ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 18 DAYS MOS YRS Sex (✓) MALE ( ) FEMALE

ASA Physical State 1 2 3 4 5 E
WT: 78 KG/LB HT: ____ IN.
ALLERGIES: NKDA

PROPOSED PROCEDURE: I+D
SURGICAL SERVICE: General/ortho
NPO SINCE: p MN

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

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) Ø
( )
( )
( )
( )
( )

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

LABORATORY STUDIES:

HB/HCT: ____/____
U/A: ____
OTHER: ____

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:			
Hypertension	N	Y	
Angina	N	Y	
MI	N	Y	
CVA	N	Y	
Other	N	Y	
Pulmonary System:			
Asthma	N	Y	
Bronchitis/URI	N	Y	
COPD	N	Y	
Other	N	Y	
Renal System:			
Acute/Chronic RF	N	Y	
Gastrointestinal:			
Hepatitis	N	Y	
Hiatal Hernia	N	Y	
PUD/GERD	N	Y	
Endocrine System:			
Diabetes	N	Y	
Steriods	N	Y	
Thyroid	N	Y	
Neurological:			
Seizures	N	Y	
Neuropathy	N	Y	
Other	N	Y	
Gynecological :			
Pregnancy	N	Y	
Other Significant Hx:			
	N	Y	
	N	Y	
Familial HX	N	Y	

ASSESSMENT
PAST SURGICAL/ANESTHETIC

Ø

PHYSICAL EXAMINATION
BP ___ HR ___ R ___ T ___
Pain Scale 0-10 ____
HEENT - Teeth edent
Trachea midline
TMJ/Neck > 3 FBS,
Oropharnyx MP ET
Nares ____
CHEST: CTA
CARDIAC: RRR
EXTREMITIES: ____
IV Access: (L) AC
Ulnar Filling: ____
BACK: ____
OTHER: ____

NPO Since ____

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

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

The patient seems to understand and agrees. Questions answered.
Signed: [redacted] (6)(6)-2 Date: 24 FEB 05 Time: 1000 Hrs

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

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward) ____

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

SEDATION KEY:

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

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 9.26.03 1205	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. prn for SaO_2 ↓ 93%		
(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		
	[redacted] LTC 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, 28th CSH			1 of 1

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

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	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. PRN		
(3)	Morphine / Meperidine 2-3 mg IV now and 2-3 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 25 mg IV prn N/V x 1.		
8	Benadryl 25-50mg IVP q1 hr prn, itching while in PACU.		
(9)	IVF: NS @ 100 cc/hr.		
10	Discharge from recovery status when PACU discharge criteria met.		
	[redacted] RN (b)(6)-2		
10/Now	Start IV c #20, peripheral		
	[redacted] RN (b)(6)-2		

PATIENT IDENTIFICATION

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

Diagnosis: _____

Height: _____ Weight: _____ Diet: _____

Allergies: _____

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

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

MEDICAL RECORD - DOCTOR'S ORDERS

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

DIRECTIONS: The provider will DATE, TIME, and SIGN each order or set of orders recorded. Only one order is allowed per line. Nursing will list the time the new order(s) are noted and initial in the column provided. Orders completed during the shift in which they were written do not require recopying. They may be signed off, as completed, in the far right column.

ORDER NUMBER	DATE, TIME, & SIGNATURE REQUIRED FOR EACH ORDER OR SET OF ORDERS	ORDER NOTED TIME & INITIALS	COMPLETED TIME & INITIALS
	POST ANESTHESIA ORDERS (circled Items)		
1	VS q 5 min X 15 min, then q 15 min until discharge. ----		
2	Supplemental oxygen.		
3	Morphine / Meperidine 2 mg IV now and 2 mg q 3-5 min prn pain for a		
	max dose of 20 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 .625 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 @ 125 cc/hr.		
10	Discharge from recovery status when PACU discharge criteria met.		
	[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] (b)(2)-2			1 of 1

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

IDENTIFICATION	↓	ORDERS	LIST TIME ORDER NOTED AND SIGN
EPW # [redacted] (b)(6)-4		DATE OF ORDER 25 SEPT 03 TIME OF ORDER 1440 HOURS	
	1	ADMIT TO ICW-1	
	2	DX - OPEN (L) TIB-FIB FX	
	3	CONDITION - STABLE	
	4	VS ROUTINE	
	5	UP AD LIB WITH CRUTCHES PER EPW ROUTINE	1530 [redacted] 25 SEPT 03 (b)(6)-2
NURSING UNIT: ICW 1 ROOM NO.: BED NO.:			
PATIENT IDENTIFICATION		DATE OF ORDER TIME OF ORDER HOURS NPO after midnight	
	6	REGULAR DIET, NPO after midnight	
	7	TO O.R. IN AM	
06,14,22	8	IV - HEP LOCK	
	9	ANCEF 1 GRAM IVPB Q 8 HRS	
	10	TYLENOL 650MG P.O. Q 4 HRS PRN	
	11	PERCOCET 1-2 P.O. Q 4-6 HRS PRN	
	12	PHENERGAN 25 MG IVP Q 6 HRS PRN	[redacted] (b)(6)-2
NURSING UNIT: ICW 1 ROOM NO.: 24° chart BED NO.: 2330 25 SEP 03			
PATIENT IDENTIFICATION		DATE OF ORDER 26 SEPT 03 TIME OF ORDER 1140 [redacted] HOURS	
		Resume previous orders	
	1	Regular diet	
	2	IV D5 LR at 125cc/hr Hep lock when taking P.O. well	
	3	MSO4 2-8 mg IVP Q 2 HRS PRN	
	4	[redacted]	
	5	NPO after midnight	[redacted] (b)(6)-2 26 SEP 03 (b)(6)-2
NURSING UNIT: ICW 1 ROOM NO.: BED NO.:		DATE OF ORDER Sunday 28 Sept TIME OF ORDER [redacted] HOURS	
PATIENT IDENTIFICATION			
NURSING UNIT ROOM NO. BED NO.			

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

DA FORM 4256 1 APR 79

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

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.
24 V 29 Dep 03		030

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED SIG
	28 Dec 03	0430 HOURS	
1	NPO after midnight.		
2	WPD after midnight. To OR tomorrow		

(b)(6)-2

(b)(6)-2

(b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-2

NURSING UNIT	ROOM NO.	BED NO.
24 V 0700	1700	03

	DATE OF ORDER	TIME OF ORDER
	15 Dec 03	1250 HOURS
1	Resume parenteral orders	
2	Regular diet	
3	Keep lock IV	
4	Pt to dry dressing change BID	

(b)(6)-2

(b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-2

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.
24 V 0200	1800	03

	DATE OF ORDER	TIME OF ORDER
	17 Dec 03	1600 HOURS
1	NPO after midnight	
2	TO OR tomorrow	

(b)(6)-2

(b)(6)-2

(b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-2

NURSING UNIT	ROOM NO.	BED NO.
24 V		

	DATE OF ORDER	TIME OF ORDER
	18 Dec	1600 HOURS
1	MSO4, 2-8mg q 1-2° PRN IV Sw	

(b)(6)-2

(b)(6)-2

(b)(6)-2

RN 2330 10/15/03

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

(b)(6)-2

CLINICAL RECORD - DOCTOR'S ORDERS

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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 29 SEP 03 TIME OF ORDER 1830 HOURS

LIST TIME ORDER NOTED AND SIGN

1. RESUME PRIOR ORDERS
2. D/C SWAN
3. CIPRO FLOXACIN 400 mg IVPB Q 12 Hrs
4. GENTAMYCIN 400 mg IVPB Q DAY
5. REGULAR DIET
6. IV - HEP LOCK WHEN TOLERATING PO INTAKE

PATIENT IDENTIFICATION

[redacted] (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER

7. BID WET TO DRY DRESSING [redacted] (b)(6)-2

(b)(6)-2

30 SEP/0730 30 SEP 03 [redacted] (b)(6)-2

PATIENT IDENTIFICATION

[redacted] (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

24 SEP 2230 [redacted] 30 SEP 03

DATE OF ORDER 30 SEP 03 TIME OF ORDER 2145 HOURS

1. NPO
2. TO OR TOMORROW [redacted] (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.

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

NURSING UNIT: 24° ✓ | ROOM NO.: 10CT@2040 | BED NO.: 30CT03

DATE OF ORDER: 30CT03 | TIME OF ORDER: 1845 HOURS | LIST TIME ORDER NOTED AND SIGN

1. Routine postop orders
2. Regular diet
3. IV-D Lr at 125 cc/hr. Hep lock when taking PO well
4. VAC device on (L) leg to low continuous suction

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

[redacted] (b)(6)-2

Noted 9W/MB SpC 30CT03 1400

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 30CT03 | TIME OF ORDER: 1850 HOURS

1. Routine postop orders
2. Regular diet.
3. IV-D Lr at 125 cc/hr. HEP LOCK when taking P.O well
4. VAC device on (L) leg to low continuous suction

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

[redacted] (b)(6)-2

24° ✓ 30CT03 1845

NURSING UNIT: 24° ✓ | ROOM NO.: [redacted] | BED NO.: 50CT 2100.

DATE OF ORDER: 30CT03 | TIME OF ORDER: 1545 [redacted] (b)(6)-2

1. NPO after midnight for OR 31 OCT 03

[redacted] (b)(6)-2

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

[redacted] (b)(6)-2

9OCT03 2000 [redacted] (b)(6)-2

NURSING UNIT: 9W/9OCT02 | ROOM NO.: [redacted] | BED NO.: 2000

DATE OF ORDER: 9 OCT 03 | TIME OF ORDER: 1950 HOURS

1. NPO after midnight for OR tomorrow

[redacted] (b)(6)-2

[redacted] (b)(6)-2

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

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

NURSING UNIT [redacted] ROOM NO. [redacted] BED NO.

DATE OF ORDER 6 OCT 03 TIME OF ORDER 1605 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Routine postop orders
2. Regular diet
3. IVD LR at 125 cc/hr. Hep Lock when IV is not in use. PO.
4. VAC device to low, continuous suction

(b)(6)-2

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

NURSING UNIT [redacted] ROOM NO. [redacted] BED NO. [redacted]

DATE OF ORDER TIME OF ORDER

(b)(6)-2

NURSING UNIT ROOM NO. BED NO.

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

DATE OF ORDER 10 OCT 03 TIME OF ORDER 1345 HOURS

1. Routine postop orders
2. Regular diet
3. IVD LR at 125 cc/hr. Hep Lock when not in use. PO.
4. VAC device to low, continuous suction

(b)(6)-2

NURSING UNIT CW1 ROOM NO. BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 10/11/03 05 TIME OF ORDER HOURS

5. OP + LRT (L) Lib - 1 in NPO
6. CBC, BMP, LYTE, PT in AM

10/11/03 04

(b)(6)-2

NURSING UNIT [redacted] ROOM NO. [redacted] BED NO. [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	↓	DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
[redacted] (b)(6)-4		DATE OF ORDER 18 OCT 03 TIME OF ORDER 1415 HOURS	
(b)(6)-2 [redacted]	1	Resume previous orders	
	2	Regular diet	
	3	IV LR @ 125 cc/hr. Hep lock when taking PO well	
NURSING UNIT / ROOM NO. / BED NO. 18 OCT 03 1545	4	NPO after midnight 20 OCT for OR on 21 OCT.	
PATIENT IDENTIFICATION	5	DATE OF ORDER / TIME OF ORDER HOURS Empty and record drain q shift.	
	6	CBG MSV62 HS & in AM	
	7	Lovenox 30mg SQ BID to start 20 OCT 03 in PM	[redacted] (b)(6)-2
		(b)(6)-2 [illegible]	
NURSING UNIT 24° ROOM NO. V BED NO. 20 Oct @ 0230		[redacted] (b)(6)-2	
PATIENT IDENTIFICATION 24°V 24 Oct 24°V 25 OCT		DATE OF ORDER [redacted] HOURS (b)(6)-2	
		1 NOV 03 0725	
Noted [redacted] 1 NOV 03 @ 0800 (b)(6)-2	1	DP to LBT @ TB/KB 1830	[redacted] (b)(6)-2
NURSING UNIT / ROOM NO. / BED NO. 24°/ 02 NOV 03 @ 0030 [redacted]			
PATIENT IDENTIFICATION (b)(6)-4 [redacted]		DATE OF ORDER 5 Nov 03 TIME OF ORDER 1620 HOURS	
	1	[illegible] 150mg P.O. BID	
	2	D/C [illegible]	
	3	[illegible] #3 1-2 P.O. Q 4-6 hrs PRN	
Noted [redacted] (b)(6)-2	4	CBG [illegible] & in [illegible]	[redacted]
NURSING UNIT 24°/ 0400 ROOM NO. / BED NO. 5 NOV 03 @ 1640			

DA FORM 1 APR 79 4[redacted] (b)(6)-2 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED [redacted] (b)(6)-2

MEDCOM - 20650

ACLU-RDI 1658 p.10

DOD-034224

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

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

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 21 Oct 03 TIME OF ORDER 1220 HOURS

LIST TYPE ORDERS NOTED SIG

1. Resume previous orders
2. Regular diet
3. IVD LR at 125cc/hr. Hep Lock when taking P.O. (b)(6)-2
4. CBC, Metabolic 8 [redacted]

(b)(6)-2

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

NOTED 22 OCT 03 1345. [redacted] (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 22 Oct-03 TIME OF ORDER HOURS

Stat PCXR
line placement
AM wet read
call me result

(b)(6)-2 [redacted]

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

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

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

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: ICU1 | ROOM NO.: 240 | BED NO.: 045

DATE OF ORDER: 7 NOV 03 | TIME OF ORDER: 1212 HOURS | LIST TIME ORDER NOTED AND SIGN

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

D/C Zantac

[redacted] (b)(6)-2

[redacted] (b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT: 240 | ROOM NO.: 0214 | BED NO.: [redacted]

DATE OF ORDER: 08 NOV 03 | TIME OF ORDER: 1425 HOURS

CBC, Met-8 now

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

(b)(6)-2

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT: 240V | ROOM NO.: 10 NOV 03 | BED NO.: @ 0100

DATE OF ORDER: 9 Nov 03 | TIME OF ORDER: 1400 HOURS

1. Chem 12 / Electrolytes / U/A now
2. ABD Flat / Upright (b)(6)-2
3. ~~IV~~ Suit [redacted] (b)(6)-2 / [redacted] suit J & C

[redacted] (b)(6)-2 [redacted] 647

(b)(6)-2

PATIENT IDENTIFICATION

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.

CLINICAL RECORD - DOCTOR'S ORDERS

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

[DO]CTOR 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.

[PATIEN]T IDENTIFICATION

(b)(6)-4

[redacted]

noted

(b)(6)-2

[redacted]

[NUR]SING UNIT | ROOM NO 10 | BED NO 9 NOV 03

DATE OF ORDER 9 NOV 03 | TIME OF ORDER 1600 HOURS | LIST TIME ORDER NOTED AND SIGN

1. D/C Gastrostomy ✓
2. N - LL at 200 cc/hour, then 0/S 2 liters, T/W 0/S ✓
3. Zofran 2mg IV now ✓
4. Midazolam 8 in A.M. ✓
5. Ensure T [illegible] with meals.
6. NPO after midnight [redacted] ✓

(b)(6)-2

PATIENT IDENTIFICATION

24°V 0100 10 NOV 03 [redacted] 2(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER ______ HOURS

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER ______ HOURS

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

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

DA FORM 1 APR 79 4256

MEDCOM - 20653

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

[redacted]

Noted / INb

NURSING UNIT | ROOM NO. | BED NO.

24 [redacted]

(b)(6)-2

DATE OF ORDER: 10 NOV 03 | TIME OF ORDER: 1930 HOURS | LIST TIME ORDER NOTED AND SIGN

1. Resume previous orders
2. Regular diet
3. Hep lock IV
4. AP [?] LAT T15 FIX [redacted] X-RAY TODAY

(b)(6)-2 [redacted] EXTUBATION 11NOV03 @ 0130

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.

MEDCOM - 20654

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4 [redacted]

(b)(6)-2 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	11 NOV 03	0129 HOURS	
1	DISCHARGE TODAY TO EPW CAMP		
2	CEFUROXIME, WITH BOOK AS TOLERATED		
3	LOVOFLOXACIN 250MG P.O. Q DAY		
4	FOLLOW UP IN 4 WEEKS		
	(b)(6)-2 [redacted]		

Noted 11 NOV 03 0400

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

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

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

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

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

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

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

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 9 Yr. 2003

VERIFY BY INITIALING			INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION													
ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED												
				25	26	27	28	29	30	1	2	3	4	5	6	7
b)(6)-2 9/25	[redacted]	VS Routine	06	[redacted]												
			18													
			06													
b)(6)-2 9/25	[redacted]	Up ad lib with crutches pos. Ella) Routine	06	[redacted]												
			18													
			06													
b)(6)-2 9/25	[redacted]	Regular Diet	06	[redacted]												
			18													
			06													
b)(6)-2 9/26	[redacted]	BID dsg AS WTD	10							[redacted]						
			22													
b)(6)-2 10/03	[redacted]	Reg Diet	06	/	/	/	/	/	/	/	/	[redacted]				
			18	/	/	/	/	/	/	/	/					
b)(6)-2 10/3	[redacted]	Vac clinic on (L) leg to have continuous suct.	06	/	/	/	/	/	/	/	/	/	[redacted]			
			18	/	/	/	/	/	/	/	/					

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO	PRIMARY DIAGNOSIS: Open (L) Tib-Fib Fx	ADDITIONAL PAGES IN USE: ☐ YES ☐ NO PAGE NO:

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo Sep Yr 2003

Verity by Initialing

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
9/25	[redacted]	Admit to ICU #1, Condition	9/25		1520	[redacted]
		Stable				
9/25	[redacted]	NPO p MN. For	9/25	2400		[redacted]
9/25	[redacted]	? OR in AM	9/26			[redacted]
9/26	[redacted]	Resume previous orders	9/26	noted		[redacted]
9/26	[redacted]	NPO p MN 27 Sep	9/27	2400	noted	[redacted]
9/26	[redacted]	Surgery 28 Sep (Cancelled)	9/28			
9/28	[redacted]	NPO p MN 28 Sep (for OR in	9/29	0001	noted	[redacted]
9/28	[redacted]	AM on 9/29 (OR)	9/29	done		
9/29	[redacted]	NPO p MN for OR tom.	10/1	0001	~	[redacted]
5 OCT	[redacted]	NPO p MN for OR	6 OCT	0001	noted	[redacted]
5 OCT	[redacted]	OR (6 OCT 03	6 OCT			
6	[redacted]	Resume previous orders	now			[redacted]

(b)(6)-2

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

MEDCOM - 20657

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. Oct Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 8 9 10 11 12 13 14 15 16 17 18 19 20
(b)(6)-2 9/25	[redacted]	VS Routine	06 18	[redacted]
(b)(6)-2 9/25	[redacted]	Up ad lib c crutches	06 18	[redacted]
(b)(6)-2 9/25	[redacted]	Reg. EPW routine	06 18	[redacted]
(b)(6)-2 9/25	[redacted]	Regular diet	06 18	[redacted]
(b)(6)-2 9/25	[redacted]	~~BID dsg A's WTD~~	06 18	[redacted]
(b)(6)-2 9/28	[redacted]	BID dsg A WTD	10	[redacted]
(b)(6)-2 9/25	[redacted]	Vac device on (L) leg to low continuous suction	12 06 18	[redacted] D/C
(b)(6)-2 18	[redacted]	empty + record drain qs	06 18	[redacted]

7.19(9)

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Open (L) tib-fib fx

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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. OCT Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 21 22 23 24 25 26 27 28 29 30 31 1 2
(b)(6)-2 9/25	[redacted]	VS Routine	6	[redacted]
			18	
(b)(6)-2 9/25	[redacted]	Up ad Lib = Crutches	6	[redacted]
			18	
(b)(6)-2 9/25	[redacted]	Regular Diet	6	[redacted]
			12	
			18	
(b)(6)-2 9/25	[redacted]	BID DSG & WTD	10	[redacted]
			22	
		Empty & Record JP	6	[redacted]
(b)(6)-2 10/18	[redacted]	& S	18	

1.(a)(a)

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Open ② T.6- F.6 Fx

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO: 1

PATIENT IDENTIFICATION:

E # [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

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo 10 Yr 2003

Verity by Initialing

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
9 Oct	[redacted]	NPO p MN for OR tomorrow	10 Oct 03 2001			[redacted]
10/10	[redacted]	Resume previous orders	10/10	—	—	[redacted]
10/10	[redacted]	AP & Lat (L) tib-fib in AM	10/11	0500	—	[redacted]
10/10	[redacted]	CBC, metlite 8 in A.M.	10/11	0400	—	[redacted]
15 Oct	[redacted]	Resume previous orders, neg dict.	15 Oct	—	—	[redacted]
10/17	[redacted]	NPO p MN	10/17	2400	2400	[redacted]
10/17	[redacted]	to OR tomorrow	10/18	D/C		
18	[redacted]	Resume preop orders	18 OCT	NOW		[redacted]
16	[redacted]	NPO @ MN 20 OCT for OR on 21 OCT	20 OCT	0000		
18	[redacted]	CBC, Metlyte 8 in AM	19 OCT	0500		

(b)(6)-2

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

USAPA V1.00

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Verity by Initialing | Mo OCT Yr 2003

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
21OCT 03	[redacted]	CBC, Met 8 in AM	22OCT 03			
22OCT 03	[redacted]	STAT PCXR, LINE PLACEMENT, "WET READ"	22OCT		1400	[redacted] (b)(6)-2
	----	CALL ME RESULT				
WOU03	[redacted]	PA & LAT (L) Tib Fib today	WOU03		0900	[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

Recopied 11/2

CLINICAL RECORD | **THERAPEUTIC DOCUMENTATION CARE PLAN** *(NON-MEDICATION)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General. | Mo. 11 Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 3	4	5	6	7	8	9	10	11	12
9/25	[redacted]	VS Routine	06	[redacted]									
			18										
			06										
9/25	[redacted]	Up ad lib c crutches	06	[redacted]									
			18										
			06										
9/25	[redacted]	Regular diet	06	[redacted]									
			18										
			06										
9/25	[redacted]	BID DRSG Δ WTD	06	[redacted]									
			18										
			06										
8 NOV	[redacted]	NIO: CLdrsgΔ c	20	/	/	/	/	/	[redacted]	/	/	[redacted]	/	/	/
		sterile technique QD°		X									
9 NOV	[redacted]	ensure 1 can c	06	→							[redacted]		
		meals	12	→							[redacted]		
			18	→							[redacted]		

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

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Open (L) Tib-Fib Fx

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

PATIENT IDENTIFICATION:

LPW# [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

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo Nov Yr 2003

Verity by Initialing		SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
Order Date	Clerk Nurse					
05 NOV	[redacted]	CBC, Metlyte 8 in AM	05 NOV 03	0500	0500	[redacted]
08 NOV	[redacted]	CBC, met 8 now	08	1430	1430	[redacted]
9 NOV	[redacted]	Chem 12 / electrolytes / UA now	11/9	—	1430	[redacted]
9 NOV	[redacted]	Abd Flat / upright /	11/9	—	1456	[redacted]
9 NOV	[redacted]	metlyte 8 in AM	10 NOV	0400	0401 1430	[redacted]
9 NOV	[redacted]	NPO p MN	10 NOV	0001	0001 1456	[redacted]
10 NOV 03	[redacted]	Resume previous orders	10 NOV 03	—	—	[redacted]
10	[redacted]	AP and LAT TIB FIB X-RAY TODAY	10			
11 NOV	[redacted]	Discharge today to EPW camp				
11	[redacted]	Crutches - weight bearing as tol.				
Y	[redacted]	Follow up in 4 weeks				

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

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (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 9	10	11	12	13	14	15	16	17	18	19	20	21	22
1/26	[redacted]	IV LR @ 125cc° then	06	[redacted]													
(b)(6)-2	-----	heplock when taking	18	[redacted]													
	-----	20 well	X														
1/29	[redacted]	Ciprofloxacin 400mg	10	[redacted]													
(b)(6)-2	-----	IVPB Q12°	22	[redacted]													
1/29	[redacted]	Gentamycin 400mg	22	[redacted]													
(b)(6)-2	-----	IVPB QDay	X									[redacted]					
Bed	[redacted]	Heplock W	06								[redacted]						
(b)(6)-2	-----		18										[redacted]				
18	[redacted]	LR @ 125cc/hr; heplock	06										[redacted]				
(b)(6)-2	-----	when tol po well	18													[redacted]	
20	[redacted]	Lovenox 30mg SQ	10	A												[redacted]	
(b)(6)-2	-----	BID	22	/													

(b)(6)-2

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: OPEN L Tib Fib Fx

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

PATIENT IDENTIFICATION:

EPW

[redacted] (b)(6)-4

DISPENSING TIMES

USE PENCIL, CIRCLE MED TIMES

D 7 8 9 10 11 12 13 14

E 15 16 17 18 19 20 21 22

N 23 24 01 02 03 04 05 06

DA FORM 1 FEB 79 4678

EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. 10 Yr. 03

Verify by Initialing: Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
15 OCT	[redacted]	Heplock IV	15 OCT	—		[redacted]

(6)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
9/25	[redacted]	Percocet 1-2 tabs po Q4°-6° PRN	D/T 11 OCT 1035; 11 OCT 1915; 12 OCT 2055; 13 OCT 1720; 15 OCT 0303 2130; 16 OCT 2215; 17 OCT 2240; 18 OCT 1547; 19 OCT 2215; 20 OCT 0627; 20 OCT 1915; 21 OCT 0545
9/25	[redacted]	Phenergan 25mg IVPQ6° PRN	D/I [redacted]
9/25	[redacted]	Tylenol 650mg po Q4° PRN	D/T 20 OCT 0649; D/I 2
15 OCT	[redacted]	MSO4 2-8mg Q 1-2° PRN	D/T 18 OCT 1615; 19 OCT 1747; 16 OCT 2011; 18 OCT 2309; 18 OCT 0036; 19 OCT 1100; 19 OCT 1830; 20 OCT 0625; 20 OCT 2230; 21 OCT 0855; D/I 8mg; 8mg; 4; 4; 4; 8mg; 5mg; 2; 5mg; 4 [redacted]
9/25	[redacted]	Percocet 1-2 tabs po q4-6° PRN	D/T 21 OCT 1600; 21 OCT 2000; D/I 2; ½ [redacted]

(6)(6)-2

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLA[illegible] MEDICATIONS)

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

Mo. [illegible] Yr [illegible]

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

VERIFY BY INITIALING ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 25 26 27 28 29 30 1 2 3 4 5 6 7 8
9/25	[redacted]	IV - Heplock	06	[redacted] DC
	(b)(6)-2		18	
9/25	[redacted]	Ancef 1 gram	06	[redacted] DC'd 9/29
(b)(6)-2		IVPB q 8 hrs	14	
	(b)(6)-2		22	
9/26	[redacted]	IV LR @ 125 cc° then	06	[redacted]
		Heplock when taking.	18	
(b)(6)-2		p.o. Wells	X	
9/29	[redacted]	Ciprofloxacin 400mg	10	[redacted]
		IVPB Q12°	22	
9/29	[redacted]	Gentamycin 400mg	22	[redacted]
(b)(6)-2		IVPB QDay	X	

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Open (2) Tib-Fib Fx

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION: EPW # [redacted]

(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

DA FORM 4678, 1 FEB 79

EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

USAPA V1.00

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Initialing

Mo. Sep Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
(b)(6)-2 6CT	[redacted]	Resume prev orders:				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
(b)(6)-2 9/25	[redacted]	Tylenol 650mg po q 4hrs prn	
(b)(6)-2 9/25 9/28 Exp	[redacted]	Percocet 1-2 p.o. Q 4-6hrs prn	Date / Time / Dose / Init: 25SEP 1310 ii; 26 1830 ii; 27 2215 2; 28 2210 2; 29 2010 ii; 30 Sep 2030 ii; 1OCT 2130 ii; 2OCT 2100 2; 4OCT 2020 1; 5OCT 2030 2; 6OCT 1400 ii; 7OCT 2000 2; 8OCT 2300 ii; [redacted] I/E ⊖
(b)(6)-2 9/25	[redacted]	Phenergan 25mg IV Q 6hrs prn	
(b)(6)-2 9/26	[redacted]	MSO4 2-8mg IV Q 2hrs prn	Date / Time / Dose / Init / I/E
(b)(6)-2 9/25	[redacted]	Percocet 1-2 PO Q4-6 HRS PRN	D/T/I: 9Oct03 2215 10 ii; 10 oct 1000 ii; 10OCT 1430 ii; 10OCT 2245 IIPO; [redacted]

(b)(6)-2

USAPA V1.00

MEDCOM - 20667

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 23 24 25 26 27 28 29 30 31 1 2 3 4 5
9/29	[redacted]	Ciprofloxin 400mg IVPB Q12°	10	[redacted]
			22	
9/29	[redacted]	Gentamycin 400mg IVPB QD	22	[redacted]
			X	X X X X X X X X X X X X X
10/18	[redacted]	Heplock IV	06	[redacted]
			18	
10/18	[redacted]	LR@125cc/hr; heplock when to; Powell	06	[redacted] Heplocked
			18	
			X	
10/20	[redacted]	Levaquin 30mg PO BID	10	[redacted]
			22	

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Open (L) Tib fib Ex

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

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

ICW #1

DISPENSING TIMES

USE PENCIL, CIRCLE MED TIMES

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

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

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
10/15	[redacted]	heplock IV	15 Oct			[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
9/25	[redacted]	Percocet 1-11 PO q4-q8 PRN	D/T 23 Oct 1105 · 23 Oct 2000 · 24 Oct 0000 · 24 Oct 0241 · 24 Oct 2115 · 25 Oct 1330 · 26 Oct 1100 · 27 Oct 1430 · 28 Oct 1000
			D/I [redacted]
9/25	[redacted]	Phenergan 25mg IVP Q6° PRN	D/T [redacted]
			D/I
9/25	[redacted]	Tylenol 650mg PO Q4° PRN	D/T
			D/I
10/18	[redacted]	MS042-8mg q 1-2° PRN	D/T
			D/I
9/25	[redacted]	Percocet tabs PO q4-6° PRN	D/T 28 Oct 1640 · 28 Oct 2015 · 29 Oct 0220 · 29 Oct 1015 · 29 Oct 0500 · 30 Oct 1104 · 30 Oct 1740 · 30 Oct 2145 · 31 Oct 2210 · 1 Nov 1500 · 1 Nov 2000 · 2 Nov 1800
			D/I [redacted]
9/25	[redacted]	Percocet 1-11 PO Q4°-6° PRN	D/T
			D/I

(b)(6)-2

MEDCOM - 20669

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. 11 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 3 4 5 6 7 8 09 10 11
(b)(6)-2 9/29	[redacted]	Ciprofloxin 400mg	10	[redacted] D/C @ 9NOV @ 1600
	-----	IVPB Q12°	22	[redacted]
(b)(6)-2 9/29	[redacted]	Gentamycin 400mg	22	[redacted] D/C 9NOV 1600
	-----	IVPB QD	/	[redacted]
(b)(6)-2 10/18	[redacted]	Heplock IV	06	[redacted]
	-----		18	[redacted]
			06	[redacted]
(b)(6)-2 10/20	[redacted]	Lorenox 30mg SQ	10	[redacted]
	-----	BID	22	[redacted]
(b)(6)-2 9NOV03	[redacted]	Zantac 150mg po BID	10	[redacted] D/C'd w/ Levaquin
	-----		22	[redacted]
(b)(6)-2 9/29	[redacted]	CIPROFLAXIN 400mg	10	[redacted]
	-----	IVPB Q12°	22	[redacted]
(b)(6)-2 9NOV	[redacted]	LR@200cc/° X	06	[redacted] Completed
	-----	2 Liters then D/C	18	[redacted]

7.(9)(9)

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Open (L) Tib-Fib Fx

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO. 2

PATIENT IDENTIFICATION:

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

ICW # 1

DISPENSING TIMES

USE PENCIL, CIRCLE MED TIMES

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

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

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Verify by Initialing | Mo. NOV Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
(b)(6)-2 QS NOV	[redacted]	DC Percocet	QS NOV			[redacted]
(b)(6)-2 9 NOV	[redacted]	Zofran 2mg IV now	9 NOV	1600	1600	[redacted]
(b)(6)-2 11 NOV	[redacted]	~~Levofloxacin~~ DC med - Levofloxacin 250mg po qday	11			[redacted]

(6)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
(b)(6)-2 9/25	[redacted]	Percocet 1-11 po q4°-6° prn	Date 6 NOV Time 1040 Dose 11 Init [redacted] T/E
(b)(6)-2 9/25	[redacted]	Phenergan 25mg IVP Q4° prn	P/T 6 NOV D/I 25mg [redacted]
(b)(6)-2 9/25	[redacted]	Tylenol 650mg po Q 4° prn	
(b)(6)-2 10/18	[redacted]	MSO4 2-8mg q 1-2° prn	Date Time Dose Init T/E
(6)(6)-2 QS NOV	[redacted]	Tylenol #3 1-2 po q 4-6° pm	P/T P/I

DC QS NOV 03

2-(9)(9)

MEDCOM - 20671

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

OTSG APPROVED *(Date)*

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

Date: 29 APR 05 Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
Time In: 1842
Allergies: NKDA OR Intake: Crystalloid 500 c/s Colloid Ø
Pre-op V/S: [illegible] OR Output: UOP Ø EBL: Min.
Procedures: [illegible] Meds/Times: [illegible]

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds History

Time	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
SaO2	100	96	97	100	97	100
FiO2						
Methods	NC	RA	RA	RA	RA	RA
240						
220						
200						
180						
160						
140						
120						
100						
80						
60						
40						
20						
RR	14	19	19	20	20	20
T	95.0			97	97	97

Time								
Pain (0-10)								
LOS								

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

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1845	NS	450	LF	[illegible]	

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	0	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	1	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	Ø	Ø	Ø
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	7	9	10

Codes

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

V/S
X = A-line BP
˅ = Cuff BP
= Pulse

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

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

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC PACU

DATE 29 APR 05

[redacted] *st, middle; grade; date; hospital or medical facility)* Name — last,

[redacted] (b)(6)-4

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

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

MEDCOM - 20672

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	LTib	+ROM	+	+	B	C	PK
15'							
30'	LTib	+ROM	+	+	B	C	PK
45'							
60'							
90'							
D/C	LTib	+Rom	+	+	B	C	DC

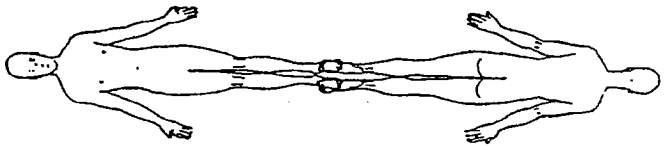
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm 1845	L Tibia	Curlex	Ø
30' 1915	L Tibia	Curlex	Ø
60'			
D/C 1935	L Tibia	Curlex	Ø



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1935	NSR	Ø	Ø

NURSING NOTES

PT recovered in OR Due TO MRSA. SIP 18 on L Tibia
PARS Score 7 PT still asleep. PFC [redacted] (b)(6)-2
PT Awake @ 30 min mark + ROM
@ Drainage on OR site — PFC [redacted] (b)(6)-2
PT Transferred by PFC [redacted] (b)(6)-2 to
ICU Report Given to CA [redacted] (b)(6)-2

Discharge Criteria:
Date: 25SEP05 **Time:** 1945 **PARS:** 10
BP: 122/79 **T:** 97 **HR:** 90 **RR:** 20 **Sa02:** 95
Pain Level at D/C (0-10):
Intake: 2500 cc **Output:** Ø
Additional Data: Ø
Transferred To: ICU
Report Given To: CRT [redacted] (b)(6)-2
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: PFC [redacted] (b)(6)-2
Cleared IAW Recovery Room SOP B-3
rse Signature: [redacted] (b)(6)-2 CPT/AN

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

Anesthesia Type (Circle)): General Spinal Epidural Sub Arach IV Sedation Nerve Block Dorsiflex

Time In:

Allergies: NKA OR Intake: Crystalloid 300 Colloid

Pre-op V/S: 124/60-76 OR Output: UOP 0 EBL- Min

Procedures: Meds/Times:

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

Pre Op Meds

History (b)(6)-2 Washout

Time	1845	1850	1855	1900	1915
SaO2	no	91	98	98	98
FiO2	RA	RA	RA	RA	RA
Methods					
240					
220					
200					
180					
160					
140					
120	V	V			V
100			V	V	
80					
60					
40	^	^	^	^	^
20					
RR					
T	98				
Time					
Pain (0-10)					
LOS					

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1845	NS	@ A C	R A C	[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) [redacted] (b)(6)-2
SGT

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 010CT03

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

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

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

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

MEDCOM - 20674

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
15						

NEUROVASCULAR

Time 1845	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	L (L) leg	Limited	+	P	B	W	PK
15'	L (L) leg	Limited	+	P	B	W	PK
30'	L (L) leg	Limited	+	P	B	W	PK
45'							
60'							
90'							
D/C	L (L) leg	Limited	+	P	B	W	PK

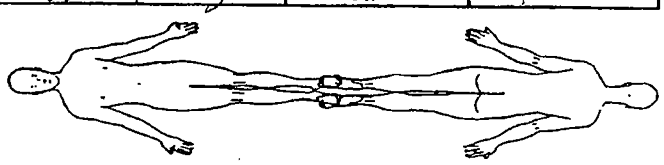
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm 1845	L (L) leg	Gauze	c/d/i
30' 1915	L (L) leg	Gauze	c/d/i
60'			
D/C 1930	(L) leg	Gauze	c/d/i



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1845	NSR	Ø	Ø

WAMC OP 173-E

NURSING NOTES

Received from OR via gurney
To Room 14 OR to Recovery + MRSA.
VSS - Alert x3. Gauze to L (L) leg
c/d/i. Pearla 3 mm - HR NSR - Lungs
CTA B/L Resp even Reg. BS (+) x4 quads
Pedal and Radial pulses +2. on
RA O2 SAT 98%. Ø c/o L (L) leg pain (b)(6)-2
@ present. — SGT [redacted]
Pins to operative site L (L) leg
in place Ø drainage. — SGT [redacted]
(b)(6)-2

Discharge Criteria:
Date: Ø1 Oct **Time:** 1930 **PARS:** 10
BP: 115/50 **T:** 95 **HR:** 77 **RR:** 16 **Sa02:** 98
Pain Level at D/C (0-10):
Intake:______ **Output:**______
Additional Data:
Transferred To: ICW #1
Report Given To:
Transferred Via: W/C Litter (Gurney) Ambulance
Transferred By: SGT [redacted] (b)(6)-2
Cleared IAW Recovery Room SOP R-3 (b)(6)-2
MEDCOM - 20675 **Nurse Signature:** SGT [redacted]

ACLU-RDI 1658 p.35

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: 30oct03 | Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
Time In: 1055
Allergies: NKDA | OR Intake: Crystalloid LR 300 | Colloid
Pre-op V/S: 116/74-95 | OR Output: UOP | EBL
Procedures: DeD (L) LE | Meds/Times:

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

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds | History

Time	1055	1105	1115	1130	1145
SaO2	96	95	96	96	96
FiO2	RA	RA	RA	RA	RA
Methods					
240					
220					
200					
180					
160					
140					
120					
100					
80					
60					
40					
20					
RR	10	12	12	14	12
T	97		98		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		AIRWAY A = Ambu BB = Blow-by M = Mask FT = Face Tent RA = RoomAir NC = Nasal Cannula
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2		V/S X = A-line BP ^ = Cuff BP = Pulse
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2		TEMP S = Skin O = Oral A = Axillary T = Tympanic R = Rectal
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	2	2		LOS C = Cervical T = Thoracic L = Lumbar S = Sacral
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2		
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	✓	✓		
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C,	10	10		

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 (Si[redacted] (b)(6)-2 | DEPARTMENT/SERVICE/CLINIC: PACU | DATE: 10-3-03

PATIENT'S ID[redacted] e: | Name – last, first, middle; grade; date; hospital or medical facility)

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

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

MEDICATIONS

Allergies:

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

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	(L) lower leg	limited	intact	P	S	cool	
15'		limited	intact +	P	S	cool	
30'							
45'							
60'							
90'							
D/C							

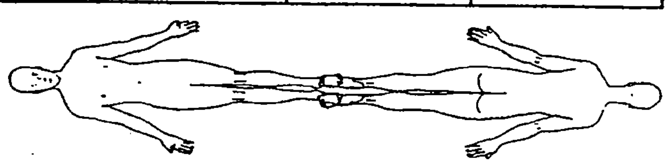
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(L) lower leg	Kerlix	scant sanguinous.
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount
1140	(L) leg	red/sang	<10cc

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

Assumed pt care from MAJ Fidele.
pt a/o, VSS, afebrile @ time of
arrival. PE in no apparent distress.
N alert, appropriate follows
commands PERRLA 3mm sluggish
(L) LE LRS ... +2 radial pulses radial
& pedal
Resp even unlabored CTA (B) ...
SpO2 96-97 on RA
GI soft nontender abdomen hypo BS.
[illegible]
GU [illegible]
[illegible]

[signature] (b)(6)-2 [redacted]
10-3-03

Discharge Criteria:
Date: 10.3.03 Time: 1130 PARS: 10
BP: 129/59 T: 97.6 HR: 66 RR: 14 Sa02: 96 on RA
Pain Level at D/C (0-10):
Intake: Ø Output: <10cc OP.
Additional Data: Ø
Transferred To: ICW
Report Given To: SPC [redacted] (b)(6)-2
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: 1LT [redacted] SSG [redacted] (b)(6)-2
Cleared IAW Recovery Room SOP p.3
...se Signature: [redacted] (b)(6)-2

MEDCOM - 20677

ACLU-RDI 1658 p.37

DOD-034251

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 6 OCT 03
Time In: 1630
Allergies: NKDA
Pre-op V/S: 120/62 70
Procedures: TKD (L) + TIBIA

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 400 Colloid
OR Output: UOP EBL
Meds/Times: MSO4, Propofol, Inhgas

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

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds

History

Time	1620	1633	1640	1650
SaO2	97	95	96	98
FiO2				
Methods	RA	RA	RA	RA
240				
220				
200				
180				
160				
140				
120	V	V	V	V
100				
80	•	•	•	•
60	^	^	^	^
40				
20				
RR	16	16	16	16
T				

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1630	LR	400	LFA	LYC	600

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	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)

PREPA[redacted], LPN (6)(6)-2 | DEPARTMENT/SERVICE/CLINIC: PACU | DATE: 6 OCT 03

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

EPN #[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

MEDCOM - 20678

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	WNL	+	+	B	W	Pk
15'							
30'							
45'							
60'							
90'							
D/C							

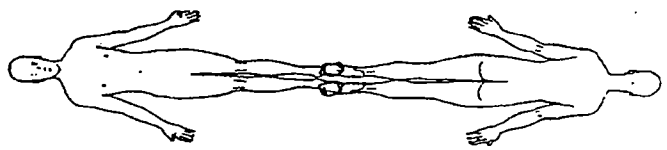
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(L) leg	Ioban 2	ø
30'	"	Ext fix	
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1630	SR	ø	ø

NURSING NOTES

Pt to recovery room from OR via litter s/p I&D (L) tibia. Ioban & Ext fix C drsg intact. ø drainage noted. IV of LR infusing into (L) AC. ø S/S of redness or swelling to ext. ø c/o. Will continue to monitor pt. [redacted] (b)(6)-2
Pt to [redacted] (b)(6)-2

Discharge Criteria:

Date: 6 Dec 05 Time: PARS: 9
BP: 137/76 T: 96.3 HR: 69 RR: 16 Sa02: 98
Pain Level at D/C (0-10):
Intake: 50 Output: 0
Additional Data:
Transferred To: [redacted]
Report Given To: [redacted] (b)(6)-2
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: [redacted] (b)(6)-2
Cleared IAW Recovery Ro[redacted] (b)(6)-2
[redacted] rse Signature: [redacted]

WAMC OP 173-E

MEDCOM - 20679

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: 1353
Allergies: NKA
Pre-op V/S: 101/58, 77
Procedures: I&D L hip

Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 400 Colloid
OR Output: UOP EBL NIL
Meds/Times: Sublimaze, Propofol

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds

History

Time	1353	1400	1411	1425
SaO2	96	95	97	98
FiO2				
Methods	RA	RA	RA	RA
240				
220				
200				
180				
160				
140				
	V	V		
120			V	V
100				
80				
60				
40				
20				
RR	16	24	20	18
T				

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1355	LR	1000	RU	DR	400

X-rays:

Labs:

Post-Anesthesia Recovery score

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

Codes

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

V/S
X = A-line BP
° = Cuff BP
= Pulse

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

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

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)

(b)(6)-2 PREPARED BY (Signature) [redacted] 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 [illegible] facility)

[redacted] (b)(6)-4

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

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

USAPPC V2.00

MEDCOM - 20680

MEDICATIONS

Allergies:

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

NEUROVASCULAR

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

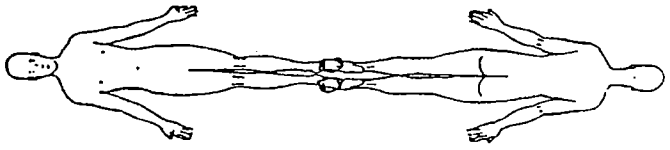
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(L) leg	4x4 Tx C	
30'		Tubigrip	
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1355	SR		

WAMC OP 173-E

NURSING NOTES

Pt to Recovery room from OR, s/p I+D (L) leg. Ext fix c tubigrip dressing intact. IV of LR infusing into (R) IJ c/d/i. S/S of bleeding or hematoma to site. NVS intact. VSS. c/o 4/10 pain. Will continue to monit[redacted]

(b)(6)-2

Discharge Criteria:
Date: 10 OCT Time: 1415 PARS: 10
BP: 128/67 T: 96.7 HR: 65 RR: 17 Sa02: 97
Pain Level at D/C (0-10):
Intake: 300 Output: 0
Additional Data:
Transferred To: ICU
Report Given To [redacted] (b)(6)-2
Transferred Via: W/C [redacted] Ambulance
Transferred By: [redacted] (b)(6)-2
Cleared IAW Recovery R[redacted]
Charge Nurse Sig[redacted]

(b)(6)-2

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 15 OCT 13
Time In: 1300
Allergies: NKDA
Pre-op V/S: 117/68 168
Procedures: Washout + Debridement

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 350 Colloid 0
OR Output: UOP 0 EBL 0
Meds/Times: VERSED, FENTANYL, PROPOFOL

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

Pre Op Meds: History

Time	1300	1315	1330	1345
SaO2	98	98	96	98
FiO2				
Methods	RA	RA	RA	RA
240				
220				
200				
180				
160				
140				
120	V	V	V	V
100				
80	A	A	A	A
60	•	•	•	•
40				
20				
RR	17	10	12	16
T	97			
Time				
Pain (0-10)				
LOS				

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1320	LR	500	R hand	DR	500

X-rays: Labs:

Post-Anesthesia Recovery score

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

Codes

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

V/S
X = A-line BP
˙ = Cuff BP
= Pulse

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

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

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

(Continue on reverse)

PRINTED NAME AND GRADE OF PERSON MAKING ENTRY: [redacted] DR

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 15 OCT 13

(b)(6)-2

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

(b)(6)-4 [redacted]

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

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

MEDCOM - 20682

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	WDM	+	+	B	W	Pk
15'							
30'							
45'							
60'							
90'							
D/C							

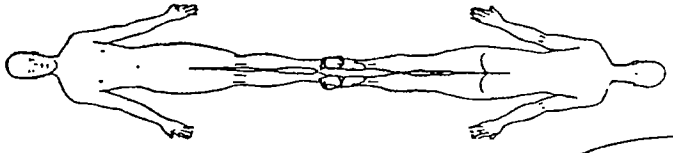
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(L) leg	Ext fix c Knee	ø
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1300	SR	ø	ø

WAMC OP 173-E

NURSING NOTES

Pt to recovery room from OR via litter s/p WBAT (L) tibia. Ext fix c knee intact. NVS intact. IV of LR infusing into (L) hand. c/o s/s of redness or swelling to site. VSS & C/O @ this time. Will continue to Monitor [redacted] (b)(6)-2 RN

Discharge Criteria:

Date: 15/07 Time: PARS: 10
BP: 120/66 T: 97 HR: 62 RR: 10 Sa02: 98
Pain Level at D/C (0-10):
Intake: 100 Output: ø
Additional Data:
Transferred To: PCU bed 1
Report Given To:
Transferred Via: W/C Gurney Ambulance
Transferred By: DA [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.

OTSG APPROVED *(Date)*

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

Date: 18 Oct 03
Time In: [illegible]
Allergies: [illegible]
Pre-op V/S: WKDA [illegible]
Procedures: (L) leg washout + closure EXFix

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

OR Intake: Crystalloid 8000 Colloid ______
OR Output: UOP [illegible] EBL 950 EBL
Meds/Times: ______

Single vessel, 60 mg Schnitt[illegible], 00 mg MSO4 [illegible]

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

Pre Op Meds   History

Time	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
SaO2	96	98	98	97	98	98
FiO2	RA	RA	RA	RA	RA	RA
Methods						
RR	14	19	12	14	15	13
T	98					
Time						
Pain (0-10)						
LOS						

(Vital signs graph scale: 240, 220, 200, 180, 160, 140, 120, 100, 80, 60, 40, 20)

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
ˇ = Cuff BP
= Pulse

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

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

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

(Continue on reverse)

PREPARE[redacted] SSC/CN

(b)(6)-2

DEPARTMENT/SERVICE/CLINIC PACC

DATE 18 Oct 03

PATIENT'S [redacted] *first, middle; grade; date; hospital or medical fa*[redacted]

Name — last,

(b)(6)-4

[redacted]

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

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

MEDCOM - 20684

MEDICATIONS

Allergies:

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

NEUROVASCULAR

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

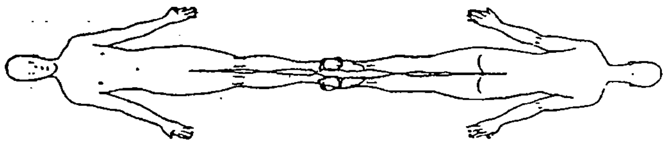
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic, P = Pale, Pk = Pink
Capillary Refill: B = Brisk, S = Sluggish

C-SECTIONS

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

DRESSINGS

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



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

male Iraqi Admitted to PACU S/P
~~I+D~~ Washout ExFix + closure
PSO2 98% RA VSS. JP to (L) leg
at Exfix site. all dsgs C/D/I
Bilate pedal pulses. 700cc
LR @ TKO Port. — SG [redacted] N
(b)(6)-2

Discharge Criteria:
Date: 18Oct03 Time: 1530 PARS: 10
BP: 137/70 T: HR: 89 RR: 12 Sa02: 99
Pain Level at D/C (0-10):
Intake: Output: Ø
Additional Data:
Transferred To: ICW 1
Report Given To:
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: [redacted] (b)(6)-2
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature:

MEDCOM - 20685

ACLU-RDI 1658 p.45

DOD-034259

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

OTSG APPROVED (Date)

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

Date: 21
Time In: 1236
Allergies:
Pre-op V/S: 124/62 76
Procedures: I+D left leg

Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 350 Colloid
OR Output: UOP EBL
Meds/Times: 2 Fent 2 Versed

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

History

Pre Op Meds

Time	1236	1239	1246	1301
SaO2	2L	99	99	99
FiO2				
Methods	NK	NK	NK	NK

240 / 220 / 200 / 180 / 160 / 140 / 120 / 100 / 80 / 60 / 40 / 20

RR	12	14	11	9
T	98.7			
Time				
Pain (0-10)				
LOS				

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1240	LR	200	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	0	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	2	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse			2
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)

PREPARING OFFICER [redacted] Sgt

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 21 Oct 03

(b)(6)-2

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

Name – last,

(b)(6)-4 [redacted]

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

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
1136		2mg MSO4	IV			[redacted]
1247		2mg MSO4	IV			[redacted]
1256		2mg MSO4	IV			[redacted]
1306		2mg MSO4	IV			[redacted]
1318		2mg MSO4	IV			[redacted]

NEUROVASCULAR

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

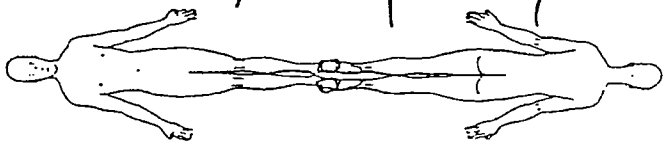
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm 1136	L leg	ex fix/ace	Ø
30' 1206	L leg	ex fix/ace	Ø
60'			
D/C 1	L leg	ex fix/ace	Ø



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1136	TSR	0	0

WAMC OP 173-E

NURSING NOTES

Pt received s/p I+D. Pt c/o pain 2mg MSO4 given. SpO2 100% RA. Pt keeps c/o pain 2mg MSO4 given at a time. Report given to Pt [redacted] VSS. SpO2 99% [redacted] (b)(6)-2 (b)(6)-2 LPN

Discharge Criteria:
Date: 20 Oct 03 Time: 1312 PARS: 10
BP: 118/69 T: 97.9 HR: 104 RR: 11 Sa02: 99
Pain Level at D/C (0-10):
Intake: 200 Output: 0
Additional Data: —
Transferred To: ICU
Report Given To: Lt [redacted] (b)(6)-2
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: Sgt [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.

OTSG APPROVED (Date)

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

Date: 10 NOV
Time In: 1413
Allergies: NKDA
Pre-op V/S: 114/56 C 89
Procedures: RLE TKR
Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 350 Colloid 0
OR Output: UOP 0 EBL 0
Meds/Times: Ten-Toradol, Toradol

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

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds

History

Time	1415	1430	1445	1500
SaO2	96	97	96	96
FiO2				
Methods	RA	RA	RA	RA
240				
220				
200				
180				
160				
140				
120	V	V	V	V
100				
80	^	^	^	
60				^
40				
20				
RR	16	14	16	16
T	96			
Time				
Pain (0-10)				
LOS				

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1415	NS	150	SC	DL	350

X-rays: Labs:

Post-Anesthesia Recovery score

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

Codes

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

V/S
X = A-line BP
˚ = Cuff BP
= Pulse

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

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

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

(Continue on reverse)

PREPARER: [redacted], LPN (b)(6)-2

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 10 NOV 03

IDENTIFICATION (If 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

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1435		MSO4 3mg	IVP			[illegible]

NEUROVASCULAR

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

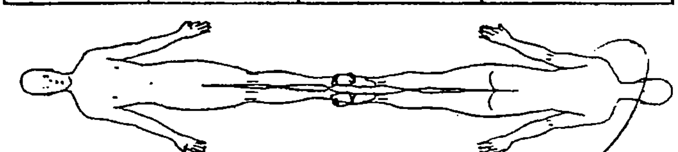
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent Color: C = Cyanotic, Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(L) leg	cast	—
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1435	ST	—	—

NURSING NOTES

Pt to Recovery Room from OR s/p ext fix removal. Long leg cast to (L) leg intact. NV √s intact. IV @ NS infusing to hep lock. c/o pain. Medicated c 3mg MSO4. Will continue to monitor. [redacted] (b)(6)-2

Initial line removed. #20 gauge IV started (L) hand. Will continue to mon[redacted]

(b)(6)-2

Discharge Criteria:

Date: 10 Nov Time: 1515 PARS: 10

BP: 170/[illegible] T: 96.8 HR: 87 RR: 18 Sa02: 96

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

Intake: 200 Output: —

Additional Data:

Transferred To: ICW [redacted]

Report Given To:

Transferred Via: W/C [redacted] Gurney Ambulance

Transferred By: [illegible] (b)(6)-2

Cleared IAW Recovery R[redacted]

Charge Nurse Signature: [redacted] [illegible]

(b)(6)-2

WAMC OP 173-E

MEDCOM - 20689

ACLU-RDI 1658 p.49

DOD-034263

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 1 1 D 1	I Z

3. REGISTER NUMBER: [redacted]

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

4. PAY GRADE:

5. SEX: M

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

7. AGE AT ADMISSION: 1 5 Y

8. RACE: X

9. ETHNIC BACKGROUND: 9

RELIGION: MOSLIM

10. LENGTH OF SERVICE:

ETS:

11. FMP: ~~9~~ 20

12. SOCIAL SECURITY NUMBER: [redacted]

ORGANIZATION (Active Duty Only):

13. MARITAL STATUS: U

HOUR OF ADMISSION: 1010

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

14. FLYING STATUS:

15. BENEFICIARY CATEGORY: ~~K~~ 7 8

16. ZIP CODE OF RESIDENCE:

17. UNIT LOCATION (State or Country Code):

18. MOS:

19. TRAUMA: Ø

PREV. ADMISSION: YEAR [X] NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: Ø

WARD: ICU/

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE:

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code):

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: 28TH CSH SOUTH (b)(2)-2

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE:

21. TYPE OF DISPOSITION: 2 4

22. MTF TRANSFERRED TO:

23. DATE OF DISPOSITION (Y Y M M D D): Ø 3 Ø 1 1 1

24. CLINIC SVC - ADMITTING: A E A A

25. MTF TRANSFERRED FROM:

26. DATE THIS ADMISSION (Y Y M M D D): Ø 3 Ø 9 2 5

27. LOCATION OF OCCURRENCE (Battle Casualty Only):

28. MTF OF INITIAL ADMISSION:

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

FOR LOCAL USE

DX: OPEN ~~FIB~~ / FIB FX

(b)(6)-2

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

DR [redacted]

SIGNATURE OF ADMITTING CLERK: [redacted]

DA FORM 2985, MAR 80

MEDCOM - 20690

(b)(6)-4

INPATIENT TREATMENT RECORD COVER SHEET

For use of this form, see AR 40-400; the proponent age[illegible]GG

1. REGISTER NUMBER	2. [redacted] (b)(6)-4	3. GRADE	ADMISSION REMARKS
[redacted]		CI	

4. SEX	5. AGE	6. RACE	7. RELIGION	8. [illegible]	9. ETS	10. PREVIOUS ADMISSION
M	17	—	—	—	—	Ø

11. EMF	12. SSN	13. ORGANIZATION	14. WARD
99	[redacted] (b)(6)-4	—	ICU

15. PLYING STATUS	16. RATING OSG	17. DSPT BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
NO	—	K7878	—	—	—

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
Direct from ER	Ø100	AAAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
UNK	50	8 , 03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
UNK	UNK	28 , 03	[redacted] (b)(6)-2

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

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: ① [redacted] colon repair (b)(6)-2
② multi Shrapnal wounds

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV LV/COCP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
Ø	Ø	Ø	Ø	27	27

35. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV LV/COCP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
(b)(6)-2	[redacted] (b)(6)-2				

SIGNATURE OF ATTENDING MEDICAL OFFICER: [redacted] MA

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

DA FORM 3647, MAY 79 EDITION OF 1 AUG 75 IS OBSOLETE USAPPC V1.1

MEDCOM - 20691

ACLU-RDI 1658 p.51

DOD-034265

MEDICAL RECORD | 28 Aug 0100 **ABBREVIATED MEDICAL RECORD**

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

17 y/o ♂ injured by grage ~ 24 h ago presented to FST ~ 1700
c c/o abd pain, arrived by ground ambulance, T 103 P 110 120/60
PMH ⊖ all ⊖ per FST hx

OR ~ 3 h
4.5 L
500 colloid
EBL ____

had 1° resection/~~repair~~ anastomosis (ileocolectomy c i° EEA)
at FST, also exp ⊕ knee - ō Ax - drain left in place
Pt extubated postop but had to be reintubated; tx'd c/o
diff providing 100% O_2, PEEP

140/70 110 38° CVP 8

PHYSICAL EXAMINATION

PERRL TM
mucl dic
neck - ō wounds
chest clear
cor - ō ⓜ
abd - midline incision c JP wt ⓡ side
pelvis - stable
rectal - ⊕ tone
ext - moves all

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

CXR - bil alveolar infiltrates consistent c ARDS, pulm edema (ⓡ mid placed)
Hct 40 w WBC 3.9

A - ARDS

P - PEEP 12 100% F_iO_2 TV 600 ~~RR~~ 16
[redacted] from CTS, gm stain

7.26 42 HCO_3 19
~~7.30~~ ~~28~~ CO_2 [redacted]
Sat 95%
BE - 12

SIGNATURE	DATE	IDENTIFICATION NO.	ORGANIZATION
[redacted] MD (b)(6)-2	28 Aug 00		

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

REGISTER NO. | WARD NO.

[redacted] (b)(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
9/23/0	Pre-op Note (cont) pt febrile c̄ peripheral signs c̄ Hemoccult (+) stool. Location of (L) & (R) flank injuries suspicion for possible bowel injury; do not suspect IVMA-ABD Hemorrhage based on Hb c̄ US. We do not have CT scan readily available. Based on ↑ T, (+) Hem in stool c̄ peripheral signs we recind to take pt to OR for exploration plan: to OR now Fluid resus Unasyn 3gram IVPB now (b)(6)-2 [redacted]

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

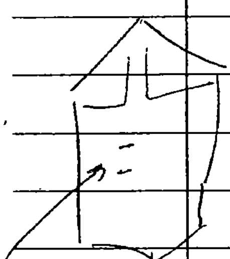
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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	NKDA 17y/o ♂	

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
9/27/03	Pre-op H&P (c̄ translation)
	17 y.o ♂ suffered frag injuries to (L)
	leg, back and (L) hip/flank region
PMH Ø	approx 18° prior. Arrival in stable cond^
PSH Ø	via ground evac c̄ cc of abd pain
meds:	Exam: Gen: thin ♂ appeared uncomfortable
flagyl?	Head: AT Neck: NT; trachea ML Ø JVD
all: Ø	Eyes: EOMI; PERRL; sclera Ø icterus
~~SH: unknown~~	Heart: HR 110 RR BP
	Temp 103 (R): (L) flank c̄ frag wounds
	Lungs: BS = (B) CTA
	Abd: soft; diffusely tender c̄ guarding
	Ext: (L) hip open wound 3 cm
	(L) knee c̄ wounds & (+) hematoma
	Neuro: GCS = 15
injuries	Rectal: hemoccult (+) Ø gross blood
	GU: (+) Foley; AT
	Labs: WBC 8 Hb 15 UA 3+ blood
	Studies: CXR Ø PTX ABD NIBGP
	ØFA (+) shrapnel in pelvis
	(L) femur/knee Ø fx
	I/P: Pt arrival from outside hospital
	p̄ suffering frag injuries ~ 18° prior
	(cont)

(b)(6)-2 [redacted]

509-113 NSN 7540-00-634-4122

MEDICAL RECORD | PROGRESS NOTES

DATE	
27 Sep 2003	Op - Note - OrDo
2100	Pre-op Dx - 1) multiple shrapnel wounds (L) Thigh
	2) ? (L) knee open joint
	Post-op Dx - 1) multiple shrapnel wounds (L) Thigh
	2) Penetrating wound (L) knee
	Surg: Bal
	Findings - Insufflated (L) knee c 40 cc NS - got
	50 cc bloody aspirate back
	Followed penetrating tract through Quad
	tendon into joint.
	Performed Ant Med, lat arthrotomy - I&D
	knee joint c 3 l pulse lavage, closed
	arthrotomy over drain.
	I&D multiple soft tissue wounds, irrigated
	c 2 l pulse lavage.
	Dressing c xeroform, kerlix
	JP drain left knee [redacted]
	(b)(6)-2

(Continue on reverse side)

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

174005

[redacted]

(b)(6)-4

PROGRESS NOTES

Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

9/27/03

Post op order:

Admit to post-op ✓

Dx: s/p ex lap; bowel necrosis ✓

Cond: stable ✓

Vitals: q 4° ✓

All: NKDA ✓

Nursing: I's/O's; Foley to gravity; IP to bulb suction ✓

Adv to ICUs; call M.D. T > 38° HR > 100 < 60 ✓

RR > 30 < 10 SBP > 160 < 100; UOP < 30 cc/hr ✓

Diet: NPO ✓

IVF: ~~D5 1/2 NS + 20 meq KCl/L @~~ 120 cc/hr ✓

Meds: Phenergan 25 mg IV q 6° prn N/V ✓

Morphine sulfate 2-4 mg IV q 2-4° prn pain

Vivaxin 3g IV q 6° (give 1st dose now) ✓

Labs: AM CBC, chem 7 ✓

(b)(6)-2 [redacted]

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 (41 CFR) 101-11.203(b)(10)

[redacted] (b)(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES (b)(6)-2
28Sep03	Late entry: Dr [redacted] @ bedside, Legal Ped. (b)(6)-2 [redacted]
	1510 ABG drawn per A-line. Reviewed by Dr [redacted] orders received, ↓ peep 8, ↓ rate, TV 600, FiO_2 40% (b)(6)-2 [redacted]
(b)(6)-2	1715 Dr [redacted] @ bedside. update given, about elevate HR rate. 120s-160s. ectopy beats noted (b)(6)-2 [redacted]
1900	report recvd; pt sedated c MSO4/Versed; vent; febrile (38.4); VSS; tachy; assmt complete (b)(6)-2 [redacted]
0100	MD Davis called for HR reading 130's occasionally; CBC ordered + drawn; amt by pt @ 123 (b)(6)-2 [redacted]
0400	no change in assmt status; peep ↓ 6; sat ≥ 99%; CTM
0400	CBC results seen by MD; no changes made; pt weaned to peep 6; FiO_2 35%; (b)(6)-2 [redacted]
29Sep03	0600 Assumed care. Report given. VSS. See ICU-3 flowsheet for initial assessment. (b)(6)-2 [redacted]
	0630 Tylenol supp. given. Temp [illegible] ↓ sedation. (b)(6)-2 [redacted]
	0720 ↓ rate to 10, ↓ peep 5cm (b)(6)-2 [redacted]
	0800 ABG drawn per A-line, Versed ↓ to 2mg/hr. (b)(6)-2 (b)(6)-2 [redacted]
	0910 ABG reviewed by Dr [redacted] orders received to ↓ sedation, plan to extubate

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

(b)(6)-4 [redacted]

[redacted] (b)(6)-4

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
28 Sep 09 0100 (24hrs)	Dust admit from FST; pt packaged, bagged by EMT; NR, ETT c BBS; Sao2 90s; VSS; Pt plcd on monitors, TLC to (R) SC c CXR; A line to (L) Radial; (R) Weaned; FTG; HOB 30°; MSO4/ Versed for sedation/ Vent Settings for wn; to be weaned; multiple labs drawn & received; orders to RT for full; VSS @ this time. (b)(6)-2 [redacted]
(0400)	(b)(6)-2 [redacted] making rounds; VSS; vent #'s c ABG noted
28 Sep 09	0600 Assumed care. Report given see flow sheet for initial assessment (b)(6)-2 [redacted]
(b)(6)-2	0700 Dr [redacted] @ bedside. labs reviewed, orders received. (b)(6)-2 [redacted]
	10. @ 0800 ABG sent. (b)(6)-2 [redacted]
	0810 updated Dr [redacted] on elevated temp 102.1 Rectal. (b)(6)-2 [redacted]
	1200 ABG results in. Notified Dr [redacted] (b)(6)-2 result. (b)(6)-2 [redacted]
(b)(6)-2	1250 Dr [redacted] present, Update 14, [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. 6/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
	1100 (b)(6)-2
29Sep03	D/C'd x2 PIV (R) E (L) ARM. — [redacted]
	1150 oral care given. repositioned — [redacted]
	1340 DAsg on ABG done. (D) reg [illegible]
	dosg [illegible]. [illegible] [illegible] ō [illegible]
	intact. Ø [illegible] noted — (b)(6)-2 [redacted]
	1500 (↓) MSO4 3mg/hr per Dr (b)(6)-2 [redacted]
	1540 (D) reg TP drain pulled. dsg (b)(6)-2
	C/D/I Ø new orders received — [redacted]
(b)(6)-2	1615 Dr [redacted] present update given [redacted]
	1735 pt more alert, open eyes to
	commands. translator @ bedside,
	update given about [illegible] ē [illegible]
	once awake. — (b)(6)-2 [redacted]
1900	pt sleepy but arousable; VSS; assessment complete +
	charted; no new orders — [redacted] (b)(6)-2
2000	sedation turned on for ↑ agitation; ↓ SaO2, ↑ RR,
	bucking vent; will wean as ASAP — [redacted] (b)(6)-2
	Sx done ē above ē minimal secretions out; Tylenol
	650mg per NGT — [redacted] (b)(6)-2
2300	temp ↓ 38.2; VSS; SaO2 98% on 40% FiO2 — [redacted]
0100	no change in assessment status; VSS; temp ↓ — [redacted]

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

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

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

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

PROGRESS NOTES
Medical Record

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

[redacted] (b)(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
(Cont)	0430 ABG drawn; CO2 45; PH 7.36; RR↑ from 10 to 12 ; other labs pending ——— [signature] (b)(6)-2
30 Sep 03	0600 Assumed care. Report given. See ICU-3 flowsheet for initial assessment (b)(6)-2 ——— [redacted] (b)(6)-2
	0650 Dr. [redacted] @ bedside. Labs reviewed sedation turned off. Will get x-ray @ [illegible]. pt arousable opens eyes to command
	0915 RT @ bedside, pt arousable to command instruction by translator for that extubation. ——— [redacted] (b)(6)-2
	1000 translator @ bedside to support & [illegible] pt. placed on O2 @ 2L/min pt remains drowsy. RR even & unlabored. rate 22-27. ——— [redacted] (b)(6)-2
	1030 sips of H2O given RR 25-28 SPO2 94%-100% [redacted] (b)(6)-2
30 Sep	1330
	S - arousable
	O - T 102 P 123 150/85 sat 97% on nasal O2
	chest clear but cough productive
	abd - soft BS wound OK
	BS +
	ext - 3+ edema WBC 8 Hct 33 IV site OK
	A - fever ? 2° to atelect. will watch wound + IV site, may [illegible] // possibly intra abd abs

[redacted] (b)(6)-4

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

MEDCOM - 20700

ACLU-RDI 1658 p.60

DOD-034274

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
10Oct03	1300 R/w back to bed — [redacted] (b)(6)-2
	1530 pt refused to crutch, OOB to chair, sat up s̄ difficulty (b)(6)-2 [redacted]
	1730 R/w back to bed, sips of [illegible] soda & juice given (b)(6)-2 [redacted]
1900	pt alert, responsive; equal rise/fall; [illegible]; [illegible] 2L; NAD; pt resting; assessment charted; (b)(6)-2 [redacted]
0400	no change in assessment status; pt hungry, wants something to eat; pt NPO [redacted] (b)(6)-2
(0220)	rpt given to ICW2 RN; pt to be transferred — (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.

OIU [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

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MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
	20 Oct POD 3
	BS(+) wound good, lo grade temp 100
	A total
	P - ↑ act + diet

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
	(b)(6)-2 (b)(6)-2 Management Palliative Measures [redacted]
30Oct03	0530: Dr [redacted] here, staples to midline wound removed, steri strips placed CDI, DSG to (L) hip d'd CDI. (b)(6)-2 [redacted]
@30Oct03	(1500) Assumed care of pt @ 0600 c report from night shift. Pt alert, speaking some English. VSS. Pain controlled c Tylenol. Pt OOB to amb in hallway X2 this shift. DRSGS to @ hip and thigh CDI. Sutures to @ knee CDI. midline and incision intact c steri strips. CL to @SC infusing IVF s S/Sx infection/ infiltration. Tol small amount of reg diet. Voiding clear yellow urine s difficulty. 4 point restraints in place s S/Sx complications. Will continue to monitor. (b)(6)-2 [redacted]
30Oct03	1900: VSS, 0/10 pain @ present time, A+Ox3, speaks some English to verbalize needs, OOB to bathroom s difficulty, x1 BM this evening, CL intact to (R) upper CW → running D5 1/2 NSE 20meq KCl @ 75cc/° s difficulty, dsg to site CDi, 0 S/S infiltration/erythema, midline abdominal incision has steri strips applied CDi, DSG to (L) hip CDi, shrapnel wounds scattered to back & open to air-healing. x2 restraints when in bed. Skin integrity intact. Continue to monitor for acute Δ's. (b)(6)-2 [redacted]

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

DATE	(b)(6)-2 NOTES
20Oct03 0900	Received Pt from [redacted] ICW 2 ambulators @ SC Triple lumen IV patent infusing D5 1/2NS @ 20meq KCl @ 75cc/hr. Peripheral pulses +2 Drsg to (R) flank, (L) thigh, (L) knee Dry/intact. VSS. Lungs clear Bilateral. BS (+) x4 quad. Abd soft, tender to touch, non distended. Midline Abd. incision @ staples intact & dry. Will continue plan of care. (b)(6)-2 [redacted] ZLT RN
20Oct03 2045	VSS, Ø c/o pain @ this time, A+O x3, CL to (R) upper chest wall (triple lumen) running D5 1/2NS @ 20meq KCl @ 75cc/° S difficulty. CL site S erythema/irritation or S/S infection. CL Dsg Δ done, NID initiated. Midline Abdominal incision @ staples intact and open to air, 2x2 Dsg CDI to (R) Upper quad, Dsg to (L) hip area CDI (QDay Δ's). Shrapnel Wounds scattered to back, healing and open to air. Pt. got OOB & walked in hall for ~10 minutes @ walker @ assistance. x2 restraints when in bed. POC: Infection Control, Wound Care, Pain →

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

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
8OCT03 0135	VSS. AO. Multiple Abdominal incision replaced/reinforced c̄ steri strips @ base of incision. WTD saturated and d/c'd and debrided site. Appeared pink s̄ s/s infection. Tolerated well. Replaced WTD DSG's @ (L) hip and applied Bacitracin to scabbed shrapnel wounds. — (b)(6)-2 [redacted] RN
8 Oct '03	Pt A+Ox3, VSS pt has ∅ c/o pain at this time, drsg to (L) hip (L) flank and sacral area changed minimal drainage, most appear reddish pink, a couple had some light greenish drainage, bacitracin applied to sutured shrapnel/wound, restraints x2 in place (R) circulation [redacted] (b)(6)-2
	(1330) I concur c̄ above assessment. Pt d/c to Iraqi hosp. - ambulatory in stable cond. [redacted] (b)(6)-2

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

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
09Oct03	2030= VSS, c/o pain @ this time, A+O x3, ambulates as needed c minimal assist, Dsg to ⓛ hip CDI, Dsg W→D Δ'd to midline abdominal wound - scant sero sanguinous drainage noted. Tolerates PO well, ø N/V/D. Shrapnel wounds scattered to back - healing & open to air. POC: Pain Mgt, wound care, infection control. ↓ restraints when in bed, ⊖ Skin breakdown. Continue to monitor for acute Δ's. [redacted] (b)(6)-2
10Oct03 0900	Assumed care of pt. Pt tolerated reg diet ⊖ S/Sx of resp distress, pain or discomfort @ present time. Suture removed from ⓛ hip and wet to dry dsg Δ. Dsg D&I on ⓛ thigh and abdomen. Lungs CTA BS(+)ⓑ dorsal pulses ⊖ Skin breakdown under restraints. Will [redacted] (b)(6)-2 SIW46. continue to monitor -
1115	Dsg Δ to abd, hip and ⓛ thigh. Abd wound pink. wet → dry [redacted] (b)(6)-2 91W46

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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MEDICAL RECORD — **PROGRESS NOTES**

DATE: 28 Sep - 8 Oct 2003 NOTES

Patient a 17 year old male with fragment injuries to left back and flank & 18 hours before arriving at ER with abdominal pain. Patient taken to OR and right hemicolectomy done for perforated ascending colon with primary end to end anastamosis. Right knee explored - no penetrating. Patient transferred (b)(2)-2 to [redacted] 28 Sep intubated and had developed ARDS picture but was extubated 48 h later and has done well with rapid advancement of diet. On 7th postop day a 2 cm of wound opened below umbilicus and 2 cc pus released. Wound packed open with saline soaked gauze changed every 8 hours. Small wounds on left hip also drained purulent daily. Will need continued dressing change til wound heals in 2-3 weeks.

Patient received Unasyn for 5 days then discontinued and was on subcutaneous heparin til ambulatory. No problem with knee. No fractures of knee; CXR now normal

1 Oct '03 Hct 30 WBC 6.5 platelets 291

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

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted] (b)(6)-4 (pt [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
10/4/03	light amber urine, quantity sufficient. ⊕ pulses. [redacted] (b)(6)-2 RN
10/5/03 :0920	Pt A&O. Communication adequate to express needs. HRR. Nailbeds pink c brisk capillary refill. Lungs CTA(B). Resp even/unlabored. Abd. soft. (+)BS x 4 quads. Voiding s difficulty clear yellow urine. MAE. Good ROM. Ambulates in hall for exercise. Skin warm & dry. Midline abd incision c steristrips & dsg to open wound c serosanguineous drainage. (2) Lip dsg's & shaped wounds c dsg's. All sites healing. (2) knee sutures to air. Bacitracin applied. Dsg CDI to old central line site. (0) subclavian. (0) complaints @ this time. A.M. care done. Will continue monitoring & providing emotional support [redacted] (b)(6)-2 most
10/5/03 1700	Pt ambulating in hall for exercise. OOB to chair for approx 25 min. Ate 1/2 chicken for dinner. Will continue to monitor [redacted] (b)(6)-2 most
5 OCT 03 2105	VSS. AO. LSCTA(B). S1, S2. BS(+) x 4. Voiding light yellow urine s difficulty. OOBT ambulate s difficulty. S/d abdominal DSG c WTD. Noted serosanguinous drainage in small amount to abdominal dressing. [redacted] (b)(6)-2 RN
6 OCT 03 0850	PT A&O S1S2 present LSCTA(B) (+) BS x 4 quads. small mid line abd. wound covered c 2x2 CDI. Denies pain at this time. Will cont[redacted] to Monitor. (b)(6)-2 Lx. RWMB

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

DATE	NOTES
4OCT03	(b)(6)-2 0530: D1 [redacted] here, abd wound a little opened to center of incision site, packed c gauze W→D Dsg applied CD1—Continuing 28; Ⓔ drainage noted light brown liquid scant amount. CL to Ⓡ SC D/C'd intact, IVF's D/C'd Continuing to monitor pt's PO Status/tolerance [redacted] (b)(6)-2 VSS/AN
Ø4OCTØ3	(1500) Assumed care of pt w/ ØbØØ p report from night shift. Pt alert, speaking Arabic. VSS. Ø c/o pain. Steri strips to abd incision CD1 x for small area in center. wet → dry dsg applied to area. Drsg to Ⓒ hip and thigh Ⓐd. Sutures intact to Ⓒ knee. Ø S/Sx infection w/ wound sites. Pt amb to BR this am for personal hygiene. Pt amb well. Tol. small amount reg diet. Voiding s difficulty. 2 point restraints in place s S/Sx complications. Will continue to monitor. (b)(6)-2 [redacted] W)AW
4OCT03 2306	VSS, Afeb. Speaking Arabic & English. BS Ⓒ x4. A'd multiple Abd. Dsg. Wound is baby pink c serosanguinous Dsg removed. Dsg intact to Ⓒ flank and subgluteal area. Voiding

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)-2

PROGRESS NOTES
Medical Record

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

DATE	NOTES
Ø1 30sep03 2200	Tylenol supp i (gr) given for ↑T of 102.4 (R). NG drainage dk brown 50cml at @ this time. Foley to gravity 100-120 per hr [illegible] yellow. MS04 4mg IVP given for c/o pain @ 2100. (b)(6)-2 [redacted]
Ø1 oct Ø3 0200	MS04 4mg given IVP for c/o pain. T-38.7°C O2 @ 2L/m O2 SATS @ 100%. (b)(6)-2 [redacted] 91W
Ø1 oct 0300	Tylenol supp i (gr) given for T of 38.4°C. MS04 2mg given for c/o pain. (b)(6)-2 [redacted] 91W
01 oct Ø3 0600	MS04 4mg IVP given for c/o pain. T-37.1°C. Sitting c HOB↑ quietly. O2 on @ 2L/m O2 100%. (b)(6)-2 [redacted] 91W
1 Oct 03	0600 Assumed care. Report given. See ICU-3 flowsheet for initial assessment. (b)(6)-2 [redacted]
	0720 sips of H2O given. Tolerated well. VSS. (b)(6)-2 [redacted]
	0800 Dr [redacted] @ bedside. Orders given. NG d/c'd. NG removed. [illegible] @ bedside to update pt on plan of care. (b)(6)-2 [redacted]
	0930 pt up ambulating [illegible]. [illegible] @ bedside, [illegible] given. pt not eating @ this time. (b)(6)-2 [redacted]
	1140 OOB to chair. IS given. [illegible] given on use. x8 attempts made. Only able to [illegible] (b)(6)-2 [illegible] will continue to encourage. [redacted]
	1230 sips of H2O given, tolerated [illegible]

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	(b)(6)-2
30Sep03/1330	Dr [redacted] @ bedside. JP x 2 ® lower removed. new orders received sips of H_2O. Tylenol 650mg per NGT given (b)(6)-2 [redacted]
1350	DC'ed @ A-line. pt yo [illegible] DA will monitor (b)(6)-2 [redacted]
1700	pt more alert, able to cough up secretion and spit them on the bed. (b)(6)-2 [redacted]
1810	Report given. VSS. (b)(6)-2 [redacted]
30Sep03 1900	VSS - arousable to verbal stimuli. ® subclavian line multilumen all ports patent. w/fluid D5½NS ē 20 meq of KCl @ 100ml/hr. Pearla 3mm HR S-Tach - Lungs CTA B/L Resp Reg. BS⊕ 4 quads hypoactive 1 quads Pedal pulses +2 ē +2 edema B/L Radial +2 +2 edema B/L. staples to midline abd intact ⊖ Redness or drainage. Dressing to Ⓛ hip dry & intact. drsg to ® [illegible] Lab'd dry intact. foley to gravity draining clr yellow urine 100-150/hr. ⊘ c/o pain or discomfort ē present. (b)(6)-2 SGT [redacted] 91C20

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.

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

PROGRESS NOTES
Medical Record

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MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
17 Sept 2003	Ortho
	17 yo ♂ s/p multiple GSW, shrapnel
	≈12 hrs ago. Presents alert, oriented
	[illegible] multiple penetrating
	abdominal [illegible]. Evaluated by Gen Surg
	wounds to Ⓛ flank.
	Has swollen Ⓛ knee c̄ ant wound
	PE Ⓛ LE - NV intact. ⊕ knee effusion
	Severe pain c̄ ROM
	stable ligament exam.
	∅ thigh pain
	Scattered penetrating wounds prox thigh, pelvis
	Xrs - pelvis - multiple metal fragments. ∅ Fx
	femur - ∅ Fx
	knee - ∅ Fx, ∅ fragments
	A/P 1) multiple soft tissue wounds Ⓛ thigh
	2) ? penetrating Ⓛ knee [illegible]
	Will evaluate in OR after Gen Surg
	ex-lap.
	(b)(6)-2 [redacted]

HOSPITAL OR MEDICAL FACILITY	STATUS	[redacted]	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	
		REGISTER NO.	WARD NO.

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

[redacted] 17 y/o ♂

(b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

STANDARD FORM 600 (REV. 6-97)
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FIRMR (41 CFR) 201-9.202-1

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*

4/27/03

Post-op note

pre-op Dx: R/O Bowel injury

post-op Dx: Ascending colon perforation

Procedure: Ex Laparotomy; partial Bowel resection of Ascending colon including TI; placement of 10mm JP in @ pericolic gutter; 1° anastamosis of Ileum to distal Ascending colon

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

EBL: 200cc

Fluids:

UOP

Finding: perforation mid Ascending colon c localized contamination; small Bowel, stomach, duodenum ureter, kidneys explored & E/O injury

D/E/O injury to Ascending colon on solid organs

Drains: 10mm JP @ pericolic gutter

Compl: Ø

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

HOSPITAL OR MEDICAL FACILITY	STATUS	[illegible] 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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
28 Aug	0100
	dx 2145 at FST pH 7.17, pCO_2 45, pO_2 40, HCO_3 17, BE -12
	dx 2214 7.32 pCO_2 29 pO_2 47
	(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.

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

MEDCOM - 20714

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

For use of this form, see MEDCOM Circula

SECTION I - PATIENT ASSESSMENT

DATE: 02Oct 03 | PATIENT ACUITY LEVEL: IA | POST-OP DAY: 6 | HOSPITAL DAY: 5

TRANSFER

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

Time 0230 To ICU2 From ICU3 ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☒ STRETCHER

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

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

LOC awake & alert Neurovascular checks _____

Dressing/cast (R) side, (L) knee Tubes _____

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

Medication _____

Other _____

Report From CPT [redacted] (b)(6)-2 Received By Lt [redacted] (b)(6)-2

VITAL SIGNS

TIME:	0400															
BP ARTERIAL LINE	/															
BP CUFF	124/67															
TEMPERATURE	99.4															
PULSE	94															
RESPIRATORY RATE	16															
OXYGEN (L/%)	/															
PULSE OXIMETER	98															
O_2 METHOD	/															

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

PAIN

TIME:	0230															
PAIN INTENSITY (10 / 5 / 0)	X															
MED ADMINISTERED (Y/N)	N															
RELIEF ACCEPTABLE (Y/N)	NA															

OTHER

TIME:																
FINGER STICK GLUCOSE																
INSULIN (Y/N)																

SPECIAL NEEDS

TIME:	0230															
*Skin breakdown prevention (b)(6)-2	[redacted]															
*Falls prevention protocol	NA															
*Restraint protocol																
*Seizure precautions																
*Isolation precautions																

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

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

PATIENT IDENTIFICATION

CIV [redacted]

(b)(6)-4

DIAGNOSIS: Multiple Shrapnel Wounds

DRG: _____ ADMISSION DATE: 28Sep03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: _____

ISOLATION REQUIRED (*Specify*): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

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

	TIME: 0230 INITIALS: [redacted]	TIME: INITIALS:	TIME: INITIALS:
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑ (b)(6)-2	☐	☐
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☐	☐
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☐	☐
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☐	☐
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☐	☐
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ Aft ↓ ROM to (b) knee 2° to wounds	☐	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ Dsg to (b) side, knee, CDI	☐	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☑	☐	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☐	☐

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

TIME: 0230 INITIALS: [redacted]	TIME: INITIALS:	TIME: INITIALS:	
IV patency ✓ q 4 hr: (b)(6)-2	IV patency ✓ q hr:	IV patency ✓ q hr:	
IV site care provided: flushed	IV site care provided:	IV site care provided:	
IV tubing changed:	IV tubing changed:	IV tubing changed:	
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION	
IV Site #1: triple lumen	IV Site #1:	IV Site #1:	
IV Site #2: subclavian	IV Site #2:	IV Site #2:	
Comments: site OK flushing easily & drawing back blood.	Comments:	Comments:	

SECTION III - PATIENT INTERVENTIONS & TEACHING

(b)(6)-2

NEUROVASCULAR

SITE: (L) UE	TIME: [illegible]					
COLOR						
CAPILLARY REFILL	1					
TEMPERATURE	W					
EDEMA	0					
SENSATION	S					
MOTION	M					
PASSIVE FLEXION	0					
PERIPHERAL PULSE	2					

LEGEND

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

SAFETY

	TIME: 0230			
[illegible] visible/legible	[redacted]			
Orient to environment prn	[redacted]			
Side rails (2/4) up	NA			
Bed position low				
Call light within reach	✓			

OTHER

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

DIET

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

ADLs

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

TEACHING

TIME: 0230 INITIAL [redacted] (b)(6)-2	TIME: INITIALS:	TIME: INITIALS:
CONTENT: - Orient toward/ staff - plds - pain meds	CONTENT:	CONTENT:
☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION

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

INITIALS	SIGNATURE	SHIFT
[redacted]	[redacted] LT/AN	2200
(b)(6)-2	(b)(6)-2	

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	0230	(R) side (L) knee	} ds & CDI	} assessed

SECTION IV - NOTES

02Oct03 0230 Readmitted to ICU2 from ICU3 via stable condition via litter. Ø reported allergies Intubated from litter to bed I assistance. Ø c/o pain [redacted] (b)(6)-2 (A/Br)

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 BY

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY

3. DATE TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM
TIME NUMBER

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)* Head to foot, Arms abd <90° to

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

COMMENTS: padded armboards legs straight, bed padded.

8. SKIN PREPARATION

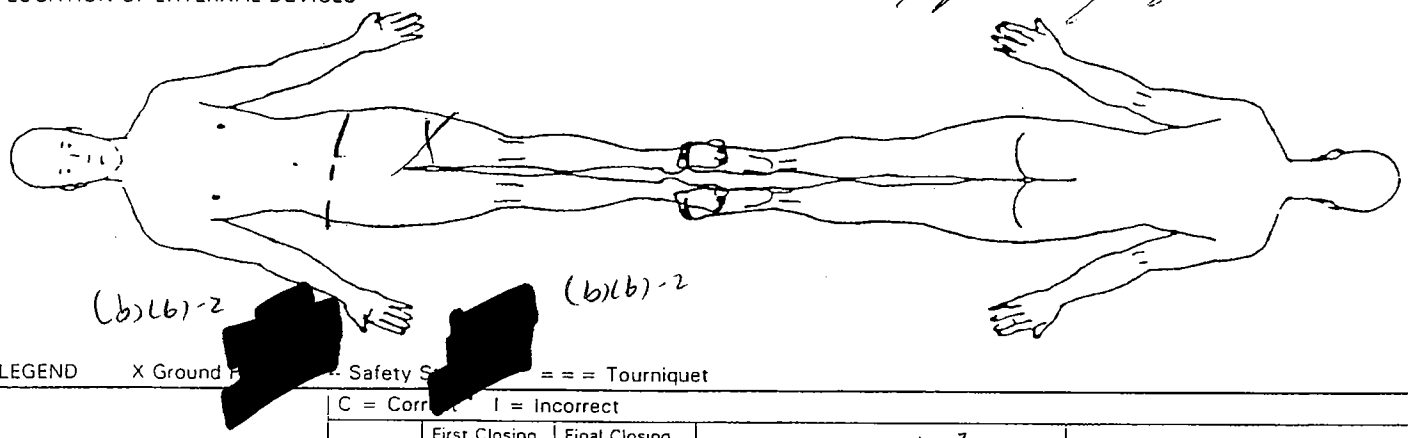
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

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

COMMENTS: 4 pass / 2 pass

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground P... Safety S... = = = Tourniquet

C = Corr... I = Incorrect

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

SCRUB (b)(6)-2 SGT [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;)*

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

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

☒ ESU NO: A
GROUND PAD: BRAND 3M (b)(6)-2
LOT NO: 1999[redacted]

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES D... MEDCOM - 20719 ...ICH IS OBSOLETE. USAPA V1.01

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION X ☐ YES ☐ NO, TYPE(S): NSS

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM YES — NO X 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) ABD 4X8 Xeroform 4X8 Coban Ace 5.1k tape

17. TUBES, DRAINS, PACKING YES X NO ☐

	1.	2.	3.
TYPE SIZE	16 F Foley	J/P 10mm	J/P 10mm
SITE	bladder	(L) knee	(R) calf

19. ADDITIONAL INFORMATION

WC II

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

75cc out from Abd J/P

- Bone pad site clear

20. OPERATION(S) PERFORMED

Ex Lap, (L) knee Arthrotomy

postop.

21. PATIENT TRANSFERRED TO PACU TIME METHOD litter

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

REVERSE OF DA FORM 5179-1, OCT 87 MEDCOM - 20720 USAPA V1.01

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY
POST- DAY
MONTH-YEAR DAY
19 HOUR

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

BLOOD PRESSURE

HEIGHT: | WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

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

(6)(6)-4

(b)(6)-4

PACU

(b)(2)-2

[redacted] VENTILATOR FLOW SHEET

1740 ↓

8 SET 22@teeth

DATE	TIME	MODE	RATE	VOLUME	FI02	PEEP	PIP	PT RATE	HR	SO2	BP	Ph	Pco2	Po2	BE	HCO3	SaO2	REMARKS
28 Sep	0010	SIMV	16	600	100	12	30	22	91	94	153/77	7.27	42	86	-8	19	95	[redacted] (R) main stem VS ARDS
	0230	SIMV	18	600	55	12	36	18	104	100	127/72	7.35	39	122	-4	21	98	
	0430	SIMV	18	600	40	12	35	18	118	100	124/66							
	0540	SIMV	18	600	40	12	36	18	115	100	126/62	7.35	37	133	-4	21	99	
	0800	SIMV	18	600	40	10	30	18	122	100	134/69							
	1000	SIMV	18	600	40	10	31	18	119	100	124/69							
	1200	SIMV	18	600	40	10	33	18	118	100	130/68							
	1400	SIMV	18	600	40	10	29	14	112	100	125/67	7.37	36	159	-2	22	99	
	1810	SIMV	14	600	40	8	26	14	120	100	98/51							014
	2000	SIMV	14	600	40	8	30	15	121	99	119/60							011
	2221	SIMV	14	600	40	8	25	14	119	100	112/64							011
29 Sep	0100	SIMV	14	600	40	8	29	14	114	100	123/63							[redacted]
	0400	SIMV	14	600	40	6	28	14	109	100	118/54							
	0510	SIMV	14	600	35	6	28	14	109	100	126/53							
	0800	SIMV	14	600	35	6	25	14	95	100	116/62							
	1000	SIMV	10	600	35	6	23	10	96	100	118/63							
	1546	SIMV	10	600	35	6	29	10	90	100	125/70							
	1900	SIMV	10	600	35	5	25	12	114	97	146/92							
	2217	SIMV	10	600	40	6	24	10	114	100	124/69							3
	2350	SIMV	16	600	40	6	24	12	107	99	131/66							
	0200	SIMV	16	600	40	6	26	12	104	100	125/75							
	0415	SIMV	16	600	35	6	29	13	107	99	126/74							
	0540	SIMV	16	600	35	6	23	14	108	98	126/76							- rolling, pt eyes open
	0800	SIMV	16	600	35	6	24	20	121	100								
	0900		EXT.															

(b)(6)-2 all

MEDCOM - 20722

DOD-034296

ACLU-RDI 1658 p.82

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY: 8 Oct

19 | HOUR: 0830

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	O	
60		
50	A	
40		

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD: 116/60

BLOOD PRESSURE: P 72

T 97.7

SpO2 97

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 - 20723

(b)(6)-4

[redacted]

			09:16
		Patient Limits	
WBC	5.0	4.5	10.5
RBC	3.99 L	4.00	[illegible]
Hgb	[illegible] L	11.0	18.0
Hct	32.6 L	35.0	[illegible]
MCV	84.1	[illegible]	99.9
MCH	26.7 L	[illegible]	31.0
MCHC	31.7 L	[illegible]	37.0
Plt	196.	150.	[illegible]
LY%	15.4	[illegible]	51.1
LY#	0.8	[illegible]	[illegible]

(b)(6)-4

[redacted]

			28-09-03
			05:35
		Patient Limits	
WBC	[illegible] L	[illegible]	10.5
RBC	4.47	4.00	6.00
Hgb	11.9	11.0	18.0
Hct	37.6	35.0	[illegible]
MCV	84.1	80.0	99.9
MCH	26.7 L	27.0	31.0
MCHC	31.7 L	33.0	37.0
Plt	225.	150.	450.
LY%	17.6	20.5	51.1
LY#	0.7	[illegible]	[illegible]

[redacted] (b)(6)-4

ICU 3

PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

DATE 28 Sep

URGENCY: ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT ☒

PATIENT STATUS: BED ☒ OUTPATIENT ☐ AMB ☐ NP ☐ DOM ☐

SPECIMEN SOURCE (Specify) Blood

LAB ID NO.

SPECIMEN/LAB RPT. NO.

PATIENT'S MED. RECORD

MISCELLANEOUS
STANDARD FORM 557 (Rev. 3-77)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45-505

557-107

Rqu 28Sep03

3

TECH 25 Sep 03

[redacted] (b)(6)-4

[redacted] (b)(6)-4

TEST | SPECIMEN | DATE | REQUEST | RESULTS

Ser# [redacted] (b)(6)-4
Ver: JAM5046A
CLEW A93

14 Vials

[redacted] (b)(6)-4

_____118 mg/dL
_____6 mg/dL
_____137 mmol/L
_____3.6 mmol/L
_____105 mmol/L
_____23 mmol/L
_____14 mmol/L
_____37 %PCV
_____13 g/dL

_____7.291
_____44.7 mmHg
_____22 mmol/L
_____-5 mmol/L

Sample Type_: ART
_____: 98.1

30SEP03 01:42

Physician:_____

Ser# JAM5046A
CLEW A93

i-STAT G3+

P# 0
P ame:_____

TCO2_____25 mmol/L

At 37C
PH_____7.406
PCO2_____38.6 mmHg
_____57 mmHg
HCO3_____24 mmol/L
BEecf_____-1 mmol/L
sO2*_____89 %
*calculated

At Patient Temp
PH_____7.374
P _____42.3 mmHg
PO2_____66 mmHg

Patient Temp: 102.4F
FIO2_____: 21
ample Type_:

30SEP03 09:54

Oper: 0

Physician:_____

Ser# [redacted] (b)(6)-4
Ver: JAM5046A
CLEW A93

Ser# JAM5046A
CLEW A93

3540
K-10
Calculated

At Patient Temp
PH_____7.360
PCO2_____47.8 mmHg
PO2_____101 mmHg

Test Temp: 98.6F
FIO2_____: 85
Sample Type_: ART

30SEP03 04:56

Physician: [redacted] (b)(6)-4

Ver: JAM5046A
CLEW A93

======= PICCOLO =======
29/09/03 04:34
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
BASIC METABOLIC
DISC LOT #: (b)(6)-2 3203AA4
OPER # [redacted] DR #: 000
SERIAL #: (b)(6)-4 [redacted]

GLU	99	73-118	MG/DL
BUN	10	7-22	MG/DL
CA++	7.8*	8.0-10.3	MG/DL
CRE	0.7	0.6-1.2	MG/DL
NA+	~~134~~* 134	128-145	MMOL/L
K+	4.1	3.3-4.7	MMOL/L
CL-	102	98-108	MMOL/L
tCO2	26	18-33	MMOL/L

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

Chem 7

REMARKS
Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REQUESTING PHYSICIAN'S SIGNATURE [redacted] (b)(6)-2
REPORTED BY
MD DATE 29 Sep 03
TECH
LAB ID NO.
☐ PRE-OP
STAT ☒
SPECIMEN (Specify)
[redacted] (b)(6)-4
1W3

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/30/03 05:02 AM
Patient ID [redacted] (b)(6)-4
Test Name :PT
Test Result:- 13.5 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.1
Calculated INR = 1.18
Sample Type:Citrated wh. blood
Test Date :09/30/03
Test Time :05:01 AM
Card Lot :040302
Operator : MCCARTER

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/30/03 05:07 AM
Patient ID [redacted] (b)(6)-4
Test Name :APTT
Test Result:- 42.7 sec.
RESULT NOT RANGE CHECKED
Sample Type:Citrated wh. blood
Test Date :09/30/03
Test Time :05:03 AM
Card Lot :100208
Operator : MCCARTER

0121 ... 1412

MISC
URGENCY
☐ ROUTINE
PATIENT STATUS
☒ BED
☐ AMB
SPECIMEN/LAB RPT. NO.
COPY

[redacted]
(b)(6)-4
1W3

MISC
URGENCY
☐ ROUTINE
TODAY ☐
☐ PRE-OP
STAT ☒
PATIENT STATUS
☒ BED ☐ AMB
OUTPATIENT ☐
☐ NP ☐ DOM
SPECIMEN SOURCE (Specify)
SPECIMEN/LAB RPT. NO.
PATIENT'S MED. RECORD

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REQUESTING PHYSICIAN'S SIGNATURE | REPORTED BY | MD | DATE 29 Sep 03 | LAB ID NO.

557-107
MISCELLANEOUS
STANDARD FORM 557 (Rev. 3-77)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45-505

Ward/Section:	REQUESTING PHYSICIAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI.	DATE	TIME G3+

i-STAT | (Piccolo) Che[redacted] (b)(6)-4

TEST(S)

TEST(S)

SPECIMEN TAKEN

DATE: 27SEP03 TIME: 1605 A.M. P.M.

RESULTS	REQUESTED	(X)
	RBC COUNT	
1[illegible]	HEMOGLOBIN	
1	HEMATOCRIT	
	MCV	
	MCH	
	MCHC	
3.6 x10³	WBC COUNT	
30	WBC DIFF AND BLOOD CELL MORPH: IMMATURE	
47	NEUTRO-BANDS	
19	NEUTROSEGS	
	LYMPHS	
4	EOSINOPHILS	
	BASOPHILS	
Normocytic	MONOCYTES	
	PLATELETS	
	RBC	
	SED. RATE	
	PLATELET COUNT	
	RETICULOCYTE COUNT	
	CLOTTING TIME	
	BLEEDING TIME	
	PTT CONTROL	
	PTT PATIENT	
	PROTIME CONTROL	
	PROTIME PATIENT	
	PROTIME % ACTIVITY	
	PROTIME RATIO	
	SICKLING TEST	
	LE PREP	

LAB ID NO.

HEMATOLOGY
STANDARD FORM 549 (Rev. 7-78)
General Services Administration and Interagency
FIRMR (41 CFR) 201-45.505

[redacted] (b)(6)-4

WBC	3.9 L	x10³/uL	4.5 11.0
RBC	4.60	x10⁶/uL	4.00 6.00
Hgb	12.9	g/dL	11.0 16.0
Hct	40.8	%	35.0 60.0
MCV	84.9	fL	80.0 99.0
MCH	26.7 L	pg	27.0 31.0
MCHC	31.4 L	g/dL	33.0 37.0
Plt	252.	x10³/uL	150. 450.
LYM	20.6 *	%	20.6 51.1
LY#	0.8 *	x10³/uL	1.2 3.4

MISCELLANEOUS
STANDARD FORM 557 (Rev. 3-77)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45-505
557-107

Name:_____

TCO2_____25 mmol

At 37C

PH_____7.351

PCO2_____43.6 mmHg

PO2_____184 mmHg

HCO_____24 mmol

BEecf_____-1 mmol

sO2*_____100 %

*calculated

At Patient Temp

PH_____7.332

PCO2_____46.2 mmHg

PO2_____192 mmHg

Patient Temp: 101.0F

FIO2_____: 35

Sample Type_: ART

27SEP03 08:39

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

Physician:_____

Ser# 42015

Ver: JAM5046A
CLEW A93

i-STAT EC8+

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

Pt Name:_____

Glu_____106 mg/dL

BUN_____5 mg/dL

Na_____134 mmol/L

K_____3.5 mmol/L

Cl_____102 mmol/L

TCO2_____28 mmol/L

AnGap_____9 mmol/L

Hct_____33 %PCV

Hb*_____11 g/dL

*via Hct

pH_____7.371

PCO2_____45.1 mmHg

HCO3_____26 mmol/L

BEecf_____1 mmol/L

Sample Type_:

30SEP03 04:50

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

Physician:_____

Ser# 42015

Ver: JAM5046A
CLEW A93

						Cl^-	98-108 mmol/l
						tCO_2	18-33 mmol/l

REMARKS:

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

Ward/Section: ICU #3

REQUESTING PHYSICIAN: [redacted] (b)(6)-2

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

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

DATE: 01OCT03 TIME: 0600

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

CBC			Urinalysis			Misc. Serology		
REF. RANGE	TEST	RESULT	REF RANGE	TEST	RESULT	REF RANGE		

(b)(6)-4

[redacted] 01-10-03 04:06

			Patient Limits	
WBC	6.5	x10^3/uL	4.5	10.5
RBC	3.62 L	x10^6/uL	4.00	6.00
Hgb	9.6 L	g/dL	11.0	18.0
Hct	30.1 L	%	35.0	60.0
MCV	83.2	fL	80.0	99.9
MCH	26.6 L	pg	27.0	31.0
MCHC	32.0 L	g/dL	33.0	37.0
Plt	291	x10^3/uL	150.	450.
LYM	13.5 #L	%	20.5	51.1
LYM	0.9 #L	x10^3/uL	1.2	3.4

DATE

i-STAT G3+

[redacted] (b)(6)-4

Pt Name:_____

TCO2_____25 mmol/L

At 37C

pH_____7.446

PCO2_____34.1 mmHg

PO2_____161 mmHg

HCO3_____24 mmol/L

BEecf_____-1 mmol/L

sO2*_____100 %

*calculated

Sample Type_:

29SEP03 04:51

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

Physician:_____

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

Ver: JAMS046A
CLEW A93

---

i-STAT CREA

[redacted] (b)(6)-4

Pt Name:_____

Crea_____0.9 mg/dL

Sample Type_:

30SEP03 04:51

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

Physician:_____

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

Ver: JAMS046A
CLEW A93

[redacted] (b)(6)-4

[redacted] (b)(6)-4

DATE 30 Sep 03

MISC URGENCY: ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT ☒

PATIENT STATUS: BED ☐ OUTPATIENT ☐ AMB ☐ DOM ☐ NP ☐

SPECIMEN SOURCE (Specify): blood

SPECIMEN/LAB RPT. NO.: 07

LAB ID NO.:

PATIENT'S MED. RECORD

LABORATORY FILE

TEST	RESULT				
Spun Hematocrit					
Sed Rate					
Other					
Coagulation					
PT					
APTT		21-34 secs			
D dimer		<20 ug/ml			
FDP		<10 ug/ml			

REMARKS:

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

TEST(S)
SPECIMEN TAKEN
DATE 010103 TIME 0400 A.M. P.M.
REQUESTED
Chem 7
& LFT
RESULTS

REMARKS [redacted]

Enter in above space REQUESTING PHYSICIAN'S SIGNATURE [redacted] (b)(6)-2

PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REPORTED BY TECH MD DATE

LAB ID NO.

SPECIMEN SOURCE (Specify) NP OUTPATIENT BED

PATIENT STATUS

TODAY ROUTINE EMERGENCY

PRE-OP STAT

MISC

SPECIMEN/LAB RPT. NO.

======= PICCOLO =======
01/10/03 05:29
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	2.1*	3.3-5.5	G/DL
ALP	114*	26-84	U/L
ALT	♦♦♦	10-47	U/L
AMY	228*	14-97	U/L
AST	71*	11-38	U/L
TBIL	0.8	0.2-1.6	MG/DL
GGT	27	5-65	U/L
TP	5.2*	6.4-8.1	G/DL

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

======= F ... 0 ===
10/01/03 05:12 AM
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: (b)(6)-2 3152AA1
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]
.....(b)(6)-4.....

GLU	132*	73-118	MG/DL
BUN	♦♦♦	7-22	MG/DL
CRE	0.9	0.6-1.2	MG/DL
CK	2141*	39-380	U/L
NA+	[redacted]*[13]	128-145	MMOL
K+	3.9	3.3-4.7	MMOL
CL-	97*	98-108	MMOL
tCO2	23	18-33	MMOL

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

PREVIOUS EDITION USABLE

PATIENT

(b)(6)-4
[redacted] /1103

SPECIMEN/LAB RPT. NO.

URG ROUTINE TODAY PRE-OP STAT

PATIENT STATUS BED AMB OUTPATIENT NP DOM

SPECIMEN SOURCE (Specify)

PATIENT'S MED. RECORD

Enter in above space PATIENT IDENTIFICATION

======= PICCOLO =======
09/28/03 06:05 AM
REFERENCE RANGE: MALE
PATIENT #: (b)(6)-4
BASIC METABOLIC
DISC LOT #: (b)(6)-2 3203AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]
.....(b)(6)-4.....

GLU	104	73-118	MG/DL
BUN	♦♦♦	7-22	MG/DL
CA++	7.7*	8.0-10.3	MG/DL
CRE	0.6	0.6-1.2	MG/DL
NA+	~~121*~~	128-145	MMOL
K+	4.2	3.3-4.7	MMOL
CL-	104	98-108	MMOL
tCO2	21	18-33	MMOL

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

*U.S. GPO: 1982-312-063/60027

Prescribed by GSA/ICMR FIRMR (41 CFR) 201-45.505

MEDCOM - 20729

IBN-SINA HOSPITAL
[redacted] (b)(2)-2
Baghdad, Iraq

Microbiology Request Form

Last Name: IRAQI
First Name:
Patient # or SSN: [redacted] (b)(6)-4
Collected by:
Date: 28 Sep 03
Time: 0110

Ward: ICU3
Room:
Bed:
Physician: [redacted] (b)(6)-2
Source: Sputum
Site:

[redacted]

Received by: SGT [redacted] (b)(6)-2
Date:
Time:

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

Laboratory Results

Alpha hemolytic Streptococcus, Not group pneumoniae
Streptococcus sanguis

Reported
Date: 10-2-03
Time: 1230
Tech: SP
Reviewer: [redacted] (b)(6)-2

Number of attached sheets:

Microbiology Report

IBN SINA - HOSPITAL Laboratory

Name:	Specimen [redacted] (b)(6)-4	Status: **Final**
Patient ID [redacted] (b)(6)-4	Source: Sputum	Collected:
Ward/Rm: U3/	Ward of Iso:	Attd. Phys:

1 Streptococcus sanguis Status: Final

1 **S. sanguis**

Drug	MIC	Interps	Drug	MIC	Interps

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:	Specim [redacted] (b)(6)-4	Status: **Final**
Patient ID [redacted] (b)(6)-4	Source: Sputum	Collected: (b)(6)-2
Ward/Rm: U3/	Ward of Iso:	Req. Phys [redacted]

Printed 10/2/2003 9:56:36 AM

MEDCOM - 20731

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

MEDIC RECORD — ANESTHESIA

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

DRUG (Units)		TOTALS
FENTANYL (mcg)	100 <150> 100 50 <100>	500
STP (mg)	250	250
SUX (mg)	60	60
VEC (mg)	5 2 2 1 2	12
MSO4 (mg)	<5> 2	7
VOLAT AGENT (150) % del / % e.t.		
AIR L/Min	1.0 1.0 1.0 1.0 1.0 1.0 1.0 1.0 1.0 1.0	
N2O L/Min		
O2 L/Min	5 2 2 2 2 2 2 2 2 2 2 2	

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

TOTAL EBL: 200

TOTAL URINE: 500

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

FLUIDS — LINE site 18G x 2; Warmed
2L — HESPAN <500> — 3L — 4L — (4.5)

LOSSES — EST BLOOD LOSS: 100 — 200
URINE – 100 — 150 — 350 — 500

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

TIME: (17)00 15 30 45 (18) 15 30 45 (19) 15 30 45 (20) 15 30 45 (21)

BODY WEIGHT: 60 (KG) LB

HEMATOCRIT: 45

INITIAL DATA: BP – 122/61; HR – 106

EQUIP CHECK: OK?– (Y) N

PATIENT RECHECK: (OK) for PROCEDURE? Y; TIME 1700

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

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

Grid annotations: Pref; 120 100 80 60 40; Sat 99 100 100 99

REMARKS– Code drugs with numbers, events with letters
① Preop / Lab / VSS.
② Room / Monitors / O2
I/I as below.
③ [redacted] relieves for dinner.
④ Pass Role

PACU. initially O2 Sat 99% then ↓ to < 90%. bagged and ambu. O2 100% NRB → partial Sat → 85-90% Sat. — CXR — ABG

VENTIL												
VT – ml	UPAC →											
f – breaths/min	12	8	8	8	8	8	8	10	8	18	16	17
Peak inf pres / PEEP	UPAC →											
MODE– S(pon), A(ssist), C(on)	S A S C	C →	C		C	— A	S S S	S — S				

MONITORS / ACCESSORIES													
BP/Auto Cuff	ET CO2 (torr)	—	38	36	35	35	34	36	37	36	48	50	46
BP / oth	FIO2 (Frac or %)	.77	.71	.72	.74	.72	.71	.71	.72	.72	.68	.72	.71
ART line	SpO2 (%)	100	100	100	100	100	100	100	100	100	100	100	90
Steth– PC/ES	ECG	ST	ST	ST	ST	ST	ST	SR	SR	SR	SR	SR	SR
Gas analyzer	TEMP– site (R)	—	38.9	38.5	38.2	—	38.2	—	37	37.1	—	36.9	
	N-M Block (T/4)	4/4	4/4	x/4	3/4	1/4	x/2		2/4	4/4 X			
									25 ST				
Warming blkt	X upper blkt →												
Conv warmer													

Mark with letters & symbols, explain under REMARKS — EVENTS ① ② → ③ ④; Position — 0 →

RECOVERY AT: PACU ICU [redacted] (specify); OTHER
CONDITION: (b)(2)-2
RESP– SpO2–
BP– HR–

ANESTHESIA / PROCEDURE TIME

	Start	Room	End
ANES	1630	1700	

	Ready	Begin	End
PROC	1705	1720	2100

PROCEDURES and CPT Codes
EX LAP

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
UPAC / SCCS / GETA / RSI c cricoid / NGT Foley / IV x 2

AIRWAY MANAGEMENT: intubation route, blade, technique, comments
OETT 7.5 Mac 3 Grade 1 Cricoid / BBS. Taped 22 teeth.

PATIENT IDENTIFICATION– Typed or written entries: Name, Grade/Rate, Medical facility
17 y/o IRAQI ♂ NKDA
[redacted] (b)(6)-4

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

PROCEDURE LOCATION: FST
DATE: 27 SEP 03
PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA
WAMC OP 376 REVISED
1 Jan 9

MEDCOM - 20732

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

CLINICAL RECORD - DOCTOR'S ORDE
F ...f this form, see AR 40-66, the proponent age... ...TSG

THE DOCTOR SHALL RECORD DATE, ...ME 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 28 SEP TIME OF ORDER 2230 HOURS

LIST TIME ORDER NOTED AND SIGN

↓ PEEP to 8

Maintain sat ≥ 90%

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

2yo Clin FU [redacted]

PATIENT IDENTIFICATION

(b)(6)-4

[redacted]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER 29 Sep TIME OF ORDER 0700 HOURS

1. ↓ IMV to 10
2. ↓ PEEP to 5
3. portable CXR this am [redacted]

(b)(6)-2 [redacted]

Offered [redacted]

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER 2100 HOURS

1. Tylenol 650 mg PR or per NG q 4 prn temp >101
2. ↑ IV to 100 cc/h
3. Heparin 4000 wt SQ q 12 h
4. PT, PTT i am labs

(b)(6)-2 [redacted]

PATIENT IDENTIFICATION

(b)(6)-4

[redacted]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER 30 Sep TIME OF ORDER HOURS

1. CBC LFT's lytes am 10 cx
2. portable CXR am 10 cx
3. DC abd drsg - dsn
4. DC (L) radial A line done @ 1415
5. OOB ad lib
6. MS 2-4 mg IV q 1-2 h prn pain
7. DBC [redacted]

(b)(6)-2 [redacted]

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH M...

☆ U.S. GOVERNM...

(b)(6)-2 [redacted]

[redacted]

MEDCOM - 20733

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
28 Sep 0100	HOURS	
Admit to ICU		
Cond fair		(b)(6)-2
Diet - NPO ✓		[redacted]
Act - turn q 2h		
VS - q 1h ; include CVP		
Dx - Colon inj ARDS		
IV LR at 100 cc/h ✓		

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	
Unasyn 3 gm IVPB q 6h ✓	HOURS	
MS drip 2-5 mg/h ✓		
Versed drip 2-5 mg/h ✓		
ranitidine 50 mg IVPB q 8h ✓		
NG to LS continuous suction ✓		
Foley to gravity drain ✓		
Central line -		
portable CXR done - report 0400 ✓		

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	
	HOURS	
CBC 'lyte ABG 0400 ✓		
A line		
100% FiO_2 PEEP 12 IMV 16		IV 800
wean FiO_2, maintain sat > 90%		
ABG at 0200 ✓		(b)(6)-2 [redacted]
24° chest tube		

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	
28 Sep 0600	HOURS	
(1) ↓ PEEP to 10		
(2) Δ IV to D_5 - ½ NS 1000 cc ... KCl		[redacted]
at 75 cc/hr		(b)(6)-2
[redacted]		

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHI[redacted] E USED. (b)(6)-2

MEDCOM - 20734

CLINICAL RECORD - DOCTOR'S ORDE

f this form, see AR 40-66, the proponent ager ,TSG

THE DOCTOR SHALL RECORD DATE 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

6/12-18-24

(b)(6)-2

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
30 ~~Oct~~ Sep 03	2100 HOURS	
1. Dc IVPB Zantac (due to out of stock in Pharmacy)		
2. IVPB [redacted] (b)(6)-2		(b)(6)-2
V.O. Dr. [redacted]		MAJ [redacted] CPT (AN
Noted Sat [redacted] 9/[redacted] (b)(6)-2		

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.
1W3		

DATE OF ORDER TIME OF ORDER _____ HOURS

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.
1W3		

DATE OF ORDER TIME OF ORDER _____ HOURS

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

[redacted] (b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER _____ HOURS

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 1994 – 563-710

MEDCOM - 20735

NICAL RECORD - DOCTOR'S ORDER

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]

C1

NURSING UNIT	ROOM NO.	BED NO.
ICW2	10	A

DATE OF ORDER 1 Oct TIME OF ORDER 0800 HOURS

DC NG done

DC foley done

OOB chair done @1310 [redacted]

(b)(6)-2

[redacted] (b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-4

[redacted]

C1

NURSING UNIT	ROOM NO.	BED NO.
ICW2	10	A

DATE OF ORDER 2 Oct TIME 0700 HOURS

(1) Change dressing (R) flank (L) thigh + (L) knee qd xeroform on (L) th

(2) DC Zantac

(3) full liq diet

[redacted] (b)(6)-2

(b)(6)-2

0915

PATIENT IDENTIFICATION

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

[redacted] (b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICW2	10	A

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER ______ HOURS

[redacted] (b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

LIST TIME ORDER NOTED AND SIGN

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

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

ICAL RECORD - DOCTOR'S ORDERS

For use s form, see AR 40-66, the proponent agency is SG

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

CT

NURSING UNIT | ROOM NO. | BED NO.

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

20 Oct 0130 _____ HOURS

Transfer to ward late this am

Cont stable

Diet - clear liq

Act - ambulate BID

VS q shift

Dx - L sided colon repair

IV D½NS 1000 cc @ 20 meq KCl at 75 cc/h

DC Urocyn

Heparin 4000 u SQ q 12h

Acetaminophen ☓ gr ii PO q 4 prn pain or temp > 101

[redacted] (b)(6)-2

PATIENT IDENTIFICATION

[redacted] (b)(6)-2

CT

[redacted] (b)(6)-4

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.

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

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MEDCOM - 20737

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

EPW [redacted]

(b)(6)-4

30 Oct 03 0530 W/AN

(b)(6)-2 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

24 V | 30 Oct 03 1900 [redacted] W/AN

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

30 Oct 03 | 0530 | HOURS

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

ADVANCE Diet as tolerated

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

(b)(6)-2 [redacted]

(b)(6)-2 [redacted]

PATIENT IDENTIFICATION

40ct03 0530 W/AN

(b)(6)-2 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

24 V [redacted]

DATE OF ORDER | TIME OF ORDER

40ct 0430 | HOURS

Q pack abd wound q 8h c NS soaked gauze &

(2) DC IV + IV ABs

(b)(6)-2 [redacted]

(b)(6)-2

EN 10/5/03 0205

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

24 V [redacted]

DATE OF ORDER | TIME OF ORDER

7Oct 0900 | HOURS

Remove staple (L) hip

Dress hip wounds Qd c NS gauze

Continue midline dressing change q8h

(b)(6)-2 [redacted]

EN 10/5/03 0400

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2 | HOURS

NURSING UNIT | ROOM NO. | BED NO.

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

MEDCOM - 20738

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
[redacted] (b)(6)-4 Noted with [redacted] (b)(6)-2	8 Oct	1200 HOURS	
NURSING UNIT: R[redacted] 2300 ROOM NO.: 703 BED NO.: 2	Transfer pt to Iraqui Hosp Summary done No meds [redacted] (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 1 APR 79 **4256** REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 20739

ADL's

CLINICAL RECORD | THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.
Mo. ___ Yr. 2003

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 27	28	29	30
(b)(6)-2 27 Sep	[redacted]	Dx S/P Ex-lap Bowel Resec	08	/			
			16	/			
			24				
(b)(6)-2 27 Sep	[redacted]	Cond: Stable	08	/			
			16	/			
			24				
(b)(6)-2 27 Sep	[redacted]	V.S q 4°	08	/			
			16	/			
			24				
(b)(6)-2 27 Sep	[redacted]	All: NKDA	08	/			
			16	/			
			24				
(b)(6)-2 27 Sep	[redacted]	I & O	08	/			
			16	/			
			24				
(b)(6)-2 27 Sep	[redacted]	Foley to gravity	08	/			
			16	/			
			24				
(b)(6)-2 27 Sep	[redacted]	SP to Bulb Sx	08	/			
			16	/			
			24				
(b)(6)-2 27 Sep	[redacted]	NG → LCWS	08	/			
			16	/			
			24				
(b)(6)-2 27 Sep	[redacted]	Diet NPO	08	/			
			16	/			
			24				

ALLERGIES: ☐ YES ☑ NO

PRIMARY DIAGNOSIS: S/P: Ex lap / resection

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

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

17/1/05

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 - 20740

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo ____ Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
(b)(6)-2 27 Sep	[redacted]	Admit to post-op	27 Sep	/	2110	[redacted] (b)(6)-2
(b)(6)-2 28 Sep	[redacted]	CBC, chem 7 in am	28 Sep		0800	

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED
(b)(6)-2 27 Sep	[redacted]	Call MD T > 38.5	
		HR > 100 < 60, RR < 10 > 30	
		SBP > 160 < 100, UOP < 30/hr	

USAPA V1.00

(NON-MEDICATION)

Mo _____ Yr 2003

Initialing: Order Date	Initialing: Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
[redacted]	[redacted]	IV [illegible] IV (b)(6)-2			0713	[redacted] (b)(6)-2

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. 10 Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 01 02 03 4 5 6 7 8 9 10
		Δ's see below		
20 Oct	[redacted]	~~Diet: clear liquids~~	D6	/ [redacted]
2	[redacted]	full liquid diet	12	/ [redacted] D/C'd
			17	/ [redacted] /
20 Oct	[redacted]	Activity: amb BID	08	/ [redacted]
			20	/ [redacted]
20 Oct	[redacted]	VS q shift	D	/ [redacted]
			E	/ / / / / / / / / / /
			N	[redacted]
2	[redacted]	change dressings c—	10	/ [redacted]
		(R) flank, (L) thigh, (L)		
		knee QD		
		xeroform on (L) thigh		
20 OCT 03	[redacted]	NIO: CL DSG Δ	20	X [redacted] / / / / / / / / / / /
		Q 3 Days		D/C'd 4 Oct 03
3 Oct 03	[redacted]	Advance diet as	06	X X [redacted]
		tolerated	18	X X [redacted]
4 Oct 03	[redacted]	Pack abd wound q8h	06	X X [redacted]
		c NS soaked gauze	14	X X X [redacted]
			22	X X X [redacted]

7-9(a)

ALLERGIES: ☐ YES ☐ NO — NKDA

PRIMARY DIAGNOSIS: ~~Oswald~~ Colon repair, multiple shrapnel wounds

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

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

MEDCOM - 20743

Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo 10 Yr 2003

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
(b)(6)-2 20ct	[redacted]	Transfer to ward later this am - Stable	20ct		0230	[redacted] (b)(6)-2
(b)(6)-2 20ct03	[redacted]	Transfer pt to Iraq. hosp. Summerone No meds				

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

CLINICAL RECORD

...ERAPEUTIC 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 27	28	29	30
(b)(6)-2 27 Sep	[redacted]	LR @ 120 cc/hr	08	/			
			16	/			
			24				
(b)(6)-2 27 Sep	[redacted]	Unasyn 3gm EV q 6°	06	/			
			12	/			
			18	/			
			24	/			

ALLERGIES: ☐ YES ☑ NO

PRIMARY DIAGNOSIS: S/P: Ex lap / Resection

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ___

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

17 y/o ♂

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

MEDCOM - 20745

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
27 Sep	[redacted]	Unasyn 3gm I.V q 6° 1st dose now	27Sep03	2052		[redacted]
						(b)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
27Sep	[redacted]	Phenergan 25mg IVD q 6° PRN N/V A	
		T	
27Sep	[redacted]	MSO4 2-4mg IV q 2-4° D PRN pain A	
		T	

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. Sept Yr. 03

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 28 29 30 1 2 3 4 5 6 7 8 9 10 11
(b)(6)-2 28 Sep	[redacted]	IVF: ~~LR @ 125 ml/hr~~	06	[redacted]
	-----	D5 1/2 NS 1000cc + 20 KCl	18	
(b)(6)-2	[redacted]	Unasyn 3gm IV	06	
	-----	q 6°	12	
	-----		18	
	-----		24	
(b)(6)-2	[redacted]	~~NS 50cc~~ dup 2-5mg/hr	06	
	-----		18	
(b)(6)-2	[redacted]	Versed 2-5mg/hr	06	
	-----		18	
(b)(6)-2	[redacted]	Ranitidine 50mg	08	
	-----	IVPB q 8°	14	
	-----		22	
(b)(6)-2 29 Sep	[redacted]	Heparin 4000 units SQ	10	/ /
	-----	q 12	22	/
(b)(6)-2 30 Sep	[redacted]	Tygamecut 300mg	06	
	-----	Q 6 hrs	12	
	-----		18	
	-----		24	

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Colon schrapnel injury / ARDS

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

D 7 8 9 10 11 12 13 14

E 15 16 17 18 19 20 21 22

N 23 24 01 02 03 04 05 06

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

MEDCOM - 20747

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Verify by Initialing

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 30 Sep	[redacted]	MS 2-4mg IV Q1-2 prn pain	30 Sep 2100 [redacted]	01 Oct 0700	03 Oct 0100	0430	2330 4mg IV [redacted]										(b)(6)-2
(b)(6)-2 30 Sep	[redacted]	Tylenol 650mg PR or per NG Q4 prn Temp >101	30 Sep 2200 1g [redacted]	01 Oct 0330 1g													(b)(6)-2

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

MEDCOM - 20748

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, 9 10 02 03 04 5 6 7 8 9 10
(b)(6)-2 02 Oct	[redacted]	IV D5 1/2 NS @ 20 mEq KCL @ 75 cc/hr	D	[redacted]
			E	
			N	[redacted]
(b)(6)-2 02 Oct	[redacted]	Heparin 4000 u SQ q 12°	08	[redacted]
			20	[redacted]

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
S/P Osmond Colon repair

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

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

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

DA FORM 4678, 1 FEB 79 MEDCOM - 20749 ED UNTIL EXHAUSTED. USAPA V1.00

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. Oct Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
02 Oct	[redacted]	D/C Unasyn				done
04 Oct 03	[redacted]	D/C IV and IV abx's	04 Oct 03			[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED													
02 Oct	[redacted]	Acetaminophen 1gm PO q4° prn pain or temp >101	2 Oct 1330 TSM	03 Oct 1300 TSM	5 Oct 1530 TSM 1 GM	[redacted]										

USAPA V1.00

MEDCOM - 20750

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

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

INITIAL SHIFT ASSESSMENT

	TIME	0600 INTILAS [redacted] (b)(6)-2	INTILAS
NEURO	PUPLIS	pupils 2mm	2mm, sluggish; ∅
	SENSORIUM	sluggish, sedated	responsive; pt on
		on versed @	versed/msO4 5/5mg
		[illegible]	∅ response to pain
		[illegible]	
RESPIRATORY	RESPIRATION PATTERN	[illegible]	equal and full; SaO2
	BREATH SOUNDS	orally intubated	100% on 40% FiO2
	SECRETIONS	[illegible]	vent. LCTA (B);
		[illegible]	ETT 22 cm @ teeth
		[illegible]	SX blood tinged sputum
		[illegible]	
SKIN	COLOR	[illegible]	NFR; multiple surgical
	INTEGRITY	[illegible]	sites; peppered back.
IV SITE	LOCATION	[illegible]	PIV / PIV / TLC
	CONDITION	[illegible]	(L) FA / (R) FA / (R) SC
		[illegible]	CDI / CDI / CDI
		[illegible]	
		[illegible]	
		[illegible]	
GASTRO	ABDOMEN	[illegible]	soft; (+) BS x 4 quads
	BOWEL SOUNDS	[illegible]	JP drain c s/s fluid
		[illegible]	R incision covered c
		[illegible]	bulky dsg
GU	URINE	[illegible]	FTC; yellow/clear
	COLOR/CLARITY	[illegible]	quantity > 30 cc/hr
		[illegible]	
CARDIOVASCULAR	CARDIACRHYTHM	[illegible]	ST; ∅ ectopy
		[illegible]	(+) P, QRS, T waves
		[illegible]	
		[illegible]	
		[illegible]	

LEGEND: Cr - Creatinine; FiO2 - Fraction of inspired O2; HCO3 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - PRESSURE OF ARTRIAL CO_2; PEEP - Positive end Expiratory Pressure; S/A - Fractional; SAI - Saturation; TRACH - Iracheostomy

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC ICU-3 DATE [illegible]

[redacted] *typed or written entries give: Name—Last, First, middle* [redacted] *; date; hospital or medical facility* [redacted]

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

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER *(Specify)*

☐ DIGNOSTIC STUDIES

☐ TRETMENT

DA FORM 1 MAY78 4700 Proponent Dept of Nurs

WAMC OP 375 (Redesignated) 1 APR 90 (HSXC - NU)

MEDCOM - 20751

DATE 28 Sep | DX [illegible] | HOSPITAL DAY

VITAL SIGNS / TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial line	125/76	122/64	126/76	138/70	124/65	124/62	126/68	126/61		135/68	114/68	116/64	120/63	134/65	108/61	111/62	125/61	
BP Cuff	123/64					104/54												
Temperature	38.1	38.9	38.9	38.7	38.8	38.9	38.9	39.1		38.7	39.0	37.9	37.7	37.8	38	38	37.8	
Pulse	104	112	103	114	114	116	115	126		131	124	115	114	113	114	112	111	
Respiratory Rate	21	18	18	18	18	18	18	18		18	16	18	18	18	14	14	14	
SaO2	100	100	100	100	100	100	100	100		100	100	100	100	100	100	100	100	
FiO2	90	60	55	40	40	40	40	40		40	40	40	40	40	40	40	40	
CVP	8	9	10	7	7	7	7	6		7	7	8	8	9	8	9	6	

INTAKE / TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
~~LR~~ D5½ 20K	100	100	100	100	100	100	100	700	800	75	75	75	75	75	75	75	75	800
Versed	5	5	5	5	5	5	5	5	40	5	5	5	5	5	5	5	5	40
MSO4	3	3	3	3	3	3	3	3	24	3	3	3	3	3	3	3	3	24
IV Abx		50 (Zantac)					100 (Unasyn)		150	50						50		100
TOTALS			(skip)						1014									968

OUTPUT		24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
URINE	HOUR / TOTAL	300/300	46/346	50/396	0/396	60/456	200/651	90/744	110/844	844	80	80/160	60/220	50/270	60/340	70/410	55/465	35/500	500
	SP gr																		
	S/A																		
NG	OUTPUT																		
	PH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS	JP#1	80cc		70		40		40	250		50						80		130
	JP#2	70cc		Ø		Ø					10						10		20
TOTALS																			150

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

		14	17	18	19	20	21	22	23
VITAL SIGNS	T	38.4	38.7	38.7	38.3	38.2	38.9	38.7	38.4
	A	110	121	124	114	120	123	119	112
	R	14	14	14	14	14	14	14	14
RT Sat		100	100	100	97	99	100	100	100
Flow		40	40	40	40	40	40	40	40
CVP		6	7	6	5	5	4	4	6

		14	17	18	19	20	21	22	23	8°T
INTAKE	I	75	75	75	75	75	75	75	75	88
		5	5	5	5	5	5	5	5	40
	N	3	3	3	5	5	6	6	6	37
										165
OUTPUT	O	110	110	100	100	120	200	100	30	760
			160	280	350	420	620	680	710	
			40						50	90
	T									800

RESPIRATORY		TIME	340	620	0820	1200	1630	1800
		MODE	SIMV	SIMV	SIMV	SIMV		SIMV
		F_iO_2	80	60	40	40	40	40
		TV	600	600	600	600	600	600
		RATE	16	18	18	18	14	14
		PEEP	12	12	12	10	8	8
ARTERIAL BLOOD GAS	A	pH	7.29	7.35	7.35	7.4	7.38	7.38
	A	PCO_2	44.7	39.2	37.7	31.6	37.8	
	B	pO_2	*	122	133	77	164	
	B	HCO_3	22	21	21	21	22	
	G	SAT	100	98	99	95	99	
	G	BASE	-5	-4	-4	-3	-2	

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

ACTIVITIES DAILY LIVING	TIME				TURN	TIME			
	MOUTH CARE								
	BATCH								
	SKIN CARE								
	FOLEY CARE				SUCTION				
	TRACH CARE								
	ROM EXERCISES								

24°1800 TOTALS

NURSE'S SIGNATURE | INITIALS

[redacted] (b)(6)-2

(b)(6)-2

WT Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
Po			
TOTAL	2343	TOTAL	2347
BALANCE			0832

MEDCOM - 20753

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET (b)(6)-2 (b)(6)-2

OTSG APPROVED (Date) QA Appr 8Mar 89

INITIAL SHIFT ASSESSMENT

		TIME 0600	INT [redacted]	1900	INT [redacted]		INTILAS
NEURO	PUPLIS	2mm sluggish to		2mm sluggish;			
	SENSORIUM	light. sedated [illegible] noted. sedated on Versed @ 5mg/hr		lightly sedated on MSO4; arousable to tactile stimuli			
RESPIRATORY	RESPIRATION PATTERN	[illegible]		equal and full			
	BREATH SOUNDS	[illegible]		SaO2 99% on			
	SECRETIONS	[illegible]		35% SIMV;			
SKIN	COLOR	[illegible]					
	INTEGRITY	[illegible]					
IV SITE	LOCATION	[illegible]					
	CONDITION	[illegible]					
GASTRO	ABDOMEN	[illegible]					
	BOWEL SOUNDS	[illegible]					
GU	URINE	[illegible]					
	COLOR/CLARITY	[illegible]					
CARDIOVASCULAR	CARDIACRHYTHM	[illegible]					

LEGEND
F_IO - Fraction of inspired O_2
F_IO_2 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - PRESSURE OF ARTRIAL CO_2
PEEP - Positive end Expiratory Pressure
S/A - Fractional
SAI - Saturation
TRACH - Iracheostomy

(Continue on reverse)

PREPARED BY (S[redacted] (b)(6)-2 | DEPARTMENT/SERVICE/CLINIC ICU-3 | DATE 29 Sep 03

PATIENT'S INDICATIONS [redacted] or written entries give: Name—Last, First, middle; grade; date; ho[redacted] medical facility)

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

☐ HISTORY/PHYSICAL ☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)
☐ DIGNOSTIC STUDIES
☐ TRETMENT

DA FORM 1 MAY78 4700
Proponent Dept of Nurs

WAMC OP 375 (Redesignated)
1 APR 90 (HSXC - NU)

MEDCOM - 20754

DATE 29Sep05 | DX | HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial line	114/57	126/65	125/63	124/56	118/53	135/66	127/60	132/60		118/65	117/62	127/67	124/67	120/69	126/72	128/74	121/70	
BP Cuff																		
Temperature	38.5	38.5	38.4	38.5	38.9	38.8	38.9	37.9		35.4	37.1	37.3	37.2	37.2	37.1	37.0	37.1	
Pulse	112	110	110	106	105	114	109	112		111	94	92	91	83	89	95	90	
Respiratory Rate	15	14	14	14	14	14	14	14		10	10	10	10	10	10	10	10	
SaO2	100	100	100	100	100	100	100	100		100	100	100	100	100	100	100	100	
FIO2	40	40	35	35	35	35	35	35		35	35	35	35	35	35	35	35	
CVP	5	5	4	6	6	6	6	6		7	6	6	6	5	6	6	6	

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
D5½120K	75	75	75	75	75	75	75	75	600	75	75	75	75	75	75	75	75	600
Versed	5	5	5	5	5	5	5	5	40	5	3	2	2	1	1			13
NS04	6	6	6	6	6	6	6	6	48	6	6	6	6	6	6			33
ABX	50/100								150	50				100		50		350
TOTALS									838									996

OUTPUT

		HOUR / TOTAL	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
URINE			30/30	30/60	30/90	30/120	50/170	35/205	40/245	30/275	200	40	30/110	45/121	100/221	110/331	110/441	110/511	95/606	600
		SP gr																		
		S/A																		
NG		OUTPUT																		
		PH																		
		GUIAC																		
EMESIS																				
STOOL																				
DRAINS	JP1					20				20					30				30	
	JP2					10				10					5				5	
TOTALS										335									641	

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS

16	17	18	19	20	21	22	23	
138/84	145/73	133/68	149/91	134/60	130/67	125/71	128/77	
37.7	38.2	38.8	38.7	39.4	39.2	38.4	38.2	
92	108	102	111	119	119	114	112	
10	10	10	10	11	10	10	11	
100	100	100	97	100	98	99	98	
35/[illegible]	35/[illegible]	35/[illegible]	35	50	40	40	40	
[illegible]	5	5	5	7	6	6	4	

RESPIRATORY DATA

		TIME	0700	0730	0910
		MODE	SIMV	SIMV	
		F_IO_2	35%	35%	
		TV	600	600	
		RATE	14	10	
		PEEP	6	5	
A		pH			7.37
		PCO_2			46.2
B		pO_2			192
		HCO_3			24
G		SAT			100
		BASE			-1

LABORATORY DATA

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

INTAKE

14	17	18	19	20	21	22	23	8°T
75	75	75	75	75	75	100	105	850
				3	3	3	3	12
3	3	3	3	3	3	3	3	24
		100						
								886

OUTPUT

110	120/230	30/260	30/290	35/325	35/360	40/400	35/435	435
pulled 10								10
								1445

ACTIVITIES OF DAILY LIVING

TIME	07	11	
MOUTH CARE	[redacted]		(b)(6)-2
BATCH			
SKIN CARE			
FOLEY CARE			
TRACH CARE			
ROM EXERCISES			

TURN
SUCTION
TIME

24°180 TOTALS

WT Yesterday ______ wt Today (b)(6)-2

(b)(6)-2

INTAKE	OUTPUT
IV	Urine:
Po	
TOTAL 2610	TOTAL 1391

BALANCE +1219

NURSE'S SIGNATURE | INITIALS

[redacted]

MEDCOM - 20756

MEDICAL RECORD–SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

(b)(6)-2

OTSG APPROVED *(Date)*

QA Appr 8 Mar 89

INITIAL [redacted] ASSESSMENT

		TIME	0600	INITIALS [redacted]	1800	[redacted]	(b)(6)-2	INITIALS
NEURO	PUPILS		[illegible]		PeerLa 3 mm			
	SENSORIUM		[illegible]		ARousable to verbal			
			[illegible]		stimuli			
			[illegible]					
			[illegible]					
RESPIRATORY	RESPIRATORY PATTERN		[illegible]		Reg even			
	BREATH SOUNDS		[illegible]		CTA BIL			
	SECRETIONS		[illegible]					
			[illegible]					
			[illegible]					
			[illegible]					
SKIN	COLOR		[illegible]		Skin w/d dsg to			
	INTEGRITY				Ⓡ L abd & Ⓛ hip [illegible]			
IV SITE	LOCATION		[illegible]		Ⓡ Subclavian central line			
	CONDITION		[illegible]		[illegible] all ports			
			[illegible]		patent			
			[illegible]					
			[illegible]					
GASTRO	ABDOMEN		[illegible]		soft flat NT			
	BOWEL SOUNDS		[illegible]		⊕BS U quads L			
			[illegible]		quads hypoactive			
			[illegible]					
GU	URINE:		[illegible]		foley to gravity			
	COLOR/CLARITY		[illegible]		clr yellow			
			[illegible]					
CARDIOVASCULAR	CARDIAC RHYTHM		[illegible]		S-Tach			
			[illegible]					
			[illegible]					
			[illegible]					

LEGEND

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

(Continue on reverse)

PREPARED BY *(Si*[redacted] RN

(b)(6)-2

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: 30 Sep 0[illegible]

PATIENT'S IDENTIFIC[redacted]*ive: Name—last, first, middle; grade; da*[redacted]*medical facility)*

[redacted]

(b)(6)-4

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

DA FORM 1 MAY 78 **4700**

Proponent: Dept of Nurs

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

MEDCOM - 20757

[redacted] (b)(6)-4

diff BP

DATE 30 Sep | DX | PAGE 2 OF | HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15
BP Arterial Line			114/68														
BP Cuff	125/70	124/70	116/99		139/[illegible] 126/74	122/63 125/67	132/76	133/80		133/76	132/76	125/75	167/74	128/85	144/92	124/75	132/80
Temperature	38.1	38.1	38.4		38.5	38.3	38.3	38.[illegible]		38.[illegible]	38.[illegible]	38.[illegible]	38.9	38.9	38.9	38.9	
Pulse	100	102	105		107	101	119	189		124	127	125	114	125	120	125	119
Respiratory Rate	10	10	12		13	12	12	18		28	22	25	23	24	29	25	30
SaO2	100	100	100		99	100	100	100		100	100	97	100	100	100	100	100
FiO2	40	40	35		35	35	35	35		35	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	2	2
CVP	/	/	6		6	6	4	6		6	8	8	[illegible]	8	13	8	8

INTAKE

TIME	24	01	02	03	04	05	06	07	8° T	08	09	10	11	12	13	14	15	8° T
IVF	100	100	100	100	100	100	100	100	800	100	100	100	100	100	100	100	100	800
Vers	3	3	3	3	3	1	1	[illegible]	17	[illegible]								
MSO4	3	3	3	3	3	1	1	1	17	[illegible]								
Abx	100/50						100		850	50				100	50			300
TOTALS																		

OUTPUT

		24	01	02	03	04	05	06	07	8° T	08	09	10	11	12	13	14	15	8° T
URINE	HOUR / TOTAL	30/30	30/60	40/100	/	80/180	30/210	30/240	50/290	290 (1084)	75	110/186	130/305	100/405	70/475	100/575	110/685	120/805	805 (1000)
	sp gr																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS	JP (Abd)													25					25
TOTALS																			335

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS

INTAKE

OUTPUT

RESPIRATORY DATA

LABORATORY DATA

ACTIVITIES OF DAILY LIVING

TURN

SUCTION

24°I&O TOTALS

wt Yesterday

wt Today

(b)(6)-2

INTAKE

IV

po

TOTAL

OUTPUT

Urine:

TOTAL

BALANCE

INITIALS

(b)(6)-2

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA Appr 8 Mar 89 (b)(6)-2

INITIAL SHIFT ASSESSMENT

TIME	0600	INITIALS [redacted] (b)(6)-2	INITIALS	1900	INITIALS [redacted]
NEURO: PUPILS / SENSORIUM	[illegible]			PERRLA 3mm; sluggish; alert, responsive; appropriate	
RESPIRATORY: RESPIRATORY PATTERN / BREATH SOUNDS / SECRETIONS	[illegible]			equal rise/fall; NAD; Ø ↑WOB; RR 20-25 Sat 298% 2LNC	
SKIN: COLOR / INTEGRITY	[illegible]			NFR; ML incision c̄ staples; RLE c̄ staples;	
IV SITE: LOCATION / CONDITION	[illegible]			R Hip CDI. TLC Ⓡ SC CDI	
GASTRO: ABDOMEN / BOWEL SOUNDS	[illegible]			soft, NT, ↓ BS throughout	
GU: URINE: COLOR/CLARITY	[illegible]			Voids clear, yellow	
CARDIOVASCULAR: CARDIAC RHYTHM	[illegible]			SR→ST; Ø ectopy	

LEGEND
Cr - Creatinine
F_IO_2 - Fraction of Inspired O_2
HCO_3 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
S/A - Fractional
SAT - Saturation
TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY [redacted] (b)(6)-2
DEPARTMENT/SERVICE/CLINIC: ICU-3
DATE: 10 Oct 03

PATIENT'S IDENT[redacted]tries give: Name—last, first, middle; grad[redacted]al facility)
CIU
[redacted]
(b)(6)-4

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

DA FORM 4700, 1 MAY 78
Proponent: Dept of Nurs
MEDDAC FBg OP 375, 1 Apr 90 (HSXC-NU)
MEDCOM - 20760

OCT 03

DATE | DX | HOSPITAL DAY

VITAL SIGNS	TIME	24	01	02	03	04	05	06	07	08									
	BP Arterial Line																		
	BP Cuff																		
	Temperature																		
	Pulse																		
	Respiratory Rate																		
	SPO2																		
INTAKE	TIME									8° T									8° T
	IV D5½ as																		
	20 KCL																		
	IVF																		
	TOTALS																		
OUTPUT	URINE HOUR																		
	URINE TOTAL																		
	URINE sp gr																		
	URINE S/A																		
	NG OUTPUT																		
	NG pH																		
	NG GUIAC																		
	EMESIS																		
	STOOL																		
	DRAINS																		
	TOTALS																		

POST-OP DAY

VITAL SIGNS									
	16	17	18	19	20	21	22	23	ITL
	133/83	130/77	132/79	135/79	127/69	136/71	129/71	122/63	
	98					100.2			
	92	93	104	101	102	99	116	95	
	[illegible]	[illegible]	[illegible]	24	31	30	16	23	
	99	98	98	98	99	99	99	97	
				2L	2L	2L	2L	2L	
				NC	NC	NC	NC	NC	

INTAKE									8° T
	100	100	100	100	100	100	100	100	800
							100		100
									900

OUTPUT									
		400		500					900
									910

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA			
TIME		0400	1446
MODE			
F_iO_2			
TV			
RATE			
PEEP	~~[illegible]~~	6	
ABG	pH	~~7.43~~	7.48
	PCO_2	~~47~~	41
	pO_2	~~43~~	76
	HCO_3	~~31~~	31
	SAT ~~[illegible]~~	~~32~~	96
	BASE ~~[illegible]~~	~~7~~	7

LABORATORY DATA	
TIME	6
GLUCOSE	
Na/K	
Cl/CO_2	
BUN/Cr	
WBC/PLATELET	
Hct/Hgb	

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

TURN — TIME

SUCTION

24° I&O TOTALS

wt Yesterday ______ wt Today (b)(6)-2

(b)(6)-2

INTAKE — IV ______ po ______

OUTPUT — Urine: (b)(6)-2

TOTAL ______ TOTAL ______

BALANCE ______

NURSE'S SIGNATURE	INITIALS
[redacted]	[redacted]

DATE | DX | HOSPITAL DAY

VITAL SIGNS	TIME	24	01	02	03	04	05	06	07	~~08~~	08										
	BP Arterial Line																				
	BP Cuff	124/64	122/65	124/68																	
	Temperature																				
	Pulse	95	89	92																	
	Respiratory Rate	23	14	24																	
	Sa02	97	97	97																	
	Mode	RA	RA	RA																	
INTAKE	TIME									8° T											8° T
	IVF	100	100	100																	
	ABX																				
	TOTALS																				
OUTPUT	URINE — HOUR / TOTAL																				
	URINE — sp gr																				
	URINE — S/A																				
	NG — OUTPUT																				
	NG — pH																				
	NG — GUIAC																				
	EMESIS																				
	STOOL																				
	DRAINS																				
	TOTALS																				

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF: A 1 1 D 1
2. LOCATION (State or Country Code.): I Z

3. REGISTER NUMBER: [redacted]

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

4. PAY GRADE: CI
5. SEX: M

6. DATE OF BIRTH (YYYYMMDD): 19860101
7. AGE AT ADMISSION: 017
8. RACE: Z
9. ETHNIC BACKGROUND: Z
RELIGION: unk

10. LENGTH OF SERVICE:
ETS:
11. FMP: 99 20
12. SOCIAL SECURITY NUMBER: [redacted]

ORGANIZATION (Active Duty Only):
13. MARITAL STATUS: Z
HOUR OF ADMISSION: 0100
BRANCH / CORPS: (b)(6)-4

14. FLYING STATUS: I I
15. BENEFICIARY CATEGORY: K 7 8 (00)
16. ZIP CODE OF RESIDENCE:

17. UNIT LOCATION (State or Country Code): I Z
18. MOS:
19. TRAUMA: 9
PREV. ADMISSION: YEAR — NO: X

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: 0 (b)(2)-2
WARD: Icu/
NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: unk
ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): unk
TELEPHONE NUMBER OF EMERGENCY ADDRESSEE: unk

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted]

21. TYPE OF DISPOSITION: 5 0
22. MTF TRANSFERRED TO:
23. DATE OF DISPOSITION (YYMMDD): 031008

24. CLINIC SVC - ADMITTING: A A A A
25. MTF TRANSFERRED FROM:
26. DATE THIS ADMISSION (YYMMDD): 030928

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

FOR LOCAL USE

Dx ① oswald colon repair
② multi shrapnel wounds

Dx: 891.0 / 879.9 / 863.83 / 879.8 / 892.1 (crossed out)
Px: 45.79

863.51
890.1
891.1, 5185
E991.2
E991.9

45.73
45.94
86.04
80.16

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

SIGNATURE OF ADMITTING CLERK (b)(6)-2

DA FORM 2985, MAR 80 — EDITION OF ... IS OBSOLETE

(b)(6)-2

MEDCOM - 20764

ACLU-RDI 1658 p.124

DOD-034338

Automated Facsimile

INPATIENT TREATMENT RECORD COVER SHEET

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

1. Register Nbr	2. Name	3. Grade	Admission Remarks
(b)(6)-4 [redacted]	TOUKIF, OUTMAN SALMAN (b)(6)-4	FGN	

4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm
M	26Y	X	ISLAMIC			NO

11. FMP	12. SSN	13. Organization	14. Ward
20	[redacted]	(b)(6)-4	ICU1

15. FlyStatus	17. Dept / Ben	18. BranchCorps	19. UIC / ZIP	20. Type Case
	K78-PRISONER OF WAR/INTER			DIS

21. Source of Admission	22. Hour Of Adm:	23. Clinic Service
Direct from ER		ABA - GENERAL SURGERY

24. Name/Relation of Emergency Addressee	25. Type Disp	26. Date of Disp
	TRF-OTH	2003-10-08

27a. Address of Emergency Addressee	27b. Telephone No	28. Date This Adm:	AdmittingOfficer:
		2003-10-02	[redacted] (b)(6)-2

29. ReportingMTF	30. Date Init Adm	32. Units Blood Components
[redacted] (b)(2)-2	2003-10-02	

31. Selected Administrative Data

Marital Status:

DoB: 1977-01-01

In/Out Patient: Inpatient

MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

GSW TO THE ~~ABDOMEN~~ Chest

Hemothorax

Pulmonary Contusion

861.31
860.3
E991.2

2
87.41

35. Total Days This Facility					
Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	0	6

35. Total Days This Facility					
Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days

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

[redacted] of PAD or Medical Records Officer (b)(6)-2

MEDCOM - 20763

Automated Facsimile [redacted], May 79

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

28 yo ♂ Iraqi (EPW or CI) s/p GSW (R) back approx 4-5 PM yesterday. Taken to Iraqi hospital, CT placed and, by report, 600 cc blood out. Air Evac to 28CSH, arrived ≈ 2 AM. Pt upon admission c/o pain at entry site, pain anterior chest. Denies abd pain, other body pain.

PMHx: ∅ Meds: ∅ All NKDA

PHYSICAL EXAMINATION

130/60 RR 23 P96

NAD. Cooperative

Head: AT ♂ clear. Neck FROM. NT

Chest: Lower BS (B) bases.

CV: Tachy RR. S1S2

Abd: benign. NT. ∅ peritoneal signs

Ext: ∅ fracture. (R) NV intact.

21 \ 14 / 248
/ 45 \

Cr 1.7

In 1.26

CXR ∅ PTx CT ok

FAST: ∅ blood.

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

A/ GSW (R) back. Hemothorax

P/ Admit / observation.

[redacted]

(b)(6)-2

[redacted]

	DATE	IDENTIFICATION NO.	ORGANIZATION
	[illegible] 2		

PATIENT'S IDENTIFICATION *(For typed or written entries give Name last, first, middle; grade; date; hospital or medical facility)*	REGISTER NO.	WARD NO.
[redacted]		

ABBREVIATED MEDICAL RECORD
Standard Form 539

[redacted] (b)(6)-4

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
3 Oct 03 1800	UD Alb tx given Pt awake & alert HR 71 RR 16 SpO2 97% on 2L NC BBS CTA Post tx Hr 86 RR 18 SpO2 97% BBS No change (b)(6)-2 Sgt [redacted] 9W2Q
4 Oct 03 0040	HR 115, RR 35, SPO_2 91% on 4L NC. ⊕ cough productive. UD Alb neb given. Post HR 106, RR 33, SPO_2 93%. BBS (b)(6)-2 Pleural rubs — bubbly, ⊖ wheezing. IS done. Sgt [redacted] Pt had bloody sputum X2 ≈ 3cc each time dark blood. (b)(6)-2 Sgt [redacted] 9W2Q
4 Oct 03 0410	HR 92, RR 21, SPO_2 96% on 8L SM. UD Alb neb given. Post tx HR 97 RR 30 SPO_2 98% on 8L aerosol mask. BBS CTA but diminished. ⊕ cough IS done c good effort. Pt asked about CT. coming out. (b)(6)-2 Sgt [redacted] 9W2Q
4 Oct 1805	Pt resting pre tx HR 106 RR 25 SpO2 92% on 3L NC BBS clear upper Dimished lower UD Alb tx given Post UD Alb tx given post tx HR 105 RR 02 SpO2 94% BBS NO change Pt instructed a doing I S (b)(6)-2 Sgt [redacted] 9W2Q
05 Oct 03 0625	HR-86, RR-22, 94 SPO_2 on 4L NC. UD Alb neb given Post tx HR 85, RR 25, SPO_2 97 on 6L aerosol mask. BBS CTA. will continue to monitor (b)(6)-2 Sgt [redacted] 11W2Q
5 Oct 03 1010	HR-100, RR 21, SPO_2 95 on 4L NC. UD Alb neb given. BBS CTA. Post Tx 99, RR 25, SPO_2 96%. Pt tranfer to ICW — Sgt [redacted] 14W2Q

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

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

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

[redacted] (b)(6)-4

Alb neb Q4

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
2015 (OCT 03 1000)	restraints on 5 compromise to skin or circulation — will mon — (b)(6)-2 [redacted] SC Altered Treatment started. due for CXR in AM @ 0500 — (b)(6)-2 [redacted] 91WM6.
(0200)	X-ray consult put in per orders — [redacted] 91WM6. (b)(6)-2 (not portable).
(0500)	CXR done — (b)(6)-2 [redacted] 91WM6, SC
1 Oct 03 0700-	Assumed care of pt. A+O x 3. VSS remains afebrile. Denies SOB or chest pain @ this time. O2 sats 90% on 3L O2. Orders to wean off O2. GSW to back entrance wound and exit wound dressing D CDT. OCD chest tube site sutures intact @ s/s of infection. Will cont to monitor. — (b)(6)-2 [redacted] gearner
(1910)	Pt alo, VSS, sitting Tun bed, POx@ 91% (RA), @ SOB resp even + unlabored. wounds OTA c @ drainage noted. prev. CT site sutures intact, @ s/s of infection noted. C/O chest pain (R) II. Percocet given. LCTAB, @BS, HRRR, 2 pt restraints on 5 compromise to skin/circulation Will monitor — (b)(6)-2 [redacted] 91WM6 SC

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

MEDCOM - 20768

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
8 October 2003	DC Summary
	Admit Date 2 October 03
	DC Date 8 Oct 03
	Dx - 1) GSW to Right Chest / Back entrance
	2) Hemothorax
	Procedure - Chest tube placed outside facility
	Hospital Course Pt admitted in transfer from Iraqi
	hospital with (R) chest GSW with resulting hemothorax
	which was treated with (R) chest tube. Pt stable on
	transfer. CXR revealed opacification of (R) lower
	lung field. Chest CT revealed Right lower lobe
	pulmonary contusion minimal residual hemothorax
	Minimal CT output. CT removed HD#2. Patient
	continued to need aggressive pulmonary toilet and required
	O_2 until 7 Oct. Has been off O_2 for 36°
	CXR shows RLL contusion.
	Disposition 1) DC to EPW camp 2) Sutures need to be removed in 2 weeks
	MEDS Percocet 1 po Q6° PRN pain 3) F/u CXR in
	Levoquin 500mg po QD x8 6 weeks
	Motrin 800mg po TID prn.

[redacted] (b)(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME LAST	FIRST	[redacted]	SPONSOR'S ID NUMBER (SSN or Other)
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	[redacted]	…NED 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.

E # [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
10/10	Narrative Summary
	Admit 10/9
	D/C 10/10
	Diagnosis: Stroke
	Reason Readmitted c stroke from CT site.
	Pt Stable. CT chest (-) for retained hardware
	Pt D/C Stable
	Disposition: Home
	Meds: None
	(b)(6)-2 [redacted] (b)(6)-2
	[redacted] (b)(6)-4

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10/3/03	HD #2
	S/P GSW to (R) chest. CTR
	[illegible] [illegible] [illegible] [illegible] residual
	retained hemothorax, ↑ O2 requirement
	last PM. CXR shows ↑ collapse of
	middle lobe.
	[illegible] [illegible] [illegible] [illegible] [illegible]
	[redacted] (b)(6)-2

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

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

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 - 20771

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

DATE	NOTES
5 OCT 1800	Pt awake HR 96 RR 16 SPO2 94% 4 LNC BBS CTA UD Alb tx given Post tx HR 86 RR 18 SpO2 94% on 4 LC NC BBS No change (b)(6)-2 Sgt [redacted] Given
6 Oct 03 0030	Nurse gave pt tx (b)(6)-2 Sgt [redacted] 91V2
6 Oct 03 0645	Pt note: Pt awake HR 88, RR 18, SPO2 94% on 3 LNC. BBS CTA still diminshd @ bases. UD Alb given. Post tx HR 94 RR 22 SPO2 on 94% 3 L NC (b)(6)-2 Sgt [redacted] 91V2
6 OCT 1757	Pt awake HR 86 RR 14 SPO2 95% 4 LNC BBS CTA + Rhonchi UD Alb tx given Post tx HR 86, SPO2 95 BBS clear Diminished in Bases (b)(6)-2 Sgt [redacted] 91V2
7 Oct 03 0005	O2 tank not working, removed flowmeter + notice threads were bent. Told nurse to Δ tanks, call back when ready for tx - nurse went ahead + did tx (b)(6)-2 Sgt [redacted] Gives
7 Oct 03 0620	Pt tx HR 76, RR 16, SPO2 94% on 3 LNC. UD Alb given via HHN c mouthpiece. BBS CTA c slightly diminished bases. Post tx HR 72 RR 18 SPO2 93% on 3 LNC. (b)(6)-2 Sgt [redacted]
8 OCT 03 0700	- Assumed care pt. A+O x 3. VSS O2 SAT throughout the night 92-94% RA. Lungs clear c diminished (R) base. Encouraged deep breathing exercises. IS @ bedside. Increased ambulation. GSW to chest healing. Chest tube site c sutures intact Ø active bleeding open to air Ø c/o pain or discomfort denies SOB Will cont to monitor (b)(6)-2 [redacted]

(b)(6)-4 Pt [redacted] Alb x 72 hrs Q6

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
5 Oct 03	1300 I concur c̄ transfer note. Pt in 2pt restraint s̄ compromise to skin integrity or circulation. Will continue monitoring & providing emotional support (b)(6)-2 [redacted]
(1930)	Pt a/o, sitting ↑ in bed to assist c̄ breathing. O2 4L by NC on, lungs: clear but diminished @ bases. HRRR, ⊕BS x4, drsg to Ⓡ upper chest wall CDI, entrance wound to back c̄ opsite over area Ø c/o pain or discomfort @ this time. resp even & unlabored, O2 sats 91-94%. albuterol treatment to be done @ midnight. 2pt restraints on s̄ any compromise to circulation/skin. Will monitor (b)(6)-2 [redacted] 91WM6.
(6 OCT) 0001	Albuterol treatment started. O2 sat between 90-94%. Will monitor (b)(6)-2 [redacted] 91WM6.
6 Oct 03 0900	Rec'd report and assume care of pt. Pt ↑ in bed. 3L NC POX 95. Dsg to Ⓡ [redacted] (b)(6)-2 lateral chest D&I. lungs CTA BS⊕. Pt ambulated in hallway Pt instructed to continue to use incentive spirometer q hr while awake and DB exercises will continue to monitor [redacted] 91WM6
1630	Pt ambulated in hallway POX 92% while ambulated.
(2015)	Pt a/o, sitting ↑ in bed POX 90%, IS & deep breathing encouraged. POX 93% while ambulating. drsg Ⓡ chest CDI, ⅱ Percocet given for pain. On O2 by NC @ 3L @ this time. 2pt

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
05 OCT 03 0400	Pt sitting up in bed. Requesting H2O. O2 sats remain 94%. Will cont. care. (b)(6)-2 [redacted] USAF
0600	Gave report to oncoming shift. (b)(6)-2 [redacted] USAF
0700	Received report from ongoing shift. Pt in bed resting. O2 4L NC in use, O2 sat @ 95%. Plan: Respiratory toilet, cough & deep breath, OOB-chair. (b)(6)-2 [redacted] Maj/AN
1000	Received M150 4mg @ 0930 for c/o incisional pain. Pt is cleared by MD for transfer to ICW. Pt A&OX3. Hx to C&DB, use of incentive spirometer and O2 2-4L NC, maintain O2 sat > 95%. Ambulatory & self care. T98.6-102-17-118/58 (b)(6)-2 [redacted] Maj/AN
1100	Pt transferred: Transferred ambulatory to ICW T/ O2 tank @ 4L NC. Report given to ward nurse. (b)(6)-2 [redacted] Maj/AN
5 Oct 03 1110	- Assumed care of pt. transfer from ICU #2 to ICW #1 Ambulatory. Lungs clear diminished @ bases 4L O2 per NC O2 saturation between 92-96% @ this time 95% instructed on deep breathing exercises IS @ bedside instructions given. Dressing to @ upper chest wall bulky dressing CDI. Chest tube d/c'd site c sutures minimal bleeding dressing CDI. Entrance GSW to back c opsite. C/o pain or discomfort Will cont to monitor (b)(6)-2 [redacted] Grade

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

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

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/1988)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
04 Oct 03 1500	Chest tube discontinued @ 1000 HH, chest X-ray done & reviewed. Pt OOB - chair x 3 this shift. Complaint c C+DB and incentive spirometer. VSS (b)(6)(b)(7)-2 [redacted] Nsg IA
4 Oct 03 2246	RT note: Pt c tx HR 91, RR 28, SPO2 95% on 4L NC. UO adequate given. BBS diminished. Post tx HR 94, RR 26, SPO2 96 back on 4L NC. (b)(6)(b)(7)-2 Sgt [redacted]
04 OCT 03 1800	Received report from previous shift. Pt sitting up in bed. O2 @ [redacted] 3L via NC. O2 sats 94%. O2 humidified. 0% pain at this time. Dsg @ side C, D, I. IV @ RAC intact + H.L. @ needs expressed at this time. Will cont. care (b)(6)(b)(7)-2 [redacted]
1820	Pt temp 101.1°, Will notify MD. O2 sats ↓ 92%. ↑ O2 to 4L via NC. O2 ↑ 94-96%. Pt ate 25% dinner. Pt cough + deep breath. 0% pain at this time. Will cont. care (b)(6)(b)(7)-2 [redacted]
1925	MD notified of temp. tylenol given. Will cont to monitor temp. (b)(6)(b)(7)-2 [redacted]
2230	Pt c/o pain @ flank. Gave 4mg MSO4 IVP. Will cont to assess pain level. Temp ↓ 99.7°. Will cont. care [redacted]
Late entry 1935	New order for CBC + Blood Cx. Drew labs per (b)(6)(b)(7)-2 order. CBC results: WBC 12.8, H+H 12.4 38.8, Plt 246. Will notify MD of results. (b)(6)(b)(7)-2 [redacted]
05 OCT 03 0210	Pt c/o pain on @ side. Gave 4mg MSO4 IVP. RT tx done @ this time. Will cont. care (b)(6)(b)(7)-2 [redacted]
0240	RT note: Pt c tx HR 93, RR 22, SPO2 95% on 4L NC. UO adequate given. BBS diminished. Post tx HR 97, RR 19, SPO2 96% on 4L NC. (b)(6)(b)(7)-2 Sgt [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

[redacted] [redacted] AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
03Oct03 1400	Pt wean off from NR to 3L-4L NC @ 4L NC @ then Pt turn, O2 sat @ 94%. Continue to encourage IS x 5 qi. (b)(6)-2 [redacted] Nij RN
1800	Received report from day shift. Pt has chest tube to @ side of chest. Blisters to high chest around tape. Pt A+O, (b)(6)-2 will continue to monitor. [redacted] SPC, 9/WMG
2000	Pt resting comfortably in bed. VSS (b)(6)-2 Will continue to monitor. [redacted] SPC, 9/WMG
4Oct03 2400	Pt resting comfortably in bed. VSS Moved pt up in bed. Gave pt 4 mg MSO4 Will continue to monitor
(b)(6)-2	[redacted] SPC, [redacted] 9/WMG (b)(6)-2
4Oct03 0230	Pt placed on simple masks. SATs ↓ to 89%. 6L O2 SATs ↑ to 94% will (b)(6)-2 continue to monitor [redacted] SPC 9/WMG
0600	Received report from ongoing shift. Pt in bed, FM in place due to Hematuria O2 last night. CT in place draining small coat of sero-sanguinous drainage. T 99.6. Plan: Pulmonary toilet, C+DB. Advance diet as tolerated [redacted] (b)(6) Nij RN

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/1989)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

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

[redacted]

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
~~3 Oct 03~~ 03 Oct 03 ~~1800~~	RT note: Pt awaken easily. Pre tx HR 94, RR 16, SPO_2 98%
	on 10L NRB. Breathing even + unlabored. BBS diminished
	@ bases c̄ Ⓡ side [illegible]. UD Alb given via facemask.
	Post tx HR-110, RR 28, SPO_2 98%. Pt tol well. — Sgt [redacted] 91W
2000	Pt agitated, pulsox in ↓ 80's. Dr (b)(6)-2 [redacted] placed
	pt on NRmask. SPO_2 ↑ to 99%. Will (b)(6)-2
	continue to monitor. (b)(6)-2 [redacted] SPC, 91WM6 —
03Oct03	Pt resting comfortably in. VSS. SPO_2 @ 99%
2400	on NR 10L. Will continue to monitor.
	(b)(6)-2 [redacted] SPC, 91WM6
0200	Pt resting comfortably in bed. VSS. Will
	continue to monitor (b)(6)-2 [redacted] SPC, 91WM6 —
0600	Gave report to day shift (b)(6)-2 [redacted] SPC, 91WM6
03 Oct 03 [illegible]	RT note: Pt lethargic. Pre tx HR 90, RR 22, SPO_2 96%
	on 10L NRB. UD Alb given. BBS diminished. Post
	tx HR 92, RR 22, 95% on 8L aerosol mask. Placed
	back on 10L NRB. TJ done (b)(6)-2 — Sgt [redacted] 91W
03 Oct 03	Received report from ongoing shift. Pt awake on NR FM,
0800	sat 94%. Verbalizes need for pain medicine. IV LR @ 75
T100.6	on the Ⓛ arm, site D+I, site started 02 Oct 03. ~~afebrile~~ error
	Low grade T100.1. Received nebs treatment by RR, see note
	above. CT Ⓛ mid axillary site intact draining serosanguinous
	drainage. Continue to monitor respiratory status — (b)(6)-2 [redacted]
1300	C+DB 3X hour, compliant c̄ coaching. O_2 sat is maintained
T100.6	@ 98% from 92% this AM. Foley draining q 5 per
	hour. Medicated c̄ MSO_4 4mg @ 0700 and 2mg @ 1130.
	Pt alert c̄ intermittent sleepiness — (b)(6)-2 [redacted]

[redacted] (b)(6)-2

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	Nursing Notes
20Oct03	Received Pt Item 1 Bed #6 Pt alert follow commands. See
0630	Intensive care flow sheet for more information included assessment
0700	Pt C/O pain to right side of chest MSO4 4mg IV given Pt Encourag
	to use and instructed on use of incentive spirometer able to get 250
0730	ml/x3. DR Matsumoto visited Pt. Chest tube has bubbling on
0900	fluid draining. Pt Resting No distress noted Hx/ Emphysema
0900	DR Mulligan visited and examined Pt He is now the attending MD.
	O_2 Tapered to 4 L via NC tolerating well Sat 96% via pulse oximeter. C/O
	pain MSO4 3 mg IV given [redacted] (b)(6)-2, LT
1100	Pt Placed on OOB to chair chest tube to suction. C/O Pain MSO4 3 mg IV
	given Pt has ground at bedside [redacted] (b)(6)-2 RN (b)(6)-2
1500	VSS Pt's condition unchanged Medicine Meal Pt OOB to chair [redacted]
1530	Blood drawn and Sent to Lab for CBC. Pt C/O Pain MSO4 4mg IVP
1630	given. MSO4 3 mg IV given Pt returned to bed. Foley Cath
	inserted. dark amber urine noted. Cipro 200 mg IV given
1750	DR Mulligan aware of Pt's Condition. Pt Transported to CT Dept
1815	for CT of the Chest. CT of chest done DR Mulligan aware
	of results. Pt returned to Tent 1. Report given to Neil Jensen
	[redacted] RN, LT (b)(6)-2
1830	Received report from day shift RN VSS, NC 4L, Foley
	to gravity, Chest tube to [redacted] SPC 9 with

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME (b)(6)-2 | 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

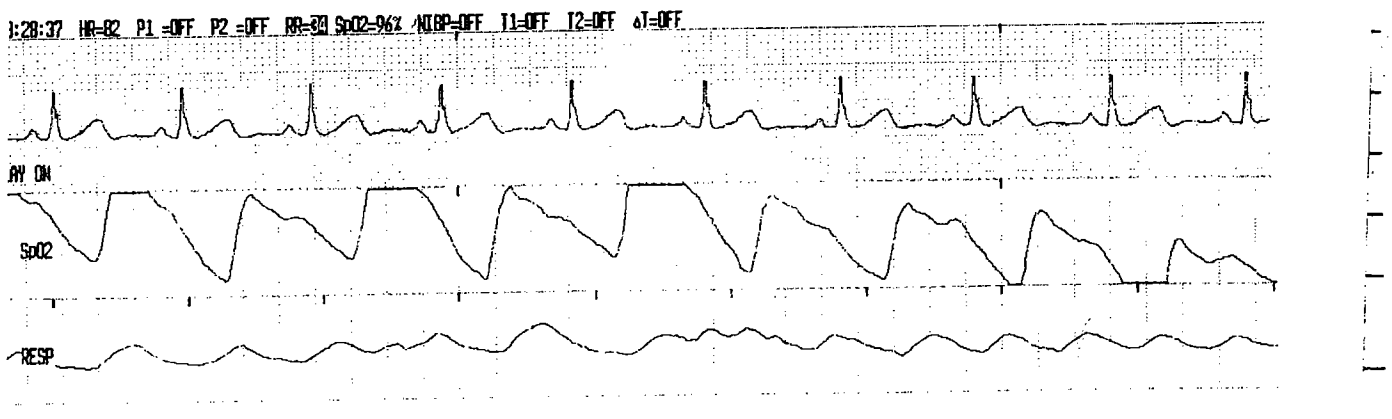
STANDARD FORM 509 (REV. 6/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

[redacted] MEDCOM - 20778 [redacted]

[redacted] [redacted] AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
02 OCT 03 0235	Received pt from EMT via stretcher. Pt on NRB mask. O2 sats 97%. (R) flank chest tube to 20cm continuous suction. Drsg on (R) upper chest C,D,I. Drsg (R) flank C,D,I. Pt arrived c 23cc of bloody drainage in chest tube. Pt awake + able to speak some english. MP @ bedside. 1-point leather restraint on (R) ankle placed due to pt status. Interpretor @ bedside. Explained NPO status, restraints, + IS. Pt able to move up 2nd ball in IS. 0% pain @ this time. Pt does have pain if touch (R) flank. LR @ 150cc/hr started. Will cont. care. (b)(6)-2 [redacted] ICT/LPN
0245	Placed pt on NC 5 L/min. O2 sats 94-95%. Will cont to monitor. (b)(6)-2 [redacted] ICT/LPN
0330	Placed pt on NRB mask to ↑ sats to 100%. Will cont. to monitor. (b)(6)-2 [redacted] ICT/LPN



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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
02 OCT 03 0440	Pt resting quietly c eyes closed. NRB mask in place @ 10 L/min O2. O2 sats 100%. Will cont to monitor. [redacted] (6)(6)-2
0507	Pt c/o pain in (R) chest area. Gave 4mg MSO4 IVP. Pt quietly resting c eyes closed @ this time. RR Low 20s O2 Sat 98%. Will cont. care. [redacted] (6)(6)-2 LCT/RN
0600	Drew labs per order. Gave report to next shift. [redacted] (6)(6)-2 LCT/RN

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

NSN 7540-01-075-3786

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT *(Patient)*

LOG NUMBER | TREATMENT FACILITY

RECORDS MAINTAINED AT

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)* | TIME

TRANSPORTATION TO FACILITY

SEX: M

AGE: 27

DUTY/LOCAL PHONE — AREA CODE | NUMBER

HOME PHONE — AREA CODE | NUMBER

MILITARY STATUS

ITEM	YES	NO	N/A
PRP			
FLYING STATUS			

MEDICAL HISTORY OBTAINED FROM

THIRD PARTY INSURANCE

ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2568 IN CHART		

NAME OF INSURANCE COMPANY

CURRENT MEDICATIONS: Ø

ALLERGIES: Ø

INJURY OR OCCUPATIONAL ILLNESS

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

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INTITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT

CATEGORY OF TREATMENT

☐ EMERGENT
☐ URGENT
☒ NON-URGENT

TIME: 1500

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

VITAL SIGNS

TIME	1500					
BP	112/63					
PULSE	128					
RESP	18					
TEMP	97.9					
WT						

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

DISPOSITION
☐ HOME ☐ FULL DUTY

MODIFIED DUTY UNTIL

DISPOSITION QUARTERS /OFF DUTY
☐ 24 HRS. ☐ 48 HRS. ☐ 78 HRS.

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE
☐ IMPROVED ☐ UNCHANGED
☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ | TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

PATIENT'S IDENTIFICATION

(For typed or written entries, give: Name – last, first, middle; ID no. (SSN or other); hospital or medical facility)

[redacted] (6)(6)-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

NSN 7540-01-075-3786

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

TEST RESULTS

CBC	WBC 11.5	SMAC	129	103	14 / 105	ABG/PULSE OX		RADIOLOGY	Check if read by radiologist ☐
	H/H 13 / 43		4.6	21	1.1	SUP O2 / PH / PO2		RESULTS
	PLT 571					PCO2 / SAT / OTHER		
PT						UA: DIP		EKG INTERPRETATION
APTT	BHCG	ETOH	GLU			UA: MICRO		

PROVIDER HISTORY/PHYSICAL

27yo ♂ EPW brought back from EPW camp for DRNG @ CT Site. Pt seen here & D/C'd yesterday. CT pulled by Dr. [redacted] (b)(6)-2

(b)(6)-2 [redacted] CT
(b)(6)-2 [redacted] CT
Pneumothx 20CT03

O: ↓BS ® side ō scattered rhonch.
Alert, stable
CXR ® ® hemothorax

A: See gen. surg note.

P: Admit.

CONSULT WITH	TIME	ACTION

DIAGNOSIS

see "A"

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

[redacted] (b)(6)-2

PROVIDER SIGNATURE AND STAMP

[redacted] (b)(6)-2

CODES

PATIENT'S IDENTIFICATION

(For typed or written entries, give: Name – last, first, middle; ID no. (SSN or other); hospital or medical facility)

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

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

NSN 7540-01-075-3786

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT (Patient)

LOG NUMBER [redacted] (b)(2)-2

RECORDS MAINTAINED AT

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

ARRIVAL

DATE (Day, Month, Year): 20CT03 | TIME: 0128

TRANSPORTATION TO FACILITY: AIR

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 28	HOME PHONE		FLYING STATUS				DD 2568 IN CHART		
	AREA CODE	NUMBER	MEDICAL HISTORY OBTAINED FROM				NAME OF INSURANCE COMPANY		

CURRENT MEDICATIONS: Ø

ALLERGIES: NKDA

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: Ø PSH Ø PMH GSW (R) flank Back

CATEGORY OF TREATMENT

☒ EMERGENT ☐ URGENT ☐ NON-URGENT

TIME: 0128

INITIALS: T

VITAL SIGNS

TIME	0128	0135	0140	0155		
BP	135/85	138/65		120/61		
PULSE	114	96	100	89		
RESP	32	23	30	30		
TEMP			99.3			
WT						

LAB ORDERS

☒ CBC/DIFF ☒ ABG ☒ PT/PTT ☐ BHCG/URINE/BLOOD/QUANT

☒ URINE C&S ☒ UA MSCC/CATH ☒ CHEM: 12

☒ BLOOD C&S X 2 ☒ 1 IV fld

X-RAY ORDERS

☒ CXR PA & LAT/PORTABLE ☐ C-SPINE

☒ ACUTE ABDOMEN ☐ LS SPINE

☐ SINUS ☐ HEAD CT

☐ ANKLE R/L

ORDERS

☒ PULSE OX 87, 97, 100 (b)(6)-2 ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
0140	50mg Toradol IV	DT [redacted]	LT [redacted]	0140	(b)(6)-2
	Fentanyl 50mcg IV (b)(6)-2		0150		
	Fentanyl 50mcg IV (b)(6)-2		0200		

DISPOSITION	DISPOSITION QUARTERS /OFF DUTY	PATIENT/DISCHARGE INSTRUCTIONS
☐ HOME ☐ FULL DUTY	☐ 24 HRS. ☐ 48 HRS. ☐ 78 HRS.	
MODIFIED DUTY UNTIL	RETURN TO DUTY	

CONDITION UPON RELEASE	ADMIT TO UNIT/SERVICE	REFERRED ▶	TO	WHEN
☒ IMPROVED ☐ UNCHANGED ☐ DETERIORATE	TIME OF RELEASE	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)*

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

[redacted] (b)(6)-4

MEDCOM - 20783

NSN 7540-01-075-3786

MEDICAL RECORD	EMERGENCY CARE AND TREATMENT *(Doctor)*	TIME SEEN BY PROVIDER [redacted] (b)(6)-2

TEST RESULTS

CBC		SMAC		ABG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐
WBC			P	SUP 02	PH	PO2	RESULTS	CXR CT in place, ∅ PTX, ⊕ FB
H/H				PCO2	SAT	OTHER		
PLT								
PT				U/A DIP			EKG INTERPRETATION	
APTT	BHCG	ETOH	GLU	U/A MICRO				

PROVIDER HISTORY/PHYSICAL

Hema check ⊖

28 y/o ♂ seen by Iraqi hospital for GSW to Ⓡ chest (back) tx unclear. Pt states he was shot accidentally by another Iraqi teenager approx 1700 tonight. CT placed. Sent to 28 CSH 2° to investigation by QRFs. Pt c/o SOB, ∅ N/V/Abd pain

O: A&O x1 — mod distress. VSS

⊕ to 66

Pulls to NC

Heent: OP/mm clear pst mucosa neck supple, ∅ trach dev. eyes clear

Chest ↓BS Ⓡ side c̄ diffuse course sounds. Ⓛ CTA

CT in place c̄

Abd: soft, ⊕BS, NT

Ext: ⊕ 2 rad pulses Ⓑ from arms/shoulders Ⓑ

A/P GSW to back

Stable → Admit ICU I

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

(b)(6)-2 [redacted]

PROVIDER SIGNATURE

DIAGNOSIS

GSW to ~~chest~~ back

CODES

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

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

[redacted] (b)(6)-4

511-119

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY: 3

POST- DAY

MONTH-YEAR Oct 2003 | DAY | HOUR

5 Oct 0600 | 7 Oct 0100 | 8 Oct 0200

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° / 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

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.

CH [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 - 20785

Ward/Section: EMT	REQUESTING PHYSICIAN: [redacted] (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST: [redacted] (b)(6)-4	DATE: 90ct03	TIME: 1505
SSN/PSEUDO SSN: ID# [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		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

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		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

======= PICCOLO =======
09/10/03 15:17
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: (b)(6)-2 3151AAA
OPER #: [redacted] DR #: 000
SERIAL #: [redacted] (b)(6)-4

GLU	105	73-118	MG/DL
BUN	18	7-22	MG/DL
CRE	1.1	0.6-1.2	MG/DL
CK	135	39-380	U/L
NA+	129	128-145	MMOL/L
K+	4.6	3.3-4.7	MMOL/L
CL-	103	98-108	MMOL/L
tCO2	21	18-33	MMOL/L

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Methyte 8

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

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

(b)(6)-2

Ward/Section: EMT	REQUESTING [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted] (b)(6)-4	DATE: 8OCT03	TIME: 0128	SSN/PSEUDO SSN: [redacted] (b)(6)-4

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3	Color		N/A	RPR		Negative
RBC		4.7-6.1 x 10^6	App		N/A	Mono		Negative
Hgb		14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	**Microbiology**		
Hct		42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV		80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
Plt		130-500 x 10^3 verified	SG		N/A	Occ Bld		Negative
Lymph %		20.5-51.1%	Bld		Negative	H. pylori		Negative
			pH		N/A	Micro Parasites		
			Prot		Negative	Malaria		
			Urob		0.2-1.0	O & P		
			Nit		Negative	Other		
			Leuk		Negative	**Microscopic Urinalysis**		
			HCG		Negative			

(Hematology) Manual Differential			
Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

CSF		
Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

MEDCOM - 20789

Ward/Section: Fem 1	REQUESTING PHYSICIAN: DR [redacted] (b)(6)-2	**LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted] (b)(6)-4	DATE: 20 Oct	TIME: 1511r	SSN/PSEUDO SSN: [redacted] (b)(6)-4

Hematology CBC

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

Hematology Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] (b)(6)-2	**DATE:** 20 Oct 03	**LAB ID NO.:**

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

LAST, FIRST, MI.	DATE	TIME	SSN/PSEUDO SSN:
# [redacted] (b)(6)-4	4OCT03	1935	

(Hematology) CBC

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

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS: Blood culture

REPORTED BY: [redacted] (b)(6)-2	DATE: 10-4-03	LAB ID NO.:

======= PICCOLO =======
10/02/03 01:49 AM
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: (b)(6)-2 3152AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]
(b)(6)-4

GLU	112	73-118	MG/DL
BUN	19	7-22	MG/DL
CRE	1.3*	0.6-1.2	MG/DL
CK	583*	39-380	U/L
NA+	142	128-145	MMOL
K+	5.0*	3.3-4.7	MMOL
CL-	107	98-108	MMOL
tCO2	21	18-33	MMOL

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

======= PICCOLO =======
02/10/03 01:50
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
GENERAL CHEMISTRY 12
DISC LOT #: (b)(6)-2 3142AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]
(b)(6)-4

ALB	3.7	3.3-5.5	G/DL
ALP	61	26-84	U/L
ALT	182*	10-47	U/L
AMY	21	14-97	U/L
AST	107*	11-38	U/L
TBIL	2.3*	0.2-1.6	MG/DL
BUN	22	7-22	MG/DL
CA++	8.9	8.0-10.3	MG/DL
CHOL	117	100-200	MG/DL
CRE	1.1	0.6-1.2	MG/DL
GLU	111	73-118	MG/DL
TP	7.0	6.4-8.1	G/DL

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

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 10/02/03 01:54 AM

Patient ID [redacted] (b)(6)-4
Test Name :PT
Test Result:= 14.1 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.2
Calculated INR = 1.26
Sample Type:citrated wh. blood
Test Date :10/02/03
Test Time :01:52 AM
Card Lot :040302
Operator [redacted] (b)(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 10/02/03 01:56 AM

Patient ID [redacted] (b)(6)-4
Test Name [redacted] (b)(6)-4
Test Result:= 26.6 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :10/02/03
Test Time :01:54 AM
Card Lot :100208
Operator [redacted] (b)(6)-2

(b)(6)-4

ID [redacted] 02-10-03
WB 01:53

			Patient Limits	
WBC	24.4 H	x10^3/uL	4.5	10.5
RBC	4.93	x10^6/uL	4.00	6.00
Hgb	14.8	g/dL	11.0	18.0
Hct	45.9	%	35.0	60.0
MCV	93.2	fL	80.0	99.9
MCH	30.0	pg	27.0	31.0
MCHC	32.2 L	g/dL	33.0	37.0
Plt	248.	x10^3/uL	150.	450.
LY%	5.4 *	%	20.5	51.1
LY#	1.3 *	x10^3/uL	1.2	3.4

[redacted] (b)(6)-4 04-10-03 15:17

			Patient Limits	
WBC	10.5 H	x10^3/uL	4.5	10.5
RBC	[illegible]	x10^6/uL	4.00	6.00
Hgb	13.5	g/dL	11.0	18.0
Hct	[illegible]	%	35.0	60.0
MCV	92.0	fL	80.0	99.9
MCH	29.1	pg	27.0	31.0
MCHC	31.6 L	g/dL	33.0	37.0
Plt	511. H	x10^3/uL	150.	450.
LY%	25.5 *	%	20.5	51.1
LY#	2.7 *	x10^3/uL	1.2	3.4

[redacted] (b)(6)-4

WB 02-10-03 15:30

			Patient Limits	
WBC	16.1 H	x10^3/uL	4.5	10.5
RBC	5.11	x10^6/uL	4.00	6.00
Hgb	15.0	g/dL	11.0	18.0
Hct	47.2	%	35.0	60.0
MCV	92.3	fL	80.0	99.9
MCH	29.3	pg	27.0	31.0
MCHC	31.7 L	g/dL	33.0	37.0
Plt	239.	x10^3/uL	150.	450.
LY%	16.4 *	%	20.5	51.1
LY#	2.6 *	x10^3/uL	1.2	3.4

[redacted] (b)(6)-4

WB 04-10-03 20:18

			Patient Limits	
WBC	12.8 H	x10^3/uL	4.5	10.5
RBC	4.17	x10^6/uL	4.00	6.00
Hgb	12.4	g/dL	11.0	18.0
Hct	38.8	%	35.0	60.0
MCV	92.9	fL	80.0	99.9
MCH	29.7	pg	27.0	31.0
MCHC	32.0 L	g/dL	33.0	37.0
Plt	246.	x10^3/uL	150.	450.
LY%	16.2 *	%	20.5	51.1
LY#	2.1 *	x10^3/uL	1.2	3.4

MEDCOM - 20792

MEDCOM - 20793

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

DATE OF ORDER: 10/2/03 TIME OF ORDER: ______ HOURS

LIST TIME ORDER NOTED AND SIGN

1) Wear O2 to NC Sat > 92%
2) CT to walk [illegible]
3) [illegible]
4) Albuterol neb 2.5 [illegible] CG Q 4°
5) [illegible]
6) [illegible]

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

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER [redacted] HOURS

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

DATE OF ORDER: 10/2/03 TIME OF ORDER: ______ HOURS

1) [illegible]
2) [illegible]
3) CT chest w/ IV contrast R/O [illegible] VS pulmonary [illegible]

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

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

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

02OCT03 2315

1. Nonrebreather mask now
2. ABG now (b)(6)-2 (b)(6)-2

V.O. Dr [redacted] / 1LT [redacted], AN

NURSING UNIT | ROOM NO. | BED NO.

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

VOted 02 Oct 03 2320 [redacted] (b)(6)-2

[redacted] (b)(6)-4

MEDCOM - 20794

ACLU-RDI 1658 p.154

DOD-034368

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION	↓	DATE OF ORDER / TIME OF ORDER / ORDERS	LIST TIME ORDER NOTED AND SIGN
[redacted] (b)(6)-4		DATE OF ORDER: 2 Oct 03 TIME OF ORDER: 2359 HOURS	
	1.	Tagamet 300mg IVPB q6°	
		(b)(6)-2 [redacted] / [redacted]	
NURSING UNIT / ROOM NO. / BED NO.: 24° Chart Check [illegible] (b)(6)-2 LT/AN 03OCT03 0530			
PATIENT IDENTIFICATION		DATE OF ORDER: 3 Oct 03 TIME OF ORDER: ___ HOURS	
	1)	[illegible] toilet.	noted [redacted] (b)(6)-2
		Cough deep breathe q1°	
	2)	NT suction q2°	
	3)	Incentive Spirometer 5x q1° while awake	
		(b)(6)-2 [redacted]	
NURSING UNIT / ROOM NO. / BED NO.			
PATIENT IDENTIFICATION		DATE OF O[redacted] TIME OF ORDER: 1420 HOURS	
		03 Oc[redacted]	
		V.O. [redacted]	
		Wean off NR to NC 2-4L	
		to keep O_2 sat ≥ 92%	
24° chart (b)(6)-2 [redacted] CPT [redacted]		4OCT 0100 [redacted] Maj / AN (b)(6)-2	
NURSING UNIT / ROOM NO. / BED NO.			
PATIENT IDENTIFICATION		DATE OF ORDER: 4 Oct 03 TIME OF ORDER: ___ HOURS	
noted [redacted] (b)(6)-2 5OCT 1900		PA/lat CXR in 4° to r/o pneumo	
		(b)(6)-2 [redacted]	
NURSING UNIT / ROOM NO. / BED NO.			

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

MEDCOM - 20795

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

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

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER (HOURS) | LIST TIME ORDER NOTED AND SIGN

4 Oct 03 2020

1. Blood Cx / CBC now. KBS
2. Tylenol 650mg po q4° PRN 1925
3. q4° VS.
4. D/C IVF per Verbal (b)(6)-2

(b)(6)-2 [redacted]

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

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER (HOURS)

04 OCT 03 2320

91 PN

1) Transfer to ICU
2) Dx: S/P GTW to Chest
3) Vitals q4° with Sat check
4) Activity OOB Ambulate
5) Diet Regular
6) IV hep lock

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER (HOURS)

7) Incent Spirometry 5x q1° while awake.
8) Albuterol 2.5/3.0cc NEB q6° for 72°
9) MEDS
Record I+O q4°
Levofloxacin 500mg po qD
10) PA/Lat CXR qAM

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER (HOURS)

11) Enteral NG Tylenol, SBP>80 q4° Sat <90%
12) 4L NC.

(b)(6)-2 [redacted]

[redacted] 5DCU 2300

(b)(6)-2

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

MEDCOM - 20796

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
(b)(6)-4 E# [redacted] (b)(6)-2 [redacted]				8 Oct 03	_____ HOURS	
				1) D/C to EPW Camp		
				[redacted] (b)(6)-2		
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.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
					_____ HOURS	
NURSING UNIT	ROOM NO.	BED NO.				

DA FORM 1 APR 79 4256 REPLACES EDITION MEDCOM - 20797 WHICH MAY BE USED.

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. ___ Yr. 2003

VERIFY BY INITIALING

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 3	4	5	6
03 Oct	[redacted]	Incentive spirometry	10	/	[redacted]		
(b)(6)-2		5X q 1° while	18	[redacted]			
		awake	X				
			X				
03 Oct	[redacted]	Wean off NR	06				
(b)(6)-2		to 2-4L NC to	18	[redacted]			
		maintain O2 sat	X				
		≥ 92%	X				
30 Oct	[redacted]	NT suctioning q 2°	06				
(b)(6)-2			18	[redacted]			
			/				
04 OCT 03	[redacted]	VS Q4°	06	/	[redacted]		
(b)(6)-2			18	[redacted]			

Repeat order

DCd 4 Oct 03

2-(9)(a)

ALLERGIES: ☐ YES ☒ NO NKDA

PRIMARY DIAGNOSIS: DOA 02 Oct 03 S/P GSW to Chest & Back

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

PATIENT IDENTIFICATION:

[redacted]

(b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

DA FORM 4677, 1 OCT 78 EDITION OF 1 DEC 77 MAY BE USED. 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 5	6	7	8
05OCT (b)(6)-2	[redacted]	IV heplock	06 18	[redacted]	NO IV 6 Oct 03 @ 1000		
05OCT (b)(6)-2	[redacted]	Albuterol [redacted] (b)(6)-2 2.5/3.0 cc Neb q 6° for 72°	06 12 18 24	[redacted]			
05OCT (b)(6)-2	[redacted]	Levofloxen 500mg PO qd	10	[redacted]			
05 Oct (b)(6)-2	[redacted]	4l NC (wean off O2)	06 18 18 24	[redacted]			
(b)(6)-2 05OCT [redacted] 8 Oct (b)(6)-2	[redacted]	Percocet i-ii tabs PO q4-6° PRN	D/N D/N E/N	600 200 2 [redacted]	7OCT 2100 2 [redacted]		

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO PRIMARY DIAGNOSIS: S/P GSW to Chest

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

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

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

MEDCOM - 20799

Admission and Coding Information

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

1. Reporting MTF	2. MTF Location	
[redacted] (b)(6)-2	IZ	

3. Register Number	Name (Last, First, MI)	4. Pay Grade	5. Sex
[redacted] (b)(6)-4	[redacted] (b)(6)-4	FGN	M

6. DoB (YYYYMMDD)	7. Age at Admission	8. Race	9. Ethnicity	Religion
1977-01-01	26Y	X	9	ISLAMIC

10. Length of Service	ETS	11. FMP	12. Social Security Number	
		20	[redacted] (b)(6)-4	

Organization (Active Duty Only)	13. Marital Status	Hour of Admission	Branch / Corps:

14. Flying Status	15. Beneficiary Category	16. Zip Code of Residence:
	K78-PRISONER OF WAR/INTERNEES	

17. Unit Location	18. MOS	19. Trauma	Prev. Admission
IZ		DIS	NO

20. Source of Admission	Ward:	Name / Relationship of Emergency Addressee
Direct from ER	ICU1	Address of Emergency Addressee
Name and Location of Medical Treatment Facility: 0580 - 28th CSH - Iraq; No Install Provided		Telephone Number of Emergency Addressee

21. Type of Disposition	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD)
TRF-OTH		2003-10-08
24. Clinic Svc - Admitting	25. MTF Transferred From	26. Date this Admission (YYYYMMDD)
ABA - GENERAL SURGERY		2003-10-02
27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission
		2003-10-02

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: GSW TO THE ~~ABDOMEN~~ Chest
Hemothorax
Rt lung contusion

Procedure Narrative(s):

Cause of Injury Narrative:

Admitting Officer (Signature, as requi[redacted] (b)(6)-2 [redacted] of Admitting Clerk

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

Automated Facsimile - DA FORM 2985, MAR 200[redacted] MEDCOM - 20800

9	10	11	12	13	14	15

4. PAY GRADE		5. SEX
16	17	18

6. DATE OF BIRTH (YYYYMMDD)								7. AGE AT ADMISSION			8. RACE	9. ETHNIC BACK-GROUND		RELIGION
19	20	21	22	23	24	25	26	27	28	29	30	31		

10. LENGTH OF SERVICE			ETS	11. FMP		12. SOCIAL SECURITY NUMBER									
32	33	34		35	36	37	38	39	40	41	42	43	44	45	

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS		HOUR OF ADMISSION	BRANCH / CORPS
	46			

14. FLYING STATUS			15. BENEFICIARY CATEGORY			16. ZIP CODE OF RESIDENCE								
47	48	49	50	51	52	53	54	55	56	57	58	59	60	61

17. UNIT LOCATION (State or Country Code)		18. MOS							19. TRAUMA	PREV. ADMISSION	
62	63	64	65	66	67	68	69	70	71	YEAR	NO
											☐

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72		ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION		22. MTF TRANSFERRED TO						23. DATE OF DISPOSITION (YYMMDD)					
73	74	75	76	77	78	79	80	81	82	83	84	85	86

24. CLINIC SVC - ADMITTING				25. MTF TRANSFERRED FROM						26. DATE THIS ADMISSION (YYMMDD)					
87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102

27. LOCATION OF OCCURRENCE (Battle Casualty Only)		28. MTF OF INITIAL ADMISSION						29. DATE INITIAL ADMISSION (YYMMDD)					
103	104	105	106	107	108	109	110	111	112	113	114	115	116

FOR LOCAL USE

Dx 86131
8603
E9912

Pr: 3404
9394

Inj Trauma
450 1

ADMITTING OFFICER (Signature, as required)	SIGNATURE OF ADMITTING CLERK

DA FORM 2985, MAR 89 EDITION OF MAY 79 IS OBSOLETE USAPPC V1.00

CLINICAL RECORD

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

Mo. ____ Yr. 2003

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 1 2 3 4 5 6 7 8
2Oct	[redacted]	Chest tube to suction	08	[redacted]
			18	[redacted] > D/Cd 4 Oct 03
2Oct	[redacted]	Routine VS TID	06	[redacted]
			18	[redacted] > D/Cd 4 OCT 03
2Oct	[redacted]	PCXR @ 0400 qAM	04	[redacted]
2Oct	[redacted]	NPO	06	[redacted]
			18	[redacted] D/C'd
2Oct	[redacted]	Incentive Spirometer q Shift	08	[redacted]
		while awake	18	[redacted]
2Oct	[redacted]	wean O2 to NC SAT >92	06	[redacted]
			18	[redacted]
2Oct	[redacted]	up in chair	06	[redacted]
			18	[redacted] > D/C
2Oct	[redacted]	clear liquid diet	06	[redacted]
		AAT Regular	18	[redacted]
2Oct	[redacted]	Place foley Cath	06	[redacted]
2 Oct	[redacted]	foley care q S	18	[redacted] > D/C'd 4 OCT 03
			X	
3 Oct 03	[redacted]	Hygiene and pulmo	06	[redacted]
		diary, toilet q 1°	18	[redacted]
3 Oct 03	[redacted]	Cough + deep breath	06	[redacted]
			18	[redacted]

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P GSW (R) chest/back - hemothorax

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO: 1

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

MEDCOM - 20802

(b)(6)-2 all.

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo ______ Yr 2003

Verify by Initialing

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
02OCT03	[redacted]	Admit ICU	02OCT03		0535	[redacted]
	-----	Stable	02OCT03		1935	[redacted]
2Oct	[redacted]	CBC q 4° X3 start @ 0600	2Oct	0600	0545	[redacted]
2Oct		~~CT chest with contrast~~ Error	↓	1000	Not Done	[redacted]
	-----		↓	1400	1535	[redacted]
2Oct	[redacted]	CT chest ē contrast	2Oct	today		
2Oct	[redacted]	ABG Now	2Oct	Now	2315	[redacted]
02Oct	[redacted]	↑ in chair today	02Oct			
02Oct	[redacted]	Dr [redacted] is attending	02Oct			
04OCT	[redacted]	Blood C/CBC now	04OCT	NOW	1935	[redacted]
04OCT	[redacted]	PA/lat CXR in 4° to R/O pneumonia	04OCT			

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

USAPA V1.00

MEDCOM - 20803

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 10 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 5	6	7	8
5OCT	[redacted]	IS @ 4° with Sat Check	06	[redacted]			
			18	[redacted]			
5OCT	[redacted]	Act OOB amb	06	[redacted]			
			18	[redacted]			
5OCT	[redacted]	Diet Regular	06	[redacted]			
			18	[redacted]			
5OCT	[redacted]	Incentive Spirometer 5x @ 1° while awake	06	[redacted]			
			18	[redacted]			
			/				
06OCT	[redacted]	PA/LAT CXR qam	05	/ [redacted]			
			/				
05OCT	[redacted]	4L NC	06	[redacted]			
			18	[redacted]			

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P GSW to Chest

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

E [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

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
10/5	[redacted]	Transfer to ICW				
10/5	[redacted]	D/C to EPW camp				

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED
	[redacted]	Contact MD T > 101.8	
		SBP > 180	
		Sat < 90%	

MEDCOM - 20805

CLINICAL RECORD

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

Mo.____ Yr.____

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 2 3 4 5 6 7 8 9 10
20ct	[redacted]	IVF: LR @ 75cc/hr	08	[redacted] → DC'd 4 Oct 03
			16	[redacted]
20ct	[redacted]	Ancef 1g IVPB q 8°	08	[redacted]
			16	[redacted]
			24	[redacted]
		MSO4		error
20ct	[redacted]	Zantac 50mg IV Q8°	00	[redacted]
			16	[redacted] DC'd Replaced by Tagamet [redacted]
			24	
20ct	[redacted]	Albuterol Neb 2.5cc/3.0	06	[redacted]
		cc Q4h	10	[redacted]
			14	[redacted]
			18	[redacted]
			22	[redacted]
			02	[redacted]
20ct03		IOL NR Mask	06	[redacted] → DC'd
			18	[redacted]
20ct03	[redacted]	Tagamet 300mg IVPB	06	[redacted]
		q 8°	12	[redacted]
			18	[redacted]
			24	[redacted]

7-(97(90)

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/p GSW Chest/back = hemothorax

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

D 7 8 9 10 11 12 13 14

E 15 16 17 18 19 20 21 22

N 23 24 01 02 03 04 05 06

DA FORM 1 FEB 79 4678

EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

MEDCOM - 20806

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
20Oct	[redacted]	Lasix 20mg IV	20Oct	1630	1630	[redacted]

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
20Oct	[redacted]	MSO4 2-4mg IVP	D	20Oct 0615	20Oct 0700	20Oct 0830	20Oct 1100	20Oct 1530	20Oct 1630	20Oct 1730	20Oct 2045	20Oct 2330	30Oct 0045	30Oct 2015	40ct 0700	40ct 1130
		q 30 min PRN pain	T	0615 4mg	4mg	3mg	3mg	4mg	3mg	3mg IV			2mg	4mg	4mg	2mg
			I	[redacted]												
				30Oct 1400	30Oct 1930	30Oct 2000	30Oct 2330	40ct 0400	40ct 1220							
				3mg IM	3mg	4mg	2mg	4mg	4mg							
[redacted]		Tylenol 650mg po Q4° pm	D	[redacted]												
			T	7925												
			I	[redacted]												

(b)(6)-2

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

MEDCOM - 20807

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

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

INITIAL SHIFT ASSESSMENT

		TIME	0240	INTILA [redacted]	(b)(6)1-2	INTILAS		INTILAS
NEURO		PUPLIS	3mm PERRLA					
		SENSORIUM	Able to speak some English + express needs					
RESPIRATORY		RESPIRATION PATTERN	Equal chest rise, Tachypnea RR 30s, BS clear @ LL					
		BREATH SOUNDS						
		SECRETIONS	diminished @ LLobe + RLL @ secretions noted @ this time					
SKIN		COLOR	WNL for race. Chest tube to continuous suction @ Plant Drg C.D.I					
		INTEGRITY						
I V SITE		LOCATION	PIV @ AC + @ ACENS					
		CONDITION	@ KVO. @ S/s of infection Patent.					
GASTRO		ABDOMEN	Soft, nontender					
		BOWEL SOUNDS	(+) normoactive all 4 quad.					
GU		URINE	urinal, dark yellow urine					
		COLOR/CLARITY						
CARDIOVASCULAR		CARDIACRHYTHM	SR c @ S/S of ectopy HR 80s. +2 palpable pulses + 2-3sec Cap refill in all ext.					

LEGEND

Cr - Creatinine
F_IO - Fraction of inspired O_2
F_IO_2 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - PRESSURE OF ARTRIAL CO_2
PEEP - Positive end Expiratory Pressure
S/A - Fractional
SAI - Saturation
TRACH - Iracheostomy

(Continue on reverse)

PREPARED BY *(Signature & Title)*

DEPARTMENT/SERVICE/CINC ICU1

DATE 02 OCT 03

PATIENT'S INDICATIONS *(For typed or written entries give: Name—Last, First, middle; grade; date; hospital or medical facility)*

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

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

0248
↓
02

DATE | DX 03 04 05 ~~06~~ | HOSPITAL DAY

VITAL SIGNS

TIME	~~24~~	~~01~~	~~02~~	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial line	129																	
BP Cuff	CW	127/69	104/61	124/72														
Temperature	99.2	99.2		98.4														
Pulse	80	88	73	78														
Respiratory Rate	32	30	20	31														
SpO2	100	96	99	100														
Source	NRB	NC	NRB	NRB														

INTAKE

TIME	~~24~~	~~01~~	~~02~~	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	02	03	04	05	~~06~~													
IVF (LR)	75	75	75	75					300									
IVPB									0									
TOTALS									304									

OUTPUT

URINE	HOUR / TOTAL	650 / 650							1650									
	SP gr																	
	S/A																	
~~NG~~	OUTPUT																	
	PH																	
	GUIAC																	
EMESIS																		
STOOL																		
DRAINS	~~Chest Tube~~	23		73					96									
TOTALS																		

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS

14 | 17 | 18 | 19 | 20 | 21 | 22 | 23

INTAKE

14 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 8°T

OUTPUT

RESPIRATORY DATA

TIME

MODE

F_IO_2

TV

RATE

PEEP

A: pH, PCO_2

B: pO_2, HCO_3

G: SAT, BASE

LABORATORY DATA

TIME

CLUCOSE

Na/K

Cl/CO_2

BUN/Cr

WBC/PLATELET

Hct/Hgb

ACTIVITIES DAILY LIVING

TIME

MOUTH CARE

BATH

SKIN CARE

FOLEY CARE

TRACH CARE

ROM EXERCISES

TURN

TIME

SUCTION

24 HR TOTALS

NURSE'S SIGNATURE

INITIALS

(b)(6)-2

(b)(6)-2

WT Yesterday

wt Today

INTAKE

IV

Po

TOTAL 3000

OUTPUT

Urine:

TOTAL 746

-446

MEDCOM - 20810

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

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

INITIAL SHIFT ASSESSMENT

Section	Item		INTILAS		INTILAS		INTILAS
	0615 TIME		[redacted]				
NEURO	PUPLIS	PERL 3 mm brisk				PERRL 3mm	
	SENSORIUM	A&O ·				A&O x3	
		Active Rom to				Active ROM to	
		All Extremities				X4 extremities	
RESPIRATORY	RESPIRATION PATTERN	15-27 Reg.				Clear c diminished	
	BREATH SOUNDS	Clear c Diminished (R) base				bases	
	SECRETIONS	Ø				4L NC SpO2 @ 95%	
		Sat 97-100% on 10L				chest tube to (R)	
		NRB. Mask.				chest wall draining scant	
		chest tube to (R) chest wall				sanguinous fluid	
SKIN	COLOR	Normal				NFL BSW to (R)	
	INTEGRITY	Intact except for				side back & chest	
		BSW (R) side of back & chest				tube.	
IV SITE	LOCATION	(L) hand				(L) AC c LR @ 75cc/hr.	
	CONDITION	Patent. LR 75h				(R) side H/L to (R)	
		(+) left AC				AC (+) Flush Ø	
						S/S of infection	
						[illegible]	
GASTRO	ABDOMEN	Nontender soft to touch				Soft round	
	BOWEL SOUNDS	(+)				nontender. (+)	
						BS X4 quad	
GU	URINE	clear urine				Foley draining	
	COLOR/CLARITY	Not seen				to gravity clear	
						yellow	
CARDIOVASCULAR	CARDIACRHYTHM	SR. HR 80's All				S1 S2 (+) pulses	
		peripheral pulses (+)				X4 quad	
		S1S2 (+) JVD or edema					
		(-) chest pain.					

LEGEND

Cr - Creatinine	ICP - Intracranial Pressure	S/A - Fractional
F_iO - Fraction of inspired O_2	PCO_2 - PRESSURE OF ARTRIAL CO_2	SAI - Saturation
F_iO_2 - Bicarbonate	PEEP - Positive end Expiratory Pressure	TRACH - Iracheostomy

(Continue on reverse)

[redacted] (b)(6)-2

DEPARTMENT/SERVICE/CINC: ICU

DATE: 02OCT03

PATIEN[redacted] For typed or written entries give: Name—Last, First, middle; grade; date; hospital or medical facility)

(b)(6)-4 [redacted]

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

DA FORM 4700, 1 MAY78
Proponent Dept of Nurs

MEDCOM - 20811

WAMC OP 375 (Redesignated)
1 APR 90 (HSXC - NU)

DATE | DX | HOSPITAL DAY

VITAL SIGNS	TIME	06	07	08	09	10	11	12	13		14	15	16	17	18	19	20	21	
	BP Arterial line																		
	BP Cuff	116/70	118/70	123/77	117/67	113/60	118/67	115/67	113/78		136/78	127/64	127/66	121/73	119/64	114/67	119/69	124/76	
	Temperature	98.3				98.2					98.4				100.1				
	Pulse	71	90	95	82	80	81	107	83		93	98	85	83	87	97	92	114	
	Respiratory Rate	21	23	22	18	18	17	19	19		22	24	20	20	20	25	26	34	
	O2sats	100	100	100	97	96	97	96	98		99	97	94	95	94	95	95	94	
	Source	NRB	NRB	NRB	NC	NC	NC	NC	NC		NC	NC	NC	NC	NC	NC	NC	NC	
			10L	10L	4L	4L	4L	4L	4L		4L	4L	4L	4L	4L	4L	4L	4L	
INTAKE	TIME	06	07	08	09	10	11	12	13	8°T	14	15	16	17	18	19	20	21	8°T
	IVF	75	75	75	75	75	75	75	75		75	75	75	75	75	75	75	75	
	IVPB			100									100						
	PO							240	240		240			500	100 / 200				
	TOTALS	75	75	175	75	75	75	315	315		315	75	175	575					
OUTPUT	URINE HOUR / TOTAL												500 / 500						
	URINE SP gr																		
	URINE S/A																		
	NG OUTPUT																		
	NG PH																		
	NG GUIAC																		
	EMESIS																		
	STOOL																		
	DRAINS CT														130				
	TOTALS																		

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS

	22	23	24	01	02	03	04	05
	129/62	125/69	118/69	131/61	104/71	123/59	129/71	111/68
	101.5	101.4	"	100.8				
	101	106	100	87	90	88	92	100
	31	26	31	23	40	23	30	36
	97	95	97	100	96	95	96	99
	NC	NC	NR	NC	NR	NC	NR	NC
	4L	10	10	10	10	10	10	10

INTAKE

	14	17	18	19	20	21	22	23	8°T
	75	75	75	75	75	75	75	75	
		150							

OUTPUT

RESPIRATORY

		TIME	0800	2330						
		MODE	NRB	NRB						
		F_iO_2	10L	70						
		TV		—						
		RATE		28						
		PEEP		—						
	A	pH		7.36						
	A	PCO_2		42						
	B	pO_2		76						
	B	HCO_3		25						
	G	SAT		93						
	G	BASE		0						

LABORATORY

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

ACTIVITIES OF DAILY LIVING

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

24*180 TOTALS

NURSE'S SIGNATURE | INITIALS

WT Yesterday _____ wt Today _____

INTAKE

IV _____

Po _____

OUTPUT

Urine: _____

_____

TOTAL _____

MEDCOM - 20813

ACLU-RDI 1658 p.173

DOD-034387

Patients Name: [redacted] (b)(6)-4 Date: 4OCT05

ITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
ine																										
P	108/64	121/54	117/59		122/63	134/75	125/66					110/49		123/57	106/51	118/59		130/63				104/62				
MP	99.0								100.0					101.1	100.4	100.0		99.7				99.2				
	103	86	99	106	87	128	117	110	107		110	97		107	116	114		105				92				
	(45)	(80)	30	22	27	27	25	29				24		23	32	36		25				31				
02	96	96	96	98	98	98	91	96	95		94	95		92%	93%	91%		94%				93%				
2	FM		FM	NC	NC	NC	NC	NC	NC		NC	NC		NC	NC	NC		NC				NC				
urce	9	6L	6L	7L	4L	4L	4L	4L	4L		4C	4L		3L	4L	4L		4L				4L				
P	82	83	83		85	96	86	∅			0	75		80	73	83		90				79				
															Gave Tylenol @1925											

KE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
	75	75	75	75	75	75	75	75	75	DC	DC		825													∅
			50										500			90				100						150
														120				360				180				660
				240						DC IV																
Total													875													810

TPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
NE			1700						30 / 200				1900	600								600				1200
OL									Foley Dced																	
IN																										
Total													1900													2100

Total in: 1685 total out: 2100 (−415)

MEDCOM - 20814

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE	OTSG APPROVED *(Date)*
INTENSIVE CARE NURSING FLOW SHEET	**QA APPR 08MAR8**

INITIAL SHIFT ASSESSMENT			
N E U R O		Time: 0800 Initals [redacted] (b)(6)-2	Time: 1605 Initals [redacted] (b)(6)-2
	Pupils	PERRLA	PERRLA 3mm brisk
	Sensorium	Alert + oriented	alert, able to follow commands + express needs
	LOC / GCS	Verbalizes needs	
C A R D I A C	Cardiac Rhythm	SR, 100's S1 S2	SR HR100s S1,S2, Ø ectopy noted. +2 palpable pulses in all ext. Cap refill <3sec in all ext. Ø edema noted. Denies chest pain but c/o tenderness on Ⓡ side chest + side
	PRI: / QRS:	Ø ectopy	
	Pulse Strength	++ radial + pedal	
	Cap Refil / JVD	<3 seconds	
	Edema	Ø	
	Chest Pain	denies ✗ chest tube site + pain R/t tenderness	
	(non cardiac)		
R E S P	Respiratory Pattern	RRR, shallow breathing	tachypnea RR 30s, shallow breathing. ↓ BS Ⓑ ↓ lobes Ø secretions noted @ this time IS q 1°
	Breath Sounds	CTA ↓ BS Ⓡ side	
	Secretions	↓ air exchange throughout	
	Cough	C+DB, IS	
S K I N	Color	WNL	WNL for race. Drsg Ⓡ chest + Plant C, D, I
	Integrity	GSW entry site back exit Ⓡ side below the nipple CT Ⓡ MAxilla	
	Backside		
I V	Access Devices	Ⓡ IV Ⓛ AC D+I	Ⓡ AC ± Ø s/s of infection H.L. patent.
	Location	Ⓛ PIV LR @ 75 + IVPB	
	Condition	patent Ⓡ AC	
G I	Abdomen	Bilateral BS	Distended, tender Ⓡ side (+) BS small quad
	Bowel Sounds	Active	
	Stoma/Ostomy	Ø	
G U	Device	foley to gravity	urinal, dark amber urine ± Ø sediment
	Color / Clarity	clear amber	

(Continue on reverse)

PREPARED BY *(Signature & Title)*	DEPARTMENT/SERVICE/CLINIC	DATE
	ICU3, 28th Combat Support Hospital	4 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

ICU1

Patients Name:

Date: 3 OCT 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04	05
A-Line																								
NBP	126/64	120/66	139/68	124/75	122/66	116/61	133/72	116/60	119/72	115/62	124/61	114/60	118/60	130/60	133/55	133/64	133/63	121/64	131/63	131/63	124/59	124/58	126/60	121/50
TEMP	100.6					100.6			100.6															
HR	85	92	91	99	95	83	86	86	92	87	92	92	119	92	96	101	104	97	97	99	98	107	98	98
RR	28	23	26	30	22	21	35	22	(51)	21	(51)	27	30	32	30	38	40	28	26	32	30	35	24	42
SaO2	96	92	93	92	96	98	94	96	96	(87)	96	97	93	91	94	95	92	93	90	93	90	93	96	94
FiO2	NR	NR	NR	NR	NR	NRoom	NR	NR	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	N	SM	SM
Source	~~FM~~		92		96	100%	97	96	96															
MAP	88																							
Flow									4L	4L	4L	4L	4L	4L	4L	4L	4L	4L	4L	4L	4L	4L	6L	6L

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
IVF	75	75	75	75	75	75	75	75	75	75	75	75		75	75	75	75	75	75	75	75	75	75	75	75	
IVPB																										
NGT																										
PO								150				150														
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05
URINE	50					~~200~~ 250						600	850	850											
NGT																									
STOOL																									
DRAIN																									
CT	100											100													
Total																									

MEDCOM - 20816

ACLU-RDI 1658 p.176

DOD-034390

DICAL RECORD-SUPPLEMENTAL MED DATA

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

OTSG APPROVED (Date): QA Appr 8 Mar 89

REPORT TITLE: INTENSIVE CARE NURSING FLOW SHEET

SHIFT ASSESSMENT

		TIME: 0700 INITIAL [redacted] (b)(6)-2	TIME: INITIALS:
NEURO	PUPILS	PERRLA	PERRL
	SENSORIUM	Awake	A+O x 3
	EXTREMITY MOVEMENT	(+) strong all 4 extremities	Move x4 extremities
	SEDATION	MSO4 4mg @ this time	MSO4 4mg q 30 min PRN
	PAIN CONTROL	well controlled	
RESP	RESPIRATORY PATTERN	UL Bilateral BS	[redacted]
	BREATH SOUNDS	RL (R) ↓ BS (R) chest tube	Slightly labored
	SECRETIONS	none	BS (R) RL dim
	O2 SOURCE/FLOW/SAO2	NR FM	LL
	VENTILATOR SETTINGS	—	
CV	CARDIAC RHYTHM	SR 91	S1 S2
	CAPILLARY REFILL	< 3 seconds	< 3 sec
	PULSES	Radial + pedal pulses (+)	(+) Pulses x 4 extremities
	EDEMA	(-)	
GI	ABDOMEN	Hyperactive BS	(+) BS x4 quad
	BOWEL SOUNDS	soft non tender	Soft Round nontender
	BOWEL MOVEMENT	∅	
	NGT/OGT	∅	
	TUBE FEDDINGS	∅	
	DRAINS	∅	
GU	VOIDING	foley to gravity	Foley to gravity
	COLOR/CLARITY	clear brownish yellow	dark yellow clear
SKIN	COLOR	WNL for race	WNL for race
	INTEGRITY	(R) mid axillary CT site GSW (R) upper back entry wound (R) chest exit wound	CT to (R) chest wall
ACCESS	#1 TYPE/LOCATION/SIZE	# 18	18G to (R) AC & LR
	DRESSING CONDITION	(R) arm	@ 75cc/hr
	IV FLUID/RATE	LR @ 75 cc/hr	
	#2 TYPE/LOCATION/SIZE		
	DRESSING CONDITION		
	IV FLUIDS/RATE		

(Continue on reverse)

PREPARED BY (Name & Title) [redacted] (b)(6)-2 Maj AN

DEPARTMENT/SERVICE/CLINIC (b)(7)-2 ICU #1 [redacted]

DATE: 03 Oct 02

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

NAME: [redacted] (b)(6)-4 RANK: AGE:

UNIT: [redacted] GENDER:

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

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

DA FORM 4700, MAY 78

MEDCOM - 20817

USAPPC V2.00

MEDICAL RECORD

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

OTSG APPROVED (Date) QA APPR 08MAR8

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

INITIAL SHIFT ASSESSMENT

		Time: 0800 Inita[redacted] (b)(6)-2	Time: Initals:
NEURO	Pupils	PERRLA	
	Sensorium	Alert + Oriented	
	LOC / GCS	Verbalizes needs	
CARDIAC	Cardiac Rhythm	S1 S2 NSR ↑90 - SR ↓100	
	PRI: / QRS:		
	Pulse Strength	++ radial + pedal	
	Cap Refil / JVD	< 3 seconds	
	Edema	Ø	
	Chest Pain	Ø	
RESP	Respiratory Pattern	BBS, CTA	
	Breath Sounds	↓ BS throughout lower lobe ® side diminished from mid + lower lobe 2° pneumo c + DB for lung expansion	
	Secretions		
	Cough		
SKIN	Color	WNL	
	Integrity	Back entry site CSW + ® chest exit wound, ® Mid axillary CT site dressing	
	Backside		
IV	Access Devices	® RC HL for antibiotic	
	Location		
	Condition	D+I	
GI	Abdomen	BBS soft non tender	
	Bowel Sounds		
	Stoma/Ostomy	Ø	
GU	Device	voiding spontaneously	
	Color / Clarity	@ 50 clear yellow urine	

(Continue on reverse)

PREPARED BY (Signature & Title)

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

DATE 05OCT03

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

USAPPC V2.00

MEDCOM - 20818

1003 Patients Name: [redacted] (6)(6)-4 Date: 05 OCT 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line	/																									
NBP	110/69	118/58			135/65																					
TEMP	99	98.8																								
HR	96	102			95																					
RR	14	17			22																					
SaO2	94%	92			95																					
FiO2	~~RA~~	4L			4L																					
Source	NC	NC			NC																					
MAP	93				84																					

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
VF																										
VPB	~~100~~																									
IGT																										
O																										
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
RINE																										
GT																										
TOOL																										
RAIN																										
Total																										

MEDCOM - 20819

ACLU-RDI 1658 p.179

DOD-034393

INPATIENT TREATMENT RECORD

For use of this form, see AR 40-66; the proponent agency is [illegible]

1. REGISTRATION NUMBER	4. NAME (Last, First, MI)	5. SERVICE	ADMISSION REMARKS
[redacted] (b)(6)-4	UNK EPW# [redacted] (b)(6)-4	NA	

6. SEX	7. AGE	8. RACE	9. RELIGION	10. LENGTH OF SVC	11. GRD	12. PREVIOUS ADMISSION
M	26	UNK	UNK	NA	NA	NO

13. PAY	14. SSN	15. ORGANIZATION	16. WARD
99	[redacted]	(b)(6)-4 NA	IAW I

17. RATING STATUS	18. RATING DSG	19. DEPT/ BEN	20. BRANCH/CORPS	21. DIC/ZIP	22. TYPE CASE
NA		NA	NA		NBI

23. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	24. HOURS OF ADMISSION	25. CLINIC SERVICE
Direct from Emt	1340	ABAA

26. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	27. TYPE DISPOSITION	28. DATE OF DISPOSITION
UNK	24	10/5/03

29a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	29b. TELEPHONE NO.	30. DATE OF THIS ADMISSION	ADMITTING OFFICER
UNK	UNK	10/3/03	(b)(6)-2 Dr [redacted]

31. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	32. DATE OF INITIAL ADMISSION	33. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
[redacted] (b)(2)-2	10/3/03	

34. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

35. CAUSE OF INJURY

36. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Dx: NASAL FX. 802.0 E886.0

21.71

37. Total Days This Facility

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

38. Total Days All Facilities

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

39a. [redacted] 39b. (b)(6)-2 (b)(6)-2 SIGNATURE OF CHIEF OF MEDICAL [illegible] DATE (b)(6)-2

Dr [redacted] FOR [redacted]

DA FORM [illegible]

MEDCOM - 20820

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

26 yo dm EPW playing soccer fell down broke his nose. Pt c nasal deviation to the pt's left. no septal hematoma

PMH: Ø

PSH: Ø

aller: NKDA

Medo: Ø

PHYSICAL EXAMINATION

WDWN 26 yo Im in NAD
NC - Perrl, EOMI
unifacial bilateral ecchymosis present
nasal bones deviated to pts left.
Ø septal hematoma. dried blood around nares.
mart unstable.
Pt missing tooth #9 fell out during fall

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

A/P 26 yo dm EPW c nasal fx.

1. Admit
2. to OR for SX.

(b)(6)-2

SI [redacted]	DATE 03 OCT 03	IDENTIFICATION NO.	ORGANIZATION

PATIENT'S IDENTIFICATION	*(For typed or written entries give Name last, first, middle; grade; date; hospital or medical facility)*	REGISTER NO.	WARD NO.
# [redacted] EPW (b)(6)-4			

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
04 OCT 03 cont	IV Percocet administered, Yankaur suction @ bedside. Pt 2 point restraints. Will continue to monitor. [redacted] (b)(6)(b)-2 9LWMb (1600D) I concur c above assessment. [redacted] (b)(6)(b)-2 WA
4 OCT. 03 1945	Pt A+Ox3, VSS, LS CTA (B), (+)BS x4, Pt tol PO well, voiding c difficulty, HOB ↑ 30°, pain controlled c percs, steristrips on nose CDI, ø s/sx of poor circulation or skin breakdown on pts of restraint. [redacted] (b)(6)(b)-2 9LW
Saturday 0700	Received pt resting in bed, VSS, tol PO clrs, void adeq to neg. SOBs, A+Ox3. 1/4 percocets for pain this shift. Dsg to Nose intact. Suction @ BS. Restraints per OPW pain protocol, ø breakdown noted, ø other remarkable assessments. HOB ↑, ø new distress noted [redacted] (b)(6)(b)-2
5 OCT 03	2130 = VSS, 0/10 pain @ present time, packed PEG's to (B) nares intact, ø active drainage assessed @ present time, HOB ↑ 30°, IV HL to (R) FA flushed & patent. Continuing IV ancef around the clock, Suction @ BS, x2 restraints c (-) skin breakdown, POC = Pain Mgt & palliative care. Will continue to monitor for acute Δ's throughout shift. [redacted] (b)(6)(b)-2 LT/SM
Sunday 0800	Pt D/C w/ meds to MP custody, amb steady and IV d/c [redacted] (b)(6)(b)-2

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — PROGRESS NOTES

DATE	NOTES
3 Oct	Pt brought from EMT to ICU #1, pt has nasal fx head to OR Oct 4, VSS, pt A+OX3, pt c/o pain in (L) knee from old gunshot wound. PERRLA, pulse regular and rate within range for age. swelling around upper nasal region, respiration normal lungs clear bi-laterally, depth is regular & cough, abd soft non-distended, no problem swallowing voiding & difficult after urine skin warm/dry no breakdown, circulation intact restraints x2 in place [redacted] (b)(6)-2 Fx (1735) I concur c above assessment [redacted] (b)(6)-2 MD
3 OCT 03	Pt A+OX3, VSS, LS CTA (B), +BSx4, abd
1145	soft flat non tender, HOB↑ 30°, pt medicated for pain c 2 percs, swelling noted (L) side of nose, able to breath through (R) nostril, IV (R) FA intact infusing NS @ 125cc/hr ø s/sx of infex or infiltration, voiding c diff, ø s/sx of poor circulation or skin breakdown on pts of restraint. [redacted] (b)(6)-2 RN
4 OCT 03	Pt A+O LS CTA (B). [redacted] (b)(6)-2 P/O Nasal repair. S1, S2 present
1130	+BSx4 quads. Liquid Diet. [redacted] (b)(6)-2 Tol PO well. c/o pain

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

RELATIONSHIP TO SPONSOR | PT. SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

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

EPW #I [redacted] (b)(6)-2

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/1
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b
USAPA V

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE | NOTES

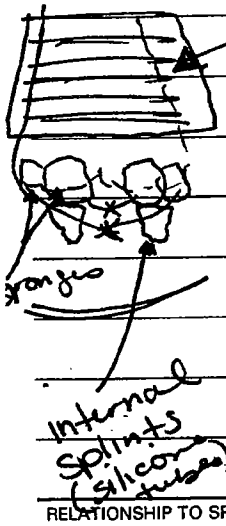
Discharge Summary

05 OCT 03 @ 0915 — 26 y/o wm EPW S/P closed reduction of nasal fracture on 04 OCT 03. Pt tolerated procedure well.

D/C cond: Stable

D/C Diet: Regular

D/C meds: Percocet 1-2 tab po q 4-6° prn pain
Augmentin 1 tab po BID
Afrin 1-2 sprays per nostril BID x 3 days (when nasal packing removed)



Plan

(1) Please remove internal Silicone Splints and 4 Sponges (2 each nostril) on 07 OCT 03 tuesday.

(2) Please remove external nasal Splint on 11 ~~OCT~~ OCT 03 and remind pt - NO Pressure to nose

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.

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

PROGRESS NOTES
Medical Record

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

MEDCOM - 20824

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	For 4-6 weeks. ③ use afrin spray x 3days once nasal packing removed. (b)(6)-2 [redacted] MAJ/DC cc: OMFS.

MEDICAL RECORD — **INTRAOPERATIVE DOCUMENT**

For use of this form, see AR 40-407, the [redacted] the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING VIA litter BY anesthesia

2. PATIENT IDENTIFIED AND PROCEDURE VERIFIED BY [redacted] CRT/AN (b)(6)-2

3. DATE 40CT03 TIME PATIENT ARRIVED IN SUITE —

4. PATIENT IN ROOM TIME 0800 NUMBER 2-1 (1)

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

PT & english speaker. No translator available

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

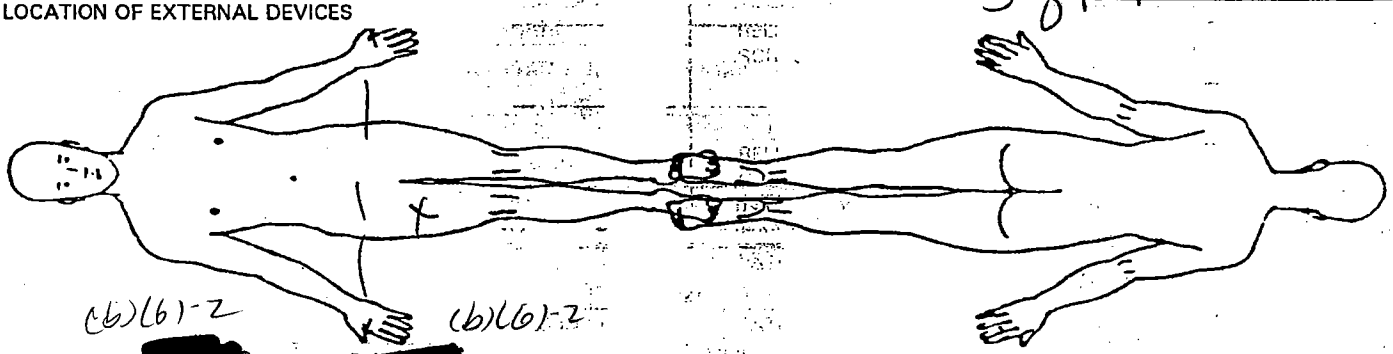
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Beta
SITE: Face 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

LEGEND [redacted] ad -- [redacted] p = = = Tourniquet

10. COUNTS			C = Correct I = Incorrect 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 [redacted] PFC

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

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

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

(b)(2)-2 [redacted]

40CT03

12. ELECTROSURGERY DEVICE(S) (ESU) ☐ YES ☒ NO (b)(6)-4

☐ ESU NO: CUT Valleylab [redacted]
GROUND PAD: BRAND Valleylab E7507
LOT NO [redacted] 2005-02 (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 - 20826

13. PROSTHESIS, IMPLANTS ☐ IF YES NAME: ID NUMBE[illegible] URER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
1% Xylocaine w epi (1:1000)	1cc	Intraop	inject	[redacted] (b)(6)-2	DR [redacted]
Genasal Nasal Spray	QS	Intraop	topical	[redacted] (b)(6)-2	DR
Bacitracin ointment	QS	Intraop	topical	[redacted] (b)(6)-2	DR

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

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

OTHER ORDERS	TIME	CARRIED OUT BY

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

[redacted] 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	

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE/SIZE	1. Merocel Sinus Pack		
SITE	1 (L) + (R) Nostrils	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
- EXTERNAL NASAL SPLINT
- 2x2

19. ADDITIONAL INFORMATION
Splint → PEEL
68L1182 E F520

20. OPERATION(S) PERFORMED
Closed reduction of nasal fracture.

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU 3 (b)(6)-2	0900	litter

22. REGISTERED NURSE SIGNATU[redacted] CPT/AN

REVERSE OF D[illegible]M 5179-1, OCT 87 MEDCOM - 20827 USAPA V1.00

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR Oct 2003 | DAY | HOUR

30 Oct 1430 | 1 | 8 | 4 Oct 2000 | 5 Oct 0900

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° 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

BLOOD PRESSURE

103/40 | 109/62 | 109/61 | 125/63 | 112/66

67 | 73 | 99 4 | 98 | 71

98% | 98% | 98% | 98% | (D2) 98% RA

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 - 20828

MEDICAL RECORD — ANESTHESIA

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

DRUG (Units)		TOTALS
Fentanyl (mcg)	150 100	250
Lidocaine (mg)	100	
Propofol (mg)	150	
SCh (mg)	100	
Zemuron (mg)	25	
VOLAT AGENT ISO % del	2.0	
% e.t.		
AIR L/Min		
N2O L/Min		
O2 L/Min	10 – 2 – 2 – 10	

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

TOTAL EBL: minimal

TOTAL URINE: Ø

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

FLUIDS — LINE site: 18g (R) — ☐ Warmed — NS (1000) ——— 400

LOSSES — EST BLOOD LOSS; URINE– Not measured

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 75 (KG) LB

HEMATOCRIT:

INITIAL DATA: BP– 126/68 HR– 78

EQUIP CHECK: OK?– (Y) N

PATIENT RECHECK: OK for PROCEDURE: Okay; TIME– 0745

TIME: 0800 15 30 45 0900

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

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

REMARKS- Code drugs with numbers, events with letters

0745 Pt i/d in ICW, To OR via litter.
0800 Induction. ⊕ monitors, ⊕ O2, Smooth IV induction, PP padded,
0815 10cc 1% Lido c̄ 1:100k Epi inj by surgeon.
0845 Pt reversed c̄ 7mg Neostigmine ⊕ 2cc Robi
0853 40mg Narcan, A SXW x 2.
0855 Pt awake, extubated s̄ diff, Moved self to litter, To PACU stable.

VENT	VT – ml		620	800	600
	f – breaths/min	20	12	8	12
	Peak inf pres / PEEP		15	18	
	MODE– S(pon), A(ssist), C(on)	S	C	C	S

MONITORS / ACCESSORIES

X BP/Auto Cuff	X ET CO2 (torr)	⊕	36	34	36	
BP / oth	X FIO2 (Frac or %)	.91	.91	.91	.91	
ART line	X SpO2 (%)	100	100	100	100	
Steth- PC/ES	X ECG	SR	SR	SR	SR	
Gas analyzer	X TEMP- site					
	X N-M Block (T/4)		4/4		4/4 c̄ STEP	
Warming blkt						
Conv warmer						

Mark with letters & symbols, explain under REMARKS — EVENTS; Position — Sup – TT 90° ———→

RECOVERY AT: 0900 — (PACU) ICU ____ (Specify) OTHER
CONDITION: Stable/Awake
RESP– SpO2– 96%
BP– HR–

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0745	0800	0903

	Ready	Begin	End
PROC	0810	0823	0852

PROCEDURES and CPT Codes: CR Nasal Bone Fx

ANESTHETIC TECHNIQUES: Describe block technique under Remarks — GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments — NL x 1 attempt, Grade 1 view, #8 ETT, 4 MAC, ⊕ BBS ⊕ ETCO2, Secured @ 23 lip. Soft bite block. Atraumatic

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

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

PROCEDURE LOCATION: OR 2

DATE: 4 Oct 03

PAGE 1 OF 1

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

[redacted] (b)(6)-4

WAMC OP 376 REVISED
1 Jan 99

PATIENT RECORD
MEDCOM - 20829

ACLU-RDI 1658 p.189

DOD-034403

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 26 DAYS MOS YRS Sex (X) MALE ( ) FEMALE

ASA Physical State 1 2 3 4 5 E
WT: 75 KG/LB HT: ____ IN.
ALLERGIES: NKDA

PROPOSED PROCEDURE: CR Nasal Bone Fx
SURGICAL SERVICE: OMFS
NPO SINCE: Mid

HABITS:
TOBACCO: (+)
ETOH: ____
DRUGS: ____

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) NS @ 125cc/hr
( ) Ancef 1gm
( ) ____
( ) ____
( ) ____
( ) ____

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

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

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:			
Hypertension	N	Y	____
Angina	N	Y	____
MI	N	Y	____
CVA	N	Y	____
Other	N	Y	____
Pulmonary System:			
Asthma	N	Y	____
Bronchitis/URI	N	Y	____
COPD	N	Y	____
Other	N	Y	____
Renal System:			
Acute/Chronic RF	N	Y	____
Gastrointestinal:			
Hepatitis	N	Y	____
Hiatal Hernia	N	Y	____
PUD/GERD	N	Y	____
Endocrine System:			
Diabetes	N	Y	____
Steriods	N	Y	____
Thyroid	N	Y	____
Neurological:			
Seizures	N	Y	____
Neuropathy	N	Y	____
Other	N	Y	____
Gynecological :			
Pregnancy	N	Y	N/A
Other Significant Hx:	N	Y	Playing Sports – fell down
	N	Y	Nasal deviation to Left.
Familial HX	N	Y	No bleeding

ASSESSMENT
PAST SURGICAL/ANESTHETIC
(2)

PHYSICAL EXAMINATION
BP ___ HR ___ R ___ T ___
Pain Scale 0-10 ____
HEENT - Teeth ____
Trachea ____
TMJ/Neck ____
Oropharnyx WNL
Nares ____
CHEST: ____
CARDIAC: ____
EXTREMITIES: ____
IV Access: 18g (R)
Ulnar Filling: ____
BACK: ____
OTHER: ____

NPO Since Mid

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

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

The patie[redacted]eems to understand and agrees. Questions answered.
Signed: [redacted] CPT CMA Date: 4 Oct 03 Time: 0730 Hrs

POST-ANE[redacted]D 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) ICU 1 9B

[redacted] (b)(6)-4

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	Admission NOTE
03OCT03 @1845	26 years EPW S/P playing soccer + fell + sustained nasal fx. admitted for CR nasal fx. (b)(6)-2 [redacted]
04OCT03 @0845	OMFS Brief OP NOTE
	Pre OP dx: nasal fx
	Post op dx: Same
	Procedure: closed reduction of nasal fx.
	Surgeon: [redacted] (b)(6)-2
	Assist: [redacted] (b)(6)-2
	Anesth: GETA
	EBL: minimal
	fluids: 400cc LR
	comp: 0.
	cond: Stable, extubated and transferred to recovery Event (b)(6)-2 [redacted] MAJ

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 - 20831

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
5OCT03 @0910	OMS POD #1 Pt doing well s/p closed reduction of nasal fracture. ϕ c/o Pain, no active bleeding noted. VSS AF will D/C to camp today [redacted] (b)(6)-2
[illegible]	[illegible]
6 Oct 03	[illegible]
[illegible]	[illegible]
7 Oct 03	[illegible]

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

MEDCOM - 20832

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

EPW

(b)(6)(b)-4

NURSING UNIT: ICW1 | ROOM NO. | BED NO.

DATE OF ORDER / TIME OF ORDER: 03 OCT 03 @ 1340 — HOURS — LIST TIME ORDER NOTED AND SIGN

1. Admit to ICW 1 – Dr [redacted]
2. Dx: Nasal fx (b)(6)(b)-2
3. Cond: Stable
4. Vitals: Per routine
5. Aller: NKDA
6. Activ: Ad lib
7. Nurs: HOB T 30°

PATIENT IDENTIFICATION

8. Diet: Regular — HOURS
   * NPO P MN *
9. IV: NS @ 125cc/hr @ MN
10. Meds: Percocet 1-2 tab po q 4° pm pain
11. On call to OR in AM
12. VOID on call to OR in AM
13. Ancef 1gm IV Q 8° (b)(6)(b)-2 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

(b)(6)(b)-4

[redacted]

EPW

DATE OF ORDER / TIME OF ORDER: 04 OCT 03 @ 0845 — HOURS — MM 7 Dr

1. Admit PACU then ICW2 – Dr [redacted]
2. Dx: S/P CR nasal fx
3. Cond: Stable (b)(6)(b)-2
4. Vitals: Per routine
5. Aller: NKDA
6. Activ: Ad lib
7. Nurs: HOB T 30°

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

(b)(6)(b)-2 Noted [redacted] 04 OCT 03 1000

DATE OF ORDER / TIME OF ORDER: Yankauer suction to BS — HOURS

△ drip sponge PRN

8. Diet: clears then Regular diet as tolerated
9. IV: HLIV when taking PO
10. Meds: Percocet 1-2 tab po q 4° pm po
    Ancef 1gm IV q 8°
    toradol 30mg IV @ 6° pm pain

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1 APR 79 4256 REPL MEDCOM - 20833 ...HICH MAY BE USED.

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION				DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
# [redacted] (b)(6)-4				05 OCT 03 @ 0910 HOURS	[redacted]
			①	D/C IV (b)(6)-2	1026
			②	D/C meds	
			③	D/C to MP custody.	3 [illegible]
NURSING UNIT	ROOM NO.	BED NO.		(b)(6)-2 [redacted]	

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

MEDCOM - 20834

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo 10 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 3	4	5	6	7	8
10/3	[redacted]	Vitals per Routine	06	[redacted]					
			18						
			06						
10/3	[redacted]	Activity: ad lib	06						
			18						
			06				DRE	OP	
10/3	[redacted]	HOB ↑ 30°	06						
			18						
			06						
10/3	[redacted]	Diet: Regular	06						
			18						
			06						
04 10/03	[redacted]	Vitals: per routine	06	/					
			18	[redacted]					
04	[redacted]	Activ.: ad lib	06	/					
			18	[redacted]					
04	[redacted]	NURS: HOB ↑ 30°	06	/					
			18	[redacted]					
04	[redacted]	Yankauer suction to	06	[redacted]					
		BS	18	/					
04	[redacted]	Diet: clears then	06	/					
		reg diet as tolerated	18	[redacted]					

(b)(6)-2

ALLERGIES: ☐ YES ☒ NO	PRIMARY DIAGNOSIS: S/P CR nasal fx	ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
NKDA	Nasal Fx	PAGE NO:

PATIENT IDENTIFICATION:

EPW# [redacted]

(b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

DA FORM 4677, 1 OCT 78 MEDCOM - 20835 ISED. USAPA V1.00

(b)(6)-2 all

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
10/03	[redacted]	Admit to ICW 1 - Dr [redacted]	10/3			[redacted]
10/3	[redacted]	Condition, Stable.	10/3			[redacted]
10/3	[redacted]	NPO p MN	10/3	2400		[redacted]
10/3	[redacted]	On call to OR in AM	10/4			[redacted]
10/3	[redacted]	Void on call to OR in AM	10/4			[redacted]
04 OCT 03	[redacted]	Admit PACU then ICW 2 - Dr [redacted]	04 OCT 03			[redacted]
04	[redacted]	Cond. - stable	04			[redacted]
05	[redacted]	D/C to MP custody	05			[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED
04 OCT 03	[redacted]	Sponge prn	

USAPA V1.00

CLINICAL RECORD | THE[illegible]UTIC DOCUMENTATION CARE PLAN (M[illegible]CATIONS)

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

Mo. 10 Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 3	4	5	6	7
10/3	[redacted]	IV: NS @ 125cc/h	06	I				
			18	[redacted]				
10/3	[redacted]	Ancef 1gm IV Q8°	06	[redacted]				
			14					
10/3	[redacted]	IV: HL IV when taking Po	22	[redacted]				
			06	[redacted]				
10/4	[redacted]	Ancef 1gm IV q 8°	18	[redacted]				
			06	[redacted]				
			14	[redacted]				
			22	[redacted]				

ALLERGIES: ☐ YES ☒ NO — NKDA

PRIMARY DIAGNOSIS: Sp CR nasal fx — Nasal Fx

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

EPW # [redacted]

(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

MEDCOM - 20837

(b)(6)-2 all

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. OCT Yr. 03

Verify by Initialing: Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
10/3	[redacted]	NS @ 125 cc° @ MN	10/3	2400	—	[redacted]
5 Oct	[redacted]	D/C IV				
5 Oct	[redacted]	D/C meds				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED					
10/3 Exp 10/6	[redacted]	Percocet 1-2 tab po q 4° prn pain	Date / Time / Dose / Ini	3 Oct / 1940 / II / [redacted]	} pre-op			
04OCT03	[redacted]	Percocet 1-2 tab po q 4° prn pain	D/T	4 Oct 0950	4 Oct 1600	4 Oct 2000	5 Oct 0520	5 Oct 1400
			D/I	II [redacted]	II [redacted]	II [redacted]	II [redacted]	II [redacted]
04OCT03	[redacted]	Toradol 30mg IV q 6° prn pain	D/T					
			D/I					

USAPA V1.00

MEDCOM - 20838

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: 1400
Allergies: NKA
Pre-op V/S: 126/68 78
Procedures: Closed Reduction Nasal bone Fx

Anesthesia Type (Circle)): General Spinal Epidural
IV Sedation Nerve Block
OR Intake: Crystalloid 400 Colloid
OR Output: UOP EBL
Meds/Times: Fentanyl, Narcan

Local lidocaine w EPI

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

Pre Op Meds

History

Time	1400	1405	1409	1415
SaO2	99	96	97	97
FIO2				
Methods	RA	RA	RA	RA
240				
220				
200				
180				
160				
140				
120	V	V	V	V
100				
80				
60				
40				
20				
RR	15	19	16	
T	96			

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1400	NS	400	(R) FA	OR	400

X-rays:

Labs:

Post-Anesthesia Recovery score

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

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

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 4 OCT 03

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

EPIC # [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

NURSING NOTES

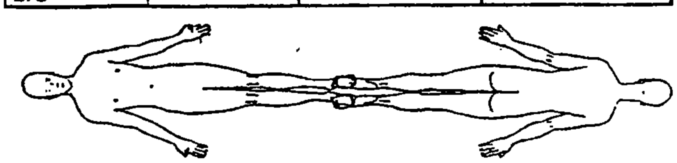
Pt to recovery room from OR s/p closed reduction nasal bone fx. IV of NS infusing into (L) arm s̄ s/s of redness or swelling to site. Nasal brace c̄ drip pad intact. ∅ drainage. VSS. ∅ c/o @ this time. Will continue to monitor & assess. [redacted] (b)(6)-2
-TO ICW#1 via litter [redacted]
(b)(6)-2

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, 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	NOSE	Nasal brace c̄	∅
30'		drip pad	
60'			
D/C			



PACU OUTPUT			
Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM			
Time	Rhythm	Symptomatic?	Rhythm Strip Run?
0900	SR	∅	∅

Discharge Criteria:
Date: 4 OCT **Time:** 0930 **PARS:** 9
BP: 109/52 **T:** 96.2 **HR:** 50 **RR:** 12 **Sa02:** 96-RA
Pain Level at D/C (0-10):
Intake: 50 **Output:** ∅
Additional Data:
Transferred To: ICW # [redacted]
Report Given To: SPC [redacted] (b)(6)-2
Transferred Via: W/C [redacted]ey **Ambulance**
Transferred By: SGT [redacted] (b)(6)-2
Cleared IAW Recovery R[redacted]
Charge Nurse Signature[redacted]

(b)(6)-2