6/uL     4.00 6.00
Hgb   11.7    g/dL        11.0  18.0
Hct   38.3    %           35.0  60.0
MCV   72.6    fL           80.0  99.9
MCH   28.4    pg          27.0  31.0
MCHC  30.6 L  g/dL        33.0  37.0
Plt   201.    x10^3/uL    150.  450.
LY%   51.7 *H %            20.5  51.1
LY#    5.9 *H x10^3/uL     1.2   3.4
```

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Blood Bank Unit Crossmatch
(MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	**DATE:**	**LAB ID NO.:**

CBC ē C+T x 2 units

MEDCOM - 13271

27Aug03 —

@ 0510

```
ID: 000[redacted]  b6-4          08-26-03
PB                                  [illegible]
                                 Patient
                                  Limits
WBC   16.4    x10^3/uL     4.5  10.5
RBC   3.37 L  x10^6/uL    4.00  6.00
Hgb   [illegible] L g/dL  11.0  18.0
Hct   31.1 L  %           35.0  60.0
MCV   92.4    fL          80.0  99.9
MCH   28.2    pg          27.0  31.0
MCHC  30.5 L  g/dL        33.0  37.0
Plt   530.  H x10^3/uL    150.  450.
LY%   46.8  * %           20.5  51.1
LY#    4.9  * x10^3/uL     1.2   3.4
```

REQUESTING PHYSICIAN [redacted] b6-2	**LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)

# [redacted]	DATE 27Aug03	TIME 0600	SSN/PSEUDO SSN: # [redacted] EPW

	b6-4 **Urinalysis**			**Misc. Serology** b6-4			
F. RANGE	*TEST*	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*	
.8 x 10^3	Color		N/A	RPR		Negative	
1 x 10^9	App		N/A	Mono		Negative	
g/dl (M) g/dl (F)	Glu		Negative	**Microbiology**			
% (M) % (F)	Bili		Negative	Source			
fl (M) fl (F)	Ket		Negative	Gram Stain			
0 x 10^3 ed	SG		N/A	Occ Bld		Negative	
51.1%	Bld		Negative	H. pylori		Negative	
ferential	pH		N/A	Micro Parasites			

Segs		Mono		Prot		Negative	Malaria	
Bands		Eos		Urob		0.2-1.0	O & P	
Lymph		Baso		Nit		Negative	Other	
Atyp		Imm		Leuk		Negative	**Microscopic Urinalysis**	
RBC Morph				HCG		Negative		

Spun Hematocrit		42-52% (M) 37-47% (F)	**CSF**			**Blood Bank**
Sed Rate			Cell Count			**MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED**
Other			Directigen		Negative	ABO/Rh

Coagulation Studies			**Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)**		
TEST	*RESULT*	*REF. RANGE*	*UNIT*	*TYPE*	*CROSSMATCH*
PT		9.8-13.6 secs			
APTT		21-34 secs			
D dimer		<20 ug/ml			
FDP		<10 ug/ml			

REMARKS:

REPORTED BY:	**DATE:**	**LAB ID NO.:**

CBC only!

MEDCOM - 13272

Ward/Section: KW#1	REQUESTING PHYSICIAN: [redacted] b6-2	**LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. #[redacted] b6-4	DATE 27AUG03 TIME 1715	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE

27aug @1715

```
ID# 000[redacted]
#5                          08-27-03
                               17:27
                             Patient
                              Limits
WBC    9.3    x10^3/uL     4.5  10.5
RBC    3.30 L x10^6/uL     4.00 [illegible]
Hgb    9.7 L  g/dL         12.0 18.0
Hct    30.1 L %            35.0 60.0
MCV    92.1   fL           80.0 99.[illegible]
MCH    29.2   pg           27.0 31.0
MCHC   30.6 L g/dL         33.0 37.0
Plt    37[illegible]   x10^3/uL     150. 450.
LY%    46.6 + %            20.5 51.[illegible]
LY#    4.3 H  x10^3/uL     1.[illegible]  [illegible]
```

Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk	–	Negative
HCG		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Blood Bank Unit Crossmatch
(MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted]	**DATE:** 8-27-03	**LAB ID NO.:**

b6-2

MEDCOM - 13273

#1

```
27SEP03      21:45
```

b6-4

```
ID: [redacted]                     08-28-03
WB                                    20:14
                                  Patient
                                   Limits
WBC     9.4     x10^3/uL      4.5   10.5
RBC    2.98 L   x10^6/uL     4.00   6.00
Hgb     8.6 L   g/dL         11.0   18.0
Hct    27.2 L   %            35.0   60.0
MCV    91.1     fL           80.0   99.9
MCH    28.8     pg           27.0   31.0
MCHC   31.6 L   g/dL         33.0   37.0
Plt   417.      x10^3/uL     150.   450.
LY%    52.8  *H %            20.5   51.1
LY#     5.0  *H x10^3/uL      1.2    3.4
```

#2

```
                  mg/dL
               .38 mmol/L
     ____4.5 mmol/L
 __________16 mmol/L
iCa_______1.26 mmol/L
Hct___________ %PCV
__________1 g/dL
  ia Hct

  37C

pH_______7.328
p________29.2 mmHg
PO2__________47 mmHg
HCO3________15 mmol/L
BEecf______-11 mmol/L
sO2*________80 %
   *calculated


Sample Type_:

   27SEP03       22:14
```

MEDCOM - 13274

66-4

[redacted] epw

ICW#1

29Aug03 @ 0500.

SPECIMEN/LAB RPT. NO.		
ATOLOGY URGENCY ☐ ROUTINE TODAY ☐ ☐ PRE-OP STAT ☐	PATIENT STATUS ☐ BED ☐ AMB OUTPATIENT ☐ ☐ NP ☐ DOM	SPECIMEN SOURCE ☐ VEIN ☐ CAP ☐ OTHER (Specify)

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE Nessen	REPORTED BY MD TECH	DATE	LAB. ID. NO.

REMARKS

CBC

TEST(S)			REQUESTED (X)	RBC COUNT	HEMOGLOBIN	HEMATOCRIT	MCV	MCH	MCHC	WBC COUNT	IMMATURE	NEUTRO-BANDS	NEUTROSEGS	LYMPHS	EOSINOPHILS	BASOPHILS	MONOCYTES	PLATELETS	RBC	SED. RATE	PLATELET COUNT	RETICULOCYTE COUNT	CLOTTING TIME	BLEEDING TIME	P.T. CONTROL	P.T. PATIENT	CONTROL	PATIENT	% ACTIVITY	RATIO	SICKLING TEST	LE PREP
SPECIMEN TAKEN	TIME	A.M. P.M.									WBC DIFF AND BLOOD CELL MORPH																					
	DATE		RESULTS																													

549-107

HEMATOLOGY
STANDARD FORM 549 (Rev. 7-76)
PRESCRIBED BY GSA/ICMR
FIRMR (41 CFR) 201-45.505

PATIENT'S MED. RECORD

☐ OTHER (Specify)

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING | REPORTED BY MD | TECH | DATE | LAB. ID. NO.

REMARKS

C

TEST(S) SPECIMEN TAKEN | TIME | DATE

```
===== PICCOLO =====
29/08/03          04:16
REFERENCE RANGE: 0[redacted]  MALE
PATIENT #:               66-4
METLYTE 8           3151AA4
DISC LOT #:      DR #: 000
OPER #: 034
SERIAL #:         000010067B
.........................
GLU   99
BUN   4
CRE   0.
CK
NA+   1
K+    3.5
CL-   103            98-10
tCO2  23
```

PROFILE (Specify)

546-107

CHEMISTRY I
STANDARD FORM 546 (Rev. 8-77)
PRESCRIBED BY GSA ICMR
FIRMR (41 CFR) 201-45.505

☐ PRE-OP
STAT ☐

SPECIMEN SOURCE (Specify)

DATE | LAB ID NO.

PATIENT'S

```
ID: [redacted]                     08-29-03
WB                                  21:50
                                   Patient
                                   Limits
WBC   12.0 H  x10^3/uL      4.5  10.5
RBC   2.73 L  x10^6/uL      4.00 6.00
Hgb    7.8 L  g/dL         11.9 18.0
Hct   24.8 L  %            35.0 60.0
MCV   91.0    fL           80.0 99.9
MCH   28.6    pg           27.0 31.0
MCHC  31.4 L  g/dL         33.0 37.0
Plt   441.    x10^3/uL     150. 450.
LY%   50.4 *  %            20.5 51.1
LY#    6.0 *H x10^3/uL      1.2  3.4
```

66-4

DATE

557-107

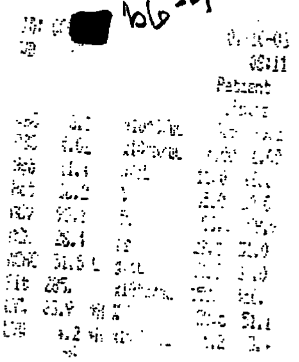
MISCELLANEOUS
STANDARD FORM 557 (Rev. 3-77)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45-505

b6-2

Ward/Section: 1CW#1	**REQUESTING PHYSICAN** [redacted]	**LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. C[redacted] b6-4	**DATE** 07OCT03 **TIME** 0735	**SSN/PEEUDO SSN:**

(Hematology) CBC

TE		REF RANGE
WI		
RI		
Hg		
H		
M		
P		
I		


[redacted] b6-4
Patient
[illegible]

Set Rate			
Other			

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Macroscopic Urinalysis

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 SESS
D dimer		<20 ug/ml
FDP		< 10 ug /ml

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITHE EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted]	**DATE:** 7 Oct 03	**LAB ID NO.:**

b6-2

MEDCOM - 13276

Ward/Section: ICW#1	**REQUESTING PHYSICAN:** [redacted] b6-2	**CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)
LAST, FIRST,MI. #[redacted] b6-4	**DATE** 07OCT03 **TIME** 0735	**SSN/PEEUDO SSN:**

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/dL
K		3.5-4.9 mmol/L
CI		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (art)
SO2		95-98%
BEecf		(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
T		
I		
C		
C		
C		
T		
G		
Bi		
Cl		
Cl		
Na		
K		
Cl		
tCi		

```
======= PICCOLO =======
10/07/03            08:17
REFERENCE RANGE:     MALE
PATIENT #: [redacted]
GENERAL CHEMISTRY 12
DISC LOT #:        3204AA4
OPER #: 678      DR #: 000
SERIAL #:       0000100684
.........................
ALB   3.3   3.3-5.5   G/DL
ALP   65    26-84      U/L
ALT   112*  10-47      U/L
AMY   51    14-97      U/L
AST   61*   11-38      U/L
TBIL  0.7   0.2-1.6  MG/DL
BUN    7    7-22     MG/DL
CA++  9.0   8.0-10.3 MG/DL
CHOL  216*  100-200  MG/DL
CRE   0.7   0.6-1.2  MG/DL
GLU   92    73-118   MG/DL
TP    6.9   6.4-8.1   G/DL

INST QC: OK    CHEM QC: OK
HEM 0 ,  LIP 0 ,  ICT 0
```

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
A^{+}		128-145 mmol/dl
$^{+}$		3.3-4.7 mmol/l
L^{-}		98-108 mmol/l
CO2		18-33 mmol/l

(Piccolo) Liver Panel Plus

EST	RESULT	REF. RANGE
B		3.3-5.5 g/dl
P		26-84 u/l
T		10-47 u/l
T		14-97 u/l
IY		11-38 u/l
IL		0.2-1.6 mg/dl
T		5-65 u/l
		6.4-8.1 g/dl

(Piccolo) Electrolyte

ST	RESULT	REF. RANGE
+		128-145 mmol/l
		3.3-4.7 mmol/l
		98-108 mmol/l
2		18-33 mmol/l

Misc. Chemistry

TEST	RESULT	REF. RANGE
Tropoin-I		
Drug of Abuse		

REMARKS:

REPORTED BY: [redacted]	**DATE:** 7Oct03	**LAB ID NO.:**

b6-2

START

MEDIC..L RECORD ANES..HESIA

CONTINUOUS, REPEATED DRUGS SPECIFY UNITS - (MG / MCG / ML) "T"=CONSTANT INFUSION

DRUG (Units)							TOTALS
Fentanyl 25mcg/cc	3 2	2	1	2			250
Versed (mg/cc)	4	2	1	1			8
Ketamine (10mg/cc)	4 1	2 2	1				100

VOLAT. AGENT % del. % e.t. T

AIR L/Min NRB

N2O L/Min

O2 L/Min

SINGLE DOSE DRUGS - MARK ON GRID WITH NUMBERS & ENTER IN REMARKS

LINE site ☐ Warmed

☐ Warmed

☐ Warmed

☐ Warmed

TOTAL EBL

TOTAL URINE ?

FLUIDS - SUMMARY

CRYSTALLOID - 75 LR

COLLOID - 0

BLOOD - 0

REMARKS - Code drugs with numbers, events with letters

- Robinul .2mg prior to procedure
- 1000 pt lethargic, ~~[illegible]~~ interacts c staff & follows commands
- 98% on RA, 12-14

[redacted] ILT ~~[illegible]~~

b6-2

LOSSES EST BLOOD LOSS URINE -

TIME → | 15 30 45 0900 15 30 45 1000

ASA STATUS 1 2 [✓ 3] 4 5 E

BODY WEIGHT 80 [✓ KG] LB

HEMATOCRIT

INITIAL DATA

BP 100/55

HR - 107

EQUIP CHECK

K - [✓ Y] N

PATIENT RECHECK

for PROCEDURE? Y

TIME - 0800

SYMBOLS:

BP by cuff V Λ

Heart rate ●

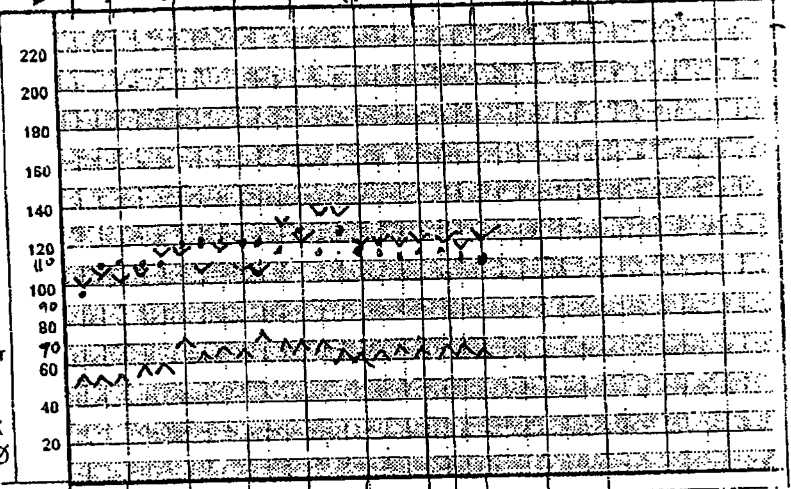
Resp rate

BP (transduced)

TOURNIQUET T - X

ANES- X-X

PROC-(•)-Ø



VT - ml	
f - breaths/min	15 12 12 15 20 12 27 15 30 20 25 25 28 14 24 14 12
	22 13
Peak insl pres / PEEP	
MODE - S(pon), A(ssist), C(on)	
BP/Auto Cuff / ET CO2 (torr)	
BP / oth / FIO2 (Frac or %)	
ART line / SpO2 (%)	99 100 100 100 100 100 100 100 100 100 95 91 97 97
Steth PC/ES / ECG	ST ST ST ST ST RA
Gas analyzer / TEMP - site	
N-M Block (T/4)	
Warming blkt	
Conv warmer	

Mark with letters & symbols, explain under REMARKS EVENTS

Position — Begin 9/ms AFO Roll

RECOVERY AT - PACU ICU (CJ) (Specify)

OTHER

CONDITION:

RESP - 16 SpO2 - 96 RA

BP - 112 HR - 119/64

ANESTHESIA / PROCEDURE TIMES

ANES	Start 0806	Room 0806	End
PROC	Ready 0800	Begin 0810	End 0920

PROCEDURES and CPT Codes

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

Versed, fentanyl, ketamine

AIRWAY MANAGEMENT: intubation route, blade, technique, comments

PATIENT IDENTIFICATION - Typed or written entries. Name, Grade/Rate, Medical facility

[redacted] b6-4

SURGEONS: b6-2

~~ANESTHETISTS~~ 1LT [redacted] RN,

PROCEDURE LOCATION (CJ)

DATE

PAGE 1 OF 1

MEDICAL RECORD - ANESTHESIA

WAMC OP 376 REVISED 1 Jan 99

U.S. GPO. 1999 523-336/1

PATIENT RECORD

MEDCOM - 13278

THESIA PLAN OF CARE PRE CEDURAL ASSESSMENT (Sedation/ sthesia)

__ DAYS MOS YRS

Sex ( ) MALE ( ) FEMALE

ASA Physical State 1 2 [✓ 3] 4 5 E
WT: 70 [✓ KG]/LB HT: ____ IN.
ALLERGIES: NKDA

SED PROCEDURE: CONSCIOUS Sedation
CAL SERVICE: ____
NCE: ____

S:
CCO: 2pk/day
ETOH: ____
UGS: ____

NT MEDICATIONS:
tered as premed
Fentanyl patch
Albuterol.
Lovenox

DICATIONS:
es (@ ____ Hrs) /CC
. ____ mg IV IM PO
. ____ mg IV IM PO
. ____ mg IV IM PO

ATORY STUDIES:
: 8.7, 28.
____
: ____

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:
- Hypertension N Y ____
- Angina N Y ____
- MI N Y ____
- CVA N Y ____
- Other N Y ____

Pulmonary System:
- Asthma N Y ____
- Bronchitis/URI N Y ____
- COPD N Y ____
- Other N Y ____

Renal System:
- Acute/Chronic RF N Y ____

Gastrointestinal:
- Hepatitis N Y ____
- Hiatal Hernia N Y ____
- PUD/GERD N Y ____

Endocrine System:
- Diabetes N Y ____
- Steriods N Y ____
- Thyroid N Y ____

Neurological:
- Seizures N Y ____
- Neuropathy N Y ____
- Other N Y ____

Gynecological :
- Pregnancy N Y ____

Other Significant Hx:
- N Y ____
- N Y ____

Familial HX N Y ____

ASSESSMENT

PAST SURGICAL/ANESTHETIC

PHYSICAL EXAMINATION

BP 106/58 HR 77 R 20 T __ 98%
Pain Scale 0-10 ____
HEENT - Teeth ____
Trachea Midline.
TMJ/Neck ____
Oropharnyx ____
Nares patent
CHEST: Equal.
CARDIAC: S1-S2
EXTREMITIES:
IV Access: Ⓡ hand palm
Ulnar Filling: ____
LR @ 100.
BACK: ____
OTHER: ____

NPO Since ____

HETIC PLAN: ( ) LOCAL ( ) MAC ( ) Regional (Specify): ____ ( ) General: Mask Intubation

Conscious Sedation

IED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to an ed with the patient/legal guardian.

ient/legal guardian seems to understand and agrees. Questions answered.

____ Date: ____ Time: ____ Hrs

NESTHESIA EVALUATION AND NOTE (NON ASU)
APPARENT ANESTHETIC COMPLICATIONS ( ) OTHER

____ Date: ____ Time: ____ Hrs

Identification: (Ward) ICU 3.

SEDATION KEY:

1. MINIMAL (Anxiolysis) Patient responds normally to verbal commands
2. MODERATE (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is not necessary.
3. DEEP SEDATION/ANALGESIA. Patient responds purposefully following repeated or painful stimulation. Airway assistance may

#[redacted] 66-4

MEDCOM - 13279

STHESIA PLAN OF CARE PRE-PROCEDURAL ASSESSMENT (Sedation/Anesthesia)

__ DAYS MOS YRS Sex [✓ MALE] ( ) FEMALE

OSED PROCEDURE: Conscious sedation
ICAL SERVICE: ____
INCE: ____

ASA Physical State 1 2 3 4 5 E
WT: ____ KG/LB HT: ____ IN.
ALLERGIES: NKDA

S:
ACCO: 2/day.
ETOH: ____
RUGS: ____

ENT MEDICATIONS:
dered as premed
Levaquin.
[illegible]
MSO4

EDICATIONS:
Yes (@ ____ Hrs) /CC
. ____ mg IV IM PO
. ____ mg IV IM PO
. ____ mg IV IM PO

RATORY STUDIES:
T: 9, 31
____
R: ____

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:		
Hypertension	[✓ N] Y	
Angina	[✓ N] Y	
MI	[✓ N] Y	
CVA	[✓ N] Y	
Other	[✓ N] Y	
Pulmonary System:		
Asthma	N [✓ Y]	
Bronchitis/URI	[✓ N] Y	
COPD	N [✓ Y]	
Other	[✓ N] Y	
Renal System:		
Acute/Chronic RF	[✓ N] Y	
Gastrointestinal:		
Hepatitis	[✓ N] Y	
Hiatal Hernia	[✓ N] Y	
PUD/GERD	[✓ N] Y	
Endocrine System:		
Diabetes	[✓ N] Y	
Steriods	[✓ N] Y	
Thyroid	[✓ N] Y	
Neurological:		
Seizures	[✓ N] Y	
Neuropathy	[✓ N] Y	
Other	[✓ N] Y	
Gynecological :		
Pregnancy	N Y	
Other Significant Hx:		
	N Y	
	N Y	
Familial HX	N Y	

ASSESSMENT

PAST SURGICAL/ANESTHETIC

PHYSICAL EXAMINATION
BP 116/64 HR 110 R 10 T 101 2
Pain Scale 0-10 ____
HEENT - Teeth intact
Trachea Midline.
TMJ/Neck ____
Oropharnyx ____
Nares ____
CHEST: ____
CARDIAC: S1-S2-0ectopy.
EXTREMITIES:
IV Access: (R) IJ CVC
Ulnar Filling: ____
BACK: ____
OTHER: ____

NPO Since ____

THETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ____ { } General: Mask Intubation

Conscious sedation

MED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to a sed with the patient/legal guardian.

tient/legal guardian seems to understand and agrees. Questions answered.
: ____ Date: 05 Jul 03 Time: 0900 Hrs

ANESTHESIA EVALUATION AND NOTE (NON ASU)
APPARENT ANESTHETIC COMPLICATIONS { } OTHER

: ____ Date: ____ Time: ____ Hrs

t Identification: (Ward) ____

SEDATION KEY:

1. **MINIMAL** (Anxiolysis) Patient responds normally to verbal commands
2. **MODERATE** (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is no necessary.
3. **DEEP SEDATION/ANALGESIA.** Patient responds purposefully following repeated or painful stimulation. Airway assistance may

#[redacted]-106-4

MEDCOM - 13280

Le: vin 500mg IVPB : Tusi g from ICU.

MEDICAL RECORD ANESTHESIA

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML. "!"=CONSTANT INFUSION

DRUG	Units		TOTALS
versed	mg	3	3
fentanyl	µg	100 50 50	250
propofol	mg	120	
SUX/Roc	mg	100/ 30 10 10	
Morphine	mg	4 2 2 2-4	10
	( )		
VOLAT AGENT Iso	% del	1.5 1.5 1.5 1.5 1.5 1.2 1.2X	
	% e.t.		
AIR	L/Min		
N2O	L/Min		
O2	L/Min	6 — 2 — 2 — 2 — 2 — 2 — 2 — 2	

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS ▸ ① ② ③ ④

TOTAL EBL 100

TOTAL URINE 200

FLUIDS — SUMMARY
CRYSTALLOID– 800
COLLOID– 0
BLOOD– 0

FLUIDS
LINE size 18g L EJ ☐ Warmed NS ——— 500 ——— 600 — 800
☐ Warmed
☐ Warmed
☐ Warmed

LOSSES
EST BLOOD LOSS 100
URINE – foley 200

TIME ▸ X 30 X 11 X 30 X 12 X 30 X 13

PHYS STATUS 1 [✓ 2] 3 4 5 E

BODY WEIGHT 85 [✓ KG] LB

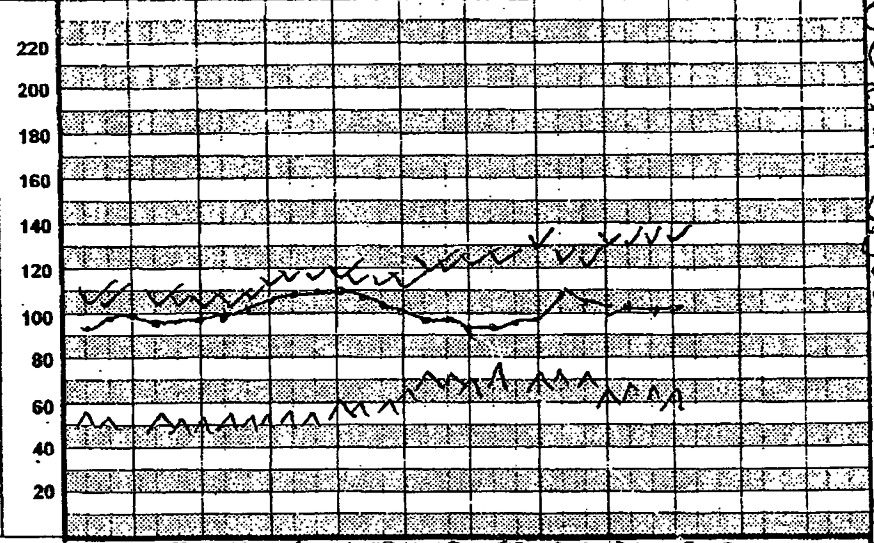
HEMATOCRIT 37.2

INITIAL DATA:
BP – 103/54
HR – 102

EQUIP CHECK OK? [✓ Y] N

PATIENT RECHECK OK for PROCEDURE ✓
TIME – 1010

SYMBOLS:
BP by cuff ∨ ∧
Heart rate ●
Resp rate
BP (transduced) ╧
TOURNIQUET T – ✗
ANES – X-X
PROC ⊙ – Ø



REMARKS—
Code drugs with numbers, events with letters
Pt ē chart ✓. OK to proceed.
① To room, SOC monitors, preO2.
② Smooth IV Ind.
③ 7F triple lumen placed via Seldinger technique to rt IJ. Unused ports flushed c heparinized saline. EJ removed.
④ Lasix 10mg IVPB.
⑤ Responds to commands, suct & extub, to recovery stable.

VENTILATION

VT – ml		550	600	600	600	600	180	200	240	350
f – breaths/min		10	10	10	10	10	24	16	14	14
Peak insp pres / PEEP		28	30	28	27	29	—			
MODE– S(pon), A(ssist), C(on)	S	C	C	C	C	C	S	S	S	S

MONITORS / ACCESSORIES

✓ BP/Auto Cuff	✓ ET CO2 (torr)	38	38	38	34	32	31	40	48	35	3
BP / oth	✓ FIO2 (Frac or %)	0.86	0.86	0.87	0.57	0.27	0.87	0.87	87	.87	
ART line	✓ SpO2 (%)	99	99	99	100	100	100	100	100	100	
Steth- PC/ES ✓	ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR	
Gas analyzer	TEMP- site										
	N-M Block (T/4)	2/4	2/4	3/4	3/4	4/4	4/4				
		X —— X Lt [redacted] 66-2									
Warming blkt											
Conv warmer											

Mark with letters & symbols, explain under REMARKS
EVENTS
Position — O— ——→ ←——→

RECOVERY AT PACU [✓ ICU] 3 (Specify)
OTHER
CONDITION:
RESP– 21 SpO2– 94
BP– 133/72 HR– 104

ANES / PROCEDURE TIME

ANES	Start	Room	End
	1010	1020	1250
PROC	Ready	Begin	End
	1025	1100	1230

PROCEDURES and CPT Codes
① Excision/debridement 10% BSA burns
② Burn Dsg Δ ③ Central line

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GETA

8.0 ETT
4 mac
23 cm @ teeth

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
Eyes taped. DL x1 s̄ trauma, ⊕ EtCO2, BSEB, secured c̄ tape.

PATIENT IDENTIFICATION— Typed or written entries: Name, Grade/Rate, Medical facility
[redacted] -66-4
[redacted]
47 yo ASA 2 (asthma

SURGEON [redacted]
ANESTHETIST [redacted] MAJ, CRNA 66-2

PROCEDURE LOCATION 1-1

7/6/03

MEDCOM - 13281

STHESIA PLAN OF CARE PRE-PROCEDURAL ASSESSMENT (Sedation/Anesthesia)

47 DAYS MOS [✓ YRS] Sex [✓ MALE] () FEMALE

ASA Physical State 1 [✓ 2] 3 4 5 E
WT: 85 [✓ KG] LB HT: ____ IN.
ALLERGIES: NKDA

OSED PROCEDURE: Debride/STSG burn
ICAL SERVICE: GS
INCE: 2400

S:
ACCO: +
ETOH: 0
RUGS: 0

ENT MEDICATIONS:
dered as premed
Lovenox
Proventil
Levaquin

EDICATIONS:
Yes (@ ____ Hrs) /CC
____ mg IV IM PO
____ mg IV IM PO
____ mg IV IM PO

RATORY STUDIES:
T: 11.9 / 37.2
R: ____

— | — | 100 / 102
4.1 | 0.9 | 27

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:
- Hypertension [✓ N] Y
- Angina [✓ N] Y
- MI [✓ N] Y
- CVA [✓ N] Y
- Other N [✓ Y] LLE DVT

Pulmonary System:
- Asthma ~~N~~ [✓ Y] asthma
- Bronchitis/URI [✓ N] Y
- COPD [✓ N] Y
- Other [✓ N] Y

Renal System:
- Acute/Chronic RF N [✓ Y] foley

Gastrointestinal:
- Hepatitis [✓ N] Y
- Hiatal Hernia [✓ N] Y
- PUD/GERD [✓ N] Y

Endocrine System:
- Diabetes [✓ N] Y
- Steriods [✓ N] Y
- Thyroid [✓ N] Y

Neurological:
- Seizures [✓ N] Y
- Neuropathy [✓ N] Y
- Other [✓ N] Y

Gynecological :
- Pregnancy [✓ N] Y

Other Significant Hx:
- N [✓ Y] 10% BSA burns
- N [✓ Y] Signif generolized edema

Familial HX [✓ N] Y

ASSESSMENT
PAST SURGICAL/ANESTHETIC
0 PSHx

PHYSICAL EXAMINATION
BP 114/62 HR 93 R 12 T ____
Pain Scale 0-10 2
HEENT - Teeth Solid
Trachea ML
TMJ/Neck MPI
Oropharnyx FROM
Nares N/A
CHEST: CTAB
CARDIAC: RRR
EXTREMITIES:
IV Access: x1 RFA 20g
Ulnar Filling: ____
BACK: N/A
OTHER: N/A

NPO Since 2400

THETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ____ [✓] General: Mask [✓ Intubation]

Some english, counselled for GA

MED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to a
sed with the patient/legal guardian.

itien[redacted]ms to understand and agrees. Questions answered.
1: [redacted] MAJ, CRNA Date: 7/6/03 Time: 0845 Hrs

AN[redacted]ESIA EVALUA[redacted]NOTE (NON ASU)
APPARENT ANESTHETIC COMPLICATIONS { } OTHER
66-2

1: ____ Date: ____ Time: ____ Hrs

SEDATION KEY:
1. MINIMAL (Anxiolysis) Patient responds normally to verbal commands
2. MODERATE (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is no necessary.
3. DEEP SEDATION/ANALGESIA. Patient responds purposefully following repeated or painful stimulation. Airway assistance may

t Identification: (Ward) ICW3

[redacted] — 66-4

[redacted]

MEDCOM - 13282

ꞋTHESIA PLAN OF CARE PRE-PROCEDURAL ASSESSMENT (Sedation/Anesthesia)

47 DAYS MOS [✓ YRS] Sex [✓ MALE] ( ) FEMALE

ASA Physical State 1 2 [✓ 3] 4 5 E
WT: 80 KG/LB HT: ____ IN.
ALLERGIES: 0

ꞋOSED PROCEDURE: [illegible]
ꞋICAL SERVICE: ____
ꞋNCE: MN

S:
ꞋACCO: 2/day
ETOH: ____
ꞋRUGS: 0

ꞋENT MEDICATIONS:
Ꞌdered as premed

ꞋEDICATIONS: 0
Ꞌes (@ ____ Hrs) /CC
.. ____ mg IV IM PO
.. ____ mg IV IM PO
.. ____ mg IV IM PO

ꞋRATORY STUDIES:
ꞋT: 10 / 32
Ꞌ: ____

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:
Hypertension [✓ N] Y
Angina [✓ N] Y
MI [✓ N] Y
CVA [✓ N] Y
Other N Y

Pulmonary System:
Asthma N [✓ Y]
Bronchitis/URI [✓ N] Y
COPD N [✓ Y]
Other N Y

Renal System:
Acute/Chronic RF [✓ N] Y

Gastrointestinal:
Hepatitis [✓ N] Y
Hiatal Hernia [✓ N] Y
PUD/GERD [✓ N] Y

Endocrine System:
Diabetes [✓ N] Y
Steriods [✓ N] Y
Thyroid [✓ N] Y

Neurological:
Seizures [✓ N] Y
Neuropathy [✓ N] Y
Other [✓ N] Y

Gynecological :
Pregnancy N Y

Other Significant Hx:
N Y
N Y

Familial HX N Y

ASSESSMENT

PAST SURGICAL/ANESTHETIC

PHYSICAL EXAMINATION
BP 106/68 HR 112 R 19 T ____
Pain Scale 0-10 ____
HEENT - Teeth intact
Trachea midline
TMJ/Neck ____
Oropharnyx ____
Nares ____
CHEST: CTA
CARDIAC: S1 S2 ST 0 ectopy
EXTREMITIES:
IV Access: (R) IJ
Ulnar Filling: ____
BACK: ____
OTHER: ____

NPO Since MN

ꞋTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ____ { } General: Mask Intubation

ꞋMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to a
Ꞌsed with the patient/legal guardian.

b6-2

[redacted] seems to understand and agrees. Questions answered.
Ꞌ: LT /[illegible] Date: 7/1/03 Time: 1030 Hrs

ꞋANESTHESIA EVALUATION AND NOTE (NON ASU)
Ꞌ APPARENT ANESTHETIC COMPLICATIONS { } OTHER

Ꞌ: ____ Date: ____ Time: ____ Hrs

Ꞌt Identification: (Ward) ____

SEDATION KEY:

1. **MINIMAL** (Anxiolysis) Patient responds normally to verbal commands
2. **MODERATE** (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is no necessary.
3. **DEEP SEDATION/ANALGESIA.** Patient responds purposefully following repeated or painful stimulation. Airway assistance may

[redacted] b6-4

MEDCOM - 13283

MEDICAL RECORD ANESTHESIA

ANESTHETIC AGENTS / DRUGS — CONTINUOUS / REPEATED DRUGS, SPECIFY UNITS – MG / MCG / ML, * = CONSTANT INFUSION

DRUG	Units						TOTALS
Versed	1mg/a	3	1	1			7
Ketamine	10mg/a	3	1	2	1		80
Fent	25mcg/a	4	1	2	1		200

VOLAT AGENT % del / % e.t.

AIR L/Min

N2O L/Min

O2 L/Min

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS

FLUIDS: LINE site ☐ Warmed ☐ Warmed ☐ Warmed ☐ Warmed

LOSSES: EST BLOOD LOSS – URINE –

FLUIDS SUMMARY

CRYSTALLOID – LR 200

COLLOID – 0

BLOOD – 0

TOTAL EBL

TOTAL URINE

REMARKS: Code drugs with numbers, events with letters

.2 mg robinul given

PHYS STATUS: 1 2 [✓ 3] 4 5 E

BODY WEIGHT: 80 KG

HEMATOCRIT:

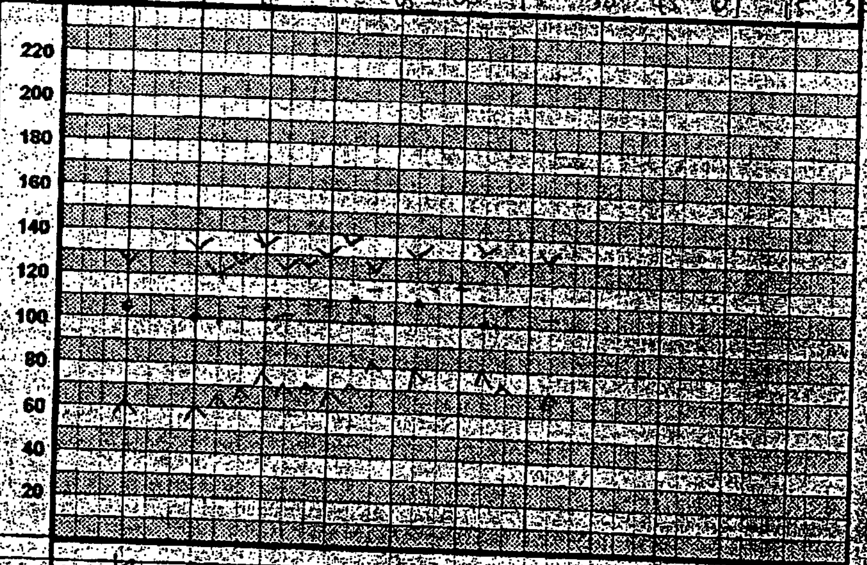
INITIAL DATA: BP – 122, 62 HR – 98

EQUIP CHECK: OK? – Y [✓ N]

PATIENT READINESS: OK for PROCEDURE? Y TIME – 0650

TIME → 45 07⁰⁰ 15 30 45 08⁰⁰ 15 30 45 09⁰⁰ 15 30

SYMBOLS: BP by cuff ∨ ∧ ; Heart rate ● ; Resp rate ; BP (transduced) ; TOURNIQUET T – T ; ANES – X-X ; PROC ⊙ – Ø



VT – ml

f – breaths/min: 12 10 10 12 14 10 12 10 8 12 16 16

Peak inf pres / PEEP: NPB

MODE – S(pon), A(ssist), C(on): RA RA NPB → RA

BP/Auto Cuff; BP / oth; ART line; Steth. PC/ES; Gas analyzer

ET CO2 (torr)

FIO2 (Frac or %)

SpO2 (%): 97 96 99 100 100 100 100 100 100 100

ECG: ST ST

TEMP- site

N-M Block (T/4)

Warming blkt

Conv. warmer

Mark with letters & symbols, explain under REMARKS

EVENTS: pre legs arms buttock

Position →

RECOVERY AT: PACU ICU (Specify) OTHER

CONDITION: RESP 14 SpO2 97 RA BP HR 105

	Start	Room	End
ANES	0702	0702	0850

	Ready	Begin	End
PROC	0705	0706	0815

PROCEDURES and CPT Codes

dressing changed

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

versed, fent, ketamine

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

PATIENT IDENTIFICATION – Typed or written entries: Name, Grade/Rate, Medical facility –

[redacted] b6-4

SURGEONS:

ANESTHETISTS:

PROCEDURE LOCATION ICU 3

DATE 8 Jul 03

PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED Jan 99

MEDCOM - 13284

U.S. GPO: 2002-729-180/40137

ANESTHESIA PLAN OF CARE PR OCEDURAL ASSESSMENT (Sedation esthesia)

Age 47 DAYS MOS [✓ YRS]
Sex [✓ MALE] ( ) FEMALE

PROPOSED PROCEDURE: dressing Δ
SURGICAL SERVICE:
NPO SINCE: MN

ASA Physical State 1 2 [✓ 3] 4 5 E
WT: 80 KG/LB HT: ____ IN.
ALLERGIES: 0

HABITS:
TOBACCO: 2 ppd
ETOH: 0
DRUGS: 0

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) percocet
( ) MSO4 prn
( ) versed prn
( ) levaquin
( ) lovenox
( ) proventil

PREMEDICATIONS: 0
None Yes (@ ______ Hrs) /CC
______ . ______ mg IV IM PO
______ . ______ mg IV IM PO
______ . ______ mg IV IM PO

LABORATORY STUDIES:
HB/HCT: 9.3 / 30.1
U/A: 0
OTHER: K=3.3

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:
Hypertension [✓ N] Y
Angina [✓ N] Y
MI [✓ N] Y
CVA [✓ N] Y
Other [✓ N] Y
Pulmonary System:
Asthma N [✓ Y]
Bronchitis/URI [✓ N] Y
COPD N [✓ Y]
Other [✓ N] Y
Renal System:
Acute/Chronic RF [✓ N] Y
Gastrointestinal:
Hepatitis [✓ N] Y
Hiatal Hernia [✓ N] Y
PUD/GERD [✓ N] Y
Endocrine System:
Diabetes [✓ N] Y
Steriods [✓ N] Y
Thyroid [✓ N] Y
Neurological:
Seizures [✓ N] Y
Neuropathy [✓ N] Y
Other [✓ N] Y
Gynecological :
Pregnancy NA Y
Other Significant Hx:
N Y
N Y
Familial HX N Y

ASSESSMENT
PAST SURGICAL/ANESTHETIC

PHYSICAL EXAMINATION
BP 122/62 HR 91 R 12 T 97
Pain Scale 0-10
HEENT - Teeth intact
Trachea midline
TMJ/Neck
Oropharnyx
Nares
CHEST: CTA bil
CARDIAC: S_1 S_2 NSR 0 [illegible]
EXTREMITIES:
IV Access:
Ulnar Filling:
BACK:
OTHER:

NPO Since MN

ANESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ________ { } General: Mask Intubation

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discussed with the patient/legal guardian.

b6-2

The p[redacted] seems to understand and agrees. Questions answered.
Signed: 1C7/AN Date: 8 JUL 03 Time: 0655 Hrs

POST-ANESTHESIA EVALUATION AND NOTE (NON ASU)
{ } NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER
Signed: ________ Date: ______ Time: ______ Hrs

Patient Identification: (Ward) ICU3

[redacted] b6-4

SEDATION KEY:
1. MINIMAL (Anxiolysis) Patient responds normally to verbal commands
2. MODERATE (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is not necessary.
3. DEEP SEDATION/ANALGESIA. Patient responds purposefully following repeated or painful stimulation. Airway assistance may

MEDCOM - 13285

MEDICAL RECORD ANESTHESIA

ANESTHETIC AGENTS AND DRUGS

CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML, " | "=CONSTANT INFUSION

DRUG (Units)		TOTALS
Fent 25mcg/(cc)	4 2 |||	|| ||	350
Ketamine 10mg/(cc)	||||||| ||| ||	100
Versed 1mg/(cc)	3 2	5
( )		
( )		
( )		
VOLAT AGENT % del		
% e.t.		
AIR L/Min		
N2O L/Min		
O2 L/Min		

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS &ENTER IN REMARKS

FLUIDS

LINE site ☐ Warmed
☐ Warmed
☐ Warmed
☐ Warmed

LOSSES EST BLOOD LOSS
URINE –

TOTAL EBL

TOTAL URINE

FLUIDS – SUMMARY
CRYSTALLOID–
COLLOID–
BLOOD–

REMARKS–
Code drugs with numbers, events with letters

.2 mg ~~Reg~~ Robinul

PHYS STATUS 1 2 [✓ 3] 4 5 E

BODY WEIGHT 85 [✓ KG] LB

HEMATOCRIT

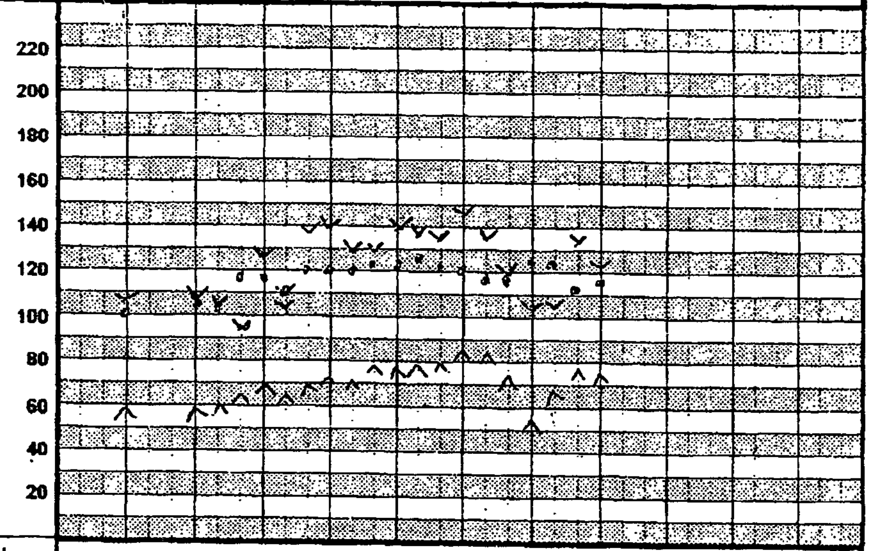
INITIAL DATA
BP 106/58
HR– 112

EQUIP CHECK OK?– [✓ Y] N

PATIENT RECHECK
OK for PROCEDURE? Y
TIME– 1030

TIME → 10^30 ·45 11^00 15 30 45 12^00 15 30 45 13^00

SYMBOLS:
BP by cuff V Λ
Heart rate ●
Resp rate
BP (transduced)
TOURNIQUET T – T
ANES– X-X
PROC ⊙ – Ø



VENT
VT – ml
f – breaths/min: 18 12 16 10 21 20 12 15 15 12 20 12 16 12 24
Peak inf pres / PEEP
MODE– S(pon), A(ssist), C(on): RA NRB ——→ RA NRB

MONITORS / ACCESSORIES
BP/Auto Cuff | ET CO2 (torr)
BP / oth | FIO2 (Frac or %)
ART line | SpO2 (%): 93 99 97 97 97 99 98 99 99 99 99 95 100
Steth- PC/ES | ECG: ST
Gas analyzer | TEMP- site
N-M Block (T/4)
Warming blkt
Conv warmer

Mark with letters & symbols, explain under REMARKS
EVENTS
Position → start hands feet legs ab on side

RECOVERY AT
PACU ICU ||| (Specify)
OTHER
CONDITION:
RESP– 20 SpO2– 96 RA
BP– 127/77 HR– 119

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES			

	Ready	Begin	End
PROC			

PROCEDURES and CPT Codes

ANESTHETIC TECHNIQUES– *Describe block technique under Remarks*
Versed, fent, Ketamine

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*

SURGEONS:

PROCEDURE LOCATION

ANESTHETISTS:

PATIENT IDENTIFICATION– *Typed or written entries: Name, Grade/Rate, Medical facility*

[redacted] 66-4

MEDCOM - 13286

MEDICAL RECORD — ANESTHESIA

ANESTHETIC AGENTS AND DRUGS

CONTINUOUS / REPEATED DRUGS SPECIFY UNITS = MG / MCG / ML. "I"=CONSTANT INFUSION

DRUG (Units)		TOTALS
Robinul . ( )	[illegible]	
Versed 1mg/cc ( )	2 2 1 1 1	7mg
Fentanyl [illegible] ( )	2 1 1 1 1 2 2	250mcg
Ketamine 10mg/cc ( )	1 2 1 1 1 1 1	80mg
( )		
( )		
VOLAT AGENT % del		
% e.t.		
AIR L/Min		
N2O L/Min		
O2 L/Min		

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS

FLUIDS
LINE site ☐ Warmed
☐ Warmed
☐ Warmed
☐ Warmed

LOSSES
EST BLOOD LOSS
URINE –

TOTAL EBL
TOTAL URINE

FLUIDS – SUMMARY
CRYSTALLOID– 200
COLLOID–
BLOOD–

REMARKS
Code drugs with numbers, events with letters

- Anesthesia start 0905
- Procedure 0910
End 1015

PHYS STATUS 1 2 3 4 5 E

BODY WEIGHT 85 [✓ KG] LB

HEMATOCRIT 31

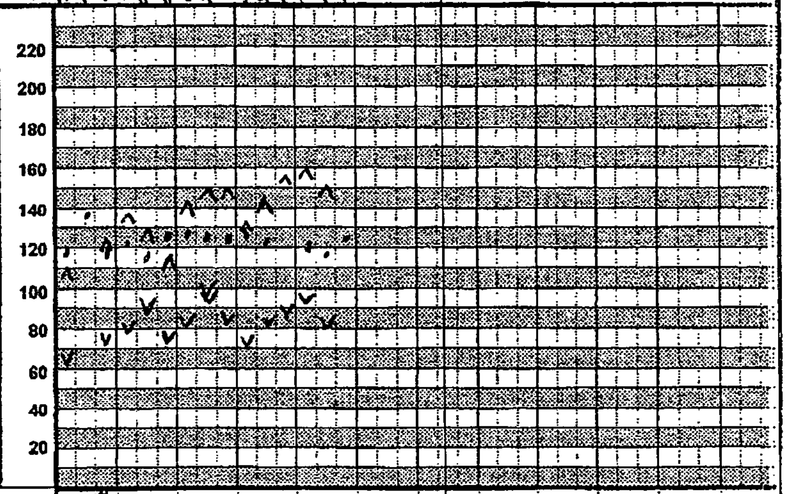
INITIAL DATA
BP – 116/44
HR– 110

EQUIP CHECK OK? [✓ Y] N

PATIENT RECHECK
OK for PROCEDURE? Y
TIME– 0900

TIME → [illegible]

SYMBOLS:
BP by cuff ∨ ∧
Heart rate ●
Resp rate
BP (transduced) ⊥ ⊤
TOURNIQUET T – ✗
ANES– X-X
PROC– ⊙–Ø



VENT
VT – ml
f – breaths/min [illegible]
Peak inf pres / PEEP [illegible]
MODE– S(pon), A(ssist), C(on) [illegible] NRB NRB NRB NRB

MONITORS / ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)
BP / oth	FIO2 (Frac or %)
ART line	SpO2 (%)
Steth- PC/ES	ECG
Gas analyzer	TEMP- site
	N-M Block (T/4)
Warming blkt	
Conv warmer	

Mark with letters & symbols, explain under REMARKS EVENTS
Position ——→

RECOVERY AT
PACU ICU________ (Specify)
OTHER________
CONDITION:
RESP– SpO2–
BP– HR–

ANESTHESIA / PROCEDURE TIMES

ANES	Start 0905	Room	End 0940
PROC	Ready 0910	Begin	End 1015

PROCEDURES and CPT Codes

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*

SURGEONS:

ANESTHETISTS: LT [redacted] certified conscious sedation

PROCEDURE LOCATION ICU3.

DATE 09Jul03

PAGE OF

PATIENT IDENTIFICATION– *Typed or written entries: Name, Grade/Rate, Medical facility*

[redacted]

b6-4

b6-2

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED
1 Jan 99

☆ U.S. GPO: 1999 – 528-336/10085

PATIENT RECORD

MEDCOM - 13287

s/p Shin bugs to heels ASA II ? Hx RAD
NKA
Fent Patch / Lincocett [redacted]
b6-2 OPMH (BSCTA, Hrrcom @ PIV 18g
pm 107/64-66-.. SO2 98% T. 98?
10/7/03
GETA
[redacted]
b6-2

MEDICAL RECORD - ANESTHESIA

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

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML, "I" = CONSTANT INFUSION

DRUG (Units)							TOTALS
Fentanyl (mcg)	50 100				50		200
Propofol (mg)	200						
Sux (mg)	100						
Roc (mg)		20					
( )							
( )							
VOLAT AGENT Iso % del / % e.t.	1.5	2.0	1.5	1.2	1.0X		
AIR L/Min							
N2O L/Min							
O2 L/Min	6 —	2 —	2 —	2 —	2 —	10	
SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS	① ② ③ ④				⑤		

TOTAL EBL: min

TOTAL URINE: None

FLUIDS

LINE site		
20g RFA	☐ Warmed	RL — 500 — 700
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOSSES: EST BLOOD LOSS / URINE -

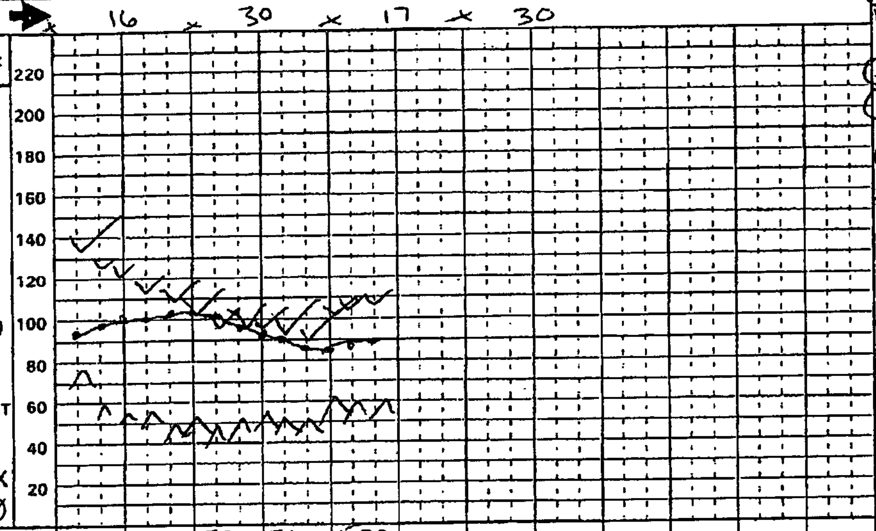
FLUIDS - SUMMARY
CRYSTALLOID- 700
COLLOID- 0
BLOOD- 0

REMARKS
Code drugs with numbers, events with letters
① Robinul 0.2 & phenergan 12.5mg IV.
② To room via litter, SOC mon's, preO2
③ I & S on litter.
④ Pt turned prone to bed.
⑤ Suctioned & extubated p̄ turning supine to litter. To PACU stable.

RAD

PHYS STATUS: 1 [✓ 2] 3 4 5 E
BODY WEIGHT: 75 [✓ KG] LB
HEMATOCRIT: 36.2
INITIAL DATA:
BP- 134/73
HR- 91
EQUIP CHECK OK?- [✓ Y] N
PATIENT RECHECK OK for PROCEDURE ✓
TIME- 1545

SYMBOLS:
BP by cuff V Λ
Heart rate ●
Resp rate
BR (transduced)
TOURNIQUET T—T
ANES- X-X
PROC- ⊙-⊘



VENTIL

VT - ml		700	700	710	500
f - breaths/min		10	10	10	10
Peak inf pres / PEEP		14	17	16	—
MODE - S(pon), A(ssist), C(on)	S	C	C	C	S

MONITORS/ACCESSORIES

✓ BP/Auto Cuff	✓ ET CO2 (torr)	40	42	34	36	
BP/oth	✓ FIO2 (Frac or %)	0.6	0.6	0.6	0.6	0.6
ART line	✓ SpO2 (%)	100	100	100	100	
Steth- PC/ES	✓ ECG	SR	ST	ST	SR	SR
Gas analyzer	TEMP-site					
	N-M Block (T/4)					
Warming blkt						
Conv warmer						

Arms x-tucked all pressure points & padded, blue foam pillow under face

Mark with letters & symbols, explain under REMARKS EVENTS Position → O—O

RECOVERY AT 1700
[✓ PACU] ICU ______ (Specify)
OTHER ______
CONDITION:
RESP- SpO2- 99
BP- 122/77 HR- 100

ANESTHESIA / PROCEDURE TIMES

ANES	Start	Room	End
	1545	1550	1710
PROC	Ready	Begin	End
	1600	1610	1655

PROCEDURES and CPT Codes:
Close Buttocks Wounds

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*
#[redacted] - Wd / 2A
-b6-4
[redacted]

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*
GETA
3 miller
8.0 ETT

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*
Eyes taped, DL x 1 s̄ trauma, ⊕ ETCO2, BBS. Secured benzoin & tape, 23 cm @ teeth

SURGEONS: [redacted] -
ANESTHETISTS: [redacted] -b6-2
MAJ, CRNA

PROCEDURE LOCATION: 2-2
DATE: 10/7/03
PAGE 1 OF

DA FORM 7389, FEB 1998
MEDCOM - 13286 COPY 2 - ANESTHESIA PROVIDER
USAPA V1.00

THESIA PLAN OF CARE PRE- OCEDURAL ASSESSMENT (Sedation/ esthesia)

__ DAYS MOS YRS　　Sex ( ) MALE ( ) FEMALE

SED PROCEDURE: conscious sedation for drsg Δ.
CAL SERVICE: -
NCE:

ASA Physical State 1 2 [✓ 3] 4 5 E
WT: 55 [✓ KG]/LB HT: _____ IN.
ALLERGIES: NKDA

:
CCO: 2pack/day
ETOH:
RUGS:

NT MEDICATIONS:
ered as premed

Vancomycin
Levaquin
Lovenox
Albuterol
LR

DICATIONS:
es (@ ______ Hrs) /CC
. ______ mg IV IM PO
. ______ mg IV IM PO
. ______ mg IV IM PO

ATORY STUDIES:
: 9.7 / 30.5
:

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:
- Hypertension [✓ N] Y
- Angina [✓ N] Y
- MI [✓ N] Y
- CVA [✓ N] Y
- Other [✓ N] Y

Pulmonary System:
- Asthma N [✓ Y]
- Bronchitis/URi N Y
- COPD N [✓ Y]
- Other N Y

Renal System:
- Acute/Chronic RF [✓ N] Y

Gastrointestinal:
- Hepatitis [✓ N] Y
- Hiatal Hernia [✓ N] Y
- PUD/GERD [✓ N] Y

Endocrine System:
- Diabetes [✓ N] Y
- Steriods [✓ N] Y
- Thyroid [✓ N] Y

Neurological:
- Seizures [✓ N] Y
- Neuropathy [✓ N] Y
- Other [✓ N] Y

Gynecological :
- Pregnancy [✓ N] Y

Other Significant Hx:
- [✓ N] Y
- [✓ N] Y

Familial HX [✓ N] Y

ASSESSMENT
PAST SURGICAL/ANESTHETIC
conscious sedation c̄ wound debridement.

PHYSICAL EXAMINATION
BP 104/58 HR 111 R 14 T 100.8 94%
Pain Scale 0-10
HEENT - Teeth intact
Trachea Midline.
TMJ/Neck
Oropharnyx
Nares
CHEST: Equal expansion.
CARDIAC:
EXTREMITIES:
IV Access: Ⓡ IJ CVC
Ulnar Filling:
BACK:
OTHER:

NPO Since

HETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ______ { } General: Mask Intubation
conscious sedation.

IED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to an ed with the patient/legal guardian.

ient/legal guardian seems to understand and agrees. Questions answered.

______ Date: ______ Time: ______ Hrs

NESTHESIA EVALUATION AND NOTE (NON ASU)
APPARENT ANESTHETIC COMPLICATIONS { } OTHER

______ Date: ______ Time: ______ Hrs

Identification: (Ward) ICU3

#[redacted]. 66-4

SEDATION KEY:

1. MINIMAL (Anxiolysis) Patient responds normally to verbal commands
2. MODERATE (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is not necessary.
3. DEEP SEDATION/ANALGESIA. Patient responds purposefully following repeated or painful stimulation. Airway assistance may

MEDCOM - 13289

MEDICAL RECORD ANESTHESIA

CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML. " I "=CONSTANT INFUSION

DRUG	(Units)		TOTALS
MSO4	(mg)	5 5	10mg
Versed	(mg)	2.5 2.5 5	10mg
Ketamine	(mg)	50 50	100mg
Propofol	( )	20 10 5 70 5 5 40 20	180mg
Fent	( )	25 25 25 25 25 25	
	( )		

TOTAL EBL

TOTAL URINE

VOLAT AGENT % del

% e.t.

AIR RA L/Min

N2O L/Min

O2 mask L/Min

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS

LINE site ☐ Warmed

☐ Warmed

☐ Warmed

☐ Warmed

LOSSES EST BLOOD LOSS

URINE –

FLUIDS – SUMMARY

CRYSTALLOID– 300 LR

COLLOID– Ø

BLOOD– Ø

REMARKS–

Code drugs with numbers, events with letters

IV Sed for dressing Δ. Chart reviewed ST, KRK See Pre-op 10 July –

@ 2230 Dressing Δ complete. Pt responding to voice commands, VSS. ICU nurse @ bedside

Fentanyl 100ug

ASA STATUS (2) 3 4 5 E

BODY WEIGHT 80 (KG) LB

HEMATOCRIT

VITAL DATA

P –

__/__

R–

EQUIP CHECK

K?– Y N

PATIENT RECHECK

. for PROCEDURE?

AE–

TIME → 21 X 30 X 22 X 30 X 23

SYMBOLS:

BP by cuff V Λ

Heart rate ●

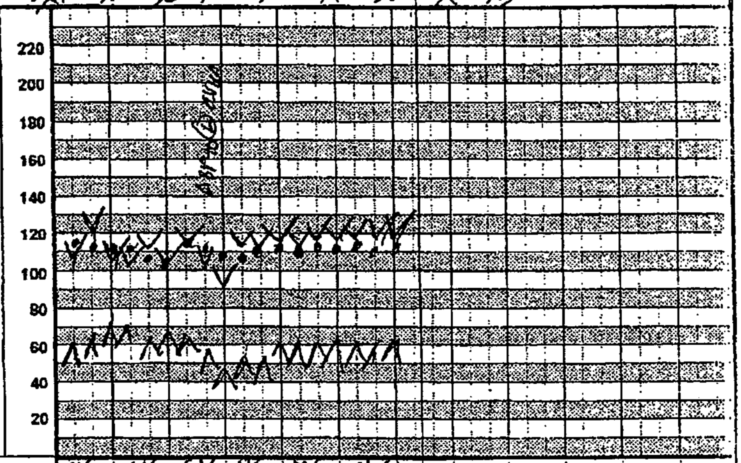
Resp rate

BP (transduced) ⊥ ⊤

TOURNIQUET T – ✗

ANES– X-X

PROC ⊙ – Ø



VT – ml	SV	SV	SV	SV	SV	SV
f – breaths/min	16	16	13	12	12	15
Peak inf pres / PEEP						
MODE– S(pon), A(ssist), C(on)						

BP/Auto Cuff	ET CO2 (torr)							
BP / oth	FIO2 (Frac or %)	>.21	>.21	>.21	>.21	>.21	>.21	
ART line	SpO2 (%)	94 98 97	96	98	96	97		
Steth- PC/ES	ECG	SR	SR	SR	SR	SR	SR	
Gas analyzer	TEMP- site							
	N-M Block (T/4)							
Warming blkt								
Conv warmer								

RECOVERY AT

PACU ICU______ (Specify

OTHER______

CONDITION:

RESP– SpO2–

BP– HR–

ANES THESIA / PROCEDURE TIMES

	Start	Room	End
ANES	2055		2230
PROC	Ready	Begin	End

[redacted]

Mark with letters & symbols, explain under REMARKS EVENTS

Position — a

PROCEDURES and CPT Codes

Dressing Δ

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

IV Sedation Spont Resp

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

PATIENT IDENTIFICATION– Typed or written entries: Name, Grade/Rate, Medical facility

[redacted] 66-4

[redacted]

SURGEONS: [redacted]

ANESTHETIST CRNA

66-2

MEDICAL RECORD – ANESTHESIA

PROCEDURE LOCATION ICU 3

DATE 7/10/03

PAGE 1 OF 1

WAMC OP 376 REVISED
1 Jan 99

PATIENT RECORD

☆ U.S. GPO: 1999 – 528-336/10

MEDCOM - 13290

MEDICAL RECORD — ANESTHESIA

CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML, * I = CONSTANT INFUSION

DRUG (Units)		
Fentanyl (ug)	(5)	
propofol ( )	100 50	
Rocuronium ( )	50	30
lidocaine (mg)	80	
( )		
( )		
VOLAT. AGENT Forane % del		2.5 2.5 1.0 X
% e.t.		
AIR L/Min		
N2O L/Min		
O2 L/Min		2 2 8

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS ▸ [illegible]

LINE site LR, ☐ Warmed
NS ☐ Warmed
PRBC ☐ Warmed
☐ Warmed

LOSSES: EST BLOOD LOSS 200 — 400 50/400
URINE – 175/175

TOTALS	
TOTAL EBL	450
TOTAL URINE	175

FLUIDS – SUMMARY
CRYSTALLOID– ~~16~~ 1100 600LR 500NS
COLLOID–
BLOOD– 2units PRBCs

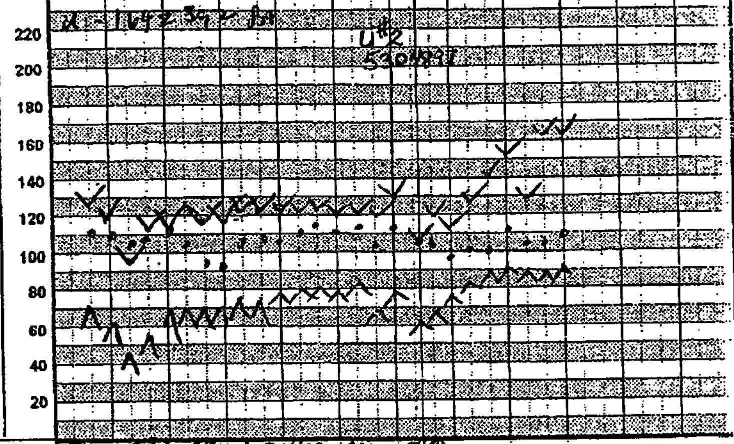
REMARKS– Code drugs with numbers, event with letters
0.6 g
2mg versed

07^15 ALBRITTON RELIEF
07^20 REPLACED EET 2° BAD CUFF
07^25 UNIT#2 PRBCs ↑ 119/70 109
07^45 10mg MORPHINE / IM
07^55 20mg LASIX / SURG REQ
08^13 Suction Agreed to EXTUB

ASA STATUS [✓ 2] 3 4 5 E
BODY WEIGHT 80 [✓ KG] LB
HEMATOCRIT 8/28
INITIAL DATA 119, 61
R– 105
HIP CHECK
K?– [illegible] N
PATIENT RECHECK for PROCEDURE ✓
TIME– 0550

TIME ➡ 06 x 30 x 07 x 30 45 0800 15 30 45

SYMBOLS:
BP by cuff V Λ
Heart rate ●
Resp rate
BP (transduced) ⊥ T
TOURNIQUET T — X
ANES– X-X
PROC– ⊙ – Ø



	VT – ml	750	990	850	600	920	820	840		
	f – breaths/min	10	8	7	9	9	6	6	24	20
	Peak inf pres / PEEP	25	27	22	20	20	21	20		
	MODE– S(pon), A(ssist), C(on)	SV	C	C	C	C	C	C	S	S
✓ BP/Auto Cuff	✓ ET CO2 (torr)	35	30	30	30	28	32	33	39	46
BP / oth	✓ FIO2 (Frac or %)	.87	.87	.87	.86	.86	.85	.85	.85	.88
ART line	✓ SpO2 (%)	100	100	100	100	100	100	100	100	100
Steth- PC/ES	✓ ECG	ST	ST	SR	SR	SR	SR	SR	SR	SR
Gas analyzer	✓ TEMP- site			36.5					36.1	
	✓ N-M Block (T/4)									
Warming blkt										
Conv warmer										

Report to [redacted] b6-2

Mark with letters & symbols, explain under REMARKS EVENTS
Position ⟶ OW —

RECOVERY AT
PACU [✓ ICU 3] (Specify)
OTHER
CONDITION: STABLE Room Air
RESP– 16 SpO2– 93%
BP– 129/72 HR– 118

[redacted]

ANESTHESIA / PROCEDURE TIMES

ANES	Start	Room	End
	0550	0610	08^30
PROC	Ready	Begin	End
	0625	0643	08^07

PROCEDURES and CPT Codes
Debridement burns

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GETA
(+) wheezing Exp Bilat

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
SIVI, DVOI x1 Atraumatic, cuff T, BS=BS

PATIENT IDENTIFICATION– Typed or written entries: Name, Grade/Rate, Medical facility
[redacted] b6-4
ICU-3 / ICU-3

SURGEONS: [redacted]
ANESTHETIST: [redacted] WATERS
b6-2

PROCEDURE LOCATION OR #1
DATE 11 Jul 03

MEDICAL RECORD – ANESTHESIA
WAMC OP 376 REVISED
1 Jan 99

PAGE 1 OF 1

☆ U.S. GPO. 1999 – 528-338/10

PATIENT RECORD

MEDCOM - 13291

ANESTHESIA PLAN OF CARE PR. OCEDURAL ASSESSMENT (Sedation, esthesia)

Age 41 DAYS MOS [✓ YRS] Sex [✓ MALE] ( ) FEMALE

PROPOSED PROCEDURE: wound debridement
SURGICAL SERVICE: GS
NPO SINCE:

ASA Physical State 1 [✓ 2] [✓ 3] 4 5 E
WT: ~80 [✓ KG]/LB HT: ____ IN.
ALLERGIES: ∅

HABITS:
TOBACCO: (+)
ETOH: (+)
DRUGS: ∅

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) Vancomycin 1Gm Q12
( ) proventil MDI
( ) Lovenox 90mg SQ BID
( ) Levaquin 500mg IV QD
( ) Lasix 10mg IV q?
( ) KCl 40mEq IV x1

PREMEDICATIONS:
None Yes (@ ______ Hrs) /CC
______ · ______ mg IV IM PO
______ · ______ mg IV IM PO
______ · ______ mg IV IM PO

LABORATORY STUDIES:
HB/HCT: 9 / 28
U/A:
OTHER:

TAC - 2u PRBC 9 Jul

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:
Hypertension [✓ N] Y
Angina [✓ N] Y
MI [✓ N] Y
CVA [✓ N] Y
Other [✓ N] Y
Pulmonary System:
Asthma N [✓ Y]
Bronchitis/URI N Y
COPD N [✓ Y]
Other N Y
Renal System:
Acute/Chronic RF N Y Foley
Gastrointestinal:
Hepatitis N Y
Hiatal Hernia N Y
PUD/GERD N Y Dobhoff tube Feeding OFF @ 2200
Endocrine System:
Diabetes [✓ N] Y
Steriods [✓ N] Y
Thyroid [✓ N] Y
Neurological:
Seizures [✓ N] Y
Neuropathy [✓ N] Y
Other [✓ N] Y
Gynecological :
Pregnancy N Y N/A
Other Significant Hx:
[✓ N] Y
[✓ N] Y
Familial HX N Y

DVT, Burn

ASSESSMENT
PAST SURGICAL/ANESTHETIC
None Known
pt. denies
? understands

PHYSICAL EXAMINATION SpO_2 97% RA
BP 119/6 HR 105 R 16 T 99
Pain Scale 0-10
HEENT - Teeth Chips ↑ central Inci
Trachea poor dentition
TMJ/Neck 3FB
Oropharynx grade II-III
Nares
CHEST: Scattered Ronchi Decr bilat
CARDIAC: S_1S_2 s̄ (M) ↑HR
EXTREMITIES:
IV Access: (R) EJ
Ulnar Filling:
BACK:
OTHER:

NPO Since 2200

ANESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): [redacted] { } General: Mask Intubation
Prepare Chart ? patient MAJ CRNA

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discussed with the patient/legal guardian.

The patient/legal guardian seems to understand and agrees. Questions answered.
66-2
Signed: ______________ Date: 10 Jul 03 Time: 0030 Hrs

POST-ANESTHESIA EVALUATION AND NOTE (NON ASU)
{ } NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER

Signed: ______________ Date: ________ Time: ______ Hrs

Patient Identification: (Ward) ______________
[redacted] (ICU 3) 66-4

SEDATION KEY:
1. MINIMAL (Anxiolysis) Patient responds normally to verbal commands
2. MODERATE (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is not necessary.
3. DEEP SEDATION/ANALGESIA. Patient responds purposefully following repeated or painful stimulation. Airway assistance may

MEDICAL RECORD ANESTHESIA

ANESTHETIC AGENTS AND DRUGS

CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML. "I"=CONSTANT INFUSION

DRUG (Units)		TOTALS
Fentanyl (25mcg/cc)	8 1 1 1 2 1 3	250mcg
Ketamine (10mg/ml)	1 2 1 1 1 1 1 1	100 mg
Versed (1mg/ml)	3 2 1 1	7mg
( )		
( )		
Robinul (.2mg)		.2mg
VOLAT. AGENT % del		
% e.t.		
AIR L/Min		
N2O L/Min		
O2 L/Min		

TOTAL IN

TOTAL URINE

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS

FLUIDS

LINE site ☐ Warmed

☐ Warmed

☐ Warmed

☐ Warmed

FLUIDS SUMMARY

CRYSTALLOID– 150

COLLOID–

BLOOD–

LOSSES EST BLOOD LOSS

URINE –

PHYS STATUS: 1 2 3 4 5 E

TIME → [illegible]

BODY WEIGHT: 85 [✓ KG] LB

HEMATOCRIT: 30.

INITIAL DATA:

BP– 117 / 57

HR– 111

EQUIP CHECK

OK?– [✓ Y] N

PATIENT PROGRESS

OK for PROCEDURE?

TIME– 0750

SYMBOLS:

BP by cuff ∨ ∧

Heart rate ●

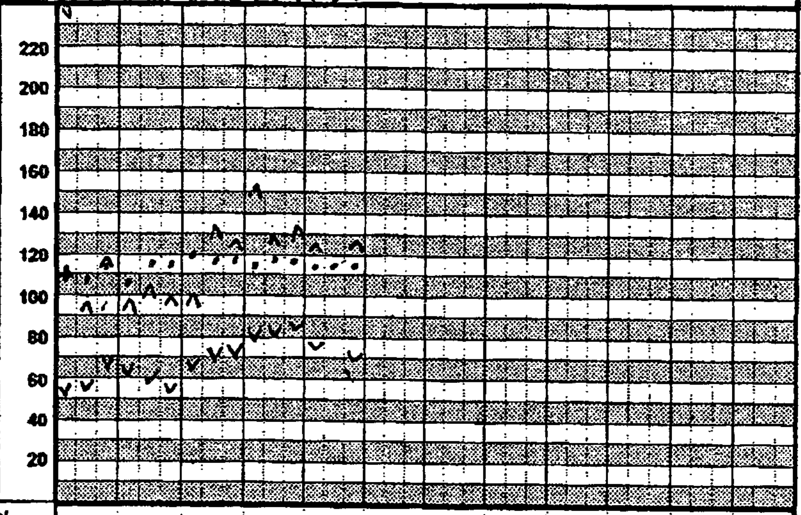
Resp rate

BP (transduced)

TOURNIQUET T – ⊤

ANES– X-X

PROC-⊙-Ø



REMARKS

Code drugs with numbers, events with letters

-Anesthesia Start 0910

-Procedure Start 0915

-Procedure stop 1010

No complications

VENTILATION

VT – ml

f – breaths/min 31 17 12 25 20 23 20 25 14 20 18 15 15 16 16

SpO2 ~~Peak insp pres / PEEP~~ 97 99 100 100 100 100 100 100 100 100 99 98 98 97

MODE– S(pon), A(ssist), C(on) RA NRB NRB NRB NRB NR NRB

MONITORS

[✓ BP/Auto Cuff]	ET CO2 (torr)	
BP / oth	FIO2 (Frac or %)	
ART line	SpO2 (%)	
Steth- PC/ES	ECG	
Gas analyzer	TEMP- site	
	N-M Block (T/4)	
Warming blkt		
Conv warmer		

Mark with letters & symbols, explain under REMARKS EVENTS

Position →

RECOVERY AT

PACU ICU_________(Specify)

OTHER___________

CONDITION:

RESP– SpO2–

BP– HR–

ANESTHESIA / PROCEDURE TIME

	Start	Room	End
ANES	0910		0955
	Ready	Begin	End
PROC	0915		1010

PROCEDURES and CPT Codes

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

PATIENT IDENTIFICATION– (Typed or written entries: Name, Grade/Rate, Medical facility)

[redacted] b6-4

SURGEONS:

ANESTHETISTS: conscious sedation certified

[redacted]

MEDICAL RECORD – ANESTHESIA

b6-2

PROCEDURE LOCATION ICU 3

DATE 11July03

PAGE OF

WAMC OP 376 REVISED
1 [illegible]n 99

MEDCOM - 13293

*U.S. GPO: 2002-729-180/40137

IESTHESIA PLAN OF CARE P. OCEDURAL ASSESSMENT (Sedation. thesia)

je ___ DAYS MOS YRS

Sex [✓ ( )] MALE ( ) FEMALE

ASA Physical State 1 2 [✓ 3] 4 5 E
WT: 80 KG/LB HT: ____ IN.
ALLERGIES: NKDA

OPOSED PROCEDURE: Pressing A
RGICAL SERVICE:
O SINCE: MN

BITS:
)BACCO:
ETOH:
DRUGS:

RRENT MEDICATIONS:
: ordered as premed
Vancomycin 1g BID
Fentanyl patch
Lovenox
Albuterol
Cipro

EMEDICATIONS: ~~ye~~ Yes (@ ____ Hrs) /CC
____ mg IV IM PO
Fentanyl patch mg IV IM PO 50mcg/hr
____ . ____ mg IV IM PO

3ORATORY STUDIES:
HCT: 9 / 28.4
:
HER:

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:
- Hypertension [✓ N] Y
- Angina [✓ N] Y
- MI [✓ N] Y
- CVA [✓ N] Y
- Other [✓ N] Y

Pulmonary System:
- Asthma N [✓ Y]
- Bronchitis/URI [✓ N] Y
- COPD N [✓ Y]
- Other [✓ N] Y

Renal System:
- Acute/Chronic RF [✓ N] Y

Gastrointestinal:
- Hepatitis [✓ N] Y
- Hiatal Hernia [✓ N] Y
- PUD/GERD [✓ N] Y

Endocrine System:
- Diabetes [✓ N] Y
- Steriods [✓ N] Y
- Thyroid [✓ N] Y

Neurological:
- Seizures [✓ N] Y
- Neuropathy [✓ N] Y
- Other [✓ N] Y

Gynecological :
- Pregnancy [✓ N] Y

Other Significant Hx:
- [✓ N] Y
- [✓ N] Y

Familial HX [✓ N] Y

ASSESSMENT
PAST SURGICAL/ANESTHETIC
wound debridement

PHYSICAL EXAMINATION
BP 115/58 HR 104 R 15 T 98.7
Pain Scale 0-10 8
HEENT - Teeth intact
Trachea midline
TMJ/Neck
Oropharnyx
Nares
CHEST: C
CARDIAC: ST Ø ectopy
EXTREMITIES:
IV Access: (R) IJ CVC
Ulnar Filling:
BACK:
OTHER:

NPO Since

IESTHETIC PLAN: ( ) LOCAL ( ) MAC ( ) Regional (Specify): ____ ( ) General: Mask Intubation
Conscious sedation

ORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and cussed with the patient/legal guardian.

: pati [redacted] seems to understand and agrees. Questions answered. b6-2
ned: MD/ [illegible] Date: 12 Jul Time: 0700 Hrs

ST-ANE VALUATION AND NOTE (NON ASU)
NO APP ESTHETIC COMPLICATIONS ( ) OTHER

ned: ____ Date: ____ Time: ____ Hrs

SEDATION KEY:
1. MINIMAL (Anxiolysis) Patient responds normally to verbal commands
2. MODERATE (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is not necessary.
3. DEEP SEDATION/ANALGESIA. Patient responds purposefully following repeated or painful stimulation. Airway assistance may be necessary.
4. ANESTHESIA. Patient does not respond to painful stimulation.

ient Identification: (Ward) ICW 3

[redacted] b6-4

MEDCOM - 13294

MEDICAL RECORD - ANESTHESIA

For u this form, see AR 40-66; the proponent agency a OTSG

PreOp Robinul 0.2mg

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML. "I" = CONSTANT INFUSION

DRUG (Units)				TOTALS
Midaz (mg)	5			5mg
Fent (mcg)	50 50	50	25	175mcg
Ketamine (mg)	50/50/50/20/30/100			300mg
( )				
( )				
( )				
VOLAT AGENT % del				
% e.t.				
AIR L/Min				
N2O L/Min				
Mask O2 L/Min				

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS →

TOTAL EBL: min

TOTAL URINE: NA

FLUIDS

LINE site (R) 20 IJ/3	☐ Warmed	LR, →
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

FLUIDS SUMMARY

CRYSTALLOID- 400 LR

COLLOID-

BLOOD-

LOSSES

EST BLOOD LOSS

URINE -

REMARKS

Code drugs with numbers, events with letters

0800 PreOp eval review, no Δ.

0815 OR #2 monitors↑ Mask O2

PHYS STATUS 1 [✓ 2] 3 4 5 E

BODY WEIGHT 80 [✓ KG] LB

HEMATOCRIT

INITIAL DATA

BP- 102/63

HR- 123

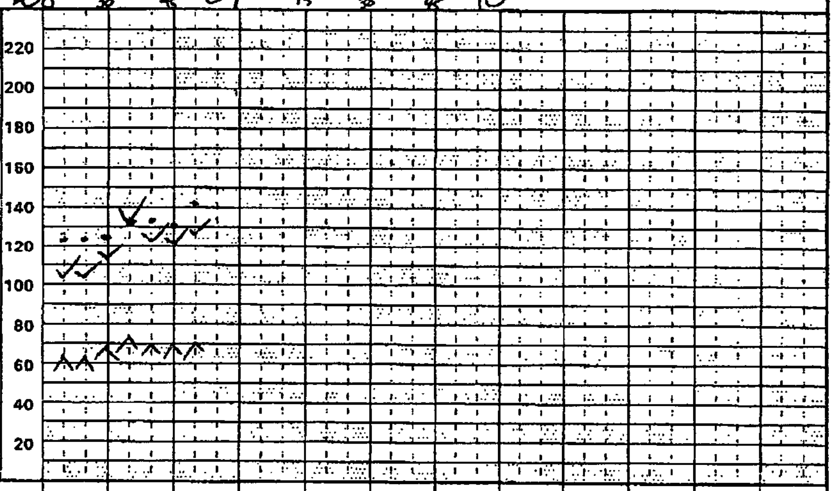
EQUIP CHECK [✓ OK?] Y N

PATIENT RECHECK [✓ OK for PROCEDURE?]

TIME-

TIME → 0815 30 45 0900 15 30 45 1000

SYMBOLS: BP by cuff V Λ; Heart rate ●; Resp rate ○; BR (transduced) ╪; TOURNIQUET T—T; ANES- X-X; PROC- ⊙-Ø



VENTIL

VT - ml				
f - breaths/min	16	20	12	12
Peak inf pres / PEEP				
MODE - S(pon), A(ssist), C(on)	S	S	S	S

MONITORS/ACCESSORIES

✓ BP/Auto Cuff	ET CO2 (torr)	
BP/oth	FIO2 (Frac or %)	>.21
ART line	SpO2 (%)	96 98 100
✓ Steth- PC/ES	ECG	ST
Gas analyzer	TEMP-site	Avail →
	N-M Block (T/4)	
Warming blkt		
Conv warmer		

Mark with letters & symbols, explain under REMARKS — EVENTS → Position → Supine

Report to [redacted] LT 66-2

RECOVERY AT

PACU [✓ ICU 3] (Specify)

OTHER

CONDITION: Stable

RESP- O2/mask 16 SpO2- 99

BP- 119/59 HR- 131

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0800	0815	0910
	Ready	**Begin**	**End**
PROC	0820	0825	0855

PROCEDURES and CPT Codes: Burn Wd Debridement & Dsg Δ.

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

Sed

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*

[redacted] [redacted]

66-4

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*

Mask O2

SURGEONS: [redacted] 66-2

ANESTHETIST: [redacted]

PROCEDURE LOCATION: OR #2

DATE: 13 July 03

PAGE 1 OF 1

[redacted]

DA FORM 7389, FEB 1998 MEDCOM - 13295 'Y 1 - PATIENT'S MEDICAL RECORD USAPA V1.00

ANESTHESIA PLAN OF CARE PRE EDURAL ASSESSMENT (Sedation thesia)

Age 47 DAYS MOS [✓ YRS]

Sex (X) MALE ( ) FEMALE

PROPOSED PROCEDURE: WD DEBRIDEMENT/DSG Δ

SURGICAL SERVICE:

NPO SINCE:

ASA Physical State 1 [✓ 2] 3 4 5 E

WT: 80 [✓ KG]/LB HT: _____ IN.

ALLERGIES: NKDA

HABITS:

TOBACCO: Smoker

ETOH: yes

DRUGS: 0

CURRENT MEDICATIONS:

( ) = ordered as premed

( ) Ket

( ) Fent

( ) Versed

( ) Lovenox

( ) Albuterol

( ) Ciprofloxin

PREMEDICATIONS:

None Yes (@ _____ Hrs) /CC

_____ . _____ mg IV IM PO

_____ . _____ mg IV IM PO

_____ . _____ mg IV IM PO

LABORATORY STUDIES:

HB/HCT: _____ / _____

U/A:

OTHER:

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:

Hypertension [✓ N] Y

Angina [✓ N] Y

MI [✓ N] Y

CVA [✓ N] Y

Other N Y

Pulmonary System:

Asthma N [✓ Y]

Bronchitis/URI N Y

COPD N [✓ Y]

Other N Y

Renal System:

Acute/Chronic RF N Y Foley

Gastrointestinal:

Hepatitis N Y DOB

Hiatal Hernia N Y

PUD/GERD N Y

Endocrine System:

Diabetes [✓ N] Y

Steriods [✓ N] Y

Thyroid [✓ N] Y

Neurological:

Seizures [✓ N] Y

Neuropathy [✓ N] Y

Other [✓ N] Y

Gynecological :

Pregnancy N Y

Other Significant Hx:

N Y

N Y

Familial HX N Y

DVT, Burn

ASSESSMENT

PAST SURGICAL/ANESTHETIC

Debridement &

Dsg Δ

PHYSICAL EXAMINATION

BP 107/55 HR 107 R 16 T ___

Pain Scale 0-10

HEENT - Teeth Chipped c̄ Poor Dent

Trachea

TMJ/Neck 3+

Oropharnyx MP 2+

Nares

CHEST:

CARDIAC:

EXTREMITIES:

IV Access:

Ulnar Filling:

BACK:

OTHER:

NPO Since

ANESTHETIC PLAN: ( ) LOCAL ( ) MAC ( ) Regional (Specify): _____ ( ) General: Mask Intubation

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discussed with the patient/legal guardian.

b6-2

The patie [redacted] nderstand and agrees. Questions answered.

Signed: _____ Date: 13 Jul 03 Time: 0800 Hrs

POST-ANESTHESIA EVALUATION AND NOTE (NON ASU)

( ) NO APPARENT ANESTHETIC COMPLICATIONS ( ) OTHER

Signed: _____ Date: _____ Time: _____ Hrs

SEDATION KEY:

1. MINIMAL (Anxiolysis) Patient responds normally to verbal commands
2. MODERATE (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is not necessary.
3. DEEP SEDATION/ANALGESIA. Patient responds purposefully following repeated or painful stimulation. Airway assistance may be necessary.
4. ANESTHESIA. Patient does not respond to painful stimulation.

Patient Identification: (Ward)

[redacted]

b6-4

ICU3

ICU3

[redacted]

WAMC Form 2300 (Revised) 15 Mar 01 MCXC-DOS

MEDCOM - 13296

Previous edition is obsolete

☆ U.S. GPO: 2002-729-283

MEDICAL RECORD ANESTHESIA

CONTINUOUS / REPEATED DRUGS
SPECIFY UNITS – MG / MCG / ML
– * = CONSTANT INFUSION

DRUG	Units					
Ketamine (10 mg/cc)		5	2	1	1	1
Fentanyl	mcg	41		2	2	
Versed	(mg)	42		2		

VOLAT. AGENT % del % e.t.
AIR L/Min
N2O L/Min
O2 L/Min

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS

LINE site ☐ Warmed
☐ Warmed
☐ Warmed
☐ Warmed

LOSSES EST BLOOD LOSS
URINE –

TOTALS
T 60
150
8

TOTAL EBL 0

TOTAL URINE

FLUIDS – SUMMARY
CRYSTALLOID– 100
COLLOID–
BLOOD–

REMARKS–
Code drugs with numbers, events with letters

Robinul .2 mg
Pt recovered c ICU 3
0 complications

ASA STATUS 1 2 [✓ 3] 4 5 E

BODY WEIGHT 85 KG

HEMATOCRIT 27.8

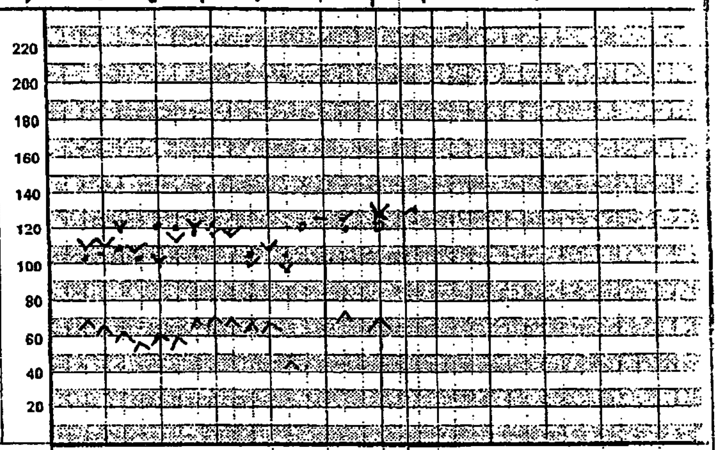
INITIAL DATA
159, 70
R– 109

EQUIP CHECK
OK /– [✓ Y] N

PATIENT RECHECK
... PROCEDURE? Y
TIME – 0745

TIME → 45 8⁰⁰ 15 30 45 9⁰⁰ 15 30 45

SYMBOLS:
BP by cuff V Λ
Heart rate ●
Resp rate
BP (transduced)
TOURNIQUET T – ✗
ANES– X-X
PROC-⊙-Ø



VT – ml		
f – breaths/min	18 18 13 20 14 15 14 14 16 16 18 20 22	
Peak insp pres / PEEP		
MODE– S(pon), A(ssist), C(on)	S S S S S S S S S S S S S	
BP/Auto Cuff	ET CO2 (torr)	
BP / oth	FIO2 (Frac or %)	NRB
ART line	SpO2 (%)	96 100 100 100 100 100 100 100 100 100
Steth- PC/ES	ECG	ST ST
Gas analyzer	TEMP- site	
	N-M Block (T/4)	
Warming blkt		
Conv warmer		

Mark with letters & symbols, explain under REMARKS EVENTS
Position → legs arms trm

RECOVERY AT
PACU ICU 3 (Specify)
OTHER
CONDITION:
RESP- 18 SpO2- 99 on NRB
BP- 128/68 HR- 124

ANESTHESIA / PROCEDURE TIME

	Start	Room	End
ANES	0750	0750	0900
	Ready	Begin	End
PROC	0755	0755	0900

PROCEDURES and CPT Codes

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
Versed, fentanyl, ketamine

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

PATIENT IDENTIFICATION– Typed or written entries: Name, Grade/Rate, Medical facility

SURGEONS: 66-2

ANESTHETIST 1LT [redacted] RN

PROCEDURE LOCATION ICU 3

DATE 14 Jul

PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED
1 Jan 99

U.S. GPO 1999 – 528 338/10

PATIENT RECORD

[redacted] 66-4

[redacted]

MEDCOM - 13297

IESTHESIA PLAN OF CARE PR OCEDURAL ASSESSMENT (Sedation/A nesthesia)

? je 45 DAYS MOS [✓ YRS] Sex [✓ MALE] ( ) FEMALE

OPOSED PROCEDURE: drsg Δ
RGICAL SERVICE:
O SINCE: 0200

ASA Physical State 1 2 [✓ 3] 4 5 E
WT: 80 KG/LB HT: ______ IN.
ALLERGIES: 0

BITS:
OBACCO: 0 2ppd
ETOH: 0
DRUGS:

RRENT MEDICATIONS:
: ordered as premed
Vanc
CIPRO
[illegible] prn
Lovenox
Albuterol

EMEDICATIONS: none
ie Yes (@ ______ Hrs) /CC
___ . ______ mg IV IM PO
___ . ______ mg IV IM PO
___ . ______ mg IV IM PO

BORATORY STUDIES:
HCT: 8.7 / 27.8
:
HER:

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:		
Hypertension	[✓ N] Y	
Angina	[✓ N] Y	
MI	[✓ N] Y	
CVA	[✓ N] Y	
Other	[✓ N] Y	
Pulmonary System:		
Asthma	N [✓ Y]	
Bronchitis/URI	[✓ N] Y	
COPD	N [✓ Y]	
Other	[✓ N] Y	
Renal System:		
Acute/Chronic RF	[✓ N] Y	
Gastrointestinal:		
Hepatitis	[✓ N] Y	
Hiatal Hernia	[✓ N] Y	
PUD/GERD	[✓ N] Y	
Endocrine System:		
Diabetes	[✓ N] Y	
Steriods	[✓ N] Y	
Thyroid	[✓ N] Y	
Neurological:		
Seizures	[✓ N] Y	
Neuropathy	[✓ N] Y	
Other	[✓ N] Y	
Gynecological :		
Pregnancy	N Y	
Other Significant Hx:		
	N Y	
	N Y	
Familial HX	N Y	

ASSESSMENT
PAST SURGICAL/ANESTHETIC

PHYSICAL EXAMINATION 5
BP ___ HR 105 R 18 T 99
Pain Scale 0-10 0
HEENT - Teeth intact
Trachea midline
TMJ/Neck
Oropharnyx
Nares
CHEST: CTA bil
CARDIAC: ST $S_1 S_2$
EXTREMITIES:
IV Access: (R) SC
Ulnar Filling:
BACK:
OTHER:

NPO Since ______

IESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ______ { } General: Mask Intubation

ORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and cussed with the patient/legal guardian.

b6-2

: patie[redacted]eems to understand and agrees. Questions answered.
ned: ICT / Date: 14 Jul 03 Time: 0700 Hrs

ST-ANES[redacted]UATION AND NOTE (NON ASU)
NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER

ned: ______ Date: ______ Time: ______ Hrs

SEDATION KEY:

1. MINIMAL (Anxiolysis) Patient responds normally to verbal commands
2. MODERATE (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is not necessary.
3. DEEP SEDATION/ANALGESIA. Patient responds purposefully following repeated or painful stimulation. Airway assistance may be necessary.
4. ANESTHESIA. Patient does not respond to painful stimulation.

ient Identification: (Ward) ICU 3

[redacted] b6-4

MEDCOM - 13298

45/MALE - NKDA

MEDICAL RECORD - ANESTHESIA

For u this form, see AR 40-66; the proponent agency e OTSG

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS, SPECIFY UNITS - MG/MCG/ML, "I" = CONSTANT INFUSION

DRUG (Units)												TOTALS
MIDAZ (mg)	15											5mg
FENT (mcg)	200	50										250mcg
PROPOFOL (mg)	150											150mg
( )												
MSO4 ( )		5		5					5	5		20mg
Succ (mg)	100											
VOLAT AGENT FORANE % del	2 4	2					1.5		1	X		
% e.t.												
AIR L/Min												
N2O L/Min												
O2 L/Min	4 2 4											

TOTAL EBL:

TOTAL URINE:

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS: 1 4N

FLUIDS

LINE site (R) IJ 3L ☐ Warmed LR —— 1000

☒ Warmed PRBC [XXXXXXX]

☐ Warmed

☐ Warmed

LOSSES EST BLOOD LOSS

URINE -

FLUIDS SUMMARY

CRYSTALLOID L/R 1350

COLLOID-

BLOOD- PRBC 2 u

PHYS STATUS: 1 2 [✓ 3] 4 5 E

BODY WEIGHT: 80 60 ~~75~~

HEMATOCRIT:

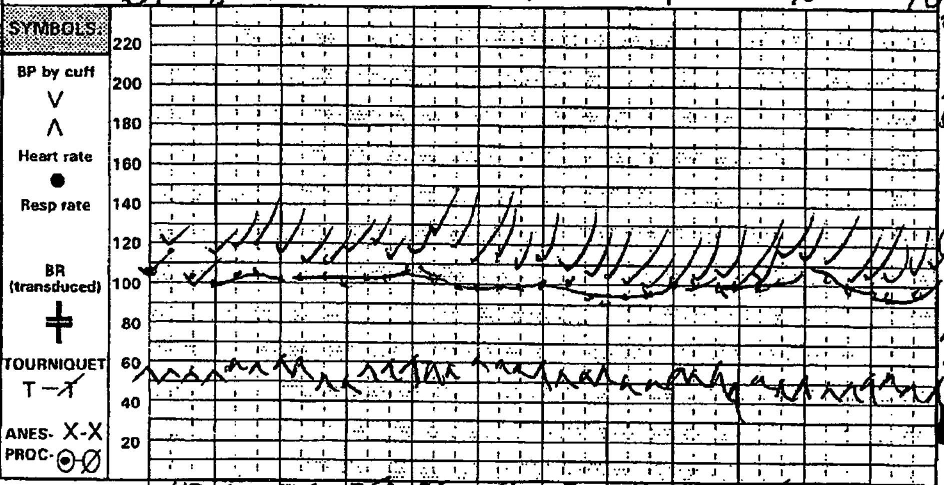
INITIAL DATA: BP- 104/67 HR- 104

EQUIP CHECK: [✓ OK?] Y N

PATIENT RECHECK: [✓ OK for PROCEDURE?] TIME- 0658

TIME → 0700 15 30 8 30 9 30 10

SYMBOLS: BP by cuff V ∧ Heart rate ● Resp rate BR (transduced) TOURNIQUET T — T ANES- X-X PROC- ⊙-⊘



VT - ml	640		750	750	750	750	730	730	730	600		
f - breaths/min 12	8	12	9	9	9	9	8	8	8	14		
Peak Inf pres / PEEP	23		26	27	27	27	27	27	27	30		
MODE - S(pon), A(ssist), C(on) S	C	A	C	C	C	C	C	C	C	A	SV	SV
✓ BP/Auto Cuff ✓ ET CO2 (torr)	40	45	40	28	30	29	27	29	23	36	40	
BP/oth ✓ FIO2 (Frac or %)	.82	.8	.83	.8	.8	.8	.8	.8	.8	.8	.8	.9
ART line ✓ SpO2 (%)	100	100	100	100	100	100	100	100	100	100	100	100
✓ Steth- PC/ES ✓ ECG	ST	ST	ST	ST	SR	SR	SR	SR	SR	SR	SR	SR
Gas analyzer ✓ TEMP site AVAIL	→	34	34	34	34	34	34	34	34	34	34	33
N-M Block (T/4)	4/4 4/4 4/4	4/4										
Warming blkt												
Conv warmer												

Mark with letters & symbols, explain under REMARKS EVENTS → *Position*

REMARKS

Code drugs with numbers, events with letters

0645 PreOp EVAL REVIEW. (R) IJ 3L → LR

0657 OR #2 MONITORS ↑ PreO2 IND/INT

Roland [redacted] @ 0725

0755 PRBC (B+)

1860465

0805 PRBC (O+)

4824472

HCT - 30.2 @ 9

Lasix 20 [redacted]

@ 0935

[redacted]

0948

To ICU 3 @ 10cc obe

RECOVERY AT: PACU [✓ ICU 3] (Specify)

OTHER

CONDITION: RESP 18 SpO2- 99 BP- 133/82 HR- 93

ANESTHESIA / PROCEDURE TIMES

ANES	Start 0615	Room 0659	End :
PROC	Ready 0705	Begin 0715	End 0945

PROCEDURES and CPT Codes: SKIN GRAFT & DEBRIDEMENT

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* GETA

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*

[redacted] b6-4 ICU-3/ICU-3

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* DLx1/MAC 3, 8.0 ETT → VC c̄ BBS⊜ ETCO2 (+), EYES TAPED, SECURED 22cm/TEETH

SURGEONS [redacted] — b6-2

[redacted] [redacted]

PROCEDURE 28 CSH LOCATION: OR #2

DATE: 15 July 03

PAGE 1 OF

DA FORM 7389, FEB 1998 MEDCOM - 13299 1 - PATIENT'S MEDICAL RECORD USAPA V1.00

ANESTHESIA PLAN OF CARE PRE. :EDURAL ASSESSMENT (Sedation/. .thesia)

Age 45 DAYS MOS [✓ YRS]   Sex ( ) MALE ( ) FEMALE

PROPOSED PROCEDURE: Debridement + Graft Burns
SURGICAL SERVICE: ____
NPO SINCE: 24°

ASA Physical State 1 2 [✓ 3] 4 5 E
WT: 80 KG/LB HT: ____ IN.
ALLERGIES: Ø

HABITS:
TOBACCO: ____
ETOH: ____
DRUGS: ____

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) Vanco
( ) Cipro
( ) Lovenox
( ) Albuterol
( ) ____
( ) ____

PREMEDICATIONS: Ø
None Yes (@ ____ Hrs) /CC
____ . ____ mg IV IM PO
____ . ____ mg IV IM PO
____ . ____ mg IV IM PO

LABORATORY STUDIES:
HB/HCT: 8.7 / 27.8
U/A: ____
OTHER: ____

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:			
Hypertension	[✓ N]	Y	
Angina	[✓ N]	Y	
MI	[✓ N]	Y	
CVA	[✓ N]	Y	
Other	N	Y	
Pulmonary System:			
Asthma	N	[✓ Y]	
Bronchitis/URI	[✓ N]	Y	
COPD	N	[✓ Y]	
Other	[✓ N]	Y	
Renal System:			
Acute/Chronic RF	[✓ N]	Y	
Gastrointestinal:			
Hepatitis	[✓ N]	Y	
Hiatal Hernia	[✓ N]	Y	
PUD/GERD	[✓ N]	Y	
Endocrine System:			
Diabetes	[✓ N]	Y	
Steriods	[✓ N]	Y	
Thyroid	[✓ N]	Y	
Neurological:			
Seizures	[✓ N]	Y	
Neuropathy	[✓ N]	Y	
Other	[✓ N]	Y	
Gynecological :			
Pregnancy	N	Y	
Other Significant Hx:			
	N	Y	
	N	Y	
Familial HX	N	Y	

ASSESSMENT
PAST SURGICAL/ANESTHETIC
____

PHYSICAL EXAMINATION
BP ___ HR ___ R ___ T ___
Pain Scale 0-10 ____
HEENT - Teeth ____
Trachea ____
TMJ/Neck ____
Oropharnyx ____
Nares ____
CHEST: ____
CARDIAC: ____
EXTREMITIES: ____
IV Access: ____
Ulnar Filling: ____
BACK: ____
OTHER: ____

NPO Since ____

ANESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ____ {✓} General: Mask Intubation

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discussed with the patient/legal guardian.

66-2

The patient/l [redacted] grees. Questions answered.
Signed: [redacted] Date: 15 Jul 03 Time: 07 10 Hrs

POST-ANESTHESIA EVALUATION AND NOTE (NON ASU)
{ } NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER

Signed: ____ Date: ____ Time: ____ Hrs

SEDATION KEY:

1. MINIMAL (Anxiolysis) Patient responds normally to verbal commands
2. MODERATE (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is not necessary.
3. DEEP SEDATION/ANALGESIA. Patient responds purposefully following repeated or painful stimulation. Airway assistance may be necessary.
4. ANESTHESIA. Patient does not respond to painful stimulation.

Patient Identification: (Ward) ____

#[redacted] 66-4   ICU-3/ICU-3

WAMC Form 2300 (Revised) 15 Mar 01 MCXC-DOS

MEDCOM - 13300

Previous edition is obsolete
☆ U.S GPO: 2002-729-283

IVSed Dressing Δ

MEDICAL RECORD - ANESTHESIA

For use of this form, see AR 40-66; the proponent agency is ... Surgeon General

Chart Reviewed
~~1450~~ 100/50 T100.4
RR16 HR108 sat 96%

ANESTHETIC AGENTS AND DRUGS

CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML. "I" = CONSTANT INFUSION

DRUG (Units)							TOTALS
Versed (mg)	5	5					10mg
Ketamine (mg)	50	25/25					100mg
MSO4 (mg)	5	5					10mg
Fentanyl (µg)	25 25	50	50	50	50		250µg
Propofol (mg)	10<	30> <70	>	<50>			110mg
( )							
VOLAT AGENT % del							
VOLAT AGENT % e.t.							
AIR L/Min							
N2O L/Min							
O2 NC L/Min	4	4	4	4	4		
SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS							

TOTAL EBL: 0

TOTAL URINE: 0

FLUIDS SUMMARY

CRYSTALLOID- LR 200

COLLOID- 0

BLOOD- 0

FLUIDS

LINE site LR 1000 ☐ Warmed		100		200	
☐ Warmed					
☐ Warmed					
☐ Warmed					

LOSSES: EST BLOOD LOSS
URINE -

REMARKS

Code drugs with numbers, events with letters

TO ICU 3 for Dressing Δ. Pt NPO since 0500. monitors on

1245 Dressing Δ complete spont resp @ responsive throughout

1255 VSS Report given.

PHYS STATUS: 1 [✓ 2] 3 4 5 E

BODY WEIGHT: 90 [✓ KG] LB

HEMATOCRIT:

INITIAL DATA: BP- 102/51

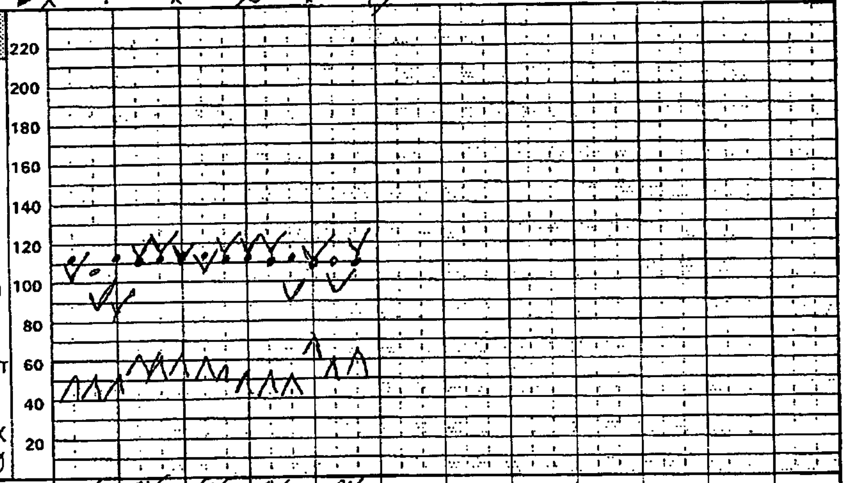
HR- 111

EQUIP CHECK: OK?- Y N

PATIENT RECHECK: OK for PROCEDURE? TIME-

TIME ➔ X 12 X 30 X 13

SYMBOLS: BP by cuff ∨ ∧; Heart rate ●; Resp rate ○; BP (transduced) ╪; TOURNIQUET T—T; ANES- X-X; PROC- ⊙-Ø



VENTIL

VT - ml	SV	SV	SV	SV	SV
f - breaths/min	24	28	20	21	18
Peak Inf pres / PEEP					
MODE - S(pon), A(ssist), C(on)					

MONITORS/ACCESSORIES

BP/Auto Cuff	~~ET CO2 (torr)~~					
BP/oth	~~FIO2 (Frac or %)~~	↑.21	↑.21	↑.21	↑.21	↑.21
ART line	~~SpO2~~ (%) NC	98	100	92	96	98
Steth- PC/ES	ECG	SR ~~98~~	~~100~~	SR	SR	SR
Gas analyzer	TEMP-site					
	N-M Block (T/4)					
Warming blkt						
Conv warmer						

Mark with letters & symbols, explain under REMARKS EVENTS ➔ Position

RECOVERY AT: ICU3

PACU ICU ______ (Specify)

OTHER

CONDITION:

RESP- 16 SpO2- 98

BP- 110/74 HR- 110

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1150		1245
PROC	Ready	Begin	End

PROCEDURES and CPT Codes:
Burn Dressing Δ

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*

ETW [redacted] b6-4

SURGEONS: [redacted] b6-2

[redacted] CRNA

PROCEDURE LOCATION: ICU 3

DATE: 7/16/03

PAGE 1 OF 1

DA FORM 7389, FEB 1998 COPY 1 - PATIENT'S MEDICAL RECORD USAPA V1.00

MEDCOM - 13301

MEDICAL RECORD ANESTHESIA

CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML, * (*CONSTANT INFUSION

DRUGS (Units)	45	8⁰⁰	15	30	45	TOTALS
KETAmine (10mg/cc)		50	30 20			100
fentanyl 25mcg/cc		125		50 75 25		275
Versed 1mg/cc ( )		5	2	1		8
MSO4 ( )				2		2
( )						
( )						

VOLAT AGENT % del
% e.t.
AIR L/Min
N2O L/Min
O2 L/Min

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS

TOTAL EBL: 0

TOTAL URINE

FLUIDS – SUMMARY
CRYSTALLOID– 50
COLLOID–
BLOOD–

FLUIDS
LINE site ☐ Warmed
☐ Warmed
☐ Warmed
☐ Warmed

LOSSES EST BLOOD LOSS
URINE –

REMARKS–
Code drugs with numbers, events with letters

0.2 mg Robinul
→ monitors on
– 0 complications

PHYS STATUS: 1 2 [✓ 3] 4 5 E

BODY WEIGHT: 80 [✓ KG] LB

HEMATOCRIT: 35

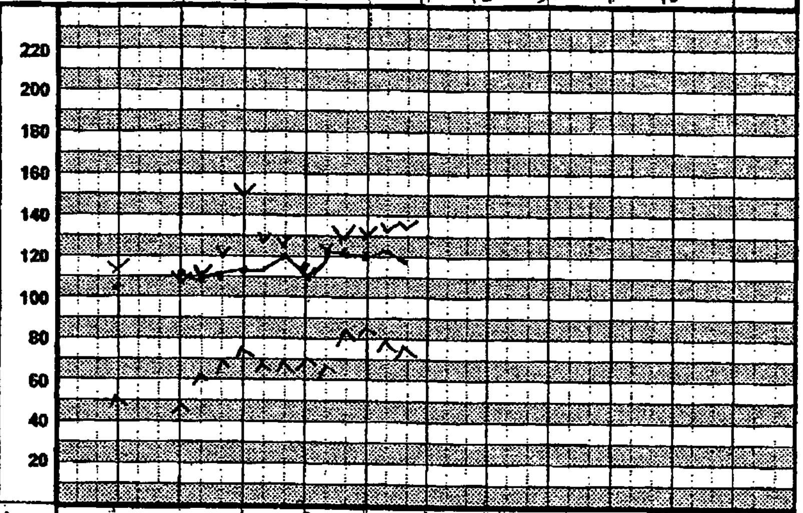
INITIAL DATA:
BP– 105/55
HR– 107

OK?– [✓ Y] N

OK for PROCEDURE? Y
TIME– 0746

TIME → 45 8⁰⁰ 15 30 45 9⁰⁰ 15 30 45 10⁰⁰

SYMBOLS:
BP by cuff V Λ
Heart rate ●
Resp rate
BP (transduced)
TOURNIQUET T – ⊤
ANES– X-X
PROC– ⊙-Ø



	45	8⁰⁰	15	30	45	9⁰⁰
VT – ml						
f – breaths/min	16	12 19	20 30	18 20	18 19	
Peak inf pres / PEEP						
MODE– S(pon), A(ssist), C(on)	S	S S	S			
ET CO2 (torr)						
FIO2 (Frac or %)	RA	NRB →		→ RA		
SpO2 (%)	94	95 97	94 95 96	91 94	94	
ECG	ST	ST			ST	
TEMP- site						
N-M Block (T/4)						

BP/Auto Cuff
BP / oth
ART line
Steth- PC/ES
Gas analyzer
Warming blkt
Conv warmer

Mark with letters & symbols, explain under REMARKS EVENTS: start dressing, drugs turn
Position → legs

RECOVERY AT
PACU ICU 3 (Specify)
OTHER
CONDITION: stable, awake
RESP– 14 SpO2– 94 RA
BP– 121/69 HR– 117

	Start	Room	End
ANES	0800	0800	0900
	Ready	**Begin**	**End**
PROC	0745	0805	0850

PROCEDURES and CPT Codes
dressing change

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*
versed, fentanyl, Ketamine

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*

PATIENT IDENTIFICATION – *Typed or written entries: Name, Grade/Rate, Medical facility*

[redacted] b6-4

SURGEONS: [redacted]

ANESTHETISTS: [redacted] – b6-2

PROCEDURE LOCATION: ICU 3

DATE: 17 Jul 03

PAGE OF

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED
1 Jan 99

MEDCOM - 13302

*U.S. GPO: 2002-729-180/40137

ANESTHESIA PLAN OF CARE PRE CEDURAL ASSESSMENT (Sedation/ sthesia)

Age ___ DAYS MOS YRS

Sex [✓ MALE] ( ) FEMALE

ASA Physical State 1 2 [✓ 3] 4 5 E
WT: 80 KG/LB HT: _____ IN.
ALLERGIES: unk

PROPOSED PROCEDURE: dressing change
SURGICAL SERVICE: ____________
NPO SINCE: 0200

HABITS:
TOBACCO: Y
ETOH: ____________
DRUGS: ____________

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) lovenox
( ) 50 mcg fentanyl patch
( ) ____________
( ) ____________
( ) ____________
( ) ____________

PREMEDICATIONS: 0
None Yes (@ ______ Hrs) /CC
______ . ______ mg IV IM PO
______ . ______ mg IV IM PO
______ . ______ mg IV IM PO

LABORATORY STUDIES:
HB/HCT: 11 / 35
U/A: ____________
OTHER: ____________

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:
Hypertension [✓ N] Y
Angina [✓ N] Y
MI [✓ N] Y
CVA [✓ N] Y
Other N Y
Pulmonary System:
Asthma N [✓ Y]
Bronchitis/URI [✓ N] Y
COPD N [✓ Y]
Other N Y
Renal System:
Acute/Chronic RF [✓ N] Y
Gastrointestinal:
Hepatitis [✓ N] Y
Hiatal Hernia [✓ N] Y
PUD/GERD [✓ N] Y
Endocrine System:
Diabetes [✓ N] Y
Steriods [✓ N] Y
Thyroid [✓ N] Y
Neurological:
Seizures [✓ N] Y
Neuropathy [✓ N] Y
Other N Y
Gynecological :
Pregnancy [✓ N] Y
Other Significant Hx:
N Y
N Y
Familial HX N Y

ASSESSMENT
PAST SURGICAL/ANESTHETIC
____

PHYSICAL EXAMINATION
BP 10/75 HR 109 R 18 T 100.4
Pain Scale 0-10 4/10
HEENT - Teeth intact
Trachea midline
TMJ/Neck ____________
Oropharnyx ____________
Nares ____________
CHEST: CTA dim bases
CARDIAC: S1S2 ST 0 ectopy
EXTREMITIES:
IV Access: (R) SC
Ulnar Filling: ____________
BACK: ____________
OTHER: ____________

NPO Since 0200

ANESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ____________ { } General: Mask Intubation

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discussed with the patient/legal guardian.

b6-2

The pa[redacted] seems to understand and agrees. Questions answered.
Signed: Date: 17 Jul 03 Time: 0745 Hrs

POST-ANES IA EVALUATION AND NOTE (NON ASU)
{ } NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER

Signed: ____________ Date: ______ Time: ______ Hrs

Patient Identification: (Ward) ____________

[redacted] b6-4

SEDATION KEY:

1. MINIMAL (Anxiolysis) Patient responds normally to verbal commands
2. MODERATE (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is not necessary.
3. DEEP SEDATION/ANALGESIA. Patient responds purposefully following repeated or painful stimulation. Airway assistance may be necessary.
4. ANESTHESIA. Patient does not respond to painful stimulation.

WAMC Form 2300 (Revised) 15 Mar 01 MCXC-DOS

MEDCOM - 13303
PATIENT RECORD COPY

Previous edition is obsolete

☆ U.S. GPO. 2002-729-253

MEDICAL RECORD ANESTHESIA

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML. "I"=CONSTANT INFUSION

DRUG	Units							TOTALS
Ketamine	10mg/cc	50	20	20 10	30	20	30	180
Fent	25mcg/cc	150	50	50				250
Versed	1mg/cc	5 2		1				8
MSO4	1mg/cc	(5) 3		3	2	2		13
	( )							
	( )							

VOLAT. AGENT % del / % e.t.

AIR L/Min
N2O L/Min
O2 L/Min

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS

FLUIDS: LINE site ☐ Warmed ☐ Warmed ☐ Warmed ☐ Warmed

LOSSES: EST BLOOD LOSS / URINE –

TOTAL EBL

TOTAL URINE

FLUIDS – SUMMARY
CRYSTALLOID– 100
COLLOID– 0
BLOOD– 0

REMARKS
Code drugs with numbers, events with letters
.2 mg robinul

TIME → 8⁰⁰ 15 30 45 9⁰⁰ 15 30 45 10⁰⁰ 15 30 45

PHYS STATUS 1 2 [✓ 3] 4 5 E

BODY WEIGHT 70 KG

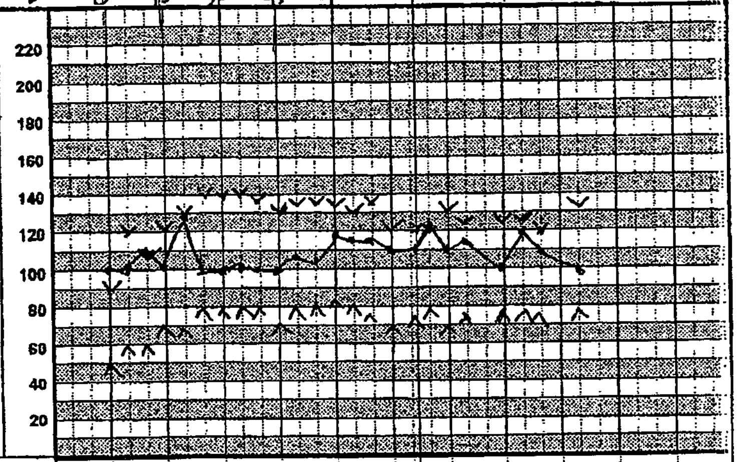
HEMATOCRIT

INITIAL DATA
BP– 107/57
HR– 94

EQUIP CHECK
OK?– [✓ Y] N

PATIENT RECHECK
OK for PROCEDURE? Y
TIME– 0800

SYMBOLS:
BP by cuff ∨ ∧
Heart rate ●
Resp rate
BP (transduced)
TOURNIQUET T – ✗
ANES– X-X
PROC– ⊙ – 0



VENTIL.
VT – ml
f – breaths/min 16 14 12 14 14 16 14 14 14 12 14 14 10 12 14 14
Peak inf pres / PEEP
MODE– S(pon), A(ssist), C(on) S S S S S S S S S

MONITORS / ACCESSORIES
BP/Auto Cuff — ET CO2 (torr)
BP / oth — FIO2 (Frac or %) NRB NRB
ART line — SpO2 (%) 99 98 99 99 99 100 100 100 100 100 98 99 100 100 99 100
Steth- PC/ES — ECG
Gas analyzer — TEMP- site
N-M Block (T/4)
Warming blkt
Conv warmer

Mark with letters & symbols, explain under REMARKS — EVENTS / Position → belly graft, legs graft, hands, legs, roll

RECOVERY AT
PACU ICU ______ (Specify)
OTHER ______
CONDITION:
RESP– SpO2–
BP– HR–

ANES / PROCEDURE TIMES
	Start	Room	End
ANES	0800	0800	
	Ready	Begin	End
PROC	0800	0805	

PROCEDURES and CPT Codes

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
Versed, Ketamine, Fent, MSO4

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

PATIENT IDENTIFICATION– Typed or written entries: Name, Grade/Rate, Medical facility

[redacted] 66-4

SURGEONS: [redacted]

ANESTHETISTS: [redacted] RN 66-2

PROCEDURE LOCATION ICU 3

DATE 18 Jul

PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED
1 Jan 99

☆ U.S. GPO: 1999 – 528-336/10085

PATIENT RECORD

MEDCOM - 13304

Ste

MEDICAL RECORD — ANESTHESIA

ANESTHETIC AGENTS AND DRUGS

CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML. "I" = CONSTANT INFUSION

DRUG	UNITS					TOTALS
Versed	1mg/cc	8				8
Ketamine	10mg/cc	50 30				80
Fentanyl	25mcg/cc	25	100/50	75		325
MSO4	1mg/cc	4				4
	( )					
	( )					
VOLAT AGENT	% del					
	% e.t.					
AIR	L/Min					
N2O	L/Min					
O2	L/Min					

TOTAL EBL

TOTAL URINE

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS

FLUIDS

LINE site ☐ Warmed

☐ Warmed

☐ Warmed

☐ Warmed

FLUIDS – SUMMARY

CRYSTALLOID– 50

COLLOID–

BLOOD–

LOSSES EST BLOOD LOSS

URINE –

REMARKS–

Code drugs with numbers, events with letters

.2 mg robinul

Ø Complications on RA awake recovering in ICU3

PHYS STATUS 1 2 [✓ 3] 4 5 E

BODY WEIGHT 70 KG LB

HEMATOCRIT 30.5

INITIAL DATA: BP– 114/64 HR– 101

EQUIP CHECK OK?– [✓ Y] N

PATIENT RECHECK OK for PROCEDURE? Y TIME– 0820

TIME → 30 45 9⁰⁰ 15 30 45 10

SYMBOLS:

BP by cuff ∨ ∧

Heart rate ●

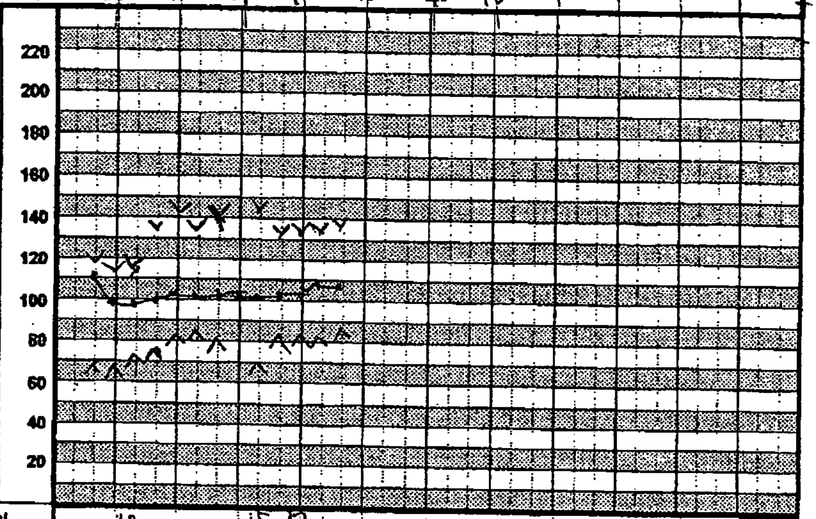
Resp rate

BP (transduced) ⊥ T

TOURNIQUET T – ⊤

ANES– X-X

PROC ⊙ – Ø



VENTIL

VT – ml	30	15 17	
f – breaths/min	20 16 22 23	25 22 24	
Peak inf pres / PEEP			
MODE– S(pon), A(ssist), C(on)	S S	S S	

MONITORS

BP/Auto Cuff	ET CO2 (torr)			
BP / oth	FIO2 (Frac or %)	NC3	NC3	RA
ART line	SpO2 (%)	99	100	99 100 99 100
Steth- PC/ES	ECG			
Gas analyzer	TEMP- site			
	N-M Block (T/4)			
Warming blkt				
Conv warmer				

Mark with letters & symbols, explain under REMARKS EVENTS

Position ⟶ arms legs torso abdomen

RECOVERY AT

PACU ICU #3 (Specify)

OTHER

CONDITION:

RESP– 14 SpO2– 98 RA

BP– 130/70 HR– 103

ANESTHESIA / PROCEDURE TIME

ANES	Start 0825	Room 0825	End 0930
PROC	Ready 0825	Begin 0830	End 0915

PROCEDURES and CPT Codes

dressing Δ

PATIENT IDENTIFICATION– *Typed or written entries: Name, Grade/Rate, Medical facility*

[redacted] 66-4

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

versed. fentanyl, MSO4, Ketamine

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*

b6-2

SURGEONS: [redacted]

ANESTHETISTS: [redacted], RN

PROCEDURE LOCATION ICU3

DATE 19 JUL 03

PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED ~~~ n 99

MEDCOM - 13305

*U.S. GPO: 2002-729-180/40137

24
20
00
480
480

480
700
1180
938
2118
50
2168
50
2218

1
480
700
50
1230

- 2
2329

938
50

THESIA PLAN OF CARE PRE- CEDURAL ASSESSMENT (Sedation/Anesthesia)

__ DAYS MOS YRS   Sex [✓ MALE] ( ) FEMALE

SED PROCEDURE: dressing Δ
CAL SERVICE:
NCE: ~~Mg~~ 0030

ASA Physical State 1 2 [✓ 3] 4 5 E
WT: 70 KG/LB HT: ____ IN.
ALLERGIES: 0

:
CCO: 2ppd
ETOH: 0
RUGS: 0

NT MEDICATIONS:
ered as premed
fent patch 50 mcg/hr
albuterol
lovenox
7mg MSO4 @ 0700

DICATIONS:
es (@ ____ Hrs) /CC
. ____ mg IV IM PO
. ____ mg IV IM PO
. ____ mg IV IM PO

ATORY STUDIES:
: 9.5 / 30.5
:
:

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:
- Hypertension [✓ N] Y
- Angina [✓ N] Y
- MI [✓ N] Y
- CVA [✓ N] Y
- Other N Y

Pulmonary System:
- Asthma N [✓ Y]
- Bronchitis/URI [✓ N] Y
- COPD N [✓ Y]
- Other N Y

Renal System:
- Acute/Chronic RF [✓ N] Y

Gastrointestinal:
- Hepatitis [✓ N] Y
- Hiatal Hernia [✓ N] Y
- PUD/GERD [✓ N] Y

Endocrine System:
- Diabetes [✓ N] Y
- Steriods [✓ N] Y
- Thyroid [✓ N] Y

Neurological:
- Seizures [✓ N] Y
- Neuropathy [✓ N] Y
- Other N Y

Gynecological :
- Pregnancy NA N Y

Other Significant Hx:
- N Y
- N Y

Familial HX N Y

ASSESSMENT

PAST SURGICAL/ANESTHETIC
dressing change
debridement
grafting

PHYSICAL EXAMINATION
BP 11/64 HR 111 R 20 T 101.8
Pain Scale 0-10 5
HEENT - Teeth intact
Trachea midline
TMJ/Neck
Oropharnyx
Nares
CHEST: CTA c̄ diminished bases
CARDIAC: S1 S2 ST
EXTREMITIES:
IV Access: ⊖ SC
Ulnar Filling:
BACK:
OTHER:

NPO Since 0030

HETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ____ { } General: Mask Intubation

MED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to an ed with the patient/legal guardian.

[redacted] b6-2
n seems to understand and agrees. Questions answered.
17/RN Date: 19Jul 03 Time: 0748 Hrs

A EVALUATION AND NOTE (NON ASU)
AP ANESTHETIC COMPLICATIONS { } OTHER
____ Date: ____ Time: ____ Hrs

Identification: (Ward) ICU3

[redacted] b6-4

SEDATION KEY:

1. MINIMAL (Anxiolysis) Patient responds normally to verbal commands
2. MODERATE (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is not necessary.
3. DEEP SEDATION/ANALGESIA. Patient responds purposefully following repeated or painful stimulation. Airway assistance may

MEDCOM - 13307

Smoker
57/M NKDA

MEDICAL RECORD - ANESTHESI/

For this form, see AR 40-66; the proponent agenc .e UTSG

Page 1 of 2

ANESTHETIC AGENTS AND DRUGS – CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML. "I" = CONSTANT INFUSION

DRUG (Units)													TOTALS
Midaz (mg)	2 3 /					/				/			5mg
Fent (mcg)	200 50/		150			50 50 /		100	100	50/			1000mcg
Propofol (mg)	200												
Lido (mg)	50												
( )									b6-2				
( )													
VOLAT AGENT Forane % del	3	1.5	1.5	1.5	1.5	1.5	1.5	1.5	0.8 [redacted]	0.8	1.0	1.5 1.5	
% e.t.										1.5			
AIR L/Min													
N2O L/Min													
O2 L/Min	8 4	2	2	2	2	2	2	2	2	2	2	2 2	

TOTAL EBL: 50

TOTAL URINE: 100

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS

FLUIDS

LINE site (R)A ☐ Warmed LR₁ → 500 → LR₂ → 1500 → LR₃ →

☐ Warmed

☐ Warmed

☐ Warmed

LOSSES

EST BLOOD LOSS 50/50

URINE - 50/50

FLUIDS - SUMMARY

CRYSTALLOID- 2000 LR

COLLOID-

BLOOD-

REMARKS

Code drugs with numbers, events with letters

0735 PreOp EVAL
IV → (R)A
0748 OR#2 monitors ↑
PreO₂ IND/INT
Log Roll → Prone
onto OR table
✓BBS(=) ✓Pressure
Points
0845 0.2mg Robinul
0920 Log Roll → Stretcher
lift → OR table, Supine

PHYS STATUS: 1 [✓ 2] 3 4 5 E

BODY WEIGHT: 70 [✓ KG] LB

HEMATOCRIT:

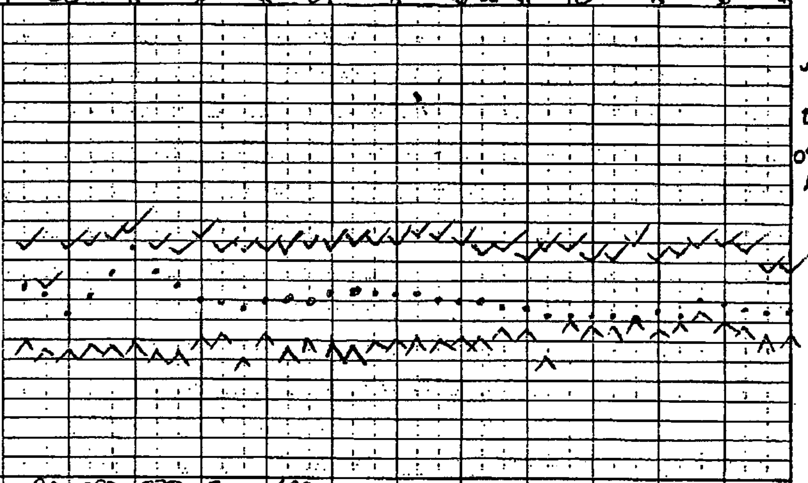
INITIAL DATA:
BP- 116/70
HR- 98

EQUIP CHECK: [✓ OK?] Y N

PATIENT RECHECK: [✓ OK for PROCEDURE?]
TIME- 0749

TIME → 0745 0800 15 30 45 0900 15 30 50 45 1000 15 30 45

SYMBOLS:
BP by cuff V Λ
Heart rate ●
Resp rate
BR (transduced)
TOURNIQUET T—T
ANES- X-X
PROC- ⊙-Ø



VENTIL

VT - ml		920	890	870	720	690							740 760
f - breaths/min	12	10	10	8	8	8	20 24	20	12	16	16	12 8	8
Peak inf pres / PEEP		30	28	28	27	27						22	22
MODE - S(pon), A(ssist), C(on)	S	C	C	C	C	C	S S	S	S	S	S	S C	C

MONITORS/ACCESSORIES

✓BP/Auto Cuff	ET CO2 (torr)	38	36	31	30	31	33	33	31	26	38	30 740	800
BP/oth	FIO2 (Frac or %)	.75	.75	.75	.75	.75	.73	.73	.73	.73	.72	.73 .72	.72
ART line	SpO2 (%)	100	99	99	99	100	100	100	94/100	100	100	100 100	100
✓Steth- PC/ES	ECG	SR	SR	ST	SR	SR	SR	SR	SR	SR	SR	SR SR	SR
Gas analyzer	TEMP-site	AVAILABLE →											
	N-M Block (T/4)												
Warming blkt							Report to		SPC [redacted]		b6-2		
Conv warmer													

Mark with letters & symbols, explain under REMARKS EVENTS → Position →

RECOVERY AT

PACU [✓ ICU 3] (Specify)

OTHER

CONDITION: Stable

RESP- 20 O2/Room Air SpO2- 97

BP- 106/62 HR- 87

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0735	0748	1215
	Ready	**Begin**	**End**
PROC	0800	0829	1155

PROCEDURES and CPT Codes: Skingraft from back to front
Dsg Δ 1

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*
GETA

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*
DLx1/Mac 4 8.0 ETT → VC c̄ BBS(=), ETCO₂(+) Secured 22cm lips

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*
[redacted] b6-4 ICU3 - ICU3

SURGEONS: [redacted] b6-2

ANES [redacted]

PROCEDURE LOCATION: [redacted] OR #2

b6-2

DATE: 20 July 03

PAGE 1 OF 2

DA FORM 7389, FEB 1998 MEDCOM - 13308 Y 1 - PATIENT'S MEDICAL RECORD USAPA V1.00

Smoker
57/m NKDA

MEDICAL RECORD - ANESTHESI

For this form, see AR 40-66; the proponent agen ·e OTSG

Page 2 of 2

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML. "I" = CONSTANT INFUSION

DRUG (Units)					TOTALS
( )					
FENT (mcg)	100	100	50/		1000mcg
( )					
( )					
( )					
( )					
VOLAT AGENT FORANE % del	1.5	1.5/0.6	0.6/2.0	2.0/1.0	
% e.t.					
AIR L/Min					
N2O L/Min					
O2 L/Min	2	2 8	2 8/2	8	
SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS →					

TOTAL EBL

TOTAL URINE

FLUIDS - SUMMARY
CRYSTALLOID-
COLLOID-
BLOOD-

FLUIDS

LINE site (R)A	☐ Warmed	LR3 →
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOSSES
EST BLOOD LOSS
URINE - 50/100

REMARKS
Code drugs with numbers, events with letters

1158 Suction
Strong Spont
VENT. DEEP
EXTUB
Oral airway ↑

PHYS STATUS
1 2 3 4 5 E

BODY WEIGHT
KG
LB

HEMATOCRIT

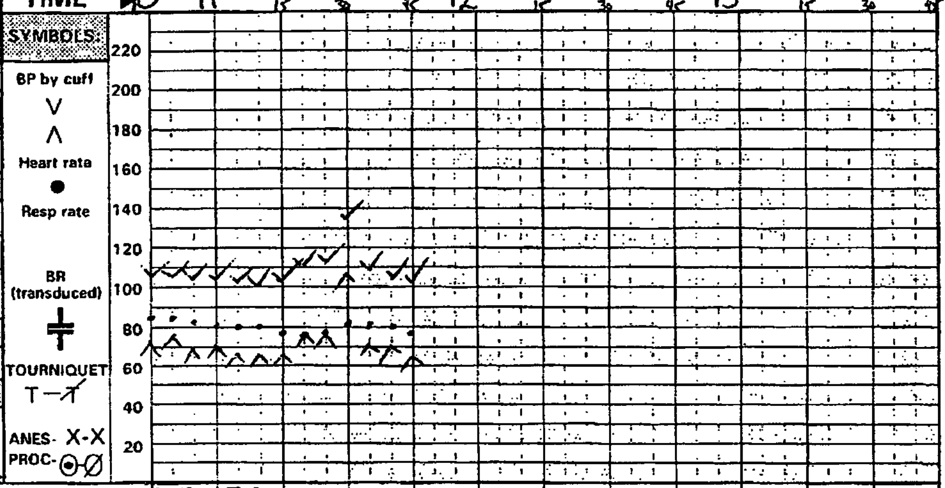
INITIAL DATA
BP- /
HR-

EQUIP CHECK
OK?- Y N

PATIENT RECHECK
OK for PROCEDURE?
TIME-

See Pg ONE

TIME → 10^45 1100 15 30 45 12^Noon 15 30 45 1300 15 30 45



VENTIL

VT - ml	740	720			
f - breaths/min	6	6 12	8	12	20
Peak inf pres / PEEP	20	20			
MODE - S(pon), A(ssist), C(on)	C	C S	S	S	S

MONITORS/ACCESSORIES

✓ BP/Auto Cuff	ET CO2 (torr)	30	30	41	41	30
BP/oth	FIO2 (Frac or %)	.73	.74	.75	.73	.73
ART line	SpO2 (%)	100	100	100	100	100
✓ Steth- PC/ES	ECG	SR	SR	SR	SR	SR
Gas analyzer	TEMP-site	AVAILABLE →				
	N-M Block (T/4)					
Warming blkt						
Conv warmer						

Mark with letters & symbols, explain under REMARKS EVENTS → Position →

See Pg ONE

RECOVERY AT:
PACU ICU ______ (Specify)
OTHER ______
CONDITION:
RESP- SpO2-
BP- HR-

ANESTHESIA / PROCEDURE TIMES

ANES	Start	Room	End
PROC	Ready	Begin	End
			1155

PROCEDURES and CPT Codes: See

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* Page ONE

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*

#[redacted]
b6-4

SURGEONS:

ANESTHETIST: [redacted] b6-2

PROCEDURE LOCATION: 28 CSH OR#2

DATE: 20 July 03

PAGE 2 OF 2

DA FORM 7389, FEB 1998 OPY 1 - PATIENT'S MEDICAL RECORD USAPA V1.00

ANESTHESIA PLAN OF CARE PRE( )EDURAL ASSESSMENT (Sedation/A( )hesia)

Age 57 DAYS MOS [✓ YRS]   Sex [✓ MALE] ( ) ~~FEMALE~~

PROPOSED PROCEDURE: Desg Δ SkinGraft/Prone off back
SURGICAL SERVICE: ____
NPO SINCE: MN

ASA Physical State 1 [✓ 2] 3 4 5 E
WT: 70 [✓ KG]/LBS HT: ____ IN.
ALLERGIES: NKDA

HABITS:
TOBACCO: Smoker
ETOH: 0
DRUGS: ____

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) Lovenox
( ) Fent Patch
( ) Albuterol
( ) MSO4
( ) ____
( ) ____

PREMEDICATIONS:
None Yes (@ ____ Hrs) /CC
____ . ____ mg IV IM PO
____ . ____ mg IV IM PO
____ . ____ mg IV IM PO

LABORATORY STUDIES: 20 July
HB/HCT: 10 / 29
U/A: ____
OTHER: ____

19 July
★ PLT=959

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:
Hypertension [✓ N] Y
Angina [✓ N] Y
MI [✓ N] Y
CVA [✓ N] Y
Other [✓ N] Y
Pulmonary System:
Asthma N [✓ Y]
Bronchitis/URI [✓ N] Y
COPD N [✓ Y]
Other N Y
Renal System:
Acute/Chronic RF [✓ N] Y
Gastrointestinal:
Hepatitis [✓ N] Y
Hiatal Hernia [✓ N] Y
PUD/GERD [✓ N] Y
Endocrine System:
Diabetes [✓ N] Y
Steriods [✓ N] Y
Thyroid [✓ N] Y
Neurological:
Seizures [✓ N] Y
Neuropathy [✓ N] Y
Other [✓ N] Y
Gynecological :
Pregnancy N Y
Other Significant Hx:
N Y
N Y
Familial HX N Y

ASSESSMENT
PAST SURGICAL/ANESTHETIC
Multiple Dsg Δs
& Debridement

PHYSICAL EXAMINATION
BP ___ HR ___ R ___ T ___
Pain Scale 0-10 ____
HEENT - Teeth
Trachea WNL
TMJ/Neck 3+
Oropharynx MP-3
Nares ____
CHEST: CTA
CARDIAC: S1, S2
EXTREMITIES:
IV Access: 18G / (R) A
Ulnar Filling: ____
BACK: ____
OTHER: ____

NPO Since ____

ANESTHETIC PLAN: (✓) LOCAL (✓) MAC ( ) Regional (Specify): ____ (✓) General: Mask [✓ Intubation]

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discussed with the patient/legal guardian.

66-2

The patient/legal [redacted] understand and agrees. Questions answered.
Signed: ____ Date: 20 July 03 Time: ____ Hrs

POST-ANESTHESIA EVALUATION AND NOTE (NON ASU)
( ) NO APPARENT ANESTHETIC COMPLICATIONS ( ) OTHER

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward) ICU-3, ICU-3

[redacted] 66-4

SEDATION KEY:
1. **MINIMAL** (Anxiolysis) Patient responds normally to verbal commands
2. **MODERATE** (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is not necessary.
3. **DEEP SEDATION/ANALGESIA.** Patient responds purposefully following repeated or painful stimulation. Airway assistance may be necessary.
4. **ANESTHESIA.** Patient does not respond to painful stimulation.

WAMC Form 2300 (Revised) 15 Mar 01 MCXC-DOS

Previous edition is obsolete
☆ U.S. GPO: 2002-728-283

MEDCOM - 13310
PATIENT RECORD COPY

MEDICAL RECORD — ANESTHESIA

CONTINUOUS / REPEATED DRUGS SPECIFY UNITS — MG / MCG / ML, * | *=CONSTANT INFUSION

DRUG		TOTALS
Fentanyl 25mcg/cc	2 2 2 2 1	225mcg
Versed 1mg/cc	2	2mg
( )		
( )		
( )		
( )		

% del

% e.t.

AIR L/Min

N2O L/Min

O2 L/Min

SINGLE DOSE DRUGS — MARK ON GRID WITH NUMBERS & ENTER IN REMARKS

LINE site ☐ Warmed

☐ Warmed

☐ Warmed

☐ Warmed

EST BLOOD LOSS

URINE —

FLUIDS — SUMMARY

CRYSTALLOID— 1L

COLLOID—

BLOOD—

REMARKS Code drugs with numbers, events with letters

0930 - conscious sedation start

0935 - Procedure start

1030 - Procedure end.

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 70 [✓ KG] LB

HEMATOCRIT

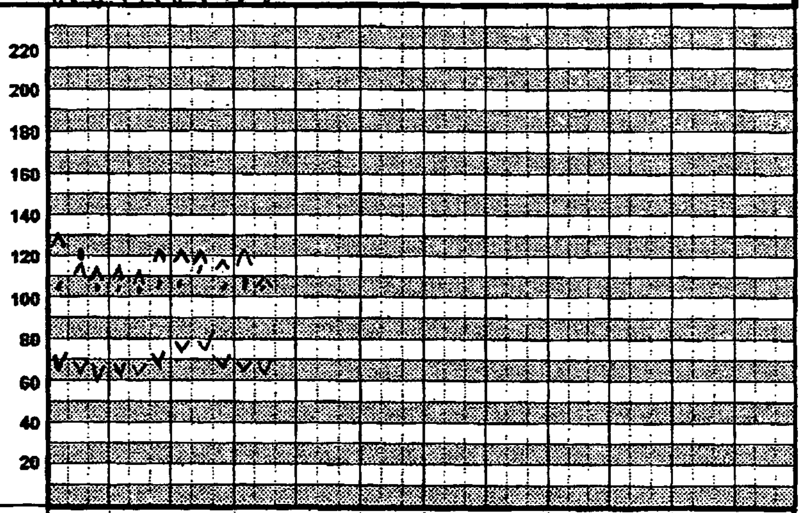
INITIAL DATA: BP — 106/56 HR — 97

EQUIP CHECK: OK? — [✓ Y] N

PATIENT EVIDENCE: OK for PROCEDURE? TIME—

TIME → [illegible]

SYMBOLS: BP by cuff V Λ; Heart rate ●; Resp rate; BP (transduced); TOURNIQUET T — ✗; ANES— X-X; PROC— ⊙ — Ø



VT — ml

f — breaths/min: [illegible]

Peak inf pres / PEEP: [illegible]

MODE— S(pon), A(ssist), C(on): [illegible]

BP/Auto Cuff	ET CO2 (torr)
BP / cath	FiO2 (Frac or %)
ART line	SpO2 (%)
Steth- PC/ES	ECG
Gas analyzer	TEMP- site
	N-M Block (T/4)
Warming blkt	
Conv warmer	

Mark with letters & symbols, explain under REMARKS EVENTS Position ——

RECOVERY AT: PACU ICU ______ (Specify) OTHER ______

CONDITION:

RESP— SpO2—

BP— HR—

ANESTHESIA / PROCEDURE TIME

ANES	Start	Room	End
PROC	Ready	Begin	End

PROCEDURES and CPT Codes

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

PATIENT IDENTIFICATION— Typed or written entries: Name, Grade/Rate, Medical facility

#[redacted] b6-4

SURGEONS:

ANESTH[redacted] ua certified MD

b6-2

PROCEDURE LOCATION ICU3

DATE 21 Jul 03

PAGE OF

[redacted]ICAL RECORD — ANESTHESIA

WAMC OP 376 REVISED n 99

MEDCOM - 13311

*U.S. GPO: 2002-729-180/40137

MEDICAL RECORD ANESTHESIA

CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML, "I" = CONSTANT INFUSION

DRUG	(Units)	
fentanyl	mcg	25 2
Versed	mg/cc	4 2 3
VOLAT AGENT	% del	
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS

LINE site ☐ Warmed
☐ Warmed
☐ Warmed
☐ Warmed

LOSSES EST BLOOD LOSS
URINE –

TOTALS

TOTAL EBL

TOTAL URINE

FLUIDS – SUMMARY
CRYSTALLOID–
COLLOID–
BLOOD–

REMARKS
Code drugs with numbers, events with letters:

ASA STATUS 2 [✓ 3] 4 5 E

BODY WEIGHT 70 KG LB

HEMATOCRIT 29.8

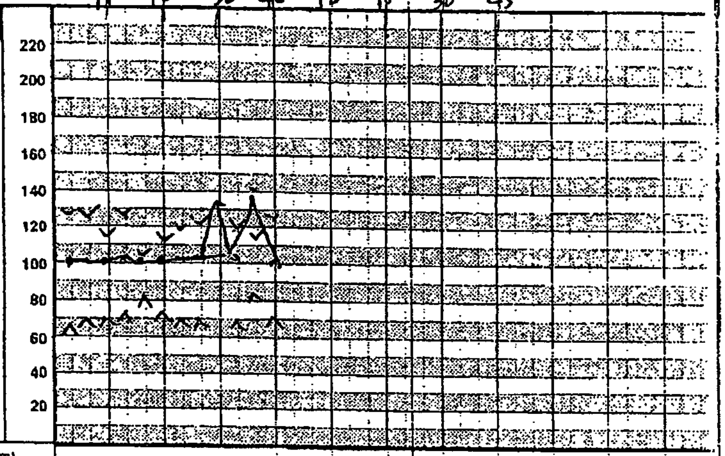
INITIAL DATA 114/64
P– 100

EQUIP CHECK
OK?– [✓ Y] N

PATIENT RECHECK
... procedure? ✓
TIME– 1045

TIME → 11⁰⁰ 15 30 45 12⁰⁰ 15 30 45

SYMBOLS:
BP by cuff V Λ
Heart rate ●
Resp rate
BP (transduced) ⊥ ⊤
TOURNIQUET T – ✗
ANES– X-X
PROC ⊙ – Ø



VT – ml	
f – breaths/min	22 23 24
Peak inl pres / PEEP	
MODE– S(pon), A(ssist), C(on)	S S S
BP/Auto Cuff / ET CO2 (torr)	
BP / oth / FIO2 (Frac or %)	NRB RA
ART line / SpO2 (%)	100 100 100
Steth– PC/ES / ECG	
Gas analyzer / TEMP– site	
N-M Block (T/4)	
Warming blkt	
Conv warmer	

Mark with letters & symbols, explain under REMARKS EVENTS
Position → upr

RECOVERY AT
PACU ICU ______ (Specify)
OTHER ______
CONDITION
RESP– SpO2–
BP– HR–

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1055		
	Ready	**Begin**	**End**
PROC			

PROCEDURES and CPT Codes

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

b6-2

SURGEONS: [redacted], LPN

ANESTHETISTS [redacted] RN

PATIENT IDENTIFICATION – Typed or written entries: Name, Grade/Rate, Medical facility

[redacted] b6-4

PROCEDURE LOCATION ICU3

DATE 22 Jul 03

PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED
1 Jan 99

PATIENT RECORD

U.S. GPO 1999 – 528-336/10

[redacted]

[redacted]

THESIA PLAN OF CARE PRE CEDURAL ASSESSMENT (Sedation/ sthesia)

__ DAYS MOS YRS

Sex [✓ MALE] ( ) FEMALE

ASA Physical State 1 2 [✓ 3] 4 5 E
WT: 70 KG/LB HT: ____ IN.
ALLERGIES: Unk

SED PROCEDURE: dressing change
CAL SERVICE: ____
NCE: OWO

CCO: 2ppd
ETOH: ____
UGS: ____

NT MEDICATIONS:
ered as premed
fent patch
albuterol
lovenox

DICATIONS:
es (@ ____ Hrs) /CC
. ____ mg IV IM PO
. ____ mg IV IM PO
. ____ mg IV IM PO

ATORY STUDIES:
: 9.2 / 29.8
: 21 Jul

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:
- Hypertension [✓ N] Y
- Angina [✓ N] Y
- MI [✓ N] Y
- CVA [✓ N] Y
- Other N Y

Pulmonary System:
- Asthma N [✓ Y]
- Bronchitis/URI [✓ N] Y
- COPD N [✓ Y]
- Other [✓ N] Y

Renal System:
- Acute/Chronic RF [✓ N] Y

Gastrointestinal:
- Hepatitis [✓ N] Y
- Hiatal Hernia [✓ N] Y
- PUD/GERD [✓ N] Y

Endocrine System:
- Diabetes [✓ N] Y
- Steriods [✓ N] Y
- Thyroid [✓ N] Y

Neurological:
- Seizures [✓ N] Y
- Neuropathy [✓ N] Y
- Other N Y

Gynecological :
- Pregnancy N Y

Other Significant Hx:
- N Y
- N Y

Familial HX N Y

ASSESSMENT

PAST SURGICAL/ANESTHETIC

PHYSICAL EXAMINATION

BP 116/6 HR 101 R 18 T 99.1
Pain Scale 0-10 0
HEENT - Teeth intact
Trachea midline
TMJ/Neck ____
Oropharnyx ____
Nares ____
CHEST: equal CTA b/l
CARDIAC: S1S2 ST 0 ectopy
EXTREMITIES:
IV Access: (R) wrist
Ulnar Filling: ____
BACK: ____
OTHER: ____

NPO Since 0200

HETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ____ { } General: Mask Intubation

IED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to an ed with the patient/legal guardian.

ien [redacted] ems to understand and agrees. Questions answered.
66-2 Date: 22 July 03 Time: 1025 Hrs

NESTHESIA EVALUATION AND NOTE (NON ASU)
APPARENT ANESTHETIC COMPLICATIONS { } OTHER

____ Date: ____ Time: ____ Hrs

SEDATION KEY:

1. MINIMAL (Anxiolysis) Patient responds normally to verbal commands
2. MODERATE (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is not necessary.
3. DEEP SEDATION/ANALGESIA. Patient responds purposefully following repeated or painful stimulation. Airway assistance may

Identification: (Ward) ____

[redacted] 66-4

MEDCOM - 13313

MEDICAL RECORD - ANESTHESI/

For . this form, see AR 40-66; the proponent agenc, ie OTSG

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML, "I" = CONSTANT INFUSION

DRUG (Units)										TOTALS
Versed (mg)	1 1									
Fentanyl (mcg)	50, 50,	50,	50 50,	50,	50, 50	50	50 50			500
Propofol (mg)	150						30			
Rocuronium (mg)	40									
MSO4 (mg)							4		4	
( )										
VOLAT AGENT 150 % del	1.0	1.4	1.5	1.0	1.0	0.6/	2.0	1.5	1.7 ⊗	
% e.t.										
AIR L/Min										
N2O L/Min										
O2 L/Min	8/1	1	1	1	1	1	3	2	10	

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS

TOTAL EBL

TOTAL URINE

FLUIDS SUMMARY

CRYSTALLOID-

COLLOID-

BLOOD-

FLUIDS

LINE site									
18, (L) AC ☐ Warmed			1000				2000	2300	
☐ Warmed									
☐ Warmed									
☐ Warmed									

LOSSES

EST BLOOD LOSS — Minimal

URINE - No Foley

REMARKS

Code drugs with numbers, events with letters

(0745) ID PT, start [illegible]

(0800) To room. Standard monitors placed.

(0945) LMA switch out.

PHYS STATUS 1 [✓ 2] 3 4 5 E

BODY WEIGHT 70 [✓ KG] LB

HEMATOCRIT

INITIAL DATA

BP- 113/67

HR- 113

EQUIP CHECK

OK?- [✓ Y] N

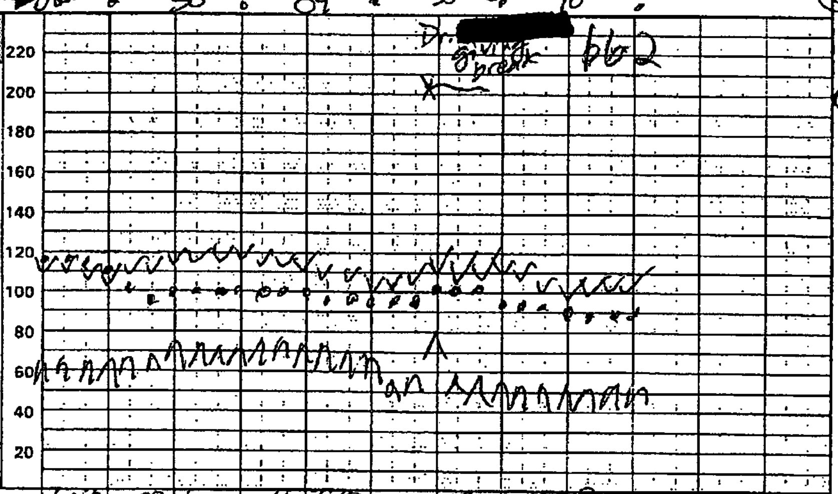
PATIENT RECHECK

OK for PROCEDURE?

TIME-

TIME → 0800 · 30 · 0900 · 30 · 1000 ·

SYMBOLS: BP by cuff V Λ; Heart rate ●; Resp rate; BR (transduced); TOURNIQUET T—T; ANES- X-X; PROC- ⊙-Ø



VT - ml	640	670	600	410	530	240	330	410	510
f - breaths/min	8	8	7	18	11	12	11	12	12
Peak inf pres / PEEP	18	16	14						
MODE - S(pon), A(ssist), C(on)	S/A/C	C	C	SV	SV	SV	SV	SV	SV

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	(4)	29	30	41	43	41	44	48	46
BP/oth	FIO2 (Frac or %)	.86	.86	.86	.85	.81	.87	.86	.84	.86
ART line	SpO2 (%)	96	100	100	100	100	100	100	100	100
Steth- PC/ES	ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR
Gas analyzer	TEMP-site Skin	94	94	94	96	96	96	96	—	96
	N-M Block (T/4)	4/4	0/4	1/4	4/4	4/4	4/4	c sustained tetany		
Warming blkt										
Conv warmer										

See Previous Pre-op

Mark with letters & symbols, explain under REMARKS EVENTS Position → (O)

RECOVERY AT

[✓ PACU] ICU ______ (Specify)

OTHER ______

CONDITION:

RESP- 16 SpO2- 99%

BP- HR- 109

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0745	0800	1030
	Ready	Begin	End
PROC	0810	0820	1015

PROCEDURES and CPT Codes: Burn debridement.

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* GETA.

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*

[redacted] b6-4

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* Pre-oxy 5 min 100% O2, IV induction, easy mask ventilation, [illegible] Miller 2, grade I view 7.0 ETT placed @ 23cm @ lip (+) BBS (+) ETCO2

SURGEONS: (Dr.) [illegible] SN.

[redacted] b6-2

ANESTHETISTS:

[redacted]

PROCEDURE LOCATION: OR 1

DATE: 1 AUG 05

PAGE 1 OF 1

DA FORM 7389, FEB 1998 MEDCOM - 13314 Y 1 - PATIENT'S MEDICAL RECORD USAPA V1.00

MEDICAL RECORD - ANESTHESIA

For u. .is form, see AR 40-66; the proponent agency G .G

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML, "I" = CONSTANT INFUSION

DRUG (Units)	1100	x	30	x	1200	x	30	TOTALS
Versed (mg)	3							3
Fent (cc)	2	2	1					5
Lido/Propofol (mg)	20/150							
( )								
Ephedrine (mg)		5						
( )								
VOLAT AGENT Forane % del	X1.5 — 2 X							
% e.t.								
AIR L/Min								
N2O L/Min								
O2 L/Min	X6 — 2 — 6							

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS →

TOTAL EBL: min

TOTAL URINE: 0

FLUIDS SUMMARY

CRYSTALLOID- LR 800

COLLOID- 0

BLOOD- 0

FLUIDS

LINE site 20g LR ☐ Warmed	700	400
☐ Warmed		
☐ Warmed		
☐ Warmed		

LOSSES

EST BLOOD LOSS

URINE -

PHYS STATUS: 1 2 [✓ 3] 4 5 [✓ E]

BODY WEIGHT: 70 [✓ KG] LB

HEMATOCRIT: 38

INITIAL DATA:

BP- 106/62

HR- 93

EQUIP CHECK

OK?- [✓ Y] N

PATIENT RECHECK

OK for PROCEDURE? Yes

TIME- 1030

TIME → 1100 x 30 x 1200 x 30

SYMBOLS:

BP by cuff V Λ

Heart rate ●

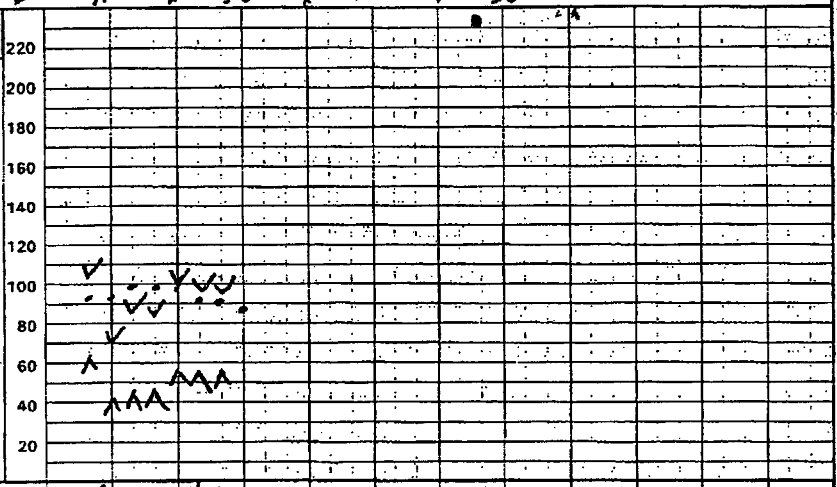
Resp rate

BR (transduced) ╪

TOURNIQUET T—T

ANES- X-X

PROC- ⊙-Ø



VENTIL

VT - ml	680	400	
f - breaths/min	9	9	
Peak inf pres / PEEP	16	16	
MODE - S(pon), A(ssist), C(on)	C	C	S

MONITORS/ACCESSORIES

X BP/Auto Cuff	X ET CO2 (torr)		34	35
BP/oth	X FIO2 (Frac or %)		.86	.90
ART line	X SpO2 (%)	100	100	100
Steth- PC/ES	X ECG		SR	SR
Gas analyzer	TEMP-site	AXIL.		
	N-M Block (T/4)			
Warming blkt				
Conv warmer				

Mark with letters & symbols. explain under REMARKS EVENTS Position →

REMARKS

Code drugs with numbers, events with letters

Preop, PN, NAC
agrees to GA
for (B) Heel Surgery
OR O2 monitors
Stable IV induction
post/prep/drape
drsg on SV
LMA out
To gurney

RECOVERY AT:

PACU [✓ ICU #3] (Specify)

OTHER

CONDITION: [illegible]

RESP- 14 SpO2- [illegible]

BP- 115/73 HR- 101

ANESTHESIA / PROCEDURE TIMES

ANES	Start	Room	End
	1050	1055	1140
PROC	Ready	Begin	End
	1100	1108	1123

PROCEDURES and CPT Codes: (B) Heel Debridement

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* GA LMA #4

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*

#[redacted] ICU #3
b6-4

SURGEONS: [redacted] — b6-2

ANESTHETISTS: [redacted] C [redacted]

PROCEDURE LOCATION: OR1

DATE: 16 Aug 03

PAGE 1 OF 1

DA FORM 7389, FEB 1998 MEDCOM - 13315 1 - PATIENT'S MEDICAL RECORD USAPA V1.00

PRE-ANESTHETIC ASSESSM .ND PLAN OF CARE

AGE: 47 Days Mos [✓ Yrs]
GENDER: ☒ Male ( ) Female
ALLERGIES: NKDA
P S: 1 2 [✓ 3] 4 5 E
WT: 85 [✓ Kg]/Lb HT: ____ In.

PROPOSED PROCEDURE: (B) Heel Debridement
SURGICAL SERVICE: Gen
NPO SINCE: p MN
PREOP DX / MECHANISM OF INJURY: 10% Burn BSA 2° to Hot Humvee
ASA III Case reviewed c Cpt McMasters MDA preoperatively

HABITS:
Tobacco: Hx 2 ppd
EtOH: ________
Drugs: ________

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) Fent Patch 8/15
( )
( ) ATARAX 2400
( )
( ) PAXIL 2200
( ) LOVENOX 2200
ALBUTEROL 8/15

PREMEDICATIONS:
None / Yes @ ________ Hrs

LABORATORY STUDIES:
8/14
127 | 99 | 6 < 86
5.4 | 19 | .9
8/12
38 × 13 38 12
Other: ________

PAST MEDICAL HISTORY / SYSTEMS REVIEW

Cardiovascular:			
Hypertension	N	Y	
Angina	N	Y	Hx DVT
MI	N	Y	
CVA	N	Y	
Other	N	Y	
Pulmonary:			
Asthma	N	Y	
URI	N	Y	RAD
COPD	N	Y	
Other	N	Y	
Renal System:			
ARF/CRF	N	Y	∅
Other	N	Y	
Gastrointestinal:			
Hepatitis	N	Y	
Hiatal Hernia	N	Y	∅
GERD/PUD	N	Y	
Endocrine:			
Diabetes	N	Y	
Steroids	N	Y	∅
Thyroid	N	Y	
Neurological:			
Seizures	N	Y	∅
Neuropathy	N	Y	
Gynecological:			
Pregnancy	N	Y	
Other	N	Y	
Other Problems:	N	Y	S/P BURNS Hands/Knees
Familial Hx	N	Y	

SURGICAL HISTORY
8/1 Debridement
7/15 STSG
7/20 drsg Δ
7/6 debridement

PHYSICAL EXAMINATION
BP: 114/71 HR: 75 RR: 12 T: 97.6
Pain (0/10 Scale): ∅ Sa 96%
Airway Exam:
Dentition: Nl
Trachea: MID
TMJ/C-spine: MP Cl I
Oropharynx: 3FB M → H
Chest:
Lungs: RRR
Heart: BS = B + wheeze
IV Access: ∅
Ulnar Filling: Allen's test MD I
Back: X + III
Other: ________

ANESTHETIC PLAN: ( ) Local/MAC ( ) Regional: ________ ☒ General: Intubation / Mask-LMA Notes: ________

NFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives, and risks of anesthesia including death have been explained to and :cussed with patient and/or legal guardian. The patient/legal guardian seems to understand and agrees to proceed. Questions answered.

Speaks English
( ) Sedated/nonresponsive/minor patient with no family or guardian present.

b6-2
d: [redacted] CPT Date: 16 Aug 03 Time: 0850

:NT IDENTIFICATION:
4 [redacted] ICU # 3
b6-4

[redacted] . [redacted]
b6-2

POST-ANESTHESIA EVALUATION AND NOTE:
( ) No apparent anesthetic complications.
( ) Other (see progress notes)
Signed: ________ Date: ________ Time: ________

MEDCOM - 13316 T HOSPITAL & MEDICAL TASK FORCE-BAGHDAD

Never Hospitalized Fentanyl patch 50mcg/hr placed 8-24-03

RAD; Hx DUT; S/F Pilonidal Ventriculoz [illegible] 66-2 NKDA

MEDICAL RECORD - ANESTHESIA

For use of this form, see AR 40-66; the proponent agency ... Discussed case c Dr. [redacted] anesthesiologist

[redacted]

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML. "I" = CONSTANT INFUSION

DRUG (Units)										TOTALS
Glycopyrrolate 0.2mg IV pre-op										
Midazolam (1 mg)	1									2
Fentanyl (mcg)		100	<150>							250
Lidocaine (mg)	50									50
Propofol (mg)	200									200
VCB (mg)	5-	2				3				10
MSO4 (mg)			3-	3		4	32			15
VOLAT AGENT Iso % del	2.0~	1.5~	1.5~	2~	1.7~	1.7	1.7	0.4	X	
% e.t.										
AIR L/Min										
N2O L/Min										
O2 L/Min	10	10	2	2	2	2	2	1.5	10	

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS

TOTAL EBL <50

TOTAL URINE Voided pre-op Ø

FLUIDS SUMMARY

CRYSTALLOID- 500

COLLOID- Ø

BLOOD- Ø

FLUIDS

LINE site ② 18G AC ☐ Warmed LR#1 ——————— 400 —

☐ Warmed

☐ Warmed

☐ Warmed

LOSSES

EST BLOOD LOSS Ø

URINE - 25

PHYS STATUS 1 2 [✓3] 4 5 E

BODY WEIGHT 80 [✓KG] LB

HEMATOCRIT 39.9

INITIAL DATA: BP- 96/59 SaO2 97%

HR- 88

EQUIP CHECK OK?- [✓Y] N

PATIENT RECHECK OK for PROCEDURE? JS

TIME- 0800

TIME 0830 · 0900 · 30 · 1000 · 30 · 1100 ·

SYMBOLS

BP by cuff V ∧

Heart rate ●

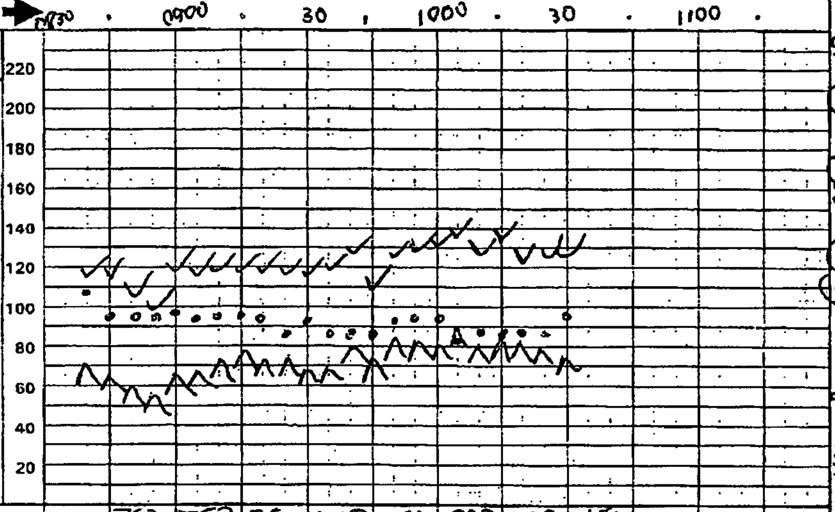
Resp rate

BR (transduced)

TOURNIQUET T—T

ANES- X-X

PROC- ⊙-Ø



REMARKS

Code drugs with numbers. events with letters

① Expirato wheeze RUL LL CTA HRR Ø [illegible]. Albuterol inhaler Today. Speaks english & discussed anesthesia c pt. Reevaluated c clear lungs equal ⓑ

② RSon, monitors O2 Induced, eyelids taped, soft Bite block

③ Ancef 1gm IVPB Fentanyl, eyelids arms neck & nose checked post prone position

④ Zofran 4mg IV

⑤ Turned Supine Suctioned OA, SV TV >4ml/kg; Reversed Neostigmine 5mg IV & Glycopyrrolate 0.8mg Responsive, Extubated s Complication To PACU. Report to nurse pt left attended

VT - ml	+	750	750	750	690	690	700	700	450
f - breaths/min	+	10	7	7	6	6	6	6	15
Peak inf pres / PEEP	—	24	24	24	24	24	23	23	—
MODE - S(pon), A(ssist), C(on)	S C	—C	C	C	C	C	C	C	S

MONITORS/ACCESSORIES

✓ BP/Auto Cuff	✓ ET CO2 (torr)	+	32	27	27	28	28	29	30	
BP/oth	✓ FIO2 (Frac or %)	0.89	0.89	0.89	0.89	0.88	0.88	0.87	0.88	0.88
ART line	✓ SpO2 (%)	100	100	100	100	100	100	100	100	
Steth- PC/ES	✓ ECG	SR	SR	SR	SR	SR	SR	SR	SR	
Gas analyzer	✓ TEMP-site	available	—	SK-35.2	— 35	— 35	34.8	34.6		
	✓ N-M Block (T/4)	0/4	~	1/4	—	4/4	0/4	—	1/4 sustained lift	
	✓ BS	+	+	+	—	—	—			
✓ Warming blkt	✓ x1 Blanket	———	——→	——→	——→	——→	——→	——→		
Conv warmer										

Mark with letters & symbols, explain under REMARKS EVENTS ①② ③ ——→ ④ ⑤

Position O——

RECOVERY AT 1030

[✓PACU] ICU ______ (Specify)

OTHER T-95.'Ax

CONDITION: Stable

RESP- 24 SpO2- 99

BP- 156/78 HR- 98

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0815	0835	1040
	Ready	Begin	End
PROC	0845	0910	1025

PROCEDURES and CPT Codes: Harvested from buttocks. Full Thickness Skin Graft Bilateral heels

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

GETA

PATIENT IDENTIFICATION: Typed or written entries: Name, Grade/Rate, Medical facility

Ⓡ Partial thumb amputation

[redacted] ICW #1/ b6 abf

[redacted], [redacted]

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

#4 LMA Fast track; 7.5 OETT placed verified +BBS; sust ETCO2 Salair cuff; LMA removed

SURGEONS: [redacted] / [redacted] / [redacted]

ANESTHETIST: [redacted] CRNA/MAJ

PROCEDURE LOCATION: 2#(2)

DATE: 28 Aug 03

PAGE 1 OF 1

DA FORM 7389, FEB 1998 MEDCOM - 13317 b6-2 1 - PATIENT'S MEDICAL RECORD [redacted] USAPA V1.00

Procedure verified

MEDICAL RECORD - ANESTHESIA

For u... his form, see AR 40-66; the proponent agency ... OT...

ANESTHETIC AGENTS AND DRUGS

CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML. "I" = CONSTANT INFUSION

DRUG (Units)						TOTALS
fentanyl (UG)	150	50	50			250UG
propofol (MG)	130					
lidocaine (MG)	40					
zemuron (MG)	50					
( )						
( )						
VOLAT AGENT 150 % del		1.5	1.0	1.0	1.0	
% e.t.						
AIR L/Min						
~~N2O~~ L/Min						
O2 L/Min	6	2	2	2	2 - 6	

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS →

TOTAL EBL: Min

TOTAL URINE: —

FLUIDS SUMMARY

CRYSTALLOID- LR - 500

COLLOID-

BLOOD- PRBC - kept

FLUIDS

LINE site* 18 (L) UE ☐ Warmed — LR

*20 (L) At ☐ Warmed — PRBC's in

☐ Warmed

☐ Warmed

LOSSES

EST BLOOD LOSS

URINE -

PHYS STATUS: 1 [✓ 2] 3 4 5 E

BODY WEIGHT: 70 [✓ KG] LB

HEMATOCRIT: 31

INITIAL DATA:

BP- 100/60

HR- 120

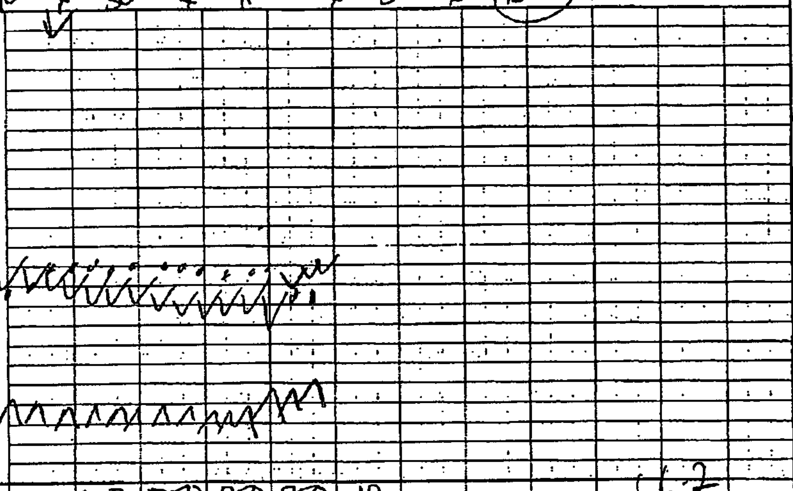
EQUIP CHECK OK?- [✓ Y] N

PATIENT RECHECK OK for PROCEDURE? (+)

TIME- 0945

TIME → 1000 x 30 x 1100 x 30 x (1200) x

SYMBOLS: BP by cuff V Λ · Heart rate ● · Resp rate · BR (transduced) · TOURNIQUET T—T · ANES- X-X · PROC- ⊙-⊘



VENTIL

VT - ml		430	750	750	750	210
f - breaths/min		10	10	6	6	10
Peak inf pres / PEEP		21	22	22	30	
MODE - S(pon), A(ssist), C(on)	SV	CV	CV	CV	CV	SV

b6-2 [redacted] [redacted]

MONITORS/ACCESSORIES

~~BP/Auto Cuff~~	~~ET CO2 (torr)~~		33	33	33	33	39
BP/oth	~~FIO2 (Frac or %)~~	.76	.76	.76	.76	.76	.74
ART line	~~SpO2 (%)~~	100	100	100	100	100	100
~~Steth- PC/ES~~	~~ECG~~	ST	ST	ST	ST	ST	ST
~~Gas analyzer~~	~~TEMP-site~~	skin		35		35	
	~~N-M Block (T/4)~~		0/4	2/4		4/4 5"	
~~Warming blkt~~	sheets/head wrap						
Conv warmer							

95°

Eyes/Ears Vd

Mark with letters & symbols, explain under REMARKS EVENTS → Position: arms <90° abducted/padded

REMARKS

Code drugs with numbers, events with letters

0945: Pat ID - IV in place - Preop done Chart rvd

1002- Ox face mask induction albut puffs for B wheezing p intubation

1115- Neostig 2mg / Robinul .2 IV

1130 Spont. Opened eyes suctioned/extubated TO PACU VS

RECOVERY AT

PACU ICU ____ (Specify)

OTHER Stable

CONDITION

RESP- 14 SpO2- 95

BP- 132/60 HR- 120

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0945	1000	1130
	Ready	Begin	End
PROC	1000	1040	1110

PROCEDURES and CPT Codes: Washout closure

ANESTHETIC TECHNIQUES: Describe block technique under Remarks GETA

8.0 ETT #3 Miller taped 22cm teeth, eyes taped, OGT LC ⊕, other soft bite block

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

DLxT p preox. Gr I view, ETT easily passed BBS+ ICO2+. Atraumatic.

PATIENT IDENTIFICATION: Typed or written entries: Name, Grade/Rate, Medical facility

[redacted] b6-4

SURGEONS [redacted] b6-2

ANESTHETISTS [redacted]

PROCEDURE LOCATION: #1

DATE: 27AUG03

PAGE 1 OF 1

DA FORM 7389, FEB 1998 MEDCOM - 13318 ...PY 1 - PATIENT'S MEDICAL RECORD USAPA V1.00

W0013 03 011374

MEDICAL RECORD | **BLOOD OR BLOOD COMPONENT TRANSFUSION**

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

☒ RED BLOOD CELLS
☐ FRESH FROZEN PLASMA
☐ PLATELETS *(Pool of _____ units)*
☐ CRYOPRECIPITATE *(Pool of _____ units)*
☐ Rh IMMUNE GLOBULIN
☐ OTHER *(Specify)* ____________

VOLUME REQUESTED *(If applicable)* 1 unit ML

REMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*

☒ TYPE AND SCREEN
☒ CROSSMATCH

DATE REQUESTED 9 ~~10~~ Jul03

DATE AND HOUR REQUIRED 10 Jul 03

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)* unknown

IF PATIENT IS FEMALE, IS THERE HISTORY OF:
RhIG TREATMENT? DATE GIVEN: ______
HEMOLYTIC DISEASE OF NEWBORN? ____

REQUESTING PHYSICIAN *(Print)* [redacted] b6-2

DIAGNOSIS OR OPERATIVE PROCEDURE Burn Debridement

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER [redacted] b6-2

DATE VERIFIED 9 Jul 03 [redacted]

TIME VERIFIED 1350

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. 1642392
1642392

TRANSFUSION NO.

PATIENT NO.

DONOR
ABO B
Rh positive

RECIPIENT
ABO B
Rh positive

TEST INTERPRETATION
ANTIBODY SCREEN N/A
CROSSMATCH Compatable

PREVIOUS RECORD CHECK: ☑ RECORD ☐ NO RECORD

SIGNATURE OF PERSON PERFORMING TEST [redacted] b6-2

☐ CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED | DATE 9 Jul 03

REMARKS: EXP 15 JUL 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED [redacted] (Signature) b6-2

AT *(Hour)* 0646 | ON *(Date)* 10 Jul 03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER *(Signature)* [redacted]

2nd [redacted] *(Signature)* [redacted] b6-2

PRE-TRANSFU[redacted]
TEMP. 36 PULSE 104 BP 122/70

DATE OF TRA[redacted]SION 10 Jul 03 | TIME STARTED 0630

POST-TRANSFUSION DATA

AMOUNT GIVEN 250 ML

TIME DATE COMPLETED INTERRUPTED 10Jul03

REACTION ☐ NONE ☐ SUSPECTED

If reaction is suspected – IMMEDIATELY:
1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION

☐ URTICARIA ☐ CHILL ☐ FEVER ☐ PAIN
☐ OTHER ____________

OTHER DIFFICULTIES *(Equipment, clots, etc.)*
☐ NO ☐ YES *(Specify)* ____________

SIGNA[redacted] PERSON NOTING ABOVE [redacted]

PATIENT IDENTIFICATION - USE EMBOSSER *(For typed or written entries give: NAME - Last, first, middle; rank/rate; hospital number and name of facility.)*

b6-2 M | WARD OR

[redacted] b6-4

BLOOD OR BLOOD COMPONENT TRANSFUSION
STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

MEDCOM - 13319

MEDICAL RECORD COPY

MEDICAL RECORD | **BLOOD OR BLOOD COMPONENT TRANSFUSION**

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

☑ RED BLOOD CELLS
☐ FRESH FROZEN PLASMA
☐ PLATELETS *(Pool of ____ units)*
☐ CRYOPRECIPITATE *(Pool of ____ units)*
☐ Rh IMMUNE GLOBULIN
☐ OTHER *(Specify)* ________

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*

☑ TYPE AND SCREEN
☑ CROSSMATCH

REQUESTING PHYSICIAN *(Print)* [redacted] b6-2

DIAGNOSIS OR OPERATIVE PROCEDURE Burn debridement

DATE REQUESTED 9 Jul 03

DATE AND HOUR REQUIRED 10 Jul 03

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER [redacted] b6-2 AW

DATE 9 Jul 03

TIME VERIFIED 1350

VOLUME REQUESTED *(If applicable)* 1 unit ML

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)* unknown

REMARKS:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:
RhIG TREATMENT? DATE GIVEN: ____
HEMOLYTIC DISEASE OF NEWBORN? ____

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. 5304891
5304891

TRANSFUSION NO.

PATIENT NO.

DONOR	RECIPIENT
ABO B	ABO B
Rh positive	Rh positive

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	Compatable

PREVIOUS RECORD CHECK: ☑ RECORD ☐ NO RECORD

SIGNATURE OF PERSON PERFORMING TEST [redacted] b6-2

☐ CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED DATE [illegible]

REMARKS: EXP DATE 15 JUL 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND [redacted] b6-2

AT *(Hour)* 0646 ON *(Date)* 10 Jul 03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER *(Signature)*

2nd [redacted] b6-2

PRE-TRA

TEMP. 0 4 PULSE 122 BP 120/82

DATE OF TRANSFUSION 10 Jul 02 TIME STARTED 0725

POST-TRANSFUSION DATA

AMOUNT GIVEN 250 ML

TIME DATE [✓ COMPLETED] INTERRUPTED 0742 09 July 03

REACTION ☑ NONE ☐ SUSPECTED

If reaction is suspected – IMMEDIATELY:
1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION

☐ URTICARIA ☐ CHILL ☐ FEVER ☐ PAIN
☐ OTHER ________

OTHER DIFFICULTIES *(Equipment, clots, etc.)*
☑ NO ☐ YES *(Specify)* ________

SIGNATURE OF [redacted] ING ABOVE b6-2

PATIENT IDENTIFICATION - USE EMBOSSER *(For typed or written entries give: NAME - Last, first, middle; rank/rate; hospital number and name of facility.)*

# [redacted] b6-4

SEX M | WARD

BLOOD OR BLOOD COMPONENT TRANSFUSION
STANDARD FORM 518 (REV. 9-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

MEDCOM - 13320

MEDICAL RECORD COPY

MEDICAL RECORD | # BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

☒ RED BLOOD CELLS

☐ FRESH FROZEN PLASMA

☐ PLATELETS *(Pool of ____ units)*

☐ CRYOPRECIPITATE *(Pool of ____ units)*

☐ Rh IMMUNE GLOBULIN

☐ OTHER *(Specify)* ________

VOLUME REQUESTED *(If applicable)* 10 ML

REMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*

☐ TYPE AND SCREEN

☒ CROSSMATCH

DATE REQUESTED 10 Jul 03

DATE AND HOUR REQUIRED 10 Jul 03 ~~0900~~

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: ______

HEMOLYTIC DISEASE OF NEWBORN? ____

REQUESTING PHYSICIAN *(Print)* Dr. [redacted] b6-2

DIAGNOSIS OR OPERATIVE PROCEDURE Burn Debridement

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER Previous

DATE VERIFIED Clot

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. 5304904

5304904

TRANSFUSION NO.

PATIENT NO.

DONOR

ABO B

Rh positive

RECIPIENT

ABO B

Rh positive

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	Compatible

☐ CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

REMARKS: EXP 15, JUL 03

PREVIOUS RECORD CHECK:

☒ RECORD ☐ NO RECORD

SIGNATURE OF PERSON PERFORMING TEST [redacted] b6-2

DATE 10 JUL 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)* [redacted] b6-2

AT *(Hour)* 0900 ON *(Date)* 10 JUL 03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

[redacted] ture) INT/RN

2nd VERIFIER [redacted] > b6-2 – LPN

PRE-TRANSFUSION

TEMP. 98.3 PULSE 123 BP 129/72

DATE OF TRANSFUSION 10 Jul 03

TIME STARTED 0908

POST-TRANSFUSION DATA

AMOUNT GIVEN 350 ML

TIME 1111 DATE 10 Jul 03 [✓ COMPLETED] INTERRUPTED

REACTION ☒ NONE ☐ SUSPECTED

If reaction is suspected – IMMEDIATELY:

1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION

☐ URTICARIA ☐ CHILL ☐ FEVER ☐ PAIN

☐ OTHER ________

OTHER DIFFICULTIES *(Equipment, clots, etc.)*

☒ NO ☐ YES *(Specify)*

SIGNATURE OF PERSON NOTING ABOVE [redacted] 1C/RN

b6-2

PATIENT IDENTIFICATION - USE EMBOSSER *(For typed or written entries give: NAME - Last, first, middle; rank/rate; hospital number and name of facility.)*

[redacted] b6-4

SEX M

WARD ICU 3

BLOOD OR BLOOD COMPONENT TRANSFUSION
STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

MEDCOM - 13321

MEDICAL RECORD COPY

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

☒ RED BLOOD CELLS
☐ FRESH FROZEN PLASMA
☐ PLATELETS *(Pool of ____ units)*
☐ CRYOPRECIPITATE *(Pool of ____ units)*
☐ Rh IMMUNE GLOBULIN
☐ OTHER *(Specify)* ____

VOLUME REQUESTED *(If applicable)* 10 ML

REMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*

☐ TYPE AND SCREEN
☒ CROSSMATCH

DATE REQUESTED 10 Jul 03

DATE AND HOUR REQUIRED 10 Jul 03 0900

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: ____

HEMOLYTIC DISEASE OF NEWBORN? ____

REQUESTING PHYSICIAN *(Print)* Dr [redacted] b6-2

DIAGNOSIS OR OPERATIVE PROCEDURE Burn Debridement

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER Previous

DATE VERIFIED Clay

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. **1199964**

1199964

TRANSFUSION NO.

PATIENT NO.

DONOR	RECIPIENT
ABO O	ABO B
Rh positive	Rh positive

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	Compatible

PREVIOUS RECORD CHECK:

☒ RECORD ☐ NO RECORD

SIGNATURE OF PERSON PERFORMING TEST [redacted] b6-2

☐ CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED DATE 10 JUL 03

REMARKS:

EXP DATE 11, JUL 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)* [redacted] b6-2

AT *(Hour)* 1123 ON *(Date)* 10 JUL 03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient [redacted] item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

(Signature) [redacted] b6-2

PRE-TRANSFUSION

TEMP. PULSE 119 BP 128/78

DATE OF TRANSFUSION 10 Jul 03

TIME STARTED 1135

PATIENT IDENTIFICATION - USE EMBOSSER *(For typed or written entries give: NAME - Last, first, middle; rank/rate; hospital number and name of facility.)*

[redacted] b6-4

POST-TRANSFUSION DATA

AMOUNT GIVEN 350 ML

TIME DATE [✓ COMPLETED] INTERRUPTED 1250 10 Jul

REACTION ☒ NONE ☐ SUSPECTED

If reaction is suspected – IMMEDIATELY:

1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION

☐ URTICARIA ☐ CHILL ☐ FEVER ☐ PAIN
☐ OTHER ____

OTHER DIFFICULTIES *(Equipment, clots, etc.)*

☒ NO ☐ YES *(Specify)* ____

SIGNATURE OF PERSON NOTING ABOVE [redacted] b6-2

SEX M WARD ICU 3

BLOOD OR BLOOD COMPONENT TRANSFUSION
STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

MEDCOM - 13322

MEDICAL RECORD COPY

518-123

NSN 7540-00-634-4158

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

☒ RED BLOOD CELLS
☐ FRESH FROZEN PLASMA
☐ PLATELETS *(Pool of ______ units)*
☐ CRYOPRECIPITATE *(Pool of ______ units)*
☐ Rh IMMUNE GLOBULIN
☐ OTHER *(Specify)* ______

VOLUME REQUESTED *(If applicable)* ______ ML

REMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*

☒ TYPE AND SCREEN
☒ CROSSMATCH

DATE REQUESTED 15 July 03

DATE AND HOUR REQUIRED

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: ______

HEMOLYTIC DISEASE OF NEWBORN? ______

REQUESTING PHYSICIAN *(Print)* [redacted] b6-2

DIAGNOSIS OR OPERATIVE PROCEDURE SKIN GRAFT + DEBRIDEMENT

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct. b6-2

SIG [redacted]

DATE [redacted] 15 July 03

TIME VERIFIED 0758

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. 4824472

TRANSFUSION NO.

PATIENT NO. 000-00-0386

DONOR
ABO / Rh O pos

RECIPIENT
ABO / Rh B pos

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	Comp

☐ CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

REMARKS:
Exp. Date: 17Jul03

PREVIOUS RECORD CHECK:
☒ RECORD ☐ NO RECORD b6-2

SIGNAT [redacted]

DATE 15Jul03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

[redacted] b6-2

AT *(Hour)* 0845 [redacted] ON *(Date)* 15 JUL 03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER *(Signature)* [redacted] b6-2

2nd VERI [redacted]

PRE-TRANSFUS

TEMP. 37 | PULSE 88 | BP 100/85

DATE OF TRANSFUSION 15 July 03

TIME STARTED 0825

POST-TRANSFUSION DATA

AMOUNT GIVEN 250 ML

TIME/DATE COMPLETED/INTERRUPTED 15 Jly 03 0920

REACTION
☒ NONE ☐ SUSPECTED

TEMPERATURE 37.0

PULSE 90

BLOOD PRESSURE 98/64

If reaction is suspected—IMMEDIATELY:

1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. Solutions to the Blood Bank.

DESCRIPTION OF REACTION

☐ URTICARIA ☐ CHILL ☐ FEVER ☐ PAIN
☐ OTHER *(Specify)*

OTHER DIFFICULTIES *(Equipment, clots, etc.)*

☐ NO ☐ YES *(Speci* [redacted]

SIGNATU [redacted] b6-2

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle; grade; rank; rate; hospital or medical facility)

SEX M

WARD OR

[redacted] b6-4

BLOOD OR BLOOD COMPONENT TRANSFUSION
Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 13323

518-123

NSN 7540-00-634-4158

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I - REQUISITION

COMPONENT REQUESTED *(Check one)*
☒ RED BLOOD CELLS
☐ FRESH FROZEN PLASMA
☐ PLATELETS *(Pool of* ______ *units)*
☐ CRYOPRECIPITATE *(Pool of* ______ *units)*
☐ Rh IMMUNE GLOBULIN
☐ OTHER *(Specify)* ______

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*
☒ TYPE AND SCREEN
☒ CROSSMATCH

REQUESTING PHYSICIAN *(Print)* b6-2
[redacted]

DIAGNOSIS OR OPERATIVE PROCEDURE
SKIN GRAFT &
DEBRIDEMENT

DATE REQUESTED 15 JULY 03

DATE AND HOUR REQUIRED

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

[redacted] b6-2

15 JULY 03

TIME VERIFIED 0750

VOLUME REQUESTED *(If applicable)* ______ ML

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

REMARKS:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:
RhIG TREATMENT? DATE GIVEN: ______
HEMOLYTIC DISEASE OF NEWBORN? ______

SECTION II - PRE-TRANSFUSION TESTING

UNIT NO. 1860465

TRANSFUSION NO. b6-4
PATIENT NO. [redacted]

TEST INTERPRETATION
ANTIBODY SCREEN N/A
CROSSMATCH Comp

PREVIOUS RECORD CHECK:
☒ RECORD ☐ NO RECORD

[redacted] PERSON PERFORMING TEST b6-2
DATE 15Jul03

☐ CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DONOR
ABO
Rh B Pos

RECIPIENT
ABO
Rh B Pos

REMARKS:
Exp. Date: 26Jul03

SECTION III - RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY [redacted] b6-2

AT *(Hour)* 0832 ON *(Date)* 15Jul03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER *(Signature)* [redacted] b6-2
2nd VERIFIER

PRE-TRANSFUSION
TEMP. 37 PULSE 100 BP 110/60

DATE OF TRANSFUSION 15 July 03

TIME STARTED 0830

POST-TRANSFUSION DATA

AMOUNT GIVEN 250 ML

TIME/DATE COMPLETED/INTERRUPTED 15 Jul 03 0858

REACTION
☒ NONE ☐ SUSPECTED

TEMPERATURE 36

PULSE 99

BLOOD PRESSURE 110/64

If reaction is suspected—IMMEDIATELY:
1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. Solutions to the Blood Bank.

DESCRIPTION OF REACTION
☐ URTICARIA ☐ CHILL ☐ FEVER ☐ PAIN
☐ OTHER *(Specify)*

OTHER DIFFICULTIES *(Equipment, clots, etc.)*
☐ NO ☐ YES *(Specify)*

SIGNATURE OF PERSON [redacted] b6-2

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle; grade; rank; rate; hospital or medical facility)

SEX M

WARD OR

[redacted] b6-4

BLOOD OR BLOOD COMPONENT TRANSFUSION
Medical Record
STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 13324

518-124 NSN 7540-00-634-4159

MEDICAL RECORD | **BLOOD OR BLOOD COMPONENT TRANSFUSION**

SECTION I - REQUISITION

COMPONENT REQUESTED *(Check one)*
- ☒ RED BLOOD CELLS
- ☒ ~~FRESH FROZEN PLASMA~~
- ☐ PLATELETS *(Pool of ______ units)*
- ☐ CRYOPRECIPITATE *(Pool of ______ units)*
- ☐ Rh IMMUNE GLOBULIN
- ☐ OTHER *(Specify)* ______

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*
- ☒ TYPE AND SCREEN
- ☒ CROSSMATCH

REQUESTING PHYSICIAN *(Print)* [redacted] b6-2

DIAGNOSIS OR OPERATIVE PROCEDURE s/p SKIN graft

DATE REQUESTED 27AUG03

DATE AND HOUR REQUIRED ASAP

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

VOLUME REQUESTED *(If applicable)* ______ ML

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

SIGNATURE OF VERIFIER [redacted] b6-2

REMARKS: 1 of 2

IF PATIENT IS FEMALE, IS THERE HISTORY OF:
RhIG TREATMENT? DATE GIVEN: ______
HEMOLYTIC DISEASE OF NEWBORN? ______

DATE VERIFIED 27AUG03

TIME VERIFIED [illegible]

SECTION II - PRE-TRANSFUSION TESTING

UNIT NO. 55W45666

TRANSFUSION NO.

PATIENT NO.

	DONOR	RECIPIENT
ABO	B	B
Rh	Pos	Pos

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	Comp

PREVIOUS RECORD CHECK: ☐ RECORD ☑ NO RECORD b6-2

SIGNATURE OF PERSON PERFORMING TEST [redacted]

☐ CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED DATE

REMARKS: EXP 08 SEP 03

SECTION III - RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)* [redacted] b6-2

AT *(Hour)* 1235 ON *(Date)* 27 Aug 03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER *(Signature)* [redacted] b6-2 27 AUG

2nd VERIFIER *(Signature)* [redacted] b6-2

PRE-TRANSFUSION TEMP. 97.4 PULSE 91 BP 98/58

DATE OF TRANSFUSION 27 AUG 03 TIME STARTED 1250

POST-TRANSFUSION DATA

AMOUNT GIVEN 500 ML

TIME/DATE ~~COMPLETED/INTERRUPTED~~ 27 [illegible]

REACTION ☒ NONE ☐ SUSPECTED

TEMPERATURE [illegible] PULSE [illegible] BLOOD PRESSURE [illegible]

If reaction is suspected—IMMEDIATELY:
1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION OF REACTION
☐ URTICARIA ☐ CHILL ☐ FEVER ☐ PAIN
☐ OTHER *(Specify)*

OTHER DIFFICULTIES *(Equipment, clots, etc.)*
☒ NO ☐ YES *(Specify)*

SIGNATURE OF PERSON NOTING ABOVE [redacted] b6-2

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle; grade; rank; rate; hospital or medical facility)

SEX

WARD

1305

[redacted]

BP 97/56

b6-4

BLOOD OR BLOOD COMPONENT TRANSFUSION
Medical Record
STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 13325

Return to Transfusion Service

518-124

NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

- ☒ RED BLOOD CELLS
- ☐ FRESH FROZEN PLASMA
- ☐ PLATELETS *(Pool of _______ units)*
- ☐ CRYOPRECIPITATE *(Pool of _______ units)*
- ☐ Rh IMMUNE GLOBULIN
- ☐ OTHER *(Specify)*

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*

- ☒ TYPE AND SCREEN
- ☐ CROSSMATCH

REQUESTING PHYSICIAN *(Print)* [redacted] b6-2

DIAGNOSIS OR OPERATIVE PROCEDURE S/P skingraft

DATE REQUESTED 27Aug03

DATE AND HOUR REQUIRED ASAP

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

VOLUME REQUESTED *(If applicable)* __________ ML

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

SIGNATURE OF VERIFIER b6-2 [redacted]

REMARKS: 2 of 2

IF PATIENT IS FEMALE, IS THERE HISTORY OF:
RhIG TREATMENT? DATE GIVEN N/A
HEMOLYTIC DISEASE OF NEWBORN?

DATE VERIFIED 27Aug03

TIME VERIFIED 0245

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. 011374

TRANSFUSION NO.

PATIENT NO.

TEST INTERPRETATION

ANTIBODY SCREEN N/A

CROSSMATCH Comp

PREVIOUS RECORD CHECK: ☐ RECORD ☑ NO RECORD

SIGNATURE OF PERSON PERFORMING TEST b6-2 [redacted]

DONOR
ABO B
Rh Pos

RECIPIENT
ABO B
Rh Pos

☐ CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE

REMARKS:

EXP 02 SEP 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)* b6-2 [redacted]

AT *(Hour)* 1035

ON *(Date)* 27 Aug 03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER *(Signature)* [redacted] b6-2

2nd VERIFIER *(Signature)* [redacted]

PRE-TRANSFUSION

TEMP. 36

PULSE 104

BP 82/56

DATE OF TRANSFUSION 27AUG03

TIME STARTED 1030

POST-TRANSFUSION DATA

AMOUNT GIVEN 1unit ML

TIME/DATE [✓ COMPLETED]/~~INTERRUPTED~~ 1055 / 27AUG03

REACTION ☒ NONE ☐ SUSPECTED

TEMPERATURE 36

PULSE 103

BLOOD PRESSURE 80/53

If reaction is suspected—IMMEDIATELY:

1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION OF REACTION

☐ URTICARIA ☐ CHILL ☐ FEVER ☐ PAIN

☐ OTHER *(Specify)*

OTHER DIFFICULTIES *(Equipment, clots, etc.)*

☒ NO ☐ YES *(Specify)*

SIGNATURE OF PERSON NOTING ABOVE [redacted] b6-2

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle; grade; rank; rate; hospital or medical facility)

SEX

WARD

SECTION I—REA...

INSTRUCTI...

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9 202-1

MEDCOM - 13326

518-124 NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

☒ RED BLOOD CELLS
☐ FRESH FROZEN PLASMA
☐ PLATELETS *(Pool of ______ units)*
☐ CRYOPRECIPITATE *(Pool of ______ units)*
☐ Rh IMMUNE GLOBULIN
☐ OTHER *(Specify)* ______

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*

☐ TYPE AND SCREEN
☒ CROSSMATCH

REQUESTING PHYSICIAN *(Print)* [redacted] b6-2

DIAGNOSIS OR OPERATIVE PROCEDURE S/P Ⓑ skin grafts to heels

DATE REQUESTED 30AUG03

DATE AND HOUR REQUIRED ASAP

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

VOLUME REQUESTED *(If applicable)* 1 unit/250 ML

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

SIGNATURE OF VERIFIER [redacted] b6-2

REMARKS: HCT 24.8

IF PATIENT IS FEMALE, IS THERE HISTORY OF:
RhIG TREATMENT? DATE GIVEN: ______
HEMOLYTIC DISEASE OF NEWBORN? ______

DATE VERIFIED 30AUG03

TIME VERIFIED 0915

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. 1262548

TRANSFUSION NO.

PATIENT NO.

TEST INTERPRETATION

ANTIBODY SCREEN

CROSSMATCH comp

PREVIOUS RECORD CHECK: ☒ RECORD ☐ NO RECORD

SIGNATURE OF PERSON PERFORMING TEST

	DONOR	RECIPIENT
ABO	B	B
Rh	pos	pos

☐ CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED DATE 30 Aug 03

REMARKS: EXP: 9 SEP 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*

AT *(Hour)* ON *(Date)*

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER *(Signature)* [redacted] UT/AW b6-2

2nd VERIFIER *(Signature)* [redacted]

[redacted]ION TEMP. 99^{8} PULSE 99 BP 96/50

DATE OF TRANSFUSION 30AUG03

TIME STARTED 1310

POST-TRANSFUSION DATA

AMOUNT GIVEN 250 ML

TIME/DATE COMPLETED/INTERRUPTED 1515 30AUG03

REACTION	TEMPERATURE	PULSE	BLOOD PRESSURE
☒ NONE ☐ SUSPECTED	100.°	97	92/52

If reaction is suspected—IMMEDIATELY:

1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION OF REACTION

☐ URTICARIA ☐ CHILL ☐ FEVER ☐ PAIN
☐ OTHER *(Specify)*

OTHER DIFFICULTIES *(Equipment, clots, etc.)*

☒ NO ☐ YES *(Specify)*

SIGNATURE OF PERSON NOTING ABOVE [redacted] UT/AW

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle; grade; rank; rate: hospital or medical facility) b6-2

#[redacted] b6-4

SEX MALE

WARD ICW#1

BLOOD OR BLOOD COMPONENT TRANSFUSION
Medical Record
STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 13327

Medical Record Copy

518-124

NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

☒ RED BLOOD CELLS

☐ FRESH FROZEN PLASMA

☐ PLATELETS *(Pool of ________ units)*

☐ CRYOPRECIPITATE *(Pool of ________ units)*

☐ Rh IMMUNE GLOBULIN

☐ OTHER *(Specify)* ________

VOLUME REQUESTED *(If applicable)* 1 unit/250 ML

REMARKS: HCT 24.8

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*

☐ TYPE AND SCREEN

☒ CROSSMATCH

DATE REQUESTED 30AUG03

DATE AND HOUR REQUIRED ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: ________

HEMOLYTIC DISEASE OF NEWBORN? ________

REQUESTING PHYSICIAN *(Print)* [redacted] 66-2

DIAGNOSIS OR OPERATIVE PROCEDURE S/P Ⓑ skin graft to heels

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER [redacted] 66-2

DATE VERIFIED 30AUG03

TIME VERIFIED 0915

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. 1644311

TRANSFUSION NO.

PATIENT NO.

DONOR

ABO B

Rh POS

RECIPIENT

ABO B

Rh POS

TEST INTERPRETATION

ANTIBODY SCREEN

CROSSMATCH Comp

PREVIOUS RECORD CHECK:

☒ RECORD ☐ NO RECORD

SIGNATURE OF PERSON PERFORMING TEST

☐ CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 30Aug03

REMARKS: EXP: 9Sep03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*

AT *(Hour)* 1017 ON *(Date)* 30Aug03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER *(Signature)* [redacted] ZLTAW

2nd VERIFIER *(Signature)* [redacted] 66-2

PRE-TRANSFUSION

TEMP. 99.3 PULSE 94 BP 89/47

DATE OF TRANSFUSION 30AUG03

TIME STARTED 1020

POST-TRANSFUSION DATA

AMOUNT GIVEN 250 ML

TIME/DATE COMPLETED/INTERRUPTED 30AUG03 1245

REACTION ☒ NONE ☐ SUSPECTED

TEMPERATURE 99.9

PULSE ~~99~~ 103

BLOOD PRESSURE 99/53

If reaction is suspected—IMMEDIATELY: [redacted] 66-2

1. Discontinue transfusion, treat shock if present, [redacted]avenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION OF REACTION

☐ URTICARIA ☐ CHILL ☐ FEVER ☐ PAIN

☐ OTHER *(Specify)*

OTHER DIFFICULTIES *(Equipment, clots, etc.)*

☒ NO ☐ YES *(Specify)*

SIGNATURE [redacted] NOTING ABOVE

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, [redacted] rank: rate; hospital or medical facility)

66-2

SEX MALE

WARD ICW#1

#[redacted] 66-4

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 13328

Medical Record Copy

MEDICAL RECORD - DOCTOR'S ORD

For use of this form, see MEDCOM Circular 40-5

DIRECTIONS: The provider will DATE, TIME, and SIGN each order or set of orders recorded. Only one order is allowed per line. Nursing will list the time the new order(s) are noted and initial in the column provided. Orders completed during the shift in which they were written do not require recopying. They may be signed off, as completed, in the far right column.

ORDER NUMBER	DATE, TIME, & SIGNATURE REQUIRED FOR EACH ORDER OR SET OF ORDERS	ORDER NOTED TIME & INITIALS	COMPLETED TIME & INITIALS
	POST ANESTHESIA ORDERS (circled Items)		
①	VS q 5 min X 15 min, then q 15 min until discharge.		
2	Supplemental oxygen.		
③	Morphine / Meperidine 2-3mg IV now and 2 mg q 3-5 min prn pain for a		1730 [redacted]
	~~max~~ dose of 10 mg.		
④	Zofran 4 mg IV prn N/V q 15 min, may repeat x 1.		
5	Metoclopramide____mg IV prn N/V x 1.		
6	Droperidol____mg IV prn N/V x 1.		
7	Phenergan____mg IV prn N/V x 1.		
8	Benadryl 25-50mg IVP q1 hr prn, itching while in PACU.		
9	IVF:__________@______cc/hr. per surgeon		
⑩	Discharge from recovery status when PACU discharge criteria met.		
⑪	Demerol 25mg IV x1 PRN shivering		1720 [redacted]
	[redacted] CRNA		
	66-2		

PATIENT IDENTIFICATION

[redacted] 66-4

Complete the following information on page 1 only. Note any changes on subsequent pages.

Diagnosis:

Height: ______ Weight: ______ Diet:

Allergies:

Nursing Unit	Room No.	Bed No.	Page No.
PACU, 28th CSH			1 of 1

MEDCOM FORM 688-R (TEST) (MCHO) MAR 99 PREVIOUS EDITIONS ARE OBSOLETE MC V1.00

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

# [redacted] b6-4

[redacted]

Copy to Pharm: Y/N

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER ~~X~~ HOURS | LIST TIME ORDER NOTED AND SIGN

① Admit to 1C03 X

~~Stp~~ Burn X

DVT X

Cond stable

VS Q1°, I/O, SAT ✓

All Ø X

Act Bedrest X

PATIENT IDENTIFICATION

# [redacted] b6-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER HOURS

Mex ① Bleg to Grante X

② Burn Dressing Δ's Per protocol X

Diet Regular X

IVF LR@150 cc/hr X

meds

MoDy 1-10 mg IV Q1° PRN pain Fever X

PATIENT IDENTIFICATION

# [redacted] b6-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER HOURS

Dressing Δ

Versed 2-5 mg IV Q1° PRN sedation X

For Dressing Δ

Percocet ī-ii tabs PO Q4° PRN Pain X

Proventil MDI ii puffs Q4° X

Lovenox 90mg SQ BID X ?

LAB- CXR, CBC medly LB Q am X

PATIENT IDENTIFICATION

# [redacted] b6-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER HOURS

Levaquin 500mg IV QD X

[redacted]

24 [redacted] Maj/AW 210V

b6-2

b6-2 [redacted] 1711 3 Jul 03

MEDCOM - 13330

ACLU-RDI 1592 p.1223

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-400; the proponent agency is the Office of The Surgeon General.

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

HVD #[redacted] — b6-4

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 02 July 03 TIME OF ORDER 0609 HOURS

LIST TIME ORDER NOTED AND SIGN

Admit to patient hold for ~10% BSA Burns
NKDA
Meds [redacted] Albuterol MDI 2 p q 4° 0830
~~ASA 325~~ [redacted] ~~qd~~
0600
Unasyn 3g IV q 6° x 3 doses
MSO4 2mg IV every 2 hours as needed for
severe pain or Dressing changes

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

Apply Silvadene cream to wound BID & cover
with sterile dressing
Tylenol 650 po q 6° [redacted] 0830
Aciphex 20mg po qd 0830
IVF - LR @ 200cc/hr
Foley to gravity
Record Strict I&O's

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER ↓↓ TIME OF ORDER HOURS

notify MD if UOP is <40cc/hr
ISTAT 6 & creatinine now & q AM 0830
Diet Regular, give more food than normal as burns
require ↑ energy to heal
Vitals q 4° x 2 then q 8° notify MD for
SBP >160 <100, DBP >110 <50 HR >110 <50
Sats <90% on RA; Temp >101 <96 RR >24 <12

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER ↓↓ TIME OF ORDER HOURS

wound care BID to include scrubbing wound with sterile
water & sponge then dry w/ sterile bandages & apply
Silvadene cream & then dress w/ sterile dressing
Range of Motion Exercises To ~~[illegible]~~ extremities 3x a day

[redacted]

b6-2

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

MEDCOM - 13331

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
[redacted] b6-4
NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 3Jul03
TIME OF ORDER: 1848 HOURS
LIST TIME ORDER NOTED AND SIGN

Albuterol 0.5cc in 2.5cc NS
Q4° x48hrs

[redacted] b6-2

PATIENT IDENTIFICATION
[redacted] b6-4
NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 3 Jul 03
TIME OF ORDER: 1609 HOURS

① ABG Now ✓
② EKG Now ✓
③ NS 500cc Bolus IV x 1 ✓
④ Narcan 0.2 mg IV Now ✓
v.o. per Dr. [redacted]
b6-2

1721 3Jul03

PATIENT IDENTIFICATION
0 [redacted] b6-4
NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 3 Jul 03
TIME OF ORDER: [redacted] 656 HOURS

① Give another 500cc NS Bolus N[redacted]
v.o. per Dr. [redacted] / [redacted]
b6-2

PATIENT IDENTIFICATION
0 [redacted] b6-4
NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 3Jul
TIME OF ORDER: 1800 HOURS

① LR 500cc Bolus IV Now
② Albuterol Neb 0.5/2.5 Now
b6-2 [redacted]
b6-2
20 [redacted] Maj AN 2100

DA FORM 1 APR 79 **4256** REPLACES MEDCOM - 13332 MAY BE USED.

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-400; the proponent agency is the Office of The Surgeon General.

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

[redacted]

b6-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 03 July 03

TIME OF ORDER 0700 HOURS

LIST TIME ORDER NOTED AND SIGN

1) Add WBC count to AM Labs

2) have patient out of bed into chair QID

3) Rupture any cloudy blisters

[redacted]

b6-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 03 July 03

TIME OF ORDER 0800 HOURS

1) vitals q 2° x 10 then q 4°

2) WBC count q 8° x 4 then q AM

[redacted]

b6-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER

TIME OF ORDER ______ HOURS

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER

TIME OF ORDER ______ HOURS

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

MEDCOM - 13333

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

[redacted] -b6-4
[redacted] [redacted]

NURSING UNIT | ROOM NO. | BED NO.
24 [redacted] Maj/AN 2100

DATE OF ORDER: 3JUL03 TIME OF ORDER: 0920 HOURS

LIST TIME ORDER NOTED AND SIGN

① ↑ IVF to 200 cc/hr — done

noted

[redacted] b6-2

PATIENT IDENTIFICATION b6-2

[redacted] b6-4

b6-2

NURSING UNIT | ROOM NO. | BED NO.
24 [redacted] Maj/AN 0300

DATE OF ORDER: 4 Jul 02 TIME OF ORDER: 0255 HOURS

V.O. Dr [redacted]

Give Lasix 20 mg IVP X1 now

[redacted] Maj/AN

b6-2 [redacted]

done

PATIENT IDENTIFICATION

[redacted]

b6-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 5 July 03 TIME OF ORDER: 0700 HOURS

① Pt may Ambulate

② No labs today

b6-2 [redacted]

PATIENT IDENTIFICATION

[redacted] b6-4

DATE OF ORDER: 5Jul03 TIME OF ORDER: 2035 HOURS

① Type & Cross x 2 units of Blood

② NPO p̄ MN

noted 2100 5Jul [redacted] 1LT/AN

[redacted] b6-2

NURSING UNIT | ROOM NO. | BED NO.
24° Chart Check 0030 06JUL03 [redacted] 1LT/AN

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

MEDCOM - 13334

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

[redacted]

b6-4

NURSING UNIT 24' [redacted] Maj/Aw **ROOM NO.** **BED NO.**

DATE OF ORDER 6JUL03 **TIME OF ORDER** ________ **HOURS**

LIST TIME ORDER NOTED AND SIGN

✓ ① Resume Previous ORDERS
except
✓ ② ↓ IVF to LR @ 100 cc/hr
✓ ③ W-D dressing QD @ excision site.
4 Regular Diet
2300

[redacted]

noted 6JUL03 1450.

b6-2

PATIENT IDENTIFICATION

[redacted]

b6-4

NURSING UNIT **ROOM NO.** **BED NO.**

DATE OF ORDER 7JUL03 **TIME OF ORDER** 0700 **HOURS**

① D/c Daily CXR

noted

[redacted]

b6-2

PATIENT IDENTIFICATION

[redacted]

b6-4

NURSING UNIT **ROOM NO.** **BED NO.**

DATE OF ORDER **TIME OF ORDER** ________ **HOURS**

PATIENT IDENTIFICATION

[redacted]

b6-4

NURSING UNIT **ROOM NO.** **BED NO.**

DATE OF ORDER **TIME OF ORDER** ________ **HOURS**

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

MEDCOM - 13335

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
[redacted] b6-4

NURSING UNIT
ROOM NO. 24' ✓
BED NO. [redacted]

DATE OF ORDER 8 Jul 03
TIME OF ORDER 0710 HOURS

LIST TIME ORDER NOTED AND SIGN

① KCl 40 meq in 100 cc NS
over 2hrs.
[redacted]

Noted 8 Jul 03 0750 b6-2 [redacted] 1410

Mg PhW 2110

PATIENT IDENTIFICATION b6-2
[redacted] b6-4

NURSING UNIT
ROOM NO.
BED NO.

DATE OF ORDER 9 Jul 03
TIME OF ORDER 0935 HOURS

Type and cross 2u PRBC
for OR tomorrow
NPO p̄ MN. ✓
✓ incentive spirometry ✓
Vancomycin 1gm IV Q12
Lasix 10mg IV @ 1600 [redacted]
↓ IVF to 30 cc/hr.

Noted b6-2 [redacted] 1440 9 Jul 03 b6-2

PATIENT IDENTIFICATION
[redacted] b6-4

NURSING UNIT
ROOM NO.
BED NO.

DATE OF ORDER 9 July 03
TIME OF ORDER 2300 HOURS

① ↑ IVF to 100cc/h p̄ Tube feeding off
[redacted] 1/0 2h [redacted] b6-2

noted b6-2 [redacted] [illegible]

PATIENT IDENTIFICATION
[redacted] - b6-4

NURSING UNIT
ROOM NO.
BED NO.

DATE OF ORDER 10 Jul 03
TIME OF ORDER 1600 HOURS

~~① Lasix~~
① Lasix 20mg IV x1 Now
[redacted] b6-2

DA FORM 1 APR 79 4256

REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 13336

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
[redacted] b6-4

DATE OF ORDER 10 Jul 03
TIME OF ORDER 1600 HOURS
LIST TIME ORDER NOTED AND SIGN [redacted]

① start TF: 2000 Kcal/day, start @ 40cc/hr & advance to goal rate as tolerated.
② 20mg Lasix IVP x1 now — done
③ Lovenox 90 mg SQ BID b6-2
④ Albuterol 2 puff Q4°

NURSING UNIT
ROOM NO.
BED NO.

PATIENT IDENTIFICATION
24° ✓ [redacted] Mj/AN ~~0600~~ 11 June 03 b6-2

DATE OF ORDER
TIME OF ORDER [redacted] HOURS

NURSING UNIT
ROOM NO.
BED NO.

PATIENT IDENTIFICATION
[redacted] b6-4

DATE OF ORDER 11 Jul 03
TIME OF ORDER 1130 HOURS

① Lasix 20 mg IV x i now (1125)
② Cipro 400 mg IV BID.
D/c levoquin
③ thorazine 10mg IM BID [redacted] b6-2

noted 11 Jul 03 1130 [redacted] AN

NURSING UNIT
ROOM NO.
BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER
TIME OF ORDER 1940 11 July 03 HOURS

V.O. Dr [redacted] b6-2
DC IM Thorazine give 25 mg P.O. BID
MOM now + 2 hours later if no result. [redacted] /AN

NURSING UNIT
ROOM NO.
BED NO.

24° Chart Check 12 JUL 0100 [redacted] ILT/AN b6-2

DA FORM 1 APR 79 **4256** REPLACES EDITION ... MAY BE USED.

MEDCOM - 13337

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
[redacted] b6-4

DATE OF ORDER 13Jul03 TIME OF ORDER 1630 HOURS

LIST TIME ORDER NOTED AND SIGN

(i) Tylenol 650 mg PO Q4-6° PRN fever

noted 13Jul03 1630 [redacted] RN

b6-2 [redacted]

NURSING UNIT / ROOM NO. / BED NO.

14 JUL 0030 24° Chart Check [redacted] /AN

PATIENT IDENTIFICATION

DATE OF ORDER 15 Jul 03 TIME OF ORDER 1130 HOURS

V.O. Cont. Suction to Abdominal drsg.

Bedrest until taken back to OR then re-evaluate.

From Dr. [redacted] / [redacted] LTC/a

b6-2 [redacted]

NURSING UNIT / ROOM NO. / BED NO.

PATIENT IDENTIFICATION
[redacted] b6-4

DATE OF ORDER 15Jul03 TIME OF ORDER 1200 HOURS

① Resume previous order x̄ 125 mmHg ~~to~~ A Suction to Abdominal JP's continuous

② Keep thigh STSG dressings Moist c̄ 5% sulfamylon solution

Noted [redacted] b6-2 15 Jul 03 @1600

[redacted]

NURSING UNIT / ROOM NO. / BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 16Jul03 TIME OF ORDER 0700 HOURS

① D/C Cipro

② D/C Vancomycin

b6-2 [redacted]

NOTED 16Jul03 0900 [redacted] b6-2

NURSING UNIT / ROOM NO. / BED NO.

24° ✓ [redacted] 0130 DM

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

MEDCOM - 13338

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

[redacted] b6-4

ICU-3

[redacted] b2-2

NOTED
16JUL03
1410 [redacted] b6-2

NURSING UNIT: 24'√ [redacted] Maj / AN 0130

ROOM NO.

BED NO.

DATE OF ORDER: 16JUL03

TIME OF ORDER: 1400 HOURS

LIST TIME ORDER NOTED AND SIGN

① D/C THORAZINE

V.O. DR [redacted] b6-2

Δ

PATIENT IDENTIFICATION b6-2

NOTED
19JUL03
0945 [redacted]

NURSING UNIT

ROOM NO.

BED NO. b6-2

DATE OF ORDER: 19JUL03

TIME OF ORDER: 0845 HOURS

① NPO pMN

② T & Cross 2u PRBC

③ Hold Lovenox tonite and in AM.

b6-2 [redacted]

PATIENT IDENTIFICATION

[redacted] b6-4

ICU-3

[redacted] b2-2

NURSING UNIT

ROOM NO.

BED NO.

DATE OF ORDER: 19JUL03

TIME OF ORDER: 1716 HOURS

① Silvadene to Ant Abd wound QD √

② D/c central line when PIV placed

[redacted] b6-2

PATIENT IDENTIFICATION

NURSING UNIT

ROOM NO.

BED NO.

DATE OF ORDER

TIME OF ORDER ______ HOURS

DA FORM 1 APR 79 4256

REPLACES EDITION OF 1 JUL 77 WHICH MAY BE USED.

MEDCOM - 13339

CLINICAL RECORD DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] b6-4

NURSING UNIT | ROOM NO | BED NO

DATE OF ORDER 20 Jul 03 TIME OF ORDER 1200 HOURS

A Admit to ICW3
S/P STSG
cond stable
vitals Q1° ē SAT
All ∅
Act - Bed rest

PATIENT IDENTIFICATION

[redacted] b6-4

NURSING UNIT | ROOM NO | BED NO

DATE OF ORDER TIME OF ORDER HOURS

Nurse - JPs to 125 mm Hg continuous
Suction (4 JP's)
Moisten Ⓡ calf STSG site ē 5% Sulfamylon
Foley to gravity
NO TF for the next 7 days
Diet - Clears
IVF LR @ 100 cc/h

1415 [redacted] b6-2

PATIENT IDENTIFICATION

[redacted] b6-4

NURSING UNIT | ROOM NO | BED NO

DATE OF ORDER TIME OF ORDER HOURS

Meds
① [illegible]drin on tab while Awake
[illegible] ī tab with each Dressing change
[illegible] as needed.
② MSO4 2-10 mg Q1° as need
③ continue previous sedation orders
④ QD silvadene Dressing, Δ's to

PATIENT IDENTIFICATION

[redacted] b6-4

NURSING UNIT | ROOM NO | BED NO

DATE OF ORDER TIME OF ORDER HOURS

remaining Burns, older STSG sites
and Open Donor sites
Position Pt on sides most of Day.
Albuterol ĪĪ puffs Q6°
Labs CBC, Chem 8 QOD.
Ace wrap to Ⓑ leg [illegible] splints
Lovenox 90 mg SQ BID [illegible]

[redacted] b6-2

b6-2

[illegible] [redacted] [illegible]

MEDCOM - 13340

ACLU-RDI 1592 p.1233

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
[redacted] b6-4

DATE OF ORDER 24 Jul 03
TIME OF ORDER 1610 HOURS
LIST TIME ORDER NOTED AND SIGN

Ambien 5mg PO QHS PRN
V.O per Dr. [redacted]
b6-2
24 Jul 03 [redacted] 1729

NURSING UNIT | ROOM NO. | BED NO.
24 [redacted] Jky / RAw 7/24 21[redacted]

PATIENT IDENTIFICATION b6-2
[redacted] b6-4

DATE OF ORDER 25 Jul 03
TIME OF ORDER 0811 HOURS

✓ ↑ Ambien to 10mg qHS PRN
✓ Add Dietary Supplements
✓ (Ensure / Carnation instant breakfast) tid of 3 cans / day.
noted 25 July 03 0855 [redacted]
[redacted] b6-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION
[redacted] b6-4

DATE OF ORDER 25 July 03
TIME 1545 HOURS

① 1 L NS bolus x 1 now.
V.O. Dr. [redacted] / [redacted] 1? RN [redacted]
b6-2
noted 25 July 03 15[illegible]
[redacted]

NURSING UNIT ICU 3 | ROOM NO. | BED NO. 3

PATIENT IDENTIFICATION
[redacted] b6-4

DATE OF ORDER 27 Jul 03
TIME OF ORDER 0712 HOURS

DC labs QOD
Δ to labs
TUESDAY and [redacted]
Saturday
b6-2
Δ [illegible] to q4° [redacted]

Transcribed 27 July 03 @ 0712 via Sgt [redacted]

NURSING UNIT ICU3 | ROOM NO. | BED NO. 3

DA FORM 4256, 1 APR 79 2[redacted] MEDCOM - 13341 MAY BE [redacted] b6-2

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 [redacted] b6-4

DATE OF ORDER 28 Jul 03 TIME OF ORDER 0718 HOURS

LIST TIME ORDER NOTED AND SIGN

Percocet 1-2 tablets PO q4°
PRN dressing Δ's and/or pain

[redacted] b6-2

NURSING UNIT 24° ROOM NO. [redacted] BED NO.

Noted/ AW 0300 7/29/03 24° Chart VACE

b6-2

PATIENT IDENTIFICATION [redacted] b6-4

DATE OF ORDER 31 Jul 03 TIME OF ORDER 0819 HOURS

NPO after midnight
Start IV @ 1800 hrs
Fluid NS @ 100 cc/hr.
Ancef 1 gm on call to OR

[redacted] b6-2

NURSING UNIT 24° ROOM NO. b6-2 [redacted] BED NO.

Noted/ AW 0830

PATIENT IDENTIFICATION [redacted] b6-4

DATE OF ORDER TIME OF ORDER 04AUG03 HOURS

Δ Albuterol to 2 puffs q6° PRN wheezing

noted 04AUG @ 0915 VTA/ 3GH [redacted] b6-2

NURSING UNIT ROOM NO. BED NO.

PATIENT IDENTIFICATION [redacted] b6-4

DATE OF ORDER TIME OF ORDER ________ HOURS

NURSING UNIT 24° Chart ROOM NO. BED NO. [redacted] Noted/ AW 4 August 0939

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

b6-2

MEDCOM - 13342

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

[redacted] 66-41

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 1 Aug 03
TIME OF ORDER: 1030 HOURS
LIST TIME ORDER NOTED AND SIGN

Resume previous orders
Δ heel dressings BID
Paxil 20mg PO qd
MSO4 2-6mg IVP q 2° prn pain
Phenergan 12.5mg IVP q 6° prn nausea

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER
TIME OF ORDER HOURS

IVF LR @ 100cc/h 662

[redacted]

[redacted]

1125 1 Aug 03

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 1 Aug 03
TIME OF ORDER: 1828 HOURS

(1) ↑ Ensure+1 to 6 cans/day
+ regular meal
(Target Calories 4000 cal/day
if unable to eat/drink 6kg
replace Dobhoff)

(2) Plain X-rays of both feet to

PATIENT IDENTIFICATION

DATE OF ORDER
TIME OF ORDER HOURS

r/o Osteomyelitis of bilat
calcanees

[redacted] 66-2

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

24° [redacted] 66-2

May 1AW 0300 [redacted]

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

MEDCOM - 13343

CLINICAL REC JRD · DOCTOR'S ORDERS

For us… form, see AR 40-66, the proponent agency i… TSG

THE DOCTOR SHALL RECORD DATE, T… ID SIGN EACH SET OF ORDERS. IF PRO… G…E …D MEDICAL RECORD
SYSTEM IS USED, WRITE PROBLEM NUM… IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION
[redacted] b6-4
b6-2
24° Chart ✓ [redacted] /AW 0937 4 Aug 03 [redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICU3	[redacted]	4

DATE OF ORDER 4 Aug 03 TIME OF ORDER 0724 HOURS
- Δ Albuterol to 2 puff q 6° PRN @
Colace 100 g PO BID

ORDER NOTED AND SIGN: noted 04AUG03 @ 0915 via SGT [redacted] b6-2

PATIENT IDENTIFICATION
[redacted] b6-4

DATE OF ORDER 6 Aug 03 TIME OF ORDER 1634 HOURS
D/C Foley
V.O. per Dr. [redacted] /AW [redacted]
b6-2
[redacted] 6 Aug 03 /AW

NURSING UNIT	ROOM NO.	BED NO.
ICU3		

24° Chart by [redacted] /AW 07 AUG 03 0400

PATIENT IDENTIFICATION
[redacted] b6-4

DATE OF ORDER 8/8/03 TIME OF ORDER 0718 HOURS
Cipro 500 g PO BID X 3 days
[redacted]

ORDER NOTED AND SIGN: Ntd by [redacted] RN 08 Aug @ 1115 b6-2

NURSING UNIT	ROOM NO.	BED NO.
ICU3	24°	[redacted]

b6-2 /AW 8 Aug 03 1249

PATIENT IDENTIFICATION
[redacted] b6-4

DATE OF ORDER 8/9/03 TIME OF ORDER 0830 HOURS
① D/C PIV
② Benadryl 25 mg PO Q6° PRN itch
③ Atarax 10 mg PO Q8°.
Δ Atarax 10 mg PO Q8° to Atarax 25 mg PO Q8°
[redacted]
b6-2

ORDER NOTED AND SIGN: noted 1007 on 09 Aug 03 SGT [redacted] b6-2

NURSING UNIT	ROOM NO.	BED NO.
ICU3		4

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

24° Chart ✓ [redacted] /AW 1726 11 Aug 03

*U.S. GOVERNMENT PRINTING OFFICE: 2002-488-041

"USE BALL POINT PEN—PRESS FIRMLY I NO CARBON PAPER REQUIRED"

MEDCOM - 13344

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

[redacted] b6-4

DATE OF ORDER: 16 Aug 03

TIME OF ORDER: 1000 HOURS

LIST TIME ORDER NOTED AND SIGN

① Resume pre op orders

② Add (B) heel wet to dry

Dressing Δ's BID

[redacted] b6-2

q/Aw 1715 17 Aug 03

NURSING UNIT: 24° Chart

ROOM NO.: V [illegible]

BED NO.: [redacted]

PATIENT IDENTIFICATION

b6-2

DATE OF ORDER: 18 Aug 03

TIME OF ORDER: 0713 HOURS

Δ VS to Q shift

V.O. per Dr. [redacted] [redacted] b6-2

q/Aw

[redacted] b6-2

0716 18 Aug 03

NURSING UNIT

ROOM NO.: 24° Chart/

BED NO.: [redacted] b6-2

UT/Aw 2200 19 Aug 03

PATIENT IDENTIFICATION

DATE OF ORDER: 31 Aug 03

TIME OF ORDER: 1016 HOURS

Please give patient

MSO4 ℥ mg IVP now

[redacted] b6-2

[redacted]

NURSING UNIT

ROOM NO.

BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 31 Aug 03

TIME OF ORDER: 1034 HOURS

Dressing Δ's to both heels

c̄ Vaseline gauze QD

[redacted] b6-2

NURSING UNIT

ROOM NO.

BED NO. [redacted] b6-2

1 SEP 03

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

MEDCOM - 13345

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: [redacted] b6-4

DATE OF ORDER: 22 AUG 03 TIME OF ORDER: 1430 HOURS

LIST TIME ORDER NOTED AND SIGN

① Please Apply Silvadene to Ⓛ heel wound. BID

② [illegible] word

[redacted] b6-2

[redacted] b6-2

Noted [redacted] [illegible] 1435

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION: #0 [redacted] b6-4

DATE OF ORDER: 23 AUG 03 TIME OF ORDER: 0945 HOURS

① NPO ō MN

② Cipro 500 mg PO BID × 3 days

③ on call to OR .. AM

[redacted]

[redacted] 23 Aug 03 0955 b6-2

NURSING UNIT: ICW ROOM NO.: ~~2R~~/~~[illegible]~~ [illegible] BED NO.: [redacted] b6-2

PATIENT IDENTIFICATION

DATE OF ORDER: 24 Aug 03 TIME OF ORDER: 1450 HOURS

① LR @ KVO for surgery in AM

~~② Regular Diet~~

③ NPO p̄ MN

④ Please assess PIV site q 4°

[redacted] MAJ/C[redacted]

[redacted] b6-2

b6-2 [redacted] 150 24 Aug

NURSING UNIT | ROOM NO. | BED NO. [redacted] [illegible]

PATIENT IDENTIFICATION: Ø [redacted] b6-4

DATE OF ORDER: 24 AUG 03 TIME OF ORDER: 1810 HOURS

① NPO p̄ MN

Regular Diet Now

b6-2

[redacted]

NURSING UNIT | ROOM NO.: 2R/ 2330 | BED NO.: [redacted] b6-2 [illegible]

DA FORM 1 APR 79 4256 REP[redacted]DITION OF 1 JUL 77, WHICH MAY BE USED.

☆ U.S. GO MEDCOM - 13346 710

Jan 9

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

[redacted] b6-4

[redacted] b6-2

Noted 26 Aug 03 @ 1140

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 26AUG03 TIME OF ORDER 1030 HOURS | LIST TIME ORDER NOTED AND SIGN

① Admit to PACU → ward ✓

S/p skin graft to heels

Cond stable ✓

Vitals @ Bedside Q shift ✓

All Ø ✓

Act Bed rest ✓

Nurse ① Apply Eucerin Cream to

DATE OF ORDER TIME OF ORDER ______ HOURS

all Healed Graft sites ✓

Silvadene with kerlix to STSG sites

② with openings ✓

③ JP to 125 cm H2O wall suction

continuous. ✓

④ Do not change Dressings o. Heels

or Buttock creases or Ⓡ thumb. ✓

DATE OF ORDER TIME OF ORDER ______ HOURS

Regular Diet ✓

IVF - HL

meds

✓ Ancef 1 gm IV Q 8° × 24hrs

✓ Lovenox 80mg SQ BID start tonite

[redacted] b6-2

DATE OF ORDER 26Aug 03 TIME OF ORDER 1115 HOURS

① MSO4 2mg q 5min to max 10mg IV

Keep RR ↑ 10 @ Sat ↑ 95 [redacted]

b6-2

① MSO4 2-10 mg IV Q1° Prn Pain

[redacted]

DA FORM 1 APR 79 **4256** REPLA[CES] MEDCOM - 13347 [WH]ICH MAY BE USED.

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
[redacted] b6-4
noted [redacted] b6-2

DATE OF ORDER 27aug03 TIME OF ORDER 0030 HOURS
LIST TIME ORDER NOTED AND SIGN

① LR bolus 1L x1 now
② CBC T+C x2 units p̄ bolus
③ Notify MD if Hct < 28, cont'd saturated drsgs, HR > 100
④ O2 2L NC PRN to keep sats > 95%
V.O. DR [redacted] / RN [redacted]

NURSING UNIT 1W#1 ROOM NO. BED NO.

0115 27aug03

PATIENT IDENTIFICATION

DATE OF ORDER 27aug03 b6-2 TIME OF ORDER 0300 b6-2 HOURS

① LR @ 125cc/hr
② CBC in AM
③ NPO for OR in AM.
b6-2
V.O. DR [redacted] / RN [redacted] [redacted]
b6-2

noted 27aug [redacted]

NURSING UNIT ROOM NO. BED NO.

PATIENT IDENTIFICATION
[redacted] noted 27 Aug 03 1200 [redacted] b6-4 b6-2

DATE OF ORDER 27 AUG 03 TIME OF ORDER HOURS

✓ Give 10mg Vit K SubCut qd for 3 days
2 - Transfuse 1u PRBC
3 - ✓ CBC + PT/PTT p̄ transfusion
4 - Regular Diet
5 - VS q4° ✓
6 - Continue previous orders [redacted] b6-2

NURSING UNIT ROOM NO. BED NO.

PATIENT IDENTIFICATION
noted [redacted] b6-2

DATE OF ORDER 27aug03 TIME [redacted] 2130 HOURS

① D/C IVF
② Percocet 1-2 # PO q4-6° PRN pain
V.O. DR [redacted] / [redacted]
b6-2

NURSING UNIT 240 ROOM NO. BED NO. 28aug03 [redacted]

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77 WHICH MAY BE USED.
MEDCOM - 13348

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

[redacted] b6-4

Noted 28 Aug 03 0900 [redacted] b6-2

DATE OF ORDER 28 AUG 03 TIME OF ORDER ______ HOURS

LIST TIME ORDER NOTED AND SIGN

1/ Start IVF @ 100cc/hr

2/ [illegible] 25mg [illegible] BP > 180 [illegible]

3/ CBC + Chem 7 in A.M.

b6-2 [redacted]

NURSING UNIT ICW ROOM NO. BED NO.

29aug03 0200 24 Chart V [redacted] b6-2 RN

PATIENT IDENTIFICATION

DATE OF ORDER 29AUG03 TIME OF ORDER 1550 HOURS

1 CBC in AM [redacted] b6-2

Noted [illegible] [redacted] b6-2

NURSING UNIT 2P/ ROOM NO. 2215 BED NO. 29aug03 [redacted] b6-2

PATIENT IDENTIFICATION

DATE OF ORDER 30 AUG 03 TIME OF ORDER ______ HOURS

1. Transfuse two (2) units PRBC

2. [illegible] 320mg tid PO

[redacted] b6-2

b6-2 Noted [redacted] 30Aug03 0830

NURSING UNIT 2P/ 0800 30aug03 ROOM NO. [redacted] BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 31aug03 TIME OF ORDER 1000 HOURS

VO Dr. [redacted] b6-2

Drsg Δ's to bilat heels

w/ vaseline gauze +

kerlix wrap [redacted]

[redacted]

NURSING UNIT 2P/2 ROOM NO. 20 1sep03 BED NO.

MEDCOM - 13349

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
[redacted]
b6-4
Noted 28 Aug 03 0900 [redacted]
b6-2

DATE OF ORDER 28 Aug 03 TIME OF ORDER ______ HOURS
LIST TIME ORDER NOTED AND SIGN

1/ Start IVF @ 100cc/hr
2/ Phenergan 25mg [illegible] q8° prn nausea
3/ CBC + Chem 7 in A.M.

[redacted] b6-2

NURSING UNIT ICW
ROOM NO. / BED NO. 29 Aug 03 0020 24 Chart ✓ [redacted] [illegible]/AN

PATIENT IDENTIFICATION
Noted w/RN [redacted]
b6-2

DATE OF ORDER 29 Aug 03 TIME OF ORDER 1550 HOURS

1 CBC in AM

[redacted] b6-2

NURSING UNIT 2W
ROOM NO. 2215 [redacted]
BED NO. 30 Aug 03
[redacted] b6-2

PATIENT IDENTIFICATION
b6-2
Noted w/RN [redacted] 30 Aug 03 0850

DATE OF ORDER 30 Aug 03 TIME OF ORDER ______ HOURS

1. Transfuse two (2) units PRBC
2. Lasix 20mg [illegible]

[redacted] b6-2

NURSING UNIT 2W
ROOM NO. [illegible] 30 Aug 03
BED NO. [redacted]

PATIENT IDENTIFICATION

DATE OF ORDER 31 Aug 03 TIME OF ORDER 1000 HOURS

VO Dr. [redacted] -b6-2
Drsg Δ's to bilat heels
w/ vaseline gauze & Kerlix wrap [redacted]

[redacted]

NURSING UNIT 2W/2
ROOM NO. 201 Sep 03
BED NO. [redacted]

DA FORM 4256 REPLACES [redacted] OF 1 JUL 77, WHICH MAY BE USED.
MEDCOM - 13350

CLINICAL RECORD - DOCTOR'S ORDERS

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

THE DOCTOR SHALL RECORD DATE, TI SIGN EACH SET OF ORDERS. IF PROB. RIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMB IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION
#0[redacted] b6-4

DATE OF ORDER 06SEP03
TIME OF ORDER 1000 HOURS
LIST TIME ORDER NOTED AND SIGN

OOB to chair X3 days, then
pt may ambulate ad lib
VO Dr[redacted]
b6-2
24°/2115 06SEP03 [redacted]

NURSING UNIT ICW#1
ROOM NO. 2
BED NO. A

PATIENT IDENTIFICATION

DATE OF ORDER 08 Sept
TIME OF ORDER 1500 HOURS

① D/C Lovenox
② D/C IV
Per Dr[redacted] b6-2
[redacted]

NURSING UNIT
ROOM NO.
BED NO.
~~24°/2215 8Sept~~

PATIENT IDENTIFICATION
[redacted] b6-4
Noted 9 Sept

DATE OF ORDER 9 Sep 03
TIME OF ORDER 0820 HOURS

① Pt may Ambulate with Assist.
② D/C ATARAX
③ Ace wrap to heels for Ambulation.
[redacted]
b6-2

NURSING UNIT
ROOM NO.
BED NO.
24°/2215 9SEP[redacted]

PATIENT IDENTIFICATION
b6-4 Noted
[redacted]
[redacted] b6-2

DATE OF ORDER 10 Sep 03
TIME OF ORDER 920 HOURS

① Wet to Dry Dressing to Buttock Wounds BID
② Warm compress to foot [illegible] Q6
[redacted]
b6-2

NURSING UNIT
ROOM NO.
BED NO.
24° 2100 10 SEP 03

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

MEDCOM - 13351

ᐟ'.INICAL RECORD - DOCTOR'S ORDERS

For u is form, see AR 40-66, the proponent agency ⁵G

ORIENTED MEDICAL RECORD

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

PATIENT IDENTIFICATION

#[redacted] b6-4

Noted [redacted] b6-2 13SEP03 0810

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 13sep03

TIME OF ORDER 0710 HOURS

LIST TIME ORDER NOTED AND SIGN

① warm compresses to tender areas on ® leg Q6° As needed

[redacted] b6-2

PATIENT IDENTIFICATION

Noted [redacted] b6-2 13SEP03 1650

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 13sep03

TIME OF ORDER 1620 HOURS

① Motrin 800 m PO TID

b6-2

[redacted]

b6-2 [redacted] 9/14/03 0500

PATIENT IDENTIFICATION

NURSING UNIT ICW | ROOM NO. 24 | BED NO.

27sep03 @ 0445

DATE OF ORDER 26Sept03

TIME OF ORDER 1630 HOURS

b6-2

VO DR [redacted] [redacted]

Begin drsg OS to ⒷButtock w/ WS D and Dakins Solution. BID.

PATIENT IDENTIFICATION

Noted

O [redacted]

b6-4

noted

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 2 OCT 03

TIME OF ORDER 1402 HOURS

Ventolin inhaler 2 puff Q6° PRN

[redacted]

b6-2

DA FORM 4256 REPLACES MEDCOM - 13352 MAY BE USED.

ACLU-RDI 1592 p.1245

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
#[redacted]
66-41

NURSING UNIT: ICW#1
ROOM NO.: 2
BED NO.: A

DATE OF ORDER: 6 OCT 03
TIME OF ORDER: 0913 HOURS
LIST TIME ORDER NOTED AND SIGN

NPO after midnight
[redacted]
24 2205 [redacted] 66-2

PATIENT IDENTIFICATION

NURSING UNIT
ROOM NO.
BED NO.

DATE OF ORDER
TIME OF ORDER ____ HOURS

PATIENT IDENTIFICATION

NURSING UNIT
ROOM NO.
BED NO.

DATE OF ORDER
TIME OF ORDER ____ HOURS

PATIENT IDENTIFICATION

NURSING UNIT
ROOM NO.
BED NO.

DATE OF ORDER
TIME OF ORDER ____ HOURS

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77 WHICH MAY BE USED.
MEDCOM - 13353

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

[redacted] b6-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 7 OCT 03 TIME OF ORDER 1700 HOURS

LIST TIME ORDER NOTED AND SIGN

transfer to ward

Dx: s/p closure buttock wound

condition stable

IV LR @ 100 cc/hr heplock when tolerating PO

Ancef 1 gm q 8° x 48°

first dose on return to ward

Ventolin 2 puffs q 6° PRN

PATIENT IDENTIFICATION

b6-2 Noted [redacted] [illegible]/AN

07OCT03

1750

DATE OF ORDER TIME OF ORDER HOURS

Percocet 1-2 PO q 4° PRN pain

MSO4 2-6 mg IVP q 3° PRN pain

Dressing changes QD to buttock wound

MCDA

Dr. [redacted] [redacted] b6-2

NURSING UNIT ROOM NO. BED NO.

10/8/03 0135 24º [redacted]

PATIENT IDENTIFICATION

b6-2

EPW # [redacted] b6-4

DATE OF ORDER 12 OCT 03 HOURS

Eucerin cream to wound (healed)

have patient apply himself

May have Tylenol # 3 1-2 tabs

PO q 4° PRN pain for pain more mild

[redacted] b6-2

12OCT [redacted]

NURSING UNIT ICW | ROOM NO. 24ºV | BED NO. 12OCT03 2045

PATIENT IDENTIFICATION

12OCT03 [redacted] [illegible]/AN 2045 b6-2

DATE OF ORDER 12Oct03 TIME OF ORDER 2045 HOURS

① loperamide T after each stool

max 4 per day

[redacted] b6-2

NURSING UNIT 24ºV | ROOM NO. 13Oct03 | BED NO. 1910 RD1 [illegible]/AN

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

MEDCOM - 13354

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.

LIST TIME ORDER NOTED AND SIGN

PATIENT IDENTIFICATION

[redacted] b6-4

Noted [redacted] b6-2
07OCT03

NURSING UNIT

ROOM NO. 0750

BED NO.

DATE OF ORDER 7 OCT 03

TIME OF ORDER 0723 HOURS

Please send CBC, chem 7
and start IV
IVF LR @ 100 cc/h

[redacted] b6-2

PATIENT IDENTIFICATION

NURSING UNIT

ROOM NO.

BED NO.

DATE OF ORDER

TIME OF ORDER ______ HOURS

PATIENT IDENTIFICATION

NURSING UNIT

ROOM NO.

BED NO.

DATE OF ORDER

TIME OF ORDER ______ HOURS

PATIENT IDENTIFICATION

NURSING UNIT

ROOM NO.

BED NO.

DATE OF ORDER

TIME OF ORDER ______ HOURS

DA FORM 1 APR 79 4256

REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 13355

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

[redacted] b6-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 10/10/03 TIME OF ORDER 0800 HOURS

LIST TIME ORDER NOTED AND SIGN

① Admit to ICU 3
Full thickness Burn
cond stable
Vitals Q1° c̄ I/O s̄ SAT
All Ø
Act. OOB -> Chair

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

b6-2 [redacted]

Foley to gravity
Foley care
Ace wrap to Ⓛ Leg at All times
central line care.
Silvadene Dressing Δ's
per protocol

EG/RN 10Jul03 2020

PATIENT IDENTIFICATION

[redacted] b6-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

Diet Regular NTO p̄ 0200 for Conc Sedat
IVF LR @ 50cc/hr
Meds
Levaquin 500 mg IV QD
Vancomycin 1g IV BID
~~Ketamine~~ } for ~~sedation Titrate~~ to Effect
Fentanyl

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

Versed } for sedation
Fentanyl Patch 50 μg/hr to CW
Q 3 days
MSO4 1-5 mg Q1° for Break through

CRC Medlyte 3 QAm

[redacted]

11 Jun, 03 24 [redacted]

DA FORM 1 APR 79 **4256** [redacted] WHICH MAY BE U [redacted]

b6-2

MEDCOM - 13356

CLINICAL RECORD - DOCTOR'S ORDERS

F of this form, see AR 40-66, the proponent ager OTSG

THE DOCTOR SHALL RECORD DA AE AND SIGN EACH SET OF ORDERS. IF EM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM ABER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

[redacted]

66-41 noted

NURSING UNIT: CW1
ROOM NO.:
BED NO.:

DATE OF ORDER: 16OCT03
TIME OF ORDER: 1456 HOURS
LIST TIME ORDER NOTED AND SIGN: [redacted]

D/C to Camp in Am
Recommend / [illegible] for outpt med
Please give adequate
Supply of 10 days [illegible]

[redacted]

[redacted]

66-2

PATIENT IDENTIFICATION

NURSING UNIT:
ROOM NO.:
BED NO.:

DATE OF ORDER:
TIME [redacted] HOURS

PATIENT IDENTIFICATION

NURSING UNIT:
ROOM NO.:
BED NO.:

DATE OF ORDER:
TIME OF ORDER: HOURS

PATIENT IDENTIFICATION

NURSING UNIT:
ROOM NO.:
BED NO.:

DATE OF ORDER:
TIME OF ORDER: HOURS

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

MEDCOM - 13357

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo Jul Yr 2003

Verify by Initialing: Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
3Jul	[redacted]	Admit to ICU 3	3 Jul		Done	[redacted]
3Jul03	[redacted]	ABG Now	3Jul03		1530	[redacted]
3Jul03	[redacted]	EKG Now	3Jul03		1545	[redacted]
5Jul	[redacted]	No Labs on 6/Jul/03	6Jul	0400	0400	[redacted]
5Jul	[redacted]	T&C 2 units blood	6Jul	—	0245	[redacted]
5Jul	[redacted]	NPO p̄ MN	6Jul	0000	0000	[redacted]
9Jul	[redacted]	Dobhoff Placement ✓	9Jul	stat		[redacted]
9Jul03	[redacted]	Type + Cross 2units PRBCs for	9Jul03			[redacted]
	[redacted]	OR tomorrow				
9Jul03	[redacted]	NPO p̄ MN	9Jul03			

b6-2

b6-2

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION: TIME/DATE COMPLETED

USAPA V1.00

MEDCOM - 13358

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	*Mo.* Jul *Yr.* 2003

VERIFY BY INITIALING — *INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION*

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 3	4	5	6	7	8	9	10	11	12	13	14	15	16
3 Jul	[redacted]	Condition Stable	05	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
			17	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
3 Jul	[redacted]	Vitals q 1°, I+O, Sat	05	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
			17	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
3 Jul	[redacted]	Activity: bedrest	05	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	5 Jul 0700						
			17	[redacted]	[redacted]	[redacted]	/	/	[redacted]	[redacted]							
3 Jul	[redacted]	Foley to gravity	05	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
			17	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
3 Jul	[redacted]	Burn dressing Δ's	05	[redacted]	[redacted]	[redacted]		> Δ'd 6 Jul 03									
		per protocol (bid)	17	[redacted]	[redacted]												
3 Jul	[redacted]	Reg diet	05	[redacted]	[redacted]	[redacted]	[redacted]							all			
			17	[redacted]	[redacted]	[redacted]	[redacted]							66-2			
3 Jul	[redacted]	Labs: ~~CXR~~ DC, CBC,	05	/	[redacted]	[redacted]	X	[redacted]									
		Chem 8 q am															
5 JUL	[redacted]	Patient may ambulate	05	X	X	X	[redacted]	[redacted]	[redacted]	[redacted]							
			17	X	X	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
6 JUL	[redacted]	Wet to Dry drsg QD@	10 05	[redacted]	/	/	[redacted]	[redacted]	[redacted]	[redacted]							
		excision sites (bilat legs															
		and stomach)															
6 JUL	[redacted]	Regular diet	05	/	/	/	[redacted]	[redacted]	[redacted]	[redacted]							
			17	/	/	/	[redacted]	[redacted]	[redacted]	[redacted]							
9 Jul 03	[redacted]	Incentive Spirometry	05	/					/	[redacted]							
			17	/				/	/	[redacted]							

ALLERGIES: ☐ YES ☒ NO	PRIMARY DIAGNOSIS: DVT, Burn	ADDITIONAL PAGES IN USE: ☐ YES ☐ NO PAGE NO: ______

PATIENT IDENTIFICATION:
[redacted]

[redacted] 66-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 MEDCOM - 13359 JSED. USAPA V1.00

CLINICAL RECORD

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

Mo. Jul *Yr.* 2003

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED													
				10	11	12	13	14	15	16	17	18	19	20	21	22	23
10 Jul	[redacted]	Vitals q1° c̄ I&O & Sat	05	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]			
			17	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]				
10 Jul	[redacted]	~~Activity OOB → chair~~	05	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		[redacted]			
17 Jul		Bedrest	17	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	7/17/03				
10 Jul	[redacted]	foley to gravity	05	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]			
			17	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]				
10 Jul	[redacted]	foley care q shift	05	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]			
			17	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]				
10 Jul	[redacted]	Ice wrap to Ⓛ leg at all times	05	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]			
			17	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]				
10 Jul	[redacted]	Central line care	05	[redacted]			[redacted]		[redacted]	[redacted]	[redacted]		[redacted]		[redacted]	[redacted]	
			17	[redacted]	[redacted]						[redacted]			July 03			
10 Jul	[redacted]	Silvadene dressing Δ's per protocol (Lakes [illegible])	05	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		
			17	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]				
10 Jul	[redacted]	Diet regular	05	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	c			
			17	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]				
10 Jul	[redacted]	NPO p̄ 0200 for conscious sedation	05	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	c			
			17	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]				

b6-2

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
S/P Burn Debridement

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO
PAGE NO: 1

PATIENT IDENTIFICATION:
[redacted]
b6-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 EDITION OF 1 DEC 77 MAY BE USED. USAPA V1.00

MEDCOM - 13360

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	*Mo.* Jul *Yr.* 2003

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED											
				10	11	12	13	14	15	16	17	18	19	20	21
10 Jul	[redacted]	CBC, mellyte 8		[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]			[redacted]	
		q AM													
10 Jul	[redacted]	TF @ 2000 Kcal/day	05	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		
		start @ 40a/hr and	17	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]			
		advance to goal rate													
		as tolerated													
15 Jul	[redacted]	Continuous suction to	05	/	/	/	/	/	[redacted]	[redacted]		[redacted]	[redacted]	185U403	
		abdominal JPS dressing.	17	/	/	/	/	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		
		Keep suction @ 125 mmHg	/												
15 Jul	[redacted]	Bedrest until taken	05	/	/	/	/	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		
		back to OR then	17	/	/	/	/	[redacted]	[redacted]	[redacted]	[redacted]				
		re-evaluate	/												
15 Jul	[redacted]	Keep graft sites	05	/	/	/	/	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		
		(bilateral upper	17	/	/	/	/	/	[redacted]	[redacted]	[redacted]	[redacted]			
		thighs) moist	/												
15 Jul	[redacted]														

all 66-2

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: S/P Burn Debridement

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO: 2

PATIENT IDENTIFICATION:

[redacted] 66-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78

EDITION OF 1 DEC 77 MAY BE USED.

USAPA V1.00

MEDCOM - 13361

Verify by Initialing		**THERAPEUTIC DOCUMENTATION CARE PLAN** *(NON-MEDICATION)*	Mo JUL		Yr 2003	
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
		Admit to ICU 3, Full Thickness				
		Burn, Condition Stable,				
19 JUL03	[redacted]	DIET: NPO p̄ MN 19JUL03 FOR SURGERY	19 JUL03	2400		
19 JUL03	[redacted]	LAB: T/C FOR 2UNITS PRBC	19 JUL03		15:30	[redacted]
		b6-2				b6-2

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING COMPLETION* TIME/DATE COMPLETED													

USAPA V1.00

MEDCOM - 13362

CLINICAL RECORD

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

Mo. ____ *Yr.* 2003

VERIFY BY INITIALING — *INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION*

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 20	21	22	23
20 Jul	[redacted]	Condition stable	05	[redacted]		[redacted]	[redacted]
			17	[redacted]			
20 Jul	[redacted]	V.S. q 1° c̄ sat	05	[redacted]			[redacted]
			17	[redacted]			
20 Jul	[redacted]	Bedrest	05	[redacted]			[redacted]
			17	[redacted]			
20 Jul	[redacted]	JPs to 125 mmHg	05	[redacted]			[redacted]
		Continuous suction	17	[redacted]			
		(4 JPs)	/				
20 Jul	[redacted]	Moisten Ⓡ calf STSG	05	/	[redacted]		[redacted]
		site c̄ 5% Sulfamylon	17	[redacted]			
20 Jul	[redacted]	Foley to gravity	05	[redacted]			[redacted]
			17	[redacted]			
20 Jul	[redacted]	No TF for the next	05	[redacted]		3	[redacted]
		3 days.	17	[redacted]			
20 Jul	[redacted]	Diet - clear	05	[redacted]			[redacted]
			17	[redacted]			
20 Jul	[redacted]	QD Silvadene Dressing	05	[redacted]			[redacted]
		Δ's to remaining					
		burns, older STSG					
		sites and open donor					
		sites.					
20 Jul	[redacted]	Position pt on sides	05	[redacted]			[redacted]
N.O.	[redacted]	most of day. (N.O. document	17	[redacted]			
		on nursing flowsheet)					
20 Jul	[redacted]	CBC, Chem 8 QOD	04		[redacted]		

Δ ½d [redacted]

all 66-2

ALLERGIES: ☐ YES ☑ NO

∅

PRIMARY DIAGNOSIS:

S/P STSG

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ______

PATIENT IDENTIFICATION:

[redacted] 66-41

Duplicates

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 EDITION OF 1 DEC 77 MAY BE USED. USAPA V1.00

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*			Mo ____ Yr 2003	
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
20Jul	[redacted]	Admit to ICU 3	20Jul		Done	[redacted]
		b6-2				b6-2

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING COMPLETION* TIME/DATE COMPLETED													

USAPA V1.00

MEDCOM - 13364

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*

For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo. ____ *Yr.* 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 20	21	22	23	24
20 Jul	[redacted]	Ace wraps to (B) legs	05	[redacted]	[redacted]	[redacted]		[redacted]
		w/ splints.	17	[redacted]	[redacted]	[redacted]		
10 Jul	[redacted]	NPO p̄ 0200 for	05	[redacted]	[redacted]	[redacted]		[redacted]
		conscious Sedation	17	[redacted]	[redacted]	[redacted]		

all 66-2

ALLERGIES: ☐ YES ☑ NO

PRIMARY DIAGNOSIS: S/p STSG

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ____

PATIENT IDENTIFICATION:

#[redacted] 66-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

D 8 9 10 11 12 13 14 15

E 16 17 18 19 20 21 22 23

N 24 01 02 03 04 05 06 07

DA FORM 4677, 1 OCT 78

EDITION OF 1 DEC 77 MAY BE USED.

MEDCOM - 13365

USAPA V1.00

CLINICAL RECORD | **THERAPEUTIC DOCUMENTATION CARE PLAN** *(NON-MEDICATION)*

For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo. Jul *Yr.* 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	22	23	24	25	26	27	28	29	30	31	1	2	3	4
20 Jul	[redacted]	Ace wraps to Ⓑ legs	06	[redacted]													
		c̄ splints	18	[redacted]													
10 Jul	[redacted]	NPO p̄ 0200 for	06	[redacted]													
		conscious sedation	18	[redacted]													
25 Jul 03	[redacted]	Add Dietary supplement	06	/	/		[redacted]										
		(Ensure/Carnation) with	18	/	/		[redacted]										
		breakfast to equate of	—														
		3 cans/day	—														
07 July 03	[redacted]	Labs Ⓠ Tuesday and	04							→	[redacted]					[redacted]	
		Saturday CBC + Chem 8															
27 July 03	[redacted]	Vital Signs Ⓠ 4°	06	→						[redacted]							
			18	→					[redacted]								
1 Aug 03	[redacted]	Δ Heel Dressings	08	/									/	[redacted]			
		BID (Use Silvadene Cream)	20	/									/	[redacted]			
1 Aug 03	[redacted]	↑ Ensure +1 to 6 cans/	6											[redacted]			
		day + Regular meal	18											[redacted]			
		(Target Calories 4000															
		cal/day. If unable															
		to eat/drink 6 cans															
		replace dobhoff.															

AIC 66-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P STSG

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ______

PATIENT IDENTIFICATION:

Ft [redacted]

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 EDITION OF 1 DEC 77 MAY BE USED. USAPA V1.00

MEDCOM - 13366

CLINICAL RECORD

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

Mo. July Yr. 2003

VERIFY BY INITIALING — *INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION*

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 22 23 24 25 26 27 28 29 30 31 1 2 3 4
22 Jul	[redacted]	Condition stable	06	[redacted]
			18	[redacted]
22 Jul	[redacted]	VS q1° c̄ SATS	06	[redacted]
			18	[redacted]
22 Jul	[redacted]	Bedrest	06	[redacted]
			18	[redacted]
22 Jul	[redacted]	JP's to 125 mmHg	06	[redacted]
		continuous suction	18	[redacted]
		(4 JP.)	/	
22 Jul	[redacted]	Moisten Ⓛ calf STSG	06	[redacted]
		site c̄ 5cc Sufamylon	18	[redacted]
22 Jul	[redacted]	Foley to gravity	06	[redacted]
			18	[redacted]
22 Jul	[redacted]	NO TF for the next	06	[redacted]
		3 days	18	[redacted]
22 Jul	[redacted]	Diet ~~clear~~ regular	06	[redacted]
			18	[redacted]
22 Jul	[redacted]	QD silvadene Dressing	06	[redacted]
		Δ's to remaining		
		burns, older STSG		
		sites and open donor		
		sites		
22 Jul	[redacted]	Position pt on sides	06	[redacted]
		most of day (document	18	[redacted]
		on nursing flow sheet	/	
22 Jul	[redacted]	CBC, chem 8 QOD	04	[redacted]
				[redacted] D/C'd 27 July 03

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: S/P STSG

ADDITIONAL PAGES IN USE: [redacted] ☐ YES ☐ NO

PAGE NO: ______

PATIENT IDENTIFICATION:

[redacted] 66-4

a11 66-2

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 EDITION OF 1 DEC 77 MAY BE USED. USAPA V1.00
MEDCOM - 13367

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo ______ *Yr* 2003

Verify by Initialing Order Date	Verify by Initialing Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
1Avg	[redacted]	Plan X-rays of both feet to R/O	2Avg	0400		
	[illegible]	osteomyelitis				

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													

USAPA V1.00

MEDCOM - 13368

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo Jul *Yr* 2003

Order Date	Clerk Nurse	66-2 SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
1 Aug 03	[redacted]	Resume previous orders	1 Aug 03		1042	[redacted] 66-2

<table>
<tr><th rowspan="2">Order/ Expir Date</th><th rowspan="2">Clerk/ Nurse</th><th rowspan="2">PRN ACTION, FREQUENCY</th><th colspan="14"><i>INITIAL PROPER COLUMN FOLLOWING COMPLETION</i>
TIME/DATE COMPLETED</th></tr>
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USAPA V1.00

MEDCOM - 13369

CLINICAL RECORD

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

Mo. 07 *Yr.* 2003

VERIFY BY INITIALING — *INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION*

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Recopy 5 Aug	[redacted]	Labs Q Tuesday	04	[redacted]	/	/	/	[redacted]	/	/	[redacted]	/	/	/		/	/
		and Saturday		Recopied													
		CBC + Chem 8															
Recopy 5 Aug	[redacted]	Vital Signs Q4°	06	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	
			18	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	
Recopy 5 Aug	[redacted]	Δ Heel Dressings BID	06	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		[redacted]	[redacted]	[redacted]			
		(Use Silvadene Cream)	18	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]				
Recopy 5 Aug	[redacted]	↑ Ensure Plus to 6	06	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
		cans/day + Reg meals	18	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
		Target Calories 4000															
		Cal															
5 Aug 03	[redacted]	Diet Reg	06	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
			18	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Recopy 5 Aug	[redacted]	QD Silvadene Dressing	06	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
		Δ to remaining burns	18	[redacted]	[redacted]												
		STSG sites + open															
		donor sites															
Recopy 5 Aug	[redacted]	Position pt on	06	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
		Sides most of day	18	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
		(document on nursing															
		flow sheets)															
14 Aug 03	[redacted]	Add (R) heel wet to dry dressing	06	/	/	/	/	/	/	/	/	/	/	/	/	[redacted]	
		BID	18	/	/	/	/	/	/	/	/	/	/	/	[redacted]	[redacted]	

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
S/P STSG

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
PAGE NO: ____________

PATIENT IDENTIFICATION:
[redacted]

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 EDITION OF 1 DEC 77 MAY BE USED. USAPA V1.00

MEDCOM - 13370

THERAPEUTIC DOCUMENTATION CARE PLAN

(NON-MEDICATION)

Mo ______ *Yr* 2003

b6-2

Verify by Initialing						
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
6Aug03	[redacted]	D/C Foley	6Aug03			[redacted]
2		NPO p̄ MN				b6-2

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION													
			TIME/DATE COMPLETED													

USAPA V1.00

MEDCOM - 13371

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	*Mo.* Aug *Yr.* 2003

VERIFY BY INITIALING — *INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION*

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	17	18	19	20	21	22	23	24	25	26	27			
17Aug03	[redacted]	Add (B) heel wet to	06	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]					
		dry dressing Δ's	18	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]					
		BID															
18Aug03	[redacted]	Δ VS to Q shift	06	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]					
			18	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]					
recopy 05 Aug	[redacted]	Labs Q Tuesday + Saturday	04	/	/	/	/	/	/	[redacted]	/	/		/	/	/	
		CBC + Chem 8															
Recopy 05 Aug	[redacted]	↑Ensure Plus to 6 cans/day	06	/	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]					
		NC + Reg meals, Target Calorie	18	/	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]					
		4000															
		~~Diet Reg~~ NC	~~06~~														
Recopy 05 Aug	[redacted]	QD drsng Δ's to remaining	06	/	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]					
		burns, STSG sites, + open	18	/	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]					
		Donor sites c̄ Silvidine															
recopy 05 Aug	[redacted]	Diet Reg (NPO p̄ MN 24Aug03)	06	/	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]					
			18	/	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]					
Recopy 05 Aug	[redacted]	Position Pt on sides most	06	/	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]					
		of day (document on	18	/	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]					
		Nursing Flowsheet)															
2Aug	[redacted]	Please assess PIV	06	/	/	/	/	/	/	/	[redacted]	[redacted]					
		site q4°	18	/	/	/	/	/	/	/	[redacted]	[redacted]					

all b6-2

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS: s/p STSG

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ______

PATIENT IDENTIFICATION:

[redacted] b6-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 — EDITION OF 1 DEC 77 MAY BE USED. — USAPA V1.00

Verify by Initialing		T....APEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*			*Mo* ______ *Yr* 2003	
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
22 Aug03	[redacted]	UA c̄ next void	22 Aug03	—	1530	[redacted]
23 Aug	[redacted]	NPO p̄ MN	23 Aug	2400	cancelled	
23 Aug	[redacted]	O/C to OR in AM	[redacted] ~~23~~ 24 Aug	— cancelled		
25	[redacted]	O/C to OR in Am, NPO p̄ MN	25 Aug	AM		
	.....		25 Aug	0001		
	.....	all b6-2				
	.....					
	.....					
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Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING COMPLETION* TIME/DATE COMPLETED													
.....	.....															
.....	.....															
.....	.....															
.....	.....															
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.....	.....															
.....	.....															
.....	.....															

USAPA V1.00

MEDCOM - 13373

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)	Mo Aug		Yr 2003	
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
26Aug	[redacted]	Admit to PACU → ward	26Aug	done	1140	[redacted]
26Aug	r	Condition stable	26	—	[illegible]	[redacted]
27	[redacted]	CBC, T+C x2units p̄ bolus	27Aug	p̄ bolus	—	[redacted]
27	[redacted]	Notify MD tonight if HCT<28, contd saturated drsg, HR>100	27Aug	0600	noted	[redacted]
27	[redacted]	CBC in AM	27Aug	0600	→	[redacted]
27	[redacted]	NPO for OR in AM.	27Aug	AM	noted	[redacted]
27	[redacted]	✓ CBC & PT PTT p̄ transfusion	27Aug	1630	J	[redacted]
28	[redacted]	CBC & Chem 7 in AM	29Aug	0400	—	[redacted]

all b6-2

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED

USAPA V1.00

MEDCOM - 13374

CLINICAL RECORD

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

Mo. 8 *Yr.* 2003

VERIFY BY INITIALING — *INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION*

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 26	27	28	29	30
26 Aug	[redacted]	VS @ BS Q Shift	06	[redacted]				
			18					
26 Aug	[redacted]	Activity Bedrest	06	[redacted]				
			18					
26 Aug	[redacted]	Apply Eucerin	06	[redacted]				
		Cream to all	18					
		healed Graft	X					
		sites	X					
26 Aug	[redacted]	Silvadene with	06	[redacted]				
		Kerlex to STSG	18					
		sites with openings	X					
26 Aug	[redacted]	JP to 125 cc H_2O	06	[redacted]				
		wall suction	18					
		continuous	X					
26 Aug	[redacted]	Do NOT change	06	[redacted]				
		Dressings on	18					
		heels, or Buttocks	X					
		creases or Ⓡ thumb	X					
26 Aug	[redacted]	Regular Diet	06	[redacted]				
			18					
27 Aug	[redacted]	Vitals Q4°	06	[redacted]				
			18					

ed 27 Aug 03

recopied

All b6-2

ALLERGIES: ☐ YES ☑ NO
NKA

PRIMARY DIAGNOSIS:
S/P Skin Graft to heels

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

PATIENT IDENTIFICATION:
[redacted] b6-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 — EDITION OF 1 DEC 77 MAY BE USED. — USAPA V1.00

MEDCOM - 13375

~ REWRITTEN ~

CLINICAL RECORD | **THERAPEUTIC DOCUMENTATION CARE PLAN** *(NON-MEDICATION)*
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.
Mo. 09 *Yr.* 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	11	12	13	14	15	16	17	18	19	20	21	22	23	24
27aug	[redacted]	Regular diet	6	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
			14	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
			22	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
27aug	[redacted]	VS Q4°	6	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
			14	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
			22	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
27aug	[redacted]	Apply Eucerin	10	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
		Cream to all healed	22	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
		graft sites	X														
27aug	[redacted]	Silvadene c̄ Kerlex	10	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		
		to STSG sites c̄	22	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]			
		openings	X														
2Jun	[redacted]	Incentive Spirometry	6	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		
			14		[redacted]	[redacted]	[redacted]	[redacted]		[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
			22	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		[redacted]	[redacted]	[redacted]
3aug	[redacted]	Drsg Δ QD to BILAT	10	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
		heels c̄ vaseline	X														
		gauze & Kerlex wrap	X														
			X														
9sep	[redacted]	may ambulate c̄	6	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
		assist, Ace wrap	14		[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
		to heels for AMB	22	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
		~~Warm compress to ms~~															
		~~border areas on Ⓡ m~~															
20 Sept	[redacted]	Wet → Dry Drsg to	10	→										[redacted]	[redacted]	[redacted]	[redacted]
		Ⓛ knee open area BID	22	→										[redacted]	[redacted]	[redacted]	[redacted]

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS:
STSG

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

PATIENT IDENTIFICATION:
[redacted] 66-4

All 66-2

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 USED. USAPA V1.00
MEDCOM - 13376

17/11

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*

For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeo l.

Mo. 09 *Yr.* 2003

VERIFY BY INITIALING | *INITIAL PROPER C N FOLLOWING EACH COMPLETION*

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	25	26	27	28	29	30	1	2	3	4	5	6	7
27 AUG03	[redacted]	Regular diet	06	[redacted]												
			18	[redacted]												
27	[redacted]	VS ~~q4°~~ KAS q shift	06	[redacted]												
			18	[redacted]												
27	[redacted]	Apply Eucerin cream	06	[redacted]												
		to all healed graft sites	18	[redacted]												
27	[redacted]	incentive spirometry	06	[redacted]												
			18	[redacted]												
31 AUG03	[redacted]	drsg Δ QD to (B) heels c̄	10	[redacted]												
		vaseline gauze/kerlex	/													
		wrap	/													
09 SEP03	[redacted]	may amb c̄ assist, ace	06	[redacted]												
		wrap to heels for amb	18	[redacted]												
20 SEP03	[redacted]	wet-dry drsg to (L)	10	[redacted]												
		knee open area BID	22	[redacted]												
26 SEP03	[redacted]	Begin (B) buttock drsg	10	/	/	[redacted]										
		w/ Dakin's solution	22	/	[redacted]											
		W→D BID	/													

D11 b6-2

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS:
STSG

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
PAGE NO: ______

PATIENT IDENTIFICATION:
#0[redacted] b6-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 EDITION OF 1 DEC 77 MAY BE USED. USAPA V1.00

MEDCOM - 13377

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo 08 *Yr* 2003

Verify by initialing: Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
28 Aug 03	[redacted]	CBC, Chem 7 in AM	29 Aug 03	—	—	[redacted]
29 AUG 03	[redacted]	CBC in AM	30 AUG 03	0520	0520	[redacted]
30 AUG 03	[redacted]	Transfuse two (2) units PRBC	30 AUG 03	—	1020	[redacted]
	-----	6/6-2				

6/6-2

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING COMPLETION* TIME/DATE COMPLETED
27 Aug	[redacted]	Notify MD if HCT <28, cont'd Saturated dsg's, HR >100	30 AUG 0700 IAS
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USAPA V1.00

MEDCOM - 13378

CLINICAL RECORD

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

Mo. 09 *Yr.* 2003

VERIFY BY INITIALING — *INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION*

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	06	07	08	09	10
06SEP03	[redacted]	OOB to chair X3	06	[redacted]				
		days, then amb ad	18	[redacted]				
		lib (09SEP03)						
9Sept	[redacted]	may Ambulate c̄	X					
9Sept	[redacted]	asst Ace wraps	06	/	/	/	[redacted]	
		to Heels for	18	/	/	/	[redacted]	
		ambulation	X					
10Sep	[redacted]	Wet to Dry Drsg	10	/	/	/	/	[redacted]
		to Buttocks wound	22	/	/	/	/	[redacted]
		BID						
10Sep	[redacted]	Warm Compress to	06 18	—	—	—	[redacted]	
		(R) foot IV site Q6°	18 06	—	—	—	[redacted]	

d/c 9Sep03

recopied

all b6-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P SKIN GRAFTS TO HEELS

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ____________

PATIENT IDENTIFICATION:
#0[redacted] b6-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 MEDCOM - 13379 SED. USAPA V1.00

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo 09 *Yr* 2003

Verify by Initialing						
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION													
			TIME/DATE COMPLETED													
13Sep03	[redacted]	Warm compress to tender areas on Ⓡ leg q6° as needed.														

USAPA V1.00

MEDCOM - 13380

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo 09 Yr 2003

Verity by Initialing						
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
6	[redacted]	NPO p MN	6OCT03	2359	—	[redacted]
07 OCT03	[redacted]	Please send CBC, chem 7	07 OCT03	—	0735	[redacted]
10/16	[redacted]	D/C to camp in Am	10/17	Am		
10/16		Please give adequate supplies of 10	10/17			
		day drsg Δs				

b6-2

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING COMPLETION* TIME/DATE COMPLETED
13SEP03	[redacted]	Warm compress to tender areas on (L) leg q 6° as needed	D/T

b6-2

MEDCOM - 13381

CLINICAL RECORD

THERA TIC DOCUMENTATION CARE PLAN *(N -MEDICATION)*
For use of this form, see AR 40-407;
he proponent agency is the Office of The Surgeon

Mo. 10 *Yr.* 2003

VERIFY BY INITIALING

INITIAL PROPER CO FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED												
				07	08	9	10	11	12	13	14	15	16	17	18	19
07 OCT 03	[redacted]	Dressing changed QD	10	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		
b6-2		to buttocks wound						b6-2								
		(Ⓛ buttock only 10/10)														

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS:
S/P CLOSURE BUTTOCK WOUND

ADDITIONAL PAGES IN USE:
☐ YES ☐ NO
PAGE NO: ______

PATIENT IDENTIFICATION:
#C[redacted] b6-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 EDITION OF 1 DEC 77 MAY BE USED. USAPA V1.00

MEDCOM - 13382

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo 10 Yr 2003

Verify by Initialing						
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
07 OCT03	[redacted]	Transfer to ward, Cond. - Stable	07 OCT03	—		[redacted]
	----	66-2				66-2

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION													
			TIME/DATE COMPLETED													
----	----															
----	----															
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MEDCOM - 13383

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*	*Mo.* July *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													
3Jul	[redacted]	Recopied 10 July 03 MSO4 1-10mg IV q1° prn														
	16-2	pain for dressing Δ's														
3Jul	[redacted]	Recopied 10 July 03 Versed 1-5mg IV q1° prn														
	16-2	sedation for dsg Δ														
3July	[redacted]	percocet i-ii q4° po														
	16-2	prn pain														

USAPA V1.00

MEDCOM - 13384

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*	Mo. JUL	Yr. 03		
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
3Jul03	[redacted]	NS 500cc Bolus x1 IV	3Jul03		1545	[redacted]
3Jul03	[redacted]	Narcan 0.2mg IV Now	3Jul03		1550	[redacted]
3Jul03	[redacted]	Give another 500cc NS Bolus Now	3Jul03		1656	[redacted]
4Jul	[redacted]	Lasix 20 mg IVP	4Jul03		0255	[redacted]
6Jul	[redacted]	Resume previous orders except	6Jul03	done	1255	[redacted]
	-----	⊘↓IVF to KR@100cc/hr				[redacted]
8Jul	[redacted]	KCl 40mEq in 100cc NS over 2 hrs	8Jul03	Now	[illegible]	[redacted]
9Jul03	[redacted]	Lasix 10mg IV Now	09Jul03		1100	[redacted]

	-----					

all 66-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY		INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED														
3Jul	Kr	MSO4 1-10mg IV	D	3Jul03	3Jul03	3Jul	3Jul	3Jul	3Jul03	3Jul	3Jul	3Jul	3Jul	[illegible]	5Jul	5Jul	6Jul	
			T	1200	1213	1235	1243	1250	1308	1316	1320	1342	1355	0400	2045	2200	1400	
-----	-----	q 1° prn pain for	D	2mg	2mg	2mg	2mg	2mg	2mg	2mg	2mg	2mg	2mg	10mg	10mg	10mg	2mg	
			I	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	
-----	-----	dressing Δ's																
3Jul	Kr	Versed 1-5mg IV	D	3Jul03	3Jul03	3Jul	3Jul03	3Jul03	3Jul	3Jul	3Jul	[illegible]	5Jul	5Jul	6Jul	8Jul	8Jul	10Jul
			T	1204	1213	1235	1243	1308	1316	1325	1342	[illegible]	2045	2200	2107	2245	2330	0010
-----	-----	q 1° prn sedation	D	2mg	1mg	1mg	1mg	2mg	1mg	1mg	1mg	5mg	5mg	5mg	4mg	3mg	4mg	3mg IV
			I	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
-----	-----	for dressing Δ'																
3Jul	Kr	Percocet i-ii po q 4°		8Jul 2300	8Jul 2300	8Jul 1334	8Jul 2300	9Jul03 1345										
-----	-----	prn pain		ii	ii	2 tabs	2 tabs	2200										
				[redacted]	[redacted]	[redacted]	[redacted]	[redacted]										
-----	-----	Recopied 7/8/03		SN ⊕	SN ⊕													
3Jul 03	w	MSO4 1-10mg IV		7Jul 2150	7Jul 2200	8Jul 2100	0200	8Jul 0400	8Jul 2215	8Jul 2300	9Jul03 0630	9Jul03 1300	9Jul 18:30	10Jul 0010				
-----	-----	q 1° prn pain +		6mg	4mg	2	4	4	5mg	3mg	3mg IV	3mg	[illegible]	[illegible]				
				⊖	⊕	⊕	⊕	⊕	⊖	⊕	[redacted]	[redacted]	[redacted]	[redacted]				
-----	-----	dressing Δ																
-----	-----																	

renew 10 July 03

[redacted]

USAPA V1.00

MEDCOM - 13385

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. July Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 3	4	5	6	7	8	9	10	11	12	13	14	15	16
3 Jul	[redacted]	IVF LR e ~~150cc/hr~~	05	[redacted]	[redacted]	[redacted]	[redacted]	>	Δ d/c 6 Jul 03								
0920	[redacted]	↑ rate to 200cc/hr	17	[redacted]	[redacted]	[redacted]		/									
3 Jul	[redacted]	Proventil MDI II	04	/	[redacted]		[redacted]	[redacted]	[redacted]		[redacted]						
		puffs q 4°	08	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
			12	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
			16	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
			20	[redacted]		[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
			24	/	[redacted]		[redacted]	[redacted]	[redacted]	[redacted]							
3 Jul	[redacted]	Lovenox 90mg SQ	10	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
		bid°	22	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
3 Jul	[redacted]	Levoquin 500mg IV q day	10	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
6 Jul	[redacted]	↓ IVF to LR @ 100cc/hr	05	/	/	/	[redacted]	[redacted]	[redacted]	/	Δ 9 July 03 [redacted]						
			17	/	/	/	[redacted]	[redacted]		/							
9 Jul 03	[redacted]	vancomycin I gm IV	12	/	—	—	/	/	/	[redacted]							
		q 12°	24	/	—	—	—	—	/	[redacted]							
9 Jul 03	[redacted]	↓ IVF (LR) to 20cc/hr	05	/	—	—	—	—	/	[redacted]							
			17	/	—	—	—	—	/	[redacted]							
9 July 03	[redacted]	↑ IVF to 100cc/h p	05	/	/	/	/	/	/	/							
		Tube feeding stopped	17	/	/	/	/	/	/	[redacted]							

all b6-2

ALLERGIES: ☐ YES ☑ NO	PRIMARY DIAGNOSIS: Burn, DVT	ADDITIONAL PAGES IN USE: ☐ YES ☐ NO PAGE NO. ______

PATIENT IDENTIFICATION:
[redacted]

b6-4

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 - 13386

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 — *INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION*

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 11	12	13	14	15	16	17	18
			11								
11 JUL	[redacted]	Thorazine 10mg IM	10	[redacted]	DC ∆ to p.o. 11 July 03 2000						
		BID	22								
11 Jul	[redacted]	Thorazine 25mg p.o.	06	/	NPO	[redacted]	Held	Held NPO	[redacted]		
		TID	14	/	[redacted]					D/c'd 16 JUL 03	
			22	m	[redacted]					[redacted]	
			X								
15 July	[redacted]	Keep thighs STSG dressings	05	/	/	/	/	[redacted]			
		moist c̄ 5% Sulfamylon Soln	20	/	/	/	/	[redacted]			
19 July	[redacted]	Silvadene to ANT	10	X	X	X	X	X	X	X	X
		ABD QD									

b6-2

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: S/P Burn debridement

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ________

PATIENT IDENTIFICATION: [redacted] b6-4

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

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

MEDCOM - 13387

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*		Mo. JUL Yr. 03		
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
10Jul	[redacted]	20 mg lasix IVP X1 now	10 Jul	1600	1600	[redacted]
11Jul	[redacted]	Lasix 20mg IV x i now	11Jul	NOW	1125	[redacted]
11Jul	[redacted]	MOM now + 2 hours after if no	11Jul	1940	1940	[redacted]
		result (BM)	11July	2240	NA	[redacted]
19 JUL03	[redacted]	HOLD LOVENOX TONIGHT AND IN AM 19JUL03 20JUL03 15	19JUL03			

all b6-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY		*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* TIME/DATE DISPENSED												
10Jul	[redacted]	MSO4 1-5mg q1°	D	11 July 03	12JUL	12JUL	13Jul 1040	13JUL 2100	13JUL 0100	14Jul 1500	14 Jul 2000	15 JUL 1130	15 JUL 1530	15 July 1750	16 JUL03 0615	17 July 2030
		for breakthrough pain	T	2230 4mg	2345 4mg	0300 4mg	4mg	4mg	4mg	4mg	6mg	[redacted]	[redacted]	[redacted]	2mg	10mg
			I	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]				[redacted]	[redacted]
13Jul	[redacted]	Tylenol 650mg PO	D	13Jul 1630	14JUL 0200	14Jul 1230	15 July 0130	15 July 610	19 JUL03 0615	19 JUL03 17	20 July 0315					
		q4-6° prn fever	T		101.5	101.0	101.?	101.5	101.8	102						
			I	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]					
10 JUL03	[redacted]	MSO4 1-5 mg IV		18 JUL03 1000	18 JUL03 1400	18 JUL03 1645	19 July 0615	19 Jul 1200	19 Jul 2030							
		q1° FOR PAIN		5mg	5mg	5mg	7mg	4mg	5mg							
				[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							

USAPA V1.00

MEDCOM - 13388

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. Jul Yr. 03

all b6-2

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	10	11	12	13	14	15	16	17	18	19	20	21	22
10 Jul	[redacted]	IVF: LR @ 50 cc/hr	05	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		
			17	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]			
10 Jul	[redacted]	Levaquin 500mg IV qD	10	[redacted]	— D/C'd 11 Jul 03											
10 Jul	[redacted]	Vancomycin 1g IV BID	10	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	D/c'd 16 Jul 03					
			22	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
10 Jul	[redacted]	Ketamine } for conscious	05	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		
		Fentanyl } sedation, tit-	17	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		
		Versed } rate to effect														
10 Jul	[redacted]	Fentanyl patch 50µg/hr to q3 days	05	[redacted]			[redacted]	[redacted]		[redacted]	[redacted]		[redacted]			☐
			~~17~~	[redacted]												
10 Jul	[redacted]	Lovenox 90mg SQ BID	10	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	HOLD		
			22	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	HOLD	HOLD		
10 Jul	[redacted]	Albuterol 2puffs q4°	04	/	[redacted]	[redacted]			[redacted]	[redacted]		[redacted]				
			08	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]			
			12	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]			
			16	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]			
			20	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]			
			24	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]			
11 Jul	ACC	Cipro 400mg IV BID	02	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	D/c'd 16 Jul 03					
			24	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
S/P Burn Debridement

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

PATIENT IDENTIFICATION:
[redacted] b6-4

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 - 13389

Verify by Initialing	THER... UTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*				*Mo.* ______ *Yr.* ______

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
20 Jul	[redacted]	Immodium one tab when awake then i tab with each Diarrheal stool as needed.	20 Jul	ASAP	1400	[redacted]
25 Jul 03	[redacted]	1 L NS bolus x i now	25 Jul 03		1550	[redacted]

D11 66-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED													
20 Jul	[redacted]	Immodium tab i with each diarrheal stool	20 Jul 1845	20 Jul 2400	23 July 03 [illegible]											
			[redacted]													
20 Jul	[redacted]	MSO4 2-10mg q 1° as needed	22 July 1500 5mg	21 Jul 0340 6mg	21 Jul 1140 3mg	21 Jul 2150 4mg	22 July 0110 4mg	23 July 03 @1900 5mg	03 23 July @2130 5mg	23 Jul @2334 5mg	25 Jul 1145 4mg	25 Jul 1600 2mg	> DC'd			
			[redacted]													
20 Jul	[redacted]	Continue previous sedation orders	23 Jul 03 0800 250 mcg Fentanyl IV	[redacted]	24 Jul 03 250 Fentanyl IV	1454 [redacted]	> DC'd									
23 Jul	[redacted]	Tylenol 650mg po q 4-6° prn fever	20 Jul 1515 100.8 [redacted]	23 July 03 1215 100.4	22 Aug 1250 ii	23 Aug 2000 2										
				[redacted]												
24 Jul 03	[redacted]	Ambien 5mg PO QHS PRN	24 July [redacted]	> Δ'd 25 July 03												
25 Jul 03	[redacted]	Ambien 10mg qHS PRN	25 July 2100 (+)	31 Aug 0050 i	1 Aug 0100 i											
				[redacted]												

USAPA V1.00

MEDCOM - 13390

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 — *INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION*

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED													
				20	21	22	23	24	25	26	27	28	29	30	31	Aug 1	2
20Jul	[redacted]	IVF: LR @ 100cc/hr	05	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	/
			17	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
20Jul	[redacted]	Albuterol ii puffs	06	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
		q 6°	12	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
			18	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
			24	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
20Jul	[redacted]	Lovenox 90mg SQ	10	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
		bid (start tonight)	22	[redacted]	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
20Jul	[redacted]	Continue previous	05	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
		sedation orders	17	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
10Jul	[redacted]	Ketamine ⎫ for conscious	05	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
		Fentanyl ⎬ sedation -	17	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
		Versed ⎭ titrate to effect	/														
10Jul	[redacted]	Fentanyl patch 50ug/hr	05	/	/	[redacted]	/	/	[redacted]	/	/	[redacted]	/	/	[redacted]	/	/
		q 3 day															

all b6-2

ALLERGIES: ☐ YES ☑ NO	PRIMARY DIAGNOSIS:	ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
0	S/P STSG	PAGE NO. ____

PATIENT IDENTIFICATION:

[redacted] b6-4

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 EXHA' D. USAPA V1.00

MEDCOM - 13391

THERA Ū. UMENTATION CARE PLAN
…DICATIONS)

Mo. Yr.

SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials

all 66-2

	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION													
		TIME/DATE DISPENSED													
28 July [redacted]	Percocet 1-2 tablet	0800 29July 03	0740 30July	0730 31July	1500 31Jul	1225 1Aug	2Aug 0050	2Aug 0113	03 Aug 0757	04 Aug 0715	4Aug 2200	06Aug 0745	07Aug 0644	8Aug 1345	9Aug03 0824
	p.o. q4° PRN	II po	II po	II po	II po	II po	II	II	II	II	II	II	II	II	II
		[redacted]													
	dressing Δ's and/or														
	pain														
1Aug03 [redacted]	MSO4 2-6mg D T	2Aug 03 0912	2 Aug 4mg	2 Aug 2mg	3Aug 2110	4Aug 2310	6Aug03 2145	7Aug 0113	9Aug 0045						
	IVP Q2° PRN Pain D I	6mg [redacted]	2115	2125	6mg	4mg [redacted]	6mg IV [redacted]	4mg IV [redacted]	6mg [redacted]						
1Aug03	Phenergan 12.5mg	2Aug03 1430													
	IVP Q6° PRN Nausea	12.5mg [redacted]													
04AUG03 [redacted]	Albuterol 2puffs	5Aug03 0830	7Aug 0826												
	Q6° prn wheeze	IIMG	II [redacted]												
09AUG03 [redacted]	Benadryl 25mg PO	9AUG03 0830													
	Q6° prn itch	I po [redacted]													

Rewritten

EPW [redacted] 66-4

MEDCOM - 13392

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

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 15	16	17	18	19	20	21	22	23	24	25	26	27	28
recopy 01Aug03	[redacted]	Paxil 20mg po QD	22	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]			
20Jul recopy	[redacted]	Lovenox 90mg SQBID	10	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]			
			22	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]				
10Jul	[redacted]	Fentanyl Patch 50mg/h	05	[redacted]		/	[redacted]	/	/	[redacted]	/	/	[redacted]	/	/		/
		Q3day															
04Aug	[redacted]	Colace 100mg PO	10	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]			
		BID	22	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]				
09Aug	[redacted]	Atarax 25 mg PO	08	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]				
		Q8°	16	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]				
			24	w		/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]				
22 Aug03	[redacted]	Please apply Silvadene	10	/	/	/	/	/	/	/	[redacted]	[redacted]	[redacted]				
		to Ⓛ heel wound BID	22	/	/	/	/	/	/	/	[redacted]	[redacted]	[redacted]				
23 Aug	[redacted]	Cipro 500mg po	10								/	[redacted]	[redacted]				
		BID x 3 days	22								/	[redacted]	[redacted]				
21 Aug	[redacted]	LR KVO	06	/	/	/	/	/	/	/	/	[redacted]	[redacted]				
			18	/	/	/	/	/	/	/	/	/	[redacted]				

all 66-2

ALLERGIES: ☐ YES ☐ NO NKDA	PRIMARY DIAGNOSIS: s/p STSG
ADDITIONAL PAGES IN USE: ☐ YES ☐ NO	PAGE NO. ____

PATIENT IDENTIFICATION:

EPW [redacted] 66-4

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 - 13393

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. 07 *Yr.* ____

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	1	2	3	4	5	6	7	8	9	10	11	12	13	14
1Aug03	[redacted]	Paxil 20mg PO QD	19	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
1Aug03	[redacted]	IVF LR @ 100cc/hr	0	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	
			15	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	09AUG03			
20Jul	[redacted]	Lovenox 90mg SQ Bid	10	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Recopy			22	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
10Jul	[redacted]	Fentanyl Patch															
		50mg/hr q 3day	06	/	/	[redacted]		/	[redacted]	/	/	[redacted]		/	[redacted]	/	/
~~14Aug~~	[redacted]	~~Albuterol~~				[redacted]			[redacted]			[redacted]					
01AUG03	[redacted]	Colace 100mg PO	06	/	/	/	[redacted]	[redacted]	[redacted]		Δ'd time						
		BID	18	/	/	1	[redacted]	[redacted]	[redacted]		ALZ						
~~4Aug03~~	[redacted]	~~Δ Albuterol (4 Aug03 0936~~															
04Aug03	[redacted]	Colace 100mg PO	10	/			/	/	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
		BID	22	/			/	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
08Aug03	[redacted]	Cipro 500mg PO	/														
		Bid X 3 days	10	/	/	/		/	/	/	[redacted]	[redacted]	/	/	/	/	/
			22	/	/	/	/	/	/	/	[redacted]	[redacted]	/	/	/	/	/
08Aug03	[redacted]	Atarax 25mg PO	08	/							/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
		Q 8°	16	/							/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	
			24	/							/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	

all 66-2

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS:

S/P STSG

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

PATIENT IDENTIFICATION:

EPW [redacted] 66-4

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 MEDCOM - 13394 UNTIL EXHAUSTED. USAPA V...

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 09 Yr 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	11	12	13	14	15	16	17	18	19	20	21	22	23	24
9 aug	[redacted]	FENTANYL PATCH 50mcg/	06	X	X	[redacted]	X	X	[redacted]	X	X	[redacted]	X	X	[redacted]	X	X
		hr to CW Q3days	X														
30 aug	[redacted]	FeSO4 325mg po TID	06	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
			12	O	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
			18	O	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
13 Sep	[redacted]	Motrin 800mg PO	08	—	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
		TID	16	—	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
			24	—	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

all 66-2

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS:
STS67

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

PATIENT IDENTIFICATION:
EPW# [redacted] 66-4

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 - 13395

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*	*Mo.* ______ *Yr.* ______

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													
rewrite 10Aug03	[redacted]	Percocet i - ii tabs	10Aug 03 0733	11Aug 03 1206	11Aug 2230	12Aug 0730	13Aug 0749	13Aug 2200 ii [redacted]	14Aug 1015 ii	14Aug 2139	15Aug 0633	16Aug 1200	16 Aug 1600	[illegible]	17Aug 0151 ii [illegible]	17Aug [illegible]
-----	-----	p.o. Q4° prn	ii [redacted]	ii	ii [illegible]	ii [redacted]	ii		[redacted]	ii [redacted]	ii	2 tabs	2 tabs	[redacted]	[redacted]	[redacted]
10Aug03	[redacted]	Percocet ii tabs	18Aug 03	18Aug 03	19Aug 1515	19Aug 2005	20Aug 03	21Aug 03								
-----	-----	PO Q4° PRN	ii 1001 [redacted]	ii 1345	2 tabs	2 tabs	ii 1340	ii 0740								
-----	-----															
-----	-----															
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Rewrite

a11 b6-2

USAPA V1.00

MEDCOM - 13396

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 — *INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION*

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED
				26 27 28 29
~~26 Aug~~	[redacted]	~~IV HL~~	~~06~~	[redacted] D/C'd [illegible]
		~~*LR@125cc/hr*~~	~~18~~	[redacted]
~~26 Aug~~	[redacted]	~~Ancef 1 gm IV~~	~~08~~	[redacted] X
		~~Q 8° x 24°~~	~~16~~	[redacted] X
			~~24~~	[redacted] X
26 Aug	[redacted]	Lovenox 80 mg	10	[redacted]
		SQ BID start	22	[redacted]
		tonight	X	
27	[redacted]	O2 2LNC PRN	6	X [redacted]
		to keep sats >95%	18	[redacted]
27	[redacted]	Give 10mg Vit K	13	X [redacted] S
		SubQ QD for	X	T
		3day.		P
28 Aug	[redacted]	Start LR @ 100cc/hr	06	→ [redacted]
			18	→

all 66-2

ALLERGIES: ☐ YES ☑ NO	PRIMARY DIAGNOSIS:	ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
NKA	s/p (B) skingraft to heels	PAGE NO. ______

PATIENT IDENTIFICATION:

[redacted] 66-4

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 - 13397

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLA… (…EDICATIONS) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 8/09 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 28	29	30	31	1	2	3	4	5	6	7	8	9	10
28Aug03	[redacted]	Start LR @ 100cc/	06-18	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
		(recopied)	18-06	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
27Aug03	[redacted]	Give 10mg Vit K															
		Subcutaneous QD x	13	X	[redacted]	X	X	X	X	X	X	X	X	X	X	X	X
		3days (recopied)															
26Aug	[redacted]	Lovenox 80mg SQ	10	X	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
		BID (recopied)	22	X	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
9 Aug 03	[redacted]	Atarax ~~10mg PO Q8~~	06	X	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
		25mg PO Q8	14	X	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
		(recopied)	22	X	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
9aug03	[redacted]	FENTANYL PATCH	06	X	[redacted]	X	X	[redacted]	X	X	[redacted]	X	X	[redacted]	X	X	[redacted]
		50mcg/hr to CW															
		Q3 days (recopied)															
30Aug03	[redacted]	FeSO4 325mg TID	06	/	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
		PO	12	/	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
			18	/	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

all b6-2

ALLERGIES: ☐ YES ☑ NO

NKDA

PRIMARY DIAGNOSIS: S/P skin graft to heels

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ______

PATIENT IDENTIFICATION: EPW # [redacted] b6-4

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 - 13398

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*	Mo. 09 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													
27Aug 03	[redacted]	Percocet i - ii	D/T	8Sep 1930	9Sep 0835	9Sep 1246	10Sep 0415	10Sep 2235	11Sep 0545	11Sep 2145	12Sep 2300	13Sep 0045	14Sep 0430	14Sep 2335	15Sep 1135	18Sep 1915	21Sep 0002
-----	-----	PO, PRN pain	D/I	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
-----	-----	Q 4-6 (rewritten)	E/I	Ⓔ											e	E	
28Aug	[redacted]	Phenergan 25mg IVPB 8° PRN nausea	D/T														
-----	-----		D/I														
27	[redacted]	O2 2LNC prn to keep Sats ≥95%	D/T/I														
27	[redacted]	MSO4 2-10mg IV Q1°	D/T														
-----	-----		D/I														
27	[redacted]	Benadryl 25mg IV/PO Q6° PRN ITCH	D/T														
-----	-----		D/I														
27	[redacted]	Albuterol # puffs Q6° PRN	D/T/I														
27Aug03	[redacted]	Percocet i - ii	D/T	15Sep 2145	17Sep 0800	17Sep 2215	18Sep 2310	21Sep 0710	22Sep 2326	23Sep 2355	28Sep 0030						
-----	-----	PO, PRN pain	D/I	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]						

all b6-2

USAPA V1.00

MEDCOM - 13399

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*	Mo. 08-09 Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
8/31	[redacted]	Please give patient 5mg MgSO4 IVP now	8/31		—	[redacted]

all 66-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED															
28Aug 03	[redacted]	PHENERgan 25mg IVPB Q8 PRN nausea	D/T/I	29AUG 0700	1Sep 2000	2Sep 0530	3Sep 2230	3SEP 1615										
					12.5mg	12.5mg	25mg	12.5mg										
					[redacted]													
27 Aug03	[redacted]	O2 2LNC PRN to keep sats >95%	D/T/I															
27 Aug03	[redacted]	Percocet i - ii PO PRN pain Q4-6	D/T/I	28 0030	29AUG 0645	1Sept 704	2Sep 0555	2Sep 1820	2Sep 2305	3Sep 2035	4Sep 0040	4Sep 2226	5Sep 2245	06SEP 0700	06SEP 1535	6Sep 2245	08Sept 0800	8 Sep 1340
				i	ii	ii	ii	ii	ii	ii	ii	ii	ii	ii	ii	ii	ii	ii
				[redacted]														
26 aug	[redacted]	MSO4 ~~2mg Q5min to max 10mg IV - keep RR ↑ 10 sat ↑95%~~ 2-10mg IV Q1°	D/T/I	29AUG 1000	30AUG 525	31AUG 1000	1Sep 2000											
				6mg	6mg	5mg	12.5											
				[redacted]														
9Aug	[redacted]	Benadryl 25mg IV/PO Q6 PRN itch	D/T/I															
6Aug	[redacted]	albuterol ii puffs Q6 PRN	D/T/I	10Sep 0915														
				[redacted]														

USAPA V1.00

MEDCOM - 13400

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*			*Mo.* ______ *Yr.* ______	
Order Date	**Clerk/ Nurse**	**SINGLE ORDER, PRE-OPERATIVES**	**Date to be Given**	**Time to be Given**	**Time Given**	**Initials**
26	[redacted]	LR bolus 1L x now	0045	27 aug		[redacted]
27	[redacted]	Transfuse 1u PRBC	27 Aug	1250	[redacted]	
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					

all 66.2

Order/ Expir Date	**Clerk/ Nurse**	**PRN MEDICATION, DOSE, FREQUENCY**	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* **TIME/DATE DISPENSED**													
26 Aug	[redacted]	MSO4 2-10 mg	26 Aug 1200	26 Aug 1438	26 Aug 1650	26 Aug 1535	26 Aug 1830	26 Aug 2200	26 2310	27 Aug 0220						
.....	.....	IV Q1°	5mg	5mg	5mg	5mg	5mg	10mg	10mg	4mg						
			[redacted]													
.....	.....	Keep RR ↑10 @														
.....	.....	SAT ↑ 95%														
27	[redacted]	Percocet i-ii po Q4-6° prn pain	D/C	[redacted]												
.....	.....		D/I	TI												
28 Aug	[redacted]	Phenergan 25mg IVPB Q8 prn nausea	D/C/I													
.....	.....															
.....	.....															
.....	.....															
.....	.....	1														
.....	.....															
.....	.....															

USAPA V1.00

MEDCOM - 13401

Verify by Initialing	THERA TIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*	*Mo.* 09 *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													
07AUG03	[redacted]	Percocet i-ii po prn pain q4-6	D/T	25SEP 2350	26SEP 2230	27SEP 0300	28SEP 2358	29SEP 0010	30SEP 0920	30SEP 2345	01OCT 0910	1OCT 0000	2Oct 2245	3Oct 2235	4Oct 2235	5Oct 2245	
-----	-----		D/I	2 [redacted]	ii [redacted]	ii [redacted]	ii [redacted]	2 [redacted]	ii [redacted]	2 [redacted]	ii [redacted]	ii [redacted]	ii [redacted]	ii [redacted]	ii [redacted]	ii [redacted]	
08AUG03	[redacted]	Phenergan 25mg IVPq 8° prn nausea	D/T														
-----	-----		D/I														
07AUG03	[redacted]	O2 2LNC prn to keep sat >95%	D/T/I														
07AUG03	[redacted]	MSO4 2-10mg IV q1°	D/T														
-----	-----		D/I														
07AUG03	[redacted]	Benadryl 25mg IV/PO q6° prn itch	D/T														
-----	-----		D/I														
07AUG03	[redacted]	Albuterol ii puffs q6° prn	D/T														
-----	-----		D/I														
06OCT03	[redacted]	Percocet i-ii po prn pain q4 6	D/T	~~06OCT 1750~~	ERROR	6OCT 2110											
-----	-----		D/I	~~ii~~ [redacted]		ii [redacted]											

all b6-2

USAPA V1.00

MEDCOM - 13402

ACLU-RDI 1592 p.1295

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.* 10 *Yr.* 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED													
				07	08	9	10	11	12	13	14	15	16	17	18	19	20
07 OCT 03	[redacted]	IV: LR@100cc/hr, HL	06	[redacted]													
	-----	when tol po	18	[redacted]													
07	[redacted]	Ancef 1gm q8°x48°	08	/	[redacted]												
	-----	(1st dose on return to ward)	16	[redacted]													
	-----		24	[redacted]													
10/12	[redacted]	Eucerin Cream	06 18					/	[redacted]								
	[redacted]	to wound (healed).	18 06					/	[redacted]								
	-----	have patient apply	/														
	-----	himself	/														

	-----																

all b6-2

ALLERGIES: ☐ YES ☒ NO	PRIMARY DIAGNOSIS:	ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
NKDA	S/P CLOSURE BUTTOCK WOUND	PAGE NO.

PATIENT IDENTIFICATION:

#[redacted] b6-4

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

MEDCOM - 13403

ACLU-RDI 1592 p.1296

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*	Mo. 10 Yr. 03

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

all b6-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* TIME/DATE DISPENSED														
07Oct03	[redacted]	ventolin 2puffs q6° prn	D/T														
			D/I														
07Oct03	[redacted]	MSO4 2-6mg IVP q3° prn pain	D/T	07oct 1750	9oct 0845	9oct 1330											
			D/I	6mg [redacted]	4mg [redacted]	4mg [redacted]											
07Oct03	[redacted]	Percocet 1-2 po q4° prn pain	D/T	7oct 2250	8oct 0250	8oct 1000	8oct 1745	8oct03 2215	9oct 0730	9oct 2030	10oct 0900	10oct 1745	11 oct 0800	11oct03 2130	12 oct 1030		15 oct 1000
			D/I	ii [redacted]	ii [redacted]	ii [redacted]	ii [redacted]	ii [redacted]	ii [redacted]	2 [redacted]	ii [redacted]	ii [redacted]	ii [redacted]	ii pp [redacted]	i [redacted]	[redacted]	ii [redacted]
Exp 10/12 10/15	[redacted]	May have T#3	Date Time	12 oct 1000	12oct03 2115		13oct03 2330		14 oct 0730	14 oct 2230							
		1-2 tabs po	Dose	ii [redacted]	ii [redacted]	[redacted]	ii [redacted]	[redacted]	ii [redacted]	ii [redacted]							
		q 4° per pain	I/E														
		if pain more															
		mild															
12Oct03	RD	Loperamide i after each stool, max 4/day	D/T/I		12Oct03 2115 [redacted] i												

CLINICAL RECORD | **Th. .PEUTIC DOCUMENTATION CARE PL. .EDICATIONS)** | Mo. 09 Yr. 03

For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED													
				25	26	27	28	29	30	OCT 01	2	3	4	5	6	7	8
09 AUG03	[redacted]	Fentanyl patch 50mcg/	06	[redacted]	/	/	[redacted]	/	/	[redacted]	/	/	[redacted]	/	/	[redacted]	
		hr to CW q 3days															
30 AUG03	[redacted]	FeSO4 325mg po TID	06	☐	○	[redacted]											
			12	[redacted]													
			18	[redacted]													
13 SEP03	[redacted]	motrin 800mg po	08	[redacted]													
		TID	16	[redacted]													
			24	[redacted]													
07 OCT03	[redacted]	IVF: LR@100cc/hr	06	/	/	/	/	/	/	/	/	/	/	/	/	KAS	
		(start IV)	18	/	/	/	/	/	/	/	/	/	/	/	/		
		PRN meds															
27 AUG03	[redacted]	Percocet i-ii po q4°	D/T	01OCT 1105													
		prn pain	D/I	[redacted]													
		PRN meds (cont)															
5OCT	[redacted]	Ventolin inh 2puffs	D/T/I														
		Q6° prn															

all b6-2

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS:

STSG

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ______

PATIENT IDENTIFICATION:

#[redacted] b6-4

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 - 13405

PAGE

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	1230 INITIALS [redacted]	INITIALS	INITIALS
NEURO	PUPILS	PERRLA	b6-2	Drowsy but responsive
	SENSORIUM	Alert, Follows		to verbal stimuli. Appears
		Commands.		to understand English
		Understands some		
		English.		
RESPIRATORY	RESPIRATORY PATTERN	Regular & Unlabored		Regular unlabored
	BREATH SOUNDS	Exp Wheez (B) Upper Lobes		↓BS throughout c̄ mild
	SECRETIONS	c̄ diminished Middle		exp wheezing. history of asthma
		& Lower lobes		sat 90% on face mask, receiv
		Pt Denies any		MSO4 20mg c̄ Versed 5mg earlier
		difficulty Breathing		today.
SKIN	COLOR	Normal for Race		NL for race
	INTEGRITY	~10% TBSA Burn		10% BSA. both arms bil
		Debridement in progress		feet dressing intact
	LOCATION	IV in (R)+(L) FA		IV (R)+(L) FA started
	CONDITION	Dressing Changed,		7/3/03 on admission
		∅ s/s of infection		(L) arm LR 150cc/hr.
		noted		
	ABDOMEN	Soft, Nontender		soft non-tender
	BOWEL SOUNDS	Normal		(+)BS all quadrants
		∅ N/V, ∅ BM		
	URINE:	Foley to gravity		Foley to gravity
	COLOR/CLARITY	Clear, Yellow		clear yellow urine
	CARDIAC RHYTHM	ST, ∅ ectopy		ST 110, ∅ ectopy
		Pulses weak but		radial pulses (B) palpable
		palpable. Cap refill		(R) pedal pulse faint palpable
		<3secs Edema noted		(L) pedal pulse palpable c̄
		in BUE & BLE		doppler edema (L) [redacted]

LEGEND

Cr - Creatinine	ICP - Intracranial Pressure	S/A - Fractional
F_IO_2 - Fraction of Inspired O_2	PCO_2 - Pressure of Arterial CO_2	SAT - Saturation
HCO_3 - Bicarbonate	PEEP - Positive End Expiratory Pressure	TRACH - Tracheostomy

b6-2

b6-2

(Continue on reverse)

PREPARED BY *(Signature & Title)* [redacted] 47/AN

DEPARTMENT/SERVICE/CLINIC ICU 2 west

DATE 3 Jul 03

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

EPW [redacted] b6-4

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

MEDCOM - 13406

	DX													HOSPITAL DAY				
TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
Arterial Line								130/79		13?/83	131/81		105/72	118/77	116/76	115/79		
Cuff																		
mperature										99.5		99.3		98.9			99.3	
lse								103		106	118	134	121	121	92	92	100	
spiratory Rate								26		26	27	26	13	14	20	26	22	
SaO2								97%		96	91	91	93	91	90	92	90	
O2								2L		2L	4L	6L	50%	50%	50%	50%	50%	
O2 Mode								NC		NC	NC	NC	VM	VM	VM	VM	VM	
MAP								96		98	98		86	93	92	92	90	
[illegible]																		
Transition																		
TIME									8°T									
LR								150	150	150	150	150	150	150	150	150	150	1200
IVPB																		
NS													500	500	500		1500	
PO														240			150	
TALS									150									
INE HOUR / TOTAL	/	/	/	/	/	/	/	/		/	350 /	25 /	10 /	30 /	/	300 /	50 /	665
INE SP. GR.																		
INE S/A																		
IG OUTPUT																		
IG pH																		
IG GUIAC																		
ESIS																		
OL																		

350
25
40

615
770
1385

1200
1500
390
1550
4640

	21	22	23	24	01	02	03	~~04~~
BP	122/90	130/73	120/73	124/74	113/94	124/74		
T	98.7							
P	163	100	96	103		104	97	
R	11	16	16	16	14	13		
O2 Sat	99	100	100	100	94	92	97	
O2	50%	2L	2L	RA	RA	RA	RA	
mode	FM	NC	←					
MAP	89	90	89	89	88	88	90	
								8° T
LR	~~250~~	200	200	200	200	200	200	200
								1550
	35	60	50	20	20	200	200	200
								770

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA

	TIME								
	MODE								
	F_iO_2								
	TV								
	RATE								
	PEEP								
A	pH								
A	PCO_2								
A	pO_2								
B	HCO_3								
B	SAT								
G	BASE								

LABORATORY DATA

TIME							
GLUCOSE							
Na/K							
Cl/CO2							
BUN/Cr							
WBC/PLATELET							
Hct/Hgb							

ACTIVITIES OF DAILY LIVING

TIME					TIME			
MOUTH CARE				TURN				
BATH				TURN				
SKIN CARE				TURN				
FOLEY CARE				SUCTION				
TRACH CARE				SUCTION				
ROM EXERCISES				SUCTION				
				SUCTION				

24° I&O TOTALS

wt Yesterday ________ wt Today ________

INTAKE

IV 4640

PO

OUTPUT

Urine: ~~1385~~ 1475

200

1675

~~1585~~

Balance: +2965

NURSE'S SIGNATURE

[redacted]

66-2

MEDCOM - 13408

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA
For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
DA Appr 8 Mar 89

INIT[redacted]HIFT ASSESSMENT

	TIME	0600 INITIALS [redacted]	b6-2 INITIALS	1700 INITIALS [redacted]
NEURO	PUPILS	A x O x3		A + O x 3
	SENSORIUM	expresses needs appro-		PERRLA
		priately		Verbalizes needs
		cooperates ō care		Interactive ē staff
		interacts ō staff		
RESPIRATORY	RESPIRATORY PATTERN			Unlabored, even
	BREATH SOUNDS	regular unlabored		decreased BS throughout
	SECRETIONS	CTA bil		CTA ē mild wheezing
		Ri 90's on RA		upper lobe. On
				RA, sat 94%.
SKIN	COLOR	normal to race		Normal to race
	INTEGRITY	1°, 2° & 3° burns		10% BSA on back
				hands & feet
IV SITE	LOCATION			
	CONDITION	Ⓛ + Ⓡ AC PIV		Ⓛ + Ⓡ AC PIV
GASTRO	ABDOMEN	round, soft NT ND		Soft non-tender
	BOWEL SOUNDS	BS x 4 quads		BBS x 4 quadrant
		Ø BM		Ø BM
GU	URINE:	good response to		Urine borderline
	COLOR/CLARITY	Lasix,		output 40 cc /hr
		light yellow, clear		clear yellow
CARDIOVASCULAR	CARDIAC RHYTHM	S_1, S_2		ST 110s $S_1 S_2$
		RRR Ø ectopy,		edema hands + feet
		ST		Ⓛ > Ⓡ

LEGEND
Cr - Creatinine
F_iO_2 - Fraction of Inspired O_2
HCO_3 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
S/A - Fractional
SAT - Saturation
TRACH - Tracheostomy

(Continue on reverse)

PREPARED [redacted] b6-2

DEPARTMENT/SERVICE/CLINIC: ICU 3

DATE: 4 July 03

PATIENT'S IDENT[redacted]d or written entries give: Name—last, first, middle; grade[redacted]or medical facility)

EPW [redacted] — b6-4

[redacted] [redacted] [redacted]

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

DA FORM 1 MAY 78 4700
Proponent: Dept of Nurs

WAMC OP 375 (Redesignated)
1 Apr 90 (HSXC-NU)

MEDCOM - 13409

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
BP Arterial Line	115	118	117	119		104		98		97	91	91	99	95	97	105	110	
BP Cuff	68	60	71	79		81		60		59	58	58	59	55	55	62	59	
Temperature	98.9							100.4							100.6			
Pulse	102	104	110	120	119	120	131	128		134	131	129	129	128	118	116	122	
Respiratory Rate	13	14	15	15	15	15	15	18		19	21	18	18	21	21	22	26	
	100	97	98	97	97	96	97	98		98	100	100	100	100	93	94	90	
	RA	RA	RA	RA	RA	RA	RA	RA		RA	RA	RA	RA	RA	RA	RA	RA	
pain																		
intervention																		

INTAKE

TIME	05	06	07	08	09	10	11	12	8° T	13	14	15	16	17	18	19	20	8° T
LR	200	250	200	200	150	[illegible]	150	200		200	200	200	200	200	200	200	200	
PO				120				120					[illegible]		150		150	300
TOTALS																		

OUTPUT

URINE	HOUR / TOTAL	200	170	210	100	65	50	50	50	895	50	40	40	40	40	35 / 35	30 / 65	30 / 95	95
	sp gr																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS																			

Dobhoff out 1105
in 1840
1735

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS

21	22	23	00	01	02	03	04	
NS	NS		104/60	102/58	101/51	104/44	93/52	
			101	102	97	102	103	
			18	16	17	20	16	
			94	92	90	92	93	
			RA	RA	RA	RA	15	
							98.6	

INTAKE

21	22	23	00	01	02	03	04	8° T
200	200	200	200	200	200	200	200	2200
	150		NPO	p̄	MN			450

OUTPUT

21	22	23	00	01	02	03	04	
							70	785
35/35	40/75	40/115	40/155	200/355	260/615	100/715	~~1100~~/~~1815~~	~~1815~~

stool ī large rept

RESPIRATORY DATA

	TIME									
	MODE									
	F_iO_2									
	TV									
	RATE									
	PEEP									
A	pH									
A	PCO_2									
B	pO_2									
B	HCO_3									
G	SAT									
G	BASE									

LABORATORY DATA

TIME									
GLUCOSE									
Na/K									
Cl/CO_2									
BUN/Cr									
WBC/PLATELET									
Hct/Hgb									

ACTIVITIES OF DAILY LIVING

TIME			
MOUTH CARE			
BATH			
SKIN CARE			
FOLEY CARE			
TRACH CARE			
ROM EXERCISES			

TURN

SUCTION

TIME

24° I&O TOTALS

wt Yesterday ______

wt Today ______

INTAKE

IV/PO 2650

OUTPUT

Urine: ~~1815~~ 785

TOTAL ______

TOTAL ______

BALANCE ~~1035~~ +1865

SIGNATURE	INITIALS
[redacted]	[redacted]
66-2	

MEDCOM - 13411

PAGE 1 OF 4

MEDICAL RECORD–SUPPLEMENTAL MEDICAL DATA
For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA Appr 8 Mar 89 b6-2

INITIAL SHIFT ASSESSMENT

	TIME	0600 INITIAL [redacted] b6-2	INITIALS	1800 IN [redacted]
NEURO	PUPILS	A&O x 3		
	SENSORIUM	interacts appropriately		A:O x 3 PERLA 3mm
				Able to follow simple
				commands. Moves
				extremities.
RESPIRATORY	RESPIRATORY PATTERN	unlabored		
	BREATH SOUNDS	CTA bilaterally		RRR
	SECRETIONS	Hi-90s on RA		Ⓑ Clear
				∅ secretions
				$SaO_2 > 94\%$ RA
SKIN	COLOR	normal for race		
	INTEGRITY	1° 2° 3° burns		Normal for Race
				10% BSA Burns
IV SITE	LOCATION			
	CONDITION	Ⓡ & Ⓛ PIV		Ⓡ FA 20g PIV
				LR@ 200cc/h
GASTRO	ABDOMEN	round, soft, NT		
	BOWEL SOUNDS	hyp BS x 4 quad		soft, round, nontender
				BS⊕
GU	URINE:	marginally adequate		
	COLOR/CLARITY	clear yellow		Foley to gravity
				clear yellow urine
CARDIOVASCULAR	CARDIAC RHYTHM	S1 S2, RRR		
		ST ∅ ectopy		SR, S1/S2
		Generalized edema		Pulses +2 x 4 extremities
		+2 pulses x 4 ext		Cap refill <3 sec x 4 extremiti
				Generalized edema, +3
				pitting to extremities

LEGEND
Cr - Creatinine
F_iO_2 - Fraction of inspired O_2
HCO_3 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
SA - Fractional
SAT - Saturation
TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY *(Signature & Title)*

DEPARTMENT/SERVICE/CLINIC
ICU 3

DATE
05JUL03

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

[redacted] b6-4

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

DA FORM 1 MAY 78 4700
Proponent: Dept of Nurs

MEDCOM - 13412

WAMC OP 375 (Redesignated)
1 Apr 90 (HSXC-NU)

[redacted] 106-4

DATE 05JUL03	DX												HOSPITAL DAY					
VITAL SIGNS TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
BP Arterial Line	107	98	112			101	82	91		88	93	95	84	94	75/52			
BP Cuff	51	51	53			48	45	49		47	51	53	53	53		94/50	106/52	
Temperature	99.9							100.4								98.8		
Pulse	106	105	109	110	108	111	111	119	~~119~~	119	122	121	115	114	111	103	103	
Respiratory Rate	16	12	20	20	20	23	23	20		21	24	20	18	25	27	22	16	
	93%	93	96	95	96	95	92	95		95	93	94	93	93	90	92	94	
	RA	RA	RA	RA	RA	RA	RA	RA		RA	RA	RA	RA	RA	RA	RA	RA	
[illegible]																		
intermittent																		
INTAKE TIME	05	06	07	08	09	10	11	12	8° T	13	14	15	16	17	18	19	20	8° T
LR	200	200	200	200	200	200	200	200	1600	200	200	200	200	200	200	200	200	1600
PO						120			120	120			360					480
TOTALS	200/200	200/400	200/600	200/800	200/1000	320/1320	200/1520	200/1720	1720	320/320	200/520	200/720	560/1280	200/1480	200/1680	200/1880	200/2080	2080
OUTPUT URINE HOUR / TOTAL	40/40	60/100	60/160	60/220	50/270	40/310	40/350	50/400	400	60/60	60/120	40/160	40/200	50/250	60/310	60/370	60/430	430
URINE sp gr																		
URINE S/A																		
NG OUTPUT																		
NG pH																		
NG GUIAC																		
EMESIS																		
STOOL																		
DRAINS																		
TOTALS									400									430

830

Dress Δ MSO4
20mg
10mg Versed

POST-OP DAY

VITAL SIGNS	21	22	23	00	01	02	03	04	
SP	103/52	98/54	120/69	110/59	115/60	97/56	102/59	108/55	
T				979					
)	89	96	100	96	92	91	92	91	
R	16	14	22	13	12	14	20	11	
202	95	87	97	94	96	96	96	98	
ure	RA	RA	RA	RA	RA	RA	RA	RA	

INTAKE	21	22	23	00	01	02	03	04	8°T
	200	200	200	200	200	200	200	200	1600
	200/200	200/400	200/600	200/800	200/1000	200/1200	200/1400	200/1600	1600

OUTPUT	80/80	80/160	70/230	80/310	90/400	100/500	85/585	70/655	655
									635

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA										
TIME										
MODE										
F_iO_2										
TV										
RATE										
PEEP										
ABG	pH									
	PCO_2									
	pO_2									
	HCO_3									
	SAT									
	BASE									

LABORATORY DATA									
TIME									
GLUCOSE									
Na/K									
Cl/CO2									
BUN/Cr									
WBC/PLATELET									
Hct/Hgb									

ACTIVITIES OF DAILY LIVING			
TIME	2200		
MOUTH CARE			
BATH			
SKIN CARE	[redacted]		
FOLEY CARE			
TRACH CARE			b6
ROM EXERCISES	[redacted]		

TURN SUCTION	TIME				
	self				

24° I&O TOTALS

wt Yesterday ______ wt Today ______

	INTAKE		OUTPUT
IV	1720	Urine:	830
po	2080		655
	1600		
TOTAL	5400	TOTAL	1485

BALANCE ______

NURSE'S SIGNATURE	INITIALS
[redacted] LT/AN b6-2	[redacted]

MEDCOM - 13414 5

PAGE

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA
For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0520 INITIAL [redacted]	66-2 INITIALS	1800 INITIALS
NEURO	PUPILS			Alert, verbalizes
	SENSORIUM	Alert able to follow		needs, PERRLA
		simple commands and		
		express needs, speaks		
		some english.		
RESPIRATORY	RESPIRATORY PATTERN	RRR, equal chest rise		BBS, CTA ē intermittent
	BREATH SOUNDS	clear throughout		mild wheezing, on NAD
	SECRETIONS	∅ noted @ this time		sat >95%
SKIN	COLOR	WNL for race		WNL for race
	INTEGRITY	40-50% BSA burn		40-50% BSA, post
				debridement
IV SITE	LOCATION	Ⓡ FA ē ∅ S/s of infection		Ⓡ SC triple lumen
	CONDITION	LR infusing @ 200cc/h		intact LR @ 100cc/hr
GASTRO	ABDOMEN	soft, nondistended		soft non tender
	BOWEL SOUNDS	(+) throughout hyperactive		BS x 4 quadrants
		(pt NPO p̄ MN 5 Jul 03)		tolerating po, appetite
				poor
GU	URINE:	Foley to gravity drainage		Foley to gravity
	COLOR/CLARITY	clear yellow urine ē ∅		drainage clear yellow
		sediment		urine
CARDIOVASCULAR	CARDIAC RHYTHM	SR HR 90s ē ∅ ectopy,		ST 100's palpable
		pulses palpable		pulses radial (+)
		throughout, +3-+4 pitting		pedal pulses (+)
		edema throughout		edema LE + UE.

LEGEND
Cr - Creatinine
F_iO_2 - Fraction of inspired O_2
HCO_3 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
S/A - Fractional
SAT - Saturation
TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC
ICU 2 west

DATE
06JUL03

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

[redacted] 66-4

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

MEDCOM - 13415

EBL 100cc

PAG

06 JUL	DX DVT, 10% BSA BURNS												HOSPITAL DAY				
TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20
Arterial Line																	
Cuff	105/62	93/54	104/61	114/62	106/57					136/76	126/69	120/60		124/65		104/51	117/56
mperature	98^{7}	99^{1}	99^{4}	99^{1}	99^{1}					97^{2}	98^{3}	98^{7}	-	99^{6}	100		
lse	92	88	91	94	97					106	103	111	105	111	103	104	106
spiratory Rate	9	16	11	13	13		OR			20	12	9	13	20	8	12	14
SAO2	95	96	100	94	96					91	91	94	95	96	96	95	97
Source	RA	RA	RA	RA	RA	in				5L NC	RA	RA	RA	RA	RA	RA	RA

TIME	05	06	07	08	09	10	11	12	8°T	13	14	15	16	17	18	19	20	
LR	200	200	200	200	200				1000	100	100	100	100	100	100	100	100	800
PO											300					240		240
OR(NS)						200		cc	200				300					300
																		1340
																		1190
																		2530

TALS

INE	HOUR / TOTAL	50/50	60/110	65/175	160/335	100/435	200cc	OR	in	635	140/775	110/885	70/955	75/1030	100	100/1130	60/1190	90/1280	1280
	sp gr																		440
	S/A																		1720
IG	OUTPUT																		
	pH																		
	GUIAC																		
ESIS																			
IOL																			

O[redacted] 66-4

21	22	23	00	01	02	03	04	
112/56	120/57	124/57		120/54	[illegible]		113/6	
		98.8					100.2	
100	101	102	101	104	111	106	105	
13	13	16	14	16	14	14	17	
97	97	98	96	97	96	96	95	
RA	RA	RA	RA	RA	RA	RA	RA	

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA								
TIME								
MODE								
F_iO_2								
TV								
RATE								
PEEP								
ABG pH								
ABG PCO_2								
ABG pO_2								
ABG HCO_3								
ABG SAT								
ABG BASE								

21	22	23	00	01	02	03	04	8° T
100	100	100	100	100	100	100	100	800
PO		240			150			390
								1190

LABORATORY DATA								
TIME								
GLUCOSE								
Na/K								
Cl/CO_2								
BUN/Cr								
WBC/PLATELET								
Hct/Hgb								

50	60/100	50/150	50/200	50/250	60/310	70/380	60/440	440

loose
ī large
BM

ACTIVITIES OF DAILY LIVING					TURN / SUCTION	TIME			
TIME									
MOUTH CARE									
BATH									
SKIN CARE									
FOLEY CARE									
TRACH CARE									
ROM EXERCISES									

24° I&O TOTALS

wt Yesterday ______ wt Today ______

INTAKE
IV 2530
PO
- 1720
(+810) balance

OUTPUT
Urine: 1720

NURSE'S SIGNATURE
[redacted] [illegible]
b6-2

O [redacted] b6-4

MEDCOM - 13417

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA
For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
DA Appr 8 Mar 89 b6-2

INITIAL SHIFT ASSESSMENT

	TIME	0530.	INITIALS [redacted]	b6-2	INITIALS	2330	INITIALS [redacted]
NEURO	PUPILS	Pt is ↗responsive to				pt appropriately responsive	
	SENSORIUM	verbal and voice stimuli.				able to move all extremities	
		Pt able to follow simple				PERL bilat	
		commands. Pt c/o pain					
		c̄ mvmt.					
RESPIRATORY	RESPIRATORY PATTERN	Clear breath sounds				clear breath sound in all	
	BREATH SOUNDS	bilat. Diminished @ bases.				lung fields ∅ cough	
	SECRETIONS	SpO2 97-98% on RA. RR				reg unlabored breathing	
		12/min. Pt has snoring					
		resps while sleeping					
SKIN	COLOR	~10% BSA Burns to abd.				≈10% BSA Burns to abd	
	INTEGRITY	Bleg (B) arms. Drsg moist				Bilat leg + arms dressing	
		but intact.				to burn areas intact	
IV SITE	LOCATION	(R) IJ TLCVC. LR @				Central line R ~~[illegible]~~	
	CONDITION	100cc/hr infusing via				internal jugular 3 lumen	
		white port. Drsg D+I				catheter	
		s̄ redness or drng noted.					
GASTRO	ABDOMEN	Hypo BS. Dobhoff to				hypoactive bowel sounds	
	BOWEL SOUNDS	(R) nare in stomach as				feeding tube in (R) nare	
		per KUB this AM. Jevity					
		@100cc/hr. last BM 07Jul03					
GU	URINE:	Foley to gravity drng.				foley to gravity drain	
	COLOR/CLARITY	Clear yellow urine.				clear yellow urine in adequate	
						amounts	
CARDIOVASCULAR	CARDIAC RHYTHM	Rate 100's. ASF sinus				S1S2 [illegible] rhythm ⇒ sinus	
		tach. S1-S2. (+)2 (B)				tachycardia edema to lower	
		radial pulses and				extremities + radial pulses	
		(+)2 (B) pedal pulses. (+)4				palpable x 4 extremities	
		pitting edema to (B) feet and scrotal edema.					

LEGEND

Cr - Creatinine	ICP - Intracranial Pressure	S/A - Fractional
F_IO_2 - Fraction of Inspired O_2	PCO_2 - Pressure of Arterial CO_2	SAT - Saturation
HCO_3 - Bicarbonate	PEEP - Positive End Expiratory Pressure	TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title) [redacted] b6-2

DEPARTMENT/SERVICE/CLINIC ICU 3

DATE 09Jul03.

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

[redacted] b6-4
[redacted]

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

DA FORM 1 MAY 78 4700
Proponent: Dept of Nurs

WAMC OP 375 (Redesignated)
1 Apr 90 (HSXC-NU)

MEDCOM - 13418

PAGE 2 OF 4

DATE	DX													HOSPITAL DAY				

VITAL SIGNS

TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
BP Arterial Line																		
BP Cuff		113/65	115/68	121/65	116/64		127/68	101/56		126/66	120/88	117/63	117/65		120/59	133/61	117/67	
Temperature axil		99.9			101.2			101.3		101.4	100.4							
Pulse		107	106	108	110		120	128		129	136	123	115		99	104	105	
Respiratory Rate		15	11	9	10		16	21		13	13	21	22		18	16	30	
SpO2		99%	96%	95%	95%		93%	90%		97%	95%	97%	95%		91	91	97	
Mode		RA	RA	RA	RA		RA	RA		RA	RA	RA	RA		RA	RA	RA	
[illegible]																		
[illegible]																		

INTAKE

TIME	05	06	07	08	09	10	11	12	8° T	13	14	15	16	17	18	19	20	8° T
LR	100	100	100	100	100	100	20	20		20	20	20	20	20	20	20	20	
IVPB						100		250						1140				
TF							125	125		125	125	125	125	125	80	80	80	
TF flush														875 240				
										200				1115				
PO							100			140		60	150		100		100	
										350			450					
TOTALS																		

OUTPUT

URINE	HOUR / TOTAL	/	70/70	60/130	60/190	70/260	30/290	30/320	360/680		240/920	80/1000	30/1030	[illegible]/1058 1068	/	/	/	200/1268	
	sp gr																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS																			

MEDCOM - 13419

PAGE 3 OF 4

POST-OP DAY

VITAL SIGNS									
	21	22	23	00	01	02	03	04	
	122/58	114/62	119/61	121/61	114/53	116/57	120/56	116/60	
							100.5		
	107	108	105	111	105	105	106	106	
	20	19	16	22	12	17	17	12	
	100	97	97	96	94	97	95	97	
	RA	RA	RA	RA	RA	RA	RA	RA	

INTAKE	21	22	23	00	01	02	03	04	8° T
LR	20	20	20	20	100	100	100	100	1280
IVPB				250					600
									1115
TF									
[illegible]									650
PO									
									3645

OUTPUT									
			200/1465					550/2018	

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA	TIME								
	MODE								
	F$_i$O$_2$								
	TV								
	RATE								
	PEEP								
ABG	pH								
	PCO$_2$								
	pO$_2$								
	HCO$_3$								
	SAT								
	BASE								

LABORATORY DATA	TIME								
	GLUCOSE								
	Na/K								
	Cl/CO$_2$								
	BUN/Cr								
	WBC/PLATELET								
	Hct/Hgb								

ACTIVITIES OF DAILY LIVING	TIME				TURN / SUCTION	TIME			
	MOUTH CARE								
	BATH								
	SKIN CARE								
	FOLEY CARE								
	TRACH CARE								
	ROM EXERCISES								

24° I&O TOTALS

wt Yesterday ______ wt Today ______

INTAKE
IV 3645
po ______
TOTAL 3645

OUTPUT
Urine: 2018
______
TOTAL 2018

BALANCE______

NURSE'S SIGNATURE | INITIALS

[redacted]

h6-2

MEDCOM - 13420

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

TIME	0600	INITIAL [redacted]	b6-2	INITIALS		INITIALS
PUPILS	PERRLA				PERRLA	
SENSORIUM	~~pt~~ lethargic but				Arousing easily	
	Oriented X3				aroused.	
RESPIRATORY PATTERN	CTA bil diminished				BBS, CTA ē diminished	
BREATH SOUNDS	on bases				air exchange (equal	
SECRETIONS	regular unlabored				throughout ē bases)	
	IS X 10 q1° when				I+S	
	awake (2-3 balls)					
COLOR	dressing to burn				NL, 30% burn to	
INTEGRITY	areas				arms, hands, legs, abd	
					+ buttocks, back.	
LOCATION	Ⓛ IJ 3L				Ⓡ SC, IVF LR @ 50	
CONDITION	Ø S/S of infexn				flushed 2 lumens	
					patent.	
ABDOMEN	Ø BS				Hypoactive BS	
BOWEL SOUNDS					TF, c/o bloating	
					ō BM	
URINE. COLOR/CLARITY	clear yellow					
CARDIAC RHYTHM	S1 S2 ST Ø ectopy				ST 110-113, ē ectopy	
	generalized edema				edema arms + LE	
	4+				Ⓡ side > Ⓛ side	
					radial/pedal pulses	
					palpable.	

LEGEND
Cr - Creatinine
F_iO_2 - Fraction of Inspired O_2
HCO_3 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
S/A - Fractional
SAT - Saturation
TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY *(Signature & Title)*

DEPARTMENT/SERVICE/CLINIC: ICU 2 west

DATE: 10 July 03

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

~~424~~ [redacted] b6-4

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

PAG

DX 0830

HOSPITAL DAY

TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20
Arterial Line	120	OR	OR	129		122	121	123		119	118	115		124	114	101	
Cuff	72			72		70	74	70		70	70	60		71	65		
mperature				96	98,3			100,9									
lse	113			121	123	118	113	112	11	112	118	119	115	117	[illegible]	115	
spiratory Rate	16			14	16	16	16	15		20	14	15	16	16	13	22	
O2 Sats	94			98	98	98	97	97		97	94	95	95	95	96	94	
O2 Source	RA			RA	NRB	RA	RA	RA		RA	RA	RA	RA	RA	RA	RA	

TIME	05	06	[illegible]	08	09	10	11	12	8°T	13	14	15	16	17	18	19	20	
LR	100	~~100~~	~~100~~	50	50	50	50	50	1450	50	50	50	50	50	50	50	50	400
IVPB						350												
TF		OR						50		50	50	50	50	Ø	Ø	Ø		250
PRBC		[illegible]		350		350												700
																		1350

TALS																			
INE	HOUR / TOTAL	40	OR	OR	500	150	100	70	70	930	70	70	70	30	200	260	200	120	1020
	sp gr																		
	S/A																		
IG	OUTPUT																		
	pH																		
	GUIAC																		
ESIS																			
OL																			

MEDCOM - 13422

ACLU-RDI 1592 p.1315

	21	22	23	24	01	02	03	~~04~~
BP	109/64	115/62	119/62	112/62		112/54		
T		99.0		99.2		99.7		
P	110	110	112	112		114		114
R	27	12	8	16		15		19
O2 sat	92	99	100	94		98		95
Mode	RA	RA	FM	RA		RA		RA
		sedation	sedation					
~~foley~~	~~60~~	50						
~~Output~~								300
LR		50	50	50	50	50	50	8° T 400
TF		0	50	50	50	50	0	0
IVPB		250						
	60/	50/	/	80/	/	80/	50/	40/
								360

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA	TIME							
	MODE							
	F_iO_2							
	TV							
	RATE							
	PEEP							
ABG	pH							
	PCO_2							
	pO_2							
	HCO_3							
	SAT							
	BASE							

LABORATORY DATA	TIME							
	GLUCOSE							
	Na/K							
	Cl/CO₂							
	BUN/Cr							
	WBC/PLATELET							
	Hct/Hgb							

ACTIVITIES OF DAILY LIVING	TIME		2200	
	MOUTH CARE			
	BATH			
	SKIN CARE		✓	
	FOLEY CARE		✓	
	TRACH CARE		✓	
	ROM EXERCISES		✓	

	TIME			
TURN				
SUCTION				

24° I&O TOTALS

wt Yesterday ______ wt Today ______

INTAKE

IV/PO 2050

OUTPUT

Urine: 1380

Bal: +670
+500 blood OR

NURSE'S SIGNATURE

[redacted] [redacted]

b6-2

MEDCOM - 13423
1:1 ('' '0)

PAGE

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)* QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0510	INITIALS [redacted]	b6-2	INITIALS	1800-0500	INITIALS
NEURO	PUPILS	PERRLA 2mm				PERRLA, drowsy	
	SENSORIUM	Alert and able to				most of the time	
		follow simple commands				but arousable.	
		and express needs				Verbalizes needs,	
						cooperative	
RESPIRATORY	RESPIRATORY PATTERN	RRR				RRR, BBS,	
	BREATH SOUNDS	clear, diminished bilat				diminished throughout	
	SECRETIONS	↓ bases.				RA, sat 96-100%	
		Ø secretions noted @					
		this time.					
SKIN	COLOR	WNL for race.				WNL, burn up	
	INTEGRITY	burn wound debridement				to 35% post	
		throughout body surface.				debridement x 2 days, [illegible]	
IV SITE	LOCATION	(R) IJ 3-lumen c̄ Ø s/s				(R) SC, triple lumen	
	CONDITION	of infection infusing				clean D+I, LR @ 50cc/hr	
		LR @ 50cc/hr				antibiotic as ordered	
GASTRO	ABDOMEN					BBS, hypoactive.	
	BOWEL SOUNDS	dophoff (R) nare clamped				Had BM c̄ moderate amt.	
		@ this time BS(+) x 4				soft stool	
		quad hypoactive					
GU	URINE:	Foley to gravity draining				Foley draining clear, tea	
	COLOR/CLARITY	dark yellow urine.				yellow urine, varies	
						q hour but > 35cc/hr	
CARDIOVASCULAR	CARDIAC RHYTHM	ST c̄ Ø ectopy. All ext				ST 110, ø ectopy	
		pulses palpable. 3+				Radial & pedal pulses (+)	
		pitting edema on bilat				Edema hands & legs, UE	
		↓ext, + edema bilat ↑ext				resolving, (L)LE > (R)LE	
		Scrotal edema					

LEGEND

- Cr - Creatinine
- F_iO_2 - Fraction of Inspired O_2
- HCO_3 - Bicarbonate
- ICP - Intracranial Pressure
- PCO_2 - Pressure of Arterial CO_2
- PEEP - Positive End Expiratory Pressure
- S/A - Fractional
- SAT - Saturation
- TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY *(Signature & Title)*

DEPARTMENT/SERVICE/CLINIC: ICU 2 west

DATE: 11 July 03

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

[redacted] b6-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER *(Specify)*

☐ DIAGNOSTIC STUDIES

MEDCOM - 13424

PAG

DX

HOSPITAL DAY

TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	21
Arterial Line																		
Cuff	106/60	103/56	117/57	106/47	112/52	152/79	123/78	123/70		113/57	107/56	104/54	104/61	114/59	125/64	116/57	114/53	105/53
mperature	101.0	100^5	101^1	100^8	100^5		100^2	100^1		99^5		101^4	100^7	100^5		100.2		
lse	112	112	111	111	109	112	112	105		117	119	118	121	111	106	109	107	116
spiratory Rate	22	14	14	14	11	11	27	15		20	21	20	21	14	14	10	21	
O2sats	96	94	96	94	97	99	97	97		97	96	94	90	96	95	95	95	96
Source	RA	RA	RA	RA	RA	[illegible]	RA	RA		RA	RA	RA	RA	RA	RA	RA	RA	RA
						@ 0920 - 1020 Conscious Sedation												
[illegible]																		
[illegible]																		

TIME	05	06	07	08	09	10	11	12	8° T	13	14	15	16	17	18	19	20	21	
LR	50	50	50	50	50	50	30	50	400	50	50	50	40	50	50	50	50	50	80
TF	0	0	0	0	0	0	50	50	100	50	50	hold	hold	hold	50	50	50	50	40
IVPB								100	1100	250									350
PO		60			60			60	180			100			150				430
Residual																	T:		1980

TALS		05	06	07	08	09	10	11	12	8° T	13	14	15	16	17	18	19	20	21
INE	HOUR / TOTAL	50/50	24/74	30/104	40/144	36/180	30/210	30/240	246/486	486	280/766	50/816	50/866	30/896	30/926	32/958	200	70	90/1318
	SP GR																		
	S/A																		
IG	OUTPUT																		
	pH																		
	GUIAC																		
ESIS																		Moderate	
OOL																	+	loose stool	

PAGE

ACUITY LEVEL CLASSIFICATION

22	23	24	01	02	03	04	
153/53	141/68	E	150/55	108/52	/25		
110	110	9??	110	105	103	103	
9	14				7		
95	95	96	99	97	97		
RA	RA	RA	RA	RA	RA	RA	

REQUESTING PHYSICIAN: Go

LAST FIRST MI

(Hematology) CBC

REF RANGE

TIME

MODE

LABORATORY RESULT FORM

~~(Subject to the Privacy Act of 1974)~~

F$_i$O$_2$	DATE	TIME	SSN/PSEUDO SSN:
	9/19/03	2150	[redacted] 66-4

Urinalysis

RATE

TEST	RESULT	REF RANGE
Color	yellow	N/A
App	Cl	N/A
Glu	N	Negative
Bili	4	Negative
Ket	N	Negative
SG	1.030	N/A
Bld	mod	Negative
pH		N/A
Prot	trace	Negative
Urob		0.2-1.0
Nit	Neg	Negative
LKA	N	Negative
		Negative

PEEP pH PCO$_2$ PO$_2$ HCO$_3$ SAT BASE GLUCOSE Na/K CKO$_2$Co BUN/Cr WBC PLATELET Hct/Hgb

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

Rbc - 1-5
Epi - 1-5

ID: [redacted] 66-4 19-09-03
HB 21:5
Patient
Limits

	22	23	24	01	02	03	04	8° T
IV	50	50	50	50	50	50	50	400
TF	75	100	100	50	off	off	off	325
IVPB	250							510
PO	150	100						360

WBC
RBC
Hgb
Hct
MCV 28 fL 80.0 99.
MCH 29.7 pg 27.0 31.0
MCHC 33.0 L g/dL 33.0 37.0
Plt 366. x10^3/uL 150. 450.
LY% 27.4 % 20.5 51.1
LY# 1.2 x10^3/uL 1.2 3.4

NPO check

T 1515

490

45 | 45 | 90 | 90 | 70 | 70 | 560

RAPIDPOINT
SERIAL

Patient ID: [redacted] 66-4
Test Name :PT
Test Result: 14. sec
RESULT NOT RANGE CHECKED
Ratio =
Calculated INR
Sample Type:citrated wh. blood
Test Date :09/19/03
Test Time :09:58 PM
Card Lot :010308
Operator :[redacted] 66-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/19/03 10:02 PM

Patient ID: [redacted] 66-4
Test Name :APTT
Test Result:= 32.6 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/19/03
Test Time :09:59 PM

ACTIVITIES OF DAILY LIVING
MOUTH CARE
BATH
SKIN CARE Negative
FOLEY CARE
HOME EXERCISES

CSF TIME

Blood Bank TIME

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

Blood Bank Unit Crossmatch
(MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

24° I&O TOTALS

NURSE'S SIGNATURE [redacted]

66-2

wt Yesterday
wt Today

INTAKE
IV 3555

OUTPUT
Urine: 1808

Balance: + 1747

LAB ID NO.

MEDCOM - 13426

PAGE 1 OF 4

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA
For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
DA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

TIME	0600 INITIALS [redacted]	b6-2 INITIALS	1830 INITIALS [redacted]
NEURO PUPILS –	alert but confuse		PERRL 3mm b6-2
SENSORIUM –	Ø oriented to time or		Follows simple commands
	place		Confused at times
–	follows commands		
RESPIRATORY PATTERN –	unlabored, shallow		RRR
BREATH SOUNDS –	96% on RA		wheezes Ⓑ on inspiration
SECRETIONS –	bilateral inspiratory		Ø secretions
	wheeze, albuterol neb		RA SaO2 96
	given → CTA bil		
SKIN COLOR –	dressing on burn area		Normal for Race
INTEGRITY			Multiple burn sites
			c̄ drsg
IV SITE LOCATION –	Ⓡ IJ 3LC all ports		Ⓡ IJ TLC
CONDITION	patent, flushed		LR 50cc/h
			~~Fentanyl 50 mcg/hr~~ [redacted] b6-2
			Tube feeding 100cc/°
			currently on hold 1 hour
GASTRO ABDOMEN –	+ BS x 4 quad		BS↓
BOWEL SOUNDS			Jevity @ 100cc/° on
			hold for one hour,
			hiccups @ 1810
GU URINE: –	clear yellow, foley		Foley to gravity
COLOR/CLARITY	positional		Clear yellow urine
CARDIOVASCULAR CARDIAC RHYTHM –	ST Ø ectopy		ST S1/S2
–	dependent edema on		Pulses +2 x4 quads
	Lt flank area		Cap Refill < 3 sec x 4 quads
–	penile, scrotal edema		generalized edema.
–	+ pulses x 4 ext		

LEGEND
Cr - Creatinine
F_1O_2 - Fraction of Inspired O_2
HCO_3 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
SA - Fractional
SAT - Saturation
TRACH - Tracheostomy

(Continue on reverse)

PREPA[redacted] *itle)* b6-2 UI/pr

DEPARTMENT/SERVICE/CLINIC
ICU 3

DATE
12 July 03

PATIEN[redacted] *(For typed or written entries give: Name—last, first, middle; g*[redacted] *hospital or medical facility)*

IPW 0[redacted] b6-4

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

DA FORM 1 MAY 78 **4700**
Proponent: Dept of Nurs

WAMC OP 375 (Redesignated)
1 Apr 90 (HSXC-NU)

MEDCOM - 13427

DATE	DX	HOSPITAL DAY

V I T A L S I G N S

TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
BP Arterial Line	108	108	115	101	121	127	110	105		102			110	92	104/53	104/53		
BP Cuff	53	53	58	50	69	67	55	55		98			65	58				
Temperature	100			98.7			100						98.7				98.8	
Pulse	103	102	103	110	116	111	109	112		109	116	115	107	112	109	113	119	
Respiratory Rate	10	12	9	12	18	22	11	14		17	14	22	20	10	14	19	19	
SAO2	99	98	98	98	99	97	96	96		98	97	98	99	97	96	95	94	
Source O2	RA	RA	RA	RA	RA	RA	RA	RA		RA	RA	RA	RA	RA	RA	RA	RA	
pain																		
intervention																		

I N T A K E

TIME	05	06	07	08	09	10	11	12	8° T	13	14	15	16	17	18	19	20	8° T
IV	50	50	50	50	50	50	50	50		50	50	50	50	50	50	50	50	
TF	0					50	50	75		75	75	90	90	100		100	0	
IVPB	0					250		200										
PO	0	0	0	0		120		120		120		240						
TOTALS	50/50	50/100	50/150	50/200	50/250	470/520	100/620	445/1065	1065	245/245	125/370	380/750	140/890	150/1040	50/1090	150/1240	50/1290	1290

O U T P U T

		05	06	07	08	09	10	11	12	8° T	13	14	15	16	17	18	19	20	8° T
URINE	HOUR / TOTAL	90/90	140/230	100/330	100/430	50/480	50/530	200/730	260/990	990	200/200	200/400	130/530	100/630	70/700	100/800	180/980	250/1230	1230
	sp gr																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS																			

MEDCOM - 13428

POST-OP DAY

VITAL SIGNS

21	22	23	00	01	02	03	04	
		107/57		108/54	107/51	106/53	104/51	
	98⁶			99⁸				
119	115	111	111	109	107	109	110	
26	20	22	15	15	16	13	10	
		96	96	95	96	96	97	
				RA	RA	RA	RA	

INTAKE

21	22	23	00	01	02	03	04	8° T
50	50	50	50	50	50	50	50	
0	100	0	100	0				
	250		200					
			240					
50/50	400/450	50/500	590/1090	50/1140	50/1190	50/1240	50/1290	1290

OUTPUT

240/240	250/490	200/690	200/890	200/1090	180/1170	200/1370	200/1570	1570

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA

TIME
MODE
F_iO_2
TV
RATE
PEEP
ABG: pH, PCO_2, pO_2, HCO_3, SAT, BASE

LABORATORY DATA

TIME
GLUCOSE
Na/K
Cl/CO_2
BUN/Cr
WBC/PLATELET
Hct/Hgb

ACTIVITIES OF DAILY LIVING

TIME		
MOUTH CARE		
BATH		
SKIN CARE	2330 [redacted]	66-2
FOLEY CARE	0030 [redacted]	
TRACH CARE	—	
ROM EXERCISES		

TURN / SUCTION — TIME

24° I&O TOTALS

wt Yesterday ________ wt Today ________

	INTAKE		OUTPUT
IV	1065	Urine:	990
po	1290		1230
	1290		1570
TOTAL	3645	TOTAL	3790

BALANCE________

NURSE'S SIGNATURE
[redacted] 14/[illegible] [redacted]
66-2

MEDCOM - 13429

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)* QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0500 INITIALS [redacted]	b6-2 INITIALS	1730 INITIALS [redacted] b6-2
NEURO	PUPILS	PERRLA, 2mm		PERRLA 2mm brisk
	SENSORIUM	Alert and oriented		Alert, follows simple
		x2. Able to follow		commands. Able to move
		simple commands		extremities
RESPIRATORY	RESPIRATORY PATTERN	RRR		RRR
	BREATH SOUNDS	inspiratory wheezes Ⓛ		CTA
	SECRETIONS	lobe and Ⓡ upper and		Ø secretions
		middle lobe Ø secretions		RA $SaO_2 > 94\%$
		noted @ this time.		
SKIN	COLOR	WNL for skin		Normal for Race
	INTEGRITY	40% BSA burn, drsg D+I		BSA burns covered c̄
				drsg, CDI
IV SITE	LOCATION	Ⓡ IJ 3 lumen catheter.		Ⓡ IJ TLC
	CONDITION	c̄ Ø s/s of infection c̄ LR		LR @ 500cc/h
		@ 500cc/h		Ports flushed c̄ 10cc
				N/S.
GASTRO	ABDOMEN	slightly distended		Rounded, tender, c̄
	BOWEL SOUNDS	hypoactive throughout		BS ↓
		dobhoff Ⓡ nare clamped		Dobbhoff Ⓡ nare, Jevity
		@ this time		@ 100cc/h
GU	URINE:	foley to gravity draining		Foley to gravity
	COLOR/CLARITY	clear yellow urine, u/o [illegible]		Clear, light yellow
		cc/hr		urine s̄ sediment
CARDIOVASCULAR	CARDIAC RHYTHM	ST c̄ Ø ectopy, pulses		ST, S1/S2
		palpable in all ext.		Pulses +2 x4 quads/extremities
		pitting edema BLE and		Cap Refill <3 sec x4 extremities
		BUE. S_1S_2 present		Generalized edema, pitting
				on extremities.

LEGEND
- Cr - Creatinine
- F_iO_2 - Fraction of inspired O_2
- HCO_3 - Bicarbonate
- ICP - Intracranial Pressure
- PCO_2 - Pressure of Arterial CO_2
- PEEP - Positive End Expiratory Pressure
- S/A - Fractional
- SAT - Saturation
- TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY *(Signature & Title)*

DEPARTMENT/SERVICE/CLINIC: ICU 3

DATE: 13 JUL

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

[redacted] b6-4

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

DA FORM 1 MAY 78 **4700**
Proponent: Dept of Nurs

WAMC OP 375 (Redesignated)
1 Apr 90 (HSXC-NU)

MEDCOM - 13430

UP TO DSC
PAGE 2 OF 4

DATE 13JUL	DX												HOSPITAL DAY				
VITAL SIGNS																	
TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
BP Arterial Line																		
BP Cuff	103/55	105/51	107/58	107/55	119/59	130/70	118/64	123/69		114/58	102/57	105/84	112/84	107/55	105/53	104/48		
Temperature		96^{7}	98^{7}			98^{7}	99^{5}	100^{6}		~~[illegible]~~ 101	100^{2}	100^{4}	101^{3}	101^{7}		100^{3}		
Pulse	106	108	107	107	125	121	125	128		121	121	119	114	117	97	115	115	
Respiratory Rate	8	9	14	16	20	20	25	20		18	22	13	19	11	21	19		
SaO2	97	97	97	97	99	95	99	97		97	96	95	94	95	95	95	95	
O2 Source	RA	RA	RA	RA	FM	RA	RA	RA		RA	RA	RA	RA	RA	RA	RA	RA	
													Gave tylenol @ 16:30					
[illegible]																		
intervention																		
INTAKE																		
TIME	05	06	07	08	09	10	11	12	8° T	13	14	15	16	17	18	19	20	8° T
IVF	50	50	50	400 in LR		50	50	50	700	50	50	50	50	50	50	50	50	400
TF						75	75	100	250	100	100	100	100	100	100	100	100	800
PO		60			60			60	180		200						220	~~[illegible]~~ 420
IVPB						250		200	450		360							360
										150/150	710/860	150/1010	150/1160	150/1310	150/1460	150/1610	370/1980	1980
TOTALS	50/50	110/160	50/210	400/610	60/670	375/1045	125/1170	410/1580	1580	~~150/150~~	~~[illegible]/880~~	~~150/[illegible]~~	~~150/[illegible]~~	~~150/[illegible]~~	~~150/[illegible]~~	~~150/[illegible]~~	~~370/[illegible]~~	~~1880~~
OUTPUT																		
URINE HOUR/TOTAL	180/180	370/550	[illegible]/620	36/656	96/752	377/1129	465/1194	295/1489	1489	130/1619	130/1749	140/1889	100/1989	75/2064	75/2139	80/2219	75/2294	2294
URINE sp gr																		
URINE S/A																		
NG OUTPUT																		
NG pH																		
NG GUIAC																		
EMESIS																		
STOOL																		
DRAINS																		
TOTALS									1489									2294

Standing @ Bedside

POST-OP DAY

V	21	22	23	00	01	02	03	04	
I									
T		105/58	93/45	100/52	101/55	96/49	85/45	107/52	
A		100^{4}				100^{5}		98^{8}	
L	107		116	112	111	114	111	106	
			21	17	19	19	10	10	
S	97		94	97	96	90	92	93	
I	RA		RA	RA	RA	RA	RA	RA	
G									
N									
S									

	21	22	23	00	01	02	03	04	8° T
IVF	50	50	50	50	50	50	50	50	
PP	200	200	~~200~~	150	50	OFF	OFF	OFF	
PO	220	220	150	200		200			
NFB		250		200					
Flush			10		10	30			
A									
K									
	450/450								
E	370/2350	320/2970	240/3280	600/3880	110/3990	280/4270	50/4320	50/4370	
O	70/2364	70/2434	70/2504	65/2569	65/2634	70/2704	100/2804	90/2894	
U									
T									
P									

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA		TIME
		MODE
		F_IO_2
		TV
		RATE
		PEEP
	A	pH
		PCO_2
	B	pO_2
		HCO_3
		SAT
	G	BASE

LABORATORY DATA	TIME
	GLUCOSE
	Na/K
	Cl/CO_2
	BUN/Cr
	WBC/PLATELET
	Hct/Hgb

ACTIVITIES OF DAILY LIVING	TIME		TURN	2100	2200	
	MOUTH CARE			[redacted]	[redacted]	
	BATH					
	SKIN CARE					
	FOLEY CARE	200[redacted]	SUCTION			
	TRACH CARE	—				
	ROM EXERCISES	—				

24° I&O TOTALS

wt Yesterday ______ wt Today ______

INTAKE		OUTPUT	
IV	1580	Urine:	
po	~~1980~~		
	4370		
TOTAL	6950	TOTAL	2894

BALANCE ______

NURSE'S SIGNATURE | INITIALS

[redacted]

MEDCOM - 13432

PAGE 1 OF 4

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

b6-2

OTSG APPROVED *(Date)* QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0600	INITIALS [redacted]	1700	INITIALS [redacted]		INITIALS
NEURO	PUPILS	PERRL b6-2		2mm PERRLA (+)			
	SENSORIUM	Pt alert + Responsive to touch + Voice stimuli		Alert, Oriented, co-operative, appropriate ↑ Crying out c̄ MAE + transferring. —			
RESPIRATORY	RESPIRATORY PATTERN	Reg RtR		RR 20's s̄ s/sx dyspnea			
	BREATH SOUNDS	CTA bilat		RA Sats 96-100%.			
	SECRETIONS	Ø Ntd secretions equal rise + fall		Ø cough no sec. ↓ Bases. Uses IS exercise correctly. —			
SKIN	COLOR	NSR		membrane pink.			
	INTEGRITY	See Dressings intact See Burn Note.		See DOT SF 509 for Assessment. —			
IV SITE	LOCATION	Ⓡ IJ TLC		Ⓡ IJ TL			
	CONDITION	All Ports Flush well Ø Ntd erythema / Edema LR @ 50cc/hr		Proximal - Clamped Medial LR 50° Distal - clamped. Ports flush easily c̄ ⊕ FlashBack. — Site s̄ s/sx infec. / inf. —			
GASTRO	ABDOMEN	Soft, Non distended					
	BOWEL SOUNDS	Active X 4 Quads		⊕ BS in ABD, Soft, Tender ABD.			
GU	URINE: COLOR/CLARITY	Clr Yellow Urine in adequate Amounts to Foley		H/L F Foley c̄ U.O. ≥ 30ml/hr clear yellow urine. —			
CARDIOVASCULAR	CARDIAC RHYTHM	S1, S2 Present Ø Ntd ectopy, +3 pitting edema. Radial + Pedal Pulses @ +2 c̄ brisk cap refill.		S S c̄ no ectopy ST c̄ HR ↓ 100's. Edema per. ph. + to scrotum + glans penis PPP c̄ + 2 density.			

LEGEND
Cr - Creatinine
F$_I$O$_2$ - Fraction of Inspired O$_2$
HCO$_3$ - Bicarbonate
ICP - Intracranial Pressure
PCO$_2$ - Pressure of Arterial CO$_2$
PEEP - Positive End Expiratory Pressure
S/A - Fractional
SAT - Saturation
TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY *(Signature & Title)*	DEPARTMENT/SERVICE/CLINIC	DATE
b6-2 [redacted] 91WM6	ICU 3	14 JUL 03

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

[redacted] b6-4

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

DA FORM 1 MAY 78 **4700**
Proponent: Dept of Nurs

WAMC OP 375 (Redesignated)
1 Apr 90 (HSXC-NU)

MEDCOM - 13433

DATE 14JUL

DX

HOSPITAL DAY

VITAL SIGNS

TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
BP Arterial Line																		
BP Cuff	104/54	95/49	109/70		126/64	116/65	112/58	105/43		103/47	99/49	98/61	115/65	105/66	113/68	108/53		
Temperature		99.2	99.5		99.1		100.1	101.0	~~101.0~~	101.0	101.9	100.8	X	100	X	X		
Pulse	105	101	110		114	117	114	115	~~110~~	110	115	120	115	112	107	109		
Respiratory Rate	18	16	14		15	14	15	18	~~18~~	18	18	24	22	20	18	12		
SaO_2	93	95	96		100	99	97	97	~~96~~	96	93	92	95	95	97	100		
O_2 Source	RA	RA	RA		NRB	NRB	RA	RA	~~RA~~	RA	RA	RA	RA	RA	RA	RA		

[illegible]

INTAKE

TIME	05	06	07	08	09	10	11	12	8°T	13	14	15	16	17	18	19	20	8°T
IVF	50	50	50	50	50	50	50	50	400	50	50	50	50	50	50	50	50	450
TF					25	101	101	101	328	101	101	101	10.1	101	101	10.1	101	808
PO												480			240			720
IVPB						250		250	500									
Flush			20						20									
TOTALS																		

OUTPUT

URINE	HOUR / TOTAL	140/140	80/220	110/330	110/440	40/480	45/525	45/570	60/630		110/740	90/830	50/880	45/925	X	70/995	X	70/1065	1065
	sp gr																		
	S/A																		
~~Dob-Ho F~~ NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS																			

MEDCOM - 13434

POST-OP DAY

VITAL SIGNS

	21	22	23	00	01	02	03	04	
AL BP	103/62			117/57	108/52	115/57	100/56	114/49	
T	100¹	X	X	X	101²	X	100¹	X	
P	115	105	106	116	109	125	110	108	
RR	16	16	15	15	16	19	11	12	
SAT	99	100	95	100	95	95	93	94	
MODE	RA	RA	RA	RA	RA	RA	RA	RA	

INTAKE

	21	22	23	00	01	02	03	04	8° T
	50	50	50	50	50	50	50	50	450
	101	101	101	101	—	—	—	—	404
		250		250					500
									1304

OUTPUT

	100/100	50/150	50/200	60/260	85/345	200/845	250/795	70/865	865
			SM BM Voms						

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA

TIME									
MODE									
F_iO_2									
TV									
RATE									
PEEP									
ABG pH									
ABG PCO_2									
ABG pO_2									
ABG HCO_3									
ABG SAT									
ABG BASE									

LABORATORY DATA

TIME									
GLUCOSE									
Na/K									
Cl/CO₂									
BUN/Cr									
WBC/PLATELET									
Hct/Hgb									

ACTIVITIES OF DAILY LIVING

TIME			
MOUTH CARE	2100		
BATH			
SKIN CARE	2100		
FOLEY CARE	2100		
TRACH CARE			
ROM EXERCISES	Passive		

TURN / SUCTION

TIME					
c̄ ASSIST					

24° I&O TOTALS

wt Yesterday ____________ wt Today ____________

INTAKE

IV ____________

po ____________

TOTAL ____________

OUTPUT

Urine: ____________

TOTAL ____________

BALANCE ____________

NURSE'S SIGNATURE	INITIALS
[redacted]	[redacted]
No-2	

MEDCOM - 13435

NEUROLOGICAL ASSESSMENT

	HOURS		05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04	LEGEND
COMA SCALE — EYES OPEN	SPONTANEOUSLY	4													4				4				4				C Closed by swelling
	TO SPEECH	3																									
	TO PAIN	2																									
	NO EYE OPENING	1																									
BEST VERBAL RESPONSE	ORIENTED	5													5				5				5				T Trach/Endo
	CONFUSED	4																									S Slurring
	VERBALIZES	3																									D Dysphasia
	VOCALIZES	2																									R Receptive
	NO VOCALIZATION	1																									E Expressive
BEST MOTOR RESPONSE	OBEYS COMMANDS	6													6				6				6				
	LOCALIZES PAIN	5																									
	FLEXION WITHDRAWAL	4																									
	ABNORMAL FLEXION	3																									
	EXTENSION TO PAIN	2																									
	NO MOTOR RESPONSE	1																									
LIMB MOVEMENT — ARMS	NORMAL POWER																										R Right
	MILD WEAKNESS																										L Left
	SEVERE WEAKNESS														X				X				X				Record separately if there is a difference between the two sides.
	ABNORMAL FLEXION																										
	ABNORMAL EXTENSION																										
	NO RESPONSE																										
LEGS	NORMAL POWER																										
	MILD WEAKNESS																										
	SEVERE WEAKNESS														X				X				X				
	ABNORMAL FLEXION																										
	ABNORMAL EXTENSION																										
	NO RESPONSE																										
PUPILS — RIGHT	SIZE														2				2				2				++ Brisk
	REACTION														+				+				+				+ Slow
LEFT	SIZE														2				2				2				- No Response
	REACTION														+				+				+				
PUPIL SCALE	● 2 ● 3 ● 4 ● 5 ● 6 ● 7 mm																										
ICP																											+ Intact
CEREBRAL PERFUSION PRESSURE																											- Abnormal

VASCULAR ASSESSMENT

	HOURS	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04	LEGEND
Pedal	R													+				+				+				++ Normal
	L													+				+				+				
Radial	R													+				+				+				+ Weak
	L													+				+				+				
	R																									- Absent
	L																									D Doppler
	R																									R Right
	L																									
	R																									L Left
	L																									

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA
For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
DA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0600	INITIALS [redacted]	1700	INITIALS [redacted]	b6-2	INITIALS
NEURO	PUPILS	2+ PERRL b6-2		PERRLA 2mm (+)			
	SENSORIUM	A&O x3		Alert, oriented, Ap-			
		purpose Full movement x4		propriate, cooperative			
		pt follows commands		MAE c̄ purpose			
RESPIRATORY	RESPIRATORY PATTERN	RR-14 SPO2-97%		RA Sats 90's > 93.			
	BREATH SOUNDS	on RA		MDI Albuterol Q4°			
	SECRETIONS	Lung Sounds CTA (B) ∅		Occ. Exp. Wheeze ī			
		in RLL no secretions		Rhonchi.			
		@ present		↓d Bases esp. (R)			
				Base			
SKIN	COLOR	normal for Race		Membranes Ant.			
	INTEGRITY	partial thickness burns		SEE SF600			
		to head, stomach, legs CDI		\ \ \ \			
IV SITE	LOCATION	Triple lumen Cath to		(R) I.J. TL			
	CONDITION	(R) jugular flushes well		Proximal LR 50			
		x3 (+) blood return		Medial Clamped			
		dressing CDI		distal Clamped			
				Site c̄ S/Sx infection			
				infiltration & dressing			
GASTRO	ABDOMEN	Firm Round non-distended		Firm Obese,			
	BOWEL SOUNDS	sensitive due to burns		tender c̄ (+) BS in			
		Bowel sound Normoactive		(4) Quads. Dobhoff c̄			
		x4 dobhoff @ NPO @ Present		Jevity (+) @ 128ml/hr			
GU	URINE:	Clear Yellow QS		QNK. SEE SF600 —			
	COLOR/CLARITY	voiding via Catheter		Foley # 16 F c̄ concen-			
				trated yellow urine > 75 ml/hr			
CARDIOVASCULAR	CARDIAC RHYTHM	HR - 106 BP-108/53		$S_1 S_2$ ST ↓100's s̄			
		peripheral pulses x4		[illegible] ectopy. PP			
		capillary Refill ≤ 3sec		LE (+) 2+ doppler.			
		NST		Bilat Radials palp. +2			
				generalized dependent Edema			

LEGEND
Cr - Creatinine
F_iO_2 - Fraction of Inspired O_2
HCO_3 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
S/A - Fractional
SAT - Saturation
TRACH - Tracheostomy

b6-2

(Continue on reverse)

PREPARED BY *(Signature & Title)* [redacted] 91WM6

DEPARTMENT/SERVICE/CLINIC ICU 3

DATE 15 July 03

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

[redacted] b6-4

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

DA FORM 1 MAY 78 4700
Proponent: Dept of Nurs

WAMC OP 375 (Redesignated)
1 Apr 90 (HSXC-NU)

MEDCOM - 13437

PAGE 2 OF 4

DATE 15 July 03 | DX | HOSPITAL DAY

TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
BP Arterial Line	104/51	~~108/53~~				See PACU flowsheet	See PACU flowsheet											
BP Cuff		108/53						106/60		104/58	104/54	104/55	91/50	116/55		109/55	114/60	
Temperature	100.8	99.7						99.2		99.7	99.8	101.5	101.1	99.9	99.4	X	X	
Pulse	107	105						114		113	122	120	115	99		106	109	
Respiratory Rate	11	20						16		17	20	16	12	12		20	19	
MODE	RA	RA						RA		RA	RA	RA	RA	RA		RA	RA	
SAT	95	97	To OR					98		100	97	98	96	95		95	98	
			Recovering															
pain intervention			Post			Return		[illegible]										

TIME	05	06	07	08	09	10	11	12	8°T	13	14	15	16	17	18	19	20	8°T
LR	50	50	—(in	OR	—	50	50	50	250	50	50	50	50	50	50	50	50	400
IVPB						250		200	450									
OR (LR)						1350			1350									
TF	0	0	—	OR	—		~~0~~	128	128	128	128	128	128	128	128	128	128	1024
FLUSH	30	0	—	OR	—		20	0	40									
PRBC (OR) x2 HCT 30 p 2 units					600 ~~400~~ KA				600									
PO	NPO	NPO						0		0		200		0			100	300
TOTALS																		

		05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
Foley URINE	HOUR / TOTAL	90	80			OR ~~1750~~		1150	550		50	0	0	370	8	200	140	30	
	sp gr																		
	S/A																		
Dsg loss	OUTPUT																		
~~NG~~	pH																		
wound	~~GUAIAC~~																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS																			

MEDCOM - 13438

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS

	21	22	23	00	01	02	03	04	
	101/62	116/51	107/61	123/56	112/62	106/51			
HR	103	105	105	109	107	109	111		
RR	22	14	16	24	27	27	13		
	RA	RA	RA	RA	RA	RA	RA		
SAT	96	96	96	98	97	95	97		
Temp						99.7	X		

INTAKE

21	22	23	00	01	02	03	04	8° T
50	50	50	50	50	50	50	50	400
	200		200					400
128	128	128	128	128	128	128		1024
20	~~200~~		~~200~~					
								1824

OUTPUT

150	90	250	325	100	150	160	135	1235
								175

RESPIRATORY DATA

TIME		
MODE		
F_iO_2		
TV		
RATE		
PEEP		
A	pH	7414
	PCO_2	40.4
	pO_2	
B	HCO_3	30
	SAT	
G	BASE	5

LABORATORY DATA

TIME	0330
GLUCOSE	118
Na/K	131/4.1
Cl/CO₂	97/31
BUN/Cr	11
WBC/PLATELET	
Hct/Hgb	28/9

ACTIVITIES OF DAILY LIVING

TIME			
MOUTH CARE			
BATH			
SKIN CARE	1800		
FOLEY CARE	1800		
TRACH CARE			
ROM EXERCISES	1800	2100	2330

	TIME
TURN	1800
	2100
	2330
SUCTION	

24° I&O TOTALS

wt Yesterday ______ wt Today ______

INTAKE
IV 3450
po 2476
TOTAL 5926

OUTPUT
Urine: 3965
wound 175
4140
TOTAL

BALANCE 1786

NURSE'S SIGNATURE	INITIALS
[redacted]	[redacted]
W6-2	

NEUROLOGICAL ASSESSMENT

			HOURS	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
COMA SCALE	EYES OPEN	SPONTANEOUSLY	4														4				4				4		
		TO SPEECH	3																								
		TO PAIN	2																								
		NO EYE OPENING	1																								
	BEST VERBAL RESPONSE	ORIENTED	5														5				5				5		
		CONFUSED	4																								
		VERBALIZES	3																								
		VOCALIZES	2																								
		NO VOCALIZATION	1																								
	BEST MOTOR RESPONSE	OBEYS COMMANDS	6														6				6				6		
		LOCALIZES PAIN	5																								
		FLEXION WITHDRAWAL	4																								
		ABNORMAL FLEXION	3																								
		EXTENSION TO PAIN	2																								
		NO MOTOR RESPONSE	1																								
LIMB MOVEMENT	ARMS	NORMAL POWER																									
		MILD WEAKNESS																									
		SEVERE WEAKNESS															X				X				X		
		ABNORMAL FLEXION																									
		ABNORMAL EXTENSION																									
		NO RESPONSE																									
	LEGS	NORMAL POWER																									
		MILD WEAKNESS																									
		SEVERE WEAKNESS															X				X				X		
		ABNORMAL FLEXION																									
		ABNORMAL EXTENSION																									
		NO RESPONSE																									
PUPILS	RIGHT	SIZE															2				2				2		
		REACTION															⊕				+				+		
	LEFT	SIZE															2				2				2		
		REACTION															⊕				+				+		
ICP																											
CEREBRAL PERFUSION PRESSURE																											

PUPIL SCALE ● 2 ● 3 ● 4 ● 5 ● 6 ● 7 mm

LEGEND

C Closed by swelling

T Trach/Endo
S Slurring
D Dysphasia
R Receptive
E Expressive

R Right
L Left

Record separately if there is a difference between the two sides.

+ + Brisk
+ Slow
- No Response

+ Intact
- Abnormal

VASCULAR ASSESSMENT

		HOURS	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
Radial	R															+				+				+		
	L															+				+				+		
Pedal	R															D				D				D		
	L															D				D				D		
	R																									
	L																									
	R																									
	L																									
	R																									
	L																									

LEGEND

+ + Normal
+ Weak
- Absent
D Doppler
R Right
L Left

MEDCOM - 13440

MEDICAL RECORD-SUPPLEMENTAL MEDICAL . . A

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE Post-Anesthesia Care Unit (PACU) Flow Sheet

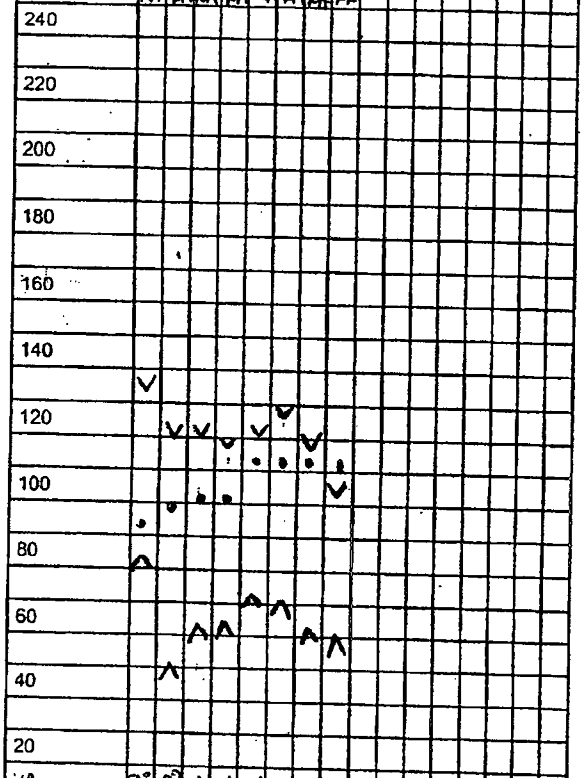
OTSG APPROVED *(Date)*

Date: 15 Jul 03 Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
Time In: 1010
Allergies: NKA OR Intake: Crystalloid ______ Colloid ______
Pre-op V/S: 65 108/53, 99 7, 2 OR Output: UOP ______ EBL min.
Procedures: Graft Meds/Times: ______

Drains	Airway
Hemovac	Nasal
NG	Oral
JP	ETT
T-tube	Trach
Foley	Other
TLS	

Pre Op Meds History

Time	10^10	10^15	10^20	10^55	10^20	11^05	11^20	12^20
SaO2	92	97	92	95	96	96	97	98
FiO2								
Methods	RA	RA	RA	RA	RA	RA	RA	RA



HR	93	102	101	101	114	114	118	116
RR	22	31	28	24	25	24	20	20
T	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

Time						
Pain (0-10)						
LOS						

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities			
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea			
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op			
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain			
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic			
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse			
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.			

Codes

AIRWAY
A = Ambu
BB = Blow-by
M = Mask
FT = Face Tent
RA = RoomAir
NC = Nasal Cannula

V/S
X = A-line BP
˅ = Cuff BP
˄ = Pulse

TEMP
S = Skin
O = Oral
A = Axillary
T = Tympanic
R = Rectal

LOS
C = Cervical
T = Thoracic
L = Lumbar
S = Sacral

Patient teaching done: Wound Care, Pain Management,
T, C, & DB,. Incentive Spirometer, Comfort Measures
Safety: SR up X 2, Falls Precautions. Privacy Maintained

(Continue on reverse)

PREPARED BY *(Signature & Title)*

DEPARTMENT/SERVICE/CLINIC

DATE 15 Jul 03

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

Name —last,

#[redacted] (b)(6)-4

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

MEDCOM - 13441

MEDICAL RECORD-SUPPLEMENTAL MEDICAL . . .A

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE **Post-Anesthesia Care Unit (PACU) Flow Sheet**

OTSG APPROVED *(Date)*

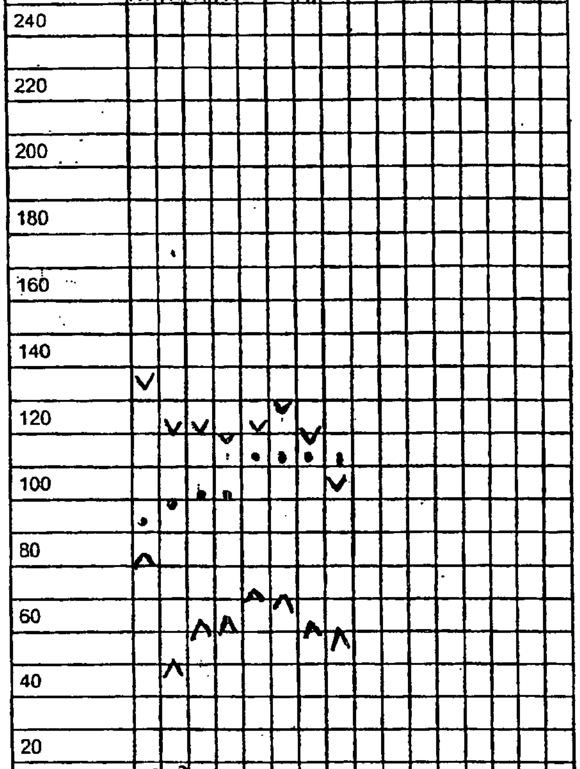
Date: 15 Jul 03 Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
Time In: 1010
Allergies: NKA OR Intake: Crystalloid ______ Colloid ______
Pre-op V/S: 105 108/53, 99 1, 2 OR Output: UOP ______ EBL min.
Procedures: Graft Meds/Times: ______

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds History

Time	1010	1015	1025	1035	1050	1105	1129	1229								
SaO2	92	97	92	95	96	96	97	98								
FiO2																
Methods	RA	RA	RA	RA	RA	RA	RA	RA								



HR	93	100	101	101	114	114	118	116								
RR	22	31	28	24	25	24	23	20								
T	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]								

Time							
Pain (0-10)							
LOS							

Patient teaching done; Wound Care, Pain Management,
T, C, & DB,. Incentive Spirometer, Comfort Measures
Safety: SR up X 2, Falls Precautions. Privacy Maintained

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities			
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea			
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op			
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain			
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic			
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse			
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.			

Codes

AIRWAY
A = Ambu
BB = Blow-by
M = Mask
FT = Face Tent
RA = RoomAir
NC = Nasal Cannula

V/S
X = A-line BP
ˇ = Cuff BP
= Pulse

TEMP
S = Skin
O = Oral
A = Axillary
T = Tympanic
R = Rectal

LOS
C = Cervical
T = Thoracic
L = Lumbar
S = Sacral

(Continue on reverse)

PREPARED BY *(Signature & Title)*

DEPARTMENT/SERVICE/CLINIC

DATE 15 Jul 03

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

[redacted] (b)(6) - 4

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

MEDCOM - 13441

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA
For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET (b)(6)-2

OTSG APPROVED *(Date)*
DA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

NEURO	TIME	0630 INITIALS [redacted]	1800 INITIALS [redacted]	INITIALS
	PUPILS	PERRLA 2-3mm BILAT	PERRL	
	SENSORIUM	A/OX3 PLEAS/COOP	A+O X3 responds to	
		FOLLOWS COMMANDS	Verbal + pain stimuli	
		MAEX4		
RESPIRATORY	RESPIRATORY PATTERN	UNLABORED REG	= bilaterally	
	BREATH SOUNDS	CLEAR BILAT APEX	CTA	
	SECRETIONS	TO BASE. STRONG	Non productive cough	
		NON-PRODUCTIVE	SaO_2 94%	
		COUGH		
SKIN	COLOR	PINK	UFR	
	INTEGRITY	SEE NN	skin graft	
IV SITE	LOCATION	Ⓡ IJ TLC INFUSING	Ⓡ IJ infusing	
	CONDITION	LR PATENT	LR @ 50cc/hr Ø	
		NO S/S INFILTRATION OR	erythema, swelling or heat	
		INFECTION		
GASTRO	ABDOMEN	SOFT ROUND TENDER	Soft round Tender	
	BOWEL SOUNDS	TO TOUCH BS ⊕ X4.	to touch skin graft	
			BS X4 quads	
GU	URINE:	FOLEY TO GRAVITY	Foley to gravity	
	COLOR/CLARITY	DRAINING CLEAR YELLOW	clear yellow urine	
		URINE > 60ML/HR		
CARDIOVASCULAR	CARDIAC RHYTHM	ST 100-110'S NO	S_1S_2 Ø extra sounds	
		ECTOPY NOTED. Ⓡ	+2 radial and pedal pulse	
		RAD PULSE +3, CAP	<3sec cap refill	
		REFILL < 2SEC X4 EXT	Edema to scrotum +	
		S_1S_2 NOTED	Ⓡ leg	

LEGEND
Cr - Creatinine
F_IO_2 - Fraction of Inspired O_2
HCO_3 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
S/A - Fractional
SAT - Saturation
TRACH - Tracheostomy

(b)(6)-2

(Continue on reverse)

PREPARED BY *(Signature & Title)*: [redacted] 91WM6

DEPARTMENT/SERVICE/CLINIC: ICU 3

DATE: 16 July 03

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

[redacted] (b)(6)-4

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

DA FORM 1 MAY 78 **4700**
Proponent: Dept of Nurs

MEDCOM - 13442

WAMC OP 375 (Redesignated)
1 Apr 90 (HSXC-NU)

DATE		DX	HOSPITAL DAY

VITAL SIGNS	TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
	BP Arterial Line	X									~~118/66~~	~~116/64~~	~~105/67~~	~~108/58~~	~~106/53~~				
	BP Cuff		109/51	107/54	101/54	109/49	100/50	107/50	116/66		119/66	116/64	105/67	108/58	106/53	100/54	114/52	104/49	
	Temperature		100.6				100.4					100.0							
	Pulse	117	110	112	114	114	108	110	112		110	122	120	124	114	115	113	117	
	Respiratory Rate	96	16	16	20	20	16	16	12		14	16	14	16	14	18	18	20	
	MODE	RA	RA	RA	RA	RA	RA	RA	4LNC		4LNC	2LNC	RA	RA	RA	RA	RA	RA	
	SATS		96%	95%	94%	95%	96%	95%	98%		98%	96%	95%	94%	96%	95	95	95	
	pain																		
	intervention																		
INTAKE	TIME	05	06	07	08	09	10	11	12	8° T	13	14	15	16	17	18	19	20	8° T
	LR	50	50	50	50	50	50	50	50	400	50	50	50	50	50	50	50	50	
	IVPB																		
	TF	128	0	0	0	0	0	0	0		100	110	120	128	128	128	129	128	
	PO											240		240					
	TOTALS									400									
OUTPUT	Foley URINE HOUR / TOTAL	80/80	110/190	60/250	70/320	60/	80/480	60/540	30/570	570	80/80	40/120	/120	60/180	50/230	90/320	80/400	40/440	440
	URINE sp gr																		
	URINE S/A																		
	NG OUTPUT																		
	NG pH																		
	NG GUIAC																		
	EMESIS WOUND								100	100									
	STOOL																		
	DRAINS																		
	TOTALS									670									

#[redacted]
(b)(6)-4

16 July 03

POST-OP DAY

VITAL SIGNS

21	22	23	00	01	02	03	04	
102/50	107/59	114/55	107/50	109/50	96/49	97/49	100/48	
113	117	119	115	111	110	107	109	
18	18	21	20	21	19	20	15	
RA	3L	2L	2L	2L	RA	RA	RA	
94	95	96	96	96	95	95	96	

INTAKE

21	22	23	00	01	02	03	04	8° T
50	50	50	50	50	50	50	50	1200
128	128	128	128	128	off	off	off	

OUTPUT

90/520	45/565	50/615	50/665	45/710	45/755	70/825	60/885	885 440
								570
								1395

ACUITY LEVEL CLASSIFICATION

RESPIRATORY

	TIME	0410
	MODE	
	F_iO_2	
	TV	
	RATE	
	PEEP	
A	pH	7.449
	PCO_2	41.6
	pO_2	
B	HCO_3	29
	SAT	
G	BASE	5

LABORATORY DATA

TIME	040
GLUCOSE	178
Na/K	135/4.1
Cl/CO_2	98/30
BUN/Cr	11
WBC/PLATELET	8.3/329
Hct/Hgb	29/10
RBC	3.12
ØLYmpH	26.4

ACTIVITIES OF DAILY LIVING

TIME	1080
MOUTH CARE	[redacted]
BATH	
SKIN CARE	[redacted]
FOLEY CARE	[redacted]
TRACH CARE	
ROM EXERCISES	[redacted]

(b)(6)

TURN / **SUCTION**

TIME
0800 [redacted]
1000 [redacted]

24° I&O TOTALS

wt Yesterday ______ wt Today ______

INTAKE
IV ______
po ______
TOTAL ______

OUTPUT
Urine: ______
TOTAL ______

BALANCE______

NURSE'S SIGNATURE INITIALS

[redacted]

(b)(6)-2

MEDCOM - 13444

PAGE

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

TIME	1630.	INITIALS [redacted]	(b)(6)-2	INITIALS	1800	INITIALS
PUPILS	Pt is awake and alert.				Alert, verbalizes	
SENSORIUM	Pt is able to follow				needs, follows	
	simple verbal commands.				verbal commands	
RESPIRATORY PATTERN	Inspiratory wheezes noted					
BREATH SOUNDS	to Ⓛ ~~[illegible]~~ lung, otherwise				Even unlabored, BBS	
SECRETIONS	clear but diminished at				but diminished throughout	
	the bases. SpO2 92-93%				(baseline) RA, sat 93-98%	
	on RA. Incentive spirometry				c̄ incentive spirometer	
	used-SpO2 ↑ to 98% c̄ use. RR 12-15.					
COLOR	Skin grafts to abd, Ⓑ thighs c̄					
INTEGRITY	dsg intact. Suction 125 mm				Skin grafts to abdomen &	
	to abd. graft sites. ~~W~~ All other				thigh, 3035% burns	
LOCATION	burns c̄ drsgs intact.				S/P debridement dressing to sites	
CONDITION	Ⓡ IJ TLC CVC cath				Ⓡ IJ TLC, patent - LR @ 50cc	
	inserted.				hour, no signs of infection	
	LR infusing @ 50cc/hr via					
	medial port. Proximal &					
	distal ports capped.					
ABDOMEN	BS x 4. last BM overnight					
BOWEL SOUNDS	Dobhoff to Ⓡ nare clamped.				BBS all quadrants,	
	Pt NPO for sedation today.				no reported stool	
	Abd large and round. Soft c̄					
URINE:	palpation. Foley to gravity					
COLOR/CLARITY	drng clear dark yellow				Foley to gravity, sediments	
	urine.				noted, yellow.	
CARDIAC RHYTHM	S1-S2. Sinus tach. Rate					
	100's-110. Brisk cap refill				S_1 S_2, Sinus tach, rate	
	to Ⓑ LE. Will assess further				100-110. Bilateral pedal	
	c̄ drsg change. Scrotal and				and radial pulses,	
	generalized edema noted				generalized edema. Cap	
					refill < 3 seconds.	

LEGEND

Cr - Creatinine
F_IO_2 - Fraction of Inspired O_2
HCO_3 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
SA - Fractional
SAT - Saturation
TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY *(Signature & Title)*

DEPARTMENT/SERVICE/CLINIC
ICU 2 west

DATE
17 July 03

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

[redacted] (b)(6)-4

☐ HISTORY/PHYSICAL
☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION
☐ OTHER *(Specify)*

MEDCOM - 13445

DATE

DX

HOSPITAL DAY

VITAL SIGNS

TIME	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22
BP Arterial Line																		
BP Cuff	97/52	99/45	109/55	107/48	139/48	124/78	117/61	117/63	103/50	102/50	112/50	100/52	104/51	117/61	93/53	114/61		122/66 114/63
Temperature	100⁹		100⁴	100²	100³			99⁹	100¹		100⁵			100.4				100.4
Pulse	109	110	110	105	119	118	111	107	101	107	101	108	108	104	107	107	107	103
Respiratory Rate	15	12	18	16	21	21	11	20	12	20	22	17	11	11	nw	18	nw	17
Mode	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA
SaO2	93%	93%	94%	93%	90%	92%	93%	93%	95%	93%	96%	92%	95%	93	94	93	94	93
pain																		
intervention																		

INTAKE

TIME	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	
LR	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	324
IVPB																			
PO																			
TF					98	98	98	98	98	98	98	98	98	98	98	98	98	98	1372
TOTALS																			1696

OUTPUT

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	
Foley URINE HOUR / TOTAL	80/80	80/160	65/225		80/305	45/350	70/420	90/510	120/510 630	100/740		150/890	95/985	70/1055	120/1175	85/		150	1325
sp gr																			
S/A																			
NG OUTPUT																			
NG pH																			
NG GUIAC																			
~~EMESIS~~ wound																			
STOOL																			
DRAINS																			
TOTALS																			

POST-OP DAY

VITAL SIGNS

	23	24	01	02	03	04			
T				98.6					
BP	123/65	118/68	113/57	118/69	118/65	118/65			
R	14	10	12	10					
	102	122	103	104	104	101			
	RA	RA	RA	RA	RA	RA			
	95	96		97	95	98			

INTAKE

	23	24	01	02	03	04			
IV	50	50	50	50	50	50			300
TF	98	98	98	96	~~98~~	~~98~~			392
									692

I: 2388
O: 2025
363

OUTPUT

	130/130	160/290	180/310	180/550	100/650	50/700	/	/	700
stool	ī mucous								

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA

TIME	
MODE	
F_iO_2	
TV	
RATE	
PEEP	
ABG pH	
PCO_2	
pO_2	
HCO_3	
SAT	
BASE	

LABORATORY DATA

TIME	
GLUCOSE	
Na/K	
Cl/CO_2	
BUN/Cr	
WBC/PLATELET	
Hct/Hgb	

ACTIVITIES OF DAILY LIVING

TIME	
MOUTH CARE	
BATH	
SKIN CARE	
FOLEY CARE	
TRACH CARE	
ROM EXERCISES	

TURN

SUCTION

TIME

24° I&O TOTALS

wt Yesterday ______ wt Today ______

INTAKE
IV 2388
PO

OUTPUT
Urine: 2025

TOTAL ______ TOTAL ______

BALANCE +363

NURSE'S SIGNATURE | INITIALS

[redacted] [redacted]

(b)(6)-2

MEDCOM - 13447

REPORT TITLE — proponent agency is the Office of The Surgeon General.

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date
OA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0C00	INITIALS	1730	INITIALS [redacted] (b)(6)-2		INITIALS
NEURO	PUPILS	PERRL		PEERLA 3mm ++			
	SENSORIUM	Pt "Alert & responsive to touch & voice Follows simple commands		Alert, cooperative, pleasant. Follows simple commands MAE c̄ purpose.			
RESPIRATORY	RESPIRATORY PATTERN	Reg R+R equal rise+		RA SATS 90's. BS			
	BREATH SOUNDS	fall CTA bilat		CTA Bilat c̄ ↓↓ Bases			
	SECRETIONS	Ø Ntd secretions Ø Ntd diff. breathing Pt on RA, c̄ O2 sats from 94-96%		MDI Albuterol & incentive spirometry per Rx.			
SKIN	COLOR	NFR					
	INTEGRITY	dressings in tact		Membranes pink See SF600 for wound assessment			
IV SITE	LOCATION	(R) FA 18G c̄ LR		PIV 18g site to			
	CONDITION	@ 50cc/hr. Ø Ntd eryethema/edema		(R) Anterior FA c̄ LR 100° via dial A-Flow s̄ S/Sx in- fection/infiltration			
GASTRO	ABDOMEN						
	BOWEL SOUNDS			Soft, Obese, Tender (+) BS in (4) Quads. MOD. Amt loose Brown Stool (continent)			
GU	URINE:						
	COLOR/CLARITY	Clr yellow via Foley in adequate Amounts.		Foley 16F c̄ clear yellow. U.O. > 100ml/hr.			
CARDIOVASCULAR	CARDIAC RHYTHM	S1, S2 Present, Ø Ntd ectopy. Bilat Radial pulses +3 + (R) Pedal +3. c̄ brisk cap refill x4 extremeties.		S S s̄ ectopy no STΔ. HR 80's. PP present x4. LE Palp. Pedal doppler.			

LEGEND
Cr - Creatinine
F_iO_2 - Fraction of Inspired O_2
HCO_3 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
S/A - Fractional
SAT - Saturation
TRACH - Tracheostomy

(Continue on reverse)

(b)(6)-2

PREPARED BY (Signature & Title) [redacted] 91WM6

DEPARTMENT/SERVICE/CLINIC ICU 3

DATE 20 July 03

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

#[redacted] (b)(6)-4

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

DA FORM 1 MAY 78 4700
Proponent Dept of Nurs

MEDCOM - 13448

WAMC OP 375 (Redesignated)
1 Apr 90 (HSXC-NU)

	DX													HOSPITAL DAY			
TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20
BP Arterial Line																	
BP Cuff		113/58	114/59		Pt to OR					127/72	122/67	103/52	106/59	107/54	97/55	112/55	119/60
Temperature	994	96.8	97.6							97.4	98.8	100.8	100.5	99.1	98.6		
Pulse	93	92	91							109	109	112	114	102	102	98	98
Respiratory Rate	19	20	19							34	16	20	23	15	14	22	18
SAT	94	96	94							94%	100%	98%	96%	99%	98%	100	100
MODE	RA	RA	RA							RA	RA	RA	RA	RA	RA	RA	RA
[illegible]																	
[illegible]																	

TIME	05	06	07	08	09	10	11	12	8° T	13	14	15	16	17	18	19	20
LR	50	50	400	400	400	400	400	50	2150	100	100	100	100	100	100	100	100
NPB																	
Bolus																	
OR								2000									
Po												240			50		
TOTALS																	

URINE	HOUR / TOTAL	90/90	140/230	140/370	90/460	25/	25/	25/	25/50		75/635	80/715	125/840	125/965	50/1015	205/1220	40/	/
	10 gr								(1500 3R)									
	S/A																	
NG	OUTPUT																	
	pH																	
(b)(6)-2	GUIAC																	
E[redacted] EBL									50									
STOOL																Brown Loose		
Wound DRAINS VAC																		

PAGE

21	22	23	00	01	02	03	04	
125/63	129/69	123/65	X	120/63	112/56	113/64		
100	99	X	X	X	X	99	X	
103	105	106	111	107	61	100	101	
20	21	22	26	26	22	16	14	
100	100	100	95	98	98	95	96	
RA	RA	RA	RA	RA	RA	RA	RA	

	22	23	00	01	02	03	04	8° T
100	100	100	100	100	100	100	100	

		50					
315	75	200	200	150	160	200	
		Brain Chem					
					100		

ACUITY LEVEL CLASSIFICATION

RESPIRATORY		TIME								
		MODE								
		F_iO_2								
		TV								
		RATE								
		PEEP								
DATA	A	pH								
		PCO_2								
		pO_2								
	B	HCO_3								
		SAT								
	G	BASE								

LABORATORY DATA	TIME								
	GLUCOSE								
	Na/K								
	Cl/CO_2								
	BUN/Cr								
	WBC/PLATELET								
	Hct/Hgb								

ACTIVITIES OF DAILY LIVING	TIME			
	MOUTH CARE			
	BATH			
	SKIN CARE			
	FOLEY CARE			
	TRACH CARE			
	ROM EXERCISES			
	Per Care	1830		

TURN	TIME	
	1800	0200
	2030	0400
	2200	
	2400	
SUCTION		

24° I&O TOTALS

wt Yesterday ______ wt Today ______

INTAKE		OUTPUT	
IV	5700	Urine:	2460
po	340	EBL	50
	6040	VAC	100
			2610

NURSE'S SIGNATURE

[redacted]

(b)(6)-2

(b)(6)-4

[redacted]

20 Jul 03

R I - 2430

MEDCOM - 13450

QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0700 INITIALS [redacted] (b)(6)-2	INITIALS	INITIALS
NEURO	PUPILS	PERRL		PERRL, 3mm
	SENSORIUM	Pt Alert + responsive to touch + Voice stimuli.		Pt A+O1
RESPIRATORY	RESPIRATORY PATTERN	Reg R+R		
	BREATH SOUNDS	CTA bilat		R R + Rhythm
	SECRETIONS	0 Ntd secretions or difficulty breathing.		CTA Bilat Symmetrical rise + fall of chest
SKIN	COLOR	NFR		
	INTEGRITY	dressings intact		NFR Dressing intact
IV SITE	LOCATION	Ⓡ FA LR@100		Ⓡ FA ⊕ flush LR@100 cc/hr Dob-hoff to Ⓡ nare no tube feeds at this time.
	CONDITION	0 Ntd erythema/edema		
GASTRO	ABDOMEN			
	BOWEL SOUNDS	BS + X 4 Quads NO BM		BS ⊕ X 4 quad no BM at this time
GU	URINE. COLOR/CLARITY	Clr Yellow to Foley		Foley to gravity clear yellow urine
CARDIOVASCULAR	CARDIAC RHYTHM	S1, S2 Present 0 Ntd ectopy, HR-100		S1 S2, HR 99 BP 125/74

LEGEND	Cr - Creatinine F_iO_2 - Fraction of Inspired O_2 HCO_3 - Bicarbonate	ICP - Intracranial Pressure PCO_2 - Pressure of Arterial CO_2 PEEP - Positive End Expiratory Pressure	S/A - Fractional SAT - Saturation TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title) (b)(6)-2 [redacted] 91Wm6

DEPARTMENT/SERVICE/CLINIC: ICU 3 (b)(6)-2

DATE [redacted] 20 21 July 03

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

[redacted] (b)(6)-4

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

DA FORM 4700, 1 MAY 78
Supplement Dept of Nurs

WAMC OP 375 (Redesignated)
1 Apr 90 (HSXC-NU)

21 July 03
386

PAGE

DATE 21 July | DX S/P grafting | HOSPITAL DAY

VITAL SIGNS

TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20
BP Arterial Line																	
BP Cuff	114/59		112/58	114/58	106/56	114/62	110/59	111/62	~~106/65~~	116/63	107/56	113/63	108/60	113/65	121/68	125/74	119/69
Temperature	X	100R	99.1	99.2	99.2	X	99.4	99.4	~~99.1~~	99.1	99.6	99.6		99.8	99.6		98.9
Pulse	101	100	100	100	94	102	104	104	~~105~~	105	104	102	100	99	100	99	98
Respiratory Rate	20	15	18	17	17	22	18	22	~~20~~	20	17	15	21	23	21	20	23
SAT	98	96	97%	99%	99%	99%	93%	100%	~~97%~~	97%	100%	94%	93%	97%	100%	100%	93
MODE	RA	RA	RA	RA	RA	RA	RA	RA	~~RA~~	RA	RA	RA	RA	RA	RA	RA	RA
PAIN																	
Intervention																	

INTAKE

TIME	05	06	07	08	09	10	11	12	8°T	13	14	15	16	17	18	19	20
LR	100	100	100	100	100	100	100	100	800	100	100	100	100	100	100	100	100
IVPB																	
Bolus																	
PO											128						
TOTALS																	

OUTPUT

Foley URINE	HOUR / TOTAL	60/60	50/110	40/150	40/190	40/230	55/285	45/330	55/385	385	75/460	120/580	120/700	125/825	140/965	50/1015	50/	150/
	sp gr																	
	S/A																	
NG	OUTPUT																	
	pH																	
	GUIAC																	
EMESIS																		
STOOL																		
WOUND VAC																		

(b)(6)-4

21 July 03

[redacted]

116/62	129/67	173/74	124/77	99/67	106/68	108/72	
93	93	97	95	98	94	93	
13	11	18	15	28	13	21	
100	95	95	95	97	95	98	

22	23	00	01	02	03	04	8° T
100	100	100	100	100	100	100	100

75/128	140	72	100	15	100	100	

RESPIRATORY DATA

TIME	
MODE	
F_iO_2	
TV	
RATE	
PEEP	
ABG pH	
ABG PCO_2	
ABG pO_2	
ABG HCO_3	
ABG SAT	
ABG BASE	

LABORATORY DATA

TIME	
GLUCOSE	
Na/K	
Cl/CO_2	
BUN/Cr	
WBC/PLATELET	
Hct/Hgb	

ACTIVITIES OF DAILY LIVING

TIME	
MOUTH CARE	
BATH	
SKIN CARE	
FOLEY CARE	
TRACH CARE	
ROM EXERCISES	

TIME	
TURN	
SUCTION	

24° I&O TOTALS

wt Yesterday ____ wt Today ____

INTAKE
IV ____
po ____

OUTPUT
Urine: ____

NURSE'S SIGNATURE

[redacted]

(b)(6)-2

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA
For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General

EPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

(b)(6)-2

OTSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

TIME	0700	INITIALS [redacted]	1800	INITIALS [redacted]		INITIALS
PUPILS	PERRL 3mm		PERRLA 3mm #			
SENSORIUM	Brisk		MAE c̄ purpose,			
			Pleasant, cooperative			
			Disoriented x to			
			person.			
RESPIRATORY PATTERN	RRR Ø Sounds		R:R 20s, BS CTA			
BREATH SOUNDS	CTA Bilat		c̄ ↓↓ Bases, Uses			
SECRETIONS	Ø secretions		incentive spirometer			
			Ø cough/secretions			
COLOR	Normal for Race		membranes pink			
INTEGRITY	Dressings intact		See SF 600 for			
			Skin assess.			
LOCATION	IV to Ⓡ wrist site.		PIV Ⓡ lat wrist			
CONDITION	CDI Ø S/S erythema		18g LR 100° via			
			Dial-a-Flow.			
			Site s̄ S/Sx in-			
			fection/infiltration			
ABDOMEN	⊕ BS x4 quads		Obese, soft,			
BOWEL SOUNDS	Soft Ø distention		Tender to touch			
			2° wound. ⊕ BS			
			loose Brown stool			
URINE:	Clear yellow		foley c̄ cl. yellow			
COLOR/CLARITY	Foley to gravity		urine. U.O. ≥ 30			
			ml/hr.			
CARDIAC RHYTHM	S1S2 +2 pulses x		S/S HR 90-100s			
	4 extremities.		Ø ectopy notes			
			PPP ā ⊕3 density			
			MAP > 60. Cap			
			Refill < 3 Sec.			

LEGEND			
Cr - Creatinine	ICP - Intracranial Pressure	S/A - Fractional
F_iO_2 - Fraction of Inspired O_2	PCO_2 - Pressure of Arterial CO_2	SAT - Saturation
HCO_3 - Bicarbonate	PEEP - Positive End Expiratory Pressure	TRACH - Tracheostomy

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC: ICU 3

DATE: 22 July 03

IENT [redacted] typed or written entries give: Name—last, first, title; grade; date; hospital or medical facility)

[redacted] (b)(6)-4

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

DX

HOSPITAL DAY 21

TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
BP Arterial Line																	
BP Cuff		114/67	129/69	120/67	114/68	114/64	115/66	119/71		131/75	132/73	119/64	120/67	110/64		112/50	100/68	112/63
Temperature						99.1		99.3					99.8		93	~~110~~	X	X
Pulse		98	100	101	98	99	100	113		132	118	107	105	120	112	110	113	100
Respiratory Rate		19	16	20	19	19	20	35		25	29	22	37	28	32	32	32	16
SaO2		94	96	97	97	97	100	98		96	96	96	96	97	96	96	96	96

TIME	05	06	07	08	09	10	11	12	8° T	13	14	15	16	17	18	19	20	8° T
IV		100	100	100	100	100	100	100	700	100	100	100	100	100	100	100	100	
IVPB																		
TOTALS																		
URINE HOUR / TOTAL	/	80/80	80/120	80/240	80/320	50/320	75/395	75/470	470	50/50	50/100	70/170	120/290	55/345	65/410	8/	110/
URINE sp gr																	
URINE S/A																	
NG OUTPUT																	
NG pH																	
NG GUIAC																	
EMESIS																	
STOOL																	
DRAINS																	

ACUITY LEVEL CLASSIFICATION

22	23	00	01	02	03	04	
109/83	121/69	108/69	129/68	119/64	131/76	126/79	
X	X	X	X	X	X	X	
102	104	106	101	94	96	99	
32	21	17	27	31	32	35	
96	95	95	97	98	97	99	

22	23	00	01	02	03	04	8° T
100	100	108	102	100	100	102	

RESPIRATORY DATA									
	TIME								
	MODE								
	F_iO_2								
	TV								
	RATE								
	PEEP								
ABG	pH								
	PCO_2								
	pO_2								
	HCO_3								
	SAT								
	BASE								

LABORATORY DATA								
TIME								
GLUCOSE								
Na/K								
Cl/CO_2								
BUN/Cr								
WBC/PLATELET								
Hct/Hgb								

ACTIVITIES OF DAILY LIVING				
TIME				
MOUTH CARE				
BATH				
SKIN CARE				
FOLEY CARE				
TRACH CARE				
ROM EXERCISES				

TURN / SUCTION				
TIME				

24° I&O TOTALS

wt Yesterday ________ wt Today ________

INTAKE
IV ________
po ________

OUTPUT
Urine: ________

NURSE'S SIGNATURE

[redacted]

(b)(6)-2

PAGE 1 OF 4

MEDICAL RECORD–SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
DA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0644	INITIALS [redacted]		INITIALS	1800	INITIALS [redacted]
NEURO	PUPILS	PERL		(b)(6)-2		PERRL	
	SENSORIUM	Pt. alert & Oriented				pt A&O x2	
		to place & name				purposefull movement x4	
						moves all extremities	
RESPIRATORY	RESPIRATORY PATTERN	45				Reg-RR SpO2-97% on	
	BREATH SOUNDS	normal				RA ∅ cough @ present	
	SECRETIONS	∅ cough @ present					
		time					
SKIN	COLOR	Normal for race					
	INTEGRITY	warm & dry to touch				Normal for race	
						warm dry	
IV SITE	LOCATION	(R) arm				burns, graft sites, donor sites	
	CONDITION	patent to s̄				Rt ARM	
		swelling/redness				patent no S/S of	
		noted to area.				infection/infiltration	
						@100 infusing LR	
GASTRO	ABDOMEN	soft s̄ distention, dressing					
	BOWEL SOUNDS	applied to abd.				Soft flat no distention	
		bowel sounds x 4 quadrant				or tenderness noted	
						bowel sound hyperactive	
						x4	
GU	URINE:	dark yellow. F/C to					
	COLOR/CLARITY	BSD				dark yellow clear	
						draining via catheter	
CARDIOVASCULAR	CARDIAC RHYTHM	S-T					
						HR-91 pulse x4	
						capillary refill ≤3sec	

LEGEND
Cr - Creatinine
F_iO_2 - Fraction of inspired O_2
HCO_3 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
S/A - Fractional
SAT - Saturation
TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY *(Signature & Title)* [redacted] 91WM6

DEPARTMENT/SERVICE/CLINIC: ICU 3

DATE: 23 July 03

PA[redacted] ...ive: Name—last, first,
middl[redacted] ...pital or medical facility)

(b)(6)-2

[redacted]
(b)(6)-4

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

DA FORM 1 MAY 78 **4700**
Proponent: Dept of Nurs

MEDCOM - 13457

WAMC OP 375 (Redesignated)
1 Apr 90 (HSXC-NU)

#[redacted] (b)(6)-4

PAGE 2 OF 4

DATE 03 July 03 | DX | HOSPITAL DAY

VITAL SIGNS

TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
BP Arterial Line	134/																	
BP Cuff	77	135/109	125/71			118/69	123/70	122/69		129/80	111/64	117/74	119/62	123/63	105/61	120/60	126/60	
Temperature	99.3	98.6	98.5			99.3		100.4		98.2		99.2		99.2	99.8	99.7	/	
Pulse	97	97	105			112	98	104		139	101	99	90	94	99	91	95	
Respiratory Rate	30	45	46			28	20	33		35	21	24	20	30	25	17	15	
SAT	99	99	96			95	95	91		92	96	98	99	97	96	96	95	
MODE	RA	RA	RA			RA	RA	RA		RA	RA	RA	RA	RA	RA	RA	RA	
pain																		
intervention																		

INTAKE

TIME	05	06	07	08	09	10	11	12	8° T	13	14	15	16	17	18	19	20	8° T
LR	100	100	100	100	100	100	100	100	800	100	100	100	100	100	100	100		
IVPB																		
Bolus																		
Dobhoff																		
PO				340				420	780		320							
TOTALS									[illegible]									

320
360
420
1140

1300 IV
1140 p.o.
2440

OUTPUT

		05	06	07	08	09	10	11	12	8° T	13	14	15	16	17	18	19	20	
Foley URINE	HOUR / TOTAL	200/	250/[illegible]	100/550	110/[illegible]	110/[illegible]	100/550	/	110/820	820	100/[illegible]	80/1000	50/1050	50/1100	80/1240	115/	65/	/	
	sp gr																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL			1 loose																
DRAINS																			
TOTALS																			

POST-OP [illegible]

VITAL SIGNS

	21	22	23	00	01	02	03	04	
	113/61	110/59	112/65	101/65	105/54	114/65	109/58	114/61	
T	99.7	99.8	99.3	99.5	99.3	99.8	99.7	99.5	
R	105	99	98	102	97	94	93	94	
Pox	93%	95%	94%	94%	96%	95%	96%	96%	
	RA	RA	RA	RA	RA	RA	RA	RA	
RR	20	24	24	24	25	19	24	19	

INTAKE

	21	22	23	00	01	02	03	04	8° T
R	100	100	100	100	100	100	100	100	

OUTPUT

100/	100/	100/	150/	100/	100/	0/	0/	

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA

TIME	
MODE	
F_iO_2	
TV	
RATE	
PEEP	
ABG pH	
PCO_2	
pO_2	
HCO_3	
SAT	
BASE	

LABORATORY DATA

TIME	
GLUCOSE	
Na/K	
Cl/CO_2	
BUN/Cr	
WBC/PLATELET	
Hct/Hgb	

ACTIVITIES OF DAILY LIVING

TIME	
MOUTH CARE	✓
BATH	
SKIN CARE	✓
FOLEY CARE	✓
TRACH CARE	
ROM EXERCISES	✓

TURN

TIME				
0000		0200	0300	0400
Lt side	[illegible]	Rt side	Lt side	Rt side

SUCTION

[illegible]

24° I&O TOTALS

wt Yesterday ________ wt Today ________

INTAKE
IV ________
po ________
____
TOTAL ________

OUTPUT
Urine: ________
____
____
TOTAL ________

BALANCE ________

NURSE'S SIGNATURE | INITIALS

[redacted]

(b)(6)-2

MEDCOM - 13459

NEUROLOGICAL ASSESSMENT

		HOURS	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
COMA SCALE – EYES OPEN	SPONTANEOUSLY	4	✓																							
	TO SPEECH	3																								
	TO PAIN	2																								
	NO EYE OPENING	1																								
BEST VERBAL RESPONSE	ORIENTED	5																								
	CONFUSED	4	✓																							
	VERBALIZES	3																								
	VOCALIZES	2																								
	NO VOCALIZATION	1																								
BEST MOTOR RESPONSE	OBEYS COMMANDS	6	✓																							
	LOCALIZES PAIN	5																								
	FLEXION WITHDRAWAL	4																								
	ABNORMAL FLEXION	3																								
	EXTENSION TO PAIN	2																								
	NO MOTOR RESPONSE	1																								
LIMB MOVEMENT – ARMS	NORMAL POWER																									
	MILD WEAKNESS		✓																							
	SEVERE WEAKNESS																									
	ABNORMAL FLEXION																									
	ABNORMAL EXTENSION																									
	NO RESPONSE																									
LEGS	NORMAL POWER																									
	MILD WEAKNESS		✓																							
	SEVERE WEAKNESS																									
	ABNORMAL FLEXION																									
	ABNORMAL EXTENSION																									
	NO RESPONSE																									
PUPILS – RIGHT	SIZE		3																							
	REACTION		++																							
LEFT	SIZE		3																							
	REACTION		++																							

PUPIL SCALE ● 2 ● 3 ● 4 ● 5 ● 6 ● 7 mm

ICP																								
CEREBRAL PERFUSION PRESSURE																								

LEGEND
- C Closed by swelling
- T Trach/Endo
- S Slurring
- D Dysphasia
- R Receptive
- E Expressive
- R Right
- L Left
- Record separately if there is a difference between the two sides.
- ++ Brisk
- + Slow
- - No Response
- + Intact
- - Abnormal

VASCULAR ASSESSMENT

		HOURS	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
	R L																									
	R L																									
	R L																									
	R L																									
	R L																									

LEGEND
- ++ Normal
- + Weak
- - Absent
- D Doppler
- R Right
- L Left

MEDCOM - 13460

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

PAGE 1 OF 2

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

(b)(6)-2

OTSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0700 INITIALS [redacted]	1800 INITIALS [redacted]	INITIALS
NEURO	PUPILS	3mm PERRL PT.	PERRLA 2mm #)	
	SENSORIUM	moves all extremities	Oriented to person	
		c̄ purposeful movement	only. Cooperative,	
			pleasant. MAE c̄	
RESPIRATORY	RESPIRATORY PATTERN	RRR equal rise & fall	purpose.	
	BREATH SOUNDS	Ø secretions	RA sats ↑90's.	
	SECRETIONS	CTA Bilat	RR 20's. Ø cough	
			noted. BS ↓↓ Bilat	
			Bases.	
SKIN	COLOR	Normal for Race	Membranes pink	
	INTEGRITY		See SF600 for skin	
			assess.	
IV SITE	LOCATION	18ga to Ⓡ FA	PIV restart 20g	
	CONDITION	LR @ 100cc/hr	to Ⓛ upper arm.	
		Site CDI	LR 100°	
		Ø redness		
GASTRO	ABDOMEN	+BS X 4 quads		
	BOWEL SOUNDS		Obese soft ABD	
			tender 2° [illegible]	
			Site to Anterior ABD.	
GU	URINE:	Clear yellow, foley	(+) BS in (4) QUADS	
	COLOR/CLARITY	to gravity	Foley 16F c̄ Clear	
			yellow u.o. > 30ml/hr	
CARDIOVASCULAR	CARDIAC RHYTHM	$S_1 S_2$, +Pulses +2		
		X 4 extremities	SS c̄ HR 90's.	
			Ø ectopy via monitor.	
			PPP c̄ (+) 3 density	
			Cap Ref: < 3 Sec.	

LEGEND
Cr - Creatinine
F_iO_2 - Fraction of inspired O_2
HCO_3 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
SA - Fractional
SAT - Saturation
TRACH - Tracheostomy

(Continue on reverse)

PRE[redacted]le) (b)(6)-2

DEPARTMENT/SERVICE/CLINIC
ICU 3

DATE
24 July 03

PATIENT'S [redacted] or typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)

[redacted] (b)(6)-4

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

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE Post-Anesthesia Care Unit (PACU) Flow Sheet	OTSG APPROVED *(Date)*

Date: 1 Aug 03 Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
Time In: 1020
Allergies: ____ OR Intake: Crystalloid ____ Colloid ____
Pre-op V/S: ____ OR Output: UOP ____ EBL ____
Procedures: debriment Meds/Times: ____

Drains	Airway
Hemovac	Nasal
NG	Oral
JP	ETT
T-tube	Trach
Foley	Other
TLS	

Pre Op Meds History

Time	1035	1040	1045	1115	1145
SaO2	97	97	99	99	
FiO2					
Methods	RA	RA	RA	RA	RA
240					
220					
200					
180					
160					
140					
120		∧	∧	∧	
	∧				∧
100	●		●	●	
		●			●
80					
	∨	∨	∨	∨	∨
60					
40					
20					
RR	10	11	9	12	11
T	[illegible]			[illegible]	

Time					
Pain (0-10)					
LOS					

Patient teaching done; Wound Care, Pain Management,
T, C, & DB., Incentive Spirometer, Comfort Measures
Safety: SR up X 2, Falls Precautions, Privacy Maintained

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	2	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	2	2	2
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	12	12	12

Codes

AIRWAY
A = Ambu
BB = Blow-by
M = Mask
FT = Face Tent
RA = RoomAir
NC = Nasal Cannula

V/S
X = A-line BP
˅ = Cuff BP
● = Pulse

TEMP
S = Skin
O = Oral
A = Axillary
T = Tympanic
R = Rectal

LOS
C = Cervical
T = Thoracic
L = Lumbar
S = Sacral

(Continue on reverse)

PREPARED BY *(Signature & Title)* [redacted] (b)(6)-2
DEPARTMENT/SERVICE/CLINIC ICU
DATE 1 Aug 03

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

EPW [redacted] (b)(6)-4

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

DA FORM 4700, MAY 78 WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) Previous edition is obsolete
USAPPC V2.00

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
No Meds						

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm							
15'							
30'							
45'	See		SF		600		
60'							
90'							
D/C							

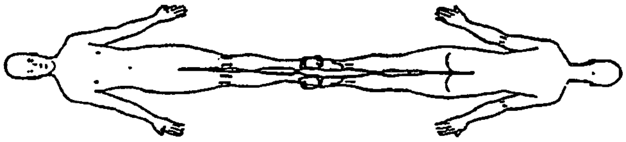
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

	Adm	15'	30'	45'	60'	90'	D/C
Fund. Height							
Lochia							
Peripad#							
Fund. Cond.							

DRESSINGS

Time	Location	Type	Drainage
Adm	Dressings	Δ'd in	OR
30'	CDI		
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

1035 - pt back from surgery fully awake and talking. VSS -

1100 - pt VSS SpO2 96% on room air. Will continue to monitor - [redacted]

1130 - pt VSS, SpO2 98 on room air. pt being D/C'd (b)(6)-2 from pacu procedures - [redacted]

Discharge Criteria:
Date: **Time:** **PARS:**
BP: **T:** **HR:** **RR:** **Sa02:**
Pain Level at D/C (0-10):
Intake:________ **Output:**________
Additional Data:________
Transferred To:________
Report Given To:________
Transferred Via: W/C Litter Gurney Ambulance
Transferred By:________
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature: ________

REPORT TITLE ... proponent agency is the Office of The Surgeon General.

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date
OA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0141 INITIALS [redacted] -(b)(6)-2	INITIALS	INITIALS
NEURO	PUPILS	Pt. alert & responsive.		
	SENSORIUM	PERL. Follows command		
		well. Able to communicate		
		needs well.		
RESPIRATORY	RESPIRATORY PATTERN	17 normal		
	BREATH SOUNDS	CTA		
	SECRETIONS	Ø : Ø cough noted		
		@ this time		
SKIN	COLOR	normal for race		
	INTEGRITY	Warm + dry to touch		
IV SITE	LOCATION	Ⓛ wrist.		
	CONDITION	LR @ 100cc/hr infusing		
		s̄ complications. Ø		
		s/sx of infiltration		
GASTRO	ABDOMEN	soft + distended		
	BOWEL SOUNDS	Bowels Q4°		
GU	URINE:	F/C to BS		
	COLOR/CLARITY	Clear yellow urine		
CARDIOVASCULAR	CARDIAC RHYTHM	HR 101 normal		
		edema noted to		
		Ⓑ feet.		

LEGEND
Cr - Creatinine
F_IO_2 - Fraction of Inspired O_2
HCO_3 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
S/A - Fractional
SAT - Saturation
TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title)
[redacted] 91WM6

DEPARTMENT/SERVICE/CLINIC
ICU 3

DATE
03Aug03

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)
(b)(6)-2

H [redacted] -(b)(6)-4

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

DA FORM 1 MAY 78 4700
Proponent Dept of Nurs

MEDCOM - 13464

WAMC OP 375 (Redesignated)
WAMC OP 375 (Redesignated)
1 Apr 90 (HSXC-NU)

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA
For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89 (b)(6)-2

INITIAL SHIFT ASSESSMENT

	TIME	Ø7ØØ INITIALS [redacted]	(b)(6)-2 INITIALS	1845 INITIALS [redacted]
NEURO	PUPILS	3mm brisk		pupils 3mm PERRL
	SENSORIUM	Alert and oriented		A&Ox3
		Able to follow commands		
		and express needs		
RESPIRATORY	RESPIRATORY PATTERN	RRR		equal rise/fall of
	BREATH SOUNDS	Diminished bilat		chest. lung sounds
	SECRETIONS	↓ bases.		clear in all fields
		Ø secretions @ this		
		time		
SKIN	COLOR	WNL for race		normal for race
	INTEGRITY	Drsg Bilat ↓ ext and		
		BUE D+I		
IV SITE	LOCATION	(R) FA		(R) FA c̄ LR @ 100cc/hr
	CONDITION	Ø S/S of infection c̄ LR		Ø S/S of infection/
		infusing @ 100cc/°		infiltration
GASTRO	ABDOMEN	soft, nontender		(→) TND, (+) Bowel
	BOWEL SOUNDS	(+) throughout all quad		sounds x 4 quads
GU	URINE:	foley to gravity draining		foley to gravity
	COLOR/CLARITY	clear yellow urine c̄ Ø		(QS), clear yellow
		sediments		
CARDIOVASCULAR	CARDIAC RHYTHM	SR c̄ Ø ectopy, Edema		NSR, S_1S_2 normal
		+4 BLE, pulses palpable		No ectopy/murmur
		throughout. Cap refill		noted.
		<3 sec.		

LEGEND
Cr - Creatinine
F_IO_2 - Fraction of Inspired O_2
HCO_3 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
S/A - Fractional
SAT - Saturation
TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title): [redacted] 91WM6
DEPARTMENT/SERVICE/CLINIC: ICU 2 west
DATE: 5 Aug 03

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)
(b)(6)-2

[redacted] — (b)(6)-4

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

DA FORM 1 MAY 78 4700
MEDCOM - 13465
WAMC OP 375 (Redesignated)

PAGE 2 OF 4

DATE	DX	HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial Line																		
BP Cuff																		
Temperature																		
Pulse																		
Respiratory Rate																		
pain																		
intervention																		

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
TOTALS																		

OUTPUT

URINE	HOUR / TOTAL																		
	Sp gr																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUAIAC																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS																			

MEDCOM - 13466

5Aug #[redacted] - (b)(6)-4

ICU Flowsheet **Patient Name:** **Date:** 08 / 05 / 2003

Vital Signs	24	01	02	03	04	05	06	07	08	09	10	11		12	13	14	15	16	17	18	19	20	21	22	23	
Temperature								98.4												98'			98	98^8		
Pulse	98				101			~~98.4~~ 91						97						90			94	94		
B/P A-Line																										
MAP																										
B/P Cuff								110/63												110/63				115/60		
Respirations	85				14			20						10						14				16		
a02	99				97			97						100						100				99		
Intake	**24**	**01**	**02**	**03**	**04**	**05**	**06**	**07**	**08**	**09**	**10**	**11**	**Total**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**Total**
LR100	100	100	100	100	100	100	100	100	100	100	100	100	1200	100	100	100	100	100	100	100	100	100	100	100	100	
[redacted]			(b)(6)-2																							
PO								300					300													
O.R. IN																										
Totals																										
Output	**24**	**01**	**02**	**03**	**04**	**05**	**06**	**07**	**08**	**09**	**10**	**11**	**Total**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**Total**
Urine Hourly					450/450	58/508	58/566	58/624	71/695	71/766	71/837	71/908	908	71/979	71/1050	72/1122				125/1247	100	150	70	30	50	
NG Tube																										
s #1																										
#2																										
#3																										
Emesis																										
Stool																										
O.R. OUT						[redacted]		(b)(6)-2																		
Totals																										

24 hour input	
24 hour output	
24 hour balance	

MEDCOM - 13467

CAL RECORD-SUPPLEMENTAL MEDICAL D

Fo his form, see AR 40-66; the proponent agency is the Office of The Surge al.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA APPR 08MAR89

INITIAL SHIFT ASSESSMENT

N		Time: 2000 Initals: [redacted] (b)(6)-2	Time: Initals:
E	Pupils	PERRL	
U	Sensorium	Alert & Orientated x3	
R	LOC / GCS	Follows all commands move	
O		all extremitres	
C	Cardiac Rhythm	NSR HR-85 BP-122/64	
A	PRI: / QRS:	peripheral pulses ⊕⊕ x 4	
R	Pulse Strength	Cap Refill ≤3sec Ø edema	
D	Cap Refil / JVD	noted @ present Ø chest	
I	Edema	pain	
A	Chest Pain		
C			
R	Respiratory Pattern	RR- 12	
E	Breath Sounds	Breath sound CTA Ⓑ	
S	Secretions	Ø secretions Ø cough	
P	Cough		
S	Color	Normal For Race	
K	Integrity	Burns scattered small	
I	Backside	breakdown noted Pt on side	
N		or up ↑ of Bed when possible.	
	Access Devices	Ø	
I	Location		
V	Condition		
	Abdomen	Soft Round/Flat nontender	
G	Bowel Sounds	non distended B.S. Normoactive	
I	Stoma/Ostomy	x4 Ø Stoma/ostomy	
G	Device	Pt voiding via urinal	
U	Color / Clarity		

(Continue on reverse)

PREPARED BY *(Signature & Title)*

DEPARTMENT/SERVICE/CLINIC (b)(2)-2 [redacted]

DATE 12 Aug 03

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

Name — last,

#[redacted] (b)(6)-4

☐ HISTORY/PHYSICAL
☐ OTHER EXAMINATION OR EVALUATION
☐ DIAGNOSTIC STUDIES
☐ TREATMENT

☐ FLOW CHART
☐ OTHER *(Specify)*

DA FORM 4700, MAY 78

USAPPC V2.00

'3

(b)(6)-4

Patients Name: [redacted] # [redacted]

Date: 12 Aug, 03

See SF 511

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP														98.1				129/56				134/62				
TEMP														122/64				97.9				98.8				
HR														85				78				96				
RR														12				12				12				
SaO2														95%				95%				96%				
FiO2																										
Source														RA				RA				RA				
M																										

MEDCOM - 13469

NTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
None														0				1								
PB																										
T																										
PO																		100		200						
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	al
URINE																		350								
NGT																										
STOOL																										
DRAIN																										
Total																		350								

ICAL RECORD-SUPPLEMENTAL MEDICAL DAT

For us. . .is form, see AR 40-66; the proponent agency is the Office of The Surgeon

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA APPR 08MAR89

INITIAL SHIFT ASSESSMENT

N		Time: 0730 Initals: [redacted] (b)(6)-2	Time: 1900 Initals: [redacted] (b)(6)-2
E	Pupils	PERL: alert & Oriented	PERRLA: Alert/Oriented
U	Sensorium	Able to communicate	follows all commands c̄
R	LOC / GCS	all needs.	communicates c̄ difficulty
O			
C	Cardiac Rhythm	normal. HR 90	NSR
A	PRI: / QRS:	+ pulses c̄ good cap.	
R	Pulse Strength	Refill. Edema noted	Strong UE pulses. LE's warm
D	Cap Refil / JVD	to (Lt) foot. ⊖ chest pain	to touch. cap refill < 2 secs
I	Edema		none noted
A	Chest Pain		⊖ complaints
C			
R	Respiratory Pattern	normal. RR 12	normal on RA
E	Breath Sounds	normal	CTA (B)
S	Secretions		none
P	Cough	non productive cough	none
		noted.	
S	Color	normal for race	NFR
K	Integrity	warm + loose. Burns to	Dressings to UE's, abd, LE's
I	Backside	buttocks, back, abd. (B) legs	feet
N		also (B) hands.	
	Access Devices		⊖ IV access
I	Location	∅ IV access	
V	Condition		
	Abdomen	soft c̄ nondistended	soft; nontender
G	Bowel Sounds	x4 quadrant	BS hypoactive
I	Stoma/Ostomy	⊖ stoma/ostomy	⊖
G	Device	cont. of B+B.	no void witnessed
U	Color / Clarity		yet
		(b)(6)-2	

(Continue on reverse)

PREPARED BY *(Signature & Title)* [redacted] CPT/AN

DEPARTMENT/SERVICE/CLINIC
ICU 3, 28th Combat Support Hospital

DATE
13 Aug 03

PA[redacted] *(For typed or written entries* *Name — last,*
first, middle, grade; date; hospital or medical facility)

#[redacted]
13Aug03 (b)(6)-4

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

DA FORM 4700, MAY 78

USAPPC V2.00

MEDCOM - 13470

Name: #[redacted] – (b)(6)-4 Date: 13Aug03

(b)(6)-2

	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	06
A																						[illegible]				
NB.	118/70				110/68				108/70						110/60		[redacted]	110/60								105/65
TEMP	98.1				97.2				97.2						97.4		[redacted]	98.4								97.0
HR	90				91				85						77			89								80
RR	12				11				10						12			12								12
SaO2	95				95				95						97%			95%								98%
FiO2	RA				RA										RA			RA								RA
Source																										
M.																										

MEDCOM - 13471

TAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
B																										
T																										
PO			360		120		360					120														
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE										400			400						350							350
NGT																										
STOOL																										
DRAIN																										
Total																										

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE **Post-Anesthesia Care Unit (PACU) Flow Sheet**

OTSG APPROVED *(Date)*

Date: 16 AUG 03
Time In: 1145
Allergies: ____
Pre-op V/S: 106/60 93
Procedures: ____

Anesthesia Type (Circle)): [✓ General] Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 800 Colloid ____
OR Output: UOP 0 EBL Min
Meds/Times: 3 Versed, 250 Fent

Drains
- Hemovac
- NG
- JP
- T-tube
- Foley
- TLS

Airway
- Nasal
- Oral
- ETT
- Trach
- Other

Pre Op Meds

History

Time	1145	1150	1155	1200	1215	1230										
SaO2	98	96	95	97		98										
FIO2																
Methods	RA	RA	RA	RA		RA										
240																
220																
200																
180																
160																
140																
120			Λ													
(b)(6)-2	Λ	Λ	[redacted]	Λ		Λ										
100																
	●	●	●	●												
80						●										
	Λ	Λ	Λ	Λ		Λ										
60																
40																
20																
RR	12	14	12	12		14										
T	[illegible]			99.2												

Time								
Pain (0-10)								
LOS								

Patient teaching done; Wound Care, Pain Management.
T, C, & DB,. Incentive Spirometer, Comfort Measures
Safety: SR up X 2, Falls Precautions. Privacy Maintained

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays:
Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	2	
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse			
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C,	9	10	

Codes

AIRWAY
A = Ambu
BB = Blow-by
M = Mask
FT = Face Tent
RA = RoomAir
NC = Nasal Cannula

V/S
X = A-line BP
˅ = Cuff BP
• = Pulse

TEMP
S = Skin
O = Oral
A = Axillary
T = Tympanic
R = Rectal

LOS
C = Cervical
T = Thoracic
L = Lumbar
S = Sacral

(Continue on reverse)

PREPARED BY *(Signature & Title)*

DEPARTMENT/SERVICE/CLINIC

DATE

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

Name — last,

#[redacted]-(b)(6)-4

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

DA FORM 4700, MAY 78 WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) Previous edition is obsolete
USAPPC V2.00

MEDCOM - 13472

CAL RECORD-SUPPLEMENTAL MEDICAL DAT

For use ... this form, see AR 40-66; the proponent agency is the Office of The Surgeon ...

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA APPR 08MAR89

INITIAL SHIFT ASSESSMENT

N		Time: 0600 Initals: [redacted] (b)(6)-2	Time: Initals:
E	Pupils	3mm PERRL	PERRL
U	Sensorium	Alert, speak some english	A+O, able to follow
R	LOC / GCS	Able to follow commands	simple commands
O			
C	Cardiac Rhythm	SR HR 80	
A	PRI: / QRS:		
R	Pulse Strength	+2 pulses throughout all 4 ext.	⊕ pulses x4 extremities
D	Cap Refil / JVD	cap refill < 3sec all 4 ext.	< 3sec
I	Edema	Ø noted	
A	Chest Pain	Ø noted	
C			
R	Respiratory Pattern	equal chest rise, RRR 12	CTA B/lat
E	Breath Sounds	CTA throughout	
S	Secretions	Ø noted	
P	Cough	Ø noted	
S	Color	WNL FOR RACE	WNL for Race
K	Integrity	50% BSA BURNS, DRSGS ABD,	Drsgs to ABD, Thigh, BLE
I	Backside	THIGH, BLE, BUE, BACK D+I	BUE + Back c/D/I
N			
	Access Devices	Ø ACCESS	No IV access
I	Location		
V	Condition		
	Abdomen	Soft, nontender	Soft nontender, nondistended
G	Bowel Sounds	(+) normal all 4 quadrants	⊕ BS x 4 quad
I	Stoma/Ostomy	Ø	
G	Device	urinal s̄ assist	Uses urinal c̄ assist.
U	Color / Clarity		

(Continue on reverse)

PREPARED BY *(Signature & Title)*

DEPARTMENT/SERVICE/CLINIC (b)(2)-2 [redacted]

DATE 14 AUG 03

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

(b)(6)-4
EPW [redacted]

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

DA FORM 4700, MAY 78

USAPPC V2.00

ICU3 Patients Name: # [redacted] (b)(6)-4 Date: 14 Aug 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP	105/65				112/70				116/76					116/76				107/74				115/78				
TEMP	97.9				96.7				96.9					97.2				98.3				98.4				
HR	80				75				82					82				82				80				
RR	12				12				13					13				16				12				
SaO2	96%				95%				96%					96%				96%				96%				
FiO2	RA																									
Source	↓				RA				RA					RA				RA				RA				
M.																										

TAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
B																										
r																										
PO																										
Total																										

MEDCOM - 13474

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE																										
NGT																										
STOOL																										
DRAIN																										
Total																										

ICAL RECORD-SUPPLEMENTAL MEDICAL DAT

For th s form, see AR 40-66; the proponent agency is the Office of The Surgeon .

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA APPR 08MAR89

		INITIAL SHIFT ASSESSMENT	
N		Time: 0730 Initals: [redacted] (b)(6)-2	Time: 1900 Initals: [redacted] (b)(6)-2
E	Pupils	PERL	
U	Sensorium		A & O Verbalizes needs.
R	LOC / GCS	Alert & Oriented	
O			
C	Cardiac Rhythm	normal 91	NS @ 91
A	PRI: / QRS:	+3 c̄ Good Cap	
R	Pulse Strength	refill	Radial/pedal pulses palpable
D	Cap Refil / JVD		
I	Edema	Edema to (LF) feet	edem to (L) LE +1
A	Chest Pain	Ø chest pain	
C			no chest pain
R	Respiratory Pattern	normal 11	RRR
E	Breath Sounds	normal - CTA	CTA
S	Secretions	N/A	NA
P	Cough	Ø cough noted	Ø cough
		Ø wheezing noted	
S	Color	Normal for race	Normal for race
K	Integrity	warm & dry to touch	Wound abdomen, thigh, heels
I	Backside	Burn area to Buttocks	& buttocks applied
N			silvadene.
	Access Devices		
I	Location	N/A	NA
V	Condition		
	Abdomen	Soft non distended	Soft non-tender
G	Bowel Sounds	Bowels @ 4 Quadrant	Positive BS
I	Stoma/Ostomy		
G	Device	Conti B&B	Voiding spontaneously
U	Color / Clarity	dark yellow urine	amber/yellow urine

(Continue on reverse)

PREPARED BY *(Signature & Title)*

DEPARTMENT/SERVICE/CLINIC (b)(2)-2 [redacted]

DATE 15AUG03

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

EPW # [redacted] (b)(6)-4

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

DA FORM 4700, MAY 78

USAPPC V2.00

MEDCOM - 13475

ICU3 Patients Name: EPW [redacted] (b)(6)-4 Date: 15AUG03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP	102/58				112/72				116/68		100/68			104/60				106/64			104/66			106/68		
TEMP	97.7				97.8				97.8		97.8			97.4				97.6			97.7			97.6		
HR	93				91				87		87			86				84			86			87		
RR	12				12				11		1			12				14			12			12		
SaO2	96				95				97		9[illegible]			97				96			96			94		
FiO2																										
Source	RA				RA				RA		RA			RA				RA			RA			RA		
M																										

MEDCOM - 13476

TAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
B																										
PO	358	188					466																			
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE	550																						Voided c̄ BM			
NGT																										
STOOL																							c̄ large			
DRAIN																							hardstools			
Total																										

MEL RECORD-SUPPLEMENTAL MEDICAL A

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA APPR 08MAR8

INITIAL SHIFT ASSESSMENT

N		Time: 0700 Initals: [redacted] (b)(6)-2	Time: 1900 Initals: [redacted] (b)(6)-2
E	Pupils	PERRL	PERRL
U	Sensorium		A&O x3
R	LOC / GCS		pt follows all commands, purposefull
O			movement to All Extremities
C	Cardiac Rhythm		HR- 79 BP- 116/69
A	PRI: / QRS:		
R	Pulse Strength		peripheal pulse strong x4
D	Cap Refil / JVD		Cap Refill ≤ 5 sec Ø JVD
I	Edema		Slight edema noted to ↓ Extremities
A	Chest Pain		Ø chest pain
C			
R	Respiratory Pattern		RR- SPO2
E	Breath Sounds		Regular CTA Ⓑ
S	Secretions		Ø secretion
P	Cough		Ø cough @ present
S	Color		Normal for Race
K	Integrity		Burns healing well Ⓑ heel dressing A
I	Backside		daily no backside issues
N			
	Access Devices		I.V. @ TKO in Ⓛ AC
I	Location		patent s̄ S/S OF infection or infiltration
V	Condition		
	Abdomen		Soft Flat Non tender non distended
G	Bowel Sounds		BS Normo-active x4
I	Stoma/Ostomy		Ø ostomy
			Ø stoma
G	Device		urinal @ bedside
U	Color / Clarity		clear yellow (DARK)

(Continue on reverse)

PREPARED BY *(Signature & Title)*

DEPARTMENT/SERVICE/CLINIC (b)(2)-2 [redacted]

DATE 8-16-03

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

[redacted] (b)(6)-4

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

DA FORM 4700, MAY 78

USAPPC V2.00

ICU3 Patients Name: # [redacted] (b)(6)-4 Date: 16 Aug 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line	110/64				104/64		110/71																			
NBP														116/69				105/68				102/66				
TEMP	97.2				98.2		97.6							97.4				97.6				98.4				
HR	89				81		92							79				78				84				
RR	12				16		12							14				16				16				
SaO2	94				99%		97%							96%				94%				95%				
FiO2	RA				RA		RA																			
Source														RA				RA				RA				
M/														88				80				73				

MEDCOM - 13478

ITAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
														TKO					~~250~~							
B																										
T																										
2	NPO																									
PO																										
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE																			250							
NGT																										
STOOL																										
DRAIN																										
Total																										

ME . RECORD-SUPPLEMENTAL MEDICA

For use of this fo... ; see AR 40-66; the proponent agency is the Office of T... urgeon General.

REPORT TITLE	OTSG APPROVED *(Date)*
INTENSIVE CARE NURSING FLOW SHEET	**QA APPR 08MAR8**

INITIAL SHIFT ASSESSMENT

N		Time: 0700 Initals: [redacted] (b)(6)-2	Time: 0700 Initals:
E	Pupils		PERRL
U	Sensorium		A&O x3
R	LOC / GCS		purposeful movement x4
O			Follows commands
C	Cardiac Rhythm		HR-86 BP- 128/62
A	PRI: / QRS:		
R	Pulse Strength		⊕3 Peripheral pulses
D	Cap Refil / JVD		≥3 sec Ø JVD
I	Edema		Slight edema in lower extremities
A	Chest Pain		Ø chest pain
C			
R	Respiratory Pattern		RR-12 SPO2 97% RA
E	Breath Sounds		breath sounds CTA Ⓑ
S	Secretions		Ø sec
P	Cough		Ø cough
S	Color		NFR T-98.4
K	Integrity		healing burns Ⓑ heel dressing A
I	Backside		no breakdown
N			
	Access Devices		IV in Ⓛ forearm @ TKO
I	Location		
V	Condition		Patent
	Abdomen		Soft flat nontender
G	Bowel Sounds		BS normoactive x4
I	Stoma/Ostomy		Ø ostomy
			Ø stoma
G	Device		urinal @ bedside
U	Color / Clarity		dark yellow/Amber clear

(Continue on reverse)

PREPARED BY *(Signature & Title)*	DEPARTMENT/SERVICE/CLINIC	DATE
	(b)(2)-2 [redacted]	17 Aug 03

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

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

DA FORM 4700, MAY 78

USAPPC V2.00

ICU3 Patients Name: #[redacted] (b)(6)-4 Date: 17Aug03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP	116/74				102/60				102/62					128/62				118/68				122/66				
TEMP	98.4				97.9				96.6					98.4				98.6				97.6				
HR	94				72				64					86				77				73				
RR	11				12				10					12				12				14				
SaO2	91													97				97%				98%				
FiO2																										
Source	RA													RA				RA				RA				
M																										

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	To
IVF																										
IVPB																										
NGT																										
F																										
otal																										

O PUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
U NE									X1-500cc																	
NGT																										
STOOL																										
DRAIN																										
Total																										

MEDCOM - 13480

ME . RECORD-SUPPLEMENTAL MEDICA T.

For use of this f... see AR 40-66; the proponent agency is the Office of ... Surgeon General.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA APPR 08MAR8

INITIAL SHIFT ASSESSMENT

		Time: 0710 Initals: [redacted] (b)(6)-2	Time: Initals:
N			
E	Pupils	PERRLA	
U	Sensorium	A+O×3	
R	LOC / GCS	Responsive, Cooperative	
O			
C	Cardiac Rhythm	———	
A	PRI: / QRS:	———	
R	Pulse Strength	+3 in all extremeties	
D	Cap Refil / JVD	<3 secs, Ø JVD	
I	Edema	BLE	
A	Chest Pain	None	
C			
R	Respiratory Pattern	Regular, Unlabored	
E	Breath Sounds	Exp. Wheezing in upper & middle	
S	Secretions	lobes, Base's CTA	
P	Cough	Ø cough or secretions	
S	Color	Normal for race	
K	Integrity	Burn to chest Ⓑ arms, BLE, back	
I	Backside	& Buttocks	
N			
	Access Devices	IV ⊕ erythema, ⊕ pain	
I	Location	IV DC'd	
V	Condition		
	Abdomen	Soft & Nontender	
G	Bowel Sounds	Active x4	
I	Stoma/Ostomy	None	
G	Device	Not yet Voided	
U	Color / Clarity		

(Continue on reverse)

PREPARED BY *(Signature & Title)* [redacted] /sn

DEPARTMENT/SERVICE/CLINIC (b)(2)-2 [redacted]

DATE 18 Aug 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name – last, first, middle; grade; date; hospital or medical facility)* (b)(6)-2

[redacted] (b)(6)-4

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

DA FORM 4700, MAY 78

USAPPC V2.00

MEDCOM - 13481

ICU3

Patients Name: [redacted] (b)(6)-4 Date: 18 Aug 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP					98/70										101/68											
TEMP															98^{9}											
HR					96										92											
RR																										
SaO2					96										98%											
FiO2					RA																					
Source																										

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
/F																										
/PB																										
IGT																										
I		118					240			60			418													
otal																										

TPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE			500										500													
NGT																										
STOOL																										
DRAIN																										
Total																										

MEDCOM - 13482

MEI RECORD-SUPPLEMENTAL MEDICA. A

For use of this fo.. .ee AR 40-66; the proponent agency is the Office of Th.. .urgeon General.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA APPR 08MAR8

INITIAL SHIFT ASSESSMENT

N		Time: 0700 Initals: [redacted] (b)(6)-2	Time: 1850. Initals: [redacted] (b)(6)-2
E	Pupils	PERRL	3mm PERRL. Pt is responsive to
U	Sensorium	Pt responsive to touch	verbal stimuli and is able to
R	LOC / GCS	+ Voice stimuli	follow simple commands
O			
C	Cardiac Rhythm		Reg Rate + Rhythm.
A	PRI: / QRS:	(b)(6)-2	(+)2 Radial and (B) pedal
R	Pulse Strength	[redacted] Radial + Pedal @ +2 c̄ brisk cap	pulses. <2sec cap refill
D	Cap Refil / JVD	refill. 0 JVD	
I	Edema	BLE	
A	Chest Pain	0 Ntd	
C			
R	Respiratory Pattern	Reg R+R c̄ equal rise + fall	Even and unlabored. (L)
E	Breath Sounds	inpiratory + expiratory wheezes	side Insp/Exp wheezes
S	Secretions	in upper + middle lobes bilat.	noted.
P	Cough	Bases CTA. 0 Ntd cough or	
		Secretions.	
S	Color	NFR	Normal for race; Drsg to
K	Integrity	dressings intact	burn areas D + I.
I	Backside		
N			
	Access Devices	0	None.
I	Location		
V	Condition		
	Abdomen	Soft + round	BSx4. Abd soft and non
G	Bowel Sounds	+ x 4 quads	tender. Pt States last
I	Stoma/Ostomy	0	BM 3 days ago.
G	Device	Pt voids to urinal @ bedside	Voiding per urinal
U	Color / Clarity		

(Continue on reverse)

PREPARED BY *(Signature & Title)*

DEPARTMENT/SERVICE/CLINIC (b)(2)-2 [redacted]

DATE

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

[redacted] (b)(6)-4

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

DA FORM 4700, MAY 78

USAPPC V2.00

MEDCOM - 13483

ICU3

Patients Name: # [redacted] (b)(6)-4 Date: 19 Aug 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line	~~103/~~		103/																							
NBP	~~69~~		69													104/65										
TEMP	~~98.6~~		98.6													96.6										
HR	~~87~~		87													79										
RR	~~14~~		14													16										
SaO2	~~97%~~		97%													95%										
FiO2																										
Source																RA										

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Tota
IVF																										
IVPB																										
NGT																										
PO																										
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE																					350					350
NGT																										
STOOL																										
DRAIN																										
Total																										

ME . RECORD-SUPPLEMENTAL MEDIC TA

For use of this ... see AR 40-66; the proponent agency is the Office of ... urgeon General.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA APPR 08MAR8

INITIAL SHIFT ASSESSMENT

N		Time: 0800 Initals: [redacted] (b)(6)-2	Time: 1845. Initals: [redacted] (b)(6)-2
E	Pupils	PERLLA	2mm PERL. Pt is A+O X3. Pt
U	Sensorium	A+O x 3	able to follow commands and
R	LOC / GCS	~~Foll~~ Follows Commands	is responsive to verbal stimuli.
O		[redacted] (b)(6)-2	
C	Cardiac Rhythm	—	~~+2~~ Reg rate - S1-S2. +2 Ⓑ
A	PRI: / QRS:	—	palpable radial + pedal pulses.
R	Pulse Strength	+3 in all extremities	cap refill <3sec.
D	Cap Refil / JVD	<3 secs, Ø JVD	
I	Edema	None	
A	Chest Pain	None	
C			
R	Respiratory Pattern	Regular & Unlabored	Reg. + unlabored. Insp & Exp.
E	Breath Sounds	Insp/Exp. Wheezing auscultated	wheezes noted to Ⓑ upper & middle
S	Secretions	in Ⓑ upper + lobes.	lat lobes. Diminished @ bases.
P	Cough	Ø Cough or Secretions	Ø cough noted
S	Color	Normal for race	Warm & dry. Dsg intact to
K	Integrity	Burn to chest, Ⓑ UE, Ⓑ LE,	burn areas s̄ drng noted
I	Backside	Back, + [redacted] Buttocks	
N		(b)(6)-2	
	Access Devices	None	None.
I	Location		
V	Condition		
	Abdomen	Soft, Nontender	Soft and nontender. Hypo BS x4
G	Bowel Sounds	Hypoactive	last BM ~ 4 days ago per
I	Stoma/Ostomy	—	patient.
		Ø N/V	
G	Device	Pt has not yet voided	Voids per urinal
	Color / Clarity		
U		(b)(6)-2	

(Continue on reverse)

PREPARED BY *(Signature & Title)* [redacted] (b)(6)-2

DEPARTMENT/SERVICE/CLINIC (b)(2)-2 [redacted]

DATE 20Aug03

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

EPW #[redacted] (b)(6)-4

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

DA FORM 4700, MAY 78

USAPPC V2.00

ICU3 Patients Name: [redacted] (b)(6)-4 Date: 20 Aug 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP			100/68													110/72		~~[illegible]/75~~								
TEMP			98													974										
HR			75													80		~~88~~								
RR			14													15		~~12~~								
SaO2			95													99%		~~100%~~								
FiO2			RA													RA		~~RA~~								
Source																										
N																										

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Tot
IVF																										
IVPB																										
NGT																										
PO			180						240	236			656													
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	al
URINE															280								500			
NGT																										
STOOL																										
DRAIN																										
Total																										

MEDCOM - 13486

ME RECORD-SUPPLEMENTAL MEDICAl

For use of this fo se AR 40-66; the proponent agency is the Office of T geon General.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA APPR 08MAR8

INITIAL SHIFT ASSESSMENT

N		Time: Initals:	Time: Initals:
E	Pupils		
U	Sensorium		
R	LOC / GCS		
O			
C	Cardiac Rhythm		
A	PRI: / QRS:		
R	Pulse Strength		
D	Cap Refil / JVD		
I	Edema		
A	Chest Pain		
C			
R	Respiratory Pattern		
E	Breath Sounds		
S	Secretions		
P	Cough		
S	Color		
K	Integrity		
I	Backside		
N			
	Access Devices		
I	Location		
V	Condition		
	Abdomen		
G	Bowel Sounds		
I	Stoma/Ostomy		
G	Device		
U	Color / Clarity		

(Continue on reverse)

PREPARED BY *(Signature & Title)*

DEPARTMENT/SERVICE/CLINIC (b)(2)-2 [redacted]

DATE 21Aug03

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

EPW [redacted] (b)(6)-4

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

DA FORM 4700, MAY 78

USAPPC V2.00

MEDCOM - 13487

ICU3

Patients Name: [redacted] (b)(6)-4 Date: 21 Aug 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP				108/70																						
TEMP				97.7																						
HR				103																						
RR				16																						
SaO2				96																						
FiO2				RA																						
Source																										
MAP																										
TAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
B																										
T																										
PO																										
Total																										
OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	
URINE																										
NGT																										
STOOL																										
DRAIN																										
Total																										

MEDCOM - 13488

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE **Post-Anesthesia Care Unit (PACU) Flow Sheet**

OTSG APPROVED *(Date)*

Date: 26 Aug03 Anesthesia Type (Circle)): [✓ General] Spinal Epidural IV Sedation Nerve Block
Time In: 1030
Allergies: NKDA OR Intake: Crystalloid 300 Colloid
Pre-op V/S: 96/59 P-88 OR Output: UOP Ø EBL min
Procedures: full thickness skin graft to b/l heels, partial (R) thumb amp. Meds/Times: Ancef, Zofran, fentanyl patch 50mcg. MSO4

Drains
Hemovac
NG
[✓ JP] bil
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds History

Time	1030	1035	1040	1055	1110	1125	1130
SaO2	99	98	98	97	98	97	92
FiO2							
Methods							
240							
220							
200							
180							
160							
140							
	V						
120		V	V	V	V		V
						V	
100					•		
	•	•	•	•		•	
80							•
	Λ	Λ	Λ	Λ	Λ	Λ	
60							Λ
40							
20							
RR	16						
T	95.7	96.2			97		

Time					
Pain (0-10)					
LOS					

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1030	LR	300	(L) AC	OR	100

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30"	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	1	1	1
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	1	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	2	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	N/A	—	—
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	9	8	9

Codes

AIRWAY
A = Ambu
BB = Blow-by
M = Mask
FT = Face Tent
RA = RoomAir
NC = Nasal Cannula

V/S
X = A-line BP
˅ = Cuff BP
• = Pulse

TEMP
S = Skin
O = Oral
A = Axillary
T = Tympanic
R = Rectal

LOS
C = Cervical
T = Thoracic
L = Lumbar
S = Sacral

Patient teaching done: Wound Care, Pain Management,
T, C, & DB,. Incentive Spirometer, Comfort Measures
Safety: SR up X 2, Falls Precautions. Privacy Maintained

(Continue on reverse)

PRE[redacted]*Signature & Title)* LPN / [redacted] LPN

DEPARTMENT/SERVICE/CLINIC PACU

DATE 26 Aug03

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

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

#[redacted] (b)(6)-4

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

DA FORM 4700, MAY 78 **WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN)** **Previous edition is obsolete**
USAPPC V2.00

97% ASA III
hx Asthma, DVT.

MEDCOM - 13489

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1120		MSO4 2mg	IV		E	RL

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm							
15'							
30'							
45'							
60'							
90'							
D/C							

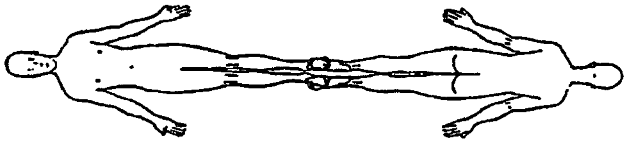
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

	Adm	15'	30'	45'	60'	90'	D/C
Fund. Height							
Lochia							
Peripad#							
Fund. Cond.							

DRESSINGS

Time	Location	Type	Drainage
Adm 1030	B/L heels	Ioband	0
~~30'~~	B/L buttocks	4X4 gauze	0
~~60'~~	(R) hand	Kerlix	0
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1130	NSR	NO	NO

WAMC OP 173-E

NURSING NOTES

1030 pt rec'd via litter by OR. pt breathing on his own JP drains hooked up to cont ox. VSS. O2 given via face mask @6L Will cont to monitor [redacted] (b)(6)-2
1040 O2 ↓ to 4L c̄ NC [redacted]
1050 O2 ↓ to 2L pt O2 Sat 98% [redacted]
1100 O2 ↓ to 0.5L pt O2 Sat 97%
1110 O2 ↓ to 0, pt Sat 97% pt c/o Pain in (R) hand, [redacted] (b)(6)-2 notified [redacted] (b)(6)-2
1120 2mg MSO4 IV given by [redacted] (b)(6)-2 [redacted] (b)(6)-2

Discharge Criteria:
Date: 8/24/03 **Time:** 1130 **PARS:** 9
BP: 121/68 **T** 97.2 **HR:** 87 **RR:** 16 **SaO2:** 97%
Pain Level at D/C (0-10):
Intake: 325 **Output:** 0
Additional Data:
Transferred To: ICW2
Report Given To:
Transferred Via: W/C [✓ Litter] Gurney Ambulance
Transferred By: SGT [redacted] (b)(6)-2
Cleared IAW Recovery Room SO[redacted]
Charge Nurse Signature: [redacted]

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE **Post-Anesthesia Care Unit (PACU) Flow Sheet**

OTSG APPROVED *(Date)*

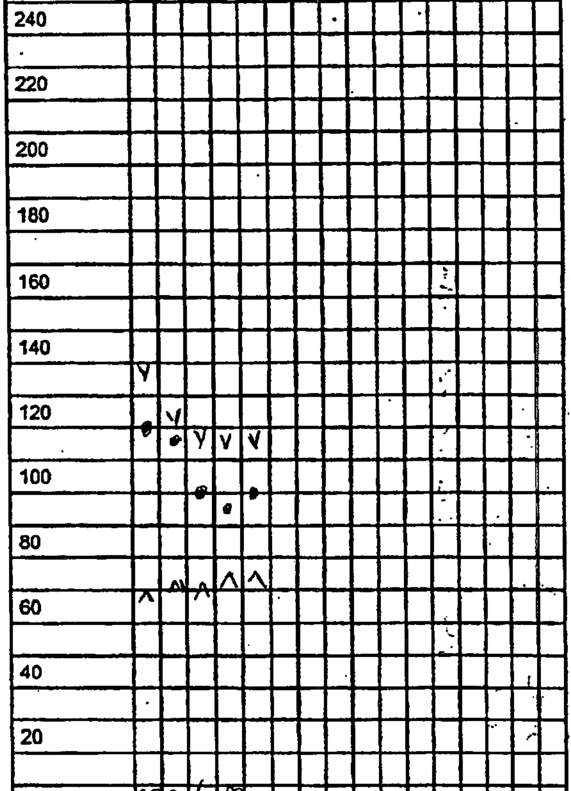
Date: 27 AUG 03 Anesthesia Type (Circle)): [✓ General] Spinal Epidural IV Sedation Nerve Block + PRBC
Time In: 1120
Allergies: NKDA OR Intake: Crystalloid 800 Colloid 1 unit blood 500cc LR
Pre-op V/S: 100/60 120 OR Output: UOP Ø EBL 50
Procedures: Washout closure buttocks area Meds/Times: Fentanyl 250mcg

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds History

Time	1120	1125	1135	1145
SaO2	96	100	95	95
FiO2	2L	2L		
Methods	NC	NC	RA	RA



RR	13	10	16	13	18
T	[illegible]	[illegible]			

Time								Patient teaching done: Wound Care, Pain Management.
Pain (0-10)								T, C, & DB,. Incentive Spirometer, Comfort Measures
LOS								Safety: SR up X 2, Falls Precautions. Privacy Maintained

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1120	LR	600	(L) AC	DR	400

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	2	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	1	1	1
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	N	A	
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	9	9	9

Codes

AIRWAY
A = Ambu
BB = Blow-by
M = Mask
FT = Face Tent
RA = RoomAir
NC = Nasal Cannula

V/S
X = A-line BP
˅ = Cuff BP
• = Pulse

TEMP
S = Skin
O = Oral
A = Axillary
T = Tympanic
R = Rectal

LOS
C = Cervical
T = Thoracic
L = Lumbar
S = Sacral

(Continue on reverse)

PREPARE[redacted] & Title) (b)(6)-2

DEPARTMENT/SERVICE/CLINIC PACU

DATE 27 AUG 03

[redacted] typed or written entries give: *Name — last, first, middle; grade; date; hospital or medical facility)*

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

[redacted] (b)(6)-4

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

DA FORM 4700, MAY 78 WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) Previous edition is obsolete USAPPC V2.00

MEDCOM - 13491

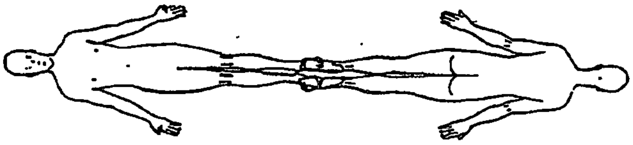
MEDICATIONS						
Allergies:						
Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By

NEUROVASCULAR							
Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm							
15'							
30'							
45'							
60'							
90'							
D/C							

Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS							
	Adm	15'	30'	45'	60'	90'	D/C
Fund. Height							
Lochia							
Peripad#							
Fund. Cond.							

DRESSINGS			
Time	Location	Type	Drainage
Adm	buttocks	2X2 c̄ tape	Ø
30'			
60'			
D/C			



PACU OUTPUT			
Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM			
Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1110	NSR	Ø	Ø

WAMC OP 173-E

NURSING NOTES

Pt to Recovery Room from OR s/p washout/closure. 2X2 c̄ tape to buttocks Area. Kerlix to (R) hand Coban to bil. heels. IV of LR infusing into (L) AC. Ø s/s of Redness or edema to site. VS-BP 116/68 P-87 R-12 SpO2 95% RA. Ø c/o. (b)(6)-2 Will continue to monitor [redacted] to ICW #1 Report given to LA 2LT [redacted] [redacted] RN
(b)(6)-2 (b)(6)-2

Discharge Criteria:
Date: 27Aug03 Time: 1150 PARS: 9
BP: 115/66 T: 96.9 HR: 88 RR: 16 SaO2: 97%
Pain Level at D/C (0-10): 0
Intake: 50 Output: Ø
Additional Data:
Transferred To: ICW #1
Report Given To: 2LT [redacted] (b)(6)-2
Transferred Via: W/C [✓ Litter] Gurney Ambulance
Transferred By: SGT [redacted] (b)(6)-2
Cleared IAW Recovery R[redacted]
Charge Nurse Signature[redacted]
(b)(6)-2

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DAT

this form, see AR 40-66; the proponent agency is the Office of The Surg

OTSG APPROVED *(Date)*

REPORT TITLE Post-Anesthesia Care unit (PACU) Flow Sheet

Date: 7OCT03
Time In: 1703
Allergies: NKDA
Pre-op V/S: 134/73 91
Procedures: CLOSURE buttocks wounds

Anesthesia Type (Circle)): [✓ General] Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 700 Colloid
OR Output: UOP 45 EBL min
Meds/Times: Fentanyl

Drains
~~Hemovac~~
~~NG~~
~~JP~~
~~T-tube~~
~~Foley~~
~~TLS~~

Airway
~~Nasal~~
~~Oral~~
~~ETT~~
~~Trach~~
~~Other~~

Pre Op Meds

History

Time	1705	1710	1715	1720												
SaO2	100	100	8													
FIO2																
Methods	RA	RA	RA													
240																
220																
200																
180																
160																
140																
120	V	V														
	•		V													
100				V												
80	^	^														
		•	•	•												
60			^	^												
40																
20																
RR	18	25	18													
T	96															

Time									
Pain (0-10)	[redacted]								
LOS									

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1705	LR	200	L Arm	LR	800

X-rays:

Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	2	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse			
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	10	10	10

Codes

AIRWAY
A = Ambu
BB = Blow-by
M = Mask
FT = Face Tent
RA = RoomAir
NC = Nasal Cannula

V/S
X = A-line BP
˅ = Cuff BP
• = Pulse

TEMP
S = Skin
O = Oral
A = Axillary
T = Tympanic
R = Rectal

LOS
C = Cervical
T = Thoracic
L = Lumbar
S = Sacral

Patient teaching done; Wound Care, Pain Management,
T. C. & DB.: Incentive Spirometer, Comfort Measures
Safety: SR up X 2, Falls Precautions. Privacy Maintained

(Continue on reverse)

[redacted] (b)(6)-2

DEPARTMENT/SERVICE/CLINIC PACU

DATE 7OCT03

or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)

[redacted] (b)(6)-4

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

DA FORM 4700, MAY 78 WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) Previous edition is obsolete
USAPPC V2.00

MEDCOM - 13493

All (b)(6)-2

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Roule	Pain 1-10	I/E	By
1720		Demerol 25mg	IV	for shivering		[redacted]
1730		MSO4 3mg	IVP			
					(b)(6)-2	

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm							
15'							
30'							
45'							
60'							
90'							
D/C							

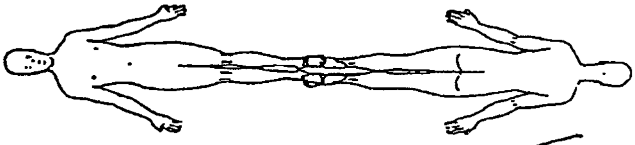
Movement/Sensation: + = present,- = absent Temp:C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

	Adm	15'	30'	45'	60'	90'	D/C
Fund. Height							
Lochia							
Peripad#							
Fund. Cond.							

DRESSINGS

Time	Location	Type	Drainage
Adm	buttocks	bulky gauze & tape	mod
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1705	SR	∅	∅

NURSING NOTES

Pt to recovery room from OR via litter s/p closure buttocks wounds. Bulky gauze & tape to buttocks area c̄ mod amt drainage. IV of LR infusing into (L) arm. ∅ s/s of redness or swelling. ∅ c/o. VSS. Will continue to monitor [redacted]
-1730- Pt c/o pain. Medicated c̄ 3mg MSO4! [redacted]
(b)(6)-2

Discharge Criteria:
Date: 7 Oct Time: 1730 PARS:
BP: 92/54 T: 96.2 HR: 69 RR: 22 Sa02: 100
Pain Level at D/C (0-10):
Intake: 50 Output: ∅
Additional Data:
Transferred To: ICW #1
Report Given To:
Transferred Via: W/C [redacted] Gurney Ambulance
Transferred By: [redacted] (b)(6)-2
Cleared IAW Rec Room SOP [redacted]
Charge Nurse Signature: [redacted]

WAMC OP 173-E MEDCOM - 13494

ACLU-RDI 1592 p.1388

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF

1	2	3	4	5	6
A	1	1	D	1	▨

2. MTF LOCATION *(State or Country Code.)*

7
I

3. REGISTER NUMBER

9	10	11	12	13	14	15
[redacted]						

NAME *(Last, First, Middle Initial)* (b)(6)-4
[redacted]

4. PAY GRADE

16	17

5. SEX

18
M

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

19	20	21	22	23	24	25	26

7. AGE AT ADMISSION

27	28	29

8. RACE

30
2

9. ETHNIC BACKGROUND

31
9

RELIGION UNK

10. LENGTH OF SERVICE

32	33	34

ETS NA

11. FMP

35	36
9	9

12. SOCIAL SECURITY NUMBER

37	38	39	40	41	42	43	44	45
[redacted]								

ORGANIZATION *(Active Duty Only)* NA

13. MARITAL STATUS

46
Z

HOUR OF ADMISSION 1000

BRANCH / CORPS (b)(6)-4 NA

14. FLYING STATUS

47	48	49
N		

15. BENEFICIARY CATEGORY

50	51	52
K	7	8

16. ZIP CODE OF RESIDENCE

53	54	55	56	57	58	59	60	61

17. UNIT LOCATION *(State or Country Code)*

62	63
I	Z

18. MOS

64	65	66	67	68	69	70

19. TRAUMA

71

PREV. ADMISSION
YEAR
☒ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION

72
O

WARD ICW1

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE UNK

ADDRESS OF EMERGENCY ADDRESSEE *(Include ZIP Code)* UNK

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE UNK

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(2)-2
[redacted]

21. TYPE OF DISPOSITION

73	74
2	4

22. MTF TRANSFERRED TO

75	76	77	78	79	80

23. DATE OF DISPOSITION *(Y Y M M D D)*

81	82	83	84	85	86
0	3	1	0	1	6

24. CLINIC SVC - ADMITTING

87	88	89	90
A	B	A	A

25. MTF TRANSFERRED FROM

91	92	93	94	95	96

26. DATE THIS ADMISSION *(Y Y M M D D)*

97	98	99	100	101	102
0	3	0	9	0	6

27. LOCATION OF OCCURRENCE *(Battle Casualty Only)*

103	104

28. MTF OF INITIAL ADMISSION

105	106	107	108	109	110

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

111	112	113	114	115	116

FOR LOCAL USE

ADMITTING OFFICER *(Signature, as required)*

SIGNATURE OF ADMITTING CLERK (b)(6)-2
Dr [redacted] [redacted]

DA FORM 3985 MAR 89

MEDCOM - 13495

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF

1	2	3	4	5	6
A	l	l	D	l	▨

2. MTF LOCATION (State or Country Code.)

7	8
I	Z

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

[redacted]

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

HVD [redacted]

[redacted] (b)(6)-4

4. PAY GRADE

16	17

HVD

5. SEX

18
m

6. DATE OF BIRTH (Y Y Y Y M M D D) (b)(6)-4

[redacted]

7. AGE AT ADMISSION

27	28	29
[redacted]		

8. RACE

30
Z

9. ETHNIC BACK-GROUND

31
Z

RELIGION unk

10. LENGTH OF SERVICE

32	33	34

ETS

11. FMP (b)(6)-4

35	36
9	9

20

12. SOCIAL SECURITY NUMBER

37	38	39	40	41	42	43	44	45
[redacted]								

ORGANIZATION (Active Duty Only)

13. MARITAL STATUS

46
Z

HOUR OF ADMISSION 0929

BRANCH / CORPS (b)(6)-4 —

14. FLYING STATUS

47	48	49

15. BENEFICIARY CATEGORY

50	51	52
K	7	8

16. ZIP CODE OF RESIDENCE

53	54	55	56	57	58	59	60	61

17. UNIT LOCATION (State or Country Code)

62	63
I	Z

18. MOS

64	65	66	67	68	69	70

19. TRAUMA

71
9

PREV. ADMISSION YEAR ☒ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION

72
0

WARD ICU3

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE unk

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) unk

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE unk

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] (b)(6)-2

21. TYPE OF DISPOSITION

73	74
0	5

22. MTF TRANSFERRED TO

75	76	77	78	79	80

23. DATE OF DISPOSITION (Y Y M M D D)

81	82	83	84	85	86
0	3	1	0	1	7

24. CLINIC SVC - ADMITTING

87	88	89	90
A	B	M	A

25. MTF TRANSFERRED FROM

91	92	93	94	95	96

26. DATE THIS ADMISSION (Y Y M M D D)

97	98	99	100	101	102
0	3	0	7	0	3

27. LOCATION OF OCCURRENCE (Battle Casualty Only)

103	104

28. MTF OF INITIAL ADMISSION

105	106	107	108	109	110

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

111	112	113	114	115	116

FOR LOCAL USE

DX: 3T56

DX: 0389
4538
94524
94523
94520
94522
94810
E988.1

Px: 8609
863
8669 (X2)

(b)(6)-2

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

Dr. [redacted]

[redacted]

[redacted]

F ADMITTING CLERK

—(b)(6)-2

MEDCOM - 13496

INPATIENT TREATMENT RECORD COVER SHEET

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

(b)(6)-4

1. REGISTER NUMBER [redacted]
2. NAME (Last, First, MI) EPW # [redacted] (b)(6)-4
3. GRADE EPW
4. SEX M
5. AGE [redacted] (b)(6)-4
6. RACE
7. RELIGION ——
8. LENGTH OF SVC ——
9. ETS ——
10. PREVIOUS ADMISSION NO
11. FMP 99
12. SSN (b)(6)-4 [redacted]
13. ORGANIZATION ——
14. WARD ICW2
15. FLYING STATUS ——
16. RATING/DSG ——
17. DEPT./BEN K78
18. BRANCH/CORPS ——
19. UIC/ZIP ——
20. TYPE CASE WIA
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct From ER
22. HOURS OF ADMISSION 1010
23. CLINIC SERVICE AEAA
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE UNK
25. TYPE DISPOSITION 50
26. DATE OF DISPOSITION 10 Aug03
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) UNK
27b. TELEPHONE NO. UNK
28. DATE OF THIS ADMISSION 3 July 03
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] (b)(2)-2
30. DATE OF INITIAL ADMISSION
31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

ADMISSION REMARKS

ADMITTING OFFICER DR. [redacted] (b)(6)-2

32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED

33. CAUSE OF INJURY unknown

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Dx: GSW to Ⓡ thigh, ex fix

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	1mth/7days	1mth/7days

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
	(b)(6)-2				

SIGNATURE OF ATTENDING MEDICAL OFFICER DR [redacted] [redacted]

SIGNATURE [redacted] OR MEDICAL RECORDS OFFICER (b)(6)-2

MEDCOM - 13497

MEDICAL RECORD	**ABBREVIATED MEDICA :CORD**

PERTINENT HISTORY, CHIEF COMPLAINT, AND CONDITION ON ADMISSION *(Enter date of admission)*

(b)(6)-4
[redacted] y/o EPW, shot in (R) thigh while attempting to escape. Had ext fix applied to (R) femur at local hospital

PMH - ⊖

NKDA

PHYSICAL EXAMINATION

HEENT - AT/NL

Lungs - clear

Chest - AT/NL

~~LUE~~ EXT - EXT FIX ON (R). Shows draining pin sites. Entire thigh wound closed with staples. No motor in (R) ~~foot.~~ No [illegible] ↓ sensation (R) foot

PROGRESS *(Enter date of discharge and final diagnosis)*

X-rays - pending

(A) (R) thigh GSW with fem Fx

(P). Admit. [illegible] consult, etc

(b)(6)-2

SIGNATURE OF PHYSICIAN	DATE	IDENTIFICATION NO.	ORGANIZATION
[redacted]	30 Nov 03		

PATIENT'S IDENTI[redacted] *(For typed or written entries give Name last, first, middle; grade; date; hospital or medical facility)*

REGISTER NO.	WARD NO.

(b)(6)-4
[redacted]

ABBREVIATED MEDICAL RECORD
Standard Form 539

GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
USAPPC V1.00

509-113

MEDICAL RECORD | (b)(6)-4 | PROGRESS NOTES

DATE

2215 EPW # [redacted] presented to Aid station with
2Jul03 Ⓡ thigh external fixature. Upon arrival
IV was initiated. (b)(6)-2
T: 101 - 18 GA Ⓛ AC. Bag #2 — SGT [redacted]
P: 112 - Ancef 1 Gram @ 2145 91W
R: 18 - Tylenol 500mg x2 @ 2200
BP: 124/65 - Morphine 10mg IM @ 2210
SAO2: 98% Patient was shooting at Americans and got shot in
the thigh. He was taken to an Iraqi Hospital
PMHx: where an external fixation was placed. He
None cannot feel his Ⓡ foot or move his Ⓡ foot
PSHx:
None
O: Ⓡ femur with anterolateral incision with
All: 24 staples for closure ~ 20cm long. He has
NKDA ex Fix on Ⓡ thigh. Weeping fluid from
Meds: Pin sites. There is swelling at the incision
None site that weeps serous fluid.

He cannot feel or move his Ⓡ foot.
while he has no problem with the Ⓛ.
Mild Ⓡ LE swelling

3:10 BP 110/51 P-104 SpO_2-91 R-16 T-98.6. Pt given 975 mg
Tylenol po. Pt. given 1gr. Ancef. IV. — [redacted]
(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.

EPW # [redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV.)
Prescribed by GSA/ICMR

P) 1. admit to Pt Hold (See orders.)
2. Ancef 1 gm IV Q6H
3. Morphine Sulfate 10mg IM Q8H
4. tylenol 1000 mg Q6H prn.
5. Regular diet
6. Vitals Q4H
call HO for SBP ≥ 150 ≤ 90, DBP ≥ 110 ≤ 50
pulse ≥ 110 ≤ 60 temp ≥ 100.4
7. will hold in patient hold ~~for~~ ~~[illegible]~~ observation.

(b)(6)-2

[redacted] MD
MAJ, MC, USA

NSN 7540-00-634-4176 AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
0600 3 July03	Pt given 10mg IM [redacted] (b)(6)-2 S: Patient slept all night s̄ discomfort O: Gen NAD Lungs: CTAB CV: RRR s̄m Abd- soft NT ND+BS A: (R) Femur FX c̄ Ex-Fix P: 1. Continues to weep large amounts of fluid from surgical wound 2. Continue to Monitor (b)(6)-2 [redacted] MAJ, MC, USA

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.

EPW # [redacted] (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

MEDCOM - 13501

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
3JUN03 8:30	BP $^{107}/_{53}$ P-101 SpO$_2$-92 R-20 T-99 pt. given 975mg Tylenol po (b)(6)-2 [redacted]
8:4	Pt. evacted to (b)(2)-2 [redacted]. relesed from Patient hold (b)(6)-2 [redacted]

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.

EPW # [redacted] (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

MEDCOM - 13502

A11: (b)(6)-2

ME | FIRST NAME | MIDDLE INITIAL | ID NUMBER

ATE | NOTES

3 Jul 03 (1230) Pt received via litter from EMT. EXT. Fix Ⓡ leg intact. Pt awake & alert. VSS. Lungs CTA & =. Pulses strong & =. Ⓡ foot edematous. BS⊕x4. IV SL. intact Ⓛ arm. [redacted]

1245 98.8 / 108 / 18 / 126/70 / 98%

3 July 03-1400: assumed pt care @ 1300. VSS. pt awake & alert. lung sounds CTA, abd soft nontender, nondistented BS⊕x4 quads. BUE c̄ full ROM ⊕ pulses, IV Ⓡ FA HL'd flushes well ⊘ redness/swelling noted. Ⓡ leg c̄ ext fix drsing CDI, knee ↓ to toes c̄ edema ⊕ pulse. Ⓛ LE c̄ full ROM ⊕ pulse. Foley cath to gravity intact, emptied 1600 cc cl yellow urine. ⊘ c/o pain voiced @ this time. Will cont to monitor —— [redacted] 91WM6 SGT

2030 Emptied 400cc cl yellow urine from foley. [redacted] 91WM6 SGT

3 Jul 03 2150 Rec'd pt @ 21:00. Pt awake + alert in bed. VS WNL x ↑ temp 101.0°. will monitor + retake. Skin W/D. PERRLA⊕ WNL. LCA Ⓑ BS⊕x4. ⊕PPP Ⓑ. Ⓡ LE Ext DSD removed small abrasion noted + open to air. to Ⓛ of abrasion small blister noted. Ⓡ LE ext fix in place c̄ ACE wrap dsg applied. C/D/I. PIV Ⓡ FA patent. ~~Able to move and feel sensation in toes.~~ toes warm to touch. Pt. ⊖ able to move toes, but able to feel toes. Will cont. to mon [redacted]

0013 Temp retake 100.2 ii Tylenol given [redacted]

late entry @ 2205 Pt c/o pain to Ⓡ LE. 5mg MSO4 given Will monitor. [redacted]

All (b)(6)-2 except bottom one.

AUTHORIZED FOR LOCAL REPRODUC

:AL RECORD | PROGRESS NOTES

'E | NOTES

4Jul03 (0600) Pt awake and alert. VSS-NAD. Ext. fix. intact.
Lungs CTA B=. Pulses strong B=. BS ⊕ x4. —
Ⓡ foot edematous. IV as ordered saline
0500 98.6 locked, flushes easily, site s̄ redness
95 or edema. Resting quietly @ present [redacted]
18
120/54 (1000) Pin site care done c̄ 1/2 str H2O2, dry sterile
96% dsg to pins as ordered. Wounds c̄ small amt serous
drainage. Ace wrap to Ⓡ thigh. Procedure
tol. well. ——— [redacted]

4Jul03 assumed care @ 1300 - VSS, T 100.0°F -
1510 ex fix in place in Ⓡ femur, dsg CDI, staples
intact on outer Ⓡ thigh, pt. can't wiggle Ⓡ
toes, <2 sec. cap. refill in Ⓡ toes. - no c/o
pain @ this time - SL patent - [redacted]

[illegible]Jul03 pt. up to bedside commode, had large
1830 soft BM - pt. very unsteady when standing,
can't bear weight or move Ⓡ leg independently,
Ⓡ foot appears floppy, can't wiggle toes
——— [redacted]

4Jul03 @ 2300 Restarted IV to Ⓛ FA. Antbx infusing s̄
complications. Will cont to mon [redacted]

HIP TO SPONSOR | SPONSOR'S NAME LAST | FIRST | MI | (SSN or Other)

RVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

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

REGISTER NO

WARD NO ICW 2

EPW [redacted] (b)(6)-4

PROGRESS NOTES
Medical Record
STANDARD FORM 509 (REV 5-)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11 203(b)

DICAL RECORD

AUTHORIZED FOR LOCAL RE

PROGRESS NOTES

DATE	NOTES
4 Jul @ 2330	Pt a/ox3, VSS, lcTA Ⓑ ⊕ BS x4 qds. abd soft, ND ⊖TTP. Ⓡ foot slightly edematous. Ex fix in place drsg CDI, Staples intact Ⓡ foot has brisk cap refill, pt can wiggle toes Pin care done. Small amt of serous drainage noted. ∅ c/o pain @ this time. Will cont to monitor & support (b)(6)-2 [redacted] 91WM6-Spc
5 JUL 03	VSS. NAD. EXT. FIX. INTACT. Pt awake, alert. S.L. intact, flushes easily. Lungs CTA & =. Pulses strong & =. BS ⊕ x4. DSG to incision on thigh D&I. Resting quietly ē present. (b)(6)-2 [redacted]
5 July 03 1320	assumed pt care @ 1300. pt awake & alert. lungs CTA b/lat, abd soft, nontender BS ⊕ x4 quads. foley cath intact. Ⓛ leg c̄ full ROM ⊕ pulse. Ⓡ thigh c̄ ext fix drsng CDI. Ⓡ foot edematous ⊕. pulse. BUE c̄ full ROM ⊕ pulses. HL to Ⓛ FA ∅ S/Sx of infection noted. pt voices ∅ complaints @ this time. Will cont to monitor [redacted] 91WM6, SGT (b)(6)-2

NSHIP TO SPONSOR

SPONSOR'S NAME

LAST

FIRST

MI

SPONSOR'S ID N (SSN or Other)

SERVICE

HOSPITAL OR MEDICAL FACILITY

RECORDS MAINTAINED AT

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

EPW # [redacted] (b)(6)-4

PROGRESS NOTES
Medical Record
STANDARD FORM 509

All (b)(6)-2 except one at bottom.

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
05Jul 2324	Received pt resting in bed. Alert, easily awoken.
	LSCTAB, BS⊕x4, HRR, ABD SNT. RLE ↑ on folded
	blanket. Toes warm, pulse strong. Drsg Δ'd
	small amt serosang. drainage noted around pins.
	pin care done. Drsg c/d/i. IV patent & intact
	Ⓛ fa. Will cont to monitor. [redacted]
6 July 03	0700 - Pt alert lying in bed. VSS, Lungs CTA,
	HR reg, BS⊕. Pulses strong & equal bilat to
	↑ & ↓ extremities. Dsg to Ⓡ ext fix thigh. HL to
	Ⓛ forearm infusing Antibiotics. No complaints
	this AM. Will cont. to monitor —— [redacted] 2Lt
6 July 03 1030	Foley D/C'd @ 1030 —— [redacted] 2Lt AN
6 July 03 1320	assumed pt care @ 1300. pt resting quietly. VSS. lungs
	CTA, abd soft BS⊕x4. Ⓛ ext c̄ full ROM ⊕ pulse. Ⓡ thigh
	c̄ ext fix drsng CDI. ⊕ pulse. BUE c̄ full ROM ⊕
	pulses; HL to Ⓛ FA ⊖ S/Sx of infection noted. ⊖ c/o
	pain voiced @ this time. Will cont to monitor - [redacted] 91W
07Jul03 0131	Received pt resting in bed. Alert, VSS, LSCTAB,
	HRR, ABD SNT, BS⊕x4. 3VQS. RLE ↑ on one folded
	blanket, Pin care + RLE drg Δ'd. minimal serosang.
	drainage noted. Will cont to monitor. R toes warm; cap refill good [redacted]

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

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.

EPW # [redacted] (b)(6)-4

PROGRESS NOTES
Medical Record
STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10

MEDCOM - 13506

7 July03 (0800) VSS. NAD. EXT. Fix intact. DSG to pin sites D+I. S.L. flushes easily, site s̄ redness or edema. BBS CTA&=. Pulses strong&=

0800 99.0 pulse distal to ex strong. Tolerated reg diet
95 well. Resting quietly @ present. [redacted]
14 (b)(6)-2
134/74
98%

1430 Assumed care of Pt @ 1300. VSS. A+Ox3. Ø c/o pain. D/S9 15x Fix Ⓡ LE CDI. Ⓕ sensation, cap refil <3sec, palpable pulse Ⓡ foot. Pt unable to move foot/toes voluntarily O/W assessment WNL. Will Monitor — (b)(6)-2 [redacted]

7 Jul 2340 Received pt resting in bed. Alert, VSS, S&S SF 511. DSG to Ⓡ LE c/d/i, N/d+pin care done this shift. toes warm, cap refill good, ⊕ pulse Ⓡ LE, Ⓡ LE 9. IV Ⓛ fa patent. Will cont to monitor pt [redacted]
(b)(6)-2

3 July03 Assumed care of pt @ 0500. Pt is asleep. VSS. Lungs CTA. Bowel sounds x 4 quads.
0530 98.7 Abd. soft and Tender. Dsg Δ done @
91
14 1015. Pin care done. Pin site near hip
120/58
96% looks infected. Site looks pale pink. Ø drainage - Ø odor. H2 in Ⓛ arm - patent. Ø c/o pain or discomfort. [redacted] LPN, SGT
(b)(6)-2

NOTES

.TE

EPW [redacted] (b)(6)-4

MEDCOM - 13507

AUTHORIZED FOR LOCAL REPR

ICAL RECORD | **PROGRESS NOTES**

ATE	NOTES
8 July 03 1340	assumed pt care @ 1300. pt awake et alert. VSS. lungs CTA, abd soft nontender, BS⊕. LLE c̄ full ROM ⊕ pulse. Ⓡ thigh c̄ ext fix drsng CDI. ⊕ pulse. BUE c̄ full ROM ⊕ pulses. HL to Ⓛ FA flushes s̄ diff. ∅ c/o pain or discomfort voiced. Will cont to monitor (b)(6)-2 [redacted] SGT
8 JUL 03 21:35	Assumed c/o pt @ 21:00. Awake + alert in bed. VS WL per flowsheet. PERRLA⊕. LCA Ⓑ. BS⊕x4. HL Ⓛ FA patent. Ⓡ thigh ext fix in place, dsg C/D/I. ⊕ PPP Ⓡ foot. ~~⊖~~ Babinski to Ⓡ foot. Pt. states can feel light touch to Ⓡ foot and pressure Ⓛ foot ⊖ Babinski Ⓡ foot ⊕ <3sec cap refill. ∅ c/o pain will cont. to mon. [redacted] 2LT/AN (b)(6)-2
0119 ~~0030~~ error [redacted] (b)(6)-2	Pincare done. Sm. amt yellow drainage @ pin sites on old dsg. Skin healing and healthy looking. Staples intact and skin well approximated. Sm. ~~apress~~ abrasion to Ⓡ Buttocks covered c̄ DSD ∅ drainage noted on old dsg. DSD applied to all other wounds C/D/I. Will mon [redacted] 2LT/AN (b)(6)-2
9 Jul 03 0645	Pt. asleep in bed easily aroused by verbal stimuli. VSS. HR Reg, lung sounds clear bilat, bowel sounds (+) x4 quads.

IONSHIP TO SPONSOR	SPONSOR'S NAME LAST	FIRST	MI	SPONSOR'S ID (SSN or Other)

T./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

T'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 EPW # [redacted]		ICW2

PROGRESS NOTES
Medical Record

STANDARD FORM 509
Prescribed by GSA/ICMR FPMR (41CFR) 101-

All: (b)(6)-2

.TE	NOTES
9 July 03 0645	HL in Ⓛ FA flushed well c̄ 5cc NS s̄ s/s of infection or infiltration. Ext. fix on Ⓡ LE ↑ c̄ rolled up blanket underneath. Popliteal pulse & pedal pulse on Ⓡ extremity palpable, sensation (–), ROM absent, cap refill <3sec. All other assessment findings WNL. Pt s̄ complaints @ this time. Will continue to monitor. [redacted] 2LT
1420	Assumed care of Pt @ 1300 - VSS. A+O x 3; Ø c/o pain - Ⓡ femur ExFIX/DRSG CDI. (+) palapable pulse, cap refil <3 sec Ⓛ foot. minimal voluntary mvt Ⓡ foot, sensation to pain Ⓛ foot. IV ABX via Ⓛ wrist IV HL. Tol REG DIET; O/W assessment WNL. Will Monitor —— [redacted]
9 Jul 03 21:21	Rec'd c/o pt. @ 21:00. Pt awake and alert in bed. Restraints x2 Ⓡ wrist Ⓛ ankle. Skin color WNL. LCAB. BS (+) x4. C/O Generalized ABD pain. Dr. [redacted] notified. 1 dose Maalox given in substitution of mylanta. will mon. for results. HL Ⓛ FA in place. Ⓡ thigh ex-fix intact. Staples intact skin approximated. Serosang. drainage to most distal pin site noted, mod. amt. 4x4 dsd to Ⓡ Buttocks C/D/I. ~~&~~ c/o of pain O/W. error [redacted] ~~[illegible]~~ Ⓡ foot has sensation, is warm to touch. <3sec cap refill (+) PP. Will cont. to mon. [redacted] 2LT AN
10 July 03 0730 0500 98.7 P 93 RR 16 BP 128/60 Sats 99%	New IV placed in Ⓡ FA. VSS. HR Reg, lung sounds clear, bowel sounds (+) x 4 quads. Dressing to Ⓡ upper thigh & Ⓡ LE ext. fix CDI. Pt has (+) sensation in Ⓡ feet & digits, minimal ROM, <3 sec cap refill. pt awake & alert in bed s̄ complaints @ this time. All other assessment findings WNL. Will continue to monitor. [redacted] 2L

MEDCOM - 13509

All (b)(6)-2 except bottom one.

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10 July 03	Dressing Δ'd to Ⓡ ext. fix on LE ī dressing on upper Ⓡ thigh.
1100	Insertion sites are healing well s̄ s/s of infection. [redacted]
10 July 03	assumed pt care @ 1300. pt awake & alert. VSS.
1323	lungs CTA, abd soft BS⊕ x4. Ⓡ thigh c̄ ext fix, staples
	intact OTA, drsng to ext fix CDI. ⊕ pulse. Ⓛ LE c̄
	full ROM ⊕ pulse. ↑ ext c̄ full ROM ⊕ pulse. Ⓡ BKA c̄ HL
	flushes s̄ diff Ⓞ swelling/redness noted. Ⓞ complaints
	voiced @ this time. Will cont to monitor — [redacted] 91Wmc
10 July 03	Rec'd c/o pt @ 2100. Pt. awake and alert in bed. Restraint
2250	x2 Ⓛ wrist and ankle. VS WNL per flowsheet. PERRLA ⊕
	Skin W/D. LCA Ⓑ. BS⊕ x4. HL Ⓡ wrist patent. Ⓡ leg.
	ext. fix in place c̄ pin dsg C/D/I. Staples C/D/I. DSD
	to Ⓡ buttocks C/D/I. Able to move and feel sensation in
	Ⓡ foot. Warm to touch c̄ <3 sec cap refill. c/o pain to
	Ⓡ leg. ii Tylenol given @ this time. Will cont. to mon—
	[redacted] /AW
0235	Ⓞ further c/o pain @ this time. Will mon. [redacted] /AW
11 July 03	Assumed pt. care @ 0500: Pt. awake. A&O x3. lungs
0530	CTA. ⊕ pulses x4. Hypoactive BS x4. Ext-Fix c̄
	drsg on Ⓡ thigh CDI. ⊕ ROM in EXTREMITIES. HL
	Ⓡ BKA. C/o pain to Ⓡ thigh. Will continue to
	monitor [redacted] 91wmcb

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

EPW# [redacted] (b)(6)-4

RECORDS MAINTAINED AT: ▶

PATIENT'S NAME *(Last, First, Middle initial)*			SEX
RELATIONSHIP TO SPONSOR	STATUS		RANK/GRADE
SPONSOR'S NAME		ORGANIZATION	
DEPART./SERVICE	SSN/IDENTIFICATION NO.		DATE OF BIRTH

CHRONOLOGICAL RECORD OF MEDICAL CARE
MEDCOM - 13510

STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

A11: (b)(6)-2

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
11 July 03 1315	pt awake et alert. VSS. lungs CTA, abd soft BS ⊕ x4. Ⓡ thigh c̄ ext fix, drsing CDI ⊕ pulse. Ⓛ leg c̄ full rom ⊕ pulse. Ⓡ arm c̄ ⊕ pulse HL to ⓇFA, ∅ s/sx of infection noted Ⓛ arm c̄ ⊕ pulse. ∅ C/O pain voiced @ this time. Will cont to monitor - [redacted] 91WM6
11 JUL 03 21:45	Rec'd c/o pt @ 21:00. Awake and alert in bed. Restraints x2 Ⓛ wrist Ⓛ ankle. VS WNL per flowsheet. PERRLA ⊕ WNL Skin W/D. LCA Ⓑ. BS ⊕ x4. ⊕ PPP Ⓑ. HL ⓇFA patent. DSD x 2 to Ⓡ buttocks C/D/I. Staples to Ⓡ thigh intact Ⓡ ext. fix to thigh intact DSG C/D/I. able to move and feel sensation in Ⓡ foot and toes. Toes warm to touch and <3sec cap refill. C/o pain x1 ii Percocet given. Will cont to mon [redacted]
12 July 03	0550 Assume pt care @ 0500. Awake and alert. C/O sm amt of pain to Ⓡ femur. VSS. HL to Ⓡ wrist no s/s redness / infection. HR reg. Lungs CTA. Abd flat soft BS x4. Ex-fix and dsg to Ⓡ femur CD+I. Dsg's to Ⓡ buttocks CD+I. Will continue to monitor ——— [redacted] 91WM6
12 July 03 1300	assumed pt care @ 1300. pt awake et alert. VSS. assessment findings WNL, Ⓡ thigh c̄ ext fix, staples OTA, drsing around pin CDI. HL to ⓇFA ∅ s/sx of infection. ∅ Complaints voiced. Will cont to monitor —— [redacted] 91WM6
12 JUL 03	Assumed C/O Pt. @ 21:00 Pt. awake and alert in bed. Restraints x2 Ⓛ ankle Ⓡ wrist. VS WNL per flowsheet. PERRLA ⊕ WNL LCA Ⓑ. BS ⊕ x4. HL ⓇFA patent. Ⓡ thigh ext. fix intact c̄ old dsg yellow drainage c̄ foul odor noted, mod amt @ top pin site. Staples C/D/I. DSD x 2 to Ⓡ Buttocks C/D/I. Pin care done. open wounds @ pin insertion sites x8 well approx. New dsg applied C/D/I. DSD x 2 applied to Ⓡ Buttocks C/D/I ⊕ PPP Ⓑ. Able to move and feel toes. Toes

*U.S. Government Printing Office: 1996 - 404-763/40001

STANDARD FORM 600 BACK (REV. 5-84)

MEDCOM - 13511

All (b)(6)-2 except bottom one.

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
Cont'd	to Ⓡ foot warm to touch c̄ <3sec cap refill. c/o pain x1
	4mg MSO4 given. s̄ further complaints Will Cont to mon.
	[redacted] BLT/AN ————
13 July 03	0555 Assume pt care @ 0500. Pt asleep easy
	to awake. HL to Ⓡ hand no s/s redness/infiltration
	c̄ flush. VSS. HR reg. Lungs CTA. Abd. soft No tenderness
0528 96.7	or distension noted. Ex fix to Ⓡ thigh Dsg CD+I. Ⓡ
60 16	knee swollen. Ⓡ foot pulse palpable warm to touch. pt
114/60 98%	can move toes as one but unable to wiggle them. Dsg's
	to Ⓡ buttock CD+I. No c/o pain @ this time Will
	continue to monitor. ———— [redacted] 91WM6
1035	Dsg Δ and pin care done. Top pin site
	yellow drainage noted to old dsg. No drainage noted
	to other pins. ———— [redacted] 91WM6
13 July 03	assumed pt care @ 1300. pt awake & alert. VSS. lungs CTA
1400	abd soft non-tender BS ⊕ x4 quads. L leg c̄ full ROM ⊕ pulse Ⓡ
	thigh c̄ ext fix drsing CDI. Staples OTA. ⊕ pulse. ↑ ext c̄
	full ROM ⊕ pulse. HL to Ⓡ FA Ø s/sx of infection. drsing to Ⓡ
	buttock CDI. Ø c/o pain voiced @ this time. Will cont
	to monitor ———— [redacted] 91WMe

RELATIONSHIP TO SPONSOR

SPONSOR'S NAME: LAST | FIRST | MI

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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.

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[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

MEDCOM - 13512

All (b)(6)-2 except bottom one.

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
7-13 2215	Pt. care assumed @ 2100. VSS. Pt. alert c̄ compliant
	c̄ care. C/o mild pain to Ⓡ LE. ii percocet given. HR reg
	lungs CTA, ABD soft c̄ BS ⊕ x4. Ex-fix to Ⓡ thigh
	intact. Pin-care done. Scant amt. serosanguinous damage
	noted from pin sites. Drsng Δ'd, CDI. Ⓡ ft. c̄ pulses
	2+, ⊕ ROM, ⊕ sensation, brisk cap refill. HL to Ⓛ AC
	intact, flushes easily. Will cont. to monitor. — [redacted] RN
14 July 03	Assumed care of pt @ 0500. Pt asleep. VSS.
	Lungs CTA. Bowel sounds x4 quads. Abd.
	soft and tender. Pin care done @ 1000 hrs.
0530 97.5	Pins in place. Bandage applied - dry and
78	intact. Pt given ii percocet @ 0810 for Ⓡ
184/76 98%	leg pain. Will continue to monitor. — [redacted] LPN SGT
1330	Assumed Care Pt @ 1300. VSS. A+O x3. ∅ c/o pain
	Ⓡ FA PIV HL c̄ IVABX patent. Ⓡ LE EXFIX/DRSG CDI. STAPLES
	above EXFIX CTA CDI. ⊕ sensation, cap refil <3sec, palpable pulse, mvt
	of Ⓡ foot. o/w assess - WNL. Will Monitor [redacted]
14 July 03	~~2030~~ Assume pt care @ 2100. Pt awake and
	alert. VSS. HR reg Lungs CTA Abd soft BS x4 active
	Ex-fix dsg Δ done. drainage noted from top pin
	sm yellow amt. C/o pain @ site Ⓡ thigh ii percocet
	per order. ⊕ movement ⊕ sensation below dsg. HL
	to Ⓡ FA flushes well no s/s redness/infiltration
	Will continue to Monitor — [redacted]

#[redacted] (b)(6)-4

All (b)(6)-2 except bottom one.

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DICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
15July03	0700 - Pt alert lying in bed. VSS, lungs CTA, HR reg, BS ⊕, Pulses ⊜ & strong bilat to ↑+↓ extremities. Dsg to ext fix on Ⓡ thigh, staples intact. Voicing ∅ complaints this AM. Will cont to monitor —— [redacted]
15July03 1335	assumed pt care @ 1300. pt awake et alert. VSS. assessment findings WNL. Ⓡ thigh drsng CDI, staples OTA, ∅s/sx of infection noted. ∅ Complaints voiced @ this time. Will cont to monitor —— [redacted] 91WMe
15July03	2135 Assume pt care @ 2100. pt awake and alert. HL to Ⓡ wrist no s/s redness/infiltration c̄ flush. VSS. HR reg Lungs CTA. Abd soft BS x 4. Dsg to Ⓡ thigh c̄ Ex Fix CD+I. Staples intact. No s/s infection. no c/o pain @ this time. will continue to mon[redacted]
16July03	0910 - Pt alert sitting upright in bed. VSS, lungs CTA, HR reg, BS ⊕. Dsg Δ'd & pin care done to Ⓡ leg. Pulses ⊜ & strong bilat to ↑+↓ extremities. Voicing ∅ complaints. Will cont to monitor —— [redacted]

ONSHIP TO SPONSOR	SPONSOR'S NAME LAST	FIRST	MI	SPONSOR'S ID NUI (SSN or Other)

T./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

'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.
# [redacted] (b)(6)-4		

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (RE
Prescribed by GSA/ICMR FPMR (41CFR) 101-11

MEDCOM - 13514

All (b)(6)-2

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
16 July 03 1320	assumed pt care @ 1300. VSS. lungs CTA, abd soft BS⊕x4. Ⓡ thigh c̄ ext. fix drsing CDI, staples intact OTA Ø S/Sx of infection, ⊕ pulse. ⓁLE c̄ full ROM ⊕ pulse. BUE c̄ full ROM ⊕ pulses. HL to ⓇFA Ø S/Sx of infection noted. Ø c/o pain voiced @ this time. Will cont to monitor – [redacted] 91WM6
16 July 03 1545	New HL started in ⓁFA c̄ a 18g x 1 stick, good blood return et flushes well. old HL ⓇFA dc'd. Ø complaints voiced @ this time. Will cont to monitor —— [redacted] 91WM6
16 July 03	2225 Assume pt care @ 2100. pt Awake and Alert. HL to ⓁFA no s/s redness/infiltration c̄ flush. VSS. Lungs CTA Abd soft non tender. Urinates to urinal s̄ difficulty. Ex-Fix c̄ dsg to Ⓡ thigh CD+I. Dsg Δ top pin draining yellow drainage. Staples intact. ⊕ movement ⊕ pulse below Ex-fix. No c/o pain @ this time. —— Will cont. to monitor —— [redacted] 91WM6
17 Jul 03 0530	Assumed pt. care @ 0500: Pt. awake. A+O x 3. Lungs CTA. ⊕ Pulses x 4. ⊕ BS x 4. HL in ⓁFA, no signs of redness or infection. Drsg c̄ Ex-Fix on Ⓡ thigh intact. Staples on Ⓡ thigh intact. Denies any discomfort @ this time. [redacted] 91WM6
17 July 03 1330	assumed pt care @ 1300. pt awake et alert. VSS. assessment findings WNL. Ⓡ thigh c̄ ext fix drsing CDI. Staples intact OTA Ø S/Sx of infection. HL to ⓁFA Ø S/Sx of infection noted. pt denies pain @ this time. Will cont to monitor – [redacted] 91WM6

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IEDICAL RECORD | **PROGRESS NOTES**

DATE | NOTES

17 July 03 2315 Assume pt care @ 2100 - pt awake and alert - HL to Ⓛ hand. no s/s redness/infiltration c̄ flush. VSS - HR reg. Lungs CTA. Abd soft. BS x4. Ex-fix c̄ dsg to Ⓛ thigh CD+I. ⊕ movement ⊕ sensation below ex fix. Tylenol 650 mg for pain. Will cont to monitor — (b)(6)-2 [redacted] 91WM6

18 Jul 03 Assumed pt. care @ 0500: Pt sleeping awake easily. A+O x3. lungs CTA. ⊕ pulses x4. ⊕ BS x4. HL to Ⓛ FA s̄ signs of infection. VSS. Dsng c̄ Ex-Fix on Ⓡ thigh CDI. ⊕ sensation + movement below ~~Right~~ site. (b)(6)-2 [redacted] 91WM6 —

(b)(6)-2 [redacted]

18 July 03 1325 assumed pt care @ 1300. pt awake et alert. VSS. lungs CTA, abd soft nontender BS ⊕ x4. BUE c̄ full rom ⊕ pulses. HL to LFA ⊖ redness/swelling noted. Ⓡ thigh c̄ ext. fix, dressing CDI. Ⓛ leg c̄ full ROM, both + ext c̄ ⊕ pulses. ⊖ c/o pain voiced. Will cont to monitor — (b)(6)-2 [redacted] 91WM6

18 July 03 2230 Pt. awake & alert in bed s̄ complaints @ this time. HL in Ⓛ FA flushes well c̄ NS s̄ S/S of infection. HR Regular, lung sounds clear bilat, bowel sounds (+) x 4 quads. Ⓡ LE ↑ 30° c̄ folded blanket. Pin care done, new dressing applied, insertion sites s̄ S/S of infection. Ⓡ pedal pulses (+) (+) sensation in digits, cap refill < 3 sec, minimal ROM. Pt. assessment

IIP TO SPONSOR

SPONSOR'S NAME

LAST

FIRST

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SPONSOR'S ID NUMBER *(SSN or Other)*

RVICE

HOSPITAL OR MEDICAL FACILITY

RECORDS MAINTAINED AT

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

REGISTER NO.

WARD NO. ICW2

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (R
Prescribed by GSA/ICMR FPMR (41CFR) 101-1

A11: (b)(6)-2

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
18 July03 2030	findings WNL. Will continue to monitor. —— [redacted] 2LT/AN
18 July03	Performed pin care on pt. small amt of drainage
	on bandage noted. ∅ edema, ∅ obvious drainage, ∅ foul
	odor. Changed s̄ difficulty. Sgt [redacted]
0545	Pt care assumed @ 0500. VSS, sleeping awoken by verbal
19 July	stimuli. Pt c̄ c/o pain in rle, no pain meds requested.
	lung sounds CTA, pulses palpable x4, bs(+)x4 quads. HL
	in (L) wrist flushes well, no s/s infection or infiltration.
	Rle Dsg c̄ exfix CDI, pt able to wiggle toes c̄ (+)
	pulse and sensation in rle. IV ABX, pin care to
	be performed @ 0900. Will continue to monitor. [redacted] 91WM6
19 July 03	assumed pt care @ 1300. pt awake et alert. VSS.
1310	assessment findings WNL x̄ (R) thigh c̄ ext fix dressing
	CDI, staples intact OTA, (+) movement (+) sensation noted
	HL (R)FA ∅ s/s of infection. ∅ c/o pain voiced @ this
	time. Will cont to monitor —— [redacted] 91WM6

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
19 JUL 03	Rec'd c/o pt @ 21:00. Pt. awake and alert in bed. Restraints
21:47	x2 Ⓓ wrist/ankle. Skin color WNL W/D. PERRLA ⊕ WNL. LCA Ⓑ
	BS ⊕ x4. ⊕ PPP Ⓑ. Ⓡ thigh ex-fix intact c̄ DSG C/D/I. p̄ pin
	care performed. Pinsites s̄ s/s infection. Staples C/D/I.
	⊕ sensation ⊕ ROM ⊕ <3 sec cap. refill. (b)(6)-2 [redacted] c/o pain ñ tylenol
	given. Pt. requesting narcotics. able to read numbers on meds.
	and dictating what type of med. pt. receives. Will cont. to
	mon [redacted] [illegible] (b)(6)-2
20 Jul 03	0520: Assumed pt. care @ 0500: Pt. A+Ox3. Lungs CTA
	⊕ pulses x4 and strong. ⊕ BS x4. HL Ⓡ FA s̄ signs
	of infection. Dsg c̄ Ex-Fix to Ⓡ thigh CDI. c/o
	pain to Ⓡ thigh. Will continue to monitor.
	(b)(6)-2 [redacted] 91WM6
20 July 03	assumed pt care @ 1300. pt awake & alert. VSS
1330	assessment findings WNL. Ⓡ thigh c̄ ext fix drsng
	CDI, staples OTA ⊝ s/sx of infection noted HL to Ⓛ
	FA ⊝ redness/swelling noted. pt denies pain @ this
	time. Will cont to monitor (b)(6)-2 [redacted] 91WM6
21 July 03	Pt. having difficulty sleeping, 50mg Benedryl given po. HR Regular
0210	lung sounds clear bilat, bowel sounds (+) x4 quads. HL in Ⓡ FA flushes
	well s̄ s/s of infection. DSG Δ'd c̄ pin care completed to Ⓡ thigh, ext.

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.
		ICW2

EPW [redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

All (b)(6) -2

21 July03 fix. Pt. c̄ seemingly more c/o pain during procedure, inser
0210 sites appear to be s̄ infection, healing well. Pt. ō limited ROM
in ⓇLE, pedal pulse palpable, (+) sensation, cap refill <3sec
Pt. s̄ other complaints @ this time. All other assessment
findings WNL. Will continue to monitor. ——— [redacted] 2LT AN

21July03 0650 - Pt alert lying in bed. VSS, lungs CTA, HR reg,
BS⊕, HL to Ⓛ arm infusing antibiotics. Ext fix
intact to Ⓡ leg c̄ dsg CDI. Voicing ∅ complaints
at this time. Will cont. to monitor ——— [redacted] Dlwm

21Jul03 assumed care @1300 - VSS - medicated
2000 c̄ 650mg tylenol for c/o pain p̄ dsg Δ, pins
cleaned c̄ ½ strength H_2O_2 and wrapped
c̄ Kerlix to put pressure between skin &
fixature - staples CDI & incision closed
and dry - SL patent ——— [redacted] cn

2200 Pt care assumed @ 2100. VSS, pt awake
and alert c̄ c/o mild pain in RLE. Lungs
CTA, pulses ⊕ x4, bs⊕ x4 quads. Ex fix c̄ Kerlix on RLE
CDI. SL on Ⓛ wrist patent, IV ABX running, will continue
to monitor. ——— [redacted] 91WM6

22July03 0700 - Pt sleeping easily arousable in bed. VSS,
lungs CTA, HR reg, BS⊕. Pulses ⊖ & strong bilat
to ↑ & ↓ extremities. Ext fix intact to Ⓡ leg
c̄ Dsg applied around pins. HL to Ⓛ forearm
for antibiotics. Voicing ∅ complaints at this
time. Will cont to monitor. ——— [redacted] 2LT AN

22July03 assumed pt care @ 1300. pt awake & alert eating
1335 lunch. VSS. assessment findings WNL. Ⓡ thigh c̄ ext
fix, drsing CDI ⊕ pulse. ∅ complaints voiced. Will
cont to monitor. HL to Ⓛ FA ∅ redness / swelling noted.
——— [redacted] 91WM6

All (b)(6)-2 except one at bottom.

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
22 July 2100	Pt care assumed @2100. VSS, pt awake and alert c̄ c/o slight pain @ wound site. Lungs CTA, pulses palpable x4, bs⊕. HL @ L wrist flushes well, Exfix c̄ Kerlix on rle CDI. Pin care to be done @23, will continue to monitor. [redacted] alumc
22 July 2300	Pin care done @2200. Exudate more prevelant at lower pin insertion site, pt also c/o pain @ lower site. ii̅ percocet were given 10 minutes prior to pin care. [redacted] alumc
23 July 03	0920 - Pt alert lying in bed. VSS, lungs CTA, HR reg, BS⊕. Pulses ⊖ & strong bilat to ↑ + ↓ extremities. Ext fix intact to Ⓡ leg. HL to Ⓛ forearm → patent. Gave Tylenol for pain. Will cont to monitor. [redacted]
	1430 - Pt stable at this time. VSS. PERRLA. Mucous membranes pink moist & intact. Neck supple FROM. Lungs CTA bilat, ø resp distress. NSR. Abd soft, non-tender, bowel sounds active x4 quads. External fixator to Ⓡ upper femur. Drsg CDI. Pin sites CDI. Strong pulses and brisk cap refill x4 extremities. Good movement to Ⓡ LE. ø complaints [redacted]
23 July 0125	Pt care assumed @2100. VSS, alert and awake, 650mg Tylenol given for pain @2230, 50mg Benadryl given @ 2300. Lung sounds CTA, pulses⊕x4, bs⊕x4. Pin care done, c/o pain @ lower pin site. ⊕ pulse and sensation in rle. HL in L wrist flushes well, IV ABX treatment. Cont to monitor. [redacted] alumc

STANDARD FORM 509 (REV. 5/1999) BACK
USAPA V1.00

EV MEDCOM - 13520 [redacted] (b)(6)-4

All (b)(6)-2 except ones at bottom labeled "(b)(6)-4"

DATE	NOTES
240600 July 03	Nursing Assessment: Pt awake, alert, A&O x3. Airway intact, breathing even and unlabored, LS clear to all fields (B). Abd soft, nontender, s̄ distention. BS⊕x4. Voiding s̄ difficulty. FROM and neurovascularly intact to (B) UE and (L) LE. (R) LE neurovascularly intact c̄ ex-fix to (R) lateral thigh. No significant drainage to pin sites. Incision to (R) lateral thigh c̄ steri-strips, CDI — IV to (L) FA flushes well s̄ s̄ s/s infection/infiltration. —— [redacted] LT, AN
24 July 03 1315	assumed pt care @ 1300. pt awake et alert. HL to (L) FA ∅ s/s of infection noted. lungs CTA, abd soft non-tender BS⊕ x4 quads. (R) thigh c̄ ex-fix, drsing around pins CDI, steristripes CDI, ⊕ movement ⊕ sensation ⊕ pulse. (L) leg c̄ full ROM ⊕ pulse. BUE c̄ full ROM ⊕ pulses ∅ complaints voiced @ this time. Will cont to monitor. —— [redacted] 91WM6
24 July 03 0120	Pt care assumed @ 2100. VSS, awake and alert, ii po percocet given for pain @ 2300. Lung sounds CTA, pulses ⊕ x4, BS⊕ x4. Pincare done on rle. Top 4 pin sites have minimal drainage and little pustulant, no pain noted, ~~Top~~ [redacted] Lower insertion site have moderate pain, and more pustulant then upper ones. Lower pin sites appear worse then yesterday. No c/o pain p̄ dsg Δ, will continue to monitor. [redacted] 91WM6
250600 July 03	Nursing Assessment: Assumed care of pt. Airway intact. Breathing even and unlabored, LS clear to all fields (B). Abd soft, nontender, s̄ distention. BS⊕x4. Voids s̄ difficulty. FROM and neurovascularly intact to (B) UE and (L) LE. (R) LE neurovascularly intact. Incision to RLE has steri-strips and is CDI. Pin drsgs are CDI at this time. IV to (L) FA flushes s̄ difficulty and is s̄ s/s infection or infiltration. —— [redacted] USA, AN
251000 July 03	Nursing Note: Drsg to pins CDI. Most proximal two pins have mod amount of purulent, serosang drng upon removal of drsg. Middle two pins bleeding slightly ↑ drsg removed. (continued over)

STANDARD FORM 509 (REV. 5/1999) BACK
USAPA V1.00

EPW [redacted] -(b)(6)-4

MEDCOM - 13521

[redacted]

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EDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
25 1000 July 03	(continued) Ø pain reported to those four pins. Two most distal pins have no drainage to removed dsg, no bleeding, but significant pain. Sites are not overly reddened. Clean 4x4 & gauze applied to each pin site. ———— [redacted] 1LT AN
25 July 03 1300	Assumed pt care from previous shift. Pt resting quietly, easily aroused to verbal stimuli. VSS. Assessment findings WNL. Ⓡ thigh c̄ ex-fix, dressing around pins CDI, steri strips intact CDI. ⊕ movement ⊕ sensation. Ⓘ c/o pain/discomfort. Will cont to monitor ———— [redacted] 91WM6
25 July 03 2300	Pt care assumed at 2100. VSS, alert and awake, ii percocet given for pain @ 2200. Lung sounds CTA, pulses + x4, BSØ. HL @ RFA intact, IV ABX. ~~Dsg car~~ [redacted] Pin care performed, more pain still noted at lower pin site. Some purulent discharge noted. Pt s̄ no complaints, will continue to monitor. ———— [redacted] 91WM6
26 0555 July 03	Nursing Assessment: Assumed care of pt. Airway intact, breathing even and unlabored, LS clear to all fields. Abd soft, nontender, s̄ distention. BS ⊕ x4. Voids spontaneously. FROM and neurovascularly intact to Ⓑ UE and Ⓛ LE. Ⓡ LE neurovascularly intact, ROM limited 2° pain. Ex fix c̄ 6 pin sites to Ⓡ lateral thigh are CDI, but c̄ ↑ pain to two most distal pins. This pain ~~rate~~ radiates to toes per pt report. IV to Ⓛ FA flushes well s̄ s/s infiltration or inflammation. ———— [redacted] [illegible]

IP TO SPONSOR

SPONSOR'S NAME

LAST

FIRST

MI

SPONSOR'S ID NUMBER (SSN or Other)

RVICE

HOSPITAL OR MEDICAL FACILITY

RECORDS MAINTAINED AT

ENTIFICATION: *(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

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EDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
26 1200 July 03	Nursing Note: Completed PROM exercises c̄ pt. ROM to Ⓡ knee very limited 2° pain. Pt will not allow you to bend the knee greater than approx 15°. Pt unable to lift Ⓡ leg off of bed when doing straight leg raises. Also, Ⓡ leg tends to lay supinated to Ⓡ when pt is lying in bed. Encouraged pt to ~~[illegible]~~ pronate leg throughout day. —
	(b)(6)-2 [redacted] 1LT, AN
26 July 03 1330	Assumed pt care @ 1300. pt awake et alert, voiding via urin. lungs CTA, abd soft non-tender BS ⊕ x4 quads. Ⓡ thigh c̄ ex-fix OTA, steri stripes intact Ø drainage noted ⊕ movement ⊕ sensation ⊕ pulse LLE c̄ full ROM ⊕ pulse. BUE c̄ full ROM ⊕ pulses. HL to Ⓛ FA Ø signs of infection noted. pt rec'd orders for PT consult, will notify PT. Ø complaints voiced @ this time. Will cont to monitor —
	(b)(6)-2 [redacted] 91WM6
1800	During knee bends pts leg started oozing blood around pin sites, site covered c̄ 4x4 gauzes, pt c/o pain, given ii percocet per prn orders. pt joking et laughing while complaining of pain. Will cont to monitor
	(b)(6)-2 [redacted] 91WM6 —

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

RVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

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

EPW # [redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509

DATE	NOTES
~~2235~~ 26 Jul	Pt care assumed @2100. VSS, pt awake and alert s̄ c/o pain. Lung sounds CTA, pulses ⊕x4, BS+. ii percocet given at 2200 for c/o pain and to premedicate for dsg Δ. Exfix on rle intact; CDI. Passive ROM done to rle, leg bent and raised x10 each. Pin care to be performed @2300. Pt c̄ ⊕ sensation and able to wiggle toes, c/o slight pain in Ⓡfoot. Continue to monitor. ——— (b)(6)-2 [redacted] 91WM6
2300	Pin care performed by PFC (b)(6)-2 [redacted]. Wound clean, Ø signs infection. Minimal pain during pin care, patient being taught so that he can perform it himself. ——— (b)(6)-2 [redacted] 91WM6
27 July 03	0710 - Pt alert sitting upright in bed. Tolerated breakfast. ROM completed ē Ⓡ leg. VSS, lungs CTA, HR reg, BS⊕. Ext fix intact to Ⓡ leg. ⊕ sensation, ⊕ pulse, able to wiggle toes, warm to touch. Gave Percocet for pain - will cont to monitor ——— (b)(6)-2 [redacted] 2Lt
	1430 Pt stable at this time AAOx3. PERRLA. Mucous membranes pink, moist & intact. Neck supple FROM. Lungs CTA bilat, Ø resp distress. NSR. Abd soft, nontender ~~bilat~~ error [redacted] (b)(6)-2, bowel sounds active x4 quads. Strong pulses & brisk cap refill x4 extremities. Ⓡ leg ex fix CDI. Ø drainage Ø S/S infection at pin sites. Ø complaints ——— [redacted] LT/AN (b)(6)-2

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
27 Jul 03	Rec'd c/o pt @ 21:20. Restraints x2 Ⓛ wrist Ⓛ ankle. VS
2206	WNL per flowsheet. Pt. awake and alert in bed. LCAⒷ
	BS⊕x4. ⊕PPPⒷ. Ⓡ ↑ thigh ex-fix intact. Steristrips intact
	@ incision site. Pin sites c̄ ⊕ dried blood @ sites. 10 straight
	leg lifts and 10 knee bends to Ⓡ leg c̄ difficulty. c/o pain ĭĭ
	Percocets given. Will cont. to mon [redacted]
28 Jul 03	(b)(6)-2 0948 - VSS, lungs CTA, HR reg, BS⊕. Pt alert
	A&Ox3 ambulating c̄ crutches x1. Gave percocet
	& MSO4 for pain. Pt did own pin care c̄
	nurse watching. ⊕ sensation, ⊕ pulse, able
	to wiggle toes. Will cont to monitor (b)(6)-2 [redacted]
28 July 03	Received PT Alert sitting up in bed. VSS. ⊖ c/o pain
1300	or discomfort. Leg wounds are clean Bilateral. PT has
	⊕ Rom to Ⓡ thigh ex-fix, Toes. Cap Ref +3 sec. PT
	has + sensation to Ⓡ foot. Physical Therapy will come
	in to assist in ⊕ Range of motion exercise. Will
	cont to monitor PT. Pins are clean Dry & intact.
	[redacted] LPN
28 July 03	(b)(6)-2 Pt care assumed @ 2100. VSS, A+Ox3, no c/o pain. Lung sounds CTA,
2300	pulses ⊕ x4, BS+ x4. ROM performed on rle s̄ c/o pain. Pin care
	performed by pt and PFC [redacted] little bloody drainage noted. Pt c̄ +
	sensation and cap refill in rle, slight pain in foot. 50mg benadryl

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. TCW2

EPW

[redacted] (b)(6)-4

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

MEDCOM - 13525

A11 (b)(6)-2

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	given @ 2300. No complaints at this time, continue to
	monitor. ——— [redacted] 91WMC
29 July 03	1030 - Pt alert lying in bed with Ⓡ knee elevated.
	ROM exercises done. Pin care completed by pt.
	⊕ pulse, ⊕ sensation + warm to touch on Ⓡ leg.
	VSS, lungs CTA, BS⊕. Will cont to monitor
	——— [redacted]
29 July 03	pt care assumed @ 1300. pt resting quietly. Ø
1320	complaints voiced. lungs CTA, abd soft BS⊕. Ⓡ thigh
	c̄ ex-fix Ø signs of infection noted ⊕ movement ⊕
	sensation ⊕ pulse. LLE & BUE c̄ full ROM ⊕ pulse.
	will cont to monitor ——— [redacted] 91WMC
29 July	Pt care assumed @ 2100. VSS, alert and awake, no
2145	c/o pain at this time, lungs CTA, pulses x4, bs to R/e
	c̄ exfix C01. Pt performed pin care c̄ nurse at bedside,
	Ø signs infection. Passive ROM performed x10. No complains
	at this time, will continue to monitor [redacted] 91WMC
30 July 03	P.T. IV flushed @ 0005 good blood return [redacted]
	0910 - Pt A&Ox3. VSS, lungs CTA, BS⊕, Pulses ⊕ + strong
	bilat to ↑ + ↓ extremities ROM performed on Ⓡ leg
	Ext fix intact. Pin care completed by pt. Voicing Ø
	complaints now. Will cont to monitor [redacted]
30 July 03	pt care assumed from previous shift. VSS. pin care
1300	completed. lungs CTA, abd soft BS⊕. Ⓡ thigh c̄ ex-fix pins OTA
	steri strips intact ⊕ pulse, movement & sensation. LLE c̄ full ROM
	⊕ pulse. BUE c̄ full ROM ⊕ pulse. HL to Ⓛ FA flushes s̄ diff
	Ø S/S infection. Ø c/o pain. Will cont to monitor — [redacted] 91WMC

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Progress Notes

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MEDICAL RECORD ~~CHRONOLOGICAL RECORD OF MEDICAL CARE~~

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
30 July03	pt given ii percocet @ the request of CPT (b)(6)-2 [redacted]
1630	for PT. (b)(6)-2 (b)(6)-2 [redacted] 91WM6
1700	CPT [redacted] @ bs giving PT (b)(6)-2 [redacted] 91WM6.
1720	pin site oozing bright red blood. Site cleared Et
	pins wrapped c̄ gauze secured c̄ tape, pt tol well.
	will cont to monitor —— (b)(6)-2 [redacted] 91WM6
30July03	Pt care assumed @ 2100, VSS, AOx3, c/o slight
2145	pain in rle, 650mg Tylenol given. Lung sounds CTA,
	pulses ⊕x4, BS+, Pincare on rle done by pfc (b)(6)-2 [redacted].
	Pt c̄ ⊕ sensation and rom in rle. States pain is sharp
	on Ⓡ thigh, and absent on calf then continues on at
	the foot. During pincare more bloody drainage
	is noted then usual. Active and passive ROM
	x10 each. Will continue to monitor (b)(6)-2 [redacted] 91WM6
31July03 0730	Pt. awake & alert in bed. HR Regular, lung sounds clear bilat,
	bowel sounds (+) x 4 quads. Ext fix to Ⓡ leg, insertion sites drainin
	bright red bld & yellowish fluid. Pincare done & DSG's applied to
	catch drainage. Pt. c/o pain @ 0530, ii percocet given. Pedal pulse palpab
	in Ⓡ foot, (+) sensation, cap refill < 3sec. ROM exercise completed,
	10 leg raises, 10 small knee bends. Pt. in obvious pain, facial grimacing
	c̄ knee bends. All other assessment findings WNL. Pt s̄ complaints
	@ this time. Will continue to monitor. —— (b)(6)-2 [redacted] 91W | 4A

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. ICW2

[redacted] (b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
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All: (b)(6)-2

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
31July03 1335	assumed pt care @ 1300. VSS. pt c/o pain. medicated c̄ ii percocet per prn orders. BUE c̄ full ROM ⊕ pulse HL Ⓛ FA flushes s̄ diff. ⊖ redness/swelling noted lungs CTA, abd soft BS⊕ x4. Ⓡ thigh c̄ ex-fix drsing c̄ scant amt of drainage noted, ⊕ pulse. LLE c̄ full ROM ⊕ pulse. Will cont to monitor — [redacted] 91WM
31July 2345	Pt care assumed @2100. VSS, alert and awake, pt OOB to wheelchair c̄ c/o slight pain in Ⓡ foot. Lung sounds CTA, pulses palpable x4, BS+. Pincare done on rle, small amount of bleeding noticed, exfix insertion site s̄ s/s infection. Rle c̄ + sensation, passive ROM performed. No new complaints, will continue to monitor. — [redacted] 91WM6
1Aug03	1110 - Pt alert resting in bed. Completed ROM exercises s̄ difficulty. Pin care done to ext fix on Ⓡ leg. VSS, lungs CTA, BS⊕. Will cont to monitor — [redacted]
1Aug03 1345	assumed pt care @1300. pt reading a magazine voices ⊘ complaints. assessment findings WNL. Ⓡ thigh c̄ ex-fix pin care completed. Will cont to monitor — [redacted] 91WM6
2230	Pt care assumed @2100. VSS, no complaints. ROM performed, pincare done. Assessment WNL, will continue to monitor. — [redacted] 91WM6

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HEALTH RECORD | Progress ~~CHRONOLOGICAL RECORD OF MEDICAL CA~~RE Note

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
2 Aug 03	0930 - Pt alert OOB x1 in wheelchair: VSS, lungs CTA, HR reg, BS ⊕ x4, pulses ⊕ x4. Pin care performed by patient. Ext fix intact to Ⓡ leg. Voicing ø complaints at this time. Will cont. to monitor ——— [redacted]
2 Aug 03 1315	assumed pt care @ 1300. pt awake et alert, VSS assessment findings WNL. x̄ Ⓡ thigh c̄ ex-fix, drsng to pin sites CDI. ø complaints voiced @ this time. Will cont to monitor ——— [redacted] 91WM6
2 Aug 03 2130	Pt care assumed @ 2100. VSS, aware and alert c̄ c/o pain in Ⓡ foot. lung sounds CTA, pulses + x4, bs ⊕ x4. Pincare to be done @ 2200. Ex fix site on RLE intact, draining blood from pin sites to gauze p̄ ROM. passive ROM performed, c/o pain during ROM. Will continue to monitor ——— [redacted] 91WM6
3 Aug 03	0635 Assume pt care @ 0500. pt awake and alert no c/o pain @ this time. VSS. ex-fix to RLE intact dsg to pins CD+I. ROM performed. Tylenol ii for pain. ⊕ pulse ⊕ sensation ⊕ movement below ex-fix. Will cont to monitor ——— [redacted] 91WM6
	1024 pt OOB to chair. pincare done by pt. Sm amt of red drainage from middle pins. pt encouraged to bend knee while OOB ——— [redacted] 91WM6

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

EPW [redacted] (b)(6)-4
#

RECORDS MAINTAINED AT: ▶		
PATIENT'S NAME *(Last, First, Middle initial)*		**SEX**
RELATIONSHIP TO SPONSOR	**STATUS**	**RANK/GRADE**
SPONSOR'S NAME		**ORGANIZATION**
DEPART./SERVICE	**SSN/IDENTIFICATION NO.**	**DATE OF BIRTH**

~~CHRONOLOGICAL RECORD OF MEDICAL CARE~~

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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
3Aug03	assumed pt care @ 1300. VSS. pt AAOx3. lungs
1305	CTA, abd soft BS⊕. Ⓑ thigh c̄ ex-fix, drsing c̄ sm amount
	of drainage noted. LLE c̄ FROM ⊕ pulses in both Left
	BUE c̄ FROM ⊕ pulses. ⊕ IV access noted. Ø complaints
	voiced. Will cont to monitor ——— [redacted] 91WM6
3Aug03	CPT [redacted] c̄ pt for PT. pt given ii Percocet @
1800	the request of CPT [redacted] ——— [redacted] 91WM6
3Aug03	Pt care assumed @2100. VSS, alert and aware s̄ c/o
2300	pain; ii percocet given for pain @2200. Lung sounds
	CTA, pulses⊕x4, bs+x4 quads. Pincare done @ 1930 by
	previous shift. ROM performed x10mins. Ex-fix intact, Ø draining,
	⊕ sensation and cap refill to rle. Continue to monitor. [redacted] 91WM6
4 Aug 03	0825- Pt alert c̄ oriented. VSS, lungs CTA, HR reg, BS⊕
	x4, pulse ⊕ x4. Ext fix intact to Ⓡ thigh. Pin Care
	Completed by patient. Voicing Ø complaints at
	this time. ROM completed s̄ difficulty. Will cont.
	monitor ——— [redacted] 2Lt AN
4AUG03	-Received PT Alert + oriented. VSS, HRR. Breath sound
1302	clear Bilateral. BSx4. Skin is warm + Dry. Ex-Fix
	to Ⓡ leg is intact c̄ Dressing CDI. PT has ⊕ ROM
	to all extremity c̄ good Pulse motor function +
	Cap Ref +2 sec to all extremity. PT Performed
	Active Range of motion exersise to Ⓡ leg, resulting
	in minor bleeding to pin site. PT Given Percocet ii
	for pain + Dressing was changed. Will cont to
	monitor [redacted] LPN

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NSN 7540-00-634-4176 600-108

HEALTH RECORD	**CHRONOLOGICAL RECORD OF MEDICAL CARE**
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
4 Aug 03 20:38	Rec'd c/o pt @ 21:00. VS WNL per flow sheet. Awake and alert in bed. Restraints x 2 Ⓛ wrist Ⓛ ankle. Skin W/D. Perrla ⊕ WNL. LCA Ⓑ. HRRS, S1 S2. BS ⊕ x4 ABD soft and ⊘ tender ⊕ PP Ⓑ Ⓡ thigh ex-fix in place. Pin care performed by pt and 91W PFC [redacted] c̄ guidance. Old dsgs c̄ bloody drainage noted. Pin sites well approximated. DSG's applied C/D/I. ā DSG Δ pt. performed AROM c̄ difficulty and pain expressed. Improvemen noted. Pt premedicated c̄ ii Percocet ā AROM/DSG Δ Ⓡ ~~food~~ error foot ⊕ PP ⊕ <3 sec cap refill ⊕ sensation ⊕ Plantar flexion/extension. ⊘ c/o's @ this time will cont to mon. [redacted] RLT/RN
5 Aug 03	1020: Pt alert & oriented lying in bed. VSS, lungs CTA, HR reg, BS ⊕ x4, pulses ⊕ x4. Ext fix intact to Ⓡ thigh. Pin care carried out by patient. ROM done s̄ difficulty. Voicing ⊘ complaints at this time. Will cont. to monitor [redacted]
5 Aug 03 1300	pt awake et alert. VSS, lungs CTA, abd soft BS ⊕ x4. Ⓡ thigh c̄ ex-fix - drsing c̄ sm amount of drainage noted ⊕ pulse. LLE et BUE c̄ full ROM ⊕ pulses. ⊘ IV access noted. ⊘ c/o pain/discomfort voiced @ this time. Will cont to monitor [redacted] 91W
5 Aug 03 22:45	Rec'd c/o pt @ 21:00. Restraints x2 Ⓛ wrist Ⓛ ankle. VS WNL per flow sheet. Awake and alert in bed. PERRLA ⊕ WNL. LCA Ⓑ HRRS, S1 S2. BS ⊕ x4. Ⓡ thigh ex-fix intact. Pin

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

EPW

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[redacted]

RECORDS MAINTAINED AT:		
PATIENT'S NAME *(Last, First, Middle initial)*		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME		ORGANIZATION
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

CHRONOLOGICAL RECORD OF MEDICAL CARE

STANDARD FORM 600 (REV. 5-84)
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all : (b)(6)-2

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	site dsgs C/D/I. Pt amb. length of ward c̄ crutches. 3 point gait unsteady. needs assistance when amb. AROM c̄ assist. exercises performed. Premedicated c̄ ii Percocet ā amb and exercising. Pin care performed. Old dsgs to pin sites c̄ bloody mod. amt drainage. pin sites ø s/s infection, notable healed tissue. W→D dsgs wrapped around pins applied C/D/I. ø further complaints [redacted] 2LT [redacted]
Addendum	⊕ROM, ⊕sensation ⊕<3sec cap refill RLE [redacted] 2LT/AN
6Aug03	1140- Pt alert c̄ oriented OOB to chair x1 today. VSS, HR reg, lungs CTA, BS⊕x4, pulse ⊕x4, Ext fx intact to Ⓡ leg. Pin care done by pt. Gave percocet for pain. Will cont to monitor [redacted] 2Lt
6Aug03 1310	pt resting c̄ eyes closed, easily aroused to verbal stimuli. VSS. assessment findings WNL x̄ Ⓡ thigh, Ⓡ thigh c̄ ex-fix, drsing c̄ sm amount of pinkish color drainage, ⊕ pulse. Ⓝ complaint of pain/discomfort voiced @ this time. Will cont to monitor [redacted] 91WM6
6Aug03 21:09	Rec'd c/o pt @ 21:00. Restraints x1 Ⓛ ankle. Awake and alert in bed. PERRLA ⊕WNL. LCAⒷ. HRRS1S2. BS⊕x4. Ⓡ thigh ex-fix intact. Pinsite dsgs c̄ scant amt. bloody drainage noted. ⊕ROM ⊕sensation ⊕ PPPⒷ to Ⓡ foot digits. ø c/o pain @ this time [redacted] 2LT/AN
6Aug03 2200	Pin care done p̄ pt amb on crutches and performed AROM c̄ assistance. Old dsgs to pinsites c̄ mod. amt bloody drainage noted. pin site wounds all well approx. c̄ healthy tissue noted ø s/s infection present. New W→D dsgs applied C/D/I. c/o pain ī Percocet given for premedication ā AROM ī Percocet given for c/o pain p̄ dsg Δ. Will mon [redacted] 2LT/AN

All (b)(6)-2 except bottom one.

NSN 7540-00-634-4178 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
070945 Aug 03	NURSING ASSESSMENT: Awake, alert, Ox3. Airway intact, breathing even and unlabored, LS
	clear to all fields (B). Abd soft, nontender, s̄ distention, BS⊕x4. Voids spontaneously. FROM and
	neurovascularly intact to (B)UE, (L)LE. (R)LE has ex fix to lateral thigh, 6 pins. 4 distal
	pins have moderate amount of serosang drg noted. ROM to (R) limited by pain and joint
	stiffness -- otherwise neurovascularly intact. —— Ø IV access. —— [redacted]
7 Aug 03	assumed pt care @ 1300. pt AAOx3. VSS. assessment
1330	findings WNL. (R) thigh c̄ ex-fix, dressing CDI, ⊕ pulse.
	Ø IV access noted. Ø complaints voiced @ this time.
	Will cont to monitor —— [redacted] 91WM6
1400	pt given ii percocet @ CPT [redacted] request — [redacted] 91WM6
9 Aug 03	Rec'd c/o pt @ 21:00. Restraints x2 (L) wrist/ankle. VS WNL
22:49	per flow sheet. Awake and alert in bed. Skin W/D. PERRLA⊕
	WNL. LCA⊕ HPPS, S2 BS⊕x4. ⊕PP(B). (R) thigh ex-fix in
	place. ROM ~~excersized~~ Error [redacted] exercises performed, and pt amb
	length of ward x 1½. Blood draining from proximal pin site
	down leg upon return to bed. Pin care done s̄ s/s infection
	noted. Bloody drainage on old dsgs. Pt c/o pain x 1 ii Percocet
	given. will cont. to mon. [redacted] 2LT/AN
Addendum	⊕ sensation ⊕ ROM ⊕ <3 sec cap refill will mon [redacted] 2LT, A
8 Aug 03	Assumed pt. care @ 0500. Pt. asleep. Awaken easily
0610	VSS. A+Ox3. lungs CTA. ⊕ pulses x4 ⊕ BS x4. (R) thigh
	c̄ ex-fix c̄ slight drainage from pin site. Ø complaints
	@ this time —— [redacted] 91WM6

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

EPW (b)(6)-4

[redacted]

RECORDS MAINTAINED AT:

PATIENT'S NAME *(Last, First, Middle initial)*		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME		ORGANIZATION
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

CHRONOLOGICAL RECORD OF MEDICAL CARE
MEDCOM - 13533

STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

A11: (b)(6)-2

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
8 Aug 03 1315	assumed pt care @1300. VSS. pt awake et alert. assessment findings WNL. Ⓡ thigh c̄ ex-fix, CPT [redacted] @ BS for PT, pt given ī percocet prior to PT @ CPT [redacted] request. will cont to monitor —— [redacted] 91WM6
8 Aug 03 21:56	Rec'd c/o pt. @21:00. Restraints x 2 Ⓛ wrist/ankle. VS WNL per flow sheet. Awake and alert in bed. PERRLA⊕WNL. LCA⊕ HRRS, S2. BS⊕x4 ABD soft non-tender. Ex-fix in place DSGs [redacted] c̄ to pin sites. c̄ scant amt. bloody drainage noted. Ⓡ foot ⊕ sensation ⊕ <3sec cap refill ⊕ PP⊕ ROM. c/o pain Ⓛ bicept. Small hardened area noted. Will cont to mon[redacted] [redacted] 2LT/AN
9 Aug 03	0530: Assumed pt. care @ 0500: VSS. A+O x3. lungs CTA. ⊕ Pulses x4. ⊕ BS x4. Ⓡ thigh ex-fix c̄ dsng to pin CDI. Denies any complaints @ this time —— [redacted] [illegible]
9 Aug 03 1450	pt care assumed @ 1300. pt AAO x3. VSS. assessment findings WNL. Ⓡ thigh c̄ ex-fix. CPT [redacted] @ BS c̄ pt to do ROM exercise, pt given ī percocet @ 1330 @ CPT [redacted] request. 1430 pin care completed. ⓪ complaints voiced, Will cont to monitor —— [redacted] 91WM6
9 Aug 03 22:15	Rec'd ~~pt~~ error [redacted] c/o pt @21:00. VS WNL x̄ ↑ temp 100.2. Will retake temp in 1°. Skin W/D. PERRLA⊕WNL LCA⊕ HRRS, S2. BS⊕x4. ABD soft-non-tender. ⊕PP⊕. Ⓡ thigh ex-fix in place. DSD's to pin sites c̄ scant amt visible bloody drainage. ⊕ ROM ⊕ sensation ⊕ warmth ⊕ Pedal pulse ⊕ <3sec cap refill to Ⓡ foot. Amb c̄ crutches s̄ difficulty. AROM c̄ assistance performed s̄ difficulty. [redacted] 2LT/AN

*U.S. Government Printing Office: 1996 - 404-763/40001

STANDARD FORM 600 BACK (REV. 5-84)

NSN 7540-00-634-4176 AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | Progress [redacted]

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10 Aug 03	1130 - Pt alert & oriented OOB x1 utilizing crutches while ambulating. VSS, lungs CTA, HR, BS⊕, pulses ⊕ x4. Ext fix intact to Ⓡ leg. Pin care completed by pt. Minimal drainage noted on old dsg. Voicing Ø complaints at this time. Will cont to monitor — (b)(6)-2 [redacted]
10 Aug 03 1400	pt AAOx3. VSS. lungs CTA, abd soft non-tender BS⊕x4. Ⓡ thigh c̄ ex-fix drsing CDI. LLE c̄ fROM ⊕ pulses to B.ext. BUE c̄ fROM ⊕ pulses. Ø c/o pain/discomfort voiced @ this time. Will cont to monitor — (b)(6)-2 [redacted]
10 Aug 03 03:30	Rec'd c/o pt @ 01:00. Restraints x2 Ⓛ wrist/ankle. VS WNL per flowsheet. Pt. awake and alert in bed. PERRLA ⊕ WNL LCA Ⓑ H&RS, Sa. BS⊕x4 ⊕ PP Ⓑ. Ⓡ thigh ex-fix dsgs D&I skin to pinsites well approx. s̄ s/s infection. Ⓡ foot digits ⊕ ROM ⊕ warmth ⊕ sensation ⊕ <3sec cap refill. ø c/o pain during AROM c̄ assist of AMB on crutches. Will cont. to mon [redacted] (b)(6)-2
10 Aug 03 1010	ORTHO STAFF Pin sites still clean. Improved ROM @ knee and hip. Jt c̄ some callous but still not united.

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.

EPW [redacted] (b)(6)-4

[redacted]

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

MEDCOM - 13535

Progress Note

All: (b)(6)-2

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
11Aug03	1211: Pt alert & oriented OOB x1 ambulatory c̄ crutches. VSS, lungs CTA, BS⊕, pulses ⊕x4. Ext fix intact Ⓡ thigh. Pin care done by pt. Voicing Ø complaints. Will cont to monitor —— [redacted] 2Lt AN
11Aug03 1300	Pt stable. AAOx3. PERRLA. Resting in bed c̄ Ⓡ knee bent. Lungs CTA bilat, Ø resp distress. NSR. Abd soft, non-tender, bowel sounds active x4 quads. Ext fix to Ⓡ thigh intact, dsgs to pins CDI. Ø complaints. Strong pulses & brisk cap refill x4 extremities. —— [redacted] 1LT/AN
1545	ROM done c̄ PT. Pt premedicated c̄ Percocet. Leg raises done, knee bent to 90° and stretched. Pin sites CDI. Pt tolerated procedure c̄ some difficulty —— [redacted] 1LT/AN
1900	Pin care and dsg Δ's done by pt c̄ supervision. Pin sites CDI. Dsgs c̄ minimal drainage from ROM exercises. Ø complaints —— [redacted] 1LT/AN
2330	Pt care assumed @2100. VSS, AAOx3 c̄ c/o pain p̄ ambulation and rom. Lung sounds clear, pulses ⊕x4, BS⊕. Pt ambulated x15 min and active and passive rom performed s̄ difficulty. Pt performed pin care, sites are pink and free of S/S infection. On PO ABX, continue to monitor. —— [redacted]
12Aug03	1040- Pt A&Ox3. VSS, lungs CTA, BS⊕, pulses ⊕x4. Ext fix intact to Ⓡ leg. Pin care done by pt. Ø pain meds given. Voicing Ø complaints, will cont to monitor —— [redacted] 2Lt AN

NSN 7540-00-634-4178 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
12 Aug 03 1320	assumed pt care @1300. VSS. pt awake et alert. assessment findings WNL. Ⓡ thigh c̄ ext-fix, drsing CDI. ⊕ pulse. ⊘ IV access noted. ⊘ complaints voiced @ this time. Will cont to monitor (b)(6)-2 [redacted] 91WM6
12 Aug 03 22:39	Rec'd c/o pt. @ 21:00. Restraints x 2 Ⓡ wrist/Ankle. VS WNL per FS Awake and alert in bed. PERRLA ⊕ WNL LCA Ⓑ BS⊕ x4. ABD soft - non-tender. ⊕ PPⒷ. Ⓡ thigh ex-fix intact DSGs applied to pin sites ⊕ ROM ⊕ sensation ⊕ <3sec cap refill to Ⓡ foot digits. Pt amb. length of ward x 2. AROM s̄ assist. performed ⊘ c/o's @ this time will cont to mon-
(b)(6)-2	[redacted] SPC/AN
0251	c/o pain to Ⓡ LE while amb. only completed 1 length of ward ii Tylenol given for pain
13 Aug 03	1100 - Pt alert & oriented lying in bed c̄ Ⓡ leg elevated. VSS, lungs CTA, BS⊕, pulses ⊕ x4. Ext fix intact, pin care done by pt. AM care completed. Tolerated breakfast. Voicing Ø complaints at this time. Will cont to monitor (b)(6)-2 [redacted] 2Lt
13 Aug 03 1330	pt awake et alert. VSS. assessment findings WNL x̄ Ⓡ thigh c̄ ex-fix drsing CDI ⊕ pulse ⊕ movement ⊕ sensation. ⊘ c/o pain/discomfort voiced Will cont to monitor [redacted] 91WM6

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

EPW

#[redacted] (b)(6)-4

RECORDS MAINTAINED AT: ▶ (b)(6)-2

PATIENT'S NAME *(Last, First, Middle initial)*

SEX

RELATIONSHIP TO SPONSOR

STATUS

RANK/GRADE

SPONSOR'S NAME

ORGANIZATION

DEPART./SERVICE

SSN/IDENTIFICATION NO.

DATE OF BIRTH

CHRONOLOGICAL RECORD OF MEDICAL CARE

STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

MEDCOM - 13537

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
13 Aug 03 21:05	Rec'd c/o pt @ 21:00. Restraints x 2 Ⓛ wrist/Ankle. VS WNL per flowsheet. Awake and alert in bed. Skin W/D/I. PERRLA ⊕ WNL. LCA ⊕ HRR S1S2. BS ⊕ x4. ABD soft and ⊖ tender. Ⓡ thigh ex-fix intact. 1st 2 prox. pins c̄ ⊕ exudate 2nd 2 medial pins c̄ ⊖ s/s infection ⊕ healing tissue @ pin sites 3rd set distal pins c̄ healing tissue/pink in color. Prox and distal pins DSD's applied. Medial pins OTA. ⊕ sensation ⊕ ROM ⊕ <3 sec cap refill to Ⓡ foot digits. Pt. premedicated for PT. CPT [redacted] performed pt. PT. ⊖ c/o's Will cont. to mon. (b)(6)-2 [redacted] 2LT/AN
140530 Aug 03	NURSING ASSESSMENT: Assumed pt care. AAOx3. Airway intact, breathing even and unlabored, LS CTA Ⓑ. Abd soft, nontender, s̄ distention. BS ⊕ x4. Voiding spontaneously. ROM and neurovascularly intact to Ⓑ UE and LLE. Ⓡ LE ROM limited by pain to knee & hip. ROM to Ⓡ ankle. Neurovascularly intact to Ⓡ LE. Ø IV access. Ex fix to Ⓡ lateral thigh x 6 pins – drsgs CDI. (b)(6)-2 [redacted] [illegible]
141030 Aug 03	NURSING NOTE: Proximal two pins have small amount of purulent drng to pin sites. Cleansed c̄ H_2O_2 & NS. ~~[illegible]~~ Middle two pins and distal two pins have pink skin growing in around pins. Sites have beefy red tissue new as well. (b)(6)-2 [redacted] [illegible]
14 Aug 03 1415	pt care assumed @ 1300. pt awake & alert. VSS. pt given ii percocet prior to PT. SPC [redacted] @ (b)(6)-2 bedside performing ROM exercise. pt tol well. Drsing to pin sites Ⓡ thigh ex-fix c̄ sm amt of red bloody drainage, site cleaned c̄ 1/2 NS & 1/2 H_2O_2. new drsings applied. lungs CTA, abd soft nontender BS ⊕ x4. BLExt c̄ ⊕ pulses. BUE c̄ f ROM ⊕ pulses. pt ambulated c̄ ~~crutches~~ [redacted] (b)(6)-2 crutches. ⊖ c/o pain/discomfort voiced. Will cont to monitor [redacted] (b)(6)-2 [illegible]

*U.S. Government Printing Office: 1996 - 404-763/40001

STANDARD FORM 600 BACK (REV. 5-84)

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
14Aug03	Rec'd c/o pt @ 21:00. VS WNL per FS. Alert and awake
22:11	in bed. Restraints x2 Ⓛ wrist/Ankle. Skin W/D. PERRLA
	LCA Ⓑ. BS ⊕ x4. ⊕ PP Ⓑ Ⓡ thigh ex-fix in place. ⊕ ROM
	⊕ sensation ⊕ pedal pulse. ⊕ <3 sec cap refill ⊕ Ⓡ foot digits
	⊕ c/o pain. will cont. to mon. (b)(6)-2 [redacted] 2LT/AN
14Aug03	Pt. temp 99.2 @ 2345. Sc [redacted] (b)(6)-2
15Aug03	ii Tylenol given for ↑ temp and c/o pain to Ⓡ thigh. Will
0041	mon. (b)(6)-2 [redacted] 2LT/AN
15 Aug 03	1215 - VSS, lungs CTA, HR reg, BS ⊕ x4, pulses
	⊕ x4. Pt A+O x3. Ext fix intact to Ⓡ leg
	Pin care done by pt. PO antibiotics. Ø
	complaints at this time. Will cont to
	monitor. (b)(6)-2 [redacted]
15Aug03	pt care assumed @ 1300. pt awake & alert, VSS
1330	lungs CTA, abd soft BS ⊕ x4. Ⓡ thigh c̄ ex-fix drsing
	CDI. ⊕ pulse. LLE c̄ full ROM ⊕ pulse. BUE c̄ full ROM
	⊕ pulse. Ø complaints voiced @ this time. Will cont
	to monitor (b)(6)-2 [redacted] 9/WM
15Aug03	Rec'd c/o pt @ 21:00. VS WNL per flow sheet. Restraints
21:55	x2 Ⓛ wrist/ankle. Awake and alert in bed. PERRLA ⊕ WNL. Skin
	W/D/I. LCA Ⓑ. error [redacted] (b)(6)-2 HR SSR. BS ⊕ x4. ⊕ PP Ⓑ. Ⓡ thigh ex-fix in pla
	DSG's to pinsites error [redacted] (b)(6)-2 ⊕ CDI. ⊕ ROM ⊕ sensation ⊕ <3 sec cap refill

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.

[redacted] (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

MEDCOM - 13539

All: (b)(6)-2

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
cont'd	to Ⓡ foot digits. ø c/o pain @ this time. Will cont to mon —
	[redacted] 2LT/AN
0116	c/o pain to Ⓡ knee and Ⓡ thigh ii Percocet given
	[redacted] 2LT/AN
16 Aug 03	1130. Pt alert & oriented lying in bed. VSS, lungs
	CTA, HR reg, BS⊕, pulses ⊕x4. Ext fix intact
	to Ⓡ leg. Pin care done by pt. Voicing ø
	complaints. Will cont to monitor - [redacted] 1LT AN
16 Aug 03	pt care assumed @ 1300. pt awake et alert. VSS.
1520	assessment findings WNL x̄ Ⓡ thigh c̄ ex-fix, drsing
	CDI ⊕ movement, ⊕ sensation ⊕ pulse. 1500 PT c̄
	pt doing ROM exercise. pt premedicated c̄ ii percocet
	p̄ exercise, drsing Δ'd et pin care done. ø S/SX
	of infection noted to pin sites, ø complaint
	of pain/discomfort voiced @ this time. Will cont
	to monitor —— [redacted] 91WM6
16 Aug 03	Rec'd c/o pt @ 21:00. Restraints x 2 Ⓛ wrist/Ankle. VS WNL per flow
21:35	sheet. Awake and alert in bed. Skin W/D/I. PERRLA⊕WNL. LCA⊕. HRR S,S2
	BS⊕x4. ⊕PPB Ⓡ thigh ex-fix in place c̄ pin site dsgs C/D/I. ⊕ROM⊕
	sensation⊕ <3 sec cap refill Ⓡ foot/ankle/digits. ø c/o pain will
	cont to mon [redacted] 2LT/AN
17 Aug 03	VSS. Pt. awake & alert in bed s̄ complaints @ this time. HR Regular
0630	lung sounds clear bilat, bowel sounds (+) x 4 quads. ø IV access. Ext fix
	to Ⓡ leg intact, DSG to pins CDI. ⒷLE pedal pulses palpable, (+) sensation
	<3 sec cap refill, full ROM in digits & ankle, limited ROM in knee.
	All other assessment findings WNL. Will continue to monitor. [redacted] 2LT/AN

NSN 7540-00-634-4176 AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	**CHRONOLOGICAL RECORD OF MEDICAL CARE**
DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17 Aug 03 1330	pt care assumed @ 1300. pt awake & alert. VSS. assessment findings WNL. Ⓡ thigh c̄ ex-fix intact drsing to pin sites CDI, ⊕ movement ⊕ sensation ⊕ pulse. ⊖ IV access noted. pt denies pain @ this time. Will cont to monitor (b)(6)-2 [redacted] 91WM6
17 Aug 03 21:47	Rec'd c/o pt @ 21:00. Restraints x2. VS WNL per flowsheet. Awake and alert in bed. Skin W/D/I. Perrla ⊕ WNL. LCA Ⓑ. HRR S1S2. BS ⊕ x4. Ⓡ thigh ex-fix in place. Pin site dsgs C/D/I. Ø apparent s/s infection. Ⓡ LE FROM ⊕, sensation ⊕, ⊕ <3 sec cap refil ⊕ PP Ⓑ. Ø c/o pain @ this time. Will cont. to mon. (b)(6)-2 [redacted]
18 Aug 03	1215 - Pt A+O x 3 OOB x 1 using crutches VSS, lungs CTA, BS ⊕, pulses ⊕ x4. Ext fix intact to Ⓡ leg. Pin care done by pt. D/C orders written. Will be evac to camp today (b)(6)-2 [redacted]

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. ICW2

#EPW [redacted] (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

NSN 7540-00-634-4176 AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
8/18/03	D/C Summary This Iraqi male had a gunshot wound to right femur which was stabilized with an external fixator late June 2003. He has a subtrochanteric femur fracture. He is progressing well with ambulation and ranges of motion and strength. His fracture is still not healed. He is proficient in his own pin site care. He should remain non weight bearing on his right leg with crutches for assistance and continue to use prophylactic oral antibiotics as well as continue to perform his own pin site care daily (b)(6)-2 [redacted]

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.

EPW

[redacted] (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

NSN 7540-01-075-3786

MEDICAL RECORD	**EMERGENCY CARE AND TREATMENT** *(Patient)*	LOG NUMBER TREATMENT FAC[redacted] RECORDS MAINTAINED AT (b)(2)-2

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY

STATE

ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)* 30 Jul

TIME 0930

TRANSPORTATION TO FACILITY AMB

SEX M

DUTY/LOCAL PHONE

AREA CODE (b)(6)-4

NUMBER

AGE [redacted]

HOME PHONE

AREA CODE

NUMBER

MILITARY STATUS

ITEM	YES	NO	N/A
PRP			
FLYING STATUS			
MEDICAL HISTORY OBTAINED FROM			

THIRD PARTY INSURANCE

ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2568 IN CHART		
NAME OF INSURANCE COMPANY		

CURRENT MEDICATIONS

ALLERGIES

INJURY OR OCCUPATIONAL ILLNESS

ITEM	YES	NO	WHEN *(Date)*
IS THIS AN INJURY?			WHERE
INJURY/SAFETY FORMS			

HOW

EMERGENCY ROOM VISIT

DATE LAST VISIT

24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT

COMPLETED INTITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT Ex Fix Ⓡ Femur

CATEGORY OF TREATMENT

☐ EMERGENT

☐ URGENT

☒ NON-URGENT

TIME 0935

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

VITAL SIGNS

TIME 0930					
BP 108/60					
PULSE 101					
RESP 18					
TEMP 998					
WT 706					

LAB ORDERS

X	CBC/DIFF [redacted]	ABG		PT/PTT	BHCG/URINE/BLOOD/QUANT
	URINE C&S		UA MSCC/CATH	[redacted]	[redacted]EM: N
	BLOOD C&S X				

X-RAY ORDERS

CXR PA & LAT/PORTABLE	C-SPINE
ACUTE ABDOMEN	LS SPINE
SINUS	HEAD CT
ANKLE R/L	
Ⓡ femur xray	

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE

DISPOSITION

☐ HOME ☐ FULL DUTY

MODIFIED DUTY UNTIL

DISPOSITION QUARTERS /OFF DUTY

☐ 24 HRS. ☐ 48 HRS. ☐ 78 HRS.

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE

☐ IMPROVED ☐ UNCHANGED

☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ TO

WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

PATIENT'S IDENTIFICATION *(For typed or written entries, give: Name -- last, first, middle; ID no. (SSN or other); hospital or medical facility)*

[redacted] (b)(6)-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

STANDARD FORM 558 (REV. 9-96)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.203(b)(10)
USAPA V1.00

TWENTY-FOUR HOUR PATIENT IN AKE AND OUTPUT WORKSHEET	FROM _____ HOURS TO _____ HOURS	TOTAL HOURS COVERED	DATE 7/26/03

INT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL

Foley **~~IRRIGATIONS~~ (N/G, Bladder, etc.)** output

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0100	urine, med yellow	600	600
0400	urine	450	1050
1900			

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl. Alb. P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

Gpw [redacted] (b)(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

MEDICINE GLASS (1 oz)	30	HALF PINT MILK	240
SMALL FRUIT CUP	120	LARGE SOUP BOWL	240
COFFEE CUP	160	LARGE WATER GLASS	240
LARGE COFFEE MUG	180	PLASTIC OR PAPER JUICE CONTAINER	180

DD FORM 1 JAN 74 792 EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3630(TEMP) 1 JUL 72

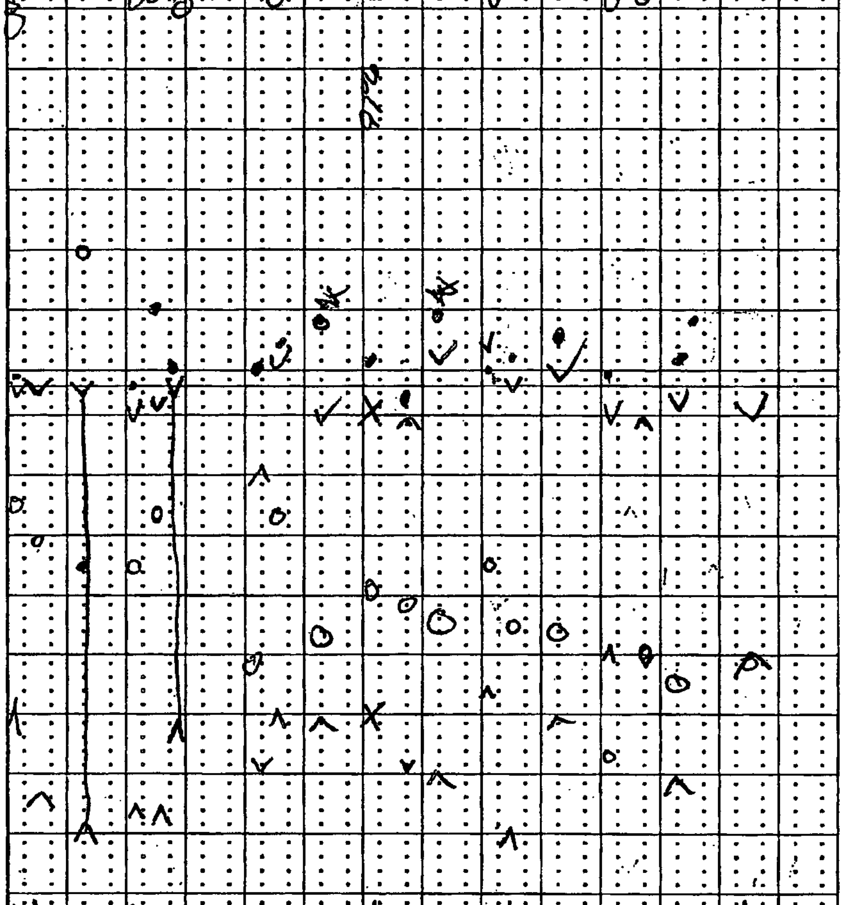
MEDCOM - 13544

*U.S.GPO:1998-404-813/30343

MEDICAL REC

VITAL SIGNS RECORD

HOSPITAL DAY							
POST- DAY							
MONTH-YEAR / DAY	3	4	5	6	7	8	9
July ~~18~~ 2003 / HOUR	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]



RESPIRATION RECORD	18 14 14	18 18	16 16	18 16	14 16 18	18 16	18
BLOOD PRESSURE	126/70 124/56	120/54 122/54 124/68	119/62 130/70 118/[illegible]	118/60 134/60	134/64 122/50 [illegible]	124/80 118/78 124/[illegible]	120/80
HEIGHT: / WEIGHT →							
	98% 98% 93%	96% 96%	98% 98%	97%	98% 98%	98% 98%	98%

Record special data only when so ordered

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*

REGISTER NO.

WARD NO. ICW2

STANDARD FORM 511 (REV. 7-95) BACK

EPW # [redacted] (b)(6)-4

MEDCOM - 13545

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

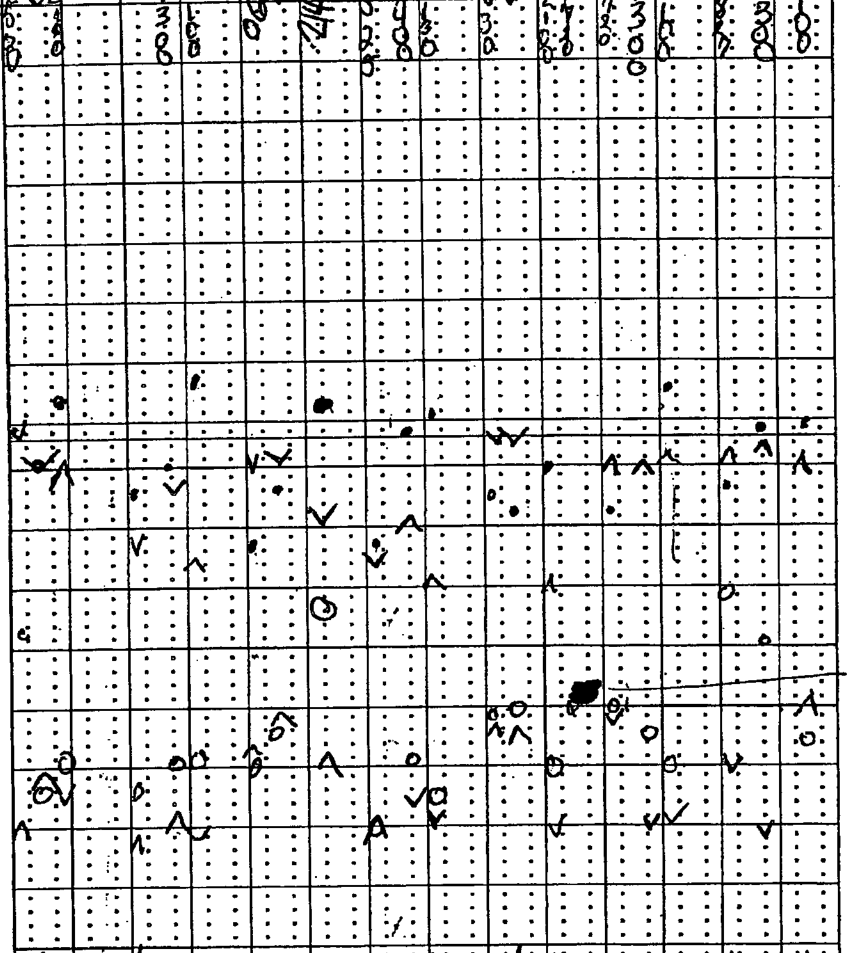
VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR July 19

DAY	10	11	12	13	14	15	16
HOUR	[illegible]	1308 2100	0800 2147	[illegible] 1408 2130	[illegible]	[illegible] 1300 2108	[illegible] 1338 2108
RESPIRATION RECORD	16 14 16	16 16	16 16	16 16	14 16	16	12 16
BLOOD PRESSURE	128/60 120/68	106/58 114/62	124/74 110/72 120/78	114/60 110/60	124/76 124/70	120/78 120/60	95% [redacted] (b)(6)-2 120/70 122/58
HEIGHT: WEIGHT →						(b)(6)-2	
	99% 100%	99%	98% 96%	98%	98% 100% 98%	[redacted] 100%	95%



Record special data only when so ordered

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)

REGISTER NO.

WARD NO. ICW2

EPW# [redacted] (b)(6)-4

VITAL SIGNS RECORDS

Medical Record

STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 13546

(b)(6)-2

MEDICAL RECORD

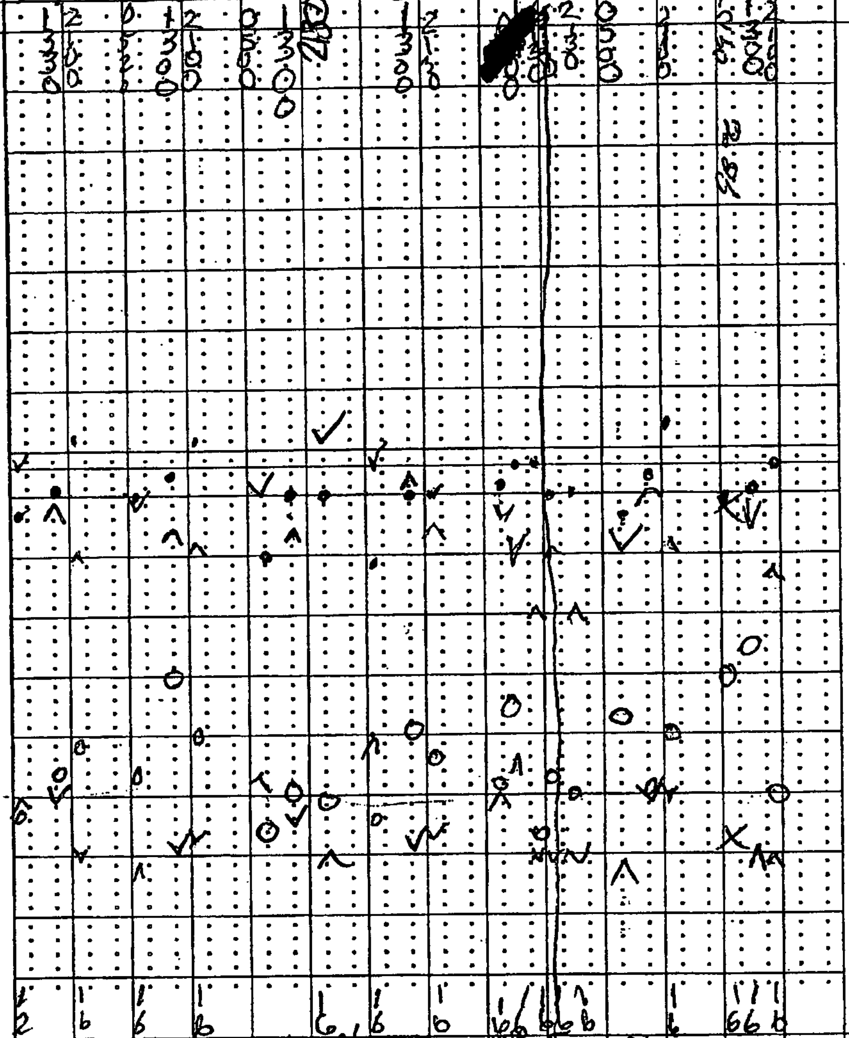
VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR June 03 | DAY: 17 | 18 | 19 | 20 | 21 | 22 | 23

19 | HOUR



RESPIRATION RECORD: 12 | 16 | 16 | 16 | 16 | 16 | 16 | 16 | 16 | 16 | 16 | 16 | 16 | 16 16 16

BLOOD PRESSURE: 128/70, 118/70 | 113/58, 114/62 | 122/72 | 114/68 | 131/80 | 126/80, 124/62 | 110/70, 110/76 | 112/58, 120/70 | 116/60

HEIGHT: | WEIGHT → 98% | 98% | 98% | 96% | 98% | 98% | 98 | 99

Record special data only when so ordered

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; ID No.. (SSN or other); hospital or medical facility)

REGISTER NO.

WARD NO. ICW2

STANDARD FORM 511 (REV. 7-95) BACK

EPW # [redacted] (b)(6)-4

MEDCOM - 13547

511-119

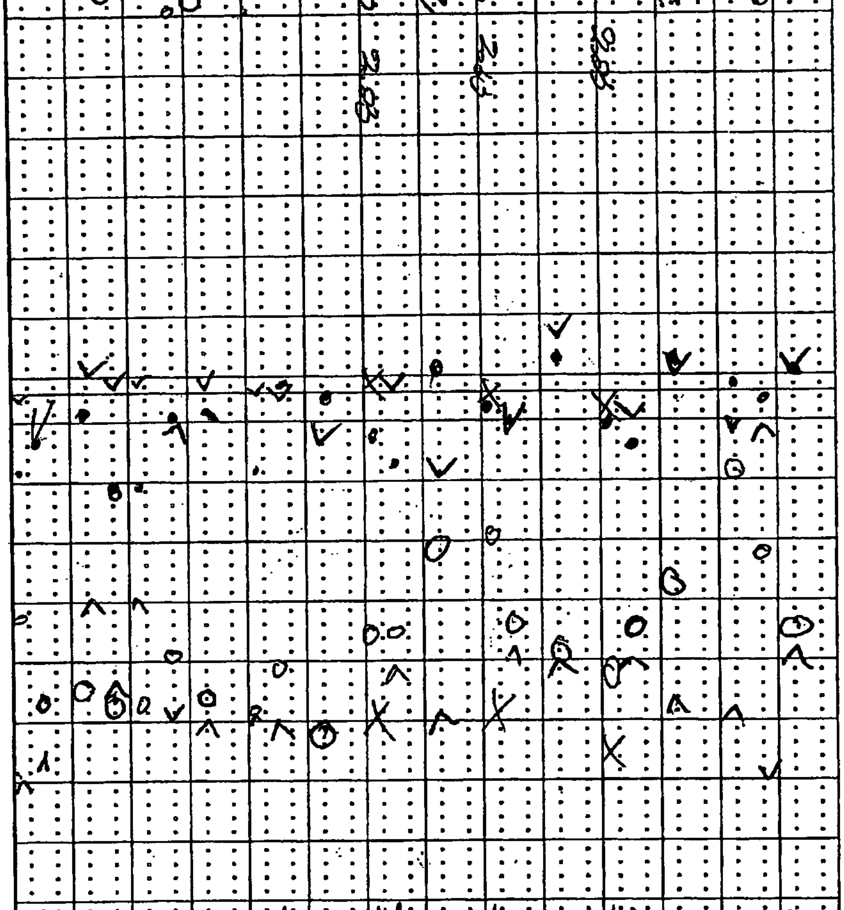
NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY														
POST- DAY														
MONTH-YEAR July 19 03 / DAY	24		25		26		27		28		29		30	
HOUR	[illegible]	2150	1300	[illegible]	0800	2100	0200	2140	0800		0830	2120	[illegible]	2100

PULSE (O) — TEMP. F (•) — TEMP. C



(Centigrade Equivalents, for Reference only)

Record special data only when so ordered

RESPIRATION RECORD	16	18 16	16		16	16	16 16	16	18	16	16	1[illegible]	16	16
BLOOD PRESSURE	124/60	[illegible]	130/90	128/70	126/72	116/70		110/70	130/80	136/80		130/74	118/72	130/82
	120/60		118/70		124/70		138/78				138/80		116/60	
HEIGHT: / WEIGHT →													97/	98%
	97%	97% 100%		98%	98% 98%	98%	98%	98%		98%	98%	98%		

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*

REGISTER NO.

WARD NO.

EBW [redacted] (b)(6)-4

VITAL SIGNS RECORDS

Medical Record

STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 13548

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

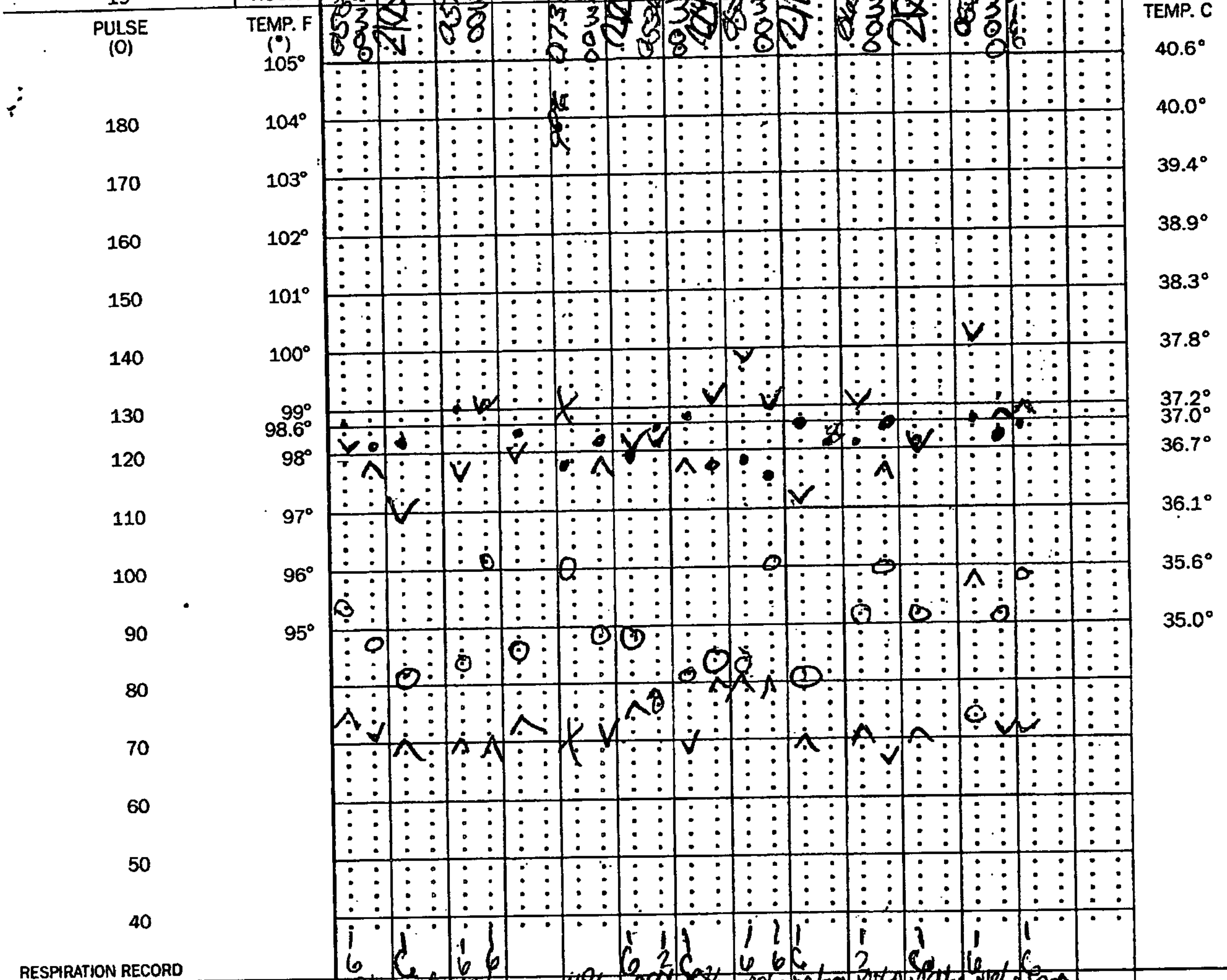
HOSPITAL DAY

POST- DAY

MONTH-YEAR: July August

DAY: 31 1 2-3 3-4 4-5 5-6 6

19 HOUR: 0800 1300 2100 0800 1300 0730 1300 2100 0800 1300 2100 0800 1300 2100 0800 1300 2100 0800 1300 06



RESPIRATION RECORD: 16 16 16 16 16 12 16 16 16 16 12 16 16 16

Record special data only when so ordered

BLOOD PRESSURE: 122/76 118/70 110/72 116/70 130/70 119/74 118/72 120/76 122/78 98/88 138/80 138/82 130/80 112/70 134/70 116/66 124/72 140/96 128/72 98%

SPO2: 97 98% 97 90 99% 98 98% 97 98% 98 99% 99

HEIGHT: WEIGHT →

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*

REGISTER NO.

WARD NO. ICW

epw

[redacted] (b)(6)-4

VITAL SIGNS RECORDS

Medical Record

STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 13549

MEDICAL RECORD

VITAL SIGNS RECORD

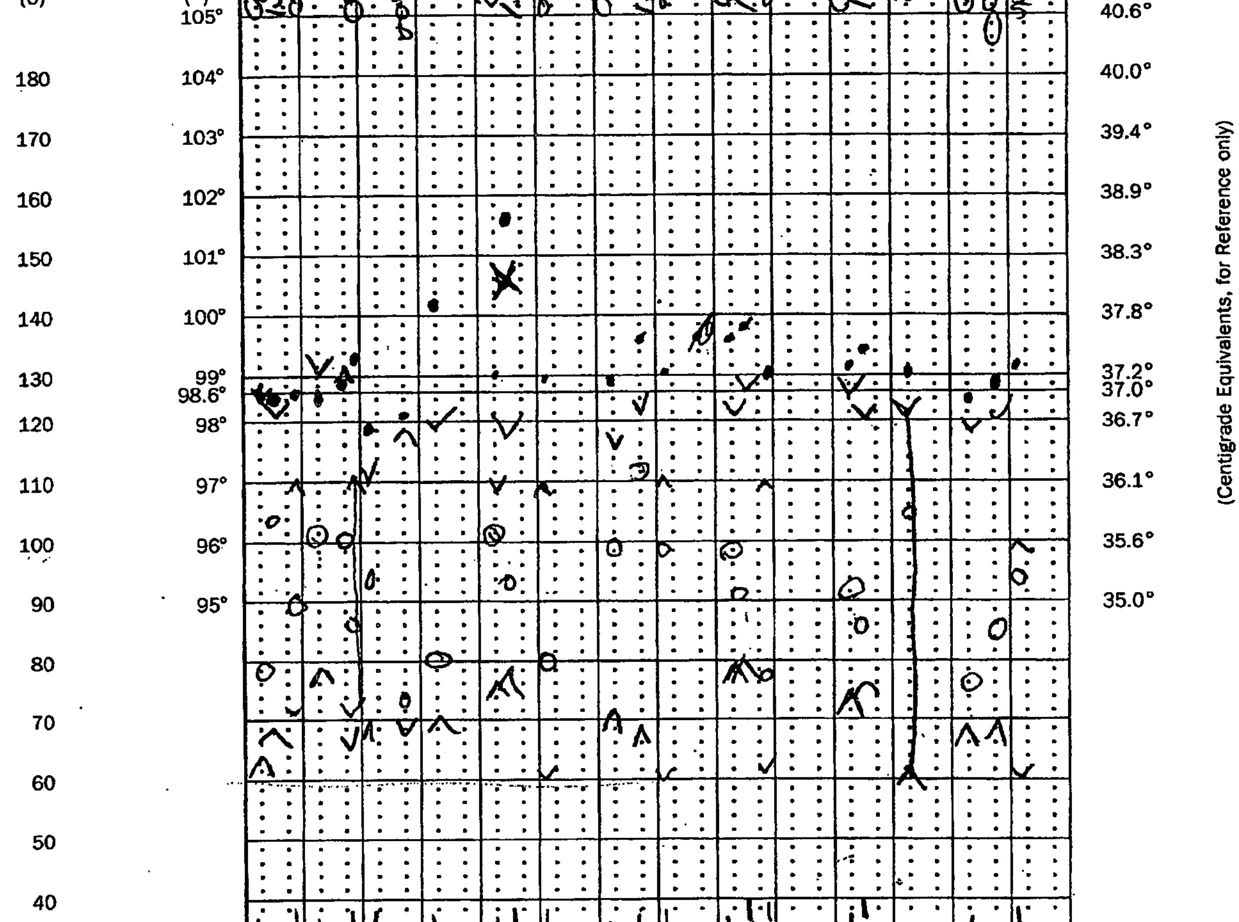
HOSPITAL DAY

POST-Ex-fix placement DAY I/A

MONTH-YEAR Aug ~~18~~ 2003

DAY	7-8	9	10	11	12	13	14
HOUR	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

PULSE (0) TEMP. F (•)



(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD	16	16	16	16	16	16	18	16	16	16	16	18	16	16
BLOOD PRESSURE	124/64 122/60	130/70 134/64	110/70 116/68	108/70	118/76 114/80		116/72 98/60	~~[illegible]~~	122/78 120/80		124/74 124/76	108/60	118/60 120/70	
	98	98%	98%	98%	97		98	99%	97 98		98		98	99
HEIGHT: / WEIGHT →	96%	98%			96%	98%	96%		98%		98%	98%		

Record special data only when so ordered

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)

REGISTER NO.

WARD NO. ICW2

STANDARD FORM 511 (REV. 7-95) BACK

EPW

[redacted] (b)(6)-4

MEDCOM - 13550

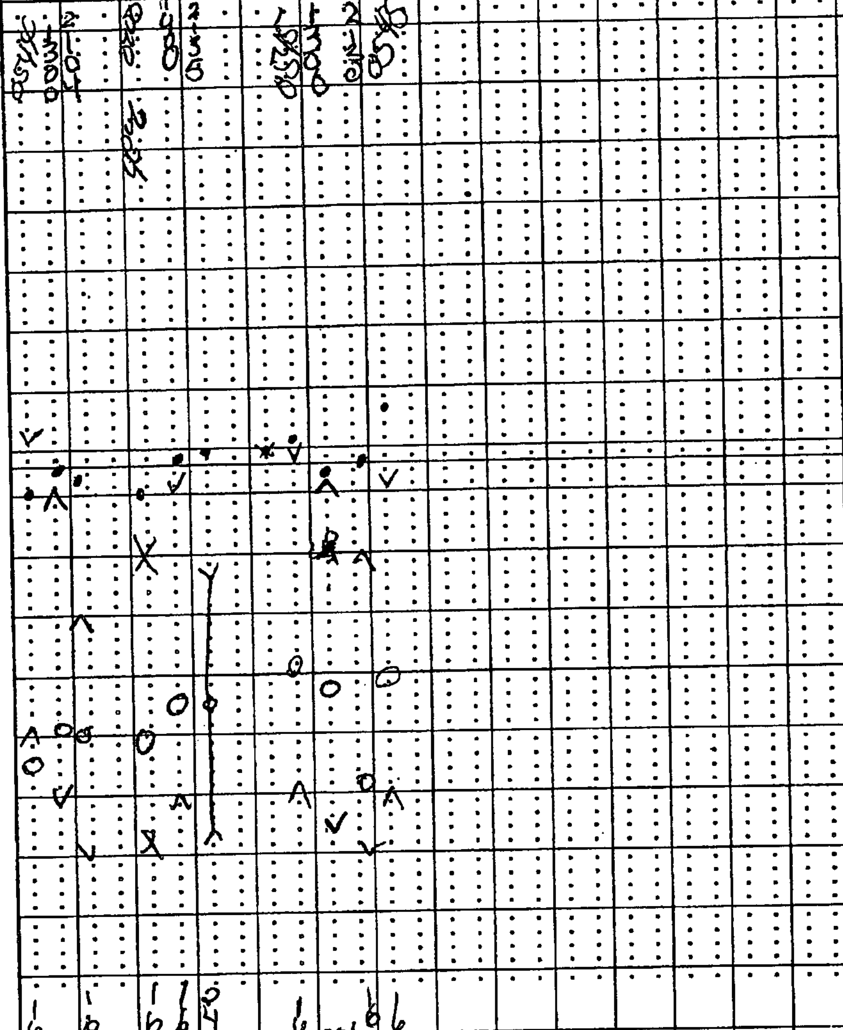
511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY							
POST- DAY							
MONTH-YEAR AUG	DAY	15	16	17	18	19	20	21
19 03	HOUR	[illegible] 2	[illegible] 2135	[illegible] 2	[illegible]			



	15	16	17	18	19	20	21
RESPIRATION RECORD	16 10	16 16 24	16	16 16			
BLOOD PRESSURE	132/80			109/62 122/90			
	120/70	110/70 1?/74	120/70				
	97 98	100%	98 98	98			
HEIGHT: WEIGHT →							

Record special data only when so ordered

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)

EPW

[redacted] (b)(6)-4

REGISTER NO.

WARD NO. KWD

VITAL SIGNS RECORDS

Medical Record

STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 13551

Ward Section 1Cw 2	R TING PHYSICIAN:	LA	RY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI EPW# [redacted] -(b)(6)-4	DATE 3Jul03	TIME 1320	SSN/PSEUDO SSN

(Hematology) CBC

TEST	RESULT	REF RANGE
WBC	6.4	4.8-10.8 x 10^3
RBC	2.34	4.7-6.1 x 10^6
Hgb	6.4	14-18 g/dl (M) 12-16 g/dl (F)
Hct	20.9	42-52% (M) 37-47% (F)
MCV	89.5	80-94 fl (M) 81-99 fl (F)
Plt	242	130-400 x 10^3 verified
Lymph %	27.8	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

Misc. Serology

TEST	RESULT	REF RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

CSF

Cell Count			
Directigen		Negative	

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Blood Bank Unit Crossmatch
(MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS: [illegible]

REPORTED BY: [redacted] (b)(6)-2	DATE: 3Jul03	LAB ID NO.:

MEDCOM - 13552

Ward/Section: ICW2

…QUESTING PHYSICIAN: [redacted] (b)(6)-2

…TRY RESULT FORM
(Sub… to the Privacy Act of 1974)

LAST, FIRST… [redacted] (b)(6)-4

DATE 3 Jul

TIME 1100

SSN/PSEUDO… [redacted] (b)(6)-4

(I-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		[illegible]

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU	100	73-118 mg/dl
BUN	4	7-22 mg/dl
CRE	0.9	0.6-1.2 mg/dl
CK	2977	39-380 u/l (M) 30-190 u/l (F)
NA^+	120	128-145 mmol/l
K^+	3.6	3.3-4.7 mmol/l
CL^-	101	98-108 mmol/l
tCO_2	28	18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		Negative
Drug of Abuse		Negative
		Negative
		Negative
		Negative

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

REMARKS:

REPORTED BY: [redacted] (b)(6)-2

DATE: 3Jul03

LAB ID NO.:

Ward/Section: ~~EMA~~ ICU	QUES [redacted] IAN: (b)(6)-2	**ATORY RESULT FORM** to the Privacy Act of 1974)
LAST, FIRST, M [redacted] (b)(6)-4	DATE 3 July, TIME 1010	SSN [redacted] SN: (b)(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	7.1	4.8-10.8 x 10³
RBC	2.47	4.7-6.1 x 10⁹
Hgb	7.0	14-18 g/dl (M) 12-16 g/dl (F)
Hct	22.1	42-52% (M) 37-47% (F)
MCV	89.4	80-94 fl (M) 81-99 fl (F)
Plt	239	130-500 x 10³ verified
Lymph %	28.8	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			
Spun Hematocrit		42-52% (M) 37-47% (F)	
Sed Rate			
Other			

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

Misc Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: (b)(6)-2 [redacted]	**DATE:** 3 Jun 03	**LAB ID NO.:**

MEDCOM - 13554

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-400; the proponent agency is the Office of The Surgeon General.

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
EPW [redacted]
(b)(6)-4
[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 2 July 03 TIME OF ORDER 1037 HOURS

LIST TIME ORDER NOTED AND SIGN

admit to Pt. Hold
Activity: Bedrest
Meds:
Ancef 1 gm IV Q6H
Morphine Sulfate 10mg/mL
10mg IM Q 8H
Tylenol 1000mg PO Q6H

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER ______ HOURS

Diet: Regular
Vitals: Q 4H
call H.O. for
SBP ≥ 150; ≤ 90
DBP ≥ 110 ≤ 50
Pulse ≥ 110 ≤ 60
Temp > 100.4

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER ______ HOURS

Pin Care: Q 8H (b)(6)-2
Diagnosis? (R) Femur Fx S/P [redacted]
Gunshot wound (R) thigh +
S/P Ex Fix

(b)(6)-2
[redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 3 July 03 0800 HOURS (b)(2)-2

Routine Evacuation to [redacted]
Today for wound inspection
~~Dressing Δs and Position~~
~~assessment~~. R/O Infection
(b)(6)-2
[redacted]

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

MEDCOM - 13555

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
EPW
[redacted]
(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 3 June 03 TIME OF ORDER 1010 HOURS

LIST TIME ORDER NOTED AND SIGN

① Admit ✓
② Dx: GSW (R) thigh, ext fix ✓
③ Condition stable ✓
④ VS routine ✓
⑤ Up to [illegible], crutches [illegible]
⑥ Dressing changes daily

[redacted] (b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

⑦ Regular diet
⑧ Hep lock IV
⑨ √ [illegible] Q 8hrs
⑩ √ Percocet 1-2 p.o. Q 4-6 hrs prn
⑪ Tylenol 650 mg p.o. Q 4 hrs prn ✓
⑫ MSO4 2-6 mg IVP Q 2 hrs prn
⑬ (R) femur x-ray
⑭ CBC [illegible] 8 [redacted]

NURSING UNIT | ROOM NO. | BED NO.
2B/[illegible] [redacted] (b)(6)-2

(b)(6)-2

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

DATE OF ORDER 4 June TIME OF ORDER 0830 HOURS

Pin care BID
1/2 str H2O2
DSD [illegible]

(b)(6)-2 [redacted] 1445

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

NURSING UNIT | ROOM NO. | BED NO.
ICW2 [redacted]

✓ [redacted] 06 Jul 20[illegible] [redacted]

PATIENT IDENTIFICATION

DATE OF ORDER 6 July 03 TIME OF ORDER 0930 HOURS

① D/C Foley now

6 July 03 0930 [redacted] (b)(6)-2

(b)(6)-2 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

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

MEDCOM - 13556

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

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

[redacted] (b)(6)-4

UNIT ICW2 | ROOM NO. | BED NO. [redacted]

DATE OF ORDER 9 Jul 03 TIME OF ORDER 21:31 HOURS

LIST TIME ORDER NOTED AND SIGN

V.O.

1 dose mylanta x1 now for generalized abd. discomfort

Dr [redacted] / [redacted]

(b)(6)-2

24°/done [redacted] 2LT/AN

noted 21:31 9 Jul 03 [redacted] 2LT/AN

IDENTIFICATION 24° VS

24°VS [redacted] (b)(6)-2

1LT/AN 7-12-03 2350

1LT/AN 7-15-03 0030.

(b)(6)-2

[redacted] (b)(6)-4

UNIT ICW2 | ROOM NO. | BED NO. [redacted]

IDENTIFICATION ~~ICW~~ [redacted] (b)(6)-4

DATE OF ORDER 24 July 03 TIME OF ORDER 0130 HOURS

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

V.O. from Dr. [redacted] to LT [redacted]

① 50mg Benadryl po QHS PRN

(b)(6)-2

[redacted] 2LT/AN

noted 24 July 0130 [redacted]

UNIT ICW2 | ROOM NO. | BED NO. [redacted]

24 chart ✓ 24° ✓ 24 Jul 03 0300 [redacted] 2LT/AN (b)(6)-2

(b)(6)-2 [redacted]

IDENTIFICATION ~~ICW~~ [redacted] (b)(6)-4

[redacted] 1LT/AN 7-24-03 0030

(b)(6)-2

26 July 03 0900

① DC Ancef

② Keflex 500 mg PO ~~TID~~ QID [redacted] (b)(6)-2

③ Δ Drsg changes to Peroxide & H2O. No drsg to pins.

④ Straight leg raises x10 QID (right leg)

⑤ Knee bend to (R) LE x10 QID

V.O. Dr. [redacted] / [redacted] LT/AN

⑥ Consult PT for exercises

(b)(6)-2

(b)(6)-2 [redacted] LT, AN 26 July 03 0910

UNIT ICW2 | ROOM NO. | BED [redacted]

24°VS 2200 26 July 03 [redacted] (b)(6)-2

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

EPW

[redacted] (b)(6)-4

DATE OF ORDER 26 July 03 TIME OF ORDER 1605 HOURS

V.O. D/C M504

Dr. [redacted] / [redacted] 91Wm6

(b)(6)-2

(b)(6)-2 noted [redacted] 91Wm6 1605

NURSING UNIT ICW 2 ROOM NO. 24°VS BED NO. 26 July 03 [redacted] -(b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER 7/28/03 TIME OF ORDER 0630 HOURS

Start Lovenox 30mg SQ BID

(b)(6)-2 [redacted]

(b)(6)-2 [redacted]

28 July 03 0740

NURSING UNIT ROOM NO. 24°VS BED NO. 28 July 03 2300 [redacted] (b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-4

[redacted]

DATE OF ORDER 7/30/03 TIME OF ORDER 1010 HOURS

① XR AP + LATeral of Ⓡ HIP

(b)(6)-2 noted [redacted] 30 July 03 1010

NURSING UNIT ROOM NO. 24°VS BED NO. 30 July 03 2200 [redacted] (b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-4

[redacted]

DATE OF ORDER 8/10/03 TIME OF ORDER 1550 HOURS

① XR AP & Lateral of Ⓡ HIP

(b)(6)-2 [redacted]

noted 91Wm6 10 Aug 1000

NURSING UNIT ROOM NO. BED NO. 24 ✓ done [redacted] 2020/AN

(b)(6)-2

MEDCOM - 13558

For use of [illegible] form, see AR 40-[illegible] the proponent agency is [illegible]

[illegible] SHALL REC[illegible] [illegible] WHITE [illegible] SHOW [illegible] SET OF ORDERS. [illegible] COLUMN INDICATED BY ARROW [illegible]

[illegible] IDENTIFICATION

DATE OF ORDER 13 Aug 03 TIME [illegible] ORDER 0800 HOURS

[illegible] NOTED AND [illegible]

V.O.

Clindamycin 150 mg PO

Dr. [redacted] / [redacted] 2HAN

(b)(6)-2

13 Aug 03 0000 [redacted] (b)(6)-2

[illegible] UNIT | ROOM | BED NO.

[illegible] IDENTIFICATION

[redacted]

(b)(6)-4

DATE OF ORDER 14 Aug TIME OF ORDER 23:16 HOURS

1 Imodium 2mg ii po now, then i po p̄ ea. BM; no more than 5/24hr PRN diarrhea

(b)(6)-2

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

(b)(6)-2

noted 14 Aug 23:16 [redacted] (b)(6)-2

0040 ✓ done [redacted] 2HAN

[illegible] UNIT | ROOM | BED NO.

[illegible] IDENTIFICATION

[redacted]

(b)(6)-4

DATE OF ORDER 8/18/03 [illegible] ORDER 0900 HOURS

① D/C to EPW camp

② Contact for ambulation

③ Rx on chart

[redacted]

(b)(6)-2

[illegible] UNIT | ROOM | BED NO.

[illegible] IDENTIFICATION

EPW

(b)(6)-4

[redacted]

DATE OF ORDER TIME OF ORDER HOURS

[illegible] UNIT | ROOM | BED NO.

FORM [illegible] 79 4256

REPLACES EDITION OF 1 JUL 77, WHICH MAY BE [illegible]

*U.S. GOVERNMENT PRINTING OFFICE: 2002-[illegible]

All (b)(6)-2 except one at bottom

CLINICAL RECORD

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

Mo. ____ *Yr.* ____

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	12	13	14	15	16	17	18	19	20	21	22	23	24	25
11 Aug	[redacted]	VS Routine	5	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
			13	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
			21	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
11 Aug	[redacted]	Up ad-lib c̄ crutches	5	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
		NWB Ⓡ leg	13	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
			21	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
11 Aug	[redacted]	Reg Diet	8	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
			12	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
			17	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
11 Aug	[redacted]	Pin care BID	10	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
			22	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
11 Aug	[redacted]	Straight leg raises	6	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
		x10 to Ⓡ leg QID	12	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
			18	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
			22	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
17 Aug	[redacted]	RLE knee bends x10	6	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
		QID	12	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
			18	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
			22	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
S/P GSW Ⓡ thigh c̄ ex fix

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

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 EDITION OF 1 DEC 77 MAY BE USED. USAPA V1.00

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All (b)(6)-2 (EXCEPT Bottom one)

CLINICAL RECORD

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

Mo. 7 *Yr.* 2003

VERIFY BY INITIALING — *INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION*

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED													
				3	4	5	6	7	8	9	10	11	12	13	14	15	16
3 July	[redacted]	VS - routine	05	[redacted]													
			13	[redacted]													
			21	[redacted]													
3 July	[redacted]	Up ad lib, crutches	05	[redacted]													
		NWB	13	[redacted]													
			21	[redacted]													
3 July	[redacted]	Dressing Δ daily	10	/	[redacted]					03	[redacted]						
3 July	[redacted]	Regular diet	07	[redacted]													
			12	[redacted]													
			17	[redacted]													
4 Jul 03	[redacted]	PINCARE Bid ½ STR.	10	/	[redacted]												
		H_2O_2/DAY STERILE	22	/	[redacted]												
		DSG TO WOUND															

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW Ⓡ thigh, ext fix

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

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 EDITION OF 1 DEC 73 MAY BE USED. USAPA V1.00
MEDCOM - 13561

All: (b)(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*	Mo 7	Yr 2003		
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
3 July	[redacted]	Admit ICW-II ; Cond: Stable	———	done ———		[redacted]
3 July	[redacted]	(R) femur X-Ray today				
	-----	CBC, [illegible]	3 July		done	[redacted]
4 July	[redacted]	D'C Foley			done	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING COMPLETION* TIME/DATE COMPLETED													
-----	-----															
-----	-----															
-----	-----															
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USAPA V1.00

All (b)(6)-2 (except bottom one)

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. 7 *Yr.* 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	3	4	5	6	7	8	9	10	11	12	13	14	15	16
3 July	[redacted]	Ancef I gm IVPB	06	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
		Q8°	14	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
			22	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
3 July	[redacted]	HL IV	05	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
			13	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
			21	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW Ⓡ thigh, ext fix

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____________

PATIENT IDENTIFICATION: EPW # [redacted] (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 - 13563

A11 (b)(6)-2

Verify by Initialing		**THERAPEUTIC DOCUMENTATION CARE PLAN** *(MEDICATIONS)*	Mo. 7	Yr. 03		
Order Date	**Clerk/ Nurse**	**SINGLE ORDER, PRE-OPERATIVES**	**Date to be Given**	**Time to be Given**	**Time Given**	**Initials**
9 JUL	[redacted]	1 dose Mylanta x1 now for generalized	9 JUL	21:31	21:34	[redacted]
	-----	ABD pain				

INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION

Order/ Expir Date	**Clerk/ Nurse**	**PRN MEDICATION, DOSE, FREQUENCY**	**TIME/DATE DISPENSED**														
3 July	[redacted]	Percocet i-ii PO Q4-6° PRN	4 JUL 2200 ii [redacted]	10 JUL 0840 ii [redacted]	11 JUL 2241 ii [redacted]	12 JUL 0740 ii PO [redacted]	13 JUL 0104 ii PO [redacted]	13 July 0645 ii PO [redacted]	7/13 1445 ii [redacted]	7/13 2015 ii [redacted]	7/15 2230 ii PO [redacted]	15 July 0710 ii [redacted]	18 Jul 0410 ii [redacted]	19 July 0315 ii PO [redacted]	19 JUL 0715 ii PO [redacted]	20 JUL 2007 ii PO [redacted]	20 July 2400 ii PO [redacted]
3 July	[redacted]	Tylenol 650mg PO Q4° PRN	0030 4 JUL ii PO [redacted]	2300 10 JUL ii PO [redacted]	12 July 2010 ii	17 July 0230 ii PO [redacted]	17 July 2100 ii PO [redacted]	18 July 2330 ii PO [redacted]	19 JUL 00:11 ii PO [redacted]	[redacted]							
3 July	[redacted]	MSO4 2-6 mg IVP Q2° PRN	2005 8 JUL 3mg IVP [redacted]	12 JUL 2015 4mg IVP [redacted]													
9 July	[redacted]	50mg Benadryl po QHS PRN	9 JUL 0130 ii po [redacted]														
3 July	[redacted]	percocet i-ii po q 4-6° PRN	30 July 1630 [redacted]														
-----	-----																
-----	-----																
-----	-----																

USAPA V1.00

MEDCOM - 13564

All (b)(6)-2 (EXCEPT Bottom one)

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

INITIAL PROPER C~~ UMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 17 18 19 20 21 22 23 24 25 26 27 28 29 30
3 July	[redacted]	Ancef 1gm IVPB Q8°	6	[redacted] DC'd
			14	
			22	
3 July	[redacted]	IV HL	5	[redacted]
			13	
			21	
26 July	[redacted]	Keflex 500mg PO QID	06	[redacted]
			12	
			18	
			24	
		Lovenox 30mg	08	[redacted]
26 July	[redacted]	SQ BID	20	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW (R) thigh ext. fix

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

PATIENT IDENTIFICATION:

EPW # [redacted] (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

MEDCOM - 13565

be Given | be Given

All (b)(6)-2

er/ ir e	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION												
			TIME/DATE DISPENSED												
21 July	[redacted]	Benedryl 50mg PO QHS PRN	2300 23 Jul 50mg [redacted]	50 mg 2300 24 J [redacted]	50 mg 2200 25 July [redacted]	28 JUL 0131 50mg PO [redacted]	28 July 2202 PO [redacted]	30 July 2202 50mg [redacted]							
23 July	[redacted]	Percocet i-ii PO q4-6 prn pain	ii 2300 24 Jul [redacted]	25 Jul 0945 ii PO [redacted]	ii 2200 25 Jul [redacted]	26 Jul 0215 ii [redacted]	26 July 1155 [illegible]	26 July 2200 [redacted]	27 July 0700 ii [redacted]	27 Jul 01:47 ii PO [redacted]	28 Jul 0730 ii [redacted]	28 July 1320 ii [redacted]	30 July 1630 ii [redacted]	[illegible] 1430 ii [redacted]	
23 July	[redacted]	Tylenol 650 mg PO q4° prn	23 July 1430 ii [redacted]		2230 23 July 650mg [redacted]	24 July 0215 650mg [redacted]	30 July ii [redacted] 1830	30 July [redacted] 2230	4 Aug i [redacted] 1645						
30 July	[redacted]	Versed 2-6mg IVP q2° prn	26 July 3mg IV 0715 [redacted]	} DC'd 26 July 03											

USAPA V1.

All : (b)(6)-2 EXCEPT bottom one.

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 — *INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION*

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 31	2	3	4	5	6	7	8	9	10	11	12	13
3 July	[redacted]	HL IV	5	[redacted]				Discontinued 2 Aug								
			13	[redacted]												
			21	[redacted]												
26 July	[redacted]	Keflex 500mg PO QID	6	[redacted]												
			12	[redacted]												
			18	[redacted]												
			24	[redacted]												
26 July	[redacted]	Lovenox 30mg SQ BID	8	[redacted]												
			20	[redacted]												
1 Aug	[redacted]	Clindamycin 150mg	4													
		PO Q6	10													
			16													
			22													

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS:

S/P GSW to Ⓡ thigh c̄ ext. fix

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO. ____

PATIENT IDENTIFICATION:

EPW

[redacted] (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

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Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*	Mo.	Yr.

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

All: (b)(6)-2

INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	TIME/DATE DISPENSED													
21Jul	[redacted]	Benadryl 50mg	1Aug 50mg 2220	5Aug 50mg 0830												
-----	-----	QHS Prn	[redacted]	[redacted]												
3Jul	[redacted]	Percocet i̇–ii̇ PO	31July 0520	31July 1335	31July 1945	1Aug 1830	3Aug 1755	3Aug 2220	4Aug 1430	4Aug 2059 ii PO	5 Aug 1520	6 Aug 1130	6 Aug 1330	6Aug 2059 i PO	6Aug 0146 i PO	7 Aug 1904
-----	-----	q4-6 prn pain	ii po [redacted]	ii [redacted]	ii [redacted]	ii [redacted]	ii [redacted]	ii [redacted]	ii [redacted]	[redacted]	ii [redacted]	i [redacted]	ii [redacted]	[redacted]	[redacted]	ii [redacted]
3Jul	[redacted]	Tylenol 650mg	2230 650mg PO	0035 3Aug PO	7Aug 1240	10Aug 2039										
-----	-----	PO Q4° prn	[redacted]	ii [redacted]	ii PO [redacted]	ii PO [redacted]										
7Aug	[redacted]	Percocet i–ii PO	7Aug 2039 ii PO	8Aug 1350 ii PO	10 Aug 1445	14 aug 1400										
-----	-----	q 4-6° pRN pain	[redacted]	[redacted]	ii [redacted]	ii [redacted]										
-----	-----															
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USAPA V1.00

MEDCOM - 13568

All (b)(6)-2 Except bottom one

ORD

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.* ____

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

		RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 13	14	15	16	17	18	19	20	21	22	23	24	25	2
26 Aug	[redacted]	Lovenox 30mg	8	[redacted]													
		SQ BID	20														
		Clindamycin 150mg	4	/	[redacted]												
13 Aug	[redacted]	PO Q6	10								DC						
			16														
			22														

☒ NO

PRIMARY DIAGNOSIS: S/P GSW to Ⓡ thigh c̄ ext. fix

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

EPW # [redacted] (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

FEB 79 EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED. USAPA V1.00

MEDCOM - 13569

All (b)(6)-2 (except ones at bottom)

MO. ____ YR 2003

the proponent agency is the Office of The Surgeon General.

RIFY BY INITIALING				INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION												
ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED												
				30	31	1	2	3	4	5	6	7	8	9	10	11
3 July	[redacted]	VS Routine	5	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
			13	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
			21	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
3 July	[redacted]	Up ad lib Crutches WB	5	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
			13	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
			21	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
3 July	[redacted]	Regular Diet	6	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
			11	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
			17	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
26 July	[redacted]	Pincare BID ½ H_2O_2 ½ H_2O Ⓡ leg to pins	5	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
			13	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
			21	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
26 July	[redacted]	Straight leg raises x10 to Ⓡ leg QID	6	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
			12	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
			18	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
			24	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
26 July	[redacted]	R/L Knee bends x10 QID	6	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
			12	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
			18	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
			24	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS:

GSW R thigh c̄ exfix

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO: ____

PATIENT IDENTIFICATION:

[redacted] EPW [redacted]

(b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIME

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 EDITION OF 1 DEC 77 MAY BE USED. USA

MEDCOM - 13570

A11: (b)(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*			*Mo* July *Yr* 2003	
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
30	[redacted]	XR AP + LAT Ⓡ hip	30	today	Done	
10Aug	[redacted]	XR AP + Lat Ⓡ hip	10 Aug	today	1645	[redacted]

Order/ Expir Date		PRN ACTION, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING COMPLETION* TIME/DATE COMPLETED

MEDCOM - 13571

A11 (b)(6)-2
Except bottom one.

the proponent agency is the Office of The Surgeon General.

MO. 7 YR 2003

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

RIFY BY INITIALING ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 17 18 19 20 21 22 23 24 25 26 27 28 22
3 July	[redacted]	VS - routine	5	[redacted]
			13	
			21	
3 July	[redacted]	Up ad lib, crutches, NWB	5	[redacted]
			13	
			21	
3 July	[redacted]	Regular Diet	6	[redacted]
			12	
			17	
3 July	[redacted]	pincare BID 1/2 STR	10	[redacted] D/C'd 26 Jul 03 [redacted]
		H2O2/Dry sterile DSG	22	
		to wound		
26 July	[redacted]	Pincare BID ½ H2O2/water	10	/ [redacted]
		∅ drsg to pins.	22	/ [redacted]
26 July	[redacted]	Straight leg raises x10 to	06	/ / [redacted]
		(R) leg QID	12	/ [redacted]
			18	/ [redacted]
			22	/ [redacted]
26 July	[redacted]	(R) LE knee bends x10 QID	06	/ [redacted]
			12	/ [redacted]
			18	/ [redacted]
			22	/ [redacted]

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:
GSW (R) thigh, ext fix

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
PAGE NO: ______

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIME

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 EDITION OF 1 DEC 77 MAY BE USED. USA

MEDCOM - 13572

A11: (b)(6)-2

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Verify by Initialing

Mo ________ Yr 2003

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
26	[redacted]	consult PT for exercises				

INITIAL PROPER COLUMN FOLLOWING COMPLETION

Order/ Expir Date		PRN ACTION, FREQUENCY	TIME/DATE COMPLETED	
3 July	[redacted]	Percocet i-ii PO Q4-6 PRN pain	ii PO 2200 2230 [redacted]	
3 July	[redacted]	Tylenol 650mg PO Q4° prn	2200 0TJ1 [redacted] 650	2330 0415 [redacted]
3 July	[redacted]	MSO4 2-6mg IVP Q2° prn		
3 July	[redacted]	50mg Benadryl PO QHS PRN		

See medication Sheet

MEDCOM - 13573

A11: (b)(6)-2

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

*Mo.*__________ *Yr.* __________

rder Dat	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
	error [redacted] ~~Immodium~~				

INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION

rde Expi Dat		PRN DICATION, DOSE, FREQUENCY	TIME/DATE DISPENSED													
21 July	[redacted]	Benedryl 50mg														
		QHS PRN														
3 July	[redacted]	Percocet i-ii PO	13Aug 2058 ii PO	14Aug 1305 "	15 Aug 1600 "	16Aug 0116 ii PO	16 Aug 1330 "									
		Q4-6 PRN Pain	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]									
3 July	[redacted]	Tylenol 650mg	15Aug 0:38 ii PO													
		PO Q4° PRN	[redacted]													
14Aug	[redacted]	Immodium 2mg ii PO	15Aug 23:16 ii PO													
		now then i PO p̄	[redacted]													
		ea. BM; no more than														
		5/24° PRN diarrhea														

USAPA V1.00

MEDCOM - 13574

1. DATE AND TIME OF CAPTURE 1930 29JUN

2. SERIAL NO. 0070004 **A**

3. NAME [redacted]

4. DATE OF BIRTH (b)(6)-4

5. RANK

6. SERVICE NO.

7. UNIT OF EPW

8. CAPTURING UNIT 1/2 ACR

9. LOCATION OF CAPTURE (*Grid coordinates*) [redacted] (b)(6)-4

10. CIRCUMSTANCES OF CAPTURE Stole Bus & Assault on US Forces

11. PHYSICAL CONDITION OF EPW Shot

12. WEAPONS, EQUIPMENT, DOCUMENTS

---

1. DATE AND TIME OF CAPTURE

2. SERIAL NO. 0070004 **B**

3. NAME

4. DATE OF BIRTH

5. RANK

6. SERVICE NO.

7. UNIT OF EPW

8. CAPTURING UNIT

9. LOCATION OF CAPTURE (*Grid coordinates*)

10. CIRCUMSTANCES OF CAPTURE

11. PHYSICAL CONDITION OF EPW

12. WEAPONS, EQUIPMENT, DOCUMENTS

---

1. DATE AND TIME OF CAPTURE

2. SERIAL NO. 0070004 **C**

3. NAME

4. DATE OF BIRTH

5. RANK

6. SERVICE NO.

7. UNIT OF EPW

8. CAPTURING UNIT

9. LOCATION OF CAPTURE (*Grid coordinates*)

10. DESCRIPTION OF WEAPONS, SPECIAL EQUIPMENT, DOCUMENTS

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF / 2. MTF LOCATION *(State or Country Code.)*

1	2	3	4	5	6	7	8
A	1	1	D	1	▨	I	Z

3. REGISTER NUMBER

9	10	11	12	13	14	15
[redacted]						

NAME *(Last, First, Middle Initial)* EPW # [redacted] (b)(6)-4

4. PAY GRADE

16	17

EPW

5. SEX

18
M

6. DATE OF BIRTH *(Y Y Y Y M M D D)* (b)(6)-4

19	20	21	22	23	24	25	26

7. AGE AT ADMISSION

27	28	29
[redacted]		

8. RACE

30
Z

9. ETHNIC BACKGROUND

31
Z

RELIGION UNK

10. LENGTH OF SERVICE

32	33	34

ETS

11. FMP (b)(6)-4

35	36
9	9

12. SOCIAL SECURITY NUMBER

37	38	39	40	41	42	43	44	45
[redacted]								

ORGANIZATION *(Active Duty Only)*

13. MARITAL STATUS

46
Z

HOUR OF ADMISSION 1010

BRANCH / CORPS (b)(6)-4

14. FLYING STATUS

47	48	49

15. BENEFICIARY CATEGORY

50	51	52
K	7	8

16. ZIP CODE OF RESIDENCE

53	54	55	56	57	58	59	60	61

17. UNIT LOCATION *(State or Country Code)*

62	63

18. MOS

64	65	66	67	68	69	70

19. TRAUMA

71
9

PREV. ADMISSION YEAR ☒ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION

72
0

WARD ICW 2

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE UNK

ADDRESS OF EMERGENCY ADDRESSEE *(Include ZIP Code)* UNK

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] (b)(2)-2

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE UNK

21. TYPE OF DISPOSITION

73	74
5	0

22. MTF TRANSFERRED TO

75	76	77	78	79	80

23. DATE OF DISPOSITION *(Y Y M M D D)*

81	82	83	84	85	86
0	3	0	7	1	0

24. CLINIC SVC - ADMITTING

87	88	89	90
A	E	A	A

25. MTF TRANSFERRED FROM

91	92	93	94	95	96

26. DATE THIS ADMISSION *(Y Y M M D D)*

97	98	99	100	101	102
0	3	0	7	0	3

27. LOCATION OF OCCURRENCE *(Battle Casualty Only)*

103	104

28. MTF OF INITIAL ADMISSION

105	106	107	108	109	110

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

111	112	113	114	115	116

FOR LOCAL USE

Dx: GSW to Ⓡ thigh exfix

Dx: 82110
E9912
Px: 7965
7815

(b)(6)-2

ADMITTING OFFICER *(Signature, as required)* Dr [redacted] [redacted]

SIGNATURE OF ADMITTING CLERK [redacted]

DA FORM 2985, MAR 89

MEDCOM - 13576

USAPPCV1.0

INPATIENT TREATMENT RECORD COV... SHEET

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

(b)(6)-4

1. REGISTER NUMBER [redacted]
2. NAME (Last, First, MI) EPW [redacted] (b)(6)-4
3. GRADE N/A

ADMISSION REMARKS

4. SEX M
5. [redacted]
6. RACE Z
7. RELIGION unk
8. LENGTH OF SVC N/A
9. ETS N/A
10. PREVIOUS ADMISSION NO
11. FMP 99
12. SSN (b)(6)-4 [redacted]
13. ORGANIZATION N/A
14. WARD ICU1
15. FLYING STATUS N/A
16. RATING DSG —
17. DEPT./BEN K79
18. BRANCH/CORPS N/A
19. UIC/ZIP —
20 TYPE CASE WIA
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct from ER
22. HOURS OF ADMISSION 1810
23. CLINIC SERVICE ABAA
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE —
25. TYPE DISPOSITION 50
28. DATE OF DISPOSITION 11 July 03

ADMITTING OFFICER

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) —
27b. TELEPHONE NO. —
28. DATE OF THIS ADMISSION 04 July 03
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] b2-2
30. DATE OF INITIAL ADMISSION
31. SELECTED ADMINISTRATIVE DATA
32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

S/P GSW's

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	7	7

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
[redacted]	0	0	0	7	7

SI[redacted] ← (b)(6)-2 →

SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER [redacted] (b)(6)-2

EDITION OF 1 AUG 78 IS OBSOLETE

USAPPC V1.10

MEDCOM - 13577

INPATIENT TREATMENT RECORD COVER SHEET

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

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

1. REGISTER NUMBER [redacted]	2. NAME (Last, First, MI) [redacted] CIV # [redacted]	3. GRADE CIV	ADMISSION REMARKS

4. SEX M	5. AGE [redacted]	6. RACE —	7. RELIGION —	8. LENGTH OF SVC —	9. ETS —	10. PREVIOUS ADMISSION NO

11. FMP 99	12. SSN (b)(6)-4 [redacted]	13. ORGANIZATION —	14. WARD ICU 1

15. FLYING STATUS —	16. RATING/DSG —	17. DEPT/GEN K76	18. BRANCH/CORPS —	19. UIC/ZIP —	20. TYPE CASE WIA

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct from ER	22. HOURS OF ADMISSION 0900	23. CLINIC SERVICE AEAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE UNK	25. TYPE DISPOSITION 03	26. DATE OF DISPOSITION 11 Jul 03	(b)(6)-2
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) UNK	27b. TELEPHONE NO. UNK	28. DATE OF THIS ADMISSION 4 Jul 03	ADMITTING OFFICER Dr. [redacted]

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] (b)(2)-2	30. DATE OF INITIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Dx: GSW to abn, (L) femer, Bilateral arms

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	7	7

36. Total Days All Facilites

(b)(6)-2

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

SIGNATURE OF ATTENDING MEDICAL OFFICER Dr. [redacted] [redacted]	[redacted] MEDICAL RECORDS OFFICER

DA FORM 3647, MAY 79

MEDCOM - 13578

EDITION OF 1 AUG 78 IS OBSOLETE

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

PERTINENT HISTORY, CHIEF COMPLAINT, AND CONDITION ON ADMISSION *(Enter date of admission)*

(b)(6)-4

~[redacted]20 MALE PW SHOT BY REPORT AFTER ATTACKING US TROOPS TO BOTH UE & LEFT LOWER EXTREMITY & ABDOMEN S/P EX-LAP c RESECTION OF DESCENDING COLON c̄ TRANSVERSE COLOSTOMY + HARTMANN'S. ALSO S/P RESECTION OF SMALL BOWEL ENTEROTOMIES c̄ PRIMARY REPAIR, ALSO WASHOUT OF EXTREMITY WOUNDS

PMH: PSH: All: MEDS:

PHYSICAL EXAMINATION

VS: 98 127/87 24 98%

GEN: SEDATED – MOVES EXTREMITIES TO PAINFUL STIMULI

H: NC
E: EOMI PERRL
E: CLEAR
N: Ø DC
T: CLEAR

PULSES: STABLE

EXT: GSW TO B/L UE & LLE

NECK: NT
LUNGS: LTA
COR: RRR

NEURO: SEDATED
MOVES EXTREM · TSD

ABD: SOFT, APPROPRIATE SURGICAL TTP

PROGRESS *(Enter date of discharge and final diagnosis)*

A/P: B MULTIPLE GSWs – SEE HPI

PLAN: TO ICU – SEE ORDERS
CONSULT ORTHO

(b)(6)-2

SIGNA[redacted]	DATE 4/2/03	IDENTIFICATION NO.	ORGANIZATION

[redacted] r typed or written entries give Name last, first, ddle; grade; date; hospital or

REGISTER NO.	WARD NO.

[redacted]

-(b)(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
USAPPC V1.00

MEDCOM - 13579

MEDICAL RECORD | **PROGRESS NOTES**

DATE 3 JUL 03

BP: 2100

P:

R:

T:

O2 SAT:

ALLERGIES ?

PMH: ?

PSH:

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

(b)(6)-4
[redacted] yo IM
Was shooting at US soldiers.
US ~~the~~ soldiers returned fire.
Pt hit in both arms | Ⓛ leg | abdomen
HD stable @ scene.
Ground evac.
TOI = 2030 hrs.

PE) On arrival minimally responsive
but conscious. Moving all 4.
↓ respirations. Thready fem pulse.
Taken directly to OR. Intubated.
Resuscitated to BP 100/70 HR 85.
NC/AT BOMI PERRLA o/p cl
Neck supple
Chest - CTA c BS ⊖ bullet wounds
CV - RRR Back - 2 small entrance wound
Ⓡ lower back
Abd - 2 exit Ⓛ side. Lower one c omentum
Pelvis - stable Rectal - ⊖ heme
Ext - GSW superficial thru-thru Ⓛ thigh
⊖ fx. NVI distally. RUE - wnd entrance &
exit. ⊖ fx. NVI distally.

(Continue on reverse side)

GSW x 2 to abd
GSW Ⓡ UE Ⓛ UE Ⓛ thigh
To OR. Ex lap.

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

NAME: [redacted]

SSN:

UNIT:

(b)(6)-4

REGISTER NO.

WARD NO. (b)(2)-2 [redacted]

PROGRESS NOTES

Medical Record

(b)(6)-2 [redacted]

PPC V1.00

MEDCOM - 13580

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
4 Jul 03	Assumed pt care from EMT nurse. pt hemodynamically stable ~~approved~~ [redacted] (b)(6)-2 upon arrival, pt on RA 99-100% SpO2. NG placed to LIS, LR started @ 150cc/hr, fentanyl drip started @ 50mcg/hr. pt resting comfortably @ this time [redacted] RTAN (b)(6)-2
	1800 04JUL03 – NS pt sedated on fent for pain relief. ∅ FC; PERRL @ 2mm. CV / RESP S1/S2, RRR, SaO2 98 on RA, CTA B/L ⊖ S/S resp distr. NM B/L UEs have ⊕ pulses (+3), <3 sec cap refill, will ⊖ motor/sensory.
	PLAN I&D on 5JUL03
	(b)(6)-2 [redacted] 1LT AN
5 Jul/0600	Assumed pt care from 1LT [redacted], pt resting comfortably, fentanyl infusing @ 30mcg/hr, LR @ 150cc/hr. NG LIS ⓒ small amount of yellow drainage, dressings to GSW bilat arms C/D/I, colostomy same, not as pink as yesterday, no output from colostomy noted. No other issues noted. (b)(6)-2 [redacted] pt scheduled for OR today [redacted] (b)(6)-2 RN BSN
5 Jul/[illegible]	Received pt from OR, pt arrived c̄ VSS. No complications during surgery. pt currently on RA SpO2 98-96%, follows all commands; appropriate c̄ staff. LR infusing @ 125cc/hr. Also ~~[illegible]~~ to raise [illegible] in [illegible], pt resting comfortably [illegible] (b)(6)-2 [redacted]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	(b)(6)-2

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

REGISTER [redacted] WARD NO.

EPW [redacted] (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

MEDCOM - 13581

A11: (b)(6)-2

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
5 June 03	Brief Op Note
	Pre Op Dx MGSW (R arm (L) arm / (R) thigh)
	Post Op Dx same
	Procedure washout / I+D GSW's (R) & (L) arms, (R) leg
	Surgeon [redacted] / [redacted] / [redacted]
	Anesth GETA EBL min
	Findings - Clean, non-bleeding GSW's (R) + (L) arm.
	(R) thigh GSW c̄ min drainage.
	Pt tol procedure well, to ICU stable & extubated.
	[redacted] MD.
05 Jul 03 1540	Report given. Pt. asleep-resting comfortably in NAD. NGT clamped.
	Dsgs to bil. biceps & (R) thigh C,D,&I. Mid abd. dsg also C,D,+I
	c̄ colostomy bag secured/empty. Stoma pink/moist. ∅ complaints
	voiced when a[redacted] aroused. LR @ 125 to PFA IV pt./benign.
	Sats in mid/high 90s on RA. See flowsheet for further assessment.
06 Jul 03 0405	Pt. slept through entire shift. Po flds encouraged. / Taking
	sips only. Temp ↓ 99.5 Med x1 w/ Perco; effect relief. ∅ complaints
	voiced. Dsgs C,D+I. HOB ↑. NGT clamped — [redacted] LPN.

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

All (b)(6)-2 (EXCEPT one at bottom)

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
6 JUL	(1020) pt returned to bed c̄ min assist; ivfs returned + removed by WO; new orders transcribed & copied for RX;
	CTM [redacted]
	(1200) no change in assessment status; no change in
	air in colostomy bag; continues npo [redacted]
	(1600) IVF ↓ to 50cc/hr; no change in status or assessment [redacted]
06 Jul 03	Rec'd pt alert/coherent. HOB↑. See flowsheet for assessment.
1730	Care plan reinforced; act. level, diet, IV fluids, meds/pain
	control; needs reinforcement. ∅ air/drainage in colostomy
	bag. 2R↓50cc/° [redacted] Sgt/LPN
7 Jul 03	0500 ASSUMED CARE. REPORT GIVEN.
	SEE ICU-2 FLOWSHEET FOR INITIAL
	ASSESSMENT. [redacted]
	0630 DRSG Δ'ed TO BOTH ARMS ?
	WOUND c̄ SCANT AMT OF OOZING OF SEROSANGUINOUS
	NOTED. MIDLINE DRSG INTACT. COLOSTOMY
	AREA CLEANSED, NOTED c̄ BROWNISH
	STOOL. STOMA PINK 3/4 IN IN DIAMETER
	PLACED A NEW COLOSTOMY BAG. LEG DRSG
	CLEANSED APPLIED NEW DRSG [redacted]
	0730. UPDATED DR [redacted] ON PT'S
	STATUS [redacted]

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.)*

[redacted] (b)(6)-4

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
7/7/03	0815 cl. liquid diet given. tolerated well s̄ difficulty. colostomy noted c̄ liquid brown stool (b)(6)-2 [redacted]
	1000 denies any pain @ this time (b)(6)-2 [redacted]
	1215 tolerated lunch meal s̄ difficulty. advance diet (b)(6)-2 [redacted] (b)(6)-4
	1430 VS. ∅ distress noted @ [redacted] time [redacted]
	1600 colostomy bag emptied of loose liquid stool, brown color. translator @ bedside to explain procedure (b)(6)-2 [redacted]
	1630 Foley emptied. VS. ∅ distress noted (b)(6)-2 [redacted]

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.

EPW [redacted] -(b)(6)-4

7 Jul 03

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

MEDCOM - 13584

All (b)(6)-2 (EXCEPT bottom one.)

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

8 Jul DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
0500	Assumed care of pt. A/O x3, follows commands. LR infusing into Ⓡ FA @ 100cc/hr, patent. Dressings to both UE & abdomen, midline. All CDI. + 2 radial pulses. Colostomy bag intact & draining well. foley to gravity draining yellow urine. Ø complaints @ this time, resting well. Remains NPO due to scheduled to go to OR today. Will monitor [redacted] 9W
0700	Pt. resting quietly. Ate breakfast @ 0630, tolerated well. Ø complaints. Ø s/s of distress. Will continue to monitor [redacted]
0900	Ø change in pt. status, awaiting O.R. [redacted] 9W
1100	Pt. to O.R [redacted] 9W
1215	Pt. arrives from O.R., washout & DPC. Dressing to abdomen (remains open) Dressings to
1400	Pt. rest quietly c̄ Ø complaints. Ø distress noted [redacted] 9W
1700	Will brief oncoming shift. Ø change in assessment [redacted] 9W
1850	Rpt Received Physical assessment Completed + Recorded on Flowsheet [redacted] CPT/AN
1-9-03 0224	Pt had large Liquidy Black Stool. Stool cupped + Noted to smell like Blood [redacted] CPT/AN
0402	AM Labs drawn [redacted] CPT/AN

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.)*

EPW # [redacted] (b)(6)-4

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
9/Jul/03	0500 Assumed care. See ICU I flow sheet for initial assessment. 0640 pt awake, denies any pain/distress @ this time. 0830 ate breakfast meal. tolerate well — 1040 OOB to chair tolerated well [redacted] (b)(6)-2
9Jul03	Surgery Pt SMBR ABS VSS ABD SOFT, NT, ND ⊕ BS Zyl SMBR Plan TO WARD [redacted] (b)(6)-2
9/Jul/03	(b)(6)-2 1230 remains sitting up. emptied colostomy bag. area cleansed — 1400 R/N back to bed. — 1600 colostomy bag fed. wound site area cleansed — [redacted]

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI | [redacted] (Other) (b)(6)-2

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.

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

All: (b)(6)-2

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
[illegible]/03	Surgery USS [illegible] Wound healing well AL in A.M [redacted]
10Jul03	0500 Assumed care. Report given See ICU-I flowsheet for initial assessment. [redacted] 0820 DC'ed Foley. Urinal given; voided [redacted] 0940 Void. Amber UOP in urinal s̄ difficulty. [redacted] 1310 pt assist c̄ ostomy emptying of care. bed bath given assist c̄ care. [redacted] 1700 Rpt Received [redacted] Cpt/[illegible]
11July	0815: A/O; VSS; Colostomy draining; surgical sites C/D/I; tolerating diet; ↑activity OOB ambulating [redacted]

(b)(6)-2 [redacted]

558-103

(See Instructions on Back of

NSN

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY *(stamp)* [redacted] (b)(2)-2

LOG NUMBER

ARRIVAL				TRANSPORTATION TO HOSPITAL *(Attach care enroute sheet)*	CURRENT MEDS. *(tetanus immunization and other data)*	HISTORY OBTAINE
DATE			TIME	☐ PRIVATE VEHICLE ☐ AMBULANCE		☐ PATIENT ☐
DAY	MONTH	YR.		☑ OTHER *(Specify)* Medevac		ALLERGIES NKDA
4	Jul	03	0900			

PATIENT'S HOME ADDRESS OR DUTY STATION *(City, State and ZIP Code)*

HOME TELE. NO. *(Ir*

(b)(6)-4

CHIEF COMPLAINT(S) *(Include symptom(s), duration)* GSW'S

SEX M

AGE [redacted]

POSSIBLE THIRD P ☐ YES ☐

TIME SEEN BY PRO

VITAL SIGNS			
TIME	0900	0930	
BP	137/87		
PULSE	91	94	
RESP.	24	20	
TEMP.	99.3		
WT. *(Child)*	55kg	98%.	

96%.

CATEGORY *(See reverse)*
- EMERGENT
- ✓ URGENT
- NON-URGENT

ORDERS	INITS.	TIME
IVF 3	[redacted]	0905
CBC, U/A, PT, PTT,	[redacted]	
Chem 12/Lytes, T+S	[redacted]	0905
Xray Hum & Elb	[redacted]	
Bilateral PA+LAT	[redacted]	0925
Ⓛ US femur PA+lat	[redacted]	

(b)(6)-2

ASSESSMENT/DIAGNOSIS

DESCRIBE (1) Subjective data *(Pertinent History)*; (2) Objective data *(Examination - include results of tests and x-rays)*; (3) Assessment *(Diagnosis)*; (4) Plan *(Treatment/Procedures - include medication given and follow-up)*

(b)(6)-4 [redacted] yo ♂ Iraqi s/p GSW's to abdomen, upper arms bilaterally & Ⓛ femur. Nasal-trumpet to Ⓡ nare. A+O, sleepy + arousable. IV to Ⓛ wrist. Foley to grav c̄ clear yellow urine, drained 700cc. Abd. wound midline R/T GSW packed c̄ gauze & covered c̄ Opsite. NGT to Ⓛ nare. Bilat. UE's GSW's Ⓛ upper of LE (femur) c̄ wound c̄ penrose drain

– See abbreviated medical record –

DISPOSITION *(Check all that apply)*

	HOME		FULL DUTY		
QUARTERS					
	24 Hrs.		48 Hrs.		72 Hrs.

MODIFIED DUTY UNTIL:

DAY	MONTH	YEAR

REFERRED TO *(Indicate clinic)*

	EMERGENCY		TODAY
	72 HOURS		ROUTINE

ADMIT. TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE

	IMPROVED		UNCHANGED
	DETERIORATED		

TIME OF RELEASE:

(CONTINUE ON SF 507, IF NEEDED)

PATIENT'S IDENTIFICATION *(Mechanical imprint)* FOR WRITTEN ENTRIES GIVE: *Name - last, first, middle; SSN; DOB, service status, name and relation of sponsor or next of kin. (IMPORTANT: LIST FACILITY HOLDING TREATMENT RECORD).*

#[redacted] (b)(6)-4

[redacted] (b)(6)-4

SIGNATURE OF PROVIDER AND ID STAMP

INSTRUCTIONS TO PATIENT *(Include medications ordered, any limitatio plans)*

MEDCOM - 13588

DATE: 4 July PATIEN .SSME
TIME: 1030 SIGNATURE: [redacted] (b)(6)-2

SKIN AND MUCOUS ME NE

Skin: Loose / Tight / Diaphoretic / Shiny /
Skin: Temperature warm
Color: Pale / Cyanotic / Jaundiced appropriate for race
Mucous Membranes: [✓ Moist] / Dry / Cracked
Skin Breakdown: [✓ None] Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / ~~Unresponsive~~ to verbal stimuli GCS:
Orientated / Disoriented Pupils: 3mm sluggish
Extremity Movement: [✓ Full] / Limited / None

CARDIOVASCULAR

Pulse (0-4). Radials +2 Pedals +2
Capillary Refill: <3 Seconds 0 Homan's Sign
Jugular Venous Distension 0 Edema 0
Heart Sounds $S_1 S_2$ NSR s̄ ectopy
~~Rhythm~~ PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site			RFA	
Solution			LR	

Chest Pain

RESPIRATORY

Chest Expansion / [✓ Symmetrical] / Asymmetrical
Respiration / [✓ No Distress] / SOB / Labored / Use of Access Muscles
Breathing Patterns: even
Cough: Productive / Nonproductive / [✓ None]
Sputum: Color / Amount / Consistency / ~~Odor~~
~~Chest Drainage System Gravity: Suction cm:~~
~~Air Leak No~~ Yes Crepitus
Character of Drainage:
Trachea / [✓ Midline] / Deviated (R) / Deviated (L)
Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles	CTA Bilat.	
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: [✓ Soft] / Firm / Hard / Distended cm Girth
Bowel Sounds: Normal / Hyperactive / Hypoactive / [✓ Absent]
Dressings:
NG Tube: Clamped/[✓ Inter/ Suction]/Cont. Suction/Dependent Drainage
NG Drainage: Color Character
~~Tube Feeding: Day No:~~ Strength: ~~Rate:~~ Aspirate:
Stool. Character
~~Drains~~: Colostomy pink stoma

GENITOURINARY

Urine Color: amber Character: clear
Voiding: Continent / Incontinent / [✓ Catheter] PTC

EMOTIONAL/PSYCHOSOCIAL

Sedated c̄ fentanyl [illegible]
pain controlled

OTHER:

..TIENT ASSESSMENT
TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin: Loose [✓ / Tight] / Diaphoretic / Shiny [✓ / Dry]
Skin: Temperature warm
Color: Pale / Cyanotic / Jaundiced NDR
Mucous Membranes: [✓ Moist] / Dry / Cracked
Skin Breakdown: [✓ None] Location: Size:

NEUROLOGICAL

Loc / Alert [✓ / Lethargic] / Unresponsive GCS:
Orientated / ~~Disoriented~~ Pupils: 2mm PERRL - sluggish
Extremity Movement: [✓ Full] / Limited / None

CARDIOVASCULAR

Pulse (0-4): +3x4 Radials Pedals
Capillary Refill: <3 Seconds Homan's Sign
Jugular Venous Distension 0 Edema 0
Heart Sounds S_1/S_2 NSR
Rhythm PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site			RFA	
Solution			LR	

Chest Pain

RESPIRATORY

Chest ~~Expansion /~~ [✓ Symmetrical] / Asymmetrical
Respiration / [✓ No Distress] / SOB / ~~Labored / Use of~~ Access Muscles
Breathing Patterns: CTA
Cough: Productive / Nonproductive / [✓ None]
Sputum: Color / Amount / Consistency / Odor 0
Chest Drainage System Gravity: Suction cm.
~~Air Leak No~~ Yes Crepitus
~~Character~~ of Drainage: --
Trachea [✓ / Midline /] Deviated (R) / Deviated (L)
Artificial Airway Size: Type: Position:

Breath Sounds	~~Anterior/Location~~	Posterior/Location
Crackles	CTA b/l	
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: [✓ Soft] / Firm / Hard / Distended ND/NT cm Girth
MIDLN ABD INC- C/D/I
Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent
~~Dressings~~: colostomy - 0 OR
NG Tube: Clamped/[✓ Inter. Suction]/Cont. Suction/Dependent Drainage
NG Drainage: Color clear ~~Character~~ moderate amount
~~Tube Feeding: Day No: Strength: Rate: Aspirate~~
~~Stool: Character~~
~~Drains:~~

GENITOURINARY

Urine Color: light to ~~Character~~: -clear, yellow
~~Voiding: Continent / Incontinent /~~ Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER: see [illegible]

Date 4 Jul 03 Bed # 3

Patient's Name: EPW# [redacted] (b)(6)-4

Time	05	06	07	08	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
BP						158/84	154/67	148/68	121/65	131/43 144/88	147/64	161/78	159/68	135/67	137/64	140/70	147/72	145/71	140/50	151/54	153/62	153/46	157/63	176/68
TEMP						99.4	[illegible]				99.2													
HR						91	92	90	89	91	92	95	97	99	97	110	102	101	93	110	102	103	106	104
RR						17	18	16	16	16	15	15		17	18	15	15	15	16	12	16	18	19	19
SAO2						100	100	99	99	100	97	99		99	98	100	100	100	100	99	100	100	98	100
FIO2														RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA
INPUT																								
PO																								
IV LR						150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150
NGT																								
Fent						10	10	10	10	10	8	8	8	8	7	7	7	7	7	7	7	7	7	7
TURN Q 2															1903					2017				
[illegible] IV																100		100		100				
TOTAL																								
OUTPUT																								
URINE						300	360	150	160	200	250	100	180	200	175	150	220	250	250	100	110	110	110	110
NGT											100													
STOOL																								
OTAL																								
ALANCE																								
Initials																								

2950

MEDCOM - 13590

Date 05JUL03

PATIENT ASSESSMEN

TIME: 0600 SIGNATURE: [redacted]

SKIN AND MUCOUS MEMBRA

Skin : Loose / Tight / Diaphoretic / Shiny / [✓ Dry]
Skin : Temperature warm
Color: Pale / Cyanotic / Jaundiced appropriate for race
Mucous Membranes: [✓ Moist] / Dry / Cracked
Skin Breakdown: [✓ None] Location: Size:

NEUROLOGICAL

Loc / [✓ Alert] / Lethargic / Unresponsive GCS:
Orientated / Disoriented Pupils: 3mm sluggish
Extremity Movement: [✓ Full] / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): +2 Radials --- Pedals [illegible]
Capillary Refill: <3 Seconds Homan's Sign ø
Jugular Venous Distension ø Edema ø
Heart Sounds S1S2
Rhythm ST s ectopy PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site			R wrist	
Solution			LR	

Chest Pain ø

RESPIRATORY

Chest Expansion / [✓ Symmetrical] / Asymmetrical
Respiration / [✓ No Distress] / SOB / Labored / Use of Access Muscles
Breathing Patterns: even
Cough: Productive / Nonproductive / [✓ None]
Sputum: Color / Amount / Consistency / Odor
Chest Drainage System Gravity: Suction cm:
Air Leak No Yes -- Crepitus
Character of Drainage:
Trachea / Midline / Deviated (R) / Deviated (L)
Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles	CTA - b/lat	
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen [✓ Soft] / Firm / Hard / Distended cm Girth
Bowel Sounds: Normal / Hyperactive / [✓ Hypoactive] / Absent
Dressings: Stoma - colostomy pink,
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage
NG Drainage: Color Character
Tube Feeding: Day No: Strength: Rate: Aspirate:
Stool: Character
Drains:

GENITOURINARY

Urine Color: amber Character: clear
Voiding: Continent / Incontinent / Catheter FTG

EMOTIONAL/PSYCHOSOCIAL

OTHER: pt remains on [illegible] / drape
30mg/hr. LR@ [illegible]

PATIENT ASSESSMENT

TIME: 1740 SIGNATURE: [redacted]

SKIN AND MUCOUS MEMBRANES

Skin : Loose / Tight / Diaphoretic / Shiny / [✓ Dry]
Skin : Temperature W
Color: Pale / Cyanotic / Jaundiced NFR
Mucous Membranes: [✓ Moist] / Dry / Cracked
Skin Breakdown: [✓ None] Location: Size:

NEUROLOGICAL

Loc / [✓ Alert] / Lethargic / Unresponsive GCS:
Orientated / Disoriented Pupils:
Extremity Movement: [✓ Full] / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radials Pedals Strong + bilat
Capillary Refill: <3 Seconds Homan's Sign ø
Jugular Venous Distension ø Edema ø
Heart Sounds S1S2 only
Rhythm ST [illegible] PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site			R FA	patent + benign
Solution				

Chest Pain ø

RESPIRATORY

Chest Expansion / [✓ Symmetrical] / Asymmetrical
Respiration / [✓ No Distress] / SOB / Labored / Use of Access Muscles
Breathing Patterns: even
Cough: [✓ Productive] / Nonproductive / None
Sputum: Color / Amount / Consistency / Odor
Chest Drainage System Gravity: Suction cm:
Air Leak No Yes Crepitus
Character of Drainage: —
Trachea / Midline / Deviated (R) / Deviated (L)
Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles	CTA [illegible]	bases
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen [✓ Soft] / Firm / Hard / Distended cm Girth
Bowel Sounds: Normal / Hyperactive / [✓ Hypoactive] / Absent
Dressings: RUE/RLE C,D,+I
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage clamped
NG Drainage: Color Character
Tube Feeding: Day No: Strength: Rate: Aspirate:
Stool: Character
Drains:

GENITOURINARY

Urine Color: yellow Character: Cl
Voiding: Continent / Incontinent / Catheter FTG

EMOTIONAL/PSYCHOSOCIAL

OTHER: colostomy bag secured/clean + empty
stoma moist/pink ø/s/sof infx. noted

[redacted] (b)(6)-4

ICU #1

Date 5 JUL 03 Bed #

Patient's Name (b)(6)-4 [redacted] 136/67

Time	05	06	07	08	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
			121	140	161	156		124	120		[illegible]	OR	137	146	165	165	153	138	131	141	135	138	134	136
BP	135/59	123/75	42	58	63	68		47	57					65	68	73	70	59	57		74	66	64	72
TEMP		98		100.9		100.7					100.5		99	101.2		101.3		100.3		101.0		99.8		99.3
HR	105	110	111						111		111		112	110	110	114	86	83	119	110	108	103	99	96
RR	19	19	21	20	20	25		21	20		21		19	20	20	16	16	18	20	17	18	18	16	18
SAO2	98	100	98	97	98	95		96	96		99		98	96	96	96	96	97	96	96	96	97	96	96
FIO2	RA	RA	RA	RA	RA	RA.		RA	RA.		RA		RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA
INPUT	~~150~~																							
PO																			60	60				
IV (ml)	150	150	100	100	100	100	100	100	100	100	100		100	125	125	125	125	125	125	125	125	125	125	125
NGT																								
[illegible]		100	100																					
TURN Q 2																								
[illegible]	7	7	7	7	7	7	2	7	7	7	7		7											
TOTAL																								
OUTPUT																								
URINE	100	120	120	40	50	150	100	125	95									900 emptied						700 emptied
NGT																								
TOOL																								
TOTAL																								
BALANCE																								
Initials																								

MEDCOM - 13592

Date 06/11/07 [redacted] (b)(6)-4 ICU 1

EPW

PATIENT ASSESSMENT

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES
Skin : Loose / Tight / Diaphoretic / Shiny / Dry
Skin : Temperature
Color: Pale / Cyanotic / Jaundiced
Mucous Membranes: Moist / Dry / Cracked
Skin Breakdown: None Location: Size:

NEUROLOGICAL
Loc / Alert / Lethargic / Unresponsive GCS:
Orientated / Disoriented Pupils:
Extremity Movement: Full / Limited / None

CARDIOVASCULAR
Pulse (0 - 4): Radials Pedals
Capillary Refill: Seconds Homan's Sign
Jugular Venous Distension Edema
Heart Sounds
Rhythm PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			▨	▨
Site				
Solution				

Chest Pain

RESPIRATORY
Chest Expansion / Symmetrical / Asymmetrical
Respiration / No Distress / SOB / Labored / Use of Access Muscles
Breathing Patterns:
Cough: Productive / Nonproductive / None
Sputum: Color / Amount / Consistency / Odor
Chest Drainage System Gravity: Suction cm:
Air Leak No Yes Crepitus
Character of Drainage:
Trachea / Midline / Deviated (R) / Deviated (L)
Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL
Abdomen: Soft / Firm / Hard / Distended cm Girth
Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent
Dressings:
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage
NG Drainage: Color Character
Tube Feeding: Day No: Strength: Rate: Aspirate:
Stool: Character
Drains:

GENITOURINARY
Urine Color: Character:
Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

PATIENT ASSESSMENT

(b)(6)-2

TIME: 1730 SIGNATURE: [redacted]

SKIN AND MUCOUS MEMBRANES
Skin : Loose / Tight / Diaphoretic / Shiny / [✓ Dry]
Skin : Temperature warm
Color: Pale / Cyanotic / Jaundiced NFR
Mucous Membranes: [✓ Moist] / Dry / Cracked
Skin Breakdown: [✓ None] Location: Size:

NEUROLOGICAL
Loc / [✓ Alert] / Lethargic / Unresponsive GCS:
[✓ Orientated] / Disoriented Pupils:
Extremity Movement: [✓ Full] / Limited / None

CARDIOVASCULAR
Pulse (0 - 4): Radials Pedals
Capillary Refill: Seconds Homan's Sign Ø
Jugular Venous Distension Ø Edema Ø
Heart Sounds
Rhythm NSR 87 PRI: QRS:

Vascular Catheter	Central	Arterial	[✓ Peripheral 1]	Peripheral 2
Waveforms			▨	▨
Site			RFA patent + benign	
Solution				

Chest Pain Ø

RESPIRATORY
Chest Expansion / [✓ Symmetrical] / Asymmetrical
Respiration / [✓ No Distress] / SOB / Labored / Use of Access Muscles
Breathing Patterns: even
Cough: Productive / Nonproductive / [✓ None]
Sputum: Color / Amount / Consistency / Odor
Chest Drainage System Gravity: Ø Suction cm:
Air Leak No Yes Crepitus
Character of Drainage:
Trachea / Midline / Deviated (R) / Deviated (L)
Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes	CTA	(B)
Diminished		
Absent	↓ at	bases

GASTROINTESTINAL
Abdomen: [✓ Soft] / Firm / Hard / Distended NT/ND cm Girth
Bowel Sounds: Normal / Hyperactive / [✓ Hypoactive] / Absent
Dressings: BVE, R thigh Midabd c,D,I
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage
NG Drainage: Color Character
Tube Feeding: Day No: Strength: Rate: Aspirate:
Stool: Character
Drains:

GENITOURINARY
Urine Color: yel Character: cl
Voiding: Continent / Incontinent / [✓ Catheter] c

EMOTIONAL/PSYCHOSOCIAL

OTHER: Colostomy bag placed + empty!

MS04 5

Date 06 Apr Bed [redacted]

Patient's Name EPW [redacted] (b)(6)-4

Time	05	06	07	08	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
BP		140/64				151/73	161/63	163/68	124/48	123/45	124/44	132/50	139/55	143/61	141/60	132/71	131/60	120/60	140/67	145/71	136/67	145/71	142/72	155/7
TEMP		98.6						100.0								99.5				99.9				99.9
HR	Ø	96				94	109	101	104	104	103	106	104	102	93	91	90	90	97	108	94	90	96	93
RR		20				20	23	12	12	14	12	14	16	17	16	18	18	18	18	18	16	19	18	17
SAO2		97%				97%	95%		93%		92%	98%	98	100	100	100	100	100	100	100	100	100	100	99
FIO2		RA				RA	RA	RA	RA	RA	RA	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	RA	RA	RA
											100.6													
INPUT LR	125	125	125	125	125	125	125	125	125	125	125	125	~~125~~ 50	50	50	50	50	50	50	50	50	50	50	50
PO				50																				
IV																								
NGT			D/C																					
IVPB				50							100			100				100		100				
TURN Q 2																								
TOTAL												IN (1700)												
OUTPUT URINE		(cal) →				200	100	140	60	160	180	70	60	60	40	30	50	50	60	60	100	100	200	100
NGT												(440) +L out												
TOOL																								
TOTAL BALANCE																								
Initials																								

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ACLU-RDI 1592 p.1488

DATE: 07 Jul 03 PATIENT ASSESSMENT [redacted] (b)(6)-2 PATIENT ASSESSMENT

TIME: 7 Jul 03 SIGNATURE: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin: [✓ Loose] / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature 97.3

Color: [✓ Pale] / Cyanotic / Jaundiced

Mucous Membranes: Moist / [✓ Dry] / Cracked

Skin Breakdown: [✓ None] Location: Size:

NEUROLOGICAL

Loc [✓ Alert] / Lethargic / Unresponsive GCS:

[✓ Oriented] / Disoriented Pupils:

Extremity Movement: Full / [✓ Limited] / None

CARDIOVASCULAR

Pulse (0 - 4): +2 Radials +2 Pedals

Capillary Refill: <2 Seconds Homan's Sign Ø

Jugular Venous Distension Ø Edema Ø

Heart Sounds [illegible]

Rhythm NSR 90-110s PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site			(R) FA	
Solution			LR @ [illegible]	

Chest Pain

RESPIRATORY

Chest Expansion / [✓ Symmetrical] / Asymmetrical

Respiration / [✓ No Distress] / SOB / Labored / Use of Access Muscles

Breathing Patterns: Reg.

Cough: Productive / Nonproductive / [✓ None]

Sputum: Color / Amount / Consistency / Odor Ø

Chest Drainage System Gravity: Ø Suction cm: Ø

Air Leak Ø No Ø Yes Ø Crepitus Ø

Character of Drainage: Ø

Trachea / Midline / Deviated (R) / Deviated (L) Ø

Artificial Airway Size: Type: Ø Position: Ø

Breath Sounds	Anterior/Location	Posterior/Location
Crackles	BS CTA	
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: [✓ Soft] / Firm / Hard / Distended Tender [illegible] cm Girth

Bowel Sounds: [✓ Normal] / Hyperactive / Hypoactive / Absent

Dressings: mid line abd dsg c colostomy bag

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Ø Character Ø

Tube Feeding: Day No: Ø Strength: Ø Rate: Ø Aspirate: Ø

Stool: Character Brown liquid stool

Drains: Ø

GENITOURINARY

Urine Color: cl. yellow Character:

Voiding Continent / Incontinent / [✓ Catheter]

EMOTIONAL/PSYCHOSOCIAL

Appropriate

OTHER:

SKIN AND MUCOUS MEMBRANES

Skin / [✓ Loose] / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature warm

Color: Pale / Cyanotic / Jaundiced WNL

Mucous Membranes: [✓ Moist] / Dry / Cracked

Skin Breakdown: [✓ None] Location: Size:

NEUROLOGICAL

Loc / [✓ Alert] / Lethargic / Unresponsive GCS:

[✓ Orientated] / Disoriented Pupils:

Extremity Movement: Full / [✓ Limited] / None

CARDIOVASCULAR

Pulse (0 - 4): +3 x4 Radials +3 Pedals +3

Capillary Refill: <3 Seconds Homan's Sign

Jugular Venous Distension Ø Edema

Heart Sounds S1 S2 - NSR → ST

Rhythm regular PRI: QRS

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site			(R) [illegible]	[illegible]
Solution			(L) [illegible]	[illegible]

Chest Pain

RESPIRATORY

Chest Expansion / [✓ Symmetrical] / Asymmetrical

Respiration / [✓ No Distress] / SOB / Labored / Use of Access Muscles

Breathing Patterns: Reg.

Cough: Productive / [✓ Nonproductive] / None

Sputum: Color / Amount / Consistency / Odor

Chest Drainage System Gravity: Suction cm:

Air Leak No Yes Crepitus

Character of Drainage: --

Trachea / [✓ Midline] / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes	CTA	S/L
Diminished		
Absent		

GASTROINTESTINAL

Abdomen / [✓ Soft] / Firm / Hard / Distended cm Girth

Bowel Sounds: [✓ Normal] / Hyperactive / Hypoactive / Absent

Dressings: colostomy intact

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate

Stool: Character Tol. reg diet

Drains: Ø ~ OU

GENITOURINARY

Urine Color: [illegible] Character: [illegible]

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

7 Jul 03

[redacted] (b)(6)-4

MEDCOM - 13595

Date 07 Jul 03 Bed # 3

Patient's Name: EPW [redacted] (b)(6)-4

Time	05	06	07	08	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
BP		[illegible]	129/50	113/47	162/75	132/44	124/54	132/62	135/56	134/54	126/58	131/58	124/58	103/50	114/53	138/59	135/57	140/61	137/56	148/73	132/56	139/71	122/43	124/53
TEMP	97.5	[illegible]	[illegible]	[illegible]																				
HR		96	88	87	101	92	88	97	95	87	97	89	96	93	94	90	84	85	88	85	82	86	93	82
RR		30	14	13	19	16	14	15	13	14	17	16	22	22	18	12	12	19	15	14	14	18	20	14
SAO2		100	100	100	100	100	100	100	100	100	100	100	100	98	100	100	100	100	100	100	99	100	100	100
FIO2		RA																						
~~MIVF~~										400				KVO	KVO	KVO	KVO	KVO	KVO	100	100	100	100	100
INPUT																								
~~PO~~ 100				240				240				240	240	400										
IV PB					100	50		100					320	100										
NGT																								
																q4								
TURN Q 2																								
TOTAL													940											
OUTPUT																								
URINE		300	100	250	300	300	100	100	125	150	100	200	1825	160	170	70	130	80	100	70	60	90	50	100
NGT																								
STOOL		colostomy ⊕								300			300		300									
OTAL																								
BALANCE																								
Initials																								

600 IV-intake

1220

900

2925

MEDCOM - 13596

DOD-026510

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
11 Jul 03	DC Summary (b)(6)-2
	[redacted] yo male POD # [redacted] for GSW to abdomen
	(b)(6)-2 small bowel + colon injury c̄ colostomy
	+ delayed primary closure of all wounds including
	extremity wounds. Patient doing well s̄
	problems + normal vital signs
	DX: 1-GSW to abdomen s/p colonic resection
	c̄ diverting colostomy + Hartmann's
	2- Repair of enterotomies
	3- GSW to B/L UE + LLE s/p washout
	s̄ bone injuries
	Treatment: 1- will need sutures & staples removal
	~ 20 Jul 03
	2 basic ostomy care - patient trained
	3- T3 1-2 po q4° prn pain (b)(6)-2 [redacted]
	4 Colace 100 mg po bid
	(b)(6)-2
11 Jul 03	Ostomy care given; demonstrated by pt; pt OOB to chair, (b)(6)-2
	ambulating; no s/s of distress [redacted]

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.

[redacted] (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

MEDCOM - 13597

[redacted] (b)(6) -2

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

FOR Use of this form, see AR 40-407; the proponent agency is The Office of the Surgeon General.

1. AGE: [redacted] (b)(6)-4

HEIGHT:

WEIGHT:

2. KNOWN ALLERGIC SENSITIVITIES (e.g.. Iodine, Tape, Medication)
☐ NKDA ☐ PCN ☐ LATEX ☐ IODINE ☐ TAPE ☐ FOOD
REACTION:

3. PREVIOUS SURGERY [ ] NO [ ] YES (type):
See H&P

4. PROPOSED SURGICAL PROCEDURE:
I+D (L) Thigh (B) Arms

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition____
Tobacco____ppd X___yrs. Body Piercing____ Diabetes (Y) (N) ROM____ ASA/Motrin w/72 hrs (Y) (N)
ETOH____ Implants____ Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS:

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to: ____1) Surgical Procedure & Operating Room Environment ____2) ~~Separation Anxiety (Child)~~ [redacted] (b)(6) -2 ____3) Surgical Outcomes	o Pt. verbalizes any specific anxiety. o Pt. Exhibits relaxed body posture.	c Allow pt. to verbalize freely. c Explain OR environment and answer questions regarding surgery. c Offer comfort measures. (e.g.. warm blanket. touch). c Explain all nursing procedures before they are done. c Remain with pt. whenever possible. c Maintain family interface. Parents to stay with pt.
B. AERATION ✓ Potential for respiratory dysfunction due to: ____1) Positioning ____2) Effects of Anesthesia ____3) Medical/Smoking History	o Pt. will be able to breathe without difficulty during immediate intraoperative phase.	c Offer to elevate head of litter or offer pillow. c Observe pt. while awaiting surgery for signs of distress. c Assist anesthesia during intubation and extubation.
C. INTEGUMENT ✓ Potential impairment of skin integrity due to: ____1) Intraoperative Immobility ____2) ESU Pad Placement ____3) Positional Aids ____4) Prosthesis ____5) Pooling of Prep Solutions	o Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened areas).	c Utilize pressure preventing devices on OR table and accessories. c Check for proper positioning and support to maintain good body alignment. o Pad pressure points. o Place ESU ground pad on non compromised skin surface area. o Keep prep fluids from pooling.

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

#[redacted] (b)(6)-4
ICU-1

VERIFICATIONS AT HOLDING AREA:
(b)(6)-2
! ~~ID/Allergy Band~~
! H & P
! NPO Since [redacted]
! ~~UHCG/LMP~~
[redacted] Dentures Removed
Contacts Removed
Jewelry Removed
Body Pierce Removed
[redacted] Consent/Blood Transfusion
Signed/Witnessed/Dated
Surgical Site/Consent verified by (L) Thigh (B) Arm
Pt./Anesthesia/Surgeon
! Contact Precautions (Y) [✓ (N)]
! Family/Friend: NONE

USAPA V1.0

DA FORM 5179, JUN 91 Previous editions are obsolete.

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6. PATIENT PROBLEMS AND NEEDS	7. NT GOALS AND EXPECTED OUTCOMES	8. URSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to: ____ 1) Intraoperative Mobility ____ 2) Positioning ____ 3) Existing Disease ____ 4) Safety Devices ____ 5) Hypothermia	o Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse.	✓ o Check for support stockings or ace wraps. If none, check with doctors. ✓ o Check that safety straps are correctly applied. (b)(6)-2 ✓ o Offer pillow for under knees. ~~o Place and take down legs from~~ [redacted] ~~stirrups with slow bilateral motio~~ ✓ o Check that rings and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL ✓ E.1. ✓ Potential impairment of mobility due to: ____ 1) Pain ____ 2) Intraoperative Hazards ____ 3) Prosthesis ____ 4) Positioning ____ 5) Transfer pt. to/from OR table E.2. ✓ Potential discomfort due to: ____ 1) Length of Surgery ____ 2) Positioning ____ 3) Arthritis	o Pt. will be transferred to OR table without difficulty. o Pt. will not experience unnecessary physical discomfort.	✓ o Have sufficient people available for transfer. ✓ o Insure proper body alignment. ✓ o Allow patient to lie in position of comfort while waiting for surgery. ✓ o Offer support (i.e., pillows, bath towels, etc.) for positioning.
F. SPECIAL SENSES ✓ F.1. ✓ Diminished visual perception due to being: ____ 1) Pre-Medicated ____ 2) W/O Glasses F.2. ✓ Potential for decreased communication due to: ____ 1) Diminished Hearing ____ 2) Language Barrier F.3. ____ Potential injury due to dentures: ____ 1) Upper ____ 4) Caps ____ 2) Lower ____ 5) Crowns ____ 3) Bridges	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR table. o Pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	✓ o Introduce self. Keep pt. informed as to where he/she is and what is happening. ✓ o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. ✓ o Address pt. from Either side. ✓ o Validate pt.'s understanding of verbal communication. ✓ o Verify removal of dentures.
G OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs. (b)(6)-2	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

10. OR [redacted] /ADDITIONAL INTRAOPERATIVE INTERVENTIONS NOTED.

CPT/AN 5 Jul 03 DATE

11. POS [redacted] ON: SKIN INTEGRITY: Bovie Pad Site: ☐ Clean and Dry ☐ Red ☐ N/A DRESSING DRY & INTACT: (Y) (N)
LEVEL OF CONSCIOU[redacted]S: ☐ A&O ☐ Drowsy ☐ Sleepy ☐ Intubated BREATHING EASY: (Y) (N)
LEVEL OF ACTIVITY: ☒ Moves All Extremities ☐ Moves Upper Extremities
[redacted] sferred to litter with roller due to spinal

12. PREOPER [redacted] ED BY (Signature and [redacted] CPT/AN
13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title)

DATE: 5 Jul 03 TIME: 0740 (b)(6)-2 DATE: TIME:

REVERSE OF FORM 5179, JUN 91

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USAPA V1.0

MEDICAL RECORI | **INTRA DOCUMENT**

For use of this form, see AR 40-407, ... proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Litter BY [redacted] (b)(6)-2

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY [redacted] Cpt

3. DATE 3 July 03 TIME PATIENT ARRIVED IN SUITE 2030

4. PATIENT IN ROOM TIME 2030 (b)(6)-2 NUMBER [redacted] (b)(6)-4

5. PREOPERATIVE EMOTIONAL STATUS

☐ CALM ☒ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SSG [redacted] (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	Cpt [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

COMMENTS:

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

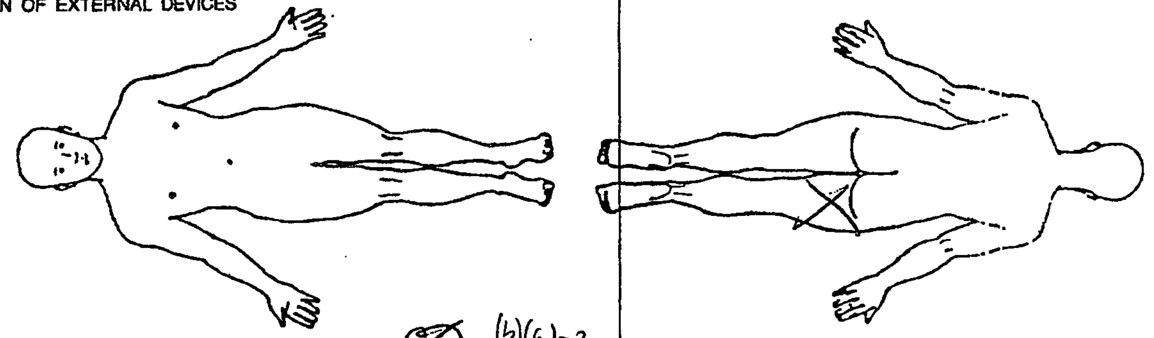
PREP SOLUTION *(Specify)* Beta / Beta

SITE: ABD + (L) thigh BY WHOM: Cpt [redacted]

SITE: (R) Arm (L) Arm BY WHOM: Cpt [redacted]

COMMENTS: (b)(6)-2

9. LOCATION OF EXTERNAL DEVICES



LEGEND ·X Ground Pad -- Safety Strap === Tourniquet (b)(6)-2

10. COUNTS

C = Correct I = Incorrect

10. COUNTS		Initial/ Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☑ Yes ☐ No	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Needle Sharp	☑ Yes ☐ No	[redacted]	[redacted]	[redacted]	[redacted] (b)(6)-2	[redacted] (b)(6)-2
Instrument	☑ Yes ☐ No	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Other	☑ Yes ☐ No	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

[redacted]

(b)(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☑ YES ☐ NO

☑ ESU NO: F1043

GROUND PAD: BRAND Valleylab

LOT NO: [redacted] (b)(6)-4

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE.

MEDCOM - 13600

13. PROSTHESIS, IMPLANTS ☒ NO IF YES NAMI R; MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☒

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):
6L NSS

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM IF YES, SITE
YES ☐ NO ☒

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 5/8 Penrose	2.	3.
SITE	(L) thigh	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
4X8 Ioban
Xeroform Fluffs Kerlix
Colostomy

19. ADDITIONAL INFORMATION
DR [redacted] LTC
DR. MAJ (b)(6)-2
Anes - LTC - Gen

20. OPERATION(S) PERFORMED
Exploratory lap, Small Bowel Resection x2

21. PATIENT TRANSFERRED TO ICU | TIME [redacted] | METHOD Litter

22. REGISTERED NURSE SIGNATURE (b)(6)-2

REVERSE OF DA FORM 5179-1, OCT 87

*U.S. Government Printing Office: 1995 — 388-733/23952

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MEDICAL RECORD

INTRAO TIVE DOCUMENT

For use of this form, see AR 40-66, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Litter BY Anesthesia

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY CPT [redacted] / CPT [redacted] (b)(6)-2

3. DATE 5 Jul 03 TIME PATIENT ARRIVED IN SUITE 1549

4. PATIENT IN ROOM TIME 1549 NUMBER 1-1 5th

5. PREOPERATIVE EMOTIONAL STATUS

☒ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS: uncomfortable-moaned

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted] SGT [redacted] (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] CPT [redacted] CPT [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

COMMENTS: Proper body alignment

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

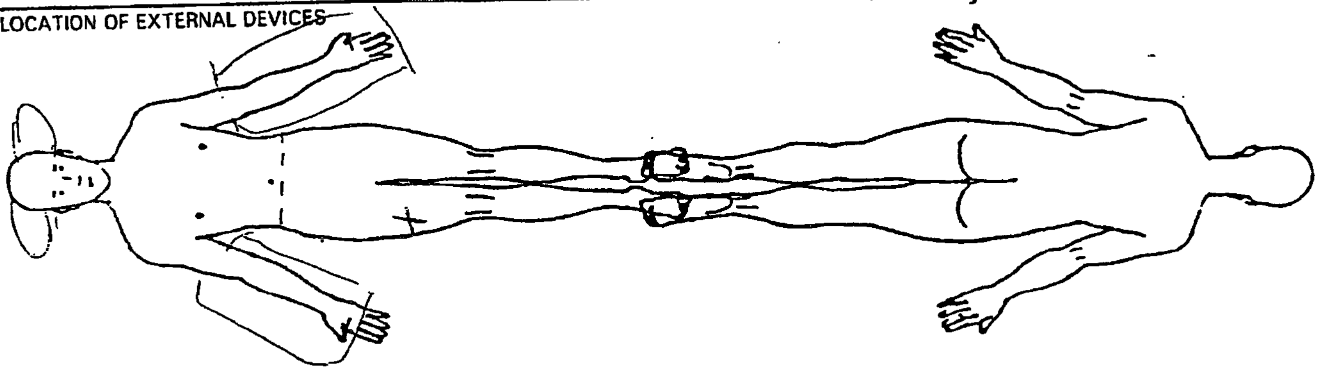
PREP SOLUTION *(Specify)*

SITE: Ⓛ thigh BY WHOM: CPT [redacted]

SITE: BY WHOM: (b)(6)-2

COMMENTS: No pooling of fluids

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Strap = = = Tourniquet

C = Correct I = Incorrect initial -

10. COUNTS			~~Other**~~ initial	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes	☐ No	[redacted]		[redacted]	PFC [redacted] /SGT [redacted]	CPT [redacted]
Needle Sharp	☐ Yes	☐ No		(b)(6)-2			
Instrument	☐ Yes	☐ No				(b)(6)-2	(b)(6)-2
Other	☒ Yes	☐ No	[redacted]		[redacted]	PFC [redacted] /Sgt [redacted]	CPT [redacted]

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

# [redacted] -(b)(6)-4

ICU-1

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO

☒ ESU NO: #4 Cut

GROUND PAD: BRAND Valleylab

LOT NO: [redacted] -(b)(6)-4

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES D MEDCOM - 13602 ICH IS OBSOLETE. USAPA V1.01

13. PROSTHESIS, IMPLANTS ☐ YES ☒ NO IF YES NAME: ID NUMBER; MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☐

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
~~0.9% NS~~ [redacted] (b)(6)-2					

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):
0.9% NS

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S S[redacted] (b)(6)-2

15. X-RAY IN OPER[redacted]ING ROOM IF YES, SITE
YES ☐ NO ☒

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. Kerlix	2. Kerlix	3. Kerlix
SITE	1. Ⓛ Arm Kerlix [redacted]	2. Ⓡ Arm Kerlix [redacted]	3. Ⓛ thigh

(b)(6)-2

18. DRESSING/IMMOBILIZATION *(Specify)*
Wet-dry Kerlix Ⓛ & Ⓡ arm &
Ⓛ Thigh

19. ADDITIONAL INFORMATION

F/C in place on arrival

Maj. [redacted]
CPT [redacted]
Col. [redacted]
(b)(6)-2

Ⓛ & Ⓡ arm cleaned w/ H_2O

20. OPERATION(S) PERFORMED
I & D Ⓡ & Ⓛ Arm
I & D Ⓛ thigh

21. PATIENT TRANSFERRED TO (b)(6)-2 ICU 1 TIME 1638 METHOD Litter

22. REGISTERED NURSE SIGNATURE [redacted] CP-'AN

REVERSE OF DA FORM [redacted] *, O* USAPA V1.01

MEDCOM - 13603

MEDICAL RECORD | **INTRAC ATIVE DOCUMENT**

For use of this form, see AR 40-66, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: LITTER BY Anesthesia

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY 1LT [redacted] (b)(6)-2

3. DATE 8 JUL 03 TIME PATIENT ARRIVED IN SUITE 1105

4. PATIENT IN ROOM TIME 1105 NUMBER 1-1 #3

5. PREOPERATIVE EMOTIONAL STATUS

☐ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS: NPO p̄ MN, NKDA

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted] 91D (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	1LT [redacted] 66E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)* Supine on padded OR table BUE on padded armboards <90°

☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

COMMENTS: Normal anatomic body alignment maintained

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS: N/A

PREP SOLUTION *(Specify)* Betadine / Betadine

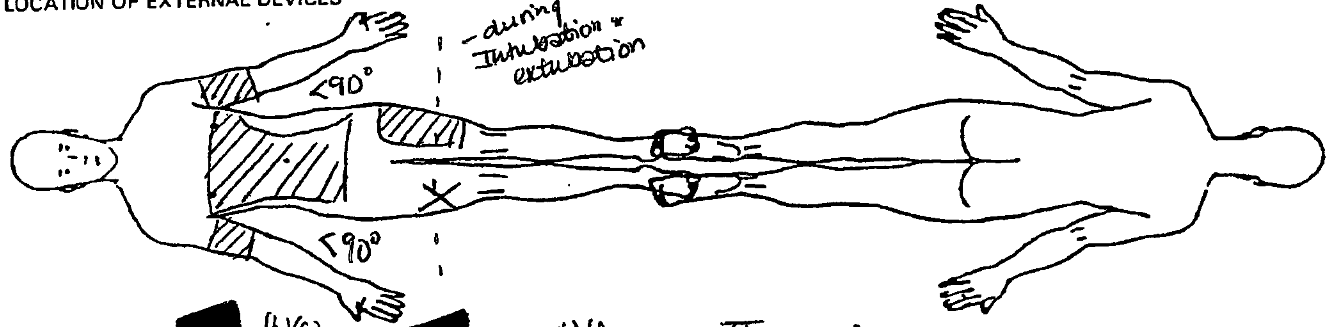
SITE: Abdomen, BUE, BY WHOM:

SITE: ~~Rig~~ Left thigh BY WHOM:

(b)(6)-2

COMMENTS: No pooling or adverse reaction

9. LOCATION OF EXTERNAL DEVICES



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

LEGEND X Ground Pad -- Safety Strap === Tourniquet N/A ▨ prep

Initial PFC [redacted]
1LT

10. COUNTS (b)(6)-2

C = Correct I = Incorrect

		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No		C	C	PFC [redacted]	1LT [redacted]
Needle Sharp	☒ Yes ☐ No				(b)(6)-2	(b)(6)-2
Instrument	☐ Yes ☒ No					
Other	☐ Yes ☒ No					

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

[redacted] (b)(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO

☒ ESU NO: #4 Cut: 30 Coag: 30

GROUND PAD: BRAND VL Rem PolyHesive II

LOT NO: [redacted] Exp 2004-11

(b)(6)-4

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES I MEDCOM - 13604 IICH IS OBSOLETE. USAPA V1.01

13. PROSTHESIS, IMPLANTS ☐ YES ☒ NO **IF YES NAME: ID NUMBER; MANUFACTURER**

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☒

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
N/A					

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):
0.9% NaCl. QS.

OTHER ORDERS	TIME	CARRIED OUT BY
N/A		

PHYSICIAN'S SIGNATURE [redacted] -(b)(6)-2

15. X-RAY IN OPERATING ROOM YES ☐ NO ☒ **IF YES, SITE**

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

TYPE/SIZE	1.	2.	3.
SITE	1.	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
4X8 and Tape on all sites.
Ostomy bag Δ.

19. ADDITIONAL INFORMATION
Surgeon: Dr. [redacted]
Anesthesia: MAJ [redacted] > (b)(6)-2

Patent Foley cath. & ostomy.

DA 5179 In Chart

20. OPERATION(S) PERFORMED
Washout & DPC

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU 1 (b)(6)-2	1206	LITTER c̄ O2

22. REGISTERED NURSE SIGNATURE [redacted] RN

REVERSE OF DA FORM 5179-1, OCT USAPA V1.01

MEDCOM - 13605

ACLU-RDI 1592 p.1499

(b)(6)-2

Ward/Section: ZMT	REQUESTING P[redacted]	**LABORATORY RESULT FORM** (Subject to Privacy Act of 1974)
LAST, FIRST, MI. (b)(6)-4 [redacted]	DATE 4JUL03 TIM. 0105	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	14.0	4.8-10.8 x 10^3
RBC	3.35	4.7-6.1 x 10^9
Hgb	9.5	14-18 g/dl (M) 12-16 g/dl (F)
Hct	30.3	42-52% (M) 37-47% (F)
MCV	90.5	80-94 fl (M) 81-99 fl (F)
Plt	209	130-500 x 10^3 verified
Lymph %	7.2	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis

TEST	RESULT	REF. RANGE
Color	Straw	N/A
App	Clear	N/A
Glu	neg	Negative
Bili	neg	Negative
Ket	trace	Negative
SG	1.020	N/A
Bld	trace	Negative
pH	6.0	N/A
Prot	neg	Negative
Urob	neg	0.2-1.0
Nit	neg	Negative
Leuk	neg	Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF. RANGE
PT	14.9	9.8-13.6 secs
APTT	25.1	21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	**DATE:**	**LAB ID NO.:**

MEDCOM - 13606

Ward-Section: EMT

UESTING PHYSICIAN: [redacted] (b)(6)-2

ƸмISTRY ʀESULT FORM
(Subject to the Privacy Act of 1974)

LAST, FIRST, MI: [redacted] (b)(6)-4

DATE: 4Sep03

TIME: 0905

SSN/PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		Negative
Drug of Abuse		Negative
		Negative
		Negative
		Negative

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB	2.8	3.5-5.5 g/dl
ALP	52	26-84 u/l
ALT	23	10-47 u/l
AMY	76	14-97 u/l
AST	63	11-38 u/l
TBIL	0.8	0.2-1.6 mg/dl
BUN	8	7-22 mg/dl
CA⁺⁺	7.6	8.0-10.3mg/dl
CHOL	47	100-200 mg/dl
CRE	1.1	0.6-1.2 mg/dl
GLU	126	73-118 mg/dl
TP	5.1	6.4-8.1 g/dl

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 u/l (M) 30-190 u/l (F)
NA⁺		128-145 mmol/l
K⁺		3.3-4.7 mmol/l
CL⁻		98-108 mmol/l
tCO₂		18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA⁺⁺		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA⁺		128-145 mmol/l
K⁺		3.3-4.7 mmol/l
CL⁻		98-108 mmol/l
tCO₂		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA⁺	135	128-145 mmol/l
K⁺	4.5	3.3-4.7 mmol/l
CL⁻	108	98-108 mmol/l
tCO₂	22	18-33 mmol/l

REMARKS:

REPORTED BY: (b)(6)-2 [redacted]

DATE: 4-Sep03

LAB ID NO.:

MEDCOM - 13607

Vard/Section: ICU #1 JESTING PHYSICIAN (b)(6)-2 [redacted]

LABORATORY RESULT F
(Subject to the Privacy Act of 1

AST, FIRST, MI. [redacted] (b)(6)-4	DATE 5 Jul 03	TIME [illegible]	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	13.2	4.8-10.8 x 10^3
RBC	3.48	4.7-6.1 x 10^9
Hgb	9.8	14-18 g/dl (M) 12-16 g/dl (F)
Hct	31.2	42-52% (M) 37-47% (F)
MCV	89.8	80-94 fl (M) 81-99 fl (F)
Plt	194	130-500 x 10^3 verified
Lymph %	14.6	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc Serology

TEST	RESULT	REF
RPR		Negati
Mono		Negati

Microbiology

Source		
Gram Stain		
Occ Bld		Neg
H. pylori		Neg
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinaly

Blood Bank

MUST SUBMIT SF 518 W
EVERY UNIT REQUES

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Blood Bank Unit Crossmatch
MUST SUBMIT SF 518 WITH EVERY UNIT OF BLO REQUESTED

UNIT	TYPE	CROSSMA

REMARKS:

REPORTED BY: (b)(6)-4 [redacted]

DATE: 5 Jul 03

LAB ID NO.:

MEDCOM - 13608

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		Negative
Drug of Abuse		Negative
		Negative
		Negative
		Negative

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA++		8.0-10.3mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU	104	73-118 mg/dl
BUN	10	7-22 mg/dl
CRE	0.9	0.6-1.2 mg/dl
CK	2935	39-380 u/l (M) 30-190 u/l (F)
NA+	136	128-145 mmol/l
K+	4.2	3.3-4.7 mmol/l
CL-	99	98-108 mmol/l
tCO2	25	18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA+		128-145 mmol/l
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
tCO2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA+		128-145 mmol/l
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
tCO2		18-33 mmol/l

REMARKS: [redacted] (b)(6)-4 ICU #2

REPORTED BY:

DATE: 5Jul03

LAB ID NO.:

[redacted] (b)(6)-2

Ward/Section: ICU #1

[redacted]G PHYSICIAN: (b)(6)-2

LABORATORY RESULT
(Subject to the Privacy Act of

LAST, FIRST, MI [redacted] (b)(6)-4

DATE 6 Jul 03

TIME 0835

SSN[redacted]O SSN: (b)(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	11.5	$4.8\text{-}10.8 \times 10^3$
RBC	3.32	$4.7\text{-}6.1 \times 10^6$
Hgb	9.3	14-18 g/dl (M) 12-16 g/dl (F)
Hct	29.7	42-52% (M) 37-47% (F)
MCV	89.3	80-94 fl (M) 81-99 fl (F)
Plt	241	$130\text{-}500 \times 10^3$ verified
Lymph %	20.4	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF
RPR		Negati
Mono		Negati

Microbiology

Source		
Gram Stain		
Occ Bld		Neg
H. pylori		Neg
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinaly

Blood Bank

MUST SUBMIT SF 518 W
EVERY UNIT REQUEST

ABO/Rh

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Blood Bank Unit Crossmatch
(MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOO REQUESTED)

UNIT	TYPE	CROSSMAT

REMARKS:

REPORTED BY: **DATE:** **LAB ID NO.:**

MEDCOM - 13610

ICU #1

[redacted] (b)(6)-4

(i-STAT)

TEST	RESULT	REF. RANGE
Na	140	138-146 mmol/L
K	3.7	3.5-4.9 mmol/L
Cl	100	98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN	10	8-26 mg/dl
GLU	106	70-105 mg/dl
Creat	0.7	0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		Negative
Drug of Abuse		Negative
		Negative
		Negative
		Negative

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA++		8.0-10.3mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 u/l (M) 30-190 u/l (F)
NA+		128-145 mmol/l
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
tCO2		18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA++		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA+		128-145 mmol/l
K+		3.3-4.7 mmol/l
CL		98-108 mmol/l
tCO2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA		128-145 mmol/l
K		3.3-4.7 mmol/l
CL		98-108 mmol/l
tCO2		18-33 mmol/l

REMARKS:
Chem 7

REPORTED BY:	DATE:	LAB ID NO.:
	6 Jul 03	ICU #1

[redacted] (b)(6)-4

MEDCOM - 13611

d/Section: ICU

Q STING PHYSICIAN: (b)(6)-4

LABORATORY RESULT FORM
(Subject to the Privacy Act of 1974)

ST, FIRST, MI. EPW [redacted]

DATE 07/24/03

TIME 0400

SSN/PSEUDO SSN:

(Hematology) CBC

EST	RESULT	REF. RANGE
WABC	8.5	4.8-10.8 x 10^3
RB C	2.99	4.7-6.1 x 10^6
Hgb	8.5	14-18 g/dl (M) 12-16 g/dl (F)
Hct	26.6	42-52% (M) 37-47% (F)
MCV	88.9	80-94 fl (M) 81-99 fl (F)
Plt	226.	150-500 x 10^3 verified
mph %	[redacted] 24.2	20.5-51.1%

(Hematology) Manual Differential

(b)(6)-2

gs		Mono	
nds		Eos	
mph		Baso	
/p		Imm	
C orph			

m matocrit		42-52% (M) 37-47% (F)
l Rate		
her		

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

Misc. Serology

TEST	RESULT	REF. RANG
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

EST	RESULT	REF. RANGE
		9.8-13.6 secs
TT		21-34 secs
dimer		<20 ug/ml
DP		<10 ug/ml

Blood Bank Unit Crossmatch
(MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

EMARKS:

EPORTED BY: (b)(6)-2 [redacted] | DATE: | LAB ID NO.:

MEDCOM - 13612

EPW [redacted] (b)(6)-4 04 - 07Jul03

ICU (

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
iCa		1.12-1.32 mmol/L
BUN		8-26 mg/dl
[illegible]		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
[illegible]		Negative
Drug of Abuse		Negative
		Negative
		Negative
		Negative

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU	85	73-118 mg/dl
BUN	7	7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 u/l (M) 30-190 u/l (F)
NA^+	137	128-145 mmol/l
K^+	3.6	3.3-4.7 mmol/l
CL^-	98	98-108 mmol/l
tCO_2	31	18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA		128-145 mmol/l
K		3.3-4.7 mmol/l
CL		98-108 mmol/l
tCO₂		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA		128-145 mmol/l
K		3.3-4.7 mmol/l
CL		98-108 mmol/l
tCO₂		18-33 mmol/l

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
[redacted]	7Jul03	

(b)(6)-2

(ICU#) | REQUESTING PHYSICIAN: [redacted] (b)(6)-2

(b)(6)-4 EPW [redacted]

DATE 8 JUL 03 | TIME 0400

LABORATORY RESULT F

(Subject to the Privacy Act of 1

SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	7.1	4.8-10.8 x 10^3
RBC	3.13	4.7-6.1 x 10^9
Hgb	8.6	14-18 g/dl (M) 12-16 g/dl (F)
Hct	27.8	42-52% (M) 37-47% (F)
MCV	88.7	80-94 fl (M) 81-99 fl (F)
Plt	308	130-500 x 10^3 verified
Lymph %	31.0	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			
Spun Hematocrit		42-52% (M) 37-47% (F)	
Sed Rate			
Other			

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

Misc. Serology

TEST	RESULT	REF
RPR		Negati
Mono		Negati

Microbiology

Source		
Gram Stain		
Occ Bld		Neg
H. pylori		Neg
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinaly

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 W EVERY UNIT REQUEST

ABO/Rh

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EACH UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMA

REMARKS:

(b)(6)-2

REPORTED BY: [redacted] | DATE: | LAB ID NO.:

MEDCOM - 13614

Ward/Section: ICU #	QUESTING PHYSICIAN: (b)(6)-2 [redacted]	**CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI. [illegible] [redacted] (b)(6)-4	DATE 8 Jul	TIME [illegible]	SSN/PSEUDO SSN:

(i-STAT)

TEST	*RESULT*	*REF. RANGE*
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	*RESULT*	*REF. RANGE*
Troponin-I		Negative
Drug of Abuse		Negative
		Negative
		Negative
		Negative

(Piccolo) Chemistry 12

TEST	*RESULT*	*REF. RANGE*
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA++		8.0-10.3mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

(Piccolo) Metlyte 8

TEST	*RESULT*	*REF. RANGE*
GLU	115	73-118 mg/dl
BUN	6	7-22 mg/dl
CRE	0.8	0.6-1.2 mg/dl
CK	773	39-380 u/l (M) 30-190 u/l (F)
NA+	139	128-145 mmol/l
K+	3.8	3.3-4.7 mmol/l
CL-	101	98-108 mmol/l
tCO$_2$	25	18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	*RESULT*	*REF. RANGE*
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA++		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA+		128-145 mmol/l
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
tCO$_2$		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	*RESULT*	*REF. RANGE*
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	*RESULT*	*REF. RANGE*
NA+		128-145 mmol/l
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
tCO$_2$		18-33 mmol/l

REMARKS:

REPORTED BY: [redacted] (b)(6)-2	**DATE:** 8 Jul 03	**LAB ID NO.:**

MEDCOM - 13615

/Section: ICU# 1

UESTING PHYSICIAN: [redacted] (b)(6)-2

CHEMISTRY RESULT FORM
(Subject to the Privacy Act of 1974)

, FIRST, MI. EPW # [redacted] (b)(6)-4

DATE 7/9/03

TIME 0400

SSN/PSEUDO SSN [redacted] (b)(6)-4

[redacted] (b)(6)-2

T		REF. RANGE
		138-146 mmol/L
		3.5-4.9 mmol/L
		98-109 mmol/L
		7.31-7.45
		35-45 mmHg (art) 41-51 mmHg (ven)
		80-105 mmHg (art) N/A (ven)
		23-27 mmol/L (art) 24-29 mmol/L (ven)
		22-26 mmol/L (art) 23-28 mmol/L (ven)
		95-98%
		(-2) – (+3) mmol/L
p		10-20 mmol/L
		1.12-1.32 mmol/L
		8-26 mg/dl
		70-105 mg/dl
		0.7-1.5 mg/dl
		38-51% PCV
		12-17 g/dl

Misc. Chemistry

	RESULT	REF. RANGE
n-I		
of		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU	94	73-118 mg/dl
BUN	6	7-22 mg/dl
CRE	1.0	0.6-1.2 mg/dl
CK	716	39-380 u/l (M) 30-190 u/l (F)
NA^+	128	128-145 mmol/l
K^+	4.0	3.3-4.7 mmol/l
CL^-	102	98-108 mmol/l
tCO_2	25	18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

RKS:

RTED BY: [redacted] (b)(6)-2

DATE:

LAB ID NO.:

MEDCOM - 13616

on: CU #1 | REQ

[redacted] PHYSICIAN: (b)(6)-2

BORATORY RESULT FORM
(Subject to the Privacy Act of 1974)

ST. MI. EPW [redacted] (b)(6)-4

DATE 7/9/03

TIME 0400

SSN/PSEUDO SSN: [redacted] (b)(6)-4

(Hematology) CBC

	RESULT	REF. RANGE
	5.9	4.8-10.8 x 10^3
	2.78	4.7-6.1 x 10^6
	7.7	14-18 g/dl (M) 12-16 g/dl (F)
	24.7	42-52% (M) 37-47% (F)
	89.1	80-94 fl (M) 81-99 fl (F)
	354	130-500 x 10^3 verified
	28.7	20.5-51.1%

ology) Manual Differential

	Mono	
	Eos	
	Baso	
	Imm	

		42-52% (M) 37-47% (F)

Coagulation Studies

	RESULT	REF. RANGE
		9.8-13.6 secs
		21-34 secs
		<20 ug/ml
		<10 ug/ml

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Blood Bank Unit Crossmatch
(MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

KS: [redacted] (b)(6)-2

ED BY: | DATE: | LAB ID NO.:

MEDCOM - 13617

ICU#1 | RFI | PHYSICIAN: [redacted] (b)(6)-2

LABORATORY RESULT FORM
(Subject to the Privacy Act of 1974)

ST, MI: EPW# [redacted] (b)(6)-4 | DATE 7/10/03 | TIME 0345 | SSN PSEUDO SSN:

(Hematology) CBC

RESULT	REF RANGE
	4.8-10.8 x 10³
	4.7-6.1 x 10⁶
	14-18 g/dl (M) 12-16 g/dl (F)
	42-52% (M) 37-47% (F)
	80-94 fl (M) 81-99 fl (F)
	150-400 x 10³ verified 20.5-51.1%

(Hematology) Manual Differential

	Mono	
	Eos	
	Baso	
	Imm	

	42-52% (M) 37-47% (F)

Urinalysis

TEST	RESULT	REF RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

Misc. Serology

TEST	RESULT	REF RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

RESULT	REF RANGE
	9.8-13.0 secs
	21-34 secs
	<20 ug/ml
	<10 ug/ml

Blood Bank Unit Crossmatch
(MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

COMMENTS:

PERFORMED BY: [redacted] (b)(6)-2 | DATE: | LAB ID NO:

MEDCOM - 13618

/Section: ICU#1

UESTING PHYSICIAN: [redacted] (b)(6) - 2

CHEMISTRY RESULT FORM

(Subject to the Privacy Act of 1974)

, FIRST, MI. EPW# [redacted] (b)(6)-4

DATE 7/10/03

TIME 0345

SSN/PSEUDO SSN:

~~(i-STAT)~~

ST	~~RESULT~~	REF. RANGE
		138-146 mmol/L
		3.5-4.9 mmol/L
		98-109 mmol/L
		7.31-7.45
2		35-45 mmHg (art) 41-51 mmHg (ven)
		80-105 mmHg (art) N/A (ven)
2		23-27 mmol/L (art) 24-29 mmol/L (ven)
3		22-26 mmol/L (art) 23-28 mmol/L (ven)
		95-98%
		(-2) – (+3) mmol/L
p		10-20 mmol/L
		1.12-1.32 mmol/L
		8-26 mg/dl
		70-105 mg/dl
		0.7-1.5 mg/dl
		38-51% PCV
		12-17 g/dl

Misc. Chemistry

	RESULT	REF. RANGE
n-l		
f		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3mg/dl

```
======= PICCOLO =======
10/07/03              04:45
REFERENCE RANGE:        MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: (b)(6)-4 [redacted]
OPER #: [redacted] (b)(6)-2 DR #: 000
SERIAL #(b)(6)-4 [redacted]
..........................
GLU     84    73-118    MG/DL
BUN      8    7-22      MG/DL
CRE    0.5*   0.6-1.2   MG/DL
CK     464*   39-380      U/L
NA+    136    128-145   MMOL/L
K+     4.1    3.3-4.7   MMOL/L
CL-    104    98-108    MMOL/L
tC02    26    18-33     MMOL/L

INST QC: OK     CHEM QC: OK
HEM 0 ,  LIP 0 ,  ICT 0
```

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^{+}		128-145 mmol/l
K^{+}		3.3-4.7 mmol/l
CL^{-}		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA^{+}		128-145 mmol/l
K^{+}		3.3-4.7 mmol/l
CL^{-}		98-108 mmol/l
tCO_2		18-33 mmol/l

RKS:

[redacted] (b)(6)-2

RTED BY

O.:

MEDCOM - 13619

```
ID: [redacted] (b)(6)-4    10-07-03
WB                            04:06
                            Patient
                             Limits
WBC    6.6   x10^3/uL    4.5  10.5
RBC   2.87 L x10^6/uL   4.00  6.00
Hgb    8.0 L g/dL       11.0  18.0
Hct   25.7 L %          35.0  60.0
MCV   89.4   fL          80.0  99.9
MCH   27.8   pg         27.0  31.0
MCHC  31.1 L g/dL       33.0  37.0
Plt  415.    x10^3/uL  150.   450.
LY%  37.0    %           20.5  51.1
LY#    2.5   x10^3/uL    1.2   3.4
```

2030 = Unasyn - 3gm

MEDICAL RECORD ANESTHESIA

ANESTHETIC AGENTS AND DRUGS – CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML, "I"=CONSTANT INFUSION

DRUG	ROUTE	30	x	2100	x	30	x	2200	x	30	x	2300	x
ITS	( )	200											
SUX	( )	100											
Fent	( )		2	2		1		2				1	
Vec	( )		5		2		3			2			
	( )												
	( )												
VOLAT. AGENT 250	% del	1	1.5	2.5	1.5	1.5	1.5		1.5	1.5	1.5		
	% e.t.												
AIR	L/Min												
N2O	L/Min												
O2	L/Min	5		5	5	5	5		5	5	5		
SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS		Unasyn 3gm											

FLUIDS

LINE site		30	x	2100	x	30	x	2200	x	30	x	2300	x
(L) 18	☐ Warmed	→ 300				800	1000	→	1300	1400			
(R) 16	☐ Warmed		300			1000	1200	→	1400	1600			
	☐ Warmed												
	☐ Warmed												

LOSSES

	30	x	2100	x	30	x	2200	x	30	x	2300	x
EST BLOOD LOSS												
URINE –			150					250				

TOTALS	TOTAL EBL
	TOTAL URINE

FLUIDS SUMMARY

CRYSTALLOID–

COLLOID–

BLOOD–

REMARKS–

Code drugs with numbers, events with letters

2030 pt brought Directly to OR.

2100 - NGT placed Onoros ⊕ yellow fluid returned.

PHYS STATUS 1 [✓ 2] 3 4 5 [✓ E]

BODY WEIGHT ? KG LB

HEMATOCRIT

INITIAL DATA

BP – 130 / 80

HR– 74

EQUIP CHECK

OK?– [✓ Y] N

PATIENT RECHECK

OK for PROCEDURE? yes

TIME– 2030

TIME → 2030 x 2100 x 30 x 2200 x 30 x 2300 x

SYMBOLS:

BP by cuff ∨ ∧

Heart rate ●

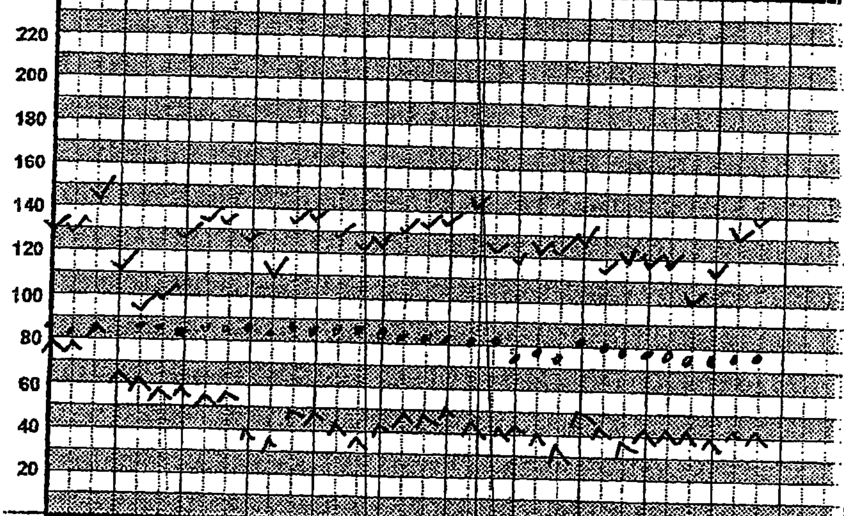
Resp rate

BP (transduced)

TOURNIQUET T – T̸

ANES– X–X

PROC– ⊙ – Ø



VENTILATION / MONITORS

		30	x	2100	x	30	x	2200	x	30	x	2300	x
	VT – ml												
	f – breaths/min		10	10	10	10	10	10	10	10	10		
	Peak insp pres / PEEP												
	MODE– S(pon), A(ssist), C(on)												
☒ BP/Auto Cuff	☒ ET CO2 (torr)		32	30	28	32	30	31	35	32	31	30	
BP / oth	☒ FIO2 (Frac or %)		.4	.6	.6	.6	.6	.6	.6	.6	.59		
ART line	☒ SpO2 (%)	100	100	100	100	100	100	100	100	100	100		
☒ Steth- PC/ES	☒ ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR		
Gas analyzer	TEMP- site												
	N-M Block (T/4)			1/4		2/4			1/4	1/4		2/4	
Warming blkt													
Conv warmer													

Mark with letters & symbols, explain under REMARKS **EVENTS**

Position → supine

RECOVERY AT 0084

[✓ PACU] · ICU ______ (Specify)

OTHER

CONDITION:

RESP– 15 SpO2– 100

BP– 161/78 HR– 91

ANES. PROCEDURE TIMES

	Start	Room	End
ANES	2030	2030	
	Ready	**Begin**	**End**
PROC	2045	2107	0014

PROCEDURES and CPT Codes

Exp Lap.

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

GETA

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* Pre O2. RSI

DLx1, view Grade I, 8.0 ETT c BS=BL. ETCO2 ✓, ETT taped @ 24cm teeth eyes taped.

PATIENT IDENTIFICATION– *Typed or written entries: Name, Grade/Rate, Medical facility*

Iraqi OJ (b)(6)-4

[redacted]

SURGEONS: [redacted], [redacted] A1

ANESTHETISTS: [redacted] (b)(6)2

PROCEDURE LOCATION OR

DATE 3/20/03

PAGE 1 OF 2

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED
1 Jan 99

MEDCOM - 13621

MEDICAL RECORD ANESTHESIA

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML. "I"=CONSTANT INFUSION

DRUG (Units)					
Fent (cc)		.5	1		
( )					
( )					
MSO4 (mg)	2	2	2		
( )					
( )					
VOLAT AGENT ISO % del	1	1	1	X	
% e.t.					
AIR L/Min					
N2O L/Min					
O2 L/Min	5	5	5	5	5

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS ▶

FLUIDS

LINE site Ⓛ	☐ Warmed	1700 ——	2000
Ⓡ	☐ Warmed	2000 ——	2200
	☐ Warmed		
	☐ Warmed		

LOSSES

EST BLOOD LOSS	100	
URINE –	250	350

TOTALS	
500	TOTAL EBL
6	TOTAL URINE

FLUIDS – SUMMARY
CRYSTALLOID–
COLLOID–
BLOOD–

REMARKS–

Code drugs with numbers, events with letters

0005 - mouth suctioned
0015 - extubated p̄ SV, responds to voice command.

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: KG LB

HEMATOCRIT:

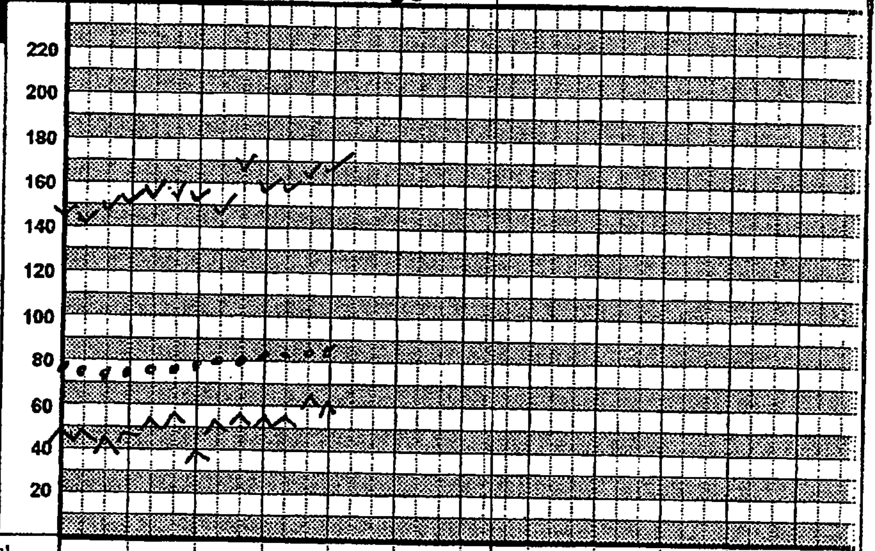
INITIAL DATA: BP– HR–

EQUIP CHECK: OK?– Y N

PATIENT RECHECK: OK for PROCEDURE? ✓ TIME–

TIME ➡ 15 30 X 240 ✓ 30

SYMBOLS: BP by cuff ∨ ∧; Heart rate ●; Resp rate; BP (transduced) ⊥ ⊤; TOURNIQUET T – ⊤; ANES– X-X; PROC-⊙-Ø



VENT

VT – ml					
f – breaths/min	10	20	21	18	18
Peak insp pres / PEEP					
MODE– S(pon), A(ssist), C(on)	A	A	S	S	S

MONITORS / ACCESSORIES

✓ BP/Auto Cuff	✓ ET CO2 (torr)	35	39	45	44	
BP / oth	✓ FIO2 (Frac or %)	.59	.6	.6	.6	
ART line	✓ SpO2 (%)	100	100	100	100	
✓ Steth- PC/ES	✓ ECG	SR	SR	SR	SR	
Gas analyzer	TEMP- site					
	N-M Block (T/4)	4/4			4/4 sust tet.	
Warming blkt						
Conv warmer						

Mark with letters & symbols, explain under REMARKS EVENTS Position —— O —————

RECOVERY AT
PACU ICU ______ (Specify)
OTHER ______
CONDITION:
RESP– SpO2–
BP– HR–

ANESTHESIA / PROCEDURE TIMES

ANES	Start	Room	End
PROC	Ready	Begin	End
			0014

PROCEDURES and CPT Codes
Exp Lap. Small Bowel Resec ×2, colectomy transverse & Ⓛ colon resection. colostomy.

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*

PATIENT IDENTIFICATION– *Typed or written entries: Name, Grade/Rate, Medical facility*
IED GSW Ⓛ thigh & RUE & BUE
Drain Ⓛ thigh

A11
(b)(6)-2

Iraqi ♂ (b)(6)-4

[redacted]

SURGEONS: [redacted]

ANESTHETISTS: [redacted] LTC CRNA

MEDICAL RECORD – ANESTHESIA

PROCEDURE LOCATION OR

DATE 3 Jul 03

PAGE 2 OF 2

WAMC OP 376 REVISED
1 Jan 99

MEDCOM - 13622

☆ U.S. GPO: 1999 – 528-336/10085

MEDICAL RECORD — ANESTHESIA

ANESTHETIC AGENTS AND DRUGS
CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML, * ("=CONSTANT INFUSION

DRUG	(Units)	
VERSED	(mg)	2
Fentanyl	(.u)	3
propofol	(mg)	180
Sux	(mg)	8+
	( )	
Forane	( )	

VOLAT AGENT	% del	1.5 — X
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	8 — 2 — 8

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS ▶

FLUIDS
LINE site LA
☐ Warmed — 300 —
☐ Warmed
☐ Warmed
☐ Warmed

LOSSES
EST BLOOD LOSS
URINE – Foley

TOTALS	TOTAL EBL
	min

TOTAL URINE
200

FLUIDS – SUMMARY
CRYSTALLOID– 400
COLLOID– 0
BLOOD– 0

REMARKS–
Code drugs with numbers, events with letters

Emergence c̄ diff c̄ spont Resp, Extubated (suction prior)

PHYS STATUS
1 [✓ 2] 3 4 5 E

BODY WEIGHT
~70 [✓ KG] LB

HEMATOCRIT
9.8/31.2

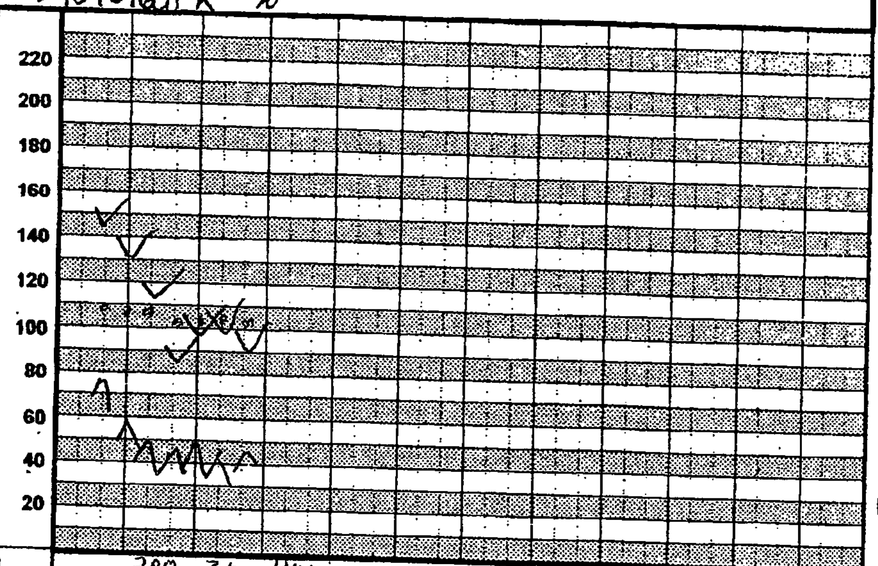
INITIAL DATA
BP – 120/57
HR – 111

EQUIP CHECK
OK?– [✓ Y] N

PATIENT REQUEST
OK for PROCEDURE? yes
TIME– ~~1540~~ 1545

TIME ➡ 1545 1600 K 30

SYMBOLS:
BP by cuff ∨ ∧
Heart rate ●
Resp rate
BP (transduced) ⊥ ⊤
TOURNIQUET T – ⊥
ANES– X-X
PROC ⊙ – Ø



VT – ml		200	300	400	
f – breaths/min		9	18	15	
Peak inf pres / PEEP					
MODE– S(pon), A(ssist), C(on)	SC	S(A)	S	S	
ET CO2 (torr)	45	45	41	46	
FIO2 (Frac or %)	.85	.85	.85	.85	
SpO2 (%)	100	100	100	99	
ECG	ST	ST	ST	ST	
TEMP- site					
N-M Block (T/4)	Avent				

BP/Auto Cuff ✓
BP / oth
ART line
Steth- [✓ PC]/ES
Gas analyzer
Warming blkt
Conv warmer

RECOVERY AT 1645
PACU [✓ ICU] # (Specify)
OTHER
CONDITION: 10/2 LLFM
RESP– 20 SpO2– 95
BP– 134/71 HR– 117

ANESTHESIA / PROCEDURE TIME

	Start	Room	End
ANES	1545	1600	1650

	Ready	Begin	End
PROC	1610	1615	1625

Mark with letters & symbols, explain under REMARKS
EVENTS
Position → [redacted] (b)(6)-2

PROCEDURES and CPT Codes
I+D (L) leg wound

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GETA Eyes taped –

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
SIVI, DVOE x1, atraumatic, cuff ↑, BS=BS

SURGEONS:

PROCEDURE LOCATION OR #1

PATIENT IDENTIFICATION– Typed or written entries: Name, Grade/Rate, Medical facility
[redacted] EPW
(b)(6)-4
ICU 1

ANEST [redacted]
(b)(6)-2 MAJ, CRNA

5 Jul 03

MEDCOM - 13623

(b)(6)-4 **HESIA PLAN OF CARE P... ROCEDURAL ASSESSMENT (Sedation/Anesthesia)**

[redacted] DAYS MOS [✓ YRS] Sex [✓ MALE] ( ) FEMALE

ED PROCEDURE: I+D (L) Leg / Drsg Δ both arms
L SERVICE: ortho
CE: JMN

ASA Physical State 1 [✓ 2] 3 4 5 E
WT: ~70 [✓ KG]/LB HT: ____ IN.
ALLERGIES: NKDA

CO: 7
OH: 7
GS: /

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:
- Hypertension N Y
- Angina N Y
- MI N Y
- CVA N Y
- Other N Y

Pulmonary System:
- Asthma N Y
- Bronchitis/URI N Y
- COPD N Y
- Other N Y

Renal System:
- Acute/Chronic RF N Y

Gastrointestinal:
- Hepatitis N Y
- Hiatal Hernia N Y
- PUD/GERD N Y

Endocrine System:
- Diabetes N Y
- Steriods N Y
- Thyroid N Y

Neurological:
- Seizures N Y
- Neuropathy N Y
- Other N Y

Gynecological :
- Pregnancy N Y

Other Significant Hx:
- N Y
- N Y

Familial HX N [✓ Y] GSW both Arms + (L) Leg

See previous pre-op on 3 Jul 03

T MEDICATIONS:
red as premed
Fent drip
~~Tagamet~~
Cefotetan

CATIONS:
(@ ______ Hrs) /CC
______ mg IV IM PO
______ mg IV IM PO
______ mg IV IM PO

TORY STUDIES:
9.8, 31.2
13.2 WBC
194 K

ASSESSMENT
PAST SURGICAL/ANESTHETIC
Ex lap
Colostomy
I+D (GSW)
3 Jul 03

PHYSICAL EXAMINATION
96% 9A
BP 120/58 HR 111 R 20 T ___
Pain Scale 0-10 ______
HEENT - Teeth poor dentition
Trachea midline
TMJ/Neck 73 FB
Oropharnyx Grade II
Nares ______
CHEST: ______
CARDIAC: ______
EXTREMITIES: ______
IV Access: #16G (R) Arm
Ulnar Filling: ______
BACK: ______
OTHER: ______

NPO Since ∅ MN

ETIC PLAN: ( ) LOCAL ( ) MAC ( ) Regional (Specify): ______ [✓ General]: Mask Intubation GETA

No interpreter present

D CONSENT/COUNSELING STATEMENT: Plans, alternative[redacted]s of anesthesia including death have been explained to a
l with the patient/legal guardian. (b)(6)-2 [redacted] MAJ CRNA
t/legal guardian seems to understand and agrees. Questions answered.
______ Date: 5 Jul 03 Time: 1545 Hrs

ESTHESIA EVALUATION AND NOTE (NON ASU)
PARENT ANESTHETIC COMPLICATIONS ( ) OTHER

______ Date:______ Time:______ Hrs

SEDATION KEY:

1. MINIMAL (Anxiolysis) Patient responds normally to verbal commands
2. MODERATE (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is no necessary.
3. DEEP SEDATION/ANALGESIA. Patient responds purposefully following repeated or painful stimulation. Airway assistance may

entification: (Ward) ______

EPW # [redacted] (b)(6)-4
ICU, ICU,

MEDCOM - 13624

ICU 1
NKDA

MEDICAL RECORD ANESTHESIA

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML, "|"=CONSTANT INFUSION

DRUG (Units)					
lidocaine (MG)	40				
propofol (MG)	150				
[illegible] (MG)	110				
( )					
( )					
( )					
VOLAT AGENT (S) % del	2.0	2.0	2.0	X	
% e.t.					
AIR L/Min					
N2O L/Min					
O2 L/Min	1 –	2 –	2 –	2 –	6

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS ▶

FLUIDS

LINE site #18 (R) ARM ☐ Warmed LR ↑
☐ Warmed
☐ Warmed
☐ Warmed

LOSSES EST BLOOD LOSS
URINE –

PHYS STATUS 1 [✓ 2] 3 4 5 E

BODY WEIGHT 70 [✓ KG] LB

HEMATOCRIT

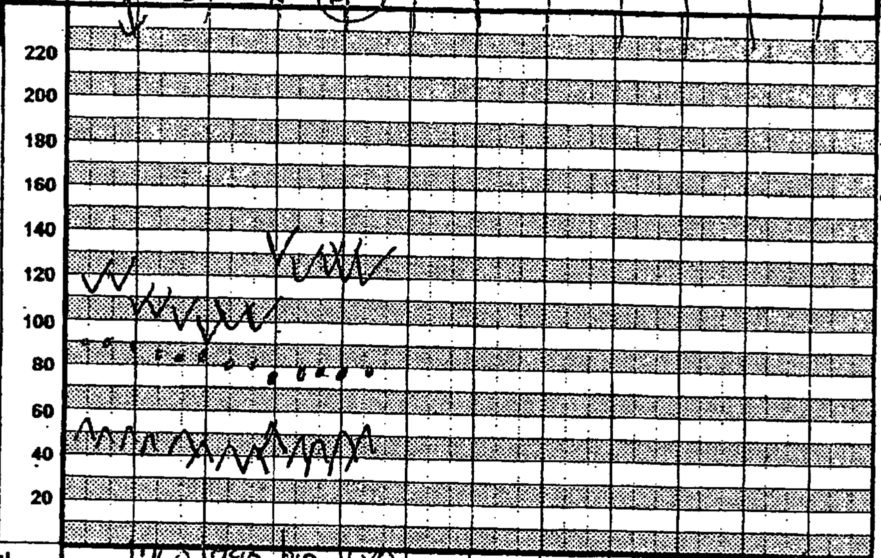
INITIAL DATA
BP – 155/71
HR – 93

EQUIP. CHECK OK? – [✓ Y] N

PATIENT RECHECK OK for PROCEDURE? (+)
TIME – 0850

TIME ➡ 1100 x 30 Induction x (D/W)

SYMBOLS:
BP by cuff ∨ ∧
Heart rate ●
Resp rate
BP (transduced) ┼ ┴
TOURNIQUET T – ↗
ANES – X-X
PROC ⊙ – Ø



VT – ml		710	790	810	680
f – breaths/min		7	7	6	12
Peak inf pres / PEEP		20	20/		
MODE – S(pon), A(ssist), C(on)	SV	CV	CV	SV	SV
ET CO2 (torr)		30	31	55	51
FIO2 (Frac or %)	1.0	1.0	1.0	1.0	1.0
SpO2 (%)	100	100	100	100	100
ECG	ST	ST	ST	ST	ST
TEMP – site skin		97	97	97	
N-M Block (T/4)					

✓ BP/Auto Cuff
BP / oth
ART line
Steth – PC/ES
✓ Gas analyzer CO2
✓ Warming blkt
Conv warmer
sheets / drapes

Mark with letters & symbols, explain under REMARKS
EVENTS
Position → arms < 90° abducted & padded

PROCEDURES and CPT Codes
Washout & DPC

PATIENT IDENTIFICATION – Typed or written entries: Name, Grade/Rate, Medical facility

EPW [redacted] (b)(6)-4

TOTALS

TOTAL EBL min

TOTAL URINE 600

FLUIDS – SUMMARY
CRYSTALLOID – LR – 700
COLLOID – ——
BLOOD – ——

REMARKS Code drugs with numbers, events with letters

~~1030~~ 1100 [illegible] [illegible] → Procedure verified. (b)(6)-2
~~1110~~ 1105 D/W room-monitors on
1115 Induction [illegible]
1205 – spont resp. Suctioned, eyes opened. Extubated – TO ICU 1/USS

(b)(6)-2 [redacted]

RECOVERY AT
PACU ICU ______ (Specify)
OTHER stable
CONDITION: [illegible]
RESP – 30 SpO2 – 97%
BP – 141/89 HR – 120

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	~~1030~~ 1100	1125	1220
	Ready	**Begin**	**End**
PROC	1115	1125	1200

ANESTHETIC TECHNIQUES: Describe block technique under Remarks GETA – A 8.0 cuffed ETT #3 MAC, taped 22 cm teeth. Eyes taped. OGT ↓ L c (+) return, soft bite block

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
[illegible] Gr 1 view. ETT easily passed. [illegible] x3. Atraumatic. Teeth ok

SURGEONS: [redacted] (b)(6)-2

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

PROCEDURE LOCATION #2

ICW1 - ICU1

ETHESIA PLAN OF CARE - PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

[redacted] DAYS MOS [✓ YRS] Sex (✓)MALE ( ) FEMALE

(b)(6)-4

OSED PROCEDURE: Washout & DPC

ICAL SERVICE: Gen

INCE: Mid

ASA Physical State 1 [✓ 2] 3 4 5 E

WT: 70 [✓ KG]/LB HT: ____ IN.

ALLERGIES: NKDA

S:

ACCO: Neg

ETOH: Neg

RUGS: Neg

ENT MEDICATIONS:
dered as premed

Ancef q8

Heparin 5000 SC q12

Tagamet q6

MSO4 / Percocet } prn

EDICATIONS:

Yes (@ ______ Hrs) /CC

______ mg IV IM PO

______ mg IV IM PO

______ mg IV IM PO

RATORY STUDIES:

T: ______/______

R: ______

7 Jul 85 > 8.5 / 26.6 < 226

137 | 98 | - < 85

3.6 | 31 | -

8 Jul 7.1 > 8.6 / 27.8 < 308

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:
- Hypertension [✓ N] Y
- Angina [✓ N] Y
- MI [✓ N] Y
- CVA [✓ N] Y
- Other [✓ N] Y

Pulmonary System:
- Asthma [✓ N] Y
- Bronchitis/URI [✓ N] Y
- COPD [✓ N] Y
- Other [✓ N] Y

Renal System:
- Acute/Chronic RF N Y Foley

Gastrointestinal:
- Hepatitis N Y (L) Colostomy
- Hiatal Hernia N Y
- PUD/GERD N Y

Endocrine System:
- Diabetes [✓ N] Y
- Steriods [✓ N] Y
- Thyroid [✓ N] Y

Neurological:
- Seizures [✓ N] Y
- Neuropathy [✓ N] Y
- Other [✓ N] Y

Gynecological:
- Pregnancy N Y NA

Other Significant Hx:
- N [✓ Y] s/p GSW to abdomen, bilat
- N Y Arms, (L) femur.

Familial HX N Y

ASSESSMENT

PAST SURGICAL/ANESTHETIC

3 July Ex lap - Colon Resection
∅ comp

155 **PHYSICAL EXAMINATION** 9

BP 21 HR 93 R 17 T 99

Pain Scale 0-10 —

HEENT - Teeth intact Dentition

Trachea ______

TMJ/Neck ______

Oropharnyx MP I

Nares ______

CHEST: ______

CARDIAC: ______

EXTREMITIES: ______

IV Access: 18g (R) Arm

Ulnar Filling: ______

BACK: ______

OTHER: LR @ 100cc/hr

NPO Since Mid

THETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ______ (X) General: Mask [✓ Intubation]

MED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to a
ssed with the patient/legal guardian.

atien[redacted]rdian seems to understand and agrees. Questions answered.

t: CRNA CPT (b)(6)-2 Date: 8 Jul 03 Time: 0710 Hrs

ANE NOTE (NON ASU)

APPARENT ANESTHETIC COMPLICATIONS { } OTHER

d: ______ Date: ______ Time: ______ Hrs

t Identification: (Ward) ______

EPW # [redacted] (b)(6)-4

SEDATION KEY:
1. MINIMAL (Anxiolysis) Patient responds normally to verbal commands
2. MODERATE (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is no necessary.
3. DEEP SEDATION/ANALGESIA. Patient responds purposefully following repeated or painful stimulation. Airway assistance may

MEDCOM - 13626

DATE: 3 Jul 03
TIME: 2355
Name: [redacted]
SSN:
DOB: (b)(6)-4
Unit:
Nationality: Iraqi

HT:
WT: lb
WT: kg

Additional Orders w/ Date & Time/Charting:

1. **Admit:** Recovery transfe[illegible]vs Holding Company
2. **Diagnosis:** s/p expl lap / SB rsxn / colectomy / colost
3. **Condition:** VSI SI Critical Guarded [✓ Stable]
4. **~~Allergies:~~** ?
5. **VS:** [✓ Q 1 hr]; Q 2 hrs; Q 4 hrs; Q 8 hrs.
   Notify MD for SBP: >180 or <90; DBP: > 100 < 50;
   HR: >120, <60; RR: > 20, < 10; Temp: > 102
6. **IVF:** IVF: [✓ LR] @ 75 cc/hr; NS @ ______ cc/hr;
7. **Monitor:** [✓ Cardiac]; [✓ Pulse Ox]; Neuro Checks Q ___ m/hr; A-line;
8. **I & Os:** [✓ Q1 hr]; Q ___ hrs
9. **Drains:** ~~NG to Low~~/Cont suction; JP Drain; [✓ Foley] to gravity
10. **~~Chest Tube~~:** 20 cm H2O suction, H2O seal; Heimlich
11. **~~LABS~~:** ABG now & Q1 hr; Q2 hrs; Q ___ hrs; PRN
    Hct now & Q ___ hrs; Chem now & Q ___ hrs; Urine Dip
12. **~~BLOOD~~:** T & S ____ units; T & C ____ units;
    Transfuse: ___ units PRBC or Whole Blood for Hct < ___ %
13. **Oxygen:** 2L NC; [✓ 4L NC]; 5L FM; NRB; __________
    Keep Stats > 92%. > 95%, ________
14. **~~VENT~~:** SIMV; TV: ____; RR: ____; Fio2: ____%; PEEP: _____;
15. **~~Diet~~:** [✓ NPO], ~~Sips~~ of H2O, Clear liquids, Regular, MRE,
16. **Activity:** [✓ Bed Rest]; BRP; HOB Up; Holding area/Unit; Other
17. **MEDS:** [✓ Morphine] 2, 4, or 6 mg IVP Q 10 min/hr prn Pain
    ~~Demerol~~ 12.5 mg; 25 mg; 50-75 mg IVP prn Pain/shivering
    ~~Toradol~~ 15/30 mg IVP/IM Q 6 hrs/prn Pain (up to 5 days)
    ~~Percocet~~ 1 -2 tabs or Tylenol III 1-2 tabs PO Q 6 hrs prn Pain
    [✓ Zofran] 2-4 mg or Phenergan 12.5 – 25 mg IVP Q ___ hrs prn Nausea
    [✓ Zantac] 50 mg IVPB Q 8 hrs
    Vent ~~Sedation~~: Diprivan / Propafol: 5–50 mcg/kg/min on a pump
    ~~Sedation~~: Versed (1mg/ml) 1mg slow IVP q2-3min up to 5mg
    Abx: Ancef 1 gram in 100cc NS IVPB Q6-8 hrs
    [✓ Abx:] Cefotan 2 grams in 100cc NS IVPB Q12 hrs starting now x 2
    ~~Abx: Clindamycin~~ 600 - 900mg 100cc NS IVPB over 30 minQ8 hrs [redacted]
    ~~Abx:~~ Gentamicin 5 or 7 mg/kg/day IVBP over 30 min Q day (b)(6)-2
    ~~Abx~~: Pen G 2 mil units in 100cc NS IVPB Q4-6 hrs
    ~~Abx~~: Unasyn 1.5 or 3 grams in 100cc NS IVPB Q 6 hrs
    Xrays: (B) humerus Done [illegible]
18. **~~Ortho~~:** Wound Irrigation w/ NS; Batadine & Gauze Dsg
    Soiled Dsg = Reinforce & notify MD; Splint; Cast
    [✓ Neurovascular checks] Q 1 hrs; Distal Pulse/Circulation
    Elevate extremity above heart on blankets
19. **~~Wound~~ Care:** Wet to Dry Dsg Change NS Q ____ to ________
20. **~~BURNS~~:** IVF of LR: 4 cc/% BSA burn/kg = total 24 hr fluids;
    Give ½ over 1st 8 hrs from Time of Burn; Clean Sterile dsg
21. **~~Head Injury~~:** Neuro checks (GCS) Q ___ min/hrs;
    C-Spine: Clear/NOT Clear; Keep Head in midline position;
    Mannitol (20%): 0.25/0.50/1 gm/kg IVPB over 30-60 min
    Notify MD for Mental Status changes [redacted] (b)(6)-2
20. **EVAC:** Priority w/in [✓ 4-6 hrs]; R
21. **Signature of Provider:**

274th FST Post-OP Orders, By CP Jun 2003

MEDICAL RECORD | **PROGRESS NOTES**

DATE

3 Jul 03
2345

OPERATIVE NOTE

DIAGNOSIS: GSW to abd / Ⓡ UE / Ⓛ UE / Ⓛ thigh

PROCEDURE: Expl lap / SB resxn x 2 / Ⓛ colectomy c̄ end transverse colostomy / I+D of other GSWs.

Anesth: GETA.

SURGEON: [redacted] / [redacted] } both (b)(6)-2

FINDINGS: Inj to Ⓡ gastroepiploic artery → ligated Stomach / lesser sac) ok. Liver/spleen ok. Ⓛ colon c̄ 2 holes (1 circumferential) stool in abd. 4 holes in SB - removed in 2 seg c̄ 8-10 cm long @. Kidney/ureter ok. ⊖ retroperitoneal hematoma

FLUIDS:

EBL:

Ø comps.

EBL: 200 cc

Fluids 4000 crystalloid

U/O: 350 cc

To ~~P~~ICU, stable, extubated

(b)(6)-2

[redacted] [redacted] MD

(Contin[redacted]

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

[redacted]NO. | WARD NO.

[redacted]

(b)(6)-4

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

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

EPW [redacted] (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 4 JUL 03
TIME OF ORDER: ______ HOURS
LIST TIME ORDER NOTED AND SIGN: 0830 [redacted] (b)(6)-2

1- Admit to ICU
2- NPO
3- VS per ICU Routine
4- I/O q1° Foley to Gravity
5- Bed Rest
6- NG to low intermittent suction
7- Heparin 5000U SC q12°

PATIENT IDENTIFICATION

EPW [redacted] (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER
TIME OF ORDER: ______ HOURS

~~8- Zantac 50mg IVPB q8°~~
9- Fentanyl 50 µg/hr titrate for pain control (b)(6)-2
10- Phenergan 25mg IVPB q4 prn [redacted]
11- Cefotetan 2gm q8° IVPB
12- CBC + Chem 7 q AM
13- Tigan 300mg q6° IVPB [redacted]

PATIENT IDENTIFICATION

EPW [redacted] (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 7.4.03
TIME OF ORDER: 1100 HOURS
LIST TIME ORDER NOTED AND SIGN: [redacted] 1100 (b)(6)-2

per Dr. [redacted] (b)(6)-2 LR @ 150cc/h [redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 5 JUL 03
TIME OF ORDER: (b)(6)-2 [redacted] HOURS

1- ↓ IVF to 100cc/hr

MEDCOM - 13629

:DICAL RECORD

AUTHORIZED FOR LOCA

PROGRESS NOTES

DATE	NOTES
5 Jul 03	Surgery Progress
	22 yo male c̄ multiple GSW to abdomen &
	extremities s̄ colostomy stable. Pt to OR today
	for wash-out of wounds.
	CNS: appropriate
	Lungs: CTA 100% RA RR 20
	CV: HR 90-112 BP 123/45
	Abd: soft, appropriate TTP ØBS ostomy pink
	Renal: 136 | 98 | 10 / 4.2 | 25 | .9 < 101 I/O 997/2550
	Heme: 13.2 > 9.8/31.2 < 194
	Imp: stable POD#1
	Plan: ↓ IFV
	to OR today
	DC NG later p̄ OR
	cont current orders
	[redacted] (b)(6)-2

ONSHIP TO SPONSOR

SPONSOR'S NAME: LAST / FIRST / MI

SPONSOR'S I (SSN or Other)

/SERVICE

HOSPITAL OR MEDICAL FACILITY

RECORDS MAINTAINED AT

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 NC

PROGRESS NOTES
Medical Record
STANDARD FORM 50

MEDCOM - 13630

8 Jul 03

OP NOTE

PRE-OP DX: MULTIPLE GSW TO ABD AND EXT
c̄ OPEN WOUNDS

PROC: DPC + I&D + WASHOUT ABD WOUNDS + EXT.

SURG: [redacted] (b)(6)-2

FLUID: 700cc LR

UO: 600cc UO

EBL: min

Complications: ∅

(b)(6)-2 [redacted]

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

[redacted]

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 5 JUNE 03 TIME OF ORDER 1610 HOURS

LIST T ORDE NOTED SIGN 1700

① TO ICU / TRANSFER TO ICW

② S/P I+D OF MULTIPLE GSW

③ CONDITION FAIR (b)(6)-2 →

④ VS - ROUTINE

⑤ UP AD LIB PER GSW ROUTINE

⑥ REGULAR DIET

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

⑦ IV LR AT 125cc/hr HLP LOCK WHEN TOLERATING PO. WELL

⑧ ANCEF 1 GRAM IVPB Q 8 HRS x 3 DOSES

⑨ TYLENOL 650 MG P.O. Q 4 HRS PRN

⑩ PERCOCET, 1-2 P.O. Q 4-6 HRS PRN

⑪ MSO4, 2-6 MG ~~PO~~ IVP Q 2 HRS PRN.

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 6 JUL 03 TIME OF ORDER (b)(6)-2 HOURS

1- NPO ✓

2- TAGAMET 300 mg IVPB q 6° ✓

3- CBC & CHEM 7 q A.M. ✓

4- VS @ regular ✓

5- UP c̄ assistance ✓

6- Heparin 5000 u SC q12°

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 6 Jul 03 TIME OF ORDER 1610

① ↓ IVF to 50cc/h

Rod [redacted]

(b)(6)-2

[redacted]

(b)(6)-2

DA FORM 4256 1 APR 79 REPLACES EDITION OF 1 JUL 77, WHICH MA

☆ U.S. GOVERNMENT PRINTING OFFICE: 2001-478-200

MEDCOM - 13632

"USE BALL POINT PEN, PRESS FIRMLY / NO CARBON PAPER REQUIRED"

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
7JUL03	SURGERY
	(b)(6)-4
	[redacted] 20 MALE S/P GSW TO EXTREMITIES & ABDOMEN
	STABLE.
	CNS: AWAKE, ALERT
	CVR: RRR HR 80s 113/47
	ABD: SOFT, NT, ND ⊕BS ⊕ AIR + STOOL IN OSTOMY - OSTOMY PINK
	RENAL: 137 | 98 | 7 < 85 I/O 2500/1420 424/2500
	3.6 | 31 |
	HEME 4.5 > 8.8/26.6 < 226
	ID: AFEB
	RESP: STABLE
	PLAN: TO OR TOMORROW FOR DPC & WASHOUT
	NPO P MIDNIGHT
	[redacted] (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.

388

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

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

[redacted]

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 7 Jul 03 TIME OF ORDER ______ HOURS

LIST T ORDE NOTED SIGN

1- Regular Diet
2- NPO p midnight
3- Hep-lock IV ~~until~~ until midnight & then start LR @ 100 cc/hr (b)(6)-2

[redacted]

PATIENT IDENTIFICATION

(b)(6)-4 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 8 Jul 03 TIME OF ORDER ______ HOURS

-1- ~~Clear liquid~~ D/C Admit to ICW
-2- Clear liquid Diet advance as tolerated
-3- Hep-lock IV
-4- UP AD-LIB
-5- VS for routine
-6- Routine ostomy care

PATIENT IDENTIFICATION

(b)(6)-2 [redacted]

8 JUL 03
1230 HRS

DATE OF ORDER ______ TIME OF ORDER ______ HOURS

7- Percocet 1-2 po q4-6° prn pain
8- Colace 100g po bid
9- Ancef 1gm q8° X 3 doses
10- Phenergan 25 mg IVPB q6° prn

(b)(6)-2 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 9 Jul 03 TIME OF ORDER ______ HOURS

1- Transfer to ICW
2- Regular Diet
3- Percocet 1-2 po q4° prn pain
4- UP AD-LIB
5- Hep-lock IV (b)(6)-2
6- VS for routine
7- Colace 100g po bid

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 2001-478-200

MEDCOM - 13634

"USE BALL POINT PEN. PRESS FIRMLY - NO CARBON PAPER REQUIRED"

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

ATIENT IDENTIFICATION

[redacted] (b)(6)-4

URSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER
10 JUL 03

TIME OF ORDER
HOURS

LIST ORD NOTED SIG

1 - DC Foley 0900/done
2 - DC LABS
3 - TRANSFER TO WARD
4 - TO EPW CAMP in A [redacted]

(b)(6)-4 [redacted] (b)(6)-2

(b)(6)-2

ATIENT IDENTIFICATION

URSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER

TIME OF ORDER
HOURS

ATIENT IDENTIFICATION

URSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER

TIME OF ORDER
HOURS

ATIENT IDENTIFICATION

URSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER

TIME OF ORDER
HOURS

MEDCOM - 13635

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

ATIENT IDENTIFICATION

[redacted] (b)(6)-4

IURSING UNIT | ROOM NO. | BED NO.

↓

DATE OF ORDER 11 Jul 03

TIME OF ORDER ____ HOURS

LIST ORD NOTED SIG

1- DC TO EPW Camp

(b)(6)-2 [redacted]

ATIENT IDENTIFICATION

IURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER

TIME OF ORDER ____ HOURS

ATIENT IDENTIFICATION

IURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER

TIME OF ORDER ____ HOURS

ATIENT IDENTIFICATION

IURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER

TIME OF ORDER ____ HOURS

All (b)(6)-2 Except one on bottom.

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

Mo. ____ *Yr.* 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 4	5	6	7	8	9	10
7-4	[redacted]	NPO	05	[redacted]	[redacted]					
			17							
7-4	[redacted]	VS per ICU routine	05		[redacted]					
			17							
7-4	[redacted]	I/O q1° FTG	05							
			17							
7-4	[redacted]	Bedrest	05							
			17							
7-4	[redacted]	NG to LIS	05	[redacted]						
			17							
7-4	[redacted]	CBC & Chem 7 q AM	05		[redacted]					
7-5	[redacted]	Up ad lib per EPW routine	05	/						
			17	/	[redacted]					
7-5	[redacted]	Regular diet	05	/						
			17	/	[redacted]					
7/6	[redacted]	VS / I+O q 1°	05			[redacted]				
			17							
	[redacted]	~~NPO until air in bag, or drainage in bag.~~	05	[redacted]						
			17							
	[redacted]	~~CBC + Chem 7 in AM~~	05			[redacted]				
	[redacted]	OOB c̄ Assist 05								
			17							
7/6	[redacted]	Reg. Diet	05	/	/	/	[redacted]			
			17	/	/	/		8JUL03 [redacted]		
8JUL	[redacted]	Clear Liquid Diet Advance As Tolerated	05	/	/	/	/	[redacted]		
			17	/	/	/	/			

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW to abd / [illegible] LE,

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ____

PATIENT IDENTIFICATION:

EPW [redacted] (b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 EDITION OF 1 DEC 77 MAY BE USED. USAPA V1.00

MEDCOM - 13637

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo ______ Yr 2003

Verify by Initialing Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
8/11	[redacted]	NPO p̄ MN (b)(6)-2	8/11/03	0000	000	[redacted] (b)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING COMPLETION* TIME/DATE COMPLETED													

USAPA V1.00

MEDCOM - 13638

All (b)(6)-2 Except Bottom One

CLINICAL RECORD

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

Mo. ____ *Yr.* 2003

VERIFY BY INITIALING — *INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION*

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED													
				8	9	10	11										
8 JUL	[redacted]	ACTIVITY: UP AD LIB	05	[redacted]	[redacted]	[redacted]											
			17	[redacted]	[redacted]	[redacted]											
8 JUL	[redacted]	Vitals Per Routine	05	[redacted]	[redacted]	[redacted]											
			17	[redacted]	[redacted]	[redacted]											
8 JUL	[redacted]	Routine ostomy Care	05	[redacted]	[redacted]	[redacted]											
			17	[redacted]	[redacted]	[redacted]											
		[redacted]															

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P GSW

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ____________

PATIENT IDENTIFICATION:

EPW - [redacted] (b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 — EDITION OF 1 DEC 77 MAY BE USED. — USAPA V1.00

MEDCOM - 13639

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*	*Mo* ____ *Yr* 2003			
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
7/10/03	[redacted]	To ward				
7/11/03		to EPW Comp in AM				
	-----	(b)(6)-2				

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING COMPLETION*													
			TIME/DATE COMPLETED													
-----	-----															
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USAPA V1.00

MEDCOM - 13640

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 — *INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION*

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 4	5	6	7	8
7-4	[redacted]	Heparin 5000U SC q12°	10	[redacted]				
7-4	[redacted]	~~Zantac 50mg IVPB q8°~~						
~~7-4~~	[redacted]	~~Phenergan 25mg IVPB~~						
7-4	[redacted]	Cefotetan 2g IV q8° IVPB	06	/				
				[redacted]				
			22	M				
7-4	[redacted]	Fentanyl 50mcg/hr	05	[redacted]				
		titrate for pain control	17					
7-4	[redacted]	LR @ 150cc/hr	05					
			17					
7-4-01		Tagamet 300mg IVPB	06	/	[redacted]			
		Q6	12	[redacted]				
			18					
			00					
7-4	[redacted]	LR @ 150cc/hr	05					
			17					
7-5	[redacted]	LR @ 100cc/hr	05	/	[redacted]			
			17	/				
7-5	[redacted]	LR @ 125cc/hr HL	05	/	[redacted]			
		when tolerating PO well	17	/				
7-5	[redacted]	[illegible] IVPB	06	/	/			
		Q6hrs x3days	14	/	/			
			22	/	[redacted]			

D/C 4 Jul 03

DC

DC

(b)(6)-2

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW to b/l upper ext / abd.

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ________

PATIENT IDENTIFICATION:

EPW [redacted]

(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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*				Mo.______ Yr.______
Order Date	**Clerk/ Nurse**	**SINGLE ORDER, PRE-OPERATIVES**	**Date to be Given**	**Time to be Given**	**Time Given**	**Initials**

INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	TIME/DATE DISPENSED
7/5	TB	Tylenol 650mg PO Q4hrs prn	
7/5	TB	Percocet 1-2 po Q4hrs PRN	0801 2 0001 [redacted]
7/8	TB	morph 2-6mg IVP q 2-4hrs PRN.	

[redacted] (b)(6)-7

USAPA V1.00

MEDCOM - 13642

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. 7 *Yr.* 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 6	7	8	9	10	11
6 JUL	[redacted]	LR ~~@ 125~~ ↓50 KVO	05	[redacted]					
			17						
	[redacted]	Tagamet 300mg	6	/	[redacted]				
		IVPB q6	12	/					
			18	[redacted]					
			24						
	[redacted]	Heparin 5000 SC	06	[redacted]					
		q 12°	18						
	[redacted]	Ancef 1gm IVPB	06	[redacted]					
		q 8° x 3 days	14						
			22						
7 Jul 03	[redacted]	Hep Lock IV	05	/	[redacted]				
		until midnight +	17	/	[redacted]	→ DC		[redacted]	
		then start LR @							
		100cc/hr							
8 JUL	[redacted]	Hep-Lock IV	05	/	/	[redacted]			
			17	/	/				
				/					
8 JUL	[redacted]	ANCEF 1gm Q8°	06	/	/	[redacted]	/	/	/
		X 3 Doses	14	/	/	[redacted]	/	/	/
			22	/	/		/	/	/
				/					
8 JUL	[redacted]	Colace 100mg PO BID	10	/	/	[redacted]			
			22	/	/				

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P GSWs

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____________

PATIENT IDENTIFICATION:

[redacted] (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 - 13643

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*				*Mo.* ______ *Yr.* ______

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

(b)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED													
[redacted]	[redacted]	Tylenol 650 po														
		q4° prn														
[redacted]	~~7/5~~ 7/8	Percocet 1-2 po	7-9-08 0224 II [redacted]	7-1-08 1140 II [redacted]	7/10 2034	7-11 0300 II 2400	7-11 0200 II [redacted]		(b)							
7/8	[redacted]	q4-6 prn pain							(6)							
	[redacted]	MSO4 2-4mg	6 Jul 1220	06 Jul 2035	07 Jul 0400	7 Jul 1?0 [redacted]	2130 5mg	0400 mg	2							
		IVP q2-4 hrs	5mg [redacted]	5mg	5mg		7 Jul	8 Jul								
		PRN														
8 Jul	[redacted]	Phenergan 25mg														
		IVPB Q6° PRN														
		Nausea														

USAPA V1.00

MEDCOM - 13644

\ exp. Lap. small Bowel resection x2
- transverse(T " \ resection
- colostomy
I+D. GSW to Ⓛ ·righ
ⓁUE + ⓇUE

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE **Post-Anesthesia Care Unit (PACU) Flow Sheet**

OTSG APPROVED *(Date)*

Date: 4 JUL 03
Time In: 0035
Allergies: ?.
Pre-op V/S: 130/80-84
Procedures: ______
Anesthesia Type (Circle): [✓ General] Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 4200 Colloid Ø
OR Output: UOP 350 EBL 100
Meds/Times: Unasyn 3 gms @ 2330

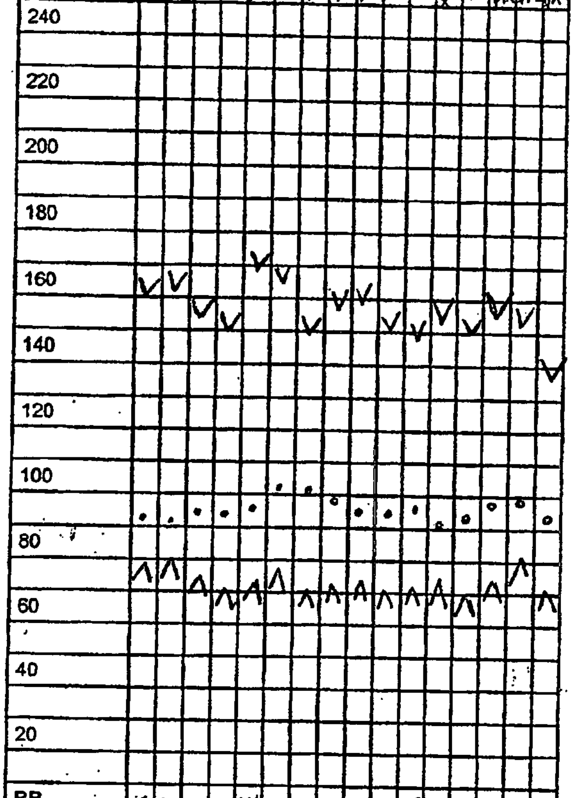
Drains: Hemovac NG JP T-tube [✓ Foley] TLS Penrose Ⓛ [illegible]

Airway: ~~Nasal~~ Oral ETT Trach Other

Pre Op Meds

History

Time	0035	[illegible]	0040	0050	0100	0115	0130	0145	0200	0230	0300	0330	0400	0430	0500	0530
SaO2	96	100	100	100	100	98	100	100	100	100	100	100	100	100	100	100
FiO2	5L	5L	5L	5L	5L	5L	5L	5L	5L	5L	5L	5L	5L	5L	5L	5L
Methods	Fm	Fm	Fm	Fm	Fm	Fm	Fm	Fm	Fm	Fm	Fm	Fm	Fm	Fm	Fm	Fm



RR	16	14	18	22	18	14	16	17	17	18	22	16	17	17	18	19
T																
Time																
Pain (0-10)																
LOS																

Pacu Intake

Time	Solution	Amount	Site	By	Infused
0130	0.9% NSL	100 mL	Ⓛ Arm		100
0230	0.9% NSL	100 mL	Ⓡ Arm		100
0330	0.9% NSL	100 cc	Ⓡ Arm		100
0430	0.9% NSL	100 mL	Ⓡ Arm		100
0530	0.9% NSL	100 cc	Ⓡ Arm		100

X-rays:
Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	Ø	Ø	
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	1	
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	1	1	
Circulation (Peds <5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	/	/	
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	6	6	

Codes
AIRWAY
A = Ambu
BB = Blow-by
M = Mask
FT = Face Tent
RA = RoomAir
NC = Nasal Cannula

V/S
X = A-line BP
ˇ = Cuff BP
= Pulse

TEMP
S = Skin
O = Oral
A = Axillary
T = Tympanic
R = Rectal

LOS
C = Cervical
T = Thoracic
L = Lumbar
S = Sacral

Patient teaching done: Wound Care, Pain Management, T, C, & DB., Incentive Spirometer, Comfort Measures
Safety: SR up X 2, Falls Precautions. Privacy Maintained

PREPARED BY *(Signature & Title)* [redacted] (b)(6)-2 LPN
DEPARTMENT/SERVICE/CLINIC [redacted] (b)(2)-2 ICU
(Continue on reverse)
DATE 04 Jul 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: first, middle; grade; date; hospital or medical facility)* Name — last,
Iraqi 07 ~2090.
[redacted]
(b)(6)-4

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

DA FORM 4700, MAY 78 WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) Previous edition is obsolete USAPPC V2.00

MEDCOM - 13645

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
0058		Cefotan 2 gm	IVPB		(b)(6)-2	[redacted]
0200		Zantac 50mg	IVPB			
0620		[illegible] Ø.2 mg	IVPB			

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	Pedal			P	B	C	Pk
15'	Radial			P	S	C	Pk
30'	Pedal			P	B	C	Pk
45'	Radial			P	S	C	Pk
60'	Pedal			P	B	C	Pk
90'	Radial			P	B	C	Pk
D/C							

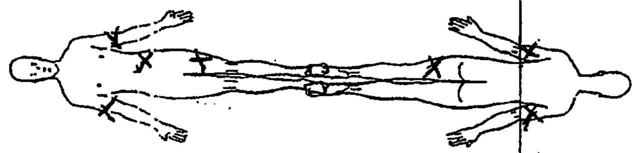
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

	Adm	15'	30'	45'	60'	90'	D/C
Fund. Height							
Lochia							
Peripad#							
Fund. Cond.							

DRESSINGS

Time	Location	Type	Drainage
Adm	Ⓛ arm	Kerlix	min. drainage
30'	Ⓛ arm	Kerlix	CDI
60'	Ⓛ arm	Kerlix	CDI
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount
Ø13Ø	Foley	clear yellow	700 mL
Ø23Ø	Foley	clear yellow	500 mL
0330	Foley	clear yellow	200 mL
0430	Foley	clear yellow	300 mL

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
0030	NSR	N/A	

WAMC OP 173-E

NURSING NOTES

Ø03Ø- Pt arrives from OR via litter, arousable to verbal stimuli; nasal airway placed, even, deep, regular respirations LCTA all fields, O2 via facemask @ 5LPM SaO2 100%. Radial pulses weak but palpable bilateral. Pedal pulses strong bilateral. Skin cool, dry, cap refill ≤ 3 sec. IV Ⓛ AC & Ⓡ arm running Ø.9% NaCl. Ⓛ & Ⓡ bicep bandages, colostomy LLQ, Foley to gravity, bandage to Ⓛ thigh. Gastric tube in place. [redacted]

0130- Strong pedal pulses, cap refill <3sec, weak but palpable radial bilat, cap refill 3 sec [redacted]

0145- IV Ⓛ arm D/C'd, not flowing, poor flush & flashback [redacted]

Ø23Ø- Radial pulses weak, palpable bilateral, pedal pulses strong bilat. Cap refill < 3 sec Skin cool, moist.

Ø33Ø- Radial pulses present weak bilat; pedal pulses strong bilat [redacted]

Ø43Ø- Pedal pulses strong, radials weak but palpable, bilat skin cool, dry, cap refill < 3 sec [redacted]

Ø53Ø- pt with movement of all extremities, distal pulses present [redacted]

Ø62Ø- Pt starting to wake up, interpreter @ bedside VSS [redacted]

(b)(6)-2

Discharge Criteria:
Date: Time: PARS:
BP: T: HR: RR: Sa02:
Pain Level at D/C (0-10):
Intake: Output:
Additional Data:
Transferred To: PT Holding
Report Given To:
Transferred Via: W/C Litter Gurney Ambulance
Transferred By:
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature:

MEDCOM - 13646

PAGE 2 OF 4

DATE

DX

HOSPITAL DAY

VITAL SIGNS TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial Line			109/78								120/72							
BP Cuff																		
Temperature																		
Pulse			78								76							
Respiratory Rate			14								16							
SpO2			99								99%							
RA/O2											[redacted]	(b)(6)-2						
pain																		
intervention																		
INTAKE TIME	24	01	02	03	04	05	06	07	8° T	08	09	10	11	12	13	14	15	8° T
											0							
TOTALS																		
OUTPUT URINE HOUR/TOTAL					300													
URINE sp gr																		
URINE S/A																		
NG OUTPUT																		
NG pH																		
NG GUIAC																		
EMESIS																		
STOOL																		
DRAINS																		
DRAINS																		
DRAINS																		
TOTALS																		

[redacted] (b)(6)-4

POST-OP DAY

16	17	18	19	20	21	22	23	
16	17	18	19	20	21	22	23	8°T

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA

	TIME									
	MODE									
	F_iO_2									
	TV									
	RATE									
	PEEP									
A	pH									
	PCO_2									
	pO_2									
B	HCO_3									
	SAT									
G	BASE									

LABORATORY DATA

TIME									
GLUCOSE									
Na/K									
Cl/CO2									
BUN/Cr									
WBC/PLATELET									
Hct/Hgb									

ACTIVITIES OF DAILY LIVING

TIME			
MOUTH CARE			
BATH			
SKIN CARE			
FOLEY CARE			
TRACH CARE			
ROM EXERCISES			

	TIME				
TURN					
SUCTION					

24° I&O TOTALS

wt Yesterday ______ wt Today ______

INTAKE OUTPUT

IV ______ Urine: ______

PO ______ ______

______ ______

TOTAL ______ TOTAL ______

BALANCE ______

NURSE'S SIGNATURE	INITIALS

[illegible]

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0836 INITIALS [redacted]	(b)(6)-2 INITIALS	INITIALS
NEURO	PUPILS	PERRLA, 3mm		
	SENSORIUM	AYO x3		
RESPIRATORY	RESPIRATORY PATTERN	even unlabored		
	BREATH SOUNDS	CTA (B)		
	SECRETIONS			
SKIN	COLOR	NFL		
	INTEGRITY	warm & dry		
IV SITE	LOCATION	(R) FA		
	CONDITION	Ø s/s edema or red-		
		ness, patent		
GASTRO	ABDOMEN	soft ND ⊕ tender-		
	BOWEL SOUNDS	ness		
		midline abd. drsg. c̄		
		colostomy bag, intact		
GU	URINE:	foley to gravity		
	COLOR/CLARITY	yellow s̄ sediment		
CARDIOVASCULAR	CARDIAC RHYTHM	NSR		
		$S_1 S_2$		

LEGEND			
	Cr - Creatinine	ICP - Intracranial Pressure	S/A - Fractional
	F_iO_2 - Fraction of Inspired O_2	PCO_2 - Pressure of Arterial CO_2	SAT - Saturation
	HCO_3 - Bicarbonate	PEEP - Positive End Expiratory Pressure	TRACH - Tracheostomy

(Continue on reverse)

[redacted] PARED BY *(Signature & Title)* (b)(6)-2	DEPARTMENT/SERVICE/CLINIC ICU 2 west	DATE

PATIENT [redacted] ENTIFICATION *(For typed or written entries give: Name—last, first, middle [redacted] ade; date; hospital or medical facility)*

EPW) #[redacted]
(b)(6)-4

☐ HISTORY/PHYSICAL
☐ OTHER EXAMINATION OR EVALUATION
☐ DIAGNOSTIC STUDIES
☐ TREATMENT
☐ FLOW CHAR
☐ OTHER *(Spe*

DA FORM 1 MAY 78 **4700**
Proponent Dept of Nurs

MEDCOM - 13649

WAMC OP 375 (Redesignated)
1 Apr 90 (HSXC-NU)

ACLU-RDI 1592 p.1543

PA

	DX													HOSPITAL DAY			
TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15
P Arterial Line						120/				121/	135/				141/		
P Cuff						/52				/53	/69				/89		
emperature															96.8		
ulse						88				81	78				120		
espiratory Rate						18				12	13				16		
SpO2						100				100	100				100		
						[redacted]				[redacted]	[redacted]				[redacted]		
[illegible]																	
intervention																	

(b)(6)-2

TIME	24	01	02	03	04	05	06	07	8° T	08	09	10	11	12	13	14	15
LR						100	100/	100/300		100	100	100		100	100	100	100
OTALS																	700
JRINE HOUR / TOTAL	/	/	/	/	/	100/	200/300	200/500	500	100/600	150/550	/	/	/	100/	100/	50/850
JRINE sp gr																	
JRINE S/A																	
NG OUTPUT																	
NG pH																	
NG GUAIAC																	
MESIS																	
TOOL																	

700

MEDCOM - 13650

PA

17	18	19	20	21	22	23	
140/	140/	124/	149/	140/	102/	130/	
85	85	64	64	64	56	66	
		99.1				100.2	
96	96	98	95	88	91	93	
17	23	10	27	18	26	10	
100	100	100	100	100	100	99	
RA	RA	RA	RA	RA	RA	RA	

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA		TIME								
		MODE								
		F_iO_2								
		TV								
		RATE								
		PEEP								
	A	pH								
		PCO_2								
		pO_2								
	B	HCO_3								
		SAT								
	G	BASE								

16 125 PO

17	18	19	20	21	22	23	8°T
125/250	125/375	125/250	125	125	125	125	1000

LABORATORY DATA	TIME								
	GLUCOSE								
	Na/K								
	Cl/CO$_2$								
	BUN/Cr								
	WBC/PLATELET								
	Hct/Hgb								

16 200/2000

50/250	120/375	130/505	200/700	180/880	50/930	180/1110	100

ACTIVITIES OF DAILY LIVING	TIME					
	MOUTH CARE					
	BATH					
	SKIN CARE					
	FOLEY CARE					
	TRACH CARE					
	ROM EXERCISES					

	TIME				
TURN					
SUCTION					

24° I&O TOTALS

wt Yesterday ________ wt Today ________

INTAKE OUTPUT

IV ________ Urine: ________

NURSE'S SIGNATURE

MEDCOM - 13651

MEDICAL RECORD–SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

(b)(6)-2

OTSG APPROVED (
QA Appr 8 Mar 8

INITIAL SHIFT ASSESSMENT

	TIME	2500 INITIALS [redacted]	2000 INITIALS [illegible]	INI
NEURO	PUPILS	[illegible]	4mm PERRLA	
	SENSORIUM	[illegible]	A+O x3 Cooperative	
		[illegible]		
		[illegible]		
RESPIRATORY	RESPIRATORY PATTERN	[illegible]	Unlabored, even	
	BREATH SOUNDS	[illegible]	CTA (B)	
	SECRETIONS	[illegible]	0	
		[illegible]		
		[illegible]		
SKIN	COLOR	[illegible]	W,D,	
	INTEGRITY	[illegible]	Intact	
		[illegible]		
IV SITE	LOCATION	[illegible]	(R) PIV	
	CONDITION	[illegible]	Abd midline CDI	
		[illegible]	Bil-UE CDI	
		[illegible]		
		[illegible]		
GASTRO	ABDOMEN	[illegible]	Soft, non-Tender	
	BOWEL SOUNDS	[illegible]	BS x4	
		[illegible]		
		[illegible]		
GU	URINE:	[illegible]	Foley	
	COLOR/CLARITY	[illegible]	Clear Yellow	
		[illegible]		
CARDIOVASCULAR	CARDIAC RHYTHM	[illegible]	NSR	
		[illegible]	S_1 S_2	
		[illegible]	+2 Pulses UE/LE (B)	
		[illegible] noted.		

LEGEND

Cr - Creatinine
F_IO_2 - Fraction of Inspired O_2
HCO_3 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
S/A - Fractional
SAT - Saturation
TRACH - Tracheostomy

(Continue on revers

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC
ICU 2nd

DATE

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

EPW # [redacted] (b)(6)-4
ICU # 1

☐ HISTORY/PHYSICAL ☐ FLOW CHA
☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (S
☐ DIAGNOSTIC STUDIES

MEDCOM - 13652

DX

HOSPITAL DAY

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	
BP Arterial Line	130	143	134	131	115	110	114	114		130	116	120	130	116	104		
BP Cuff	60	68	63	55	45	43	65	54		65	53	65	61	41	61		
Temperature	100.2		98.6		97.5							98					
Pulse	85	79	94	78	75	69	71	69		86	80	91	92	90	76	71	
Respiratory Rate	18	18	18	14	10	9	11	12		13	17	16	15	21	22	23	
O2	100	99%	100%	100%	99%	100%	[illegible]	100		99	97	96	99	97	98	99	
	[redacted]									[redacted]							
(b)(6)-2																	
[illegible]																	
[illegible]																	
TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	1
IV	125/125	125/250	50/300	50/350	[illegible]	[illegible]	[illegible]	[illegible]	950	[illegible]/340	[illegible]	[illegible]					
PO														460			700
TOTALS									950								700
URINE HOUR / TOTAL	70/70	110/180	150/330	80/410	75/485	475/960	200/1160	100/1260	1260	300	100/300	200/500	150/650	200/850	150/1000	200/1200	150/1350
URINE sp gr																	
URINE S/A																	
NG OUTPUT												300					
NG pH																	
NG GUIAC																	
EMESIS																	
STOOL																	
DRAINS																	

MEDCOM - 13653

DAY

	6	17	18	19	20	21	22	23	
BP			175/62				119/76		
T									
P			93				86		
R			16				18		
O2			98				99		
RA/O2			RA				RA		

	6	17	18	19	20	21	22	23	8°T
IV									
PO									
urine	200/300	105		~~[illegible]~~		~~[illegible]~~			

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA		TIME							
		MODE							
		F_iO_2							
		TV							
		RATE							
		PEEP							
	A	pH							
		PCO_2							
		pO_2							
	B	HCO_3							
		SAT							
	G	BASE							

LABORATORY DATA	TIME	0410						
	GLUCOSE							
	Na/K							
	Cl/CO_2							
	BUN/Cr							
	WBC/PLATELET	5.9/254						
	Hct/Hgb	24.7/7.7						

ACTIVITIES OF DAILY LIVING	TIME			TURN	TIME
	MOUTH CARE				
	BATH				
	SKIN CARE				
	FOLEY CARE			SUCTION	
	TRACH CARE				
	ROM EXERCISES				

24° I&O TOTALS

wt Yesterday ______ wt Today ______

INTAKE
IV ______
po

OUTPUT
Urine: ______

NURSE'S SIGNATURE

[redacted] (b)(6)-2

MEDICAL RECORD—SUPPLEMENTAL MED[illegible] DATA

For [illegible] form, see AR 40-66; the proponent agency is the O[illegible] Surge[illegible] [illegible]neral

REPORT TITLE

INTENSIVE CA[illegible] NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0510	INITIALS [redacted]	(b)(6)-2	INITIALS		INITIALS
NEURO	PUPILS	pupils [illegible]		PERRLA			
	SENSORIUM	[illegible] ox3. follows		A+OX3			
		commands ̄s					
		difficulty					
RESPIRATORY	RESPIRATORY PATTERN	RR [illegible] un-		even-unlabored			
	BREATH SOUNDS	labored. [illegible]		CTA			
	SECRETIONS	[illegible]		Ø secretions.			
		on RA [illegible]					
		[illegible] @ 90%					
		Ø SOB/distress					
SKIN	COLOR	[illegible] skin		normal for race			
	INTEGRITY	[illegible] Ⓡ [illegible]		intact			
		[illegible]					
IV SITE	LOCATION	[illegible] flush		Ⓡ FA heplocked			
	CONDITION	well.		CDI			
GASTRO	ABDOMEN	[illegible] soft, NT/ND		soft - complains of			
	BOWEL SOUNDS	c̄ ⊕ BS x4		upset stomach			
		midline [illegible]		bs x 4			
		[illegible]					
GU	URINE:	[illegible] yellow [illegible]		clear foley			
	COLOR/CLARITY	[illegible]		yellow			
		[illegible]					
CARDIOVASCULAR	CARDIAC RHYTHM	NSR noted.		NSR			
		[illegible] 80-90s Ø		$S_1 S_2$			
		[illegible]		+2 pulses x4 extremities			
		noted					

LEGEND

Cr - Creatinine	ICP - Intracranial Pressure	S/A - Fractional
F_iO_2 - Fraction of Inspired O_2	PCO_2 - Pressure of Arterial CO_2	SAT - Saturation
HCO_3 - Bicarbonate	PEEP - Positive End Expiratory Pressure	TRACH - Tracheostomy

(Continue on reverse)

PREPARED [redacted]

DEPARTMENT/SERVICE/CLINIC
ICU 2 unit

DATE
10/[illegible]/03

PATIE[redacted] [illegible] *(For typed or [illegible] name—last, first, mid[illegible] date; hospital or medical f[illegible]*

(b)(6)-2

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

DA FORM 1 MAY 78 **4700**
Proponent: Dept of Nurs

WAMC OP 375 (Redesignated)
1 Apr 90 (HSXC-NU)

[redacted]
EPW

MEDCOM - 13655

PAGE 2 OF 4

DATE	DX	HOSPITAL DAY

VITAL SIGNS																		
TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial Line			113				120											
BP Cuff			61				60											
Temperature						97.4												
Pulse			73				93											
Respiratory Rate			14				13											
SpO2			100				100											
			RA				RA											
pain																		
intervention																		

INTAKE																		
TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
PO								360	360					240	120			360
TOTALS																		

OUTPUT																			
URINE	HOUR / TOTAL				350				250	600						500			500
	sp gr																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS										600									500

[redacted]

(b)(6)-4

PAGE 3 OF 4

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23	
BP			[illegible]			115/60			
T			99.3						
P			88			77			
R			12			16			
O2			100			98			
RA/O2			RA			RA			

INTAKE	16	17	18	19	20	21	22	23	8° T
PO									
Urine						600			

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA									
TIME									
MODE									
F_iO_2									
TV									
RATE									
PEEP									
ABG pH									
ABG PCO_2									
ABG pO_2									
ABG HCO_3									
ABG SAT									
ABG BASE									

LABORATORY DATA									
TIME									
GLUCOSE									
Na/K									
Cl/CO_2									
BUN/Cr									
WBC/PLATELET									
Hct/Hgb									

ACTIVITIES DAILY LIVING			
TIME			
MOUTH CARE			
BATH			
SKIN CARE			
FOLEY CARE			
TRACH CARE			
ROM EXERCISES			

TURN / SUCTION				
TIME				

24° I&O TOTALS

wt Yesterday ________ wt Today ________

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL		TOTAL	

BALANCE ________

NURSE'S SIGNATURE	INITIALS
[redacted]	
(b)(6)-2	

MEDCOM - 13657

ADMISSIO AND CODING INFORMATION

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

1. REPORTING MTF — **MTF LOCATION** *(State or Country Code.)*

1	2	3	4	5	6	7	8
A	1	1	D	1	▨	I	Z

3. REGISTER NUMBER

9	10	11	12	13	14	15
[redacted]						

NAME *(Last, First, Middle Initial)* (b)(6)-2 EPW [redacted]

4. PAY GRADE

16	17	
		EPW

5. SEX

18
M

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

19	20	21	22	23	24	25	26
Z	Z	Z	Z	Z	Z	Z	Z

7. AGE AT ADMISSION

27	28	29
Z	Z	Y

8. RACE

30
Z

9. ETHNIC BACKGROUND

31
9

RELIGION unk

10. LENGTH OF SERVICE

32	33	34
—	—	—

ETS N/A

11. FMP

35	36
[redacted]	[redacted]

12. SOCIAL SECURITY NUMBER

37	38	39	40	41	42	43	44	45
[redacted]								

ORGANIZATION *(Active Duty Only)* N/A

13. MARITAL STATUS

46
U

HOUR OF ADMISSION 1800

BRANCH / CORPS (b)(6)-2 N/A

14. FLYING STATUS

47	48	49
—	—	—

15. BENEFICIARY CATEGORY

50	51	52
[redacted]	[redacted]	[redacted]

16. ZIP CODE OF RESIDENCE

53	54	55	56	57	58	59	60	61
Z	Z	Z	Z	Z				

17. UNIT LOCATION *(State or Country Code)*

62	63
—	—

18. MOS

64	65	66	67	68	69	70
—	—	—	—	—	—	—

19. TRAUMA

71
1

PREV. ADMISSION YEAR ☒ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION

72
0

WARD ICU1

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE —

ADDRESS OF EMERGENCY ADDRESSEE *(Include ZIP Code)* —

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted]

21. TYPE OF DISPOSITION (b)(2)-2

73	74
5	0

22. MTF TRANSFERRED TO

75	76	77	78	79	80

23. DATE OF DISPOSITION *(Y Y M M D D)*

81	82	83	84	85	86
0	3	0	7	1	1

24. CLINIC SVC - ADMITTING

87	88	89	90
A	B	A	A

25. MTF TRANSFERRED FROM

91	92	93	94	95	96

26. DATE THIS ADMISSION *(Y Y M M D D)*

97	98	99	100	101	102
0	3	0	7	0	5

27. LOCATION OF OCCURRENCE *(Battle Casualty Only)*

103	104

28. MTF OF INITIAL ADMISSION

105	106	107	108	109	110

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

111	112	113	114	115	116

FOR LOCAL USE

Dx: s/p GSW

Dx: 86330
86250
E9912
82110

Px: 8622
8364
8659
4579
7905
96

(b)(6)-2 [redacted]

A[redacted]FICER *(Signat[redacted]uired)*

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

[redacted] SPC, 916 ...

MEDCOM - 13658

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF

1	2	3	4	5	6
A	1	1	D	1	▨

2. MTF LOCATION *(State or Country Code.)*

7	8
I	Z

3. REGISTER NUMBER

9	10	11	12	13	14	15
[redacted]						

NAME *(Last, First, Middle Initial)* (b)(6)-4 [redacted] (b)(6)-4 # [redacted] CIV.

4. PAY GRADE

16	17

CIV

5. SEX

18
M

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

19	20	21	22	23	24	25	26

7. AGE AT ADMISSION

27	28	29
0	2	0

8. RACE

30
Z

9. ETHNIC BACKGROUND

31
Z

RELIGION UNK

10. LENGTH OF SERVICE

32	33	34

ETS

11. FMP

35	36
9	9

12. SOCIAL SECURITY NUMBER

37	38	39	40	41	42	43	44	45
[redacted]								

ORGANIZATION *(Active Duty Only)*

13. MARITAL STATUS

46
Z

HOUR OF ADMISSION 0900

BRANCH / CORPS (b)(6)-4 ——

14. FLYING STATUS

47	48	49

15. BENEFICIARY CATEGORY

50	51	52
[redacted]	[redacted]	[redacted]

16. ZIP CODE OF RESIDENCE

53	54	55	56	57	58	59	60	61

17. UNIT LOCATION *(State or Country Code)*

62	63

18. MOS

64	65	66	67	68	69	70

19. TRAUMA

71
9

PREV. ADMISSION YEAR ☒ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION

72
0

WARD ICU-1

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE UNK

ADDRESS OF EMERGENCY ADDRESSEE *(Include ZIP Code)* UNK

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE UNK

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(2)-2 [redacted]

21. TYPE OF DISPOSITION

73	74
0	5

22. MTF TRANSFERRED TO

75	76	77	78	79	80

23. DATE OF DISPOSITION *(Y Y M M D D)*

81	82	83	84	85	86
0	3	0			

24. CLINIC SVC - ADMITTING

87	88	89	90
A	E	A	A

25. MTF TRANSFERRED FROM

91	92	93	94	95	96

26. DATE THIS ADMISSION *(Y Y M M D D)*

97	98	99	100	101	102
0	3	0	7	0	4

27. LOCATION OF OCCURRENCE *(Battle Casualty Only)*

103	104

28. MTF OF INITIAL ADMISSION

105	106	107	108	109	110

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

111	112	113	114	115	116

FOR LOCAL USE

Dx: GSW's to abn, (L) thigh, Bilateral arms

Dx: 86330
86350
82110
E9912

Px: 8622
8364
8659
4519
4905
79

(b)(6)-2

ADMITTING OFFICER *(Signature, as required)* Dr [redacted]

SIGNATURE OF ADMITTING CLERK [redacted]

DA FORM 3985 MAR 89

MEDCOM - 13659

INPATIENT TREATMENT RECORD COVER S

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

(b)(6)-4

1. REGISTER NUMBER [redacted]	2. NAME (Last, First, MI) EPW [redacted]	3. GRADE N/A	ADMISSION REMARKS
4. SEX M	5. AGE [redacted]	6. RACE Z	7. RELIGION unk
8. LENGTH OF SVC N/A	9. ETS N/A	10. PREVIOUS ADMISSION No	
11. FMP [redacted]	12. SSN [redacted]	13. ORGANIZATION N/A	14. WARD ICW2
15. FLYING STATUS N/A	16. RATING/DSG	17. DEPT/BEN ~~K79~~ K90	18. BRANCH/CORPS ~~K40~~ N/A
19. UIC/ZIP	20. TYPE CASE WIA		
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct from ER	22. HOURS OF ADMISSION 0930	23. CLINIC SERVICE AEAA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE —	25. TYPE DISPOSITION 50	26. DATE OF DISPOSITION 12Jul03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) —	27b. TELEPHONE NO. —	28. DATE OF THIS ADMISSION 4Jul03	ADMITTING OFFICER (b)(6)-2 Dr. [redacted]
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted]	30. DATE OF INITIAL ADMISSION	32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED	

31. SELECTED ADMINISTRATIVE DATA

(b)(2)-2

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

GSW Ⓛ ankle fx

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	9	9

36. Total Days All Facilities

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP. CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	9	9

SIGNATURE OF ATTENDING [redacted] Dr. [redacted]	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER For [redacted]

DA FORM 3647, MAY 79

EDITION OF 1 AUG 76 IS OBSOLETE

USAPPC V1.10

(b)(6)-2

MEDICAL RECORD

ABBREVIATED MEDICAL RECORD

PERTINENT HISTORY, CHIEF COMPLAINT, AND CONDITION ON ADMISSION *(Enter date of admission)*

S 28 y/o c/o s/p GSW to (L) Ankle in attempt to steal car.
Shot by another Iraqi. No incident.
pain (L) ankle

O - VSS Afebrile
PMH ∅
Allergy ∅
- No meds

PHYSICAL EXAMINATION

VSS Afebrile
HEENT clear
Neck clear
Neck supple
Chest lungs clear
heart RRR
Abd benign.
Genit nl male.

PROGRESS *(Enter date of discharge and final diagnosis)*

Ext: Wound was (L) lateral Ankle. c entrance and no exit wound.
bullet frag in Ankle
fibular hole.
Ortho admit

(b)(6)-2

SIGNATURE OF PHYSICIAN [redacted]

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)	DATE 7/1/03	IDENTIFICATION NO.
		ORGANIZATION
	REGISTER NO.	WARD NO.

ABBREVIATED MEDICAL RECORD
Standard Form 539
GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL
RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975

539-106

[redacted]

MEDICAL RECORD

PROGRESS NOTES

AUTHORIZED FOR LOCAL RE

DATE	NOTES
4Aug03 0830	Ortho consult
	22 y/o Iraqi Felon car theft
	GSW (L) ankle handgun by
	car owner
	Ø PMHx Ø PSHx Ø Meds
	PE: [illegible] NV ⊕ (L) LE
	Lateral Ent/Exit wound
	c̄ Return easy to Bullet
	Ant/Lateral
	A) (L) [illegible] fibula
	GSW Fx
	Pl) washout (I&D)
	Splint
	consider IM Steinman Pin

RELATIONSHIP TO SPONSOR

SPONSOR'S NAME

LAST

FIRST

MI

SPONSOR'S ID NO. (SSN or Other)

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. ICW2

EPW [redacted] (b)(6)-4

PROGRESS NOTES
Medical Record
STANDARD FORM 509

MEDCOM - 13662

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
4 July 03	1225 - Pt alert lying in bed c̄ Ⓡ foot elevated
	VSS, HR regular, BS⊕. Cast applied to Ⓡ
	leg below knee. Able to wiggle toes, ⊕
	sensation. Pulses equal + strong bilat to ↑ + ↓
1200 96.8	extremities. LR @ 100 into Ⓛ AC Voicing Ø
68	complaints. Will cont. to monitor (b)(6)-2 [redacted]
16	1300 → Assumed care of Pt @ 1300. VSS A+Ox3
126/74	Ø c/o pain. Ⓛ AC PIV c̄ LR @ 100cc/hr. ⓁLE
98%	s̄ splint/ace CDI. ⊕ sensation, cap refil <3sec, mvt Ⓛ
	foot. NPO for OR. Ø/W assess. WNL. Will
	Cont. to monitor (b)(6)-2 [redacted]
5 July	Assumed @ ~~care~~ 2100. Pt has been sleeping.
	Lungs CTA. Bowel sounds x4 quads. Pt has
	Ø c/o pain/discomfort @ this time. Will con-
	tinue to monitor. (b)(6)-2 [redacted]
5 July 03	0540 Assume pt care @ 0500. pt awake and
	alert. c/o sm amt of pain. LR @ 100cc/hr to Ⓛ
	AC no s/s redness/infiltration. VSS. HR regular. Lungs
	CTA. BS x4 abd soft no c/o pain/tenderness on
	palpation. LLE dsg CD+I. ⊕ movement ⊕ sensation
	to toes. NPO for OR today. Will continue to monitor.
	(b)(6)-2 [redacted]

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. ICW2

EPW # [redacted]

(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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
5Jul03	assumed care @ 1300 - VSS - SL patent
1400	c̄ LR @ 100cc/hr into Ⓛ FA - pt. c/o to OR,
	NPO - dsg intact on Ⓛ ankle, <2 sec.
	cap refill in Ⓛ toes - no c/o pain @
	this time ——— (b)(6)-2 [redacted]
5Jul03	pt. surgery cancelled for today - pt. ate
1900	regular diet for dinner - IV patent c̄
	LR @ 100cc/hr - no c/o pain @ this time
	——— (b)(6)-2 [redacted] CR, AN
5Jul03	Pt A/O x3, VSS, LCTAB, ⊕ BS all quads. ∅ c/o pain @
	this time. LLE drsg CDI ⊕ movement ⊕ sensation
	to toes. brisk cap refill. will cont to monitor
	(b)(6)-2 [redacted] SPC 91WM6 ———
6 JUL 03	Assumed pt. care @ 0500. Pt. A+O x3. Lungs
0540	CTA. ⊕ BS x4. LLE dsg CDI ⊕ movement
0530 96.4	c/o no feeling in toes. IV LR infusing @
55 22	100cc/hr in Ⓛ FA. Will continue to monitor.
118/76 98%	(b)(6)-2 [redacted] 91WM6.
6JUL03 1230	Pt. returned from Recovery room. Pt. A+O x3. Lungs
T 97.1	CTA. ⊕ PERRLA. ⊕ movement in Ⓛ toes c̄ decrease sensation
P 56	Ace wrap on Ⓛ leg CDI. IV LR TKO. SAT @ 97%
R 16	on room air. Will continue to monitor ———
B/P 120/70	——— [redacted] (b)(6)-2
SATS: 97	
6Jul03	assumed care @ 1300 - VSS - pt. tolerating
1520	water - IV HL'd - pt. due to void by
	1800 - dsg cdi on Ⓛ LE, no c/o pain - [redacted] em
	(b)(6)-2

STANDARD FORM 600 (REV. 6-97) BACK

FPI. LEX. Printed on Recycled Paper

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	Ortho OP / Brief Note
6 Jul 03	28 yo Iraqi EPW Carjacker
	Preop Dx: (L) GSW Fibula R
	procedure I&D / Fragment Rem
	Surgeon: [redacted] (b)(6)-2
	EBL: min
	TT = 25 m
	To PACU Stable
	Findings: Small Distal Fibula
	Fragment c̄ Defect
	(L) Medial Level
	disruption of Syndesmosis
	on Flouro Exam
	Plan / SL 7 Days then SCC NWB
	6 wks

[redacted] (b)(6)-2

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME LAST | FIRST | …OR'S ID NUMBER (…or Other)

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINT…

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. ICW2

[redacted] (b)(6)-4

EPW

PROGRESS NOTES
Medical Record
STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
12/31/03	am
	wnd clean/dry
	Pln) [illegible]
	SLWC
	D/C to EPW Camp [redacted] (b)(6)-2

TANDARD FORM 509 (REV. 5/1999) BACK
USAPA V1.00

MEDCOM - 13666

AUTHORIZED FOR LOCAL REPR

ICAL RECORD | **PROGRESS NOTES**

ATE	NOTES
6 Jul 03 1925	SL restarted in Ⓛ AC, center - outer AL Ⓛ site c̄ s̄ s/s infection - no c/o pain - pt. voided 300cc urine @ 1730 - pt can wiggle Ⓛ toes & has good sensation <2 sec cap. refill in Ⓛ toes — (b)(6)-2 [redacted] CPT AN
6 Jul 03 @	2200 Pt. sleeping, easily aroused. VSS. CTA Ⓑ, ⊕ BS x 4 quads & c/o pain. HL flushing easily. abd soft, ND ⊖ TTP. Ⓛ LE drsg CDI ⊕ movement + sensation to toes. taking PO well. Will cont to monitor — (b)(6)-2 [redacted] SPC 91WM6
7 July 03 0700	Pt. asleep in bed easily aroused by verbal stimuli. VSS, slightly bradycardic P 47. Lung sounds clear bilat. HL in Ⓛ AC s̄ s/s of infection. Pt. has cast to Ⓛ LE, full ROM in Ⓛ LE digits, cap refill <3sec, ⊕ sensation. All other assessment findings WNL. Pt. s̄ complaints @ this time. Will continue to monitor. (b)(6)-2 [redacted] 2LT/AN
7 Jul 03 1335	assumed care @ 1300 - VSS - split cast, ace wrap CDI on Ⓛ LE - given scheduled motrin - SL patent in Ⓛ AC - pt. can wiggle Ⓛ toes, <2 sec. cap. refill in Ⓛ toes - no c/o pain @ this time [redacted] CPT, AN

(b)(6)-2

IONSHIP TO SPONSOR	SPONSOR'S NAME LAST	FIRST	MI	SPONSOR'S ID (SSN or Other)

T./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

T'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. ICW 2

EPW

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509
Prescribed by GSA/ICMR FPMR (41CFR) 101-

MEDCOM - 13667

.TE	NOTES
l 03@	2345: Pt resting, easily aroused, VSS, (CTAB), ⊕BS x4 quads. ∅ c/o pain or discomfort @ this time. abd soft, NT. (L)LE drsg CDI ⊕ movement & sensation to toes, brisk cap refill. Will cont to monitor —— [redacted] 91WM6 (b)(6)-2
'July03	0600. Assume pt care @ 0500. Pt asleep easy to awake. No c/o pain. (L)LE Splint/ace wrap CD+I. ⊕ sensation ⊕ movement to toes. VSS. HR reg LUNGS CTA BS x4 HL to (R) AC flushes well. Will continue to monitor [redacted] 91WM6 (b)(6)-2
5Jul03 1600	assumed care @ 1300 - VSS - SL patent in (L) AC - pt. ambulated to bathroom c̄ one crutch c̄ some difficulty - no c/o pain @ this time - splint/ace wrap intact on (L) foot, <2sec. cap. refill and good movement in (L) toes —— [redacted] CPN (b)(6)-2
2230	Pt care assumed @ 2100. VSS, alert and awake, no c/o pain. Lung sounds CTA, pulses palpable x4, BS ⊕ x4, Dsg on lle CDI, ⊕ pulse and sensation, pt able to wiggle toes. Pt resting, will continue to monitor. —— [redacted] 91WM6 (b)(6)-2
ly03 0530	Assumed pt. care @ 0500: pt. A+Ox3. lungs CTA ⊕ pulses x4. ⊕ BS x4. HL in (L) AC patent. Dsg c̄ ace wrap on (L) leg CDI. ⊕ Sensation + Movement in (L) toes. ∅ Complaints —— [redacted] 91WM6. (b)(6)-2
96.7 54 16 112/66 98%	

AUTHORIZED FOR LOCAL RE

:DICAL RECORD | PROGRESS NOTES

DATE	NOTES
9 July 03	assumed pt care @ 1300. pt awake & alert. VSS.
1400	lungs CTA, abd soft, nontender. BS ⊕ X4. RLE c̄ full ROM
	⊕ pulses. LLE c̄ dsg CDI, pt able to wiggle toes.
	HL to LFA flushes well. Ø redness/swelling noted.
	Ø c/o pain/discomfort voiced @ this time. Will cont
	to monitor ——— (b)(6)-2 [redacted] 91WM6
2230	Pt care assumed @ 2100. VSS, lungs CTA, pulses
9 July	palpable x4, bs ⊕ x4. Dsg to lle CDI, pt c̄ +
	sensation and capillary refill to lle. No complaints (b)(6)-2
	at this time. HL to lfa intact flushes well. [redacted] 91WM6
10 July 03	Assumed care of pt @ 0500. Pt asleep.
	Lungs CTA. Bowel sounds x 4 quads. Pulses
	palpable. HL to Ⓛ arm - patent. Pt has Ø
	c/o pain / discomfort @ this. Will continue to
0500 96.5	monitor ——— [redacted], LPN, SGT
61	(b)(6)-2
18	
110/72	
98%	
10 Jul 03	assumed care @ 1300 - VSS - SL patent -
2030	pt. can ambulate c̄ crutches per Dr. [redacted]
	neurov's intact for Ⓛ LE ———

NSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI | SSN or Other (b)(6)-2

SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

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. ICW 2

PROGRESS NOTES
Medical Record
STANDARD FORM 509

EPW [redacted] (b)(6)-4

MEDCOM - 13669

ACLU-RDI 1592 p.1563

MIDDLE INITIAL | ID NUMBER

NOTES

2130
10 July
Pt care assumed @ 2100 VSS, pt resting s̄ c/o pain.
Lung sounds CTA, ø BS ⊕ x4 quads. HL @ L wrist
patent. Dsg on lle CDI, ⊕ sensation, ⊕ cap refill.
Pt s̄ complaints at this time, will continue to monitor.
(b)(6)-2 [redacted] 91WM6

11Jul03 0840
Pt. awake & alert sitting up in bed bathing. HR Regular, Lung sounds
clear bilat, bowel sounds (+) x 4 quads. Pt HL in Ⓛ FA flushed well
0525 96.7 c̄ 5cc NS s̄ s/s of infection or infiltration. Splint dressing to Ⓛ LE
53 CDI, sensation in digits (+), full ROM, <3 sec cap refill. Pt. has
18 white splotches over upper trunk & neck, looks like a fungus of
100/69
98% some sort. Pt. VSS, s̄ complaints @ this time. All other assessment
findings WNL. Will continue to monitor (b)(6)-2 [redacted] 217 AN

11Jul03
1745 assumed care @ 1300 - VSS - Ⓛ FA SL patent -
splint intact on Ⓛ LE, neuro √'s intact - pt. to
have sutures removed 13Jul03 - [redacted] CR, AN
(b)(6)-2

AUTHORIZED FOR LOCAL REPR

:AL RECORD

PROGRESS NOTES

TE

NOTES

12 July 0145 Pt care assumed @ 2100. VSS, alert and awake, no c/o pain.
Lung sounds CTA, BS ⊕ x4 quads. Dsg on LLE CDI, Pt able to
wiggle toes, ⊕ sensation, ⊕ cap refill. HL flushes well, IV
ABX tx continues. No complaints at this time, will continue
to monitor. (b)(6)-2 [redacted] 9LWMC

12 July 0600 Pt. VSS, asleep in bed easily aroused by verbal stimuli. HR reg,
Lung sounds clear bilat, bowel sounds (+) x 4 quads Ⓛ LE c̄ cast, digits
c̄ (+) sensation, full ROM, cap refill <3sec. Pt. c̄ fungus-like white splotche
on neck & upper back, pt. c/o the site being itchy. HL Ⓡ FA s̄ s/s of infection.
All other assessment findings WNL. Pt. s̄ other complaints @ this
time. Will continue to monitor. (b)(6)-2 [redacted] 2LYK

12 Jul 03 1530 assumed care @ 1300 - VSS - SL patent -
Splint removed by MD - SPC [redacted] (b)(6)-2 removed
Sutures and placed steri strips on Ⓛ LE
wound, all edges approximated except
Small area in middle of wound, no suture
was on that spot, MD aware of that area -
SL WC placed by ortho tech, Ⓛ LE elevated
@ present - pt. awaiting transport to
EPW camp [redacted] CR

12 Jul 03 1600 neuro √'s intact in ② toes [redacted] CR, AV

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME LAST	FIRST	MI	SPONSOR'S ID (SSN or Other)
		(b)(6)-2		

SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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. ICW 2

EPW [redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509
Prescribed by GSA/ICMR FPMR (41 CFR) 101

TE

NOTES

2300 Pt care assumed @2100. VSS, no c/o pain. Lung sounds
12JUY CTA, pulses palpable x4. Dsg on lle SLC, C/D/I. Pt c̄
(+) sensation, able to wiggle/pss toes. Pt c̄ no IV access, taking
(b)(6)-2
PO meds. Possible D/C in am, continue to monitor. [redacted] 91WM6

13July 0545 Pt. asleep in bed easily aroused by verbal stimuli. HR Regular,
Lung sounds clear bilat, bowel sounds (+) x4 quads. (L) LE c̄ cast, digits
c̄ full ROM, (+) sensation, cap refill <3sec. Pt. s̄ complaints @ this
0605 96.8 time. Pt ready to D/C to EPW camp. All other assessment findings
64
18 WNL. (b)(6)-2 [redacted] 2LT/AN
110/72
97%

13Jul03 assumed care @ 1300 - VSS - no c/o pain @
1600 this time - neuro V's intact in (L) toes, pt.
can walk slowly s̄ difficulty - had BM
today - awaiting transport to camp - [redacted] CPT, AN
(b)(6)-2

13Jul03 pt's wrists restrained (Flex Tix)
1900 escorted to x rays, dc summary & meds
by MP to helicopter for transport
back to EPW camp [redacted] AN
(b)(6)-2

558-103 Spc. [redacted] (b)(6)-2

Instructions on Back of ... et)

NSN

EMERGENCY CARE AND TREATMENT

(Medical Record)

TREATMENT FACILITY (Stamp)

LOG NUMBER

ARRIVAL

DATE DAY	MONTH	YR.	TIME
4	Jul	03	0925

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet)
☐ PRIVATE VEHICLE ☐ AMBULANCE
☒ OTHER (Specify) Medi Vac

CURRENT MEDS. (tetanus immunization and other data) —

HISTORY OBTAINED ☐ PATIENT ☐ O

ALLERGIES NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (I

CHIEF COMPLAINT(S) (Include symptom(s), duration)

(b)(6)-2 [redacted]

SEX M AGE 28

POSSIBLE THIRD P ☐ YES ☐

TIME SEEN BY PRO

SpO2 97

VITAL SIGNS

TIME	0919		
BP	124/64		
PULSE	92		
RESP.	16		
TEMP.	96.5		
WT. (Child)	75kg		

CATEGORY (See reverse)
☐ EMERGENT
☐ URGENT
☐ NON-URGENT

ORDERS	INITS.	TIME
X-Ray Ⓛ Ankle.		

ASSESSMENT/DIAGNOSIS
GSW to Ⓛ fibula ankle.

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

28 y/o ō hx of attempting to steal car and driver of car or other iraqi, shot him in self defense in the Ⓛ ankle.

O. VSS Afebrile
HEENT clear
NMT clear
Neck supple
Chest lungs clear
heart RRR
Abd benign.
Genit nl male ↓↓
Ext pulses reflexes ok.
Entrance wound lateral Ⓛ ankle.
Dorsi plantar flexion ok.
minimal bleeding
xray: Ⓛ ankle
bullet through fibula.

DISPOSITION (Check all that apply)
☐ HOME ☐ FULL DUTY
QUARTERS ☐ 24 Hrs. ☐ 48 Hrs. ☐ 72 Hrs.
MODIFIED DUTY UNTIL: DAY MONTH YEAR
REFERRED TO (Indicate clinic)
☐ EMERGENCY ☐ TODAY
☐ 72 HOURS ☐ ROUTINE
ADMIT. TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE
☐ IMPROVED ☐ UNCHANGED
☐ DETERIORATED
TIME OF RELEASE:

(b)(6)-2 (CONTINUE ON SF 507, IF NEEDED)

PATIENT'S IDENTIFICATION (Mechanical imprint)
FOR WRITTEN ENTRIES GIVE: Name - last, first, middle; SSN; DOB, service status, name and relation of sponsor or next of kin. (IMPORTANT: LIST FACILITY HOLDING TREATMENT RECORD).

SIGNATURE OF PROVIDER AND ID STAMP
[redacted] LTC MC 735

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitatio plans)
Ortho Admit

[redacted] (b)(6)-4

MEDCOM - 13673

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

FOR Use of this form, see AR 40-407; the proponent agency is The Office of the Surgeon General.

1. AGE: 28
HEIGHT:
WEIGHT:

2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication)
☑ NKDA ☐ PCN ☐ LATEX ☐ IODINE ☐ TAPE ☐ FOOD
REACTION:

3. PREVIOUS SURGERY [ ] NO [✓] YES (type):
I&D (L) ankle

4. PROPOSED SURGICAL PROCEDURE:
(Lt) Ankle I&D.

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition ______
Tobacco ___ ppd X ___ yrs. Body Piercing ______ Diabetes (Y) (N) ROM ______ ASA/Motrin w/72 hrs (Y) (N)
ETOH ______ Implants ______ Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS:

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to: ✓ 1) Surgical Procedure & Operating Room Environment ✓ 2) Separation Anxiety (Child) ___ 3) Surgical Outcomes	✓ Pt. verbalizes any specific anxiety. ✓ Pt. Exhibits relaxed body posture.	✓ Allow pt. to verbalize freely. ✓ Explain OR environment and answer questions regarding surgery. ✓ Offer comfort measures. (e.g., warm blanket, touch). ✓ Explain all nursing procedures before they are done. ✓ Remain with pt. whenever possible. ✓ Maintain family interface. Parents to stay with pt.
B. AERATION ✓ Potential for respiratory dysfunction due to: ✓ 1) Positioning ✓ 2) Effects of Anesthesia ✓ 3) Medical/Smoking History	✓ Pt. will be able to breathe without difficulty during immediate intraoperative phase.	✓ Offer to elevate head of litter or offer pillow. ✓ Observe pt. while awaiting surgery for signs of distress. ✓ Assist anesthesia during intubation and extubation.
C. INTEGUMENT ✓ Potential impairment of skin integrity due to: ✓ 1) Intraoperative Immobility ✓ 2) ESU Pad Placement ✓ 3) Positional Aids ✓ 4) Prosthesis ✓ 5) Pooling of Prep Solutions	✓ Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened areas).	✓ Utilize pressure preventing devices on OR table and accessories. ✓ Check for proper positioning and support to maintain good body alignment. ✓ Pad pressure points. ✓ Place ESU ground pad on non compromised skin surface area. ✓ Keep prep fluids from pooling.

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

EPW [redacted] .(b)(6)-4

VERIFICATIONS AT HOLDING AREA:
! ID/Allergy Band ! Dentures Removed
! H & P ! Contacts Removed N/A
! NPO Since MN ! Jewelry Removed
! UHCG/CMP N/A ! Body Pierce Removed
! Consent/Blood Transfusion Signed/Witnessed/Dated
! Surgical Site/Consent verified by Pt./Anesthesia/Surgeon
! Contact Precautions (Y) (N)
! Family/Friend: N/A

DA FORM 5179, JUN 91 Previous editions are obsolete. USAPA V1.0

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to: ✓ 1) Intraoperative Mobility ✓ 2) Positioning ___ 3) Existing Disease ✓ 4) Safety Devices ___ 5) Hypothermia	✓ Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse.	o Check for support stockings or ace wraps. If none, check with doctors. o Check that safety straps are correctly applied. ✓ o Offer pillow for under knees. ✓ o Place and take down legs from stirrups with slow bilateral motion. ✓ o Check that rings and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to: ✓ 1) Pain ✓ 2) Intraoperative Hazards ✓ 3) Prosthesis ✓ 4) Positioning ___ 5) ✓ Transfer pt. to/from OR table E.2. ✓ Potential discomfort due to: ✓ 1) Length of Surgery ✓ 2) Positioning N/A ✓ Arthritis	✓ Pt. will be transferred to OR table without difficulty. ✓ Pt. will not experience unnecessary physical discomfort.	✓ o Have sufficient people available for transfer. ✓ o Insure proper body alignment. ✓ o Allow patient to lie in position of comfort while waiting for surgery. ✓ o Offer support (i.e.. pillows. bath towels. etc.) for positioning.
F. SPECIAL SENSES F.1. ✓ Diminished visual perception due to being: N/A 1) Pre-Medicated ___ 2) W/O Glasses F.2. ✓ Potential for decreased communication due to: ___ 1) Diminished Hearing ✓ 2) Language Barrier F.3. ___ Potential injury due to dentures: N/A ___ 1) Upper ___ 2) Lower ___ 3) Bridges ___ 4) Caps ___ 5) Crowns	✓ Pt. will be made aware of surroundings prior to anesthesia induction. ✓ Pt. will be transferred safely to OR table. ✓ Pt. will be able to understand instructions. ✓ Minimize danger of injury during intraop period.	✓ o Introduce self. Keep pt. informed as to where he/she is and what is happening. ✓ o Inform pt. in which direction to move and assist if necessary. ✓ o Speak clearly and slowly. o Address pt. from ________ side. o Validate pt.'s understanding of verbal communication. o Verify removal of dentures.
G. OTHER PATIENT PROBLEMS/NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

10. OR NURSING INTERVENTIONS COMPLETE D/ADDITIONAL INTRAOPERATIVE INTERVENTION S NOTED.

(b)(6)-2 [redacted] CPT/AN 5 July 03 DATE

11. POSTOPERATIVE EVALUATION: SKIN INTEGRITY: Bovie Pad Site: ☒ Clean and Dry ☐ Red ☐ N/A

DRESSING DRY & INTACT (✓Y) (N)

LEVEL OF CONSCIOUSNESS: ☐ A&O ☒ Drowsy ☐ Sleepy ☐ Intubated

BREATHING EASY: (✓Y) (N)

LEVEL OF ACTIVITY: ☒ Moves All Extremities ☐ Moves Upper Extremities ☐ Transferred to litter with roller due to spinal

12. PREOPERATIVE [redacted] PREPARED BY (Signature and Title) [redacted] CPT/AN

DATE: 5 July 03 TIME: 07 (b)(6)-2

13. POSTOPERATIVE [redacted] TION PREPARED BY (Signature and Title) [redacted] 2w (b)(6)-2

DATE: 7 JUL 03 TIME:

MEDCOM - 13675

REVERSE OF FORM 5179, JUN 91

USAPA V1.0

MEDICAL RECORD | **INTRAOP.. ATIVE DOCUMENT**

For use of this form, see AR 40-66, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: ~~G~~ Litter BY CPT [redacted] (b)(6)-2

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY MAJ [redacted] (b)(6)-2

3. DATE 6 Jul 03 TIME PATIENT ARRIVED IN SUITE 1030

4. PATIENT IN ROOM TIME 1030 NUMBER 2-1

5. PREOPERATIVE EMOTIONAL STATUS

☑ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS: NPO p̄ MN, NKDA

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted] (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	2LT [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)* Pt. supine on padded OR table. BUE on padded armboards <90°.

☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

COMMENTS: Normal anatomic body alignment maintained

8. SKIN PREPARATION

HAIR REMOVAL ☒ YES ☐ NO 1LT Malach

DONE BY: ☒ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☒ RAZOR

☐ CLIP Bovie Pad site

COMMENTS: No ni

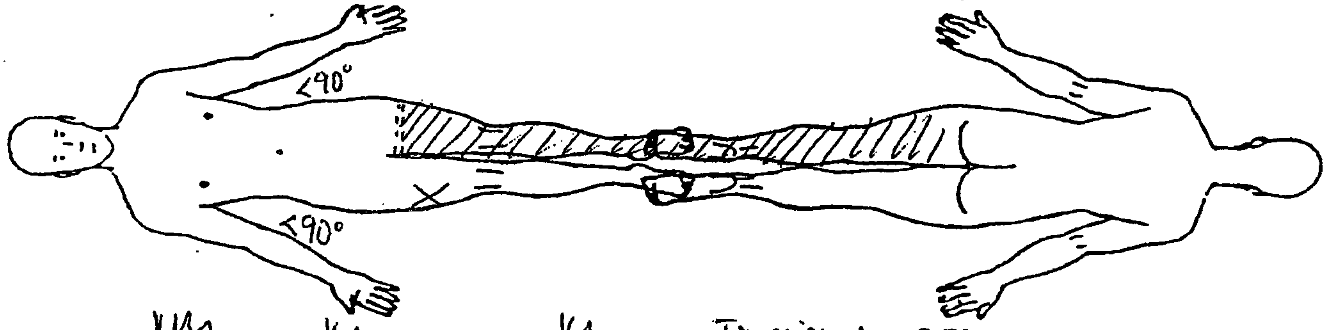
PREP SOLUTION *(Specify)* Betadine / Betadine

SITE: Left leg BY WHOM: 1LT [redacted]

SITE: BY WHOM: (b)(6)-2

COMMENTS: No pooling or adverse reaction

9. LOCATION OF EXTERNAL DEVICES



LEGEND KM X Ground Pad KM -- Safety Strap KM = = = Tourniquet Tourniquet @ 250mmHg X

Initial: PFC Gesellchen 1LT Malach

C = Correct I = Incorrect

10. COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB (b)(6)-2	CIRCULATOR (b)(6)-2
Sponge	☒ Yes	☐ No		C	C	PFC [redacted]	1LT [redacted]
Needle Sharp	☒ Yes	☐ No					
Instrument	☐ Yes	☒ No					
Other	☐ Yes	☒ No					

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

[redacted] (b)(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☑ YES ☐ NO

☑ ESU NO: Valleylab #3 cut 30 coag 30

GROUND PAD: BRAND Valleylab

LOT NO: 65706 Exp 2004-11

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

13. PROSTHESIS, IMPLANTS ☐ YES ☒ NO IF YES NAME: ID NUMBER; MANUFACTURER

MEDICATIONS/ORDERS

14. IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☐

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S): NS.

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE [redacted] (b)(6)-2

15. X-RAY IN OPERATING ROOM YES ☑ NO ☐ IF YES, SITE

LABORATORY SPECIMENS

16.

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

TYPE/SIZE	1.	2.	3.
SITE	1.	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

Fluffs
Kerlix
webril
Splint ACE

19. ADDITIONAL INFORMATION

GETA

Surgeon: Dr [redacted]
Anes: CPT [redacted] (b)(6)-2

DA 5179 in Chart

20. OPERATION(S) PERFORMED

Left ankle I&D

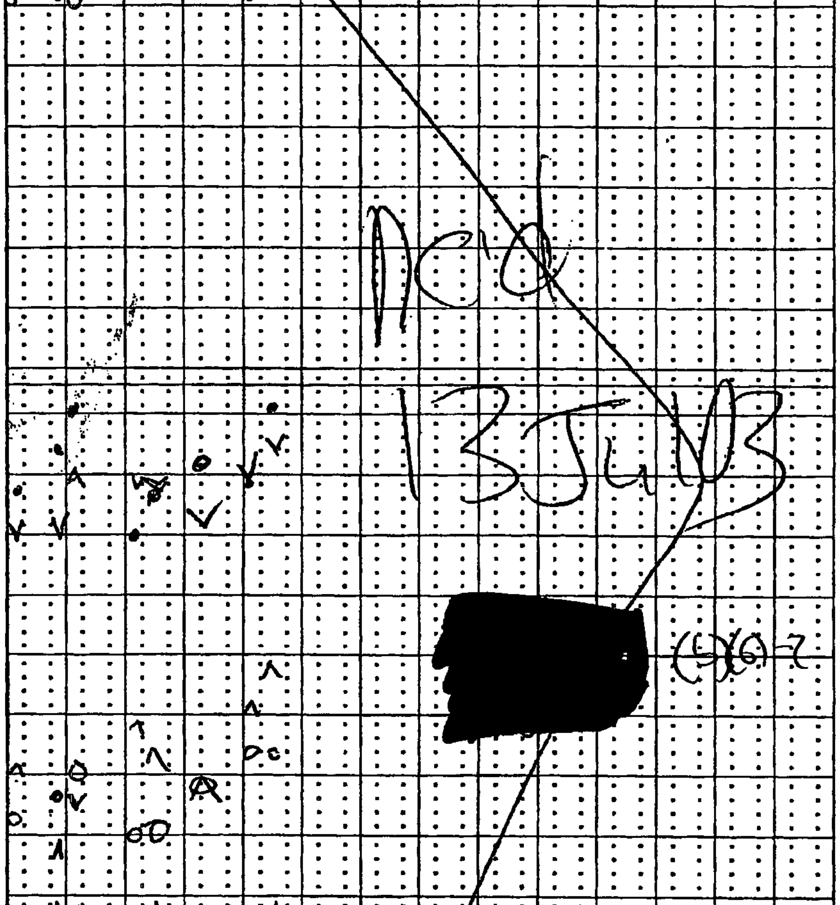
21. PATIENT TRANSFERRED TO ICU 2 (b)(6)-2 TIME See DA 7389 METHOD Litter

22. REGISTERED NURSE SIGNATURE [redacted] 1T (AN)

REVERSE OF DA FORM 5179-1, O USAPA V1.01

MEDCOM - 13677

MEDICAL RECORD		VITAL SIGNS RECORD						
HOSPITAL DAY								
POST- DAY								
MONTH-YEAR	DAY	11		12		13		
19	HOUR	0556	1338	2180	0614	2013	0625	



DC'd

13Jun03

[redacted] (b)(6)-2

RESPIRATION RECORD	18	16	20	18	16	18	16	
BLOOD PRESSURE	100/67			101/60	102/58	110/72		
	120/78			105/64		114/78		
HEIGHT: WEIGHT →								
	98%			98%	97%	97%		
				98%		98%		

Record special data only when so ordered

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*

REGISTER NO.

WARD NO. ICW2

STANDARD FORM 511 (REV. 7-95) **BACK**

EPW # [redacted] (b)(6)-4

MEDCOM - 13678

NSN 7540-00-6

511-119

MEDICAL RECORD

VITAL SI

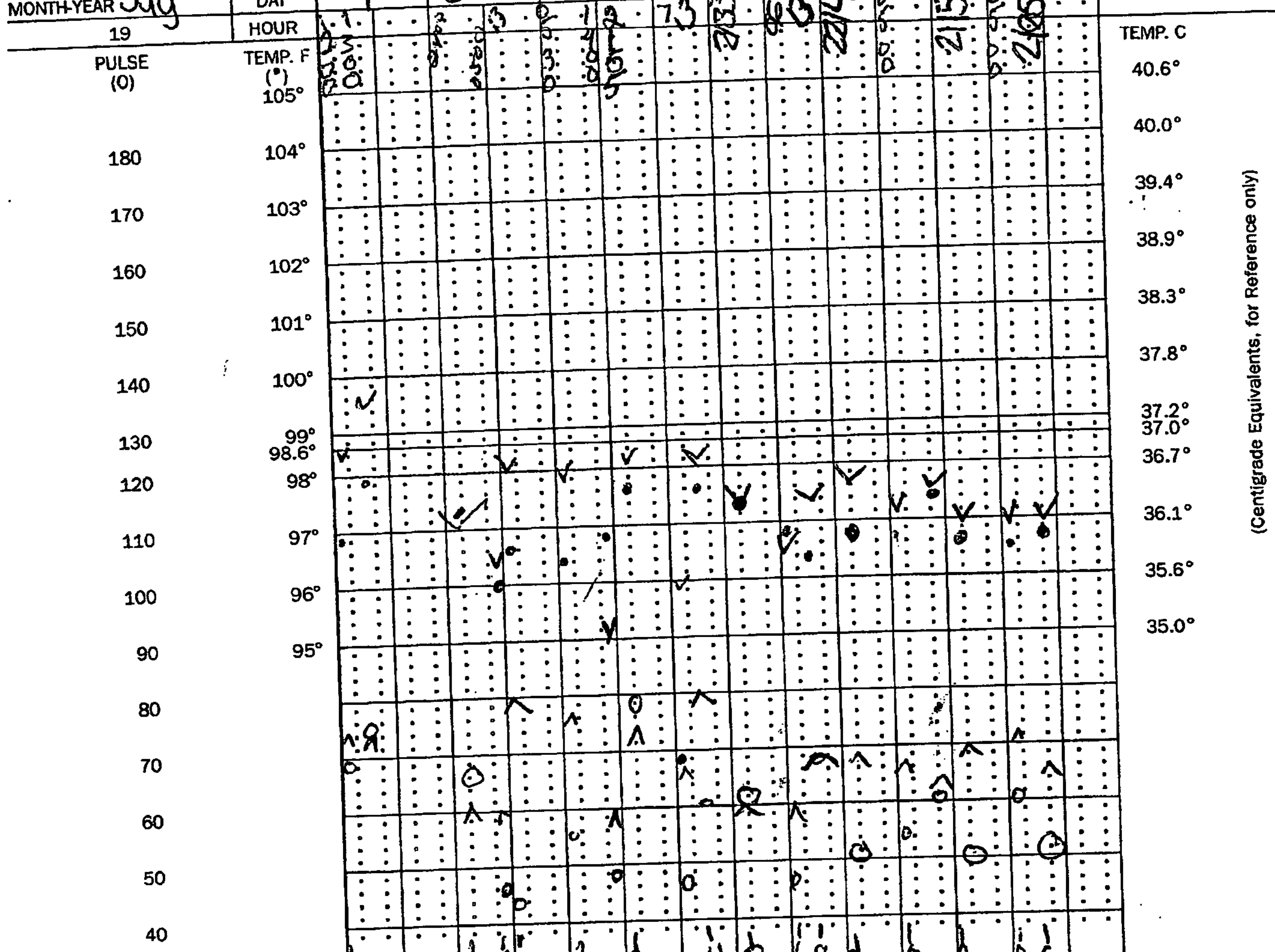
HOSPITAL DAY

POST- DAY

DAY: 4 | 5 | 6 | 7 | 8 | 9 | 10

MONTH-YEAR July

19 HOUR



RESPIRATION RECORD 16 | 16 18 16 | 22 | 18 | 14 18 | 16 18 16 | 16 16 | 18 16

Record special data only when so ordered

BLOOD PRESSURE 126/74 136/76 | 104/60 | 128/80 | 118/76 99/100 | 122/74 | 99/66 122/50 | 114/60 | 109/60 114/68 | 116/68 | 108/66 118/64 | 110/70 | 110/72 [illegible]

HEIGHT: | WEIGHT ⟶

98% | 96% | 98% | 98% | 98% | 98% 96% | 98% | 93% | 97% | 98% | 98% | 98% 97%

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)

REGISTER NO.

WARD NO. ICW 2

EPW # [redacted] (b)(6)-4

VITAL SIGNS RECORDS

Medical Record

STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 13679

MEDICAL RECORD — ANESTHESIA

ANESTHETIC AGENTS AND DRUGS

CONTINUOUS / REPEATED DRUGS
SPECIFY UNITS – MG / MCG / ML,
* (*=CONSTANT INFUSION

DRUG	(Units)	
Versed	(mg)	2.5
Fent	(ug)	200 50
Lido/succs	(mg)	75/80
Propofol	(mg)	200
Nimbex	(mg)	6
	(/)	
VOLAT AGENT	% del	1.5/2.0 X
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	8 2 2 8

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS

FLUIDS

LINE site LR	☐ Warmed	800
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOSSES

EST BLOOD LOSS min

URINE – 0

TOTALS

TOTAL EBL: min

TOTAL URINE: 0

FLUIDS – SUMMARY

CRYSTALLOID– 806

COLLOID– 0

BLOOD– 0

PHYS STATUS: 1 [✓ 2] 3 4 5 E

BODY WEIGHT: 80 [✓ KG] LB

HEMATOCRIT: NI

INITIAL DATA:

BP – 117/60

HR– 59

EQUIP CHECK:

OK?– [✓ Y] N

PATIENT RECHECK:

OK for PROCEDURE?

TIME– 1000

TIME → 10 X 11 X 30 X 12 X 30 X 13 X

SYMBOLS:

BP by cuff V Λ

Heart rate ●

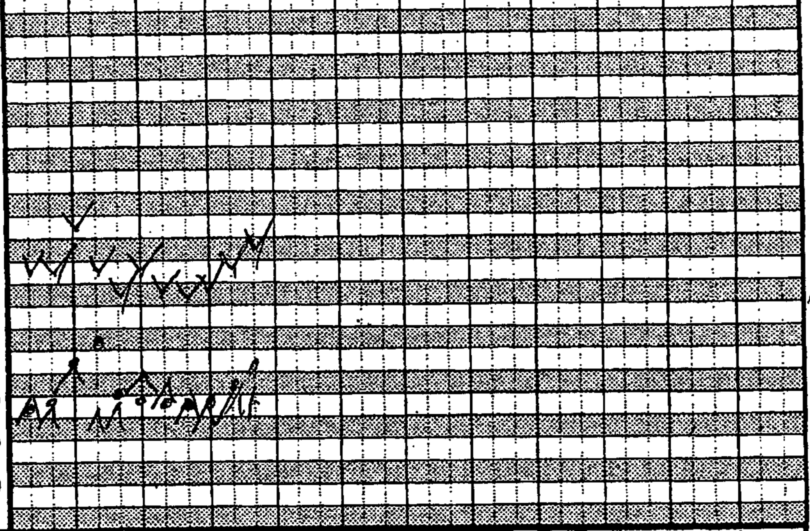
Resp rate

BP (transduced)

TOURNIQUET T – ↗

ANES– X-X

PROC ⊙ – Ø



VENTILATION

VT – ml	S 870 660 AV SV
f – breaths/min	12 8 8 5 17
Peak inf pres / PEEP	20 20
MODE– S(pon), A(ssist), C(on)	S-C C C

MONITORS / ACCESSORIES

✓ BP/Auto Cuff	✓ ET CO2 (torr)	38 32 31 42
BP / oth	✓ FIO2 (Frac or %)	.87 .57 .87
ART line	✓ SpO2 (%)	99 99 100
Steth- PC/ES	✓ ECG	SR SR SR
Gas analyzer	✓ TEMP- site	Available
	✓ N-M Block (T/4)	⊕ twitch
Warming blkt		
Conv warmer		

Mark with letters & symbols, explain under REMARKS

EVENTS

Position → o—|

REMARKS–

Code drugs with numbers, events with letters

1030 in OR pt IVD – monitors applied.
1035 I@I S diff.
⊕ Bilat BS ⊕ ETCO2

Tourniquet Set 250mmHg
1055 T↑119 ↓25 TTT

1118 Reversal 5mg Neostigmine, .8mg Robinol

1125 Spont Resp oral suction extubated ⊕ P purposeful movement

1128 transferred to ICU2
Report given

RECOVERY AT 1130

PACU ICU ICU2 (Specify)

OTHER 96.5

CONDITION: awake responsive

RESP– 18 SpO2– 96%

BP– 117/59 HR– 87

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1000	1030	1140
	Ready	**Begin**	**End**
PROC	1040	1055	1120

PROCEDURES and CPT Codes
I@D (L) foot GSW

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments 8.0 ETT placed one attempt grade 2 view, ē 3 MAC Blade. ⊕ ETCO2 ⊕ Bilat BS

PATIENT IDENTIFICATION– Typed or written entries: Name, Grade/Rate, Medical facility

EPW [redacted] ICW2/ICU2
(b)(6)-4

SURGEONS [redacted]

ANESTHETISTS: [redacted] MAJ CRNA [redacted]
(b)(6)-2

PROCEDURE LOCATION [redacted]

DATE 7/6/03 (b)(2)-2

PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA
WAMC OP 376 REVISED
1 Jan 99

MEDCOM - 13680

*U.S. GPO: 2002-729-180/40137

HESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

28_ DAYS MOS [✓ YRS] Sex (✓) MALE ( ) FEMALE

ED PROCEDURE: I&D (L) foot GSW
L SERVICE: Ortho
CE: NPO p MN

ASA Physical State 1 [✓ 2] 3 4 5 E
WT: 80 KG/LB HT: ____ IN.
ALLERGIES: NKDA

CO: (+)
OH: (+)
GS: ____

T MEDICATIONS:
red as premed
Ancef
motrin

CATIONS:
(@ ____ Hrs) /CC
LR ____ mg IV IM PO
____ mg IV IM PO
____ mg IV IM PO

TORY STUDIES:
____ / ____

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:		
Hypertension	[✓ N] Y	[redacted] (b)(6)-2
Angina	[✓ N] Y	
MI	[✓ N] Y	
CVA	[✓ N] Y	
Other	[✓ N] Y	
Pulmonary System:		
Asthma	[✓ N] Y	
Bronchitis/URI	[✓ N] Y	
COPD	[✓ N] Y	
Other	[✓ N] Y	
Renal System:		
Acute/Chronic RF	[✓ N] Y	
Gastrointestinal:		
Hepatitis	[✓ N] Y	
Hiatal Hernia	[✓ N] Y	
PUD/GERD	[✓ N] Y	
Endocrine System:		
Diabetes	N Y	
Steriods	N Y	
Thyroid	N Y	
Neurological:		
Seizures	N Y	
Neuropathy	N Y	
Other	N Y	
Gynecological :		
Pregnancy	N Y	NA
Other Significant Hx:		
	N Y	GSW (L) foot, shot
	N Y	while trying to steal
Familial HX	N Y	car —

ASSESSMENT
PAST SURGICAL/ANESTHETIC
0

PHYSICAL EXAMINATION
BP 118/76 HR 56 R 22 T 96.4
Pain Scale 0-10 ____
HEENT - Teeth Intact Poor condition —
Trachea midline
TMJ/Neck Oral 3FB TM 3FB
Oropharnyx ____
Nares ____
CHEST: RRR
CARDIAC: CTA
EXTREMITIES:
IV Access: ____
Ulnar Filling: ____
BACK: ____
OTHER: ____

NPO Since MN

ETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ____ [✓ { } General]: Mask Intubation
Questions asked c assistance of interpreter prior

D CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to a
with the patient/legal guardian.

(b)(6)-2
nt/legal [redacted] to understand and agrees. Questions answered.
Date: 7/6/03 Time: 1000 Hrs

ESTHESIA EVALUATION AND NOTE (NON ASU)
PARENT ANESTHETIC COMPLICATIONS { } OTHER

____ Date: ____ Time: ____ Hrs

SEDATION KEY:

1. MINIMAL (Anxiolysis) Patient responds normally to verbal commands
2. MODERATE (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is no necessary.
3. DEEP SEDATION/ANALGESIA. Patient responds purposefully following repeated or painful stimulation. Airway assistance may

entification: (Ward) ICW2 - ICU2

[redacted] (b)(6)-4

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
EPW # [redacted]
(b)(6)-4

NURSING UNIT: ICW2
ROOM NO.:
BED NO.:

DATE OF ORDER: 4Jul 03
TIME OF ORDER: 0930 HOURS
LIST TIME ORDER NOTED AND SIGN

✓ Admit: ICW 2
✓ (L) Ankle GSW Fx
✓ Stable
✓VS per unit
Act: Bedrest ō
Leg Elevate (L) LE
~~Reg Diet~~

PATIENT IDENTIFICATION
(b)(6)-2 [redacted]

NURSING UNIT
ROOM NO.
BED NO.

DATE OF ORDER
TIME OF ORDER ______ HOURS

NPO
✓IV: LR @ 100cc/hr
✓Meds: Ancef 1gm IV q8°
✓MSO4 2mg IV q2° prn
Percocet ii PO q4h prn
✓Motrin 800 PO TID
✓For OR Surgery or Later today

PATIENT IDENTIFICATION

NURSING UNIT
ROOM NO.
BED NO.

DATE OF ORDER
TIME OF ORDER ______ HOURS

✓ If we do any [illegible]

(b)(6)-2 [redacted]

4JUL03

PATIENT IDENTIFICATION

NURSING UNIT
ROOM NO.
BED NO.

DATE OF ORDER
TIME OF ORDER ______ HOURS

MEDCOM - 13682

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
EPW [redacted]

NURSING UNIT: ICW2
ROOM NO.:
BED NO.: 19

DATE OF ORDER: 6 Jun 03
TIME OF ORDER: 1130 HOURS

Trnsfr PACU → ICW2
s/p I&D (L) Ankle GSW Rx
[illegible]
(b)(6)-2 [redacted] noted
Resume preop meds
Rx [illegible]

LIST TIME ORDER NOTED AND SIGN: 1500

PATIENT IDENTIFICATION
EPW [redacted]

NURSING UNIT: ICW2
ROOM NO.: 24°/s
BED NO.: 19 0000 09 Jun 03

DATE OF ORDER
TIME OF ORDER
HOURS

Plan: Trnsfr to DHA 7 Day
p SR [redacted] noted

(b)(6)-2

PATIENT IDENTIFICATION
EPW [redacted]

NURSING UNIT: ICW2
ROOM NO.:
BED NO.: 19

DATE OF ORDER: 12 Jul 03
TIME OF ORDER: 0750 HOURS

Clotrimazole cream apply to affected area TID

noted 12 July 0740

[redacted]

PATIENT IDENTIFICATION
EPW [redacted]

NURSING UNIT: ICW2
ROOM NO.:
BED NO.: 19

DATE OF ORDER: 12 Jun
TIME OF ORDER: 1300 HOURS

SR/SS (b)(6)-2 [redacted] noted
SIWC
DC to DHA

[redacted]

12 Jun 03
1520

(b)(6)-4

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

[redacted]

MEDCOM - 13683

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

EPW

[redacted] (b)(6)-4

NURSING UNIT: ICW2

ROOM NO.: 24/5222

BED NO.: 19

↓

DATE OF ORDER: 12Jul03

TIME OF ORDER: 2115 HOURS

LIST T ORDE NOTED SIGN

① DC ancef

② Keflex 250mg PO

Q1D per Dr [redacted]

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

noted

2100

13 July 03 [redacted]

PATIENT IDENTIFICATION

NURSING UNIT

ROOM NO.

BED NO.

DATE OF ORDER

TIME OF ORDER

HOURS

PATIENT IDENTIFICATION

NURSING UNIT

ROOM NO.

BED NO.

DATE OF ORDER

TIME OF ORDER

HOURS

PATIENT IDENTIFICATION

NURSING UNIT

ROOM NO.

BED NO.

DATE OF ORDER

TIME OF ORDER

HOURS

DA FORM 1 APR 79 4256

REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 13684

CLINICAL RECORD | **THERAPEUTIC DOCUMENTATION CARE PLAN** *(NON-MEDICATION)*
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.
Mo. July *Yr.* 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 4 5 6 7 8 9 10 11 12 13
4 July	[redacted]	vitals: per routine	06 14 22	[redacted]
4 July	[redacted]	Activity: Bedrest c̄ ice/ elevate (L) LE	06 22	[redacted] D/C'd [redacted] see below
4 July 6 Jul	[redacted]	Diet: NPO→Δ'd to Regular diet	07 11 17	[redacted] DC'd per [illegible] 9/10
~~10~~	[redacted]	~~Activity: may SS~~ ~~[illegible]~~		(b)(6)-2 [redacted]
10	[redacted]	Pt. may ambulate c̄ crutches	05 13 21	✓ ✓ ✓ [redacted]

(b)(6)-2

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: (L) ankle GSW fx

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ________

PATIENT IDENTIFICATION:

EPW # [redacted] (b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 EDITION OF 1 DEC 77 MAY BE USED. USAPA V1.00

MEDCOM - 13685

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo July *Yr* 2003

Verify by Initialing

(b)(6)-2

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
4 July	[redacted]	Admit to ICW2:	—	—	—	[redacted]
4 July	[redacted]	condition stable	—	—	—	[redacted]
4 July	[redacted]	For OR 5 July or later today if we do	4 or 5 July			[redacted]
		any cases			Well	
6	[redacted]	transfer PACU → ICW2	6	1230	—	
6	[redacted]	resume preop orders	6	1230	—	
6	[redacted]	Plan: transfer to dist 7d p̄ suture	—	—	—	
		removal and casting	noted			[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING COMPLETION* TIME/DATE COMPLETED													

(b)(6)-2

USAPA V1.00

MEDCOM - 13686

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. July *Yr.* 03

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION !

VERIFY BY INITIALING

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 4	5	6	7	8	9	10	11	12	13					
4 July 6 Jul	[redacted]	~~IV: LR @ 100cc/hr~~ HL	06 14 22	[redacted]										DC'd 12 Jul 03				
4 July	[redacted]	Ancef 1gram IV q 8°	8 16 24	[redacted]										DC'd 12 Jul 03 [redacted]				
4 July	[redacted]	Motrin 800mg PO TID	06 14 22	[redacted]										DC'd				
12 July	[redacted]	Clotrimazole cream: apply to affected area TID	06 14 22									[redacted]		13 Jul 03				
12	[redacted]	Keflex 250mg PO QID - see outpt. meds	06 12 18 24									[redacted]		[redacted]				

(b)(6)-2

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: (L) ankle GSW fx.

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ______

PATIENT IDENTIFICATION:

EPW # [redacted] (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

USAPA V1.00

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

MEDCOM - 13687

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*	Mo. July Yr. 03

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

(b)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* TIME/DATE DISPENSED
4 July	[redacted]	MSO4 2mg IV q2° PRN	
-----	-----		
4 JUL -03	[redacted]	PERCOCET ii PO Q	DC'd [redacted] 13 Jul 03
-----	-----	4 h prn	(b)(6)-2
-----	-----		
-----	-----		
-----	-----		
-----	-----		
-----	-----		
-----	-----		
-----	-----		
-----	-----		
-----	-----		

USAPA V1.00

MEDCOM - 13688

28y/o

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

OTSG APPROVED *(Date)*

REPORT TITLE **Post-Anesthesia Care Unit (PACU) Flow Sheet**

Date: 6 Jul 03
Time In: 1130
Allergies: NKDA
Pre-op V/S: 117/60, 59
Procedures: GSW (L) ankle

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
.5 2mg Versed
250 fent
OR Intake: Crystalloid 800 Colloid —
OR Output: UOP Ø EBL minimal
Meds/Times:

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds

History

Time	1130	1135	1140	1145	1150	1155	1200	1205									
SaO2	96	96	96	95	94	94	95	94									
FIO2	/	/	/	/	/	/	/	/									
Methods	RA	RA	RA	RA	RA	RA	RA	RA									
240																	
220																	
200																	
180																	
160																	
140																	
120		^															
	^		^	^	^	^	✓	✓									
100																	
80																	
	•	•	•														
60	•	✓ •	•	✓	•			^									
	✓		✓	•	✓	✓ •	•	•									
40																	
20																	
RR	10	10	12	12	12	12											
T	97.5					97.1											

Time	1150							
Pain (0-10)	8							
LOS								

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays:

Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	2	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	2	2	2
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	12	12	12

Codes

AIRWAY
A = Ambu
BB = Blow-by
M = Mask
FT = Face Tent
RA = RoomAir
NC = Nasal Cannula

V/S
X = A-line BP
˅ = Cuff BP
= Pulse

TEMP
S = Skin
O = Oral
A = Axillary
T = Tympanic
R = Rectal

LOS
C = Cervical
T = Thoracic
L = Lumbar
S = Sacral

Patient teaching done; Wound Care, Pain Management,
T, C, & DB,. Incentive Spirometer, Comfort Measures
Safety: SR up X 2, Falls Precautions. Privacy Maintained

(Continue on reverse)

PREPARED BY *(Signature & Title)*
(b)(6)-7 [redacted] SGT 91WM6

DEPARTMENT/SERVICE/CLINIC
ICU 2

DATE
6 Jul 03

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

EPW # [redacted] (b)(6)-7

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

DA FORM 4700, MAY 78 WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) Previous edition is obsolete USAPPC V2.00

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	LUE	+	+	+	B	C	PK
15'	LUE	+	+	+	B	C	PK
30'	LUE	+	+	+	B	C	PK
45'							
60'							
90'							
D/C							

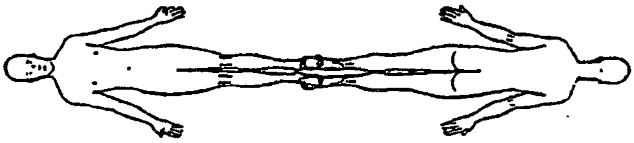
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

	Adm	15'	30'	45'	60'	90'	D/C
Fund. Height							
Lochia							
Peripad#							
Fund. Cond.							

DRESSINGS

Time	Location	Type	Drainage
Adm	ⓛ LE	Soft Splint	0
30'	ⓛ LE	Soft Splint	0
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

1130 Recieved from OR A+Ox3. VSS O2 SAT 96. Able to move LUE ⊕ Pulse. Lungs CTA bilaterally. ⊕ BS x4 Quads. Able to cough & Deep breath. Will Continue to monitor [redacted] 91WM6 SGT (b)(6)-2

1155 Cardiac Rhythm is Sinus brady @ 58 bpm. Non-Symptomatic. No Complaints of pain or discomfort. DRSG ⓛ LE CDI. Will Continue to monitor. [redacted] SGT 91WM6 (b)(6)-2

1210 Report Given to ICW 2. Condition Stable for transport. Recovery time 40 minutes VSS O2 SAT 95% Will Continue to monitor [redacted] SGT 91WM6

(b)(6)-2

Discharge Criteria:
Date: 6 Jul 03 **Time:** 1210 hr **PARS:** 12
BP: 119/60 **T:** 97' **HR:** 59 **RR:** 12 **Sa02:** 95%
Pain Level at D/C (0-10): 0
Intake: 100 **Output:** 0
Additional Data: —
Transferred To: ICW 2
Report Given To: SFC [redacted]
Transferred Via: W/C [✓ Litter] Gurney Ambulance
Transferred By: SGT [redacted]
Cleared IAW Recovery Ro [redacted] **OP B-3**
Charge Nurse Signature:

(b)(6)-2

1. DATE AND TIME OF CAPTURE
2000 3 JUN

2. SERIAL NO. [redacted]

A

3. NAME [redacted]

4. DATE OF BIRTH

5. RANK

6.

(b)(6)-4

7. UNIT OF EPW

8. CAPTURING UNIT
1/1 CAV

9. LOCATION OF CAPTURE (*Grid coordinates*)

10. CIRCUMSTANCES OF CAPTURE
Car theft

11. PHYSICAL CONDITION OF EPW
Shot in Ⓛ foot

12. WEAPONS, EQUIPMENT, DOCUMENTS

(b)(6)-4

---

1. DATE AND TIME OF CAPTURE

2. SERIAL NO. [redacted]

B

3. NAME

4. DATE OF BIRTH

5. RANK

6. SERVICE NO.

7. UNIT OF EPW

8. CAPTURING UNIT

9. LOCATION OF CAPTURE (*Grid coordinates*)

10. CIRCUMSTANCES OF CAPTURE

11. PHYSICAL CONDITION OF EPW

12. WEAPONS, EQUIPMENT, DOCUMENTS

---

1. DATE AND TIME OF CAPTURE

2. SERIAL NO. [redacted]

C

3. NAME

4. DATE OF BIRTH

5. RANK

6. SERVICE NO.

7. UNIT OF EPW

8. CAPTURING UNIT

9. LOCATION OF CAPTURE (*Grid coordinates*)

10. DESCRIPTION OF WEAPONS, SPECIAL EQUIPMENT, DOCUMENTS

12. REASSESSMENT / RÉASSESSMENT

DATE / DATE (YYMMDD) 03703

TIME OF ARR[illegible] D'ARRIVÉE 2[illegible]

TIME / HEURE 2215	T			
BP / PS 119/59	SaO2 96			
PULSE / POULS 59				
RESP / RESP 20				

DATE / TIME
DATE / HEURE

13. CLINICAL COMMENTS / DIAGNOSIS
INFORMATION MÉDICALE / DIAGNOSTIQUES

2nd Bag @ 2235 1000mL LR c̄ 1gm Ancef in Bag

14. ORDERS / ANTIBIOTICS (Specify) / TETANUS / IV FLUIDS
DIRECTIVES MÉDICALES / ANTIBIOTIQUES (Spécifier) / TÉTANOS / IV FLUIDE

Has "punch out" fx. Ⓛ distal fibula w/ entry / exit wounds

A: Distal fibula fx. 2° GSW

P: Evac to CSH for cast vs. possible debridement

(b)(6)-2

581 ASMC

[redacted] MD

DATE / DATE (YYMMDD) 030703

TIME / HEURE 2300

DISPOSITION
- ☐ RETURNED TO DUTY / RETOUR À L'UNITÉ
- ☒ EVACUATED / EVACUÉ
- ☐ DECEASED / DÉCÉDÉ

17. RELIGIOUS SERVICES / SERVICES RELIGIEUX
- ☐ BAPTISM / BAPTISÉ
- ☐ ANOINTING / ONCTION
- ☐ CONFESSION / CONFESSION
- ☐ PRAYER / PRIÈRE
- ☐ COMMUNION / COMMUNION
- ☐ OTHER / AUTRE

CHAPLAIN / CHAPELAIN

DD Form 1380, DEC 91 (Back)

---

1. LAST NAME, FIRST NAME / NOM ET PRÉNOM

RANK / GRADE

☐ MALE / HOMME
☐ FEMALE / FEMME

SSN / NUMÉRO MATRICULE

SPECIALTY CODE / GPM

RELIGION / RELIGION

2. [redacted] (b)(2)-2

FORCE / ÉLÉMENT

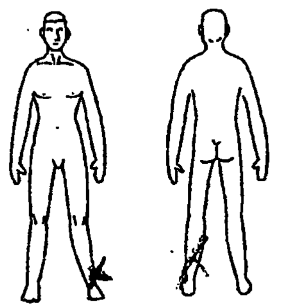
NATIONALITY / NATIONALITÉ IRAQ

A/T AF/A N/M MC/M

BC / BC ☐ NBI / BNC ☐ DISEASE / MALADIE ☐ PSYCH / PSYCH

3. INJURY / BLESSURE

FRONT / DEVANT BACK / ARRIÈRE



- ☐ AIRWAY / TRACHÉE
- ☐ HEAD / TÊTE
- ☑ WOUND / BLESSURE
- ☐ NECK/BACK INJURY / BLESSURE AU COU/AU DOS
- ☐ BURN / BRÛLURE
- ☐ AMPUTATION / AMPUTATION
- ☐ STRESS / TENSION
- ☐ OTHER (Specify) / AUTRE (Spécifier)

GSW

Ⓛ ANKLE

4. LEVEL OF CONSCIOUSNESS / NIVEAU DE CONSCIENCE
- ☒ ALERT / ALERTE
- ☐ VERBAL RESPONSE / RÉPONSE VERBALE
- ☐ PAIN RESPONSE / RÉPONSE À LA DOULEUR
- ☐ UNRESPONSIVE / SANS RÉPONSE

5. PULSE / POULS 120 TIME / HEURE 1932

6. TOURNIQUET / GARROT ☒ NO / NON ☐ YES / OUI TIME / HEURE

7. MORPHINE / MORPHINE ☒ NO / NON ☐ YES / OUI DOSE / DOSE TIME / HEURE

8. IV / IV 500 [illegible] TIME / HEURE 2152

9. TREATMENT / OBSERVATIONS / CURRENT MEDICATION / ALLERGIES / NBC (ANTIDOTE)
TRAITEMENT / OBSERVATIONS / PRESENTE MEDICATION / ALLERGIES / ANTIDOTES

DRESS AND SPLINT WITH BACITRACIN

⊕ DISTAL PULSE AND CAP REFILL

100/52 R: 22

* entrance : Achel. tend. near top of foot

exit : lat ankle

10. DISPOSITION / DISPOSITION 58
- ☐ RETURNED TO DUTY / RETOUR À L'UNITÉ
- ☒ EVACUATED / EVACUÉ
- ☐ DECEASED / DÉCÉDÉ

TIME / HEURE 2152

[redacted] OFFICER MÉDICALE / UNITÉ (b)(6)-2

DATE / DATE (YYMMDD) [illegible]

DD Form 1380, DEC 91 [redacted] previous editions of DD Form 1380 and DD Form 1380 (TEST), which are obsolete.

U.S. FIELD MEDICAL CARD
FICHE MÉDICALE DE L'AVANT ÉTATS-UNIS

1 AN

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF

1	2	3	4	5	6
A	1	1	D	1	▨

2. MTF LOCATION *(State or Country Code.)*

7	8
I	Z

3. REGISTER NUMBER

9	10	11	12	13	14	15
[redacted]						

NAME *(Last, First, Middle Initial)*

(b)(6)-4 (b)(6)-4
EPW [redacted]

4. PAY GRADE

16	17

5. SEX

18
m

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

19	20	21	22	23	24	25	26

7. AGE AT ADMISSION

27	28	29
2	8	y

8. RACE

30
Z

9. ETHNIC BACKGROUND

31
9

RELIGION

unk

10. LENGTH OF SERVICE

32	33	34

ETS

N/A

11. FMP

35	36
9	9

12. SOCIAL SECURITY NUMBER

37	38	39	40	41	42	43	44	45
[redacted]								

ORGANIZATION *(Active Duty Only)*

N/A

13. MARITAL STATUS

46
u

HOUR OF ADMISSION

0930

BRANCH / CORPS

(b)(6)-4
N/A

14. FLYING STATUS

47	48	49

15. BENEFICIARY CATEGORY

50	51	52
[redacted]	[redacted]	[redacted]

16. ZIP CODE OF RESIDENCE

53	54	55	56	57	58	59	60	61

17. UNIT LOCATION *(State or Country Code)*

62	63

18. MOS

64	65	66	67	68	69	70

19. TRAUMA

71

PREV. ADMISSION

YEAR ☒ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION

72
0

WARD

ICW2

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE *(Include ZIP Code)*

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY

[redacted] (b)(2)-2

21. TYPE OF DISPOSITION

73	74
5	0

22. MTF TRANSFERRED TO

75	76	77	78	79	80

23. DATE OF DISPOSITION *(Y Y M M D D)*

81	82	83	84	85	86
0	3				

24. CLINIC SVC - ADMITTING

87	88	89	90
A	E	A	A

25. MTF TRANSFERRED FROM

91	92	93	94	95	96

26. DATE THIS ADMISSION *(Y Y M M D D)*

97	98	99	100	101	102
0	3				

27. LOCATION OF OCCURRENCE *(Battle Casualty Only)*

103	104

28. MTF OF INITIAL ADMISSION

105	106	107	108	109	110

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

111	112	113	114	115	116

FOR LOCAL USE

Dx; Ⓛ ankle GSW fx

Dx: 8911
E9912
Px: 7966

ADMITTING OFFICER *(Signature, as required)* [redacted] (b)(6)-2

Dr [redacted]

SIGNATURE OF ADMITTING CLERK

DA FORM 2985, MAR 90

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER [redacted]
2. NAME (Last, First, MI) EPW [redacted]
3. GRADE N/A
4. SEX m
5. AGE 28y
6. RACE Z
7. RELIGION (b)(6)-4
8. LENGTH OF SVC N/A
9. ETS N/A
10. PREVIOUS ADMISSION No
11. FMP 20
12. SSN [redacted]
13. ORGANIZATION N/A
14. WARD ICW2
15. FLYING STATUS N/A
16. RANK
17. DSG K79
BEN N/A
18. BRANCH/CORPS
19. UIC/ZIP
20. TYPE CASE WIA

ADMISSION REMARKS

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct from ER
22. HOURS OF ADMISSION 1915
23. CLINIC SERVICE AEAA
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE ——
25. TYPE DISPOSITION 50
26. DATE OF DISPOSITION 5 Jul 03
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) ——
27b. TELEPHONE NO. ——
28. DATE OF THIS ADMISSION 4 Jul 03
ADMITTING OFFICER (b)(6)-2 Dr [redacted]
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] (b)(2)-2
30. DATE OF INTIAL ADMISSION
32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED
31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Ⓡ humerous fx

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	2	2

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	2	2

SIGNATURE OF ATTENDING MEDICAL OFFICER [redacted] Dr [redacted]

SIGNATURE OF [redacted] RECORDS OFFICER [redacted]

DA FORM 2985, MAY 79

AUTHORIZED FOR LOCAL R

DICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	admit note: Pt. admitted as boarder only. Pt a&ox3, VSS. ∅ complaints. cast on Ⓡ Arm. good cap refill ⊕ sensation & movement of digits. Pt is to be D/C'd @ 0700 to epw camp. Will cont to monitor — (b)(6)-2 [redacted] 91WM6.
5 Jul 03 0800 122/70 HR 76 RR 16 T 98.0	Pt awake & alert. VSS. NAD. Cast intact to Ⓡ arm, D&G to Ⓡ neck D&I. Lungs CTA & =. Pulses strong & =. BS ⊕ x4. Resting quietly @ present [redacted] (b)(6)-2 MAS/AN6
5 July 03 1315	assumed pt care @ 1300. pt is a boarder. pt awake & alert, VSS. cast to Ⓡ arm ⊕ sensation ⊕ movement <3 sec cap refill. assessment finds WNL. ∅ complaints voiced. will cont to monitor — [redacted] 91WM6 S6T (b)(6)-2

NSHIP TO SPONSOR

SPONSOR'S NAME: LAST | FIRST | MI

SPONSOR'S ID N (SSN or Other)

SERVICE

HOSPITAL OR MEDICAL FACILITY

RECORDS MAINTAINED AT

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.

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record
STANDARD FORM 509

MEDCOM - 13695

NSN 7540-01-075-3786

MEDICAL RECORD	**EMERGENCY CARE AND TREATMENT** *(Patient)*	LOG NUMBER	TREATMENT FACILITY
		RECORDS MAINTAINED AT	

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)* 4 July 03 | TIME 1830

TRANSPORTATION TO FACILITY Aero

SEX M

DUTY/LOCAL PHONE: AREA CODE | NUMBER

AGE ~~[illegible]~~ 28

HOME PHONE: AREA CODE | NUMBER

MILITARY STATUS

ITEM	YES	NO	N/A
PRP			
FLYING STATUS			
MEDICAL HISTORY OBTAINED FROM			

THIRD PARTY INSURANCE

ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2568 IN CHART		
NAME OF INSURANCE COMPANY		

CURRENT MEDICATIONS Ø / Ø Sx Hx

ALLERGIES NKDA

INJURY OR OCCUPATIONAL ILLNESS

ITEM	YES	NO	WHEN *(Date)*
IS THIS AN INJURY?	✓		WHERE
INJURY/SAFETY FORMS	N/A		
HOW			

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INTITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT GSW to Right Humerous

CATEGORY OF TREATMENT

☐ EMERGENT

☐ URGENT

☒ NON-URGENT

TIME

INITIALS

VITAL SIGNS

TIME 1830					
BP 105/66					
PULSE 81					
RESP 14					
TEMP 99.4					
~~WT~~ SaO2 97%					

LAB ORDERS

✓	CBC/DIFF		ABG		PT/PTT		BHCG/URINE/BLOOD/QUANT
	URINE C&S		UA MSCC/CATH			X	CHEM: Mult 7
	BLOOD C&S X						

X-RAY ORDERS

	CXR PA & LAT/PORTABLE		C-SPINE
	ACUTE ABDOMEN		LS SPINE
	SINUS		HEAD CT
	ANKLE R/L	X	Ⓡ Humerous

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
1830	1L LR	[redacted]	[redacted]		
↓	1g Ancef			(b)(6)-2	
↓	Td .5ml				
2030	10mg MSO4		in ER		

DISPOSITION

☐ HOME ☐ FULL DUTY

MODIFIED DUTY UNTIL

DISPOSITION QUARTERS /OFF DUTY

☐ 24 HRS. ☐ 48 HRS. ☐ 78 HRS.

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE

☐ IMPROVED ☐ UNCHANGED

☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

PATIENT'S IDENTIFICATION *(For typed or written entries, give: Name -- last, first, middle; ID no. (SSN or other); hospital or medical facility)*

[redacted] (b)(6)-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

STANDARD FORM 558 (REV. 9-96)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.203(b)(10)
USAPA V1.00

NSN 7540-01-075-3786

MEDICAL RECORD	**EMERGENCY CARE AND TREATMENT** *(Doctor)*	TIME SEEN BY PROVIDER

TEST RESULTS

CBC	WBC H/H PLT	SMAC	
PT			
APTT	BHCG	ETOH	GLU

ABG/PULSE OX		
SUP 02	PH	PO2
PCO2	SAT	OTHER
U/A DIP		
U/A MICRO		

RADIOLOGY	Check if read by radiologist ☐
RESULTS	⊕ Fractured Humerus
EKG INTERPRETATION	

PROVIDER HISTORY/PHYSICAL

25 y/o EPW ♂ c̄ c/o GSW to Right humerous. X 10 DAYS ago pt was shot for Burgerly. Pt has FROM in digits and wrist, ⊕ bounding pulse distal to injury. PT came in Alert X3, no prior surgerys. pt states that he is anemic. GSW was stitched up and pt came with a SAM splint on. 9/10

SGT [redacted]

(b)(6)-2

PE: WD, WN, NAD A&Ox3
Ext: well healed wounds ®, NV↓ FROM wrist/fingers.
NO compartment [illegible]

(b)(6)-2

Pt seen + examined by ortho Dr [redacted] - Hangig Arm CAST

A/P Hangig Arm cast. Return to ER w [illegible] c̄

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP

[redacted]

DIAGNOSIS

® Arm Humerus Fx, 10 Days old

CODES (b)(6)-2

PATIENT'S IDENTIFICATION *(For typed or written entries, give: Name -- last, first, middle; ID no. (SSN or other); hospital or medical facility)*

[redacted] (b)(6)-4

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

STANDARD FORM 558 (REV. 9-96)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.203(b)(10)
USAPA V1.00

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY	1	2
POST- DAY		
MONTH-YEAR 008 / 19 2003 — DAY	424	5
HOUR	21 3	
	1.8 60	

PULSE (O)	TEMP. F (•)	TEMP. C
	105°	40.6°
180	104°	40.0°
170	103°	39.4°
160	102°	38.9°
150	101°	38.3°
140	100°	37.8°
130	99°	37.2°
	98.6°	37.0°
120	98°	36.7°
110	97°	36.1°
100	96°	35.6°
90	95°	35.0°
80		
70		
60		
50		
40		

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD	11 66
BLOOD PRESSURE	120/80 120/60
HEIGHT: WEIGHT →	
	96% RA

Record special data only when so ordered

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*

REGISTER NO.

WARD NO. ICU2

EPW [redacted] (b)(6)-4

VITAL SIGNS RECORDS

Medical Record

STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 13698

(b)(6)-2

Ward/Section: Emr

QUESTING PHYSICIAN: [redacted]

LAST, FIRST, MI [redacted]

DATE 7/4/03

TIME

TRY RESULT FORM

ect to the Privacy Act of 1974)

SSN/PSEUDO SSN: [redacted] (b)(6)-4

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		Negative
Drug of Abuse		Negative
		Negative
		Negative
		Negative

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		20-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU	145	73-118 mg/dl
BUN	11	7-22 mg/dl
CRE	1.1	0.6-1.2 mg/dl
CK	234	39-380 u/l (M) 30-190 u/l (F)
NA^{+}	130	128-145 mmol/l
K^{+}	4.0	3.3-4.7 mmol/l
CL^{-}	106	98-108 mmol/l
tCO_2	23	18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^{+}		128-145 mmol/l
K^{+}		3.3-4.7 mmol/l
CL^{-}		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA^{+}		128-145 mmol/l
K^{+}		3.3-4.7 mmol/l
CL^{-}		98-108 mmol/l
tCO_2		18-33 mmol/l

REMARKS:

REPORTED BY: [redacted]

DATE: 4 Jul 03

LAB ID NO.:

(b)(6)-2

Ward/Section: Unit 7

REQUESTING PHYSICIAN: [redacted] (b)(6)-2

ORATORY RESULT FORM
to the Privacy Act of 1974)

LAST, FIRST, MI [redacted] (b)(6)-2

DATE 7/4/03

TIME

SSN/PSEUDO SSN: [redacted] (b)(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	6.8	4.8-10.8 x 10^3
RBC	5.54	4.7-6.1 x 10^9
Hgb	13.7	14-18 g/dl (M) 12-16 g/dl (F)
Hct	46.7	42-52% (M) 37-47% (F)
MCV	84.3	80-94 fl (M) 81-99 fl (F)
Plt	516	130-500 x 10^3 verified
Lymph %	25.3	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] (b)(6)-2

DATE:

LAB ID NO.:

MEDCOM - 13700

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

[redacted]

EPW

NURSING UNIT: ICW2
ROOM NO.:
BED NO.: 2

DATE OF ORDER: 04 July 03
TIME OF ORDER: 1915 HOURS
LIST TIME ORDER NOTED AND SIGN

Admit to ICW #2
Dx: Ⓡ Humerus Fracture
Condition: Stable
Vitals per routine (b)(6)-2
All: NKDA
Meds: ~~250mg po ⊙~~
650mg Tylenol po. Q6° prn

[redacted] 2030

PATIENT IDENTIFICATION

EPW

[redacted]

NURSING UNIT: ICW2
ROOM NO.:
BED NO.: 2

DATE OF ORDER:
TIME OF ORDER: HOURS

Diet: Regular
Activity: As tolerated.
Nursg: Fill prescriptions for motrin + Keflex
Discharge patient @ 0700 and
Return him to EPW camp.
- Pt is a Boarder only (b)(6)-2

[redacted]

PATIENT IDENTIFICATION

EPW

[redacted]

NURSING UNIT:
ROOM NO.:
BED NO.:

DATE OF ORDER:
TIME OF ORDER: HOURS

PATIENT IDENTIFICATION

EPW

[redacted]

NURSING UNIT:
ROOM NO.:
BED NO.:

DATE OF ORDER:
TIME OF ORDER: HOURS

(b)(6)-5

MEDCOM - 13701

CLINICAL RECORD | **THERAPEUTIC DOCUMENTATION CARE PLAN** *(NON-MEDICATION)*
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.
Mo. 7 Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 4	5	6	7
4	[redacted]	vitals per routine	06	/	[redacted]		
			14	/			
			22	[redacted]	–		
			/				
4	[redacted]	diet-regular	07	/	[redacted]		
			11	/			
			17	/			
			/				
4	[redacted]	activity: as tol	06	/	[redacted]		
			14	/			
			22	[redacted]			

(b)(6)-2

(b)(6)-2

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: (R) humerus fx

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
PAGE NO: ______

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES
D 8 9 10 11 12 13 14 15
E 16 17 18 19 20 21 22 23
N 24 01 02 03 04 05 06 07

DA FORM 4677, 1 OCT 78 EDITION OF 1 DEC 77 MAY BE USED. USAPA V1.00

MEDCOM - 13702

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*			Mo 7 Yr 2003	
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
4	[redacted]	admit to ICW 2	4th	2100	—	[redacted]
4	[redacted]	Condition stable	4			
4	[redacted]	DC pt. @0700 and return him				
	-----	to EPW camp	5			
4	[redacted]	Pt is a boarder	4	noted		[redacted]

(b)(6)-2

(b)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING COMPLETION* TIME/DATE COMPLETED													
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															

USAPA V1.00

MEDCOM - 13703

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. 7 *Yr.* 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: Ⓡ humerus Fx

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____________

PATIENT IDENTIFICATION:

EPW [redacted] (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 - 13704

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. 7 Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
4	[redacted]	motrin & Keflex prescriptions				
	(b)(6)-2	in pharmacy				

INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION

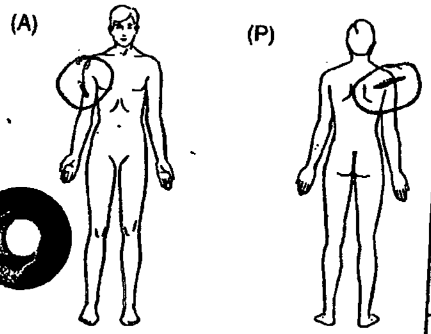
Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	TIME/DATE DISPENSED													
4	[redacted]	Tylenol 650mg PO														
(b)(6)-2		Q6° - prn														

USAPA V1.00

MEDCOM - 13705

DECEASED [redacted] (b)(6)-4

Mass Casualty Incident Tag
©Eastern PA EMS Council - 1997



TIME			
AGE		SEX	
LUNGS			
PULSE			
RESP.			
B.P.			

A	V	P	U

Patient Name (if known) [redacted] (b)(6)-4

Notes/Treatment GS,W TO Ⓡ side Distal to Scapula thrue the Ⓡ ARM possible fracture to Ⓡ humerus with deformity with no range of motion to ARM. Pt has good pulses and Capillary refill

To be given to:
TRANSPORTATION OFFICER

TAG# [redacted] (b)(6)-4

Priority # [redacted] 2 [redacted]

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF						**2. LOCATION**		*(State or Country Code.)*
1	2	3	4	5	6	7	8	
A	1	1	D	1	▨	I	Z	

3. REGISTER NUMBER

9	10	11	12	13	14	15
[redacted]						

NAME *(Last, First, Middle Initial)* (b)(6)-4 EPW [redacted]

4. PAY GRADE

16	17

5. SEX

18
m

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

19	20	21	22	23	24	25	26

7. AGE AT ADMISSION

27	28	29
[redacted]	[redacted]	4

8. RACE

30
Z

9. ETHNIC BACKGROUND

31
9

RELIGION unk

10. LENGTH OF SERVICE

32	33	34

ETS N/A

11. FMP

35	36
9	9

12. SOCIAL SECURITY NUMBER

37	38	39	40	41	42	43	44	45
[redacted]								

ORGANIZATION *(Active Duty Only)* N/A

13. MARITAL STATUS

46
u

HOUR OF ADMISSION 1915

BRANCH / CORPS (b)(6)-4 N/A

14. FLYING STATUS

47	48	49

15. BENEFICIARY CATEGORY

50	51	52
K	7	9

16. ZIP CODE OF RESIDENCE

53	54	55	56	57	58	59	60	61

17. UNIT LOCATION *(State or Country Code)*

62	63

18. MOS

64	65	66	67	68	69	70

19. TRAUMA

71

PREV. ADMISSION

YEAR

☒ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION

72
0

WARD 1CW2

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE *(Include ZIP Code)*

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] (b)(2)-2

21. TYPE OF DISPOSITION

73	74
5	0

22. MTF TRANSFERRED TO

75	76	77	78	79	80

23. DATE OF DISPOSITION *(Y Y M M D D)*

81	82	83	84	85	86
0	3	0	7	2	5

24. CLINIC SVC - ADMITTING

87	88	89	90
A	E	A	A

25. MTF TRANSFERRED FROM

91	92	93	94	95	96

26. DATE THIS ADMISSION *(Y Y M M D D)*

97	98	99	100	101	102
0	3	0	7	0	4

27. LOCATION OF OCCURRENCE *(Battle Casualty Only)*

103	104

28. MTF OF INITIAL ADMISSION

105	106	107	108	109	110

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

111	112	113	114	115	116

FOR LOCAL USE

Dx: Ⓡ humerous fx

Dx: 81230
E9912
Px: 7961

ADMITTING OFFICER *(Signature, as required)* (b)(6)-2 [redacted]

SIGNATURE OF ADMITTING CLERK Dr [redacted] [redacted] 91618, PFC

DA FORM 2985, MAR 90

MEDCOM - 13707

INPATIENT TREATMENT RECORD COVER SH

use of this form, see AR 40-400; the proponent agency is O

1. REGISTER NUMBER: [redacted]
2. NAME (La... ...d): EPW [redacted]
3. GRADE: N/A

ADMISSION REMARKS

4. SEX: M
5. AGE: unk
6. RACE: Z (b)(6)-7
7. RELIGION:
8. LENGTH OF SVC: N/A
9. ETS: N/A
10. PREVIOUS ADMISSION: No
11. FMP: 99
12. SSN: [redacted]
13. ORGANIZATION: N/A
14. WARD: ICW4
15. FLYING STATUS: N/A
16. RATING/OSG:
17. DEPT/BEN: K78
18. BRANCH/CORPS: N/A
19. UIC/ZIP:
20. TYPE CASE: WIA
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: Direct from ER
22. HOURS OF ADMISSION: 1430
23. CLINIC SERVICE: AEAA
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: ——
25. TYPE DISPOSITION: 50
26. DATE OF DISPOSITION: 26 Aug 03
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): ——
27b. TELEPHONE NO.: ——
28. DATE OF THIS ADMISSION: 5 Jul 03

ADMITTING OFFICER

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted] (b)(2)-2
30. DATE OF INTIAL ADMISSION:
32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED:
31.

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

GSW (R) Femur fx

821.11
E991.2

7/5	79.25
	78.15
7/13	79.65
	93.59
7/21	79.65
8/4	79.95
	93.57

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	51	51

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	51	51

SIGNATURE [redacted] MEDICAL OFFICER (b)(6)-2

SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

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

DA FORM ... MAY 78

ACLU-RDI 1592 p.1602

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

PERTINENT HISTORY, CHIEF COMPLAINT, AND CONDITION ON ADMISSION *(Enter date of admission)*

40 y/o [illegible] s/p GSW
cc: Ⓡ thigh pain [illegible]
HPI: Shot in Aggravated Assault / Burglary
PMH ∅
meds ∅
NKDA

PHYSICAL EXAMINATION

WDWN [illegible] NAD
[illegible]
[illegible]
[illegible]
[illegible]

Ⓡ LE in thigh c̄
Thru And thru
[illegible] D/3 lat [illegible]
NV Ⓘ mvt Ⓘ
2+ pul

PROGRESS *(Enter date of discharge and final diagnosis)*

A/ Ⓡ mid shaft femur Fx [illegible] mid shaft femur Fx
P/ Ⓡ femur Ex Fix

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

DATE [illegible]

IDENTIFICATION NO.

ORGANIZATION

PATIENT'S IDENTIFICA[redacted] *(For typed or written entries give Name last, first, middle; grade; date; hospital or medical facility)*

REGISTER NO.

WARD NO.

EPW [redacted] (b)(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
USAPPC V1.00

(b)(6)-2

8-25-03 1640 Pt. refi d cleocin. [redacted] CPTAN

1942 Discussed pt's refusal of care c MD. If pt. is compliant c care, MD will D/C to camp tomorrow. Pt. is aware of plan [redacted] CPTAN

(b)(6)-2

2200 98.0
88
20
100%
118/74

26Aug03 0015 assumed care @ 2200 - VSS - took 2400 abx as ordered - dsgs intact on pin sites, sutures in thigh wound intact, neuro √'s WNL in ② foot - pt. expressed desire to be discharged since he feels his surgeries have been unsuccessful (b)(6)-2 [redacted] CPTAN

0400 Pt vitals BP 108/61 P 78 T 99.6 R 14 SpO₂ 99 SPC [redacted] 91I

0315 - Pt alert c oriented lying in bed. C/o pain, gave percocet ii. VSS, lungs CTA, BS⊕, pulses ⊕ x4. Ext fix intact to Ⓡ leg. Pt wishing to get D/C to camp today. Will cont to monitor (b)(6)-2 [redacted] 2Lt

0826 pt. care assumed @ 1400. HR Reg, lungs CTA, BS ⊕ x4. Pt. performed self pin-care and self drsg Δ. Ex-fix to Ⓡ leg intact, drsg to pin sites CDI. Ⓡ lext. NV checks WNL. pt. awaiting D/C to camp. Will cont. to monitor (b)(6)-2 [redacted] 1LT AN

26Aug03 2200
98.3
83
24
100%
122/71
∅

27Aug03 0015 assumed care @ 2200 - VSS - no c/o pain @ this time - dsg intact on Ⓡ ex fix pin sites - neuro √'s WNL in Ⓡ foot - pt. to be d/c'd to EPW camp today - DC summary in chart [redacted] CPT

27AUG03 0400 P 79, BR 99, BP 103/65, T 96 [redacted] SPC FUQUA 91W
(b)(6)-2

27 Aug03 Pt. awake & alert s̄ complaints @ this time. VSS. AM care completed
1215 HR Regular, lung sounds clear bilat, bowel sounds (+) x4 quads. Pt s̄
IV access. Pt. c/o pain x 1 @ 0800, īī percocet given. Pt. c̄ D/C summary
& order in place, meds @ bedside, awaiting evac to EPW camp. Will
continue to monitor. ——————— (b)(6)-2 [redacted] 2LT/AN

1620 Pt. care assumed @ 1400. Pt stable c̄ ø complaints. HR Reg,
lungs CTA, BS Ⓟ x4. Ex-fix to Ⓡ ↓ ext intact, drsng
to pin sites C.D.I. Neuro vasc. checks Ⓡ ↓ ext WNL. Will
cont. to monitor. ——————— (b)(6)-2 [redacted] 1LT/AN

28Aug03 assumed care @ 2200 - VSS - pt. refused
~~1930~~ 2000 dsg Δ and 2400 dose of cleocin - medicated
0250 for pain @ 0215 c̄ 800 mg motrin PO - pt. to be dc'd
to EPW camp @ 1800 28Aug03 [redacted] CPT/AN
(b)(6)-2

EPW# [redacted] (b)(6)-4

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
7/4/03/	0500 Assume care. Report given. (b)(6)-2
	See initial assessment ~~for~~ [redacted]
	0630 5mg MSO4 IVP. for leg pain [redacted]
	0700 pt asleep. VSS. Ø distress
	noted [redacted]
	0800 pt ate s difficulty.
	1030 VSS. Ø distress. leg (R) warm
	able to wiggle toes s difficulty. oozing
	from the wound. +2 pulse noted [redacted]
	1250 Drsg remains intact. area
	cleansed around ext. fix. [redacted] (b)(6)-2
	1510 Assist partial bath. new
	linen along c clean shirt on [redacted]
1600/	denies any pain @ this time
	1730 07 Jul 03 - Resumed care of patient. VSS (NM) Ø pain
	<3 sec cap refill, cool to touch, (B) pulses + (R) LE.
	[redacted] RN
	(b)(6)-2

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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

EPW [redacted] (b)(6)-4

7/4/03

PROGRESS NOTES
Medical Record
STANDARD FORM 509 (REV. 5/1999)
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USAPA V1.00

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
8 Jul 03	pt A/O, VSS; assessment complete; distal pulses palpable;
0600	VS: 135/71, 83, 16, 92% RA, 98.3 [redacted]
0830	pt tolerated breakfast; MSO4 for pain. (b)(6)-2
0945	UOP 800; no chge in status
1100	no chge in status; ~~to~~ MSO4 5mg 1400 for pain; UOP 1000 cc
	tolerated lunch well [redacted] (b)(6)-2
1100:	126/68, 89, 12, 96%; 99.3 CPT
1835-8 July 03	Rpt Received, physical assessment Completed + Recorded on physical assessment Form, (R) PIV Flushed IV D/Ced, (L) PIV Flushed, pt consumed 90% evening meal, 250cc po Fluid [redacted] CPT/[illegible]
2000-8 July 03	Pt ↑ Chair c̄ 2x Assists, (b)(6)-2 Some Bleeding Noted From Lower Pin site, Oriented to crutches, c/o pain 2Mg MSO4 IV Given [redacted]
2200-8 July 03	Pin Care Completed with 1/2 strength Hydrogen peroxide [redacted] (b)(6)-2

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

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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

[redacted]

PROGRESS NOTES
Medical Record
STANDARD FORM 509 (REV. 5/1999)
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:DICAL RECORD | PROGRESS NOTES

DATE	NOTES
15Jul03 21:42	Rec'd c/o pt. @21:00. Awake and alert in bed. Restraints x2 Ⓡ wrist Ⓛ ankle. PERRLA⊕. Skin color WNL. LCA Ⓑ. BS⊕x4. ⊕PPP Ⓑ. Ⓡ Δ ext. fix in place ⊕ sxs infection @ pin sites. ⊕redness ⊕swelling ⊕drainage. ⊕ROM to toes. ⊕ <3sec cap refill. sutures to Ⓡ thigh intact. c/o pain x1. ii Percocet given. Will cont. to mon (b)(6)-2 [redacted] /AN (b)(6)-2
0320	c/o pain in Ⓡ leg x1. ~~tor~~ ii Percocet given will mon [redacted] /AN
0540	Pt. care assumed @ 0500. Pt. awake, resting quietly. HR Reg, Lungs CTA throughout. BS ⊕ x4, ABD soft, flat. Ⓡ ex-fix to femur intact. 1+ edema noted to Ⓡ femur. Pedal pulses Ⓑ ft 2+ c̄ brisk cap refill, ⊕ROM, ⊕ Sensation Ⓡ LE. Ⓡ leg ↑ on blankets. Pin sites Ⓡ femur OTA s̄ new drainage. Crusted drainage noted at pin sites. Will assist pt. c̄ pin care. Pt. c/o min pain @ this time. (medicated @ 0330). Will cont. to moniter. —— [redacted] LCT/AN
0710	Pt. given ii Percocet for pain Ⓡ LE. —— (b)(6)-2 [redacted] LT/AN
1000	Pt. assisted c̄ pin care. Skin to pin sites 3 & 4 [illegible] adhered to pins, erythema & purulent drainage noted. p̄ pin care, pin sites covered c̄ W→D. —— [redacted] LT/AN (b)(6)-2

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EPW #1 [redacted] (b)(6)-4

PROGRESS NOTES
Medical Record
STANDARD FORM 50!

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CAL RECORD | **PROGRESS NOTES**

NOTES

16July03 - Assumed pt care @ 1300 hrs. Received pt resting comfortably in bed. c̄ N/O c/o pain. VSS. BS in all 4 quads present, c̄ no abdominal distention. Breath sounds are equal on both sides. Pt has good pulse motor function on Ⓡ foot. Minimal amount of swelling noted on Ⓡ foot. Good pedal pulse present (+2). Ⓡ leg elevated 15°. No drainage noted in pin care. No S/S of infection is visible, but will continue to monitor for drainage.

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

17July03 0020 Pt awake c̄ alert in bed s̄ complaints @ this time. HR Reg. Lung sounds clear bilat, bowel sounds slightly hypoactive x4 quads, ABD hard, pt s̄ c/o pain c̄ palpation. DSG to Ⓡ ext. fix on leg CDI. Ⓡ pedal pulses palpable, sensation (+), cap refill <3sec, full ROM. ⓇLE ↑ @ 30°. Pin care done via pt. All other assessment findings WNL. Pt s̄ IV access. Will continue to monitor. (b)(6)-2 [redacted] LTA

0620 pt. care assumed @ 0500. VSS. Pt. c/o min pain @ this time. HR Reg. Lungs CTA, BS⊕ x4. Ex-fix to Ⓡ femur intact, drsng CDI. 1+ edema to Ⓡ thigh. Ⓡ ft c̄ ⊕ sensation, ⊕ ROM, brisk cap refill, pulse 2+. Ⓡ leg ↑ on blanket. Will cont. to monitor (b)(6)-2 [redacted] 1LT AN

0730. ~~Pt. care~~ AB Pt. assisted c̄ pin care. Pin sites 1,2 s̄ drainage. #3 c̄ purulent drainage. #4 ø drainage. Pin sites covered c̄ Kerlix. See diagram over

RELATIONSHIP TO SPONSOR

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PROGRESS NOTES
Medical Record

STANDARD FORM 509
Prescribed by GSA/ICMR FPMR (41CFR) 101

EPW # [redacted] (b)(6)-4

MEDCOM - 13715

ACLU-RDI 1592 p.1609

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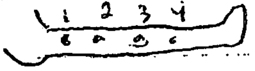
NOTES

7.17 cont. 

. Pinsite #3 c̄ skin breakdown approx. 1cm diameter. (b)(6)-2 [redacted] 1417 AN.

17Jul03 1410 assumed care @ 1300 - VSS - dsg intact on Ⓡ leg ex fix, pinsites covered, stitches above lower pins have small open area c̄ small amt of drainage - c/o small amount of pain will continue to monitor, given 800mg motrin PO (b)(6)-2 [redacted] CRNA

17JUL03 2236 Rec'd c/o pt @ 21:00. VS WNL per flow sheet. Awake and alert in bed. Restraints x2 Ⓛ wrist and ankle. Skin color WNL. PERRLA ⊕ WNL. LCA Ⓑ. BS ⊕ x4. ⊕ PPP Ⓑ. Ⓡ ↓ ext ex. fix intact. Kerlix dsg C/D/I. Pin sites ⊕ Redness ⊕ drainage ⊕ swelling Ⓡ leg. c/o pain x1 ī Percocet given. Will cont to mon

(b)(6)-2 [redacted] 2237/AN

17JUL03 23:31 Pin care done. 3rd and 4th distal pins debrided c̄ Dr. [redacted] guidance. Copious amt pus ~~dp~~ debrided c̄ sterile scissors. Eschar debrided from sutures to outer aspect of thigh. Dr (b)(6)-2 [redacted] to discuss possible washout for 18JUL c̄ surgeons. Ⓡ Thigh cool to touch @ patella hot to touch and tender. Will cont to mon.

(b)(6)-2 [redacted] 2337/AN

0640 Pt care assumed @ 0500. VSS. HR Reg, lungs CTA, BS ⊕ x4. Pt denies pain @ this time. Ⓡ LE ex-fix intact, dsng CDI. Ⓡ LE edematous, hot to touch, appears shorter than Ⓛ leg. Ⓡ LE has pedal pulse 2+ c̄ ⊕ sensation, ⊕ ROM, brisk cap refill. Will cont. to monitor. [redacted] 1417/AN (b)(6)-2

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IEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
7·19	0620 Pt. care assumed @ 0500. VSS. Pt. awake and alert. LR running KVO to Ⓡ AC. IV site CDI s̄ s/s infection. HR Reg, lungs CTA, BS ⊕ x4. ⓇLE ex-fix intact, dsng D/I. ⓇLE ⊕ ROM, ⊕ sensation, pulse 2+, brisk cap refill, 1+ edema, warm to touch. Will cont. to moniter. — (b)(6)-2 [redacted] LT/AN
1900	Assumed care Pt @ 1300. VSS. A+O x3. Ø c/o pain. SL Ⓡ AC c̄ IV ABX patent. Ⓡ Femur EXFIX intact. Drsg c̄ Dry Bld, intact ⊕ sensation, palapable pulse, cap refil <3 sec, mvt toes Ⓡ Foot. O/w assessment WNL. Will Monitor — (b)(6)-2 [redacted]
20 July 0030	Pt. asleep in bed. HR Regular, lung sounds clear bilat, bowel sounds (+) x 4 quads. HL in ⓇAC flushed well with 3cc NS. DSG to Ⓡ femur CDI, pedal pulses palpable, full ROM in ⓇLE digits, (+) sensation. Dr [redacted] (b)(6)-2 or Dr [redacted] wants to Δ the DSG to ⓇLE ext. fix c̄ Iodoform packing. Pt. s̄ complaints @ this time. All other assessment findings WNL. Will continue to monitor. — [redacted] 2LT/AN (b)(6)-2

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

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WARD NO. ICW2

EPW

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509
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	FIRST NAME	MIDDLE INITIAL	ID NUMBER

TE NOTES

7-18-03 0800. MD consulted about drainage from pin sites. CBC drawn, sent, X-Ray order sent. IV started Ⓛ AC. Pin care done c̄ Dakins solution. Mod. purulent drainage noted pin sites #3, #4 (two most distal pins). W-T-D dsng applied two distal pins dry dsng to two proximal pins. ———— (b)(6)-2 [redacted]

0930 Pt. to X-Ray on crutches c̄ assist & gait belt, Pt returned @ 1000 ———— (b)(6)-2 [redacted]

1630 Assumed care of Pt @ 1300. VSS. A+O x3. Ø c/o pain Ⓡ LE EX FIX (Dsg CDI. ⊕ sensation, palpable pulse, mvt of toes, cap refil < 3 sec Ⓡ foot. ⊕ to OR NPO. IV ABX via Ⓛ AC SL ~~...~~ w assess w/ Will Monitor ———— (b)(6)-2 [redacted]

18 Jul 03 Rec'd c/o pt @ 22:00. Returned from OR @ 2200 via

22:53 stretcher. Awake and alert. VS WNL per flowsheet. PERRLA ⊕ WNL Skin color WNL. LCA Ⓑ BS ⊕ x4. ⊕ PPP Ⓑ. Ⓡ thigh ex.fix in place and adjusted. Dsgs to pins intact c̄ bloody drainage 3rd and 4th distal pins. ~~Ø~~ Dsg to underside of Ex.Fix. c̄ moderate amt. Red orange tinged drainage. Ⓡ foot cool to touch ⊕ < 3 sec. cap refill. Ø c/o pain @ ~~first~~ prg this time. Will cont to mon.

(b)(6)-2 [redacted] ~~2LT~~/AN

0330 Reinforced DSG to Ⓡ ex-fix x1 c̄ 4 4x4's and 1 Kerlix wrap d/t copious amt. drainage. Will mon

(b)(6)-2 [redacted] ~~2LT~~/AN

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PROGRESS NOTES

23July 2310 Pt. care assumed @ 2100. VSS. Pt. has Ø complaints. HR Reg, lungs CTA, ABD soft c̄ BS ⊕ x4. Ex-fix to Ⓡ thigh intact, dressings CDI, Ioban intact. Ⓛ thigh edematous, warm to palpation. Ⓡ foot c̄ pulse 2+, ⊕ sensation, ⊕ brisk cap refill. Will cont. to monitor. (b)(6)-2 [redacted] 2LT AN

24July03 0600 Pt. awake & alert sitting up in bed. VSS. HL in Ⓛ FA flushed well c̄ 3cc NS s̄ s/s of infection. HR regular, bowel sounds (+) x4 quads, lung sounds clear bilat. Ⓡ leg ↑ on folded blanket, full ROM in digits & feet pedal pulse palpable, (+) sensation, <3sec cap refill. Pt. s̄ complaints @ this time. All other assessment findings WNL. (b)(6)-2 [redacted] A

24Jul03 2100 assumed care @ 1300 - VSS - medicated for pain c̄ motrin c̄ good results and premedicated c̄ Percocet PO for Ⓡ ex fix pin care - SL patent - ioban intact but leaking serosang, 4x4 placed at leak site, MD aware and 4x4's will be replaced as necessary - neuro V/S WNL in Ⓡ foot (b)(6)-2 [redacted] CPT AN

24Jul03 21:49 Rec'd c/o pt @ 21:00, Restraints x2 Ⓡ wrist Ⓛ ankle. VS WNL per flowsheet. Skin W/D. LCA Ⓑ. BS ⊕ x4. ⊕ PP Ⓑ Ø O2 Ⓛ thigh ex-fix intact c̄ DSD to pin sites and ioban to 4th and

SPONSOR'S NAME	FIRST	MI	SPONSOR'S ID NUMBER

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[redacted] (b)(6)-4

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
25 JULY 2214	Pt. care assumed @ 2100. VSS. HR Reg, lungs CTA, BS ⊕ x4. Ⓡ↓E ex-fix intact, dsngs to pin sites CDI. Bloody drainage noted from pin c̄ Coban. Dsg reinforced w/ABD. Ⓡ↓E edematous c̄ pedal pulse 2+, ⊕ ROM toes, ⊕ sensation, brisk cap refill, will cont. to moniter. —— (b)(6)-2 [redacted] CPT AN
26 July 02	0540 Assume pt care @ 0500. Pt Awake and alert. C/o pain to Ⓡ LE @ Distal pin sites. Dsgs CD+I ex-fix intact. ⊕ pulse ⊕ movement ⊕ sensation below site. HL to Ⓛ FA no s/s redness/infiltration c̄ flush. VSS. HR reg Lungs CTA Abd soft BSx4 Will cont. to monitor —— (b)(6)-2 [redacted] LUMC
	1430 Pt stable at this time. AAOx3. PERRLA. Mucous membranes pink, moist & intact. Neck supple FROM, Lungs CTA bilat, ∅ resp distress. NSR. Abd soft, non-tender, bowel sounds active x4 quads. Ⓡ leg dsg reinforced to Coban due to drainage. Pin care done. Sites swollen red, dsgs wrapped tightly. Wet to dry dsg done to pin on Ⓛ side. Strong pulses and brisk cap refill x4 extremities [redacted] 1LT AN

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

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PROGRESS NOTES
Medical Record

STANDARD FORM 509

EPW # [redacted] (b)(6)-4

MEDCOM - 13720

DATE	NOTES
cont'd.	5th distal pins, Ioban c̄ ~~of~~ sm bloody drainage in pocket. ⊕ ROM ⊕ sensation ⊕ PPP Ⓑ. ō c/o pain @ this time will cont. to mon (b)(6)-2 [redacted] RN/AW
25 July 0515	Pt. awake c̄ alert in bed. HR Regular, Lung sounds clear bilat, bowel sounds (+) x 4 quads. HL in Ⓛ FA s̄ s/s of infection. Ⓡ LE ↑ on folded blanket. Kerlex around pins c̄ DSG to ext fix CDI, pedal pulse palpable, (+) sensation, limited ROM in digits, cap refill <3 sec. Pt s̄ complaints @ this time. Will continue to monitor. (b)(6)-2 [redacted] 2LT/AN
1115	DSGs to pins Δ'd on ext fixater Ⓡ femur. Insertion sites s̄ s/s of infection, Kerlex to pins removed, cleaned c̄ ½ sterile water ½ peroxide Q-tips, rewrapped c̄ Kerlex. Pt. c/o pain, 2 percocets given. (b)(6)-2 [redacted]
1130	Dr. [redacted] notified about status of ext fix. insertion sites, requested to please come by c̄ visualize them. MD agreed to come by this afternoon. (b)(6)-2 [redacted]
25 Jul 03 1945	assumed care @ 1330 - VSS - medicated for pain @ 1800 c̄ ii Percocet PO, Ⓡ ex fix pin care done, W→D dsg placed on pin above knee per Dr. [redacted] instructions - medicated @ 1845 for pain @ pin sites c̄ motrin 800mg PO - SL patent - ioban remains on sutures, 4x4s replaced, serosang drg still present - abx beads to be removed from Ⓡ thigh wound in one wk from 21 Jul per Dr. [redacted] [redacted] CR/AN (b)(6)-2

[redacted] (b)(6)-4

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MEDICAL RECORD | **PROGRESS NOTES**

DATE | NOTES

28Jul03 0020 pedal pulse palpable, cap refill <3sec, pt. states that 3,4,5th
digits are painful c̄ palpation. Insertion sites from ext. fixator c̄
DSG's that are CDI. Pt. c̄ full ROM in Ⓡ foot & digits. All other assessment
findings WNL. Will continue to monitor. (b)(6)-2 [redacted] 2LT/AN

28Jul03 assumed care @ 1300 - VSS - medicated
2030 c̄ ii Percocet PO @ 2000 for dsg Δ -
dsg Δ and wet D packing loosely placed in
wound, Dr. [redacted] saw wound and wants
loose packing in wound - pin care done - jaban
continues to drain serosang fluid, ~~reinforce~~ RS
4x4S replaced near leak in jaban - SL
patent - pt. ambulated to BR c̄ crutches -
had BM today - stitches removed
from wound on thigh, wound healed,
skin open @ site of removed suture 2° to
skin growth on sutures - [redacted] (b)(6)-2

2117 Pt. care assumed @ 2100. HR Reg, lungs CTA, BS ⊕ x4
Ⓡ LE ex-fix intact. Drsngs to pins C/D/I. scant drainage from Jaban.
Ⓡ leg edematous but ↓ from yesterday. Pedal pulse pt c̄ ⊕ sensation, ⊕ ROM toe
brisk cap refill. will cont. to monitor. (b)(6)-2 [redacted] 2LT/AN

7-28-03 0040 IV Δ'd to Ⓛ FA. Ⓡ FA IV D/c'd 2° c/o pain @ site. Hot pack applied [redacted] (b)(6)-2 2LT/AN

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME LAST	FIRST	MI	SPONSOR'S ID NUMBER (SSN or Other)
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WARD NO. BCW 2

EPW [redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509

MEDCOM - 13722

DATE	NOTES
7-26-03	Pt. care assumed @ 2100. VSS Pt c/o pain @
2116	distal pins sites on ex-fix. HR Reg, lungs CTA, BS
	⊕ x4. Ⓡ↓E ex-fix intact. Drsngs to pins CDI. Bright
	red bloody drainage from pin site c̄ Ioban. Site
	reinforced c̄ ABD drsng. Ⓡ↓E c̄ pedal pulse 2+, ⊕ Sensation,
	⊕ ROM toes, brisk cap refill. Ⓡ↓E is warm,
	edematous. will cont. to monitor. (b)(6)-2 [redacted]
27July03	0635 Assume pt care @ 0500. pt Awake and
	Alert. No c/o pain or discomfort @ this time. HL to
	Ⓛ FA no s/o redness/infiltration c̄ flush. VSS.
	HR reg Lungs CTA Abd soft BSx4. Ⓡ LE ex-fix
	intact. Dsg ~~dry~~ intact ⊕ red drainage noted. Red drainage
	noted under Ioban. ⊕ movement ⊕ sensation ⊕ pulse
	below ex-fix. Will continue to monitor (b)(6)-2 [redacted]
	1200 DSG Δ and pin care done @ 0900. Red drainage
	from Ioban and serosang drainage from pin sites
	percocet given for pain @ 0730, no other complaints
	since (b)(6)-2 [redacted]
2245	Pt. care assumed @ 2100. VSS. HR Reg. Lungs CTA, BS ⊕x4.
	Ex-fix to Ⓡ femur intact. Drng to pin sites CDI.
	Some scant amt. bloody drainage from pin-sites c̄ Ioban.
	Site reinforced c̄ ABD. Neuro √s Ⓡ↓E WNL. Ⓡ leg
	edematous, warm to touch. Will cont. to monitor —
	(b)(6)-2 [redacted]
28July03 0600	Pt. awake c̄ alert sitting up in bed. Pt. c/o pain, motrin 800mg
	given. HR Regular, lungsounds clear bilat, bowelsounds ~~clear~~ ⊕ x4 quads
	HL in Ⓡ AC flushed well c̄ 3cc NS s̄ s/s of infection. Ⓡ LE ↑ on folded blanket,

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
23Aug03	1400 - Pt alert + oriented OOB x 1 utilizing crutches
	Physical therapy worked c̄ Pt this AM. VSS,
	lungs CTA, BS⊕, pulses ⊕ x4. Ext fix
	intact to Ⓡ leg. Pin care done by pt.
	Voicing Ø complaints. Will cont to monitor
	(b)(6)-2 [redacted]
23 Aug 03	2100: Assumed care @ 1500. A+Ox3. T-98.1°F P-83 R-16
	BP-108/61 SPO2-100%. HR-regular. Lung sounds clear bilat.
	BSx4, NO c/o pain or discomfort @ this time. Ex fix
	to Ⓡ Femur. Pin care done. Iodoform packing to pins 1, 2 + 4,
	sm amt. serousanguinous drainage noted. ⊕ sensation
	to Ⓡ LE. Will continue \ to monitor. [redacted] 2LT
23Aug03	Pt awake and alert. PERRLA. Lungs CTA (b)(6)-2
2330	bilat; Ø resp distress. NSR. Abd soft, non
	tender, bowel sounds active x4 quads.
	Ex fix to Ⓡ femur intact, dsgs to pin
	sites CDI. Pt encouraged to do active
	ROM to Ⓡ knee. Assisted c̄ ROM to increa
	amt of flexion to knee. Ø complaints [redacted]
24Aug03	Pt A+O x 3 OOB x1 ambulating c̄ physical therapy. (b)(6)-2
1332	VSS; lungs CTA, BS⊕x4, pulses ⊕x4. Ext fix

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. ICW2

EPW
[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(
USAPA

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MEDICAL RECORD	**CHRONOLOGICAL RECORD OF MEDICAL CARE**
DATE	**SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION** *(Sign each entry)*
5 JUL	1600) pt arrived from OR EMT on litter, transferred to
	bed; distal pulses palpable; traction splint in (b)(6)-2
	place; pt A/O x3; See assmnt flowsheet — [redacted]
1713	Pt received from Dayshift Assessment Completed (See Assessment Form)
	VSS. Pt. Denies pain. Request Blanket. — (b)(6)-2 [redacted] PTN
05 July 03	Pt. c/o pain @ (R) leg - 2mg IVP MSO4 given. As
0750	ordered — (b)(6)-2 [redacted] PTN
0300	Pt c/o pain @ (R) leg ~~8mg~~ 5mg IVP MSO4 given PTN
0545	report received from night shift; pt resting @ this time —
0700	medicated for pain; MSO4 5mg IVP [redacted]
0900	tolerated Reg diet this AM (50%). — [redacted]
0933	medicated for pain; MSO4 5mg IVP — [redacted]
1400	no change in status; pin care done; area clean, dry, mild
	drainage, ø hemorrhage; distal pulses palpable; pt
	using PS; MSO4 for during Δ — (b)(6)-2 [redacted]
06 July 03	Rec'd alert/calm/cooperative. Positioned ↑ for dinner. PIV to
1700	RFA patent/benign. (R) ext. fix. intact ~~at~~ Ace drsg intact c̄ scant-
distal/pedal	mod. serosang. drainage. Tol po well ø complaints voiced. See flowsheet
pulses/drsng	for further assessment. — (b)(6)-2 [redacted] Sgt/LPN
07 Jul 03	Pt assessment unchanged. Medicated PRN c̄ effect. relief.
0420	— [redacted] Sgt/LPN
	(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.

EPW [redacted] (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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
9 Jul 03 /	0500 Received report. See report sheet for initial assessment —— (b)(6)-2 [redacted]
	1000 OOB to chair s̄ difficulty [redacted]
	1400 RTN back to bed s̄ difficulty.
	VSS. Ø distress noted —— (b)(6)-2 [redacted]
	1600 VSS. Ø distress noted ——
9 Jul 03	Rpt recieved, physical assessment completed
1914	+ Recorded on Flowsheet, Pin Care Completed [redacted] cpt/AN
	(b)(6)-2
10 Jul 03 /	0500 Report given. See ICU-1 flowsheet
	for initial assessment. —— (b)(6)-2 [redacted]
	0630 5mg MSO4 IVP c/o leg pain.
	® —— (b)(6)-2 [redacted]
	0800 VSS. Ø distress noted.
	1330 OOB to chair, tolerated getting
	up s̄ difficulty —— [redacted] (b)(6)-2
	1430 RTN back to bed c̄ assist [redacted]
10 July 03 1700	Rpt Received [redacted] (b)(6)-2 CPT/AN (b)(6)-2
11 July 03	Received report, Pt tolerated a.m. meal well.
0905	Pt OOB for crutch training. AM care performed.
	Pt c/o pain after crutch training. Medicated c̄ 5mg
	MSO4. Will continue to monitor —— [redacted], LT

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	[redacted]D AT
			(b)(6)-2
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.

EPW [redacted] (b)(6)-4

ICU-1

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
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MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
11 Jul 03	Tolerated lunch meal. OOB to chair. Pt c/o
1400	slight pain. Medicated c̄ 800mg Motrin. for
	pain & inflammation. Pt continues using incentive
	spirometer Q1° while awake. ⊘ other c/o @
	this time. Will continue to assess. — [redacted]
	(b)(6)-2
1800 11 JuL 03	VSS - Ate lock c supper drank 30ml h2o. A&O x 3. Amb length
	of ward x 2. Percocet ii for c/o Ⓡ leg pain. Saline lock
	to Ⓡ FA is patent ⊘ s/s of infiltration. (b)(6)-2 [redacted] 91C20
2200 11 JuL 03	VSS - Amb ward back and forth x1 c̄ ii Assist and crutches.
	Pin care done to Ⓡ Leg. mod. amt of serosangous drainage
	from pins. 3RD Pin from top is reddened c̄ some inflamation. (b)(6)-2
	Restraints tace in place and secure. — SAT [redacted] 91C20
0400 12 JuL 03	VSS - ⊘ further c/o Ⓡ leg pain. Resting quietly c̄ eyes
	closed. Restraints in place and secure. —— SG [redacted] 91C20
0730	Percs for pain; assessment complete; [redacted] (b)(6)-2
0840	pt tolerated breakfast; ambulated c̄ crutches x 10min;
	steady gait; OOB playing cards —— [redacted]
	pin care done; betadine applied to surgical site (b)(6)-2
1200	no change in status; percs for pain ——
12 Jul, 1700	Received pt VSS. c/o pain. 2 percs given. OOB &
	walked around, Pin care done —— (b)(6)-2 [redacted]
0000	Pt slept through most of night. 2 percs given for pain [redacted] CM

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.

E PW [redacted] (b)(6)-7

ICU-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 - 13727

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
13 July 03	0440 - Pt c/o pain. Can't get percocet until 0630. Will notify day shift to talk to doco about pain control. — [redacted] LPN (b)(6)-2
13 July 03 0530	Rec'd report from previous shift, Pt sleeping at this time. VSS, A see flowsheet for pt assessment. [redacted] (b)(6)-2
0730	Pt OOB to chair w/ minimal help, precaution taken for moving (R) thigh ex fix pins no S/S infection [redacted] (b)(6)-2 (b)(6)-2
0800	Pt ate 100% of breakfast, c/o pain ~~[illegible]~~ ii percocet PO, [redacted]
1000	Pt back into bed, sleeping NAD will cont. to monitor. [redacted]
1330	Pt OOB to chair w/ minimal Difficulty, walked down to [redacted] (b)(6)-2
1415	Pin care done, (+) S/S of inf noted, notified Dr [redacted]
	started on Keflex 250 QID x10D. — [redacted]
7.14/0600	Assumed pt care from ICT [illegible], pt resting comfortably in no apparent distress, pt denied any pain @ this time [redacted] RN
	(b)(6)-2 [redacted]
	[redacted]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
			[redacted]
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. ICW 2

[redacted] EPW

(b)(6)-2

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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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	**SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION** *(Sign each entry)*
15 July 03	0630 Received report, Pt. sleeping in bed, no
	distress. Will continue to monitor — [redacted]
	0845 Pt. OOB, self pin care performed using 1/2 hydrogen peroxide (b)(6)-2
	1/2 sterile saline. Pt. ate 100% of Breakfast tray. [redacted] LPN
15 Jul 03	pt. transferred to ICW2 from ICU 1 ambulatory
~~18~~ 1945	in stable condition - VSS - medicated for
BS	pain @ 1800 prior to transfer - pt. received
	@ ~1830 - Ⓡ femur ex fix in place, lower pin
	sites red and serosang drainage noted, upper
	pin sites also red c̄ drainage, sutures on
	outer aspect of thigh intact, sutures on
	inner thigh also intact, small healing
	wound noted on posterior thigh - ∅ IV
	access - neurov's WNL on Ⓡ foot - ⊕ 2
	peripheral pulses in extremeties - lungs CTA Ⓑ -
	BS ⊕ x4 quads - pt. understands and speaks
	small amount of english - [redacted] RN
	(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. ICW2

[redacted]

ICU 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

NSN 7540-00-634-4176

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MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
21 JUL 03	@ 1340. Assumed care of Pt @ 1300. VSS. A+O x3. 0 c/o pain Ⓑ LS CTA ⊕ BS x4 HRR Ⓡ Femur Ex Fix/Drsg ĉ drainage on backside of leg. ⊕ sensation, palpable pulse, cap refill <3 sec, mvt of toes Ⓡ foot. Ⓡ FA PIV patent. Amb ĉ crutches ŝ assistance. O/W assessment WNL. Will Monitor — [redacted] (b)(6)-2 ICW
21 Jul 03	Admi Op Note preop Dx: Ⓡ Femur Fx Infection Procedure: I&D / Tobramycin Bead pouch Surgeon [redacted] (b)(6)-2 EBL = To PACU stable Pass pouch p̄ to chart @ Fosd Dc order
	Pln) Bead x 2wks then consider for ORIF w/ wound improves
	[redacted] (b)(6)-2

HOSPITAL OR MEDICAL FACILITY

STATUS

DEPART./SERVICE

MAINTAINED AT

SPONSOR'S NAME

SSN/ID NO.

RELATIONSHIP TO SPONSO

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. ICW2

EPW # [redacted] (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

MEDCOM - 13730

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
7-20-03	0650: Pt. care assumed @ 0500. VSS. ∅ pain.
	HR Reg, lungs CTA Bilat, ABD soft c̄ BS ⊕ x4.
	HL to Ⓡ AC intact, flushes s̄ diff. Ex-fix to
	Ⓡ thigh intact, drsg CDI. Ⓡ LE c̄ edema +1,
	pulses 2+, warm to touch, ⊕ sensation, brisk cap
	refill. Pt c/o ↓ ROM toes to Ⓡ ft x great toe.
	Will cont. to monitor. (b)(6)-2 [redacted]
1000	MD in to do drsg Δ. Pt. premedicated
	c̄ 4mg MSO4 (b)(6)-2 [redacted]
1340	Assumed care of pt @ 1300. VSS. A+Ox3. ∅ c/o pain.
	Ⓡ Femur EXFIX / Drsg CDI. MD to do DRSG Δ. ⊕ sensation, palpable
	pulse, cap refil <3 sec, moty toes Ⓡ foot. ⊕ 1 Edema Below knee
	Ⓡ LE. PIV Ⓡ FA HL c̄ IV ABX patent. O/W assess
	WNL. Will monitor (b)(6)-2 [redacted]
1900	MD stated no drsg Δ, pt s/c to OR in AM
20JUL03	Recd pt @ 21:00. VS WNL per flowsheet. Restraints
23:33	x2 Ⓛ wrist/Ankle. Awake and alert in bed. PERRLA [illegible]
	LCA Ⓑ. BS ⊕ x4. ⊕ PPP Ⓑ. Ⓡ ↓ ext. ex-fix intact c̄ DSG
	intact mod amt. drainage noted from evening shift. Scant
	amt. exceeded border drawn. c/o pain & 1 T Percocet
	given. Ⓡ FA IV patent. Will cont. to mon [redacted]
	(b)(6)-2
0538	Pt. care assumed @ 0500. Pt. resting quietly. Pt.
	NPO for surgery. HL to Ⓡ FA flushed s̄ diff, ∅ s/s
	infection or infiltration. HR Reg, lungs CTA ABD
	soft c̄ BS ⊕ x4. Ex-fix to Ⓡ femur intact. Drsg c̄
	serosanguinous drainage back of leg. Ⓡ leg edematous
	warm to touch c̄ pulses 2+, brisk cap refill, ⊕
	sensation, ↓ ROM toes. Will cont. to monitor — [redacted]

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STANDARD FORM 600 (REV. 6-97) BACK

(b)(6)-2

NSN 7540-00-634-4176 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
22 July03 0125	Pt. back from OR via litter. Pt. asleep in bed s̄ complaints @ this time. HR regular, Lung sounds clear bilat, bowel sounds (+) x4 quads. Ⓡ leg ↑ on folded blanket, insertion sites on ext. fix appear clean s̄ s/s of infection, DSG CDI, pedal pulse palpable, digits c̄ limited ROM, (+) sensation. HL in Ⓡ FA flushes well c̄ 3cc NS s̄ s/s of infection. ~~Pt.~~ All other assessments WNL. Will continue to monitor. [redacted] AN (b)(6)-2
0535	Assume pt care @ 0500. Pt awake and alert. VSS. HR reg. Lungs CTA. Abd soft. BSx4 Ⓡ thigh c̄ ex-fix intact. Dsg c̄ red drainage Ioban intact. Stitches to inner thigh intact. HL to Ⓡ FA no s/s redness/infiltration c̄ flush. Ⓡ pedal pulse palpable ⊕ movement ⊕ sensation below ex-fix. No c/o pain or discomfort @ this time [redacted]
1330	HL DC'd from Ⓡ FA. New HL placed to Ⓛ FA (b)(6)-2 no s/s redness/infiltration c̄ flush [redacted]
22Jul03 2025	assumed care @1300 - VSS - SL patent - medicated c̄ motrin @1700 for pain c̄ good results - pin care done c̄ H_2O_2, Ioban removed and replaced, Ioban should not be removed again, it is holding beads in wound, serosang. drg small this shift - neuro √'s WNL in Ⓡ foot - [redacted] (b)(6)-2

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

[redacted] (b)(6)-4

RECORDS MAINTAINED AT:			
PATIENT'S NAME *(Last, First, Middle initial)*			SEX
RELATIONSHIP TO SPONSOR	STATUS		RANK/GRADE
SPONSOR'S NAME		ORGANIZATION	
DEPART./SERVICE	SSN/IDENTIFICATION NO.		DATE OF BIRTH

MEDCOM - 13732 OF MEDICAL CARE

STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
7·22·03	2130 Pt. care assumed @ 2100. VSS. pt. resting quietly. Ex-fix to Ⓛ femur intact. Dsng to pin sites CDI ₛ drainage @ this time. Ⓡ leg edematous, warm to palpation c̄ pedal pulse 2+, ⊕ sensation, ⊕ but ↓ ROM toes. Will cont. to monitor. [redacted] /utpar
23July03	0520 Assume pt care @ 0500. Pt Awake and (b)(6)-2 Alert. VSS. HR reg. Lungs CTA Abd soft no tenderness or disension on palpation. BS×4. RLE Ex-Fix @ thigh intact. Dsg's to pins CD+I. Ioban intact sm. amt of red drainage pooling. ⊕ pulse ⊕ movement ⊕ sensation ↓ ex-fix. HL to Ⓛ FA no s/s redness/infiltration c̄ flush. No c/o pain or discomfort @ this time. Will cont. to monitor (b)(6)-2 [redacted] 91wm6
1210	pin care done @ 1000. no signs of infection noted. no drainage from pins. pt c/o pain 800mg motrin given. (b)(6)-2 [redacted] m6
23July03 1930	assumed pt care @ 1300. VSS. pt sleeping easily aroused to verbal stimuli. Lungs CTA, abd soft BS⊕ x4 quads. RLE c̄ ext fix @ thigh, dsing around pins CDI. ⊕ pulse. LLE c̄ full ROM⊕ pulse. BUE c̄ full ROM⊕ pulses. HL to Ⓛ FA ⊖ redness/swelling noted. ⊖ C/O pain/discomfort voiced @ this time. Will cont to monitor -Davis 91wm6
2015	pin care done, ⊖ S/Sx of infection noted. mod amt of red drainage pooling under Ioban. ⊖ C/O of pain voiced @ this time [redacted] 91wm6 (b)(6)-2

*U.S. Government Printing Office: 1996 - 404-763/40001

STANDARD FORM 600 BACK (REV. 5-84)

MEDCOM - 13733

NSN 7540-00-634-4176 AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
290600 JUL 03	NURSING ASSESSMENT: Assumed care of pt. Airway intact, breathing even and unlabored. LS clear to all fields (B). Abd soft, nontender, s̄ distention. BS(+)x4. Voids spontaneously. AROM and neurovascularly intact to (B) UE and (L) LE. (R) LE has ex fix and drsgs to thigh but is neurovascularly intact. ROM to (R) LE limited by pain. Drsg to [illegible] (L) IV to (L) FA [illegible] s̄ s/s infection/infiltration. Flushes well. (b)(6)-2 [redacted]
29 July 03 1500	Pt awake at this time. A&Ox3. PERRLA. Lungs CTA bilat, ∅ resp distress. NSR. Abd soft, non-tender, bowel sounds active x 4 quads. Strong pulses and brisk cap refill x 4 extremities. Drsg to (R) ~~leg~~ groin, leg ex fix changed. Pins clean. Middle pin site packed w/ D. Pins wrapped tightly, minimal drainage noted. Given Percocet for pain (b)(6)-2 [redacted] RN
29 JUL 03 2218	Rec'd c/o pt @ 21:00. Restraints x 2 (R) wrist (L) ankle. VS WNL per flowsheet. Awake and alert in bed. Skin W/D. PERRLA (+) WNL. LCA (B). BS(+)x4. (+)PPP (B). HR Reg S1S2. (R) thigh ex-fix intact. 1st and 2nd Proximal pins c̄ DSD's C/D/I. 3rd/4th distal pins c̄ (+) s/s infection. ~~[illegible] C/D~~ I ntact c̄ (+) pus and serous drainage noted. DSD on anter aspect of thigh C/D/I. (+) sensation (+) ROM (+) strength to foot. c/o sm. amt. pain. Motrin 800 given. will mon [redacted] RN

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	(b)(6)-2
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. ICW 2

EPW [redacted] (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

MEDCOM - 13734

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
30July03	0630 Assume pt care @ 0500. Pt awake and
	Alert. No c/o pain @ this time. VSS. HL to Ⓡ FA
	no s/s redness/infiltration c̄ flush. Ex-fix to Ⓡ LE
	intact. Toban dsg draining used fluid. Dsgs to
-	pins CD+I. HR reg Lungs CTA Abd BSx4. no EPO
	noted. ⊕ movement ⊕ pulse cap refill <3sec below
	exfix. Will continue to monitor ~~(b)(6)-2~~ [redacted] Slump
	1045 pin care and dsg Δ done. proximal pin
	c̄ green drainage. ioban c̄ red drainage. Dsgs CD+I
	(b)(6)-2 [redacted] Slump
30Jul03	Rec'd p/o pt. @ 21:00. Restraints x 2 Ⓡ wrist Ⓛ ankle. Pt.
22:12	awake and alert in ~~pt~~ error bed Skin W/D, PERRLA ⊕ WNL
	LCA ⊕. BS ⊕ x4. HR APTM WNL Reg. Ⓛ AC HL patent. Ⓡ
	thigh ex. fix intact. ~~1st and 2nd dist Proximal pin sites c̄ DSD~~ error EM
	~~C/D/I~~ 5th distal pin site c̄ ioban dsg present c̄ ⊕ drainage.
	All other pin sites c̄ DSD's C/D/I. ⊕ PPP Ⓡ equal @ 2+. ⊕
	sensation ⊕ ROM ⊕ <3sec cap refill Ⓡ foot. ⊗ c/o pain
	@ this time. Will cont. to mon [redacted] 22T/AD (b)(6)-2
310520 Jul 03	Nursing Assessment: Assumed care of pt. Airway intact, breathing even and unlabored, LS clear
	to all fields Ⓑ. Abd soft, nontender, s̄ distention, BS ⊕ x4. Void's spontaneously. FROM and
	neurovascularly intact to Ⓑ UE and LLE. RLE has ex fix to lateral thigh c̄ Toband dsg to distal
	posterior portion of pins. Moderate amt of serosang drng to Toban dsg. Pin sites have minimal
	serosang drng. IV to Ⓛ AC flushes well s̄ s̄ s/s infection or infiltration. [redacted]
31 July03	- Regard PT resting in bed c̄ ⊖ c/o pain or discomfort. VSS (b)(6)-2
1300	Breath sounds clear bilateral. ⊕ ROM on all extremity c̄ ex fix
	to Ⓡ leg CDI. +2 second cap Ref. +BSx4. HL to Ⓛ
	Arm Flushes well c̄ 3 cc. ⊖ s/s of infection to HL. will
	cont to monitor. [redacted] CRN

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(b)(6)-2

STANDARD FORM 600 (REV. 6-97) BACK

NSN 7540-00-634-4176 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
31 Jul 03	Rec'd c/o pt. @ 21:00. Restraints x2 Ⓡ wrist Ⓛ ankle. VS
2253	WNL per flowsheet. Sleeping in bed. Easily awakened.
	Alert. PERRLA ⊕ WNL LCA Ⓑ. BS ⊕ x4. ⊕ PPP Ⓑ. Ⓡ thigh
	exfix intact. 5th pin c̄ Ioban in place. all other pin
	sites c̄ DSD's C/D/I. Drainage, pus and serous noted @
	5th pin site c/o pain @ this time ⊕ sensation ⊕ ROM ⊕ <3
	sec cap refill to Ⓡ foot. will cont. to mon [redacted]
010530 Aug 03	Nursing Assessment: Assumed care of pt. Airway intact, breathing even and unlabored, LS (b)(6)-2
	clear to all fields Ⓑ. Abd soft, nontender s̄ palpable distention BS ⊕ x4. IV to Ⓛ FA flushes well
	and is s̄ s/s infection or infiltration. Voids spontaneously. AROM and neurovascularly intact to Ⓡ UE
	and Ⓛ LE. Ⓡ LE has ExFix x 6 pins c̄ Ioban to ~~thigh~~ Ⓡ lateroposterior portion of thigh. Pins
	are tightly wrapped to act as packing for wounds around pins. Drsgs currently show little drainage,
	serosang, to pins. (b)(6)-2 [redacted]
1 Aug 03	assumed care @ 1300 - VSS - no c/o pain
2030	throughout shift - SL patent - wound @
	pin above knee packed c̄ iodoform soaked in
	saline, 2x2 placed on top, pin care done on
	other pins c̄ H_2O_2, no dsg applied on other
	pins, ioban in place, no drainage noted -
	(b)(6)-2 [redacted] CRNA
01 Aug 03	Rec'd c/o pt @ 21:00. Restraints x2 Ⓡ wrist Ⓛ ankle. VS WNL
22:12	per flow sheet. Pt awake and alert in bed. Skin W/D PERRLA
	⊕ WNL. LCA Ⓑ HR & S1S2. BS ⊕ x4. ⊕ PPP Ⓑ Ⓡ thigh ex-fix in place

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

EPW

[redacted] (b)(6)-4

RECORDS MAINTAINED AT:

PATIENT'S NAME *(Last, First, Middle initial)*		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME		ORGANIZATION
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

CHRONOLOGICAL RECORD OF MEDICAL CARE
MEDCOM - 13736

STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
cont'd	5th distal pin c̄ ioban intact. All other pinsites OTA approximated c̄ pins. ⊖ sxs infection. (R) foot digits ⊕ROM ⊕ plantar flexion/extension ⊕<3 sec cap refill ⊕PPP(B). ⊖ c/o pain @ this time. Will cont. to mon [redacted] 2LT/AN (b)(6)-2
020730 ~~Aug~~ Aug 03	Nursing Assessment: Assumed care of pt. Airway intact, pt's breathing is even and unlabored, LS clear to all fields (B). Abd soft, nontender, s̄ distention. BS⊕x4. Voids spontaneously. FROM and neurovascularly intact to (B) UE and (L) LE. (R) LE ex-fix to (R) lateral thigh, pins are open to air. Minimal serosang drng noted to 1st-3rd distal pins. 4th distal pin has packing of iodoform gauze (serosang drainage noted). 5th distal pin continues to have ioban + beads in place. Ø drng seeping from posterior portion of ioban. 6th distal pin open to air. IV to (L) FA flushes well s̄ s/s infection/infiltration. (b)(6)-2 [redacted]
2 Aug 03 1945	assumed care of pt @ 1300 - VSS - no c/o pain throughout shift - pin care done, wound packed c̄ iodoform/NS saline, scant amount of serosang. drainage noted from 3 pin sites - SL patent - pt. ambulated on ward during shift - ioban remains in place on incision, no drainage noted (b)(6)-2 [redacted] CPT/AN
2 Aug 03 21:12	Rec'd c/o pt @ 21:00. Restraints x 2 (R) wrist (L) ankle. VS WNL per flow sheet. Pt. sleeping, easily awakened. Skin W/D. PERRLA. LOC⊕. HRRS, S1S2 WNL. BS⊕x4 hypoactive. (R) thigh ex-fix inplace 5th distal pin site c̄ Ioban intact. dried bloody drainage noted. All other pins OTA c̄ serous drainage noted ⊖ redness noted. ⊕PPP(B). ⊕<3 sec cap refill ⊕ROM to ankle and digits ⊕ sensation c/o pain x1 ī Motrin 800 given will cont. to mon [redacted] 2LT/AN
0323	Pt c/o pain x 2 ī Percocet given. Will mon [redacted] 2LT/AN (b)(6)-2 (b)(6)-2

*U.S. Government Printing Office: 1996 - 404-763/40001

STANDARD FORM 600 BACK (REV. 5-84)

NSN 7540-00-634-4176 600-108

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
030530 Jul 03	Nursing Assessment: Assumed care of pt. Airway intact, breathing even and unlabored, LS clear to all fields Ⓑ. Abd soft, nontender, s̄ distention, BS⊕x4. Voids spontaneously. ROM and neurovascularity intact to Ⓑ UE and LLE. Ⓡ LE limited ROM at knee 2° pain. Pins to Ⓡ LE ex-fix (thigh) are open to air. 5th pin site continues to be packed c̄ iodoform gauze. Minimal serosang drng to all pins. [redacted]
3 AUG 03 1300	- Received PT sleeping in bed. VSS. HR R. Breathsounds (b)(6)-2 clear bilateral. BSx4. PT has ⊕ ROM to Ⓡ leg ex-fix. ⊕ PMS c̄ cap ref <2 seconds. (HL) to Ⓛ arm flushes well c̄ 3cc NS. Drsg to Ⓡ ex-fix CDI. Will cont to monitor PT. [redacted] (b)(6)-2
3 AUG 03 1700	PT is to be NPO after midnight. [redacted]
2121	Pt care assumed @ 2100. VSS. HR Reg. lungs CTA, BS⊕ x4. Ex-fix to Ⓡ LE intact. Neuro checks Ⓡ LE WNL x̄ edema to Ⓡ Leg. Drsng to Ⓡ LE intact. HL to Ⓛ FA flushed s̄ diff. Pt to be NPO p̄ MN for surgery. Will cont. to monitor. (b)(6)-2 [redacted] TAr
4 Aug 03	0625 Assume pt care @ 0500. Pt awake and alert. percocet for pain. VSS. HR reg lungs CTA. Abd soft BS×4. Ex-fix RLE intact. Dsg CD+I. New HL placed to Ⓡ FA ⊕ flush. NPO for surgery @ this time. Will monitor [redacted] 9lump (b)(6)-2

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

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[redacted] (b)(6)-2

RECORDS MAINTAINED AT:

PATIENT'S NAME *(Last, First, Middle initial)*

SEX

RELATIONSHIP TO SPONSOR

STATUS

RANK/GRADE

SPONSOR'S NAME

ORGANIZATION

DEPART./SERVICE

SSN/IDENTIFICATION NO.

DATE OF BIRTH

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
4 Aug 03 1330	Op Nt Dx ® Femur Fx s/p Ex Fix c̄ Abx Bead placement Rx ① Abx Removal ② I & D ③ Ex Fix Adjustment ④ Knee Manipulation Surgeon Guzman [illegible] (b)(6)-2 [redacted]
4Aug03 1500	pt. returned from Surgery ~1445-VSS-medicated c̄ ii Percocet tabs - ace wrap intact around ex-fix, no drainage noted on dressing, neurov's WNL in ® foot-pt. alert and oriented - SL in ® FA patent, IVF d/c'd, pt. tol. juice & crackers - S/P ex fix readjustment and abx bead removal under general anesthesia - lungs CTA ⓑ - ⊕ BS - ⊕ urine output since surgery, DTV by 2130 — [redacted] CR, AN (b)(6)-2

*U.S. Government Printing Office: 1996 - 404-763/40001

STANDARD FORM 600 BACK (REV. 5-84)

NSN 7540-00-634-4178 600-108

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
8/4/03 2200	Pt. care assumed @ 2100. VSS. HR Reg, lungs CTA, BS ⊕ x4. Ex-fix c̄ Ace wrap to Ⓡ LE intact, C,D. Ⓡ LE c̄ ⊕ sensation, pulse 2+, brisk cap refill. PROM performed Ⓡ knee to approx. 20-30°. will cont. to monitor. —— (b)(6)-2 [redacted] CTAN
5Aug03 0600	Assume pt care @ 0500. Pt awake and alert. temp 99.8 HR reg Lungs CTA Abd soft non tender BS x4 Ⓡ thigh ex fix intact c̄ ace wrap CD+I. ⊕ movement ⊕ pulse ⊕ sensation. Passive ROM performed encouraged pt to do active ROM. HL to Ⓡ FA ⊕ flush s̄ redness/infiltration. Will continue to monitor —— (b)(6)-2 [redacted] 91WM6
5Aug03 1430	assumed care @ 1300 - VSS - dsg Δ'd on Ⓡ exfix, pin care done, W→D dsg placed on 4 pins, 4x4's placed on stitches - medicated c̄ 800mg motrin PO ~~given~~ PRN for pain @ 1400 - neurovasc V'S WNL in Ⓡ foot, ROM done c̄ Ⓡ knee —— (b)(6)-2 [redacted] C.R, AN
5Aug03 2115	Pt care assumed @ 2100 VSS, alert and awake c̄ c/o small amount of pain in le. Lung sounds CTA, pulses ⊕x4, BS ⊕ x4 Exfix on r/e draining small amounts of bloody fluid. Pt c/o pain @ middle pin site and small toe on @ foot. HL on r/e flushes well. will continue to monitor. —— [redacted] 91WM6 (b)(6)-2

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

#[redacted] (b)(6)-4

EPW

RECORDS MAINTAINED AT: ▶		
PATIENT'S NAME *(Last, First, Middle initial)*		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME		ORGANIZATION
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

CHRONOLOGICAL RECORD OF MEDICAL CARE

MEDCOM - 13740

STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
6Aug03	0555 Assume pt care at 0500. Pt awake and alert. No c/o pain or discomfort at this time. VSS. HR reg Lungs CTA Ⓑ. Abd soft non-tender BS×4. Ex-Fix to RLE intact. Dsgs to pins c̄ sm amt of red drainage. ⊕ pulse ⊕ movement ⊕ sensation. HL to Ⓡ FA ⊕ flush s̄ redness or infiltration. Will continue to monitor (b)(6)-2 [redacted] 91WM6
6Aug03 1400	Pt stable. AAO×3. PERRLA. Lungs CTA bilat, Ø resp distress. NSR. Abd soft, non-tender bowel sounds active ×4 quads. Strong pulses and brisk cap refill ×4 extremities Ⓡ leg/knee exercised by PT today c̄ good results. Ø complaints. Ex fix c̄ packing, Dsg CDI. (b)(6)-2 [redacted]
6Aug03 1900	Dsgs to pins Δ'd. Pins not wrapped. Pins packed and wounds at pin sites covered. Ø complaints minimal bleeding at sites p̄ ROM exercises c̄ PT. (b)(6)-2 [redacted]
2215	Pt care assumed @ 2100. VSS, alert and awake c̄ c/o slight pain in mid thigh and toes. Lung sounds CTA, pulses+ ×4, BS+. HL in Rt FA flushes well, IV abx. Pins on rt CDI, ⊕ sensation and ROM. Aggressive ROM done at 2200 s̄ c/o increased pain. Pt c̄ no complaints, will continue to monitor. (b)(6)-2 [redacted]
7Aug03	0605 Assume pt care @ 0500. Alert, VSS. No c/o pain @ this time. HR reg Lungs CTA Abd. soft BS×4. Ex-fix intact. dsgs c̄ sm amt of red drainage. HL to Ⓡ FA ⊕ flush s̄ redness/infiltration. Will continue to monitor [redacted] M6 (b)(6)-2

*U.S. Government Printing Office: 1996 - 404-763/40001

STANDARD FORM 600 BACK (REV. 5-84)

NSN 7540-00-634-4176 600-108

HEALTH RECORD progress ~~CHRONOLOGICAL RECORD OF MEDICAL CARE~~ notes

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
7AUG03 2040	A+Ox3. Ø pain in Ⓡ leg. Motrin 800mg PO given. Dressing Δ to Ⓡ leg done - wet to dry dressings x5. Idoform to 1 pin. Wounds putting out sm. amt. serosanguinous drainage. Stitches to Ⓡ leg clean & intact. Capillary refill to Ⓡ foot good. Pedal [redacted] pulses palpable —— (b)(6)-2 [redacted]
8 Aug 03 0100	Pt care assumed @2100. VSS, 650mg Tylenol given for pain @2200. Lung sounds CTA, pulses ⊕x4, BS+x4 quads. Exfix on rle. CDI. Active rom done @2200. ⊕ sensation, ⊕ rom in rle. IV ABX, will continue to monitor. —— [redacted] (b)(6)-2
080515 Aug 03	Nursing Assessment: Assumed care of pt. Airway intact, breathing even and unlabored, LS clear to all fields Ⓑ. Abd soft, nontender, s̄ distention. BS⊕x4. Voids spontaneously. AROM and neurovascularly intact to ⒷUE, ⓁLE. ⓇLE exfix ē 6 pins, site drsgs are CDI. Neurovascularly intact and ROM limited by pins to knee of RLE. IV to ⓇFA s̄ s/s of infection or infiltration. —— (b)(6)-2 [redacted]
8AUG03 2015	Assumed care @ 1300. VSS. Alert & oriented. Denies pain or discomfort @ this time. Lung sounds clear. BSx4. SL Ⓡ forearm patent. Ⓡ leg fixed ē pins. Dressings Δ'd wet to dry ē Idoform packed in 4th pin. Draining small amt. serosanguinous drainage. Good capillary refill in ⓇLE, sensation present. PPP. (b)(6)-2 [redacted]
2100	Pt. care assumed @ 2100. HR Reg, lungs CTA, BS ⊕x4. ⓇLE ex-fix intact. ⓇLE ē ⊕ROM, ⊕sensation, pulse 2+, brisk cap refill. Will cont. to monitor. —— [redacted]

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

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[redacted] (b)(6)-4

RECORDS MAINTAINED AT: (b)(6)-2

PATIENT'S NAME *(Last, First, Middle initial)*		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME		ORGANIZATION
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

CHRONOLOGICAL RECORD OF MEDICAL CARE
MEDCOM - 13742

STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

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

9Aug03 0745 Assume pt care @ 0500. Pt awake and alert.
C/o pain to Ⓛ thigh @ distal pin sites and to third
thru fifth toe. HL to Ⓡ FA ⊕ flush s̄ redness/infiltratio.
VSS. HR reg Lungs CTA. Abd. soft BSx4. Ex fix to
LLE intact dsg to distal pin c̄ red drainage. percocet
for pain. Will continue to monitor (b)(6)-2 [redacted] 91WMG

9AUG03 2030 Assumed care @ 1300. VSS. Lung sounds clear b/lat, SL Ⓡ FA patent.
c/o pain in Ⓛ leg @ 1330 + 1730, Percocet ii PO given.
Exfix to Ⓛ leg. Dressing Δ done - wet to dry c̄ Idoform to
4th pin. Sm amt. serosanguinous drainage noted. [redacted]

2215 pt care assumed @ 2100. VSS HR reg, lungs CTA (b)(6)-2
BS ⊕ x4. ⓁLE ex-fix intact - Drsngs to pin sites CDI,
s̄ drainage Ⓛ ft, c̄ pulse x4, ⊕ sensation, ⊕ warm brisk
cap refill. Will cont. to monitor. [redacted] CT/AW

10Aug03 0625 Assume pt care @ 0500. pt awake and (b)(6)-2
alert. VSS. HR reg Lungs CTA Abd soft BSx4.
HL to Ⓡ FA ⊕ flush s̄ redness/infiltration. Ex-fix
to RLE intact. Dsgs c̄ sm amt of red drainage.
Pt c/o pain to inner thigh and 3-5 toes. ⊕ pulse
⊕ movement ⊕ sensation. Will continue to monitor 91WMG

10Aug03 1120 pin care done sm amt of drainage noted
from 1st and 4th pin. W→D dsg. [redacted] 91WMG

2126 Pt caught stashing percocet and cigarettes under (b)(6)-2
pillow and mattress [redacted]

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MEDICAL RECORD | PROGRESS ~~CHRONOLOGICAL RECORD OF MEDICAL~~ CARE

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
12 Aug 03 5a–12n	Pt alert and oriented x3. Ate breakfast, Pt medicated [illegible] PO, had pins cleaned and area dressed. Pt performed own AM care. [illegible] rested comfortably during shift. Medicated [illegible] with AB therapy as PO with meds. No S/S of distress — VSS stable [redacted] (b)(6)-2
12 Aug 03 2000	Patient care assumed @ 1300. VSS. Lung sounds clear bilat. BS x4. c/o pain in Ⓡ leg. Motrin 800mg given PO @ 1505. Ex fix to Ⓡ leg. Pin care done – wet to dry dressings c̄ Iodoform to 4th pin. Sm amt. serosanguinous drainage noted. Will continue to monitor. [redacted]
12 Aug 03 2020	No PT done today. Therapist has not come. [redacted]
12 Aug 03 2300	Pt care assumed @ 2100. VSS, A+Ox3, no complaints. (b)(6)-2 Lung sounds CTA, pulses ⊕ x4, DSS. Exfix on rle CDI, sutures CTA. Pt able to wiggle toes and good cap refill. Will continue to monitor. (b)(6)-2 [redacted] 9LWMC
13 aug 03 (b)(6)-2 0.M [redacted] 0610	0559 Assume pt care @ 0500. pt awake and alert. No c/o pain @ this time. VSS. HR reg lungs CTA Abd soft BS x4 last BM yesterday. Ex-fix to RLE intact; drsg to pins CD+I. pt performed active ROM to Ⓡ leg. ⊕ ROM ⊕ sensation below ex-fix. HL to Ⓛ FA ⊕ flush s̄ redness/infiltration — [redacted] 9LWMC

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	REC[redacted] AT
			(b)(6)-2
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.)*

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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 - 13744

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10 Aug. 2313	Pt. care assumed @ 2100. VSS. HR Reg, lungs CTA, BS ⊕ x4. Ⓡ↓ext. ex-fix intact, pin site drsngs CDI s̄ drainage. Ⓡ ft. c̄ ⊕ sensation, ⊕ ROM, brisk cap refill, pulse 2+. Will cont. to monitor. (b)(6)-2 [redacted] LT AN.
11 Aug 03 0900	Pt alert and oriented x3. Pt able to ambulate with crutches at least 20 yds. Pt able to climb back into bed. Pt ate breakfast and after dressing changed to Ⓡ leg with external fix. Neuro done. Pins cleaned and no exudate nor swelling noted around leg. Pt medicated PO for pain. Pt went to bed at 9 AM [redacted]
11 Aug 03 2030	Assumed care @ 1300. VSS. Lung sounds clear bilat. [redacted] BS x 4. Percocet ii premed for PT. Pin care done. Wet-to-dry drsgs c̄ idoform packing to 4th pin. Ex-fix to ⓇLE. Good capillary refill, sensation present. (b)(6)-2 [redacted]
2215	Pt. care assumed @ 2100. VSS. Pt. c/o ∅ pain @ this time. HR Reg, lungs CTA, BS ⊕ x4. Ex-fix to Ⓡ↓E intact. Drsngs to pin sites CDI. NV checks Ⓡ↓E CDI. Will cont. to monitor. [redacted] (b)(6)-2

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MEDICAL RECORD | PROGRESS ~~CHRONOLOGICAL~~ **RECORD OF MEDICAL CARE**

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
13AUG03	2000: Assumed care @ 1300. VSS. Lung sounds clear, BS x4,
	0/10 pain @ 2000. Percocet II PO given. SL Ⓛ FA patent.
	Ex-fix to Ⓡ leg. Pin care done, wet-to-dry c̄ idoform to
	4th pin. Sm. amt. serosanguinous drainage noted. Will continue
	to monitor. (b)(6)-2 [redacted]
2300	Pt. care assumed @ 2100. VSS. HR Reg, lungs
	CTA, BS ⊕ x4. Ex-fix Ⓡ LE intact, dsngs
	to pin sites CDI. Ⓡ ft, c̄ pulse 2+, ⊕ sensation
	⊕ ROM, brisk cap refill. Will cont. to monitor.
	(b)(6)-2 [redacted] 1LT/AN
14Aug03	Pt. asleep in bed easily aroused by verbal stimuli. HR Reg; lungsound
0555	clear bilat, bowel sounds ⊕ [redacted] quads. Ext fix to Ⓡ femur intact, DSG
	(b)(6)-2
	around pin insertion site c̄ sm amt [illegible] reddish, yellow drainage, (+) sensation
	pedal pulse palpable, <3sec cap refill, full ROM in digits c̄ ankle. Pt. s̄
	complaints @ this time. VSS. HL in Ⓛ FA s̄ s/s of infection, flushed well c̄
	3cc NS. All other assessment findings WNL. Will continue to monitor. C. [illegible]
0955	Pt. c/o pain II tylenol given (b)(6)-2 [redacted]
1330	Pt alert and oriented. PERRLA. Lungs CTA bilat,
	Ø resp distress. NSR. Abd soft, non-tender,
	bowel sounds active x4 quads. External fix
	to Ⓡ femur intact. Dsg to pin sites ~~at~~ error CDI.
	Packing to 4th pin. Aggressive ROM to Ⓡ

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. 1CW2

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	leg done by PT. Pt able to bend knee to
	>90° s̄ assist. Given Percocet for pain.
	Ambulating to BR on crutches s̄ assist.
	Strong pulses and brisk cap refill to
	bilat LE. ——— (b)(6)-2 [redacted] LCT/AN
1930	Pin care and drsg Δ's done to ex-fix in Ⓡ
14 Aug 03	femur. H2O2/H2O soln used to clean pins
	and sites. Pins 5 and 6 sites packed c̄
	iodoform gauze, all other pins wrapped
	loosely Ø complaints ——— (b)(6)-2 [redacted] LCT/AN
2300	Care assumed @ 2100. VSS, A+Ox3, 650 mg tylenol given
	for pain @ 2300. Lung sounds CTA, pulses ⊕ x4, BS ⊕.
	ROM done on RLE, slight pain during rom. Pt ambulate
	to BRx1. Exfix site CDI, ⊕ pulse and sensation on rk.
	Will continue to monitor. ——— [redacted]
15 Aug 03	Pt. c/o pain in Ⓡ femur, ii tylenol given. ——— (b)(6)-2 [redacted] LCT AN
0525 0630	Pt. awake ē alert sitting up in bed performing ROM exercises on Ⓡ leg.
	HR Regular, lung sounds clear bilat, bowel sounds ⊕ x 4 quads. Ext.
	fix to Ⓡ femur intact, pin 3 & 4 sites c̄ small amt. of yellowish fluid drain
	⊕ sensation in digits, <3 sec cap refill, full rom in digits & ankle, limited
	ROM in knoe. Pt. s̄ other complaints @ this time. All other assessment
	findings WNL. Will continue to monitor ——— (b)(6)-2 [redacted] LCT/AN
1330	Pt awake and alert. PERRLA. Lungs CTA bilat, Ø resp
	distress. NSR. Abd soft, non-tender, bowel sounds active
	x4 quads. Ex-fix to Ⓡ femur intact. Dsgs to pin sites CDI.
	Pt doing ROM exercises to Ⓡ knee. Strong pedal pulses
	and brisk cap refill to bilat LE. New started to
	Ⓡ FA. Ø complaints ——— [redacted] LCT/AN

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MEDICAL RECORD | Progress notes ~~CHRONOLOGICAL RECORD OF MEDICAL CARE~~

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1830	DSG Δ to ex-fix pin sites done. 1, 2 and 4
15 Aug 03	pins packed c̄ iodoform gauze. Site @ 4th
	pin deep 3-4 cm. Other pins wrapped c̄ dry
	gauze. Ø complaints (b)(6)-2 [redacted] 1LT/AN
2215	Care assumed @ 2100. VSS, A&Ox3, 650mg tylenol for pain.
	Lungs CTA, pulses ⊕x4, BS⊕. RLE ROM performed.
	Sutures CTA and exfix sites CDI. PT c̄ ⊕ pulse and sensation (b)(6)-2
	on rle. HL on LFA. No complaints at this time. [redacted]
16 Aug 03	0515 650mg Tylenol for pain to ®LE [redacted]
	0542 Assume pt care @ 0500. pt awake and
	alert. No c/o pain @ this time. VSS. HR reg. Lungs
	CTA. Abd soft BS×4. HL to Ⓛ FA ⊕ flush s̄ redness/
	infiltration. Ex-fix ® thigh intact. pin site dsgs
	intact c̄ yellow drainage. ⊕ ROM below exfix (b)(6)-2
	⊕ pulse ⊕ sensation. Will continue to monitor [redacted]
16 Aug 03	Sleeping, easily arousable c̄ verbal
1330	stimuli. PERRLA. Lungs CTA bilat, Ø resp distress
	NSR. Abd soft, non-tender, bowel sounds
	active ×4 quads. Ex-fix to ® femur intact
	aggressive ROM done by PT. Pin sites CDI.
	Strong pulses and brisk cap refill to bilat
	LE. (b)(6)-2 [redacted] 1LT/AN

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. ICW2

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#[redacted] (b)(6)-4

PROGRESS Notes ~~CHRONOLOGICAL RECORD OF MEDICAL CARE~~

Medical Record

STANDARD FORM 600 (REV. 6-97)
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FIRMR (41 CFR) 201-9.202-1

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
16 Aug 03 1730	Pin care done to Ⓡ femur ex-fix. Pins cleaned c̄ H_2O_2/H_2O soln. 1, 2, 4 pins packed c̄ iodoform gauze. All other pins wrapped c̄ plain dry gauze. 0 complaints —— [redacted] LT/DV (b)(6)-2
2220	Care assumed @2100. VSS, A+Ox3, 800 mg motrin given for pain @2100. Lung sounds CTA, pulses ⊕ x4 extremeties, bs ⊕ x4. Pins on lle intact, sites clean, good rom on lle. HL on LFA intact, 0 s/s infection. Will continue to monitor. —— (b)(6)-2 [redacted] glumc
17 Aug 03 0700	Pt. awake & alert in bed c̄ c/o pain to Ⓡ femur, c̄ Motrin given. HR Regular, Lung sounds clear bilat, bowel sounds ⊕ x 4 quads. New IV started in Ⓡ FA. VSS. Ext Fix to Ⓡ femur intact, DSG's over pin sites CDI. Ⓡ pedal pulse palpable, ⊕ sensation, cap refill <3sec. Full ROM in digits & ankle, limited ROM in knee. Pt s̄ other complaints @ this time. All other assessment findings WNL. —— [redacted] SVT/AN (b)(6)-2
17 Aug 03 1500	Awake and alert in bed. PERRLA. Lungs CTA bilat, 0 resp distress. NSR. Abd soft, non-tender, bowel sounds active x4 quads. Ex-fix to Ⓡ femur intact, dsgs to pins CDI. Strong pedal pulse and brisk cap refill to bilat LE. Pt doing active ROM to Ⓡ knee. 0 complaints at this time. —— (b)(6)-2 [redacted] LT/DN
1900	Pin care done. Pins and pin sites cleaned c̄ H_2O_2/H_2O soln. 1, 2, 4th pins packed c̄ Iodoform gauze, then all pins wrapped c̄ plain gauze. 0 complaints [redacted] LT/D (b)(6)-2

FPI. LEX. Printed on Recycled Paper

STANDARD FORM 600 (REV. 6-97) BACK

NSN 7540-00-634-4176 AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
8-17-03	Pt. care assumed @2100. HR Reg, lungs CTA,
2100.	BS ⊕ x4. Ⓡ ↓ ext. ex-fix intact, pin sites CDI.
	Ⓡ ft. c̄ pulse 2+, brisk cap refill, ⊕ ROM,
	⊕ sensation. Will cont. to monitor — (b)(6)-2 [redacted] /1CWh
18Aug03	Pt. awake & alert c/o pain in Ⓡ femur, ī percocet given. HR
0520	regular, lung sounds clear bilat, bowel sounds (+) x4 quads. Ext.
	fix to Ⓡ femur intact, pin site dsgs CDI, pedal pulse palpable, (+)
	sensation, <3sec cap refill, Full ROM in digits & ankle, pain c̄ ROM
	to knee. HL in Ⓡ FA s̄ s/s of infection. VSS. All other assessment
	findings WNL. Will continue to monitor. — (b)(6)-2 [redacted] 2LT/AN
18Aug03	2045: Assumed care @1300: VSS, Lung sounds clear bilat. Abd.
	Soft, non-distended, BSx4. c/o pain @1330. Motrin 800mg
	PO given. Relief acceptable. Pin care done. Iodoform
	packing to pins 1, 2, & 4. ROM exercises done. Will
	monitor. — [redacted] 2LT,
19Aug	Care assumed @2100. VSS, ī motrin given for pain. (b)(6)-2
0000	Lung sounds CTA, pulses ⊕ x4, BS ⊕. Pins intact s̄ drainage,
	⊕ pulse and sensation in RLE. Pt ambulated x2 and ROM
	performed. Will continue to monitor. [redacted] 91WMC
	(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. 1CW2

EPW # [redacted] (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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
19Aug03	0645 Assume pt care @ 0500. pt awake and
	Alert. c/o pain to ⓁLE requesting motrin. VSS.
	HR reg Lungs CTA. Abd soft BSx4. ⓁLE ex-fix
	intact Dsgs to pins CD+I. ⊕ pulse ⊕ movement
	⊕ sensation below ex-fix. pt doing active ROM exercise
	to knee. HL to Ⓡ FA ⊕ flush s̄ redness/infiltration
	will cont. to monitor ——— (b)(6)-2 [redacted]
19Aug03	2030: Assumed care @ 1300. A+Ox3, VSS. No c/o pain @ this time.
	C/o pain @ 1645. Motrin 800 mg given PO. Abd. soft, non-distended,
	Lung sounds clear bilat. Pin care done to ex-fix c̄ packing to pins
	1,2+4. SL to Ⓡ FA patent. Will continue to monitor [redacted]
2220	Pt. care assumed @ 2100. HR reg, lungs CTA, (b)(6)-2
	BS⊕ x4. Ex-fix Ⓡ ext intact. dsg to
	pin sites CDI s̄ drainage Ⓡ ft. c̄ pulse gt, ⊕
	ROM, ⊖ sensation. Ø c/o pain @ this time.
	Will cont. to moniter. ——— (b)(6)-2 [redacted]
20Aug03	0639. Assume pt care @ 0500. Awake and
	Alert. C/o large amt of pain to Ⓡ thigh and Ⓡ
	foot. percocet given. Ex-fix Ⓡ thigh intact Dsgs
	to pins CD+I. ⊕ pulse ⊕ movement ⊕ sensation.
	VSS. Will continue to monitor ——— (b)(6)-2 [redacted]
	0640 Ⓡ FA HL ⊕ flush s̄ redness/infiltration [redacted] (b)(6)-2
20Aug03	2010: Assumed care @ 1300. VSS. Lung sounds clear bilat. BSx4,
	Ex-fix to Ⓡ Leg. Pin care done c̄ Iodoform packing to
	pins 1,2&4. No c/o pain @ this time. Will continue
	to monitor. ——— [redacted], 2LT, AN
	(b)(6)-2

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STANDARD FORM 600 (REV. 6-97) BACK

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
21 Aug 03	2105: VSS, A+O x3, IV HL to Ⓡ FA patent,
	continuing IV+PO antibiotics routinely. Pin
	care & W→D dsg Δ's done tonight, aggressive
	ROM exercises done to Ⓡ LE/Ⓡ knee. Neuro-
	Vascular checks done ⊕ sensation ⊕ movement
	to Ⓡ LE. 2+ pedal 2+ popliteal pulse to Ⓡ LE.
	No other remarkable assessment findings. Ø
	c/o pain. Will continue to monitor — [redacted] 2LT/AN
22 Aug 0715	Pt VS BP 118/68, HR 84, RR 16, T 98.3, SpO2 99% — [redacted] 91W
22 Aug 1600	Pt. c/o pain. ĉ tylenol given po ——— (b)(6)-2
1610	Pt. awake & alert ŝ complaints @ this time. HR Regular, Lung sounds clear
	bilat, bowel sounds (+) x 4 quads. Ext fix to Ⓛ femur intact, pin care completed
	ĉ all insertion sites ŝ s/s of infection. BM x 2. All other assessments WNL
	HL in Ⓡ FA ŝ s/s of infection. VSS. Will continue to monitor. — [redacted]
22 Aug 03	2120: Assumed care @ 1700; A+O x3, No c/o pain or discomfort (b)(6)-2
	@ this time. c/o diarrhea x5, Immodium 2mg PO given, HR-regular,
	Lung sounds clear bilat. Abd. soft, non-distended. BS x4, Ex fix
	to Ⓛ Femur, Pin care done, no s/s of infection. Will continue
	to monitor. ——— [redacted] 2LT, AN
23 Aug 03	0415, late entry for 22 Aug 03 1700, T-98.6°F, P-82 R-16 BP-126/74
	SpO2-98% ——— (b)(6)-2 [redacted] 2LT
23 Aug 0720	PtVS, BP 119/69, HR 89, T 98.2, RR 16, SpO2 99% — [redacted] 91W

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. ICW2

[redacted] (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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
8/20	Pt. care assumed @ 2100. VSS. Ⓡ ↓ ext. ex-fix
2134	intact. Ⓡ ft. c̄ pulse 2+, ⊕ ROM ⊕ sensation, brisk
	cap refill. Pt c/o ∅ pain @ this time. Will cont. to
	monitor. —— (b)(6)-2 [redacted]
21Aug03	Pt awake and alert. Lungs CTA bilat, ∅ resp
0630	distress. VSS. Abd soft, non-tender, bowel
	sounds active x4 quads. IV to Ⓡ arm flushing
	easily. Ex fix to Ⓡ femur intact, pin sites
	and dsg CDI. Strong pulses and brisk cap
	refill to bilat LE. Pt doing ROM to Ⓡ knee.
	∅ complaints —— (b)(6)-2 [redacted]
0930	ROM done to Ⓡ knee. Pt premed c̄ Percocet
	for pain. Pin care done c̄ H_2O_2/H_2O soln.
	1st, 2nd & 4th pins packed c̄ Iodoform
	gauze. All pins wrapped with plain
	dry gauze. Minimal serosanguinous
	drainage noted to 1,2,4 pins. ∅ noted
	to 3,5,6. ∅ complaints —— (b)(6)-2 [redacted]
	Received pt ~~resting~~ [illegible] in stable condition from
	Dogwood facility. VS as noted in above assessment.
	Dsg c/d/intact, minimal drainage noted on 4th
	pin dsg, dsg Δ due @ 2000. Leg warm, ~~[illegible]~~ pulse
	intact. Amb on crutches down hallway to bedpan
	room. IV flushes easily, ∅ redness or swelling
	noted. Pt placed in restraints per protocol.
	Will cont to monitor [redacted]
	(b)(6)-2

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STANDARD FORM 600 (REV. 6-97) BACK

58-103

(See Instructions on Back of this Sheet)

NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp) [redacted] (b)(2)-2

LOG NUMBER

ARRIVAL

DAY	MONTH	YR.	TIME
5	JUN	03	1800

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet)
☐ PRIVATE VEHICLE ☐ AMBULANCE
☐ OTHER (Specify) AV2

CURRENT MEDS. (tetanus immunization and other data) Ø

HISTORY OBTAINED FROM ☒ PATIENT ☐ OTHER (Specify)

ALLERGIES NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration) Femur Fx

SEX M

AGE

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER

VITAL SIGNS

TIME	1700		
BP	123/69		
PULSE	105		
RESP.	16		
TEMP.			
WT. (Child)	80kg		

CATEGORY (See reverse)
☐ EMERGENT
☐ URGENT
☐ NON-URGENT

ORDERS	INITS.	TIME
CBC	[redacted]	1700
T+S		1700
IV NS		1700
	(b)(6)-2	

ASSESSMENT/DIAGNOSIS

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

DISPOSITION (Check all that apply)
☐ HOME ☐ FULL DUTY
QUARTERS ☐ 24 Hrs. ☐ 48 Hrs. ☐ 72 Hrs.
MODIFIED DUTY UNTIL: DAY MONTH YEAR

REFERRED TO (Indicate clinic)
☐ EMERGENCY ☐ TODAY
☐ 72 HOURS ☐ ROUTINE

ADMIT. TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE
☐ IMPROVED ☐ UNCHANGED
☐ DETERIORATED

TIME OF RELEASE:

(CONTINUE ON SF 507, IF NEEDED)

PATIENT'S IDENTIFICATION (Mechanical imprint) FOR WRITTEN ENTRIES GIVE: Name - last, first, middle; SSN; DOB, service status, name and relation of sponsor or next of kin. (IMPORTANT: LIST FACILITY HOLDING TREATMENT RECORD).

[redacted]

(b)(6)-4

SIGNATURE OF PROVIDER AND ID STAMP

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans)

EMERGENCY CARE AND TREATMENT
Medical Record Copy

STANDARD FORM 558 (Rev. 6-82)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

PATIENT ASSESS NT

IME: 1600 SIGNATUR [redacted]

SKIN AND MUCOUS MEMBRANES

in : [✓ Loose] / Tight / Diaphoretic / Shiny / Dry
in : Temperature W/D
lor: Pale / Cyanotic / Jaundiced NFR
ucous Membranes: [✓ Moist] / Dry / Cracked
in Breakdown: [✓ None] / Location: Size:

NEUROLOGICAL

c / [✓ Alert] / Lethargic / Unresponsive GCS: 15
[✓ ientated] / Disoriented Pupils: 3 R
tremity Movement: Full / [✓ Limited] / None RLE

CARDIOVASCULAR

lse (0 - 4): 2+ Radials 2+ Pedals
pillary Refill: <3 Seconds Homan's Sign
ular Venous Distension Ø Edema Ø
art Sounds WNL
ythm SR PRI: QRS:

scular Catheter	Central	Arterial	Peripheral 1...	Peripheral-2
veforms			▨	▨
ution				

est Pain

RESPIRATORY

st Expansion / [✓ Symmetrical] / Asymmetrical
piration / [✓ No Distress] / SOB / Labored / Use of Access Muscles
athing Patterns: Norml
gh: Productive / Nonproductive / None NA
tum: Color / Amount / Consistency / Odor
st Drainage System Gravity: Suction cm:
Leak No Yes -- Crepitus
racter of Drainage:
chea / Midline / Deviated (R) / Deviated (L)
icial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
ckles	CTA(B)	
eezes		
inished		
ent		

GASTROINTESTINAL

omen: [✓ Soft] / Firm / Hard / Distended cm Girth
el Sounds: [✓ Normal] / Hyperactive / Hypoactive / Absent
ssings: Ø
Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage
Drainage: Color Character
e Feeding: Day No: Strength: Rate: Aspirate:
l: Character
ns:

GENITOURINARY

e Color: WNL Character:
ding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

WNL

ER: [redacted]

P T ASSESSMENT [redacted]

TIME: IGNATURE [redacted]

SKIN AND MUCOUS MEMBRANES

Skin : Loose / [✓ Tight] / Diaphoretic / Shiny / Dry
Skin : Temperature W/D
Color: Pale / Cyanotic / Jaundiced WNL for Race
Mucous Membranes: [✓ Moist] / Dry / Cracked
Skin Breakdown: [✓ None] Location: Size:

NEUROLOGICAL

Loc / [✓ Alert] / Lethargic / Unresponsive GCS:
[✓ Orientated] / Disoriented Pupils: 3mm (B) Perrla
Extremity Movement: Full / [✓ Limited] / None (R) LE X Fx

CARDIOVASCULAR

Pulse (0 - 4): 2+ Radials 2+ Pedals
Capillary Refill: <3 Seconds Ø Homan's Sign
Jugular Venous Distension Ø Edema Ø
Heart Sounds $S_1 S_2$
Rhythm SR PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Periphera
Waveforms			▨	▨
Site				
Solution				

Chest Pain

RESPIRATORY

Chest Expansion [✓ / Symmetrical] / Asymmetrical
Respiration / [✓ No Distress] / SOB / Labored / Use of Access Muscles
Breathing Patterns: E/U
Cough: Productive / Nonproductive / [✓ None]
Sputum: Color / Amount / Consistency / Odor Ø
Chest Drainage System Gravity: Suction cm:
Air Leak No Yes Crepitus
Character of Drainage: —
Trachea / Midline / Deviated (R) / Deviated (L)
Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Locatio
Crackles	CTA(B)	
Wheezes		
Diminished	[illegible]	
Absent		

GASTROINTESTINAL

Abdomen: [✓ Soft] / Firm / Hard / Distended cm Girth
Bowel Sounds: [✓ Normal] / Hyperactive / Hypoactive / Absent
Dressings: (R) LE
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainag Ø
NG Drainage: Color Character
Tube Feeding: Day No: Strength: Rate: Aspirate
Stool: Character
Drains:

GENITOURINARY

Urine Color: Character:
Voiding: [✓ Continent] / Normal Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

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

5 Jul 03 CIV- [redacted]

Date 5 July Bed # 5

Patient's Name EPW [redacted] (b)(6)-4

Time	05	06	07	08	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
BP																	149/87			130/80				136/86
TEMP																	99.4							
HR																	99			89				87
RR																	20			14				16
SAO2																	99			100				95
FIO2																	4L							
																	NC			RA				RA
INPUT																								
PO																								
IV																	10	10	10	10	10	10	10	10
~~NGT~~ IVPB																	100			100				
TURN Q 2																								
TOTAL																								
OUTPUT																								
URINE																						550		
NGT																								
STOOL																								
OTAL																								
BALANCE																								
Initials																								

[redacted] (b)(6)-4

Date 06 Apr

PATIENT ASSESSMENT

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin : Loose / Tight / Diaphoretic / Shiny / Dry
Skin : Temperature
Color: Pale / Cyanotic / Jaundiced
Mucous Membranes: Moist / Dry / Cracked
Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:
Orientated / Disoriented Pupils:
Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radials Pedals
Capillary Refill: Seconds Homan's Sign
Jugular Venous Distension Edema
Heart Sounds
Rhythm PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			▨	▨
Site				
Solution				

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical
Respiration / No Distress / SOB / Labored / Use of Access Muscles
Breathing Patterns:
Cough: Productive / Nonproductive / None
Sputum: Color / Amount / Consistency / Odor
Chest Drainage System Gravity: Suction cm:
Air Leak No Yes Crepitus
Character of Drainage:
Trachea / Midline / Deviated (R) / Deviated (L)
Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth
Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent
Dressings:
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage
NG Drainage: Color Character
Tube Feeding: Day No: Strength: Rate: Aspirate:
Stool: Character
Drains:

GENITOURINARY

Urine Color: Character:
Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

PATIENT ASSESSMENT

(b)(6)-2

TIME: 1710 SIGNATURE [redacted]

SKIN AND MUCOUS MEMBRANES

Skin : Loose / Tight / Diaphoretic / Shiny / [✓ Dry]
Skin : Temperature warm
Color: Pale / Cyanotic / Jaundiced NFR
Mucous Membranes: [✓ Moist] / Dry / Cracked
Skin Breakdown: [✓ None] Location: Size:

NEUROLOGICAL

Loc / [✓ Alert] / Lethargic / Unresponsive GCS:
[✓ Orientated] / Disoriented Pupils:
Extremity Movement: Full / [✓ Limited] / None RLE

CARDIOVASCULAR

Pulse (0 - 4): Radials Pedals strong & palp
Capillary Refill: 2 Seconds 3 Homan's Sign ∅
Jugular Venous Distension ∅ Edema generalized RLE
Heart Sounds $S_1 S_2$ only
Rhythm PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			▨	▨
Site				
Solution				

Chest Pain

RESPIRATORY

Chest Expansion / [✓ Symmetrical] / Asymmetrical
Respiration / [✓ No Distress] / SOB / Labored / Use of Access Muscles
Breathing Patterns: even
Cough: Productive / Nonproductive / [✓ None]
Sputum: Color / Amount / Consistency / [✓ Odor]
Chest Drainage System Gravity: Suction cm:
Air Leak No Yes Crepitus
Character of Drainage:
Trachea / Midline / Deviated (R) / Deviated (L)
Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles	CTA (B)	
Wheezes		↓ @ Bases
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: [✓ Soft] / Firm / Hard / Distended cm Girth
Bowel Sounds: [✓ Normal] / Hyperactive / Hypoactive / Absent
Dressings: RLE c̄ Moist-Mod. sang drainage
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage
NG Drainage: Color Character
Tube Feeding: Day No: Strength: Rate: Aspirate:
Stool: Character
Drains:

GENITOURINARY

Urine Color: yellow Character: cl
Voiding: [✓ Continent] Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

Date 06JUL03 Bed # 3 [redacted] (b)(6)-4

Patient's Name EPW [redacted]

Time	05	06	07	08	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
BP		125/76														126/73				129/73				120/70
TEMP																98.0				98.6				100.5
HR		92														80				80				76
RR		26														18				18				16
SAO2		98														96				98				96
FIO2		RA														RA				RA				RA
INPUT																								~~[illegible]~~ [redacted]
PO													250											
IV																								
NGT																								
TURN Q 2																								
TOTAL																								
OUTPUT															70 [redacted]									
URINE															700								500	
NGT																								
STOOL																								
TOTAL																								
BALANCE																								
Initials																								

(b)(6)-2

(b)(6)-2

DATE 07 Jul 03 PATIENT ASS[redacted] (b)(6)-2

TIME: SIGNATURE

SKIN AND MUCOUS MEMBRANES

Skin [✓ Loose] / Tight / Diaphoretic / Shiny / Dry

Skin Temperature W/D

Color: Pale / Cyanotic / Jaundiced WNL

Mucous Membranes: [✓ Moist] / Dry / Cracked

Skin Breakdown: [✓ None] Location: Size:

NEUROLOGICAL

Loc / [✓ Alert] / Lethargic / Unresponsive GCS:

[✓ Orientated] / Disoriented Pupils:

Extremity Movement: Full / [✓ Limited] / None (R) leg ext. fix

CARDIOVASCULAR

Pulse (0 - 4). +2 Radials +2 Pedals

Capillary Refill: <3 Seconds Homan's Sign

Jugular Venous Distension 0 Edema 0

Heart Sounds [illegible]

Rhythm [illegible] PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site			(R) hand	20 KVO
Solution			NS	

Chest Pain

RESPIRATORY

Chest Expansion [✓ Symmetrical] / Asymmetrical

Respiration / [✓ No Distress] / SOB / Labored / Use of Access Muscles

Breathing Patterns: REG

Cough Productive / Nonproductive / [✓ None]

Sputum: Color / Amount / Consistency / Odor NONE

Chest Drainage System Gravity: 0 Suction cm: 0

Air Leak 0 No 0 Yes 0 Crepitus 0

Character of Drainage: 0

Trachea / Midline / Deviated (R) / Deviated (L) 0

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles	CTA	
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen [✓ Soft] / ~~Firm~~ / Hard / Distended cm Girth

Bowel Sounds [✓ Normal] / Hyperactive / Hypoactive / Absent

Dressings: Oozing from site

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color 0 Character 0

Tube Feeding: Day No 0 Strength 0 Rate 0 Aspirate 0

Stool. Character 0

Drains External fixator

GENITOURINARY

Urine Color WNL Character:

Voiding [✓ Continent] / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER - Appropriate

F. .. ASSESSMENT

SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin : [✓ Loose] / Tight / Diaphoretic / Shiny / Dry

Skin : Temperature warm

Color: Pale / Cyanotic / Jaundiced NML

Mucous Membranes: [✓ Moist] / Dry / Cracked

Skin Breakdown: [✓ None] Location: Size:

NEUROLOGICAL

Loc / [✓ Alert] / Lethargic / Unresponsive GCS:

[✓ Orientated] / Disoriented Pupils:

Extremity Movement: Full / [✓ Limited] / None See above

CARDIOVASCULAR

Pulse (0 - 4): +3 Radials +3 Pedals +3

Capillary Refill: <3 Seconds Homan's Sign

Jugular Venous Distension [✓ −] Edema

Heart Sounds S1/S2

Rhythm NSR PRI: QRS

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site			(L) FA	D/C
Solution			(R) FA	[illegible]

Chest Pain

RESPIRATORY

IS use

Chest Expansion [✓ Symmetrical] / Asymmetrical

Respiration [✓ No Distress] / SOB / Labored / Use of Access Muscles

Breathing Patterns:

Cough: Productive / [✓ Nonproductive] / None

Sputum: Color / Amount / Consistency / Odor none

Chest Drainage System Gravity: Suction cm.

Air Leak No Yes Crepitus

Character of Drainage: -

Trachea [✓ Midline] / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes	CTA [illegible]	
Diminished		
Absent		

GASTROINTESTINAL

Abdomen [✓ Soft] / Firm / Hard [✓ Distended] cm Girth

Bowel Sounds [✓ Normal] / Hyperactive / Hypoactive / Absent

Dressings: [illegible]

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate

Stool: Character

Drains:

GENITOURINARY

Urine Color: Character:

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER: See [illegible]

EPW [redacted] (b)(6)-4

MEDCOM - 13759

Date 07 Jul 03 Bed # [redacted] (b)(6)-2

Patient's Name. EPW [redacted] (b)(6)-4

Time	05	06	07	08	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
BP		[illegible]/76				134/88				140/82				133/76						130/68				130/59
TEMP																								
HR		92				91				94				96						94				90
RR		26				26				16				20						28				20
SAO2		99				99				98				97						98				97
FIO2		RA				RA				RA				RA						RA				RA
INPUT																								
PO														410										
IV																								
NGT																								
TURN Q 2																				98 - N				
TOTAL																								
OUTPUT		900											700 [illegible]		350									350
URINE																								
NGT																								
STOOL																								
TOTAL																								
BALANCE																								
Initials																								

[redacted] LTC, MC [redacted] (b)(6)-2

[redacted] M.D.
LTC, MC
Family Physician (b)(6)-2

1450

Date 08JUL [redacted]

(b)(6)-4

PATIENT ASSESSMENT (b)(6)-2

TIME: 1600 SIGNATURE: [redacted]

SKIN AND MUCOUS MEMBRANES

Skin : [✓ Loose] / Tight / Diaphoretic / Shiny / Dry
Skin : Temperature Warm
Color: Pale / Cyanotic / Jaundiced NFR
Mucous Membranes: [✓ Moist] / Dry / Cracked
Skin Breakdown: [✓ None] Location: Size:

NEUROLOGICAL

Loc / [✓ Alert] / Lethargic / Unresponsive GCS:
[✓ Orientated] / Disoriented Pupils:
Extremity Movement: Full / [✓ Limited] / None RUE

CARDIOVASCULAR

Pulse (0 - 4): 2 Radials 2 Pedals
Capillary Refill: < 3 Seconds Homan's Sign
Jugular Venous Distension Ø Edema
Heart Sounds S1S2
Rhythm SR PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			▨	▨
Site				
Solution				

Chest Pain

RESPIRATORY

Chest Expansion / [✓ Symmetrical] / Asymmetrical
Respiration / [✓ No Distress] / SOB / Labored / Use of Access Muscles
Breathing Patterns: equal
Cough: Productive / Nonproductive / [✓ None]
Sputum: Color / Amount / Consistency / Odor
Chest Drainage System Gravity: Suction cm:
Air Leak No Yes Crepitus
Character of Drainage:
Trachea / Midline / Deviated (R) / Deviated (L)
Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes		
Diminished	CTA (B)	
Absent		

GASTROINTESTINAL

Abdomen: [✓ Soft] / Firm / Hard / Distended cm Girth
Bowel Sounds: [✓ Normal] / Hyperactive / Hypoactive / Absent
Dressings:
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage
NG Drainage: Color Character
Tube Feeding: Day No: Ø Strength: Rate: Aspirate:
Stool: Character
Drains:

GENITOURINARY

Urine Color: yellow Character: clear
Voiding: Continent ✓ Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

NA

OTHER:

PATIENT ASSESSMENT

TIME: 1835 SIGNATURE: [redacted] (b)(6)-2

SKIN AND MUCOUS MEMBRANES

Skin : [✓ Loose] / Tight / Diaphoretic / Shiny / [✓ Dry]
Skin : Temperature Warm
Color: Pale / Cyanotic / Jaundiced Normal
Mucous Membranes: [✓ Moist] / Dry / Cracked
Skin Breakdown: [✓ None] Location: Size:

NEUROLOGICAL

Loc / [✓ Alert] / Lethargic / Unresponsive GCS:
[✓ Orientated] / Disoriented Pupils:
Extremity Movement: Full / [✓ Limited] / None RLE

CARDIOVASCULAR

Pulse (0 - 4): B/ Radials +2 Pedals +2
Capillary Refill: <3sec Seconds Homan's Sign
Jugular Venous Distension ⊖ Edema ⊖
Heart Sounds $S_1 S_2$
Rhythm SR PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			▨	▨
Site			RPIV	
Solution			LPIV	

Chest Pain

RESPIRATORY

Chest Expansion / [✓ Symmetrical] / Asymmetrical
Respiration / [✓ No Distress] / SOB / Labored / Use of Access Muscles
Breathing Patterns: Equal unlabored
Cough: Productive / Nonproductive / [✓ None]
Sputum: Color / Amount / Consistency / Odor N/A
Chest Drainage System Gravity: Suction cm:
Air Leak ~~No Yes Crepitus~~
Character of Drainage:
Trachea / Midline / Deviated (R) / Deviated (L)
Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles	CTA (B)	CTA (B)
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: [✓ Soft] / Firm / Hard / Distended cm Girth
Bowel Sounds: [✓ Normal] / Hyperactive / Hypoactive / Absent
Dressings:
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage
NG Drainage: Color Character
Tube Feeding: Day No: Strength: Rate: Aspirate
Stool: Character
Drains:

GENITOURINARY

Urine Color: Yellow Character Clear
Voiding: [✓ Continent] / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

For use of this form, see AR 40-66; the proponent agency is The Office of the Surgeon General.

1. AGE: 40
HEIGHT:
WEIGHT:

2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication):
NKDA

3. PREVIOUS SURGERY ☐ NO ☑ YES (type):
Ex fix (R) thigh

4. PROPOSED SURGICAL PROCEDURE:
I+D (R) thigh, adjust ex-fix.

5. ADDITIONAL INFORMATION: Last PO: Since midnight Medical Hx: 0 Implants: 0 Medications: Cleocin Unasyn
Jewelry removed: [✓ yes]/no Family waiting: yes/[✓ no]
Smokes, Drinks 0 Drug use

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to traumatic injury; language barrier; ~~family separation~~; surgical environment	☑ Pt. verbalizes any specific anxiety. ☑ Pt. exhibits relaxed body posture.	☑ Allow pt. to verbalize freely. ☑ Explain OR environment and answer questions regarding surgery. ☑ Offer comfort measures, (e.g., warm blanket, touch) ☑ Explain all nursing procedures before they are done. ☑ Remain with pt. whenever possible. ☑ Maintain family interface.
B. AERATION ✓ Potential for respiratory dysfunction due to sedation; positioning; injury	☑ ~~PT.~~ will be able to breathe without difficulty during immediate intra-operative phase.	☑ Offer to elevate head of litter or offer pillow. ☑ Observe pt. while awaiting surgery for signs of distress ☑ Assist anesthesia during intubation and extubation
C. INTEGUMENT ✓ Potential impairment of skin integuity due to bovie pad; position; fluid shift	☑ ~~PT.~~ will not exhibit signs of impairment of skin integrity (e.g., reddened areas.	☑ Utilize pressure preventing devices on OR table and accessories. ☑ Check for proper positioning and support to maintain good body alignment. ☑ Pad pressure points. ☑ Place ESU ground pad on non compromised skin surface area. ☑ Keep prep fluids from pooling.

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

[redacted] (b)(6)-2

ICW 2

DA FORM 5179, JUN 91 Previoius editions are obsolete. USAPA V1.01
MEDCOM - 13762

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to anesthesia; traumatic injury; position; shock; previous surgery	~~o~~ Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse).	o Check for support stockings or ace wraps. If none, check with doctors. ~~o Check~~ that safety straps are correctly applied. o Offer pillow for under knees. ~~o Place and take down legs from stirrups with slow bilateral motio~~ [redacted] (b)(6)-2 ~~o Check~~ that rings have been removed.
E. NEUROMUSCULAR CONTROL ✓ E.1. ___ Potential impairment of mobility due to sedation; pain; injury E.2. ✓ Potential discomfort due to injury; pain	o Pt. will be transferred to OR table without difficulty. o Pt. will not experience unnecessary physical discomfort.	o Have sufficient people available for transfer. o Insure proper body alignment. o Allow patient to lie in position of comfort while waiting for surgery. o Offer support (i.e., pillows, bathtowels, etc.) for positioning.
F. NEUROMUSCULAR CONTROL F.1. ✓ Disminished visual perception due to being injury; sedation; F.2. ✓ Potential for decreased communictaion due to language barrier; sedation F.3. Potential injury due to dentures. N/A	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR table. o Pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt. from either side. o Validate pt.'s understanding of verbal communications. o Verify removal of dentures.
G. OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS: Or continuation of above interventions.

10. OR NURSING INTERVENTIONS COMPLETED/ADDITIONAL INTEROPERATIVE INTERVENTIONS NOTED.

[redacted] CPT/RN 4 Aug 03 DATE

11. POSTOPERATIVE EVALUATION:

Bovie site:
Drsg:
Breathing:

(b)(6)-2

12. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title) [redacted] MAJ AN

DATE: 4 apr TIME: 0919

13. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title) [redacted]

DATE: 4 Aug 03 TIME: 1340

REVERSE OF DA FORM 5179, JUN 91

USAPA V1.01

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

FOR Use of this form, see AR 40-407; the proponent agency is The Office of the Surgeon General.

1. AGE: 40

HEIGHT:

WEIGHT:

2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication)
☑ NKDA ☐ PCN ☐ LATEX ☐ IODINE ☐ TAPE ☐ FOOD
REACTION:

3. PREVIOUS SURGERY [✓] NO [ ] YES (type):

4. PROPOSED SURGICAL PROCEDURE:
ORIF Right Femur.

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition________
Tobacco____ppd X___yrs. Body Piercing________ Diabetes (Y) (N) ROM________ ASA/Motrin w/72 hrs (Y) (N)
ETOH________ Implants________ Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS:

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to: ✓ 1) Surgical Procedure & Operating Room Environment ✓ 2) Separation Anxiety (Child) ✓ 3) Surgical Outcomes	o Pt. verbalizes any specific anxiety. o Pt. Exhibits relaxed body posture.	c Allow pt. to verbalize freely. c Explain OR environment and answer questions regarding surgery. c Offer comfort measures. (e.g., warm blanket, touch). c Explain all nursing procedures before they are done. c Remain with pt. whenever possible. c Maintain family interface. Parents to stay with pt.
B. AERATION ✓ Potential for respiratory dysfunction due to: ✓ 1) Positioning ✓ 2) Effects of Anesthesia ✓ 3) Medical/Smoking History	o Pt. will be able to breathe without difficulty during immediate intraoperative phase.	c Offer to elevate head of litter or offer pillow. c Observe pt. while awaiting surgery for signs of distress. c Assist anesthesia during intubation and extubation.
C. INTEGUMENT ✓ Potential impairment of skin integrity due to: ✓ 1) Intraoperative Immobility ✓ 2) ESU Pad Placement ✓ 3) Positional Aids ✓ 4) Prosthesis ✓ 5) Pooling of Prep Solutions	o Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened areas).	c Utilize pressure preventing devices on OR table and accessories. c Check for proper positioning and support to maintain good body alignment. c Pad pressure points. c Place ESU ground pad on non compromised skin surface area. c Keep prep fluids from pooling.

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

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

VERIFICATIONS AT HOLDING AREA:
! ID/Allergy Band
! H & P
! NPO Since_____
! UHCG/LMP
! Consent/Blood Transfusion Signed/Witnessed/Dated
! Surgical Site/Consent verified by Pt./Anesthesia/Surgeon
! Contact Precautions (Y) (N)
! Family/Friend:________

! Dentures Removed N/A
! Contacts Removed
! Jewelry Removed
! Body Pierce Removed

DA FORM 5179, JUN 91 Pr[illegible] USAPA V1.0
MEDCOM - 13764

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to: ✓ 1) Intraoperative Mobility ✓ 2) Positioning ✓ 3) Existing Disease ✓ 4) Safety Devices ✓ 5) Hypothermia	o Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse.	o Check for support stockings/ace wraps. If none, check with doctors. N/A o Check that safety straps are correctly applied. o Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. o. Check that rings and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to: ✓ 1) Pain ✓ 2) Intraoperative Hazards 3) Prosthesis ✓ 4) Positioning ✓ 5) Transfer pt. to/from OR table E.2. ✓ Potential discomfort due to: ✓ 1) Length of Surgery ✓ 2) Positioning N/A 3) Arthritis	o Pt. will be transferred to OR table without difficulty. o Pt. will not experience unnecessary physical discomfort.	o Have sufficient people available for transfer. o Insure proper body alignment. o Allow patient to lie in position of comfort while waiting for surgery. o Offer support (i.e., pillows, bath towels, etc.) for positioning.
F. SPECIAL SENSES F.1. ✓ Diminished visual perception due to being: ✓ 1) Pre-Medicated ✓ 2) W/O Glasses F.2. ✓ Potential for decreased communication due to: N/A 1) Diminished Hearing ✓ 2) Language Barrier F.3. ✓ Potential injury due to dentures: N/A ____ 1) Upper ____ 4) Caps ____ 2) Lower ____ 5) Crowns ____ 3) Bridges	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR table. o Pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly o Address pt. from ________ side. o Validate pt.'s understanding of verbal communication. o Verify removal of dentures!
G OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs. /	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes. /	OTHER NURSING INTERVENTIONS Or continuation of above interventions /

(b)(6)-2

10. OR NURSING INTERVENTIONS COMPLETE D/ADDITIONAL INTRAOPERATIVE INTERVENTION S NOTED.

[redacted] CPT/AN 5 July 03 DATE

11. POSTOPERATIVE EVALUATION: SKIN INTEGRITY: Bovie Pad Site: ☒ Clean and Dry ☐ Red ☐ N/A DRESSING DRY & INTACT: [✓ (Y)] (N)
LEVEL OF CONSCIOUSNESS: ☐ A&O ☒ Drowsy ☐ Sleepy ☐ Intubated
LEVEL OF ACTIVITY: ☒ Moves All Extremities ☐ Moves Upper Extremities BREATHING EASY: [✓ (Y)] (N)
☐ Transferred to litter with roller due to spinal

(b)(6)-2

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] CPT/AN
DATE: 5 July 03 TIME: 1610

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted]
DATE: 05 Jul 03 TIME: 2003 (b)(6)-2

REVERSE OF FORM 5179, JUN 91 MEDCOM - 13765 USAPA V1.0

MEDICAL RECORD | **PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT**

FOR Use of this form, see AR 40-407; the proponent agency is The Office of the Surgeon General.

1. AGE: 40

HEIGHT:

WEIGHT:

2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication)
☒ NKDA ☐ PCN ☐ LATEX ☐ IODINE ☐ TAPE ☐ FOOD
REACTION:

3. PREVIOUS SURGERY [ ] NO [✓] YES (type):
Ex F Rt femur

4. PROPOSED SURGICAL PROCEDURE:
I + D Rt femur, adjust Ex fix

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition intact
Tobacco yes ppd X ___ yrs. Body Piercing Ø Diabetes (Y) [✓ (N)] ROM limited (R) leg ~~ASA~~/Motrin w/72 hrs (Y) [✓ (N)]
ETOH yes Implants Rt femur Respiratory Disease (Asthma/COPD) (Y) [✓ (N)] Anticoagulants (Y) [✓ (N)]
Glasses/Contact (Y) [✓ (N)] Dentures Ø Hypertension (Y) [✓ (N)] Herbal Medicines (Y) [✓ (N)] MEDS: Ø

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to: ✓ ✓ 1) Surgical Procedure & Operating Room Environment ✓ 2) Separation Anxiety (Child) ✓ 3) Surgical Outcomes	o Pt. verbalizes any specific anxiety. o Pt. Exhibits relaxed body posture.	✓ Allow pt. to verbalize freely. ✓ Explain OR environment and answer questions regarding surgery. ✓ Offer comfort measures. (e.g., warm blanket, touch). ✓ Explain all nursing procedures before they are done. ✓ Remain with pt. whenever possible. ✓ Maintain family interface. Parents to stay with pt.
B. AERATION ✓ Potential for respiratory dysfunction due to: ✓ 1) Positioning ✓ 2) Effects of Anesthesia ✓ 3) Medical/Smoking History	o Pt. will be able to breathe without difficulty during immediate intraoperative phase.	✓ Offer to elevate head of litter or offer pillow. ✓ Observe pt. while awaiting surgery for signs of distress. ✓ Assist anesthesia during intubation and extubation.
C. INTEGUMENT ✓ Potential impairment of skin integrity due to: ✓ 1) Intraoperative Immobility ✓ 2) ESU Pad Placement ✓ 3) Positional Aids ✓ 4) Prosthesis ✓ 5) Pooling of Prep Solutions	o Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened areas).	✓ Utilize pressure preventing devices on OR table and accessories. ✓ Check for proper positioning and support to maintain good body alignment. ✓ Pad pressure points. ✓ Place ESU ground pad on non compromised skin surface area. ✓ Keep prep fluids from pooling.

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

[redacted] (b)(6)-4

VERIFICATIONS AT HOLDING AREA:
! ID/Allergy Band ! Dentures Removed
! H & P ! Contacts Removed
! NPO Since_____ ! Jewelry Removed
! UHCG/LMP ! Body Pierce Removed
! Consent/Blood Transfusion Signed/Witnessed/Dated
! Surgical Site/Consent verified by Pt./Anesthesia/Surgeon
! Contact Precautions (Y) (N)
! Family/Friend:_______________

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MEDCOM - 13766

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION __✓__ Potential for inadequate tissue perfusion due to: __✓__ 1) Intraoperative Mobility __✓__ 2) Positioning __✓__ 3) Existing Disease __✓__ 4) Safety Devices __✓__ 5) Hypothermia	ø Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse.	ø Check for support stockings or ace wraps. If none, check with doctors. ø Check that safety straps are correctly applied. ø Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. ø. Check that rings and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL E.1. __✓__ Potential impairment of mobility due to: ____ 1) Pain __✓__ 2) Intraoperative Hazards ____ 3) Prosthesis __✓__ 4) Positioning __✓__ 5) Transfer pt. to/from OR table E.2. __✓__ Potential discomfort due to: __✓__ 1) Length of Surgery __✓__ 2) Positioning __✓__ 3) Arthritis	ø Pt. will be transferred to OR table without difficulty. ø Pt. will not experience unnecessary physical discomfort.	ø Have sufficient people available for transfer. ø Insure proper body alignment. ø Allow patient to lie in position of comfort while waiting for surgery. ø Offer support (i.e., pillows, bath towels, etc.) for positioning.
F. SPECIAL SENSES F.1. __✓__ Diminished visual perception due to being: __✓__ 1) Pre-Medicated __✓__ 2) W/O Glasses F.2. __✓__ Potential for decreased communication due to: __✓__ 1) Diminished Hearing __✓__ 2) Language Barrier F.3. __NA__ Potential injury due to dentures: ____ 1) Upper ____ 4) Caps ____ 2) Lower ____ 5) Crowns ____ 3) Bridges	ø Pt. will be made aware of surroundings prior to anesthesia induction. ø Pt. will be transferred safely to OR table. ø Pt. will be able to understand instructions. ø Minimize danger of injury during intraop period.	ø Introduce self. Keep pt. informed as to where he/she is and what is happening. ø Inform pt. in which direction to move and assist if necessary. ø Speak clearly and slowly. ø Address pt from either side. ø Validate pt.'s understanding of verbal communication. o Verify removal of dentures.
G OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

10. OR NURSING INTERVENTIONS COMPLETED/ADDITIONAL INTRAOPERATIVE INTERVENTIONS NOTED.

[redacted] MD 18 Jul 03 DATE

11. POSTOPERATIVE EVALUATION: SKIN INTEGRITY: Bovie Pad Site: ☒ Clean and Dry ☐ Red ☐ N/A DRESSING DRY & INTACT: [✓ (Y)] (N)

LEVEL OF CONSCIOUSNESS: ☐ A&O ☒ Drowsy ☐ Sleepy ☐ Intubated BREATHING EASY [✓ (Y)] (N)

LEVEL OF ACTIVITY: ☒ Moves All Extremities ☐ Moves Upper Extremities ☐ Transferred to litter with roller due to spinal

(b)(6)-2

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] MAJ A

DATE: 18 Jul 03 TIME: 1055

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted]

DATE: 18 Jul 03 TIME: 2045

(b)(6)-2

REVERSE OF FORM 5179, JUN 91 MEDCOM - 13767 USAPA V1.0

MEDICAL RECORD

INTRAOPER...IVE DOCUMENT

For use of this form, see AR 40-66, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Litter BY [redacted] Staff

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY [redacted] CPT/AN

3. DATE 5 July 03 TIME PATIENT ARRIVED IN SUITE ICW → OR

4. PATIENT IN ROOM TIME 1809 (b)(6)-7 NUMBER 2-1/4

5. PREOPERATIVE EMOTIONAL STATUS

☑ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS: NKDA.
NPO since yesterday.

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] (91D) (b)(6)-7	RELIEF SCRUB	SPC [redacted] (1945-ECC) (b)(6)-7
ASSIGNED CIRCULATOR	CPT. [redacted] (66G)	RELIEF CIRCULATOR	CPT [redacted] (1940-ECC)

7. POSITION AND POSITIONAL AIDS *(Specify)*

☑ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

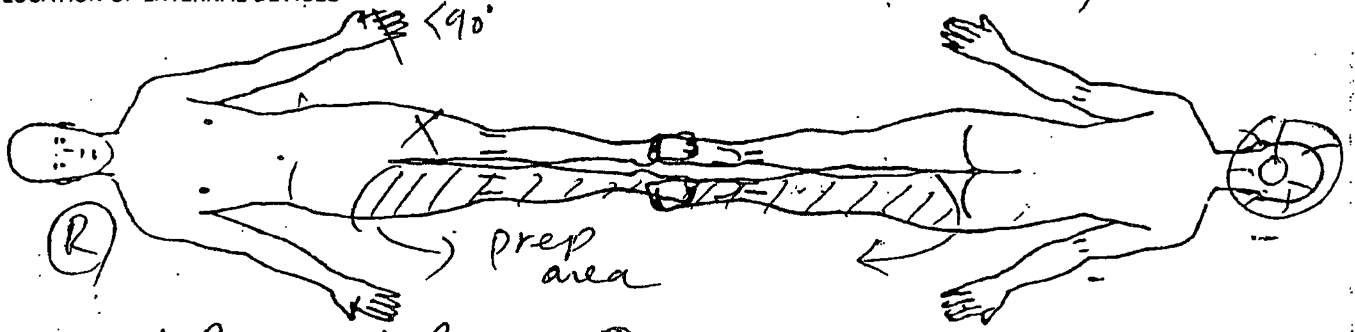
COMMENTS: Bil arm to padded armboard <90°, Roll under Ⓡ Hip.

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☑ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP
COMMENTS: ∅

PREP SOLUTION *(Specify)* Betadine S/Sol
SITE: Rt. leg BY WHOM: CPT. [redacted]
SITE: ~ BY WHOM: ~
COMMENTS: ∅ pooling of sol

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad ✓ -- Safety Strap ✓ = = = Tourniquet ∅

C = Correct I = Incorrect

10. COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☑ Yes	☐ No	/	C	C	SPC [redacted]	∅ [redacted]
Needle Sharp	☑ Yes	☐ No		C			
Instrument	☐ Yes	☑ No		/	/		
Other	☐ Yes	☑ No					

(b)(6)-7

11. PATIENT IDENTIFICATION *(F[redacted] entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

(b)(6)-7

EPW [redacted] (b)(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☑ YES ☐ NO

☑ ESU NO: Valley Lab #1
GROUND PAD: BRAND 3M
LOT NO: 2005-10 07
☐ ESU NO:
GROUND PAD: BRAND
LOT NO:
☐ BIPOLAR NO:
Coag = 30
cut = 30

MEDCOM - 13768

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.01

13. PROSTHESIS. IMPLANTS ☐ YES ☑ NO IF YES NAME: ID NUMBER; MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☑

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S):
0.9% NaCl

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE [redacted] (b)(6)-2

15. X-RAY IN OPERATING R[redacted] YES ☑ NO ☐ [redacted] ARM. IF YES, SITE Rt Femur

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☑	NAME	NAME [redacted] (b)(6)-2
FROZEN SECTION (FS) YES ☐ NO ☑	NAME	NAME
CULTURE (C) YES ☐ NO ☑	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

TYPE/SIZE	1.	2.	3.
SITE	1.	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Xeroform, Fluffs, Kerlix, Ace

19. ADDITIONAL INFORMATION

Surgeon: Dr [redacted] (b)(6)-2
Anes: Maj [redacted] (CRNA)
CPT [redacted] (CRNA)

20. OPERATION(S) PERFORMED
Ex-Fix to Right Femur

21. PATIENT TRANSFERRED TO ICU TIME See Anes Record METHOD Litter c̄ O_2

22. REGISTERED NURSE SIGNATURE [redacted] CPT/AN

REVERSE OF DA FORM 5179-1, OCT 87 (b)(6)-2

MEDCOM - 13769

USAPA V1.01

MEDICAL RECORD | **INTRAOPERA...VE DOCUMENT**

For use of this form, see AR 40-66, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Litter BY Anesthesia

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY Maj [redacted]

3. DATE 18 JUL 03 TIME PATIENT ARRIVED IN SUITE 1845

4. PATIENT IN ROOM TIME 1845 (b)(6)-2 NUMBER

5. PREOPERATIVE EMOTIONAL STATUS

☒ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS: NKDA

6. NURSING PERSONNEL

ASSIGNED SCRUB	SSG [redacted] (b)(6)-2	RELIEF SCRUB	Spc. [redacted] p 1900 (b)(6)-2
ASSIGNED CIRCULATOR	1LT [redacted]	RELIEF CIRCULATOR	LTC [redacted] p 1900

7. POSITION AND POSITIONAL AIDS *(Specify)* Pt. supine on padded OR table. BUE on padded armboards < 90°

☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

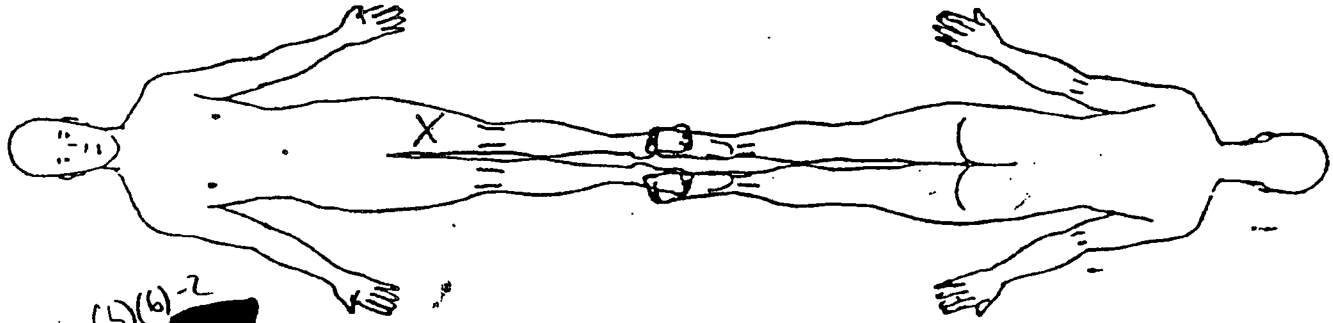
COMMENTS: Normal anatomic body alignment maintained.

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☐ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR
☐ CLIP
COMMENTS:

PREP SOLUTION *(Specify)*
SITE: BY WHOM:
SITE: BY WHOM:
COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



(b)(6)-2 [redacted]

LEGEND X G[redacted]ad -- Safety Strap === Tourniquet

Initial: SSG 1LT [redacted]

C = Correct I = Incorrect

10. COUNTS			Other**	First Closing Count *	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes	☐ No		C	C	Spc [redacted]	Lt [redacted]
Needle Sharp	☒ Yes	☐ No				Spc	LTC
Instrument	☐ Yes	☒ No					
Other	☐ Yes	☒ No					

(b)(6)-2

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

[redacted] (b)(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO

☒ ESU NO: 000450
GROUND PAD: BRAND VL REM Polyhesive II
LOT NO: 68936 EXP 2005-03

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

cut: 30 coag: 30

MEDCOM - 13770

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.01

13. PROSTHESIS, IMPLANTS ☐ YES ☒ NO IF YES NAME: ID NUMBER; MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☐

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO. TYPE(S):
0.9% NaCl- Q.S.

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE [redacted] (b)(6)-2

15. X-RAY IN OPERATING ROOM YES ☒ NO ☐ IF YES, SITE C-Arm Ⓡ femur

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☐ NO ☐

TYPE/SIZE	1.	2.	3.
SITE	1.	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Iodoform Gauze
kerlix fluffs
kerlix Rolls

19. ADDITIONAL INFORMATION (b)(6)-2
Surgeon: Dr. [redacted] Dr. [redacted]
Anesthesia: MAJ [redacted], MAJ [redacted]

DA 5179 initiated

20. OPERATION(S) PERFORMED
I+D Ext. fix. pins; revision of pins

21. PATIENT TRANSFERRED TO ICU 2 TIME 2030 METHOD LITTER c̄ O2

22. REGISTERED NURSE SIGNATURE [redacted] [redacted]

REVERSE OF DA FORM 5179-1, OCT 87 USAPA V1.01

(b)(6)-2 MEDCOM - 13771

MEDICAL RECORD | **INTRAOPERA_E DOCUMENT**

For use of this form, see AR 40-66, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Litter BY anes	2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY [redacted] CPT/AN
3. DATE 21 July 03 — TIME PATIENT ARRIVED IN SUITE —	4. PATIENT IN ROOM TIME 2125 (b)(6)-7 NUMBER 2-1

5. PREOPERATIVE EMOTIONAL STATUS

☒ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	Spc [redacted] 91D (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] 66E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

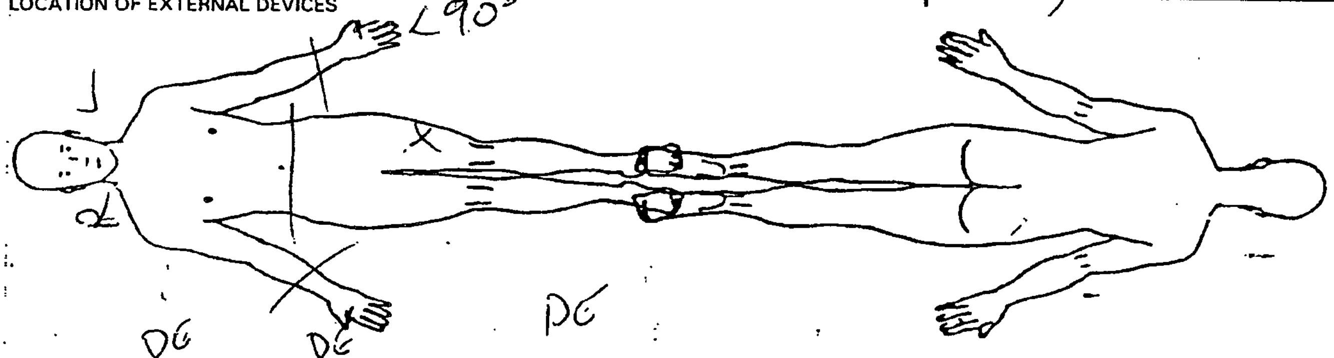
COMMENTS: Bump placed under Ⓡ hip by [redacted] (b)(6)-2

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR
☐ CLIP
COMMENTS:

PREP SOLUTION *(Specify)* Beta / Beta
SITE: Ⓡ thigh BY WHOM: [redacted]
SITE: Ex fix frame BY WHOM:
COMMENTS: Ø pooling

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Strap = = = Tourniquet

10. COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
			C = Correct I = Incorrect				
Sponge	☐ Yes	☐ No					
Needle Sharp	☐ Yes	☐ No					
Instrument	☐ Yes	☐ No					
Other	☐ Yes	☐ No					

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

#[redacted] (b)(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO

☐ ESU NO: VL #3 25/25
GROUND PAD: BRAND VL Rem PolyH
LOT NO: 68936
☐ ESU NO:
GROUND PAD: BRAND
LOT NO:
☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 MEDCOM - 13772 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.01

PROSTHESIS, IMPLANTS ☑ YES ☐ NO IF YES NAME:

Surgical Simplex® P
Howmedica Int. S. de R.L.
Raheen Business Park
Limerick, Ireland.
Full Dose
REF 6191 0 001
LOT CLJ157

Surgical Simplex® P
RADIOPAQUE BONE CEMENT
Distributed by:
Stryker®
Howmedica
Osteonics Mahwah, New Jersey
Full Dose
Cat. No. 6191 1 001
Control No. RAJ019

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANES

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY
Tobramycin 1.2gm	1.2gm	Intraop	mixed c̄ cement	[redacted] (b)(6)-2

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S):
0.9 NaCl

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE [redacted] (b)(6)-2

15. X-RAY IN OPERATING ROOM
YES ☐ NO ☒
IF YES, SITE

16. ORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☐	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☐	NAME	NAME
CULTURE (C) YES ☐ NO ☐	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☑ NO ☐

TYPE/SIZE	1. antibiotic beads	2.	3.
SITE	1. (R) thigh	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
fluffs
Kerlix
Ioban

19. ADDITIONAL INFORMATION
[redacted]
(b)(6)-2

20. OPERATION(S) PERFORMED
I+D (R) LE Ex Fix

21. PATIENT TRANSFERRED TO ICU 2	TIME 2242	METHOD litter w/anesth

22. REGISTERED NURSE SIGNATURE [redacted] ROT/AN

REVERSE OF DA FORM 5179-1, ... 87
(b)(6)-2

MEDCOM - 13773 USAPA V1.01

MEDICAL RECORD — INTRAOPER : DOCUMENT

For use of this form, see AR 40-66, the pro . agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Litter BY Anesthesia / OR nurse

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY [redacted] MAJ AN

3. DATE 4 Aug 03
TIME PATIENT ARRIVED IN SUITE 1220

4. PATIENT TIME 1220 (b)(6)-2 NUMBER 2-2

5. PREOPERATIVE EMOTIONAL STATUS

☒ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS: Allergies: nkda

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

COMMENTS: proper body alignment maintained

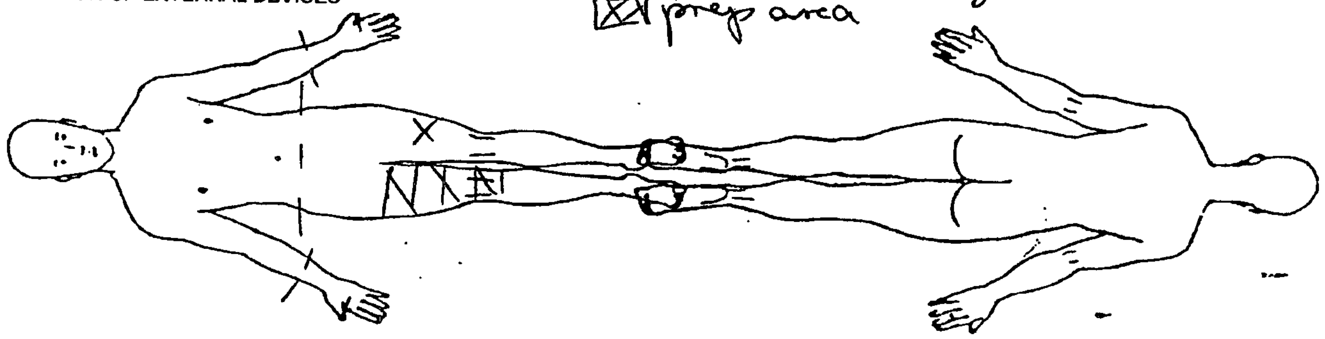
8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR
☐ CLIP
COMMENTS:

PREP SOLUTION *(Specify)* Beta / Beta
SITE: Thigh to 2 in below Knee (R) BY WHOM: Humphrey
SITE: BY WHOM:
COMMENTS: no pooling or skin Δ's noted

9. LOCATION OF EXTERNAL DEVICES

☒ prep area



LEGEND X Ground Pad – Safety Strap === Tourniquet

10. COUNTS — C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No		C	C	[redacted] (b)(6)-2	[redacted]
Needle Sharp	☒ Yes ☐ No					
Instrument	☐ Yes ☒ No					
Other	☐ Yes ☒ No					

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

#[redacted] (b)(6)-4
ICW2

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO

☒ ESU NO: VL Force 2 # 3
GROUND PAD: BRAND VL Rem Polyhesive II
LOT NO: 68936 2005-03

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

[redacted]

DA FORM 5179-1, OCT 87 REPLACES D/ I IS OBSOLETE. USAPA V1.01

MEDCOM - 13774

13. PROSTHESIS, IMPLANTS ☐ YES ☒ NO IF YES NAME: ID NUMBER; MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☒

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):
0.9% NaCl

OTHER ORDERS	TIME	CARRIED OUT BY
none		

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM
YES ☒ NO ☐
IF YES, SITE (R) Femur C-arm

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☐	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☐	NAME	NAME
CULTURE (C) YES ☐ NO ☐	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

TYPE/SIZE	1.	2.	3.
SITE	1.	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Kerlix
Fluffs
Acewraps

19. ADDITIONAL INFORMATION
WC II
Surgeons: [redacted] Anesthesia: [redacted] Anesthesia Type: GETA (LMA)
(b)(6)-2

Bovie Pad site intact pre-op ✓; post-op ✓ Bovie Settings: Coag/Cut
30/30

20. OPERATION(S) PERFORMED
I+D (R) thigh + ExFix Adjustment

21. PATIENT TRANSFERRED TO ICU 2
TIME See DA7389
METHOD Litter

22. REGISTERED NURSE SIGNATURE
[redacted] FTMN

REVERSE OF DA FORM 5

USAPA V1.01

MEDCOM - 13775

(b)(6)-2

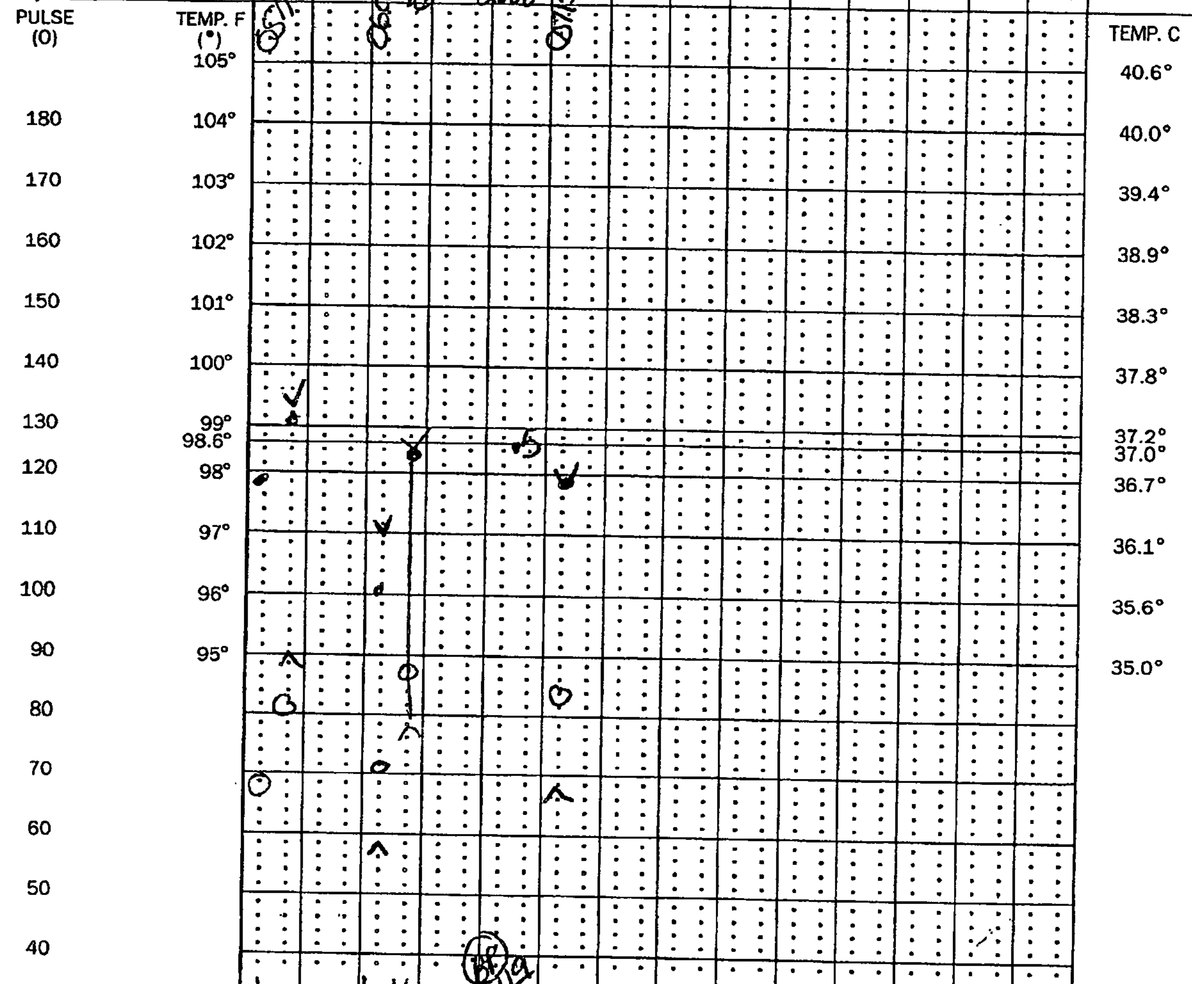
511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY					
POST- DAY			21 Aug 03		
MONTH-YEAR Aug	DAY	20	21		
19 03	HOUR	0511	0816	2000	0715



RESPIRATION RECORD

	16	16	BP 119/72	
BLOOD PRESSURE	128/94 131/70	110/58 120/70	P 81 R 16	
	97		O2	
HEIGHT: WEIGHT →	98%	98% 99% RA	98% RA	99%

Data only when so ordered

IDENTIFICATION (For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)

REGISTER NO.

WARD NO.

[redacted] (b)(6)-4

VITAL SIGNS RECORDS

Medical Record

STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

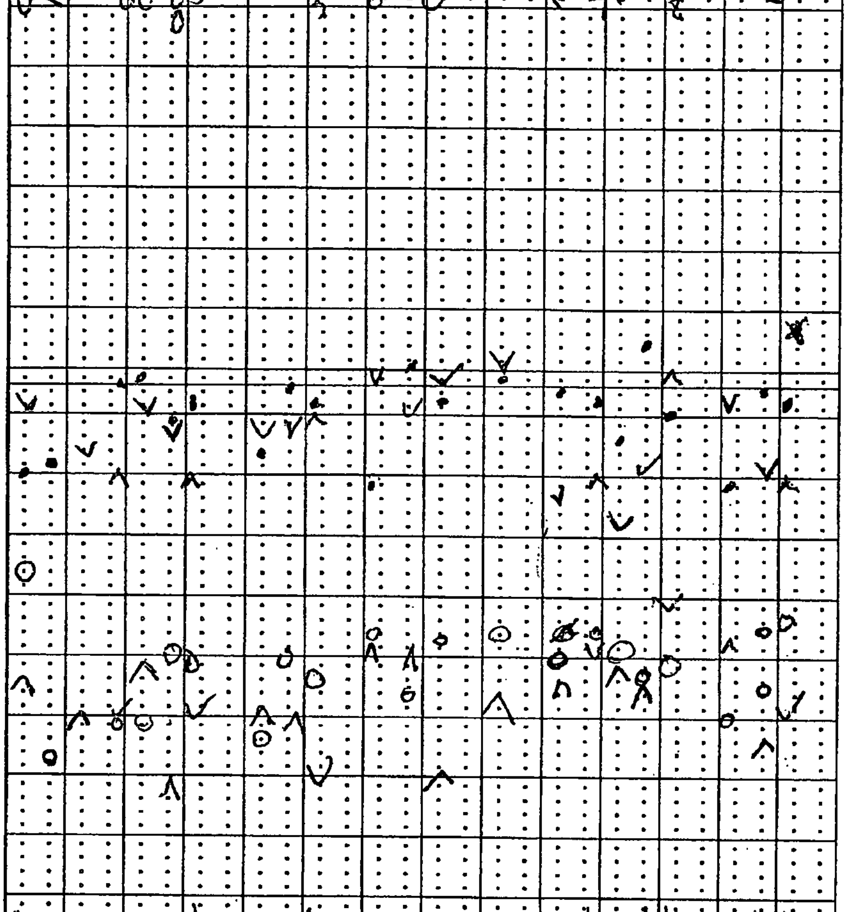
MEDCOM - 13776

MEDICAL RECORD

VITAL SIGNS REC

(REV. 7-95)
FIRMR (41 CFR) 201-9.202-1

HOSPITAL DAY														
POST- DAY														
MONTH-YEAR Aug DAY	13		14		15		16		17		18		19	
19 2003 HOUR	[illegible]		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	1330



RESPIRATION RECORD	16		16	16	14	16			16	18	16 14	16	16	16
BLOOD PRESSURE	122/76		132/78		14/72		126/82		130/74		112/78		124/84	–
	114/70		118/60		117/70		120/80				110/76		110/68	
	97		97	98	97	98%	97%	99	97	98	97			
HEIGHT: WEIGHT →	98%	98%								99		98	71%	98%

Record special data only when so ordered

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*

REGISTER NO.

WARD NO. 1CW2

[redacted] (b)(6)-4

[redacted]

STANDARD FORM 511 (REV. 7-95) **BACK**

MEDCOM - 13777

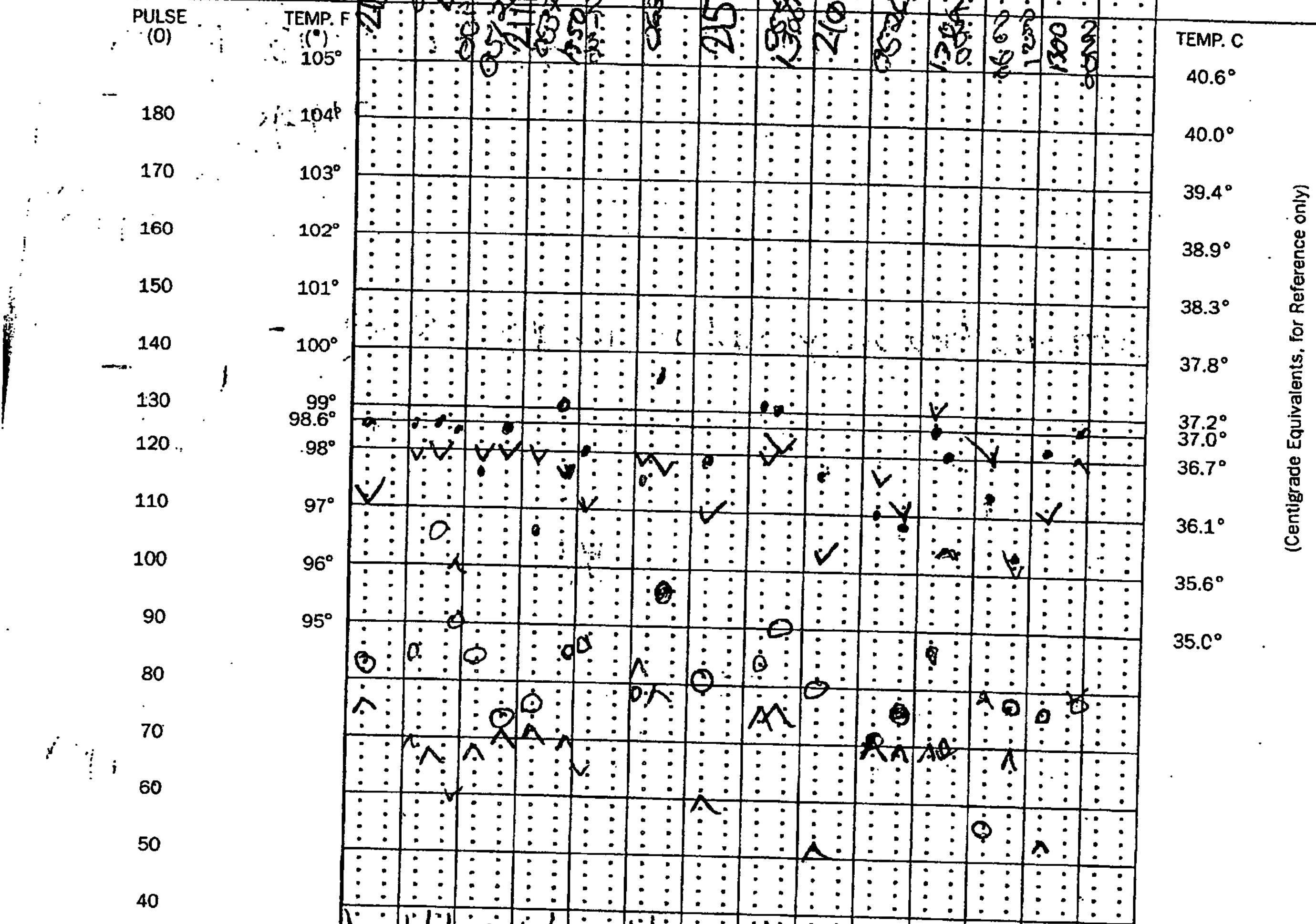
511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY															
POST- DAY															
MONTH-YEAR	DAY	5	6	7	8	8	9		10		11		12		
19	HOUR	2153	0832	0830	2117	0830	0830	2157	1300	2107	0832	1330	0830	1300	2030



RESPIRATION RECORD	18	16 18 16	16 16	16 16	16	18 18		16 18	16	16	16	18 20	16	
BLOOD PRESSURE	114/70	114/70 115/68	118/68 118/72	118/73		113/74 114/80	108/66	114/76 122/76	108/65	116/72	130/70	120/70 110/72	110/54	
HEIGHT: / WEIGHT →	98%		97 98%	98	98%	96%	98%	98 100%	98%	97	97% 98%	97%	97% 98%	

Record special data only when so ordered

X

PATIENT'S IDENTIFICATION (*For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility*)

REGISTER NO.

WARD NO. ICW

CPW [redacted] (b)(6)-4

VITAL SIGNS RECORDS
Medical Record

MEDCOM - 13778

511-119 NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY		1						
POST-	DAY							
MONTH-YEAR	DAY	5 JUL						
19	HOUR	1600						

PULSE (O)	TEMP. F (•)		TEMP. C
	105°		40.6°
180	104°		40.0°
170	103°		39.4°
160	102°		38.9°
150	101°		38.3°
140	100°		37.8°
130	99°		37.2°
	98.6°		37.0°
120	98°	V	36.7°
110	97°		36.1°
100	96°	O	35.6°
90	95°		35.0°
80			
70			
60		Λ	
50			
40			

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD	RR	16	
Record special data only when so ordered	BLOOD PRESSURE	115/67	
	HEIGHT:	WEIGHT →	
	SPO2	96%	
	RR	RA	

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*

GPW GTV - [redacted] (b)(6)-2

5 JUL 03

REGISTER NO.

WARD NO. CU #1

VITAL SIGNS RECORDS

Medical Record

STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 13779

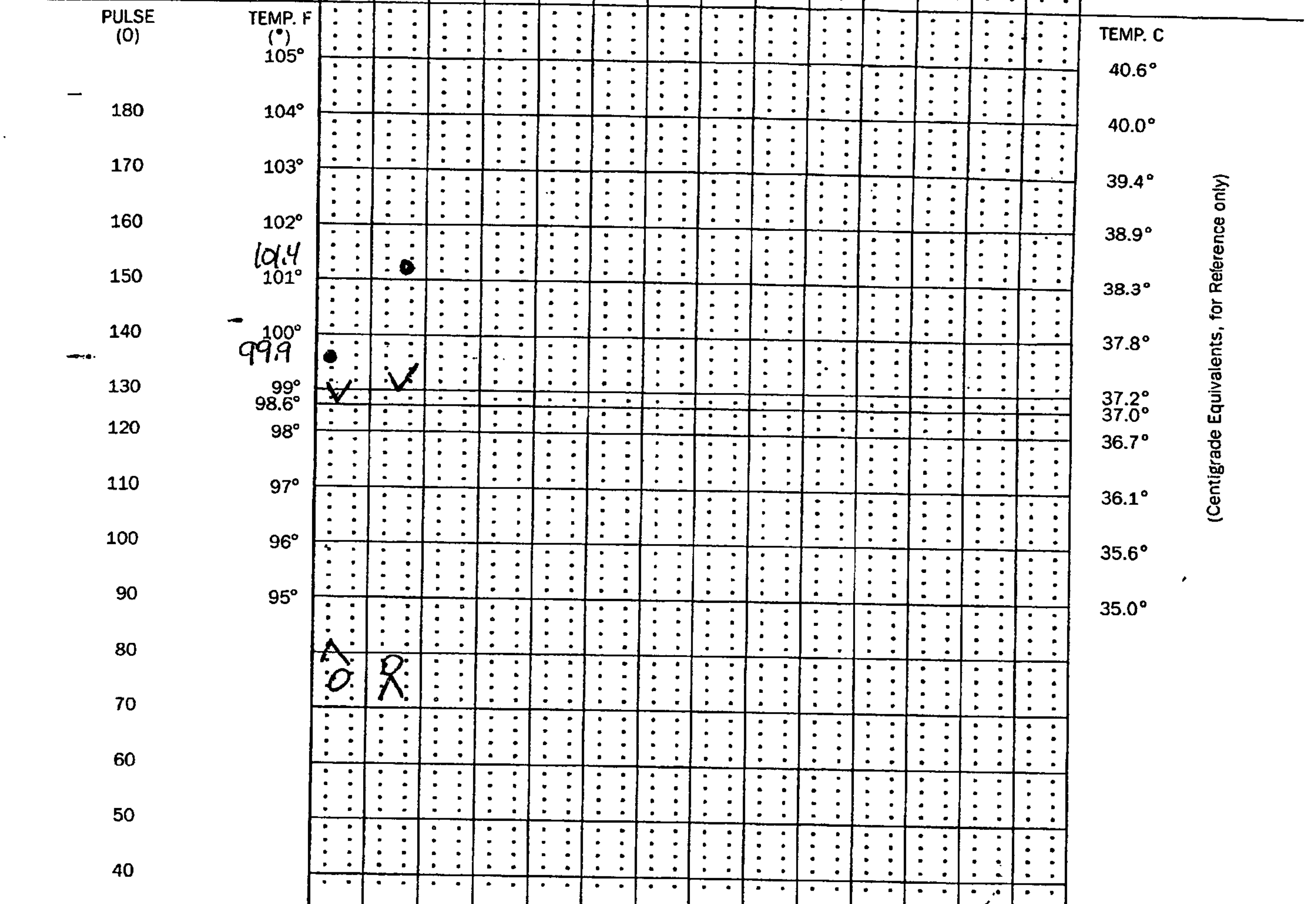
__ _19

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY				
POST- DAY				
MONTH-YEAR DAY	08	12	16	20
19 HOUR				



RESPIRATION RECORD

Record special data only when so ordered

BLOOD PRESSURE	128/81	129/75	
HEIGHT: WEIGHT →			
RR	20	20	
SaO2	100%		See flowsheet
	RA		

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*

REGISTER NO.

WARD NO.

[redacted] (b)(6)-4

6 Jul 03

VITAL SIGNS RECORDS

Medical Record

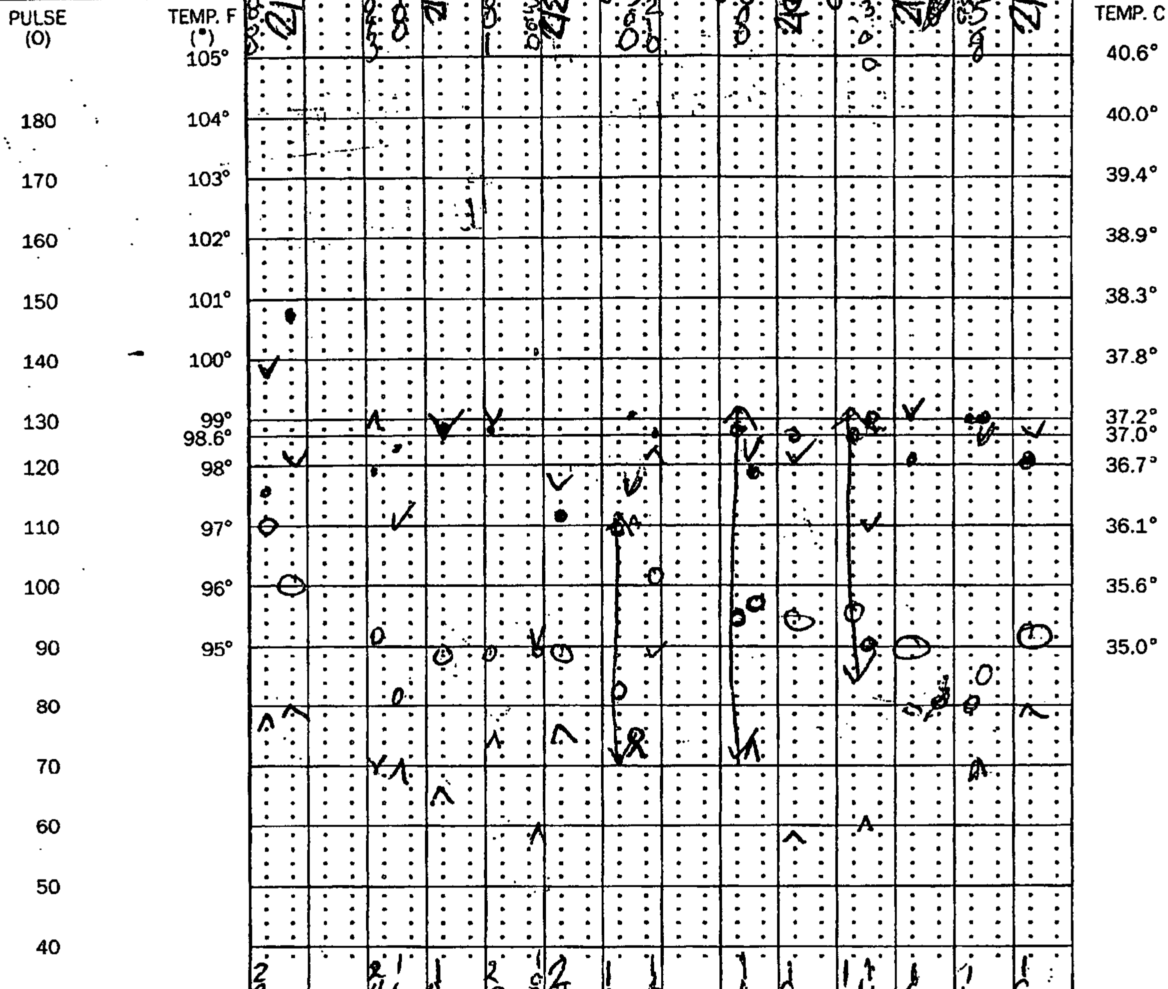
STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 13780

MEDICA[illegible]

VITAL SIGNS RECORD

HOSPITAL DAY														
POST- DAY														
MONTH-YEAR / DAY	15		16		17		18		19		20		21	
19 / HOUR	[illegible]		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]



RESPIRATION RECORD	22		24 16	16	20	18	16	10		16	16	14 16	16	14	16
BLOOD PRESSURE	138/78		128/70	124/62	124/72	114/76	1			120/58	110/62	130/80	130/70	126/80
	120/80		110/70		90/40		118/74		122/78				120/72	
HEIGHT: / WEIGHT →	97%		97%	98%	98	98%	98%		95%	98%	98%	97%	97/	97%
										98%	97			
O2 Sat	99%													

Record special data only when so ordered

M.D. [redacted] (b)(6)-2

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

REGISTER NO.

WARD NO.

STANDARD FORM 511 (REV. 7-95) **BACK**

EPW [redacted]

(b)(6)-4

MEDCOM - 13781

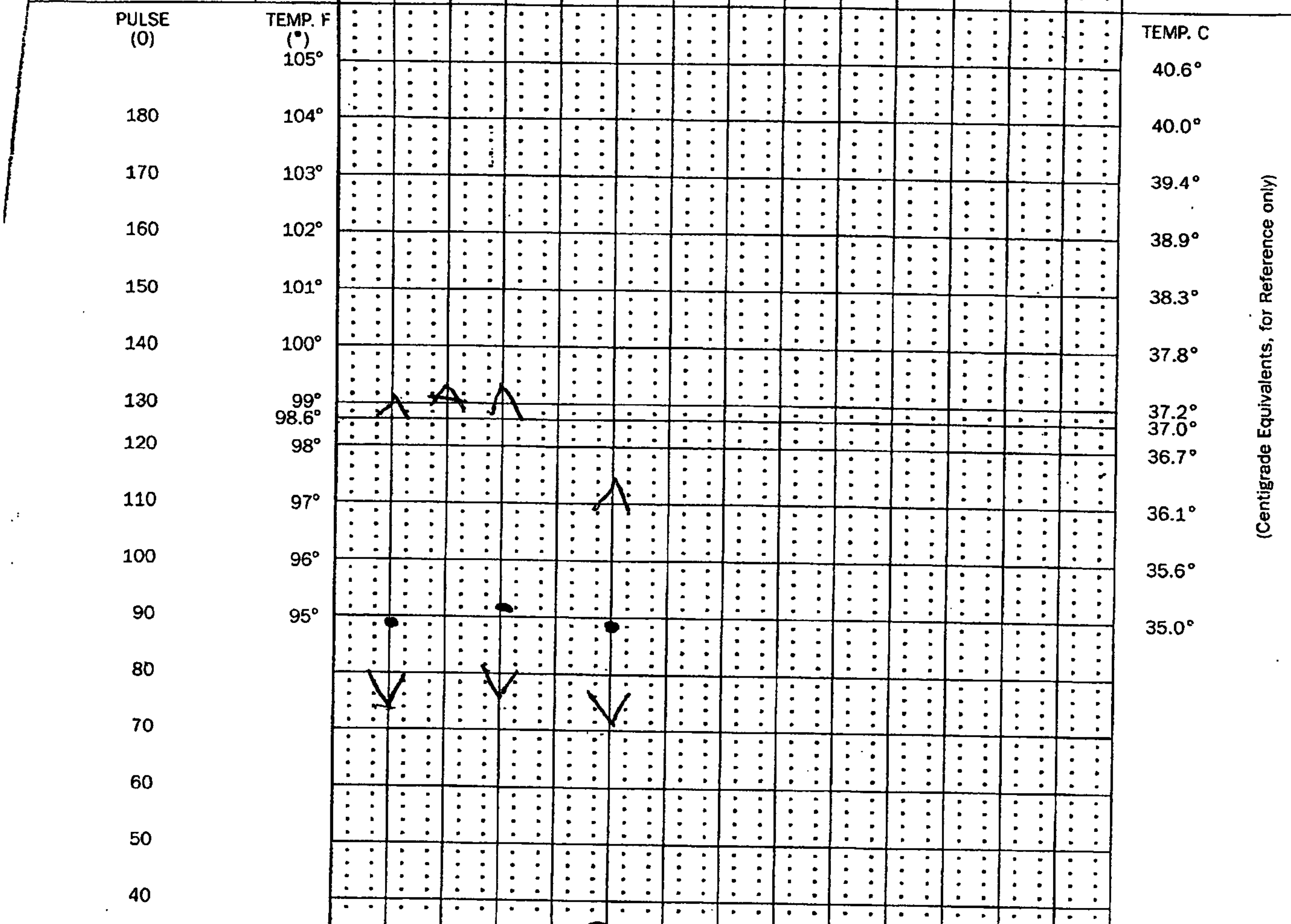
1-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY	
POST- DAY	7/8/03
MONTH-YEAR DAY	08200 2400 0400
19 HOUR	



RESPIRATION RECORD 16 16 18

Record special data only when so ordered

BLOOD PRESSURE

HEIGHT: WEIGHT →

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*

REGISTER NO.

WARD NO.

[redacted] (b)(6)-4

VITAL SIGNS RECORDS

Medical Record

STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-

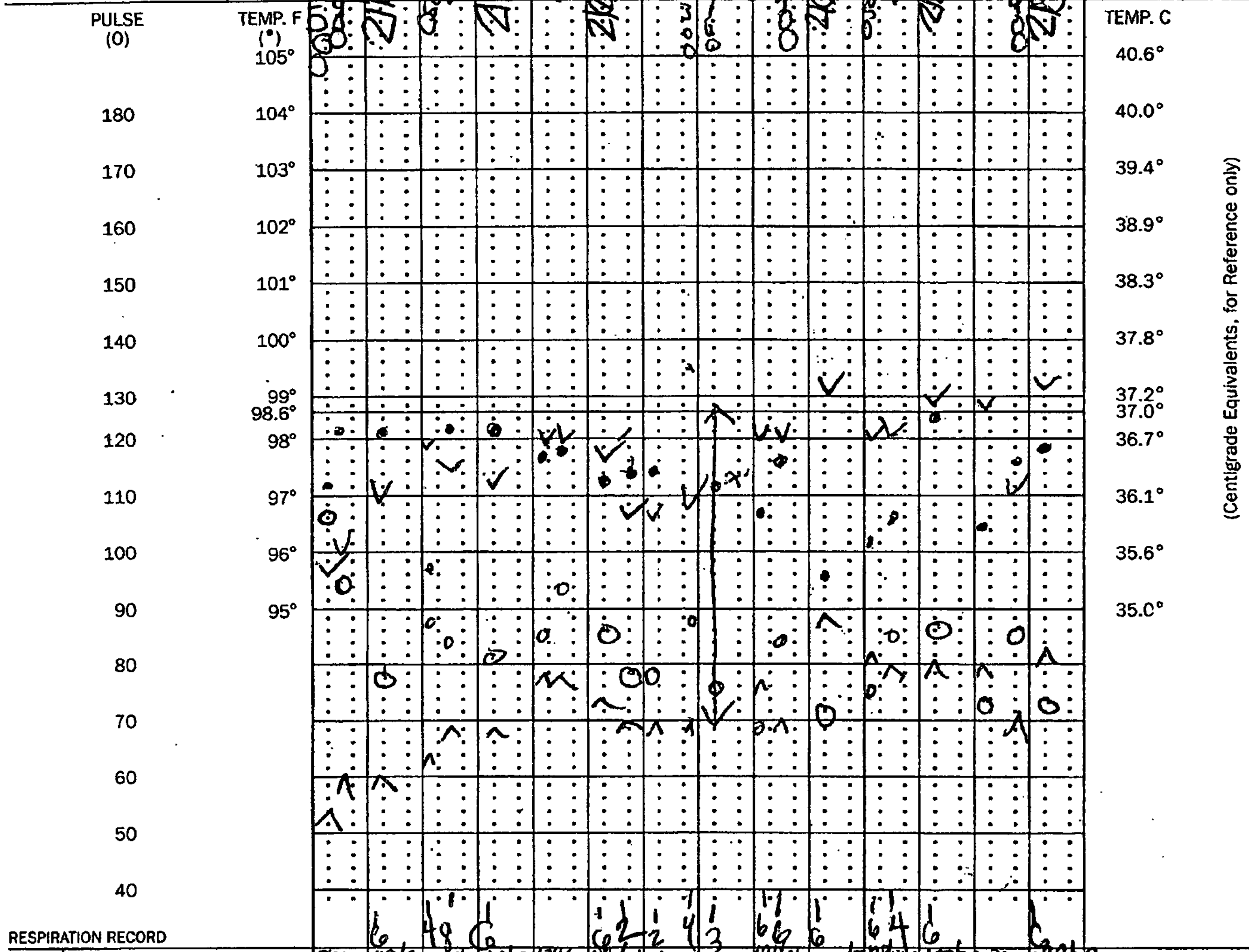
MEDCOM - 13782

NSN 7540-00-634-4124

AL RECORD

VITAL SIGNS RECORD

SPITAL DAY															
DAY															
MONTH-YEAR	DAY	22		23		24		25		26		27		28	
19	HOUR	[illegible]	2115	0800	2112	0630	2100	0500	1300 1600	0800	2100	0530	[illegible]	0640	2100



RESPIRATION RECORD		16	18	16		16	12	14	13	16	16	16	16	16
BLOOD PRESSURE	96/54	110/60	114/68	110/80	124/78	116/74	110/70		120/76	130/78	120/82	128/80	124/80	132/82
	100/60				120/78	100/60	100/70		130/70		120/80		110/70	
	97%	95%	98%	99%	99%	98%								
HEIGHT: WEIGHT →					98%	98%	96%	98%		98%	98%	98%	99%	99%

Record special data only when so ordered

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*	REGISTER NO.	WARD NO.
		[illegible]

[redacted] (b)(6)-4

VITAL SIGNS RECORDS

Medical Record

STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDICAL RECORD

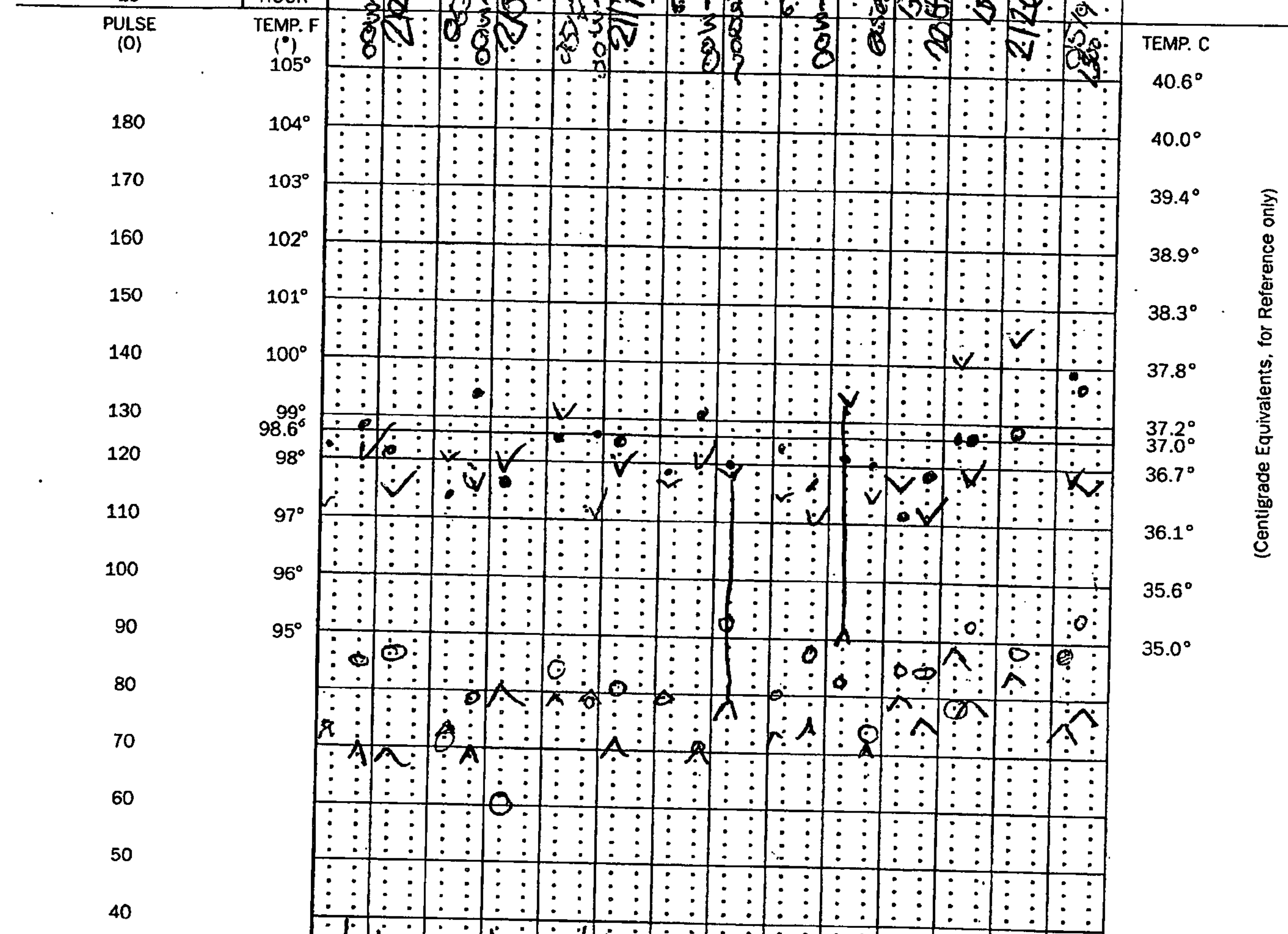
VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR July 03 DAY 29 30 31 August 1 2-3 3-4 4-5

19 HOUR [illegible]



RESPIRATION RECORD 18 16 16 16 16 18 18 16 14 14 18 16 14 16 26 18 16 18

Record special data only when so ordered

BLOOD PRESSURE 114/74 120/80 114/80 120/74 114/70 118/80 130/78 118/72 116/80 120/70 118/78 114/72 120/76 114/72 116/80 110/76 140/82 118/80 144/80 118/76 114/78

HEIGHT: WEIGHT → 98% 98% 97/98% 98/97% 98% 99% 98% 98/99 96/98% 98/98% 98% 97

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*

EPW [redacted] (b)(6)-4

REGISTER NO.

WARD NO. ICU 2

STANDARD FORM 511 (REV. 7-95) **BACK**

MEDCOM - 13784

ACLU-RDI 1592 p.1678

Vard/Section: CW (b)(6)-2

QUESTING PHYSICIAN: [redacted] (b)(6)-2

ABORATORY RESULT F
(Subject to the Privacy Act of

AST, FIRST, MI: [redacted] EPW [redacted] (b)(6)

DATE: 6JUL03

TIME: 0330

SSN/PSEUDO SSN: [redacted] (b)(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	16.3	4.8-10.8 x 10^3
RBC	3.80	4.7-6.1 x 10^9
Hgb	11.3	14-18 g/dl (M) 12-16 g/dl (F)
Hct	36.7	42-52% (M) 37-47% (F)
MCV	96.5	80-94 fl (M) 81-99 fl (F)
Plt	278	130-500 x 10^3 verified
Lymph %	17.0	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			
Spun Hematocrit		42-52% (M) 37-47% (F)	
Sed Rate			
Other			

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

Misc. Serology

TEST	RESULT	REF
RPR		Negati
Mono		Negati

Microbiology

Source		
Gram Stain		
Occ Bld		Neg
H. pylori		Neg
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinaly

CSF

Cell Count		
Directigen		Negative

Blood Bank

**MUST SUBMIT SF 518 \
EVERY UNIT REQUES**

ABO/Rh:

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Blood Bank Unit Crossmatch
(MUST SUBMIT SF 518 WITH EVERY UNIT OF BLO REQUESTED)

UNIT	TYPE	CROSSMA

REMARKS:

REPORTED BY: [redacted] (b)(6)-2

DATE: 6 Jul 03

LAB ID NO.:

MEDCOM - 13785

Ward/Section: ERT	RE[illegible]ING PHYSICIAN: [redacted]		**LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)
LAST, FIRST MI [redacted] (b)(6)-4 (b)(6)-2	DATE 5 Jul	TIME 1520	SSN/PSEUDO SSN: [redacted] (b)(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	16.[illegible]	4.8-10.8 x 10^3
RBC	[illegible]	4.7-6.1 x 10^9
Hgb	16.2	14-18 g/dl (M) 12-16 g/dl (F)
Hct	36.9	42-52% (M) 37-47% (F)
MCV	95.6	80-94 fl (M) 81-99 fl (F)
Plt	376	130-500 x 10^3 verified
Lymph %	16.4	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			
Spun Hematocrit		42-52% (M) 37-47% (F)	
Sed Rate			
Other			

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] (b)(6)-2	**DATE:** 5 Jul 03	**LAB ID NO.:**

MEDCOM - 13786

ACLU-RDI 1592 p.1680

# [redacted] (b)(6)-4 ICW#2 7-18-03 0730

(Hematology) CBC

ST	RESULT	REF. RANGE
BC		4.8-10.8 x 10³
RBC		4.7-6.1 x 10⁶
Hgb		14-18 g/dl (M) 12-16 g/dl (F)
Hct		42-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-400 x 10³ verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Myo		Imm	
RBC Morph			

Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source	
Gram	

Negative

Negative

lysis

WITH
STED

```
[illegible]
                         Patient
                          Limits
WBC   9.6   [illegible]   4.5  10.5
RBC   [illegible]         4.7? 6.00
Hgb   10.? L [illegible]  14.0 18.0
Hct   3?.? L              [illegible] [illegible]
MCV   7?.4                [illegible] 99.9
MCH   27.?                [illegible]
RDW   31.?                [illegible]
Plt   [illegible]         [illegible]
LY    32.?                20.5 51.1
MO    [illegible]
```

CSF

Cell Count		
Directigen		Negati

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D-dimer		30 ug/ml
FDP		10 ug/ml

Blood Bank Unit Crossmatch
(MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: **DATE:** **LAB ID NO:**

[redacted] (b)(6)-2

EPW [redacted] (b)(6)-4 19 July 0422

(Hematology) CBC

TEST	RESULT	REF RANGE
WBC		4.8-10.8 x 10³
RBC		4.7-6.1 x 10⁶
Hgb		14-18 g/dl (M) 12-16 g/dl (F)
Hct		42-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-400 x 10³ verified*
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis

TEST	RESULT	REF RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		
SG		
Bld		
pH		
Prot		
Urob		
Nit		
Leuk		
HCG		

Patient
Limits

Cell Count	
Direcigen	

Misc. Serology

TEST	RESULT	REF RANGE
RPR		Negative
Mono		Negative

Microbiology

Source

	Negative
	Negative

Microscopic Urinalysis

Blood Bank

SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

Coagulation Studies

TEST	RESULT	REF RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D-dimer		<20 ug/ml
FDP		<10 ug/ml

Blood Bank Unit Crossmatch
(MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: (b)(6)-2 [redacted] **DATE:** 19 Jul 03 **LAB ID NO:**

O/M NKDA

MEDICAL RECORD — ANESTHESIA

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML. "|"=CONSTANT INFUSION

DRUG	(Units)	
MIDAZ	(mg)	2
FENT	(mcg)	50 50 150 / 1854 – 10 —— 10
PROPOFOL	(mg)	150 50
LIDO	(mg)	50
VEC	( )	(NM) 30 6 —— 1 – 1
SUCC	(mg)	100
VOLAT AGENT FORANE	% del	4 1.5 / .6 / 1.0 / .06 / 1 / .4 / 1 / 0
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	8 2 2 / 2 / 2 / 2 / 2 / 2 / 4 / 5

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS ▶

FLUIDS

LINE site		
(R) FA 16 G	☐ Warmed	LR ——> 500 – 200↓ – LR 2 ↑ – 300↓
(L) FA 18 g	☐ Warmed	1000 LR 3 ↑ – 300↓ /
	☐ Warmed	/ 1600
	☐ Warmed	

LOSSES EST BLOOD LOSS
URINE –

TOTALS — TOTAL EBL <100 — TOTAL URINE 0

FLUIDS – SUMMARY
CRYSTALLOID – 1600
COLLOID – 0
BLOOD – 0

PHYS STATUS [✓ 1] 2 3 4 5 E

BODY WEIGHT 70 [✓ KG] LB

HEMATOCRIT

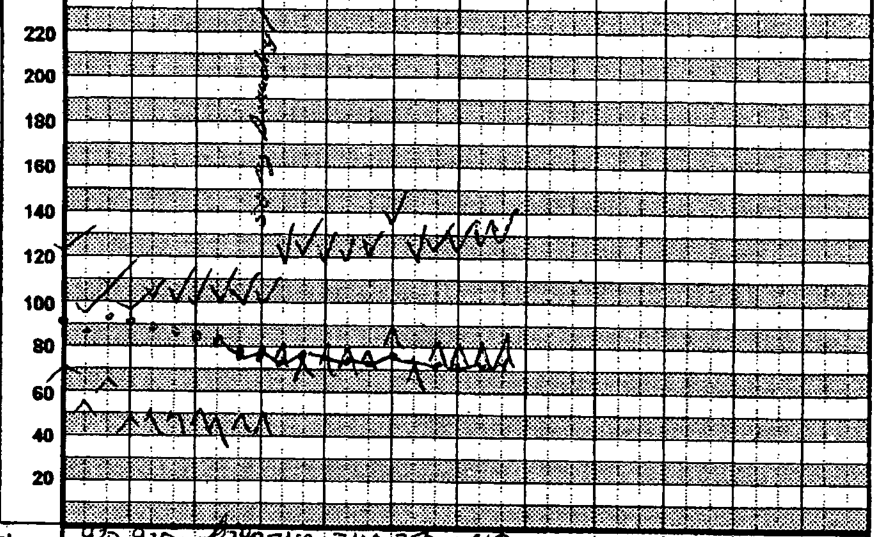
INITIAL DATA
BP – 122, 71
HR – 93

EQUIP CHECK [✓ OK?] Y N

PATIENT RECHECK [✓ OK for PROCEDURE?]
TIME – 1810

TIME ➡ 1815 30 45 1900 15 30 45 2000 15 30 45 2100

SYMBOLS:
BP by cuff ∨ ∧
Heart rate ●
Resp rate
BP (transduced)
TOURNIQUET T – ✗
ANES – X-X
PROC-⊙-Ø



VENTILATION

VT – ml	920	920	~~8~~ 740	740	740	750	750
f – breaths/min	6 ~~26~~	~~26~~ 6	6	6	8	7	
Peak inf pres / PEEP	26	26	25	26	26	26	15
MODE – S(pon), A(ssist), C(ont)	SC	C	C	C	C	C	S

MONITORS / ACCESSORIES

✓ BP/Auto Cuff	ET CO2 (torr)	35	36	33	35	34	34	45
BP / oth	FIO2 (Frac or %)	.81	.81	.82	.81	.81	.81	.81
ART line	SpO2 (%)	100	100	100	100	100	100	100
✓ Steth- PC/ES	ECG	SR	SR	SR	SR	SR	SR	SR
Gas analyzer	TEMP- site	AVAIL ——>						
	N-M Block (T/4)			0/4	0/4 – R16	1/4	1/4	4/4 TF
✓ Warming blkt								
Conv warmer								

Mark with letters & symbols, explain under REMARKS — EVENTS
Position ——>

REMARKS – Code drugs with numbers, events with letters

1800 PreOp EVAL REVIEW
IV's x 2 (B) FA's
TRANS ——> OR
1809 OR #2 MONITORS ↑
PreO2 IND/INT
1845 CASE ASSUMED BY
CPT [redacted] CRNA
RPT GIVEN BY MAJ
[redacted]
(b)(6)-7
1855 2g Ancef IVPB.
1945 5mg Neost / .8 Rob
1/4 TOF
1950 TOF 4/4
1955 ST
1959 PT c̄ VT > 4ml/kg
Ext – Sxn
2000 OOR TO ICU
2005 RPT TO CPT
[redacted]

RECOVERY AT 2002
PACU ICU ✓ (Specify)
OTHER
CONDITION: Stable
RESP – SpO2 – 95
BP – HR – 117

ANESTHESIA / PROCEDURE TIME

	Start	Room	End
ANES	1800	1809	2015

	Ready	Begin	End
PROC	1815	1830	1958

PROCEDURES and CPT Codes
Ex Fix (R) Femur

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
DLX1 / mac 5 8.0 ETT → VC c̄ BBS ⊜, ETCO2 ⊕ Secured 20cm LIPS

SURGEONS: [redacted]

CPT CRNA

PATIENT IDENTIFICATION – Typed or written entries: Name, Grade/Rate, Medical facility
[redacted] ICU / ICU
(b)(6)-4

(b)(6)-2

PROCEDURE LOCATION OR 2
DATE 05 Jun 03
PAGE 1 OF

MEDICAL RECORD – ANESTHESIA
WAMC OP 376 REVISED
1 Jan 99
MEDCOM - 13789
*U.S. GPO: 2002-729-180/40137

ANESTHESIA PLAN OF CARE Pr ROCEDURAL ASSESSMENT (Sedation Anesthesia)

Age 40 DAYS MOS YRS

Sex [✓ MALE] ~~( ) FEMALE~~

ASA Physical State [✓ 1] 2 3 4 5 E
WT: 70 [✓ KG]/LB HT: _____ IN.
ALLERGIES: NKDA

PROPOSED PROCEDURE: Ex Fix (R) Femur
SURGICAL SERVICE: ____
NPO SINCE: ____

HABITS:
TOBACCO: Smoker
ETOH: Yes
DRUGS: No

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) ____
( ) ____
( ) ____
( ) ____
( ) ____
( ) ____

PREMEDICATIONS:
None Yes (@ ____ Hrs) /CC
____ . ____ mg IV IM PO
____ . ____ mg IV IM PO
____ . ____ mg IV IM PO

LABORATORY STUDIES:
HB/HCT: 11.2 / 36.9
U/A: ____
OTHER: Plt 326

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:		
Hypertension	[✓ N] Y	
Angina	[✓ N] Y	
MI	[✓ N] Y	
CVA	[✓ N] Y	
Other	[✓ N] Y	
Pulmonary System:		
Asthma	[✓ N] Y	
Bronchitis/URI	[✓ N] Y	
COPD	[✓ N] Y	
Other	N Y	
Renal System:		
Acute/Chronic RF	[✓ N] Y	
Gastrointestinal:		
Hepatitis	[✓ N] Y	
Hiatal Hernia	[✓ N] Y	
PUD/GERD	[✓ N] Y	
Endocrine System:		
Diabetes	[✓ N] Y	
Steriods	[✓ N] Y	
Thyroid	[✓ N] Y	
Neurological:		
Seizures	[✓ N] Y	
Neuropathy	[✓ N] Y	
Other	[✓ N] Y	
Gynecological :		
Pregnancy	N Y	
Other Significant Hx:		
	N Y	
	N Y	
Familial HX	N Y	

ASSESSMENT
PAST SURGICAL/ANESTHETIC
X 1 ABD '83
No Anes Prob

PHYSICAL EXAMINATION
BP 115/67 HR 98 R 16 T ____
Pain Scale 0-10 ____
HEENT - Teeth WNL
Trachea ____
TMJ/Neck 3
Oropharnyx MP 2
Nares ____
CHEST: CTA
CARDIAC: S1 S2
EXTREMITIES:
IV Access: (B) FA's
Ulnar Filling: ____
BACK: ____
OTHER: ____

NPO Since yesterday

ANESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ____ [✓ General]: Mask [✓ Intubation]

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discussed with the patient/[redacted]uardian.

The patient/legal guard derstand and agrees. Questions answered.
Signed: (b)(6)-7 Date: 05 July 03 Time: 1630 Hrs

POST-ANESTHESIA EVALUATION AND NOTE (NON ASU)
{ } NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER

Signed: ____ Date: ____ Time: ____ Hrs

SEDATION KEY:

1. **MINIMAL** (Anxiolysis) Patient responds normally to verbal commands
2. **MODERATE** (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is not necessary.
3. **DEEP SEDATION/ANALGESIA.** Patient responds purposefully following repeated or painful stimulation. Airway assistance may

Patient Identification: (Ward) ____

#[redacted] (b)(6)4 ICU1/ICU1

MEDICAL RECORD — ANESTHESIA

CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML. "I"=CONSTANT INFUSION

DRUG	(Units)		TOTALS
Versed	(mg)	2	2.5 mg
MSO4	(mg)	5/5 5/5/5/5(10)	40 mg
[illegible]	( )	12.5	
[illegible]	(mcg)	50	
Propofol	(mg)	200	500
	( )		
VOLAT AGENT Halo	% del	X1-2 – 1.5 – 1.5 – 1.5 – 1 X	
	% e.t.		
AIR	L/Min		
N2O	L/Min		
O2	L/Min	4 – 4 – 4 – 4 – 4 – 6 – 10	

TOTAL EBL: min

TOTAL URINE: ~~0~~

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS

LINE site LR 20g ☐ Warmed — no

☐ Warmed

☐ Warmed

☐ Warmed

LOSSES — EST BLOOD LOSS / URINE –

ASA STATUS: [✓ 2] 3 4 5 E — T.

BODY WEIGHT: 70 LB [✓ G] — NKA

HEMATOCRIT:

INITIAL DATA: 120/60

R– 705

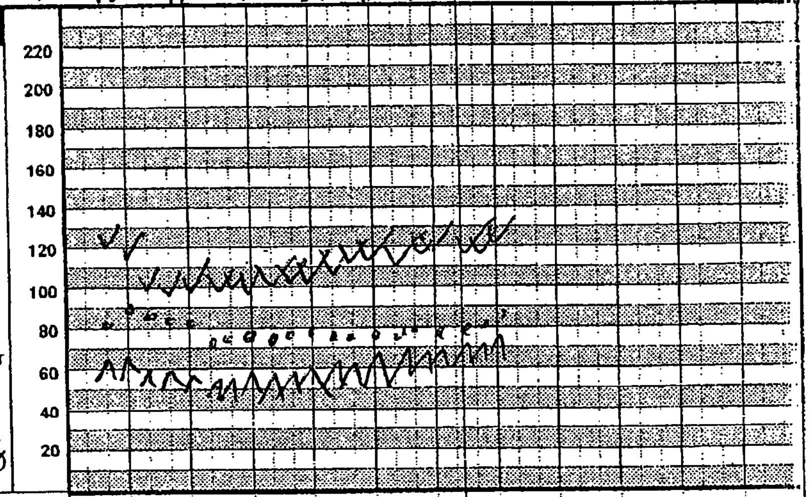
EQUIP CHECK — OK?– [✓ Y] N

PATIENT RECHECK — for PROCEDURE [✓ +]

TIME– 1840

TIME → 1845 1900 X 30 X 2007 X 30

SYMBOLS:
BP by cuff V Λ
Heart rate ●
Resp rate
BP (transduced) ⊥ T
TOURNIQUET T – ⊤̸
ANES– X-X
PROC– ⊙ – Ø



VT – ml								
f – breaths/min	34	26	29	16	20		18	
Peak inf pres / PEEP								
MODE– S(pon), A(ssist), C(on)	S	S	S	S	S	S	S	
BP/Auto Cuff ✓ — ET CO2 (torr)	4	40	46	48	53	53	58	
BP / oth ✓ — FIO2 (Frac or %)	7.21	7.21	7.21	7.21	7.21	7.21	7.21	
ART line ✓ — SpO2 (%)	100	100	100	100	100	100	100	
Steth- PC/ES ✓ — ECG	SR	SR	SR	SR	SR	SR	SR	
Gas analyzer — TEMP- site	available							
N-M Block (T/4)								
~~Warming blkt~~	Wool Blanket							
Conv warmer								

Mark with letters & symbols, explain under REMARKS — EVENTS Position → arms <90° abducted/padded

FLUIDS – SUMMARY

CRYSTALLOID– LR - 600

COLLOID–

BLOOD–

REMARKS– Code drugs with numbers, event with letters

1840 - Met c ID c IV in place - Hosp chart red

1845 - On room-monitors on Induction

2027 - Awake LMA D/C c TX ICU2 for recovery

RECOVERY AT — PACU ICU ________ (Specify)

OTHER ________ 97.1 stable

CONDITION

RESP– 16 SpO2– 93%

BP– 117/76 HR– 125

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1840	1840	2040
	Ready	**Begin**	**End**
PROC	1857	1910	2010

PROCEDURES and CPT Codes
I&D Rt Femur Fx Fix/Adjustment

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
Masked down using drawover, LMA #4 inserted x 1 attempt

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
20 c air in cuff - Eyes taped - atraumatic Soft bite block

PATIENT IDENTIFICATION– Typed or written entries: Name, Grade/Rate, Medical facility

#[redacted] (b)(6)-4
ICW 2

SURGEON [redacted]

ANESTHETIST

(b)(6)-7

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED
1 Jan 99

PATIENT RECORD

PROCEDURE LOCATION OR 2

DATE 13 Jul 03

PAGE 1 OF 1

☆ U.S. GPO: 1999 – 528-336/10

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 40 DAYS MOS YRS
Sex ( ) MALE ( ) FEMALE

PROPOSED PROCEDURE: I+D (R) femur, adjust ex fix.
SURGICAL SERVICE: ortho
NPO SINCE:

ASA Physical Status [✓ 1] 2 3 4
WT: 70 [✓ KG]/LB HT:
ALLERGIES: NKA

HABITS:
TOBACCO: Smoker
ETOH: Yes
DRUGS: no

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) Clindamycin
( ) Unasyn
( )
( )
( )
( )

PREMEDICATIONS:
None Yes (@ ______ Hrs) /CC
______ - ______ mg IV IM PO
______ - ______ mg IV IM PO
______ - ______ mg IV IM PO

LABORATORY STUDIES:
HB/HCT: ______ / ______
U/A:
OTHER:

9.0 > 10.2 / 32.3 < 916

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:
Hypertension [✓ N] Y
Angina [✓ N] Y
MI [✓ N] Y
CVA [✓ N] Y
Other [✓ N] Y
Pulmonary System:
Asthma [✓ N] Y
Bronchitis/URI [✓ N] Y
COPD [✓ N] Y
Other [✓ N] Y
Renal System:
Acute/Chronic RF N Y
Gastrointestinal:
Hepatitis [✓ N] Y
Hiatal Hernia [✓ N] Y
PUD/GERD [✓ N] Y
Endocrine System:
Diabetes [✓ N] Y
Steriods [✓ N] Y
Thyroid [✓ N] Y
Neurological:
Seizures [✓ N] Y
Neuropathy [✓ N] Y
Other [✓ N] Y
Gynecological :
Pregnancy [✓ N] Y
Other Significant Hx:
N Y
N Y
Familial HX [✓ N] Y

ASSESSMENT
PAST SURGICAL/ANES Hx
x (ABD) '83
no anes. prob

PHYSICAL EXAMINATION
BP 116/76 HR 98 R 16 T 98
Pain Scale 0-10
HEENT - Teeth: WNL
Trachea
TMJ/Neck 3
Oropharynx MP2
Nares
CHEST: CTA
CARDIAC: S, S2
EXTREMITIES:
IV Access:
Ulnar Filling:
BACK:
OTHER:

NPO Since

ANESTHETIC PLAN: ( ) LOCAL ( ) MAC ( ) Regional (Specify): ______ [✓ General:] Mask Intubation LMA.

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained discussed with the patient/legal guardian.

(b)(6)-2

The patient/legal [redacted] to understand and agrees. Questions answered.
Signed: RN Date: 18 July 03 Time: 1210 Hrs

POST-ANESTHESIA EVALUATION AND NOTE (NON ASU)
( ) NO APPARENT ANESTHETIC COMPLICATIONS ( ) OTHER

Signed: ______ Date: ______ Time: ______ Hrs

SEDATION KEY:
1. MINIMAL (Anxiolysis) Patient responds normally to verbal commands
2. MODERATE (conscious sedat Patient responds purposefully t verbal commands alone or accompanied by light tactile stimulation. Airway assistance necessary.
3. DEEP SEDATION/ANALGE Patient responds purposefully following repeated or painful stimulation. Airway assistance

Patient Identification: (Ward)

(b)(6)-4

[redacted]

$f\,CW_2 - f\,CU_2$

MEDCOM - 13792

MEDICAL RECORD - ANESTHESI

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

ANESTHETIC AGENTS AND DRUGS

CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML. "I" = CONSTANT INFUSION

DRUG (Units)							TOTALS
Versed (mg)	①.5 ①						25 mg
fentanyl (ml)	② ⑥ ①	①					5 ml
Propofol (mg)	(100)						100 mg
( )							
( )							
( )							
VOLAT AGENT 1.50 % del	2	1.4	1.4	1.5	0.5 X		
% e.t.	—	—	—	—	—	—	
AIR L/Min	—	—	—	—	—	—	
N2O L/Min	—	—	—	—	—	—	
O2 L/Min	RA 4	2 - 2	2 - 2	2	8	RA	

TOTAL EBL: 0

TOTAL URINE: N-M

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS

FLUIDS

LINE site						
☐ Warmed						
#18g Ⓡ PA ☒ Warmed	10/20	10/100				350/350
☐ Warmed						
☐ Warmed						

LOSSES

EST BLOOD LOSS	0	—	—	—	—	
URINE -	N-M	—	—	—	—	

FLUIDS - SUMMARY

CRYSTALLOID- LR 350

COLLOID- 0

BLOOD- 0

PHYS STATUS: [✓ 1] 2 3 4 5 E

BODY WEIGHT: 70 [✓ KG] LB

HEMATOCRIT:

INITIAL DATA:

BP- 130/79

HR- 87

EQUIP CHECK

OK?- [✓ Y] N

PATIENT RECHECK

OK for PROCEDURE? yes

TIME- 2125

SYMBOLS:

BP by cuff V Λ

Heart rate ●

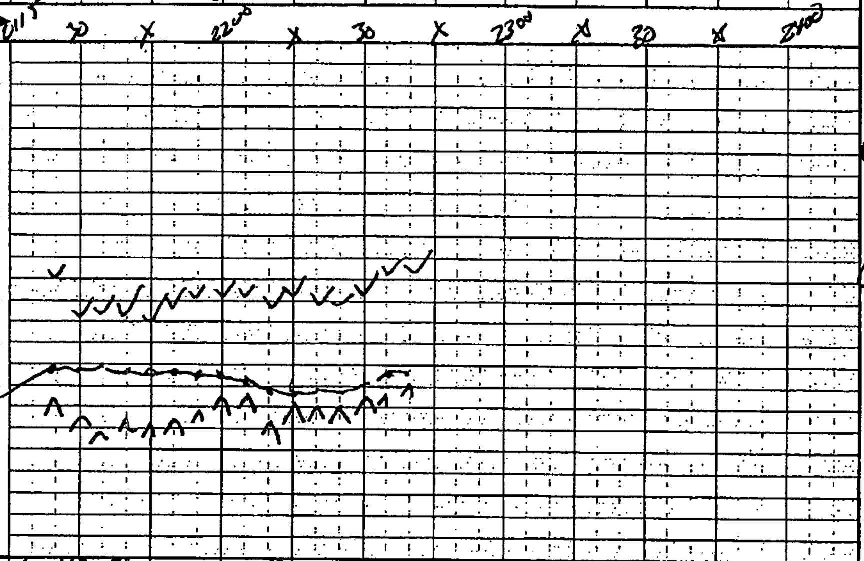
Resp rate

BR (transduced)

TOURNIQUET T-T

ANES- X-X

PROC- ⊙-∅



REMARKS

Code drugs with numbers, events with lettters

① ~ room, mon applied

② induction + placement of LMA

③ Eyes taped and bite block

④ pt awake + LMA removed c̄ reflexes intact

⑤ TO PACU

VENTIL

VT - ml	X - 440	360	410	380	440	600
f - breaths/min	18 - 12 - 16	30	20	18	19	15
Peak inf pres / PEEP	X - 6	6	6	6	6	—
MODE - S(pon), A(ssist), C(on)	S - A	A	A	A	A	S

MONITORS/ACCESSORIES

BP/Auto Cuff	☒ ET CO2 (torr)	34 - 36	39	37	40	36	38
BP/oth	FIO2 (Frac or %)	10	10	10	10	12	12
ART line	SpO2 (%)	100	100	100	100	100	100
Steth- PC/ES	ECG	SR	SR	SR	SR	SR	SR
Gas analyzer	TEMP-site	—	—	—	—	—	—
	N-M Block (T/4)	—	—	—	—	—	—
Warming blkt							
Conv warmer							

Mark with letters & symbols, explain under REMARKS EVENTS Position → ①②③ ④⑤

RECOVERY AT 2240

[✓ PACU] ICU ______(Specify)

OTHER Pain 0/10

CONDITION: Sleepy Tolerating

RESP- 19 SpO2- 98

BP- HR- 104

ANESTHESIA / PROCEDURE TIMES

ANES	Start	Room	End
	2115	2125	2250
PROC	Ready	Begin	End
	2132	2140	2235

PROCEDURES and CPT Codes:

I&D Ⓡ femur

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

GEN/LMA SCIA

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*

[redacted] (b)(6)-4

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*

#4 LMA EASY PLACEMENT

SURGEONS:

Dr [redacted] (b)(6)2

ANESTHETISTS:

PROCEDURE LOCATION: 3

DATE: 21 July 03

PAGE 1 OF 1

DA FORM 7389, FEB 1998 MEDCOM - 13793 PATIENT'S MEDICAL RECORD USAPA V1.00

ICW-2 - ICW-2

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 40 DAYS MOS [✓ YRS] Sex [✓ MALE] ( ) FEMALE

PROPOSED PROCEDURE: I&D Ⓡ Fem.
SURGICAL SERVICE: Ortho.
NPO SINCE:

ASA Physical State [✓ 1] 2 3 4 5 E
WT: 70 [✓ KG]/LB HT: _____ IN.
ALLERGIES: NKA

HABITS:
TOBACCO: yes
ETOH: -yes
DRUGS: Ø

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) clindamycin
( )
( )
( )
( )
( )

PREMEDICATIONS:
None Yes (@ ______ Hrs) /CC
______ . ______ mg IV IM PO
______ . ______ mg IV IM PO
______ . ______ mg IV IM PO

LABORATORY STUDIES:
HB/HCT: ________/________
U/A:
OTHER:

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:		
Hypertension	[✓ N] Y	
Angina	[✓ N] Y	
MI	[✓ N] Y	
CVA	[✓ N] Y	
Other	[✓ N] Y	
Pulmonary System:		
Asthma	[✓ N] Y	
Bronchitis/URI	[✓ N] Y	
COPD	[✓ N] Y	
Other	[✓ N] Y	
Renal System:		
Acute/Chronic RF	[✓ N] Y	
Gastrointestinal:		
Hepatitis	[✓ N] Y	
Hiatal Hernia	[✓ N] Y	
PUD/GERD	[✓ N] Y	
Endocrine System:		
Diabetes	[✓ N] Y	
Steriods	[✓ N] Y	
Thyroid	[✓ N] Y	
Neurological:		
Seizures	[✓ N] Y	
Neuropathy	[✓ N] Y	
Other	[✓ N] Y	
Gynecological :		
Pregnancy	N Y	
Other Significant Hx:		
	[✓ N] Y	
	[✓ N] Y	
Familial HX	[✓ N] Y	

ASSESSMENT
PAST SURGICAL/ANESTHETIC
Ø Anes problem

PHYSICAL EXAMINATION
BP 114/59 HR 80 R ___ T ___
Pain Scale 0-10 Ø
HEENT - Teeth
Trachea
TMJ/Neck
Oropharnyx
Nares
CHEST: CTA
CARDIAC: RRR s Ⓜ
EXTREMITIES:
IV Access:
Ulnar Filling:
BACK:
OTHER:

NPO Since x 24°

ANESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ______________ [✓ General]: Mask Intubation

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discussed with the patient/legal guardian. (b)(6)-2

The patient/le[redacted]nd agrees. Questions answered.
Signed: [redacted] Date: 21 July 03 Time: 2000 Hrs

POST-ANESTHESIA EVALUATION AND NOTE (NON ASU)
{ } NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER
Signed: ________________ Date: ________ Time: ______ Hrs

SEDATION KEY:
1. MINIMAL (Anxiolysis) Patient responds normally to verbal commands
2. MODERATE (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is not necessary.
3. DEEP SEDATION/ANALGESIA. Patient responds purposefully following repeated or painful stimulation. Airway assistance may be necessary.
4. ANESTHESIA. Patient does not respond to painful stimulation.

Patient Identification: (Ward) ________________________

[redacted] (b)(6)-4

WAMC Form 2300 (Revised) 15 Mar 01 MCXC-DOS

Previous edition is obsolete
☆ U.S. GPO 2002-729-283

PATIENT RECORD COPY

① ~~477~~ U_3 Burn Deb Saun

0930 ① ~~376~~ W_2/U_2 R BKA Surg Δ pro AKA Gen Mul/Alh

② ~~366~~ U_1 Cholangiogram Brenz MAC

② ~~478~~ W_2/U_1 I&D perpain Ⓛ Thumb Gen Gen

~~? Ant U_3 pt ?~~

~~EX TUB~~

texasbyrnes@yahoo.com

7 swopes@MSN.com

Tobacco
S/P GSW → Ⓡ thigh

MEDICAL RECORD - ANESTHESI/

For u this form, see AR 40-66; the proponent agenc, e OTSG

NKDA

ANESTHETIC AGENTS AND DRUGS

CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML, "I" = CONSTANT INFUSION

DRUG (Units)							TOTALS
Lidocaine (mg)	100						100
Propofol (mg)	200						200
Fentanyl (mcg)	<150> <100>			50	50	25	375
Midazolam (mg)	2						2
( )							
Reglan (mg)	10						10
VOLAT AGENT Sevo % del	2.0~	2.0~2.0	2.0	1.8X			
% e.t.							
AIR L/Min							
N2O L/Min							
O2 L/Min	10~2-2	-2	2	2	10		

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS →

TOTAL EBL: 30

TOTAL URINE: 0

FLUIDS - SUMMARY

CRYSTALLOID- 600

COLLOID- 0

BLOOD- 0

FLUIDS

LINE site 18G Ⓡ FA ☐ Warmed LR #1 ———— 500

☐ Warmed

☐ Warmed

☐ Warmed

LOSSES

EST BLOOD LOSS 25

URINE -

REMARKS

Code drugs with numbers, events with letters

① Pre-op assessment, NPO verified
② Room, monitors, 100% O2, induced, eyelids taped
③ awake, alert LMA removed s̄ complication
④ To ICU-2 Report to RN.

PHYS STATUS: 1 [✓ 2] 3 4 5 E

BODY WEIGHT: 70 [✓ KG] LB

HEMATOCRIT: —

INITIAL DATA

BP- 142/88

HR- 78

EQUIP CHECK

OK?- [✓ Y] N

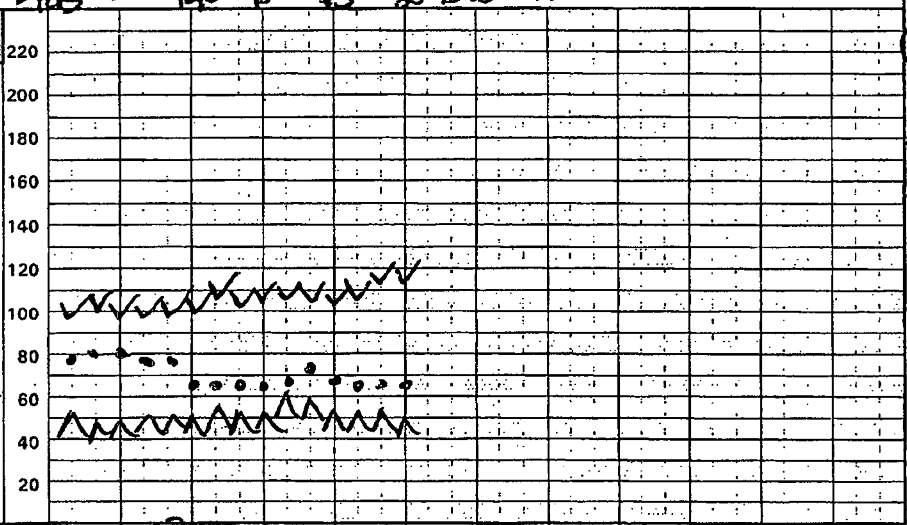
PATIENT RECHECK

OK for PROCEDURE? JR

TIME- 1200

TIME → ~~1215~~ · ~~1245~~ 1300 ~~15~~ 30 ~~1340~~ 1400

SYMBOLS:
BP by cuff V Λ
Heart rate ●
Resp rate ·
BR (transduced) ‡
TOURNIQUET T—T
ANES- X-X
PROC- ⊙-Ø



VENTIL

VT - ml	—	300	410	570	450	570
f - breaths/min	—	8	7	12	6	12
Peak inf pres / PEEP	—	—	—	—	—	
MODE - S(pon), A(ssist), C(on)	S	S	S	S	S	S

MONITORS/ACCESSORIES

✓BP/Auto Cuff	✓ET CO2 (torr)	48	52	49	42	51	50
✓BP/oth	✓FIO2 (Frac or %)	0.66	0.66	0.66	0.65	0.65	0.65
ART line	✓SpO2 (%)	100	100	100	100	100	100
Steth- PC/ES	✓ECG	SR	SR	SR	SR	SR	
Gas analyzer	TEMP-site Skin	—		34	~	34	
	N-M Block (T/4)						
	BS	+	+				
✓Warming blkt	x1 Blanket	———	→	→			
Conv warmer							

Mark with letters & symbols, explain under REMARKS EVENTS Position → ① ② ③ ④

RECOVERY AT: 1335

PACU [✓ ICU] 2 (Specify)

OTHER T-95.9 Ax

CONDITION: Stable, awake

RESP- SpO2- 99

BP- 138/82 HR- 78

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1210	1220	1345
	Ready	Begin	End
PROC	1230	1250	1327

PROCEDURES and CPT Codes:
I+D Ⓡ LE external fixator adjustment

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*
G-LMA

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*
[redacted] (b)(6)-4

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*
LMA#4; Easy placement; seated; PPV; Sust ETCO2 +BBS

SURGEONS: [redacted] (b)(6)-2

ANESTHE [redacted] CRNA/MAJ

PROCEDURE LOCATION: 2

DATE: 4 Aug 03

PAGE 1 OF 1

DA FORM 7389, FEB 1998 MEDCO [redacted] - PATIENT'S MEDICAL RECORD USAPA V1.00

ACLU-RDI 1592 p.1690

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 40 DAYS MOS [✓ YRS]   **Sex** (X) MALE ( ) FEMALE

PROPOSED PROCEDURE: (R) thigh I+D and Ex Fix Adjustment
SURGICAL SERVICE: Orthopedics
NPO SINCE: MN

ASA Physical State 1 [✓ 2] 3 4 5 E
WT: 70 [✓ KG] LB **HT:** _____ IN.
ALLERGIES: NKDA

HABITS:
TOBACCO: yes
ETOH: yes
DRUGS: Ø

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) Percocet
( ) Cleocin 300mg po tid
( ) Unasyn 3g IV q 6°
( ) ______
( ) ______
( ) ______

PREMEDICATIONS:
None Yes (@ ______ Hrs) /CC
______ . ______ mg IV IM PO
______ . ______ mg IV IM PO
______ . ______ mg IV IM PO

LABORATORY STUDIES:
HB/HCT: ______ / ______
U/A: ______
OTHER: ______

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:
Hypertension [✓ N] Y
Angina [✓ N] Y
MI [✓ N] Y
CVA [✓ N] Y
Other [✓ N] Y

Pulmonary System:
Asthma [✓ N] Y
Bronchitis/URI [✓ N] Y
COPD [✓ N] Y
Other [✓ N] Y

Renal System:
Acute/Chronic RF [✓ N] Y

Gastrointestinal:
Hepatitis [✓ N] Y
Hiatal Hernia [✓ N] Y
PUD/GERD [✓ N] Y

Endocrine System:
Diabetes [✓ N] Y
Steriods [✓ N] Y
Thyroid [✓ N] Y

Neurological:
Seizures [✓ N] Y
Neuropathy [✓ N] Y
Other [✓ N] Y

Gynecological :
Pregnancy N Y NA

Other Significant Hx:
N [✓ Y] S/P GSW to
N Y Right Thigh

Familial HX [✓ N] Y

ASSESSMENT
PAST SURGICAL/ANESTHETIC
No problems

PHYSICAL EXAMINATION
BP 142/88 HR 78 R 12 T 37°C
Pain Scale 0-10 ______
HEENT - Teeth oK
Trachea Midline
TMJ/Neck WNL / Full ROM
Oropharynx MP I TMD 3
Nares ______
CHEST: ______
CARDIAC: ______
EXTREMITIES:
IV Access: PIV - 18 ga (R)
Ulnar Filling: forearm
BACK: ______
OTHER: ______

NPO Since MN

ANESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ______ {X} General: Mask [✓ Intubation] vs [✓ LMA]

LMA size 4 used c̄ last anesthetic – no problems

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discussed with the patient/legal guardian.

(b)(6)-2

The patien[redacted] and agrees. Questions answered.
Signed: [redacted] MD Date: 04 AUG 03 Time: 0920 Hrs

POST-ANE[redacted]ESIA EVALUATION AND NOTE (NON ASU)
{ } NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER

Signed: ______ Date: ______ Time: ______ Hrs

SEDATION KEY:
1. **MINIMAL** (Anxiolysis) Patient responds normally to verbal commands
2. **MODERATE** (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is not necessary.
3. **DEEP SEDATION/ANALGESIA.** Patient responds purposefully following repeated or painful stimulation. Airway assistance may be necessary.
4. **ANESTHESIA.** Patient does not respond to painful stimulation.

Patient Identification: (Ward) ICW #2

[redacted] (b)(6)-4

WAMC Form 2300 (Revised) 15 Mar 01 MCXC-DOS   MEDCOM - 13797   Previous edition is obsolete

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
[redacted] (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 5Jul03 TIME OF ORDER 1430 HOURS | LIST TIME ORDER NOTED AND SIGN

Admit ICW1 after
— Dx ① Femur GSW Fx
— stable
— NPO
— Keep Thomas splint as per ORDER Dr [illegible]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER [redacted]

1. Add dx
— MSO4 2mg IVPQ2

(b)(6)-2

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

NURSING UNIT ICW2 | ROOM NO. | BED NO. 1

DATE OF ORDER 8Jul03 TIME OF ORDER 1733 HOURS

① Admit to ICW when bed Available
② Saline Lock IV
③ Pin Care Bid c̄ half strenght hydrogen Peroxide

Noted 8July03 @ 1854 [redacted] RN
(b)(6)-2

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

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 8Jul03 TIME OF ORDER 1930 HOURS

① OOB x 3/day

[illegible] 0847

Noted 8 July03 @ 1942 [redacted] RN
(b)(6)-2

DA FORM 1 APR 79 **4256**

REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 13798

U.S. GOVERNMENT PRINTING OFFICE 2001-478-200

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

EPW

[redacted] (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

5 Jul 2050
Done

[redacted]

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

[illegible]

7

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 5 Jul TIME OF ORDER 1940 HOURS

LIST TIME ORDER NOTED AND SIGN

Trnsfr [illegible] ~~[illegible]~~ ICW2
s/p Ⓡ GSW Femur [illegible] Ex Fix
I&D
Stable
VS per rout
Act Adv Ad lib NWB on Ⓡ
Reg Diet

DATE OF ORDER TIME OF ORDER HOURS

NS LR @ TKO
Meds: Ancef 1 gm IV Q8° x72°
Gentamycin 80 mg IV x72hr
MSO4 2-5 mg IV q2° prn
Percocet ii PO Q4 prn
Motrin 800 PO TID
Pin CARE BID ½ str

DATE OF ORDER TIME OF ORDER H202 HOURS

Xray - AP/Lat Ⓡ femur in PACU
CBC in AM

[redacted]

DATE OF ORDER 6 Jul 03 TIME OF ORDER 093 HOURS

①. Transfer to ICW#2
with same orders.
VO [redacted]

10 Jul 03 / 1300
OOB and walk around unit c̄ assist
V.O. Dr [redacted]

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

MEDCOM - 13799

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

'ATIENT IDENTIFICATION

[redacted]

IURSING UNIT ICU I | ROOM NO. | BED NO.

DATE OF ORDER 13Jul03 TIME OF ORDER 1730 HOURS

LIST ORD NOTED SIG

Keflex 750 PO x10 days

(b)(6)-2
24° [redacted]

(b)(6)-4

'ATIENT IDENTIFICATION

EPW

[redacted]

IURSING UNIT ICW2 | ROOM NO.

[redacted]

7-18-03 0730

DATE OF ORDER 18Jul03 TIME OF ORDER 0720 HOURS

CBC
AP knee (R) femur
Pin care Betadine solution x3 days
Clindamycin 300 PO TID
Unasyn 1.5 gm IV Q6 [redacted]

Noted [illegible]

'ATIENT IDENTIFICATION

DATE OF ORDER 7-18-03 0735 TIME OF ORDER

V.O. Dr [redacted] / LT [redacted]
① D/C Keflex
(b)(6)-2

7-18-03 1000
V.O. Dr - [redacted] / LT [redacted]
(b)(6)-2
① NPO on call OR

IURSING UNIT | ROOM NO. | BED NO.

ATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER [redacted] HOURS

URSING UNIT | ROOM NO. | BED NO.

MEDCOM - 13800

ACLU-RDI 1592 p.1694

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

[illegible] SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM [illegible] IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW

PATIENT IDENTIFICATION #[redacted] NURSING UNIT ICW2 | ROOM NO. | BED NO. 14	DATE OF ORDER 18 Jul 03 TIME OF ORDER 2000 Transfer PACU → ICW2 ✓ SD [illegible] to be [illegible] packing / I&D [illegible] ✓ Stable ✓ VS [illegible] ✓ Act: Ad lib w/ NWB cast
PATIENT IDENTIFICATION EPW [redacted] noted 2200 [redacted] 18 Jul 03 (b)(6)-2 NURSING UNIT ICW2 | ROOM NO. | BED NO. 14	DATE OF ORDER TIME OF ORDER by Dr [illegible] ✓ IV: Heplock meds: Unasyn 3gm IV Q6° ✓ Clindamycin 300mg PO TID ✓ MSO4 2mg IV Q2° prn ✓ Motrin 800 PO TID ✓ Percocet [illegible] PO Q4 prn ✓
PATIENT IDENTIFICATION EPW [redacted] NURSING UNIT ICW2 | ROOM NO. | BED NO. 14	DATE OF ORDER TIME OF ORDER CBC in AM ✓ Pin Care c̄ Gumm or Grayce ✓ tomorrow PM Δ Iodoform packing ✓ (b)(6)-2 24° Vanc [redacted] 2217/[illegible]
PATIENT IDENTIFICATION [redacted] EPW NURSING UNIT ICW2 | ROOM NO. | BED NO. 14	DATE OF ORDER 21 Jul 03 TIME OF ORDER 223[redacted] ✓ Transfer PACU → ICW2 ✓ [illegible]	Bed [illegible] ✓ Resume all preop orders / meds ✓ pin care H2O2 BID x pin covered c̄ Iodine (b)(6)-2 [redacted]

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
#[redacted]

NOTED [illegible]

(b)(6)-4

NURSING UNIT: ICU 2
ROOM NO.: PACU
BED NO.:

DATE OF ORDER: 21 Jun
TIME OF ORDER: 2300 HOURS

Bending Only ~~[illegible]~~ [redacted]

[redacted] (b)(6)-2

24° VS 07 JUN [illegible] LTJAN [redacted] 0322 05

LIST TIME ORDER NOTED AND SIGN

PATIENT IDENTIFICATION
[redacted]

NURSING UNIT: ICW #2
ROOM NO.:
BED NO.: 12

DATE OF ORDER: 3/4/03
TIME OF ORDER: 1230 HOURS

Do NOT wrap pins.
Pack wound ~~to~~ 4th pin ~~from~~ c̄ iodoform gauze
as previously ordered.
V.O. Dr [redacted] AN

(b)(6)-2

24° V done [redacted] DDJAN

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

PATIENT IDENTIFICATION 24° VS 07 [illegible] 1 [illegible] 5 [illegible]

NURSING UNIT:
ROOM NO.:
BED NO.:

DATE OF ORDER:
TIME OF ORDER: HOURS

PATIENT IDENTIFICATION

NURSING UNIT:
ROOM NO.:
BED NO.:

DATE OF ORDER:
TIME OF ORDER: HOURS

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

MEDCOM - 13802

...ICAL RECORD - DOCTOR'S ORDERS

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

...SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ...
... USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW

4 Aug 03 1530

...IDENTIFICATION

[redacted]

EPW

ROOM NO
BED NO. 14

ICW2

DATE OF ORDER
TIME OF ORDER

Post-op s/p I&D ® thigh
& Ex Fix Adjustment
resume all p/o
in recovery
MSO4 2.5 mg IV

[redacted]

(b)(6)-2 [redacted]

1530

...IDENTIFICATION

EPW

[redacted]

ROOM NO.
BED NO. 14

ICW2

DATE OF ORDER 4Aug03
TIME OF ORDER 2015

① resume dsg Δ in AM
② w-t-D dsg o pins c̄ deep tracts
③ aggressive ROM c̄ ® leg/knee

Der Dr [redacted]

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

2020

24° VS [redacted]

8/4/03 2200

...IDENTIFICATION

[redacted]

8/4 0014 V.O. Dr. [redacted] CT [redacted]
① 2mg Immodium P.O. x1 NOW

(b)(6)-2 [redacted] 2105

noted

ROOM NO.
BED NO.

ICW2

2 Aug 2200 [redacted]

(b)(6)-2

...IDENTIFICATION

EPW

[redacted]

DATE OF ORDER 8/22/03
TIME OF ORDER 1920

✓ - D/C Unasyn
✓ - Start Keflex 500mg po QID
✓ - XR ® femur ~~[illegible]~~ AP + LAT

[redacted]

noted 22Aug 1420 [redacted]

(b)(6)-2

ROOM NO.
BED NO.

ICW2

22 Aug 03
Immodium 2mg PO x1 NOW
V.O.

[redacted]

(b)(6)-2

Noted 22Aug03 2130 [redacted]

[redacted]

24° ✓ 23Aug03 0400 [redacted]

(b)(6)-2

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

EPW

[redacted]

NURSING UNIT ICW2 **ROOM NO.** 5 **BED NO.** F

DATE OF ORDER 25Aug **TIME OF ORDER** 0930 **HOURS**

V.O. from Dr. [redacted] to LT [redacted]:

① ΙΙ tabs Peptobismal X1 NOW

(b)(6)-2

[redacted] nO

noted 25Aug 1000 [redacted] (b)(6)-2

24° ✓ 26Aug03 0100 [redacted] An

PATIENT IDENTIFICATION

EPW

[redacted]

NURSING UNIT ICW2 **ROOM NO.** 5 **BED NO.** F

DATE OF ORDER 8/26/03 **TIME OF ORDER** ______ **HOURS**

D/C to EPW Camp

Noted 8/26/03 1130 [redacted] (b)(6)-2

24° ✓ 0015 27Aug03 [redacted] CB, An

PATIENT IDENTIFICATION

EPW

[redacted]

(b)(6)-2

NURSING UNIT ICW2 **ROOM NO.** 5 **BED NO.** F

DATE OF ORDER ______ **TIME OF ORDER** ______ **HOURS**

PATIENT IDENTIFICATION

NURSING UNIT **ROOM NO.** **BED NO.**

DATE OF ORDER **TIME OF ORDER** ______ **HOURS**

LIST TIME ORDER NOTED AND SIGN

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

MEDCOM - 13804

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE | NOTES

Ortho OP / EVAC Note

5 July 03

40 y/o Iraqi ♂ Felony Army Robber
Preop Dx: Ⓡ GSW Femur Fx
Procedure: I&D, Open Reduce
Exfixil Beam

Surgeon: [redacted] (b)(6)-2

EBL: 300cc
TF: 0
To PACU Stable

Findings: Severely Comminuted Distal Shaft Fx 2° Low Velocity GSW
Anatomic Reduce
Stable Hoffman II Ex Fix placed

Plan) BED pin care
OBS wounds x72
D/C to EPW Camp 3-7 Days

RELATIONSHIP TO SPONSOR

SPONSOR'S NAME
LAST
FIRST

[redacted]

SPONSOR'S ID NUMBER (SSN or Other)
(b)(6)-2

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)*

EPW [redacted] (b)(6)-4

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
18Jul03	Ortho OP Note
	Preop Dx: Ⓡ Femur Fx c̄ Loss Reduce in Ex Fx
	Pin tract Drnk
	procedure: I&D/washout Revision Ex Fx
	Surgeon: [redacted]
	EBL [redacted] (b)(6)-7 Packed I&D with
	TO gauze pads
	TO PACU Sr & Sinus tract
	Findings: Sinus tract to Fx site Easily Reduced placed in 2 new Pins and Anchor Bar
	Plan | Remove Pack 48° Plan for Vanco Beads FNB
	[redacted]
	(b)(6)-7

STANDARD FORM 509 (REV. 5/1999) BACK
USAPA V1.00

CLINICAL RECORD

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

Mo. 7 *Yr.* 2003

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	5	6	7	8	9	10	11	12	13	14	15	16	17	18
5 Jul 03	[redacted]	VS PER ROUTINE (~~[illegible]~~) QS	05	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
			17	KS	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
5 Jul 03	[redacted]	ACTIVITY ADVANCE AD LIB	05	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
			17	KS	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
5 Jul 03	[redacted]	REG DIET	05	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
			17	KS	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
8 Jul 03	[redacted]	PIN CARE BID	10	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
		c̄ ½ strength Hydrogen Peroxide	22	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
6 Jul	[redacted]	IS q 1° w/a	05		[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
			17		[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
8 Jul	[redacted]	OOB 3x daily	05	/	/	/	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
			17	/	/	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[illegible]	[redacted]	OOB and walk around unit c̄ assist	05	/	/	/	/	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
			17	/	/	/	/	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
7/18	[redacted]	Pin care c̄ Dakins Solution BID x3days	10														[redacted]
			22														

(b)(6)-2

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: DX GSW Femur Fx/S/P readjustment (R) ex-fix/I+D

ADDITIONAL PAGES IN USE: ☐ YES ☒ NO

PAGE NO: 1

PATIENT IDENTIFICATION: EPW [redacted]

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 MEDCOM - 13807 USED. USAPA V1.00

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo ________ *Yr* 2003

Verify by Initialing Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
5Jul	[redacted]	CBC in Am	6Jul	0400	0400	[redacted]
8Jul	[redacted]	Admit to ICW when bed Available	8Jul03	1250	1250	[redacted]
18Jul	[redacted]	CBC x1 now	18Jul	0730	0730	[redacted]
18Jul	[redacted]	AP ī LAT Ⓡ femur x1 now	18Jul	0900	0930	[redacted]
7-18	[redacted]	NPO ; on-call OK	18Jul	1000	1000	[redacted]
18Jul	[redacted]	Transfer pt to ICW 2: Stable	18Jul	2210	—	[redacted]
	(b)(6)-2					(b)(6)-2

Order/Expir Date	Clerk/Nurse	PRN ACTION, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING COMPLETION* TIME/DATE COMPLETED
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USAPA V1.00

MEDCOM - 13808

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. __

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINIST.

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	5	6	7	8	9	10	11	12	13	14	15	16	17	18
5 Jul 03	[redacted]	LR @ TKO	06	/	[redacted]				D/c'ed 8 Jul 03								
			17	m													
5 Jul 03	[redacted]	Ancef 1 Gm IV q8h x 72°	08	/	[redacted]				/ (b)(6)-2								
			16	/					/								
			24						/	[redacted]		DC Jul 03					
5 Jul 03	[redacted]	Gentamycin 500mg x 1 now	22	[redacted]					(6)								
8 Jul 03	[redacted]	Saline Lock IV	03	/	/	/	[redacted]							[redacted]			/
			17	/	/	/									[redacted]		/
7/13	[redacted]	Keflex 250mg QID x 10 D	04	/	/	/	/	/	/	/	/	/	/	[redacted]			
			12	/	/	/	/	/	/	/	/	/	/				
			18	/	/	/	/	/	/	/	/	/	/				
			24	/	/	/	/	/	/	/	/	/					
7/18	[redacted]	Clindamycin 300mg PO TID	08														[redacted]
			16														
			24														
7/18	[redacted]	Unasyn 1.5gm IV Q4°	00														X
			04														X
			08														[redacted]
			12														
			16														
			20														

(b)(6)-2

(b)(6)

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Dx Ⓡ Femur GSW Fx S/P Readjustment Ⓡ ex-fix I&D

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ______

PATIENT IDENTIFICATION: EPW-[redacted]

(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	

DA FORM 4678, 1 FEB 79

EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

MEDCOM - 13809

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*	Mo. 7 Yr. 03

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

INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	TIME/DATE DISPENSED													
5JUL	[redacted]	MS04 2mg IVP			[redacted]											
		Q2°				(5)(6)-2										
5JUL	[redacted]	MSO4 2-5mg IVP Q2° PRN	2mg 0300	5mg 0300	~~5mg~~ [illegible]	6JUL 0700 5mg	6JUL 0930 5mg	6 JUL 5mg	7JUL 0400	[redacted]				1120 4mg 7JUL	5mg 2200	5mg 0930
5JUL	[redacted]	PERCOCET ii PO Q4° PRN	6JUL 2 2035	9JUL 1730 ii	9JUL [illegible] ii	[illegible]	[illegible]	2000	5mg	[redacted]				② 7/7 1800	0200 7/11 ii	[redacted] ii
5JUL	[redacted]	MOTRIN 800mg PO TID PRN	6JUL [redacted]	6JUL	11JUL 800mg 1230	13JUL 800mg 2100	7/13 0130	7/15 0845	17JUL 1410	1800 [illegible]						
			5mg 0700	5mg 1330	[redacted]	[illegible]		[redacted]		[redacted]						
5JUL	[redacted]	MSO4 2-5MG IVP	8JUL 0330	8JUL 0330	8JUL 0830	13JUL 1100	8JUL 2000	[illegible]	11JUL 0835	ERROR 13JUL [illegible]	(5)(6)-2					
		Q2° PRN	5mg	5mg	5mg	5.0	[redacted]		5mg [redacted]	[illegible]						
12JUL	[redacted]	Percocet ii PO											rewritten			
		Q4° PRN	7/12 0130 ii	7/12 07[illegible] ii	7/12 1200 ii	7/12 1850 ii	7/12 2250 ii	7/13 0230 ii [redacted]	7/13 ii 0830 [redacted]	7/13 ii 1250	7/13 ② 2100 [redacted]	7/14 ii 0800	7/14 ii 1320	7/14 2330	7/15 ii 0630	7/15 2400
15JUL	[redacted]	P														
15JUL	[redacted]	Percocet ii P.O Q4°	16JUL 2200 ii PO	16JUL 0315 ii PO	16JUL 0710 ii PO	7JUL 1105 [illegible]	16JUL 2230 ii PO	17JUL 0230 ii PO	17JUL 0810 ii PO	17JUL 2059 ii PO	18JUL 0800 ii PO	18JUL 0730 [illegible]	18JUL 1630 ii	18JUL 1930 ii PO		
		PRN	[redacted]							RM	[redacted]					

rewritten

11JUL 2000 1 ii

12JUL 2400 ii

(5)(6)-2

(5)(6)-2

USAPA V1.00

MEDCOM - 13810

the proponent agency is the Office of The Surgeon General.

MO. 7 YR 2003

RIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 22	23	24	25	26	27	28	29	30	31	1	2	3
21 July	[redacted]	pincare H_2O_2 BID	10	[redacted]										See below		
		pin covered c̄ Ioban	20													
		dont remove Ioban	/				(b)(6)-2								D/C 1 Aug	[redacted]
		from pin!	/													
			/													
25 Jul	[redacted]	W→D dsg. in	10				[redacted]									
		wound around pin	20													
		above knee - do	/							(b)(6)-2						
		not touch ioban	/													
		-all other pincare	/													
		remains the same	/													
			/													
														(b)(6)-2		
1 Aug	[redacted]	Do not wrap pins. Continue	10											[redacted]		
		~~[illegible]~~ packing wound to	20											[redacted]		
		4th pin c̄ iodoform gauze														
		as previously ordered.														

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P washout (R) LE

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ______

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

EPW

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIME

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 EDITION OF 1 DEC 73 MAY BE USED. USA

MEDCOM - 13811

Recopied

the proponent agency is the Office of The Surgeon General.

M.D. VR 2003

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

(b)(6)-2

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	2	3	4	5	6	7	8	9	10	11	12	13	14	15
01 Aug03	[redacted]	VS per Routine	05	[redacted]													
			13														
			21														
01 Aug03	[redacted]	Activity: Advance to	05														
		ad lib	13														
			21														
01 Aug03	[redacted]	Reg Diet	07														
			12														
			17														
01 Aug03	[redacted]	OOB 3x daily	05														
		walk around unit	13														
		c̄ assist NWB Ⓡ leg	21														
										(b)(6)-2							
01 Aug	[redacted]	W→D Drsg in wound around	10	/	/	[redacted]											
		pin above knee - do not touch	20	/	/												
		ioban.															
01 Aug	[redacted]	Do not wrap pins. Continue	10	/	/	[redacted]											
		packing wound to 4th pin c̄	20	/													
		iodoform gauze as previously															
		ordered.								(b)(6)-2							
			/														
4	[redacted]	aggressive ROM c̄	15	/	/	/	[redacted]										
		Ⓡ leg/knee	13	/	/												
			21	/	/												

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS:

GSW Ⓡ femur ~~ex~~ fix

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ____

PATIENT IDENTIFICATION:

EPW # [redacted] (b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 MEDCOM - 13812 USED. USAPA V1.00

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo 7 *Yr* 2003

Verify by Initialing						
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
4	[redacted]	S/P I&D (R) thigh - ex fix adjustment	4	1530		[redacted]
4		resume dsg Δ in Am		noted		
	(b)(6)-2					(b)(6)-2

Order/ Expir Date		PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION													
			TIME/DATE COMPLETED													
-----	-----															
-----	-----															
-----	-----															
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MEDCOM - 13813

recopied 1 Aug 03

CLINICAL RECORD

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

Mo. 8 *Yr.* 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 2	3	4	5	6	7	8	9	10	11	12	13	14	15
1950 ~~01Aug03~~ 4Aug	[redacted]	SLIV	05	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
			13	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
			21	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
1950 ~~01Aug03~~ 4Aug	[redacted]	Cleocin 300mg PO TID	08	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
			16	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
			24	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
1950 ~~01Aug03~~ 4Aug	[redacted]	Unasyn 3.0gm IV q6°	0	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
			12	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
			18	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
			24	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

(b)(6)-2

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
Ⓡ femur GSW Ⓡ thigh ex-fix
s/p I&D Ⓡ thigh / ex fix readjustment

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
PAGE NO: ____________

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 MEDCOM - 13814 USAPA V1.00

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*			*Mo* 8	*Yr* 05
Order Date	**Clerk Nurse**	**SINGLE ACTIONS**	**Date to be Done**	**Time to be Done**	**Time Done**	**Initials**
2|	[redacted] (b)(6)-2	resume all previous orders	4	—	1530	[redacted] (b)(6)-2
	.....					
	.....					
	.....					
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	.....					
	.....					
	.....					

Order/ Expir Date	**Clerk/ Nurse**	**PRN ACTION, FREQUENCY**	*INITIAL PROPER COLUMN FOLLOWING COMPLETION* TIME/DATE COMPLETED													
copied 27JUL	[redacted]	Motrin 800mg PO TID	11Aug 2015 800mg PO	12Aug 1505 800mg PO	13Aug 0935 800mg PO											
.....	1	PRN	[redacted]													
.....	(b)(6)-2															
8/14	[redacted]	Percocet ii PO	8/14	8/14		(b)(6)-2										
.....	.....	Q 4° PRN pain	[redacted]													
.....	.....															
.....	.....															
.....	.....															
.....	.....															
.....	.....															

USAPA V1.00

MEDCOM - 13815

CLINI RECORD [redacted]

For use [redacted] the proponent agency is the Office of The Surgeon General.

Mo. 8 Yr. 03

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 16 17 18 19 20 21 22 23 24 25 26 27 28 29
4Aug	[redacted]	SL IV	5 13 21	[redacted] D'C
4Aug	[redacted]	Cleocin 300 mg PO TID	8 16 24	[redacted]
4Aug	[redacted]	Unasyn 3.0 gm IV q6°	6 12 18 24	[redacted] D/c'd 22Aug03 1600 [redacted]
22Aug03	[redacted]	Keflex 500mg po QID	06 12 18 24	[redacted] D/c'd 27Aug

(b)(6)-2

(b)(6)-2

(b)(6)-2

ALLERGIES: YES ☐ NO
NKDA

PRIMARY DIAGNOSIS: (R) thigh ex-fix

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION:
EPW

[redacted] (b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM , 1 OCT 78 MEDCOM - 13816 ED. USAPA V1.00

er	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
8/18 0154	2mg Immodium P.O. x1 now	8/18	0154	0154	[redacted]
22Aug03	2mg Immodium PO x 1 Now	8/22	2120	2120	[redacted]
25Aug	ii tabs Pepto bismol x 1 Now	25Aug	0930	0930	[redacted]
					(b)(6)-2
					SE:

INITIAL PROPER COLUMN FOLLOWING COMPLETION

		PRN ACTION, FREQUENCY	TIME/DATE COMPLETED												
27 Jul	[redacted]	Motrin 800mg	16Aug 1010 ī PO	17Aug 0630 ī PO	17Aug 2015 ī PO	18Aug 1330 ī PO	19Aug 0047 ī PO	19Aug 1645 ī PO	UAug 0730 ī	20Aug 2015 ī PO	22Aug03 0030 800mg	23Aug 1050 ī PO	24Aug 2015 !	27Aug 1110	31Aug 1415 ī PO
		PO TID PRN	[redacted]												
									(b)(6)-2						
4Aug	[redacted]	Percocet ii PO	16Aug 1430 ii	20Aug 0630 ii PO	21Aug 0945 ii	23 Aug 1000 ii	26 Aug 0?8 ii	27Aug 0805 ii PO							
		Q4° PRN pain	[redacted]						(b)(6)-2						
27 Jul	[redacted]	Motrin 800mg	28 0200												
		PO TID prn-pain	[redacted]	(b)(6)-2											

USAPA V1.00

MEDCOM - 13817

the proponent agency is the Office of The Surgeon General.

MO. 5 YR 2003

VERIFY BY INITIALING ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION DATE COMPLETED 19 20 21 22 23 24 25 26 27 28 29 30 31 1
7.5	[redacted]	VS per routine	05	[redacted]
			13	
			2	
7.5	[redacted]	Act. Advance APLIB	0	[redacted]
			3	
			21	
7.5	[redacted]	Reg Diet	7	[redacted]
			11	
			17	
7.8	[redacted]	PIN care BID c̄	10	Pin care c̄ Dr [redacted] [redacted]
		Dsng Δ	22	c̄ Δ Iodoform packing 19[redacted]
7.8	[redacted]	IS Q1° WA	5	[redacted] D/C'd
			13	
			2	
7.8	[redacted]	OOB 3x daily	5	[redacted]
			13	
			21	
7.8	[redacted]	OOB s̄ walk around	5	[redacted]
		unit c̄ assist NWB	13	
		Ⓡ leg	2	

(b)(6)-2

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW Ⓡ femur fx.

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ____

PATIENT IDENTIFICATION:

#[redacted] (b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

FORM 4677, 1 OCT 78 MEDCOM - 13818 USED. USAPA V1.00

Verify by Initialing		**THERAPEUTIC DOCUMENTATION CARE PLAN** *(NON-MEDICATION)*	Mo 7 Yr 2003			
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
18	[redacted]	CBC in Am	19 0400	0410	Done	[redacted]
	(b)(6)-2					(b)(6)-2

Order/ Expir Date		PRN ACTION, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING COMPLETION* TIME/DATE COMPLETED													
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MEDCOM - 13819

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. 8 *Yr.* 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	16	17	18	19	20	21	22	23	24	25	26	27	28	29
1Aug	[redacted]	VS Routine	5	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
			13	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
			21	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
1Aug	[redacted]	Activity: Advance	5	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
		Ad Lib	13	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
			21	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
1Aug	[redacted]	Diet: Regular	7	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
			12	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
			17	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
1Aug	[redacted]	OOB 3x daily	5	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
		Walk around Unit	13	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
		c̄ assistance NWB Ⓡ le	21	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
1Aug	[redacted]	W→D Dsg in wound	10	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
		around pin above knee - don't	20	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
		twen iodan															
1Aug	[redacted]	Don't wrap pins Continue	10	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
		packing wound to 4th pin c̄	20	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
		iodoform gauze as prev ordered															
4Aug	[redacted]	Aggressive ROM c̄ Ⓡ leg/	5	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
		knee	13	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
			21	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

(b)(6)-2

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Ⓡ le ex fix

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____________

PATIENT IDENTIFICATION:

EPW [redacted]

(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 E MEDCOM - 13820 ITIL EXHAUSTED. USAPA V1.00

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. ________ *Yr.* ________

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
22Ag	[redacted] (b)(6)-2	XRay Ⓡ femur, AP c̄ LAT	22Ag	today	1500	[redacted] (b)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION*													
			TIME/DATE DISPENSED													
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MEDCOM - 13821

USAPA V1.00

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. 7 *Yr.* [illegible]

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 19 · 20 · 21 · 22 · 23 · 24 · 25 · 26 · 27 · 28 · 29 · 30 · 31 · 1
7·18	[redacted]	SL IV	05	[redacted]
			13	
			21	
7·18	[redacted]	Clindamycin 300mg po TID	08	[redacted]
			16	
			24	
7·18	[redacted]	Unasyn 3.0mg IV Q6°	00	[redacted]
			06	
			12	
			18	
			~~24~~	
			~~22~~	
		Dakins sol. c̄ pin care BID x 3 days	16	D/C
			22	

(b)(6)-2

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: (R) Femur GSW FX.

S/P readjustment (R) ex-fix/I+D

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ______

PATIENT IDENTIFICATION:

[redacted] (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 MEDCOM - 13822 [illegible]ED UNTIL EXHAUSTED. USAPA V1.00

Verify by Initialing	THERAPEU CUMENTATION CARE PLAN *(MEDICATIONS)*	Mo.____ Yr.____

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
20 July	[redacted]	Benedryl 50mg				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* TIME/DATE DISPENSED
18 Jul	[redacted]	Motrin 800mg PO TID PRN	7-19 800mg 1239 [illegible] 7-20 800mg 1300 21 Jul 0425 ī PO 22 Jul [illegible] B.S. [illegible] 0100 23 Jul 2210 24 Jul 0705 ī PO 24 Jul 1500 ī PO 24 Jul 2338 ī PO 25 Jul 1940 ī PO 26 July 0545 ī PO 26 Jul 1400 ī PO [redacted] (5)(6)-2
18 Jul	[redacted]	MSO4 2-10mg IVP Q2° PRN for Pain	7-20 0918 2mg IV 1000 2mg IV [redacted] 7-21 2mg IV 1500 [redacted] (5)(6)-2
19 Jul	[redacted]	Percocet ii PO Q 4° PRN	7/19 0900 ii 19 July 2250 ii po 20 July 0430 ii po 20 July 1030 ii 21 July 1035 ii 22 July 0300 ii po 22 July 0830 ii po 7-23 0210 ii 7-24 0041 ii [illegible] 24 July 1115 ī po 25 July 2000 ii PO [redacted] (5)(6)-2
7-22	[redacted]	Benadryl 50mg IV Q4° PRN	20 July 0900 50mg IV [redacted]

> copied

(5)(6)-2

USAPA V1.00

MEDCOM - 13823

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*			*Mo.* 7	*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**													
20 JUL	[redacted]	Percocet ii PO q	0108 25Jul ii PO	0320 25Jul ii PO	25July 1140 ii po	25Jul 1810 ii PO	21 July 0000	26 Jul 1900	26 July 7:28	27 July 0400		27 July 0045 ii	27 Jul 2030 ii BOS	28 July 0100 ii	28 July 1200 ii
.....	.....	4° PRN	[redacted]													
.....	.....															
27 Jul copied	[redacted]	MOTRIN 800MG PO	30 July 0730 ii PO	31 Jul 1545 i	31 July 0620 i PO	31 Jul 9:25 i PO	31 Jul 1400 i PO	1 Aug 0000 i PO	2 Aug 1430 i PO	02 Aug 0100 i PO	3 Aug 1215 i PO	3 AUG 1615 i	4 Aug 1400 i PO	6 Aug 0705 i PO	7 AUG 2040 i PO	8 Aug 0615
.....	.....	TID PRN	[redacted]													
.....	.....															
2C	[redacted]	Percocet ii PO q 4°	28 Jul 2000 BOS ii	29 July ii ii 420	X	29 Jul ii PO 0945	29 Jul ii 1500	29 Jul i 2000	30 Jul ii 0000	30 July 0400 ii PO	31 Jul 0046 ii PO	31 Jul 0645 ii PO	31 Jul 1245 ii PO	2 Aug 0410 ii PO	3 Aug 0805 ii PO	3 Aug 0945 ii PO
.....	.....	prn pain	[redacted]													
.....	.....															
20	[redacted]	Percocet ii PO q 4°	3 Aug 2100 i		4 Aug 0620 ii PO	4 Aug 1500 PO ii	4 Aug 2115 ii PO BOS	5 Aug 0044 ii	5 Aug 0520 ii PO	6 Aug 0000 ii PO	6 Aug 1345 ii	7 Aug 0705 ii PO	7 AUG 1410 ii PO	8 Aug 0915 ii PO	8 Aug 1315 ii PO	8 AUG 2030 ii PO
.....	.....	PRN pain.	[redacted]													
20 JUL	[redacted]	Percocet ii PO q 4°	9 Aug 740 ii PO	9 AUG 1330 ii PO	9 AUG 1730 ii PO	10 Aug 0030 ii PO	10 Aug 2100 ii	11 Aug 0003 i	X	11 Aug 0600 ii PO	11 AUG 1415 ii PO	11 Aug 2227 ii PO		12 Aug 730 ii	13 Aug 1030 ii PO	13 Aug 2000 ii PO
.....	.....	PRN pain.	[redacted]													

(b)(6)-2

(b)(6)-2

USAPA V1.00

MEDCOM - 13824

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA
For use of this form see AR 40-66, the proponent agency is the Office of The Surgeon General

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
OTSG Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME		INITIALS	1700	INITIALS QD		INITIALS
NEURO	PUPILS	2 R		Perrla 3mm			
	SENSORIUM	A/O		A+0x3			
RESPIRATORY	RESPIRATORY PATTERN	equal		even, unlabored			
	BREATH SOUNDS	LCTA (B)		CTA -B			
	SECRETIONS	Ø		0			
SKIN	COLOR	NHR		NIR			
	INTEGRITY	Ø		dry, intact			
				ex fix on right [illegible]			
IV SITE	LOCATION	Ø		Ø			
	CONDITION						
GASTRO	ABDOMEN	⊕		soft, nontender			
	BOWEL SOUNDS	⊕		+BS x4 quads			
GU	URINE			urinal			
	COLOR/CLARITY	yellow/clear		clear, yellow			
CARDIOVASCULAR	CARDIAC RHYTHM	SR		$S_1 S_2$			
				NSR			
				+2 pulses radial/			
				pedal			
				<3sec cap refill			

LEGEND
Cr - Creatinine
F_iO_2 - Fraction of Inspired O_2
HCO_3 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
SA - Fractional
SAT - Saturation
TRACH - Tracheostomy

(Continue on reverse)

PREPA [redacted]

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

(b)(6)-7

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

DA FORM 1 MAY 78 **4700**
Proponent: Dept of Nurs

WAMC OP 375 (Redesignated)
1 Apr 90 (HSXC-NU)

12)c 03

DATE	DX		HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07	/	08	09	10	11	12	13	14	15	/
BP Arterial Line										124/72								
BP Cuff			115/68															
Temperature			99							98°								
Pulse			88							84								
Respiratory Rate			16							16								
SPO2			98							98								

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
TOTALS																		

OUTPUT

		24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
URINE	HOUR / TOTAL	200																	
	Sp gr																		
	Sm																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS																			

POST-OP DAY .

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS

16	17	18	19	20	21	22	23	
	[illegible]							
	[illegible]							
	98							
	18							
	97%							
	RA							

PO

INTAKE

16	17	18	19	20	21	22	23	8°T
						240		

OUTPUT

						275		

RESPIRATORY DATA

TIME									
MODE									
F_iO_2									
TV									
RATE									
PEEP									
A pH									
B PCO_2									
G pO_2									
HCO_3									
SAT									
BASE									

LABORATORY DATA

TIME								
GLUCOSE								
Na/K								
Cl/CO_2								
BUN/Cr								
WBC/PLATELET								
Hct/Hgb								

ACTIVITIES OF DAILY LIVING

TIME					
MOUTH CARE					
BATH					
SKIN CARE					
FOLEY CARE					
TRACH CARE					
ROM EXERCISES					

	TIME					
TURN						
SUCTION						

24° I&O TOTALS

wt Yesterday ______ wt Today ______

INTAKE
IV ______
PO ______
______
TOTAL ______

OUTPUT
Urine: ______
______
______
TOTAL ______

BALANCE ______

NURSE'S SIGNATURE	INITIALS

NEUROLOGICAL ASSESSMENT

				HOURS	0	LEGEND
COMA SCALE	EYES OPEN	SPONTANEOUSLY	4		✓	C Closed by swelling
		TO SPEECH	3			
		TO PAIN	2			
		NO EYE OPENING	1			
	BEST VERBAL RESPONSE	ORIENTED	5		✓	T Trach/Endo S Slurring D Dysphasia R Receptive E Expressive
		CONFUSED	4			
		VERBALIZES	3			
		VOCALIZES	2			
		NO VOCALIZATION	1			
	BEST MOTOR RESPONSE	OBEYS COMMANDS	6		✓	
		LOCALIZES PAIN	5			
		FLEXION WITHDRAWAL	4			
		ABNORMAL FLEXION	3			
		EXTENSION TO PAIN	2			
		NO MOTOR RESPONSE	1			
LIMB MOVEMENT	ARMS	NORMAL POWER			✓	R Right L Left Record separately if there is a difference between the two sides.
		MILD WEAKNESS				
		SEVERE WEAKNESS		L		
		ABNORMAL FLEXION				
		ABNORMAL EXTENSION				
		NO RESPONSE				
	LEGS	NORMAL POWER				
		MILD WEAKNESS		R		
		SEVERE WEAKNESS			✓	
		ABNORMAL FLEXION				
		ABNORMAL EXTENSION				
		NO RESPONSE				
PUPILS	RIGHT	SIZE			2	+ + Brisk + Slow - No Response
		REACTION			+	
	LEFT	SIZE			2	
		REACTION			+	
PUPIL SCALE					● 2 ● 3 ● 4 ● 5 ● 6 ● 7 mm	
ICP						+ Intact
CEREBRAL PERFUSION PRESSURE						- Abnormal

VASCULAR ASSESSMENT

		HOURS		LEGEND
RLE	R		2+	+ + Normal
	L		2+	+ Weak
	R			- Absent
	L			
	R			D Doppler
	L			
	R			R Right
	L			
	R			L Left
	L			

MEDCOM - 13828

MEDICAL RECORD–SUPPLEMENTAL MEDICAL DATA
For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

(b)(6)-2

OTSG APPROVED (
QA Appr 8 Mar 8

INITIAL SHIFT ASSESSMENT

	TIME	0500 INITIALS [redacted]	1914 INITIALS [illegible]	INI
NEURO	PUPILS	[illegible]	3mm PERRLA	
	SENSORIUM	[illegible]	Ox3, Cooperative	
		[illegible]		
		[illegible]		
RESPIRATORY	RESPIRATORY PATTERN	[illegible]	Unlabored	
	BREATH SOUNDS	[illegible]	CTA (B)	
	SECRETIONS	[illegible]	⊖	
		[illegible]		
		[illegible]		
SKIN	COLOR	Skin [illegible]	W, D, I	
	INTEGRITY	[illegible]	Intact	
		[illegible]		
IV SITE	LOCATION	(R) forearm	(R) FA – ⊖	
	CONDITION	[illegible]		
		[illegible]		
GASTRO	ABDOMEN	[illegible]	Soft, Non-tender	
	BOWEL SOUNDS	[illegible]	BS x4	
GU	URINE:	[illegible]		
	COLOR/CLARITY	[illegible] assessment		
CARDIOVASCULAR	CARDIAC RHYTHM	[illegible]	RSR	
		[illegible]	S, S,	
		[illegible]	+2 LE/UE (Bilat)	
		[illegible]	Pulses	
		[illegible]		

LEGEND

Cr - Creatinine	ICP - Intracranial Pressure	S/A - Fractional
F_iO_2 - Fraction of Inspired O_2	PCO_2 - Pressure of Arterial CO_2	SAT - Saturation
HCO_3 - Bicarbonate	PEEP - Positive End Expiratory Pressure	TRACH - Tracheostomy

(Continue on revers

PREPARED BY (*Signature & Title*)	DEPARTMENT/SERVICE/CLINIC ICU 2 ust	DATE 9/4/03

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

EPW [redacted] (b)(6)-4
ICU#1

☐ HISTORY/PHYSICAL
☑ FLOW CHA
☐ OTHER EXAMINATION OR EVALUATION
☐ OTHER (S
☐ DIAGNOSTIC STUDIES

MEDCOM - 13829

P

E | DX | HOSPITAL DAY

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	1
BP Arterial Line						126/68	118/67	118/73		138/68				130/70			
BP Cuff																	
Temperature						92	83	85		99				91			
Pulse						✓	✓	✓		✓							
Respiratory Rate						12	10	14		16				18			
[illegible]						RA								RA			
														100			
pain																	
intervention																	

TIME	24	01	02	03	04	05	06	07	8° T	08	09	10	11	12	13	14	1
PO																	
										240				120		270	600

TOTALS

		24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	1
URINE	HOUR / TOTAL												90/90				50/140	/190
	sp gr																	
	S/A																	
NG	OUTPUT																	
	pH																	
	GUAIAC																	
EMESIS																		
STOOL																		
DRAINS																		

[redacted] 9Ju/03

(b)(6)-4

MEDCOM - 13830

DAY

		17	18	19	20	21	22	23	
BP			135/70		[illegible]		130/80		
Temp									
Pulse			95		[illegible]		92		
RR			16		[illegible]		14		
O2			98		[illegible]		99		
			RA		[illegible]		RA		

		17	18	19	20	21	22	23	8° T
IV									
PO					100				
Urine				660	[illegible]				

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA		TIME							
		MODE							
		F_IO_2							
		TV							
		RATE							
		PEEP							
	ABG	pH							
		PCO_2							
		pO_2							
		HCO_3							
		SAT							
		BASE							

LABORATORY DATA	TIME							
	GLUCOSE							
	Na/K							
	Cl/CO2							
	BUN/Cr							
	WBC/PLATELET							
	Hct/Hgb							

ACTIVITIES OF DAILY LIVING	TIME				TURN / SUCTION	TIME		
	MOUTH CARE							
	BATH							
	SKIN CARE							
	FOLEY CARE							
	TRACH CARE							
	ROM EXERCISES							

24° I&O TOTALS

wt Yesterday ________ wt Today ________

INTAKE
IV ________
po

OUTPUT
Urine: ________

NURSE'S SIGNATURE
[redacted]
(b)(6)-2

MEDCOM - 13831

CAL RECORD—SUPPLEMENTAL MEDICA ATA
For us to e AR 40-66; the proponent agency is the Offic Surg eneral

REPORT TITLE
INTENSIVE CAR NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0500	INITIALS [illegible]	1800	INITIALS		INITIALS
NEURO	PUPILS	[illegible]		3mm PERRLA			
	SENSORIUM	[illegible]		A+Ox3 very			
		[illegible]		cooperative			
		[illegible]					
		[illegible]					
RESPIRATORY	RESPIRATORY PATTERN	[illegible]		even-unlabored			
	BREATH SOUNDS	[illegible]		CTA bilat			
	SECRETIONS	[illegible]		Ø secretions			
		[illegible]					
		[illegible]					
		[illegible]					
SKIN	COLOR	[illegible]		normal for race			
	INTEGRITY	[illegible]		intact			
		[illegible]					
IV SITE	LOCATION	[illegible]		(R) FA			
	CONDITION	[illegible]		CDI			
		[illegible]					
		[illegible]					
GASTRO	ABDOMEN	[illegible]		soft nontender			
	BOWEL SOUNDS	[illegible]		⊕BS x4			
GU	URINE:	[illegible]		clear			
	COLOR/CLARITY	[illegible]		yellow			
CARDIOVASCULAR	CARDIAC RHYTHM	[illegible]		NSR			
		[illegible]		S_1S_2			
		[illegible]		pulses 2+ x4			
		[illegible]		distal extremities			
		[illegible]					

LEGEND

Cr - Creatinine	ICP - Intracranial Pressure	SjA - Fractional
F_iO_2 - Fraction of Inspired O_2	PCO_2 - Pressure of Arterial CO_2	SAt - Saturation
HCO_3 - Bicarbonate	PEEP - Positive End Expiratory Pressure	TRACH - Tracheostomy

(Continue on reverse)

PREPARED [redacted]

DEPARTMENT/SERVICE/CLINIC
ICU 2 west

DATE
10/4/03

PATIENT'S ID [redacted] tries give: Name—last, first, middle; [redacted] ility)

(b)(6)-2

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

DA FORM 1 MAY 78 **4700**
Proponent: Dept of Nurs

WAMC OP 375 (Redesignated)
1 Apr 90 (HSXC-NU)

PAGE 2 OF 4

DATE	DX	HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07	/	08	09	10	11	12	13	14	15	/
BP Arterial Line			128/71				128/62				130/67					132/71		
BP Cuff																		
Temperature																		
Pulse			92				90				76					88		
Respiratory Rate			12				14				12					14		
SpO2			98				98				99					99		
			RA				RA				RA					RA		
pain																		
intervention																		

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
PO								360	360					360				960
TOTALS																		

OUTPUT

		24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
URINE	HOUR / TOTAL				300							300					600		900
	sp gr																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS																			

[redacted] (b)(6)-4

10/24/03

POST-OP DAY

VITAL SIGNS	14	17	18	19	20	21	22	23	
BP			40/72				162/102		
T			99.9						
P			96				87		
R			12				16		
O2							98		
			RA				RA		

INTAKE / OUTPUT	16	17	18	19	20	21	22	23	8° T
PO									
urin				400		200		500	

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA										
TIME										
MODE										
F_iO_2										
TV										
RATE										
PEEP										
ABG	pH									
	PCO_2									
	pO_2									
	HCO_3									
	SAT									
	BASE									

LABORATORY DATA									
TIME									
GLUCOSE									
Na/K									
Cl/CO$_2$									
BUN/Cr									
WBC/PLATELET									
Hct/Hgb									

ACTIVITIES OF DAILY LIVING				
TIME				
MOUTH CARE				
BATH				
SKIN CARE				
FOLEY CARE				
TRACH CARE				
ROM EXERCISES				

	TIME				
TURN					
SUCTION					

24° I&O TOTALS

wt Yesterday ________ wt Today ________

INTAKE

IV ________

po ________

TOTAL ________

OUTPUT

Urine: ________

TOTAL ________

BALANCE ________

NURSE'S SIGNATURE

[redacted]

(b)(6)-7

NAME is [redacted]

[redacted] (b)(6)-4

bed 5

MEDCOM - 13834

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

For us see AR 40-66; the proponent agency is the Offic Su , General.

REPORT TITLE
INTENSIVE CAR NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0840	INITIALS [redacted]	(b)(6)/1800	INITIALS		INITIALS
NEURO	PUPILS	PERRLA @ 3mm		PeRRLA			
	SENSORIUM	Alert + Oriented		Alert x 3			
RESPIRATORY	RESPIRATORY PATTERN	Even, unlabored		even, unlabored			
	BREATH SOUNDS	BBS CTA		CTA B/L			
	SECRETIONS						
SKIN	COLOR	Normal for		Normal for Race			
	INTEGRITY	Race		intact -			
IV SITE	LOCATION	(R) FA		(R) FA			
	CONDITION	patent + intact.		Patent & intact			
GASTRO	ABDOMEN	~~BS~~ Abd soft +		BS ⊕ & soft			
	BOWEL SOUNDS	nontender		Non-Tend			
		BS x 4					
GU	URINE.	Voids per urinal		Uses urinal			
	COLOR/CLARITY	Clear yellow		clear yell			
CARDIOVASCULAR	CARDIAC RHYTHM	S_1 + S_2		S_1 S_2			
		⊖ JVD, ⊖ edema		NSR			

LEGEND
Cr - Creatinine
F_iO_2 - Fraction of Inspired O_2
HCO_3 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
S/A - Fractional
SAT - Saturation
TRACH - Tracheostomy

(Continue on reverse)

(b)(6)-7

PREPARED BY [redacted] LPN

DEPARTMENT/SERVICE/CLINIC: ICU 2 unit

DATE: 11 Jul 03

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

EPW # [redacted] (b)(6)-4

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

DA FORM 4700, 1 MAY 78
Proponent: Dept of Nurs

WAMC OP 375 (Redesignated)
1 Apr 90 (HSXC-NU)

DATE	DX		HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial Line																		
BP Cuff			53/81							124/79						135/80		
Temperature										97.1								
Pulse			84							97						88		
Respiratory Rate			17							22						20		
SpO2			97							98						98		
RA/O2										RA						RA		
pain intervention																		

PO

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
TOTALS																		

OUTPUT

		24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
URINE	HOUR / TOTAL							400									500		
	sp gr																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS																			

[redacted] (b)(6)-4

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS									
	16	17	18	19	20	21	22	23	
B/P			170/60				133/74		
P			90				94		
T			97				98.6		
R			16				18		
SpO2							91		

	16	17	18	19	20	21	22	23	8°T
Urine								250	

RESPIRATORY DATA		
TIME		
MODE		
FiO2		
TV		
RATE		
PEEP		
ABG	pH	
	PCO2	
	pO2	
	HCO3	
	SAT	
	BASE	

LABORATORY DATA	
TIME	
GLUCOSE	
Na/K	
Cl/CO2	
BUN/Cr	
WBC/PLATELET	
Hct/Hgb	

ACTIVITIES OF DAILY LIVING	
TIME	
MOUTH CARE	
BATH	
SKIN CARE	
FOLEY CARE	
TRACH CARE	
ROM EXERCISES	

TURN — TIME

SUCTION

24° I&O TOTALS

wt Yesterday ______ wt Today ______

INTAKE
IV ______
po ______
TOTAL ______

OUTPUT
Urine: ______
TOTAL ______

BALANCE ______

NURSE'S SIGNATURE	INITIALS
[redacted]	
(b)(6)-2	

MEDCOM - 13837

NEUROLOGICAL ASSESSMENT

HOURS		16	17
ɪNTANEOUSLY	4	✓	✓
SPEECH	3		
PAIN	2		
EYE OPENING	1		
ENTED	5	✓	✓
FUSED	4		
BALIZES	3		
ALIZES	2		
VOCALIZATION	1		
YS AMANDS	6	✓	✓
ALIZES PAIN	5		
ION HDRAWAL	4		
ORMAL ION	3		
ENSION PAIN	2		
MOTOR PONSE	1		
RLE MAL POWER		Vt	
D WEAKNESS		V	
ERE WEAKNESS		q	✓
ORMAL FLEXION		C	
ORMAL EXTENSION		I	
RESPONSE		ln	
LLE MAL POWER		✓	
D WEAKNESS			
ERE WEAKNESS			
ORMAL FLEXION			
ORMAL EXTENSION			
RESPONSE			
SIZE		3	
REACTION		R	
SIZE		3	
REACTION		R	
ERFUSION E			

● 2 ● 3 ● 4 ● 5 ● 6 ● 7 mm

LEGEN

C Clos by swell

T Trach/E.
S Slurring
D Dyspha
R Recept
E Express

R Right
L Left

Record separatel there is a difference between t two sides.

++ Bris
+ Slov
- No Respor

+ Intact
- Abnorn

VASCULAR ASSESSMENT

HOURS			17
Ant tib	R	2+	1+
	L	2+	1+
Radial	R	2+	1+
	L	2+	1+
Pedal	R		1+
	L		1+

LEGENC

++ Norm
+ Weal
- Abse
D Doppl

CW-[redacted] (b)(6)-4

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DA

For … m. see AR 40-66; the proponent agency is the Office of Th

REPORT TITLE

INTENSIVE C. NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89

(b)(6)-2

INITIAL SHIFT ASSESSMENT

	TIME		INITIALS		INITIALS	0830	[redacted]
NEURO	PUPILS	2mm PERRLA					
	SENSORIUM					Awake, Fol. cmd	
						A+O x3	
RESPIRATORY	RESPIRATORY PATTERN	even unlabored				even, unlab	
	BREATH SOUNDS	CTA(B)				Sats 100% [illegible]	
	SECRETIONS	Ø					
		RR 12				RR 18-15	
						(+) [illegible]	
SKIN	COLOR	NFR				NFR	
	INTEGRITY	Dry				Dry	
						(L) [illegible] area —	
IV SITE	LOCATION	Ø				Ø	
	CONDITION	N/A					
GASTRO	ABDOMEN	Soft, NT/ND				S/F NT/ND	
	BOWEL SOUNDS	(+) all (quads)				Ø BM	
GU	URINE	via URINAL				[illegible]	
	COLOR/CLARITY	Clear yellow				[illegible]	
		0					
CARDIOVASCULAR	CARDIAC RHYTHM	S1S2 audible				S1/S2	
		PP [illegible]				palp pulses	

pressure [illegible]

LEGEND:
Cr - Creatinine
FiO2 - Fraction of Inspired O2
HCO3 - Bicarbonate
ICP - Intracranial Pressure
PCO2 - Pressure of Arterial CO2
PEEP - Positive End Expiratory Pressure
SIA - Fractional
SAT - Saturation
TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC
ICU 2 west

DATE

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

[redacted]

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

DA FORM 1 MAY 78 4700
Proponent: Dept of Nurs

WAMC OP 375 (Redesignated)
1 Apr 90 (HSXC-NU)

13 Jul 03

(b)(6)-4

4:403 EPIC [redacted]

PAGE 2 OF 4

DATE

HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07	/	08	09	10	11	12	13	14	15	/
BP Arterial Line										117								
BP Cuff										/84								
Temperature										97.6								
Pulse										89								
Respiratory Rate										18								

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
TOTALS																		

OUTPUT

URINE	HOUR / TOTAL	/	/	100 /	/	/	/	/	/		225 /	/	/	/	225 /	/	/	/	
	spgr																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS																			

MEDCOM - 13840