AUTHORIZED FOR LOCAL REPRODUCTIO

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
18NOV03 0836	D/C Summary GPW s/p superficial schrapnel injuries to chest, s/p XRT 8 Adx c Ancef. Will d/c to camp c q 72° dressing D's + Keflex x 7 days.

(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)*

(b)(6)-4

#[redacted]

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

511–119

NSN 7540–00–634–4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY
POST- DAY
MONTH-YEAR | DAY
19 | HOUR

PULSE (O) | TEMP. F (°)

105° 104° 103° 102° 101° 100° 99° 98.6° 98° 97° 96° 95°

180 170 160 150 140 130 120 110 100 90 80 70 60 50 40

TEMP. C: 40.6° 40.0° 39.4° 38.9° 38.3° 37.8° 37.2° 37.0° 36.7° 36.1° 35.6° 35.0°

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

123/60 | 102/58 | 108/63 | 104/64
98.3 | 112/62 | 98.9
120/62 | 78 | H76 | 99.3

HEIGHT: | WEIGHT →

O2 Sat 99(RA) 98 | 98 | 98% | 98%
Pulse 78

Record special data only when so ordered

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

[redacted] (6)(6)-4

REGISTER NO.

WARD NO.

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 23642

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

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

LAST, FIRST, MI: [redacted] (6)(6)-4 | DATE: 8 NOV 03 | TIME: | SSN/PSEUDO SSN: [redacted] (6)(6)-4

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		

LIVER PANEL PLUS
DISC LOT #: 3154AA7
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

ALB	4.0	3.3-5.5	G/DL
ALP	88*	26-84	U/L
ALT	35	10-47	U/L
AMY	36	14-97	U/L
AST	36	11-38	U/L
TBIL	0.6	0.2-1.6	MG/DL
GGT	13	5-65	U/L
TP	7.3	6.4-8.1	G/DL

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

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		

======= PICCOLO =======
08/11/03 11:04
REFERENCE RANGE: (6)(6)-MALE
PATIENT #: [redacted]
BASIC METABOLIC
DISC LOT #: 3325AA1
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	112	73-118	MG/DL
BUN	7	7-22	MG/DL
CA++	9.7	8.0-10.3	MG/DL
CRE	1.1	0.6-1.2	MG/DL
NA+	147*	128-145	MMOL/L
K+	4.5	3.3-4.7	MMOL/L
CL-	106	98-108	MMOL/L
tCO2	24	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
tCO_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
LB		3.3-5.5 g/dl
LP		26-84 u/l
LT		10-47 u/l
MY		14-97 u/l
T		11-38 u/l
L		0.2-1.6 mg/dl
T		5-65 u/l
		6.4-8.1 g/dl

(Piccolo) Electrolyte

T	RESULT	REF. RANGE
		128-145 mmol/l
		3.3-4.7 mmol/l
		98-108 mmol/l
		18-33 mmol/l

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

(6)(6)-4
[redacted]
COM - 23643

(b)(6)-2

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

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

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
RBC		4.7-6.1 x 10^6
Hgb		14-18 g/dl (M) 12-16 g/dl (F)
Hct		42-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-500 x 10^3 verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

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	Straw	N/A
App	Clear	N/A
Glu	neg	Negative
Bili	neg	Negative
Ket	neg	Negative
SG	1.010	N/A
Bld	neg	Negative
pH	7.0	N/A
Prot	neg	Negative
Urob	0.2	0.2-1.0
Nit	neg	Negative
Leuk	neg	Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

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

UNIT	TYPE	CROSSMATCH

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

REMARKS:

REPORTED BY: [redacted] (b)(6)-2 DT: 9 Nov 03 | LAB ID NO.:

RAPIDPOINT COAG ANALYZER
SERIA

Patient ID: [redacted] (b)(6)-4
Test Name :PT
Test Result:= 15.5 sec.
Ratio = 1.3
Calculated INR = 1.47
Sample Type:citrated wh. blood
Test Date :11/08/03
Test Time :11:01
Card Lot [redacted] (b)(6)-2
Operator [redacted]

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

08-11-03
10:50

				Patient Limits	
WBC	11.9	H	x10^3/uL	4.5	10.5
RBC	5.48		x10^6/uL	4.00	6.00
Hgb	15.7		g/dL	11.0	18.0
Hct	49.8		%	35.0	60.0
MCV	90.8		fL	80.0	99.9
MCH	28.7		pg	27.0	31.0
MCHC	31.6	L	g/dL	33.0	37.0
Plt	231.		x10^3/uL	150.	450.
LY%	11.1	*L	%	20.5	51.1
LY#	1.3	*	x10^3/uL	1.2	3.4

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/08/03 11:04

Patient ID: [redacted] (b)(6)-4
Test Name :APTT
Test Result:= 25.2 sec.
RESULT OUT OF RANGE
Sample Type:citrated wh. blood
Test Date :11/08/03
Test Time :11:02
Card Lot [redacted] (b)(6)-2
Operator [redacted]

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

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

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	8 NOV 03	1158 HOURS	
1	Admit to ICW #1		
2	Dx - Subsqual injury ① Chest		
3	Condition - Stable		
4	Vitals - per flow		
5	Allergies - NKA		

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	
		HOURS	
6	Activity - OOW protocol		
7	Nursing - notify MD for temp > 100.4 / BP > 160/90 or < 90/50 HR > 120 or < 50 RR > 25 or < 10		

PATIENT IDENTIFICATION

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

8 NOV 03

NURSING UNIT 300 | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	
		HOURS	
8	Diet - Regular		
9	IVF - Heplock		
10	LABS - Q		
11	Meds - Ancef 1 gm IVPB q 8°		

PATIENT IDENTIFICATION

NURSING UNIT 94V | ROOM NO. 10 | BED NO. NOV 03 @ 0100

	DATE OF ORDER	TIME OF ORDER	
		HOURS	
12	BID Dressing [redacted]		
	[redacted] (b)(6)-2		

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

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

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

DATE OF ORDER: 10NOV03 | TIME OF ORDER: 0838 HOURS | LIST TIME ORDER NOTED AND SIGN

1. D/C to camp c Hyp

[redacted]

(b)(6)-2

10 NOV 03 0833

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

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

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
03 Nov 03	[redacted]	Vitals per floor	08 12 16 20	[redacted] (6)(6)-2
03	[redacted]	Activity - EAW protocol	08 12 16 20	
03	[redacted]	Diet: Regular	08 12 16 20	
03	[redacted]	BID dressing AS (L) chest RT Buttocks	10 22	

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS:
SHRAPNEL INJURY @ CHEST

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

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

MEDCOM - 23648

(b)(6)-2 all

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)		Mo 11 Yr 2003		
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
05 NOV	[redacted]	Admit to ICW! Condition-Stable	08			[redacted]
08	[redacted]	Labs - ϕ	08			[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED
08 NOV	[redacted]	Notify MD for temp > 100.4 BP 160/90 or < 90/50	DH/I
		HR > 120 or < 50 RR > 25 or < 10	

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
				[redacted] (b)(6)-2
08Nov03	-[redacted]	IVF-heplock	06 18	
	-----		13 02	
08	-[redacted]	Ancef 1gm IVPB q8°	08	
	-----		16	
	-----		24	

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS:

SHRAPNEL INJURY Ⓛ CHEST

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ________

PATIENT IDENTIFICATION:

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

DISPENSING TIMES

USE PENCIL, CIRCLE MED TIMES

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

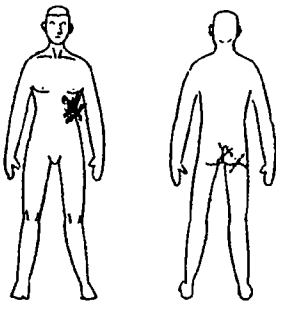
DA FORM 1 FEB 79 4678 EDITION OF 1 D... HAUSTED.

MEDCOM - 23650

@ 140/65 P-68
0923 SPO2: 98%

1. LAST NAME, FIRST NAME, MI (b)(6)-4 | RANK / GRADE | MALE / HOMME | FEMALE / FEMME
SSN / NUMÉRO MATRICULE | SPECIALTY CODE / GRADE | RELIGION / RELIGION
2. UNIT / UNITÉ
FORCE / ÉLÉMENT: A/T | AF/A | N/M | MC/M
NATIONALITY / NATIONALITÉ: Iraqi
BC / BC | NBI / BNC | DISEASE / MALADIE | PSYCH / PSY

3. INJURY / BLESSURE



- AIRWAY / TRACHÉE
- HEAD / TÊTE
- WOUND / BLESSURE
- NECK/BACK INJURY / BLESSURE AU COU/AU DOS
- BURN / BRÛLURE
- AMPUTATION / AMPUTATION
- STRESS / TENSION
- OTHER (Specify) / AUTRE (Spécifier)

Shrapnel (L) calf
(L) buttock
pt 2 : no movement

4. LEVEL OF CONSCIOUSNESS / NIVEAU DE CONSCIENCE
ALERT / ALERTE | PAIN RESPONSE / RÉPONSE À LA DOULEUR
VERBAL RESPONSE / RÉPONSE VERBALE | UNRESPONSIVE / SANS RÉPONSE

5. PULSE / POULS: 124 | TIME / HEURE: 0850
6. TOURNIQUET / GARROT: NO / NON | YES / OUI | TIME / HEURE
7. MORPHINE / MORPHINE: NO / NON | YES / OUI | DOSE / DOSE | TIME / HEURE
8. IV / IV: yes | TIME / HEURE

9. TREATMENT / OBSERVATIONS / CURRENT MEDICATION / ALLERGIES / NBC (ANTIDOTE)
TRAITEMENT / OBSERVATIONS / PRESENTE MEDICATION / ALLERGIES / ANTIDOTES

0850 hrs
BP- 136/63 → Morphine 2 mg @ 0900 hrs
P- 89
Fentanyl 2 mg @ 0910
P/Oxox 99% RA - Ig Analgesia
0932
BP 155/64
P- 104
SPO2 = 100% on 2L

10. DISPOSITION / DISPOSITION: RETURNED TO DUTY / RETOUR À L'UNITÉ | TIME / HEURE: 0900
11. PROVIDER: [redacted] | DATE/DATE (YYMMDD): 02 11 [illegible]

DD Form 1380, DEC 91 — This form replaces previous editions of DD Form 1380 and DD Form 1380 (TEST), which are obsolete.
U.S. FIELD MEDICAL CARD
FICHE MÉDICALE DE L'AVANT ÉTATS-UNIS

(b)(6) -4 all

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION (State or Country Code.)	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
A		[redacted]	[redacted]		M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
[redacted]	29			

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

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

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
	178	

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION 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 (YYYYMMDD)
		20031111

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYYYMMDD)
		20031108

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

FOR LOCAL USE

Dx 8751
E9919

Ins Trauma

[redacted]

ADMITTING OFFICER (Signature, as required)	SIGNATURE OF ADMITTING CLERK

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

MEDCOM - 23652

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)(2)-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
[redacted]	27Y	X	9	

10. Length of Service	ETS	11. FMP	12. Social Security Number
		99	[redacted] (b)(6)-4

Organization (Active Duty Only)	13. Marital Status	Hour of Admission	Branch / Corps:
		10:35	

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
		DIS	NO

20. Source of Admission	Ward:	Name / Relationship of Emergency Addressee
Direct from ER	ICW1	Address of Emergency Addressee

Name and Location of Medical Treatment Facility:	Telephone Number of Emergency Addressee
[redacted] No Install Provided (b)(2)-2	

21. Type of Disposition	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD)
TRF-OTH		2003-11-11

24. Clinic Svc - Admitting	25. MTF Transferred From	26. Date this Admission (YYYYMMDD)
-		2003-11-08

27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission
		2003-11-08

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: SHRAP INJURY L CHEST

Procedure Narrative(s):

Cause of Injury Narrative:

Admitting Officer (Signature, as required)	Signature of Admitting Clerk
[redacted] (b)(6)-2	[redacted] (b)(6)-2

Automated Facsimile - DA FORM 2 [redacted]

MEDCOM - 23653

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
[redacted]	[redacted]					FGN	
4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm	
M	27Y	X (b)(6)-4				NO	
11. FMP	12. SSN	13. Organization				14. Ward	
20	[redacted]					ICW1	
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		10:35	AAA - INTERNAL MEDICINE				
24. Name/Relation of Emergency Addressee		25. Type Disp	26. Date of Disp				
		TRF-OTH	2003-11-11				
27a. Address of Emergency Addressee		27b. Telephone No	28. Date This Adm:	AdmittingOfficer:			
			2003-11-08	[redacted] (b)(6)-2			
29. ReportingMTF			30. Date Init Adm	32. Units Blood Components			
[redacted] (b)(2)-2			2003-11-08				

31. Selected Administrative Data

Marital Status: Z DoB [redacted] (b)(6)-4

In/Out Patient: Inpatient MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

INTRATHORACIC SHRAPNEL

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days

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	2	2

Signature of [redacted] Officer

Signature [redacted]

Automated F[redacted]y 79

(b)(6)-2

MEDCOM - 23654

ABBREVIATED MEDICAL RECORD

1. ADMISSION DATE *(YYYYMMDD)*: 2003 11 08

2. CHIEF COMPLAINT, PERTINENT HISTORY, AND PERTINENT SYSTEM REVIEW

Dfg. GPW s/p s/p IED injury c resultant schrapnel wounds to back x 3 c T-tit superficial and T intrathoracic. & other Clo. ↑ SOB or chest pain

3. PHYSICAL EXAMINATION *(Including pertinent positives and negatives)*

BP - 133/89 HR - 92 RR - 24 T - 97.6

A+ox4
HEENT - Clear
CV - RRR
Lungs CTA (B)

ABD benign
Back - Multiple superficial wounds

(R) ext (N)

15.6 / 8.1 / 47.9 / 315
U/A - (N)
13.9 / 103 / 8 / 8.8 / 21 / 1.4 / 114

4. IMPRESSION *(Enter admission note with plan on progress notes)*

IED injury c schrapnel to chest
- Admit
- CT scan
- DCU observation

5. ADMITTING OFFICER

a. SIGNATURE [redacted] (6)(6)-2

b. DATE SIGNED *(YYYYMMDD)*: 2003 11 08

6. DISCHARGE NOTE *(Brief hospital course, diagnoses, procedures, condition on discharge, pertinent discharge information (including medications, diet, activity limitations, follow-up instructions).)*

7. DISCHARGE DATE *(YYYYMMDD)*

8. DISCHARGING OFFICER

a. NAME *(Last, First, Middle Initial)*	b. GRADE	c. TITLE	d. SIGNATURE

9. PATIENT IDENTIFICATION *(For typed or written entries: Name (last, first, middle), grade, SSN, date of birth, hospital or medical facility, ward number, and register number)*

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

10. OUTPATIENT/HEALTH RECORD MAINTAINED AT:

11. COPY PLACED IN OUTPATIENT RECORD *(X when done)*

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
8NOV 03 1400	- Assumed care of pt transfer from EMT per wheelchair. DX shrapnel wounds to upper back wall Denies pain CBC drawn results at bedside. Foley removed urinating spontaneously lungs clear SPO2 98% on RA Ø SOB noted. HRRR Active BS Remains NPO PIV @ AC LR @ 125 cc/hr patent Ø s/s of infection will cont to monitor [redacted] (6)(6)
8NOV03 2100	Pt A+OX3, VSS, LS CTA(B), OBSX4, SCS present, Ø c/o pain, shrapnel wounds to the upper back, tender around wound minor swelling noted, peripheral pulses +2, IV (R) ~~FA~~ AC infusing LR @ 125cc/hr, NPO OOB to BR 3 complications, IV abx, 2 point restraint, Ø complications. [redacted]
9NOV@1600	Pt. resting quietly in bed. V.S.S. A+O x3, Ø c/o pain. (6)(6)-2 DRSN to shrapnel wounds on back, Pt. reports Ø SOB or vertigo Pt. ambulates ∃ difficulty to BR ∄ in hallway. (+) BM This AM, Urinal at bedside, clear yellow urine, LR infusing at 125cc/ hr to (R) AC. Pt. is NPO status Δ'd to regular for lunch and

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] (6)(6)-4		

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10
USAPA V1.0C

(b)(6)-2 of 11

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	(cont.) dinner; Pt. not going to OR today. Pt. will be NPO 5 MN, Pt. in 2-point restraints, Ø signs of skin breakdown. Will cont. to monitor. [redacted] CT, RN
9NOV.03 1900	Pt A+O x3, VSS, dsg to wounds on back D'd, minimal blood drainage on old dsg, Ø active bleeding, tender around wound, minor swelling around wound on Ⓡ side, OOB→ BR ⊼ diff, IV Ⓡ AC intact, infusing LR@ 125 cc/hr, Ø c/o pain or discomfort, IV abx, Diet advanced to Regular, tol. well, possible discharge tomorrow, 2 point restraint ⊼ any complications. [redacted]
	I Cencan With alone assessment [redacted]
10 NOV 03 0945	VSS. Ao. Up ad lib. Has AM to BR to perform self and oral care. HRR. LSCTABS. DSG's to back CDI ⊼ s/s infection. Awaits for D/C today by attending physician. [redacted]
10NOV.03 1930	Pt A+Ox3, VSS, LS CTA Ⓑ, ⊕BSx4, OOB to BR, voiding ⊼ complications, pain controlled ⊼ MSO4 4mg, dsg to back CDI, tender around wounds, Ø s/sx of infx, HL IV Ⓡ AC intact, flushes well, possible d/c tomorrow. Ate most of diet, 2 point restraint, Ø complications [redacted]
11 NOV 03 1045	Assumed care of pt. @0600, Pt. A+O, V.S.S., c/o mild pain to abdomen & shrapnel wounds on back. Abdomen soft, non-distended, ⊕ BS all four quads. Shrapnel wounds to back scabbed over, Dressings removed, Ø drainage. Pt. OOB to

AUTHORIZED FOR LOCAL REPRODUCTIOI

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
11NOV03@1045	(cont.) shower this AM. ⊕BM this AM. Pt. given 4mg MSO4 for pain @ 1030. Pt. resting quietly in bed at this time, 2-point restraints. ∅ signs of skin breakdown. All other assessments WNL. Pt. to be D/C'd to EPW camp today. [redacted] 2CT, AN (b)(6)-2

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

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUC

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

D/C Summary

18 NOV 03

0830 EPW s/p superficial scrape injuries to chest, s/p 48 hr ABX (Ancef). Will d/c to Camp C for dressing changes x 7 days & Keflex.

(6)(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] (6)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/199
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(1

USAPA V1.0

SKIN AND WOUND ASSESSMENT

MEDICAL RECORD — PROGRESS NOTES

Admission Date: 11-8-03 Diagnosis: Laparathoracic Shrapnel HD: 4 POD: 4

Braden Scale Evaluation (See Braden Evaluation Table for Details)

Sensory Perception	No impairment	(4)	Mobility	No limitations	(4)
	Slightly limited	3		Slightly limited	3
	Very limited	2		Very limited	2
	Completed	1		Completely immobile	1
Moisture	Rarely moist	(4)	Nutrition	Excellent	4
	Occasionally moist	3		Adequate (Eats >50%)	(3)
	Moist	2		Adequate (Rarely eats)	2
	Constantly moist	1		Very poor	1
Activity	Walks frequently	(4)	Friction and Shear	No apparent problem	(3)
	Walks occasionally	3		Potential problems	2
	Chairfast	2		Problems	1
	Bedfast	1			

Total Score 22

Add the total score

Above 20	Low Risk
Between 16 and 20	Medium Risk
Between 11 and 15	High Risk
Below 10	Very High Risk

Note: A Braden Scale Score of less than or equal to 15 indicates HIGH RISK –Requires immediate Ulcer prevention program.

Surgical wound (s): (Yes) No Location: BACK Size: 2-3 cm Drainage: Ø
Tubes: Ø Appearance: CDI
Dressing change: Ø

Pressure Ulcer (s): Yes (No)
Stage I, II, III, IV (Circle the one that applies and describe below)

Location: _____ Size: _____
Wound character: Pint_____ Moist _____ Dry _____ Granulation tissue _____ Yellow slough_____
Odor _____ Purulent discharge _____ Eschar _____ Exudates _____

Type of dressing change: Wet-to-dry_____ Comfeel dressing _____ Carrasyn V-Gel_____ Alginate _____

Physician notified/consulted for wound debridement: Yes_____ No_____
CNS notified/consulted for Stage II and greater: Yes_____ No_____
Nutrition Referral: Yes _____ No _____
Physical Therapy Referral: Yes_____ No _____
Action Taken: _____ Date & Time: _____

REGISTER NO. | WARD NO.

Patient's Identification (For typed or written entries give: Name-last, first, middle: Grade: rank: hospital or medical facilithy)

PROGRESS NOTES

Medical Record
STANDARD FORM 509

[redacted] (b)(6)-4

[redacted]

(ASSESSED 11 NOV 03)

MEDCOM - 23660

E/ smoker

NSN 7540-01-075-3786

MEDICAL RECORD	EMERGENCY CARE AND TREATMENT *(Patient)*	LOG NUMBER [redacted]
		RECORDS MAINTAINED AT (b)(2)-2

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)* 8 AUG 03 | TIME 1045

TRANSPORTATION TO FACILITY

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

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

CURRENT MEDICATIONS: Ø

ALLERGIES: NKDA

CHIEF COMPLAINT

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

CATEGORY OF TREATMENT

☐ EMERGENT
☒ URGENT
☐ NON-URGENT

TIME: 1045 (b)(6)-2

INITIALS: [redacted]

VITAL SIGNS

TIME	1045				
BP	133/85				
PULSE	132				
RESP	24				
TEMP	97.6				
WT					

LAB ORDERS

☒ CBC/DIFF	ABG	☒ PT/PTT	BHCG/URINE/BLOOD/QUANT		
URINE C&S	UA MSCC/CATH		☒ CHEM: 12 C 14 15		
BLOOD C&S X					
T&S					

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
1045	SCC Tetanus IM	[redacted]			
1100	D5 1/2 NS Bolus x2				
1200	Ambulate IM				
1230	Follow				

DISPOSITION: ☐ HOME ☐ FULL DUTY

DISPOSITION QUARTERS [illegible]: ☐ 24 HRS. ☐ 48 HRS. ☐ 78 HRS.

MODIFIED DUTY UNTIL

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ | TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

(b)(6)-4

[redacted]

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

MEDCOM - 23661

NSN 7540-01-075-3786

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

TEST RESULTS

CBC: WBC 8.1; H/H 14.4; PLT
SMAC:
PT
APTT
BHCG
ETOH
GLU
U/A: DIP; MICRO

ABG/PULSE OX: SUP 02; PH; PO2; PCO2; SAT; OTHER

RADIOLOGY — Check if read by radiologist ☐
RESULTS: CXR ⊖ shrapnel in Chest ⊕ T9 bone
Ab/Abd CT
EKG INTERPRETATION

PROVIDER HISTORY/PHYSICAL
27 yo Ci detainee arrived via medevac ambulatory, NAD ⊘SOB. ⊖ smoker
IED while a convoy
⊘ head inj ⊘LOC

⊘s A&O x4, NAD, VS
HEENT unremarkable
Chest, LTA ⊕ bilat BS equally
CV: RRR ⊘m/r/g Abd soft, NT or deep palp
Back ⊕ shrapnel wound T9/10 paraspinous ⊕ shrapnel wound
genit NL

PMH: ⊘
PSH: ⊘
FH: ⊘
SH: ⊘
UA 1.025 neg blood

A/P ⊕ Shrapnel + back into chest cavity ⊕ side
Chest/Abd CT ⊕ → Admit ICU

CONSULT WITH	TIME	ACTION

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

DIAGNOSIS ⊕ GSW/Shrapnel ⊕ chest

CODES

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 *(Doctor)*
Medical Record

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

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY: 8 | 9 | 10 Nov 03

19 | HOUR: 1150

PULSE (O) | TEMP. F (°)

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

123/69 | 128/72 | 121/66 | 132/81

98 | 98H | T98.4 | 98 | 98 | 98 | 97.3 | 97.1

HEIGHT: | WEIGHT →

96 | 98 | 98 | 98 | 98 | 97%

RA | RA | RA | 2L | 2L

Pulse 58

Record special data only when so ordered

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

[redacted] (b)(6)-4

REGISTER NO.

WARD NO.

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 23663

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

HEMATOLOGY

SPECIMEN/LAB RPT. NO. ICW1

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

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

SPECIMEN SOURCE: ☐ VEIN ☐ CAP ☐ OTHER (Specify)

PATIENT'S MED. RECORD

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

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

REPORTED BY [redacted] (b)(6)-2 MD TECH

DATE 8 NOV 03

LAB. ID. NO. 1400

REMARKS CBC

TEST(S)	RESULTS	REQUESTED (X)	RBC COUNT	HEMOGLOBIN	HEMATOCRIT	MCV	MCH	MCHC	WBC COUNT	WBC DIFF AND BLOOD CELL MORPH: IMMATURE	NEUTRO-BANDS	NEUTROSEGS	LYMPHS	EOSINOPHILS	BASOPHILS	MONOCYTES	PLATELETS	RBC	SED. RATE	PLATELET COUNT	RETICULOCYTE COUNT	CLOTTING TIME	BLEEDING TIME	PT CONTROL	PT PATIENT	PTT CONTROL	PTT PATIENT	% ACTIVITY	RATIO	SICKLING TEST	LE PREP
SPECIMEN TAKEN DATE	TIME A.M. P.M.																														

549-107

HEMATOLOGY
STANDARD FORM 549 (Rev. 7-78)
PRESCRIBED BY GSA/ICMR
FIRMR (41 CFR) 201-45.505

ID: [redacted] (b)(6)-4
WB

08-11-03
14:07

			Patient Limits
WBC	8.6	x10^3/uL	4.5 10.5
RBC	5.80	x10^6/uL	4.00 6.00
Hgb	16.2	g/dL	11.0 18.0
Hct	50.7	%	35.0 60.0
MCV	87.3	fL	80.0 99.9
MCH	27.9	pg	27.0 31.0
MCHC	31.9 L	g/dL	33.0 37.0
Plt	243.	x10^3/uL	150. 450.
LY%	23.5	%	20.5 51.1
LY#	2.0	x10^3/uL	1.2 3.4

Ward/Section: EMT [redacted] (b)(6)-2

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

LAST, FIRST, MI: [redacted] (b)(6)-4 DATE: 8 NOV TIME: 1702 SSN/PSEUDO SSN: [redacted] (b)(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		
RBC		
Hgb		
Hct		
MCV		
Plt		
Lymph %		
(Hematol...)		

ID: [redacted] (b)(6)-4 WB 08-11-03 11:03

			Patient Limits
WBC	8.1	x10^3/uL	4.5 10.5
RBC	5.66	x10^6/uL	4.00 6.00
Hgb	15.6	g/dL	11.0 18.0
Hct	49.4	%	35.0 60.0
MCV	87.2	fL	80.0 99.9
MCH	27.6	pg	27.0 31.0
MCHC	31.6 L	g/dL	33.0 37.0
Plt	315.	x10^3/uL	150. 450.
LY%	26.8	%	20.5 51.1
LYM	2.2	x10^3/uL	1.2 3.4

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

Urinalysis

TEST	RESULT	REF. RANGE
Color	yellow	N/A
Appr	Cla Neg	N/A
Glu	neg	Negative
Bili	neg	Negative
Ket	neg	Negative
SG	1.025	N/A
Bld	neg	Negative
pH	6.0	N/A
Prot	neg	Negative
Urob	0.2	0.2-1.0
Nit	neg	Negative
Leuk	neg	Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

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

UNIT	TYPE	CROSSMATCH

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh:

REMARKS:

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

Ward/Section: EMT	REQUESTING PHYSICIAN: [redacted] (b)(6)-2	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI.	DATE: 7NOV	TIME: 1103
	SSN/PSEUDO SSN: [redacted] (b)(6)-4	

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

======= PICCOLO =======
08/11/03 11:27
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
LIVER PANEL PLUS
DISC LOT #: 3154AA7
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

ALB	4.5	3.3-5.5	G/DL
ALP	105*	26-84	U/L
ALT	60*	10-47	U/L
AMY	52	14-97	U/L
AST	37	11-38	U/L
TBIL	0.6	0.2-1.6	MG/DL
GGT	38	5-65	U/L
TP	8.9*	6.4-8.1	G/DL

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl

======= PICCOLO =======
08/11/03 11:1< AM
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: 3151AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	114	73-118	MG/DL
BUN	8	7-22	MG/DL
CRE	1.4*	0.6-1.2	MG/DL
CK	233	39-380	U/L
NA+	130	128-145	MMOL/L
K+	4.5	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 0 , LIP 1+, ICT 0

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED

CT chest / abd

AGE | SEX | SSN (Sponsor) | WARD/CLINIC | REGISTER #

FILM NO.

PREGNANT ☐ YES

REQUESTED BY (Print) (b)(6)-2 TELEPHONE

SIGNATURE OF REQUESTOR

DATE REQUE

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

Shrapnel in chest R/o shrapnel in Peritn

DATE OF EXAMINATION (Month, day, year) | DATE OF REPORT (Month, day, year) | DATE OF TRANSCRIPTION (Month, day, ye

RADIOLOGIC REPORT

Bardi and (L) axillary shrapnel

chest/A/P normal.

(b)(6)-2

PATIENT IDENTIFICATION (Last name, first name, middle initial, Medical Facility)

(b)(6)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT 2 — RADIOLOGY

STANDARD FORM 513 PRESCRIBED BY GSA/ICMR FPMR (41 CFR) 101-11.4

MEDCOM - 23667

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	9 Nov 05	1200 HOURS	
1	Admit to ICU/MU #1		
2	Dx - intrathoracic esophageal		
3	Condition - stable		
4	Vitals - per routine		
	NC O2 titrate to maintain		
	Pox > 95%		

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	
		HOURS	
5	Allergy - NKDA [redacted]		
6	Activity: ~~bedrest~~ [redacted]		ERAS protocol
7	Foley to gravity		
8	Nursing notify MD		
	for temp > 100.4, BP < 90/50 HR > 120 or < 50		
	RR > 25 or < 10		

(b)(6)-2

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	
		HOURS	
	Pox < 95% or SBP		
9	DIET - NPO		
10	LABS - Repeat CBC & -		
	admission to unit		
11	IVF 125 cc/hr CR		
12	Meds - MSO4 2-4 mg IVP & 2-4 mg for		
	Anxiety from IVPB & -		

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	
13	Remove foley on floor	HOURS	(b)(6)-2
	[redacted]		
14	Regular diet		
	[redacted]		

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

MEDCOM - 23668

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				10 NOV 03	0830 HOURS	
			4	D/C to Comfort Inn		
				[redacted]		
NURSING UNIT	ROOM NO.	BED NO.		(b)(6)-2		
ICU	24	[redacted]		AN 11 NOV 03 @ 0335		
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 - 23669

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 08	9	10	11
08 NOV 03	[redacted]	Vitals per routine	06	[redacted]			
			12				
			18				
08	[redacted]	Act: EAW protocol	00				
			06				
08	[redacted]	Foley to gravity	12				
			18				
			00				
08	[redacted]	Diet: NPO	06				
			12				
			18				
09 NOV	[redacted]	Diet: Regular	D	—	—		
			N	—	—		

8 NOV 03 1400

E 9 NOV 03

(b)(6)-2

ALLERGIES: ☐ YES ☒ NO	PRIMARY DIAGNOSIS:	ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
NKDA	INTRATHORACIC SHRAPNEL	PAGE NO:

PATIENT IDENTIFICATION:

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

(b)(6)-2 all

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)		Mo 11 Yr 2003		
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
08 NOV	[redacted]	Admit to KW!	08 NOV 03			[redacted]
08	[redacted]	Cont-stable	08			[redacted]
08	[redacted]	Repeat CBC on adm to unit	08	1400		[redacted]
08	[redacted]	Remove foley on floor	08	1400		[redacted]
ID	[redacted]	D/C to camp ↑ Abx	ID			

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED
08 NOV	[redacted]	NCO2 titrate to maintain POX >95%.	D/T/I
08	[redacted]	Nrsg: notify MD for temp >100.4 BP >169/90 or <90/50 HR >129 or <56 RR >25 or <10 POX <95% or SOB	D/T/I

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 08 09 10 11
08 NOV 03	[redacted]	IVFS: 125cc/hr LR	08	[redacted] (b)(6)-2
	-----		12	
08	[redacted]	Ancef 1gm IVPB q 8°	08	
	-----		16	
	-----		24	

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS:
INTRATHORACIC SCHRAPNEL

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 - 23672

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

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED															
28NOV	[redacted]	MSO4 2-4mg IVP q 3-4° PM	D/T	10 NOV	10NOV 2100	11NOV 0535	11NOV 1030											
			D/T	1616 4mg	4MG	4MG	4mg [redacted]											

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

Admission and Coding Information

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

1. Reporting MTF	2. M (b)(6)-2			
[redacted]	[redacted]			
3. Register Number (b)(6)-4	Name (Last, First, MI) (b)(6)-4		4. Pay Grade	5. Sex
[redacted]	[redacted]		FGN	M
6. DoB (YYYYMMDD)	7. Age at Admission	8. Race	9. Ethnicity	Religion
[redacted]	27Y	X	9	1
10. Length of Service	ETS	11. FMP	12. Social Security Number (b)(6)-4	
		20	[redacted]	
Organization (Active Duty Only)		13. Marital Status	Hour of Admission	Branch / Corps:
		Z	10:35	
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	
		DIS	NO	
20. Source of Admission	Ward:	Name / Relationship of Emergency Addressee		
Direct from ER	ICW1	Address of Emergency Addressee		
Name and Location of Medical Treatment Facility: [redacted] Iraq; No Install Provided (b)(6)-2		Telephone Number of Emergency Addressee		
21. Type of Disposition	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD)		
TRF-OTH		2003-11-11		
24. Clinic Svc - Admitting	25. MTF Transferred From	26. Date this Admission (YYYYMMDD)		
AAA - INTERNAL MEDICINE		2003-11-08		
27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission		
		2003-11-08		

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: INTRATHORACIC SHRAPNEL

Procedure Narrative(s): T: 1 Dx: 8750, 8760, E993; Inj: 443

876.1
875.1
E991.9

Cause of Injury Narrative:

Admitting Officer (Signature, as PONDER [redacted] (b)(6)-2

Signature of Admitting Clerk [redacted] (b)(6)-2

(b)(6)-4 INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER	2. NAME (Last, First, MI) (b)(6)-4	3. GRADE E4	ADMISSION REMARKS
4. SEX M	5. AGE —	6. RACE W	7. RELIGION UNK
8. LENGTH OF SVC UNK	9. ETS UNK	10. PREVIOUS ADMISSION NO	
11. EMP 99730	12. SSN [redacted]	13. ORGANIZATION (b)(6)-4	14. WARD —
15. FLYING STATUS —	16. RATING/ DSG —	17. DEPT./ SER K78	18. BRANCH/CORPS —
19. UIC/ZIP —	20. TYPE CASE BC NBI		
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct from ER	22. HOURS OF ADMISSION 2345	23. CLINIC SERVICE XXXX	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE UNK	25. TYPE DISPOSITION 41	26. DATE OF DISPOSITION 030816	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) UNK	27b. TELEPHONE NO. UNK	28. DATE OF THIS ADMISSION 030816	ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] (b)(2)-2		30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. [redacted]

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX Shrapnel to head

DX 873.9
E9819

873.8

Inj Trauma

5-19 9

DX 873.9 Injury 9-599

35. Total Days This Facility

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

36. Total Days All Facilites

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

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

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

DA FORM 3647, MAY 79 EDITION OF 1 AUG 78 IS OBSOLETE USAPPC V1.10

MEDCOM - 23675

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION (State or Country Code.)	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
A	IZ	[redacted]	[redacted] (b)(6)-4		M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
[redacted]		Z	9	UNK

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	Z	2345	

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

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION
		9	YEAR [X] NO

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

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

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYYYMMDD)
SX 41		20030816

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYYYMMDD)
XXXA		20030816

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

FOR LOCAL USE

DX: Shrapnel to head

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

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

MEDCOM -

Automated Facsimile

INPATIENT TREATMENT RECORD COVER SHEET

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

1. Register No (b)(6)-4	2. Name (b)(6)-4 [redacted]					3. Grade FGN	Admission Remarks
4. Sex M	5. Age	6. Race X	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm NO	
11. FMP 20	12. SSN [redacted] (b)(6)-4	13. Organization				14. Ward ICU1	
15. FlyStatus NO	17. Dept / Ben K78-PRISONER OF WAR/INTER	18. BranchCorps	19. UIC / ZIP	20. Type Case DIS			
21. Source of Admission Direct from ER		22. Hour Of Adm: 09:20	23. Clinic Service ABA - GENERAL SURGERY				
24. Name/Relation of Emergency Addressee		25. Type Disp HOME	26. Date of Disp 2003-11-23				
27a. Address of Emergency Addressee		27b. Telephone No	28. Date This Adm: 2003-11-11	AdmittingOfficer: (b)(6)-2 [redacted]			
29. ReportingMTF [redacted] (b)(2)-2			30. Date Init Adm 2003-11-11	32. Units Blood Components			

31. Selected Administrative Data

Marital Status: DoB:

In/Out Patient: Inpatient MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

GSW R CHEST/ ABDOMEN RENAL FAILURE

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	6	0	13	13

Signature of Attending Medical Officer [redacted] MEDCOM - 23677 [redacted] (b)(6)-2

SUNDBERG

Automated Facsimile

[illegible]IENT TREATMENT RECORD [illegible]R SHEET

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

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

4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm
M		X				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
NO	K78-PRISONER OF WAR/INTER			DIS

21. Source of Admission	22. Hour Of Adm:	23. Clinic Service
Direct from ER	09:20	ABA - GENERAL SURGERY

24. Name/Relation of Emergency Addressee	25. Type Disp	26. Date of Disp
	HOME	2003-11-23

27a. Address of Emergency Addressee	27b. Telephone No	28. Date This Adm:	AdmittingOfficer:
		2003-11-11	[redacted] (b)(6)-2

29. ReportingMTF	30. Date Init Adm	32. Units Blood Components
[redacted] (b)(2)-2	2003-11-11	

31. Selected Administrative Data

Marital Status: DoB:

In/Out Patient: Inpatient MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

GSW R CHEST/ ABDOMEN RENAL FAILURE

Blood 4

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days

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	13	13

Signature of Attending Medical Officer [redacted] (b)(6)-2

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

Automated Facsimile - DA FORM 3647, May 79

MEDCOM - 23678

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

≈ 40yo Iraqi male shot in the Right back @ 1730 last PM. Taken to a nearby FST. Found to have a Right tension PTX; diaphragm injury and liver laceration. Chest tube placed & ex lap done. Pt transferred in stable condition this AM. Pt. arrived sedated & on the ventilator

PHYSICAL EXAMINATION 98% Sat 142/80 93=HR

HEENT = WNL
CV = RRR
Lungs = intubated; coarse bilat; CT in place w/o airleak; 1000cc fluid in Rt hemithorax
Abd = dressing in place; BS+; quiet
Ext = WNL
Back = WNL other than puncture wound Rt lateral to spine
No exit wound

PROGRESS (Enter date of discharge and final diagnosis)

A = GSW to Right back c injury to lung, diaphragm and liver

Plan = CT scan of Chest + Abd; Admit to ICU; follow exam; wean off vent + extubate as soon as possible

(b)(6)-2

[redacted] | DATE 11 NOV 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] (b)(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR 101 OPP 201 AR 5XX
OCTOBER 1975
USAPPC V1.00

MEDCOM - 23679

ACLU-RDI 1682 p.39

DOD-037257

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
11 NOV 03	Dropi of GSW thoracic abdomen + liver injury.
1130	back injury. CXR, CT scan done. Sedated c
CIV VS EPW	Versed + MSO4 on the scat. SIMV14, TV 750,
T 93.4	Peep 5, FIO2 to keep > 95%. ET #8 placement
~~T tuned~~	NGT, foley, CT (R) axillary. 2° dx lesion +
	Lung pneumothorax. VS 94.5 - 111 - 19 - 177/93, sat 99%
	@ 100%
1430	T 97.2 - 114 - 152/94 - 29 - 94% SAO2 70%. MD aware of
	↑ BP. Increase sedation Nitrate to effect ↓ BP
1500	Skin Care Assessment.
	Braden scale done pt score 12 high
	risk. Turn pt q 2°. Turned left side from
	1330 - 1500. Pt lays on his back @ this time
	Turn to (R) side @ 1700. BP ↓ 148/92 - RR 35
	Versed @ 1.5 mg MSO4 12. Continue to monitor BP. A line
	started @ 1530 c good waveform. ABG, Lytes + CBC
	sent. [redacted] (b)(6)-2
1700	FIO2 ↓ 50% per MD. BP under control 130/90. Sent
	ABG @ 1830.
1900	Report given to oncoming shift [redacted] (b)(6)-2

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

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

REGISTER NO. | WARD NO.

[redacted] (b)(6)-4

EPW / CI

PROGRESS NOTES
Medical Record

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

(b)(6)-2 all

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
11 Aug 03	Received report on EPW 1275. Bed #4. PT
1830	moves extremities occasionally. PT at this time tachycardic 120's. ABG PH 7.18 PCO_2 59.2. MD. Aware & vent setting Bd to RR 20 from 14 & FIO_2 55 from 50. Will monitor and report as appropriate. [redacted] 1LT/AN
1900	Assessment: PT is sedated on versed & morphine titrated to effect. NS @ 20K infusing at 175 cc/hr. ↑ K+ level and orders changed to NS @ 175 cc/hr. PT is vented @ 8.0 ETT 26 cm lip. Setting are now FIO_2 55 PEEP 5. RR 20 TV 750 PEAK 45. Breath sounds coarse but diminished R>L. CT to 20cm H_2O suction @ dressing reinforced periodically due to bleeding at site. PT remains tachardic 120's. BP 100's/80's. Pulses are 2+ palpable U/L Ext. No ectopy noted. NG Tube to LIS @ minimal secretions. BS hypoactive. Abdomen soft & distended. midline incision dry & intact. Foley to Gravity draining clear yellow urine >100 cc/hr!
2130	PT positioned to (R) side. Lateral. 1943 ABG results. PH: 7.33 CO_2 43.1 PO_2 83 BE −3 HCO_3 23 SaO_2 95. Will continue to monitor until next ABG check. [redacted]
2200	ABG results PH: 7.334 PCO_2 41.2 PO_2 90 BE −4 HCO_3 22 SO_2 96. FIO_2 U/I 50%. [redacted]
2220	T. 101.2 Tylenol suppository give. [redacted]

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

(b)(6)-2 all except bottom

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
12NOV03 0036	ABG drawn. Results are Ph 7.346, PCO_2 39.6 Po_2 96. BE -4 Hco_3 22 Sao_2 96. Will titrate F_{IO_2} to goal rate 40%. [redacted] LT/AN
0125	PT urine output drop to 30 cc over 2hr period. MD notified and ordered 1L NS bolus. Will initiate orders and report post bolus urine output. [redacted] LT/AN
0225	PT start putting out urine about 80cc/hr. Will continue to monitor progress. [redacted] LT/AN
0400	ABG results pH 7.343 PCO_2 40.9 Po_2 84 BE -3 Hco_3 22 So_2 96. Will d/c RR to 14 to prevent excess blowing off Co_2 [redacted]
0615	Report & Care of pt received from previous shift. VSS VENT Settings PEEP-5 TV-750 RR-15 FIO_2-35% S_pO_2 98% HR-120's T-101.1. Sedated on Versed 2mg/hr. Chest tube to (R) chest incl @ 20cm suction. Will cont to monitor [redacted] LPN
1000	PT DSG to abdomen changed. Wound appears to be healing well & s/s of infection/redness & swelling. T-100.7 VSS will cont to monitor [redacted] LPN

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. ICU

(b)(6)-4

[redacted]

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1988)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
12NOV03	Surgery HD #2 ICU #2 POV #2 Vent D#2
0821	Incent D#2
129/109/20Ø/93	Neuro = sedated
51/18/2.7	HEENT = intubated; No injury
~~8.4~~/177	Lungs = Coarse BS bilat. FIO2 down to 35% c
~~8.1~~/26.5	sat ≥ 95% / CXR pending
	CV = RRR. no murmurs
	Abd = benign, dressing place, quiet c <500cc NGT out
	Ext = No injury
	FEN = stopped all KT infusions; Now on NS @ 75cc/hr. Cr has increased from 1.8 on admission to 2.7 this AM. Likely ATN from low flow p injury. UOP = 50-170/hr for last 3 hours
	A= 1) diaphragm injury; tension PTX + liver lac
	2) Now with bilat pulmonary inf. Likely possibly contusions and non oliguric renal failure with Cr increasing to 2.7 from 1.8. Will d/w Medicine
	Plan = Vent support as needed
	follow electrolytes + adjust fluids as needed [redacted]
	(6)(6)-2

(b)(6)-2 all except very bottom

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
12 Nov 03 1900	PT. T-101.5 VSS. Will cont to monitor [redacted]
1700	PT temp ↑ 101.9. Pt given Tylenol Suppository. VSS will cont to monitor [redacted] (DN)
1800	PT turned to Left Side S_aO_2 ↓ 89% Report Cas. & pt given to oncoming shift [redacted] (AA)
1805	Received report from day shift. Pt vented TV 750, 15 BPM, PEEP 5, FIO2 35% NG to @ Nare on LIS, CT to @ Flank on wall suction. Foley to gravity. Cordis to @ ES @ flush, A-Line to @ Radial. Will continue to monitor. [redacted]
2000	Pt dressing changed and suctioned. Sats ↑ to 94% [redacted] SC, 9 WMG
2200	Pt No-SATing ↓ to 78. Bagged and called RT. RT ↑ FIO2 to 100%. Suctioned pt vigorously. Results of ABG as follows. PH of 7.249, PCO2 of 49, PO2 of 110, BEef -6, HCO3 of 21, TCO2 of 23, SO2 of 97%. Informed [redacted] Ordered BPM ↑ to 18. RT ↓ FIO2 to 85%. Will continue to monitor. [redacted] SC, 9 WMG
13 NOV 03	(0100) Pt resting well VSS. FiO2 @ 64% & sats >95%. Will continue to monitor. [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. ICU 2

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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

(b)(6)-2 all

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
13Nov03 (0830)	At temp 100.4, F), & 64% & 2L nt & 100%. At this rate 18. VSS. will continue to monitor. [redacted]
	(0500) PI's labs came back Hgb of 7.1 & Hct of 22.4. called MD on call Dr. Davis. ordered 2 units PRBC & Pt/Pt. will draw. VSS. UOP 25. chest tube put out 130, NG tube put out 300. Temp. 100.7. Pt transferred on stretcher with T&C down & labs @ 0500. [redacted]
13Nov03 Q615	Received report & care of patient from previous shift. VSS VENT settings - PEEP-5 TV-750 RR-18 FIO2-65 will cont to monitor [redacted] PC 2PN
Q730	18ga IV started to (L) bicep. VSS CBC redraw will cont. to monitor [redacted] 2PN
Q830	10mg Vecuronium IVP given to pt per MD. [redacted]
13Nov03	Surgery #1 #3 ICU #3 POD #3 Vent #3 Trach #3
	Pt. had had increased peak pressures throughout the day in spite of adequate sedation & pain control. Was planning to decrease vent. requirements but unable to @ this time.
	Placed a new L SC line & Right radial A-line. Old lines removed
	CT to water seal
	Hct this AM was 22 so given 2 units PRBCs. Will continue support. [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK
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MEDICAL RECORD	PROGRESS NOTES
DATE 13 NOV	NOTES
0900	TLC placed to (L) SC all lines patent. VSS will cont to monitor [redacted]
0930	A-line started to (R) radial [redacted]
1030	Transfusion of 1st Unit PRBC's started at this time. VS - T-100.1 HR-125 BP 157/77. will continue to monitor [redacted] SC LPN
1035	18ga IV to (L) bicep D/C'd [redacted] SC LPN
1155	1st unit of PRBC's transfusion completed at this time & reaction noted. VS - BP 159/79 HR-140 T-101.2 [redacted] SC LPN
1245	Transfusion of 2nd Unit of PRBC's started at this time. VS - BP 144/88 HR-141 T-101.1. will cont to monitor [redacted] SC LPN
1330	Cordis to (R) IJ D/C'd & A-line to (L) radial D/C'd. 2nd unit PBBC's finished transfusing at this time. VS - BP. 169/89 HR-146 T-101.9. Versed increased to 10mg/hr and Morphine increased to 7mg PRN. will cont to monitor [redacted] SC LPN
1600	Pt Temp @ 102.2. T~~SP~~ Cold packs placed to b/l axilla pits & groin. will cont to monitor [redacted]

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PROGRESS NOTES
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STANDARD FORM 509 (REV. 5/1999)
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(b)(6)-2 all

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
1800R	Report + care of pt. given to oncoming shift VSS [redacted] PALPI
1800	Received report from day shift. See flow sheet for physical assessment. [redacted]
2000	Started pt on Vec drip. 2LT Simple finished IVP adminn. Titrated versed IV to [redacted] Pmg/hr. Will continue to monitor.
2005	RT advanced ETT 2cm. 27 at lip. Will continue to monitor. [redacted]
2200	Pt resting comfortably in bed. VSS. Will continue to monitor. [redacted] SPC
2330	Pt BP @ 212/85. Rechecked manually, still elevated. Contacted Dr. [redacted] Versed to [redacted] Pmg/hr. Will continue to monitor. [redacted]
14NOV03 0100	Pt BP down to 112/67. VSS. Will continue to monitor. [redacted] SPC 91WM6
0300	Results of pt ABG as follows: PH of 7.362, PCO2 of 43.7, PO2 of 119, BEecf of -8, HCO3 of 19, TCO2 of 21, SAO2 of 98%. Will continue to monitor. [redacted] SPC, 91WM6
0430	Contacted MD [redacted] about ABG Results. Dr. [redacted] came by, did not assess pt, requested pt be [redacted] raised to 20 mg q 4hrs. Will repeat ABG in 1hr. [redacted] SPC, 91WM6

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

DATE	NOTES
14 NOV 03	Contacted Dr. [redacted] over pt
0445	H+H) 7.6/24.1. Dr [redacted] said "Fine" and
	No new orders given. [redacted] SPC, 9 WDM6-
0500	Held due to [redacted]
0500	Held atrvan due to ↓ BP 96/52. Pt already
	on Versed @ 6 mg/hr. [redacted] SPC 9 WDM6
0600	Reported off to day shift. [redacted] SPC Glen
14 NOV 03	Surgery #0 #4 ICU #4 POD #4 Vent day #4 Accept #4
7.6/24.1/157	Received 2 Units of PRBC's yesterday with increase from
	22 to 27; this AM = down to 24.1; will transfuse again.
27/113/27/88	If continues to have blood requirement, will CT Abd
7.5/18/3.2	or re-explore to check liver injury or missed injuries.
32/35.5/125/18/-8	Has episodes of decreased UOP which have responded to fluids.
99%	Cr has decreased from high of 3.8 to 3.2 today. BUN
	cont. to increase slightly. Will follow renal function.
	Tolerated Right CT for wet seal x 24 hours, so removed
	this AM. Will check CXR. Pt fighting the vent
	yesterday in spite of sedation so started on Vec with
	mild improvement in peak pressures. Will switch
	from Versed to Ativan since pt. likely to require sedation
	for several more days

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PROGRESS NOTES
Medical Record

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

(b)(6)-2 all

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
14 Nov 03 1125	Accept pt @ 0600 from night shift. Pt had drainage fr CT site ad evaluated by Pt [redacted]. CT pulled @ 0830 ad packed c petrolem + Gauze. The site below CT insertion was pack c W→D dressing. ABG done FiO2 ↓ to 45% will reassess @ noon. CXR to be done @ 1130 to eval for PTX. last H/H this am @ 0400 was 23/7.5 a Type and Cross done ad pt to receive 2 units PRBCs. Benadryl 25mg IV/ad tylenol 650mg PR given prior to 1st Unit. PIP @ mid 30's. UA @ 0600 was 20 Tan next hour 40. Foley was flush c 30cc NS. Pt Urine has increased since 0800. will continue to monitor [redacted]
14 Nov 03 1328	Gave 20mg/Lasix/tabs IVP. Art BP 160/56 HR 97 SpO2 98% due to S. Art pressures 190's - 180's. @ 1520 pt Art SBP 163/95 MAP (115) ad Auto BP Cuff @ 150/54 MAP (115) will continue to monitor Pt. Hemodynamics. Pt continues to get PRBC ad as 2nd Unit c no adverse rxn thus far [redacted] PT/last
14 Nov 03 1520	At 1345 pt SaO2 ↓ to low 90's ABG done ad PO2 @ 73. ↑ FiO2 from 45% to 50%. will repeat Gas @ 1600. Lungs were auscultated ~~[illegible]~~ ad lungs were unchanged from previous assessment @ Noon [redacted] pt/ca
14 NOV 03 1610H	Received report from previous shift. Pt intubated c ETT #8.0 28.5cm @ hub SIMV 24, TV 750, p-5, FiO2 45%, PIP 40, O2 sat 96%. HOB ↑ 30°. @ nare NGT to LIS. 3 lumen central line + A-line intact. Dsg intact. Foley present UO 100cc. will cont care [redacted]

STANDARD FORM 509 (REV. [redacted] BACK

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(b)(6)-2 all except for very bottom

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
14NOV03 1900	Transduced CVP per Dr. [redacted] order. CVP 11-14. Deep suctioned pt x III; Thick yellowish secretions noted. PIP 44 → 38 p suctioning. Frequent suctioning prn. [redacted]
2200	Drew ABG per Dr. [redacted] will report results. Reported CVP + UO levels. ϕ new orders given [redacted]
2230- 2300	Completed dsg Δ. Dry dsg c bacitracin on stables on midline abd incision. Wound well approximated c stables intact. Little sanguinous drainage noted. Wet → dry dsg (R) flank wound. Sanguinous drainage noted. Replaced petroleum gauze on CT wound. Wet to dry dsg entrance wound on back. ϕ drainage noted. New orders. ↓ed FiO2 45%. 1 LNS bolus, fluid Δ to DSNS @ 250cc/°. CVP 8, O2 sat 98-99%. Versed bolus 3mg for ↑ed BP. [redacted] longer correlate c cuff. 40 point difference systolically. ↑ed versed rate to 5mg/°. Will turn pt to (R) side. will cont. care. [redacted]
15NOV03 0100	O2 sats remain 99-100%. ↓ed FiO2 40%. Will cont to monitor. CVP 8-13. will cont to monitor. [redacted]

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PROGRESS NOTES
Medical Record

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

(b)(6)-2 all

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
15-16 0303 0215	Deep sxn pt x III c RT. Thick yellow secretions noted. Will cont care. CVP 13-15 while on back. [redacted]
0500	Redid drsg (R) flank due to saturation c serous drainage. Wet to dry drsg. Turned pt into (L) side. Noticed scrotal edema + tighter abd. Elevated scrotum. Deep suctioned pt x III using saline bullets + manually ventilating pt. Thick yellowish sputum noted. O2sats 94%. PIP 46. Will cont. care. Abnormal ABG + labs. Notified Dr. [redacted]. No new orders given. Will show primary doctor. [redacted]
0600	Gave report to next shift. [redacted]
1511 0303 0950	Surgery 140#s ICU 105#s Ve 4.8#s 900#s Aug 49#s Continues to have high peak pressures at 40-50. CXR ordered c Bilat. contusions / infiltrates. Also continues to have HTN in spite of Versed 10 mg/hr c good sedation. Will discuss possible β-blocker c Dr. [redacted] Received 2 units PRBCs, yesterday Hct is 30.5. CVP transduced at 15 14 on PEEP of 5. Will hold Vec this AM until pt. overbreaths vent + check peak pressures
7.7) 9.9 / 30.5 (192	
137 / 120 / 4.3 / 21 / 3.2 (138	
7.295 / 39 / 81 / 19 / -7 94%	

[redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

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MEDICAL RECORD

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PROGRESS NOTES

DATE	NOTES
15 NOV 03 1830	Received report on pt. 1257. PT lying supine c HOB ↑ 30°. At this time pt is vented c 8.0 ETTc 29.5 cm to securing device. Simv - RR 20 TV 750 Fio2 40 PEEP 5 PIP 30's. PT is sedated on Versed 10mg and Pain control c morphine sulfate @ 8mg. Pupils are 2mm sluggish to light. OBT to LD and Dobhoff pending verification by MD. Kelly B aware. Pt has (+) gag reflex to suctioning. Breath sound clear/wet. moderate amount of light yellow secretions suctioned from ETT and bloody secretion orally. Breath sounds are coarse & diminished to bases bilaterally. Equal expansion noted. HR 90's c S1,S2 dectopy. Pulses are palpable c cap refill <3 sec. Generalized edema c 1+ pitting to ankles. BS hypoactive, distended c midline incision c dsg. C/D/I. Foley to gravity draining yellow urine 730cc/hr. [redacted]
1920	PT suctioned. thick bloody secretion orally and light yellow secretion to ETT. [redacted]

RELATIONSHIP TO SPONSOR

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(b)(6)-4

PROGRESS NOTES
Medical Record

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

USAPA V1.00

(b)(6)-2 all

	FIRST NAME	MIDDLE INITIAL	ID NUMBER

NOTES

PT Suctioned. OIH suctioned removed [redacted] LCT/AN

PT @ gurgling breathing pt suctioned. Sao2 remained at 94% [redacted] LCT/AN

PT continues to have gurgling breath sound. ETT securing device removed & PT suctioned @ yankeur. PT also suctioned through ETT and Sao2 improved to 95% then decreased back to 92-93%. ABG done to (R) side. Wound bed pink. [redacted]

1411 P00 mg Labetalol given per NGT. Tube clamped for thr [redacted] LCT/AN

305 PT suctioned. ABD BSG D. done. Sutures intact. minimal leakage to site. PT turned to (R) side. MD at bedside states DCHoff & NGT O.K & WOTH re-verify in am [redacted] LT/AN

0100 PT. suctioned. [redacted]

0200 PT suctioned [redacted] LT/AN

0320 ETT securing device removed. Oral care done and new securing device placed. [redacted] LCT/AN.

0400 morning Labs done. ABG results PH: 7.256 PCO_2 46 PO_2 57 HCO_3 20 Sao2 85 BE -7. MD notified and vent D's. are RR ↑ 24 & FIO_2 ↑ 50. Will redraw Gas at 0600. [redacted] LCT/AN.

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

DATE	NOTES
15 NOV 03 1030	Pt had increase art SBP and DBP and MAPs in 130's. Notified Dr [redacted] which wanted to try Versed to increase sedation. MAPs stayed the same. Dr [redacted] notified @ 0930 and came to assess pt. IVF changed to D5 1/2 NS @ 200cc/hr at Vecuronium or hold due to some PIP pressures or prior to on Vec. PIP @ 40-50 CVP bn 12-16. UOP today has been >100cc/hr and adequate. CXR from this am was noted and Dr [redacted] +/+ for today. Secretions from ETT have been Thick and yellow. Oral/nasal secretions have been copious and yellow. Continue to monitor Respiratory + UOP [redacted] CPT/RN
15 NOV 03 1200	Pt SBP + DBP continues to trend upwards. Pressures 150's SBP and DBP 110 MAP 140's will contact MD [redacted] CPT/RN
15 NOV 03 1330	Given @ 1210 labetalol 20mg IVP through TLC. BP now 150's over 90's HR mid 90's. Pt to get labetalol q6. Will continue to monitor [redacted] CPT/RN
15 NOV 03 1730	Dobhoff inserted into (L) nare. Xray done, awaiting Dr [redacted] to see film. Distal on TLC not flushing, will notify next shift. [redacted] CPT/RN

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PROGRESS NOTES
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STANDARD FORM 509 (REV. 5/1999)
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(6)(6)-2 all

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
16 NOV 03 0850	Surgery HD#6 ICU D#6 Vent D#6 POD#6 Facet D#6 Started on Labetalol + Hydralazine per Recs from Dr. [redacted] with decrease of BP to 150/70 - 160/80 which is a significant improvement. OGT placed + will slowly start TF
7-9 / 16.2 / 181 / 31.6	
124 / 117 / 94 / 113	
4.1 / 22 / 3.1	
7.28 / 39.7 / 74 / 19 / -8	Neuro = oriented x 3, follows commands + moves extremities will continue to record neurological status
93%	Resp = required increase in FiO_2 and RR last PM for $\uparrow pCO_2$ and $\downarrow pO_2$. Responded well peak pressures now in the 30's to low 40's which is an improvement. CXR w/o improvement but stable
I/O = +1532	CV = Responding to BP control w/ CVP = 14-18
	Abd = incision intact, distended but soft will slowly start TF
	FEN = UOP stable @ 55-116cc/hr Up 1500cc yesterday Cr stable @ 3.1 K^+ stable @ 4.1
	H/H = stable Hct @ 31.6
	ID = Tmax = 99.2 on Ancef, will d/c after tomorrow if no fevers.
	Pt. continues to have increased pulmonary/vent. requirements. Will track tomorrow. [redacted]

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
16NOV03 1000	Nutrition Note: Osmolite HN TF started this am via DHT. 11/16 labs: Hgb: 10.2↓, Hct: 31.6↓, BUN: 34↑, Creat: 3.1↑, Na: 124↓, Cl: 117↑ ENN based on 75 kg ~~today~~ weight: 2250-2625 Kcal/day (30-35 ~~Kg~~ Kcal/kg) + 105-112.5 g Pro/day (1.4-1.5 g/kg). Recommend continuing TF at low rate 2° lung + renal function. Will continue to monitor + follow. [redacted] RD/LD
16NOV03 1025	SpO2 ↓ to 88% pt bagged and suctioned ETT. Thick beige secretions removed. Thick oral secretions beige also removed. PIP@40. Dr [redacted] notified ↑ FiO2 to 65%. SpO2 @ 91%. [redacted] sounds = Inspiratory [redacted] in upper lobes as well as lower. Respiratory to give Albuterol + treatment @ [redacted] CRT/a
16NOV03 1310	@ 1130. ↑ peep to 8 from 5 FiO2 @ 70%. Gas done @ 1220 T 99/37.7/162/18/89%. Box -7. Pt has thick thick secretions suctioned out frequently. Rales heard in [redacted] will notify physician [redacted] CRT/a
16NOV03 1328	Dr [redacted] Dr [redacted] both come & evaluate pt. Pt was not responding to suction nor to either side. positioning ↑ peep to 10 FiO2 ↑ 100%.
16NOV03 1600	Dr [redacted] ordered albuterol/atrovent. 1st dose of albuterol given. Pt stable again on vocerem

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PROGRESS NOTES
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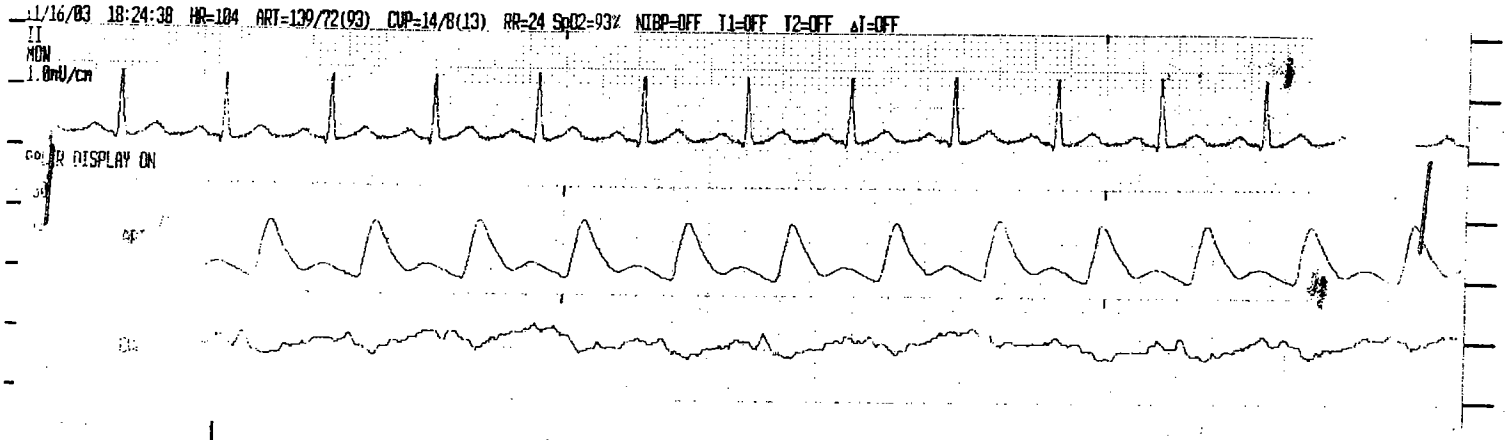
[redacted] MEDCOM - 23696 [redacted]

(b)(6)-2 all

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	due to Ped. Pt [redacted] Vent. Expectorator cultured ~~from~~ results from Micro Come Sucks. The Cx was for pt Sputum ETT. Stated/ ordered by Dr [redacted] Cipro 400mg IV to be @ 2000 - will give report to next shift [redacted]

NOV03 1800



1904 2200	Received report from previous shift. Pt vented #8.0 ETT 28.5cm@hub. SIMV 24, P-10, TV 750, FIO2 70%, O2 sats 95%. Pt HOB 30° c osmolite @ 10cc/° infusing via dobhoff Pt turned onto L side. BUE+BLE elevated due to edema. Vec, versed, MSO4 + NS infusing into medial port. CVP + A-line zeroed. A-line 26 ~~mm~~ values different from NIBP value systolically. NGT to LIS c large amt yellowish fluid. [redacted] Deep suctioned pt x III. O2 sats ↓ 80s. Manually ventilated pt c RT @ bedside. Copious amt yellowish sputum noted. O2 sats ↑ 91% for ≈ 1 minute then desat to 81%. Notified surgeon on call. Lasix 40mg ordered + NS ↓ 25cc/°. NO ↑ lasix ↑ by 50cc/°. Dr [redacted] also notified. Ventilated pt ≈ 10 min. c no ↑ in SaO2. Dr [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK
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(6)(6) - 2 all except bottom

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
16 NOV 03 1900-2200	cont'd... + Dr. [redacted] notified. No new orders written. Will cont. to monitor. — [redacted]
0245	Dr. [redacted] to see pt. Ted peep to 15. O_2 sats ↑ 93-94%. Will draw abg in 30 hr. Will cont to monitor [redacted]
2305	Drew ABG Showed results to Dr. [redacted] Ø vent Δ's made. Pt O_2 sats ↑ 94-96%. Will cont to monitor. — [redacted]
17 NOV 03 0030	Completed dsg Δ on midline abd + (R) flank. Staples intact midline abd. Small section of belly button open. Serous drainage noted on old dsg. Applied bactroban + covered c 4x4. (R) flank open wound saturated c serous drainage. Wound beefy red c minimal yellow exudate. Cleaned c NS. Wet to dry dsg covered in tegaderm. Will cont. care. — [redacted]
0045	Completed foley care. Elevated scrotum + applied bactroban to penile area. Deep suctioned pt x III. Copious amt yellow tinged sputum from nose, mouth, + ETT noted. P/P ↓ 43 from 46. Will cont. care. — [redacted]
0345	Drew am labs + ABGs. Due to results, ↓ FiO2 90%. cont'd

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[redacted] (6)(6) - 4

PROGRESS NOTES
Medical Record

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

(b)(6) - 2 all

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
[redacted]			

DATE	NOTES
17 NOV 03 0845	cont'd... O2 sats 100%. Will cont to monitor. — [redacted]
0845 ~~0845~~	Ved FiO2 85%. Due to SaO2 100%. Will cont. to monitor. [redacted]
0845	Ved FiO2 75% due to O2 sats 99-100%. Deep sxn done by RT p neb tx. PIP 41-42. CVP 12. Will cont. care. [redacted]
0600	Gave report to next shift. [redacted]
0605	Called MD concerning Na+ level + low UO 35cc/1°. Dr. [redacted] notified. Rx's to be made by primary MD. [redacted]
17 NOV 03 0830	Surgery Cipro D#2 for Enterobacter bacteremia in pt's Pt. had a significant decline in his pulmonary status yesterday and required PEEP increase to 15, Rate to 24 and FiO2 now @ 75%. CXR still c/w/ bilat. infiltrates. Neuro = sedated & paralyzed Resp = SIMV Rate 24 PEEP 15 FiO2 75% 7.27/37.9/97/18/97%/-9 Will try to wean support, trach cancelled CV = BP stabilized but CVP only 10's 11 c a PEEP of 15, will give volume GI = distended but soft, started TF @ 10cc/hr Renal = Cr T to 3.5, likely due to ↑PEEP and low volume will hold Rx + increase fluids ID = Cipro D#2 WBC = 10.2 W. will continue c support in this pt.'s ARDS picture. Realize the mortality is high.

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(b)(6) - 2 except for bottom

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	Nursing Notes
17Nov03 0615	Received Pt # D75 in from Bed #4. Pt unresponsive to verbal stimuli. See Intensive Care nursing flow sheet for assessment and VS. INNS 25 cc/h Vecuronium drip @ 4 mg/h. Versed drip 10 mg/h. MSO4 8 mg/h in regular A-Line to right Radial artery. Pt has generalized edema. Intubated
0730	Dr. [redacted] visited and examined Pt. he is aware of Pt's lab results and Pt's current condition. Pt sedated. [redacted]
0830	Dr. [redacted] visit Pt. He ordered IV NS TL Bolus and 1/2 NS rate to 250 Tube feeding restarted to 30 cc/h thru pump. He ordered cancellation of planned tracheotomy for today. FiO2 VT to 70% Pt 98-99 via pulseoximeter
0900	Temp 96.2 Sat 98% via pulseoximeter FiO2 VT to 65% via pulseoximeter [redacted]
1100	Temp 96. Oral care ET Tube care Foley catheter care and skin care done all dressings changed. TAR. Extra blankets used to cover Pt will Report temp.
1330	Dr. [redacted] visited Pt. He is aware of Pt's condition. He ordered chest xray. Chest xray done Dr. [redacted] reviewed xray. He ordered Dobutamine drip @ 5 mcg/kg/hr
1500	Dobutamine drip started at 5 mcg/kg/hr FiO2 70% Pt 96% via pulseoximeter
1745	Pt's condition unchanged Temp 97.7 Groom IVPB given Versed 60 mg/h MSO4 8 mg/h Vecuronium 4 mg/h NS 250 cc/h continues. No distress noted Report given to relief nurse [redacted]
17 NOV 03 1800	Received report from previous shift. Pt intubated ETT # 8.0 · 26cm @ teeth SIMV 24, TV 750, p-15, FIO2 65%, PIP 42. All IV lines in place. cath.

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(b)(6) - 4

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PROGRESS NOTES
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STANDARD FORM 509 (REV. 6/1988)
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USAPA V1.00

(b)(6) - 2 all

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
17 NOV 03 1800	cont'd... A-line ® radial c good waveform but does not correlate c BP cuff. Will record both values. ©SC TLC c versed @ 1Ø mg/1°, MSO4 @ 8mg/1°, vecuronium @ 4mg/1° NS @ 250cc/1° infusing in medial port, CVP monitor in proximal port + dobutamine @ 5mcg/kg/min infusing in distal port. NGT to LIS c some beige colored drainage. Dobhoff c osmolite @ 10cc/1° infusing. Replaced ®flank drsg wet→dry due to saturated drsg c serous fluid. HOB 30°. ©BUE ©BLE + scrotum elevated due to edema. Will cont. care. [redacted]
2000	Deep sxn pt x III due to PIP 46. Thick yellowish secretions noted from mouth, nares, + ETT.
2200	Pt NO ↓ 15cc. Dr. [redacted] notified. + liter NS bolus ordered. CVP currently 17, O2 sats 96% on 100% FiO2. Will titrate O2 to keep sats >93%.. Will monitor UO. [redacted]
2230-2400	Completed Bley care + drsg Δ to midline abd, ® flank + back. Midline abd incision staples well approximated c small amt drainage from belly button area. Bacitracin applied + dry drsg. Wet to dry drsg on ®flank. Large amt serous fluid from ®flank wound. Yellow/edate noted but mostly beefy red. Xeroformgauze over CT incision c ∅ drainage noted. Suture in place, wet→dry drsg on back. ∅ S/S of infection. UO remains low 14cc ỳ 30 of ½ liter bolus. Will cont to monitor [redacted]

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

(6)(6)-2 of 11

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
17 Nov 03	HHN Tx given c 0.5 Alb/ATRovent /2.5 NS. BBS for
1400	Rhonchi throughout. HR 92-90, O2 SAT 94%. P Tx
Resp Therapy	BBS unchanged. NAR ——— [redacted] CRT
1802	Neb Tx given to pt pre tx HR 98 RR 24 SpO2 94% on BBS Coarse
	Post tx HR 99 RR 24 SpO2 94% BBS No change Sgt [redacted] 91V2P
17 NOV 03	
2206	UD Alb/Atro given pre tx HR 93 RR 24 SpO2 96% on 100% FIO2
	BBS coarse Post tx HR 95 SpO2 97% on 100% FIO2 RR 24
	BBS No change pt SX by nurse ——— [redacted]
18 NOV 03	
0150	UD Alb given. Pre tx HR 91, RR 24, SpO_2 93% on 80% FO_2.
	BBS coarse rhonchi + faint wheezing. Post tx HR 88 RR 24, SpO_2 93%
	back on 80%. Suctioned pt c 10cc NS thin secretions.
	BS unchanged ——— Sgt [redacted] 91V2P
18 NOV 03	
0550	UD Alb & Atro given. Pre tx HR 98, RR 24 SpO_2 92% on 100% FiO_2
	BBS coarse. Post tx HR 103 RR 24 SpO_2 95% on 100%. Suction
	by nurse. ——— [redacted] given
1010	Pt. given UDAIB via inline neb @ 6L/m x 15 min.
	Pulses 92-95 RR 24-24 BBS c CTA p CTA Pt.
	SX for minimal amount of clear yellow sputum [redacted] CRT
1400	TX given by nurse. Pt. suctioned for minimal
	amount of clear to yellow secretions. [redacted] CRT
1605	Tx given by nurse ——— Sgt [redacted] 91V2P
2148	PL given Neb Tx c Sec Alb/Atrovent pre tx HR 122 [redacted]
	24 SpO2 92% on 85% FIO2 BBS coarse Rhonchi throughout
	Post tx HR 122 RR 24 SpO2 93% on 100% FIO2 BBS no change
	Pt lavaged & suction c 3cc secretions Removed Sgt [redacted]
19 NOV	
0100	Alb tx given. Pre tx HR 117, RR 24, SpO_2 90% on 90 FO_2. BBS
	coarse. EMT called. Tx taken off per nurse. ——— Sgt [redacted]

(b)(6)-2 except bottom

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
16 NOV 03	UD Alb neb given pre tx HR 101 RR 24 SpO2 93%
1854	BBS coarse Post tx HR 102 RR 24 SpO2 95%
	BBS coarse pt SX — Sgt [redacted] 9Nov03
2225	UD Alb Neb given pre tx HR 93 RR 24 SpO2 87% on 100% FiO2 Post tx HR 98 SpO2 94% RR 24 BBS no change
	Pt SX — Sgt [redacted] 17Nov03
17 NOV 03 0230	UD Alb-Ab neb given. HR 94-100, RR 24, SPO2 98-100%. BBS coarse c faint wheeze. Suction scant amount — Sgt [redacted]
0530	UD Alb given. HR 110, SPO2 78%, RR 28. BBS coarse. Post tx HR 109, RR 24, SPO2 75. Suctioned pt. — Sgt [redacted]
17 Nov 03	Pt was Extubated @ 0655 and placed on 100% NRB. Pt c/o
0920	Resp distress, BBS ~~c~~ Scattered Rhonchi. O2 SAT 98%.
Resp Therapy	Δd to 40% Venti mask @ [redacted] RR [redacted] O2 SAT 96%. BBS for Scattered Rhonchi. Pt c strong Productive cough No Resp distress noted. — [redacted] CRT
17 Nov 03	HHN Tx given c 0.5 Alb/2.5 NS. BBS for coarse
1000	c Exp wheeze. HR 96-97, O2 SAT @ 65%, 94%.
Resp Therapy	

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		

Alb Q4
Atrv Q8

PROGRESS NOTES
Medical Record

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(b)(6)-2 except bottom

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
18NOV03 0010	UO 27cc p bolus. Notified Dr. [redacted] 1 Liter NS bolus ordered. MIVF rate ↑ed 300cc/°. Temp ↓ 95.5 Place x-tra blankets + heating lamp on pt. CVP 26. Deep sxn pt x III. Copious amt yellowish secretions noted from mouth, nose + ETT. O2 sats 93%. Will cont to monitor. [redacted] CT/RN
0300	UO ↓ 10cc. Temp ↑ 96.1 O2 sats remain 90-91%. Dr [redacted] aware. Lasix 40 mg ordered. MIVF ↓ed 200cc/°. Will cont to monitor. [redacted]
0445	Reported abnormal ABG results to Dr. [redacted] @ vent ∆'s made @ new orders. [redacted] RN
0500	@ improvement in uo. will cont to monitor. [redacted] RN
0600	Gave report to next shift. [redacted] (RN)
18NOV03 0730	Upon shift Change this am pt on back c HOB 30° TIC 3 all ports in use. NS @ 300cc/h, IVC @ 4cc/h Dobutamine @ 5cc/h 4 mcg/kg/h; Versed 10cc/h, MSO4 8cc/h. TF through OBT w (L) nare @ 10cc/h c no gas leak. OGT via nare adapter NGT to (R) nare c ~~Hydrocare~~ Surgical suction to (R) chest tube from CT site are wet, red, swollen c drainage. Dependent edema. Scrotum very large and edematous.

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

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

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

(b)(6)-4

[redacted]

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
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(6)(6)- 2 all

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	Cont - Sat o rooi @ 94 c Current Vent setting on flow sheet. Will titrate Vent & FiO_2 to keep O_2 sats > 93%. Will continue Urine OP is decreased. Cont @ 30 c physician aware. Will Continue to monitor respiratory status — [redacted] cont
1030 18 Nov 03	pt UOP continues to trend ↓. 20-28 cc/h Notified physician — [redacted] cont/m
18 Nov 03 1200	non assesment. NO change in report. UOP Continues to trend in 20's. Physician aware — [redacted] cont/m
18 Nov 03 1400	for 1400 UOP @ 16 cc. Dr [redacted] notified ordered 80 mg Lasix IVP. Will Monitor response — [redacted] cont/m
18 Nov 03	Received report on 1275. Presently heavily sedated c Versed, Vecuronium, + MSO4 gtts. Will continue to work on wean O_2 down. Lungs: coarse rales. Ventilator keeping off c delivered tidal vol. not equal set TV. Respiratory aware. SIMV c rate 24 Ratio 1:1 TV 750 PEEP 15. FiO_2 85% c O_2 sats 92%. [redacted] BV Respiratory admin treatments c loosening of secretions. Unable to get O_2 sat ↑ 89 ∴ Resp. ↑ O_2 to 100% Several attempts to get O_2 back to 85% c resulting desat 89%. Finally @ 1400 FiO_2 90% c sats 91-92% 0430 ↓ 85% c sat 93% Obtained ABG. — [redacted]
0600	Reported off to day shift

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
19 NOV 03	General Surgery HR# 9 / ICU# 9 Vent D# 9 / POD# 9 ~~Foley D# 7~~ Cipro d#4 for Empedobacter pneumonia Pt. continues to have very poor pulmonary status still on a PEEP of 15 and FiO2 of 80% and paO2 of 66 peak pressure of 50 ABG this AM = 7.041/53.1/66/14/-16/81% given Bicarb and one blood CXR = no A's ~~this AM~~ Renal = Cr has increased to 5.2 and UOP still 45cc/hr on Lasix 40mg/hr. Will give blood today and HD if it helps This patient continues to have a severe decline w/ no obvious source other than his pneumonia which we are treating w/ continued aggressive support. If he continues to decline, I will consider a DNR order.

(b)(6)-2

[redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
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PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)*

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PROGRESS NOTES
Medical Record

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Pt 1275 (b)(6)-2 all

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
19 NOV 03 1530	Pt arr received report. Pt Abd ↓ c pH @ 7.041 153, 1/66/14/-16 SiO_2 8/1. Received 6 Amps BiCarb 2u PRBCs. Noon Blood Gas 7.16/49.7/61/18/-11 c 84% Received 2 Amps Bicarb and Charged MUF to BiCarb drips @ 100cc/h. Pt suctioned c bloody thick mucous c thick plugs suctioned out x treatments from RT. Sats are currently @ 95% c FiO2 @ 87%. will ↓ FiO2 @ 1600 if Sats remain above 93%. Medications were Changed over to day/to renal doses. (R) Femoral Cords began for more access will do another ABG. — [redacted] CPT/RN
19 NOV 1735	@ 1545 done Bladder pressures done R/O ABD Compartment Syndrome. Pt presents @ 23. Dr [redacted] aware. Set up for ABD monitor @ Bedside. — [redacted]
20 NOV 03 0925	This am LABS 21.1 → 9.6/30/332 PT/PTT repeated and PT 39/PTT 102. ABG 7.278/51.2/137/24/-3/99% CHEM 144/114/99/146 / 4.4/23/5.9. Dr [redacted] aware of all labs. Pt Continues to be on MV c peep 15 RR 30 TV 690 and FiO2 @ 87 c keeping Sats @ 93%. Rales/scattered Rhonchi heard throughout. Rales auscultated in middle to upper lung fields Pt has BS and distended. UOP has been normal on 20 cc/h Size shift S. Continues on ABX. When Pt suctioned secretion bloody/beige. Skin tears and weepy. Pt is now DNR. Will continue to monitor resp/renal status — [redacted] CPT/RN

STANDARD FORM 509 (REV. 5/1999) BACK

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(b)(6)-2 except bottom

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
19 NOV 03 0600	Pre tx HR 115, RR 24, SpO_2 96 on 85% FiO_2. UD Alb & Atro given BBS coarse. Post tx HR , RR , SpO_2 on 85% FiO_2. Sgt [redacted] 91W2A
1000	Pt. given UD Alb via inline neb @ 6 L/m x 15 min. Pulse 119-114 RR 30-30 BBS ↓ ins ↓ exp wheezing P NOD Pt. suctioned for moderate amount of bloody sputum and large bloody plug [redacted] CATT
1400	Pt. tx given by nurses. CATT [redacted]
1814	Pt tx given by nurse Sgt [redacted] 91W2A
2200	Pt given Sch Alb/Atro neb tx Pre tx HR 114 RR 30 SpO_2 94% 80% FiO_2 BBS coarse insp + exp wheezes
20 NOV 03 0200	Pre tx HR 115, 92 SpO_2 on 75% FiO_2, RR 30, BBS ⊕coarse ⊕wheezes. UD Alb neb given. Post tx 117, RR 30, SpO_2 96 on 75%, Suctioned thin bloody-tinged sputum Sgt [redacted] 91W2A
0600	Pre tx HR 111, SpO_2 91% on 96% FiO_2, RR 30. BBS coarse ⊕ wheezes UD Alb + atrovent given. Post tx HR RR SpO_2 on 96% FiO_2 Suction:
1000	Pt. given UD Alb via inline neb @ 6 L/m x 15 min Pulse 107-110 RR 30-30 BBS ⊕ insp. ↓ exp. wheezing P NOD pt. suctioned for small amount of brown to clear secretions. [redacted] CATT

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

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

[redacted] (b)(6)-4

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PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/1998)
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(b)(6)-2 all

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
Nov 20 03	Pt. given UD AIB & UD Atro. via inlin neb @ 6 L/m
1400	W/5 min. Pulse 114-112 RR 30-30 BBS & exp wheez & no D. [redacted] CRTT
1830	Pt Given UD Alb tx pre tx HR 109 RR 30 SpO2 95% BBS insp & exp wheezing, Post tx HR 112 RR 30 SpO2 94% BBS No change pt SX — Sgt [redacted]
2147	Pt Given UD Alb/Atro pre tx HR 102 RR 30 SpO2 92% On 87% FIO2 BBS coarse insp & exp wheezing Post tx HR 102 RR 30 SpO2 94%, BBS No change pt SX — Sgt [redacted] 91U2P
NOV 21 03 0300	UD Alb neb given. Pre tx HR 94, RR 30, SpO2 89 on 87% FiO2. BBS coarse & wheezes. Post tx HR 102, RR 30, SpO2 90 on 90%. No O/S in BS — Sgt [redacted] 91U2P
0400	Suctioned pt & 5cc NS scant blood tinged mucus. PIP remain @ 53. — Sgt [redacted] 91U2P
0545	Pre tx HR 111, RR 30, SpO2 90 on 90% FiO2. BBS coarse & wheezed watery sounding. UD Alb & Atro given. Suctioned pt & 5cc NS clear blood tinged secretions - thin. Post tx HR 107, RR 30, SpO2 89 on 90% FiO2, BBS same. — Sgt [redacted] 91U2P
1000	Pt. given UD AIB & via inlin neb @ 6 L/m x 15 min. Pulse 119-119 RR 30-30 BBS a little wet sound. & CTA Pt. suctioned using 20 cc NS for thick bloody secretions. [redacted] CRTT
1400	Pt. given 5cc AIB & UD Atrovent via inlin neb @ 6 L/m x 15 min. Pulse 121-115 RR 30-30 - BBS a little coarse & less coarse - Pt. sx for moderate amounts of bloody sputum. [redacted] CRTT

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	Nursing Notes
19Nov03	Received PT # 1275 in Tent 1 Bed # 4 Pt Clinically pronounced dead
1830	movement of any extremities noted. Left & mm PLW
	reaction. Pt grossly edematous scrotum and Penis grossly
	edematous. Pt Orally intubated ETT 7.5 cm Uplin Vented
	Rate 30 SIMV TV 620 FiO2 75% Peep 15. Bilateral breath sounds
	has scattered rhonchi with rales to mid lobes Equal chest
	expansion noted. Sat 94-96 Diagnostic edematous. Cardiac
	Monitor shows ST HR 110-120's BP grossly edematous. Bilateral
	TLC Tube left side evacuation tubing done CVP 18-22. Pt on levophed drip
	18 mg/kg. Hourly drip of 8 mg/kg Vecuronium at 4 mg/kg. Dopamine
	drip at 3 mcg/kg/min Dobutrex drip at 10 mcg/kg/min Levo
	drip at 40 mg/kg. and D5NTLC 3 amps Sodium Bicarbonate
	at 150 cc/h. Cordis to Right groin at 6cm to right radial art
	Foley Empty tube thru Right Nare to suction Dopplor tube thru Rt
	nare with Osmolyte 10 cc/h infusing. Bowel Sounds very hyperactive
	Foley Catheter draining scant yellow urine to bag. Mid
	abdominal Surgical wound covered with dry dressing Old
	chest tube site to right chest wall covered with dry dressing
1900	Pt Suctioned Turned and positioned. Pt dead at 1904
	after suctioning HR 40's Pt bagged for approximately
	Placed back on Vent at 1910. HR 118 VSS [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	(b)(6)-2
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PATIENT'S IDENTIFICATION (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)

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WARD NO. ICU 1

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
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[redacted] (b)(6)-4

(b)(6)-2 all

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	Nursing Notes Cont. NOTES
19 Nov 0330	VSS FiO2 titrated to 80% PA [redacted] visited Pt Lo is aware of Pts most
	ABG results and of Pts condition. Pt turned and repositioned.
2300	FiO2 titrated to 75% Sat 93-95% via pulse oximeter. No distress noted [redacted]
0100	VSS Pt turned Turned and repositioned
0300	Pt Sat 94% via pulse oximeter FiO2 to 80% then 85% [redacted]
0430	Chest xray done Blood drawn and sent to Lab [redacted]
0500	Sat 91% via pulse oximeter. FiO2 to 90% Pt turned repositioned Sat of 93%
0600	via pulse oximeter. Pts condition unchanged. Report given to nurse [redacted]
20 NOV 03	Surgery HD#16 ICU#16 Vent D#16 POD#16
	Cipro D#5 1 episode Bag #
PT=39	Pt. still doing very poorly. Still requiring PEEP
PTT=162	and FiO2 for oxygenation. Peak pressures at 50.
INR=7.66	CXR unchanged.
21.4 > 9.6 / 332 < 30	So far this patient so far has pulmonary failure and
7.27/51.2/137/24	renal failure. He is developing liver failure and
~3 / 99%	hematologic failure with his LAEs going up and his
144 / 114 / 99 / 146	coagulation studies going out. And his WBC continues
4.4 / 23 / 5.9	to increase in spite of broad coverage of Zosyn
bili 2.8	and focused coverage for his pneumonia with
Amylase 59	Ciprofloxacin.
	This patient is now developing systems failure
	and is on maximal ventilatory support and
	dopamine and dobutamine. I do not feel it will
	be appropriate to continue escalating his care in
	light of his very high mortality. I will continue what
	supportive care we have him on and make him a
	DNR. I have discussed this c Dr [redacted] and
	he agrees.
	[redacted]

STANDARD FORM 509 (REV. 5/1999) BACK
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(b)(6)-2 except bottom

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
201800 Nov 03	Received report from day shift. Assumed pt care. Ambu bag at bedside. O2 tank full. All medications infusing appropriately. Drsg to (R) femoral cordis is loose, c serous fluid leaking out around cordis and into creases of groin. Bed saturated c serous fluid. Groin. Scrotum swollen to size of football. Penis also very swollen, c superficial layer of skin along (R) lateral side and anterior portion of penis sloughing off. Pale white tissue visible beneath sloughed skin. [redacted]
202000 Nov 03	Assessment and medications completed. Turned pt to left side. Drsg d to (R) flank and middle of back completed. Ø skin breakdown noted to sacral area or other bony prominences. All of bed linens and moisture pads changed. Ankles elevated on towels, keeping heels off of bed. Scrotum elevated on towel. Drsg to (R) femoral cordis changed using sterile technique, replacing op site & cleaning c ~~ETO~~ alcohol & iodine. Noted significant facial swelling, tie for ETT dislodged into face. ETT tie replaced c bite-block. ETT holder. Skin breakdown noted to (R) cheek and (R) canthus of mouth. MD will be notified. Wool blanket & warmer lamp placed over pt to aid in keeping warm. [redacted]
210400 Nov 03	Suctioning through ETT produces small amounts of thick, brown tinged mucus. RT has completed after each treatment (which is being done q 2hrs). [redacted]
210440 Nov 03	Labs drawn. ABG/C-stat ~~done~~ drawn. Specimen keeps clotting. Machine cannot pull blood through cartridge. Will inform MD. [redacted]
210500 Nov 03	O2 Sats & RT suctioned small amount of clear mucous (c slight blood tinge) & placed 5cc NS down ETT. No ↑ S_aO_2. RT ↑ FiO_2 to 90%. [redacted]
210530 Nov 03	ABG & Chem 7 redrawn & sent to Lab. Results pending. [redacted]

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

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

(b)(6)-4

Civ [redacted]

PROGRESS NOTES
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STANDARD FORM 509 (REV. 5/1999)
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(b)(6)-2 all

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
210500 Nov 03	LATE ENTRY: New bag of Lasix retrieved. I asked that lasix be put in 50mL bag after the 250mL bag to reduce amount of fluid entering body. New concentration is 5mg/cc lasix. New IV rate will be 8cc/hr. [redacted]
21 NOV 03	Surgery HP#11 ICU#11 Vent#11 POD#11
22.5/16/317 / 31.5	Cipro #6 Imipenem #2
7.29/3/63.5/58/27 BE=6/84%	Continues to downward course. UOP <10cc/hr BUN + Cr continued to increase and oxygenation decreased and he has a low temperature requiring heat lamp. Will continue current care c/ no circulation and no CPR if needed [redacted]
21Nov03 0000	Initial assessment completed see DA4700, pt VSS, ETT #8, 27cm @ hub, SIMV 30, PEEP 15, TV 690, F 16, 90% O2 Sats 88-91%, patient draining serous fluid throughout body, +3 pitting edema generalized, sedation c Versed and MSO4, paralyzed c Vecuronium; pupils are equal round, non reactive to light @ 2mm [redacted]
0700	Dr [redacted] @ bedside updated on pt condition no new orders, continue palliative care [redacted]
0805	Babcock flushed c 100cc NS c complications TF placed back to 300cc/hr. [redacted]
0900	Pt turned to back. [redacted]
21Nov03 1015	Pt sx c scant blood tinged thick secretions. VSS O2 sat 93% after suctioning. [redacted]
21Nov03 1150	Pt VSS, no change in pt status. [redacted]

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

(b)(6)-2

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
21aB 0040	(cont) PIP ≥ 60, ETT #8, SIMV 30, PEEP 15, FiO_2 90%, TV 600, c suction, bright red secretion, Ogog, scants amounts of drainage from foley catheter c blood tinged urine, NGT to (R) nares c dark brown drainage, Ashoff to (L) nares c Jevity @ 30cc/hr + q4° 60cc flushes, Sedation c Versed, MSO4, c Vec, MIVF D5W c 3amp Bicarb @ 100cc/hr. [redacted]
21aB 0750	Pt sx due to PIP ≥ 60, sx c bright red secretions O_2 sat 83% prior to sx c O_2 sat 85% after suctioning. [redacted]
21aB 0800	RT aware of PIP. [redacted]
21aB 0830	PIP remain > 60, RT paged and aware [redacted]
21aB 0930	Dr. [redacted] aware of PIP and secretions, no new orders at this time. [redacted]
21aB 1100	Dr. [redacted] @ bedside, updated on Pt status. No new orders noted. [redacted]
22 NOV 03	Surgery Pt's condition continues to worsen with peak pressures of 60 and FiO_2 requirement at 100%. Also c diguric renal failure and Cr of 6.8, and liver failure c coagulopathy. In light of his continued decline in spite of maximal support I feel it is most appropriate to stop all antibiotics, stop his bicarb drip and his tube feedings. I will leave him on the ventilator and give him IV fluids, sedation + pain meds. I have discussed this c Dr. [redacted] and he agrees. [redacted]

8.4 / 25.9 (34)

136 / 103 / 120 / 16
4.6 / 24 / 6.7

7.29 / 61.4 / 57 / 1
+3 / 85%
30

(b)(6)-2 except bottom

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
21 Nov 03 1420	Pt sx x 2 c bright red secretions c expiratory crackles post suction. [redacted]
21 Nov 03 1530	Pt bathed c linens changed, no signs of skin breakdown, pt repositioned to (L) side. Drsg Δ to (R) back, (R) side, and midline abd. New duoderm applied to (R) femoral cordis due to drainage. [redacted]
21 Nov 03 1600	Dr [redacted] @ bedside, updated on pt status & new orders noted. [redacted]
21 Nov 03 1700	Pt VSS, no change in current status [redacted]
21 1800 Nov 03	Assumed pt care & receiving report from day shift [redacted]
21 1830 Nov 03	Weeping from all wounds continues. Bedding saturated c serous fluid. Bed linens changed. Pt turned to (L) side. Wounds to mouth remain from ETT tube. (L) new orders regarding treatment of those wounds. Skin to penis continues to slough off. Significant weeping from sloughed areas. Scrotum elevated on towel. [redacted]
21 1830 Nov 03	LATE ENTRY: Noted during assessment that sclera to both eyes are yellowed and swollen. Akwa tears applied to both eyes. Some purulent drainage noted [redacted]
22 0400 Nov 03	Ventilator began annotating very high peak inspiratory pressures. RT [redacted]
22 0500 Nov 03	Noted to have blood tinge to pt's urine. [redacted]
22 Nov 03 0610	Initial assessment complete see DA 4700. Noted sclera edema c jaundice color to sclera, weeping serous fluid all over body. (cont) RS

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. 5/1998)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.2C3(b)(10)
USAPA V1.00

[redacted] (b)(6)-4

(b)(6)-2 except bottom

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

DATE	NOTES
21NOV 03 1755	RT Note Pt given UD Alb Neb pre tx HR 109 RR 30 Spo2 94% BBS coarse Rhonci throughout post tx HR 110 RR 30 Spo2 94% BBS NO change pt SX Bright red blood suctioned stoped — Sgt [redacted] SIVD
~~2235~~	UD Alb/Atro Given to pt pre tx HR 110 RR 30 ~~Spo2 [redacted]~~ 91% on 90% FiO2 BBS coarse Post tx HR 106 RR 30 Spo2 92% BBS NO change — Sgt [redacted] 91V2D
22NOV03 0150	UD Alb given, pre tx HR 104, RR 30, SPO2 94 on 90% FiO2, BBS coarse, Post tx HR 107, RR 30, SPO2 92. — Sgt [redacted] IVY
0600	UD Alb & Atrovent given. Pre tx HR 90, RR 30, SPO2 90% on 90% FiO2. Post tx HR 111, RR 30, SPO2 91% on 90% FiO2. Suctioned Pt bloody secretion c plug — Sgt [redacted] IVD
1000	Pt given UD Alb via inline neb @ 6L/m x 15 min pulses 112-107 RR 30-30 BBS a coarse p NO [redacted] CRTT —
1400	Pt given UD Alb c UD Atrovent via inline neb @ 6L/m x 15 min Pulse 107-111 RR 30-30 BBS a coarse p NO [redacted] CRTT —
1757	UD Alb tx given pre tx HR 106 RR 30 Spo2 89% on 90% FiO2 BBS Diminished Post tx HR 117 RR 30 Spo2 92 BBS coarse exp wh [redacted] Pt SX Bright red blood tinged sputum — Sgt [redacted]

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

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

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

(b)(6)-4

[redacted]

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1998)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
22NOV03	Pt Given .5cc Alb/Atro nebs inline pre tx HR 108 RR 30
2149	SpO2 88% on 100% FIO2 BBS Coarse Bronci throughout
	Post tx HR 105 RR 30 SpO2 95% BBS Coarse
	Pt SX Red blood sgt [redacted] (b)(6)-2 91U20

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

(b)(6)-2 except bottom

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD , **PROGRESS NOTES**

DATE	NOTES
21Nov03 1400	Bed padding changed due to saturation; drsg Δ to back, abd, and old chest tube sites; pt positioned on backside/ pt tolerate ∃ much change in status.
21Nov03 1500	Dr [redacted] @ bedside, updated on pt status, new orders noted. [redacted]
221800 Nov03	Assumed pt care. Received report from day staff. Noted significant oral drainage, NC of antibiotics and tube feeds. BP ranging lower than yesterday. Scrotum still significantly smaller ∃ slowly to penis continuing. Drainage from penis continues. Drsg to abd and R flank minimal at this time. Drsgs to these areas are intact. [redacted]
221930 Nov03	Completed oral care. Brushed teeth, tongue. Noted bleeding to gums after brushing. Suctioned large amounts of mucous from oropharynx, some blood-tinged. Replaced bite block/ ETT holder. Placed bacitracin to nares where NG & Dobhoff had irritated. NG & dobhoff moved to different area of nares. Just as ∃ finished the oral care, noticed SaO_2 ↓ to 83%. Suctioned lungs. Ø significant drainage. ↑ FiO_2 to 100% ∃ RT recommended. [redacted]
222300 Nov03	Urine output was 14cc. However, urine appeared to be 100% blood. [redacted]
230113 Nov03	At 0100 (error) 0030, noticed that pts HR had significantly dropped to mid-fifties. SaO_2 was 78% ∃ SIMV at 30 bpm, FiO_2 100%, PEEP 15, TV 690. A-line showed smaller and smaller waves ∃ lengthening pulse waveforms. ECG demonstrated widening QRS interval ∃ a weaker amplitude on the QRS wave. By 0100, pulse had reduced to twenties, ∃ QRS was weakening and interval widening further on ECG. SaO_2 dropped to 70% ∃ no changes to (over)

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1998)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

(b)(6)-2 all

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES

ventilator settings. At this time, Surgeon on call was notified. Dr [redacted] asked that we notify Dr. [redacted] the attending for the pt. At 0113, the # ECG was asystolic. Ventilation continued via mechanical ventilator at previous setting's. Dr [redacted] pronounced the patient at 0113. Ventilator was turned off and breathing stopped. Absence of a heart beat was verified by myself via auscultation and ECG after ventilator stopped. Pt was cleansed. All tubes and wires were removed from the patient. The dressings to the abdomen, the right flank, and the back were also removed. Sutures were placed in the left subclavian area and the right femoral area to close of bleeding arterial that had central lines inplace. Wound to right flank also sutured closed. Pt photographed for identification purposes by TOC personnel. Pt bound at hands, feet, and tied a band around the head to keep the mouth shut. Placed in body bag and taken to morgue c toe tag in place. Nursing supervisor notified and aided c transfer to morgue. Death packet completed by Dr. [redacted] and taken to PAD [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

1447 HR + 7% IV 1838

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE | SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*

10 Nov 03 1759 pt arrives by MP's on litter 1826: 5 bags 1000 IV
1802 IV ® intercostal arm Bolus LR O2 15 Lts. : 86 pulse Ox
1803 IV ® intercostal arm " " 131 pulse
palpable deformity ® thorax 1827 98 SPO
pt is alert ✕O x 3 130 pulse
entrance wound posterior ® shoulder 1828 98 SPO
positive bowels sounds, belly soft 127 pulse
Lungs: good breath sounds on (L), wheezes on ®
ext clear ✕4 c 2+ pulses ✕4
C spine clear non tender
10mg morphine, IM in field.
1812 Morphine - heat packs applied to chest area + groin area
5mg. by 18 - pt. states by head shake, no longer cold
IV ® arm 182 - 1gm. Ancef given by IV push
130/80 182 - leads applied to pt. from defib.
96 SPO. 18 sinus Tack on monitor
117 pulse 1829 chest tube attempt c xylocaine 1831 tube in c drainage, 1837 condom placed on end of chest tube
Resp. 30 Chest tube secured c #2 suture 1832 81, 132
P18: Pulse 114 1843 dazolam 5ml by IV ® arm
P19: SPO 90 1847 Midazolam 5ml by IV ® arm 76 151 1831 132 P SPO 76
P. 123 1830 79 SPO
P20 SPO 89 P. 126 1833 74 SPO, 135 P 133 pulse
1834 625 Po, 139 P.
1835 65, 136 P 1836 68, 135 P.

HOSPITAL OR MEDICAL FACILITY | STATUS | DEPART./SERVICE 70, 138 | RECORDS MAINTAINED AT

SPONSOR'S NAME | SSN/ID NO. | RELATIONSHIP TO SPONSOR

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

REGISTER NO. 1837 69, 134 P | WARD NO. 1839: 68, 132 P

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

MEDCOM - 23720

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
	1843- [illegible], 136p.
	1844- [illegible]ction
	1845 pt. being resistant, pt. calm 1846 63sat pulse 155
	Lungs (R) side wheezing heard, (L) side clear 1849 74sat 141p.
	1848 5ml morphine by IV
	1850 [illegible]ed blankets X2 applied to pt. (L) back side, leg + thoracic area
	1852 J tube inserted, suction then O_2 by BVM reapplied 1854 76sat 133p.
	1856 5ml morphine by IV (R) arm 1858 79SPO 135p.
	1859 J tube out 1900: 78 142p / 65sat 143p
	1903 Pt. [illegible] sit up position by head board 1904: 66 151, 1908: 78, 137p.
1330, 150	[illegible]pplied to litter
	Pulse Ox applied to (R) middle toe 1906: 72, 142p.
1326: pulse strong	1913 Morphine 5ml by IV
	1912 [illegible]uction) 1914: 44, 153
	1915 Bagging ± O_2 1915: 30, 157p. 1916: 43, 146p
	1918 Ø Resp. being assisted ± BVM + O_2 @ 15 Lit. 1917: 53, 144p ± Bagging
	1919 Suction 1918: 60, 137 ± BVM
	1922 pt. on back Ø elevation board removed 1920: 67, 134p. 1922: 49, 136p.
	1923 oral airway (Stule) inserted, BVM ± O_2 reapplied 1924: 68, 129p. 1926: 82, 123
	1927 oral airway removed, BVM replaced by non rebreather 1928: 90, 141
	1928 pt. breathing on own 1929: 66, 142
	1929 BVM reapplied ± O_2 1930 55, 140, 1931: 69, 139
	1935 suction 73, 105p 1932: 72, 139
	1937 pt. struggles 1934: 72, 139

STANDARD FORM 600 (REV. 6-97) BACK

USAPA V2.00

MEDCOM - 23721

MEDICAL RECORD

AUTHORIZED FOR LOCAL REPRODUCTION

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)	
1943	Succinylcholine 90mg/4½cc slow push by IV	1939 62, 145
1942	demerol by IV	1940: 40, 150
		1941: 54, 144
1945	ET tube, c stylet & scope inserted c laryng. scope.	1944: 45, 132
	1945: suction through tube	
1946	tube removed	1945: 22, 73
1946	BVM c O2, J tube inserted	1947: 23, 112 / 57, 120
1947	suction c J tube in place	1948: 61, 92p. 1949: 53, 118
1948	NG tubing inserted	1950: 50, 118
1950	Combi tube inserted, BVM applied	1951: 47, 112, 1953: 38, 111
2000	Combi tube deflated	1954: 44, 109, 1956: 65, 108
2000	ET tube inserted 78, 111	1957: 71, 106, 1958: 74, 113
	and taped in place.	2002: 74, 133, 2003: 70, 133
2004	bite block inserted	2006: 83, 132 /
2014	succinylcholine 30mg by IV	2009: 85, 125
2016	(2ml/hr) 500ml NS c lgt. succinylcholine drip.	2010: 84, 124
	20gtt/min.	2014: 82, 132
2021	(+) abd. distention	2018: 77, 125
2028	suction c tube in place	2020: 84, 128
2030	midazolam 5mg pt has strong reg. pulse	2022: 82, 133
		2030 81, 123p.
2032	chest seal applied to (R) thorax entry wound	
2031	hand restraints applied 91, 139p.	

HOSPITAL OR MEDICAL FACILITY		STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME		SSN/ID NO.	RELATIONSHIP TO SPONSOR	
PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)	[redacted] (b)(6)-4		REGISTER NO.	WARD NO.

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10 NOV 03	2038: [illegible], 145
2039	still, SVM ± O_2 20 Lit.
2054	suction
2058 BP 110/64	2102: lungs (B) breath sounds good
2112	pt. hooked to ventilator
2112	pt. moving around
2114	BUN after removal from ventilator
218	blood withdrew from cath. (L) arm for ISTAT 2cc
2129	midazolam 5mg given by IV
2129	suction
2133	[illegible] 144
2136	[illegible] 150
2140	[illegible], 137
2145	[illegible] 150
2148	[illegible] 114
2153	[illegible], 132
2155	50 cc NaCl ± succinylcholine

2043: 77, 149
2045: 77, 148
2053: 76, 147
2055: 79, 150
2056: 80, 148
2058: 83, 151
2059: 69, 153
2101: 86, 155p
2103: 59, 154/65, 153
2105: 71, 154
2106: 72, 153
2109: 70, 151
2111: 72, 150
2114: 46, 120
2115: 38, 137
2116: 50, 140
2118: 71, 131
2120: 79, 129
2121: 78, 127
2127: 73, 132
2130: 45, 141
2123: 83, 128
2126: 78, 131
2132: 58, 143
2133: 65, 145
2133: 61, 145
2135: 63, 143
2158 76, 143
2201 81, 126
2209: 82, 120p

(b)(6)-2

(b)(6)-4

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

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

MEDCOM - 23723

ACLU-RDI 1682 p.83

DOD-037301

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
18 NOV 03	(b)(6)-4
2045	TREATMENT SUMMARY

APPRO 40 Y/O IRAQI MALE SHOT BY MP'S WHILE FLEE[illegible] IN A MVE[illegible]. BULLET STRUCK IT IN RIGHT UPPER BACK (b)(3)-γ [redacted] Ø EXIT WOUND. Ø OTHER INJURY. TAKEN TO [redacted] IN RESP. DISTRESS. O2 SAT INITIALLY 90% ON [illegible] L O2 PER MASK. PT GIVEN AMPP I GM P 2 LARGE BORE IV'S PLACED. @ 2L LR. RT CT PLACED (32 Fr) @ REMOVAL OF ~ [illegible] L BLOOD. CT TO WATER SEAL OVER PERIOD OF ~ 1 HR. O2 SATS GRADUALLY ↓ TO 5[illegible]S. PT WAS PARALYZED & INTUBATED. O2 SATS ↑ TO HIGH 80S LOW 90S ON 100% O2. CONTINUED TO FLUID RESUSITATE. TOTAL FLUID ~ 10 L. PLACED ON SUCCINOCHOLINE GTT @ ~ 4 mg/min. AND DOSED @ VENTED 10 mg Q 1°. ALSO RECEIVED 5 mg MSO4 IN FIELD & 100 mg DEMEROL PRIOR TO INTUBATION. UNABLE TO FLY IT TO 3° CARE 2° TO POOR WEATHER.

[redacted] (b)(6)-2
MD
MAJ, MC, USA
FIELD SURGEON

[redacted] (b)(2)-2

0NOV03 - Pt presented to EMEDS off Helo 2304L/ Pt on ET Tube, Two IV lines to Antecubital space on (L) FA arm. Pt on Atropine @ 2305L. Pt on chest tube (R) intercostal space VS. BP- 191/114, P-131 O2%-87%@2318 Good distal pulses. Pt placed on foley 2309L. NG tube placed in pt @2318L. Chest X-ray taken @ 2320.

STANDARD FORM 600 (REV. 6-97) BACK

USAPA V2.00

0228 Surg ends 1 Blade 10 1 Blade 15
6 needles Complete
2.5cm needles

OR Pam called @ 2319

2322: O2 SAT 78, P-135
2323: 100cc blood in suction unit
2325 - 2nd clot tubes inserted @ 2327
2326: 1200cc urine output
2328: 192/114
2329: 59 29%
2329: 187/113
Pt placed on O2 @ 2330
2332 Abdominal x-ray taken
2333 - 177/120 P-114 O2% - 84
2334 90 O2 SAT P-106
2334 - Another liter placed on pt. 9% Sodium Chloride WO
2336 184/123 O2 - 94% P-104
2337 179/121 P-104 O2 - 93%
2338 183/122 O2 - 94% P-103
2339 95 2%
2341 1600cc urine
2342 Continuous suction applied off NG tube
2343 Ultrasound done on abdomen
2343 Urine bag drained 1300cc slightly yellow urine Ø blood
2344 Pleurovac suction applied
2345 96% P-112 BP
2351 Bladder tip for laparotomy

2352 181/12
2352 Cut into pt abdomen 159th aerovac
2352 HR/111
2353 Ambu bag taken off pt
2353 - Stomach clear
2354 - Good bilateral breath sounds after hooked up to ventilator
2356 Pt bundle prepared taken to OR
2356 - 181/118 P-107 02%-92
2356 - Pt placed on ambu bag
2359 - P-144
2359 - 02-9[illegible]% 189/114 P-104
0001 - Securing ET tube
0005 - 97 02% 161/108 P-107
0007 - Pt taken INTO ER 181/125 P-106 02-89%
0008 Pt Being prep Lower AB and Shave Above/below
0009 1st Count 15 LaP 10 raypec Umb. Nipple line
3 Blade 2 Bovie tips 1 scratch pad
0016 Bullet wound expose Centermeter wide.
r+/below ~~Nipple~~ Umb.
#10 Blade.
0020 excision begins using Bovie to Coag
Lap Pack x15 two retractor ARmy to NAVY
Yank. Suct (+5) = 20+5
(2) 0-prolene tapered x 2) = 4
0023 Intestine exposed 2 prolene x 2
10 raypec 7 pieces Balfour
0145 (Interim) Count Lap pack 20+5+5+5+5
7 pcs Balfour 0- Prolene tapered x2 +4 +5
0125 2. Prolene " " x2+[illegible]

OR Note

Preop Dx: GSW @ back x 1

Postop Dx: Diaphragmatic Injury / ~~duodenal~~, superficial liver laceration on top of dome

Proc: Ex. Lap & Diaphragmatic Injury Repair

Surgeon: [redacted] Asst: [redacted]

EBL: ~150cc

NF: 4

SPC:

Findings: Small Diaphragmatic Injury, minimal

Disp: ~~A~~ ~~F~~ ~~spleen~~ when BE -1 to -3 ~90'

Diaphragmatic Injury/superficial liver laceration on top of dome Repair

[redacted]

(b)(6)-2

LAB POST-OP	
NH	9/27
BE	-7
Cl	111
Na	139
K	5.2

pCO_2 41

O_2 sat 100%

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (*sign each entry*)

DATE:

TIME:

BP:

P: 110003

R: 0300

TEMP:

Pox:

PATIENT COMPLAINT:

ALLERGIES: CURRENT MEDS:

LMP: SMOKER: YES NO FLYING STATUS: YES NO

(Surgery)

(accurred 6p.m.) Underwent Urogram SIP GSW to (R) back by security forces. Treated initially at [redacted] (b)(2)-2 c chest tube, subsequent intubation 2° to declining pulm. status. Unable to transport 2° to weather. Pt dropped off at [redacted] (b)(2)-2 (MIDNIGHT)

Physicians Orders:

1. On arrival here, tachycardic, O2sat 50% on 100% O2, BP approp. Coarse BS on R, abdomen firm, distended. 11/19/22. x-ray c (R) CT noted of position. Entry (R) lat. 2/t CT placement release of quch of air, fluid. UGT/Foley placed. O2sat improved. Unable to initially identify bullet and trajectory by x-ray (grey area on the liver). US abd. revealed fluid, DPL grossly positive. To OR. Exp. lap. Liver ~~laceration~~ to (R) diaphragm. No other obvious injuries. Intraoperative base deficit -10, hypothermia (90°F), developing coagulopathy, ~~small~~ x small laceration, further exploration terminated pt. closed and taken for further warming in ICU. Pt. will be monitored overnight then sent to CH in a.m.

[redacted] (b)(2)-2

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

RECORDS MAINTAINED AT:	**Home Base**
PATIENT'S NAME (*Last, First, Middle Initial*)	SEX
TENT NUMBER / STATUS / SERVICE	RANK / GRADE
SUPERVISORS NAME / RANK	ORGANIZATION HERE
DATE ARRIVED AOR / SSN/IDENTIFICATION NO.	DATE OF BIRTH

CHRONOLOGICAL RECORD OF MEDICAL CARE : STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

STANDARD FORM 600 BACK (REV. 5-84)

MEDCOM - 23728

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (*sign each entry*)

DATE:

TIME:

BP:

P:

R:

TEMP:

Pox:

PATIENT COMPLAINT:

ALLERGIES:

CURRENT MEDS:

LMP:

SMOKER: YES NO

FLYING STATUS: YES NO

Physicians Orders:

1. 5mg IVP q4h PRN
2.
3.
4.
5.
6.

PA SIP GSW to (R) back. (L) CT for tension PTX, exp. lap i anal diaphragmatic injury, minimal superficial liver abrasion & lower chest wounds primarily.

Versed sedated i Propofol

Arrive L carotid AT upper airway. O_2 sat 97% on 60%. FiO2. CT: 60cc

C.V.S. RRR, P. 88 BP 157/103

RS: abd: sl dist, quiet BS, NGT: minimal

GENIT: U.O 230ml UA: NIL (25ml)

ID: Tm: 96 Amp

A1M Arrange for transfer to the [redacted] Discussed i Dr. [redacted]

(b)(6)-2

(b)(6)-2

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

RECORDS MAINTAINED AT:	**Home Base**		
PATIENT'S NAME (*Last, First, Middle Initial*)			SEX
TENT NUMBER	STATUS / SERVICE		RANK / GRADE
SUPERVISORS NAME / RANK		ORGANIZATION HERE	
DATE ARRIVED AOR	SSN/IDENTIFICATION NO.		DATE OF BIRTH

CHRONOLOGICAL RECORD OF MEDICAL CARE : STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

STANDARD FORM 600 BACK (REV. 5-84)

MEDCOM - 23729

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (*sign each entry*)

DATE:

TIME:

BP:

P:

R:

TEMP:

Pox:

Physicians Orders:

PATIENT COMPLAINT:

ALLERGIES:

CURRENT MEDS:

LMP:

SMOKER: YES NO

FLYING STATUS: YES NO

1. 5mg Morphine IV. Q4h
2. [redacted]
3. (6)(6)-2
4.
5.
6.

① Foley
② CT to 20 cm H_2O suction
③ NS → LS
④ Foley → gravity
⑤ Vitals: routine
⑥ MSO_4 / Versed q1h
⑦ VT: 700 R: 12 FiO_2 CR. Peel S
⑧ IVF: LR @125cc/h
⑨ Meds: ① Ofloxacin 5th
⑩ NPO

[redacted]

(6)(6)-2

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

RECORDS MAINTAINED AT:	**Home Base**
PATIENT'S NAME (*Last, First, Middle Initial*)	SEX
TENT NUMBER / STATUS / SERVICE / RANK / GRADE	
SUPERVISORS NAME / RANK / ORGANIZATION HERE	
DATE ARRIVED AOR / SSN/IDENTIFICATION NO. / DATE OF BIRTH	

CHRONOLOGICAL RECORD OF MEDICAL CARE : STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

STANDARD FORM 600 BACK (REV. 5-84)

(b)(6) - 2 all

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (*sign each entry*)

DATE: 11 NOV 03 PATIENT COMPLAINT: John Doe - Iraqi National

TIME: 0250L ALLERGIES: Unknown CURRENT MEDS:

BP: see below LMP: N/A SMOKER: YES NO FLYING STATUS: YES NO

P:

R: 0250 - Pt returned from OR to Rec. Area. VS - 164/88 P=86

TEMP: SaO_2 100 ~~Room Temp~~ Temp = 97.7 NSR on monitor.

Pox: ET tube in place, placement verified.

0310 50 mg Phentanyl / 2mg Versed given for sedation.

Physicians Orders:

1. (b) sites patent and benign. Abd dsg CDI. CT to LWS patent - 56 cc bloody output, Foley patent and intact - Clear yellow urine present. DJ patent IVF mtf @100cc/hr
2.
3. 0315 150/90 P=76 NSR SaO_2=100 16 BPM SIMV
4. 0320 142/92 =82 NSR SaO_2=100 16 BPM SIMV
5. 0330 145/95 P=87 NSR SaO_2=100% 16 BPM SIMV
6. 0345 142/97 P=88 NSR SaO_2=98% 16 BPM SIMV. Pt remains sedated. 5cc DT given (b) Deltoid [redacted]

0350 Pt remains sedated. Vent settings as follows. 16 BPM, SIMV TV 900 FIO_2 60%. ET tube in place 22=26 cm. Lungs slightly rhonchorous, Sxn ~ bloody sputum. Foley patent

ABG: Na 138 K=5.2 Cl=111 TCO_2=21 BUN=16 Gl=96 Hct=28

Ph=7.279 PCO_2 41.3 Bicarb=19 Be=-7 AnGAP=14 Hgb=10.

U/O=400cc CT output since exiting OR = ≈4cc [redacted]

PATIENT'S IDENTIFICATION (Use this space for Mechanical imprint)

RECORDS MAINTAINED AT:	Home Base
PATIENT'S NAME (Last, First, Middle Initial)	Unknown - Iraqi National
SEX	
TENT NUMBER	EMEDS
STATUS / SERVICE	
RANK / GRADE	
SUPERVISOR: Cpt [redacted]	ORGANIZATION HERE
DATE ARRIVED AOR	N/IDENTIFICATION NO.
DATE OF BIRTH	

CHRONOLOGICAL RECORD OF MEDICAL CARE : STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

STANDARD FORM 600 BACK (REV. 5-84)

MEDCOM - 23731

(b)(6) - 2 all

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (*sign each entry*)

DATE:

TIME:

BP:

P:

R:

TEMP:

Pox:

Physicians Orders:

PATIENT COMPLAINT: DG #2

ALLERGIES: CURRENT MEDS:

LMP: SMOKER: YES NO FLYING STATUS: YES NO

0420 - Additional blankets placed on pt. Temp ↑ 97.9°
all IVF Δ'd to .9NS per Dr [redacted] order. NGT placed
to Int. Sxn. Scant amt of brown/tan drainage -
142/96 P-94 SaO_2=97. Lungs CTA(B). RRR NSR
Abd dog COT. [redacted] patent. Remains sedated [redacted]
0456 L - 164/104 - P=101 RR=16 SaO_2 = 97%.
1. Hal 5mg IVP by Capt [redacted]. Lungs slightly rhonchorous
2. ET tube in place Vent settings ☆ no Δ - Propofol
3. gtt ↑@0505 - 25mcg/kg/min ≅ 12gtt/min. 5mg MSO4
4. given per Capt [redacted] order - IV sites patent and
5. [redacted]
6. 0525 L - 142/96 SaO_2=97 HR=91 RR=16. Remains sedated.
Sxn for scant bloody sputum. ET tube in place @ 26 cm
Abd dog COT Foley patent, clear yellow urine.
NG to Int. Sxn - scant tan drainage. Propofol gtt cont
@ 25mcg/kg/min. IVF @ 100 cc/hr. Full monitor [redacted]
0600 VS 150/98, HR 91, Ventilated 16bpm, SaO_2 99% [redacted] CRW

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

RECORDS MAINTAINED AT:	Home Base
PATIENT'S NAME (*Last, First, Middle Initial*)	SEX
TENT NUMBER / STATUS / SERVICE	RANK / GRADE
SUPERVISORS NAME / RANK	ORGANIZATION HERE
DATE ARRIVED AOR / SSN/IDENTIFICATION NO.	DATE OF BIRTH

CHRONOLOGICAL RECORD OF MEDICAL CARE : STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

STANDARD FORM 600 BACK (REV. 5-84)

MEDCOM - 23732

(b)(6)-2 all

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(sign each entry)*

DATE: 11 Nov 03

TIME: 0700

BP:

P:

R:

TEMP:

Pox:

PATIENT COMPLAINT: Pg #3

ALLERGIES: CURRENT MEDS:

LMP: SMOKER: YES NO FLYING STATUS: YES NO

0700 U/O = 400cc - ± 2cc out of CT - bloody drainage. VSS, slightly hypertensive. Core temp via esoph. = 34.0°C - NBT int oxn - CT drg occlusive will monitor [redacted]

Physicians Orders:

1. 0730 34.0 C, BP 156/104, HR 85, RR 12, SpO2 98
2. Pt on SIMV TV 900, Rate 16 Sent bloody drainage. Normal Sinus Rhythm, Lungs Clear, +3 radial & peripheral pulses, Abdomen dressing intact.
3. L & R antecubital normal saline locked & flushed. Urine
4. output 75-100 cc/hr, Slightly hypertensive. [redacted]
5. Chest Tube bloody drainage 50cc [redacted]
6. 0730 Given Morphine 5mg I.V. [redacted]

PATIENT'S IDENTIFICATION (Use this space for Mechanical imprint)

RECORDS MAINTAINED AT:	Home Base	
PATIENT'S NAME (*Last, First, Middle Initial*)		SEX
TENT NUMBER	STATUS / SERVICE	RANK / GRADE
SUPERVISORS NAME / RANK	ORGANIZATION HERE	
DATE ARRIVED AOR	SSN/IDENTIFICATION NO.	DATE OF BIRTH

CHRONOLOGICAL RECORD OF MEDICAL CARE : STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

STANDARD FORM 600 BACK (REV. 5-84)

MEDCOM - 23733

SKIN AND WOUND ASSESSMENT

PROGRESS NOTES

MEDICAL RECORD

Admission Date: VD Nov 03 **Diagnosis:** B-22 to Abdo Diaphragm **HD:** D **POD:** 2

Skin assessment must be done initially and every 7 days.

Braden Scale Evaluation (See Braden Evaluation Table for Details)

Sensory Perception	No impairment Slightly limited Very limited Completed	4 3 (2) 1	2	**Mobility**	No limitations Slightly limited Very limited Completely immobile	4 3 (2) 1	12
Moisture	Rarely moist Occasionally moist Moist Constantly moist	(4) 3 2 1	4	**Nutrition**	Excellent Adequate (Eats >50%) Adequate (Rarely eats) Very poor	4 3 2 (1)	1
Activity	Walks frequently Walks occasionally Chairfast Bedfast	4 3 2 (1)	1	**Friction and Shear**	No apparent problem Potential problems Problems	3 (2) 1	2

Add the total score

Above 20	Low Risk
Between 16 and 20	Medium Risk
Between 11 and 15	High Risk
Below 10	Very High Risk

Total Score: 12

Note: A Braden Scale Score of less than 15 indicates **HIGH RISK**-requires immediate Ulcer Prevention program.

Surgical wound (s): Yes✓ No__ Location: Abd midline
Size:_____ Drainage: Ø
Tubes: Ø Pins: Ø Appearance: CDI
Dressing change:
Location: (B) chest
Size:_____ Drainage: serosanguinous fluid
Tubes: Chest tube Pins: Ø Appearance:
Dressing change: none

Burn wound (s): Yes__ No✓ % BSA_____ Partial_____ Full_____
Location:_____ Size_____
Appearance:
Dressing change:
Location:_____ Size_____
Appearance:
Dressing change:

Pressure Ulcer (s): Yes___ No✓
Stage I, II, III, IV (Circle the one that applies and describe below)
Location:_____ Size:_____
Wound character: Pink___ Moist___ Dry___ Granulation tissue___ Yellow slough___ Tunneling___
Undermining___ Odor___ Purulent discharge___ Eschar___ Exudates___
Type of dressing change: Wet-to-dry___ Comfeel dressing___ Carrasyn-V Gel___ Alginate___

Physician notified/consulted for wound debridement: Yes___ No___ Date/time MD notified_____
CNS notified/consulted for Stage II and greater: Yes___ No___
Nutrition Referral: Yes___ No___
Physical Therapy Referral: Yes___ No___
Action taken:
Date & Time

REGISTER NO.	WARD NO.

Patient's Identification (For typed or written entries give: Name-last, first, middle: Grade: rank; hospital or medical facility)

PROGRESS NOTES
Medical Record
STANDARD FORM 509

PLAN OF C[illegible] E[illegible] N BREAKDOWN AND [illegible] N[illegible]EMENT

PROGRE[illegible]OTES

MEDICAL RECORD

Admission Date: 10 Nov 03 **Diagnosis:** GSW to ABD **HD:** 2 **POD:** 2

(6)(6)72

Date: 12 Nov 03 Time: 1200 RN Signatur[redacted] C LPN

Skin breakdown as evidenced by immobility, friction, shear, moisture, abrasions, surgical wound, skin tear.

Wound type: Surgical wound (s) Location: Abd midline

Drainage: none

Size:_____

Diabetic ulcer Tubes:_____ Pins:_____ Appearance:_____

Venous stasis ulcer Dressing change:_____

Other_____ Describe_____

Burn wound (s): % BSA_____ Partial_____ Full_____

Location:_____ Size_____

Appearance:_____

Dressing change:_____

Pressure Ulcer (s):

Stage I, II, III, IV (Circle the one that applies and describe below)

Location:_____ Size:_____

Wound character: Pink____Moist____Dry____ Granulation tissue_____ Yellow slough _____

Tunneling_____Undermining_____Odor_____ Purulent discharge_____ Eschar_____ Exudates _____

Refer to SOP for Dressing Change Instructions.

Please check the appropriate dressing Change:

- ☐ Wet to Dry Dressing
- ☐ Carrasyn-V GelDressing
- ☐ Alginate Dressing
- ☐ Comfeel Dressing
- ☐ Pin Site Care
- ☐ J-Tube Care
- ☐ Colostomy Care
- ☐ Chest Tube Care
- ☐ Burn Care

NOTE: Document daily wound and dressing change on Progress Note or Nursing Note.

Select the appropriate products used:

- ☑ Sterile 4x4 gauze dressing
- ☐ Sterile 2x2 gauze dressing
- ☐ Sterile gloves
- ☐ Kerlix (super sponge)
- ☐ Gauze bandage
- ☐ Sterile Normal Saline
- ☐ Sterile Water
- ☐ 8 x 4 Sponge gauze
- ☐ Op-site
- ☐ Tegaderm clear dressing
- ☐ Alkare skin prep
- ☐ Comfeel clear
- ☐ Comfeel pressure ulcer drsg
- ☐ Carrasyn-V Gel
- ☐ Alginate
- ☐ Bacitracin
- ☐ Silvadene Cream
- ☐ Petrolatum gauze
- ☐ Hibicleanse
- ☐ Non-adhesive dressing
- ☐ Telpha Pad
- ☐ Carra-smart film
- ☐ Sterile Q-tip applicator
- ☐ Xeroform 5 x 9.
- ☐ Moisture barrier cream
- ☐ 0.125% Dakins sol
- ☐ Betadine Swab sticks
- ☐ ½ Hydrogen Peroxide & ½ Sterile Normal Saline

Select the frequency of dressing change:

- ☐ b.i.d.
- ☐ t.i.d
- ☑ qd

MD Signature and Date:

_____

CNS Signature and Date:

_____

Patient's Identification (For typed or written entries give: Name-last, first, middle: Grade; rank; hospital or medical facility)

Medical Record, SF 509

PLAN OF CARE FOR SKIN BREAKDOWN AND WOUND MANAGEMENT

MEDICAL RECORD — **PROGRESS NOTES**

Admission Date: 11/11/03 **Diagnosis:** GSW abd, daydream, liver [redacted] **HD:** 1 **POD:**

Date: 11/11 Time: 1500 RN Signatur[redacted] (b)(6)-2

Skin breakdown as evidenced by immobility, friction, shear, moisture, abrasions, surgical wound, skin tear.

Wound type: Surgical wound (s) ✓ Location: abd Size: 12(L) Drainage: 0
Diabetic ulcer 0 Tubes: CT Pins: 0 Appearance: dressing
Venous stasis ulcer Dressing change: NA
Other 0 Describe 0

Burn wound (s): % BSA N/A Partial ____ Full ____
Location: ____ Size ____
Appearance: ____
Dressing change: ____

Pressure Ulcer (s): 0
Stage I, II, III, IV (Circle the one that applies and describe below)

Location: NA Size: ____
Wound character: Pink ____ Moist ____ Dry ____ Granulation tissue ____ Yellow slough ____
Tunneling ____ Undermining ____ Odor ____ Purulent discharge ____ Eschar ____ Exudates ____

Refer to SOP for Dressing Change Instrucitons.

Please check the appropriate dressing Change:

- ☐ Wet to Dry Dressing
- ☐ Carrasyn-V GelDressing
- ☐ Alginate Dressing
- ☐ Comfeel Dressing
- ☐ Pin Site Care
- ☐ J-Tube Care
- ☐ Colostomy Care
- ☐ Chest Tube Care
- ☐ Burn Care

NOTE: Document daily wound and dressing change on Progress Note or Nursing Note.

Select the appropriate products used:

- ☐ Sterile 4x4 gauze dressing
- ☐ Sterile 2x2 gauze dressing
- ☐ Sterile gloves
- ☐ Kerlix (super sponge)
- ☐ Gauze bandage
- ☐ Sterile Normal Saline
- ☐ Sterile Water
- ☐ 8 x 4 Sponge gauze
- ☐ Op-site
- ☐ Tegaderm clear dressing
- ☐ Alkare skin prep
- ☐ Comfeel clear
- ☐ Comfeel pressure ulcer drsg
- ☐ Carrasyn-V Gel
- ☐ Alginate
- ☐ Bacitracin
- ☐ Silvadene Cream
- ☐ Petrolatum gauze
- ☐ Hibicleanse
- ☐ Non-adhesive dressing
- ☐ Telpha Pad
- ☐ Carra-smart film
- ☐ Sterile Q-tip applicator
- ☐ Xeroform 5 x 9.
- ☐ Moisture barrier cream
- ☐ 0.125% Dakins sol
- ☐ Betadine Swab sticks
- ☐ ½ Hydrogen Peroxide & ½ Sterile Normal Saline

Select the frequency of dressing change:

- ☐ b.i.d.
- ☐ t.i.d

MD Signature and Date: ____

CNS Signature and Date: ____

Patient's Identification (For typed or written entries give: Name-last, first, middle: Grade; rank; hospital or medical facility)

Medical Record, SF 509

SKIN AND WOUND ASSESSMENT

MEDICAL RECORD — **PROGRESS NOTES**

Admission Date:_____ **Diagnosis:**_____ **HD:**_____ **POD:**_____

Skin assessment must be done initially and every 7 days.

Braden Scale Evaluation (See Braden Evaluation Table for Details)

Sensory Perception	No impairment	4		**Mobility**	No limitations	4	
	Slightly limited	3			Slightly limited	3	
	Very limited	(2)	2		Very limited	2	1
	Completed	1			Completely immobile	(1)	
Moisture	Rarely moist	(4)		**Nutrition**	Excellent	4	
	Occasionally moist	3			Adequate (Eats >50%)	3	
	Moist	2	4		Adequate (Rarely eats)	2	
	Constantly moist	1			Very poor	(1)	1
Activity	Walks frequently	4		**Friction and Shear**	No apparent problem	3	
	Walks occasionally	3			Potential problems	2	
	Chairfast	2			Problems	(1)	1
	Bedfast	(1)	1				

Add the total score

Above 20	Low Risk
Between 16 and 20	Medium Risk
Between 11 and 15	(High Risk)
Below 10	~~Very High Risk~~

Total Score: (12)

Note: A Braden Scale Score of less than 15 indicates **HIGH RISK**-requires immediate Ulcer Prevention program.

Surgical wound (s): Yes(X) No__ Location: Abdomen
Size: 12" Drainage: dressing
Tubes: CT Pins: — Appearance: dressing
Dressing change: NA
Location: (R) mid axillary
Size: NA Drainage: CT 20 cm H20 CS
Tubes: — Pins: — Appearance:
Dressing change: —

Burn wound (s): Yes__ No__ % BSA_____ Partial_____ Full_____
Location:_____ Size_____
Appearance:_____
Dressing change:_____
Location:_____ Size_____
Appearance:_____
Dressing change:_____

NA

Pressure Ulcer (s): Yes___ No(X)
Stage I, II, III, IV (Circle the one that applies and describe below)
Location:_____ Size:_____
Wound character: Pink___ Moist___ Dry___ Granulation tissue____ Yellow slough_____ Tunneling____
Undermining____ Odor____ Purulent discharge_____ Eschar_____ Exudates_____
Type of dressing change: Wet-to-dry____ Comfeel dressing_____ Carrasyn-V Gel_____ Alginate_____

Physician notified/consulted for wound debridement: Yes___ No___ Date/time MD notified_____
CNS notified/consulted for Stage II and greater: Yes___ No____
Nutrition Referral: Yes(✓) No_____
Physical Therapy Referral: Yes_____ No(X)
Action taken:_____
Date & Time_____

REGISTER NO.	WARD NO.

Patient's Identification (For typed or written entries give: Name-last, first, middle: Grade: rank: hospital or medical facility)

PROGRESS NOTES
Medical Record
STANDARD FORM 569

(b)(2)-2

[redacted]

ICU #1
BED# 4

PT# [redacted]

(b)(6)-4

VENTILATOR FLOW SHEET

DATE	TIME	MODE	RATE	VOLUME	FIO2	PEEP	PIP	PT RATE	HR	SO2	BP	Ph	Pco2	Po2	BE	HCO3	SaO2	REMARKS
14 Nov 03	2015	SIMV	20	750	50%	+5	38	0	111	91%	166/85							(b)(6)-2
14 Nov	2210	SIMV	20	750	50%	+5	39	0	111	99%	162/85							
	2330	SIMV	20	750	45	+5	40	0	109	100	157/96							
15 Nov	0200	SIMV	20	750	40	5	46	0	111	99	150/100							
	0500	SIMV	20	750	40	5	47	0	115	94%	180/86							
	0640	SIMV	20	750	40	5	46	0	114	93	152/87							
	0830	SIMV	20	750	40	5	40	25	114	95	149/107							
	1000	SIMV	20	750	40	5	40	20	110	98	176/93							
	1200	SIMV	20	750	40	5	40	20	89	98	161/101							
	1400	SIMV	20	750	40	5	39	20	92	99	160/100							
	1546	SIMV	20	750	40	5	40	20	91	97	161/95							
	1846	SIMV	20	750	40	5	41	0	92	95	153/85							
	2000	SIMV	20	750	40	5	40	0	93	95	173/95							
	2203	SIMV	20	750	40	5	48	0	91	92	177/97							
16 Nov	0010	SIMV	20	750	40%	+5	38	0	94	94%	159/82							
16 Nov	0205	SIMV	20	750	40%	+5	39	0	91	94%	164/87							
16 Nov	0410	SIMV	24	750	50%	+5	42	0	101	94%	175/97							
16 Nov	0640	SIMV	24	750	50%	+5	44	0	98	96%	161/93							
	0830	SIMV	24	750	50	5	38	24	95		154/94							
	1000	SIMV	24	750	60	5	38	24	102	91	179/92							
	1200	SIMV	24	750	70	10	39	25	102	93	145/94							
	1400	SIMV	24	750	80	10	36	25	101	93	149/94							
	1656	SIMV	24	750	75	10	37	0	103	95	143/92							
	1848	SIMV	24	750	70	10	42	0	101	93	147/95							
	2018	SIMV	24	750	100	10	45	0	101	86	148/92							
	2237	SIMV	24	750	100	10	45	0	95	89	134/82							
17 Oct	0030	SIMV	24	750	100	15	45	0	91	94	150/75							BBS coarse.
	0230	SIMV	24	750	100	15	47	0	94	98	147/78							TX SI CHAIT
	0410	SIMV	24	750	90	15	48	0	105	100	138/74							· nurse suctioned albuterol
	0534	SIMV	24	750	75	15	46	0	110	98	126/71							nurse suction
17 Nov	0800	SIMV	24	750	75%	15	41	0	106	100%	132/71							
17 Nov	1000	SIMV	24	750	65%	15	40	0	94	97%	108/65							
17 Nov	1210	SIMV	24	750	60%	15	41	0	88	93%	133/71							Neb
17 Nov	1400	SIMV	24	750	70%	15	42	0	91	96%	144/83							
	1540	SIMV	24	750	70	15	42	0	95	95	151/81							Neb BS coarse

[redacted]

(b)(2)-2 Pt # [redacted] (b)(6)-4 OET

[redacted] VENTILATOR FLOW SHEET

2 @ lip
27 @ lip

ICU 1

DATE	TIME	MODE	RATE	VOLUME	FIO2	PEEP	PIP	PT RATE	HR	SO2	BP	Ph	Pco2	Po2	BE	HCO3	SaO2	REMARKS
11 Nov 03	1200	SIMV	14	750	80	5	42	14	106	97	163/103							
	1400	SIMV	14	750	60	5	43	29	114	95	182/99							
	1805	SIMV	14	750	50	5	44	23	122	95	153/							
	1740	SIMV	20	750	55	5	36	27	130	98	158/88							
	2010	SIMV	20	750	50	5	37	22	122	100	148/92	7.33	41.2	90	-4	22	96	
	2345	SIMV	20	750	45	5	49	20	118	100	112/71							
	0210	SIMV	17	750	40	5	44	17	114	99	112/75							
	0510	SIMV	15	750	40	5	48	15	115	100	161/88							-suction dark brown ≈ 5cc
	0800	SIMV	15	750	39	5	34	16	128	98	132/73							
	0815	SIMV	15	750	32	5	35	26	130	98	131/104							
12 Nov 03	1040	SIMV	15	750	35%	+5	40	4	137	97%	124/110							
	1400	SIMV	18	750	32	5	41	18	138	95%	125/108							
	1756	SIMV	18	750	35	5	34	18	142	95	111/53							
	1946	SIMV	15	750	35	5	42	21	141	95	119/98							
	2203	SIMV	15	750	100	5	48	30	144	100	104/96							suction thick dark chunks
	0020	SIMV	18	750	70	6	40	30	129	100	158/86							
	0120	SIMV	18	750	65	6	37	18	124	100	138/88							
	0410	SIMV	18	750	65	6	40	20	128	96	144/71							suction pt,
	0800	SIMV	18	750	65	6	39	19	120	100	129/109							
	1040	SIMV	18	750	65	6	41	31	128	100	95/81							
13 Nov 03	1210	SIMV	18	750	100%	5	43	6	141	96%	193/85							
13 Nov 03	1415	SIMV	18	750	100%	+5	40	5	141	98%	188/88							
	1556	SIMV	18	750	60	+5	42	8	136	100	181/							
	1742	SIMV	18	750	60	5	37	0	131	100	145/							
	2009	SIMV	18	750	60	5	38	0	127	100	146/							advanced 1cm cord
	2156	SIMV	14	750	60	5	36	0	121	100	121/70							
14 NOV	0050	SIMV	18	750	60	5	32	0	129	96%	119/69							
	0330	SIMV	18	750	60	5	32	0	114	98	85/							
	0900	SIMV	18	750	55	5	38	0	112	100	95/13							↑ RR 20 per Naturopath, PvO2 98%
	1030	SIMV	20	750	50	5	37	0	100	100	114/73							
	0815	SIMV	20	750	50	5	39	20	102	100	149/83							
	1030	SIMV	20	750	46	5	36	20	106	100	172/93							
	1400	SIMV	20	750	50	5	39	20	98	99	160/94	7.29	35.6	73	-9	17	93	
14 Nov 03	1545	SIMV	20	750	50%	+5	38	0	104	100%	165/88							
14 Nov 03	1755	SIMV	20	750	45	+5	38	0	106	96%	154/89							

[redacted]

TEST(S)

SPECIMEN TAKEN

DATE 13 Nov03 TIME 0500 A.M. P.M.

REQUESTED

ABG

RESULTS

REMARKS [redacted]

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE (b)(6)-2

REPORTED BY

MD DATE

TECH 13 Nov 03

(b)(6)-4

T 100.1

F102

65%

ICU 1

MISC

URGENCY ☐ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT

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

SPECIMEN SOURCE (Specify)

LAB ID NO.

SPECIMEN/LAB RPT. NO.

PHYSICIAN'S COPY

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

557-107

[redacted]

MEDCOM - 23740

i-STAT EG6+

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

Pt Name:_____

Na_____141 mmol/L
K_____5.3 mmol/L
TCO2_____23 mmol/L
Hct_____30 %PCV
Hb*_____10 g/dL
*via Hct

At 37C
PH_____7.270
PCO2_____47.9 mmHg
PO2_____91 mmHg
HCO3_____22 mmol/L
BEecf_____-5 mmol/L
sO2*_____96 %
*calculated

At Patient Temp:
PH_____7.269
PCO2_____48.0 mmHg
PO2_____91 mmHg

Patient Temp: 98.7F
FIO2_____: 55
Sample Type_:

11NOV03 19:55

Oper: [redacted]

Physician:_____

Ser# [redacted]
Ver: [redacted]

** PRINT CANCELLED **

[redacted]

i-STAT EG6+

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

Pt Name:_____

Na_____139 mmol/L
K_____6.2 mmol/L
TCO2_____24 mmol/L
Hct_____31 %PCV
Hb*_____11 g/dL
*via Hct

At 37C
PH_____7.182
PCO2_____59.2 mmHg
PO2_____77 mmHg
HCO3_____22 mmol/L
BEecf_____-6 mmol/L
sO2*_____91 %
*calculated

At Patient Temp
PH_____7.189
PCO2_____57.8 mmHg
PO2_____74 mmHg

Patient Temp: 97.6F
FIO2_____: 75
Sample Type_:

11NOV03 16:25

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/11/03 19:55

Patient ID: [redacted] (b)(6)-4
Test Name :PT
Test Result:= 15.1 sec.
Ratio = 1.2
Calculated INR = 1.41
Sample Type:citrated wh. blood
Test Date :11/11/03
Test Time :19:53
Card Lot [redacted] (b)(6)-2
Operator [redacted]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/11/03 20:01

Patient ID: [redacted] (b)(6)-4
Test Name :APTT
Test Result:= 32.4 sec.
Sample Type:citrated wh. blood
Test Date :11/11/03
Test Time :19:59
Card Lot [redacted] (b)(6)-2
Operator [redacted]

[redacted] (b)(6)-4
WB 09:35

				Patient Limits	
WBC	3.4	L	x10^3/uL	4.5	10.5
RBC	3.90	L	x10^6/uL	4.00	6.00
Hgb	10.6	L	g/dL	11.0	18.0
Hct	34.2	L	%	35.0	60.0
MCV	87.7		fL	80.0	99.9
MCH	27.3		pg	27.0	31.0
MCHC	31.1	L	g/dL	33.0	37.0
Plt	236.		x10^3/uL	150.	450.
LY%	18.8	*L	%	20.5	51.1
LY#	0.6	*L	x10^3/uL	1.2	3.4

ID: 001275 11-11-03
WB 19:56

				Patient Limits	
WBC	6.3		x10^3/uL	4.5	10.5
RBC	3.63	L	x10^6/uL	4.00	6.00
Hgb	10.2	L	g/dL	11.0	18.0
Hct	32.1	L	%	35.0	60.0
MCV	88.3		fL	80.0	99.9
MCH	28.0		pg	27.0	31.0
MCHC	31.7	L	g/dL	33.0	37.0
Plt	234.		x10^3/uL	150.	450.
LY%	17.7	*L	%	20.5	51.1

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/11/03 09:39

Patient ID: [redacted] (b)(6)-4
Test Name :PT
Test Result:= 16.0 sec.
Ratio = 1.3
Calculated INR = 1.55
Sample Type:citrated wh. blood
Test Date :11/11/03
Test Time :09:38
Card Lot [redacted] (b)(6)-2
Operator [redacted]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/11/03 09:42

Patient ID: [redacted] (b)(6)-4
Test Name :APTT
Test Result:= 37.9 sec.
Sample Type:citrated wh. bloc
Test Date :11/11/03
Test Time :09:40
Card Lot [redacted] (b)(6)-2
Operator [redacted]

[redacted] (b)(6)-4
WB 11-11-03 16:23

				Patient Limits	
WBC	6.1		x10^3/uL	4.5	10.5
RBC	3.81	L	x10^6/uL	4.00	6.00
Hgb	10.6	L	g/dL	11.0	18.0
Hct	33.8	L	%	35.0	60.0
MCV	88.5		fL	80.0	99.9
MCH	27.7		pg	27.0	31.0
MCHC	31.3	L	g/dL	33.0	37.0
Plt	255.		x10^3/uL	150.	450.
LY%	14.8	*L	%	20.5	51.1
LY#	0.9	*L	x10^3/uL	1.2	3.4

MEDCOM - 23741

DOD-037319

ACLU-RDI 1682 p.101

(b)(6)-4 all except otherwise indicated

ID: [redacted] 12-11-03
WE 04:02

Patient Limits

WBC	8.1	x10^3/uL	4.5	10.5
RBC	3.00 L	x10^6/uL	4.00	6.00
Hgb	8.4 L	g/dL	11.0	18.0
Hct	26.5 L	%	35.0	60.0
MCV	88.5	fL	80.0	99.9
MCH	28.1	pg	27.0	31.0
MCHC	31.8 L	g/dL	33.0	37.0
Plt	177.	x10^3/uL	150.	450.
LY%	16.7 L	%	20.5	51.1
LY#	1.3	x10^3/uL	1.2	3.4

[redacted] 13-11-03
07:47

Patient Limits

WBC	8.3 *	x10^3/uL	4.5	10.5
RBC	2.54 L	x10^6/uL	4.00	6.00
Hgb	7.1 L	g/dL	11.0	18.0
Hct	22.6 L	%	35.0	60.0
MCV	88.9	fL	80.0	99.9
MCH	28.1	pg	27.0	31.0
MCHC	31.6 L	g/dL	33.0	37.0
Plt	168.	x10^3/uL	150.	450.
LY%	15.2 #L	%	20.5	51.1
LY#	1.3 *	x10^3/uL	1.2	3.4

ID: [redacted] 13-11-03
WB 04:51

Patient Limits

WBC	6.9	x10^3/uL	4.5	10.5
RBC	2.32 L	x10^6/uL	4.00	6.00
Hgb	6.5 L	g/dL	11.0	18.0
Hct	20.7 L	%	35.0	60.0
MCV	89.5	fL	80.0	99.9
MCH	28.0	pg	27.0	31.0
MCHC	31.3 L	g/dL	33.0	37.0
Plt	149. L	x10^3/uL	150.	450.
LY%	19.2 L	%	20.5	51.1
LY#	1.3	x10^3/uL	1.2	3.4

ID: [redacted] 13-11-03
WE 03:47

Patient Limits

WBC	8.0 *	x10^3/uL	4.5	10.5
RBC	2.52 L	x10^6/uL	4.00	6.00
Hgb	7.1 L	g/dL	11.0	18.0
Hct	22.4 L	%	35.0	60.0
MCV	89.1	fL	80.0	99.9
MCH	28.3	pg	27.0	31.0
MCHC	31.7 L	g/dL	33.0	37.0
Plt	169.	x10^3/uL	150.	450.
LY%	16.4 #L	%	20.5	51.1
LY#	1.3 *	x10^3/uL	1.2	3.4

RAPIDPOINT [illegible] ANALYZER V4.54
SERIAL #005485 11/13/03 04:57

Patient ID: [redacted]
Test Name :PT
Test Result:= 16.2 sec.
Ratio = 1.3
Calculated INR:= 1.58
Sample Type:citrated wh. blood
Test Date :11/13/03
Test Time :04:55
Card Lot [redacted] (b)(6)-2
Operator :

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/13/03 05:00

Patient ID: [redacted]
Test Name :APTT
Test Result:= 32.8 sec.
Sample Type:citrated wh. blood
Test Date :11/13/03
Test Time :04:57
Card Lot [redacted] (b)(6)-2
Operator

1-STAT EG7+

Pt: [redacted]
Pt Name:_____

Na_____144 mmol/L
K_____4.3 mmol/L
TCO2_____23 mmol/L
iCa_____1.01 mmol/L
Hct_____18 %PCV
Hb*_____6 g/dL
*via Hct

At 37C
pH_____7.259
PCO2_____48.1 mmHg
PO2_____127 mmHg
HCO3_____22 mmol/L
BEecf_____-6 mmol/L
sO2*_____98 %
*calculated

At Patient Temp
pH_____7.247
PCO2_____49.9 mmHg
PO2_____133 mmHg

Patient Temp: 100.1F
FIO2_____: 65
Sample Type_:

[illegible] 03:26

(b)(6)-4 all

ID: [redacted]

			Patient Limits	
WBC	10.[illegible]	x10^3/uL	4.5	10.5
RBC	3.47 L	x10^6/uL	4.00	6.00
Hgb	9.9 L	g/dL	11.0	18.0
Hct	31.3 L	%	35.0	60.0
MCV	90.2	fL	80.0	99.9
MCH	28.6	pg	27.0	31.0
MCHC	31.7 L	g/dL	33.0	37.0
Plt	181.	x10^3/uL	150.	450.
LY%	10.2	*L %	20.5	51.1
LY#	1.0	*L x10^3/uL	1.2	3.4

ID: [redacted]
WB
15-11-03
04:23

			Patient Limits	
WBC	7.7	x10^3/uL	4.5	10.5
RBC	3.40 L	x10^6/uL	4.00	6.00
Hgb	9.9 L	g/dL	11.0	18.0
Hct	30.5 L	%	35.0	60.0
MCV	89.7	fL	80.0	99.9
MCH	29.0	pg	27.0	31.0
MCHC	32.3 L	g/dL	33.0	37.0
Plt	192.	x10^3/uL	150.	450.
LY%	10.1	*L %	20.5	51.1
LY#	0.8	*L x10^3/uL	1.2	3.4

i-STAT G3+

Pt: [redacted]

Pt Name:____________

TCO2________19 mmol/L

At 37C

pH_______7.272

PCO2______37.9 mmHg

PO2_________97 mmHg

HCO3________18 mmol/L

BEecf_______-9 mmol/L

sO2*________97 %

*calculated

Sample Type_:

17NOV03 06:07

Oper: [redacted]

Physician:______________

Ser# [redacted]

Ver: [redacted]

ID: [redacted]
WB
1[illegible]-11-03
0[illegible]

			Patient Limits	
WBC	8.6 *	x10^3/uL	4.5	10.5
RBC	2.61 L	x10^6/uL	4.00	6.00
Hgb	7.5 L	g/dL	11.0	18.0
Hct	23.4 L	%	35.0	60.0
MCV	89.7	fL	80.0	99.9
MCH	25.7	pg	27.0	31.0
MCHC	32.0 L	g/dL	33.0	37.0
Plt	140.	*L x10^3/uL	150.	450.
LY%	10.4	*L %	20.5	51.1

[redacted]

Patient Limits

[illegible]

Patient Limits

[illegible]

ID: [redacted]
WB
19-11-03
05:41

			Patient Limits	
WBC	19.8 H	x10^3/uL	4.5	10.5
RBC	3.14 L	x10^6/uL	4.00	6.00
Hgb	9.0 L	g/dL	11.0	18.0
Hct	28.3 L	%	35.0	60.0
MCV	90.1	fL	80.0	99.9
MCH	28.7	pg	27.0	31.0
MCHC	31.9 L	g/dL	33.0	37.0
Plt	298.	x10^3/uL	[illegible]	[illegible]
LY%	5.1			
LY#	1.0	*L x10^3/uL	1.2	3.4

ID: [redacted]
WB
14-11-03
04:03

			Patient Limits	
WBC	8.9	x10^3/uL	4.5	10.5
RBC	2.6[illegible] L	x10^6/uL	4.00	6.00
Hgb	7.6 L	g/dL	11.0	18.0
Hct	24.1 L	%	35.0	60.0
MCV	87.6	fL	80.0	99.9
MCH	28.3	pg	27.0	31.0
MCHC	31.6 L	g/dL	33.0	37.0
Plt	1[illegible].	x10^3/uL	150.	450.
LY%	7.[illegible]	*L %	20.5	51.1
LY#	[illegible]	* x10^3/uL	1.2	3.4

i-STAT EG7+

Pt: [redacted]

Pt Name:____________

Na_________148 mmol/L

K__________4.6 mmol/L

TCO2________16 mmol/L

iCa_______0.92 mmol/L

Hct_________36 %PCV

Hb*_________12 g/dL

*via Hct

At 37C

pH_______7.041

PCO2______53.1 mmHg

PO2_________66 mmHg

HCO3________14 mmol/L

BEecf______-16 mmol/L

sO2*________81 %

*calculated

At Patient Temp

pH_______7.045

PCO2______52.4 mmHg

PO2_________64 mmHg

Patient Temp: 98.0F

FIO2________: 85

Sample Type_:

19NOV03 05:19

Oper: [redacted]

Physician:______________

Ser# [redacted]

Ver: [redacted]

MEDCOM - 23743

(b)(6)-4 all unless indicated otherwise

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/20/03 08:33

Patient ID: [redacted]
Test Name :PT
Test Result:= 39.1 sec.
RESULT NOT RANGE CHECKED
Ratio = 3.5
Calculated INR = 7.66
Sample Type:citrated plasma
Test Date :11/20/03
Test Time :08:31
Card Lot [redacted] (b)(6)-2
Operator

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/20/03 08:51

Patient ID: [redacted]
Test Name :APTT
Test Result:=102.9 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated plasma
Test Date :11/20/03
Test Time :08:46
Card Lot [redacted] (b)(6)-2
Operator

ID: [redacted]
WB 22-11-03 04:44

			Patient Limits	
WBC	20.4 H	x10^3/uL	4.5	10.5
RBC	2.95 L	x10^6/uL	4.00	6.00
Hgb	8.4 L	g/dL	11.0	18.0
Hct	25.9 L	%	35.0	60.0
MCV	87.9	fL	80.0	99.9
MCH	28.5	pg	27.0	31.0
MCHC	32.4 L	g/dL	33.0	37.0
Plt	315.	x10^3/uL	150.	450.
LYX	5.8 *L	%	20.5	51.1
LY#	1.2 *	x10^3/uL	1.2	3.4

ID: [redacted]
WB 21-11-03 04:57

			Patient Limits	
WBC	23.5 H	x10^3/uL	4.5	10.5
RBC	3.56 L	x10^6/uL	4.00	6.00
Hgb	10.0 L	g/dL	11.0	18.0
Hct	31.5 L	%	35.0	60.0
MCV	88.5	fL	80.0	99.9
MCH	28.0	pg	27.0	31.0
MCHC	31.6 L	g/dL	33.0	37.0
Plt	317.	x10^3/uL	150.	450.
LYX	4.4 *L	%	20.5	51.1
LY#	1.0 *L	x10^3/uL	1.2	3.4

i-STAT EG7+
Pt: [redacted]
Pt Name:_____

Na_____145 mmol/L
K_____3.8 mmol/L
TCO2_____32 mmol/L
iCa_____0.76 mmol/L
Hct_____31 %PCV
Hb*_____11 g/dL
*via Hct

At 37C
pH_____7.294
PCO2_____41.4 mmHg
PO2_____57 mmHg
HCO3_____30 mmol/L
BEecf_____3 mmol/L
sO2*_____85 %
*calculated

At Patient Temp
pH_____7.294
PCO2_____61.6 mmHg
PO2_____58 mmHg
Patient Temp: 98.7F
FIO2_____: 90
Sample Type_:

22NOV03 04:35
Oper: [redacted]
Physician:_____
Ser# [redacted]
Ver:

i-STAT EG7+
Pt: [redacted]
Pt Name:_____

Na_____147 mmol/L
K_____4.0 mmol/L
TCO2_____29 mmol/L
iCa_____0.91 mmol/L
Hct_____24 %PCV
Hb*_____8 g/dL
*via Hct

At 37C
pH_____7.243
PCO2_____63.5 mmHg
PO2_____58 mmHg
HCO3_____27 mmol/L
BEecf_____0 mmol/L
sO2*_____84 %
*calculated

Sample Type_:

21NOV03 05:53
Oper: [redacted]
Physician:_____
Ser# [redacted]
Ver:

(b)(6)-4

NAME: [redacted]

17NOV03

RESPIRATORY DATA

	DATE	17NOV	17NOV	17NOV	17NOV	17NOV	17NOV	17NOV	17NOV	17NOV	17NOV	17NOV	17NOV	17NOV	17NOV	18NOV	18NOV	18NOV	18NOV	18NOV	18NOV	18NOV	18NOV	18NOV	18NOV
	TIME	03	0345	0515	0545	0607	0830	0900	1000	1300	1600	1720	2100	2225	2300	0005	0035	0100	0210	0325	0336	1000	1200	1300
VENT	Mode	SIMV					SIMV	SIMV	SIMV	SIMV	SIMV	SIMV									SIMV	S		
	FiO2	100%	↓90%	↓85%	↓75%		70	65	60	70	65	65	↑100	↓90	↓80	↑100	↓90	↓80	↑85	↑100	100	↓90	↓80	↑90
	TV	750					750	750	750	750	750	750									750	750		
	Rate	24					24	24	24	24	24	24									24	24		
	PEEP	15					15	15	15	15	15	15									15	15		
ABG	pH	7.326				7.272															7.178			
	pCO2	36.0				37.9															42.7			
	pO2	104				97															60			
	HCO3	19				18															16			
	SaO2	98				97															89			
	BE	-7				-9															-13			

LABORATORY DATA

DATE	17NOV	18NOV
TIME	0356	0418
Glucose	99	109
Na / K	151 / 4.6	149 / 4.6
Cl / CO2	116 / 19	118 / 18
BUN / Cr	58 / 3.6	58 / 3.8
WBC / Platelet	10.7 / 187	13.2 / 334
Hct / Hgb	31.0 / 10.0	29.9 / 9.5

(b)(6) - 4 all

Ward/Section:	REQUESTING PHYSICIAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted]	DATE	TIME / SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
RBC		4.7-6.1 x 10^6
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

REMARKS:

REPORTED BY:

Urinalysis

TEST	RESULT	REF. RANGE
Color	Straw	N/A
App	Clear	N/A
Glu	neg	Negative
Bili	neg	Negative
Ket	neg	Negative
SG	1.005	N/A
Bld	trace	Negative
pH	5.0	N/A
Prot	tr	Negative
Urob	neg	0.2-1.0
Nit	neg	Negative
Leuk	neg	Negative
HCG		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

SSA neg
WBC - 4-6
RBC - 8-12
EP - 0-2

CSF

Blood Bank

JUST SUBMIT OR [illegible]

======= PICCOLO =======
11/11/03 09:36 AM
REFERENCE RANGE: MALE
PATIENT #: [redacted]
BASIC METABOLIC
DISC LOT #: 3325AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	101	73-118	MG/DL
BUN	15	7-22	MG/DL
CA++	6.6*	8.0-10.3	MG/DL
CRE	1.8*	0.6-1.2	MG/DL
NA+	138	128-145	MMOL/L
K+	5.6*	3.3-4.7	MMOL/L
CL-	112*	98-108	MMOL/L
tCO2	20	18-33	MMOL/L

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

======= PICCOLO =======
11/11/03 0::0: AM
REFERENCE RANGE: MALE
PATIENT #: [redacted]
LIVER PANEL PLUS
DISC LOT #: 3154AA7
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

ALB	1.7*	3.3-5.5	G/DL
ALP	41	26-84	U/L
ALT	57*	10-47	U/L
AMY	41	14-97	U/L
AST	65*	11-38	U/L
TBIL	0.9	0.2-1.6	MG/DL
GGT	9	5-65	U/L
TP	3.8*	6.4-8.1	G/DL

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

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) Metlyte 8

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: ICU | REQUESTING PHYSICIAN: [redacted] (6)(6)-2

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

LAST, FIRST, MI: [redacted] (6)(6)-4 | DATE: 11/11/03 | TIME: 1620 | SSN/PSEUDO SSN:

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

TEST		
GLU		
BUN		
CA^{++}		
CRE		
NA^+		
K^+		
CL^-		
tCO_2		

(Pi

TEST		
ALB		
ALP		
ALT		
AMY		
AST		
TBIL		
GGT		
TP		

TEST		
NA^+		
K^+		
CL^-		
tCO_2		18-33 mmol/l

======= PICCOLO =======
11/11/03 10:2? AM
REFERENCE RANGE: MALE
PATIENT #: [redacted] (6)(6)-4
BASIC METABOLIC
DISC LOT #: 3325AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	87	73-118	MG/DL
BUN	16	7-22	MG/DL
CA++	6.5*	8.0-10.3	MG/DL
CRE	2.1*	0.6-1.2	MG/DL
NA+	136	128-145	MMOL
K+	6.4*	3.3-4.7	MMOL
CL-	110*	98-108	MMOL
tCO2	20	18-33	MMOL

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

REMARKS: FIO2 75% T97-6

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

Ward/Section:	REQUESTING PHYSICIAN: (b)(6)-4	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI [redacted]	DATE	TIME / SSN/PSEUDO SSN:

(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 10^9	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
(Hematology) Manual Differential			pH		N/A	Micro Parasites		
Segs		Mono	Prot		Negative	Malaria		
Bands		Eos	Urob		0.2-1.0	O & P		
Lymph		Baso	Nit		Negative	Other		
Atyp		Imm	Leuk		Negative	**Microscopic Urinalysis**		
RBC Morph			HCG		Negative			
Spun Hematocrit		42-52% (M) 37-47% (F)	**CSF**			**Blood Bank**		
Sed Rate			Cell Count			**MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED**		
Other			Directigen		Negative	ABO/Rh		

Coagulation Studies			Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)		
TEST	*RESULT*	*REF. RANGE*	*UNIT*	*TYPE*	*CROSSMATCH*
PT		9.8-13.6 secs			
APTT		21-34 secs			
D dimer		<20 ug/ml			
FDP		<10 ug/ml			

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: Cen1	REQUESTING PHYSICIAN: (b)(6)-4	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted]	DATE 4/4	TIME	SSN/PSEUDO SSN:

(Hematology) CBC

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

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

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

UNIT	TYPE	CROSSMATCH

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

REMARKS: [redacted] (b)(6)-2 PT/PTT

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

Ward/Section: ICU-1	REQUESTING PHYSICIAN: (b)(6)-2	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted] (b)(6)-4	DATE: 11/11	TIME: 1943
		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		
CA^{++}		
CHOL		
CRE		
GLU		
TP		
TEST		
GLU		
BUN		
CRE		
CK		
NA^{+}		
K^{+}		
CL^{-}		
tCO_2		

======= PICCOLO =======
11/11/03 19:51
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
BASIC METABOLIC
DISC LOT #: 3325AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	92	73-118	MG/DL
BUN	17	7-22	MG/DL
CA++	7.0*	8.0-10.3	MG/DL
CRE	2.3*	0.6-1.2	MG/DL
NA+	134	128-145	MMOL/L
K+	5.7*	3.3-4.7	MMOL/L
CL-	111*	98-108	MMOL/L
tCO2	22	18-33	MMOL/L

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

RESULT	REF. RANGE
	3.3-5.5 g/dl
	26-84 u/l
	10-47 u/l
	14-97 u/l
	11-38 u/l
	0.2-1.6 mg/dl
	5-65 u/l
	6.4-8.1 g/dl

(Piccolo) Electrolyte

RESULT	REF. RANGE
	128-145 mmol/l
	3.3-4.7 mmol/l
	98-108 mmol/l
	18-33 mmol/l

REMARKS: ABG : (T)
Chem8
sao_2 98.7

REPORTED BY: DAT

(b)(6)-4 all

Ward/Section: ICU-1	REQUESTING PHYSICIAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted]	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
GLU		
BUN		
CRE		
CK		
NA+		
K+		
CL-		
tCO_2		

```
======= PICCOLO =======
12/11/03              04:19 AM
REFERENCE RANGE:          MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #:            3151AA4
OPER #: [redacted]     DR #: 000
SERIAL #: [redacted]
.............................
GLU    93    73-118     MG/DL
BUN    20    7-22       MG/DL
CRE    2.7*  0.6-1.2    MG/DL
CK     771*  39-380     U/L
NA+    129   128-145    MMOL/L
K+     5.1*  3.3-4.7    MMOL/L
CL-    109*  98-108     MMOL/L
tCO2   18    18-33      MMOL/L

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
		3.3-5.5 g/dl
		26-84 u/l
		10-47 u/l
		14-97 u/l
		11-38 u/l
		0.2-1.6 mg/dl
		5-65 u/l
		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
		128-145 mmol/l
		3.3-4.7 mmol/l
		98-108 mmol/l
		18-33 mmol/l

REMARKS: [illegible] [illegible] [illegible]
Chem 8

REPORTED BY:	DATE:	LAB ID NO.:

Chem 8 & CBC only.

Ward/Section: ICU-1	TESTING PHYSICIAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] (b)(6)-4	DATE 12/11 TIME 0400	SSN/PSEUDO SSN:

(Hematology) CBC ✓		
TEST	*RESULT*	*REF. RANGE*
WBC		4.8-10.8 x 10^3
RBC		4.7-6.1 x 10^3
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: CBC

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section:

REQUESTING PHYSICIAN:

LAST, FIRST, MI.

DATE

TIME

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

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

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE

======= PICCOLO =======
13/11/03 04:02 AM
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: 3152AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	91	73-118	MG/DL
BUN	22	7-22	MG/DL
CRE	3.4*	0.6-1.2	MG/DL
CK	827*	39-380	U/L
NA+	128	128-145	MMOL
K+	4.8*	3.3-4.7	MMOL
CL-	113*	98-108	MMOL
tCO2	18	18-33	MMOL

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
UN		7-22 mg/dl
A++		8.0-10.3 mg/dl
RE		0.6-1.2 mg/dl
A+		128-145 mmol/l
+		3.3-4.7 mmol/l
L-		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
tCO_2		18-33 mmol/l

REMARKS:

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

DATE: 13Nov03

LAB ID NO.:

Ward/Section: CU 1	REQUESTING PHYSICIAN: [redacted] (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted] (b)(6)-4	DATE: 13 Jan 03	TIME:	SSN/PSEUDO SSN: [redacted] (b)(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
RBC		4.7-6.1 x 10^6
Hgb		14-18 g/dl (M) 12-16 g/dl (F)
Hct		42-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-500 x 10^3 verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

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: SMA-7

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

Ward/Section: TCMH	REQUESTING PHYSICIAN: [redacted] (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted] (b)(6)-4	DATE: 13 Oct	TIME	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 10^9	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
(Hematology) Manual Differential			pH		N/A	Micro Parasites		
Segs		Mono	Prot		Negative	Malaria		
Bands		Eos	Urob		0.2-1.0	O & P		
Lymph		Baso	Nit		Negative	Other		
Atyp		Imm	Leuk		Negative	**Microscopic Urinalysis**		
RBC Morph			HCG		Negative			
Spun Hematocrit		42-52% (M) 37-47% (F)	**CSF**			**Blood Bank**		
Sed Rate			Cell Count			**MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED**		
Other			Directigen		Negative	ABO/Rh		

Coagulation Studies

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: ICU | REQUESTING PHYSICIAN: (6)(6)-2 | **CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)

LAST, FIRST, MI: [redacted] (6)(6)-4 | DATE: 13 Nov | TIME: | SSN/PSEUDO-SSN: [redacted] (6)(6)-4

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

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

(b)(6)-2

Ward/Section: ICU 1	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted]	DATE 15 Nov 93	TIME 0730	SSN/PSEUDO SSN:

(Hematology) CBC (b)(6)-4

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: ICU

REQUESTING PHYSICIAN: (b)(6)-2

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

DATE: 12 Nov 13 TIME: 1922

LABORATORY RESULT FORM

(Subject to the Privacy Act of 1974)

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

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
RBC		4.7-6.1 x 10^6
Hgb		14-18 g/dl (M) 12-16 g/dl (F)
Hct		42-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-500 x 10^3 verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

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: DATE: LAB ID NO.:

Ward/Section: ICU | REQUESTING PHYSICIAN: [redacted] (6)(6)-2

LABORATORY RESULT FORM

LAST, FIRST, MI: [redacted] (6)(6)-4 | DATE: 14Nov | TIME: | SSN/PSEUDO SSN: [redacted] (6)(6)-4

(Privacy Act of 1974)

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
RBC		4.7-6.1 x 10^6
Hgb		14-18 g/dl (M) 12-16 g/dl (F)
Hct		42-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-500 x 10^3 verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Blood Bank Us
(MUST SUBMIT SF 518 WIT
REQUE

UNIT	TYP

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

======= PICCOLO =======
14/11/03 04:04
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #: 3152AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	88	73-118	MG/DL
BUN	29*	7-22	MG/DL
CRE	3.2*	0.6-1.2	MG/DL
CK	587*	39-380	U/L
NA+	128	128-145	MMOL/L
K+	4.5	3.3-4.7	MMOL/L
CL-	113*	98-108	MMOL/L
tCO2	18	18-33	MMOL/L

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

REMARKS: SMA 7

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

Ward/Section: ICU #1 | TESTING PHYSICIAN: (b)(6)-2 | T+C MATCH

LAST, FIRST, MI. [redacted] (b)(6)-4 | DATE NOV 13,03 | TIME 09:10 | SSN/PSEUDO SSN:

LABORATORY RESULT FORM

(Subject to the Privacy Act of 1974)

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
RBC		4.7-6.1 x 10^3
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: B POS

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH
[redacted]	B POS	comp
[redacted]	"	"

REMARKS:

REPORTED BY: | DATE: NOV. 13, 03 | LAB ID NO.:

[redacted] (b)(6)-4

ICU #1

Ward/Section: ICU ED | TESTING PHYSICIAN: (b)(6)-2 | LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI: [redacted] (b)(6)-4 | DATE: 14NOV03 | TIME: 1920 | SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
RBC		4.7-6.1 x 10^3
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: CBC

REPORTED BY: [redacted] (b)(6)-2 | DATE: 14 NOV 03 | LAB ID NO.:

Ward/Section: ICU-1	REQUESTING PHYSICIAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] (b)(6)-4	DATE 16 NOV	TIME 0400	SSN/PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
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 =======
16/11/03 04:23
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: 3152AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	113	73-118	MG/DL
BUN	34*	7-22	MG/DL
CRE	3.1*	0.6-1.2	MG/DL
CK	209	39-380	U/L
NA+	124*	128-145	MMOL/L
K+	4.1	3.3-4.7	MMOL/L
CL-	117*	98-108	MMOL/L
tCO2	22	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
tCO2		18-33 mmol/l

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:
Metlyte 8.

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: ICU1 | REQUESTING PHYSICIAN: [redacted] (b)(6)-2 | CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI: [redacted] (b)(6)-4 | DATE: 15NOV03 | TIME: 0334 | SSN/PSEUDO SSN:

i-STAT

TEST	RESULT	REF. RANGE
Na		139-146 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		22-25 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		3-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE

======= PICCOLO =======
15/11/03 04:27 AM
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
BASIC METABOLIC
DISC LOT #: 3325AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	138*	73-118	MG/DL
~~BUN~~	+++	7-22	MG/DL
CA++	7.9*	8.0-10.3	MG/DL
CRE	3.2*	0.6-1.2	MG/DL
NA+	137	128-145	MMOL
K+	4.3	3.3-4.7	MMOL
CL-	120*	98-108	MMOL
tCO2	21	18-33	MMOL

INST QC: OK CHEM QC: OK
HEM 2+, LIP 0 , ICT 1+

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

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

Ward/Section: ICU | REQUESTER: [redacted] (b)(6)-2

LAST, FIRST, MI: [redacted] (b)(6)-4 | DATE: 15NOV03 | TIME: 0330

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

SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
RBC		4.7-6.1 x 10^6
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		9.3-13.5 secs
APTT		21-34 secs
D-Dimer		<0.5 ug/ml
FDP		<10 ug/ml

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Blood Bank

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

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

REMARKS:

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

Ward/Section: ICU1	REQUESTING PHYSICIAN: [redacted] (b)(6)-2	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI. [redacted] (b)(6)-4	DATE 17NOV03	TIME 0334	SSN/PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na	151	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	19	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	58	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 =======
17/11/03 03:56
REFERENCE RANGE: (b)(6)-4 MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #: 3152AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	99	73-118	MG/DL
~~BUN~~	~~+++~~	7-22	MG/DL
CRE	3.5*	0.6-1.2	MG/DL
CK	121	39-380	U/L
~~NA+~~	~~123*~~	128-145	MMOL
K+	4.6	3.3-4.7	MMOL
CL-	116*	98-108	MMOL
~~tCO2~~	~~+++~~	18-33	MMOL

INST QC: OK CHEM QC: OK
HEM 2+, LIP 0, ICT 1+

(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
A^+		128-145 mmol/l
		3.3-4.7 mmol/l
		98-108 mmol/l
O_2		18-33 mmol/l

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: ICU (b)(6)-2	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FORM (subject to the Privacy Act of 1974)	
LAST, FIRST, MI: [redacted]	DATE: 18NOV03	TIME:	SSN/PSEUDO SSN:

(Hematology) CBC			(b)(6)-4 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 10^9	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
(Hematology) Manual Differential			pH		N/A	Micro Parasites		
Segs		Mono	Prot		Negative	Malaria		
Bands		Eos	Urob		0.2-1.0	O & P		
Lymph		Baso	Nit		Negative	Other		
Atyp		Imm	Leuk		Negative	**Microscopic Urinalysis**		
RBC Morph			HCG		Negative			
Spun Hematocrit		42-52% (M) 37-47% (F)	**CSF**			**Blood Bank**		
Sed Rate			Cell Count			**MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED**		
Other			Directigen		Negative	ABO/Rh		

Coagulation Studies			Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)		
TEST	*RESULT*	*REF. RANGE*	*UNIT*	*TYPE*	*CROSSMATCH*
PT		9.8-13.6 secs			
APTT		21-34 secs			
D dimer		<20 ug/ml			
FDP		<10 ug/ml			

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: ICU	REQUESTING PHYSICIAN: [redacted] (b)(6)-2	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] (b)(6)-4	DATE 18NOV03	TIME	SSN/PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na	149	~~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
AL		
AL		
AL		
AL		
AL		
TI		
BI		
CI		
CI		
CI		

======= PICCOLO =======
18/11/03 04:18
REFERENCE RANGE:
PATIENT #: [redacted] (b)(6)-4 MALE
METLYTE 8
DISC LOT #: 3152AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	109	73-118	MG/DL
BUN	58*	7-22	MG/DL
CRE	3.8*	0.6-1.2	MG/DL
CK	62	39-380	U/L
NA+	***	128-145	MMOL
K+	4.6	3.3-4.7	MMOL
CL-	118*	98-108	MMOL
tCO2	18	18-33	MMOL

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
J		73-118 mg/dl
N		7-22 mg/dl
+		8.0-10.3 mg/dl
E		0.6-1.2 mg/dl
+		128-145 mmol/l
		3.3-4.7 mmol/l
		98-108 mmol/l
O_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
LB		3.3-5.5 g/dl
LP		26-84 u/l
LT		10-47 u/l
MY		14-97 u/l
AST		11-38 u/l
BIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

(b)(6)-4 unless indicated otherwise

T98th 702-88

Ward/Section: ICU/4th | REQUESTING PHYSICIAN: [redacted] (b)(6)-2 | CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI.: [redacted] | DATE: NOV 19 | TIME: 6:00 | SSN/PSEUDO SSN:

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE	
======= PICCOLO =======			
19/11/03		05:31	
REFERENCE RANGE:		MALE	
PATIENT #:	[redacted]		
LIVER PANEL PLUS			
DISC LOT #:		3154AA7	
OPER #:	[redacted]	DR #: 000	
SERIAL #:	[redacted]		
ALB	♦♦♦	3.3-5.5	G/DL
ALP	70	26-84	U/L
ALT	14	10-47	U/L
AMY	76	14-97	U/L
AST	90*	11-38	U/L
TBIL	6.5*	0.2-1.6	MG/DL
GGT	12	5-65	U/L
TP	♦♦♦	6.4-8.1	G/DL

INST QC: OK CHEM QC: OK
HEM 1+, LIP 0, ICT 2+

(Piccolo) Metabolic Panel

======= PICCOLO =======			
19/11/03		06:02 AM	
REFERENCE RANGE:		MALE	
PATIENT #:	[redacted]		
BASIC METABOLIC			
DISC LOT #:		3325AA4	
OPER #:	[redacted]	DR #: 000	
SERIAL #:	[redacted]		
GLU	106	73-118	MG/DL
BUN	♦♦♦	7-22	MG/DL
CA++	8.0	8.0-10.3	MG/DL
CRE	5.2*	0.6-1.2	MG/DL
NA+	♦♦♦	128-145	MMOL
K+	5.6*	3.3-4.7	MMOL
CL-	120*	98-108	MMOL
tCO2	16*	18-33	MMOL

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

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

REMARKS:

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

ABG CBC Chem

Ward/Section: ICU #1	REQUESTING PHYSICIAN: DR [redacted] (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] (b)(6)-1	DATE Nov 19	TIME 4:00	SSN/PSEUDO SSN:

(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 10^9	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
(Hematology) Manual Differential			pH		N/A	Micro Parasites		
Segs		Mono		Prot		Negative	Malaria	
Bands		Eos		Urob		0.2-1.0	O & P	
Lymph		Baso		Nit		Negative	Other	
Atyp		Imm		Leuk		Negative	**Microscopic Urinalysis**	
RBC Morph				HCG		Negative		

Spun Hematocrit		42-52% (M) 37-47% (F)	**CSF**			**Blood Bank**	
Sed Rate			Cell Count			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED	
Other			Directigen		Negative	ABO/Rh	

Coagulation Studies			Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)		
TEST	*RESULT*	*REF. RANGE*	*UNIT*	*TYPE*	*CROSSMATCH*
PT		9.8-13.6 secs			
APTT		21-34 secs			
D dimer		<20 ug/ml			
FDP		<10 ug/ml			

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

T 98.1 FIO2 85

MEDCOM - 23770

Ward/Section: TCU #1	REQUESTING PHYSICIAN: [redacted] (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI: [redacted] (b)(6)-4	DATE: 21 Nov 07	TIME: 0415	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 10^9	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
(Hematology) Manual Differential			pH		N/A	Micro Parasites		
Segs		Mono	Prot		Negative	Malaria		
Bands		Eos	Urob		0.2-1.0	O & P		
Lymph		Baso	Nit		Negative	Other		
Atyp		Imm	Leuk		Negative	**Microscopic Urinalysis**		
RBC Morph			HCG		Negative			
Spun Hematocrit		42-52% (M) 37-47% (F)	**CSF**			**Blood Bank**		
Sed Rate			Cell Count			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED		
Other			Directigen		Negative	ABO/Rh		

Coagulation Studies.			Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)		
TEST	*RESULT*	*REF. RANGE*	*UNIT*	*TYPE*	*CROSSMATCH*
PT		9.8-13.6 secs			
APTT		21-34 secs			
D dimer		<20 ug/ml			
FDP		<10 ug/ml			

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: ICU 4	REQUESTING PHYSICIAN: [redacted] (b)(6)-2	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted] (b)(6)-4	DATE: 21 Nov 03 TIME: 0405	SSN/PSEUDO SSN: [redacted] (b)(6)-4

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

No green top'.

REPORTED BY:	DATE:	LAB ID NO.:

(b)(6)-4 unless otherwise indicated

Ward/Section: ZCU #1	REQUESTING PHYSICIAN: [redacted] (b)(6)-2	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI.: [redacted]	DATE: 21 Nov 03 / TIME: 0530	SSN/PSEUDO SSN: [redacted]

i-STAT

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
tCO_2		18-33 mmol/l

======= PICCOLO =======
1?/11/03 06:0> AM
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #: 3152AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	155*	73-118	MG/DL
~~BUN~~	~~***~~	7-22	MG/DL
CRE	6.5*	0.6-1.2	MG/DL
CK	362	39-380	U/L
~~NA+~~	~~***~~	128-145	MMOL/L
K+	4.7	3.3-4.7	MMOL/L
CL-	103	98-108	MMOL/L
tCO2	22	18-33	MMOL/L

INST QC: OK CHEM QC: OK
HEM 0 , LIP 1+, ICT 2+

Bun 112

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

(b)(6) - 4 unless otherwise indicated

Ward/Section: ICU #1	REQUESTING PHYSICIAN: (b)(6)-2 [redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. SE [redacted]	DATE 22 Nov 03	TIME 0415
		SSN/PSEUDO SSN: [redacted]

i-STAT

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

==== == PICCOLO =======
22/11/03 04:55
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #: 3152AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	130*	73-118	MG/DL
BUN	+++	7-22	MG/DL
CRE	6.7*	0.6-1.2	MG/DL
CK	790*	39-380	U/L
NA+	136	128-145	MMOL/L
K+	4.6	3.3-4.7	MMOL/L
CL-	103	98-108	MMOL/L
tCO2	24	18-33	MMOL/L

INST QC: OK CHEM QC: OK
HEM 0 , LIP 1+, ICT 2+

Bun 120

(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
TB		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
DBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

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

REMARKS: T = 98° ~~[redacted]~~ F_iO_2 = 90%

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: ICU#1	TESTING PHYSICIAN: [redacted] (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted] (b)(6)-4	DATE: 20NN	TIME: 0730
		SSN/PSEUDO SSN:

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

(Hematology) Manual Differential			
Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

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

CSF		
Cell Count		
Directigen		Negative

Misc. Serology		
TEST	*RESULT*	*REF. RANGE*
RPR		Negative
Mono		Negative

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

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

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

UNIT	*TYPE*	*CROSSMATCH*

REMARKS: PT / PTT

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: ICU	REQUESTING PHYSICIAN: (b)(6)-2	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted] (b)(6)-4	DATE: 20 MAY	TIME: 0730
		SSN/PSEUDO SSN:

i-STAT			(Piccolo) Chemistry 12			(Piccolo) Metabolic Panel		
TEST	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*
Na		138-146 mmol/L	ALB		3.5-5.5 g/dl	GLU		73-118 mg/dl
K		3.5-4.9 mmol/L	ALP		26-84 u/l	BUN		7-22 mg/dl
Cl		98-109 mmol/L	ALT		10-47 u/l	CA^{++}		8.0-10.3 mg/dl
pH		7.31-7.45	AMY		14-97 u/l	CRE		0.6-1.2 mg/dl
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)	AST		11-38 u/l	NA^{+}		128-145 mmol/l
PO2		80-105 mmHg (art) N/A (ven)	TBIL		0.2-1.6 mg/dl	K^{+}		3.3-4.7 mmol/l
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)	BUN		7-22 mg/dl	CL^{-}		98-108 mmol/l
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)	CA^{++}		8.0-10.3mg/dl	tCO_2		18-33 mmol/l
sO2		95-98%	CHOL		100-200 mg/dl	(Piccolo) Liver Panel Plus		
BEecf		(-2) – (+3) mmol/L	CRE		0.6-1.2 mg/dl	*TEST*	*RESULT*	*REF. RANGE*
AnGap		10-20 mmol/L	GLU		73-118 mg/dl	ALB		3.3-5.5 g/dl
Ca		1.12-1.32 mmol/L	TP		6.4-8.1 g/dl	ALP		26-84 u/l
BUN		8-26 mg/dl	(Piccolo) Metlyte 8			ALT		10-47 u/l
GLU		70-105 mg/dl	*TEST*	*RESULT*	*REF. RANGE*	AMY		14-97 u/l
Creat		0.7-1.5 mg/dl	GLU		73-118 mg/dl	AST		11-38 u/l
Hct		38-51% PCV	BUN		7-22 mg/dl	TBIL		0.2-1.6 mg/dl
Hgb		12-17 g/dl	CRE		0.6-1.2 mg/dl	GGT		5-65 u/l
Misc. Chemistry			CK		39-380 u/l (M) 30-190 u/l (F)	TP		6.4-8.1 g/dl
TEST	*RESULT*	*REF. RANGE*	NA^{+}		128-145 mmol/l	(Piccolo) Electrolyte		
Troponin-I			K^{+}		3.3-4.7 mmol/l	*TEST*	*RESULT*	*REF. RANGE*
Drug of Abuse			CL^{-}		98-108 mmol/l	NA^{+}		128-145 mmol/l
			tCO_2		18-33 mmol/l	K^{+}		3.3-4.7 mmol/l
						CL^{-}		98-108 mmol/l
						tCO_2		18-33 mmol/l

REMARKS: PT / PTT

REPORTED BY:	DATE:	LAB ID NO.:

Microbiology Report

(b)(6)-1 (b)(2)-2

Name: [redacted]
Patient ID: [redacted]
Ward/Rm: U1/

Specimen: [redacted]
Source: Sputum
Ward of Iso:

Status: Final
Collected:
Attd. Phys:

1A Empedobacter (F.) brevis Status: Final

1A E. brevis

Drug	MIC	Interps	Drug	MIC	Interps
Amox/K Clav (c)	>16/8				
Amp/Sulbactam (c)	>16/8				
Ampicillin	>16				
Aztreonam	>16	R			
Cefazolin	>16				
Cefepime	>16	R			
Cefotaxime (c)	>32	R			
Cefotetan	>32				
Cefoxitin	>16				
Ceftazidime (a)	>16	R			
Ceftriaxone (c)	>32	R			
Cefuroxime (b)	>16				
Cephalothin	>16				
Chloramphenicol	>16	R			
Ciprofloxacin	<=1	S			
ESBL-a Scrn	>4				
ESBL-b Scrn	>1				
Gatifloxacin	<=2				
Gentamicin	>8	R			
Imipenem (c)	>8	R			
Levofloxacin	<=2	S			
Meropenem (c)	>8	R			
Moxifloxacin	<=2				
Nitrofurantoin	>64				
Norfloxacin	8				
Pip/Tazo (d)	>64	R			
Piperacillin (a)	>64	R			
Tetracycline	>8	R			
Ticar/K Clav (a)	>64	R			
Tobramycin	>8	R			
Trimeth/Sulfa	>2/38	R			

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

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

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

R* = Resistant due to extended spectrum beta-lactamases (ESBL)
EBL? = Suspected ESBL. Confirmatory tests needed to differentiate ESBL from other beta-lactamases.
IB = Inducible Bela-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 bela-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: [redacted] (b)(6)-1
Patient ID: [redacted]
Ward/Rm: U1/

Specimen: [redacted]
Source: Sputum
Ward of Iso:

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

Printed 11/16/2003 9:03:57 AM

MEDCOM - 23777

(b)(6)-2 unless otherwise indicated

[redacted] (b)(2)-2

Baghdad, Iraq

Microbiology Request Form

Preliminary Report

Last Name: [redacted] (b)(6)-4

First Name:

Patient # or SSN:

Collected by: SPC [redacted]

Date: 13 Nov 03

Time: 1910

Ward: ICU

Room:

Bed: 4

Physician: [redacted]

Source: sputum

Site: ETT

Received by: [redacted]

Date: 13NOV03

Time: 1918

Specimen #: [redacted]

Preliminary Laboratory Results

Good specimen
No organisms seen

Reported
Date: 13NOV03
Time: 2017
Tech: [redacted]
Reviewer: [redacted]

Number of attached sheets:

Preliminary Report

[redacted] (b)(2)-2
Baghdad, Iraq

Microbiology Request Form

Last Name: [redacted] (b)(6)-4
First Name:
Patient # or SSN:
Collected by: SPC [redacted] (b)(6)-2
Date: 13NOV03
Time: 1910

Ward: ICU
Room:
Bed: 4
Physician [redacted] (b)(6)-4
Source: Sputum
Site: ET

[redacted]

Received by: [redacted] (b)(6)-2
Date: 13NOV03
Time: 1918

Specimen #: [redacted]

Laboratory Results

Enterobacter (F.) brevis

Reported
Date: 16 NOV 03
Time: 1000
Tech: [redacted]
Reviewer: [redacted] (b)(6)-2

Number of attached sheets:

[redacted] (b)(2)-2
Baghdad, Iraq

Microbiology Request Form

Last Name: [redacted] (b)(6)-4
First Name:
Patient # or SSN:
Collected by: SPC [redacted] (b)(6)-2
Date: 13 NOV 03
Time: 1245

Ward: ICU 1
Room:
Bed: 4
Physician: [redacted] (b)(6)-2
Source: Foley
Site:

[redacted]

Received by: [redacted]
Date: 13NOV03
Time: 1918

Specimen #: [redacted]

Laboratory Results

No Growth

Reported
Date: 14 NOV 03
Time: 1000
Tech: [redacted]
Reviewer: [redacted] (b)(6)-2

Number of attached sheets:

(b)(6)-2 unless otherwise indicated

[redacted] (b)(2)-2
Baghdad, Iraq

Microbiology Request Form

(b)(6)-4

Last Name: [redacted] Ward: ICU I
First Name: Room: Bed 4
Patient # or SSN: Bed:
Physician: [redacted]

Collected by: SPC [redacted]
Date: 13Nov03 Source: Venous
Time: 1830 Site: ◯ FA + ◯ Brach

[redacted]

Received by: [redacted] Specimen #: [redacted]
Date: 13NOV03
Time: 1918

Laboratory Results

No Growth

Reported
Date: 18NOV03
Time: 1000
Tech: [redacted]
Reviewer: Number of attached sheets:

MEDCOM - 23781

DOD-037359

ACLU-RDI 1682 p.141

PRE-ANESTHESIA EVALUATION

M F | in/cm. ~90 kg lb

Proposed Procedure: Ex Lap Diaphragm Repair

Pre-Procedure Vital Signs: B/P 194/110 P [illegible] S R 40 T

Previous Anesthesia/Operations: unk

None o

Current Medications: unk

Family History of Anesthesia Complications

None o

Allergies: unk

AIRWAY/TEETH/HEAD & NECK: intubated

History From: o Patient o Parent/Guardian o Significant Oth o Chart o Poor Historian

SYSTEM	WNL	COMMENTS	PERTINENT STUDY RESULTS
RESPIRATORY Asthma Pneumonia Bronchitis Productive Cough COPD Recent Cold Dyspnea SOB Orthopnea Tuberculosis	o	Tobacco Use: o Yes o No ____ Packs/Day for ____ Years	Chest X-ray Pulmonary Studies
CARDIOVASCULAR Angina MI Arrhythmia Murmur CHF MVP Exercise tolerance Pacemaker Hypertension Rheumatic Fever	o		EKG
HEPATO/GASTROINTESTINAL Bowel Obstruction N&V Cirrhosis Reflux/heartburn Hepatitis Ulcers Hiatal Hernia Jaundice	o	Ethanol Use: o Yes o No Frequency ____	
NEURO/MUSCULOSKETAL Arthritis Paralysis Back problems Paresthesia CVA/Stroke Syncope DJD Seizures Headaches TIAs Loss of Consciousness Weakness Neuromuscular disease	o		
RENAL/ENDOCRINE Diabetes Weight loss/gain Renal Failure/Dialysis Thyroid Disease Urinary Retention Urinary tract infection			
OTHER Anemia Transfusion history Bleeding tendencies Pregnancy Hemophilia Sickle cell trait			

Problem List/Diagnosis: EPW GSW Bchest

ASA PS: 1 2 3 Other 4 5 E

LAB STUDIES Hgb/Hct/CBC [illegible] Electrolytes Urinalysis

Planned Anesthesia/Special Monitors: GETA

Pre-Anesthesia Medications Ordered

POST-ANESTHESIA NOTE

Evaluator Signature(s) Date

MEDCOM - 23782

DATE	NO.		SOLUTION	MEDICATIONS ADDED	RATE	TIME START	INITIAL	TIME STOP1	INITIAL
								(6)(6) - 2	
11Nov03	1		NS	Ø	KVO	0420	[redacted]		
	2		NS	Ø	KVO	0420			
	3		NS	Ø	10cc	0420			

(b)(6)-2 all

ANESTHESIA RECO

Dep Leg / Nephrec

START | STOP

Anesthesia 0000 0345

Procedure 0005 0230

PRE-PROCEDURE

- Verified ☐ ID Band ☐ Questioning
- Chart Review ☐ Permit Signed
- NPO Since _____
- Pre-anesthetic State: ☐ Calm ☐ Awake ☐ Asleep ☐ Apprehensive ☐ Confused ☐ Uncooperative ☐ Unresponsive

PATIENT SAFETY

- ☐ Anes. Machine & _____ Checked
- ☐ Safety Belt On ☐ Axillary Roll
- ☐ Arm Restraints ☐ Arms Tucked
- ☐ Pressure points checked and padded
- Eye Care: ☐ Ointment ☐ Saline ☐ Taped ☐ Pads ☐ Goggles

MONITORS & EQUIPMENT

- ☐ Precord ☐ Other
- ☐ Nerve Stimulator
- ☐ V Lead EKG
- ☐ Oxygen Analyzer
- ☐ Resp Gas Anlyzr
- ☐ EEG
- ☐ Fluid Warmer
- ☐ Foley Catheter

ANESTHETIC TECHNIQUE

Method: ☐ General ☐ Spinal ☐ Epidural ☐ Caudal ☐ Brachial ☐ Beer Block ☐ Ankle Blk ☐ M.A.C.

General: ☐ Pre-O_2 ☐ LTA ☐ Rapid Sequence ☐ Cricoid Pressure ☐ Intravenous ☐ Inhalation ☐ Intramuscular ☐ Rectal

Regional: ☐ Position _____ ☐ Prep _____ ☐ Local _____ ☐ Needle _____ ☐ Drug(s) _____ ☐ Dose _____ ☐ Attempts x ___ ☐ Site _____ ☐ Level _____ ☐ Catheter _____ ☐ See Remarks

AIRWAY MANAGEMENT

- ☐ Intubation ☐ Oral ☐ Nasal
- ☐ Direct Vision ☐ Magill's ☐ Blind
- ☐ Diff. see Rmks ☐ Fiber Op ☐ Stylet
- ☐ Attempts x ___ ☐ Blade _____
- ☐ Tube size ____ ☐ Endobronchial
- ☐ Regular ☐ RAE ☐ Armored ☐ Laser
- ☐ Cuffed ☐ Min. occ. pres. ☐ Air ☐ NS
- ☐ Uncuffed, leaks at ___ cm H_2O
- ☐ Secured at _____ ☐ ET CO_2 Present
- ☐ Breath Sounds _____
- ☐ Circuit: ☐ Circle ☐ Non-rebreathing
- ☐ Airway: ☐ Oral ☐ Nasal ☐ Natural
- ☐ Mask Case ☐ Via Tracheostomy
- ☐ Nasal Cannula ☐ Simple O_2 Mask

RECOVERY ROOM

Time | B/P | O_2 Sat. | P | R | T

☐ PACU ☐ ICU ☐ L&D

- ☐ Awake ☐ Sport Resp ☐ Oral Airway
- ☐ Asleep ☐ Ventilator ☐ Nasal Airway
- ☐ Stable ☐ Extubated ☐ Face Shield O_2
- ☐ Unstable ☐ Intubated ☐ T-Piece O_2

CONTROLLED DRUGS

Drug	Used	Destroyed	Returned
Fentanyl			

Provider _____ Witness _____

TIME: 0000 X 30 X 0100 X 30 X 0200 X 30 X 0300

													TOTALS
☐ Hal ☐ Enf ☐ Iso (%)	1.0	.8		.8	.8	.8	.8	.8	.8	.8	.8	.8	
☐ N_2O ☐ Air (L/min)													
Oxygen (L/min)	2	2	2	2	2	2	2	2	2	2	2	2	
Fent (ug)	50	50		50		50		50		50	50	100	450
Vec (mg)				5						3		5	25 mg
Versed (mg)						1							3
Ancef (g)													1 gm
LR	#1 1000				1000			1000					6000
NS	#1 1000			1000			2000			3000			
Urine (ml)													
EBL (ml)												2000	2000
EKG	ST	ST	ST	ST	ST	ST	ST	ST	ST	ST	ST	ST	250
%O_2 Inspired (FIO_2)	1.0	1.0		1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	
O_2 Saturation (SaO_2)	95	99		99	100	100	100	100	100	100	100	100	
End Tidal CO_2	35	35		30	29	29	29	27	27	28	28	28	
Temp: ☐ °C ☐ °F	32.5	32.5	32.5	32.1	32.1	32.1	32.1	32.1	32.1	33.0	33.0	33.0	

SYMBOLS

X ANESTHESIA

© OPERATION

v ^ B/P CUFF PRESSURE

⊥ ⊤ ARTERIAL LINE PRESSURE

▲ MEAN ARTERIAL PRESSURE

● PULSE

○ SPONTANEOUS RESP

Ø ASSISTED RESP

⊠ CONTROLLED RESP

TOURNIQUET

Baseline Values

P 119

B/P 150/

P

R

200 180 160 140 120 100 80 60 40 20

Tidal Vol. (ml)	850	850	850	800	850	850	850	800	850	850	850	850	
Resp. Rate	10	10	10	10	10	10	10	10	10	10	10	10	
Peak Pressure (H_2O)	25												
PEEP (cm H_2O)													
Symbols for Remarks													
Position													
Anesthesia Provider(s)													

REMARKS

0000 Received pt already intubated, unresponsive → to OR

Monitors, O_2. 0100 IJ introducer placed 3 difficulty

0245 Pt X-ported to ICU - Monitors, placed on vent

RR=16, TV=900 FiO2 1.0 - pt stable

MEDCOM - 23784

AMC FORM 142 JUL 93

WARD COPY (b)(6)-2 all except very bottom

518–124 NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*
- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of _____ units)*
- [ ] CRYOPRECIPITATE *(Pool of _____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* _____

VOLUME REQUESTED *(If applicable)* 1U ML

REMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*
- [ ] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED 13 NOV 03

DATE AND HOUR REQUIRED 13 NOV 03

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)* [redacted]

DIAGNOSIS OR OPERATIVE PROCEDURE GSW to ABD

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER [redacted]

DATE VERIFIED 13 NOV 03

TIME VERIFIED 0445

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. [redacted]

TRANSFUSION NO.

PATIENT NO.

DONOR ABO B Rh POS

RECIPIENT ABO B Rh POS

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	Comp

PREVIOUS RECORD CHECK: [X] RECORD [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST [redacted]

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED DATE 13 NOV 03

REMARKS: ex 14 NOV 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND I[redacted]

AT *(Hour)* 1024 ON *(Date)* 13 NOV 03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER *(Signature)* [redacted]

2nd VERIFIER *(Signature)* [redacted]

PRE-TRANSFUSI[redacted]

TEMP. 1[redacted] PULSE 125 BP 157/77

DATE OF T[redacted]ON 13 [redacted]V 03

TIME STARTED 1030

POST-TRANSFUSION DATA

AMOUNT GIVEN ML

TIME/DATE COMPLETED/INTERRUPTED 1155 13 NOV 03

REACTION [X] NONE [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
101.2	146	154/79

If reaction is suspected—IMMEDIATELY:

1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION OF REACTION
- [ ] URTICARIA [ ] CHILL [ ] FEVER [ ] PAIN
- [ ] OTHER *(Specify)*

OTHER DIFFICULTIES *(Equipment, clots, etc.)*
- [X] NO [ ] YES *(Specify)*

[redacted]

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle, [redacted] rate; hospital or medical facility)

[redacted]

WARD ICU 1

BLOOD OR BLOOD COMPONENT TRANSFUSION
Medical Record

MEDCOM - 23785

STANDARD FORM 518 (REV. 9–92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201–9.202–1

ACLU-RDI 1682 p.145

DOD-037363

(b)(6)-2 except for very bottom

518-124

NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*
- [x] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of _____ units)*
- [ ] CRYOPRECIPITATE *(Pool of _____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* _____

VOLUME REQUESTED *(If applicable)* 4 ML

REMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*
- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED 13 Nov 03

DATE AND HOUR REQUIRED 13 Nov 03

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)* [redacted]

DIAGNOSIS OR OPERATIVE PROCEDURE GSW to ABD

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER [redacted]

DATE VERIFIED 13 Nov 03

TIME VERIFIED 0445

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. [redacted]

TRANSFUSION NO.

PATIENT NO.

DONOR: ABO B, Rh pos

RECIPIENT: ABO B, Rh pos

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	comp

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

REMARKS: ex 13 14 Nov 03

PREVIOUS RECORD CHECK:
- [x] RECORD
- [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST [redacted]

DATE 13 NOV 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

ID [redacted]

AT *(Hour)* 1157 ON *(Date)* 13 NOV 03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

[redacted]

2nd VERIFIER *(Signature)* [redacted]

PRE-TRANSFUSION

TEMP. 101.1 PULSE 141 BP 144/88

DATE OF TRANSFUSION 13 Nov 03 TIME STARTED

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle initial; rate; hospital or medical facility)

[redacted] (b)(6)-4

POST-TRANSFUSION DATA

AMOUNT GIVEN 1 unit ML

TIME/DATE COMPLETED/INTERRUPTED 1530 13NOV03

REACTION
- [x] NONE
- [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
101.9	146	169/87

If reaction is suspected—IMMEDIATELY:
1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION OF REACTION
- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER *(Specify)*

OTHER DIFFICULTIES *(Equipment, clots, etc.)*
- [x] NO
- [ ] YES *(Specify)*

SIGNATURE OF PERSON NOTING ABOVE [redacted]

M WARD ICU 1

BLOOD OR BLOOD COMPONENT TRANSFUSION
Medical Record

MEDCOM - 23786

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

(b)(6)-2 except very bottom

518–124 NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*
- [x] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of _____ units)*
- [ ] CRYOPRECIPITATE *(Pool of _____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* _____

VOLUME REQUESTED *(If applicable)*
_____ ML

REMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*
- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED: NOV 14, 03

DATE AND HOUR REQUIRED: NOV 14, 03

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:
RhIG TREATMENT? DATE GIVEN: _____
HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)*
[redacted]

DIAGNOSIS OR OPERATIVE PROCEDURE

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER
[redacted]

DATE VERIFIED [redacted]

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. [redacted]

TRANSFUSION NO.

PATIENT NO.

DONOR
ABO B
Rh POS

RECIPIENT
ABO B
Rh POS

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
	COMP

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 14 NOV 03

REMARKS: 5 APH 17 NOV 03

PREVIOUS RECORD CHECK:
- [x] RECORD
- [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST
[redacted]

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*
[redacted]

AT *(Hour)* 1030 ON *(Date)* 14 NOV 03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER *(Signature)*
[redacted] CPT AN

2nd VERIFIER *(Signature)*
[redacted]

PRE-TRANSFUSION
TEMP. 97.1 PULSE 107 BP 172/89

DATE OF TRANSFUSION 14 NOV 03

TIME STARTED

POST-TRANSFUSION DATA

AMOUNT GIVEN 300 ML

TIME/DATE COMPLETED/INTERRUPTED 14 NOV 03

REACTION
- [x] NONE
- [ ] SUSPECTED

TEMPERATURE 98.4

PULSE 111

BLOOD PRESSURE 170/97

If reaction is suspected—IMMEDIATELY:
1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION OF REACTION
- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER *(Specify)*

OTHER DIFFICULTIES *(Equipment, clots, etc.)*
- [x] NO
- [ ] YES *(Specify)*

SIGNATURE OF PERSON NOTING ABOVE
[redacted] CPT AN

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle; grade; rank; rate; hospital or medical facility)
[redacted] (b)(6)-4

SEX M

WARD ICU #1

ICU #1

BLOOD OR BLOOD COMPONENT TRANSFUSION
Medical Record

MEDCOM - 23787

STANDARD FORM 518 (REV. 9–92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201–9.202–1

(b)(6) - 2 except very bottom

518-124

NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

- [x] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of _____ units)*
- [ ] CRYOPRECIPITATE *(Pool of _____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* _____

VOLUME REQUESTED *(If applicable)*

_____ ML

REMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*

- [ ] TYPE AND SCREEN
- [ ] CROSSMATCH

DATE REQUESTED: NOV 14, 03

DATE AND HOUR REQUIRED: NOV 14 03

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)*: [redacted]

DIAGNOSIS OR OPERATIVE PROCEDURE: Chest TUBE GSW

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER: [redacted]

DATE VE[redacted]

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. [redacted] (b)(6)-4

TRANSFUSION NO.

PATIENT NO.

DONOR

ABO B

Rh POS

RECIPIENT

ABO B

Rh POS

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
	Comp

PREVIOUS RECORD CHECK:

- [x] RECORD
- [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST: C

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 14 Nov 03

REMARKS: ECHO 14NOV03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY: [redacted]

AT *(Hour)* 1324

ON *(Date)* 14 NOV 03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER *(Signature)*: [redacted] CPT/MN

2[redacted] RN/AN

PRE-TRANSFUSI[redacted]

TEMP. 9[redacted]

PULSE 114

BP 157/93

DATE OF TRANSFUSION: 14 Nov 03

TIME STARTED: 1336

POST-TRANSFUSION DATA

AMOUNT GIVEN: 350 ML

TIME/DATE COMPLETED/INTERRUPTED: 1605 14 NOV

REACTION

- [x] NONE
- [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
98.5	101	149/92

If reaction is suspected—IMMEDIATELY:

1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION OF REACTION

- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER *(Specify)*

OTHER DIFFICULTIES *(Equipment, clots, etc.)*

- [x] NO
- [ ] YES *(Specify)*

SIGNAT[redacted] CPT/[redacted]

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, midd[redacted]; rank; [redacted] rate; hospital or medical facility)

[redacted] (b)(6)-4

SEX

WARD

ICU #1

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

MEDCOM - 23788

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

(b)(6)-2 all except very bottom

518-124 NSN 7540-00-634-4159

MEDICAL RECORD	BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*
- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of _____ units)*
- [ ] CRYOPRECIPITATE *(Pool of _____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* _____

VOLUME REQUESTED *(If applicable)*
_____ ML

REMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*
- [X] TYPE AND SCREEN
- [X] CROSSMATCH ✓

DATE REQUESTED: 19 NOV 03

DATE AND HOUR REQUIRED: 19 NOV 03 ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:
RhIG TREATMENT? DATE GIVEN: _____
HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)*: [redacted]

DIAGNOSIS OR OPERATION/PROCEDURE: GSW to back

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER: [redacted]

DATE VERIFIED: 19 NOV 03

TIME VERIFIED: 0830

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.: [redacted]

TRANSFUSION NO.

PATIENT NO.

DONOR: ABO B; Rh POS

RECIPIENT: ABO B; Rh POS

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	Comp

PREVIOUS RECORD CHECK:
- [X] RECORD
- [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST: [redacted]

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE: 19 NOV 03

REMARKS: Exp 19 NOV 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*: [redacted]

AT *(Hour)*: 0947 ON *(Date)*: 19 NOV 03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER *(Signature)*: [redacted] CRT/AC

2nd VERIFIER *(Signature)*: [redacted] CRT/AN

PRE-TRANSFUSION
TEMP. 98.3 | PULSE 117 | BP 123/75

DATE OF TRANSFUSION: 19 NOV 03

TIME STARTED: 1600

POST-TRANSFUSION DATA

AMOUNT GIVEN: 250 ML

TIME/DATE COMPLETED/INTERRUPTED: NN/19 03

REACTION
- [X] NONE
- [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
98.2	114	135/64

If reaction is suspected—IMMEDIATELY:
1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION OF REACTION
- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER *(Specify)*

OTHER DIFFICULTIES *(Equipment, clots, etc.)*
- [X] NO
- [ ] YES *(Specify)*

SIGNATURE OF PERSON NOTING ABOVE: [redacted] CRT/AN

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, ... rate; hospital or medical facility)

[redacted] (b)(6)-4

SEX: M

WARD: ICU-1

BLOOD OR BLOOD COMPONENT TRANSFUSION
Medical Record

MEDCOM - 23789

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

(b)(6)-2 except very bottom

518-124

NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of _____ units)*
- [ ] CRYOPRECIPITATE *(Pool of _____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* _____

VOLUME REQUESTED *(If applicable)*

_____ ML

REMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*

- [X] TYPE AND SCREEN
- [X] CROSSMATCH ✓

DATE REQUESTED: 19Nov03

DATE AND HOUR REQUIRED: 19Nov03 ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)*: [redacted]

DIAGNOSIS OR OPERATION/PROCEDURE: GSW to back

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

[redacted]

DATE: 19Nov03

TIME VERIFIED: 0830

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.	TRANSFUSION NO.
[redacted]	PATIENT NO.

DONOR		RECIPIENT	
ABO	B	ABO	B
Rh	POS	Rh	POS

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	Comp

PREVIOUS RECORD CHECK: [X] RECORD [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST: [redacted]

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED — DATE 19Nov03

REMARKS: Exp 19Nov03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*: [redacted]

AT *(Hour)*: 1045 — ON *(Date)*: 19Nov03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER *(Signature)*: [redacted] CPT

2nd VERIFIER: [redacted]

PRE-TRANSFUSION: TEMP. 98.2 — PULSE 115 — BP 137/67

DATE OF TRANSFUSION: 19Nov03 — TIME STARTED: 1042

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle; grade, rank; rate; hospital or medical facility)

[redacted] (b)(6)-4

POST-TRANSFUSION DATA

AMOUNT GIVEN	TIME/DATE COMPLETED/INTERRUPTED
300 ML	19Nov03

REACTION	TEMPERATURE	PULSE	BLOOD PRESSURE
[X] NONE [ ] SUSPECTED	117	98.2	137/61

If reaction is suspected—IMMEDIATELY:

1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION OF REACTION

- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER *(Specify)*

OTHER DIFFICULTIES *(Equipment, clots, etc.)*

- [X] NO
- [ ] YES *(Specify)*

SIGNATURE OF [redacted] ABOVE

SEX: M — WARD: ICU-1

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

MEDCOM - 23790

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

EXAMINATION(S) REQUESTED

CX-RAY in 2 hours to evaluate for PTX - C.T. Removal

AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.

FILM NO.

PREGNANT ☐ YES ☐ NO

REQUESTED BY (Print)

TELEPHONE/PAGER

SIGNATURE OF REQUESTOR

DATE REQUESTED

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

Plan: 1) ~~80~~ KM

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

RADIOLOGIC REPORT

PATIENT'S IDENTIFICATION (For typed or written entries use: Name - last, first, middle, Medical Facility)

[redacted] ICU #1

(b)(6)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT
1 — MEDICAL RECORDS

STANDARD FORM 515 B
Prescribed by GSA/ITMRR
FPMR (41 CFR) 101-11.313

MEDCOM - 23791

NSN 7540-01-165-7294

519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED

KUB

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

FILM NO.

PREGNANT ☐ YES ☐ NO

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

TELEPHONE/PAGE NO.

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

DATE REQUESTED 15 Nov 03

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

Placement of Dobhoff

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

RADIOLOGIC REPORT

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

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION
MEDCOM - 23792

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

(b)(6) - 4 except very bottom

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]

ICU I

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	HOURS	LIST TIME ORDER NOTED AND SIGN
1	11 NOV 03	0943		
2	Admit to ICU Dr. [redacted]			
3	Mx: GSW to back c diaphragm + liver injury			
4	Condition - stable			
5	Activity c Bed rest c HOB elevated @ least 30°			
6	Vitals = per ICU protocol			
7	NKDA (unknown)			
8	Vent Setting = SIMV rate = 14, TV 750 PEEP 5, FiO2 = titrate down as low as possible to keep sat % ≥ 95%			
9	CXR q AM			
10	CT to Chest, Abd/pelvis			
11	Foley to Gravity			
12	NPT to 4 CVS or 4 PVS, whichever is available			
13	IVFs			
14	Diet = NPO			
15	IVF = NS c 20 MEQ KCl/Liter @ 175 c/hr			
16	Tagamet 400mg IVPB q 6h			
17	Tylenol 650mg supp. PR as needed temp ≥ 100.5			
18	Ancef 1gram IVPB q 8°			
19	MSO4 Prn; titrate to effect			
	Versed Prn; titrate to effect			
	CBC; SMA-7 and ABG q AM			

PATIENT IDENTIFICATION

[redacted]

ICU I

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

[redacted]

ICU I

NURSING UNIT | ROOM NO. | BED NO.

(b)(6) - 2

[redacted]

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

(b)(6)-2 unless otherwise noted

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
11NOV03	1737 HOURS	

1. NC [illegible]
2. Zantac 50 mg IVPB q8h

[redacted]

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER
11NOV03	1910 HOURS

1. Δ IVF to NS (NoK+ added)
2. TRK to 20

[redacted]

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER
12 NOV 03	0125 HOURS

V.O.: Dr. Ellison to LT Kari Stewart: 1L NS bolus.

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER
	HOURS

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

(b)(6)-2 unless otherwise indicated

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

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

NURSING UNIT | ROOM NO. | BED NO.

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

13 NOV 03 | 0425

1. Transfuse 2 units PRBC (
V.O. Dr. [redacted]

0545 13 NOV 03 [redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

13 NOV 03 | 1000

1. CXR now for Line placement
2. Increase RL to 200 per hour
3. Place CT to Water Seal
4. D/C II Central line
5. May use LSC Line
6. D/C all Peripheral IV's
7. Infuse each unit of blood over 2 hours

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

NURSING UNIT | ROOM NO. | BED NO.

ICU 1

DATE OF ORDER | TIME OF ORDER | HOURS

13 NOV 03 | 1600

8. Vecuronium 10 mg IVP now
9. Vecuronium Drip 2-5 mg/hr
10. Ativan 1-2 mg/hr and titrate to mean of 4 on Versed

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

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

14 NOV 03 0220

MEDCOM - 23795

(b)(6)-2 unless indicated otherwise

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

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

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
14 NOV 03	1553 HOURS	
(1) Lasix 10mg IV x 1 now		@ 1600 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION [redacted]

DATE OF ORDER	TIME OF ORDER	
19 NOV 03	1612 HOURS	
(1) IVC Advan		[redacted]
(2) Vered Bilj; titrate to effect		

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION [redacted]

DATE OF ORDER	TIME OF ORDER	
14 NOV 03	1816 HOURS	
(1) Heparin 5000 Units SubQ BID		noted 14 NOV 03 1900 [redacted]
(2) Transduce CVP.		

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION [redacted]

DATE OF ORDER	TIME OF ORDER	
14 NOV 03	2231 HOURS	
(1) Liter bolus of NS		noted 14 NOV 03 2230 [redacted]
(2) Δ TVF to D5 NS @ 250cc/hr		

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 72 WHICH MAY BE USED

[redacted]

(b)(6)-2 unless otherwise indicated

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
	14NOV03	0820 HOURS	
1	PC Versed Drip ~ this gag complete		
2	Ativan 2-5 mg /hr ; titrate to appropriate sedation		
3	CXR in 2 hours to evaluate for PTX ~ CT Removal		
4	BID W→Dry Dressing Δ's to Lg A chest wound + back wound		

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

	DATE OF ORDER	TIME OF ORDER	
		HOURS	
5	Transfuse 2 units PRBCs; each over 2 hours		
6	½ Liter NS Bolus x 1 now		
7	Tylenol 650mg PR prior to 1st Unit PRBCs		
8	Benadryl 25mg IV prior to 1st unit of blood		

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

	DATE OF ORDER	TIME OF ORDER	
	14NOV03	1300 HOURS	
1	Give Ativan 10mg IVPx1 now		
2	VO Dr [redacted] / CPT [redacted]		1300

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

	DATE OF ORDER	TIME OF ORDER	
		1345 HOURS	
1	Labetol 20mg x1 now		
	V/O Dr [redacted] / CPT [redacted]		1345

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

(b)(6)-2 unless otherwise indicated

CLINICAL RECORD · DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION [redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICU 1		

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
15 NOV 03	0956 HOURS	

1. Hold Vecuronium Drip. ✓
2. Δ IVF to D5 1/2 NS @ 200cc/hr ✓

done 15 Nov [redacted]

PATIENT IDENTIFICATION [redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICU #1		

DATE OF ORDER	TIME OF ORDER
15 NOV 03	1225 HOURS

1. Labetalol 20 mg IV x 1 now and q6° ✓ Note for [redacted]

PATIENT IDENTIFICATION [redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICU 1		

DATE OF ORDER	TIME OF ORDER
15 Nov 03	1300 HOURS

1. ~~Labetalol 10 mg IVP~~
2. ~~Call Dr if SBP < 110~~

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.
ICU		

DATE OF ORDER	TIME OF ORDER
15 Nov 03	1415 HOURS

1. Labetalol 100 mg po NOT q 6° 1st dose now ✓
2. hold IV labetalol for SBP < 150

15 Nov [redacted]

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

MEDCOM - 23798

(b)(6)-2 unless otherwise noted

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICU 1		

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	15 NOV 03	1625 HOURS	
1	Place DHT ✓		
2	Abdominal X-ray to check placement		
3	Reglan 10mg IVq6° ✓	Noted done 1650	

[redacted]

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICU 1		

	DATE OF ORDER	TIME OF ORDER	
	16 NOV 03	0730 HOURS	
1	D Labetalol to 200mg per NGT BID ✓		
2	Adalat 30mg per NGT BID ✓		

Noted done 0740

[redacted]

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICU 1		

	DATE OF ORDER	TIME OF ORDER	
	16 NOV 03	0846 HOURS	
1	Start TF with Osmolyte @ 10cc/hr ✓		
2	Do Not Advance TF ✓		
3	Flush DHT c 60cc H_2O every 4 hours		
4	D IVF to NS @ 175cc/hr ✓		
5	Hold TF p MN [redacted]		

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

	DATE OF ORDER	TIME OF ORDER	
		HOURS	

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

(b)(c)-2 unless otherwise indicated

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
1		1000 HOURS	
	Maxipime 2gm = 3cc @ 600mg x1 VO Dr [redacted] / CPT [redacted]		
	[redacted]		

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	
	16 NOV 03	1230 HOURS	
1	D/C IV Cathetel / Notified Dr [redacted] 1230 hrs		
	[redacted]		

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	
	16 Nov 03	HOURS	
1)	Albuterol 2.5/3.0 cc neb @ 4 hrs		
2)	Atrovent neb @ 8 hrs		
	[redacted]		

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	
	16 Nov 03	HOURS	
	Cipro 400mg IV @ 12 hrs		
	[redacted]		

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(b)(6)-2 unless otherwise indicated

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] (6)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

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

16NOV03

Lasix 40mg IVP

10 MIVFs to 25cc/hr

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

16NOV03 2240

(1) Increase PEEP to 15

(2) ABG in 30 minutes

[redacted]

240 17NOV03 0400 [redacted]

PATIENT IDENTIFICATION

[redacted] (6)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

17NOV03 0826

(1) Bolus 1 L. to NS now

(2) ↑ IVF to 250cc/hr

(3) Restart TF @ 10cc/hr

(4) Flush DHTE 60cc H2O q 4

(5) Cancel bronchoscopy today

(6) ↓FiO2 to keep Sat% ≥ 93%

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

17NOV03 1407

(1) Dobutamine drip @ 5mcg/kg/min NJR

(2) Zosyn 3.375 grams IVPB q 6° NJR

[redacted]

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

MEDCOM - 23801

(b)(6)-2 unless otherwise noted

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 17 NOV 03 TIME OF ORDER 2232 HOURS — LIST TIME ORDER NOTED AND SIGNED

2230 (1) 1 Liter NS bolus x 1 now — noted 17 NOV 03 2305

[redacted]

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 18 NOV 03 TIME OF ORDER 0024 HOURS — noted 18 NOV 0055

0025 (1) 1 Liter NS bolus x 1 now

(2) ↑ MIVF to 300 cc/h

V.O [redacted]

240 V 18 NOV 03 0315 [redacted]

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 18 NOV 03 TIME OF ORDER 0311 HOURS — noted 18 NOV 03 0315

(1) Lasix 40 mg IV x 1 now

(2) ↓ IVF to 200 cc/h

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 18 Nov 03 TIME OF ORDER 0930 HOURS

(1) D/C Adalat ✓ Now Due HOD

[redacted]

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

(b)(6)-2 unless otherwise noted

CLINICAL RECORD · DOCTOR'S ORDERS

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

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

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

NURSING UNIT | ROOM NO. | BED NO.

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

18 Nov 03 1400 HOURS

① Lasix 80mg IVP x1 V.O

[redacted]

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

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

18 Nov 03 HOURS

② Dopamine 5mcg/kg/min

[redacted]

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

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

18 Nov 03 1600 HOURS

③ o/c Labetalol

[redacted]

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

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

18 NOV 03 1630 HOURS

④ Lasix 35mg IV x 1 now

[redacted]

2hr check

1159 19 Nov 03

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

(b)(6)-2 unless otherwise indicated

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 19 NOV 03 TIME OF ORDER 1816 HOURS

LIST TIME ORDER NOTED AND SIGN

(6) Lasix drip @ 4 mg/hr

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER 19 Nov 03 TIME OF ORDER HOURS

1) 24 PASC nsw ✓
2) TC if needed ✓
3) 6 Amps Bicarb nsw ✓
4) ↑ 30 Fluids/min
5) Repeat ABG after Aline placed

[redacted]

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

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER 19 Nov 03 HOURS

Pharm Consult
Pt est wt = 80kg; age = 30yrs.
Cr = 5.2 (19 Nov 03)
Est CLcr = 23 mL/min
Rec: ① Zosyn 2.0gm q6°
② Cipro 400 mg q24
③ Zantac 50mg IVPB q24°

[redacted]

Dr noted → Shower [redacted] Dr see rec following Orders.

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

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER 19 NOV 03 TIME OF ORDER 1647 HOURS

(1) Δ Zosyn to 2 gram IVPB q6° ✓
(2) Δ Cipro to 400mg IVPB q12° ✓
(3) Δ Zantac 50mg IVPB q24° ✓
(4) ~~Titrate~~ Decrease IVF to 150cc/hr and Δ to ~~D5 1/2 NS~~ D5W with 4 amps NaHCO3 per liter

[redacted]

None @ 1300

(b)(6)-2 unless otherwise indicated

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.
ICU1		

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	19 Nov 03	1250 HOURS	
1	Cipro IV to 400mg IVPB q 24° from 96°		
2	D5W c 3 Amp NaHCO3 per (L) c 150cc/L VO Dr [redacted]		
3	GIVE 4Amps NaHCO3 VO Dr [redacted]		

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER HOURS

4 Increase Bolus to 1.0mg/kg/hr Done @ 1550 Note /Bmcle

19 Nov 03 1259 [redacted]

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER 20 NOV 03 TIME OF ORDER 0725 HOURS

1 Increase TF to 30cc/hr Done [redacted]

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER 20 NOV 03 TIME OF ORDER 0782 HOURS

1 No CPR. No chest compressions, No increase in pressors; No defibrillation. Pt is A+ DNR

[redacted]

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

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CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(6)(6) - 4

[redacted]

NURSING UNIT: ICU1 | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	20 NOV 03	1900 HOURS	
1	N/C Norpramin + Robutrex		
2	N/C Zoloft		
3	Imipenem 250mg IVPB q6°		

[redacted]

1930 20 Nov 03

PATIENT IDENTIFICATION

(6)(6) - 2

24 hr / 2345 20 Nov 03

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

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

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

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

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

NURSING UNIT | ROOM NO. | BED NO.

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

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(b)(6) - 2 unless otherwise indicated

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 21 NOV 03 TIME OF ORDER 1606 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Maximally concentrate all drips & fluids
2. Decrease
3. Decrease Bicarb drip to 100 d/c

noted 1603 21 Nov 03 [redacted]

24°V / 21 Nov 03 2245 [redacted]

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 22 NOV 03 TIME OF ORDER 1604 HOURS

1. D/C Ancef
2. D/C Cipro
3. D/C Imipenem
4. Change TVF to 0.5 NS @ 100 cc/hr d/c bicarb drip
5. D/C 4AM CXR
6. D/C Tube feeds

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

7. D/C Lasix drip

DATE OF ORDER TIME OF ORDER HOURS

noted 1630 22 Nov 03 [redacted]

24°V / 22 2050 Nov 03 [redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

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

MEDCOM - 23807

(b)(6)-2 except very bottom

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

VERIFY BY INITIALING

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED (18 12 13 14 15 16 17 18 19 20 21 22)
14/1K	[redacted]	Diet: NPO	06	[redacted]
			18	
14/11	[redacted]	CBC, SMA-7, ABG in AM	04	[redacted]
14/11	[redacted]	↑ RR to 20	06	[redacted]
			18	
13 Nov	[redacted]	CT to Water Seal	06	[redacted]
			18	
14 AM		Blow → Dry Dsg	10	[redacted]
		Δs to (R) chest wound	22	
		+ back wound		
11 NOV	[redacted]	CXR q AM	01	[redacted]
14 NOV	[redacted]	Transduce CVP	06	[redacted]
			10	
[redacted]	[redacted]	START TF @ 3ml/hr	06	[redacted]
17 Nov	[redacted]	@ 10cc/L DO NOT	18	
		ADVANCE TF @		
		30cc/H		
16 Nov	[redacted]	Flush DHT c Ldpac	04	[redacted]
17 Nov	[redacted]	H2O q 4hrs	08	
			12	
			16	
			20	
			24	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ____

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

(6)(6) - 2 all

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)			Mo ____ Yr 2003	
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
11/16	[redacted]	~~Diet~~ Place DHT	15MIN	1620	1620	[redacted]
11/15	[redacted]	~~AND~~ ~~XRAY~~ - KUB for Placement	15MIN	ASAP		
11/16	[redacted]	Hold TF p MN ~~9~~ 7a	11/16	~~0000~~	2400	[redacted]

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

(b)(6)-2 except very bottom

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

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED (11 12 13 14 15 16 17 18 19 20 21 22 23)
11/11	[redacted]	Activity c Bedrest	06	[redacted]
		c HOB elevated 30°	18	
11/11	[redacted]			
11/11	[redacted]	Vitals Q 1°	06	[redacted]
			18	
11/11	[redacted]	NKDA (unknown)		
11/11	[redacted]	NKDA (unknown)	06	[redacted]
			18	
11/11	[redacted]	Vent setting: SIMV	06	[redacted] > Ad 16 Oct
		RR 14 TV 450 peep 5	18	
		FiO2 = intake ↓ as low as possible to keep Sats % ≥ 95%		
11/11	[redacted]	CXR 9 AM	06	[redacted] > Reorder
			18	
11/11	[redacted]	CT to 20cm, wall suction	06	[redacted] > Ad 13 Nov 03
			18	
11/11	[redacted]	Foley to gravity	06	[redacted]
			18	
11/11	[redacted]	NGT to LCWS or LIS; whichever is available	06	[redacted]
			18	
11/11	[redacted]	I/O	06	[redacted]
			18	[redacted]

ALLERGIES: ☐ YES ☐ NO | PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ____

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

EPW vs CI

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

(b)(6)-2 all

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)		Mo ____ Yr 2003		
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
11/11	[redacted]	Admit to ICU under DR [redacted]	11/11	ASAP		[redacted]
11/11	[redacted]	Dx GSW to back c diaphragm/liver injury	11/11	ASAP		[redacted]
11/11	----	Condition stable	11/11	NOW		[redacted]
13Nov	[redacted]	CXR for Line Placement	13Nov	Now	1138	[redacted]
13Nov	[redacted]	DC IJ Central Line	13 Nov	Now	1215	[redacted]
13 Nov	[redacted]	DC all peripheral IVs	13NOV	done		
14 NOV	[redacted]	↑RR to 20 ~~minutes~~ per minutes	13NOV	done		
14 NOV	[redacted]	May use LSC line	13NOV	done		
14 NOV	[redacted]	CXR in 2hr to eval pt for PTX	14NOV	1400	1130	[redacted]
	----	p CT removal				
16NOV	[redacted]	↑ peep to 15	16NOV	done	2246	[redacted]
16NOV	[redacted]	ABGin 30min	16NOV	done	2304	[redacted]
17NOV	[redacted]	cancel tracheostomy today	17NOV	done		
19	[redacted]	Repeat ABGs p transfuse	19NOV	ASAP	Done	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED
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(b)(6)-2 except very bottom

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 16	17	18	19	20	21	22	23
16 Nov 03	[redacted]	Vent: See RT sheet for setting As	06								
			18								
17 Nov	[redacted]	↓ FiO2 to keep Sat ≥ 93%	06								
			18								
10 Nov Received 11 Nov	[redacted]	CBC, SMA-7, ABG in AM	04								
10 Nov Received 14 Nov	[redacted]	W→ Dry as 3's to anterior wound + back wound BID	10								
			22								
10 Nov Received 14 Nov	[redacted]	Translate CVP	06								
			18								
10 Nov Received 17 Nov	[redacted]	Flush Dobhoff c 60cc H2O q 4°	04								
			08								
			12								
			16								
			20								
			24								
10 Nov Received 11 Nov	[redacted]	Activity: Bedrest c HOB elevated 30°	06								
10 Nov Received 11 Nov	[redacted]	Vitals q 1°	18								
			06								
			18								
10 Nov Received 11 Nov	[redacted]	Foley to gravity	06								
			18								
10 Nov Received 11 Nov	[redacted]	NGT to LCWS or LTS; whichever is available	06								
			18								
10 Nov Received 11 Nov	[redacted]	I/O	06								
			18								

ALLERGIES: ☐ YES ☐ NO	PRIMARY DIAGNOSIS:	ADDITIONAL PAGES IN USE: ☐ YES ☐ NO PAGE NO: ____

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

MEDCOM - 23812

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 20	21	22	23
10 NOV	[redacted]	NO CPR NO CHEST COMPRESSIONS, NO INCREASE IN PRESSORS, NO DEFRIBILLATION; PT IS A DNR	04 18	[redacted]			

(6)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[redacted] (6)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

(6)(6)-2 except very bottom

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

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 11 12 13 14 15 16 17 18 19 20 21 22 23 24
11/11	[redacted]	1VF = NS @ 20 MEQ	06	/ [redacted]
		KCL / L @ 175cc/h	18	[redacted]
11/11	[redacted]	TAGAMET 400mg IVPB	03	/
		Q6	09	/
			15	/
			21	
N 11/11	[redacted]	Ancef 1 gram IVPB	06	[redacted]
		q 8°	14	
			22	
11/11	[redacted]	MSO4 / drip Titrate	06	[redacted]
		to effect	18	
11/11	[redacted]	Versed Drip titrate	06	[redacted] 14 Nov 03
		to effect (Wean)	18	
C 11/11		Zantac 50mg IVP	16	[redacted]
		Q8°	24	
			08	
13 Nov 03	[redacted]	Vecuronium Drip	06	/ / [redacted]
		2.5mg/hr	18	/ / [redacted]
13 Nov 03	[redacted]	Ativan 1-2mg/hr and	06	/ / [redacted] 14 Nov 03
		try to wean off versed	18	/ / [redacted]
14 Nov 03	[redacted]	Ativan 2-5mg/h ;	06	/ / [redacted] D/C 14 Nov 03
		titrate to appropriate sedation	18	/ / [redacted]
14 NOV	[redacted]	D/C IVF. to D5NS @ 250cc/°	06	/ / / [redacted] D/C 15 NOV 03
			18	/ / / [redacted]

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:

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

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

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

MEDCOM - 23814

(b)(6)-2 all

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)			Mo. 11 Yr. 03	
Order Date / Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
12NOV [redacted]	1L NS bolus	12NOV	NOW	0175	[redacted]
13NOV [redacted]	Transfuse 2units PRBCs' ①	13NOV	ASAP	1030	[redacted]
~~13Nov~~ [redacted]	over2° ②	13NOV		1245	[redacted]
13Nov [redacted]	Vecuronium 10mg IVPT now	13 Nov	Now	0830	[redacted]
14NOV [redacted]	D/C Versed drip PD bag completed	14Nov	Now	1015	[redacted]
14Nov [redacted]	Transfuse 2units PRBCs; eachover	14Nov	ASAP	①1030 ②1300	[redacted]
	2hours				
14Nov [redacted]	1Liter NS Bolus x 1 Now	14Nov	ASAP	0800	[redacted]
14Nov [redacted]	Tylenol 650mg PR prior to 1st	14Nov	ASAP	1030	[redacted]
	unit of PRBCs				
14Nov [redacted]	Benadryl 25mg IV prior to 1st	14Nov	ASAP	1030	[redacted]
	Unit PRBCs				
14Nov [redacted]	Ativan 10mg IVP x1 Now	14/Nov	1700	1300	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED													
[redacted]	[redacted]	Tylenol 650mg/Supp D	11 Nov	13 Nov												
		PR as need temp I	2220 KS	1000 CP												
		≥ 100.5 T														

USAPA V1.00

(b)(6)-2 except very bottom

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 14 15 16 17 18 19 20 21 22 23
14Nov	[redacted]	Versed Drip, titrate to effect	06	[redacted]
			18	[redacted]
14Nov	[redacted]	heparin 5000 units SQ BID	08	[redacted]
			20	[redacted]
15Nov03	[redacted]	D5 ½NS @ 200cc/h	06	[redacted] D/C 11/16/03
			18	[redacted]
15Nov03	[redacted]	labetalol 20mg IVP q6°	06	[redacted]
		Hold IV labetalol for SBP <150	06	[redacted] D/C 11/16/03
			12	[redacted]
			18	[redacted]
15Nov	[redacted]	labetalol 100mg per NGT q 8°	06	[redacted]
			14	[redacted] see Δs
			22	[redacted] D/C 11/16/06
15Nov	[redacted]	Reglan 10mg IV q 6°	06	[redacted]
			12	[redacted]
			18	[redacted]
			24	[redacted]
16Nov	[redacted]	Labetalol 200mg per NGT BID	08	[redacted] D/C 11/16/03
			20	[redacted]
16Nov	[redacted]	Adulat 30mg per NGT BID	08	[redacted] D/C 11/18/03
			20	[redacted]

ALLERGIES: ☐ YES ☐ NO | PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ___

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

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

D 7 8 9 10 11 12 13 14

E 15 16 17 18 19 20 21 22

N 23 24 01 02 03 04 05 06

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

MEDCOM - 23816

(b)(6)-2 all

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. ____ Yr. ____
Order Date / Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
14Nov [redacted]	Labetalol 20mg IVP x1 now	14Nov	1800	1800	[redacted]
14Nov [redacted]	Lasix 40mg IV x 1 now	14Nov	1600	1600	[redacted]
14Nov [redacted]	D/C Ativan	14Nov	1615	1615	[redacted]
14Nov [redacted]	1 liter bolus of NS	14Nov	2230	2300	[redacted]
15Nov [redacted]	Hold Vecuronium Drip	15Nov	1000	1000	[redacted]
15Nov [redacted]	Labetalol 20mg IVP now	15Nov	now	now	[redacted]
15Nov [redacted]	Labetalol 100mg tab NGT now	15Nov	1400	now 1400	[redacted]
16Nov [redacted]	Mucomyst-20 600mg = 7cc x 1 now	16Nov	1030	1030	[redacted]
16Nov [redacted]	Vecuron. c.ine 10mg Bolus Now	16Nov	1545	1600	[redacted]
16Nov [redacted]	Lasix 40mg IV x 1 now	16Nov	2045	2047	[redacted]
17Nov [redacted]	1 Liter NS bolus x 1 now	17Nov	2230	2230	[redacted]
18Nov [redacted]	1 Liter NS bolus x 1 now	18Nov03	0025	0025	[redacted]
18Nov [redacted]	Lasix 40mg IV x 1 now	18Nov03		0314	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
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USAPA V1.00

(b)(6)-2 all

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 16 17 18 19 20 21 22
11/16	[redacted]	IVF to NS @ 175 cc/h	06	[redacted] D'd 16 NOV 03
			18	
11/16	[redacted]	Albuterol 2.5/3.0cc Neb Q4°	08	[redacted]
			12	
			16	
			20	
11/16	[redacted]	ATROVENT Neb Q8°	06	[redacted]
			14	
			22	
11/16	[redacted]	Cipro 400mg IV Q12	08	[redacted] 19 NOV 03 D/cd @ 1300
			20	
11/16	[redacted]	Vecuronium @ 4mg/h	06	[redacted]
			18	
11/16/03	[redacted]	VMIVF (NS) to 25cc/h	06	[redacted]
			18	
		1 IVP NS to 250cc/h	06	[redacted] DC 18 NOV 03
	[redacted] 03	300cc/h 200cc/h	18	
17 NOV	[redacted]	Dobutamine drip:	06	[redacted] DC'd 20 Nov 03 1430
		5 mcg/kg/min	18	
		10 mcg/kg/min		

ALLERGIES: ☐ YES ☐ NO	PRIMARY DIAGNOSIS:	ADDITIONAL PAGES IN USE: ☑ YES ☐ NO PAGE NO. ___

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

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

MEDCOM - 23818

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	
DNW	[redacted]	Bolus 1 liter NS now	DNW	NOW			

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

USAPA V1.00

(b)(6)-2 except very bottom

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 19	20	21	22	23
19 Nov	[redacted]	Zosyn 2.gm IVPB q6°	06	/	[redacted]			
			12	/				
			18	[redacted]				
			24	[redacted]				
19Nov	[redacted]	Cipro 400mg IVPB q 24°	20	[redacted]				
19Nov	[redacted]	Zantac 50mg IVPB q 24°	08	/ [redacted]				
19Nov		D5W c 3 Amps NaHCO3 per Liter @ 150cc/h	06	[redacted]				
			18	[redacted]				
18Nov	[redacted]	Dopamine 3mcg/kg/hr	06	[redacted]				
			18	[redacted]				
18Nov	[redacted]	Lasix 40mg/hour	06	[redacted]				
			18	[redacted]				
		Imipenem						
20	[redacted]	[redacted]	06	X X [redacted]				
			12	X X				
			18	X X				
			24	X [redacted]				
21Nov	[redacted]	1/2 NaHCO3 gtt to 100cc/hr	06	/ [redacted]				
			18	/ [redacted]				

DC'd 20 Nov 03 1930

ALLERGIES: ☐ YES ☐ NO | PRIMARY DIAGNOSIS: | ADDITIONAL PAGES IN USE: ☐ YES ☐ NO PAGE NO. ___

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

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

MEDCOM - 23820

(b)(6)-2 all

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)			Mo. ____ Yr. ____	
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
18Nov	[redacted]	Lasix 80mg IVP x 1	18Nov	1400	1488	[redacted]
18Nov	[redacted]	Lasix 350mg IVP x 1 NOW	18Nov	NOW	1700	[redacted]
19Nov	[redacted]	T+C if necessary	19Nov	NOW	0806	[redacted]
19Nov	[redacted]	2 U PRBC NOW	19Nov	NOW	①1000 ②1155	[redacted]
19Nov	[redacted]	6 Amps Bicarb now	19Nov	0815	0815	[redacted]
19Nov	[redacted]	4 Amps Bicarb NOW	19Nov	1200	1200	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED
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USAPA V1.00

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CLINICAL RECORD

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

Mo.___ Yr.___

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 21	22
21Nov	[redacted]	Maximally concentrate all drips & fluids	06	[redacted]	
			18	[redacted]	
22Nov	[redacted]	D IVF to D5NS @ 100cc/hr	06	/	[redacted]
			18	/	[redacted]
22Nov	[redacted]	Zantac 50mg IVPB q 24°	08	/	/
Reapplied 19Nov					
22Nov	[redacted]	MSIV gtt titrate to effect	06	/	/
Reapplied 19Nov			18	/	[redacted]
22Nov	[redacted]	Versed gtt titrate to effect	06	/	/
Reapplied 19Nov			18	/	[redacted]
22Nov	[redacted]	Heparin 5000 Units SQ BID	08	/	/
Reapplied 19Nov			20	/	[redacted]
22Nov	[redacted]	Reglan 10mg IV q6°	06	/	/
Reapplied 15Nov			12	/	/
			18	/	[redacted]
			24	/	[redacted]

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

[redacted]

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

D 7 8 9 10 11 12 13 14

E 15 16 17 18 19 20 21 22

N 23 24 01 02 03 04 05 06

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

MEDCOM - 23822

MEDICATION ADMINISTRATION RECORD

(ALL ENTRIES MUST BE PRINTED)

(THIS FORM IS SUBJECT TO THE PRIVACY ACT OF 1974 · Use Blanket PAS · DD Form 2005)

DATES ORDER	DATES RENEWAL	MEDICATION, DOSE, FREQUENCY	HOUR	DATE GIVEN
11 Nov 03		Diprivan - 25 mcg/kg/min	start	
		Dose 12 gtts/min	0505 L	11 Nov 03
11 Nov 03	—	MSO4 5mg IVP x1	0610 L	—
11 Nov 03	—	MSO4 5mg IVP x1	0625 L	—
11 Nov 03	—	Vecuronium 10mg IVP x1	0600	—
11 Nov 03		Morphine 5mg IV PRN	0730 L	
11 Nov 03		Ancef 1gm I.V x1	0830 L	
11 Nov 03		morphine 5mg I.V. x1	0835 L	

PLATE IMPRINTER

BED NAME

CHECK IF A SECOND PAGE IS IN USE

P - PASS

* - REFER TO NURSING NOTES

ALLERGIC TO

DIAGNOSIS

TIME

24 01 02 03 04 05 06 07 08 09 10 11 12 13 14 15 16 17 18 19 20 21 22 23

AF FORM 3069, OCT 84 (EF-V (PerFORM PRO) PREVIOUS EDITION WILL BE BE USED.

A RE RD-SUPPLEMENTAL A

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89

		SHIFT ASSESSMENT	
		TIME: 0645 INITIALS: [redacted]	TIME: 1830 INITIALS: [redacted]
NEURO	PUPILS	2mm PERRL	2mm PERRL. Pt has scleral
	SENSORIUM	Sedated c Morphine + Versed	edema greater in Left eye. Pt
	EXTREMITY MOVEMENT	to effect	has 4mg/hr Versed for sedation
	SEDATION		& 4mg/hr of MSO4 for pain control
	PAIN CONTROL		
RESP	RESPIRATORY PATTERN	VENT: PEEP 5 TV 750 RR 15	Vent, RRR equal rise & fall
	BREATH SOUNDS	FIO2 35% SaO2 98%	of chest, lung sounds coarse in
	SECRETIONS	ETT 26 @ lips	all fields. Vent set @ 750 TV,
	O2 SOURCE/FLOW/SAO2		PEEP of 5. FIO2 of 35%, RR 15. Pts
	VENTILATOR SETTINGS		ET tube is 26 @ lips.
CV	CARDIAC RHYTHM	S1S2 HR 120's	S1S2 normal w ectopy / murmurs noted.
	CAPILLARY REFILL		Pt has strong Pulses in all 4 extremities
	PULSES		cap refill < 2 sec. Pt has generalized
	EDEMA		edema throughout.
GI	ABDOMEN	Hyperactive BS x 9 quads	Pt does not respond when stomach is
	BOWEL SOUNDS	NG tube to LIS	palpated BS x 4 quads. NO BM
	BOWEL MOVEMENT	Abd soft + non distended	on shift. Pt has NG tube to LIS
	NGT/OGT		NPO.
	TUBE FEDDINGS		
	DRAINS		
GU	VOIDING	Foley to Gravity	Pt has foley to gravity DS, clear
	COLOR/CLARITY	clear yellow urine	yellow urine. no S/S of infection of
			foley
SKIN	COLOR	NFR DSG to midline	NFR c chest tube in (R) side, dressing
	INTEGRITY	abdomen CDI	CDI. mid line abdominal wound,
			dressing CDI.
ACCESS	#1 TYPE/LOCATION/SIZE	A line to (L) Radial	Pt has (R) cordis c NS @ 175cc/hr.
	DRESSING CONDITION	Cordis to (R) IJ NS @ 175cc/hr	Pt has (L) radial A-line zeroed.
	IV FLUID/RATE	Site CDI	site shows no signs of infection.
	#2 TYPE/LOCATION/SIZE		
	DRESSING CONDITION		
	IV FLUIDS/RATE		

(Continue on reverse)

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

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

DATE 12 Nov 03

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

NAME: (b)(6)-4 RANK: AGE:

UNIT [redacted] GENDER: M

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 - 23824

USAPPC V2.00

ICU1

Patients Name: _____ Date: _____

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	128/77	124/77	134/70	129/76	146/76	139/74	145/73	137/75	140/76	132/71	132/74	140/80		139/76	119/68 118/94	128/78 159/79	134/70	140/79	134/74	141/76	133/81			134/61	133/80
TEMP	100.1	100.1	100.4	100.4	100.7	101.3	101.3	101.3	101.5	101.3	101.6	101.9		101.8	101.5	101.8	101.3	101.9	101.5	101.2		100.2	100.4	100.4	100.7
HR	125	125	128	128	134	136	139	136	136	135	138			139	142	144	144	145	134	131	125	123	120	117	120
RR	15	19	18	24	21	17	21	13	15	16	16	17		12	18	27	26	30	28	27	18	17	18	18	16
SaO2	98	97	97	98	98	97	97	98	98	100	98	97		94	94	95	94	100	100	100	100	100	100	100	100
FiO2	40	35	35	35	35	35	35	35	35	35	35	35		35	35	35	35	100	85	80	64	64	64	64	64
Source	V	VENT	VENT	VENT	VENT	VENT	VENT	VENT	VENT	VENT	VENT	VENT		VENT	V	V	V	V	V	V	V	V	V	V	V
AP	98	100	99	99	98	99	102	97	101	100	96	104		94	103	105	99	102	101	101	100	110	100	111	99

I AKE	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	T
IVF	175	175	170	175	175	175	175	175	175	125	175	175	2188	175	175	175	175	175	175	175	175	175	175	175	175	2
IVPB	0	0	50	0	0	0	50	0	0	0	50	0	150	0	0	50				50				50		1
NGT	0	0	0	0	0	0	0	0	0	0	0	0	0	0												
MSO4	3	3	3	2	5	5	5	5	4	4	4	4	49	4	4	4	4	4	4	4	4	4	4	4	4	5
Versed	2	2	2	4	6	6	6	6	4	4	4	4	52	4	4	4	4	4	9	9	9	9	9	9	9	8
Bolus	0	0	0	0	0	0	0	0	0	0	0	0	0	0					100							1
Total													2351													3381

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE	50/50	85/185	170/355	120/475	160/635	135/770	160/930	100/1030	100/1130	140/1270	170/1440	175/1620	1620	150/1770	90/1860	70/1930	120/2050	100/2150	110/2260		130/2390	200/2590	120/2710	150/2860	120/2980	1370
STOOL																									130	130
DRAIN																										
CT①																										
Total																										

RECORD-SUPPLEMENTAL ME[illegible]TA

For use of this [illegible]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

SHIFT ASSES[illegible]

		TIME: 0730 INITIALS: [redacted]	TIME: INITIALS:
NEURO	PUPILS	PUPILS 2mm PERRL	2mm PERRL
	SENSORIUM	pt sedated c Morphine +	pt on 10mg/hr Versed,
	EXTREMITY MOVEMENT	Versed	7mg/hr MSO4, will
	SEDATION		continue to monitor
	PAIN CONTROL		sedation
RESP	RESPIRATORY PATTERN	VENT - PEEP-5 TV-750 RR-18	Vented PEEP 5, TV
	BREATH SOUNDS	FIO2-65%. Ronchi throughout	750, RR 18, FIO2 60%
	SECRETIONS		SAT's @100%.
	O2 SOURCE/FLOW/SAO2		thick white secretion
	VENTILATOR SETTINGS		through ETT. Ronchi
			throughout B/L.f
CV	CARDIAC RHYTHM	S1 S2 +2 pulses x4 extremities	S1 S2 (+) pulses to ↑ ↓
	CAPILLARY REFILL		extremities. <3sec
	PULSES		cap refill.
	EDEMA		
GI	ABDOMEN	Hypoactive BS x 4 quads	(+)BS x4 quad
	BOWEL SOUNDS	Abd soft + non-distended	hypoactive
	BOWEL MOVEMENT	NGT to LIS to (R) nare	soft round non distended
	NGT/OGT		NGT to LIS.
	TUBE FEDDINGS		
	DRAINS		
GU	VOIDING	Foley to gravity	Foley to gravity
	COLOR/CLARITY	clear yellow	clear yellow urine
SKIN	COLOR	NFR CT tube to 20cm	NFR
	INTEGRITY	Suction (R) side chest	Midline ~~Bruises~~ to abd,
		Midline Abd DSG site CDI	Dressing CDI. CT to
			(R) Flask on water seal.
ACCESS	#1 TYPE/LOCATION/SIZE	Cordis to (R) IJ NSG	TL to (R) SC (P) flush all
	DRESSING CONDITION	175 cc/hr SITE CDI &	ports NS to Blue port c
	IV FLUID/RATE	redness	NS @ 175cc/hr c fentanyl
	#2 TYPE/LOCATION/SIZE	A-line to (L) Radial Site	IVPB, Keep to White port.
	DRESSING CONDITION	CDI & redness	Brown port clamped. A line
	IV FLUIDS/RATE		to (L) Radial (A)

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC: ICU #1 [redacted] (b)(6)-2

DATE: 13 Nov 03

PATIENT'S 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: M

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 - 23826 USAPPC V2.00

ICU1

Patients Name: [redacted] (b)(6)-4

Date: 13 NOV 03

Started for pump 14 NOV 03 1700

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	144/70	141/64		149/66	139/78	165/79	148/87	164/89	132/76	135/78	135/83	134/78		130/74	138/80	137/66	114/66	111/64	173/90	165/83	112/67	99/65			93/62
TEMP	98.8		99.9		100.2	100.4	101.3	101.9	102.3	101.5	102.2			101.5		101°		99.5		99.6		99.8		99.1	
HR	175	123	120	130	123	135	142	144	140	134	138	138		131	132	127	121	120	130	138	127	114	113	111	106
RR	18	34	18	18	31	20	25	28	27	20	37	28		19	18	18	18	18	20	19	18	18	18	16	20
SaO2	99	100	100	100	100	100	97	96	99	100	100	99		100	99	100	100	100	95	93	97	98	99	97	99
FiO2	60	65	65	65	60	60	60	60	60	60	60	60		60	60	60	60	60	60	60	60	60	60	60	60
Source	V	VENT	VENT	VENT	VENT	VENT	VENT	VENT	VENT	VENT	VENT	VENT		VENT	V	V	V	V	V	V	V	V	V	V	V
MAP	97	99		97	108	111	121		102	103	104	99		96	123	86	86	88	124	116	74	70	65	71	73

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
	175	175	175	175	175	175	175	175	175	175	175	175	2100	175	175	175	175	175	175	175	175	175	175	175	175	2100
B	0	0	50	0	0	0	50	0	0	0	0	50	150	0	0	0	0	50	0	50	0	0	0	0	0	100
r	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Aseed	9	9	9	9	9	9	9	9	10	10	10	10	112	10	10	10	6	6	4	4	8	8	8	10	6	74
45@4	4	4	4	4	4	4	4	7	7	7	7	7	63	7	7	7	7	7	7	7	7	7	7	7	7	84
Flus	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
C	0	0	0	0	0	372 370	370	0	0	0	0	0	742	0	0	0	0	0	0	0	0	0	0	0	0	0
c															2	2	2	2	2	2	2	2	2	2	2	24
Ativan														3167	1	1	1	1								4
PO																										
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE	140 140 150	140 280	140 420	150 570	140 710	100 810	100 910	150 1060	100 1160	100 1260	95 1355	100 1455	1455	120 120	100 220	120 340	100 440	100 540	124 664	100 764	100 880	120 1000	100 1100	110 1210	120 1330 1450	
STOOL																										
DRAIN										3167 in 1455 out																
										+1712																
CT																										
Total																										

IN: 2386

out: 1780

+ 606

(b)(6)-4

ICU1 Patients Name: [redacted] Date: 15NOV03

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																				147/63	146/94	159/100	148/95	155/85	151/87
NBP																									
TEMP																				98.2	98.3	98.9	98.7	98.9	98.6
HR																				107	112	111	116	112	117
RR																				19	10	16	20	26	20
SaO2																				100%	100%	100%	99%	97%	96%
FiO2																				45%	40%	40%	40%	40%	40%
Source																				vent	vent	vent	vent	vent	vent
MAP																				113	118	120	116	112	100
L P																				5	5	5	5	5	5
																				42	41	44	40	47	46
P																				12	9	14	13	13	19

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	
IVF																					250	250	250	250	250	
IVPB																				500						
NGT																										
MSO4																				7	7	7	7	7	7	
Versed																				5	5	7	7	7	7	
Vec																				3	3	3	3	3	3	
bolus																				bolus cont'd.						
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	Tot
URINE																				95/95	100/195	115/310	85/395	120/515	70/585	580
T																									405	405
STOOL																										
DRAIN																										
Total																										

Total in: 7116 Total out: 3313 (+4003)

MEDCOM - 23828

RE RD-SUPPLEMENTAL ME DA A

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

REPORT TITLE: INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date): QA Appr 8 Mar 89

		SHIFT ASSESSMENT	
		TIME: 1700 INITIALS: [redacted]	TIME: 1820 INITIALS: [redacted]
NEURO	PUPILS	2+	1+ slow
	SENSORIUM	fully sedated	sedated on versed 2mg
	EXTREMITY MOVEMENT		No voluntary movement
	SEDATION	Versed + MSO4 titrate to sedation	versed 2mg, MSO4 1mg
	PAIN CONTROL		MSO4
RESP	RESPIRATORY PATTERN	BBS ET #8 26@ the lip	BBS. ETT #8.0 26cm VSP
	BREATH SOUNDS	CTA ↓ BS (R) side	URight. dim. Vest.
	SECRETIONS	thick brownish	
	O2 SOURCE/FLOW/SAO2	Vent	vent: Fio2 50% PEEP 5 RR 14
	VENTILATOR SETTINGS	SIMV 14, Peep 5, FIO2 100% ↓ to maintain sat ≥ 95%.	to keep sao2 ≥ 95%.
CV	CARDIAC RHYTHM	ST 119 c pelopy	ST 128
	CAPILLARY REFILL	sluggish	<3sec
	PULSES	weak but palpable.	2+ palpable.
	EDEMA	insignificant on admission	Generalized 1+
GI	ABDOMEN	hyperactive BS, abd wound	hyperactive. soft c DRSG. midline C/D/I.
	BOWEL SOUNDS	sept	BS hypo. c no BM
	BOWEL MOVEMENT	0	LWIS
	(NG) OGT	LWIS	0
	TUBE FEDDINGS	0	CT CWS
	DRAINS	CT to CWS	
GU	VOIDING	foley to gravity QS	foley clear yellow
	COLOR/CLARITY	>100cc/hr clear yellow urine	>100cc/hr.
SKIN	COLOR	WNL for race	NFR. ABD. Dressing CDI
	INTEGRITY	Abd draining 2° wound (R) med axillary CT dressing.	CT dressing reinforced
	Bedsore	Baseline skin assessment (-)	
ACCESS	#1 TYPE/LOCATION/SIZE	(R) SC cordis sedation	(R) cordis NS c 20K
	DRESSING CONDITION	+ maintenance fluid	(L) AC 18g heplock
	IV FLUID/RATE	@ 175cc/hr NS c 20KU	(L) AC 18g heplock
	#2 TYPE/LOCATION/SIZE	Bilateral IV AC heplocked	No SSS infection -
	DRESSING CONDITION	D+I	D&I
	IV FLUIDS/RATE		175cc/hr NS c 20KU

(Continued on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC: ICU #1 [redacted]

DATE

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

NAME: [redacted] RANK: (b)(6)-4 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 - 23829

USAPPC V2.00

ICU1

Patients Name: EPW [redacted] (b)(6)-4

Date: 11/11/03

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						167/107	91/114	153/92	154/98	154/91	106/72	117/71		143/87			140/88	132/85	112/81	112/74	102/67	108/72	—	—	103/90	
NBP									154/98	154/91	146/80	119/79			129/72	126/81			112/74	—	—	115/65	104/45	132/58	115/67	
TEMP						93.4	94.1	95.1	96.6	97.1	98.6	98.6			99.4	100.2	100.1	101.2	99.6	100.7	100.6	100.5	100.3	100.2	100.1	
HR						116	108	105	116	115	117	117		121	131	129	123	122	121	116	114	118	116	115	115	
RR						14	14	21	19	41	30	30		30	29	21	16	20	22	20	14	16	20	20	15	
SaO2						100	98	96	96	97	92	96		92	95	100	100	100	100	100	99	99	99	99	100	
FiO2						100	80	75	75	75	65	50		50	55	55	55	50	45	45	40	40	40	40	40	
Source						Vent	Vent	Vent	Vent	Vent	Vent	Vent		Vent	V	V	V	V	V	V	V	V	V	V	V	
AP											111	95		100	99	101	106	104	91	86	81	86	92	96	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	To
IV						300	175	175	175	175	175	175	200/1550	175	175	175	175	175	175	175	175	175	175	175	175	2
IVPB						300					50					50				50	—			50		1
NGT																										
MSO4						4	8	5/8	10	6	5/4	1	1	1	1	1	4	4	4	4	4	4	4	4	3	3
Versed						4	4	4	6	8	10	2	2	2	2	2	3	3	3	3	3	3	3	3	2	3
Bolus																						1000				1
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE							950/950					100/1650	1650/300		600/600	100/700	120/820	90/910	60/970		30/1000	34/1034		80/1084	50/1134	1934
STOOL																										
DRAIN																										
CT												222	222												25	25
NGT												300	300													
Total																										

MEDCOM - 23830

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	0640	INTILAS [redacted]	1930	INTILAS [redacted]		INTILAS
NEURO		PUPLIS	PERRLA @ 2mm, sluggish		2, minimal reactivity, PERRLA.			
		SENSORIUM	pt sedated c versed & MSO4/ paralyzed c VEC, drowsy, opens eyes to pain, responds		Sedated c MSO4, Vecuronium. Versed. Gag, Cough, corneal reflexes. Non-reactive to pain. Scleral edema & jaundice persist			
RESPIRATORY		RESPIRATION PATTERN	ETT #8, 22cm @ lip,		Lungs expand evenly bilat.			
		BREATH SOUNDS	lung fields c bil crackles/		Lungs wheezy, diminished to			
		SECRETIONS	wheezes in upper lobes c diminished bases, SIMV @		all fields (B). ETT #8, 28cm at lip, SIMV, 30 b/m, FiO2			
			PEEP 15, FiO2 90%, TV 690,		90%, PEEP=15. O2 sats = 91-92			
			O2 sat 89-90%		& Tidal volume 680			
SKIN		COLOR	Warm, weeping serous		Warm, normal color for race.			
		INTEGRITY	drainage from old IV site		Weeping serous fluid from any			
			and current IV sites		open wounds. 3+ pitting edema.			
I.V. SITE		LOCATION	(C) SCTLC c MIVF, Versed,		(C) subclavian TLC continues c			
		CONDITION	VEC, MSO4, Lasix, (R) femoral		CVP no new pat. (C) s/s infection			
			cordis c MIVF, sites intact		(R) femoral cordis continues c			
			c no s/s of infection, dsg		D5NS @ 100 cc/hr, c s/s infection			
			intact		(R) radial art line continues c good			
					blood return & flow, c s/s infection			
GASTRO		ABDOMEN	large, round, distend, firm,		Round, firm, (-) BS. (+) flatus.			
		BOWEL SOUNDS	hypoactive to absent BS		Abd wound dsg intact. Continues			
					to leak serous fluid from abd			
					scabs.			
GU		URINE	foley to gravity c dark		Foley to gravity, draining dark			
		COLOR/CLARITY	amber c blood tinge		brown colored urine. Sediment			
					present. Occasional blood-color.			
CARDIOVASCULAR		CARDIAC RHYTHM	Sinus-tach in 130s on tape, HR in		Tachycardic, difficult to dis-			
			90s, S3 murmur (apical) &		tinguish if p-wave flutter is			
			ext, +3 pitting edema		artifact or true atrial flutter.		Pulses (+) to all extremities.	
			generalized		3+ pitting edema to all of body. (+) JVD noted. (-) S3, S4 murmur.			

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

PREPAR [redacted] (b)(6)-2 — ICT, AN

(Continue on reverse)

DEPARTMENT/SERVICE/CINC: ICU #1

DATE: 22 Nov 03

PATIENT'S INDICATIONS (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)
- ☐ DIGNOSTIC STUDIES
- ☐ TRETMENT

DA FORM 1 MAY78 4700
Proponent Dept of Nurs

MEDCOM - 23831

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

22 Nov 03 — DX — HOSPITAL DAY 12

	TIME	24	07	08	09	00	05	02	03		08	09	10	11	12	13	14	15	
VITAL SIGNS	BP Arterial line	142/70	132/50	136/60	142/100	118/52	110/47	107/41	105/44		138/46	130/57	120/55	150/44	100/35	123/53	100/40	113/48	
	BP Cuff																		
	Temperature	98.6				99.7					99.6				99.2		99.8		
	Pulse	117	113	112	112	116	117	115	111		112	108	111	111	107	112	111	112	
	Respiratory Rate	30	30	30	30	30	30	30	30		30	30	30	30	30	30	30	30	
	Vent Mode	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	S		SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	
	PIP	60	63	65	53	51	55	57	55		54	51	50	51	49	50	47	49	
	PEEP	15	15	15	15	15	15	15	15		15	15	15	15	15	15	15	15	
	F_iO_2	90	90	90	90	100	100	100	100		100	90	90	90	90	90	100	100	
	CVP	22	20	21	22	21	24	23	24		25	20	15	16	14	14	13	21	
	MAP	90	74	86	91	74	109	65	66		105	76	74	63	54	74	60	66	
	S_aO_2	93	90	85	81	82	91	99	99		100	98	85	87	94	88	92	87	
INTAKE	TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	~~NaHCO3~~ MIVF	100	100	100	100	100	100	100	100	800	100	100	100	100	100	100	100	100	800
	IVPB	102		50						152									
	Versed	10	10	10	10	10	10	10	10	80	10	10	10	10	10	10	10	10	80
	Vecuronium	4	4	4	4	4	4	4	4	32	4	4	4	4	4	4	4	4	32
	MSO_4	8	8	8	8	8	8	8	8	64	8	8	8	8	8	8	8	8	64
	Lasix	4	4	4	4	4	4	4	4	32	4	4	2	—				—	10
	Tube feeds	30	30	90	30	30	30	90	30	600	30	30	15	—				—	75
	Tube Flush																30		30
	TOTALS									1760									0
										960									1091
OUTPUT	HOUR / TOTAL	15/15	7/22	13/35	14/49	4/53	7/60	3/63	2/65	65	3	4/71	5/12	4/16	0/16	0/16	2/18	6/24	24
	URINE — SP gr																		
	URINE — S/A																		
	NG — OUTPUT																		
	NG — PH																		
	NG — GUIAC																		
	EMESIS								Ø										
	STOOL								Ø										
	DRAINS																		
	TOTALS																		

POST-OP DAY 11

ACUITY LEVEL CLASSIFICATION

		22	23	24	01	02	03	04	05	
VITAL SIGNS		98/38	103/37	98/35	30/20					
		100.4		100.6	100.6					
		112	112	110	29					
		30	30	30	30					
		SIMV	SIMV	SIMV	SIMV					
		53	47	48	42					
		15	15	15	15					
		100	100	100	100					
		18	15	16	21					
		58	59	56	19					
		93	81	79	70					
INTAKE		18	17	18	18	20	21	22	23	8°T
		100	100	100	100					400
		10	10	10	10					40
		4	4	4	4					16
		8	8	8	8					32
		—								
		—								
										128
OUTPUT		5/5	14/19	0/19	0/19	/	/	/	/	19
										19

RESPIRATORY		TIME	0400
		MODE	SIMV
		F_iO_2	90
		TV	690
		RATE	30
		PEEP	15
	A	pH	7.294
		PCO_2	61.4
	B	pO_2	57
		HCO_3	30
	G	SAT	85
		BASE	3

LABORATORY	TIME	0400
	GLUCOSE	130
	Na/K	136/4.6
	Cl/CO_2	103/24
	BUN/Cr	120/6.7
	WBC/PLATELET	20.4/315
	Hct/Hgb	25.9/8.4

ACTIVITY	TIME	1900
	MOUTH CARE	[redacted]
	BATCH	
	SKIN CARE	[redacted]
	FOLEY CARE	
	TRACH CARE	
	ROM EXERCISES	

TURN	TIME	2000	2200	2400
SUCTION		800	2000	1200	2400

24°180 TOTALS

NURSE'S SIGNATURE INITIALS

[redacted]

(b)(6)-2

WT Yesterday

wt. Today

INTAKE

IV

Po

TOTAL

OUTPUT

Urine:

TOTAL

BALANCE

MEDCOM - 23833

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	0630	INTILAS [redacted]	1830	INTILA [redacted]		INTILAS
NEURO	PUPLIS		PER non reactive @ 2 mm,		Pupils 4 2mm, slightly reactive (B).			
	SENSORIUM		pt sedated & Versed, MSO4,		Versed, MSay, Vecuronium cont'ive.			
			+Vec, Ø grimace to pain,		Ø response to painful stimuli			
			Ø MAE, (-) corneal, Ø gag		Ø posturing. (-) corneal reaction			
					or gag reflex. Abnormal posturing			
RESPIRATORY	RESPIRATION PATTERN		Even, unlabored chest expansion		Even, unlabored chest expansion			
	BREATH SOUNDS		lungs & coarse rhonchi &		Coarse sounds to all fields (B).			
	SECRETIONS		crackles, ETT #8, 27cm @		Wheezing & inspiratory crackles			
			lip, SIMV 30, PEEP 15,		ETT #8 @ 27 cm lip. SIMV 30			
			TV 690, FiO2 90%, sx & blood		bpm, PEEP = 15, TV = 690, FiO2 90%.			
			tinged secretions		Blood tinged sputum & suction			
SKIN	COLOR		warm, dry, (+) 2 pitting		Skin color normal for race. Generalized skin to penis is slightly			
	INTEGRITY		edema generalized, midline		3+ pitting edema. Skin warm, surgical scrotum swollen to size of			
			incision area to (B) flank		and midline abd, (B) flank, back,			
					both all (cleaned). Weeping noted to all			
IV SITE	LOCATION		(B) femoral cordis & drsg		(B) femoral cordis. Dry, soaked (-)		open wounds on body.	
	CONDITION		intact, Ø s/s of infection;		for s/s infection (-) Subclavian			
			(C) SCTC drsg intact, Ø s/s of		TLC intact, dated dry (C) Mon,			
			infection; (B) radial A-line		(B) radial art line patent, & s/s			
			patent & drsg intact, Ø s/s of		infection. Zeroed, CVP to			
			infection		(C) Subclavian zeroed.			
GASTRO	ABDOMEN		large, round, distended,		Large, rotund abd. Firm.			
	BOWEL SOUNDS		firm, BS absent (B) x 4		(+) pink ecchymosis BS (+), NG			
			NGT to LIS, (B) x 4 & Dobhoff		to LIS, Brown drng, to (B) x 4			
			& 5 ml/hr osmolite		Dobhoff to (C) x 4, continues @ 30 ml/hr			
GU	URINE		foley to gravity & dark		Foley to gravity. Putty out			
	COLOR/CLARITY		clear yellow UO in scant		small amts of dark brown			
			amounts		urine & sediment.			
CARDIOVASCULAR	CARDIAC RHYTHM		Sinus tach & ectopy,		Sinus tach continues. (-) ectopy,			
			HR 110s, BS S murmur,		S1, S2 audible & assimilation.			
			CVP 23-26, (+) pulses all		(+) peripheral pulses. Edema 3+			
			ext.		to all portions of body. (+) JVD noted.			

LEGEND
Cr - Creatinine
F_1O - Fraction of inspired O_2
F_1O_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)

PR [redacted] (b)(6)-2 — LT, AN

DEPARTMENT/SERVICE/CINC: CCU #1

DATE: 21 Nov 03

PATIENT'S INDICATIONS (For typed or written entries give: Name — Last, First, middle; grade; date; hospital or medical facility)

Civ [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

MEDCOM - 23834

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

DATE 21 Nov 03 | DX | HOSPITAL DAY

	TIME	24	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	
VITAL SIGNS	BP Arterial line	144/72	150/65	138/66	132/69	115/56	124/58	123/57	114/52	129/60	138/70	138/62	137/50	115/52	131/66	125/58	119/50	120/62	
	BP Cuff																		
	Temperature	96.8			97.5						98.5			98.3	98.1	98.4	98.3		
	Pulse	115	110	110	113	115	112	113	116	115	115	111	114	111	112	107	105	109	
	Respiratory Rate	29	30	30	30	30	30	30	36	31	31	32	30	30	30	30	30	30	
	Vent Type	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	
	PIP	53	51	52	54	56	51	55	50	52	52	51	54	53	54	42	49	52	
	PEEP	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	
	F_iO_2	90	90	90	90	90	90	90	90	90	90	90	100	100	90	100	90	90	
	CVP	23	26	25	22	23	24	22	24	22	22	21	20	21	20	18	17	22	
	MAP	85	86	84	87	76	80	77	74	86	80	83	76	73	80	82	77	80	
	S_aO_2	91	89	89	88	87	92	54	91	91	91	90	95	96	95	99	95	92	

	TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
INTAKE	$NaHCO_3$	150	150	150	150	150	150	150	150	150	150	150	150	100	100	100	100	100	950
	IVPB	100		50					100	250	50				100				152
	Versed	10	10	10	10	10	10	10	10	120	10	10	10	10	10	10	10	10	80
	Vecuronium	4	4	4	4	4	4	4	4	48	4	4	4	4	4	4	4	4	32
	MSO4	8	8	8	8	8	8	8	8	96	8	8	8	8	8	8	8	8	64
	Lasix	8	8	8	8	8	8	8	8	96	40	40	40	40	40	4	4	4	212
	Tube Feeds	30	30	90	30	30	30	90	30	360	30	30	90	30	30	30	30	30	300
																			2590
	TOTALS								210	210									~~2590~~

		HOUR / TOTAL	14/14	17/31	15/46	15/61	10/71	7/78	8/86	7/93	8/101	9/110	7/117	7/124	6/130	9/139	7/146	7/153	5/158	57
OUTPUT	URINE	SP gr																		
		S/A																		
	NG	OUTPUT													900					900
		PH																		
		GUIAC-																		
	EMESIS																			
	STOOL																			
	DRAINS																			
	TOTALS																			957

POST-OP DAY

VITAL SIGNS	22	23	24	01	02	03	04	05	
	140/68	108/43	132/65	131/65	158/81	119/51	129/58	140/71	
T		98.2			98.3		98.7		
A	101	112	108	106	109	110	107	109	
L	30	30	30	30	30	30	30	30	
	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	
S	54	58	60	51	47	59	60	56	
	15	15	15	15	15	15	15	15	
I	90	90	90	90	90	90	90	90	
G	23	20	18	16	20	21	22	19	
N	91	66	85	83	100	75	91	90	
S	90	92	90	93	86	98	91	91	

INTAKE	16	17	18	19	20	21	22	23	8°T
I	100	100	100	100	100	100	100	100	2 600
	50		102						152
N	10	10	10	10	10	10	10	10	80
T	4	4	4	4	4	4	4	4	32
A	8	8	8	8	8	8	8	8	64
K	4	4	4	4	4	4	4	4	32
E	30	30	60	30	60	30	60	30	330
									1490

OUTPUT	16/16	10/26	5/31	8/39	12/51	4/55	7/62	8/70	70
			600					500	1100

1490
2172

ACUITY LEVEL CLASSIFICATION

RESPIRATORY		TIME	0530									
		MODE	SIMV									
		F_iO_2	90									
		TV	650									
		RATE	30									
		PEEP	15									
	A	pH	7.243									
		PCO_2	63.5									
	B	pO_2	58									
		HCO_3	27									
	G	SAT	84									
		BASE	Ø									

LABORATORY	TIME	0530									
	GLUCOSE	155									
	Na/K	4.7									
	Cl/CO_2	103/22									
	BUN/Cr	112/6.5									
	WBC/PLATELET	23.5/317									
	Hct/Hgb	34.5/10.0									

ACTIVITIES DAILY LIVING	TIME	0400									
	MOUTH CARE	[redacted]									
	BATH										
	SKIN CARE										
	FOLEY CARE										
	TRACH CARE										
	ROM EXERCISES										

TURN — TIME: 2000 | 2200 | 2400 | 0200 | 0400 | 0600 [redacted]

SUCTION: 2000 [redacted] | 2200 | 2400 | 0200 | 0400 | 0600

24°180 TOTALS

WT Yesterday ____ wt Today ____

INTAKE		OUTPUT	
IV	6252	Urine:	207
Po	—		2000
TOTAL	6252	TOTAL	2207
		CE	6045

NURSE'S SIGNATURE | INITIALS

[redacted]

(b)(6)-2

MEDCOM - 23836

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	0730	INTILAS [redacted]	1830	INTILAS [redacted]		INTILAS
NEURO	PUPLIS		2.5mm sluggish		2.5mm, sluggish. EQUAL			
	SENSORIUM		paralyzed chemically		Remixe. Versed drip 4 mg/hr			
			c Vec. 4cc/h. Dmeph		for analysis. Versed @ 10 mg/hr.			
			Sedation: Versed @ 10cc/h		MSO4 @ 2 mg/hr.			
			Fentanyl MSO4 each 1:1 c anabolic					
RESPIRATORY	RESPIRATION PATTERN		Bilateral : MV		Equal Bilaterally.			
	BREATH SOUNDS		Rhonchi scattered		Coarse lung sounds to lobes			
	SECRETIONS		c Coarse lung sounds/rales		(R). v breath sounds to bases.			
			to middle upper lobes. Blood		tinged/beige. ETT @ 24 at lip. #8. SIMV			
			Secretions from ETT		572 F, O2, PEEP=15, S O2 95%, P.P.=51			
			ETT 8 24@lip Simv TV650		RR30 peep15 FiO2 to keep SaO2 90			
SKIN	COLOR		Normal for Rx.		Skin color normal for race.			
	INTEGRITY		Mult. Skin tears. Surgical		3+ pitting edema generalized. Sacral			
			Skin and 3+ edema		wounds to abd & extremities. Surgical wounds to midline abd. (R) flank.			
IV SITE	LOCATION		(R) Fem Cordis Start 11/19/03		(R) femoral cordis. Started yesterday.			
	CONDITION		(L) SC TLC		(L) subclavian TLC.			
			(R) RAD aline		(R) Radial art line. All lines			
			see note for fluid		in test. Art line & CVP record.			
			infusion + pt's		All lines flushed & dressings			
			intact lines		c s/s infection. Drsg to (R) femoral cordis redressed 2° to being loose.			
GASTRO	ABDOMEN		large hard distended		Abd rotund, distended. (+) BS			
	BOWEL SOUNDS		Hyperactive (+) BS		Dobhoff to (L) nare. Tube feeds			
			NBH - (L) nare - TPN 30cc/h		@ 30 c/hr. NG to (R) nare. LIS.			
			NGT (R) nare - LIS - brown drainage		Large, dark brown drainage.			
GU	URINE		Foley & spouts		Foley to gravity drng brown, tea			
	COLOR/CLARITY		10-20cc/h yellow c		colored urine. UOP @ 10-20 c/hr.			
			sediment		Lasix continues. Stool +			
CARDIOVASCULAR	CARDIACRHYTHM		S1 S2 distant occ brady		S1 S2 audible, occ ectopy noted			
			ST 110's (+) pulses using		HR @ 110's. Pulses (+) x 4 c edema.			
			Doppler due to edema		CVP & MAP stable.			
			Aline c good waveform					

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

(b)(6)-2

(Continue on reverse)

PREPARED BY (Name, Grade & Title) [redacted] CPT/AN

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

DATE 20 NOV 03

PATIENT'S INDICATIONS (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)
☐ DIGNOSTIC STUDIES
☐ TRETMENT

1Cu/

DA FORM 1 MAY78 4700
Proponent Dept of Nurs

MEDCOM - 23837

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

		DX	07	08	09	10	11	12	13		14	15	16	17	HOSPITAL DAY 18	19	20	21	
VITAL SIGNS	TIME	~~24~~	~~01~~	~~02~~	~~03~~	~~04~~	~~05~~	~~06~~	~~07~~		~~08~~	~~09~~	10	11	12	13	14	15	
	BP Arterial line	147/62	151/64	149/64	144/64	113/65	140/45	143/63	135/64		145/64	144/65	144/65	104/65	147/61	149/64	138/68	141/72	
	BP Cuff																		
	Temperature	97.4											95.7		95.8	95.8	95.7	95.7	
	Pulse	111	113	115	110	110	114	112	106		112	107	108	110	115	111	106	104	
	Respiratory Rate	30	30	30	30	30	30	30	24		28	30	13	28	13	30	30	30	
	MAP	87	92	89	87	88	108	86	85		88	89	87	88	82	91	80	92	
	CVP	17	18	19	18	19	16	18	23		19	23	19	21	18	21	20	24	
	O_2 SAT	93	94	94	93	92	93	96	95		95	95	95	94	95	94	95	93	
	FiO_2	90	90	90	87	87	87	87	87		87	87	87	87	87	87	87	87	
	MODE	S	S	S	S	S	S	SIMV	SV		SIMV	SIMV	SIMV	S	SIMV	SIMV	SIMV	SIMV	
	PEEP	15	15	15	15	15	15	15	15		15	15	15	15	15	15	15	15	
	PIP	48	48	47	48	47	50	47	46		46	45	47	47	51	48	47	49	
INTAKE	TIME	~~24~~	~~01~~	~~02~~	~~03~~	~~04~~	~~05~~	~~06~~	~~07~~	8°T	~~08~~	~~09~~	~~10~~	~~11~~	~~12~~	~~13~~	14	15	8°T
	MIVF	150	150	150	150	150	150	150	150	1200	150	150	150	150	150	150	150	150	1200
	IVPB	100		50						150	50				50		200		300
	Dobutamine	10	10	10	10	10	10	10	10	80	10	10	10	10	10	10	—	—	60
	Dopamine	9	9	9	9	9	9	9	9	72	9	9	9	9	9	9	—	—	54
	VERSED	10	10	10	10	10	10	10	10	80	10	10	10	10	10	10	10	10	80
	VECURONIUM	4	4	4	4	4	4	4	4	32	4	4	4	4	4	4	4	4	32
	MSO4	8	8	8	8	8	8	8	8	64	8	8	8	8	8	8	8	8	64
	LASIX	40	40	40	40	40	40	40	40	320	40	40	40	40	40	40	40	40	320
	TPOSMol/hr	10	10	90	30	30	30	90	30	320	30	30	60	30	30	30	60	30	300
	TOTALS									2318									2410
OUTPUT	URINE HOUR / TOTAL	18	24	24	20	16	17	15	24	157	→	20	25	22	20	21	10	15	133
	URINE SP gr																		
	URINE S/A																		
	NG OUTPUT																		
	NG PH																		
	NG GUIAC																		
	EMESIS																		
	STOOL																		
	DRAINS																		
	TOTALS																		133

POST-OP DAY 22 23 24 01 02 03 04 05

ACUITY LEVEL CLASSIFICATION

VITALSIGNS	16	17	18	19	20	21	22	23	
	141/68	142/66	139/68	136/68	132/68	134/67	150/74	127/64	
		95.2	95.7	95.7	95.9	96.0	96.4		
	107	103	106	106	106	108	117	111	
	30	30	30	30	30	24	30	30	
	87	89	89	88	89	86	96	84	
	19	21	21	18	18	25	25	21	
	94	93	93	93	94	91	90	87	
	87	87	87	87	87	872	87	90	
	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	
	15	15	15	15	15	15	15	15	
	51	48	48	48	52	52	57	51	

RESPIRATORY	TIME	0600							
	MODE	SIMV							
	F_iO_2	90							
	TV	690							
	RATE	30							
	PEEP	15							
	A pH	0422 7.228							
	A PCO_2	57.2							
	B pO_2	137							
	B HCO_3	24							
	G SAT	99							
	G BASE	-3							

LABORATORY	TIME	0422							
	CLUCOSE	148							
	Na/K	144 / 4.4							
	Cl/CO_2	114							
	BUN/Cr	99 / 5.9							
	WBC/PLATELET	21.4 / 832							
	Hct/Hgb	9.6 / 30.0							
	PBC	340							
	PT	>50							
	APTT	>30							

JUNTAKE	16	17	18	19	20	21	22	23	8°T
	150	150	150	150	150	150	150	150	1200
	50		50						
	—	—	—	—					
	—	—	—	—					
	10	10	10	10	10	10	10	10	80
	4	4	4	4	4	4	4	4	32
	8	8	8	8	8	8	8	8	64
	40	40	40	40	40	40	40	40	320
	30	30	60	30	30	30	60	30	300
									1990

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

TURN

TIME	2000	2200	2400	0200	0400
0600					

SUCTION

TIME	2000	2200	2400	0200	0400
0600					

OUTPUT	— / —	24 / 24	19 / 43	2 / 45	19 / 64	9 / 73	17 / 90	7 / 97	97
			300					150	450
									547

24°180 TOTALS

NURSE'S SIGNATURE | INITIALS

[redacted]

(b)(6)-2

WT Yesterday ____ wt Today ____

INTAKE		OUTPUT	
IV	6724	Urine:	[redacted]
Po	0		340
TOTAL	6724	TOTAL	837
BALANCE			+5887

MEDCOM - 23839

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	INTIL	INTILAS		INTILAS
NEURO	PUPLIS	2.5 mm sluggish			PERL 2 mm Slow	
	SENSORIUM	Vec. 4cch ⊖ Mont			chemically paralyzed	
		MSO4 8cc/h Versed Ord.				
		Sclera - Yellow				
RESPIRATORY	RESPIRATION PATTERN	(B) Equal: MV			VENTED Oscillyator	
	BREATH SOUNDS	Coarse Rales/Rhonchi			ETT 24cm (a)	
	SECRETIONS	ETT via tube - thick beige			Breath Sounds diminished	
	MODE	SIMV RR24 ETT 24cm @ teeth			w/ rhonchi scattered	
		FiO2 TV 750 PEEP 5 ABG			Pulse Ox Sat 94% throughout	
		SCV Sats 90-91				
SKIN	COLOR	normal for race			Normal	
	INTEGRITY	dependent edema, +3 pitting			Multiple Skin Tears	
		anas + scrotal edema. Sternotomy			Surgical wound Midabdomen	
IV SITE	LOCATION	(L) Sub TLC			(B) groin cordis	
	CONDITION	Prox - CVP line			(D) SB TLC	
		Distal, NS 20cc/h Open			(R) Rad a-line	
		Bones/Keyla Obst.			See Notes for Fluids x Pigs	
		Medical Versed 10mg/1 Morphine/1			Sites in place	
		VSE 4mg/1 (R) Rad a-line				
GASTRO	ABDOMEN	Large distended firm			Salem Sump tube to right	
	BOWEL SOUNDS	hypoactive BS			Nares To suction Dopoff	
		TF @ 10cc/h Promote 1.2			tube thru Right Nare with	
		KBIT @ Nare → GIS bowel regimen			good gag reflex. BS hypo	
GU	URINE	Foley to gravity			to active	
	COLOR/CLARITY	Amber w/ sediment			14 Lab. yellow/clear	
		<30/1 lasix @ 40 IV			urine	
CARDIOVASCULAR	CARDIACRHYTHM	S1 S2 Distant Bradycardic			ST. HR 110-120's BP's	
		ST Mods T60's-I, Ts			Pulses 3+ throughout edema	
		Pulses Dopplered in depth			A-Lines (R) Radial and	
		# in all extremities.			Dopamine drip. Robinul drip	

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)

[redacted] (b)(6)-2 | DEPARTMENT/SERVICE/CLINIC [redacted] (b)(2)-2 | DATE 19 NOV 03

PATIENT'S INDICATIONS (If typed or written entries give: 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)
☐ DIGNOSTIC STUDIES
☐ TRETMENT