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

d/Section:	REQUESTING PHYSICAN:	DATE	TIME	SSN/PEEUDO SSN:
T, FIRST,MI:				

(Hematology) CBC

ST	RESULT	REF. RANGE
ID: [redacted]		10-10-03 03:51
WB		Patient Limits
WBC	6.3	x10^3/uL 4.5 10.5
RBC	4.32	x10^6/uL 4.00 6.00
Hgb	12.2	g/dL 11.0 18.0
Hct	38.4	% 35.0 60.0
MCV	88.9	fL 80.0 99.9
MCH	28.2	pg 27.0 31.0
MCHC	31.7 L	g/dL 33.0 37.0
Plt	313.	x10^3/uL 150. 450.
LY%	33.9	% 20.5 51.1
LY#	2.1	x10^3/uL 1.2 3.4
Lymph		Baso
Atyp		Imm
RBC Morph		
Spun Hematocrit		42-52%(M) 37-47%(F)
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

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		

Macroscopic 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 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: | DATE: | LAB ID NO.:

MEDCOM - 19841

Ward/Section: ER

REQUESTING PHYSIC [redacted]

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

LAST, FIRST, MI: [redacted] b(6)-4

DATE

TIME

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

b(6)-2

(Hematology) CBC

TEST	RESULT	REF. RANGE
ID: [redacted] b(6)-4		19-09-03
MR		16:33
		Patient Limits
WBC	7.0	x10^3/uL 4.5 10.5
RBC	3.88 L	x10^6/uL 4.00 6.00
Hgb	12.0	g/dL 11.0 18.0
Hct	36.5	% 35.0 60.0
MCV	94.0	fL 80.0 99.9
MCH	30.8	pg 27.0 31.0
MCHC	32.8 L	g/dL 33.0 37.0
Plt	402.	x10^3/uL 150. 450.
LYX	29.1	% 20.5 51.1
LY#	2.0	x10^3/uL 1.2 3.4

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 - 19842

b(6)-2

Ward/Section: =MT | REQUESTING PHYSICIAN: [redacted] | **CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. b(6)-4 [redacted] | DATE 19 Sept | TIME 1620 | SSN/PSEUDO SSN: [redacted] 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 (a 41-51 mmHg (ve
PO2		80-105 mmHg (ar N/A (ven)
TCO2		23-27 mmol/L (ar 24-29 mmol/L (ve
HCO3		22-26 mmol/L (ar 23-28 mmol/L (ve
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmo
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. RANG
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl

======= PICCOLO =======
19/09/03 16:31
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #: 3141AA4
OPER #: [redacted] DR #: 000
SERIAL #: b(6)- [redacted]

GLU	104	73-118	MG/DL
BUN	18	7-22	MG/DL
CRE	0.8	0.6-1.2	MG/DL
CK	162	39-380	U/L
NA+	♦♦♦	128-145	MMOL
K+	4.4	3.3-4.7	MMOL
CL-	♦♦♦	98-108	MMOL
tCO2	24	18-33	MMOL

INST QC: OK CHEM QC: OK
HEM 0 , LIP 1+, ICT 0

I-Stat
Na - 136
Cl - 104

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		

======= PICCOLO =======
19/09/03 16:31
REFERENCE RANGE: MALE
PATIENT #: [redacted]
GENERAL CHEMISTRY 12
DISC LOT #: 3204AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

ALB	2.9*	3.3-5.5	G/DL
ALP	97*	26-84	U/L
ALT	55*	10-47	U/L
AMY	50	14-97	U/L
AST	<5*	11-38	U/L
TBIL	0.5	0.2-1.6	MG/DL
BUN	19	7-22	MG/DL
CA++	9.2	8.0-10.3	MG/DL
CHOL	182	100-200	MG/DL
CRE	1.0	0.6-1.2	MG/DL
GLU	110	73-118	MG/DL
TP	7.7	6.4-8.1	G/DL

INST QC: OK CHEM QC: OK
HEM 0 , LIP 0 , ICT 0

N
K
C
tC

REMARKS:

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

b(6)-2

Ward/Section: ICU #1 | REQUESTING PHYSICIAN: [redacted] | **LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)

LAST, FIRST, MI: [redacted] b(6)-4 | DATE: 10OCT03 | TIME: 1420 | SSN/PSEUDO SSN: [redacted] b(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
ID: [redacted]		
WBC	7.9	4.8-10.8 x10^3/uL
RBC	4.06	4.2-5.4 x10^6/uL
HGB	11.5	12.0-16.0 g/dL
HCT	35.4	37.0-47.0 %
MCV	87.2	80.0-94.0 fL
MCH	28.3	27.0-31.0 pg
MCHC	32.4 L	32.0-37.0 g/dL
PLT	382	150-450 x10^3/uL
LYM	22.4	20.5-51.1 %
LYM	1.8	1.2-3.4 x10^3/uL

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:** 10OCT03 | **LAB ID NO.:**

b(6)-2

Ward/Section:	...STING PHYSICIAN: b(6)-4	...STRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted]	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*
Na		138-146 mmol/L	ALB		3.5-5.5 g/dl	GLU		73-118 mg/dl
K		3.5-4.9 mmol/L	ALP		26-84 u/l	BUN		7-22 mg/dl
Cl		98-109 mmol/L	ALT		10-47 u/l	CA^{++}		8.0-10.3 mg/dl
pH		7.31-7.45	AMY		14-97 u/l	CRE		0.6-1.2 mg/dl
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)	AST		11-38 u/l	NA^-		128-145 mmol/l
PO2		80-105 mmHg (art) N/A (ven)	TBIL		0.2-1.6 mg/dl	K^+		3.3-4.7 mmol/l
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)	BUN		7-22 mg/dl	CL^-		98-108 mmol/l
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)	CA^{++}		8.0-10.3mg/dl	tCO_2		18-33 mmol/l
sO2		95-98%	CHOL		100-200 mg/dl	**(Piccolo) Liver Panel Plus**		
BEecf		(-2) – (+3) mmol/L	CRE		0.6-1.2 mg/dl	*TEST*	*RESULT*	*REF. RANGE*
AnGap		10-20 mmol/L	GLU		73-118 mg/dl	ALB		3.3-5.5 g/dl
Ca		1.12-1.32 mmol/L	TP		6.4-8.1 g/dl	ALP		26-84 u/l
BUN		8-26 mg/dl	**(Piccolo) Metlyte 8**			ALT		10-47 u/l
GLU		70-105 mg/dl	*TEST*	*RESULT*	*REF. RANGE*	AMY		14-97 u/l
Creat		0.7-1.5 mg/dl	GLU		73-118 mg/dl	AST		11-38 u/l
Hct		38-51% PCV	BUN		7-22 mg/dl	TBIL		0.2-1.6 mg/dl
Hgb		12-17 g/dl	CRE		0.6-1.2 mg/dl	GGT		5-65 u/l
Misc. Chemistry			CK		39-380 u/l (M) 30-190 u/l (F)	TP		6.4-8.1 g/dl
TEST	*RESULT*	*REF. RANGE*	NA^+		128-145 mmol/l	**(Piccolo) Electrolyte**		
Troponin-I	neg		K^+		3.3-4.7 mmol/l	*TEST*	*RESULT*	*REF. RANGE*
Drug of Abuse			CL^-		98-108 mmol/l	NA^+		128-145 mmol/l
			tCO_2		18-33 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:** 2oct03	**LAB ID NO.:**

[redacted] b(2)-2

Microbiology Request Form

Preliminary Report

Last Name: EPW[redacted]
First Name:
Patient # or SSN: [redacted] b(6)-4
Collected by: DR. [redacted] b(6)-2
Date: 18 OCT 03
Time: 1024

Ward: ICW 1
Room:
Bed:
Physician: DR. [redacted]
Source: WOUND
Site: FEMUR

Received by:
Date: 18 OCT 03
Time:

Specimen #[redacted]

Preliminary Laboratory Results

Staphlococcus epidermidis

Reported
Date: 22 OCT 03
Time: 1419
Tech [redacted] b(6)-2
Reviewer:

Number of attached sheets: 1

Preliminary Report

[redacted]

Microbiology Request Form

b (6) - 4

Last Name: # [redacted]
First Name:
Patient # or SSN:

Ward: ICU
Room:
Bed:
Physician: Dr. [redacted]

Collected by: Dr. [redacted]
Date: 19 Oct 03
Time: 1024

Source: wound
Site: (R) femur

[redacted]

Received by:
Date:
Time:

Specimen #: Aerobic / Anaerobic [redacted]

Laboratory Results

Staphylococcus epidermidis x2

Reported
Date: 24 Oct 03
Time: 1245
Tech: [redacted]
Reviewer: [redacted]

b(6)-2

Number of attached sheets:

[redacted]

Microbiology Request Form

Last Name: # [redacted]
First Name:
Patient # or SSN:

Ward: ICU
Room:
Bed:
Physician: Dr. [redacted]

Collected by: Dr. [redacted]
Date: 19 OCT 03
Time: 1024

Source: wound
Site: (R) Femur

[redacted]

Received by:
Date:
Time:

Specimen #: Aerobic / Anaerobic [redacted]

Laboratory Results

Staphylococcus epidermidis x2

Reported
Date: 24 Oct 03
Time: 1245
Tech: [redacted]
Reviewer: [redacted]

Number of attached sheets:

[redacted] b(2)-2

Microbiology Request Form

Last Name: [redacted] b(a)-4
First Name:
Patient # or SSN: [redacted] b(a)-4
Collected by:
Date: 20 Sep 03
Time: 1620

Ward: ICU 1
Room:
Bed:
Physician: [redacted] b(a)-2
Source: Rt femur Swab
Site: Rt femur

[redacted]

Received by: [redacted] b(a)-2
Date: 20 Sep 03
Time: 1630

Specimen #: [redacted]

Laboratory Results

initial gram stain – few gram positive cocci pairs
few gram negative rods
Staphylococcus xylosus
Proteus mirabilis

Reported
Date: 23 Sep 03
Time: 0900
Tech: [redacted]
Reviewer: [redacted] b(a)-2

Number of attached sheets:

Microbiology Report

[redacted] b(2)-2

Name: CIV
Patient ID: [redacted]
Ward/Rm: /

Specimen: [redacted]
Source: Wound/Sterile site
Ward of Iso:

Status: Final
Collected:
Attd. Phys:

1 Staphylococcus epidermidis Status: Final

1 S. epidermidis

Drug	MIC	Interps	Drug	MIC	Interps
Amox/K Clav (c)	>4/2	R			
Amp/Sulbactam (c)	16/8	R			
Ampicillin	>8	BLAC			
Azithromycin	>4	R			
Cefazolin	>16	R			
Cefepime	>16	R			
Cefotaxime (c)	>32	R			
Ceftriaxone (c)	>32	R			
Cephalothin	>16	R			
Chloramphenicol	>16	R			
Ciprofloxacin	<=1	S			
Clindamycin	>2	R			
Erythromycin	>4	R			
Gatifloxacin	<=2	S			
Gentamicin	8	I			
Imipenem (c)	<=4	R			
Levofloxacin	<=2	S			
Linezolid	>4				
Moxifloxacin	>4	R			
Nitrofurantoin	>64				
Norfloxacin	<=4				
Ofloxacin	4	I			
Oxacillin	>2	R			
Penicillin	>8	BLAC			
Rifampin	>2	R			
Synercid	>2	R			
Tetracycline	>8	R			
Trimeth/Sulfa	<=2/38	S			
Vancomycin	>16	R			

S = Susceptible
I = Intermediate
R = Resistance
MIC = mcg/ml (mg/L)

N/R = Not Reported
— = Not Tested
TFG = Thymidine-dependent strain

Blank = Data not available, or drug not advisable or tested
ESBL = Extended spectrum beta-lactamase
Blac = Beta-lactamase positive

R* = Resistant due to extended spectrum beta-lactamases (ESBL)
EBL? = Suspected ESBL. Confirmatory tests needed to differentiate ESBL from other beta-lactamases.
IB = Inducible Beta-lactamase. Appears in place of Sensitive with species known to possess inducible beta-lactamases; potentially they may become resistant to all beta-lactam drugs. Monitoring of patients during/after therapy is recommended. Avoid other/combined beta-lactam drugs.

For blood and CSF isolates, a beta-lactamase test is recommended for Enterococcus species.

(a) Use maximum doses of drug with an aminoglycoside for P. aeruginosa in patients with granulocytopenia or serious infections.
(b) Breakpoints based on parenteral dose. For cefuroxime axetil (PO) use (8=S, 8-16=I, >16=R). Footnote (c) applies to this drug.
(c) For streptococci refer to penicillin interpretations. For amoxicillin/K clavulanate or ampicillin/sulbactam with enterococci, refer to the penicillin interpretation.
(d) For non beta-lactamase producing enterococci, refer to the penicillin interpretation. Footnote (a) also applies to this drug.

Interpretive breakpoints are based on NCCLS M100-S12 Jan 2002. Sparfloxacin (for Gram Negative isolates) and moxifloxacin are based on FDA approved breakpoints. For S. pneumoniae, cefotaxime and ceftriaxone breakpoints are based on isolates from patients with meningitis. For non-meningitis infections, use <2=S, 2=I, >2=R.

Name: CIV
Patient ID: [redacted] b(4)-1
Ward/Rm: /

Specimen: [redacted]
Source: Wound/Sterile site
Ward of Iso:

Status: Final
Collected:
Req. Phys: [redacted]

b(4)-2

Microbiology Report

Name: CIV
Patient ID: [redacted] b(6)-4
Ward/Rm: /
Specimen: [redacted] b(2)-2
Source: Wound/Sterile site
Ward of Iso:
Status: Final
Collected:
Attd. Phys:

1	Staphylococcus epidermidis	Status: Final
2	Staphylococcus epidermidis	Status: Final

1 S. epidermidis

Drug	MIC	Interps
Amox/K Clav (c)	>4/2	R
Amp/Sulbactam (c)	16/8	R
Ampicillin	>8	BLAC
Azithromycin	>4	R
Cefazolin	>16	R
Cefepime	>16	R
Cefotaxime (c)	>32	R
Ceftriaxone (c)	>32	R
Cephalothin	>16	R
Chloramphenicol	>16	R
Ciprofloxacin	<=1	S
Clindamycin	>2	R
Erythromycin	>4	R
Gatifloxacin	<=2	S
Gentamicin	8	I
Imipenem (c)	<=4	R
Levofloxacin	<=2	S
Linezolid	>4	
Moxifloxacin	>4	R
Nitrofurantoin	>64	
Norfloxacin	<=4	
Ofloxacin	4	I
Oxacillin	>2	R
Penicillin	>8	BLAC
Rifampin	>2	R
Synercid	>2	R
Tetracycline	>8	R
Trimeth/Sulfa	<=2/38	S
Vancomycin	>16	R

2 S. epidermidis

Drug	MIC	Interps
Amox/K Clav (c)	>4/2	R
Amp/Sulbactam (c)	>16/8	R
Ampicillin	>8	BLAC
Azithromycin	>4	R
Cefazolin	>16	R
Cefepime	<=8	R
Cefotaxime (c)	>32	R
Ceftriaxone (c)	>32	R
Cephalothin	>16	R
Chloramphenicol	>16	R
Ciprofloxacin	2	I
Clindamycin	>2	R
Erythromycin	>4	R
Gatifloxacin	>4	R
Gentamicin	>8	R
Imipenem (c)	<=4	R
Levofloxacin	>4	R
Linezolid	>4	
Moxifloxacin	>4	R
Nitrofurantoin	>64	
Norfloxacin	<=4	
Ofloxacin	>4	R
Oxacillin	>2	R
Penicillin	>8	BLAC
Rifampin	>2	R
Synercid	>2	R
Tetracycline	>8	R
Trimeth/Sulfa	>2/38	R
Vancomycin	>16	R

S = Susceptible
I = Intermediate
R = Resistance
MIC = mcg/ml (mg/L)

N/R = Not Reported
— = Not Tested
TFG = Thymidine-dependent strain

Blank = Data not available, or drug not advisable or tested
ESBL = Extended spectrum beta-lactamase
Blac = Beta-lactamase positive

R* = Resistant due to extended spectrum beta-lactamases (ESBL)
EBL? = Suspected ESBL. Confirmatory tests needed to differentiate ESBL from other beta-lactamases.
IB = Inducible Beta-lactamase. Appears in place of Sensitive with species known to possess inducible beta-lactamases; potentially they may become resistant to all beta-lactam drugs. Monitoring of patients during/after therapy is recommended. Avoid other/combined beta-lactam drugs.

For blood and CSF Isolates, a beta-lactamase test is recommended for Enterococcus species.

(a) Use maximum doses of drug with an aminoglycoside for P. aeruginosa in patients with granulocytopenia or serious infections.
(b) Breakpoints based on parenteral dose. For cefuroxime axetil (PO) use (S=S, 8-16=I, >16=R). Footnote (c) applies to this drug.
(c) For streptococci refer to penicillin interpretations. For amoxicillin/K clavulanate or ampicillin/sulbactam with enterococci, refer to the penicillin interpretation.
(d) For non beta-lactamase producing enterococci, refer to the penicillin interpretation. Footnote (a) also applies to this drug.

Interpretive breakpoints are based on NCCLS M100-S12 Jan 2002. Sparfloxacin (for Gram Negative isolates) and moxifloxacin are based on FDA approved breakpoints. For S. pneumoniae, cefotaxime and ceftriaxone breakpoints are based on isolates from patients with meningitis. For non-meningitis infections, use <2=S, 2=I, >2=R.

Name: CIV
Patient ID: [redacted] b(6)-4
Ward/Rm: /
Specimen: [redacted]
Source: Wound/Sterile site
Ward of Iso:
Status: Final
Collected:
Req. Phys: [redacted]
Tech: [redacted]

Microbiology Report

Name: CIV
Patient ID: [redacted] b(6)-4
Ward/Rm:
Specimen: [redacted] b(7)-2
Source: Wound/Sterile site
Ward of Iso:
Status: **Final**
Collected:
Attd. Phys:

1	Staphylococcus epidermidis	Status: Final
2	Staphylococcus epidermidis	Status: Final

1 S. epidermidis

Drug	MIC	Interps
Amox/K Clav (c)	>4/2	R
Amp/Sulbactam (c)	16/8	R
Ampicillin	>8	BLAC
Azithromycin	>4	R
Cefazolin	>16	R
Cefepime	>16	R
Cefotaxime (c)	>32	R
Ceftriaxone (c)	>32	R
Cephalothin	>16	R
Chloramphenicol	>16	R
Ciprofloxacin	<=1	S
Clindamycin	>2	R
Erythromycin	>4	R
Gatifloxacin	<=2	S
Gentamicin	8	I
Imipenem (c)	<=4	R
Levofloxacin	<=2	S
Linezolid	>4	
Moxifloxacin	>4	R
Nitrofurantoin	>64	
Norfloxacin	<=4	
Ofloxacin	4	I
Oxacillin	>2	R
Penicillin	>8	BLAC
Rifampin	>2	R
Synercid	>2	R
Tetracycline	>8	R
Trimeth/Sulfa	<=2/38	S
Vancomycin	>16	R

2 S. epidermidis

Drug	MIC	Interps
Amox/K Clav (c)	>4/2	R
Amp/Sulbactam (c)	>16/8	R
Ampicillin	>8	BLAC
Azithromycin	>4	R
Cefazolin	>16	R
Cefepime	<=8	R
Cefotaxime (c)	>32	R
Ceftriaxone (c)	>32	R
Cephalothin	>16	R
Chloramphenicol	>16	R
Ciprofloxacin	2	I
Clindamycin	>2	R
Erythromycin	>4	R
Gatifloxacin	>4	R
Gentamicin	>8	R
Imipenem (c)	<=4	R
Levofloxacin	>4	R
Linezolid	>4	
Moxifloxacin	>4	R
Nitrofurantoin	>64	
Norfloxacin	<=4	
Ofloxacin	>4	R
Oxacillin	>2	R
Penicillin	>8	BLAC
Rifampin	>2	R
Synercid	>2	R
Tetracycline	>8	R
Trimeth/Sulfa	>2/38	R
Vancomycin	>16	R

S = Susceptible
I = Intermediate
R = Resistance
MIC = mcg/ml (mg/L)

N/R = Not Reported
--- = Not Tested
TFG = Thymidine-dependent strain

Blank = Data not available, or drug not advisable or tested
ESBL = Extended spectrum beta-lactamase
Blac = Beta-lactamase positive

R* = Resistant due to extended spectrum beta-lactamases (ESBL)
EBL? = Suspected ESBL. Confirmatory tests needed to differentiate ESBL from other beta-lactamases.
IB = Inducible Beta-lactamase. Appears in place of Sensitive with species known to possess inducible beta-lactamases; potentially they may become resistant to all beta-lactam drugs. Monitoring of patients during/after therapy is recommended. Avoid other/combined beta-lactam drugs.

For blood and CSF Isolates, a beta-lactamase test is recommended for Enterococcus species.

(a) Use maximum doses of drug with an aminoglycoside for P. aeruginosa in patients with granulocytopenia or serious infections.
(b) Breakpoints based on parenteral dose. For cefuroxime axetil (PO) use (8=S, 8-16=I, >16=R). Footnote (c) applies to this drug.
(c) For streptococci refer to penicillin interpretations. For amoxicillin/K clavulanate or ampicillin/sulbactam with enterococci, refer to the penicillin interpretation.
(d) For non beta-lactamase producing enterococci, refer to the penicillin interpretation. Footnote (a) also applies to this drug.

Interpretive breakpoints are based on NCCLS M100-S12 Jan 2002. Sparfloxacin (for Gram Negative isolates) and moxifloxacin are based on FDA approved breakpoints. For S. pneumoniae, cefotaxime and ceftriaxone breakpoints are based on isolates from patients with meningitis. For non-meningitis infections, use <2=S, 2=I, >2=R.

Name: CIV
Patient ID: [redacted] b(6)-4
Ward/Rm: /
Specimen: [redacted]
Source: Wound/Sterile site
Ward of Iso:
Status: **Final** b(6)-2
Collected:
Req. Phys: [redacted]

Microbiology Report

[redacted] b(2)-2

Name: CIV
Patient ID: [redacted] b(6)-4
Ward/Rm: /

Specimen: [redacted]
Source: Wound/non-sterile body site
Ward of Iso:

Status: **Final**
Collected:
Attd. Phys:

1	Staphylococcus xylosus	Status:	Final
2	Proteus mirabilis	Status:	Final

1 S. xylosus

Drug	MIC	Interps
Amox/K Clav (c)	>4/2	R
Amp/Sulbactam (c)	16/8	R
Ampicillin	>8	BLAC
Azithromycin	>4	R
Cefazolin	>16	R
Cefepime	>16	R
Cefotaxime (c)	>32	R
Ceftriaxone (c)	>32	R
Cephalothin	>16	R
Chloramphenicol	<=8	S
Ciprofloxacin	<=1	S
Clindamycin	>2	R
Erythromycin	>4	R
Gatifloxacin	<=2	S
Gentamicin	<=4	S
Imipenem (c)	<=4	R
Levofloxacin	<=2	S
Linezolid	>4	
Moxifloxacin	<=2	S
Nitrofurantoin	64	
Norfloxacin	<=4	
Ofloxacin	<=2	S
Oxacillin	>2	R
Penicillin	>8	BLAC
Rifampin	>2	R
Synercid	>2	R
Tetracycline	<=4	S
Trimeth/Sulfa	<=2/38	S
Vancomycin	>16	R

2 P. mirabilis

Drug	MIC	Interps
Amox/K Clav (c)	<=8/4	S
Amp/Sulbactam (c)	<=8/4	S
Ampicillin	<=8	S
Aztreonam	<=8	S
Cefazolin	>16	R
Cefepime	<=8	S
Cefotaxime (c)	<=8	S
Cefotetan	<=16	S
Cefoxitin	<=8	S
Ceftazidime (a)	<=8	S
Ceftriaxone (c)	<=8	S
Cefuroxime (b)	<=4	S
Cephalothin	<=8	S
Chloramphenicol	<=8	S
Ciprofloxacin	<=1	S
ESBL-a Scrn	<=4	
ESBL-b Scrn	<=1	
Gatifloxacin	<=2	S
Gentamicin	<=4	S
Imipenem (c)	<=4	S
Levofloxacin	<=2	S
Meropenem (c)	<=4	S
Moxifloxacin	<=2	S
Nitrofurantoin	>64	
Norfloxacin	<=4	
Pip/Tazo (d)	<=16	S
Piperacillin (a)	<=16	S
Tetracycline	<=4	S
Ticar/K Clav (a)	<=16	S
Tobramycin	<=4	S
Trimeth/Sulfa	<=2/38	S

S = Susceptible
I = Intermediate
R = Resistance
MIC = mcg/ml (mg/L)

N/R = Not Reported
— = Not Tested
TFG = Thymidine-dependent strain

Blank = Data not available, or drug not advisable or tested
ESBL = Extended spectrum beta-lactamase
Blac = Beta-lactamase positive

R* = Resistant due to extended spectrum beta-lactamases (ESBL)
EBL? = Suspected ESBL. Confirmatory tests needed to differentiate ESBL from other beta-lactamases.
IB = Inducible Beta-lactamase. Appears in place of Sensitive with species known to possess inducible beta-lactamases; potentially they may become resistant to all beta-lactam drugs. Monitoring of patients during/after therapy is recommended. Avoid other/combined beta-lactam drugs.

For blood and CSF Isolates, a beta-lactamase test is recommended for Enterococcus species.

(a) Use maximum doses of drug with an aminoglycoside for P. aeruginosa in patients with granulocytopenia or serious infections.
(b) Breakpoints based on parenteral dose. For cefuroxime axetil (PO) use (8=S, 8-16=I, >16=R). Footnote (c) applies to this drug.
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(d) For non beta-lactamase producing enterococci, refer to the penicillin interpretation. Footnote (a) also applies to this drug.

Interpretive breakpoints are based on NCCLS M100-S12 Jan 2002. Sparfloxacin (for Gram Negative isolates) and moxifloxacin are based on FDA approved breakpoints.
For S. pneumoniae, cefotaxime and ceftriaxone breakpoints are based on isolates from patients with meningitis. For non-meningitis infections, use <2=S, 2=I, >2=R.

Name: CIV
Patient ID: [redacted] b(6)-4
Ward/Rm: /

Specimen: [redacted]
Source: Wound/non-sterile body site
Ward of Iso:

Status: **Final**
Collected: [redacted] b(6)-2
Req. Phys: [redacted]

Printed 9/23/2003 9:01:28 AM

MEDCOM - 19853

Tech: [redacted]

Microbiology Report

[redacted] b(2)-2

Name: CIV
Patient ID: [redacted] b(6)-4
Ward/Rm: /

Specimen: [redacted]
Source: Wound/non-sterile body site
Ward of Iso:

Status: Final
Collected:
Attd. Phys:

1	Staphylococcus xylosus	Status: Final
2	Proteus mirabilis	Status: Final

1 S. xylosus

Drug	MIC	Interps
Amox/K Clav (c)	>4/2	R
Amp/Sulbactam (c)	16/8	R
Ampicillin	>8	BLAC
Azithromycin	>4	R
Cefazolin	>16	R
Cefepime	>16	R
Cefotaxime (c)	>32	R
Ceftriaxone (c)	>32	R
Cephalothin	>16	R
Chloramphenicol	<=8	S
Ciprofloxacin	<=1	S
Clindamycin	>2	R
Erythromycin	>4	R
Gatifloxacin	<=2	S
Gentamicin	<=4	S
Imipenem (c)	<=4	R
Levofloxacin	<=2	S
Linezolid	>4	Not Tested
Moxifloxacin	<=2	S
Nitrofurantoin	64	
Norfloxacin	<=4	
Ofloxacin	<=2	S
Oxacillin	>2	R
Penicillin	>8	BLAC
Rifampin	>2	R
Synercid	>2	R
Tetracycline	<=4	S
Trimeth/Sulfa	<=2/38	S
Vancomycin	>16	R

2 P. mirabilis

Drug	MIC	Interps
Amox/K Clav (c)	<=8/4	S
Amp/Sulbactam (c)	<=8/4	S
Ampicillin	<=8	S
Aztreonam	<=8	S
Cefazolin	>16	R
Cefepime	<=8	S
Cefotaxime (c)	<=8	S
Cefotetan	<=16	S
Cefoxitin	<=8	S
Ceftazidime (a)	<=8	S
Ceftriaxone (c)	<=8	S
Cefuroxime (b)	<=4	S
Cephalothin	<=8	S
Chloramphenicol	<=8	S
Ciprofloxacin	<=1	S
ESBL-a Scrn	<=4	
ESBL-b Scrn	<=1	
Gatifloxacin	<=2	S
Gentamicin	<=4	S
Imipenem (c)	<=4	S
Levofloxacin	<=2	S
Meropenem (c)	<=4	S
Moxifloxacin	<=2	S
Nitrofurantoin	>64	
Norfloxacin	<=4	
Pip/Tazo (d)	<=16	S
Piperacillin (a)	<=16	S
Tetracycline	<=4	S
Ticar/K Clav (a)	<=16	S
Tobramycin	<=4	S
Trimeth/Sulfa	<=2/38	S

S = Susceptible
I = Intermediate
R = Resistance
MIC = mcg/ml (mg/L)

N/R = Not Reported
— = Not Tested
TFG = Thymidine-dependent strain

Blank = Data not available, or drug not advisable or tested
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R* = Resistant due to extended spectrum beta-lactamases (ESBL)
EBL? = Suspected ESBL. Confirmatory tests needed to differentiate ESBL from other beta-lactameses.
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Name: CIV
Patient ID: [redacted] b(6)-4
Ward/Rm: /

Specimen: [redacted]
Source: Wound/non-sterile body site
Ward MEDCOM - 19854

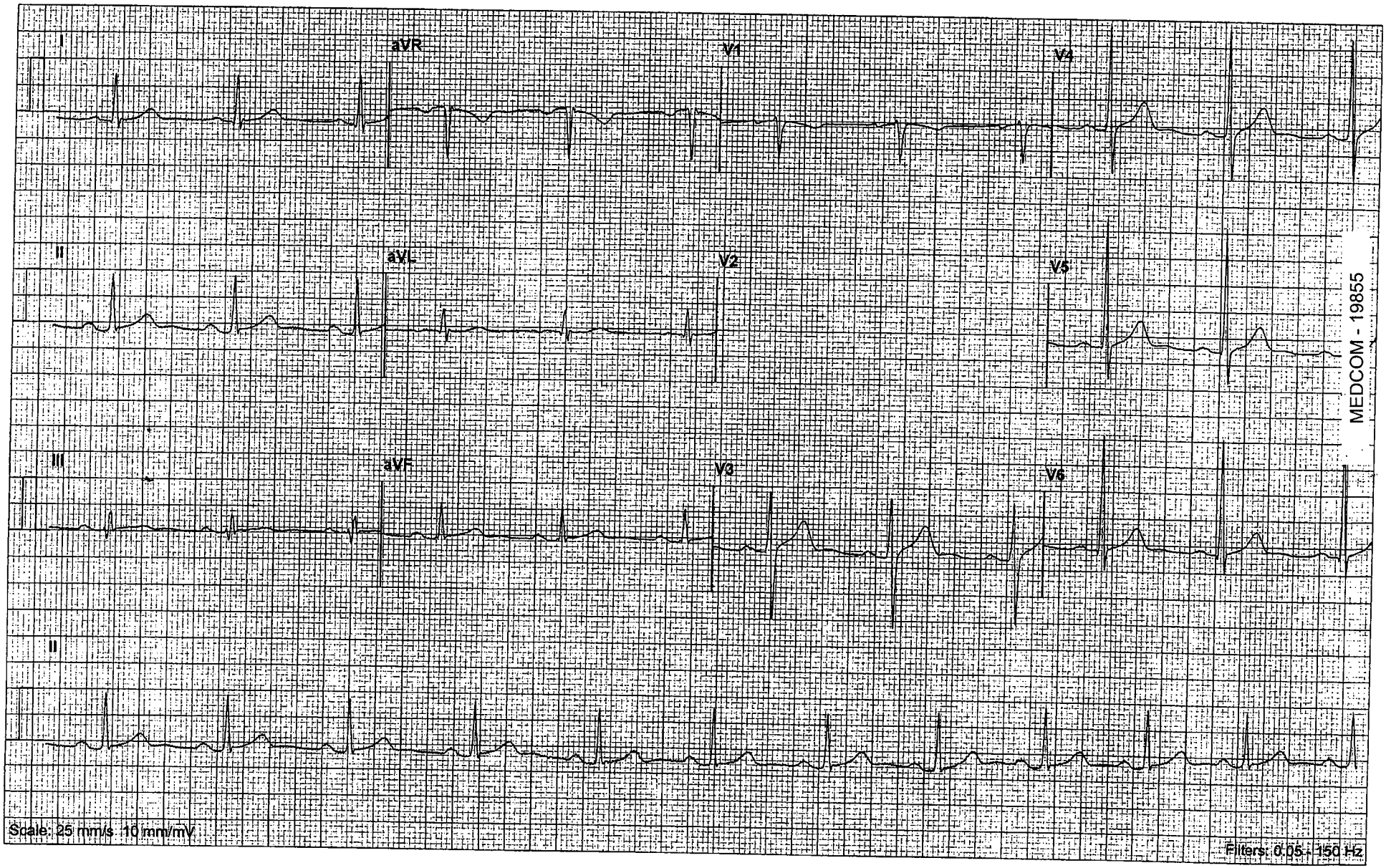
Status: Final
Collected: b(6)-2
Req. Phys: [redacted]

3x4 Simultaneous Report

Name: [redacted]
Number:
Sex: Male
Date of Birth: 10/20/2003
Height/Weight: 71in / NA

Recorded: 10/20/2003 1:30:28 PM
Device: CL 131132

Interpretation (Unconfirmed)
Leads off. ECG not analysed.



NKDA

Procedure site verified

MEDICAL RECORD — ANESTHESIA

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

DRUG	(Units)	
Fentanyl	(ug)	150 100
Lidocaine	(mg)	
Propofol	(mg)	160
Versed	(mg)	10
	( )	
	( )	
VOLAT AGENT Forane	% del	1.25-1.8-1.5 — .84
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	1 — 1

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

FLUIDS — LINE site L18 (R) A C

- ☐ Warmed — LR
- ☐ Warmed
- ☐ Warmed
- ☐ Warmed

LOSSES — EST BLOOD LOSS — URINE –

TOTALS

TOTAL EBL <25cc

TOTAL URINE 0 foley

FLUIDS - SUMMARY

CRYSTALLOID– 2L = 450

COLLOID–

BLOOD–

REMARKS-

Code drugs with numbers, events with letters

0930 Met + ID's Chart rev - Prep done. IV in place
(1) V/S Taken
(2) Inducted c Diprivan 160mg Anectine 100mg, O_2 Intubated
(3) Procedure begun
(4) Procedure ended
(5) O_2, breathing suctioned, ↓ cuff extubated, to recovery

PHYS STATUS 1 (2) 3 4 5 E

BODY WEIGHT 87 (KG) LB

HEMATOCRIT: 36.5

INITIAL DATA:

BP – 144/84

HR– 92 95%

EQUIP CHECK: OK? (Y) N

PATIENT IDENTIFIED: OK for PROCEDURE (Y)

TIME– 0930

SYMBOLS: BP by cuff ∨ ∧ · Heart rate · Resp rate · BP (transduced) ⊥ T · TOURNIQUET T – X · ANES– X-X · PROC– ⊙ – Ø

TIME → 1515 30 45 1600 15 30 45

VT – ml		730	720	760	780	750
f – breaths/min		10	10	10	10	11
Peak inf pres / PEEP		23	23	23	24	22
MODE– S(pon) A(ssist), C(on)		CV	CV	CV	CV	
✓ BP/Auto Cuff	✓ ET CO2 (torr)	41	36	35	37	38
BP / oth	✓ FIO2 (Frac or %)	51%	51%	52%	55%	54%
ART line	✓ SpO2 (%)	96	98	99	98	98
Steth- PC/ES	✓ ECG	SR	ST	SR	SR	
✓ Gas analyzer	TEMP- site					
	N-M Block (T/4)					
		(1)	(2)	(3)		(4) (5)
Warming blkt						
Conv warmer						

Mark with letters & symbols, explain under REMARKS — EVENTS Position → 6

RECOVERY AT

PACU ICU_____(Specify)

OTHER_____

CONDITION: Good

RESP– 16 SpO2– 93

BP– 151/72 HR– 111

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1508	1519	1635
PROC	Ready 1525	Begin 1537	End 1621

PROCEDURES and CPT Codes

D&D @ femur / tibia & foot

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

Gen Endo

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

#8.0 ET tube

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

[redacted] b(6)-4

SURGEONS: [redacted] b(6)-2

ANESTHETIS MA [redacted]

PROCEDURE LOCATION OR #2

DATE 20 Sept 03

PAGE 1 OF

WAMC OP 376 REVISED 1 Jan 99

PATIENT RECORD

MEDCOM - 19856

1

N/A

MEDICAL RECORD — ANESTHESIA

ANESTHETIC AGENTS AND DRUGS (Continuous / repeated drugs — specify units – MG / MCG / ML, "I" = constant infusion)

DRUG	(Units)					TOTALS
Fentanyl	(mcg)	250				250
Propofol	(mg)	200				
Sch	(mg)	100				
Lidocaine	(mg)	100				
Zemuron	(mg)		30			
	( )					
VOLAT AGENT Iso	% del / % e.t.	2.0 – 2.0 X				
AIR	L/Min					
N2O	L/Min					
O2	L/Min	10 – 2 – 2 – 10				

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

FLUIDS

LINE site		
18g (L) AC	☐ Warmed	LR ——— 400
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOSSES: EST BLOOD LOSS / URINE – Not measured

TOTAL EBL: Ø

TOTAL URINE: N/A

FLUIDS - SUMMARY
- CRYSTALLOID– 400
- COLLOID– Ø
- BLOOD– Ø

REMARKS- (Code drugs with numbers, events with letters)

1940 Pt id'd in ICW 1, chart reviewed. To OR via litter.
1950 In room, ⊕monitors ⊕O2. Smooth IV induction. Easy vent, Eyes taped.
2000 Placed in LLD, neck midline, Axroll placed, PP padded, Eyes free pressure ⊕BBS ⊕ETCO2.
2015 Procedure started.
2030 Reversed c̄ 5mg Neostig ⊕0.6mg Robinul.
2035 Extubated c̄ awake, to 60 x 2. To PACU stable, Report to [redacted]

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 87 (KG) LB

HEMATOCRIT: 12/36

INITIAL DATA: BP 119/66, HR– 103

EQUIP CHECK: OK? (Y) N

PATIENT RECHECK: OK for PROCEDURE? Okay. TIME– 1930

TIME → 45 2000 15 30 45

SYMBOLS: BP by cuff ∨ ∧; Heart rate ●; Resp rate; BP (transduced); TOURNIQUET T – ✗; ANES– X-X; PROC ⊙–Ø

Grid scale: 220, 200, 180, 160, 140, 120, 100, 80, 60, 40, 20

	45	2000	15	30	45
VT – ml	–	750	750	1000	
f – breaths/min	16	12	12	20	
Peak Inf pres / PEEP	–	21	21	–	
MODE– S(pon), A(ssist), C(on)	S	C	C	S	
ET CO2 (torr)	⊕	43	38	40	
FIO2 (Frac or %)	.81	.81	.81	.81	
SpO2 (%)	100	100	100	100	
ECG	ST	ST	SR	SR	
TEMP- site Skin					
N-M Block (T/4)		4/4		4/4 c̄ ST	

MONITORS / ACCESSORIES: ☒ BP/Auto Cuff; BP / oth; ART line; Steth- PC/ES ☒; Gas analyzer ☒; ☒ ET CO2; ☒ FIO2; ☒ SpO2; ☒ ECG; ☒ TEMP; N-M Block; Warming blkt; Conv warmer

Mark with letters & symbols, explain under REMARKS. EVENTS / Position —O→ LLD →

RECOVERY AT 2039 — (PACU) ICU ____ (Specify) OTHER

CONDITION: Stable, awake

RESP– 24 SpO2– 95 RA BP– HR– 88

ANESTHESIA / PROCEDURE TIME

	Start	Room	End
ANES	1940	1950	2045

	Ready	Begin	End
PROC	2000	2015	2032

PROCEDURES and CPT Codes: I&D (R) Femur

ANESTHETIC TECHNIQUES: (Describe block technique under Remarks) GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments — DVL x 1 attempt, #8 ETT, MAC 4, Grade I view ⊕BBS ⊕ETCO2, Secured @ 22 cm teeth, soft bite block placed

SURGEONS:

[redacted] C.CPT

PROCEDURE LOCATION: OR 2

DATE: 22 Sep 03

PAGE 1 OF 1

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

b(6)-4 [redacted] ICW-1 2F

b(6)-2

PATIENT RECORD

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 19857

WT 87kg NKDA

MEDICAL RECORD — ANESTHESIA

ANESTHETIC AGENTS AND DRUGS (Continuous / repeated drugs — specify units — MG / MCG / ML, "I" = constant infusion)

DRUG (Units)					TOTALS
Versed ( )	3/2				5mg
Fent ( )	100	50	50	50	250 mg
Propofol ( )	186				/
( )					
( )					
( )					
VOLAT AGENT Forane % del	1.5	2.25			
% e.t.					
AIR L/Min					
N2O L/Min					
O2 L/Min	8	2	2		

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

TOTAL EBL: MIN

TOTAL URINE: Ø

FLUIDS

LINE site		
LR ☐ Warmed	400	(600)
☐ Warmed		
☐ Warmed		
☐ Warmed		

FLUIDS - SUMMARY
CRYSTALLOID– 600
COLLOID– Ø
BLOOD– Ø

LOSSES: EST BLOOD LOSS / URINE –

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 87 (KG) LB

HEMATOCRIT:

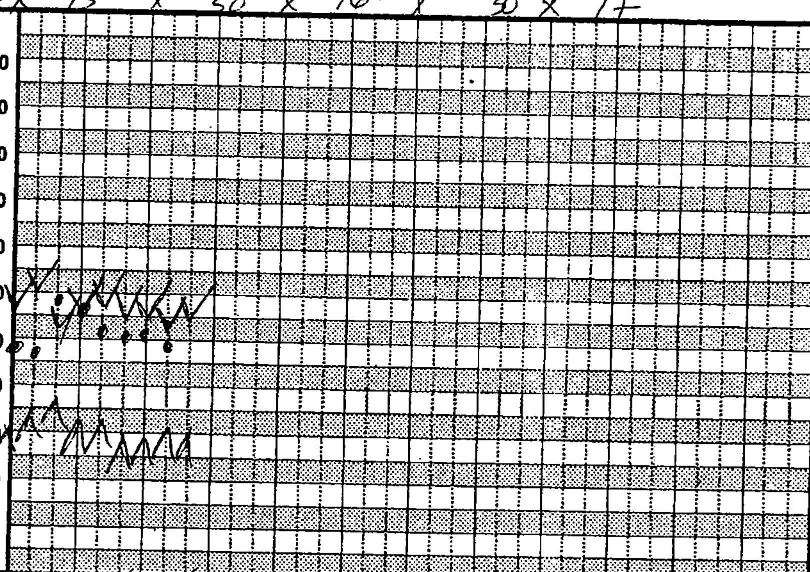
INITIAL DATA: BP – 14/64, 138 1.74 (?) HR – 84

EQUIP CHECK: OK? – (Y) N

PATIENT RECHECK: OK for PROCEDURE? TIME – 1430

TIME → X 15 X 30 X 16 X 30 X 17

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

1440 in OR monitors applied.
1445 proseal placed
1500 placed
(L) side (+) bilat BS
Proseal in place
eyes checked
1530 Pt spont
Resp Proseal out
oral airway in.
purposeful movement
oral airway out.
to PACU RA sat 98%
Report given

VENT

VT – ml	5V	5V	5V
f – breaths/min	10	10	5
Peak inf pres / PEEP			
MODE– S(pon), A(ssist), C(on)	A	A	AS

MONITORS / ACCESSORIES

BP/Auto Cuff ✓	ET CO2 (torr)	53	60	65
BP / oth	FIO2 (Frac or %)	.60	.64	.60
ART line	SpO2 (%)	100	100	100
Steth- PC/ES	ECG	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 → SP (?) ...

RECOVERY AT: 1540
(PACU) ICU ______ (Specify) OTHER
CONDITION: purposeful cooperative.
RESP– 20 SpO2– 98%
BP– 137/68 HR– 117

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1000	1440	1535

	Ready	Begin	End
PROC	1450	1510	1522

1555

PROCEDURES and CPT Codes
(R) Fem wash out

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
Proseal #5

AIRWAY MANAGEMENT: intubation route, blade, technique, comments
#5 Proseal placed
c introducer one attempt. (+) Bilat BS (+) ETCO2
eyes ...

PATIENT IDENTIFICATION– Typed or written entries: Name, Grade/Rate, Medical facility
EPW
[redacted]
b(6)-4

SURGEONS: [redacted] b(6)-2

ANESTHETISTS: [redacted] CRNA

PROCEDURE LOCATION: OR 1

DATE: 9/29/03

PAGE 1 OF 1

WAMC OP 376 REVISED
1 Jan 99

PATIENT RECORD

MEDCOM - 19858

ACLU-RDI 1654 p.18

DOD-033432

MEDICAL RECORD — ANESTHESIA

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

DRUG	(Units)		TOTALS
Fentanyl	(mcg)	250	250
Zemuron	(mg)	40	
Propofol	(mg)	180	
Lidocaine	(mg)	100	
VOLAT AGENT Iso	% del / % e.t.	1.0 – 1.8 – X	
AIR	L/Min		
N2O	L/Min		
O2	L/Min	10 – 2 – 2 – 10	

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

FLUIDS — LINE site: 18g (L) Arm ☐ Warmed — LR — (800)

LOSSES — EST BLOOD LOSS / URINE –

TOTAL EBL: Ø

TOTAL URINE: not measured

FLUIDS - SUMMARY
- CRYSTALLOID– 400
- COLLOID– Ø
- BLOOD– Ø

REMARKS- *Code drugs with numbers, events with letters*

0845 Pt identified, ICW, Chart reviewed, TOOL,
0900 In room, monitors, ⊕ oxygenation, smooth IV induction, easy ventilation, Eyes taped,
0910 turned LLD – pp padded, Ax roll placed, Eyes, ears, nose free pressure
0930 [illegible]
1000 Pt awake, extubated s difficulty → to PO [illegible], To PACU stable
Report to [redacted]

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 82 KG

HEMATOCRIT: 12/36

INITIAL DATA: BP– 144/57, HR– 96

EQUIP CHECK OK?– (Y) N

PATIENT RECHECK: OK for PROCEDURE– Okay, TIME– 0845

TIME: 0900 15 30 45 1000 15

SYMBOLS: BP by cuff ∨ ∧; Heart rate •; Resp rate; BP (transduced); TOURNIQUET T – ⁄; ANES– X-X; PROC ⊙ – Ø

	0900	15	30	45	1000
VT – ml	–	700	710	710	800
f – breaths/min	16	12	12	10	20
Peak Inf pres / PEEP	–	20	22	20	–
MODE– S(pon), A(ssist), C(on)	S	C	C	C	S
ET CO2 (torr)	⊕	38	35	36	48
FIO2 (Frac or %)	.59	.59	.59	.59	.59
SpO2 (%)	100	100	100	100	100
ECG	SR	SR	SR	SR	SR
TEMP- site Skin		97	97		
N-M Block (T/4)				4/4 0ST	

MONITORS / ACCESSORIES: X BP/Auto Cuff; BP/oth; ART line; Steth- PC/ES; Gas analyzer; Warming blkt; Conv warmer

Mark with letters & symbols, explain under REMARKS — EVENTS Position — 0→ LLD → 0

RECOVERY AT 1005: (PACU) ICU ___ (Specify) OTHER

CONDITION: Stable/Awake

RESP– 20, SpO2– 98 – RA

BP– 144/81, HR– 107

ANESTHESIA / PROCEDURE TIME

	Start	Room	End
ANES	0845	0900	1020

	Ready	Begin	End
PROC	0910	0930	1000

PROCEDURES and CPT Codes: I&D (R) Femur

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* — GETA

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* — [illegible] MAC 4, #8 ETT, Grade I view, ⊕ BBS ⊕ ETCO2, Secured @ 23 cm teeth, Soft bite block

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

b(6)-4 [redacted]

SURGEONS: [redacted] b(6)-2 [redacted] CKWA EPT

PROCEDURE LOCATION: OR 8-2

DATE: 26 Sep 03

PAGE 1 OF 1

WAMC OP 376 REVISED 1 Jan 99

PATIENT RECORD

MEDCOM - 19859

ASA-2 scrubbing LR Gen a profloxacin HL ② Proteus mirabilis

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)													
morphine (mg)	10			5	5								
phenergan (mg)	12.5												
propofol (mg)	200												
( )													
( )													
( )													
VOLAT AGENT I 50 % del / % e.t.	2.0	2.0	2.0	1.5	1.5								
AIR L/Min													
N2O L/Min													
O2 L/Min	6	2	2	2	2								

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS → ① ② ③ ④

FLUIDS

LINE site													
20g RFA ☐ Warmed	LR	1000			500								
☐ Warmed													
☐ Warmed													

LOSSES EST BLOOD LOSS / URINE -

TOTALS: 20mg | TOTAL EBL: min | TOTAL URINE: 0

FLUIDS - SUMMARY: CRYSTALLOID- 1000 | COLLOID- 0 | BLOOD- 0

REMARKS (Code drugs with numbers, events with letters)

① To room, SOC mons, preO2.
② Induction & LMA pcmt
③ Pt turned 1x lateral.
④ [redacted] removed to PACU, stable, report given.

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 87 KG LB

HEMATOCRIT: [redacted]

INITIAL DATA:
BP- 137/71
HR- 68

EQUIP CHECK OK? (Y) N

PATIENT RECHECK OK for PROCEDURE? Y TIME- 1330

TIME → 30 × 14 × 30 × 15 × 30 × 16 × 30

SYMBOLS: BP by cuff V ^ | Heart rate ● | Resp rate | BR (transduced) ╪ | TOURNIQUET T—T | ANES- X-X PROC- ⊙-⊙

220 200 180 160 140 120 100 80 60 40 20

VENTIL

VT - ml	500	320	320	310	380	
f - breaths/min	16	13	12	12	12	
Peak inf pres / PEEP	—	—	—	—	—	
MODE - S(pon), A(assist), C(on)	S	S	S	S	S	

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	42	46	47	48	41	
BP/oth	FIO2 (Frac or %)	0.7	0.7	0.7	0.7	0.7	
ART line	SpO2 (%)	100	100	100	100	100	
Steth- PC/ES	ECG	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 → O LLD →

RECOVERY AT: PACU ICU (Specify) OTHER 9608
CONDITION:
RESP- 22 SpO2- 95
BP- 132/83 HR- 76

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1330	1336	1451
PROC	Ready 1345	Begin 1400	End 1445

PROCEDURES and CPT Codes:
I&D Rt femur, abx beads

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*
GLMA

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*
[redacted] b(6)-4

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*
Eyes taped, LMA #4 in 5 trauma. ⊕ OT CO2, BSEB. Secured soft bite block & tape.

SURGEONS: [redacted] b(6)-2

[redacted] MAS, CRNA

PROCEDURE LOCATION: 1
DATE: 10/6/03
PAGE 1 OF 1

DA FORM 7389, FEB 1998 — ANESTHESIA PROVIDER — USAPA V1.00

MEDCOM - 19860

NO PMN

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
Propofol (mg)	200					200 mg
Fentanyl (cc)	2					
Sux (mg)	140					140 mg
( )						
( )						
phenylephrine (mcg)		100	200			
VOLAT AGENT forane % del	3 — 2 — 1.5 — 1.5 — X					
% e.t.						
AIR L/Min						
N2O L/Min						
O2 L/Min	8 — 3 — 2 — 2 — 2 — 8					

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

TOTAL EBL — ; TOTAL URINE —

FLUIDS - SUMMARY
CRYSTALLOID- 800
COLLOID-
BLOOD-

FLUIDS
LINE site LR ☐ Warmed — LR ↑
☐ Warmed
☐ Warmed
☐ Warmed

LOSSES EST BLOOD LOSS; URINE -

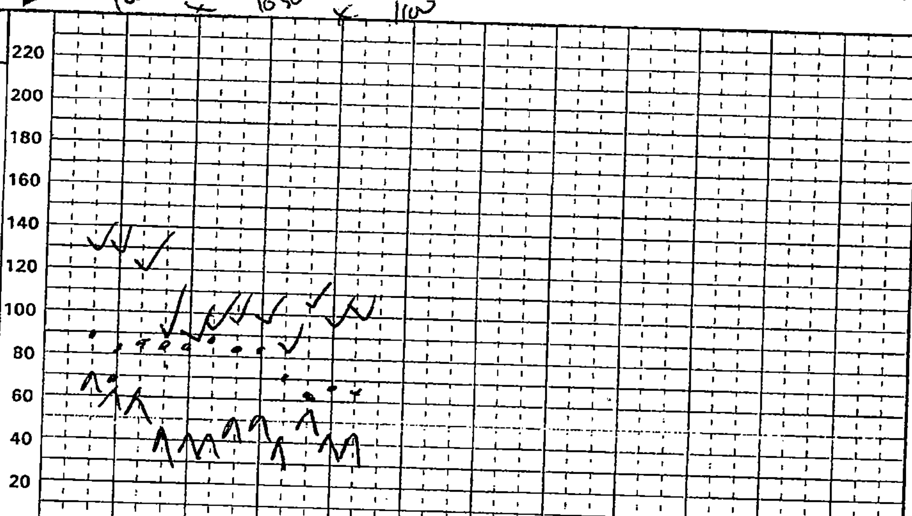
REMARKS
Code drugs with numbers, events with letters

TO OR #2. Preox O2. Smooth IV induction - ESS typed shut. Placed L Lat Decub. Head/neck neutral.
Awake. SX Extubated c̄ (+) press to 10 L/mask - TOPACU

PHYS STATUS: 1 (2) 3 4 5 E
BODY WEIGHT: 87 (KG)
HEMATOCRIT: 12.2 / 38.4
INITIAL DATA: BP- 104/64; HR- 77
EQUIP CHECK OK?- (Y) N
PATIENT RECHECK OK for PROCEDURE? Y
TIME-

TIME → 1000 × 1030 × 1100

SYMBOLS: BP by cuff V Λ; Heart rate ●; Resp rate; BR (transduced); TOURNIQUET T—T; ANES- X-X; PROC- ⊙-⊘



VENTIL VT - ml		930	940	890		
f - breaths/min		10	10	10	16	
Peak inf pres / PEEP		25	25	25		
MODE - S(pon), A(ssist), C(on)	S/A	CV	CV	CV —	SV	
BP/Auto Cuff — ET CO2 (torr)	40	36	32	32	50	
BP/oth — FIO2 (Frac or %)	.76	.76	.78	.78	.78	
ART line — SpO2 (%)	100	100	100	100	100	
Steth- PC/ES — ECG	SR	SR	SR	SR	SR	
Gas analyzer — TEMP-site skin		97	97	97	—	
N-M Block (T/4)						
Warming blkt						
Conv warmer						

MONITORS/ACCESSORIES

Mark with letters & symbols, explain under REMARKS EVENTS Position → (L) Lat Decub

RECOVERY AT 1102
(PACU) ICU ____ (Specify)
OTHER
CONDITION: Awake RA
RESP- 18 SpO2- 100%
BP- 118/53 HR- 93

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0955	1000	1107
	Ready	**Begin**	**End**
PROC	1005	1017	1054

PROCEDURES and CPT Codes:
Washout (R) fem

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*
GA

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*
DL X 1 MAC #3. (+)VC (+)B=BS (+)ETCO2 @ 25 cm lip Atraumatic Grade I view

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*
[redacted] b(6)-4
ICW1

SURGEONS: [redacted]

ANESTHETISTS: [redacted] b(6)-2

PROCEDURE LOCATION: OR #2-2
DATE: 18 OCT 03
PAGE 1 OF 1

DA FORM 7389, FEB 1998 — 2 - ANESTHESIA PROVIDER — USAPA V1.00

MEDCOM - 19861

ACLU-RDI 1654 p.21

DOD-033435

PROPOSED PROCEDURE: [illegible] [illegible] feet
SURGICAL SERVICE: [illegible]
NPO SINCE: midnight 19 Sept 03

Physical State 1 (2) 3 4 5 E
: 87 (KG)/LB HT: 68 IN.
ALLERGIES: NKDA

HABITS:
TOBACCO: (+)
ETOH: (-)
DRUGS: —

CURRENT MEDICATIONS:
() = ordered as premed
() N/A
()
()
()
()
()

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

LABORATORY STUDIES:
HB/HCT: ______/______
U/A:
OTHER:
19 Sept 03
136 | 104 | 18 / 104
4.4 | 24 | 1.8
12
7.0 / 36.5 \ 402

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)	(R) femur fx
	N Y	bullets to feet
Familial HX	N Y	

ASSESSMENT
PAST SURGICAL/ANESTHETIC
finger surgery - Gaines compl.
∅ fx hx GETA compl.

PHYSICAL EXAMINATION
BP 144/84 HR 72 R ___ T ___
Pain Scale 0-10
HEENT - Teeth: Poor dentition
Trachea: midline
TMJ/Neck: FROM
Oropharynx: C13, 3 fb TM
Nares:
CHEST: BBS+ / coarse
CARDIAC: S1S2 ∅ e
EXTREMITIES: OK ∅ (R) LE
IV Access: # 18 A/C (R)
Ulnar Filling: OK
BACK: OK
OTHER:

NPO Since MN 19 Sept 03

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. Via Translator

The patient/legal guardian [redacted]es. Questions answered.
Signed: [redacted] Date: 20 Sept 03 Time: 0930 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
2F-ICW1

WAMC Form 2300 (Revised) 15 Mar 01 MCXC-DOS

ANESTHESIA RECORD

Previous edition is obsolete
*U.S. GPO: 2001-629-183/40002

MEDCOM - 19862

ICW1

NSN 7540-01-165-7294

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

519-301

EXAMINATION(S) REQUESTED

Duplex (R) LE

+

PA & LAT CXR

AGE | SEX | SSN (Sponsor) [redacted] b(6)-4 | WARD/CLINIC ICW-1 | REGISTER NO.

FILM NO.

REQUESTED [redacted] b(6)-3 | PREGNANT ☐ YES ☐ NO

SIGN [redacted] | TELEPHONE/PAGE NO.

DATE REQUESTED 20 OCT 03

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

Chest pain

(R) Fem Fx; R/o DVT & Chest Pain

Thanks!

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

RADIOLOGIC REPORT

N/o evidence of DVT.

[redacted] b(6)-2

[redacted] b(2)-2

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

[redacted] b(6)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT : — MEDICAL RECORD

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

MEDCOM - 19863

NSN 7540-01-165-7294

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

519-301

EXAMINATION(S) REQUESTED

R leg

AGE	SEX	SSN	WARD/CLINIC	REGISTER NO.
33	M	[redacted] EPW b(6)-4	EMT	

FILM NO.

REQUESTED BY (Print) [redacted] b(6)-2

SIGNATURE OF REQUESTOR

PREGNANT ☐ YES ☒ NO

TELEPHONE/PAGE NO.

DATE REQUESTED

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

GSW

DATE OF EXAMINATION *(Month, day, year)*

19 Sept 03

DATE OF REPORT *(Month, day, year)*

19 Sept 03

DATE OF TRANSCRIPTION *(Month, day, year)*

RADIOLOGIC REPORT

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

[redacted] EPW

b(6)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT

MEDCOM - 19864

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

CLINICAL RECORD - DOCTO

For use of this form, see AR 40-66; the pro... TSG

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]

noted transcribed 19Sep03 2030 [redacted] TW

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 19 SEP 03 TIME OF ORDER 1950 HOURS

1. ADMIT TO ICW-1
2. DX - (R) [illegible] FX, FOOT BURNS
3. CONDITION - [illegible]
4. VS - ROUTINE
5. BED REST
6. DRESSING CHANGE AND PRN
   CARE Q DAY
7. IV - LR AT 125 cc/hr. ~~HEP LOCK~~
8. NPO AFTER MIDNIGHT.
9. TO OR TOMORROW
10. TYLENOL 650 mg P.O. Q 4 hrs PRN
11. MSO4 2-8 mg IVP Q 2 hrs PRN
12. [illegible] 25 mg IV or P.O. Q 6 hrs PRN

PATIENT IDENTIFICATION

24 CRAAV 19Sep03 @2100 [redacted] VT/AN

b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 20 SEP 03 TIME OF ORDER b(6)-2 [redacted]

1. RESUME PREVIOUS ORDERS
2. REGULAR DIET
3. IV - LR AT 125 cc/hr, HEP LOCK
   WHEN FLUIDS P.O. WELL
4. PERCOCET 1-2 P.O. Q 4 hrs PRN
5. ANCEF 1 Gm IVPB Q 8 hrs
6. [illegible] 500 mg IVPB Q DAY
7. PIN CARE TO X-FIX BID
8. SILVADENE OINTMENT AND DRESSING CHANGES TO (B) FEET BID

b(6)-2

PATIENT IDENTIFICATION

b(6)-2 noted [redacted] 20Sep03 1705

NURSING UNIT | ROOM NO. | BED NO.

24° 20Sep03 @ 2045 [redacted]

b(6)-2 [redacted]

MEDCOM - 19865

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(4)-4

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 22 SEP 03 TIME OF ORDER 2030 HOURS

LIST TIME ORDER NOTED AND SIGN

1. RESUME PREVIOUS ORDERS
2. S/P I+D (R) BUTTOCK, FOOT BURN
3. VS - ROUTINE
4. BED REST, ROLL ON SIDE PRN
5. REGULAR DIET
6. N - LR @ 125 cc/hr. KEEP LOCK

PATIENT IDENTIFICATION

b(4)-2 [redacted]

DATE OF ORDER TIME OF ORDER HOURS

7. MAY TAKE P.O. WHEN
8. BID PIN CARE
9. BID DRY DRESSING COVER TO BUTTOCK, DO NOT REMOVE PREVIOUS DRESSINGS TO (R) FOOT.
10. WPO AFTER MIDNIGHT 23 SEP FOR SURGERY 24 SEP

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

[redacted]

b(4)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

NURSING UNIT | ROOM NO. | BED NO.

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

[redacted]

b(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICWF4	2	F

	DATE OF ORDER	TIME OF ORDER		LIST TIME ORDER NOTED AND SIGN
	24 SEPT 03	1540	HOURS	
(1)	RESUME PREVIOUS ORDERS			
(2)	NEBULIZER TO LEFT			
(3)	N- UR AT 125 CC/HR. HEP LOCK WHEN FLUID PIO, WD			
(4)	D/C FOLEY			
(5)	CIPRO PO 500MG NOW THEN 12 HRS			

PATIENT IDENTIFICATION

[redacted]

b(6)-2 Noted 24 SEP 03 1640

DATE OF ORDER	TIME OF ORDER	
		HOURS
(6) continue BID dressing changes to foot and thigh. Do not remove stockings.		
(7) NPO after midnight 25 SEP 03 FOR OR 26 SEP 03		

NURSING UNIT	ROOM NO.	BED NO.
24 [illegible]	2345	24 Sep

[redacted]

PATIENT IDENTIFICATION

[redacted]

b(6)-4

DATE OF ORDER	TIME OF ORDER	
10-5-03	1245	HOURS
XR - AP+LAT (L) TIBIA		

[redacted] b(6)-2

[redacted] b(6)-2

Marked 24 Sept 03 1250 hrs

NURSING UNIT	ROOM NO.
ICW1	[illegible]

[redacted] b(6)-2

PATIENT IDENTIFICATION

[redacted]

500 @ 2100

DATE OF ORDER	TIME OF ORDER	
		HOURS

NURSING UNIT	ROOM NO.	BED NO.

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

b(6)-4

[redacted]

b(6)-2 Noted [redacted]

26SEP03 1045

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 26 SEPT 03 TIME OF ORDER 1005 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Resume previous orders
2. Regular diet
3. IV LR at 125 cc/hr. [illegible] [illegible] [illegible] PO well
4. Gentamicin 400 mg IVPB Q 24
5. Ciprofloxacin 400 mg IVPB Q 12 hrs
6. PIN care BID.

[redacted]

b(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

NURSING UNIT 1CW | ROOM NO. 24 27sep03 @1320 | BED NO.

[redacted]

PATIENT IDENTIFICATION

EPW # [redacted] b(6)-4

DATE OF ORDER 5 OCT 03 TIME OF ORDER 1544 HOURS

1. NPO after midnight for surgery 6 OCT 03

[redacted] 5 OCT 03 1600

NURSING UNIT 1CW | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

[redacted] b(6)-4

b(6)-2 Noted [redacted]

DATE OF ORDER 6 OCT 03 TIME OF ORDER 2245 HOURS

b(6)-2

1. Resume previous orders
2. Regular diet
3. IV LR at 125 cc/hr. [illegible] [illegible] [illegible] PO well
4. PIN care BID
5. May D/C [illegible] to [illegible]
6. AP + LAT (R) FEMUR [redacted]

NURSING UNIT 1CW#1 | ROOM NO. 2 1605 | BED NO. F

b(6)-2

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

[illegible] 0002 hrs

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]

b(6)-2 Noted [redacted] 1800

DATE OF ORDER: 8 Oct 03 TIME OF ORDER: 1600 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Motrin 800 mg TID

[redacted]

NURSING UNIT: ICW#1 ROOM NO. 2 BED NO. F

b(6)-2

24 V [redacted] ... 8 Oct 03 1910

PATIENT IDENTIFICATION

b(6)-4

[redacted]

#

Noted b(6)-2 [redacted]

DATE OF ORDER: 17 Oct 03 TIME OF ORDER: 1600 HOURS

1. NPO after midnight
2. To OR tomorrow
3. CBG midnight & [redacted] A.M.

[redacted]

b(6)-2

NURSING UNIT: ICW#1 BED NO. [redacted]

17 Oct @ 2030

PATIENT IDENTIFICATION

b(6)-4

#

[redacted]

DATE OF ORDER TIME OF ORDER HOURS

NURSING UNIT ROOM NO. BED NO.

PATIENT IDENTIFICATION

b(6)-4

#

[redacted]

DATE OF ORDER TIME OF ORDER HOURS

NURSING UNIT ROOM NO. BED NO.

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

MEDCOM - 19869

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b(6)-4

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 18 OCT 03 TIME OF ORDER 1100 HOURS | LIST TIME ORDER NOTED AND SIGN

(1) Resume previous orders
(2) Empty & record drain q shift
(3) VS - routine
(4) Regular diet
(5) IV - LR at 125 cc/hr. Hep lock when taking P.O. well
(6) Pin care BID. Do not change bandage.

PATIENT IDENTIFICATION

b(6)-2 Noted [illegible]

[redacted]

18 OCT 03 1100

[redacted]

NURSING UNIT ROOM NO

24 ✓

b(6)-2

[redacted]

b(6)-2

19 OCT @ 0200

PATIENT IDENTIFICATION

240 ✓

DATE OF ORDER 20 Oct @ 0200 TIME OF ORDER HOURS

20 OCT 2003 1322

* PA/LAT CXR
* Hct [illegible]
- Duplex (R) LE - R/O DVT.
- O2 to keep sats >92% - ✓ O2 sat Room air first [redacted]
[illegible]
- Troponin I [redacted]
- EKG
[illegible]
- Lovenox 30 mg SQ BID

b(6)-2

[redacted]

b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER HOURS

NURSING UNIT | ROOM NO. | BED NO.

ICW1 | 240 ✓ 20 Oct 03 @ 2330 |

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

MEDCOM - 19870

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	↓	DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
b(6)-4 Noted 29 Oct 03 [redacted] b(6)-2		29 Oct 03 2045 HOURS	
	①	DISCHARGE 30 OCT 03	
		TO EPW CAMP.	
	②	LEVOFLOXACIN 250 mg PO Q day #30	
	③	F/U 1 month [redacted]	
NURSING UNIT / ROOM NO. / BED NO.	④	D/C IV & DRSG [redacted]	b(6)-2

PATIENT IDENTIFICATION	↓	DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
		______ HOURS	
NURSING UNIT / ROOM NO. / BED NO.			

PATIENT IDENTIFICATION	↓	DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
		______ HOURS	
NURSING UNIT / ROOM NO. / BED NO.			

PATIENT IDENTIFICATION	↓	DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
		______ HOURS	
NURSING UNIT / ROOM NO. / BED NO.			

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

MEDCOM - 19871

.EDICAL RECORD - DOCTOR'S ORDE.

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. to Keep Sat ↑ 95%		
3	Morphine / ~~Meperidine~~ 2 mg IV now and ____ mg q 3-5 min prn pain for a		
	max dose of 10 mg.		
~~4~~	~~Zofran ____ mg IV prn N/V q 15 min, may repeat x ____.~~		
5	Metoclopramide 10 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 order or TKO if not written.		
10	Discharge from recovery status when PACU discharge criteria met. [redacted] MAJ CRNA b(6)-2		

PATIENT IDENTIFICATION

[redacted] b(6)-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, [redacted] b(6)(2)			1 of 1

MEDCOM FORM 688-R (TEST) (MCHO) MAR 99 PREVIOUS EDITIONS ARE OBSOLETE MC V1.00

MEDICAL RECORD - DOCTOR'S ORDERS

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 ____mg IV now and ____mg q 3-5 min prn pain for a		
	max dose of ____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.		
	[redacted] MD, CRNA		
	b(6)-2		

PATIENT IDENTIFICATION

[redacted]

b(6)-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 [redacted]			1 of 1

MEDCOM FORM 688-R (TEST) (MCHO) MAR 99 PREVIOUS EDITIONS ARE OBSOLETE

MC V1.00

(b)(2)-2

MEDICAL RECORD - DOCTOR'S ORDERS

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 5 mg IV now and 3 mg q 3-5 min prn pain for a max dose of 20 mg.		
4	Zofran____mg IV prn N/V q 15 min, may repeat x ____.		
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.		
10	Discharge from recovery status when PACU discharge criteria met.		
	[redacted] CRNA, CNT b(6)-2		

PATIENT IDENTIFICATION

[redacted] b(6)-4

Complete the following information on page 1 only. Note any changes on subsequent pages.

Diagnosis: _____

Ht: _____ Weight: _____ Diet: _____

Allergies: _____

Nursing Unit	Room No.	Bed No.	Page No.
PACU, [redacted] b(6)-2			1 of 1

MEDCOM FORM 688-R (TEST) (MCHO) MAR 99 PREVIOUS EDITIONS ARE OBSOLETE MC V1.00

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. 10 Yr. 2003

VERIFY BY INITIALING

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
19 Sep 03	[redacted]	VS. routine	06	[redacted]
19	[redacted]	BR. rail on side frequently	18	
19	[redacted]	regular diet	06	
19	[redacted]	pin care to ex. fix BID (do not change bandage)	18	
19	[redacted]	wet drsg Δ to femur- do not remove packing	18	DIC 18 OCT 03
19 Oct 03	[redacted]	empty and record drain q shift	06 18 06	// [redacted] DIC 21 OCT 03
20 Oct 03	[redacted]	O_2 to keep Sats > 92% $\sqrt{O_2}$ Sats Start = RA	6 18	[redacted] PRN ORDER

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
@ FEMUR FX / FOOT BURNS
S/P I/D @ FEMUR

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 MEDCOM - 19875 USED. USAPA V1.00

b(6)-2 A11

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 10 Yr 2003	
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials	
17 Oct	[redacted]	NPO p MN	18 Oct	0600 noted			
17 Oct	[redacted]	TO OR TOMORROW	18				
17 Oct	[redacted]	CBC, MET 8 in AM	18	0500			
18 Oct 03	[redacted]	Resume previous orders	18 Oct 03				
20 Oct	[redacted]	PA & LAT CXR	20 Oct 03				
30 Oct	[redacted]	Duplex RLE R/O DVT	30 Oct 03	1500			
30 Oct	[redacted]	Troponin I	30 Oct 03	1800			
30 Oct	[redacted]	EKG	30 Oct 03				
29 Oct	[redacted]	D/C to EPW Camp + Rx	30 Oct				

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED
20 Oct 03	[redacted]	O2 to keep sats >92%. VO2 sats on RA to start	

USAPA V1.00

D(w)-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. 10 Yr. 2003

VERIFY BY INITIALING

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED (3 4 5 6 7 8 9 10 11 12 13 14 15)
19	[redacted]	VS-routine	6	[redacted]
			18	
19	[redacted]	BR-roll on side frequently	6	
			18	
19	[redacted]	Regular Diet	6	
			18	
19	[redacted]	Pin care to ex-fix BID	10	
			22	
19	[redacted]	Silvadene cream dsg AS to BIL/ext BID	10	
			22	DIC 00CCT03
			X	
19	[redacted]	Dry dsg Δ to femur DO NOT REMOVE packing	10	[redacted]
			22	
			X	

ALLERGIES: ☐ YES ☑ NO
NKDA

PRIMARY DIAGNOSIS:
(R) femur fx / foot burns
S/P I+D (R) femur

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

PATIENT IDENTIFICATION:
[redacted]

b(w)-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 - 19877

blue-2

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)			Mo 10 Yr 2003	
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
06 OCT03	[redacted]	Resume previous orders	06 OCT03	—		
06		AP/LAT R ~~Hum~~ FAS femur in am	07	—	0505	
17 OCT03		NPO p MN	18 OCT03	0001	note	
17		To OR tomorrow	18			
17		CBC, Metlyte 8 in am	18	0500		

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

USAPA V1.00

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 ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 30
19Sep	[redacted]	VS Routine	D	
			N	
19Sep	[redacted]	Reg diet	D	
			N	
		Pin Care PO Ex.	D	
		fix BID (DO	N	
		not change bandage)	X	
29Oct	[redacted]	Act Up Ad Lib	D	
		& crutches	N	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: (R) femur FLD

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 - 19879

b(6)-2

Verity 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
29Jul	[redacted]	D/C to EPW Campe Rx	29Jul			

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

USAPA V1.00

b(6)-2A71

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 30
1 Sept	[redacted]	Hep Lock Flush	D	[redacted]
	-----	@ Shift	N	
20 Sep	[redacted]	Gentamycin 400mg	20	
	-----	IVPB QD	X	
21 Sep	[redacted]	Ciprofloxin 400mg	10	
	-----	IVPB @120	22	
22 Oct	[redacted]	MOTRIN 800mg	08	[redacted]
	-----	TID	16	
	-----		24	
22 Oct	[redacted]	Lovenox 30mg	10	
	-----	BID SQ	22	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: (R) Femur 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 1 FEB 79 4678

EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

MEDCOM - 19881

b(4)-2 A11

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
29 [redacted]	D/C to IV @ D/C to SPW Camp	30 Oct			

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
17 Sept	[redacted]	Tylenol 650 mg PO Q4° PRN	
20 Sept	[redacted]	Percocet 1-2 PO Q4-6 hrs PRN	

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

to (c) - 2 A/L

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 17	18	19	20	21	22	23	24	25	26	27	28	29	30
19 SEP 03	[redacted]	IV: LR @ 125cc/hr, HEPLOCK	6	[redacted]													
	-----	WHEN TOL. PO WELL	18														
20 SEP 03	[redacted]	GENTAMYCIN 400mg IVPB QD	20														
	-----		X														
24 SEP 03	[redacted]	CIPROFLOXIN 400mg IVPB Q12°	10														
	-----		22														
8 OCT 03	[redacted]	MOTRIN 800mg TID	06														
	-----		16														
	-----		24														
20 OCT 03	[redacted]	Lovenox 30mg BID	10	/													
	-----		22	/													

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS:
Ⓡ FEMUR I&D

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

PATIENT IDENTIFICATION:
[redacted]

DISPENSING TIMES
USE PENCIL. CIRCLE MED TIMES

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

b(6)-4

DA FORM 1 FEB 79 4678 EDITI ... MEDCOM - 19883

b(6)-2 Ar1

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**
28 Oct	[redacted]	D/C IV @ D/C to EPW-camp	30 Oct			

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
19 Sep	[redacted]	Tylenol 650mg PO Q4° PRN	D/T; D/I
19 Sep		MSO4 2-8mg IVP Q2°-4° PRN	D/T 18 OCT 1430, 20 OCT 1400; D/I 5mg, 5; [redacted]
19 Sep		Phenergan 25mg IV/PO Q6° PRN	D/T; D/I
20 Sep		Percocet 1-2 po Q4-6° PRN	D/T 17 OCT 2030, 18 OCT 0300, 18 OCT 1300, 18 OCT 2355, 19 OCT 1035, 19 OCT 1611, 19 OCT 2215, 20 OCT 0900, 20 OCT 1410, 20 OCT 1930, 21 OCT 0730, 21 OCT 1610; D/I 2, 2, II, 2, II, II, II, 2, 2, II, II, II; [redacted]
			D/T 22 OCT 1630 II, 22 OCT 2245, 23 OCT 1030, 24 OCT 0215, 24 OCT 1440, 24 OCT 2210, 25 OCT 1020, 25 OCT 1745, 25 OCT 2300, 26 OCT 1350, 26 OCT 2000, 27 OCT 1155; D/I II, II, II, II, II, II, II, II, 2, 2; [redacted]
			28 OCT 1650 II; [redacted]

*U.S. GPO: 1996-454-110/95216

MEDCOM - 19884

ACLU-RDI 1654 p.44

DOD-033458

b(6)-2 A11

CLINICAL RECORD

EUTIC DOCUMENTATION CARE PLA... EDICATIONS)

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 3 4 5 6 07 8 9 10 11 12 13 14 15 16
19Sep	[redacted]	IV: LR @ 125cc/hr	6	[redacted]
		HL when tol po x 1	12	
20Sep	[redacted]	Gentamycin 480mg IVPB QD	24	
			X	
24Sep	[redacted]	Ciprofloxacin 400mg IVPB Q12°	10	[redacted]
			22	
08 Oct 03	[redacted]	Motrin 800mg TID	08	
			16	
			24	

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS:

(R) femur I+D | BIL foot burns

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 - 19885

b(6)-2A71

Verify by Initialing	THER. [illegible]IC 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
06 OCT03	[redacted]	ay Dic Silvadene to feet	06 OCT03	—		[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
19 Sep	[redacted]	Tylenol #3 50mg po Q4° prn	D/T; D/I
19 Sep	[redacted]	MSO4 2-8mg IVP q2-4° prn	D/T 3 Oct 2355 8mg; D/I [redacted]
19 Sep	[redacted]	Phenergan 25mg IV/PO q6° prn	D/T; D/I
20	[redacted]	Percocet 1-2 po Q4-6° prn	D/T 3 Oct 0200 / 3 Oct 1100 / 3 Oct 1235 / 3 Oct 1340 / 4 Oct 1740 / 5 Oct 1100 / 5 Oct 1835 / 6 Oct 1000 / 6 Oct 1745 / 7 Oct 0510 / 7 Oct 1106; D/I [redacted]
			D/T 8 Oct 1840 / 9 Oct 2250 / 8 Oct 03 2000 / 9 Oct 1330 / 10 Oct 0835 / 10 Oct 1555 / 10 Oct 1934 / 11 Oct 0013 / 11 Oct 0835 / 11 Oct 1700 / 11 Oct 03 2115; D/I [redacted]
			D/T 12 Oct 0400 / 12 Oct 03 2100 / 13 Oct 0806 / 13 Oct 2200 / 14 Oct 0900 / 14 Oct 1905 / 15 Oct 2300 / 16 Oct 0946 / 16 Oct 1458 / 16 Oct 2317; D/I [redacted]
			D/T 17 Oct 0950 / 17 Oct 1515; D/I [redacted]

USAPA V1.00

MEDCOM - 19886

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: 9/20
Time In: 1635
Allergies: NKDA
Pre-op V/S: 144/84 92
Procedures: Washout

Anesthesia Type (Circle)): (General) Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 450 Colloid
OR Output: UOP — EBL 25cc
Meds/Times: 5cc Fent @

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

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds

History

Time	1638	1643	1648	1703
SaO2	94	95	97	94
FiO2				
Methods	RA	RA	LX	RA
240				
220				
200				
180				
160				
140	V	V	V	V
120				
100	°			
	^	°	^	°
80			°	
		^		^
60				
40				
20				
RR	20	16	16	20
T	99			

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	Codes
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	1	1	1	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
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	1	1	1	
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	9	9	9	

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

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

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	L Ext	Limited	+	UA	B	W	PK
15'	L Ext	Limited	+	UA	B	W	PK
30'	L Ext	"	+	UA	B	W	PK
45'							
60'							
90'							
D/C	L Ext	"	+	UA	B	W	PK

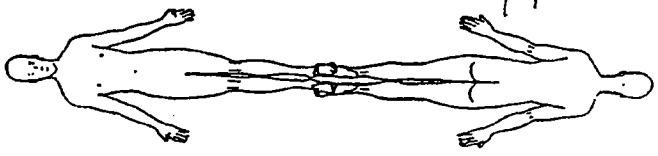
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic, P = Pale, Pk = Pink
Capillary Refill: B = Brisk, S = Sluggish

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm 1638	L Ext	Ace band.	c/d/i
30' 1638	L Ext	" "	c/d/i
60'			
D/C 1708	L Ext	Ace band.	c/d/i



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1638	NSR	∅	∅

WAMC OP 173-E

NURSING NOTES

Received pt from OR. Pt sats 94% RA. VSS. Pt awake, moving around. Had washout of R leg and debridement of left. Pt able to wiggle toes. Report given to Spc [redacted]. Pt VSS No c/o pain sats 95% [redacted] b(6)-2 /LPN

Discharge Criteria:

Date: **Time:** **PARS:**

BP: 147/72 **T:** 96.9 **HR:** 99 **RR:** 16 **Sa02:** 95

Pain Level at D/C (0-10): 0

Intake: 0 **Output:** 0

Additional Data: NONE

Transferred To: ICU

Report Given To: Spc [redacted]

Transferred Via: W/C Litter Gurney Ambulance

Transferred By: Spc [redacted] b(6)-2

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: 22 Sep 13
Time In: 2042
Allergies:
Pre-op V/S: 114/66 135
Procedures: I&D
Anesthesia Type (Circle)): General Spinal Epidural MAC IV Sedation Nerve Block
OR Intake: Crystalloid 400 Colloid
OR Output: UOP EBL
Meds/Times: fentanyl, propofol, lidocaine

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

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds

History

Time	2040	2045	2050	2055	2100	2105
SaO2	96%	97		97	97	95
FiO2	RA	2L		2L		
Methods		NC		NC	RA	
240						
220						
200						
180						
160						
140	W					
120		-	V			
100				V		
80	•	•	•	•	•	
60	^	^	^	^		
40						
20						
RR	20	19	19	18	21	
T	98.1					
Time						
Pain (0-10)						
LOS						

Pacu Intake

Time	Solution	Amount	Site	By	Infused
2115	NS		(2) AC		100cc

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

PREPARED BY [redacted] b(6)-4

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 22 Sep 13

(Continue on reverse)

PATIENT'S IDENTIFICATION (For typed or written entries, enter last name, first, middle; grade; date; hospital or medical facility)

Name - last,

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

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	(R)leg	+	+	P	B	C	P
15'	(R)leg	+	+	D	B	C	PK
30'	(R)leg	+	+	D	B	C	PK
45'							
60'							
90'							
D/C	(R)leg	+	+	P	B	C	PK

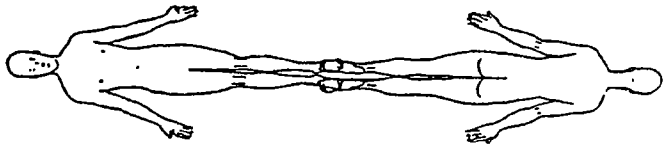
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(L)ankle	Ace wrap	0
~~30'~~	(R)femur	Ace wrap	0
~~60'~~	(R)ankle	Ace wrap	0
D/C			0



PACU OUTPUT

Time	Source	Color/Appearance	Amount
2045	URINE	Amber	580

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
2105	NSR	NO	NO

WAMC OP 173-E

NURSING NOTES

2042 Recd pt from OR via litter. pt Maintaing own Airway pt Awake, able to follow Commands & Infusing into (L) AC. VSS. [redacted] RN

2115 Report given to [redacted] pt transported via litter in Stable Cond. VSS. SGT [redacted]

D/W - 2 ANL

Discharge Criteria:
Date: 9.22.03 Time: 2115 PARS: 10
BP: 132/75 T: 98.2 HR: 93 RR: 22 Sa02: 98% RA
Pain Level at D/C (0-10): —
Intake: 100cc Output: 580cc
Additional Data:
Transferred To: ICU
Report Given To: SGT [redacted]
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: SGT [redacted]
Cleared IAW Recovery [redacted]
Charge Nurse Signature: [redacted] RN/ASW

[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: 24 Sep 03
Time In: 1545
Allergies: NKDA
Pre-op V/S: 116/64 84
Procedures: I+D @ Groin site

Anesthesia Type (Circle)) General Spinal Epidural
IV Sedation Nerve Block
OR Intake: Crystalloid 600 cc Colloid
OR Output: UOP ~~nnn~~ 0 EBL min
Meds/Times: versed 5mg & Fent 250 mcg

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

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds

History

Time	1545	1550	1555	1600	1615	1730
SaO2	94	98	94	94	96	96
FiO2	RA	4L	4L	4L	2L	RA
Methods		NC	NC	NC	NC	
240						
220						
200						
180						
160						
140	^					
	v	v	v	v	v	v
120	•					
		•	•	•	•	
100						•
80						
	v	^	^	^	^	^
60						
40						
20						
RR	21	13	15	26	22	17
T	98				98	99

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	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	/		
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

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

(Continue on reverse)

[redacted] SUPLOPN blw-2

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 24 Sep 03

PATIENT [redacted] or written entries give: first, middle; grade; date, [redacted] medical facility)

Name – last,

EAW [redacted] blw-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

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	R leg	limited	+	P	B	W	PK
15'							
30'							
45'							
60'							
90'							
D/C							

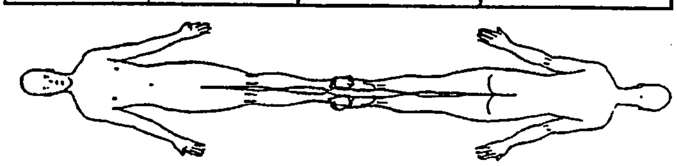
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent Color: C = Cyanotic, Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	R leg	Kerlex	C/D/I
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1550	NSR	Ø	Ø

WAMC OP 173-E

NURSING NOTES

Received pt from OR. VSS O2 sats 95% 4LNC. No c/o pain. S/P I/P of R Femur. Able to move all extremities (-injured leg). IV @ Arm LR @ TKO. No S/S infiltration.
1630 - Pt O2 DC'd Sa02 @ 93% c no s/s Respiratory [illegible] [redacted] SG/CPx

ICW - 2 AN

Discharge Criteria:
Date: 25Sep03 **Time:** 1636 **PARS:** 10
BP: 124/75 **T:** 99.2 **HR:** 106 **RR:** 17 **Sa02:** 94%
Pain Level at D/C (0-10):
Intake: 200cc LR **Output:**
Additional Data:
Transferred To: ICW
Report Given To: 1LT [redacted]
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: SSG [redacted]
Cleared IAW Recovery Ro[redacted]**B-3**
Charge Nurse Signature:

MEDCOM - 19892

ACLU-RDI 1654 p.52

DOD-033466

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**

DTSG APPROVED (Date)

Date: 26 Sep 03
Time In: 1016
Allergies: NKDA
Pre-op V/S: 144/57/96
Procedures: I&D Perirectal Abscess Dressing to Feet

Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 400 Colloid 0
OR Output: UOP 0 EBL 0
Meds/Times: 250 Fent.

Anabotic yes

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds

History

Time	1010	1015	1020	1040	1055
SaO2	95%	96%	96%	98%	98%
FiO2					
Methods	RA	RA	RA	RA	RA
240					
220					
200					
180					
160					
140	V	V	V	V	V
120					
100					
80					
60					
40					
20					
RR	20	15	16	14	18	20
T	97.5			98.0		97.6

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1055	LR	650	[redacted]	[redacted]	50 cc

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	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	0	0	0
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

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

(Continue on reverse)

[redacted] (Name & Title) blw-2

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 26 Sep 03

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

[redacted]

blw-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	(R) (L) Foot	LROM		P	B	W	PK
15'							
30'							
45'	(R) (L) Foot	LROM		P	B	W	PK
60'							
90'							
D/C	(R) (L) Foot	LROM		P	B	W	PK

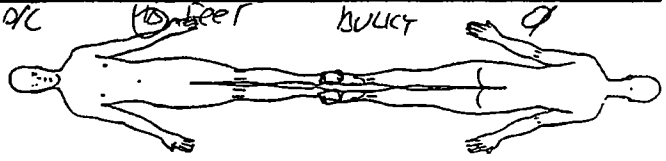
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(R) Thigh	Bulky ACE	0
~~30'~~ Adm	(R) Feet	Bulky	0
60'			
D/C	(R) Thigh	Bulky	0
D/C	(R) Feet	Bulky	0



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1055	NSR	0	0

WAMC OP 173-E

NURSING NOTES

Pt admitted to PACU @ 1010. SP I&D (R) Thigh & dressing change to both feet. PAD 9. SATS 96% on RA — pte [redacted] PT transferred to [redacted] by PF [redacted] via Litter. Report given to LT [redacted] pfc [redacted]

blw-2

Discharge Criteria:
Date: 26SEP05 Time: 1055 PARS: 10
BP: 136/91 T: ~~98~~ 97.6 HR: 81 RR: 23 Sa02: 97
Pain Level at D/C (0-10):
Intake: 50cc LR Output: 0
Additional Data: 0
Transferred To: ICU
Report Given To: LT [redacted]
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: PFC [redacted] blw-2
Cleared IAW Recover [redacted]
Charge Nurse Signatu [redacted]

NKDA.

33 y/o M.

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	OTSG APPROVED *(Date)*
Post-Anesthesia Care Unit (PACU) Flow Sheet	

Date: 10-6-03.
Time In: 1456
Allergies: NKDA.
Pre-op V/S: 137/71 68
Procedures: 2/0 (R) femur ... AB ... placed open ...

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 700 Colloid ~~700~~
OR Output: UOP ∅ EBL minimal
Meds/Times:

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

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds — History

Time	1456	1500	1515	1530	1545
SaO2	96	95	94	95	95
FIO2	RA	RA	RA	RA	RA
Methods					
240					
220					
200					
180					
160					
140					
120					
100					
80					
60					
40					
20					
RR	12	12	10	12	10
T	98		97	95	97
Time					
Pain (0-10)					
LOS					

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1500	LR	400	(R) FA	[redacted]	

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	2		
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, 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: [redacted] b(6)-4

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 10-6-03

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

MEDCOM - 19895

MEDICATIONS

Allergies:

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

NURSING NOTES

Assumed pt care from MAJ Cannady
A/I VSS, afebrile and in no apparent
distress @ [redacted]
N arousable by voice, appropriate [illegible]
3mm sluggish.
CV NSR S edema S₁S₂ +2 radial pulse
+2 pedal pulses extrem warm to touch
Resp even unlabored CT Δ (B) [illegible]
SpO2 96-97% on RA nasal trumpet
removed upon arrival to PACU
GI hypo BS Soft ~~[illegible]~~ nontender slightly
distended. ØN/V/D.
GU Ø U/O ¢ foley.
Lines (R) FA PIV patent

Markus Salou

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	Bilat feet	full	[illegible]	P	<3 sec	warm	appr
15'	"	"	"	"	"	"	"
30'							
45'							
60'							
90'							
D/C	Bilat feet	full	[illegible]	P	<3 sec	warm	appr

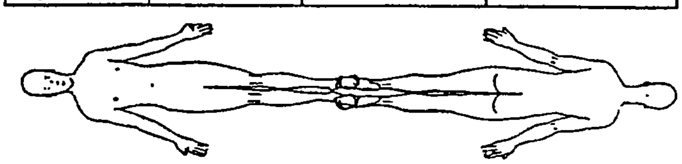
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic, P = Pale, Pk = Pink
Capillary Refill: B = Brisk, S = Sluggish

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	Bilat feet	Kerlix	Ø
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

Discharge Criteria:
Date: 10-6-03 **Time:** **PARS:** 10
BP: 124/61 **T:** **HR:** 82 **RR:** 26 **Sa02:** 98%
Pain Level at D/C (0-10):
Intake: Ø **Output:** Ø
Additional Data: Ø
Transferred To: ICW #1
Report Given To:
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: KT [redacted]
Cleared IAW Recovery [redacted]
Charge Nurse Signatur[redacted]

b(6)-2

WAMC OP 173-E

MEDCOM - 19896

ACLU-RDI 1654 p.56

DOD-033470

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: 18Oct03 Anesthesia Type (Circle)) General Spinal Epidural
Time In: 1105 IV Sedation Nerve Block
Allergies: NKDA OR Intake: Crystalloid 800 Colloid
Pre-op V/S: 104/64 OR Output: UOP 0 EBL min
Procedures: L09S Meds/Times:

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

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds History

Time	1105	1110	1115	1120	1125
SaO2	98	100	100	100	100
FiO2	RA	RA	RA	RA	RA
Methods					
240					
220					
200					
180					
160					
140					
120					
100					
80					
60					
40					
20					
RR	13	9	18	20	20
T	98				

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1105	UR	50	LArm	[redacted]	

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

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

(Continue on reverse)

PREPARER [redacted] b(6)-2 DEPARTMENT/SERVICE/CLINIC PACU DATE 18Oct03

PATIENT'S IDENTIFICATION (For th... entries give: first, middle; grade; date; hospital or m... ty) Name – last, [redacted] b(6)-1

- ☐ 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
1120	Adm	5mg MSO4				

NURSING NOTES

male iraqi Admitted to PACU/Preop for Femur fx closure. PSD, 99% RA VSS. IV @ Arm LR @ 75cc/hr. Dressing CDI

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm							
15'							
30'							
45'							
60'							
90'							
D/C							

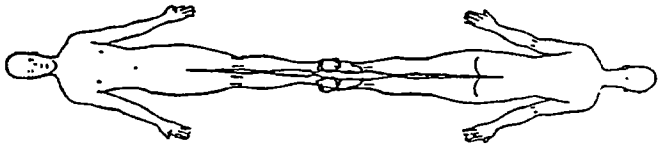
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm			
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:** Ø
Additional Data: _____
Transferred To: ICU 1
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

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. [illegible] LOCATION (State or Country Code.)	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
A110 1	IZ			M

3. REGISTER NUMBER	6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
		33y	Z	9	UNK

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
	NA	99	[redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
NA	Z	1950	NA b(2)-1

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
N	K78	

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION YEAR / NO
IZ			NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
O	ICU1	UNK

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
[redacted] b(2)-2	UNK	UNK

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
21		031029

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y M M D D)
AEAA		030919

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y M M D D)

FOR LOCAL USE

Dx: (R) FEMUR FX / FOOT BURNS

Dx: 8211D
94502
E899

Px: 7965X3
8622X2

ADMITTING OFFICER (Signature, as required)

Dr [redacted]

SIGNATURE OF ADMITTING CLERK

[redacted]

DA FORM 2005 MAR 90

MEDCOM - 19899

EPW # [redacted]
b(6)-4

PATIENT'S DEPOSIT RECORD
For use of this form, see AR 40-2; the proponent agency is the Office of The Surgeon General.

I have been informed that any funds or valuables in my possession while a patient in this hospital are retained at my own risk and that I may and should deposit same in the patient trust fund.

I do ☐ *do not* ☐ w[redacted]

Witness [redacted]
Patient's

FUNDS & VALU[redacted] *and date)*

b(6)-2

PATIENT'S IDENTIFICATION *(For plate imprint, typewriter or hand)*

FUNDS

DATE	DEPOSITS	WITHDRAWALS	BALANCE
2/8/03	02x250 dinars $20,500 dinero		[redacted]
	b(6)-2 [redacted]		

VALUABLES

NUMBER	DESCRIPTION OF VALUABLES	DEPOSITS DATE	DEPOSITS SIGNATURE (Custodian)	WITHDRAWALS DATE	WITHDRAWALS SIGNATURE (Patient or intermediate individual)
	b(6)-2 [redacted]				

DA FORM 3696, DEC 77 REPLACES EDITION OF 1 AUG 76, WHICH MAY BE USED. USAPPC V1.00

I LT [redacted] b(a)-2 was dispatched by Mustang base [redacted] (b)(2)-2 Company to Iraqi Police Station Rabia near Aco 2-3FA. Once the- ach Contact with the Iraqi Police and LT [redacted] b(a)-2 When we entered the Detain- ell to pick up Detainee # [redacted] b(a)-4 Named [redacted] b(a)-2 He was placed on a litter nd taken to [redacted] (b)(2)-2. His crim is ctions against Coalition Forces and is a own Gang member, Do not release to y non MP/IP personnel or on own recogniz.

[redacted] b(a)-2
LT.
[redacted] (b)(2)-2

COALITION PROVISIONAL AUTHORITY FORCES APPREHENSION FORM

YELLOW FIELDS MUST BE FILLED IN, IF APPLICABLE, UPON APPREHENSION

Offense against Civilian(s) [check one] If "Other" then describe:

- [ ] Arson (I.P.C. 342)
- [ ] Solicitation of Fornication/Prostitution (I.P.C. 399)
- [ ] Rape/Indecent/Sexual Assaults/Acts (I.P.C. 393-98, 402)
- [ ] Murder (I.P.C. 405)
- [ ] Aggravated Assault/Assault With Intent To Kill (I.P.C. 410)
- [ ] Maiming (I.P.C. 412)
- [ ] Simple Assault (I.P.C. 415)
- [ ] Kidnapping (I.P.C. 421)
- [ ] Burglary or Housebreaking (I.P.C. 428)
- [ ] Extortion/Communicating Threats (I.P.C. 430)
- [ ] Theft (I.P.C. 439)
- [ ] Destruction of Property (I.P.C. 477)
- [ ] Obstructing a Public Highway/Place (I.P.C. 487)
- [ ] Discharging Firearm/ Explosive in City/Town/Village (I.P.C. 495)
- [ ] Riot or Breach of Peace (I.P.C. 495(3))
- [ ] Other

Offense against Coalition Forces [check one] If "Other" then describe: Iraqi gang member

- [ ] Violation of Curfew
- [ ] Illegal Possession of Weapon
- [x] Assault/Attack on Coalition Forces
- [ ] Theft of Coalition Force Property
- [ ] Trespass on Military Installation or Facility
- [ ] Photographing/Surveilling Military Installation or Facility
- [ ] Obstructing Performance of Military Mission
- [x] Other

b(6)-2

Apprehending Unit: [redacted]		Location Grid:	
Date of Incident: (D/M/Y) 19/09/08	Time of Incident: hrs to hrs	Date of Report: (D/M/Y) / /	Time of Report: hrs

Detainee #:		Key Connected Person: [ ] Victim [ ] Witness	
Last Name: [redacted]		Last Name:	
First Name: [redacted]		First Name:	Given Name:
Hair Color: Black	Scars/Tattoos/Deformities: b(6)-4	Hair Color:	Scars/Tattoos/Deformities:
Eye-Color: Br.	Weight: lb Height: in	Eye-Color:	Weight: lb Height: in
Address:		Address:	
Place of Birth:		Place of Birth:	
Ethn/Tribe/ Sect:	Sex: [x] M [ ] F; Phone#: DOB D/M/Y: [ ] Mobile [ ] Regular	Ethn/Tribe/ Sect:	Sex: [ ] M [ ] F; Phone#: DOB D/M/Y: [ ] Mobile [ ] Regular
[ ] Passport [ ] Dr. license [ ] Other (specify) Document #:		[ ] Passport [ ] Dr. license [ ] Other (specify) Document #:	

Total Number of Persons Involved: (list names/identifying info on reverse under "Additional Helpful Information")

[ ] Vehicle Information — Vehicle Number: of Vehicle(s) — Owner:

Make:	Color:	VIN:	
Model:	Type:	Plate No:	Number of People in Vehicle:
Year:	Names of People in Vehicle:		
Contraband/Weapons in Vehicle:			

[ ] Property/Contraband [ ] Weapon — Photo Taken of Suspect with Weapon/Contraband: Yes/ No

Type:	Model:		Color/Caliber:
Serial No.:	Quantity:	Make:	Receipt Provided to Owner: Yes/ No
Other Details:	Where Found:		Owner:

Name of Assisting Interpreter: b(6)-2 — Email, Phone, or Contact Info.

[redacted]

Signature: — Supervising Officer's Name (Print): Last, First MI

Email: — Signature:

Unit Phone: — Date: / / — Email: — Unit Phone: — Date: / /

COALITION PROVISIONAL AUTHORITY FORCES APPREHENSION FORM

Why was this person detained? committed crime against coalition forces

Who witnessed [redacted] ion? Give names, contact numbers, addresses. b(6)-2

[redacted]

(b)(2)-2

How was this person traveling (car, bus, on foot)?

Who was with this person?

What weapons was this person carrying?

What contraband was this person carrying?

What other weapons were seized?

What other information did you get from this person?

Additional Helpful Information:

MEDCOM - 19903

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)			3. GRADE	ADMISSION REMARKS
[redacted]	EPW [redacted] b(6)-4			N/A	
4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	37y	Z	unk	N/A	N/A	NO
11. FMP	12. SSN		13. ORGANIZATION			14. WARD
99	[redacted]		N/A			ICU
15. FLYING STATUS	16. RATING/ OSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP		20. TYPE CASE
N/A		K78	N/A			WIA
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION			22. HOURS OF ADMISSION	23. CLINIC SERVICE		
Direct from ER			2150	ABAA		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE		25. TYPE DISPOSITION	26. DATE OF DISPOSITION			
—		50	30 Sep 03			
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)		27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION		ADMITTING OFFICER	
—		—	19 Sep 03			
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY			30. DATE OF INTIAL ADMISSION		32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED	
[redacted] b(2)-2						

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

GSW Abd

863.50
864.02
868.03
518.0

45.73
54.4
45.94
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
Ø	Ø	Ø	Ø	12	12

36. Total Days All Facilites b(6)-2

a. ABSENT SICK DAYS	b. [redacted]	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
Ø		Ø	Ø	12	12

SIGNATURE [redacted]

SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER [redacted] b(6)-2

DA FORM 26 MEDCOM - 19904 USAPPC V2.00

ACLU-RDI 1654 p.64

DOD-033478

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

37 yo I Male shot x 3 in abd under-went Rhemi at FST. Liver lac (Minor) noted. Here for P op care.

PMH ⊖ PSH ⊖ as above

medi ⊖

PHYSICAL EXAMINATION

HR 101 BP 125/83

T 99.4

Lungs clear

Heart - RR

Abd midline lap + 3 holes ant

Ext ⊖

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

Imp asx to abd s/p Rhemi

Plan - P op care

[redacted] b(6)-2

DATE	IDENTIFICATION NO.	ORGANIZATION
	REGISTER NO.	WARD NO.

entries give Name last, first, hospital or medical facility)

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] / FST Trauma Fl[ ]Sheet

34yo

Name: #[redacted] SSN _____ Unit _____

Blood Type
B+

Date and time of injury: 1600 **Time of Arrival** 1620

MOI: GSW to ABD

HPI:

PMHX:

PSHX:

Meds:

Allergies:

Primary Survey

Airway: (Patent) Mechanically maintained by

Breathing: (Spontaneous) Assisted by O2 15L

Circulation:

Pulse: (Present) Absent CPR

Color: (Normal) Abnormal

Cap refill: (Normal) Delayed

Secondary Survey

Intial Vital Signs: b/p 146/82 pulse 76 Resp 22 Pulse Ox 99 Temp ___

GEN: Alert

HEAD: no trauma Perrla TM clear (B)

NECK: ~~[redacted]~~

HEART: RRR

LUNGS: Clear (B)

CHEST: Normal

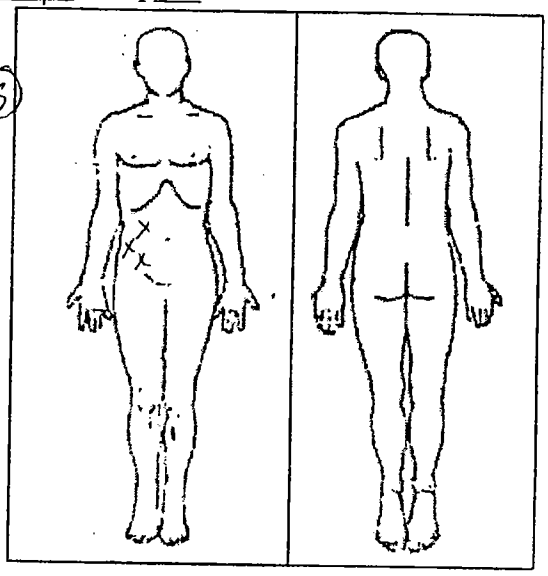
ABD: 3 GSW, NR, (R) lateral, soft, Ø

PELVIS: Bowel sounds normal

EXT: no lesions

RECTAL: Hem - no gross Blood

NEURO: Alert able to move all extermities



GLASCOW COMA		
EYES OPEN	Spontaneously	(4)
	To Speech	3
	To Pain	2
	None	1
BEST VERBAL RESPONSE	Oriented	(5)
	Confused	4
	Inappropriate sounds	3
	Incomprehensible sounds	2
	None	1
BEST MOTOR REPONSE	Obeys Commands	(6)
	Localizes Pain	5
	Withdraws to Pain	4
	Flexes to Pain	3
	Extends to Pain	2
	None	1
	TOTAL	15

Revised Trauma Score		
GLASCOW COMA TOTAL	13-15	(4)
	9-12	3
	6-8	2
	4-5	1
	3	0
SYSTOLIC BLOOD PRESSURE	>89 mmHg	(4)
	76-89 mmHg	3
	50-75 mmHg	2
	01-49 mmHg	1
	No pulse	0
RESPIRATORY RATE	10-29 / min	(4)
	>29 / min	3
	6-9 / min	2
	1-5 / min	1
	None	0
	TOTAL	16

MEDCOM - 19906

Interventions

Airway:

Breathing: O_2 NRB 15mL

Circulation: (2)AC Nor. Saline
(2)AC Sod. Chloride

Other:
NO meds in the field

MEDICATIONS

Time	Drug	Dose	Route	Initials
~~1624~~	~~IV~~	~~1000mL~~	~~LFA~~	[redacted] b(6)-2
~~16~~	~~IV~~		RFA	
1626	Flagyl	500mg	IV	
1626	Cefotetan	2g	IV	

Blood Components

Unit #	Type	Time	Response

Vital Signs

Time	B/P	Pulse	Resp	Pulse Ox	Temp	GCS
1628	128/72	83		99		
	/					
	/					
	/					
	/					
	/					

Transfer Instructions:

NOTES:

Prepared By:

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
19SEP03 20:00	Brief Op Note Pre Op Dx: GSW Abdomen, Minor liver [redacted] Post Op Dx: GSW ō (R) Colon injury Procedure: Ex lap ō (R) Colectomy and 1° anastomosis. Omentectomy Surgeons: [redacted] (b)(6)-2 Anesth: GA/ETA Comp: Ø EBL: 400 UOP: 600 Fluids: 4600 ml Crystalloid 600 Hespan. Findings: Minor liver lac. (R) Colon injury. Omental hematoma To PACU in stable condition b(6)-2 [redacted]
19SEP03 20:00	Transfer Note Pt arrived s/p ō multiple GSW to (R) Abdominal wall. CXR was negative. Pt taken to OR for ex lap. (R) Colectomy c primary anastomosis performed. Medial visceral rotation performed, but no sig retroperitoneal injury. Transferred to [redacted] when awake

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME (LAST, FIRST) | SPONSOR'S ID NUMBER

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY [redacted]

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. b(6)-2

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
0645 20 Sep 03	Assumed care of pt EPW # [redacted] b(6)-4. VSS. Pt resting in bed & eyes closed. Woke pt up to inform him of the DRSG Δ. Δ'D DRSG @ 0615. Will continue to monitor throughout shift. OPC [redacted] b(6)-2 9 Wards
20 Sep 03 0715	Assumed care of pt report given by [redacted] See b(6)-2 Assessment Sheet. NKFDLS. D/C @ 2L NC. Will Cont. to Monitor — [redacted]
1330	ABD DSG (R) Quads Δ'd - old DSG: large amt bloody/brown drainage noted on old DSG. Wounds (3) packed & wet to dry DSG's. Applied 4x4's & Conform & ABD pads. Secure & tape. ABD Midline DSG Δ'd - small amt bloody drainage noted on old DSG. Incision & Staples intact. Oozing small amt bloody drainage & incision. Applied 4x4's & ABD pad Secured & tape. Will Cont. to Monitor — [redacted]
1425	Pt. [redacted] ordered new meds (ordered MD & Tylenol) for pain. Will Cont. to Monitor — [redacted]
1615	T 100.6 A. Tylenol 650 mg PTL given. Will Cont. to Monitor — [redacted]
1630	5 mg MSO4 given per CPT [redacted] for HA. Will Cont. to Monitor. — [redacted]
1700	Pt. resting in bed. Said felt better. — [redacted]

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI | (Rank 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.

EPW # [redacted] b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/1999)
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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
21 Aug	0800 POD 2 GSW (R) colon 1° anast S- ↓ c/o some pain O- T m 100° 132 120/90 93% on nasal O2 ↓ BS (R) UO 50-75/h Hct 45.0 wound clean dry (R) flank - brownish drainage, thin, slightly odor A- stable P- ↑ ODs, wound dressing PRN, labs [redacted] b(6)-2
21-SEP-03 1244	PT refused Tylenol Suppository 650 mg PR, ↑ 10.5, will monitor PT using I.S. but can only elevate 1 ball to [redacted] b(6)-2 but will not cough forcefully. SS6 9/W m.b
21 SEP 03 1505	PT's (R) chest wx dressing D/I'd of drainage noted, 3 holes approx 2 cm diameter each and 1 cm deep. Wx's cleansed c NS and packed c Kerlix fluff. PT tolerated dressing I. STATES no pain. [redacted] b(6)-2 SS6
21 SEP 03 1600	PT ↑ ODs to chair. Minimal assistance given. PT motivated to move. STATES there is only a "little pain" when moving. ABD staples intact. PT using IS while in chair. [redacted] SS6 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

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[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
21-SEP-03 0630	Assumed care of PT. PT POD 3, verbalizes needs & follows commands. Assessment on DB @0700 date 21-SEP-03. VSS will monitor [redacted] 68W
21-SEP-03 0700	PT OOB to chair. Minimal assistance needed. VSS. will monitor [redacted] 68W

b(6)-2

STANDARD FORM 509 (REV. 6/1999) BACK
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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
21Sep03 1815	Received report from SSG [redacted] b(6)-2 Pt. lying in bed ↑ HOB @ 45°. C/O lower back pain and asks if he can sit up in bed. Pt. set at foot of bed for 15 minutes before lying back down. Pt. given + used IS. Pt. refused ~~tam~~ Tylenol PR for temp of 101.8. SPC [redacted] b(6)-2
1930	NG tube pulled out 2 inches by pt., repositioned and placement checked by injecting air. SPC [redacted]
2200	SaO_2 dropped to 91%. O_2 via NC @ 4LPM applied bringing SaO_2 to 96%. Will continue to monitor - SPC [redacted]
0000	Pt. rewired own O_2 SaO_2 @ 94%, will continue to monitor SPC [redacted] b(6)-2
0100	2LNC put back on for SaO_2 of 92%, rose back up to 95% b(6)-2 SPC [redacted]
0445	Pt. C/O pain, refuses to take Tylenol PR SPC [redacted]
0600	Pts. 0700 DRSG change performed at this time due to DRSG being saturated ↑ serosanguinous fluid. SPC [redacted]
0605	Assumed care of pt. Pt resting in bed ↑ eyes closed. (2 Arm restrained). VSS. Will continue to monitor. SPC [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

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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
22 Sep 03	0700 POD 3
	S - ō c/o ō flatus or BM
	O - Tm 101.6 107 O2 sat > 90% room air — WBC 6.7
	NG ~150, UO adequate — Hb 10.9
	chest - egophony both bases — plt 241
	abd - mild distension wound OK (midline centrally) — 139 / 104
	ō BS — 3.7 / 24
	A - atelectasis developing pneumonia — 41.0
	P - remove NG & foley ↑ act watch wound, consider
	CT abd obscure [redacted]
	note: central (R) flank wound still grayish appearance,
	will ↑ freq dressing Δ + watch closely [redacted]
22 Sep 03 Ø730	Dr. [redacted] D/C'd NG @ Ø710. D/C'd Foley @ Ø730. VSS.
Ø905	Transfer to ICW 1. SPC [redacted] 91WM6
22 Sept 03 1135	Recd pt from ICU 2. IV Δ in (R) forearm due to infiltration. IV in (L) AC patent TNF. ⊖ swelling @ site. Midline abd staples intact c̄ minimal redness. (R) flank dsg Δ. Fentanyl patch intact. Lungs CTA. VSS. Will continue to monitor [redacted] 91WM6
1540	Pt ♀ to BR pt voided @ 250 cc. Dsg Δ minimal drainage noted [redacted] 91WM6
@1945	assumed care of pt @ 1800. VSS. Wanting H2O to drink through NPO status. no c/o pain. IVx2 (R) FA HL, (L) FA c̄ IVFs, Ø S/SX of infection or infiltration.

cor [redacted]

STANDARD [redacted]

b(6)-2 All

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ACLU-RDI 1654 p.73

DOD-033487

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES b(6)-2 All
23Sep@0945	LS CTA, ⊕BS hypoactive ⊖flatus ⊖BM.
cont'd	Ⓡ flank drsg CDI, ecchymoses noted behind drsg on lower back. Voiding per urinal s̄ difficulty. Pt restraints on s̄ signs of skin or circulation compromise. Plan: monitor GI status, drsg Δs Q4°, ↑amb as tolerated. [redacted]
2230 -	Drsg Δ to Ⓡ flank completed. X3 wounds noted range from 2in, 1in, ½in in width. Packed c̄ saline damp 4X4s. Wounds red c̄ patches of green noted. Sero-sanguinous drainage on old drsg noted. ML abd ~~[redacted]~~ incision OTA c̄ staples, CDI. On flank wounds, all 3 wound edges reddened & inflamed. Will continue to monitor. [redacted]
23Sept03 @1000	Pt ↑ in bed ⊖ s/s of resp distress or discomfort @ present time. Drsg Δ to Ⓡ flank. Minimal drainage on abd pad. Midline abd staples intact. Slight redness around stapled area. Pt has T 100.6. Pt given incentive spirometer, blankets taken off. A/C ↑. Will recheck temp. IV D'cd in Ⓛ arm due to infiltration. IV in

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PROGRESS NOTES
Medical Record

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	Ⓡ forearm patent INF. ⊖ swelling or edema
	@ site. lungs CTA. hypoactive bowel sounds.
	Will continue to monitor pt. condition [redacted]
1900	Pt a/o, temp 99.5, resp even & unlabored, ø c/o
	pain @ this time. LCTAB, HRRR, hypoactive BSx4
	Drsg to Ⓡ flank D/I. D5½NS ē 20 KCl @ 100cc/
	hr infusing into Ⓡ AC. ø edema or swelling
	@ site. TCD done. Restraint on Ⓡ LE. Pt
	ē minimal swelling to Ⓛ LE. ⊕ circulation.
	Will cont to monitor [redacted]
2000	Drsg Δ'd, sero-sang drainage noted. All 3
	wound edges reddened. midline abd. ē
	some redness noted. [redacted]
0001	Pt c/o pain 2/10 on inoperation, denies any
	pain meds @ this time. Abx given [redacted]
24 Sep 0630	
	S- flatus ⊕
	O- T100.5 b(6)-2 A11
	midline wound OK BS +
	central lat wound still ē some pus, ō surrounding pain,
	has ecchymosis of flank
	A- stable
	P- cont IV AB's, dressing Δ, watch for necrotizing fasciitis,
	advance diet [redacted]

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
24 Sept 03 @ 1200	Received pt in stable condition this a.m. VSS, A+O x3, speaks small amt English. IV patent & intact (R) fa. (R) flank dsg D/C'd per order. small amt of serosang drainage noted. Skin around wound sites appears red + irritated. OOB and amb to BR. (+) BM and [illegible]. Restraints in place per EPW protocol. ∅ S/S of skin breakdown or circulation issues noted. Tol full liquid diet c this time. Will cont to monitor [redacted]
	Midline abd incision [redacted] staples w edges well approximated [redacted] b(6)-2
24 Sep 03 @ 2345	Assumed care of pt @ 1900. VSS. No % @ this time. Speaking some English, pleasant, alert.
b(6)-2	LSCTA, ↓ (B/L) [redacted] bases, IS encouraged & used. (+) BS, (+) flatus, ∅ BM this shift. Tol sm amts of full liquid diet s difficulty. (R) AC IV c D5 1/2NS + 20KCl @ 100, flowing s s/sx of infiltration. Midline abd incision c staples CDI, healing well. (R) flank c 3 wounds WTD drsgs, some purulent areas noted in each wound; wound borders reddened and ecchymosis to flank behind wounds. (CONT)

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI | SPONSOR'S [redacted]

b(6)-2

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

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PROGRESS NOTES
Medical Record

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C [redacted]

b(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
24Sep @ 2345	(CONT-) Voiding per urinal s̄ difficulty. Plan: cont IV abx, monitor pain, monitor drsg, cont drsg Δs q4°. [redacted]
25 Sept 03 0900	VSS A+O. Ⓡ ~~AC~~ AC IV patent & intact infusing D5 1/2 NS c̄ 20 Kcl/l @ 100cc/hr. Continued multiple IV ABX. OOB to BR ambulating c̄ steady gait. Denies pain @ this time. Lungs Clear Bilateral. Uses Incentive spirometer properly @ 900cc/sec. Has non ~~[illegible]~~ productive cough. Old drsg packing to Ⓡ Flank c̄ minimal serosanguin. drainage noted, Redness noted around edges of Ⓡ flank wounds. Midline ~~AC~~ Abd incision c̄ staples intact + ∅ drainage noted. Peripheral pulses +2. Will continue care as planned. [redacted] 2LTA
25 Sept 03 1400	Pt OOB ambulated to BR c̄ assist. Had BM x1 small brown form. Tolerated well. Continues to use Incentive Spirometer @ 900cc/sec with non productive cough. Will continue plan of care. [redacted] 2LT

b(6)-2 All

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
25 SEP 03 2225	VSS. AO. DSG's c/d to bullet wound @ (R) torso. Tolerated well. BS@x4. Ambulated x1 to BR c/o pain. [redacted] b(6)-2
26 Sep 03 715 AM POD#7	Surg Lol d/c'd Temp < 100 wound c/d/i stable CPM [redacted] b(6)-2
26 Sep 03	0850. Assumed care of pt @ 0800. Assessment completed. VSS - A+O. LSCTA(B). Resp even unlabored. Abd. soft non tender, BS x4, S1S2 present. IV (L) FA KCl. NEW IV started (R) FA 18G. CDI @ SIS INF. Pt. ambulated to BR. Performed AM care. midline incision c staples intact. dsg dry CDI. Pt. resting well @ b(6)-2 this time will cont. to monitor pt. [redacted]
26 Sep 03	0930 Pt. ambulated to BR. Pt. stated

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[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE

NOTES

he could not pass BM because it feels like his staples will come out. 2 midline Incision has min drainage. b(6) [redacted]

27sep03@0430 Assumed care @1800; A&O USS; pt A&OX3 speaking arabic, ambs to BR x 15 difficulty; ⊖BM; pt c/o pain to staples to midline, staples well approximated, Ⓐ s/sx infection, red around the site, warm to touch, moderate amt purulent drainage; staples cleaned ± ½ sterile H2O, ½ peroxide; dsg to Ⓡ chest wall Ad, 3 deep wounds packed ± iodoform & reinforced abd pad; dsg Ad q4° slow CDI; PW intact, s/s/sx infection/infiltration; cont ± IV abx; restraints in place; Ⓐ circulation, ⊖ skin breakdown; cont to monitor [redacted] b(6)-2

9/27

9/27/3 Surg

POD#8 ⊖ n/v

⊖ BM

wound clean

dsg wet

Mom [redacted] b(6)-2

27Sept03 0930- Assessment completed. assumed care of patient @ 0900. PERRLA, (S CTA(B), Resp. even unlabored, abd distended. Mom (30cc) given PO as ordered. 1/2 staples removed. significant amount of drainage noted to mid-line incision. IV Ⓐ FA c/DI. ⊖ s/s inf, restraints in place, Ⓐ circulation, ⊖ skin breakdown. will cont. to monitor pt. [redacted]

27Sept03 1000- pt had BM. [redacted]

b(6)-2

STAN[illegible] FORM 509 (REV. 5/1999) BACK

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
26sep03	1734- Pt. resting in bed @ this time c (+) drainage from mid-line incision. 4x4's placed on incision. Δ'd dressing to right flank. moderate drainage to wounds packed wounds c NuGauze + covered c abd. pad. IV @ KVO 3 S/SΛ inf. ~~BD~~ CDI c D5½ 20meq KCl. Pt. tolerating PO well. Ambulated in hallway x 10 mins c restraints applied (+) circulation (-) skin breakdown. voiding per urinal will cont. to monitor pt — b(6)-2 [redacted]
27sep03	1500- Changed Pt. dressing. moderate amount of drainage to wound + mid line incision. NuGauze packed into wounds. (-) S/Sx of infection. midline incision (+) redness. will continue to monitor pt. — b(6)-2 [redacted]
	(1628) I concur c above assessment. b(6)-2 [redacted]
27sep03@2180	Assumed care @1800; A&Ox3, pt A&Ox3 speaking both English & Arabic pt ↑ amb to BR x1, ⊖BM c difficulty; Cont c 94° Dsg Δ's; (R) chest wall packed c iodoform gauze covered c abd pad; (+) purulent/sero-sang

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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#[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	(cont) drainage; moderate amt of drainage from midline incis - purulent sero-sanguinous. PIV in (R) FA, patent & infusing D5½NS + 20meq KCL, 3 & 5x infection/infiltration; restraints in place, D/C. (-) skin breakdown; cont to monitor [redacted] b(6)-2
9/28 0427 POD#9	Surgery (-) N/V +BM wounds clean doing well d/c asx
	[redacted] b(6)-2
28Sep03	0946 - VSS - A+O x3 speaking English + Arabic. Assessment completed. Pain is 5 c/a (B), Resp. even unlabored, Abd firm, BS x4. voiding per urinal. Ambulated to BR x2. conducted personal hygiene (-) c/o pain. 2 restraints applied. (-) skin breakdown. (+) circulation. midline incision Staples x omae. cleaned area c ½ peroxide + ½ sterile water. D/C Abx. + FL. HL to (R) FA. c/o (-) s/s infection. Pt. resting well @ this time. Will cont. to monitor pt [redacted] b(6)-2

STANDARD FORM 509 (REV. 5/1998) BACK
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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
28Sept03 1500	- conducted dressing Δ. Pt c/o pain. medicated c tylenol percocets. Three circular D&W to (R) side of abdomen c min. drainage + bleeding (+) redness to area packed wounds c NU Gauze + abd pad on top. Remains afebrile. Pt resting well @ this time. Will cont. to monitor [redacted] b(6)-2
28Sept03 1515	Pt. had BM.
28Sep.03 2030	Pt A+O x3, VSS, LS CTA (B), (+) BS x4, dsg (R) flank has minimal amount of drainage, denies pain, HL (R) FA intact voiding well, OOB to BR, denies pain @ this time, proper circulation + skin integrity on pts of restraint. [redacted] RN b(6)-2
9/29 POD#10	Surg - doing well wounds OK cont [redacted] care b(6)-2

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

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#[redacted] b(6)-1

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
Sept 29	0620 assumed care pt awake/oriented speaking english PERRLA, lungs ctaB, respiration unlabored but guarded abd soft, BS x 4, pt cording clear yellow urine via urinal pt ambulated to BR without difficulty, DSW repack draining dark red blood, circulation intact around wound with some redness/pinkness and tenderness around edges [redacted] no s/s infection or infiltration, no other unauthorized [redacted]
29Sep.03	Pt resting in bed, AtOx3, VSS, denies pain, dsg on R flank CDI, HLIV R FA intact, ø s/sx of infex, ambulates ⊼ complications, voiding well, ø s/sx of poor circulation or skin breakdown on pts of restraint [redacted]
29Sep03	2100: I concur ⊼ above assessment [redacted]
	b(6) 2 Atl
9/30	Surgery
0720	doing well
POD#11	cont wound care
	[redacted]

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
30 sep 03 0700	- Assumed care pt. A+O x 3 OOB to BR ambulates 3 difficulty. Midline incision dressing D/I 4X4 CDI minimal drainage. 3 GSW ~~[redacted]~~ wounds to @ abdominal wall packed & 2X2 surgipad abdominal dressing applied. Lung clear Heart RRR Active BS x 4 quads. OK for discharge to iraqi hospital when transportation is available. Will cont to monitor [redacted] 91C b(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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REGISTER NO.	WARD NO.

[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
9/30/3	d/c Summary
	admit 9/19/3
	d/c 9/30/3
	d/c dx - GSW To abd c colon injury
	hosp course - pt underwent R hemi at FST here for recovery. Did well & d/c'ed 9/30
	d/c Rx's
	Motrin 600mg po tid prn
	[redacted] b(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	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

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
9/20/3	Surg 7
POD#1	Only ambul
	and void, dressings ok
	stable
	NPO / NG / IV
	[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

MEDCOM - 19926

[redacted] / Cp# [redacted] b(2)-2 [redacted]

NSN 7540-01-075-3786

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT *(Patient)*

LOG NUMBER [redacted] b(2)-2

RECORDS MAINTAINED AT

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

ARRIVAL

DATE (Day, Month, Year) 19 Sept 03 | TIME 2150

TRANSPORTATION TO FACILITY AIR

SEX	DUTY/LOCAL PHONE		MILITARY STATUS			
M	AREA CODE	NUMBER	ITEM	YES	NO	N/A
			PRP			
AGE	HOME PHONE		FLYING STATUS			
37	AREA CODE	NUMBER	MEDICAL HISTORY OBTAINED FROM			

THIRD PARTY INSURANCE		
ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2568 IN CHART		
NAME OF INSURANCE COMPANY		

CURRENT MEDICATIONS: Ø

ALLERGIES: Eczema

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: 3 65lb to Lower chest

CATEGORY OF TREATMENT

☐ EMERGENT
☒ URGENT
☐ NON-URGENT

TIME: 2150

INITIALS: 2

VITAL SIGNS

TIME	2150					
BP	125/83					
PULSE	104					
RESP	14					
TEMP	99.4 P					
WT						

LAB ORDERS

☒ CBC/DIFF	ABG	PT/PTT	BHCG/URINE/BLOOD/QUANT
☒ URINE C&S	UA MSCC/CATH	2	CHEM: 12 Lytes
☒ BLOOD C&S X 2	X		

X-RAY ORDERS

☒ CXR PA & LAT/PORTABLE 2155	C-SPINE	
ACUTE ABDOMEN	LS SPINE	
SINUS	HEAD CT	
ANKLE R/L		

KUB 2155

ORDERS

☒ PULSE OX 96 ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
2150	Bolus TCW	[redacted]	[redacted]	2155	
			b(6)-2		

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 [redacted] b(6)-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

STANDARD FORM 558 (REV. 9-96)
Prescribed by GSA/CMR
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 [redacted]

TEST RESULTS

CBC: WBC / H/H / PLT	SMAC	ABG/PULSE OX: SUP 02 / PH / PO2 / PCO2 / SAT / OTHER	RADIOLOGY — Check if read by radiologist ☐ — RESULTS
PT		U/A: DIP / MICRO	EKG INTERPRETATION
APTT	BHCG / ETOH / GLU		

PROVIDER HISTORY/PHYSICAL

37 y/o M s/p GSW ... seen @ FST s/p lap ex c̄ laparotomy ⊖ liver lac.

Abx given @ FST. IV stable preop

See Surgery H&P

O: A&O x3 ~ mod distress. VS as doc

HEENT: OP/NO clear/pat Chest: CTAB talks full sentences breathing non-labored

Cor: RRR ... Abd: staples mid line & contr ...

⊕ 3x lap open GSW (R) flank/abd c̄ ∅ active bleed

Back & lesion 5/5 strength UL ext c̄ N/V intact

→ Admit ICU 2

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP [redacted] b(6)-2

PROVIDER SIGNATURE AND STAMP [redacted]

DIAGNOSIS

① GSW to Abd stable Admit

CODES

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 *(Doctor)*
Medical Record

STANDARD FORM 558 (REV. 9-96)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.203(b)(10)
USAPA V1.00

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY

19 | HOUR

PULSE (O) | TEMP. F (°)

105° | 180 | 104° | 170 | 103° | 160 | 102° | 150 | 101° | 140 | 100° | 130 | 99° | 98.6° | 120 | 98° | 110 | 97° | 100 | 96° | 90 | 95° | 80 | 70 | 60 | 50 | 40

TEMP. C

40.6° | 40.0° | 39.4° | 38.9° | 38.3° | 37.8° | 37.2° | 37.0° | 36.7° | 36.1° | 35.6° | 35.0°

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

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.

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

[redacted] b(6)-4

MEDCOM - 19929

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY						
POST- DAY		23 Sept	24 Sept 24 Sept	25 Sept	26 Sept	27 Sept
MONTH-YEAR / DAY	22				0900	0914
Sept 2003 / HOUR	1	1000 1005	07 1830	0800 1800		

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

Record special data only when so ordered

BLOOD PRESSURE: 126/83 111; 131/86 121 98.4; 141 107; 139/88; 131/80 101 98.1; 140/80; 131/76 P 101 T 99.3; 123/76 105; 131/80 125/76; 117/74; 88

HEIGHT: WEIGHT →

SpO2: 95% RA; 95%; 99% RA; 95% RA; 99% RA

[illegible]

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 - 19930

Ward/Section: EMT | REQUESTING PHYSICIAN: Dr. [redacted] b(6)-2

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

LAST, FIRST, MI: EPW [redacted] b(6)-4 | DATE: 19/09/03 | TIME: 2150 | SSN/PSEUDO: EPW [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		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl

======= PICCOLO =======
19/09/03 21:55
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
LIVER PANEL PLUS
DISC LOT #: 3154AA7
OPER #: [redacted] DR #: 000
SERIAL #: b(6)-2 [redacted]

ALB	2.5*	3.3-5.5	G/DL
ALP	56	26-84	U/L
ALT	68*	10-47	U/L
AMY	119*	14-97	U/L
AST	64*	11-38	U/L
TBIL	0.9	0.2-1.6	MG/DL
GGT	62	5-65	U/L
TP	4.3*	6.4-8.1	G/DL

INST QC: OK CHEM QC: OK
HEM 1+, LIP 0 , ICT 0

(Piccolo) Metabolic

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl

======= PICCOLO =======
19/09/03 21:55
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
BASIC METABOLIC
DISC LOT #: 3145AA4
OPER #: [redacted] DR #: 000
SERIAL #: b(6)-2 [redacted]

GLU	143*	73-118	MG/DL
BUN	7	7-22	MG/DL
CA++	7.6*	8.0-10.3	MG/DL
CRE	1.2	0.6-1.2	MG/DL
NA+	134	128-145	MMOL/L
K+	5.4*	3.3-4.7	MMOL/L
CL-	105	98-108	MMOL/L
tCO2	22	18-33	MMOL/L

INST QC: OK CHEM QC: OK
HEM 0 , LIP 0 , ICT 0

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: I Clin 2 | REQUESTING PHYSICIAN: [redacted] b(6)-7 | LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. EPW # [redacted] b(6)-4 | DATE 20SEP | TIME 0415 | SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WI		4.8-10.8 x 10³
R		
H		

Urinalysis

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

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Negative
Negative

ID: [redacted]
WB

20-09-03
04:52

			Patient Limits	
WBC	5.9	x10^3/uL	4.5	10.5
RBC	4.92	x10^6/uL	4.00	6.00
Hgb	14.4	g/dL	11.0	16.0
Hct	43.1	%	35.0	60.0
MCV	87.5	fL	80.0	99.9
MCH	29.3	pg	27.0	31.0
MCHC	33.5	g/dL	33.0	37.0
Plt	293.	x10^3/uL	150.	450.
LYM	16.3	%	20.5	51.1
LY#	1.0	x10^3/uL	1.2	3.4

52% (M)
47% (F)

======= PICCOLO =======
20/09/03 05:36
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
BASIC METABOLIC
DISC LOT #: 3145AA4
OPER #: [redacted] DR #: 000
SERIAL #: b(6) [redacted]

GLU	124*	73-118	MG/DL
BUN	8	7-22	MG/DL
CA++	7.4*	8.0-10.3	MG/DL
CRE	0.9	0.6-1.2	MG/DL
NA+	137	128-145	MMOL/L
K+	4.4	3.3-4.7	MMOL/L
CL-	106	98-108	MMOL/L
tCO2	21	18-33	MMOL/L

INST QC: OK CHEM QC: OK
HEM 0 , LIP 1+, ICT 0

Urinalysis

Sed Rate

Cell Count

Other

Directigen

lank

F 518 WITH QUESTED

F BLOOD

OSSMATCH

Coagulation Studies

(MUST SI

TEST	RESULT	REF. RANGE	UNIT
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.:

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

REQUESTING PHYSICIAN: [redacted] b(6)-7

[redacted] b(6)-4

DATE: 0914

TIME: 21-Sep-03

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

BC				Urinalysis			Misc. Serology		
EF. RANGE				TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
4.8-10.8 x10				Color		N/A	RPR		Negative
4.7-6.1 x10				App		N/A	Mono		Negative
14-18 g/dl(M) 12-16 g/dl(F)				Glu		Negative	Microbiology		
42-52%(M) 37-47%(F)				Bili		Negative	Source		
80-94 fi(M) 81-99 fi(F)				Ket		Negative	Gram Stain		
130-500 x 10³ verified				SG		N/A	Occ Bld		Negative
20.5-51.1%				Bld		Negative	H. pylori		Negative
Differential				pH		N/A	Micro Parasites		
		Mono		Prot		Negative	Malaria		
Bands		Eos		Urob		0.2-1.0	O & P		
Lymph		Baso		Nit		Negative	Other		
Atyp		Imm		Leuk		Negative	Macroscopic Urinalysis		
RBC Morph				HCG		Negative			

Spun Hematocrit		42-52%(M) 37-47%(F)	CSF			Blood Bank	
Set Rate			Cell Count			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED	
Other			Directigen		Negative	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: | DATE: | LAB ID NO.:

Ward/Section:	REQUESTING PHYSICAN:			CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST,MI.		DATE	TIME		SSN/PEEUDO SSN:

(i-STAT)

======= PICCOLO =======
21/09/03 09:17
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(a)-2
BASIC METABOLIC
DISC LOT #: 3203AA4
OPER #: [redacted] DR #: 000
SERIAL #: b(a)- [redacted]

GLU	131*	73-118	MG/DL
BUN	♦♦♦	7-22	MG/DL
CA++	8.3	8.0-10.3	MG/DL
CRE	0.9	0.6-1.2	MG/DL
NA+	118*	128-145	MMOL/L
K+	4.2	3.3-4.7	MMOL/L
CL-	101	98-108	MMOL/L
tCO2	♦♦♦	18-33	MMOL/L

28

INST QC: OK CHEM QC: OK
HEM 0 , LIP 0 , ICT 0

(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		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 /l (M) 30-190 /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

======= PICCOLO =======
21/09/03 09:19
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(a)-4
LIVER PANEL PLUS
DISC LOT #: 3154AA7
OPER #: [redacted] DR #: 000
SERIAL #: b(a)- [redacted]

ALB	2.2*	3.3-5.5	G/DL
ALP	46	26-84	U/L
ALT	21	10-47	U/L
AMY	414*	14-97	U/L
AST	99*	11-38	U/L
TBIL	1.2	0.2-1.6	MG/DL
GGT	44	5-65	U/L
TP	5.3*	6.4-8.1	G/DL

INST QC: OK CHEM QC: OK
HEM 1+, LIP 0 , ICT 0

tCO2		18-33 mmol/l

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

MEDCOM - 19934

b(6)-2

Wa[illegible]ion: 1142	REQUESTING PHYSICIAN: Dr. [redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted] b(6)-4	DATE: 21Sep TIME: 2049	SSN/PSEUDO SSN: [redacted] b(6)-4

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/dL
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 (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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Tropoin-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^{++}		8.0-10.3 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		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 /l (M) 30-190 /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

======= PICCOLO =======
21/09/03 20:40
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
BASIC METABOLIC
DISC LOT #: 3203AA4
OPER #: [redacted] DR #: 000
SERIAL #: b(6)-2 [redacted]

GLU	111	73-118	MG/DL
BUN	♦♦♦	7-22	MG/DL
CA++	8.1	8.0-10.3	MG/DL
CRE	0.6	0.6-1.2	MG/DL
NA+	117*	128-145	MMOL/L
K+	4.1	3.3-4.7	MMOL/L
CL-	101	98-108	MMOL/L
tCO2	♦♦♦	18-33	MMOL/L

INST QC: OK CHEM QC: OK
HEM 0 , LIP 2+, ICT 0

REMARKS:		
REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: ICU2	REQUESTING PHYSICIAN: [redacted] b(6)-2		CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST,MI. [redacted] b(6)-4		DATE 21-SEP-03	TIME 1027
SSN/PSEUDO SSN: [redacted] b(6)-4			

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/dL
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 (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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Tropoin-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^{++}		8.0-10.3 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		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 U/l 30-190 U/l
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

======= PICCOLO =======
21/09/03 10:24
REFERENCE RANGE: MALE
PATIENT #: [redacted]
BASIC METABOLIC
DISC LOT #: 3203AA4
OPER #[redacted] DR #: 000
SERIAL #: [redacted]

GLU	138*	73-118	MG/DL
BUN	8	7-22	MG/DL
CA++	8.2	8.0-10.3	MG/DL
CRE	0.8	0.6-1.2	MG/DL
NA+	116*	128-145	MMOL
K+	3.9	3.3-4.7	MMOL
CL-	101	98-108	MMOL
tCO2	33	18-33	MMOL

INST QC: OK CHEM QC: OK
HEM 0 , LIP 1+, ICT 0

						CL^-		98-108 mmol/l
						tCO2		18-33 mmol/l

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

MEDCOM - 19936

MEDICAL RECORD — ANESTHESIA

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

DRUG (Units)		TOTALS
FENTANYL (mcg)	(250) (250)	500
KETAMINE (mg)	150	150
SUX (mg)	100	100
VEC (mg)	5 2 2	9
A.P.V. (mg)	(5)(5)(5)(5)	20
VOLAT AGENT (ISO) % del / % e.t.	1.0 1.0 1.0 1.0 1.0 1.0 1.0 .8 .5 .5 MgSO4 (4)	
AIR L/Min		
N2O L/Min		
O2 L/Min	5 2 2 2 2 2 2 2 2 2 2 5	

SINGLE DOSE DRUGS — MARK ON GRID WITH NUMBERS & ENTER IN REMARKS: (1)(2) (3)

TOTAL EBL: 400

TOTAL URINE: 600

FLUIDS — SUMMARY
CRYSTALLOID— 4.5L
COLLOID— 500ml
BLOOD—

FLUIDS
LINE site: 18 G (L) ☐ Warmed; 18 G (R) ☐ Warmed; ☐ Warmed; (L) ☐ Warmed
1L — 2L — 3L — 4L — (4.5L)
HESPAN 500

LOSSES
EST BLOOD LOSS: 300 — 400
URINE—: 500 — 600

PHYS STATUS: 1 2 (3) 4 5 (E)

BODY WEIGHT: 80 (KG) LB

HEMATOCRIT:

INITIAL DATA:
BP — 117/83
HR— 96

EQUIP CHECK
OK?— (Y) N

PATIENT RECHECK
OK for PROCEDURE? Y
TIME—1630

TIME → 1630 45 (17) 15 30 45 (18) 15 30 45 (19)

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

Scale: 220 200 180 160 140 120 100 80 60 40 20

pH 7.31
PCO2 57.2
PO2 155

REMARKS—
Code drugs with numbers, events with letters
(A) Arrived → OR Unknown Hx. GSW x3 to ABD.
(B) OR/Monitors/RSI cricoid.
Est. FM, fluid, debridement & PRBC.
(C) ABG sent. 7.12/34
(1) 2G CEFOTAN
(2) 500mg FLAGYL

VENTIL

VT — ml	VPAC →									
f — breaths/min	12	10	10	10	10	10	12	10	14	16
Peak Inf pres / PEEP	VPAC									
MODE— S(pon), A(ssist), C(on)	S	C	C	C →	→	A →	95	S	S	

MONITORS / ACCESSORIES

ET CO2 (torr)	✓	32	31	30	32	30	32	34	49	42
FIO2 (Frac or %)	.21	.81	.72	.68	.72	.71	.71	.76	.78	.79
SpO2 (%)	100	99	100	100	100	100	100	100	99	100
ECG	ST	SR	SR	SR	SR	SR	SR	SR	SR	SR
TEMP- site	SKIN	100 —	99	—	99					
N-M Block (T/4)	4/4	4/4	4/4	1/4	—	1/4	—	2/4	4/4	

BP/Auto Cuff; BP / oth; ART line; Steth- PC/ES; Gas analyzer
245 5mg NEOSTIG 1mg ROBINUL
0 → Blanket upper → →
Warming blkt
Conv warmer

Mark with letters & symbols, explain under REMARKS. EVENTS
Position — 0 → → → →

RECOVERY AT 1905
(PACU) ICU ____ (Specify)
OTHER ____
CONDITION:
RESP 18 SpO2 96%
BP 145/80 HR— 92

ANESTHESIA / PROCEDURE TIME

	Start	Room	End
ANES	1630	1630	1915

	Ready	Begin	End
PROC	1640	1645	1850

PROCEDURES and CPT Codes
EX LAP / GSW ABD x3

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
SLCS/GETA/RSI cricoid/HME/ES Steth

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
DL x1 Sab B, 8.0 ETT cuff. (+)ETCO2 (+)BBS. Taped 23 lips.

PATIENT IDENTIFICATION— Typed or written entries: Name, Grade/Rate, Medical facility
IRAQI M

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

PROCEDURE LOCATION: FST
DATE: 19 SEPT 03

PAGE 1 OF 1

MEDICAL RECORD — ANESTHESIA

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 19937

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

...DIOLOGIC CONSULTATION REQUEST/REPORT

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

AMINATION(S) REQUESTED	AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
CXR / KUB	37	M	EPW 801	EMT	
	FILM NO.			PREGNANT ☐ YES ☒ NA	
	REQUESTED B Dr. [redacted]			TELEPHONE/PAGE	
	SIGNATURE OF REQUESTOR b(6)-2			DATE REQUESTED 19 Sept 03	

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

GSW

TE OF EXAMINATION *(Month, day, year)*	DATE OF REPORT *(Month, day, year)*	DATE OF TRANSCRIPTION *(Month, day, year)*

DIOLOGIC REPORT

ENT'S IDENTIFICATION *(For typed or written entries give: — last, first, middle, Medical Facility)*	LOCATION OF MEDICAL RECORDS
EPW [redacted] b(6)-4	LOCATION OF RADIOLOGIC FACILITY
	SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT
1 — MEDICAL RECORD

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

MEDCOM - 19938

MEDICAL RECORD - DOCTOR'S ORDE
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
1988	P03 Admit PT Mobl Dx: S/P Exlap Cond: Stable Vitals: Routine, q4°, & I/O Act: Ad lib Diet: NPO Nurs: ① Foley to gravity ② NG to LWS Med to dry to abdominal wall TID, VSD dressing ∆ tomorrow Diet: NPO IV: D5 ½ NS ~~D5 NS~~ ∆ 20 kcl @ 110 cc/hr Meds: ① Cefoteten 1gm IV ~~q8°~~ ~~start to OR~~ ② Morphine 2-5 mg IV q2-3° PRN pain ③ Ranitidine 50 mg IV q8°		

[redacted] b(4)-2

PATIENT IDENTIFICATION

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

MC V

MEDCOM FORM 688-R (TEST) (MCHO) MAR 99 PREVIOUS EDITIONS ARE OBSOLETE

MEDCOM - 19939

CLINICAL RECORD - DOCTORS 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 9/19/13 TIME OF ORDER HOURS

1) admit to ICU
2) dx - s/p Rhem.
3) VS q1° x 6 then q2°
4) NPO
5) NG to CIS
6) Pepcid 20Mg IV q12°
7) MSO4 1-6Mg IV q2° PRN

PATIENT IDENTIFICATION

b(6)-2 [redacted]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER HOURS

8) Ancef 2gm IV q8° x 5 days
9) Flagyl 500mg IV q8°
10) CBC, Chem 7 in AM
11) Incentive spirometer [redacted] CMF

b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER HOURS

12) LR 150 cc/hr
13) NPO → D ~~bid~~ tid to abd wound
14) dry dressing on inc Δ prn

[redacted] b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER 9/20/13 TIME OF ORDER HOURS

1) D5 1/2 NS + 20 KCl @ 100 cc/hr
2) NPO → D tid to abd

Note [redacted] b(6)-2

[redacted]

NURSING UNIT	ROOM NO.	BED NO.

[redacted] b(6)-2

ICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is ...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 | ROOM NO. | BED NO.

DATE OF ORDER: 9/20 — TIME OF ORDER: ________ HOURS — LIST TIME ORDER NOTED AND SIGN

1) Zantac 50mg IV q8°
2) d/c Pepcid
3) Tylenol 650 T po q4 prn

[redacted]

b(6)-2

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 21 Sep 0800 HOURS

(1) portable CXR this am
(2) CBC, lytes, LFT's this am
(3) CBC, lytes 22 Sep
(4) change (R) flank dress [redacted] q 8h - NS soaked / Kerlix fluff
(5) OOB chair TID

b(6)-2

[redacted]

PATIENT IDENTIFICATION

DATE OF ORDER — TIME OF ORDER

(6) culture wound - drn

[redacted]

b(6)-2

[redacted]

21 Sep 1300
(1) Δ IV to NS1000cc c̄ 20 mEq KCl at 100/h
(2) lytes at 2000

[redacted]

b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

[redacted]

DATE OF ORDER: 22 Sep 0700 — TIME OF ORDER: ________ HOURS

(1) DC NG ✓
(2) DC foley ✓
(3) NPO ✓
(4) DBC ✓
(5) ambulate

[redacted]

(6) 4 drains ... q4h

(7) ... change q...

(8) DC ...

b(6)-2

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 1994-363-710

MEDCOM - 19941

CLINICAL RECORD - DOCTOR'S C S

se of this form, see AR 40-66, the proponent y 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

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	22 Sept 03	0900 HOURS	
(1)	Transfer to ICU	[redacted]	
(2)	D/C SCD GSW abd	b(6)-2	
(3)	Cont. stable		
(4)	VS q shift		
(5)	Ort: BR		
(6)	NICOA		
(7)	NPO		

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

noted 22Sept03 @1130

b(6)-2

	DATE OF ORDER	TIME OF ORDER	
(8)	HUF:NS @ 100cc/hr	[redacted] HOURS	
(9)	Flagyl 500mg IV q 8°		
(10)	Cefepime 2gm IV q 8°		
(11)	Zantac 50mg IV q 8°		
(12)	Lasix 20 mg q 24°	b(6)-2	
(13)	D/5 ½ NS + 20	[redacted]	
(14)	Fentanyl patch		

NURSING UNIT | ROOM NO. | BED NO.

24° 2300 22Sep

PATIENT IDENTIFICATION

	DATE OF ORDER	TIME OF	
	22SEP03	2000 HOURS	
(1)	V.O. DR [redacted]	b(6)-2	
	Pt may have use of HOD.	[redacted]	

NURSING UNIT | ROOM NO. | BED NO.

24° 2300 22 [redacted] b(6)-2

PATIENT IDENTIFICATION

noted 24Sept@ 0630 [redacted] b(6)-2

	DATE OF ORDER	TIME OF ORDER	
	24 Sep	0530 HOURS	
	full liq diet	[redacted] b(6)-2	

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

24° / 2346 24Sep02 [redacted] b(6)-2

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 1994-363-710

MEDCOM - 19942

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] Noted 2-5-84

NURSING UNIT: FCW | ROOM NO. | BED NO.

DATE OF ORDER: 25 Jan | TIME OF ORDER: 1500 HOURS | LIST TIME ORDER NOTED AND SIGN

1) Reg diet
2) Reg ambulate b(6)-2 [redacted]

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

NURSING UNIT: ICW | 24 | 04 [redacted] | BED NO.: b(6)-2

DATE OF ORDER: 1/26 | TIME OF ORDER: 7:30 HOURS

1) Zantac 150 mg po bid
2) Dulcolax 2 po now

b(6)-2 [redacted]

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

NURSING UNIT: ICW | 24 | 25 [redacted] | ROOM NO.: 04 [redacted]

DATE OF ORDER: 1/27 HOURS

1) d/c [redacted]
2) MOM 30 cc po now
3) if no BM by 4pm - Dulcolax 10 pr

b(6)-2 [redacted]

PATIENT IDENTIFICATION: b(6)-2 [redacted]

NURSING UNIT: 24W | ROOM NO.: 0800 | BED NO.: 2 [redacted]

DATE OF ORDER: 28 Sept 0800 HOURS

1) MSO4 2-5 mg IV Q4° PRN for disq A.
2) Percocet 1-2 tabs po Q4-6° PRN.

V.O. Dr [redacted] b(6)-2 [redacted] b(6)-2 [redacted]

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

MEDCOM - 19943

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	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
[redacted] Noted 28 Sept 0900 b(6)-2	9/28/3	0824 HOURS	
NURSING UNIT: TEN7 / ROOM NO. / BED NO.	1) d/c MSO4 2) Percocet 1-2 po q 4° prn pain 3) hep lock IVF 4) d/c Ancef 5) d/c Flagyl 6) cont to pack wounds		
PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
		HOURS	
	7) w→d tid 7) d/c rest staples		
NURSING UNIT / ROOM NO. / BED NO.	[redacted] b(6)-2		
PATIENT IDENTIFICATION	DA[redacted] ORDER		
	9/30	834 HOURS	
	1) d/c home 2) Teach wound care pack tid w→d send with few days of supplies		
NURSING UNIT / ROOM NO. / BED NO.	[redacted]		
PATIENT IDENTIFICATION	DATE OF ORDER	HOURS	
	[redacted] b(6)-2		
NURSING UNIT / ROOM NO. / BED NO.			

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

MEDCOM - 19944

b(a)-2 All

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 (Sept/Oct): 19 20 21 22 23 24 25 26 27 28 29 30 1 2
9/19	[redacted]	V.S. q 1° x6	06	[redacted] Δ'D 22Sep03
		then q 2°	18	
9/19	[redacted]	Diet NPO	06	[redacted] Rewritten
			12	
			18	
9/19	[redacted]	NG to LIS	06	[redacted] Δ'D 22Sep03
			18	
9/19	[redacted]	Incentive Spirometr	06	[redacted]
			18	
9/19	[redacted]	W→D tid to	06	[redacted]
		abd wound	18	Δ'D 22Sep03
			22	
9/19	[redacted]	Dry dressing on	06	[redacted]
		inc. Δ prn	18	
21-Sep-03	[redacted]	Δ (R) Flank Dressing Q8h	07	[redacted]
		- NS soaked Kerlex Fluff	15	Δ'D 22Sep03
			23	
21Sep03	[redacted]	OOB chair TID	07	[redacted]
			15	
			23	
22Sep03	[redacted]	DC NG	07	[redacted] Done @ 0710
22Sep03		DC Foley	07	Done @ 0730
22Sep03		DBC exercises.	06	
			18	

ALLIES: ☐ YES ☐ NO — ALLERGIES

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P Rhemi

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ____________

PATIENT IDENTIFICATION:

EPW [redacted] b(a)-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

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
9/14	[redacted]	Admit to ICU				
9/14		CBC, chem 7 in A.M.				
9/21		Portable CXR this A.M.	21SEP03	NOW	0900	
9/21		CBC, Lytes, CPK-3 this A.M.	22SEP03	NOW	0900	
9/21		Culture wound drainage	21SEP03	NOW	0900	
9/21		CBC, Lytes 22 SEP	22SEP03	0500	0430	
9/21		Lytes @ 2000	21SEP03	2000	2032	

	-----	b(a)-2 AR				

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED
-----	-----		
-----	-----		
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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. ___ Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 22
22Sep03	[redacted]	DRSG Δ Q4hr	07	[redacted]
			11	
		b(6)-2	15	
			19	
			23	
			03	
22Sep03	[redacted]	VS Q Shift	06	[redacted]
			18	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

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 MEDCOM - 19947 SED. USAPA V1.00

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. Sept Yr. 2003

VERIFY BY INITIALING

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME
22Sept		NPO -
		Sips of H2O
22Sep		DBC
22Sep		Ambulate
22Sep		Δ dsg q 4 hrs
		@ Flank
		W → D
		Continue
22Sep		BR
24Sep	[redacted]	Full liquid diet
25Sep	[redacted]	Regular diet
25Sept	[redacted]	May Ambulate
27 Sept	[redacted]	Continue to pack
		@ Flank wound
		W → D TID

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

HR / DATE COMPLETED — 22 23 24 25 26 27 28 29 30

[redacted] D/cd 24Sept03

[redacted] D/cd 22 Sept

[redacted] Δ cd 25 Sept

[redacted] Δ cd 25Sept03

[redacted] Δ cd 25 Sept03

[redacted]

[redacted]

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW ABD

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

MEDCOM - 19948

EDITION OF 1 DEC 77 MAY BE USED — USAPA V1.00

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)		Mo 09 Yr 2003		
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
27 Sept 03	[redacted]	D/C 1/2 staples	27 Sept 03	Today	[redacted]	
28 Sept	----	D/C rest of staples	28 Sept	Today		

	----	to (6)-2 +11				

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

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. ___ Yr. ___

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
9/19	[redacted]	Pepcid 20mg IV q 12°	06	/ / DCd Pharmacy does not have
			18	/ /
9/19	[redacted]	Ancef 2gm IV q 8° x 5 days	06	
			14	/ / Rewritten
			22	/
9/19	[redacted]	Flagyl 500mg IV q 8°	06	
			14	/ / Rewritten
			22	/
9/19	[redacted]	LR @ 150cc/hr	06	[redacted] A'D 20 Sep 03
			18	
9/19	[redacted]	Ancef 2gm IV q 8° x 5 days	08	[redacted]
			16	[redacted]
			24	[redacted] Rewritten
9/19		Flagyl 500mg IV q 8	08	[redacted]
	[redacted]		16	[redacted]
			24	[redacted]
9/20	[redacted]	D5 ½ NS + 20K @ 100cc/hr	06	[redacted] A'd 21 Sep 03
			18	[redacted]
20 Sept 03	[redacted]	Zantac 50mg IV q 8°	08	[redacted]
			16	[redacted]
			24	[redacted] Rewritten
21 Sept 03	[redacted]	D.IV to NS/1000cc @ 200cc/hr	06	[redacted]
		KCl @ 10 / 1/4	18	[redacted]
22/9	[redacted]	Fentanyl Patch	07	[redacted]
		50ug/hr Replace		
		q 72 hrs		

ALLERGIES: ☐ YES ☐ NO	PRIMARY DIAGNOSIS: S/P Rhemi b(6)-2	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 - 19950 JSED 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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED														
1 Sept	[redacted]	MSO4 + 6mg	20 Sept 4mg	20 Sept 4mg	20 Sept 5mg	20 Sept 5mg	21 Sept 03 3mg										
		IV q 20	1115	1115	1630	2130	1730										
20 Sept	[redacted]	Tylenol 650mg PR	20 Sept 1125	20 Sept 1125													
		q 4° prn	1650	1650													
		b(6)-2															

USAPA V1.00

b(6)-2 All

CLINICAL RECORD — THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS) — Sep 03

ORDER DATE	CLASS/ ROUTE	PROGRAMS MEDICATIONS, DOSE, FREQUENCY
22Sept	[redacted]	Fentanyl patch 50mcg Δ q 72 hrs
22Sept	[redacted]	Flagyl 500mg IV q 8
22Sept	[redacted]	Rocephin 2 gm IV
22Sept	[redacted]	Phenergan 50mg IV
22Sept	[redacted]	D5 ½ NS ε 20 meq KCL @ 100/hr
26SEP03	[redacted]	Zantac 150mg po bid
28Sept	[redacted]	Heplock IVF

	22	23	24	25	26	27	28	29	30	1
18	[redacted]									
08	[redacted]									
16	[redacted]									
24	[redacted]									
08	[redacted]									
16	[redacted]									
24	[redacted]									
08	[redacted]									
16	[redacted]									
24	[redacted]									
06	[redacted]									
18	[redacted]									
18	[redacted]									
06	[redacted]									
10	[redacted]									
22	[redacted]									
00	[redacted]									
18	[redacted]									
18	[redacted]									
06	[redacted]									

D/C Sept 28

D/C Sept 28

DC 26SEP03

Del 28 Sept 03

D/C

GSW ABD

[redacted] b(6)-4

Verify by Initials | THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)

Order Date	Check Date	b(6)-2 SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
26 SEP03	[redacted]	Dulcolax 2 po now	26 SEP03	—	0725	[redacted] b(6)-2
27 SEP03	[redacted]	MOM 30cc po now	27 SEP03		0748	[redacted]

Order Date	Renewal Date	b(6)-2 PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOR EACH DOSE ADMINISTERED TIME/DATE DISPENSED
27SEP03	[redacted]	If no BM by 4pm, Dulcolax II pr	
28		MSO4 2-5mg IV q4° prn discomfort D/T D/I	D/Ced 28 Sept 03
28	[redacted]	Percocet 1-2po Q4-6° prn D/T D/I	2854 KM RMY II

MEDCOM - 19953

ACLU-RDI 1654 p.113

DOD-033527

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	1015	INITIALS [redacted]	2157	INITIALS [redacted]		INITIALS
NEURO	PUPILS	PERRL @ 1mm		2mm reactive PERRLA			
	SENSORIUM	A A+O		✓ intact			
				pain in mid line area			
				Abd. msoygen			
				1100-2000			
RESPIRATORY	RESPIRATORY PATTERN	= rise & fall of		B/L equal-symmetrical			
	BREATH SOUNDS	Chest bil BS wheez		BS wheezy			
	SECRETIONS	noted bil. No color		∅			
		noted @ present time		Breathing deep BS			
		No Secretions noted		and cough encouraged			
SKIN	COLOR	WNL for race		NFR			
	INTEGRITY	good		Good			
IV SITE	LOCATION	(L) AC D5½NS c 20		(R) FA D5½NS-20KCl			
	CONDITION	Meq K @ 100cc/hr		(L) AC patent			
		(R) AC IV HL No S/S		∅ S/S of trouble in			
		of infection or infiltration		either IV			
		noted Flushs well.					
GASTRO	ABDOMEN	ABD soft nondistended		ABD soft nondistended			
	BOWEL SOUNDS	BS (+) all 4 quads.		BS active x4 quad			
		Midline DSG CDI.		midline DSG CDI			
		(R) ABD DSG CDI.					
GU	URINE:	Foley to gravity c		F/C to gravity			
	COLOR/CLARITY	dark amber color					
		urine					
CARDIOVASCULAR	CARDIAC RHYTHM	Sinus Tachy 130's		ST			
		(+) Radial & Pedal		Good pulses ↓ Pedal/trunk			
		pulses bil.		+4			

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]

DEPARTMENT/SERVICE/CLINIC: ICW

DATE: 20 SEPT 03

[redacted] 'S IDENTIFICATION *(For typed or written entries give: Name—last, first, [redacted]; 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

MEDCOM - 19954

MEDDAC FBg OP 375, 1 Apr 90 (HSXC-NU)

VS

Admin'd

DATE | DX | 1 2 3 4 5 (6) | HOSPITAL DAY

TIME	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	
BP Arterial Line																		
BP Cuff		114/76			114/69	124/76	116/72	106/69	110/71	110/72	115/79	115/74	127/79	123/71	115/72	117/72		
Temperature					99.6 A	100.5 A	100.4 A	100.2 A	100.6 A		100.9 A	100.4 A	100					
Pulse		128			129	129	133	133	137	136	130	136	141	135	133	131		
Respiratory Rate		20			21	22	23	22	25	21	24	21	22	23	24	19		
O2		RA			2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L		
Method		RA			NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC		
SPO2		99			98	98	94	94	96	98	97	97	97	97	96	96		
Pain																		

INTAKE

TIME	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	
D5 1/2 NS E20K					100	100	100	100	8° T 100	100	100	100	100	100	100	100	100	8° T
(IV)																		
Ancef needs due				50							(50)							
Flagyl @ (CK 600)				100							(100)							
Zantac				50							(50)							
MSO4 Flush										1630	0.5 5mg 10				2130	0.5 5mg 10 =	11cc	(11)
TOTALS									(500)				800	900	1000	1100	1200	(1200)

OUTPUT

	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	
URINE HOUR / TOTAL					200	50/250	50/300	50/350		50/400	50/450	50/500	30/530	50/680	50/730	50/780	50/830	
URINE sp gr																		
URINE S/A																		
NG OUTPUT								300				100	50					
NG pH																		
NG GUIAC																		
EMESIS																		
STOOL																		
DRAINS																		
TOTALS									(300)				530				830	(830)

MEDCOM - 19955

ACLU-RDI 1654 p.115

DOD-033529

POST-OP DAY	23	23	24	01	02	03	04	05	06
VITAL SIGNS	07	24	02	02	03	04	05	06	—
	119/76								
	128	1[illegible]/[illegible]	120/[illegible]	10[illegible]/94		138/87		144/90	
	24	130	130	98	Fem	99		99.7	(T)
	97%	22	21	22		136		123	
	RA	NC 22	NC 22	22		21		22	
	99°	97	96	NC		22		22	
TEB	97	97	96	96		NC		NC	
						96%		97	

INTAKE									
	150	100	100	100	100	100	100	100	BRT
Ancef			50						[crossed out]
Fentanyl			100						[crossed out]
Zantac			50						[crossed out]
		100	300	100	100	100	100	100	100
		1310	1111						2211

OUTPUT								
	50/50	50/180	50/150	50/210	75	75	75	
375								
							150	
	880	930	480	1030			1180	

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	0230		
MOUTH CARE	✓		
BATH	✓		
SKIN CARE	✓		
FOLEY CARE	✓		
TRACH CARE	Ø		
ROM EXERCISES	✓		

TURN / SUCTION — TIME					

24° I&O TOTALS

wt Yesterday ______ wt Today ______

INTAKE		OUTPUT	
IV		Urine:	~~1180~~
po	2211		1,180
TOTAL		TOTAL	

BALANCE (+) 1,031

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

NEUROLOGICAL ASSESSMENT

			HOURS	1800	2000
COMA SCALE	EYES OPEN	SPONTANEOUSLY	4	4	4
		TO SPEECH	3		
		TO PAIN	2		
		NO EYE OPENING	1		
	BEST VERBAL RESPONSE	ORIENTED	5	5	5
		CONFUSED	4		
		VERBALIZES	3		
		VOCALIZES	2		
		NO VOCALIZATION	1		
	BEST MOTOR RESPONSE	OBEYS COMMANDS	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			
		ABNORMAL FLEXION			
		ABNORMAL EXTENSION			
		NO RESPONSE			
	LEGS	NORMAL POWER		✓	✓
		MILD WEAKNESS			
		SEVERE WEAKNESS			
		ABNORMAL FLEXION			
		ABNORMAL EXTENSION			
		NO RESPONSE			
PUPILS	RIGHT	SIZE		2	2
		REACTION		+	+
	LEFT	SIZE		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 Respons

+ Intact
- Abnorma

VASCULAR ASSESSMENT

HOURS		
	R	
	L	
	R	
	L	
	R	
	L	
	R	
	L	
	R	
	L	

LEGEND

++ Norma
+ Weak
- Absen
D Dopple
R Right
L Left

ITIAL SHIFT ASSESSMENT

b(6)-2

		Time: 0630 Initals: [redacted] b(6)-2	Time: 1820 Initals: [redacted]
NEURO	Pupils	2-3 mm Reactive Brisk	3 mm reactive & brisk
	Sensorium	Aox3, Can verbalize needs	A+Ox3, can verbalize needs in English
	LOC / GCS		
CARDIAC	Cardiac Rhythm	Sinus Tach, rate 130's	ST @ 129
	PRI / QRS:		
	Pulse Strength	+3 pulses throughout	3+ pulses x4 extremities
	Cap Refil / JVD	cap refill < 3sec x 4 extremities	< 3 sec x4 extremities
	Edema	Ø edema	⊖ edema, ⊖ JVD
	Chest Pain		⊖ CP
RESP	Respiratory Pattern	even non-labored, CTA Ⓑ	RRR, even & unlabored.
	Breath Sounds	O_2 via NC @ 2LPM SpO_2 95%	CTA to all lobes
	Secretions	Ø	⊖ secretions, ⊖ cough
	Cough	Can cough, non productive	RA, SaO_2 94-96%
SKIN	Color	normal for race	normal for race
	Integrity	Abd staples intact Ø s/s infection	ABD staples, intact ⊖ s/s infection
	Backside	Ⓡ chest wall - minimal	Ⓡ flank DRSG, CDI
IV	Access Devices	Ⓛ AC -18g,	Ⓛ AC - 18G - NS c̄ 20k @ 100 cc/HR
	Location	Ⓡ forearm - 18G,	⊖ s/s infiltration
	Condition	Both sites C/D/I	Ⓡ FA - 18G - SL, patent - ⊖ s/s infiltration
GI	Abdomen	↓ BS x 4 Quadrants	⊖ BS x4 quads.
	Bowel Sounds	ND, ⊖ TTP, soft	soft non-distended tender
	Stoma/Ostomy		⊖ N/V, ⊖ flatus, ⊖ BM NG to LIS - green fluid
GU	Device	Foley to gravity	Foley to gravity 16 FR
	Color / Clarity	clear yellow	clear amber urine

[redacted] b(6)-2 556

DEPARTMENT/SERVICE/CLINIC (b)(6)-2 [redacted]

DATE 21 Sep 03

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

NAME: [redacted] RANK: AGE:

UNIT: [redacted] b(6)-4 GENDER:

STATUS: US: AD / CIV IRAQI: CIV / EPW

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, MAY 78

USAPPC V2.00

MEDCOM - 19958

37 y/o ♂ — Report VS q 2° Antibiotic Therapy — 21 – 22 SEPT 03

PT'S NAME: EPW [redacted] b(6)-4

H.D. 19 SEPT 2150

O VS ③ vital signs

Neuro: Infect

CV: ST—AC 18 G x2 — Ancef 2gm, Flagyl 500mg

RL Coarse wheezes

GI: BS q 1°, NG LIS — Zantac 50mg, NPO

GU: F/C 16Fr

DATE:

	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
BP INV																								
BP NIBP		140/78	142/93	146/78	140/76	139/83	137/80	135/[illegible]	133/56	12[illegible]/76	156/75	124/79	142/71	12[illegible]/67	155/82	136/79	134/82	132/64	124/83		123/80		134/46	
TEMP		99.6	100.8	101.3	101.3	101.7	101.9	101.5	101.7	100.[illegible]	101.0	101.8	101.4		100.8	99.9	99.8	99.9	100.2		99		100.[illegible]	
PULSE		135	132	133	130	128	135	130	140	124	123	127	132	129	120	122	123	117	111		97		104	
RESP		24	22	30	30	32	12	20	24	24	24	30	27	22	28	24	24	22	27		33		30	
SP02		96	96	96	97	93	95	94	97	95	95	94	94	94	94	96	96	94	95		96		97	
FIO2		2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	RA	RA	RA	2LNC	2LNC	RA	2LNC		2LNC		2LNC	
Pain																								
INPUT																								
D5½NS TKO Rate	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	
Ancef		50								50								50						
Flagyl		100								100							100							
Zantac		50								50								50						
PAIN MEDS																								
PO																								
NGT																								
O.R. IN																								
SUB TOTAL																								
TOTAL	100	400	500	600	700	800	900	1000	[illegible]	1400	1500	1600	1700	1800	1900	2000	2230	2400	2500	2600	2700	2800	2900	
OUTPUT																								
URINE	75	75	75	75	75	75	75	75	75	75	75		125		175		200	120	80	150	130	—	80	
NGT		50	Ø	100	Ø	50	Ø	Ø	Ø	Ø	Ø		200	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø		
STOOL																								
O.R. OUT																								
SUBTOTAL																								
TOTAL	75	200	275	350	525	600	725	800	875	950	1050		1375		1550		1750	1870	1950	2100	2230	2230	2310	
BALANCE																								

MEDCOM - 19959

PT'S NAME: [redacted] b(6)-4

DATE: 22Sep03-23Sep03

O2 > 90% Keep off NC

	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05
BP INV	142/		143/																				
BP NIBP	/80		/83																				
TEMP	100.5		100.5																				
PULSE	101		103																				
RESP	23		29																				
SP02	94		92																				
FIO2	RA		RA																				
INPUT																							
IV																							
PO																							
NGT																							
O.R. IN																							
SUB TOTAL																							
TOTAL																							
OUTPUT																							
URINE	350																						
NGT																							
STOOL																							
O.R. OUT																							
SUBTOTAL																							
TOTAL																							
BALANCE																							

MEDCOM - 19960

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]	blk 2	INITIALS		INITIALS
NEURO		PUPILS	Perrla 2m					
		SENSORIUM	Lethargic					
RESPIRATORY		RESPIRATORY PATTERN	Equal rise + fall of chest					
		BREATH SOUNDS	Clear B. Lat					
		SECRETIONS	∅					
SKIN		COLOR	Normal					
		INTEGRITY	ABD Gunshot wound x3					
IV SITE		LOCATION	(L) AC, (R) AC					
		CONDITION	∅ Sign of infection Pt. teeth					
GASTRO		ABDOMEN	Gunshot wound x3					
		BOWEL SOUNDS	unable to assess due to dog.					
GU		URINE:	Foley + UO Sufficient					
		COLOR/CLARITY	Clear + yellow					
CARDIOVASCULAR		CARDIAC RHYTHM	Sinus tach.					

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] blk-2

DEPARTMENT/SERVICE/CLINIC ICU HD

DATE 23 Sep

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

EPW # [redacted] blk-4

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

DATE | DX | HOSPITAL DAY

		06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22
VITAL SIGNS	TIME																	
	BP Arterial Line																	
	BP Cuff																	
	Temperature																	
	Pulse																	
	Respiratory Rate																	
		@																
INTAKE	TIME	06	07	08	09	10	11	12	13	~~14~~	15	16	17	18	19	20	21	22 ~~23~~
	LR																	
	Antef																	
	Flush																	
	TOTALS																	
OUTPUT	URINE — HOUR / TOTAL																	
	URINE — sp gr																	
	URINE — S/A																	
	NG — OUTPUT																	
	NG — pH																	
	NG — GUIAC																	
	EMESIS																	
	STOOL																	
	DRAINS																	
	TOTALS																	

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS

	23	24	01	02	03	04	05
	114/68	110/84	120/90	104/82	116/80	119/80	117/81
	98			98			
	110	112	118	114	120	124	123
	29	28	24	20	15	13	17
	100	100	96	97	98	100	97
	2L	2L	RA	RA	2L	2L	2L

INTAKE

	23	24	01	02	03	04	06	06	8° T
	150	150	150	150	150	150	150	150	
		50							
			100						
	150/150	200/150	250/150	150/150	150/150	150/150	150/150	150/150	

OUTPUT

			500					
			800					

RESPIRATORY

	TIME									
	MODE									
	F_iO_2									
	TV									
	RATE									
	PEEP									
A	pH									
A	PCO_2									
	pO_2									
B	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									

TURN

TIME						

SUCTION

24°I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV	_____	Urine:	_____
po	_____		_____
	_____		_____
TOTAL	_____	TOTAL	_____

BALANCE _____

[redacted]

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.)	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
[redacted]	I Z	[redacted]	EPW [redacted] b(a)-4		m

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
	37y	Z	9	unk

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
	N/A	99	b(6)-4 [redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
N/A	U	2150	N/A

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
	K 7 8	

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION YEAR / NO
			☑ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
0	ICU1	

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
[redacted] b(2)-2		

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
50		030930

24. CLINIC SVC · ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
ABAA		030919

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYMMDD)

FOR LOCAL USE

Dx: GSW Abd. Trauma Surgery

86351 Proc 1: 450

[redacted] 86402 4573

E9912

ADM[redacted]uired) b(6)-2

SIGNATURE OF ADMITTING CLERK [redacted]

DA FORM 2985, MAR 89 MEDCOM - 19964 USAPPCV1.0

INPATIENT TREATMENT RECORD COVER SHEET

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

1.	2. NAME (Last, First, MI)	3. GRADE	ADMISSION REMARKS
[redacted]	CIV # [redacted] b(6)-4	CIV	

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	28y	UNK	UNK	—	—	N

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
99	[redacted]	—	ICU2

15. FLYING STATUS	16. OSG	17. DEPT./BEN	18. BRANCH/CORPS	18. UIC/ZIP	20. TYPE CASE
—	—	K91 K7Q	—	—	WIA

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
05 direct from ER	2112	AEAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
UNK	d/c	25 Sep 03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
UNK	UNK	20 Sep 03	

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
[redacted] b(2)-2		

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Shrapnel ① forearm, ② chest & ③ leg, Grade II open ① ulna fx

903.3
955.2
813.92
891.1
880.12
E-993

21 Sep 03
28.82
86.28
86.59
93.54

23 Sep 03
86.28
79.62
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
Ø	Ø	Ø	Ø	5	5

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]	b(6)-2	[redacted]		

SIG [redacted] CPT [redacted]

DA [redacted] MEDCOM - 19965

USAPPC V1.10

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

28yo ♂ Iraqi civilian
ambushed @ ~9AM today.
Shrapnel to (L) Forearm (R) Leg, (L) chest/flank.
c/o numb ulnar (L) hand/weakness.
Seen initially @ Iraqi hospital → Tfered. ∅ procedure performed there per his Hx. presents in LUE post splint, (R) leg post splint.

NKDA ∅ pmedHx ∅ psurgHx.

PHYSICAL EXAMINATION

AAOX3 NAD
SUBER adult sheet PE
Focused: LUE: Complex lac/entrance + exit wound dorso/ulnar forearm c exposed tendons. ⊖ intrinsics. ⊖ ulnar sensation. palpable radial pulse. otherwise NVI
RLE - NVI entrance/exit wounds posterior to midline mid leg. compartments soft. palp DP/PT. intact sensation. ∅ active bleeding.

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

Admit
to OR for I/D of wounds today. High Risk infection (known 9° out from injury). Ulnar NV is out.. will explore. I/D for now, will require reconstruction @ future operative sittings.

b(6)-2

[redacted] CPT. | DATE 20Sept03 | IDENTIFICATION NO. | ORGANIZATION
(written entries give Name last, first, middle; grade; date; hospital or medical facility)
REGISTER NO. | WARD NO.

2108

[redacted] b(6)-4

Iraqi Civilian.

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 - 19966

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
21Sept03 1000	ORTHO prep ex. shrapnel (L) forearm / (R) leg / (L) chest poster ex: same I/D + splint. GETA Qcomp ESI 100 to PR Stable. - Ulnar NV WAD continuous. - Ulnar artery traumatically interrupted by shrapnel & ligated. palpable radial pulse [redacted] b(6)-2
22Sept03 0902	ORTHO POD#1 ~~prep ex~~ QC/O's. AFUSS XRay - ulnar. NV clinically out (same as prev) Splint c/o/i Stable to OR tomorrow for repeat I/P + Boat [redacted] b(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERV	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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
23Sept03 1026	Ortho Op note Preop Dx: Soft tissue shrapnel wound (R) leg Grade II open (L) Ulna Fx 2° shrapnel postop Dx: same repeat I/D both injuries + Abx beads [redacted] b(6)-2 GETA Pcamp to RR Stable
24Sept03	Ortho POD # 1/4 Pt new c/o NPWS exam unch'd Stable Await disp Cont IV Abx

[redacted] b(6)-2

[redacted] b(6)-2

RELATIONSHIP TO SPONSOR | SPONSOR'S LAST | FIRST | MI | (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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
25 Sept 03	ortho Pod # 2/5 @ new cpos. AF VSS Ulnar claw ↓ sensation ulnar 2 digits. - claw / ↓ sens 2° Ulnar NV injury + scar/damage to ulnar extremities. Stable from preop. - D/C on keflex tomorrow - will need to F/U with cardiac doc for recostr. have written detailed D/C summary.

[redacted]

b(6)-2

STANDARD FORM 509 (REV. 5/1998) BACK
USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

25sept03 0900

Discharge Summary

28 yo male Iraqi civilian admitted 20 sept 03 with shrapnel injury to left forearm. Suffered grade II open Left Ulna fracture with segmental loss of 4cm Ulna, blast contusion to Ulnar nerve with subsequent Ulnar nerve palsy (Ulna nerve was found to be contuscos, though), traumatic injury to Ulnar artery. Was taken to the OR on 21sept03 for I/D. Again went to OR on 23sept03 for I/D with placement of antibiotic impregnated beads at that time (tobramycin). was able to close entrance wound on dorsal forearm, but volar wound is still open (about 3cm in diameter). he was on IV kefzol while in-house here. remained Afebrile.

Also suffered soft tissue injury to Right leg (entrance laterally, exit medially) without Neuromuscular compromise was able to close medial wound, but lateral wound would not close - Approx 3cm in diameter

→ over.

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

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]

blw-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
15Sept03	Discharge Summary, cont.

Discharge Medication:
- Keflex 500 mg po QID x 7d.
- percocet as needed for pain.

Disposition: Grade II open (C) ulna fx c segmental loss and ulnar nv palsy.
- Discharged in sugartong splint with antibiotics x 7 days
- will need splint off and sutures out in 10 days.
- would consider ulnar reconstruction once skin is closed over and he proves to be free of infection
- consider bridge plating ulna with fibular graft versus iliac crest bone graft for reconstruction.
- Ulnar nv function may or may not return.

will D/C to civilian care to arrange potential reconstruction.

b(6)-4

[redacted]

b(2)-2

STANDARD FORM 509 (REV. 5/1999) BACK
USAPA V1.00

Bed 5

b(2)-7

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT (Patient)

Law

NSN 7540-01-075-37

LOG NUMBER | TREATMENT FACILITY [redacted]

RECORDS MAINTAINED AT [redacted]

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

ARRIVAL

DATE (Day, Month, Year): 20 Sep 03 | TIME: 1958

TRANSPORTATION TO FACILITY

SEX: M

AGE: 28

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

INJURY OR OCCUPATIONAL ILLNESS

ITEM	YES	NO	WHEN (Date)
IS THIS AN INJURY?			
INJURY/SAFETY FORMS			WHERE
HOW			

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INTITIAL SERIES ☐ YES ☐ NO

ALLERGIES: NKDA's

CHIEF COMPLAINT: Mult. GSW

CATEGORY OF TREATMENT

☐ EMERGENT
☒ URGENT
☐ NON-URGENT

TIME: 2000

INITIALS: [redacted]

VITAL SIGNS

TIME	2000	2110			
BP	155/96	145/97			
PULSE	103	68			
RESP	20	16			
TEMP oral	100.0				
WT		206 lbs			

2010

LAB ORDERS

- ☒ CBC/DIFF
- ☐ ABG
- ☐ PT/PTT
- ☒ URINE C&S
- ☒ UA/SCC/CATH
- ☐ BHCG/URINE/BLOOD/QUANT
- ☐ BLOOD C&S X
- CHEM: 12 lytes
- Type & Screen

X-RAY ORDERS

- ☒ CXR PA & LAT ~~PORTABLE~~
- ☐ ACUTE ABDOMEN KUB
- ☐ SINUS
- ☐ ANKLE R/L
- ☐ C-SPINE
- ☐ LS SPINE
- ☐ HEAD CT
- (R) Leg (L) arm
- (R) Pelvis

☐ PULSE OX

ORDERS

☐ MONITOR

TIME	ORDERS	BY	COMPLETED BY	TIME
	Bolus 2 L NS		b(6)-2	2010
	Cefazolin 500mg IV		[redacted]	2016
	Ancef 1g IV			2030
	Tetanus IM			2035

☐ ECG

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)

Civilian

[redacted]

b(6)-4

[redacted]

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 [redacted]

TEST RESULTS

CBC		SMAC	ABG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐
	WBC 11.2	139 | 104 / 16 4.4 | 24 / .9 > 107	SUP O2	PH	PO2	RESULTS	GSW open comminuted (L) ulnar fx
	H/H 14.2/43.2		PCO2	SAT	OTHER		
	PLT 328		U/A DIP			EKG INTERPRETATION	
PT		CK 2746	U/A MICRO				
APTT		BHCG | ETOH | GLU					

PROVIDER HISTORY/PHYSICAL

28 y/o ♂ s/p GSW approx 8° ago to (L) arm/flank/(R) leg. Seen @ Iraqi hospital

ø operation

(+) language barrier

~~Zg Aorf~~ [redacted]

O: A&O x1 vs mm distress. VS as above

HEENT: OP/NP clear/pink, mm moist, neck supple, NT, atraumatic, eyes clear/dry

Chest: CTA(B) = CV: RRR (-)C/G/F Abd soft, NT on deep palp

(+) GSW (L) mid axillary line T-11 ×2 (L) axillary surround

Ext: 5/5 lower ext strength, N/V intact (L) GSW (R) calf, ø active bleed

Open wound (L) volar forearm c̄ exposed

A/P GSW (L) ulna c̄

→ ICW 2

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND [redacted] b(6)-2

PROVIDER SIGNATURE AND ST[redacted]

DIAGNOSIS (1) GSW (L) arm/(R) leg/(L) flank

CODES

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

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

For use of this form, see MEDCOM Circular 40-5

[redacted]

SECTION I - PATIENT ASSESSMENT

DATE: | PATIENT ACUITY LEVEL : | POST-OP DAY: | HOSPITAL DAY:

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time 2120 To ICW2 From ____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☑ STRETCHER

Total ER/RR/PACU time ____ Physician ____ Anesthesia (Specify): ____

Procedure/Diagnosis GSW BLE, DFA, Dchest B/P 145/47 P 68 R 16 T ____

LOC ____ Neurovascular checks ____

Dressing/cast ____ Tubes ____

Intake (IV, po): ____ Output (EBL, other) ____ Voided ☐ No ☐ Yes Amount: ____

Medication Fentanyl, Kacef

Other ____

Report From LT [redacted] Received By LT McLean

VITAL SIGNS

TIME:	2130	0400	0740													
BP ARTERIAL LINE		/														
BP CUFF	148/76	145/76	139/74													
TEMPERATURE	99 F	98.4	98.5													
PULSE	86	95	103													
RESPIRATORY RATE	16	20	18													
OXYGEN (L/%)	—	/	/													
PULSE OXIMETER	98	99	96													
O2 METHOD	RA		RA													

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	2130								
PAIN INTENSITY (10 / 5 / 0)	X								
MED ADMINISTERED (Y/N)									
RELIEF ACCEPTABLE (Y/N)									

OTHER

TIME:									
FINGER STICK GLUCOSE									
INSULIN (Y/N)									

SPECIAL NEEDS

TIME:	2300		
*Skin breakdown prevention	N/A		
*Falls prevention protocol			
*Restraint protocol			
*Seizure precautions			
*Isolation precautions			

YESTERDAY'S WEIGHT: ____

TODAY'S WEIGHT: ____

WEIGHT CHANGE: ____

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

[redacted] blw-4

DIAGNOSIS: GSW BLE, DFA, Dchest

DRG: ____ ADMISSION DATE: ____

LOS: ____ EXPECTED RELEASE: ____

CASE MANAGER: ____

PRIMARY CARE MANAGER: ____

ISOLATION REQUIRED (Specify): ____

MEDCOM - 19974

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column. [redacted] b(6)-2

	TIME: 2300 INITIALS: [redacted]	TIME: INITIALS:	TIME: INITIALS:
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑	☐	☐
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☐	☐
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☐	☐
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☐	☐
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑ voids S a/o	☐	☐
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ (L) FA c Kerlix dsng (R) leg c open dime shape around	☐	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☑ (B) chest c dsng	☐	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☑ c/o pain @ 1801130 given 4mg MSO4	☐	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☐	☐

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 2300 INITIALS: (P)	TIME: INITIALS:	TIME: INITIALS:
IV patency ✓ q 8 hr:	IV patency ✓ q ___ hr:	IV patency ✓ q ___ hr:
IV site care provided:	IV site care provided:	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION CONDITION	LOCATION CONDITION	LOCATION CONDITION
IV Site #1: (R) FA OK	IV Site #1:	IV Site #1:
IV Site #2:	IV Site #2:	IV Site #2:
Comments: LR @ 100cc/hr	Comments:	Comments:

(R) leg (L) chest (L) FA

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: 2300 TIME: 2300						
COLOR	P					
CAPILLARY REFILL	2					
TEMPERATURE	W					
EDEMA	1					
SENSATION	S					
MOTION	P					
PASSIVE FLEXION	P/D					
PERIPHERAL PULSE	2					

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

TIME: 2300						
ID band visible/legible	[redacted]					
Orient to environment pm	[redacted]					
Side rails (2/4) up						
Bed position low						
Call light within reach						

OTHER

Review & post lab results						
Notify MD abnormal labs						
Incontinent urine/stool						
Linen change pm						
Turn/reposition q2h						
ROM q2h if immobile						
Antiembolic hose						

DIET

BREAKFAST	LUNCH	DINNER
TYPE:	TYPE:	TYPE:
PERCENT CONSUMED:	PERCENT CONSUMED:	PERCENT CONSUMED:
HOW TOLERATED:	HOW TOLERATED:	HOW TOLERATED:
☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST ☐ SELF AMBULATE ☐ ASSIST BSC BRP # TIMES/SHIFT CHAIR b(6)-2	BEDREST ☐ SELF AMBULATE ☐ ASSIST BSC BRP # TIMES/SHIFT CHAIR	BEDREST ☐ SELF AMBULATE ☐ ASSIST BSC BRP # TIMES/SHIFT CHAIR

TEACHING

TIME: 2300 INITIALS: [redacted]	TIME: INITIALS:	TIME: INITIALS:
CONTENT: NPO Orientation to staff Pain management Plan of care Call for assistance	CONTENT:	CONTENT:
☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION [redacted] b(6)-4

INITIALS	SIGNATURE	SHIFT
[redacted]	[redacted] 9/WMC	N

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE

TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
2300	Chest RFA Rleg	Groin CDI Groin c Mod amt of bloody drainage Sweater	assessed

SECTION IV - NOTES

2130: Admitted to ICW2 from EMT, NKDA, VSS, No [redacted] or discomfort @ this time, will monitor. —

2300 - pt care assumed @ 2300, pt awaiting OB. pt resting @ this time. Will cont to monitor — [redacted] nurse

b(6)-2
ATI

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

For use of this form, see MEDCOM Circular 40-5

SECTION I - PATIENT ASSESSMENT

DATE: 21 Sept 03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: | HOSPITAL DAY: 2

PERTINENT DATA

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (*Specify*): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	1355	1600	2000	0400 (22 Sep)	0800										
BP ARTERIAL LINE															
BP CUFF	146/85	130/100	109/50	144/63	132/82										
TEMPERATURE	97.5	99.1	99.5	99.2	100.8										
PULSE	92	100	101	98	97										
RESPIRATORY RATE	16	16	12	16	16										
OXYGEN (L/%)															
PULSE OXIMETER	98%	97%	96%	98	95%										
O_2 METHOD	RA	RA	RA	RA	RA										

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	0730	1430	1600	2000	2230				
PAIN INTENSITY (10 / 5 / 0)	6	5	X		X				
MED ADMINISTERED (Y/N)	Y	Y		NA	Y				
RELIEF ACCEPTABLE (Y/N)	Y	Y			Y				

OTHER

TIME:									
FINGER STICK GLUCOSE									
INSULIN (Y/N)		N/A							

SPECIAL NEEDS

TIME:	1430	2230
*Skin breakdown prevention	NA	NA
*Falls prevention protocol		
*Restraint protocol		
*Seizure precautions		
*Isolation precautions		

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

#[redacted]

b(4) -4

DIAGNOSIS: GSW RLE, (L) FA, @ chest SIP 1 ED

DRG: _____ ADMISSION DATE: 20 Sept 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: _____

ISOLATION REQUIRED (*Specify*): _____

MEDCOM - 19978

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column. b(6)-2

	TIME: 0730 INITIALS: [redacted]	TIME: 1430 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted] b(6)-2
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑	☑	☑ speaks a little English
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☑	☑
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☑
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☐ Bowel sounds hypoactive.	☑
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☑	☑
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ moved slow	☐ Pain upon movement of RUE.	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ Dsg to (L) arm (L) backside & (R) Leg.	☐ 5 shrapnel wounds to (L) arm, (L) chest, & (R) leg. Dsgs, CD+I	☐ (L) arm, (L) side & chest et (R) leg c dressings
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐ Gave MSO4 for pain	☐ c/o moderate pain in (L) arm. MSO4 4mg IV given	☐ c/o pain @ 2230 given ☥ percocet
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☑

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 0730 INITIALS: [redacted]	TIME: 1430 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
IV patency ✓ q ___ hr:	IV patency ✓ q 8 hr:	IV patency ✓ q 8 hr:
IV site care provided:	IV site care provided:	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: (R) forearm / OK	IV Site #1: (R) FA / ok	IV Site #1: (R) FA / OK
IV Site #2:	IV Site #2:	IV Site #2:
Comments: LR @ 100cc	Comments: LR @ 100 cc/hr.	Comments: HL'd

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: / TIME:							
COLOR							
CAPILLARY REFILL							
TEMPERATURE							
EDEMA							
SENSATION							
MOTION							
PASSIVE FLEXION							
PERIPHERAL PULSE							

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(> 5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

TIME:	0730	1430	2230
ID band visible/legible	[redacted]		
Orient to environment pm			
Side rails (2/4) up			
Bed position low			
Call light within reach			

OTHER

Review & post lab results			
Notify MD abnormal labs			
Incontinent urine/stool	[redacted]		
Linen change pm			
Turn/reposition q2h			
ROM q2h if immobile			
Antiembolic hose			

DIET

BREAKFAST	LUNCH	DINNER
TYPE: NPO	TYPE:	TYPE:
PERCENT CONSUMED:	PERCENT CONSUMED: 0%	PERCENT CONSUMED:
HOW TOLERATED:	HOW TOLERATED:	HOW TOLERATED:
☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☑ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	(BEDREST) AMBULATE BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT	(BEDREST) AMBULATE BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT	BEDREST AMBULATE BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT

TEACHING

TIME: / INITIALS:	TIME: 1430 / INITIALS: [redacted]	TIME: 2230 / INITIALS: [redacted]
CONTENT: Pain control	CONTENT: Plan of Care. Pain meds.	CONTENT: pain management plan of care
☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION [redacted] b(6)-4

INITIALS	SIGNATURE b(6)-2	SHIFT
[redacted]		

MEDCOM 19080

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND PROBE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	1430	ⓁUE, Ⓓchest, Ⓡleg	Sm amt. serosanguinous drainage noted to Ⓓchest, others CDI	Reinforce PRN
	2230	ⓁUE Ⓓchest ⓇLeg	Ⓐ splint & ace wrap - CDI dressing CDI splint/ace wrap CDI	ammed

SECTION IV - NOTES

1200 - Pt received from PACU via Gurney. VSS, Lungs CTA, HR reg, BS⊕. Dsg to Ⓛarm & Ⓡlower extremity CDI ⊕ sensation, able to move digits, warm to touch. Dsg intact to Ⓛ side. IV LR@100 to Ⓡ forearm. Crave 4mg MSO4 for pain. Pt sleeping [redacted] now. Will cont. to monitor. [redacted]

1430: Asleep, easily aroused to pain in Ⓛarm, MSO4 4mg IVP given. Splint to Ⓛarm. Good cap. refill, fingers warm to touch. Will continue to monitor. [redacted]

b(6) - 7

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

For use of this form, see MEDCOM Circular 40-5

SECTION I - PATIENT ASSESSMENT

DATE: 22 Sept 03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 2 | HOSPITAL DAY: 3

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (*Specify*): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	0730	1600	2000	2400	0400											
BP ARTERIAL LINE																
BP CUFF	144/72	85/66	123/48	130/71	100/60											
TEMPERATURE	100.4	99.6	100.9	99.3	100.7											
PULSE	103	85	105	88	106											
RESPIRATORY RATE	22	20	20	16	16											
OXYGEN (L/%)	✓		✓													
PULSE OXIMETER	98%	98%	96%	98	96											
O_2 METHOD	RA	RA	RA	RA												

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	0730	1500	1600	2000	2230				
PAIN INTENSITY (10 / 5 / 0)									
MED ADMINISTERED (Y/N)	N	N		NA	N				
RELIEF ACCEPTABLE (Y/N)		NA			NA				

OTHER

TIME:									
FINGER STICK GLUCOSE									
INSULIN (Y/N)		N/A							

SPECIAL NEEDS

TIME:	1500	2230
*Skin breakdown prevention	NA	NA
*Falls prevention protocol		
*Restraint protocol		
*Seizure precautions		
*Isolation precautions		

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

[redacted]

blood-4

DIAGNOSIS: GSW ® LE, ORIF, ® chest, S/P I&D

DRG: _____ ADMISSION DATE: 20 Sept 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: _____

ISOLATION REQUIRED (*Specify*): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

	TIME: 0730 INITIALS: [redacted]	TIME: 1500 INITIAL[redacted]	TIME: 2230 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑ Speaks a little English	☑ bLW-2	☑
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☑	☑
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☑
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☑	☑
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☑	☑
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ Weak gait Splint d ALE Wrap to (L) arm & (R) leg	☐ Generalized weakness Dsg to (R) leg & arm, ↓ ROM to those extremities	☐ Dsg to (L) arm CDI, able to move fingers, transp pulses, brisk cap refill Dsg to (R) leg CDI & able to move toes, same pulses & brisk cap refill
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ Small wounds to (R) arm & abd.	☐ wounds to (L) arm & (R) leg - Dsgs CD+I. small wounds to (L) chest, dsgs CD+I.	☐ Small wound dsg to (L) side of chest CDI
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☑	☑ c/o sm amt. pain states medication is not needed @ this time.	☑
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☑

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 0730 INITIALS: [redacted]	TIME: 1500 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
IV patency ✓ q ___ hr:	IV patency ✓ q 8 hr:	IV patency ✓ q 8 hr:
IV site care provided:	IV site care provided:	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: (R) arm / OK	IV Site #1: (R) FA / OK	IV Site #1: (R) FA / OK
IV Site #2:	IV Site #2:	IV Site #2:
Comments: HL	Comments:	Comments: LR @ 100° TPMW
IV Antibiotics		

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: RLE RLUE TIME:	1500	2230				
COLOR	P	P/P				
CAPILLARY REFILL	1	1/1				
TEMPERATURE	W	W/W				
EDEMA	0	0/0				
SENSATION	S	S/S				
MOTION	M	M/M				
PASSIVE FLEXION	0	0 knee to toes				
PERIPHERAL PULSE	2	2P/DP				

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY / OTHER

	TIME:	0750	1500	2230
SAFETY	ID band visible/legible	[redacted]		
	Orient to environment prn	[redacted]		
	Side rails (2/4) up			
	Bed position low			
	Call light within reach			
OTHER	Review & post lab results			
	Notify MD abnormal labs			
	Incontinent urine/stool			
	Linen change prn			
	Turn/reposition q2h			
	ROM q2h if immobile			
	Antiembolic hose			

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Regular	TYPE:	TYPE:
PERCENT CONSUMED: 100%	PERCENT CONSUMED:	PERCENT CONSUMED:
HOW TOLERATED: well	HOW TOLERATED:	HOW TOLERATED:
☐ SELF ☒ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☑ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	(BEDREST) AMBULATE BSC BRP (CHAIR) ☐ SELF ☐ ASSIST # TIMES/SHIFT	~~BEDREST~~ AMBULATE BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT	(BEDREST) AMBULATE BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT

TEACHING

TIME: 1500 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]	TIME: INITIALS:
CONTENT: Plan of Care, Pain meds,	CONTENT: Call for assist NPO p MN Fluids p MN	CONTENT:
☑ (Patient/Family Verbalizes Understanding)	☐ Patient/Family Verbalizes Understanding	b(6)-2 A71 ☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
b(6)-4 C[redacted]	[redacted]	[redacted]	[redacted]

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	1500	(L)arm, (L)chest, (R)leg	Dsgs. CD&I	NA
	2230	(L)arm (L)chest (R)leg	DSgs CDI	assessed

SECTION IV - NOTES

1500: A&Ox3. C/o mild pain - states does not need pain medication @ this time. Body guard @ bedside. —— [redacted] RN

22Sep03 2230 Pt sleeping, easily arousable to verbal stimuli. Ø C/O pain. Pt concerned she might have a temp, temp checked was 99! To go to OR tomorrow. Will continue to monitor —— [redacted] RN

b(4)-2

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

For use of this form, see MEDCOM Circular 40-5

SECTION I - PATIENT ASSESSMENT

DATE: 23 Sep 03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 3 | HOSPITAL DAY: 4

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (Specify): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	2400	0800	1105	1600	2000	2400	0400									
BP ARTERIAL LINE																
BP CUFF	137/71	143/86	155/200	110/20	129/63	127/62	137/71									
TEMPERATURE	99.3	98.3	97.5	97.4	98.2	98.7	98.0									
PULSE	88	93	97	88	93	90	90									
RESPIRATORY RATE	16	20	20	20	18	20	16									
OXYGEN (L/%)																
PULSE OXIMETER	98	96	95%	97%	97%	96	97									
O2 METHOD		RA	RA	RA	RA											

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	1110	1130	1200	1600	2000				
PAIN INTENSITY (10 / 5 / 0)									
MED ADMINISTERED (Y/N)	Y	Y	Y	N	N				
RELIEF ACCEPTABLE (Y/N)	Y	Y	Y	Y					

OTHER

TIME:									
FINGER STICK GLUCOSE									
INSULIN (Y/N)									

SPECIAL NEEDS

TIME:	0830	1600	2330
*Skin breakdown prevention	Q	NA	NA
*Falls prevention protocol	NA		
*Restraint protocol	NA		
*Seizure precautions	[redacted]		
*Isolation precautions	NA		

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

Civ [redacted] blk-4

DIAGNOSIS: GSW ®LE, ⓛFA, ⓒChest S/P I&D

DRG: _____ ADMISSION DATE: 20Sep03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: _____

ISOLATION REQUIRED (Specify): _____

MEDCOM - 19986

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

	TIME: INITIALS:	TIME: 1600 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑	☑	☑
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☑	☑
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑ Cough Sleep Breathing Encamped	☑
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☑	☑
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☑	☑
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ (R) Left splinted (L) HAND/ARM splinted	☐ (R) LE splinted c ACE, COC (L) LE splinted c ACE, COC	☐ (R) LE c splint & ace wrap COI (L) LE c splint & ace wrap COI
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ PELLETS in (R) ARM & (L) SIDE of CHEST	☐ Abrasions to (L) arm & (L) chest. Ø day	☐ abrasions (L) chest & R arm
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☑	☑	☑
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑ Brother in room c pt.	☑

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 0800 INITIALS: [redacted]	TIME: 1600 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
IV patency ✓ q ___ hr: RA	IV patency ✓ q 8 hr:	IV patency ✓ q 8 hr:
IV site care provided:	IV site care provided:	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: IV. FOR / OK	IV Site #1: (R) FA / OK	IV Site #1: (R) FA / OK
IV Site #2:	IV Site #2:	IV Site #2:
Comments: PT DUE FOR OR	Comments: LR @ 100 c/hr	Comments: LR @ KVO c/hr

CIV [redacted] 1/10/4

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: (R) Arm, (R) Leg TIME:	0830	1500	2230			
COLOR	N	P	P			
CAPILLARY REFILL	1	1	1			
TEMPERATURE	W	W	W			
EDEMA	2	1	1			
SENSATION	S	S	S			
MOTION	P	P	P			
PASSIVE FLEXION	0	—	—			
PERIPHERAL PULSE	2	unable to assess				

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

TIME:	0830	1500	2230
ID band visible/legible	[redacted]		
Orient to environment prn			
Side rails (2/4) up			
Bed position low			
Call light within reach			

OTHER

Review & post lab results	[redacted]		
Notify MD abnormal labs			
Incontinent urine/stool	[redacted]		
Linen change prn			
Turn/reposition q2h	[redacted]		
ROM q2h if immobile			
Antiembolic hose			

DIET

BREAKFAST	LUNCH	DINNER
TYPE: NPO	TYPE: ad lib.	TYPE: Regular
PERCENT CONSUMED:	PERCENT CONSUMED:	PERCENT CONSUMED: 50%
HOW TOLERATED:	HOW TOLERATED:	HOW TOLERATED: OK
☒ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	(BEDREST) AMBULATE BSC BRP CHAIR ☒ SELF ☐ ASSIST # TIMES/SHIFT	BEDREST AMBULATE BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT b(6)-7	BEDREST AMBULATE BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT

TEACHING

TIME:	INITIALS:	TIME: 2230	INITIALS: [redacted]	TIME:	INITIALS:
CONTENT: 1. TO REPORT TIGHTNESS IN CAST 2. TO ASK FOR PAIN MED WHEN RETURN FROM OR.		CONTENT: pain management plan of care call for assistance		CONTENT:	
☐ Patient/Family Verbalizes Understanding		☐ Patient/Family Verbalizes Understanding		☐ Patient/Family Verbalizes Understanding	

PATIENT IDENTIFICATION

Civ [redacted]
b(6)-4

INITIALS	SIGNATURE	SHIFT
[redacted] b(6)-2		b-2
	9 Wms	N

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE

TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	1. (L) ARM	FINGER SWOLLEN +1	SPLINT. CAST
	2. (R) LEG	SWOLLEN +1	SPLINT CAST

SECTION IV - NOTES

0830 Pt alert and oriented x3. Pt able to communicate with use of minimal verbal contact and gestures. Pt able to sit-up in bed and perform ADLs with assistance. IV infusing as order. Due for OR today. V/S stable. [redacted] 1LWMC.

1100 Pt returned from [redacted] - V/S stable, alert and oriented x3. Pt medicated for pain, [illegible] 100 [illegible]. (L) arm and (R) leg in [illegible] bandage - with [illegible] splint for support. Pt able to tolerate PO fluids. No s/s of distress [redacted] Pt has cap refill in [illegible] < 2 sec. Skin warm [illegible] to touch. Pt able to dorsi and plantar flex extremities.

1200 Pt medicated for pain. [illegible] [redacted]

1300 Pt preferred to sleep. V/S stable. — [redacted] b(6)-2 A11

X-ray of (L) arm done, [illegible] at Pt bedside. [redacted]

1500 → Assumed pt care @ 1400. [redacted] [illegible]

2300 - pt c/o "(L) hand 3 digit & 4 digit feeling numb, c pain radiating ↑ arm. Pt given percocet @ 2215 by LT [redacted] Informed pt through interpreter that MD will be notified in am. Will cont to monitor [redacted] 91WMC

[redacted] b(6)-4

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

For use of this form, see MEDCOM Circular 40-5

SECTION I - PATIENT ASSESSMENT

DATE: 24 Sept 03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 4 | HOSPITAL DAY: 5

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia *(Specify)*: _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	0500	1600	2000	0400 (25 Sep)												
BP ARTERIAL LINE	—		—													
BP CUFF	149/79	140/80	161/69	137/78												
TEMPERATURE	98.2	98.4	100.6	98.3												
PULSE	101	88	101	84												
RESPIRATORY RATE	18	16	16	16												
OXYGEN (L/%)	—		—													
PULSE OXIMETER	97	97%	97%	97												
O2 METHOD	RA	RA	RA													

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	0800	1200	1600							
PAIN INTENSITY (10 / 5 / 0)	X		0	0						
MED ADMINISTERED (Y/N)	Y	Y	N	N/A						
RELIEF ACCEPTABLE (Y/N)	Y	Y								

OTHER

TIME:	1600	2000								
FINGER STICK GLUCOSE	N/A									
INSULIN (Y/N)			N	A						

SPECIAL NEEDS

TIME:	0800	1600	2400
*Skin breakdown prevention	Q	N/A	NA
*Falls prevention protocol	WA		
*Restraint protocol	NA		
*Seizure precautions	N [redacted]		
*Isolation precautions	NA		

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: N/A

WEIGHT CHANGE: _____

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

Civ [redacted]

blw-4

DIAGNOSIS: GSW R.E. (LFA, Chest

DRG: _____ ADMISSION DATE: 20 Sept 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: _____

ISOLATION REQUIRED *(Specify)*: _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

	TIME: 0800 INITIALS: [redacted]	TIME: 1600 INITIALS: [redacted]	TIME: 0020 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☐ MOVEMENT WITH ② FINGERS PAINFUL	☑	☑
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☑	☑
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☑
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☑	☑
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☑	☑
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ ② HAND ③ ELBOW IN SHORT CAST ROM ② PAIN	☐ ROM 5th, 4th digits ② hand, ① wrist. RLE in cast, ↓ ROM ® foot.	☐ ① arm in splint & ace wrap, 4 & 5th digits numb. RLE ⊃ splint & ace wrap
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐	☐ two wounds to ① chestwall.	☑
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐ PAIN [illegible] RUSH 7 PO MSOS RUSH	☑	☑ ck pain @ 0020 4mg MSO4 by LT walker EN
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☑

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 0800 INITIALS: [redacted]	TIME: 1600 INITIALS: [redacted]	TIME: 0020 INITIALS: [redacted]
IV patency ✓ q ___ hr: LK	IV patency ✓ q 5 hr: RN	IV patency ✓ q 8 hr: Pen
IV site care provided:	IV site care provided: assessed	IV site care provided: flushed
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: LT ® AM wnl	IV Site #1: HL ® FA OK	IV Site #1: ® FA OK
IV Site #2:	IV Site #2:	IV Site #2:
Comments:	Comments: HL	Comments: HL

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: (L) HAND (R) LEG TIME:	0800	1600	2400			
COLOR	P	P	P	P		
CAPILLARY REFILL	2	1	1	1		
TEMPERATURE	W	W	W	W		
EDEMA	2	2	0	0		
SENSATION	S	S	S	S		
MOTION	P	Ø	Ø	UØ		
PASSIVE FLEXION	P/D	Ø	Ø			
PERIPHERAL PULSE	2	Ø	Ø	Ø Ø		

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

	TIME: [redacted]		
SAFETY	ID band visible/legible		
	Orient to environment prn		
	Side rails (2/4) up		
	Bed position low		
	Call light within reach		
OTHER	Review & post lab results		
	Notify MD abnormal labs		
	Incontinent urine/stool		
	Linen change prn		
	Turn/reposition q2h		
	ROM q2h if immobile		
	Antiembolic hose		

DIET

BREAKFAST	LUNCH	DINNER
TYPE: regular	TYPE: regular diet	TYPE:
PERCENT CONSUMED: 80%	PERCENT CONSUMED: 100%	PERCENT CONSUMED:
HOW TOLERATED: well	HOW TOLERATED: well	HOW TOLERATED:
☐ SELF ☒ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST AMBULATE BSC BRP CHAIR ☒ SELF ☐ ASSIST # TIMES/SHIFT	(BEDREST) AMBULATE BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT	BEDREST AMBULATE BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT

TEACHING

TIME: INITIALS:	TIME: 1600 INITIALS: [redacted]	TIME: INITIALS:
CONTENT: 1. to report s/s of impaired circulation. 2. to request pain meds.	CONTENT: 1) Pain medication only 4-6°. Next dose @ 1645.	CONTENT:
☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION

INITIALS	SIGNATURE	SHIFT
[redacted]	[redacted] / CT/AN	
	[redacted] Qiuwm	[redacted]

b(6)-2

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
		ⓛ HAND	FINGERS SWOLLEN-2	SOFT CAST & SPLINT
		ⓡ LEG.	TOES SWOLLEN	SOFT CAST & SPLINT

SECTION IV - NOTES

0900 PT complained of pain at beginning of shift. PT given PO pain med. CT did ROM with assistance. PT ate breakfast tolerated well. PT ⓡ hand and ⓛ leg in soft cast with splint. PT elevated PT found rest after eating. PT asleep. PR

1400 PT complained of pain at lunch time especially in ⓛ arm medicated with percocet 5/325, PT able to manage pain as evident by nodding 'slightly' affirmative,

~~1600: Dressing to distal chest wall on ⓡ~~ [redacted]

1600: Dressing to ⓛ distal aspect chest wall removed and wound left OTA to heal. Dressing to medial aspect ⓡ CW [redacted] JAN

CDI.

b(6)-7 A11

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

For use of this form, see MEDCOM Circular 40-5

SECTION I - PATIENT ASSESSMENT

DATE: 25 Sep 03 | PATIENT ACUITY LEVEL: IIL | POST-OP DAY: 5 | HOSPITAL DAY: 6

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (*Specify*): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	0400	1200																
BP ARTERIAL LINE	/	/																
BP CUFF	133/78	134/77																
TEMPERATURE	98.3	98.2																
PULSE	84	93																
RESPIRATORY RATE	16	18																
OXYGEN (L/%)	/	/																
PULSE OXIMETER	97	99																
O2 METHOD	RA	RA																

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	0800	1200																
PAIN INTENSITY (10 / 5 / 0)	X	X																
MED ADMINISTERED (Y/N)	N																	
RELIEF ACCEPTABLE (Y/N)	N/A																	

OTHER

TIME:	0800																	
FINGER STICK GLUCOSE																		
INSULIN (Y/N)																		

SPECIAL NEEDS

TIME:	0800																	
*Skin breakdown prevention	N/A																	
*Falls prevention protocol	✓																	
*Restraint protocol																		
*Seizure precautions																		
*Isolation precautions																		

YESTERDAY'S WEIGHT: N/A

TODAY'S WEIGHT: /

WEIGHT CHANGE: /

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT
	N/A													

PATIENT IDENTIFICATION

C[redacted]

b(6)-4

DIAGNOSIS: GSW RLE, BTA, chest

DRG: _____ ADMISSION DATE: 25 Sep 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: _____

ISOLATION REQUIRED (*Specify*): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

	TIME: 0800 INITIALS: [redacted]	TIME: INITIALS:	TIME: INITIALS:
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑ blw-2	☐	☐
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☐	☐
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☐	☐
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☐	☐
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☐	☐
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ weakness to RUE & RLE. – soft cast to RUE & RLE – ↓ sensation to 4.5cm fingers on RUE.	☐	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☑	☐	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☑ 0/10	☐	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑ brother @ bedside	☐	☐

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 0800 INITIALS: [redacted]	TIME: INITIALS:	TIME: INITIALS:
IV patency ✓ q 8 hr: Good	IV patency ✓ q ___ hr:	IV patency ✓ q ___ hr:
IV site care provided: N/A	IV site care provided:	IV site care provided:
IV tubing changed: N/A	IV tubing changed:	IV tubing changed:
LOCATION CONDITION	LOCATION CONDITION	LOCATION CONDITION
IV Site #1: RFA OK	IV Site #1:	IV Site #1:
IV Site #2:	IV Site #2:	IV Site #2:
Comments: Hl flushed well c 3cc NS 5 S/S of infection.	Comments:	Comments:

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: ~~BL~~ LUE/RUE	TIME: 0800					
COLOR	P	P				
CAPILLARY REFILL	1	1				
TEMPERATURE	W	W				
EDEMA	Ø	Ø				
SENSATION	N	S				
MOTION	P	P				
PASSIVE FLEXION	[illegible]	[illegible]				
PERIPHERAL PULSE	[illegible]	[illegible]				

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY / OTHER

	TIME: 0800		
ID band visible/legible			
Orient to environment prn			
Side rails (2/4) up			
Bed position low			
Call light within reach			
Review & post lab results			
Notify MD abnormal labs			
Incontinent urine/stool			
Linen change prn			
Turn/reposition q2h			
ROM q2h if immobile			
Antiembolic hose			

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Regular	TYPE:	TYPE:
PERCENT CONSUMED: 75%	PERCENT CONSUMED:	PERCENT CONSUMED:
HOW TOLERATED: well	HOW TOLERATED:	HOW TOLERATED:
☒ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR	☒ SELF ☐ ASSIST	# TIMES/SHIFT
	BEDREST AMBULATE BSC BRP CHAIR	☐ SELF ☐ ASSIST	# TIMES/SHIFT
	BEDREST AMBULATE BSC BRP CHAIR	☐ SELF ☐ ASSIST	# TIMES/SHIFT

TEACHING

TIME: 0800 INITIALS: [redacted]	TIME: INITIALS:	TIME: INITIALS:
CONTENT: plan of care, medication b(6)-2	CONTENT:	CONTENT:
☒ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
CIV [redacted] b(6)-4	[redacted]	[redacted] Dvr/AW	06-14

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE

SECTION IV - NOTES

1327 Pt c transfer order & summary in place. Pt to transfer to Iraqi hospital.

[redacted] RN

b(6)-7

anc v

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: 28 HEIGHT: WEIGHT: 82 Kg	2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): NKDA 3. PREVIOUS SURGERY [✓] NO [ ] YES (type):

4. PROPOSED SURGICAL PROCEDURE: (L) FA I+D (R) leg I+D

5. ADDITIONAL INFORMATION: Last PO: NPO p 0700 Medical Hx: Ø ~~Ø~~ TOD-2104 Implants: Ø Medications: Ø
Jewelry removed: yes/no Family waiting: yes/no Ø jewelry

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL X Potential for anxiety related to traumatic injury; language barrier; family separation; surgical environment speaks some English	✓ 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. o Maintain family interface.
B. AERATION X 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(4)-4

DA FORM 5179, JUN 91 Previous editions are obsolete. USAPA V1.01

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION 1 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. 1 Potential impairment of mobility due to sedation; pain; injury E.2. 1 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.	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 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 [redacted] COMPLETED/ADDITIONAL INTEROPERATIVE INTERVENTIONS NOTED.
[redacted] AN, LTC 21 Sep. 03 DATE

11. POSTOPERATIVE EVALUATION:
Dsg. clean & dry
ESU site clear & intact

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

12. PREOPERATIVE EVALUATION PREPARED BY [redacted] AN
DATE: 20 Sep 03 TIME: 2230

13. PREOPERATIVE EVALUATION PREPARED BY (Signature) [redacted] TC AN
DATE: 21 Sep 03 TIME: 1105

REVERSE OF DA FORM 5179, JUN 91 V1.01

MEDCOM - 19999

MEDICAL RECORD — INTRAOPERATIVE [redacted]CUMENT

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 Anesth.

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY LTC [redacted] b(6)-2

3. DATE: 21 Sep. 03 TIME PATIENT ARRIVED IN SUITE: 0920

4. PATIENT IN ROOM TIME: 0920 NUMBER: 1

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	LTC [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify)

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

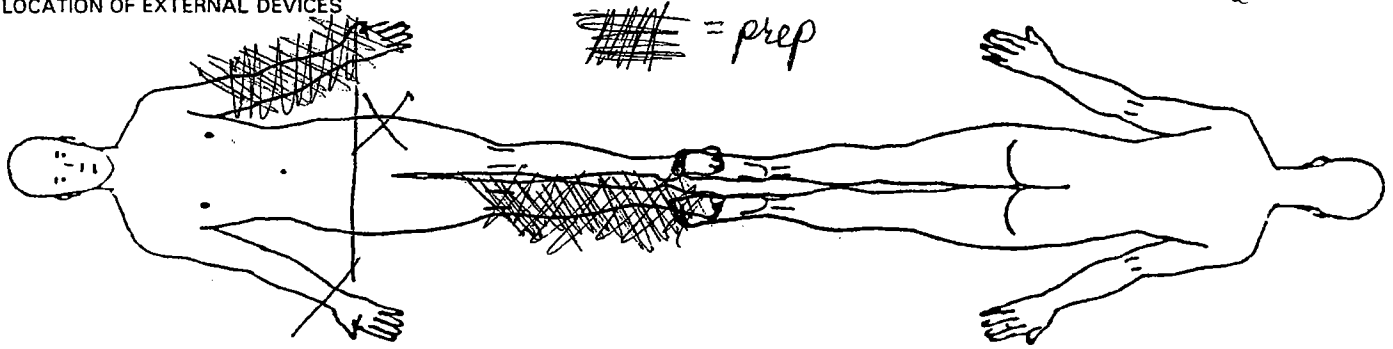
COMMENTS: Body maintained in correct alignment

8. SKIN PREPARATION

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

PREP SOLUTION (Specify): Betadine Scrub/Sol
SITE: Rt leg BY WHOM: LTC [redacted]
SITE: Lt. arm BY WHOM: LTC [redacted]
COMMENTS: b(6)-2

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect b(6)-2

10. COUNTS		Other**	First Closing Count	Final Closing Count
Sponge	☒ Yes ☐ No	✓	C	C
Needle Sharp	☒ Yes ☐ No	✓		
Instrument	☐ Yes ☒ No			
Other	☐ Yes ☒ No			

SCRUB: SSG [redacted] CIRCULA[redacted] LTC [redacted]

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

#[redacted] b(6)-2

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

☒ ESU NO: Valleylab Force 40
GROUND PAD: BRAND REM Polyhesive
LOT NO: 68936

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

cut: 30 coag: 30

DA FORM 5179-1, OCT 87 REPLACES D MEDCOM - 20000 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

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	

18. DRESSING/IMMOBILIZATION (Specify) DSD = Lt flank
Rt. leg: long leg splint, kerlix fluffs, kerlix roll, ACE Bandage } Rt leg
Lt. arm

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

	1.	2.	3.
TYPE/SIZE			
SITE			

19. ADDITIONAL INFORMATION
Surgeon: Dr [redacted]
Anesth: Cpt [redacted] CRNA
b(6)-2

20. OPERATION(S) PERFORMED
I+D Rt ↓ leg + lt. forearm
(clean + dress 2 wounds Lt flank)

21. PATIENT TRANSFERRED TO b(6)-2 | PACU | TIME 1050 | METHOD Via Gurney

[redacted] LTC, AN

REVERSE OF DA FORM 5179-1, OCT 87 MEDCOM - 20001 USAPA V1.01

MEDICAL RECORD — INTRAOPERATIVE DOCUMENT

For use of this form, see AR 40-407, the proponent ag ... the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING R — VIA gurney — BY anesthesia
2. PATIENT IDENTIFIED ... AND PROCEDURE VERIFIED BY [redacted] CPT / AN
3. DATE 23Sep03 — TIME PATIENT ARRIVED IN SUITE —
4. PATIENT IN ROOM TIME 0810 b(6)-2 NUMBER 2-1 (1)

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Pt not english speaker;

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted] 91D b(6)-2	RELIEF SCRUB	b(6)-2
ASSIGNED CIRCULATOR	CPT [redacted] 66E	RELIEF CIRCULATOR (INT)	LTC [redacted] 0930-0945

7. POSITION AND POSITIONAL AIDS (Specify)

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

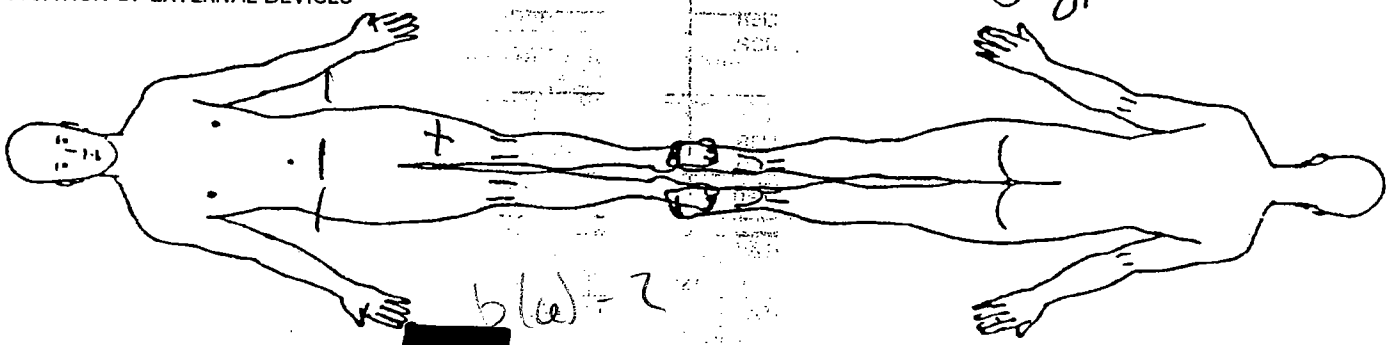
COMMENTS:

8. SKIN PREPARATION

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

PREP SOLUTION (Specify) Betad/Betad BY WHOM: CPT [redacted]
SITE: BY WHOM:
SITE: BY WHOM:
COMMENTS: no pooling of prep noted.

9. LOCATION OF EXTERNAL DEVICES



b(6)-2

LEGEND X Ground Pad -- Safe [redacted] === Tourniquet

C = Correct I = Incorrect

10. COUNTS			Initial Other	First Closing Count	Final Closing Count
Sponge	☒ Yes	☐ No	C		C
Needle Sharp	☒ Yes	☐ No	C		C
Instrument	☐ Yes	☒ No	/	/	/
Other	☐ Yes	☒ No	/	/	/

SCRUB	CIRCULATOR
PFC [redacted] b(6)-2	CPT [redacted]

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

CIV [redacted] b(6)-2

[redacted] b(6)-2

23Sep03

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

☒ ESU NO: CUT 45 Valleylab COAG 45
GROUND PAD: BRAND Valleylab E7507
LOT NO: 7000 2005-04

☐ 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

13. PROSTHESIS, IMPLANTS

Surgical Simplex® P
RADIOPAQUE BONE CEMENT
Distributed by:
Stryker®
Howmedica
Osteonics Mahwah, New Jersey
Full Dose
Cat. No.
Control No. [redacted]

17 set 03 lot # 9221 Cement Dec 2004

Tobramycin lot # 27[redacted]

S NAME: ID NUMB | JFACTURER

14. IRRIGATION/MEDICATIONS G /ORDERS

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 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	

18. DRESSING/IMMOBILIZATION *(Specify)*
- fluffs - Splint
- Kerlix
- ace wrap

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

19. ADDITIONAL INFORMATION

Surgeon:
Dr. [redacted]

blw-2 A11

Anesthesia:
MA[redacted] CRNA

20. OPERATION(S) PERFORMED
I & D (L) ulna Fx / (R) leg GSW
C DPC

21. PATIENT TRANSFERRED TO	TIME	METHOD
NU 3	10:08	gurney.

22. REGISTERED NURSE SIGNATURE [redacted] CPT/AN [redacted] LTC, AN

REVERSE OF DA FORM 5179-1, OCT 87 USAPA V1.00

MEDCOM - 20003

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR 09-03 DAY 23 24 24 25

19 HOUR

PULSE (0) | TEMP. F (°)

105° | 104° | 103° | 102° | 101° | 100° | 99° | 98.6° | 98° | 97° | 96° | 95°

180 | 170 | 160 | 150 | 140 | 130 | 120 | 110 | 100 | 90 | 80 | 70 | 60 | 50 | 40

TEMP. C (Centigrade Equivalents, for Reference only)

40.6° | 40.0° | 39.4° | 38.9° | 38.3° | 37.8° | 37.2° | 37.0° | 36.7° | 36.1° | 35.6° | 35.0°

RESPIRATION RECORD

BLOOD PRESSURE

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.

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

[redacted]

b(6)-4

MEDCOM - 20004

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR Dec DAY 21 22 Dec - 23

19 2003 HOUR 12 1 4

PULSE (0)	TEMP. F (°)
	105°
180	104°
170	103°
160	102°
150	101°
140	100°
130	99°
	98.6°
120	98°
110	97°
100	96°
90	95°
80	
70	
60	
50	
40	

TEMP. C

40.6°
40.0°
39.4°
38.9°
38.3°
37.8°
37.2°
37.0°
36.7°
36.1°
35.6°
35.0°

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

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)*

[redacted]

b(6) -4

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

MEDCOM - 20005

b(6)-2

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

Ward/Section: ER

REQUESTING PHYSICIAN: [redacted]

DATE: 20 Sep 03 TIME: 2005

SSN/PSEUDO SSN:

LAST, FIRST, MI. [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 (a 41-51 mmHg (ve
PO2		80-105 mmHg (ar N/A (ven)
TCO2		23-27 mmol/L (ar 24-29 mmol/L (ve
HCO3		22-26 mmol/L (ar 23-28 mmol/L (ve
sO2		95-98%
BBecf		(-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

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

======= PICCOLO =======
20/09/03 20:22
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #: 3141AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	107	73-118	MG/DL
BUN	16	7-22	MG/DL
CRE	0.9	0.6-1.2	MG/DL
CK	2746*	39-380	U/L
NA+	139	128-145	MMOL/L
K+	4.4	3.3-4.7	MMOL/L
CL-	104	98-108	MMOL/L
tCO2	24	18-33	MMOL/L

INST QC: OK CHEM QC: OK
HEM 0 , LIP 0 , ICT 0

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE

======= PICCOLO =======
20/09/03 20:22
REFERENCE RANGE: MALE
PATIENT #: [redacted]
LIVER PANEL PLUS
DISC LOT #: 3154AA7
OPER #: [redacted] DR #: 000
SERIAL #: [redacted] b(6)-3

ALB	4.2	3.3-5.5	G/DL
ALP	72	26-84	U/L
ALT	33	10-47	U/L
AMY	43	14-97	U/L
AST	72*	11-38	U/L
TBIL	1.1	0.2-1.6	MG/DL
GGT	23	5-65	U/L
TP	7.3	6.4-8.1	G/DL

INST QC: OK CHEM QC: OK
HEM 0 , LIP 0 , ICT 0

REMARKS:

REPORTED BY: DATE: LAB ID NO.:

ID: [redacted]
DOB

			Patient Limits
WBC	11.2 H	x10^3/uL	4.5 10.5
RBC	4.79	x10^6/uL	4.00 6.00
Hgb	14.1	g/dL	11.0 16.0
Hct	43.2	%	35.0 50.0
MCV	90.1	fL	85.0 99.0
MCH	29.5	pg	27.0 31.0
MCHC	32.6 L	g/dL	33.0 37.0
Plt	328.	x10^3/uL	150. 450.
Lym	18.5	%	20.5 51.1
Lym#	2.1	x10^3/uL	1.0 3.4

MEDCOM - 20007

b(6) - 2

Ward/Section: ER	REQ [redacted] PHYSICIAN	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. b(6)-2 [redacted]	DATE 20Sep03	TIME 2005	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		

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: b(6) - 2

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

MEDCOM - 20008

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 28 DAYS MOS YRS Sex ( ) MALE ( ) FEMALE

PROPOSED PROCEDURE: (R)forarm, Chest (R) Leg Ancef
SURGICAL SERVICE: Ortho Foot
NPO SINCE: 0700 2LEmT

Physical State 1 2 3 4 5 E
WT: 82 KG/LB HT: ____ IN.
ALLERGIES: NKDA

HABITS:
TOBACCO: Ø
ETOH: Ø
DRUGS: ____

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: ____/____
U/A: ____
OTHER: ____

11.2 / 14.2 / 328
43.2

139 | 104 | 16 / 107
4.4 | 24 | .9

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	Schrapnel @ forarm
	N	Y	chest, (R) leg
Familial HX	N	Y	

ASSESSMENT
PAST SURGICAL/ANESTHETIC
Ø

PHYSICAL EXAMINATION
BACK: ____
OTHER: ____

NPO Since ____

ANESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ____ {X} General: Mask Intubation
Anesthesia plan discussed w pt. pt understood English
questions answered [redacted]

INFORMED CONSENT/COUNSELING S[redacted]thesia including death have been explained to and discussed with the patient/legal guardian [redacted] KNA

The patient/legal guardian seems to unders[redacted] agrees. Questions answered.

Signed: ____ Date: 9/20/02 Time: 2330 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) FCW 2

[redacted] b(6)-4

WAMC Form 2300 (Revised) 15 Mar 01 MCXC-DOS

PATIENT RECORD COPY

Previous edition is obsolete
*U.S. GPO: 2001-629-183/40002

MEDCOM - 20009

MEDICAL RECORD — ANESTHESIA

DRUG (Units)		TOTALS
Ketamine (mg)	50	50
lidocaine (mg)	50 50	100
fentanyl (ug)	50 / 100 / 50 / 50	250
Propofol (mg)	150	150
Succinylcholine (mg)	120	120
Zemuron (mg)	30 20	50
VOLAT AGENT 150 % del / % e.t.	1.0 / 1.0 / 1.0 / 0.6 / .5 / .8 / 1.0 / off	
AIR L/Min		
N2O L/Min		
O2 L/Min	4 / 8 / 3 / 3 / 3 / 3 / 3 / 2 / 2 / 2 / 2	

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

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS: ① ② ③ ... ④ ⑤

TOTAL [illegible]: 100

TOTAL URINE: Ø

FLUIDS - SUMMARY
CRYSTALLOID– 800
COLLOID– Ø
BLOOD– Ø

FLUIDS: LINE site 18g — ☐ Warmed — LR — LR

LOSSES: EST BLOOD LOSS 100; URINE –

PHYS STATUS 1 ②3 4 5 E

BODY WEIGHT 82 KG

HEMATOCRIT 43.2

INITIAL DATA: BP– 159/83; HR– 111

EQUIP CHECK: OK?– Ⓨ N

PATIENT RECHECK: OK for PROCEDURE? ✓; TIME–

TIME → 915, 0930, 1000, 1030

SYMBOLS: BP by cuff ∨ ∧; Heart rate ●; Resp rate; BP (transduced); TOURNIQUET T – ✗; ANES– X-X; PROC ⊙ – Ø

VT – ml	980 – 990	990	800	750	710	500	
f – breaths/min	10	10	10	8	8	13	16
Peak Inf pres / PEEP		20	20	20	20	20	
MODE– S(pon), A(ssist), C(on)	SV–CV–CV	CV	CV	CV	SV	SV	
✓ BP/Auto Cuff / ✓ ET CO2 (torr)	41	33	34	34	43	57	52
BP / oth / ✓ FIO2 (Frac or %)	.93	.93	.93	.93	.93	.66	.66
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	Axial						
✓ N-M Block (T/4)	4/4	4/4	4/4	4/4	4/4		
Warming blkt							
Conv warmer							

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

REMARKS-
Code drugs with numbers, events with letters
① PT ID IN ICW PREOP HX ✓ Δ
② rm - O2 - monitors
③ ind / intubation - meds admin per DR. [redacted]
④ PT making purposeful mvmt - extubated
⑤ OOR TO PACU
⑥ RPT TO [redacted]

RECOVERY AT 1100 — PACU ICU ___ (Specify) OTHER ___
CONDITION: RESP– 10, SpO2– 96, BP– 147/75, HR– 92

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0910	0922	1105
	Ready	Begin	End
PROC	0930	0952	1051

PROCEDURES and CPT Codes: I+D Ⓛ arm Ⓡ Ⓛ Leg

ANESTHETIC TECHNIQUES: Describe block technique under Remarks — GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments — DL x1 ē 3 mac, grade I view, #8.0 ETT @ 23 @ Lip. cuff ↑, ⊕BBS per DR. [illegible], ⊕ ETCO2 Tape to Ⓡ OA in for BB

PATIENT IDENTIFICATION– Typed or written entries: Name, Grade/Rate, Medical facility
[redacted] b(6)-4

SURGEONS [redacted] b(6)-2
ANESTH [redacted] CPT CRNA

PROCEDURE LOCATION OR 2-2
DATE 21 Sep 03
PAGE 1 OF 1

WAMC OP 376 REVISED 1 Jan 99
PATIENT RECORD
MEDCOM - 20010

ACLU-RDI 1654 p.170

DOD-033584

MEDICAL RECORD — ANESTHESIA

ANESTHETIC AGENTS AND DRUGS (CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML. "I"=CONSTANT INFUSION)

DRUG	(Units)							
Versed	(mg)	3/2						
Fent	(ug)	100	50		50	50		
Propofol	(ug)	200						
Lido	(mg)	20						
MS04	( )					4	1	5
	( )							
VOLAT AGENT: Forane	% del	2	2	2	1.5	1	1	1X
	% e.t.							
AIR	L/Min							
N2O	L/Min							
O2	L/Min	8	2	2	2	2	2	2 10

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

FLUIDS

LINE site LK				
☐ Warmed		500	750	1000
☐ Warmed				
☐ Warmed				
☐ Warmed				

LOSSES — EST BLOOD LOSS / URINE –

TOTALS

	TOTAL FLUIDS
5 mg	50
250 mg	
	TOTAL URINE
10 mg	Ø

FLUIDS - SUMMARY

CRYSTALLOID– 1000
COLLOID– Ø
BLOOD– Ø

REMARKS-

Code drugs with numbers, events with letters

0810 in OR Monitors applied.
0815 I@ Proseal/ placed-

0955 spont R-esp proseal out oral airway in- monitored for purposeful movement oral airway out to PACU - Report given 1005

PHYS STATUS (1) 2 3 4 5 (E)

BODY WEIGHT 82 (KG) LB

HEMATOCRIT:

INITIAL DATA: BP– 144, 80 HR– 89

BOARD CHECK OK?– (Y) N

PATIENT CHECK OK for PROCEDURE? TIME– 0715

TIME → x 30 x 09 x 30 x 10 x 30 x 11

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

220 / 200 / 180 / 160 / 140 / 120 / 100 / 80 / 60 / 40 / 20

VENTILATION

VT – ml		700	700	530	SV	SV	SV	
f – breaths/min		10	10	8	C	9	11	
Peak Inf pres / PEEP		15	15	14	13			
MODE– S(pon), A(ssist), C(on)		S	C	C	C	S	S	S

MONITORS & ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	36	35	37	45	55	54	51	
BP / oth	FIO2 (Frac or %)	.75	.75	.75	.35	.35	.75	.35	
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 SKin	0C	35		36	36	X		
	N-M Block (T/4)								
Warming blkt									
Conv warmer									

Mark with letters & symbols, explain under REMARKS — EVENTS Position → 0

RECOVERY AT HC 1016
PACU ICU _____ (Specify) OTHER 95.3 HX
CONDITION: Spont Resp Responsive
RESP– 14 SpO2– 95 BP– HR– 88

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0715	0810	1020
PROC	Ready 0820	Begin 0844	End 0955 1004

PROCEDURES and CPT Codes

I@D (L)arm (R)Leg

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

Pro Seal #5

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: Place Combitube attempt ⊕ Bilat BS, ⊕ ETCO2 - eyes taped

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

b(6)-4 [redacted]

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

PROCEDURE LOCATION 9/23/02
DATE 9/23/02
PAGE 1 OF 1

WAMC OP 376 REVISED
1 Jan 99

PATIENT RECORD
MEDCOM - 20011

MEDICAL RECORD - DOCTOR'S ORDERS

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. for Sat V/S 95% KK V/O		
3	~~Morphine~~ / Meperidine 12 mg IV ~~now and~~ ____ mg q 3-5 min prn pain for a		
	max dose of 10 mg.		
4	Zofran 4 mg IV prn N/V q 15 min, ~~may repeat x ____~~.		
5	Metoclopramide 10 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 svc order [redacted]	b(6)-2	
10	Discharge from recovery status when PACU discharge criteria met. [redacted]	MJCKNA	

PATIENT IDENTIFICATION

[redacted] b(6)-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, [redacted] b(6)-2			1 of 1

MEDCOM FORM 688-R (TEST) (MCHO) MAR 99 PREVIOUS EDITIONS ARE OBSOLETE MC V1.00

All b(6)-2 unless otherwise noted

CLINICAL RECORD - D OR S
or 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]
iraqi civilian.

DATE OF ORDER | TIME OF ORDER | HOURS

20Sept03 2112
✓Admit to Floor / [redacted]
✓Shrapnel (L) Forearm / (L) chest / R leg
✓Stable
✓Vitals q2° x 4, then
✓NKDA
✓Bedrest elevate (R) LE (L) UE
✓NPO

NURSING UNIT | ROOM NO | BED NO.

Noted 20SEP03 2142 [redacted]

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

✓LR @ 100 cc/°
✓Tylenol 650 mg po/PR q6° prn
✓Kefzol 1g IV q8°
✓MSO4 1-4 mg IV q 20min prn
✓Percocet i-ii po q4° prn
~~Colace i po~~
[redacted]

NURSING UNIT | ROOM NO. | BED NO.

ICW2 24° chart ✓ [redacted] 21 Sept03 0300
[redacted] 21 Sept03 0400 [redacted]

PATIENT IDENTIFICATION
b(6)-4 [redacted]

HOURS

21Sept03 1050
✓VS per I/D
✓FFNWB (R) LE
✓NWB LUE
✓ADAT
✓Resume other preop orders
✓LR @ 100cc/° until tol po/then hep lock
✓Kefzol 1g IV q8°
✓AP/LAT (L) Forearm p[redacted]

Noted 21Sep 2300 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

ICW 2

PATIENT IDENTIFICATION
b(6)-4 [redacted]

DATE OF ORDER

24° chart ✓ [redacted] 22 Sept03 0015 [redacted]
24 [redacted] 0445 22Sept03 [redacted]

NURSING UNIT | BED NO.

22Sept03 1135
NPO p MN for OR today
AP/LAT (L) Forearm please (if not already done postop)
LR @ 100cc/° p MN [redacted]

Noted [redacted] 22Sep03 0300

MEDCOM - 20013

ACLU-RDI 1654 p.173

DOD-033587

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

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

23 Sept 03
1000
s/p I/D (R) Leg, (L) forearm injury
Stable
resume preop orders
ADAT to Regular
XRAYS: AP + LAT (L) Forearm today
[redacted]
NSG

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION
b(6)-4
[redacted]

DATE OF ORDER | TIME OF ORDER ____ HOURS

LR @ 100 cc/° until tol po, then hepwell
~~[illegible]~~
continue kefzol 1g IV q8° b(6)-2
elevate LUE, (R) LE [redacted]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION
b(6)-4
[redacted]

DATE OF ORDER | TIME OF ORDER ____ HOURS

23 Sept 03
1500
Demerol 100mg IV x1 — [redacted] NSG 23 Sept
b(6)-2

NURSING UNIT | ROOM NO. | BED NO.
b(6)-2
24° Chart [redacted] 91WM6 24 Sept 03 0045 24 [redacted] 24 Sep 03 0310

PATIENT IDENTIFICATION

DATE OF ORDER | TIME ____ HOURS

25 Sept 03
1214
May D/C to Iraqi civilian medical care
Noted time [redacted]
b(6)-2
[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 4256, 1 APR 79 — REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.
MEDCOM - 20014

blk-2 Ant

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. 9 Yr. 2003

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 20 21 22 23 24 25
20SEP	[redacted]	Vitals q2°x4, then QS	D E N	[redacted]
20SEP	[redacted]	Bedrest, elevate RLE RUE	D E N	[redacted] 1 0'C
20SEP	[redacted]	NPO	D E N	[redacted] 7 0'C
20SEP	[redacted]	LR @ 100cc/h	D E N	[redacted]
21Sep03	[redacted]	FF NWB RLE, NWB LUE	D E N	[redacted]
21Sep03 23Sep03	[redacted]	ADAT to Regular	D E N	[redacted]
21Sep03	[redacted]	Diet Regular	07 11 17	[redacted] see above

ALLERGIES: ☐ YES ☑ NO
NKDA

PRIMARY DIAGNOSIS: S/P I&D
Shrapnel ⓛ Forearm / ⓡ chest / R leg

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

PATIENT IDENTIFICATION:
[redacted]
blk-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 - 20015

THERAPEUTIC DOCUMENTATION CARE [illegible] (NON-MEDICATION)

Mo _____ Yr 2005

Verity by Initialing: Order Date	Verity by Initialing: Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
20SEP	[redacted]	Admit to Floor / Hygate - Stable	20SEP	Done		[redacted]
21Sept	[redacted]	AP/LAT (L) FA please	21Sept	today	done	
22Sep	[redacted]	NPOp MN for OR	23Sep	2400	done	
23Sep	[redacted]	Resume pre-op orders	23Sep	1100	done	
23Sep	[redacted]	xrays: AP + Lat (L) forearm today	23Sep	1300	done	
		blood - 2 A11				

Order Exp Dat	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED

USAPA V1

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. 9 Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED
				23 [redacted] 25
23Sep	[redacted]	Elevate (L)UE & (R)LE	D	[redacted]
			E	
			N	

ALLERGIES: ☐ YES ☑ NO

NKDA

PRIMARY DIAGNOSIS:

S/P I+D (L) forearm

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

Civ [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 - 20017

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. ___ 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
20SEP	[redacted]	LR @ 100cc/h until tolerating po then heplak	D	[redacted] neutratten see below
			E	
			N	
20SEP 23 SEP	[redacted]	Kefzol 1g IVq8°	08	[redacted]
			16	
			24	
22 Sep	[redacted]	LR@100cc/hr TP MN 22 Sep 03 - until TOLERATE PO, THEN HEPLOCK	D	X
			E	X
			N	X [redacted] D23Sep03
23Sep	[redacted]	LR @ 100cc/hr until tolerating po, then heplock	D	[redacted]
			E	
			N	

ALLERGIES: ☐ YES ☑ NO
NKDA

PRIMARY DIAGNOSIS: SP ICD
Shrapnel/ⓛ Forearm/Ⓑ chest/Ⓐ leg

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 - 20018 — 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
	-----					

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED
20SEP	[redacted]	Tylenol 650mg PO PR q6° PRN	
-----	-----		
20SEP	[redacted]	MSO4 1-4 mg IV q 20 min PRN	
-----	-----		
20SEP	[redacted]	Percocet 1-2 PO q4° PRN	
-----	-----		
23SEP	[redacted]	Ceftriaxone 1gm q. IV.	
-----	-----		
-----	-----	blw-2AM	
-----	-----		
-----	-----		
-----	-----		
-----	-----		

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	OTSG APPROVED *(Date)*
Post-Anesthesia Care Unit (PACU) Flow Sheet	

Date: 9-21-03 Anesthesia Type (Circle): (General) Spinal Epidural IV Sedation Nerve Block
Time In: 11[illegible]
Allergies: NKDA OR Intake: Crystalloid 800 Colloid
Pre-op V/S: 159/83, [illegible] OR Output: UOP EBL 100
Procedures: [illegible] Meds/Times: [illegible]
[illegible] [illegible]

Drains	Airway
Hemovac	Nasal
NG	Oral
JP	(ETT)
T-tube	Trach
Foley	Other
TLS	

Pre Op Meds History

Time	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
SaO2	97	97	98	97	9[illegible]	96
FiO2	RA	[illegible]	[illegible]	RA	[illegible]	[illegible]
Methods						
240						
220						
200						
180						
160						
140						
120						
100						
80						
60						
40						
20						
RR		18	24	12	22	14
T	[illegible]				AT[illegible]	
Time						
Pain (0-10)						
LOS						

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1100	LR	350	(R) Arm	[redacted]	100
					b(6)-2

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	2	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	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	V/S X = A-line BP ˅ = Cuff BP • = Pulse
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	2	2	TEMP S = Skin O = Oral A = Axillary T = Tympanic R = Rectal
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	/			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.	9	10	10	

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)

b(6)-2

[redacted] 717A[illegible]

DEPARTMENT/SERVICE/CLINIC	DATE
ICU #3	9-21-03

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

#[redacted] Civilian
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

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm							
15'							
30'							
45'							
60'							
90'							
D/C							

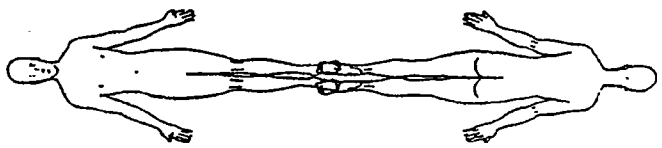
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic, Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm			
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount
1145	urine	clear/yellow	250cc

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

NURSING NOTES

1100: Civilian Traj Male admitted to PACU c IAD @ Lod + IHD @ Arm
PaO_2 95% RA. IV @ Rt Arm
patent. Pt awake & [redacted] oriented
circulation. Pt resting [redacted]
1145 Report given to [redacted]
Pt transferred to ICW 2
VS stable Pt urinated
250cc. Pt [redacted]
[redacted]
D(cw)-2 An1

Discharge Criteria:
Date: 2 Sep 03 Time: 1151 PARS: 10
BP: 124/72 T: 97.8 HR: 82 RR: 14 Sa02: 97
Pain Level at D/C (0-10):
Intake: 1600cc Output: 250cc
Additional Data:
Transferred To: ICW 2
Report Given To: LCT [redacted]
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: [redacted]
Cleared IAW Recovery Room [redacted]
Charge Nurse Signature:

WAMC OP 173-E

MEDCOM - 20021

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: 23 Sep 03   Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
Time In: 1012
Allergies: NKDA   OR Intake: Crystalloid 1000   Colloid Ø
Pre-op V/S: 144/80 / 89   OR Output: UOP Ø   EBL 50
Procedures: Washout   Meds/Times: Versed · 250 mc Fent
OA (B)LL   10mg morphine

Drains	Airway
Hemovac	Nasal
NG	Oral
JP	ETT
T-tube	Trach
Foley	Other
TLS	

250
5
10

Pre Op Meds   History

Time	1012	1020	1030	1040	1055
SaO2	96	96	96	99	97
FiO2					
Methods	RA	RA	RA	RA	RA
RR	16	21	12	17	12
T	97.6			97.6	

Vertical scale: 240, 220, 200, 180, 160, 140, 120, 100, 80, 60, 40, 20

Time	1066					
Pain (0-10)						
LOS						

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1055	LR	950cc	(L) forearm	[redacted]	50cc

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 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	Ø	Ø	Ø
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

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)

b(6)-2

PREPARED BY	DEPARTMENT/SERVICE/CLINIC	DATE
[redacted] 91wmb	PACU	23 Sep 03

[redacted] TIFICATION *(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

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	(UA)	CROM			B	W	PK
15'							
30'	(RL)	CROM			B	W	PK
45'							
60'							
90'	(UA)	CROM	+		B	W	PK
D/C	(RL)	CROM	+		B	W	PK

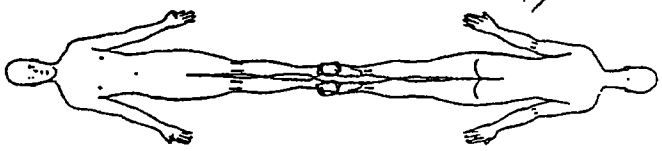
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic, P = Pale, Pk = Pink
Capillary Refill: B = Brisk, S = Sluggish

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(UA) (R) L L	ACE / ACE	Ø / Ø
30'	(UA) (R) L L	ACE / ACE	Ø / Ø
60'			
D/C	(UA) (RL)	ACE / ACE	Ø / Ø



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1055	NSR	Ø	Ø

NURSING NOTES

PT ADMITTED TO PACU S/P I&D (UA) (RL) DRESSINGS CDI. IV (R) FOREARM. PATIENT RUMINS LR. AROUSABLE TO STIMULUS. CAP REFILL BRISK TO DRESSING SITES. (+) MOVEMENT TO R HAND & (R) FOOT. PFC [redacted]

PT TRANSFERRED TO ICU 2 VIA LITTER BY PFC [redacted] PFC [redacted]

b(6)-2

Discharge Criteria:

Date: 23SEP05 Time: PARS: 10

BP: 144/86 T: 97.6 HR: 88 RR: 21 Sa02: 96

Pain Level at D/C (0-10):

Intake: 50 cc LR Output: Ø

Additional Data: Ø

Transferred To: ICU 2

Report Given To: SGT [redacted]

Transferred Via: W/C Litter Gurney Ambulance

Transferred By: PFC [redacted] b(6)-2

Cleared IAW Reco[redacted]

Charge Nurse Signa[redacted] AT

WAMC OP 173-E

MEDCOM - 20023

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF: A D I
2. MTF LOCATION (State or Country Code.): I Z
3. REGISTER NUMBER: [redacted]
NAME (Last, First, Middle Initial): [redacted] b(4)-4 CIV#
4. PAY GRADE: CIV
5. SEX: M
6. DATE OF BIRTH (Y Y Y Y M M D D): [redacted]
7. AGE AT ADMISSION: 28 y
8. RACE: X
9. ETHNIC BACK-GROUND: 9
RELIGION: UNK
10. LENGTH OF SERVICE:
ETS:
11. FMP: 9 9
12. SOCIAL SECURITY NUMBER: [redacted]
ORGANIZATION (Active Duty Only):
13. MARITAL STATUS: Z
HOUR OF ADMISSION: 2112
BRANCH / CORPS: b(4)-4
14. FLYING STATUS:
15. BENEFICIARY CATEGORY: K 91
16. ZIP CODE OF RESIDENCE:
17. UNIT LOCATION (State or Country Code):
18. MOS:
19. TRAUMA: 1
PREV. ADMISSION: YEAR [X] NO
20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: Ø b(2)-2
WARD: ICW2
NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: UNK
ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): UNK
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted]
TELEPHONE NUMBER OF EMERGENCY ADDRESSEE: UNK
21. TYPE OF DISPOSITION: Ø S
22. [illegible] RED TO:
23. DATE OF DISPOSITION (Y Y M M D D): Ø 3 Ø 9 2 5
24. CLINIC SVC - ADMITTING: A E A A
25. MTF TRANSFERRED FROM:
26. DATE THIS ADMISSION (Y Y M M D D): Ø 3 Ø 9 2 Ø
27. LOCATION OF OCCURRENCE (Battle Casualty Only):
28. MTF OF INITIAL ADMISSION:
29. DATE INITIAL ADMISSION (Y Y M M D D):

FOR LOCAL USE

Shrapnel (L) forearm, (L) chest & (R) leg. Grade II open (L) ulna fx

DX - 81392
9552
8910
8750
E0919

PR - 7962
8622

Trauma - 1
Injury - 449

ADMITTING OFFICER (Signature, as required): [redacted] b(4)-2

DA FORM 3985 MAR 89

MEDCOM - 20024

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)		3. GRADE	ADMISSION REMARKS
[redacted]	Dog, Cliff [redacted] b(6)-4		EPW	
4. SEX: M	5. AGE	6. RACE	7. RELIGION: O	8. LENGTH OF SVC: N/A	9. ETS: N/A	10. PREVIOUS ADMISSION	
11. FMP: 99	12. SSN: [redacted]		13. ORGANIZATION: N/A		14. WARD: ICU3	
15. FLYING STATUS: N/A	16. DSG: N/A	17. DEPT./ BEN: K91	18. BRANCH/CORPS: N/A	19. UIC/ZIP: N/A	20. TYPE CASE: WIA	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: direct from ER			22. HOURS OF ADMISSION: 0257	23. CLINIC SERVICE: Neurosurgery		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE			25. TYPE DISPOSITION: DOW	26. DATE OF DISPOSITION: 02 OCT 03		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)			27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION: 22 Sept 03		ADMITTING OFFICER: [redacted]
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY				30. DATE OF INTIAL ADMISSION: 22 Sept 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

GSW Head

Dx: 85175
486
E9112

Px: 5941

Trauma
9
Injury
E69

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
0	[redacted]	0	0	12	12

SIGNATURE OF ATTENDING ME[redacted] b(6)-4 [redacted] SIGNATURE PRIMARY MEDICAL RECORDS OFFICER

DA FORM 3647, MA[redacted] MEDCOM - 20025 USAPPC V1.10

b(6)-4

MEDICAL RECORD [redacted] **ABBREVIATED MEDICAL RECORD**

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

NOI Teenage Iraqi m/e suffered a GSW head after soldiers returned fire when he and another individual initiated. On presentation exam, E~~0~~V~~0~~M5 (GCS 7) prior to intubation. By report, he struggled with full strength x 4 extremities.

PMH Unknown.

Exam HEENT - Midline occipital scalp penetration site with underlying crepitence, no significant bleeding.
Neck - No injury. Clear by mechanism.

PHYSICAL EXAMINATION

Chest - Clear. Benign.
Abdomen - Flat. Benign.
Pelvis - Stable. Benign.
Perineum - Uninjured.
TLS Spines - Uninjured. Clear by mechanism.
Extremities - Uninjured.

Neuro (Intubated):
Rpl's 2/NR.
GCS 3T.

CT Head - Single high density fragment consistent with small caliber bullet or shrapnel. Cisterns patent. No ICH. Blood/Fragment in (R) lateral ventricle.

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

Impression: GSW Head, severe Head injury by exam.

Plan: To ICU for ICP monitor.

b(6)-2

[redacted]

SIGNATURE OF PHYSICIAN | DATE 22SEP03 | IDENTIFICATION NO. | ORGANIZATION

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
22SEP03	Neurosurgery Progress / Procedures.
0255	(1) (R) Frontal Cadman ICP monitor placed. ICP was 45-60 mmHg. Removed.
	(2) (R) Frontal Ventriculostomy placed 1ST PASS. CSF serosanguinous. OP > 20 mmHg. Left open to drain @ 5 mmHg. CP 25 mmHg.
	(3) Scalp (occipital) closed c staples. [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 - 20027

All b(6)-2 unless otherwise noted

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
22Sep03	0600 assumed care. Report given. See ICU 24hr sheet for initial assessment. Pt 30408. c̄ [redacted] RN for support.
	0730 Dr [redacted] @ bedside. ICP [illegible] removed. Update given on Pt temp. (L) [illegible] not placed. verified by 2 RN's [redacted] ABG taken per A-line
	0750 ABG results rec'd. PCO2 29.6. ↓ Rate 18 [redacted]
	0815 Tylenol PR given. Temp 103.
	0830 75g mannitol IV given over 3 min. Dr [redacted] @ bedside. Tylenol PR given [redacted]
	0900 ABG results back. Keep rate @ 18, will repeat in 1hr [redacted]
	0950 ICP 34. Dr [redacted] @ bedside orders received [redacted]
	1100 ICP 34-36. new IV started (L) FA 18g SL patent [redacted]
	1130 26 ICP [redacted]

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | (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]

[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 - 20028

All b(6)-2, unless noted otherwise

b(6)-4 EPW [redacted]

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
[redacted]			

DATE	NOTES
22Sep03	1230 Dr [redacted] @ bedside, placed a cerebral oximeter, initial reading (L) 56, (R) 73. [illegible] placed in [illegible] q 30 sec. [redacted]
	1300 ICP 36, cerebral oximeter (L) 61, (R) 74 [redacted]
	1400 C.O. (L) 54 (R) 67, ICP 37. [redacted]
	1530 Dr [redacted] @ bedside, update given. orders received. cool towel placed on body and temp to 96. [redacted]
	1540 Dr [redacted] paged. C.O. ↓ 44 (L), (R) 67 ICP 45 [redacted]
	1545 mannitol 12 g IVP given [illegible] Dr [redacted] @ bedside, update given [redacted]
	1610 Dr [redacted] back to bedside, update given about SBP > 170 [illegible] this time. [redacted]
	1640 labs drawn per A-line sent. Tylenol pr given. Temp 100 [redacted]
	1730 labs given to Dr [redacted] received orders [redacted]
	1740 Dr [redacted] @ bedside, [illegible] line placement. labs [illegible] repeat Chem 8 [illegible] [redacted]
	1810 Chem 8 drawn per A-line. CVL area cleansed, applied [illegible]. started 3% sodium chloride @ 10cc/hr. Report given [illegible] [redacted]

STANDARD FORM [redacted]

EPW [redacted]

b(6)-4

b(6)-2 A11

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
23Sep03	Pt's ICP noted @ 50 despite repositioning; rezeroing.
0100	serum sodium 128 (0000hrs labs). Dr [redacted] notified. 3% NS increased to 30 cc/hr as ordered, mannitol given as scheduled. measures to ↓ ICP reinforced. Will continue to monitor [redacted]
23Sep 0300	Pt's ICP reading 25 mmHg. ABG drawn @ 0145 showed CO_2 @ 36.3. RR ↑ 20 by RT. Tylenol 650mg PR given for ax temp 100.1. Wet towel placed over body to keep control temp. NOB @ 30°; head/neck maintained in neutral position. Will continue to monitor [redacted] PT/AVT
23Sep03 0635	Neurosurgery NO 2 (SL) Tm 100.1, VSS. ICP 35-50, received 1 NaCl 3%. Paralyzed, intubated, Gaze extrapit. Pup. 1.5 2mm. I/O 2781/3426, Ventric 11-20/hr. 14.1 / 11.4 / 36.3 · 236 · 136 / 3.5 / 103 / 21 / 5 / 0.4 / 106 CT yesterday – No major edema despite ↑ ICP. (NP) Findings c/w Sinus thrombosis. Will continue aggressive ICP management. Heparin when more stable. [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)*

EPW [redacted]

b(6)-4

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/1998)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

MEDCOM - 20030

b(6)-2 all unless noted otherwise

b(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
EPW [redacted]			

DATE	NOTES
9/23/0700	Assumed pt care from Cpt [redacted] Pt in no apparent distress. Versed infusing @ 6mg/hr fentanyl @ 50mcg/hr, vecuronium 5mg/hr, 3/ NS @ 30cc/hr, NS @ 50cc/hr, ETT, NG clamped, ventric catheter, CSF draining well @ 5mmHg, FiO2 600, peep 5, RR 21, 35/ no issues noted [redacted]
9/23/0900	per Dr. [redacted] ETT pulled out 1cm to 23cm @ teeth. CXR [redacted] will cont to monitor [redacted]
9/23/1400	Per Dr. [redacted] ETT pulled out to 24cm @ lip, per Dr [redacted] no x-ray rqd, SpO2 96% [redacted]
9/23/1800	Report for change of shift given to Cpt [redacted] Pt in no apparent distress all VSS / afebrile Nursing note [redacted]
9/23/1810	ABG sent post vanc's post ↑ peep to 8 per Dr. [redacted]
	[redacted]
9/24/03 0900-1650	Nursing note Assumed pt's care @ 0600, assessment done see flow sheet Pt hemodynamically stable VSS afebrile ICP 8 to 10 ↓ thiopental @ 100mg/hr @ 0940. Suction pt q 1 to 2hrs for obtaining thick mucous secretions. Bronchoscopy @ 12:00 sample sent for Gram stain. @ 1500 ICP 23 [redacted] mannitol IVP. Dr [redacted] notified. Will continue to monitor [redacted]
9/25/0630	Assumed pt care from Cpt [redacted] no apparent 0600. Pt hemodynamically stable & afebrile @ change of shift. NS @ 100cc/hr, 3/ NS @ 25cc/hr, ensure @ 10cc/hr, thiopental @ 100mg/hr No issues noted, will cont to monitor [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK
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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
25SEP03	Neurosurgery HD 4
0649	(S/O) Nurse reports improvement overnight.
	Tm 100.2, VSS. ICP 10.
	I/O 2860 / 2074, Ventric 10-31/hr.
	Remains in Pentothal Coma.
	Vent SIMV 600 / 22 / 10 / 50% ⇒ 7.37 / 30.8 / 126
	16.9) 11.6 / 37.4 (245 145 / 110 / 15 (132 3.7 / 29 / 0.9
	(A/P) Overall, improved.
	(1) D/C IS & NS
	(2) ↑ TF to 30/hr.
	(3) Will Consider wean Pentothal / midday today.
	(4) Continue antibiotics for pneumonia
	[redacted] (7) b(6)-2

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
25 Sep 1600 Wt. 70kg	Nutrition Note: Pt currently receiving Perative at 30cc/hr providing 936 kcals/d. If pt remains NPO > 5days, recommend ↑ TF to goal rate of 75cc/hr. (2340 kcals) to meet pt's ENN of 2100 - 2450 kcals/day (30-35 kcal/kg) + 84-98 g Pro/day (1.2-1.4 g/kg). [redacted] D/LD
25Sep03 (2033)	Received report from LT [redacted] @ 1815. See DA Form 4700 OP 375 for assessment data. ICP needed correct leveling it was too high. Leveled to middle ear. ICP ↑ 20-21 CPP 63-68. Dr [redacted] called around 1935. said to water for the hour. Pt temp slightly up. cold towel on pt & room A/C turned up. Hands elevated on pillows to help c swelling. TOF to @ wrist & no response. ABG checked and settings left the same. All lines flushed. [redacted]
(2040)	ICP 14-16 CPP 68-72. Wet cloth put on pt for temp [redacted]
(2125)	Pt suctioned @ 2100. ICP's went up to 30's. Approx 10 min ICP's to 15 & CPP 70. Fan on blow by for pt. Temp down to 98.5 Appreciated. K-run finished. Labs drawn. [redacted]
(0030)	Pt. suctioned, thick yellow secretions, moderate. ICP went up to 17. Preoxygenated & sats @ 100%. Suctioning pt going in and out of Bigeminy. Labs received and K+ & Na+ low. 2.8/120. Pt SR at this time. More blood @ lab. Pt's mouth suctioned also, thick secretions & some blood. 7/20 2x2 placed on tongue to prevent drying. [redacted]
(0110)	Dr [redacted] notified of pt's labs. KCl started in @ few. TLC. Pt still in SR. [redacted]

STA [redacted] 509 (REV. 5/1999) BACK
USAPA V1.00

b (6) - 2 A11

b(6)-2 #11 unless otherwise noted

MEDICAL RECORD — PROGRESS NOTES — AUTHORIZED FOR LOCAL REPRODUCT

DATE	NOTES
26 Sep 03 (0320)	Pt sedated. Min thick yellowish white secretio Tried lavaging c 3cc NS. Didn't get much mo that way. ICP's up to 21 and back down c 20 Still getting K-tape. No PVC's. [redacted]
(0555)	Pt given bed bath, linen chg. ABM. Pt sedated very thick yellow secretions from ETT & mouth. ICP 335. Pt put back in proper alignment. Response [redacted]
26 Sep 03 1415	Assumed pt's care @ 0600. Pt's ICP 30's. gave thiopental [redacted] IVP per Dr's order & started Thiopental drip @ 50mg/hr @ [redacted]. ↑ rat to keep desire ICP now 20's. Dr. notified. Found 1000 pt's started ove breath the vent. ICP ↑ 30's Dr. [redacted] notified. ↑ thiopental @ 200 & start Vecuronium drip @ 10mg/hr. ICP @ 1100 23 Dr. [redacted] notified. Pt's ICP @ this time 19-20. 1400 ↓ PCCP to 8. [redacted] ed ABG @ 1430. Will continue to monitor.
160	[redacted] 24° secretions are thick yellow. ∅ cough. [redacted] AN
	doctor's orde [redacted] IVP given & ↑ drip to 300mg/hr. per
1715	ABG @ 170 [redacted] ICP/SN will de ↑ RR [redacted] 7.1 mmHg. Dr. [redacted] notified.

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
26Sep05	Neurosurgery HOS
0838	(1) NSA. ICP < 15 until Section this Am.
	I/O 4190/2256.
	155 | 110 | 19 (132 18.5) 9.8 (347
	3.0 | 24 | 0.6 31.6
	PERRLS 3/sluggish.
	Oculocephalic (-) Cough (-).
	No response to noxious.
	Vent SIMV 18, 700, Peep 10, 50%.
	(2) Improving ICP & PBI.
	(1) OFF NS
	(2) FTF to 60/hr.
	(3) Wean FIO2, Then Peep.
	(4) Avoid Potential Wakeup.

[redacted] b(6)-2

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
27SEP03	Neurosurgery
0636	(S/O) Tm 100.0, VSS. ICP > 30 yesterday, now 15-20.
	I/O 3205/2676. Ventriculostomy 10-15/hr.
	154 / 115 / 19 (14.1 13.7) 8.8 (237) 2.9 / 30 / 1.0 28.7
	Vent SIMV 600, 16, Peep 5, 40%
	Back into Pentothal Coma for ICP problems yesterday.
	(A/P) Recurrent ICP troubles with workup yesterday.
	Continue pentothal @ 300/hr.
	TF @ 6cc/.
	Will discuss trach/feeding tube when weaning pentothal
	Vancomycin #2 for LLL pneumonia.
	ICU care.
	[redacted] b(a)-2

STANDARD FORM 509 (REV. 5/1999) BACK
USAPA V1.00

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	b(6)-2 NOTES
9.27/0700	Assumed pt care from CPT [redacted] pt in no apparent distress, Ventric intact, CSF draining, FTC, [redacted] edge @ 6ccc/hr, Vec @ 10mg/hr, Thiopental 300mg/hr. No issues noted, all WSS checked, will cont to monitor — b(6)-2 [redacted] ICU RN.
28SEP03	Neuro: Yes
CC 47	S/O Afebrile, VSS., ICP <20
	I/O ~~2558~~ / 3070/2658, Ventric 11-17/hr.
	157 / 115 / 20 (138 8.9) 10.3 (401
	4.1 / 31 / 0.5 33.6
	Pentothal Cont.
	A/P (1.) GSW head - prolonged ↑ ICP c/w SSS thrombosis. Angiogram tomorrow. Cont. Pentothal today.
	(2.) Pneumonia - On Cipro. Day 4/10. Continue.
	ICU care [redacted] b(6)-2

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

ICUS

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
28 Sep 03 1730	Pt hemodinamically stable afebrile. ICP < 15mmHg all shift. Suctioned prn large amount of thick clear mucous pt. desat after suctioning but recovers immediately. ABG's drawn Dr. [redacted] notified. Will continue to monitor [redacted] RT/RN
29 Sep 03 (2100)	Received report from CT [redacted] assumed care of pt @ 1815. See DA Form 4700 OP 375 for assessment data. Preoxygenated pt c BVM. Suctioned pt x 3. Thick white/yellow secretions. Sats as low as 96%. Adjusting FiO2 per ABG's. Questioned Dr. [redacted] about CPP's of 50-55. Only concerned c ICP's >20. Continue to monitor [redacted] RN
29 Sep 03 (0100)	Pt Suctioned @ 2110. Moderate amt of Whitish yellow Secretions. Pt sats over the next hour went from 97% to 92% on 50% FiO2. Resuctioned pt @ 2220. P Suctioning pts Sats were @ 88% - 90%. ICP's stayed @ 22-24. Dr. [redacted] notified. PCXR done. Dr. [redacted] tried bagging pt thinking he had a mucous plug. Sats p bagging stayed @ 93-94%. Moved Resp to 10 and FiO2 to 70%. Pt's sats didn't do much. Gave pt a bolus of pentothol and increased Pentothol to 400mg/hr. Didn't help ICP's to much. Later gave pt 50mg lidocaine p Suctioning. Suctioned moderate amts of thick yellowish - white secretions. Adjusting settings on the ventilator in relationship to ABG's.
(0330)	Pt give lidocaine p suctioning @ 0200. Kept ICP's < 17 while suctioning and after. HR ↓ from 120's to 115. BP improved Suction a lot from ETT. Sats from 94% to 98%. Pt tolerate well. Will continue to monitor. [redacted] CT
(0625)	Pt did well throughout rest of night. Sats stayed

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b(6)-2 A11

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
24sep03 (0625 cont.	above 97%. on 70%. FiO_2 SIMV20, TV 600, Peep 10. Lidocaine given a tracheostomy. ICP's never went above 20. HR down from 120's to 105. Temp down to 99.2. Sats down @ 99%. and ICP around 10. Tube feeds stopped @ 0430 for angiogram today. Report given to LT [redacted] b(6)-2 [redacted] LT (NP)
25Sep03 0625	Neurosurgery b(6)-2 Vanc/Cipro.
	(SO) Afebrile, SBP ~ 100. ICP 12-22.
	I/O 2250/2750 Ventriculostomy ~ 10-15/hr.
	Pentothal @ 400/hr. FiO_2 70%. Peep 10.
	10.8) 10.5 / 34C (37.9 133 / 4.9 114 / 37 23 / 0.6 (134
	Barb Coma. LLL Consolidation.
	(NP) (1) PBI - Problems overnight likely related to pulmonary issues. Responded to ↑ Pentobarb and pretreatment suctioning with lidocaine.
	(2) Pneumonia - LLL a bit worse. Plugging seems to be a problem. ↑ TV to 700. Vanc added to cipro.
	Angio scheduled for today [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.

b(6)-4 [redacted]

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/1999)
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USAPA V1.00

b(c)-2 All

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
29Sep03	Assumed pt care @ 0615. BP 90's/40's. Dr [redacted] wave 0635 ↑ TV @ 700
~~0~~ on 0645	Gave 500cc [redacted] bolus per doctor's order. Will do ABGs @ 0700. Continue to monitor [redacted] ILT/AW
0740	Called Dr. [redacted] 28.0 PO_2 76 HCO_3 25 SO_2 97%. Will ↓ BB to 16 & ↑ Nipride to 350mg/hr. Will continue to monitor [redacted] ILT/AW
0830	Pt to OR [redacted]. ABGs done @ 0815 results given to OR [redacted] ILT/AW
29Sep03 1210	Pt a[redacted] @ 1010 BP 70's/40's Ephedra 10mg IVP given & started Dopamine drip @ 5mcg/Kg/min. Pt responded well. BP ↑ 120's/5[illegible] O_2 sat @ 92% given lidocaine 50mg IVP & suctioned pt, obtained large amount of thick greenish secretions. O_2 sat ↑ 98%. Per CRNA report pt. given in OR a total of 625mg Penthabol, 10mg Vecuronium & 500cc NS. EBL <100cc, urine output 700cc. Pt started on D5NS c 20mEq KCl @ 150cc/hr. & @ 1120 penthabol ↓ 300mg/hr. Pt hemodinamica[illegible] @ this moment. @ groin puncture site c no signs of bleed[illegible] +2 pedal pulses bilateral ~~leg~~. Will continue to monitor. [redacted] ILT/AW
29Sep03 1950	Received rep[redacted] and assumed care of pt @ [redacted] DA Form 4700 OP 375 for assessment data. RT came in and gave pt RT tx around 1950. Placed pt on some humidified air. Pt's sats started dropping from 98% to 88% on same settings. Installed 3cc NS, preoxygenated, gave lidocaine 50mg. Then suctioned ICP's as bp's 26. D/C suctioned a lot of thick whitish yellow secretions. W/P suctioning Sats up to 95% or >. ICP's around 22. Monitoring to see if

STANDARD FORM 509 (REV. 5/1999) BACK

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