MEDICAL RECORD	PROGRESS NOTES
DATE	
	has good ROM in Thumb and index finger, but unable to move other fingers due to dressing. Dressing is CDI. Will continue to monitor. SPC [redacted] 91WMC (b)(6)-2
6 May 03	
0630	PT vitals T 96.6 P 51 R 18 BP 108/66 — Spc [redacted] 91W (b)(6)-2
6 MAY 03 0645	Pt. awake & A+O x3. Al in OR for patient. NPO + awaiting surgery. Denies any discomfort. Will continue to monitor — [redacted] 91WMC (b)(6)-2
	(b)(6)-2 [redacted] NoCe
5/6/03	PreOp Dx: gsw (R) 5th MC FR, FDP to SK, EDC to 5th PostOp Dx: same Procedure: Tendon FDP/FDS (R) SF, Repair EDC, ORIF (R) 5th MC Surgeon: Olcweyo Anesthesia: GEN LMA Age 75 HT 135 cm @ 45 cm/kg Findings: segmental loss 5th MC & FDP. Cx: ∅ Fluids: 1/50 ∞ (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)

[redacted]

(b)(6)-4

REGISTER NO.

WARD NO. 4CW2

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)
USAPPC V1.00

MEDICAL RECORD	PROGRESS NOTES

DATE

8 May 03 1355. Assumed pt care. Pt c/o pain. 50 mg Demerol given per prn order, HL site flushed c̄ NS ease of diff. Lungs CTA bilat c̄ equal rise & fall of chest. Abd soft & distended. Pedal pulses (+). BS (+) x4 quads. HL (-) EFA & redness or edema noted. (R) hand c̄ splint and wrapped c̄ ace wrap. Will cont to monitor — [redacted] (b)(6)-2 91WM6

8 May 03 1400 Pt vitals taken BP 102/60, P. 64, R. 16, Temp. 98.3 SPC [redacted] (b)(6)-2

8 May 03 2150: Assumed care @ 2100. Pt in bed, awake, alert, no evidence pain — [redacted] (b)(6)-2

2150: PIV - 18g flushed w/3cc NS (+) flush (-) aspiration to (L) wrist. (+) cast to (R) arm up to elbow (-) evidence drainage. (+) sensation to thumb, index, middle, fingers (+) movement to same digits; (-) movement or sensation to ring finger (R) hand. (+) S1 S2 Regular, cap refill <3 sec; (-) swelling extremities, pulses 2+ pedal & radial. Lung sounds clear throughout, CTA (-) c/o dyspnea (SOB) ↓ BS x4 q. soft, non tender, Pt voiding per unit commode w/o problems. Ambulates self w/o difficulties. — [redacted] (b)(6)-2

BP 106/62
HR 62
RR 12
T: 97.8
Spo2 97% RA

2100: Dilaudid IV administered per MD order. PIV flushed S2'd s/p administration. — [redacted] (b)(6)-2

0300 - Pt sleeping quietly — (b)(6)-2 [redacted]

0330 - Pt awake, (-) facial grimacing, hand gesturing to (R) arm stating "Pain" in arabic. Tylenol #3 II PO administered, EVAL pending — [redacted] (b)(6)-2

0425: Pt sleeping quietly — [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
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)
USAPPC V1.00

[redacted]
(b)(6)-4

PROGRESS NOTES

DATE	
0530 hrs	Pt's assessment is unchanged from previous assessment. Pt remains neurovascularly intact to (R) UE, with some movement to thumb. Pain controlled c̄ IV Demerol and T̄ 3. BS(+) x4. Pt tolerating PO. Pt ambulates c̄ difficulty. Pt resting at this time c̄ c/o pain. (b)(6)-2 [redacted]
0700	Vital signs taken BP 128/82 P 67 T 96.8 R 14 - SPC [redacted] 91
9 MAY 03	Vitals taken. BP 122/68, P. 72, R. 18, TEMP 98. (b)(6)-2
1400	SPC [redacted] (b)(6)-2
9 may 03 2000	pt. [redacted] clear on privilege status, rules and privileges explained again - dsg D'd by Dr. [redacted] - pt. continues on ancef (b)(6)-2 [redacted] (b)(6)-2
9 May 03	2100: Received Report. (-) awake, alert, oriented. (R) Hand dressed, splinted and w/ace b. (+) sensation to 4 visible digits, (+) movement. Lacerations to middle, ring digits healing w/o s/s of infection. (+) swelling noted to digs. 1° swelling around elbow. (+) c/o pain to (R) ARM. Demerol 50mg SIVP administered. Eval pending. PA: CV: S1S2 regular, (-) swelling to extremities, cap refill to (L) index, (L) Big toe ≤3 sec. Lung sounds clear anteriorly. (-) evidence resp distress, mucous membranes pink. Normal color for race. Chest movement symmetrical - equal. (+) RA. ABD: Bs q quadrant x4. (-) distention; (-) tenderness. Pt ambulates to unit commode for bowel / voiding needs. voiding w/o difficulties. Pt appears comfortable. (+) calm, (+) cooperative. Will cont. to monitor. (b)(6)-2 [redacted]
	2430- PIV infiltrated. D/C'd. 20g placed to (L) FA. (+) flush (+) blood return. Ancef reinstituted. [redacted] (b)(6)-2
	0100 - Pt c/o pain to (R) hand. Tylenol #3 ii PO administered - [illegible]
10 MAY 03	0540: ASSESSMENT Complete - VSS. T 96.0 F P 64 R 16 B/P 120/68. Pt. c/o pain in (R) arm. Demerol given. HL on (R) FA patent. Will continue to monitor - [redacted] [illegible] (b)(6)-2

STANDARD FORM 509 (REV. 7-91) BACK
USAPPC V1.00

MEDICAL RECORD	PROGRESS NOTES
DATE	
10May03	1310 Pt CAOx4. Ø drains dishes. Pt in real good mood today. Pt has heplock in (R) forearm. Pt ambulator. Ø C/O @ this time Ø C/O V/S BP 110/66 P83 R R16 BETA T 98.3 [redacted] SPC 9/10 (b)(6)-2
10may03 1500	pt. prepared for discharge - VSS - [redacted] (b)(6)-2 removed = condition stable - no C/O pain - dsg intact on (R) hand — [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. ICW2

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)
USAPPC V1.00

[redacted]
(b)(6)-4

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
3 MAY 03	0515: Pt. awake + A+Ox3. Dsg to (R) arm DI. HL to (R) FA patent. Movement + Sensation in (R) hand. Denies any discomfort. Will continue to monitor — [redacted] SPC (b)(6)-2
0546	Vital Signs taken BP 120/74 P 55 T 98.1 R 14 — SPC [redacted] (b)(6)-2
1330	Assumed care of pt @ 1300. VSS. A+Ox3. Dressing on (R) UE CDI. (+) sensation cap refill c3sec, ROM of (R) UE. Pt c/o (R) UE pain relieved by ⅟ T#3. O/W assessment WNL. Will monitor — [redacted]
1830	IV infiltrated. D/C IV cath intact. New 18G IV to (L) FA patent. Cont IV Clindamycin — [redacted] (b)(6)-2
2200	Assumed pt care @ 2100. Pt VSS, A+Ox3, no complaints of pain at this time. Lung sounds are clear to auscultation with equal rise and fall of chest. Heart sounds normal with palpable pulses x3. Dressing on RUE is CDI. Cap refill <3 seconds, positive sensation to fingers. Will continue to monitor. SPC [redacted] 91WM6 (b)(6)-2
2330	Pt c/o pain. 13 given, will continue to monitor. SPC [redacted] 91WM6 (b)(6)-2
4 MAY 03	0510: Received report on pt. Pt. awake + A+Ox3. VSS. Dsg to (R) arm D+I. HL (R) FA patent. Denies any discomfort @ this time — [redacted] (b)(6)-2 91WM6
4 MAY 03 1330	Assumed care of Pt @ 1300. VSS. O/C for OR NPO [redacted]
1445	Pt to OR via stretcher c̄ anesthesia — [redacted] (b)(6)-2
1645	Pt returned from recovery in ICU #2. VSS. (R) FA/hand dressing CDI. (+) cap refill c3sec, mvt of (R) hand. (+) stitches CDI to finger tips. Denies pain. O/W assessment WNL. Plan to return to OR again in future. Will monitor — [redacted] (b)(6)-2

FPI. LEX. Printed on Recycled Paper

STANDARD FORM 600 (REV. 6-97) BACK

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
2May03	@ 1315 received Pt from ICU. Pt ambulatory RA CABG ✓ obvious distress. Pt has I.V. (L) AC. Pt in RA RN [redacted] (b)(6)-2 [redacted] (b)(6)-2 B/P stable. B CBS. B/P 110/P (b)(6)-2 R 16 P 72 R T 97.6 [redacted]
2may03 1330	medicated for pain c good results - IV patent in (L) antecubital - cap refill good in (R) thumb, other fingers covered c Kerlix dressing - pt. eating in RE @ this time [redacted] Ch+A
@ May 2215 BP 110/70 HR 52 RR 12 T: 96.8	Assumed care of pt. Pt in bed [redacted] (b)(6)-2 awake, alert oriented. VS Normal. CV: S1S2 present, Regular, cap refill ≤3 sec, (L) digit, (L) radial pulse 2+, Bilat 2E 2+. (R) radial unable to palpate r/t splint interference. Resp: lungs sounds clear throughout. ⊘ evidence resp. difficulties. GI: BS x4q, ⊖ distention, discomfort. GU: ⊕ Voiding w urinal clear yellow w/o difficulty. Ambulates w/o assist ⊕ steady gait. PIV SL'd ⊕ flush, ⊖ BR. Pt tol Reg diet. Monitoring to cont. [redacted] (b)(6)-2
	2400: Chloramphenicol 900 mg IVPB ↑ over 30 min w/o evidence infiltration PIV flushed ≈ 3cc NS. [redacted] (b)(6)-2
	0300: Pt sleeping quietly @ this time [redacted] (b)(6)-2
	0315 - Pt up BR x1. Returned to sleep [redacted] (b)(6)-2

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

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

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

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

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
6 May 03	1545 received Pt from OR Pt had morphine. RN gave Pt Demerol. Pt c/o sore PN on (R) hand where he had OR. Pt asleep now. VS 120/72 P55 R 14 elevated T 94.2° Pt resting now. SPC [redacted] 9W (b)(6)-2
6 May 03 2230	Assumed pt care @ 2100. VSS, A+O x3, pt has complaints of pain in (R) FA. T3 given for pain. Pt has lungs sounds CTA with equal rise and fall of chest. Pt has • Bowel sounds x4 quadrants. Dressing on (R) FA CDI. Fingers (+) ROM (+) sensation and capillary refill <3 seconds. Hepflock on (L) FA CDI. Will Continue to monitor. SPC [redacted] 9WMC (b)(6)-2
0100	Ancef given. IV site infiltrated prior to medication being given. On IV flush, patient reports pain and saline leaked at cpcyte. IV changed, and Ancef given. Also, demerol given for pain in (R) fa. Will continue to monitor. SPC [redacted] 9WMC (b)(6)-2
0420	Pt c/o pain that awoken him in (R) fa. T3 given for pain, pt requested more demerol. Will continue to monitor. SPC [redacted] 9WMC (b)(6)-2
7 MAY 03	0550: Receive report on Pt. H. awake and A+O x3. Pt in (R) FA patent. Cast and dressing on (R) arm CDI. C/O pain to (R) FA 9 on a scale of 1-10. VSS. Will Continue to monitor. (b)(6)-2 [redacted] 9WMC

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

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* | REGISTER NO. | WARD NO. TCW2

[redacted]

(b)(6)-4

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
7 May 03 0555	Vital Signs taken BP 120/84 P 62 T 99.5 R 14 — SPC [redacted] (b)(6)-2 9N
7 May 03 0600	Pt c/o ↑ pain. Too early for Demerol inj. T#3 given PO. Dr. [redacted] (b)(6)-2 contacted. Pt tells me that the pain is tight inside base/splint. Pt wants splint off. Pt instructed to leave splint on and MD will come to see pt. — [redacted] (b)(6)-2
7 May 03	Assumed care of Pt @ 1300. VSS. (R) FA/hand in dressing/ace wrap CDI. (R) mvt of (R) thump (R) cap refill ≤3 sec. Pt c/o (R) UE pain, in and out of sleep from IV demerol. (R) FA IV flushes. O/W assessment WNL. Will cont to monitor — [redacted] (b)(6)-2
7 May 03 1400	Pt vitals taken. BP 112/62, P. 64, R. 16, TEMP. 98.0 SPC [redacted] (b)(6)-2
2100	Assumed care of Pt @ 2100. Pt. c/o pain in (R) UE. Pt. just received IV Demerol & T#3. Pt. instructed that medicine takes time to kick in & not all of his pain will go away & the medicine is not for sleep but for pain only. Pt. alert & oriented. Drsng to (R) UE is CDI. UTA NVC on hand 2° drsng & thumb. Pt. able to move thumb c/o pain. Caprefill <3 sec. Ht Reg, Ins. wheezes noted to RUL post. BS (+) x4. Will continue to monitor. — [redacted] (b)(6)-2
0700-0710 May 03	Pt is awake, alert, Ox3. Airway is patent, Breathing is even and unlabored. Breath sounds are clear to all fields. Abd is soft and non-tender, ↓ distention. BS (+) x4. Pt voiding spontaneously. (B) LE are neurovascularly intact. (L) UE is neurovascularly intact. (R) UE has ACE & splint. Pt c/o pain to (R) UE and swelling. Feeling to (R) fingers intact. MD aware of feeling of swelling. Pt unable to have any additional pain medication — [redacted] (b)(6)-2 9N
0700-0715 May 03	Pt asleep & c/o pain at this time. — [redacted] (b)(6)-2 9N
0715	Vital Signs taken BP 126/86 P 58 T 96.7 R 16 — SPC [redacted] (b)(6)-2 9N

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STANDARD FORM 600 (REV. 6-97) BACK

558-104

7540-01-075-371

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT *(Patient)*

LOG NUMBER | TREATMENT FACILITY

RECORDS MAINTAINED AT

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

SEX: M

AGE: 29

DUTY/LOCAL PHONE — AREA CODE | NUMBER

HOME PHONE — AREA CODE | NUMBER

MILITARY STATUS

ITEM	YES	NO	N/A
PRP			
FLYING STATUS			

MEDICAL HISTORY OBTAINED FROM

ARRIVAL

DATE *(Day, Month, Year)*: 01 05 03 | TIME: 2100

TRANSPORTATION TO FACILITY: AIR

THIRD PARTY INSURANCE

ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2568 IN CHART		

NAME OF INSURANCE COMPANY

CURRENT MEDICATIONS: Ø

ALLERGIES: NKDA

INJURY OR OCCUPATIONAL ILLNESS

ITEM	YES	NO
IS THIS AN INJURY?		
INJURY/SAFETY FORMS		

WHEN *(Date)*

WHERE

HOW

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: (R) HAND

CATEGORY OF TREATMENT

☐ EMERGENT

☐ URGENT

☑ NON-URGENT

TIME: 2130

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

VITAL SIGNS

TIME	2130				
BP	128/68				
PULSE	88				
RESP	18				
TEMP	97.9				
WT					

LAB ORDERS

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

X-RAY ORDERS

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

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS		BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
2130	MSO4 IV 5mg	(b)(6)-2	[redacted]	2130 CPT [redacted]		(b)(6)-2
2140	Ø70.5 Fm	(b)(6)-2		1LT [redacted]	2140	(b)(6)-2
	1mg Ativ IV	(b)(6)-2				
	5mg ms ON IV					

DISPOSITION: ☐ HOME ☐ FULL DUTY

DISPOSITION QUARTERS /OFF DUTY: ☐ 24 HRS. ☐ 48 HRS. ☐ 72 HRS

MODIFIED DUTY UNTIL

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED | TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

[redacted] (b)(6)-4

[redacted] (b)(6)-4

[redacted] (b)(6)-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

038

MEDCOM - 8449

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

TEST RESULTS

CBC		SMAC	ABG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐
WBC			SUP O2	PH	PO2	RESULTS	
H/H			PCO2	SAT	OTHER	(R) Hand — (L) mid shaft 5th metacarpal Fx	
PLT							
T			U/A DIP			EKG INTERPRETATION	
PTT	BHCG	ETOH	GLU	U/A MICRO			

PROVIDER HISTORY/PHYSICAL

29 y/o ♂ s/p Fire/Bullet/Trauma to (R) Hand 7 Days Ago
or per interpreter sent today for further evaluation

6: 45 w/ w/ NAD, normal
Ext: NVI, (R) TTP/ Edema/ Foreign site wound (R) Hand
(L) Elbow, (L) w/o sensation.

(A/P) Splinted ~~tonight~~ tomorrow to OR tomorrow.

CONSULT WITH	TIME	ACTION
ortho		ADMIT - OR MAN

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP (b)(6)-2 MAJ [redacted] (b)(6)-2
[redacted] BOARD CERTIFIED EMERGENCY PHYSICIAN

DIAGNOSIS

(R) Hand 5th metacarpal Fx.
mid shaft, comminuted.

CODES

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

[redacted] (b)(6)-4

[redacted] (b)(6)-4

[redacted] (b)(6)-4

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

CIV/FOW

MEDCOM - 8450

038

MEDICAL RECORD	**PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT** For use of this form, see AR 40-407; the proponent agency is The Office of the Surgeon General.
1. AGE: 29 HEIGHT: WEIGHT:	2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): NKDA 3. PREVIOUS SURGERY [X] NO [ ] YES (type):

4. PROPOSED SURGICAL PROCEDURE:
(R) Hand

5. ADDITIONAL INFORMATION: MEDS: Clindamycin
LAST PO: before midnight
Family

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

9. PATIENT'S IDENTIFICATION (For typed or written entries give: Name- last, first, middle; grade; date; hospital or medical facility)
[redacted] (b)(6)-4
[redacted] (b)(6)-4

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

10. OR NURSING INTERVENTIONS COMPLETED/ADDITIONAL INTEROPERATIVE INTERVENTIONS NOTED.

[redacted] (b)(6)-2 02 May 03 DATE

11. POSTOPERATIVE EVALUATION:

Alert & oriented
Breathing spontaneously
Moves extremities
SR & pal with clear
Dry & dry intact
To clear
Ø Sent to Ø Recovery

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

DATE: 02 May 03 TIME: 0931

13. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title) [redacted]

DATE: 02 May 03 TIME: 1215 (b)(6)-2

REVERSE OF DA FORM 5179, JUN 91 USAPA V1.0

MEDICAL RECORD — **INTRAOPERA[illegible] DOCUMENT**

For use of this form, see AR 40-66, the [illegible]opo[illegible] [illegible]ency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Litter BY CPT [redacted] (b)(6)-2

2. PATIENT I[illegible] [illegible]IED, RECORD REVIEWED AND PROCEDURE VERIFIED BY [redacted] MAJ AN

3. DATE 02 May 03 TIME PATIENT ARRIVED IN SUITE

4. PATIEN[illegible] TIME [redacted] (b)(6)-2 NUMBER 2-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: NKDA
Eggplant.

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*
Pt in proper body alignment. Arm left arm on arm board @ 90°. Right arm on two arm boards together as a head table. Cushion between tourniquet & skin.

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

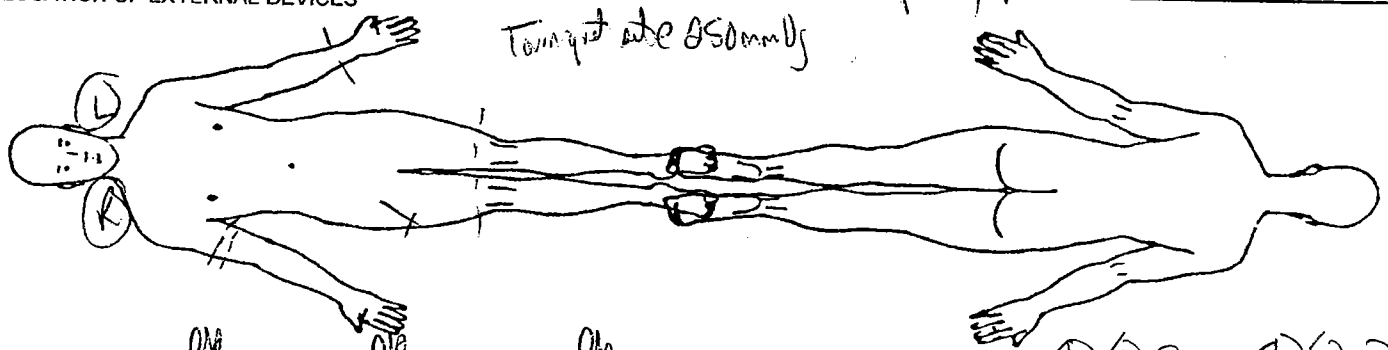
COMMENTS: (b)(6)-2

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* [redacted] Scrub/Paint
SITE: Right Arm BY WHOM: CPT [redacted]
SITE: BY WHOM:
COMMENTS: No paint noted (b)(6)-2

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

Initial counts SPC [redacted] CPT [redacted]

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No	/			(b)(6)-2	
Needle Sharp	☒ Yes ☐ No		C	C		
Instrument	☐ Yes ☒ No		/	/	SPC [redacted]	CPT [redacted] (b)(6)-2
Other	☐ Yes ☒ No					

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*
[redacted] (b)(6)-4
(b)(6)-4

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

☒ ESU NO: 4
GROUND PAD: BRAND Valleylab
LOT NO: H9408

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY
Ø		

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

15. X-RAY IN OPERATING ROOM [redacted] IF YES, SITE
YES ☐ NO [redacted]

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☐ NO ☑

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

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

19. ADDITIONAL INFORMATION
WC III
Surgeons: [redacted] (b)(6)-2 Anesthesia: MDS [redacted], CRNA (b)(6)-2 Anesthesia Type: General

Bovie Pad site intact pre-op clear; post-op intact clear Bovie Settings: Coag/Cut 20/20
Tourniquet Site intact pre-op clear : post-op clear, intact
Tourniquet Time: Up 1138 Down 1159 31 min total

20. OPERATION(S) PERFORMED
I&D Right Hand

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICW	1261	Litter

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

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

MEDICAL RECORD — **INTRAOPERA[illegible]CUMENT**

For use of this form, see AR 40-66, the propo[illegible]ency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA LITTER BY ANESTHESIA

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY [redacted] (b)(6)-2

3. DATE 4 May 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME 14 NUMBER 2-1 #4

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: none. Apnea. ϕ implant.

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS (Specify) Pt placed in OR bed. Arms on arm boards <90° strapped. Stand above knees. warm cover used.

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

COMMENTS:

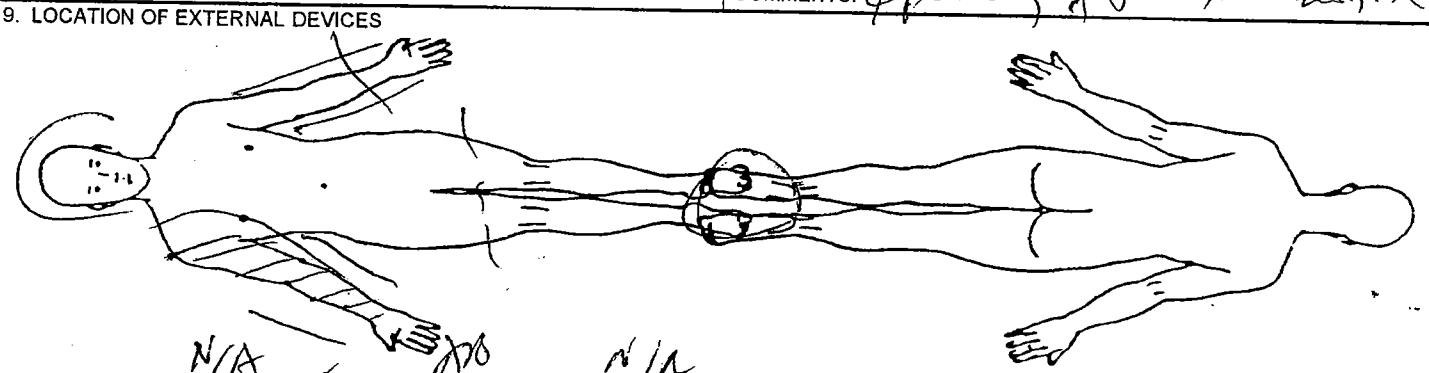
8. SKIN PREPARATION

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

PREP SOLUTION (Specify) BETA / BETA (b)(6)-2
SITE: Right Arm BY WHOM:
SITE: BY WHOM: [redacted]

COMMENTS: ϕ pooling of solution noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad (N/A) -- Safety Strap (ϕ) === Tourniquet (N/A)

10. COUNTS

C = Correct I = Incorrect

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

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

(b)(6)-4

[redacted]

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

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

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

☐ BIPOLAR NO: _____

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):
NS

OTHER ORDERS	TIME	CARRIED OUT BY

(b)(6)-2

PHYSICIAN'S SIGNATURE [redacted]

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

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

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

19. ADDITIONAL INFORMATION
WC
Surgeons: [redacted] Anesthesia: [redacted] Anesthesia Type: General

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

Bovie Pad site intact pre-op X ; post-op X Bovie Settings: Coag/Cut
Tourniquet Site intact pre-op X : post-op X
Tourniquet Time: Up X Down X

20. OPERATION(S) PERFORMED
I & D (R) wrist

21. PATIENT TRANSFERRED TO ICU TIME 1540 METHOD Litter

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

REVERSE OF DA F(5179-1, OCT 87 USAPA V1.01

MEDICAL RECORD | **INTRAOPE[redacted] DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: [redacted] BY LTC [redacted]

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY CPT [redacted] (b)(6)-2

3. DATE (b)(6)-2 [redacted] 06 May 03 TIME PATIENT ARRIVED IN SUITE (b)(6)-2 0800

4. PATIENT IN ROOM TIME 0800 NUMBER 2-2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] (b)(6)-2	RELIEF SCRUB	(b)(6)-2
ASSIGNED CIRCULATOR	CPT [redacted] (b)(6)-2	RELIEF CIRCULATOR	MAJ [redacted] (1120)-(1220)

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: Double armboard to (R) arm, padded

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

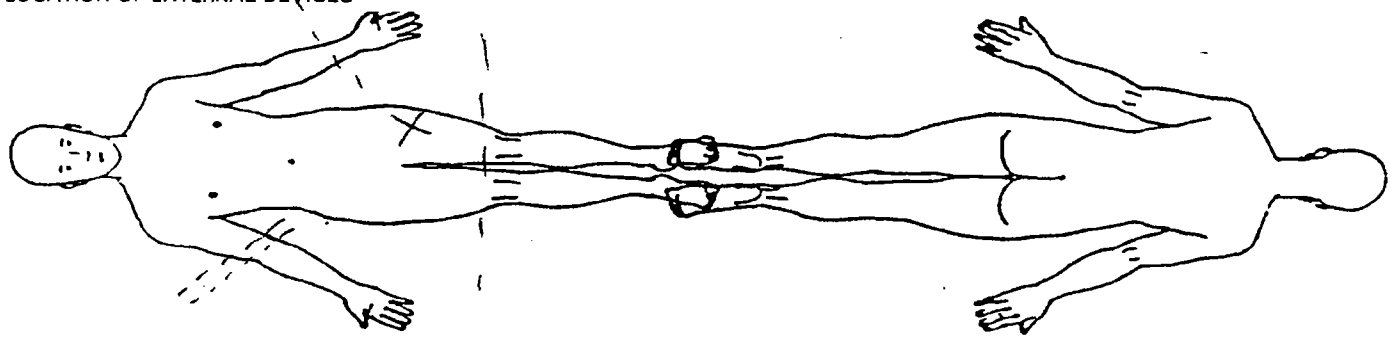
PREP SOLUTION *(Specify)* Betadine/Betadine

SITE: (R) hand/arm BY WHOM: CPT [redacted]

SITE: Bicep to hand BY WHOM: (b)(6)-2

COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

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

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

EPW # [redacted]

(b)(6)-4

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

☒ ESU NO: 3

GROUND PAD: BRAND 3M

LOT NO: 4165 Exp 10/2005

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

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

Synthes Mini-Frag set: Plate 243.15 #5-hole 1.5 mm screw 200.007 x 1
2.0 mm screws 200.010 x 2
200.014 x 2 .012 x 3

14. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

0.9% NACL

OTHER ORDERS	TIME	CARRIED OUT BY

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

15. X-RAY IN OPERATI[redacted] IF YES, SITE
YES ☑ NO ☐ Rt. hand

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*

fluffs, kerlix, ace
webril 4x15" plaster splint

19. ADDITIONAL INFORMATION

Surgeon: [redacted] (b)(6)-2 Anesthesia Lt [redacted] CRNA (b)(6)-2
Maj. (Dr.) [redacted], M.D. (b)(6)-2

Surg. Start 0920 End 1255

Tourniquet ↑ 0921 ↓ 1140 Bovie 20/20 & 15/15 @ 0930

20. OPERATION(S) PERFORMED

1) Flexor/Ext Tendon Repair @ Hand
2) ORIF 5th Metacarpal

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

22. REGISTERED NURSE SIGNATURE [redacted] -LAN / [redacted] MAN AR[redacted]

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

(b)(6)-2

MEDCOM - 8458

511-119

NSN 7540-00-634

MEDICAL RECORD

VITAL SIGNS RECORD

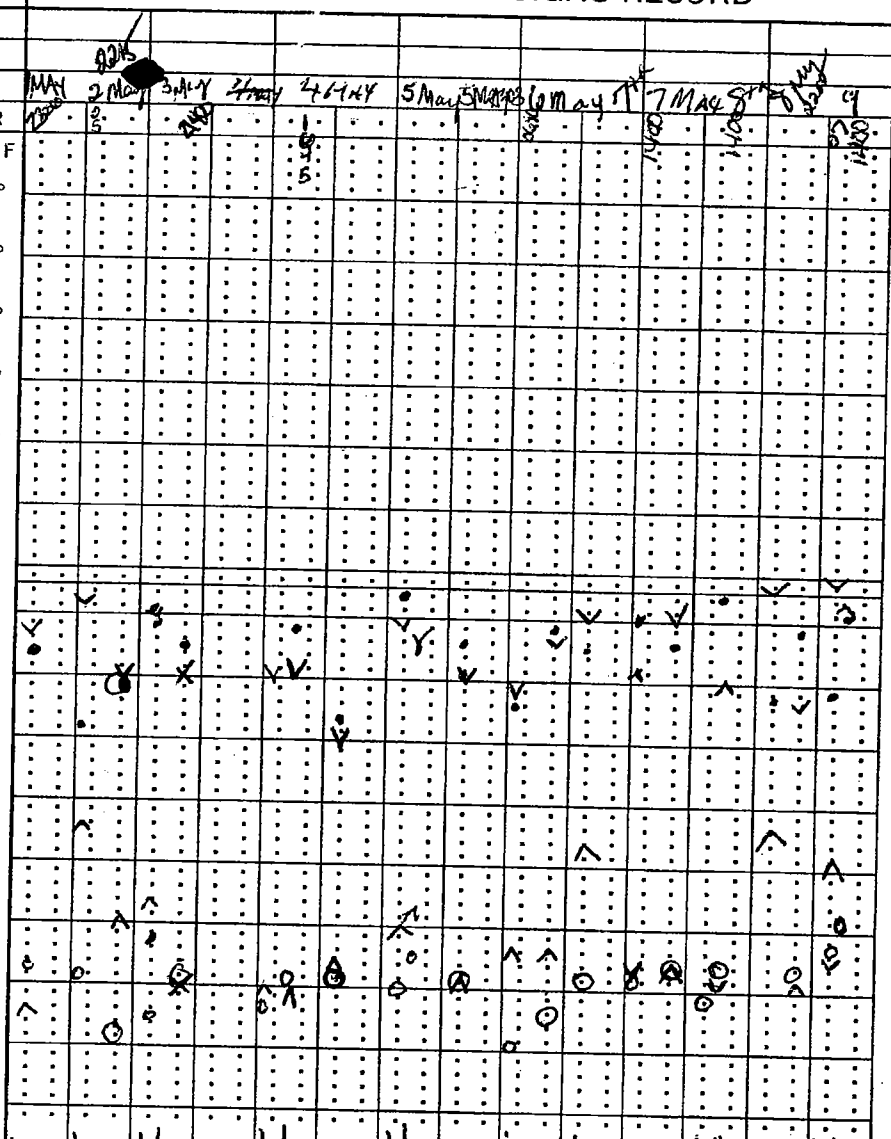
HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY | HOUR

PULSE (O) | TEMP. F (•)

TEMP. C (Centigrade Equivalents, for Reference only)



RESPIRATION RECORD

BLOOD PRESSURE

SPO2

HEIGHT: | WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO. ICW2

[redacted] (b)(6)-4

VITAL SIGNS RECORDS

Medical Record

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

[redacted] (b)(6)-4

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST-OP DAY

MONTH-YEAR

DAY

HOUR

PULSE (0)

TEMP. F (°)

TEMP. C

(Centigrade Equivalents, for Reference only)

PULSE (0)	TEMP. F (°)	TEMP. C
	105°	40.6°
		40.0°
180	104°	
		39.4°
170	103°	
		38.9°
160	102°	
		38.3°
150	101°	
		37.8°
140	100°	
		37.2°
	99°	37.0°
130	98.6°	
		36.7°
120	98°	
		36.1°
110	97°	
		35.6°
100	96°	
		35.0°
90	95°	
80		
70		
60		
50		
40		

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT:

WEIGHT →

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

REGISTER NO.

WARD NO. ICW2

STANDARD FORM 511 (REV. 7-95)

[redacted] (b)(6)-4

— 1.5x4 /mg given to on ICU2

NKDA
TOBACCO

MEDICAL RECORD — ANESTHESIA

DRUG	(Units)	
Midazolam (mg)		<3>
Fentanyl (mcg)		50 - 50 <100> 50
Lidocaine (mg)		50
Propofol (mg)		200
Sux (Q)		100
MgSO4 (mg)		
VOLAT AGENT	Sevo % fiel	2.0 2.2 2.2 2.2 1.5 X
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	10 2 2 2

CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML, "I"=CONSTANT INFUSION

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

TOTALS	
3	
250	MIN
50	
200	
100	
3	Ø

TOTAL URINE: Ø

FLUIDS – SUMMARY
CRYSTALLOID– 700
COLLOID– Ø
BLOOD– Ø

LINE site 18(r)(L)A ☒ Warmed ☐ Warmed ☐ Warmed ☐ Warmed

LOSSES: EST BLOOD LOSS; URINE –

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 65 KG LB

HEMATOCRIT: —

INITIAL DATA: BP – 120/74; HR – 55

SEMP CHECK: OK? – Y N

PATIENT READINESS: OK for PROCEDURE? TIME – 1400

TIME → 1430 . 1500 . 30 . 1600

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

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

VT – ml	500	200	100	350	400	500
f – breaths/min	—	5	25	10	8	—
Peak inf pres / PEEP	22	—	—	—	—	—
MODE – S(pon), A(ssist), C(on)	S-C	S/A	S	S	S	S
✓ BP/Auto Cuff / ET CO2 (torr)		40	45	44	50	
✓ BP / oth / FIO2 (Frac or %)	0.77	0.77	0.76	0.76	0.76	
✓ ART line / SpO2 (%)	100	97	98	99	97	
✓ Steth- PC/ES / ECG	SR	SR	SR	SR	SR	
Gas analyzer / TEMP- site	AJ	→	→	→		
N-M Block (T/4)	BS	+	—	+	—	
✓ Warming blkt	Blanket	→	→	→	—	
Conv warmer						

Mark with letters & symbols, explain under REMARKS

EVENTS ① ② ③ ④ ⑤

Position → ③ on turned 45°

REMARKS – Code drugs with numbers, events with letters

① Pre-op ROS. Comm questions answered.
② Room, monitors, 100% O_2
③ Induced, see airway management
④ Awake, auditory OP; responsive. Extubated & complete
⑤ To ICU-2 for recovery. Report to A.N.

RECOVERY AT 1540
PACU (ICU) 2 (Specify)
OTHER Recovery
CONDITION: Stable; awake
T – 96.5
RESP – 12 SpO2 – 96
BP – 123/66 HR – 101

ANESTHESIA & PROCEDURE TIMES

	Start	Room	End
ANES	1415	1430	1545
	Ready	Begin	End
PROC	1445	1510	1525

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

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: OLx1 MAC 3 Grade 1 view; Teeth NOT touched; 8.0 Styletted ETT 22cm @ teeth; 8mL air cuff; stylette out; + BBS; sust ETCO2

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

[redacted] (b)(6)-4

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

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

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

PROCEDURE LOCATION 1

DATE 4 May 03

PAGE 1 OF 1

CPT [redacted] AL RECORD – ANESTHESIA

WAMC OP 376 REVISED 1 Jan 99

PATIENT RECORD

MEDCOM - 8461

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

MEDICAL RECORD ANESTHESIA

DRUG	(Units)
Versed	( )
Fentanyl	( )
propofol	( )
	( )
	( )
	( )
VOLAT AGENT	Forane % del
	% e.t.
AIR	L/Min
N2O	L/Min
O2	L/Min

CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML. "I"=CONSTANT INFUSION

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

TIME	0815	0830	0900	30	1000	30	1100
Versed	3	1	1	45	6900	30	1000 30
Fentanyl	50	50	50				
propofol		20	20	X	25		25
					1.0	1.5	
Forane % del					1.0	1.5	1.5 1.5 1.0 1.0 1.0 1.0
% e.t.							
AIR L/Min							
N2O L/Min							
O2 L/Min							
SINGLE DOSE DRUGS	4	4	2	2	2	2	2 2 2 2

LINE site UR	
Warmed	
Warmed	
Warmed	
Warmed	

LOSSES	
EST BLOOD LOSS	
URINE –	

TOTALS	
5mg	
250mg	
TOTAL	75
TOTAL URINE	0

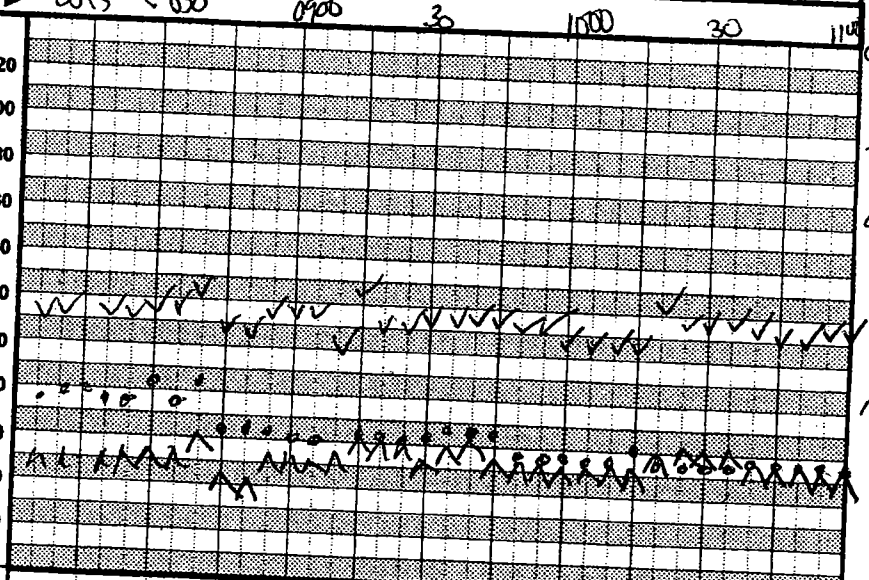
FLUIDS – PRIMARY	
CRYSTALLOID	1600
COLLOID –	
BLOOD –	

REMARKS – Code drugs with numbers, events with letters

PT FROM Chart Placed
0800 to Room Monitor
0820 AX Block
0920 AX Block
Not working to
middle finger.
– 0920 induced
LMA # 4 Insertion
0921 TQ Applied 75 mm Hg
1021 TQ 60 min
Surgeon notified
1051 90 min TQ
Surgeon notified
1151 120 min TQ
Surgeon notified.

PHYS STATUS	
1 2 3 4 5 E	
BODY WEIGHT	65 KG LB
HEMATOCRIT	—
INITIAL DATA	BP – 112/55
	HR – 60
SCRUB CHECK	OK? – Y N
PATIENT RECOVERY	OK for PROCEDURE? Y
	TIME – 0730

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



VT – ml											
f – breaths/min					17	14	15	19	17	18	16	12
Peak inf pres / PEEP											
MODE – S(pon), A(ssist), C(on)	SV	SV	SV	SV	SV	SV	SV	SV	SV	SV	SV	SV
BP/Auto Cuff / ET CO2 (torr)					36	38	35	36	39	34	34	37
BP / oth / FIO2 (Frac or %)	.21	.21	.21	.21	.21	.86	.86	.86	.86	.86	.86	.86
ART line / SpO2 (%)	98	98	98	100	100	100	100	100	100	100	100	100
Steth – PC/ES / ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR
Gas analyzer / TEMP – site	Available											
N-M Block (T/4)												
Warming blkt												
Conv warmer												

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

RECOVERY AT 1300	
PACU ICU ____ (Specify)	
OTHER ____	
CONDITION:	
RESP – 21	SpO2 – 100% on Ne
BP – 117/55	HR – 69 T 94.4

ANESTHESIA PROCEDURE TIMES			
ANES	Start	Room	End
	0745	0800	1305
PROC	Ready	Begin	End
	0850	0920	1259

PROCEDURES and CPT Codes: ORIF 5th Metacarpal Fx / Flexor tendon Repair Right hand

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: Right AX prepped, transarterial cutaneous located. Thru 0% lidocaine, .5% Marcaine c 1:200,000 epi 50cc all after 40cc – Tel Corcobrachialis + Ring block

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: Natural; NC 0920 #4 LMA Inserted BBS = Stridor x 6 ventilated

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

[redacted] (b)(6)-4

(b)(6)-4

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

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

PROCEDURE LOCATION: OR2

DATE: 6 Mar 03

PAGE 1 OF 2

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED 1 Jan 99

PATIENT RECORD

MEDCOM - 8462

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

MEDICAL RECORD – ANESTHESIA

DRUG	(Units)	1100	30	1200	30	1300
Fentanyl	( )	25		25		
	( )					
	( )					
	( )					
	( )					
	( )					
VOLAT AGENT	Forane % del	1.0	1.0	1.0	1.0	0.8 .7 .6
	% e.t.					
AIR	L/Min					
N2O	L/Min					
O2	L/Min	2	2	2	2	2 2 2 6

CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML, "I" = CONSTANT INFUSION

ANESTHETIC AGENTS AND DRUGS

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

FLUIDS: LINE site LR ☐ Warmed 1000 ☐ Warmed ☐ Warmed ☐ Warmed 1200 (2)

LOSSES: EST BLOOD LOSS; URINE –

TOTALS: TOTAL FLUID; TOTAL URINE

FLUIDS – SUMMARY: CRYSTALLOID–; COLLOID–; BLOOD–

REMARKS – Code drugs with numbers, events with letters

Page 2 of 2
1141 TQ & TTQ = 135mm
1250
SP ventilate awake
LMA - Removed
1300 TO PACU
ICU 2
for recovery

PHYS. STATUS: 1 2 3 4 5 E

BODY WEIGHT: KG / LB

HEMATOCRIT:

INITIAL DATA: BP – / ; HR–

EQUIP CHECK: OK?– Y N

PATIENT RECHECK: OK for PROCEDURE? TIME–

TIME ▶ 1100 30 1200 30 1300

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

220 200 180 160 140 120 100 80 60 40 20

		1100	30	1200	30	1300
VT – ml						
f – breaths/min		14	17	13	12	12 12 10
Peak inf pres / PEEP						
MODE– S(pon), A(ssist), C(on)		SV	SV	SV	SV	SV SV SV
BP/Auto Cuff	ET CO2 (torr)	35	37	35	33	32 35 35
BP / oth	FIO2 (Frac or %)	.84	.84	.84	.84	.84 .84 .84
ART line	SpO2 (%)	100	100	100	100	100 100 100
Steth- PC/ES	ECG	SR	SR	SR	SB	SB SB SB
Gas analyzer	TEMP- site	Available				
	N-M Block (T/4)					
Warming blkt						
Conv warmer						

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

RECOVERY AT: PACU ICU _____ (Specify) OTHER _____

CONDITION: RESP– SpO2– BP– HR–

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES			
PROC	Ready	Begin	End

PROCEDURES and CPT Codes: Flex. Ext Repair Right hand

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

AIRWAY MANAGEMENT: Intubation/Induction, Mode, technique, comments

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

[redacted] (b)(6)-4

(b)(6)-4 [redacted]

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

(b)(6)-2

PROCEDURE LOCATION: 2

DATE: 6 May 03

PAGE 2 OF 2

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED 1 Jan 99

PATIENT RECORD

MEDCOM - 8463

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

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

Age 24 DAYS MOS YRS Sex (X) MALE ( ) FEMALE

PROPOSED PROCEDURE: (R) Arm I&D and washout
SURGICAL SERVICE: ortho
NPO SINCE:

ASA Physical State (4) 2 3 4 5 E
WT: 65 (KG)/LB HT: 175 CM/IN.
ALLERGIES: NKDA

HABITS:
TOBACCO:
ETOH:
DRUGS: Ø

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) Clinda 900mg
( )
( )
( )
( )
( )

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

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

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

ASSESSMENT
PAST SURGICAL/ANESTHETIC

PHYSICAL EXAMINATION
BP 129/74 HR 55 R 14 T 98.1
Pain Scale 0-10
HEENT - Teeth chipped (L) front
Trachea midline
TMJ/Neck FROM
Oropharnyx MPI
Nares
CHEST: CTA
CARDIAC: S.S2
EXTREMITIES: Cast to (R) lower arm
IV Access: #18g (L) Arm
Ulnar Filling:
BACK:
OTHER:

NPO Since Last night

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

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

The patient/legal guardian seems to understand and agrees. Questions answered.
Signed: ____ Date: ____ Time: ____ Hrs

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

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward)

[redacted] (b)(6)-4

[redacted] (b)(6)-4

MAJ [redacted] AN, CRNA
Nurse Anesthetist (b)(6)-2

SEDATION KEY:

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

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

Age ___ DAYS MOS YRS Sex ( ) MALE ( ) FEMALE

PROPOSED PROCEDURE: I & D Right hand
SURGICAL SERVICE: ORTHO
NPO SINCE: ___

ASA Physical State 1 (2) 3 4 5 E
WT: 65 (KG/LB HT: ___ IN.
ALLERGIES: NKDA

HABITS:
TOBACCO: ___
ETOH: ___
DRUGS: ___

CURRENT MEDICATIONS:
( ) = ordered as premed

(Keflex q 6 h
( ) ___
( ) ___
( ) ___
( ) ___
( ) ___

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

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

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

ASSESSMENT
PAST SURGICAL/ANESTHETIC
___

PHYSICAL EXAMINATION
BP ___ HR ___ R ___ T ___
Pain Scale 0-10 ___ MI
HEENT - Teeth Chipped Rt Front tooth
Trachea 3.5
TMJ/Neck ___
Oropharnyx ___
Nares ___
CHEST: ~~RRR~~ Clear
CARDIAC: RRR
EXTREMITIES: Bandage Rt hand
IV Access: ___
Ulnar Filling: ___
BACK: ___
OTHER: ___

NPO Since 2400

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

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

The patient/legal guardian seems to understand and agrees. Questions answered.

Signed: (b)(6)-2 [redacted] LTC Clem Date: 6 May 03 Time: ___ Hrs

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

Signed: ___ Date: ___ Time: ___ Hrs

SEDATION KEY:

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

Patient Identification: (Ward) ___

[redacted] (b)(6)-4

[redacted] (b)(6)-4

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

Previous edition is obsolete
☆ U.S. GPO: 2002-729-283

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

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

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER 5/1/03 TIME OF ORDER 2200 HOURS

LIST TIME ORDER NOTED AND SIGN

- Admit ICW ✓
- GSW @ HANDS ✓
- Stable ✓
- Routine Vitals ✓
- Bedrest ✓
- Regular Diet ✓
- IVF - LR @ 100 cc/hr

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

NURSING UNIT	ROOM NO.	BED NO.
chest ✓ done	[redacted]	0330 2 May 03

DATE OF ORDER 5/1/03 TIME OF ORDER 2150 HOURS

- Chemotherapy on 900 mg IV q 8° ✓
- Demerol 50 mg IV q 4 PRN pain
- To OR in AM

[redacted] (b)(6)-2

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

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER 5/2/03 (b)(6)-2 TIME OF ORDER 1300 HOURS

- Up Ad lib
- Stable
- Routine vitals
- Regular Diet
- Hydrate IV
- Chemotherapy 900 mg IV q 8°
- T#3 tab q 4° PRN pain

(b)(6)-2 [redacted]

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER HOURS

- Demerol 50-75 mg IV q 4 PRN pain

[redacted] (b)(6)-2

NURSING UNIT	ROOM NO.	BED NO.
24° chest ✓ done	[redacted]	(b)(6)-2

03 May 03 0255

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

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

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 5/3/03 TIME OF ORDER 2100 HOURS

- NPO PMN

[redacted] (b)(6)-2

24° VS GBWM ICTAN. 5/3/03 0300

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 5/4/03 TIME OF ORDER 1130 HOURS

- Bathe pt
- Up ad lib
- Routine V. tals
- D/c Chlorpromazine
- Heplock IV
- Regular Diet
- T#3 tab q4° PRN

PATIENT IDENTIFICATION

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

24° VS [redacted] ICTAN 5/4/03 0100

b6-2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

- Demerol 50 mg IM q4° PRN breakthrough
- Keflex 500 mg QID
- X-R - 3V (R) HAND

[redacted] (b)(6)-2

5/5/03 1830

NPO PMN

[redacted] (b)(6)-2

24° VS [redacted] ICTAN 5/5/03 0045

PATIENT IDENTIFICATION (b)(6)-2

EPW (b)(6)-4

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

ICW2 | 1 |

DATE OF ORDER 5/6/03 TIME OF ORDER 1300 HOURS

- Up ad lib
- Stable - Routine V. tals
- Heplock IV
- Amoxil 1gm IVPB q8°
- T#3 tab q4° PRN pain
- Demerol 50 mg IM q4° PRN breakthrough
- Regular Diet

[redacted] (b)(6)-2

[redacted] (b)(6)-2

[redacted] (b)(6)-2

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION			↓	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
[redacted] (b)(6)-4				6 May 03	1510 HOURS	
				Keflex D/C PRN		
				per Dr. [redacted]		(b)(6)-2
						(b)(6)-2
NURSING UNIT	ROOM NO.	BED NO.				
ICW2	T	1				

PATIENT IDENTIFICATION			↓	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
Noted [redacted] 7 May 03				5/6/03	1700 HOURS	Verified
SPC Salwine 0230				D/C when transport available		[redacted] (b)(6)-2
				(b)(6)-2 [redacted]		7 May 03
NURSING UNIT	ROOM NO.	BED NO.				
24° ✓ done	[redacted]			7 May 03 0300		

PATIENT IDENTIFICATION			↓	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
(b)(6)-2					HOURS	
NURSING UNIT	ROOM NO.	BED NO.				

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

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

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. May Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 1	2	3	4	5	6	7	8	9	10
5/1/03	[redacted]	Routine vitals.	05	X	X								
		(b)(6)-2	13	X									
			21	[redacted]									
							(b)(6)-2						
5/1/03	[redacted]	Bedrest (b)(6)-2	05	X	[redacted]								
			13	X									
			21	[redacted]									
5/1/03	[redacted]	Reg Diet now/NPOP	7	X									
		MN, (b)(6)-2	11	X			D/C						
			17	X		(b)(6)-2							
1 May 03	[redacted]	DIET: NPO (b)(6)-2	06	X	[redacted]								
			11	X									
			18	X									
			7										
2 May	[redacted]	Up ad lib (b)(6)-2	07	/	/	[redacted]							
		(cont 4 May 03)	15	/	[redacted]								
6 May	[redacted]	(b)(6)-2	23	/	[redacted]								
				/									
2 May	[redacted]	vitals QS (b)(6)-2	06	/	/	[redacted]							
6 May	[redacted]	(cont 4 May 03) (b)(6)-2	14	/	[redacted]								
			22	/	[redacted]								
2 May	[redacted]	DIET: Regular (b)(6)-2	06	/	/	[redacted]	X		X				
		(cont. 4 May 03)	11	/	/	[redacted]	X						
6 May	[redacted]	(b)(6)-2	17	/	/	[redacted]							

All (b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW @ hand

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION: [redacted] (b)(6)-4 (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 5 Yr 2003

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
5/1	[redacted]	Admit ICW ; stable	5/1	2250	2250	[redacted]
5/1	[redacted]	To OR in AM	5/2	AM	Done	[redacted]
5/3	[redacted]	NPO p MN	5/3	AM	Done	[redacted]
5/4	[redacted]	Bathe PE	5/4	1600	Done	
5/4	[redacted]	XR - 3 V (R) Hand	5/4	1700		[redacted]
5/5	[redacted]	NPO p MN	5/5	2359	—	[redacted]
5/6	[redacted]	Discharge when transportation is available	ASAP			

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 1	2	3	4	5	6	7	8	9	10
5/1/03	[redacted]	IVF - LR @ 100cc/hr	05	X	[redacted]								
		(b)(6)-2	13	X									
			21	[redacted]									
		(b)(6)-2											
5/1/03	[redacted]	Clindamycin 900mg	08	X	[redacted]								
2may03	[redacted]	IV Q 8°	16	X	[redacted]								
		(b)(6)-2	24	[redacted]									
		(b)(6)-2											
2may03	[redacted]	HL IV	07	/	/	[redacted]							
		(cont 4MAY03)	15	/	[redacted]								
6may	[redacted]	(b)(6)-2	22	/	[redacted]								
4May03	[redacted]	Keflex 500mg QID	06	/	/	/	/	[redacted]					
		(b)(6)-2	12	/	/	/	/	[redacted]					
			18	/	/	/	[redacted]						
			24	/	/	/	[redacted]						
		(b)(6)-2											
6may	[redacted]	ancef 1gm IVPB	08					/	[redacted]				
		98°	16				/	[redacted]					
			24			/	/	[redacted]					

DC'd 2may03 — (b)(6)-2

DC'd 4May03

DC'd 6may03 5 10

(b)(6)-2

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW (R) hand.

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

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

[redacted] (b)(6)-4 Civ Erw

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*				Mo._____ Yr. _____
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED												
5/1/03 5/4/03	[redacted]	Demerol 50mg													
- - - -	(b)(6)-2	IVP Q 4° PRN.													
- - - -	(b)(6)-2	pain													
2 May - 3 May	[redacted]	demerol 50-75mg	2 May 1315												
- - - -	- - -	IVP q6° prn	[redacted]	(b)(6)-2											
- - - -	(b)(6)-2	pain													
2 May - 3 May	[redacted]	#3 ii q4°	2 May 1400 ii [redacted]	2 May 2225 ii [redacted]	3 May 1300 ii [redacted]	3 May 2300 i [redacted]	4 May 2315 [redacted]	5 May 05 1430 ii [redacted]	6 May 1400 ii [redacted]	6 May 2230 i [redacted]	7 May 0420 ii [redacted]	7 May 0900 ii [redacted]	7 May 1600 ii po [redacted]		
- - - -	(b)(6)-2	prn pain													
Cont.	[redacted]	(cont. 4 May 03)													
4 May	[redacted]	Demerol 50mg IM	6 May [redacted] 50mg 1430	7 May [redacted] 50mg 0230	(b)(6)-2			(b)(6)-2							
- - - -	(b)(6)-2	Q4° PRN breakthrough													
6 May	[redacted]	pain - IV													
- - - -	(b)(6)-2	Demerol 50mg IV morphine													

See below

Rewritten following page

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

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: GSW (R) hand S/P I&D & tendon repair

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

Verify by Initialing	THER. TIC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo._____ Yr. _____

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
8 11	[redacted]	Demerol 50mg IVP														
- - - -	(b)(6)	2 q2° prn breakthrough														
8 11	[redacted]	Tylenol #3 ii po q4°														
- - - -	(b)(6)	2 prn - pain														
- - - -	- - - - -															
- - - -	- - - - -															
- - - -	- - - - -															
- - - -	- - - - -															
- - - -	- - - - -															
- - - -	- - - - -															
- - - -	- - - - -															
- - - -	- - - - -															
- - - -	- - - - -															
- - - -	- - - - -															

USAPA V1.00

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*

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

Mo. ____ Yr. ____

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW (R) hand

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

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

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

All (b)(6)-2

Verify by Initialing	THERA IC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo. _____ Yr. _____

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED												
7 May	[redacted]	Demerol 50 mg IV	50mg IVP 0330	7 May 0600 50mg IV	7 May 1200 50mg IV	7 May 1600 50mg IV	7 May 2000 50mg IV	7 May 2345 50mg IV	8 May 0410 50mg IV	8 May 0815 50mg	8 May 1355 50mg				
	(b)(6)-2	q 4° PRN Breakthrough	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]				
	(b)(6)-2														
5 May 8 May	[redacted]	Tylenol #3 ½ tab Q4°	7 May 2300 ½ tab 0000	7 May 4 tab 0400	8 May 4 tab 0400	8 May 4 tab 1100	8 May 2 tab 1445	8 May 0330 1 tab	8 May 1200 1 tab	8 May 1700 PO 1 tab	10 May 0100	10 May 0520			
		PRN Pain	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]				
	(b)(6)-2														
8 May	[redacted]	Demerol 50mg IV q 4° prn Breakthrough	8 May 50mg 2030	8 May 50mg 0030	9 May 50mg	9 May 2115 50mg IVP									
			[redacted]	[redacted]	[redacted]	[redacted]									

USAPA V1.00

AL RECORD-SUPPLEMENTAL MED ;A

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

REPORT TITLE

PRE-ANESTHETIC EVALUATION

The proponent is Dept of Surgery

OTSG APPROVED (Date) QI Appr 11 Dec 96

DATE OF PROPOSED SURGERY	AGE	WEIGHT	ALLERGIES (List react)	FAMILY HISTORY	Tob HX-	CONSULTATIONS (Check when completed)
2 May 03	7.20	70?	☐ NKDA	☐ NO ANES PROB	EtOH-	☐ 1
PROPOSED SURGERY	SEX	HEIGHT		?	DRUGS	☐ 2
I+D (R) hand	M					☐ 3

PREVIOUS ANESTHESIA/SURGERY ☐ NO PROBLEM

I+D (R) hand.

MEDICATIONS ☐ NONE * = ORDERED AS PRE-MED

Clindamycin 900 IV Q 8h

93% RA

1. CARDIOVASCULAR
- ☐ No Pathology
- ☐ Angina
- ☐ MI
- ☐ Hypertension
- ☐ Low Exercise Tol
- ☐ Arrhythmia
- ☐ CHF
- ☐ Valvular Disease
- ☐ CABG
- ☐ Periph Vasc Dis
- ☐ Other

2. RESPIRATORY
- ☐ No Pathology
- ☐ Asthma
- ☐ COPD
- ☐ URI
- ☐ Other

3. RENAL
- ☐ No Pathology
- ☐ CRF/Renal Insufficiency
- ☐ Other

4. HEPATIC
- ☐ No Pathology
- ☐ Hepatitis
- ☐ Cirrhosis
- ☐ Other

5. GI
- ☐ No Pathology
- ☐ Reflux
- ☐ Hiatal Hernia
- ☐ Other

6. NEURO
- ☐ No Pathology
- ☐ CVA
- ☐ Neuropathy
- ☐ Seizures
- ☐ Other

7. ENDOCRINE
- ☐ No Pathology
- ☐ Insulin-Dep Diabetes
- ☐ Non-Insulin-Dep Diabetes
- ☐ Thyroid
- ☐ Steroids
- ☐ Other

8. HEMATOLOGIC
- ☐ No Pathology
- ☐ Anemia
- ☐ Coagulopathy
- ☐ Sickle Cell Dis
- ☐ Hx Transfusion
- ☐ Other

9. MUSC-SKELETAL
- ☐ No Pathology
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ TMJ Disease
- ☐ Other

10. OB/GYN
- ☐ Non-Preg
- ☐ Preg
- ☐ EGA

G P

- ☐ Preeclampsia
- ☐ Other

11. PEDIATRIC
- ☐ Normal Growth Dev
- ☐ < 48 wks PCA
- ☐ Congenital Defects
- ☐ Cerebral Palsy
- ☐ Other

- ☐ DENTURES
- ☐ CONTACTS
- ☐ PROSTHESIS

NOTES
- ☐ See Anesthesia Consult for more details.
- ☐ Other Medical Conditions (List)

PHYSICAL EXAM: HR 100 BP 116/56 T RR 16

AIRWAY: MP 1 2 3 4

Teeth Chipped 7 & front

ROM

TMD (FB) <2 2 1/3 >3

HEART:

LUNGS: ☐ CTAB

NEURO/BACK:

BLOCK SITE:

VASC ASSESS:

EXT/OTHER:

Na	Cl	glu	ECG ☐ WNL
K	CO_2	BUN/Cr	
WBC	Hct	plts	
PT	PTT	βHCG	CXR ☐ WNL
ABG			

PFT

OTHER

PROBLEM LIST

(b)(6)-2 [redacted]

NPO x [illegible]

ASA 1 2 3 4 5 E

☐ Counselled to remain NPO

PLAN

____ General ____ MAC

____ Regional: ____

____ Block: ____

☐ Post Op ICU/Vent ☐ Awake Intubation

☐ Art Line ☐ CVP ☐ PA

☐ Special Techniques

PREMED: EPW/POW

Does not speak English

PATIENT'S CONSENT

☐ All plans, risks, options discussed and understood. All questions answered. Final plan subject to change by the assigned anesthesia team.

PATIENT'S SIGNATURE: ____

(Continue on reverse)

PREPARED BY (Signature & Title)

(b)(6)-2 [redacted] MAJ, CRNA

DEPARTMENT/SERVICE/CLINIC REVIEWED BY:

DATE 2 May 03

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

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

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☒ OTHER (Specify) Suppl SF 517

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700 PREVIOUS EDITION IS OBSOLETE

For use o... ...ml, see AR 40-66; the proponent agency is the O...

DRUG (Units)	1100					TOTALS	TOTAL EBL
VERSED (mg)	3					3mg	min
MSO4 (mg)	2			3		5mg	
propofol (mg)	150		50				TOTAL URINE
Fentanyl (mg)	2						0
Sux (mg)	70						
( )							

SPECIFY UNITS - MG/MCG/ML. "I" = CONSTANT INFUSION

VOLAT AGENT Forane	% del	1.0	.5	.8	.5	.5	X
	% e.t.						
AIR	L/Min						
N2O	L/Min						
O2	L/Min	8 — 2 —	2 —	2 — 8			

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS → 1045 - Reglan 10mg 1145 2mg [illegible]

FLUIDS - SUMMARY
CRYSTALLOID- 1200
COLLOID- 0
BLOOD- 0

REMARKS
Code drugs with numbers, events with letters

IV site LR ☐ Warmed — LR
☐ Warmed
☐ Warmed
☐ Warmed

LOSSES: EST BLOOD LOSS
URINE -

TIME → 1100 x 30 x 1200

ASA STATUS: 2 3 4 5 E (2 circled)

BODY WEIGHT: 60? KG/LB

HEMATOCRIT:

VITAL DATA: 100, 50

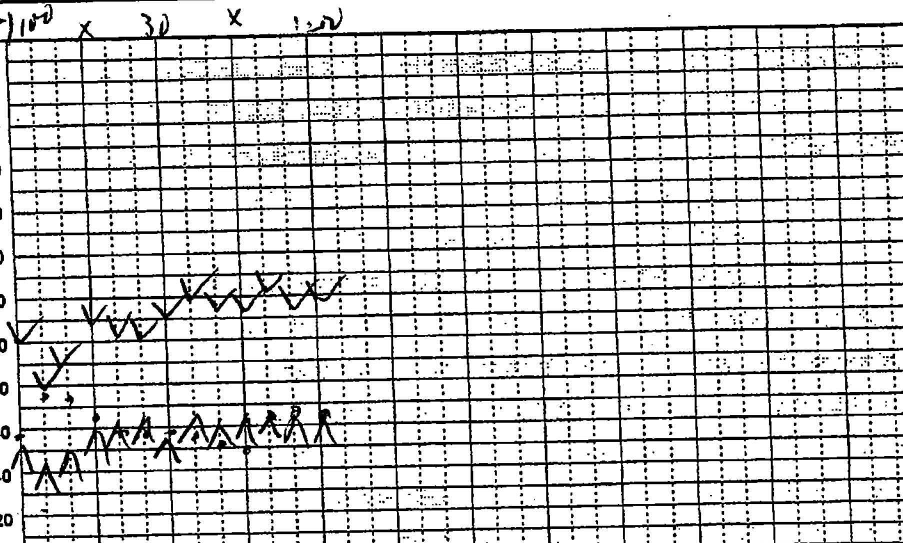
54

EQUIP CHECK: Y N (Y circled)

PATIENT ... FOR PROCEDURE: ✓

TIME: 1045

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



① Spont Resp extubated. To ICU #2

1250 ® FA
↑ 1130) 3l min
↓ 1201)
1215

VT - ml		200	220	200	250
f - breaths/min		14	16	14	16
Peak inf pres / PEEP		—	—	—	
MODE - S(pon), A(ssist), C(on)	S A	S	S	S	S
ET CO2 (torr)		43	39	40	
FIO2 (Frac or %)	.60	.60	.60	.60	
SpO2 (%)	100	99	99	100	
ECG	SB	SB	SB	SR	
TEMP-site					
N-M Block (T/4)					

BP/Auto Cuff
BP/oth
ART line
Steth- PC/ES
Gas analyzer
Warming blkt
Conv warmer

RECOVERY AT: ICU #2
PACU ICU ____ (Specify)
OTHER 1220pm
CONDITION:
RESP- SpO2-
BP- 123/65 HR- 63

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1045	1100	1225
	Ready	**Begin**	**End**
PROC	1110	1130	1210

Code events with letters & symbols, explain under REMARKS — EVENTS Position → ⓐ APPP, Arms < 90°

PROCEDURES and CPT Codes:
I+D (R) hand

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*
GETA

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*
SIVI, DVOT x1 atraumatic, cuff +, BS=BS, tube taped, Eyes taped

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

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

ANESTHETISTS: [redacted] MAJ CRNA (b)(6)-2

PROCEDURE LOCATION: OR # 2
DATE: 2 May 03
PAGE 1 OF 1

DA FORM 7389, FEB 1998 MEDCOM - 8478 COPY 1 - PATIENT'S MEDICAL RECORD USAPA V1.0

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 4 May 02
Time In: 1540
Allergies:
Pre-op V/S: 120/74 55
Procedures: I+D Splint

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

120/74
55

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

Pre Op Meds

History

smoke

65kg

VR 3
Fent 250
MSO4 3

Time	1540	1545	1550	1555	1610	1625	1640
SaO2	96	98	97	98	95	97	
FiO2	2	2	2	[illegible]	[illegible]	[illegible]	
Methods	NC	NC	NC				
240							
220							
200							
180							
160							
140							
120	^	^		^	^	^	
	•	•	^				
100			•				
				•			
80					•	•	
60							
	✓	✓	✓	✓	✓		
40						✓	
20							
RR	20	12	14	22	20	12	
T	96.5						
Time							
Pain (0-10)							
LOS							

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	2	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	2	2	2
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	12	12	12

Codes

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

V/S
X = A-line BP
˙ = Cuff BP
= Pulse

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

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

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

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

DEPARTMENT/SERVICE/CLINIC: ICU 2

(Continue on reverse)

DATE: 4 May 03

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

Name – last, (b)(6)-4

[redacted]

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

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

Previous edition is obsolete
USAPPC V2.00

11 21 09 35/01

MEDICATIONS

Allergies:

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

NEUROVASCULAR

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

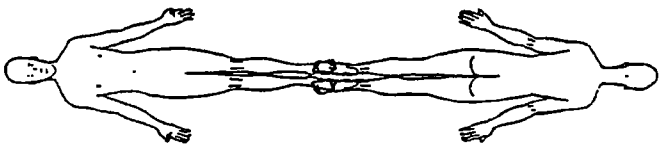
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(R) arm	Ace	Ø
30'	"	"	"
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
	NSR		

WAMC OP 173-E

NURSING NOTES

1540 Arrived to ICU2 Awake sitting up on litter talking. Respirations unlabored VSS. IVF cont. to infuse. ØN/V Ø pain

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

1625 AOX3 ØN/V Ø pain IVF cont. to infuse. Drsg CDI No respiratory distress [redacted]

(b)(6)-2

Discharge Criteria:
Date: 4 May **Time:** 1625 **PARS:** 12
BP: 105/48 **T:** **HR:** 74 **RR:** 12 **Sa02:** 97
Pain Level at D/C (0-10):
Intake: _____ **Output:** _____
Additional Data: _____
Transferred To: ICW 2
Report Given To: _____
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: Cpt [redacted] (b)(6)-2
Cleared IAW Recovery Room SOP R-3
Charge Nurse Signature: [redacted] (b)(6)-2

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

DTSG APPROVED (Date)

Date: 6 may 03
Time In: 0800 / 1300
Allergies: NKDA
Pre-op V/S: 112/60 63
Procedures: ORIF, Flex/tendon

Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 1100 Colloid Ø
OR Output: UOP Ø EBL 75
Meds/Times: Ancef 1000, versed/Fentanyl

TQ 135mins

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

Pre Op Meds

History

Time	1300	1305	1310	1315	1320	1325	1400
SaO2	100	100	100	100	98	98	100
FiO2	NC 4L	NC 4L	NC 4L	RA /	RA /	RA /	RA /
Methods							
240							
220							
200							
180							
160							
140							
120	V	Y	V	V		V	
100					V	V	
80							
60							
40							
20							
RR	10	11	18	15	14	19	11
T	94.1	94.5	95.5	96.0			
Time							
Pain (0-10)							
LOS							

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1300	LR	1000↑	(L) FA		

X-rays: Ø Labs: Ø

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	1	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	2	2	2
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	11	11	12

Codes

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

V/S
X = A-line BP
˙ = Cuff BP
= Pulse

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

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

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

(Continue on reverse)

PREPARED BY (Signature & Title): [redacted] CPT/AN (b)(6)-2

DEPARTMENT/SERVICE/CLINIC: ICU #2

DATE: 06 may 03

PAT[redacted] (For typed or written entries give: [redacted] middle; grade; date; hospital or medical facility)

Name — last, [redacted]

(b)(6)-4

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

DA FORM 4700, MAY 78

WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN)

Previous edition is obsolete

USAPPC V2.00

MEDICATIONS

Allergies: NKDA

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1330	UTA	MSO4 2mg	IV	UTA	(b)(6)-2	[redacted]
1340	UTA	Zofran 4mg	IV	UTA	(b)(6)-2	[redacted]
1400	UTA	MSO4 1mg	IV	UTA	(b)(6)-2	[redacted]
1415	UTA	MSO4 1mg	IV	UTA	(b)(6)-2	[redacted]

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	(R)UE	UTA	+	UTA	3sec	cool	pale
15'	(R)UE	UTA	+	UTA	<3sec	warm	pale
30'	(R)UE	+	+	UTA	<3sec	warm	pink
45'	(R)UE	+	+	UTA	<3sec	warm	pink
60'	(R)UE	+	+	UTA	<3sec	warm	pink
90'							
D/C							

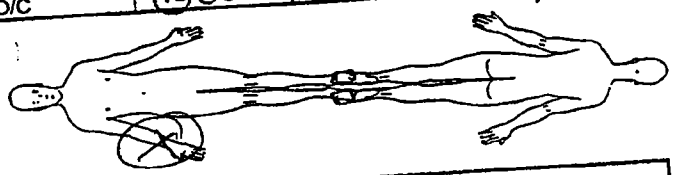
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic, P = Pale, Pk = Pink
Capillary Refill: B = Brisk, S = Sluggish

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(R)UE	ACE	Ø
30'	(R)UE	ACE	Ø
60'	(R)UE	ACE	Ø
D/C	(R)UE	ACE	Ø



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

NURSING NOTES

Patient received in ICU #2 on Litter. VSS, c/o "burning" pain to (R) UE Ø relief from MSO4, MD aware medicated c̄ 4mg Zofran pm nausea. CMS ✓ WNL. Report given [redacted] to ICU #2. [redacted] (b)(6)-2

Discharge Criteria:
Date: 6 May Time: 1415 PARS: 12
BP: 125/5 T: 96° HR: 61 RR: 12 Sa02: 100
Pain Level at D/C (0-10): UTA
Intake: 200cc Output: Ø
Additional Data:
Transferred To: ICU #2
Report Given To: [redacted] (b)(6)-2
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: [redacted] (b)(6)-2
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature: [redacted] CPT/MN
(b)(6)-2

WAMC OP 173-E

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

OTSG APPROVED *(Date)*

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

Date: 02may03
Time In: 1215
Allergies: NKDA
Pre-op V/S: 100/90 54
Procedures: I+D (R) hand

Anesthesia Type (Circle)): (General) Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 1200 Colloid Ø
OR Output: UOP Ø EBL min
Meds/Times: Regcun 1045 MS04 5mg

(R) FA
Torniq Time 31min

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

Pre Op Meds / History

Time	1215	1220	1225	1230	1300
SaO2	100	100	100	100	99
FIO2	10	30	70	70	RA/FA
Methods	SM	SM	SM	SM	

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

RR	22	20	18	16	22
T	96.1		96.3		
Time					
Pain (0-10)					
LOS					

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1215	LR	500cc/o	(L) FA		

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	2	2	
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	2	2	
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C,	12	12	

Codes

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

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

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

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

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

(Continue on reverse)

PREPARED BY *(Signature & Title)* [redacted] CPT. IAN

DEPARTMENT/SERVICE/CLINIC

DATE

(b)(6)-2

PA[redacted]S IDENTIFICATION *(For typed or written entries give: Name – last, first, middle; grade; date; hospital or medical facility)*

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

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

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

038

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF						LOCATION		
1	2	3	4	5	6	7	8	(State or Country Code.)
A	\	\	D	\		I	Z	

3. REGISTER NUMBER							NAME (Last, First, Middle Initial)	4. PAY GRADE		5. SEX
9	10	11	12	13	14	15	(b)(6)-4 [redacted]	16	17	18
0	0	1	2	9	1	0		—		M

6. DATE OF BIRTH (YYYYMMDD)								7. AGE AT ADMISSION			8. RACE	9. ETHNIC BACK-GROUND	RELIGION
19	20	21	22	23	24	25	26	27	28	29	30	31	
—	—							2	9	Y	X	9	UNK

10. LENGTH OF SERVICE			ETS	11. FMP		12. SOCIAL SECURITY NUMBER								
32	33	34		35	36	37	38	39	40	41	42	43	44	45
—	—		—	9	9	0	0	0	0	0	0	0	9	8

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
—	46: U	2230	—

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
—	—		K	7	8	—	—							

17. UNIT LOCATION (State or Country Code)		18. MOS							19. TRAUMA	PREV. ADMISSION	
62	63	64	65	66	67	68	69	70	71	YEAR	
I	Z	—	—	—					1		X NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72: 0	ICW2	UNK
		ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): UNK
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: (b)(2)-2 [redacted] (b)(6)-2		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE: UNK.

21. TYPE OF DISPOSITION		[redacted] TRANSFERRED TO						23. DATE OF DISPOSITION (YYYYMMDD)							
73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88
0	5							2	0	0	3	0	5	0	6

24. CLINIC SVC - ADMITTING				25. MTF TRANSFERRED FROM						26. DATE THIS ADMISSION (YYYYMMDD)							
89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106
A	E	A	A							2	0	0	3	0	5	0	1

27. LOCATION OF OCCURRENCE (Battle Casualty Only)		28. MTF OF INITIAL ADMISSION						29. DATE INITIAL ADMISSION (YYYYMMDD)							
107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122

FOR LOCAL USE

GSW

Dx: 883.1 E998 Px: 7409 8946

(b)(6)-2

MITTING OFFICER (Signat[redacted] SIGNATURE OF ADMITTING [redacted] (b)(6)-2

(b)(2)-2 [redacted]

FORM 2985, MAR 2000 MEDCOM - 8484 USAPA V1.00

(b)(6)-4

PATIENT TREATMENT RECORD COVER SHEET

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

(b)(6)-4

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

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	224	—	—	N/A	N/A	NO

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
99	(b)(6)-4 [redacted]	N/A	ICW #2

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

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
Direct From ER	1300	AEAA.

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
UNK	26	20030525

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
UNK	UNK	20030518	Dr. [redacted] (b)(6)-2

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

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

UNK

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

997.62
86.28
84.3

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
Ø	Ø	Ø	Ø	7	7

36. Total Days All Facilites

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

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

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

DA FORM 3647, MAY 79 EDITION OF 1 AUG 76 IS OBSOLETE

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

22y/o♂ GSW (B) LE late March. Treated at Baghdad hospital & subsequent (R) BKA. D/c'd home. Now in Iraq.

PMHx: denies
PSHx: (L) BKA
MeDs: ∅
Allergies: denies

PHYSICAL EXAMINATION

pleasant d/c (L) BKA

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

(A) Imported (L) BKA
(P) to OR for I&D

SIGNATURE OF PHYSICIAN	DATE	IDENTIFICATION NO.	ORGANIZATION
[redacted]	5/4/03		

(b)(6)-2

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

REGISTER NO.	WARD NO.

[redacted]

(b)(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
5/4/93	Beaufort
	Preop Dx: [illegible] (E) BKA
	Postop Dx: same
	Procedure: I+D [illegible]
	Est: 150cc
	Flow: 750cc
	Surgeon: Olivero
	Anesthesia: spinal
	Cx: 0
	Fully ambulatory pendent soft tissue [illegible]
	(b)(6)-2 [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/199
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(1
USAPA V1.0

038

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
25May03 1440.	Pt AAOx3. VSS. Pt airway patent, lung sounds CTA abd soft BS(+)x4 quads. (L)BKA dressing CDI. (R)LE Kerlix dressing CDI. (+) pulse. BUE c̄ FROM (+) pulses. HL (R)TA flushed c̄ diff. BP 120/68 P84 T97.4 R16 S_pO_2 98% will cont to monitor — [redacted] 91WM6 (b)(6)-2
25May03	Wounds continue to improve (R)LE, (L)BKA stump. No evidence of infection, or d/c or infection. D/c IV ASX. Start half by steel count per full weight (R)LE 20 mmHg tube body. LR body (b)(6)-2 [redacted]
25May03 1530	MD c̄ pt, new orders rec'd. HL dc'd per orders, dc'd intact c̄ diff. (R)LE dressing removed now OTA. (L)BKA c̄ 4x4 over area secured c̄ tape. Will cont to monitor (b)(6)-2 [redacted] 91WM6
25May03 2100	Pt. received resting in bed. A+Ox3. PERRLA(+) WNL. Skin W+D. VS WNL. LCA(B). BS(+)x4. (+) PPP. (L)BKA c̄ 4x4 drsg C/D/I. Pt expressed itching @ the BKA site. Benadryl given. Will cont to mon [redacted] (b)(6)-2
25May03 2315	UOP 240cc CLEAR YELLOW FLUID → [redacted] 91

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME LAST	FIRST	MI	SPONSOR'S ID NUMBER (SSN or Other) (b)(6)-2
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		

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

REGISTER NO. | WARD NO.

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

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
230545 May 03	Pt is asleep but arousable. Airway is patent; breathing is even and unlabored. Lung sounds are clear to all fields. Abd is soft, nontender, and ≠ distention. BS (+) x 4. Tolerating PO very well. (R) LE have FROM and are neurovascularly intact. (R) LE has wound to ~~[illegible]~~ distal portion of lower leg; dressing CDI. Foot to (R) LE is dry; ~~[illegible]~~ use of lotion is encouraged -- pt applies liberally several times a day. (L) LE is BKA stump c̄ ACE wrap and Kerlix to stump; Dressing is CDI. — [redacted] (b)(6)-2 LCAN
230900 May 03 May 23	Pt given haircut on ward. Pt expressed happiness c̄ haircut. — [redacted] (b)(6)-2 Assumed care of patient at 1300. VSS. A+O x 3. Resting comfortably. Ø c/o pain at this time. (R) LE Dressing CDI. (+) serosanguinous drainage, refill < 3 sec., mvt of toes. (L) LE BKA Dressing CDI. FROM (R) LE. IV Abx Q 8 via (R) FA PIV. D/W Assesment. WNL. Will MONITOR — [redacted] (b)(6)-2
2130	Assumed pt care @ 2100. VSS. HR RES, lungs CTA, BS (+) x 4. Dressing to (L) stump CDI. CSMTS (R) LE WNL. Dressing to (R) calf CDI. Will continue to monitor. — (b)(6)-2 [redacted] LCT/AN
24MAY03 0630	Pt lying in bed awake c̄ resting comfortably. Pt. eager to help c̄ taking vitals. VSS Temp 97.5, P 60, Sats 99%, BP 90/58. IV in (R) AC flushed well with 3cc NS, no signs of infection or infiltration. Pt c̄ no c/o pain @ this time. Will continue to monitor. — (b)(6)-2 [redacted] 2CT/AN
1000	DSG Δ done on both LE. (R) LE c̄ clear yellow drainage. (L) LE also c̄ clear yellow drainage, c̄ well approximated. — (b)(6)-2 [redacted] 2CT/AN

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.

WARD NO. 2CW2

PROGRESS NOTES
Medical Record

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

[redacted] (b)(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
24May03 1330	pt awake & alert. VSS. Airway patent, lung sounds CTA abd soft BS(+) x4 quads (L) BKA draining CDI, RLE draining CDI (+) pedal pulse (R) LE. BUE c̄ FROM strong (+) pulses HL (b)(6)-2 flushes ⊼ diff Ø S/SX of infection. Will cont to monitor — [redacted] 9110MC
24May03 2300	pt AAO x3. VSS. PERRLA. Mucous membranes pink, moist and intact, neck supple c̄ FROM. BS clear bilaterally abd soft, non-distended bowel sounds x4 quads. RLE c̄ brisk cap refill, drsg CDI. (L) BKA drsg c̄ minimal old drainage no complaint of pain. IV to (R) AC patent, flushes easily Ø S/S infiltration. Voiding to urinal ⊼ difficulty clear yellow urine. Ø BM noted (b)(6)-2 non wt bearing to (R) leg. Will cont. to monitor [redacted] ILT/AN
25May03 0130	Drsg to (L) BKA rewrapped. Site clean. Minimal drainage to gauze. Given 50mg Benedryl for itching (b)(6)-2 [redacted] ILT/AN
0420	Medium BM to commode. Pt c̄ complaint of pain to (R) LE. Given T#3 1/11 tabs. Returned to bed. Ø other complaints at this time (b)(6)-2 [redacted] ILT/AN
25MAY03 0800	Pt. up ambulated c̄ assistance to middle of ward to help clean. VSS BP 90/64, P90, RR14, sats 98%. SL in (R) AC c̄ no signs of infection or infiltration. Dressings on both LE are clean & dry. Pt. has no complaint @ this time. (b)(6)-2 [redacted] JLP
0930	Dressing Δ done to LE bilat. site on (R) side has improved since yesterday Site is now concentrated on aft portion of shin, approx 3 inches in length c̄ clear yellow drainage. Site on (L) leg below the knee is the size of a quarter & also c̄ small amt clear yellow drainage. Pt. c/o itching, Benedryl given.

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

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:EDICAL RECORD | PROGRESS NOTES

DATE	NOTES
0530 May 03	Pt is asleep but arousable. Denies pain or itching. Breathing is even and unlabored. Lung sounds clear to all fields. Abd is soft, nontender, + distention. BS ⊕ x 4. Denies N/V. Pt voids spontaneously. Strong cast to (L) LE is CDI. (R) LE cast is CDI. Neurovascularly intact to all extremities and FROM to (B) LE. Pt is NPO for possible surgery in AM. — [redacted] LCT, AN (b)(6)-2
211030 May 03	Pt sent to OR via litter. — [redacted] LCT, AN (b)(6)-2
1135 May 03	Pt to ward via litter, + incident. IV LR OTKO. Will Leflock + good PO. Airway intact. Lung sounds clear to all fields. IV to (L) FA. Pulses intact. Tolerated lunch well. Drsg to (D) LE (stump) is ACE wrap + drsg ↑ is CDI. — [redacted] LCT, AN (b)(6)-2
21 May 03 1340	Pt awake et alert. Lung sounds CTA throughout. Abd soft nontender nondistended, BS ⊕ x 4 quads. (D) BKA c̄ wrap CDI. (B) LE c̄ Kerlex drsng, drsng CDI. ⊕ pulse. (B) UE c̄ FROM strong ⊕ pulses. IV to (R) AC infusing LR 5 diff. will hl when pt takes good po. (D) complaints voiced @ this time. Will cont to monitor — (b)(6)-2 [redacted] 9WM4
5/21 /0321/15:	Assumed care of PT @ 2100. PT A & O. Pt c/o pain. Tylenol #3 given. HR Reg, Lungs CTA, BS ⊕ X4. Drsng to (L) stump CDI. Drsng to (R) calf CDI. PT stretching (L) hip in bed on own & exercising (L) knee. CSMT's (R) LE WNL. Will continue to monitor. — (b)(6)-2 [redacted] LCT, AN
[redacted]	UOP 420cc CLEAR yellow fluid — [redacted] (b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | AWARD NO. LCW2

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

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
20May03 0015	Pt care assumed @2100. VSS, pt alert and awake w/complaints of pruritis. 50mg given of Benadryl for relief. Lung sounds CTA, bowel sounds present x4. Pt has ROM in L BKA, claned in bed earlier on shift. Cast on lle CDI. Dressing on RLE CDI, ⊕ sensation, ROM, cap refill <3 seconds. None complaints, will continue to monitor. SPC [redacted] 91W MG (b)(6)-2
20May03 0245	UOP 320cc CLEAR PALE YELLOW FLUID → [redacted] 91W
20May03 0400	Pt complains of mild pain in @ BKA, T3 ⅔ given for relief. Will continue to monitor. SPC [redacted] 91WMG (b)(6)-2
20May03 0545 B/P 114/76 P72 R16 T98.5	pt care assumed @ 0500. pt awake alert and oriented to surrounding. No c/o pain @ this time VSS HR regular. Lungs CTA throughout. Bowel sounds active x4. no c/o pain/tenderness on palpation @ BKA cast CDI. Dsg to ⊕ ankle CDI. HL to ⊕ ae. no S/S redness/ infiltration. Will continue to monitor. [redacted] (b)(6)-2
20May03 1930	MD Δ'd ankle dsg and indicated he would take pt. to OR 21 may to remove excess skin from wound and close - no new orders written - pt. resting bed 5 c/o pain - IV patent — [redacted] CBAF (b)(6)-2
2230	Assumed pt care @2100. VSS, A&O x3, c/o pruritis @ LBKA. 50mg benadryl given @ 2200 for relief. No c/o pain at this time. Cast on L BKA CDI, dressing on RLE. CDI. Pt has ⊕ sensation, ROM, and cap refill <3 seconds on RLE. Bowel sounds + x4 quadrants, lung sounds CTA. No other complaints at this time. Will continue to monitor. SPC [redacted] 91WMG
0100	Pt given ⅔ T3 for pain. SPC [redacted] 91WMG — (b)(6)-2

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

(b)(6)-2

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
4May03 2100	Admission Note: VS 115/64, P101, R21, T98.8 Pt is a 23yo ♂ admitted to ICW #1 for preop I&D of (L) BKA infection. Pt was placed in restraints. Pt was reported to have a (R) lower leg break as well. Dsg to (L)BKA ≡ gauze is CDI. Dsg to (R)LE has dried blood. Calf muscle appears atrophied and pedal pulses are weak. Pt is to go to the OR tonight. IVF LR @100cc/h. Pt asked for urinal upon arriving on floor but could not void. Does not currently feel distended. Will ask OR if they will place foley. — [redacted] ILT AN (b)(6)-2
4MAY03 2220	Pt transfered to OR via litter. — [redacted] ILT AN — (b)(6)-2
5MAY03 0130	Pt returned from post-op recovery in the ICU to ICW#1 @ 0130. VS 120/69, R15, P88, T98.5. Pt S/P I&D of (L)BNA. Dsg to (L) stump C/D/I. (L) stump elevated slightly with blanket. (R)LE dsg was not removed. Pt C/O pain upon return to ICW#1, given 50mg IV Demerol. Pt now sleeping. IVF LR @ TKO via 20G in (R)AC. Will continue to monitor & support. Restraints placed on (B) wrists. — [redacted] ILT AN —

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

[redacted] (b)(6)-4

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

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
5May03	PT AAOX3 PERRLA 3mm $S_1 S_2$ present ↑ ext pulses equal/strong, (R) ↓ ext present, ~~LGT~~ 4BR [redacted] CTA Bowel sounds present in all 4 quads, voiding via urinal clear/yellow/urine, (R) ankle bandaged c̄ ~~sm~~ slight drainage (marked c̄ pen), (L) leg BKA dressing clean/dry/intact, complains of pain, medicated, will continue to monitor. (b)(6)-2 — SGT [redacted] 91WM6-CPN —
05 ~~1800 May 03~~	~~Stumbled on way to restroom. May have jostled fixator. CMS intact in (R) foot. No immediate bleeding noted on dressing.~~ Error (b)(6)-2 [redacted] 2LT/AN
5May03 1800	Pt resting in bed. A&OX3. LCTA(B), BS x4 hypoactive IV Hz'd. (L)BKA dsg CDI. (R)LE dsg with old drainage marked. Pt has had difficulty voiding for the last two days. Day shift reported pt voided once this morning. Pt felt very distended. Foley ordered and placed, 1400cc clear yellow urine out. Pt tolerating Regular diet w̄ difficulty. Will continue to monitor & support. (b)(6)-2 — [redacted] INT RN
6May03 0400	Pt sleeping on and off. c/o pain several times, given Demerol last @ 0140, 50mg IV. Pt received a new cast to his (R)LE last night @ 1900. Cap refil <3 seconds to (R) foot. No further Δs. — [redacted] (b)(6)-2 —
06May03 @	0730 Asleep. Easily aroused. c/o abd pain Abd flat and soft. Nondistended. Foley patent. Draining clear yellow urine. Resp even and NL. Lungs clear. Heart (S1S2) rate regular and strong. HL (R) AC. Flushes easily. (R) leg c̄ cast on. Warm to touch. Sensation present. (L) BKA c̄ ace bandage present and elevated on pillow. Leather restraints on x2 c̄ guard present.

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
16May03	PT vitals T 97.5 P 79 R 12 BP 118/74 — Spc [redacted] (b)(6)-2 9/LW
0530	
16May03 0555	Pt is awake, alert, O&3. C/o itching, MD notified. No new orders. Itching is primarily to (R) LE around cast. (L) stump is CDI. Pt has FROM to (R) knee and (R) UE. IV to (R) FA flushes well & no s/s of infiltration. No abnormalities noted to neurological, pulmonary, cardiovascular, GI, GU systems. Pt voids spontaneously and tolerates PO — (b)(6)-2 [redacted]
16MAY03 1600	Pt vitals taken, BP 108/68, P. 78, R-20, TEMP. 98.0 SPC [redacted] (b)(6)-2
16May03 1500	Assumed pt care @1300. pt sleeping easily aroused to verbal stimuli. Lung sounds CTA, abd soft BS(+)X4 quads. (L)BKA c̄ cast elevated. (R)LE c̄ cast able to wiggle toes. BUE c̄ FROM. IV HL to (R)FA infiltrated new one started (L)FA c̄ 18g 3 diff, flushes well. Ø C/O pain or discomfort voiced @ this time. Will cont to monitor — [redacted] 9/LWM6 (b)(6)-2
16May03 2300	Pt care assumed @2100. Pt aware and alert, VSS, Ø complaints at this time. Lung sounds CTA, Bowel sounds(+)x4 quadrants. (L)BKA cast CDI, pt Ø complaints of pain or itchiness. Cast on RLE CDI, (+)ROM, sensation, and capillary refill (3 seconds in toes. HL IV @ LFA CDI, flushes well, will continue to monitor. SPC [redacted] 9/LWM6 (b)(6)-2
0230	Pt C/O mild pain @ LBKA, T3 ii given. SPC [redacted] 9/LWM6

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.

WARD NO. 2CW2

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

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
17MAY03 0515	Assumed Pt. care @ 0500: T 97.0 P 64 R 16 B/P 104/58 SATS 98%. Pt awake and cooperative. A&Ox3. (+) BS x4. HL in (R) FA patent to flush. Cast on (R) leg and cast on (R) stump CDI. Denies any (b)(6)-2 discomfort @ this time — [redacted] 91WMD
17May03 1350	assumed pt care @ 1300. pt awake & alert. lung sounds CTA, abd soft nondistended BS(+)x4. HL (L) FA s/s of infection. ortho techs @ bedside A'd (L) BKA stump cast. (L) BKA healing s/s of infection new cast applied. (R) LE cast removed wound site approx 4-5" c̄ mod amt of yellowish pus. MD aware & @ bedside. Damp to dry 4x4's applied to area & secured c̄ kerlix. (R) pedal pulse (+). pt given ⅓ Tylenol #3 per prn orders during cast A. pt now resting s/s of distress noted. VS BP 100/72, P: (b)(6)-2 70, R: 20, Temp 96.6. will cont to monitor — [redacted] 91WMD
17MAY03 2345	UOP 120cc CLEAR YELLOW FLUID → [redacted]
18May03 0030	Pt care assumed @2100. Pt Awake and alert, vss, (b)(6)-2 (-) complaint of pain. Lung sounds CTA with equal rise and fall of the chest, Bowel sounds (+) x4 quadrants, pulses (+) in RLE, and RUE, and LUE. Heplock on LFA flushes well without s/s infiltration. L BKA cast CDI, RLE dressing CDI. Pt has (+) sensation, rom, and cap refill <3 seconds in RLE. Right foot has very dry skin near toes. No new complaints, will continue to monitor. SPC [redacted] 91W MC (b)(6)-2
18MAY03	Assumed pt care @ 0500: T 96.8 P 70 R 16 B/P 102/56 SATS 98 Pt awake and oriented. Lungs CTA. (+) BS x4. Dsing on (R) leg and cast on (R) stump CDI. (-) Complaints. [redacted] 91WMD

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
14 May 0830 (cont.)	Radial pulses strong bilat. (L) BKA cast CD&I. (R) below knee cast CD&I, pt has + sensation able to wiggle toes. 18G HL to (R) FA flushes well. no S/S redness (b)(6)-2 infiltration. dated 13 May. Will continue to monitor. — [redacted] S/Hall
14 May 03 1300	Pt vitals taken BP 100/58, P. 84, R. 16, Temp 98.3 SPC [redacted] (b)(6)-2
15 May 03 0100	Pt care assumed @ 2100. VSS, A+O×3, T3 given for pain @ 2330. Lung sounds CTA, with equal rise and fall of chest. Pulses palpable×4. No bowel movement made on shift, bowel sounds hyperactive. IV infiltrated on (L) FA, started again in (R) FA. Heplock flushes well. Cast on (L) BKA CDI, cast on (R) le CDI. RLE has (+) sensation, ROM, and (b)(6)-2 capillary refill <3 seconds. Will continue to monitor. SPC [redacted] 91WMC
15 MAY 03 0450	ASSUME PT CARE AT 0500. VS B/P 108/70 P 86 R 16 T 97.3° SpO2 99%. PT ALERT & AWAKE. HR REGULAR. LUNGS CTA THROUGHOUT. BOWEL SOUNDS PRESENT X4. RADIAL PULSES STRONG. CAST ON RLE CD&I, PT HAS + SENSATION AND ABLE TO WIGGLE TOES. (L) BKA CAST CD&I. HL R FA FLUSHES WELL. NO C/O PAIN AT THIS TIME. WILL CONTINUE TO MONITOR. (b)(6)-2 [redacted] 91WMC
15 May 03 1300	Pt vitals taken BP 126/62, P. 82, R. 16, Temp. 98.3 SPC [redacted] (b)(6)-2

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

REGISTER NO.

WARD NO. CWE

[redacted] (b)(6)-4

PROGRESS NOTES
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DATE	NOTES
15May03 1345	assumed pt care @ 1300. VSS. lung sounds CTA throughout, breathing equal & unlabored. abd soft nondistended, BS(+) x4 quads. RLE c̄ cast from mid calf to toes, pt able to wiggle toes c̄ good cap refill. (-) BKA c̄ cast from mid thigh to stump. EPW protocol in use, leather restraints on bilat. (-) complaints voiced @ this time. Will cont to monitor — [redacted] 91WMC (b)(6)-2
15May03 2020	pt's been laughing & joking c̄ staff on & off throughout the day. (-) complaints voiced. — [redacted] 91WMC
15may03 2130	Pt care assumed @ 2100. pt awake and alert, vss, no complaints of pain, but pt complains of itching underneath cast. Pt had BM @ onset of shift, soft and formed texture. Lung sounds CTA with equal rise and fall of chest, UE pulses palpable x2, bowel sounds present x4. LLE cast on BKA CDI. Cast on RLE CDI, pt able to wiggle toes (+) sensation, (+) ROM, + capillary refill <3 seconds. will continue to monitor, SPC [redacted] 91WMC (b)(6)-2
to 2230	Heplock on RFA flushes well. SPC [redacted] 91WMC (b)(6)-2
16May03 0100	Benadryl given @ 2230 for relief of itching, will continue to monitor. SPC [redacted] 91WMC (b)(6)-2
16May03	0115 LBP 650 cc CLEAR YELLOW FLUID → FC [redacted] 91W
16May03	0345 LBP 250 cc CLEAR PALE YELLOW FLUID - FC [redacted] 91W (b)(6)-2

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
2May03	0730 (cont.) Radial pulses strong bilat. pt c/o pain Lyfenol #3 ÷ given for pain. pt vorded 250cc Clear yellow. No signs of distress at this time pt resting. Will continue to monitor pain levels. ~~HL~~ to (L) forearm flushes well ~~s/p~~ [redacted] (b)(6)-2. no s/s infection/infiltration. (b)(6)-2 [redacted] 9/Lp
2MAY03 1305	PT vitals taken T98.3 P 80 R 14 B/p 102/64 (b)(6)-2 [redacted] 9/W
13May0000	Pt care assumed @ 2100. VSS, A+Ox3, pt has no complaints of pain at this time. Demerol given for pain @ 2400. Pt has cast on (R) BKA, CDI. (R) LE cast CDI. (R) LE (+) sensation, (+) capillary refill <3 seconds. Heplock in (R) fa flushes well. Lung sounds CTA with equal rise and fall of chest. Bowel sounds present x4, patient had bowel movement @ 0100. Will continue to monitor. SPC [redacted] 9/WM (b)(6)-2
13May 0545	VS B/P 114/60 P 75 R 14 T 98.4 SpO2 98%. Assume pt care at 0500. Pt Awake c/o pain. Pt HR regular. Lung sounds CTA. Bowel sounds present x4 no c/o pain tenderness of palpation of abd. Full Rom to upper extremities. HL to (R) ac flushes well. cast ~~to~~ error (b)(6)-2 [redacted] below (R) knee to foot. Pt has + sensation in toes cap refill <3sec. (L) BKA cast to thigh. Casts CD+I bilate. pt voids per urinal @ BS. 200cc clear yellow (cont)

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

REGISTER NO.

WARD NO. 1CW2

[redacted] (b)(6)-4

PROGRESS NOTES
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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
0545	(Cont.) ∴ tylenol #3 given for pain. Pt still c/o pain at this time. Will continue to monitor. (b)(6)-2 [redacted] 91WMP
13 May 03 1300	Pt. vital taken. BP 104/68 P. 80, R. 16, Temp. 98.4 SPC [redacted] (b)(6)-2
13May03 1345	assumed pt care @ 1300. VSS. pt crying wanting restraints taken off. ⊘ complaint of pain @ this time. pt on RA, lung sounds CTA, abd soft nontender, BS⊕ x4 quads. ⊘ BKA c̄ cast. ⊘ LE c̄ cast, pt able to wiggle toes. ⊘ AC HL flushed s̄ diff ⊘ S/S infiltration. leather restraints on bilat. will cont to monitor (b)(6)-2 [redacted] 91WM
13May03 2024	pt been joking c̄ staff most of day. c/o pain @ 1820 given ∴ Tylenol #3 per prn orders. ⊘ complaints voiced @ this time [redacted] 91WM
13 May03 2300	Pt care assumed @ 2100. Pt complains of pain, no meds given. Pt VSS, awake and alert. Cast on ⊘ BKA CDI, Cast on ⊘ LE CDI. Pt has ⊕ sensation, BOM, capillary refill <3 seconds. Pt complains he wants to walk, PT states they have no walking device at this time. Pt also tried BM x2, ⊘ assist. Bowel sounds hyper active. Lung sounds CTA with equal rise and fall of chest. Pulses palpable in UE. IV line replaced @ 2300 in ⊘ forearm. Old IV had no start date recorded. IV 18 gauge @ LFA. Will continue to monitor. SPC [redacted] 91WMC
(b)(6)-2	
14May03	0830 - VS B/P 110/60 P 78 R 14 T 97.6 SpO2 99%. pt VSS. alert and awake. No c/o pain at this time. HR regular. Lungs CTA throughout. Bowel sounds active x4. No BM this am, VOP 360cc clear yellow. (cont.) [redacted] 91WMC

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MEDICAL RECORD	PROGRESS NOTES
DATE	
10 May 03 1340	Assumed care of Pt @ 1300. VSS, Denies pain. (R) LE c̄ drsg/splint CDI (R) cap refill <3 sec, (+) sensation, (+) mvt of toes. (L) LE BKA cast CDI. Pt teary/upset about losing (L) LE. O/W assessment WNL. Will cont to monitor (b)(6)-2 [redacted]
10 May 03 1730	VSS – (L) stump cast Δ'd by ortho & cast tech, Knee straight – (R) leg cast intact, cap-refill <2 sec in (R) foot toes – IV patent – pt. medicated for pain before cast change done – pt. now resting in bed [redacted] CRA (b)(6)-2
2210 10 May 03	Assumed care of Pt 2100. Pt awake, alert, oriented in bed sugui
BP 104/64	(L) BKA elevated, RW sl'd to (R) AC 18g (+) flush @ 3n. PA: ev: (+) S152
HR 77	Regular (-) swelling peripherally, cap refill <3 sec (R) foot, (R) leg.
SpO2 99%	Radial pulse 2+, (R) dp. 2+. Resp: Lungs clear throughout.
T: 98.7	(+) BS. Normal x4, urine @ 35, clear yellow 400cc out @ this time.
RR: 14	(R) LE cast clean, dry intact (-) excessive drainage. (+) sensation (+) movement, (+) sensation. Unable to palpate pulse r/t cast.
2300-0430	(L) BKA cast CDI (-) excessive drainage. (+) elevation. Denied
UOP = 450	50 mg SIVP administered s/p c/o pain. (+) pain control result. [redacted] (b)(6)-2
Clear	
Yellow	0000: Pt c/o pain to (L) BKA. Tylenol #3 ii tabs PO administered [redacted] (b)(6)-2
	0435: Pt slept throughout shift w/o further needs or complaints. [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)

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WARD NO. ICW

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

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DATE	(b)(6)-2
11May03 0630	PT Vitals T 97.0 P78 R14 BP106/64 — Spec [redacted]
11 MAY 03	0700: Assumed pt care @ 0500. Pt. A&Ox3. VSS. HLP FSB patent to flush. Lungs CTA (+) BS x 4 quadrants. c/o pain as 8/10. Two Tylenol #3 given PO prn for pain. Will continue to monitor. (b)(6)-2 [redacted] 91W MB
11 May 03 1400	R vitals taken. BP 102/56, P. 80, R. 20, Temp 98.5 SPC [redacted] (b)(6)-2
11may03 1915	VSS [redacted] cast intact on (L) stump and cast in place on (R) lower leg, cap refill < 2 sec in toes of (R) foot — SL patient — medicated for pain ~ 1400 & good results [redacted] (b)(6)-2
11 May 03 2238 BP 102/56 HR 72 RR 12 Spo2 98% T: 97.8°	Pt awake, alert, oriented VS STABLE WNL. PIV sl'd 20g R. Ac (+) flush (+) BR (-) infection, (-) infiltration. S1 S2 present, regular, lungs sounds clear, movement to chest symmetrical and equal, Abd non distended, nontender, BS present x 4, (L) BKA cast CDI no drainage. (R) BK cast CDI no drainage (+) sensation, (+) movement to toes. unable to palpate D.P pulse.
12May03 0630	Vitalsigns taken BP 118/78 P77 R16 T 98.1 (b)(6)-2 SPC [redacted] 91W
0730	Assume pt care @ 0500. pt awake alert oriented NSS. S1 + S2 audible regular. Lungs CTA throughout. No c/o chest pain. Bowel sounds x4 active. No c/o pain/tenderness on palpation of abd. Full ROM of extremities. (L) BKA cast CDI + T. (R) BK cast CDI. pt able to wiggle toes (cont.)

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MEDICAL RECORD	PROGRESS NOTES
DATE	
8 May 03 2145	Pt awake, alert supine watching activity in ward. No evidence of pain or
VS: 120/72	discomfort. 20g PIV SL'd ⊖ flush ⊖ ER. to (L) wrist. ⊖ evidence infection or infiltrate.
HR 76	LL: S1S2 present, Regular. ⊖ swelling to extremities cap refill (L)/(R) fingers ≤ 3 sec. hyperdem
RR 16	throughout, but not symmetrical venous. ABD: ⊖ distention or tenderness. ⊕ hyperactive Bowel sounds.
T: 98.6	GU: ⊖ VOP at this time urinal @ BS. (L) BKA Bandage clean dry intact ⊖ drainage
Spo2: 98%	⊕ cast to (R) LE below the knee, ⊖ drainage, ⊕ sensation to all toes, ⊕ normal
	color normal for race, cap refill ≤ 3 sec. unable to palpate pulses in foot r/t
1210 UO: clear yellow	Cast. No complaints at this time. Dressing placed to Buttocks r/t
	redness and ↑ risk for pressure ulcer. Pt indicates discomfort to
	coccyx on palpation. Pt placed on side. ⊕ pt restraints, leather
	to BUE. Guard on duty. [redacted] (b)(6)-2
	2330: Pt c/o (L) leg pain. Demerol 50mg IVP administered. Eval pending.
	(b)(6)-2 [redacted]
	2430: pt sleeping quietly (b)(6)-2 [redacted]
	0100: Pt awake, groaning, holding stump rocking (L) to (R). Tylenol #3 ii po
	administered. Eval Pending. [redacted] (b)(6)-2
	0210: Pt awake, moaning, rocking, holding stump cont. Dr [redacted] (b)(6)-2 notified
	Demerol 50mg IVP ordered and administered through ⊖ PIV. Eval pending. [redacted] (b)(6)-2
	0345: Pt sleeping quietly w/o evidence of pain/discomfort (b)(6)-2 [redacted]
	0413: pt cont to sleep w/o s/s of pain. (b)(6)-2 [redacted]
0905 30/Ry B3	Pt assessment is unchanged from previous assessment ▼ to note that foley is DC'd. Pt
	voiding spontaneously per previous RN reports. ⊖ urination yet this shift. Sacral area
	padded to prevent skin breakdown. Encouraged pt to turn frequently. Pt acknowledged
	understanding. ⊖ c/o pain at this time. Neurovascularly intact to (R) LE. FROM (continued 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. CW2

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DATE	
09 05 30 May 03	to (R) UE. Stump dry to (L) leg is CDI — [redacted] 15 AW
0745	Vital signs taken BP 120/74 P 79 T 97.2 R 18 (b)(6)-2 SPC [redacted] 91W
9 May 03 1400	assumed pt care @ 1300. pt awake & alert. pt on RA, lung sounds CTA bilat c̄ equal rise & fall of chest. Abd soft nondistended BS(+) x4 quads. pedal pulse R LE (+). R leg c̄ cast - neurovasc ✓'s good. (L) BKA stump c̄ drsg CDI. HL (R) wrist flushed ⅤS diff. (-) redness or edema noted. pt voided 750cc amber color urine will cont to monitor — (b)(6)-2 [redacted] 91WM6
9 MAY 03 1400	Pt. vitals taken. BP 108/58, P. 60, R. 18, 97.7 SPC [redacted] (b)(6)-2
9 May 03 1645	pt has IV HL in (R) AC. HL site flushed ⅤS diff. HL (L) wrist dc'd. — (b)(6)-2 [redacted] 91WM6
9 May 1800	pt ate 50% supper tray. voided 600cc cl yellow urine. (-) complaints voiced @ this time — (b)(6)-2 [redacted] 91WM6
9 May 2035	pt voided 475cc cl yellow urine ⅤS diff — (b)(6)-2 [redacted] 91WM6
10 May 0245	Pt care assumed @ 2100. Pt a+o x3, had complaints of pain relieved by T3. Lung sounds CTA, with equal rise and fall of chest. ~~Dre~~ SS Bowel sounds present x4 quadrants. Cast on (R) leg, CDI. Pedal pulse on (L) ankle (+), Rom and sensation (+), capillary refill <3 seconds. (L) BKA dressing CDI. IV site on (L) ~~wrist~~ forearm without S/S infection. Pt voided 350cc yellow clear urine. Pt has not slept all night, just states. Will continue to monitor. SPC [redacted] 91WM6 (b)(6)-2
10 MAY 03	Assumed Pt. care @ 0500. VSS, T 96.9 P 78 RR [illegible] BP 108/[illegible]. Will continue to monitor — [redacted] 91WM6 (b)(6)-2

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PROGRESS NOTES

(b)(6)-2

DATE	
8 May 03	0430: UOP 250cc Total output 450cc this shift. [redacted] RN/AN
8 May 03	0800 = pt. alert & oriented, Heart = $S_1 S_2$, HR WNL, VSS & on graphic sheet, Lungs CTAB, BS x 4 quads, good appetite - ate 90% of breakfast tray, pulses 2+ in ↑ ext's, 2+ in (R) LE. (R) leg is casted - neurovasc v's good c̄ CRT < 3 secs, (L) leg stump c̄ dsg CDI. c/o no pain @ present time, verbalizes in Arabic (translated) that wants to go home. IV HL to (L) wrist. Foley to grav draining clear yellow urine. [redacted] (b)(6)-2 RN/AN
8 May 03	0900 - pt. transferred to ICW #2 via litter, report given to Charge Nurse [redacted] RN/AN (b)(6)-2
080900 May 03	Pt arrived to ward via litter c̄ incident. Pt is awake, alert, Ox3. Airway is patent. Breath sounds to (B) fields clear. Abd is soft, nontender, and c̄ distention. BS(+) x 4. Pt has foley catheter draining clear, yellow urine. (R) LE have FROM and good capillary refill. (R) LE has cast c̄ ace wrap from toes to just below the knee. (R) LE is neurovascularly intact. (L) LE has ACE wrap that is CDI. IV access to LUE & flushes well. [redacted] (b)(6)-2 LT, AN
8 May 03 1320	Foley removed c̄ 7cc water removed from balloon - pt. due to void WLT 1920 - will monitor [redacted] CRN (b)(6)-2
1415	Pt fed 4s Zofran. c/o c/o c̄ chronic distress. Pt non-ambulatory B/P 100/50, P 85 R R18 T 98.2° [redacted] SPC RN (b)(6)-2
8 May 03 2000	VSS - no c/o pain - dressings intact on (B) LE - HL patent - voided 600cc clear yellow urine @ 1800 - Alert & Ox3 [redacted] CRN, AN (b)(6)-2

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MEDICAL RECORD	PROGRESS NOTES

DATE (continued 7 May 03 @ 0615) = CTAB, BS x4 quads, appears very thin - ribcage is showing, foley cath intact draining clear, yellow urine, UOP = 1000cc this AM @ 0530. Will continue to monitor. (b)(6)-2 [redacted] ZU/AN

0630: IV HL to (L) hand intact + patent, flushed well c̄ 3cc of NS. (b)(6)-2 [redacted] ZU/AN

7 May 03 1000 = IV restarted in (L) wrist, flushed c̄ 3cc NS, HL'd. (b)(6)-2 [redacted] ZU/AN

1000 = D/C'd IV HL in (L) hand - infiltrated and erythema assessed when flushed. [redacted] ZU/AN

7 May 03 1340 Pt Awake in Bed resting. A&O x 3 PERRLA, Lungs CTAB, S1, S2 Present, HRRR. (+) BS x 4 quads. Pt ate 75% of meal (R) LE in Hard cast (R) Toes able to move, Cap refill ≤ 2 sec, Warm and dry to touch. (L) LE ~~BK~~ BKA in Drsg CDI. Skin superior to drsg warm and dry to touch. Pt received ii Tylenol 3 for pain. (b)(6)-2 Will continue To monitor (b)(6)-2 [redacted] PFC, LPN

7 May 03 1700 VS: BP 108/58 P 85 T 97.9 SpO2 98% Pt received sleeping. Neuro: A&O PERRL C.V: S1, S2, (+) pulses all extremities c̄ capillary refill < 3 sec. Resp: Lungs CTA in all lobes G.I: (+) bowel sounds in all 4 quadrants & nontender to palpation G.U: 2000 cc clear yellow urine via foley Skin: Warm dry c̄ brisk turgor. (L) LE c̄ drsg to stump & (R) LE c̄ cast, pt able to feel & move toes. Cont. to monitor [redacted] PNL/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)

REGISTER NO. (b)(6)-2

WARD NO. [redacted]

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

[redacted] (b)(6)-4

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
06 May 03 @	1400 Go OR per litter c̄ medical staff in (b)(6)-2 attendance. [redacted] CPT, AN
	1625 Received from RR per litter c̄ 2 nurses in attendance. Temp 98.4 BP 123/72 P 105 R 16 Sp O2 @ 97 %. (L) BKA c̄ dsg intact. No drainage noted. Thigh above BKA warm to touch and pink. IV infusing c̄ difficulty. Foley patent. Scant clear yellow urine present. Resting quietly. No c/o pain or distress. Will continue to monitor.
	(b)(6)-2 [redacted] CPT, AN
6 May 03 1730	Pt recieved in bed awake. A&O x3 PERRLA (L) BKA c̄ Dressg CDI. ~~Upper Stump~~ Skin superior to Dressg warm & Dry to touch. IV Heplocked. Foley Draining to gravity clear ~~yellow~~ yellow urine. Lungs CTAB, $S_1 S_2$ Present + RRR. (+) BS x4 quads. Pt ate 15% of meal. Pt ~~c/o~~ c/o nausea, 25 mg phenagrin administered. Pt now sleeping. Will continue to monitor.
	(b)(6)-2 [redacted] PFC LPN
06 May 03	2100: Concur c̄ above assessment. [redacted] (b)(6)-2
7 May 03	0615: pt. alert & oriented, makes eye contact, communicate in his language (Arabic) as needed, no S/S pain, resting comfortably. VSS & on graphic chart. Heart $S_1 S_2$ & HR WNL, CRT in toes on (R) foot < 3 secs c̄ good color - acyanotic, can wiggle toes c̄ good movement, good sensation, cast to (R) leg CDI, (L) leg is BKA c̄ stump covered c̄ dsg CDI. Lungs

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES (b)(6)-2
06 May 03	@ 0730 continued. VSS. Will continue to monitor. — [redacted] CPT, AN
	0745 Demerol 50 mg IV given. — (b)(6)-2 [redacted], CPT, AN
(b)(6)-2	0755 Dr. [redacted] here. Update provided. Plan of care reviewed. Orders received. — (b)(6)-2 [redacted], CPT, AN
	0930 Complete bath provided by pt c̄ mouthcare. Leather restraint off x 1 c̄ guard @ bedside. — (b)(6)-2 [redacted], CPT, AN
	1000 c/o abdominal discomfort. Refused medication. Leather restraints on x 2. — [redacted] CPT, AN (b)(6)-2
	1245 Emptied FC of >1600 clear yellow urine. No sedimentation present. Reminded pt of NPO status. — (b)(6)-2 [redacted] CPT, AN
1400	TOR via litter c̄ OR team. — [redacted] LTC, [illegible]
5/6/03	Brief Op Note (b)(6)-2
1500	Pre Op Dx: Open (L) BKA stump
	Post Op Dx - stump
	Revision of Stump — CC: Q
	EBL 100 — Post op Pla
	Fluids: 700cc — IV NS x 1 pull down 48
	Sponge Count — Plan stump cast
	Anesthesia General MSK

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

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

REGISTER NO. | WARD NO.

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

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
211530 May 03	Pt is asleep but arousable. Denies pain or itching. Breathing is even and unlabored. Lung sounds clear to all fields. Abd is soft, non-tender, ± distention. BS⊕x4. Denies N/V. Pt voids spontaneously. Strong cast to (L)LE is CDI. (R)LE cast is CDI. Neurovascularly intact to all extremities and FROM to (B)UE. Pt is NPO for possible surgery in AM. — [redacted] (b)(6)-2 USAAN
211030 May 03	Pt sent to OR via litter. — (b)(6)-2 [redacted] USAAN
H 1135 May 03	Pt to ward via litter ± incident. IV LR @TKO. Will keplock ± good PO. Airway intact. Lung sounds clear to all fields. IV to (L)FA flushes intact. Tolerated lunch well. Drsg to (R)LE (stump) is ACE wrap ± drsg ± is CDI. — (b)(6)-2 [redacted] USAAN
21May03 1340	pt awake et alert. lung sounds CTA throughout. abd soft nontender nondistended, BS⊕ x 4 quads. (L)BKA c̄ wrap CDI. (R)LE c̄ Kerlex drsing, drsing CDI. ⊕ pulse. (B)UE c̄ FROM strong ⊕ pulses. IV to (R)AC infusing LR ⅕ diff. will hl when pt takes good po. (0) complaints voiced @ this time. Will cont to monitor — (b)(6)-2 [redacted] 91WM4
5/21 /0321/15:	Assumed care of PT @ 2100. PT A & O. Pt c/o pain. Tylenol #3 given. HR Reg, Lungs CTA, BS⊕ X4. Drsng to (L) stump CDI. Drsng to (R) calf CDI. PT stretching (L) hip in bed on own & exercising (L) knee. CSMTS (R)LE WNL. Will continue to monitor. — (b)(6)-2 [redacted] USAAN
22May03 0800	UOP 420cc CLEAR yellow fluid — [redacted] (b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.

AWARD NO. LW2

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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

(b)(6)-4

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

DATE	NOTES
22May03 0530 B/P 120/60 P84 R18 T.98.4	Assume pt care @ 0500. VSS. no c/o pain @ this time. pt awake and alert or oriented to surroundings. HR regular. Lungs CTA throughout. Non-productive cough. Bowel sounds active x4. no c/o pain tenderness on palpation of abd. Dsg to RLE CD&I. Dsg to LBKA CD&I. HL to (R) AC no s/s redness/ infiltration. Radial pulses strong. L pedal pulse palpable. Will continue to monitor. (b)(6)-2 [redacted] 9/W/M6
0930	pt c/o pain to LLE. ∴ Tylenol #3 adm. (b)(6)-2 [redacted] 9/W/M6
1000	Dsg Δ to Both LE. RLE wound clean healing well. Xeroform applied with gauze wrap. (L) BKA no signs infection. Xeroform applied with gauze and ace wrap. (b)(6)-2 [redacted] 9/W/M6
1400	Vital signs taken BP 124/64 P 79 T 97.8 R 14 SpO2 99% (b)(6)-2 SPC [redacted] 9/W
22May03 1415	assumed pt care @ 1300. VSS. pt c/o pain given ∴ Tylenol #3 per prn orders. lungs CTA, abd soft BS(+)x4 quads. (L) BKA draing CDI, (R) LE drsing CDI pedal (+) (B) LE ĉ FROM strong (+) pulses. HL RFA flushes ī diff (b)(6)-2 [redacted] 9/W/M6
22May 2300	Pt care assumed @2100. A+O x3, VSS, @ c/o pain. lungs CTA, bowel sounds (+) x4 quadrants, no complaints at this time. Dressing on RLE CDI. pt took dressing off LLE, wet→dry dressing reapplied @2130. Dressing CDI, pt has great ROM in both lower extremeties. HL @ RFA flushes well, will continue to monitor. SPC [redacted] 9/W/M6 (b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

558-104

7540-01-075-37

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT *(Patient)*

LOG NUMBER | TREATMENT FACILITY

RECORDS MAINTAINED AT

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

SEX: M

DUTY/LOCAL PHONE — AREA CODE | NUMBER

AGE: 22

HOME PHONE — AREA CODE | NUMBER

ARRIVAL

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

TRANSPORTATION TO FACILITY

MILITARY STATUS

ITEM	YES	NO	N/A
PRP			
FLYING STATUS			

MEDICAL HISTORY OBTAINED FROM

THIRD PARTY INSURANCE

ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2568 IN CHART		

NAME OF INSURANCE COMPANY

CURRENT MEDICATIONS

ALLERGIES

CHIEF COMPLAINT

INJURY OR OCCUPATIONAL ILLNESS

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

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INITIAL SERIES ☐ YES ☐ NO

CATEGORY OF TREATMENT

☐ EMERGENT

☐ URGENT

☐ NON-URGENT

TIME

INITIALS

VITAL SIGNS

TIME	1952				
BP	106/60				
PULSE	100				
RESP	17				
TEMP	98.9				
WT					

LAB ORDERS

✓ CBC/DIFF	✓ ~~ABG~~	PT/PTT	BHCG/~~URINE/BLOOD~~/QUANT
URINE C&S	UA MSCC/CATH		X CHEM: Med 8
✓ BLOOD C&S x			
m			

X-RAY ORDERS

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

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
	Tetnis U				
2005	50 ug Fentlyn				
	~~1g ambec~~				
	1 liter LR				

DISPOSITION: ☐ HOME ☐ FULL DUTY

DISPOSITION QUARTERS /OFF DUTY: ☐ 24 HRS. ☐ 48 HRS. ☐ 72 HRS

MODIFIED DUTY UNTIL

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

EPW [redacted]

(b)(6)-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

038

MEDCOM - 8511

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

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

1. AGE: 22 y.o.

HEIGHT:

WEIGHT: 55 kg (?)

2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication)
☑ NKDA ☐ PCN ☐ LATEX ☐ IODINE ☐ TAPE ☐ FOOD
REACTION:

3. PREVIOUS SURGERY [ ] NO [✓] YES (type):
I&D Lt BKA

4. PROPOSED SURGICAL PROCEDURE: Ancef Speaks little English
Revision of Scar

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition_____
Tobacco ? ppd X___yrs. Body Piercing_____ Diabetes (Y) (N) ROM_____ ASA/Motrin w/72 hrs (Y) (N)
ETOH ? Implants_____ Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures_____ Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS: Ancef

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to: ✓ 1) Surgical Procedure & Operating Room Environment 2) Separation Anxiety (Child) ✓ 3) Surgical Outcomes	o Pt. verbalizes any specific anxiety. o Pt. Exhibits relaxed body posture.	o Allow pt. to verbalize freely. o Explain OR environment and answer questions regarding surgery. o Offer comfort measures. (e.g., warm blanket, touch). o Explain all nursing procedures before they are done. o Remain with pt. whenever possible. o Maintain family interface. Parents to stay with pt.
B. AERATION ✓ Potential for respiratory dysfunction due to: 1) Positioning ✓ 2) Effects of Anesthesia ✓ 3) Medical/Smoking History	o Pt. will be able to breathe without difficulty during immediate intraoperative phase .	o Offer to elevate head of litter or offer pillow. o Observe pt. while awaiting surgery for signs of distress. o Assist anesthesia during intubation and extubation.
C. INTEGUMENT ✓ Potential impairment of skin integrity due to: ✓ 1) Intraoperative Immobility ✓ 2) ESU Pad Placement 3) Positional Aids 4) Prosthesis ✓ 5) Pooling of Prep Solutions	o Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened areas).	o Utilize pressure preventing devices on OR table and accessories. o Check for proper positioning and support to maintain good body alignment. o Pad pressure points. o Place ESU ground pad on non compromised skin surface area. o Keep prep fluids from pooling.

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

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

[redacted] (b)(6)-4

VERIFICATIONS AT HOLDING AREA:
! ID/Allergy Band ! Dentures Removed
! H & P ! Contacts Removed
! NPO Since_____ ! Jewelry Removed
! UHCG/LMP ! Body Pierce Removed
! Consent/Blood Transfusion Signed/Witnessed/Dated
! Surgical Site/Consent verified by Pt./Anesthesia/Surgeon
! Contact Precautions (Y) (N)
! Family/Friend:_____

6. PATIENT PROBLEMS AND NEEDS	PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to: ✓ 1) Intraoperative Mobility ___ 2) Positioning ___ 3) Existing Disease ___ 4) Safety Devices ✓ 5) Hypothermia	o Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse.	o Check for support stockings or ace wraps. If none, check with doctors. o Check that safety straps are correctly applied. o Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. o. Check that rings and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to: ✓ 1) Pain ___ 2) Intraoperative Hazards ___ 3) Prosthesis ✓ 4) Positioning ___ 5) Transfer pt. to/from OR table E.2. ✓ Potential discomfort due to: ✓ 1) Length of Surgery ___ 2) Positioning ___ 3) Arthritis	o Pt. will be transferred to OR table without difficulty. o Pt. will not experience unnecessary physical discomfort.	o Have sufficient people available for transfer. o Insure proper body alignment. o Allow patient to lie in position of comfort while waiting for surgery. o Offer support (i.e., pillows, bath towels, etc.) for positioning.
F. SPECIAL SENSES F.1. ✓ Diminished visual perception due to being: ✓ 1) Pre-Medicated ___ 2) W/O Glasses F.2. ✓ Potential for decreased communication due to: ___ 1) Diminished Hearing ✓ 2) Language Barrier F.3. NA Potential injury due to dentures: ___ 1) Upper ___ 4) Caps ___ 2) Lower ___ 5) Crowns ___ 3) Bridges	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR table. o Pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt. from _____ side. o Validate pt.'s understanding of verbal communication. o Verify removal of dentures.
G OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

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

_____ DATE

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

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title)
b)(6)-2 [redacted] MAJ AN
DATE: 21 May 03 TIME:

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title)
DATE: TIME:

MEDICAL RECORD	**PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT** For use of this form, see AR 40-407; the proponent agency is The Office of the Surgeon General.
1. AGE: 22 HEIGHT: WEIGHT:	2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): NKA 3. PREVIOUS SURGERY [ ] NO [✓] YES (type): (L) BKA

4. PROPOSED SURGICAL PROCEDURE:
Revision (L) BKA & wash-out

5. ADDITIONAL INFORMATION: Pt. speaks only Arabic. Translator present.

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

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

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

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

10. OR NURSING INTERVENTIONS COMPLETED/ADDITIONAL INTEROPERATIVE INTERVENTIONS NOTED.

[redacted] 1Lt/AN (b)(6)-2 4 May 03 DATE

11. POSTOPERATIVE EVALUATION:

Pt. comfortable, ∅ s/s of distress.
Bovie pad site clear pre & post op.

12. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title)	13. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title)
[redacted] 1Lt/AN (b)(6)-2 DATE: 4 May 03 TIME: 2130	[redacted] (b)(6)-2 DATE: 4 May 03 TIME: 2340

REVERSE OF DA FORM 5179, JUN 91

USAPA V1.0

MEDICAL RECORD | **INTRAOPERA[illegible] DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: 2 Hr BY Anesthesia

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY MAJ [redacted] (b)(6)-2

3. DATE 21 May 03 TIME PATIENT ARRIVED IN SUITE 1030

4. PATIENT IN ROOM TIME 1030 NUMBER

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NPO ∅ MN. NKA

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	1LT [redacted] (b)(6)-2	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)* Pt. in supine position on padded OR table. BUE on padded armboards <90°.

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

COMMENTS: Normal anatomic body alignment maintained.

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

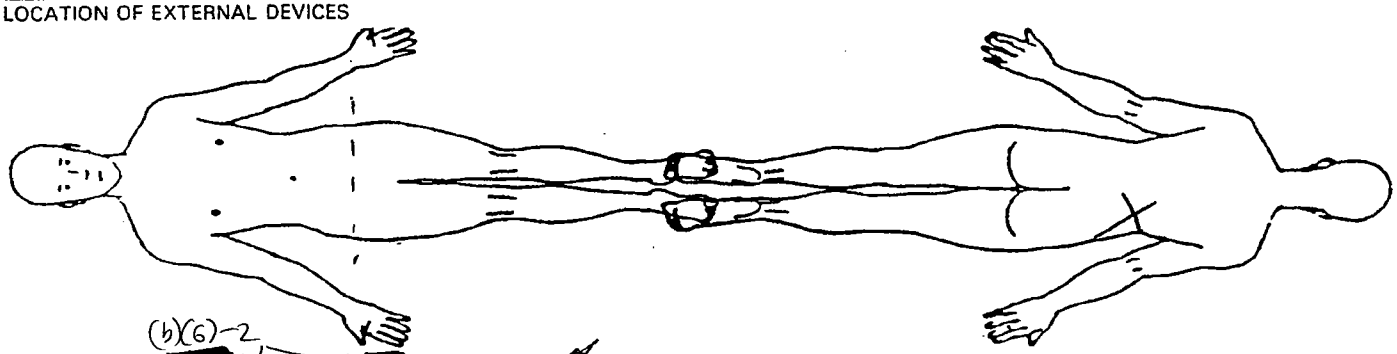
PREP SOLUTION *(Specify)*

SITE: BY WHOM:

SITE: BY WHOM:

COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



(b)(6)-2 [redacted]

LEGEND X Ground Pad -- Safety Strap = ∅ Tourniquet

Initial: SPC [redacted] ILT [redacted] (b)(6)-2 (b)(6)-2

C = Correct I = Incorrect

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

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

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

[redacted] (b)(6)-4

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

☒ ESU NO: #3

GROUND PAD: BRAND 3M

LOT NO: 2005-10 OT

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS, SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
MARCAINE 0.5% (PLAIN) Lot 593603A Exp 1 Jun 2004	1:1 Mix Ø cc	INTRA-OP	LOCAL INJ	[redacted]	[redacted]
XYLOCAINE 1% c EPI Lot 204130 Exp 4/04				[redacted]	
				(b)(6)-2	(b)(6)-2

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

OTHER ORDERS	TIME	CARRIED OUT BY
N/A		

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

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

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*
fluffs, kerlix ACE

19. ADDITIONAL INFORMATION

Surgeon - Dr [redacted] (b)(6)-2
Anesthesia. CPT [redacted] (b)(6)-2

DA 5179 initiated.

20. OPERATION(S) PERFORMED

Revision of Scar

21. PATIENT TRANSFERRED TO ICU 1 TIME 1105 METHOD Litter c O2

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

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

MEDICAL RECORD | **INTRAOPER[illegible] DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA: gurney BY LC [redacted] / CPT

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY XTC [redacted] CPT [redacted]

3. DATE 06 MAY 03 TIME PATIENT ARRIVED IN SUITE (b)(6)-2 1400 (b)(6)-2

4. PATIENT IN ROOM TIME 1450 (b)(6)-2 NUMBER 2 - 2 (b)(6)-2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NKDA NPO > 6hrs ∅metal ∅jewelry ∅glasses

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS:

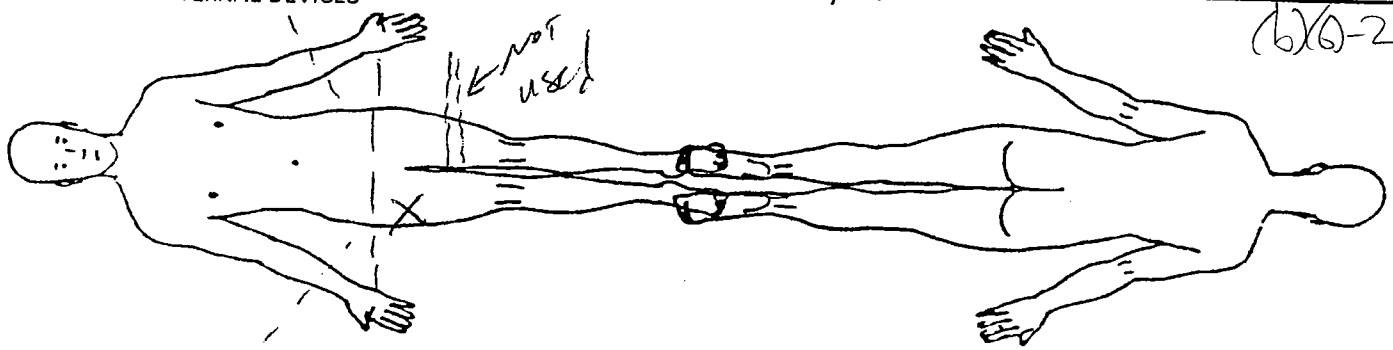
8. SKIN PREPARATION

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

COMMENTS:

PREP SOLUTION *(Specify)* Betadine / Betadine (b)(6)-2
SITE: (b) BKA Stump BY WHOM: CPT [redacted]
SITE: BY WHOM: (b)(6)-2 [redacted]
COMMENTS: prep assist c Dr [redacted]

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

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

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

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

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

☒ ESU NO: 3
GROUND PAD: BRAND 3M
LOT NO: 9165 LOT 2005-10 OT

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

0.9% NACL

OTHER ORDERS	TIME	CARRIED OUT BY

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

15. X-RAY IN OPERATING ROOM YES ☐ NO ☒ [redacted] IF YES, SITE (b)(6)-2

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

18. DRESSING/IMMOBILIZATION *(Specify)*

fluffs, Kerlix, Ace
Silk Tape

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. Penrose 5/8"	2.	3.
SITE	1. (L) BKA STUMP	2.	3.

19. ADDITIONAL INFORMATION

Anesthesia Lte [redacted] (b)(6)-2 Surgeon: Dr. [redacted] (b)(6)-2
Dr. [redacted] (b)(6)-2

Tourniquet used for case.

START 1438 STOP 1508

20. OPERATION(S) PERFORMED

I+D (L) BKA

21. PATIENT TRANSFERRED TO ICU 2 - recovery TIME 1515 METHOD gurney

22. REGISTERED NURSE SI[redacted] (b)(6)-2 [redacted] CCT/AN

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

MEDICAL RECORD | **INTRAOPERA[illegible] DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: LITTER BY ANESTHESIA

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY 1LT [redacted] (b)(6)-2

3. DATE: 4 MAY 03 TIME PATIENT ARRIVED IN SUITE: 2220

4. PATIENT IN ROOM TIME 2220 NUMBER

5. PREOPERATIVE EMOTIONAL STATUS

[X] CALM [ ] ANXIOUS [ ] EXCITED [ ] CRYING [ ] ANGRY [ ] WITHDRAWN [ ] OTHER (Specify)

COMMENTS: Ate lunch @ 1300, NKA,

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	1LT [redacted] (b)(6)-2	RELIEF CIRCULATOR	
	1LT [redacted] (b)(6)-2		

7. POSITION AND POSITIONAL AIDS (Specify) Pt. in supine position on padded OR table. BUE on padded arm boards <90°. Normal anatomic body alignment maintained. Tourniquet site protected c kling

[X] SUPINE [ ] LITHOTOMY [ ] PRONE [ ] KRASKE LATERAL: [ ] LEFT SIDE UP [ ] RIGHT SIDE UP

COMMENTS:

8. SKIN PREPARATION

HAIR REMOVAL [ ] YES [X] NO

DONE BY: [ ] OR [ ] NURSING UNIT

METHOD: [ ] DEPILATORY [ ] RAZOR [ ] CLIP

COMMENTS: N/A

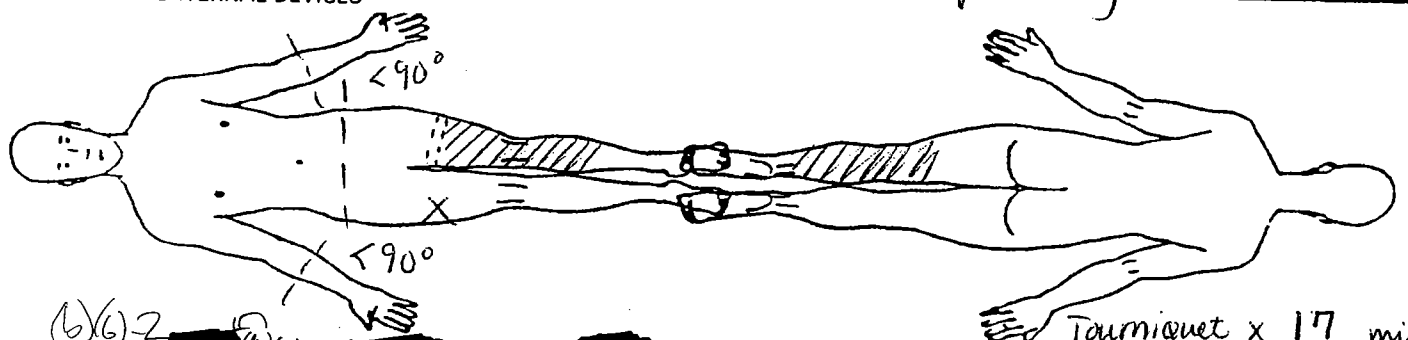
PREP SOLUTION (Specify) Betadine/Betadine

SITE: LLE circumferentially BY WHOM: 1LT [redacted] (b)(6)-2

SITE: BY WHOM:

COMMENTS: No pooling

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad — Safety Strap → [redacted] = = = Tourniquet [illegible] - prep

Initial: SPC [redacted] 1LT [redacted]

10. COUNTS

C = Correct I = Incorrect

			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge (b)(6)-2	[X] Yes	[ ] No					
Needle Sharp	[X] Yes	[ ] No					
Instrument	[ ] Yes	[X] No					
Other	[ ] Yes	[X] No					

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

[redacted] (b)(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) [X] YES [ ] NO

[X] ESU NO: #4

GROUND PAD: BRAND 3M

LOT NO: 2005-10 OT

[ ] ESU NO:

GROUND PAD: BRAND

LOT NO:

[ ] BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

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

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

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. Penrose drain	2.	3.
SITE	1. (L) BKA stump	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
ABD, fluffs, Kerlix

19. ADDITIONAL INFORMATION
Surgeon: Dr. [redacted] (b)(6)-2
Anesthesia: Dr. [redacted] (b)(6)-2

Bone pad site clear pre & post-op.

20. OPERATION(S) PERFORMED
Revision & washout (L) BKA

21. PATIENT TRANSFERRED TO ICW | TIME See DA 7389 | METHOD Litter c̄ O2

22. REGISTERED NURSE SIGNATURE [redacted] LT/AN

(b)(6)-2

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY																
POST-	DAY															
MONTH-YEAR	DAY	5 MAY 03		05 MAY		5 MAY 22	6 May 14	6 May 22	7 MAY			8 May 22				
19	HOUR	0130		16	14				06 22							

PULSE (O) / TEMP. F (•) / TEMP. C

TEMP. F	TEMP. C
105°	40.6°
104°	40.0°
103°	39.4°
102°	38.9°
101°	38.3°
100°	37.8°
99°	37.2°
98.6°	37.0°
98°	36.7°
97°	36.1°
96°	35.6°
95°	35.0°

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD	RR	15		16	16	12	20	20	107/62	115/70		16				
BLOOD PRESSURE		120		124/58	114/56	121	115/65	127/72		94			130/74	107/62		
		69	O2	100%	98%	66	91	99%	97%	98%						
						O2 98%	99%		P 87			98		98		
HEIGHT:	WEIGHT					1400			12/14	R 18						
						98.5 T										
						110/62 BP										
						16 R										
						94 P										
						98%										

Record special data only when so ordered

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

REGISTER NO.

WARD NO. ICW

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

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

[redacted] (b)(6)-4

511-119

NSN 7540-00-634-41:

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR MAY03 DAY 13 14 15 16 May 17 May 18 May 19

19 HOUR 8:30 12:00 8:30 12:00 8:30 12:00 8:30 12:00 8:30 12:00

PULSE (O) / TEMP. F (•)

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

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD RR 16 16 16 16 16 16 16 16 16 16 16 16

BLOOD PRESSURE 114/60 112/76 110/100 104/70 122/60 118/54 104/62 104/58 102/56 118/60 116/76 124/68

SpO2 99 97 98 94 99 100 98 98 98 99 99

HEIGHT: WEIGHT: 90 kg

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

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

VITAL SIGNS RECORDS

Medical Record

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

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR May 03 | DAY | 20 | 21 | 22 | 23 | 24 | 25 | 26

19 | HOUR

PULSE (0) | TEMP. F (•)

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

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

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD RR

BLOOD PRESSURE

HEIGHT: WEIGHT: 50

Record special data only when so ordered

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

[redacted] (b)(6)-4

REGISTER NO.

WARD NO. ICW2

STANDARD FORM 511 (REV. 7–95) BACK

NSN 7540-00-634-4124

.DICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

ST- DAY

MONTH-YEAR | DAY: 10 May | 11 May | 12 May

19 | HOUR: 4 | 8 | 12 | 16 | 20 | 24

PULSE (O) | TEMP. F (°)

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

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

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD: RR 16 | 14 | 12 | 40 | 16 | 16 | 16 | 12 | 20 | 16 | 16

BLOOD PRESSURE: 106/60 | 116/70 | 118/78 | 102/64 | 100/72 | 110/64 | 108/40 | 116/70 | 108/64

SpO2: 98 | 98 | 99

HEIGHT: | WEIGHT

Record special data only when so ordered

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

REGISTER NO.

WARD NO. ICW2

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

[redacted] (b)(6)-4

VITAL SIGNS RECORDS

Medical Record

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

(b)(6)-2

CHEMISTRY RESULT F

(Subject to the Privacy Act of 19

Ward/Section: EMM

REQUESTING PHYSICIAN: [redacted]

SSN/PSEUDO SSN

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

DATE: 4May03 TIME: 2002

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU	97	73-118 mg/dl
BUN	12	7-22 mg/dl
CRE	0.6	0.6-1.2 mg/dl
CK	54	39-380 u/l (M) 30-190 u/l (F)
NA^+	138	128-145 mmol/l
K^+	4.4	3.3-4.7 mmol/l
CL^-	102	98-108 mmol/l
tCO_2	25	18-33 mmol/l

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

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

DATE: 4May 03

LAB ID NO.:

Ward/Section: EMT	REQUESTING PHYSICIAN: [redacted] (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI. [redacted] (b)(6)-4	DATE 4 May 03	TIME 2002	SSN/PSEUDO SSN:

(Hematology) CBC			(Urinalysis)			(Misc Serology)		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC	6.7	4.8-10.8 X10^3	Color		N/A	RPR		Negative
RBC	3.21	4.7-6.1 X10^9	App		N/A	(Microbiology)		
Hgb	8.5	14-18 g/dL M 12-16 g/dL F	Glu		Negative	Source		
Hct	27.9	42-52% M 37-47% F	Bili		Negative	Gram Stain		
MCV	86.9	80-94 fl M 81-99 fl F	Ket		Negative	O & P		
Plt	579	130-500 X10^3 verified	SG		N/A	Occ Bld		Negative
Lymph %	26.6	20.5-51.1%	Bld		Negative	H. pylori		Negative
(Hematology) Manual Differential			pH		N/A	Micro Parasites		
Segs		Mono	Prot		Negative	Malaria		
Bands		Eos	Urob		0.2-1.0	Other		
Lymph		Baso	Nit		Negative	(Microscopic Urinalysis)		
Atyp		Imm	Leuk		Negative			
RBC Morph			HCG		Negative			
Spun Hematocrit		42-52% (M) 37-47% (F)	(CSF)			(Blood Bank)		
Sed Rate			Cell Count			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED		
Other			Directigen		Negative	ABO/Rh	AB Pos	

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

REMARKS:

REPORTED BY: (b)(6)-2 [redacted]	DATE: 4 May 03	LAB ID NO.:

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

LAST, FIRST, MI	DATE	TIME	SSN/PSEUDO SSN:
EPW [redacted] (b)(6)-4	5/5/03	0410	[redacted] (b)(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	6.1	4.8-10.8 X10³
RBC	2.69	4.7-6.1 X10⁹
Hgb	7.0	14-18 g/dL M 12-16 g/dL F
Hct	23.4	42-52% M 37-47% F
MCV	87.0	80-94 fl M 81-99 fl F
Plt	450	130-500 X10³ verified
Lymph %	30.5	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Coagulation Studies

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

Mycology

TEST	RESULT	REF. RANGE
RPR		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
(b)(6)-2 [redacted]	5 May 03	

MEDICAL RECORD — ANESTHESIA

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML, "I"=CONSTANT INFUSION		1400	30	1500	30	1600
DRUG	(Units)					
Versed	( )	2 1				
Fentanyl	( )	50 25 25 25 50 50				
Propofol	( )	60 90				
Mosnin	( )		4 2 2 2			
	( )					
	( )					
VOLAT. AGENT: Sevoflurane	% del		3.0 2.5 2.5 2.5			
	% e.t.					
AIR	L/Min					
N2O	L/Min					
O2	L/Min	10 2 2 2 2.8				
SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS						

FLUIDS		
LINE site IV	☐ Warmed	
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOSSES		
EST BLOOD LOSS		~~150~~
URINE –		120

TOTALS	
3 mg	
250	
10 mg	
TOTAL IN	100
TOTAL URINE	150

FLUIDS – SUMMARY	
CRYSTALLOID–	700
COLLOID–	
BLOOD–	

REMARKS– Code drugs with numbers, events with letters

PT IV Chart Review
IV Restarted 18g Left hand
1400 In Room Monitors on
1420 Anesthesia induction

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 55 (KG) LB

HEMATOCRIT: 23.4

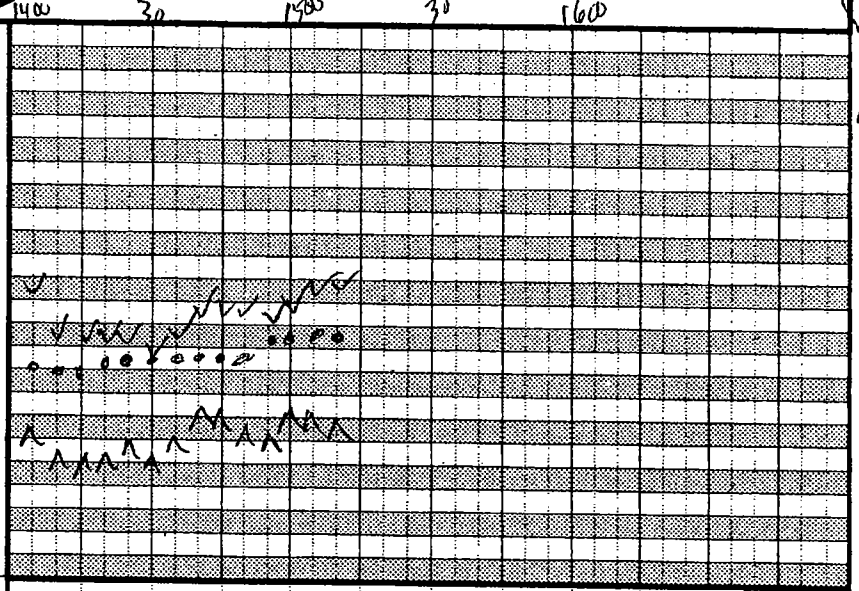
INITIAL DATA: BP – 124/63 HR– 90

BOHP CHECK: OK?– (Y) N

PATIENT REMARKS: OK for PROCEDURE? (Y) TIME– 1345

TIME → 1400 30 1500 30 1600

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



		1400	30	1500	30	1600
VT – ml						
f – breaths/min			20	24	18	22
Peak inf pres / PEEP						
MODE– S(pon), A(ssist), C(on)			SV	SV	SV	SV
BP/Auto Cuff	ET CO2 (torr)		34	34	34	34
BP / oth	FIO2 (Frac or %)		.80	.80	.80	.80
ART line	SpO2 (%)		100	100	100	100
Steth- PC/ES	ECG		SR	SR	SR	SR
Gas analyzer	TEMP- site		Axillary			
	N-M Block (T/4)					
Warming blkt						
Conv warmer						

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

RECOVERY AT 1520	
PACU / ICU ____ (Specify)	
OTHER	
CONDITION: Stable	
RESP– 9	SpO2– 98% O2 Fm
BP– 124/70	HR– 107

ANESTHESIA & PROCEDURE TIMES	Start	Room	End
ANES	1345	1400	1575
PROC	Ready	Begin	End
	1420	1438	1508

PROCEDURES and CPT Codes

I&D left BKA

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

Gen mask

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

BBS= ETCO2 x6 eyes taped

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

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

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

ANESTHETISTS: [redacted] LT Tech

[redacted] (b)(6)-2

PROCEDURE LOCATION 2

DATE 6 May 03

PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 8529

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

MEDICAL RECORD — ANESTHESIA

DRUG	(Units)	
Versed	(mg)	1 1 1 1 1
Fentanyl	(mcg)	25 50 25 50 50
Propofol	(mg)	20 20 20 20 20 20 20 20 20 20 20 20 20 20 20 20
VOLAT AGENT	% del	
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	RA FM - FM FM (62 68 68)

CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML, "I" = CONSTANT INFUSION

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

FLUIDS		
LINE site	☐ Warmed	
Lt	☐ Warmed	SDD — 600 700
	☐ Warmed	
	☐ Warmed	

LOSSES	
EST BLOOD LOSS	
URINE –	

PHYS STATUS: 1 2 3 4 5 (E)

BODY WEIGHT: ~55 (KG) LB

HEMATOCRIT:

INITIAL DATA: BP – 116 163; HR – 89

COMP CHECK: OK? – (Y) N

PATIENT RECHECK: OK for PROCEDURE? TIME – yes 2215

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

TIME → 22[15] ✓ 23[00] 15 30 45

VT – ml						
f – breaths/min	22	18	20	18	20	27
Peak inf pres / PEEP						
MODE– S(pon), A(ssist), C(on)	S	S	S	S	S	S
ET CO2 (torr)	VBICE — VBICE					
FIO2 (Frac or %)	RA	FM	FM	.5		
SpO2 (%)	101	99	100	99	100	
ECG	—	SR	SR	SR	SR	
TEMP- site	available					
N-M Block (T/4)						
			BX	BX		

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

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

PROCEDURES and CPT Codes: (L) BKA 1877 / Revision

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

[redacted] (b)(6)-4

lot #: K136484 exp 03/2004

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: SAB: SNIM - sitting - stand betadine prep 3cc 1% lidoSQ. #25 quink to SAS 2nd pass (+) CSF (-) paresthesia (-) heme ∴ easy inject 12mg hyperbaric tetracaine c̄ 25 mcg fentanyl.

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: Natural c̄ FM O2

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

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

TOTALS		
	N	W
	5	0
	250	0
	140	

TOTAL INT: 300

TOTAL URINE: Ø

FLUIDS – SUMMARY: CRYSTALLOID – LR 700 mg; COLLOID –; BLOOD – Ø

REMARKS – Code drugs with numbers, events with letters

2220: To OR #2 SNIM

2235-40: SAB (see below

2301: (T) 1 (L) LE @ 300 mm Hg

2315 Case Relief LTC [redacted] (b)(6)-2

2323 (T) + 17 min

2340 To ICU #2 via litter

Report to CPT [redacted] AW (b)(6)-2

RECOVERY AT 2345: PACU / ICU (Specify); OTHER I 927; CONDITION: Nausy; RESP – 16; SpO2 – 100% RA; BP – 125/69; HR – 88

ANESTHESIA & PROCEDURE TIMES

	Start	Room	End
ANES	2200	2220	2355
PROC	Ready	Begin	End
	2245	2310	2338

MEDICAL RECORD – ANESTHESIA

PROCEDURE LOCATION: OR 2

DATE: 4 MAY 03

PAGE 1 OF 1

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 8530

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

NKDA

MEDICAL RECORD — ANESTHESIA

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML, "1"=CONSTANT INFUSION		
DRUG	(Route)	
Midazolam	(iv)	2-1 ~1
Fentanyl	(iv)	25-25 <100 250>
Propofol	(iv)	<80> 20-20-20
	( )	
	( )	
	( )	
VOLAT AGENT	% del	
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2 SFM	L/Min	5 5 5 RA
SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS		

TOTALS	
4mg	
250mcg	
40mg	
X	

TOTAL STH: Min.

TOTAL URINE: Ø

FLUIDS – SUMMARY
CRYSTALLOID– LR=300cc
COLLOID– Ø
BLOOD– Ø

FLUIDS		
LINE site	20g (R) AC	☐ Warmed — LR → #1
		☐ Warmed
		☐ Warmed
		☐ Warmed

LOSSES	
EST BLOOD LOSS	
URINE –	

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 55 (KG) LB

HEMATOCRIT: —

INITIAL DATA: BP – 122/58 HR – 79

EQUIP CHECK: OK? – (Y) N

PATIENT RECHECK: OK for PROCEDURE? JR TIME – 1100

TIME → 0930 · 1100 · 30 · 1200

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

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

VENTILATOR		
VT – ml		
f – breaths/min		18 20 20
Peak inf pres / PEEP		
MODE – S(pon), A(ssist), C(on)		S S S
MONITORS & ACCESSORIES	BP/Auto Cuff	ET CO2 (torr)
	BP / oth	FIO2 (Frac or %) 2.21 2.21 2.21 [redacted] (b)(6)-2
	ART line	SpO2 (%) 100 100 100 [redacted] (b)(6)-2
	Steth- PC/ES	ECG SR SR SR
	Gas analyzer	TEMP- site
		N-M Block (T/4)
	Warming blkt	Blanket x1 →
	Conv warmer	

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

REMARKS – Code drugs with numbers, events with letters

(1) Pre-op assessment
(2) Consented by Dr. [redacted]
(3) Room, monitors, Sedation, ETT, O2 (b)(6)-2
(4) To ICU #1 via litter VSS. Resp even/Reg. Report to nursing staff. Pt stable

RECOVERY AT 1100
PACU ICU #1 (Specify) for recovery
OTHER
CONDITION: Stable RA
RESP-15 SpO2-99%
BP-106/57 HR-88

ANESTHESIA PROCEDURE TIMES

	Start	Room	End
ANES	1015	1030	1115
	Ready	Begin	End
PROC	1035	1040	1057

PROCEDURES and CPT Codes: I&D (L) BKA / Revision of scar

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: MAC sedation + local

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: Natural SFM

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

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

ICW #2

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

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

PROCEDURE LOCATION: 2

DATE: 21 May 03

PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA
RMC OP 376 REVISED Jan 99

MEDCOM - 8531 [redacted] (b)(6)-2 CRNA

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

ANESTHESIA PLAN OF CARE / PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 22 DAYS MOS (YRS) Sex (X) MALE ( ) FEMALE

ASA Physical State 1 (2) 3 4 5 E
WT: ~55 (KG/LB HT: ____ IN.
ALLERGIES: NKDA

PROPOSED PROCEDURE: I+D (L) BKA
SURGICAL SERVICE: Ortho - [redacted] (b)(6)-2
NPO SINCE: ____

HABITS:
TOBACCO: ____
ETOH: ____
DRUGS: ____

CURRENT MEDICATIONS:
( ) = ordered as premed

() Ancef 1g 78° IVB Q8 x 2
() ____
() TC3 PRN
() Demerol PRN
() ____
() ____

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

LABORATORY STUDIES:
HB/HCT: ____ / ____
U/A: ____
OTHER: ____
5/5/03 6.1 / 7.0 / 23.4 / 450

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

ASSESSMENT
PAST SURGICAL/ANESTHETIC
BKA

PHYSICAL EXAMINATION 99%
BP 110/64 HR 91 R 20 T 98.5
Pain Scale 0-10 ____
HEENT - Teeth ____
Trachea ____
TMJ/Neck ____
Oropharnyx ____
Nares ____
CHEST: ____
CARDIAC: ____
EXTREMITIES: ____
IV Access: PAC Heparin
Ulnar Filling: ____
BACK: ____
OTHER: Foley

NPO Since ____

ANESTHETIC PLAN: ( ) LOCAL ( ) MAC (X) Regional (Specify): SAB (X) General: Mask Intubation → B/u
Switched to Gen due to Short case.

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discussed with the patient/legal guardian. [redacted] (b)(6)-2 Free
CPT (b)(6)-2

The patient/legal guardian seems to understand and agrees. Questions answered.
Signed: [redacted] CRNA Date: 6 May 03 Time: 1235 Hrs

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

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward) ____

EPW [redacted] (b)(6)-4
ICW #1

SEDATION KEY:

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

ANESTHESIA PLAN OF CARE / PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 22 **DAYS MOS YRS** **Sex** (X) **MALE** ( ) **FEMALE**

PROPOSED PROCEDURE: work out infected [redacted] (b)(6)-2
SURGICAL SERVICE: Ortho
NPO SINCE: Ate + Drank

ASA Physical State 1 (2) 3 4 5 (E)
WT: 55 (KG/LB HT: ____ IN.
ALLERGIES: NKDA

HABITS:
TOBACCO: ____
ETOH: ____
DRUGS: ____

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) tetanus
( ) Strep Fecalis
( ) ____
( ) ____
( ) ____
( ) ____

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

LABORATORY STUDIES:
HB/HCT: ____ / ____
U/A: ____
OTHER: ____
T+S
Chest - 8/ Pending

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

Unobtainable

ASSESSMENT
PAST SURGICAL/ANESTHETIC
BKA

PHYSICAL EXAMINATION
BP 104/60 HR 100 R 17 T 98.9
Pain Scale 0-10 ____
HEENT - Teeth Intact - poor MI
Trachea ____
TMJ/Neck ____
Oropharnyx ____
Nares ____
CHEST: ____
CARDIAC: ____
EXTREMITIES: ____
IV Access: ____
Ulnar Filling: ____
BACK: ____
OTHER: ____

NPO Since ____

(b)(6)-2
ANESTHETIC PLAN ( ) **LOCAL** ( ) **MAC** (X) **Regional (Specify):** SAB (X) **General:** Mask Intubation BLK
For [redacted] (b)(6)-2

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

The patient/legal guardian seems to understand and agrees. Questions answered.
Signed: ____ **Date:** ____ **Time:** ____ **Hrs**

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

Signed: ____ **Date:** ____ **Time:** ____ **Hrs**

SEDATION KEY:

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

Patient Identification: (Ward) ____

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

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 22 DAYS MOS YRS Sex (✓) MALE ( ) FEMALE

ASA Physical State 1 (2) 3 4 5 E
WT: 55 (KG/LB) HT: ____ IN.
ALLERGIES: NKDA

PROPOSED PROCEDURE:
SURGICAL SERVICE: OR Tho- [redacted] (b)(6)-2
NPO SINCE: 2400

HABITS:
TOBACCO: Ø
ETOH: Ø
DRUGS:

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) Cimetidine IVPB @ 0600
( )
( )
( )
( )
( )

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

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

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:
- Hypertension N Y
- Angina N Y
- MI N Y
- CVA N Y
- Other N Y

Pulmonary System:
- Asthma N Y
- Bronchitis/URI N Y
- COPD N Y
- Other N Y

Renal System:
- Acute/Chronic RF N Y

Gastrointestinal:
- Hepatitis N Y
- Hiatal Hernia N Y
- PUD/GERD N Y

Endocrine System:
- Diabetes N Y
- Steriods N Y
- Thyroid N Y

Neurological:
- Seizures N Y
- Neuropathy N Y
- Other N Y

Gynecological :
- Pregnancy N Y

Other Significant Hx:
- N Y GSW Left LE
- N Y Late March 4
- Familial HX N Y (L) BKA admitted for infection

Unobtainable

ASSESSMENT
PAST SURGICAL/ANESTHETIC
(L) BKA
I&D (L) leg / BKA

PHYSICAL EXAMINATION
BP 127/68 HR 79 R 18 T 96
Pain Scale 0-10 8
HEENT - Teeth intact
Trachea midline
TMJ/Neck FROM
Oropharynx MP1
Nares patent
CHEST: CTA (B)
CARDIAC: RRR (-) (-)
EXTREMITIES:
IV Access: 20G (R) AC
Ulnar Filling:
BACK:
OTHER: Scar mandible from previous MVA

NPO Since

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

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

The patient/legal guardian [redacted] understand and agrees. Questions answered.
Signed: [redacted] (b)(6)-2 CRNA Date: 21 May 04 Time: 0730 Hrs

POST-ANESTHESIA EVALUATION AND NOTE (NON ASU)
{ ✓ } NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER
Signed: [redacted] (b)(6)-2 CRNA Date: May 21, 2003 Time: 1745 Hrs

Patient Identification: (Ward)

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

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

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

NURSING UNIT: 5/21/03 | ROOM NO.: 2310 | BED NO.: 24 °V/S

DATE OF ORDER: 5/21/03 | TIME OF ORDER: 1100 HOURS | LIST TIME ORDER NOTED AND SIGN

- Resume pre op orders
- Regular Diet
- Start daily wet to dry [redacted] dressing Δ's (R) LE + (L) LE [redacted]

[redacted] (b)(6)-2 | (b)(6)-2 | Noted [redacted] 21 May 03

[redacted] 1CTAN (b)(6)-2 | 1200

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

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

DATE OF ORDER: 5/25/03 (b)(6)-2 | TIME OF ORDER: 1530 HOURS | (b)(6)-2

- D/C IV
- D/C Ancef
- start keflex 500mg Q6h po [redacted]
- D/C (R) LE dressing Δ's
- XR (R) leg [redacted]

(b)(6)-2 | noted [redacted] 25 May 03 1535

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

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

DATE OF ORDER: 5/25/03 | TIME OF ORDER: 00:36 HOURS

VO Percocet ÷ PO q 4-6° PRN for breakthrough pain

Dr. [redacted] (b)(6)-2 (b)(6)-2 | noted 00:40 26 May 03 [redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

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

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

Sent

DATE OF ORDER: 15 May 03 TIME OF ORDER: 2200 HOURS

LIST TIME ORDER NOTED AND SIGN

0 Benadryl 50 g po now } noted 15 May 03 2330

[redacted] (b)(6)-2

NURSING UNIT: 24° V/S ROOM NO. BED NO. 2400

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

15 May 03

PATIENT IDENTIFICATION

DATE OF ORDER [redacted] ORDER

16 MAY 03 0215 HOURS

2 mg MSO4 IV

10 mg Ambien P.O. } noted 0230 16 may

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

NURSING UNIT: 24° V/S ROOM NO. BED NO. 2400

16 may 03 [redacted] (b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER

5/17/03 1330 HOURS

XR - (R) leg 2-Views

[redacted] noted [redacted] 14 May 03 1455

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

NURSING UNIT: 24° V/S ROOM NO. BED NO. 0030

18 May 03 [redacted] (b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER [redacted] TIME OF ORDER

5/19/03 1100 HOURS

[redacted] (b)(6)-2

- Daily Dressing b's (R) LE wet to dry

- Benadryl 25-50 mg q6° po prn pruritis

Notes (b)(6)-2 [redacted] 5-19-03 1030

[redacted] (b)(6)-2

NURSING UNIT: Ward #2 ROOM NO. 24° V/S BED NO. 0100

20 may 03 [redacted] (b)(6)-2

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MEDCOM - 8536

CLINICAL RECORD - DOCTOR'S ORDERS

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

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

Transcribed [redacted] 0200 9 May 03

(b)(6)-2

NURSING UNIT	ROOM NO.	BED NO.
ICW2	F	2

DATE OF ORDER: 9 May 03 TIME OF ORDER: 0200 HOURS

LIST TIME ORDER NOTED AND SIGN

1/0 DR [redacted] (b)(6)-2

(1) Demerol 50 mg IVSP x 1 now

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

X

MD Signature

Chart v done [redacted] 9 May 03

PATIENT IDENTIFICATION

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

NURSING UNIT	ROOM NO.	BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

NURSING UNIT	ROOM NO.	BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

NURSING UNIT	ROOM NO.	BED NO.

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

MEDCOM - 8537

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION			DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
(b)(6)-4 [redacted] (b)(6)-2 [redacted] EPW # [redacted] (b)(6)-4			5 MAY 03 (b)(6)-2 1725 HOURS V.O. PER DR [redacted] TO LT [redacted] PLACE FOLEY CATH FOR DIFFICULTY VOIDING. — [redacted] (b)(6)-2 5/6/03 0800 - NPO NOW (b)(6)-2 [redacted]	(b)(6)-2 Noted 5/6/03 0835 [redacted] (b)(6)-2
NURSING UNIT	ROOM NO.	BED NO.		
PATIENT IDENTIFICATION			DATE OF ORDER / TIME OF ORDER	
			5/6/03 1500 HOURS - 8 bible - Routine v/s - Heplock IV - Regular Diet - Ancef 1 gm IV PB q8° - T#3 ii po q4° prn - Demerol 50 mg IV q4° prn (premedication)	Noted & sent 5/6/03 1600 [redacted]
NURSING UNIT	ROOM NO.	BED NO.		
PATIENT IDENTIFICATION			DATE OF ORDER / TIME OF ORDER	
(b)(6)-4 [redacted] EPW # [redacted] (b)(6)-4			- Phenergan 25 mg IV q6° prn nausea HOURS - Colace 100 mg po BID - Reinforce dressing prn [redacted] (b)(6)-2	[redacted] (b)(6)-2
NURSING UNIT	ROOM NO.	BED NO.		
24 V [redacted]		MAY 5/7/03	0400	
PATIENT IDENTIFICATION			DATE OF ORDER / TIME OF ORDER	
(b)(6)-2 [redacted] (b)(6)-4			5/20/03 1800 HOURS NPO MN 2R @ 100 cc/hr pMN [redacted] (b)(6)-2	
NURSING UNIT	ROOM NO.	BED NO.		
ICW2				

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

MEDCOM - 8538

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 5/4/03 TIME OF ORDER 2000 HOURS

LIST TIME ORDER NOTED AND SIGN

- Admit ICW #1
- NPO
- LRC 100cc/hr -

[redacted]

(b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-4

[redacted]

(b)(6)-4

[redacted]

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

Admit ICW #1
Dx = (L) Amputee & (R) Lower Leg Fx
VS = q8hrs
Cond. = Stable
ALL = NKDA
Meds = Fentyl 50mcg IV q1h PRN pain

[redacted] (b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 5/4/03 TIME OF ORDER 2300 HOURS

- Admit ICW #1
- Stable
- Bedrest
- Routine Vitals
- Regular Diet
- Heplock IV
- Ancef 1gm IVPB 8hr 06-14-22

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

- T+3 Tylo q4h PRN pain
- Demerol 50mg IV q4h PRN breakthrough
- Phenergan 25mg IV q6h PRN nausea
- CBC in AM

[redacted] (b)(6)-2

(b)(6)-2

038

NURSING UNIT | ROOM NO. | BED NO.

24 V Unit [redacted] 0200 06 MAY 03

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

(b)(6)-2

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CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

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

↓	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	4 MAY 03	2350 HOURS	
	Anesth post op Orders		
1	Zofran 4mg IV for N/V may repeat		
	x 1 if ineffective p 30 min		(b)(6)-2
2	Morphine Sulfate 2mg IV q 5min prn		
	for pain MAX dose 20 mg		
	(b)(6)-2 [redacted]	[redacted] LTC/CRNA	[redacted] 2350

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	
	HOURS	

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	
	HOURS	

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	
	HOURS	

NURSING UNIT | ROOM NO. | BED NO.

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

all (b)(6)-2

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 5 Yr. 2003

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
5/4	[redacted]	NPO	06	/					
			12	/					
			18	[redacted]					
5/4	[redacted]	VS : q shift ; routine	06	/	[redacted]				
			14	/					
			22	[redacted]					
5/5	[redacted]	Bedrest	05	/	[redacted]				
			17	[redacted]					
5/5	[redacted]	Diet : Regular	06	/	[redacted]				
			12	/					
			18	/					
5/5	[redacted]	Foley to gravity	05	/	/	[redacted]			
			17	/					
5/6	[redacted]	NPO	08	/	/	/			
			12	/	/				
			18	/	/				

Pre Op

DIC 6 May 04 [redacted]

Pre Op

ALLERGIES: ☐ YES ☑ NO
NKDA

PRIMARY DIAGNOSIS:
(L) amputee + (R) Lt leg Fx

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

PATIENT IDENTIFICATION:

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

[redacted] (b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

all (b)(6) -2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo MAY Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
5/4	[redacted]	Admit ICW #1; Cond. stable				[redacted]
5/5	[redacted]	CBC in a.m.	5/5	0400	0410	[redacted]
5/5	[redacted]	Place foley catheter	5/5	1730	1730	[redacted]

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

USAPA V1.00

all (b)(6)-2

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 20	21	22	23	24	25
5/6	[redacted]	Routine Vitals	06	[redacted]					
			14	[redacted]					
			22	[redacted]					
5/6	[redacted]	Regular Diet	08	[redacted]					
			12	[redacted]					
			18	[redacted]					
5/19	[redacted]	Daily Dsg Δ's to RLE W→D	10	[redacted]					DC'd
5/21	[redacted]	W→D Dsg Δ to LLE	10	/ / [redacted]					DC'd

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P T3,4 (L) BKA

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO: 9

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

all (b)(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo _____ Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
21	[redacted]	Resume Pre-op orders	21	Now		[redacted]
21	[redacted]	Regular diet	21	Now		[redacted]
25	[redacted]	X Ray (R) leg	25	today	1600	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
3/10	[redacted]	Reinforce DSG														
-----	-----	PRN														
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															

USAPA V1.00

all (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. 5 Yr. 03

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
5/16	[redacted]	Heplock IV	06	/	[redacted]												
	[redacted]	flush q8°	14	/													
			22	[redacted]													
5/16	[redacted]	Ancef 1gm IVPB q8°	06	/													
			14	/													
			22	[redacted]													
5/16	[redacted]	Colace 100mg po BID	10	/													
			22	[redacted]													

ALLERGIES: ☐ YES ☑ NO

NKDA

PRIMARY DIAGNOSIS:

S/P I+D (L) BKA

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO. 1

PATIENT IDENTIFICATION:

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

[redacted] (b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

all (b)(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. May Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
9May03	[redacted]	~~Demerol 50mg IVP x1 now~~	9May	0230	0230	[redacted]
15May03	[redacted]	Benadryl 50mg PO now	now	2300	2300	[redacted]
16May03	[redacted]	MSO4 2mg IVP now	16May03	0230	0230	[redacted]
16May03	[redacted]	Ambien 10mg PO now	16May03	0230	0230	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED														
5-6 5-9	[redacted]	Tylenol #3 II po q4° prn	D/T	6May 1830	7May 0226	5/7/03 0600	7May 1340	[redacted]	9May 1820	9May 0130	9May 1500	9May 2100	10May 1630	11May 0000	11May 0700	11May 1336	11 May 2045
			D/I	II	II	II	II	[redacted]	II	[redacted]	[redacted]	[redacted]	II	[redacted]	II	[redacted]	II
			I/E			E											
5-6 5-9	[redacted]	Demerol 50mg IV q4° prn breakthrough	D/T	5May 0034	8May 0330	9May 0230	9May 0750	9May 1600	10May 1645	10May 2130		11May 0300	13May 0010				
			D/I	50mg	50mg	50mg	50mg IV	50mg	50mg	50mg E		50mg IV	50mg				
			I/E														
5-6	[redacted]	Phenergan 25mg IV q6° prn nausea	May 1735	7May 2340	11May 0100	15May 0550											
			25mg	25mg	25mg	25mg											
			E														
11May	[redacted]	Tylenol #3 II PO q4° prn	II 11May 0102	12May 0730	13May 0530												

See new sheet

USAPA V1.00

all (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. 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
5/4	[redacted]	LR @ 100 cc/hr	05	/			
			17	[redacted]			
5/5	[redacted]	Heplock IV	05	/	[redacted]		
			17	[redacted]			
5/5	[redacted]	Ancef 1gm IVPB q8°	06	/			
			12	/			
			18	/			
			24	/			
5/5	[redacted]	Ancef 1gm IVPB q8°	06	/	[redacted]		
			14	/			
			22	/			

error [redacted] PROP

ALLERGIES: ☐ YES ☑ NO
NKDA

PRIMARY DIAGNOSIS: (L) amputee + (R) Loleg Fx

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

PATIENT IDENTIFICATION:

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

[redacted] (b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

all (b)(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo._____ Yr._____
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials

Pre-OP

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
5/4	[redacted]	Fentanyl 50mcg q 1°	date													
		IV prn pain	time													
			dose													
			init.													
5/5	[redacted]	T #3 ÷ PO q4° prn	date	5/5	5MAY	5MAY	5/5	5MAY	6MAY							
		pain	time	0415	0815	1300	1905	2305	0430							
			dose	÷	÷	÷	÷	÷	÷							
			init.	[redacted]												
5/5	[redacted]	Demerol 50mg IV q4°	date	5MAY	5MAY	5MAY	5MAY	5MAY	6MAY	6MAY	6MAY					
		prn breakthrough	time	0130	0655	1300	1740	2140	0140	0445	1215					
			dose	50mg	50mg	50	50mg	50mg	50mg	50mg	50mg					
			init.	[redacted]												
5/5	[redacted]	Phenergan 25mg IV	date													
		q6° prn nausea	time													
			dose													
			init.													
5/5	[redacted]	CBC														

Pre-OP

USAPA V1.00

all (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. 5 Y. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 20	21	22	23	24	25
5/6	[redacted]	Heplock IV	06	[redacted]					
		flush q8°	14						
			22						
5/6	[redacted]	Ancef ÷ gm IVPB q8°	06	[redacted]					
			14						
			22						
5/6	[redacted]	Colace 100mg PO BID	10	[redacted]					
			22						
5/25	[redacted]	Keflex 500mg QID PO	6						[redacted]
			12						
			18						[redacted]
			24						[redacted]

DC'd

DC'd

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: S/P I-3D (L) BKA

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO. 2

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

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

all (b)(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)					Mo. _____ Yr. _____
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials	

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED												
	[redacted]	Tylenol #3 tabs	5/13 1030	5/13 1320	5/14 1605	5/14 2330	5/15 1140	5/17 0080	5/17 1305	18 May 1030		20 May 0400	20 May 850	20 May 1400	21 May 1130
		ii q4° prn pain	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		[redacted]	[redacted]	[redacted]	[redacted]
19 May	[redacted]	Benadryl 25mg-50mg	5/19 1145	5/19 50mg 2330	5/20 50mg 2100	5/21 50mg 0130	5/25 25mg 0720	5/25 50mg 2241							
		PO q6hrs pm prn	[redacted]												
		Tylenol #3 tabs	5/19 0115	5/20 ii 0830	5/20 ii 1210	5/21 ii 2210	5/24 ii tabs 0005		24 May ii tabs 0420	25 May 1445	25 May 05 21:50				
	[redacted]	ii q4° PRN Pain	[redacted]												
5 May 05	[redacted]	Percocet i PO q4-6°	24 May 0014-420												
		PRN for breakthrough	[redacted]												
		pain													

USAPA V1.00

all (b)(6)-2

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 5 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 6	7	8	9	10	11	12	13	14	15	16	17	18	19
5/6	[redacted]	Routine vitals	06	/	[redacted]												
			14	/													
			22														
5/6	[redacted]	Regular Diet	08	/													
			12	/													
			18														
~~5/10~~	[redacted]																
5/19	[redacted]	Daily Drs dx to RLE W→D	10	/	/	/	/	/								/	

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS:

S/P I+D @ BKA

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION:

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

[redacted] (b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

all (b)(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 5 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
5/6	[redacted]	Stable			noted	[redacted]
5/17		X Ray (R) leg 2-Views	17 May	Now		[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													
5-6	[redacted]	Reinforce Dressing														
		prn														

USAPA V1.00

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED *(Date)*

Date: 4MAY03
Time In: 2345
Allergies: NKDA
Pre-op V/S: 114/63, 84
Procedures: D&A (L) leg revision

Anesthesia Type (Circle): General Spinal Epidural (IV Sedation) Nerve Block
OR Intake: Crystalloid 700 Colloid
OR Output: UOP -0 EBL 300
Meds/Times: 5mg Versed, 5pm, 250mcg Fentanyl 1400 PROP

ASA II

55 kg

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

Pre Op Meds History

Time	2345	2350	2355	100	0015	0020	0025	
SaO2	100	100	100	99	100	99	100	100
FiO2	/	/	/	/	/	/	/	/
Methods	RA	RA	RA	RA	RA	RA	RA	RA
240								
220								
200								
180								
160								
140								
120	125	131	130	133	131	130	131	
							117	118
100								
80								
60	69	68	72	72	71	71	66	66
40								
20								
RR	16	16	16	16	16	14	16	16
T	RA							

Pacu Intake

Time	Solution	Amount	Site	By	Infused
2345	LR	+300	(R) Arm	L	+300
0025	LR	+1000			1300

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	1	1	1
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	2	2	1
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	/	/	/
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	9	9	8

Codes

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

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

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

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

Time	
Pain (0-10)	
LOS	

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

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC: PA T CLIN

DATE: 5MAY03

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

[redacted] (b)(6)-4

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

all (b)(6)-2

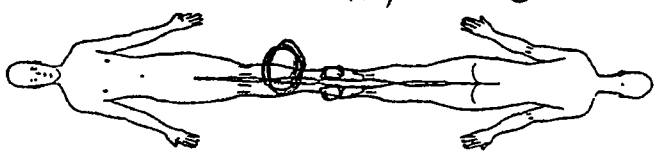
MEDICATIONS						
Allergies:						
Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
0000		MSO4/2mg	IV			[redacted]
0005		MSO4/2mg	IV			[redacted]
0010		MSO4/2mg	IV			[redacted]
0015		Zofran/4mg	IV			[redacted]
0015		MSO4/2mg	IV			

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

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

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

DRESSINGS			
Time	Location	Type	Drainage
Adm	(L) Knee	Bulky	Ø
30' 0015	(L) Knee	Bulky	Ø
60'			
D/C 0010	(L) Knee	Bulky	Ø



PACU OUTPUT			
Time	Source	Color/Appearance	Amount
~~0000~~			

CARDIAC RHYTHM			
Time	Rhythm	Symptomatic?	Rhythm Strip Run?
0000	SR	NO	NO

NURSING NOTES

0000: Pt. admitted to ICU #2 for recovery on gurney on room air. V.S.S. upon arrival. Dsg to (L) BKA is Pt I. Pt. placed on cardiac monitors. Will continue to monitor. — CPT [redacted]
0020: MSO4 2mg IVP: CPT [redacted]
0029: MSO4 2mg IVP: CPT [redacted]
0030: unable to determine pain level on a scale of 1-10. Pain med given due to pt. moaning and facial expressions. Pt. is resting comfortably at this time. — CPT [redacted]

Discharge Criteria:
Date: 5 MAY Time: 0102 PARS: 8
BP: 117/66 T: 98 HR: 91 RR: 14 SaO2: 100%
Pain Level at D/C (0-10):
Intake: LR 600 Output: 0
Additional Data:
Transferred To: ~~Ward~~ ICW #1
Report Given To: LT [redacted]
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: CPT [redacted]
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature: [redacted] CPT

WAMC OP 173-E

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 6 May 03
Time In: 1400 / 1530
Allergies: NKDA
Pre-op V/S: 124 63 90
Procedures: (L) BKA TFD

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

OR Intake: Crystalloid 700 Colloid 0
OR Output: UOP 150 EBL 100
Meds/Times: Ancef 1400 versed/fentanyl

1500-1520 MSO4 10mg

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

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds / History

Time	1520	1525	1530	1535	1550	1605	1620
SaO2	100	100	100	99	97	97	98
FiO2	FT	FT	FT	/	/	/	/
Methods	FM	FM	FM	RA	RA	RA	RA
240							
220							
200							
180							
160							
140							
120	V	V	V	V	V	V	V
100	•	•	•	•	•	•	•
80	^	^	^	^	^	^	^
60							
40							
20							
RR	10	10	9	11	9	10	11
T	98.1	98.3	98.2				

Time							
Pain (0-10)							
LOS							

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

(Continue on reverse)

Pacu Intake (b)(6)-2

Time	Solution	Amount	Site	By	Infused
1520	LR	1200	Shoul	[redacted]	150

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	1	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	1	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	2	2	2
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	10	11	12

Codes

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

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

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

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

PREPARED BY (Signature & Title): [redacted] CPT/AN (b)(6)-2

DEPARTMENT/SERVICE/CLINIC: ICU #2

DATE: 6 May 03

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

(b)(6)-4

EPW [redacted]

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

MEDICATIONS

Allergies:

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

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	RLE	+	+	UTA	<3	warm	pink
15'	RLE	+	+	UTA	<3	warm	pink
30'	RLE	+	+	UTA	<3	warm	pink
45'							
60'							
90'							
D/C							

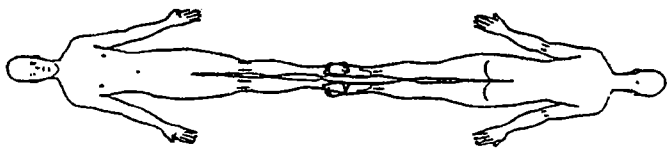
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

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



PACU OUTPUT

Time	Source	Color/Appearance	Amount
1600	Foley	clear	100

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

Patient recovered in ICU #2 on litter. Ø c/o pain. VSS, Ø N/V. Awakens to voice. DSG CDI, CMS ✓ good. (b)(6)-2
Report given to CPT [redacted]

[redacted] CPT/MN
(b)(6)-2

Discharge Criteria:
Date: 6 May 03 **Time:** 1620 **PARS:** 12
BP: 126/68 **T:** 98.2 **HR:** 103 **RR:** 11 **SaO2:** 98%
Pain Level at D/C (0-10): UTA
Intake: 150 LR **Output:** 100cc
Additional Data:
Transferred To: ICU #2
Report Given To: CPT [redacted] (b)(6)-2
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: [redacted] (b)(6)-2
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature: [redacted] (b)(6)-2

1103

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 21 May 03
Time In: 1103
Allergies: NKDA
Pre-op V/S:
Procedures: I&D

Anesthesia Type (Circle)): ~~General~~ Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 3000cc ~~Colloid~~
OR Output: UOP EBL Minimal
Meds/Times:

reversed
200mcg Fentanyl
3000cc LR

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

Pre Op Meds History

Time	1100	1120	1135
SaO2	99	99	99
FiO2			
Methods	RA	RA	RA
240			
220			
200			
180			
160			
140			
120			
100			
80			
60			
40			
20			
~~PO2~~			
RR	10	12	16
T	97.8	97.8	97.9

Time			
Pain (0-10)			
LOS			

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

(Continue on reverse)

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

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

Codes

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

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

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

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

PREPARED BY (Signature & Title): [redacted] 91Wm6

(b)(6)-2

DEPARTMENT/SERVICE/CLINIC: KU #1

DATE: 21 May 03

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

[redacted] (b)(6)-4

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

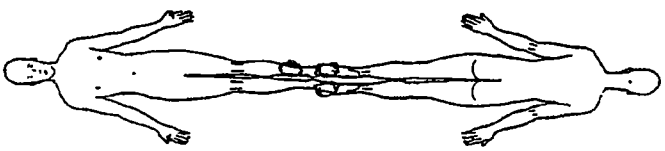
MEDICATIONS						
Allergies:						
Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By

NEUROVASCULAR							
Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	(L) leg	full	present	P	NA	warm	normal
15'	(L) leg	full	present	P	NA	warm	normal
30'	(L) leg	full	present	P	NA	warm	normal
45'							
60'							
90'							
D/C							

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

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

DRESSINGS			
Time	Location	Type	Drainage
Adm	(L) leg	fluffs/kerlix	none
30'	(L) leg	fluffs/kerlix	none
60'			
D/C			



PACU OUTPUT			
Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM			
Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1125	NSR		

WAMC OP 173-E

NURSING NOTES

pt received from OR fully awake and responds to commands. USS Able to move non combative. Able to bear weight on own leg - [redacted] 9 lumen IV (R) forearm CDI in place.
(b)(6)-2

Discharge Criteria:
Date: 21May03 **Time:** 1135 **PARS:**
BP: 110/61 **T:** 97.8 **HR:** 81 **RR:** 16 **SaO2:** 99
Pain Level at D/C (0-10):
Intake:_____ **Output:**_____
Additional Data:_____
Transferred To:_____
Report Given To:_____
Transferred Via: W/C Litter Gurney Ambulance
Transferred By:_____
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature:_____

Ø38

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF								LOCATION (State or Country Code.)
1	2	3	4	5	6	7	8	
A	/	1	D	/		I	Z	

3. REGISTER NUMBER						
9	10	11	12	13	14	15
[redacted]						

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

4. PAY GRADE		5. SEX
16	17	18
	EPW	M

6. DATE OF BIRTH (YYYYMMDD)							
19	20	21	22	23	24	25	26
U	N	K					

7. AGE AT ADMISSION		
27	28	29
2	2	4

8. RACE	9. ETHNIC BACKGROUND	RELIGION
30	31	
X	9	UNK

10. LENGTH OF SERVICE			ETS
32	33	34	
		N/A	N/A

11. FMP	
35	36
9	9

12. SOCIAL SECURITY NUMBER								
37	38	39	40	41	42	43	44	45
[redacted]								

ORGANIZATION (Active Duty Only) N/A

13. MARITAL STATUS
46
U

HOUR OF ADMISSION	BRANCH / CORPS
1300	N/A (b)(6)-4

14. FLYING STATUS		
47	48	49
		N/A

15. BENEFICIARY CATEGORY		
50	51	52
K	7	6

16. ZIP CODE OF RESIDENCE								
53	54	55	56	57	58	59	60	61

17. UNIT LOCATION (State or Country Code)		
62	63	
N		N/A

18. MOS						
64	65	66	67	68	69	70
U	N	K				

19. TRAUMA
71

PREV. ADMISSION YEAR ☐ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION
72
Ø

WARD: JCW#2

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: UNK

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): UNK

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted] (b)(2)-2

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE: UNK

21. TYPE OF DISPOSITION	
73	74
2	6

22. MTF TRANSFERRED TO					
75	76	77	78	79	80

23. DATE OF DISPOSITION (YYYYMMDD)							
81	82	83	84	85	86	87	88
2	0	0	3	0	5	2	5

24. CLINIC SVC - ADMITTING			
89	90	91	92
A	A	A	A

25. MTF TRANSFERRED FROM					
93	94	95	96	97	98

26. DATE THIS ADMISSION (YYYYMMDD)							
99	100	101	102	103	104	105	106
2	0	0	3	0	5	1	8

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	
107	108

28. MTF OF INITIAL ADMISSION					
109	110	111	112	113	114

29. DATE INITIAL ADMISSION (YYYYMMDD)							
115	116	117	118	119	120	121	122

FOR LOCAL USE

DX: S/P I & D BKA

Inj Trauma

284 9

Dx 99762 82300 7092 E8799

Pr 843 (4) 8684

ADMITTING OFFICER (Signature, as required): [redacted]

SIGNATURE OF ADMITTING CLERK: [redacted]

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER 12987	2. NAME (Last, First, MI) EPW- [redacted] (b)(6)-4			3. GRADE EPW	ADMISSION REMARKS
4. SEX M	5. AGE 27Y	6. RACE X	7. RELIGION UNK	8. LENGTH OF SVC —	9. ETS —	10. PREVIOUS ADMISSION NO
11. FMP 99	12. SSN [redacted]		13. ORGANIZATION — (b)(6)-4		14. WARD ICW#2
15. FLYING STATUS NO	16. RATING/ DSG	17. DEPT./ BEN K78	18. BRANCH/CORPS —	19. UIC/ZIP —	20. TYPE CASE NBI
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION DIRECT FROM ER			22. HOURS OF ADMISSION 1400	23. CLINIC SERVICE AEAA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE UNK		25. TYPE DISPOSITION 05		26. DATE OF DISPOSITION 14 MAY 2003	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) UNK		27b. TELEPHONE NO. UNK		28. DATE OF THIS ADMISSION 9 MAY 2003	ADMITTING OFFICER (b)(6)-2 DR. [redacted]
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY				30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

GSW to Leg.

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

680.6
891.1
E 991.2

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
Ø	Ø	Ø	Ø	5	5

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL [redacted]

Dr. [redacted]

SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER [redacted]

DA FORM 3647, MAY 79 (b)(6)-2 MEDCOM - 8560 (b)(6)-2

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

S/P GSW TO (L) LEG ABOUT 5 DAYS AGO. WOUND CLOSED. ALL WITH PAIN FROM WOUND. UNABLE TO OBTAIN ADDITIONAL INFORMATION

PHYSICAL EXAMINATION

IN NAD
HEART - WNL
CHEST - CLEAR
EXT (L) LEG - ≈ 10 CM WOUND, DISTAL 1/3 OF THIGH

X-RAYS - GSW, WITH LYTIC AREA ≈ 2 x 1 CM, OVER THIGH,

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

(1) SUBACUTE CLOSED OSTEOMYELITIS
(2) I TO (L) LEG.

SIGNATURE	DATE	IDENTIFICATION NO.	ORGANIZATION
[redacted]	9 MAY 03		

b)(6)-2

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

REGISTER NO.	WARD NO.

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

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

MEDICAL RECORD	PROGRESS NOTES
DATE	
9 May 03	Vitals taken BP 120/88, P. 80, R. 16 TEMP 98.5
1400	SPO [redacted] (b)(6)-2
9 May 03 1420	[redacted] assumed pt care @ 1300. pt resting c̄ eyes closed. pt awaiting surgery this afternoon. lung sounds CTA bilat. BS(+)x4. pulses (+). IV site (0) AC infusing 5 diff. will cont to monitor (b)(6)-2 [redacted] 9 Wm Mp
9 May 03 1455	pt to surgery [redacted] 9 Wm Mp (b)(6)-2
9 MAY 03	ORTHO OP NOTE
1556	PRE-OP DX - GSW TO (L) TIBIA
	POST-OP DX - SAME
	PROCEDURE - I+D (L) LE
	SURGEON - [redacted]
	ANESTHESIA - SAB
	FLUIDS - 500 LR EBL - MIN
	FINDINGS: SMALL SHARP OFS PER IN SUPERIOR HOLDING, NO LOT CONTAMINATION TO BONE. BONE CONTUSION
	PLAN: IV ABXS [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)

(b)(6)-4

#[redacted]

REGISTER NO.

WARD NO. ICW2

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)
USAPPC V1.00

PROGRESS NOTES

DATE	
0800 9may03	Pt transferred from ICU @ 2230. Pt VSS, A+Ox3, no complaints of pain at this time. Pt lung sounds CTA with equal rise and fall of the chest. Pulses palpable x4, Bowel sounds ⊕ x4 quadrants. Dressing on ⓛ leg CDI. Patient has ⊕ ROM + sensation in ⓛ leg, capr refill <3 seconds. Will continue to monitor. SPC [redacted] (b)(6)-2 9IWMO
10MAY03 0700	(S) SOB/N PRN (O) DWB2L CLW + IOW (A) SPRB3V (P) DRSG TO CDI IN AM. (b)(6)-2 [redacted]
10MAY03	~~Assumed Pt care @ 0500. VSS. A&Ox3. Lungs CTA. ⊕BS x4 quad. Drsg on ⓛ leg CDI. AL in ⓛ FA patent. Denies c/o discomfort (b)(6)-2 [redacted] 9IWMO~~
10MAY03 2045	Pt. stable and c/o complaints throughout shift - SL patient (b)(6)-2 [redacted] CR
2330	~~Assumed care of Pt @ 2100. Pt. A&O. Pt. c/o ∅ pain. HL to ⓛ AC flushes well c ∅ s/s of infection or infiltration. HR Reg. Insp. wheezes noted to upper lobes bilat. Pt. reports he smokes ∅ DAY. BS ⊕ x4. Drsg to ⓛ LE CDI. Pt has ⊕ sensation, ⊕ ROM toes, capr refill <3 sec. UTA pulse 2° drsng. Pt. instructed to keep ⓛ LE ↑. Will continue to monitor [redacted] (b)(6)-2 (b)(6)-2 [redacted]~~
(b)(6)-2 [redacted]	Assumed care of Pt @ 2100. Pt. A&O. Pt. c/o pain ⅟ Percocet given c good results. HL to ⓛ AC flushes well c ∅ s/s infection/infiltration. HR Reg, Lungs CTA, BS ⊕ x4. ⓛ LE drsg CDI. Capr refill <3 sec. ⊕ sensation, ⊕ ROM toes. Will continue

STANDARD FORM 509 (REV. 7-91) BACK
USAPPC V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
14May03 0815	(cont.) HR Regular. Lungs CTA throughout. Bowel sounds active x4. pt ambulate to BR UOP clear yellow.
(b)(6)-2	w/ [redacted] Radial/pedal pulses strong bilat. Pt given 650 mg tylenol for c/o HA. Will continue to monitor [redacted]
	(b)(6)-2
14 May 03	
1435	(S) [illegible]
	(O) VSS
	WDWN [illegible]
	(A) STABLE [illegible]
	(P) DISCHARGE [illegible]
	[illegible] 250 [illegible]
	SUTURES OUT 17 or 18 [illegible]
	[redacted]
14May03	1245. Dsg to LLE A&d. Stitches intact. [redacted] (b)(6)-2 Sm amt drainage [redacted] (b)(6)-2 pink. Orders to DC today: DC prescription @ pharmacy. (b)(6)-2 [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	to monitor. (b)(6)-2 [redacted] ICTXN.
11 May 03 0620	PT vitals T 96.1 P 67 R 12 BP 90/72 → Spe[redacted] (b)(6)-2
11 May 03	0710: Assumed pt care @ 0500. Pt. awake & sitting up in bed. VSS. HL in (R) FA patent to flush. Lungs CTA. (+) BS x4. Movement x 4 extremities. Dressing on (R) leg CDT. Denies any discomfort @ this time [redacted]
11 May 03 1700	1330: assumed care of Pt @ 1300. VSS - BP 100/56, P.88, R.18 (b)(6)-2 Temp 98.6. c/o med (L) LE pain. ++ percocet given. Drsg/splint to (L) LE Dry, intact. Sm amount of Bldy drainage marked. (+) sensation, mvt, cap refill <3 sec of (L) toes. O/W assessment WNL. Will monitor. (b)(6)-2 [redacted]
11 May 03 1500	D/C (D) AC PIV @ pt request "causing pain" d/c cath intact ~~@ s/s~~ of infection. New 16G PIV started (R) AC, flushes well. (b)(6)-2 [redacted]
11 May 03 0330	Assumed care @ 2300. Pt presently alert, awake oriented, obeys commands (-) evidence of pain - denies "Flam." Pt sports (L) LE ace wrap. (+) quarter sized old drainage spot noted to ace wrap anterior, L.e. (+) sensation (+) movement, cap refill <3 sec. +1 swelling to foot. 1+ pulse dorsalis pedis. lung sounds clear throughout, (-) s/s resp difficulties. S1 S2 normal, regular. abd-soft distended, non tender on palpation. BS present x 4 q. 1800 q (R) FA flushes (-) BR - (-) infection (-) infiltration. Pt rested @ this time [redacted]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT [redacted] (b)(6)-2
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.)* EPW [redacted] (b)(6)-2

REGISTER NO. | WARD NO. ICW2

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	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
	0225: pt sleeping w/out evidence of pain or discomfort. [redacted]
12May03	0615 VS B/P 120/68 P 73 R 12 T96.0° (b)(6)-2 [redacted]
	Assume care @ 0500. pt awake, alert & oriented. S1 & S2 audible, regular. Lung sounds CTA. No c/o chest pain @ this time. Bowel sounds x4 active. No pain/tenderness during palpation of abd. Radial pulses strong bilat. pedal pulses palpable. Ace wrap to (L) LE pt able to wiggle toes. pt amb w/ crutches to BR. c/o pain in LLE. HL to (R) forearm flushes well. pt awake now. Will give percocet for pain and continue to monitor. (b)(6)-2 [redacted]
12MAY031255	PT Vitals taken T97.9 P81 R12 B/P 104/70 (b)(6)-2 [redacted] 9W
12may03 1820	pt. quiet throughout shift, periodically sleeping - crutches to bathroom to void, voiding QS - SL patent - no c/o pain [redacted] (b)(6)-2

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
0300 13May03	Pt care assumed @ 2100. Pt a+ox3, VSS, with no complaints of pain. Lung sounds CTA with equal use and fall of chest. Pulses palpable x4, Bowel sounds present x4. Dressing on LLE CDI. Pt has sensation, ROM, and capillary refill <3 seconds on LLE. Pt ambulates on his own to commode. Will continue to monitor. SPC [redacted] 91WM6 (b)(6)-2
13MAY03	0745. VS B/P 122/70 P 86 R 16 T 97.1 SpO2 99% pt awake A&O. VSS. c/o pain in LLE. HR regular. Lung sounds CTA. Pulses palpable. Bowel Sounds present x4. No c/o pain/tenderness during palpation of abd. Full ROM to upper extremities and RLE. Ace wrap to ankle and foot CDI. Cap Refill <3sec, pt has sensation and able to wiggle toes of LLE. HL was d/c, unable to flush. Will discuss with MD to d/c permanantly along with IV meds. (b)(6)-2 Pt ambulates to BR. Will continue to monitor. [redacted] 91WM6
13May03	1125 HL to L forearm, by SPC [redacted] (b)(6)-2 Site free of Redness or infiltration. Flushed with 3cc. Timed, dated and initialed. Pt awake. No c/o pain @ this time. [redacted] 91WM6 (b)(6)-2
13May03 1330	Pt vitals taken BP 102/62 P-80, R-16, Temp 98.1 SPC [redacted] (b)(6)-2

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

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

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

REGISTER NO.

WARD NO. 7CW2

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	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
13May03 1400	assumed pt care @ 1300. VSS. lung sounds CTA, abd soft nontender. BS(+) x4 quads. (R)LE draing CDI. (R)LE c̄ ace wrap to ankle & foot. HL (L)AC flushes ∃ diff (+) s/s of infiltration. (+) complaints voiced @ this time. Will cont to monitor ——— [redacted] 91WMC (b)(6)-2
13 MAY 03 1600	(S) NO COMPLAINTS (O) WBAR - <BSW & BLW GAIT WITH WALKER NO SWELLING (-) TTT (A) STABLE (P) D/C BRACE. BSW & KNEE [redacted] (b)(6)-2
1615 HRS	PT - D/C CRUTCHES, PNT ABLE TO AMBULATE INDEPENDANTLY. SPC [redacted], [redacted] 91WMC ——— (b)(2)-2 (b)(6)-2 (b)(6)-2 (b)(2)-2 [redacted]
14May 03 0015	Assumed pt care @ 2100. VSS, pt alert and awake, no complaints of pain. Dressing on (R)LE CDI. (R)LE is ace wrapped, CDI. Lung sounds [redacted] CTA with equal rise and fall of chest, bowel sounds present x4 quadrants. No complaints at this time, will continue to monitor. SPC [redacted] (b)(6)-2 91WMC ———
14May03 0625	PT vitals T 97.3 P 82 R 12 BP 104/74 ——— Spc [redacted] (b)(6)-2
14May 0855	Assume pt care @ 0500. pt alert & awake - no c/o pain @ this time. Dsg on LLE CDI & I. (cont) [redacted] (b)(6)-2

FPI. LEX. Printed on Recycled Paper

STANDARD FORM 600 (REV. 6-97) BACK

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

14 MAY 03 ORTHO TRANSFER NOTE

IHB OF (L) LEG WOUND MODE. WOUND CLEAN. BOY WEIGHT BEAR AS TOLERATED:

PLAN: KEFLEX 250 MG 4x/DAY x 10 DAYS DENY WEIGHT TO DAY DRESSING CHANGES SUTURES OUT 17 OR 18 MAY.

(b)(6)-2 [redacted]

(b)(6)-2 [redacted]

14 MAY 03 1300 Pt vitals taken: BP 102/64, P. 82, R. 16, Temp 98.3 (b)(6)-2 SPC [redacted]

14 May 03 1325 VSS. Pt sitting ↑ in bed. ⊖ complaints voiced. lung sounds CTA, abd soft nontender BS⊕ x 4 quads (L) LE: dressing Δ'd on prior shift, site c̄ Kerlix dressing. pulses ⊕. Will cont to monitor — [redacted] 91WM

(b)(6)-2

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

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

[redacted] (b)(6)-4

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
14May031445	Pt d/c'd per orders @ 1430 to custody of the MP's. pt in stable condition [redacted] 9/wmk
	(b)(6)-2

FPI. LEX. Printed on Recycled Paper

STANDARD FORM 600 (REV. 6-97) BACK

MEDCOM - 8570

NPO

NSN 7540-01-075-3786

MEDICAL RECORD	EMERGENCY CARE AND TREATMENT *(Patient)*	LOG NUMBER	TREATMENT FACILITY
		RECORDS MAINTAINED AT	

PATIENT'S HOME ADDRESS OR DUTY STATION			ARRIVAL	
STREET ADDRESS			DATE *(Day, Month, Year)*	TIME
CITY EPW	STATE	ZIP CODE	TRANSPORTATION TO FACILITY	

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

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

CHIEF COMPLAINT GSW to ⓒ dist hf fig x 5d

CATEGORY OF TREATMENT		VITAL SIGNS					
☐ EMERGENT	TIME	TIME	1125				
		BP	115/70				
☐ URGENT		PULSE	73				
	INITIALS	RESP	28				
☐ NON-URGENT		TEMP					
		WT					

LAB ORDERS						X-RAY ORDERS			
X	CBC/DIFF	ABG	PT/PTT	BHCG/URINE/BLOOD/QUANT			CXR PA & LAT/PORTABLE		C-SPINE
	URINE C&S	UA MSCC/CATH		~~CHEM-12~~			ACUTE ABDOMEN		LS SPINE
	BLOOD C&S X			MET-8			SINUS		HEAD CT
							ANKLE R/L		
	T&C			LFTS					

ORDERS

☐ PULSE OX ☐ MONITOR (b)(6)-2 ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
	~~IV bolus + LR~~	[redacted]	[redacted]	[redacted]	
	~~Td, Sec Im~~				
	~~Ancef 1gm IV~~		(b)(6)-2		

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

CONDITION UPON RELEASE	ADMIT TO UNIT/SERVICE	REFERRED ▶	TO	WHEN
☒ IMPROVED ☐ UNCHANGED ☐ DETERIORATED	TIME OF RELEASE	I have received and understand these instructions.		
		PATIENT'S SIGNATURE		

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

[redacted] (b)(6)-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

NSN 7540-01-075-3786

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

TEST RESULTS

CBC		SMAC					ABG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐
WBC 9.6			136	103	11	Bo	SUP 02	PH	PO2	RESULTS Xrg ⊕ shrapnel ⊕ bony involvement	
H/Hct 14.3	41.5		~~152~~				PCO2	SAT	OTHER		
PLT 532			4.7	25	.8						
PT			CK 152				U/A	DIP		EKG INTERPRETATION	
APTT		BHCG	ETOH	GLU				MICRO			

PROVIDER HISTORY/PHYSICAL

27 yo ♂ S/P GSW x 5 d T-T ⓛ t6/t6 w/ [illegible] for eval. 1° repair done

[redacted] (b)(6)-2

O: A&O x 4 in min distress. VS as above

HEENT ⊕ lip laceration/[illegible] unremarkable neck supple

CVS: [illegible] ⊕

Lungs: [illegible]

Abd: [illegible] soft [illegible]

Ext: ⓛ lower ext: ⊕ sutures in place ⓛ t6/t6 distal [illegible] ⊕ [illegible]. [illegible] M/V.

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNAT[redacted]P (b)(6)-2

DIAGNOSIS Gallstones s/p GSW to ⓛ t6/t6

CODES

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

(b)(6)-4

[redacted]

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

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

1. AGE: 27
HEIGHT: /
WEIGHT: /

2. KNOWN ALLERGIC SENSITIVITIES (e.g.. Iodine, Tape, Medication)
☒ NKDA ☐ PCN ☐ LATEX ☐ IODINE ☐ TAPE ☐ FOOD
REACTION:

3. PREVIOUS SURGERY [ ] NO [X] YES (type):
5 da (L) Tib Fib wD closure

4. PROPOSED SURGICAL PROCEDURE: (L) Tib Fib I+D

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition LLE wD
Tobacco unk ppd X___ yrs. Body Piercing Ø Diabetes (Y) (N) ROM WNL ASA/Motrin w/72 hrs (Y) (N)
ETOH unk Implants Ø Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures Ø Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS: Ø

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to: ✓ 1) Surgical Procedure & Operating Room Environment NA 2) Separation Anxiety (Child) ✓ 3) Surgical Outcomes	✓ Pt. verbalizes any specific anxiety. ✓ Pt. Exhibits relaxed body posture.	✓ Allow pt. to verbalize freely. ✓ Explain OR environment and answer questions regarding surgery. ✓ Offer comfort measures. (e.g.. warm blanket. touch). ✓ Explain all nursing procedures before they are done. ✓ Remain with pt. whenever possible. ✓ Maintain family interface. Parents to stay with pt.
B. AERATION ✓ Potential for respiratory dysfunction due to: ✓ 1) Positioning ✓ 2) Effects of Anesthesia ✓ 3) Medical/Smoking History	✓ Pt. will be able to breathe without difficulty during immediate intraoperative phase .	✓ Offer to elevate head of litter or offer pillow. ✓ Observe pt. while awaiting surgery for signs of distress. ✓ Assist anesthesia during intubation and extubation.
C. INTEGUMENT ✓ Potential impairment of skin integrity due to: ✓ 1) Intraoperative Immobility ✓ 2) ESU Pad Placement ✓ 3) Positional Aids NA 4) Prosthesis ✓ 5) Pooling of Prep Solutions	✓ Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened areas).	✓ Utilize pressure preventing devices on OR table and accessories. ✓ Check for proper positioning and support to maintain good body alignment. ✓ Pad pressure points. ✓ Place ESU ground pad on non compromised skin surface area. ✓ Keep prep fluids from pooling.

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

[redacted] (b)(6)-4

VERIFICATIONS AT HOLDING AREA:
✓ ! ID/Allergy Band ! Dentures Removed
✓ ! H & P ! Contacts Removed
! NPO Since____ ✓ ! Jewelry Removed
~~! UHCG/LMP~~ NA ! Body Pierce Removed
NA Consent/Blood Transfusion Signed/Witnessed/Dated
✓ Surgical Site/Consent verified by Pt./Anesthesia/Surgeon
! Contact Precautions (Y) (N)
! Family/Friend: Ø

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to: ✓ 1) Intraoperative Mobility ✓ 2) Positioning ✓ 3) Existing Disease ✓ 4) Safety Devices ✓ 5) Hypothermia	✓ Pt. will exhibit signs of adequate tissue perfusion (e.g.. color, warmth, pedal pulse.	✓ Check for support stockings or ace wraps. If none, check with doctors. ✓ Check that safety straps are correctly applied. ✓ Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. MA ✓ Check that rings and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to: ✓ 1) Pain ✓ 2) Intraoperative Hazards MA 3) Prosthesis ✓ 4) Positioning ✓ 5) Transfer pt. to/from OR table E.2. ✓ Potential discomfort due to: ✓ 1) Length of Surgery ✓ 2) Positioning ✓ 3) Arthritis	✓ Pt. will be transferred to OR table without difficulty. ✓ Pt. will not experience unnecessary physical discomfort.	✓ Have sufficient people available for transfer. ✓ Insure proper body alignment. ✓ Allow patient to lie in position of comfort while waiting for surgery. ✓ Offer support (i.e.. pillows. bath towels. etc.) for positioning.
F. SPECIAL SENSES F.1. ✓ Diminished visual perception due to being: ✓ 1) Pre-Medicated MA 2) W/O Glasses F.2. ✓ Potential for decreased communication due to: MA 1) Diminished Hearing ✓ 2) Language Barrier F.3. MA Potential injury due to dentures: 1) Upper 4) Caps 2) Lower 5) Crowns ✓ 3) Bridges	✓ Pt. will be made aware of surroundings prior to anesthesia induction. ✓ Pt. will be transferred safely to OR table. ✓ Pt. will be able to understand instructions. ✓ Minimize danger of injury during intraop period.	✓ Introduce self. Keep pt. informed as to where he she is and what is happening. ✓ Inform pt. in which direction to move and assist if necessary. ✓ Speak clearly and slowly. ✓ Address pt from either side. ✓ Validate pt.'s understanding of verbal communication. ✓ Verify removal of dentures.
G OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

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

(b)(6)-2 [redacted] CRT/AN 9 May 03 DATE

11. POSTOPERATIVE EVALUATION: SKIN INTEGRITY: Bovie Pad Site: ☒ Clean and Dry ☐ Red ☐ N/A DRESSING DRY & INTACT: (Y) (N)

LEVEL OF CONSCIOUSNESS: ☐ A&O ☒ Drowsy ☐ Sleepy ☐ Intubated BREATHING EASY: (Y) (N)

LEVEL OF ACTIVITY: ☒ Moves Upper Extremities ☐ Moves Upper Extremities (b)(6)-2

Spinal ☐ Transferred to liner with roller due to spinal

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) (b)(6)-2 [redacted] CRT/AN

DATE: 9 May 03 TIME: 1430

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] CRT/AN

DATE: 9 May 03 TIME: 1600

MEDICAL RECORD | **INTRAOPERAT[redacted] DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM (b)(6)-2
VIA: Litter (b)(6)-2 BY: [redacted] / [redacted]

2. PATIENT IDEN[redacted] AND PROCEDURE
VERIFIED BY [redacted]

3. DATE: 9 May 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN RO[redacted] (b)(6)-2
TIME: 1510 NUMBER: # 2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: non English speaking

6. NURSING PERSONNEL

ASSIGNED SCRUB	Spc [redacted], 91D (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	lt [redacted], 66E (b)(6)-2	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

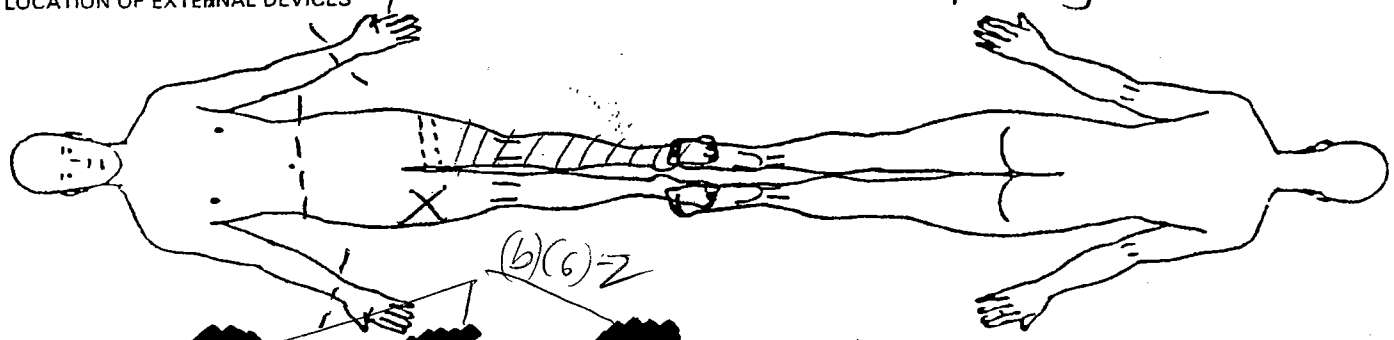
COMMENTS:

8. SKIN PREPARATION (b)(6)-2

HAIR REMOVAL: ☒ YES ☐ NO
DONE BY: ☒ OR [redacted] ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☒ CLIP
COMMENTS: ∅ nicks / cuts

PREP SOLUTION *(Specify)* Beta / Beta (b)(6)-2
SITE: LLE - foot to mid thigh BY WHOM: [redacted]
SITE: BY WHOM: [redacted]
COMMENTS: ∅ pooling or irritation

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Strap = = = Tourniquet – on but not used /// = prep

10. COUNTS

C = Correct I = Incorrect

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

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

[redacted] (b)(6)-2

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

☐ ESU NO: [redacted] (b)(6)-2 & #4
GROUND PAD: BRAND ~~Valley lab~~ / 3M
LOT NO: 20005-10 OT

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

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

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

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☒ NO ☒	NAME gram stain - LLE WD (Tib-Fib)	NAME
FROZEN SECTION (S) YES ☐ NO ☒	NAME	NAME
CULTURE (S) YES ☒ NO ☐	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

	1.	2.	3.
TYPE/SIZE			
SITE			

18. DRESSING/IMMOBILIZATION *(Specify)*
Kerlex
fluffs
Ace

19. ADDITIONAL INFORMATION
Dr [redacted] (b)(6)-2
Dr [redacted] (b)(6)-2

(b)(6)-2 (b)(6)-2
CPT [redacted], CRNA / LTC [redacted], CRNA = Spinal

20. OPERATION(S) PERFORMED
I+D (L) tib-fib WD

21. PATIENT TRANSFERRED TO ICU #2 TIME 1600 METHOD litter

22. REGISTERED NURSE SIGNATURE [redacted]

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR MAY 03 DAY

19 HOUR

PULSE (O) — TEMP. F (•)

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

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

TEMP. C (Centigrade Equivalents, for Reference only): 40.6° 40.0° 39.4° 38.9° 38.3° 37.8° 37.2° 37.0° 36.7° 36.1° 35.6° 35.0°

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT

Record special data only when so ordered

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

REGISTER NO.

WARD NO. ICW2

[redacted] (b)(6)-4

[redacted] (b)(6)-4

VITAL SIGNS RECORDS

Medical Record

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

(b)(6)-2 (b)(6)-4

Ward/Section: ER	REQUESTING PHYSICIAN: [redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 19[redacted])
LAST, FIRST, MI.	DATE: 9 Mar 03 / TIME: 1243	SSN/PSEUDO SSN: [redacted] (b)(6)-4

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU	90	73-118 mg/dl
BUN	11	7-22 mg/dl
CRE	0.8	0.6-1.2 mg/dl
CK	152	39-380 u/l (M) 30-190 u/l (F)
NA^+	136	128-145 mmol/l
K^+	4.7	3.3-4.7 mmol/l
CL^-	103	98-108 mmol/l
tCO_2	25	18-33 mmol/l

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB	3.8	3.3-5.5 g/dl
ALP	117	26-84 u/l
ALT	18	10-47 u/l
AMY	59	14-97 u/l
AST	37	11-38 u/l
TBIL	0.7	0.2-1.6 mg/dl
GGT	30	5-65 u/l
TP	7.9	6.4-8.1 g/dl

(Piccolo) Electrolyte

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

REMARKS: Metlyte 8 / Liver Panel

REPORTED BY:	DATE:	LAB ID NO.:
[redacted] (b)(6)-2	09 Mar 03	007

(b)(6)-2 (b)(6)-4

Ward/Section: ER	REQUESTING PHYSICIAN: Dr. [redacted]	LABORATORY RESULT FORM [redacted] (Subject to the Privacy Act of 19[redacted])
LAST, FIRST, MI.	DATE 9 May 03 / TIME 1242	SSN/PSEUDO SSN: [redacted] (b)(6)-4

Hematology/CBC

TEST	RESULT	REF. RANGE
WBC	9.6	4.8-10.8 x 10^3
RBC	5.04	4.7-6.1 x 10^9
Hgb	14.3	14-18 g/dl (M) 12-16 g/dl (F)
Hct	46.5	42-52% (M) 37-47% (F)
MCV	92.3	80-94 fl (M) 81-99 fl (F)
Plt	532	130-500 x 10^3 verified
Lymph %	15.0	20.5-51.1%

Hematology/Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

GSH

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS: CB (b)

REPORTED BY: [redacted]	DATE: 09 May	LAB ID NO.: 209

(b)(6)-2

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

[redacted]

(b)(6)-4

SPECIMEN/LAB RPT. NO.

MISC

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

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

SPECIMEN SOURCE (Specify) L + Hb fib wound

PATIENT'S MED. RECORD

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

REQUESTING PHYSICIAN'S SIGNATURE [redacted]

REPORTED BY [redacted] MD TECH

DATE 09MAY03

LAB ID NO. C07

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

557-107

TEST(S)

SPECIMEN TAKEN

DATE 9 MAY 03 TIME 1535 A.M. P.M.

REQUESTED Gram Stain

RESULTS

No organisms seen.

MISCELLANEOUS

STANDARD FORM 557 (Rev. 3-77)
Prescribed by SG-SGHA
FIRMR (41 CFR) 201-45.505

MEDCOM - 8580

NKDA

MEDICAL RECORD — ANESTHESIA

DRUG	(Units)	
Fentanyl	(mcg)	50 - 50 - 25 - (+SAB)
Midazolam	(mg)	2 - 1 / 1
	( )	
	( )	
	( )	
Tetracaine E 10% Dextrose 12mg + 25mg Fentanyl @1519 Intrathecal		
ISOLAT AGENT	% del	
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2 NC	L/Min	4 4 4

CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML, "I"=CONSTANT INFUSION

ANESTHETIC AGENTS AND DRUGS

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

TOTALS	TOTAL INS
150	25
5	
	TOTAL URINE
	Ø

FLUIDS – SUMMARY
CRYSTALLOID– 500
COLLOID– Ø
BLOOD– Ø

FLUIDS

LINE site		
PIV (L) A	☒ Warmed	LR – #1
	☐ Warmed	100+
	☐ Warmed	
	☐ Warmed	

LOSSES: EST BLOOD LOSS; URINE – Ø

PHYS STATUS: (1) 2 3 4 5 E

BODY WEIGHT: 70 (KG) LB

HEMATOCRIT: 46.5

INITIAL DATA: BP – 115/70; HR – 75

SOHIP CHECK: OK? – (Y) N

PATIENT RECHECK: OK for PROCEDURE? JP; TIME – 1523

TIME → 1519 • • 1600 • 30 • 1700

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

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

REMARKS –

Code drugs with numbers, events with letters

(1) Pre-op Review of systems. To OR. 1510
(2) Room, monitors O2 NC sitting position SAB L3-L4 Portex NO 479 x2 attempts; neg paresthesia (CSF x2 quadr). + CSF swirl pre-injection Tetracaine E 10% Dextrose 12mg + Fentanyl 25mg @1519.
(3) To stretcher & To ICU for recovery. Pt moved to assist to stretcher
(4) Report to nurse

VENTILATION

VT – ml		+ + +
f – breaths/min		20 16 16
Peak inf pres / PEEP		
MODE– S(pon), A(ssist), C(on)		S S S

MONITORS / ASSESSMENTS

BP/Auto Cuff	ET CO2 (torr)	— — —
BP / oth	FIO2 (Frac or %)	7.21 7.21 7.21
ART line	SpO2 (%)	100 100 100
Steth- PC/ES	ECG	SR →
Gas analyzer	TEMP- site	warm →
	N-M Block (T/4)	
	talking to pt	+ – +
Warming blkt	blanket	→
Conv warmer		

Mark with letters & symbols, explain under REMARKS — EVENTS (2) (E) (3) (4); Position → O →

RECOVERY AT 1602
PACU ICU (Specify) OTHER Recovery
CONDITION: stable awake
T-97.2
RESP– 16 SpO2– 100
BP– 121/77 HR– 71

ANESTHESIA PROCEDURE TIME

	Start	Room	End
ANES	1500	1510	1605
	Ready	Begin	End
PROC	1522	1532	1553

PROCEDURES and CPT Codes: I&D (L) LE

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: SAB

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: Natural, nasal cannula (b)(6)-2

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

SURGEON: [redacted]

ANESTHETISTS: [redacted] CRNA/CPT

PROCEDURE LOCATION: 2

DATE: 9 May 03

PAGE 1 OF 1

(b)(6)-2

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 7 DAYS MOS YRS Sex (X) MALE ( ) FEMALE

ASA Physical State 1 2 3 4 5 E
WT: 70 KG/LB HT: ____ IN.
ALLERGIES: NKDA

PROPOSED PROCEDURE: I/D Gastrostomy
SURGICAL SERVICE: Pediatrics
NPO SINCE: ____

HABITS:
TOBACCO: ____
ETOH: ____
DRUGS: ____

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) ____
( ) ____
( ) ____
( ) ____
( ) ____
( ) ____

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

LABORATORY STUDIES:

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

9.6 / 14.3 / 46.5 / 532
136 | 103 | 11 / 4.7 | 95 | .8 / 90

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:			
Hypertension	N	Y	____
Angina	N	Y	____
MI	N	Y	____
CVA	N	Y	____
Other	N	Y	____
Pulmonary System:			
Asthma	N	Y	____
Bronchitis/URI	N	Y	____
COPD	N	Y	____
Other	N	Y	____
Renal System:			
Acute/Chronic RF	N	Y	____
Gastrointestinal:			
Hepatitis	N	Y	____
Hiatal Hernia	N	Y	____
PUD/GERD	N	Y	____
Endocrine System:			
Diabetes	N	Y	____
Steriods	N	Y	____
Thyroid	N	Y	____
Neurological:			
Seizures	N	Y	____
Neuropathy	N	Y	____
Other	N	Y	____
Gynecological :			
Pregnancy	N	Y	____
Other Significant Hx:	N	Y	GSW (L) tib/fib
	N	Y	5 days ago
Familial HX	N	Y	____

Prefum on OR ≈ 1300

ASSESSMENT
PAST SURGICAL/ANESTHETIC

____
____
____
____
____
____

PHYSICAL EXAMINATION
BP 115/70 HR 95 R 28 T ____
Pain Scale 0-10 ____
HEENT - Teeth NPW
Trachea ____
TMJ/Neck WNL
Oropharnyx ____
Nares ____
CHEST: ____
CARDIAC: ____
EXTREMITIES: ____
IV Access: ____
Ulnar Filling: ____
BACK: ____
OTHER: ____
(L) AC IV

NPO Since ____

ANESTHETIC PLAN: { } LOCAL { } MAC (X) Regional (Specify): SAB vs GA { } General: Mask Intubation

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

The patient/legal guardian seems to understand and agrees. Questions answered.

Signed: ____ Date: ____ Time: ____ Hrs

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

(b)(6)-2

Sig: [redacted] Date: 5/9/03 Time: 1402 Hrs

Patient Identification: (Ward) ____

GPW #: [redacted] (b)(6)-4
ICW 2

SEDATION KEY:

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

NURSING UNIT: ICW2 | ROOM NO.: F | BED NO.: 3

DATE OF ORDER: 9 May 03 | TIME OF ORDER: 1300 HOURS | LIST TIME ORDER NOTED AND SIGN

1. Admit ICW2
2. Dx GSW (L) hip/fx
3. Stable
4. Allergies NKDA
5. Diet NPO
6. Bedrest
7. IVFs bolus 500cc LR then 150cc/h

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

NURSING UNIT: ICW2 | ROOM NO.: F | BED NO.: 3

DATE OF ORDER | TIME OF ORDER | HOURS

8. ~~Meds~~ error
9. Ancef ~~I~~ gm IV q 6° x 24°
10. call Dr [redacted] upon pt arrival to unit

[redacted] (b)(6)-2

noted 9 May 1400 [redacted] 9 May 03

(b)(6)-2

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

NURSING UNIT: ICW2 | ROOM NO.: F | BED NO.: 3

DATE OF ORDER: 9 May 03 | TIME OF ORDER: 1553 HOURS

1. TO ICW 2 AFTER RECOVERY
2. S/P GSW TO (L) LEG, I&D
3. STABLE
4. VS Q SHIFT
5. ~~OP~~ RESTRAINT PER GPW ROUTINE
6. REPORT TO DIST
7. IV-LR AT 125cc/HR, HEP LOCK WHEN TOLERATED PO, WHL
8. ANCEF 1 GRAM IVPB Q 8 HRS
9. PERCOCET, 1-2 PO Q 4 HRS PRN
10. TYLENOL 650 MG PO Q 4 HRS PRN

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

NURSING UNIT: ICW2 | ROOM NO.: F | BED NO.: 3

DATE OF ORDER | TIME OF ORDER | HOURS

IUTAN 5/10/03 0330

noted 0200

(b)(6)-2 [redacted] 9 May 03

(b)(6)-2

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

MEDCOM - 8583

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION			↓	DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
[redacted] (b)(6)-2				13 May 03 1555 HOURS	
			1	D/C SVC [redacted] (b)(6)-2	noted [redacted]
			2	D/C IV	
			3	KEFLEX 250 mg QID, 10d	LC
			4	WBCT, Chest	
NURSING UNIT	ROOM NO.	BED NO.			
ICW2	F	3		24° Chart ✓ 14 May 03 [redacted]	(b)(6)-2
PATIENT IDENTIFICATION				DATE OF ORDER / TIME OF ORDER	
				14 May 03 1260 HOURS	noted
[redacted] (b)(6)-4			1	DISCHARGE TODAY	[redacted] 1245 (b)(6)-2
NURSING UNIT	ROOM NO.	BED NO.		[redacted] (b)(6)-2	
ICW2	F	3			
PATIENT IDENTIFICATION				DATE OF ORDER / TIME OF ORDER	
				HOURS	
NURSING UNIT	ROOM NO.	BED NO.			
PATIENT IDENTIFICATION				DATE OF ORDER / TIME OF ORDER	
				HOURS	
NURSING UNIT	ROOM NO.	BED NO.			

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

all (b)(6)-2

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 5 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 9	10	11	12	13	14
9 May	[redacted]	Diet: NPO	07	/					
			11	/					
			15						
9 May	[redacted]	Activity Bedrest	08	/	[redacted]				
		Restrain per EPW protocol	16	/					
			24	[redacted]					
9 May	[redacted]	Regular Diet	5	/	[redacted]				
			17	/					
9 May	[redacted]	VS Q Shift	6	/	[redacted]				
			14	/					
			22	/					
			/						
13	[redacted]	WBAT - crutches	06				/	[redacted]	
		restrain per EPW	14				/		
		protocol	22				/		

See Pg (b)(6)-2

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS: GSW ⓛ tib/fib / Rt D

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

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

(b)(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 5 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
9May	[redacted]	admit ICU 2	9May	NOW	1300	[redacted]
9May	[redacted]	Dx GSW ⓒ tib/fib				
9May	[redacted]	condition: stable				
14May	[redacted]	Discharge Today	14May			

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

all (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. 5 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 9	10	11	12	13								
9 May	[redacted]	LR @ 150cc/hr	08	✓												
			16													
			24	[redacted]												
9 May	[redacted]	Ancef 1 gm IV q 6° x 24	06	✓	[redacted]											
			12	✓	[redacted]											
			18	[redacted]												
			24	[redacted]												
9	[redacted]	~~LR @ 125/hr~~	08	X	[redacted]											
		heplock when tolerating	16	✓												
		PO	24	✓												
				✓												
9	[redacted]	Ancef 1 gm IV q 8°	06	✓	✓	[redacted]										
			14	✓	✓											
			22	✓												
				✓												
13	[redacted]	Keflex 250 mg PO QID	06	✓	✓	✓	✓	✓	[redacted]							
			12	✓	✓	✓	✓	✓								
			18	✓	✓	✓	✓	✓								
			24	✓	✓	✓	✓	[redacted]								

DC see below

order Δ q see below

DC'd 13 May 03 [redacted]

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS: GSW (L) tib/fib / FSD

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

all (b)(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*				Mo. _____ Yr. _____
Order Date	**Clerk/ Nurse**	**SINGLE ORDER, PRE-OPERATIVES**	**Date to be Given**	**Time to be Given**	**Time Given**	**Initials**
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					

Order/ Expir Date	**Clerk/ Nurse**	**PRN MEDICATION, DOSE, FREQUENCY**	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* **TIME/DATE DISPENSED**													
9may	[redacted]	Tylenol 650mg PO	[redacted]													
- - - - -	- - - - -	Q4 hrs prn-pain	[redacted]													
9may	[redacted]	Percocet 1-2 PO	10 May 0915 [redacted]	10 May 2300 [redacted]	11 May 1330 [redacted]	11 May 2030 [redacted]	12 May 1030 [redacted]	12 May 2000 [redacted]								
- - - - -	- - - - -	Q4hrs prn-pain														
- - - - -	- - - - -															
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USAPA V1.00

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Fentanyl
Tetra
spinal

Date: 9 May 03
Time In: 1600
Allergies: NKDA
Pre-op V/S: 115/70 76
Procedures: (L) hip fix IV

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 500 Colloid
OR Output: UOP 0 EBL 25 cc
Meds/Times:

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other
none

Pre Op Meds History

Time	1610	1615	1620	1625	1640	1655	1710	1740	1805	2020	2120
SaO2	100	99	99	100	100	99	99	99		99	
FiO2											
Methods											
240											
220											
200											
180											
160											
140											
120											
100											
80											
60											
40											
20											
RR	20	16	14	16	14	12	12	10	20	18	20
T	97			96.5							

Time									
Pain (0-10)									
LOS									

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

(Continue on reverse)

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1611	LR	500cc	LAC	[redacted]	500
2050	LR	500	LAC	[redacted]	500

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	1	1	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	2	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	2	2	2
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C,	11	11	12

Codes

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

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

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

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

PREPARED BY (Signature & Title): SGT [redacted]

DEPARTMENT/SERVICE/CLINIC: ICU 2

DATE: 09 May 03

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

(b)(6)-2

EPW [redacted]

(b)(6)-4

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

MEDICATIONS

Allergies: NKDA

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1850		Percocet 1 tab	po		E	[redacted]

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	1600	FUE	mothight T	+	B	97.2	PK
15'	1640	FUE	mothight T	+	B	96.8	PK
30'	1655	FUE	"	"	+	97	"
45'	1700	FUE	[illegible]	+	B		PK
60'	1800	FUE	[illegible]	+	B		PK
90'	2000	FUE	[illegible]	+	B		PK
D/C	2055	FUE		+	B		PK

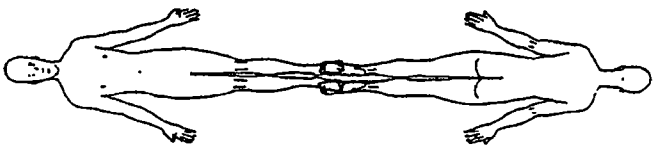
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm 1600	(L) calf	pressure wrap, 1 ace	Ø
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

1600 - Transfer from OR to ICU 2 VS 121/79 80 97.2 A+O x 3 IV 2R TKO (L) AC patent drg (L) Foley CDI, (L) extremity warm to touch. Sensation mid thigh T will cont to mon SGT [redacted] 9 Nov 03 (b)(6)-2

1640 - VSS NAD A+O X 3, ext warm drg (L) calf CDI, R - even unlabored SGT [redacted] 9 Nov 03 (b)(6)-2

1700 - Patient stable c/o numbness to (L) leg [illegible] to wiggle toes

1800 - Denies c/o left hip pain [illegible] bed c/o pain given [illegible]. Sensation to toes complete. [redacted] (b)(6)-2

1820 [illegible] to floor.

2000

2050 - VSS. Pt alert + oriented [redacted] (b)(6)-2

Discharge Criteria:
Date: 9 Nov 03 **Time:** 2050 **PARS:** 14
BP: 120/48 **T:** **HR:** 70 **RR:** 18 **SaO2:** 99%
Pain Level at D/C (0-10):
Intake: 1000 cc **Output:** Ø
Additional Data:
Transferred To: ICU 2
Report Given To:
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: [redacted] (b)(6)-2
Cleared IAW Recovery Room SOP B.3
Charge Nurse Signature: [redacted]
(b)(6)-2

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. [redacted] LOCATION (State or Country Code.)	3. REGISTER NUMBER (b)(6)-4	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
A 1 1 0 1	I 2	[redacted]	#[redacted] EPW (b)(6)-4	EPW	M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
	27	X	9	UNK

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
UNK	U	1400	(b)(6)-4

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

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
	ICW #2	UNK

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

21. TYPE OF DISPOSITION (b)(2)-2	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
05		030514

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
AEAA		030509

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

FOR LOCAL USE

Dx: ~~GSW to (L) Leg (fib/tib) I & D~~

PROC. T IND

8604 1 450

8659

DX:

82392

9228.

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

ADMITTING OFFICER (Signature, as [redacted]

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

DA FORM 2085, MAR 80 [redacted]

BATES PAGES MEDCOM 8592-8822 ARE NONRESPONSIVE AND HAVE BEEN WITHHELD IN THEIR ENTIRITY

IN .NT TREATMENT RECORD COVER SH.

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

REGISTER NUMBER	NAME (Last, First, MI)	3. GRADE	ADMISSION REMARKS
0013035	EPW [redacted] 664	EPW	
5. SEX M / 6. AGE 42 / 7. RACE	8. LENGTH OF SVC / 9. ETS	10. PREVIOUS ADMISSION	
UNK			
11. SSN 99	12. ORGANIZATION	14. WARD ICW2	
15. FLYING STATUS / 16. RATING DSG	18. BRANCH/CORPS / 19. UIC/ZIP	20. TYPE CASE SI	
78 K76			
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE	
Direct from E.R.	1131	AEAA	
24. RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION 05 ~~TRANS ASMC~~	26. DATE OF DISPOSITION 14 MAY 03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION 12 MAY 03	ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] b(2)2		30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
Ø	Ø	Ø	Ø	3	3

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDIC[redacted] b(6)2

Dr. [redacted] MAJ

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

DA FORM 4647, MAY 79 EDITION [redacted]

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

42 y/o ♂ Iraqi assisted by Marine @ Baghdad palace and fell - ↓ twisted ankle.

PMH: ↓

PSH: Hand ↓ surgery Iran Iraq war

Meds ↓

Allergy: PCN → rash

Soc Hx: 4 ppd tob

PHYSICAL EXAMINATION

HEENT: WNL

Chest: CTA

Ext: swollen (R) ankle 2+ DP/PT

Left: Bunion tender

alcohol medically

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

(A) closed (R) ankle sp

(B) DRW

b(6)2

SIGN [redacted]	DATE 3/12/03	IDENTIFICATION NO.	ORGANIZATION

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

EPW # [redacted] b6-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

PROGRESS NOTES

DATE	
	Brief Op note
5/12/03	Pre op dx: (R) Bimalleolar ankle fx Post op dx: same Procedure: ORIF Surgeon: [redacted] 66-2 ASA: 4 PT 120@300am Kg Times: 1400 Findings: displaced (R) ankle fx Cpx: 4
	[redacted]
12May03 2030	admitted to ICW2 p (R) LE ORIF - VSS - 42 yo Iraqi male EPW - (R) LE in cast, cap refill <2 sec, pt. can wiggle toes of (R) foot - pt's O2 sat when sleeping go to 85-90%, placed on 3L NC O2 - IV heplocked - pt. c/o pain but then falls back asleep and snores - BS (+) but hypoactive - lung sounds clear TA (B) - [redacted] b(6)2
13May03 0140	Pt care assumed at 2100. VSS, pt complains of headache @2200, Tylox ii given for pain. (R) LE dressing CDI, (+) sensation, + ROM, Capillary refill <3 seconds. Pt on 3L O2 via nasal cannula, O2 sats above 97%. Heplock flushes well. Lung sounds CTA with equal rise and fall of the chest. Bowel sounds present, but hypo active. Pt currently resting, will continue to monitor. SPC [redacted] 66-2 9Ku MC b(6)2
13May03 0645	PT vitals T 101.0 P93 R 20 Spo2 93 BP 130/86 - [redacted]

STANDARD FORM 509 (REV. 7-91) BACK
USAPPC V1.00

EPW [redacted] 66-4

MEDICAL RECORD	PROGRESS NOTES
DATE 13 MAY 03	0855. pt sleeping VSS with elevated temp. 101°. Encouraged IS and H_2O. pt has O_2 via N/C @ 3L. HR regular. Lung sounds CTA throughout. Radial pulses strong b/lat. Full ROM to upper extremities. Pt has bandage and ace wrap splint to (R) LE below knee. Dsg CD&I. pt has (+) sensation, cap refill < 3 able to wiggle toes. LLE Full ROM pedal pulses palpable. b6-2 Pt c/o pain to RLE, ÷ Tylox adm. for pain. HL IV (R) AC flushes well site free of s/s infection. Will continue to monitor. b(6)2 [redacted] SLWMP
13 May 03	1135 Reassessed pt temp. 99.4°, Encouraged H_2O and IS. pt sleeping at this time. b(6)2 [redacted] SLWMP
13 MAY	1200 pt sitting up eating lunch c/o pain ÷ Tylox given.. b(6)2 [redacted] SLWMP
13 MAY 02 1300	Pt vitals taken BP. 108/72, P. 104, R. 22, Temp 99.5 SpO_2 91-94% ↑ O_2 to 4 LPM N/C SpO_2 ↑ to 98%. I/S used for 3 min. O_2 DC'd. Pt. O_2 sat remained @ 98%. SPC b(6)2 [redacted]
13 May 03 1335	assumed pt care @ 1300. pt on RA @ this time sats 96%. lung sounds CTA. abd soft BS(+) x 4 quads. (R) LE c̄ splint and ace wrap, pt able to wiggle toes, <3 cap refill (L) LE (+) pulse HL (R) AC 5 s/s of infection. will cont to monitor — [redacted] SLWMP 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
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)
USAPPC V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

1603 HRS PNT [redacted] FITTED FOR CRUTCHES AND TAUGHT AMBULATION, 3PT GATT NON WT. BEARING. SPC [redacted] A. SIWIONS
b(6)2 b(6)2 [redacted] CPT, SP
28 CSM

13May03 1745 pt refused supper tray. Ø complaints voiced. will cont b(6)2 to monitor [redacted] SIWIONS

13May 03 2145. Assume care of pt 2100. 2145: Ax asleep Ø evidence pain discomfort. 18g. PIV to (R) FA, (+) flush, (-) BR (-) evidence infiltr SIS2 present, regular, (-) edema to bilat UEx or (R) LE. (+) pulses (+) swelling to toes of (R) foot. (R) foot elevated, (+) sensation Ø drainage dressing dry (+) movement, (-) evidence pain. ABD soft, non tender (+) BS x 4. Pt quiet, alert, oriented upon awakening c/t external stimuli. Pt resting will cont. to monitor. [redacted] b(6)2

0013: Pt sleeping Ø evidence discomfort. [redacted]

0435: Pt conts to sleep quietly [redacted]

14May03 0900 VS B/P 130/68 P 78 R 18 T 97.3 SPO2 97%. Pt alert. VSS, HR regular. Lungs CTA throughout. Bowel sounds active, x4. No BM this am no UOP. Radial pulses strong bilat. Full ROM to u/extremities. Splint ace wrap to (R) foot. Toes visible sm amt swelling. (+) sensation. Cap refill x3sec. pt has no c/o pain. just wants to smoke. Pt resting @ this time. (Cont)

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

b(6)4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
[redacted]			

DATE	NOTES
14May03 0900 (cont.)	PIV HL to (R) forearm flushes well. pt refused breakfast. — b(6)2 [redacted]
	1035 pt amb. to commode. UOP 800cc Clear amber. IV antibiotics D/C new order for PO antibiotics. pt waiting for cast to (R) LE then possible Discharge today [redacted] b(6)5
	1040 ÷ Tylox adm. for c/o pain. — b(6)2 [redacted]
14MAY03 1300	Pt vitals taken. BP 122/80, P. 100, R. 20, TEMP 99.1 SPO2 94% SPC [redacted]
14May03 1320	VSS. pt resting c̄ eyes closed. lung sounds CTA bilat c̄ equal rise & fall of chest. abd soft BS(+) x4 quads. (R) LE c̄ splint & ace wrap unable to palpate pulse. (L) LE (+) pulse good cap refill HL RFA flushes well, ∅ S/S of infection noted. Will cont to monitor — [redacted]
13May 1330	pt has dc orders. HL dc'd intact ⅀ diff pt being escorted to waiting area by MP in stable condition — [redacted] b(6)2 b(6)2
	D/C Summary
14MAY03	Dx: (R) Ankle Fx ∓ ORIF
	Rec: keep foot elevated x 72°
	Keep NWB on (R) lower extremity
	Flu 2 weeks for cast change.
	[redacted] b(6)2

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

558-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp) [redacted] b(2)-2

LOG NUMBER

ARRIVAL DATE DAY	MONTH	YR.	TIME
12	May	03	11:31

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☒ AMBULANCE ☐ OTHER (Specify)

CURRENT MEDS. (Tetanus immunization and other data): None

HISTORY OBTAINED FROM: ☒ PATIENT ☐ OTHER (Specify)

ALLERGIES: NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration)

SEX: M AGE: 23

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

VITAL SIGNS			
TIME	11:31	12:19	
BP	135/72	124/65	
PULSE	151	89	
RESP.	14	14	
TEMP.	98.8		
WT. (Child)			

O2 Sat 100%

CATEGORY (See reverse)
- EMERGENT
- URGENT
- NON-URGENT

ORDERS	INITS.	TIME
Ancef 1g IV		
Td .5cc IM		
Fentanyl 50mg		

ASSESSMENT/DIAGNOSIS

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

TIME SEEN BY PROVIDER

(3) EPW ♂ c/o Double fracture of (R) Tib Fib fracture. ~~[redacted]~~ Pt. is stable and presented with pain. Pt. states he was pushed into vehicle.

(4) Splint Double (R) Tib fib. was given Morphine 10mg and Ancef 1g.

Last med 7/12 ago

DISPOSITION (Check all that apply)
- HOME
- FULL DUTY
- QUARTERS: 24 Hrs. / 48 Hrs. / 72 Hrs.
- MODIFIED DUTY UNTIL: DAY / MONTH / YEAR
- REFERRED TO (Indicate clinic)
- EMERGENCY / TODAY
- 72 HOURS / ROUTINE
- ADMIT. TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE
- X IMPROVED
- UNCHANGED
- DETERIORATED

TIME OF RELEASE:

(CONTINUE ON SF 507, IF NE[redacted]

PATIENT'S IDENTIFICATION (Mechanical imprint) FOR WRITTEN ENTRIES GIVE: Name - last, first, middle; SSN; DOB, service status, name and relation of sponsor or next of kin. (IMPORTANT: LIST FACILITY HOLDING TREATMENT RECORD).

[redacted] b(6)4

SIGNATURE OF PROVIDER AND ID STAM[redacted] b(6)2

INSTRUCTIONS TO PATIENT (Include [redacted] any limitations and follow-up plans)

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

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

1. AGE: 42

HEIGHT:

WEIGHT:

2. KNOWN ALLERGIC SENSITIVITIES (e.g.. Iodine, Tape, Medication)
☐ NKDA ☑ PCN ☐ LATEX ☐ IODINE ☐ TAPE ☐ FOOD
REACTION:

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

4. PROPOSED SURGICAL PROCEDURE: ORIF Rt, Ankle

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition_____
Tobacco Yes ppd X___yrs. Body Piercing_____ Diabetes (Y) (N) ROM_____ ASA/Motrin w/72 hrs (Y) (N)
ETOH_____ Implants_____ Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures_____ Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS:

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to: _____1) Surgical Procedure & Operating Room Environment _____2) Separation Anxiety (Child) _____3) Surgical Outcomes	o Pt. verbalizes any specific anxiety. o Pt. Exhibits relaxed body posture.	✓ Allow pt. to verbalize freely. ✓ Explain OR environment and answer questions regarding surgery. ✓ Offer comfort measures. (e.g.. warm blanket. touch). ✓ Explain all nursing procedures before they are done. ✓ Remain with pt. whenever possible. ✓ Maintain family interface. Parents to stay with pt.
B. AERATION ✓ Potential for respiratory dysfunction due to: _____1) Positioning _____2) Effects of Anesthesia _____3) Medical/Smoking History	o Pt. will be able to breathe without difficulty during immediate intraoperative phase .	o Offer to elevate head of litter or offer pillow. o Observe pt. while awaiting surgery for signs of distress. o Assist anesthesia during intubation and extubation.
C. INTEGUMENT ✓ Potential impairment of skin integrity due to: _____1) Intraoperative Immobility _____2) ESU Pad Placement _____3) Positional Aids _____4) Prosthesis _____5) Pooling of Prep Solutions	o Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened areas).	o Utilize pressure preventing devices on OR table and accessories. o Check for proper positioning and support to maintain good body alignment. o Pad pressure points. o Place ESU ground pad on non compromised skin surface area. o Keep prep fluids from pooling.

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

EPW [redacted] b(6)4

VERIFICATIONS AT HOLDING AREA:
✓ ID/Allergy Band ! Dentures Removed
✓ H & P ! Contacts Removed
✓ NPO Since_____ ! Jewelry Removed
! UHCG/LMP ! Body Pierce Removed
! Consent/Blood Transfusion Signed/Witnessed/Dated
! Surgical Site/Consent verified by Pt./Anesthesia/Surgeon
! Contact Precautions (Y) (N)
! Family/Friend:_____

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOME	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to: ____ 1) Intraoperative Mobility ____ 2) Positioning ____ 3) Existing Disease ____ 4) Safety Devices ____ 5) Hypothermia	o Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse.	o Check for support stockings or ace wraps. If none, check with doctor. o Check that safety straps are correctly applied. o Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. o Check that rings and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to: ____ 1) Pain ____ 2) Intraoperative Hazards ____ 3) Prosthesis ____ 4) Positioning ____ 5) Transfer pt. to/from OR table E.2. ____ Potential discomfort due to: ____ 1) Length of Surgery ____ 2) Positioning ____ 3) Arthritis	o Pt. will be transferred to OR table without difficulty. o Pt. will not experience unnecessary physical discomfort.	o Have sufficient people available for transfer. o Insure proper body alignment. o Allow patient to lie in position of comfort while waiting for surgery. o Offer support (i.e., pillows, bath towels, etc.) for positioning.
F. SPECIAL SENSES F.1. ✓ Diminished visual perception due to being: ____ 1) Pre-Medicated ____ 2) W/O Glasses F.2. ____ Potential for decreased communication due to. ____ 1) Diminished Hearing ____ 2) Language Barrier F.3. ____ Potential injury due to dentures: ____ 1) Upper ____ 4) Caps ____ 2) Lower ____ 5) Crowns ____ 3) Bridges	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR table. o Pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt. from ____ side. o Validate pt.'s understanding of verbal communication. o Verify removal of dentures.
G OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

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

b(6)2 [redacted] CPT-AN 12 May 03 DATE

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

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) b(6)2 [redacted] CPT AN
DATE: 12 May 03 TIME: 1250

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title)
DATE: TIME:

MEDICAL RECORD — **INTRAOPERA[illegible] DOCUMENT**

For use of this form, see AR 40-66, the propo[illegible] agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Cart BY Anes & OR Staff

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY [redacted] b(6)2 CPT Ad

3. DATE 12 May 2003 TIME PATIENT ARRIVED IN SUITE ER → OR

4. PATIENT IN ROOM TIME 1312 NUMBER 2-1 / 2 cases

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: PCN. Rpo more than 12° ✱ Diabetes. ✱ Smoker 4 PPD. ✱ DMH. ✱ Asthma.

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] b(6)2 (91D)	RELIEF SCRUB	b(6)2
ASSIGNED CIRCULATOR	CPT [redacted] b(6)2 (66E) : 1500	RELIEF CIRCULATOR	CPT [redacted] (1500-End)

7. POSITION AND POSITIONAL AIDS (Specify)

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

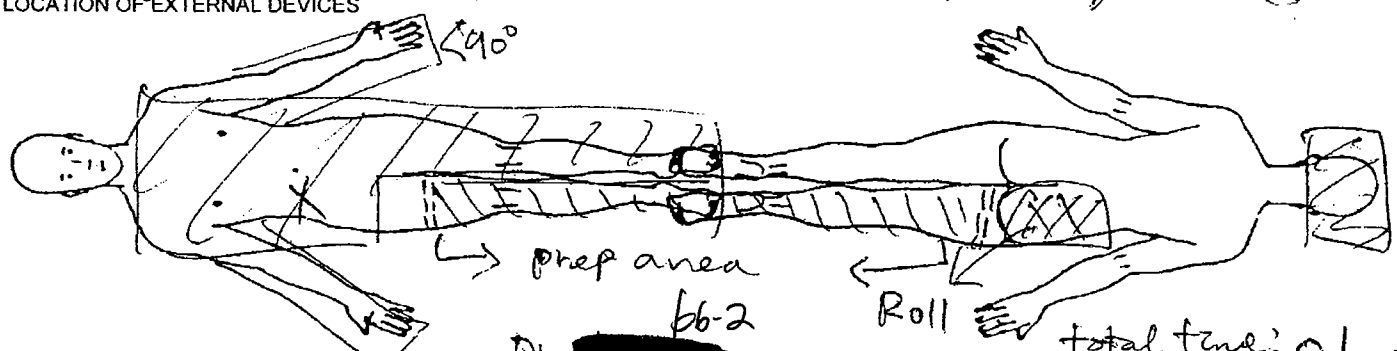
COMMENTS: Roll under Rt Hip, Bil arm to padded armboard <90°

8. SKIN PREPARATION

HAIR REMOVAL ☑ YES ☐ NO
DONE BY: ☑ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☑ RAZOR ☐ CLIP
COMMENTS: ✱ Cuts noted.

PREP SOLUTION (Specify) Betadine Scrub & Paint
SITE: Rt leg BY WHOM: CPT [redacted] Ad / b6-2
SITE: BY WHOM:
COMMENTS: ✱ Pooling of sol.

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Strap === Tourniquet [redacted] @ 300mmHg

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB b(6)2	CIRCULATOR b(6)2
Sponge	☑ Yes ☐ No					
Needle Sharp	☑ Yes ☐ No		C	C	[redacted], SPC	CPT [redacted]
Instrument	☐ Yes ☑ No					
Other	☐ Yes ☑ No					

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

EPW [redacted] b(6)4

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

☑ ESU NO: Valley Lab FT4.
GROUND PAD: BRAND 3M.
LOT NO: 2005-10 OT.

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

Coag: 30
Cut: 30

DA FORM 5179-1, OCT 87 RE[illegible]ES D[illegible] WHICH IS OBSOLETE. USAPA V1.01

MEDCOM - 8832

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

"Synthes" Small Fragment AO/ASIF Screws

① Synthes Plate 248.07 x 4 ② 3.5 x 18mm (204.18) x 3

3.5mm Cortical Screws: ~~3.5 (204.12)~~ ③ 4.0mm x 45mm (207.45) x 2

④ 3.5mm x 12mm (204.12) x 5

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S):

0.9% NaCl

OTHER ORDERS	TIME	CARRIED OUT BY
N/A		

PHYSICIAN'S SIGN[redacted] b(6)2

15. X-RAY IN OPERATING ROOM YES ☒ NO ☐ IF YES, SITE ① Ankle

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☑	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☑	NAME	NAME
CULTURE (C) YES ☐ NO ☑	NAME	NAME
NAME	NAME	NAME
NAME	NAME	NAME

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*

fluffs. "LtU" Splint
Kerlix Webril. 10 Thick plaster x 2
Ace 6"
xeroform

19. ADDITIONAL INFORMATION

WC b(6)2

Surgeons: [redacted] Anesthesia: [redacted] b(6)2 Anesthesia Type: Gen

(CRNA)

[redacted] b(6)2

(CRNA)

Bovie Pad site intact pre-op Yes; post-op Yes Bovie Settings: Coag/Cut 30/30.

20. OPERATION(S) PERFORMED

Rt. Ankle, ORIF.

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU	1610	Litter CO2

22. REGISTERED NURSE SIGNATURE [redacted] IAN.

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

b(6)2

MEDCOM - 8833

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY 12 May 03

POST- DAY 12 May 03

MONTH-YEAR | DAY | HOUR

19 2002

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

(Centigrade Equivalents, for Reference only)

DAY	12 May 03		13 May		14 May
HOUR	8		8		8
RESPIRATION RECORD	RR 6	6	22	22	20
BLOOD PRESSURE	140/70		130/160	1[illegible]/80	
	140/68				
	SpO2 98		93	99	94%

Record special data only when so ordered

HEIGHT: WEIGHT →

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

REGISTER NO.

WARD NO. IC-W2

EPW

[redacted]

[redacted] 1

b6-4

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 8834

MEDICAL RECORD — ANESTHESIA

DRUG	(Units)	
Midazolam	(mg)	3 2
Fentanyl	(mcg)	25 25 100 100 100 100 50
Lidocaine	(mg)	50
PPD propofol	(mg)	100
Succ	(mg)	100
MSO4	(mg)	
VOLAT AGENT 1.50	% del	1.8 1.7 1.7 1.6 1.5 1.6 1.6 1.6 1.5 1.5 1.0
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	6 2 2 2 2 2 2 2 2 2 2 10

CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML, "I"=CONSTANT INFUSION

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

TOTALS	
5mg	
500mcg	
160	
100	
100	
3	

TOTAL EBL: 50cc

TOTAL URINE: Ø

FLUIDS – SUMMARY

CRYSTALLOID– LR 1600

COLLOID– Ø

BLOOD– Ø

FLUIDS

LINE site R (ec) 18g RAC ☐ Warmed — 1000 — 1300 — 1600 — 1600

☐ Warmed

Anesthesia in local R IV/AP ☐ Warmed — x — x

☐ Warmed

LOSSES: EST BLOOD LOSS — URINE – (Not measured) (50)

PRE-VS STATUS: 1 2 3 4 5 (E)

BODY WEIGHT: ~70 (KG) LB

HEMATOCRIT:

INITIAL DATA: BP – 136/84 HR– 92

EQUIP CHECK: OK?– (Y) N

PATIENT READINESS: OK for PROCEDURE? Y/N TIME– 1250

TIME → 1200 15 30 45 1300 15 30 45 1500 15 30 45

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

220 200 180 160 140 120 100 80 60 40 20

I:E=1:2	VT – ml	770	800	850	900	920	910	930	920	700	730	
@time	f – breaths/min	10	8	9	9	8	8	8	8	6	8	10
Peak inf pres / PEEP		17	18	18	14	19	20	20	19	–	20	20
MODE– S(pon), A(ssist), C(on)		S	C	C	C	C	C	C	C	A	C	C
BP/Auto Cuff	ET CO2 (torr)	38	36	33	32	31	32	31	31	40	52	36
BP / oth	FIO2 (Frac or %)	.86	.86	.85	.86	.86	.85	.85	.85	.84	.83	.86
ART line	SpO2 (%)	100	100	100	100	100	100	99	99	98	98	100
Steth- PC/ES	ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR
Gas analyzer	TEMP- site Skin		97°	97°	97°	97°	97°	97°	97°	97°	97°	97°
	N-M Block (T/4)	4/4	0/4	4/4								4/4 @ 1251
	Tourniquet @ kg 3 pounds					@ 1253						@ 1257 120-min
Warming blkt												
Conv warmer												

Mark with letters & symbols, explain under REMARKS — EVENTS — Position → Arms <90° secured on padded armboards

REMARKS – Code drugs with numbers, events with letters

1250 → Pt seen. ⊕ID. Preop completed via interpreter. Plan GETA. Denies questions. IV, R patent.
1312 in OR via other. Moves self to OR bed. Monitors on. FiO2
1317 Induction. Eyes taped shut. See airway note below. Sp bilat block plane. OGT + stomach decompressed.
1320 Anesthesia in local LR IV started per request Dr [redacted]
1425 Depart to CT [redacted]
1520 4mg Zofran IV, b6-2
1610 Pt awake, VT 2000, TO SMV x 2. Extubated 5 diff, TO Ice ⊂ mask O2. Report to Rec

RECOVERY AT 1612

PACU ICU 2 (Specify)

OTHER

CONDITION: Stable

RESP– 16 SpO2– 97 %

BP– 135/62 HR– 87

ANESTHESIA & PROCEDURE TIMES

	Start	Room	End
ANES	1240	1312	1615
	Ready	Begin	End
PROC	1322	1354	1600

PROCEDURES and CPT Codes: ORIF (R) Ankle

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GETA O2/150

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: Easy mask vent. DL #1 & Mac 3 Grade I Intubation VC. 8.0 OETT secured @23cm @ teeth & tape ⊕ stylet, ⊕ sustained ETCO2, ⊕ BBS. Atraumatic by Med Student.

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

SURGEONS: [redacted] b(6)2

ANESTHETISTS: [redacted] CPT/CRNA. b(6)2 [redacted] CPT/CRNA

PROCEDURE LOCATION: OR Iso 2-1

DATE: 12 MAY 03

PAGE 1 OF 2

MEDICAL RECORD – ANESTHESIA
WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 8835

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

MEDICAL RECORD — ANESTHESIA

ANESTHETIC AGENTS AND DRUGS	DOSING	(Units)
CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML, "I" = CONSTANT INFUSION		( )
		( )
		( )
		( )
		( )
		( )
	VOLAT AGENT	% del
		% e.t.
	AIR	L/Min
	N2O	L/Min
	O2	L/Min 10
SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS ▶		

FLUIDS		
LINE site	☐ Warmed	
	☐ Warmed	1600
	☐ Warmed	
	☐ Warmed	
LOSSES	EST BLOOD LOSS	
	URINE –	

TOTALS	
TOTAL FLUID	
TOTAL URINE	
FLUIDS – SUMMARY	
CRYSTALLOID–	
COLLOID–	See p1
BLOOD–	

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

See p1

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: KG / LB

HEMATOCRIT:

INITIAL DATA: BP – See p1 HR–

BLOOD CHECK: OK? – Y N

PATIENT RECORD: OK for PROCEDURE? TIME–

TIME → 1600

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

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

MONITORS		
	VT – ml	1500
	f – breaths/min	12
	Peak inf pres / PEEP	—
	MODE– S(pon), A(ssist), C(on)	S
BP/Auto Cuff	ET CO2 (torr)	38
BP / oth	FIO2 (Frac or %)	.85
ART line	SpO2 (%)	100
Steth- PC/ES	ECG	SR
Gas analyzer	TEMP- site	97°
	N-M Block (T/4)	
Warming blkt		
Conv warmer		

Mark with letters & symbols, explain under REMARKS **EVENTS** *Position* → a

RECOVERY AT	
PACU ICU_____ (Specify)	
OTHER_____	
CONDITION:	
RESP–	SpO2–
BP–	HR–

ANESTHESIA & PROCEDURE TIMES			
ANES	Start	Room	End
PROC	Ready	Begin	End

PROCEDURES and CPT Codes

ORIF (R) Ankle

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

See p1

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*

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

EPW # [redacted] b(6)2

SURGEONS: [redacted] b(6)2

ANESTHETIST: [redacted] b(6)2 CPT/CRNA

PROCEDURE LOCATION	OR 2-1
DATE	12 may 03
PAGE	2 OF 2

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 8836

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

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 42 DAYS MOS YRS Sex (✓) MALE ( ) FEMALE

ASA Physical State 1 (2) 3 4 5 (E)
WT: 70-75 (KG)/LB HT: 2 IN.
ALLERGIES: PCN → Rash

PROPOSED PROCEDURE: ORIF ankle fx
SURGICAL SERVICE: [redacted] b(6)2
NPO SINCE:

HABITS:
TOBACCO: 4PPD
ETOH:
DRUGS:

CURRENT MEDICATIONS: Ø
( ) = ordered as premed

( ) fentanyl 40mcg
( )
( )
( )
( )
( )

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

LABORATORY STUDIES:

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

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:
- Hypertension N Y
- Angina N Y
- MI N Y
- CVA N Y
- Other N Y

Pulmonary System:
- Asthma N Y
- Bronchitis/URI N Y Smoker
- COPD N Y
- Other N Y

Renal System:
- Acute/Chronic RF N Y

Gastrointestinal:
- Hepatitis N Y
- Hiatal Hernia N Y
- PUD/GERD N Y

Endocrine System:
- Diabetes N Y
- Steriods N Y
- Thyroid N Y

Neurological:
- Seizures N Y
- Neuropathy N Y
- Other N Y

Gynecological :
- Pregnancy N Y

Other Significant Hx:
- N Y
- N Y

Familial HX N Y

Closed Open fib fx

ASSESSMENT
PAST SURGICAL/ANESTHETIC

Hand + leg Surgery Tran/in wa

PHYSICAL EXAMINATION NORM

BP 124/85 HR 85 R 16 T ____
Pain Scale 0-10 ____
HEENT - Teeth poor dentition
Trachea midline
TMJ/Neck FROM
Oropharnyx MPII
Nares
CHEST: CTA (2)
CARDIAC: S1 S2
EXTREMITIES:
IV Access: RFC 18g
Ulnar Filling:
BACK: Ø
OTHER: Ø

NPO Since >12hr.

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

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

The patient/legal guardian seems to understand and agrees. Questions answered. b(6)2
Signed: [redacted] CPT/CRNA Date: 12 May 03 Time: 1300 Hrs

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

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward) ____

EPW # [redacted] b(1)2

SEDATION KEY:

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b(6)4

[redacted]

b(6)4

[redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICW2	F	1

DATE OF ORDER 5/13/02 TIME OF ORDER _____ HOURS

- Admit ICW-2 pOR
- (R) Ankle fx pORIF
- Elevate (R) leg
- Routine Vitals
- PT for gait training, NWB (R) LE
- Regular Diet pOR
- Tylox 1 po q4PRN

LIST TIME ORDER NOTED AND SIGN

Noted [redacted] b(6)2

PATIENT IDENTIFICATION

b(6)4

[redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICW2	F	1

DATE OF ORDER TIME OF ORDER _____ HOURS

- Incentive Spirometry q20°
- Demerol 50mg IV PRN breakthrough
- Phenergan 25mg IV PRN nausea
- Ancef 1gm IVPB q8°
- Heplock IV
- Remove bumper
- [redacted] b(6)2 5/13/02 0200

b(6)2

PATIENT IDENTIFICATION

#[redacted] b(6)4

NURSING UNIT	ROOM NO.	BED NO.
ICW2		F1

DATE OF ORDER 5/14 TIME OF ORDER 0000 HOURS

D/C Ancef

start Keflex 500mg QID

[redacted] b(6)2

noted [redacted] 1000

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER 5/14/03 TIME OF ORDER _____ HOURS

- D/C Pt to ASMC
- Keep foot elevated x 72°
- NWB (R) LE
- F/u 2 weeks for cast change

[redacted] b(6)2

Noted [redacted] b(6)2 14 May 03 1445

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

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 5 Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 13	18	4
13	[redacted]	elevate (R) leg	06	/	[redacted]	
			13	/	[redacted]	
			21	[redacted]		
			/			
13	[redacted]	routine vitals	06	/	[redacted]	
			13	/	[redacted]	
			21	[redacted]		
			/			
13	[redacted]	regular diet	07	/	[redacted]	
			13	/	[redacted]	
			18	/	[redacted]	
			/			
13	[redacted]	Incentive spirometer q20 minutes	05-13	/	[redacted]	
			13-21	[redacted]		
			21-05	[redacted]		
			/			
13	[redacted]	Heplock IV	06	/		
			13	/		
			21	[redacted]	/	
13	[redacted]	Reinforce dsg. prn	05-13	/	[redacted]	
			13-21	[redacted]		
			21-05	[redacted]	[redacted]	

b(6)2

b(6)2

b(6)2

Write a check KW

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: (R) ankle fx p ORIF

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[redacted] b(6)2

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

Verbal by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo 5 Yr 2003

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
13	[redacted]	admit ICW2 POR	—	—	2030	[redacted]
13	[redacted]	PT for gait training NWB RLE				
b(6)2						

b(6)2

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

USAPA V1.00