23 APR 03

		1430	1445	1500	1515	1545						
NEUROLOGICAL CHECK — EXTREMITY (L) LOWER EXTREMITY												
PAIN pain	(b)(6)-2											
	AFLEBAL											
	MODERATE											
	SEVERE											
SENSATION (sensation)	NORMAL											
	NUMBNESS											
	TINGLING	(b)(6)-2										
	ABSENT											
BLANCHING Blanching (N - Normal; S - Sluggish)		(b)(6)-2										
ACTIVE MOTOR FUNCTION	NORMAL	(b)(6)-2										
	LIMITED											
	ABSENT											
SIGNS OF COMPARTMENT SYNDROME	PAIN ON PASSIVE MOTION											
	PAIN UNRELIEVED BY ANALGESICS											
VASCULAR CHECK — COLOR COLOR	RED											
	PINK											
	PALE	(b)(6)-2										
	BLUE											
SKIN TEMPERATURE (SKIN TEMP)	HOT											
	WARM											
	COOL	(b)(6)-2										
	COLD											
PULSE SITE (PULSE) DORSALIS PEDIS	NORMAL	(b)(6)-2										
	WEAK											
	ABSENT											
EDEMA SITE (EDEMA)	NONE	(b)(6)-2										
	SMALL											
	MODERATE											
	LARGE											

COMMENTS

INITIAL	SIGNATURE / TITLE	INITIAL	SIGNATURE / TITLE	INITIAL	SIGNATURE / TITLE
(b)(6)-2					

NNMC 6320/279 (Dec-10)

Pre / Post-anesthetic Summary

Proposed Operation	Age	Weight (kg)	Height (in)	ASA Status	Allergies
I+D GSWs & closure wounds	47	69	170cm	(b)(6)-2 1 2 3 4 5 E	NKDA

Chemistries 4/13/03
135 | 101 | 8
3.4 | 32 | 192
0.8

Hematology 4/10/03
H/H - 8.9/26.3
Platelets - 292
WBCs - 9.6

Coags 4/10
PT - 11.8
INR - 0.8
PTT - 30.4↓

Urinalysis / HCG
Ø

NPO – p MN
Teeth – multiple missing + ↑ front loose
Airway – MP (1) II / III / IV
FROM, 3 FB O, 3 FB HM

Respiratory
Cough:
Sputum:
Asthma:
COPD:
Recent URI:
TB:
Ø

Lung Exam:
CTA (B)

CXR: mild cardiomegaly, mild diffuse interstitial markings throughout lungs. ? possible long smoking hx vs occup. dust exposure

CV
HTN:
CAD:
MI:
CHF:
VHD:
Arrythmias:
Ø
Exercise Tolerance: good
Cardiac Exam: RRR (N)
ECG:

CNS / Skeletal
Seizure:
CVA:
LOC:
Neuro:
Muscle:
Skeletal:
Ø

Misc
Multiple GSWs – (soft tissue)
→ (L) leg
(R) elbow

Other
Hepatic:
Renal:
GI:
Ø
Endo: Type I diabetes
Heme: Ø
EtOH: Ø
Tobacco: (b)(6)-2 Ø probably

Previous Anesthetics:
I+D GSWs - GA → Ø comps

Family Hx: Ø

Current Medications:
Ancef
Keflex
Glibenide

Premedication:
Regular Insulin 5u sq @ 0835

Preoperative Diagnoses
(1) Multiple GSWs

Vitals	Pre-op	DOS
BP:	139/72	136/70
HR:	80	72
Resp:	16	18
Temp:	98.8	
FHR:		

Evaluator Signature | Date

Day of Surgery
☒ Chart Reviewed / patient examined
☐ Risks / benefits / options discussed with patient
☐ Patient questions answered
☐ Patient / parent / guardian understands and accepts risks
☒ NPO after see above liq., clears, ____ solids
Plan: GETA

Staff MD / CRNA signature: (b)(6)-2
Date & Time: 15 APR Ø3 (0830)
CRNA/LCDR/NC

Patient identification: (b)(6)-4

Post-operative note

☐ No apparent anesthetic complications

Signature: (b)(6)-2
Date: 15 APR Ø3
CRNA/LCDR/NC

Pre / Post-anesthetic Summary

NNMC 6320/279 (Dec-00)

Proposed Operation	Age	Weight (kg)	Height (in)	ASA Status	Allergies
I&D (B) ant. thigh wounds	48	~75	170 cm	1 2 (3) 4 5 E	Ø

Chemistries
132 / 4.8 / 9 / 198
3.6 / 29 / 0.8 / Repeat 89
P3.4
Alb 2.4 Ca 7.4 Mg 2.1

Hematology
H/H - 9/26
Platelets - 419
WBCs -

Coags
PT -
INR -
PTT -

Urinalysis / HCG

NPO – yes
Teeth – loose, protruding incisors
Airway – MP I / II / III / IV
FROM, ____ FB O, ____ FB HM

Respiratory
Cough:
Sputum:
Asthma:
COPD:
Recent URI:
TB:
Lung Exam:
CXR:
Ø

CV
HTN:
CAD:
MI:
CHF:
VHD:
Arrythmias:
Exercise Tolerance: good
Cardiac Exam:
ECG:
Ø

CNS / Skeletal
Seizure:
CVA:
LOC:
Neuro:
Muscle:
Skeletal:
Ø

Misc
Frag. wounds (B) thighs (R) arm

Other
Hepatic:
Renal: ↓Na, ↓K
GI: ↓ alb
Endo: DM ?Insulin
Heme: anemia
EtOH: denies
Tobacco: denies

Previous Anesthetics:
I&D (B) thigh frag wounds – GA
Family Hx: Ø

Current Medications:
Ancef
Glucotrol
LSS
Pain Meds PRN

Premedication:

Preoperative Diagnoses
Glucose intolerance ?
Anemia
Hyponatremia
Hypokalemia
Malnutrition
Mult. frag. wounds w/ infection

Vitals	Pre-op	DOS
BP:		
HR:		
Resp:		
Temp:		
FHR:		

Evaluator Signature Date

Day of Surgery
- ☑ Chart Reviewed / patient examined
- ☐ Risks / benefits / options discussed with patient
- ☐ Patient questions answered
- ☐ Patient / parent / guardian understands and accepts risks
- ☐ NPO after _____ liq., _____ clears, _____ solids

Plan: GA / LMA vs. mask

Staff MD / CRNA signature (b)(6)-2 MD (b)(6)-2 Date & Time LCDR 4/17/03

Patient identification (b)(6)-4

Post-operative note

☐ No apparent anesthetic complications

Signature Date

Pre / Post-anesthetic Summary

NNMC 6320/279 (Dec-10)

Proposed Operation	Age	Weight (kg)	Height (in)	ASA Status	Allergies
Fx D (L) Ank FB Removal / Pins & Plate	47	69	170cm	1 (2) 3 4 5 E	NKMA

Chemistries 04/1/03
132 / 98 / 9
3.4 / 29 / 0.8 (198)
Alb 2.7 Ca 7.7

Hematology 04/2/03
H/H - 9.2/26
Platelets - 419
WBCs -

Coags
PT -
INR -
PTT -

Urinalysis / HCG

NPO – 0 mn
Teeth – missing
Airway – MP I / II / III / IV
FROM, ___ FB O, ___ FB HM

Respiratory Mg 2.1
Cough:
Sputum:
Asthma:
COPD:
Recent URI:
TB:
Lung Exam: Mild crackings, Poss Cag Smoker 1D.
CXR:

CV
HTN:
CAD:
MI:
CHF:
VHD:
Arrythmias:
Exercise Tolerance:
Cardiac Exam:
ECG:

CNS / Skeletal
Seizure:
CVA:
LOC:
Neuro:
Muscle:
Skeletal:

Misc

Other
Hepatic:
Renal:
GI:
Endo: Type II Diabetic
Heme:
EtOH:
Tobacco:

Previous Anesthetics:
Family Hx:

Current Medications: Amaryl, Insulin, Keflex, Glimepiride

Premedication:

Preoperative Diagnoses
① Multiple Sprains

Vitals	Pre-op	DOS
BP:	120/60	
HR:	90	
Resp:		
Temp:		
FHR:		

Day of Surgery
- ☑ Chart Reviewed / patient examined
- ☑ Risks / benefits / options discussed with patient
- ☑ Patient questions answered
- ☑ Patient / parent / guardian understands and accepts risks
- ☐ NPO after ___ liq., ___ clears, ___ solids

Plan:

Evaluator Signature	Date	Staff MD / CRNA signature	Date & Time
(b)(6)-2	04/2/03	(b)(6)-2	04/2/03 1215

~~Hgb~~ Hg 9.2 Stewart
BSFS 203 / 1215

Patient identification
(b)(6)-4

Post-operative note

☐ No apparent anesthetic complications

Signature Date

Pre / Post-anesthetic Summary

NNMC 6320/279 (Dec-00)

Proposed Operation	Age	Weight (kg)	Height (in)	ASA Status	Allergies
Bullet Removal / Delay closure	36	69		1 2 (3) 4 5 E	NKDA

Chemistries: (108)

Hematology: H/H ? (23); Platelets -; WBCs -

Coags: PT -; INR -; PTT -

Urinalysis / HCG:

NPO – ?
Teeth – Very poor dentition; loose #8/#9.
Airway – MP I / (II) / III / IV
FROM 4 FB O. 3 FB HM

Respiratory
Cough:
Sputum:
Asthma:
COPD: Denied
Recent URI:
TB:
Lung Exam: CTA (B)
CXR:

CV
HTN:
CAD:
MI: Denied
CHF:
VHD:
Arrythmias:
Exercise Tolerance:
Cardiac Exam:
ECG: NSR

CNS / Skeletal
Seizure:
CVA:
LOC:
Neuro: GSW
Muscle: BLE
Skeletal:

Misc

Other
Hepatic: ?
Renal:
GI: IRDM
Endo:
Heme: ?
EtOH: ?
Tobacco: denies

Previous Anesthetics: mult GA ≈ diff.
Family Hx: ?

Current Medications:
- 4 NPH
- glyburide QAm
- Lovenox Q12

Premedication:

Preoperative Diagnoses
1. s/p GSW
2. IRDM
3. Anemia.
4. Acinetobacter colonized.

Vitals	Pre-op	DOS
BP:		135/78
HR:		82
Resp:		
Temp:		
FHR:		

Day of Surgery
- ☑ Chart Reviewed / patient examined
- ☑ Risks / benefits / options discussed with patient
- ☑ Patient questions answered
- ☑ Patient / parent / guardian understands and accepts risks
- ☐ NPO after _____ liq., _____ clears, _____ solids

Plan: GA / RSI

Staff MD / CRNA Signature (b)(6)-2

Date & Time 2/23/03

(b)(6)-2

Patient identification (b)(6)-4

Post-operative note

☐ No apparent anesthetic complications

Signature Date

Pre / Post-anesthetic Summary

NNMC 6320/279 (Dec-10)

Proposed Operation	Age	Weight (kg)	Height (in)	ASA Status	Allergies
(R) Tympanoplasty	~30	~70	~5'10"	1 (2) 3 4 5 E	NKDA

Chemistries: —

Hematology: H / H - ; Platelets - — ; WBCs -

Coags: PT - ; INR - — ; PTT -

Urinalysis / HCG: —

NPO – p MN
Teeth – ∅ loose
Airway – MP (1) / II / III / IV
FROM, 3 FB O, 3 FB HM

Respiratory: Cough: ; Sputum: ; Asthma: ; COPD: ; Recent URI: ; TB: — UNK

Lung Exam: CTA (A)
CXR: —

CV: HTN: ; CAD: ; MI: ; CHF: ; VHD: ; Arrythmias: ; Exercise Tolerance: — UNK

Cardiac Exam: RRR ∅ m/r/g's
ECG: —

CNS / Skeletal: Seizure: ; CVA: ; LOC: ; Neuro: ; Muscle: ; Skeletal: — UNK

Misc: —

Other: Hepatic: ; Renal: ; GI: ; Endo: - DM ; Heme: ; EtOH: ; Tobacco: — UNK

Previous Anesthetics: 3/03 - GETA - ∅ complic (GSW's)

Pain: ?

Current Medications: —

Premedication: —

Preoperative Diagnoses: (1) Blast injury to (R) tympanic membrane

Vitals	Pre-op	DOS
BP:	110/68	
HR:	68	
Resp:	16 →	
Temp:	—	
FHR:	—	

Anesthesiologist: (b)(6)-2 Date 4.25.03

Day of Surgery
- ☐ Chart Reviewed / patient examined
- ☑ Risks / benefits / options discussed with patient
- ☐ Patient questions answered
- ☐ Patient / parent / guardian understands and accepts risks
- ☑ NPO after MN liq., _____ clears, _____ solids

Plan: GETA

Staff MD / CRNA signature: (b)(6)-2 Date & Time: 4-25-03 0810

Patient identification: (b)(6)-4

Post-operative note

☐ No apparent anesthetic complications

10 APR 03

(b)(3)-1

PERSONAL DATA PR... ACT 1974

Signature Date

(b)(3)-1

Pe perative Plan Of Care & Nursing N

Patient Assessment For Surgery - Potential For Injury - Outcome: Patient is free from signs and symptoms of injury ☐ Yes ☐ No

rauma# or atient #

Diagnosis: GSW Thigh Planned Procedure: I&D Bilateral thigh / (R) Elbow

Date: 4/15/03 Arrival Time: 0750 Interviewer: L C Na (b)(6)-2

Side: ☐ N/A ☒ Right ☐ Left
Age: HT: WT:

rom:
CASREC
ICU
Ward 5 E
OTHER:

Transport Via:
☒ Gurney
☐ Litter
☐ Ambulated
☐ Wheelchair
☐ Other

Patient ID:
☐ Trauma card
☐ Verbal
☒ Chart
☐ Armband
☐ Other

Blood Ordered:
☒ N/A
☐ Yes ☐ Consent
☐ T/C #Units
☐ T/H #Units
Comments:

Surgical/Anesthesia Consent Verified:
☐ Procedure
☐ Consent complete, dated, signed
☒ Emergent case; no consent, MD note

reop Labs (HCG, etc):
None ☒ Yes
st/Results:

Drug/Latex Allergies:
☒ NKDA
Allergy/Reaction:

Present On Admission:
☐ N/A
☐ Oxygen
☒ IV Site: #1 (R) ulnar
#2
☐ Foley
☐ Endotrachial Tube
☐ Arterial Line Site:
☐ Drain(s)
☐ Chest Tube(s)
☐ See RN Note #

Past Medical History:
☐ None known
☐ Smoker ppd/yrs ___/___
☐ ETOH ☐ Asthma
☐ HTN ☐ CAD
☐ GERD ☐ CBR exposure
☐ Other: DMII

Past Surgical History:
☐ None known
☒ Yes
List:

Cultural Needs Addressed:
☐ Yes ☒ No
List:

e-Op Pain:
No
Yes Level ____(0-10)
tion Taken:
cation/type:

Last PO Intake: (date/time)
Solid: 4/14/03 2400
Liquid: 4/14/03 2400

Chart:
H&P ☒ Yes ☐ No
EKG ☐ Yes ☐ No
CXR ☐ Yes ☐ No
Other:

Skin Condition:
☐ Intact
☐ Other: Dressing of thigh / (R) Elbow

Limitations:
☐ N/A
☒ Language
☐ Mobility
☐ Other:
☐ Auditory
☐ Visual
☐ Prosthesis

Personal Items:
☒ None
☐ Military gear
☐ Glasses
☐ Dentures
☐ Jewelry/wallet
☐ Other
Disposition:

Potential For Anxiety – Outcome: Patent demonstrates knowledge of psychological responses to an invasive procedure ☐ Yes ☐ No

ental/Emotional Status:
Alert/Oriented
Disoriented
Anxious
Appropriate for age
Other
☐ Calm
☐ Sedated
☐ Unresponsive

Comfort Measures Implemented:
☐ Clear, concise explanations
☐ Communicated patient concerns to other staff members
☐ Remain with patient during induction

Pre-op Teaching Included:
☒ N/A due to patient condition
☐ Physical layout of OR
☐ Personnel present during procedure
☐ Environment (noise, temperature, etc.)
☐ Post-op expectation (PACU, drains, etc.)

Potential For Impaired Skin Integrity Related To Surgical Procedure – Outcome: Patient is injury free ☒ Yes ☐ No

erative Position:
Supine
Prone
Jackknife
Lithotomy
Other:
☐ Beach chair
☐ Sitting
☐ Lateral L / R

Positional Aids:
☒ Arms <90
Armboard: ☐ L ☒ R
Tucked: ☐ L ☐ R
☐ Airplane
☐ Fracture Table
☐ Hand Table
☐ Stirrups
☐ Other:
☐ Axillary roll
☐ Gel Pad
☐ Leg Holder
☐ Tape
☐ Bean Bag
☐ Gel donut
☐ Pillows
☐ Wilson Frame
Comments:

U # 4
l Site: (R) Elbow
l Lot # 39050
Clear at end of case? ☐ No ☒ Yes
No, see RN note #
olar: ___ Max Cut 30 Coag 30

DVT Prevention:
SCD used ☐ No ☐ Yes
Pressure: ___ ☐ Left ☐ Right
Teds: ☐ No ☐ Yes
Bair Hugger used: ☐ No ☒ Yes
Other warming techniques:

Tourniquet:
☐ Arm ☐ Leg
☐ Left ☐ Right
☐ webril applied
N/A
Applied by:
↑ ___ ↓ ___
↑ ↓
Total Min:
Comments:

(b)(6)-4

Comments:

(b)(3)-1 Perit e Plan Of Care & Nursing Note

MEDCOM - 4806

Potential For Infect[illegible] Outcome: Appropriate Actions Taken to [illegible] Infection ☑ Yes ☐ No

Wound Classification: I ☐ II ☐ III ☑ IV

Shave Prep: ☐ Shave ☑ Clipper
Area: _____ By: _____
Both legs around wounds

Skin Prep:
☑ Betadine Scrub
☐ Hibiclens
☐ Duraprep
☐ Other:

Solutions/M[illegible]ications:
☑ Normal saline
☐ Sterile water
☐ Local _____
☐ Antibiotics Bacitracin 2% mupirocin
☐ Other: _____

Drains/Packing: ☐ None
Foley FR: _____
JP #1 Fr ___ Location: _____ #2 Fr ___ Location: _____
Hemovac: Size ____ Location _____
Chest tube: Location _____
Size _____ H2O Pressure: _____
Packing: type/location: ½" Iodoform
See RN Note # ____ for comments to wounds

Dressing: Location: Bilateral Thighs / (R) Elbow

☑ ABD	☐ Cervical Collar	☐ Kling	☐ Steri-strips	☐ Benzoin
☐ Ace	☐ Coban	☐ Immobilizer	☐ Tape	☐ Mastisol
☐ Bias	☐ Drip Pad	~~☐ Plains~~	☐ Webril	☐ Bacitracin
☐ Band-Aid(s)	☐ Fluffs	☐ Sling	☐ Xeroform	
☐ Cast	☑ Kerlix	☐ Splint	☐ Other:	

Iodoform ½"

Miscellaneous

Counts: (initials)
Scrub: RN: Correct?
(b)(6)-2 (b)(6)-2
Sharps ☑ Yes ☐ No ☐ N/A
Sponges ☑ Yes ☐ No ☐ N/A
Instruments ☐ Yes ☐ No ☐ N/A
See RN note # ____ for additional comments

Xray:
☑ None ☐ Other:
☐ Portable
☐ C-Arm

Skin Integrity:
☑ Clear & Intact (other than incision)
Comments: _____
☐ See RN note # ____ for additional comments.

Implants:
Item / Lot # / Exp Date:
See RN note # ____ for additional comments.

Discharge from Operating Room

Complications:
☑ None Comments: _____
See RN note # ____ for additional comments

Transport From OR:
☑ gurney w/ siderails up
☐ Litter w/ safety strap in place
☐ w/ Oxygen
☐ w/ Monitor
☐ Other:

Transferred To:
☑ PACU
☐ ICU
☐ Medivac
☐ Ward _____
☐ Other

Report by:
☐ Anesthesia provider ☐ RN

Surgical Procedure Performed: I&D Bilateral Thighs / (R) Elbow

RN Note: (number each note to corresponding area above)

Initial/Name Box: (please print)

(b)(6)-2
Primary OR RN Signature Date 4/10/05 **Relief OR RN Signature** **Date/Time**

(b)(3)-1

PeriOperative Plan Of Care & Nursing N

'atient Assessment For Surgery - Potential For Injury - Outcome: Patient is free from signs and symptoms of injury ☐ Yes ☐ No

'auma# or ıtient # 1

Diagnosis: Multi GSW (R) LE/groin Planned Procedure: I&D of groin / LE GSW.

Date: 17 APR03 Arrival Time: 07:30 Interviewer: LT (b)(6)-2

Side: ☐ N/A ☐ Right ☐ Left
Age: HT: WT:

'om:	Transport Via:	Patient ID:	Blood Ordered:	Surgical/Anesthesia Consent Verified:
CASREC	☑ Gurney	☐ Trauma card	☐ N/A	☐ Procedure
ICU	☐ Litter	☐ Verbal	☑ Yes ☐ Consent	☐ Consent complete, dated, signed
Ward _____	☐ Ambulated	☑ Chart	☑ T/C #Units 1	☑ Emergent case; no consent, MD note
OTHER:	☐ Wheelchair	☑ Armband	☐ T/H #Units _____	
	☐ Other	☐ Other	Comments:	

'eop Labs (HCG, etc):	Drug/Latex Allergies:	Present On Admission:	Past Medical History:	Cultural Needs Addressed:
None ☑ Yes	☑ NKDA	☐ N/A	☐ None known	☑ Yes ☐ No
:st/Results: _____	Allergy/Reaction: _____	☐ Oxygen	☐ Smoker ppd/yrs ___/___	List: _____
		☑ IV Site: #1 #18 LFA	☐ ETOH ☐ Asthma	
		#2 _____	☐ HTN ☐ CAD	
		☐ Foley	☐ GERD ☐ CBR exposure	
		☐ Endotrachial Tube	☑ Other: NIDDM	
		☐ Arterial Line Site: _____	**Past Surgical History:**	**Last PO Intake: (date/time)**
		☐ Drain(s) _____	☐ None known	Solid: NPO prior
		☐ Chest Tube(s) _____	☑ Yes	Liquid: _____
		☐ See RN Note # _____	List: Refer to Progress/OP note.	

re-Op Pain:		Skin Condition:	Limitations:	Personal Items:
No		☐ Intact	☐ N/A ☐ Auditory	☑ None Disposition:
Yes Level ? (0-10)		☑ Other: See progress notes	☑ Language ☐ Visual	☐ Military gear
ction Taken: Pain med by Anesthesia			☑ Mobility ☐ Prosthesis	☐ Glasses
ocation/type: Groin/LE			☐ Other: _____	☐ Dentures
				☐ Jewelry/wallet
				☐ Other

ı Chart:	
H&P	☑ Yes ☐ No
EKG	☐ Yes ☑ No
CXR	☐ Yes ☑ No
Other: _____	

Potential For Anxiety – Outcome: Patent demonstrates knowledge of psychological responses to an invasive procedure ☐ Yes ☐ No

Iental/Emotional Status:	Comfort Measures Implemented:	Pre-op Teaching Included:
☑ Alert/Oriented ☑ Calm	☐ Clear, concise explanations	☑ N/A due to patient condition / language
Disoriented ☐ Sedated	☐ Communicated patient concerns to other staff members	☐ Physical layout of OR
Anxious ☐ Unresponsive	☑ Remain with patient during induction	☐ Personnel present during procedure
☑ Appropriate for age		☐ Environment (noise, temperature, etc.)
Other		☐ Post-op expectation (PACU, drains, etc.)

Potential For Impaired Skin Integrity Related To Surgical Procedure – Outcome: Patient is injury free ☑ Yes ☐ No

ıperative Position:	Positional Aids:				Comments:
Supine ☐ Beach chair		☐ Airplane	☐ Axillary roll	☐ Bean Bag	
Prone ☐ Sitting	☑ Arms <90	☐ Fracture Table	☑ Gel Pad	☑ Gel donut	
Jackknife ☐ Lateral L / R	Armboard: ☑ L ☑ R	☐ Hand Table	☐ Leg Holder	☐ Pillows	
Lithotomy	Tucked: ☐ L ☐ R	☐ Stirrups	☑ Tape	☐ Wilson Frame	
Other:		☐ Other:			

,SU # 6	DVT Prevention:	Tourniquet: ☒	
ad Site: Rt Flank	SCD used ☑ No ☐ Yes	☐ Arm ☐ Leg # _____	Comments:
ad Lot # 61277	Pressure: ___ ☐ Left ☐ Right	☐ Left ☐ Right	
ite Clear at end of case? ☐ No ☑ Yes	Teds: ☑ No ☐ Yes	☐ webril applied	Applied by:
No, see RN note # 0	Bair Hugger used: ☑ No ☐ Yes	↑ ___ ↓ ___	Total Min:
ipolar: ☒ Max Cut 30 Coag 30	Other warming techniques:	↑ ↓	

Comments: _____

(b)(6)-4

(b)(3)-1 10APR03

PERSONAL DATA PRIV ACT

(b)(3)-1 P ative Plan Of Care & Nursing Note

MEDCOM - 4808

Potential For Infect — Outcome: Appropriate Actions Taken to Prevent Infection ☐ Yes ☐ No

Wound Classification: ☐ I ☑ II ☐ III ☐ IV

Shave Prep: ☒ ☐ Shave ☐ Clipper Area: _____ By: _____

Skin Prep: ☑ Betadine Scrub / Povid ☐ Hibiclens ☐ Duraprep ☐ Other:

Solutions/Medications: ☑ Normal saline ☐ Sterile water ☐ Local _____ ☐ Antibiotics _____ ☐ Other: _____

Drains/Packing: ☐ None
☐ Foley FR: _____
☐ JP #1 Fr ___ Location: _____ #2 Fr ___ Location: _____
☐ Hemovac: Size ____ Location _____
☐ Chest tube: Location _____
Size _____ H2O Pressure: _____
☑ Packing: type/location: W-D
☐ See RN Note # ____ for comments

Dressing: Location: _____

☑ ABD	☐ Cervical Collar	☐ Kling	☐ Steri-strips	☐ Benzoin
☐ Ace	☐ Coban	☐ Immobilizer	☐ Tape	☐ Mastisol
☐ Bias	☐ Drip Pad	☑ Plains	☐ Webril	☑ Bacitracin
☐ Band-Aid(s)	☐ Fluffs	☐ Sling	☐ Xeroform	
☐ Cast	☑ Kerlix	☐ Splint	☐ Other:	

Miscellaneous

Counts: (initials)
Scrub: _____ RN: _____
(b)(6)-2 _____ (b)(6)-2 _____

Correct?
Sharps ☑ Yes ☐ No ☐ N/A
Sponges ☑ Yes ☐ No ☐ N/A
Instruments ☐ Yes ☐ No ☐ N/A

☐ See RN note # ____ for additional comments

Xray: ☐ None ☐ Portable ☐ C-Arm ☐ Other:

Skin Integrity: ☐ Clear & Intact (other than incision)
Comments: Multiple Staples / Gauze.
☐ See RN note # ___ for additional comments.

Implants:
Item / Lot # / Exp Date: Ø

☐ See RN note # ____ for additional comments.

Discharge from Operating Room

Complications: ☑ None Comments: _____
☐ See RN note # ____ for additional comments

Transport From OR: ☑ gurney w/ siderails up ☐ Litter w/ safety strap in place ☐ w/ Oxygen ☐ w/ Monitor ☐ Other:

Transferred To: ☑ PACU ☐ ICU ☐ Medivac ☐ Ward ____ ☐ Other

Report by: ☑ Anesthesia provider ☐ RN

Surgical Procedure Performed: (+2) / W-D packing Thigh / gauze wounds

RN Note: (number each note to corresponding area above) Ø

(b)(6)-2 **Name Box: (Please Print)** (b)(6)-2

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

Primary OR RN Signature **Date** 17 APR 03

Relief OR RN Signature **Date/Time**

PeriO rative Plan Of Care & Nursing Note

Patient Assessment For Surgery - Potential For Injury - Outcome: Patient is free from signs and symptoms of injury ☑ Yes ☐ No

Trauma# or Patient # (b)(6)-4 | Diagnosis: Shrapnel BLE | Planned Procedure: Bullet Extraction / Wound Closure | Side: ☑ N/A ☐ Right ☐ Left

Date: 04/23/03 Arrival Time: 1300 Interviewer: (b)(6)-2 Age: 47 HT: WT:

From:
☐ CASREC
☐ ICU
☑ Ward
☐ OTHER:

Transport Via:
☑ Gurney
☐ Litter
☐ Ambulated
☐ Wheelchair
☐ Other

Patient ID:
☐ Trauma card
☐ Verbal
☑ Chart
☑ Armband
☐ Other

Blood Ordered:
☑ N/A
☐ Yes ☐ Consent
☐ T/C #Units
☐ T/H #Units
Comments:

Surgical/Anesthesia Consent Verified:
☐ Procedure
☐ Consent complete, dated, signed
☑ Emergent case; no consent, MD note

Preop Labs (HCG, etc):
☐ None ☐ Yes
Test/Results:

Drug/Latex Allergies:
☑ NKDA
Allergy/Reaction:

Present On Admission:
☐ N/A
☐ Oxygen
☑ IV Site: #1 RA
#2 LA
☐ Foley
☐ Endotrachial Tube
☐ Arterial Line Site:
☐ Drain(s)
☐ Chest Tube(s)
☐ See RN Note #

Past Medical History:
☑ None known
☐ Smoker ppd/yrs ___/___
☐ ETOH ☐ Asthma
☐ HTN ☐ CAD
☐ GERD ☐ CBR exposure
☐ Other: diabetic

Past Surgical History:
☐ None known
☐ Yes
List:

Cultural Needs Addressed:
☑ Yes ☐ No
List: Iraqi EPW

Pre-Op Pain:
☑ No
☐ Yes Level ____(0-10)
Action Taken:
Location/type:

unable to assess

Last PO Intake: (date/time)
Solid: 7p MN
Liquid:

In Chart:
☑ H&P ☐ Yes ☐ No
☑ EKG ☐ Yes ☐ No
☑ CXR ☐ Yes ☐ No
☐ Other:

Skin Condition:
☐ Intact
☑ Other:

Limitations:
☑ N/A
☑ Language
☑ Mobility
☑ Other:
☐ Auditory
☐ Visual
☐ Prosthesis

Personal Items:
☑ None
☐ Military gear
☐ Glasses
☐ Dentures
☐ Jewelry/wallet
☐ Other
Disposition:

Potential For Anxiety – Outcome: Patent demonstrates knowledge of psychological responses to an invasive procedure ☑ Yes ☐ No

Mental/Emotional Status:
☑ Alert/Oriented
☐ Disoriented
☐ Anxious
☑ Appropriate for age
☐ Other
☑ Calm
☐ Sedated
☐ Unresponsive

Comfort Measures Implemented:
☐ Clear, concise explanations
☐ Communicated patient concerns to other staff members
☑ Remain with patient during induction

Pre-op Teaching Included:
☑ N/A due to patient condition
☐ Physical layout of OR
☐ Personnel present during procedure
☐ Environment (noise, temperature, etc.)
☐ Post-op expectation (PACU, drains, etc.)

Potential For Impaired Skin Integrity Related To Surgical Procedure – Outcome: Patient is injury free ☑ Yes ☐ No

Operative Position:
☑ Supine
☐ Prone
☐ Jackknife
☐ Lithotomy
☐ Other:
☐ Beach chair
☐ Sitting
☐ Lateral L / R

Positional Aids:
☑ Arms <90
Armboard: ☑ L ☑ R
Tucked: ☐ L ☐ R
☐ Airplane
☐ Fracture Table
☐ Hand Table
☐ Stirrups
☐ Other:
☐ Axillary roll
☑ Gel Pad
☐ Leg Holder
☐ Tape
☐ Bean Bag
☐ Gel donut
☐ Pillows
☐ Wilson Frame

Comments:

ESU # 009
Pad Site: 106978
Pad Lot # 0Nom
Site Clear at end of case? ☐ No ☑ Yes
If No, see RN note #
Bipolar: ___ Max Cut 30 Coag 30

DVT Prevention:
SCD used ☑ No ☐ Yes
Pressure: ___ ☐ Left ☐ Right
Teds: ☑ No ☐ Yes
Bair Hugger used: ☐ No ☑ Yes Upper
Other warming techniques:
Warm Sheet

Tourniquet: N/A
☐ Arm ☐ Leg
☐ Left ☐ Right
☐ webril applied
#
Applied by:
Total Min:
↑ ___ ↓ ___
↑ ↓

Comments:

(b)(6)-4

Comments:

Potential For Infec' ' – Outcome: Appropriate Actions Taken to ' 'ent Infection ☐ Yes ☐ No

Vound Classification: I ☐ II ☐ III ☐ IV

Shave Prep: N/A ☐ Shave ☐ Clipper Area: _____ By: _____

Skin Prep: ☐ Betadine Scrub ☐ Hibiclens ☐ Duraprep ☐ Other: Paint BLG Goin

Solutions/Medications: ☐ Normal saline ☐ Sterile water ☐ Local _____ ☐ Antibiotics _____ ☐ Other: _____ 0.25% Marcaine c Epi

'rains/Packing: ☐ None
Foley FR: _____
JP #1 Fr ___ Location: _____ #2 Fr ___ Location: _____
Hemovac: Size ____ Location _____
Chest tube: Location _____
Size _____ H2O Pressure: _____
Packing: type/location: Bthigh Kerlix
See RN Note # ____ for comments

Dressing: Location: BLG
☐ ABD ☐ Ace ☐ Bias ☐ Band-Aid(s) ☐ Cast
☐ Cervical Collar ☐ Coban ☐ Drip Pad ☐ Fluffs ☐ Kerlix Bthigh
☐ Kling ☐ Immobilizer ☐ Plains ☐ Sling ☐ Splint
☐ Steri-strips ☐ Tape Silk ☐ Webril ☐ Xeroform ☐ Other: Sutures, Kling
☐ Benzoin ☐ Mastisol ☐ Bacitracin
BANDAIDS Bthigh

Miscellaneous

ounts (initials)
crub: (b)(6)-2 Pad (b)(6)-2
(b)(6)-2 (b)(6)-2
Correct?
Sharps ☐ Yes ☐ No ☐ N/A
Sponges ☐ Yes ☐ No ☐ N/A
Instruments ☐ Yes ☐ No ☐ N/A
See RN note # ____ for additional comments

Xray: ☐ None ☐ Other: ☐ Portable ☐ C-Arm

Skin Integrity: ☐ Clear & Intact (other than incision)
Comments: _____
☐ See RN note # ___ for additional comments.

nplants:
em / Lot # / Exp Date:

See RN note # ___ for additional comments.

Discharge from Operating Room

omplications: None Comments: _____
See RN note # ____ for additional comments

Transport From OR: ☐ gurney w/ siderails up ☐ Litter w/ safety strap in place ☐ w/ Oxygen ☐ w/ Monitor ☐ Other:

Transferred To: ☐ PACU ☐ ICU ☐ Medivac ☐ Ward _____ ☐ Other
Report by: ☐ Anesthesia provider ☐ RN

ırgical Procedure Performed: Bullet Extraction Bthigh, Closure Wound Bthigh

N Note: (number each note to corresponding area above)

Initial/Name Box: (please print)
(b)(6)-2 (b)(6)-2

(b)(6)-2
Primary OR RN Signature **Date** 04/23/03 **Relief OR RN Signature** **Date/Time**

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 4/14/03

DATE AND HOUR REQUIRED 4/15/03 O.R.

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)* DR (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE

MULTIPLE 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 (b)(6)-2

DATE VERIFIED 14APR03

TIME VERIFIED 1930

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. (b)(6)-4

TRANSFUSION NO. (b)(6)-4

PATIENT NO.

TEST INTERPRETATION

ANTIBODY SCREEN: NEG

CROSSMATCH: Comp

[ ] CROSSMATCH NOT REQUIRED FOR THE COMP

REMARKS: EXP 27APR03

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

SIGNATURE OF PERSON PERFORMING TEST (b)(6)-2

(b)(6)-2

DATE 4/14/03

DONOR ABO A Rh POS

RECIPIENT ABO A Rh POS

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)* (b)(6)-2

AT *(Hour)* 2205 ON *(Date)* 4/14/03

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)* (b)(6)-2 2210 4/14/03

2nd VERIFIER *(Signature)* (b)(6)-2 2210 4/14/03 LT/SLNC

PRE-TRANSFUSION TEMP. 99.1 PULSE 87 BP 120/70

DATE OF TRANSFUSION 14APR03 TIME STARTED 2220

POST-TRANSFUSION DATA

AMOUNT GIVEN 300 ML

TIME/DATE COMPLETED/INTERRUPTED 0210 15 APR 03

REACTION [X] NONE [ ] SUSPECTED

TEMPERATURE 98.7 PULSE 72 BLOOD PRESSURE 118/70

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 (b)(6)-2 LT/SLNC

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

(b)(6)-4

SEX M

WARD 5FWD STBL

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

Medical Record Copy

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
- [ ] CROSSMATCH

DATE REQUESTED: 18APR03

DATE AND HOUR REQUIRED: 18APR03 1030

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)*: Dr (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE: Shrapnel wounds

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: (b)(6)-2, EWS, NC

DATE VERIFIED: 18APR03

TIME VERIFIED: 1030

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.: (b)(6)-4

TRANSFUSION NO.: (b)(6)-4

PATIENT NO.:

DONOR	RECIPIENT
ABO: A	ABO: A
Rh: POS	Rh: POS

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NEG	Comp

[ ] CROSSMATCH NOT REQUIRED FOR TH... ED

REMARKS: Exp 27 Apr 03

PREVIOUS RECORD CHECK: [ ] RECORD [x] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST: (b)(6)-2

DATE: 4-18-03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*: (b)(6)-2

AT *(Hour)* 2040 ON *(Date)* 4-18-03

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.

(b)(6)-2 LCDR/NC

(b)(6)-2 CDR/NC

PRE-TRANSFUSION

TEMP. 102.0 PULSE 94 BP 96/52

DATE OF TRANSFUSION: 4/18/03

TIME STARTED: 2058

POST-TRANSFUSION DATA

AMOUNT GIVEN	TIME	DATE	COMPLETED	INTERRUPTED
1 unit ML	0030	19Apr03	yes	NO

REACTION [ ] NONE [ ] SUSPECTED

If reaction is suspected – IMMEDIATELY:

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

DESCRIPTION

- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER _____

OTHER DIFFICULTIES *(Equipment, clots, etc.)*

- [x] NO
- [ ] YES *(Specify)* _____

SIGNATURE OF PERSON NOTING ABOVE: (b)(6)-2

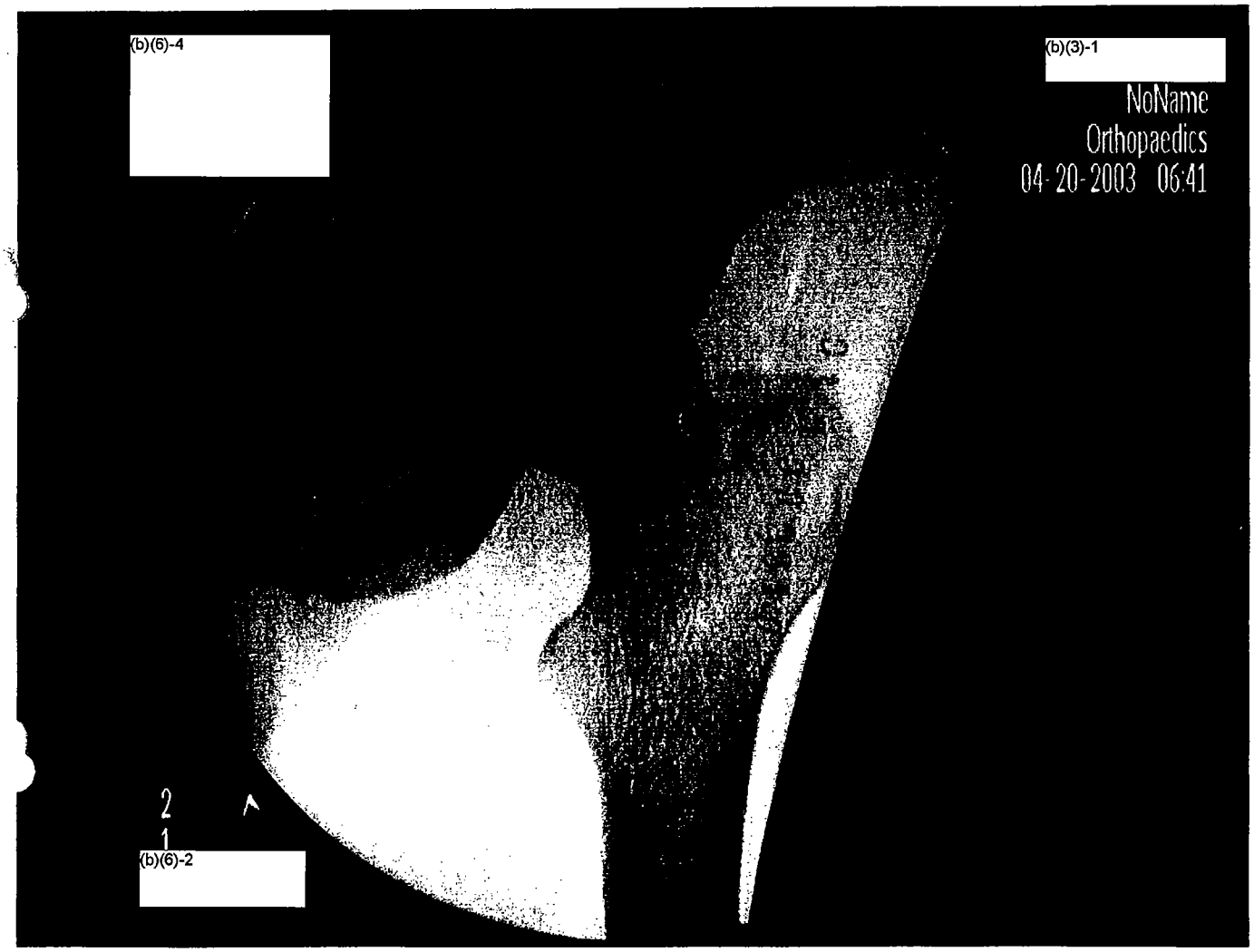
PATIENT IDENTIFICATION - USE EMBOSSER *(For typed or written entries give: NAME - Last, first, middle; rank/rate; hospital number and name of facility.)*

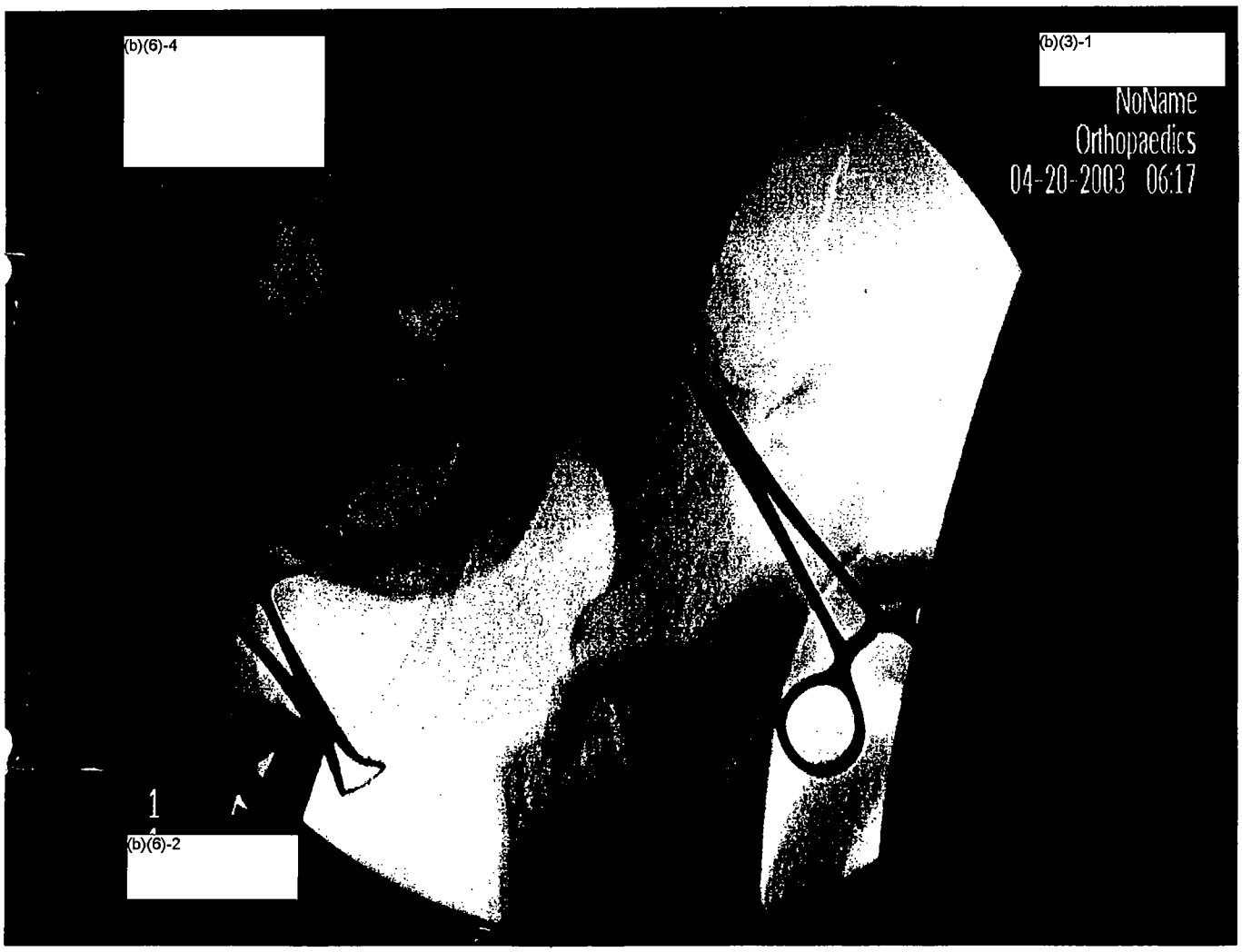
(b)(6)-4

SEX:

WARD: 5 FWD

BLOOD OR BLOOD COMPONENT TRANSFUSION
STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-121


(b)(6)-4
(b)(3)-1
NoName
Orthopaedics
04-20-2003 06:41
2
1
(b)(6)-2


(b)(6)-4
(b)(3)-1
NoName
Orthopaedics
04-20-2003 06:17
1
(b)(6)-2

NSN 7540-00-634-4162

519-218

PATIENT IDENTIFICATION *(For typed or written entries give: Name — last, first, middle, Medical Facility)*
(b)(6)-4

Bed T

AGE	SEX	SSN *(Sponsor)*	WARD/CLINIC	REGISTER NO.
	M		CAS RK	

EXAMINATION REQUESTED *(Use F 519-B for multiple exams)*
Abdomen, Right Femur, Left Femur, Left Knee, Right Elbow, Skull Series

REQUESTED BY (b)(6)-2

TELEPHONE NO.

LOCATION OF MEDICAL RECORDS

FILM NO.

DATE REQUESTED 06 AUG 03

PREGNANT ☐ YES ☐ NO

SPECIFIC REASON(S) FOR REQUEST *(Complaints and findings)*
(b)(6)-2

Ward III

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

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

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

RADIOLOGIC REPORT

KUB – air from stomach to rectum, LUQ ⅓ air in sm bowel. ? shrapnel frag in mid (R) abd. Shrapnel frags over (L) hip.
(R) elbow – single view lg shrapnel frag posterior to distal humerus, multiple sm frags over olecranon ? Fx fragment over inferior prox ulna vs guaze.
(over)

SIGNATURE

LOCATION OF RADIOLOGIC FACILITY

1 — MEDI

MEDCOM - 4816

REPORT

STANDARD FORM 519-A (REV. 8-83)
Prescribed by GSA/ICMR

Single view (R) femur - shrapnel in lat ST's. Ø dif Fx or cortical infraction.

(R) knee - Ø Fx

(L) femur single view shrapnel in medial ST's of prox thigh and 2 fragments over distal diaphysis Ø Fx but can't exclude cortical infraction.

(L) knee single view - 2 shrapnel frags over distal femur prox tib ~~fib~~ fib ~~s~~ Fx

Skull AP/lat - prominent dural vasc markings Ø depressed skull Fx can't exclude linear Fx

(b)(6)-2

NSN 7540-00-634-4162 519-218

PATIENT IDENTIFICATION *(For typed or written entries give: Name — last, first, middle, Medical Facility)*
(b)(6)-4
Bed T

AGE	SEX	SSN *(Sponsor)*	WARD/CLINIC	REGISTER NO.
	M		CAS RK	

EXAMINATION REQUESTED *(Use 519-B for multiple exams)*
Abdomen, Right Femur, left Femur, left Knee, Right Elbow, Skull Series

REQUESTED BY	TELEPHONE NO.
(b)(6)-2	

LOCATION OF MEDICAL RECORDS	FILM NO.	DATE REQUESTED	PREGNANT
		06 AUG 03	☐ YES ☐ NO

SPECIFIC REASON(S) FOR REQUEST *(Complaints and findings)*
(b)(6)-2
Ward III

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

RADIOLOGIC REPORT

KUB - air from stomach to rectum, LUQ ≤ air in sm bowel. ? shrapnel frag in mid (R) abd. Shrapnel frags over (L) hip.
(R) elbow - single view lg shrapnel frag posterior to distal humerus, multiple sm frags over olecranon ? Fx fragment over inferior prox ulna vs gauze.
(over)

SIGNATURE | **LOCATION OF RADIOLOGIC FACILITY**

1 – MEDICAL RECORD

RADIOLOGIC CONSULTATION REQUEST/REPORT

STANDARD FORM 519-A (REV. 8-83)
Prescribed by GSA/ICMR
FPMR (41 CFR) 201-45.505

☆ U.S GOVERNMENT PRINTING OFFICE : 1987-181-243/40522

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

IENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
5/4/03	2300 HOURS	

Admit to: ECW3
DX - Sepsis diff unknown
DDIM
COAD - [illegible]
VS PR
Activity - As tolerated

ISING UNIT | ROOM NO. | BED NO.

IENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	
	HOURS	

MSO4 2-5 mg IV Q 3-4 PRN
Tylenol #3 ½-1 PO Q 3-4 PRN
Diet: regular
Continue current insulin order
A/C in AM
~~Prinivil~~ (b)(6)-2 (b)(6)-2 noted

ISING UNIT | ROOM NO. | BED NO.

IENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	
	HOURS	

MPH 3cc IV Bolus ~~at~~ s/
P evening meal
Chart vel MAS (b)(6)-2
4 May 03 2357
Chart vel MAS (b)(6)-2
5 May 03 2350 (b)(6)-2

4 May 03 2030

ISING UNIT | ROOM NO. | BED NO.

IENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	
	HOURS	

ISING UNIT | ROOM NO. | BED NO.

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

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

508-111

NSN 7540-00-634-4121

MEDICAL RECORD — DOCTOR'S ORDERS

(Sign all orders)

DATE AND TIME START	DATE AND TIME STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
10 Apr 03			1) Admit to Surgery.		(b)(6)-2
1840			2) Attending, CAPT (b)(6)-2		(b)(6)-2
			3) Condition, Stable		(b)(6)-2
Faxed			4) NKDA		(b)(6)-2
			5) Meds -		(b)(6)-2
			a) Ancef 1gm IVPB, first dose in CAS RES		(b)(6)-2
			6) IV - LR @ 75cc/hour		(b)(6)-2
			7) Foley to gravity		(b)(6)-2
			8) I+O Q8H		(b)(6)-2
			9) Vitals Q8H		(b)(6)-2
			10) Trauma lab services, done in CAS REC		(b)(6)-2
			11) Fasting Blood glucose in a.m., 11 April		(b)(6)-2
			12) Daily wet to dry wound care to (R) arm, (L) groin, both thighs, penis		(b)(6)-2
			13) Call MO if temp >101.5, BP >180, ≤ 100 Systolic		(b)(6)-2
			14) ~~Fentanyl~~ Meds Morphine 2-4 mg IV Q 15 minutes, max 10 mg, for severe pain.		(b)(6)-2
			b) Tylenol #3, 1 or 2 PO Q4H PRN moderate pain.		(b)(6)-2
			c) Tylenol 650mg PO Q4H PRN temp >100.0		(b)(6)-2
			d) Maalox 30 cc PO Q4H PRN gastric irritation		(b)(6)-2
			e) Milk of Magnesia 30cc PO Q4H PRN constipation		(b)(6)-2
			f) Ambien 5mg PO QHS PRN sleep.		(b)(6)-2

(Continue on reverse side)

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

4/10/03 2145

(b)(6)-4

REGISTER NO. Covers CAPT (b)(6)-2

(b)(6)-2

DOCTOR'S ORDERS

(b)(6)-2

STANDARD FORM 508 (Rev. 3-84)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDICAL RECORD		DOCTOR'S ORDERS (Sign all orders)		
DATE AND TIME START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
		15	Diet - regular	(b)(6)-2	(b)(6)-2
		16	X-rays - femur both legs, R forearm, CXR - compare	CAPT (b)(6)-2	MC USN (b)(6)-2
					(b)(6)-2
4/10/03	2130			(b)(6)-2	
4/11/03	1400		Ativan 1mg - 1/2 tab tid prn anxiety. Glucotrol 5mg qam c̄ breakfast.	(b)(6)-2	
11 APR 03	1615	1	Δ IV to .9% NSS.	(b)(6)-2	
		2	Multivit qAM.	CDR/NC/USN	
		3	High K+ diet. ADA diet.	(b)(6)-2 516 FNP	
			Noted (b)(6)-2 LTJG NC 4/11/03 1645		
11APR03	1655	4	Glucotrol Δ to Glibenclamide - pharmacy noted.	(b)(6)-2	
			Noted (b)(6)-2 4/11/03 1800		
12APR03	0950		Valium 5mg IVP tid prn agitation q6° prn	(b)(6)-2	
				(b)(6)-2	
					4-12-03 0950
	(b)(6)-4				

☆ U.S. GOVERNMENT PRINTING OFFICE: 1995-397-818

STANDARD FORM 508 (Rev. 3-94) BACK

MEDICAL RECORD		DOCTOR'S ORDERS (Sign all orders)		
DATE AND TIME START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
11 APR 03	1900	①	0.5ml (H) Td [illegible]	(b)(6)-2	(b)(6)-2
			0.5mL Td given @ 1958	(b)(6)-2 CDR/NC/USN 2516	
4/12/03 @0245			Noted [illegible]	(b)(6)-2 /NC	
			24° chart verification [illegible]	(b)(6)-2 /NC	
4/12/03	1415	①	BMP in AM - in CHCS	(b)(6)-2	
			Noted (b)(6)-2 LT/LC 1600 4/12/03	CDR/NC/USN 2516	
4/13/03	0125		24° chart verification	(b)(6)-2	EN/NT
4-13-03	1435		BMP in am.	(b)(6)-2	FNP
			(b)(6)-2 1600		
4-13-03	1622	①	CBC in AM	(b)(6)-2	
		②	D/C IV	(b)(6)-2	(b)(6)-2
		③	D/C Ancef	(b)(6)-2 CDR/NC/USN 2516	(b)(6)-2
		④	Keflex 250mg PO q6° x 7 days.		(b)(6)-2
			Noted (b)(6)-2 LT/LC 4/13/03 1700	(b)(6)-2	FNP
Apr 14 @ 0045			24° chart verification		(b)(6)-2

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO.

WARD NO.

DOCTOR'S ORDERS

STANDARD FORM 508 (Rev. 10-75)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45-505
508-112

MEDICAL RECORD		DOCTOR'S ORDERS (Sign all orders)		
DATE AND TIME START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
14 Apr 03		1	Void on call to OR.		(b)(6)-2
		2	NPO p̄ MN		(b)(6)-2
		3	meds ĉ sip H_2O		(b)(6)-2
		4	FBS in AM @ 0500		(b)(6)-2
			(b)(6)-2	(b)(6)-2 CDR MC	
			(b)(6)-2 14 Apr 03 ~~1335~~		
14 Apr 03		1	Repeat CBC.		(b)(6)-2
		2	T+C x 2 units pRBC.		(b)(6)-2
			Noted (b)(6)-2 (b)(6)-2 CDR MC		
			1940 4/14/03 LJJ (b)(6)-2		
14 Apr 03 1950		1	Fasting glucose 0500 ~~on 4-16-03~~ 9 AM	(b)(6)-2	
			Noted (b)(6)-2 LJJ/CNC 4/14/03 2040		
4/14/03 2150			T.O. Dr. (b)(6)-2 / LJJ/C (b)(6)-2		
			Transfuse 1u PRBC		
			Premedicate Tylenol 650mg + Benadryl 25mg PO X1		
			K Phos 20mEq PO X1 now		
			K Phos 20mEq PO X1 in 2hrs		
			(Continue on reverse side)		

PATIENT'S IDENTIFICATION (For typed or written ... middle; grade; rank; rate; hospital or medical facility) (b)(6)-4

Noted (b)(6)-2 LJJ/CNC 4/14/03 2205 Cont. (b)(6)-2

REGISTER NO.

DOCTOR'S ORDERS

STANDARD FORM 508 (Rev. 10-75) Prescribed by GSA and ICMB FPMR (41 CFR) 101-45-505 508-142

4/15/03 @ 0045 24° chart rev ADC (b)(6)-2

MEDICAL RECORD		DOCTOR'S ORDERS (Sign all orders)		
DATE AND TIME START	DATE AND TIME STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
4/14/03 2150			3u Humulin Insulin SQ X1 now CBC + Fasting Glucose in AM 4/15 Noted (b)(6)-2 LTJG NC (b)(6)-2 LTJG NC 4/14/03 2210		
4/14/03 2240			T.O. Dr (b)(6)-2 / LTJG (b)(6)-2 Δ KPhos to KDur (b)(6)-2 (b)(6)-2 LTJG NC Noted (b)(6)-2 LTJG NC		
4/15/03 @ 0045			24° chart verification (b)(6)-2		
4/15/03 0830			① Humulin SQ 5u now ② Ancef 1gm IVPB now (b)(6)-2 (b)(6)-2	4/15/03 0825	CDR

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO.

WARD NO.

DOCTOR'S ORDERS

STANDARD FORM 508 (Rev. 10-75)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45-505
508-112

506-111

NSN 7540-00-634-4129

MEDICAL RECORD

DOCTOR'S ORDERS
(Sign all orders)

DATE AND TIME START	DATE AND TIME STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
			ANESTHESIA PACU ORDERS		
4/15/03 (0930)		1.	Admit to PACU.		
		2.	Allergies: NKDA		
		3.	Vital signs per PACU protocol.		
		4.	O2: ✓ FM @ 10LPM, ___ ___% Blowby, ___ NP @ _____ LPM.		
		5.	IVF: NS at KVO cc/hr		
		6.	On ward: 02 @ 2-3 LPM via NC: YES (NO)		
		7.	Pain medication:		
			Ketorolac ____mg IV x1 dose (adults 30 mg max; peds consider 0.2-0.4 mg/kg)		
		1st	MSO4 1-2 mg IV q 5 min prn; max dose 20 mg		
		2nd	Fentanyl 25-50 mcg IV q 5 min prn; max dose 150 mcg		
			Percocet _____ tab(s) p.o. with sip of water		
			Other: Demerol 12.5-25mg (max) IV prn shivering		
		8.	Antiemetics:		
		#1	Ondansetron 4 mg IVP, may repeat x1 in 15 min (0.1mg/kg; max 4 mg)		
		#2	Metoclopramide 10 mg IV x1 (0.15 mg/kg; max 10 mg)		
			~~Droperidol Ø mg IV x 1 dose (0.01 mg/kg; max 0.625 mg) Must have baseline ECG available before administration.~~		
			Other Ø		
		9.	Clear liquids as tolerated: YES (NO)		
		10.	Notify Anesthesia (pager 1506) for airway issues, pain, nausea/vomiting not responsive to above orders or other patient problems/concerns per PACU protocol.	(b)(6)-2	CRNA/LCDR

(b)(6)-2

(b)(6)-2

(rev 3/2002)

(OVER) 4/15/03 (0930)

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name–last, first, ... ate: hospital or medical facility)

(b)(6)-4

REGISTER NO.

WARD NO.

DOCTOR'S ORDERS
Medical Record

STANDARD FORM 508 (Rev. 3-94)
Prescribed by GSA-ICMR FIRMR (41 CFR) 201-9.202-1

MEDICAL RECORD

DOCTOR'S ORDERS
(Sign all orders)

DATE AND TIME START	DATE AND TIME STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
			ANESTHESIA PACU ORDERS -- CONTINUED		
		11.	Discharge patient from PACU per protocol: YES NO		
4/15/03 (0930)		12.	When epidural/spinal patients meet discharge criteria per PACU protocol, discharge to ward. On ward: bedrest pending full recovery of sensory and motor function; progress to ambulation with assistance.		
			FOR PACU KEEP PATIENTS ONLY		
		13.	Release patient from anesthesia care to KEEP status when patient meets anesthesia discharge criteria: YES NO		
		14.	Notify anesthesia (1506) for airway management and: (circle if applicable)		
			a. Pain management		
			b. Fluid management		
			c. Other _____		
		15.	TOW patient to ward in a.m. if patient meets discharge criteria: YES NO		
		16.	Finger stick blood glucose now.		
			Signature (b)(6)-2 Beeper (b)(6)-2	LCDR/NC 4/15/03 (0930)	

STANDARD FORM 508 (Rev. 3-94) BACK

MEDICAL RECORD	DOCTOR'S ORDERS (Sign all orders)		
DATE AND TIME START / STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE / NURSE'S SIGNATURE
15 April 03	1	PACU then Tower 5 forward starboard.	[(b)(6)-2]
	2	DX Sip Multiple I+D's GSW	[(b)(6)-2]
	3	Stable.	[(b)(6)-2]
	4	VS q 6 hrs	[(b)(6)-2]
	5	NKDA.	[(b)(6)-2]
	6	Dressings: DO NOT Pull out Wicks placed in the wounds. IF Soaking through → CAREFully Remove Spandage, Remove Kerlex + all gauze. Replace with sterile gauze. PRN. DO NOT pull out Wicks placed.	[(b)(6)-2]
	7	Resume medical regimen pt was on pre-op.	[(b)(6)-2]
	8	CBC + BMP in AM (fasting). 16, 17 Apr 03	[(b)(6)-2]
		FBS before meals. (mid day, evening + qhs)	
		If BG ≤ 200 ∅ Humulin Taken 12 Pacel @1145 186.	
		>201 ≤250 5u Humulin SQ.	
		>251 ≤300 8u " "	[(b)(6)-2]
		>301 ≤350 12u " "	
		>351 15u call MO	
1251		T.O. DR [(b)(6)-2] / ENS [(b)(6)-2] [(b)(6)-2] EVENING	
		INDWELLING FOLEY [(b)(6)-2]	USA
		[(b)(6)-2]	
		[(b)(6)-2]	CRY 15 April 1430

(Continue on re[illegible])

PATIENT'S IDENTIFICATION (For typed or written entries give: Name – last, f[illegible] middle; grade; rank; rate; hospital or medical facility) [(b)(6)-4]

WARD NO.

5 Forward Starboard

16 Apr @0030 — 24° chart verification [illegible]

DOCTOR'S ORDERS

STANDARD FORM 508 (Rev. 10-75)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45-505
508-112

[(b)(6)-2]

Voided + faxed 15 Apr 1222 [(b)(6)-2]

MEDICAL RECORD | **DOCTOR'S ORDERS** (Sign all orders)

DATE AND TIME START	DATE AND TIME STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
16 Apr 03		1	DC Foley @ 2300 today		
		2	Due to void. 17 Apr 0900		
		3	If Dressing get soaked → Δ c sterile technique.		
		4	ADA Diet.		
			(b)(6)-2 (b)(6)-2		
			noted (b)(6)-2 1215		
4/16	1600		V.O. from Dr. (b)(6)-2 to ENS (b)(6)-2		
			1) Blood Cultures x2	(b)(6)-2	
			2) Urine C+S	(b)(6)-2	
			3) Tylenol 650mg	(b)(6)-2	
			(b)(6)-2 noted (b)(6)-2		
4-16-03	1630	11.	Tolbutamide to 10mg c breakfast/dn	(b)(6)-2	
			Noted (b)(6)-2 LTJG NC 4/16/03 1650		
16 Apr 03 1745		1	I&S qt		
		2	CXR PA+Lat	(b)(6)-2	
		3	Thank you		
			Noted (b)(6)-2		

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written Name - last, first, middle; grade; rank; rate; hospital or medical facility)

(b)(6)-2 (b)(6)-2 4/16/03 1945

(b)(6)-4

REGISTER NO. | WARD NO.

DOCTOR'S ORDERS

STANDARD FORM 508 (Rev. 10-76)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505
508-111
☆U.S. GPO: 1988—201-780/80076

MEDICAL RECORD		DOCTOR'S ORDERS (Sign all orders)		
DATE AND TIME START	DATE AND TIME STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
16 Apr 03 1745		①	Δ Sliding Scale. Humulin		(b)(6)-2
			≤ 200 Ø U		
			>201 ≤250 8 u		
			>251 ≤300 12 u		
			>301 ≤350 16 u.		
			>351 18 u call MO		
		②	Ancef 1gm IVPB q 8°	(b)(6)-2	
		③	DC Keflex.		
			Noted (b)(6)-2 LTJC (b)(6)-2 4/16/03 2000		
			T.O. DR. (b)(6)-2 /HN (b)(6)-2		(b)(6)-2
			① PT TO OR 17APRØ3 @ ØØ3Ø.		
			② MUST HAVE INTERPRETER ON STAND BY BY ØØØØ.		
			③ PT NPO P MN.		
			④ IF PT SPIKES TEMP, SEND BLOOD CX X2 AND GIVE TYLENOL.		
			⑤ PT DTV BY ØØØØ 17APRØ3.		
			(b)(6)-2		
4/17/03	0030		Noted (b)(6)-2 24° chart verification (b)(6)-2		

(Continue on reverse side)

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

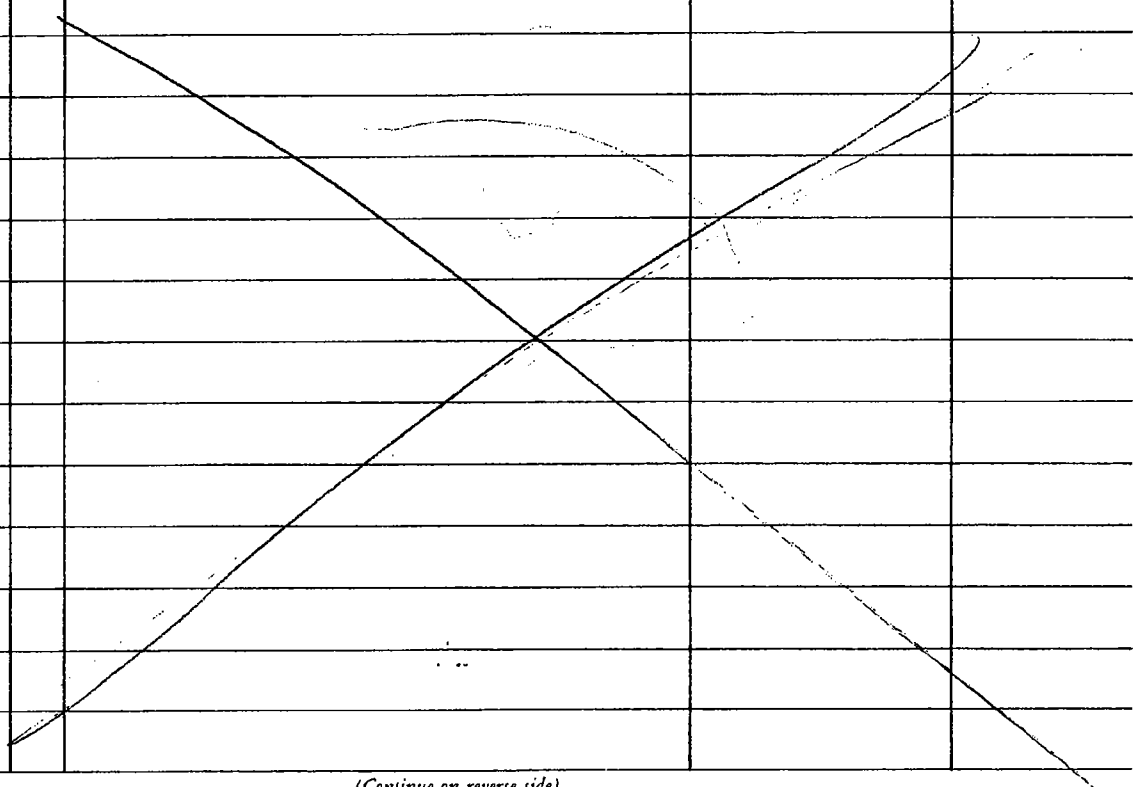
(b)(6)-4

REGISTER NO.	WARD NO.

DOCTOR'S ORDERS

STANDARD FORM 508 (Rev. 10-75)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45-505
508-112

MEDICAL RECORD		DOCTOR'S ORDERS (Sign all orders)		
DATE AND TIME				
START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
17 Apr 03		1	DC Avcef -		(b)(6)-2
		2	Primaxin 500 mg IV q 6°		
		3	Contact Precautions for acinetobacter		
		4	1 l acetic acid solution 3% for dressing Δ's		
			(b)(6)-2		
			(b)(6)-2 CDR MC		
			Noted by (b)(6)-2 ENS/NC, RN (b)(6)-2 17APR03		



(Continue on reverse side)

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

(b)(6)-4

REGISTER NO.	WARD NO.

DOCTOR'S ORDERS

STANDARD FORM 508 (Rev. 10-75)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45-505
508-112

508-111

NSN 7540-00-634-4121

MEDICAL RECORD — **DOCTOR'S ORDERS** (Sign all orders)

DATE AND TIME START	DATE AND TIME STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
4/17/07			**ANESTHESIA PACU ORDERS**		
0958		1.	Admit to PACU.		
		2.	Allergies: Ø		
		3.	Vital signs per PACU protocol.		
		4.	O2: ~~1~~ 2 FM @ ~~10~~ 5 LPM, ___ ___% Blowby, ___ NP @ _____ LPM.		
		5.	IVF: NS at 100 cc/hr		
		6.	On ward: 02 @ 2-3 LPM via NC: YES (NO)		
		7.	Pain medication:		
			~~Ketorolac ___ mg IV x1 dose (adults 30 mg max; peds consider 0.2-0.4 mg/kg)~~		
			MSO4 25 mg IV q 5 min prn; max dose 30 mg		
			~~Fentanyl ___ mcg IV q ___ min prn; max dose ___ mcg~~		
			~~Percocet ___ tab(s) p.o. with sip of water~~		
			Other: _____		
		8.	Antiemetics:		
			Ondansetron 4 mg IVP, may repeat x1 in 15 min (0.1mg/kg; max 4 mg)		
			Metoclopramide ___ mg IV x1 (0.15 mg/kg; max 10 mg)		
			~~Droperidol ___ mg IV x 1 dose (0.01 mg/kg; max 0.625 mg) Must have baseline ECG available before administration.~~		
			Other _____		
		9.	Clear liquids as tolerated: (YES) NO		
		10.	Notify Anesthesia (pager 1506) for airway issues, pain, nausea/vomiting not responsive to above orders or other patient problems/concerns per PACU protocol.		
			(rev 3/2002)	(OVER)	

(b)(6)-2

Notified

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name–last, first, rade; rank; rate; hospital or medical facility)

(b)(6)-4

REGISTER NO.

WARD NO.

Printed on Recycled Paper

DOCTOR'S ORDERS
Medical Record

STANDARD FORM

MEDICAL RECORD		DOCTOR'S ORDERS (Sign all orders)		
DATE AND TIME START	DATE AND TIME STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
			ANESTHESIA PACU ORDERS -- CONTINUED		
		11.	Discharge patient from PACU per protocol: YES NO		
		12.	When epidural/spinal patients meet discharge criteria per PACU protocol, ~~discharge to ward. On ward: bedrest pending full recovery of sensory and motor function; progress to ambulation with assistance.~~		
			FOR PACU KEEP PATIENTS ONLY		
		13.	Release patient from anesthesia care to KEEP status when patient meets anesthesia discharge criteria: YES NO		
		14.	Notify anesthesia (1506) for airway management and: (circle if applicable)		
			a. Pain management		
			b. Fluid management		
			c. Other _____		
		15.	TOW patient to ward in a.m. if patient meets discharge criteria: YES NO		
			Signature _____ Beeper (b)(6)-2	MD, CDR (b)(6)-2	

STANDARD FORM 508 (Rev. 3-94) BACK

MEDICAL RECORD | **DOCTOR'S ORDERS** *(Sign all orders)*

DATE AND TIME START	DATE AND TIME STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
			Post op.		
17Apr03		(1)	Resume Pre-op orders.		
		(2)	BID Dressing Δ's ± MD only		
			on call 5-10mg MSO4 IVP		
			1-2mg Versed. IVP		
			Pulse ox. + Nasal O2 6L min.		
			Kerlex on hand 4 rolls.		
			2" tape, CTA's 10		
			4x4 gauze 3 tubs, Suture set.		
			ABD x 2		
		(3)	For Dressing Δ's → prefer gowns		
			& an exam lamp.		
		(4)	MD will call to premediate.		
		(5)	BC ± diff in AM of 19 Apr, BMP in AM + 19 Apr		
		(6)	Advance Diet to AD A Results		
			(b)(6)-2		
			(b)(6)-2 CDR MC		
			(b)(6)-2		
			(b)(6)-2		
17Apr03		(1)	Cooling blanket, Ice, Cool Bags prn T>101		
		(2)	CBC, Bld cx's x2 UA, Urine Cx.		
		(3)	Tylenol 1 tt po q4h		

(b)(6)-2

(Continue on reverse side)

PATIENT'S IDENTIFICATION (b)(6)-2 give: Name - last, first, middle; grade; rank; rate; hosp

LT Stone 4/17/03 2150

(b)(6)-2

DOCTOR'S ORDERS

STANDARD FORM 509 (Rev. 10-75) Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505
508-111
☆U.S. GPO: 1988—201-760/80076

(b)(6)-4

(b)(3)-1

10APR03

PERSONAL DATA PRIV ACT 1974

3s-4/18
3rd round

MEDICAL RECORD			DOCTOR'S ORDERS (Sign all orders)		
DATE AND TIME START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
4/18/03	0110		24° chart verification done	(b)(6)-2	Ens, nc
4/18/03		(1)	Transfuse 1 u PRBC (b)(6)-2		
		(2)	Tylenol ii po Benadryl 25 mg po } Z txn		
		(3)	Q6 temp > 101.5, ux bld x 2 give tylenol ii po + call MD page 140		
			(b)(6)-2		
			Ens Sproull, nc 18APR03 @ 1000		
Apr 18 03 1220		(1)	~~Heparin~~ Lovenox ~~30 mg~~ 40 mg 30 mg Sub Q qD BID	(b)(6)-2 (b)(6)-2	
			(b)(6)-2	(b)(6)-2	
Noted 4/18/03 @ 1900			(b)(6)-2		
			(b)(6)-2		

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO.

WARD NO.

DOCTOR'S ORDERS

STANDARD FORM 508 (Rev. 10-75)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45-505
508-112

MEDICAL RECORD			DOCTOR'S ORDERS (Sign all orders)		
DATE AND TIME START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
APR 18 '03 2037		(1)	Tighten Sliding Scale as follows: (qAC / qHS)		(b)(6)-2
			Blood Sugar — units Reg. insulin		
			< 140 — 0		
			140 - 170 — 2		
			171 - 200 — 4		
			201 - 230 — 6		
			231 - 260 — 8		
			261 - 290 — 10		
			291 + — 12		
		(3)	In addition to sliding scale, give NPH insulin: 4 units pre-breakfast		(b)(6)-2
			4 units pre-dinner		
		(2)	CBC + Bmp in AM (dr CHCS/pediatrics)		(b)(6)-2
			Thank you (b)(6)-2		
			(b)(6)-2		4/18/03
4/18/03 2100			V.O. Dr (b)(6)-2 to 2CDR. (b)(6)-2		
		(1)	Give tylenol 650mg PO q 4 hrs for Temp >101.		
		(2)	Ice packs / cooling blanket to ↓ temps. (b)(6)-2		2CDR
			(b)(6)-2		
			Chart Verification 19 Apr 03		

PATIENT'S IDENTIFICATION (For typed or writ middle; grade; rank; rate; hospital or medical facility

REGISTER NO. (b)(6)-2 WARD NO. 0500

(b)(6)-2

(b)(6)-4

DOCTOR'S ORDERS

STANDARD FORM 508 (Rev. 10-75)
Prescribed by GSA and ICMR
FPMR 101-11. 806-8
508-110

MEDICAL RECORD		DOCTOR'S ORDERS (Sign all orders)		
DATE AND TIME				
START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
19Apr03		(1)	J Glycaride 10mg q AM before breakfast		(b)(6)-2
		(2)	K phos 20 meq po now + repeat q 1° x 2		
		(3)	Add table salt to diet		
		(4)	Encourage ICS / TCDB.		
Noted 1040. 4/19/03					
(b)(6)-2			(b)(6)-2		
Apr 1903 1134		(1)	Vered ... in pain distress with mobilization in addition to pain med — x1 (trial)		(b)(6)-2
Noted 1220 4/19/03					
(b)(6)-2			(b)(6)-2		
19Apr 03 1400		(1)	Pt not to mobilate pending ortho eval — fragment intrac. (L) lin joint		(b)(6)-2
Noted 1410 4/19/03					
(b)(6)-2			(b)(6)-2		

PATIENT'S IDENTIFICATION (For typed or writ... middle; grade; rank; rate; hospital or medical facility)

(b)(6)-4

...GISTER NO. | WARD NO.

DOCTOR'S ORDERS

STANDARD FORM 508 (Rev. 10-75)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45-505
508-112

508-112 7540-01-044-5515

MEDICAL RECORD

DOCTOR'S ORDERS

INSTRUCTIONS: Place form on **firm surface**; use pressure on ball point pen. Sign all orders.
Nurse: Remove one copy and send to Pharmacy after each order is written.

DATE AND TIME START	STOP	Rx	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
4/19/03			NPO p MN		(b)(6)-2
			OR in AM (4/20/03)		(b)(6)-2
	Noted 4/19/03 1818		(b)(6)-2 (b)(6)-2		
			24° Chest [illegible] 30 [illegible] 2003 (b)(6)-2		

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO.

WARD NO.

DOCTOR'S ORDERS
Medical Record

STANDARD FORM 508 (Rev. 3-94)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDICAL RECORD

DOCTOR'S ORDE'

(Sign all orders)

DATE AND TIME START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE

ANESTHESIA PACU ORDERS

1. Admit to PACU. (b)(6)-2
2. Allergies: NKA (b)(6)-2
3. Vital signs per PACU protocol. (b)(6)-2
4. O2: ___FM @ 10LPM, ___ ___% Blowby, 1 NP @ 2 LPM. (b)(6)-2
5. IVF: LR at KVO cc/hr (b)(6)-2
6. On ward: 02 @ 2-3 LPM via NC: YES NO (b)(6)-2
7. Pain medication:

~~Ketorolac ____ mg IV x1 dose (adults 30 mg max; peds consider 0.2-0.4 mg/kg)~~

MSO4 1-2 mg IV q 2-3 min prn; max dose 20 mg (b)(6)-2

Fentanyl 25 mcg IV q5-7 min prn; max dose 75 mcg Hold RR (b)(6)-2

Percocet 2 tab(s) p.o. with sip of water 10L BPM (b)(6)-2

(b)(6)-2 ~~O~~ Demerol 12.5-25mg IV PRN Shivering MAX Dose 25mg. (b)(6)-2

8. Antiemetics:

Ondansetron 4 mg IVP, may repeat x1 in 15 min (0.1mg/kg; max 4 mg) (b)(6)-2

Metoclopramide 10 mg IV x1 (0.15 mg/kg; max 10 mg)

~~Droperidol ____ mg IV x 1 dose (0.01 mg/kg; max 0.625 mg) Must have baseline ECG available before administration.~~

Other BFS Now Please (b)(6)-2 BFS 168 @ 1445

9. Clear liquids as tolerated: YES NO (b)(6)-2
10. Notify Anesthesia (pager 1506) for airway issues, pain, nausea/vomiting not responsive to above orders or other patient problems/concerns per PACU protocol. (b)(6)-2 (b)(6)-2

Mark 4/20/03 1445 (b)(6)-2

(rev 3/2002)

(OVER)

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO.

WARD NO.

DOCTOR'S ORDERS
Medical Record

STANDARD FORM 508 (Rev. 3-94)
Prescribed by GSA-ICMR, FIRMR (41 CFR) 201-9.202-1

MEDICAL RECORD

DOCTOR'S ORDERS
(Sign all orders)

DATE AND TIME START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
			ANESTHESIA PACU ORDERS -- CONTINUED		
		11.	Discharge patient from PACU per protocol: YES NO	(b)(6)-2	
		12.	When epidural/spinal patients meet discharge criteria per PACU protocol, discharge to ward. On ward: bedrest pending full recovery of sensory and motor function; progress to ambulation with assistance.		
			FOR PACU KEEP PATIENTS ONLY		
		13.	Release patient from anesthesia care to KEEP status when patient meets anesthesia discharge criteria: YES NO		
		14.	Notify anesthesia (1506) for airway management and: (circle if applicable)		
			a. Pain management		
			b. Fluid management		
			c. Other _____		
		15.	TOW patient to ward in a.m. if patient meets discharge criteria: YES NO		
			Signature (b)(6)-2 Beeper (b)(6)-2		
			CMO		
			Mtg 4/20/03 1425 (b)(6)-2		

STANDARD FORM 508 (Rev. 3-94) BAC

MEDICAL RECORD			DOCTOR'S ORDERS (Sign all orders)		
DATE AND TIME					
START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
20 Apr 03			Resume Pre-op Diet.	(b)(6)-2	
			(b)(6)-2		
			(b)(6)-2 4/20/03 1/503		
20 Apr 03 2200			Increase Oxycodone to 10 mg po BID		(b)(6)-2
			(b)(6)-2		
20 Apr 03	1		Heplock IV.		(b)(6)-2
	2		VS & Shaves		(b)(6)-2
	3		CBC in AM & FBS		(b)(6)-2
	4		OOB to Chair.	(b)(6)-2	(b)(6)-2
			PT w/ Assist & Ambul	(b)(6)-2	(b)(6)-2
			(b)(6)-2 COR, NC 4/20/03 2230		
21 Apr 03 2200	1		~~Soy~~ 1% Acetic Acid Soln 1 L. for Douches.		(b)(6)-2
			Cepacol lozenges. 1 po prn.		(b)(6)-2
			Add Table Salt to Diet.		(b)(6)-2
			K phosphate po 20 mcg now & in 1 hr.		(b)(6)-2
			PT Consult Gait Training Walker	(b)(6)-2	(b)(6)-2

(Continue on reverse side)

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

REGISTER NO.

(b)(6)-4

DOCTOR'S ORDERS

(b)(6)-2

STANDARD FORM 508 (R
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505
508-111
☆U.S. GPO: 1988—201-760/80076

5 FWD — PORT
5-43-1

508-112 7540-01-044-5515

MEDICAL RECORD

DOCTOR'S ORDERS

INSTRUCTIONS: Place form on **firm surface**; use pressure on ball point pen. Sign all orders.
Nurse: Remove one copy and send to Pharmacy after each order is written.

DATE AND TIME START	STOP	Rx	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
22 Apr 03 @ 0330			24° Chest Ventilator	(b)(6)-2	
22 Apr 03 @ 0600			T.O. Dr (b)(6)-2 - may substitute Potassium Chloride 20 mcg now and in 1 hr		
			(b)(6)-2	(b)(6)-2	
			Noted 22 Apr 03 @ 0600		
4/22/03	1040	D	FeSO4 325 mg PO QDAY V.O. Dr (b)(6)-2 MD	(b)(6)-2	CDR
4/22/03 1415		①	CBC, Iron, Retic Ct. — Orders in CHCS	(b)(6)-2	
		②	PT Consult in CHCS		
		③	Dressing Change & minor surgery — Will need a sterile suture kit. — 2 packs of sterile hand towels — Betadine paint spray. — 1% Lidocaine, 20cc syringe, 26 gauge needle — I'll bring the suture & scalpel.	(b)(6)-2	
Noted 1315 4/22/03				(b)(6)-2	
			(b)(6)-2 CDR	(b)(6)-2	
				CDR MC Chart verified	

(Continue on reverse side)

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

REGISTER NO. (b)(6)-2 WARD NO. 4/23/03 0100

DOCTOR'S ORDERS
Medical Record

(b)(6)-4

STANDARD FORM 508 (Rev. 3-94)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

508-112 7540-01-044-5515

MEDICAL RECORD

DOCTOR'S ORDERS

INSTRUCTIONS: Place form on **firm surface**; use pressure on ball point pen. Sign all orders.
Nurse: Remove one copy and send to Pharmacy after each order is written.

DATE AND TIME START	STOP	Rx	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
22 Apr 03		1	NPO - MN		
		2	Hold NPH insulin in AM.		
		3	Give oral meds c sip H_2O.		
		4	Void as call.		
			(b)(6)-2		
			22 APR 2003 2200 (b)(6)-2		MC
4/23/03	0100		chart verified	(b)(6)-2	
23 Apr 03		1	Resume all orders as written.		(b)(6)-2
		2	Post op Dressing Δ + Extracting Schrapnell Rt thigh		
		3	Advance Diet	(b)(6)-2	X2.
			4/23/03 1615 (b)(6)-2		CDMC.
4/24/03	0130		chart verified		(b)(6)-2

Moved per pharm (b)(6)-2

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO.

WARD NO.

DOCTOR'S ORDERS
Medical Record

STANDARD FORM 508 (Rev. 3-94)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

508-111

NSN 7540-00-634-4121

MEDICAL RECORD — **DOCTOR'S ORDERS** (Sign all orders)

DATE AND TIME START	DATE AND TIME STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
4/23/03 1430			**ANESTHESIA PACU ORDERS**		
		1.	Admit to PACU.		
		2.	Allergies: NKDA (b)(6)-2		
		3.	Vital signs per PACU protocol.		
		4.	O2: ✓ FM @ 10LPM, ___ ___% Blowby, ___ NP @ _____ LPM.		
		5.	IVF: LR at 75 cc/hr		
		6.	On ward: 02 @ 2-3 LPM via NC: YES NO		
		7.	Pain medication:	(b)(6)-2	
			Ketorolac ____mg IV x1 dose (adults 30 mg max; peds consider 0.2-0.4 mg/kg)		
			MSO4 1-2 mg IV q 6-8 min prn; max dose 20 mg		
			Fentanyl _____mcg IV q ____ min prn; max dose _____mcg		
			Percocet _____ tab(s) p.o. with sip of water		
			Other: _____ (b)(6)-2		
		8.	Antiemetics:		
			✓ Ondansetron 4 mg IVP, may repeat x1 in 15 min (0.1mg/kg; max 4 mg)	(b)(6)-2	
			Metoclopramide _____ mg IV x1 (0.15 mg/kg; max 10 mg)		
			~~Droperidol _____mg IV x 1 dose (0.01 mg/kg; max 0.625 mg) Must have baseline ECG available before administration.~~		
			Other _____		
		9.	Clear liquids as tolerated: YES NO		
		10.	Notify Anesthesia (pager 1506) for airway issues, pain, nausea/vomiting not responsive to above orders or other patient problems/concerns per PACU protocol.	(b)(6)-2	

(rev 3/2002) Noted (b)(6)-2 LCDR /MC 1430 (OVER) 4/23/03

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

(b)(6)-4

DOCTOR'S ORDERS
Medical Record

STANDARD FORM

MEDCOM - 4843

MEDICAL RECORD			DOCTOR'S ORDERS (Sign all orders)		
DATE AND TIME START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
			ANESTHESIA PACU ORDERS -- CONTINUED		
		11.	Discharge patient from PACU per protocol: YES NO		
		12.	When epidural/spinal patients meet discharge criteria per PACU protocol, discharge to ward. On ward: bedrest pending full recovery of sensory and motor function; progress to ambulation with assistance.	(b)(6)-2	
			FOR PACU KEEP PATIENTS ONLY		
		13.	Release patient from anesthesia care to KEEP status when patient meets anesthesia discharge criteria: YES NO		
		14.	Notify anesthesia (1506) for airway management and: (circle if applicable)		
			a. Pain management		
			b. Fluid management	(b)(6)-2	
			c. Other _____		
		15.	TOW patient to ward in a.m. if patient meets discharge criteria: YES NO		
			Signature _____	(b)(6)-2 Beeper	
			(b)(6)-2	PS	
			Noted (b)(6)-2	LCDR/NC 4/23/03 @ 1413	

STANDARD FORM 508 (Rev. 3-94) BACK

508-112 7540-01-044-5515

MEDICAL RECORD

DOCTOR'S ORDERS

INSTRUCTIONS: Place form on **firm surface**; use pressure on ball point pen. Sign all orders.
Nurse: Remove one copy and send to Pharmacy after each order is written.

DATE AND TIME			DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
START	STOP	Rx			
Apr 24 '03 1650			Additional d/c meds for pt per Dr (b)(6)-2		
			$FeSO_4$ 1 po TID #15		
			MVT 1 po QD #5		
			(b)(6)-2		
				24 Apr 03 1445	(b)(6)-2
25 Apr 03 0000			24° Chart Review	(b)(6)-2	

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

(b)(6)-4

DOCTOR'S ORDERS
Medical Record

STANDARD FORM 508 (Rev. 3-94)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDICAL RECORD			DOCTOR'S ORDERS (Sign all orders)		
DATE AND TIME					
START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
24 Apr 03			(1) LOO		
			(2) DC Meds: Lovenox 30mg SQ BID. X 6 weeks		
			NPH Insulin 8u SQ a breakfast		
			4u SQ a Dinner		
			Glyburide 10mg po BID. #60 days		
			Primaxin 500mg IV q6° X 4 days.		
			Percoset 1-2 po q4° prn pain #30 tabs		
			NS for irrigation 2L.		
			20 rolls Kerlex		
			2 Boxes Iodoform 2" wide gauze.		
			4x4's 15 packs.		
			Wet to Dry NS or Iodoform gauze BID.		
			Staples Left Hip out Monday 28 Apr 03		
			Rt Thigh Wed 30 Apr 03		
			(3) Dx Multiple Schrapnel Wounds Rt Elbow.		
			Left Groin, Penis, Bilateral Thighs.		
			DM type II requires NPH through infection.		
			Perforated AD Ear Drum		
			Left Hip with Acetabular Fragment Excised.		

(b)(6)-2

(Continue on reverse side)

(b)(6)-2

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

(b)(6)-4

DOCTOR'S ORDERS 1/10

24 Apr 03

STANDARD FORM 508 (Rev. 10-76)
Prescribed by GSA and ICMR

FIRMR (41 CFR) 201-45.505
508-111

☆U.S. GPO: 1988—201-750/80076

506-111 NSN 7540-00-634-4121

MEDICAL RECORD

DOCTOR'S ORD'
(Sign all orders)

DATE AND TIME START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
4.25.03			**ANESTHESIA PACU ORDERS**		
		1.	Admit to PACU. (b)(6)-2		
		2.	Allergies: NKDA (b)(6)-2		
		3.	Vital signs per PACU protocol. (b)(6)-2		
		4.	O2: ✓ FM @ 10LPM, ___ ___% Blowby, ___ NP @ _____ LPM.		(b)(6)-2
		5.	IVF: LR at 110 cc/hr (b)(6)-2		
		6.	On ward: 02 @ 2-3 LPM via NC: YES NO (b)(6)-2		
		7.	Pain medication:		
			Ketorolac ____mg IV x1 dose (adults 30 mg max; peds consider 0.2-0.4 mg/kg) N/A		
			MSO4 1-2 mg IV q 3 min prn; max dose 20 mg q 1°		(b)(6)-2
			Fentanyl _____mcg IV q____ min prn; max dose _____mcg		
			Percocet _____ tab(s) p.o. with sip of water		
			Other:		
		8.	Antiemetics:		
		1	Ondansetron 10 mg IVP, may repeat x1 in 15 min (0.1mg/kg; max 4 mg)		(b)(6)-2
		2	Metoclopramide 4 mg IV x1 (0.15 mg/kg; max 10 mg)		(b)(6)-2
			~~Droperidol _____mg IV x 1 dose (0.01 mg/kg; max 0.625 mg) Must have baseline ECG available before administration.~~		
			Other		
		9.	Clear liquids as tolerated: YES NO (b)(6)-2		
		10.	Notify Anesthesia (pager 1506) for airway issues, pain, nausea/vomiting not responsive to above orders or other patient problems/concerns per PACU protocol. (b)(6)-2 MD (b)(6)-2		(b)(6)-2

(rev 3/2002) (OVER)

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO.

WARD NO.

DOCTOR'S ORDERS
Medical Record

STANDARD FORM 508 (Rev. 3-94)
Prescribed by GSA-ICMR, FIRMR (41 CFR) 201-9.202-1

10APR03

(b)(3)-1

PERSONAL DATA PRIV ACT 1974

MEDCOM - 4847

MEDICAL RECORD

DOCTOR'S ORDERS

(Sign all orders)

DATE AND TIME START	DATE AND TIME STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
		(b)(6)-4			

(b)(6)-4

THESIA PACU ORDERS -- CONTINUED

(b)(6)-2

4.25.03

11. Discharge patient from PACU per protocol: YES NO

12. When epidural/spinal patients meet discharge criteria per PACU protocol, discharge to ward. On ward: bedrest pending full recovery of sensory and motor function; progress to ambulation with assistance.

FOR PACU KEEP PATIENTS ONLY

13. Release patient from anesthesia care to KEEP status when patient meets anesthesia discharge criteria. YES NO

14. Notify anesthesia (1506) for airway management and: (circle if applicable)

    a. Pain management

    b. Fluid management

    c. Other _____

15. TOW patient to ward in a.m. if patient meets discharge criteria:

    YES NO

(b)(6)-2

MD

Signature _____ Beeper _____

(b)(6)-2

STANDARD FORM 508 (Rev. 3-94) BACI

MEDICAL RECORD			DOCTOR'S ORDERS (Sign all orders)		
DATE AND TIME					
START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
25 APR 2003		(1)	Resume pre op orders		(b)(6)-2
		(2)	Advance diet from clears to pre op diet.		(b)(6)-2
				(b)(6)-2	
					25 April 03 C. 1235
				P.R.	(b)(6)-2 NC
26 Apr 03 @ 0100			24° Chart verification	(b)(6)-2	
28 APR	0330		Chart verified		(b)(6)-2

(b)(6)-2

(b)(6)-2

3 1 1 5

(b)(6)-2

4/25/03

FAXED

(Continue on reverse side)

PATIENT (b)(6)-4 ...e: Name - last, first, middle; ...

REGISTER NO. | WARD NO.

10APR03

(b)(6)-4

DOCTOR'S ORDERS

(b)(3)-1

PERSONAL DATA PRIV ACT 1974

STANDARD FORM 508 (Rev. 10-75)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505
508-111
☆U.S. GPO: 1988—201-760/80076

MEDICAL RECORD			DOCTOR'S ORDERS (Sign all orders)		
DATE AND TIME START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
26 Apr 03		(1)	Ambulate 3 x a day minimum (b)(6)-2		
			c assistance if required. (b)(6)-2		
			(b)(6)-2 (b)(6)-2		
			6 Bakelon ~		
			4/26/03 Noted 450 EN S (b)(6)-2		
27 Apr 03	0000		240 Chart Check EN S	(b)(6)-2	J Ne
Apr 27 03 1048		(1)	D/c PM NPH		(b)(6)-2
			(make change on		(b)(6)-2
			discharge med instructions too)		(b)(6)-2
		(3)	Clarification on PM		
			NPH dose: it has been		
			4 units here on ward.		
			Has been written (b)(6)-2		
			8 units on discharge. Will		(b)(6)-2
			continue on 4 units for		
			now + Rx dose for d/c		
			when d/c is imminent		
1420		4/27/03	(b)(6)-2	KOR/	(b)(6)-2

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO.

WARD NO.

DOCTOR'S ORDERS

STANDARD FORM 508 (Rev. 10-75)
Prescribed by GSA and ICMR
FPMR 101-11. 806-8
508-110

508-112

7540-01-044-5515

MEDICAL RECORD

DOCTOR'S ORDERS

INSTRUCTIONS: Place form on firm surface; use pressure on ball point pen. Sign all orders.
Nurse: Remove one copy and send to Pharmacy after each order is written.

DATE AND TIME			DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
START	STOP	Rx			
30 Apr		1	QOD AM FBS		
			DC all other sticks.		
		2	NPH 3u ac breakfast + ac evening meal.		
		3	DC PRIMAXIN		
			(b)(6)-2		
				CDR MC	
			noted 30APR02 1235		
Maybe			MD chest check EKG	(b)(6)-2	re

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

(b)(6)-4

DOCTOR'S ORDERS
MEDICAL RECORD
STANDARD FORM 508 (Rev. 3-64)

MEDICAL RECORD			DOCTOR'S ORDERS (Sign all orders)		
DATE AND TIME					
START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
5/1/03			permethrin cream apply to scalp for 8 hours then rinse off		
	FAXED		(b)(6)-2		
			noted 1MAY03 1100	(b)(6)-2	
2May03	0421		24° Chart Check EWS	(b)(6)-2	ne
3May03	0418		24° Chart Check EWS	(b)(6)-2	ne

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO.

WARD NO.

DOCTOR'S ORDERS

STANDARD FORM 508 (Rev. 10-75)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45-505
508-112

MEDICATION ADMINISTRATIO' 'ORD (Back) S/N 0105-LF-216-5581

SINGLE ORDERS - PRE-OPERATIVE

MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	TIME	INITIAL	MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	TIME	INITIAL

PRN AND VARIABLE DOSE MEDICATIONS

ORDER DATE	MEDICATION-DOSAGE FREQUENCY ROUTE OF ADMINISTRATION	DOSES GIVEN																	
4/10	MSO4 2-4mg	DATE	4/11	4/12	4/12	4/13													
	IV q 10 for	TIME	2330	0130	0930	1243													
	Severe pain	DOSE	4	4	4	5mg													
		INIT.	(b)(6)-2																
4/10	Tylenol #3	DATE	4/11	4/12															
	1-2 po q4°	TIME	0700	0115															
	prn moderate	DOSE	2 TAB	11															
	pain	INIT.	(b)(6)-2																
4/10	Tylenol 650mg	DATE	4/11	4/12															
	po q4° prn	TIME	1900	1900															
	Temp > 100.0	DOSE	1	1															
		INIT.	(b)(6)-2																
4/10	Mylanta 30cc	DATE																	
	po q4° prn	TIME																	
	gastric irritation	DOSE																	
		INIT.																	
4/10	MOM 30cc po	DATE																	
	q4° prn	TIME																	
	constipation	DOSE																	
		INIT.																	
4/10	Ambien 5mg	DATE																	
	po qHS	TIME																	
	prn sleep	DOSE																	
		INIT.																	
4/12	~~Ativan~~ Valium	DATE																	
	5mg IV prn	TIME																	
	agitation	DOSE																	
	Q6° prn	INIT.																	

MEDICATION ADMINISTRATION **RD (Back) S/N 0105-LF-216-5581**

SINGLE ORDERS - PRE-OPERATIVE

MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	GIVEN TIME	GIVEN INITIAL	MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	GIVEN TIME	GIVEN INITIAL
K Phos 20mEQ PO X1 Now	4/14	2300	(b)(6)-2				
K Phos 20mEQ PO in 2hrs	4/15	0100					
Tylenol 650mg PO X1	4/14	2145					
Benadryl 25mg PO X1	4/14	2145					
Humulin Insulin 3u SQ X1	4/14	2300					
Humulin Insulin 5u SQ	4/15	0125					
Tylenol 650mg PO X1	4/16	1650					

PRN AND VARIABLE DOSE MEDICATIONS

ORDER DATE	MEDICATION-DOSAGE FREQUENCY ROUTE OF ADMINISTRATION	DOSES GIVEN					
4/10	MSO4 2-4MG	DATE	4/13				
	IV Q1° FOR	TIME	1243				
	SEVERE PAIN	DOSE	5MG				
		INIT.	(b)(6)-2				
4/10	TYLENOL #3	DATE	4/13	4/15	4/15	4/16	
	1-2 TABS PO	TIME	2355	1600	2000	0300	
	Q4° PRN MOD.	DOSE	2tabs	2	2	2	
	PAIN	INIT.	(b)(6)-2				
4/10	TYLENOL 650MG	DATE	4/16				
	PO Q4° PRN	TIME	1645				
	TEMP >100.0	DOSE	650mg				
		INIT.	(b)(6)-2				
4/10	MYLANTA 30CC	DATE					
	PO Q4° PRN	TIME					
	GASTRIC IRRITATION	DOSE					
		INIT.					
4/10	MOM 30cc PO	DATE					
	Q4° PRN	TIME					
	CONSTIPATION	DOSE					
		INIT.					
4/10	AMBIEN 5MG	DATE	4/14	4/14	4/16		
	PO QHS	TIME	0100	1030	0300		
	PRN SLEEP	DOSE	5mg	5mg	5mg		
		INIT.	(b)(6)-2				
4/12	VALIUM 5MG	DATE					
	IV PRN	TIME					
	AGITATION Q6°	DOSE					
		INIT.					

MEDICATION ADMINISTRATION ORD (Back) S/N 0105-LF-216-5581

SINGLE ORDERS - PRE-OPERATIVE

MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	GIVEN TIME	GIVEN INITIAL	MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	GIVEN TIME	GIVEN INITIAL
(BID) on call for dressing ① 5-10 mg				K PHOSPHATE 20mEq PO	4/19	1200	
Versed 2 mg IVP				K PHOSPHATE 20mEq PO	4/19	1300	
② 1-2 mg Versed IVP				K PHOSPHATE 20mEq PO	4/19	1400	
MSO4 30 mg IVP For Dsg A 2-3 mg IVP	4/18/03	1630	(b)(6)-2				
Benadryl 25mg PO PreMed	4/18/03	2000					
Tylenol 650 mg PO PreMed	4/18/03	2400					

PRN AND VARIABLE DOSE MEDICATIONS

ORDER DATE	MEDICATION-DOSAGE FREQUENCY ROUTE OF ADMINISTRATION		DOSES GIVEN															
4/10	Morphine	DATE	4/18															
	2-4 mg IV Q1°	TIME	1600															
	PRN	DOSE	3															
	Severe Pain	INIT.																
4/10	Tylenol #3	DATE																
	1-2 Tabs PO	TIME																
	Q4° PRN	DOSE																
	Mod. Pain	INIT.																
4/10	Tylenol 650 mg	DATE	4/17	4/17														
	PO Q4° PRN	TIME	1930	2225														
	T >100.0	DOSE	1	1														
		INIT.	(b)(6)-2															
4/10	MOM 30cc	DATE																
	PO Q4° PRN	TIME																
	~~Gastric Dilitation~~	DOSE																
	Constipation	INIT.																
4/10	Mylanta	DATE																
	30cc PO	TIME																
	Q4° PRN	DOSE																
	Gastric Dilitation	INIT.																
4/10	Ambien 5mg	DATE																
	PO QHS PRN	TIME																
	Sleep	DOSE																
		INIT.																
4/12	Valium 5mg	DATE																
	IV PRN Q6°	TIME																
	Agitation	DOSE																
		INIT.																

MEDICATION ADMINISTRATION RECORD (Back) S/N 0105-LF-216-5581

SINGLE ORDERS - PRE-OPERATIVE

MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	GIVEN TIME	GIVEN INITIAL	MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	GIVEN TIME	GIVEN INITIAL
VERSED 1-2mg IVP c ANB	4/19		(b)(6)-2				
Versed 3mg IV	4/20	2130					
Dressing Δ — 3.5 mg MSO4 IVP 2.5 mg VERSED IVP	4/20	2145					
BENADRYL 50mg PO	4/23	2355					

PRN AND VARIABLE DOSE MEDICATIONS

ORDER DATE	MEDICATION-DOSAGE FREQUENCY ROUTE OF ADMINISTRATION		DOSES GIVEN					
4/10	MORPHINE	DATE	4/20	4/20	4/22	4/22	4/24	
	2-4 mg IV Q1°	TIME	1825		2130	1900	1830	
	PRN	DOSE	5mg		20mg	10mg	6mg	
	SEVERE PAIN	INIT.	(b)(6)-2					
4/10	TYLENOL #3	DATE	4/23	4/24	4/24			
	1-2 TABS PO	TIME	1155	1940	1745			
	Q4° PRN	DOSE	1T	1T	2			
	MOD. PAIN	INIT.	(b)(6)-2					
4/10	TYLENOL 650mg	DATE	4/19	4/19				
	PO Q4° PRN	TIME	0300	2045				
	T > 100.0	DOSE	650mg	650				
		INIT.	(b)(6)-2					
4/10	MOM 30cc	DATE						
	PO Q4° PRN	TIME						
	CONSTIPATION	DOSE						
		INIT.						
4/10	MYLANTA	DATE						
	30cc PO	TIME						
	Q4 PRN	DOSE						
	GASTRIC IRRITATION	INIT.						
4/10	AMBIEN 5mg	DATE	4/10	4/19	4/21	4/23		
	PO QHS PRN	TIME	0300	2330	2345	2355		
	SLEEP	DOSE	5mg	5mg	5mg	5		
		INIT.	(b)(6)-2					
4/12	VALIUM 5mg	DATE						
	IV PRN Q6	TIME						
	AGITATION	DOSE						
		INIT.						

NKDA

NAVMED 6550/8 (REV. 4-74) S/N 0105-LF-216-5581

MEDICAL RECORD	MEDICATION ADMINISTRATION RECORD

SCHEDULED DRUGS — MONTH April 2003 — DATES GIVEN

ORDER DATE	MEDICATION- DOSAGE- FREQUENCY ROUTE OF ADMINISTRATION	HOURS	10	11	12	13	14	15	16
4/10	Ancef 1gram IVPB q 8	0200	X	(b)(6)-2			X	X	X
		1000	X				X	X	X
		1800	Cas rec	(b)(6)-2			X	X	X
4/11	MVI 1 Tab PO QD	0900	X	X	(b)(6)-2				
4/11	Glibeside 5mg q AM c Breakfast	0700	X	X					
4/13	Keflex 250mg PO	0600	X	X	X	X			
	q 6° x 7 days	1200	X	X	X	X			
		1800	X	X	X				
		2400	X	X	X				

INITIAL CODE

INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE
(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2		
				(b)(6)-2	(b)(6)-2

ADDRESSOGRAPH PLATE

(b)(6)-4

Injection Site Code

1 = Left Buttock
2 = Right Buttock
3 = Left Deltoid
4 = Right Deltoid
5 = Left Leg
6 = Right Leg
7 = Left Arm
8 = Right Arm
9 = Abdomen

WARD NO.

SINGLE DOSE, PRE- OP PRN & VARIABLE DOSE ORDERS SEE REVERSE

PATIENT PROFILE

NAVMED 6550/12 (5-80) S/N 0105-LF-206-5560

√	ACTIVITY	DATE	√	BATH	DATE	DIET	DATE	√	VITAL SIGNS	FREQ	√	SPECIAL NOTES
	Bedrest			Bed bath		NPO			Temp			Dentures
	Bathroom Privileges			Shower		REG	4/17		Pulse	96°		Speech impediment
	Up in chair			Tub					Resp			Language barrier
	Ambulate			Needs assistance		ADD TABLE SALT			B/P			Prosthetic device
	Commode					NO ENSURE			Other			Visual impairment
	Needs assistance					(4 Bld Glvc)						Blind
	Restricted to unit											Contact lenses
	Hospital Privileges			ORAL HYGIENE	DATE							Glasses
	Other			Self		FEEDING	DATE		FLUIDS			Hearing defect
				Needs assistance		Self			Forced to:			Other
				Special		Needs assistance			Restricted to:			
						Gavage	4/16		I & O 98°			

DATE ORD.	DATE RENEW	TREATMENTS/SPECIAL NOTES	TIMES	DATE ORD.	DATE RENEW	TREATMENTS/SPECIAL NOTES	TIMES
4/16		Daily w-D wound care to (R) arm (L) groin, both thighs, penis		4/17		1 L acetic acid solution 3% for dressing Δ's.	
						See new profile	
4/16		Call MO if temp > 102.5° BP > 180 ≤ 100 systolic		4/16		IS x Q 1° - TCDB	
				4/16		If spikes temp send blood cx x 2 & give tylenol	
				4/17		BID dressing Δ's w D only	
						on call 20-30 mg MSO4 IVP	
						2-3 mg Ativan IVP	
						Kerlix on hand 4 rolls, 2" tape, ABD 10, 4x4 gauze	
4/15		DO NOT REMOVE Wicks: reinforce dsg as needed (c fresh dsg. Don't remove wicks! use sterile technique		4/17		3 tubs, suture set, ABD x 2 For dressing Δ's - perform under ⊕ in exam room MD will call to [illegible]	
						Dr (b)(6)-2	

ADDRESSOGRAPH

(b)(6)-4

(b)(6)-4

DIAGNOSIS DM
Multiple GSW
Sharpnel penis
Knee Elbow

AGE | HEIGHT | WEIGHT

PATIENT CLASSIFICATION
stable

OP/SPECIAL PROCEDURES
Multiple I+D's
4/15 Dr (b)(6)-2

	DATE ON	DATE OFF
SI		
VSI		
RELIGIOUS RITES		

FINDINGS:

1 of 2

(b)(6)-4

ALLERGIES:

NKDA

DATE ORD.	DATE RENEW	MEDICATIONS	TIME (HOURS TO BE GIVEN)	DATE OF ORDER	LABORATORY/DIAGNOSTIC TESTS EXAMINATIONS/ CONSULTATIONS	DATE SENT	DATE COMP
4/10		Ancef 1 gram IVPB q 8°	02 10 18	4/10	Trauma Lab done	in OR	re...
4/11		MVI 1 Tab QD	09	4/10	Fasting Blood	4/11	
4/11		Glyburide 5mg qAM c̄ Breakfast	07		Sugar in Am		
4/13		Keflex 250mg PO Q6° X 7 days		4/10	X-ray femur, both Legs, R forearm CPR	4/10	
4/15		FBS q AC + HS 07, 11, 16, 22					
		See Sliding Scale					
4/16		Glyburide 10mg PO c̄ Breakfast	0700	4/10	Repeat CXR	☑	
4/16		Ancef 1gm IVPB Q8° 4/17		4/12	BMP in AM 4/13		☐
4/17		Primaxin 500mg IV q6°		4/11	0.5ml Td given ☑		
4/18		Lovenox 30mg SQ BID	9/21	4/13	BMP in AM 4/14		☑
				4/13	CBC in AM 4/14		☑
				4/14	Fasting Glucose in AM 4/15		☒
4/14		Tylenol 650mg / Benadryl 25mg PO X1 for Premedication		4/14	Repeat CBC ~~in AM~~		☒
				4/14	Type + Cross 2u		☒
4/14		Humulin Insulin 3u X1 now		4/14	Fasting Glucose qAM		
4/14		KPhos 20mEQ PO X1 now		4/14	CBC + Fasting Glucose in AM 4/15		☒
4/14		KPhos 20mEQ PO in 2hrs X1		4/15	CBC + BMP in AM		
4/16		Tylenol 650mg PO X1			4/16 ☒ 4/17 ☒		
4/17		Tylenol 650mg PO X1		4/16	Blood Cultures		☒
4/17		Begin Morphine drip 5-10 mg MSO4 IVP		4/16	Urine C+S		☒
		1-2 mg versed IVP		4/16	CXR PA + LAT		☒
				4/17	CBC, Blood cx		☒
					UA, Urine Cx		☒
				4/17	CBC c̄ diff 4/18 ☒	BMP	☒
4/17		Valium 5 mg IVP TID prn agitation			CBC c̄ diff, BMP 4/19		
4/18		Ambien 5mg po qhs prn		4/18	CT Scan (R) Elbow and Pelvis	☒ 4/19	
4/18		MOM 30cc po q4° prn constipation					
4/18		Mylanta 30cc po q4° prn gastric irritation					
4/18		Tylenol 650mg po q4° prn Temp 7/100.0					
4/18		Tylenol #3 1-2 po q4° prn moderate pain					
4/18		MSO4 2-4mg IV q1° for severe pain					

ADDRESSOGRAPH

(b)(6)-4

NAVMED 6550/8 (REV. 4-74) S/N 0105-LF-216-5581

MEDICAL RECORD	MEDICATION ADMINISTRATION RECORD

SCHEDULED DRUGS — MONTH APR 19 03 — DATES GIVEN

ORDER DATE	MEDICATION- DOSAGE- FREQUENCY ROUTE OF ADMINISTRATION	HOURS	13	14	15	16	17	18	19
4/15 4/11	MVI 1TAB PO QD	0900	HOLD	HOLD	(b)(6)-2				
4/15 4/11	GLIBERIDE 5MG QAM C	0900	(b)(6)-2						
	BREAKFAST								
4/15 4/13	KEFLEX 250 MG PO	0600	X	(b)(6)-2					
	Q6° x 7 DAYS	1200	X	(b)(6)-2					
		1800	held	(b)(6)-2					
		2400	(b)(6)-2						
4/14	Fingerstick BS AM 4/15	0500	X	X	(b)(6)-2	X	X	X	X
4/15	FBS before meals	0700	X	X	X	X			
	See sliding scale	1100	X	X	X	X			
	& give Regular Humulin	1600	X	X	(b)(6)-2				
	insulin if needed	2200	X	X	(b)(6)-2				
4/15	Sliding Scale BC <200 = 0 units				(b)(6)-2				
	>201 ≤ 250 = 5 units								
	>251 ≤ 300 = 8 units								
	>301 ≤ 350 = 12 units								
	> 351 15 units call MO								
4/16	Glyburide 10mg PO c̄ Breakfast	0700	X	X	X	X			

INITIAL CODE

INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE
(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2

ADDRESSOGRAPH PLATE

(b)(6)-4

Injection Site Code

① = Left Buttock ⑤ = Left Leg
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③ = Left Deltoid ⑦ = Left Arm
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WARD NO.

SINGLE DOSE, PRE- OP PRN & VARIABLE DOSE ORDERS SEE REVERSE

NAVMED 6550/8 (REV. 4-74) S/N 0105-LF-216-5581

MEDICAL RECORD	MEDICATION ADMINISTRATION RECORD

SCHEDULED DRUGS — MONTH April 19 2003 — DATES GIVEN

ORDER DATE	MEDICATION- DOSAGE- FREQUENCY ROUTE OF ADMINISTRATION	HOURS	16	17	18	19	20	21	22
4/15	MVI 1 Tab PO QD	0900	X	IN OR	(b)(6)-2				
4/14	Fingerstick BS AM	0500	X	87	207				
4/16	Sliding Scale - Humulin	0700	X	8 units	8 units				
	≤ 200 0 units	1100	X	IN OR	~~BS 160~~ 0 units				
	> 201 ≤ 250 8 units	1600	X	(b)(6)-2	~~193~~ 124				
	> 251 ≤ 300 12 units	2200	874 (b)(6)-2						
	> 301 ≤ 350 16 units	X	X	X					
	> 351 18 units Call MD	X	(b)(6)-2	374 (b)(6)-2	(b)(6)-2				
~~4/16~~	~~Ancef 1 gm IVPB Q8°~~			1430 60 Given					
4/16	Glyburide 10 mg PO c Breakfast	0700	X	~~HOLD~~ ~~NPO~~	(b)(6)-2				
4/16	Ancef 1 gm IVPB Q8°	0800	X	IN OR					
		1600	X						
		2400	(b)(6)-2						
4/17	Primaxim 500 mg q6° IVPB	0600	X	X	(b)(6)-2				
		1200	X	X	(b)(6)-2				
		1800	X	(b)(6)-2					
		2400	X	(b)(6)-2					
4/18	Lovenox 30 mg SQ BID	0900	X	X	X				
		2100	X	X	(b)(6)-2				

INITIAL CODE

INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE
(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2

ADDRESSOGRAPH PLATE

(b)(6)-4

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WARD NO.

SINGLE DOSE, PRE- OP PRN & VARIABLE DOSE ORDERS SEE REVERSE

NAVMED 6550/8 (REV. 4-74) S/N 0105-LF-216-5581

MEDICAL RECORD	MEDICATION ADMINISTRATION RECORD

SCHEDULED DRUGS — MONTH APRIL 19 2003 — DATES GIVEN

ORDER DATE	MEDICATION- DOSAGE- FREQUENCY ROUTE OF ADMINISTRATION		HOURS	4/18	4/19	4/20	4/21	4/22	4/23	4/24
4/18	SLIDING SCALE (qAC/qHS)									
	Blood sugar	Units Regular Insulin								
	<140	0	0700		166/2U	138/0	144/2U	68/0 (Juice)	196/4U	186/
	140-170	2	1100			220/0	156/2U	147/2U	107/0	155/held
	171-200	4	1600		336/12U	219/6U	98/0U	162/2U	186/4U NOB	84/0U
	201-230	6	2200	204/6U	201/6U	163/2U	140/0U	163/2U		120/0U
	231-260	8								
	261-290	10								
	291 +	12								
4/18	In addition to sliding scale			Pre-B	(b)(6)-2		(b)(6)-2		[redacted]	b-6-2
	give NPH insulin:			PRE-D		(b)(6)-2				
	4 units pre-breakfast									
	4 units predinner									
4/15	MVI TAB PO QD		0900				(b)(6)-2		(b)(6)-2	
4/14	FINGERSTICK BS AM		0500		166 (b)(6)-2	138 (b)(6)-2	144 (b)(6)-2	68 (b)(6)-	196 (b)(6)-2	
4/17	PRIMAXIM 500mg q6° IVPB		0600		(b)(6)-2					
			1200			(b)(6)-2				(b)(6)-2
			1900	(b)(6)-2						
4/18			2400	(b)(6)-2						
4/18	LOVENOX 90mg SQ BID		0900		(b)(6)-2					
			2100	(b)(6)-2					(b)(6)-2	
4/18	GLYBESIDE 10mg PO c̄ BREAKFAST		0700		(b)(6)-2					
4/20	Glyberide 10mg BID									

INITIAL CODE

INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE
(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2

ADDRESSOGRAPH PLATE

(b)(6)-4

WARD NO.

Injection Site Code

① = Left Buttock ⑤ = Left Leg
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SINGLE DOSE, PRE- OP PRN & VARIABLE DOSE ORDERS SEE REVERSE

1 of 2

NAVMED 6550/8 (REV. 4-74) S/N 0105-LF-216-5581

MEDICAL RECORD	MEDICATION ADMINISTRATION RECORD

SCHEDULED DRUGS — MONTH APRIL 2003 — DATES GIVEN

ORDER DATE	MEDICATION- DOSAGE- FREQUENCY ROUTE OF ADMINISTRATION	HOURS	4/21	22	23	24	25	26	27
4/20	Glyberide 10 mg po BID	0900	(b)(6)-2				Hold (b)(6)-2	(b)(6)-2	(b)(6)-2
		2100							
4/22	FeSO4 ~~TPAB~~ (325mg) PO QD	0900			(b)(6)-2	(b)(6)-2			(b)(6)-2
4/12	Primixim 500mg IVPB Q6H	0600							
		1200							
		1800			(b)(6)-2				
		2400							
4/18	Lovenox 30mg SQ BID	0900							(b)(6)-2
	~~HVI ÷ PO~~ (D8)	2100							
4/15	HVI ÷ PO QDay	0900							
4/18	SLIDING SCALE (qAC / qHS)	0700					80/00 (b)(6)-2	60/00	40/00
	Blood sugar — units Reg insulin	1100					hold	60/00 (b)(6)-	120/ (b)(6)-2
	< 140 — Ø	1600					80/00 (b)(6)-2	180/40	
	140 - 170 — 2	2200					80/00 (b)(6)-2	160/20	
	171 - 200 — 4								
	201 - 230 — 6								
	231 - 260 — 8								
	261 - 290 — 10								
	291 + — 12								
4/18	IN Addition to sliding Scale	Pre-B					Hold	HOLD	
	give NPH insulin: 4 units pre-	Pre-D					(b)(6)-2		
	breakfast and 4 ~~units pre-dinner~~								
4/14	Fingerstick BS AM	0500					80/ (b)(6)-2	60/	60/

INITIAL CODE

INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE
(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2

ADDRESSOGRAPH PLATE (b)(6)-4

WARD NO.

Injection Site Code

① = Left Buttock ⑤ = Left Leg
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④ = Right Deltoid ⑧ = Right Arm
= Abdomen

SINGLE DOSE, PRE- OP PRN & VARIABLE DOSE ORDERS SEE REVERSE

2 of 7

MEDICATION ADMINISTRATION RD (Back) S/N 0105-LF-216-5581

SINGLE ORDERS - PRE-OPERATIVE

MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	GIVEN TIME	GIVEN INITIAL	MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	GIVEN TIME	GIVEN INITIAL
K phosphate 20 meq PO	4/22	~~0400~~	(b)(6)-2				
K phosphate 20 meq PO	4/22	~~0500~~					
Potassium Chloride 20 meq PO	4/22	0600					
Potassium Chloride 20 meq PO	4/22	0700					
Morphine 10 mg IVP	4/22	1322					
Versed 2 mg IVP	4/22	1322					
MSO4 10 mg IVP	4/23	1945					
Benadryl 50 mg	4/27	0030					

PRN AND VARIABLE DOSE MEDICATIONS

ORDER DATE	MEDICATION-DOSAGE FREQUENCY ROUTE OF ADMINISTRATION	DOSES GIVEN																
4/21	Ciprofl 1 tab PO PRN	DATE																
		TIME																
		DOSE																
		INIT.																
	VALIUM 5mg IVP TID AGITATION	DATE																
		TIME																
		DOSE																
		INIT.																
	AMBIEN 5MG PO QHS	DATE	4/25	4/26														
		TIME	2300	2330														
		DOSE	5mg	5mg														
		INIT.	(b)(6)-2															
	MOM 30cc PO Q4° CONSTIPATION	DATE																
		TIME																
		DOSE																
		INIT.																
	MV/ANTA 30cc PO Q4° GASTRIC IRRITATION	DATE																
		TIME																
		DOSE																
		INIT.																
	TYLENOL 650mg PO Q4° T>100°	DATE																
		TIME																
		DOSE																
		INIT.																
	TYLENOL #3 I-II PO Q4 PAIN	DATE	4/25	4/25	4/26	4/26												
		TIME	1325	1545	1900	2330												
		DOSE	II	2	2	2												
		INIT.	(b)(6)-2															

4/30 recopied

NAVMED 6550/8 (REV. 4-74) S/N 0105-LF-216-5581

MEDICAL RECORD | **MEDICATION ADMINISTRATION RECORD**

SCHEDULED DRUGS — MONTH APRIL 19 2003 — DATES GIVEN

ORDER DATE	MEDICATION- DOSAGE- FREQUENCY ROUTE OF ADMINISTRATION	HOURS	4/27	4/28	4/29	4/30	5/1	5/2	5/3
4/20	Glyberide 10mg PO BID	0900		(b)(6)-2					
		2100	(b)(6)-2						
4/22	Fe SO4 ÷ Tab (325mg) PO QD	0900		(b)(6)-2					
4/17	Primixim 500mg IV PB	0600		(b)(6)-2					
	Q6hr	1200		(b)(6)-2					
		1800	(b)(6)-2						
		2400	(b)(6)-2						
4/18	Lovenox 30mg SQ BID	0900		(b)(6)-2					
		2100	(b)(6)-2						
4/15	MVI ÷ PO QDAY	0900		(b)(6)-2					
4/18	[illegible]	AM		(b)(6)-2					
	[illegible]								
4/18	[illegible] Insulin Al & NS								
[illegible]	[illegible]	0700		(b)(6)-2					
	[illegible]	BG		(b)(6)-2					
	[illegible]	1100		(b)(6)-2					
	[illegible]	BG		(b)(6)-2					
	[illegible]	1600	(b)(6)-2						
	[illegible]	BG	138	140	137				
	[illegible]	2200	(b)(6)-2	(b)(6)-2					
	[illegible]	BG	180						

(b)(6)-2

INITIAL CODE

INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE
(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2

ADDRESSOGRAPH PLATE

(b)(6)-4

Injection Site Code

1 = Left Buttock
2 = Right Buttock
3 = Left Deltoid
4 = Right Deltoid
5 = Left Leg
6 = Right Leg
7 = Left Arm
8 = Right Arm
= Abdomen

WARD NO. 5 FWD P.

SINGLE DOSE, PRE- OP PRN & VARIABLE DOSE ORDERS SEE REVERSE

MEDICATION ADMINISTRATION RD (Back) S/N 0105-LF-216-5581

SINGLE ORDERS - PRE-OPERATIVE

MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	TIME	INITIAL	MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	TIME	INITIAL

PRN AND VARIABLE DOSE MEDICATIONS

ORDER DATE	MEDICATION-DOSAGE FREQUENCY ROUTE OF ADMINISTRATION	DOSES GIVEN																
	MSO4	DATE	25	25	25	4/25	4/29											
	2-4 mg IV Q1°	TIME	1215	1300	2000	1015	1425											
	PRN	DOSE	4mg	4mg	4mg	4mg	4mg											
	Severe Pain	INIT.	(b)(6)-2															
	Tylenol #3 1-2	DATE																
	Q4hr pain	TIME																
		DOSE																
		INIT.																
	AMBIEN 5mg	DATE	29 HALR															
	po Qhs	TIME	2220															
		DOSE	25															
		INIT.	(b)(6)-2															
	MOM 30cc po	DATE																
	Q4°	TIME																
	Constipation	DOSE																
		INIT.																
	Mylanta 30cc	DATE																
	po q4°	TIME																
	Gastric	DOSE																
	Irritation	INIT.																
	Tylenol 650mg	DATE																
	PO Q4hr	TIME																
	T > 100°	DOSE																
		INIT.																
	VALIUM 5mg	DATE	4/28															
	IVP TID	TIME	2212															
	Agitation	DOSE	5															
		INIT.	(b)(6)-2															

MEDICATION ADMINISTRATION RD (Back) S/N 0105-LF-216-5581

SINGLE ORDERS - PRE-OPERATIVE

MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN			MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN		
	DATE	TIME	INITIAL		DATE	TIME	INITIAL

PRN AND VARIABLE DOSE MEDICATIONS

ORDER DATE	MEDICATION-DOSAGE FREQUENCY ROUTE OF ADMINISTRATION	DOSES GIVEN																
4/30	Meclizine 25mg	DATE																
	po QD PRN	TIME																
	motionsickness	DOSE																
		INIT.																
		DATE																
		TIME																
		DOSE																
		INIT.																
		DATE																
		TIME																
		DOSE																
		INIT.																
		DATE																
		TIME																
		DOSE																
		INIT.																
		DATE																
		TIME																
		DOSE																
		INIT.																
		DATE																
		TIME																
		DOSE																
		INIT.																
		DATE																
		TIME																
		DOSE																
		INIT.																

4/30 recopied

NAVMED 6550/8 (REV. 4-74) S/N 0105-LF-216-5581

MEDICAL RECORD	MEDICATION ADMINISTRATION RECORD

SCHEDULED DRUGS — MONTH ~~APR~~/MAY ~~19~~ 2003 — DATES GIVEN

ORDER DATE	MEDICATION- DOSAGE- FREQUENCY ROUTE OF ADMINISTRATION	HOURS	4/30	5/1	5/2	5/3	5/4	5/5	5/6
4/20	Glyberide 10mg PO BID	0900	X	(b)(6)-2					
		2100	(b)(6)-2						
4/22	Fe SO4 1 tab (325mg) PO QD	0900	X						
4/18	Lovenox 30mg SQ BID	0900	X						
		2100	(b)(6)-2						
4/15	MVI 1 tab po QD	0900	X						
4/30	FSBS QOD in AM	0600	done	X		X		X	
4/30	NPH 3 units SQ ā breakfast	0600		(b)(6)-2					
	and ā evening meals	1600	(b)(6)-2						

INITIAL CODE

INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE
(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2		

ADDRESSOGRAPH PLATE

(b)(6)-4

Injection Site Code

① = Left Buttock ⑤ = Left Leg
② = Right Buttock ⑥ = Right Leg
③ = Left Deltoid ⑦ = Left Arm
④ = Right Deltoid ⑧ = Right Arm
= Abdomen

WARD NO.

SINGLE DOSE, PRE- OP PRN & VARIABLE DOSE ORDERS SEE REVERSE

MEDICATION ADMINISTRATION RECORD (Back) S/N 0105-LF-216-5581

SINGLE ORDERS - PRE-OPERATIVE

MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	GIVEN TIME	GIVEN INITIAL	MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	GIVEN TIME	GIVEN INITIAL
pellmethrin cream 8oz once	5/1	1630	(b)(6)-2				

PRN AND VARIABLE DOSE MEDICATIONS

ORDER DATE	MEDICATION-DOSAGE FREQUENCY ROUTE OF ADMINISTRATION	DOSES GIVEN																
	MSO4 2-4mg IVP Q1° PRN severe pain (last dose 4/29)	DATE																
		TIME																
		DOSE																
		INIT.																
	Tylenol #3 1-2 tabs Q4h PRN for Pain	DATE	4/30	5/2	5/3	5/4	5/5											
		TIME	2008	1820	0850	1350	0700											
		DOSE	2	2	2	2	2											
		INIT.	(b)(6)-2															
	Ambien 5mg po QHS (4/29 last dose)	DATE	4/30															
		TIME	2008															
		DOSE	5															
		INIT.	(b)(6)-2															
	MOM 30cc PO Q4° Constipation PRN	DATE																
		TIME																
		DOSE																
		INIT.																
	Mylanta 30cc PO Q4° PRN Gastric Irritation	DATE																
		TIME																
		DOSE																
		INIT.																
	Tylenol 650mg PO Q4° T>100°	DATE	5/2															
		TIME	0500															
		DOSE	1650															
		INIT.	(b)(6)-2															
	Valium 5mg IVP TID PRN for aggitation (4/28 last dose)	DATE																
		TIME																
		DOSE																
		INIT.																

Addressograph:

(b)(6)-4

Date: 4/7/03

Allergies

Diagnosis

Age:

DOB:

SIGNATURE

(b)(6)-2

(b)(6)-2

(b)(6)-2

(b)(6)-2

(b)(3)-1

	7:00	8:00	9:00	10:00	11:00	12:00	13:00	14:00	15:00
SpO2	120/70								
Respirations	14				16				
Temp	98.7				99.7				

IV'S	LRL										1000	
INTAKE	PO											
	NG/TF											
	Other											
	Cummulative Intake											
OUTPUT	Urine Volume											
	Emesis	UOU										
	NG Residual/sump											
	Bowel Movement											
	OTHER											
	Cummulative Output											

RAMSEY SEDATION SCALE:

1 - Pt. Anxious and irritated or restless

2 - Cooperative, oriented and tranquil

3 - Responds to commands only

4 - Brisk respons

5 - Sluggish respon

PAIN	Medicated											
	Dose / Route											
	Intensity (1-10) Pre / Post Med											
	Sedation Scale											
Nursing care	BATH PARTIAL/COMPLETE											
	ACTIVITY(Turn L, R, B, ch, amb)											
	IV Site CDI? Q2 hrs		✓									
	IV Site CDI? Q2 hrs		✓									
	TCBD											
	Wound care		✓									
Miscellaneous												

(b)(6)-4

TE WARD - 24 HOUR FLOW SHEET

18:00	19:00	20:00	21:00	22:00	23:00	0:00	1:00	2:00	3:00	4:00	5:00	6:00
				22:30								
				95								
				26								
				99.6								

200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20

Temp

glabellar tap or loud auditory stimulus

6 - No response to light glabellar tap or loud auditory stimulus

t glabellar tap or loud auditory stimulus

2230

1900-0700 | Time: | Signatu (b)(6)-2

Pt arrived via Convoy Security in Tow. MSO4 10mg IVP upon arrival. Wounds as follows (R)(L) inguinal Nickle size (+) Femoral Pulse; Multiple lacerations to (R) medial thigh (3) from to (L) mid thigh. 2 Nickle size holes to (R) thigh superior to knee. 2 Penny size whole to (R) elbow.

NEUROLOGICAL

Level of Consciousness

Oriented to: Person X Place X Time X

Responds to: Verbal X Pain ___ Unresponsive ___

Pupils R L

Size / 3 / B 3 / B

Motor Strength S = Strong W = Weak TR = Trace A = Absent

Extremities: Upper L S R S; Lower L S R S

☐ See Narrative

CARDIOVASCULAR

Pulses R L

Radial + + Posterior Tibial + +

Femoral + + Dorsalis Pedis + +

+ = Normal - = Weak 0 = Absent

Rhythm: RRR Ectopy: ___

Murmur: ___ Rub: ___ S1: ✓ S2: ✓

Neck Veins: ___

Edema: ___

☐ See Narrative

RESPIRATORY

Breath Sounds: ☐ Clear ☐ Bilat

Location:

Crackles /Rales: ___ Dim: ___

Wheezes: ___ Absent: ___

Rhonchi: ___

Cough: Productive / Unproductive: ___

Sputum: Color and Character: ___

Tubes: ☐ ET ☐ Trach

Size: ___ Location: ___

O2: ☐ Canula ☐ Mask

Chest Tubes: ___

☐ See Narrative

GASTROINTESTINAL

Observation:

Auscultation: BS x 4 Quad.

Palpation:

Stool: ☐ Incontinent ☐ Formed ☐ Soft ☐ Frequent ☐ Liquid ☐ Hard

Tubes / Bags / Suction / Drainage:

☐ See Narrative ☐ NGT Placement

GU

☐ Void **Urine: Color / Character**

Catheter: Laceration 1 inch at (L) side of shaft of Penis

Other:

☐ See Narrative

SKIN

Color / Turgur / Temperature / Moisture

Incisions / Dressings / Leisions / Dermal Ulcers

☑ See Narrative

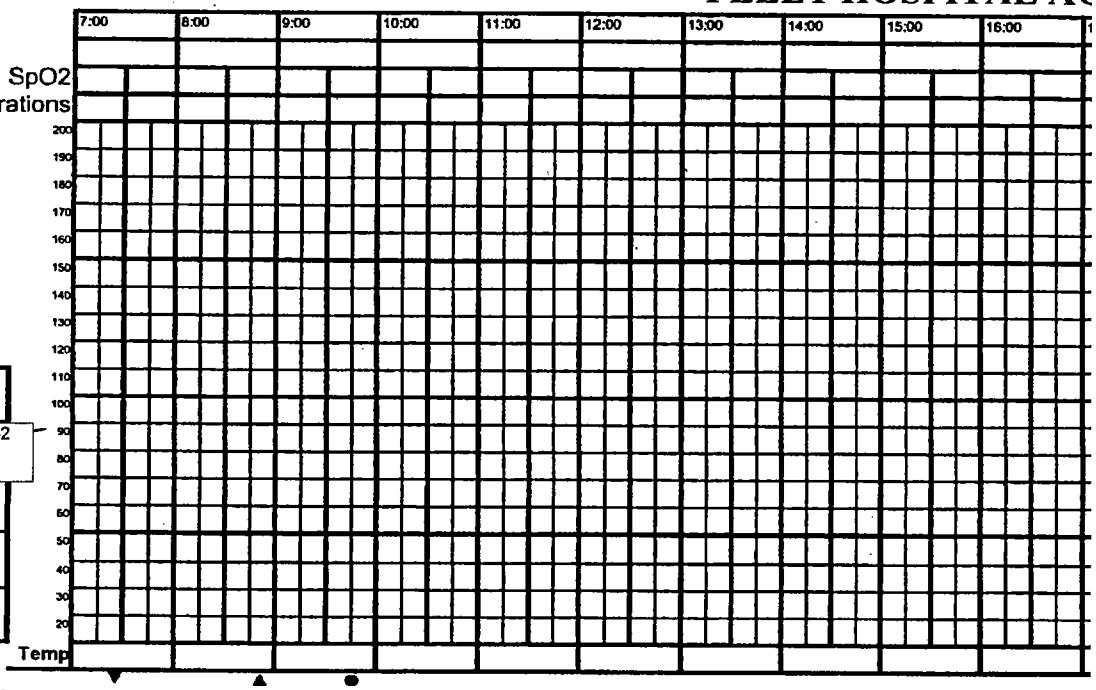
FLEET HOSPITAL AC

Addressograph:

Date:
Allergies

Diagnosis
Age:
DOB:

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



IV'S											
INTAKE	PO										
	NG/TF										
	Other										
	Cummulative Intake										
OUTPUT	Urine Volume										
	Emesis										
	NG Residual/sump										
	Bowel Movement										
	OTHER										
	Cummulative Output										

RAMSEY SEDATION SCALE:
1 - Pt. Anxious and irritated or restless
2 - Cooperative, oriented and tranquil
3 - Responds to commands only
4 - Brisk response to
5 - Sluggish response t

PAIN	Medicated										
	Dose / Route										
	Intensity (1-10) Pre / Post Med										
	Sedation Scale										
Nursing care	BATH PARTIAL/COMPLETE										
	ACTIVITY(Turn L, R, B, ch, amb)										
	IV Site CDI? Q2 hrs										
	IV Site CDI? Q2 hrs										
	TCBD										
	Wound care										
Miscellaneous											

FLEET HOSPITAL A(

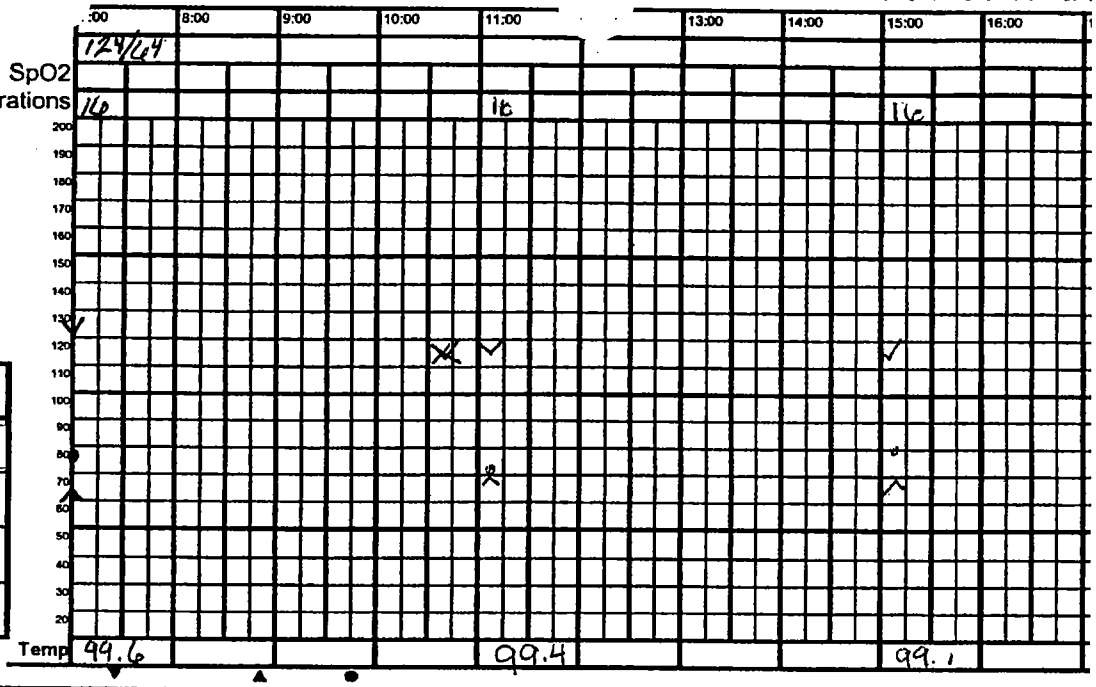
Addressograph:

(b)(6)-4

Date: 08 APR 03
Allergies NKDA

Diagnosis
Age:
DOB:

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

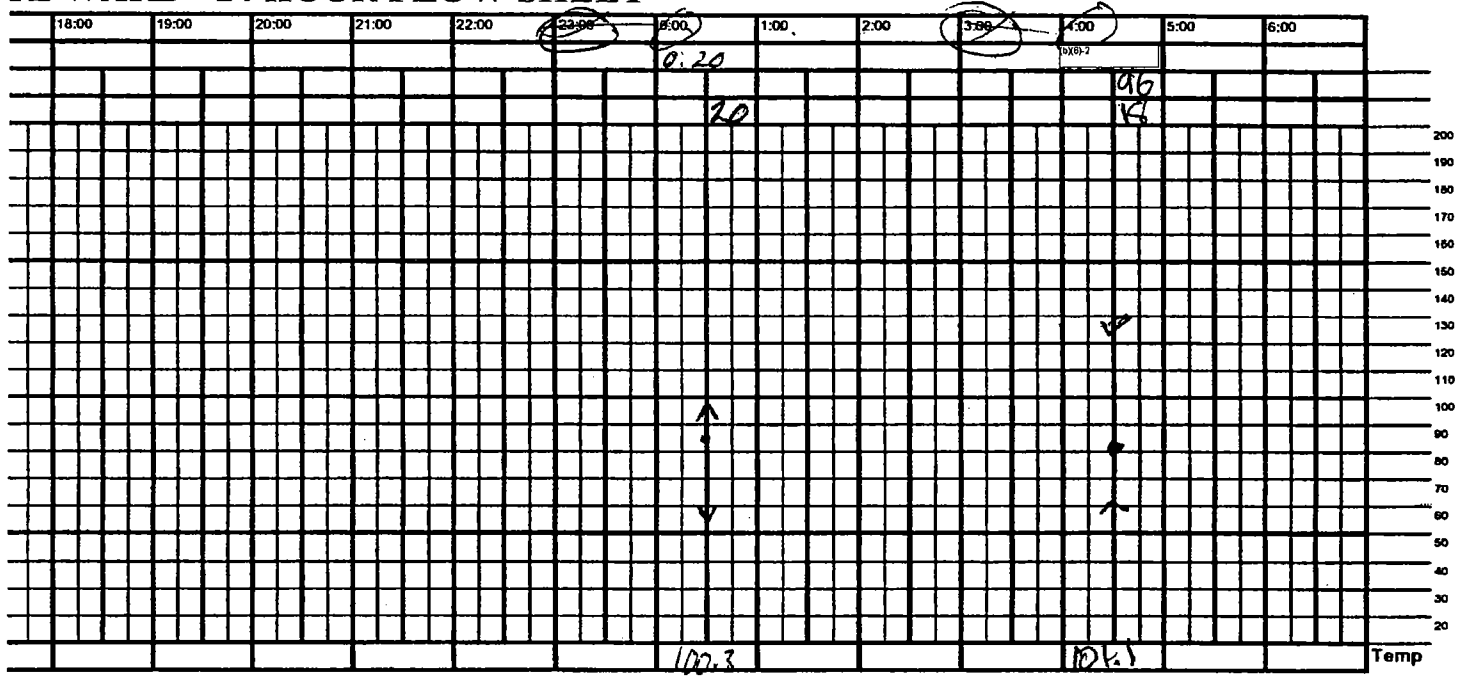


IV'S	LR										
INTAKE	PO										
	NG/TF										
	Other										
	Cummulative Intake										
OUTPUT	Urine Volume										
	Emesis										
	NG Residual/sump										
	Bowel Movement										
	OTHER										
	Cummulative Output										

RAMSEY SEDATION SCALE:
1 - Pt. Anxious and irritated or restless
2 - Cooperative, oriented and tranquil
3 - Responds to commands only
4 - Brisk response to
5 - Sluggish response t

PAIN	Medicated										
	Dose / Route										
	Intensity (1-10) Pre / Post Med										
	Sedation Scale										
Nursing care	BATH PARTIAL/COMPLETE										
	ACTIVITY(Turn L, R, B, ch, amb)										
	IV Site CDI? Q2 hrs										
	IV Site CDI? Q2 hrs										
	TCBD										
	Wound care										
Miscellaneous											

ΓE WARD - 24 HOUR FLOW SHEET



glabellar tap or loud auditory stimulus

ıt glabellar tap or loud auditory stimulus

6 - No response to light glabellar tap or loud auditory stimulus

0700-1900	Time:	Signature:

NEUROLOGICAL

Level of Consciousness
Oriented to: Person ✓ Place ✓ Time ✓
Responds to: Verbal ✓ Pain ✓ Unresponsive

Pupils R / L
Size / Reaction: ___ / ___ / ___ / ___

Motor Strength Extremities:
S = Strong
W = Weak
TR = Trace
A = Absent

	L	R
Upper	W	S
Lower	~~S~~	W

☐ See Narrative

CARDIOVASCULAR

Pulses

	R	L		R	L
Radial	+	+	Posterior Tibial	-	-
Femoral			Dorsalis Pedis	-	-

+ = Normal - = Weak 0 = Absent

Rhythm: Reg Ectopy: ___
Murmur: ___ Rub: ___ S1: ___ S2: ___
Neck Veins: ___
Edema: ___
☐ See Narrative

RESPIRATORY

Breath Sounds: ✓ Clear ☐ Bilat
Location:
Crackles /Rales: ___ Dim: ___
Wheezes: ___ Absent: ___
Rhonchi: ___
Cough: Productive / Unproductive: ___
Sputum: Color and Character: ___
Tubes: ☐ ET ☐ Trach
Size: ___ Location: ___
O2: ☐ Canula ☐ Mask
Chest Tubes: ___
☐ See Narrative

GASTROINTESTINAL

Observation: WNL
Auscultation: BSX4
Palpation: ∅ pain, ∅ distention
Stool: ☐ Incontinent ☐ Formed ☐ Soft
☐ Frequent ☐ Liquid ☐ Hard
Diet: ___
Tubes / Bags / Suction / Drainage:
☐ See Narrative ☐ NGT Placement

GU

✓ Void Urine: Color / Character
DARK Amber
Catheter: ___
Other: ___
☐ See Narrative

SKIN

Color / Turgur / Temperature / Moisture
warm / Bronze / Dry
Incisions / Dressings / Leisions / Dermal Ulcers
✓ See Narrative

0600 Pt Resting In Gurney - USS, Pt Dressing to (R) Elbow c/D/I, Pressure Dressing to (L) UL, Mid thigh c/D/I, (R) thigh SA. Drainage - ___

(b)(6)-2

(b)(3)-1

Addressograph:

(b)(6)-4

Date: 4/9/03

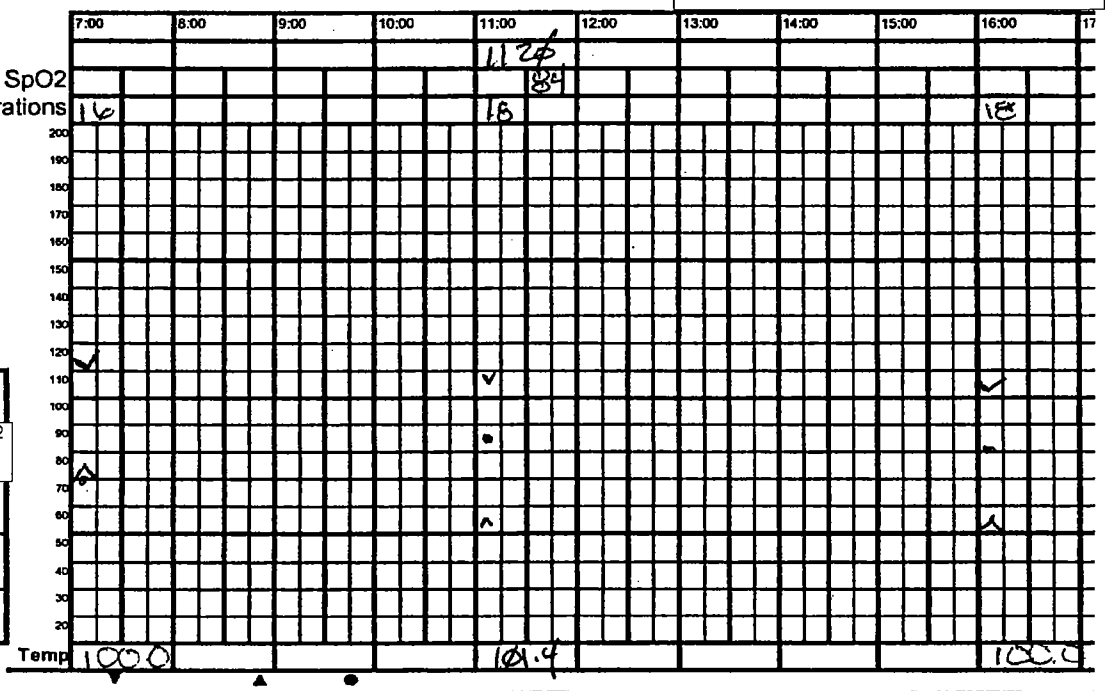
Allergies

Diagnosis

Age:

DOB:

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



		7:00	8:00	9:00	10:00	11:00	12:00	13:00	14:00	15:00	16:00
IV'S											
INTAKE	PO										
	NG/TF										
	Other										
	Cummulative Intake										
OUTPUT	Urine Volume										
	Emesis										
	NG Residual/sump										
	Bowel Movement										
	OTHER										
	Cummulative Output										

RAMSEY SEDATION SCALE:

1 - Pt. Anxious and irritated or restless
2 - Cooperative, oriented and tranquil
3 - Responds to commands only
4 - Brisk response to
5 - Sluggish response t

		7:00	8:00	9:00	10:00	11:00	12:00	13:00	14:00	15:00	16:00
PAIN	Medicated				1000						
	Dose / Route				1ul #3						
	Intensity (1-10) Pre / Post Med				UT						
	Sedation Scale				PO						
Nursing care	BATH PARTIAL/COMPLETE										
	ACTIVITY(Turn L, R, B, ch, amb)										
	IV Site CDI? Q2 hrs										
	IV Site CDI? Q2 hrs										
	TCBD				✓						
	Wound care										
Miscellaneous											

TE WARD - 24 HOUR FLOW SHEET

18:00	19:00	20:00	21:00	22:00	23:00	0:00	1:00	2:00	3:00	4:00	5:00	6:00	
	1931												
	20												
	101.2												Temp

Scale: 200, 190, 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50, 40, 30, 20

glabellar tap or loud auditory stimulus

t glabellar tap or loud auditory stimulus

6 - No response to light glabellar tap or loud auditory stimulus

0700-1900 | Time: 0600 | Signature:

~~0600 TOOK OVER~~

1200 IV d/c'ed (b)(6)-2

NEUROLOGICAL

Level of Consciousness

Oriented to: Person ✓ Place ✓ Time ✓

Responds to: Verbal ___ Pain ___ Unresponsive

Pupils R L

Size / Reaction: [ ] / [+] [ ] / [+]

Motor Strength S = Strong W = Weak TR = Trace A = Absent

Extremities: Upper L R; Lower L R

☐ See Narrative

CARDIOVASCULAR

Pulses R L

Radial ✓ ✓ Posterior Tibial

Femoral ✓ ✓ Dorsalis Pedis

+ = Normal - = Weak 0 = Absent

Rhythm: ___ Ectopy: ___

Murmur: ∅ Rub: ___ S1: ∅ S2: ✓

Neck Veins: ___

Edema: ___

☐ See Narrative

RESPIRATORY

Breath Sounds: ☑ Clear ☐ Bilat

Location:

Crackles /Rales: ___ Dim: ___

Wheezes: ___ Absent: ___

Rhonchi: ___

Cough: Productive / Unproductive: ∅

Sputum: Color and Character: ∅

Tubes: ☐ ET ☐ Trach

Size: ___ Location: ___

O2: ☐ Canula ☐ Mask

Chest Tubes: ___

☐ See Narrative

GASTROINTESTINAL

Observation: ___

Auscultation: BS +

Palpation: soft

Stool: ☐ Incontinent ☐ Formed ☐ Soft ☐ Frequent ☐ Liquid ☐ Hard

Diet: ___

Tubes / Bags / Suction / Drainage:

☑ See Narrative ☐ NGT Placement

GU

☑ Void Urine: Color / Character

incontinent x2

Catheter: ___

Other: ___

☐ See Narrative

SKIN

Color / Turgur / Temperature / Moisture

WD, good turgor

Incisions / Dressings / Lesions / Dermal Ulcers

bsg on thighs, legs, penis, groin, knee

☐ See Narrative

Surgeons in to change dressings, Medicated c MSO4 10mg IV. (b)(6)-2

1900-0700	Time:	Signature

NEUROLOGICAL

Level of Consciousness

Oriented to: Person X Place X Time X

Responds to: Verbal X Pain ___ Unresponsive ___

Pupils R L

Size / 3 / B 3 / B

Motor Strength S = Strong W = Weak TR = Trace A = Absent

Extremities:	L	R
Upper	S	S
Lower	S	S

☐ **See Narrative**

CARDIOVASCULAR

Pulses

	R	L		R	L
Radial	+	+	Posterior Tibial	+	+
Femoral	+	+	Dorsalis Pedis	+	+

+ = Normal - = Weak 0 = Absent

Rhythm: ___ Ectopy: ___

Murmur: ___ Rub: ___ S1: ___ S2: ___

Neck Veins: ___

Edema: ___

☐ **See Narrative**

RESPIRATORY

Breath Sounds: ☒ Clear ☒ Bilat

Location:

Crackles /Rales: ___ Dim: ___

Wheezes: ___ Absent: ___

Rhonchi: ___

Cough: Productive / Unproductive: ___

Sputum: Color and Character: ___

Tubes: ☐ ET ☐ Trach

Size: ___ Location: ___

O2: ☐ Canula ☐ Mask

Chest Tubes: ___

☐ **See Narrative**

GASTROINTESTINAL

Observation: Flat

Auscultation: + BS

Palpation: Soft

Stool: ☐ Incontinent ☐ Formed ☐ Soft ☐ Frequent ☐ Liquid ☐ Hard

Tubes / Bags / Suction / Drainage:

☐ **See Narrative** ☐ **NGT Placement**

GU

☐ **Void** **Urine: Color / Character**

Catheter: ___

Other: ___

☐ **See Narrative**

SKIN

Color / Turgur / Temperature / Moisture

Incisions / Dressings / Leisions / Dermal Ulcers

☒ **See Narrative**

P131 Male, 8 y, has dsg on R elbow, R thigh & L thigh & L lower abdomen. PT also has dsg on penis — (b)(6)-2

TE WARD - 24 HOUR FLOW SHEET

18:00	19:00	20:00	21:00	22:00	23:00	0:00	1:00	2:00	3:00	4:00	5:00	6:00
				92/31								
82				16					16			

200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20

99.8				99.4					97.7				Temp

glabellar tap or loud auditory stimulus

6 - No response to light glabellar tap or loud auditory stimulus

t glabellar tap or loud auditory stimulus

07001900	Time:	Signature:

PT COMPLAINS OF PAIN IN BOTH THIGHS

NEUROLOGICAL

Level of Consciousness VERBAL CUES

Oriented to: Person ___ Place ___ Time ___

Responds to: Verbal ___ Pain ___ Unresponsive

Pupils R L

Size / Reaction: ___ / ___ ___ / ___

Motor Strength Extremities:

S = Strong
W = Weak
TR = Trace
A = Absent

	L	R
Upper		
Lower		

☐ **See Narrative**

CARDIOVASCULAR

Pulses

	R	L		R	L
Radial	+	+	Posterior Tibial		
Femoral			Dorsalis Pedis	+	+

+ = Normal - = Weak 0 = Absent

Rhythm: ___ Ectopy: ___

Murmur: ___ Rub: ___ S1: ___ S2: ___

Neck Veins: FLAT

Edema: ___

☐ **See Narrative**

RESPIRATORY

Breath Sounds: ☒ Clear ☒ Bilat

Location:

Crackles /Rales: ___ Dim: ___

Wheezes: ___ Absent: ___

Rhonchi: ___

Cough: Productive / Unproductive: ___

Sputum: Color and Character: ___

Tubes: ☐ ET ☐ Trach

Size: ___ Location: ___

O2: ☐ Canula ☐ Mask

Chest Tubes: ___

☐ **See Narrative**

GASTROINTESTINAL

Observation: FLAT SOFT

Auscultation: +4Q

Palpation: NO DISCOMFORT

Stool: ☐ Incontinent ☐ Formed ☐ Soft ☐ Frequent ☐ Liquid ☐ Hard

Diet: ___

Tubes / Bags / Suction / Drainage:

☐ **See Narrative** ☐ **NGT Placement**

GU

☐ **Void** **Urine: Color / Character**

Catheter: ___

Other: ___

☐ **See Narrative**

SKIN

Color / Turgur / Temperature / Moisture

WARM DRY

Incisions / Dressings / Leisions / Dermal Ulcers

DRSG BOTH THIGHS; PENID

☒ **See Narrative**

1900-0700	Time:	Signature:

10 APR 03 0635 PT'S VS BP 118/72 T 97.9 P 66 RESP 19. PT IS A+O x 3. Ø COMPLAINTS OF PAIN. WILL CONTINUE TO MONITOR.

(b)(6)-2

NEUROLOGICAL

Level of Consciousness

Oriented to: Person X Place X Time X

Responds to: Verbal X Pain ___ Unresponsive ___

Pupils R L

Size / 3 / 3 / 3 / 3

Motor Strength Extremities:

S = Strong
W = Weak
TR = Trace
A = Absent

	L	R
Upper	5	5
Lower	5	5

☐ **See Narrative**

CARDIOVASCULAR

Pulses R L

	R	L		R	L
Radial	+	+	Posterior Tibial	+	+
Femoral	+	+	Dorsalis Pedis	+	+

+ = Normal - = Weak 0 = Absent

Rhythm: ___ Ectopy: ___

Murmur: ___ Rub: ___ S1: ___ S2: ___

Neck Veins: ___

Edema: ___

☐ **See Narrative**

RESPIRATORY

Breath Sounds: ☒ Clear ☒ Bilat

Location:

Crackles /Rales: ___ Dim: ___

Wheezes: ___ Absent: ___

Rhonchi: ___

Cough: Productive / Unproductive: ___

Sputum: Color and Character: ___

Tubes: ☐ ET ☐ Trach

Size: ___ Location: ___

O2: ☐ Canula ☐ Mask

Chest Tubes: ___

☐ **See Narrative**

GASTROINTESTINAL

Observation: Flat

Auscultation: +4Q

Palpation: No Discomfort

Stool: ☐ Incontinent ☐ Formed ☐ Soft ☐ Frequent ☐ Liquid ☐ Hard

Tubes / Bags / Suction / Drainage:

☐ **See Narrative** ☐ **NGT Placement**

GU

☐ **Void** **Urine: Color / Character**

Catheter: None

Other:

☐ **See Narrative**

SKIN

Color / Turgur / Temperature / Moisture

Incisions / Dressings / Leisions / Dermal Ulcers

DSSG Both thighs and Penis

☐ **See Narrative**

T/2DM

NNMC 6320/16 (05/91)

RECOVERY ROOM RECORD

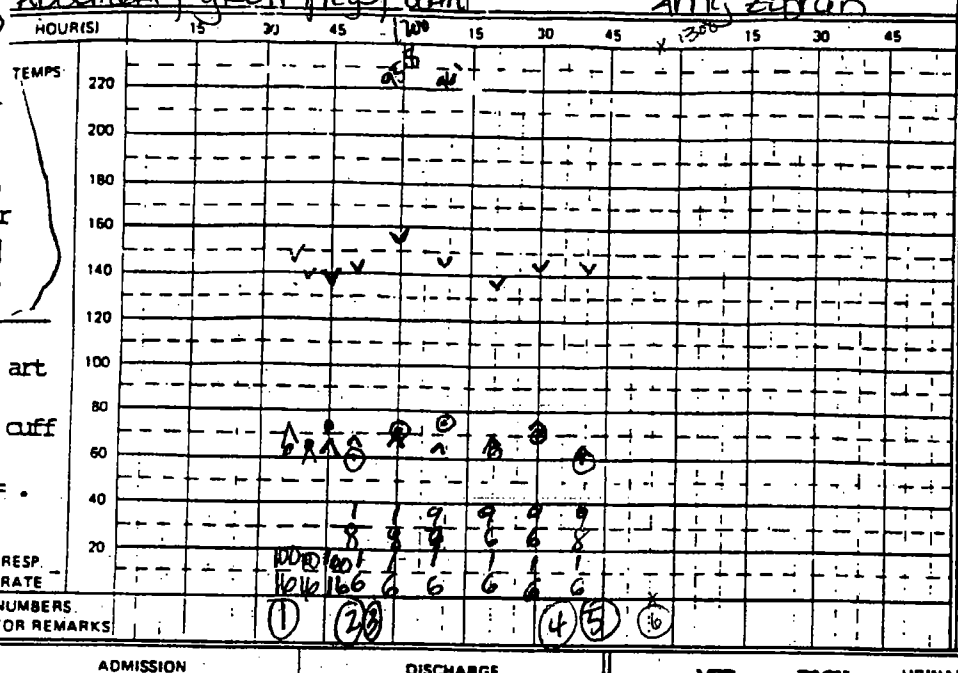
NAVMED 6320/16 (REV 11-77) S/N 0105-LF-206-3280

ANTIBIOTIC: Ancef
TIME GIVIEN: 0850
OTHER: 0

ALLERGIES: NKDA 10mg Morphine

OPERATION PERFORMED: I+D of Multiple GSW Abdomen, groin, legs, R arm

AGENTS AND TECHNICS OF ANESTHESIA: General 250mg Fentanyl IVP 2mg Versed 4mg Zofran



OXYGEN THERAPY				
ROUTE	L/M	%	ON	OFF
MASK	10		ADM 1202	
T-BAR				
VENTILAT.				

FLUID THERAPY				
TYPE	D5W	BLOOD	SALINE	OTHER
OPERATING ROOM	200			
RECOVERY ROOM	450			
TOTAL	650			

BLOOD LOSS IN OR: <50 cc

WARD PRE-OP BP 120/73 mmHg

TUBES: ☐ N/G ☐ FOLEY

IV IN Hand ≈ 300 cc OF NS AT 125 cc/hr AOW

IV IN RH ≈ 350 cc OF R AT 125 cc/hr TOW

ART. LINE IN: 0

T-TUBES, HEMOVAC IN: 0

ADMISSION	DISCHARGE
FROM MOR/SPEC. STUDY	TO WARD
DATE 15 APR HRS 1135	DATE 15 APR 03 HRS

DRESSINGS: LOCATIONS ① R forearm ② groin ③ L leg ④ R leg

STATUS: ① D+I ② D+I ③ D+I ④ D+I

STATUS: ① D+I ② Clean-sanguineous

	MOR	PACU	URINARY OUTPUT				DRAINAGE		
TIME	OR	1252							
CC	1135	1100							
TOTAL	2235	3335							
SP. GR	1100								
S/A	33 35								

ENDOTRACHEAL TUBE – ORAL OR NASAL

☐ YES ☒ NO ☐ YES ☒ NO

AIRWAY / BREATH SOUNDS

☒ CLEAR ☐ PLAST AIRWAY ☐ OBSTRUCTS EASILY

STATUS: Clear bilat

REMARKS (AS NUMBERED) AND PERTINENT PATIENT PROGRESS NOTES

1) AOW from MOR accompanied by CAPT (b)(6)-2

PMH: Multiple Surgeries ASA II

Neuro: A Opens eyes to verbal

Pain Yes/No Action: No requests for pain med

CV: NSR @ 60s IV: Patent

Other: Warm sheets applied, side rails up x2

(CONT'D ON REVERSE)

NAUSEA AND VOMITING: ☒ NO ☐ YES – 1 2 3 4 5 6 TIMES

CAUDAL, SPINAL, OR EPIDURAL BLOCK
MOVEMENT PRESENT AT N/A HRS
SENSATION PRESENT AT N/A HRS

CONDITION ON TOW: ☒ GOOD ☐ FAIR ☐ POOR ☐ CRITICAL

POST-ANESTHESIA RECOVERY SCORE (ALDRETE SCORE)			A	D
Able to move 4 extremities voluntarily or on command	2	Activity	2	2
Able to move 2 extremities voluntarily or on command	1			
Able to move 0 extremities voluntarily or on command	0			
Able to deep breathe and cough freely	2	Respiration	2	2
Dyspnea or limited breathing	1			
Apneic	0			
BP ±20% of preanesthetic level	2	Circulation	2	2
BP ±20-50% of preanesthetic level	1			
BP ±50% of preanesthetic level	0			
Fully awake	2	Consciousness	1	2
Arousable on calling	1			
Not responding	0			
Pink	2	Color	2	2
Pale, dusky, blotchy, jaundiced, other	1			
Cyanotic	0			
		TOTALS	9	10

RECOVERY: ☐ COMPLICATED ☒ UNEVENTFUL

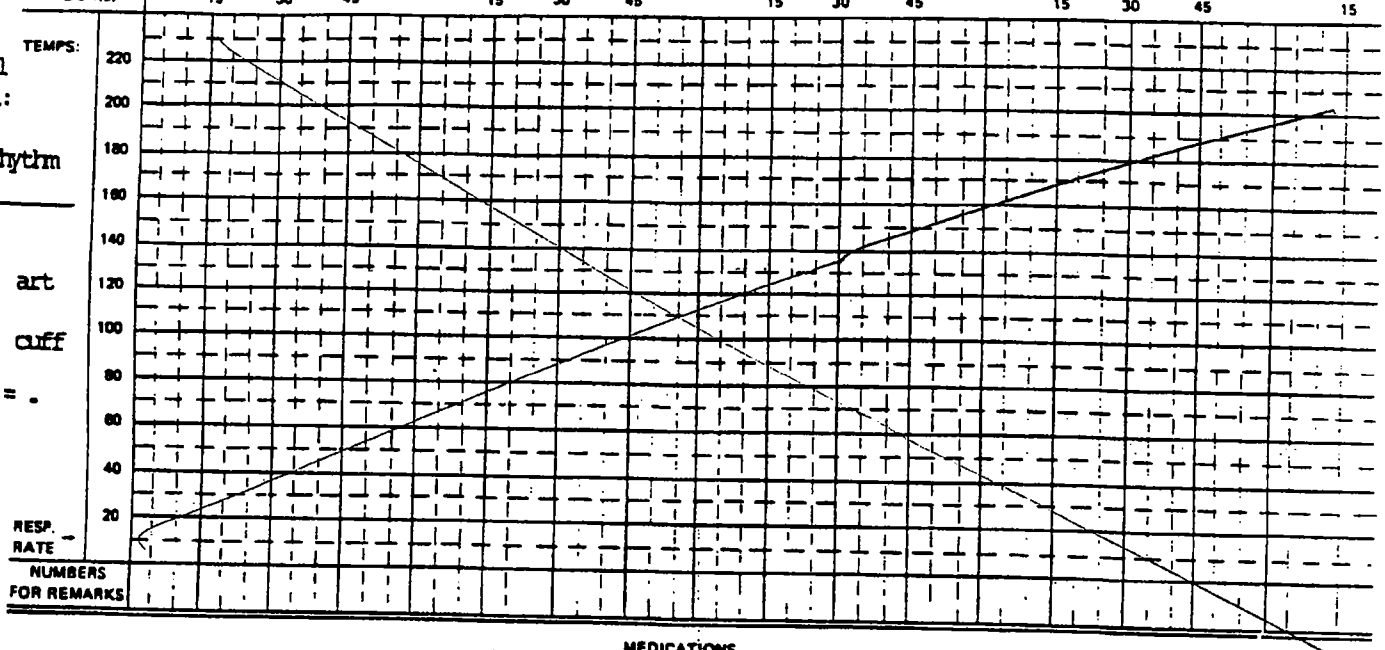
PATIENT'S IDENTIFICATION: (b)(6)-4

SIGNATURE OF RECEIVING AND RELEASING OFFICERS

AOW (b)(6)-2 CDR/NC

TOW (b)(6)-2 ENS/NC

NAVMED 6320/16 (BACK)



inal
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G Rhythm

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ulse =

Sat:

MEDICATIONS

TIME	DRUG	DOSE	ROUTE	NURSE
1150	MSO4	2MG	IVP	(b)(6)-2 ENS/NC
1200	MSO4	2MG	IVP	(b)(6)-2 ENS/NC
1205	Fentanyl	50mcg	IVP	(b)(6)-2 ENS/NC

REMARKS (AS NUMBERED) AND PERTINENT PATIENT PROGRESS NOTES (CONT'D FROM FRONT)

(2) BG = 188 (INP) (3) Pt c/o pain med per MD's orders (INP) (4) Pt c/o bladder spasm / straight cath ~~was placed by~~ Verbal order given to CDR. (b)(6)-2 Dr. (b)(6)-2 (INP) (3) c/o pain med given (INP) (5) Foley catheter placed / ordered by DR. (b)(6)-2 (INP) (6) Pt meets PACU D/C Criteria per anesthesia. Report to 5FS (b)(6)-2 ENS/NC

TOW Note: Neuro: A&O x 3

Pain: Yes/No Action: Ø

Pulmonary: Clear Bilat

CV: S1 S2 EKG Rhythm: SR IV: Patent

Skin/Wound: Warm + Dry Drainage Yes/No Color: (R) Thigh Sanguinous Edema Yes/No

GI: Ø BS

GU: Foley Yes/No Pt was straight cath Color of urine: Clear Yellow Due to void: N/A

Instructions/Interventions in PACU: Encouraged to deep breathe / straight cath / Foley catheter placed Incentiplater to BS

Report called to: LCDR (b)(6)-2 By: ENS (b)(6)-2

TOWed to: 5FS X7104 By: HMZ (b)(6)-2 / HM (b)(6)-2

NNMC 6320/16 (05/91)
RECOVERY ROOM RECORD
NAVMED 6320/16 (REV 11-77) S/N 0105-LF-206-3281

ANTIBIOTIC: Ø
TIME GIVEN:
OTHER: Fentanyl 250 mcg
5mg reSed 20mg MSO4

ALLERGIES

OPERATION PERFORMED: 14 D of (B) Interior thighs

AGENTS AND TECHNICS OF ANESTHESIA: Gen

HOUR(S) 0900 15 30 45 1000 15 30 45 15 30 45

TEMPS 220 200 180 160 140 120 100 80 60 40 20

RESP. RATE

NUMBERS FOR REMARKS

OXYGEN THERAPY

ROUTE	L/M	%	ON	OFF
MASK	10		1000	1000
T-BAR				
VENTILAT.				

FLUID THERAPY

TYPE	5% D/RL	BLOOD	SALINE	OTHER
OPERATING ROOM	1300			
RECOVERY ROOM				
TOTAL				

BLOOD LOSS IN OR: n.a. cc
WARD PRE-OP BP 125 60 mmHg
TUBES: ☐ N/G ☐ FOLEY
IV IN (L) arm ≈ 700 cc
18 OF 22 AT 100 cc/hr AOW
IV IN ____ ≈ ____ cc
OF ____ AT ____ cc/hr TOW
ART. LINE IN
T-TUBES, HEMOVAC IN

ADMISSION
FROM MOR/SPEC. STUDY
DATE ____ HRS 0950

DISCHARGE
TO WARD SES
DATE 17 APR 02 HRS 1110

DRESSINGS, LOCATIONS (B) Interior thighs (B) groin
(B) thigh sutures
STATUS: Dry and intact
(B) thigh + Groin CD: 1

STATUS:

	MOR	PACU	URINARY OUTPUT		DRAINAGE		
TIME							
CC	Ø						
TOTAL							
SP. GR							
S/A							

ENDOTRACHEAL TUBE – ORAL OR NASAL
☐ YES ☑ NO ☐ YES ☐ NO

AIRWAY / BREATH SOUNDS
☑ CLEAR ☐ PLAST AIRWAY
☐ OBSTRUCTS EASILY

STATUS:

REMARKS (AS NUMBERED) AND PERTINENT PATIENT PROGRESS NOTES

1) AOW from MOR accompanied by SR (b)(6)-2

PMH: ASA 3 Diabetes?

Neuro: PT Sleepy but arousable

Pain Yes/No Action:

CV: S1, S2 (-) murmur IV: Patent

Other: Side Rails up x2, Monitors on, Warm Blankets applied

(CONT'D ON REVERSE)

POST-ANESTHESIA RECOVERY SCORE (ALDRETE SCORE)			A	D
Able to move 4 extremities voluntarily or on command	2	Activity	2	
Able to move 2 extremities voluntarily or on command	1			
Able to move 0 extremities voluntarily or on command	0			
Able to deep breathe and cough freely	2	Respiration	2	
Dyspnea or limited breathing	1			
Apneic	0			
BP ± 20% of preanesthetic level	2	Circulation	2	
BP ± 20-50% of preanesthetic level	1			
BP ± 50% of preanesthetic level	0			
Fully awake	2	Consciousness	1	
Arousable on calling	1			
Not responding	0			
Pink	2	Color	2	
Pale, dusky, blotchy, jaundiced, other	1			
Cyanotic	0			
		TOTALS	9	

NAUSEA AND VOMITING: ☐ NO ☐ YES → 1 2 3 4 5 6 TIMES

CAUDAL, SPINAL, OR EPIDURAL BLOCK
MOVEMENT PRESENT AT ____ HRS
SENSATION PRESENT AT ____ HRS

CONDITION ON TOW: ☐ GOOD ☐ FAIR ☐ POOR ☐ CRITICAL

RECOVERY:
☐ COMPLICATED
☐ UNEVENTFUL

PATIENT'S IDENTIFICATION: (b)(6)-4

SIGNATURE OF RECEIVING AND RELEASING OFFICERS
AOW (b)(6)-2
TOW (b)(6)-2
(b)(6)-2

NAVMED 6320/16 (BACK)

HOUR(S) 15 30 45 15 30 45 15 30 45 15 30 45 15

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

RESP. RATE

NUMBERS FOR REMARKS

ɔinal
evel:

KG Rhythm

? ↓ art
? ↑ cuff

ulse = .

Sat:

MEDICATIONS

TIME	DRUG	DOSE	ROUTE	NURSE
1033	MSO4	3mg	IVP	

REMARKS (AS NUMBERED) AND PERTINENT PATIENT PROGRESS NOTES (CONT'D FROM FRONT)

@ interpreter in to see PT, PT crying and interpreter Reassured PT and informed PT on Plan of Care. PT Recieved MSO4 for Small amt of Pain.

TOW Note: Neuro: Alert orient X3

Pain: Yes (No) Action:

Pulmonary: CTA (B) PT Able to maintain Sats on RA

CV: S1, S2 - murmurs ~~HSR~~ EKG Rhythm: NSR IV: Patent

Skin/Wound: Dressings over wounds Drainage Yes/No Color: ~~Bus~~ Serosanguinous Edema Yes/(No)

GI: Bowel Sounds hyperactive Soft + Palpable

GU: Foley Yes (No) Color of urine: Ø Due to void: 1550

Instructions/Interventions in PACU:

Report called to: By: (b)(6)-2 CDR MC

TOWed to: By: (b)(6)-2 CDR

ANTIBIOTIC: PROMAXIN 500
TIME GIVIEN: 1315
OTHER:

NNMC 6320/16 (05/91)
RECOVERY ROOM RECORD
NAVMED 6320/16 (REV. 11-77) S/N 0105-LF-206-3381

ALLERGIES ~~DIABETIC~~ NKA

OPERATION PERFORMED: DELAYED GSW CLOSURE

AGENTS AND TECHNICS OF ANESTHESIA: GENITA

Spinal Level:

EKG to monitor on ☑ Rhythm NSR

BP ↓ art / ↑ cuff

Pulse = •

% Sat:

HOUR(S) 15 30 45 15 30 45 15 30 45

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

RESP. RATE

NUMBERS FOR REMARKS

OXYGEN THERAPY				
ROUTE	L/M	%	ON	OFF
MASK	10	99	AOW	1448
T-BAR				
VENTILAT.				

FLUID THERAPY				
TYPE	D5W	BLOOD	SALINE	OTHER
OPERATING ROOM	350			
RECOVERY ROOM	250			
TOTAL	600			

BLOOD LOSS IN OR: 12 CC

WARD PRE-OP BP 135 / 78 mmHg

TUBES: ~~☐ NG ☐ FOLEY~~ N/A

IV IN L EA ε 600 cc OF 20g LR AT 75 cc/hr DC@1448 AOW

IV IN R HAND ε 400 cc OF 20g LR AT 75 cc/hr TOW

ART. LINE IN N/A

T-TUBES, HEMOVAC IN N/A

ADMISSION	DISCHARGE
FROM MOR/SPEC. STUDY	TO WARD FFP
DATE 23APR93 HRS 1429	DATE 23APR93 HRS 1540

DRESSINGS: LOCATIONS (R) HIP - ABD PADS & TAPE (L) THIGH - GAUZE & CURLIX (R) THIGH

STATUS: ALL → CDI

STATUS: GAUZE & CURLIX CD & F

ENDOTRACHEAL TUBE - ORAL OR NASAL

☐ YES ☒ NO ☐ YES ☒ NO

AIRWAY / BREATH SOUNDS

☒ CLEAR ☐ PLAST AIRWAY ☐ OBSTRUCTS EASILY

STATUS: CLEAR

	MOR	PACU	URINARY OUTPUT			DRAINAGE		
TIME	AOW	TOW						
CC	0	0						
TOTAL	0							
SP. GR								
S/A								

REMARKS (AS NUMBERED) AND PERTINENT PATIENT PROGRESS NOTES

1) AOW from MOR accompanied by CDR. (b)(6)-2

PMH: DIABETIC ASA 2

Neuro: PT SLEEPY BUT AROUSABLE

Pain Yes (No) Action: NONTAKEN

CV: S'S 2

IV: NOT PATENT

Other: PT AOW VIA GURNEY WITH BEDRAILS ↑ ×2 (CONT'D ON REVERSE)

POST-ANESTHESIA RECOVERY SCORE (ALDRETE SCORE)			A	D
Able to move 4 extremities voluntarily or on command	2	Activity	2	2
Able to move 2 extremities voluntarily or on command	1			
Able to move 0 extremities voluntarily or on command	0			
Able to deep breathe and cough freely	2	Respiration	2	2
Dyspnea or limited breathing	1			
Apneic	0			
BP±20% of preanesthetic level	2	Circulation	2	2
BP±20-50% of preanesthetic level	1			
BP±50% of preanesthetic level	0			
Fully awake	2	Consciousness	1	2
Arousable on calling	1			
Not responding	0			
Pink	2	Color	2	2
Pale, dusky, blotchy, jaundiced, other	1			
Cyanotic	0			
TOTALS			9	

NAUSEA AND VOMITING: ☐ NO ☒ YES 0 1 2 3 4 5 6 TIMES

CAUDAL, SPINAL, OR EPIDURAL BLOCK
MOVEMENT PRESENT AT N/A HRS
SENSATION PRESENT AT HRS

CONDITION ON TOW: ☒ GOOD ☐ FAIR ☐ POOR ☐ CRITICAL

RECOVERY: ☐ COMPLICATED ☒ UNEVENTFUL

PATIENT'S IDENTIFICATION: (b)(6)-4

SIGNATURE OF RECEIVING AND RELEASING OFFICERS

AOW (b)(6)-2 (b)(6)-2 CDR

TOW (b)(6)-2 CDR

NAVMED 6320/18 (BACK)

HOUR(S)	15	30	45	15	30	45	15	30	45	15	30	45
TEMPS: 220												
200												
180												
160												
140												
120												
100												
80												
60												
40												
20												
RESP. RATE												
NUMBERS FOR REMARKS												

Spinal Level:

EKG Rhythm

BP ↓ art

BP ∨ ∧ cuff

Pulse = •

% Sat:

MEDICATIONS

TIME	DRUG	DOSE	ROUTE	NURSE
1435	ZOFRAN	4ml	IVP	(b)(6)-2

REMARKS (AS NUMBERED) AND PERTINENT PATIENT PROGRESS NOTES (CONT'D FROM FRONT)

(2) PT NAUSEATED. GIVEN MEDS AS NEEDED. (BLC) (3) IV SITE IN (L) FA. DC'D. 20g PUT IN (R) HAND. CONTINUE IV FLUIDS. (BLC) (4) WARM SHEETS PUT ON PT (b)(6)-2
(5) temp ↑ 96.9. No further ~~sig~~ episodes of N+V. Denies any discomfort. PACU discharge criteria met. (b)(6)-2

TOW Note: Neuro: A + OX3

Pain: Yes/No Action: NON TAKEN

Pulmonary: Breath sounds equal & clear

CV: S1 S2 no M/G EKG/Rhythm: SR IV: PATENT

Skin/Wound: CLEAN & DRY Drainage Yes/No Color: N/A Edema Yes/No

GI: Abd soft ā BST

GU: Foley Yes/No Color of urine: N/A Due to void:

Instructions/Interventions in PACU: Encourage to deep breathe

Report called to: LCDR (b)(6)-2 By: LCDR (b)(6)-2

TOWed to: 5 Forward Port By: HN (b)(6)-2 HN (b)(6)-2

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER (b)(6)-4	2. NAME (b)(6)-4 (b)(6)-4			3. GRADE	ADMISSION REMARKS
4. SEX	5. AGE	6. RACE FKHQI7	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
11. FMP 99	12. SSN (b)(6)-4		13. ORGANIZATION		14. WARD FCU3
15. FLYING STATUS NO	16. RATING/DSG	17. DEPT/BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE Inj
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct			22. HOURS OF ADMISSION 2100	23. CLINIC SERVICE ABAA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE		25. TYPE DISPOSITION		26. DATE OF DISPOSITION 8MAY03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)		27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION 4MAY03	ADMITTING OFFICER
(b)(3)-1				30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

S/P Craniotomy ~~01.01~~

S/P Trach ~~31.1~~

S/P EX LAP ~~54.10~~

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
4	4				4

36. Total Days All Facilites

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

(b)(6)-2

MAJ MC USA

SIGNATURE OF RAD OR MEDICAL RECORDS OFFICER (b)(6)-2

DA FORM 3647, MAY 79 EDITION OF 1

EPW / IRAQI UNKNOWNS INFORMATION

NAME: Unk

PSEUDO SSN: (b)(6)-4

CHCS NAME: (b)(6)-4

Home:Unk

DOB/AGE/YEAR:Unk

Capture site:Unk

MILITARY STATUS: Iraqi civilian

Rank:N/A

DIAGNOSIS: CHI with complications as listed above
Chest tube for complications arising after his trach

TREATMENT: Trach, G-tube, J-tube

RECOMMENDATIONS: 1. Keep head elevated. 2. Ventric to 0 cm. 3. Requiring hyperventilation, mannitol, propofol, narcs to control ICP.

Other names: NONE

(b)(3)-1

Name: ,

CHCS Name (b)(6)-4

(b)(6)-4 Iraqi civilian

Prognosis: Guarded

Date of Admission: 4/18/2003

Date of Transfer:

History:

8ish y/l IM in MVA. Treated at (b)(3)-1 Had a CHI and an intraparenchymal monitor was placed. However, he developed a SDH secondary to the monitor placement and required a crani for evacuation. That was evacuated and a ventriculostomy was placed.

Hospital Course:

ICP very labile and somewhat difficult to control. But gradually improved with mannitol, fentanyl, versed, intermittent vecuronium and thiopental. Ventric elevated to 7.5 cm on 4/25. Plan OR for replacement 4/27.(cancelled), CT repeat shows improvement, CT planned 4/29. D/C ventric and begin wean sedation.

Diagnoses:

CHI with complications as listed above; Chest tube for complications arising after his trach; Ventriculostomy culture positive from 4/22 for gm positive cocci on 4/25. Started intrathecal vanc 4/25.

Surgeries/Treatmen

Trach, G-tube, J-tube; ex-lap 4/13 for ct finding of ? Air near Ligament of Treitz. Ct also noted R adrenal hematoma and fracture L kidney below pelvis. Ex-lap noted only duodenal hematoma (D4) and colonic serosal tear.;

Recommendations:

1. Keep head elevated. 2. Ventric to 0 cm. 3. Requiring hyperventilation, mannitol, propofol, narcs to control ICP. 4. +/- gastrostomy tube for feeds. 5. Wound care left flank. 6. Trach care and decannulation when appropriate.

SpecialNeeds:

Will need continued ICU care until ventriculostomy out and intracranial pressure issues resolved. Then will need several weeks of inpatient rehab.

Physician:

(b)(6)-2 , LCDR Dept of Neurosurgery

5/3/2003

free fibula flap + lateral dorsi flap
to rt. humerus (0900 -

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

S: S/P MVA, S/P Closed head injury & cerebral edema
S/P trach, S/P Chest tube, S/P VP ~~shunt~~ ventriculostomy - now removed, S/P J tube
S/P EXLAP for (L) Kidney & adrenal injury, duodenal hematoma
- no purposeful movement, H/O TWBC

O: - S/P Craniectomy - healed.
- (+) tracheostomy - breathing on own
- abd - S/P EXLAP - well healed, NT, soft.
- foley in place, small (L) hip wound - healing.
- mild sacral decub.
- neck - supple
- no movement of LE to pinch
- no response to verbal cues
- will blink if touch eye.
- tolerates OG tube 5 gag.

A/P: Severe head injury, post chemically induced head/pentrauma syndrome.
- will restart ABX but suspect will not survive.

(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;	REGISTER NO.	WARD NO.
(b)(6)-4		

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

DATE	NOTES
04MAY03	DNR NOTE → pt c̄ prob infected closed head injury despite broad spectrum ABX and prior heroic efforts at tx. → Pt non-responsive to any stimuli x-cept corneal response. → Ø gag. → Pt has zero chance of survival in this location medical environment in both the acute and long term settings → After discussion with Dr [(b)(6)-2] - DCCS have placed pt DNR as further medical care is futile. Will attempt to maintain current care. [(b)(6)-2]

FPI LEX Printed on Recycled Paper

STANDARD FORM 509 (REV. 5-99) BACK

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
4 May 03 2100	T 101 P 176 R 45 BP 127/95. Pt admited to Unit via emergency room. Pt a transfer from (b)(3)-1. Pt not oriented to person, place or time. Midline incision that is healed. Oral gastric tube removed. Oral area suction. Trach area suctioned. Trach Care done. Foley Catheter draining amber urine. IV NS @ 80 cc/hr. Splints on lower legs bilaterally. Decub on (L) flank 2cm. Sacral decub Stage II. IV sites on (L) wrist and (R) wrist intact. IV infusing on (R) wrist. (b)(6)-2 CPT, AN
Tylenol PR given @ 2180	
2200	Unasyn 1.5 Gm IV. Zantac 20mg IVP. T 101.7 P 111 R 30 BP 124/80 SaO_2 = 100%. hab obtained from (L) Arc on 1st attempt. FC clamped to obtain UA. (b)(6)-2 CPT, AN
2230	UA obtained and sent to lab. CBC results returned. Critical Value of Plt @ 1062. WBC 16.6 All other labs WNL. (b)(6)-2 CPT, AN
2300	T 97 (A). Pt repositioned to (R) side. Pillow between Knees. (b)(6)-2 CPT, AN

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

(b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

DATE	NOTES
1500	Assumed care of pt. Report from MAJ Velazquez
5 May 03	Pt not alert. Resp reg and unlabored. LS
	Clear. Abd soft and nontender. Healed midline
	incision. Trach intact. c̄ O2 mask. Trach and
	oral care completed. Large blood clot
	suctioned out of trach. IV site intact.
	Splint on L foot, switched to (R) foot.
	[redacted]
1600	Pt bathed, oral care, skin care. Pt repositioned
	to (L) side. Cath care to foley. many to Verron CPT, AN
1800	Repositioned to (R) side. Suctioned. Δ Splint
	[redacted] CPT, AN
2000	Positioned on back. — [redacted] CPT, AN
2200	Positioned on (R) side. — [redacted] CPT, AN
2300	Trach care to pt. — [redacted] CPT, AN
2400 6 May 03	S/P craniotomy c̄ trach, PT c̄ incision from (L) side
	Forehead to right ear healing well. One staple in
	place. Pupils dilated, round & equal c̄ accomodation to light
	~~Tracks~~ not tracking. Trach in place c̄ 28% O2 SpO2 100%.
	Resp 20-30 CTA A to B Bilat. HR WNL, distal pulses
	+2 Bilat cap ref < 3 secs. B/S Active x 4, midline
	scar from previous surgery completely healed. Muscle tone
	weak, PT moves upper extremities to purpose, contractore
	To hands, Foot drop to feet Bilat, Foley to gravity
	draining O/S. Ulcer stage 2 dollar size in healing
	process on (R) buttocks, Stage 2 ulcer half dollar size
	on (L) hip. IV To Left forearm inf 5% dex in 0.45
	NS @ 80/cc hr [redacted] SPC CPM —

FPI LEX Printed on Recycled Paper

STANDARD FORM 509 (REV. 5-99) BACK

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
6 may 03	0030 - Turned PT to (R) side, applied Bacitracin to ulcers (b)(6)-2 SPC LPN
6 may 03	0100 - 180 cc urine clear yellow via Foley (b)(6)-2 SPC LPN
6 may 03	0400 - PT pulled IV out. Started 20G L hand inf 80cc/hr 5% Dextrose in 0.45 NS
6 may 03	1300 2.5 mg of Valium given, PT sedated, trach secretions clear
6 May 1600	Initial assessment: No response to verbal stimuli responds to pain on trunk and upper extremities. Grimaces - does not localize. Pupils ERL brisk - 3 mm. Eyes open - does not track or follow. O2 via trach collar - O2 sat 100% - BBS c̄ exp. Rhonchi. S1 S2 - ø edema. Peripheral pulses palp x4 extr. Skin warm/dry. IV to LT hand patent. Stable WNL. Abd soft, flat. Active BS x4 quads - healed mid-line incision. Foley to gravity. Urine sl. yellow. Dressing to open wound LT thigh. Sacral decubitus open (to air) - Propped on LT side. A) - Non-responsive s/p craniotomy. P) turn q2°, suction trache prn, meds as ordered (b)(6)-2
1700	Trach suctioned of Med. Amt blood tinged secretions, coughed up large clots. Air hwy clear - Sat 100% (b)(6)-2

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

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1800	Imipenem Not available from pharmacy. Dr [redacted] paged. [redacted]
6 May 03 2340	PT s/p craniotomy scar from Forehead to (R) ear. Pupils equal round & react to light sluggishly. Trach in place c̄ 40% O2, SpO2 100%. Resp 20-25, CTA, no signs of dspnea. Midline scar from prior ex lap. B/S active x4. Normal Sinus Rythm c̄ HR 60-80. PT has episodes which appear to be seizure activity. HR climbs to mid 100s during these episodes. All distal pulses +3 cap ref <3sec upper & lower ext. Foley to gravity draining Q/S. IV 20G (L) hand inf 80cc/hr D5 in 0.45 NS. Decubitus ulcer dollars size healing well stage II on (R) buttocks. Ulcer on (L) hip stage II healing well. Diet none [redacted] SPC LPN
7 May 03 0130	started 22G IV in (R) Forearm [redacted] SPC LPN
7 May 03 0340	Did Trach care, suction PT mucus is blood tinged [redacted] SPC LPN
7 May 03 2330	PT has scar from Craniotomy Forehead to (R) ear. Pupils Dilated, equal round & react to light. PT unresponsive Trach in place. Resp CTA SpO2 100% on RA. B/S Active x4. Foley to gravity draining Q/S clear Yellow Muscle tone weak. PT moves upper ext independently c̄ purpose. Lower ext flaccid. HR WNL all distal pulses +3 cap ref < 3 secs. PT has decub dollar size on (R) buttocks stage II healing well. Stage II decub on (L) hip healing well. IV to (L) hand 20G inf 80cc/hr D5 NS. [redacted] SPC LPN

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

*U.S. GPO: 2002 - 491-600/50618

STANDARD FORM 545 (rev. 10-75)
545-108

LABORATORY REPORT DISPLAY

TEST(S) SPECIMEN TAKEN		
DATE 4 Ma 03	TIME 2235 A.M. (P.M.)	
RESULTS	REQUESTED	(X)
	ROUTINE	
Yellow/Clr	COLOR / APP	
1.010	SPECIFIC GRAVITY	
1.0	UROBILINOGEN	
trace	OCCULT BLOOD	
neg	BILE	
neg	KETONES	
neg	GLUCOSE	
100	PROTEIN	
8.0	pH	
	MICROSCOPIC	
0-2	WBC	
2-5	RBC	
0-2	EPITH CELLS	
	WBC (CASTS)	
	RBC (CASTS)	
	HYALINE (CASTS)	
	GRANULAR (CASTS)	
	BACTERIA	
	CRYSTALS	
	MUCUS	
neg	NITRITE	
neg	3+ Leukocyte Est	
	BENCE-JONES PROTEIN	
	HEMOSIDERIN	
	HCG	
1+	SSA	

REMARKS: [redacted] b-6-2

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

(b)(6)-4

REQUESTING PHYSICIAN'S SIGNATURE

REPORTED BY (b)(6)-2

MD (TCH) DATE 4 May 03 2238

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

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

SPECIMEN SOURCE: ☒ ROUTINE ☐ OTHER (Specify)

LAB. ID NO.

URINALYSIS 550-107
Standard Form 550 (Rev. 4-77)
General Services Administration and Interagency Committee on Medical Records FIRMR (41 CFR) 201-45.505

PATIENTS MED. RECORD

TEST(S) SPECIMEN TAKEN		
DATE 4 APR	TIME 2200 A.M. P.M.	
RESULTS	REQUESTED	(X)
4.25x10^6 c/c	RBC COUNT	
12.4 g/dL	HEMOGLOBIN	
38.9 %	HEMATOCRIT	
91.5 fL	MCV	
29.1 pg	MCH	
31.8 g/dL	MCHC	↓
16.6x10^3/uL	WBC COUNT	↑
	WBC DIFF AND BLOOD CELL MORPH: IMMATURE	
3	NEUTRO-BANDS	
69	NEUTROSEGS	
19	LYMPHS	
	EOSINOPHILS	
	BASOPHILS	
9	MONOCYTES	
Increased	PLATELETS	
* See note	RBC	
	SED. RATE	
1062	PLATELET COUNT ↑	H*
	RETICULOCYTE COUNT	
	CLOTTING TIME	
	BLEEDING TIME	
	PTT CONTROL	
	PTT PATIENT	
	PT CONTROL	
	PT PATIENT	
	PT % ACTIVITY	
	PT RATIO	
	SICKLING TEST	
	LE PREP	

REMARKS: CBC

LYMPH % 13% ↓ Lymph # 2.1x10^3 c/c

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

(b)(6)-4

REQUESTING PHYSICIAN'S SIGNATURE

REPORTED BY (b)(6)-2

MD (b)(6)-2 DATE 4 May 03 2035

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

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

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

LAB. ID. NO.

SPECIMEN/LAB RPT. NO.

HEMATOLOGY 549-107
STANDARD FORM 549 (Rev 7-78)
PRESCRIBED BY GSA/ICMR
FIRMR (41-CFR) 201-45.505

PATIENT'S MED. RECORD

* 2+ Anisocytosis
Few polychromic
1+ Microcytic
1+ Macrocytic

1Cu-3

(1) (2) (3) (4) (5) (6) (7)

ALIGN ALL LABORATORY REPORTS ALONG THIS BASE LINE

INSTRUCTIONS: This form may be used to display laboratory reports as a flow sheet to be read as a progressive table. If so, a separate sheet should be used for each type of report form. When assorted report forms are mounted on the display sheet, both test names and results should always be visible.

ENTER IN SPACE BELOW: PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

(b)(6)-4

FORMS DISPLAYED ON THIS SHEET ARE *(Check one)*

MOUNTED ON STRIPS 1 THROUGH 7	MOUNTED ON STRIPS 1, 3, 5, AND 7
☐ CHEMISTRY I (SF 546)	☐ PARASITOLOGY (SF 552)
☐ CHEMISTRY II (SF 547)	☐ IMMUNOHEMATOLOGY (SF 556)
☐ CHEMISTRY III (SF 548)	☐ ASSORTED FORMS
☐ HEMATOLOGY (SF 549)	☐ OTHER *(Specify)*
☐ URINALYSIS (SF 550)	**MOUNTED ON STRIPS 1, 4, AND 7**
☐ SEROLOGY (SF 551)	☐ MICROBIOLOGY I (SF 553)
☐ SPINAL FLUID (SF 555)	☐ MICROBIOLOGY II (SF 554)
	☐ MISCELLANEOUS (SF 557)
	☐ ASSORTED FORMS

PRESCRIBE BY GSA/ICMR
FIRMR (41-CFR) 201-45.505

LABORATORY REPORT DISPLAY

MEDCOM - 4900

☆ U.S. GOVERNMENT PRINTING OFFICE PROG. 1752-2001/2002

CBC

(b)(6)-4

ECG-3

CHEM 1

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

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

SPECIMEN SOURCE: BLOOD ☒ OTHER (Specify)

SPECIMEN/LAB. RPT. NO.

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

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

REPORTED BY

REMARKS Chem 8

(b)(6)-2

MD ECH

DATE 4 May 03 2246

LAB. ID. NO.

PATIENT'S MED. RECORD

TEST(S)		
SPECIMEN TAKEN		
DATE 4 APR	TIME 2200	A.M. P.M.
RESULTS	REQUESTED	(X)
127	GLUCOSE	
32	UREA N.	
	CREATININE	
	URIC ACID	
142	SODIUM	
3.4	POTASSIUM	
109	CHLORIDE	
24	CO_2	
	PHOSPHATE	
	CALCIUM	
	TOTAL PROTEIN	
	ALBUMIN	
	GLOBULIN	
	ALKALINE PHOSPHATASE	
	ACID PHOSPHATASE	
	SGOT	
	LDH	
	CPK	
	BILIRUBIN (TOTAL)	
	BILIRUBIN (DIRECT)	
	CHOLESTEROL	
	TRIGLYCERIDES	
	AMYLASE	
	LIPASE	
	PROFILE (Specify)	
38	Hct	
13	Hb (calc)	
7.521	pH	

CHEMISTRY I 546-107

STANDARD FORM 546 (Rev. 8-77)
General Services Administration and Interagency
Committee on Medical Records, FIRMR (41 CFR) 201-45.505

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION: ICU-3

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICU-3		

DATE OF ORDER: 4 MAY 03 TIME OF ORDER: _____ HOURS

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

1) admit to ICU-3
2) Dx: s/p craniotomy
s/p trach
s/p EX LAP
3) Cond: serious
4) Vitals: monitor
5) activity - unable to ambulate, will need Q 2 hr rolling.
6) Nursing: ~~Q2 turn to L+R~~
- SACRAL DECUB CARE
- trach care - consult
- RESPIRATORY THERAPY
- D/C Q 6 tube
- foley & gastr
7) IVF: D5 1/2 NS IV at 80cc/H.
8) studies: CBC, UA, C/Hem 18
9) Meds: ~~tylenol~~ ~~sucral~~
Vancomycin 500mg IV Q6°
Cefepim 1.5 gm IV Q6°
Levaquin 500mg IVPB Q6°
Cantac 50mg IVPB Q6°
Lactulose 30 g BID
Phenobarb 40mg IV BID
- if meds unavailable then don't give.
10) PNR
11) tylenol 325mg PR Q6°
Valium ~~0.2~~ PRN
0.04 - 0.2 mg/kg/[illegible]/8hrs
or 2-4h PRN

(b)(6)-2

DA FORM 1 APR 79 4256 REPLACES EDITI MEDCOM - 4902 E 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 ORIE[illegible] SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER | TIME OF ORDE[illegible] | [illegible]T TIME [illegible]RDER [illegible]TED AND [illegible]SIGN

5 May 03 0840

Adm via ~~PCO Tube~~ IV 100 mg IV

qd Dilantin. First dose now

V/O per Dr (b)(6)-2

(b)(6)-2

5 May 03 (b)(6)-2

0840

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDE[illegible] | [illegible]URS

5 May 03 1330

(1) Tylenol 650 mg PR X1 prn Fever

(b)(6)-2

CPT AN CENA

02

5 May 1335 (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDE[illegible] | [illegible]URS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDE[illegible] | [illegible]URS

NURSING UNIT | ROOM NO. | BED NO.

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 1994-383-710

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

DATE OF ORDER 6 MAY 03 TIME OF ORDER 1030 HOURS

LIST TIME ORDER NOTED AND SIGN

1) Ng Stat, swab & spit
Soc PO 7 18

(b)(6)-2

6 MAY 03 (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 6 MAY 03 TIME OF ORDER HOURS

KU 2130

1) If unpleasant unabratable ~~[illegible]~~ ENT
then hold. (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 08 MAY 03 TIME OF ORDER' (b)(6)-4 HOURS

1) transfer to
when available

(b)(6)-2

8 MAY 03 (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

NURSING UNIT | ROOM NO. | BED NO.

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

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

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. 5 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 4	5	6	7	8	9	10	11	12	13	14	15	16	17
5 May	(b)(6)-2	Vitals: Monitor	07-15	/	(b)(6)-2												
		q 2°	15-23		(b)(6)-2												
			23-07														
5 May 03	(b)(6)-2	Activity - Unable to Ambulate	07-15	/	(b)(6)-2												
		Needs q 2 hr	15-23		(b)(6)-2												
		rolling	23-07														
5 May 03	(b)(6)-2	Sacrale Decub care	07-15	/	(b)(6)-2												
			15-23		(b)(6)-2												
			23-07														
5 May	(b)(6)-2	Trach Care - consult	07-15	/	(b)(6)-2												
		Resp therapy	15-23		(b)(6)-2												
			23-07		(b)(6)-2												
		Foley to gravity	07-15														
			15-23		(b)(6)-2												
			23-07														
5 May	(b)(6)-2	DNR	07-15		(b)(6)-2												
			15-23		(b)(6)-2												
			23-07														
6 May	(b)(6)-2	Turn PT Q 2hr while	07	/	/	(b)(6)-2											
		continuing to keep head	09	/	/												
		of bed 30°	11	/	/	(b)(6)-2											
			13	/	/												
			15	/	/												
			17	/	/	(b)(6)-2											
			19	/	/												
			21	/	/												
			23	/	/												

ALLERGIES: ☐ YES ☐ NO
Unk

PRIMARY DIAGNOSIS:
S/P Craniotomy/Trach/Expl Lap.

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

PATIENT IDENTIFICATION:
(b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo 5 Yr 03

Verify by Initialing: Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
5 May	(b)(6)-2	Admit ICU 3	5 May	now	2030	(b)(6)-2
5 May	(b)(6)-2	Cond. Serious.	5 May	—	NOTED	
5	(b)(6)-2	D/C OG tube	5 May	now	2100	
5		Studies: CBC, UA / Chem 12	5 May	now	2015	
8 May		Transfer to 28th CSH when available	8 May	0920	Pending	
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					

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

USAPA V1.00

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)

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

Mo. 5 Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 4	5	6	7	8	9	10	11	12	13	14	15	16	17
5 May	(b)(6)-2	D5 1/2 NS @ 80cc/hr	07-15	/	(b)(6)-2												
			15-23		(b)(6)-2												
			23-07														
5 May	(b)(6)-2	Vancomycin 200mg IV q6°	04	/	(b)(6)-2												
			10	/													
			16	/	(b)(6)-2												
			22	(b)(6)-2													
5 May	(b)(6)-2	Unasyn 1.5 gr. IV q6°	05	/	(b)(6)-2												
			11	/													
			17	/	(b)(6)-2												
			23	(b)(6)-2													
5 May	(b)(6)-2	Imepenem 500 mg IVPB q6°	06	/	(b)(6)-2												
			12	/													
			18	/	(b)(6)-2												
			24	(b)(6)-2													
5 May	(b)(6)-2	Zantac 25 mg IVPB q6°	03	/	(b)(6)-2												
			09	/													
			15	/													
			21	(b)(6)-2													
5 May	(b)(6)-2	Lacrilube OU BID	10	/	(b)(6)-2												
			22	(b)(6)-2													
5 May	(b)(6)-2	Phenobarb 40 mg IV BID	10	/	(b)(6)-2												
			22	Pt. does not [illegible]	(b)(6)-2												
5 Me	(b)(6)-2	Dilantin 100 mg qd IV	12	/	/	(b)(6)-2											
6 May		Mycostatin swish + spit 5cc PO TID	08	/	/	/	(b)(6)-2										
			14	/	/	(b)(6)-2											
			20	/	/	(b)(6)-2											

Hold

ALLERGIES: ☐ YES ☐ NO

Unk

PRIMARY DIAGNOSIS:

S/P Craniotomy / trach / exp / Lap

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO.

PATIENT IDENTIFICATION:

(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

DA FORM 1 FEB 79 4678

EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

Verify by Initialing

ERAPEUTIC DOCUMENTATION CARE ... N
(MEDICATIONS)

Mo. 5 Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
5	(b)(6)-2	If Mods NOT Available then	5 May		NOTED	
		don't give				
5	(b)(6)-2	Dilantin First dose now 100mg IV	5 May	Now	1005	(b)(6)-2
6		If Imipenem unavailable, then Hold	6 May	now		

Order/ Explr Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED															
5 May	(b)(6)-2	Tylenol 325 mg PR	2115 4 May MN	1120 5 May PR 325 (b)(6)-2	2000 5 May PR 325	6 May 1335 PR 325	7 May 2000 325 PR (b)(6)-2											
		q6° PRN																
5 May	(b)(6)-2	Tylenol 650 mg PR x 1	1345 5 May PR (b)(6)-2															
		PRN Fever																
6 May	(b)(6)-2	Valum .04 - .2 mg/kg/dose		6 May 0400	6 May 1230	6 May 1900	7 May 0845	8 May 0815	5 May 1215									
		max .6 mg/kg/8hr		2.5 mg	2.5 mg	2.5 mg	2.5 mg	2.5 mg	2.5 mg (b)(6)-2									
		2-4 hr PRN																

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

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)

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

Mo.____ Yr.____

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 6	7	8	9	10	11	12	13	14	15	16	17	18	19
	-----	Continued	01	(b)(6)-2													
	-----		03														
	-----		05														
6 May 03	(b)(6)-2 -----	Foley Care q d	08	(b)(6)-2													
5 May 03	-----	Imipenem 500 mg	06	/	/	O											
	-----	IVPB q 6°	12			(b)(6)-2											
	-----	~~(In 2nd drawer file cabinet~~	18														
	-----	~~Give to pharmacy in advance)~~	24	/	/												

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

(b)(6)-4

DISPENSING TIMES

USE PENCIL, CIRCLE MED TIMES

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

DA FORM 1 FEB 79 4678

EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

MEDICAL RECORD - ICU FLOWSHEET

SECTION I - PATIENT ASSESSMENT DATA

(b)(6)-4

PATIENT NAME:

DATE: 05/MAY 03

DIAGNOSIS: CHI

PATIENT ACUITY: HOSPITAL DAY: POST OP DAY:

	TIME:	0000	0100	0200	0300	0400	0500	0600	0700
VITAL SIGNS	BP ARTERIAL LINE							—	
	BP CUFF	130/79	133/81	123/78	123/80	146/90	125/80		122/80
	MAP	94	96	91	102	109	92		84
	TEMPERATURE								
	PULSE	98	101	110	100	97	83		92
	RESPIRATIONS	16	—	—	20	—	22		18
	PULSE OXIMETER	100	100	100	100	100	100		100
	CVP								
	PAIN (0 - 10)								
RESPIRATORY	OXYGEN (L/%)	100	100	100	100	100	100	100	100
	O2 METHOD	Trach collar	TC	TC	TC	TC	TC	TC	TC
	VENT SETTINGS:								
	FIO2								
	MODE								
	TV								
	RATE								
	PEEP								
	PS								
	Respiratory Treatments								

Oxygen Method Key: NC = Nasal cannula NR = Non-rebreather FM = Face mask VM = Venturi mask V = Ventilator TC = Trach collar
Respiratory Treatment Key: HHN = Hand-held nebulizer MDI = Metered-dose inhaler CPT = Chest physiotherapy IS = Incentive spirometer

INTAKE		80	80	80	80	80	80	80	80
	PO	0	0	0	0	0	0	0	0
	TOTALS								640
OUTPUT	URINE								
	STOOL	0	0	0	0	0	0	0	0
	TOTALS								200

(b)(6)-4

MEDICAL RECORD - ICU FLOWSHEET

SECTION I - PATIENT ASSESSMENT DATA

PATIENT NAME:

DATE:

	TIME:													
VITAL SIGNS	BP ARTERIAL LINE													
	BP CUFF													
	MAP													
	TEMPERATURE													
	PULSE													
	RESPIRATIONS													
	PULSE OXIMETER													
	CVP													
	PAIN (0 – 10)													
RESPIRATORY	OXYGEN (L/%)													
	O2 METHOD													
	VENT SETTINGS:													
	FIO2													
	MODE													
	TV													
	RATE													
	PEEP													
	PS													
	Respiratory Treatments													

Oxygen Method Key: NC = Nasal cannula NR = Non-rebreather FM = Face mask VM = Venturi mask V = Ventilator TC = Trach collar
Respiratory Treatment Key: HHN = Hand-held nebulizer MDI = Metered-dose inhaler CPT = Chest physiotherapy IS = Incentive spirometer

INTAKE														
	PO													
	TOTALS													
OUTPUT	URINE													
	STOOL													
	TOTALS													

MEDICAL RECORD - ICU FLOWSHEET

SECTION I - PATIENT ASSESSMENT DATA

PATIENT NAME: DATE:

IV SITE ASSESSMENT:

LEGEND: WNL = NO REDNESS/SWELLING/OTHER S/S INFILTRATION/INFECTION
R = REDDENED P = PUFFY I = INFILTRATED CL = CENTRAL LINE

	LOCATION	CONDITION
IV SITE # 1	~~Rt Brachial PICC~~ (R) PIV	
IV SITE # 2	(L) PIV	
IV SITE # 3		

	TIME	INITIALS
IV PATENCY CHECKED	0:00	(b)(6)-2
IV SITE CARE PROVIDED		
IV TUBING CHANGED		

COMMENTS: flushed ~~& Heparin~~. NO S/S of infection

D5½NS infusing in (R) PIV

	LOCATION	CONDITION
IV SITE # 1		
IV SITE # 2		
IV SITE # 3		

	TIME	INITIALS
IV PATENCY CHECKED		
IV SITE CARE PROVIDED		
IV TUBING CHANGED		

COMMENTS:

AM STRIP

PM STRIP

SECTION III - SHIFT NOTES

(b)(6)-4

MEDICAL RECORD - ICU FLOW SHEET

SECTION II - PATIENT ASSESSMENT DATA - REVIEW OF SYSTEMS

PATIENT NAME:

DATE:

	TIME: 0600 5 May 03 INITIALS:	TIME: INITIALS:
NEUROLOGICAL Alert and Oriented to time, place and name; Responds appropriately; Communication is adequate to express needs; Pupils equal and reactive to light.	Pupil react., but PT Does not Track and following Commands	
CARDIOVASCULAR Age appropriate Rate, Rhythm, and Pulses; Capillary refill < 3 sec; No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. Pressure monitoring	ST ; No Ectopy 2+ pulses CapRefill < 3 sec Some Edema Noted To back of Head.	
PULMONARY Respirations within normal limits for age; Breath sounds quiet and regular; Depth is regular; No dyspnea; No cough; Suction; Secretions; Oxygen; ETT; Trach	-TRACH in place -PT Sat.g 100% on O2. Breathing somewhat Laboured and Deep.	
G.I. Abdomen soft and non-distended; Bowel sounds active in all quadrants; No difficulty chewing or swallowing; No abdominal pain; Frequency and type of stool; No diarrhea; No constipation; No N/V; NG Tube placement; Type of secretions	-PT has Active BS. - ~~Foli~~ No Bm TO Note.	
G.U. Voiding; Catheters; Urine clear yellow/amber No odor, discharge, frequency, urgency, nocturia	Foley Cath in place Draining Dark yellow urine. No Discharge noted around meatus.	
MUSCULOSKELETAL: Normal muscle mass and development for age; No deformities; No assistive devices needed; Normal movement and tone; Normal active ROM without pain; No joint swelling, tenderness, weakness, or paresthesia	-PT Appearance FRAIL. PT moves, but Does not follow Command. moves only ARMS.	
SKIN Color; warm; dry; intact; Turgor; No Wounds; lesions; rashes, inflammation, ulcers, breaks in skin; No redness, blanching, irritation, over bony prominences; Mucous membranes moist; Wounds – location, condition, drainage, dressing	- mid line abdominal incision Old. - Left wrist skin Breakdown Found upon 3in x 2in OTA - Left Buttock Break down OTA - Skin Dry But warm to Touch.	
PAIN No complaints of pain/discomfort; Note Location; Duration; Intensity	UTA	
PSYCHOSOCIAL: Behavior is appropriate to the situation; Anxiety is controlled or mild and appropriate to the situation; Interacts appropriately with others	~~No Family Present~~ No Sign of Anxiety.	

MEDICAL RECORD - ICU FLOWSHEET

SECTION I - PATIENT ASSESSMENT DATA

PATIENT NAME: (b)(6)-4 DATE: 6 May 03

DIAGNOSIS: PATIENT ACUITY: HOSPITAL DAY: POST OP DAY:

	TIME:	0700	0900	1100	1300	1500	1700	1900	2100	2300	0100	0300	0500
VITAL SIGNS	BP ARTERIAL LINE												
	BP CUFF	125/80	120/71	132/77	148/81	135/83	118/63	109/60	127/72	139/72	129/78	141/83	131/94
	MAP						77						
	TEMPERATURE	99.4 (A)	99.5 (A)	101.2 (A)	102.1 (A)	98.8	99.2 (A)	97.8 (A)	97.9 (A)	97.9 (A)	96.7 (A)	96.9 (A)	96.8 (A)
	PULSE	102	99	83	128	90	124	117	125	131	69	133	118
	RESPIRATIONS	31	27	36	33	22	36	24	24	24	18	38	33
	PULSE OXIMETER	100	100	100	100	100	100	100	100	100	100	100	100
	CVP				102.1 (A)								
	Temp				99								
	PAIN (0 – 10)												
RESPIRATORY	OXYGEN (L/%)												
	O2 METHOD												
	VENT SETTINGS:												
	FIO2												
	MODE												
	TV												
	RATE												
	PEEP												
	PS												
	Respiratory Treatments												

Oxygen Method Key: NC = Nasal cannula NR = Non-rebreather FM = Face mask VM = Venturi mask V = Ventilator TC = Trach collar
Respiratory Treatment Key: HHN = Hand-held nebulizer MDI = Metered-dose inhaler CPT = Chest physiotherapy IS = Incentive spirometer

													Shift
INTAKE	IV	150		50		550				640			640
	IV	[redacted]	50	50						200		[redacted]	200
	IV	[redacted]	50		50	50							Total 840
	PO									840			
	TOTALS					1000							
OUTPUT	URINE												
	0700	220		100	100						180	200	140
	0810	200				50							160
													Total 680
	STOOL												
	TOTALS	420		100	100	50				840			

670

MEDICAL RECORD - ICU FLOWSHEET

SECTION I - PATIENT ASSESSMENT DATA

PATIENT NAME: (b)(6)-4 DATE: 5 May 03

IV SITE ASSESSMENT:

LEGEND: WNL = NO REDNESS/SWELLING/OTHER S/S INFILTRATION/INFECTION
R = REDDENED P = PUFFY I = INFILTRATED CL = CENTRAL LINE

	LOCATION	CONDITION
IV SITE # 1	Lt forearm	patent
IV SITE # 2	Rt forearm	Patent
IV SITE # 3		

	TIME	INITIALS
IV PATENCY CHECKED	0800	[illegible]
IV SITE CARE PROVIDED		
IV TUBING CHANGED		

COMMENTS: IV Rt forearm D/C @ 1415. Had. was getting puffy

	LOCATION	CONDITION
IV SITE # 1		
IV SITE # 2		
IV SITE # 3		

	TIME	INITIALS
IV PATENCY CHECKED		
IV SITE CARE PROVIDED		
IV TUBING CHANGED		

COMMENTS:

AM STRIP

PM STRIP

SECTION III - SHIFT NOTES

0700 – Initial assessment (see section II) Foley cath care performed. Positioned @ 30°. Decubitus care performed. Lacrilube placed in lower lids. IV site Lt forearm patent. Flushed x2. IV Right arm patent. Range of motion exercises. T @ 1100 101.2 325 mg Tylenol given PR. Retaken @ 1200 102.1. Consulted with Rpt (b)(6)-2 (anesthesia) who recommend cool compresses under armpits, on forehead and groin area. Receiving O2 4 l via trach. T retaken @ 1300, No changes, Tylenol 650 mg PR administered. Trach care done by resp. therapist. @ 1420 T 99.1 @ 1400, pt turned on Right side. Foot brace noted. Continue to monitor (b)(6)-2

MEDICAL RECORD - ICU FLOWS[illegible]T

SECTION II - PATIENT ASSESSMENT DATA - REVIEW OF SYSTEMS

PATIENT NAME: (b)(6)-4

DATE: 7 May 03

	TIME: / INITIALS:	TIME: / INITIALS:
NEUROLOGICAL Alert and Oriented to time, place and name; Responds appropriately; Communication is adequate to express needs; Pupils equal and reactive to light.	0700 EW Pupils equal and reactive to light	Pupils Dilated, equal, round & react to Light & accomodation
CARDIOVASCULAR Age appropriate Rate, Rhythm, and Pulses; Capillary refill < 3 sec; No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. Pressure monitoring	0700 EW Regular rhythm Capillary refill < 2 sec Nailbeds and mucous membranes pink	8-9 years old 80-100 BPM cap ref < 3 secs no signs of edema Distal pulses +2 Bilat
PULMONARY Respirations within normal limits for age; Breath sounds quiet and regular; Depth is regular; No dyspnea; No cough; Suction; Secretions; Oxygen; ETT; Trach	0700 EW Normal respirations Trach in place No cough Suctioned x 1 Labored breathing, clear lung	Resp 20-30 BPM, clear to ascultation, Trach c̄ 28% O^2 via concentrator SpO2 100%
G.I. Abdomen soft and non-distended; Bowel sounds active in all quadrants; No difficulty chewing or swallowing; No abdominal pain; Frequency and type of stool; No diarrhea; No constipation; No N/V; NG Tube placement; Type of secretions	0700 EW Abdomen soft No active bowel sounds noted - Ø swallowing	B/S active x4
G.U. Voiding; Catheters; Urine clear yellow/amber No odor, discharge, frequency, urgency, nocturia	0700 EW Foley catheter in place Draining dark colored urine	Foley to Gravity draining Clear Yellow Q/S
MUSCULOSKELETAL: Normal muscle mass and development for age; No deformities; No assistive devices needed; Normal movement and tone; Normal active ROM without pain; No joint swelling, tenderness, weakness, or paresthesia	0700 EW unable to move by himself. Ø deformities Left arm movement only	muscle tone weak, No Purpose full movement. Contractures in hands Bilat Foot drop Bilat
SKIN Color; warm; dry; intact; Turgor; No Wounds; lesions; rashes, inflammation, ulcers, breaks in skin; No redness, blanching, irritation, over bony prominences; Mucous membranes moist; Wounds – location, condition, drainage, dressing	0700 EW Right hand edema +1 Dry skin Lower sacral wound Left upper thigh wound size Multiple abd scars	skin TTR wer dry ulcer stage 2 (R) buttocks ulcer to (L) hip stage 2 midline scar cranial scar
PAIN No complaints of pain/discomfort; Note Location; Duration; Intensity	0700 EW unable to assess	unable to assess
PSYCHOSOCIAL: Behavior is appropriate to the situation; Anxiety is controlled or mild and appropriate to the situation; Interacts appropriately with others	0700 EW unable to assess	unable to assess

MEDICAL RECORD - ICU FLOWSHEET

SECTION I - PATIENT ASSESSMENT DATA

PATIENT NAME: (b)(6)-4 DATE: 7 May 03

DIAGNOSIS: s/p Craniotomy PATIENT ACUITY: HOSPITAL DAY: POST OP DAY:

	TIME:	0700	0900	1100	1300	1500	1700	1900	2100	2300	0100	0300	0500	0700
VITAL SIGNS	BP ARTERIAL LINE	115/80	109/69	133/80	106/62	124/71	~~125~~							
	BP CUFF						123/77	127/94	110/85	128/84	134/101	~~144/78~~ 138/97	138/90	103/76
	MAP													
	TEMPERATURE	97.5(A)	96.8(A)	99(A)	100(A)	99.1	98.7 AX	96.1 AX	98.3 AX	98.5 AX	97.4	98.0	98.2	
	PULSE	67	77	122	123	100	78	111	107	98	87	~~92~~	94	62
	RESPIRATIONS	18	19	38	39	31	21	22	24	18	26	~~16~~ 22	21	16
	PULSE OXIMETER	100	100	100	100	100	100	100	100	100	100	100	100	100%
	CVP													
	PAIN (0 – 10)													
RESPIRATORY	OXYGEN (L/%)													
	O2 METHOD													
	VENT SETTINGS:													
	FIO2													
	MODE													
	TV													
	RATE													
	PEEP													
	PS													
	Respiratory Treatments													

Oxygen Method Key: NC = Nasal cannula NR = Non-rebreather FM = Face mask VM = Venturi mask V = Ventilator TC = Trach collar
Respiratory Treatment Key: HHN = Hand-held nebulizer MDI = Metered-dose inhaler CPT = Chest physiotherapy IS = Incentive spirometer

	TIME:	0900	1100	1200	1300	1500	1700	1900	2100	2300		Shift	
INTAKE	IV	150	50	150	~~100~~	500	160	360	160	160		IV	640
	IVPB					50/50			50			IVPB	300
												Total	940 in
	PO												
	TOTALS	150	200	350	~~350~~	750							
OUTPUT	URINE	100	120	120	140	220	70	280	300	145	200	320	90
											shift	Total	610 out
	STOOL												
	TOTALS	100	220	340	480	700	770	1050	1350	1495			

MEDICAL RECORD - ICU FLOWSHEET

SECTION I - PATIENT ASSESSMENT DATA

PATIENT NAME: (b)(6)-4

DATE: 6 May 03

IV SITE ASSESSMENT:

LEGEND: WNL = NO REDNESS/SWELLING/OTHER S/S INFILTRATION/INFECTION
R = REDDENED P = PUFFY I = INFILTRATED CL = CENTRAL LINE

	LOCATION	CONDITION		LOCATION	CONDITION
IV SITE # 1	Lt forearm	patent	IV SITE # 1		
IV SITE # 2			IV SITE # 2		
IV SITE # 3			IV SITE # 3		

	TIME	INITIALS		TIME	INITIALS
IV PATENCY CHECKED	0800	EJ	IV PATENCY CHECKED		
IV SITE CARE PROVIDED	0800	EJ	IV SITE CARE PROVIDED		
IV TUBING CHANGED	N/A		IV TUBING CHANGED		

COMMENTS:

AM STRIP

PM STRIP

SECTION III - SHIFT NOTES

0700 - Initial assessment see section II. Foley care performed. Cleaned under foreskin. Oral care performed. Lip gloss applied. Lotion applied to dry areas. Turned q 2°. Surgeon assessed pt. states does not want to start feedings. Dressing on Lt pelvic wound. Ø drainage Dry & intact. Trach care performed @ 1120. Thick secretions removed while suctioning. — (b)(6)-2 n/a —

12:30. 2.5mg of VALIUM given DUE TO AGITATION, RR, HR AND POSTURING PROBABLE SEIZURE ACTIVITY — [redacted] b-6-2

1920. Suctioned via trach. Thick secretion removed. T-100.5 Tylenol 325 mg PR administered — (b)(6)-2 n/a —

EDICAL RECORD - ICU FLOWSI

II - PATIENT ASSESSMENT DATA - REVIEW STEMS

PATIENT NAME: (b)(6)-4 SE

DATE: 6 May 03

	TIME: 0700 INITIALS: E	TIME: INITIALS:
NEUROLOGICAL Alert and Oriented to time, place and name; **Responds appropriately; Communication is** adequate to express needs; Pupils equal and reactive to light.	Non responsive Pupils dilated, Reacts to light.	PT Non resp. Pupils Dilated, Equal round, react sluggishly
CARDIOVASCULAR Age appropriate Rate, Rhythm, and Pulses; Capillary refill < 3 sec; No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. Pressure monitoring	Capillary refill < 2 sec. Edema Rt hand going down Nailbed & mucous membrane pink.	HR Fluctuates Dramaticly Distal pulses +3, cap ref <3 sec skin TTR warm dry
PULMONARY Respirations within normal limits for age; Breath sounds quiet and regular; Depth is regular; No dyspnea; No cough; Suction; Secretions; Oxygen; ETT; Trach	Trach in place, Slight cough. Suctioned x1 via trach O_2 4 l Sat 100% Regular rhythm. Labored breathing	Resp 20-25, breath sounds CTA Equal Bilat. Trach O_2 40% SpO2 100%. Suction mucous blood tinged
G.I. Abdomen soft and non-distended; Bowel sounds active in all quadrants; No difficulty chewing or swallowing; No abdominal pain; Frequency and type of stool; No diarrhea; No constipation; No N/V; NG Tube placement; Type of secretions	Abdomen soft. Non distended Bowel sounds present	B/S Active X4 no Bowel movement, Diet None
G.U. Voiding; Catheters; Urine clear yellow/amber No odor, discharge, frequency, urgency, nocturia	Foley catheter in place Draining clear urine	Foley to bruity draining Q/S Clear Yellow
MUSCULOSKELETAL: Normal muscle mass and development for age; No deformities; No assistive devices needed; Normal movement and tone; Normal active ROM without pain; No joint swelling, tenderness, weakness, or paresthesia	Involuntary upper extremity movements. No movements upon command	PT moves upper extremities involuntarily. Lower ext Flaid muscle tone Weak,
SKIN Color; warm; dry; intact; Turgor; No Wounds; lesions; rashes, inflammation, ulcers, breaks in skin; No redness, blanching, irritation, over bony prominences; Mucous membranes moist; Wounds – location, condition, drainage, dressing	Dry skin multiple areas Good skin turgor Sacral wound Dressing Left Flank (dry + intact)	Color TTR warm & dry Stage II decub on (R) buttocks & (L) hip in healing process
PAIN No complaints of pain/discomfort; Note Location; Duration; Intensity	Unable to assess Patient non-responsive to stimuli	unable to assess
PSYCHOSOCIAL: Behavior is appropriate to the situation; Anxiety is controlled or mild and appropriate to the situation; Interacts appropriately with others	Unable to assess patient non-responsive	Unable to assess

MEDICAL RECORD - ICU FLOWSHEET

SECTION I - PATIENT ASSESSMENT DATA

PATIENT NAME: (b)(6)-4 DATE: 7 May 03

DIAGNOSIS: PATIENT ACUITY: HOSPITAL DAY: POST OP DAY:

	TIME:	0700	0900	1100	1300	1500	1700	1900	2100	2300	0100	0300	0500	0700
VITAL SIGNS	BP ARTERIAL LINE	103/76	94/74	105/73	121/79	119/78								
	BP CUFF						104/53	113/80	99/84	127/97	124/95	106/67	133/92	112/64
	MAP													
	TEMPERATURE	97.6(A)	98.4(A)	97.2(A)	99.6(A)	100.2(A)	99.1(A)	97.2(A)	98.3(A)	98.9(A)	98.5(A)	97.8	97.4	98.3
	PULSE	60	95	60	123	106	101	81	100	97	90	76	95	85
	RESPIRATIONS	15	25	17	35	38	27	16	18	22	23	16	20	22
	PULSE OXIMETER	100	100	100	100	100	99	100	100	100	100%	100%	100%	99%
	CVP													
	PAIN (0 - 10)													
RESPIRATORY	OXYGEN (L/%)	4 l					RA	RA	RA					
	O2 METHOD													
	VENT SETTINGS:													
	FIO2													
	MODE													
	TV													
	RATE													
	PEEP													
	PS													
	Respiratory Treatments													

Oxygen Method Key: NC = Nasal cannula NR = Non-rebreather FM = Face mask VM = Venturi mask V = Ventilator TC = Trach collar
Respiratory Treatment Key: HHN = Hand-held nebulizer MDI = Metered-dose inhaler CPT = Chest physiotherapy IS = Incentive spirometer

INTAKE	IV		50	50	50	50	50/50		50/100	50		[redacted]		640
	IV		50	250	[redacted]	325	160	160	160	160			Shift	200
														840
	PO													
	TOTALS		100	400	450	825				1265				
OUTPUT	URINE													
			190	110	220	200	70	85	200	325		550	200	75
	STOOL													Shift Total
	TOTALS		190	200	420	620				1300				825

MEDICAL RECORD - ICU FLOWSHEET

SECTION I - PATIENT ASSESSMENT DATA

PATIENT NAME: DATE:

IV SITE ASSESSMENT:

LEGEND: WNL = NO REDNESS/SWELLING/OTHER S/S INFILTRATION/INFECTION
R = REDDENED P = PUFFY I = INFILTRATED CL = CENTRAL LINE

	LOCATION	CONDITION	LOCATION	CONDITION
IV SITE # 1	LT forearm	patent		
IV SITE # 2	Rt forearm	patent		
IV SITE # 3				

	TIME	INITIALS	TIME	INITIALS
IV PATENCY CHECKED	0700	aw		
IV SITE CARE PROVIDED				
IV TUBING CHANGED	N/A	aw		

COMMENTS:

AM STRIP

PM STRIP

SECTION III - SHIFT NOTES

0700 - Initial assessment see section II. Oral care given, Foley care given lip gloss applied. @ 0845, pt in tachycardia (> 130). 2.5 mg Valium administered IV. ↓ Pulse 69. @ 1100 trach care provided. ∅ thick secretions. @ 1200 lotion applied to upper and lower extremities. @ 1500 T P 100.2 (A). Adm Tylenol 325 mg. Continue to monitor temp. Cold cloth placed on forehead. (b)(6)-2

1610 PT weaned to RA ∓ Trach tube Done. SpO2 97% on RA. (b)(6)-2

1620 - Initial assessment - Gr macerated pain stim. UE + trunk only. PERRL Brisk. 4mm Resp. Regular per trach. O2 weaned off by RT SaO2 97% BS CTA B/L. Skin warm; cap refill < 3 sec; Peripheral pulses palpable x4. Abd soft non-tender - BS x4 quads. Foley to gravity. Urine dk yellow. Sacral decub. & pink tissue, on L side off Decub. IV to LT hand & RT forearm A) Neuro deficits chronic P) Supportive care.

(b)(6)-2

MEDICAL RECORD - ICU FLOW SHEET

SECTION II - PATIENT ASSESSMENT DATA - REVIEW OF SYSTEMS

PATIENT NAME: (b)(6)-4

DATE: 7 May 03

	TIME: 0700 INITIALS: EW	TIME: INITIALS:
NEUROLOGICAL Alert and Oriented to time, place and name; Responds appropriately; Communication is adequate to express needs; Pupils equal and reactive to light.	Non-responsive Pupils non responsive/reactive to light Pupils dilated	
CARDIOVASCULAR Age appropriate Rate, Rhythm, and Pulses; Capillary refill < 3 sec; No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. Pressure monitoring	Frequent Episodes of tachycardia >130 beats per minute Capillary refill < 3 sec Nailbeds pink	
PULMONARY Respirations within normal limits for age; Breath sounds quiet and regular; Depth is regular; No dyspnea; No cough; Suction; Secretions; Oxygen; ETT; Trach	Breath sounds quiet labored breathing O2 4 l Trach in place	
G.I. Abdomen soft and non-distended; Bowel sounds active in all quadrants; No difficulty chewing or swallowing; No abdominal pain; Frequency and type of stool; No diarrhea; No constipation; No N/V; NG Tube placement; Type of secretions	Abdomen soft Non-distended No swallowing capability Ø BM	
G.U. Voiding; Catheters; Urine clear yellow/amber No odor, discharge, frequency, urgency, nocturia	Foley catheter in place Draining clear urine	
MUSCULOSKELETAL: Normal muscle mass and development for age; No deformities; No assistive devices needed; Normal movement and tone; Normal active ROM without pain; No joint swelling, tenderness, weakness, or paresthesia	Rigid posture ROM with assistance	
SKIN Color; warm; dry; intact; Turgor; No Wounds; lesions; rashes, inflammation, ulcers, breaks in skin; No redness, blanching, irritation, over bony prominences; Mucous membranes moist; Wounds – location, condition, drainage, dressing	Dry skin upper/lower extremities Good skin turgor Sacral wound Small wound left pelvic area. Dressing dry & intact	
PAIN No complaints of pain/discomfort; Note Location; Duration; Intensity	Unable to assess pt non-responsive	
PSYCHOSOCIAL: Behavior is appropriate to the situation; Anxiety is controlled or mild and appropriate to the situation; Interacts appropriately with others	Unable to assess pt non-responsive	

MEDICAL RECORD - ICU FLOWSHEET

SECTION I - PATIENT ASSESSMENT DATA

PATIENT NAME: (b)(6)-4 DATE: 8 May 03

DIAGNOSIS: SP Craniotomy PATIENT ACUITY: HOSPITAL DAY: POST OP DAY:

	TIME:	0700	0900	1100	1300	1500	1700	1900	2100	2300	0100	0300	0500
VITAL SIGNS	BP ARTERIAL LINE												
	BP CUFF	103/76	114/61	125/78	89/57	111/67							
	MAP												
	TEMPERATURE	99	98.7	97.2	96.6	98.1							
	PULSE	62	80	70	63	99							
	RESPIRATIONS	16	21	17	19	17							
	PULSE OXIMETER	100%	98	100	98	97							
	CVP												
	PAIN (0 – 10)												
RESPIRATORY	OXYGEN (L/%)												
	O2 METHOD												
	VENT SETTINGS:												
	FIO2												
	MODE												
	TV												
	RATE												
	PEEP												
	PS												
	Respiratory Treatments												

Oxygen Method Key: NC = Nasal cannula NR = Non-rebreather FM = Face mask VM = Venturi mask V = Ventilator TC = Trach collar
Respiratory Treatment Key: HHN = Hand-held nebulizer MDI = Metered-dose inhaler CPT = Chest physiotherapy IS = Incentive spirometer

	TIME:	0700	0900		1100	1300							
INTAKE	IV	640		350									
	IVPB	300	50	200									
	Total	940											
	PO												
	TOTALS		50	600									
OUTPUT	URINE		250	280	180	200							
	STOOL												
	TOTALS	410	250	530	710								

MEDICAL RECORD - ICU FLOWSHEET

SECTION I - PATIENT ASSESSMENT DATA

PATIENT NAME: DATE:

IV SITE ASSESSMENT:

LEGEND: WNL = NO REDNESS/SWELLING/OTHER S/S INFILTRATION/INFECTION
R = REDDENED P = PUFFY I = INFILTRATED CL = CENTRAL LINE

	LOCATION	CONDITION
IV SITE # 1	LT Forearm	Patent
IV SITE # 2		
IV SITE # 3		

	TIME	INITIALS
IV PATENCY CHECKED	0730	(b)(6)-2
IV SITE CARE PROVIDED		
IV TUBING CHANGED		

COMMENTS:

	LOCATION	CONDITION
IV SITE # 1		
IV SITE # 2		
IV SITE # 3		

	TIME	INITIALS
IV PATENCY CHECKED		
IV SITE CARE PROVIDED		
IV TUBING CHANGED		

COMMENTS:

AM STRIP

PM STRIP

SECTION III - SHIFT NOTES

0730- Initial assessment see section II: Pt non-responsive to stimuli. Resting on Rt side @ 0815 Pulse > 135. Adm Valium 2.5 mg @ 0915 Pulse 94. Turned q 2°. Passive Rom performed on upper and lower extremities. Pulse > 150 @ 1215. Adm valium 2.5 mg. @ 1330 Pulse <90. Civil affairs brought dad to pt's bedside. Surgeon spoke with Father regarding pt's condition. Foley care and oral care given. Lotion applied to upper and lower extremities. Vs stable. Continue to monitor (b)(6)-2 mg

1500 Small quarter size red area noted on Rt pelvic bone.

MEDICAL RECORD - ICU FLOWSHEET

SECTION II - PATIENT ASSESSMENT DATA - REVIEW OF SYSTEMS

PATIENT NAME: DATE:

	TIME: 0730 INITIALS:	TIME: INITIALS:
NEUROLOGICAL Alert and Oriented to time, place and name; Responds appropriately; Communication is adequate to express needs; Pupils equal and reactive to light.	Non responsive. Non communicative. Pupils dilated Non-~~responsive~~ reactive to light	
CARDIOVASCULAR Age appropriate Rate, Rhythm, and Pulses; Capillary refill < 3 sec; No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. Pressure monitoring	Episodes of tachycardia (>130 beats) Capillary refill < 2 sec. No edemas	
PULMONARY Respirations within normal limits for age; Breath sounds quiet and regular; Depth is regular; No dyspnea; No cough; Suction; Secretions; Oxygen; ETT; Trach	Labored respirations Breath sounds clear Periodic cough Trach in place	
G.I. Abdomen soft and non-distended; Bowel sounds active in all quadrants; No difficulty chewing or swallowing; No abdominal pain; Frequency and type of stool; No diarrhea; No constipation; No N/V; NG Tube placement; Type of secretions	Abdomen soft. Non-distended Bowel sounds present Ø BM Unable to chew or swallow	
G.U. Voiding; Catheters; Urine clear yellow/amber No odor, discharge, frequency, urgency, nocturia	Foley catheter in place. Draining clear urine No odor.	
MUSCULOSKELETAL: Normal muscle mass and development for age; No deformities; No assistive devices needed; Normal movement and tone; Normal active ROM without pain; No joint swelling, tenderness, weakness, or paresthesia	Rigid posture at times Passive ROM	
SKIN Color; warm; dry; intact; Turgor; No Wounds; lesions; rashes, inflammation, ulcers, breaks in skin; No redness, blanching, irritation, over bony prominences; Mucous membranes moist; Wounds – location, condition, drainage, dressing	Good skin turgor Sacral wound with Bacitracin ointment Left pelvic wound ≡ dressing (Dry and intact) Dry skin in multiple areas (mainly feet and hands)	
PAIN No complaints of pain/discomfort; Note Location; Duration; Intensity	Unable to assess. Non-responsive to pinching	
PSYCHOSOCIAL: Behavior is appropriate to the situation; Anxiety is controlled or mild and appropriate to the situation; Interacts appropriately with others	Unable to assess	

ADMISSION AND CODING INFORMATION

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

REPORTING MTF	LOCATION (State or Country Code)
1 2 3 4 5 6 7 8 (b)(3)-1	

3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
9 10 11 12 13 14 15 (b)(6)-4	(b)(6)-4	16 17	18

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
19 20 21 22 23 24 25 26: 1 9 4 8 0 1 0 1	27 28 29: 5 5 Y	30: I	31	

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34		35 36: 9 9	37 38 39 40 41 42 43 44 45 (b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	46	2100	

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
47 48 49	50 51 52	53 54 55 56 57 58 59 60 61

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION
62 63	64 65 66 67 68 69 70	71: INJ	YEAR ☐ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72: Direct	ICU 3	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

		23. DATE OF DISPOSITION (Y Y M M D D)
73 74	75 76 77 78 79 80	81 82 83 84 85 86: 0 3 0 5 0 8

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y M M D D)
87 88 89 90: A B A A	91 92 93 94 95 96	97 98 99 100 101 102: 0 3 0 5 0 4

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y M M D D)
103 104	105 106 107 108 109 110	111 112 113 114 115 116

FOR LOCAL USE

S/P ~~Caumotomy~~ PX: V5843
S/P ~~trach~~ 99859
S/P ~~ex lap~~ 85405
78003
V440
E8199

Trauma
9
Injury
109

(b)(6)-2

red)

MC USA

(b)(6)-2

DA FORM 2985, MAR 89

EDITION OF MAY 79 IS OBSOLETE

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER (b)(6)-4	2. NAME (Last, First, MI) (b)(6)-4				3. GRADE	ADMISSION REMARKS
4. SEX	5. AGE	6. RACE Iraqi	RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION No
11. FMP	12. SSN (b)(6)-4		13. ORGANIZATION			14. WARD ICW 3
15. FLYING STATUS	16. RATING/DSG	17. DEPT./BEN K-78	18. BRANCH/CORPS	19. UIC/ZIP		20. TYPE CASE
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct				22. HOURS OF ADMISSION 2100	23. CLINIC SERVICE ABAD	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE			25. TYPE DISPOSITION Home		26. DATE OF DISPOSITION 6 May 03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)			27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION 4 May 03	ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT (b)(3)-1					30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD COMPONENT TRANSFUSED
31.						

33. CAUSE OF INJURY

☐ Check if Continued on Reverse

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Open R thp Fx, GSW L leg, peronal Nerve Palsy ~~344.9~~ ~~960.0~~ ~~E911~~

~~93.5 Dressing~~

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

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

LTC, MC

(b)(6)-2

DA FORM 3647, MAY 79 EDITION OF 1 AUG 7

USAPPC V1.10

INPATIENT TREATMENT RECORD COVER SHEET

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

REGISTER NUMBER (b)(6)-4	12. NAME (b)(6)-4				3. GRADE	ADMISSION REMARKS
4. SEX	5. AGE	6. RACE Iraqi	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION No
11. FMF	12. SSN (b)(6)-4		13. ORGANIZATION			14. WARD CW 3
15. FLYING STATUS	16. RATING/DSG	17. DEPT./BEN	18. BRANCH/CORPS	19. UIC/ZIP		20. TYPE CASE IN
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct				22. HOURS OF ADMISSION 2100	23. CLINIC SERVICE ABAD	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE				25. TYPE DISPOSITION Home	26. DATE OF DISPOSITION 6 May 03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)				27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION 4 May 03	ADMITTING OFFICER
29. NAME AND LOCATION (b)(3)-1					30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED

31. ADMINISTRATIVE DATA

33. CAUSE OF INJURY

☐ Check if Continued on Reverse

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Open R Hip Fx, GSW L leg, Peronal Nerve Palsy ~~820.0~~ ~~E991~~ ~~344.9~~

~~93.5 Dressing~~

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

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 (b)(6)-2 LTC, MC

(b)(6)-2

SIGNATURE OF PAD OR MEDICAL (b)(6)-2

(b)(6)-2

DA FORM 3647, MAY 79 EDITION OF 1 AU

MEDCOM - 4928

USAPC V1.00

MEDICAL RECORD

PROGRESS NOTES

DATE

PRE OPERATIVE EVALUATION

General Diagnosis: GSW BVS Proc. Planned: Anesth:

Anesthesiologist: Surgeon:

Anesth. Risk Classification: II

Vital Signs: ROUTINE

Physical Exam Highlights:

Procedure & risks discussed with patient: YES ~~NO~~ UNAVAILABLE

Prognosis: GOOD X

IRAQI POW

(R) FEMORAL HEAD FX

Signature

POST OPERATIVE NOTE

Pre-Operative Dx: GSW (R) THIGH, (L) THIGH, (R) CALF PENS

Post-Operative Dx: SAME + (R) FEMORAL NECK FX

Anesthesia: GENA Procedure: I&D

Surgeon: NOTES / BARNES

Findings:

1. CLEAN WOUNDS MINIMALLY NECROTIC, PACKED.
2.
3.
4.
5.
6.

EBL: MIN I/O: Tissue sent to lab: Ø

Prognosis: POOR FOR (R) FEMORAL NECK FX

Plan:

DRESSING Δ'S

MEDEVAC ASAP

Sign

(Continue on rev

(b)(6)-2

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

WARD NO.

OTES

rd

(REV. 5-.99)

CFR)101-11.203(B)(10)

(b)(6)-4

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

DATE	NOTES
4 April 2003	Staff Note
0930	EPW with multiple GSW (3) → on to (R) upper inner thigh (large cutaneous defect which is packed c̄ gauze → underlying fx of head of femur noted on x-ray → not amenable to orthopedic surgery at this facility), (R) upper inner thigh → (entrance wound noted which is packed, but no exit wound), (R) calf region (5×5 cm cutaneous defect down to muscle which is packed → NO underlying fracture by x-ray) Pt also has superficial abrasion across top of penis of ? etiology. Remainder of exam WNL. USS - negative
	Imp: Multiple GSW on stated dose
	(R) hip femoral head fracture
	Plan: Pain Management
	I.V. access / Gents
	Wound Care
	To O.R. for I+D today

(b)(6)-2

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

(b)(6)-4

DATE	NOTES
5 April 2003	Staff Note:
0820	Pt stable. Offers no new complaint. Lungs clear. Heart S.S. NO MGOR. old benign. ext wounds healed, gauze intact. VSS - afebrile.
	Plan: Continue Present Meds + Support
	Observation
	Medevac to appropriate facility
	(b)(6)-2
	CDR MC USN
	Staff Note:
6 April 2003	Pt resting comfortably. When asked, he does admit to
1015	pain in inguinal area, ? saying he is having some abd discomfort.
	⊕BS. abd soft. VSS - afebrile.
	Plan: Continue Present Meds + Support
	VCBC
	Transfer to another facility when available.
	(b)(6)-2
7 April 2003	Staff Note:
0715	Pt appears to be comfortable but has obvious pain in legs with movement. Pt not eating adequately. abd - ⊕BS; soft; lungs - clear. heart - S.S.; no MGOR. VSS - T max 101.1°
	Plan: Continue Present Meds + Support
	Encourage eating
	(b)(6)-2
	CDR MC USN

PROGRESS NOTES

DATE	
2/8/03 2020	Orthopaedic Surgery (b)(6)-2 [redacted]
	ELN transferred today c open Rt hip fx, complex wounds on Rt leg. S/P I&D on 2/4/03, Dt the date of injury, or soon thereafter. Age unknown.
	PMed Hx: Non reported or documented from field hospital.
	Physical Exam (R) Buttock wound 2x3cm
	(R) groin wound 2x2cm Penile abrasion
	(L) thigh wound 12x6cm anterior medial
	(L) calf wound 3x4cm posterior distal peroneal n. palsy. Weakly palpable DP pulse on Rt.
	Pl To OR for Eval/I&D wounds, holds on chart, will transfuse Post OPR. Plan for ORIF of hip. (b)(6)-2 [redacted] MD
	(b)(6)-2 [redacted] MC USNR

(b)(6)-4 [redacted] 491-248/20616

STANDARD FORM 509 BACK (Rev. 11-77)

MEDICAL RECORD	PROGRESS NOTES
DATE	
9/4/03 2040	ORTHO op note
	I: DJ Rt hip & (L) leg. See OR sheet for details. Placed in traction. Plan for ORIF DJ Rt hip in 48 hours if wound cultures of open fracture are negative.
	(b)(6)-2 [redacted]
	LCDR USNR
9APR03 1430	Medical Nutrition Tx: O: Dx: (R) open hip fx BSW B thighs. Diet Rx: Regular. Labs 9APR Hgb/Hct 9.5/27.8. Wt. estimated @ 70kg. RD offered PT ENSURE - pt. accepted. A/P: Kcal needs: 30-35 kcal/kg/day = 2100-2450 kcal/day. Protein needs = 1.5 g/kg/day = 105 g/day. Recommend Snacks + ENSURE TID between meals; if pt. not eating meal - offer ENSURE. Recommend MVI q day - will monitor Hgb/Hct. F/U q 2-3 days.
	(b)(6)-2 [redacted] MPH, RD
	[redacted] MPH, RD LT, MSC, USNR [redacted] b-6-2

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

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

MEDICAL RECORD	PROGRESS NOTES
DATE	
4/4/07 2240	ORTHO
	Seen c translator. age 58. No Allergies. No Med Hx No Meds. feels OK in Tx
	Rx S# TX wounds dressed JP to suction
	Dx Rt T.T. hip fx
	Pl: i waiting would without Plan for ORIF hip fx on Friday (2 days) if Cultures Neg to date.
	(b)(6)-2
	MC USN

(Continue on reverse side)

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

08APR03

REGISTER NO.

WARD NO.

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

PROGRESS NOTES

DATE	
9/14/03	Orders
LA	
	Looks OK
	OK for pt in AM
	for IV 8 days
	I will try to
	close then if I
	can
	(b)(6)-2
	LA

☆ U.S.G.P.O.: 1986-491-248/20616

STANDARD FORM 509 BACK (Rev. 11-77)

PROGRESS NOTES

DATE	
4/11/03 1315	Ortho op note.
	Rt hip fx ORIF, cleaned th (h) thigh and calf wounds.
	PL: Non wt bearing on Rt leg wet → dry dressing changes on left leg. In a few days I will tentatively be able to close thigh & skin graft calf
	(b)(6)-2 (b)(6)-2 LT MC USNR

MEDICAL RECORD	PROGRESS NOTES
DATE	
13APR03	ortho.
1300	complex (B) afx hip wound.
	(B) foot drop.
	wounds dressed.
	(B) Lt. TA 0/5 GTC 2/5
	IMP. PT for AFO to wear in shoe
	hip wound care pr Dr (b)(6)-2
	(b)(6)-2

(Continue on reverse side)

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

[redacted]

20/[redacted] b-6-4

REGISTER NO.

WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FPMR (41 CFR) 101-11.806-8
509-110

MEDICAL RECORD	PROGRESS NOTES
DATE	

4/15/03 Orthopaedic Surgery
1240

① I debrided both wounds on his left leg. They should get wet to dry dressings for a few days then I can close them and skin graft or close the calf.

② I aspirated the Rt thigh because of pain & generalized swelling. No pockets of fluid identified. I plan to obtain duplex to R/O a DVT on the right.

(b)(6)-2

LCDR MC USNR

4/16/03 Internal Med WD #9
0930 s/p DHS Rt hip 4/11 + scrotal (+) ⑤ thigh + calf wounds, latest yesterday. Plan Wet to Dry then close or graft as above. Called for penile lesion. Noted by Dr (b)(6)-2 on admit - appearance today

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO. | WARD NO.

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

MEDICAL RECORD	PROGRESS NOTES
DATE	
4/16/03 0638	Cont'd Tal Med note suggests STD vs neoplasm vs abrasion. On exam ulceration c̄ heaped border ~ 3 x 3 cm (L) side distal shaft / circumcised. ∅ adenopathy. Nontender.
	ddx syphilis, chancroid, HSV - neoplasm - trauma
	✓ RPR, HIV; will do Tzanck + GS for N discharge; consider bx if lesion ∅.
	Also - pt started on coumadin on 12th, got 5 mg on 12th + 13th but no for PT, no further coumadin. Will ✓ PT/INR now + resume coumadin.
	(b)(6)-2
16APR03	P.T. Note
	Pat seen this P.M. for crutch Trng. Requires thrdl on (A) to ambulate c̄ crutches. Pat does not follow instructions and ambulated FWB (R) LE. Will cont crutch Trng until Pat is (I)
	(b)(6)-2

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

P.T. Tech

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

PROGRESS NOTES

DATE	
16APR03	Medical Nutrition Tx's
1850	O: Ate dinner tonight per RN. Diet Rx's Regular.
	Labs 14APR03 Hgb/Hct ~~10.9/31.9~~ 9.1↓/26.1↓ MCV/MCH ~~87.6/30.1~~ 87.3/30.3 [redacted] [redacted]
	A/P: PO intake fair - recommend continue to encourage PO intake = Regular diet + snacks / ENSURE TID.
	Hgb/Hct ↓, MCV/MCH WNL - recommend MVI + Fe sq.
	RD to f/u q 2-3 days. [redacted] MPH, RD
4/16/03	Orthopaedic Surgery
	Feeling OK. Go for on Rt side.
1750	T 101.7
	PE: No [illegible] swelling on Rt.
	Pl: local wound care.
	Surgery in next few days to close wounds.
	[redacted] LT MC USN

MEDICAL RECORD	PROGRESS NOTES
DATE	
17APR03	Medical Nutrition TXS
1415	O: Hgb/Hct 17APR Hgb 7.7↓/ Hct 22.9↓ MCV/MCH 88.7/29.
	Diet: Regular Per nursing - ate lunch today. Meds: MV.
	A/P. Hgb/Hct ↓; MCV/MCH WNL. Hgb/Hct ↓ since 16APR.
	Recommend FeSO4 c̄ MVI. Recommend continue
	to encourage PO intake c̄ Regular diet + snacks/ENSUR
	TID. RD to f/u ~ 2-3 days. (b)(6)-2 MPH
	(b)(6)-2 MPH, RD
	LT, MSC, (b)(6)-2
17APR03	P.T. attempted to work c̄ pt this PM. Pt refused
1438	upon arrival. will try again in AM.
	(b)(6)-2
	HM1, USN PT TECHNICIAN
	(b)(6)-2
4/17/03	O: Flaged Sing
1620	
	Resting comfortably
	Tylenol
	PE: AFO on (R)
	wounds on (R) dry
	↓ swelling.
	(L) drainage intact
	Hgb 7.7
	Plan: Transfuse, monitor, follow
	fever curve. Continue on reverse side don't suspect
	infection here.

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

(b)(6)-4

REGISTER NO. (b)(6)-2

WARD NO.

509-111

Lt, MC USNR

PROGRESS NOTES

DATE	
4/18/03	Ortho Hugard Surg
1900	feeling ok. 1/2 pin in (R) hip but ↓ AF PE: ↓ swelling — ↓ ΔL foot drop. PL up ≈ PT (b)(6)-2 LT MC USAR
4/19/03 0900	Medicine Note — (b)(6)-2 Cbc +/- Δ will repeat in AM & start MVI + FeSO4 (b)(6)-2 (b)(6)-2
4/19/03 1920	Ortho wounds look good start showering Personal n. seems to be returning (b)(6)-2 MD (b)(6)-2

☆ U.S.G.P.O.: 1986-491-248/20616

STANDARD FORM 509 BACK (Rev. 11-77)

MEDICAL RECORD | **PROGRESS NOTES**

DATE	
	Verified 0240 4/11/03 (b)(6)-2 [redacted] CDR
4/19/03 0415	Urology
	Penis beginning to granulate c/w heavy abrasion. (b)(6)-2 [redacted]
19APR03 1135	P.T. assisted pt this AM. ROM performed knee (0-110 deg). Transferred from supine to sit c min assist x1, sit to stand c mod assist x1. Ambulated 30 feet c crutches on flat surface and CGA x1. Transferred to bedside w/c c mod assist x1. Pt tolerated session well and improving. Cont P.T. RD. (R) (b)(6)-2 [redacted] HM - USN PT TECHNICIAN (b)(6)-2
21 APR03 1400	P.T. Note · Pt seen this P.M. PT Tech notified by Nurse staff that Pt ambulated on crutches approx 30ft c CGA x1 about one hour ago. Pt tolerated (R) Knee ROM exercise well. Doing well, will ~~D/C from P.T.~~ assess Pt in A.M. for (T) crutch walking (b)(6)-2 [redacted] HM3 (FMF) P.T. Tech

(Continue on reverse side)

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

(b)(6)-4 [redacted]

REGISTER NO. | WARD NO.

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

PROGRESS NOTES

DATE	
22 Apr 03	P.T. Note Pt seen this P.M. for crutch Trng, ambulated 54 ft on crutches TTWB. Instructed Pt to ambulate c̄ NWB status. Pt having difficulty c̄ this gait pattern. will Cont to Train Pt NWB — (b)(6)-2 HMC (FMP) P.T. Tech
23 Apr 03	P.T. Note Pt cont. to have difficulty wt bearing status for crutch trng. Pt able to ambulate c̄ CGA TTWB for short distances. Will cont. to trng Pt on status — (b)(6)-2 (b)(6)-2 (b)(6)-2 HMC (FMP) P.T. Tech
24 APR 03	P.T. NOTE Pt transfered from sit to stand c̄ min assist x1. Ambulated 60 feet c̄ crutches and CGA x1. Tolerated session well c̄ multiple rests during ambulation. Pt did better today but still apply of TTWB RLE. Will Cont. P.T. as per plan. — (b)(6)-2 (b)(6)-2 (b)(6)-2 HM, USN PT TECHNICIAN (b)(6)-2
24 APR 03	Medical Nutrition Tx Flus
1540	O: Per RN - "eats all of food". Labs 23 APR 03 Hgb/Hct 9.5/27.6 Diet Rx: Regular. Meds: FeSO4, MVI A/P: Hgb/Hct improving since 4/20 - recommend offer FeSO4 c̄ fruit juice to ↑ absorption. PO intake good. RD to fu q 3-5 days. (b)(6)-2 MPH, RD (b)(6)-2 MPH, RD LT, MSC, (b)(6)-2

MEDICAL RECORD	PROGRESS NOTES
DATE	
4/20/03 1930	Ortho I don't know if it's wise to close the soft tissue wounds. With dressings they will take a long time to seal. They are pretty clean. I think PT is a good idea now. He should be strickly NWB based on his XRay.
	(b)(6)-2 [redacted] LT MC USNR
4/21/03 1600	Ortho (b)(6)-2 [redacted] Day Better AF PE almost all healed I X-rays collapsed R hip but still my heal..
	(b)(6)-2 [redacted]

(Continue on reverse side)

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

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FPMR (41 CFR) 101-11.806-8
509-110

PROGRESS NOTES

DATE	
21APR03	Medical Nutrition TX: F/U:
1600	S: via translator – ate Breakfast + lunch ¢ ENSURE,
	O: Diet Rx: Regular. (b)(6)-2
	Labs 20APR: Hgb/Hct 8.6/24.4↓ MCV/MCH 88.4/30.8
	A/P: PO intake fair. Hgb/Hct ↓, but improving since 17APR03. Recommend continue encourage PO intake + offer FeSO4 c̄ fruit juice to ↑ Hgb/Hct.
	RD to f/u ē 2-3 days. (b)(6)-2 MPH, RD
	[redacted], MPH, RD LT, MSC, USNR (b)(6)-2
4/22/03	
1550	Ortho
	(h) leg wounds healing
	(R) hip wounds healing
	Pl: I'll try & close his leg ē skin graft calf.
	(b)(6)-2
4/23/03	Medicine Note
0830	Resting comfortably – ⊿ Percocet to PRN.
1130	Burning on urination:– (b)(6)-2
	UA ⊕ WBC, ⊕ Bacteria
	P: Septra DS BID x 3 days.

MEDICAL RECORD	PROGRESS NOTES
DATE	
4/23/03 1815	Ortho
	Doing OK. AF
	PE: Rt hip wounds healed Lt leg - open wounds cont dressing chg
	Imp: hip fx GSW
	Plan: Doing well c̄ PT NWB for 3wks will require long-term dressings on leg. I will consider surgical closure -
	(b)(6)-2 MD (b)(6)-2

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
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509-110

PROGRESS NOTES

DATE

4/23/03 Narrative Summary

1900

Transferred to (b)(3)-1 for treatment of Rt hip fx GSW. Initially placed in traction and treated with ORIF/I&D of wounds. Comminuted femoral neck fx, complex soft tissue wounds. Partial sciatic nerve palsy. Recovered well from surgery, partially resolving n. palsy.

Presently being treated for UTI; should remain NWB for 2-3 months. If no signs of healing may require hemiarthroplasty.

Rt leg wounds being treated by local wound care and dressing changes.

(b)(6)-2

LTC
USN

MEDICAL RECORD	PROGRESS NOTES
DATE	
4/24/03 11A	Ortho
	(L) leg wounds look very good will attempt closure in AM
	(b)(6)-2 MC
	(b)(6)-2 (b)(6)-2
4/25/03 1830	Ortho post op ✓
	in bed, comfortable AE
	Bandages intact (L) leg
	Try stable post op step skin closure (L) thigh & calf
	also developing hip flexion contracture → very concerning. will work on this.
	(b)(6)-2 CPT USNR

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO.

WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
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FPMR (41 CFR) 101-11.806-8
509-110

PROGRESS NOTES

DATE	
4/26/03 1640	Ortho
	Holding hip flexed; Developing flexion contracture
	Pl will ✓ X-Rays; Perhaps has DHS has cut out.
	(b)(6)-2
	CT MC USNR
4/26/03 1705	Internal Med
	Acetabulum ⊕ today from a venous cx from 4/23. CA test day clear UTI, tx c̄ Septra. Repeat CA today ⊖ i.e. responded to Septra. So appears to be contaminant + not Acetabulum UTI - will d/c tree drips started earlier today. Wound clinically. CBC in Am
	(b)(6)-2

PROGRESS NOTES

DATE	
4/25/03 0950A	Ortho of Mr.
	I took the opportunity to close the remaining open wounds. Have been treated c̄ dressing changes and more granulating well s̄ signs of infection. Overall closed easily c̄ absorbable suture.
	(b)(6)-2 LT MC USNR

(b)(6)-4

STANDARD FORM 509 BACK (Rev. 11-77)

MEDICAL RECORD	PROGRESS NOTES

DATE

26 Apr 03 1400 — P.T. Note

Pt seen this P.M., tolerated Hip ext. well c/o pain during P.T. session. Ambulated 60ft on crutches part of the way NWB / TTWB (R) LE. Pt requires multiple verbal ques about wt bearing status. Will cont. P.T. QD [redacted] (b)(6)-2 HMC(FMF)

P.T. Tech

27 April 03 1040 — Ortho Peach Sqn

Feeling OK. Up in Bed. Pleasant as usual.

AF

PS — incs wounds healing well [redacted] (b)(6)-2

Lt hip flexion contracture [redacted] (b)(6)-2 N15-20°

Imp — X Rays - collapse of femoral Neck

5 change from initial study

Hip screw allowed slight valgus displacement of head which is good.

Imp - GSW Rt Neck fx

GSW LT soft tissue wounds

Pln - work on hip flexion contract

NWB to Rt side [redacted] (b)(6)-2

(Continue on reverse) LT MCUSA

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

[redacted] (b)(6)-4

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FPMR (41 CFR) 101-11.806-8
509-110

PROGRESS NOTES

DATE	
27 APR 03	P.T. NOTE Pat ind in all transfers. Ambulated approx 100 feet c̄ crutches and SBA x 1. (R) hip Flexor stretch performed. Pat forth a good effort and ind c̄ crutches. Cont Hip flexor stretch QD. (b)(6)-2 (b)(6)-2
28 APR 03	P.T. NOTE Pat at EOB upon arrival. P.T. observed pat ambulating c̄ doctor using crutches. Pat did really well and ind. c̄ crutches. (R) hip flexor stretch perform. Tolerated session c̄ pain. Will cont P.T. QD for hip flexor stretch. (b)(6)-2 HM - USN PT TECHNICIAN (b)(6)-2
4/28/03 1820	Orthopaedic Surg Sig OLIF Rt hip fx / Delayed closure of (L) thigh/calf wounds. AF Pe all wounds healing - small central dehiscence of (L) calf wound Rec Cont PT to work on Rt hip flexion contracture Telfa dressing to Lt calf until sealed NWB to Rt leg. (b)(6)-2 LT MC USNR

MEDICAL RECORD	PROGRESS NOTES
DATE 28APR03 1848	Medical Nutrition Tx: FIU: S: Per translator 4/27 - Ate 3 meals. 4/28 - Ate Breakfast & Lunch. O: Diet Rx: Regular. Labs 28 APR: Hgb/Hct 8.5↓/26.6↓ A/P: Hgb/Hct ↓ - recommend offer FeSO4 c̄ fruit juice to ↑ absorption. PO intake good - recommend continue encourage PO intake. RD to f/u q̄ 3-5 days. (b)(6)-2 MPH, RD (b)(6)-2 LT, MSC, USNR (b)(6)-2 MPH, RD
29 APR 03	P.T. NOTE Pt seen this PM. (R) hip flexor stretches performed. Pt instd in ambulation c̄ crutches and bed mobility and transfers. Cont P.T. QD. (b)(6)-2 ~~HM - USN~~ PT TECHNICIAN (b)(6)-2
29 Apr 03	ORTHO (b)(6)-4 S/P R hip ORIF, soft tissue injuries L post. thigh & leg. Afebrile (b)(6)-2 R hip wounds healed. L post thigh wound healed. L leg - small 2cm area skin open P: allow granulation tissue to form No further sx necessary. Daily dressing change - L leg (b)(6)-2 (Continue on reverse side)

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

(b)(6)-4

REGISTER NO.

WARD NO.

PROGRESS NOTES

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

509-111

PROGRESS NOTES

DATE	
4/30/03	ORTHO POD 19
	Comf
	Afebrile
	P: Continue present care.
	(b)(6)-2
30APR03	P.T. NOTE
	Pt seen this AM PM. Passive (R) hip flexor stretch performed. Pt encouraged to lay (b)(6)-2 prone position. Cont P.T. (b)(6)-2 HM-USN PT-TECHNICIAN (b)(6)-2
1 May 03	ORTHO POD 20
	Comf (b)(6)-2
	Afebrile.
	P: Daily drg Ds. (b)(6)-2
1 May 03	P.T. Note (b)(6)-2
	Doing well c̄ PT sessions. Ambulated 180ft NWB (R) LE c̄ crutches (I). Tolerated with pain (R) Hip Flexion stretches. Cont. PT QD (b)(6)-2 HMC(FMF)
	P.T. Tech
1MAY03	Medical Nutrition Tx F/U:
1900	S: Per translator - eating all meals 4/30 + 5/1.
	O: Diet Rx: Regular. Labs 1MAY: Hgb/Hct 8.6/26.0
	A/P: Hgb/Hct ↓ - recommend offer FeSO4 c̄ fruit j̄ to ↑ absorption. PO intake good - recommend continue encourage. PO intake. RD to f/u q̄ 7 days.
	(b)(6)-2 MPH, RD
	(b)(6)-2 MPH, RD
	LT, MSC, USNR (b)(6)-2

MEDICAL RECORD | **PROGRESS NOTES**

(b)(6)-2

DATE	
02MAY03	P.T. CLINIC NOTE Pt ambulated approx 250 feet c̄ crutches and SBA x 1. Ind in all transfers. Passive (R) hip flexor stretch performed. Tolerated session well but screamed c̄ pain. Will cont. P.T. as per plan. (b)(6)-2 LMT2 (b)(6)-2
03MAY03	P.T. NOTE Pt at EOB upon arrival. (R) hip flexor stretch performed. Tolerated session well but screamed c̄ pain. Pt improving. Cont P.T. as per plan. (b)(6)-2 HM - USN PT TECHNICIAN (b)(6)-2

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO. | WARD NO.

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

MEDICAL RECORD	PROGRESS NOTES
DATE	
~~4 May~~ 03 2200	VS 150/90, 112, 98%, 20, 99.4°. Pt is A&O x3, ∅ complaints, drsg to (R) hip CDI, Pt is sleeping lungs CTA, + BS x4 quads. Will continue to monitor. (b)(6)-2 Sgt
4 May 2003 2330	VS. 132/62, 88, 16, 99.7. PT Has Several GSWs to Thigh post-op several days to weeks? Sites are clean & s/s of infection. PT c/o generalized discomfort to sites – ii T#3 PO. (b)(6)-2
0145	Started 20 gage IV (R) FH to deliver MSO4 IV as ordered on Med Sheet. (b)(6)-2 MAT 1/1
0200	Pain Med Effective. (b)(6)-2 MAT AN
0600	PT requested MSO4 @ 0445, Pain med effective. PT continue to sleep & comfort. (b)(6)-2 MAT AN
5 MAY 03	VSS- BP 112/59, RR-20, SAO2 95%, P-80
5 May 03 @ 0910	Pt given 5mg IV of MSO4 for c/o pain to (R) thigh. (b)(6)-2 LCR
5 MAY 03	Pt sitting in bed. Alert + Oriented x3. (b)(6)-2 Wound to posterior upper left thigh. open to air. Drsg to LLE. CDI. Pt complained of pain to (R) thigh. Open fx of (R) Hip. Lung sounds CTA. Active BS x 4 quads. Will continue to monitor (b)(6)-2 WMC
~~3 May~~ 5 May 03	1540 – 5mg MSO4 given for pain. (b)(6)-2

(continue on reverse side)

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

(b)(6)-4

REGISTER NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
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PROGRESS NOTES

DATE	
5 May 03 1540	VS - 120/50 - 82, 98%, 20, T 98.8°, Pt is asleep, lungs CTA, +BS x 4 quads. Wound to upper (R) thigh open to air, Ø signs of infection, Ace wrap to LLE tibial are odi. will continue to monitor. (b)(6)-2 /SGH
5 May 03 2345	V.S. 128/68 99.2 88 16. Pt repositioned in bed. Pt has post-op surgical wounds to thigh that are ~ s/s of infection. (b)(6)-2 MAJ AN
0100	Pt Medicated for thigh discomfort c̄ ⅐ T#3. (b)(6)-2 MAJ AN
06 MAY 03	VSS - BP 117/64, HR 64, T - 98.1, SAO2 96% RA (b)(6)-2 spe (b)(6)-2 quiet
6 May 03 1300	Pt DCd to home, states understanding of instructions and use of crutches for ambulation and wound care. Pt left ambulatory c̄ crutches for assist. (b)(6)-2 /SGH

NSN 7540-00-634-4176

600-108

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
8 April 2003	Staff Note:
0725	Resting Comfortably. Having pain in @ thigh 2° to gunshot wound. No new complaints. Had urinary retention noted yesterday — foley cath placed. US-1 - epididymitis. Plan: Continue Present meds + support. Medevac when available
	(b)(6)-2
	CPT Carlson

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

RECORDS MAINTAINED AT: ▶		
PATIENT'S NAME *(Last, First, Middle initial)*		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME	ORGANIZATION	
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

MEDCOM - 4959

MEDICAL CARE

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

CLINICAL RECORD	NURSING NOTES (Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
1100			Received for men in stretcher SBP deteriorated GSW BLE [illegible] under OBP. On Sat 92%. Slept [illegible] oral AW @ [illegible] [illegible] Thr 20/[illegible] sedated. BP 108/[illegible], HR 122. Flutters [illegible]. On [illegible] in Pay. (b)(6)-2
1230			On to 2L in [illegible] by. (b)(6)-2
1230			HOSA On off. Sat 96% (b)(6)-2
1200			Unresponsive recovery. Repeat called to LCDR (b)(6)-2 Now on AW 2 in stretcher (b)(6)-2

Continue on reverse side

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

(b)(6)-4

REGISTER NO.

WARD NO.

NURSING NOTES
Standard Form 510
General Services Administration and Interagency Committee on Medical Records
FPMR 101-11.806-8—October 1975
510-109

NSN 7540-00-634-4123

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
	0650		5 mg MSO4 ADMINISTERED BY CMD - (b)(6)-2
			PER DR. (b)(6)-2 ORDER. (b)(6)-2
	0700		ADMINISTERED #1 C7 ½ GM ANCEF PER DR. (b)(6)-2 (b)(6)-2

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

NURSING NOTES

Medical Record

STANDARD FORM 510 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

(b)(6)-2

CLINICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
09 Apr 03	0400		Pt admitted to 5FWD from PACU. A&O x 3, VSS O_2 Sat 97% ② 2LNC. Neuro checks (B) lower ext intact as well as dressings also clean & dry. Denies any SOB & pain ② this time. Will continue to monitor. (b)(6)-2 ens, rn
09APR2003 1630			Assumed pt care at 1530. Pt awake, alert. RLE - ace wrap to (R) hip/thigh. JP drain x 1 with moderate amt serosanguinous drainage. (R) hip/thigh dsg - CDI. RLE in traction. RLE - warm to touch, (+) movement, cap refill < 3 sec, (+) +1 edema, color NFR. LLE c̄ ace wrap to thigh and calf. Dsgs - CDI. LLE - warm to touch, (+) mvmnt, cap refill < 3 sec, (+) +1 edema, color NFR. Lungs CTAB. CV - RRR. BS - hyporactive LUQ, LLQ, RUQ. BS absent RLQ. Foley draining clear yellow urine. NS @ 100 cc/hr. (b)(6)-2 ens
10 Apr 03	0335		Assumed pt care @ 2400. A&O x 3. Dressings & wrap (R) & (L) lower extremities c/d/i. N/V okay. JP drain (R) thigh mod drainage serosanguinous. Foley draining amber color urine sufficient amt. Denies any pain. Pt resting comfortably no complaints. Will continue to monitor status. (b)(6)-2 ens, rn

Continue on reverse side

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle, and [illegible] facility)

(b)(6)-4

REGISTER NO.

WARD NO.

NURSING NOTES
Standard Form 510
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505
510-110

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
08APR03		1400	PT CAME TO CASREC. GSW (L) MEDIAL THIGH, (L) LE, GSW (R) BUTTOCKS, (R) FEMORAL NECK FRACTURE, ABRAISON VS GSW GLANS PENIS. V/S/S, BP=133/89 P=113 T=101.9 RESP=18 SPO2=95 CAPREFILL=PRES DRSG Δ'S DONE TO (L) MEDIAL THIGH, (L) LE, (R) BUTTOCKS 2 MG MORPHINE ADMINISTERED THROUGH IV.
			(b)(6)-2

☆U.S. GPO: 1987-181-247/60056

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
13 APR	0930		AM CARE COMPLETED @ BS. FOLEY DRAINING CLEAR YELLOW URINE. WOUNDS TO LE C/D/I. mbh (L) ANKLE IN SPLINT. (+) CMS. 1cmg MSO4 GIVEN FOR PAIN. PT. NOW BACK TO SLEEP. NS INFUSING C̄ OUT DIFFICULTY — (b)(6)-2
14Apr03	0215		Pt resting. Assumed care @ COB. Left inner thigh drsg Δ'd. Pink wound bed, minimal slough tissue noted on drsg. W-S wrapped in kerlex & ace. Tined & dated. (L) shin wrapped in ace & gauze, C/D/I. Circ/neuro WNL. (R) hip drsg c̄ scant serous drng noted. Intact. (R) buttock drsg loose; to be reinforced PRN. Circ/neuro WNL. Pt currently denying pain. — (b)(6)-2 ENS/NC
15Apr03	0000		Pt has pulled out own IV again. ABX S/C'd. Site to be established in OR in AM. — (b)(6)-2 ENS/NC
15APR03	0247		Pt resting. Assumed pt care @ COB. PT dressings to (L) thigh clean dry and intact. (L) cast also CDI. Stitches to (R) outer thigh have no ~~drainage~~ drainage and the tissue is healthy. Stitches in (R) buttocks intact and tissue is healthy there as well. Splint on (R) LE held on with kerlix. Pt lungs sound clear with a phlegmy rattle in the throat. S1 & S2 present, bowel sounds audible in all 4 quadrants. Pt pulses steady and equal. HN (b)(6)-2

CLINICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
4/11/03			Change dressing and page MO. (b)(6)-2
			(6) PT Taken of Face Mask O² will motor for SATS
			to maintain 95% 1530 Nasal Pharyngeal pulled out by Pt. Pt
			Sating 98% RA, will contu. to monitor. (7) Otho Tech at
			bedside posterior Splinting (8) New Dressing changed to
			(8) Thigh serosanguinous moderat amount, (R) Bulter Dressing Sight
			~~clean Dry~~ (b)(6)-2 CDI, Neuro checks Done within Normal limits (9) Pt met
			pacu + Anastesia discharge criteria. (b)(6)-2
12April03	0542		Assume care @ COB. Pt assessed @ 0245. Pt sleeping most of shift. RLE
			elevated on pillows; in ½ cast. R thigh - gauze; tape to lateral aspect. Wrapped
			in ace. Circ/neuro check WNL. Hemovac to R thigh c̄ ~~sero~~sanguinous (b)(6)-2
			drng. LLE circ/neuro WNL. Ace; gauze to calf CDI c̄ +2 pedal edema.
			Thigh ace; gauze CDI. (+) BS; lungs CTA. IV restarted b/c infiltrated.
			Medicated for pain. (b)(6)-2 ENS/NC
12Apr03	0605		Hemovac has come out of site. Dr (b)(6)-2 to be notified. (b)(6)-2 ENS/NC
13Apr03	0340		Assumed care @ COB. Pt sleeping. IV restarted by HM13 (b)(6)-2 18G
			in LFA. Pt S/P Washout on 12Apr. R hip dressed c̄ gauze, CDI. Pt
			has half cast on RLE; elevated on pillows. Circ/neuro WNL. +1
			edema noted. LLE ace wrap to upper; lower leg CDI. Circ/neuro
			WNL. (b)(6)-2 ENS/NC

Continue on reverse side

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

REGISTER NO. | WARD NO.

(b)(6)-4

NURSING NOTES
Standard Form 510
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
510-110

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
17 APR	2350		Pt. received 1U PRBC starting 1754 - VS 122/64-112-20-100.4. Pt. tolerated transfusion with no reaction. Post VS @ 2215 - 128/64-120-20-99.6. Foley output 600cc. Enc. pt. to turn q2h in bed. (B) Legs elevated, (R) foot brace attached. Skin on back, sacrum intact. Penile lesion - dry, excoriated, no purulent discharge - appears to be healing superficially. Pt. sleeping - no c/o pain. (b)(6)-2 CAR, RN.
18APR03 @0000			Assumed pt care. Pt resting well c̄ ∅ c/o pain. VS stable. Pt has sutures to (R) hip, OTA ∅ signs of infection Pt has dressing on (L) calf C/D/I. Pt has dressing around (R) foot, extending past ankle. C/D/I. IV in (R) arm LR100. Will continue to monitor. (b)(6)-2 HN
18Apr03 0045			Pt medicated c̄ Percocet for pain & readjusted in bed. Foley still in place. Circ/neuro WNL to all extremities. Pt currently sleeping. I concur c̄ above statement except drsg to R foot is actually a brace. (b)(6)-2
18APR03 @ 0710			Dr (b)(6)-2 notified of pt platelet count of 78K. (b)(6)-2 ENS/RN
18APR2003 1640			Assumed pt care at 1530. Pt resting comfortably at this time. (R) hip c̄ ~~staples~~ sutures OTA. RLE c̄ brace in place. ∅ c/o pain at this time. NS @ 100cc/HR. Foley draining adequate and clear yellow urine. (b)(6)-2

CLINICAL RECORD	NURSING NOTES (Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
16APR03	@ 0000		Assumed care of pt. Pt c/o pain, 2 percocets was administered. Pt has temp. 101.7 and B/P 156/70 all other VS WNL. Pt has dressing to (R) thigh, C/D/I. Pt has sutures to (L) thp, OTA, ∅ signs of infection. IV to (R) forearm intact. Neuro checks WNL. Will continue to monitor Pt. (b)(6)-2 HN
16Apr03	0200		Re assessed VS, B/P 120/60, temp. 100.7, will continue to monitor —— HN (b)(6)-2
16Apr03	0555		Pt currently resting & medicated for pain 10 mg MSO4 last T. 100.9. Will continue to monitor —— (b)(6)-2 EN-S/NC
16APR03		2020	FOLEY WAS D/C ENCOURAGED PT TO DRINK FLUIDS NO S/S OF pain or discomfort will continue to monitor —— (b)(6)-2 HN
16APR03		2315	14F FOLEY CATH PLACED W/O DIFICULTY, USED STERILE TECNIQUE. 300 CC INITIAL OUTPUT, —— (b)(6)-2 HN
17APR03	@ 0000		Assumed care of pt. Pt resting well with ∅ c/o pain. VS stable. Pt has dressing LLE C/D/I, sutures to (R) thp OTA, LR running —— (b)(6)-2 HN.
17APR03	0400		I Concur w/ HN (b)(6)-2 Assessment (b)(6)-2 EN-S, NC

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

REGISTER NO.

WARD NO.

(b)(6)-4

NURSING NOTES
Standard Form 510
General Services Administration and Interagency Committee on Medical Records
FPMR 101-11.806-8—October 1975
510-109

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
20APR03	@	2307	Pt has temp. of 100.0, IS tx initiated will continue to monitor pt. — (b)(6)-2 HN
			concur with above — (b)(6)-2
21Apr03	@	2306	Assumed Pt care no c/os for this pt Slight elevated temp no Is encouraged pt to Deep Breath will assess pt. — (b)(6)-2
22Apr03 @1700			VSS. Resting comfortably. DSXO to BLE clear. Continue to monitor. — (b)(6)-2

NFC THIS PAGE

(b)(6)-4

☆ U.S. GOVERNMENT PRINTING OFFICE : 1983 O - 421-526 (9201)

NURSING NOTES
Standard Form 510
(Reverse)

CLINICAL RECORD	NURSING NOTES (Sign all notes)	
DATE	HOUR A.M. / P.M.	OBSERVATIONS Include medication and treatment when indicated
18APR03	@2353	Assumed care of pt. Pt has temp. 101.6 all other VS stable. Foley intact draining cyu. Pt has IV site on LUE, intact. Pt has C/D/I dressing around calf of LE. Dressing to Dinner thigh reinforced c̄ gauze & tape. Neuro checks to LE WNL. LE elevated on two pillows. Will continue to monitor. HN (b)(6)-2 USN
19Apr03	0220	Concur with above, R LE splint neuro check WNL (b)(6)-2 NC
19APR03	@0400	Reassessed pt's temp. 98.2. HN (b)(6)-2 HN
19APR03	1900	DC'D FOLEY NO c/o PAIN (b)(6)-2 HN
19APR03	@2320	Assumed care of pt. Pt resting well c̄ ∅ complaints at this time. Pt has splint to RLE, C/D/I, neuro checks WNL. Dressing to Dinner thigh c/D/I. Lesion on penis scabbing. VS stable, will continue to monitor pt. IV discontinued. HN (b)(6)-2
19APR03	@2320	Pt. has temp. 100.2, medicated c̄ percocets (b)(6)-2 HN (USN)
20Apr03	0150	Concur with above (b)(6)-2 NC

Continue on reverse side

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

(b)(6)-4

REGISTER NO.

WARD NO.

NURSING NOTES
Standard Form 510
General Services Administration and Interagency Committee on Medical Records
FPMR 101-11.806-8—October 1975
510-109

CLINICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
22APR03	@2300		Pt has temp 100.6, IS tx done, will cont to monitor pt. —— HN (b)(6)-2
			Concur w/ above —— (b)(6)-2 EMS, NC
23APR03	@0301		Pt temp 99.9, all other VS WNL. Will continue to monitor. —— HN (b)(6)-2
			concur —— (b)(6)-2 EMS, NC
25APR03	2345		ASSUMED C/O PT. PT HAS TEMP OF 100.1. NURSE NOTIFIED. TYLENOL GIVEN. ALL OTHER VS WNL AND STABLE. INSISCION SIGHT TO (R) LAT. THIGH C/D. ACE WRAPS TO LLE ~~and~~ ~~to~~ BOTH C/D/I. Ø C/O PAIN. Ø SIGNS OF DISTRESS AT THIS TIME. WILL CONTINUE TO MONITOR. —— (b)(6)-2
26Apr03	0150		concur with above, interpreter paged to explain to PT to lay on stomach, PT not complian t — (b)(6)-2 NC
26APR03	0300		RECHECK PT TEMP - NOW 98.8 AND STABLE —— (b)(6)-2
26/03	1430		AW from 5 Port starboard - (R) hip — cont. PT here to assist w walking. (P) culture transferred to (P) contact isolation wards. Ø pain. Wk ~~continued on reverse side~~ Pt aware of (-) pillows under (R) hip. —— (b)(6)-2

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

(b)(6)-4

REGISTER NO.

(b)(6)-2

CARD NO.

eDrm

NURSING NOTES
Standard Form 510
General Services Administration and Interagency Committee on Medical Records
FPMR 101-11.806-8—October 1975
510-109

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
4/26/03	1820		Pt Eating well. Ambulating with crutches w/o incident. Pt OOB to chair c̄ RLE Extended on rack, good circulation to Lower Extremity. Pt c/o no complaints. (b)(6)-2 LCDR/NC
4/27/03	2045		Pt. sitting up in bed intermittently during shift. VSS. SLE - N/V check normal. Scant amt. of serous drainage from (L) thigh dressing. Reinforced dressing and reapplied ace bandage. Encouraged to lay on Abdomen. Will cont. to monitor (b)(6)-2 CDR, NC
4/28/03	1030		Pt continues to Ambulate well c̄ crutches. Showered this morning c̄ Am care. (R) thigh & (L) calf Dressing removed @ 72° post op. (R) Thigh sutures intact, wound edges approximated c/d, no s/s of infection. Wound left open to Air. (L) calf wound c̄ sutures in place. Dime sized gap in wound edges midway between incision. Minimal bleeding with dressing removal. IV heplock removed. Site clean & Dry. (b)(6)-2 LCDR/NC
28 Apr 03	1730		Assumed care PT 1500, PT sitting in chair, no c/o pain, Dressing (L) calf CDI, Sutures (R) inner thigh intact c̄ minimal serous drainage no odor OTA (b)(6)-2 LCDR, NC
29 APR 03	0630		Pt. was wakeful during night. c/o pain (R) leg. Medicated with Tylenol #3 @ 0211 + 0615. VSS. Will cont. to monitor (b)(6)-2 CDR, NC

☆ U.S. GOVERNMENT PRINTING OFFICE : 1983 O - 421-526 (9201)

NURSING NOTES
Standard Form 510
(Reverse)

(b)(6)-4

CLINICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
29APR03	0715		VSS no distress noted lying in bed A+O PERRLA S,S, RRR BS(+)x4 tol reg diet. lung sounds clear equal bilat. wound to (L) calf VTA gauze/Kerlex dressing cldl; incision to (R) chest well healed OTA Will cont to monitor — (b)(6)-2
30APR03	0345		Pt. slept well during the night. No complaints noted. Will continue to monitor — (b)(6)-2 CDR, NC
30APR03	0730		VSS, no distress noted sitting up in bed A+O PERRLA S,S, RRR, lungs clear incisions to BLE c̄ sutures cldl; gauze to (L) calf cldl. BS(+)x4 Will cont to monitor — (b)(6)-2
30APR03	2000		Assumed care of pt. v.s.s @ this time, pt is in no apparent distress. Cuently pt is in wheelchair conversing c̄ other pts and in good spirits. Will continue to monitor v.s. and pain management. — (b)(6)-2 HM3
01MAY03	0720		A+O VSS ∅ distress noted PERRLA S,S, RRR, lungs clear equal bilat. BS(+)x4 incisions to BLE c̄ sutures cldl; gauze/ACE wrap to (L) LE cldl; Cont to monitor (b)(6)-2
01May03	2000		Assumed care of pt. VSS. @ this time. pt is sleeping peacefully and is in no apparent distress. Will continue to monitor v.s and pain management — (b)(6)-2
02MAY03	0730		A+O PERRLA VSS ∅ distress noted S,S, RRR, lung sound clear equal bilat. BS(+)x4

Continue on reverse side

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

(b)(6)-4

REGISTER NO.

WARD NO.

NURSING NOTES
Standard Form 510
General Services Administration and Interagency Committee on Medical Records
FPMR 101-11.806-8—October 1975
510-109

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
2 MAY 03		0730	Incision to to (R) groin c̄ sutures OTA c/d/i (R) thigh OTA incision c/d/i (L) calf incision c̄ staples gauze/Ace wrap dsg c/d/i amb with moderate assistance will cont to monitor — (b)(6)-2
2 MAY 03		2300	Late entry — Pt. up in wheelchair conversing with other patients. Now sleeping without complaint. VSS. Cont. to monitor — (b)(6)-2 COR, NC
03 MAY 03			VSS ø distress noted S,S, RRR AND PORRLA lungs sound clear equal b/l. B3 ø x 4 incisions to BLE well healed c̄ sutures incision to (L) calf tcfa/gauze/Ace wrap c/d/i will cont to monitor.
03 May 03		2100	Assumed care of pt. V.S.S. @ this time pt is sleeping right now. Will continue to monitor V.S and pain management — (b)(6)-2
04 May 03		0800	Assumed PT care ø x ø, PT resting no c/o pain, Dsg (L) calf CDI, Sutures (R) inner thigh OTA c̄ no S/S infection — (b)(6)-2

☆ U.S. GOVERNMENT PRINTING OFFICE : 1983 O - 421-526 (9201)

NURSING NOTES
Standard Form 510
(Reverse)

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY															
POST- DAY															
MONTH-YEAR	DAY	29 APR		30 APR		31 APR		02 MAY		03 MAY		4 MAY			
19	HOUR	0		0700	1400	0300	1400	0700	1400	0700	1400	0700			

PULSE (O) — TEMP. F (●) — TEMP. C (Centigrade Equivalents, for Reference only)

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		

RESPIRATION RECORD		14	16	14 14	16	12	12	14	16	18		16			
BLOOD PRESSURE		136/76	144/90	126/80 142/82	124/80	146/74	112/60	136/70	150/72	120/60 120/60	114/58	130/70			
HEIGHT:	WEIGHT→		98%		98%		99%		98	97% 98%		99%			
VOP								225		675 250 150		375			

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

511-112

VITAL SIGNS RECORD

STANDARD FORM 511 (REV. 9-79)
Prescribed by GSA and Interagency Committee on Medical Records
FPMR (41 CFR) 101-11.806-8

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR DAY

19 HOUR

PULSE (O) TEMP. (●)

98.1

PULSE (O)	TEMP. (●)	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)

114
112/68
93%
16

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT-#

Record special data only when so ordered

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

(b)(6)-4

REGISTER NO.

WARD NO.

VITAL SIGNS RECORD

STANDARD FORM 511 (REV. 9-79)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505
511-113

516-109

NSN 7540-00-634-4156

MEDICAL RECORD | OR #

OPERATION REPORT

PREOPERATIVE DIAGNOSIS

S/P GSW TO BUE'S AND PENIS c (R) FEMORAL NECK FX

SURGEON	FIRST ASSISTANT	SECOND ASSISTANT	
MOYERS	(b)(6)-2	Ø	
ANESTHETIST (b)(6)-2	ANESTHETIC (b)(6)-2		TIME BEGAN: 1050
			TIME ENDED:
CIRCULATING NURSE (b)(6)-2 (b)(6)-2	SCRUB NURSE (b)(6)-2	TIME OPERATION BEGAN 1112	TIME OPERATION COMPLETED 1140

OPERATIVE DIAGNOSES

SAA

DRAINS *(Kind and number)* Ø

SPONGE COUNT VERIFIED PACKED WOUNDS

MATERIAL FORWARDED TO LABORATORY FOR EXAMINATION

Ø

OPERATION PERFORMED

INCISION, DEBRIDEMENT, IRRIGATION OF PENETRATING WOUNDS TO LLE, (R) THIGH, PENIS.

DESCRIPTION OF OPERATION *(Type(s) of suture used, gross findings, etc.)*

PROSTHETIC DEVICES *(LOT no.)*

DATE OF OPERATION 4/4/3

Pre-Operative Nsg Assessment:

Dentures: Y (N)

Allergies: NKDA

NPO: (Y) N

Implants: Ø

Foley inserted by: Ø

Safety Straps ACROSS THIGHS

Intra Operative Nsg Assessment

Anesthesia: GEN

Bovie Equip #: Ø

Bovie Pad #: Ø

Prep: Betadine

Irrigation: NS

Medications: Ø

/Blood

Post Operative

EBL: MIN

Wound Class: IV

DSG: PLAINS KERLIX

U/O:

Fluids: 700

PACKED WOUNDS

Report TO P.O. DURANT 1132

Counts: Initial (b)(6)-2 Final (b)(6)-2 (b)(6)-2

SIGNATURE OF SURGEON (b)(6)-2

DATE 4 APR 2003

CDR MC USNR

PATIENT (b)(6)-2

REGISTER/I.D. NO.

WARD NO.

(b)(6)-4

IRAQI EPW

FH3

OPERATION REPORT
Medical Record

MEDCOM - 4976

STANDARD FORM 516 (REV 5-83)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505

MEDICAL RECORD

PREOPERATIVE DIAGNOSIS

open Rt hip fx ; complex wounds (h) thigh & leg.

SURGEON (b)(6)-2

FIRST ASSISTANT Ø

Ø

ANESTHETIST LCDR (b)(6)-2

ANESTHETIC General - ETT

TIME OF CASE 1710

TIME ANESTHETIC 1944

CIRCULATOR LT (b)(6)-2

SCRUB NURSE HM3 (b)(6)-2

TIME 1755

OPERATION COMPLETED 1935

OPERATIVE DIAGNOSES

SAA

DRAINS (Kind and number)

(R) Buttock - 1 drain 10mm

(b)(6)-2 + slings

MATERIAL FORWARDED TO LABORATORY FOR EXAMINATION

Cultures : 1) Aerobic 2) Anaerobic } (R) Buttocks

OPERATION PERFORMED

1) I & D c̄ Delayed primary closure of open Rt hip fx
2) I & D of left leg / thigh wounds (3) Placement of tibial traction Pin

DESCRIPTION OF OPERATION (Number of incisions and, if more than one, how finished, etc.)

LCDR (b)(6)-2 1925 IVF - 1400 URINE EBL - MM 200

PROSTHESIS (Kind and no.) Ø

DATE OF OPERATION 4/8/03

In lateral position open wound on (h) buttock debrided / irrigated cultured and closed over suction drain. Ant medial (h) thigh wound (2x2) I & D c̄ loose closure over Penrose. Both clean. 5/8" Pin Placed in Proximal tibia for skeletal Traction.

Rt thigh ant medial wound ~12 x 6 cm debrided of Biceps tendon / skin / subcutaneous exposed. 3x4 cm wound in post calf debrided. Plan: local wound care; ORIF

SIGNATURE OF SURGEON

(b)(6)-2 MD

(b)(6)-2 MD

DATE 4/8/03

(b)(6)-4

516-108

MEDICAL RECORD

PREOPERATIVE DIAGNOSIS

(R) HIP FX

SURGEON

DR (b)(6)-2

ANESTHETIST

DR (b)(6)-2

CIRCULATING NURSE

LT (b)(6)-2

FIRST ASSISTANT

N/A

ANESTHETIC

GENERAL VIA ETT

SCRUB NURSE

HN (b)(6)-2

N/A

TIME OF PREOPERATIVE SCAN

1010

TIME DATE 0844

TIME ORDER 1313

TIME OPERATION COMPLETED 1308

OPERATIVE DIAGNOSES

SAA

DRAINS (Kind and number)

1/8" Hemovac (R) HIP

MATERIAL FORWARDED TO LABORATORY FOR EXAMINATION

NONE

SPONGE, NEEDLE AND INSTRUMENT COUNT CORRECT

1 2 correct + SHARPS

(b)(6)-2 LTC

OPERATION PERFORMED

ORIF (R) HIP (DHS)
I+D (L) THIGH WOUND

DESCRIPTION OF OPERATION (Type(s) of suture used, gross findings, etc.)

SYNTHES DHS
PLATE: 140° 4 HOLE
SCREW: 90mm (280.90)

SYNTHES LG FRAG SCREWS
4.5mm x 42 x 4 (214.042)

PROSTHESIS IMPLANTED (Lot no.)

SEE BELOW

DATE OF OPERATION

11 APR 03

UOP: 300

EBL: 200

IV FLUIDS: 1500

CDR (b)(6)-2

Lunch relief 1100 – 1130

Details on fx table;
Closed reduced Rt hip fx. Basicervical T comminution. 2° to open wounds not a candidate for prosthetic. 4 hole 140° DHS placed using subvastus approach. Stable T adequate reduction. Left thigh and calf wounds cleaned and irrigated and redressed.

(b)(6)-2

MD

DATE 4/11/03

(b)(6)-4

MEDCOM - 4978

516-108

NSN 7540-00-634-4156

MEDICAL RECORD

OPERATION REPORT

PREOPERATIVE DIAGNOSIS

SOFT TISSUE WOUNDS (L) THIGH & CALF

SURGEON (b)(6)-2 MD

FIRST ASSISTANT N/A

SECOND ASSISTANT N/A

ANESTHETIST CDR

ANESTHETIC General via ETT

TIME BEGAN: 1248

TIME ENDED: 1231

CIRCULATING NURSE CDR (b)(6)-2 / LT (b)(6)-2

SCRUB NURSE HM3 (b)(6)-2

TIME OPERATION BEGAN 1204

TIME OPERATION COMPLETED 1218

OPERATIVE DIAGNOSES

SAA

DRAINS (Kind and number) N/A

SPONGE COUNT VERIFIED (b)(6)-2 DEFERRED

MATERIAL FORWARDED TO LABORATORY FOR EXAMINATION (b)(6)-2 N/A

OPERATION PERFORMED

I&D (L) THIGH + CALF WOUNDS

DESCRIPTION OF OPERATION (Type(s) of suture used, gross findings, etc.)

HM3 (b)(6)-2 (SCRUB RELIEF) ↑

PROSTHETIC DEVICES (Lot no.) N/A

DATE OF OPERATION 4/15/03

SBL MIN Rm 9
Fluidr 900 WC N/A

Details - in supine position, I debrided the thigh and calf wounds. The thigh is mid-thigh medial ~10cm x 6cm to muscle c̄ copious fibrinous exudate. No abnormal infection or necrosis. Thoroughly debrided. Calf wound is posterior mid calf ~3x3 c̄ healthy granulation tissue. Both irrigated & packed c̄ wet fluff. I next aspirated the Rt thigh, No pockets of fluid identified. to PR in satisfactory condition.

SIGNATURE OF SURGEON (b)(6)-2 MD (b)(6)-2 LT MC USNR

DATE 4/15/03

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

(b)(6)-4

REGISTER/I.D. NO.

WARD NO.

OPERATION REPORT
Medical Record

*U.S. GOVERNMENT PRINTING OFFICE: 1990-259-301

MEDCOM - 4979

STANDARD FORM 516 (REV. 5-83)
Prescribed by GSA and ICMR, FPMR 101-11.806-8

516-108

NSN 7540-00-634-4156

MEDICAL RECORD

OPERATION REPORT

PREOPERATIVE DIAGNOSIS

(L) thigh / calf wound

SURGEON	FIRST ASSISTANT	SECOND ASSISTANT	
Dr. (b)(6)-2	Ø	Ø	
ANESTHETIST	**ANESTHETIC**		**TIME BEGAN:** 0820
LCDR (b)(6)-2	General - LMA		**TIME ENDED:** 0932
CIRCULATING NURSE	**SCRUB NURSE**	**TIME OPERATION BEGAN**	**TIME OPERATION COMPLETED**
LT (b)(6)-2	HN (b)(6)-2	0842	0925

OPERATIVE DIAGNOSES

SAA

DRAINS *(Kind and number)* Ø

(b)(6)-2

IFIED 4 slings

MATERIAL FORWARDED TO LABORATORY FOR EXAMINATION

Ø

OPERATION PERFORMED

Wound closure (L) thigh and (L) calf wound

DESCRIPTION OF OPERATION *(Type(s) of suture used, gross findings, etc.)*

PROSTHETIC DEVICES *(Lot no.)*	DATE OF OPERATION
✓	4/25/03

Details: under LMA

Fluids: 700
EBL: <25

I irrigated both calf & thigh wound on (L) leg. thigh wound ~12×6cm c̄ healthy granulation, calf wound ~8×4 c̄ healthy granulation. No s/s of infection. Easily mobilized skin and approximated c̄ absorbable sutures. Infiltrated c̄ local. To RR in satisfactory condition.

SIGNATURE OF SURGEON

(b)(6)-2

LT MC USNR

DATE 4/25/03

(b)(6)-4

grade; date; hospital or medical facility)

REGISTER/I.D. NO.

WARD NO.

OPERATION REPORT
Medical Record

*U.S. GOVERNMENT PRINTING OFFICE: 1990-259-301

MEDCOM - 4980

STANDARD FORM 516 (REV. 5-83)
Prescribed by GSA and ICMR, FPMR 101-11.806-8

Pre / Post-anesthetic Summary

NNMC 6320/279 (Dec-10)

Proposed Operation	Age	Weight (kg)	Height (in)	ASA Status	Allergies
I & D		70		1 2 3 4 5 E	NKDA

Chemistries

Hematology
H / H -
Platelets -
WBCs -

Coags
PT -
INR -
PTT -

Urinalysis / HCG

NPO – ?
Teeth –
Airway – MP I / II / III / IV
FROM, ____ FB O, ____ FB HM

Respiratory
Cough:
Sputum:
Asthma:
COPD:
Recent URI:
TB:
Ø

Lung Exam: Clear but ↓
CXR:

CV
HTN:
CAD:
MI:
CHF:
VHD:
Arrythmias:
Exercise Tolerance:
Ø

Cardiac Exam: RRR
ECG:

CNS / Skeletal
Seizure:
CVA:
LOC:
Neuro:
Muscle:
Skeletal:
Ø

Misc

Other
Hepatic:
Renal:
GI:
Endo:
Heme:
Ø

EtOH: ?
Tobacco: ?

Previous Anesthetics: ?

Family Hx: ?

Current Medications: Ø

Premedication: Ancef + GM
Morphine 5mg IVP

Preoperative Diagnoses
GSW's
(L) Medial thigh
(L) LE
(R) Femoral neck FX
(R) Buttock

Vitals	Pre-op	DOS
BP:	133/89	
HR:	113	
Resp:	18	
Temp:	101.9	
FHR:		

Evaluator Signature | Date

Day of Surgery
☒ Chart Reviewed / patient examined
☐ Risks / benefits / options discussed with patient
☐ Patient questions answered
☐ Patient / parent / guardian understands and accepts risks
(b)(6)-2
☐ Other _____ liq., _____ clears, _____ solids
Plan:

Staff MD / CRNA signature (b)(6)-2 | Date & Time 4/8/3

(b)(6)-2

LCDR/USN
ANESTHESIA

Patient identification
(b)(6)-4

(b)(3)-1

Post-operative note

☒ No apparent anesthetic complications
(b)(6)-2

Signature | Date 4/8/3

(b)(6)-2
LCDR/USN
ANESTHESIA

MEDCOM - 4981

Pre / Post-anesthetic Summary

NNMC 6320/279 (Dec-00)

Age	Weight (kg)	Height (in)	ASA Status	Allergies
~60's	~70		1 (2) 3 4 5 E	NKDA

Coags
PT -
INR -
PTT -

Urinalysis / HCG

NPO – PMN
Teeth – intact
Airway – MP I / (II) / III / IV
FROM. ✓ FB O. ____ FB HM

26.7
361
Cs - 8.5

CV
HTN:
CAD:
MI:
CHF:
VHD:
Arrythmias:
Exercise Tolerance:
Cardiac Exam: SINUS TACH
ECG: Ø

CNS / Skeletal
Seizure:
CVA:
LOC:
Neuro:
Muscle:
Skeletal:

Other
Hepatic:
Renal:
GI:
Endo:
Heme:
EtOH:
Tobacco:

Lung Exam: CTA
CXR: Ø

Misc

Previous Anesthetics: GA Ø prob

Current Medications:

Premedication:

Family Hx: UNK

Preoperative Diagnoses: GSW LE

Vitals	Pre-op	DOS
BP:		
HR:		
Resp:		
Temp:		
FHR:		

Evaluator Signature | Date

Day of Surgery
- ☑ Chart Reviewed / patient examined
- ☐ Risks / benefits / options discussed with patient
- ☐ Patient questions answered
- ☐ Patient / parent / guardian understands and accepts risks
- ☑ NPO after ____ liq., ____ clears, ____ solids

Plan:

Staff MD / CRNA signature: (b)(6)-2 CRNA

Date & Time: 15 APR 03

Identification: (b)(6)-4

Post-operative note

☐ No apparent anesthetic complications

Signature

PRE-ANESTHETIC EVALUATION

Date of Surgery 4/4/03

Procedure Debrid (L) thigh (L) calf (R) thigh

Age (M) F

Wt ~60 (kg) lb **Ht** ____

NPO after MN Last PO
Teeth:
Prosthetics:
Airway: Malampoti 1 2 3 4
Neck ROM: Full Limited

Surgeon (b)(6)-2

ASA 1 2 3 4 5 E

LABS

UHCG Pos Neg N/A UA: Normal Abnormal N/A

Allergies: (NKDA)
Environmental

120/72
118
98%

BP: ~~[illegible]~~/~~[illegible]~~ P: ~~[illegible]~~

Tobacco ?
ETOH

Lungs: CTA Bilat

Heart Sounds: RRR Irreg
Murmur

TESTS: CXR N/A

ECG N/A ☐

Stress test ?

Echo

PFT

Pulmonary
No problems ☐
COPD
Asthma ?
TB
URI
Other

Neurological
No problems ☐
Seizure
CVA ?
H/A
Other

Cardiovascular
No problems ☐
HTN
MI ?
Chest Pain
CHF
SOB/DOE
Arrhythmia
Exercise Tol: Good Fair Poor
Other

Other Systems
No problems ☐
Skeletal GSWs
Anemia
Bleeding
Liver
Renal
GI: GERD H/H PUD
Thyroid: Hyper ☐ Hypo ☐
Diabetes: NIDDM ☐ IDDM ☐
Other

Family History: None ☐
Prior Anesthetics/problems: ?

Preop Diagnosis
GSW Bilat LEs

Medications
MSO4
Ancef
Gent

Premed: None ☑ PO Versed ____ mg
Zantac Reglan Inhaler

Evaluator Signatu (b)(6)-2
Date 4/4/03 Time 1020

DOS: Plan reviewed. Changes since preop: None ☐
Provider Proceed ☐ Cancel ☐

PostOp Assessment via: Pt interview ☐
Chart review ☐

Anesthesia related complications reported: None ☐
Entry made in Progress Notes ☐

Evaluator Signature

Date _____ Time _____

Primary Plan: (Gen) SAB MAC CLE ISB AXB Bier
Alternate Plan: _____

☑ Proposed plan reviewed with patient/guardian who communicates understanding of the plan including risks, benefits, and options. All questions answered.

☐ Risks discussed include but are not limited to death, stroke, MI, H/A, aspiration, dental damage.

(b)(6)-4

non-English speaking

SF 517 (BACK)

Pre / Post-anesthetic Summary

NNMC 6320/279 (Dec-10)

Proposed Operation	Age	Weight (kg)	Height (in)	ASA Status	Allergies
Attempt 2nd ary closure I+D @ Rt Lower leg.	SD 58	~70	~70"	1 2 3 4 5 E	NKDA.

Chemistries

Hematology
H/H - 9.5/27.8
Platelets - 915
WBCs - 8.5
RBC - 3.2

Coags
PT -
INR -
PTT -

Urinalysis / HCG
1010
WBC - 50-100
RBC - 1-3
Bacteria 3+

NPO => 2400
Teeth - INTACT.
Airway - MP I / II / III / IV
FROM, 3 FB O, 3 FB HM

Respiratory
Cough:
Sputum:
Asthma:
COPD:
Recent URI:
TB:
& None known
(+) Smoker

Lung Exam: CTA
CXR:

CV
HTN:
CAD:
MI:
CHF:
VHD:
Arrythmias:
Exercise Tolerance:
Cardiac Exam: RRR
ECG:

CNS / Skeletal
Seizure:
CVA:
LOC:
Neuro:
Muscle:
Skeletal:
None known

Misc

Other
Hepatic:
Renal: (+) UTI
GI:
Endo:
Heme:
EtOH:
Tobacco: (+)

Previous Anesthetics:
multiple GA

Fa[illegible]x:

Current Medications:
MSO4 > 6mg.

Premedication:
Versed + my [illegible]

Preoperative Diagnoses
1. Fx R Hip
2. GSW thigh
3. GSW Buttocks

Vitals	Pre-op	DOS
BP:		142
HR:		64
Resp:		98
Temp:		14
FHR:		100

Day of Surgery
- ☐ Chart Reviewed / patient examined
- ☐ Risks / benefits / options discussed with patient
- ☐ Patient questions answered
- ☐ Patient / parent / guardian understands and accepts risks
- ☐ NPO after _____ liq. 2400 clears, _____ solids

Plan: GETA

Evaluator Signature: (b)(6)-2
Date: 25 APR 2003 0830

Staff MD / CRNA signature: (b)(6)-2
Date & Time: 25 APR 2003 0830

permit implied

Patient identification (b)(6)-4
(b)(6)-4

Post-operative note

☐ No apparent anesthetic complications

Signature Date

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)*: 250 ML

REMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*

- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED: 8 Apr 03

DATE AND HOUR REQUIRED: ~~As~~ Upon Request

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*: None Known

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: N/A

HEMOLYTIC DISEASE OF NEWBORN? ____

REQUESTING PHYSICIAN *(Print)*: (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE: (R) thigh 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: See Originals

DATE VERIFIED

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.: (b)(6)-4

TRANSFUSION NO.: (b)(6)-4

PATIENT NO.

DONOR: ABO O; Rh POS

RECIPIENT: ABO O; Rh POS

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
Neg	Comp

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

PREVIOUS RECORD CHECK:

- [ ] RECORD
- [x] NO RECORD

SIGNATURE OF PERSON PERFO (b)(6)-2

DATE 4/13/03

REMARKS: Unit Exp: 17 Apr 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*: (b)(6)-2

AT *(Hour)*: 2037 ON *(Date)*: 4/8/03

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)*: (b)(6)-2 CORPM

2 (b)(6)-2 RTNC

PRE-TRAN

TEMP. 98.5 PULSE 112 BP 108/66

DATE OF TRANSFUSION: 4/8/03

TIME STARTED: ~~2055~~ 2100

POST-TRANSFUSION DATA

AMOUNT GIVEN: 250 ML

TIME DATE COMPLETED: 2136 4/08/03

INTERRUPTED

REACTION

- [x] NONE
- [ ] SUSPECTED

If reaction is suspected – IMMEDIATELY:

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

DESCRIPTION

- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER ____

OTHER DIFFICULTIES *(Equipment, clots, etc.)*

- [x] NO
- [ ] YES *(Specify)* ____

SIGNAT (b)(6)-2

PATIENT IDENTIFICATION - USE EMBOSSER *(For typed or written entries give: NAME - Last, first, middle; rank/rate; hospital number and name of facility.)*

(b)(6)-4

SEX: M

WARD: PACU

BLOOD OR BLOOD COMPONENT TRANSFUSION
STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

MEDICAL RECORD COPY

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)* 250 ML

REMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*

- [ ] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED 8 APR 2003

DATE AND HOUR REQUIRED Upon Request

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)* None Known

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: N/A

HEMOLYTIC DISEASE OF NEWBORN?

REQUESTING PHYSICIAN *(Print)* Dr (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE

(R) thigh GSW tractor

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 Original signed

DATE VERIFIED

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. (b)(6)-4

TRANSFUSION NO. (b)(6)-4

PATIENT NO.

DONOR ABO O Rh POS

RECIPIENT ABO O Rh POS

TEST INTERPRETATION

ANTIBODY SCREEN: Neg

CROSSMATCH: Comp

PREVIOUS RECORD CHECK:

- [ ] RECORD
- [X] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST (b)(6)-2 (b)(6)-2

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 4/8/03

REMARKS:

Unit Exp: 17APR03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)* (b)(6)-2

AT *(Hour)* 2142 ON *(Date)* 4/8/03

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)* (b)(6)-2 CPH/MC

2nd VERIFIER *(Signature)* (b)(6)-2

PRE-TRANSFUSION VITALS

TEMP. 99.4 PULSE 104 BP 113/73

DATE OF TRANSFUSION 4/8/03

TIME STARTED 2152

POST-TRANSFUSION DATA

AMOUNT GIVEN 250 ML

TIME DATE COMPLETED 2225 4/8/03

INTERRUPTED

REACTION

- [X] NONE
- [ ] SUSPECTED

If reaction is suspected – IMMEDIATELY:

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

DESCRIPTION

- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER ____

OTHER DIFFICULTIES *(Equipment, clots, etc.)*

- [X] NO
- [ ] YES *(Specify)* ____

SIGNATURE OF PERSON NOTING ABOVE (b)(6)-2

PATIENT IDENTIFICATION - USE EMBOSSER *(For typed or written entries give NAME - Last, first, middle; rank/rate; hospital number and name of facility.)*

(b)(6)-4

M

WARD PACU

BLOOD OR BLOOD COMPONENT TRANSFUSION
STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

MEDICAL RECORD COPY

518-124

MEDICAL RECORD

NSN 7540-00-634-41.

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)* 1 unit ML

REMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*

- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED 17 APR 03

DATE AND HOUR REQUIRED 17 APR 03 ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: N/A

HEMOLYTIC DISEASE OF NEWBORN? N/A

REQUESTING PHYSICIAN *(Print)* DR. (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE (R) hip Fx s/p I+D LLE

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 (b)(6)-2

DATE VERIFIED 4/17/03

TIME VERIFIED 1645

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. (b)(6)-4

TRANSFUSION NO.

PATIENT NO.

TEST INTERPRETATION

ANTIBODY SCREEN

CROSSMATCH Comp.

PREVIOUS RECORD CHECK:

- [x] RECORD
- [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST (b)(6)-2

DATE 4-17-03

DONOR

ABO O

Rh Pos

RECIPIENT

ABO O

Rh Pos

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

REMARKS: EXP: 17 APR 2003 @ 2359

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY (b)(6)-2

AT *(Hour)* 1750 ON *(Date)* 4/17/03

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)* (b)(6)-2 EMS/NC

2nd VERIFIER (b)(6)-2 CDR, NC

PRE-TRANSFUSION

TEMP. 100.4 PULSE 112 BP 122/64

DATE OF TRANSFUSION 17 APR 03

TIME STARTED 1754

POST-TRANSFUSION DATA

AMOUNT GIVEN 1 unit ML

TIME/DATE COMPLETED/INTERRUPTED 17 APR 03 2215

REACTION

- [x] NONE
- [ ] SUSPECTED

TEMPERATURE 99.6

PULSE 120

BLOOD PRESSURE 128/64

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION

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

OTHER DIFFICULTIES *(Equipment, clots, etc.)*

- [ ] NO
- [ ] YES *(Specify)*

SIGNATURE OF PERSON NOTING ABOVE (b)(6)-2 CDR, NC

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

(b)(6)-4

SEX M

WARD 5FWD(P) X7104

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

MEDCOM - 4987

Medical Record Copy

NSN 7540-00-634-4162 519-218

PATIENT IDENTIFICATION (For typed or wr... ...ntries give: Name — last, first, middle, Medical Facility)

(b)(6)-4

AGE	SEX	SSN (Sponsor)	ARD/CLINIC	REGISTER NO.
			CasRec	

EXAMINATION REQUESTED (Use SF 519-B for multiple exams)

(R) FEMER/(L) TIBIA (L) FEMER.

REQUESTED BY: DR. (b)(6)-2

TELEPHONE NO.

...TION OF MEDICAL RECORDS

FILM NO.

DATE REQUESTED

PREGNANT ☐ YES ☐ NO

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

DATE OF EXAMINATION (Month, day, year)

DATE OF REPORT (Month, day, year)

DATE OF TRANSCRIPTION (Month, day, year)

RADIOLOGIC REPORT

(R) femur - pms Fx of fem neck
single view

(L) Tib/Fib - shrapnel & ST injury
2 view Ø def cortical interruption

(L) femur single view - Ø Fx

NSN 7540-00-634-4162 519-218

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

(b)(6)-4 LO

AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
	M	(b)(6)-4	CASREC → WARD 2	

EXAMINATION REQUESTED (Use SF 519-B for multiple exams)

(R) hip, CXR (AP)

REQUESTED BY: WRIGHT

TELEPHONE NO.

...ATION OF MEDICAL RECORDS

FILM NO.

DATE REQUESTED 4/4/03 0800

PREGNANT ☐ YES ☒ NO

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

DATE OF EXAMINATION (Month, day, year)

DATE OF REPORT (Month, day, year)

DATE OF TRANSCRIPTION (Month, day, year)

RADIOLOGIC REPORT

pmt CXR grossly unremarkable

(R) hip fem neck Fx

(b)(6)-2

SIGNATURE

LOCATION OF RADIOLOGIC FACILITY

1 – MEDICAL RECORD

RADIOLOGIC CONSULTATION REQUEST/REPORT

STANDARD FORM 519-A (REV. 8-83)
Prescribed by GSA/ICMR
FPMR (41 CFR) 201-45.505

☆ U.S GOVERNMENT PRINTING OFFICE : 1987-181-243/40522

NeuroVascular Check List

DATE 4/25/03 TIME 0940 0955 1010

NEUROLOGICAL CHECK	EXTREMITY LLE	LLE		
	PAIN: absent / mild / moderate / severe	pulse ✓ ✗	(b)(6)-2	
	SENSATION: normal / numbness / tingling / absent	pedal ✓	(b)(6)-2	
	BLANCHING N = NORMAL S-SLUGGISH	N	N	N
	ACTIVE MOTOR RESPONSE: normal / limited / absent	(b)(6)-2		
	SIGN OF COMPARTMENT SYNDROME: pain on passive ROM / pain unrelieved by analgeisa	No / No	NO	NO
VASCULAR CHECK	COLOR: red / pink / pale / blue	(b)(6)-2		
	SKIN TEMPERATURE: hot / warm / cool / cold	(b)(6)-2		
	PULSE: normal / weak / absent; SITE	(b)(6)-2		
	EDEMA: none / small / moderate / large; SITE	(b)(6)-2		

INITIAL	SIGNATURE/TITLE	INITIAL	SIGNATURE/TITLE	INITIAL	SIGNATURE/TITLE
(b)(6)-2	(b)(6)-2				
(b)(6)-2	(b)(6)-2				

patient stamp (b)(6)-4

(pilot 3/03)

NNMC 6520/74

NNMC CRANIO-CEREBRAL CHECK SHEET

DATE	TIME																							
PUPILS — PUPIL SIZE SCALE (MM) 1 2 3 4 5 6 7 8		R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	P	L	R	L	R	L
	SIZE																								
	REACTION																								
MOTOR STRENGTH ARMS (MOTOR STRENGTH ARMS)	STRONG																								
	WEAK																								
	NONE																								
MOTOR STRENGTH LEGS (MOTOR STRENGTH LEGS)	STRONG																								
	WEAK																								
	NONE																								
GLASGOW COMA SCALE — EYES OPEN (EYES OPEN)	SPONTANEOUSLY 4																								
	TO SPEECH 3																								
	TO PAIN 2																								
	NONE 1																								
BEST VERBAL RESPONSE (BEST VERBAL RESPONSE)	ORIENTED 5																								
	CONFUSED 4																								
	INAPPROPRIATE WORDS 3																								
	INCOMPREHENSIBLE WORDS 2																								
	NONE 1																								
BEST MOTOR RESPONSE (BEST MOTOR RESPONSE)	OBEYS COMMANDS 6																								
	LOCALIZED TO PAIN 5																								
	WITHDRAWS TO PAIN 4																								
	FLEXION TO PAIN 3																								
	EXTENSION TO PAIN 2																								
	NONE 1																								
RESPIRATORY RATE (RESPIRATORY RATE)	REGULAR																								
	IRREGULAR																								
GAG REFLEX	P = PRESENT / A = ABSENT																								

INITIAL	SIGNATURE / TITLE	INITIAL	SIGNATURE / TITLE	INITIAL	SIGNATURE / TITLE

Patient Identification

CASUALTY RECEIVING

CHIEF COMPLAINT:

GSW Bil LE

MECHANISM OF INJURY

unk.

VITAL SIGNS

BP- 93/45 P- 97 R- 20 T- 97

HISTORY

Allergies: NKDA

Medications:

Past Illnesses:

Last Meal: Last Tenanus:

Events:

Pregnant? ☐ Yes ☐ LMP_____ ☐ No

Spine protection device removed @ _____

PROCEDURES BEFORE ARRIVAL

☐ Oral airway ☐ Nasal airway ☐ EOA / PTL

☐ ETT # ☐ NTT # ☐ RSI

☐ Crico # ☐ O_2 @ _____ L/min via _____

Breath Sounds: L: CL R: CL

☐ Ivs # ☒ Peripheral ☐ Central ☐ Intraosseous

☐ IV Fluids (1) 2 3 4 5 6 ☐ Blood 1 2 3 4 5

☐ CPR ☐ PASG: ☐ Legs ☐ Abdomen

☐ Urinary cath ☐ Gastric tube

☐ Chest tube: ☐ R ☐ L ☐ Both

☐ C-spine protection ☐ Spine protection, Time on:

☐ Splints Type:

☐ Medications:

☐ Other procedures:

INITIAL ASSESSMENT

AIRWAY ☑ Normal ☐ Compromised

C-SPINE ☑ Normal ☐ Suspect Injury

BREATHING

☑ Normal

☐ Tracheal Deviation

☐ Resp. Distress

☐ Tension PTX

☐ Chest Wall trauma

FAST ⊖

CIRCULATION

Skin/mucous: ☐ Pink ☒ Pale

Membrane color: ☐ Flushed ☐ Jaundiced ☒ Ashen ☐ Cyanotic

Pulses: ☒ Normal, Site ☐ Bounding, Site ☐ Weak, Site ☐ Absent, Site

Rate 77 /minute Rhythm_____

Skin temp: ☐ Warm ☐ Hot ☐ Cool/cold

Skin moisture: ☐ WNL ☐ Dry ☐ Moist

DISABILITY

GCS Score: Eye opening score_____/4

Verbal score_____/5

Best motor score_____/6

TOTAL GCS SCORE:_____/15

RTS Score: Respiratory score_____

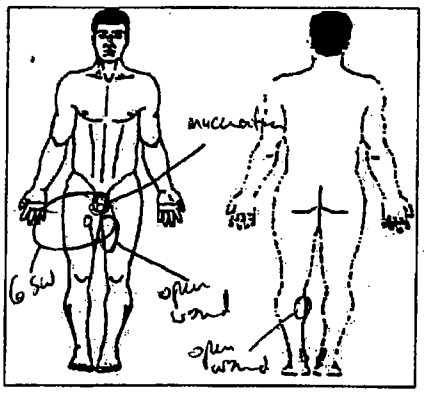
Systolic BP score_____

GCS Score_____

TOTAL GCS SCORE: 15

	Right	Left
Pupil Size:	3 mm	3 mm
Reactive?	☑	☑
Arms move?	☑	☑
Legs move?	☑	☑

IDENTIFY INJURY SITE BY LETTER



A - Abrasion F - Fracture T - Tenderness

B - Burn G - GSW

C - Contusion H - Hematoma

D - Deformity L - Laceration

E - Edema S - Stab Wound

Head: WNL

Maxillofacial: WNL

C-spine/neck: WNL

Chest: WNL

Abodomen: ? vol guarding NT Ø mass FAST ⊖ Rectal WNL

Perineum: Maceration penile glans

Musculoskeletal:

(L) thigh - open wound

(R) thigh - entry Ø exit

(L) calf - open wound

Pulses / Motor intact distally

PATIENT IDENTIFICATION:

FULL NAME:

FULL SSN:

(b)(6)-4

CASREC PROCEDURES				TIME	0823			NOTES/PLANS: (b)(6)-4
☐ Oral airway	☐ Nasal airway	☐ EOA/PTL		Cuff BP	129/90	/	/	
☐ ETT #	☐ NTT #	☐ RSI		Pulse	112			Xrays (R) Ulna & (L) tibia/fib
☐ Crico #	☐ O_2 @ _____	L/Min via _____		Resp	16			
Breath Sounds: L:	R:			Temp				
☑ IVs # ☑ Peripheral	☐ Central	☐ Intraosseous		O_2 Sat	98			
☑ IV Fluids 1 2 3 4 5 6		☐ Blood 1 2 3 4 5		GCS				Follow up Xray
☐ CPR PASG:	☐ Legs	☐ Abdomen		Urine Out				(R) hip on way to ward
☐ Urinary cath	☐ Gastric tube			Blood Out				
☐ Chest tube:	☐ R ☐ L	☐ Both		Fluid In	700cc			Tetanus, Ancef MSO4 in CASREC
☐ C-spine protection	☐ Spine protection, Time on:			Blood In				
☐ Splints Type: Tetanus in CASREC 0715								
☐ Medications: Ancef 1gm in CASREC @ 0706								

MSO4 5mg IV 0645

ADMISSION ORDERS

1. ADMIT TO: [ ] OR/PREP [X] ACW 2 [ ] ICU
2. DIAGNOSIS (print):
3. VITAL SIGNS: [ ] Q1° [X] Q4°
4. ACTIVITY: [X] Bedrest [ ] Up with Assistance
5. ALLERGIES:
6. NURSING: [ ] I/O [ ] Foley to gravity [ ] NG to LIS
   [ ] CT to -20CM H_2O Suction [ ] IS Q1° while awake
7. DIET: [X] NPO [ ] Reg [ ] Clear Liq [ ] Full Liq
8. IV FLUIDS: [X] Lactd Rngr @ 250 CC/hr [ ] Normal Saline @ ____CC/hr
9. LABS: [X] CBC [ ] Chem 7 [ ] CAMP [ ] UA
   [ ] PT, PTT [ ] LFT's [ ] NOW [ ] a.m. [ ] Type & Cross ____ units
10. PARAMETERS: Call MD T>101, SBP>180<90, DBP>100, Pulse>120, U.O. < __/__hr
11. MEDICATIONS:
    [X] MSO4 5-10 mg, Q 2-5 hr PRN PAIN IV/im
    [ ] Demerol _____ mg, Q _____ hr PRN PAIN IV
    [ ] Percocet 1-2 Q4° PO PRN PAIN
    [ ] Zantac 50mg IV Q8°
    [ ] Phenergen 12.5-25 mg IV/IM PRN N/V
    [ ] Oxygen @ _____ L per _____ Titrate to keep sat > 92%
    [X] Ancef 1g IV Q8°
    [ ] Rocephin 1g IV Q12°
    [X] Gentamycin 400 mg IV load & pharmacy to dose → 400 mg q day × 72 hours (3 days)
    [ ] Cipro _____ mg IV Q12°
    [ ] Clindamycin _____mg IV, Q _____ hr
    [ ] Unasyn _____ gram IV, Q _____ hr
    [ ] Transfuse _____ units packed cells
12. CULTURES: _____
13. RADIOLOGY: [X] Port CXR [ ] KUB

(b)(6)-2

CDR MC USN
STAFF PHYSICIAN

DOCTOR SIGNATURE: (b)(6)-2 (b)(6)-2

PATIENT IDENTIFICATION:
FULL NAME:
FULL SSN:

-111 NSN 7540-00-634-4121

MEDICAL RECORD — DOCTOR'S ORDERS

(Sign all orders)

DATE AND TIME START	DATE AND TIME STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
4/4/02		(1)	Seen by ortho (b)(6)-2		
			NPO (b)(6)-2		
			get X-rays → (B) femur, (2) tibia	Done (b)(6)-2	
				(b)(6)-2	
4 April 2003 0905			5 mg Morphine I.V. now → done		(b)(6)-2
			Thanks!		(b)(6)-2
				(b)(6)-2	
4 April 2003 0930			Wet to dry dressings to wounds q shift (b)(6)-2		(b)(6)-2
			Thanks!		
				(b)(6)-2	
			Noted NC (b)(6)-2 04 Apr 03 2033		

(Continue on reverse side)

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

DOCTOR'S ORDERS
Medical Record

STANDARD FORM 508 (Rev. 3-94)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 4993

(b)(6)-4

Post-Op Orders

Date 4 APR 2003 Time _____

1. ADMIT TO: [X] ACW [ ] ICU
2. DIAGNOSIS/PROCEDURE (print): GSW BUTTOCK, PENIS FX (R) FEMORAL NECK
3. VITAL SIGNS: [X] Per Post-op Routine [ ] Q4hr
4. ACTIVITY: [X] Bedrest ~~[ ] Up with Assistance~~ ROLL SIDE TO SIDE
5. ALLERGIES: UNK
6. NURSING: [ ] I/O [ ] Foley to gravity [ ] NG to LIS
   [ ] CT to -20CM H_2O Suction [X] IS Q1° while awake (b)(6)-2
7. DIET: [ ] NPO [X] Reg [ ] Clear Liq [ ] Full Liq
8. IV FLUIDS: [ ] Lactd Rngr @ _____ CC/hr [ ] Normal Saline @ _____ CC/hr Ø IV
9. LABS: [X] CBC [ ] Chem 7 [ ] CAMP [ ] UA [ ] PT,PTT [ ] LFT's (b)(6)-2
   Frequency (such as STAT, Q-AM) _____
10. Type and Cross _____ Units
11. PARAMETERS: Call MD T>101, SBP>180<90, DPB>100, Pulse>120, ~~UOP<[illegible] cc/hr, RR>24~~ (b)(6)-2
12. MEDICATIONS:
    [X] Morphine 2-4 mg IV, Q 1° hr, PRN Pain (b)(6)-2
    [ ] Demerol _____ mg [ ] IM [ ] IV, Q _____ hr, PRN Pain
    [X] Tylenol #3, 1-2 PO q4hr PRN Pain (b)(6)-2
    [ ] Percocet 1-2 Q4° PO PRN PAIN
    [ ] Zantac 50mg IV Q8°
    [ ] Phenergen 12.5-25 mg IV/IM PRN N/V
    [ ] Oxygen @ _____ L per _____ Titrate to keep sat > 92%
    [ ] Ancef 1g IV Q8°
    [ ] Rocephin 1g IV Q12°
    [ ] Gentamycin _____ mg IV load & pharmacy to dose
    [ ] Cipro _____ mg IV Q12°
    [ ] Clindamycin _____ mg IV, Q _____ hr
    [ ] Penicillin G, _____ Million Units IV Q _____ hrs
    [ ] Unasyn _____ gram IV, Q _____ hr
    [ ] Transfuse _____ units packed cells

13. DRESSINGS: A W → D Q8° STARTING AM 5 APR (b)(6)-2
14. DRAINS: Ø
15. RADIOLOGY: Ø
16. OTHER: Noted 04APR03 @ 1350 (b)(6)-2

(b)(6)-2

DOCTOR SIGNATURE:

PATIENT IDENTIFICATION: (b)(6)-4
FULL NAME:
FULL SSN:

DPW

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
(b)(6)-4			3/4/03	2045 HOURS	
			Admit to ICW #3, ORTHO		
			Dx: s/p I.D. (1) (R) open hip Fx		
			(2) (L) Thigh wounds s/p GSW (3) (R) peroneal n palsy		
			COND - FAIR		
			VS PR		
NURSING UNIT	ROOM NO.	BED NO.	Activity - Ambulate OOB AD Lib c̄ crutches		

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
				HOURS	(b)(6)-2 noted
			MS 50 q 2-5 mg IV q 3-4 PRN		4/4/03
			Tylenol #3 ± 2 po q 4-6 PRN		
			Diet Regular.		
			T-FER to VIPER ASAP		
			Lovenox 30 mg SQ BID		
NURSING UNIT	ROOM NO.	BED NO.	(b)(6)-2 (b)(6)-2 MD		

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
			Chart Vcd (b)(6)-2	05 Mar 03 0300	
				HOURS	
NURSING UNIT	ROOM NO.	BED NO.			

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
				HOURS	
NURSING UNIT	ROOM NO.	BED NO.			

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 1984 - 423-730

MEDICAL RECORD			DOCTOR'S ORDERS (Sign all orders)		
DATE AND TIME					
START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
6 April 2003			Transfer to another facility (Melanie)		
1020			when available		
			✓ CBC	(b)(6)-2	
			Noted (?)	CDR McCusn	
07 Apr 2003			1. Δ V/S to Q shift. (b)(6)-2		
0950			Noted (b)(6)-2 07 Apr 03 1000	(b)(6)-2 CDR McCusn	

(Continue on reverse side)

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

REGISTER NO.	WARD NO.

(b)(6)-4

MEDCOM - 4996

DOCTOR'S ORDERS

STANDARD FORM 508 (Rev. 10-75)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505
508-111

U.S.G.P.O.: 1985 - 491-248/20237

MEDICAL RECORD			DOCTOR'S ORDERS (Sign all orders)		
DATE AND TIME START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
9 Apr 03			Admit to Ortho. to OR today		
			Dx. GSW Lt medial thigh		
			GSW Lt LE		
			Rt femoral neck Fx s/p GSW Rt buttocks		
			Abrasion vs GSW glans Penis		
			Condition Stable		
			Vitals Q shift		
			Activity bedrest		
			Nursing: Call MO for Temp > 101, BP < 90/60, RR > 25, P > 120		
(b)(6)-2			Diet: NPO (to OR today)		
			Meds: Ancef 1g IV Q 8		
			Gentamycin 80 mg IV Q 8°		
			Morphine 2g IV Q4° PRN Pain		
			NKDA		
			LABS ~~CBC, Chem 7~~	(b)(6)-2	(b)(6)-2 LCDR MC USNR (b)(6)-2

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO.

WARD NO.

DOCTOR'S ORDERS

STANDARD FORM 508 (Rev. 10-75)
Prescribed by GSA and ICMR
FPMR 101-11. 806-8
508-110

MEDICAL RECORD | **DOCTOR'S ORDERS** *(Sign all orders)*

DATE AND TIME START	DATE AND TIME STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
					(b)(6)-2
4/16/03 1450			CBC & Diff in AM		(b)(6)-2
			Dic Foley		
			(b)(6)-2 (b)(6)-2	ET MC USNR	(b)(6)-2
			(b)(6)-2	CDR MC 4/16/03	
4/16/03	2240		V.O. per Dr. (b)(6)-2 to CDR	(b)(6)-2	
			Cath now if U. output is less than 200 cc begin Pyridium 200mg po t.i.d. X 2 days. If U.O. exceeds 200 cc leave foley cath intact. No pyridium necessary.	(b)(6)-2	
			(b)(6)-2	CDR MC	
4/17/03	0052		24° Chart Verification Completed		
			(b)(6)-2		

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO.

WARD NO.

DOCTOR'S ORDERS

STANDARD FORM 508 (Rev. 10-75)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45-505
508-112

506-111 NSN 7540-01-634-4121

MEDICAL RECORD

DOCTOR'S ORDERS
(Sign all orders)

DATE AND TIME START	DATE AND TIME STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
			ANESTHESIA PACU ORDERS		
4/11/03 1145		1.	Admit to PACU.		
		2.	Allergies: NKAB		
		3.	Vital signs per PACU protocol.		
		4.	O2: ___FM @ 10LPM, _____% Blowby, ✓ NP @ 3 LPM.		(b)(6)-2
		5.	IVF: LR at 100 cc/hr		
		6.	On ward: 02 @ 2-3 LPM via NC: (YES) NO		
		7.	Pain medication:		
			Ketorolac ____mg IV x1 dose (adults 30 mg max; peds consider 0.2-0.4 mg/kg)		(b)(6)-2
			MSO4 2 mg IV q 5 min prn; max dose 15 mg		
			Fentanyl 25 mcg IV q 10 min prn; max dose 100 mcg		
			Percocet _____ tab(s) p.o. with sip of water		
			Other: _____		
4/11/03		8.	Antiemetics:		
			Ondansetron _____ mg IVP, may repeat x1 in 15 min (0.1mg/kg; max 4 mg)		
			Metoclopramide 5 mg IV x1 (0.15 mg/kg; max 10 mg) Repeat x 1 if nausea		
			~~Droperidol _____mg IV x 1 dose (0.01 mg/kg; max 0.625 mg) Must have baseline ECG available before administration.~~		(b)(6)-2
			Other _____		
		9.	Clear liquids as tolerated: (YES) NO		
		10.	Notify Anesthesia (pager 1506) for airway issues, pain, nausea/vomiting not responsive to above orders or other patient problems/concerns per PACU protocol.		(b)(6)-2

(rev 3/2002) (OVER)

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name–last, first, middle initial; and accurate: hospital or medical facility) | WARD NO.

(b)(6)-4

(b)(6)-2

(b)(6)-2

(b)(6)-2

(b)(6)-2

DOCTOR'S ORDERS
Medical Record

STANDARD FORM 508 (Rev. 3-94)
Prescribed by GSA-ICMR, FIRMR (41 CFR) 201-9.202-1

MEDICAL RECORD

DOCTOR'S ORDERS

(Sign all orders)

DATE AND TIME START	DATE AND TIME STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
4/11/03			**ANESTHESIA PACU ORDERS -- CONTINUED**		
		11.	Discharge patient from PACU per protocol: YES NO		
		12.	When epidural/spinal patients meet discharge criteria per PACU protocol, discharge to ward. On ward: bedrest pending full recovery of sensory and motor function; progress to ambulation with assistance.		(b)(6)-2
	(b)(6)-2		**FOR PACU KEEP PATIENTS ONLY**		
4/11/03		13.	Release patient from anesthesia care to KEEP status when patient meets anesthesia discharge criteria: YES NO		
		14.	Notify anesthesia (1506) for airway management and: (circle if applicable)		
			a. Pain management		(b)(6)-2
			b. Fluid management		
			c. Other _____		
		15.	TOW patient to ward in a.m. if patient meets discharge criteria: YES NO		
			Signature (b)(6)-2 _____ Beeper (b)(6)-2		
			(b)(6)-2 CDR MC USN O-CA (b)(6)-2		

STANDARD FORM 506 (Rev. 3-94) BAC

NSN 7540-00-634-4121

MEDICAL RECORD

DOCTOR'S ORDER
(Sign all orders)

DATE AND TIME START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
4/8/13			**ANESTHESIA PACU ORDERS**		
		1.	Admit to PACU.		
		2.	Allergies: NKDA		
		3.	Vital signs per PACU protocol.		
		4.	O2: ___FM @ 10LPM, ___ ___% Blowby, ✓ NP @ 1-4 LPM.		(b)(6)-2
		5.	IVF: LR at 125 cc/hr		
		6.	On ward: 02 @ 2-3 LPM via NC: YES NO		
		7.	Pain medication:		
			Ketorolac ____mg IV x1 dose (adults 30 mg max; peds consider 0.2-0.4 mg/kg)		
			MSO4 1-2 mg IV q 5-10 min prn; max dose 10 mg		
			Fentanyl 25 mcg IV q 5-10 min prn; max dose 100 mcg		(b)(6)-2
			Percocet _____ tab(s) p.o. with sip of water		
			Other: Demerol 25mg IVP now for shivers		
		8.	Antiemetics:		
			Ondansetron 4 mg IVP, may repeat x1 in 15 min (0.1mg/kg; max 4 mg)		
			Metoclopramide 10 mg IV x1 (0.15 mg/kg; max 10 mg)		
			~~Droperidol 0.625 mg IV x 1 dose (0.01 mg/kg; max 0.625 mg) Must have baseline ECG available before administration.~~		
			Other _____		
		9.	Clear liquids as tolerated: YES NO		
		10.	Notify Anesthesia (page (b)(3)-1 for airway issues, pain, nausea/vomiting not responsive to above orders or other patient problems/concerns per PACU protocol.		(b)(6)-2
			~~CBC, CHEM-7, PT & PTT~~ NOW	(b)(6)-2	

(rev. 3/2002) (OVER)

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name–last, first, middle; grade; rank; rate; hospital or medical facility) | REGISTER NO. | WAR (b)(6)-2

08APR03 (b)(6)-4

DOCTOR'S ORDERS
Medical Record

STANDARD FORM 508 (Rev. 3-94)
Prescribed by GSA-ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 5001

MEDICAL RECORD

DOCTOR'S ORDERS

(Sign all orders)

DATE AND TIME START	DATE AND TIME STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
			ANESTHESIA PACU ORDERS -- CONTINUED		
		11.	Discharge patient from PACU per protocol: YES NO		
		12.	When epidural/spinal patients meet discharge criteria per PACU protocol, discharge to ward. On ward: bedrest pending full recovery of sensory and motor function; progress to ambulation with assistance.		
			FOR PACU KEEP PATIENTS ONLY		
		13.	Release patient from anesthesia care to KEEP status when patient meets anesthesia discharge criteria: YES NO		
		14.	Notify anesthesia (1506) for airway management and: (circle if applicable)		
			a. Pain management		
			b. Fluid management		
			c. Other _____		
		15.	TOW patient to ward in a.m. if patient meets discharge criteria: YES NO		
			Signature (b)(6)-2 [redacted] eeper		
			(b)(6)-2 LCDR/USN ANESTHESIA		
			4/8/03 (b)(6)-2 [redacted]		

STANDARD FORM 508 (Rev. 3-94) BAC

MEDICAL RECORD — **DOCTOR'S ORDERS (ORTHOPEDIC[redacted] IT/POST OP)**

(Sign all orders.)

DATE AND TIME START	STOP	Rx	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
4/8/03 2020		1.	ADMIT TO: ORTHO STAFF: (b)(6)-2 WARD: EPW		(b)(6)-2
		2.	DX: Rt open hip fx; complex wounds (L) thigh/leg		
		3.	CONDITION: STABLE		
		4.	ALLERGIES: None known		
		5.	VITAL SIGNS: Q 1 hr X 4 THRU Q 4 hr X 24 hr THEN Q 8 hr		
		6.	NURSING: - N/V CHECKS W/ VITALS - I & O's q 8 hr x 48 hrs - Foley to gravity ~~(remove 6 A.M. on ______)~~. - drain to self suction JP on Rt - ~~Remove wound dressing and replace w/ sterile dressing on POD #2~~		
		7.	Diet: Clears, advance as tolerated		
		8.	Activity: Skeletal traction ~~8#~~ 8 lbs If any problems try pager (b)(3)-1		
		9.	LABS: CHEM 7, CBC in AM; CBC q AM POD # 2 & #3		
		~~10.~~	~~IV: D5LR@100cc~~/hr NS @ 100cc/hr		
		11.	MEDS: - Ancef 1g IV q 8 hr x 48 hr last dose 8APR 2003 @1700 - ~~Gentamicin 80~~ mg IV q 8 hr x 48 hr OR - ~~Gentamycin (5-~~7.5mg/kg) ____mg IV x 48 hrs - ~~Heparin 5000 U SQ q 8~~ hr - Lovenox 30mg SQ BID - MSO4 6 mg IM or IV q 4hr prn pain significant - Phenergan 25 mg IM or IV q 4 hr prn - Percocet 1 - 2 tabs po q 3 hr ~~prn~~ pain moderate - Tylenol 650 mg po q 4 hr prn - MOM 30cc po q 4 hr prn - Benadryl 25mg po q 4 hr prn - Surfak 240mg po bid prn	Around the clock (may refuse) (b)(6)-2	(b)(6)-2
		12.	Other Meds: Valium 5mg PO q 12° PRN muscle spasm in traction		(b)(6)-2
		13.	Call Ortho tech for casts, splints, traction equipment or cast bivalving (b)(3)-1		(b)(6)-2
		14.	X-rays: AP/LAT Rt hip in traction in Recovery Room		(b)(6)-2
		15.	~~Transfuse 2 units PRBC if HCT less than~~ ____ ~~Type and Hold for~~ _____ units Type and Screen for _____ units		

Noted c 2026 8 Apr 03

verif (b)(6)-2 4/9/03 @145 (b)(6)-2 Ens, w

Verified 0347 4/10/03 (b)(6)-2 (b)(6)-2

(SIGNATURE)

(reverse side)

PATIENT'S IDENTIFICATION

(b)(6)-4

(b)(6)-2

LT MC USNR

(b)(3)-1

DATE AND TIME START	DATE AND TIME STOP	Rx	DOCTOR'S ORDERS (ORTHOPEDICS ADMIT/POST OP) *(Sign all orders)*	Doctor's Signature	Nurse's Signature
		16.	~~Pin care - ½ strength H202 q 8 hr to all exposed pins~~		
		17.	Dressing changes Start wet to dry on (b) thigh & leg wounds		(b)(6)-2
		18.	Traction - ~~pin care to exposed pins~~ call Ortho on call 191 if excessive drainage from pin sites		
		19.	Misc:		
		20.	If N / V changes occur, call Charge Nurse / Ward Medical Officer to assess and bivalve cast if present		(b)(6)-2
		21.	If UOP < 30 cc/hr, bolus 500 cc NS and assess results. Call Ward Medical Officer if no improvement.		
		22.	Oxygen: if needed		
		23.	Physical Therapy: None for now		
		24.	Transfuse 2u PRBC in Recovery Room		(b)(6)-2

(b)(6)-2

SICIAN SIGNATURE)

(b)(6)-2

LT

MC USNR

verified 4/9/2003 0145

(b)(6)-2

EMS, NC

PATIENT'S IDENTIFICATION

(b)(6)-4

MEDICAL RECORD		DOCTOR'S ORDERS (ORTHOPEDIC [illegible] T/POST OP) *(Sign all orders)*		
DATE AND TIME START	STOP	Rx	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
4/11/03 1315		1.	ADMIT TO: ORTHO STAFF (b)(6)-2 WARD: 5 Ground Pbrt		
		2.	DX: hip fx; wounds (L) thigh/leg		
		3.	CONDITION: STABLE		
		4.	ALLERGIES: None		
		5.	VITAL SIGNS: Q 1 hr X 4 THRU Q 4 hr X 24 hr THEN Q 8 hr		
		6.	NURSING: - N/V CHECKS W/ VITALS - I & O's q 8 hr x 48 hrs - Foley to gravity ~~(remove 6 A.M. on _____~~), - drain to self suction - Remove wound dressing and replace w/ sterile dressing on POD #2		
		7.	Diet: Clears, advance as tolerated		
		8.	Activity: Non weight bearing to Rt leg.		
		9.	LABS: CHEM 7, CBC in AM; CBC q AM POD # 2 & #3		
		10.	IV: D5LR@100cc/hr		
		11.	MEDS: Next dose @ - Ancef 1g IV q 8 hr x 48 hr 1730 - ~~Gentamicin 80 mg IV q 8 hr x 48 hr OR~~ - Gentamycin (5-7.5mg/kg) 300 mg IV x 48 hrs - ~~Heparin 5000 U SQ q 8 hr~~ - Lovenox 30mg SQ BID - MSO4 6 mg IM or IV q 4hr prn pain significant - Phenergan 25 mg IM or IV q 4 hr prn - Percocet 1 - 2 tabs po q 3 hr ~~prn~~ pain moderate - Tylenol 650 mg po q 4 hr prn - MOM 30cc po q 4 hr prn - Benadryl 25mg po q 4 hr prn - Surfak 240mg po bid prn		
		12.	Other Meds:		
		13.	Call Ortho tech for casts, splints, traction equipment or cast bivalving		
		14.	X-rays: AP/LAT Rt hip done in PACU		
		15.	~~Transfuse _____ units PRBC~~ if HCT less than _____ Type and Hold for _____ units Type and Screen for _____ units		

(b)(6)-2

(b)(6)-2

(b)(6)-2

(b)(6)-2

(PHYSICIAN SIGNATURE)

(Continue on reverse side)

PATIENT'S IDENTIFICATION

(b)(6)-4

(b)(6)-2

(b)(6)-2

MEDCOM - 5005

Faxed 11 APR 03 1323 · 11 APR 03 Revised PACU

DATE AND TIME START	DATE AND TIME STOP	Rx	DOC S ORDERS (ORTHOPEDICS ADMIT/POS 2) (Sign all orders)	Doctor's Signature	Nurse's Signature
		16.	~~Pin care - ½ strength H2O2 q 8 hr to all exposed pins~~		
		17.	Dressing changes BID to (b) thigh / leg wet → dry		
		18.	~~Traction - pin care to exposed pins~~		
		19.	Misc: Call ortho tech → posterior mold on Rt leg to hold foot in Neutral position Dx foot drop / Nerve palsy	done in PACU	
		20.	If N / V changes occur, call Charge Nurse / Ward Medical Officer to assess and bivalve cast if present		
		21.	If UOP < 30 cc/hr, bolus 500 cc NS and assess results. Call Ward Medical Officer if no improvement.		
		22.	Oxygen: As needed		
		23.	Physical Therapy:		

Paged Ortho Tech

(b)(6)-2

LT MC USNR

11APR2003 2220 (b)(6)-2 ENS/MC 11

Verified 0144 4/12/03 (b)(6)-2 SOR

PATIENT'S IDENTIFICATION

(b)(6)-4

MEDICAL RECORD		DOCTOR'S ORDERS (Sign all orders)		
DATE AND TIME START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
12 APR 03 1430		(1)	clinic – gentamicin 13 q 24°		(b)(6)-2
		(3)	Coumadin 5 mg po q HS x 2d starting today	✓	(b)(6)-2
		(3)	d/c Lovenox p̄ 1st dose tomorrow AM		(b)(6)-2
		(4)	PT/INR Mon 4/14/03 AM		(b)(6)-2
			(b)(6)-2		
			(b)(6)-2 CDR, MC 4/12/03 1800		
			Verified 0232 4/13/03 (b)(6)-2		
13 APR 03 13 00			PT. for (B) foot AFO to wear in shoe: (foot deep AFO)		
			(b)(6)-2		
			13APR2003 1735 (b)(6)-2		
	4/14/03 @ 0045		verified (b)(6)-2 (Conti		

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

(b)(6)-4

REGISTER NO.

WARD NO.

DOCTOR'S ORDERS

STANDARD FORM 508 (Rev. 10-75)
Prescribed by GSA and ICMR
FPMR 101-11. 806-8
508-110

MEDICAL RECORD			DOCTOR'S ORDERS (Sign all orders)		
DATE AND TIME START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
14 Apr 03 0942		✓	Reposition q2° to prevent decubitus sores	(b)(6)-2	
			(b)(6)-2	(b)(6)-2	
04/14/03 1130		✓	NPO p MN for EE Dx (R) leg weakness.	(b)(6)-2	
			(b)(6)-2		
			Noted EVS (b)(6)-2	14 March 03 @ 1216	
15 Apr 03 0230			24° Chest configuration (b)(6)-2	EVS NC	
4/16/03 0915		✓	Draw blood for HIV, RPR, CBC, chem 7, PT/INR		
			(b)(6)-2		
			error — see entry on later page		
			(b)(6)-2 4/16/03		

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO.

WARD NO.

DOCTOR'S ORDERS

STANDARD FORM 508 (Rev. 10-75)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45-505
508-112

506-111 NSN 7540-00-634-4121

MEDICAL RECORD

DOCTOR'S ORDE
(Sign all orders)

DATE AND TIME START	DATE AND TIME STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
			ANESTHESIA PACU ORDERS		
15apr03		1.	Admit to PACU.		
1232		2.	Allergies: Vanc		(b)(6)-2
		3.	Vital signs per PACU protocol.		
		4.	O2: ✓ FM @ 10LPM, ___ ___% Blowby, ___ NP @ _____ LPM.		
		5.	IVF: LR at KVO cc/hr		
		6.	On ward: 02 @ 2-3 LPM via NC: YES NO		
		7.	Pain medication:		
			Ketorolac ____mg IV x1 dose (adults 30 mg max; peds consider 0.2-0.4 mg/kg)		
			MSO_4 1-2 mg IV q 2-4 min prn; max dose 20 mg		
			Fentanyl _____mcg IV q ____ min prn; max dose _____mcg		
			Percocet _____ tab(s) p.o. with sip of water		
			Other:		
		8.	Antiemetics:		
			Ondansetron _____ mg IVP, may repeat x1 in 15 min (0.1mg/kg; max 4 mg)		
			Metoclopramide 20 mg IV x1 (0.15 mg/kg; max 10 mg)		
			~~Droperidol _____mg IV x 1 dose (0.01 mg/kg; max 0.625 mg) Must have baseline ECG available before administration.~~		
			Other		
		9.	Clear liquids as tolerated: YES NO		
		10.	Notify Anesthesia (b)(3)-1 for airway issues, pain, nausea/vomiting not responsive to above orders or other patient problems/concerns per PACU protocol.		
			(rev 3/2002)	(OVER)	

(Continue on reverse side)

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

(b)(6)-4

noted (b)(6)-2 15 Apr 03 12 38

DOCTOR'S ORDERS
Medical Record

STANDARD FORM 506 (Rev. 3-94)
Prescribed by GSA-ICMR, FIRMR (41 CFR) 201-9.202-1

MEDICAL RECORD

DOCTOR'S ORDERS
(Sign all orders)

DATE AND TIME START	DATE AND TIME STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
			ANESTHESIA PACU ORDERS -- CONTINUED		
		11.	Discharge patient from PACU per protocol: YES NO		(b)(6)-2
		12.	When epidural/spinal patients meet discharge criteria per PACU protocol, discharge to ward. On ward: bedrest pending full recovery of sensory and motor function; progress to ambulation with assistance.		
			FOR PACU KEEP PATIENTS ONLY		
		13.	Release patient from anesthesia care to KEEP status when patient meets anesthesia discharge criteria: YES NO		
		14.	Notify anesthesia (1506) for airway management and: (circle if applicable)		
			a. Pain management		
			b. Fluid management		
			c. Other _____		
		15.	TOW patient to ward in a.m. if patient meets discharge criteria: YES NO		
			Signature (b)(6)-2 LCDR MC USN 5CA (b)(6)-2 (b)(6)-2 Beeper 15 Apr 03		
			(b)(6)-2 15 Apr 03		

STANDARD FORM 508 (Rev. 3-94) BAC

MEDCOM - 5010

MEDICAL RECORD | **DOCTOR'S ORDERS** (Sign all orders)

DATE AND TIME START	DATE AND TIME STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
4/15/03			Adult Ortho (b)(6)-2		(b)(6)-2
1240			S/p I&D of (L) leg / Rt hip fx.		
			c sciatic n. palsy		
(b)(6)-2			Guarded condition		
			Regular diet		
			Act - NWB on Rt leg		
			c crutches.		
			AN - ϕ		
			Wound team Wet to dry		
			on (R) thigh & leg wounds		
			NS @ 100 cc/hr		
			Percocet 1 TP PO q 6° PRN		
			MS 8mg q 4° IV PRN		
			Colace 100 mg PO BID		
			Atrovent inh 2 puffs q 2° PRN		
			Aggressive pulmonary toilet	(b)(6)-2	
			Studies:		
			Duplex of RLE R/O DVT.		
			(b)(6)-2		
			LT McCURR		
			Noted 15 Apr 03 @ 1400		

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO.

(b)(6)-2

DOCTOR'S ORDERS

STANDARD FORM 508 (Rev. 10-75)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505
508-111
☆U.S. GPO: 1988—201-760/60076

MEDICAL RECORD			DOCTOR'S ORDERS (Sign all orders)		
DATE AND TIME START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
4/15/03 1920			D/C today encourage P.O. 6-8 DTV X Ray AP & LAT (R) Lip May shower - remove bandages, use soap & water		(b)(6)-2
			(b)(6)-2 (b)(6)-2 LT MC USNR		
			(b)(6)-2 noted @ 2100 4/19/03		
4/20/03 @0130			24° chart verification		(b)(6)-2
4/20/03 1430			Consult PT for gait training: strict NWB RLE		(b)(6)-2
			(b)(6)-2 LT MC USNR noted 4/20 @ 1950	(b)(6)-2	
4/21/03	0057		24° Chart Verification	(b)(6)-2	LT MC

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO.

WARD NO.

DOCTOR'S ORDERS

STANDARD FORM 508 (Rev. 10-75)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45-505
508-112

MEDICAL RECORD			DOCTOR'S ORDERS (Sign all orders)		
DATE AND TIME START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
16 APR 03 0527		1	Send blood for: RPR, HIV, CBC, PT/INR	(b)(6)-2	
			(b)(6)-2		
16 APR 03 0527		3	PT consult for crutches + crutch training	(b)(6)-2	
Farrell		3	Consult Sig Ops re	(b)(6)-2	
			Noted 16 Apr 03 0110	(b)(6)-2	
16 APR 03 1557		1	Send swab, slide for Tzanck, + slide for Gram Stain (results in CHCS/printed)	(b)(6)-2	
			(b)(6)-2 CDR, NC 4/16/03		
4/17/03	005	1	24° Chest Verification Completed	(b)(6)-2	

(continue on reverse side)

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

(b)(6)-4

REGISTER NO.

WARD NO.

DOCTOR'S ORDERS

STANDARD FORM 508 (Rev. 10-75)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45-505
508-112

MEDICAL RECORD	DOCTOR'S ORDERS (Sign all orders)				
DATE AND TIME START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
4/17/03 1614		(1)	Consult PT gentle ROM Ex of ~~leg~~ Knee on Rt side		(b)(6)-2 called PT 4/17/03 1800
		(2)	Transfuse Tuprex		(b)(6)-2
		(3)	OOB to chair starting tomorrow c̄ assistance		(b)(6)-2
			(b)(6)-2	(b)(6)-2 LT NK USNR (b)(6)-2	
Apr 17 03 2030		(1)	PT/INR in AM - And CBC of 4/18 - in CHCS/pending		(b)(6)-2
			(b)(6)-2		
			(b)(6)-2 ~~CDR MC~~ 4/17/03		
			24° chart verification completed 4/18/03 0126		

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO.

WARD NO.

DOCTOR'S ORDERS

STANDARD FORM 508 (Rev. 10-75)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45-505
508-112

MEDICAL RECORD		DOCTOR'S ORDERS (Sign all orders)		
DATE AND TIME START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
4/18/03 1855			V.O. Dr (b)(6)-2 / LT Sic Reh Lovenox 30mg PO BID Start Now		
			(b)(6)-2 (b)(6)-2	(b)(6)-2	LT/LNC
4/18/03 1910			Consult PT gait training / ~~Bed~~ TT WB RLE . Rom (R) knee.		(b)(6)-2
			(b)(6)-2 (b)(6)-2	LT NC USNR	
			Noted @ 0030	(b)(6)-2	NC
4/19/03 @ 0030			24° chart verification		(b)(6)-2
4/19/03	0900	1	CBC + BMP in AM		
		2	MVI		
		3	Fe SO4 325mg TID ≈ meals	(b)(6)-2	
			(b)(6)-2	NP	
			BNS, NC @ 0915 19APR03		

Signed 4/19/03

Signed 0920

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO.

WARD NO.

DOCTOR'S ORDERS

STANDARD FORM 508 (Rev. 10-75)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45-505
508-112

MEDICAL RECORD			DOCTOR'S ORDERS (Sign all orders)		
DATE AND TIME					
START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
22APR03	0140	–	NO NEW ORDERS SINCE 20APR03@1930 —	(b)(6)-2	LT/
4/23/03 0150			No New Orders 24° Chart Verification —	(b)(6)-2	LT/LPN
4/23/03	0820	1	Percocet tb PRN. q4-6° —	(b)(6)-2	(b)(6)-2
			(b)(6)-2 LCDR 4/23/03 0830	(b)(6)-2	
4/23/03	1140	1	Septra DS BID X 3 days — 6 Doses.	FAXED (b)(6)-2	(b)(6)-2
			(b)(6)-2 LCDR 4/23/03 1140		
4/23/03 1850			Discharge		
			(b)(6)-2 MD		
			(b)(6)-2	25 MC USNR	
			(b)(6)-2 JWS MC @2000 23APR03		
4/24/03	0057		24° Chart Verification —	(b)(6)-2	LT/LPN

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO.

WARD NO.

DOCTOR'S ORDERS

STANDARD FORM 508 (Rev. 10-75)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45-505
508-112

Standard Form 508

CLINICAL RECORD		DOCTOR'S ORDERS (Sign all orders)		
DATE AND TIME START	STOP	Rx DRUG ORDERS (Another brand of a generically equivalent product, identical in dosage form and content of active ingredient(s), may be administered UNLESS checked here)	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
24 APR 03 0600		(1) MVI tab PO qd. #30	in CACS outpatient Discharge	
		FeSO4 325 mg PO BID. #30		
		Colace 100 mg PO BID PRN #30		
		Percocet tabs PO 1/1-1/11 9 q4-6 PRN for pain. #30		
		(2) if patient transfers prior to Completion of Septra, give him enough to complete his course of therapy!! Thank you.	(b)(6)-2	
		(b)(6)-2 KPR	(b)(6)-2 FNP	
4/24/03 1100		NPO p MN for OR 4/24	(b)(6)-2	(b)(6)-2
		Hold Coumadin		
		noted @ 1115 4/24	(b)(6)-2	(b)(6)-2
4/25/03 0108		24° Chart Verification	(b)(6)-2	

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO.

WARD NO.

DOCTOR'S ORDERS
Standard Form 508
508-109

General Services Administration and Interagency Committee on Medical Records
FPMR 101-11.806-8
October 1975

508-111

NSN 7540-00-634-4121

MEDICAL RECORD | **DOCTOR'S ORDERS** (Sign all orders)

DATE AND TIME START	DATE AND TIME STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
			ANESTHESIA PACU ORDERS		
25APR2003	0900	1	Admit to PACU.		
		2	Allergies: NKDA. (b)(6)-2		
		3	Vital signs per PACU protocol.		
		4	O2: ✓ FM @ 10LPM, ____ ____% Blowby, ___ NP @ _____ LPM.		
		5	IVF: RL at 150 cc/hr		(b)(6)-2
		6	On ward: 02 @ 2-3 LPM via NC: YES NO Rm < 95%		
		7	Pain medication:		
			Ketorolac ____mg IV x1 dose (adults 30 mg max; peds consider 0.2-0.4 mg/kg)		
			MSO_4 2 mg IV q 5 min prn; max dose 12 mg		(b)(6)-2
			Fentanyl _____mcg IV q ____ min prn; max dose _____mcg		
			Percocet _____ tab(s) p.o. with sip of water		
			Other: _____		
		8	Antiemetics:		
			Ondansetron 4 mg IVP, may repeat x1 in 15 min (0.1mg/kg; max 4 mg)		
			Metoclopramide _____ mg IV x1 (0.15 mg/kg; max 10 mg)		(b)(6)-2
			~~Droperidol _____mg IV x 1 dose (0.01 mg/kg; max 0.625 mg) Must have baseline ECG available before administration.~~		
			Other _____		
		9	Clear liquids as tolerated: YES NO (b)(6)-2		
		10	Notify Anesthesia (page (b)(3)-1) for airway issues, pain, nausea/vomiting not responsive to above orders or other patient problems/concerns per PACU protocol		(b)(6)-2
			(rev 3/2002) (b)(6)-2 RN	(OVER)	

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

(b)(6)-4 (b)(6)-2 LCDR MC 25apr 03 0940

DOCTOR'S ORDERS
Medical Record

STANDARD FORM [illegible]

MEDICAL RECORD		DOCTOR'S ORDERS (Sign all orders)		
DATE AND TIME START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
			ANESTHESIA PACU ORDERS -- CONTINUED	
25 APR 2003 0900		11.	Discharge patient from PACU per protocol: YES NO (b)(6)-2	
		12.	When epidural/spinal patients meet discharge criteria per PACU protocol, discharge to ward. On ward: bedrest pending full recovery of sensory and motor function; progress to ambulation with assistance.	
			FOR PACU KEEP PATIENTS ONLY	
		13.	Release patient from anesthesia care to KEEP status when patient meets anesthesia discharge criteria: YES NO	
		14.	Notify anesthesia (b)(3)-1 for airway management and: (circle if applicable)	
			a. Pain management	
			b. Fluid management	
			c. Other _____	
		15.	TOW patient to ward in a.m. if patient meets discharge criteria: YES NO	
			Sign: (b)(6)-2 Beeper (b)(3)-1	
			(b)(6)-2 UDR NC 25 Apr 03 0940	

STANDARD FORM 508 (Rev. 3-94) BACK

MEDICAL RECORD			DOCTOR'S ORDERS (Sign all orders)		
DATE AND TIME START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
25 April 03			Post op Orders		
0950			Admit (b)(6)-2 Ortho		(b)(6)-2
			here) I (one) care		
			Rt hip fx, Lt thigh/calf GSW		
			Stable		
			Regular diet		
			NWB to RLE O/W Activity Ab Lib		
			- Please have sleep on stomach to help c developing hip flexion contracture		
			- No pillows under knees		
			Remove post op dressing in 72 hr		
			Percocet 1 PO q 6° PRN		
			Septra DS 1 PO BID x 24 hr		
			FeSO4 325mg PO TID c Meals		
			Multivitain PO q Day		(b)(6)-2
			(b)(6)-2		
			(b)(6)-2		
25 April 03	2320		24° chart Verification (b)(6)-2		

(b)(6)-2 Amended 25 April 03 0950 LCDR NC (b)(6)-2

FAX sent 0948 25 Apr

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO.

(b)(3)-1

DOCTOR'S ORDERS

STANDARD FORM 509 (Rev. 10-75)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505
508-111
☆U.S. GPO: 1988—201-760/80076

MEDICAL RECORD			DOCTOR'S ORDERS (Sign all orders)		
DATE AND TIME START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
4/26/03	0645	1	UA this AM. clean catch	(b)(6)-2 FNP	(b)(6)-2
			(b)(6)-2 LCDR 4/26/03 0740		
4/26/03	0815	1	Transfer to 5FP		(b)(6)-2
		2	Hep lock		(b)(6)-2
		3	Imipenem 500mg IV q 6°	FAXED.	(b)(6)-2
Done		4	UA, C+S 4/28		
		5	PT for hip extension rehab. called	(b)(6)-2 FNP	
			(b)(6)-2 LCDR 4/26/03 0840		
4/26/03 1040			X Rays RO AP/LAT (R) hip post op films	(b)(6)-2 (b)(6)-2 (b)(6)-2	
			(b)(6)-2 (b)(6)-2 (b)(6)-2 CT ML LCDR 4/26/03 1711		
4/26/03 1500		1	d/c imipenem	(b)(6)-2	(b)(6)-2
		2	CBC in AM — / in clinic ordered		(b)(6)-2

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO. 4/26/03 1545

(b)(6)-2

DOCTOR'S ORDERS

STANDARD FORM 508 (Rev. 10-75)
Prescribed by GSA and ICMR
FPMR 101-11. 806-8
508-110

508-112

7540-01-044-5515

MEDICAL RECORD

DOCTOR'S ORDERS

INSTRUCTIONS: Place form on firm surface; use pressure on ball point pen. Sign all orders.
Nurse: Remove one copy and send to Pharmacy after each order is written.

DATE AND TIME START	STOP	Rx	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
27 Apr 03 0035			24° Chart Check EWS	(b)(6)-2 NC	
28 APR @ 0330			Chart verified	(b)(6)-2	
Apr 27 '03 1345			Cannx 30mg SQ BID	(b)(6)-2	(b)(6)-2
				(b)(6)-2	
				(b)(6)-2 4/28/03 1355	
				Noted/A (b)(6)-2	
4/28/03 2000			600 complete / Meds in Computer		
			(b)(6)-2 (b)(6)-2	MC USNR	
4/28/03 2000			D/C Percocet		(b)(6)-2
			Tylenol #3 ii Prog 6 PRN		(b)(6)-2
			(b)(6)-2 (b)(6)-2	LT MC USNR	
			(b)(6)-2	CDR, MC 4/28/03	
29 Apr 03 0035			24° Chart Check EWS	(b)(6)-2 NC	
29 Apr 03			Daily dry kertix dressing change	(b)(6)-2	(b)(6)-2
			(b)(6)-2	(b)(6)-2	

(Continue on reverse side)

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

REGIST NO.

(b)(6)-4

DOCTOR'S ORDERS
MEDICAL RECORD
STANDARD FORM 508

508-112

7540-01-044-5515

MEDICAL RECORD

DOCTOR'S ORDERS

INSTRUCTIONS: Place form on **firm surface**; use pressure on ball point pen. Sign all orders.
Nurse: Remove one copy and send to Pharmacy after each order is written.

DATE AND TIME START	STOP	Rx	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
30 Apr 0800			24° Chart Check EWS	(b)(6)-2	NC
30 April 03		1	CBC } in A.M.		
			SMA-7 }	(b)(6)-2	
			noted 30 APR 03 1500	(b)(6)-2	
1 May 0300			24° Chart Check EWS	(b)(6)-2	NC
2 May 03 0400			24° Chart Check EWS	(b)(6)-2	NC
3 May 03 0800			24° Chart Check EWS	(b)(6)-2	NC

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO.

WARD NO.

DOCTOR'S ORDERS
MEDICAL RECORD
STANDARD FORM 508 (Rev. 6-64)

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*

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

Mo. ____ Yr. ____

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 4	5	6	7	8
4May03	(b)(6)-2	VS – PR	07	(b)(6)-2				
			15	(b)(6)-2				
			20	(b)(6)-2				
4May03	(b)(6)-2	tcm 7 – ambulate OOB	07	/ (b)(6)-2				
		ad lib & crutches	15	(b)(6)-2				
			23	(b)(6)-2				
4May03	(b)(6)-2	Diet – Regular	07	/ (b)(6)-2				
			12	/ (b)(6)-2				
			17	/ (b)(6)-2				

ALLERGIES ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P I&D (R) open hip FX, LL thigh wounds, S/P GSW 2 (R) Perineal pain

ADDITIONAL PAGES IN USE ☐ YES ☐ NO

PAGE NO: ____

PATIENT IDENTIFICATION: (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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo Yr
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
4May 03	(b)(6)-2	Admit to ICW 3 Ortho	4May03	ASAP	2230	(b)(6)-2
	-----	cardiac fac				
4May 03	-----	T-fer to (b)(3)-1 HSAP	4May03	ASAP		

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

Verify by Initialing

THERAPEUTIC DOCUMENTATION CA[illegible]N

(MEDICATIONS)

Mo. _____ Yr. _____

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED														
4mg/03	(b)(6)-2	MSO4 2-5mg IV q3-6° prn	0150 SMWA CMRD	0445 SMWA SMWA	5Ma 0910 5mg	5mg 1546 5mg											
			(b)(6)-2		IV	IV											
					(b)(6)-2												
4mg/03	(b)(6)-2	Tylenol #3 1-11 po q4-6° prn	0[illegible] SMWA 2 TB 0020	SMWA 2 TB 0660	SMWA 1 TB 0100												
			(b)(6)-2														

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)

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

Mo.____ Yr. __

VERIFY BY INITIALING

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 4	5	6
4May03	(b)(6)-2 --	levoxa 3mg SQ Bid	10	(b)(6)-2		
	-----		22	(b)(6)-2		

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P GSW (R) open hip FX (L) thigh wounds

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

PATIENT IDENTIFICATION:

(b)(6)-4

DISPENSING TIMES

USE PENCIL, CIRCLE MED TIMES

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

DA FORM 1 FEB 79 4678

EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

ADMISSION ... CODING INFORMATION

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

1. REPORTING MTF: (b)(3)-1
LOCATION (State or Country Code): I Q

3. REGISTER NUMBER: (b)(6)-4
NAME (Last, First, Middle Initial): (b)(6)-4 (b)(6)-4
4. PAY GRADE:
5. SEX:

6. DATE OF BIRTH (Y Y Y Y M M D D):
7. AGE AT ADMISSION:
8. RACE: Hispanic
9. ETHNIC BACK-GROUND:
RELIGION:

10. LENGTH OF SERVICE:
ETS:
11. FMP: 9 9
12. SOCIAL SECURITY NUMBER: (b)(6)-4

ORGANIZATION (Active Duty Only):
13. MARITAL STATUS:
HOUR OF ADMISSION: 2100
BRANCH / CORPS:

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

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: 0
WARD: 1CW2
NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE:
ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code):
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: (b)(3)-1
TELEPHONE NUMBER OF EMERGENCY ADDRESSEE:

21. TYPE OF DISPOSITION: HOMB
22. MTF TRANSFERRED TO:
23. DATE OF DISPOSITION (Y Y M M D D): 0 3 0 5 0 6

24. CLINIC SVC - ADMITTING: A B A A
25. MTF TRANSFERRED FROM:
26. DATE THIS ADMISSION (Y Y M M D D): 0 3 0 5 0 4

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

FOR LOCAL USE

open R Hip Fx GSW L leg, peroneal Nerve palsy
826.9
891.0
896.0
878.0
355.3
E99.2

ADMITTING OFFICER (Signature, as required): (b)(6)-2 MC LTC, MC (b)(6)-2 (b)(6)-2
SIGNATURE OF ADMITTING CLERK: (b)(6)-2
11010

DA FORM 2609, MAR 85 EDITION OF MAY 79 IS OBSOLETE

ADMISSION AND CODING INFORMATION

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

1 REPORTING MTF: (b)(3)-1

F LOCATION (State or Country Code): I Z

3 REGISTER NUMBER: (b)(6)-4

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

4. PAY GRADE: —

5. SEX: M

6. DATE OF BIRTH (Y Y Y Y M M D D): 1958 01 01

7. AGE AT ADMISSION: 45Y

8. RACE: X

9. ETHNIC BACKGROUND: 9

RELIGION:

10. LENGTH OF SERVICE: —

ETS:

11. FMP: 99

12. SOCIAL SECURITY NUMBER: (b)(6)-4

ORGANIZATION (Active Duty Only):

13. MARITAL STATUS: 2

HOUR OF ADMISSION: 2100

BRANCH / CORPS:

14. FLYING STATUS: —

15. BENEFICIARY CATEGORY: K 9 7 n8

16. ZIP CODE OF RESIDENCE: 0933000 0

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

18. MOS: —

19. TRAUMA:

PREV. ADMISSION: YEAR ☒ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: 1

WARD: 1CW2

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE:

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code):

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: (b)(3)-1

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE:

21. TYPE OF DISPOSITION: 05

22. MTF TRANSFERRED TO:

23. DATE OF DISPOSITION (Y Y M M D D): 200305 06

24. CLINIC SVC - ADMITTING: A B A A

25. MTF TRANSFERRED FROM:

26. DATE THIS ADMISSION (Y Y M M D D): 200305 04

27. LOCATION OF OCCURRENCE (Battle Casualty Only): I Z

28. MTF OF INITIAL ADMISSION:

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

FOR LOCAL USE

DX: 8209 open R Hip Fx GSW L leg, peroneal Nerve palsy
8901
8911
9110
3553
5990
E9912

Trauma 1 Inj 450

Dx: 7935, 7965, 8622, 8659

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

LTC, MC

SIGNATURE OF ADMITTING CLERK

D (b)(6)-2

EDITION OF MAY 79 IS OBSOLETE

MEDCOM - 5029

(b)(3)-1

(b)(6)-4

Date of Admission: 4/ 8/2003

Date of Transfer:

Age:45 Gender: M

History:

Unknow Age Iraqi presented to (b)(3)-1 4 days s/p I&D of rt open hip fx and complex wounds of lt thigh and leg from
multiple GSW

Hospital Course:

Treated w/I&D of wounds and ORIG of hip fx. Partialsciatic nerve palsy. Treated w/ local wound care to left leg wounds. Recoved nicely. Fracture location has high failure rate and may require hemiarthroplasty as salvage operation later

All wounds closed delayed.

Diagnoses:

Open right hip hx, GSW lt thigh & leg, peroneal nerve palsy,

Surgeries/Treatment:

4/8/03- I&D of all open wound, traction pin, ORIF rt hip fracture 4/10,

Recommendations:

ORIF rt hip fx, wound care/closure lt thigh and leg wounds. Low chance of fracture fixation success, will likely require hip prosthesis in the next few months

Special Needs:

crutches for up to 3 months, ~~extended dressing changes to left thigh and leg up to 4 months~~

All wounds closed. Telfa dressing change to Left calf

Prognosis: Guarded

Physician: (b)(6)-2 LT Dept of Orthopedics 4/24/2003

(b)(3)-1

(b)(6)-4

Date of Admission: 4/ 8/2003
Date of Transfer:

Age:45 Gender: M

History:
Unknow Age Iraqi presented to (b)(3)-1 4 days s/p I&D of rt open hip fx and complex wounds of lt thigh and leg from
multiple GSW

Hospital Course:
Treated w/I&D of wounds and ORIG of hip fx. Partialsciatic nerve palsy. Treated w/ local wound care to left leg wounds. Recoved nicely. Fracture location has high failure rate and may require hemiarthroplasty as salvage operation later

Diagnoses:
Open right hip hx, GSW lt thigh & leg, peroneal nerve palsy,

Surgeries/Treatment:
4/8/03- I&D of all open wound, traction pin, ORIF rt hip fracture 4/10,

Recommendations:
ORIF rt hip fx, wound care/closure lt thigh and leg wounds. Low chance of fracture fixation success, will likely require hip prosthesis in the next few months

Special Needs:
~~crutches for up to 3 months, extended~~ dressing changes to left thigh and leg up to 4 months

Prognosis: Guarded

Physician: (b)(6)-2 LT Dept of Orthopedics 4/24/2003

(b)(3)-1

MEDICAL TREATMENT FACILITY

(b)(3)-1

LIFT OF OPPORTUNITY

NAME (LAST, FIRST, MIDDLE)				SOCIAL SECURITY NUMBER
(b)(6)-4				
RANK/RATE	OFFICERS ONLY DESIG NOBC	ENLISTED NEC	BIRTH DATE	SEX
BRANCH OF SERVICE	NAMED AND ADDRESS OF PARENT MILITARY COMMAND			SHIP HOMEPORT

UIC	BLOOD TYPE	RELIGIOUS PREFERENCE	MARITAL STATUS	IS SPOUSE ACTIVE DUTY	NUMBER OF DEPENDENTS

NAME OF NEXT OF KIN (NOK)	RELATIONSHIP OF NOK
ADDRESS OF NOK	PHONE NUMBER OF NOK

PRINTED NAME OF PATIENT RECEIVING FLIGHT TRAINING

SIGNATURE OF PATIENT

PRINTED NAME OF MEDHOLD COORDINATOR

(b)(6)-2 MO LT MC USNR

SIGNATURE OF MEDHOLD COORDINATOR

(b)(6)-2 MD

PRINTED NAME OF ATTENDING PHYISICIAN

SIGNATURE OF ATTENDING PHYSICIAN

(b)(3)-1

Name: (b)(6)-4

CHCS Name (b)(6)-4

(b)(6)-4 Iraqi civilian

Date of Admission: 4/8/2003

Prognosis: Guarded

Date of Transfer:

History:

Unknow Age Iraqi presented to (b)(3)-1 4 days s/p I&D of rt open hip fx and complex wounds of lt thigh and leg from multiple GSW

Hospital Course:

Treated w/I&D of wounds and ORIf of hip fx. Partialsciatic nerve palsy resolving. Treated w/ local wound care to left leg wounds. Recoved nicely. Fracture location has high failure rate and may require hemiarthroplasty as salvage operation later,

Diagnoses:

Open right hip Fx; GSW lt thigh & leg, peroneal nerve palsy;

Surgeries/Treatmen

4/8/03- I&D of all open wound, traction pin; ORIF rt hip fracture 4/10;

Recommendations:

ORIF rt hip fx, wound care/closure lt thigh and leg wounds. Low chance of fracture fixation success, will likely require hip prosthesis in the next few months

SpecialNeeds:

crutches for up to 3 months, may need hip prosthesis of femoral head resection if fx doesn't heal

Physician: _____

(b)(6)-2 CDR Dept of Orthopedics

5/3/2003

USNS COMFORT (T-AH-20)

Perioperative Plan Of Care & Nursing Note

Patient Assessment For Surgery - Potential For Injury - Outcome: Patient is free from signs and symptoms of injury ☒ Yes ☐ No

Trauma# or Patient #

Diagnosis: (L) Thigh/Calf Wound Planned Procedure: I+D/Closure (L) Thigh/Calf Wound

Date: 4/25/03 Arrival Time: 0800 Interviewer: LT (b)(6)-2

Side: ☐ N/A ☐ Right ☐ Left Age: 53 HT: WT:

From: ☐ CASREC ☐ ICU ☒ Ward ☐ OTHER:

Transport Via: ☒ Gurney ☐ Litter ☐ Ambulated ☐ Wheelchair ☐ Other

Patient ID: ☐ Trauma card ☐ Verbal ☒ Chart ☐ Armband ☐ Other

Blood Ordered: ☒ N/A ☐ Yes ☐ Consent ☐ T/C #Units ☐ T/H #Units Comments:

Surgical/Anesthesia Consent Verified: ☒ Procedure ☐ Consent complete, dated, signed ☐ Emergent case; no consent, MD note Indicated in Progress Notes

Preop Labs (HCG, etc): ☐ None ☒ Yes Test/Results:

Drug/Latex Allergies: ☐ NKDA Allergy/Reaction: Undetermined

Present On Admission: ☒ N/A ☐ Oxygen ☐ IV Site: #1 #2 ☐ Foley ☐ Endotrachial Tube ☐ Arterial Line Site: ☐ Drain(s) ☐ Chest Tube(s) ☐ See RN Note #

Past Medical History: ☐ None known ☐ Smoker ppd/yrs ___/___ ☐ ETOH ☐ Asthma ☐ HTN ☐ CAD ☐ GERD ☐ CBR exposure ☐ Other:

Past Surgical History: ☐ None known ☐ Yes List:

Cultural Needs Addressed: ☒ Yes ☐ No List: Interpreter available

Pre-Op Pain: ☒ No ☐ Yes Level ___ (0-10) Action Taken: Referred to Anesthesia Location/type:

Last PO Intake: (date/time) Solid: 4/24/03 Liquid:

In Chart: ☐ H&P ☒ Yes ☐ No ☐ EKG ☒ Yes ☐ No ☐ CXR ☐ Yes ☐ No ☐ Other:

Skin Condition: ☒ Intact ☐ Other: Dressing to (L) Thigh/Calf

Limitations: ☐ N/A ☐ Auditory ☒ Language ☐ Visual ☐ Mobility ☐ Prosthesis ☐ Other: Arabic only

Personal Items: ☒ None ☐ Military gear ☐ Glasses ☐ Dentures ☐ Jewelry/wallet ☐ Other Disposition:

Potential For Anxiety – Outcome: Patent demonstrates knowledge of psychological responses to an invasive procedure ☐ Yes ☐ No

Mental/Emotional Status: ☒ Alert/Oriented ☐ Disoriented ☐ Anxious ☐ Appropriate for age ☐ Other ☒ Calm ☐ Sedated ☐ Unresponsive

Comfort Measures Implemented: ☐ Clear, concise explanations ☐ Communicated patient concerns to other staff members ☒ Remain with patient during induction

Preop Teaching Included: ☒ N/A due to patient condition ☐ Physical layout of OR ☐ Personnel present during procedure ☐ Environment (noise, temperature, etc.) ☐ Post-op expectation (PACU, drains, etc.)

Potential For Impaired Skin Integrity Related To Surgical Procedure – Outcome: Patient is injury free ☐ Yes ☐ No

Operative Position: ☒ Supine ☐ Prone ☐ Jackknife ☐ Lithotomy ☐ Other: ☐ Beach chair ☐ Sitting ☐ Lateral L / R

Positional Aids: ☒ Arms <90 Armboard: ☐ L ☐ R Tucked: ☐ L ☐ R ☐ Airplane ☐ Fracture Table ☐ Hand Table ☐ Stirrups ☐ Other: ☐ Axillary roll ☐ Gel Pad ☐ Leg Holder ☐ Tape ☐ Bean Bag ☐ Gel donut ☐ Pillows ☐ Wilson Frame

Comments:

ESU # Pad Site: (L) Thigh Pad Lot # 61277 Site Clear at end of case? ☐ No ☐ Yes If No, see RN note # Bipolar: ___ Max Cut ___ Coag ___

DVT Prevention: SCD used ☒ No ☐ Yes Pressure: ___ ☐ Left ☐ Right Teds: ☐ No ☐ Yes **Bair Hugger used:** ☒ No ☐ Yes Other warming techniques:

Tourniquet: ☐ Arm ☐ Leg # ☐ Left ☐ Right ☐ webril applied Applied by: Total Min:

Comments:

(b)(6)-4

Comments:

(b)(3)-1

Potential For Infection 'tcome: Appropriate Actions Taken to Prev ection ☐ Yes ☐ No

Wound Classification: ☐ I ☒ II ☐ III ☐ IV

Shave Prep: ☐ Shave ☒ Clipper
Area: (L) thigh By: ____ (b)(6)-2
Dr.

Skin Prep: ☐ Betadine Scrub ☒ Hibiclens ☐ Duraprep ☐ Other:

Solutions/Medications: ☒ Normal saline ☐ Sterile water ☐ Local ____ ☐ Antibiotics ____ ☐ Other: ____

Drains/Packing: ☒ None
☐ Foley FR: ____
☐ JP #1 Fr ___ Location: ____ #2 Fr ___ Location: ____
☐ Hemovac: Size ____ Location ____
☐ Chest tube: Location ____
Size ____ H2O Pressure: ____
☐ Packing: type/location: ____
☐ See RN Note # ____ for comments

Dressing: Location: ____

☐ ABD	☐ Cervical Collar	☐ Kling	☐ Steri-strips	☐ Benzoin
☒ Ace	☐ Coban	☐ Immobilizer	☐ Tape	☐ Mastisol
☐ Bias	☐ Drip Pad	☒ Plains	☐ Webril	☐ Bacitracin
☐ Band-Aid(s)	☐ Fluffs	☐ Sling	☐ Xeroform	
☐ Cast	☒ Kerlix	☐ Splint	☐ Other:	

Miscellaneous

Counts: (initials)

crub:	RN:				
____	____	Correct?			
____	____	Sharps	☒ Yes	☐ No	☐ N/A
____	____	Sponges	☒ Yes	☐ No	☐ N/A
____	____	Instruments	☐ Yes	☐ No	☐ N/A
____	____				

See RN note # ____ for additional comments

Xray: ☒ None ☐ Other: ☐ Portable ☐ C-Arm

Skin Integrity: ☒ Clear & Intact (other than incision)
Comments: ____
☐ See RN note # ___ for additional comments.

mplants:
em / Lot # / Exp Date: ____

See RN note # ___ for additional comments.

Discharge from Operating Room

omplications: ☒ None Comments: ____
See RN note # ____ for additional comments

Transport From OR: ☒ gurney w/ siderails up ☐ Litter w/ safety strap in place ☐ w/ Oxygen ☐ w/ Monitor ☐ Other:

Transferred To: ☒ PACU ☐ ICU ☐ Medivac ☐ Ward ____ ☐ Other
Report by: ☐ Anesthesia provider ☐ RN

urgical Procedure Performed: I + D, Wound Closure (L) LE Wounds

N Note: (number each note to corresponding area above) ____

Initial/Name Box: (please print)
____ ____ ____ ____
____ ____ ____ ____
____ ____ ____ ____

(b)(6)-2

Primary OR RN Signature **Date** 4/25/03

Relief OR RN Signature **Date/Time**

(b)(3)-1

2/3

AN...OTIC: _____
TIME GIVIEN: _____
OTHER: _____

NNMC 6320/16 (05/91)
RECOVERY ROOM RECORD
NAVMED 6320/16 (REV. 11-77) S/N 0105-LF-206-3281

ALLERGIES

OPERATION PERFORMED

AGENTS AND TECHNICS OF ANESTHESIA

HOUR(S)	15	30	45	15	30	45	15	30	45
TEMPS: 220									
200									
180									
160									
140									
120									
100									
80									
60									
40									
20									
RESP. RATE									
NUMBERS FOR REMARKS									

al
l:
to
tor
hm
art
cuff
e =
t:

OXYGEN THERAPY

ROUTE	L/M	%	ON	OFF
MASK				
T-BAR				
VENTILAT.				

FLUID THERAPY

TYPE	5% D/RL	BLOOD	SALINE	OTHER
OPERATING ROOM				
RECOVERY ROOM				
TOTAL				

BLOOD LOSS IN OR: _____ CC

WARD PRE-OP BP / mmHg

TUBES: ☐ N/G ☐ FOLEY

IV IN RA ≈ 300 cc 189
OF LR AT KVO cc/hr AGW TOW

IV IN RFA ≈ 500 cc 189
OF NS AT cc/hr TOW

ART. LINE IN _____

T-TUBES, HEMOVAC IN _____

ADMISSION	DISCHARGE
FROM MOR/SPEC. STUDY	TO WARD _____
DATE _____ HRS _____	DATE _____ HRS _____

DRESSINGS: LOCATIONS _____

STATUS: | STATUS:

ENDOTRACHEAL TUBE – ORAL OR NASAL

☐ YES ☐ NO | ☐ YES ☐ NO

AIRWAY / BREATH SOUNDS

☐ CLEAR ☐ PLAST AIRWAY ☐ OBSTRUCTS EASILY | STATUS:

	MOR	PACU					
URINARY OUTPUT					DRAINAGE		
TIME							
CC							
TOTAL							
SP. GR							
S/A							

REMARKS *(AS NUMBERED)* AND PERTINENT PATIENT PROGRESS NOTES

1) AGW from MOR accompanied by

PMH:

Neuro:

Pain Yes/No Action:

CV: IV:

Other:

(CONT'D ON REVERSE)

POST-ANESTHESIA RECOVERY SCORE (ALDRETE SCORE)			A	D
Able to move 4 extremities voluntarily or on command	2	Activity		
Able to move 2 extremities voluntarily or on command	1			
Able to move 0 extremities voluntarily or on command	0			
Able to deep breathe and cough freely	2	Respiration		
Dyspnea or limited breathing	1			
Apneic	0			
BP±20% of preanesthetic level	2	Circulation		
BP±20-50% of preanesthetic level	1			
BP±50% of preanesthetic level	0			
Fully awake	2	Consciousness		
Arousable on calling	1			
Not responding	0			
Pink	2	Color		
Pale, dusky, blotchy, jaundiced, other	1			
Cyanotic	0			
		TOTALS		

NAUSEA AND VOMITING: ☐ NO ☐ YES → 1 2 3 4 5 6 TIMES

CAUDAL, SPINAL, OR EPIDURAL BLOCK
MOVEMENT PRESENT AT _____ HRS
SENSATION PRESENT AT _____ HRS

CONDITION ON TOW: ☐ GOOD ☐ FAIR ☐ POOR ☐ CRITICAL

RECOVERY:

☐ COMPLICATED

☐ UNEVENTFUL

PATIENT'S IDENTIFICATION:

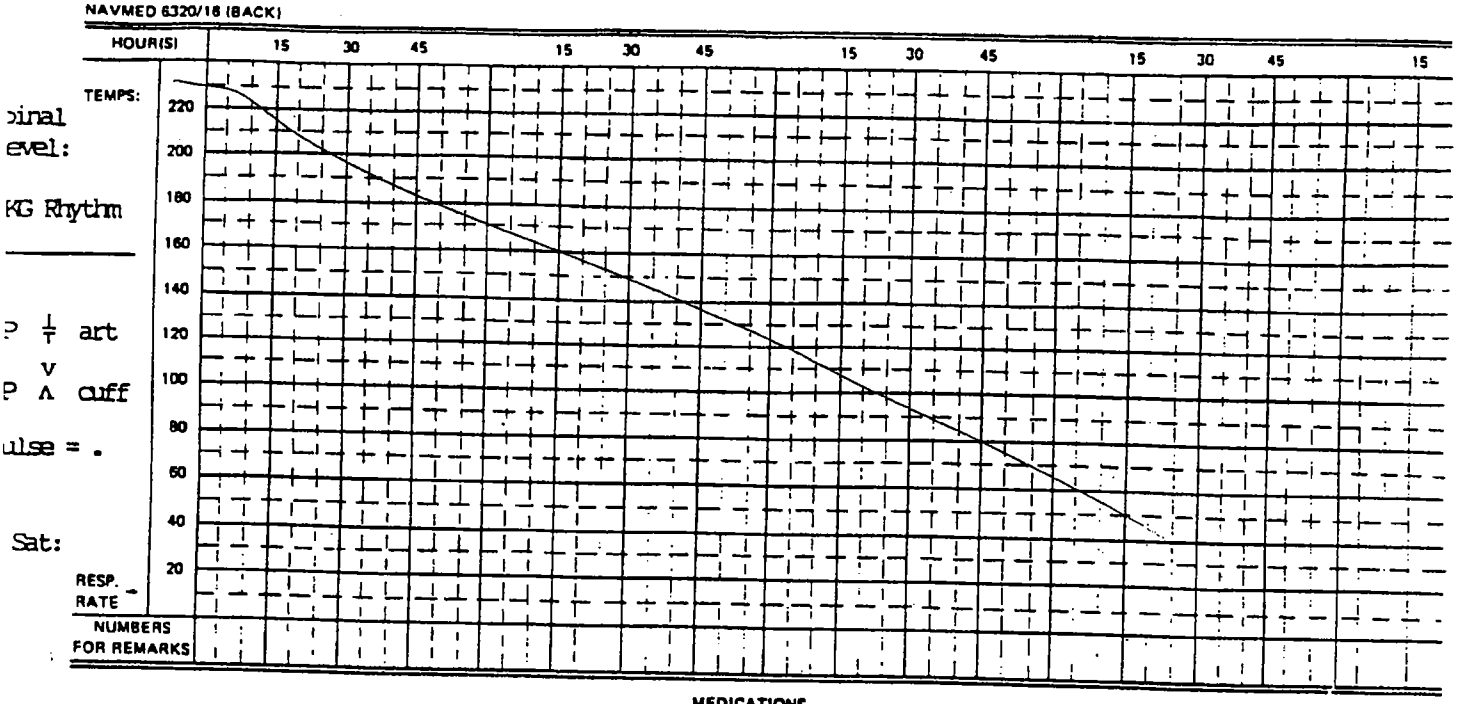
(b)(6)-4

SIGNATURE OF RECEIVING AND RELEASING OFFICERS

AGW

TOW

NAVMED 6320/16 (BACK)



MEDICATIONS

TIME	DRUG	DOSE	ROUTE	NURSE

REMARKS (AS NUMBERED) AND PERTINENT PATIENT PROGRESS NOTES (CONT'D FROM FRONT)

(12) Nasal cannula at 2L sat 99%. (13) Pt tolerating 2L O_2 98%. (14) Unit 2 of blood being hung. 2152. (15) 2225 Blood finished. (16) Blood warmer used for both transfusions (17) Pt meets dc criteria per pulmonary, VS stable [redacted] (b)(6)-2 [redacted] (b)(6)-2

TOW Note: Neuro:

Pain: Yes/No Action:

Pulmonary:

CV: EKG Rhythm: IV:

Skin/Wound: Drainage Yes/No Color: Edema Yes/No

GI:

GU: Foley Yes/No Color of urine: Due to void:

Instructions/Interventions in PACU:

Report called to: By:

TOWed to: By:

134
64

NNMC 6320/16 (05/91)

1/2

116

RECOVERY ROOM RECORD

NAVMED 6320/16 (REV. 11-77) S/N 0105-LF-206-3281

ALLERGIES NKDA

ANTIBIOTIC: Ancef 1gm
TIME GIVEN: 1710
OTHER: Gent 80mg

OPERATION PERFORMED: (R) Neck Fracture, Skel. Trac, GSW LLD (R)(T) + Calf wounds

AGENTS AND TECHNICS OF ANESTHESIA: general

HOUR(S) 1950 15 30 45 2000 20 35 50 2100 20 35 50

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

Spinal Level:

EKG to monitor on ☐ SNR Rhythm

BP ⅟ art

BP V/Λ cuff

Pulse = •

% Sat:

RESP. RATE

NUMBERS FOR REMARKS

OXYGEN THERAPY

ROUTE	L/M	%	ON	OFF
MASK	10L		1950	2000
~~T-PIECE~~	2L		2000	2027
VENTILAT. MASK	10L		2027	2114

FLUID THERAPY

TYPE	5% D/RL	BLOOD	SALINE	OTHER
OPERATING ROOM	1400			
RECOVERY ROOM	700	250 500	400	
TOTAL	2100			

BLOOD LOSS IN OR: Min. cc

WARD PRE-OP BP 133 / 89 mmHg

TUBES: ☐ ~~N/G~~ ☑ FOLEY

IV IN R(H) OF ~~NSR~~ c̄ 100 cc AT KVO cc/hr 1899 AOW

IV IN RAC OF NS c̄ 700 cc AT KVO cc/hr 1899 TOW

~~ART. LINE IN~~

~~T. TUBES, HEMOVAC IN~~

ADMISSION	DISCHARGE
FROM MOR/SPEC. STUDY	TO WARD SFA
DATE 8 APR 2003 HRS 1950	DATE 4/08/03 HRS 0000

DRESSINGS: LOCATIONS

STATUS: clean dry intact

STATUS: c/o

ENDOTRACHEAL TUBE – ORAL OR NASAL

☐ YES ☑ NO ☐ YES ☑ NO

AIRWAY / BREATH SOUNDS

☑ CLEAR ☐ PLAST AIRWAY ☐ OBSTRUCTS EASILY

STATU (b)(6)-2

	MOR	PACU		URINARY OUTPUT	JP 2150	DRAINAGE
TIME	AOW	2145	2300		2027	2145
CC	200	200	100		28	8
TOTAL	200	400	500		28	36
SP, GR						
S/A						

REMARKS (AS NUMBERED) AND PERTINENT PATIENT PROGRESS NOTES

1) AOW from MOR accompanied by (b)(6)-2

PMH: ASA 2

Neuro: appropriate response to verbal + tactile stim

Pain Yes/No Action: Morphine

CV: pulses x2, warm S/S2 IV: patent

Other: Monitor on, ~~pulses x2~~, side rails x2 warm blankets on

(CONT'D ON REVERSE)

NAUSEA AND VOMITING: ☑ NO ☐ YES → 1 2 3 4 5 6 TIMES

~~CAUDAL, SPINAL, OR EPIDURAL BLOCK~~
~~MOVEMENT PRESENT AT ____ HRS~~
~~SENSATION PRESENT AT ____ HRS~~

CONDITION ON TOW: ☑ GOOD ☐ FAIR ☐ POOR ☐ CRITICAL

POST-ANESTHESIA RECOVERY SCORE (ALDRETE SCORE)

			A	D
Able to move 4 extremities voluntarily or on command	2	Activity	2	2
Able to move 2 extremities voluntarily or on command	1			
Able to move 0 extremities voluntarily or on command	0			
Able to deep breathe and cough freely	2	Respiration	2	2
Dyspnea or limited breathing	1			
Apneic	0			
BP±20% of preanesthetic level	2	Circulation	2	2
BP±20-50% of preanesthetic level	1			
BP±50% of preanesthetic level	0			
Fully awake	2	Consciousness	2	2
Arousable on calling	1			
Not responding	0			
Pink	2	Color	2	2
Pale, dusky, blotchy, jaundiced, other	1			
Cyanotic	0			
		TOTALS	10	10

RECOVERY: ☐ COMPLICATED ☑ UNEVENTFUL

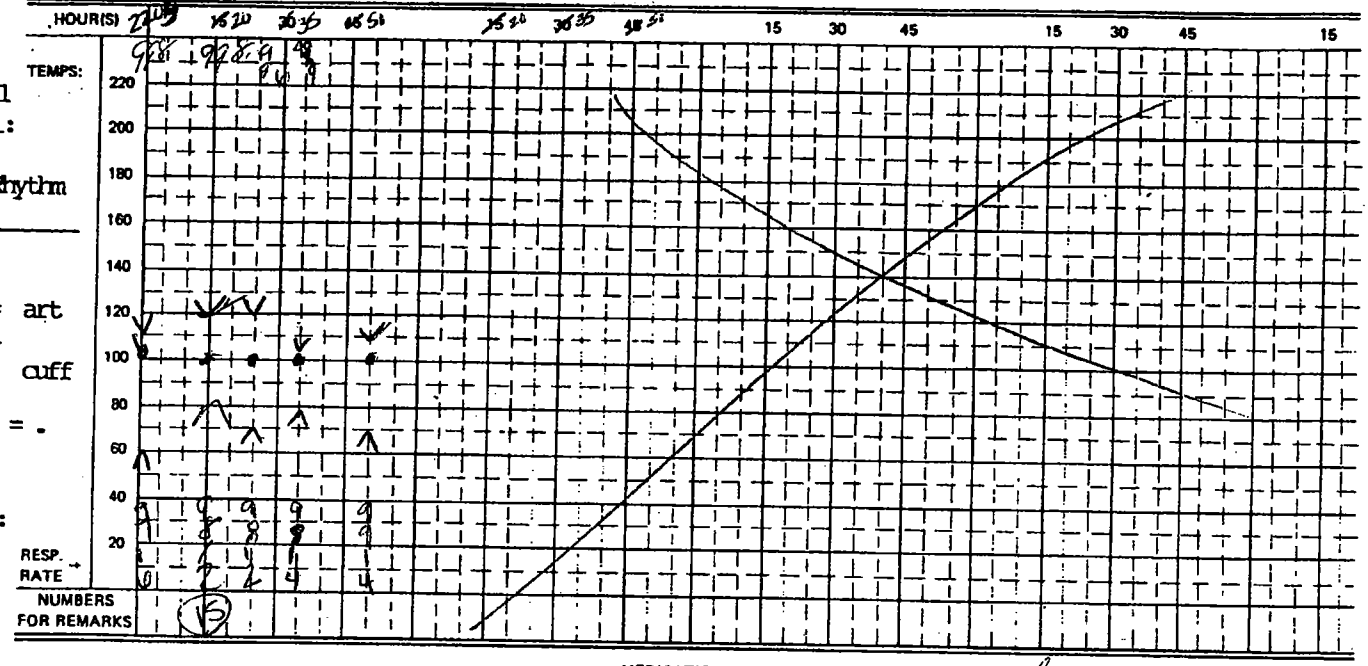
PATIENT'S IDENTIFICATION: (b)(6)-4

SIGNATURE OF RECEIVING AND RELEASING OFFICERS

AO (b)(6)-2

TOW (b)(6)-2

NAVMED 6320/16 (BACK)



MEDICATIONS

TIME	DRUG	DOSE	ROUTE	NURSE
2011	Fentanyl	25mg	IV	(b)(6)-2
2020	Fentanyl	25 mg	IV	(b)(6)-2
2023	Demerol	25 mg	IV	(b)(6)-2
				(b)(6)-2

REMARKS (AS NUMBERED) AND PERTINENT PATIENT PROGRESS NOTES (CONT'D FROM FRONT)

(2) Fentanyl 25mg given for pain. (3) Traction Dr. here. Pain seems relieved by meds. (4) Fentanyl for pain. (5) Demerol for shivering (6) Fase Mask 10L placed, sat 75% drop. (7) X-ray taken (7) Pt tolerating movement well, no longer shivering. (8) 1 unit of blood being hung up. (9) 4L nasal can. placed. (10) tolerating 4L of O_2 sat 98%. (11) 2135 Unit 1 of blood finish

TOW Note: Neuro: appropriate verbal and tactile stimuli response

Pain: Yes/No Action:

Pulmonary: clear, O_2 @ 2L/NC/min o2 sats >95%

CV: warm, S1S2, pulses x2 EKG Rhythm: NSR IV: patent

Skin/Wound: clean dry drsg. Drainage Yes/No Color: Edema Yes/No

GI: oral cavity intact no N/V

GU: Foley Yes/No Color of urine: yellow clear Due to void:

Instructions/Interventions in PACU: Transfused due to low H&H.

Report called to: (b)(6)-2 By: (b)(6)-2

TOWed to: 5 Fwd MAO By: (b)(6)-2

U.S. Government Printing Office: 1991 — 504-109/20525 2-1

ALLERGIES:

DATE ORD.	DATE RENEW	MEDICATIONS	TIME (HOURS TO BE GIVEN)	DATE OF ORDER	LABORATORY/DIAGNOSTIC TESTS EXAMINATIONS/ CONSULTATIONS	DATE SENT	DATE COMP
4-15		Percocet I-II PO Q6°	06-12 18-24	4-15	Duplex of RLE		
4-15		Colace 100mg PO BID	09-21		R/O DVT	X	
~~4-15~~		~~Atrovent inh 2 puffs Q error~~ (b)(6)-2		4/16	RPR, HIV, CBC,		4/16
4/18		Lovenox 30 mg Sq bid	09,21		PT/INR		
4/19		MVI 1 tab PO QD	0900	4/16	Gram stain	X	
4/19		FeSO4 325mg TID c meals	07,12,17	4/16	Wound culture	X	
4/23		Septra DS BID x 3 days	09,21	4/14	Giemsa stain	X	
		for 6 doses		4/16	CBC c diff 4/17	X	
4/25		Septra DS 1 po bid x 24°		4/17	~~PT/INR~~ / CBC 4/18	X	
				4/19	~~CBC c diff~~ WIP 4/20	X	
				4/19	X-ray AP / Lat		
					(P) WIP 4/20		
				4/17	UA/CTS	X 4/26	
4/23 4/25		Percocet 1-II PO q 4-6° PRN					
4-15		Atrovent inh 2 puffs Q20° PRN					
4-15		MSO4 6mg Q4° IV PRN					

ADDRESSOGRAPH

(b)(6)-4

PATIENT PROFILE

NAVMED 6550/12 (5-80) S/N 0105-LF-206-5560

NICUA

✓	ACTIVITY	DATE	✓	BATH	DATE	DIET	DATE	✓	VITAL SIGNS	FREQ	✓	SPECIAL NOTES
	Bedrest			Bed bath		NPO			Temp			Dentures
	Bathroom Privileges			Shower					Pulse			Speech impediment
✓	Up in chair			Tub		Reg	4-15		Resp			Language barrier
	Ambulate			Needs assistance		4/25			B/P			Prosthetic device
	Commode								Other			Visual impairment
	Needs assistance											Blind
	Restricted to unit											Contact lenses
	Hospital Privileges			ORAL HYGIENE	DATE							Glasses
	Other			Self		FEEDING	DATE		FLUIDS			Hearing defect
	OOB to chair 4/5 with assistance			Needs assistance		Self			Forced to:			Other
				Special		Needs assistance			Restricted to:			
						Gavage			I & O			

DATE ORD.	DATE RENEW	TREATMENTS/SPECIAL NOTES	TIMES	DATE ORD.	DATE RENEW	TREATMENTS/SPECIAL NOTES	TIMES
4-15		Dilaudid - IV (b)(6)-2		4-15	IVF	NS @100 c/hr	
4-15		NWB on RT leg + crutches		4/17		Transfuse 1 u PRBC	
4-15		Wound frozen - cut today on (L) thigh + leg wounds		4/20		Consult PT - gait training / NWB (R) LE	
4/25		please have pt sleep on stomach to help c developing hip flexion contracture		4/23		LDD clear	
				4/24		OR 4/25	
4/25		No pillows under knees		4/24		hold Lovenox	
4/25		remove post-op drsg in 72 hrs					
		28 for e 1000		4/24		pt must sleep on stomach	
4/26		PT for hip extension rehab (called)					
4/24		make sure pt has enough septra for discharge Fesal, colace, Percocet, Mxl					
				4-18		Condition - (guarded)	

ADDRESSOGRAPH

Level I

(b)(6)-4

DIAGNOSIS

s/p [illegible] (L) leg + (R) [illegible] sciatic [illegible]

OP/SPECIAL PROCEDURES

TP I + D 4/25

FINDINGS:

AGE	HEIGHT	WEIGHT

PATIENT CLASSIFICATION

Stable

	DATE ON	DATE OFF
SI		
VSI		
RELIGIOUS RITES		

NAVMED 6550/8 (REV. 4-74) S/N 0105-LF-216-5581

MEDICAL RECORD	MEDICATION ADMINISTRATION RECORD

SCHEDULED DRUGS — MONTH _____ 19 _____ — DATES GIVEN

ORDER DATE	MEDICATION- DOSAGE- FREQUENCY ROUTE OF ADMINISTRATION	HOURS	4-15	4-16	4-17	4-18	4-19	4-20	4-21
4-15	Percocet II PO Q6°	0600	X	(b)(6)-2					
		1200	X						
	R= REFUSED	1800	(b)(6)-2						
		2400	(b)(6)-2						
4-15	Colace 100mg PO BID	0900							
		2100	(b)(6)-2						
4/18	Lovenox 30 mg sq bid	0900	(b)(6)-2						
		2100	X	X	X	(b)(6)-2			
4/19	MVI 1 tab PO QD	0900					(b)(6)-2		
4/19	FeSO4 325mg TID c meals	0700						(b)(6)-2	
		1200					(b)(6)-2		
		1700							

INITIAL CODE

INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE
(b)(6)-2	(b)(6)-2	(b)(6)-2		(b)(6)-2	
(b)(6)-2	(b)(6)-2	(b)(6)-2		(b)(6)-2	
		(b)(6)-2		(b)(6)-2	
		(b)(6)-2		(b)(6)-2	BMS, NC

ADDRESSOGRAPH PLATE (b)(6)-4

WARD NO.

Injection Site Code

① = Left Buttock ⑤ = Left Leg
② = Right Buttock ⑥ = Right Leg
③ = Left Deltoid ⑦ = Left Arm
④ = Right Deltoid ⑧ = Right Arm
= Abdomen

SINGLE DOSE, PRE- OP PRN & VARIABLE DOSE ORDERS SEE REVERSE

1 of 2

MEDICATION ADMINISTRATION RECORD (Back) S/N 0105-LF-216-5581

SINGLE ORDERS - PRE-OPERATIVE

MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	GIVEN TIME	GIVEN INITIAL	MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	GIVEN TIME	GIVEN INITIAL
Coumadin 5mg PO NOW	16 Apr	1115	(b)(6)-2				

PRN AND VARIABLE DOSE MEDICATIONS

ORDER DATE	MEDICATION-DOSAGE FREQUENCY ROUTE OF ADMINISTRATION	DOSES GIVEN															
4-15	MSO4 6mg	DATE	4/15	4/16	16 Apr	16 Apr	16 Apr	16 Apr	19/4	19/21							
	Q4D IV PRN	TIME	0430	0249	0520	0930	1850	2035	0412	2230							
		DOSE	6mg	6mg	10mg	5mg	6mg	6mg	6	6mg							
		INIT.	(b)(6)-2														
4-15	Atrovent inh.	DATE															
	2 puffs Q20	TIME															
	PRN	DOSE															
		INIT.															
		DATE															
		TIME															
		DOSE															
		INIT.															
		DATE															
		TIME															
		DOSE															
		INIT.															
		DATE															
		TIME															
		DOSE															
		INIT.															
		DATE															
		TIME															
		DOSE															
		INIT.															
		DATE															
		TIME															
		DOSE															
		INIT.															

NAVMED 6550/8 (REV. 4-74) S/N 0105-LF-216-5581

MEDICAL RECORD	MEDICATION ADMINISTRATION RECORD

SCHEDULED DRUGS — MONTH APR ~~19~~ 03 — DATES GIVEN

ORDER DATE	MEDICATION- DOSAGE- FREQUENCY ROUTE OF ADMINISTRATION	HOURS	22	23	24	25	26	27	28
4/15	PERCOCET II PO Q6°	0600	(b)(6)-2						
		1200	(b)(6)-2	X	X	X	X	X	X
		1800							
		2400							
4/15	COLACE 100MG PO	0900	(b)(6)-2						
	BID	2100	(b)(6)-2						
4/18	LOVENOX 30MG SQ	0900	(b)(6)-2						
	BID	2100	(b)(6)-2				X	PIC	
4/25 4/19	MVI 1 TAB PO ~~at bedtime~~ QD	0900	(b)(6)-2						
4/25 4/19	FERGON 325MG TID	0700							
	C MEALS	1200							
		1700	(b)(6)-2						
4/23	Septra DS BID	0900	X	(b)(6)-2			X	X	X
	x 3 day (6 doses	2100	X	(b)(6)-2			X	X	X
4/25	Septra DS. 1 po bid	0900	X	X	X	X	(b)(6)-2	X	
	x 2 d°	2100	X	X	X	(b)(6)-2	X		
4/26	IMIPENEM 500mg IV q6°	0000	X	X	X	X	X		D/C'd
		0600	X	X	X	X	X		4/26/03
		1200	X	X	X	X	(b)(6)-2		1545
		1800	X	X	X	X	X		(b)(6)-2

INITIAL CODE

INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE
(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2
(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2 LCDR
		(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2 LCDR/NC

ADDRESSOGRAPH PLATE (b)(6)-4

WARD NO.

Injection Site Code

① = Left Buttock ⑤ = Left Leg
② = Right Buttock ⑥ = Right Leg
③ = Left Deltoid ⑦ = Left Arm
④ = Right Deltoid ⑧ = Right Arm
⑨ = Abdomen

SINGLE DOSE, PRE- OP PRN & VARIABLE DOSE ORDERS SEE REVERSE

2 of 2

MEDICATION ADMINISTRATIO' 'ORD (Back) S/N 0105-LF-216-5581

SINGLE ORDERS - PRE-OPERATIVE

MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	GIVEN TIME	GIVEN INITIAL	MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	GIVEN TIME	GIVEN INITIAL
TYLENOL 650 mg	4/25	2338	(b)(6)-2				
Benadryl 50 mg PO	4/27	0001					

PRN AND VARIABLE DOSE MEDICATIONS

ORDER DATE	MEDICATION-DOSAGE FREQUENCY ROUTE OF ADMINISTRATION	DOSES GIVEN																
4/23/03	PERCOCET 5/325	DATE	4/24															
	PO q 4-6° PRN	TIME	0100															
		DOSE	2															
		INIT.	(b)(6)-2															
4/25	PERCOCET 5-325	DATE	4/27	4/28	4/28													
	PO q 6° PRN	TIME	0410	0150	0440													
	PAIN	DOSE	II	II	II													
		INIT.	(b)(6)-2															
		DATE																
		TIME																
		DOSE																
		INIT.																
		DATE																
		TIME																
		DOSE																
		INIT.																
		DATE																
		TIME																
		DOSE																
		INIT.																
		DATE																
		TIME																
		DOSE																
		INIT.																
		DATE																
		TIME																
		DOSE																
		INIT.																

(b)(3)-1

Personal Data - Privacy Act of 1974 (PL 93-579)
PATIENT LAB INQUIRY
For: 20 Mar 03 - 19 Apr 03

ort requested by: (b)(6)-2

(b)(6)-4 (b)(6)-4 M/11d Reg #: (b)(6)-4
Ph: Military Unit: UNKNOWN

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18 Apr 03 @ 0534 (Coll) PLASMA

PT.	20.4	H	(11.6-14.4)	Seconds
INR	2.3			

Interpretations:
The current recommended therapeutic range for INR is 2.0-3.0 for all indications except prosthetic valves for which an INR 2.5-3.5 is recommended (Chest 108(4):231S-246S; 1995). It should be recognized that these are guidelines and adjustments may be required based on individual patient risk factors. The INR is not useful for the first 7-10 days of therapy.

18 Apr 03 @ 0534 (Coll) BLOOD

WBC	6.9		(4.8-10.8)	K/UL
RBC	2.9	L	(4.7-6.1)	1X10 6/UL
HGB	8.6	L	(14.0-18.0)	g/dL
HCT	25.8	L	(42-52)	%
MCV	89.7		(80-94)	fL
MCH	30.0		(27-32)	pg
MCHC.	33.5		(31-37)	g/dL
RDW	13.6		(12-14)	%
PLT CNT	795	H	(150-450)	1x10 3/UL

Result Comment: NOTIFIED LT (b)(6)-2 @ 0711.KF

MPV	7.4		(7.4-10.4)	FL
NEUT/100 WBC.	66.6			%
NEUT%	4.6			1x10 3/UL
LYMPHS/100 WBC.	22.3			%
LY#	1.5			1x10 3/UL
MONO/100 WBC.	11.1			%
MO#	0.8			1x10 3/UL
EO#	<0.7			1x10 3/UL
BAS#.	<0.2			1x10 3/UL

==========

L=Lo H=Hi *=Critical R=Resist S=Susc MS=Mod Susc I=Intermed
]=Uncert /A=Amended Comments= (O)rder, (I)nterpretations, (R)esult

==========

(b)(3)-1

Personal Data - Privacy Act of 1974 (PL 93-579)

PATIENT LAB INQUIRY

For: 12 Apr 03 - 13 Apr 03

Report requested by: (b)(6)-2

(b)(6)-4 (b)(6)-4 M/5d Reg #: (b)(6)-4

Ph: Military Unit: UNKNOWN

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13 Apr 03 @ 0535 (Coll) BLOOD

WBC	10.2		(4.8-10.8)	K/UL
RBC	2.8	L	(4.7-6.1)	1X10 6/UL
HGB	8.4	L	(14.0-18.0)	g/dL
HCT	25.2	L	(42-52)	%
MCV	90.1		(80-94)	fL
MCH	30.2		(27-32)	pg
MCHC.	33.5		(31-37)	g/dL
RDW	13.6		(12-14)	%
PLT CNT	463	H	(150-450)	1x10 3/UL
MPV	7.8		(7.4-10.4)	FL

L=Lo H=Hi *=Critical Resist S-Susc MS-Mod Susc . cermed

NAVMED 6550/8 (REV. 4-74) S/N 0105-LF-216-5581

MEDICAL RECORD	MEDICATION ADMINISTRATION RECORD

SCHEDULED DRUGS — MONTH Apr/May 19 2003 — DATES GIVEN

ORDER DATE	MEDICATION- DOSAGE- FREQUENCY ROUTE OF ADMINISTRATION	HOURS	4/28	4/29	4/30	5/1	5/2	5/3	5/4
4/28	LOVENOX 30mg SQ BID	0900	X	(b)(6)-2					
		2100	(b)(6)-2						
4/19	MVI 1 Tab PO QD	0900	X	(b)(6)-2					
			X	X	X	X	X	X	X
[redacted]									
4/19	FeSO4 325mg PO TID c̄ meals	0700	X	(b)(6)-2					
		1200	X						
		1700	(b)(6)-2						
4/15	COLACE 100mg PO BID	0900	X	(b)(6)-2					
		2100	(b)(6)-2						

INITIAL CODE

INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE
(b)(6)-2	(b)(6)-2				

ADDRESSOGRAPH PLATE

(b)(6)-4

Injection Site Code

① = Left Buttock ⑤ = Left Leg
② = Right Buttock ⑥ = Right Leg
③ = Left Deltoid ⑦ = Left Arm
④ = Right Deltoid ⑧ = Right Arm
) = Abdomen

WARD NO. 5FHDP

SINGLE DOSE, PRE- OP PRN & VARIABLE DOSE ORDERS SEE REVERSE

MEDICATION ADMINISTRATION RD (Back) S/N 0105-LF-216-5581

SINGLE ORDERS - PRE-OPERATIVE

MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	TIME	INITIAL	MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	TIME	INITIAL

PRN AND VARIABLE DOSE MEDICATIONS

ORDER DATE	MEDICATION-DOSAGE FREQUENCY ROUTE OF ADMINISTRATION	DOSES GIVEN																
4/25	Percocet	DATE																
	1-2 PO	TIME																
	q6hr prn	DOSE																
	pain	INIT.																
4/28	Tylenol #3 1-2	DATE	4/29	4/29	4/29	4/29	5/1	1May	5/1	5/2	5/3	3May	5/3	5/4				
	po q6° PRN	TIME	0211	0615	1420	2353	0311	1250	2311	5/2 0740	1340		2600	0815				
		DOSE	2	2	2	2	2	1/2	2	2	2	1/2	1/2	1/2				
		INIT.	(b)(6)-2															
	AMBIAN 25mg	DATE	29 APR															
	PO QHS	TIME	2220															
		DOSE	25															
		INIT.	(b)(6)-2															
4/20	Meclizine 25mg	DATE																
	PO QD PRN	TIME																
	motionsickness	DOSE																
		INIT.																
		DATE																
		TIME																
		DOSE																
		INIT.																
		DATE																
		TIME																
		DOSE																
		INIT.																
		DATE																
		TIME																
		DOSE																
		INIT.																

ANESTHESIA RECOR

NMC 2279(12/00)

Wt (kg) - 70 Ht (in) - gies - NKDA

Procedure: I&D (R) Thigh

Date: 4/8/3 Anes. Start: 1845 Pat. Room: 1710 (b)(6)-2 Surg. End: 1936 Anes. End: 1945 Resident/SRNA

LCDR/USN ANESTHESIA

OR # 2 Page 1 of 1 See Page One

Time	1715	30	45	1800	15	30	45	1900	15	30	45
O_2 L/M	8	1	1	1	1	1	1	1	1	8	
N_2O / Air L/M		1	1	1	1	1	1	1	1	X	
Halo / Iso / Sevo / Des		1	1	1	1	1	.7	.7	X		
STP / Prop / Etomidate	120										
Suc / Cistracurium	100										
Ro / Rapa / Ve curonium											
Lidocaine											
Neostigmine / Glyco											
Ephedrine / Neo											
Midazolam											
MSO_4 / Remi / Sufentanyl	100										
Epid. Lido / Bupiv / Ropiv											
Morphine					2			2	1		
NS / LR			1000			1200			1400		
U/O			200								
EBL											

Checklist - O_2 ☒ Suction ☒ Machine ☐ Consent ☐ NPO

Monitors - ☒ SaO_2 ☒ ECG ☒ FiO_2 ☒ NIBP L / R arm ☒ $EtCO_2$ ☐ PCS / ES ☒ PNS ☐ PIP ☒ Temp ☒ Mass Spec ☐ Verbal ☐ TEE ☐ Fluid warmer ☐ Air Warm ☒ Foley ☐ FHT ☐ Pulm Art cath ☐ CVP IJ / SC / Fem L / R ☐ OG / NG L / R ☐ A-Line Rad / Fem L / R

Position - ☒ Pressure points padded ☒ Arms < 90° Supine Prone Lithotomy Sitting Lateral L R

Blood Used 10 Wasted 0 Witns

Drawn Used 1.75 Wasted .25 Witns

IV - 18 Ga L R Hand Wrist FA AC EJ

☐ Tourniquet ____ mmHg Times ____ ____

60 / 90 / 120 / 130 / 140 / 150 min - Surgeons informed

Antibiotics: Agent Ancef; Total mg TGM; over 15 minutes; Total @ 1730

Total 1400 Total 200 Total Minimal

Gent 80mg 45" 1730-1815

Hemocue - 7.5 @ 1815

● = Pulse
○ = Spont. Resp.
⊘ = Asst. Resp.
⊛ = Ventilator
X = MAP
∧ / V = NIBP
⊥ / T = A-Line
I = Intubate
E = Extubate

PACU / ICU
Pulse - 116
BP 136/64
Temp - 97.5
RR - 16
SaO_2 96
Comps - + / -

ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR
Es / Np / Or / Sk / Ax Temp									
% FiO_2	1.00	0.5	0.5	0.5	0.5	0.5	0.5	0.5	1.0
% SaO_2	100	100	100	98	100	99	100	100	100
$EtCO_2$		33	33	35	35	35	37	37	38
		0	0	0	0	0	0	0	0
TV		607	0	375	384	387	445	424	
PIP (cmH₂O)		24							
Resp. Rate		8		12	13	10	10	10	14

Induction - Monitors On Preoxygenated Smooth Inhalation / IV Cricoid Pressure Rapid Sequence Mask ventilation easy Y / N

Intubation - Mac / Mil Grade ____ view Tube Size 8 Attempts 1 Oral / Nasal L / R w/o / w/ Cuff Stylet Y / N Bil BS / $EtCO_2$ x 3 / CIN

Tube taped @ 23 cm @ lips / teeth / nares Trauma Y / N FOB / LW / Blind LMA # ____ DLT ____ Fr L / R

Maintenance - Smooth Cuff checked Eyes taped / lubed

Extubation - Smooth Reversed SV / VSS Full T4 Head lift / Sustained tetanus Suctioned Awake Deep

Disposition - PACU / ICU SV / VSS Awake / sleepy Extubated / Intubated

Prep: ☐ Sterile Technique ☐ Disposable kit ☐ Betadine prep x 3 ☐ Local infiltration ☐ Site ____ L / R ☐ Attempts ____

Blocks: ☐ Nerve Stim ____ mA ☐ Trans-arterial ☐ Dual cuff

Regional: ☐ Spinal / Epidural ☐ Touhy / Whitacre / Quincke ☐ Needle guage ____ ☐ Sitting ☐ Lateral R / L ☐ LOR to Air / NS ☐ Paresthesia + / - ☐ Heme + / - ☐ CSF + / - ☐ Test dose ⊖ ☐ CSF ⊖ swi

Regional: ☐ Catheter out - tip intact ☐ Level ____

Lines: ☐ Seldinger Technique ☐ CVP manually transduced ☐ Cordis 9.5 / 8.5 Fr ☐ SLIC ☐ 2 / 3 - lumen

Comments / Drugs:

Patient Identification

UCAFRD (b)(6)-4

NNMC 6320/16 (05/91)
RECOVERY ROOM RECORD
NAVMED 6320/16 (REV 11-77) S/N 0105-LF-206-3281

ANTIBIOTIC: Ø
TIME GIVIEN: 16
OTHER:

ALLERGIES NKDA

10mg Morphine 150mg Fentanyl

OPERATION PERFORMED NASHOUT (L) LOWER LE GUN WOUND

AGENTS AND TECHNICS OF ANESTHESIA (b)(6)-2

HOUR(S) 15 30 45 15 30 45 15 30 45

TEMPS: N/A

RESP. RATE

NUMBERS FOR REMARKS

OXYGEN THERAPY

ROUTE	L/M	%	ON	OFF
MASK	10L		AOW	1300
T-BAR				
VENTILAT.				

FLUID THERAPY

TYPE	5% D/RL	BLOOD	SALINE	OTHER
OPERATING ROOM	900			
RECOVERY ROOM	100			
TOTAL	1100			

BLOOD LOSS IN OR: MIN CC

WARD PRE-OP BP 110/60 mmHg 100

TUBES: ☐ N/G ☒ FOLEY

IV IN (R) FA ≈ 1000 cc
10cg OF LR AT KVO cc/hr AOW

IV IN (R) FA ≈ 900 cc
10cg OF LR AT KVO cc/hr TOW

ART. LINE IN

T-TUBES, HEMOVAC IN N/A

ADMISSION	DISCHARGE
FROM MOR/SPEC. STUDY	TO WARD
DATE 15APR03 HRS 1231	DATE 15APR03 HRS
DRESSINGS: LOCATIONS (L) LE; (R) LF	
STATUS: Scant serosanguous drainage	STATUS: Ø D

	MOR	PACU	URINARY OUTPUT		DRAINAGE		
TIME	AOW	TOW					
CC	450cc	150					
TOTAL	450cc	600					
SP. GR							
S/A							

ENDOTRACHEAL TUBE – ORAL OR NASAL

☐ YES ☒ NO ☐ YES ☒ NO

AIRWAY / BREATH SOUNDS

☒ CLEAR (B) ☐ PLAST AIRWAY ☐ OBSTRUCTS EASILY

STATUS: lungs clear (B)

POST-ANESTHESIA RECOVERY SCORE (ALDRETE SCORE)

			A	D
Able to move 4 extremities voluntarily or on command	2	Activity	2	2
Able to move 2 extremities voluntarily or on command	1			
Able to move 0 extremities voluntarily or on command	0			
Able to deep breathe and cough freely	2	Respiration	1	2
Dyspnea or limited breathing	1			
Apneic	0			
BP±20% of preanesthetic level	2	Circulation	2	2
BP±20-50% of preanesthetic level	1			
BP±50% of preanesthetic level	0			
Fully awake	2	Consciousness	1	1
Arousable on calling	1			
Not responding	0			
Pink	2	Color	2	2
Pale, dusky, blotchy, jaundiced, other	1			
Cyanotic	0			
		TOTALS	8	9

REMARKS (AS NUMBERED) AND PERTINENT PATIENT PROGRESS NOTES

1) AOW from MOR accompanied by (b)(6)-2

PMH: UNKNOWN

Neuro: Pt. is sleepy, AOx3, responds to verbal and tactile stimuli

Pain Yes/No (No) Action: will cont. to monitor

CV: S1S2, Skin pink warm dry IV: Patent

Other: AOW via stretcher c̄ SPT X2. Applied warm sheets.

(CONT'D ON REVERSE)

NAUSEA AND VOMITING: ☒ NO ☐ YES – 1 2 3 4 5 6 TIMES

CAUDAL, SPINAL, OR EPIDURAL BLOCK
MOVEMENT PRESENT AT N/A HRS
SENSATION PRESENT AT HRS

CONDITION ON TOW: ☒ GOOD ☐ FAIR ☐ POOR ☐ CRITICAL

RECOVERY: ☐ COMPLICATED ☒ UNEVENTFUL

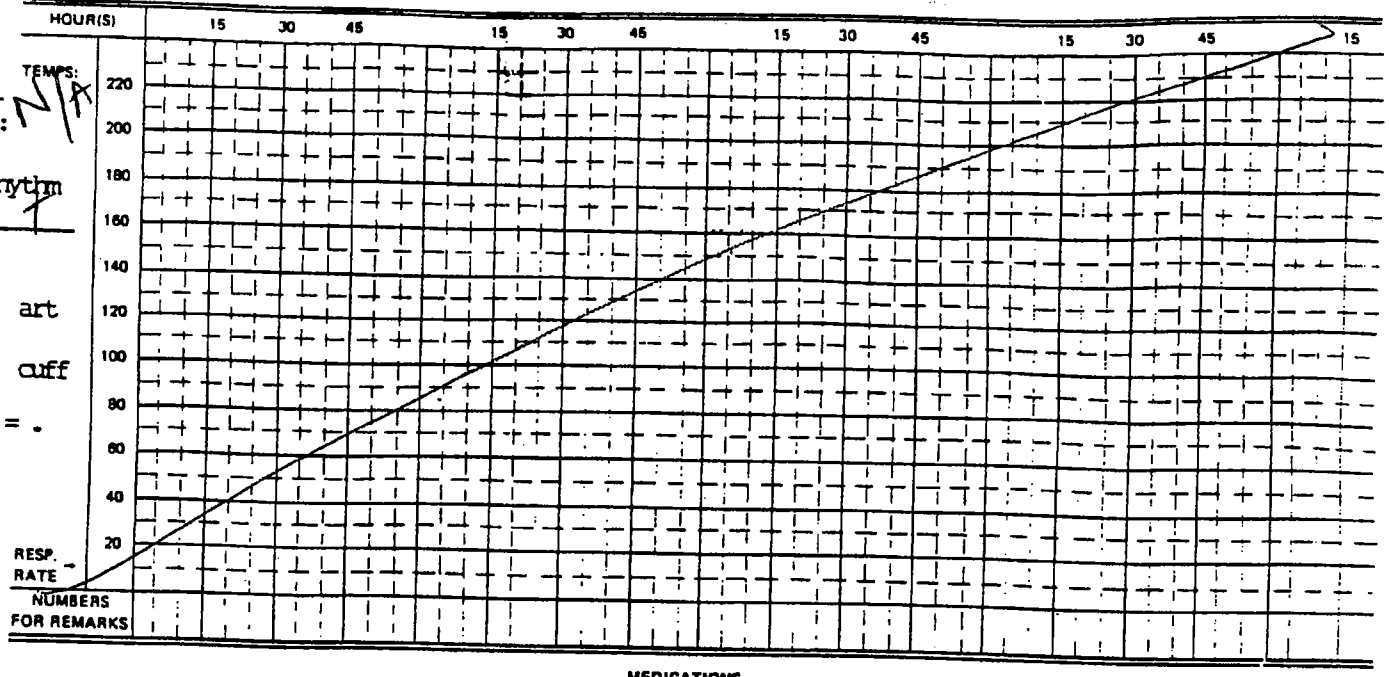
PATIENT'S IDENTIFICATION: (b)(6)-4

SIGNATURE OF RECEIVING AND RELEASING OFFICERS

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

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

NAVMED 6320/16 (BACK)



Spinal Level: N/A

EKG Rhythm ST

BP ↓ art

BP ↑ cuff

Pulse = •

% Sat:

MEDICATIONS

TIME	DRUG	DOSE	ROUTE	NURSE
1253	MORPHINE	2mg	IV PUSH	Lt. (b)(6)-2
1304	MORPHINE	2mg	IV PUSH	Lt. (b)(6)-2

REMARKS (AS NUMBERED) AND PERTINENT PATIENT PROGRESS NOTES (CONT'D FROM FRONT)

(2) Pt. is resting comfortably and has Ø % any pain or discomfort. Will cont. to monitor. (KBN) (3) Pt. medicated for pain per doctor's order. Unable to assess pain level due to language. (KBN) (4) Pt. medicated for pain per doctor's order. (b)(6)-2

TOW Note: Neuro: Pt. is sleepy, responds to verbal and tactile stimuli

Pain: Yes/No Action: Pt. has Ø % pain. Will cont. to monitor

Pulmonary: Lungs clear (B), SPO2 ≥ 95% of RA

CV: S1S2, Skin warm dry, color appropriate for pt. EKG Rhythm: ST IV: Patent

Skin/Wound: (D) Lt. Scant serosanguinous drainage Drainage Yes/No Color: Scant serosanguinous Edema Yes/No Ø

GI: Pt. has Ø % abd. Bowel sounds present x 4 quads.

GU: Foley Yes/No (b)(6)-2 Color of urine: Light yellow Due to void: 1835 N/A (b)(6)-2

Instructions/Interventions in PACU:

Report called to: ENJ (b)(6)-2 By: (b)(6)-2 NJ

TOWed to: S.F.P By: THN (b)(6)-2

ANESTHESIA RECOR

(b)(6)-2 NMC

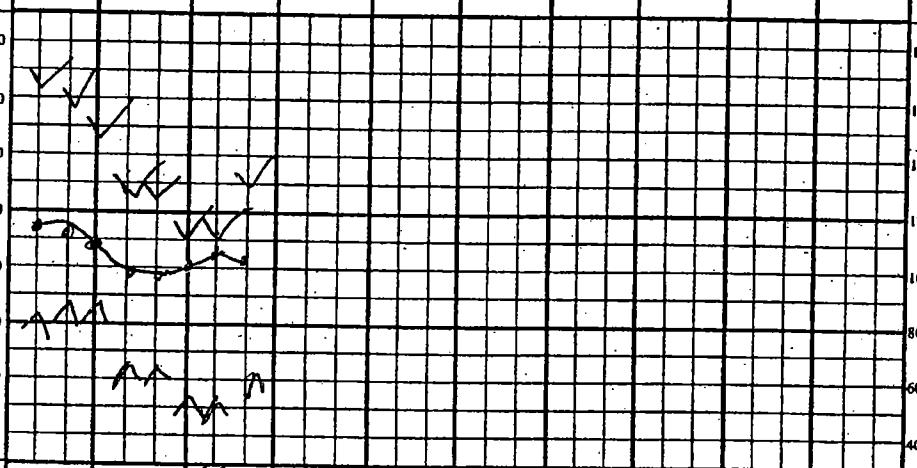
Wt (kg) ~70 Ht (in) - .gies - NKDA

Procedure	Anes. Start	Surg. Start	Surg. End	Anes. End	Surgeon	OR #	Resident/SRNA
CSW Washout LE	1148	1200	1218	1230	(b)(6)-2	9	
Date: 15 Apr 06	1135					Page 1 of 1	See Page One

LCDR NC USN (b)(6)-2 SRNA

Time	12	30	13	30	14
O_2 L/M	6-1	1	6		
N_2O / Air L/M	1	1	0		
Volatile Halo / Iso / Sevo / Des	.6	.5	0		
STP / Prop. / Etomidate	200				
Sux / Cisracurium	80				
Ro / Rapa / Ve curonium					
Lidocaine					
Neostigmine / Glyco					
Ephedrine / Neo					
MSO4 Midazolam		2-2			
MSO_4 / Remi / Su / Fentanyl	150				
Epid. Lido / Bupiv / Ropiv					
NS / LR		300	500		
U/O					
EBL					

● = Pulse
○ = Spont. Resp.
Ø = Asst. Resp.
Ⓥ = Ventilator
X = MAP
Λ / V = NIBP
⊥ / T = A-Line
I = Intubate
E = Extubate



PACU / ICU
Pulse - 109
BP 169/84
Temp - 97.5
RR - 18
SaO_2 - 100%
Comps - + 10

ECG	ST	ST	ST
Es / Np / Or / Sk / Ax Temp	Axnl		
% FiO_2	10	15	10
% SaO_2	100	100	100
$EtCO_2$	40	44	38
TV		400	390
PIP (cmH_2O)			
Resp. Rate	14	17	18

Checklist
☐ O_2 ☐ Suction ☐ Machine ☐ Consent ☐ NPO

Monitors -
☐ SaO_2 ☐ ECG ☐ FiO_2 ☐ NIBP L / R arm
☐ $EtCO_2$ ☐ PCS / ES ☐ PNS ☐ PIP ☐ Temp
☐ Mass Spec ☐ Verbal ☐ TEE ☐ Fluid warmer
☐ Air Warm ☐ Foley ☐ FHT ☐ Pulm Art cath
☐ CVP IJ / SC / Fem L / R ☐ OG / NG L / R
☐ A-Line Rad / Fem L / R

Position - ☐ Pressure points padded ☐ Arms < 90°
Supine Prone Lithotomy Sitting Lateral L / R

Drawn 10 Used 10 Wasted 0 Witns
Drawn 250 Used 150 Wasted 100 Witns

IV - 18 Ga L / R Hand Wrist FA AC EJ
☐ Tourniquet ____ mmHg Times / ____ / ____
60 / 90 / 120 / 130 / 140 / 150 min - Surgeons informed

		Antibiotics
	Total	Agent -
500 ml	Total	mg -
750 ml	Total	over minutes
NS	Total	@

● IV 18g started in Hold area

Induction - Monitors On Preoxygenated Smooth Inhalation / IV Cricoid Pressure Rapid Sequence Mask ventilation easy Y / N
Intubation - Mac / Mil 3 Grade 1 view Tube Size 6.0 Attempts ____ Oral / Nasal L / R w/o w/ Cuff Stylet Y / N Bil BS / $EtCO_2$ x 3 / CIN
Tube taped @ 24 cm @ lips / teeth / nares Trauma Y N FOB / LW / Blind LMA # ____ DLT ____ Fr L / R
Maintenance - Smooth Cuff checked Eyes taped / lubed
Extubation - Smooth Reversed SV VSS Full Fd / Head lift / Sustained tetanus Suctioned Awake / Deep
Disposition - PACU / ICU SV VSS Awake / sleepy Extubated / intubated

Prep
☐ Sterile Technique
☐ Disposable kit
☐ Betadine prep x 3
☐ Local infiltration
☐ Site ____ L / R
☐ Attempts ____

Blocks
☐ Nerve Stim ____ mA
☐ Trans-arterial
☐ Dual cuff

Regional
☐ Spinal / Epidural
☐ Touhy / Whitacre / Quincke
☐ Needle guage ____
☐ Sitting
☐ Lateral R / L
☐ LOR to Air / NS
☐ Paresthesia + / -
☐ Heme + / -
☐ CSF + / -
☐ Test dose ⊖
☐ CSF ⊖ swirl

Regional
☐ Catheter out - tip intact
☐ Level ____

Lines
☐ Seldinger Technique
☐ CVP manually transduced
☐ Cordis 9.5 / 8.5 Fr
☐ SLIC
☐ 2 / 3 - lumen

Comments / Drugs:

Patient Identification

(b)(6)-4

ANTIBIOTIC: Ancef 1gm
TIME GIVIEN: 0845
OTHER:

NNMC 6320/16 (05/91)
RECOVERY ROOM RECORD
NAVMED 6320/16 (REV. 11-77) S/N 0105-LF-206-3281

ALLERGIES NKDA

OPERATION PERFORMED: I+D + closure (L) thigh + lower leg

AGENTS AND TECHNICS OF ANESTHESIA: 150 Fent General c LMA

Spinal Level: NA

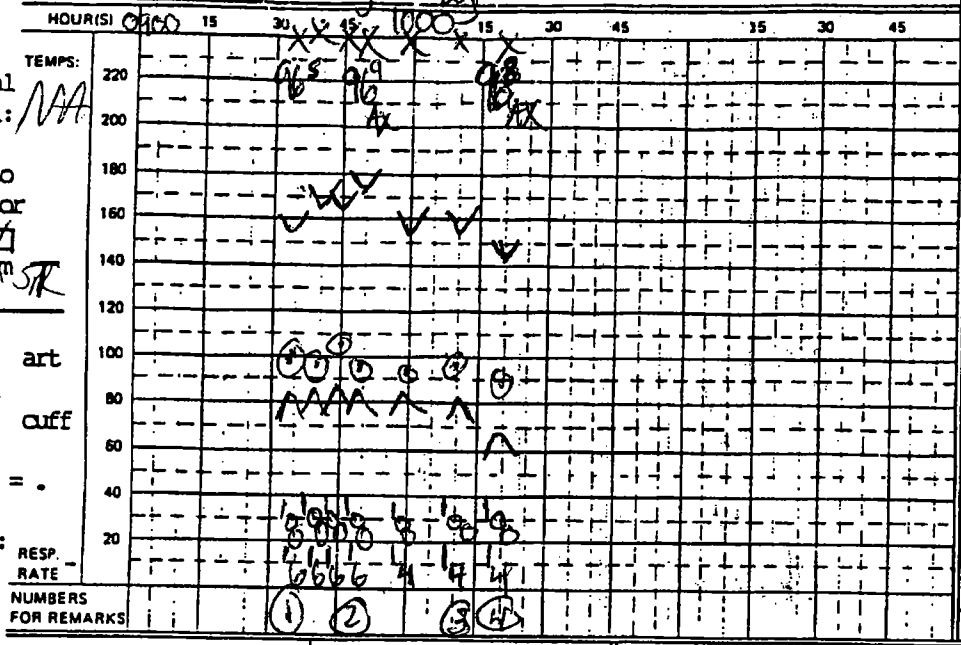
EKG to monitor on [X] Rhythm SR

BP art

BP cuff

Pulse = •

% Sat:



OXYGEN THERAPY

ROUTE	L/M	%	ON	OFF
MASK	10L	X	AOW	1000
T-BAR				
VENTILAT.				

FLUID THERAPY

TYPE	5% D/RL	BLOOD	SALINE	OTHER
OPERATING ROOM	700			
RECOVERY ROOM	50			
TOTAL	750			

BLOOD LOSS IN OR: 25 cc

WARD PRE-OP BP 142 164 mmHg

TUBES: ☐ N/G ☐ FOLEY

IV IN (R) AC ≈ 300 cc OF RL AT 150 cc/hr AOW

IV IN (R) AC ≈ 250 cc OF RL AT 150 cc/hr TOW

ART. LINE IN

T-TUBES, HEMOVAC IN N/A

ADMISSION	DISCHARGE
FROM MOR/SPEC. STUDY	TO WARD 5FS
DATE 4/25/02 HRS 0935	DATE 4/25/02 HRS 1025

DRESSINGS: LOCATIONS (L) thigh + lower (R) E Dcw wrap & wedge

STATUS: C/D/I | STATUS: C/D/I

ENDOTRACHEAL TUBE – ORAL OR NASAL

☐ YES ☒ NO | ☐ YES ☒ NO

AIRWAY / BREATH SOUNDS

☒ CLEAR ☐ PLAST AIRWAY ☐ OBSTRUCTS EASILY

STATUS: Clear (B)

	MOR	PACU
TIME	AOW	TOW
CC	N/M	N/M
TOTAL	Ø	Ø
SP. GR		
S/A		

URINARY OUTPUT

DRAINAGE

POST-ANESTHESIA RECOVERY SCORE (ALDRETE SCORE)

			A	D
Able to move 4 extremities voluntarily or on command	2	Activity	2	2
Able to move 2 extremities voluntarily or on command	1			
Able to move 0 extremities voluntarily or on command	0			
Able to deep breathe and cough freely	2	Respiration	2	2
Dyspnea or limited breathing	1			
Apneic	0			
BP±20% of preanesthetic level	2	Circulation	2	2
BP±20-50% of preanesthetic level	1			
BP±50% of preanesthetic level	0			
Fully awake	2	Consciousness	1	2
Arousable on calling	1			
Not responding	0			
Pink	2	Color	2	2
Pale, dusky, blotchy, jaundiced, other	1			
Cyanotic	0			
		TOTALS	9	10

REMARKS (AS NUMBERED) AND PERTINENT PATIENT PROGRESS NOTES

1) AOW from MOR accompanied by [redacted] (LCDR)

PMH: ASA II

Neuro: Sleepy but Arousable

Pain Yes (No) Action: will monitor

CV: t/t S'S2 HR 100's IV: Patent

Other: (1) AOW supine on gurney, warm sheets for ↓ temp. AOW

(CONT'D ON REVERSE)

NAUSEA AND VOMITING: ☒ NO ☐ YES → 1 2 3 4 5 6 TIMES

CAUDAL, SPINAL, OR EPIDURAL BLOCK
MOVEMENT PRESENT AT NA HRS
SENSATION PRESENT AT HRS

CONDITION ON TOW: ☒ GOOD ☐ FAIR ☐ POOR ☐ CRITICAL

RECOVERY: ☐ COMPLICATED ☒ UNEVENTFUL

PATIENT'S IDENTIFICATION: 58 y.O 70 kg [redacted]

SIGNATURE OF RECEIVING AND RELEASING OFFICERS

AOW [redacted] HN [redacted] LCDR [redacted]

TOW [redacted] HN [redacted] LCDR [redacted]

NAVMED 6320/18 (BACK)

HOUR(S)	15	30	45	15	30	45	15	30	45	15	30	45
TEMPS: 220												
200												
180												
160												
140												
120												
100												
80												
60												
40												
20												
RESP. RATE												
NUMBERS FOR REMARKS												

Spinal Level:

EKG Rhythm

BP ↓ art

BP ↑ cuff

Pulse = .

% Sat:

MEDICATIONS

TIME	DRUG	DOSE	ROUTE	NURSE
0955	Morphine	2mg	IV Push	LCDR NC
0959	Morphine	2mg	IV Push	LCDR NC
1003	Morphine	2mg	IVP	LCDR NC
1007	Morphine	2mg	IV Push	LCDR NC

(b)(6)-2

REMARKS (AS NUMBERED) AND PERTINENT PATIENT PROGRESS NOTES (CONT'D FROM FRONT)

(2) Pt starting to wake up, slight shivering, clo pain, medicated as ordered. (3) Pt seems to be comfortable, resting c̄ eyes closed (4) Pt meets D/C criteria for PACU, released by CDR

(b)(6)-2

(4) TOW Note: Neuro: A&O x3 MAE's, pt resting c̄ eyes closed

Pain: Yes/No Action: medicated

Pulmonary: lungs clear O2 sats 100 % on room air

CV: ¹/₄ S¹S² HR 90's EKG Rhythm: SR IV: Patent

Skin/Wound: warm, dry, pink Drainage Yes/No Color: N/A Edema Yes/No

GI: Round, soft, ↓ s N/V

GU: Foley Yes/No Color of urine: N/A Due to void: 1530

Instructions/Interventions in PACU: Pt warmed to elevate temps, medicated for pain.

Report called to: LCDR (b)(6)-2 By: LCDR (b)(6)-2

TOWed to: SFS By: LCDR (b)(6)-2, HN (b)(6)-2

Pre / Post anesthetic Summary

NNMC 6320/279 (Dec-10)

Proposed Operation	Age	Weight (kg)	Height (in)	ASA Status	Allergies
ORIF (R) Hip (DHS)	50's (late)	70		1 (2) 3 4 5 E	NKA

Chemistries: 133 / 105 / 21 → 95; 4.3 / 22 / 0.8

Hematology: H/H - 8.9/26.1; Platelets - 231; WBCs - 7.1

Coags: PT - ; INR - ; PTT -

Urinalysis / HCG: ∅

NPO – 0300 Am Sm Piece of Apple
Teeth – Intact
Airway – MP I / (II) / III / IV
FROM, 3 FB O, 3 FB HM

Respiratory
Cough:
Sputum:
Asthma: ∅
COPD:
Recent URI:
TB: ∅
Lung Exam: CTA
CXR:

CV
HTN: EPW
CAD:
MI:
CHF: ∅
VHD:
Arrythmias:
Exercise Tolerance: 60 RRR NO G/R
Cardiac Exam:
ECG: 60 RRR – NO G/R/R

CNS / Skeletal
Seizure:
CVA:
LOC: ∅
Neuro:
Muscle:
Skeletal: See Below

Misc

Other
Hepatic:
Renal: ∅
GI:
Endo:
Heme: ∅
EtOH: unknown
Tobacco:

Previous Anesthetics: No problem
Family Hx: unknown

Current Medications: Ancef prior

Premedication: 6mg MSO4 0815 Am

Preoperative Diagnoses
(1) Fx (R) Hip
(2) GSW (R) Quadriceps Thigh
(3) GSW (R) Buttock
(4) GSW Glut perineum

Vitals	Pre-op	DOS
BP:		96/50
HR:		83
Resp:		16
Temp:		37
FHR:		

Evaluator Signature (b)(6)-2 Date 4/11/03 0815 Am

Day of Surgery
- [x] Chart Reviewed / patient examined
- [ ] Risks / benefits / options discussed with patient
- [ ] Patient questions answered
- [ ] Patient / parent / guardian understands and accepts risks
- [ ] NPO after _____ liq., _____ clears, _____ solids

Plan: GETA

Staff MD / CRNA (b)(6)-2 CDR MC USN (b)(6)-2 Date & Time 4/11/03

Patient identification (b)(6)-4

Post-operative note
Doing Well
- [x] No apparent anesthetic complications

Signature (b)(6)-2 Date 4/10/03

MEDCOM - 5056

(b)(3)-1

Peri erative Plan Of Care & Nursing No

Patient Assessment For Surgery - Potential For Injury - Outcome: Patient is free from signs and symptoms of injury ☐ Yes ☐ No

Trauma# or Patient # (b)(6)-4

Diagnosis: SOFT TISSUE OPEN WOUND @ LEG x2 Planned Procedure: I&D @ LEG

Date: 15 Apr 03 Arrival Time: Interviewer: C OR (b)(6)-2

Side: ☐ N/A ☐ Right ☐ Left
Age: HT: WT:

From:
☐ CASREC
☐ ICU
☒ Ward _____
☐ OTHER:

Transport Via:
☒ Gurney
☐ Litter
☐ Ambulated
☐ Wheelchair
☐ Other

Patient ID:
☐ Trauma card
☐ Verbal
☒ Chart
☐ Armband
☐ Other

Blood Ordered:
☒ N/A
☐ Yes ☐ Consent
☐ T/C #Units
☐ T/H #Units
Comments:

Surgical/Anesthesia Consent Verified:
☐ Procedure
☐ Consent complete, dated, signed
☒ Emergent case; no consent, MD note

Preop Labs (HCG, etc):
☐ None ☐ Yes
Test/Results: CBC - in chart

Drug/Latex Allergies:
☐ NKDA
Allergy/Reaction: ?

Present On Admission:
☐ N/A
☐ Oxygen
☐ IV Site: #1 _____ #2 _____
☒ Foley
☐ Endotrachial Tube
☐ Arterial Line Site:
☐ Drain(s)
☐ Chest Tube(s)
☐ See RN Note #

Past Medical History:
☒ None known
☐ Smoker ppd/yrs ___/___
☐ ETOH ☐ Asthma
☐ HTN ☐ CAD
☐ GERD ☐ CBR exposure
☐ Other:

Past Surgical History:
☐ None known
☐ Yes
List:

Cultural Needs Addressed:
☒ Yes ☐ No
List:

Pre-Op Pain:
☐ No
☒ Yes Level ? (0-10)
Action Taken:
Location/type:

Last PO Intake: (date/time)
Solid:
Liquid: ?

In Chart:
☒ H&P ☒ Yes ☐ No
☐ EKG ☐ Yes ☐ No
☐ CXR ☐ Yes ☐ No
☐ Other:

Skin Condition:
☐ Intact
☒ Other: POSTERIOR SPLINT @ LEG
DRESSING x2 @ THIGH + @ CALF

Limitations:
☐ N/A
☒ Language
☒ Mobility
☐ Other:
☐ Auditory
☐ Visual
☐ Prosthesis

Personal Items:
☒ None
☐ Military gear
☐ Glasses
☐ Dentures
☐ Jewelry/wallet
☐ Other
Disposition:

Potential For Anxiety – Outcome: Patent demonstrates knowledge of psychological responses to an invasive procedure ☐ Yes ☐ No

Mental/Emotional Status:
☒ Alert/Oriented
☐ Disoriented
☒ Anxious
☐ Appropriate for age
☐ Other
☐ Calm
☐ Sedated
☐ Unresponsive

Comfort Measures Implemented:
☒ Clear, concise explanations
☒ Communicated patient concerns to other staff members
☒ Remain with patient during induction

Pre-op Teaching Included:
☐ N/A due to patient condition
☒ Physical layout of OR
☒ Personnel present during procedure
☒ Environment (noise, temperature, etc.)
☒ Post-op expectation (PACU, drains, etc.)

Potential For Impaired Skin Integrity Related To Surgical Procedure – Outcome: Patient is injury free ☐ Yes ☐ No

Operative Position:
☒ Supine
☐ Prone
☐ Jackknife
☐ Lithotomy
☐ Other:
☐ Beach chair
☐ Sitting
☐ Lateral L / R

Positional Aids:
☒ Arms <90
Armboard: ☒ L ☒ R
Tucked: ☐ L ☐ R
☐ Airplane
☐ Fracture Table
☐ Hand Table
☐ Stirrups
☐ Other:
☐ Axillary roll
☐ Gel Pad
☐ Leg Holder
☐ Tape
☐ Bean Bag
☐ Gel donut
☐ Pillows
☐ Wilson Frame

Comments:

ESU # VALLEYLAB #9
Pad Site:
Pad Lot # 60277 UA
Site Clear at end of case? ☐ No ☐ Yes
If No, see RN note #
Bipolar: ___ Max Cut 30 Coag 30

DVT Prevention:
SCD used ☒ No ☐ Yes
Pressure: ___ ☐ Left ☐ Right
Teds: ☒ No ☐ Yes
Bair Hugger used: ☒ No ☐ Yes
Other warming techniques:

Tourniquet:
☐ Arm ☐ Leg
☐ Left ☐ Right
☐ webril applied
N/A
Applied by:
↑ ___ ↓ ___
↑ ___ ↓ ___
Total Min:

Comments:

(b)(6)-4

Comments:

(b)(3)-1 Pe ive Plan Of Care & Nursing Note

Potential For Infect – Outcome: Appropriate Actions Taken to I nt Infection ☐ Yes ☐ No

Wound Classification:
☐ I ☒ II ☐ III ☐ IV

Shave Prep:
☐ Shave ☐ Clipper
Area: N/A By: ____

Skin Prep:
☐ Betadine Scrub / PONT
☐ Hibiclens
☐ Duraprep
☐ Other:

Solutions/Medications:
☒ Normal saline
☐ Sterile water
☐ Local ____
☐ Antibiotics ____
☐ Other: ____

Drains/Packing: ☒ None
☐ Foley FR: ____
☐ JP #1 Fr ___ Location: ____ #2 Fr ___ Location: ____
☐ Hemovac: Size ____ Location ____
☐ Chest tube: Location ____
Size ____ H2O Pressure: ____
☐ Packing: type/location: ____
☐ See RN Note # ____ for comments

Dressing: Location: ____

☐ ABD	☐ Cervical Collar	☐ Kling	☐ Steri-strips	☐ Benzoin
☒ Ace	☐ Coban	☐ Immobilizer	☐ Tape	☐ Mastisol
☐ Bias	☐ Drip Pad	☒ Plains	☐ Webril	☐ Bacitracin
☐ Band-Aid(s)	☐ Fluffs	☐ Sling	☐ Xeroform	
☐ Cast	☒ Kerlix	☐ Splint	☐ Other:	

Miscellaneous

Counts: (initials)
Scrub: RN:
Correct DEFFERED
Sharps ☐ Yes ☐ No ☐ N/A
Sponges ☐ Yes ☐ No ☐ N/A
Instruments ☐ Yes ☐ No ☐ N/A
See RN note # ____ for additional comments

Xray:
☒ None ☐ Other:
☐ Portable
☐ C-Arm

Skin Integrity:
☐ Clear & Intact (other than incision)
Comments: POSTERIOR SPLINT ON @ LEG FOR FOOT DROP
☐ See RN note # ___ for additional comments.

Implants:
Item / Lot # / Exp Date:
N/A
See RN note # ____ for additional comments.

Discharge from Operating Room

Complications:
☒ None Comments: ____
See RN note # ____ for additional comments

Transport From OR:
☒ Gurney w/ siderails up
☐ Litter w/ safety strap in place
☐ w/ Oxygen
☐ w/ Monitor
☐ Other:

Transferred To:
☒ PACU
☐ ICU
☐ Medivac
☐ Ward ____
☐ Other

Report by:
☐ Anesthesia provider ☐ RN

Surgical Procedure Performed: I & D @ THIGH WOUNDS

RN Note: (number each note to corresponding area above)

Initial/Name Box: (please print)

(b)(6)-2

Primary OR RN Signature **Date** 15APR03 **Relief OR RN Signature** **Date/Time**

1315

NNMC 6320/16 (05/91)
RECOVERY ROOM RECORD
NAVMED 6320/16 (REV. 11-77) S/N 0105-LF-206-3281

♀

ANTIBIOTIC: Ancef ~~6930~~ 1gr
TIME GIVEN: 0930
OTHER:

ALLERGIES NKDA

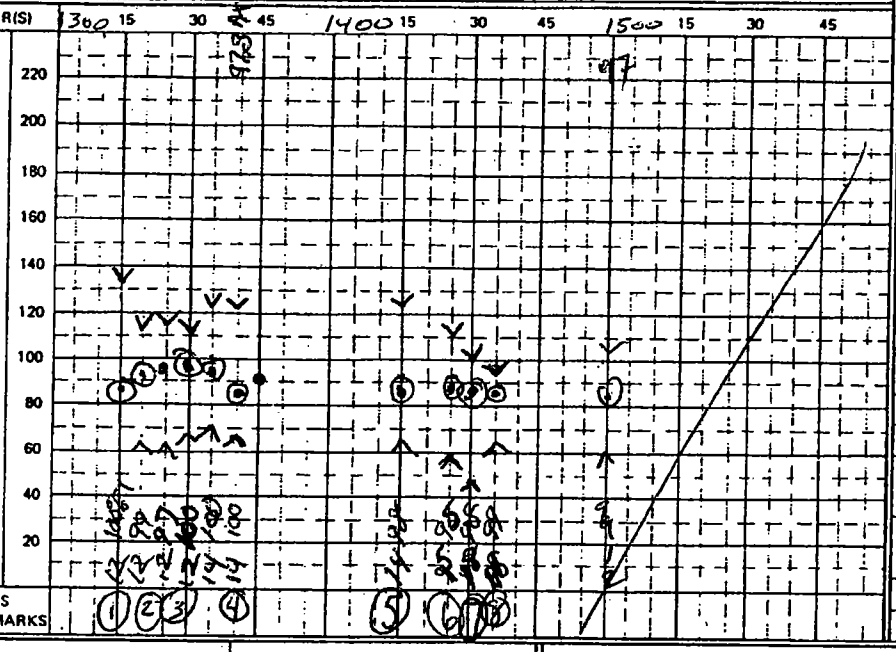
OPERATION PERFORMED
(R) Hip ORIF

AGENTS AND TECHNICS OF ANESTHESIA Morphine
(b)(6)-2

Spinal Level: NA

EKG to monitor on [X]
Rhythm SR

BP art
BP cuff
Pulse = •
% Sat:



OXYGEN THERAPY

ROUTE	L/M	%	ON	OFF
MASK	10		AOW	1400
T-BAR	2		1440	TOW
VENTILAT.				

FLUID THERAPY

TYPE	5% D/W	BLOOD	SALINE	OTHER
OPERATING ROOM	0		1500	—
RECOVERY ROOM	100			—
TOTAL	100		1500	—

BLOOD LOSS IN OR: 200 cc
WARD PRE-OP BP 120 160mmHg
TUBES: ☐ N/G ☒ FOLEY
IV IN (R) Hf @ 1800 cc
18G OF LR AT 100 cc/hr AOW
IV IN (L) Hf @ 900 cc
18G OF LR AT 100 cc/hr TOW
ART. LINE IN
T-TUBES, HEMOVAC IN (R) Thigh

ADMISSION	DISCHARGE
FROM MOR/SPEC. STUDY	TO WARD 5
DATE 4/11/03 HRS 1315	DATE 11 APR 03 HRS

DRESSINGS: LOCATIONS (R) ABD THIGH, (R) LE
STATUS: (R) Hip dressing small amount serosanguinous fluid.
CDI, CDI

ENDOTRACHEAL TUBE – ORAL OR NASAL
☒ YES ☐ NO ☐ YES ☒ NO

AIRWAY / BREATH SOUNDS
☒ CLEAR ☐ PLAST AIRWAY ☐ OBSTRUCTS EASILY
STATUS: clear

	MOR	PACU	URINARY OUTPUT		HEMOVAC		DRAINAGE
TIME	AOW	1420			1500		
CC	300	200			MIN		
TOTAL	300	500					
SP. GR							
S/A							

REMARKS (AS NUMBERED) AND PERTINENT PATIENT PROGRESS NOTES

1) AOW from MOR accompanied by DR. (b)(6)-2
PMH: ASA 3
Neuro: ~~Response~~ Arousable on calling/tactile stimulus
Pain Yes/No Action: Cont to motor
CV: BP 20 mm IV: Patent
Other: SRT x2, Warm Sheets Applied, Side rails up x2 bed locked in low position (CONT'D ON REVERSE)

NAUSEA AND VOMITING: ☐ NO ☐ YES → 1 2 3 4 5 6 TIMES

CAUDAL, SPINAL, OR EPIDURAL BLOCK
MOVEMENT PRESENT AT NA HRS
SENSATION PRESENT AT HRS

CONDITION ON TOW: ☒ GOOD ☐ FAIR ☐ POOR ☐ CRITICAL

POST-ANESTHESIA RECOVERY SCORE (ALDRETE SCORE)

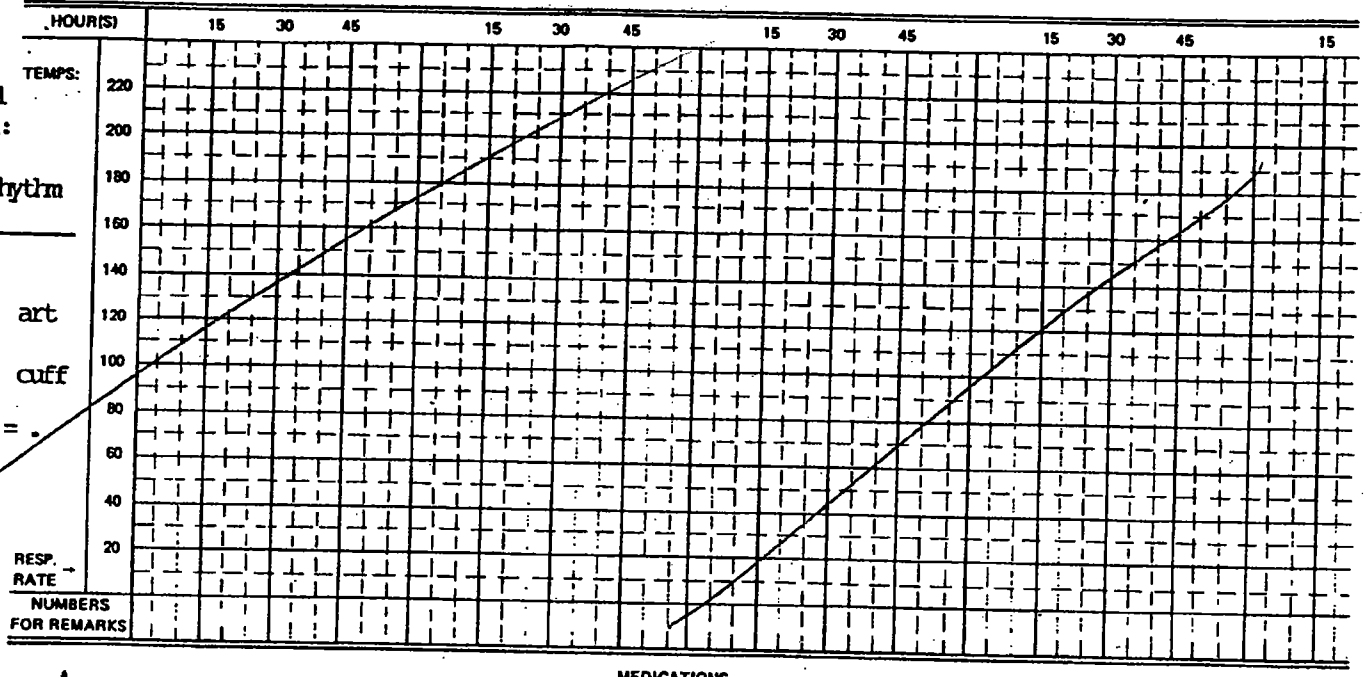
			A	D
Able to move 4 extremities voluntarily or on command	2	Activity	2	2
Able to move 2 extremities voluntarily or on command	1			
Able to move 0 extremities voluntarily or on command	0			
Able to deep breathe and cough freely	2	Respiration	1	2
Dyspnea or limited breathing	1			
Apneic	0			
BP±20% of preanesthetic level	2	Circulation	2	2
BP±20-50% of preanesthetic level	1			
BP±50% of preanesthetic level	0			
Fully awake	2	Consciousness	1	1
Arousable on calling	1			
Not responding	0			
Pink	2	Color	2	2
Pale, dusky, blotchy, jaundiced, other	1			
Cyanotic	0			
		TOTALS	8	9

RECOVERY: ☐ COMPLICATED ☒ UNEVENTFUL

PATIENT'S IDENTIFICATION:
(b)(6)-4

SIGNATURE OF RECEIVING AND RELEASING OFFICERS
AOW HN (b)(6)-2 (b)(6)-2 (b)(6)-2
TOW (b)(6)-2 (b)(6)-2 (b)(6)-2

NAVMED 6320/16 (BACK)



MEDICATIONS

TIME	DRUG	DOSE	ROUTE	NURSE
1430	Morphine	2mg	IV Push	[redacted]

REMARKS (AS NUMBERED) AND PERTINENT PATIENT PROGRESS NOTES (CONT'D FROM FRONT)

(1) Pt came in Intubated Anesthesia at bedside, Anesthesia extubated pt @ bedside pt tolerated procedure well (2) Nasal trumpet was placed by anesthesia. (4) X-Ray Tech @ Pt. X-Ray taken During X-Ray Pt sutures broke and Bright Red Drainage 5) Dr [redacted] paged order given to hold pressure. DR. [redacted] AT BED SIDE Pressure Dressing applied to (8) Buttock Sit @ Sutters And ABD Dressings conti monitor Dressing if saturated

TOW Note: Neuro: Pt rest with eyes close arosal on call

Pain: Yes/No Action:

Pulmonary: Lungs Clear Bilaterally Sat well on 2 Lpt NC SAT > 97%

CV: S1, S2 EKG Rhythm: SR IV: PAtent

Skin/Wound: Worm Pink Drainage Yes/No Color: Serosanguinous Edema Yes/No RLE

GI: Pt Bowl Are NN

GU: Foley Yes/No Color of urine: Dark Yellow Due to void: NA

Instructions/Interventions in PACU: NA

Report called to: ENS [redacted] By: [redacted] CPSC

TOWed to: 5Forward By:

*U.S. Government Printing Office: 1991 — 504-109/20525 2-1

(b)(6)-4

(b)(3)-1

TEST performed 1100

LABORATORY REQUEST FORM

FOR CHEMISTRY, SEROLOGY, AND COAGULATION, CHECK DESIRED TESTS.
FOR ALL OTHERS, CIRCLE DESIRED PANEL.

Check	CHEMISTRY	Result	URINALYSIS	Result	RBC MORPHOLOGY
	GLU		Spec Gravity		
	BUN		pH		
	CREAT		Leukocytes		
	NA		Nitrite		
	K		Protein		
	CL		Glucose		MICROBIOLOGY
	CO_2		Ketones		Culture Site:
	Phos		Urobilinogen		
	AST		Bilirubin		Results:
	ALT		Blood		
	LDH		Hemoglobin		
	TBIL		MICROSCOPIC		
	ALB				Sensitivity:
	CA				
	CHOL				
	TRIG				
	CK		HEMATOLOGY	6.4	
	TP		WBC m ~~2.94~~		6.4 WBC
	MG		RBC	2.94	
	AMYL		HGB	8.2	
	LIPASE		HCT	25.8	MCH 27.9
			MCV	87.6	MCHC 31.8
	SEROLOGY		RDW	13.3	
	MONOSPOT		PLT	195	
			MPV	7.9	
	COAGULATION		DIFFERENTIAL		
	PT		NEUTRO		
	PTT		BAND		
			META		
	BLOOD GAS		MYELO		
	pH		PROMYELO		
	PCO_2		BLAST		
	PO_2		EOSINO		
	LACTATE		BASO		
	BICARBONATE		LYMPH		
	TOTAL CO_2		MONO		
	BASE EXCESS		NUCLEATED RBC		
	O_2 SAT				

Patient Name: (b)(6)-4 Location: WARD 2

FMP/SSN: Provider: CDR (b)(6)-2

Patient ID: Date: 16APR03 1037

MEDCOM - 5061

FLTHOSPPNCLA 6510/1 (1/03)

(b)(3)-1

LABORATORY REQUEST FORM

FOR CHEMISTRY, SEROLOGY, AND COAGULATION, CHECK DESIRED TESTS.
FOR ALL OTHERS, CIRCLE DESIRED PANEL.

Check	CHEMISTRY	Result	URINALYSIS	Result	RBC MORPHOLOGY
	GLU		Spec Gravity		
	BUN		pH		
	CREAT		Leukocytes		
	NA		Nitrite		
	K		Protein		
	CL		Glucose		MICROBIOLOGY
	CO_2		Ketones		Culture Site:
	Phos		Urobilinogen		
	AST		Bilirubin		Results:
	ALT		Blood		
	LDH		Hemoglobin		
	TBIL		MICROSCOPIC		
	ALB				Sensitivity:
	CA		(b)(6)-4		
	CHOL				
	TRIG				
	CK		HEMATOLOGY		
	TP		WBC	10.5	MCH 27.5
	MG		RBC	3.78	MCHC 32.0
	AMYL		HGB	10.4	
	LIPASE		HCT	32.6	
			MCV	86.1	
	SEROLOGY		RDW	13.3	
	MONOSPOT		PLT	237	
			MPV	7.9	
	COAGULATION		DIFFERENTIAL		
	PT		NEUTRO		
	PTT		BAND		
			META		
	BLOOD GAS		MYELO		
	pH		PROMYELO		
	PCO_2		BLAST		
	PO_2		EOSINO		
	LACTATE		BASO		
	BICARBONATE		LYMPH		
	TOTAL CO_2		MONO		
	BASE EXCESS		NUCLEATED RBC		
	O_2 SAT				

Patient Name: (b)(6)-4 _____ Location: WARD 2

FMP/SSN: _____ Provider: CDR (b)(6)-2

Patient ID: _____ Date: 04APR03

MEDCOM - 5062

FLTHOSPPNCLA 6510/1 (1/03)

(b)(6)-4

(b)(3)-1

LABORATORY REQUEST F(

FOR CHEMISTRY, SEROLOGY, AND COAGULATION, CHECK DESIRED TESTS.
FOR ALL OTHERS, CIRCLE DESIRED PANEL.

Check	CHEMISTRY	Result	URINALYSIS	Result	RBC MORPHOLOGY
	GLU		Spec Gravity		
	BUN		pH		
	CREAT		Leukocytes		
	NA		Nitrite		
	K		Protein		
	CL		Glucose		MICROBIOLOGY
	CO_2		Ketones		Culture Site:
	Phos		Urobilinogen		
	AST		Bilirubin		Results:
	ALT		Blood		
	LDH		Hemoglobin		
	TBIL		MICROSCOPIC		
	ALB				Sensitivity:
	CA				
	CHOL				
	TRIG				
	CK		HEMATOLOGY		
	TP		WBC	7.2	
	MG		RBC	3.14	
	AMYL		HGB	9.0	
	LIPASE		HCT	27.3	
			MCV	86.9	
	SEROLOGY		RDW	13.6	
	MONOSPOT		PLT	194	
			MPV	7.5	
	COAGULATION		DIFFERENTIAL		
	PT		NEUTRO		
	PTT		BAND		
			META		
	BLOOD GAS		MYELO		
	pH		PROMYELO		
	PCO_2		BLAST		
	PO_2		EOSINO		
	LACTATE		BASO		
	BICARBONATE		LYMPH		
	TOTAL CO_2		MONO		
	BASE EXCESS		NUCLEATED RBC		
	O_2 SAT				

Patient Name: (b)(6)-4 _____ Location: WARD 2

FMP/SSN: _____ Provider: CDR (b)(6)-2

Patient ID: _____ Date: _____

MEDCOM - 5063

FLTHOSPPNCLA 6510/1 (1/03)

(b)(6)-4

Fleet Hospital Operations and Training Command
CHCS QUICK ADMIT/PATINET TRACKIN FORM

Date: 4 APRIL 03

PATIENT NAME: (b)(6)-4		FMP/SSN: 20-
REGISTER NO:		ALGORITHM NO:
TRIAGE CATEGORY: 1-IMMEDIATE 2-MINIMAL 3-DELAYED 4-EXPECTANT 5-EXPIRED		GSW ↓ LEFT EXTREMITY

CHCS INTERWARD TRANSFER

TRANSFER FROM WARD	TO BED #	TRANSFER TO WARD
		WARD II

PATIENT'S FINAL DISPOSITION

RETURNED TO DUTY	MEDEVAC
MORGUE	OTHERS

Patient ID

Patient Profile

Fleet Hosptial 3

Allergies	Vital Signs	Diet	Activity
Unknown	q 1 2 4 8 (12) Q Shift	Reg	Bed rest
	Call MD for:		Roll side to side
	HR > 120		
	SBP > 180 / < 90 DBP > 100		
	RR < ____ > ____	**Dressing Changes**	
	SpO2 ____	DSG Δ Q8° W → D Starting 05Apr03	
	Temp > 101		
	UOP <		

IV Therapy		O_2/Vent Settings	Misc
Fluid	Rate	O_2 ____ lpm	MSO4 5-10mg Q2-5hr prn
~~LR~~	~~KVO~~	FiO2	Ancef 1g IV Q8°
Hep Lac		Mode	~~Gentamicin 4.0mg Qd x 3~~
		Rate	
		PEEP/PS	ICS Q1° while awake

Diagnosis
GSW x 2 BIL LE
R Femoral Neck Fx
GSW PENIS

Condition
Stable
Foley to gravity.

Daily Labs/Xrays/Procedures	
CBC	Done

ONE TIME ORDERS

CBC 4/4
Port CXR.

(b)(3)-1

M.A.R.

MEDICAL ADMINISTRATION RECORD

Date	4-8	4-9	4-10	4-11	4-12					
Medication	Time Init	Time Init	Time Init	Time Init	Time Init	Time Init	Time Init	Time Init	Time Init	Time Init
MSO4										
5-10 mg Q2-5hs										
Tylenol 3										
1-2 Tabs po										
Q 4hs Prn										
MSO4 2-4mg	4mg									
IVPB Q 1° Prn	RDG/ST									

(b)(6)-4

Patient Id

PRN/ONE TIME MEDS

PRN MEDS

Date	4/8/03									
Medication	Time Init	Dose	Time Init	Dose	Time Init	Dose	Time Init	Dose	Time Init	Dose
Ancef 1gm Q 8hrs	0800 (b)(6)-2									
	1600									
	2400									
~~Ant~~										

ONE TME MEDS

Medication	Time Init	Dose	Medication	Time Init	Dose	Medication		Time Init	Dose

Patient Id

(b)(3)-1

M.A.R.

MEDICAL ADMINISTRATION RECORD

Date 4 Apr 03	4/4	4/5	4/6	4/7						
Medication	Time Init	Time Init	Time Init	Time Init	Time Init	Time Init	Time Init	Time Init	Time Init	Time Init
Ancef 1gm Q8 0800	0800 (b)(6)-2	0800	0800	0800						
1600	1600 (b)(6)-2	1600	1600	1600						
	2400 (b)(6)-2	2400	2400	2400						
Gentamycin Q8	~~1000~~ 1500 (b)(6)-2	1000	1000							

(b)(6)-4

Patient Id

PRN/ONE TIME MEDS

PRN MEDS

Date										
Medication (b)(6)-2	Time Init	Dose	Time Init	Dose	Time Init	Dose	Time Init	Dose	Time Init	Dose
MSO4 Q2-5hrs 5-10mg Q2-5hrs	DC'd 1345 04Apr03 UL									
MSO4 2-4mg IVP Q1° PRN pain	4/5 0130 4/4 2330	4/5 0130 2mg	4/8/03 0500 4mg	4/8/03 1910 4mg	08Apr03 1145 3mg UL	4mg 2110	4mg 0510	07Apr03 0720 2mg	4/7/03 1212 3mg ST	LE 1000 4/7/03 2mg ST
Tylenol #3 1-2 Tabs PO Q4° PRN Pain	4/7 1820 (b)(6)-2 TT						4/7 ST			
MSO4 2-4mg IVP Q1° PRN pain	4/8/03 0333 2mg	4/8/03 0553 (b)(6)-2								

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

4/7/03 1915 2mg (b)(6)-2 TT 4mg

ONE TME MEDS

Medication	Time Init	Dose	Medication	Time Init	Dose	Medication	Time Init	Dose

Patient Id (b)(6)-4

UL (b)(6)-2 NC

Personal Data - Privacy Act of 1974 (PL 93-579)
PATIENT LAB INQUIRY
For: 29 Mar 03 - 08 Apr 03

Report requested by: (b)(6)-2

(b)(6)-4 (b)(6)-4 M/<1d Reg #: (b)(6)-4
Ph: Military Unit: UNKNOWN

---

08 Apr 03 @ 1436 (Coll) PLASMA

APTT	17.2	L	(23.8-35.5)	Seconds
PT	10.3	L	(11.6-14.4)	Seconds
INR	0.7			

Interpretations:
The current recommended therapeutic range for INR is 2.0-3.0 for all indications except prosthetic valves for which an INR 2.5-3.5 is recommended (Chest 108(4):231S-246S; 1995). It should be recognized that these are guidelines and adjustments may be required based on individual patient risk factors. The INR is not useful for the first 7-10 days of therapy.

08 Apr 03 @ 1436 (Coll) BLOOD

STAT WBC	8.6		(4.8-10.8)	K/UL
RBC	2.9	L	(4.7-6.1)	1X10 6/UL
HGB	8.5	L	(14.0-18.0)	g/dL
HCT	25.7	L	(42-52)	%
MCV	88.4		(80-94)	fL
MCH	29.1		(27-32)	pg
MCHC	32.9		(31-37)	g/dL
RDW	13.3		(12-14)	%
PLT CNT	244		(150-450)	1x10 3/UL
MPV	7.4		(7.4-10.4)	FL
BANDS/100 WBC	1			%
SEGS/100 WBC	76			%
L CD10	20			%
MONO%	3			%
PLT EST	NORMAL			
MORPHOLOGY	ABNORMAL			

Result Comment:
2+ BURR CELLS
1+ TARGET CELLS
SLIGHT POIKILOCYTOSIS

08 Apr 03 @ 1436 (Coll) SERUM

STAT NA+	134	L	(137-145)	mmol/L
K	3.6		(3.6-5.0)	mmol/L
CL-	104		(97-107)	mmol/L
CO2	24		(22-31)	mmol/L
BUN	19		(9-21)	mg/dL
GLUCOSE	85		(76-110)	mg/dL
CREAT	0.8		(0.8-1.5)	mg/dL

L=Lo H=Hi *=Critical esist S=Susc MS=Mod Susc I ermed

(b)(3)-1 CASUALTY RECEIVING

CAL TREATMENT RECORD (*continued*)

RWAY nasal / oral Incubate nasal / oral _____ mm tube @ _____ cm teeth / nares

XYGEN Room Air Face Mask @ 12 L / min OTHER _____

JBES CHEST TUBE: size / site _____

N/G: guaiac neg/pos _____

FOLEY: dipstick blood neg / pos URINE DARK YELLOW, NON-AMBER

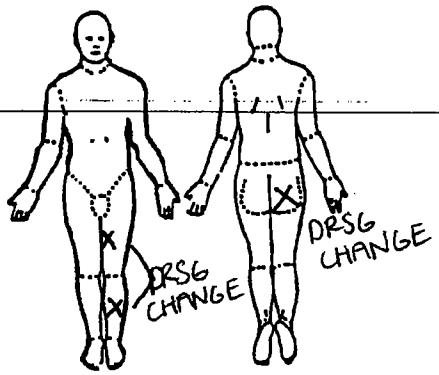
/ SITES	SIZE
(R) MID FOREARM	18G

V SOLUTION	AMT INFUSED
#1 2 mg MORPHINE	2 mg
#2	
#3	
#4	

BLOOD PRODUCTS	AMT INFUSED

TREATMENTS

1. Oxygen
2. Cricothyrotomy
3. Tracheotomy
4. IV Sites
5. Pressure Dressings
6. MAST
7. Apply Hemostat
8. Sutures
9. Tourniquet
10. Bandage
11. Splint
12. Cast
13. _____
14. _____



PERITONEAL LAVAGE

Comments _____

Results: (Circle one) POSITIVE NEGATIVE

OUTPUT

Chest Tube _____ cc

Gastric _____ cc

Foley 700 cc

TOTAL INTAKE _____ cc

TOTAL OUTPUT _____ cc

MEDICATIONS	Dose	Route	Time	Initials	MEDICATIONS	Dose	Route	Time	Initials
Morphine	2 mg	IV	1415	(b)(6)-2					
Mefoxin									
Ancef									
Tet Tox									
Hypertet									

DATE	HOUR A.M.	HOUR P.M.	TRANSFERRED Time: _____ to OR ICU BURN ICU WARD: _____
		1545	PT TO RADIOLOGY FOR X-RAYS

☆ U.S. GPO: 1987-181-247/60056

Potential For Infectio – ome: Appropriate Actions Taken to Pre nt tion ☒ Yes ☐ No

Wound Classification:
☐ I ☒ II ☐ III ☐ IV

Shave Prep:
☐ Shave ☐ Clipper
Area: _____ By: _____

Skin Prep:
☒ Betadine Scrub
☐ Hibiclens
☐ Duraprep
☐ Other: Bet Soln

Solutions. ed. ions:
☒ Normal saline
☐ Sterile water
☐ Local _____
☐ Antibiotics _____
☐ Other: _____

Drains/Packing: ☐ None
☐ Foley FR: _____
☐ JP #1 Fr 1r Location: (a) leg #2 Fr ___ Location: _____
☐ Hemovac: Size ____ Location _____
☐ Chest tube: Location _____
Size _____ H2O Pressure: _____
☐ Packing: type/location: _____
☐ See RN Note # ____ for comments

Dressing: Location: (L) + R LE
☐ ABD ☐ Cervical Collar ☐ Kling ☐ Steri-strips ☐ Benzoin
☒ Ace ☐ Coban ☐ Immobilizer ☐ Tape ☐ Mastisol
☐ Bias ☐ Drip Pad ☒ Plains ☐ Webril ☐ Bacitracin
☐ Band-Aid(s) ☐ Fluffs ☐ Sling ☐ Xeroform
☐ Cast ☒ Kerlix ☐ Splint ☐ Other:

Miscellaneous

Counts: (initials)

crub:	RN:	Correct?			
____	Pelu	Sharps	☒ Yes	☐ No	☐ N/A
____	↓	Sponges	☒ Yes	☐ No	☐ N/A
____		Instruments	☐ Yes	☐ No	☐ N/A

See RN note # ____ for additional comments

Xray:
☒ None ☐ Other:
☐ Portable
☐ C-Arm

Skin Integrity:
☒ Clear & Intact (other than incision)
Comments: _____
☐ See RN note # ___ for additional comments.

mplants:
em / Lot # / Exp Date:

See RN note # ___ for additional comments.

Discharge from Operating Room

omplications:
☒ None Comments: _____
See RN note # ____ for additional comments

Transport From OR:
☒ gurney w/ siderails up
☐ Litter w/ safety strap in place
☐ w/ Oxygen
☐ w/ Monitor
☐ Other:

Transferred To:
☒ PACU
☐ ICU
☐ Medivac
☐ Ward _____
☐ Other

Report by:
☐ Anesthesia provider ☐ RN

urgical Procedure Performed: I+D c̄ delayed 1° closure

N Note: (number each note to corresponding area above)

Initial/Name Box: (please print)

(b)(6)-2 _____ cem 4/8/03
Primary OR RN Signature **Date**

Relief OR RN Signature **Date/Time**

PriOperative Plan Of Care & Nursing Note

Patient Assessment For Surgery - Potential For Injury - Outcome: Patient is free from signs and symptoms of injury ☐ Yes ☐ No

Trauma# or Patient #

Diagnosis: (R) Buttocks Wound (L) thigh wound

Planned Procedure: I & D.

Date: 4/8/03 Arrival Time: Interviewer: LT (b)(6)-2

Side: ☐ N/A ☒ Right ☒ Left
Age: HT: WT:

From:
☐ CASREC
☐ ICU
☐ Ward _____
☐ OTHER:

Transport Via:
☒ Gurney
☐ Litter
☐ Ambulated
☐ Wheelchair
☐ Other

Patient ID:
☐ Trauma card
☐ Verbal
☒ Chart
☒ Armband
☐ Other

Blood Ordered:
☒ N/A
☐ Yes ☐ Consent
☐ T/C #Units _____
☐ T/H #Units _____
Comments:

Surgical/Anesthesia Consent Verified:
☐ Procedure
☐ Consent complete, dated, signed
☒ Emergent case; no consent, MD note

Preop Labs (HCG, etc):
☐ None ☒ Yes
Test/Results:

Drug/Latex Allergies:
☐ NKDA
Allergy/Reaction: Undetermined

Present On Admission:
☐ N/A
☐ Oxygen
☐ IV Site: #1 _____ #2 _____
☐ Foley
☐ Endotrachial Tube
☐ Arterial Line Site: _____
☐ Drain(s) _____
☐ Chest Tube(s) _____
☐ See RN Note # _____

Past Medical History:
☐ None known
☐ Smoker ppd/yrs ___/___
☐ ETOH ☐ Asthma
☐ HTN ☐ CAD
☐ GERD ☐ CBR exposure
☐ Other:

Cultural Needs Addressed:
☐ Yes ☐ No
List: EPW
Communicated thru interpreter - Arabic

Pre-Op Pain:
☐ No
☐ Yes Level _____(0-10)
Action Taken:
Location/type:

Past Surgical History:
☐ None known
☐ Yes
List:

Last PO Intake: (date/time)
Solid: 4/7/03
Liquid:

In Chart:
☐ H&P ☐ Yes ☐ No
☐ EKG ☐ Yes ☐ No
☐ CXR ☐ Yes ☐ No
☐ Other:

Skin Condition:
☐ Intact
☐ Other: Dressing to (R) buttock, Wound to (L) thigh

Limitations:
☐ N/A
☒ Language
☐ Mobility
☐ Other: Unable to communicate in English
☐ Auditory
☐ Visual
☐ Prosthesis

Personal Items:
☒ None
☐ Military gear
☐ Glasses
☐ Dentures
☐ Jewelry/wallet
☐ Other
Disposition:

Potential For Anxiety – Outcome: Patent demonstrates knowledge of psychological responses to an invasive procedure ☐ Yes ☐ No

Mental/Emotional Status:
☐ Alert/Oriented
☐ Disoriented
☐ Anxious
☐ Appropriate for age
☐ Other
☐ Calm
☐ Sedated
☐ Unresponsive

Comfort Measures Implemented:
☐ Clear, concise explanations
☐ Communicated patient concerns to other staff members
☐ Remain with patient during induction

Pre-op Teaching Included:
☐ N/A due to patient condition
☐ Physical layout of OR
☐ Personnel present during procedure
☐ Environment (noise, temperature, etc.)
☐ Post-op expectation (PACU, drains, etc.)

Potential For Impaired Skin Integrity Related To Surgical Procedure – Outcome: Patient is injury free ☐ Yes ☐ No

Operative Position: Prone
☒ Supine
☐ Prone
☐ Jackknife
☐ Lithotomy
☐ Other:
☐ Beach chair
☐ Sitting
☒ Lateral L / R 1st Procedure

Positional Aids:
☐ Arms <90
Armboard: ☐ L ☐ R
Tucked: ☐ L ☐ R
☒ Airplane
☐ Fracture Table
☐ Hand Table
☐ Stirrups
☐ Other:
☐ Axillary roll
☐ Gel Pad
☐ Leg Holder
☐ Tape
☐ Bean Bag
☐ Gel donut
☐ Pillows
☐ Wilson Frame

Comments:

CSU # 1
Pad Site: (R) thigh
Pad Lot # 66918
Site Clear at end of case? ☐ No ☐ Yes
If No, see RN note # _____
Bipolar: ___ Max Cut___ Coag ____

DVT Prevention:
SCD used ☒ No ☐ Yes
Pressure: ___ ☐ Left ☐ Right
Teds: ☐ No ☐ Yes
Bair Hugger used: ☒ No ☐ Yes
Other warming techniques:

Tourniquet:
☐ Arm ☐ Leg #_____
☐ Left ☐ Right
☐ webril applied
Applied by:
↑ _____ ↓ _____
↑ _____ ↓ _____
Total Min:

Comments:

(b)(6)-4

Comments:

PeriOperative Plan Of Care & Nursing Note

Patient Assessment For Surgery - Potential For Injury - Outcome: Patient is free from signs and symptoms of injury ☒ Yes ☐ No

Trauma# or Patient # (b)(6)-4

Diagnosis: _____ Planned Procedure: ORIF (R) HIP

Side: ☐ N/A ☒ Right ☐ Left

Date: 11 APR 03 Arrival Time: _____ Interviewer: LT (b)(6)-2 Age: HT: WT:

From:
☐ CASREC
☐ ICU
(Ward 5 FWD
☐ OTHER:

Transport Via:
☒ Gurney
☐ Litter
☐ Ambulated
☐ Wheelchair
☐ Other

Patient ID:
☐ Trauma card
☐ Verbal
☒ Chart
☒ Armband
☐ Other

Blood Ordered:
☒ N/A
☐ Yes ☐ Consent
☐ T/C #Units
☐ T/H #Units
Comments:

Surgical/Anesthesia Consent Verified:
☐ Procedure
☐ Consent complete, dated, signed
☒ Emergent case; no consent, MD note

Preop Labs (HCG, etc):
☐ None ☒ Yes 08 APR 03
Test/Results: HGB 8.5
ACT 25.7
PLT 244

Drug/Latex Allergies:
☒ NKDA
Allergy/Reaction:

Present On Admission:
☐ N/A
☐ Oxygen
☒ IV Site: #1 (R) forearm
#2
☐ Foley
☐ Endotrachial Tube
☐ Arterial Line Site:
☒ Drain(s) JP (R) HIP
☐ Chest Tube(s)
☐ See RN Note #

Past Medical History:
☒ None known
☐ Smoker ppd/yrs ___/___
☐ ETOH ☐ Asthma
☐ HTN ☐ CAD
☐ GERD ☐ CBR exposure
☐ Other:

Past Surgical History:
☐ None known
☒ Yes I+D (R) HIP
List: TRACTION PIN (R) LEG

Cultural Needs Addressed:
☒ Yes ☐ No
List: PT PRAYED RESPECTED

Pre-Op Pain: PT WAS MEDICATED @ 0815 (No
☐ Yes Level _____ (0-10)
Action Taken:
Location/type:
☐ AMBULATING IN HOLD AREA

Last PO Intake: (date/time)
Solid: > 5° AGO (PLEASE SPARING)
Liquid:
ANES PROVIDER NOTIFIED

Pre-Op Chart:
☒ H&P ☐ Yes ☐ No
☒ EKG ☐ Yes ☐ No
☒ CXR ☐ Yes ☐ No
☐ Other:

Skin Condition:
☐ Intact
☐ Other: MULTIPLE TRAUMATIC WOUNDS

Limitations:
☐ N/A ☐ Auditory
☒ Language ☐ Visual
☒ Mobility ☐ Prosthesis
☐ Other:

Personal Items:
☒ None
☐ Military gear
☐ Glasses
☐ Dentures
☐ Jewelry/wallet
☐ Other
Disposition:

Potential For Anxiety – Outcome: Patent demonstrates knowledge of psychological responses to an invasive procedure ☒ Yes ☐ No

Mental/Emotional Status:
☒ Alert/Oriented ☒ Calm
☐ Disoriented ☐ Sedated
☐ Anxious ☐ Unresponsive
☐ Appropriate for age
☐ Other

Comfort Measures Implemented:
☐ Clear, concise explanations
☐ Communicated patient concerns to other staff members
☒ Remain with patient during induction

Pre-op Teaching Included:
☒ N/A due to patient condition / LANGUAGE BARRIER
☐ Physical layout of OR
☐ Personnel present during procedure
☐ Environment (noise, temperature, etc.)
☐ Post-op expectation (PACU, drains, etc.)

Potential For Impaired Skin Integrity Related To Surgical Procedure – Outcome: Patient is injury free ☒ Yes ☐ No

Operative Position:
☒ Supine ☐ Beach chair
☐ Prone ☐ Sitting
☐ Jackknife ☐ Lateral L / R
☐ Lithotomy
☐ Other:

Positional Aids:
☒ Arms <90
Armboard: ☒ L ☒ R
Tucked: ☐ L ☐ R
☐ Airplane ☐ Axillary roll ☐ Bean Bag
☐ Fracture Table ☒ Gel Pad ☐ Gel donut
☐ Hand Table ☐ Leg Holder ☐ Pillows
☐ Stirrups ☐ Tape ☐ Wilson Frame
☐ Other:

Comments:

SU # 10
Pad Site: (L) HIP
Pad Lot # 61277/6/04
Site Clear at end of case? ☐ No ☒ Yes
If No, see RN note # _____
Bipolar: ___ Max Cut 30 Coag 30

DVT Prevention:
SCD used ☒ No ☐ Yes
Pressure: ___ ☐ Left ☐ Right
Teds: ☐ No ☐ Yes
Bair Hugger used: ☐ No ☒ Yes
Other warming techniques:

Tourniquet: N/A
☐ Arm ☐ Leg #
☐ Left ☐ Right
☐ webril applied
Applied by:
↑ ___ ↓ ___
↑ ↓
Total Min:

Comments:

Comments:

(b)(6)-4

Potential For Infection – Qu[illegible]e: Appropriate Actions Taken to Prevent Infe[illegible] ☒ Yes ☐ No

Wound Classification: I ☒ II ☐ III ☐ IV

Shave Prep: ☐ Shave ☒ Clipper
Area: (R) Hip By: DR
(b)(6)-2

Skin Prep: ☒ Betadine Scrub (b)(6)-2
☐ Hibiclens
☐ Duraprep
☐ Other:

Solutions/Me[illegible]ti[illegible]: ☒ Normal saline ☐ Other:
☐ Sterile water
☐ Local
☐ Antibiotics

Drains/Packing: ☐ None
Foley FR: IN PLACE UPON ARRIVAL TO OR
JP #1 Fr ___ Location: ___ #2 Fr ___ Location: ___
Hemovac: Size 7/8 Location (R) Hip
Chest tube: Location
Size ___ H2O Pressure:
Packing: type/location:
See RN Note # ___ for comments

Dressing: Location: (R) Hip (L) Leg
☐ ABD ☐ Cervical Collar ☒ Kling ☐ Steri-strips ☐ Benzoin
☒ Ace ☐ Coban ☐ Immobilizer ☒ Tape ☐ Mastisol
☐ Bias ☐ Drip Pad ☒ Plains ☐ Webril ☐ Bacitracin
☐ Band-Aid(s) ☐ Fluffs ☐ Sling ☒ Xeroform (b)(6)-2
☐ Cast ☒ Kerlix ☐ Splint ☐ Other:

Miscellaneous

Counts: (initials)
Scrub: RN: (b)(6)-2
Correct?
Sharps ☐ Yes ☐ No ☐ N/A
Sponges ☐ Yes ☐ No ☐ N/A
~~Instruments ☐ Yes ☐ No ☐ N/A~~
See RN note # ___ for additional comments

Xray: ☐ None ☐ Other:
☐ Portable
☒ C-Arm

Skin Integrity:
☐ Clear & Intact (other than incision)
Comments: MULTIPLE TRAUMATIC WOUNDS
☐ See RN note # ___ for additional comments.

Implants:
Item / Lot # / Exp Date:
DHS IMPLANTS TR-2452W1 280.90 90mm 40°, 140 DHS 4 hole Long Barrel DHS Screw plate
SYNTHES LC FRAC SCREW: 4.5mm x 42mm x4 (214.042)
See RN note # ___ for additional comments.

Discharge from Operating Room

Complications:
None Comments:
See RN note # ___ for additional comments

Transport From OR:
☒ gurney w/ siderails up
☐ Litter w/ safety strap in place
☒ w/ Oxygen
☐ w/ Monitor
☐ Other:

Transferred To:
☒ PACU
☐ ICU
☐ Medivac
☐ Ward ___
☐ Other

Report by:
☒ Anesthesia provider ☐ RN

Surgical Procedure Performed: DRIF (R) Hip, I+D (L) Thigh wound

RN Note: (number each note to corresponding area above)

Initial/Name Box: (please print)
(b)(6)-2 (b)(6)-2
(b)(6)-2

(b)(6)-2 LTC 11APR03
Primary OR RN Signature Date Relief OR RN Signature Date/Time

NKA

NAVMED 6550/8 (REV. 4-74) S/N 0105LF-216-5581

MEDICAL RECORD	MEDICATION ADMINISTRATION RECORD

SCHEDULED DRUGS — MONTH APR ~~19~~ 2003 — DATES GIVEN

ORDER DATE	MEDICATION- DOSAGE- FREQUENCY ROUTE OF ADMINISTRATION	HOURS	4/8	4/9	4/10	4/11	4/12	4/13	4/14
4/9	ANCEF 1g IV q 8hr x 48 hr	0800	X	(b)(6)-2	X	X	X	X	X
		1600	given in PACU		X	X	X	X	X
		2400	(b)(6)-2	(b)(6)-2	X	X	X	X	X
4/9	LOVENOX 30 mg SQ BID	0800	X	(b)(6)-2	held		(b)(6)-2		P/C P
		1600	X		(b)(6)-2			X	1st dose 4/9
4/9	PERCOCET 1-2 TAB PO q 3° for	0800	X	(b)(6)-2			refused	refused	R
	moderate pain (around the	0500	X	(b)(6)-2	Held	Refused	refused		R
	clock) pt may refuse	0800	X	(b)(6)-2					
		1100		(b)(6)-2					held
	R = Refused	1400		(b)(6)-2			(b)(6)-2	(b)(6)-2	
		1700		(b)(6)-2					
		2000		(b)(6)-2					
		2300		(b)(6)-2					
4/9	Ancef 1gm IVP q 8° x 48	0800	X	X	(b)(6)-2		auto stop		
		1600	X	X	(b)(6)-2		4/11/03		
		2400	X	X	X				
4/11	Ancef 1GM IV Q8° x 48°	2300	X	X	X	(b)(6)-2			
		0700	X	X	X	X	(b)(6)-2		
		1500	X	X	X	X	(b)(6)-2	X	auto stop 4/12 @ 0800
4/11	Gentamycin 300mg IV x 48°	~~0200~~	X	X	X	X	(b)(6)-2		X
			X	X	X	X		X	X
4/11	Coumadin 5mg po qHS		X	X	X	X	X	X	X
	x 2 days	2000	X	X	X	X	(b)(6)-2		X

INITIAL CODE

INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE
(b)(6)-2		(b)(6)-2		(b)(6)-2	
(b)(6)-2		(b)(6)-2		(b)(6)-2	
(b)(6)-2		(b)(6)-2			
		(b)(6)-2			
				(b)(6)-2	

ADDRESSOGRAPH PLATE

(b)(6)-4

2 of 2

Injection Site Code

① = Left Buttock ⑤ = Left Leg
② = Right Buttock ⑥ = Right Leg
③ = Left Deltoid ⑦ = Left Arm
④ = Right Deltoid ⑧ = Right Arm
⑨ = Abdomen

WARD NO.

SINGLE DOSE, PRE- OP PRN & VARIABLE DOSE ORDERS SEE REVERSE

MEDICATION ADMINISTRATION RECORD (Back) S/N 0105-LF-216-5581

N A

SINGLE ORDERS - PRE-OPERATIVE

MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	TIME	INITIAL	MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	TIME	INITIAL

PRN AND VARIABLE DOSE MEDICATIONS

ORDER DATE	MEDICATION-DOSAGE FREQUENCY ROUTE OF ADMINISTRATION	DOSES GIVEN																
4/9	MSO4 6mg IM or	DATE	4/11	4/12	4/12	4/12	4/13	4/13	4/14	4/14	4/15	4/15						
4/11	IV q 4° PRN for	TIME	0815	1112	1750	0860	0800	2020	0415	0910	0113	0900						
	pain significant	DOSE	6mg	6mg	6mg	6mg	6mg	6mg	10mg	6mg	6mg	6mg						
		INIT.	(b)(6)-2															
4/9	PHENERGAN 25mg	DATE																
4/11	IM or IV q 4° PRN	TIME																
		DOSE																
		INIT.																
4/9	Tylenol 650 mg	DATE	4/12	4/13	4/15													
4/11	PO q 4° PRN	TIME	1230	0730	1340													
		DOSE	II	II	II													
		INIT.	(b)(6)-2															
4/9	MOM 30cc PO	DATE																
4/11	q 4° PRN	TIME																
		DOSE																
		INIT.																
4/9	BENADRYL 25mg	DATE	4/12															
4/11	PO q 4° PRN	TIME	2400															
	~~*~~ UP TO 50mg PER	DOSE	50mg															
	WMO	INIT.	(b)(6)-2															
4/9	SURFAK 240mg	DATE																
4/11	PO BID PRN	TIME																
		DOSE																
		INIT.																
4/9	VALIUM 5mg PO	DATE	4/1															
4/11	q 12° PRN for	TIME	0630															
	muscle spasm in	DOSE	5mg															
	traction	INIT.	(b)(6)-2															

NAVMED 6550/B (REV. 4-74) S/N 0105-LF-216-5581

MEDICAL RECORD	MEDICATION ADMINISTRATION RECORD

SCHEDULED DRUGS — MONTH Apr ~~19~~ 2003 — DATES GIVEN

ORDER DATE	MEDICATION- DOSAGE- FREQUENCY ROUTE OF ADMINISTRATION	HOURS	4/15	4/16	4/17	4/18	4/19	4/20	4/21
9 Apr	Percocet 1-2 Tab po Q3° for	0300	(b)(6)-2						
	moderate pain Pt may refuse	0600							
	R= refused	0900							
		0200							
		1500							
		1800							
		2100							
		2400							

INITIAL CODE

INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE
(b)(6)-2	ENS				

ADDRESSOGRAPH PLATE

(b)(6)-4

WARD NO.

Injection Site Code

① = Left Buttock ⑤ = Left Leg
② = Right Buttock ⑥ = Right Leg
③ = Left Deltoid ⑦ = Left Arm
④ = Right Deltoid ⑧ = Right Arm
⑨ = Abdomen

SINGLE DOSE, PRE- OP PRN & VARIABLE DOSE ORDERS SEE REVERSE

1 of 2

(b)(3)-1

Personal Data - Privacy Act of 1974 (PL 93-579)

PATIENT LAB INQUIRY

For: 08 Apr 03 - 11 Apr 03

ort requested by: (b)(6)-2 Reg #: (b)(6)-4

(b)(6)-4 (b)(6)-4 M/3d Military Unit: UNKNOWN

SERUM

Apr 03 @ 1034 (Coll)				
AT NA+	133	L	(137-145)	mmol/L
K	3.4	L	(3.6-5.0)	mmol/L
CL-	103		(97-107)	mmol/L
CO2	25		(22-31)	mmol/L

BLOOD

Apr 03 @ 1033 (Coll)				
AT WBC	8.5		(4.8-10.8)	K/UL
RBC	3.0	L	(4.7-6.1)	1X10 6/UL
HGB	9.3	L	(14.0-18.0)	g/dL
HCT	26.7	L	(42-52)	%
MCV	88.5		(80-94)	fL
MCH	30.8		(27-32)	pg
MCHC	34.8		(31-37)	g/dL
RDW	13.6		(12-14)	%
PLT CNT	361		(150-450)	1x10 3/UL
MPV	8.1		(7.4-10.4)	FL
NEUT/100 WBC	74.1			%
NEUT%	6.3			1x10 3/UL
LYMPHS/100 WBC	18.3			%
LY#	1.6			1x10 3/UL
MONO/100 WBC	7.6			%
MO#	0.6			1x10 3/UL
EO#	<0.7			1x10 3/UL
BAS#	<0.2			1x10 3/UL

L=Lo H=Hi *=Critical Resist S=Susc MS=Mod Susc termed

Personal Data - Privacy Act of 1974 (PL 93-579)
Review Results

Report requested by: (b)(6)-2

(b)(6)-4 (b)(6)-4 M/15d Reg #: (b)(6)-4
Ph: Military Unit: UNKNOWN

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23 Apr 03 @ 0824 (Coll) URINE

COLOR	YELLOW			
APPEARANCE.	HAZY			
SG.	1.010		(1.010-1.020)	

Interpretations:
Normal Range provided is for first morning void.

PH.	6.0		(4.5-7.5)	
LEUKO EST	MODERATE	H	(NEGATIVE)	
NITRITE	NEG		(NEGATIVE)	
U PROT.	TRACE		(NEG)	MG/DL

Result Comment: SSA TEST PERFORMED WITH RESULT OF NEGATIVE

U GLUCOSE	NEG		(NEGATIVE)	mg/dL
U KETONES	NEG		(NEGATIVE)	mg/dL
UROBLGN	0.2		(0-1)	mg/dl
U BILI.	NEGATIVE		(NEGATIVE)	
U HGB	TRACE		(NEGATIVE)	
U WBC	50-100	H	(0-2)	/HPF
U RBC	1-3			
BACTERIA.	3+			/HPF

L=Lo H=Hi *=Critical R=Resist S=Susc MS=Mod Susc I=Intermed
[]=Uncert /A=Amended Comments= (O)rder, (I)nterpretations, (R)esult

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*** End of Report ***

NNMC NEUROVASCULAR CHECK SHEET

DATE	TIME	1945	2028	2040	2105	2120	2140	2155	2215	2235	2250		
NEUROLOGICAL CHECK													
EXTREMITY		(b)(6)-2											
PAIN	ABSENT	(b)(6)-2											
	MINIMAL												
	MODERATE												
	SEVERE												
SENSATION	NORMAL												
	NUMBNESS	(b)(6)-2											
	TINGLING												
	ABSENT												
BLANCHING (N - Normal; S - Sluggish)				N	N	N	N	N	N	N	N		
ACTIVE MOTOR FUNCTION	NORMAL												
	LIMITED												
	ABSENT	(b)(6)-2											
SIGNS OF COMPARTMENT SYNDROME	PAIN ON PASSIVE MOTION												
	PAIN UNRELIEVED BY ANALGESICS												
VASCULAR CHECK													
COLOR	RED												
	PINK	(b)(6)-2											
	PALE												
	BLUE												
SKIN TEMPERATURE	HOT												
	WARM	(b)(6)-2											
	COOL	(b)(6)-2		(b)(6)-2									
	COLD												
PULSE SITE (R) FOOT	NORMAL	(b)(6)-2											
	WEAK			(b)(6)-2									
	ABSENT												
EDEMA SITE (R) FOOT	NONE	(b)(6)-2		(b)(6)-2									
	SMALL												
	MODERATE												
	LARGE												

COMMENTS

INITIAL	SIGNATURE / TITLE	INITIAL	SIGNATURE / TITLE	INITIAL	SIGNATURE / TITLE
(b)(6)-2	HN				
(b)(6)-2	HN				

PATIENT PROFILE
NAVMED 6550/12 (5-80) S/N 0105-LF-206-5560

NKDA

✓	ACTIVITY	DATE	✓	BATH	DATE	DIET	DATE	✓	VITAL SIGNS	FREQ	✓	SPECIAL NOTES
	Bedrest			Bed bath		NPO p MN	4/14		Temp			Dentures
	Bathroom Privileges			Shower					Pulse	Q4° x 24° then Q8°		Speech impediment
	Up in chair			Tub					Resp			Language barrier
	Ambulate			Needs assistance					B/P			Prosthetic device
	Commode								Other	N/V checks & vitals		Visual impairment
	Needs assistance											Blind
	Restricted to unit											Contact lenses
	Hospital Privileges			ORAL HYGIENE	DATE							Glasses
	Other	4/18		Self		FEEDING	DATE		FLUIDS			Hearing defect
	NWB (R) leg			Needs assistance		Self			Forced to:			Other
				Special		Needs assistance			Restricted to:			
						Gavage	4/9		I&O x48°	Q8°		

DATE ORD.	DATE RENEW	TREATMENTS/SPECIAL NOTES	TIMES	DATE ORD.	DATE RENEW	TREATMENTS/SPECIAL NOTES	TIMES
4/9		TRANSFER EPW WARD		4/11		D5LR @ 100cc/Hr	
		DR [redacted] (ORTHO)					
				4/11		Foley	
				4/11		Hemovac to suction	
				4/14		Reposition Q2°	
						to prevent decub. ulcers	
4/11		CALL ORTHOTECH for casts, splints					
		traction or cast bivalving # 194		4/14		NPO p MN ID in AM 4/15	
4/9		DRESSING Δ's Wet to DRY (L)					
		THIGH & LEG WOUNDS					
4/11		CALL ORTHO # 191 if excessive					
		drainage from pin sites					
4/11		If N/V change occur, call Charge					
		Nurse / WARD M.O To assess & bivolve cast if present					
4/11		If UOP < 30 cc/hr, bolus 500 NS & assess					
		results Call ward M.O. if no improvement					
4/11		O_2 if needed					
				4/14		(R) foot AFO to wear in shoe (foot drop AFO)	
4/11		Dsg Δ (L) thigh/leg					
		wet to dry BID					

ADDRESSOGRAPH

[redacted]

DIAGNOSIS
(R) OPEN HIP FX
COMPLEX WOUNDS (R) THIGH LEG

AGE	HEIGHT	WEIGHT

PATIENT CLASSIFICATION
STABLE

OP/SPECIAL PROCEDURES
S/P transfusion 2 units PRBC

	DATE ON	DATE OFF
SI		
VSI		
RELIGIOUS RITES		

FINDINGS:

ALLERGIES:

NONE KNOWN

DATE ORD.	DATE RENEW	MEDICATIONS	TIME (HOURS TO BE GIVEN)	DATE OF ORDER	LABORATORY/DIAGNOSTIC TESTS EXAMINATIONS/ CONSULTATIONS	DATE SENT	DATE COMP
4/9		~~ANCEF 1g IV q 8 hr x 48 hr~~	08-16-24	4/9	CBC, CHEM7 4/9 ☒		
4/9	P 0800 4/13	LOVENOX 30 mg SQ BID	08-16		CBC 4/10 ☒		
4/9		PERCOCET 1-2 TAB PO q 3° (around the clock)	02-05-08 11-14-17		CBC 4/11 ☐		
		mod pain -> pt may refuse	20-23	4/11	CHEM7, CBC 4/12 ☒		
4/11		Ancef 1gm Q 8° x 48°	07-15-23	4/11	CBC 4/13 ☒		
4/11		Gentamycin 300mg IV x 48°	0200	4/11	CBC 4/14		
4/12	P 4/13	COUMADIN 5mg PO QHS x 2d	2000	4/12	PT / INR 4/14		
4/9	4/	VALIUM 5 mg PO q 12° PRN					
4/9	4/11	SURFAK 240 mg PO BID PRN					
4/9	4/11	BENADRYL 25 mg PO q 4° PRN					
4/9	4/11	MOM 30 cc PO q 4° PRN					
4/9	4/11	TYLENOL 650 mg PO q 4° PRN					
4/9	4/11	PHENERGAN 25 mg IM or IV q 4° PRN					
4/9	4/11	MSO4 6mg IM or IV q 4° PRN PAIN SIGNIFICANT					

ADDRESSOGRAPH

(b)(6)-4

FREQ. VITAL SIGNS

IME																	
P																	
R																	
R																	
EMP																	
AO2																	

otes:

INPUT/OUTPUT

	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06
O																									
/PB																									

UT	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06
OLEY																									
IOP										X/															
M																									

REVIOUS 24 HOUR INPUT _____ PREVIOUS 24 HOUR OUTPUT _____ PREVIOUS WEIGHT _____

RESENT 24 HOUR INPUT PRESENT 24 HOUR OUTPUT PRESENT WEIGHT

(b)(6)-4

MEDTREPAC 03 Temp Form

4/26/03

Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
100																								
80																								
60																								
40																								
20																								
00																								
0																								
0																								
0																								
RR												20						20						
TEMP												100.0						99.9						
SAO2																		98						
MAP																								
O2 Mode																								
												NO/LT												

FREQ. VITAL SIGNS

IME																	
P																	
R																	
R																	
EMP																	
AO2																	

otes:

INPUT/OUTPUT

V	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06
O																									
/PB																									

UT	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06
OLEY																									
IOP		600																							
M																									

PREVIOUS 24 HOUR INPUT _____ PREVIOUS 24 HOUR OUTPUT _____ PREVIOUS WEIGHT _____

PRESENT 24 HOUR INPUT PRESENT 24 HOUR OUTPUT PRESENT WEIGHT

(b)(6)-4

MEDTREPAC 6330 Temp Form

4/27/03

Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
100																								
80																								
60																								
40																								
20																								
0																								
0																								
0																								
0																								
RR		20								18								16						
TEMP		98.6								100.0								100.0						
PULSE		96																96						
Mode		RA																120/70						
BP		120/70																						

(b)(6)-4

MEDTREFAC 6550/12/Ten

26APR03

Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
CUFF																								
00																								
80																								
AL																								
60																								
40																								
20																								
00		✓																						
0																								
60		^																						
40																								
RR		12																						
TEMP		99.2																						
SAO2																								
MAP																								
O2																								
Mode																								

DRIP/DOSE

-(b)(6)-4

MEDTREFAC 6[illegible]47/Temp Form

Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
00																								
30																								
50																								
40																								
20																								
2																								
0																								
0																								
0																								
R		18								HR			20											
EMP		98.3								99.1			99.6											
A O2		98%								98			98											
1/																								
O2																								
ode		RA								RA			RA											
BP		122/60								114/60			138/70											

FREQ. VITAL SIGNS

IME																	
P																	
R																	
R																	
EMP																	
AO2																	

otes:

INPUT/OUTPUT

N	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06
O																									
VPB																									

UT	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06
OLEY																									
IOP										400	100			175			150								
M																									

PREVIOUS 24 HOUR INPUT_____ PREVIOUS 24 HOUR OUTPUT_____ PREVIOUS WEIGHT_____

PRESENT 24 HOUR INPUT_____ PRESENT 24 HOUR OUTPUT_____ PRESENT WEIGHT_____

MEDCOM - 5090

4/25/03

MEDTREFAC 6550/12/Temp Form

Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
200																								
180																								
160																								
140																								
120																								
100																								
80																								
60																								
40																								
RR				14						16							16							
TEMP				98.2						97.1							100.2				96.4			
SAO2				99						98							98							
MAP																								
O2 Mode																	30/2							

CUFF

AL

DRIP/DOSE

MEDCOM - 5091

FREQUENT VITAL SIGNS

IME																	
P																	
R																	
R																	
EMP																	
AO2																	

otes:

INPUT/OUTPUT

V	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06
O																									
/PB																									

UT	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06
OLEY																									
OP									200									275							
M																									

PREVIOUS 24 HOUR INPUT_____ PREVIOUS 24 HOUR OUTPUT_____ PREVIOUS WEIGHT_____

PRESENT 24 HOUR INPUT_____ PRESENT 24 HOUR OUTPUT_____ PRESENT WEIGHT_____

MEDCOM - 5092

(b)(6)-4

MEDTREFAC [redacted] Temp Form

24 APR 03

Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
CUFF																								
200																								
180																								
160																								
140																								
120																								
100																								
80																								
60																								
40																								
RR							14			14							14							
TEMP							99.1			99.2							99.7							
SAO2										96%							98							
MAP										82.0														
O2 Mode										RA														
										110/70							134/80							
																	86							

DRIP/DOSE

(b)(6)-4

MEDTREFAC 6550/12/Temp Form

Date: 03APR05

Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
CUFF 200																								
180																								
AL 160																								
140																								
120	✓			✓													✓							
100																								
80	•			•													•							
60	^			^													^							
40																								
RR	12			12						16							16							
TEMP	98.6			99.1						100.0							99.9							
SAO2										98%							98							
MAP										RA														
O2 Mode										120/74														
										102W							124/68							
																	88							

DRIP/DOSE

FREQ. VITAL SIGNS

ME																
R																
R																
EMP																
AO2																

tes: _____

INPUT/OUTPUT

	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
PB																										

MEDCOM - 5095

UT	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06
OLEY																									
OP	400							185	180																
M																									

REVIOUS 24 HOUR INPUT_____ PREVIOUS 24 HOUR OUTPUT_____ PREVIOUS WEIGHT_____

RESENT 24 HOUR INPUT_____ PRESENT 24 HOUR OUTPUT_____ PRESENT WEIGHT_____

(b)(6)-4

NURSING FLOW SHEET
MEDTREFAC 6550/12/Temp Form

Date: 20 Apr 03

CUFF

AL

Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
200																								
180																								
160																								
140																								
120																								
100																								
80																								
60																								
40																								
RR			12							16							16							
TEMP			99.7							99.7							100.6							
SAO2																	99							
MAP																								
O2 Mode																								
			140/90							130/78							140/74							
																	94							

DRIP/DOSE

FREQ. VITAL SIGNS

TIME															
BP															
HR															
RR															
TEMP															
SAO_2															

Notes: _____

INPUT/OUTPUT

IN	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
PO																										
IVPB																										

OUT	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
FOLEY																										
UOP						100											500									
						100																				
BM																										

PREVIOUS 24 HOUR INPUT_____ PREVIOUS 24 HOUR OUTPUT_____ PREVIOUS WEIGHT_____

PRESENT 24 HOUR INPUT_____ PRESENT 24 HOUR OUTPUT_____ PRESENT WEIGHT_____

MEDCOM - 5097

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

NURSING [redacted] W SHEET
MEDTREFAC[redacted] 2/Temp Form

Date: 21APR03 [redacted]

Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
200																								
180																								
160																								
140																								
120																								
100																								
80																								
60																								
40																								

	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
RR	14																							
TEMP	99.3									110							110							
SAO2										99%							101.6							
MAP										98%							99%							
O2 Mode																								
61/	135/																							
	84																							

DRIP/DOSE

FREQ. VITAL SIGNS

TIME															
BP															
HR															
RR															
TEMP															
SAO_2															

Notes: _____

INPUT/OUTPUT

IN	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
PO																										
IVPB																										

OUT	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOT/
FOLEY																										
UOP	225																									
					500	300									600		400	100					325		100	
BM																										

PREVIOUS 24 HOUR INPUT_____ PREVIOUS 24 HOUR OUTPUT_____ PREVIOUS WEIGHT_____

PRESENT 24 HOUR INPUT_____ PRESENT 24 HOUR OUTPUT_____ PRESENT WEIGHT_____

MEDCOM - 5099