CLINICAL RECORD - DOCTOR'S ORDERS

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

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

ATIENT IDENTIFICATION

D [redacted] b6-4

[redacted] b6-2

URSING UNIT: ICU #2 | ROOM NO. | BED NO. 6

DATE OF ORDER: 9 Jul 03 | TIME OF ORDER: 1745 | HOURS | LIST TI ORDE NOTED SIGN

(1) Admit to ICU2 [redacted] b6-2
(2) Dx: heat injury ✓
(3) Cond: VSI ✓
(4) VS: per SOP
(5) Act: BR
(6) NPO
(7) Nang: IKOO; ice to groin & axillae until core temp < 102°; fan also
(8) IVF: NS @ 150 cc/hr
(9) Vent SIMV 14 TV 700 PEEP 5 FIO2 100% & wean & keep sats > 92
(10) Sedad gtt @ 3 mg/hr + titrate
Valproate gtt @ 3 mg/hr + titrate
Fentanyl 50 mcg/hr gtt
(11) No tylenol for now
(12) Chem 8, LFT's q AM
(13) NGT clamped. Notify MD if ABD becomes distended.

✓ chart LT [redacted] 1835 9/7/03

[redacted] b6-2

ATIENT IDENTIFICATION

[redacted] b6-4

URSING UNIT: ICU #2 | ROOM NO. | BED NO. 6

DATE OF ORDER: 10 Jul 03 | TIME OF ORDER: 0645 | HOURS

(1) Pt sedated, vec, + fentanyl gtt's

b6-2 — [redacted] Noted @ 0655 hrs 10 JUL 03

[redacted]

ATIENT IDENTIFICATION

[redacted] b6-4

URSING UNIT: ICU #2 | ROOM NO. | BED NO. 6

Noted 10 Jul 03

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

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 11 July 03 — TIME OF ORDER: 0815 HOURS

(1) Transfer to ICW#2 [redacted] b6-2
(2) Dx: heat injury / gastritis
(3) Cond: good
(4) Act: BRP per wound dressing
(5) NKDA
(6) Diet: regular
(7) IVF: Heparin

noted [redacted] b6-2 9/Wrne 11July03 1750

PATIENT IDENTIFICATION

[redacted] b6-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: TIME OF ORDER:

(8) Meds: tylenol 325 g PO q4° PRN HOURS
(9) metlyte 8, CBC in (AM) - use central line

b6-2 [redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: TIME OF ORDER: [redacted]

12JUL — 21:30 HOURS

VO
D/C (R) and (2) PIV sites now
Dr [redacted] b6-2

noted 21:30 ~~D/C~~ 12JUL [redacted]

24°V done [redacted] 2D/AM

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: [redacted] TIME OF ORDER: 0457 HOURS

VO/CBC and metlyte 8 in AM/13JUL03
Dr [redacted] b6-2 2D/AM

noted 0457 13JULO3 [redacted]

12 Jul 03 — 1600
CBC now — done [redacted] b6-2

noted [redacted] 9/WRNE 12July03 1605

24°V GERHL [redacted] 1750

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] b6-4

DATE OF ORDER: 12 July 03 TIME OF ORDER: 2000 HOURS

(1) CBC in AM
(2) NPO p MidNC

noted [redacted] b6-2 9/LWM6 2053

NURSING UNIT	ROOM NO.	BED NO.
24W		[redacted]

b6-2 [redacted]

PATIENT IDENTIFICATION

[redacted] b6-4

DATE OF ORDER: 7-12-03 2350 13 July TIME: 0715 HOURS

(1) Reg diet ✓
(2) D/C Regain flushes ✓
(3) NS @ 75 cc/hr through central line

noted [redacted] b6-2 9/LWM6 13 July 03 0745

NURSING UNIT	ROOM NO.	BED NO.
ICW2		

b6-2 [redacted]

PATIENT IDENTIFICATION

DATE OF ORDER: 13 July 03 TIME OF ORDER: 0930 HOURS

V.O. from Dr. [redacted] to LT [redacted]:
(1) D/C Foley now please

noted [redacted] b6-2

b6-2 [redacted] OLT/AN b6-2 [redacted] 13 July 930

NURSING UNIT	ROOM NO.	BED NO.

[redacted]

PATIENT IDENTIFICATION

DATE OF ORDER: 13 July 03 TIME OF ORDER: 1615 HOURS

(1) NCE contrast CT of neck + chest to R/O mass

noted [redacted] b6-2 9/LWM6 1620

NURSING UNIT	ROOM NO.	BED NO.
24W		[redacted]

b6-2 [redacted] 10 [redacted] 7-13-03 2315.

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

#[redacted] b6-2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 14 Jul 03 TIME OF ORDER: 1600 HOURS

(1) CBC / new

(2) NPO p MIDNOC

b6-2 [redacted]

LIST T ORDE NOTED SIGI [redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 14 Jul 03 TIME OF ORDER: 1600 HOURS

(1) Cancel NPO / CBC

(2) Maybe D/C to EPW Camp

When Available [redacted]

b6-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: [redacted] TIME [redacted]

b6-2

24°Vs [redacted] b6-2

[redacted] 7-15-03 0035 U

15 Jul 03 0815

(1) N/C Central line

[redacted] b6-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: [redacted] b6-2 HOURS

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

CLINICAL RECORD

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

Mo. July 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	15	16	17	18	19	20	21	22
9/7	[redacted]	COND: VSI	05	[redacted]													
			17	[redacted]													
9/7	[redacted]	VS: Per SOP	05	[redacted]													
			17	[redacted]													
9/7	[redacted]	ACT: BR	05	[redacted]													
			17	[redacted]													
9/7	[redacted]	NKDA	05	[redacted]													
			17	[redacted]													
9/7	[redacted]	NURSING: Ice to GROIN + AXILLARY until core temp						D/C 10JUL03									
		<102 for also															
9/7	[redacted]	Vent: SIMV, RR14, TV 700, PS, FIO2 100%	05	[redacted]													
			17	[redacted]													
		wean to keep SATS							D/C 10JUL03								
		>92%															
9/7	[redacted]	NGT CLAMPED. NOTIFY	05	[redacted]													
		MD IF ABD BECOMES	17	[redacted]				D/C'd 10 JUL03									
		DISTENDED															
9/7	[redacted]	Chem8, LFT'S	05	[redacted]				[redacted]									
		QAM	17														

b6-2

b1 b6-2

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
DX: HEAT INJURY / GOITER

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

PATIENT IDENTIFICATION:
EPW # 0[redacted] b6-4
4y/o ♂

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo _____ Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
9/7	[redacted]	ADMIT TO ICU 2	9/7	NOW	1800	[redacted]
10 Jul	[redacted]	√K+ p K+ Plus Finished	10 Jul	p K+ Plus	1210	[redacted] b6
11 Jul	[redacted]	Markyte 8, CBC in (AM)	12 Jul	AM	→ SEE	
	b6 b2	USE CENTRAL LINE			Fwt sheet	
	-----	DC				

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

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 10	11	12	13	14	15	16
10 JUL 03	[redacted]	CLEAR LIQUIDS IN 2° THEN ADVANCE	05	[redacted]				SEE Below		
		DIET AS TOLERATED	17	[redacted]						
11 Jul	[redacted]	DIET: Regular	07			[redacted]				
			11	[redacted]						
			17	[redacted]						
11 Jul	[redacted]	ALT: BRP PER	05	[redacted]						
		WARD DISCRETION	13	[redacted]						
			21	[redacted]						
11 Jul	[redacted]	IVF: Heplock	05	[redacted]						
			13	[redacted]						
			21	[redacted]						

White Sheet

all 66-2

ALLERGIES: ☐ YES ☒ NO — NKDA

PRIMARY DIAGNOSIS: HEAT INJURY / GOITER

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION: # [redacted] 66-4

41y/o ♂

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 July Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
11Jul	[redacted]	TRANSFER TO ICW #2	11Jul	—		[redacted]
11Jul	[redacted]	DX: HEAT INJURY / GOITER	11Jul	—		[redacted]
11Jul	[redacted]	COND: GOOD	11Jul	—		[redacted]
11Jul	[redacted]	METLYTE 8, CBC IN (AM)	12Jul	AM	done	[redacted]
	-----	USE CENTRAL LINE				
11Jul	[redacted]	D/C (R) and (L) PIV x 1 now	11Jul	2130	done	[redacted]
12Jul	[redacted]	Metlyte 8, CBC in AM	13Jul	0400	done	
12Jul	[redacted]	CBC in AM	13Jul	0400	done	
12Jul	[redacted]	NPO p MN	13Jul	2400	done	[redacted]
12July	[redacted]	CBC NOW	12July	1600		DONE
13July	[redacted]	DC Foley now please	13July	0930	0930	[redacted]
13Jul	[redacted]	non-contrast CT of neck & chest to	13July			[redacted]
	-----	R/O mass				
14	[redacted]	May DC when trans avail to ICW comp				

	-----					

all 66-2

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

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. JUL 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	14
9/7	[redacted]	Versedqtt @3mg hr	05	/	[redacted]				
		titrate	17	[redacted]					
9/7	[redacted]	Vecuronium qtt 3mg	05	/	[redacted]				
			17	[redacted]					
9/7	[redacted]	~~Versed~~ Fentanyl/qtt 50 mcg/hr	05	/	[redacted]				
			17	[redacted]					
9 Jul 03		IV: NS @ 150 cc/hr	05						
			17						
11 Jul 03	[redacted]	IV: Heplock	05	[redacted]			[redacted]		
		Central Line q	13	[redacted]			[redacted]		
		Shift	21	[redacted]			[redacted]		
13 July 03	[redacted]	NS @ 75cc/hr through	05	/	/	/	/	[redacted]	
		central line	13	/	/	/	/	[redacted]	
			21	/	/	/	/	[redacted]	

DC'd

b6-2

ALLERGIES: ☐ YES ☒ NO	PRIMARY DIAGNOSIS:	ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
KNDA	DX: HEAT INJURY / GOITER	PAGE NO.

PATIENT IDENTIFICATION:

EPW # 0[redacted] b6-4

41y/o ♂

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)			Mo. July Yr. 03	
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
10 JUL	[redacted]	KCL 40 mEq in 100cc NS over 2hrs x 2	10 JUL	NOW	(1) 0835 (2) 0945	[redacted]
11 Jul	[redacted]	Ambien 10mg PO x1 for sleep	11 Jul	NOW	0050	[redacted]
	b6-2					b6-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
10 Jul	[redacted]	Tylenol 325mg	11 Jul 1000	12 Jul 2100	[redacted] 2120											
	b6-2	III Pog 4° PRN	[redacted]	[redacted] 2300	[redacted]											

b6-2

USAPA V1.00

ADMISSION AND CODING INFORMATION

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

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

3. REGISTER NUMBER							NAME (Last, First, Middle Initial)	4. PAY GRADE		5. SEX
9	10	11	12	13	14	15		16	17	18
[redacted]							EPW [redacted] b6-4			M

6. DATE OF BIRTH (YYYYMMDD)								7. AGE AT ADMISSION			8. RACE	9. ETHNIC BACKGROUND	RELIGION
19	20	21	22	23	24	25	26	27	28	29	30	31	
											Z	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
			N/A	9	9	0	0	0	0	0	0	[redacted]		

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
N/A	46: U	9925	N/A b6-4

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	M	9									

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72: 0	ICU2	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
[redacted] b2-2	

21. TYPE OF DISPOSITION		22. MTF TRANSFERRED TO						23. DATE OF DISPOSITION (YYMMDD)					
73	74	75	76	77	78	79	80	81	82	83	84	85	86
5	0							0	3	0	7	1	5

24. CLINIC SVC - ADMITTING				25. MTF TRANSFERRED FROM						26. DATE THIS ADMISSION (YYMMDD)					
87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102
A	A	A	A							0	3	0	7	0	9

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

FOR LOCAL USE

Dx: Heat injury

Dx 9925 Proc 967A
2409
Trauma 9
Inj 809

[redacted]

ADMITTING [redacted] b6-2	SIGNATURE OF ADMITTING CLERK b6-2
Dr. [redacted]	[redacted] SPC, 91G10

DA [redacted]

ATIENT TREATMENT RECORD COVER LET

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

1. REGISTER NUMBER [redacted]	2. NAME (Last, First, MI) SPW# [redacted] b6-4			3. GRADE NO	ADMISSION REMARKS
4. SEX M / 5. AGE 25y	6. RACE X	7. RELIGION muslim	8. LENGTH OF SVC unk	9. ETS unk	10. PREVIOUS ADMISSION NO
11. FMP 99	12. SSN [redacted]	13. ORGANIZATION SPW			14. WARD ICU1
15. FLYING STATUS NO	16. RATING/ DSG	17. DEPT./ BEN K78	18. BRANCH/CORPS NO	19. UIC/ZIP unk	20. TYPE CASE surg/ int. med
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Ø			22. HOURS OF ADMISSION 1745	23. CLINIC SERVICE AAAA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE —		25. TYPE DISPOSITION 21		26. DATE OF DISPOSITION 030722	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) —		27b. TELEPHONE NO. unk		28. DATE OF THIS ADMISSION 030709	ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted]				30. DATE OF INTIAL ADMISSION 030709	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

DX: Infected wound (L) chestwall

875.1
682.2
E986

34.4

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	14	14

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
Ø	Ø	Ø	Ø	14	14

SIGNATURE OF OFFICER [redacted] b6-2 [redacted] SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER [redacted] b6-2

USAPPC V1.10

DA FORM 364[redacted] EDITION OF [redacted]

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

EPW, penetrating wound
Chest wall wound S/P self inflicted
stabbing.

PHYSICAL EXAMINATION

(L) penetrating eyelid and pus
by (B) nipple
Hand right
blind by

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

2y Infect (L) chest wounds
stab wound
the Admit
2V ABX
To OR [illegible]

SIGNATURE OF PHYSICIAN	DATE	IDENTIFICATION NO.	ORGANIZATION
[redacted]			

b6-2

[redacted] *en entries give Name last, first, ...e; hospital or medical facility)*

REGISTER NO.	WARD NO.

[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

NSN 7540-01-075-3786

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

TEST RESULTS

CBC		SMAC		ABG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐
	WBC			SUP 02	PH	PO2	RESULTS	
	H/H			PCO2	SAT	OTHER		
	PLT							
PT				U/A	DIP		EKG INTERPRETATION	
APTT		BHCG	ETOH / GLU		MICRO			

PROVIDER HISTORY/PHYSICAL

NKDA

Chest: ⊕ multiple See Surgery H&P
open wounds ⊖ chest wall (anterior)
c̄ pus @ pectoralis level c̄ surrounding erythema
Lungs: ⊕ rales ⊕
⊕ retractions/accessory muscle

A/P stable

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SI[redacted]TAMP
b6-2 [redacted]

PROVIDER SIGNATURE [redacted]

DIAGNOSIS
Chest wall puncture wound
cellulitis

CODES

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

O [redacted] b6-4

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

10 Jun 03 Brief OP Note
Pre op Dx (L) Chest wall Abscess
Post op Dx SAA
Procedure Excision of Chest wall Abscess, Debridement.
Surgeon Maj
Anesthesia General
Findings Large pus pocket with density fat. Muscle Muscle Fascia intact. No vessels

PO ICU 1 Stable

Pt transferred in OR in 72°
at TID during ds.

[redacted] b6-2

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

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	1730 -10 JUL-03 VSS 96, 111/60, 16, 97 RA, 98%
	[N] Follows commands, A+O
	[R] LCT; ⊖ U/S (gross)
	[CV] NSR; ⊖ edema; 3+ pulses x4 extr, <3 sec cap refill
	[GI] tolerated evening meal ⊖ N/V; distended abdomen
	⊕ BS x4
	[GU] voids spont. clear
	[SKIN] ~~Midline~~ [redacted] midline thoracic dsg - bulky/c/d/i.
	[RESP] to OR in next few days.
	[IV] HL x2 (L/R) - b6-2 [redacted] LCT, Dr
	[redacted]
11 July 03 0730	Rcd pt lying in bed sleeping WAD, see flow sheet for assessment. Pt had wheezing in lungs. Elevate HOB & encouraged to cough & use incentive spirometer. Will auscultate breath sounds again after 2hrs. [redacted] — b6-2
0730	Pt ate 70% of meal & went back to sleep @ 0% pain [redacted]
1300	Dsg. to chest, dried tissue noted, redness w-D w/ Montgomery strips in place. — [redacted] b6-2

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] b6-4

REGISTER NO. | WARD NO.

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10JUL03 0545	Assumed care of pt. Resting quietly. Assessment complete (see flow sheet) (L) FA heplock & (R) AC IV site intact (Ø) s/s redness or edema. Dsg Δ to (L) chest @ 0100. Ø s/s of distress noted. Will continue to monitor [redacted] b6-2
0900	Pt. sitting up in bed, eating & tolerating well. Pt. using spo2 meter & will continue q1° pt. is awake. Will continue to monitor. [redacted] b6-2
1130	Pt. c/o very little pn. Tolerating meals well. Continues to use the spo2 meter. Will continue to monitor [redacted]
1400	Dsg Δ to (L) chest. Pt. resting @ this time. Ø complaints [redacted] b6-2
1600	Dr. by bedside to check on pt. status. Will brief oncoming shift [redacted]
1730 12JUL03	USS - Alert x3 Drsg to (L) chest is dry and intact. Saline lock to (R) AC and (L) FA are patent c̄ Ø s/s infiltration. o/bs Ø c/o pain or discomfort e present. Resting quietly sitting up in bed e present. — SGT [redacted] 9/C3
0200 13JUL03	USS - Drsg Δ to (L) upper chest mod. amt of blood & drainage noted on drsg. Repacked c̄ moist 4x4 covered c̄ Dry 4x4 and covered c̄ Abds pads. Ø s/s infection. IV Ancef and clindamycin given 2200. Resting quietly in bed c̄ restraints to UE in place and secure. — SGT [redacted] 9/C20 b6-2
0430 13JUL03	USS - IV Ancef Lan and clindamycin 900 g given. Resting quietly c̄ Ø c/o pain or discomfort. Restraints to UE in place and secure-Sat [redacted]

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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.

FPW # [redacted] b6-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
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AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
0300	Assumed care of pt. VSS. A/O x3. Pt. resting @ this time. (A) tenderness to (L) chest wall, wound present. Remains NPO until I&D performed in O.R. today. Ø c/o pn @ this time. Will [redacted] continue to monitor b6-2
0600	Drsg Δ to (L) chest. Slight drainage present, green in color. Redness around wound. [redacted]
0730	Urinated via urinal, output was 1050cc, dark yellow in color. [redacted] b6-2
0920	Pt. to O.R. [redacted]
1030	Pt. returns to ICU 1 fr O.R. I&D of (L) chest, stab wound. VSS. SpO2 100% on RA. LR infusing into (L) FA. Will receive remainder of Hbd, 1000cc, TKO. Pt. resting @ this time. Possibly had brief period of hallucinating, interpreter not in place, assumptions based upon gestures of pt. Pt. did receive 28mg of Ketamine in O.R. CRNA, maj [redacted] b6-2 additional 25mg of Fent. on the ward. Restraints in place. [redacted] noncombative @ this time. Will continue to monitor [redacted]
1230	Pt. continues to rest. Ø distress noted [redacted]
1630	Pt. sitting up & eating, coherent/cooperative. Ø c/o pn. [redacted] b6-2 Will brief oncoming shift

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

EPW # [redacted] b6-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
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MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
13 JUL 03 0800	Pt. A/O x3 VSS. Awake lying in bed. (D) FA Heplock & (B) AC IV site both intact Ø S/S of infiltration. +2 radial & pedal pulses palpable. Ø c/o pn on inspiration or exhalation to (D) chest wall. Dressing to (D) chest CDI. Ø S/S of distress. Will continue to monitor [redacted] b6-2
13 Jul 03 0630	Drsg Δ, minimum amt. of blood. Currently using sporameter [redacted] Will continue to monitor [redacted]
13 Jul 03 0830	Pt. ate & tolerated breakfast @ 0800. Conducted personal hygiene. Voided via urinal, output 900cc. Usually voids once per shift. Average output of 850 cc. Urine drk. yellow w/ sediment. [redacted] b6-2
13 Jul 03 1130	Pt. urinating a bit more frequently. Output 700cc. Continues to use sporameter. Will continue to monitor [redacted]
13 Jul 03 1400	Dsg Δ of (D) chest complete, pt. resting quietly [redacted]
13 Jul 03 1600	Pt. resting quietly, Ø changes, Ø S/S distress. Will brief oncoming shift [redacted] b6-2
14 July	1700 - Received pt from Sgt [redacted]. b6-2 No c/o pain. VSS. Assessment done. Dressings changed. Site has purulent drainage. Sgt [redacted] LPN 2200 - RAC IV d/c'd. LFA IV d/c'd, new IV started in left hand Sgt [redacted] LPN b6-2 0200 - Pt sleeping. No c/o pain Sgt [redacted] LPN 0400 - Pt sleeping. VSS Sgt [redacted] LPN

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EPW - [redacted] b6-4

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
14 July 03	0630 Patient assessment performed. See ICU-1 flowsheet. DRSG Δ performed to (L) chest wound. Site looks good, minimal amount of greenish-yellowish discharge noted on old DRSG. Site is red, beefy in appearance. Will continue to monitor [redacted] b6-2
14 Jul 03 1515	pt. transferred to ICW 2 from ICU 1 @ ~1400 ambulatory in stable condition - VSS - SL in (L) hand patent 18g - dsg on (L) chest CDI, montgomery straps secure - hyperactive BS - lungs CTA x (L) upper lobe, inspiratory & expiratory rhales noted - pt. restrained on (R) wrist & (L) ankle per b6-2 protocol for EPWS - pt. A&Ox3 - [redacted]
14 July 03	2310 Assume pt care @ 2100. VSS. HL to (L) hand no s/s redness/infiltration & flush. Dsg to (L) chest wall CD+I montgomery straps intact. NPO p MN for on-call to OR in am. No c/o pain @ this time will continue to monitor - [redacted] b6-2

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. ICW 2

EPW [redacted] ICU1

b6-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

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Prescribed by GSA/ICMR
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DICAL RECORD

PROGRESS NOTES

DATE	NOTES
15 July 0730	Pt care assumed @ 0500. VSS, pt awake and alert ∅ c/o pain. Lung sounds CTA, pulses palpable x4, bs(+) x4 quads. HL to (L) wrist flushes ∅ s/s infection. Dsg on chest ∅ montgomery straps CDI, ∅ s/s infection. Pt ∅ surgery today, NPO right now. Continue to monitor. [redacted] b6-2 [redacted]
15 July 03 1325	assumed care @ 1300 - VSS - no c/o pain @ this time - LR @ 100 cc/hr started thru 18g (L) hand IV 2° to NPO status - pt. o/c to OR - chest dsg CDI - [redacted] b6-2
15 July 03	Post op note Pre op Dx - Infected chest wall Post op Dx - same Procedure - chest wall wound / chest wall Surgeon - [redacted] Anesthesia - General Findings - wound look good. Skin probably and chest wall [redacted] b6-2 Complications - [redacted]

ONSHIP TO SPONSOR	SPONSOR			SPONSOR'S ID NUM (SSN or Other)
	LAST	FI[redacted]	MI	
T./SERVICE	HOSPITAL OR MEDICAL FACILIT[redacted]		INTAINED AT	
'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)		REGIS[redacted]		WARD NO.

[redacted] b6-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (RE
Prescribed by GSA/ICMR FPMR (41CFR) 101-11

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
15Jul03 1630	pt. returned from recovery @ ~1530 - S/P chestwall wound washout & closure - JP to bulb suction - dsg on (L) chestwall drainage marked - no c/o pain c this time - LR @ [redacted] 125 c/hr infusing into (R) hand 18 g IV - lungs CTA (B) - (+) BS - pt. DTV by 2200 tonight, bladder not distended - pt. awake VSS b6-2 [redacted] CRNA
15Jul03 23:00	Rec'd c/o pt. @ 21:00. Awake and alert in bed. VS WNL per flowsheet. RRR2A (+) WNL. Skin color WNL. LCA (B) ↓ diminished slightly (L) mid lobe. JP drain intact c̄ scant amt. bloody drainage. DSG to (L) ↑ chest intact c̄ sm. amt. bloody drainage. c/o pain x1. iī Percocet given. will cont. to mon [redacted]
0900 16Jun	Pt care assumed @ 0500. VSS, awake and alert c̄ b6-2 no c/o pain. Lung sounds CTA, diminished @ bases, more so in left base. Pulses palpable x4, b/(+) x4 quads. HL @ ifa intact, IV ABV. Dsg on (L) chest CDI, drainage marked by previous shift, no c/o pain @ site. JP draining minimal amount of bloody fluid, will continue to monitor. b6-2 [redacted]
16July 1325	- Received PT ~~@~~ @ 1300. PT is awake and alert. VSS PT has no c/o pain. Lungs sounds CTA. Coughing to be diminished @ base, bilateral. Good pulse motor function on all extremity. Bowel sounds x4. Dsg on (L) chest CDI. PT has drained 10cc of bright red blood, from JP. PT is resting comfortably in bed c̄ no c/o pain. will continue to monitor. [redacted] b6-2

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CAL RECORD | PROGRESS NOTES

NOTES

16 July 1830 – Performed Dressing change @ 1415. Moderate amount of drainage on the dressing. [redacted] LPN

16 July – PT had 10cc of Bright red blood from J-P. [redacted] b6 LPN

16 July 2300 New IV placed in LFA, flushes well c̄ SCC NS. s̄ S/S of infection or infiltration. HR Regular. Lung sounds diminished lower lobes bilat. DSG to L side of chest CDI, JP drain to suction draining bloody fluid. Pt. s̄ complaints @ this time. All other assessment findings WNL. Will continue to monitor. [redacted] 2LT HN b6-2

17 July 0645 Pt care assumed @0500. VSS, pt sleeping awoken by verbal stimuli, no c/o pain. Lung sounds CTA, ↓at bases, pulses ⊕x4, bowel sounds ⊕x4. Dsg on chest CDI, JP intact. JP draining small amounts of bloody fluid. HL in LFA flushes well, IV Abx running. No new complaints, cont to monitor. [redacted] b6-2 [illegible]

17 July 03 1500 assumed care @1300 – VSS – no c/o pain @ this time – SC patent in (D) FA – staples CDI on (L) chest wall, JP to bulb suction lungs CTA (B), slight expiratory wheeze heard in upper (L) lobe [redacted] b6-2 [illegible]

17 July 2300 Pt. awake & alert in bed up eating MRE. HR Regular, Lung sounds clear bilat, bowel sounds (+) x 4 quads. HL in

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

SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

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

EPN # [redacted] b6-4

PROGRESS NOTES
Medical Record
STANDARD FORM 509
Prescribed by GSA/ICMR FPMR (41 CFR) 101

TE	NOTES
17 July 2300	(L) FA flushes well c̄ 3cc NS s̄ s/s of infection. Incision on (L) upper chest 6inch horizontal below nipple is approximating well s̄ s/s of infection. JP to bulb suction draining very small amt of red tinged fluid. Pt. s̄ complaints @ this time. All other assessment findings WNL. Will continue to monitor. [redacted] JCT/AN b6-2
18 July 03 0830	Pt alert lying in bed. VSS, lungs CTA, HR reg, BS⊕. Staples to (L) chest, intact ∅ s/s infx. DSG to JP. Small amount of drainage noted in bulb. HL to (L) arm. Voicing ∅ complaints at this time. Will cont to monitor [redacted] b6-2
18 July 03	- Assumed PT care @ 1305. PT is lying in bed c̄ no c/o pain or discomfort. Staples to (L) chest, intact ∅ s/s of infection. ∅ drainage to JP. Lung sounds are clear Bilateral. Will continue to monitor PT. [redacted] b6-2
18 July 03	2000 - PT had ∅ drainage from J.P. Will continue to monitor. [redacted] b6-2
19 July 03 0200	Pt. asleep in bed. HR Regular, Lung sounds clear bilat, bowel sounds 4) X4 quads. HL in (L) FA flushed well c̄ 3cc NS s̄ s/s of infection. Horizontal incision below (L) nipple approximating well s̄ s/s of infection. DSG to (L) side of chest CDI, JP drain to bulb suction draining very small amt of red tinged fluid. Pt. s̄ complaints @ this time. All other assessment findings WNL. Will continue to monitor. [redacted] JCT/AN b6-2

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
19 July 03	0830 - Pt alert lying bed. VSS, lungs CTA, BS⊕. Pulses ⊖ & strong bilat to ↑ + ↓ extrem. Staples intact to ⓛ ↑ chest. JP drains very small amount of red fluid. Site reinforced c̄ 4x4s. HL to ⓛ forearm. Voiding ∅ complaints at this time. Will cont to monitor — b6-2 [redacted] 2600
19 July 03 1300	- Received Pt Alert + oriented. VSS. Lungs CTA. BS x 4. Staples intact to ⓛ chest. JP draining small amount of clear red blood. Pt has ⊖ c/o pain or discomfort. Will continue to monitor. [redacted] CPN —
19 July 03 1620	JP was D/C by MD [redacted] b6-2 CPN —
19 July 03 2250	Pt. awake & alert in bed. HL in ⓡFA infiltrated & red, new IV will be placed. HR Regular, Lung sounds clear bilat, bowel sounds (+) x 4 quads. Horizontal incision beneath ⓛ nipple approximating well c̄ s/s of infection. Small wound to ⓛ axillary c̄ 2x2 CDI. Pt. c̄ complaints @ this time. All other assessment findings WNL. Will continue to monitor. [redacted] 2LT HN
2300	New IV placed in ⓡFA — [redacted] b6-2

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

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

REGISTER NO.

WARD NO. ICW 2

[redacted] b6-4

PROGRESS NOTES
Medical Record

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

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
0630	Pt. care assumed @ 0500. VSS Ø pain. HR Reg, lungs CTA Bilat. Staples to chest OTA ∑ S/S infection. ABD soft ∑ BS (+) X4. HL to (R) AC intact, flushed ∑ diff., Ø S/S infection will cont. to monitor. — b6-2 [redacted] RN
20 July 03	- Received PT @ 1300 VSS. Ø pain. Leg sound are clean & intact. Staples to chest are clean + Dry. Ø S/S of infection. BS x 4. Good ROM on all extremity. HL to (R) AC wrist flushing well. will continue to monitor PT. [redacted] b6-2 CPN
21 July 03 0100	Pt. awake & alert in bed. HR Regular, Lung sounds clear bilat, bowel sounds (+) X4 quads. Horizontal incision below (L) nipple approximating well ∑ S/S of infection. Pt. ∑ complaints @ this time. VSS. All other assessment findings WNL. Will continue to monitor. — b6-2 [redacted] RN/HS
21 July 03	0535 Assume pt care @ 0500. pt awake and alert. VSS. HR reg. Lungs CTA. Abd soft BS x 4. Horizontal incision below (L) nipple staples intact. no S/S infection. No c/o pain @ this time. HL to (R) FA no S/S redness/infiltration ∑ flush. Will continue to monitor — b6-2 [redacted] SIWMC

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			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] b6-4

PROGRESS NOTES
Medical Record

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DICAL RECORD | PROGRESS NOTES

ATE | NOTES

21 July 03 1300 - Assumed PT care. PT is resting in bed c̄ ⊖ % pain or discomfort. VSS. BS x 4. Lungs are clear Bilateral. Good ROM on All extremity. SICU is warm + Dry. HC to ® forearm flushed well c̄ 3cc NS. staples to left chest are clear + Dry c̄ no S/S of infection. Will continue to monitor PT. [redacted] b6-2 LPN

→ 21 July 03 2130 Pt. awake & alert sitting up in bed c̄ complaints @ this time. HR Regular, Lung sounds clear bilat, bowel sounds (+) x 4 quads. Horizontal incision below ⓛ nipple approximated well c̄ s/s of infection. HL in ® FA c̄ s/s of infection. All other assessment findings WNL. Will continue to monitor. b6-2 [redacted] 2-7 PN

22 Jul Assumed care of pt @ 0500. Pt asleep. VSS. Lungs CTA. BS x 4 quads. Abd. soft and tender. HL in ® arm patent. Pt has ø c/o pain / discomfort. Will continue to monitor. b6-2 [redacted], LPN. SGT

22 July 2010 - Awaiting discharge to EPW camp. [redacted] b6-2 LPN

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

C	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

CATION (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] b6-4		ICW 2

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.10

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DICAL RECORD | PROGRESS NOTES

ATE	NOTES
2200	Pt care assumed @2100, VSS, no c/o pain. Lung
22July03	sounds CTA, pulses palpable x4, bs(+)x4quads.
	Wound c̄ staples OTA on chest CDI, no c/o pain @ site.
	Pt taking PO meds, c̄ d/c order and summary awaiting
	transportation to epw camp. b6-2 [redacted] akumo
22July03	- Assumed Pt care. VSS ⊖ c/o pain. Lungs clear
1305	Bilateral, Good PMS to all extremity, BS x4.
	SCD cont Dry. Pt is Awaiting transportation to
	epw camp. Will cont to monitor [redacted] yn
	b6-2

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

E	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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epw [redacted] b6-4		

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 1
Prescribed by GSA/ICMG FPMR (41CFR) 101-11.20

NSN 7540-01-075-3786

MEDICAL RECORD	EMERGENCY CARE AND TREATMENT *(Patient)*	LOG NUMBER / TREATMENT FACILITY [redacted] b2-2
		RECORDS MAINTAINED AT

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS: EPW

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)*: 9 Jul 03 | TIME: 1745

TRANSPORTATION TO FACILITY: medevac

SEX	DUTY/LOCAL PHONE	
M	AREA CODE	NUMBER
AGE 25	HOME PHONE	
	AREA CODE	NUMBER

MILITARY STATUS

ITEM	YES	NO	N/A
PRP			
FLYING STATUS			
MEDICAL HISTORY OBTAINED FROM			

THIRD PARTY INSURANCE

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

CURRENT MEDICATIONS: none

ALLERGIES: NKDA

INJURY OR OCCUPATIONAL ILLNESS

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

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INTITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: Stab wound

CATEGORY OF TREATMENT

☐ EMERGENT
☐ URGENT
☒ NON-URGENT

TIME: 17:47

INITIALS: [redacted] b6-2

VITAL SIGNS

TIME	1745					
BP	106/52					
PULSE	99					
RESP	20					
TEMP	99.0					
WT	70kg					

LAB ORDERS

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

X-RAY ORDERS

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

ORDERS

☒ PULSE OX 99% ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
1749	1gram Ancef IV	JP		1754	900mg Clindamycin IV [redacted] b6-2
1747	50mg Phen	JP			
1749	.5mg tetanus	JP			
1751	50mg Phen	JP			

DISPOSITION: ☐ HOME ☐ FULL DUTY

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

MODIFIED DUTY UNTIL | RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE: ICU

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] b6-4

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

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DICAL RECORD | PROGRESS NOTES

ATE | NOTES

7/22/03 DC Summary

EPW with infected stable wound to chest. Wound debrided and treated with Lvet to dry. Subsequently chest drain. Doing well. Wound healed

Final Dx – Infected Chest wall wound

Procedure – Chest wall Debrided
Chest wall wound closure

Day DC to EPW Camp
Levofloxacin 500 QD for 7 days
staples removed in 3 weeks
May shower

b6-2

[redacted]

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

E | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

FICATION (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] b6-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.20

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: 25

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:
I & D Lt Chest Wall abscess

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:

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)

#[redacted] b6-4

Dou 1

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 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. N/A 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.

[redacted] 06-2 MAN AN 100ct 03 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~~ by OR staff
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) [redacted] 06-2 MAN AN
DATE: 10 Oct 03 TIME: 0960

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] 06-2 MAN AN
DATE: 10 Oct 03 TIME: 1023

MEDICAL RECORD — INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM BY MAJ [redacted] / MAJ [redacted]
TIME PATIENT ARRIVED IN SUITE 0920 b6-2

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY MAJ [redacted] b6-2

3. DATE 10 Jul 03

4. PATIENT IN ROOM TIME 0920 NUMBER 1-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] b6-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	MAJ [redacted] b6-2	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify)

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

COMMENTS:

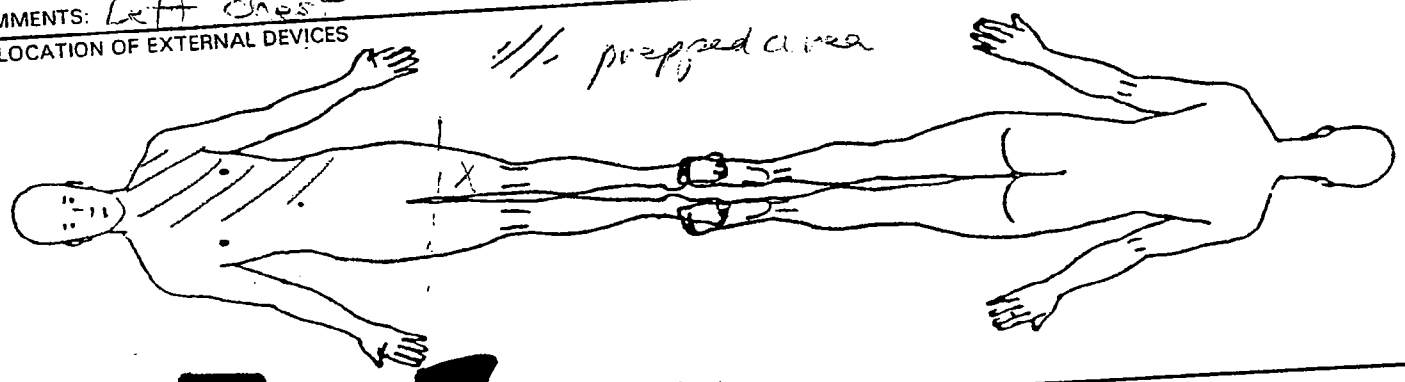
8. SKIN PREPARATION

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

COMMENTS: Left chest

PREP SOLUTION (Specify) Povidone iodine solution BY WHOM: MAJ [redacted]
SITE: Left chest BY WHOM: b6-2
SITE:
COMMENTS: No povidy of solution

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS

C = Correct I = Incorrect

		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☑ Yes ☐ No		C	C	SPC [redacted] b6-2	MAJ [redacted] b6-2
Needle Sharp	☑ Yes ☐ No		C	C	SPC [redacted]	MAJ [redacted]
Instrument	☐ Yes ☐ No					
Other	☐ Yes ☐ No					

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

[redacted] b6-4

ICU 1

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

☑ ESU NO: Valleylab #1
GROUND PAD: BRAND Valleylab
LOT NO: 65706 Exp 2004-1

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

REPLACES DA FORM 5179-1 WHICH IS OBSOLETE.

USAPA V1.

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): N.S.

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☑	NAME c) Swabs x2 from Lt chest	NAME wall for gram stain
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)*

Petrolene soaked kerlix
Fluffs
Montgomery straps

19. ADDITIONAL INFORMATION

Surgeon: Dr [redacted] b6-2
Anes MAJ [redacted]

Cut: 30 Coag: 50

20. OPERATION(S) PERFORMED

I&D left chest wall abscess

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU 1 b6-2	1015	Litter

22. REGISTERED NURSE SIGNATURE [redacted] MAJ AN

REVERSE OF DA FORM 5179-1, OCT 8

USAPA V1.01

MEDICAL RECORD | **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: Litter BY: Amb · Staff

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

3. DATE: 15 Jul 03 TIME PATIENT ARRIVED IN SUITE: 1600 → OR

4. PATIENT IN ROOM TIME: b6-2 NUMBER: 2-1 / 3

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NKDA, NPO, MW.

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] ORT b6-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT. [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: (B) arm to padded armboard (90°

8. SKIN PREPARATION

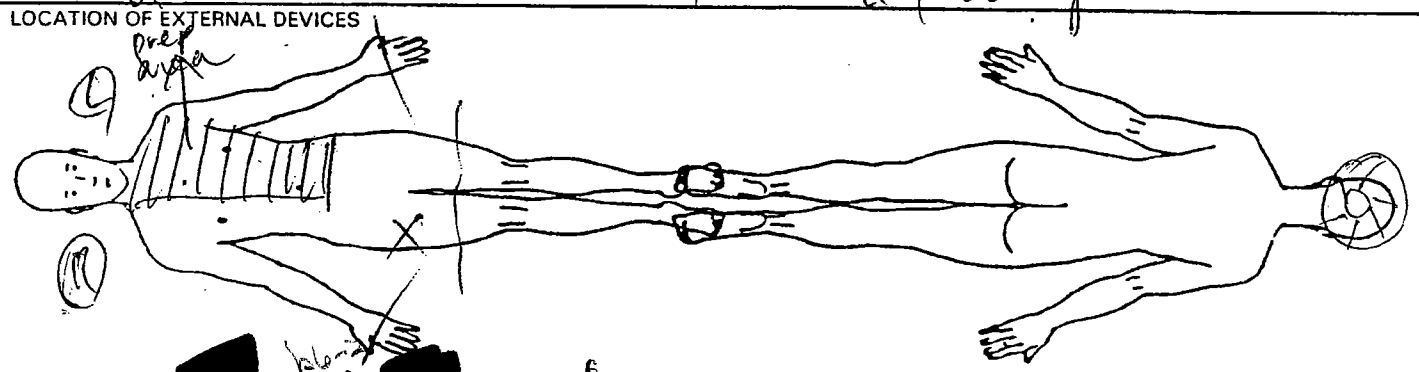
HAIR REMOVAL ☐ YES ☑ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS: ∅

PREP SOLUTION *(Specify)* Betadine s/sol
SITE: Chest BY WHOM: CPT. [redacted] b6-2
SITE: BY WHOM:

COMMENTS: ∅ prep times

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Gr[redacted]ad b6-2 -- Sa[redacted]ap = = Tourniquet

C = Correct I = Incorrect

10. COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB b6-2	CIRCULATOR b6-2
Sponge	☑ Yes	☐ No					
Needle Sharp	☑ Yes	☐ No		C	C	SPC [redacted]	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] b6-4

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

☑ ESU NO: Valley Lab #4
GROUND PAD: BRAND Polyhesive II
LOT NO: 68936

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

9:30 Cut 1:30

MEDCOM - 14075

DA FORM 5179-1, OCT 87

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
Bacitracin ointment	Qis	intra-op	topical use	[redacted]	Dr. [redacted]
					b6-2

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S):

0.9% Nacl

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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. comm Jp	2.	3.
SITE	1. Chest	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

4x8

Tape.

19. ADDITIONAL INFORMATION

Surgeon: Dr. [redacted] b6-2

Anes: [redacted] (CRNA)

20. OPERATION(S) PERFORMED

Chest wall wd clean & debridement and closure

21. PATIENT TRANSFERRED TO	TIME	METHOD
b6-2 / CU2	See Anes. Record	Litter

22. REGISTERED NURSE SIGNATURE [redacted] / IDI (AN)

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

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY

19 | HOUR

PULSE (O) | TEMP. F (•)

TEMP. C

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: | WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted] 66-4

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

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST-OP DAY

MONTH-YEAR DAY

19 HOUR

		9 July 03		10 July				6									
								4									
								14		15		16		17			
		1900	2000	2400				1300	2112	0800	2114	0800	2058	0400	2052		
PULSE (O)	TEMP. F (•)																TEMP. C
	105°																40.6°
180	104°																40.0°
170	103°																39.4°
160	102°																38.9°
150	101°																38.3°
140	100°																37.8°
130	99°																37.2°
	98.6°																37.0°
120	98°																36.7°
110	97°																36.1°
100	96°																35.6°
90	95°																35.0°
80																	
70																	
60																	
50																	
40																	

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE	B/P	92/47	98/52	101/61				100/60	108/56	120/60	102/74	104/62	105/72	104/60	100/60		
	RR	16	16	14						126/74							
	HR	78	73	77													
HEIGHT:	WEIGHT →																
	SAT	96%	95%	95%				98%	97%		98%	98%	97%	97%	97%		
	Temp	97.1		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 2

EPW [redacted] b6-4

VITAL SIGNS RECORDS

Medical Record

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

1600 - 2400
15 Jul 03

OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

[redacted] b6-2 ~~NASOGASTRIC~~ ~~GOD~~ output

TIME	AMOUNT	TYPE	ACCUM TOTAL
2000	10	bloody	10cc
July 17 1200	10	bloody	10cc
2100	5	bloody	15cc
18 Jul 04	7cc	red tinged fluid	7cc
12	2.5cc	red tinged	9.5cc
20	Ø		9.5cc
19 July 04	3cc	red tinged fluid	3cc
12	2cc	"	5cc
20			
20 July 04			
12			
20			

CHEST

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL

GRAND TOTAL OUTPUT

REMARKS

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

EPW [redacted] b6-4

INTAKE EQUIVALENTS *(Serving levels cc)*

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

DD FORM 792, JAN 74

EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3630(TEMP) 1 JUL 72 WHICH MAY BE USED.

USAPPC V1.00

ID: 000[redacted] b6-4
MB

12-07-03
03:52

			Patient Limits	
WBC	8.0	x10^3/uL	4.5	10.5
RBC	4.58	x10^6/uL	4.00	6.00
Hgb	12.7	g/dL	11.0	18.0
Hct	41.0	%	35.0	60.0
MCV	89.5	fL	80.0	99.9
MCH	27.6	pg	27.0	31.0
MCHC	30.9 L	g/dL	33.0	37.0
Plt	298.	x10^3/uL	150.	450.
LY%	39.2	%	20.5	51.1
LY#	3.2	x10^3/uL	1.2	3.4

ID: 000[redacted] b6-4
MB

13-07-03
04:13

			Patient Limits	
WBC	9.5	x10^3/uL	4.5	10.5
RBC	4.66	x10^6/uL	4.00	6.00
Hgb	12.9	g/dL	11.0	18.0
Hct	42.0	%	35.0	60.0
MCV	90.2	fL	80.0	99.9
MCH	27.7	pg	27.0	31.0
MCHC	30.7 L	g/dL	33.0	37.0
Plt	308.	x10^3/uL	150.	450.
LY%	28.9	%	20.5	51.1
LY#	2.7	x10^3/uL	1.2	3.4

ID: 000[redacted] b6-4
MB

11-07-03
03:47

			Patient Limits	
WBC	7.3	x10^3/uL	4.5	10.5
RBC	4.10	x10^6/uL	4.00	6.00
Hgb	11.6	g/dL	11.0	18.0
Hct	36.9	%	35.0	60.0
MCV	89.8	fL	80.0	99.9
MCH	28.2	pg	27.0	31.0
MCHC	31.3 L	g/dL	33.0	37.0
Plt	254.	x10^3/uL	150.	450.
LY%	37.2	%	20.5	51.1
LY#	2.7	x10^3/uL	1.2	3.4

ID: 000[redacted] b6-4
MB

10-07-03
03:59

			Patient Limits	
WBC	8.7	x10^3/uL	4.5	10.5
RBC	4.04	x10^6/uL	4.00	6.00
Hgb	11.3	g/dL	11.0	18.0
Hct	34.3	%	35.0	60.0
MCV	84.7	fL	80.0	99.9
MCH	28.0	pg	27.0	31.0
MCHC	33.2 L	g/dL	33.0	37.0
Plt	224.	x10^3/uL	150.	450.
LY%	30.6	%	20.5	51.1
LY#	2.7	x10^3/uL	1.2	3.4

ON: ICU #1	REQUEST	YSICIAN: [redacted] 66-2	LABO ORY RESULT FORM (Subject to the Privacy Act of 1974)
ST, MI: [redacted] 66-4	DATE 7-12-03	TIME 0400	SSN/PSEUDO SSN:

(Hematology) CBC

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

ology) Manual Differential

	Mono	
	Eos	
	Baso	
	Imm	
	42-52% (M) 37-47% (F)	

Coagulation Studies

RESULT	REF. RANGE
	9.8-13.6 secs
	21-34 secs
	<20 ug/ml
	<10 ug/ml

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

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

UNIT	TYPE	CROSSMATCH

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

CS:

ED BY: [redacted] **DATE:** **LAB ID NO.:**

66-4

ICU #1 | REQUES | YSICIAN:

SLMB [redacted] b6-4

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

DATE 13 Jul 03 | TIME 0400 | SSN PSEUDO SSN:

(Hematology) CBC

RESULT	REF RANGE
	4.8-10.8 x 10^3
	4.2-6.1 x 10^6
	14-18 g/dl (M) 12-16 g/dl (F)
	42-52% (M) 37-47% (F)
	80-94 fl (M) 81-99 fl (F)
	150-500 x 10^3 verified
	26.5-51.1%

(Hematology) Manual Differential

	Mono	
	Eos	
	Baso	
	Immat	
	42-52% (M) 37-47% (F)	

Coagulation Studies

RESULT	REF RANGE
	9.8-13.6 secs
	21-34 secs
	< 20 ng/ml
	10 ng/ml

Urinalysis

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

CSF

Cell Count		
Direct gen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

Misc. Serology

TEST	RESULT	REF RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

S:

ED BY: [redacted] DATE: TAR HYNY:

b6-4 13 July 03

on: ICU #1 | REQUES. | YSICIAN: [redacted] 66-2

ST. MI. | EPLU [redacted] 66-41 | DATE 7-11-03 | TIME 0330 | SSN/PSEUDO SSN:

LABO. ORY RESULT FORM
(Subject to the Privacy Act of 1974)

(Hematology) CBC

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

ology) Manual Differential

	Mono	
	Eos	
	Baso	
	Imm	

	42-52% (M) 37-47% (F)

Coagulation Studies

RESULT	REF. RANGE
	9.8-13.6 secs
	21-34 secs
	<20 ug/ml
	<10 ug/ml

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

KS:

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

on: ICU #1 REQUES. YSICIAN:

LABO ORY RESULT FORM
(Subject to the Privacy Act of 1974)

ST. MI. EPW #[redacted] b6-4 DATE 10 July TIME 0400 SSN/PSEUDO SSN:

(Hematology) CBC

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

ology) Manual Differential

	Mono	
	Eos	
	Baso	
	Imm	
		42-52% (M) 37-47% (F)

Coagulation Studies

RESULT	REF. RANGE
	9.8-13.6 secs
	21-34 secs
	<20 ug/ml
	<10 ug/ml

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

KS:

ED BY: [redacted] DATE: LAB ID NO.:

[redacted] b6-4

EMT Dr. [redacted] b6-2

O [redacted] b6-4 9 July 03 | 1819 | 0428

(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

======= PICCOLO =======
09/07/03 18:18
REFERENCE RANGE: MALE
PATIENT #: [redacted] b6-4
METLYTE 8
DISC LOT #: 3141AA4
OPER #: 678 DR #: 000
SERIAL #: 0000100697

GLU	99	73-118	MG/DL
BUN	8	7-22	MG/DL
CRE	0.5*	0.6-1.2	MG/DL
CK	214	39-380	U/L
NA+	129	128-145	MMOL/L
K+	3.8	3.3-4.7	MMOL/L
CL-	107	98-108	MMOL/L
tCO2	23	18-33	MMOL/L

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY: [redacted] b6-2

DATE: 9Jul03

LAB ID NO.:

NKDA

MEDICAL RECORD — ANESTHESIA

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

DRUG	(Units)						
Midazolam	(mg)	1.5	0.5	0.5			
Fentanyl	(mcg)	50 – 25		50	25	25	25
Lidocaine	(mg)	100					
Propofol	(mg)	180					
Ketamine	(mg)		10	10	5		
	( )						
VOLAT AGENT: ISO	% del	1.5	1.0	1.5 X			
	% e.t.						
AIR	L/Min						
N2O	L/Min						
O2	L/Min	10	2	2	10		

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

LINE site LR 18GOA ☐ Warmed — #1
☐ Warmed
☐ Warmed
☐ Warmed

EST BLOOD LOSS 25
URINE –

TIME → 900 · 30 · 1000 · 30 · 1100

SYMBOLS: BP by cuff ∨ ∧; Heart rate ●; Resp rate; BP (transduced) ‡; TOURNIQUET

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

VT – ml		380	410	450	
f – breaths/min		11	14	12	
Peak inf pres / PEEP					
MODE– S(pon), A(ssist), C(on)		S	S	S	S
BP/Auto Cuff	ET CO2 (torr)	40	42	37	42
BP / oth	FIO2 (Frac or %)	0.89	0.89	0.88	0.88
ART line	SpO2 (%)	100	100	100	100
Steth- PC/ES	ECG	SR →	→	→	
Gas analyzer	TEMP- site AU				
	N-M Block (T/4) BS				
Warming blkt	X 1 wool blanket →	→	→		
Conv warmer					

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

PROCEDURES and CPT Codes
I+D of Chest stab wound

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

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
G-LMA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
LMA #4 seated + BBS Sust ETCO2

SURGEONS: [redacted]

[redacted] MAJ/CRNA

PATIENT RECO[redacted] NAME OF 376 REVISED Jan 99

EPW # [redacted] b6-4

b6-2

TOTALS	
225	TOTAL EBL 30
200	
100	TOTAL URINE ∅
180	
25	

FLUIDS – SUMMARY
CRYSTALLOID – 400
COLLOID –
BLOOD – ∅

REMARKS – Code drugs with numbers, event with letters

① Pre-op assessment NPO, pt voided + pt understood to OR
② Glycopyrrolate 0.2 IV Room monitors O2 Induced eyelid taped Secure airway management Bite block to teeth
③ SU > 8 + < 30 BPM ETCO2 < 50, Respon LMA removed
④ T8 letter to ICU + Report to nurse.

RECOVERY AT 1015
PACU ICU 1 (Specif
OTHER T – 95.5
CONDITION: Stable
RESP – 10 SpO2 – 99
BP – 117/74 HR – 85

TIME	Start	Room	End
ANES	0855	0900	1025
PROC	Ready	Begin	End
	0905	0947	1006

PROCEDURE LOCATION 1
DATE 10 July 03
PAGE 1 OF 1

☆ U.S. GPO: 1999 – 528-336/10

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 25 DAYS MOS YRS Sex (X) MALE ( ) FEMALE

PROPOSED PROCEDURE: I+D (L) Chest wall Infection

SURGICAL SERVICE: CT

NPO SINCE: pm

ASA Physical State 1 (2) 3 4 5 E

WT: ~85 KG/LB HT: ____ IN.

ALLERGIES: NKDA

HABITS:

TOBACCO: (-)

ETOH: (-)

DRUGS: (-)

CURRENT MEDICATIONS:

( ) = ordered as premed

() Clindamycin 900mg q12.

()

() Ancef 1gm q8.

()

()

()

PREMEDICATIONS:

None Yes (@ ____ Hrs) /CC

____ . ____ mg IV IM PO

____ . ____ mg IV IM PO

____ . ____ mg IV IM PO

LABORATORY STUDIES:

pending

HB/HCT: ____ / ____

U/A: ____

OTHER: ____

129	107	8	
3.8	23	0.5	99

CK 214

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 Exp. wheeze (L) L.
- 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 NA

Other Significant Hx: N Y / N Y

Familial HX N Y Self-Inflicted Stab wounds X3 to Chest

ASSESSMENT

PAST SURGICAL/ANESTHETIC

(-)

PHYSICAL EXAMINATION

BP 101/61 HR 77 R 14 T 98.1 Sat 95.

Pain Scale 0-10 ____

HEENT - Teeth poor dentition

Trachea midline

TMJ/Neck 2+3FB

Oropharnyx grade III

Nares ____

CHEST: ~~Clear~~ scattered Ronch

CARDIAC: S1 S2 S (m)

EXTREMITIES:

IV Access: #20GAC (R) Arm

Ulnar Filling: 186 (L) Arm

BACK: ____

OTHER: ____

NPO Since pm

ANESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): b6-2 [redacted] ( ) General: Mask Intubation

Via interpreter / [redacted] MA & CRNA

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: 10 July 03 Time: 0200 Hrs

POST-ANESTHESIA EVALUATION AND NOTE (NON ASU)

{ } NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward) ____

[redacted] b6-4 (ICU)

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

)IVF

MEDICAL RECORD - ANESTHESI,

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

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML, "I" = CONSTANT INFUSION

DRUG	(Units)																
Fentanyl	(mcg)	100	50	50	50												
Versed	(mg)	3															
	( )																
Propofol	(mg)	170															
SCC	(mg)	80															
	( )																
VOLAT AGENT	Forane % del	1.2	1.5														
	% e.t.																
AIR	L/Min																
N2O	L/Min																
O2	L/Min																

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

FLUIDS — Site: 20 L/R ☐ Warmed ☐ Warmed ☐ Warmed ☐ Warmed

LOSSES — EST BLOOD LOSS; URINE -

PHYS STATUS 1 2 3 4 5 E

BODY WEIGHT: 85 KG LB

HEMATOCRIT: 41

INITIAL DATA: BP- 110 / 60; HR-

EQUIP CHECK OK?- Y N

PATIENT RECHECK OK for PROCEDURE? Y; TIME- 13 00

TIME → 13 30 14

SYMBOLS: BP by cuff V; Heart rate ∧; Resp rate ●; BR (transduced); TOURNIQUET T—T; ANES- X-X; PROC- ⊙-∅

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

VENTIL

	VT - ml	600			
	f - breaths/min	10			
	Peak inf pres / PEEP	22	23	24	24
	MODE - S(pon), A(ssist), C(on)	C	C	C	C
BP/Auto Cuff	ET CO2 (torr)	29	30	39	38
BP/oth	FIO2 (Frac or %)	100	8	8	8
ART line	SpO2 (%)	100	100	100	100
Steth- PC/ES	ECG	SR	SR	SR	SR
Gas analyzer	TEMP-site	35	35	35	35
	N-M Block (T/4)				
Warming blkt					
Conv warmer					

MONITORS/ACCESSORIES

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

TOTALS	
TOTAL EBL	10
TOTAL URINE	NM

FLUIDS SUMMARY

CRYSTALLOID- 500

COLLOID-

BLOOD-

REMARKS — Code drugs with numbers, events with letters

1. Tourn
2. See below
3. VS 1C 02

RECOVERY AT: PACU ICU 2 (Specify) OTHER

CONDITION: RESP- SpO2- 100; BP- 100/59 HR- 62

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	12 00	1335	1449
PROC	Ready 1335	Begin 1345	End 14

PROCEDURES and CPT Codes: 1 of 5 (2) Chest Wall

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GETA/SCCA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: #2 Intub W DVL BL=BS Cricoid pressure

PATIENT IDENTIFICATION: Typed or written entries: Name, Grade/Rate, Medical facility: [redacted] b6-4

SURGEONS: [redacted] b6-2

AN[redacted] Evans

PROCEDURE LOCATION:

DATE: 15 Sep 03

PAGE OF

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

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

PROPOSED PROCEDURE: I + D (2) Chest Wall

SURGICAL SERVICE: _____

NPO SINCE: MN C7

ASA Physical State 1 (2) 3 4 5 E
WT: 8 KG/LB HT: _____ IN.
ALLERGIES: _____

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

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) Clinda
( ) Cmoxf
( ) _____
( ) _____
( ) _____
( ) _____

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

LABORATORY STUDIES:
HB/HCT: 12 / 41
U/A: _____
OTHER: _____
K 3.8
Na 129

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

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

Renal System:
- Acute/Chronic RF N Y _____

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

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

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

Gynecological :
- Pregnancy N Y N/A

Other Significant Hx: N Y _____
N Y _____

Familial HX N Y Father diabetic

ASSESSMENT
PAST SURGICAL/ANESTHETIC
_____

PHYSICAL EXAMINATION
BP ___ HR ___ R ___ T ___
Pain Scale 0-10 _____
HEENT - Teeth Good
Trachea _____
TMJ/Neck _____
Oropharnyx _____
Nares _____
CHEST: _____
CARDIAC: S1 S2
EXTREMITIES: _____
IV Access: _____
Ulnar Filling: _____
BACK: _____
OTHER: _____

NPO Since _____

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 guardi[redacted] b6-2 rees. Questions answered.
Signed: _____ [redacted] Date: 13 Jly Time: 12^00 Hrs

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

Signed: _____ Date: _____ Time: _____ Hrs

Patient Identification: (Ward) _____

[redacted] b6-4

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.

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

PATIENT RECORD COPY

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

ICW2 / ICU2

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

ATIENT IDENTIFICATION

[redacted] b6-4

URSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 7/9/03 TIME OF ORDER _____ HOURS

LIST TI ORDE NOTED SIGN

1) Admit ICU
2) Dx [illegible] Occlusion Wall [illegible]
3) Vitals q 4o
4) Activity Bedrest
5) Diet regular NPO after mn

ATIENT IDENTIFICATION

URSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER _____ HOURS

6) To OR in AM [illegible]
7) MEDS
Heparin 800 mg IV q 12 1745/7
Ancef 1g IV q 8o 1730 [illegible]
Percocet 1-2 po q 4o prn
Tylenol 1-2 po q 4o prn
8) CBC in AM.

ATIENT IDENTIFICATION

URSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER _____ HOURS

9) Call MD T > 102.5, BP < 2180 < 90,
10) Dry / Dr [illegible] Drain to (L) Chest / [redacted] TTD

[redacted] b6-2

b6-2

ATIENT IDENTIFICATION

URSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER _____ HOURS

[redacted]

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] b6-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER — TIME OF ORDER — HOURS — LIST TIME ORDER NOTED AND SIGN

10 July 0[illegible]

1) To IW I
2) Dx S/P Explor Chest wall Abscess
3) Cardiac Monitor
4) Urine Q1°x2, then Q4°
5) Activity Bedrest
6) Diet [illegible] as tolerated when alert and aware

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER — TIME OF ORDER — HOURS

7) IV LRat 125cc/L
8) Incentive Spirometry Q1° when Awake
9) PO wet to dry dressing Discontinue [illegible]
10) MED
MSO4 ÷-π mg Q1-2°p

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER — TIME OF ORDER — HOURS

as

Reverse ÷-π µg Q4°pm

Clindamycin 600mg IV Q12°

11) Call MD ≥40/1.5, Stop ≥180 <E
No vom by 8° post op.

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER — TIME OF ORDER — HOURS

12) CBC in [redacted] b6-2

NURSING UNIT	ROOM NO.	BED NO.

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

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

'ATIENT IDENTIFICATION

EPW [redacted] b6-4

'URSING UNIT	ROOM NO.	BED NO.
ICW2		19

DATE OF ORDER 7/14/03 TIME OF ORDER HOURS

1) Transfer to ICW 2
2) Sb (L) until Chelsea
3) Cultures Stubs
4) Acting Adult
5) Diet Regular NPO after MN
6) IV heparin

'ATIENT IDENTIFICATION

[redacted] b6-4

EPW

'URSING UNIT	ROOM NO.	BED NO.
ICW2		19

DATE OF ORDER TIME OF ORDER b6-2 [redacted] HOURS

7) MRSI
Ancef 1gm IV q8 1410
Clindamycin 900 IV q12
Percocet 1-2 po q4p
Tylenol 1-2 po q4p

'ATIENT IDENTIFICATION

EPW [redacted] b6-4

'URSING UNIT	ROOM NO.	BED NO.
ICW2		19

DATE OF ORDER TIME OF ORDER HOURS

8) Pt OK to move to ward out.
9) Call MD T>101.5, SBP >180 <8

b6-2 [redacted]

'ATIENT IDENTIFICATION 7/15/03 [redacted] DATE OF ORDER 7:15 TIME OF ORDER 37. HOURS

EPW

[redacted] b6-4

'URSING UNIT	ROOM NO.	BED NO.
ICW2		19

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] b6-4

NURSING UNIT: ICW2 | ROOM NO. | BED NO.: 19

DATE OF ORDER: 15 July 03 | TIME OF ORDER | HOURS | LIST TIME ORDER NOTED AND SIGN

1) To ICU 2 → ICW 2
2) Bx S/P Chest wall wound and drain
3) Vitals per Manual PC Q shift
4) Activity ad lib
5) Diet regular when alert and awake

PATIENT IDENTIFICATION

EPW

[redacted] b6-4

NURSING UNIT: ICW2 | ROOM NO. | BED NO.: 19

DATE OF ORDER | TIME OF ORDER | HOURS

6) IV D5W at 125 cc/hr on heparin when bag no work
7) SP to Bulb suction / second output Q8°/QD
8) MEDS
Clindamycin 900 mg IV Q12
Ancef 1 gm IV Q8°

PATIENT IDENTIFICATION

EPW

[redacted] b6-4

NURSING UNIT: ICW2 | ROOM NO. | BED NO.: 19

DATE OF ORDER | TIME OF ORDER | HOURS

MSO4 1-2 mg IV Q4 2° pm
or
Percocet 1-2 po Q4 PRN
Zofran 4 mg IV Q8° pm.
9) Contact MD T ≥ 101.5, SBP > 180, C90, No urine 8° period or mg IV cath.

PATIENT IDENTIFICATION

EPW

[redacted] b6-4

NURSING UNIT: ICW2 | ROOM NO. | BED NO.: 19

DATE OF ORDER | TIME OF ORDER | HOURS

[redacted] b6-2

24° V [redacted] ZLT/AD

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

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

PATIENT IDENTIFICATION

[redacted] b6-4

DATE OF ORDER 7/17/03 TIME OF ORDER HOURS

1) Bacitin to wound QD
2) Remove Staples / clean JP as needed q8o.

LIST OF NOTI S

0830 17JUL03 0900

NURSING UNIT ICW2 | ROOM NO | BED NO. 19

18JUL03 900 24 chart V [redacted] b6-2 [redacted] 21JAN

PATIENT IDENTIFICATION

EPW [redacted] b6-4

DATE OF ORDER 7/22/03 ORDER HOURS

1) DC to EPW CAMP
2) Staples out in 3 weeks b6-2 noted either CAMP or here.

[redacted]

NURSING UNIT ICW2 | ROOM NO. | BED NO. 19

24VS 22JUL03 2200 healey [redacted] b6-2

PATIENT IDENTIFICATION

DATE OF ORDER [redacted] HOURS

NURSING UNIT | ROOM NO | BED NO

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

NURSING UNIT | ROOM NO | BED NO

DD FORM 1 APR 70 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 14094

U.S. GOVERNMENT PRINTING OFFICE: 1970-[illegible]

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.

Mos July 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	15	16	17	18	19	20	21
9 July	[redacted]	Vitals Q4 hrs	06	/	[redacted]											
			18	[redacted]							[redacted]					
9 July	[redacted]	Activity Bedrest	06	/	[redacted]					DC'd 14 July						
			18	[redacted]												
9 July	[redacted]	Regular diet	07	/	[redacted]											
			12	/	[redacted]						[redacted]					
			17	/	[redacted]						[redacted]					
9 July	[redacted]	CBC in Am	04	/	/	[redacted]										
		call MD for Temp >102.5	06	/	[redacted]											
9 July	[redacted]	Sys B/P >180	18	[redacted]							[redacted]					
		DSG Δ to (L) chest	06	/	[redacted]											
		TID	14	/	[redacted]				[redacted]		[redacted]					
			22	[redacted]												
11 July	[redacted]	Incentive Spirometer	06	/	/	[redacted]										
		Q 1° when awake	18	/	/	[redacted]					[redacted]					
14 July	[redacted]	~~condition stable~~	05													
			17													
14 July	[redacted]	~~Activity Ad lib~~	05													
			17							DC'd						
14 July	[redacted]	~~Regular Diet~~	07													
			12													
			17													
14 July	[redacted]	~~IV Heplock~~	05													
		flush q shift	17													
~~14 July~~	[redacted]															
14 July	[redacted]	~~call MD for T>101.5~~														
		SBP >180/90														

b6-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Infected (L) chest wall wound

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

EPW [redacted] b6-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo ____ Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
9 July	[redacted]	Admit to ICU #1				[redacted]
9 July	[redacted]	NPO p MN for I+D				[redacted]
14 July	[redacted]	transfer to ICW 2				
14 July	[redacted]	NPO after MN	14 July			
14 July	[redacted]	Plan- OR in AM 7/15/03 for washout				

All b6-2

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

USAPA V1.00

CLINICAL RECORD

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

Mo. 7 Yr. 2003

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 14	15	16	17	18	19	20	21	22
14	[redacted]	Activity: ad lib	05	/	[redacted]							
15			13									
			21									
			/									
14	[redacted]	Regular diet	07	/	[redacted]							
15			12	/								
			17									
			/									
14	[redacted]	Vitals QS - call MD	05	/	[redacted]							
15		T>101.5 SBP>180 <90	13									
			21									
			/									
15	[redacted]	JP tubul Suction	05	/	/	[redacted]						
		record output q8°	13	/	[redacted]							
		and QD	21	/	[redacted]							

D/C'd 19 July 03

All b6-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: ① infected chest wall

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

EPW [redacted] b6-4

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 7 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
14	[redacted]	transfer to ICW2	14	now	1400	[redacted]
14	[redacted]	condition stable	noted		—	[redacted]
14	[redacted]	NPO p MN	15	0001	0001	[redacted]
14	[redacted]	O/C to OR in AM for washout	15	O/C		[redacted]
15	[redacted]	NO void 8° post-op may I&O cath	15	2200		[redacted]
15	[redacted]	ICW2 → ICW2	15		1530	[redacted]
15	[redacted]	SIP chest wall washout and closure	15	noted		[redacted]
22	[redacted]	DC to Camp	22 July			
22	[redacted]	Staples out in 3 weeks; either camp	3 weeks			
	-----	or here				

	-----					

all b6-2

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

USAPA V1.00

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*

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

Mo. ____ *Yr.* ____

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 9	10	11	12	13
9 July	[redacted]	Clindomycin 900mg	18	✓		[redacted]		
		IV Q 12hrs	22	[redacted]				
9 July	[redacted]	Ancef 1gm IV Q8hrs	06	✓	[redacted]			
			14	✓	[redacted]			
			22	[redacted]				
~~14 July~~	[redacted]	~~Percocet 1-2 po q 4~~						

all b6-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Infected (L) chest wall wound

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

PATIENT IDENTIFICATION:

EPW [redacted] b6-4

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 OBSOLETE — USED UNTIL EXHAUSTED. USAPA V1.00

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

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
9 July	[redacted]	Percocet 1-II po	2220 7/11	1300 7/11	911 [redacted]											
-----	-----	Q4hrs PRN for Pain				06-2										
9 July	[redacted]	Tylenol 1-II po PRN														
-----	-----	Q4hrs for Pain														
8 Jul	[redacted]	MSO4 1-II mg Q		Died 14 July 2003												
-----	06-2	1-2° prn														
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															

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. 7 Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 14	15	16	17	18	19	20	21	22	23
14	[redacted]	SL-Flush QS	05	/ [redacted]									
			13	[redacted]									
			21	[redacted]									
			/										
14	[redacted]	ancef 1gm IVPB	06	/ [redacted]									
15		q8°	14	[redacted]									
			22	[redacted]									
			/										
14	[redacted]	clindamycin 900mg	10	/ [redacted]									
15		IV q12°	22	[redacted]									
			/										
15	[redacted]	LRC 125cc/hr	05	/ / [redacted]									
		(A2) when tol PO	13	/ [redacted]									
			21	/ [redacted]									
17	[redacted]	Bacitracin to wound	/										
		QD	10	[redacted] / [redacted] [redacted]									

D/C See below

all b6-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P chest wall washout & closure (D) infected chest wall

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

EPW [redacted] b6-4

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 ... UNTIL EXHAUSTED.

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*	Mo. 7 Yr. 03

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
14 17	[redacted]	Percocet I-II PO q4° prn-pain	2045 I [redacted] PO
14 17	[redacted]	Tylenol I-II PO q4° prn-pain/fever	
15 18	[redacted]	MSO4 1-2mg IV q1-2° prn-pain	
15	[redacted]	zofran 4mg IV q6° prn-nausea	

all 66-2

USAPA V1.00

For use of

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

MEDICAL RECORD–SUPPLEMENTAL MEDICAL D
see AR 40-66; the proponent agency is the Office of T General

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	1900	INITIALS [redacted]		INITIALS	0530	INITIALS [redacted]
NEURO	PUPILS	2mm Reactive	b6-2			PERRLA, 2mm	b6-2
	SENSORIUM	A+O x3				A/O x3	
		MAE x4					
RESPIRATORY	RESPIRATORY PATTERN	even unlabored				even, unlabored	
	BREATH SOUNDS	clear bilat				CTA(B)	
	SECRETIONS	Ø secretions noted SATS 95-97 on RA				Ø	
SKIN	COLOR	Normal for Race				NFR	
	INTEGRITY	Intact				warm & dry, intact	
IV SITE	LOCATION	(R) AC H/L				(L) FA	
	CONDITION	(L) FA IV				(R) AC H/L	
GASTRO	ABDOMEN	BS (+) x 4 quad				SOFT ND/NT x4	
	BOWEL SOUNDS						
GU	URINE:	Voiding w/o urinal				via urinal	
	COLOR/CLARITY						
CARDIOVASCULAR	CARDIAC RHYTHM	SR 70's 80's				S1S2, NSR	
		R+ pulses x4 ext				+2 radial pulses	
		S1 S2 present				+2 pedal pulses	
		Ø edema					
		A-febrile					

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

(Continue on reverse)

PREPARED BY (Signature & Title))

DEPARTMENT/SERVICE/CLINIC ICU 2nd

DATE 10 JUL 03

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

EPW [redacted] b6-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 1 MAY 78 4700
Proponent Dept of Nurs

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

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial Line	101				98	100					117		107				100	
BP Cuff	61				50	31					74		64				39	
Temperature	98.1				98.8	96.3												
Pulse	77				71	81					88		64				67	
Respiratory Rate	14				16	20					15							
SAT	95	C			96	96					97		96				97	
						RT					RA		RA				RA	

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
IVPB																		
TOTALS																		

OUTPUT

URINE	HOUR / TOTAL																	
	sp gr																	
	S/A																	
NG	OUTPUT																	
	pH																	
	GUIAC																	
EMESIS																		
STOOL																		
DRAINS																		
TOTALS																		

EPW [redacted] b6-4

POST-OP DAY

	16	17	18	19	20	21	22	23	
BP	116						114/64		
HR	96						94		
R	16						16		
SaO2	97						97		
Temp									

	16	17	18	19	20	21	22	23	8°T
I/PB							200		
O/E									

ACUITY LEVEL CLASSIFICATION

RESPIRATORY	TIME										
	MODE										
	F_IO_2										
	TV										
	RATE										
	PEEP										
ABG	pH										
	PCO_2										
	pO_2										
	HCO_3										
	SAT										
	BASE										

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

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

	TIME										
TURN											
SUCTION											

24 hr I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL		TOTAL	

BALANCE _____

NURSE'S SIGNATURE	INITIALS

EPW [redacted] b6-4

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

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

b6-2

TSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT [redacted]

		TIME	INITIALS	[redacted]	INITIALS		INITIALS
NEUROLOGICAL	PUPILS	0630		PERRL			
	SENSORIUM	AA		A+OX3			
RESPIRATORY	RESPIRATORY PATTERN	even unlabored		even unlabored			
	BREATH SOUNDS	wheezing (B)		wheezing (B)			
	SECRETIONS	∅		∅			
SKIN	COLOR	NPR T 98.5		normal for race			
	INTEGRITY	Dry, intact		intact			
IV SITE	LOCATION	(L) FA 18 (R) AC 14		(L) FA 18			
	CONDITION	HL		(R) AC 14-HL			
GASTRO	ABDOMEN	Soft NDT-D		soft nontend.			
	BOWEL SOUNDS	Hyp		present x4 quad			
GU	URINE	[illegible]		clear			
	COLOR/CLARITY			yellow			
CARDIOVASCULAR	CARDIAC RHYTHM	S1S2 Auto		NSR			
		PP x4		S1S2			
				2+ Pulse x4 extr.			

LEGEND: Cr - Creatinine; F_IO_2 - Fraction of inspired O_2; HCO_3 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - Pressure of Arterial CO_2; PEEP - Positive End Expiratory Pressure; SA - Fractional; SAT - Saturation; TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC: ICU Resp

DATE: 7-11-03

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

EPW [redacted] b6-4

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

DA FORM 1 MAY 78 4700
Proponent: Dept of Nurs

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

[redacted] b6-4

DATE 7-4-07 | DX | HOSPITAL DAY

VITAL SIGNS																		
TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial Line					91					~~85~~				~~87~~				
BP Cuff					49					60				65				
Temperature					95.9					94.6				96.7				
Pulse	~~X~~				61					69				69				
Respiratory Rate					16					18				18				
5245	~~X~~				95					96				95				
										RA				RA				

INTAKE																			
TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
IVPB								100						200				
PO								250		100				100				
TOTALS																		

OUTPUT																			
URINE	HOUR																		
	TOTAL			120			0	0	0		0	0	0	0	0				
	SP GR																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS																			

EDL [redacted] b6-4

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23	
BP	118/		120				112		
	/50		65				65		
T	99		96.4						
P	99		86				83		
R	962		16				16		
SpO2	94%		98				96		
- RA			RA				RA		

	16	17	18	19	20	21	22	23	8° T
PO Fluid	100						200		
Urine	0								

ACUITY LEVEL CLASSIFICATION

ABG'S	TIME									
	MODE									
	F_iO_2									
	TV									
	RATE									
	PEEP									
A	pH									
	PCO_2									
	pO_2									
B	HCO_3									
	SAT									
G	BASE									

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

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

24 H I&O TOTALS		NURSE'S SIGNATURE	INITIALS
wt Yesterday _____	wt Today _____		
INTAKE	OUTPUT		
IV _____	Urine: _____		
po _____	_____		
_____	_____		
TOTAL _____	TOTAL _____		
BALANCE _____			

[redacted] b6-4

For use of ...ICAL RECORD—SUPPLEMENTAL MEDICAL DATA
See AR 40-66; the proponent agency is the Office of The Surgeon General

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

APPROVED (Date)
GA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	0800	INITIALS [redacted]	1800	INITIALS [redacted]		INITIALS
NEURO	PUPILS		PERRLA		PERRLA			
	SENSORIUM		A/O x3	b6-2	Alert x3		b6-2	
RESPIRATORY	RESPIRATORY PATTERN		even, unlabored		even Resp			
	BREATH SOUNDS		CTA(B)		CTA BIL			
	SECRETIONS		Ø		Ø			
SKIN	COLOR		NFR		NFR			
	INTEGRITY		warm & dry		warm dry /			
					Dress to Ø chest bx intact			
IV SITE	LOCATION		(L) FA H/L		(L) FA			
	CONDITION		(R) AC		RAC			
GASTRO	ABDOMEN		Soft ND / Aft CC (+) tenderness around (L) chest wall wound, dressing intact BS x 4		Soft NT			
	BOWEL SOUNDS				BS (+) x 4 quads			
GU	URINE		via Urinal		via Urinal			
	COLOR/CLARITY		has not voided @ this time					
CARDIOVASCULAR	CARDIAC RHYTHM		NSR		NSR			
			S1 S2		S1 S2			

LEGEND: Cr - Creatinine; F_IO_2 - Fraction of Inspired O_2; HCO_3 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - Pressure of Arterial CO_2; PEEP - Positive End Expiratory Pressure; SVR - Systemic Vascular Resistance; SAT - Saturation; TRACH - Tracheostomy

(Continue on reverse)

[redacted] b6-2

DEPARTMENT/SERVICE/CLINIC: ICU 2nd

DATE

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

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

DA FORM 1 MAY 78 4700
Proponent: Dept of Nurs

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

[redacted] b6-4

DATE | DX | HOSPITAL DAY

VITAL SIGNS																		
TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial Line					88/					98/				110/				
BP Cuff					58					52				61				
Temperature																		
Pulse					62					83				77				
Respiratory Rate					12					14								
O2					98					97				95				
RA/O2					RA					RA				RA				

INTAKE																		
TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
IV																		
TOTALS																		

OUTPUT																		
URINE	HOUR / TOTAL																	
	10 gr																	
	S/A																	
NG	OUTPUT																	
	pH																	
	GUAIAC																	
EMESIS																		
STOOL																		
DRAINS																		
TOTALS																		

#[redacted] b6-4

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS

	16	17	18	19	20	21	22	23	
	113/65		125/68				10?/5?		
			99.2				98		
	78		93				68		
	15		16				18		
	95		96				97		
	RA		RA				RA		

INTAKE / OUTPUT

	16	17	18	19	20	21	22	23	8° T
Ancalti[illegible]							50		
Clnomycin[illegible]							100		
PO									
Urine			80cc						

RESPIRATORY / BLOOD GAS DATA

TIME									
MODE									
F_iO_2									
TV									
RATE									
PEEP									
ABG pH									
PCO_2									
pO_2									
HCO_3									
SAT									
BASE									

LABORATORY DATA

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

ACTIVITIES OF DAILY LIVING

TIME			
MOUTH CARE			
BATH			
SKIN CARE			
FOLEY CARE			
TRACH CARE			
ROM EXERCISES			

TURN / SUCTION

TIME					

24° I&O TOTALS

wt Yesterday ________ wt Today ________

INTAKE		OUTPUT	
IV	________	Urine:	________
po	________		________
	________		________
TOTAL	________	TOTAL	________

BALANCE ________

NURSE'S SIGNATURE	INITIALS

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: 17 Jul 03
Time In: 1440
Allergies: Ø
Pre-op V/S: 110/60
Procedures: Debridement

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

OR Intake: Crystalloid 500 Colloid
OR Output: UOP Ø EBL
Meds/Times: 3 Versed 350 Fent last 1400

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

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds History

Time	1440	1445	1450	1455	1510		1530
SaO2	98	100	100	100	98	98	96
FiO2	60	60	60	60	60		28
Methods	FM	FM	FM	FM	FM		
240							
220							
200							
180							
160							
140							
120							
100	^	^	^	^	^		
80							
60							
40	^	^	^	^	^		
20							
RR	11						
T	96.8	96.8		97		98	

Time	1440	1445	1450	1455	1500	1510	1530
Pain (0-10)							
~~100~~ HR	68	70	61	58	60	60	

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	0	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	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.	9	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) | DEPARTMENT/SERVICE/CLINIC | DATE

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

[redacted] b6-4

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

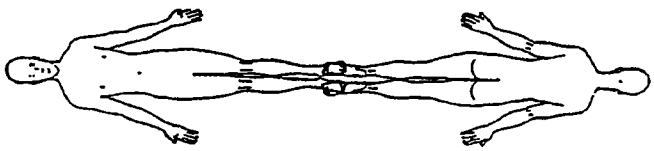
MEDICATIONS						
Allergies:						
Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1441	5					
1446	Small	Ø				

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) chest	Bulky	Ø
30'			
60'			
D/C			



PACU OUTPUT			
Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM			
Time	Rhythm	Symptomatic?	Rhythm Strip Run?

NURSING NOTES

1400 Pt arrived via litter accompanied by Anesthesia. Drsg (L) chest wall intact c̄ JP Drain pt arousable move one arm when asked to move extremities. Ø c/o pain lungs CTA ↓ (L) side Palpable b6-2 perifeval pulse. [redacted] may/kw

1510 Pt awake move all four extremities Peripheral pulses present + (B) placed on RA pulse OX sequens @ 100 will cont to monitor — b6-2 [redacted] may/kw

1535. Pt cont. VSS Chest drsg c̄ mod amount serous Sang drainage awake alert follows commands 5cc Bloody drainage from JP pt transfered via litter to ICW2 [redacted] may/kw b6-2

PACU OUTPUT			
Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM			
Time	Rhythm	Symptomatic?	Rhythm Strip Run?

Discharge Criteria:
Date: 15 Jul 03 **Time:** ~~1501~~ **PARS:**
BP: 99/45 **T:** 98 **HR:** 66 **RR:** **Sa02:**
Pain Level at D/C (0-10):
Intake: TKO IV LR **Output:** Ø
Additional Data:
Transferred To: ICW 2
Report Given To: Staff ICW 2
Transferred Via: WC (Other) Gurney Ambulance
Transferred By: [redacted] may/kw
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature: b6-2

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

SG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	INITIALS	INITIALS	INITIALS
NEURO	PUPILS	PERRLA, 3mm	Perrla 3mm	
	SENSORIUM	A/O x 3	A&Ox3	
RESPIRATORY	RESPIRATORY PATTERN	even, unlabored	even unlabored	
	BREATH SOUNDS	CTA (B)	CTA-B	
	SECRETIONS	∅	∅	
SKIN	COLOR	NFR	NFR	
	INTEGRITY	warm, dry, intact	dry, intact during	
			on left chest	
IV SITE	LOCATION	(L) FAM (R) AC site	LFA HL	
	CONDITION	∅ S/S infiltration, patent	RAC -HL	
GASTRO	ABDOMEN	soft NTD/NT	soft, non tender	
	BOWEL SOUNDS	x4	+BS x4qdx	
GU	URINE:	voiding, has	urinal	
	COLOR/CLARITY	yet to void		
CARDIOVASCULAR	CARDIAC RHYTHM	NSR	S/S2	
		S/S2	NSR	
			+2 pulses/pedal	
			radial	
			<3 sec cap refill	

LEGEND: Cr - Creatinine; F_IO_2 - Fraction of Inspired O_2; HCO_3 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - Pressure of Arterial CO_2; PEEP - Positive End Expiratory Pressure; SIA - Fractional; SA1 - Saturation; TRACH - Tracheostomy

(Continue on reverse)

[redacted] b6-2

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

EPW [redacted] b6-4

DEPARTMENT/SERVICE/CLINIC: ICU 2 east

DATE: 13JUL03

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 1 MAY 78 4700

Proponent: Dept of Nurs

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

DATE 13.2.03 L.

PAGE 2 OF 4

VITAL SIGNS	TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
	BP Arterial Line																		
	BP Cuff			105/			97/54					106/				103/			
	Temperature			97.5								/56				54			
	Pulse			68			65					107				66			
	Respiratory Rate			20			18					17				18			
	SPO2			96			96					96				96			
							KA					RA				RA			

INTAKE	TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	Clinomycin																		
	Ancef							50		30			100				50		100 / 50
	TOTALS									50									150

OUTPUT																			
URINE	HOUR																		
	TOTAL										900			1575				850	5425
	24 gr																		
	SA																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS																			

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS	16	17	18	19	20	21	52	13	
		110/51			[illegible]				
		71			[illegible]				
		17			[illegible]				
		96			[illegible]				
		RA			[illegible]				

RESPIRATORY DATA	TIME									
	MODE									
	F_iO_2									
	TV									
	RATE									
	PEEP									
A	pH									
	PCO_2									
	pO_2									
B	HCO_3									
	SAT									
G	BASE									

IV Meds:

	16	17	18	19	20	21	22	13	8°T
					100				
					875				

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

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

	TIME				
TURN					
SUCTION					

24° I&O TOTALS

wt Yesterday ______ wt Today ______

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL		TOTAL	

BALANCE______

NURSE'S SIGNATURE	INITIALS

inc. op.

√a c √a PAGE 2 OF 4

DATE | DX | HOSPITAL DAY

VITAL SIGNS																	
TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15
BP Arterial Line		124/116					70/60					96/62					
BP Cuff		68/60															
Temperature																	
Pulse		66/62					63					62					
Respiratory Rate		14/16															
SpO2		99/100					97					99					
		98/100															

INTAKE																		
TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
TOTALS																		

OUTPUT																		
URINE	HOUR / TOTAL																	
	SPGI																	
	SA																	
NG	OUTPUT																	
	pH																	
	GUIAC																	
EMESIS																		
STOOL																		
DRAINS																		
TOTALS																		

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. N. LOCATION (State or Country Code.)	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
A 1 1 D 1	I Z	[redacted]	# [redacted] EPW b6-4	unk	M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
unk	25 y	X	9	muslim

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
unk	unk	99	000 000 [redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	unk	1745	NO b6-4

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
NO	K 7 8	unk

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION
		9	YEAR / ☑ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
D	ICU 1	
NAM[redacted]	b2-2	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
21		030722

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
AAAA		030709

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYMMDD)
		030709

FOR LOCAL USE

DX: infected chest wall (R) (Wound) DX 8751
E956
Proc 3401 X2
Trauma 9
Inj 649 [redacted]

ADMITTI[redacted] (Signature, as required) [redacted] b6-2 jezek

SIGNATURE OF ADMITTING CLERK [redacted] b6-2

DA F[redacted]

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER [redacted]	2. NAME (Last, First, MI) EPW [redacted] b6-2				3. GRADE N/A	ADMISSION REMARKS
4. SEX M	5. AGE 31 y	6. RACE Z	7. RELIGION unk	8. LENGTH OF SVC N/A	9. ETS N/A	10. PREVIOUS ADMISSION NO
11. FMP 99	12. SSN [redacted]		13. ORGANIZATION N/A			14. WARD 1CW2
15. FLYING STATUS N/A	16. RATING/ DSG	17. DEPT./ BEN K79	18. BRANCH/CORPS N/A	19. UIC/ZIP		20. TYPE CASE NBI
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct from ER				22. HOURS OF ADMISSION 0130	23. CLINIC SERVICE ABAA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE —			25. TYPE DISPOSITION 50		26. DATE OF DISPOSITION 10 Jul 03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) —			27b. TELEPHONE NO. —		28. DATE OF THIS ADMISSION 10 Jul 03	ADMITTING OFFICER b6-2 Dr. [redacted]
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] 62-2					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

Scalp laceration

DX	PROC	Trauma INJ
873.0	8659	9 989
78009		
E9174		
[redacted] b6-2		

850.1
873.1
E968.2

86.59

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	1	1

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
Ø	Ø	Ø	Ø	1	1

SIGNATURE OF ATTENDING MEDICAL OFFICER [redacted] MD Dr. [redacted] b6-2

SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER For [redacted] b6-2

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

9 July 03 Abu Ghraib Prison
1 0038 Camp Vigilant
trying to break up fight
S: hit in the head with a
tent pole in the yard.
LOC, not responsive to
pain, (LOC ~30min)
O: lac ~5cm scalp.
bleeding controlled
136/82 P79 O2 100% on 100% mask
CTA PERRL but
sluggish, RRR
Neuro Unresponsive to
pain.
A: Closed Head Injury/
Laceration Scalp.
P: MEDEVAC - CT head
(2) TKO fluids (5) Pressure
(3) 100% mask O2 to Scalp
(4) C spine control lab
[redacted] b6-2
MC
MA BN Surgeon

TE	NOTES
10 July 0200	Pt admitted from emt @0130. VSS, alert and awake, c/o small amount of pain at laceration. Patient has insiratory wheezing noted bilaterally, pulses palpable x4, bs(+)x4 quads. Pt c̄ ns from emt, d/c IV after bag finishes. Laceration to scalp ⊖ stapled, CTA. Wound is intact, small amount of blood noted. Pt c̄ d/c orders, needs d/c meds. Will continue to monitor. [redacted] b6-2 91WM6
10 Jul 0500 96.1 66 16 104/60 99%	Assumed care of pt @ 0500. Pt asleep. VSS. Pt has small laceration on scalp. Lungs CTA. Abd. soft and tender. Pt c̄ d/c orders. D/C meds in medical folder. IV NS d/c'd. Ø c/o pain/discomfort @ this time. Will continue to monitor. [redacted] b6-2 91WM6, SGT
10Jul03 1530	assumed care @1300 - VSS - pt. ready to return to EPW camp when transport available - pt. has meds and discharge summary - [redacted] b6-2 CRTHAW

EPW# [redacted] b6-4

b2-2 NSN 7540-01-075-3786

MEDICAL RECORD	EMERGENCY CARE AND TREATMENT *(Patient)*	LOG NUMBER	TREATMENT FACILITY [redacted] (EMT)
		RECORDS MAINTAINED AT	

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)*: 09 July 03 | TIME: 2345

TRANSPORTATION TO FACILITY: Med Evac

SEX: M

DUTY/LOCAL PHONE: AREA CODE | NUMBER

AGE: 31

HOME PHONE: AREA CODE | NUMBER

MILITARY STATUS

ITEM	YES	NO	N/A
PRP			
FLYING STATUS			
MEDICAL HISTORY OBTAINED FROM			

THIRD PARTY INSURANCE

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

CURRENT MEDICATIONS: Z Antibiotic

ALLERGIES: NKDA

INJURY OR OCCUPATIONAL ILLNESS

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

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INTITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: laceration to head / loss of consciousness

CATEGORY OF TREATMENT

☐ EMERGENT
☒ URGENT
☐ NON-URGENT

TIME: 2358

INITIALS: C

VITAL SIGNS

TIME	2352				
BP	134/60				
PULSE	70				
RESP	19				
TEMP	97				
WT	65 kg				

LAB ORDERS

☒	CBC/DIFF	ABG ☒	PT/PTT	BHCG/URINE/BLOOD/QUANT	
	URINE C&S	UA MSCC/CATH		CHEM: ~~[illegible]~~ Chem 12 w/ Lytes	
	BLOOD C&S X				

X-RAY ORDERS

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

ORDERS

☒ PULSE OX 100 ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
2350	d70.5 Zm	[redacted]	b6-2		
2358	1 gm ancef IV				

DISPOSITION: ☐ HOME ☐ FULL DUTY

MODIFIED DUTY UNTIL

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

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ | TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

[redacted] b6-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

NSN 7540-01-075-3786

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

TEST RESULTS

CBC		SMAC		ABG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐
WBC 7.7		142 / 4.4	106 / 32	10 / 127 / 1.1	SUP 02	PH	PO2	RESULTS CT Head - WNL
H/H 12.9/41					PCO2	SAT	OTHER	
PLT 196								
PT 14.0				U/A	DIP			EKG INTERPRETATION
APTT 23.5	BHCG	ETOH	GLU		MICRO			

PROVIDER HISTORY/PHYSICAL

31 ♂ FBW hit in head c̄ tent pole while trying to break up a fight. Pt arrived via Service Ambulance c̄ scalp laceration.

GERD
BM - Clay
Bur - Ativan
Q Drink

C: Pt ambulatory, AAO, cooperative, NAD
A: Alert, Eyes open, 2mm, @ 2 inch laceration on Dorsal of skull
N: Omegis, Facial
L: CTAB, equal bilat
Abdomen
Ext: Pulses

Anesthetize scalp
close c̄ staples
(5)

(A/P) Keflex / Tylenol / remove staples in 10 days. - Return to FBW when done

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP

[redacted] 2 Kes

b6-2

DIAGNOSIS Scalp laceration 1½ inches

CODES

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

[redacted] b6-4

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY | HOUR

JULY 19 2003

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIG[redacted]

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 2

EPW

[redacted] 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 - 14124

Ward/Section: FUH	REQUESTING PHYSICIAN: DR [redacted] b6-2	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. [redacted] b6-4	DATE 9 Jul	TIME 2359	SSN/PSEUDO SSN:

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		
ALP		
ALT		
AMY		
AST		
TBIL		
BUN		
CA++		
CHOL		
CRE		
GLU		
TP		
Na		
K+		
CL		
tCO		

```
=======  PICCOLO  =======
10/07/03                 00:07
REFERENCE RANGE:         MALE
PATIENT #:  [redacted] b6-4
GENERAL CHEMISTRY 12
DISC LOT #:          3082AA4
OPER #: 678        DR #:  00
SERIAL #:        0000100684
.........................
ALB   3.5   3.3-5.5   G/DL
ALP   64    26-84     U/L
ALT   37    10-47     U/L
AMY   99*   14-97     U/L
AST   36    11-38     U/L
TBIL  0.2   0.2-1.6   MG/DL
BUN   10    7-22      MG/DL
CA++  8.9   8.0-10.3 MG/DL
CHOL  133   100-200   MG/DL
CRE   1.1   0.6-1.2   MG/DL
GLU   127*  73-118    MG/DL
TP    6.8   6.4-8.1   G/DL

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA^{+}	142	128-145 mmol/l
K^{+}	4.4	3.3-4.7 mmol/l
CL^{-}	106	98-108 mmol/l
tCO_2	32	18-33 mmol/l

REMARKS:

REPORTED BY: [redacted] b6-2	DATE: 10 Jul/03	LAB ID NO.:

b6-4

ID: 00[redacted] 10-07-03
WB 00:09

			Patient Limits	
WBC	7.7	x10^3/uL	4.5	10.5
RBC	4.55	x10^6/uL	4.00	6.00
Hgb	12.9	g/dL	11.0	18.0
Hct	41.8	%	35.0	60.0
MCV	91.8	fL	80.0	99.9
MCH	28.4	pg	27.0	31.0
MCHC	30.9 L	g/dL	33.0	37.0
Plt	196.	x10^3/uL	150.	450.
LYM	30.8	%	20.5	51.1
LYM	2.4	x10^3/uL	1.2	3.4

Ward/Section: EM 1	REQUESTING PHYSICIAN: Dr [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted]	DATE: 9 Jul 03 / TIME: 2359	SSN/PSEUDO SSN:

(Hematology) CBC

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

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			
Spun Hematocrit		42-52% (M) 37-47% (F)	
Sed Rate			
Other			

Urinalysis

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

CSF

Cell Count	
Directigen	Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF. RANGE
PT	14.0	9.8-13.6 secs
APTT	23.9	21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted]	DATE: 10 Jul 03	LAB ID NO.:

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

ATIENT IDENTIFICATION

b6-4

[redacted]

b6-2

URSING UNIT | ROOM NO. | BE[redacted]

DATE OF ORDER | TIME OF ORDER | LIST TI ORDE NOTED SIGN

10 July 03 | 0068 HOURS

Admit ICW 2

Dx: SCMP (excision)

Condition: stable

Vitals: per Routine

Allergies: NKDA

Meds: Keflex 250 mg p.o. Q.D. med Dose 0600

Tylenol #3 tablet p.o. Q.6 hrs p.r.n. Pain

ATIENT IDENTIFICATION

Noted 7/10/03

DATE OF ORDER | TIME OF ORDER

HOURS

Diet: Regular

Activity: AT tolerated

PLAN: ① Return to EPW Camp in AM

② Fill attached Keflex prescription

③ Transfer summary attached also

URSING UNIT | ROOM NO. | BED NO.

Discharge patient at 0700 and Return to EPW Camp.

ATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER

HOURS

b6-2

[redacted]

URSING UNIT | ROOM NO. | BED NO.

ATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER

HOURS

URSING UNIT | ROOM NO. | BED NO.

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. 7 Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 10	11	12
7/10	[redacted]	Vitals Per routine	5	[redacted]		
			13	[redacted]		
			21			
7/10	[redacted]	Reg Diet	7	[redacted]		
			11	[redacted]		
			17			
7/10	[redacted]	Act as tol	5	[redacted]		
			13	[redacted]		
			21			

All b6-2

ALLERGIES: ☐ YES ☒ NO	PRIMARY DIAGNOSIS: Scalp lac	ADDITIONAL PAGES IN USE: ☐ YES ☐ NO PAGE NO:

PATIENT IDENTIFICATION: # [redacted] b6-4

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 07 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
7/10-	[redacted]	Admit ICW#2	7/10	0130	0130	[redacted]
		Stable				
7/10-	[redacted]	Return to EPW camp in AM	7/10	AM		[redacted]
7/10-	[redacted]	Fill attached Keflex				
		Prescription				[redacted]
7/10-	[redacted]	Transfer Summary attached				
7/10	[redacted]	Discharge pt. @ 0700's	7/10	0700		[redacted]
		return to EPW camp				

all b6-2

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

USAPA V1.00

[redacted] [redacted]

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. 7 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 10	11	12
7/10	[redacted]	Keflex 250mg P.O.	06	[redacted]		
b6-2		QID	12	[redacted]	b6-2	
			18			
			24			

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: Scalp Lac

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

[redacted] b6-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED													
7/10	[redacted]	Tylenol #1 tab. PO														
- - - - -	- - - - -	Q10 for HA or pain														
- - - - -	- - - - -															
- - - - -	- - - - -															
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USAPA V1.00

ADMISSION AND CODING INFORMATION

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

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

3. REGISTER NUMBER							NAME (Last, First, Middle Initial)	4. PAY GRADE		5. SEX
9	10	11	12	13	14	15		16	17	18
[redacted]							EPW [redacted] b6-4			M

6. DATE OF BIRTH (YYYYMMDD)								7. AGE AT ADMISSION			8. RACE	9. ETHNIC BACKGROUND	RELIGION
19	20	21	22	23	24	25	26	27	28	29	30	31	
								3	1	y	Z	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
			NA	9	9	Ø	Ø	Ø	Ø	Ø	Ø	[redacted]		

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
N/A	46: U	Ø130	N/A

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	9									

Returned EPW Camp ~~Camp~~

17. UNIT LOCATION (State or Country Code)		18. MOS				PREV. ADMISSION	
62	63	64	65	66	67	YEAR	☒ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WA...	...SHIP OF EMERGENCY ADDRESSEE
72: Ø	1CW2	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted] b2-2		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION		22. MTF TRANSFERRED TO						23. DATE OF DISPOSITION (YYMMDD)					
73	74	75	76	77	78	79	80	81	82	83	84	85	86
5	Ø							Ø	3	Ø	7	1	Ø

24. CLINIC SVC - ADMITTING				25. MTF TRANSFERRED FROM						26. DATE THIS ADMISSION (YYMMDD)					
87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102
A	B	A	A							Ø	3	Ø	7	1	Ø

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

FOR LOCAL USE

Dx: Scalp laceration

Patient Died not die

Dx: 8231 E9289

~~Trauma~~ ~~Injury~~

ADMITTING OFFICER (Signature, as required)	SIGNATURE OF ADMITTING CLERK
[redacted] b6-2 Dr. [redacted]	[redacted] b6-2 [redacted] PFC, 91E10

DA FORM 1066, MAR 80

INPATIENT TREATMENT RECORD COVER SHE

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

1. [redacted]	2. NAME (Last, First, MI) EPW [redacted] b6-4			3. GRADE N/A	ADMISSION REMARKS
4. SEX M	5. AGE 58y	6. RACE Z	7. RELIGION unk	8. LENGTH OF SVC N/A	9. ETS N/A	10. PREVIOUS ADMISSION NO
11. FMP 99	12. SSN [redacted]		13. ORGANIZATION N/A		14. WARD ICW2
15. FLYING STATUS N/A	16. [redacted] DSG	[redacted] BEN K78	18. BRANCH/CORPS N/A	19. UIC/ZIP	20. TYPE CASE NB1
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct from ER			22. HOURS OF ADMISSION 0140	23. CLINIC SERVICE ABFA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE —			25. TYPE DISPOSITION 50	26. DATE OF DISPOSITION 14 Jul 03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) —			27b. TELEPHONE NO. —	28. DATE OF THIS ADMISSION 13 Jul 03	ADMITTING OFFICER b6-2 Dr [redacted]
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] 622				30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECT [redacted]

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

(L) auricular hematoma

380.31
920
921.1
910.0
782.3
E968.2

38031 T I
920 9 989
7245
E962

[redacted] b6-2

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	2	2

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
Ø	Ø	Ø	Ø	2	2

SIG [redacted] Dr [redacted] | SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER For [redacted]

DA [redacted] EDITION OF 1 AUG 78 IS OBSOLETE USAPPC V1.10

b6-2

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

58 yo IM Brought there By task force 20. Pt states he was assaulted by US Soldiers. Pt presents c̄ Left periorbital ecchymosis + edema. left Cheek edema c̄ pain on palpation. Pt also c̄ left ear edema + ecchymosis. left forehead abrasion & Right cheek abrasions

PHYSICAL EXAMINATION

PMH: Hepatitis B

PSH: denies

Meds: none

allergies: NKDA

VS 154/90 P 93 R18 T 98.3

CT face/head:

Head - negative

CT Face - negative for facial fractures. Pt c̄ (B) max sinus membrane thickening

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

HEENT: PERRL / EOMI
(+) Battles sign.
nares patent.
TM clear (B)
uvula and stable
no palpable steps noted

A/P 58 yo IM s/p alleged assault c̄ no s/s of facial fx.
(1) observe left ear [redacted] b6-2

SIGNATURE OF PHYSICIAN	DATE	[redacted]	ANIZATION

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

= [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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
7-13-03	0200: Pt. transfered to IEW#2 via litter. VSS ✗ O2 sat 95% RA. HR Reg, lungs ⊂ insp. ronchi throughout. Pt. has non-productive cough, has cipro in pocket. BS ⊕ X4. Large hematoma noted ⓒ peri-auricular area, TTP. PERRLA. Pt given PO motrin for pain & Ambien for sleep/anxiety. Will cont. to monitor. b6-2 [redacted] CTA
13 July 03	0525 Assume pt care @ 0500. Pt awake and alert. C/o dizziness. VSS. PERRLA, Ⓛ auricular
0500 97.6 64 24 126/82 96%	hematoma, small scrape noted to Ⓡ ear. HR reg. Lungs CTA ⊂ non-productive cough. Abd. soft No tenderness or distension noted. BS x 4. Pt has full ROM to extremities pulses strong. Has belt around waste for back problems per pt. No c/o pain @ this time. Will continue to monitor. b6-2 [redacted] GWM
13 July 03 1330	Assumed pt care @ 1300. Pt awake & alert. Dr. [redacted] @ bs new orders rec'd & noted. bruising noted to face. Ⓛ eye swollen & bruised. Ⓛ ear bruised. Airway patent, lungs CTA, Abd soft, round nondistented nontender, BS⊕x4. pt has belt around waist states "its for back problems" ↓ & ↑ Ext ⊂ full ROM ⊕ pulses. ⊕ IV access noted. pt c/o back pain, given: 800mg motrin cont'd

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

EPW# [redacted] b6-4

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
Cont'd 13 July 03 1330	given per pen orders. [redacted] will cont to monitor [redacted] b6-2 9lwmle
2145.	Pt. care assumed @ 2100. Temp 100.0. Pt. given motrin for mild discomfort to (L) side of face. Pt. provided c̄ warm compress. Pt. praying @ B.S., cooperative c̄ care. PERRLA. HR Reg, Lungs CTA. ABD rotund, soft c̄ BS (+) X4. Pt. wearing gait belt for back problems. Purple hematoma noted to (L) pri-auricular area c̄ swelling. Ø drainage noted. Will cont. to monitor. [redacted] b6-2 LCPL/AN
14 July 03	Recieved PT Alert to verbal stimuli, VSS. PT c/o mild pain to (L) side of face. PERRLA. (L) Auricular hematoma noted. No JVD noted. Lung sound clear Bilateral. Good Pulse motor function on All extremity. BSX4. Continue to monitor PT. [redacted] b6-2 LPN
14 July 03	0615 - Gave PT 1 Story motrin for c/o pain and a warm compress. Will continue to monitor PT. [redacted] LPN b6-2
14 Jul 03 @ 0719	OMFS Pt lying in bed c̄ compress to face. ecchymosis & edema still present. c̄ edema ↓ VSS AP (1) return to MP custody. [redacted] b6-2
14 July 03 @ 10:00am	- PT is resting comfortably in bed c̄ no c/o pain or discomfort. [redacted] LPN
1430	Pt D/C'd to EPW Camp c̄ escort - [redacted] b6-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

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

OMFS

13 Jul 03
@1312 PT S/P assault c̄ no facial fx's.
Pt c̄ c/o Back pain
VSS AF
facial edema + left ear ecchymosis still present.

A/P
1. Motrin 800 mg
2. warm moist compress to face.

[redacted] b6-2

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] b6-4

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

USAPA V2.00

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)*
	Discharge Summary
13 Jul 03	
@ 1843	Admit Dx: facial trauma
	D/c Dx: Same
	D/c Cond: Stable
	D/c meds: motrin 800 mg 1 tab pogo
	Procedure: CT Head + Face Both negative for fractures and intracranial Pathology
	D/c diet: regular
	Plan:
	① warm moist compress to face + left ear
	b6-2
	[redacted] MAJ
	Maxillofacial Sx

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] ~, b6-4

[redacted]

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

558-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp)

LOG NUMBER

ARRIVAL — DATE: DAY 13, MONTH JUL, YR. 03 — TIME: 0100

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): [ ] PRIVATE VEHICLE [ ] AMBULANCE [X] OTHER (Specify) AIRCRAFT

CURRENT MEDS. (tetanus immunization and other data): Ø

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): Facial Trauma

SEX: M AGE: 58

POSSIBLE THIRD PARTY PAYER? [ ] YES [ ] NO

VITAL SIGNS

TIME	0100		
BP	154/90		
PULSE	93		
RESP.	18		
TEMP.	98.3	b6-2	
Pt (Pain)	9/5 [redacted]		

CATEGORY (See reverse)
- [ ] EMERGENT
- [ ] URGENT
- [ ] NON-URGENT b6-2

ORDERS	INITIALS	TIME
CT Head	[redacted]	0110
Waters view		

ASSESSMENT/DIAGNOSIS
① Auricular Hematoma ②
② Contusion to face

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: FOW #2

CONDITION UPON RELEASE
- [X] IMPROVED
- [ ] UNCHANGED
- [ ] DETERIORATED

TIME OF RELEASE: 0135

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: 0102

Hep B

58 y/o ♂ sent Here By TASK Force 20. for a Head CT. pt with pain only on Face & EARS. pt denies other complaints.

G: WD, WN, NAD, ABC's, Handcuffed & guarded. Ambulated into ED unassisted.
H: ⊕ ⊕ Auricular Hematoma, ⊕ superficial abrasions ⊕ Ear. o/p ⊕ Hematoma TM ⊖ ⊕ Eyelids below ⊕ Eye.
PERRLA, EOMI & Dilated Exposed Face & Extremities.
N: Neurogenic
L: CTAB ⊖ R/R/Rales.
Ext: ⊖ C/C/E

PMH - Hep B
PSH - Ø
FH - ?
SOC ⊕ 70B

CT Head
WNV
Waters view
WNV
? FA

(A/P) Admit to FOW #2. consult ORF Surg.
A.M.

(CONTINUE ON SF 507, IF NEEDED)

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).

EPW [redacted]
000-00-[redacted]
b6-4

SIGNATURE OF PROVIDER AND ID STAMP: [redacted] 2nd Lt USAF

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans) b6-2

EMERGENCY CARE AND TREATMENT Copy

STANDARD FORM 558 (Rev. 6-82)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

MEDCOM - 14140

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

ATIENT IDENTIFICATION

0442

URSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 13 July 03 TIME OF ORDER: 0900 HOURS

Admit ICW #2

Dx: ① ② Anxiety w Hostility

③

Condition: stable

Vitals: per routine

Allergies: NKDA

LIST T ORDE NOTED SIGN

ATIENT IDENTIFICATION

[redacted]

URSING UNIT | ROOM | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

Meds: 800 mg motrin P.O.

5 mg Ambien tablet p.o.

Keflex 250 mg tablet P.O. Q.I.D

Diet: Regular

Activity: as tolerated

P/WN consult MAJOR [redacted] of OMS surgery in the A.M. after 0800.

b6-2

noted [redacted] 1/TAN 0800 13-03

ATIENT IDENTIFICATION

b6-2

DATE OF ORDER | TIME OF ORDER | HOURS

[redacted] MD

13 Jul 03 @ 1315 2/65

① Warm compress to ear q 4 hrs TID

[redacted]

b6-2

noted [redacted] 91WM 1330

URSING UNIT | ROOM NO. | BED NO.

24 V GRAM 1/TAN 7-13-03 23D

ATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

14 July 03 0720

① Okay to D/C from P custody

[redacted]

b6-2

URSING UNIT | ROOM NO. | BED NO.

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. LOCATION (State or Country Code.)	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
A 1 1 D 1	I Z	[redacted]	EPW [redacted] b6-4		M

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

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
	N/A	99	000 00 [redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
N/A	U	0140	unk b6-4

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
	K 7 9	

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
0	ICW2	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] b2-2

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
50		030714

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
ABFA		030713

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

FOR LOCAL USE

Dx: (L) auricular hematoma

ADM[redacted]ature, as required) [redacted] b6-4 b6-2 Dr [redacted]

SIGNATURE OF ADMITTING CLERK [redacted] b6-2 [redacted] PFC, 91G10

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY: 13 14 15 16 17 18

19 | HOUR

PULSE (O) | TEMP. F (•) | TEMP. C

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT: [redacted]

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.

EPW # [redacted] 66-4

VITAL SIGNS RECORDS

Medical Record

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

CLINICAL RECORD

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

Mo. ____ *Yr.* 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 13	M	15	16									
7-13	[redacted]	Vitals per routine.	5	[redacted]												
		b6-2	13	[redacted]												
			21	[redacted]												
7-13	[redacted]	Diet: Regular	7	[redacted]												
		b6-2	11	[redacted]												
			17	[redacted]												
7-13	[redacted]	Activity as tol	5	[redacted]												
		b6-2	13	[redacted]												
			21	[redacted]												
		b6-2														
13 Jul	[redacted]	warm compress to	6	[redacted]												
		wash at face tid	14	[redacted]												
			21	[redacted]												

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: (4) auricular hematoma

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

EPW # [redacted] b6-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo _____ Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
7-13	[redacted]	Admit ICW #2	7-13	0145	0145	[redacted]
	-----	b6-2 Stable. b6-2			b6-2	
7-13	[redacted]	Consult Major [redacted] of	7-13	0900	1300	[redacted]
	-----	Oral Surgery in A.M.P 0800				

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

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

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 13	14	15											
7-13	[redacted]	Keflex 250mg	06	[redacted]													
b6-2		PO QID	12	[redacted]													
			18	[redacted]													
			24	[redacted]													

DIC all b6-2

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: ① auricular hematoma

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

PATIENT IDENTIFICATION:

EPW# [redacted] b6-4

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

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												
7-13	[redacted]	800mg motrin PO	7-13 0200	7-13 2145	7/14 0015										
- - - - -	- - - - -	Q8° PRN	T [redacted]	T [redacted]	T [redacted]										
- - - - -	- - - bb	-2	7-13 0200	bb-2											
7-13	[redacted]	5mg Ambien PO	[redacted]												
- - - - -	- - - - -	PRN @ HS													
- - - - -	- - - - -														
- - - - -	- - - - -														
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USAPA V1.00

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER [redacted]			2. NAME (Last, First, MI) UNK # [redacted] b6-4			3. GRADE NA	ADMISSION REMARKS
4. SEX M	5. AGE UNK	6. RACE UNK	7. RELIGION UNK	8. LENGTH OF SVC NA	9. ETS NA	10. PREVIOUS ADMISSION NO	
11. FMP 99	12. SSN 000-00-0[redacted]		13. ORGANIZATION NA			14. WARD ICU1	
15. FLYING STATUS NA	16. RATING/ DSG	17. DEPT / BEN NA b6-4	18. BRANCH/CORPS NA	19. . . . UIC/ZIP		20. TYPE CASE NBI	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct from Emt				22. HOURS OF ADMISSION 1330	23. CLINIC SERVICE AAJA		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE UNK				25. TYPE DISPOSITION 24	26. DATE OF DISPOSITION 10/6/03		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) UNK				27b. TELEPHONE NO. UNK	28. DATE OF THIS ADMISSION 7/13/03	ADMITTING OFFICER b6-2 Dr. [redacted]	
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] b2-2					30. DATE OF INTIAL ADMISSION 7/13/03	32. UNITS OF [redacted] BLOOD/ COMPONENT TRANSFUSED	

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

GSW (MULTIPLE) C PARAPLEGIA

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	85	85

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0 b6-2	0 b6-2	0	85 b6-2	85

SIGNATURE OF [redacted] Dr. [redacted]

SIGNATURE OF PAO OR MEDICAL RECORDS OFFICER [redacted]

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER [redacted]	2. NAME (Last, First, MI) UNK				3. GRADE NA	ADMISSION REMARKS
4. SEX M	5. AGE UNK	6. UNK	7. RELIGION UNK	8. LENGTH OF SVC NA	9. ETS NA	10. PREVIOUS ADMISSION NO
11. FMP 99	12. SSN 000-00-0[redacted]		13. ORGANIZATION b6-4 NA			14. WARD ICU1
15. FLYING STATUS NA	16. RATING/ DSG	17. DEPT./ BEN NA	18. BRANCH/CORPS NA	19. UIC/ZIP		20. TYPE CASE NBI
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct from Emt				22. HOURS OF ADMISSION 1330	23. CLINIC SERVICE AAJA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE UNK			25. TYPE DISPOSITION 24		26. DATE OF DISPOSITION 10/6/03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) UNK			27b. TELEPHONE NO. UNK		28. DATE OF THIS ADMISSION 7/13/03	ADMITTING OFFICER b6-2 Dr. [redacted]
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] b2-2					30. DATE OF INTIAL ADMISSION 7/13/03	32. UNITS OF [redacted] COMPONENT TRANSFUSED

31. [redacted]

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

GSW (MULTIPLE) C PARAPLEGIA

Dx 874.8, 880.00, 879.2, 826.0, 597.0, 344.1, E991.2

Px 46.10, 45.79, 80.16, 84.15, 86.28, 34.04

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	85	85

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	85	85

SIGNATURE OF A[redacted] Dr. [redacted] b6-2

SIGNATURE OF PAO OR MEDICAL RECORDS OFFICER [redacted] b6-2

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER [redacted]			2. NAME (Last, First, MI) UNK			3. GRADE NA	ADMISSION REMARKS
4. SEX M	5. AGE UNK	6. RACE UNK	7. RELIGION UNK	8. LENGTH OF SVC NA	9. ETS NA	10. PREVIOUS ADMISSION NO	
11. FMP 99	12. SSN 000-00-0[redacted]		13. ORGANIZATION b6-4 NA			14. WARD ICU1	
15. FLYING STATUS NA	16. RATING/ DSG	17. DEPT./ BEN NA	18. BRANCH/CORPS NA	19. UIC/ZIP		20. TYPE CASE NBI	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct from Emt				22. HOURS OF ADMISSION 1330	23. CLINIC SERVICE AAJA		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE UNK				25. TYPE DISPOSITION 24	26. DATE OF DISPOSITION 10/6/03		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) UNK				27b. TELEPHONE NO. UNK	28. DATE OF THIS ADMISSION 7/13/03		ADMITTING OFFICER b6-2 Dr [redacted]
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] b2-2					30. DATE OF INTIAL ADMISSION 7/13/03		32. UNITS OF [redacted] COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

GSW (MULTIPLE) C PARAPLEGIA

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	85	85

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0 b6-2	0	0	85	85

SIGNATURE OF [redacted] Dr [redacted] - b6-2 - [redacted]

SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

July 03

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

EPW # [redacted] b6-4 c MGSW s/p exp/lap c Hemmons, (L) knee washout and resuscitation, med-evac to [redacted] b2-2 hemodynamically stable, hypothermic (94°), intubated, minimally responsive c (R) CT / Abdo drsg / (L) chest & bleeding from (R) neck base, (L) knee (c pressure), foley, (L) fem ✓ cardis, (L) [redacted] arm.

OR @ arrival FST found,

(1) (R) (L) retroperitoneal hematoma - non expanding

(2) thru / thru (R) colon c min spillage, ? duodenal leak, ∅ free blood.

Pt arrived @ OR in extremis; 5L crystalloid, 2 units RBC, 200 cc 25% albumin

PHYSICAL EXAMINATION

min responsive, pupils 3-4 mm responsive
lungs CTA (B) / symm
abd, (+) BSD, ∅ m/R/G
neck c̄ hematoma, small (R) base entrance wound,
(R) 3-4th toes c̄ lacerations
(R) ankle / hematoma ecchymosis
(R) thigh thru / thru
(R) ilac crest c̄ SGSW
(R) axilla c̄ large exit wound
(R) 3-4th toes c̄ lacerations
back (+) / hematoma
ecchymosis
(R) thigh thru / thru
pelvis (R) iliac flag
neck CXR ∅ fx
CXR - fully exp, ∅ hx, p ptx
(L) knee ∅ fx or frag
(R) tib / fib ∅ fx or frag
(R) 3-4th toes c̄ lacerations
(L) 1st toe
(L) arm.

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

Plan (1) Zone 2 neck injury c̄ bleeding
- explore
(2) Washout (R) axilla wound

SIGNATURE OF PH[redacted] b6-2 -UTC	DATE 15 July 03	IDENTIFICATION NO.	ORGANIZATION
PATIENT [redacted] *(For typed or written entries give Name last, first, middle; grade; date; hospital or medical facility)*		REGISTER NO.	WARD NO.

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD PROGRESS NOTES ~~CHRONOLOGICAL RECORD OF MEDICAL CARE~~

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
7 Aug 03 1330	Pt stable at this time. AAOx3. PERRLA. Mucous membranes pink, moist & intact. Neck supple from. Lungs CTA bilat, Ø resp distress. NSR. Abd soft, non-tender, bowel sounds active x 4 quads. Colostomy to (L) LQ t soft brown stool. Drg to (L) under arm, (R) shoulder and midline abd CDI. (R) leg exercised, Rom to (R) knee. Suture line to (R) lower leg CDI, open to air. (L) TKA suture line intact Ø drainage noted, open to air. Ø complaints at this time — b6-2 [redacted]
1400	Foley draining clear yellow urine. 80cc in bag at this time. [redacted]
2030	Foley emptied t 700cc clear yellow urine. Colostomy emptied t bag. Amt soft brown stool. Abd dsg Δ wet to dry, wound healing well. Dsg to (L) axillary region Δ'd wet to dry. Dsg to (R) arm CDI. Pt repositioned. [redacted]
2330	Pt care assumed @2100. VSS, alert and aware 5 % pain. Lung sounds CTA, RSTx4. Colostomy bag c̄ flatus, output. Foley site intact, draining CYU. Dsg to abd CDI, Δ'd b6-2

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. ICW 2

#[redacted] b6-4

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)
	on previous shift. Drsg to (R) shoulder and (L) axillary CDI. LBKA c̄ sutures CTA, no c/o pain. Pt c̄ head @ 20°, currently on (L) side and being log-rolled every 2°. Will continue to monitor. b6-2 [redacted] 9Lcm.o
8 August 03 0600	Pt. awake & alert c̄ HOB @ 20°. HR Regular, lung sounds clear bilat, bowel sounds (+) x 4 quads. VSS, temp slightly ↑ @ 100.2, ṫ tylenol ⁺ given, pt. also complaints of pain. HR in GTA c̄ s/s of infection. PSG's to ABD & bilat axillary areas CDI. Sutures to (L) BKA intact, site c̄ s/s of infection, incision approximating well, sm. amt. of ecchymosis on knee. Colostomy draining dark brown formed stools, stoma pink & moist c̄ s/s of infection. Foley draining clear, slightly dark colored urine. All other assessment findings WNL. Pt. c̄ other complaints @ this time. Will continue to monitor. [redacted] 2LT/AN b6-2
8 Aug 03 1300	Pt. stable. A&O x 3. PERRLA. Mucous membranes pink moist & intact. Neck supple, FROM. HOB ↑ 20°. Lungs CTA bilat, no resp distress. NSR. Abd soft, non-tender, bowel sound active x 4 quads. Colostomy producing large amts of gas. Indwelling foley draining clear yellow urine. Drsg to (L) axillary region, (R) shoulder and midline abd CDI. ROM to (R) leg & knee. Pt c̄ complaint of pain to (R) knee, repositioned. (L) TKA incision open to air, CDI. ∅ complaints b6-2 [redacted] 1Cl/m
2000	Foley emptied c̄ 720 cc clear yellow urine. Colostomy emptied & cleaned. Soft brown stool. Abd drsg Δ done w/ D, wound healing well [redacted] b6-2

NSN 7540-00-634-4176

600-108

HEALTH RECORD PROGRESS NOTES ~~CHRONOLOGICAL RECORD OF MEDICAL CARE~~

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
12 Aug 03 0030	Pt care assumed @ 2100. VSS, alert and awake, c/o slight pain to abdomen. Lung sounds clear bilaterally, pulses palpable in UE, rle, bs+x4. foley catheter intact, draining c/u ∃ difficulty. Colostomy bag intact, solid feces in bag. LBKA c̄ sutures OTA intact, some dried blood noted. Abd dsg CDI, ⊘ s/s infection. Pt turned Q2°, IV c̄ ABX intact. Will continue to monitor. — [redacted] b6-2 gilmo
12 Aug 03	0520: Assume pt. care @ 0500; pt. awake. AOx3. lungs CTA. ⊕ BSx4. Colostomy bag intact. ⓁBKA c̄ sutures intact. Dsg to abd & axilla CDI. HL ⓁFA intact ∃ signs of infection. Foley to gravity c̄ clear yellow urine. ⊘ complaints @ this time. Will continue to monitor. — [redacted] b6-2 gilmo
12 AUG 03 1305	Assumed PT care: PT is asleep in bed c̄ ⊖% pain or discomfort. VSS. Lung CTA. BSx4. colostomy bag intact colostomy is pink & moist. Dsg to abdomen is CDI. sutures to Ⓛ leg stump is dry & intact c̄ sutures. HL to ⓁFA intact. foley draining clear clear urine. Will cont to monitor PT. [redacted] b6-2 JN

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

[redacted] b6-4 ICW2

RECORDS MAINTAINED AT:		
PATIENT'S NAME *(Last, First, Middle initial)*		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME		ORGANIZATION
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

~~CHRONOLOGICAL RECORD OF MEDICAL CARE~~

STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
8.12.03 2217	Pt. care assumed @ 2100. VSS. HR Reg, lungs CTA, BS (+) X4. MC ABD dsng CDI. Foley → gravity draining yellow, Ø leakage @ meatus. Ostomy pink draining soft formed stool. Colostomy bag intact. (L) TKA sutures OTA ~ s/s infection (R) LE c̄ palpable pulse, cap refill <5 sec. HL to (L) FA flushes ~ diff. Ø s/s infection. Will cont. to monitor. — b6-2 [redacted]
2247	ROM performed to (R) LE. Pt. c/o some pain when doing ROM (R) LE. Pt. c̄ some ROM (R) LE, unable to wiggle toes or bend knee > 5°. Pt. says he has full sensation of (R) LE. Pt. repos'd to (L) side. — [redacted]
13 Aug 03 0630	Pt. colostomy bag Δ'd — b6-2 [redacted]
1030	Pt asleep in bed easily aroused by verbal stimuli. HR Reg, lungs sounds clear bilat, bowel sounds (+) x 2 quads. DSG Δ'd to ABD & (L) axilla. ~~Horizontal~~ Vertical wound to mid abd. healing well, red, moist, ~ drainage or s/s of infection. Oval wound to (L) axilla red, moist, ~ s/s of infection. Sutures on (L) TKA intact, site ~ s/s of infection. Colostomy stoma pink & moist. Pt. is able to move both (L) & (R) leg slightly, & can also bend his (R) knee slightly. HL in (L) FA flushed well c̄ 3cc NS ~ s/s of infection. Pt c̄ 2 quarter size scabs on head. Pt. ~ complaints @ this time. VSS. WJTD continue to monitor. — b6-2 [redacted] RN Pt
13 AUG 03 1300	- PT Alert + oriented X 3. PT has low Grad temp 100.0. PT is also hypertensive (150/96 BP). Breath sounds clear B. bilat. Dressing to Abdomen + Axia CDI c̄ Ø s/s of infection. Sutures on (L) TKA CDI. Colostomy stoma is pink + moist. PT is able to move both (R) Lg + (L) stump. (+L) to (L) FA flushes well c̄ 3cc NS. Will monitor PT. [redacted] RN — b6-2

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PROGRESS NOTES

DATE	NOTES
18Aug03	0600 (Cont) HL to (R) FA patent ⊼ redness/infiltration. Dsg to sacrum CD+I. Tylenol given @ this time. Will cont. to monitor [redacted] b6-2 SPecialist
	0830 Dsg Δ's done Abd ML W→D area pink no s/s infection. Dry sterile dsg to (R)HE area pink no s/s infection. Sacrum ~~area~~ wound dry dsg applied area pink no drainage noted [redacted] b6-2 SPecialist
1126	Colostomy cleaned. Formed stool approx 1 cup. Stoma pink. [redacted] b6-2 SPecialist
18Aug03	2000: Assumed care @ 1300: VSS. Lung sounds clear BS x 4. colostomy intact - no output @ this time. Abd. dressing ▷ done. W→D ⊼ NS. Sm amt serosanguinous drainage noted. Decubitus ulcer 3/4 inches to sacral area covered ⊼ 2x2 dressing. Stitches to stump intact. Turned q 1°. C/o pain. Medicated ⊼ Tylenol #3 ⅡⅡ PO @ 2000 [redacted] b6-2 SPecialist
18Aug03	2112: Late entry for 1900. Physician notified that urine is tea colored ⊼ sediment and diminishing output. Physician stated that he would tell Dr. [redacted] b6-2 SPecialist

ONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NI (SSN or Other)
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/SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		

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PROGRESS NOTES
Medical Record

STANDARD FORM 509 (F
Prescribed by GSA/ICMR FPMR (41CFR) 101-1

ST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
0530 Aug 03	NURSING (continued): BLE have some fluid per pt report but no visible edema. Stump to (L) AKA has sutures open to air c̄ no drainage. Sutures are well approximated and ∅ s/s of infection/infiltration. PROM to BLE only. Drsg to (L) tricep, abd are CDI. Stoma/colostomy site to (L) side of abd is pink and pulling out flatus. No stool noted at this time. Sacral decubitus ulcer covered c̄ 4x4 gauze. IV to (R) FA ∅ s/s infiltration or infection [redacted] b6-2
7 Aug 03	1830: Assumed care @ 1300. A&O x 3, Lung sounds clear b/l at. Abd. soft + nondistended. BS x4. Colostomy intact, draining large, brown, formed stool. Foley patent, draining tea colored urine c̄ sediment noted. Sutures to (L) leg intact. 1 inch sacral decubitus ulcer dressed c̄ 4x4 dressing, dressing Δ to abd done w/ D. Serosanguinous drainage noted. IV in (R) FA patent. Will continue to monitor. [redacted] b6-2
7 Aug 03 2000	800cc dark orange urine emptied from foley catheter. [redacted] b6-2
2126	Pt. care assumed @ 2100. VSS. HR Reg, lungs CTA, BS (+) x4. MLABD dsng CDI colostomy intact, ostomy passing soft formed stool. Foley to gravity draining amber urine c̄ sediment. Pt. c/o pain (L) TKA. ii Tylenol given. (L) TKA c̄ sutures CTA, ∅ s/s infection. (R) LE c̄ palpable pulse, (+) sensation, but ↓, (+) but ↓ ROM, capr refill <5 sec. will cont. to monitor. [redacted] b6-2
8 Aug 03	0600 Assume pt care @ 0500. pt awake and alert c̄ no c/o pain VSS x̄ temp of 99.4. HR reg. Lungs CTA Abd ML dsg CD+I BS x4. Colostomy intact Foley to gravity draining tea colored urine. (L) TKA sutures intact. (R) LE c̄ limited ROM, (+) pulse (+) sensation (cont)

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MEDICAL RECORD | PROGRES

DATE	NOTES
continued 22Aug03 2100:	(+) Sensation to top of (R) foot & bottom (R) foot, numbness in (R) toes. Turning frequently ~ Q1'-Q2' (log roll). Foley to gravity draining clear yellow urine. Continuing IV antibiotics around the clock. Will cont. to monitor. [redacted] b6-2
23AUG03 1000	VSS Pt A&O Oriented. Tylenol #3 given for pain. Dsg to (R) Axilla, Middle Abd, and sacral area changed as ordered. (R) foot elevated to keep (R) heel clear of bed to prevent pressure area. Restraints removed & reapplied and check pulses frequently to check circulation. (R) wrist splint fluck patent & intact. ∅ redness or swelling noted to IV site. Colostomy & foley drng with ostomy care. Will continue to monitor [redacted] b6-2 24
23 Aug 03	2040= VSS, A+O X3, C/O pain, T3 ii tabs given PO as ordered, Dsg to Abdomen Δ'd W→D, Colostomy care as needed, stoma site beefy red & appears very healthy, pt. putting out solid dark brown stool chunks, (R) BS x4 quads, tolerates PO well, (L) LE amputation → end has sutures approximated, (L) LE elevated, log roll & Q2' turns. Foley to gravity

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] b6-4		

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)
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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	putting out clear yellow urine. No other remarkable assessment findings. HL IV to (L) FA flushed, continuing Rocephin around the clock. Will continue to monitor. — b6-2 [redacted] /AN
24 Aug 03 0735	Pt received lying in bed awake & alert, to (R) side & turned to (L) side, [illegible] note c̄ tachycardic rhythm & (+) pulses in bilat UE & (R) LE, lungs CTA bilat, (+) bowel sounds c̄ colostomy (L) LQ, foley to gravity draining clear yellow urine. Drsg to (L) axillary Δ'd, drsg to abdomen Δ'd, sutures to (L) LE intact 3 s/s of infx, cont. to monitor. — [redacted] b6-2 [illegible]
24 Aug 03	1950 = VSS, c/o pain → ii T3 tabs PO given as ordered, A+O x3, W → D Dsg Δ'd to midline incision to Abdomen, stoma site beefy red → cleaned out & Δ'd colostomy bag → had solid brown stool, turning pt. q2° log roll, (L) LE BKA c̄ stump → sutures @ end → (L) LE elevated on pillow. (R) LE minimal movement, (+) sensation to top of foot & bottom of foot but ∅ sensation in toes. IV HL to (L) FA flushed & patent. (+) PPS x4 quads. ∅ other remarkable assessment findings. Will continue to Monitor. Foley to gravity drainage clear yellow urine. Tolerates PO well. — b6-2 [redacted] /AN
25 AUG 03	(1045) Assumed care of pt @ 0700 p̄ report from night shift. Pt alert, speaking Arabic. VSS. Pt medicated this am c̄ ii T3 for pain c̄ good relief. Pt cont. to be turned q2° using log roll. Sutures to (L) stump CDI. Stump elevated on pillow. Wet → dry drsg to

STANDARD FORM 509 (REV. 5/1999) BACK

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PROGRESS NOTES

30 Aug 03 (2015) cont: Q2 repositioning c̄ log roll. Stoma beefy & moist. BM x1 dark BM & soft. ⊕ BS x4 qd. Foley drained 1800 clear amber urine. Abd drsg d'd: CDI. Will cont to monitor. b6-2 [redacted] 9/WM

[redacted]

31 Aug 0450: pt had 1 semi-soft brown BM. voiding adequately by foley. Will cont to mon b6-2 [redacted] 9/WM

31 AUG 03 0700: VSS alert & cooperative. ~~Cont~~ Continued Regular diet. HOB↑20°. Logged roll to change position for comfort. Foley to gravity drain amber urine. Colostomy pink and moist (stoma). Ø stool present @ this time. Drsg to (L) Axilla, abd midline and sacral area bed cx ordered. All are healing well. Ø S/S of infection. IV Antibiotic DC this AM. Restraints removed and neurovascular skin intact. Will check restraints, skin integrity and circulation to extremities b6-2 [redacted] 2LTR

31 Aug @ 1900: VSS, pt alo, resting in bed. HOB 1. Q2 repositioned. Foley to gravity draining amber urine. 2 pt restraints on, circulation assessed. Ø c/o pain @ this time. abd. incision healing & open to air. Drsg to axilla CDI. Lower extr. ROM done for pt comfort. Will cont to mon b6-2 [redacted] 9/WM

01 SEP 03 (1235) Assumed care of pt @ 0000 ⊓ report from night shift. Pt alert, speaking English. VSS. Pt cont. to be turned q2° using log roll. Foley to

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

MEDICAL RECORD	PROGRESS NOTES

DATE

continued out hard dark brown feces after
29 Aug 2015 1940 stoma care. Skin around stoma
cleaned. Stoma appears beefy red &
Vascular. Encouraged pt. to ↑ H_2O
intake R/T possible constipation. IV HL
to (R) FA patent when flushed. Continuing
IV Rocephin BID. (+) BS x4, (+) appetite.
Ø other remarkable assessment findings.
will continue to monitor. [redacted] b6-2 RN

20 Aug 0800 VSS. A&O (R) FA HL Patent & intact. Flushes
without difficulty. Lungs clear bil. Resp even
and unlabored. Abd soft non distended. BS(+) x4
quadrants. Colostomy stoma ~~pink~~ covered with
closed bag with Ø stool present. Consumed
regular diet for breakfast. Repositioned for com-
fort. will change position q2 hrs, ambulate q 2°
and prn comfort. Foley draining clear amber
urine. Foley care done c̄ AM care. Restraints
removed. Skin intact. Reapplied restraints will
check frequently along with circulation and skin
integrity. [redacted] b6-2 RN

30 Aug 2015 Pt a&o x3, VSS, c/o pain to (L) leg @ venipuncture
site. ii Perc. given. HRRR, lungs CTAB, (+) circul-
ation assessed. 2 pt restraints in place.

(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.

000-00-0[redacted] b6-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)
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MEDICAL RECORD	PROGRESS NOTES
DATE 3 Sep 03 @ 1930	Pt resting in bed. pulse: tachy: ∅ c/o pain, colostomy bag intact c̄ formed brown stool. (R) stump ↑ on pillow. abd. incision open to air. drsg to axilla & sacrum CDI. cont Q2 turn c̄ leg roll. 2 pt restraints on. circulation assessed. Encouraging H2O intake. H2O @ BS within reach. Deb breathing encouraged. Will cont to monitor b6-2 [redacted] 9110M6 SPC [redacted]
4 Sept 03 0745	Resting in bed. A&O appropriately. VSS. Colostomy care completed. Formed brown stool. Stoma beefy red appearance. Skin integrity intact. Pt assisted c̄ stoma care. (L) Axilla wound & sacral wound drsg Δ complete. ∅ drainage. (L) stump ↑ on pillow & healing well. Pt foley draining dark amber/brown urine. Encouraged pt to ↑ p.o. flds. Turned to (R) side. Ant care done. Heel support to (R) ft. 2 pt restraint. Circulation & skin integrity intact. Will continue monitor b6-2 [redacted] MAD
4 Sept 03 1640	Resting in bed. Washed face. Continues brown formed stool via colostomy. Urine remains dark amber/brown. Continue monitoring & turning [redacted] MAD b6-2

(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)
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[redacted] b6-4

PROGRESS NOTES

DATE	
4SEP03 1933	LSS. AO. turned to (R) side c̄ c/o pain to (R) AKA. Provided ∂ T #3. DSG to (R) axilla CDI. Abdominal wound CDI. Catheter bed brown formed stool x1 and cleaned. (R) AKA incision site CDI. Resting comfortably in bed. b6-2 [redacted]
5Sep03	1945=VSS, tachycardic but Ø S/S of distress, encouraged pt. to drink ↑ H_2O (pt. usually runs ↑ HR), A+O X3, Ø c/o pain, did PROM exercises to (B) LE. pt. exercises (L) LE stump independently c̄ difficulty c̄ good ROM. (B) LE's elevated. Scar to (R) side of neck. Old incision wound scarring to midline abdomen — open to air. 2+ pulses to (B) LE's (L) LE has ⊕2 fem pulse). Colostomy to (L) abdominal region putting out semi-solid brown stool, stoma site beefy red & appears very vascular. Encourage pt. to do own ostomy care. Q2 turns-log roll. pt. has DSG to sacral area — some breakdown — CDI. (P) BS X4 tolerates PO well. Ø other remarkable findings. Will monitor. b6-2 [redacted]
5Sep03	2000: Addendum Note: Poly to gravity draining clear, yellow urine. Restraints x1 in place. Skin integrity intact. b6-2 [redacted]
6Sep05	0530: colostomy bag Δ'd & stoma care done this AM — had pt. assist c̄ care. [redacted]

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

MEDICAL RECORD | PROGRESS NOTES

DATE

07SEP03 Nurse Survey.

0946 (S) Nurses asked me to look in on spine fracture and skin breakdown. He has ongoing left phantom limb pain after amputation. He wishes to try a trial of Foley D/C.

Exam finds him looking well for the most par.

He has stage III breakdown ~2cm over sacrum

He has a 1-cm eschar over lateral (R) ankle

Sensation intact to Foley tug.

Meds reviewed.

(A/P) (1.) Paraplegia with decubitus ulcers x2. Will transfer to ICU for softer bed.

(2.) Wishing D/C Foley trial. Will pull and observe 6-12 hours.

(3.) Phantom Limb Pain. ↑ Neurontin to 600 TID

[redacted] b6-2

4797

07SEP03 Addendum:

1243 Pt on hospital bed.

X-rays show no change in normal alignment when upright. Will allow care team to sit patient in chair.

[redacted] b6-2

4797

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries ... name - last, middle; grade; rank; rate; hospital or facility)

REGISTER NO.

WARD NO.

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PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7
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MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
13Sep03	(cont) restraint in place c̄ complications. Will continue to monitor. b6-2 [redacted]
13Sep03 1910	Pt sleeping on & off. VIO: use SF 511. Ø c/o pain @ this time. Lungs CTA(B), HRRR, (+)BS x4. +2 pulses. colostomy care done by pt. Q2 turns c̄ occasional assistance. 1 pt restraint on, circulation to area intact. Will monitor. [redacted] 91WM6
2000	Drsg to vacuum A'd. b6-2 [redacted] 91WM6
2130	Pt OOB to chair for 1 hour. Foot care (R) done. Neurontin & Elavil for pain control. Will monitor b6-2 [redacted] 91WM6
14Sep (0510)	Pt sleeping, Ø distress noted [redacted] 91WM6
14Sep [illegible]	Received pt resting in bed, VSS, turned [illegible]. Alert and oriented x3, quiet at [illegible]. Lungs CTAB, HRR c̄ [illegible], BS(+), colostomy patent and putting out semiform stool. Supp, pt had "accident" x1. this shift. c/o pain, medicated w/ ½ tab Lyrical. Relief noted. Sacral decub dry & ; Ø other [illegible] [redacted]

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI | SPONSOR'S ID NO. (SSN or Other) [redacted]

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT b6-2

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade) | REGISTER NO. | WARD NO. ICU 1

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PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
14 Sep 03 1945	Pt resting in bed, VS: see SF511, Ø c/o pain @ this time. lungs CTAB, HRRR, ⊕BS x4, +2 pulses: Ⓛ stump ROM done by PT. Ⓡ leg ROM done. colostomy bag intact, stoma: beefy red putting out semi-solid brn stool. Pt empties own colostomy bag/care. neurontin & elavil cont for pain control. sacrum dsg Δ'd. OOB to chair for 30 min. 1 pt restraint on, circulation intact. Will monitor [redacted] b6-2
15 Sept 03 1809	Received pt resting in bed. VSS and baseline, medicated w/ ½ tylenol thus am for mild c/o pain. Turns self q2° w/ minimal assist. Sacral decub II & healing. ROM performed. Colostomy beefy red and output soft brown stool, pt performs self care. Ø other remarkable assessments noted. Restraint per CDW protocol. Ø S/S skin breakdown or circulation issues. Will cont to monitor. [redacted] b6-2
16Sep03@0215	Assumed care @ 1800; VSS; pt A&OX3, Ø c/o pain @ this time; /S S2; LS CTA B/L; ⊕BSX4; pt voiding Qs c/o urine; colostomy intact, stoma - beefy red, putting out semi-formed brown stool; pt empties own bag; sacral dsg Δd, DQ healing well; Ø Δs in assessment; 1 point restraint in place; ⊕ circulation, ⊖ skin breakdown; cont to monitor. b6-2 [redacted]
16Sep03@0220	Pt OOB to chair x 45 min; ROM completed; [redacted] b6-2

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
16 Sept 03 0800	VSS. A&O. Lungs clear Bilat. BS(+) x4 quad. Colostomy stoma pink & moist. Colostomy bag with soft brown stool. Pt perform colostomy care and emptied bag. PROM performed. (L) leg AKA stump, sting & incision well approximated. Md in to evaluate sacral decub. Dry bed @ this time. Stay under restraint contact. Will continue plan of care. b6-2 [redacted] CTA
16 Sep 03 1935	Rt a/o, ∅ c/o pain @ this time. Lungs CTAB (+) BS, HRRR, colostomy intact, stoma beefy red. (doing own stoma care) c̄ assistance if needed. Sacral decub drsg Δ'd. 1 pt restraint on, circulation intact. (L) AKA stump elevated + ROM done. neurontin & clavil cont for pain control. Q2 turns. Will monitor. [redacted] b6-2 [redacted]
17 Sept 03 0800	VSS. Client A&O. Lungs clear Bilaterale BS (+) x4 quadrant. Colostomy stoma pink and moist. Pt does colostomy care [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME: LAST	FIRST	MI	SPONSOR'S ID NUMBER SSN or Other [redacted]

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT
		b6-2

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

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PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	(Continue)
17Sept03 0800	PROM done to (L) AKA stump. Dry bed to sacral area superficial wound. Skin under restraint intact. Repositioned for comfort. Will continue plan of care [redacted] b6-2
17 Sep 1900	Pt c/o, c/o pain often. colostomy bag intact, stoma beefy, red & vascular. Pt doing own stoma care c min assistance. Distump ROM done by pt, for comfort. (R) leg ROM done. 1 pt restraint on circulation intact well men [redacted] b6-2 [redacted]
18Sept03 0800	VSS, alert & oriented. Lungs clear (B). BS (A) X4 quad. Colostomy stoma pink & moist - Colostomy drainage bag c air & stool c this time. Consume Regular diet for breakfast. (L) stump incision healed. PROM done. Repositioned self with minimal assist. Pt uses side rails to assist c repositioning. Pt emptied colostomy bag. Will continue plan of care [redacted] b6-2
18SEP03 2017	VSS. AO. LSCLAB. S,S,. BS(A)X4. (R) AKA WDI and d c/o pain @ this time. Placed comfort/elevation pillow to sacral, stage II 3cm ulcer. Scab to back of head CDI c 5cm of hair loss as well as bald of hair loss to back of head. Turned to (R) side c complaints. Phillips abdominal incision CDI and LVQ colostomy produced brown, soft stool. [redacted] b6-2

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
20SEP03	(cont) and to shower this pm. Tol. well. Will cont. to monitor. b6-2 [redacted] 4/AW
(1920)	Rt a/o, c/o limb pain often. colostomy drg intact, pt doing self care. stoma bel by red & vascular; putting out semi-solid brn stool. sacral drsg d/d. lungs CTAB, ⊖BS, HRRR, Q2 turns. voiding adeq. cyu. Neurontin + Elavil around the clock. Pt doing ROM to (D) stump for comfort. 1 pt restraint on. ⊕ circulation will monitor. b6-2 [redacted] 9/LWM6. [redacted]
21Sep03 0730-	Assumed care of pt AO x 3. VSS ⊘ c/o pain or discom @ this time sitting up in bed eating breakfast. AM care stoma care self. Q2h position change prevent breakdown 10cm stage 2 breakdown to sacrum dressing d'd CDI ⊘ drainage noted healing. Lungs CTA HRRR. Encouraged to consume Ensure [redacted] events will cont to monitor b6-2 [redacted] 9/LWM6.
1920	Pt a/o, ⊘ c/o pain @ this time. Self care done to stoma. Q2 turns. Sacral decub drsg d'd. ⊘ drainage noted. voiding adeq. cyu. OOB to chair @ this time. (R) foot ROM done, (D) stump ROM

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)

#⊘ [redacted] b6-4

REGISTER NO.

WARD NO. ICW #1

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
21Sep03 1920 (cont)	done by PT. 1 pt restraint on c̄ circulation intact. Will monitor. b6-2 [redacted] 91W MC
22SEP03	(1430) Assumed care of pt @ 0600 p̄ report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c̄ Tylenol/ Neurontin. Pt OOB to chair independently. AM care done by pt along c̄ colostomy care. Dsg to sacral decub Δd. Pt turning self q2-3° and doing ROM c̄ BLE for comfort. Tol. reg diet well. Voiding s̄ difficulty. 1 point restraint in place s̄ sisx complications. Will continue to monitor. b6-2 [redacted] USAN
22Sep03	2000 = VSS, A+O x3, ∅ c/o pain @ this time, OOB to chair s̄ difficulty, x1 restraint – skin integrity intact, colostomy bag intact, putting out adequate brown stool, pt does own colostomy care, Dsg to sacral decub Δ'd CDI, turning Q2 log rolls, ∅ other remarkable findings. Continue to monitor. b6-2 [redacted] USAN
23SEP03	(1030) Assumed care of pt @ 0600 p̄ report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c̄ Neurontin. Pt OOB to chair. Personal hygiene done by pt. Pt doing ROM c̄ BLE for comfort. Turning q2-3°. Colostomy bag Δd by pt this am. Dsg to sacral decub Δd – ∅ sisx infection. 1 point restraint in place s̄ sisx complications. Will continue to monitor. [redacted] USAN b6-2

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
23Sep03	1930 = VSS, A+O x3, Ø c/o pain @ present, pt. doing own colostomy care – pt. given supplies to do so, Drsg to sacral decub Δ'd CDI, ROM exercises to BLE's assist, DOB to chair ≅ difficulty, Q2 turns log roll, Ø other remarkable findings. Continue to monitor — b6-2 [redacted]
24SEP03	(1405) Assumed care of pt w/ Ø c/o Ø p report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c̄ ~~Percs~~ Neurontin. Pt DOB to chair and back to bed ≅ assist. Personal hygiene done by pt. Drsg to sacral decub Δ'd. Ø S/Sx infection. Pt turning self and doing ROM c̄ BLE. Colostomy care done by pt this am. Pt tol. reg diet well. Voiding ≅ difficulty. 1: point restraint in place. ≅ S/Sx complications. Will continue to monitor. b6-2 [redacted]
1940	Pt a/o, speaking arabic, colostomy bag intact, care done by pt, Drsg to sacrum Δ'd. Pt turning Q2 c̄ reminder. ROM done. neurontin & elavil cont. DOB to chair ≅ difficulty. Will monitor [redacted] b6-2 [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)

#Ø [redacted] b6-4

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
25Sept03 0900	VSS, alert & oriented. OOB to chair with minimal assist pm staff. Ate breakfast and completed AM care up in chair. Tolerated well. Pt completed colostomy care. Bed was soiled with urine. linen changed. No acute care needed. Will continue plan of care. b6-2 [redacted] RN
25sept03@2015	Assumed care @1800, AO VSS, pt A&OX3 speaking arabic; pt OOBTC for 30 min x1; tol well; ∅ c/o pain or discomfort @ this time; pt completed own colostomy care ∃ assistance; sacral DQ Δd, ⊖ s/sx infection; pt turning self & doing ROM (B) LE; No Δ in assessment; restraint in place, ⊕ circulation, ⊖ skin breakdown; Cont to monitor — b6-2 [redacted]
26Sept03 1000	Assumed care of Pt @ 0000. VSS-AO Pt speaking in arabic. Pt. completed colostomy care ∃ assistance, sacral Dressing Δd. CDT. ⊕ Pedal + Radial pulse. ∃ Restraints in place. ⊖ skin breakdown. Pt. turning himself q 2 + doing self ROM exercises will cont. to mont. b6-2 [redacted]
26Sept03 1600	Pt. resting well @ this time ⊖ c/o pain. — b6-2 [redacted]
26Sept03	2000 = VSS, ∅ c/o pain @ present [redacted] q2 turns log roll — pt. can help ∃ this very well, Dsg to Sacral decub Δd - CDT, pt. does ROM exercises to (L) stump, assist ∃ ROM exercises to (R) LE. Colostomy bag intact putting out formed stool.

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

brown colored, pt. does own colostomy care when given supplies. Other remarkable findings. Continue to monitor for Δ's — b6-2 [redacted] AN

27Sept03 1200 - received pt. @ 0800. assessment completed. Pt. tolerated breakfast well. Ø c/o pain. Encouraging pt. to do ROM exercises. Log Roll pt. Q2. Pt. turns on his own. Colostomy bag intact putting out formed stool. Pt. OOB in chair @ this time. Will continue to monitor pt. — b6-2 [redacted]

27Sept03 1414 - pt. had a spell of urinary incont. x2. changed pt. clothes + sheets. changed dressing to sacral decub. dressing dry ⊖ s/s infection. pt. OOB in chair @ this time. Will cont. to monitor. b6-2 [redacted]

28Sept03 1030 - Pt. OOB into chair. Pt. urinated onto chair. changed pt. clothes. Will cont. to monitor. — b6-2 [redacted]

(1600) I concur c̄ above assessment. — [redacted] AN

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	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.

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
27 SEP 03 2035	VSS. AO. Speaking small amount of arabic. BS⊕ x4. Abdominal incision intact and clear - ⊕ pulses to all extremities. Voiding light amber urine quantity sufficient. Urinary to LVR producing light brown stool and intact. BS⊕. Encouraged to use BS urinal as applied that fully would be placed PT unbuttoned and used urinal properly. b6-2 [redacted] AN
28 sep 03 0700	- Assumed care of pt AAO x 3. VSS. c/o pain to ⊕ AKA scheduled neurotin given c relief. Lungs clear HRRR Active BS x4 Tolerating PO well. Urinating c difficulty per urinal @ BS OOB to chair Q2° rotate to prevent breakdown. Will cont to monitor b6-2 [redacted] glumes.
29 SEP 03 0505	VSS. Patient has no significant changes. [redacted]
29 Sept	pt. awake ~~alert~~ oriented x3. VSS colostomy bag intact, sacral dsg clean dry and intact, pt moved out of bed to chair, tol food well & voiding per urinal sometimes in the bed, restraints x2 in place b6-2 [redacted]
29sep03 0200-0110	Assumed care @ 1800; VSS, pt A&Ox3, pt OOB TC x1 for 30 min; dsg to sacral Δ°, CDI; FTG draining QS, clear, dark yellow urine; cont c Q 2° turns; pt does own colostomy care, - CDI; cont c Neurontin for pain. Restraints in place, ⊕ circulation, ⊕ skin breakdown; cont to monitor [redacted] b6-2

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
30 Sep 03 0645	- Assumed care of pt. A+O X3 VSS Ø c/o pain or discomfort @ this time. Sitting up in bed eating breakfast. Foley to gravity clear yellow urine QS. Ostomy care self c̄ assistance stoma beefy red vascular. Lungs clear HRRR Active BS. Will cont to monitor b6-2 [redacted] SLWRCG
30 Sep 03 @ 2130	Assumed care @ 1800; AI VSS, pt A+O. Ø c/o pain/discomfort @ this time; OOBTC X1; FTG draining QS, clear, yellow urine; performs own colostomy care-bag CDI; stoma ~~of~~ beefy & s/sx infection; Restraints in place; ⊕ circulation ⊖ skin breakdown; cont to monitor b6-2 [redacted]
1 Oct 03 ~~30 Sep 03~~ 0700	- Assumed care A+O x 3. Ø c/o pain or discomfort @ this time. Foley to gravity draining light yellow urine QS ⊕ LQ stoma vascular beefy red self care. Clear lungs throughout. HRRR Active BS Tolerates PO well. Will cont to monitor b6-2 [redacted] SLWRCG (1740) I concur c̄ above assessment. [redacted]
1 Oct 03	2000 = VSS, Ø c/o pain, A+O X3 new duoderm dsg placed on sacral decub - white appearance breakdown ↓ing site looks like it is healing well, pt. does ROM exercises c̄ stump on his own, assist c̄ ROM exercises to ⊕ LE's PRN, pt. A's cleans out own colostomy bag &

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] b6-4

PROGRESS NOTES
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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	does colostomy care when given supplies, Foley to gravity draining clear yellow urine, OOB to chair s difficulty. ∅ other remarkable findings. POC: Pain mgt, palliative care, Q2 turns (pt. does himself) wound care/mgt. Crestraints ~~x2~~ x1 when in bed, ⊖ skin breakdown noted, will continue to monitor — b6-2 [redacted]
20Oct03	0500. USS Alert & Oriented. Colostomy stoma pink & moist. Foley to gravity drain clear yellow urine. Repositioned in bed for comfort. Using prominence pads to prevent pressure ulcer. Will continue plan of care — b6-2 [redacted]
20Oct03	2030 = VSS, ∅ c/o pain, A+Ox3, Q2 turns - pt. assists on this, Dsg Δ'd to sacral decub CDI, colostomy intact putting out brown semi-solid stool, pt. does own care when given supplies, Foley to gravity draining clear yellow urine, x1 restraint when in bed, skin integrity intact, OOB to chair s difficulty. Will continue to monitor for acute s's — [redacted] b6-2

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[redacted] b6-4

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
3 Oct 03 0700	- Assumed care of pt. A+O x3. VSS. AM care self & assist. complete @ bedside. Ostomy care self. stoma beefy red vascular open to air for 30 mins (L) AKA ∅ pain or discomfort to stump. Stage II decub to sacrum healing. ROM performed to (R) LE. Will cont to monitor — b6-2 [redacted] Grunes.
30 Oct 03	1930: VSS, ∅ c/o pain @ this time, A+O X3, Duoderm CDI to sacral wound, Q2 turns log roll, colostomy intact - pt does own colostomy care, OOB to chair s difficulty. ∅ other remarkable findings. x1 restraint when in bed (2) skin breakdown. Continue to monitor for acute Δ's — b6-2 [redacted]
	Addendum - foley to gravity draining clear yellow urine — b6-2 [redacted]
4 Oct 03	- Assumed care pt. A+O x3. (L) AKA ∅ c/o pain or discomfort @ this time. Self ostomy care performed. Stoma vascular. OOB to chair. Stage II breakdown to sacrum healing dressing intact. Will cont to monitor — b6-2 [redacted] Grunes

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	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; [redacted] No or SSN; Sex; Date of Birth; Rank/Grade)

EPW# [redacted] b6-4

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
04OCT03	(1605) I concur c̄ above assessment — [redacted] b6-2
4 OCT 03 2109	VSS. AO. ⊕ pulses to RLE and BUE. Emptied colostomy by self c̄ difficulty. Placed OOBTWC on wheel for 30 min. & tolerated well. b/o pain. Colostomy and FTG intact. Voiding light yellow urine, quantity sufficient. PSG to send when CDI. Learned to fit. b6-2 [redacted]
5 OCT 03 0700	Assumed care of pt. A+O x3. VSS c̄/o pain or discomfort @ this time. Lungs CTA HRRR Active BS x4 stoma vascular self care c̄ assistance. Foley to gravity clear yellow urine DS. DOB to wheelchair self c̄ assistance transfer from bed to wheelchair. Stage II to sacrum healing dressing CDI. Will cont to monitor — b6-2 [redacted] 91WM6.
5 OCT 03 2031	VSS. AO. OOBTWC c̄ difficulty. Colostomy and FTG intact and voiding light yellow urine quantity sufficient. provided ∆ of clothes and bedding. BS ⊕ x4. Colostomy ejecting light brown soft fecal stool. ∆'d. send PSG. b6-2 [redacted]
06OCT03 0815	Pt Awake in bed. A&O. c/o pain in lower back. Rotated to (R) side. VSS. LS CTA (B), S1 S2 present ⊕ BS x 4 quads. FTG Draining cyu. Colostomy to ~~RE~~ DUQ. CDI. Will continue to monitor. — [redacted] Sp. 9WM6 b6-2

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
11JUL03	Neurosurgery
0636	(S/O) Extubated, awake
	Moving uppers. Lowers paretic.
	Draining CSF from L-Spine.
	(A/P) Penetrating injury L-Spine with CSF leak.
	Lumbar drain today when in OR.
	Continue [redacted] Flat / Log roll.
	b6-2
	4797
17 July 03	Surgery.
	extubated, good cough-productive
	neck incision c/d/i 108 >20.1 144 HO 27 WT 9 24 ~~83~~
	lungs clear c̄ large airway secretions 734/32/91/19 7-6
	hypo BS, soft, NT, wound c/d/i SL FM
	stoma pink, min gas
	leg warm, dry, trace edema, incision c/d/i.
	Imp. ① gen BKA / anemia / complete cord L4 / lumbar-CSF leak / SIRS + lip blister
	Plan. ① OR today +/- close stump, place lumbar drain
	② cont pulm toilet.
	③ start nutrition later today - will need aspiration precaution

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
Complete K [redacted]			
SPONSOR'S NAME		**RELATIONSHIP TO SPONSOR**	
(S) Franchise [redacted] b6-2			

PATIENT'S IDENTIFICATION: *(For typed or wri[redacted]ive: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Ra[redacted]de.)*	REGISTER NO.	WARD NO.
[redacted] b6-4		

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
13 Jul 03	(1300) pt arrived from OR; USS; vented; no s/s of respiratory distress; transferred to bed 5 unaided; Blood product hemoglobin report taken
	(1600) pt stable; no change in assessment; MD called for transfusion of unassorted O+ unit PRBCs 5 adverse reaction. No new orders given by MD; lab supervisor informed; HN informed = unaided report stated by HN MD greatly; no adverse reactions noted
14 July 03	Surgery.
	CTSR for ↓ pulses in ⓛ leg c̄ ↑ swelling of leg.
	On exam pt's leg tight, monophasic flow by doppler when knee flexed; min flow leg extended. Pt not consistent c̄ neuro examination. Although cannot move legs well; min extension @ hips; min leg movement.
	Imp ① Impending ② Leg compartment syndrome
	② Question popliteal fossa injury
	③ LE weakness
	Plan ① LE fasciotomy / angiogram
	CT abdo to R/O spine injury today. b6-2 [redacted]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	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] b6-4

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

1700 13JUL03: Took care of patient. - Assumed care. CBC/Met 8 drawn; current propofol/LR hyg as ordered. Assessment as follows.

[N] PERRL 5mm at 3mm; sedated at propofol 21.6cc/h. Responds to painful stimuli; silent; ∅ Foll. commands.

[CV] Sinus rhythm - currently @ 90; S1S2; cool distal extremities x4; ↓ pulses to bilat LEs (+2 to (L) pedal; +1/DOP to (R) pedal) (L) radial pulse +2; (R) radial (+2); <3/3sec cap refill x4 to extremities. Temp: 34.7 - [R]

[Resp] (R) sine chest tube to 20 cm suction. SIMV o FiO2; FiO2 40%; 7.5cm to l.p. ETT; CTA, ↓ in bases; ⊖ rales. Fresh serous hemo; SpO2 100% on above vent settings.

[GI] Coronary for (L) sine; NGT to wall suction.

[GU] Foley to gravity with 40 ml/h, clear urine; below x1 (prev).

[Skin] Multiple ecchymoses that are days old, smaller at surgical sites. Old (R) ischial & neck dsg.

[Lines] (L) FM cath; (L) radial art line, PA x1 (L) sleeve; Foley.

b6-2

[redacted]

b6-4

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] b6-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
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NSN 7540-00-634-4176

600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
13 July 03	Brief Op Note
	Pre Op Dx GSW (R) neck, Zone 2
	Post Op Dx Same
	Procedure (R) neck exploration, washout (R) axilla
	Surgeon [redacted] b6-2 [redacted]
	Findings Jugular & subclavian v. exposed, fat over subclavian artery exposed 5 hematoma or thrill.
	EBL 75 cc
	IOF 3 u FFP / 2 u PRBC
	Pt remained intubated, to ICU stable.
	b6-2
	[redacted] CTC MC

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

EPW [redacted]

b6-4

RECORDS MAINTAINED AT:		
PATIENT'S NAME *(Last, First, Middle initial)*		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME		ORGANIZATION
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

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CHRONOLOGICAL RECORD OF MEDICAL CARE

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
13 July 2005	Attending Surgeon
0540-0700	yo Iraqi National who sustained multiple GSW to torso, base-of-neck, both legs, + arrives hypotensive + obtunded. ATLS protocol followed, 8 Fr. Cordis (L) femoral vein, 16 ga. angiocath (L) hand.
	Responded quickly to volume resuscitation, 3-4 l crystalloid, maintained SBP in 100s-110s, 1st Hct 20 → 2 units PRBCs. Foley → clear urine, no blood. (R) 36 Fr. tube thoracostomy → air, no blood.
	While being resuscitated, had improved ocs, + developed a tender/distended abdomen.
	CXR = well-positioned CT (R) side; No hemo- or pneumothorax. (+) shrapnel (R) axilla
	KUB/pelvis films = multiple shrapnel (R) pelvis
	HEENT - (R) lateral face puncture wnd.
	Neck - (R) base-of-neck, supraclavicular entry wnd → exit (R) axilla
	Chest - equal BS bilaterally; index finger enters (R) pleural space via ax. wnd.
	CV - RR + R
	⇒

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

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

CHRONOLOGICAL RECORD OF MEDICAL CARE
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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	Abdomen - flat + soft on arrival, then distended + markedly-tender ~ 2 units PRBCs + 4 l crystalloid
	(+) (R) flank entry wnd, posterior axillary line, just above iliac crest.
	(+) venous bleeding ~ resuscitation.
	Extr - thru + thru wnd. (L) tibial plateau
	(R) distal pretibial, superficial thru + thru wound.
	Perineum / anus OK.
	A/P: ~ 4 ni abd exam + ongoing blood requirements, to OR for laparotomy.
0900 ⇒	Op Note
	Dx: Penetrating Trauma flank
	Retroperitoneal hematoma
	distal descending colon laceration.
	? chylous leak.
	Proc: Laparotomy, ~~Pen~~ Hartmann I procedure.
	[redacted] / [redacted]
	GET 66-2
	EBL = 100 cc.
	Drains: ∅
	Complications: ∅
	Findings - retroperitoneal hematoma, RLQ, LLQ + central, none pulsatile / expanding; IDd both ureters → no laceration / contusion; thru + thru colon lac ~ minimal spillage; chylous fluid; no ~~fr~~ free blood.

STANDARD FORM [redacted] CK

66-2 [redacted]

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

2200 14 JUL 03 - Pt received from OR. Assessment as follows:

[N] Unresponsive. Sedated from anesthesia; Amnesty no sedation on; Ø FC; (P) eye open - when painful stimuli to chest; PERRL 3mm

[R] SINU 10; PEEP 5; SIMV FIO2 - 21 @ 1:p ATS ETT; Ø secret CTA ↓ in bas (R) side of chest sutur to (L) side; CT to LOC sut to (R) side;

[CV] ST at 111; Temp cool to touch; Placed in warming blanket; S/H; cool extremities. Ø pulses to elsewhere to (L) LE - MDS aware;

[GI] NGT to LWS; colost to (L) side ——

[GU] foley to straight. Good u/o of succ/h. ——

[SKIN] multiple lesions; DSC to upper eyelid/brow - c/d/i. Medium abdominal bas small amt of serosang fluid (R) knee - c/d/i; (L) LE has bulky dry - sensory intact.

[IV] (L) Fem angiocath / (L) jugular / (R) AC PIV.

[PM] explicate; determine LLE pulses; CT in AM will notify ——

[redacted] b6-2

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[redacted] b6-4

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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
7.14.03/0700	Assumed pt care from LT [redacted] @ approx 0500, pt in no apparent distress @ change of shift, LR infusing @ 125cc/hr, fentanyl drip off, propofol @ 42mcg/kg/min NG @ CIS CT @ continuous suction, no air bubbles detected (R) axilla wound draining mod amounts dressing reinforced, (R) leg dressing C/D/I, (L) CE C/D/I, midline abdominal dressing C/D/I, medial incision staples intact approximator in place, small amount of serosang drainage, (L) good colostomy, strong pink, (R) CT dressing C/D/I. [redacted] b6-2 LT RN
7.14./0805	Propofol drip off since 0750, fentanyl @ 50mcg/hr in preparation for extubation, pt breathing @ 20-30/min [redacted] b6-2 SpO2 100%, pt moving all extremes. Dr Saum notified LT RN
7.14/0835	Pt extubated c̄ Cpl Roberts (RT) & LTC Saum present during extubation. Pt placed on SM @ 6L pt SpO2 100%, 15 mins later pt placed on NC 2L SpO2 99-100%, RR @ 23-25, [redacted] HR 147 fentanyl ↑ 150mcg/hr. Breathing eased unlabored BS CTA diminished @ bases, will draw ABG c̄ in 15 min. [redacted] b6-2 LT RN
7.14/1500	Notified LTC [redacted] b6-2 of (R) pedal and posterior tibial pulse by palpation and doppler, Dr. [redacted] b6-2 pt @ bedside evaluating (L) extremity [redacted] LT RN b6-2

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
14 July 03	Surgery -
	Quiet night, sedated, stable Afeb 136/89 120
	anicteric, edematous conjunctiva, PRRL
	lungs coarse ⊕ c/o A_2 > Sacu/o
	⊖ SS, Lrm, stoma pink CT. 1160 total
	legs w/o, ↓ pulse ⊕ ⊖ AL
	exR ⊖ p to / hp, the good position
	10/800/.4/5 7.35/37/110/21/-5
	15.2 > 36 81 135/5 110/21 10/7 109
	Imp Stable S/P MGSW ⊤ lap / Hartmans, neck exploration.
	slightly underresuscitated still
	thrombocytopenic
	Plan IVF bolus 500 cc NS.
	wake / wean / extubate today.
	↓ tentany / ~~Acetat~~ to MSW, no gtt once extubated.
	routine drsg care
	cont NGT to LCWS
	chest / pulm toilet once extubated. [redacted] b6-2

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[redacted] b6-4

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14 July 03 Surgery Brief Op Note

Pre Op Dx ① ⓛ leg compartment syndrome

② occluded ⓛ popliteal artery

Procedure ① ⓛ leg fasciotomy

② ⓛ popliteal artery interposition graft c̄ ⓡ GSV.

③ Pre-Op / Post-Op arterial angiogram

Surgeon Fasciotomy - [redacted] b6-2

Pop bypass - [redacted]

Anaesthesia GETA

Drain ∅ Complications ∅

Specimen ∅

Findings

Pt's soleus min-mod movement, gastroc moves well, anterior compartment ∅ movement. Ant muscle beefy red & frank necrosis. Post-Op Angiogram shows spasm, pop open to trifurcation, post tib open into foot, string-like vessels ant tibial / peroneal.

foot cool, good cap refill

[redacted] b6-2 LTC

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EPW [redacted] b6-4

BED 6

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
16 July 03	Surgery-
	CT L-spine reviewed L4-L5 shattered, CT out
	Quiet AM AF VSS
	lungs coarse
	⊖ BS, soft, stoma pink, min gas
	legs cool ⊕, cold ⊖
	800/5/5/10 7-53/43/101/23/-3/97%
	10 28 70 (59/109/11) 41/25 <100 CXR ep/to
	MASW
Aug	L4-5 Spine injury anemic
	thrombosed ⊖ lower leg
	SAP ⊕ neck exploration
	SAP exp lap & Hartmans
May	To OR for anal likely BKA pos AKA
	Ortho/neuro anal spine injury
	long term placement.
	b6-2 [redacted] CDR

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EPW [redacted] b6-4

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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
15 July 03	0115 Surgery
	Pre op Dx Clotted prosp bypass graft
	Procedure ① explore bypass ② declot x many
	③ Angiogram b6-2
	Surgeon [redacted] / [redacted]
	Anesthesia GETA
	Findings: Graft clotted off; declotted c #3 fogarty x many c good back bleeding & antegrade bleeding vessels backbleed both prox/distally within minutes! Intraop angio showed PT non-off to foot after much work, but quickly clotted. Will need BKA/AKA but wait until demarcates.
	[redacted] b6-2
7/15/03	0310: NSG: Pt returned from R. USS; CTA ⑧ ↓'n bases #8 GTT 20cm to ⅓ set at SIMV 10, PEEP 5, 850 TV 40%; S1/S2 ⊖ s/s Resp.; ↓Temp - currently 36.0 - Good P to 37.0; ⓛ LE (foot) ∅ pulse; cold to touch; Urine output to be measured for first full hour 03-04; [LINES] AM to ⓛ radial, ⓛ femoral. Access; PIVC2 to ⓡ UE; Foley, ETT; [GT] colostomy to ⓛ side, NGT clamped; [PLAN] CT/XR/AM UMS to OR'n AM [redacted] CT/AM

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT [redacted]
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	b6-2

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GAW [redacted] b6-4

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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
7/15/0600	Assumed pt care from LT [illegible], pt in no apparent distress, US [redacted] @ 150cc/hr. Not clamped, CT to [redacted] b6-2 all USS CDE dressing reinforced [redacted] LTRN
7/15/0900	Pt returned from CT, VS remained stable throughout CT study @ 1yr to d from CT, CT removed nonocclusive dressing intact, c+Pray broken, physician evaluated no crepitus right, SpO2 100% on 40% flow. [redacted] LTRN b6-2

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[redacted] b6-4

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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
15JUL03	Neurosurgery Consult
0931	HPI EPW admitted here 15JUL after multiple GSW in Fire Fight. Pt suffered injuries to chest, abdomen, L-spine, and lower extremities. He will undergo (L) BKA for failed revascularization today.
	Exam Intubated, sedated, arousable.
	Back dressed (R) Flank, (-) CSF drainage.
	LEs dressed, no movement to noxious.
	Rest sensation T-12 to pinprick (R).
	(-) sensory response to foley tug.
	CT L-Spine shows L1 intact, L2 Bilateral pedicle and lamina fractures, L3 comminuted fractures of middle and posterior columns, L4 bilateral pedicle fractures and comminuted lamina fractures with fragment in (R) L4-5 foramen, L5 Right lamina fracture nondisplaced.
	Impression: T12 paraplegia with unstable fractures L2-5.
	Recommendations: Foley, bowel program, bed rest flat with log roll spine precautions.
	Will follow. b6-2
	[redacted] 4797

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EPW #[redacted] b6-4

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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
15 July 03	Brief Op Note
	PreOp Dx Thrombosis (a) Lower leg
	Procedure (a) Knee disarticulation
	Surgeon [redacted] / [redacted] / [redacted]
	Anesth GETA b6-2
	IOF 1 m MSL, 500 cc crystalloid
	EBL 150 cc.
	Findings Anterior compartment necrotic; soleus edematous and ischemic, gastrocnemius viable @ knee.
	Pt tol procedure well. To PR intubated.
16 July 03	Surgery. No problem (+) CSF leak [redacted]
	Tm 37.3 120/60 110 SaO2 100% b6-2
	omnifeni Mo 70-55cc/h
	↓ BS (R) chest CXR clear
	RMR, ⊖ 300 ⊖m/R 10 27 180 141/4.1 | 209/22 | 12/82
	hypo/- BS 7/700/40/5 → 7.31/43/95/21/-5
	warm, dry. (a) leg dress dry / (a) leg SVG site clean
	Impr STP MGSW/at lip/(R) neck exp/(a) pop bypass/(a) BKA/CSF leak lumbar spine Hx c̄ paraplegia
	Plan (1) wean to extubate
	(2) to OR thurs for washout/closure/CSF drain
	(3) CPT once extubated.
	(4) Dressing Δ's
	(5) Upper Ext care. b6-2

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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	2250 15 JUL 2003 — NURSING —
	Attempted wean patient from vent throughout night. ↓RR rate to 7; ↓ F_IO_2 to 30%; Sedation turned off. Patient off sedation for 4 hours + ↑ in agitation. RR 12-15; SATS 95-99 on monitor. Called RT for potential extubation. ABG obtained. ABG results: 7.37, 36.2 = pCO_2; DO_2 = 53, MVO_2 21, sats 86, BE -4; Pt ↑ in agitation. ↑ in peak pressure from biting on ETT; Notified on call staff (working). Keeping patient intubated for NIGHT. Placed pt. back of propofol @ 20mcg/kg/min; #8 ETT with SIMV 10, PEEP 5, 40% F_IO_2, 800 TV, 25cm to l. in place. ~~Cont~~ [redacted] Current VS: 128, 123/60, 16, 97 sats. will monitor
	[redacted] b6-2 11/7 [redacted]
16 July 03 0540	Assumed care of pt @0530. Neuro: PERRLA ↑B. ↑ pt arousers to light stimulation. Moves head spontaneously. Follows VS course throughout. Diminished bases bilat. PCXR done this am. (L) Internal chest drainage dry. Previous O tube. On SIMV 10. TV 800. F_IO_2 .40 Peep 5. Setting 98%. Possible extubation today. AM ABG unremarkable. CVS Pulses palpable x5. UTA (L) LE s/p amputation/dressing. S1S2. ST HR 100-110's. BP stable. GI: NG to LIS draining greenish fluid. BS hyperactive vs absent.

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[redacted] b6-4

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16 July 03 0852	Assessment continued: ~~GU~~ [redacted] GI: abdomen drainage minimal and serosanguinous fluid. GU: draining dark yellow urine via foley approx 50-70cc/hr. NS @ 150 via PIV (L) AK Home: Hct 26 this am down from 28 yesterday. (D) trauma dressing c̄ small amt serosanguinous drain. Bilat hip dressing c/d/I. (L) leg covered c̄ ace wrap over gauze. (L) BKA c̄ serosanguinous drainage. VS: T 37.7 Tylenol given per night shift for T>38. Propofol on titrate 20mcg/km Propofol 35mcg/kg/min for sedation. WTH Cont to monitor [redacted] /CBSL
16JUL03 0625	Neurosurgery b6-2 (S/O) Stable overnight. Afebrile. Tolerated (2) BKA. Failed vent weaning trials Now sedated c̄ propofol Labs this AM P. (A/P) Complex spinal Fx p̄ GSW L-spine Will wait more swelling / medically stable Observe for CSF drainage Continue flat bed rest / log rolls

[redacted] b6-2
4757

HOSPITAL OR MEDICAL FACILITY	[redacted]US	DEPART./SERVICE	RECORDS MAINTAINED AT
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[redacted] b6-4

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16 July 0845	Addendum: Deep suction c̄ thick green secretions possible mucous plug. (R) lung sounds improved pt suctioning. Pt failed neb vocany HR 73 possibly due to mucous plug. will attempt to wean again later this am. b6-2 [redacted]
16 July 03 1000	Pt extubated per RT @ 0950. Sating 98% on 6L SM. 28 Coarse c̄ exp crackles throughout. Will cont to monitor. b6-2 [redacted]
16 July 1130	(L) axillary dressing (L) CT dressing changed. b6-2 [redacted]
16 July 1500	(L) axillary dressing, (L) CT dressing, (L) hip (R) hip dressing changed. Bacitracin applied (L) leg wound. (R) removal catheter d/c'd. Chest PT done per RT. Pt sating 94% on 6L SM. b6-2 Coughing up thick yellow secretions spontaneously — [redacted]
NS 16 July 1800	Assumed care @ 1700. VSS. pt lying flat in bed c̄ FM @ 8L. A'd pt to 6L NC pt continues to maintain SATS @ 90-97%. Assessment done. see ICU Assessment chart for details. will continue to monitor. b6-2 [redacted] CPT/AN
17 July 0100	pt dsg Δ's done. SATS ↓ to 88% FM Applied @ 10L. SATS ↑ to 96%. pt Received 1 unit of PRBC. this shift. Assessment unchanged from earlier. will continue to monitor. [redacted] CPT/AN

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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each ent[redacted]
17 Jul 03@	1700 K,2b Received, Physical assessment Completed [redacted]
17 Jul 03@	1800 Orders Received From Dr. [redacted] Chem 8 redrawn, 500 cc Bolus NS Started [redacted] CPT/AN b6-2
17 Jul 03@	2000 SpO2 100% FiO2 80% [redacted] CPT/AN
17 Jul 03@	2200 Pt Turned to (R) Side SBP ↓ From 110-90 to 70's, Pt placed Back on Back [redacted] CPT/AN b6-2
17 Jul 03@	2330 24° I+O IN IV 4044 Out Urine 5362 No 535 Lumbar Drain 1163 Out Total 6060 [- 2012] Balance [redacted] b6-2 CPT/AN
18 Jul 03@	0200 Pt's Dressing to (L) Upperchest Med + (R) Lower back, Bedding changed + Patient turned to Right Side [redacted] CPT/AN b6-2
18 Jul 03@	0350 AM Labs drawn, ABG Completed + Recorded on Flow sheet, pH 7.43 PaO2 39.3 PaO2 161 HCO3 26 BEect 2 SO2 99% [redacted] b6-2 CPT/AN
18 Whose 0523	PERRLA. Agitated when sedation lightened. Sedated on Versed 5.5 and Fentanyl 100. ST 120's V/E Pulses ↓2 radial bilat. (R) LE +1 DP. VTA (L) leg rt ankle bilat/dsg. Intubated. ETT 25 26cm TOL. SIMV 12 TV 800 FiO2 .50. Resp 8, sats 100%. AM ABG shows metabolic alkalosis. LS coarse ē exp crackles. GI: NG (L) nare draining green contents. BS absent. Abdomy LLQ Abd staples intact midline. ⊘SIS infection. Foley draining dark yellow urine ē sediment. AM Chem shows K 2.8 will need replacement. Drsg's intact b/l (L) axillary Bilat hip. (L) leg staples C/D/I. (R) BKA dsg ē drainage. LP drain →

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[redacted] b6-4

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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17 JUL 03 0530	FM c 10L. O2. 2 SBs returned — Results show K+ at 2.9 mmol/L, HCT at 9.3 g/dL. Pt due for surgery & previously [illegible] this AM — [illegible] cough — sputum — yellow [redacted] suction [illegible] b6-2
	Pt had chest x-ray done upon leg walking Dr [redacted] observed bloody spinal fluid at site on R lateral dressing mid spinal column. NO [redacted] recommend application shield to prevent infection. — [redacted] b6-2
17 JUL 03 0900	Pt arriving [illegible] urine output adequate, as started. Pt sleep & rest with FM c 8L O2, SO2 98%, on IV Fentanyl. Orders written for KCL, also consideration for TL in OR due to potential for SW sites related to illness — [redacted] b6-2
17 JUL 03	1000, 1st U PRBC's given over 2° per ORDERS #4824487 4824487 [redacted] b6-2
	1005 KT Run started @ 25cc/hr PB 1 c NS @ 125cc/hr [redacted]
	1010 See RBC sheet for continuous VS [redacted]
	1030 Pt transport to OR c PRBC's in [illegible]

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CPW [redacted] b6-4

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i-STAT G3+

Pt: [redacted] b6-4

Pt Name:_____

TCO2_____20 mmol/L

At 37C

pH_____7.507

PCO2_____24.7 mmHg

PO2_____70 mmHg

HCO3_____20 mmol/L

BEecf_____-4 mmol/L

sO2*_____96 %

*calculated

At Patient Temp

pH_____7.461

PCO2_____28.2 mmHg

PO2_____86 mmHg

Patient Temp: 104.0F

FIO2_____: 10

Sample Type_: ART

17JUL03 16:09

Oper: [redacted]

Physic

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CHRONOLOGICAL RECORD OF MEDICAL CARE

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

ABG b6-2

ABS reviewed by DR [redacted]
ORS received.
Initial MCP 3000. [redacted]
DR [redacted] @ bedside.
ORS received. Neb Tx completed [redacted]
PBT taken via A-line,
viewed by DR [redacted]
RNA @ bedside. [redacted]
ated c̄ #8.5 ETT placed @
n lower lip c̄ bite block in [redacted]
DR [redacted] @ bedside. ORDERS [redacted]
ed
ressed OPT started @ [redacted]
- 150mcg Dilaudid given [redacted]
IV & Lido
1750 PCXR taken. DR [redacted] @
bedside
1750 Lasix given per OPT [redacted]
ORDERS REVIEWED

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] b6-4

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I-STAT CG4+

Pt: [redacted] b6-4

Pt Name: _____

TCO2 _____ 28 mmol/L

AT 370

pH _____ 7.48

PCO2 _____ 37.0 mmHg

PO2 _____ 51 mmHg

HCO3 _____ 27 mmol/L

BEec _____ -2 mmol/L

SO2% _____ 89

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CHRONOLOGICAL RECORD OF MEDICAL CARE

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

Received from OR on stretcher. O2 given. SaO2 @ 85-86% on RA via FM. Diagnosis [illegible] [illegible] [illegible] unbraced. LS @ coarse [illegible] in bases. [redacted]

[redacted] @ bedside, orders read. Pt more agitated as [illegible] [illegible]. Pt's [illegible] TV when [illegible] [redacted]

[redacted] @ bedside, orders received to drain open pelvic c. [illegible] drain placed to lower level for drainage. [redacted]

300cc UOP noted in bag. OR updated on pt's status. Orders received to hold to 12 [illegible] for now. [redacted]

10/4/03 1500 [illegible] 1500 UOP noted in bag. Pt [illegible] several times to stimulate pt to cough. [redacted]

1530 [redacted] notified on elevated temp. Trend [illegible] OR aware. Update given on [illegible]

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

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[redacted] b6-4

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17 July 03	Surgery Brief Op Note
	Pre Op Dx AP Open (2) TKA / CSF Leak
	Procedure (1) Lumbar drain
	(2) Wash out (2) TKA
	(3) Place (2) SOV 3-lumen cath.
	Surgeon [redacted] / [redacted]
	Anesthesia GETA. b6-2
	Drain - Lumbar / (2) 3-lumen SOV
	Complication Ø
	Findings: no pus, knee healthy, malodorous though
	[redacted] LTC
	b6-2

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#[redacted] b6-4

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17 Jul 03	1630 Anesthesia - Called to ICU for intubation. Preoxygenated => MAC #3, #8.5 ETT oral used, given propofol 200 + Sux 100, 1 up. Dh x 1 p̄ preoxygenation => grade 2 view; swelling in airway but cords visable => ETT easily passed. BBS+/ taped. 23 ca. teeth. f/u VS - BP 155-40-100% - put on vent. [redacted] mg/kg)
	b6-2

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

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[redacted] b6-4

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17 July 03	Surgery Brief Op Note
	Pre Op Dx AP Opera (2) TKA / CSF Leak
	Procedure (1) Lumbar drain
	(2) Wash out (2) TKA
	(3) Place (4) SOV 3-lumen cath.
	Surgeon [redacted] / [redacted]
	Anesthesia GETA. b6-2
	Drain - Lumbar / (2) 3-lumen SOV
	Complication Ø
	Findings: no pus, knee healthy, maladerous through
	[redacted] LTC
	[redacted] b6-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
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#[redacted]

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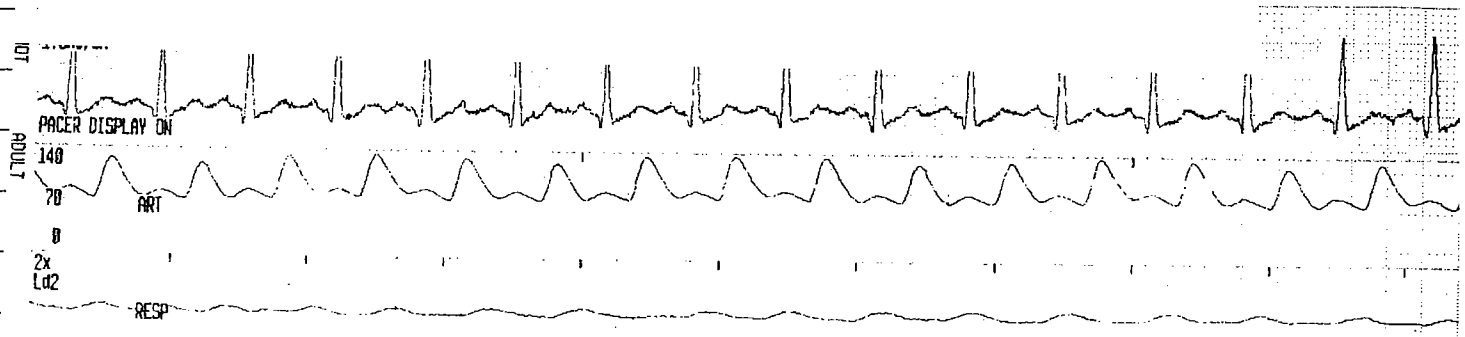
MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
7/17/03/0500	Assumed care. Report given. See initial assessment for assessment on ICU-1 flowsheet. [redacted]
	0515 labs drawn per A-line. Sent to lab. [redacted] b6-2



17Jul03 0530	Pt awoke during assessment, communicates in TRACH - gestures used to communicate injury to spine and reason for not wanting him to sit up. Dressings at sides and (R) LKA intact. Abdominal ~~dressings~~ staples intact x 30 staples. Edges approximated. No secretion at site. Pt has pronounced upper lung sounds, lung sounds diminished in lower lobe S.O. 97% with → POD

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EPW [redacted] b6-4

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
18 July 03	Pt K 2.8 in am Wrng given IV Mn cath/line pt chem K 3.1, currently receiving second Wrng in Wards. ETT suction, thick white secretions moderate amt. currently satting 100% on .40 FIO2 T 37.7. MM cont to monitor — b6-2 [redacted]
18 Jul 03 @ 1200	Rpt Received, physical assessment Completed + Recorded, (L) BKA Dressing CDI, (R) Underarm Upper Chest Wound Dressing Seeping Sero Sang Fluid, (R) Lower back Dressing CDI, Staples (R) Lower Leg Seeping Sero-Sang Fluid, Mid Line - Staples Sero-Sang Fluid, Dressing Lumbar Drain CDI [redacted]
18 July 03 @ 2100	Pt T ↑ 101.5 Tylenol 650 mg PR [redacted] b6-2 Cpt/AN
18 July 03 @ 2400	24° I+O IV in 4927 Urine 2310 Lumbar out 431 Meant 50 Total out 2791 = Balance (+2136) = Dressing (R) + (L) Lower back Change Saturated Sero-Sang Fluid, Dressings (R) Upper Chest + Arm pit Δcd Saturated Sero-Sang Fluid, Fluid Bloody Sero-Sang seeping from Lower 1/3 Mid line Abd incision Sero-Sang Fluid seeping from incision (R) Leg [redacted] b6-2 Cpt/AN
18 Jul 03 @ 0350	Pad under Patient Δcd, AM Labs drawn ABG PH 7.585 Pco2 32.5 PO2 71 HCO2 31 Bx cat 9 SO2 100% Vent Rate ↓ 10, FIO2 ↓ 30% [redacted] Cpt/AN b6-2

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
18 JUL 03 0010	Pt intubated SIMV 12, 800, 60%, +8, PIP 27. Pre tx 133, RR 13, SPO2 100%. UD Alb given. BBS CTA very diminished @ bas. Post tx HR 137, RR 12, SPO2 100%. BBS no D's — Sg [redacted]
18 July 03 0409	UD Alb tx given BBS (-) coarse (-) Rhonci (-) wheezing HR 129 SPO2 100 RR 12 Post tx HR 126 BS improved RR 12 SPO2 99% b6-2 SGT [redacted] T
18 July 03 0753	UD Alb tx given HR 120 RR 13 SPO2 100% BBS Coarse ↓ Bases Post tx BBS improved still ↓ Bases HR 123 RR 12 SPO2 100% — SGT [redacted] KT
18 JUL 03 1957	Pt intubated SIMV 12, 800 35%, +8, PIP 29. Pre tx HR 114, RR 12, SPO2 100%. UD Alb given. BBS CTA & ↓ @ bases. Post tx HR 122, RR 12, SPO2 100%
27 July	UD Alb/Atro tx given to pt HR 104 RR 37 SPO2 99 BS (+) coarse (-) wheezing CPT Done pt able to cough some Secretions Post tx HR 112 RR 38 SPO2 97% BS improved b6-2 SGT [redacted] RT
27 July 0830hrs	U/D Alb tx given. BBS coarse but ↓'d at bases. Pre tx HR 117 B/P 132/82 RR 43 PO2: 97% CPT done during tx. Post tx HR: 116 B/P: 132/82 RR: 46 SPO2%: 98 BS are unchanged post CPT tx. Post neb tx HR: 123 B/P: 135/80 RR: 43 SPO2: 95% Post neb tx BS: unchanged. Will continue to monitor pt's resp. status — CPT [redacted] b6-2 CRT
27 July 1616hrs	U/D Alb/Atrovent tx given. BBS coarse but ↓'d at bases. Pre tx HR: 127 RR: 49 BP: 138/79 SPO2 93% CPT done during tx. Post CPT HR 130 RR 46 SPO2 95 BS: Breath sounds are unchanged post tx. ABG drawn: PH 7.47 PCO2 31.7 PO2 66 HCO3 23 SPO2% 94. Placed nasal trumpet for deep suctioning.

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

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TIENT'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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[redacted] b6-4

will continue to monitor pt's resp. status ——— CRL [redacted] CRL

b6-2

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
19JUL03 0714	Neurosurgery
	(56) Afebrile.
	Lumbar drain 20/hr/Serosanguinous.
	Wounds draining Xanthochromic fluid, less output
	from flanks.
	Opens eyes to noxious.
	Localizes noxious (B)UE.
	Remains plegic in lowers
	(A/P) GSW L-spine with CSF drainage.
	Continue bed rest/log roll.
	Continue CSF drainage 20/hr.
	[redacted] b6-2
	[redacted]
19 July 03	Surgery,
Cent	T 101 127/65 117s [redacted] % 99 27/2791
Cipro	slightly icteric, anasarcic, injected
Zosyn	lungs clear NAR ⊖ NVD abdo firm, quiet, stoma pi
	min gas in bag, legs cool, edematous.
Reflex	wounds clean; weeping in axilla, leg, abdo.
MSO4/Versed	Hct ~~33~~ 187 ~~121/33~~ ~~87/21~~ ~~201~~ 133 bili. ex (B) diffuse infiltrates
b6-2	10/800/50/8 743/43/105/25/4
[redacted]	Imp CSF leak/pneumonia/complete low spine injury/ileus
HOSPITAL OR MEDICAL FACILITY	Hypomagnesemia/hypokalemia
STATUS	
DEPART./SERVICE	
RECORDS MAINTAINED AT	[redacted]
SPONSOR'S NAME	
SSN/ID NO.	
RELATIONSHIP TO SPON	[redacted]
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*	[redacted] b6-2
WARD NO.	

#0[redacted] b6-4

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
7-19-03/ 0600	Assumed pt care from CP[redacted]. Pt in no apparent distress @ change of shift. Versed infusing @ 4.5cc/hr, MSO4 4mg/hr, LR@125cc/h. Lumbar drain aff, NG to CFS draining small amt green secretions (L) LE stump elevated, pt HOB 20°. All IVs [redacted] b6-2 LT RN
7-19-03/ 1100	Pt returned from OR hemodynamically stable & in no apparent distress. [redacted] b6-2 LT RN
7-19-03/ 1500	Dressing d/s due to (R) axilla region - returned to home, pelvis & leg serosanguinous fluid from axilla region. (R) hip d/s saturated c̄ yellow serosanguinous fluid. Bacitracin applied to (R) leg incision approximating well c̄ staples OTA. Lumbar drain insertion stable. (L) flank dressing d/s, dressing saturated c̄ serosanguinous yellow fluid. Pt SpO2 ↓ 94-95% @ 35%. When rolled resumed 99% @ 35%. c̄ in 30-35 min post d/s change. [redacted] b6-2 LT RN
14Jul03@ 1916	Rpt Reviewed, Physical Assessment Complete, 3% NaCl started @ 40cc/hr for 1x Ltr, TT 102.4, Tylenol 650 mg PR, Cool Compresses to Forehead or Neck [redacted] b6-2 CPT/RN
14Jul03@ 1950	Pt SBP ↓ 80's MAP < 60 Dr Notified Order for Bolus of 250cc 5% [redacted] b6-2 CPT/RN
14Jul03@ 2200	Tube Feeding Ensure @ 10cc/hr [redacted] b6-2 CPT
14Jul03@ 2300	24° I+O IV in 4691 PO 3105 NG out 100 Lumbar drain out 330 Total out 3435 Balance +1256 [redacted] b6-2 CPT/RN

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
19 July 03	Surgery (Con't)
	Plan Replete electrolytes
	Con't vent
	Con't Abx
	CBT drain per neurosurg
	drsg Δ's to stump another 48 hrs
	develop supp.
19 July 03	Brief Op Note
	Pre Op Dx ① TKA / pneumonia / clots
	Procedure ① Bronchoscopy
	② Washout ④ knee
	⑤ close axilla wounds
	Surgeon [redacted] b6-2
	Anesthesia GETA
	Findings ① Tracheal tree clean.
	② ④ Knee still slightly maladerous, c̄ drainage
	Pt to ICU stable, intubated. b6-2
	[redacted]

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[redacted] b6-4

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
20JUL03	Neurosurgery Drain #4
0627	(8/0) Tm 39.3, VSS
	I/O 4691/3195, Drain 15-20/hr.
	Eyes open to noxious.
	Na-139 K-3.5 HCT 29 WBC 8.9
	Localizes noxious in uppers.
	Lowers remain plegic.
	Foley / Colostomy in place.
	(A/P) (1) GSW L-Spine - static paraplegia c̄ improved
	(R) Flank Wound. (L) continues to drain copious
	Xanthochromic Fluid. Continue lumbar drainage.
	(2) Lumbar Stability - remains unstable. Continue
	bed rest / log rolls.
	(3) Hyponatremia - responds to supplementation c̄
	3% NaCl. Continue BID Labs; ↑ G-Tube
	supplement. [redacted] b6-2
	1757

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

KAN [redacted] b6-4

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
20 Jul 03 @ 0205	(✓) Residual / TF 30 cc, Tube Feed Continued [redacted]
20 Jul 03 @ 0400	AM Labs + ABG Completed [redacted]
20 Jul 03 @ 0540	Na 139, 3% NACL gtt Stopped [redacted]
	h6-2
20 July 03	Surgery.
	BP dropped; responded to vol & Versed. Cardiac Mo, Tolerating TF.
	T 38.6 / 100/61 / 100 sinus / 1/0 / 4691/3435 Mo > 100 cal/o
	slightly icteric, bilat facial edema / CXR improved, infiltrates
	lungs clear / 13 > 30 / 190 / 139/3.5 / 104/27 / 12/.7 / 87
	abdo quiet, ND, wound sl full / 10/35/800/5 / 7.42/243/109/28/4
	stoma pink, some gas in bag.
	stump clean, @ leg wound clean oozing
	Dx. Hyponatremia resolved? / ileus / anemia / hypokalemia
	L-spine complete / open stump ⓐ / pneumonia / CSF leak
	Plan. Replete K with OR remove few abdo staples.
	Hold NaCl DNUT & 3% NaCl infusion
	wean sedation, hold Tube feeds.
	may extubate / fascial dehiscence
	CSF leak per Neurosurg. / will go to OR today
	recheck Na+.

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	[redacted] TAINED AT h6-2
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.)* | REGISTER NO. | WARD NO.

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
20 July 03	Surgery Brief Op Note
	Pre Op Dx fascial dehiscence
	Procedure exp lap / adhesiolysis / washout / retention sut
	Surgeon [redacted] b6-2
	Anesth GETA
	Drain Ø Specimen Ø
	Findings decompressed small bowel, gas in T-colon.
	1 l xanthochromic clear abdo fluid. No abscesses.
	No additional injury. Large retroperitoneal
	hematoma - no bleeding.
	Pt tol proc well, to ICU stable intubated.
	[redacted] b6-2

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800 NS Exp lap. 1145 50mg Fentanyl 4/150
10s Ropen 100 Albumin 2 BL PRBC

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
20 Jul 03	1300 Received from OR. Report given 800 NS given, 100 Albumin, RBC 100, 50mg Fentanyl, Foley output 150, S/P Exp lap: BP 157/89, HR 140's. RR 20's. SpO2 94. Vent setting Rate 10, FIO2 30%, TV 800, peep 5cm c [redacted] RR 12. b6-2
	1330 Dressing c/t c BJ present. Sx'd thick serous and thick white secretion per ent. Oral care given as well. b6-2 [redacted]
	1340 Tylenol supp. PR given Temp 39.8 1500 updated DR [redacted] on pt status orders received to give Ducolax supp & 1600 Ducolax supp per Dame, update given to NRS. Cur drsg & sed. orders received b6-2 [redacted]
	17 10 Report given. to oncoming [illegible]

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.

KPW # [redacted] b6-4

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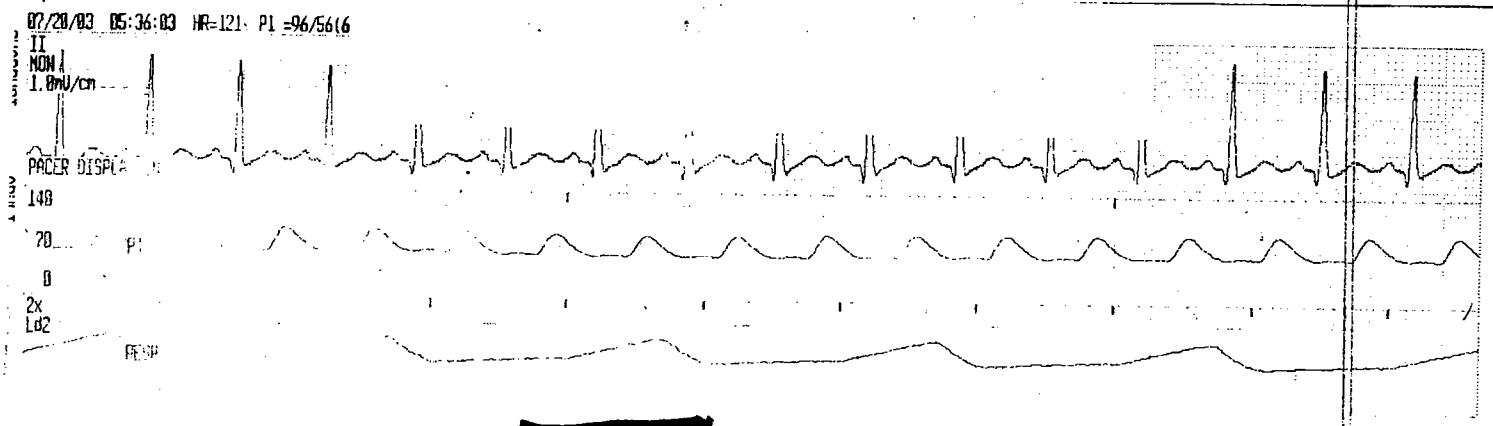
MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
20Jul03	0500 Report given. See Flow Sheet for initial assessment



20Jul03	0630 OR [redacted] @ bedside. dressing Δed on (R) side & (R) lower back [redacted]
20Jul03	0635 residuals check 300cc fed back [redacted]
	Dot. [redacted]
	0730 OCR taken [redacted]
	0900 OR [redacted] @ bedside. mid line [redacted] dressing Δed. (R) lower BKA dressing Δed by OR. [redacted]
	0920 labs drawn per Aline. [redacted]
	1000 Nat 140. update given to [redacted]
	OR [redacted]
	1130 Placed on stretcher for OR [redacted]

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

all b6-2

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.

RPW [redacted] b6-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
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Prescribed by GSA/ICMR
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AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	1700 20 JUL 03 – Resumed care of patient. Pt is comfortable in bed. Assessment as follows:
	[M] Sedated on MSO4 @ 4cc/hr and versed @ 3/hr; PRN @ 4mm;
	lumbar drain intact draining CSF/serosanguinous fluid; Retracted @ 2 to
	painful stimuli [R] PCV vent settings of SIMV of 10, PEEP of 5, 35%,
	TV 800; Coarse Breath sounds (crack/rhonchi) in upper lobes, ↓
	in bases; (+) exp. wheeze; NESD 24 as ordered; (–) s/s of symptoms
	noted [CV] S1, S2; (B) BT in 130s; hypotensive 100/60s, Resuscitated @ 39.0;
	Edema +3 in (R) LE; +2 in UEs; +2 pulses x3 [GI] (+) BS; colostomy
	intact to (L) UQ; NGT to (R) nare with LIS in place, [GU] foley
	to gravity [Skin] (R) LE inc. with (+) serosanguinous drainage, reinforced dsg;
	medial abd incs. has reduction suture in place; bilat flank
	dsg has serosanguinous fluid; (R) LE dsg C/D/I (2 incs) (L) JPC; (L) SAE and
	foley, ETT. [PLAN] in ARR to OR for provide flap coverage
	[redacted] LLT, AN
	[redacted]
	b6-2

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

[redacted] b6-4

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
7/21/03	0500 Assumed care. Report given SEE TCU-7 Flowsheet for initial assessment — [redacted]
	0615 Dr [redacted] @ bedside, class A'ed lower pack (B). CSF fluid taken. Send to lab — [redacted]
	0630 oral care given. Std. Scout pt of Jack secured on. — [redacted]
21 July 03	Surgery.
Cont	T max 104 → 98.6 ovcs 1/1000 1000 m, 50-100 b6-2
Gpn	sl icteros
Srsyn	lungs clear 18 30 234
	RRR ⊖ ⊖ / gm/R 135 / 104 / 16 / 37 / 28 / 41 tbili 13.8
Reflux	⊖ BS, RH, NT, wound c/d
Sanitar	stump c/d 10 / 35 / 800 / 5 7.4 / 44 / 107
MSOy / Versed	⊕ Axilla c/d
Mb / Atrov	hx open ⊕ TKA - clean Plan OR tomorrow for stump closure
Tylenol	open abdo incision - clean replete K / begin TF / MVI
Dilaudid	open ⊕ Axilla erythromycin PVAT
	ileus / pneumonia / malnutrition / hyperbili (? cholang) cont of supportive care.
	hypoalbumin / leukocytosis / anemia [redacted] b6-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE [redacted]	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONS[redacted] 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] b6-4

RPW

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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
2/4/03	1015 AM ambs to ed. per [redacted] orders received [redacted] 1000 meds given down 10 ft. clear EG sx'd. pt opens eyes to verbal commands. p jackey c [redacted] eyes [redacted] 1140 place back to ex dept. [redacted] pupils open c 1 eye left [redacted] 1500 TF ing started @ 100/hr of [redacted] ensure. [redacted] 1450 linen & ed. bath given, repositioned & assist. leg pain placed on R side. [redacted] 1600 p residuals repeat. USS. [redacted] 1710 Report given. [redacted]

all b6-2

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[redacted] b6-4

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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1720	Took over care of patient. Resting comfortably
21 JUL 03	in bed. Assessment as follows:
	[N] resp @ 32/m; responds to painful stimuli; sedated on MSO4
	at 4mg/hr + versed @ 2mg/hr; lumbar drain intact - drains
	small amount of CSF - see F/O. [CV] SR 110, PEAP 5, 35%, TL 502
	HR 77 [illegible] p.; O/S of cyanosis noted; O/S edema;
	[redacted] improving in both legs; ⊖ wheezing; [redacted] minimal amount
	of pitting sacral; ↓ breath sounds to (R) LL; [CV] Febrile at 38.4
	S_1/S_2; multiple +2-3 edema thighs extremities; +1-+2 pulses x 3;
	sinus tach 110-130; BP stable 120s-130s systolic; [GI] NPO for
	(R) surg + LLW; moderate amount of drainage noted; colostomy
	with minimal serous drainage from (L) side; T + @ 10cc/hr.
	⊖ BS [GU] Foley ⊕ gravity - Dark amber colored urine, F&O
	maintained; [SKIN] multiple tags + inc. sites, Moist/intact
	on midline epigastric with [illegible] serous - C/D/I; (R) groin
	JP to bead + C/D/I; (R) LE sqph. drain - C/D/I, [LINES]
	(L) radial A; ET-T; (L) IC; foley, NG to (R) nare.
	[redacted]
	b6-2

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[redacted] b6-4

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
21JUL03	Neurosurgery
0624	(S/O) Tm 39.1, VSS
	I/O 1214/2078, Lumbar drain 10-20/hr.
	Paraplegia persistent.
	Drainage (R) Flank minimal, (L) Flank Xanthochromic.
	WBC 17.7 today.
	(A/P) (1) GSW L-spine - Continue Log Roll.
	(2) CSF Leak - Day 5 drainage. Continue.
	(3) Fever - on Gent/Cipro/Zosyn. CSF Sent.
	[redacted] b6-2
	[redacted] 4797
22JUL03	Neurosurgery
0621	(S/O) Tm 38.7, VSS.
	Lumbar Drain ~10/hr/Xanthochromic.
	Paraplegia persists.
	Flank dressings: (R) Xanthochromic Fluid.
	(A/P) (1) GSW L-spine - Unstable. Log Roll. Bed Rest.
	(2) CSF Leak - Day 6 Drainage. Continue until Friday.
	(3) Fever - CSF WBC 22 / Gram Stain ⊖ Bacteria.
	Continue Gent/Cipro/Zosyn.
	[redacted] b6-2
	[redacted] 4797

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

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
22 JUL	(07A) lumbar drainage ↑ to 30 cc/hr; no other change in POC; assessment completed & charted; [redacted]
22 July 03	Surgery
	Tm ~101.5 ovss HR 60-80s 1° CXR - no change, lower lobe fluffy infiltrates
Capro	
Cont	lungs clear RRR, GSW
Zosyn	Very hypo BP, Pigas in colostomy bag, min stool.
	legs cool/dry, edematous.
Begin	abdo wound dry, ⊖ granulation, no fluid, no dehiscence.
Zosyn	stump - T. bili 11.8
Erythromycin	
Bilevlex OD	147/28 286 Na 128/3.9 Cl 99/28 <107
	Lab results 10/800/35/5 7.4/43/87/30
MSOY	lumbar spine transection / instability / CSF leak
Vorsed	pneumonia
Albut/Atrov	malnourished.
INF 125	anemia / hyponatremia / hypokalemia / hyperbilirubinemia
	Plan Con't Abx
	Con't PNGT erythromycin / Restart TF
	replete K (Mg)/Na
	Will wait till no fever 24h before closing stump.
	Δ central line today.

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE [redacted]	MAINTAINED AT b6-2
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.)* | REGISTER NO. | WARD NO.

EPW [redacted] b6-4

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
22 Jul 03	Surgery CX today; stump dry A'd; area red; drain w/ serosanguinous fluid; abdomen dry A'd; area red; drain S/S fluid; WD dre & circ; CL pr MD; CXR ordered pt tolerated procedure well; [redacted]
22 July 03	Surgery. Central line changed to new site @ SCV. Sterile technique mod-seldinger tech used, threaded easily, withdrawn easily, flushes easily. Secured c̄ 3-0 silk x 3, caps secured / locked. CXR shows good position. May use catheter now, will dc previous line. Pt tolerated procedure well. 10 cc 1% lidocaine used for local. [redacted] b6-2
	(1100) @ L RAO rec'd by MD; WD. to change arm IV site & use (R) SL TLC; (L) TLC blc intact; prune lab 3-5 mm; (B) BS; SAO2 > 96%; no A in PR; equal rise & fall of chest; TF started @ 10; goal of 2200-2500 Kcal / 24°
	(1300) no change in status; no new orders [redacted]
	(1600) no change in status; [redacted]

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EPW [redacted] b6-4

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NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
	1400 22 JUL 03: Pt recieved from recov. Resting comfortably in bed. Assessment as follows: [VS] sedated on MSO4 @ 4, paralyzed @5; PERRL @3m; reflexes to painful stimuli; [R] SIMV 10 Vt 800 PEEP 5 38%; #8 ETT 23cm to lip. ↓ in crackles/rhonchi, ↓ BS in bases. CXR improved; Neb q4; ⊖ s/s of cyanosis; minimal amount of nasal, thick, white secretions; [CV] +2 edema to UE/LE; +2 pulses x3; Pt's temp at 38.8°, SR 176; 120s-130s sys; S1/S2 [GI] abdomen to ⊕ palpation, hyperactive bowel sounds x4; NGT with feeds @ 10cc to ⊕ noted [GU] foley to gravity with moderate u/o - see F/O; [Skin] multiple abrasions most noticeable ⊕ axilla; midline epigastric; ⊕ LE - all due to bed will do dry dressings; [Lines] ⊕ SC; ⊕ PA line, radial, EDI; will monitor [Other] strings clean pending - [redacted] 1024

b6-2

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[redacted] 22 JUL 03

b6-4

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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
22 July 0	Surgery.
	still no sleep last 0m
	Afebrile ovss % M_0 > 100 cal° 147 27 1475
NS @ 125 u/o	icteric, responds to voice, touch 136 | 105 | 10 / 3.1 | 25 | .7 < 144
Albuterol q4	lungs coarse (B), large airway tb 5.6 ↓ 4.1
Aspirin 10 q50	RRR, 0m, ⊖ JVD
Foley w 0 0m	⊖ BS, stoma pink, edematous, wound granulating, ⊖ stool
TF	leg w/o, strong c/o/1, ⊖ skin necrosis
	hx lumbar spine transection c̄ CSF leak.
	pneumonia resolved — now c̄ secretions again
	ileus resolved. anemia
	mental status "resolving" retroperitoneal hematoma
	CPN abdo wound dehiscence
	Plan. D/C Reglan
	CPT c̄ ABS q4°
	translator to speak c̄ pt ⊖D.
	⊖IVF
	D/C NaCl replacement
	replete K⁺
	pt needs reclassified as civilian than to chronic care
	[redacted] 56-2

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
22 July 2003 @ 1130	Nutrition Pt current TF Ensure @ 20 cc/hr. Goal per MD is 2200-2500 Kcal/day. Recommend Jevity Plus (Ready to Hang) formula @ 85 cc/hr to provide 2448 calories per 24 hr period (including 110g protein). [redacted] b6-2
23 JUL 03 0645	Neurosurgery MAJ, SP, RD (S/O) Temp 38.7 this AM Lumber drain 6-20/hr. Dressings: Mild serosanguinous fluid. Irritable. Localizes uppers. Lowers plegic. WBC 11.3 (A/P) (1) Lumber GSW/PX - unstable. Log Roll. (2) CSF leak - CSF output decreasing. Continue drainage Day 7 today. (3) Fevers - WBC trending down. Continue Gent/Cipro/Zosyn. [redacted] b6-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERV [redacted]	RECORDS MAINTAINED AT
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EPW [redacted] b6-4

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
22 July 2003 @ 1130	Nutrition Pt current TF Ensure @ 20 cc/hr. Goal per MD is 2200-2500 Kcal/day. Recommend Jevity Plus (Ready to Hang) formula @ 85 cc/hr to provide 2448 calories per 24 hr period (including 110g protein). [redacted] b6-2
23JUL03 0645	Neurosurgery MAJ, SP, RD S/O Temp 38.7 this AM. Lumber drain 6-20/hr. Dressings: Mild sanguinous fluid. Arousable. Localizes uppers. Lowers plegic. WBC 11.3 A/P (1) Lumber GSW/FX - unstable. Log Roll. (2) CSF leak - CSF output decreasing. Continue drainage Day 7 today. (3) Fevers - WBC trending down. Continue Gent/Cipro/Zosyn. [redacted] b6-2

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

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EPW [redacted] b6-4

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NSN 7540-00-634-4176

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
23 July 05	Surgery responsive
	Avid PM, defervesced, OVSS MS 80-165 cc/o
Cont/Cipro/Zosyn	112/64 115 sinus 1/0 ?
Nystatin	slightly icteric CXR - improved
	lungs clear; productive mucous LD 6-2 leu 1°
MSO4/Versed	RRR, ØM/R 11 >-355 24
	ØBS, soft, NT 123/3.9 | 96/22 | 8 <123
Reglan/Bulk/Lip	abdo wound ī granulation or serous drainage t.bili 124
Senna	Axilla wound ī clear drainage LFTs s/up
	legs warm, dry, ++ing anasarca. 755/35/130/31/5
Albuterol/Atrov	on 10/800/35/5
	Inj. Pneumonia improved
Nacl 4% q6°	hyponatremia
	hyperbilirubinemia resolving
	ileus / open ⓓTKA / open abdo wound
	hypervolemia / anemia
Plan	↑ TF to 40 ī density PVS
	add 3% Nacl if Na really 123 (will repeat).
	↓ IMV
	Possible close in AM if 24° afebrile
	drainage. b6-2
	Cont Abx, drains; supportive care. [redacted]

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CPW # [redacted] b6-4

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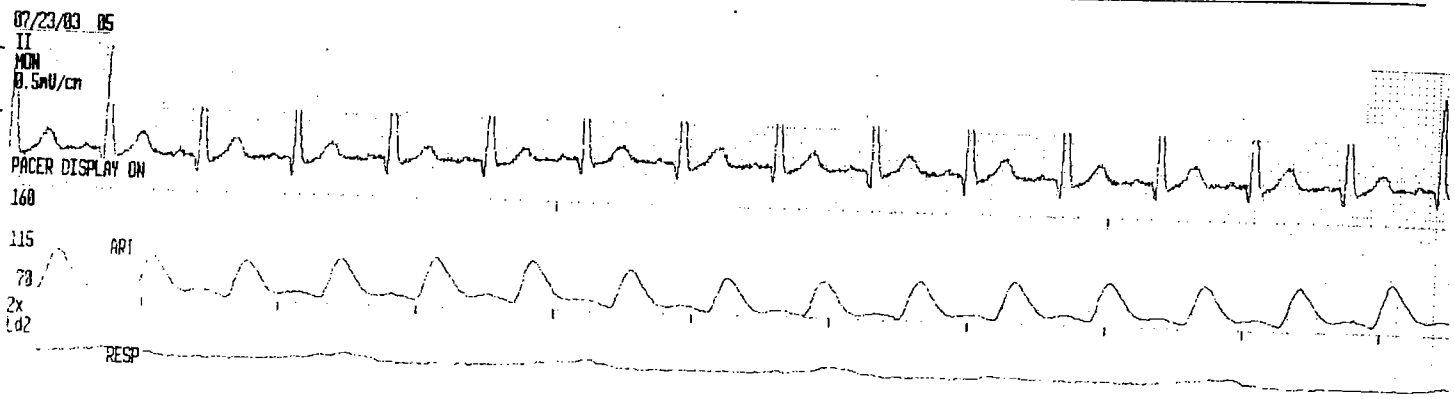
MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
7/23/03	0500 Assumed care. Report given. See ICU-4 flowsheet for initial assessment.



DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
7/23/03	0630 Gess @ bedside. Update given on pt's status [redacted] 0730 All drsg d'ed. midline, A-line drsg c̄ retention sutures intact. Weaning ventilator from sides [redacted] 0810 [redacted] @ bedside. Update given 0945 Stump drsg d'ed per [redacted] orders received [redacted] 1050 Lab drawn per A-line [redacted] 1100 [redacted] per orders [redacted] 1130 ABG drawn. Reviewed by [redacted] orders received [redacted]

22 hrs

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTA
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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
07/23/03	1140 Na 126. 3% NaCl @ 20cc/hr per [redacted]
	1230 Off scene at secure by [redacted]
	even at unknown. SpO2 @ 98% - [redacted]
	1340 Foley started. [redacted]
	1430 Oral care given. Sx'd [redacted]
	white secretion per [redacted]
	1540 Repositioned & supported. Oral care
	given [redacted]
	1700 Report given to [redacted]
	personnel [redacted]
24JUL03	Neurosurgery
0636	(S/O) Afebrile since admit WBC 10.1 Na 123.
	CSF dark (maroon) drainage overnight - hematoma from
	initial injury probably breaking down.
	Dressings minimal drainage.
	Paraplegic static.
	(N/A) (1.) Lumbar GSW - unstable - spine precautions.
	(2.) CSF leak - continue drainage, today day 8
	(3.) Fevers / WBC - improved on antibiotics. Complete
	course.
	[redacted] 4797
	[redacted]
	all b6-2

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
7/24/03	0500 Assumed care. Report given see ICU-7 flowsheet for initial assessment. [redacted] b6-2

7/24/03	0650 Updated Dr [redacted] on patients status. 0 orders received. [redacted] 0730 Dr [redacted] @ bedside. Order received update given on current labs. [redacted] 0750 IV Na @ 4 of 3% @ 30cc/hr. Na 125. [redacted] 0850 K run started @ 50cc/hr. [redacted] 0930 Extension cuff. Open using [redacted] 1300 Sponge bath given. [redacted] 1310 Prepared on stretcher for OR. [redacted]

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

all b6-2

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] b6-4

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
24 July 03	1730 Assumed care. pt post op for stump closure. Labs drawn CBC, Metlyte 8, ABG, VSS. will continue to monitor. CSK
	1905 – pt extubated. 5 difficulty. 45% via FM. C̄ SATS @ 99-100% VSS. pt given MSON for pain. [redacted] CPT/AN
	2100 – pt placed on NC 5 L C̄ SATS @ 99% [redacted] CPT/AN
	2200 pt O2 ↓ to 2L via NC C̄ SATS @ 98-100% pt takes deep breaths and coughs. VSS. pt given MSOQ for pain. will continue to monitor. [redacted] CPT/AN
25 July 03	0048 pt given Haldol for agitation and moving around in bed. pt pulling of dsg's, colostomy, + monitors. [redacted]
	0055 pt given 2mg Ativan for continued agitation will continue to monitor. VSS. [redacted] CPT/AN
	0130 pt given #2 dose of Haldol 5mg for continued agitation. VSS will continue to monitor [redacted] CPT/AN
	0300 Dsg A's done. will continue to monitor. VSS. CSK
	0400 Labs drawn. [redacted] CPT/AN
25 July 03	0500 Assumed care after report assessment done. Pt sleeps on & off talking out loud when awake All dressing CDI VS stable. Will continue to monitor [redacted] 1LT AN
	0600 Residual checked 0 cc. Increased TF @ 60cc/hr
	0800 Lasix given per Dr's Order 20mg IVP [redacted] 1LT AN

HOSPITAL OR MEDICAL F[redacted]		DEPART./SERVICE	[redacted]NED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

all b6-2

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

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
25 Jul 03@	1818 Pt Recieved, physical assessment completed, Pt Alert but Confused, Lungs CTA c̄ Diminished bases bilat, Abd Soft, Non-Tender, BS x4 hypo, +2 Pulses UE bilat, +1 Pulse RLE, (L) BKA, Dressing Midline Abd CDI, Dressing (R) Outer Chest CDI, Dressing (R) Flank CDI, (L) Flank CDI, (L) BKA CDI, LV (L) FA Patent, Ch (R) SC Patent, [redacted] CPT/AU
	b6-2
25JUL03	Neurosurgery
0652	(Pt) VSSA. WBC 15. Awake, paraplegic. (L) Flank Sealed. (R) Flank minimal drainage. Lumbar Drain q-18/hr.
	(Ap) GSW L-Spine. Log roll precautions. CSF leak. Continue drain until dry.
	b6-2
	[redacted] 4757

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
25JUL03	Neurosurgery
0638	S/O Temp 101.3 this AM. Stable overnight.
	Extubated yesterday...
	Na 129. Drain Output 10-44/hr.
	Awake, moving uppers normally. Lowers plegic.
	Flanks drying up.
	A/P Doing well from neuro standpoint.
	W/ll watch for dry flank dressings x 24°
	before removing lumbar drain.
	Continue bed rest. [redacted] b6-2
	[redacted] /79
25July03	Surgery
	Tm 101.3 0055r [redacted] IP 50 cc overnight
	afebrile lungs CTA/bym lumbar 260 cc
	RRR ON ⊕BS soft NT
	abdo wound dry, beginning granulation tissue.
	Stump dressing dry, ⊕ bed edematous. 15.3 > 27 — 871
	Lyte stable 148 / 38 / 103 / 28 — 2.4 Inc.
	Plan ① LO per neurosurgery ④ Con't 5% NaCl 120 / 97 / 6 / 3.9 / 23 / .6 < 132
	② stump dressing x 48° → Δ ⑤ diuresis
	③ ↑ TF to goal ~80cc/°

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CHRONOLOGICAL RECORD OF MEDICAL CARE
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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
26 July 03	Surgery. Agitated overnight
NS @ 25	T max 100.6 . 180/80 110-180 (agitation)
Albut	icteric, confused, slow — Lumbar drain 230/240
	lungs clear ant/post — BP 200/240
Cont Ketamin/Lipid	RRR Ø m
Nystatin	hypo BS soft, ↓ bilirs, abdo wound granulating, (+) stool in bag
	leg wld ↓ edema, stump Ø active bleeding, Ø drainage
Carry to OR	
3% NaCl	lyts: hyperbilirubinemia — 15 > 25.4 1272 — 138 / 3.6 / 105 / 22 / 8 / 7 < 162
Reglan	ileus resolving
	anemia / thrombocytosis
TF @ 60	Na normalizing / hypokalemia
	Plan D/C 3% NaCl — ~~use 4% NaCl per NS~~ hold b/c ↓ CSF leak
	D/C oral baclofen
	increase TF
	discuss c̄ neurosurg sitting more to take PO but will need to be able to protect own airway before taking PO.
	has been on Abx 7 days, will D/C & follow use/fever
	diverse
	supportive care.
	[redacted] b6-2
27JUL03	Neurosurgery
0647	(S/O) VSSA.
	Drain 20/hr.
	Flaks dry.
	(A/P) Stable ā GSW L-Spine.
	Will change Lumbar Drain. [redacted] b6-2 4777

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
28JUL03	Neurosurgery
0649	S/O VSSA. WBC 25
	Awake, nonverbal, left head turn preference. (-) Meningism
	Localizes noxious in uppers. Unable to ask questions.
	Flaks dry – lumbar drain discontinued.
	A/P (1) lumbar Fx 2° to GSW – spine precautions.
	(2) CSF leak – resolved.
	(3) Encephalopathy – unclear, presumed metabolic.
	Will stimulate to eat, interact, etc.
	b6-2
	[redacted] 1797
29 July 03	Surgery. LO out
	Alert, nonfocal stands still [redacted] tracks
MSA 325	VSS, more tachycardic (to 150 sinus) IM 2435
Albut	icteric 136/3.8 | 113/29 | 1.4/.6 <136 25 >35 2008
Nalcin 10	lungs CTA/Sym +bili 46 (3% bands)
Lasix 20 oral	abd/Qm CXR clear, tip 3/ in OA
Nystatin	Q8, stome fine dental. NGR dobhoff ? duodenum or distal stomach
	leg w/o c̄ + edema, strong c/o/ Qnecrosis
	hep fever source? central? CSF?
	Plan translator to speak with N division / begin PO / alc abstinent

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	[redacted] AINTAINED AT b6-2
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

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DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
	Ophth Svc
29 JULY 1936.	
	asked to do retina exam to investigate evidence of septic emboli or fungal retinitis
	O/M/V/P WNL ∅ hemorrhages/ retinitis
	[redacted] b6-2
	[redacted]
	607th, LTC Ophth SVC

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
28/Jul/03	1600 Pt Run along c Myrem, hung CPP to 3000 ml. Pt semi / stable c/o pain. b6-2 [redacted]
28 Jul 03/1737	Rpt Received, Physical assessment, Pt lethargic, c distant stare, Purposeful movement, Lungs CTA, Abd Soft, Non-Tender, BS x4 Active, Colostomy LUQ Pink c Brown Liquid stool, Pulses +2 UE B. lat, +1 RLE, LLE BKA, Skin Jaundice, Diaphretic, Warm, Dressing to Midline Abd incision, CDT, Dressing (R) Under Arm - CDT, TL RSC - Patent CDT, PIV (L) FA Patent CDT, Incision - (L) LE CDT. [redacted] CPT/AN b6-2
28 Jul 03/2200	Suctioning pt throat. SPO2 ↓ 91% Rt placed on Venti MASK @ 30% [redacted] b6-2 CPT/AN
28 July 03/2400	Pt Bathed, T ↑ 103.6, Tylenol 650mg PR Given, Dressings Med, Foley Med [redacted] CPT/AN b6-2
28 Jul 03/0335	T ↑ 103.6 Tylenol 650mg PR given [redacted] CPT/AN
28 JUL 03 0638	Neurosurgery (S/O) Flanks dry. Febrile overnight. WBC ↑ ~~27000~~ 27 K No meningismus. Now on antibiotics. (A/P) (1) FUO p GSW L-Spine. W/N LP today. (2) Unstable spine. Continue log roll precautions. [redacted] b6-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPO[redacted]	4757

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DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
24 Jul 03.	pt continues c̄ HR 130-140; BP WNL; SaO2 97-99% on 30% Vm decreased to 20% 3L c̄ SaO2 98%; will CTM; lungs ↓ (R); RR 30's; TF residual <30cc; ↑ TF to 60cc/hr; goal is 80cc/hr; Colostomy continues drainage; distal pulses palpable; NO Sam has been c̄ [redacted] on
	b6-2
29 July 03	Surgery. mental status still poor; large airway secretions
	Tm 103.6 130/80 120-150 reg. 16 40-85 cal°
Haldol	icteric
Mystatin	lungs coarse (R) - upper airway 27-3 > 30 — 1733
Vancomycin	RRR, ⊘m 137 | 104 | 22 / 141
	3.5 | 22 | .6
BSA 325	⊘ss, stoma pink / functional
ceftriaxone	leg w/o incision healing. urine micro ⊘ant
	on wk
Morphine / CBC / lyte	lungs fever - source ? retroperitoneal hematoma / CSF
TF @ 60/10	clouded mental status
	leukocytosis 5 bandemia / thrombocytosis
	Intravascularly dry
Plan	d/c haldol
	d/c ativan
	d/c haleion
	cont ABX
	CSF tap & send for gram stain
	b6-2
	cont supportive care [redacted]
0830	PIV x 2 to LUE; CL d/c intact, pressure held x 5 min; ⊘ drainage ↓ SaO2; Lung sounds ↓ (R) side (P); Nasal SX c̄ target (P) results; up @ bedside

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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
31 July 03	surgery
0910	Afebrile, VSS good Ao, tolerating TF/po
	mental status improved but still not "normal"
	icteric
	lungs clear, upper airway noisy 13.5 > 33 — 158.1
	RRR, Ø m
	ABS, Rectal colostomy 132 / 4.4 | 100 / 22 | 12 / .8 < 135
	wound/dry
	hx lumbar para / mental status improving
	Plan: ↓ vitals to q 4°
	begin reg diet [redacted] b6-2
	d/c Vanco
	d/c advocant
	d/c IVF
	awaiting placement.
1 August 03	Surgery
1100	Afebrile, VSS tolerating po ↓ cough
	↓ icterus lungs CTA/sym RRR Ø m ABS, Rectal ostomy.
	wounds stable. 18.3 > 34.3 — 168.2
	hx L-spine fx ↓ paraplegia 129 / 7.3 | 98 / 31 | 14 / 1.1 < 116
	stable
	Plan: Placement / lab holiday / increase calories / P[redacted]-op

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	[redacted]AINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR [redacted] b6-2	

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2 Aug 03	Surgery
0950	Afebrile, VSS, tolerating PO, Colostomy functioning
	"anuretic"
	lungs clear & symm
	abdomen
	BS
	abdo wound c̄ good granulation tissue, retention sutures loose.
	stump clean, little bleeding from medial margin. No tissue loss or edema.
	R axilla clean dry, good granulation tissue. 21.8 35 1544
	hyp stable s/p GSW c̄ lumbar spinal transection s/p paraplegia/bowel loss
	Plan. Placement, although pt ready
	remove sutures from neck, R chest, R axilla & retention sutures
	encourage calories / physical therapy
	will keep in ICU another day due to GSC, no obvious sign of infection although diffusion stopped due to supply issues.
	cont of supportive care. [redacted] b6-2

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