33 yo ♂ NKDA

ANESTHESIA PLAN OF CARE PRE-PROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 33 DAYS MOS (YRS) Sex (X) MALE ( ) FEMALE

PROPOSED PROCEDURE: I&D (R) leg
SURGICAL SERVICE: Ortho / [redacted] (b)(6)-2
NPO SINCE: MN

ASA Physical State 1 (2) 3 4 5 E
WT: 50 (KG)/LB HT: ___ IN.
ALLERGIES: NKDA

HABITS:
TOBACCO: (+) cigarettes & hookah
ETOH: (+) Ch/Occ
DRUGS: Denies Drug User

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) Ancef - last dose 6am
( ) Toradol
( ) Ativan
( ) Thiamine
( )
( )

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

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

5 / 11 / 35 / 302

136 | 104 | 7 / 95
3.9 | 19 | 0.5

PT 12.4 PTT 31.6
INR 1.03

PREOPERATIVE PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:			
Hypertension	(N)	Y	
Angina	(N)	Y	
MI	(N)	Y	
CVA	(N)	Y	
Other	(N)	Y	
Pulmonary System:			
Asthma	(N)	Y	
Bronchitis/URI	(N)	Y	
COPD	(N)	Y	
Other	(N)	Y	
Renal System:			
Acute/Chronic RF	(N)	Y	
Gastrointestinal:			
Hepatitis	(N)	Y	
Hiatal Hernia	(N)	Y	
PUD/GERD	(N)	Y	
Endocrine System:			
Diabetes	(N)	Y	
Steriods	(N)	Y	
Thyroid	(N)	Y	
Neurological:			
Seizures	(N)	Y	
Neuropathy	(N)	Y	
Other	(N)	Y	
Gynecological:			
Pregnancy	N	Y	N/A
Other Significant Hx:	N	(Y)	EPW s/p mine blast (B) arm amputation c open Tib/Fib injury (L) leg (10 wks ago)
	N	Y	
Familial HX	N	Y	

ASSESSMENT
PAST SURGICAL/ANESTHETIC
Sx on arm stumps p mine blast

PHYSICAL EXAMINATION
BP 152/63 HR 70 R ___ T 98 1/10 100
Pain Scale 0-10
HEENT - Teeth Intact
Trachea midline
TMJ/Neck
Oropharnyx MP II-III
Nares
CHEST: CTA
CARDIAC:
EXTREMITIES:
IV Access (L) 18g EJ
Ulnar Filling:
BACK:
OTHER: (R) Prox tibia c exposed black bone

NPO Since MN

ANESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ___ (X) General: Mask Intubation

Pt consented via Interpreter

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discussed with the patient/legal guardian.

The patient [redacted] seems to understand and agrees. Questions answered.
Signed: [redacted] CPT KRWA (b)(6)-2 Date: 26 Sep 03 Time: 1045 Hrs

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

Signed: ___ Date: ___ Time: ___ Hrs

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

Patient Identification: (Ward) ICW #1

[redacted] (b)(6)-4

[redacted] (b)(6)-4

MEDCOM - 20441

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

Previous edition is obsolete

ACLU-RDI 1657 p.1

DOD-034015

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
Lidocaine	(mg)	100	
Propofol	(mg)	110	
Zemuron	(mg)	40 10	
	( )		
	( )		
VOLAT AGENT: Iso	% del	0.4–0.6–0.6.5 X	
	% e.t.		
AIR	L/Min		
N2O	L/Min		
O2	L/Min	10 – 2 – 2 – 2 – 10	

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

FLUIDS

LINE site: (L) EJ — ☐ Warmed — 1L ——— (300)
☐ Warmed — (500)
☐ Warmed
☐ Warmed

LOSSES — EST BLOOD LOSS / URINE – (Not measured)

TOTAL URINE: Not measured

FLUIDS - SUMMARY

- CRYSTALLOID– 300cc
- COLLOID– Ø
- BLOOD– Ø

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

1200 Pt id'd in ICW1, Chart reviewed. To OR via litter
1215 In room. Monitors ⊕ oxygenation. Smooth IV induction, easy ventilation, PP padded, eyes taped. Bupivacaine (R) Hip.
1245 Procedure started.
1313 Reversed c̄ Sug Neost ⊕ Oxygen Robinul,
1316 At awake, ⊕ sync, extubated s̄ difficulty, To PACU stable report to RN

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 50 (KG) LB

HEMATOCRIT: 11/35

INITIAL DATA: BP – 117/73; HR – 78

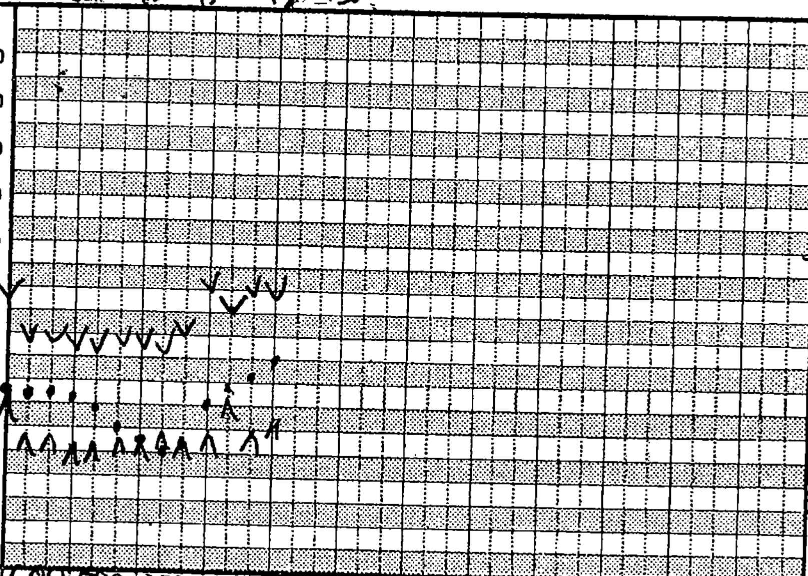
EQUIP CHECK: OK? – (Y) N

PATIENT CHECKS: OK for PROCEDURE [redacted]

TIME – 1200

TIME → 1215 30 45 1300 15 30

SYMBOLS: BP by cuff ∨ ∧; Heart rate •; Resp rate; BP (transduced); TOURNIQUET T – (b)(6)-2; ANES – X-X; PROC ⊙ – Ø



VENTILATION

VT – ml	600	590	550	560	400	
f – breaths/min	16	9	9	7	16	
Peak insp pres / PEEP	–	16	17	15	–	
MODE – S(pon), A(ssist), C(on)	S	C	C	C	S	

MONITORS / ACCESSORIES

X BP/Auto Cuff	X ET CO2 (torr)	⊕	31	32	36	38	
BP / oth	X FIO2 (Frac or %)	.55	.57	.59	.59	.90	
ART line	X SpO2 (%)	100	100	100	100	100	
Steth- PC/ES	X ECG	SR	SR	SR	SR	SR	
Gas analyzer	X TEMP- site Skin	98	98	97°	97°		
	X N-M Block (T/4)			4/4	1/4	4/4	ESTE50
Warming blkt							
Conv warmer							

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

RECOVERY AT 1320 — (PACU) ICU ____ (Specify)
OTHER
CONDITION: stable/awake
RESP– 20 SpO2– 98%
BP– 119/71 HR– 107

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1200	1215	1325
	Ready	**Begin**	**End**
PROC	1222	1245	135

PROCEDURES and CPT Codes

I&D (B) legs

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

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* — DVL x1 atraumatic c̄ MAC 3 blade #7 ETT. Grade I view ⊕ BBS ⊕ ETCO2. secured @ 23cm teeth, oral airway placed. Atraumatic.

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

[redacted] (b)(6)-4

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

ANESTHETIST: (b)(6)-2 [redacted] CRNA

PROCEDURE LOCATION: OR 2

DATE: 26 Sep 03

PAGE 1 OF 1

[redacted] OP 376 REVISED 1 Jan 99

PATIENT RECORD

MEDCOM - 20442

ACLU-RDI 1657 p.2

DOD-034016

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
[redacted] (b)(6)-2 1300 18OCT03

NURSING UNIT: 24° / ROOM NO.: 2315 / BED NO.: 18OCT03

DATE OF ORDER: 18OCT03 TIME OF ORDER: 1150 HOURS

LIST TIME ORDER NOTED AND SIGN

~~Continue Rx~~
1) Resume previous orders
2) Regular diet
3) Hep lock IV
4) Resume antibiotics
5) Vac to low continuous suction

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

DATE OF ORDER / TIME OF ORDER (b)(6)-2 [redacted]

NURSING UNIT: ICW / ROOM NO. / BED NO.

PATIENT IDENTIFICATION
[redacted] (b)(6)-4
Noted [redacted]
(b)(6)-2

DATE OF ORDER: 10/20/03 TIME OF ORDER: 2013 HOURS

Add Dilantin XL 5mg PO BID
1st dose now
[redacted] (b)(6)-2

NURSING UNIT: 24° / ROOM NO.: 2100 / BED NO.: 21OCT03 [redacted] (b)(6)-2

PATIENT IDENTIFICATION
(b)(6)-4
[redacted]
noted + done
[redacted]

DATE OF ORDER / TIME OF ORDER: 21OCT @1530 HOURS

d/c Suprapubic catheter
VO Dr [redacted] / Spc [redacted]
(b)(6)-2 (b)(6)-2

NURSING UNIT: (b)(6)-2 ROOM [redacted] NO.
21Oct @1600

24° V 21Oct @ 0046 [redacted]
(b)(6)-2

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.

ICU #1 | 24 | [redacted]

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

26 SEP 03 | 1310 HOURS

1. Resume previous orders
2. Regular diet
3. IV - LR @ 100 cc/Hr. Keep lock when taking pt. to well. Noted [redacted]
4. NPO after midnight 27 SEP 03 for surgery 28 SEP

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

DATE OF ORDER | TIME OF ORDER

(b)(6)-2

1. Change previous Ativan to Ativan 1mg IV or PO q12°

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

[redacted]

(b)(6)-2

DATE OF ORDER | TIME OF ORDER

28 SEP 03 @ 0100 HOURS

1. Place Foley V.O. DR [redacted]

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

NURSING UNIT | ROOM NO. | BED NO.

ICU / 28 SEP @ 0200

(b)(6)-2

PATIENT IDENTIFICATION

[redacted]

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

(6)(6)-4

[redacted]

NURSING UNIT: ICU | ROOM NO.: 9/25/03 | BED NO.: 24°N

DATE OF ORDER: 28 SEPT 03 | TIME OF ORDER: 0430 HOURS | LIST TIME ORDER NOTED AND SIGN

1. REGULAR DIET
2. NPO AFTER MIDNIGHT. TO OR TOMORROW.

(6)(6)-2 [redacted] (6)(6)-2 [redacted]

(6)(6)-2 [redacted] Dep ID

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 1 OCT 03 | TIME OF ORDER: 1015 HOURS

3. NASSUMS PHRONS ONDONS
4. NEBULIZER DIET
5. CBC ROUTINE TID
6. N-22 AT 125 CC/HR. HEP LOCK WITH FLUSHES P.O. WELL
7. VAC DEVICE ON (A) LOG #0

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: LOW CONTINUOUS SUCTION | TIME OF ORDER: HOURS

8. NPO AFTER MIDNIGHT 30 OCT 03, FOR OR 4 OCT 03

Voided WPR 01 OCT 03 1145

(6)(6)-2 [redacted]

(6)(6)-2 [redacted]

(6)(6)-2 [redacted]

NURSING UNIT: 24°W ICU 03 | ROOM NO. | BED NO.: 2100

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER: HOURS

1. D/C Thiamine
2. MVI qD PO
3. Δ Ativan to 0.5mg PO or IV q8° x 3 days then 0.5mg PO or IV Q12° x 3 days then 0.5mg PO or IV q4H x 3 days then stop

(6)(6)-2 [redacted]

0200/ 1200

NURSING UNIT | ROOM NO. | BED NO.

24°/ 0020 30 OCT 03 [redacted]

(6)(6)-2

(6)(6)-2

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

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] (6)(6)-4

29 SEP 03 1800 LOA

NURSING UNIT | ROOM NO. (6)(6)-2 | BED NO.

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
29 SEP 03	1715 HOURS	
1. RESUME PREVIOUS ORDERS		
2. RESUME DIET		
3. DISCONTINUE IV. WHEN FINISHED PICC WILL BE		
4. SUPPOSITORIES TUBES TO CHARTLY		
5. WBT TO HOLD DRESSING CHANGES TO (R) TIBIA BID.		

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

DATE OF ORDER	TIME OF ORDER	
6. NPO after midnight 30 September for OR 1 October.		

NURSING UNIT | ROOM NO. | BED NO.

24 IV / 29 SEP 03 | 1800 [redacted] LOA

PATIENT IDENTIFICATION (6)(6)-2

DATE OF ORDER	TIME OF ORDER	
	HOURS	

NURSING UNIT | ROOM NO. | BED NO.

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

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.

MEDICAL RECORD - DOCTOR'S ORDER

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 9.29.03 1725	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. [redacted] (b)(6)-2		
(3)	Morphine / ~~Meperidine~~ ~~2-5 mg IV~~ now and 2.5 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____mg IV prn N/V x 1.		
6	Droperidol____mg IV prn N/V x 1.		
(7)	Phenergan 12.5 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.		
	THANKS		
	(b)(6)-2 [redacted] RN		

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

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.

PATIENT IDENTIFICATION

[redacted] (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

ICW | 24 | 04[redacted] (b)(6)-2

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	25 SEP 03	1440 HOURS	
1	ADMIT TO ICW-1		
2	DX: OPEN (R) TIBIA, MULTIPLE FRACTURES		
3	CONDITION - STABLE		
4	VS: ROUTINE		
5	OOB TO CHAIR TID.		
6	NPO AFTER MIDNIGHT		
	DATE OF ORDER	TIME OF ORDER	
7	REGULAR DIET HOURS		
8	IV HEP LOCK		
9	ANCEF 1 GRAM IVPB Q 8 HRS		
10	TYLENOL 650 MG P.O. Q 4 HRS PRN		
11	TYLENOL #3, 1-2 P.O. Q 4-6 HRS PRN		
12	[redacted] (b)(6)-2 25MG P.O. OR IV Q 6 HRS PRN ~~X 24 HRS~~		
13	TORADOL 30 MG IVP Q 6 HRS X 24 HRS		
14	TO OR IN A.M.		
	DATE OF ORDER	TIME OF ORDER	
15	ATIVAN 1 MG IVP Q 8 HRS PRN HOLD IF LETHARGIC.	HOURS	
16	[redacted] (b)(6)-2		
	DATE OF ORDER	TIME OF ORDER	
	[redacted] (b)(6)-2	HOURS	
	THERAPEUTIC 10U IV OR PO QD		
	[redacted] (b)(6)-2		
	[redacted] (b)(6)-2		

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

MEDICAL RECORD | **PROGRESS NOTES** | AUTHORIZED FOR LOCAL REPRODUCTION

DATE	NOTES
29 Sep 03 1715	Ortho Op Note
	Pre Op Dx: Infected (R) tibia
	Post Op Dx: Same
	Procedure: I+D (R) tibia
	Surgeon: [redacted] (b)(6)-2
	Specimen: culture swab (R) tibia
	Findings: shaft tissue over edges of tibia then necrosed. Frank pus in wound. Closed with 3L pulse lavage
	Plan: BID wet to dry dressings. Repeat I+D 48 hours
	(b)(6)-2 [redacted]

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

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

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

REGISTER NO. | WARD NO.

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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

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] (6)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 4 OCT 03 TIME OF ORDER 1015 HOURS

LIST TIME ORDER NOTED AND SIGN

1. RESUME PRENATAL DIET
2. DC ANCEF
3. BEGIN: UNASYN 500 mg IVPB Q 6 HRS
4. 20 WK 3,375 Gm IVPB Q 6 HRS
5. RESUME DIET WITH ICE CHIPS/MEDS
6. N.S. @ 125 cc/HR KEEP LOCK WITH

PATIENT IDENTIFICATION

[redacted] (6)(6)-2

Noted WJA 04OCT03 1125

DATE OF ORDER TIME OF ORDER

FLUSH P.O. WITH HOURS

7. VAL DOWN TO LOW CONTINUOUS SUCTION.

[redacted] (6)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

ICU 24 | 5 OCT 03 | 30 [redacted]

PATIENT IDENTIFICATION

[redacted] (6)(6)-2

DATE OF ORDER 04OCT03 TIME OF ORDER 1630 HOURS

May d/c cont. suction 2 hrs
NPO p MN for SX 07OCT03
V.O. Dr. [redacted] (6)(6)-2 WJA (6)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

ICU | 030 | 7001 [redacted] (6)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER 6 OCT 03 TIME OF ORDER 1950 HOURS

8. NPO after MIDNIGHT, FOR OR 1600 hrs

NURSING UNIT | ROOM NO. | BED NO.

[redacted] (6)(6)-2

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

MEDICAL RECORD

AUTHORIZED FOR LOCAL REPRODUCTION

DATE | PROGRESS NOTES

NOTES

4 OCT 03
1015

Ortho Op Note

Pre-Op Dx - Infected open (R) Tibia
Post Op Dx - Same
Procedure: I+D (R) tibia, apply VAC dressing
Surgeon - [redacted] (b)(6)-2
Findings - Purulent exudate, but good granulation tissue. Culture results from 29 SEPT 03:
① Proteus penneri - resistant to all except Meropenem, Moxifloxacin and Gatifloxacin, and intermediate to Levofloxacin
② Pseudomonas aeruginosa -
sensitive to Levofloxacin 500 mg IV Q 12hrs, Zosyn 3.375 gm IV Q 6 hours, Pleni - repeat I+D in 72 hours

(b)(6)-2 [redacted]

(b)(6)-2 [redacted] CDR MC

RELATIONSHIP TO SPONSOR

SPONSOR'S NAME: LAST | FIRST | MI

BRANCH/SERVICE

SPONSOR'S ID NUMBER (SSN or Other)

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

HOSPITAL OR MEDICAL FACILITY

RECORDS MAINTAINED AT

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER 7 OCT 03 TIME OF ORDER 1526 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Resume previous orders
2. Hep lock IV.
3. VBL to have continuous suction may clamp at bedtime off suction
4. Regular diet.

PATIENT IDENTIFICATION

[redacted] (b)(6)-2

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICW1	A1	1000 10 OCT 03

DATE OF ORDER 10 OCT 03 TIME OF ORDER 1200 HOURS

(b)(6)-2

1. Resume previous orders
2. Hep lock IV.
3. VBL to have continuous suction
4. Regular diet.

[redacted] (b)(6)-2 10/10/03 1200 (b)(6)-2

PATIENT IDENTIFICATION

[redacted] (b)(6)-2

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER HOURS

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	Brief Op Note
7 Oct 03	Pre-Op Dx Infection (R) tibia
1323	Post Op Dx - Same
	Procedure - Surgery; I+D (R) tibia,
	application of VAC device
	Surgeon: [redacted] (b)(6)-2
	EBL min
	Fluids LR
	Findings - Granulating well [redacted]
	(b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK
USAPA 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
10Oct03	0950 POST ANESTHESIA ORDERS (circled Items)		
(1)	VS q 5 min X 15 min, then q 15 min until discharge.		
(2)	Supplemental oxygen. (PRN SaO_2 < 95%)		
(3)	Morphine / Meperidine 2 mg IV now and 2 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 25 mg IV prn N/V x 1.		
8	Benadryl 25-50mg IVP q1 hr prn, itching while in PACU.		
(9)	IVF: LR @ TKO cc/hr.		
(10)	Discharge from recovery status when PACU discharge criteria met.		
(11)	Demerol 12.5 mg IV x 2 max dose 25 mg PRN for post-op [redacted] (b)(6)-2 CRNA/MAJ (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 (b)(2)-2 MC V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10 OCT 07	Ortho Cyp - Note Pre Op Dx - Open (R) tibia fracture Post Op Dx - same Procedure - I+D, replace VAC (R) tibia Surgeon - [redacted] (b)(6)-2 EBL - min Findings - Wound clean Gangrene tissue over ~ 60% of tibia Plan - Repeat I+D with eventually need skin graft (b)(6)-2 [redacted]

HOSPITAL OR MEDICAL FACILITY!!	STATUS	DEPART./SERVICE!!	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.!!	RELATIONSHIP TO SPONSOR	

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

[redacted] (b)(6)-4

REGISTER NO. | WARD NO.!!

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

MEDCOM - 20455

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

(b)(6)-2 [redacted]

NURSING UNIT	ROOM NO.	BED NO.
24°	160CT03	[redacted] (b)(6)-2

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
15 OCT 03	1140 HOURS	

1. Resume prepare orders
2. Regular diet
3. Keep Locky IV.
4. VAC to low continuous suction

150CT@1815

(b)(6)-2 [redacted]

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

(b)(6)-2 [redacted]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	
16 OCT 03	2200 HOURS	

1. RESTORIL 15mg po QHS PRN.

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

(b)(6)-2 [redacted]

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

(b)(6)-2 [redacted]

NURSING UNIT	ROOM NO.	BED NO.
24° / 0100	170CT03	(b)(6)-2 [redacted]

DATE OF ORDER	TIME OF ORDER	
16 OCT 03	2245 HOURS	

1. RESTORIL 30 mg P.O. QHS PRN.

(b)(6)-2 [redacted]

PATIENT IDENTIFICATION

(b)(6)-4 [redacted]

(b)(6)-2 [redacted]

NURSING UNIT	ROOM NO.	BED NO.
24° / 1800	180CT03 0100	(b)(6)-2 [redacted]

DATE OF ORDER	TIME OF ORDER	
17 OCT 03	1600 HOURS	

1. NPO p MN + To on Tomorrow

(b)(6)-2 [redacted]

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

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 10/15/03 1147	ORDER NOTED TIME & INITIALS	COMPLETED TIME & INITIALS
	POST ANESTHESIA ORDERS (circled Items)		
(1)	VS q 5 min X 15 min, then q 15 min until discharge.		
2	Supplemental oxygen.		
(3)	Morphine / ~~Meperidine 2-4 mg IV~~ now and 2 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____mg IV prn N/V x 1.		
6	Droperidol____mg IV prn N/V x 1.		
(7)	Phenergan 12.5 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 (b)(6)-2		
	[redacted] (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 (b)(2)-2 MC V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	Ortho Op Note
15 Oct 03 1140	Pre-Op Dx - Infected (R) tibia, Post Op Dx - same Procedure I+D (R) tibia, change VAC Findings - Wound very clean, beefy red Granulation tissue over 75% of bone. Plan Repeat I+D prepare for STSG
	(b)(6)-2 [redacted]

HOSPITAL OR MEDICAL FACILITY!!	STATUS	DEPART./SERVICE!!	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.!!	RELATIONSHIP TO SPONSOR	

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

[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 USAPA V2.00

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.

24° / 18 OCT 0100 (b)(6)-2 [redacted]

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
17 Oct	1730 HOURS	
(1) Hold IV ABT		
V.O Dr [redacted] (b)(6)-2	[redacted] (b)(6)-2	ZLTN

PATIENT IDENTIFICATION

(b)(6)-2 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

24° ✓ | 20 OCT | 0200 [redacted] ZLTN

DATE OF ORDER	TIME OF ORDER
19 Oct 03	1600 HOURS
Hold 8mg q6° prn IVP	
V.O. Dr [redacted] (b)(6)-2	[redacted] (b)(6)-2
(b)(6)-2 [redacted]	(b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-4 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

24° ✓ | 23 OCT 03 | 1700 [redacted] (b)(6)-2

DATE OF ORDER	TIME OF ORDER
23 OCT 03	1547 HOURS
(1) 24D after midnight	
to Dr tomorrow	

PATIENT IDENTIFICATION

(b)(6)-2 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

24° ✓ | [redacted] 24 OCT 03 0200

(b)(6)-2

DATE OF ORDER	TIME OF ORDER
24 OCT 03	HOURS
VO- U/A	
[redacted]	25 OCT (2) 0049

(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.

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
18 Aug 03	On the Op Note
1150	
	Pre Op Dx: Left (L) tibia
	Post Op Dx: Same
	Procedure: I+D (L) tibia
	Surgeon - [redacted] (b)(6)-2
	Anesthesia - Wound packing,
	Plan - Repeat I+D, wait until
	ready for STSG.
	[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. 6/1998)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)

USAPA V1.00

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
1	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 3 mg IV now and 2 mg q 3-5 min prn pain for a max dose of 15 mg.		
4	Zofran 4 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 [redacted] status when PACU discharge criteria met.		

[redacted] CPT 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

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] (6)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 24 OCT 03 TIME OF ORDER: 1125 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Resume previous orders
2. N - LR @ 100 cc/hr. Hep Lock when tube D.O. NPO
3. Regular diet
4. CBC, Metabolic-8 in A.M.
5. UBC to Low Continuous Suction

PATIENT IDENTIFICATION

[redacted] (6)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 31 OCT 03 TIME OF ORDER: 1415 HOURS

1. Resume previous orders
2. Regular diet
3. OSB to Chest tube
4. CBC in A.M.

PATIENT IDENTIFICATION

[redacted] (6)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

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.

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
24 Oct 03 1125	Ortho Op Note Pre-Op Dx - Open (R) tibia, Post Op Dx - same Procedure: I+D (R) tibia Surgeon: [redacted] (b)(6)-2 Anes - MAC Findings - Required both bone leads. Still 1x3 cm area exposed bone. Plan - Wet to dry VAC x 3-5 days.
	(b)(6)-2 [redacted]
31 Oct 03 1430	Ortho Op Note Pre-Op Dx - Open (R) tibia Post Op Dx - same Procedure: STSG over (R) thigh to (R) calf Surgeon: [redacted] (b)(6)-2 Anes - MAC

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
	Findings - (B) Fasciocutaneous flaps viable. STSG from thigh to calf.
	Plan: Dressing applied. Will check in 5 days.
	(b)(6)-2 [redacted]
	(b)(6)-2 [redacted]

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

MEDCOM - 20464

ACLU-RDI 1657 p.24

DOD-034038

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

(6)(6)-4

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

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

1405 | 25 OCT 03 HOURS

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

1. Loperamide 4mg X1 now then 2mg after every stool for total of 8 mg after initial

2. Stool culture per 25 OCT 03

[redacted] (6)(6)-2 1430

1430

PATIENT IDENTIFICATION

(6)(6)-4

[redacted]

noted [redacted] (6)(6)-2

260CT03 (1510)

DATE OF ORDER | TIME OF ORDER

26 OCT 03 | 1500 HOURS

1. Foley to gravity

(6)(6)-2 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER

28 OCT 03 | 1950 HOURS

1. Benadryl 25mg IV/PO/IM q6° PRN ITCH

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

(6)(6)-2 noted [redacted]

NURSING UNIT | ROOM NO. | BED NO.

24°/0100 29OCT03 [redacted] (6)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER

29 OCT 03 | 1420 HOURS

1. Resume previous orders
2. Regular diet
3. IV - Heparin lock when taking PO well
4. Reinforce dressing prn
5. NPO after midnight 30 OCT for surgery 31 OCT.

noted [redacted] (6)(6)-2

1630 29OCT

NURSING UNIT | ROOM NO. | BED NO.

24°/ [redacted] (6)(6)-2

[redacted] (6)(6)-2

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

MEDCOM - 20465

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
	29Oct03/1400 POST ANESTHESIA ORDERS (circled Items)		
(1)	VS q 5 min X 15 min, then q 15 min until discharge.		
(2)	Supplemental oxygen. PRN SaO_2 <95%		
(3)	Morphine / Meperidine 2 mg IV now and 2 mg q 3-5 min prn pain for a		
	max dose of 10 mg.		
X	Zofran____mg IV prn N/V q 15 min, may repeat x ____.		
(5)	Metoclopramide 10 mg IV prn N/V x 1.		
X	Droperidol____mg IV prn N/V x 1.		
X	Phenergan____mg IV prn N/V x 1.		
(8)	Benadryl 25-50mg IVP q1 hr prn, itching while in PACU.		
(9)	IVF: LR @ TKO cc/hr.		
(10)	Discharge from recovery status when PACU discharge criteria met.		
	[redacted] CRNA/MAJ (b)(6)-2 (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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

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

NURSING UNIT: ICW#1 | ROOM NO. | BED NO.

noted 24° [redacted] (b)(6)-2

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

3NOV03 @ 1930 (b)(6)-2

VO Dr [redacted] / LT [redacted] (b)(6)-2

25mg Benadryl IV x1 now

3NOV03 @ 2240 (b)(6)-2

VO Dr [redacted] / LT [redacted] (b)(6)-2

25mg Atarax PO Q6° PRN

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

noted (b)(6)-2 [redacted] 5Nov03

NURSING UNIT: (b)(6)-2 | ROOM NO. | BED NO.

DATE OF ORDER: ~~4NOV03~~ | TIME OF ORDER: ~~0100~~ HOURS

5 NOV 03 1820

1. [illegible]
   [illegible]
2. [illegible]
3. [illegible] 5 mg PO. Q HS [illegible]

(b)(6)-2 [redacted]

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

noted [redacted] (b)(6)-2

6Nov03 @ 1600

DATE OF ORDER: 6NOV03 | TIME OF ORDER: 1600 [redacted] HOURS

1. daily drsg Δ (R) leg
   apply bacitracin, fluffs
   and wrap c̄ kerlix.

(b)(6)-2

V/O DR [redacted] / SPC (b)(6)-2 [redacted]

NURSING UNIT: ICW 1 | ROOM NO. | BED NO. [redacted]

24° / 0230 6NOV03 [redacted]

PATIENT IDENTIFICATION: (b)(6)-2 # [redacted] (b)(6)-4

DATE OF ORDER | TIME OF ORDER (b)(6)-2 HOURS

NURSING UNIT: ICW#1 | ROOM NO. | BED NO.

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

MEDCOM - 20467

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: (b)(6)-2 | ROOM NO. | BED NO.

Noted [redacted] 11 NOV 03 0950

DATE OF ORDER: 11 NOV 03 | TIME OF ORDER: 0910 HOURS | LIST TIME ORDER NOTED AND SIGN

1. Discharge today to EPW camp.
2. Levofloxacin 250mg P.O. Q day. #30
3. Percocet 1-2 PO Q 4-6 hrs prn #20
4. Bacitracin ointment to wounds every day.
5. Please provide [illegible] wraps w/ patient belongings.

DATE OF ORDER | TIME OF ORDER [redacted] HOURS

6. Follow-up 1 week

(b)(6)-2

PATIENT IDENTIFICATION | DATE OF ORDER | TIME OF ORDER ______ HOURS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION | DATE OF ORDER | TIME OF ORDER ______ HOURS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION | DATE OF ORDER | TIME OF ORDER ______ HOURS

NURSING UNIT | ROOM NO. | BED NO.

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

MEDICAL RECORD	PROGRESS NOTES	AUTHORIZED FOR LOCAL REPRODUCTION

DATE	NOTES
	(b)(2)-2
	Author Discharge Note, [redacted]
11 NOV 03	33 y.o. IRAQI male 25 SEP 03, who had been injured at least 10 weeks prior by bomb blast, had open wound over (R) tibial tubercle with exposed, dead bone. Also (B) upper extremity amputations s/p skin grafts (L) leg.
	Found to have chronic infection over tibia with multiple organisms. IV antibiotics, s/p multiple I+Ds but unable to get wound to close over bone. Had fascio-cutaneous flap placed over tibia, followed by split-thickness skin graft. It is doing well.
	PLAN: LEVOFLOXACIN 250mg P.O. Q DAY #30
	DRESSING CHANGES TO (R) LEG SKIN GRAFT Q DAY WITH BACITRACIN OINTMENT.
	FOLLOW UP IN 1 WEEK.
	PENTOXIFYLLINE 1200 MG. Q 4-6 HRS PRN [redacted] (b)(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME		SPONSOR'S ID NUMBER
	LAST	FIRST	[redacted] (b)(6)-2

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

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.	(b)(6)-2	(b)(6)-2
3	Morphine / Meperidine 3 mg IV now and 2 mg q 3-5 min prn pain for a max dose of 15 mg.	1330 [redacted]	[redacted]
4	Zofran 4 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	Discha[redacted]status when PACU discharge criteria met.		
	[redacted] CRNA (b)(6)-2 (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 (b)(2)-2 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. 70 Keep Sat 95-9u		
3	~~Morphine~~ / Meperidine 2 mg IV now and 1-2 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: LR @ TKO cc/hr.		
10	Dis[redacted] recovery status when PACU discharge criteria met.		
	[redacted] CRNA		
	(6)(6)-2		

PATIENT IDENTIFICATION

[redacted] (6)(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

(6)(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 2 mg IV now and 2 mg q 3-5 min prn pain for a		
	max dose of 15 mg.		
4	Zofran 4 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	Disch[redacted]ery status when PACU discharge criteria met.		
	[redacted] CPT / CRNA (b)(6)-2		
	(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

★ RE-WRITTEN ★

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.

VERIFY BY INITIALING — *INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION* — *Mo.* ___ *Yr.* 2003

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED: 22 23 24 25 26 27 28 29 30 31 1 2 3 4
25Sept (b)(6)-2	[redacted]	VS Routine	06 18 18 06	[redacted]
25Spt (b)(6)-2	[redacted]	OOB TC TID	06 18 18 06	[redacted]
25Spt (b)(6)-2	[redacted]	Regular Diet	06 18 18 06	[redacted]
1OCT03 (b)(6)-2	[redacted]	1 can ensure TID	06 12 17	[redacted]
1OCT (b)(6)-2	[redacted]	Vac device on Ⓡ Leg to low continuous suction (may d/c suction @ HS)	06 18 18 16	[redacted] } D/C
25 OCT (b)(6)-2	[redacted]	CL DSG Δ's Q72°	22	X X X [redacted] X X [redacted] X X
26OCT (b)(6)-2	[redacted]	~~NIO~~ (HL'd) foley to gravity (b)(6)-2 ~~reinforce drsg~~ ([redacted])	06 18	→ [redacted]

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Open Ⓡ tibia, multiple amputations

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO: ______

PATIENT IDENTIFICATION:

EPW #[redacted] (b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)			Mo 09 Yr 2003	
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
25	[redacted]	Admit ICW #1; condition stable	25	—	—	[redacted]
25	[redacted]	NPO after MN; To OR in AM	26 SEP 03	0001	—	[redacted]
26 SEP 03	[redacted]	Resume previous orders	26	—	—	[redacted]
26	[redacted]	NPO p MN 27 SEP 03 for surgery 28 SEP 03	28 SEP 03	0001		
28	[redacted]	Place Foley	28 Sep			
9/28	[redacted]	NPO p MN	29 Sep	24cc	—	[redacted]
9/28	[redacted]	To OR tomorrow	29 Sep			
9/29	[redacted]	Resume previous orders (post-op)	29 Sep 03	—	—	[redacted]
28 SEP 03	[redacted]	NPO p MN 30 Sep for OR 1 Oct	1 OCT	0001		[redacted]
01 OCT 03	[redacted]	Resume previous orders	01 OCT 03	—	—	[redacted]
01	[redacted]	NPO after MN 03 OCT 03 for OR 04 OCT 03	04 OCT 03	0001	—	[redacted]
04 OCT 03	[redacted]	Resume previous orders	04	—	—	[redacted]
06 OCT 03	[redacted]	May d/c suction 2 hs	06 OCT 03	2000	2200	[redacted]
06 OCT 03	[redacted]	NPO p MN for sx 07 OCT 03	07 OCT 03	0001	0001	[redacted]
		(b)(6)-2 all				

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

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. 09 Yr. 2003

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 25 26 27 28 29 30 31 1 2 3 4 5 6 7 8
25 (6)(6)-2	[redacted]	US - routine	06	[redacted]
			18	[redacted]
25 (6)(6)-2	[redacted]	OOB TC TID	06	[redacted]
			18	[redacted]
25 (6)(6)-2	[redacted]	Regular Diet	06	[redacted]
			18	[redacted]
29 Sep 03 (6)(6)-2	[redacted]	Suprapubic tube to Gravity	06	[redacted]
			18	[redacted]
29 Sep 03 (6)(6)-2	[redacted]	W-TD Dsg Δ to (R) tibia BID	10	[redacted]
			20	[redacted]
01 Oct 03 (6)(6)-2	[redacted]	I can ensure TID	06	[redacted]
			12	[redacted]
			17	[redacted]
01 (6)(6)-2	[redacted]	Vac device on (R) leg to low continuous suction (may D/C sxn @ HS)	06	[redacted]
			18	[redacted]

Z-(6)(6)

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Open (R) tibia; multiple amputations

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO: ____

PATIENT IDENTIFICATION:

E# [redacted] (6)(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 - 20475

REWRITTEN

CLINICAL RECORD

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

Mo. 11 Yr. 2003

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 5	6	7	08	09	10	11	12	13
25 Sep	[redacted]	VS: routine	6	[redacted]								
(b)(6)-2			18									
25 Sep	[redacted]	COBTC TID	6									
(b)(6)-2			18									
25 Sep	[redacted]	Regular diet	6									
(10 Oct)	(b)(6)-2	c/ cranberry TID	18									
25 Oct	[redacted]	CL drsg Δ ≤ q 72°	22	X	X		X	X		X	X	
20 Oct	[redacted]	Foley to gravity	6	[redacted]								
(b)(6)-2			18	[redacted]			DC @ 1400 03					
5 Nov	[redacted]	TRIM XENOFORM	10	[redacted]					DC 1400 03			
(b)(6)-2		from thigh wound	X									
5		daily	X									
5 Nov	[redacted]	ambulate as	06	[redacted]								
(b)(6)-2		tolerated	18	[redacted]								
6 Nov	[redacted]	drsg Δ daily (R) leg	10	[redacted]								
(b)(6)-2		& apply bactracin,	X									
		fluffs and wrap	X									
		c Kerlix.										

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: open (R) tibia, mult. amputations

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

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 2 3 4 5 6 7 8 9 10 11 12 13 14 15
10CT03	[redacted]	IV LR @125cc/HR, HL	6	X [redacted] DC
(6)(6)-2	------	when taking po well	18	X [redacted]
	------		X	
2300PT	[redacted]	Ancef 1gm IVPB	6	X [redacted] DC
(6)(6)-2	------		14	X
(6)(6)-2	------		22	X
20CT	[redacted]	MVI po QD	10	X po [redacted]
20CT	[redacted]	ATIVAN taper:	/	
(6)(6)-2	------	0.5mg IV/PO Q8° x3D	6	/ [redacted]
	------	then	14	/ [redacted]
	------	↓	22	/ [redacted]
	------	0.5mg PO/IV Q12° x 3D	10	/ [redacted]
	------	then	22	/ [redacted]
	------	0.5mg po/IV QHS x3D	22	/ [redacted]
	------	then stop!	/	
04 OCT Q3	[redacted]	Levoquin 500mg IVPB	06	/
(6)(6)-2	------	Q6°	12	/
	------		18	/ ERROR
	------		24	/
04	[redacted]	Zosyn 3.375gm IVPB	04	/ [redacted]
(6)(6)-2	------	Q6°	10	/ [redacted]
	------		16	/ [redacted]
	------		22	/ [redacted]
04	[redacted]	Levaquin 500mg IVPB	10	/ [redacted]
(6)(6)-2	(6)(6)-2	po Daily		
15 OCT 03	[redacted]	Heplock IV: flush q	06	[redacted]
	(6)(6)-2	shift	18	
			18	
			06	[redacted]

(6)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: open ® tibia, mult. amputations

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

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

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)		Mo. 10 Yr. 03			
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials	
04 0030	[redacted]	DIC Ancef	04 0030	—	—	[redacted]	(b)(6)-2
10/10	[redacted]	Heplock IV	10/10				(b)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED														
25	[redacted]	Tylenol 650mg po Q4° prn	D/T	90CT 650mg 0730	110CT 1215	110CT 1620	130CT 1900												
			D/I	1720 D6	[redacted]														
25	[redacted]	Tylenol #3 1-2 tabs po Q4-6° prn	D/T	30CT 1500	40CT 1940	50CT 1935	60CT 831	80CT 1600	90CT 1000	110CT 1750	120CT 1100	120CT 1720	120CT 0025	140CT 2145	150CT 0200	150CT 0830			
			D/I	[redacted]										2	2	2			

(b)(6)-2

USAPA V1.00

CLINICAL RECORD

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

Mo. 10 Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 01 2
(b)(6)-2 01 OCT 03	[redacted]	IV LR @125cc/hr, HL when taking po well	06	[redacted]
			18	
(b)(6)-2 25 SEP 03	[redacted]	Ancef 1gm IVPB	06	[redacted]
			14	
			22	
(b)(6)-2 25 SEP 03	[redacted]	Thiamine 100mg IV or PO qD	10	[redacted] D/C
(b)(6)-2 27 SEP 03	[redacted]	Ativan 1mg IV or PO q12°	10	[redacted] d/d see below
			22	
(b)(6)-2 01 OCT	[redacted]	MVI qD PO	10	
(b)(6)-2 OR 01 OCT	[redacted]	Ativan tab 0.5 mg) Po or IV q8° x3 days then 0.5 mg PO or IV q12° x3 days then 0.5 mg PO or IV qHS x3 days then stop	06	
			14	
			22	
			10	
			22	
			22	

(b)(6)-2

reweeeee

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: open @ tibia, mutiple amputation

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

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
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED
31OCT03 25SEP03	[redacted]	Tylenol 650mg po 9400 pm	D/T 2003 1000
- - - - -	- - - - -		D/I [redacted]
25SEP03	[redacted]	Tylenol #3 1-2 tabs po 0946 pm	D/T 31OCT 1850 / 31OCT 1853 / 1OCT 2330
- - - - -	- - - - -		D/T [redacted]
- - - - -	- - - - -		
- - - - -	- - - - -		
- - - - -	- - - - -		
- - - - -	- - - - -		
- - - - -	- - - - -		
- - - - -	- - - - -		
- - - - -	- - - - -		
- - - - -	- - - - -		
- - - - -	- - - - -		

(b)(6)-2

(b)(6)-2

(b)(6)-2

USAPA V1.00

CLINICAL RECORD

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

Mo. 09 Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 25 26 27 28 29 30 01 02 03 04 05 06
25 Sept (6)(6)-2	[redacted]	IV heplock	06 / 18	[redacted] } DIC 26 SEP 03
25 Sept (6)(6)-2	[redacted]	Ancef 1gm IVPB	06 / 14 / 22	[redacted]
25 Sept (6)(6)-2	[redacted]	Tonadol 30mg IVP q6hrs x24 hrs	06 / 12 / 18 / 24	[redacted] } DIC 26 SEP 03
25 Sept (6)(6)-2	[redacted]	Atwan 1mg IVP q8hrs – HOLD if Lethargic	06 / 14 / 22	[redacted] } see Δ below
25 Sept (6)(6)-2	[redacted]	Thiamine 100mg IV or PO qD	10 /	[redacted]
26 SEP 03 (6)(6)-2	[redacted]	LR @ 100cc/hr (HL when taking po well)	06 / 18 /	[redacted] DIC 01 OCT 03
		~~Ativan~~ [redacted] (6)(6)-2		
27 SEP 03 (6)(6)-2	[redacted]	Ativan 1mg IVor PO q 12°	10 / / 22 / /	[redacted]
28 SEP 03 (6)(6)-2	[redacted]	HL IV When tol PO Well	06 — / / 18 — / /	[redacted] (See above)

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: open tibia, multi amputations

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

E# [redacted] (6)(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

(6)(6)-2

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

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*	*Mo.* 09 *Yr.* 03

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

	-----					

b)(6)-2

b)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* TIME/DATE DISPENSED													
25Sep	[redacted]	Tylenol 650mg	D/T	26SEP 1710	27SEP 1130											
-----	-----	PO q4hrs PRN	D/I	650 [redacted]	650mg [redacted]											
25Sep	[redacted]	Tylenol #3 PRN	D/T	9/25 198	26Sep ~~2220~~	27Sep 0300	28Sep 2020	29Sep 1830	29Sep 0530	29Sep 1600	30Sep 2000					
-----		1-2 tabs PO q4-6hrs	D/I	2 [redacted]	II [redacted]	II [redacted]	II [redacted]	II [redacted]	II [redacted]	II [redacted]	2 [redacted]					
-----	-----	/ / /	E/I	E												
-----	-----															
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(b)(6)-2

USAPA V1.00

MEDCOM - 20482

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

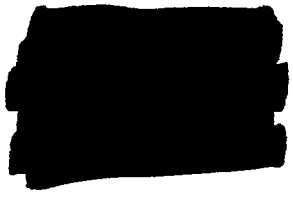
ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:



(b)(6)-4

DISPENSING TIMES

USE PENCIL, CIRCLE MED TIMES

D 7 8 9 10 11 12 13 14

E 15 16 17 18 19 20 21 22

N 23 24 01 02 03 04 05 06

DA FORM 1 FEB 79 4678 EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHA 'ED.

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
(b)(6)-2 3NOV [redacted]		Atarax 25mg PO Q6° PRN	3NOV 2300 [redacted] / 4NOV 0500 [redacted] / 4NOV 1100 25mg / 4NOV 2130 25mg / 5NOV 0945 25mg / 5NOV 1745 25mg / 6NOV 0000 25mg / 6NOV 1600 25mg / 6NOV 2330 25mg / 7NOV 0730 25 / 7NOV 1500 25mg / 7NOV 2130 25mg [redacted]
(b)(6)-2 5NOV [redacted]		Ambien 5mg PO QHS PRN	D/T 5NOV 2145 5mg / 6NOV 2350 5mg / 7NOV 2300 5mg / 8NOV 2115 5mg / 9NOV 2100 5mg [redacted]
			D/I [redacted]
			E/I E
(b)(6)-2 2NOV [redacted]		Atarax 25mg PO Q6° PRN	D/T 2NOV 2230 25mg / 3NOV 1815 25mg / 3NOV 2115 25mg / 4NOV 0730 25mg / 4NOV 1100 HELD / 4NOV 2000 25mg / 5NOV 0500 25mg / 5NOV 1230 25mg / 5NOV 1435 25mg / 6NOV 0110 25mg / 6NOV 0900 25mg
			D/I [redacted]
		~~Loperamide 2mg PO PRN stool for total~~	
05OCT [redacted]		Loperamide 2mg PO PRN stool for total 8 mg after initial	D/T
(b)(6)-2			D/I

2-(97)(9)

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

CLINICAL RECORD

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

Mo. 10 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 16 17 18 19 20 21 22 23 24 25 26 27 28 29
04 OCT 03	[redacted]	Zosyn 3.375 gm IVPB	04	[redacted]
(b)(6)-2	-----	q6°	10	[redacted]
	-----		16	[redacted]
	-----		22	[redacted]
04	[redacted]	Levaquin 500mg IVPB	10	[redacted]
(b)(6)-2	-----	daily		
15 OCT 03	[redacted]	Heplock IV: flush q	06	[redacted]
(b)(6)-2	-----	shift	18	[redacted]
02 OCT 03	[redacted]	mvi po QD	10	[redacted]
(6)(6)-2 [redacted] OCT	[redacted]	Ditropan XL 5mg po	08	[redacted]
(b)(6)-2	-----	BID	20	[redacted]
	-----			
25 OCT	[redacted]	Lopressor 2mg PO	6	/
(b)(6)-2	-----	after every vital	18	/
	-----	for total 8 mg		

25 OCT 1480 (H) (H)

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:
OPEN @ TIBIA
MULTIPLE AMPUTATIONS

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.

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
(b)(6)-2 7 oct	[redacted]	Hold IV ABT	17 oct	Now	1720	[redacted] (b)(6)-2
(b)(6)-2 16	[redacted]	Heplock IV, resume antibiotics	18 OCT			[redacted] (b)(6)-2
(b)(6)-2 25	[redacted]	Lorazepam 2mg x1 now	25 OCT	1430	1431	[redacted] (b)(6)-2

Order/Expir Date	Clerk/Nurse	PRN MEDICATION, DOSE, FREQUENCY		INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED												
(b)(6)-2 25SEP03	[redacted]	Tylenol 650mg po q 4° prn	D/T	Error 16OCT 0726	23 OCT 1830	24 OCT 0100	24 OCT 1000									
			D/I	[redacted]	ii	2	650 [redacted]									
(b)(6)-2 25SEP03	[redacted]	Tylenol #3 1-2 tabs PO q 4-6° prn	D/T	11OCT 0726	16OCT 1130	16OCT 1740	16OCT 2200	17OCT 1030	17OCT 2230	18OCT 1300	19OCT 2000	19OCT 0800	20OCT 2245	21OCT 0740	21OCT 2030	22OCT 0426
		(b)(6)-2	D/I	ii [redacted]	ii [redacted]	ii [redacted]	ii po [redacted]	ii [redacted]	ii po [redacted]	ii [redacted]	ii po [redacted]	ii po [redacted]	ii po [redacted]	2 [redacted]	2 [redacted]	2 [redacted]
(b)(6)-2 11Oct	[redacted]	RESTORIL [redacted] po QHS PRN 30mg	D/T	16OCT 2230	19OCT 2000	20OCT 2245										
			D/I	i po [redacted]	i [redacted]	i po [redacted]										
(b)(6)2 19SEP03	[redacted]	Haldol 5mg IVP q6° prn	D/T	19OCT 1600	20OCT 0900	20OCT 1900	Error 23OCT									
			D/I	5mg [redacted]	5mg [redacted]	5mg [redacted]										
(b)(6)2 25Sept	[redacted]	Rewritten Tylenol #3 1-2 tabs	D/T	22OCT 1930	25OCT 0000	26OCT 1600	26 2030									
		PO Q4-6° PRN	D/I	ii [redacted]	ii [redacted]	2 [redacted]	2 [redacted]									
(b)(6)-2 28	[redacted]	Benadryl 25mg IV/PO/IM q6° PRN	D/T	28OCT 1445	29OCT 1030	29OCT 1700										
			D/I	IV [redacted]	PO [redacted]	[redacted]										

(b)(6)-2

MEDCOM - 20486

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

30CT638

RE-WRITTEN

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. 11

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 30 31 1 2 3 4 5 6 7 8 9 10 11
04OCT	[redacted]	Zosyn 3.375 gm IVPB	04	[redacted]
(6)(6)-2	-----	q 6°	10	
	-----		16	
	-----		22	

04OCT	[redacted]	Levaquin 500mg IVPB	10	[redacted]
(6)(6)-2	-----	daily		

15OCT	[redacted]	Heplock IV: Flush q	06 18	[redacted]
(6)(6)-2	-----	shift	18 06	

02OCT	[redacted]	MVI PO QD	10	[redacted]
(6)(6)-2	-----			
20CT	[redacted]	Ditropan XL 5mg PO	08	[redacted]
(6)(6)-2	-----	BID	20	

25OCT	[redacted]	Loperamide 2mg PO		PRN
(6)(6)-2	-----	after every 2 stool for		
	-----	total 8mg after initial		

Z-19(9)

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Open ® Tibia Multiple amputations

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

[redacted] (6)(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.

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo. 11 Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials	
(b)(6)-2 3NOV	[redacted]	25mg Benadryl IV x1 now	3NOV	-	~~2050~~ 1950	[redacted]	(b)(6)-2
(b)(6)-2 11 NOV03	[redacted]	DC meds: Levofloxacin 250mg po QD, Bacitracin to wound qq, Percocet 1-2 po q4-6° prn	11			[redacted]	(b)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
(b)(6)-2 25OCT	[redacted]	Tylenol 650mg PO q4° PRN														
(b)(6)-2 25OCT	[redacted]	Tylenol #3 1-2 tabs po IV q 4-6 PRN	30OCT 0500 2	30OCT 1940 2	31 1100 2	31OCT 2300 4po	1NOV 1600 II	2NOV 0830 II	4NOV 1615 II	05NOV 1210 II	05NOV 1740 II	5NOV 2215 II	6NOV 2330 II	7NOV 2330 4	08NOV 0830 II	09NOV 1625 II
			[redacted]													
(b)(6)-2 16OCT	[redacted]	Restoril po qHS PRN 30mg	2NOV 2330 [redacted]													
(b)(6)-2 19OCT	[redacted]	Haldol 5mg IVP Q6° PRN	D/C													
(b)(6)-2 25Sept	[redacted]	Tylenol #3 1-2 tabs Po Q4-6° PRN	3NOV 2115 4po	4NOV 0730 (2)	9NOV 1610 2	10NOV 0000 2	10NOV 0955 II	10NOV 1715 II	11NOV 0605 II							
			[redacted]													
(b)(6)-2 28OCT	[redacted]	Benadryl 25mg IV/PO/IM Q6° PRN	3NOV 1200 25IV	3NOV 1800 25IV	5NOV 2130 25N	7/8NOV [illegible] 25mg	10NOV 0900 25mg IV	10NOV 1500 25mg	11NOV 0010 25mg	11NOV 1150 25mg IV						
			[redacted]													

(b)(6)-2

[redacted]OM - 20488

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

ACLU-RDI 1657 p.48

DOD-034062

Rewritten [redacted] (b)(6)-2

CLINICAL RECORD | **THERAPEUTIC DOCUMENTATION/CARE PLAN** *(NON-MEDICATION)* | Mo. 10 Yr. 2003

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

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 9 10 11 12 13 14 15 16 17 18 19 20 21
(b)(6)-2 25	[redacted]	V/S Routine	06	[redacted]
(b)(6)-2 25	[redacted]	ODSTC TID	06	[redacted]
(b)(6)-2 25	[redacted]	Regular Diet	06	[redacted]
(b)(6)-2 28	[redacted]	Suprapubic tube to Gravity	06	[redacted]
(b)(6)-2 1 Oct	[redacted]	I can ensure TID	06	[redacted]
			12	
			17	
(b)(6)-2 1 Oct	[redacted]	Vac. device on (R) leg to low continuous suction (May d/c suction @ HS)	06	[redacted]

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Open (R) fx tibia; multiple amputations

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO PAGE NO: 2

PATIENT IDENTIFICATION:

EPW # [redacted] (b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

MEDCOM - 20489

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo Oct Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
	----	Resume previous Orders				
15 OCT03	[redacted]	Resume previous orders	15 OCT03			[redacted] (b)(6)-2
18 OCT	[redacted]	Resume previous orders	18 OCT			[redacted] (b)(6)-2
21 OCT	[redacted]	remove SP cath	21 OCT	1400	done	[redacted] (b)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED
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USAPA V1.00

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo _____ Yr 2003

Verify by Initialing

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
23 Oct	[redacted]	NPO p MN to OR Tomorrow	24 Oct	0001	0001	[redacted]
24 Oct	[redacted]	U/A	[redacted]		[redacted]	
25 Oct	[redacted]	Stool culture	ASAP			
29 Oct	[redacted]	Resume prev. orders				
29 Oct	[redacted]	NPO p MN 30 OCT	30 Oct	0001	[redacted]	
29 Oct	[redacted]	for OR 31 OCT 03	31 Oct			

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED
29 Oct	[redacted]	reinforce drsg PRN	D/T
			D/T

USAPA V1.00

(b)(6)-2

(b)(6)-2

(b)(6)-2

(b)(6)-2

(b)(6)-2

(b)(6)-2

(b)(6)-2

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM _____ HOURS
TO _____ HOURS

TOTAL HOURS COVERED

DATE

INTAKE

~~ORAL~~ (condom catheter) *

TIME	TYPE	AMOUNT	ACCUM TOTAL
1400	CVU	350	350
0450		1000	1350

~~INTRAVENOUS~~ (SIP catheter) *

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
(06-1800)		Ø			Ø

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

USAPPC V1.00

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

(21OCT-22OCT03
06-0600)

MEDCOM - 20492

TWENTY-FOUR HOUR PATIENT I [illegible] KE AND OUTPUT WORKSHEET

FROM 0600 HOURS TO 0600 HOURS | TOTAL HOURS COVERED 24 | DATE 21-22OCT

INTAKE

~~ORAL~~ (ORAL)*

TIME	TYPE	AMOUNT	ACCUM TOTAL
1000	H2O	500	500cc
1600	JUICE x3	600	1100cc

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (*Include Medications*)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
		Zosyn			50cc
		Levaquin			100cc

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

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

USAPPC V1.00

(b)(6)-4

[redacted]

21OCT-22OCT03
(06-0600)

MEDCOM - 20493

(THIS FORM IS SUBJECT TO THE PRIVACY ACT OF 1974)

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM 1800 HOURS TO 1800 HOURS | TOTAL HOURS COVERED 24 | DATE 15OCT03

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
1930	500cc H20	500	500cc
2210	100 H20	600	600cc

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
2200	50ml	Zosyn	50cc	2235	50
0400	50ml	Zosyn	50cc	0440	100cc

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. B1, A1b, P. cells etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

DD FORM 792, JAN 74 (EG) EDITION OF 1 SEP 54 IS OBSOLETE. Designed using Perform Pro, WHS/DIOR, Jun 94

(6)(6)-4

[redacted]

MEDCOM - 20494

1800 → 1800

5DT

OUTPUT

* (R tibia suction)

URINE (SP cath) *

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
0300	300 (x1)	300cc			

~~NASOGASTRIC~~

TIME	AMOUNT	TYPE	ACCUM TOTAL
0400	25cc	brown.	25cc

CHEST

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL

GRAND TOTAL OUTPUT

REMARKS

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

[redacted] (61161-4

INTAKE EQUIVALENTS *(Serving levels cc)*

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

(THIS FORM IS SUBJECT TO THE PRIVACY ACT OF 1974)

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM [illegible] HOURS
TO [illegible] HOURS
TOTAL HOURS COVERED 24
DATE 2004

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL

INTRAVENOUS

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

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

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT *(i.e. B1, A1b, P. cells etc.)*	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

DD FORM 792, JAN 74 (EG) EDITION OF 1 SEP 54 IS OBSOLETE. Designed using Perform Pro, WHS/DIOR, Jun 94

[redacted] (b)(6)-4

MEDCOM - 20496

OUTPUT

(R) leg vac.

URINE — S/P cath.

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
0900	300cc	300cc			
1700	150cc	450cc			
1900	? x1	void to bed			
2030	? x1	void to bed			
0200	x 1	void to bed			
0500	200	voided			

~~NASOGASTRIC~~

TIME	AMOUNT	TYPE	ACCUM TOTAL
0600	15cc	bm	15cc
0500	0		15cc

CHEST

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL

GRAND TOTAL OUTPUT

REMARKS

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

20DEC23
(0600-0600)

#[redacted]
(6)(6)1-4

INTAKE EQUIVALENTS *(Serving levels cc)*

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

I. Output I/O's

(THIS FORM IS SUBJECT TO THE PRIVACY ACT OF 1974)

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM ______ HOURS
TO ______ HOURS

TOTAL HOURS COVERED

DATE: 14Oct03

INTAKE

ORAL				INTRAVENOUS					
TIME	TYPE	AMOUNT	ACCUM TOTAL	TIME STARTED	AMOUNT	TYPE *(Include Medications)*	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
1200	juice	240	240	2200	500cc	200yn	500cc	2250	500cc
1800	H2O	200	440	0400	500cc	200yn [illegible]	500cc	0455	1000cc
1830	juice	240	680cc						

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

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT *(i.e. B1, Alb, P. cells etc.)*	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

DD FORM 792, JAN 74 (EG)

EDITION OF 1 SEP 54 IS OBSOLETE.

Designed using Perform Pro, WHS/DIOR, Jun 94

MEDCOM - 20498

OUTPUT

SP foley URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
1725	525	525			
~~2300~~ 2300	400	925			

(R) leg vac ~~NASOGASTRIC~~

TIME	AMOUNT	TYPE	ACCUM TOTAL
0445	10cc	green/brn.	10cc

CHEST

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL

GRAND TOTAL OUTPUT

REMARKS

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

[redacted] (b)(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

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

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM ______ HOURS TO ______ HOURS	TOTAL HOURS COVERED	DATE

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
1215 ~~0715~~	Juice x3	600	600cc
1730 ~~0930~~	H_2O	800	1400cc
1800	Ensure		
1900	H2O		
2000	H2O		
0520	H2O		
1800	coke	250	

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (*Include Medications*)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
		Zosyn	5		50cc
		Levaquin			100cc
2200	3.375gm	Zosyn			

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

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

USAPPC V1.00

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

22OCT03 (22OCT–23OCT) (0600–0600)

MEDCOM - 20500

TWENTY-FOUR HOUR PATIENT I[illegible]KE AND OUTPUT WORKSHEET

FROM ___ _HOURS
TO _____HOURS

TOTAL HOURS COVERED

DATE

~~INTAKE~~ Output

~~ORAL~~ Texas Catheter

TIME	TYPE	AMOUNT	ACCUM TOTAL
1730	clear yellow urine	1100	1100
0625	dark yellow urine	1200	2300

INTRAVENOUS

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

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

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

USAPPC V1.00

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

23 OCT - 24 OCT
(06 - 0600)

MEDCOM - 20501

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM _____ HOURS
TO _____ HOURS

TOTAL HOURS COVERED

DATE

INTAKE

~~ORAL~~ (Foley)

TIME	TYPE	AMOUNT	ACCUM TOTAL
1000	900cc cyu		900
1500	600 cyu		1500cc
	5 NOV 03 06-1900		
1700	1100cc cyu		1100cc

~~INTRAVENOUS~~

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

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. BI, A1b, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

USAPPC V1.00

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

OUTPUT

(FOLEY) URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
1540	150cc	150cc			
1610	130cc	280cc			
0500	550	830cc			
1530	200	1030cc			
1700	200	1230cc			
2040	600	1830cc			
1000	300	2130cc			
1200	200	2330cc			
0550	1200	1200			
1330	700	1900cc			
2100	400	2300			
0600	800	3100cc			

~~NASOGASTRIC~~ (R) lcg SXN

TIME	AMOUNT	TYPE	ACCUM TOTAL
1610	15cc	brown	15cc
0500	0	—	15cc
		(d/c'd)	

CHEST

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL

GRAND TOTAL OUTPUT

REMARKS

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

[redacted] (b)(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

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

DD FORM 792, JAN 74 EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3630(TEMP) 1 JUL 72 WHICH MAY BE USED. USAPPC V1.00

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM 1500 HOURS
TO 0600 HOURS
TOTAL HOURS COVERED 15
DATE 26OCT03

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
1600	H2O	500	500cc

INTRAVENOUS

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

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

USAPPC V1.00

[redacted] (b)(6)-4

OUTPUT

URINE *SP foley*						NASOGASTRIC *(R) icg suction*			
TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	TYPE	ACCUM TOTAL

CHEST						EMESIS			
TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS				
TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT			
TIME	AMOUNT	TYPE	ACCUM TOTAL
GRAND TOTAL OUTPUT			

REMARKS

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

[redacted] (b)(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

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

DD FORM 792, JAN 74

1500 (a-d)

(THIS FORM IS SUBJECT TO THE PRIVACY ACT OF 1974)

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM 0600 HOURS TO 0600 HOURS | TOTAL HOURS COVERED 24 | DATE 15OCT03

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL

INTRAVENOUS *ZOSYN*

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

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT *(i.e. B1, A1b, P. cells etc.)*	TIME COMPL	AMOUNT	ACCUM TOTAL

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

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

DD FORM 792, JAN 74 (EG) EDITION OF 1 SEP 54 IS OBSOLETE. Designed using Perform Pro, WHS/DIOR, Jun 94

[redacted] (b)(6)-4

15 OCT 03
(00-00)

MEDCOM - 20506

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo 11 Yr 2003

Verity by Initialing

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
11 Nov	[redacted]	Dictate to EPW camp				
11	[redacted]	Please provide 7 Kerlex rolls when pt departs				
11	[redacted]	Follow up 1 week	18			[redacted] (6)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED
(6)(6)-2 2001	[redacted]	Reinforce dsg PRN D/T/I	
----	----		
----	----		
----	----		
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USAPA V1.00

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE: **Post-Anesthesia Care Unit (PACU) Flow Sheet** | OTSG APPROVED (Date)

Date: 26 Sep 03 | Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block

Time In: 1422

Allergies: NKDA | OR Intake: Crystalloid 300 Colloid 0

Pre-op V/S: BP 123/71 P 76 | OR Output: UOP 0 EBL 0

Procedures: Bil. 4th legs | Meds/Times: 1350 Pent.

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

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds | History

Time	1422	1425	1430	1435	1440
SaO2	96	97	96	94	96
FIO2					
Methods	RA	RA	RA	RA	RA
240					
220					
200					
180					
160					
140	V	V	V	V	V
120	V				
100	•				
80	•	•	•	•	
60	^	^	^	^	^
40					
20					
RR	11	10	10	14	16
T	96		96		96
Time					
Pain (0-10)					
LOS					

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1410	LR	425 cc	EJ	IV	100 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	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	1	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	0	0	0
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C,	10	9	10

Codes

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

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

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

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

Patient teaching done: Wound Care, Pain Management, T, C, & DB,. Incentive Spirometer, Comfort Measures

Safety: SR up X 2, Falls Precautions. Privacy Maintained

(Continue on reverse)

PREPARED BY (Signature & Title): [redacted] (b)(6)-2 | DEPARTMENT/SERVICE/CLINIC: PACU | DATE: 26 Sep 03

IDENTIFICATION (For typed or written entries give: Name – last, ...; middle; grade; date; hospital or medical facility)

[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
1326		MSO4 5mg	IV	(b)(6)	-2	[redacted]
1335		MSO4 3mg	IV	(b)(6)	-2	[redacted]

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	Lext.	+	+	P	B	W	Pk
15'							
30'	Lext.	+	+	P	B	W	P
45'							
60'							
90'							
D/C	Lext	+	+	P	B	W	P

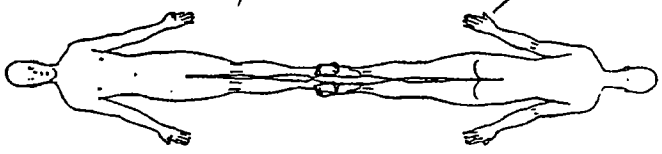
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	Both Legs	Curlex	Ø
30'	Both Legs	Curlex	Ø
60'			
D/C	Both Legs	Curlex	Ø



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1410	NSR	Ø	Ø

WAMC OP 173-E

NURSING NOTES

Pt Admitted to PACU SP I&D both legs. PARS 10. PAIN controlled w/ 5mg MSO4. (b)(6)-2
Dressing CDI w/ pulse present — pfc [redacted]
Pt discharged to ICU1 Report given to (b)(6)-2
LT [redacted] Transferred by pfc [redacted] (b)(6)-2
via Lifter pfc [redacted] (b)(6)-2

Discharge Criteria:
Date: 26SEP05 Time: 1410 PARS: 10
BP: 134/50 T: 96.5 HR: 60 RR: 7 Sa02: 95%
Pain Level at D/C (0-10):
Intake: 100cc/hr Output: Ø
Additional Data: Ø
Transferred To: ICU1
Report Given To: LT [redacted] (b)(6)-2
Transferred Via: W/C (Lifter) Gurney Ambulance
Transferred By: pfc [redacted] (b)(6)-2
Cleared IAW Recovery Room [redacted] (b)(6)-2
Charge Nurse Signature: [redacted]

MEDCOM - 20509

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: 10 JUL
Time In: 1142
Allergies: NKDA
Pre-op V/S:
Procedures: SP TOBACCO

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 100 Colloid
OR Output: UOP 100 EBL minimal
Meds/Times:

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds

History

Time	1135	1142																
SaO2																		
FIO2																		
Methods																		
240																		
220																		
200																		
180																		
160																		
140																		
120																		
100																		
80																		
60																		
40																		
20																		
RR																		
T																		

Time										
Pain (0-10)										
LOS										

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays:

Labs:

Post-Anesthesia Recovery score

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

Codes

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

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

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

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

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

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC PACU

DATE 10 JUL 4

PATIENT IDENTIFICATION (If not typed or written entries give: first, middle; grade; date; hospital or medical facility)

Name – last, [redacted] (b)(6)-4

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

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

USAPPC V2.00

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	Ⓑ	ꝑ full	full	+2	<3s	warm	[redacted]
15'						(b)(6)-2	
30'							
45'							
60'							
90'							
D/C							

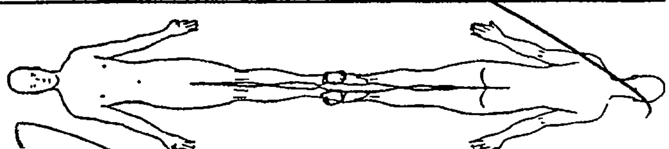
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic, P = Pale, Pk = Pink
Capillary Refill: B = Brisk, S = Sluggish

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm.			
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

Assumed pt care from OR staff, pt hemodynamically stable & in no apparent distress. A/Ox3 appropriate Non combative. Circulation sluggish ... CV ... ā ... S1 S2 +1 pedal pulses. Resp even, unlabored SpO2 100% on RA ... Ⓑ ... G3 ... BS hypo ... GU ... Lines ... patent

(b)(6)-2

[redacted]

Discharge Criteria:
Date: 10/24 Time: 1150 PARS: 10
BP: 90/60 T: 98 HR: 60 RR: 16 Sa02: 100
Pain Level at D/C (0-10): 0
Intake: ____ Output: 610 cc
Additional Data:
Transferred To: ICW
Report Given To: Spc [redacted] (b)(6)-2
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: LT [redacted] (b)(6)-2
Cleared IAW Recovery Room [redacted] (b)(6)-2
Charge Nurse Signature: [redacted]

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED *(Date)*

Date: _____ Anesthesia Type (Circle): General Spinal Epidural
Time In: 1725 IV Sedation Nerve Block
Allergies: NKDA OR Intake: Crystalloid 900 Colloid _____
Pre-op V/S: 94/45 86 OR Output: UOP 160 EBL mm
Procedures: cystoscopy Meds/Times: _____
S/P with ZHO (2) last

ASA II
Prep
Gas
2 remaining
Suprapubic

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds _____ History _____

Time	1725	1730	1735	1745	1800
SaO2	94	98	100	95	98
FiO2	RA	RA	RA	RA	RA
Methods					
240					
220					
200					
180					
160					
140					
120	^		^	^	^
100					
80					
60					
40	V	V			
20					
RR	28	13	12	12	21
T	95				97

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1926	LR	300	OES	AA	400
1600	Ringers	100	S/P Cath	MJ	100
1600	NS Flush	~120	S/P Cath	MS	120

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

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)

PRE [redacted] (b)(6)-2 SSG/CPN

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 25 May 03

PATIENT'S IDENTIFICATION [redacted] 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
1740 2030	Helan	2mg MSO4	IVP	/	/	[redacted]
1750	Helan	2mg MSO4	IVP	/	/	[redacted]
1800	Helan	2mg MSO4	IVP	/	/	[redacted]

NEUROVASCULAR

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

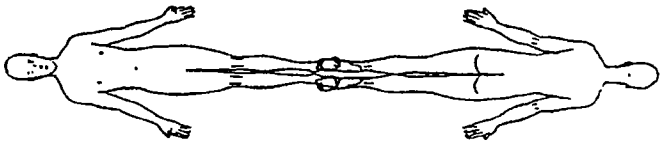
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

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?

WAMC OP 173-E

NURSING NOTES

1735 male CPW admit Head to PACU
(b)(6)-2
AP IVO @ Leg; Suprapubic cath; Cystoscopy
(b)(6)-2
Pt A+O, PSO2 99% RA VSS DSG to
(b)(6)-2
Legs CDI. Suprapubic cath draining yellow urine tegrity. @ EJ c UR @
TKO patent. Pt C/O Pain 2mg MSO4 given
[redacted] SSG/LPN (b)(6)-2
1600 Suprapubic cath complete xray c contrast
(b)(6)-2
done by Dr [redacted] Placement confirmed
by Dr [redacted] SSG/LPN
(b)(6)-2 (b)(6)-2

Discharge Criteria:
Date: 29SEP05 **Time:** 1810 **PARS:** 10
BP: 104/62 **T:** 97 **HR:** 81 **RR:** 18 **Sa02:** 95
Pain Level at D/C (0-10):
Intake: 620 **Output:** 600
Additional Data:
Transferred To: ICU
Report Given To: SPC [redacted] (b)(6)-2
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: SSG [redacted] (b)(6)-2
Cleared IAW Recovery Room S[illegible] 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: 01 Oct 03 Anesthesia Type (Circle)) General Spinal Epidural LMA
Time In: 1030 IV Sedation Nerve Block
Allergies: NKDA OR Intake: Crystalloid 400cc Colloid
Pre-op V/S: 140/88 80 OR Output: UOP 500 EBL 650cc
Procedures: I&D R leg Meds/Times: 300mg Fent
7 JP placement

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

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds

History

Time	1030	1035	1041	1055	1110													
SaO2	96	100	100	100	98													
FiO2																		
Methods	RA	RA	RA	RA	RA													
240																		
220																		
200																		
180																		
160																		
140																		
120																		
100																		
80																		
60																		
40																		
20																		
RR	16	10	20	24	12													
T																		
Time																		
Pain (0-10)																		
LOS																		

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1120	LR	150	IV		

X-rays: Labs:

Post-Anesthesia Recovery score

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

Codes

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

V/S
X = A-line BP
° = Cuff BP
= Pulse

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

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

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

(Continue on reverse)

PREPARED BY [redacted] Sig (b)(6)-2 | DEPARTMENT/SERVICE/CLINIC: PACU | DATE: 01 Oct 03

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

SPC [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
1030		Fent 100mcg	IV		(b)(6)-2	Mg [redacted]
1040		Demerol 12.5mg	IV		(b)(6)-2	Cpt [redacted]

NEUROVASCULAR

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

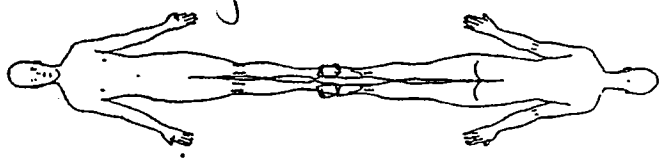
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm 1034	Rleg		JP drain
30' 1108	Rleg		JP drain
60'			
D/C 1140	Rleg		JP drain



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1030	NSR	Ø	Ø

WAMC OP 173-E

NURSING NOTES

Pt received from OR. VSS. O2 sats 96% RA. Pt very verbal and moving around in Pt keeps c/o pain. 100mcg Fent & 12.5mg Demerol given. Pt has JP drain that will be hooked up to wall suction.

Discharge Criteria:
Date: 01Oct03 Time: 1040 PARS: 10
BP: 159/48 T: 96.6 HR: 68 RR: 10 Sa02: 100
Pain Level at D/C (0-10): 0
Intake: 100cc Output: 0
Additional Data: none
Transferred To: ICU 1
Report Given To: Li [redacted] (b)(6)-2
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: SP [redacted] (b)(6)-2
Cleared IAW Recovery Roo [redacted]
Charge Nurse Signature: [redacted] (b)(6)-2

MEDCOM - 20515

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 4 OCT 03
Time In: 1025
Allergies: NKDA
Pre-op V/S: 100 / 59 / 98
Procedures: I+D I&D

Anesthesia Type (Circle)): General Spinal Epidural
IV Sedation Nerve Block MAC

OR Intake: Crystalloid 250 Colloid 0
OR Output: UOP 100 EBL 0
Meds/Times: Fentanyl, VERSED

Drains	Airway
Hemovac	Nasal
NG	Oral
JP	ETT
T-tube	Trach
Foley	Other
TLS	

Pre Op Meds / History

Time	1025	1035	1045	1050
SaO2	99	98	100	98
FiO2				
Methods	RA	RA	RA	RA
240				
220				
200				
180				
160				
140				
120	V	V	V	V
100				
80	^	^	^	^
60				
40				
20				
RR	22	10	16	
T	96			

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1025	LR	700	IV	OR	300

X-rays:

Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	1	1	1
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	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.	9	9	9

Codes

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

V/S
X = A-line BP
˚ = Cuff BP
= Pulse

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

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

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)

PREPARED [redacted] LPN (6)(6)-2

DEPARTMENT/SERVICE/CLINIC PACU

DATE 4 OCT 03

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

Name – last,

[redacted] (6)(6)-2

- ☐ 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	(R) leg	FROM	+	P	B	W	PK
15'							
30'							
45'							
60'							
90'							
D/C	(R) leg	FROM	+	P	B	W	PK

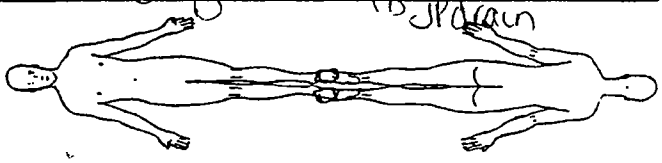
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(R) leg	IOBAN, GAUZE & SP drain	~~0~~
30'			
60'			
D/C	(R) leg	Ioban, gauze & SP drain	~~0~~



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1025	SR	~~0~~	~~0~~

WAMC OP 173-E

NURSING NOTES

Pt to recovery room from OR via litter s/p I&D (R) leg. IV of LR infusing into (R) IV. ~~0~~ s/s of redness OR edema to site. Ioban dressing to (R) leg c gauze & SP drain intact. ~~0~~ drainage noted. VSS ~~0~~ c/o @ this time. Will continue to monitor. [redacted] LR

(6)(6)-2

Discharge Criteria:
Date: 4 OCT **Time:** 1110 **PARS:** 9
BP: 121/72 **T:** 96.1 **HR:** 98 **RR:** 12 **Sa02:** 97% RA
Pain Level at D/C (0-10):
Intake: 50 **Output:** ~~0~~
Additional Data:
Transferred To: IC W#1
Report Given To: [redacted] (6)(6)-2
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: [redacted] (6)(6)-2
Cleared IAW Recovery Room S[redacted]
Charge Nurse Signature: [redacted] (6)(6)-2

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: _____ Anesthesia Type (Circle)): General Spinal Epidural
Time In: _____ IV Sedation Nerve Block
Allergies: NKDA OR Intake: Crystalloid 300 ML Colloid _____
Pre-op V/S: 90/56 86 OR Output: UOP 300cc EBL n.v.
Procedures: 710 @ Meds/Times: _____

30 MSO4
250 Fent

Drains: (Hemovac) NG JP T-tube (Foley) TLS

Airway: (Nasal) Oral ETT Trach Other — out

Pre Op Meds _____ History _____

Time	1530	1535	1540	1741	1802
SaO2	94	93	93	94	98
FiO2	RA	RA	RA	RA	RA
Methods					
240					
220					
200					
180					
160					
140					
120					
100	6				
80	^			•	
60	V	V	V	V	V
40					
20					
RR	22	16	8	12	9
T					

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1530	LRNS	700	RFJ	[redacted]	(b)(6)-2

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

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)

PREPARED BY: [redacted] (b)(6)-2 | DEPARTMENT/SERVICE/CLINIC: PACU | DATE: 7 Oct 03

PATIENT'S IDENTIFICATION (For typed or written entries: Name – last, first, middle; grade; date; hospital or medical record number)

EDW# [redacted] (b)(6)-4

[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							
15'							
30'							
45'							
60'							
90'							
D/C							

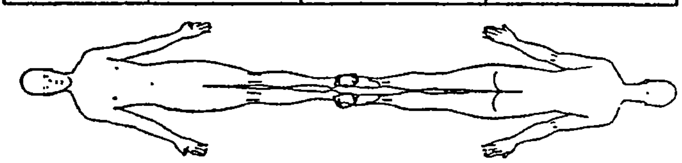
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

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?

WAMC OP 173-E

NURSING NOTES

1530 male Iraqi EPW admitted to PACU S/P (R) leg I&D. SpO_2 98% RA USS NPA removed upon admission. IV (R) EJ NS @ TKO. IV patent. Drain to (R) leg clamped off [illegible] [redacted] SSG/CPL
(b)(6)-2

Discharge Criteria:
Date: 30 Jul 03 **Time:** 1612 **PARS:** 10
BP: 98/48 **T:** 98.3 **HR:** 104 **RR:** 12 **Sa02:** 98%
Pain Level at D/C (0-10):
Intake: 200 **Output:**
Additional Data:
Transferred To: ICW 3
Report Given To: SPC [redacted] (b)(6)-2
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: SSG [redacted] (b)(6)-2
Cleared IAW Recovery Room S[redacted]-3
Charge Nurse Signature:

MEDCOM - 20519

ACLU-RDI 1657 p.79

DOD-034093

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: 10 Oct 03
Time In: 1205
Allergies: NKDA
Pre-op V/S: 98/56 63
Procedures:

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 1000 LR Colloid
OR Output: UOP 0 EBL 0
Meds/Times:

5mg Versed
10mg MSO4

Drains	Airway
Hemovac	Nasal
NG	Oral
JP	ETT
T-tube	Trach
Foley	Other
TLS	

Pre Op Meds

History

Time	1205	1210	1215	1220	1230
SaO2	100%	98%	98%	98%	99%
FiO2	RA	RA	RA	RA	RA
Methods					
240					
220					
200					
180					
160					
140					
120					
100				^	^
80	^		^		
60	^	^	^	^	^
			V	V	V
40	V	V			
20					
RR	9	9	20	18	19
T	97				

Time	
Pain (0-10)	
LOS	

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1205	LR	400	(R) ES	[redacted]	(b)(6)-2

X-rays:

Labs:

Post-Anesthesia Recovery score

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

Codes

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

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

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

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

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

(Continue on reverse)

PREPARED BY (Signature): (b)(6)-2 [redacted] SSG/LPN

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 10 Oct 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

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1210	Ifolan	2 mg MSO_4	IV		(b)(6)-2	[redacted]
1230	Ifolan	2 mg MSO_4	IV		(b)(6)-2	
0230	Ifolan	1 mg MSO_4	IV		(b)(6)-2	

NEUROVASCULAR

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

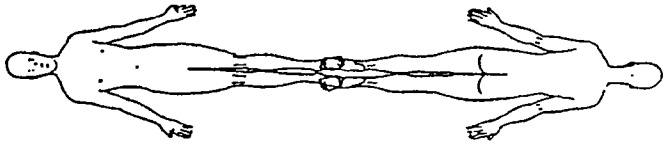
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm			
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

1400 - Male Iraqi EPW admitted to PACU S/P I&D @ Tibia / Replace Ex. Fix. Dsg's CDI. Vacuum base clamped off. IV to @ ES LR @ TKO. Patient fully to Frailty, [redacted] (b)(6)-2 SSG/USA

Discharge Criteria:
Date: 10 Oct 03 Time: 1521 PARS: 10
BP: 97/59 T: HR: 50 RR: 14 Sa02: 99% RA
Pain Level at D/C (0-10):
Intake: 1000 cc Output: 500
Additional Data:
Transferred To: ICU
Report Given To: SSG [redacted] (b)(6)-2
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: SSG [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

DTSG APPROVED (Date)

Date: 15 Oct 03
Time In: 1152
Allergies: NKDA
Pre-op V/S: 109/55 40
Procedures:

Anesthesia Type (Circle): (General) Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 400 Colloid
OR Output: UOP Ø EBL Ø
Meds/Times: 2 Versed, 150 Fent,

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

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds

History

Time	1152	1157	1202	1212
SaO2	98	100	98	100
FiO2				
Methods	RA	RA	RA	RA
240				
220				
200				
180				
160				
140				V
120			V	V
100	✓			
80	•	•		•
60			•	
40	^		^	^ ^
20				
RR	15	12	12	15
T	98			
Time				
Pain (0-10)				
LOS				

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1220	LR	100	IV		

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	1	1	1
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	10	10	10

Codes:
AIRWAY: A = Ambu, BB = Blow-by, M = Mask, FT = Face Tent, RA = RoomAir, NC = Nasal Cannula
V/S: X = A-line BP, ° = Cuff BP, = Pulse
TEMP: S = Skin, O = Oral, A = Axillary, T = Tympanic, R = Rectal
LOS: C = Cervical, T = Thoracic, L = Lumbar, S = Sacral

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

(Continue on reverse)

[redacted] (6)(6)-2

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 15 Oct 03

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

Name – last,

[redacted] (6)(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
1213		5mg Haldol				

NEUROVASCULAR

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

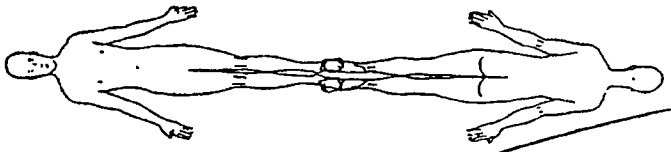
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm 1158	Rleg		4x4 to suction
30' 1222	Rleg		Dressing
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1152	NSR	Ø	Ø

WAMC OP 173-E

NURSING NOTES

Pt to pacu S/p I+D. O2 sats 100% RA. Pt very verbal about leg. No c/o pain. Pt given 5mg Haldol for extreme agitation. Pt report given to Spc [redacted] (b)(6)-2 RN by Capt [redacted] (b)(6)-2 (b)(6)-2 RN

Discharge Criteria:
Date: 15Oct13 Time: 1220 PARS: 10
BP: 139/54 T: 96.0 HR: 55 RR: 19 Sa02: 100
Pain Level at D/C (0-10): 0
Intake: 0 Output: 0
Additional Data: none
Transferred To: ICU
Report Given To: Spc [redacted] (b)(6)-2
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: 18Oct03 Anesthesia Type (Circle)): General Spinal Epidural
Time In: 1157 IV Sedation Nerve Block
Allergies: NKDA OR Intake: Crystalloid _____ Colloid 400
Pre-op V/S: 115/58 75 OR Output: UOP 0 EBL 0
Procedures: washout Meds/Times: 100 Fent 20 Propofol

Drains	Airway
Hemovac	Nasal
NG	Oral
JP	ETT
T-tube	Trach
Foley	Other
TLS	

Pre Op Meds History

Time	1157	1802	1807	1820
SaO2	90	99	99	99
FiO2				
Methods	RA	NK	NK	NK
240				
220				
200				
180				
160				
140				
120				
100				
80				
60				
40				
20				
RR	10	30	30	16
T	96			

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

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

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)

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

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

[redacted] (b)(6)-4

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

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

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 leg	+	+	P	B	WM	PK
15'	L leg	+	+	P	B	WM	PK
30'	L leg	+	R	P	R	WM	PK
45'							
60'							
90'							
D/C	L leg	+	+	P	B	WM	PK

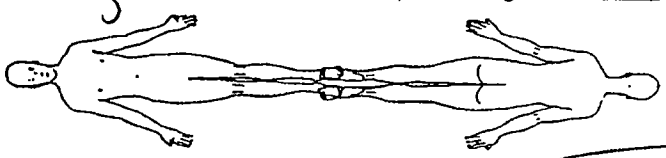
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, PK = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm L leg	→	Kerlex	Suction
30' L leg	→	Kerlex	Suction
60'			
D/C L leg	→	Kerlex	Suction



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1157	NSR	Ø	Ø

WAMC OP 173-E

NURSING NOTES

Pt received from OR s/p I&D. Pt O2 sats 100% RA Pt awoke, very agitated, asking for Valium. Pt calmed down after talking to interpreter (b)(6)-2 Pt VSS. Pt c/o pain — [redacted] Report given to Lt [redacted] (b)(6)-2

(b)(6)-2

Discharge Criteria:
Date: ~~[illegible]~~ 1600 Time: 1225 PARS: 10
BP: 153/47 T: 96.0 HR: 73 RR: 10 Sa02: 100
Pain Level at D/C (0-10): 0
Intake: 0 Output: 0
Additional Data: NONE
Transferred To: ICU
Report Given To: Lt [redacted] (b)(6)-2
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: [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: 31 OCT
Time In: 1423
Allergies: —
Pre-op V/S: 102/58 64
Procedures: 3TSG
Dress Thigh @ Ka @ Shin

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 300 Colloid
OR Output: UOP 300/50 EBL 50
Meds/Times: 250 Fent, Reversed a OR

Drains	Airway
Hemovac	Nasal
NG	Oral
JP	ETT
T-tube	Trach
Foley	Other
TLS	

Pre Op Meds

History

Time	1423	1428	1500	1510
SaO2	99	100	99	
FiO2				
Methods	RA	RA	RA	RA
240				
220				
200				
180				
160				
140			✓	✓ ✓
120	✓			
100				
80	●			
60	^	^	^	●
40		●	●	
20				
RR	20	12	10	9
T				98

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	2	2	2	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	/	/	/	
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	10	10	10	

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)

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,

CPW [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							
15'							
30'							
45'							
60'							
90'							
D/C							

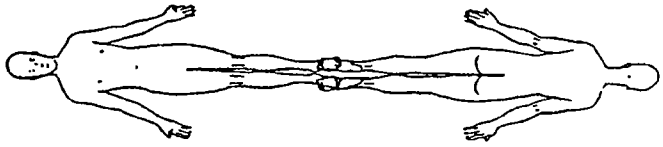
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(L) Leg	ace	Ø
30'	(L) Leg	ACE	Ø
60'	Ø		
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

Received pt from OR intubated comatose. (R) leg w/ ace wrap + gauze from thigh (donor) to foot (recipient) S/P STSG. (L) EJ patent. FTG of (L) yellow vein. USS report given to RN T. [redacted] (b)(6)-2

Discharge Criteria:
Date: 3/07 Time: 1410 PARS: 10
BP: 135/91 T: 96.5 HR: 55 RR: 9 Sa02: 99
Pain Level at D/C (0-10):
Intake: Ø Output: Ø
Additional Data:
Transferred To: ICU
Report Given To:
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: [redacted] (b)(6)-2
Cleared IAW Recovery [redacted] SOP R-3
Charge Nurse Signature [redacted] (b)(6)-2

[redacted] (b)(6)-4

ABU GHARAIB MEDICAL TRANSFER REQUEST FORM

(b)(6)-2

DATE OF REQUEST: [redacted] 24 23 SEP 03

REQUESTOR: LTC [redacted], 820th MP BN Surgeon (b)(6)-2

ISN #: [redacted] (b)(6)-4

COMPOUND: New Prison Out patient Clinic

PRIORITY: ASAP

LITTER/ AMBULATORY (CIRCLE)

DESCRIPTION OF INJURIES: Open, infected wound (R) Knee (right)
Open wound (L) leg

* Requesting surgical consultation

NUMBER OF MEDICAL PERSONNEL ACCOMPANYING: 0

DATE OF TRANSFER: _____

TIME OF TRANSFER: _____

DESTINATION: _____

POC AT DESTINATION: _____

ANTICIPATED LENGTH OF TRANSFER: _____

EQUIPMENT REQUESTS:

_____

_____

NOTE: COORIDINATION IS ALSO REQUIRED THROUGH MOVEMENT CONTROL FOR A TRIP TICKET.

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.)
A I I D I [redacted]	I Z

3. REGISTER NUMBER: [redacted]

NAME (Last, First, Middle Initial): (b)(6)-9

4. PAY GRADE:

5. SEX: M

6. DATE OF BIRTH (Y Y Y Y M M D D): UNK

7. AGE AT ADMISSION: 33Y

8. RACE: Z

9. ETHNIC BACKGROUND: 9

RELIGION: UNK

10. LENGTH OF SERVICE:

ETS:

11. FMP: 99

12. SOCIAL SECURITY NUMBER: [redacted]

ORGANIZATION (Active Duty Only):

13. MARITAL STATUS: Z

HOUR OF ADMISSION: 1010

BRANCH / CORPS: (b)(6)-4

14. FLYING STATUS:

15. BENEFICIARY CATEGORY: K79

16. ZIP CODE OF RESIDENCE:

17. UNIT LOCATION (State or Country Code):

18. MOS:

19. TRAUMA: 9

PREV. ADMISSION: YEAR [X] NO

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

WARD: ICWI

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: 24

22. MTF TRANSFERRED TO:

23. DATE OF DISPOSITION (Y Y Y Y M M D D): 20031111

24. CLINIC SVC - ADMITTING: AEAA

25. MTF TRANSFERRED FROM:

26. DATE THIS ADMISSION (Y Y Y Y M M D D): 20030925

27. LOCATION OF OCCURRENCE (Battle Casualty Only):

28. MTF OF INITIAL ADMISSION:

29. DATE INITIAL ADMISSION (Y Y Y Y M M D D):

FOR LOCAL USE

DX: (L) OPEN CHEST WOUND
(R) OPEN BACK WOUND

DX; 8911
9583
29181
30391
30411
78039
0416
0417
V4965
V4966
E9919

Trauma
9
Injury
599

ADMITTING OFFICER (Signature, as required): (b)(6)-2 DR [redacted]

SIGNATURE [redacted] ADMITTING CLERK (b)(6)-2

DA FORM 2985, MAR 2000 EDITION OF MAR 89 IS OBSOLETE USAPA V1.00

PX: 8622
8674
8669

MEDCOM - 20529

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

(b)(6)-4

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

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. DTS	10. PREVIOUS ADMISSION
M	18	X	MUSLIM	N/A	N/A	

11. PAY	12. SSN (b)(6)-4	13. ORGANIZATION	14. WARD
A 20	[redacted]	N/A	ICW1

15. LYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
N/A	K 78		N/A		WIA

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
0	1010	AEAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
	24	20031111

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
		20030925	(b)(6)-2 DR [redacted]

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

PT WAS P/C TO ABU GHARIB PRISON CAMP ON 11 NOV 2003

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

GSW

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: OPEN (L) TIB/FIB FX

PROC: DEBRIDEMENT
EXT FIX

DX:
905.4
730.86
041.11
V09.0
E999.8

PX:
77.07 77.17 (x8)
78.27 77.67
78.17
93.53

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	47	47

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	47	47

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

SIGN [redacted] (b)(6)-2

COL [redacted]

DA FORM 3647, MAY 79 EDITION OF 1 AUG 76 IS OBSOLETE USAPPC V1.10

ABU GHRAIB MEDICAL TRANSFER REQUEST FORM

DATE OF REQUEST: 22SEP 03

REQUESTOR: LTC [redacted] 320 MP BN Surgeon (b)(6)-2

ISN #: [redacted] (b)(6)-4 SEQ # [redacted] (b)(6)-4

COMPOUND: # 1

PRIORITY: ASAP

LITTER/AMBULATORY (CIRCLE) with crutches

DESCRIPTION OF INJURIES: Traumatic injury > LLE External Fixator

* requesting evaluation + R [redacted] (b)(2)-2

NUMBER OF MEDICAL PERSONNEL ACCOMPANYING: 0

DATE OF TRANSFER: _____

TIME OF TRANSFER: _____

DESTINATION: _____

POC AT DESTINATION: _____

ANTICIPATED LENGTH OF TRANSFER: _____

EQUIPMENT REQUESTS: _____

NOTE: COORDINATION IS ALSO REQUIRED THROUGH MOVEMENT CONTROL FOR A TRIP TICKET.

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
21 SEP 03 ~1500	Brought in by Iraqi police. Has an external fixator in the left lower extremity, for four months now O/A ambulates c use of crutches External fixator, LLE Foot is swollen and erythematous. Good pulses No medical records available A. Traumatic injury External Fixator → Left lower extremity P. Rocephin 1gm given at intake processing but Dr cephalosporin Refer to [redacted] (b)(2)-2 to be evaluated (b)(6)-2 [redacted] LTC M [redacted] (b)(6)-4

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

USAPA V2.00

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

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

IED VIO. GSW S/P GSW TO (2) LEGS, WSPI
EX-FIX IN PLACE x 4 MONTHS. C/O PAIN, DRAINAGE
FROM WOUND, LOOSE TO STEEL PIN.
PMH (-)
NKDA (-)

WLDA

PHYSICAL EXAMINATION

HEENT - WNL
NECK - SUPPLE
CHEST - (L) LEG - EX-FIX IN PLACE. STABLE, DRAINAGE
WOUND ON CENTRAL FIBIA WITH DRAINAGE.
SKIN FOOT ERYTHEMA
EXTREMITIES NEUROVASCULAR FIB-FIB EX, WITH
LONG HALF OF LOWER LEG.

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

(5) INFECTED FIB-FIB EX
(1). I+D & REX CLOSURE & APPLY CAST

(6)(6)-2 [redacted]

SIGNATURE OF PHYSICIAN	DATE 25 SEP 08	IDENTIFICATION NO.	ORGANIZATION
PATIENT'S IDENTIFICATION *(For typed or written entries give Name last, first, middle; grade; date; hospital or medical facility)* [redacted] (6)(6)-4		REGISTER NO.	WARD NO.

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
25 Sep 03 1520	Admitted to ICW #1 from EMT via litter. A&O. Lungs CTA(B). Resp. even & unlabored. Abd. soft non tender & (+)BS x4 quads. (2) Tib/Fib external fixator intact. Purulent drainage from wound on mid tibia area. Open to air. Pedal pulses palpable. Brisk capillary refil. (2) foot edematous. Keplock (2) AC patent & O.P.D.N.S infusing from EMT. Will D/C IVF as ordered & Continue monitoring & Abx Therapy (b)(6)-2 [redacted] MD
25 Sep 03 @ 2100	Assumed care @ 1800; All VSS, pt A&OX3 speaking arabic; (+)CMS, bridge cup Ref, palpable pulses x4; I/V intact; S1 S2, LSCTA(B); (+)BS x4, pt voiding QS & difficulty pin care to (b) LE complete & 1/2 sterile water, 1/2 peroxide-aggressively cleaned; 4x4 placed over open wound to mid Tibia area; purulent drainage noted; (2) foot remains edematous; pt NPO after MN, to OR in AM; SL in (2) AC patent, S/Sx infection/infiltration; Cont & (1) alert; restraint in place; (+) circulation (-) skin breakdown; cont to monitor (b)(6)-2 [redacted]
26 Sep 03	Assume care of PT. VSS. A+Ox3 c/o pain given percocets. Went to OR and returned at 1300 hrs. Performed Surgery on left Tibia. Distal pulse is intact. Given Ancef at 1400 hrs. Maintains a regular diet. Ambulate on crutches. Will continue to monitor. (b)(6)-2 SPC [redacted] SPW

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME: LAST	FIRST	MI	SPONSOR'S ID NO. (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)*

SPW

[redacted] (b)(6)-4

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

(b)(6)-4

LAST NAME	# [redacted]	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
26Sep03 (1930)	Rt AIO, VSS, LCTAB, HRRR, ⊕BS×4qd, ex-fix intact ⊕LE. pin care done, (Kerlix) reinforced drsg pm bloody drainage noted. (minimal amt). pedal pulses palpable. Percocet given for pain ē noted relief. Ancef cont. 2pt restraints on, ⊕ circulation will monitor (b)(6)-2 [redacted] (b)(6)-2 9Lum6,SC CPT
27Sep03	pt A+O x3, VSS, LCTAB, HRRR, ⊕BS×4 ex fix intact and wrapped with curlex to absorb drainage, pedal pulse palpable, hep lock flushed in ⊕ac. pt ambulated with little difficulty, ϕ c/o of pain, pt voiding clear yellow urine via urinal & other unremarkable findings (b)(6)-2 [redacted] (1750) I concur ē above assessment. (b)(6)-2 [redacted] (MD)
2010	Rt AIO, VSS, ϕ c/o pain or discomfort @ this time. Drsg to ⊕LE reinforced PRN. Pin care done. Pulses (pedal) palpable. Iv/k cap refill. HL to ⊕AC patent. Voiding c/u ē any difficulty. All other findings WNL. 2pt restraints on. ⊕ circulation. Will monitor (b)(6)-2 [redacted] (b)(6)-2 9Lum6,SC CPT
0001	NPO p MN for OR in AM. [redacted] (b)(6)-2

STANDARD FORM 509 (REV. 6/1999) BACK
USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
28Sep03	Received pt resting in bed, VSS, A+Ox3 arabic speaking. PMS are done, ⓁLE, edema present, dressing intact. Ambulated independently. NPO @ MN for OR in AM (OR for today cancelled). Staff notified by MD (Dr. [redacted]) that pt was MRSA ⊕, MRSA precautions taken. Pt has ⓁAC access patent + intact. flushes easily. Tol PO, SIMS, urinal @ BS. Restraints as per CDW protocol, ∅ skin breakdown noted, ∅ other remarkable assessments noted. Will cont to monitor. Dr [redacted] MD (b)(6)-2
1945	PE A&O, VSS, LCTAB, HRRR ⊕ BSx4 qd. ⓁAC intact ⓁLE. pin care done. drsg to Ⓡ leg CDI. NPO p MN for OR in am. MRSA precautions taken. ⓇAC HLd - flushing easily. ancef cont. Ⓡ foot c minimal edema. + elevated. Restraints on. ⊕
29Sep03 (0001)	circulation, will monitor (b)(6)-2 [redacted] q1hrNC. NPO for OR in AM. new 20ga IV started to Ⓛ

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[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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[redacted] (b)(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
(0001) (cont)	FA x 4 attempt. HL'd. (previous IV removed - C catheter intact) Will monitor [redacted] Received pt reading in bed [redacted] (b)(6)-2 see SF511 for (b)(6)-2 VS; A+O x3. DOA and amb w/ crutches. R arm PIV care done. (L) saline lock patent + intact flushes easily. MRSA precautions taken. LLE ↑. Restraints on per CPW protocol, ∅ breakdown noted c this time. will cont to monitor pt. [redacted] (b)(6)-2
29 Sep @ 2045	- assumed care of pt @ 1800. Pt arrived from OR/PACU @ 1945. VSS. Placed in bed, 2pt restraints in SS&X of skin or circulation compromise. A+O, speaking arabic, ↓ to pain to LLE. LLE: +CMS, EXFIX & Kerlix dsg CDI. (R) hand IV started in PACU NS @ TKO. Tol po well & SX, no N/V. Percocet given for pain. LS CTA +BS, encouraged IS. MRSA + contact precautions in place. Plan: monitor NV status, monitor pain control. (b)(6)-2 [redacted] RN
30 Sept 03 0900	VSS ∅ Ort & Oriented Peripheral pulses palpable. (R) ~~Infiltrated~~ hand IV infiltrated. Warm compress applied to IV site. Restarted IV (R) FA. Pt c/o pressure to (L) FA pm previous IV site warm compress applied no (L) FA IV site. (R) FA IV 18 gauge 1 1/4 in cath attempt x 1. ∅ c/o pain. OOB → BR pm AM care. MRSA [redacted] (b)(6)-2 precaution used. Will continue plan of care. [redacted] (b)(6)-2 RN

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DATE	NOTES
25 OCT 03 1830	On the Op Note Pre Op Dx Infected (GSW) (L) Tibia fracture Post Op Dx - Same Procedure - I+D (L) Tibia Surgeon - [redacted] (b)(6)-2 EBL - Min Findings - Necrotic muscle Plan - Repeat I+D in 48 hrs
	[redacted] (b)(6)-2
27 OCT 03 1010	On the Op Note Pre Op Dx Infected (L) tibia fx Post Op Dx Same Procedure - I+D (L) Tibia Surgeon - [redacted] (b)(6)-2 Findings - Necrotic muscle 3x3 cm open wound over Tibia Plan - VAC in 48-72 hrs
	[redacted] (b)(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
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[redacted] (b)(6)-4

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DATE	NOTES
30 sep 03 @2200	assumed care of pt @1800. A VSS, A+O, speaking Arabic c/o pain to LLE - medicated c Percocet c good relief noted. LLE W→D dsg Δ completed, granulating tissue noted c pkg placed in deepwound approx 1in deep. (Sterile technique used c MRSA/contact precautions) Pin care performed to Ex-fix. IV abx given as ordered. Plan: NPO @ MN for washout, monitor pain control. (b)(6)-2 [redacted] CPT in addendum: 2pt restraints on c sx of skin or circulation compromise. (b)(6)-2 [redacted]
1 Oct 03 @0200	VSS Alert & Oriented. (R) FA IV patent & secured. Peripheral pulses palpable. (2)+ edema dry dressings C/D/I. Pt informed of NPO status & d/c for OR. Verbalized understanding. OOB to BR for AM care. Denies pain. Po dilaudid @ 0500 time. Will continue care as planned. (b)(6)-2 [redacted] CPT
(2000)	Pt returned from OR. fully awake, VSS, Ø c/o pain or discomfort. drsg CDI. to LLE. pin care performed to ex fix. IV abx cont. 2pt restraints on, + circulation, Ø skin breakdown

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

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[redacted] (b)(6)-4		

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
(2000) 10CT03 (CONT) 20CT03 (1950)	noted (+) pulses) Will monitor (b)(6)-2 [redacted] q1wmle (2130) c/o pain to (L) LE IT Percocet given c noted ord- ers. Will monitor (b)(6)-2 [redacted] q1wmle Pt ab, VSS, amb in hallway c crutches without diff. c/o pain to (L) ex fix, IT Percocet given. LCTAB, HRRR, (+)BS x4, (L) ex fix pin care done c pt assistance, drsg's d. moderate amt serosang drainage noted. IV abx con't as ordered, (+) pedal pulses. Tol. PO well, IV HL'D. 2 pt restraints on. Will mon- (b)(6)-2 [redacted] q1wmle.
30CT03 1045	On the Op Note: Pre-Op Dx - open infected (L) tibia fx - 823.81 Post-Op Dx - same Procedure - I+D (L) tibia & application of VAC device. Surgeon: (b)(6)-2 [redacted] EBL - Min Wound clean, irrigated & L, VAC device applied Plan: recheck in 72 hours (b)(6)-2 [redacted] (b)(6)-2 [redacted] COL09

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
03 OCT 03	~~DSF~~ Pt A&O x 3, S/P present, LS CTA (B), (R) BS x 4 quads VSS, Antibiotics given. Denies Pain at this time. Am care completed. [redacted] (b)(6)-2 Sx 9WM1
(1940)	Pt alo, VSS, pin care done by pt c assistance drsg A.D. Vac device to (L) leg c continuous low suction. π Percocet given for pain. Abx con't. amb x 1 in hallway. cont MRSA precautions. (+) pedal pulses. ↓ V unfusing ↓ redness or edema. Restraints on, (+) circulation. Will monitor- [redacted] 9WM6. (b)(6)-2
04 OCT 03	PT Awake A&O LS CTA (B), Pin care and Drsg 1 completed Vac → LLE
1320	continues low suction to [redacted] (b)(6)-2 MRSA precautions. Denies pain at this time will continue to monitor. [redacted] (b)(6)-2 Sx 9WM6
(1535)	I concur c above assessment. [redacted] (b)(6)-2 USAF
4 OCT. 03	Pt A+OX3, VSS, LS C+A (B), BS x 4, OOB →
2000	BR, pain controlled c percs, continuous [redacted] (b)(6)-2 low suction to LLE, EX FIX, (L) leg in place, dsg on pins CDI, MRSA precautions, pt able to move toes, pedal pulses equal (B), HL IV (R) AC intact, ø s/sx of poor circulation or skin breakdown on pts of restraint. [redacted] (b)(6)-2 e 9WM6 USAF

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[redacted] (b)(6)-4

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Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
05OCT03 1440	Received pt resting in bed, VSS, tol PO, ax&ox3, arabic speaking. IV to @ Rfa, patent + intact, flushes easily. Amb w/ crutches independently. Pin care to @ LE done, vac device w/ occlusive dsg intact and to low cont SUCTION. MRSA precautions taken, restraints per CPN protocol, ∅ headaches noted. ⊕ pedal pulse, toes warm. ∅ other remarkably assessments c this tone. Will cont to monito (b)(6)-2
5OCT03 (1910)	Pt a&O, VSS, LCTAB, HRRR, ⊕BSx4, @ leg to cont low suction, minimal brn drainage noted. dsg Δ'd (Kerlix). dsg c ∅ saturation. ⊕ pedal pulses. Mrsa precautions Pin care done by pt c assistance. Cipro & Gentamycin cont per orders. 2pt restraints on 3 any compromise to circulation/skin. Will mon- itor (b)(6)-2 911MG
6OCT03 0700	Received pt resting in bed VSS, NPO, A&Ox3, self pin care. @ LE wound to low cont suction, amb w/ crutches. OR this afternoon, cont IV ABX. MRSA precautions. (b)(6)-2
6OCT03 0800	Assume care of pt. Pt sitting & eating breakfast. ⊖ S/S of resp distress or discomfort @ present time. Suction on low continuous to @ leg dsg D&I. Ext fix in place. ⊖ skin breakdown under restraints. Lungs CTA. BS ⊕. Reviewed that pt pulled H2 out. Will restart. Continue to monitor (b)(6)-2 911MG

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
6 OCT 03 1605	Ortho Op Note Pre-Op Dx - Infected (L) tibia fracture Post-Op Dx - Same Procedure - I+D (L) tibia, replace VAC Surgeon - [redacted] (b)(6)-2 Anes - MAC Findings - Began to get granulation at fracture site.

(b)(6)-2 [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
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[redacted] (b)(6)-4

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Medical Record

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DATE	NOTES
6OCTØ3 @(1910)	Rt a|o, VSS, lx fix untact to LLE, pin care done, low cont suction c minimal brn. drainage. Percocet 2 tabs given for pain. 2 pt restraints on c compromise to circulation or skin. Will monitor [redacted] (b)(6)-2 9IWM6.
7OCTØ3 2000	Rt a|o, VSS, LCTAB, HRRR, BS, amb x 1, ex-fix to LLeg, pin care done, minimal amt brown drainage via suction. c|o pain II percocet given for pain per MD order. Pt a cipro cont. 2 pt restraints on c compromise to skin circulation. Will monitor (b)(6)-2 [redacted] 9IWM6.
8OCTØ3 0035	Assumed care of pt. @ 0000 - pt. A|O - VSS LS CTA B, @ resp distress @ this time. Abd. soft, nontender, BS x4. Ext fix intact to LLE. Pin care completed. @ S/S infection. MRSA Precautions. Min drainage from dsng via suction. voiding per urinal. Restraints in place. @ Skin breakdown + circulation. Will cont. monitor [redacted] (b)(6)-2

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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 (b)(6)-2
08OCT03	(1700) I concur c above assessment [redacted]
~~0600~~	Pt A&O. VSS Pt LS CTA (B), S_1 S_2 present,
08OCT0	HRRR, ⊕BS x4 quads. (L) LE Drsg CDI.
1830	percocet to control pain. Will continue to
	monitor. (b)(6)-2 [redacted] Spc 91WM6
09OCT03	Pt completed self pin care. Pt cont. LCS. Denies
	pain at this time. Will continue to Monitor
	(b)(6)-2 [redacted] Spc 91WM6
9OCT03 1330	Received pt resting in bed, VSS, [illegible] PO, A&Ox3,
	wound vac to (L) LE in place & on LCS. pin
	care performed by pt. amb indep w/crutches,
	arm care done. IV to (L) fa intact, patent, flushes
	easily. ∅ redness or swelling noted. ∅ remarkable
	assessments c this time, ∅ c/o pain. [illegible]
	on [illegible] w/ ∅ skin breakdown noted [redacted] (b)(6)-2
9OCT03	2040 = VSS, c/o pain, medicating c percs
	as needed, A+O, OOB & crutch walks to
	BR s difficulty. (L) LE c ex fix intact,
	pin care done drain putting out
	sanguinous fluid, Dsg Δ'd to (L) LE CDI,
	(L) LE ↑°, neurovascularly intact, Continuing
	IV Gent & Cipro around the clock, HL IV
	to (L) arm flushed & patent. x2 restraints
	when in bed, ⊖ skin breakdown. Continue
	to Monitor. (b)(6)-2 [redacted]

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[illegible] [redacted] (b)(6)-4

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
10 OCT 03 0615	Pt Awake A&O. LS CTA (B) S_1 S_2 present HRRR. (+) BS x4 quads. Abdomen soft flat non tender. [redacted] (b)(6)-2 Ex fix on Left Lower extremity. (+) Pulses in all extremities. Skin warm and dry on (L) LE suction to LLE orig C Reverse roll CDI. Pt completes own pi[redacted]. Will cont. to monitor. [redacted] Spc. 91W M6 (b)(6)-2
10 OCT 03 1345	Pre Op Dx - Open, infected, G. tibia fx Post Op Dx - same Procedure: I+D (L) tibia, application of VAC device Surgeon: [redacted] (b)(6)-2 Anes: GA - MW Fluids: LR 300 cc Findings - Wound edges viable. Cultures taken. Bone motion at fracture site [redacted] (b)(6)-2

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

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
10OCT03 @2100	Assumed care of pt @ 1800. VSS. No c/o @ this time. (R) EJ line D/C D/t pt discomfort, poss infiltration? (D)FA IV D/C D/t infiltration. (R)FA 20G IV started flushes well. (+)CMS to LLE, ex-fix in place, wound ~~to~~ sealed c opsite, sandbag attached, minimal serosanguineous drainage noted. ↑ OOB amb c crutches. MRSA precautions in place. Plan: monitor NV status, pain control. Spt restraints on S/Sx of skin/circulation compromise. (b)(6)-2 [redacted] (R)
	Addendum: pt did own pain care c standby assist. Demonstrated good technique. [redacted] (b)(6)-2
11 OCT 03 1630	Assumed care of Pt @ 0600hrs. A&O. Pt Ambulated x1. Am care completed D/C E-Fix to continues La section. Pt c/o pain controlled with percocet. LS CTA (B). S, S2 present (+)BMx4 quads. Will continue to monitor. (b)(6)-2 [redacted] Sac 91W/mb
	(1630) I concur c above assessment. (b)(6)-2 [redacted] MD
11OCT03 @2200	Assumed care of pt @1800. VSS. Alert, speaking Arabic. LLE c ex-fix in place, pincare done. Wound covered c dsg & opsite, attached to suction, minimal drainage noted. (+)CMS to LLE, ↓ PP & popliteal pulses. ↑ amb to BR c crutches c difficulty. Spt restraints on c S/Sx of skin/circulation compromise. Plan: monitor NV status, monitor pain control, monitor suction device (b)(6)-2 [redacted] CPT

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
10 [illegible] 03	Ortho Op Note
1440	Pre-Op Dx: Infected (L) [illegible] [illegible]
	Post Op Dx: Same
	Procedure: Suture removal, cast application (LLC) and removal of
	ex-fix (b)(6)-2
	Surgeon: [redacted] / [redacted] (b)(6)-2
	Findings: LLC removed applied,
	ex-fix removal
	(b)(6)-2 [redacted]

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PROGRESS NOTES
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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
12oct@2400	Assumed care @ 1800; All VSS, pt A&Ox3, pain controlled c̄ percs; ⊕ CMS throughout, brisk cap ref, ⊕ pulses; wound vac intact to Low-Cont. suction, minimal output noted; Ex-fix in place; pt performed own pin care; voiding s̄ difficulty; pt ↑ amb c̄ crutch assistance s̄ difficulty; Restraints in place, ⊕ circ, ⊖ skin break↓, cont to monitor (b)(6)-2 [redacted]
13 Oct 03	Assumed care of pt @ 0600. Awak A&O LS CTA (B), S1 S2 present. ⊕ BS x 4 quads. Abdomen soft flat nontender. ⊕ Pulses in all extremities. (L) LE Ex fix Pin care completed. Wound c̄ Drain on Low continuous suction. Denies pain. Will continue to monitor. (b)(6)-2 [redacted] 91W
13oct03@2037	Assumed care @ 1800; All VSS, pt A&Ox3, ∅ c/o pain or discomfort @ this time; ⊕ CMS throughout, +2 ppp brisk cap. Ref; Wound vac intact to cont. Suct, minimal O.P. noted; Ex-fix in place, pt performed own pin care; pt ↑ amb c̄ crutch assistance s̄ difficulty, voiding s̄ difficulty; HL patent easily flushes; Restraints in place, ⊕ circ, ⊖ skin break↓, cont to monitor (b)(6)-2 [redacted]
14 oct 03 0900	VSS A&O. Lungs clear. BS ⊕ x4 quad. Abd soft non-distended. Peripheral pulses +2. Ex fix pin sites without crustation or drainage. Dsg intact to (L) LE c̄ opsite dsg. MRSA precautions in use. Will continue care as planned [redacted] 2LT (b)(6)-2

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
14Oct03@2000	Assumed care @1800; All VSS, pt A&OX3, ⊕CMS, +2 PP, brisk cap Ref; ∅ c/o pain or discomfort @ this time, NV intact throughout; pt OOB to amb in hall c̄ crutch assistance; wound vac intact; minimal drainage noted; Ex-fix in place, pt performed own pin care; pt voiding s̄ difficulty; HL patent; ∅ significant Δs; Restraints in place, ⊕ circ. ∅ skin breakdown; Cont to monitor [redacted] (b)(6)-2
15Oct03	Ortho Op Note
	Pre-Op Dx - Ⓛ infected open tibia fracture
	Post Op Dx - Same
	Procedure: I&D Ⓛ Tibia
	Findings - Wound clean. Culture taken
	Plan: Will D/C VAC. Plan to try soft tissue flap coverage
	Wet to dry dressings [redacted] (b)(6)-2
15OCT03@1530	Pt. sitting up in bed eating MRE. Pt. received from Gen. surg. @ 1345. Ⓛ LE washed out. Drain D/C'd. IV hep locked. Pt. has ∅ C/O pain. (b)(6)-2 [redacted] 2LT, AN
15OCT03@1630	Pt has W to D DSNG wrapped c̄ Curlex to Ⓛ LE. DSNG CDI. Pt. has no C/O pain. (b)(6)-2 [redacted] 2LT, AN

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
15OCT.03 2015	Pt A+Ox3, VSS, LS CTA Ⓑ, Ⓣ BS x4, S1, S2 present, Ex Fix to LLE covered c kerlix dsg. CDI, dsg to wound LLE CDI, pain controlled c percs, IV HL Ⓡ Hand patent, flushes well, ø s/sx of infex or infiltration, 2 pt restraint = s/sx of complications. [redacted] (b)(6)-2
16OCT03 1000	VSS Alrt & Oriented. Lungs clear diminished Ⓣ BS x4 good. Ⓛ LE wound beefy & moist. Ⓛ LE ex fix pin sites without crusting or drainage. Ⓡ hand saline lock patent & intact, OOB c crutches to BR independently. Will [redacted] (b)(6)-2 Pedal pulses +2 c toes capillary refill c 3sec. Will continue care as planned. [redacted] (b)(6)-2 RCN
16 OCT.03 1845	Pt A+O x3, VSS, IV Ⓡ hand d/c'd due to inflammation. Started new IV on Ⓡ hand, flushe well, dsg Ⓛ LE Δ'd, wound appeared beefy re, dsg W→D covered c kerlix, LS CTA Ⓑ, Ⓣ BS x4, OOB to BR + ambulate, 2 pt restraint = complications. [redacted] (b)(6)-2 9IW

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME (LAST, FIRST) | [redacted] BER RL

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[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
17OCT03 0500	VSS Alert & Oriental. @LLE trauma with healthy red tissue and small amt of bone exposed Old dsg removed (b)(6)-2 [redacted] drilled with serosang drainage. @LLE ext fix pin sites without crusting or drainage. Pedal pulses palpable Toes capillary refill < 3sec. Taking regular diet Had BM Today. Lungs clear. Will continue care as planned. (b)(6)-2 [redacted] RUTH
17OCT03 2015	Pt A+Ox3, VSS, OOB → BR c crutches, pain controlled c percs, Ex Fix LLE pin sites CDI, wound LLE covered c W→D dsg + kerlix, voiding c diff, NPO p MN to OR in AM, LS CTA(B), +BS x4, wound LLE appeared healthy, beefy red, minimal blood drainage, peripheral pulses +2, 2 pt restraint in place c s/sx of complications, cap ref < 3sec (b)(6)-2 [redacted] qw (b)(6)-2 [redacted] RN
18OCT03 0200	Received pt resting in bed, VSS, NPO per OR today. Amb indep on crutches throughout. Left for OR @ 0200. Cipro hung prior to OR. Returned from OR c approx 1530. Pt w/ new ex fix to RLE w/ dsg c/d/i. JP drain w/ sanguineous fluid (b)(6)-2 [redacted] 25cc @ end of shift (1600). Order for MSO4 to help control pain obtained. Pt assist w/ transfers on arrival to ward. Restraints per cpw protocol, ø breakdown noted to site. Will cont to monitor [redacted] (b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK
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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
19OCT.03 2030	Pt A+Ox3, VSS, LS CTA (B), ⊕ BS x4, MRSA precautions, Ex Fix LLE, dsg covering wound CDI, JP draining small amount of blood, medicated for pain c̄ 2 percs, ate small amount of diet, HL IV (R) Hand intact s̄ s/sx of infex 2 pt restraint s̄ s/sx of complications. [redacted] (b)(6)-2
	I concur with above asse[redacted] (b)(6)-2
20OCT03 0730	VSS. AO. DSG to LLE CDI. XFix in place and pins CDI. ⊕ pulses @ LLE. ⊕2 edema @ (L) foot. CR ≤2 seconds. ⊖ CNS @ all toes. ⊖ pressure sensation or pain. c/o moderate pain and provided 5mg MSO4 & 2 percocet. Tolerating PO well and voiding bright yellow urine s̄ difficulty. MRSA ⊕. (b)(6)-2 [redacted]
1800	25cc serosanguinous drainage from JP. [redacted] (b)(6)-2
20OCT.03 2030	Pt A+Ox3, VSS, Ex Fix on LLE, dsg covering wound CDI, spots of blood around pin sites, NPO p̄ MN to OR in AM, medicated c̄ 2 percs for pain, HL (R) Hand intact, ∅ s/sx of infex, voiding c/y urine to urinal, JP suction to LLE draining minimal amount of blood, ate well, pt on abx tx, 2 pt restraint s̄ s/sx of complications. (b)(6)-2 [redacted] (b)(6)-2 [redacted]
0545 21OCT.03	JP drain emptied, had 10cc of blood. (b)(6)-2 [redacted]

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DATE	NOTES
18 OCT 03 1902	Emptied 43 cc BRB from JP drain site. — [redacted] (b)(6)-2
18 OCT 03 2205	VSS. AO. @ 1 pulse to LLE c new X-fix in place. JP draining BRB in moderate amounts. c/o pain @ 6/10 and provided 2 percocet. Foot is wrm to touch and CR sluggish @ 2-3 seconds. Sensation, light yellow urine quantity sufficient. DSG's to XFX CDI.
19 OCT 03 0330	No further c/o pain. — [redacted] (b)(6)-2 Emptied
19 OCT 03	0950- assumed care of pt. @ 0000. VSS-AO. Pt. resting well @ this time. Ex fix in place to (L) LE. JP drain intact. drained 20cc [redacted] (b)(6)-2 @ 0940. HL (L) FA CDI (b)(6)-2 (-) S/Sx infect- will cont to monitor [redacted]
19 OCT 03	1600- Pt. c/o pain. 8mg MSO4 given @ 1100 via Jackson. Resting well at this time c (-) c/o pain. will (b)(6)-2 cont. to monitor — [redacted]
	(1740) I concur c above assessment. [redacted] (b)(6)-2

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C# [redacted] (b)(6)-2

PROGRESS NOTES
Medical Record

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DATE	NOTES
21OCT03 0907	VSS. AO Resting comfortably in bed s̄ c/o pain @ this time. ⊕ pulse to LLE. Prepared for OR this AM and remains NPO. CR ≤ 3 seconds. Pt unable to feel pressure or pain @ distal toes of LLE. Voiding light yellow urine, QS s̄ difficulty. LS CLAB. HOB [illegible]
	(b)(6)-2 [redacted]
21OCT.03 2000	Pt A+Ox3, VSS, OOB to ambulate, medicated for pain c̄ percs, abd soft flat non-tender, Ex Fix to LLE, dsg covered c̄ ace wrap CDI, ambulate c̄ crutches well. LS CTA(B), active BS, Tol PO well, HL (R) AC intact, peripheral pulses equal (B), cap ref <3 sec, 2 pt restraint s̄ s/sx of infex. (b)(6)-2 [redacted] [illegible]
	(b)(6)-2 [redacted] [illegible]
22Oct03	Surgery
	3 lumen
	[redacted] (b)(6)-2

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E# [redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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MEDCOM - 20555

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
22OCT03	1400 - VSS AO assumed care of pt @ 0000. LS CTA (B). Resp. even un-labored, Abd. soft non-tender, BSX4, pt. voiding per urinal. Pt. IV infiltrated. Upon re-insertion pt. become combative swinging arms wildly. Pt. then restrained per MP 3 point restraint. Multiple attempts to regain IV access failed. MD notified central line (L) SC placed. X-RAY ordered @ bedside notified MD. Drsng CDI. Will cont. to monitor Pt [redacted] (b)(6)-2
22OCT03	2030- Assumed Pt care @ 1800hrs. Pt A&O. LS CTA (B). S_1 S_2 present, (+) BS X 4 quads. Pt voiding qs cvu. LLE Ex Fx ⊼ Drsg CDI. Denies pain at this time will continue to monitor. [redacted] (b)(6)-2 Spc 9 1WM
23Oct03	Assume care of PT @ 0600. VSS, A+O x3 Ambulatory, with crutches. C/O pain, given two percocets. Pin care was completed. Δ drsg, BEA wet to dry. Skin intact @ 2pt restraint site. Will continue to monitor, [redacted] (b)(6)-2 9 1 W Spc
23OCT03 2300	Assumed care @ 1800 hrs. VSS LS CTA (B). (+) BS x4 quads. S_1 S_2 present. Pt voiding cvu ⊼ difficulty Tol PO well. D/C continue LR. LLE Ex Fix in place Drsg [redacted] Pain controlled ⊼ percoset Spc 9 1 WM 16 (b)(6)-2

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DATE	NOTES
24oct03 1539	Assume care of PT @ 0600. VSS, AAOx3 Ambulatory to bathroom c crutches. Performed PT today. Dsg Aod on (R) leg. Site looks to be healing, staples intact & bleeding or swelling. c/o pain given percocets 2x restraints present & skin irritation present. Will cont. to monitor. [redacted] 9/(b)(6)-2 (b)(6)-2
24oct03 2100	- Assumed care of pt. @ 1900. Assessment completed. LS CTA (B), Resp even - unlabored S1S2 present. Abd. soft non tender BS x4 voiding per urinal. ambulated in pt. room x 10 minutes. Tolerates PO + Reg diet well. Drsng Δ conducted to (R) LE. Ext. fix in place. conducted Pin care c 1/2 Peroxide + 1/2 NS. cleaned wound c staples intact c 1/2 Peroxide + 1/2 NS also. Ø S/Sx infection Placed w→d drsng on wound + wrapped c Kerlex. Gauze sponges placed around pin sites + wrapped leg c ace bandages. [redacted] (b)(6)-2 pt. has (+) edema to (R) foot. Elevated leg on blanket. Pt. has

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[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
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DATE	NOTES
(Cont'd)	no other complaints @ this time will continue to monitor pt (b)(6)-2 [redacted]
	(b)(6)-2 [redacted]
25Oct03 1604	Assume care of Pt @ 0600. VSS, A+O x3 c/o pain given two percocets. 2pt restraints leave ø skin breakdown. Δed drsg on (L) leg, WTD ø signs of infection or bleeding. Pin care provided. Will cont. to monitor. (b)(6)-2 [redacted]
	~~(1735) Assumed care of pt @ 1600 p̄ report from~~ [redacted] (b)(6)-2
	concur c̄ above assessment. (b)(6)-2 [redacted]
25Oct03 1930	VSS alert & Oriented. (L) LE Ex fix pin sites without drainage or crustation. (L) LE incision to anterior thigh c̄ sutures intact but edges not approximate pink moist tissue noted. Percocet given for pain. Pedal pulses palpable +2. Capillary refill to toes < 3 sec. (L) subclavian triple lumen cath patent & intact. Will continue care as planned. (b)(6)-2 [redacted]
26 OCT (1130)	Pt a/o, VSS, medicated c̄ II Percocet for pain pin care done (L) LE ex-fix. WTD drsg Δ'd. ⊕ pulses equal bil. brisk cap refill. (L) SC TL cath drsg CDI ⊖ redness or edema @ site. flushes easily. amb. around room x 2. 2pt restraints on while in bed s̄ compromise to skin or circulation. Will monitor (b)(6)-2 [redacted]

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MEDICAL RECORD | **PROGRESS**

DATE	NOTES
26Oct03 1900	VSS Alert & Oriented. OOB c crutches to BR. (L) Subclavian triple lumen cath flatent & intact. (b)(6)-2 LE external fix. pin sites w/dsg dry & intact. (L) LE Toes pink & warm Pedal pulses palpable +2. Toes c capillary refill <3sec. Will continue care as plan (b)(6)-2 RCVD
27Oct03 0920	VSS. A&O. Able to make needs known. (L) Triple lumen catheter patent & intact. LLE external fixator intact c Kerlix dsg c small amount serosanguinous drainage (b)(6)-2 Moves toes. Capillary refil brisk. (+) pedal pulse. Will do pin care & dsg A. (b)(6)-2
27Oct03 1430	Dsg A & pin care complete. Medicated c percocet two tabs p.o. for pain control (b)(6)-2
27Oct03 1600	PT sleeping. Will continue monitor (b)(6)-2
27OCT.03 2000	Pt A+Ox3, VSS, LSCTA (R), (+)BSx4, OOB > BR c crutches, LLE Ex Fix intact, dsg LLE A'd, yellow purulent drainage noted, medicated for pain,

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[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
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LAST NAME	ME	MIL	NUMBER

DATE	NOTES
Cont.	Ø s/sx of infex, triple lumen IV flushes well, Ø s/sx of infex or infiltration, pedal pulses equal (B), cap ref < 3sec, voiding ∃ diff (b)(6)-2 9IW Ø s/sx of complications on points of restraint. [redacted] (b)(6)-2
10/28/03 1000	A&O. Able to make needs known. Medicated ∈ two percocet tabs p.o. for c/o LLE pain. Will monitor for effect. (b)(6)-2 [redacted] mot
29 Oct 03 1556	Assume care of PT @ 0600. VSS, A+Ox3 Ambulate ∈ aid of crutches. c/o pain given percocets. Had b.i.c movement twice today, not normal for PT. In 2∘ restraints without any skin irritation. Dry Δ cvl on Rt leg, pin care completed on Lt leg ex fix as well. Will cont. to monitor. (b)(6)-2 9IW [redacted]
28 Oct 03 1630	I concur ∈ above assessment will continue to monitor (b)(6)-2 [redacted] mot
28OCT03 1930	Pt A+Ox3, LS CTA (B), (+)BSx4, dsg LLE D'd, sero-sang drainage on old dsg, sutures on wound intact, Ø s/sx of infex, pain controlled ∈ percs. Pt ambulates ∈ crutches, Ex Fix LLE intact, ~~HL IV~~ CL intact, flushes well, Ø s/sx of infex, IV abx adm, pt ambulates ∈ crutches, 2 point restraint ∃ complications. (b)(6)-2 [redacted] 9IW (b)(6)-2

STANDARD FORM 509 (REV. 5/1999) **BACK**
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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
28 Oct 03 1445	Ortho Op Note
	Pre Op Dx → Infected [illegible] (R)
	Post Op Dx same [illegible]
	Procedure ① Resection of infected tibia
	② Fibular ostectomy.
	③ I+D
	④ Exchange X-fix
	⑤ DPC (b)(6)-2 (b)(6)-2
	Surgeon [redacted] / [redacted] Anesth - GETA
	Findings: Infected nonunion ≈ 2-3 cms excised. Shortened, 3 cm of fibula excised. Compressed with Hoffman II fixator using previous pins, plus 2 additional pins. Wound DPC'd. Plan I+D in 48-72 hours, will close fibular incision then.
	(b)(6)-2 [redacted]
	[redacted] (b)(6)-2

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PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
29Oct03 1435	Assume care of PT @ 0600. c/o pain given two percocets. A+O, VSS ambulatory c crutches. Aid drsg to (L) leg CDI. Pin care done to (L) leg. 2pt restraints without any irritation. Will cont. to monitor (b)(6)-2 [redacted]
29OCT03 2340	c/o pain. Med c 2 perc. Will continue to monitor. DSG to (L) leg CDI. VSS. Ex-fix ⊖ S/Sx of infection. Sutures intact [redacted] Pt cont. IV ABX. (b)(6)-2 [redacted]
30 Oct 0830	pt asleep, VSS, DSG to left leg CDI, sutures + ex-fix intact. will monitor. 0940 pt awake A+O×3. Proceed with pincare and dsg change pt c/o pain during dsg change esp. from the 3 in laceration to the left of the main wound which had some red thick clotty drainage, dsg replaced pin-care complete. ⊕ circulation ⊖ s/s of infection. Pt c/o of pain but was just given 2 percs 0800. (b)(6)- [redacted] ~~Nurse to give II perc.~~ (b)(6)-2 [redacted]
	(1730) I concur c above assessment. (b)(6)-2 [redacted]
30 Oct 03 1900	VSS alert & Oriented. (L) subclavian IV patent & intact. (L) ex fix pin sites without drainage or crustation. (L) Pedal pulses +2. (L) Toes capillary refill brisk. Percocet effective for pain mgmt. Will continue plan of care (b)(6)-2 [redacted]

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[redacted] (b)(6)-4

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Medical Record
STANDARD FORM 509 (REV. 5/1999)
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DATE	NOTES
3 Oct	Pt A+O x3 pin-care completed, dsg Δ completed with minimal reddish drainage noted, sutures look intact wound approximating nicely. Bacitracin applied over suture line before redressing wound. Pt had c/o pain after pincare and dressing change given 2 pcns. Medic restraints x2 in place circulation intact. (b)(6)-2 Spc [redacted]
1NOV@ 0330	assumed care of pt @ 1800. VSS. no c/o. ⓛ UE ex-fix CDI, dsg CDI, pt did pin care. ⊕ CMS UE, +2DP pulses, equal (BIL). ⓛ SC CL flushes well, Hld. abx given as ordered. 2pt restraints on S/Sx of skin/circulation breakdown. Plan cont IV abx, monitor and. (b)(6)-2 [redacted] addendum: MRSA precautions in effect. (b)(6)-2 [redacted]
1Nov03@1755	Assumed care @ 0600; A+O VSS, pt A+O speaking arabic; pain controlled c perc x1; pt performed own pin care, Δ'd dsg, CDI, ⊖ S/Sx infection; ⊕ CMS, +2 PP, brisk cap Ref; ⓛ SC CL patent, easily flushes; cont c IV abx; MRSA precautions taken; Restraints in place, ⊕ circ, ⊖ skin breakdown, cont to monitor. (b)(6)-2 [redacted]
2NOV03@ 0100	assumed care of pt @ 1800. VSS, medicated c Percocet for pain to UE, good relief noted. UE c ex-fix to tib/fib, ⊕ CMS, +2 PP pulses, ⓛ ankle slightly edematous (+1). UE wound healing well, dsg Δ'd pt did pin care; demonstrated good technique. ⓛ SC central line Hld, flushes easily, IV ABX cont. Pt family c crutches S difficulty. Plan: cont IV ABX, monitor pain, cont MRSA precautions. 2pt restraints on S S/Sx of skin/circulation compromise. Will monitor. (b)(6)-2 [redacted]

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[redacted] (b)(6)-4

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
11/2/03 0838	Assumed care @ 0600. Pt A&O. Able to make needs known. VSS. LLE c̄ external fixator intact. Wounds c̄ stitches intact. Pt did good pin care. Wet → dry drsg Δ done. Bacitracin to wounds. AM care done. Pt ambulating c̄ crutches for exercise. (L) Subclavian catheter intact & patent. Will cont. Abx therapy & pain control as ordered. Will continue to monitor & provide emotional support. 2 pt restraints while in bed. Assess throughout shift for skin integrity & circulation. Intact. (b)(6)-2 [redacted]
11/2/03 1645	Ambulating c̄ crutches for exercise. Denies pain. Will continue to monitor (b)(6)-2 [redacted]
11/2/03 1800	Medicated c̄ percocet two tabs p.o. for c/o (b)(6)-2 [redacted] LLE pain. Will continue monitoring [redacted]
3NOV @ 0200	Pt consumed small amount of food. Had emesis x1 on previous shift. ⊖ emesis at this time. Pt did self pin care. W-D DSG to (L) LE wound. Sutures intact. ~~Wound~~ Sutures ~~are~~ not well ~~approxima~~ approximated. ~~Will con~~ Small amount of drainage noted on gauze. Med pt c̄ 2

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[redacted] (b)(6)-4

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Medical Record

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LAST NAME	FIRST NAME	MIDDLE NAME	NUMBER

DATE	NOTES
	(cont') percocets. Continuing IV ABX. ~~Pt amb~~
	Pt amb on ward x 1 c̄ steady gait on crutches.
	Pt resting quietly in bed. ——— (b)(6)-2 [redacted]
3 NOV 03	Pt a/o, VSS, ∅ c/o pain, amb. x 2 s̄ difficulty
(1240)	(c̄ crutches). ex-fix intact Ⓛ LE, pin care
	done by pt, drsg S'd, sutures intact c̄
	scant amt sang. drainage on drsg. ⊕ puls-
	es equal bil. to Ⓑ feet. IV ABX con't per orders.
	2 pt restraints on s̄ compromise to skin or
	circulation. Will monitor — [redacted]
4 NOV @ 0030	⊖ c/o pain. Cont' IV ABX. Amb x 1 c̄ crutchs + steady (b)(6)-2
	gait. Pt did own pin care. Δ'ed DSG to sutures on Ⓛ
	fib-fib. W→D. Sutures poorly approximated, but healing.
	Sm am't of yellow drainage from sutures. ⊖ odor.
	Pt tol. Reg diet ⊖ N/V. ——— (b)(6)-2 [redacted]
4 Nov 03 0854	pt awake + oriented x3, pt has ⊖ c/o pain, pt
	ate breakfast [illegible] care complete, pt [illegible]
	[illegible] via crutches, pin care completed NS + hydrogen peroxide
	pt assisted pins look clean with ⊖ drainage some skin
	around pins has a little redness & scabbing around a couple;
	sutures [illegible] Δ'd [illegible] drainage, sutures intact developing
	some reddish discoloration and slight swelling, small
	amount of yellow drainage from initial 4x4 dressing on
	Ⓛ fib-fib. restraints x2 in place. circulation intact
	decreased in left foot. ——— (b)(6)-2 [redacted]

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
5NOV@0015	Pt did own pin care using hydrogen peroxide + Sterile saline. D'ed DSG to sutures. Sutures to anterior portion of (L) LE poorly approximated. Small amount of yellow purulent drainage from sutures. 2x2 cm raised lump on ~~incision~~ sutures. Pt communicated that lump has been getting larger. No lump noted on previous night shift. Will continue to monitor. Sutures lateral on (L) LE not well approximated. (+) yellow drainage from suture site. W→D completed. Pt requested to ambulate on ward. Request denied. Pt cont IV ABX, tol reg diet. (b)(6)-2 [redacted] RUTAN
5NOV03	- Assumed care pt. sleep yet easily arousable
0700	VSS @ c/o pain or discomfort @ this time. (L) LE external fixator intact pin care self. kerlix wrap to incision under exfix. Serous drainage to dsg. Cont MRSA protocol. Lungs clear HRRR Active BS. Ambulates well c crutches. Will cont to monitor (b)(6)-2 [redacted]
1000	Upon further accessment of wound to (L) LE suture wound has a lump pus and dark red blood filled. Oozing @ site. Will inform MD (b)(6)-2 [redacted]

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PROGRESS NOTES
Medical Record

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

[redacted] (b)(6)-4

MEDCOM - 20566

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
5NOV.03 2000	Pt resting in bed, A+Ox3, VSS, LS CTA (B), (+)BS x4, Ex Fix LLE intact, self pin care, dsg Δ'd sero sang drainage noted on old dsg, lump on wound drained minimal amount of blood when applied pressure sutures intact, pt able to wiggle toes except big toe but with limited movement, cap ref <3sec, OOB to ambulate ± crutches, tol well, ate 90% of diet, CL intact flushes well, Ø S/Sx of infex, MRSA precautions, Cont on IV abx, 2 point restraint, Ø complications. (b)(6)-2 [redacted] (b)(6)-2 9IW
6NOV.03 0700	-Assumed care pt sleep yet easily arousable. External fixator to (L)LE intact surgical incision ± sutures intact Wound ± dark red blood oozing small amt. dsg CDI kerlix wrapped extremity warm to touch able to wiggle toes. Upon ambulation coloration becomes pale than dark. MD notified will and to monitor [redacted] (b)(6)-2 9IWRA
6NOV.03 1900	Pt A+Ox3, VSS, OOB to ambulate ± crutches, tol well, Ø c/o pain, Ex Fix LLE intact, sero sang drainage noted on old dsg, dsg Δ'd CDI, Ø drainage from lump on wound, sutures CDI, cap ref <3 sec, limited movement on foot + toes in LLE, pt had an episode of emesis, adm 25mg phenergan after c/o nausea tol well, 2pt restraint, Ø complications, CL flushe

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
Cont.	well, ø s/sx of infex, dsg intact, cont on abx therapy. (b)(6)-2 [redacted] fiw
7 Nov 2005	I Concur c above assmt. assumed care of sleeping SO i woke him up and gave (b)(6)-2 food & d/c that MCS food tastes nasty and encourages him to projectile vomit, pt stated that if he had to eat he would vomit on the floor, pt requested MRE so i wouldn't have to mop puke. Pivcan complete, sutures intact, redish drainage noted ø S/S of infection, restraints x2 in place @ circulation & skin contact. (b)(6)-2 "Medic" [redacted]
7Nov05 @2330	assumed care of pt @ 1800. VSS. No c/o pain. Only c/o food served, too small amt of MRE. LUE c ex-fix, dsg Δd & bacitracin applied, sm amt serosang drng noted. Pt performed non pivcare c good technique. +2 DP pulse to LUE, equal BIL. Ds wx clear and flushes well, IVABX cont. Pt c x1 emesis. approx 2300. Through interpreter, pt states nausea onset was quick & relieved p emesis. Emesis approx. 200cc. Plan: cont IVABX, monitor n/v, monitor dsg. (b)(6)-2 [redacted] CA Addendum: 2pt restraints MS s/sx of skin or circulation compromise. (b)(6)-2 [redacted] USPA

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[redacted] (b)(6)-4

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

MEDCOM - 20568

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
08NOV03	(1515) Assumed care @ 0600. Pt alert speaking Arabic. VSS. 0 c/o pain. Pt had 2 episodes of emesis this shift. Pt medicated c Phenergen IV p 1st episode c sm. amount of relief. MD aware of N/V. Labs drawn and sent to lab. 0 blood noted in vomit. Pt amb in hallway c crutches s diff. Dsg to LLE Δd. 0 drainage noted from wound. Pin care done. Pt refuses to eat NCD food. Given apple and crackers. Voiding s difficulty. @ sc triple lumen flushes well s s/sx infection/infiltration. 2-point restraints in place s s/sx complications. Will cont. to monitor (b)(6)-2 [redacted]
8NOV.03 1900	Pt A+Ox3, VSS, LS CTA(B), +BSx4, Ex Fix LLE intact, dsg LLE Δ'd, scant amount blood drainage noted on old dsg, sutures to wounds intact, 0 s/sx of infex, pt moves (L) foot with limited mobility, cap ref < 3sec, pt refused dinner due to feeling nauseas, x2 episodes of vomiting, mostly liquid vomit, refused phenergan stating it made him more nauseous, voiding s diff, 0 c/o pain, CL (L) sc patent, 0 s/sx of infex, 2 pt restraint, 0 complications. (b)(6)-2 [redacted] (b)(6)-2

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
09Nov 03 1620	Assume care of PT @ 0600. A+Ox3, VSS, PT isn't eating any food only drinking water and juice. Ted dcsg to (L) leg c DIT. Dr Wynn DC Gentamycin, due to go to surgery tomorrow. Used crutches for exercise c/o dizziness. Given Zofran for vomiting. PT in 2pt restraints without any skin irritation. Will cont. to monitor. [redacted] (b)(6)-2
09Nov03 1500	I concur c above assessment note. Chem 12, electrolytes, UA to lab. Results pending. Will have Abd Flat/Upright ok to Radiology [redacted] (b)(6)-2
10Nov03 2000	VSS; A+O. Pt awake w/ NPO status for MRI. Lungs clear BS(+) X4 quad. Denies N/V/C this time. Consumed 40% of reg diet for dinner. (L) chest SC heplock patent & intact (L) Tib/Fib dry dsg's intact. ACE pins abd to ex fix without drainage/crustation. OOB → BR c crutches. Will continue cares as planned [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)*

EPW # [redacted] (b)(6)-4

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
10 Nov 03	Assume care of PT @ 0700. VSS, A+O Ambulate this
[redacted] (b)(6)-2	morning c̄ aid of crutches. Had surgery today removed
1544	ex fix replaced with cast also removed centre line replaced
	with I.V. Medicated with morphine. X-Ray's requested for
	Ⓛ leg. Will cont to monitor. ——— 91a SR [redacted]
	(b)(6)-2
10 Nov 03	Medicine Note:
KUB = Nl	Pt. c̄ N/V x 3-4 days. Pt. describes N/V after eating assoc. c̄ epigastric
9 Nov	pain. No loss of appetite, no pain before meals. Denies dysphagia, denies
nl ┼ 2.0	~~[illegible]~~ hamemesis. BM regular N/V even with liquids. Ø F/myalgia/HA
u/a 1.030, 4+ protein	Pt. has been on Gentamycin x 6wks. Has no hx of GI problems.
LFT's = nl	Worsened c̄ Zantac.
	Ⓞ thin Non ictems ♂ ABD = flat/Soft/ND NT NABS
	Ⓐ nonspecific N/V; doubt stricture/PUD/mass/Viral.
	Prerenal Acute Renal failure: 2° ↓ PO intake (2° #1) & 1° to Aminoglycoside
	Ⓟ IVF x 2L LR; Zofran x 1; d/c Gentamycin.
	F/u 10 Nov; No N/V today; tol PO well, but cre ↑ 2.2
	Recommend repeat Cre in 2-3wks; No Renal toxic Rx
	Still able to transfer to Iraqi Civilian Hospital.
	[redacted] (b)(6)-2
11 NOV @ 0045	VSS. Pt amb c̄ crutches on ward. ⊖ c/o pain. Infusing IV ABX.
	Ⓛ Leg ⊖ Ex fix ⊕ cast. Toes warm to touch, ⊕ brisk cap refill,
	pt able to move toes. ⊖ c/o pain. ⊖ N/V on shift. Will
	continue to monitor. ——— [redacted] 2Lt/AN
	(b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BAC

USAPA V1

[redacted] (b)(6)-4

MEDCOM - 20571

[redacted]

ACLU-RDI 1657 p.131

DOD-034145

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
11 Nov 03	Assume care of PT @ 0600. VSS, Afeb. Ambulate c crutches. C/O pain @ hand due to DV, DC'ed DV. Cast @ L leg intact, able to move toes. Waiting to be released to Iraqi hospital. Will continue to monitor.

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES (b)(2)-2
	On the Discharge Summary, [redacted]
11 NOV 03	ADMITTED 25 SEPT 03
0745	18 YO Iraqi male brought here 4 months after open (L) tibia fracture. Came with ex-fix in place, large draining wound. Found to have MRSA osteomyelitis. Multiple I+Ds, attempts at VAC closure.
	Made shorting of tibia + fibula, removed dead bone, ad new fixator placed. Wound now mostly closed. Patient refused to remain to complete his care. Placed in long leg cast yesterday at his request even though he has been told this may lead to amputation.
	PLAN: LEVOFLOXACIN 250mg P.O. Q 24h
	LONG-LEG CAST - WEIGHT BEAR AS TOLERATED
	FOLLOW UP IN 4 WEEKS
	PERCOCET 1-2 P.O. Q 4-6 HRS [redacted] (b)(6)-2
	(b)(6)-2 [redacted] CDL OR

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

NSN 7540-01-075-3786

MEDICAL RECORD | **EMERGENCY CARE AND TREATMENT** *(Doctor)* | TIME SEEN BY PROVIDER: 1050

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

S: Pt is a 18 yo Iraq, ♂ EPW s/p GSW to (L) Tib/fib c ex fix placed in Iraq; INTF ~4mo. C/o pain & d/c at wound site. ↑fevers, Chills.

O: WD/WN in NAD Ambulc Crutches. NonToxic

HEENT: wnl

Lungs: (D) CTA

Cor: RRR no m

Abd: (D) BS+ S NT ND

Ext: (L) Tib/fib ex fix c mod purulent D/c from wound near Tibia mid shaft.

N/V intact.

Admit to ICW.

(b)(6)-2 D/w Dr [redacted], ortho

PMHx ∅.
PSHx
Ex Fix.
Meds ?
Abx
NKDA.

7.5 > 15/49 < 276
ESR: 15
XRay: comminuted Tib/fib fx, good alignment.

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

[redacted] (b)(6)-2

DIAGNOSIS

(L) Osteomyelitis

CODE

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

NSN 7540-01-075-3786

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT *(Patient)*

LOG NUMBER | TREATMENT FACILITY [redacted]

RECORDS MAINTAINED AT (b)(2)-2

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS: EPW

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day/Month, Year)*: 25/09/03 | TIME: 1040

TRANSPORTATION TO FACILITY: wheel vehicle

SEX	DUTY/LOCAL PHONE		MILITARY STATUS				THIRD PARTY INSURANCE		
M	AREA CODE	NUMBER	ITEM	YES	NO	N/A	ITEM	YES	NO
			PRP				ADDITIONAL INSURANCE		
AGE	HOME PHONE		FLYING STATUS				DD 2568 IN CHART		
18	AREA CODE	NUMBER	MEDICAL HISTORY OBTAINED FROM				NAME OF INSURANCE COMPANY		

CURRENT MEDICATIONS: names unknown

ALLERGIES: Ø

INJURY OR OCCUPATIONAL ILLNESS				EMERGENCY ROOM VISIT	
ITEM	YES	NO	WHEN *(Date)*	DATE LAST VISIT	24 HOUR RETURN ☐ YES ☒ NO
IS THIS AN INJURY?			WHERE	TETANUS	
INJURY/SAFETY FORMS				DATE LAST SHOT	COMPLETED INTITIAL SERIES ☐ YES ☐ NO
HOW					

CHIEF COMPLAINT: L L E Elevation

CATEGORY OF TREATMENT

☐ EMERGENT
☐ URGENT
☒ NON-URGENT

TIME: 1050

INITIALS: [redacted] (b)(6)-2

VITAL SIGNS

TIME	1053.				
BP	118/62.				
PULSE	74.				
RESP.	14.				
TEMP	98.5				
WT	97% RA				

LAB ORDERS

☑ CBC/DIFF	ABG	PT/PTT	BHCG/URINE/BLOOD/QUANT
URINE C&S	UA MSCC/CATH		CHEM:
BLOOD C&S X			

X-RAY ORDERS

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

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
	(L) Tib/fib XRay CBC				
1100	MSO4 IV Percocet po.	Kosma	Lt [redacted] (b)(6)-2	1100	

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)*

[redacted]

EPW

(b)(6)-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
26 SEPT 03 1136	Ortho Op Note Pre-Op Dx - Infected delayed union of (L) tib-fib Post-Op Dx - same Procedure - I&D debridement (L) tibia Surgeon - [redacted] (6)(6)-2 ANES - LIDU CCS Findings - Lots of fibrous tissue, no frank pus. Bone viable, Plan - Close over penrose. Left sutures O, will pack with bone graft, remove fixation, place in cast. [redacted] (6)(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 - 20576

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
21 Oct 03	Ortho Op Note
1220	
	Pre Op Dx - Infected (L) tibia fx
	Post Op Dx - idem
	Procedure - I+D DPC (L) tibia fx
	Surgeon [redacted] (b)(6)-2
	Findings - Wound clean. Fibular wound
	clean, closed with 2-0 nylon.
	Plan - IV abx
	[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
USAPA V2.00

MEDCOM - 20577

ACLU-RDI 1657 p.137

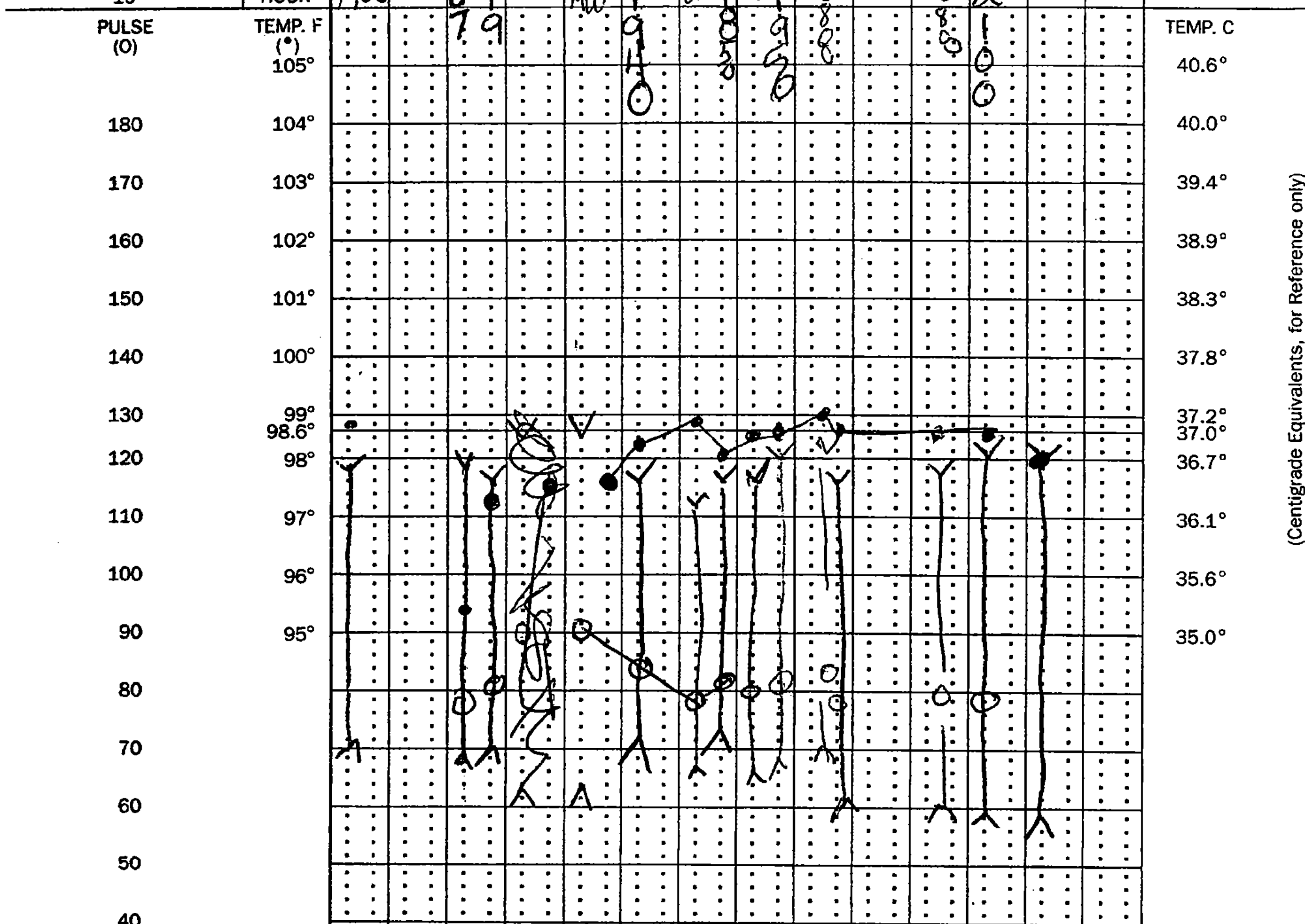
DOD-034151

511-119 NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY													
POST- DAY													
MONTH-YEAR / DAY	25Sept03		26Sept03		27Sept		28Sept	29Sept	30		Oct 1		OCT 2
19 / HOUR	1900		0 7	1 9	1417	1 9 1 0	08	8 3	08	1 9 2 0	0 8 8	0 8 0	1 0 0



RESPIRATION RECORD: 118/70 | 18 | 8 | 124/63 | 16 | 16 | 18 | 18 | 20 | 18 | 20 | 18 | 18 | 16

Record special data only when so ordered							
BLOOD PRESSURE	89 98.7	114/68 T95.5 H78	90 97.5	116/72 116/74	121/67 120/68	124/70 116/62	124/59 120/58
HEIGHT: / WEIGHT →	99%	97%	99%	98% 99%			
				(RA) RA 98%	95	98%	
		116/70 98% (RA)		96% RA (RA) 98% RA	(97% RA		98% 99% (RA) (RA)

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

REGISTER NO.

WARD NO.

[redacted] (b)(6)-4

VITAL SIGNS RECORDS

Medical Record

STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 20578

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY

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

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..

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

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY	
POST- DAY	
MONTH-YEAR / DAY	17 Oct, 18 Oct, 19 Oct 03, 20 Oct 03, 21 Oct, 22 Oct, 24 Oct 03
19 / HOUR	0800, 20, 09, 1000, 0711 3, 20, 2200

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° / 98.6°	37.2° / 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 18, 16

Record special data only when so ordered

BLOOD PRESSURE	115/73, 114/68, 125/70, 116/68, 127/63, 123/70, 121/67, 113/61, 124/70, 116/58, 114/63, 123/76
	81, 114, 100, 111, 103, 98², 101, 95
	97⁷, 98⁶, 98¹, 97⁴, 98, 98²
HEIGHT: / WEIGHT →	98¹, 99%, 94%
O2 SAT	98, 98%, 100%, 97, 98%, 97%, 98¹, 99%, RA, RA, RA

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

REGISTER NO.

WARD NO.

STANDARD FORM 511 (REV. 7-95) BACK

[redacted] (b)(6)-4

MEDCOM - 20580

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- 1 DAY

MONTH-YEAR OCT 03 DAY: 10 | 11 | 12 OCT 03 | 13 Oct | 14 Oct 03 | Sun | 16 Oct

19 HOUR: 1 | 8 | 8 | 8 | 1 | 10 | 20 | 8 | 20

PULSE (O) | TEMP. F (°) | TEMP. C

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

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.

[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 - 20581

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR NOV DAY

18 2003 HOUR

2 NOV | 3 | 4 | 5 | 6 | 7 | 7 | 08 | 09

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

	128/64	107/42	114/58	108/66	116/62	113/69	115/74	109/69	103/68	103/46	114/64
P	101	104		85	70		94		86	97.8	
T	97	96.5		96.1F 97%	98.2 99 98%		98.2		98	101H	
			98% (RA)		RA	98%	97%	98% (RA)	98%	95%	
	99%	99%			Temp 97.0F						

HEIGHT: WEIGHT →

Sat

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.

STANDARD FORM 511 (REV. 7–95) BACK

MEDCOM - 20582

511-119 NSN 7540-00-634-4124

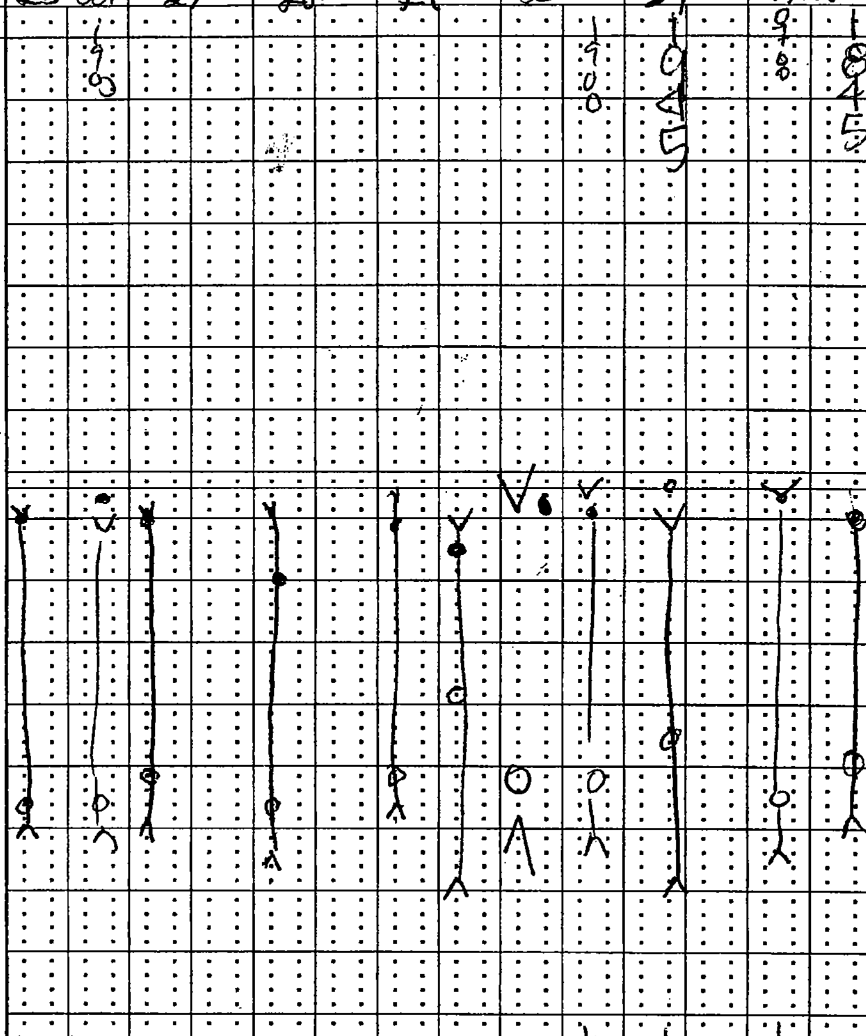
MEDICAL RECORD — VITAL SIGNS RECORD

	25 Oct		27		28		29		30		31 (Halloween)		1 Nov	
HOSPITAL DAY														
POST- DAY														
MONTH-YEAR Oct / DAY	25 Oct		27		28		29		30		31		1 Nov	
19 / HOUR		900								900	1045		980	1845
RESPIRATION RECORD	18		18	18	18					18	18		18	16
BLOOD PRESSURE	121/70	118/70	120/70	120/65	116/65		123/74	119/61	123/72	124/68	118/64			120/72
	T98		T98	T97	T97		T97.9	97.5	98.2				124/66	
	H74		H77	H75	H75		H77	92	77					
HEIGHT: / WEIGHT →														
RA	95%	96		94%	94%		98%	96%	98%	98%	97%		97%	98%
											BA			ER

PULSE (O) / TEMP. F (•) / TEMP. C

180 104° 40.0°; 170 103° 39.4°; 160 102° 38.9°; 150 101° 38.3°; 140 100° 37.8°; 130 99° 98.6° 37.2° 37.0°; 120 98° 36.7°; 110 97° 36.1°; 100 96° 35.6°; 90 95° 35.0°; 80; 70; 60; 50; 40; 105° 40.6°

(Centigrade Equivalents, for Reference only)



Record special data only when so ordered

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

REGISTER NO. | WARD NO.

[redacted] (b)(6)-4

VITAL SIGNS RECORDS

Medical Record

STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 20583

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR Nov 1963 | DAY 16 | HOUR 1 8 11

PULSE (0) | TEMP. F (°) | TEMP. C

PULSE (0)	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: 8 | 4 | 6

BLOOD PRESSURE: 118/69 | 122/69 | 115/69

Pulse: 97 | | 85

Temp: 98.5 | 98.4 | 97.3

HEIGHT: | WEIGHT ~~Temp~~:

RA O2: 95% | 99% | 98%

O2 Pulse: | 77 |

Pulse Pulse:

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted] (b)(6)-1-4

VITAL SIGNS RECORDS

Medical Record

STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 20584

ACLU-RDI 1657 p.144

DOD-034158

~~TWENTY FOUR~~ HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM _____ HOURS
TO _____ HOURS

TOTAL HOURS COVERED

DATE 18-19 OCT

~~INTAKE~~ OUTPUT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL

INTRAVENOUS

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

P bulb ~~IRRIGATIONS (N/G, Bladder, etc.)~~ OUT

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
1640	SANG.	25cc	25cc
1900+0940	Blood	700cc	45cc
1900+1730	Blood	30cc	75cc
0545	Blood	10cc	85cc

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

USAPPC V1.00

(THIS FORM IS SUBJECT TO THE PRIVACY ACT OF 1974)

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET	FROM 06 HOURS TO 06 HOURS	TOTAL HOURS COVERED	DATE 19 Oct

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT *(i.e. B1, A1b, P. cells etc.)*	TIME COMPL	AMOUNT	ACCUM TOTAL

INTRAVENOUS

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

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

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

DD FORM 792, JAN 74 (EG) EDITION OF 1 SEP 54 IS OBSOLETE. Designed using Perform Pro, WHS/DIOR, Jun 94

Voided

OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
0800	300cc	300			
1500	200	500			
1610	200	200			
1780	200	900			
1840	200	1100			
0030	350	1450			
0400	400	1850			
0620	300	2150			

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL

~~CHEST~~ Residual from supra pubic

EMESIS

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
1500	10	10	0030	30	95
1610	20	30	0400	10	105
1730	25	55	0600	0	105
1840	10	65			

TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL

GRAND TOTAL OUTPUT

REMARKS

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

[redacted] (b)(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

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

DD FORM 792, JAN 74

20 OCT 07

OUTPUT

URINE (Foley)

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
1050	250cc	250			
1757	525	775			
0200	550	1325			

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL

Suprapubic ~~CHEST~~ Residual

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
1050	0	0			
1757	0	0			
0200	0	0			

EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL

GRAND TOTAL OUTPUT

REMARKS

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

[redacted] (b)(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

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

DD FORM 792, JAN 74

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM 06 HRS TO _____ HOURS | TOTAL HOURS COVERED | DATE 21 Oct

INTAKE

Void per ~~Urinal~~

TIME	TYPE	AMOUNT	ACCUM TOTAL
0700	Clear yellow	350	
0930	clear yellow	275	

INTRAVENOUS

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

Residual ~~IRRIGATIONS (N/G, Bladder, etc.)~~

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0700	- clear yellow	20cc	20cc
0930	clear yellow	8-	28cc

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

USAPPC V1.00

MEDICAL RECORD	PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT For use of this form, see AR 40-66; the proponent agency is The Office of the Surgeon General.
1. AGE: HEIGHT: WEIGHT:	2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): 3. PREVIOUS SURGERY [ ] NO [ ] YES (type):

4. PROPOSED SURGICAL PROCEDURE:

I+D Lt tibia, Replace VAC

5. ADDITIONAL INFORMATION: Last PO: Medical Hx: Implants: Medications:
Jewelry removed: yes/no Family waiting: yes/no

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ___ Potential for anxiety related to traumatic injury; language barrier; family separation; surgical environment	o Pt. verbalizes any specific anxiety. o Pt. exhibits relaxed body posture.	o Allow pt. to verbalize freely. o Explain OR environment and answer questions regarding surgery. o Offer comfort measures, (e.g., warm blanket, touch) o Explain all nursing procedures before they are done. o Remain with pt. whenever possible. o Maintain family interface.
B. AERATION ___ Potential for respiratory dysfunction due to sedation; positioning; injury	o PT. will be able to breathe without difficulty during immediate intra-operative phase.	o Offer to elevate head of litter or offer pillow. o Observe pt. while awaiting surgery for signs of distress o Assist anesthesia during intubation and extubation
C. INTEGUMENT ___ Potential impairment of skin integuity due to bovie pad; position; fluid shift	o PT. will not exhibit signs of impair-ment of skin integrity (e.g., reddened areas.	o Utilize pressure preventing devices on OR table and accessories. o Check for proper positioning and support to maintain good body alignment. o Pad pressure points. o Place ESU ground pad on non compromised skin surface area. o Keep prep fluids from pooling.

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

Lt [redacted] (b)(6)-4

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ____ Potential for inadequate tissue perfusion due to anesthesia; traumatic injury; position; shock; previous surgery	o Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse).	o Check for support stockings or ace wraps. If none, check with doctors. o Check that safety straps are correctly applied. o Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. o Check that rings have been removed.
E. NEUROMUSCULAR CONTROL E.1. ____Potential impairment of mobility due to sedation; pain; injury E.2. ____Potential discomfort due to injury; pain	o Pt. will be transferred to OR table without difficulty. o Pt. will not experience unnecessary physical discomfort.	o Have sufficient people available for transfer. o Insure proper body alignment. o Allow patient to lie in position of comfort while waiting for surgery. o Offer support (i.e., pillows, bathtowels, etc.) for positioning.
F. NEUROMUSCULAR CONTROL F.1. ____Disminished visual perception due to being injury; sedation; F.2. ____ Potential for decreased communictaion due to language barrier; sedation F.3. Potential injury due to dentures.	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 INTERVENTIONS COMPLETED/ADDITIONAL INTEROPERATIVE INTERVENTIONS NOTED.

[redacted] MAJ AN 10 Oct 03 DATE

11. POSTOPERATIVE EVALUATION: (b)(6)-2

12. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title) (b)(6)-2

[redacted] MAJ AN

DATE: 10 Oct 03 TIME:

13. PREOPERATIVE [redacted] ON PREP BY (Signature and [redacted] (b)(6)-4

DATE: 10 OCT 03 TIME: 1400 MAJ MD

MEDCOM - 20591

REVERSE OF DA FORM 5179, JUN 91

USAPA V1.01

MEDICAL RECORD	PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT FOR Use this form. See AR 40-407: the Proponent agency is The Office of the Surgeon General.
1. AGE HEIGHT: WEIGHT:	2. KNOWN ALLERGIC SENSITIVITIES (e.g.. Iodin, Tape, Medication) ☐ NKDA ☐ PCN ☐ LATEX ☐ IODINE ☐ TAPE ☐ FOOD REACTION: unknown. 3. PREVIOUS SURGERY [ ] NO [✓] YES (type):

4. PROPOSED SURGICAL PROCEDURE:

I&D Lt Tibia

Pt not english speaker. Unable to obt Hx. [redacted] (b)(6)-2

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

Tobacco _____ ppd X ___ vrs Body Piercing _____ Diabetes (Y) (N) ROM _____ ASA/Motrin W 72hrs (Y) (N)

ETOH _____ Implants _____ Respiratory Disease (Asthma COPD) (Y) (N) Anticoagulants (Y) (N)

Glasses/Contact (Y) (N) Dentures _____ Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS:

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ potential for anxiety related to: ✓ 1) Surgical Procedure& Operating Room Environment ___ 2) Separation Anxiety (Child) ✓ 3) Surgical Outcomes	✓ Pt. verbalizes any specific anxiety. ✓ Pt. Exhibits relaxed body posture.	✓ Allow pt. to verbalize freely. ✓ Explain Or environment and answer questions regarding surgery. ✓ Offer comfort measures. (e.g. warm blanket touch). ✓ Explain all nursing procedures before they are done. ✓ Remain with pt. Whenever possible. ~~✓ Maintain family interface. Parents to stay with pt.~~ N/A [redacted] (b)(6)-2
B. AERATION ✓ Potential for respiratory dysfunction due to: ✓ 1) Positioning ✓ 2) Effects of Anesthesia ___ 3) Medical/Smoking History	✓ Pt. will be able to breath without difficulty during immediate intraoperative phase.	✓ Offer to elevate head of litter or offer pillow. ✓ Observe pt. While awaiting surgery for signs of distress. ✓ Assist anesthesia during intubatior and extubation.
C. INTEGUMENT ✓ Potential Impairment of Skin Integrity due to: ✓ 1) Intraoperative Immobility ✓ 2) ESU Pad Placement ___ 3) Positional Aids ✓ 4) Prosthesis ✓ 5) Pooling of Prep Solutions	✓ Pt. will 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 form pooling.

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

[redacted] (b)(6)-4

[redacted] (b)(2)-2

18 OCT 03

VERIFICATIONS AT HOLDING AREA:

! ID/Allergy Band ! Dentures Removed

! H & P ! Contacts Removed

! NPO Since _____ ! Jewelry Removed

! UHCG/LMP ! Body Pierce Removed

! Consent/Blood Transfusion Signed/Witnessed/Dated

! Surgical Site/Consent verified by Pt./Anesthesia/Surgeon

! Contact precautions (Y) (N)

! Family/Friend: _____

N/A [redacted] (b)(6)-2

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to: ✓ 1) Intraoperative Mobility ✓ 2) Positioning ✓ 3) Existing Disease 4) Safety Devices 5) Hypothermia	O Pt. will exhibit signs of adequate tissue perfusion (e.g. color, warmth. pedal pulse.	O Check foe support stocking or ace warps. 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 mot~~ N/A [redacted] O Check that rings and all bo[redacted] piercing has been removed. (b)(6)-2
E. NEUROMUSCULAR CONTROL E.I. Potential Impairment of Mobility due to: ✓ 1) Pain 2) Intra operative Hazzards 3) prosthesis ✓ 4) Positioning ✓ 5) Transfer pt. To/form OR table E.2. ✓ Potential Discomfort Due to: ✓ 1) Length of Surgery 2) Positioning 3) Arthritis	O pt. will be transferred to OR table without difficultly. O pt. will be not experience unnecessary physical discomfort.	O Have sufficient people available for transfer. O Insure proper body alignment. O Allow patient to lie in position of comfort while waiting for surgery. O Offer support (i,e..pillows. Bath towel. etc) for positioning.
F. Special Senses F.I. Diminished visual perception due to being: 1) pre-medicated 2) W O GLASSES F.2. Potential for Decreased Communication due to: 1) Diminished Hearing 2) Language Barrier F.3. Potential Injury due to Dentures: 1) Upper 4) Caps 2) Lower 5) Crowns 3) Bridges	o pt. will be made aware of surroundings prior to anesthesia induction. o pt. will be transferred safely to OR table. o pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	O Introduce self. keep pt informed as to where he. she is and what is happening. O Inform pt. in which direction to move and assist if necessary. Speak clearly and slowly. O Address pt. from _____ side. O Validate pt.'s understanding of verbal communication. O Verify removal of dentures.
G. OTHER PATIENT PROBLEMS NEEDS OR Continuation of Above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS OR continuation of above interventions.

10. OR NURSING INTERVENTION COMPLETE D/ADDITIONAL INTRAOPERATIVE INTERVENTIONS NOTED.

(b)(6)-2 [redacted] MAJ AN 18OCT03 DATE

11. POSTOPERATIVE EVALUATION :
LEVEL OF CONSCIOUSNESS: ☐ A&O ☐ Drowsy ☐ Sleepy ☐ Intubated
LEVEL OF ACTIVITY: ☐ MOVES ALL EXTREMITIES ☐ Moves Upper Extremities
☐ Transferred to Litter With roller due to spinal
SKIN INTEGRITY: Bovie Pad Site: ☐ Clean and Dry ☐ Red ☐ N/A
DRESSING DRY & INTACT: (Y) (N)
BREATHING EASY: (Y) (N)

12. PREOPERATIVE EVALUATION PREPARED BY (Signature) [redacted] MAJ AN
DATE: 180CT03 TIME: 1150

13. PREOPERATIVE EVALUATION PREPARED BY (Signature) [redacted] CPT/AN
(b)(6)-2
DATE: 18OCT03 TIME: 1943

MEDCOM - 20593

REVERS OF FORM 5179, JUN 91

USAPA V1.0

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

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

1. AGE:
HEIGHT:
WEIGHT:

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

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

4. PROPOSED SURGICAL PROCEDURE:

I+D Lt tibia

5. ADDITIONAL INFORMATION: Last PO: Medical Hx: See chart Implants: yes. LLE Medications See chart
Jewelry removed: yes/no Family waiting: yes/no

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to traumatic injury; language barrier; family separation; surgical environment	o ✓ Pt. verbalizes any specific anxiety. o ✓ Pt. exhibits relaxed body posture.	o ✓ Allow pt. to verbalize freely. o ✓ Explain OR environment and answer questions regarding surgery. o Offer comfort measures, (e.g., warm blanket, touch) o Explain all nursing procedures before they are done. o ✓ Remain with pt. whenever possible. o Maintain family interface.
B. AERATION ✓ Potential for respiratory dysfunction due to sedation; positioning; injury	o ✓ PT. will be able to breathe without difficulty during immediate intra-operative phase.	o ✓ Offer to elevate head of litter or offer pillow. o ✓ Observe pt. while awaiting surgery for signs of distress o ✓ Assist anesthesia during intubation and extubation
C. INTEGUMENT ✓ Potential impairment of skin integuity due to bovie pad position; fluid shift	o ✓ PT. will not exhibit signs of impairment of skin integrity (e.g., reddened areas.	o ✓ Utilize pressure preventing devices on OR table and accessories. o ✓ Check for proper positioning and support to maintain good body alignment. o ✓ Pad pressure points. o ✓ Place ESU ground pad on non compromised skin surface area. o ✓ Keep prep fluids from pooling.

as possible via translator

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

[redacted] (b)(6)-4

DA FORM 5179, JUN 91 Previous editions are obsolete. USAPA V1.01

[redacted] (b)(6)-4

[redacted] 21 Oct 03

(b)(2)-2

MEDCOM - 20594

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to anesthesia; traumatic injury; position; shock; previous surgery	✓ Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse).	o Check for support stockings or ace wraps. If none, check with doctors. o Check that safety straps are correctly applied. o Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. o Check that rings have been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to sedation; pain; injury E.2. ✓ Potential discomfort due to injury; pain	✓ Pt. will be transferred to OR table without difficulty. o Pt. will not experience unnecessary physical discomfort.	✓ Have sufficient people available for transfer. ✓ Insure proper body alignment. o Allow patient to lie in position of comfort while waiting for surgery. ✓ Offer support (i.e., pillows, bathtowels, etc.) for positioning.
F. NEUROMUSCULAR CONTROL F.1. ✓ Disminished visual perception due to being injury; sedation; F.2. ✓ Potential for decreased communictaion due to language barrier; sedation F.3. Potential injury due to dentures. NA	✓ Pt. will be made aware of surroundings prior to anesthesia induction. ✓ Pt. will be transferred safely to OR table. ✓ Pt. will be able to understand instructions. ✓ Minimize danger of injury during intraop period.	✓ Introduce self. Keep pt. informed as to where he/she is and what is happening. ✓ Inform pt. in which direction to move and assist if necessary. as possible. ✓ Speak clearly and slowly. o Address pt. from either side. o Validate pt.'s understanding of verbal communications. o Verify removal of dentures.
G. OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS. Or continuation of above interventions.

10. [redacted]G INTERVEN[redacted]LETED/ADDITIONAL INTEROPERATIVE INTERVENTIONS NOTED.

[redacted] CRT/AN (b)(6)-2 21OCT03 DATE

11. [redacted]OSTOP[redacted]IVE EVALUATION:

Dressing CDI

Resp- Even + unlabored.

O S/S of acute distress

Bovie pad site CDI

12. [redacted]REPARED BY (b)(6)-2

[redacted] CRT/AN

[redacted]TE: 21OCT03 TIME: 1130

13. P[redacted]OPERTIVE EVALUATION PREPARED

[redacted] CRT/AN (b)(6)-2

E: 21OCT03 TIME: 1245

MEDCOM - 20595

MEDICAL RECORD	INTRAOPERATIVE DOCUMENT For use of this form, see AR 40-66, the proponent agency is the office of The Surgeon General.
1. PATIENT TRANSPORTED TO OPERATING ROOM VIA gurney BY anesthesia	2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY [redacted] CRT AN
3. DATE 26 Sep 03 TIME PATIENT ARRIVED IN SUITE	4. PATIENT IN [redacted] (b)(6)-2 TIME 1010 NUMBER 2-1 (4)

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: NKDA

(b)(6)-2

6. NURSING PERSONNEL

ASSIGNED SCRUB	SSG [redacted] 91D (b)(6)-2	RELIEF SCRUB	(b)(6)-2
ASSIGNED CIRCULATOR	CPT [redacted] AN/666E	RELIEF CIRCULATOR	CPT [redacted] AN (b)(6)-2

7. POSITION AND POSITIONAL AIDS (Specify) Pt transferred to OR table anatomically aligned for surgical procedure & padding under heels (B) arms or head

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

COMMENTS:

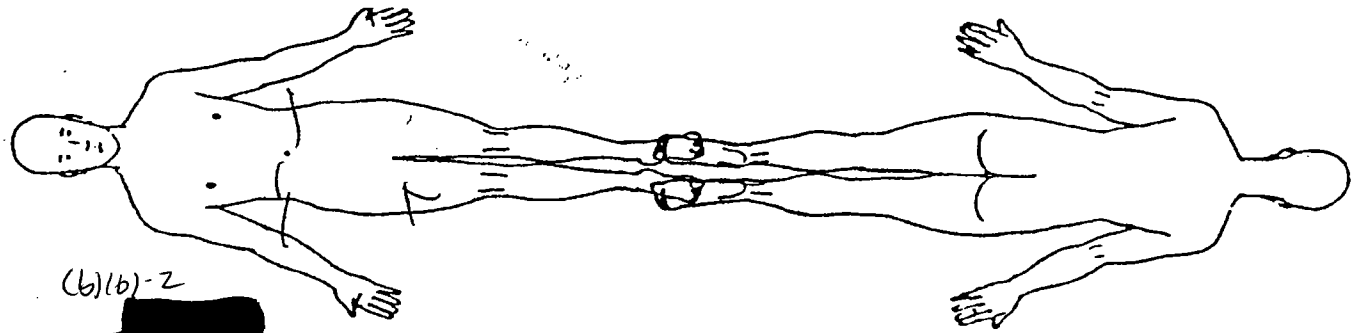
(b)(6)-2

8. SKIN PREPARATION

HAIR REMOVAL ☒ YES ☐ NO [redacted]
DONE BY: ☒ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP
COMMENTS: no nicks or cuts noted.

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

9. LOCATION OF EXTERNAL DEVICES



(b)(6)-2 [redacted]

LEGEND [redacted] Pad -- Safety Strap === Tourniquet

10. COUNTS

C = Correct I = Incorrect

		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 (b)(6)-2 SSG [redacted]
CIRCULATOR (b)(6)-2 CPT [redacted]

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

[redacted] (b)(6)-4

[redacted] (b)(2)-2

26 Sep 03

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

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:
☒ ESU NO:
GROUND PAD: BRAND
LOT NO:
☐ BIPOLAR NO:

MEDCOM - 20596

DA FORM 5179-1, OCT 87

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 ARM (L) Leg

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☒ NO ☐	NAME Injected bone (L) leg	NAME
FROZEN SECTION (FS) YES ☐ NO ☐	NAME	NAME
CULTURE (C) YES ☒ NO ☐	NAME Injected bone (L) leg	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE/SIZE	3/8 Penrose		
SITE	(L) leg		

18. DRESSING/IMMOBILIZATION *(Specify)*
fluff
Kerlix

19. ADDITIONAL INFORMATION
WC
Surgeons: [redacted] (b)(6)-2 Anesthesia: CRT [redacted] (b)(6)-2 Anesthesia Type:
[redacted] (b)(6)-2
(b)(6)-2 (b)(6)-2
Bovie Pad site intact pre-op [redacted] post-op [redacted] Bovie Settings: Coag/Cut 30/30
Tourniquet Site intact pre-op ___ : post-op [redacted]
Tourniquet Time: Up ___ Down ___ N/A
(b)(6)-2

20. OPERATION(S) PERFORMED
I & D (L) Leg wound

21. PATIENT TRANSFERRED TO ICU 3 (b)(6)-2 TIME 1155 METHOD gurney

22. REGISTERED NURSE SIGNATURE [redacted] CRT/AN

REVERSE OF DA FORM 5179-1, OCT 87 MEDCOM - 20597 USAPA V1.01

MEDICAL RECORD | **INTRAOPERATIVE DOCUMENT**

For use of this form, see AR 40-407, the p[illegible]ency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERA[illegible]OOM VIA litter BY anesthesia

2. PATIENT IDEN[illegible] VERIFIED BY [redacted] CORD REVIEWED AND PROCEDURE CPT / AN

3. DATE 29Sept 03 TIME PATIENT ARRIVED IN SUITE 1800

4. PATIENT IN ROOM (b)(6)-2 TIME 1800 NUMBER 9

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS:

8. SKIN PREPARATION

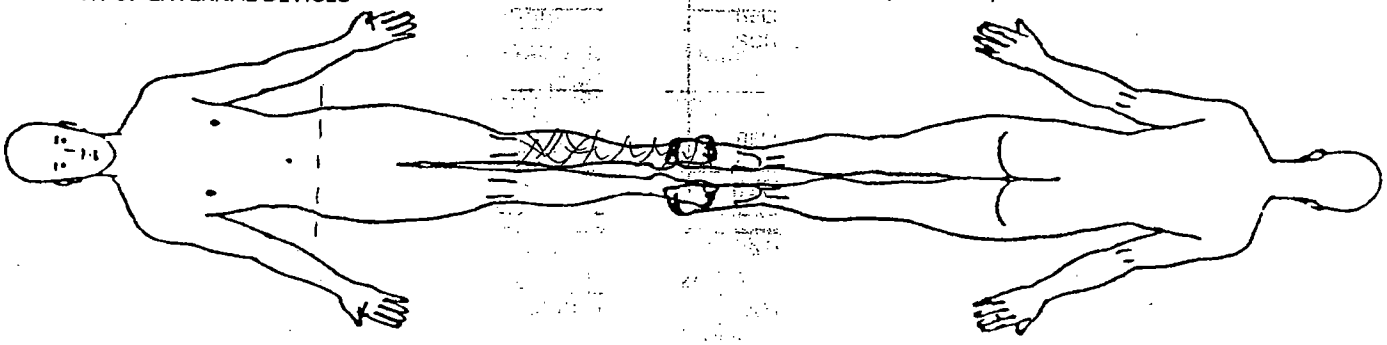
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine scrub/soln
SITE: (L) lower leg BY WHOM: [redacted] (b)(6)-2
SITE: BY WHOM:

COMMENTS: No pooling of fluids

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

10. COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☐ Yes	☐ No					
Needle Sharp	☐ Yes	☐ No					
Instrument	☐ Yes	☐ No					
Other	☐ Yes	☐ No					

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

[redacted] (b)(6)-4

[redacted] (b)(6)-4

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

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:
☐ ESU NO:
GROUND PAD: BRAND
LOT NO:
☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.00

MEDCOM - 20598

13. PROSTHESIS, IMPLANTS ☐ YES ☐ O IF YES NAME: ID NUMBER; CTURER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO; TYPE(S):

0.9% NS

OTHER ORDERS	TIME	CARRIED OUT BY
None		

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM 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
Kerlix

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

19. ADDITIONAL INFORMATION

Surg: [redacted] (b)(6)-2 Anesth: [redacted] (b)(6)-2 CENA General

20. OPERATION(S) PERFORMED

I & D (L) Lower Leg Wound

21. PATIENT TRANSFERRED TO	TIME	METHOD
PACU recovered in OR	1843	Litter

22. RE[redacted] CPT/AN (b)(6)-2

REVERSE OF DA FORM [redacted] CT 87

USAPA V1.00

MEDCOM - 20599

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

For use of this form, see AR 40-407, the prop[illegible]ency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERA[illegible]OOM
VIA Litter BY [illegible] Medic

2. PATIENT IDENTIFI[illegible] CORD REVIEWED AND PROCEDURE
VERIFIED BY CPT [redacted] (b)(6)-2

3. DATE 1 Oct 03 TIME PA[illegible]NT ARRIVED IN SUITE

4. PATIENT IN ROOM
TIME: 1810 NUMBER 1-5

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	PfC [redacted] (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] (b)(6)-2	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: -Proper body alignment maintained

8. SKIN PREPARATION

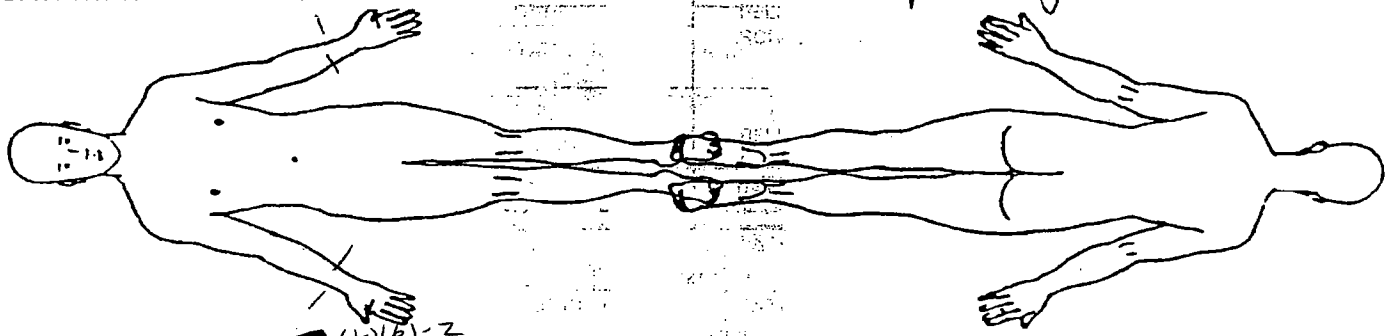
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine
SITE: (L) leg BY WHOM: [redacted] (b)(6)-2
SITE: BY WHOM:

COMMENTS: NO pooling or skin d's noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad [redacted] (b)(6)-2 -- Safety Strap = = = Tourniquet

10. COUNTS

C = Correct I = Incorrect

			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes	☐ No		C	C	[redacted] (b)(6)-2	[redacted] (b)(6)-2
Needle Sharp	☒ Yes	☐ No					
Instrument	☐ Yes	☒ No				UNMET	
Other	☐ Yes	☐ No					

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

[redacted] (b)(6)-4

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

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:
☐ ESU NO:
GROUND PAD: BRAND
LOT NO:
☐ BIPOLAR NO:

A FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.00

MEDCOM - 20600

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):
0.9% NaCl

OTHER ORDERS	TIME	CARRIED OUT BY
None		

PHYSICIAN'S SIGNATURE

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

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)* Kerlix

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

19. ADDITIONAL INFORMATION

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

Anesthesia: [redacted] (b)(6)-2

* MRSA precautions followed

- DA 5179 on chart, Ø ∆'s noted

20. OPERATION(S) PERFORMED
I+D (L) leg

21. PATIENT TRANSFERRED TO	TIME	METHOD
PACU in OR ICW-1	1439 DA 7390	Litter

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

REVERSE OF DA [redacted] 87

MEDCOM - 20601

USAPA V1.00

MEDICAL RECORD — INTRAOPERA[illegible] DOCUMENT

For use of this form, see AR 40-407, the propor[illegible]ncy is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERA[illegible]OOM VIA litter BY anesthesia

2. PATIENT IDENTIFI[illegible]OCEDURE VERIFIED BY [redacted] CRT/AW

3. DATE 30CT03 TIME PATIENT ARRIVED IN SUITE —

4. PATIENT IN [illegible]OM TIME 0949 (b)(6)-2 NUMBER 1-1 (3)

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	
ASSIGNED CIRCULATOR	CPT [redacted] 66E (b)(6)-2	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS:

8. SKIN PREPARATION

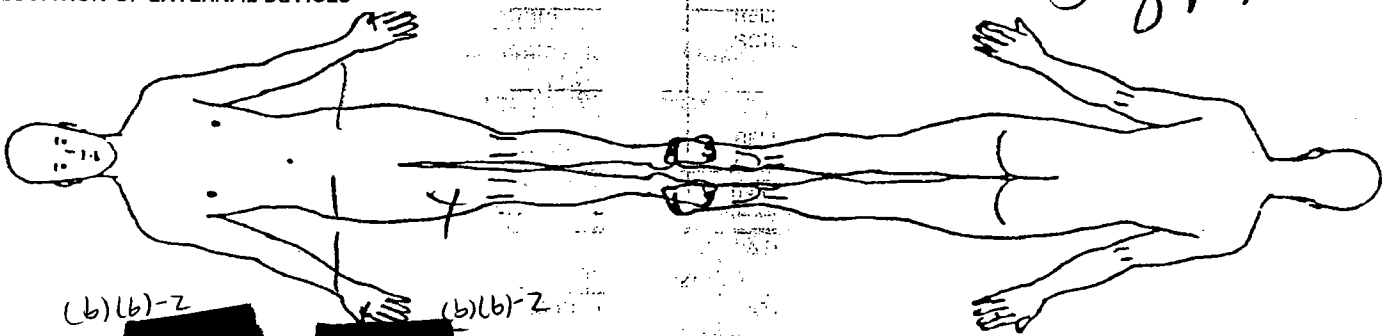
HAIR REMOVAL ☐ YES ☑ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Beta/Beta
SITE: (L) leg BY WHOM: CPT [redacted] (b)(6)-2
SITE: BY WHOM:

COMMENTS: no pooling of prep noted

9. LOCATION OF EXTERNAL DEVICES



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

LEGEND [illegible] Safety Strap = = = Tourniquet

10. COUNTS

C = Correct I = Incorrect

			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 (b)(6)-2 PFC [redacted]

CIRCULATOR (b)(6)-2 CPT [redacted]

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

[redacted] (b)(6)-4

(b)(2)-2 [redacted]

30CT03

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

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:
☐ ESU NO:
GROUND PAD: BRAND
LOT NO:
☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.00

MEDCOM - 20602

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

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 (b)(6)-2 [redacted]	18. DRESSING/IMMOBILIZATION *(Specify)* - fluffs - kerlix

17. TUBES, DRAINS/PACKING YES ☒ NO [redacted]

	1.	2.	3.
TYPE/SIZE	1. JP Drain	2.	3.
SITE	(L) leg.	2.	3.

19. ADDITIONAL INFORMATION

20. OPERATION(S) PERFORMED

I & D (L) tibia

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU3	1047	gurney

22. REGIS[redacted] CPT/AN

REVERSE OF [redacted] DRM 5179-1, OCT 87 (b)(6)-2 MEDCOM - 20603 USAPA V1.00

MEDICAL RECORD — **INTRAOPERATIVE DOCUMENT**

For use of this form, see AR 40-407, the pro[illegible]ency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPER[illegible]OM VIA litter B[illegible]esthesia	2. PATIENT IDENTIFI[illegible]CORD REVIEWED AND PROCEDURE VERIFIED BY [redacted] CPT/AN (b)(6)-2
3. DATE 6 Oct 03 TIME PATIENT ARRIVED IN SUITE 1531	4. PATIENT IN ROOM TIME 1531 NUMBER

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] (b)(6)-2	RELIEF CIRCULATOR INT	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: Proper body alignment maintained

8. SKIN PREPARATION

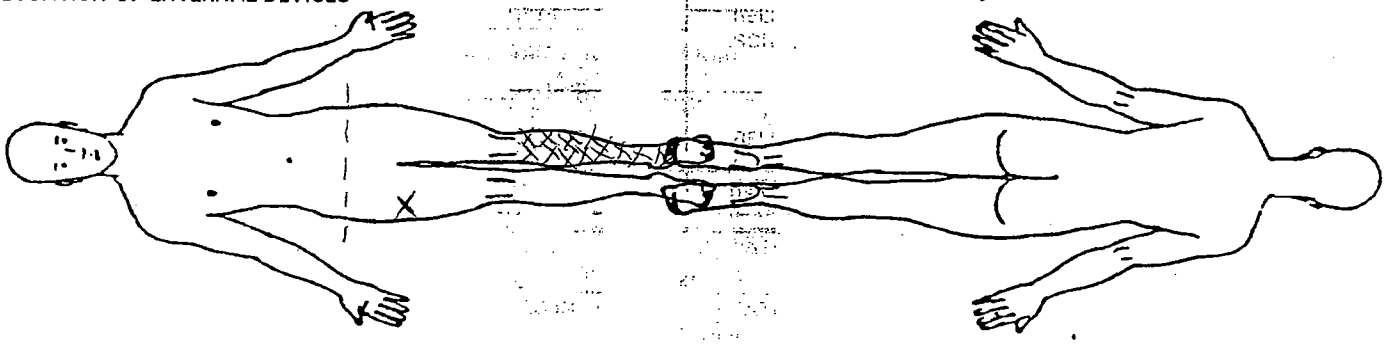
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine scrub/sol'n
SITE: Lt. Lower Leg BY WHOM: Meyer
SITE: BY WHOM:

COMMENTS: No pooling of fluids

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS — C = Correct I = Incorrect

			Other**	First Closing Count	Final Closing Count
Sponge	☒ Yes	☐ No			C
Needle Sharp	☐ Yes	☑ No			
Instrument	☐ Yes	☑ No			
Other	☐ Yes	☑ No			

I→C [redacted] (b)(6)-2

SCRUB	CIRCULATOR
DAY	[redacted] (b)(6)-2

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

[redacted] (b)(6)-4

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

☐ ESU NO:
GROUND PAD: BRAND Valleylab
LOT NO:
☐ ESU NO:
GROUND PAD: BRAND
LOT NO:
☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.00

MEDCOM - 20604

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO; TYPE(S):

0.9% NS

OTHER ORDERS	TIME	CARRIED OUT BY
None		

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM 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)*

Ioban

Fluffs

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE/SIZE	JP Drain		
SITE	Lt. Lower Leg		

19. ADDITIONAL INFORMATION

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

Anesth: (6)(6)-2 [redacted] CRNA Anes. Mask

20. OPERATION(S) PERFORMED

I & D Lt. Lower Leg

21. PATIENT TRANSFERRED TO (6)(6)-2 [redacted] TIME 1627 METHOD Litter

Recov. by PACU ~~not OR per MRSA policy~~

22. REGISTERED NURSE SIGNATURE [redacted] CPT JAN

REVERSE OF DA FORM 517[illegible], OCT 87

(6)(6)-2

MEDCOM - 20605

USAPA V1.00

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

For [illegible] of this form, see AR 40-407, the prop[illegible]ncy is the office of [illegible]e Surgeon General.

1. PATIENT TRANSPORTED TO OPERA[illegible]OOM (b)(6)-2
VIA Litter BY MAJ [redacted]

2. PATIENT IDENTIFI[illegible] CORD REVIEWED AND PROCEDURE
VERIFIED BY MAJ [redacted] (b)(6)-2

3. DATE 10 Oct 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM
TIME NUMBER 2-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	MAJ [redacted] (b)(6)-2	RELIEF CIRCULATOR INT	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS:

8. SKIN PREPARATION

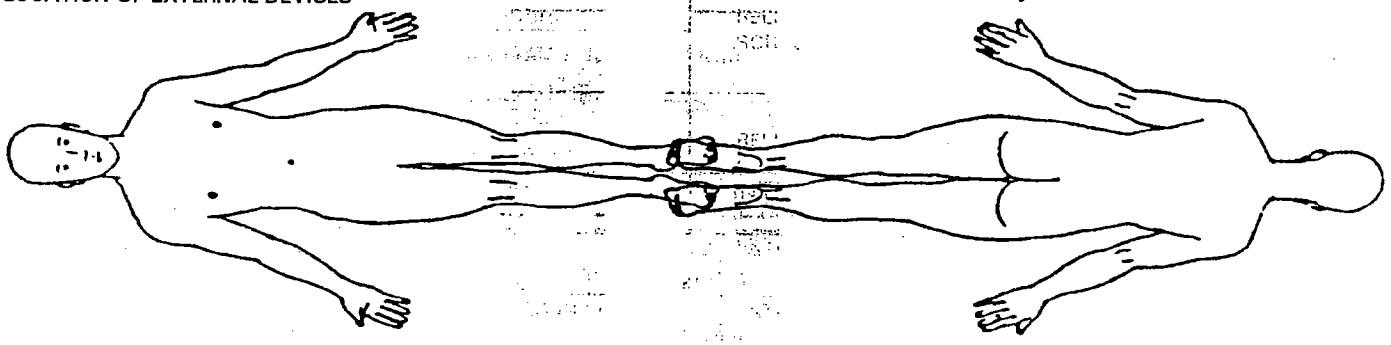
HAIR REMOVAL ☐ YES ☐ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine scrub & sol.
SITE: Left Leg BY WHOM: MAJ [redacted] (b)(6)-2
SITE: BY WHOM:

COMMENTS: No pooling of solution

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS

C = Correct I = Incorrect

			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☑ Yes	☐ No				(b)(6)-2	(b)(6)-2
Needle Sharp	☑ Yes	☐ No				SPC [redacted]	MAJ [redacted]
Instrument	☑ Yes	☐ No					
Other	☐ Yes	☑ No					

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

[redacted] (b)(6)- 4

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

☐ ESU NO: [redacted] (b)(6)-4
GROUND PAD: BRAND Valley Lab
LOT NO: [redacted] (b)(6)-4 Exp 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

MEDCOM - 20606

13. PROSTHESIS, IMPLAN' ☐ YES ☐ NO IF YES NAME: I 'UMBER; 'CTURER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☑ YES ☐ NO; TYPE(S): N.S.

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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)*

17. TUBES, DRAINS/PACKING YES ☐ NO ☐

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

19. ADDITIONAL INFORMATION

(b)(6)-2

Surgeon: Dr [redacted]

Anes: MAJ [redacted]

(b)(6)-2

20. OPERATION(S) PERFORMED

I & D Lt Tibia, Replace VAC

21. PATIENT TRANSFERRED TO	TIME	METHOD
PACU	See SF 57	OR Litter

22. REGISTERED NURSE SIGNATURE

[redacted] MAJ AN 10 Oct 03

(b)(6)-2

REVERSE OF DA FORM 5179-1, OCT 87

USAPA V1.00

MEDCOM - 20607

MEDICAL RECORD — **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERA[illegible]OOM VIA litter BY anesthesia
2. PATIENT IDENTIFI[illegible] CORD REVIEWED AND PROCEDURE VERIFIED BY ILT [redacted] (b)(6)-2
3. DATE 15 Oct TIME PATIENT ARRIVED IN SUITE
4. PATIENT IN ROOM TIME 1210 NUMBER 1 #4

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NKDA, NPO p MN

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted] (b)(6)-2 910	RELIEF SCRUB	N/A
ASSIGNED CIRCULATOR	ILT [redacted] (b)(6)-2 606	RELIEF CIRCULATOR INT	N/A

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

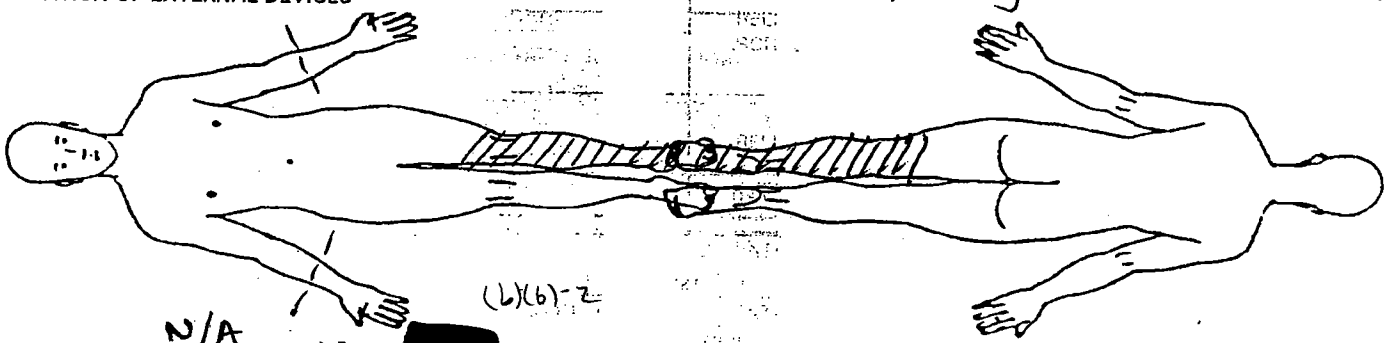
COMMENTS: Normal anatomic body alignment maintained

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* Betadine / Betadine
SITE: Left leg
SITE:
BY WHOM: ILT [redacted] (b)(6)-2
BY WHOM:
COMMENTS: No pooling or adverse reaction

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad (b)(6)-2 -- Safety Strap = = = Tourniquet N/A prep

Initial: PFC [redacted] ILT (b)(6)-2

C = Correct I = Incorrect

10. COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB (b)(6)-2	CIRCULATOR (b)(6)-2
Sponge	☒ Yes	☐ No			C	PFC [redacted]	ILT [redacted]
Needle Sharp	☒ Yes	☐ No					
Instrument	☐ Yes	☒ No					
Other	☐ Yes	☒ No					

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

[redacted] (b)(6)-4

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

☐ ESU NO:
GROUND PAD: BRAND N/A
LOT NO:
☐ ESU NO:
GROUND PAD: BRAND N/A
LOT NO:
☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 — REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. — USAPA V1.00

MEDCOM - 20608

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
N/A					

WOUND IRRIGATION ☒ YES ☐ NO; TYPE(S): 0.9% NaCl - QS.

OTHER ORDERS	TIME	CARRIED OUT BY
N/A		

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☐	NAME (A) wound inf. (L) tibia (C)	NAME
FROZEN SECTION (FS) YES ☐ NO ☐	NAME	NAME
CULTURE (C) YES ☒ NO ☐	NAME	NAME
NAME	NAME	NAME
NAME	NAME	18. DRESSING/IMMOBILIZATION *(Specify)* Fluffs Kerlix

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. Fluffs	2.	3.
SITE	1. (L) tibia	2.	3.

19. ADDITIONAL INFORMATION

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

20. OPERATION(S) PERFORMED I&D (L) tibia

21. PATIENT TRANSFERRED TO PACU	TIME See DA7389	METHOD Liter @ O2
22. REGISTERED NURSE SIGNATU [redacted] RN (b)(6)-2		

REVERSE OF DA FORM 5179-1, OCT 87 USAPA V1.00

MEDCOM - 20609

ACLU-RDI 1657 p.169

DOD-034183

MEDICAL RECORD — **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERA... ROOM (b)(6)-2 (b)(6)-2 2. PATIENT IDENTIF... RECORD REVIEWED AND PROCEDURE
VIA Litter BY MAJ [redacted] MAJ [redacted] BY MAJ [redacted] (b)(6)-2

3. DATE 18 Oct 03 TIME PATIENT ARRIVED IN SUITE 1200 4. PATIENT IN ROOM TIME 1200 NUMBER 1-1 (2)

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	MAJ [redacted] (b)(6)-2 CPT [redacted] (b)(6)-2 (12:10 - end)	RELIEF CIRCULATOR INT	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

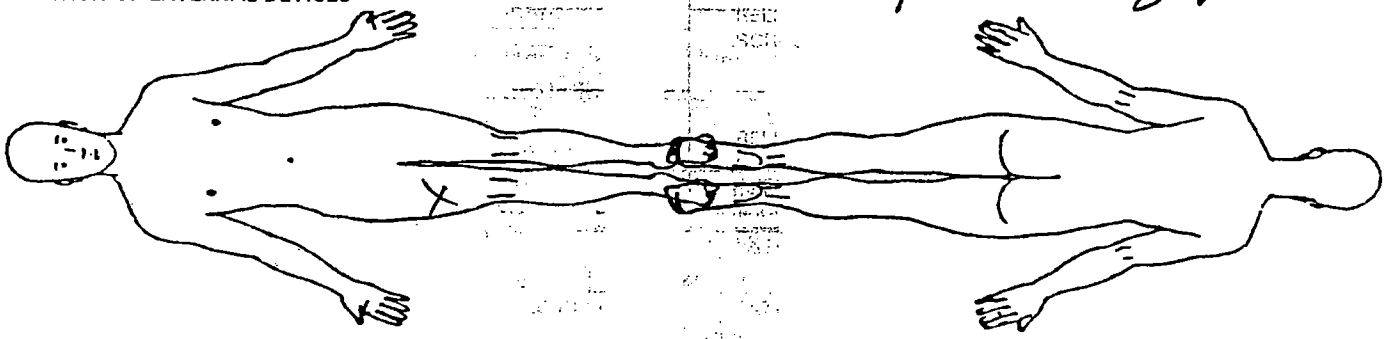
COMMENTS:

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* Beta/Beta
SITE: L leg BY WHOM: MAJ [redacted] (b)(6)-2
SITE: BY WHOM:
COMMENTS: no pooling of prep noted.

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Strap = = = 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 (b)(6)-2 SSG [redacted]
CIRCULATOR (b)(6)-2 CPT [redacted]

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

[redacted] (b)(6)-4

[redacted] (b)(2)-2

18 OCT 03

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

☑ ESU NO: [redacted] (b)(6)-4
GROUND PAD: BRAND Valley Lab
LOT NO [redacted] (b)(6)-4 Exp 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

MEDCOM - 20610

13. PROSTHESIS, IMPLANTS ☐ YES NO IF YES NAME: ID NUMBER CTURER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S): NS.

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM YES ☑ NO ☐ IF YES, SITE C-ARM (L) leg

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME (b)(6)-2	

18. DRESSING/IMMOBILIZATION *(Specify)*
- fluffs
- kerlix
- ace wrap.

17. TUBES, DRAINS/PACKING YES ☒ NO ☒ DPS

TYPE/SIZE	1. 10 mm JP	2.	3.
SITE	1. (L) leg.	2.	3.

19. ADDITIONAL INFORMATION

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

Surgeon Dr [redacted] Dr. [redacted]

anes: MAJ [redacted]

(b)(6)-2

20. OPERATION(S) PERFORMED Excision of non-viable, DOPC of wound.

I & D (L) leg. EX-FIX removal & application

21. PATIENT TRANSFERRED TO ICU 3 TIME 1743 METHOD Litter

22. REGISTERED NURSE SIGNATURE [redacted] MAJ AN (b)(6)-2 [redacted] CPT/AN

REVERSE OF DA FORM 5179-1, OCT 87 (b)(6)-2 MEDCOM - 20611 USAPA V1.00

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Litter BY MAJ [redacted] (b)(6)-2

2. PATIENT IDENTIFICATION VERIFIED AND PROCEDURE VERIFIED BY CPT [redacted] (b)(6)-2

3. DATE 21 Oct 03 TIME PATIENT ARRIVED IN SUITE 1140

4. PATIENT IN ROOM TIME 1140 NUMBER 1-1-3

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NKA

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] (b)(6)-2 9D (b)(6)-2	RELIEF SCRUB	Ø
ASSIGNED CIRCULATOR	# CPT [redacted] 66E	RELIEF CIRCULATOR INT:	Ø

7. POSITION AND POSITIONAL AIDS (Specify) PT on padded OR Bed, Head on foam doughnut, Bilateral Arms extended out to sides C90° in CAP secured to padded armboards C Safety Straps

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

Folded towel under (R) heel.

COMMENTS: Correct Body Alignment maintained.

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

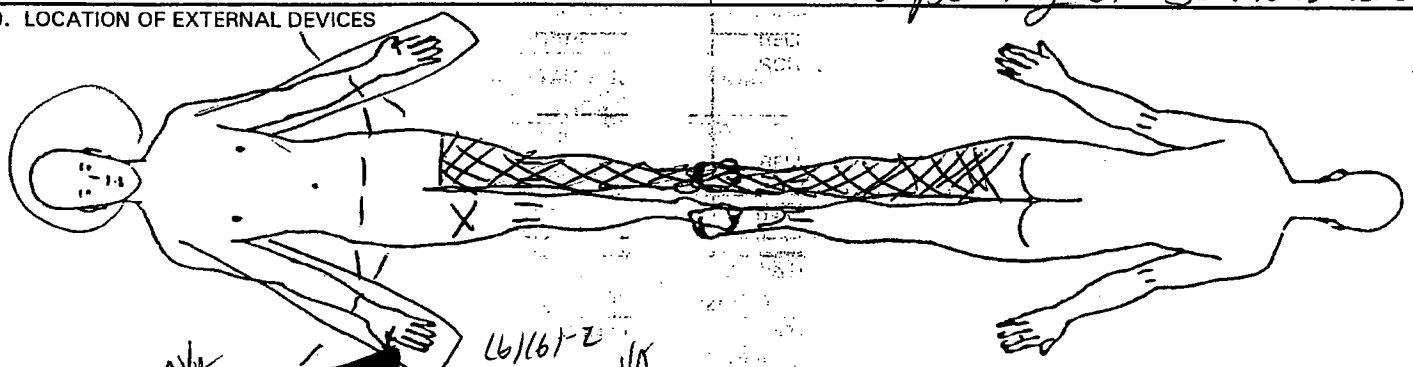
PREP SOLUTION (Specify) Betadine Scrub & Solution

SITE: LLE BY WHOM: CPT [redacted] (b)(6)-2

SITE: BY WHOM:

COMMENTS: no pooling of solutions noted

9. LOCATION OF EXTERNAL DEVICES



(b)(6)-2

LEGEND N/A X Ground Pad [redacted] Safety Strap = = = N/A Tourniquet

C = Correct I = Incorrect

10. COUNTS			Other**	First Closing Count	Final Closing Count
Sponge	☐ Yes	☑ No			
Needle Sharp	☑ Yes	☐ No	C		C
Instrument	☐ Yes	☑ No			
Other	☐ Yes	☑ No			

SCRUB (b)(6)-2 RFC [redacted]

CIRCULATOR (b)(6)-2 CPT [redacted]

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

[redacted] (b)(6)-4

(b)(2)-2

[redacted] 21 Oct 03

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

(b)(6)-4

☑ ESU NO: [redacted] -not used.

GROUND PAD: BRAND Valleylab

LOT NO: [redacted] Exp 2005-04 (b)(6)-4

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.00

MEDCOM - 20612

13. PROSTHESIS, IMPLANTS ☐ YES ☑ NO IF YES NAME: ID NUMBER: :TURER

ex-fix previously in place

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☑ YES ☐ NO; TYPE(S): N.S. 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)* Fluff, Kerlix Roll, ACE

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

19. ADDITIONAL INFORMATION WC-IV (6)(6)-2

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

anes: MAJ [redacted] CRNA - Gen/Endo

Bovie pad site pre-op + post-op COI Bovie not used

DD 5179 redone.

20. OPERATION(S) PERFORMED

IMN Lt Tibia

21. PATIENT TRANSFERRED TO PACU TIME 1235 METHOD Litter

22 [redacted] asst/Dr (6)(6)-2

[redacted] M 5179-1, OCT 87 USAPA V1.00

MEDCOM - 20613

MEDICAL RECORD — INTRAOPERA DOCUMENT

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

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

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY CPT [redacted] (b)(6)-2

3. DATE 10NOV03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME 1345 NUMBER 7

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: ø concerns voiced

6. NURSING PERSONNEL

ASSIGNED SCRUB	/	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] (b)(6)-2	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

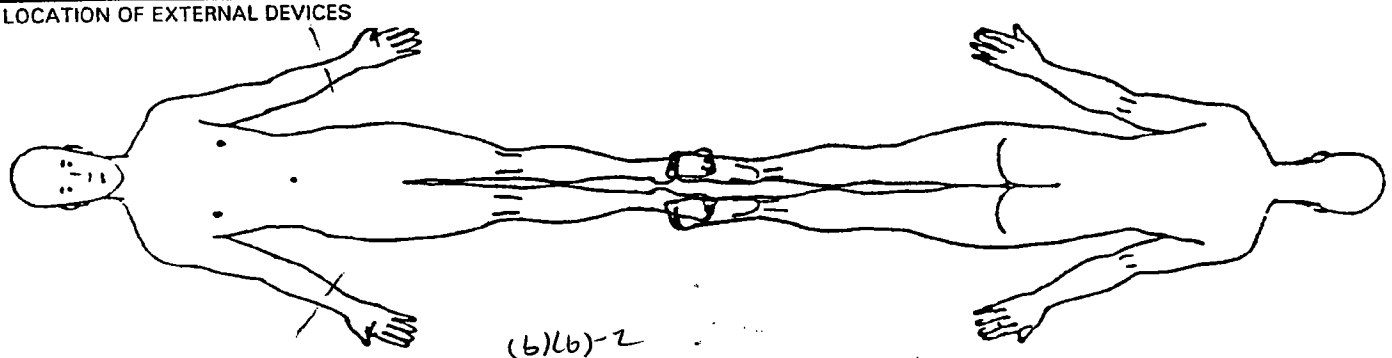
COMMENTS: correct body alignment maintained

8. SKIN PREPARATION

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

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

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Str[redacted] = = = Tourniquet

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☐ Yes ☒ No					
Needle Sharp	☐ Yes ☒ No					
Instrument	☐ Yes ☒ No					
Other	☐ Yes ☒ No					

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

#[redacted] (b)(6)-4
[redacted] (b)(2)-2
10NOV03

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

☐ ESU NO: _____
GROUND PAD: BRAND _____
LOT NO: _____

☐ ESU NO: _____
GROUND PAD: BRAND _____
LOT NO: _____

☐ BIPOLAR NO: _____

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☐ YES ☒ NO, TYPE(S):

OTHER ORDERS	TIME	CARRIED OUT BY
none		

PHYSICIAN'S SIGNATURE

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

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)*

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

19. ADDITIONAL INFORMATION

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

Anesthesia: [redacted] (b)(6)-2

-DA5179 on chart, Q1's noted

20. OPERATION(S) PERFORMED

Removal (L) LE EXFix

21. PATIENT TRANSFERRED TO PACU (ICU3) TIME 1389 METHOD Litter

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

REVERSE OF DA FORM [redacted] & MEDCOM - 20615 USAPA V1.01

Ward/Section: CMT	REQUESTING PHYSICAN: [redacted] (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] (b)(6)-4	DATE 25 Sep 03	TIME 1130
SSN: [redacted] (b)(6)-4		

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x10
RBC		4.7-6.1 x10
Hgb		14-18 g/dl(M) 12-16 g/dl(F)
Hct		42-52%(M) 37-47%(F)
MCV		
Plt		
Lym		
(Hi		
Segs		
Banc		
Lymp		
Atyp		
RBC Morp		
Spun Hematocrit		42-52%(M) 37-47%(F)
Set Rate	15	
Other		

ID [redacted] (b)(6)-4 25-09-03
WB 11:31

			Patient Limits	
WBC	7.5	x10^3/uL	4.5	10.5
RBC	5.58	x10^6/uL	4.00	6.00
Hgb	15.5	g/dL	11.0	18.0
Hct	49.2	%	35.0	60.0
MCV	88.1	fL	80.0	99.9
MCH	27.9	pg	27.0	31.0
MCHC	31.6 L	g/dL	33.0	37.0
Plt	276.	x10^3/uL	150.	450.
LY%	31.8	%	20.5	51.1
LY#	2.4	x10^3/uL	1.2	3.4

Urinalysis

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

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Macroscopic Urinalysis

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: (b)(6)-2 [redacted] DATE: 9-25-03 LAB ID NO.:

ABN-SINA HOSPITAL
[redacted] (b)(2)-2
Baghdad, Iraq

Microbiology Request Form

Last Name: #[redacted] (b)(6)-4
First Name:
Patient # or SSN:
Collected by: Dr. [redacted] (b)(6)-2
Date: 26
Time: 1106

Ward: OR
Room:
Bed:
Physician: [redacted] (b)(6)-2
Source: L leg
Site: infected bone

[redacted]

Received by: SPC [redacted] (b)(6)-2
Date: 26 Sep 03
Time: 1155

Specimen #: WO 27

Laboratory Results

MRSA S. aureus

Reported
Date: 9/28
Time: 1130
Tech: SP
Reviewer: [redacted] (b)(6)-2

Number of attached sheets:

Microbiology Report

IBN SINA - HOSPITAL Laboratory

Name:	Specimen: **W027**	Status:	**Final**
Patient ID: [redacted] (b)(6)-4	Source: Wound/Sterile site	Collected:	
Ward/Rm: OR/	Ward of Iso:	Attd. Phys:	

1 Staphylococcus aureus — Status: Final

1 **S. aureus**

Drug	MIC	Interps	Drug	MIC	Interps
Amox/K Clav (c)	>4/2	R			
Amp/Sulbactam (c)	<=8/4	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	>8	R			
Imipenem (c)	>8	R			
Levofloxacin	<=2	S			
Linezolid	4	S			
Moxifloxacin	<=2	S			
Nitrofurantoin	<=32				
Norfloxacin	<=4				
Ofloxacin	<=2	S			
Oxacillin	>2	R			
Penicillin	>8	BLAC			
Rifampin	>2	R			
Synercid	<=1	S			
Tetracycline	>8	R			
Trimeth/Sulfa	<=2/38	S			
Vancomycin	<=2	S			

Methicillin Resistant S. aureus

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:	Specimen: **W027**	Status:	**Final**
Patient ID: [redacted] (b)(6)-4	Source: Wound/Sterile site	Collected:	(b)(6)-2
Ward/Rm: OR/	MEDCOM - 20618	Req. Phys:	[redacted]

Microbiology Report

IBN SINA - HOSPITAL Laboratory

Name:		Specimen: **W027**	Status: **Final**
Patient ID: [redacted] (6)(6)-4		Source: Wound/Sterile site	Collected:
Ward/Rm: OR/		Ward of Iso:	Attd. Phys:

1 Staphylococcus aureus -- Status: Final MRSA/ORSA

1 **S. aureus**

Drug	MIC	Interps	Drug	MIC	Interps
Amox/K Clav (c)	>4/2	R			
Amp/Sulbactam (c)	<=8/4	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	>8	R			
Imipenem (c)	>8	R			
Levofloxacin	<=2	S			
Linezolid	4	S			
Moxifloxacin	<=2	S			
Nitrofurantoin	<=32				
Norfloxacin	<=4				
Ofloxacin	<=2	S			
Oxacillin	>2	R			
Penicillin	>8	BLAC			
Rifampin	>2	R			
Synercid	<=1	S			
Tetracycline	>8	R			
Trimeth/Sulfa	<=2/38	S			
Vancomycin	<=2	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.
(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:		Specimen: **W027**	Status: **Final**
Patient ID: [redacted] (6)(6)-4		Source: Wound/Sterile site	Collected: (6)(6)-2
Ward/Rm: OR/		W MEDCOM - 20619	Req. Phys: [redacted] (6)(6)-2

IBN-SINA HOSPITAL
[redacted] (b)(2)-2
Baghdad, Iraq

Microbiology Request Form

Last Name: [redacted] (b)(6)-4
First Name:
Patient # or SSN:
Collected by: Dr. [redacted] (b)(6)-2
Date: 10 OCT 03
Time: 1335

Ward: ICU-1
Room:
Bed:
Physician: [redacted] (b)(6)-2
Source: (L) Tibia / Wound M052
Site: (L) Leg M053

[redacted]

Received by: mc
Date: 10 Oct 03
Time: 1349

Specimen #: Anaerobic W
Aerobic W

Laboratory Results

No Growth @ 48 hours

Reported
Date:
Time:
Tech:
Reviewer: [redacted] (b)(6)-2

Number of attached sheets:

DOD-034194
MEDCOM - 20620
ACLU-RDI 1657 p.180

IBN-SINA HOSPITAL
[redacted] (b)(2)-2
Baghdad, Iraq

Microbiology Request Form

Last Name: [redacted] (b)(6)-4
First Name:
Patient # or SSN:

Collected by: Dr. [redacted] (b)(6)-2
Date: 10 OCT 03
Time: 1335

Ward: ICW-1
Room:
Bed:
Physician: [redacted] (b)(6)-2

Source: (L) Tibia / Wound W052
Site: (L) Leg W053

[redacted]

Received by: mc
Date: 10Oct03
Time: 1349

Specimen #: Aerobic W
Anaerobic W

Laboratory Results

No Growth @ 48 hours

Reported
Date:
Time:
Tech:
Reviewer: [redacted] (b)(6)-2

Number of attached sheets:

MEDCOM - 20621

DOD-034195

ACLU-RDI 1657 p.181

IBN-SINA HOSPITAL
[redacted] (b)(2)-2
Baghdad, Iraq

Microbiology Request Form

Last Name: [redacted] (b)(6)-4
First Name:
Patient # or SSN: [redacted] (b)(6)-4
Collected by: Dr. [redacted] (b)(6)-2
Date: 15 OCT 03
Time: 1300

Ward: ICU 1
Room:
Bed:
Physician: Dr. [redacted] (b)(6)-2
Source: Wound Infection
Site: (L) Tibia

[redacted]

Received by: rgc
Date: 150ct03
Time: 1330

Specimen #: Wo67

Laboratory Results

Staphylococcus aureus (MRSA)

Reported
Date: 170ct03
Time: 1353
Tech: rgc
Reviewer: [redacted] (b)(6)-2

Number of attached sheets:

Microbiology Report

IBN SINA - HOSPITAL Laboratory

Name:		Specimen:	**W067**	Status:	**Final**
Patient ID:	864	Source:	Wound/Sterile site	Collected:	
Ward/Rm:	OR/	Ward of Iso:		Attd. Phys:	

1 Staphylococcus aureus Status: Final MRSA/ORSA

1 **S. aureus**

Drug	MIC	Interps	Drug	MIC	Interps
Amox/K Clav (c)	>4/2	R			
Amp/Sulbactam (c)	<=8/4	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	>2	R			
Clindamycin	>2	R			
Erythromycin	>4	R			
Gatifloxacin	<=2	S			
Gentamicin	>8	R			
Imipenem (c)	>8	R			
Levofloxacin	<=2	S			
Linezolid	<=2	S			
Moxifloxacin	<=2	S			
Nitrofurantoin	<=32				
Norfloxacin	>8				
Ofloxacin	4	I			
Oxacillin	>2	R			
Penicillin	>8	BLAC			
Rifampin	>2	R			
Synercid	<=1	S			
Tetracycline	>8	R			
Trimeth/Sulfa	<=2/38	S			
Vancomycin	<=2	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.
(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:		Specimen:	**W067**	Status:	**Final**
Patient ID:	[redacted] (b)(6)-4	Source:	Wound/Sterile site	Collected:	(b)(6)-2
Ward/Rm:	OR/	Ward of Iso:		Req. Phys:	[redacted]

Printed 10/17/2003 1:45:52 PM

MEDCOM - 20623

Tech: [redacted] (b)(6)-2

ICU#1

(6)(6)-2

Ward/Section [redacted]	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST,MI. (6)(6)-4	DATE 11OCT	TIME 0502	SSN/PEEUDO SSN: [redacted] (6)(6)-4

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x10	Color		N/A	RPR		Negative
RBC		4.7-6.1 x10	App		N/A			ative
Hgb		14-18 g/dl(M) 12-16 g/dl(F)	Glu		Neg			
Hct		42-52%(M) 37-47%(F)	Bili		Neg			
MCV		80-94 fi(M) 81-99 fi(F)	Ket		Neg			
Plt		130-500 x10³ verified	SG		N/			Negative
Ly			Bld		Ne			Negative
(			pH		N/			
S			Prot		Ne			
B			Urob		0.			
Ly			Nit		N			
A			Leuk		N			nalysis
R M			HCG					
Sj H			CSF					k
S			Cell Count					18 WITH ESTED
O			Directigen					

(MUST SUBM ... OF BLOOD

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

PICCOLO

11/10/03 05:17

REFERENCE RANGE: MALE

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

METLYTE 8

DISC LOT #: (6)(6)-2 3151AA4

OPER #: [redacted] DR #: 000

SERIAL #: [redacted]

(6)(6)-4

GLU	99	73-118	MG/DL
BUN	10	7-22	MG/DL
CRE	1.1	0.6-1.2	MG/DL
CK	65	39-380	U/L
NA+	135	128-145	MMOL/L
K+	4.5	3.3-4.7	MMOL/L
CL-	101	98-108	MMOL/L
tCO2	24	18-33	MMOL/L

INST QC: OK CHEM QC: OK

HEM 0 , LIP 0 , ICT 0

Ward/Section: ICU 1	REQUESTING PHYSICIAN: [redacted] (6)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI: [redacted] (6)(6)-4	DATE: 6NOV	TIME: 0500	SSN: [redacted] (6)(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
RBC		4.7-6.1 x 10^6
Hgb		14-18 g/dl (M) 12-16 g/dl (F)
Hct		42-52% (M) 37-47% (F)
MCV		[illegible] (M) (F)
		x 10^3
		1%
		rential
		0
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

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

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section:	REQUESTING PHYSICIAN:	[redacted] TRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI.	DATE / TIME	SSN/PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art)

---

i-STAT CREA

Pt [redacted] (b)(6)-4

Pt Name:_____

Crea_____1.5 mg/dL

Sample Type_:

06NOV03 05:40

Oper:

Physician:_____

Ser [redacted] (b)(6)-4

Ver: JAMS046A
CLEW A93

Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
A		
A		
A		
T		
B		
C		
C		
C		
G		
T		
G		
B		
C		
C		
N		
K		
C		
tC		

---

i-STAT EC8+

Pt [redacted] (b)(6)-4

Pt Name:_____

Glu_____102 mg/dL

BUN_____16 mg/dL

Na_____137 mmol/L

K_____3.1 mmol/L

Cl_____97 mmol/L

TCO2_____35 mmol/L

AnGap_____9 mmol/L

Hct_____36 %PCV

Hb*_____12 g/dL

*via Hct

pH_____7.449

PCO2_____48.2 mmHg

HCO3_____33 mmol/L

BEecf_____9 mmol/L

Sample Type_:

06NOV03 05:39

Oper:

Physician:_____

Se [redacted] (b)(6)-4

Ver: JAMS046A
CLEW A93

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
UN		7-22 mg/dl
A++		8.0-10.3 mg/dl
RE		0.6-1.2 mg/dl
A-		128-145 mmol/l
		3.3-4.7 mmol/l
-		98-108 mmol/l
O2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
LB		3.3-5.5 g/dl
LP		26-84 u/l
LT		10-47 u/l
MY		14-97 u/l
ST		11-38 u/l
BIL		0.2-1.6 mg/dl
GT		5-65 u/l
		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
A-		128-145 mmol/l
		3.3-4.7 mmol/l
-		98-108 mmol/l
O2		18-33 mmol/l

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: ICW1	REQUESTING PHYSICIAN: [redacted] (6)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI: [redacted] (6)(6)-4	DATE: 08NOV03	TIME: 1430	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
RBC		
Hgb		
Hct		
MCV		
MCH		
MCHC		
Plt		
Seg		
Bands		
Lymph		
Atyp		Imm
RBC Morph		
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

ID: [redacted] (6)(6)-4 WB 08-11-03 14:41

			Patient Limits	
WBC	9.4	x10^3/uL	4.5	10.5
RBC	4.32	x10^6/uL	4.00	6.00
Hgb	11.6	g/dL	11.0	18.0
Hct	37.1	%	35.0	60.0
MCV	85.9	fL	80.0	99.9
MCH	27.0 L	pg	27.0	31.0
MCHC	31.4 L	g/dL	33.0	37.0
Plt	457. H	x10^3/uL	150.	450.
LY%	18.8 *L	%	20.5	51.1
LY#	1.8 *	x10^3/uL	1.2	3.4

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

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

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: ICU | REQUESTING PHYSICIAN: | CLINICAL LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, M: [redacted] (b)(6)-4 | DATE | TIME | SSN/PSEUDO SSN:

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l

======= PICCOLO =======
08/11/03 14:40
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: (b)(6)-2 3151AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted] (b)(6)-4

GLU	100	73-118	MG/DL
BUN	19	7-22	MG/DL
CRE	2.0*	0.6-1.2	MG/DL
CK	58	39-380	U/L
NA+	130	128-145	MMOL/L
K+	3.6	3.3-4.7	MMOL/L
CL-	90*	98-108	MMOL/L
tCO2	26	18-33	MMOL/L

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
RE		0.6-1.2 mg/dl
A⁺		128-145 mmol/l
		3.3-4.7 mmol/l
		98-108 mmol/l
O_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
LB		3.3-5.5 g/dl
LP		26-84 u/l
LT		10-47 u/l
MY		14-97 u/l
ST		11-38 u/l
BIL		0.2-1.6 mg/dl
GT		5-65 u/l
		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
A⁺		128-145 mmol/l
		3.3-4.7 mmol/l
		98-108 mmol/l
O_2		18-33 mmol/l

REMARKS:

REPORTED BY: [redacted] (b)(6)-2 | DATE: 8/[illegible]/03 | LAB ID NO.:

(b)(6)-4 1C .1 7 (b)(6)-2

Ward/Section: [redacted]	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted] (b)(6)-4	DATE: 9 NOV 03 TIME: 1430	SSN/PSEUDO: [redacted] (b)(6)-4

(Hematology) CBC

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

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

TEST	RESULT	REF. RANGE
Color	Yel	N/A
App	Hzy	N/A
Glu	N	Negative
Bili	N	Negative
Ket	Mod	Negative
SG	1.030	N/A
Bld	Trace	Negative
pH	5.0	N/A
Prot	+++4	Negative
Urob	N	0.2-1.0
Nit	N	Negative
Leuk	N	Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

SSA: Pos WBC- none
Acetest: Large RBC- 1-3
Fatty cast - Mod Amphe: Heavy
Bact: Mod

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.:

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

(i-STAT)

TEST	RESULT	REF. RANGE
Na		
K		
Cl		
pH		
PCO		
PO2		
TCC		
HCC		
sO2		
BEe		
AnG		
Ca		
BUI		
GLU		
Cre		
Hct		
Hgb		
TI		
Trop		
Dru Abu		
RE		

======= PICCOLO =======
09/11/03 14:57
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: (b)(6)-2 3151AA1
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]
(b)(6)-4

GLU	95	73-118	MG/DL
BUN	26*	7-22	MG/DL
CRE	2.0*	0.6-1.2	MG/DL
CK	58	39-380	U/L
NA+	131	128-145	MMOL
K+	3.9	3.3-4.7	MMOL
CL-	88*	98-108	MMOL
tCO2	21	18-33	MMOL

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

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
		73-118 mg/dl
		7-22 mg/dl
		8.0-10.3 mg/dl
		0.6-1.2 mg/dl
		128-145 mmol/l
		3.3-4.7 mmol/l
		98-108 mmol/l
		18-33 mmol/l

======= PICCOLO =======
09/11/03 15:06
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
LIVER PANEL PLUS
DISC LOT #: (b)(6)-2 3154AA7
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]
(b)(6)-4

ALB	4.6	[illegible]-5.5	G/DL
ALP	118*	[illegible]	U/L
ALT	9*	[illegible]	U/L
AMY	72	[illegible]	U/L
AST	39*	[illegible]	U/L
TBIL	1.2	[illegible]	MG/DL
[illegible]	28	[illegible]	U/L
[illegible]	9.3*	6.4 [illegible]	G/DL

INST QC: [illegible] CHEM QC: OK
HEM [illegible] L [illegible] , ICT 0

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
		3.3-5.5 g/dl
		26-84 u/l
		10-47 u/l
		14-97 u/l
		11-38 u/l
		0.2-1.6 mg/dl
		5-65 u/l
		6.4-8.1 g/dl

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
		3.3-5.5 g/dl
		26-84 u/l
		10-47 u/l
		14-97 u/l
		11-38 u/l
		0.2-1.6 mg/dl
		5-65 u/l
		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
		128-145 mmol/l
		3.3-4.7 mmol/l
		98-108 mmol/l
		18-33 mmol/l

El

UA (over)

REPORTED BY:	DATE:	

Ward/Section: ICW 4

REQUESTING PHYSICIAN: [redacted] (b)(6)-2

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

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

DATE: 10NOV | TIME: 0400 | SSN/PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na	134	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
PO2		80-105 mmH N/A (ven)
TCO2		23-27 mmol/l 24-29 mmol/l
HCO3		22-26 mmol/L 23-28 mmol/L
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/l
Ca		1.12-1.32 mm
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l

======= PICCOLO =======
10/11/03 04:52
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: (b)(6)-2 3151AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted] (b)(6)-4

GLU	98	73-118	MG/DL
BUN	27*	7-22	MG/DL
CRE	2.2*	0.6-1.2	MG/DL
CK	40	39-380	U/L
NA+	[redacted]*	128-145	MMOL/L
K+	3.6	3.3-4.7	MMOL/L
CL-	88*	98-108	MMOL/L
tCO2	25	18-33	MMOL/L

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
CO_2		18-33 mmol/l

REMARKS:

REPORTED BY:

MEDICAL RECORD — ANESTHESIA

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

DRUG	(Units)		TOTALS
Fentanyl	(mcg)	100, 100, 50	250
Propofol	(mg)	250	
SUX	(mg)	100	100
MSO4	(mg)	6, 4	10
	( )		
	( )		
VOLAT AGENT 150	% del	2.5 3.0 3.0 3.0 1.5 1.5	
	% e.t.		
AIR	L/Min		
N2O	L/Min		
O2	L/Min	8 2 2 2 2 2	

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

TOTAL EBL: min

TOTAL URINE: Ø

FLUIDS - SUMMARY
CRYSTALLOID– 700
COLLOID– Ø
BLOOD– Ø

REMARKS-
Code drugs with numbers, events with letters

FLUIDS
LINE site ☐ Warmed
LR Vos Ⓛ AC ☐ Warmed
☐ Warmed
☐ Warmed

LOSSES EST BLOOD LOSS / URINE –

PHYS STATUS 1 ② 3 4 5 E

BODY WEIGHT 78 (KG) LB

HEMATOCRIT:

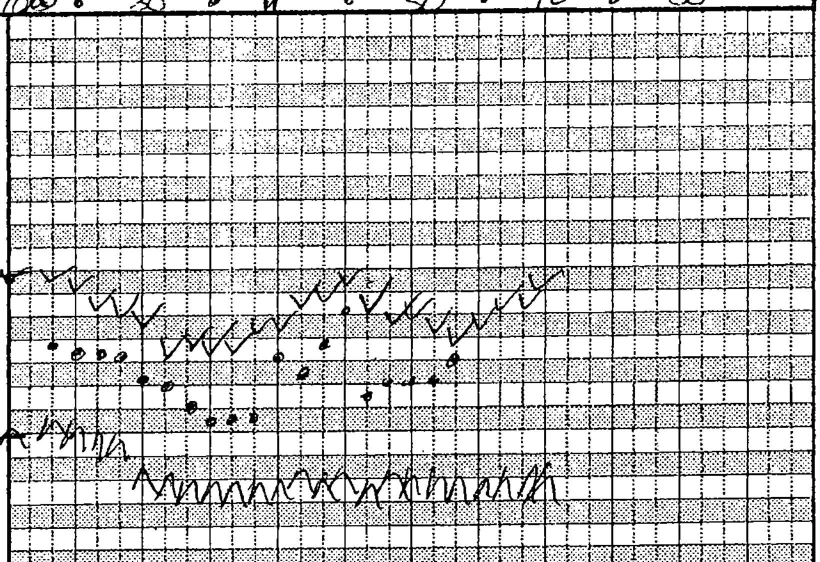
INITIAL DATA:
BP – 128/67
HR– 98

EQUIP CHECK
OK?– (Y) N

PATIENT RECHECK
OK for PROCEDURE? yes
TIME– 1010

TIME → 1000 • 30 • 1100 • 30 • 1200 • 30 •

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



VENTIL							
VT – ml	160	510	510	470	530	520	
f – breaths/min	10	10	18	15	13	9	
Peak insp pres / PEEP		25					
MODE– S(pon), A(ssist), C(on)	SIAC	S	C	SV	SV	SV	SV

MONITORS / ACCESSORIES								
BP/Auto Cuff	ET CO2 (torr)	(+)	51	46	47	48	47	46
BP / oth	FIO2 (Frac or %)	.84	.84	.84	.84	.84	.84	.84
ART line	SpO2 (%)	100	100	98	98	99	99	100
Steth- PC/ES	ECG	SR	SR	SR	SR	SR	SR	SR
Gas analyzer	TEMP- site	AVAILABLE						
	N-M Block (T/4)	4/4 c sustained tet						
Warming blkt								
Conv warmer								

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

RECOVERY AT 1150 — PACU ICU ______ (Specify) OTHER ______
CONDITION:
RESP– SpO2–
BP– HR–

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1000	1010	1200

	Ready	Begin	End
PROC	1015	1030	1040

PROCEDURES and CPT Codes
I+D Ⓛ TIB/FIB Ex-Fix

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
Pre-ox c̄ ~ 84% FIO2, IV induction, DLXT, Grade I view, MAC 3 [illegible], 8.0 ETT placed 22cm @ lip (+) BBS (+) ETCO2

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

SURGEONS [redacted]

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

(b)(6)-2

PROCEDURE LOCATION OR 2

DATE 26 FEB 03

PAGE 1 OF 1

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 20632

MEDICAL RECORD — ANESTHESIA

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

DRUG	(Units)	
Propofol	( )	200
Cefotaxime	( )	100
Fentanyl	( )	(20)
Versed	( )	2.5
Succ	( )	100
VOLAT AGENT	Forane % del % e.t.	2.0/2.0/1.0/1
AIR	L/Min	
N2O	L/Min	
O2	L/Min	2/2/2/2

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

FLUIDS

LINE site		
18g (L) arm	☐ Warmed	NS
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOSSES — EST BLOOD LOSS — URINE –

TOTALS

	TOTAL MIN
	MIN
	TOTAL URINE
20	
25	Ø

FLUIDS - SUMMARY

CRYSTALLOID– 500 NS
COLLOID– Ø
BLOOD– Ø

REMARKS-

Code drugs with numbers, events with letters

(1) Pt 10-1 CWI – Pt Adm to OR
(2) Remote monitoring
(3) Pt intubated
(4) Pt making purposeful movements, Pt extubated.
(5) Pt stays in OR for Recovery

PHYS STATUS 1 2 3 4 5 E

BODY WEIGHT 70 KG / LB

HEMATOCRIT:

INITIAL DATA:

BP – 126/86
HR– 102

EQUIP CHECK OK? – Y / N

PATIENT RECHECK OK for PROCEDURE? Y — TIME– 1805

TIME → 1800 X 1830 Y

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

220 200 180 160 140 120 100 80 60 40 20

VENTILATION

VT – ml	320	500	370	350
f – breaths/min	14	6	6	22
Peak Inf pres / PEEP	/	25	/	/
MODE– S(pon) A(ssist), C(on)	SV	CV	SV	SV

MONITORS / ACCESSORIES

✓	BP/Auto Cuff	✓	ET CO2 (torr)	38	46	48	49
✓	BP / oth	✓	FIO2 (Frac or %)	.52	.52	.52	.52
✓	ART line	✓	SpO2 (%)	100	100	100	100
✓	Steth- PC/ES	✓	ECG	ST	ST	ST	ST
✓	Gas analyzer	✓	TEMP- site	Axil			
		✓	N-M Block (T/4)	4/4	0/4	4/4	
	Warming blkt						
	Conv warmer						

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

RECOVERY AT

PACU ICU _____ (Specify)
OTHER OR Recovery
CONDITION:
RESP– 22 SpO2– 100
BP– 126/58 HR– 75

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1750	1800	1850
PROC	Ready	Begin	End
	1809	1820	1840

PROCEDURES and CPT Codes

I + D (E) TIM.

ANESTHETIC TECHNIQUES: Describe block technique under Remarks — GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments — DL x 1 – grade I view c 4 mil #7 ETT to 21 @ teeth, #10 OA in cuff + @ BBS @ ETCO2 tape to tube taped. – DTS

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

(6)(6)-4 [redacted]

SURGEONS: [redacted] (6)(6)-2

ANESTHETIST: [redacted] (6)(6)-2

PROCEDURE LOCATION: OR

DATE: 29 Sep 03

PAGE 1 OF 1

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 20633

MEDICAL RECORD — ANESTHESIA

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

DRUG	(Units)				TOTALS
versed	(mg)	3/2			5mg
Fent	(ug)	100	50	50	200ug
propofol	(mg)	<200>			∅
	( )				
	( )				
	( )				
VOLAT AGENT	% del				
	% e.t.				
AIR	L/Min				
N2O	L/Min				
100% O2 NRB	L/Min	8	8	8	

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

TOTAL EBL: Mini

TOTAL URINE: ∅

FLUIDS - SUMMARY
- CRYSTALLOID– 300
- COLLOID– ∅
- BLOOD– ∅

FLUIDS

LINE site		
LR	☐ Warmed	↑ 300
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOSSES — EST BLOOD LOSS / URINE –

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

1805 MRSA precautions to OR Monitors applied
1810 IV sed begin
1825 Surg begin s̄ pt movement Spont Resp
1856 PACU to OR staff for Recovery report given

PHYS STATUS: 1 ②3 4 5 E

BODY WEIGHT: (KG) LB

HEMATOCRIT:

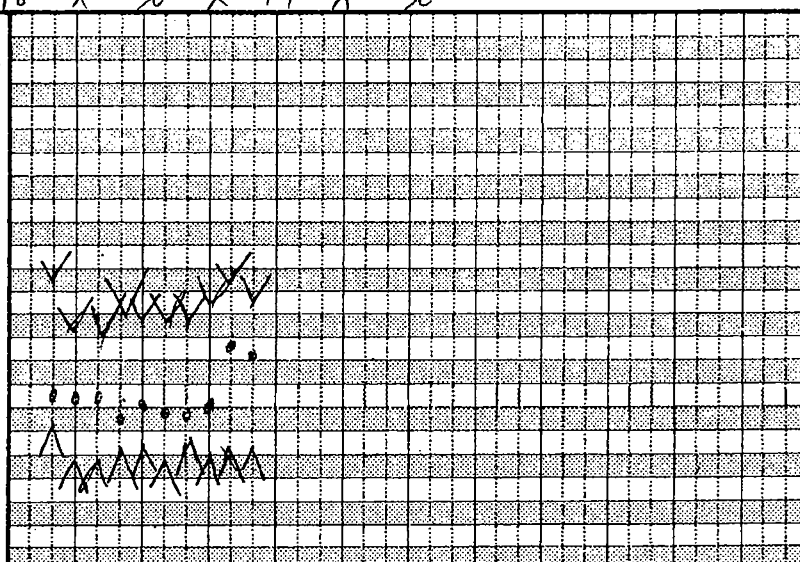
INITIAL DATA: BP – 124/60; HR – 76

EQUIP CHECK — OK?– Y N

PATIENT RECHECK — OK for PROCEDURE? TIME–

TIME ➡ 1800 X 30 X 19 X 30

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



VENT

VT – ml	5U	5U	5U	5U
f – breaths/min	14	8	8	10
Peak inf pres / PEEP				
MODE– S(pon), A(ssist), C(on)	S	S	S	S

MONITORS / ACCESSORIES

✓ BP/Auto Cuff	✓ ET CO2 (torr)				
BP / oth	✓ FIO2 (Frac or %)	>.21	>.21	>.21	>.21
ART line	✓ SpO2 (%)	100	100	99	99
Steth- PC/ES	✓ ECG	SR	SR	SR	SR
Gas analyzer	✓ TEMP- site	Axilla			
	N-M Block (T/4)				
Warming blkt					
Conv warmer					

Mark with letters & symbols, explain under REMARKS — EVENTS / Position ⟶

RECOVERY AT OR #1 — PACU ICU (Specify) OTHER staff

CONDITION: awak

RESP– 10 SpO2– 100 BP– 115/55 HR– 73

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1700	1805	1900
	Ready	**Begin**	**End**
PROC	1815	1825	1838

PROCEDURES and CPT Codes: (L) Leg wash out

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* — Natural O2 via mask IV sed

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* — Mask 100% Rebreather

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

SURGEON [redacted] (b)(6)-2

ANESTHETIST [redacted] CRNA

(b)(6)-2

PROCEDURE LOCATION: OR 1

DATE: 10/1/03

PAGE 1 OF 1

[redacted] (b)(6)-4

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 20634

MED[..]AL RECORD — ANESTHESIA

ANESTHETIC AGENTS AND DRUGS

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

DRUG (Units)		TOTALS
Phenergan (mg)	25	25 mg
Morphine (mg)	5/5 5/5	20 mg
( )		
Propofol (mg)	200	200 mg
( )		
VOLAT. AGENT Forane % del / % e.t.	5 — 3 — 3 — 4	
AIR L/Min		
N2O L/Min		
O2 L/Min	8 — 4 — 4 — 4 —	

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

TOTAL BLOOD
TOTAL URINE

FLUIDS

LINE site LR 20 (L)	☐ Warmed	200 ...
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOSSES — EST BLOOD LOSS; URINE –

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

REMARKS-
Code drugs with numbers, events with letters

D OR to Monitor, O2. Smooth IV induction easy mask ventilating Awake - [illegible] Report to [illegible]

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: KG / LB

HEMATOCRIT:

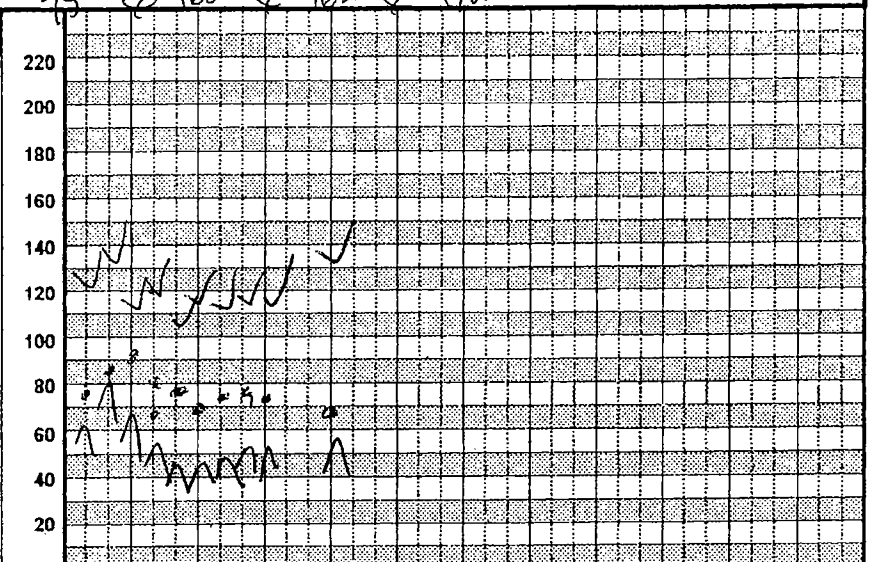
INITIAL DATA:
BP – 120/60
HR – 75

EQUIP CHECK
OK? – (Y) N

PATIENT RECHECK
OK for PROCEDURE? ✓
TIME–

TIME → 1530 x 1600 x 1630 x 1700

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



VENT				
VT – ml				
f – breaths/min				
Peak Insp pres / PEEP				
MODE– S(pon), A(ssist), C(on)	SV	SV	SV	SV

MONITORS / ACCESSORIES					
BP/Auto Cuff	ET CO2 (torr)	50	48	40	
BP / oth	FIO2 (Frac or %)	.67	.67	.67	RA
ART line	SpO2 (%)	100	100	100	98
Steth- PC/ES	ECG	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 → Supine

RECOVERY AT
(PACU) ICU ______ (Specify)
OTHER ______
CONDITION:
RESP– 16 SpO2– 100%
BP– 114/50 HR– 68

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1520	1531	1610

	Ready	Begin	End
PROC	1540	1552	1608

PROCEDURES and CPT Codes
I&D (L) Elbow

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*
GA - mask

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*
Natural Airway

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

SURGEONS: [redacted] (b)(6)-2
ANESTHETIST: [redacted] (b)(6)-2

PROCEDURE LOCATION: OR #1
DATE: 6 OCT
PAGE 1 OF 1

WAMC OP 376 REVISED
1 Jan 99

MEDCOM - 20635

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)				
Sufenta ( )	10	10		
Propofol ( )	I	200	I	
( )				
( )				
( )				
( )				
VOLAT AGENT Ethrane % del		1.8	I	
% e.t.				
AIR L/Min				
N2O L/Min				
mask O2 L/Min	8	8	8	

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

FLUIDS

LINE site LK ☐ Warmed			400	
☐ Warmed				
☐ Warmed				
☐ Warmed				

LOSSES

EST BLOOD LOSS				
URINE -				

TOTALS

TOTAL EBL	TOTAL URINE
30 ~~300~~ mm	Ø

FLUIDS - SUMMARY

CRYSTALLOID- 400

COLLOID- Ø

BLOOD- Ø

REMARKS

Code drugs with numbers, events with letters

1300 in OR - monitors applied IVinf started 20ga (L) wrist started

1310 IV set again

1340 (L) EJ unsuccessful (R) EJ started 18ga 2". secured w/ opsite tape.

1350 Pt responsive, cooperative transferred to PACU. Report given

PHYS STATUS 1 (2) 3 4 5 E

BODY WEIGHT: 70 (KG) LB

HEMATOCRIT:

INITIAL DATA:

BP- 181/57

HR- 77

EQUIP CHECK

OK?- (Y) N

PATIENT RECHECK

OK for PROCEDURE?

TIME- 1245

TIME → X 30 X 14 X 30

SYMBOLS:

BP by cuff V

Heart rate ●

Resp rate ^

BR (transduced) ╪

TOURNIQUET T—T

ANES- X-X

PROC- ⊙-Ø

220 200 180 160 140 120 100 80 60 40 20

VENTIL

VT - ml	SV	SV	SV
f - breaths/min	12	8	10
Peak inf pres / PEEP			
MODE - S(pon), A(ssist), C(on)	SV	AV	SV

MONITORS/ACCESSORIES

~~BP/Auto Cuff~~	~~ET CO2 (torr)~~	38	50	46
BP/oth	~~FIO2 (Frac or %)~~	.75	.65	.65
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 → 6—1

RECOVERY AT 1355

(PACU) ICU _____ (Specify)

OTHER _____

CONDITION: T96.7

RESP. 12 SpO2- 96%

BP- 125/67 HR- 87

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1225	1300	1400
PROC	**Ready**	**Begin**	**End**
	1320	1325	1340

PROCEDURES and CPT Codes:

Washout (L) L Leg

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

~~MAC~~ mask O2

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

[redacted] (b)(6)-4

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*

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

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

PROCEDURE LOCATION: 2

DATE: 10/10/03

PAGE 1 OF 1

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MRSA +

MEDICAL RECORD - ANESTHESIA

For use of this form, see AR 40-66; the proponent agency is the O 3

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

DRUG	(Units)	1130	45	1300
Versed	(mg)	< 5 >		
L100	(mg)	100		
	( )			
Propofol	(mg)	200		
	( )			
Fentanyl	(mcg)	50		
VOLAT AGENT	Forane % del	2.2-2.4 X		
	% e.t.			
AIR	L/Min	0		
N2O	L/Min	0		
O2	L/Min	4 → 2	4	8

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

FLUIDS

LINE site (R) LF	☒ Warmed	RAC / 500
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOSSES — EST BLOOD LOSS; URINE -

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 78 (KG) LB

HEMATOCRIT: 44 / 110 CT

INITIAL DATA:

BP- 112/68

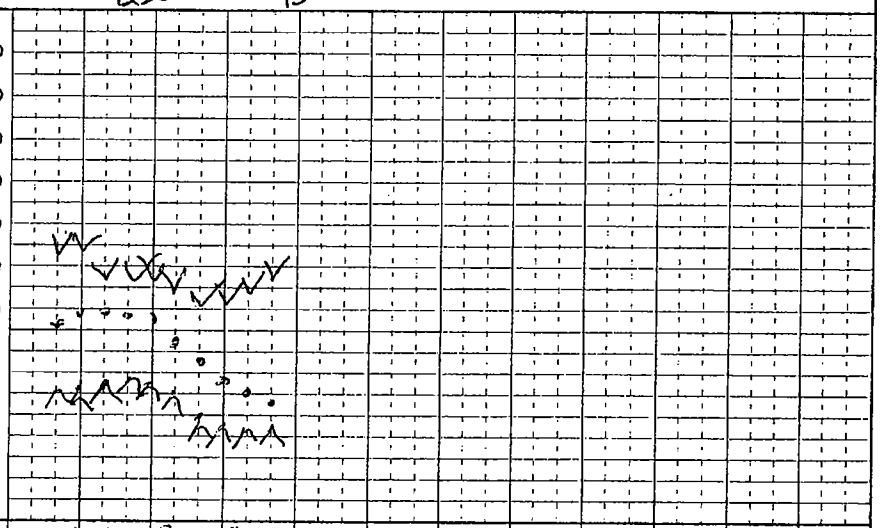
HR- 68

EQUIP CHECK: OK? (Y) N

PATIENT RECHECK: OK for PROCEDURE? TIME-

TIME → 1230 1300

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



VENTIL

VT - ml	400	440	500	400
f - breaths/min	18	22	17	14
Peak inf pres / PEEP	—	—	—	—
MODE - S(pon), A(ssist), C(on)	S	S	S	S

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	(A)	44	41	47
BP/oth	FIO2 (Frac or %)	100	100	100	100
ART line	SpO2 (%)	10	100	99	100
Steth- PC/ES	ECG	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 → Vol

TOTALS | **TOTAL EBL** | **TOTAL URINE** 0

FLUIDS - SUMMARY

CRYSTALLOID- LR 500

COLLOID- 0

BLOOD- 0

REMARKS

Code drugs with numbers, events with letters

Versed 5

Fentanyl 50

RECOVERY AT: PACU ICU _____(Specify) OTHER _____

CONDITION:

RESP- IA SpO2- 99

BP- 118/78 HR- 81

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1200	1210	1300
PROC	Ready	Begin	End
	1230	1234	1345

PROCEDURES and CPT Codes:

I & D

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

MASK GEN

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*

MASK

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

[redacted] Wd 1 Bed 7B

(6)(6)-4

SURGEONS: [redacted] (6)(6)-2

ANESTHETISTS: [redacted] (6)(6)-2

PROCEDURE LOCATION: OR 1

DATE: NOV 03

PAGE 1 OF 1

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MEDCOM - 20637

ACLU-RDI 1657 p.197

DOD-034211

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)													
Versed (ml)	5/2		10	10				3 2	5 2	1 2	5		
Sufenta (ug)	20/10												
MSO4 ( )													
Lido/propofol ( )	30/150												
Succs/vec ( )	80		5										
Neostigmine/Robinul								2.5/0.5					
VOLAT AGENT Forane % del	1.5	2	1.5	1.5	2	2	2	2	1	1	1.5		
% e.t.													
AIR L/Min													
N2O L/Min													
O2 L/Min	8	1	1	1	1	1	1	1	2	2			
SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS →													

FLUIDS

LINE site LR												
☒ Warmed		300		800	1000	1500		1800		7000		
☐ Warmed												
☐ Warmed												
☐ Warmed												

LOSSES

EST BLOOD LOSS			100	200	300	400	450					
URINE -												

TOTALS

TOTAL EBL	TOTAL URINE
5mg 50mg 450	∅

FLUIDS - SUMMARY

CRYSTALLOID- 2000

COLLOID- ∅

BLOOD- ∅

REMARKS

Code drugs with numbers, events with letters

1200 in OR monitors applied
1208 I ei
⊕ ETCO2 ⊕ BBS
1440 Spont Resp oral suction purposeful movement extubated to PACU Report given

PHYS STATUS 1 (2) 3 4 5 E

BODY WEIGHT: 78 (KG) LB

HEMATOCRIT: 44.8

INITIAL DATA:

BP- 131/66

HR- 88

EQUIP CHECK

OK?- Y N

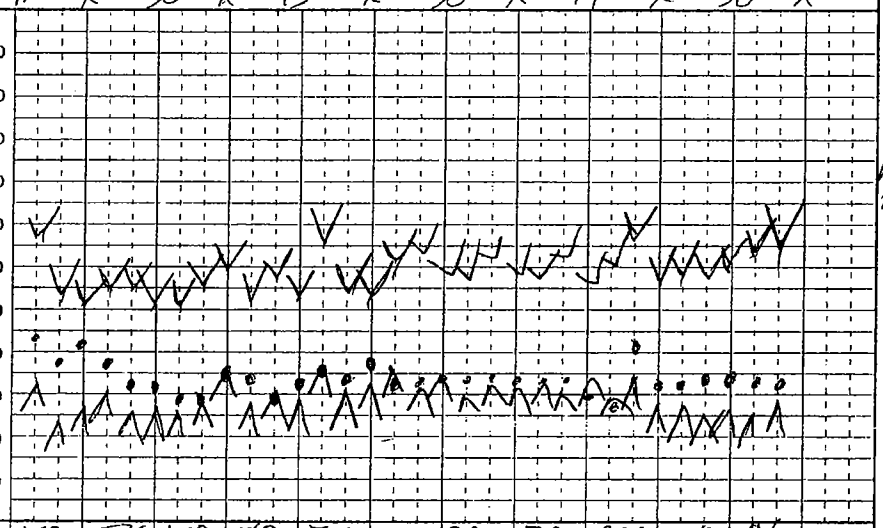
PATIENT RECHECK

OK for PROCEDURE?

TIME-

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

TIME → 1200 X 30 X 13 X 30 X 14 X 30 X



VENTIL

VT - ml	780	570	600	580	700	710	770	730	370	350	SV	
f - breaths/min	9	9	8	8	6	6	6	6	9	11	8	
Peak inf pres / PEEP	14	14	14	18	15	16	16	17				
MODE - S(pon), A(ssist), C(on)	C	C	C	C	C	C	C	C	SV	SV	SV	

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	32	35	34	34	31	34	33	33	55	40	58
BP/oth	FIO2 (Frac or %)	.68	.68	.67	.67	.67	.66	.66	.66	.67	.67	.67
ART line	SpO2 (%)	100%	100%	100%	100%	100%	100	100	100	100	100	100
Steth- PC/ES	ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR
Gas analyzer	TEMP-site Skin			35		36	36	36		35		
	N-M Block (T/4)					1/4	4/4	4/4		4/4		
										Sspretching		
Warming blkt												
Conv warmer												

Mark with letters & symbols, explain under REMARKS — EVENTS Position → 0—1

RECOVERY AT 1445

(PACU) ICU _____ (Specify)

OTHER _____

CONDITION: awake cooperative

RESP- 10 SpO2- 96%

BP- 129/72 HR- 136

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1115	1200	1500
PROC	Ready	Begin	End
	1210	1245	1440

PROCEDURES and CPT Codes: closure/ LLE washout skingraft/ ex fix

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

[redacted] (6X6)-4

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

GETA

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* 8.0 ETT placed c 3 miller blade one attempt grade 1 view ⊕ ETCO2 ⊕ BBS

SU[redacted] (6)(6)-2

ANESTHETIST[redacted] MAT CRNA

PROCEDURE LOCATION: OR 1

DATE: 10/16/03

PAGE 1 OF 1

DA FORM 7389, FEB 1998 (6)(6)-2 COPY 2 - ANESTHESIA PROVIDER USAPA V1.00

MEDCOM - 20638

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)	45	1200	30
Ctdo	( )	100		
Propof	( )	200		
Succ	( )	100		
Fentanyl	( )	(250)		
	( )			
	( )			
VOLAT AGENT: Forane	% del		1.5	X
	% e.t.			
AIR	L/Min	10	8	8
N2O	L/Min	10	8	8
O2	L/Min	8	2	2 8

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS → 45 1200 30

FLUIDS

LINE site				
	☐ Warmed			
	☐ Warmed			
	☐ Warmed			
	☐ Warmed			

LOSSES: EST BLOOD LOSS; URINE -

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: KG / LB

HEMATOCRIT:

INITIAL DATA:

BP- 124 160

HR- 74

EQUIP CHECK

OK?- Y N

PATIENT RECHECK

OK for PROCEDURE?

TIME-

TIME → 45 1200 15 30

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

220 200 180 160 140 120 100 80 60 40 20

VENTIL

VT - ml	650	650	500
f - breaths/min	10	10	12
Peak inf pres / PEEP	21	21	20
MODE - S(pon), A(ssist), C(on)	C	C	C A

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	37	33	32	
BP/oth	FIO2 (Frac or %)	100	100	100	100
ART line	SpO2 (%)	100	100	100	100
Steth- PC/ES	ECG	SR	SR	SR	SR
Gas analyzer	TEMP-site	JW			
	N-M Block (T/4)				
Warming blkt					
Conv warmer					

Mark with letters & symbols, explain under REMARKS — EVENTS Position → 0 1

TOTALS	TOTAL EBL
	TOTAL URINE

FLUIDS - SUMMARY

CRYSTALLOID- LR

COLLOID-

BLOOD-

REMARKS

Code drugs with numbers, events with letters

Cipro IV 400 mg infusion -

RECOVERY AT

PACU ICU _____ (Specify)

OTHER _____

CONDITION:

RESP- 13 SpO2- 98

BP- 120/60 HR- 97

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1130	1140	1258
PROC	Ready	Begin	End
	1150	115	1258

PROCEDURES and CPT Codes:

IFV L Leg

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

[redacted]

(b)(6)-4

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*

GETA MAC 3

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

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

PROCEDURE LOCATION: OR 1

DATE: 21 OCT 07

PAGE 1 OF

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

MEDCOM - 20639

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)	
Fentanyl (50) /cc	100 50
( )	
( )	
( )	
( )	
VOLAT AGENT: Forane % del	3-2-1 .6
% e.t.	
AIR L/Min	
N2O L/Min	
O2 3 L/Min	

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

FLUIDS

LINE site	
	☐ Warmed
	☐ Warmed
NS-500	☐ Warmed
	☐ Warmed

350

LOSSES — EST BLOOD LOSS; URINE -

TOTALS	TOTAL EBL
	<min
	TOTAL URINE

FLUIDS - SUMMARY

CRYSTALLOID- 350

COLLOID-

BLOOD-

REMARKS

Code drugs with numbers, events with letters

① NS Taken
② Induction Lidocaine 20mg Diprivan 170mg Anectine 100mg LMA O2
③ Procedure began
④ Procedure ended
⑤ O2 breathing well, to recovery

PHYS STATUS 1 2 3 4 5 E

BODY WEIGHT: KG LB

HEMATOCRIT:

INITIAL DATA:

BP- 114 156

HR- 89 97%

EQUIP CHECK

OK?- Y N

PATIENT RECHECK

OK for PROCEDURE?

TIME-

TIME → 1345 1400 15 30 45 1500 15 30 45 1600 15 30 45

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			
f - breaths/min		10	8
Peak inf pres / PEEP			
MODE - S(pon), A(ssist), C(on)		AS	AS

MONITORS/ACCESSORIES

✓	BP/Auto Cuff	✓	ET CO2 (torr)	32 33
	BP/oth	✓	FIO2 (Frac or %)	62% 65%
	ART line	✓	SpO2 (%)	97 100 100
	Steth- PC/ES	✓	ECG	ST SR
✓	Gas analyzer		TEMP-site	
			N-M Block (T/4)	
	Warming blkt			
	Conv warmer			

Mark with letters & symbols, explain under REMARKS — EVENTS Position: ① ② ③ ④ ⑤

RECOVERY AT

PACU ICU _____ (Specify)

OTHER _____

CONDITION:

RESP- SpO2- 96

BP- 120/64 HR- 114

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1328	1347	1446
PROC	Ready	Begin	End
	1353	1358	~~1435~~

PROCEDURES and CPT Codes: Removal Ex-Fix (L) Leg & Cast

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* Gen 1438

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

[redacted] (b)(6)-4

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* #5 LMA

[redacted] (b)(6)-2

[redacted] CRNA

(b)(6)-2

PROCEDURE LOCATION:

DATE: 10 Nov 03

PAGE 1 OF

DA FORM 7389, FEB 1998 — COPY 3 - ANESTHESIA DEPARTMENT — USAPA V1.00