NSN 7540-00-634-4176

600-108

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
3 Aug 03 2340	Pt transferred from ICU @ 2130. VSS, pt resting without complaints at this time. Lung sounds CTA, pulses ⊕ x3, bs ⊕. Pt on ss side resting c̄ bed blankets supporting back. Dsg on LUE CDI. Pt c̄ H/L in LUE, IV abx BID. Abd dsg mid line CDI. Pt c̄ colostomy bag c̄ minimal productive output, a lot of gas put out. Foley catheter intact draining cyu ⅀ diff. Dsg on LBK CDI, pt states he has a little pain @ the site, will continue to monitor. (b)(6)-2 [redacted] RN MC
040600 Aug 03 (b)(6)-2 [redacted]	NURSING ASSESSMENT: Assumed care of pt. Airway intact, breathing even and unlabored, LS clear to all fields, Abd soft, nontender (c̄ near surgical site and ⊕ colostomy), c̄ distention. Midline drsg is CDI. Colostomy stoma is pink and putting out stool/gas c̄ difficulty. Foley to gravity, draining clear, yellow urine. Bacitracin placed to meatus of penis. ROM and neurovascularly intact to ⊕ UE. No active movement to ⊕ LE but ROM passively. Vascularly intact to ⊕ LE. Old surgical site to ⊕ skin CDI. ⊕ stump has dsg that is CDI. Drsg also to ⊕ posterior axilla, CDI. IV to ⊕ FA flushes well, CDI. (b)(6)-2 [redacted] LCpl AN
040800 Aug 03 (b)(6)-2 [redacted]	NURSING DRESSING NOTE: Drsg to ⊕ axilla, dry to dry. Med. purulent drsg to old drsg. Wound bed beefy red c̄ minimal bleeding. Replaced c̄ sterile, dry drsg. Drsg to Abd, midline had no purulent drsg to old drsg. Replaced to open portions of midline incision c̄ wet gauze. Pt also has drsg to ⊕ interior portion of ⊕ triep. Superficial wound that has moderate amt of purulent drsg. Drsg replaced c̄ dry 4x4 gauze. ⊕ stump drsg, stitches are CDI c̄ minimal serosanguinous drainage noted. Replaced drsg c̄ 4x4 gauze, Kerlix, ACE wrap. [redacted] LCpl AN

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

eDW

[redacted]

(b)(6)-2

RECORDS MAINTAINED AT:

(b)(6)-2

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
4Aug03	Pt stable at this time. AAOx3. PERRLA.
1400	Lungs CTA bilat, Ø resp distress. NSR. Abd soft, non-tender, bowel sounds active x4 quads. Colostomy to (L) UQ Dsg to abd CDI. Pt states he can feel (R) leg, Ø control except for hip flexor. Scar to (R) Leg healed well. Wound edges well approximated. Pt c̄ c/o pain to (R) knee. Dsg to (L) TKA CDI. Ø complaints c̄ (L) leg. Pt log rolled q1°. [redacted] w/pn
	(b)(6)-2
1900	Dsg to abd b'd. w=d packing stone. Colostomy emptied and cleaned. Dsg to (L) triceps area b'd. wound c̄ drainage. Pt turned q1° to lat. (R) leg exercised, ROM and stretching exercises done. Pt c̄ c/o pain to (R) knee, less complaint p̄ exercising (L) leg repositioned during day [redacted] w/pn
	(b)(6)-2
2117	Pt. care assumed @ 2100. Pt. lying on (R) side maintaining spinal precautions. Perrla, HR Reg, lungs CTA, ABD soft c̄ BS (+) x4. Colostomy bag to (L) UQ intact, ostomy pink, passing gas. ML ABD dsng CDI, dsng to (R) axilla CDI, dsng to (L) TKA CDI. (R) ft c̄ pedal pulse 2+, brisk cap refill. HL to (L) TE flushes c̄ diff, Ø s/s infection will cont. to monitor. [redacted]
2216	Pt. turned onto (R) side [redacted]
	(b)(6)-2

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
05 0530 Aug 03	NURSING ASSESSMENT: Assumed care of pt. Airway intact, breathing, even and unlabored, LS clear to all upper fields (B) and diminished sounds to bases (B). Cough & deep breathing encouraged through interpreter but pt seemed unwilling to comply. After a couple of coughs, pt gave up. Abd soft, nontender (x̄ near incision sites), ū distention. BS(+)x 3 (B LLQ silent). Colostomy to (L) flank, putting out some small amounts of stool, large amounts of gas. Midline abd incision has w→D. drsg that has minimal drng to it. Changed using clean technique. Most superior 4 inches of incision are well approximated while last eight inches are open c̄ granulating tissue and building to wound bed. Extend to (L) triceps has good granulation tissue and moderate purulent drainage. (R) axilla wound has small amount of purulent drainage to old drsg but appears to be healing slowly. Drsg to (L) stump has no drainage to old drsg. Suture line well approximated, c̄ s/s infection. Fragment neurovascularly intact to (B) UE. ~~Al for~~ Passive ROM only to (B) LE. Vascularly intact to both LE but no sensation noted to (B) LE. (b)(6)-2 [redacted] LG.A
05 AUG 03 1309	Nursing Assessment, PT is alert resting in bed. VSS, HRR. Breath sounds unlabored. Pt has (−) difficulty breathing. PT is deep breathing + coughing. Abdomen is soft tender. BS x 3 (LLQ silent). Colostomy to (L) flank putting out some small amount of stool. Midline abd wound has Drsg, CDI. (L) Axillary Drsg CDI, c̄ (−) Drainage at present time. Drsg to (L) stump CDI, c̄ (−) s/s of infection noted. Will cont to monitor PT. [redacted] (b)(6)-2 [redacted] (b)(6)-2

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

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* | REGISTER NO. | WARD NO. ICW 2

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

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

MEDICAL RECORD

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CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
8/5/03 2112	Pt. care assumed @ 2100. VSS c̄ low grade temp 99.8(o), HR 113, S.i.S.s. Lungs CTA bilat. ABD soft, flat c̄ BS (+) x4 Ostomy pink, passing soft formed brown stool and gas. ML ABD dsng CDI, Foley to gravity draining c̄ yu. Pulses (2+) x 3 ext. c̄ brisk cap refill. Dsng to (L) BKA CDI. Pt. on (R) side. Log rolling pt. QJ°. HL to (L) FA intact c̄ s/s. infection. Will cont. to monitor.
6 Aug 03	0540: Assumed pt care @ 0580. Pt. awake. A&Ox3 (b)(6)-2 [redacted] CTA Lungs CTA. Hypo active BS x4. Foley to gravity c̄ clear yellow output. Colostomy bag c̄ soft brown stool. HL (D) FA. Dsng to (L) BKA, mid abd, CDI. Ø complaints @ this time. Will continue to monitor (b)(6)-2 [redacted]
6 Aug 03 1400	Pt stable. AAOx3. PERRL. [redacted] 91W MB. Lungs CTA bilat, Ø resp distress. NSR. Abd soft, non-tender, bowel sounds active x 4 quads. Colostomy to (D) UQ c̄ soft brown stool. Indwelling foley cath draining clear yellow urine. Small amt. old blood noted at meatus, MD aware c̄ MD. Dsgs to bilat arms and abd CDI. Pt. being log rolled and repositioned

HOSPITAL OR MEDICAL FACILITY			
SPONSOR'S NAME	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. 10W3

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

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

MEDCOM - 14244

STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-...

Progress Note

[illegible] 92°. Ø skin breakdown noted. [illegible] (L) TKA and brisk capr refill x 3 extremities. Ø complaints [redacted] TCA
Tdsg CDI. Drinking PO flds. Ø complaints at this time. (b)(6)-2

030 Foley catheter replaced per Dr. [redacted] 16 Fr, ↑ balloon intact. Drainage [redacted] clear yellow urine. Q/A

2030 Colostomy cleaned and emptied. Producing soft brown stool. Pt. log rolled to (R) side. Foley emptied 1050 dark yellow urine. Ord dsg Δ done w → D. Wound edges well approximated. [redacted] (b)(6)-2

2218 Pt. care assumed @ 2100. VSS. HR Reg, lungs CTA. BS (+) x4. MC ABD dsng CDI. colostomy bag intact. ostomy pink passing soft formed stool. Dsng to (L) BKA CDI. (R) LE ↑ brisk capr refill, Ø ROM, Ø sensation, cool and dry. HOB @ 20°. Pt. rep'd to (R) side. Pt. c/o ABD pain, ⅞ T#3 given. Will cont to monitor. [redacted] CTAN (b)(6)-2

7 Aug 03 0600 Pt. VSS. HL in (O) FA ⅁ s/s of infection. HR Regular, lung sounds clear bilat, bowel sounds (+) x 4 quads. Pt. ↑ colostomy draining brown formed stool, stoma pink & moist ⅁ s/s of infection. Foley draining clear, [redacted] urine. DSG to ABD & (L) axillary CDI. Ace wrap to (L) BKA CDI. (+) pulses to extremities & brisk cap refill. HOB @ 20°. Pt. ⅁ complaints @ this time. All other assessment findings WNL. Will continue to monitor. [redacted] (b)(6)-2 CLT/AN

0830 Bed bath given, colostomy emptied & cleaned. DSG to ABD Δ'd, wound pink & moist ⅁ drainage or s/s of infection. DSG to (L) axillary ↑ small amt of yellowish green drainage, new DSG applied, wound oval in shape, red & moist ⅁ s/s of infection. DSG to (R) axillary region Δ'd, wound approx. 2cm in size, ⅁ drainage or s/s of infection. [redacted] (b)(6)-2

NSN 7540-00-634-4176 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
8.8.03 2200	Pt. care assumed @ 2100. VSS. HR Reg, lungs CTA, BS (+) X4. ML ABD drsng CDI. Colostomy intact. Ostomy pink passing soft formed stool. Foley to gravity draining CYU. (L) BKA C.D.I. (R) LE pulse 2+, brisk cap refill. (R) axilla drsng CDI. Pt. turned to (R) side. HL in (R) FA intact ~~s~~ s/s infection. will cont. to monitor. (b)(6)-2 [redacted] CPT/N.
09 0800 by B3	Nursing Assessment: Pt awake, alert, O x 3. Airway intact, breathing even and unlabored, LS clear to all fields (B). Abd soft, nontender (x rec colostomy site), ~~s~~ distention. Colostomy to (L) UQ is pink & putting out gas and stool. Mid line abd incision intact to superior 6 inches and wound bed beefy red to midline abd. Drsd w/ABD. No drsg to (R) LE stump. Wound is well approximated ~~c~~ no drng. Wounds to (R) posterior axilla and (L) posterior tricep have moderate purulent drng and recovered ~~c~~ dry gauze. Pt c/o pain to (R) LE, especially ~~c~~ movement. However, when pt is unaware of nurses presence, does not respond to painful stimuli (B). Foley to gravity drng clear yellow urine. IV to (R) FA does not flush. IV restarted to (L) FA, 20G. Flushes well. IV to (R) FA D'c'd intact. (b)(6)-2 [redacted] LG, M
09 aug 03 1400	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 x4 quads. Foley catheter draining clear yellow urine, Ø drainage noted [redacted] (b)(6)-2

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

#[redacted] (b)(6)-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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
09aug03 1400 (cont)	insertion site. Colostomy t soft brown stool. Dsgs to (L) axillary region and (R) upper arm CDI. Dsg to midline abd intact, Ø drainage noted. Strong pulses and brisk cap refill to bilat UE and (R) leg. Pt reports sensation from groin to ankle on (R) leg. Pt c/o pain to (R) knee. PROM done to (R) leg t good results for pain relief. Suture line to (L) TKA CDI, open to air. Small area to internal edge of suture line reddened from pt scratching scab. Pt turned q2° — [redacted]
2000	1500cc clear yellow urine emptied from foley. Colostomy bag changed, site cleaned. Stoma dusky and bleeding at lower edges. Abd dsg changed w/ → D. Site healing well, minimal bleeding to dsg s. (R) leg t PROM, (R) knee exercised. Ø complaints — (b)(6)-2 [redacted]
2124	Pt. care assumed @ 2100. VSS. pt. c/o pain to ↓ ext. Pt. repos'd; given ⅓ T#3. HR Reg, lungs CTA. ABD soft c̄ active BS x4. M ABD dsng CDI. Ostomy pink, passing soft formed brown stool. Foley to gravity draining c/o. Drsngs to (R) axilla CDI. (L) stump OTA. Staples ⊼ s/s infection. (R) UE warm, dry c̄ palpable pulse, brisk cap refill. Will cont. to monitor. — [redacted]
0300	700 cc out per Foley. — [redacted] (b)(6)-2

NSN 7540-00-634-4178

600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
100545 Aug 03	NURSING NOTE: Assumed care of pt. AAO/3. Airway intact, breathing even and unlabored, LS CTA (B). Abd soft, nontender (+ near colostomy and midline incision), ± distention. BS (+)x4. Voids per foley to gravity, draining clear yellow urine. Betadine applied to penile meatus. PROM and neurovascularly intact to (B) UE. C/o some pain ē PROM to (R) knee but no active movement noted. RLE neurovascularly intact. LLE PROM produces no pain. Suture line to RLE stump is CDI ē no drainage noted. Redness to right portion of suture line remains ē no significant progression. Skin to posterior is intact ē no s/s of decubitis ulcers noted. Drsgs to abd, (R) axilla, and (L) tricep are CDI. Colostomy to (L) abd is pink and moist, pouch and soft, formed stool ± (+) flatus. IV to (L) FA flushes well ± s/s infiltration. (b)(6)-2 [redacted]
100830 Aug 03	NURSING NOTES: Drsg to (L) tricep had moderate purulent drng to old drsg. Replaced ē dry 4x4. Drsg to (R) axilla has minimal drng to old drsg. Wound appears to be healing well. ~~Drsg to midline incision~~ Midline abd wound is beefy red buds to wound bed. Appears to be healing well. Suture line is approx 8 inches long. Sutures are open and being dressed, W→D. Superior ~~most portion~~ 3 inches are well approximated and CDI. Middle wound redressed ē W→D 2x2 gauze and 4x4 cover sponges. (b)(6)-2 [redacted]
10 Aug 03	Received PT alert + oriented. (−) c/o pain or discomfort. VSS. Lungs Breathsounds clear bilateral. BS x 4. Foley WDAT drainage clear color urine. Drsg to Abdomen CDI ē no S/S of infection or drainage noted. (L) Leg stump sutures are intact ē (−) drainage or redness. Colostomy to (L) abdomen ē pink + moist. passing soft form stool. Will cont to monitor PT. [redacted] CPN

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

(b)(6)-2

ICW 03

#[redacted]

(b)(6)-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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10 AUG 03 2000	-Dressing to Abdomen wet→Dry CDI, ⊖ s/s of infection. And (b)(6)-2 Dry to (R) Shoulder also CDI. Will cont to monitor [redacted]
2000	Foley emptied 780cc clear yellow urine [redacted]
10 Aug 03 22:39	Rec'd c/o pt @ 21:00. VS WNL. per flow sheet. Pt awake and alert. Skin W/D/I. PERRLA ⊕ WNL. LCA ⊕. BS ⊕ x4. Colostomy intact ⊕ flatus ⊕ DK brown soft stool. Foley to grav. intact draining CU. ML ABD incision c̄ DSD CDI. (L) LE stump c̄ sutures intact dried crusted blood noted @ suture line. incision well approx. Pt c/o feeling tight heavy pain in LLE. ⅡT 3's given. ∞ further d/o's will cont. to mon [redacted]
~~0224~~ 0251	c/o pain to ↓ ext's ⅡT 3's given [redacted]
11 August 03 0700	Pt asleep easily awaxd by verbal stimuli c̄ HOB @ 20°. VSS. HR regular, lung sounds clear bilat, bowel sounds (+) x 2 quads. Foley draining clear orange tinged urine. Colostomy clean s̄ bowel drainage @ this time, Stoma pink & moist. DSG to ABD & (L) axilla CDI, DSG to (R) axilla removed because wound is dry c̄ scab. HL in (R) FA s̄ s/s of infection (L) BKA incision c̄ sutures intact, approximating well s̄ s/s of infection. Pt. s̄ complaints @ this time. All other assessment findings WNL. Will continue to monitor. (b)(6)-2 [redacted]
1030	DSG Δ'd to ABD & (L) axilla. Mid ABD vertical incision slowly approximating wound red, moist, s̄ s/s of infection, w→D DSG applied. (L) axilla oval wound is red, moist, s̄ drainage or s/s of infection, new DSG applied. [redacted]
11 AUG 03 1300	-Received PT in bed c̄ ⊖% pain or discomfort. VSS. HRR. (b)(6)-2 Lung sounds clear B. bilateral. BS x 3 Quads. Foley drains clear orange urine. Colostomy bag drains ⊖ feces At present time, stoma pink + moist. Dry to ABD CDI. (L) BKA incision c̄ sutures intact. (R) strip suture CDI. Will cont to monitor [redacted] (b)(6)-2

NSN 7540-00-634-4176

600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
8-13-03 2217	Pt. care assumed @ 2100. VSS. HR Reg lungs CTA, BS (+) X4. MC ABD incision c̄ sutures OTA, Ø s/s infection. ostomy pink, passing soft brown stool and flatulence. Foley → gravity draining c/y/u. (L) LE TKA c̄ sutures OTA, Ø s/s infection. (R) LE c̄ pulse 1+, cap refill < 5sec. Pt. has sensation to (R) LE that comes and goes. Pt. has constant tingling in toes (R) ft. Pt. has (+) but markedly ↓ROM to (R) LE. IV site (L) LE flushes ⊓ diff. Ø s/s infection. Will cont. to monitor. (b)(6)-2 [redacted] LT/AN
0415	Pt c/o bladder pain, urine dark, cloudy. UA sent. Foley patent. Total output 1700cc this shift. (b)(6)-2 [redacted] LT/AN
Aug 14, 2003	0850 Assume pt care @ 0500. VSS. HR reg lung CTA. Abd MC incision, dsg Δ done - no s/s infection. Colostomy intact w/o drainage @ this time. Dsg to (R) LE Δd CDI. HL to (R) FA (+) flush c̄ redness/infiltration. Foley to gravity c/y/u OP. (L) BKA sutures intact. OTA. RLE c̄ limited ROM + pulse. No c/o pain or discomfort @ this time. Will continue to monitor (b)(6)-2 [redacted] LT/MLb

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

#[redacted]

(b)(6)-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

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)*
14AUG03 1304	- Received PT alert in bed c̄ ⊖ c/o pain or discomfort. VSS, HNR. Perrla. Lung sounds CTA. BS x4. Colostomy bag intact pink & moist. Drsg to both abdomen & Ax CDI. ⊖ s/s of infection. Sutures to (L) leg strips ā dry & intact ō sutures. HL to (L) arm intact. Foley drains clear clear urine. Will cont to monitor. (b)(6)-2 [redacted]
14AUG03 1400	- PT has decubitus ulcer on sacral bone approximately 2" w diameter. Charge nurse notified - cleans area, and applied Telfa c̄ reinforced packing. Will cont to monitor [redacted] (b)(6)-2
2330	Care assumed @ 2100. VSS, alert and aware c̄ c/o pain @ decubitus site when laying on it. Lung sounds CTA, pulses+x3, bs(+). Sutures CTA on lle BKA CDI. Colostomy and foley sites clean and intact, both c̄ adequate output. Drsg to midline abd CDI. Pt with gauze over decubitus on anus. HLock lve infiltrated, restarted in rue, iv cdx. Pt being rolled q2°, will continue to monitor. [redacted] Alumne
150530Ag03	Nursing Note: Assumed pt care. AAOx3. Airway intact, breathing [redacted] (b)(6)-2 and unlabored, LS CTA(B). Abd soft, nontender (c̄ new ostomy), nondistended. BS(+)x4. Urine per foley to gravity, clear, yellow urine. ROM to (B) LE and neurovascularly intact. No active ROM to (B) LE & but neurovascularly intact. No statements of pain to (B) LE (and no translator available to ask about feeling). Stump well approximated, c̄ s/s infection. Colostomy to (L) LQ pouch cont formed, soft stool and flatus. Turned q2°. Drsg to sacral area CDI. [redacted] Author (b)(6)-2

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DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
151230 Aug 03	Nursing Note: Pt c/o pain at meatus at pendulous. Bacitracin applied. Also, c̄ manipulation of foley drainage tube, 100cc drained from bladder. Pt states that pain has improved. Dsng to (R) axilla not necessary, site is closed. Dsng to (L) triceps applied D&D. Wound is closing quickly and is s̄ s/s infection. Ø dsng applied to stump. Wound is s̄ drsgs and is well approximated. Wound to abd, midline s̄ protect dsng. Wound bed is beefy red. Replaced, W→D. Stoma site cleansed & bag replaced c̄ resistite bag. Sacral site has 1 inch-diameter stage II pressure ulcer. ½ inch kolix gauze applied to site to provide cushion & debridement. Turned q1° throughout shift. [redacted] (b)(6)-2
15AUG03 2044	Assumed care @1800. A+Ox3, HR: 113 BP: 130/98. BS audible x4. No output into colostomy bag. Dressing Δ done to midline of abd. No S/S of infection noted. NS & gauze to wound W→D. Quarter-size decubitus ulcer, stage II to sacrum. No C/O pain this shift. Foley draining to gravity cl. yellow urine. (b)(6)-2 [redacted]
2200	Pt. care assumed @ 2100. VSS. HR Reg lungs CTA BS (+) X4, ABD soft. ML Dsng to ABD CDI. Foley → gravity patent draining yellow, cloudy urine c̄ foulsmell. MD aware UA ordered for a.m. (L) TKA OTA, Ø S/S infection @ sutures (R) ↓E c̄ pulse 1+, brisk cap refill, (+) sensation, (+) but ↓ROM. Dsng to sacrum CDI HL (R) FA intact s̄ s/s infection or infiltration. Will cont. to monitor. — [redacted]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT (b)(6)-2
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

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

[redacted]

(b)(6)-4

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
160530 Aug 03	NURSING NOTE: Assumed care of pt. AAOx3. Airway intact, breathing even and unlabored, LS CTA(B). Abd soft, nontender, ~ distention. Abd middle incision dsng is CDI, no drng noted. Colostomy is pink & pouting out stool & flatus. BS(+)x4. Voids per foley, clear amber urine. FROM and neurovascularly intact to (B) UE. No movement to (B) LE but sense sensation, especially pain. Neurovascularly intact to (B) LE. Stump to (L) LE is well approximated, sutures open to air ~ drainage. IV to (R) FA ~ s/s infiltration or infiltration. (b)(6)-2 [redacted]
161100 Aug 03	NURSING NOTE: Sacral wound has not changed since yesterday. Edges have red healthy tissue. Center has yellowish white attached tissue. Dry gauze cushion dressing applied. (b)(6)-2 [redacted]
16 Aug 03 1800	Assumed care @ 1300: HR: 110. Resp easy. ↓ pain @ 1830, Tylenol 650mg PO given. Abdominal drsg Δ dove W→D. No s/s of infection. Sm amt. serosanguinous drainage noted. 1 inch stage II decubitus ulcer to sacral area, dressed ~ 2x2 gauze. Turned q1°. Colostomy intact, ~ no drainage @ this time. Foley to gravity draining cloudy yellow urine. Will continue to monitor. [redacted]
8.16.03 2135	PA. care assumed @ 2100. VSS. HR Reg, lungs CTA (b)(6)-2 throughout. ABD soft, flat ~ BS(+) x4. ML ABD dsng CDI. (L) flank colostomy intact ~ ↓ output x 2 days. Foley → gravity draining cloudy, dark yellow urine. (L) TKA sutures OTA ~ s/s infection. (R) ↓ ext. ~ pulse PT, (+) sensation, (+) but ↓ ROM. Pt. Rep'osd q2°. Dsng to sacrum CDI. Will cont. to monitor — [redacted]
0415	975cc amber, cloudy urine per Foley. Dr. [redacted] to (b)(6)-2 eval in a.m. [redacted]
170530 Aug 03	NURSING ASSESSMENT: Assumed care of pt. AAOx3. Airway intact, breathing even and unlabored, LS CTA(B). Abd soft, nontender, ~ distention. BS(+)x4. Voids per foley to gravity. Urine is a dark urine ~ some sediment. MD aware. FROM and neurovascularly intact to BUE (continued →).

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DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
8-19 0000	Pt. care assumed @ 2100. VSS. HR Reg, lungs CTA, BS(+) X4. MLABD dsng CDI. Colostomy intact Foley 7 gravity ⊂ amber urine sediment. Pt c/o pain to bladder penis. Dr. [redacted] (b)(6) aware. ⊘ new orders. Dr. [redacted] aware per Dr. [redacted]. 2IV site intact (b)(6)-2 Will cont. to monitor. [redacted]
0337	1800cc red amber urine ⊂ sediment from Foley. UA sent. [redacted]
19 0530 Aug 03	Nurses Note: Assumed pt care. AAOx3, Airway intact, breathing even and unlabored, LS CTA(B), Abd soft, nontender, ↓ distention. Colostomy to (L) flank continues to put out flatus, some stool. Midline drsg CDI ⊂ no shadowing noted. Foley to gravity, urine is red/amber & somewhat cloudy. Dr [redacted] (b)(6)-2 notified & ordered Δ of foley, Ditlam PO, & bentonyl bladder irrigation. BLE have flow and neurovascularity intact. (B)LE have some sensation and pt c/o some pain. No active movement noted to (B)LE. (L) stump is well approximated, sutures are CDI. Drsg to sacral area has small area of serosang drng noted. IV to (L) FA heparin lock ⊂ s/s infiltration or infiltration. (b)(6)-7 [redacted]
19 Aug 03 2000	Assumed care @ 1300. VSS, AAOx3. Lung sounds clear bilat. BS X4, Colostomy intact, putting out gas. Foley patent - Draining clear yellow urine. Drsg Δ to midline abd, some serosanguinous drainage noted. Stage II decubitus ulcer to sacral area dressed ⊂ 4x4 dressing. Sutures to stump intact. c/o pain in stump @ 2000. Tylenol #3 ⊂ PO given. [redacted]

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	[redacted]		(b)(6)-2
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

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

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

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
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DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
19 Aug 03 23:03	Rec'd c/o pt @ 21:00 Restraints x 1 (R) ankle. Awake and alert in bed. VS WNL per flow sheet. Skin W/D/I. LCA (6) APPS, SQ. DSD's + (B) ext's CDI. HL (R) FA patent + intact. ML ABD dsg CDI. Colostomy LUQ intact stoma beefy red in color. [redacted] draining brown soft stool. BS(+)x4 ABD soft to palpation (+) PP (B) (D) TKA sutures well approx. and intact s/s infection. OTA c/o pain x 1 Tylenol given. Will cont to m[redacted] 3rd/AN
20 Aug 03 0834	Assume pt care @ 0700. Awake and alert in bed. VSS. HR reg. Lungs CTA - Abd. ML dsg CDI. [redacted] Colostomy intact. BS x 4. Foley to gravity c̄ CYHOP. dsg to sacrum CDI. Suture to (L) TKA intact. (R) LE limited movement pt turning q 2° c̄ assistance. Will cont. to monitor [redacted] (b)(6)-2 9MMC
	0845 HL to (R) FA (+) flush c̄ redness infiltration [redacted] (b)(6)-2 9MMC
20 Aug 03	2000: A+O x 3. VSS. No % pain @ this time. Assumed care @ 1300. Lung sounds clear bilat. BS x 4. Colostomy intact. Bag changed this shift, sm amt stool, large amt flatus. Foley to gravity draining clear yellow urine. Dressing Δ to abd. Sm amt serosanguinous drainage noted. Stage II decubitus ulcer on sacrum dressed c̄ 4x4 gauze. Turning q 2°. Will continue to monitor. (b)(6)-2 [redacted] 2nd/AN
20 Aug 03 2245	Rec'd c/o pt. @ 21:00. VS WNL per flow sheet. Awake and alert in bed lying on (L) side. Repositioned to (R) side. Skin W/D/I c̄ skin to sacrum c̄ DSD CDI. All other dsgs CDI (B) ext's. PERLA (+)

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DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	2CA(R). HRLS, S2WNL. PSS(R)x4. ABD soft non-tender. colostomy LUQ intact stoma beefy red in color. HL (R) patent; new PIV initiated (L) FIA, patent and intact. FTG C (L)U draining. (L) Lat C sutures OTA intact incision well approx. c/o pain x 1 II Tylenol given. will cont to mon [redacted] PLT/AN (b)(6)-2
21Aug03 0630	Pt awake and alert. Lungs CTA bilat, ∅ resp distress. NSR. and soft, non-tender, bowel sounds active x4 quads. Colostomy draining soft brown soft. Dsg to midline and CDI. Dsg to sacral area intact. Pt logrolled to sides q1°. Foley draining clear yellow urine. Sutures to (L) TKA CDI. (R) leg T. strong pulses and brisk cap refill. Com to (R) knee. (b)(6)-2 [redacted] WF/Dr
21 Aug 03 1500.	Received pt from A/E after lite. A & O. VSS Tolerating regular diet. (L) wrist area SC patent & intact. Predness, swelling or pain noted @ IV site. Lungs CTA. Abd soft nondistended. BS (+) x4 quad. Colostomy bag intact & ∅ stool present @ this time. Dsg dcd to middle Abd. and (L) axilla area. Dsg to sacral dcd. Pt log rolled to change position frequently for comfort & [illegible]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT [redacted]
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR (Self)	(b)(6)-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.

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CHRONOLOGICAL RECORD OF MEDICAL CARE
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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
21 Aug 03 1520	patient pressure cream. Foley to gravity drainage clear yellow urine. HOB ↑ 20° for meals. Will continue to monitor [redacted]
4 Aug 03 0015	Assumed care of pt @ 1900 ~~pt~~ receiving report from daysh ift; All VSS, pt A&O, pt c/o pain, given II perc c good relief; S1S2, ⊕ pulses; LS CTA ⊕, equal & unlabored; ⊕ BS X4, colostomy bag intact, stool present. Colostomy care to be provided in AM; Foley to gravity draining clear yellow urine; ML abd drsg CDI & dry noted, drsg to ⊕ axilla area CDI & dry; drsg to Sacral area CDI; sutures to ⊕ TKA OTA, well app.; pt has ∅ c/o pain/discomfort @ this time; cont to monitor [redacted]
@0100	I concur c above assessment. [redacted] (b)(6)-2
22 Aug 03 0800	VSS. Abdomen & mid Foley to gravity drain clear amber urine. Foley care done. Saline lock patent & intact in ⊕ HA. ⊕ axilla drsg changed. Midline abdominal incision without any redness, swelling or pain. Drsg changed as ordered. Sacral wound cleaned & drsg regulated as ordered. Monitoring bony prominence areas to prevent pressure ulcers. Will continue to monitor (b)(6)-2 [redacted]
22AUG03	2100: VSS, A+O x3, C/O PAIN, Medicated c TYLENOL #3 PO ×1 TABS AS OFFERED, IV HL TO ⊕ FA Flushed & Redressed/TAPED, Midline Wound to ABDOMEN c DSG CDI, COLOSTOMY SITE WNL c BAG → EXPECTING → BROWN SOLID STOOL. ⊕ LE amputation, Stub of ⊕ LE has sutures approximated and open to AIR, ⊕ LE MINIMAL MOVEMENT, has

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DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	(cont) midline Δd this am. Drsgs to axilla and decub on sacral area Δd. All wound sites ∃ s/sx infection SL in Ⓛ wrist flushes well, ∃ s/sx infection/ infiltration. ↓ movement noted in Ⓡ LE. Skin warm to touch. Cap refill <3 secs. Colostomy bag c̄ small amount soft brown stool. Foley draining quantity sufficient clear yellow urine. 2 point restraints in place. Pt resting quietly a) this time. will cont. to monitor. [redacted] PA)
25 AUG 03	PT NOTE (b)(6)-2
	HX: PROM Ⓑ LE
	T/M: PNT STATED PAIN FELT TO Ⓡ LE c̄ KNEE FLEX ↑ ~90° & HIP FLEX ↑ ~ 70° PNT DENIED PAIN IN Ⓛ LE PNT DEMONSTRATED TRACE MUMT Ⓡ LE. PNT REQ EXCESSIVE MOTIVATIONAL COACHING PNT DEMONSTRATED Ⓘ PROM Ⓡ LE (FLEX/EXT/ABD/ADD) c̄ LITTER STRAP. PNT REQ ASSISTANCE TO Ⓛ LE 2° ∅ CONTROL OF MM, ESPECIALLY ABDUCTION/ADDUCTIONS. HEP'S Ⓡ LE INCLUDE HIP (FLEX/EXT, ABD/ADD), KNEE (FLEX/EXT), FOOT (PF/DF/INV/EV). PNT Ⓡ FOOT REMAINS AT ~10° PF.
	DX: PROM Ⓑ LE POSSIBLE NIGHT SPLINT Ⓡ FOOT.
	I: PROM. ORTHO CONSULT.
	G: ∅ Δ.
	(b)(6)-2 SPC [redacted]
	91W10 N9 DTTECH

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DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
25 Aug03	1840 = VSS, A+Ox3, Ø c/o pain @ this time, did PROM exercises to Bilatural LE's for ~ 10 minutes. Pt. can very minimally move (R) LE, has (+) sensation to (R) leg → top of (R) foot & bottom of (R) foot but not (R) toes. Ø independent movement of (L) LE. (L) LE BKA c̄ stump → sutures @ end approximated. Midline abdominal wound W → D dsg CDI. Stoma site beefy red & putting out semi-solid light brown stool, routine ostomy care. Foley to gravity draining clear yellow urine. IV ~~HL~~ to (L) wrist / FA area flushed & patent. Q2° turn-log roll. Tolerates PO well. Ø other remarkable assessment findings. Will continue to monitor. [redacted]
26AUG03	(1135) Assumed care of pt @ 0600 p̄ report from night shift. (b)(6)-2 Pt alert speaking Arabic. Pt medicated c̄ ~~II~~ T3 this am for leg pain c̄ good relief. VSS. Pt cont. to be turned using log roll q2°. Wet → dry dsgs Δd on axilla, midline abd wound and decub on sacral area. All sites s̄ S/Sx infection. Lower extremities elevated, (L) stump on pillow. Colostomy bag c̄ mod. amount of semi-formed brown stool. Foley draining quantity sufficient clear yellow urine. Foley care done this am. Pt given bed bath this am. SL in @ wrist flushes well s̄ S/Sx infection/infiltration. Tol reg. diet well. 2 point restraints in place. Will continue to monitor. [redacted] (b)(6)-2

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DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
26 AUG 03 2045	VSS. AO. Abdominal & (R) axillary DSG's change and bag voided to (R) side. BS (+) x4 and colostomy intact. Abdominal incision clean, ∅ dehiscence or exudate. S. Thibe to (R) leg CDI OTA. Patient performed staring to himself. (b)(6)-7 [redacted]
27AUG03	(1425) Assumed care of pt w/ 0000 ∅ report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c̄ T3. Cont to turn using log roll q 2°. ROM exercises done this shift x2, c̄ (B)LE. Drsgs to midline abd, (R) axilla, and decub on sacral area Δd this am. ∅ S/Sx infection w/ sites. Foley draining quantity sufficient clear yellow urine. Colostomy bag intact c̄ sm. amount soft brown stool in bag. Sutures on (R)LE stump CDI - open to air, elevated on pillow. 2 point restraints in place - ∅ S/Sx complications c̄ circulation/skin breakdown. Pt tol reg. diet well. WM. cont. to monitor. (b)(6)-7 [redacted]
28AUG03 0013	VSS. AO. Cont to turn patient q 2° per order on (R) patients convenience. Abdominal incision OTA & C&D&I. LLQ colostomy intact and contains brown, soft stool. Voiding light amber urine Q5. (L) Amputation bed sutures removed by MD. Small amount of serous drainage

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#[redacted] (b)(6)-7

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DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
	and reinforced. Provided clean sheets. (+) pulse to BLE and pt able to partially flex (R) quadriceps. Comfortable in bed. (b)(6)-2 [redacted]
28 Aug 03 0815	Pt received sleeping on his (L) side, assessed medicated then rolled on his (R), alert, S1 S2-E tachy rhythm noted, E (B) bilat UEs, E (R) LE, (R) LE E small drsg CDI, lungs CTA bilat, (B) bowel sounds E mid abd. incision to air, (L) side colostomy 3 stool but some gas, foley to gravity E yellow urine, drsg to (L) axillary Δ'd. Will cont. to monitor. [redacted]
28 Aug 03 1845 hours	Pt recieved in bed Awake and alert. PERRLA ES CTA Through out. (b)(6)-2 S1 S2 present HRRR. +BS x4 quads. colostomy Bag contains small amount of Brown soft stool. incision to mid line abdomen CDI no signs of infection noted. Denies Pain at this time. Left leg AKA E 2x2 on end of extremity foley draining to gravitity. Will continue to monitor. (b)(6)-2 [redacted] Sec 9 IWMC
29 Aug 03	Rec'd report on pt. Pt being turned q 2hrs. 2x2 on (R) stump D&I. ROM exercises per PT to (R) leg. Lungs CTA. BS (+) colostomy bag intact. (-) c/o pain or discomfort @ present time. Will continue to monitor. (b)(6)-2 [redacted] IWMC
1550 29 Aug 03	Pt medicated E [redacted] 3 for pain per MD orders. [redacted] 1940: VSS, A+O X3, Ø c/o pain @ present time, (b)(6)-2 PROM exercises done to (R) LE & (L) LE (Stump). This helps ↑ comfort for pt. Turning Q2 log roll. Pt. has sacral breakdown, dsg dirty → taken off → Δ'd W→D CDI. Dsg W→D applied to midline abdominal wound that appears to be healing very well. Stoma site cleaned and new colostomy bag attached. Pt. putting

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(cont) gravity draining quantity sufficient clear yellow urine. Colostomy bag intact c̄ sm. amount brown formed stool. Dsgs to ⊕ axilla and to decub on sacral area Δd this am. midline abd incision CDI. ϕ S/Sx infection @ wound sites. Pt tol. reg diet well. 2 point restrants in place s̄ S/Sx complications of circulation / skin breakdn. Will cont. to monitor. — (b)(6)-2 [redacted]

1Sep03 2030: VSS, Ø c/o pain, A+O×3, Dsg to sacral breakdown Δ'd W→D CDI, midline abdominal healing wound (scar) open to air. Colostomy bag Δ'd, stoma cleaned / stoma care done. Stoma appears beefy red & vascular — putting out solid brown stool. Had pt. help c̄ stoma care & Δ'ing bag to ↑ independence. Did PROM exercises to (B) LE's → helps c̄ discomfort. Q2 log roll turns. Foley to gravity running clear yellow urine. Tolerate PO well. (+) BS×4. Ø other remarkable assessment findings. Will continue to monitor. — [redacted] (b)(6)-2

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DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
02SEP03	(0920) Assumed care of pt @ 0600 p̄ report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c̄ T3s and Neurontin. Pt cont. to be turned q2° using log roll. Drsgs to decub on sacral area and axilla Ad this am - ∅ s/sx infection @ sites. Pt tol reg diet well. Colostomy bag intact c̄ small amount formed brown stool. Foley draining quantity sufficient clear yellow urine. 2 point restraints in place - ∅ s/sx complications c̄ circulation/skin breakdown. Will continue to monitor. (b)(6)-2 [redacted]
02Sep03 @2000	Pt a/o x3, resting in bed. pulse: tachy. Q2 turns using log roll. Drsgs to axilla & sacrum CDI. colostomy intact c̄ semi solid brn. stool. foley draining adeq. cyu. 2 pt restraints on. circulation assessed. (L) stump elevated. Pt. doing ROM c̄ extr. for comfort. ∅ c/o pain @ this time. Will monitor [redacted] (b)(6)-2 [redacted]
03SEP03	(0930) Assumed care of pt @ 0600 p̄ report from night shift. Pt alert, speaking Arabic. VSS. ∅ c/o pain @ this time. Cont to turn pt q2° using log roll. Drsgs to axilla and decub on sacral area Ad this am. ∅ s/sx infection. Colostomy bag intact c̄ small amount formed stool - brown. Foley draining quantity sufficient clear yellow urine. Pt tol reg diet well. (L) stump ↑ on pillow. ROM excercises done for comfort on (B) LE. 2 point restraints in place - ∅ s/sx complications in circulation/skin breakdown. Will cont to monitor [redacted]

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DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
6 Sep 03 @ 0700	- Assumed care of pt. awake alert and oriented x3 VSS c/o pain to (L) stump scheduled morphine administered. Log roll position A'q2°. break down to sacrum 4x4 dressing CDI. AM and ostomy care complete. Lungs CTA. HRRR Active BS Tolerating PO well. Will cont to monitor — (b)(6)-2 [redacted] (1040) I concur c̄ above assessment. [redacted]
6 Sep 03 @ 1914	Rt A10, VSS speaking un arabic (pulse: tachy) lungs: CTA(B), HRRR, (+) BS x4 qd. BM: x1 formed brown/colostomy intact. stoma: beefy red & vascular. 1 pt restraints on, circulation intact. Axilla, sacral drsg CDI. (L) stump ↑ on blanket. c/o pain to stump often. Q2 turn c̄ log roll. (R) leg on foam doughnut pillow to prevent breakdown. H2O @ BS within reach. Will cont to monitor — [redacted] 9 Lumb. (b)(6)-2 [redacted]
7 Sep 03 0645	Assumed care A+O x3. VSS. Lungs CTA. HRRR. Active BS x4 quads. ∅ c/o pain or discomfort @ this time. ostomy care given. breakdown to sacrum dressing CDI Q2 position change prevention of breakdown. Will cont to monitor (b)(6)-2 [redacted]
7 Sept 03 1200	I concur c̄ above. To Radiology for C spine. [redacted]

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DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
7 Sep 03 1910	Pt in bed. pulse: tachy, lungs CTAB, HRRR, ⊕BS x4. colostomy bag intact c̄ semi-formed brown stool. Pt on Hill-rom bed. to prevent/decrease skin breakdown, Q2 turns. (L) axilla + sacral drsg CDI. (L) stump ↑ on pillow. (R) foot on foam doughnut for heel support. H20 @BS. IS use encouraged. will monitor [redacted] PCM/c. (b)(6)-2

See Other Sheet!

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DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
7 Sep 03	(2300) Pt sitting ↑ in bed. c/o (L) stump pain often. Foley DC'd earlier today. voided 800cc dark yellow urine @ 2130. H20 @ BS in reach. Q² turns. drsg. to sacrum A'd. (R) leg on foam pillow to ↓ breakdown. neurontin dose ↑ to 600 mg per MD orders. colostomy care now being done by pt c̄ some assistance. Bm x1 brn, semi solid. Will monitor [redacted] 911 on 6.
08 SEP 03	(0830) Assumed care of pt @ 0800 p̄ report (b)(6)-2 from night shift. Pt alert, speaking Arabic. VSS. 0/10 pain @ this time. Cont. to turn pt q2°. Pt tol. reg diet well c̄ Ensure. Voiding quantity sufficient clear yellow urine. mod. amount soft brown stool emptied from colostomy bag. Drsgs to axilla and sacral decub Δd this am. Wounds s̄ S/Sx infection. (L) stump elevated on pillow. Restraint in place s̄ S/Sx complications from skin breakdown / circulation. Will continue to monitor [redacted] (b)(6)-2
8 Sep. 03 1930	Pt resting in bed, A+Ox3, VSS, LS CTA (B), (b)(6)-2 BS x4, S1S2 present, Δ position q 2h, voided 750 cc c/y urine, Dsg to sacrum CDI, stump rested on pillow, colostomy bag in place

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DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
Cont.	restraint in place ≈ proper circulation ∅ skin break down. (b)(6)-2 [redacted] @1WM6
9Sep03 0900	VSS; A&O. OOB to chair for [redacted] & Hygiene Care. Tolerated well. Lungs clear. BS(+) abdomen soft non-distended. Colostomy stoma pink & moist. ∅ stool in colostomy bag @ this time. Voiding clear amber urine in urinal. Dry dressing to sacral area & (L) axilla. Restraints removed & replaced. Skin intact under restraints. Peripheral pulses (+) x2. Left leg clamp incision well approximated. ∅ drainage noted. Incision healed. Will continue to reposition PRN and PRN for comfort. [redacted] 2C7 A (b)(6)-2
9Sep03@2000	Assumed care @ 1800; AII VSS, pt A&OX3, ∅ c/o pain or discomfort ~~x~~ @ this time; OOB to chair X1 ~~x~~ c/o dizziness or complications; (+) BSX4, ~~colos~~ AH stoma pink & moist draining, dark brown, soft, unformed stool; colostomy bag emptied PRN; pt voiding QS, clear, yellow urine; dsgs A'd to sacral area (L) axilla, ⊖ drainage; pt OOB to chair X1; pt being turned Q2°; restraint X1 in place; ⊖ skin breakdown, circulation intact. Will continue to monitor (b)(6)-2 [redacted]
10Sep03 1030	A&O & S_2 present HRRR. LS CTA (B), (+) BS x 3 quads. No BS in LLQ. colostomy IN LLQ. Dsg on sacral CDI. c/o pain in Leg Bilat. Tylenol Administered. Will continue to monitor. [redacted] @1WM6
	(1525) I concur ≈ above assessment. [redacted] (b)(6)-2

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10Sep03	1900= VSS, A+Ox3, c/o pain, colostomy bag putting out liquid brown stool, doing stoma care as needed throughout shift & having pt. assist w/care, tolerates PO well, ⊕ BSx4, urinal @ BS & putting out clear yellow urine independently, log roll Q2 turns, Dsg Δ'd to sacral decub, PROM exercises done to (R) LE, pt. can do ROM exercises to (L) stump himself. Restraint x1 extremity - extremity restrained → skin integrity intact. Scar to midline abdomen. ∅ other remarkable assessment findings. Will monitor — [redacted]
11Sep 03 0915	Pt Awake, completed self care on ostomy. [redacted] (b)(6)-2 OOBTC 1point restraint Dsg ⇒ ~~Sdfd~~ Sacrum CDI. Will continue to monitor
11Sep03	1930= VSS, A+Ox3, c/o pain to (B) LE's → did PROM exercises to (R) LE, pt. can independently exercise (R) LE stump. Had pt. do own colostomy care → pt. did well c̄ minimal assistance. Dsg to sacral breakdown Δ'd CDI. Q2 log roll turning, restraint x1 in place,

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

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

#[redacted]

(b)(6)-4

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
	skin integrity intact to extremity restrained, ∅ other remarkable findings. Will continue to monitor. (b)(6)-2 [redacted] /AN
12SEP03	(1710) Assumed care of pt @ 0000 ∅ report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c̄ Neurontin/Tylenol. Pt OOB to chair for 1° this pm. Tol. well. Drsg to decub on sacral area Δd wet→dry. ∅ S/Sx infection noted. Pt tol. reg. diet well. Voiding s̄ difficulty. Colostomy bag Δd this pm c̄ min assist from staff. 1-point restraint in place s̄ S/Sx complication of skin breakdown/circulation. Will cont. to monitor. (b)(6)-2 [redacted] /AN
12Sep03	2000 = VSS, A+O×3, temp 100.4, gave 650mg Tylenol Pg will reevaluate. Δ'd Dsg to Sacral area - CDI. Log roll Q2 turns. Did PROM exercises to ⓡLE, pt. can do exercises to ⓛLE independently. Colostomy bag intact, stoma site looks good (beefy red) and vascular - putting out semi-solid brown stool, pt. can do own colostomy care prn. X1 restraint in place, extremity restrained - ∅ breakdown & skin integrity intact. Will continue to monitor. (b)(6)-2 [redacted] /AN
13SEP03	(1550) Assumed care of pt @ 0000 ∅ report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c̄ Neurontin. Pt turning self q2-3°. Pt emptied own colostomy bag. Rom done by pt. Drsg to sacral decub CDI. Pt tol reg diet well. Voiding s̄ difficulty. 1-point

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)*
19 Sep 03 0700	— Assumed care pt. A+O x3 c/o of pain to (L) stump scheduled nuerontin administered. Lungs CTA. HRRR. colostomy back intact stoma beefy red self care Active BS. Urinat. QS per urinal. Breakdown to sacrum dressing changed. Activity OOB to chair this am. Will cont to monitor (b)(6)-2 [redacted] 9 Sep 03
2000	Pt C/O, X3, ∅ c/o pain @ this time. conversating un arabic. LCTAB, HRRR, (+) BS x4, colostomy bag intact, stoma beefy + red. ostoma care done by pt. sacral drsg Δ'd. (L) stump Rom being done by pt. (R) foot care done. neurontin + ulevail cont for pain control. 1 pt restraint on, (+) circulation ~~to extr~~ BE. Will monitor (b)(6)-2 [redacted] 9 Sep 03
20 Sep 03 0100	0100 - I concur c above assessment. [redacted]
20 Sep 03 0700	- Assumed care of pt. VSS A+O x3. ∅ c/o pain or discomfort @ this time Q 2 h position change to facilitate in prevention of skin breakdown. Ostomy care self c̄ assistance. stoma beefy red vascular. Lungs clear HRRR Active BS. Urinate per urinal qs. Breakdown to sacrum dressing Δ'd Will cont to monitor (b)(6)-2 [redacted] 20 Sep 03
	(1600) I concur c̄ above assessment. Pt OOB to chair

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

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

[redacted] (b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

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

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp): [redacted] (b)(2)-2

LOG NUMBER:

ARRIVAL — DATE: DAY 12, MONTH July, YR. 03 — TIME: 1054

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☐ OTHER (Specify) Bird

CURRENT MEDS. (tetanus immunization and other data):

HISTORY OBTAINED FROM: ☐ PATIENT ☒ OTHER (Specify) unstable

ALLERGIES:

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): Multi GSW POX

SEX: M

AGE:

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: 1054

VITAL SIGNS			
TIME	1052	1135	
BP	145/87	140/81	
PULSE	90	98	
RESP.	14	14	
TEMP.	<94 (R)		
WT. (Child)		100% O2	

CATEGORY (See reverse)
- ☐ EMERGENT
- ☒ URGENT
- ☐ NON-URGENT

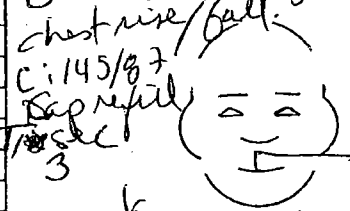
ORDERS	INITS.	TIME
Trauma: C spine	Cat	
GSB: pelvis		
(b) knee, (R) ankle		
Labs: CBC, Chem 10, PT/PTT/Plate		
ABG UA		
T&C 4 uPRBC's.		

ASSESSMENT/DIAGNOSIS: Multiple GSW

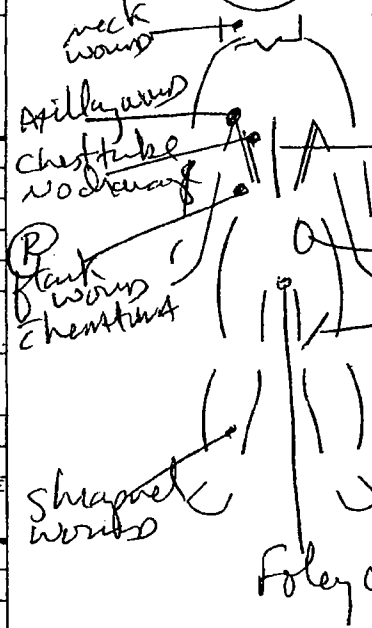
DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

Pt. GSW post op c̄ injuries below. HD stable. Gen Sx in Attendance.

1° survey
A: ETT
B: = B/L BS good chest rise/fall.
C: 145/87 Cap refill 3
D: GCS 3T
E: As below pulses palpable ext's.



2° survey
Eyes: PERRL
Pharynx: ETT & oral AW.
Heart RRS @
Lungs CTA B/L c̄ bagging.
Abd: distended ↓ BS
Back NO injuries noted
Ext: as on drawing:



A&P: multiple GSW

Plan: GS to admit OR - explore Zone II neck injury & other repairs as needed

ED course:
Pt. remains ETT & HD stable while in ED; IVF 125cc/hr
4u FFP; cover pt; blankets; warm air.

Foley clear yellow urine.

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: GS.

CONDITION UPON RELEASE
- ☐ IMPROVED ☒ UNCHANGED
- ☐ DETERIORATED

TIME OF RELEASE:

(b)(6)-2

[redacted] (DSF 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).

[redacted]

(b)(6)-4

SIGNATURE [redacted] ID STAMP

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans)
Neck tray no fx's (+) shrapnel based of neck wound area
CXR: ETT in mid trachea; NO PTX; HTX.
Pelvis: (+) shrapnel (R) flank.
GS Aware of trays.

TREATMENT

MEDCOM - 14271

Medical Record Copy

STANDARD FORM 558 (Rev. 6-82)
Prescribed by GSA and ICMR

510-112

NSN 7540-00-634-4123

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
26Jul03	0700		Received report. mild assess-
			ment on TU-1 Groinshea-
	0730		pt remains sedated c [redacted]
			130's-140's @ periods, RR (b)(6)-2
			30's-40's, SpO2 98-99.
			Received Dr. [redacted]
	0815		Dr. Yes @ bedside update (b)(6)-2
			given. orders received [redacted]
	0900		Dr Samu @ bedside, orders
			received. pt remains c [redacted]
	0930		Tylenol 2mg po given per NGT
			DRSG d'ed. on @ stump. area
			appears healing c sutures in-
			tact, marginal drainage
			noted. midline abd drsg
			d'ed. retained staple. sutures (b)(6)-2
			intact. wet to dry applied [redacted]
	0900		20mg lasix given IVP [redacted]
	1000		Respiration c assistance. VSS
			5mg MSO4 given IVP (b)(6)-2 [redacted]
	1130		54 Run given @ 50cc/hr pt
	1400		VSS. Respiration c assistance
	1540		Colostomy bag d'ed. stoma
			cleansed [redacted]

(Continue on reverse side)

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

REGISTER NO. [redacted]

[redacted]

26Jul03

(b)(6)-4

NURSING NOTES (b)(6)-2

Medical Record

MEDCOM - 14272

STANDARD FORM 510 (REV. 7-91)
Prescribed by GSA/ICMR. FIRMR (41 CFR) 201-9.202-1

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
[illegible]	1600		Update given on pt's [illegible]

*U.S. Government Printing Office: 1995 - 404-763/20065

STANDARD FORM 510 (REV. 7-91) BACK

(b)(6)-4

[redacted]

510-112 NSN 7540-00-634-4123

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
27/4/03	0500	Report received. See Flowsheet for initial assessment. Deep SX using 14F cath, copious amount of thick white secretions noted. (b)(6)-2 [redacted]
	0745	DR Samu @ bedside. Pt. dpsg A'ed, orders received labs reviewed (b)(6)-2 [redacted]
	0815	RT @ bedside neb tx given CPT done (b)(6)-2 [redacted]
	0930	Translator @ bedside. Pt will not respond to any question, remains in a six stare. Opening eyes. unable to cough secretion. deep SX to remain secretions (b)(6)-2 [redacted]
	1130	Deep SX c̄ results of thick white secretions. (b)(6)-2 [redacted]
	1210	Neb treatment given followed CPT by RT (b)(6)-2 [redacted]
	1340	Sponge bath given. colostomy bag Rec'd (b)(6)-2 [redacted]
	1600	ABG obtain. Reviewed by DR Young / DR Samu (b)(6)-2 [redacted]

(Continue on reverse side)

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

[redacted]

REGISTER NO.

NO. [redacted]

(b)(6)-2

27/4/03

(b)(6)-4

NURSING NOTES

Medical Record

MEDCOM - 14274

STANDARD FORM 510 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
2/6/03	1700		Report given. [redacted] (b)(6)-2

*U.S. Government Printing Office: 1995 - 404-763/20065

STANDARD FORM 510 (REV. 7-91) BACK

510-112 NSN 7540-00-634-4123

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
7/28/03	0500		Assumed care. Report given. pt awake follows ∅ commands. RR unlabored. labored currently on 2L/min via NC. mucous membrane dry 2/5 (B) Lungs c̄ (b) (B) bases ∅ productive cough. S ES, murmur noted. S sinus rhythm HR 130-150's @ periods. ABD soft NT/NT c̄ ∅ BS x4. colostomy c̄ loose brown stool, midline ABD drsg ∅ ET. (B) underarm c̄ drsg ∅ ET. F/C ∅ BSO patent c̄ foley. UOP noted c̄ sediment present. (R) leg BKA c̄ ace wrapped ∅ ET (B) leg c̄ staples intact c̄ weeping of yellowish drainage of moderate amount. Lower extremities. NP drain ∅ c̄ drsg ∅ ET. (B) CCXG c̄ some difficulty in flex joints. (D) F/C c̄ PT patent. Skin warm [redacted]
	0600		Med Tx given down c̄ [redacted] (b)(6)-7
	0700		[redacted] @ bedside c̄ drsg ∅ c̄ ed [redacted]

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give [redacted] last, first, middle, grade; rank; rate; hospital or medical facility)

(b)(6)-2

REGISTER NO. | WARD NO.

[redacted] (b)(6)-4

NURSING NOTES
Medical Record

MEDCOM - 14276

STANDARD FORM 510 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

[redacted]

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
28/Jul/03	0730		Placed on stretcher for CXR PRN seizure. Doxepin placed by Dr. Jess in Onset. Onset not called. [redacted]
	0800		PCXR taken. Pt back to unit placed in his bed. [redacted]
	0810		X-ray verified Dr Young for Doxepin placed. [redacted]
	0830		Doxepin verified again by Dr Samu. orders received to start IV @ 100cc/hr. @ stomp. Ted by Dr Samu. orders to received to give NS 500cc bolus sips of H2O given. Intended well. [redacted]
	0930		Staples removed from R/leg area cleansed. [redacted]
	1040		Sips H2O given. NS @ 100cc/hr. Symptoms stable. NB140/5. Pt 30 SpO2 95% on RA. [redacted]
	1230		VSS. Pt distress noted @ this time. [redacted]
	1330		Drsg Ted and pt c/o seizure. Seizures intact. [redacted]
	1450		500 NS bolus given. [redacted]
	1520		Bolus complete resume NS 100cc/hr.
	1600		2mg Ativan IVP given. [redacted]

*U.S. Government Printing Office: 1995 - 404-763/20065

STANDARD FORM [redacted]

(b)(6)-2

510-112

MEDICAL RECORD

NSN 7540-00-634-

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
29 JUL 03	0909		Neurosurgery Procedure
			LP performed at L2-3.
			Opening pressure 20 cm H_2O.
			5 cc CSF sent for routine studies.
			Closing pressure 12 cm H_2O.
			No complications.
			[redacted] (b)(6)-2
	1400		no change in status, antiemetics ~ HR > 130; SAP >95% a 3L 36% VM. [redacted]
30 JUL 03			Neurosurgery (b)(6)-2
0625			S/O Afebrile.
			Flanks dry.
			LP negative yesterday.
			WBC 18. Na 132.
			A/P (1) Paraplegia / unstable L-spine - log roll.
			(2) CSF Leak - resolved.
			(3) FUO - improved on current antibiotics.
			[redacted] (b)(6)-2

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

(Continue on reverse side)

REGISTER NO.	WARD NO.

NURSING NOTES
Medical Record

STANDARD FORM 510 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
30 July 03			0800 Surgery
			T 101.2 → 99.6 VSS HR 107 sinus % 80-120 bmp
			Uteric, halos i eyes RRR
			lungs clear / symm Abd soft NT
			cool, dry. 19 > 31 153/ 132 / 101 / 15 / 4.4 / 4 / 1 / 132
			CSF ⊖ gm stain
			Pg mental status clearing, fevers resolving as is WBC.
			malnourished bilateral pleural effusions - improving pneumonitis improving
			Plan Cont Supportive care / abx / PT
			No "mind altering" meds
			Placement / rehabilitation. [redacted] (b)(6)-2
31 JUL 03	0641		Neurosurgery
			(8) VSSA.
			more alert.
			WBC 13.5 Na 132.
			Flanks dry.
			Plegia persists
			(MP) Stable clinically s̄ GSW L-spine.
			Will perform surveillance L-spine x-rays today.
			Continue spine precautions.
			[redacted] (b)(6)-2

510-112

NSN 7540-00-634-4123

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
7/30/03	0400		Assumed care. Report given. pt AA. Speaks NS c̄ eyes. Alert & unoriented. 2S @ bedside on FM @ 84/min c̄ SpO2 @ 99-100% S/E S3 Auscultated c̄ S-Tach. NSR/Sinus on monitor. BP 106-110s @ periods of ectopy beats noted. ABD soft NB/NT c̄ colostomy noted c̄ liquid brown stool noted. midline ABD dressing intact. F/C to BSO patent c̄ yellow urine noted. @ AKA c̄ dressing intact. X2 PIV @ RRM patent. Flush noted.
	0600		VSS. Afebrile. Neb tx given.
	0700		DR Jess @ bedside. update given regarding c̄ current labs
	0800		AB dressing d̄ ecl. wound noted. ∅ drainage or odor
	1140		DR Samir @ bedside. @ report given. Ped ∅ new orders received. sips of H2O given
	1300		Reposition, sips of H2O given
	1530		H2O given. Ambulated with

(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 N

(b)(6)-2

(b)(6)-4

NURSING NOTES
Medical Record

STANDARD FORM 510 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
1650 / 7/30/03			Colostomy bag A'ch. Stoma cleansed & surrounding AREA — [redacted]
7/30/03	1710		Report given. — (b)(6)-2 [redacted]
30 July 03	1718		Assumed care of pt. VSS. TF of Jevity @ 80cc/hr HOB elevated to 40°. Assessment done see ICU flow sheet for Assessment. Chelsea
30 July 03	2200		Assessment unchanged. VSS. will continue to monitor. [redacted] CPT/AN
31 July 03	0300		Assessment unchanged from earlier. VSS will continue to monitor. Chelsea CPT/AN
	0900		Labs drawn and sent to Lab - Dsg Δ's done. top sheet Δ'd pt sweating profusely temp 99.6. will continued to monitor.
	(b)(6)-2		[redacted] CPT/AN
01 AUG 03			Neurosurgery
0640			(8) VSA.
			Flaks dry.
			Paraplegia persists
			(4) Penetrating L-Spine injuries.
			Continue Log roll.
			Surveillance lumbar x-rays Fridays
			[redacted]
			(b)(6)-2 [redacted]

510-112 NSN 7540-00-634-4123

MEDICAL RECORD — NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS (Include medication and treatment when indicated)
7/31/03	0500		Assumed care. Report given. See TCP & flowsheet for initial assessment. [redacted]
	0540		Sips of H2O given, tolerated well. [redacted]
	0635		Dr Tess @ bedside, update given of new orders received. [redacted]
	0850		Dr Samu @ bedside, family translator, pt knows name, age, update given to pt about prognosis, pt seems confused @ periods. [redacted]
	090		Orders received per Dr [redacted]
	1130		PT @ bedside. ROM exercises done, encouraged to solve neck from side to side, pt unable head to ⓑ, very difficult. [redacted] (b)(6)-2
	1350		Bath given, hair washed, lunch fed. [redacted]
	1500		Late entry: Pt 30% of dinner meal's difficulty. [redacted]
	1710		Report given to new shift. [redacted]

(Continue on reverse side)

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

[redacted]

(b)(6)-4

REGISTER NO.

WARD NO.

7/31/03

NURSING NOTES

Medical Record

MEDCOM - 14282

STANDARD FORM 510 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

510-112

NSN 7540-00-634-4123

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
8/2/03	0500		Assumed care. Report given. VSS. HR 112, SBP 103/67, RR 22 SpO2 99 on RA. See TCU Shuchea for initial assessment — [redacted]
	0515		H2O given. Suppository [redacted] pillow support. — (b)(6)-2 [redacted]
	0700		Update given to Dr [redacted] new orders — [redacted]
	0715		Dr [redacted] (b)(6)-2 @ bedside. update given on labs orders received — [redacted]
	0930		All orders rec'd by Dr [redacted] orders received — (b)(6)-2 [redacted]
	1200		Ate 50% of lunch meal [redacted] & assistance — [redacted]
	1330		Colostomy bag drain open clamped — [redacted]
	1400		Counselor @ bedside. [redacted] given on colostomy care — [redacted]
	1500		Ambulation c pillow support — [redacted]
	1700		Ate 75% of meal 3 [redacted] Feed self. — [redacted]

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

[redacted]

2 AUG 03

(b)(6)-4

MEDCOM - 14283

NURSING NOTES

Medical Record

STANDARD FORM 510 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR 201-9.202-1

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
3 Aug 03.			Surgery
0830:			Alert & VS, good no
			more alert, responsive
			anuric
			lungs - CTA/Sym 21.9 > 34 149
ASA 325 po	QD		NSR, Ø m 129 / 3.9 | 93 / 21 | 20 / .10 | 115
Ceftriaxone	1g / 12	#6	Ø BS, soft, flat
			edema Ank / Foot.
Tylenol.			leg w/o / Ø edema
Ensure TID.			wounds c/o ; abdo c̄ granulation
MSOY			Hx: High c-spine paraplegia c̄ unstable fx's
			Colostomy c̄ mucus fistula
			DKA
			deconditioned / malnourished.
			Plan: To ICW today
			needs PT / calories / placement.
			[redacted]
			(b)(6)-2

510–112

NSN 7540–00–634–4123

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
3Aug03/	1500		Assumed care. Report given
			RT ROOM 3. RR even et unlabored.
			L/S (B) coarse currently on RA
			c SpO2 @ 99%. ∅ SOB/distress
			noted. S1S2 auscultated c S...
			noted on monitor. ABD soft
			NT/ND c BS x4. Colostomy bag
			on with brown drainage. Stapled
			midline abd drsg intact. Stoma
			pink c area surrounding intact
			NG to LSC patent c yellow
			UOP noted. (R) BKA drsg C/D/I
			[illegible] [redacted]
			[illegible] well.
	0640		[illegible] @ bedside. [illegible] [redacted]
			given
	0730		ate 50% of breakfast c [redacted]
			difficulty. Fed self. [illegible] of
			ensure [illegible]
	0900		All drsg changed. Orders [redacted]
			written for transfer
	1135		[illegible] once again [redacted]
	1150		[illegible] [redacted]
	1200		[illegible]

(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. [redacted]

[redacted]

3 Aug 03

(b)(6)-4

MEDCOM - 14285

NURSING NOTES

Medical Record (b)(6)-2

STANDARD FORM 510 (REV. 7–91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201–9.202–1

06OCT2003

Discharge Summary, Patient #[redacted] (b)(6)-4

History: This enemy prisoner suffered gunshot wounds to the neck, right shoulder and chest, abdomen, lumbar spine, and left lower extremity on 13JUL2003. He had undergone surgery at a Forward Surgical Team, where they found a left retrocolic retroperitoneal hematoma and a through and through left colon injury with minimal spillage. A colostomy was performed and the abdomen closed prior to transport to the [redacted] (b)(2)-2

He arrived stable though paraplegic with penetrating injuries of the right neck, right axilla, and left leg. He was deemed a candidate for further surgery and was transported to the operating room for further wound management.

Hospital Course: In surgery he underwent exploration of the right neck, where a zone II exploration was performed and found no major injuries. The right axilla was debrided and packed. A left below knee amputation was performed for nonsalvageable injuries. A lumbar drain was placed for his cerebrospinal fluid durocutaneous fistula from his lumbar gunshot wounds.

He suffered a complicated postoperative course including pneumonia, transient mild liver failure, and multiple wound dressing changes. His lumbar fractures of L2, L3, L4, and L5 were treated with bed rest. He eventually came to left BKA revision and recovered nicely. His only ongoing problem at the time of discharge was a sacral decubitus ulcer, which was responding to pressure reduction therapy and dressing changes at the time of discharge.

Placement was delayed because a suitable prison institution was not available for paraplegic patients. Eventually he was placed at a minimal care facility to undergo prisoner processing.

Disposition: Though limiting, his ongoing paraplegia and incontinence were manageable for him. Routine foley catheter changes and colostomy management should be continued. He requires assistance to a wheel chair. He should be turned routinely to avoid further skin problems. Caretakers are asked to contact the [redacted] with any future problems.

(b)(2)-2

Discharge Medications:

Lovenox 40 mg SQ QD
Multivitamin 1 PO QD
Colace 100 mg PO BID
Neurontin 600 mg PO TID
Amitriptyline 75 mg PO QHS

(b)(6)-2
[redacted] MD
MA[redacted], USA
Ne[redacted]rgery [redacted] (b)(2)-2
Ba[redacted]
[redacted]@us.army.mil

ACUTE CARE WARD/RECOVERY ROOM
FLOW SHEET

ADMIT TIME	PROCEDURE	SURGEON	D/C TIME
0945	lap / Bowel Resection / colostomy	[redacted]	1120

7/13/03 1&D (L) Patellar i penrose

Allergies: Unknown

Anesthesia Type: (GEN) MAC REGIONAL (b)(6)-2

	ADMIT	AD+5	AD+10	AD+15	AD+30	AD +45	AD+60	DC
RESP	10	10	10	10				
SPO2	100	100	99	99				
PULSE	91	91	94	94				
BP	119/72	131/77	139/84	138/82				
TEMP		89.9						
	0945	5 0	55	100	1015	1030	1045	

(L) knee incisor o penrose

ASSESSMENT:

(R) Rock wound

(R) axillary out sequic

(L) colostomy i zerofm + Dressing

D=DRESSING

medline dressing

X= IV SITE

FLUID

(1) (2) (3)

LR NS

RATE

100 100

AMT. IN BAG

1000 900

02 ✓ LPM ecl

T= TUBE

Chest tube (R)

O=DRAINS

Penrose (L) knee

NG - (R) nare

(L) femoral cordis i introducer

MEDICATION	DOSE	TIME	ROUTE	OR/RR Total	INTAKE SOURCE	INTAKE AMT	OUTPUT SOURCE	OUTPUT AMT
Ancef	2gm	in OR		2gm				
Unasyn	3gm	in OR		3gm	Bld	4 units	foley	950
Sucpalin	0.4	in OR		0.4	NSS/LR(OR)	1500		
fentanyl	250mcg	in OR		250				
Demerol	100mg	in OR		100				
neosyn	14mg	in OR		14				
Norcuron	2mg	1012		16mg				

NAME [redacted] (b)(6)-4 frag. # [redacted]

SSN na

UNIT EPW

[redacted] MA)K

(b)(6)-2

#1 Pre op

i-STAT 6+

Pt: 000000000000

Pt Name: [redacted]

(b)(6)-4

Glu_____135 mg/dL

BUN_____7 mg/dL

Na_____148 mmol/L

_____3.9 mmol/L

_____104 mmol/L

Hct_____14 %PCV

Hb*_____5 g/dL

*via Hct

Sample Type_:

25JUL02 05:56

Oper: 0000000

Physician:_____

Ser# [redacted]

Ver: JAMS043C
CLEW A84

#2 Post op

i-STAT 6+

Pt: 000000000000

Pt Name: [redacted]

Glu_____

_____ mg/dL

Na_____148 mmol/L

_____ mmol/L

Cl_____105 mmol/L

Hct_____21 %PCV

Hb*_____7 g/dL

*via Hct

Sample Type_:

25JUL02 08:00

Oper: 0000000

Physician:_____

Ser# [redacted]

Ver: JAMS043C
CLEW A84

i-STAT EG7+

Pt: 000000000000

Pt Name:_____

Na_____143 mmol/L

K_____3.9 mmol/L

TCO2_____21 mmol/L

iCa_____1.16 mmol/L

Hct_____19 %PCV

Hb*_____6 g/dL

*via Hct

At 37C

pH_____7.151

PCO2_____56.1 mmHg

PO2_____44 mmHg

HCO3_____20 mmol/L

BEecf_____-9 mmol/L

sO2*_____65 %

*calculated

Sample Type_:

25JUL02 08:07

Oper: 0000000

Physician:_____

Ser# [redacted]

Ver: JAMS043C

NOTES

Post-Anesthesia Recovery Score

Criteria	ADM	30 Min	DC
2 Moves all extremities on command			
1 Moves 2 extremities on command	0		
0 Moves 0 extremities on command			
2 Cough, Deep breathe			
1 Dyspnea, limited breathing	2/vent		
0 Apnea			
2 SBP± 20mm Pre Op			
1 SBP±20-50mm Pre-Op			
0 SBP±50mm Pre-Op			
2 Fully Awake			
1 Arousable on call	0/meds		
0 Not Responsive to verbal stimuli			
2 Normal Skin Color and appearance			
1 Pale, dusky, blotchy or jaundice	1/3		
0 Cyanotic			

Discharge: BP HR RR SaO2

Signature and Title : _____

07/24/03 (b)(6)-4 [redacted] (b)(6)-2

PATIENT ASSESSMENT

TIME: 0500 SIGNATURE [redacted]

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature

Color: Pale / Cyanotic / Jaundiced

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils:

Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radials Pedals

Capillary Refill: Seconds Homan's Sign

Jugular Venous Distension Edema

Heart Sounds:

Rhythm PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site				
Solution				
Chest Pain				

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

Respiration / No Distress / SOB / Labored / Use of Access Muscles

Breathing Patterns:

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor

Chest Drainage System Gravity: Suction cm:

Air Leak — No — Yes — Crepitus

Character of Drainage:

Trachea / Midline / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings:

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate

Stool: Character

Drains:

GENITOURINARY

Urine Color: Character:

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER

PATIENT ASSESSMENT (b)(6)-2

TIME: 1700 SIGNATURE [redacted]

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature warm; dry → 99.8

Color: Pale / Cyanotic / Jaundiced

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils: 5mm b. (ut equal & bris

Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): 2 Radials 2 Pedals (R) 1

Capillary Refill: <3 Seconds <3 Homan's Sign

Jugular Venous Distension Edema

Heart Sounds S1 S2

Rhythm sinus tach PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site				
Solution				
Chest Pain				

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

Respiration / No Distress / SOB / Labored / Use of Access Muscles

Breathing Patterns: normal

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor

Chest Drainage System Gravity: Suction cm:

Air Leak No Yes Crepitus

Character of Drainage:

Trachea / Midline / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes	coarse	
Diminished	bilat	
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings: C, P, I

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: 80 Aspirate

Stool: Character colostomy

Drains: JP d/c'd (previous shift)

GENITOURINARY

Urine Color: Amber Character:

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

scheduled sedatives (Haldol)

[redacted] (b)(6)-2

27/Jul/03 (b)(6)-4

[redacted]

(b)(6)-2

PATIENT ASSESSMENT

TIME: 0510 SIGNATURE: [redacted]

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry
Skin: Temperature
Color: Pale / Cyanotic / Jaundiced
Mucous Membranes: Moist / Dry / Cracked
Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:
Orientated / Disoriented Pupils:
Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radials Pedals
Capillary Refill: Seconds Homan's Sign
Jugular Venous Distension Edema
Heart Sounds
Rhythm PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site				
Solution				
Chest Pain				

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical
Respiration / No Distress / SOB / Labored / Use of Access Muscles
Breathing Patterns:
Cough: Productive / Nonproductive / None
Sputum: Color / Amount / Consistency / Odor
Chest Drainage System Gravity: Suction cm:
Air Leak No Yes Crepitus
Character of Drainage:
Trachea / Midline / Deviated (R) / Deviated (L)
Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth
Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent
Dressings:
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage
NG Drainage: Color Character
Tube Feeding: Day No: Strength: Rate: Aspirate:
Stool: Character
Drains:

GENITOURINARY

Urine Color: Character:
Voiding: Continent / Incontinent / Catheter

[redacted]/PSYCHOSOCIAL

[redacted]

OTHER:

PATIENT ASSESSMENT

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry
Skin: Temperature
Color: Pale / Cyanotic / Jaundiced
Mucous Membranes: Moist / Dry / Cracked
Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:
Orientated / Disoriented Pupils:
Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radials Pedals
Capillary Refill: Seconds Homan's Sign
Jugular Venous Distension Edema
Heart Sounds
Rhythm PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral
Waveforms				
Site				
Solution				
Chest Pain				

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical
Respiration / No Distress / SOB / Labored / Use of Access Muscles
Breathing Patterns:
Cough: Productive / Nonproductive / None
Sputum: Color / Amount / Consistency / Odor
Chest Drainage System Gravity: Suction cm:
Air Leak No Yes Crepitus
Character of Drainage:
Trachea / Midline / Deviated (R) / Deviated (L)
Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth
Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent
Dressings:
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage
NG Drainage: Color Character
Tube Feeding: Day No: Strength: Rate: Aspirate:
Stool: Character
Drains:

GENITOURINARY

Urine Color: Character:
Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

POST-OP DAY

	16	17	18	19	20	21	22	23
V								
I		137					145	145
T		77					73	71
A	137	135					111	110
L	20	26					10	10
	99	99					99	100
	NL	NL					SWN	SWN
S	NL	NL					50	50
I								
G								
N								
S								

	16	17	18	19	20	21	22	23	8" T
I	150	150					150	150	
	055	011							
N	055	011							
1005								150	
T									
A									
C									
E									
	50	50/100			100			100/100	
J									
J									
	120/335								

ACUITY LEVEL CLASSIFICATION

RESPIRATORY	TIME	0600								
	MODE	SWN								
	F_IO_2	40								
	TV	800								
	RATE	10								
	PEEP	5								
ABG	A: pH									
	A: PCO_2									
	A: pO_2									
	B: HCO_3									
	B: SAT									
	G: BASE									

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

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

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

DATE | DE | PAGE 2 OF 4 | HOSPITAL DAY

VITAL SIGNS																		
TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial Line																		
BP Cuff															147	143	131	
Temperature															96	90	93	
Pulse															92.0	92.3		
Respiratory Rate															88 ~~112~~	73	77	
Mode															25	21	25	
fio2															SIMV	SIMV	SIMV	
															50%	50%	50%	

INTAKE																			
TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T	
Cal															125	125	125	375	
~~NS~~ Propofol														21.60	~~5~~	~~5~~	~~5~~	~~15~~	66
Bolus														NSE Blood prod. →	(1000)			1000	
PRBC																(750)		750	
															Blood prod				
TOTALS																		2.40	in

OUTPUT																			
URINE	HOUR / TOTAL																	600	
	30g																		
	SA																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS																		600	out

POST-OP DAY

	16	17	18	19	20	21	22	23	
V									
I	141	139	141	150	147	153	157	141	
T	89	90	88	84	85	88	83	85	
A	83	90	91	98	109	110	112	117	
L	15	12	10	10	10	10	10	10	
	100%	100	100	100	100	100	100	100	
	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	
S	40	40	40	40	40	40	40	40	
I									
G									
N				35.3	35.9	36.2	36.6	36.7	
S									

SpO2 Mode %

	16	17	18	19	20	21	22	23	8° T
	125	125	125	125					1000
	23.6	21.6	21.6	22.7	22.7	22.2	22.5	22.7	136.3
N	50						100		150
			700		500	200			1400
T				125	125	125	125	125	
A							2	2	4
C									
E									
	50	100	100	75	75	100	100	100	
	50		100	375	400	500	600	600	

OR/PAC ~~ASU~~ IVPB 3000 NS

Ent

21.4
3
64.8
1.3
22.7
5
113.5

113.5
64.8
178.3

ACUITY LEVEL CLASSIFICATION

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

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

		TIME									
ACTIVITIES DAILY LIVING		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

(BC), CT, ABG [illegible]

[redacted] (b)(6)-4 - 14 JL 03

DATE | DX | HOSPITAL DAY | PAGE 1 OF 3

VITALS	TIME	24	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15
	BP Arterial Line	149	139	134	146	126	145	140	140	135	122	122	135	127	129	130	120
	~~BP Cuff~~	90	84	80	86	85	90	84	90	84	84	82	93	88	88	81	87
	Temperature	37.2	37.4	37.4	37.1	37.1	36.9	36.8									
	Pulse	123	130	131	128	131	130	127	125	126	147	144	139	135	136	136	137
	Respiratory Rate	12	12	10	20	10	10	10	10	10	25	20	13	18		24	27
	SpO2	100	100	100	100	100	100	100	100	100	100	98	99	94	97	96	97
	MODE	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	NC	NC	NC	NC	NC	NC	NC
	F. O2	40%	40%	40%	40%	40	40	40	40	40	2L	2L	2L	4L	4L	4L	4L

INTAKE	TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	~~KDR~~ NC	125	125	125	125	125	125	125	125		125	125	150	150	150	150	150	150	
	PROPOFOL	22.7	22.7	22.7	22.7	22.7	22.7	22.7	22.7		off	off	off	off	off	off	off	off	
	FENT	4	4	4	4	Ø	Ø	10	10		10	20	20	10	5	5	off	off	
	BOLUS								500			500							
	IVPB							100											
	TOTALS																		

OUTPUT		HOUR / TOTAL	24	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15
	URINE		50 / 50	100 / 150	50 / 200	50 / 250	50 / 300	75 / 375	50 / 425	80	145	70	80	50	50	80	80	50
		IPW																
		SA																
	NG	OUTPUT																
		pH							25						75			
		Gross																
	EMESIS																	
	STOOL																	
	DRAINS	CT				140			160					205				
	TOTALS																	

EPCU [redacted]

(b)(6)-4

ABG, CBC, C7, UA, Urg - drawn

		00	01	02	03	
A-LINE		105	135	101	113	105
HR		59	58	60	62	60
HR		114	121	115	110	108
RR		10	10	10	10	10
SaO2		98	100	99	98	97
TEMP		371	372	373	372	370

		00	01	02	03	04	8° T
~~22~~	~~23~~						
NS		125	125	125	125	125	
MSO4		4	4	4	4	4	
Versed		3	2	2	2	2	
IVPB		50					
URINE		100	60	60	70	80	
LUMBAR		14	20	18	10	15	
NG						400	

VENTILATOR 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	TIME			
SUCTION				

24 HR I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
po			

NURSE'S SIGNATURE

[redacted]

(b)(6)-4

~~7 JUL~~

21 JUL 03

[redacted] (b)(6)-4

21 JUL 03 | 22 JUL 03

Date:_____ Bed#:_____

Patients Name:_____

	21	22	23	24	01	02	03	04	05											
Time	~~05~~	~~06~~	~~07~~	~~08~~	~~09~~	~~10~~	~~11~~	~~12~~	~~13~~	~~14~~	~~15~~	~~16~~	~~17~~	~~18~~	~~19~~	~~20~~	~~21~~	~~22~~	~~23~~	~~24~~
A-LINE	135	140	134	120	145	114	135	140	140											
BP	56	69	69	67	67	61	72	69	64											
TEMP	37.9	38.3	38.5	38.1	38.1	37.7	37.5	37.3	37.0											
HR	123	120	117	114	119	114	108	104	109											
RR	10	15	13	11	10	10	10	10	10											
SAO2	100	99	98	100	100	100	99	100	100											
FIO2	35%	35%	35%	35%	35%	35	35	35	35											
INPUT																				
~~PO~~ NS	125	125	125	125	125	125	125	125	125											
~~IV~~ D5W	4	4	5	5	4	4	4	4	4											
~~NGT~~ vomit	2	3	3	3	3	3	3	3	3											
IVPB																				
Feeds	10	10	10	off	off	off	off	off	off											
~~Ft~~																				
TOTAL																				
OUTPUT																				
URINE	140	150	150	170	140	110	90	130	170											
NGT																				
STOOL																				
LUMBAR	20	5	18	30	10	90	20	15	15											
residual	5			10																
TOTAL																				
BALANCE																				
TURN Q 2																				

~~21 JUL 03~~

Date: 25 Jul 03 Bed#: 8

Patients Name: EPW [redacted] (b)(6)-4

ne	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
BP							120/73	135/71	138/73	150/75	132/63	135/69	126/63	132/60	121/63	122/62	127/51	126/62	126/63	127/63
TEMP										100.4								100.6		
HR							124	125	125	128	128	128	131	133	131	120	128	123	125	121
RR							29	20	32	33	30	33	34	34	30	30	29	31	34	30
SaO2							96	96	96	98	97	98	97	98	99	99	97	98	98	98
FO2							RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA
INPUT																				
PO																				
IV							~~125~~													
NGT							60	60	60	60	60	60	60	60	100	60	60	60	60	60
NaCl 3%							30	30	30	30	30	20	20	20	20	20	20	20	20	20
NS							125	125	125	125	125	125	125	125	125	125	125	125	125	125
														90						
TOTAL																				
OUTPUT							~~200/200~~	~~150/350~~												
URINE							200/200	150/350	275/625	120/745	160/905	120/1025	170/1195	150/1315	200/1515	160/1675	160/1835	60/1895	120/2015	100/2115
NGT																				
STOOL/60/0																				
LP							23/23	21/44	19/63	17/80	15/95	23/118	15/133	7/140	14/154	15/169	15/184	15/199	24/223	7/230
JP													30							
TOTAL																				
BALANCE																				
RN Q 2																				

26 Jul 03 [redacted]

(b)(6)-4

Date: 26 Jul 03 Bed#: _____

Patients Name: CPW # [redacted]

(b)(6)-4

	00	2	4	6	8	10	12	14	16	18	20	22
ne												
MP												
O2												
O2												
PUT												
TF												
3%NS												
T NS												
TAL												
TPUT												
URINE												
NGT												
STOOL												
TAL												
LANCE												
RN Q 2												

	09	11	13	15	17	19	21	23
ne								
MP								
O2								
O2								
PUT								
TF								
3%NS								
T NS								
TAL								
TPUT								
URINE								
NGT								
STOOL								
TAL								
LANCE								
RN Q 2								

	18	20	22	24
ne				
MP				
O2				
O2				
PUT				
TF				
3%NS				
T NS				
TAL				
TPUT				
URINE				
NGT				
STOOL				
TAL				
LANCE				
RN Q 2				

Residuals

MEDCOM - 14299

[redacted] (b)(6)-4

Date: 2/24/03 Bed#: #8

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

ne	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
BP	136/79	134/79	133/79	134/80	134/78	134/81	133/80	132/80	134/80	144/81	138/79	130/80	134/79	139/79	135/77	134/79	133/77	132/81	134/80	
TMP	99							99.3												
Pulse	109	110	113	106	114	114	113	112	121	130	126	131	130	134	135	144	137	115	139	
RR	23	35	33	35	33	40	33	35						44	42	47	45	43	48	
PO2	94	89																		
SPO2	99	91	100	100	97	98	99	99	97	95	96	96	96	93	98	95	93	96	97	
															2LNC	2LNC	2LNC	2L	2L	
OUT IVF	125	125	125	125	off	off	off	off					500			10+1				
TUBE PO																				
ST IV	80	80	80	80	80	80	80	80	80	80	80	80	80	off	off	off	off	off		
K+ Run					50	50	50	50					300							
TOTAL																				
ITPUT																				
LINE	78	80	90	125	65	100	150	165	125	150	200	185	125	120	120	90	110	90	120	70
ST	10	12	20	20									20							35
0/05 TOTAL																				
TAL																				
LANCE																				
RN Q 2																				

MEDCOM - 14300

27 JUL 03

Date: 27 JUL 03 Bed#:

Patients Name: [redacted]

	01 (05)	02 (06)	03 (07)	04 (08)	05 (09)	06 (10)	07 (11)	08 (12)	09 (13)	10 (14)	11 (15)	12 (16)	13 (17)	14 (18)	15 (19)	16 (20)	17 (21)	18 (22)	19 (23)	20 (24)
ne																				
	139	132	136	140																
	77	76	79	82																
MP		99.2																		
	119	121	111	109																
	32	35	31	27																
.O2	100	97	100	100																
)2	RA	RA	RA	RA																
PUT																				
TF	80	80	80	80	80															
NS	125	125	125	125	125															
T																				
TAL																				
TPUT	100	160	160	110	170															
URINE																				
T																				
STOOL																				
	20	28	22	20	20															
Residuals		0																		
TAL																				
LANCE																				
RN Q 2																				

MEDCOM - 14301

(b)(6)-4 [redacted] 28 6/11/03

7/28

	144	140	143	140	146	149	145	137	143	133	132	118			116	132	118	118	110	114	118	116	94	108												
	132	130	126	126	124	123	122	122	121	118	118	119			146	150	149	148	146	144																
	87	86	84	86	82	87	88	86	82	78	78	79							142	143	143	155	162	159												
	45	28	40	27	43	46	41	36	39	43	39	41			40	40	41	39	45	43	43	38	42	43	46	50										
	100	96	98	97	97	97	97	95	96	96	95	96			95	95	96	97	98	94	94	95	93	94	92	93										
Oxy Source	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L			2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L										

Intake	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
IVS										100	100	100	300	100	100	100	100	100	100	100	100	100	100	100	100	1200
									Bolus	500			500				500									500
																	Bolus									
5% Dex																	50	50		100	100	100		250	150	800
NaCl Run																	50	50		100						200
Medications									10	10	10	10	40	10	10	10	10	10	20	20	20	20	20	20	20	190
O.R. IN																										
Totals													840													1890

Output	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
Urine Hourly	80	80	100	200	50	50	40	90	45	60	80	100	1500	75	60	80	100	170	90	60	20	170	120	130	40	1155
NG Tube	1000	160	260	330	350	350	990	1080	175						135	215	315	420	815	575	645	815	925	925	185	
Drains #1																										
#2																										
#3																										
Emesis																										
Stool																	1000									1000
O.R. OUT																										
Totals													1505													2155

MEDCOM - 14302

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

24 Jul 03

Temp							101.2						100.4				100.9	101.1				100.9
HR	137	137 138	136	131	131	130 126	12T	12T	128		118	123	121	128	128	128	126 131	123	125	125	124	
BP	115/66	117/69 117/68	113/62	115/70	125/72	127/72 132/80	129/77	105/60	120/66		118/66	123/71	121/71	125/70	124/69	124/69	126/72 125/71	123/71	124/71	125/72	127/74	
Resp	42	42 50	40	44	38	35 38	36	34	39		32	33	42	46	49	48 49	44 38	40	46	35		
SpO_2	97	96 98	94	96	98	97 98	92	93	97		97	97	96	94	96	96 95	91 98	100	98	100		
FiO_2	30%	30% 30%	30%	30%	30%	28% 28%	30%	35%	26%		26%	26	26%	26%	26%	24% 24%	24%	10L FM	10L FM	10L FM	10L FM	

Nurse [redacted]

(b)(6)-2

Intake	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23
NS	100	100	100	100	100	100	100	100	100	100	100	100	1200	100	100	100	100	100	100	100	100	100	100	100	100
TF								60	60	60	60 100	60	500 100	80 250	80	80	80	80	80	80	80	80	80	80	80
PO Intake (TF)	20	20	20	20	40	40	40																		
Total													1800												

Output	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23
Urine Hourly	85	85 170	80 250	50 300	80 380	30 410	40 475	75 550	100 650	100 750	100 850	100 950	950	100 1020	230 1250	175 1425	75 1500	120 1620		150	110	120	110	100	120
NG Tube																									
Drains #1																									
Res #2																									
#3																				50				20	
Emesis																									
Stool								500					500												
O.R. OUT																									
Totals													1450												

24 hour input

24 hour output

MEDCOM - 14303

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

80
160
760
800

Vital Signs	24	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23
Temperature			100				99.6						99.8						99.6				98.5	
Pulse	114	114	115	110	111	112	110	133	110	104	106	108	112	110	106	108	110	112	115	117	117	115	118	114
B/P A-Line	125	125	131	124	131	130	133	131	134	134	133	134	134	146	133	161	132	134	123	124	118	120	124	124
B/P Cuff	72	73	74	80	83	80	82		80	88	82	84					78	79	77	78	75	77	80	77
Respirations	31	31	31	28	36	29	28	31	28	28	30	29	28	21	34	28	26	27	31	33	28	29	26	29
Sp O2	100	100	100	100	98	100	100	100	100	98	98	99	100	100	100	100	100	100	98%	99	99	100	98	99
Mode							84																	

Intake	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
IVF	100	100	100	100	100	100	100	100	100	100	100	100	1200	100	100	100	100	100	100	100	100	100	100	100	100	1200
	80	80	80	80	80	80	80	80	80	80	80	80	960	80	80	80	80	80	80	80	80	80	80	80	80	960
Abx									250	50			300										350			350
PO intake									2 sips					50	30	40	60	5 sips	5 sips							
O.R. IN																										
Totals													2460													2660

Output	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
Urine Hourly	120	10	0	10	0	140	80	180	250	120	80	110	125	1485	100	170	200	250	150	150	180	160	90	130	130	2025
NG Tube																350	550	780	930	1080	1260	1420	1610	1760	1890	
Drains #1																										
#2																										
#3																										
Emesis																										
Stool																										
O.R. OUT																										
Tot. In																										

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																		
BP Cuff																		
Temperature																		
Pulse																		
Respiratory Rate																		

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																	
	Sp gr																	
	S/A																	
NG	OUTPUT																	
	pH																	
	Guiac																	
EMESIS																		
STOOL																		
DRAINS																		
TOTALS																		

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23	

	16	17	18	19	20	21	22	23	8°T

ACUITY LEVEL CLASSIFICATION

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

	TIME				
TURN					
SUCTION					

24° I&O TOTALS

wt Yesterday ______ wt Today ______

INTAKE / OUTPUT

IV ______ Urine: ______

po ______ ______

TOTAL ______ TOTAL ______

BALANCE ______

NURSE'S SIGNATURE	INITIALS

NEUROLOGICAL ASSESSMENT

COMA SCALE		HOURS	LEGEND
EYES OPEN	SPONTANEOUSLY 4		C Closed by swelling
	TO SPEECH 3		
	TO PAIN 2		
	NO EYE OPENING 1		
BEST VERBAL RESPONSE	ORIENTED 5		T Trach/Endo
	CONFUSED 4		S Slurring
	VERBALIZES 3		D Dysphasia
	VOCALIZES 2		R Receptive
	NO VOCALIZATION 1		E Expressive
BEST MOTOR RESPONSE	OBEYS COMMANDS 6		
	LOCALIZES PAIN 5		
	FLEXION WITHDRAWAL 4		
	ABNORMAL FLEXION 3		
	EXTENSION TO PAIN 2		
	NO MOTOR RESPONSE 1		
LIMB MOVEMENT — ARMS	NORMAL POWER		R Right
	MILD WEAKNESS		L Left
	SEVERE WEAKNESS		Record separately if there is a difference between the two sides.
	ABNORMAL FLEXION		
	ABNORMAL EXTENSION		
	NO RESPONSE		
LEGS	NORMAL POWER		
	MILD WEAKNESS		
	SEVERE WEAKNESS		
	ABNORMAL FLEXION		
	ABNORMAL EXTENSION		
	NO RESPONSE		
PUPILS — RIGHT	SIZE		+ + Brisk
	REACTION		+ Slow
PUPILS — LEFT	SIZE		- No Response
	REACTION		
PUPIL SCALE		● 2 ● 3 ● 4 ● 5 ● 6 ● 7 mm	
ICP			+ Intact
CEREBRAL PERFUSION PRESSURE			- Abnormal

VASCULAR ASSESSMENT

HOURS			LEGEND
	R L		+ + Normal
	R L		+ Weak
	R L		- Absent
	R L		D Doppler
	R L		R Right
	R L		L Left

DX

HOSPITAL DAY

TIME	24	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17
Arterial Line	115	145	138	140	143	126												
Cuff	63	76	69	70	70	66												
Temperature	37'	35.7	35.8	34.8	35.8	35.3												
Pulse	117	124	107	106	115	112												
Respiratory Rate	8	9	8	8	11	8												
SAT	99	99	99	98	97	99												
FIO2	35	35	35	35	35	35												
MODE	vent	vent	vent	vent	vent	vent												

Surgery

TIME																		
1150 NS	150	150	150	150	150	150												
32 Versed	4	4	4	4	4	4												
64 MSO4	4	4	4	4	4	4												
100 Sodium	20	20	20	20	20	20												
600 IVPB	100	100																
163 Lumbar	14	20	26	12	27	16												

OTALS

URINE HOUR																		
URINE TOTAL	270	490	610	840	990	1170												
NG SG																		
NG S/A																		
NG OUTPUT																		
NG pH																		
NG GUIAC																		
EMESIS																		
STOOL	0/0570	0	0															
DRAINS																		
OTALS																		

[redacted] (b)(6)-4

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD Extubated 1905

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	1800	1900	2000	2100	2200	2300	2400	0100	0200	0300	0400	0500	0600	0700	0800	0900	1000
B/P	148/77	170/89	130/71	147/68	149/78	134/65	157/85	133/55	135/60	132/61	118/64	130/69	128/66	124/64	127/68	127/73	131/66
HR	143	147	129	122	130	135	131	130	131	132	120	118	126	116	117	126	126
RR	24	25	20	24	25	30	26	21	21	25	21	21	23	24	31	25	27
Temp	37.1	36.7	37.4			99.2			101.5		99.3					99.6	
SAT	97	98	100	100	100	99	99	100	99	98	99	99	98	100	100	97	98
O2	35%	35%	45%	3L	2L	2L	2L	2L	2L	2L	2L	2L	1L	1L	1L		
MODE	vent	vent	Fm ~~vent~~	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	RA	RA
Na Cl 3%	30	30	30	30	30	30	30	30	30	30	30	30	30	Ø	30	30	30
IUPB	250	100					50							100	200		
Jevity			30	40	40	40	40	40	40	40	40	40	40	40	40	60	60
NS					125	125	125	125	125	125	125	125	125	125	125	125	125
Residuales					Ø				Ø			Ø			Ø		
Foley	90/90	110/200	140/340	140/480	130/690	100/850	220/1070	130/1200	180/1380	180/1560	175/1635	125/1760	180/1940	200/2140	210/2350	200/2550	125/3475
JP		20/20				20/40					10/50						
Lumbar	25/25	25/50	10/60		10/70		30/110	30/130	44/174	24/198	19/217		10/227	15/242	19/261	21/282	27/309
Colostomy	Ø			Ø			Ø			Ø	Changed out						

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.

EPW [redacted]
(5)(6)-4

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

(b)(6)-4

[redacted] Vital Sigs

NURSING SERVICE PERSONNEL TIME SCHEDULE

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

DATES (Inclusive) OF PERIOD COVERED

(b)(6)-4

TITLE	LAST NAME	DUTY	DUTY TIME, CLASS TIME, OR OFF-DUTY STATUS						
			~~SUN.~~	~~MON.~~	~~TUE.~~	~~WED.~~	~~THURS.~~	~~FRI.~~	~~SAT.~~
# [redacted]	1st PRBC's	4824487							
			HR	Temp	SPO2	BP	Flow		
1005	" "		128	38.7	98	155/97	5L		
1010	" "	" "	126	38.7	98	155/75	5L		
1020	" "	" "	124	38.8	99	155/73	5L		
Transfusion completed in OR									

[redacted]

(b)(6)-2

SIGNATURE OF HEAD NURSE

WARD

INSTRUCTIONS

List professional personnel first and then nonprofessional.

In column under "title" enter title, e.g., Maj., Capt., Lt., Sgt., Pvt., Mr., Mrs., Miss.

Entries for "Duty" and for "Off-Duty Status" will be symbolized as follows:

"Duty" symbols

- **HN** - Head nurse
- **ASST. HN** - Asst. head nurse
- **GEN. DUTY** - General duty
- **CL. T** - Clinical technician
- **WM** - Ward master

"Off-Duty Status" symbols

- **DO** - Day Off
- **LV** - Leave
- **SK** - Sick leave
- **HT** - Holiday time

DA FORM 3872, JUN 72 REPLACES DA FORM 8-93, 1 JAN 54, WHICH WILL BE USED. USAPPC V1.00

[redacted] (b)(6)-4

(b)(2)-2 (b)(6)-4

[redacted] **HOSPITAL VENTILATOR FLOW SHEET** [redacted]

DATE	TIME	MODE	RATE	VOLUME	FI02	PEEP	PIP	PT RATE (total)	HR	SO2	BP	Ph	Pco2	Po2	BE	HCO3	SaO2	REMARKS	INT
21 July	1240	Simv	10	800	35	5	22	12	117	97	119/68							Alb tx	[redacted]
21 July	1430	Simv	10	800	35	5	27	13	115	97	116/65								
21 July	1430	Simv	10	800	35	5	33	24	120	95	120/69							Alb tx	
21 Jul	1715	Simv	10	800	35	5	32	18	124	98	129/69								
21 Jul	2000	Simv	10	800	35	5	26	14	117	100	145/72							Alb tx	
21 Jul	2130	Simv	10	800	35	5	27	13	122	98	133/67								
22 Jul	0030	Simv	10	800	35	5	26	10	113	100	133/66							Alb tx	
22 Jul	0159	Simv	10	800	35	5	26	10	114	100	113/64								
22 Jul	0287	Simv	10	800	35	5	27	10	114	100	142/68	7.455	425	85	6	30	97	Alb tx Exp Wheeze	04:11 [redacted]
22 Jul	0641	Simv	10	800	35	5	26	10	103	100	131/64							Bs clear	
22 Jul	0756	Simv	10	800	35	5	28	10	103	99	140/70							Tx done by nurse	
22 Jul	1000	Simv	10	800	35	5	21	10	109	100	116/65								
22 Jul	1230	Simv	10	800	35	5	23	10	112	99	137/69								
22 July	1600	Simv	10	800	35	5	21	10	122	98	121/69							Tx given by nurse	
22 Jul	1725	Simv	10	800	35	5	24	10	124	97	124/72							Tx given by nurse	
22 Jul	2010	Simv	10	800	35	5	31	12	116	98	122/72							Alb tx	
22 Jul	2350	Simv	10	800	35	5	40	10	111	99	134/71							Alb tx, Sx	earthquake
23 Jul	0210	Simv	10	800	35	5	31	10	110	97	120/66								
23 Jul	0420	Simv	10	800	35	5	29	10	121	99	136/67	7.553	354	130	9	31	99%	Alb Tx, Sx	
23 Jul	0620	Simv	10	800	35	5	25	10	104	97	96/87								
23 Jul	0812	Simv	10	800	35	5	24	10	101	98	110/62							Alb tx, Sx	
23 Jul	1200	Simv	8	800	35	5	28	10	111	99	122/68							Alb tx	
23 Jul	1430	Simv	8	800	35	5	35	16	129	100	138/72								
23 July	1600	Simv	8	800	35	5	27	11	114	98	126/68							Alb tx	
23 July	1730	Simv	8	800	35	5	33	19	116	98	129/70								
23 Jul	1900	Simv	8	800	35	5	37	16	119	98	141/70							Alb tx	
23 Jul	2127	Simv	8	800	35	5	26	18	101	98	131/70								
23 Jul	2350	Simv	8	800	35	5	25	10	113	99	139/71							Alb tx	
24 Jul	0305	Simv	8	800	35	5	22	10	104	100	143/70								
24 Jul	0349	Simv	8	800	35	5	38	12	113	100	145/74							Alb tx	
24 Jul	0620	Simv	8	800	35	5	26	12	110	97	123/67								
24 Jul	0802	Simv	8	800	35	5	28	8	118	98	126/62								
24 July	1000	Simv	8	800	35	5	20	10	106	98	110/62								
24 July	1200	Simv	8	800	35	5	30	10	101	96	116/65								
24 Jul	1700	Simv	8	800	35	5	22	12	113	99	142/72								

24 Jul 1905 extubate pt placed on 12L PRB — neb tx [redacted]

(b)(6)-2

MEDCOM - 14311

(b)(2)-2

Pt # [redacted] (b)(6)-4
7.5cm ETT
23cm @ lip

[redacted] HOSPITAL VENTILATOR FLOW SHEET

DATE	TIME	MODE	RATE	VOLUME	FI02	PEEP	PIP	PT RATE	HR	SO2	BP	Ph	Pco2	Po2	BE	HCO3	SaO2	REMARKS	INT
18Jul	0627	Simv	12	800	45	8	32	6	121	100	135/64								[redacted]
18 Jul	0752	Simv	12	800	40	8	31	1	121	100	125/57								
18 July	0934	Simv	12	800	40	8	31	13	119	100	113/63							Alb tx	
18 July	1230	simv	12	800	40	8	40	12	114	100	93/48								
18 July	1425	simv	12	800	35	8	40	14	128	96	112/87							Alb tx	
18 July	1637	simv	12	800	35	8	40	12	125	99	111/61								
18 JUL	1830	simv	12	800	35	8	29	0	122	99	119/65							Alb tx	
18 JUL	1955	simv	12	800	35	8	29	0	114	100	131/70								
18 JUL	2145	simv	12	800	35	8	28	0	122	100	138/68							Alb tx	
19 JUL	0030	simv	12	800	35	8	29	0	124	100	137/63								
19 July	0150	simv	12	800	35	8	28	0	131	100	123/56							Alb tx	
19 Jul	0357	Simv	12	800	35	8	38	0	120	100	140/7	7.43	30.2	232	9	31	100%		
19 Jul	0411		40		30	8	28	0	123	100	102/55								
19 July	0540	Simv	10	800	30	8	28	0	123	100	102/55								
19 July	0743	Simv	10	800	35	8	29	0	115	100	134/72							Alb tx BBS coarse	
19 July	1000	Simv	10	800	100	8	34	14	116	99	142/70								
19 July	1200	Simv	10	800	35	5	26	10	121	100	107/61							Alb tx	
19 July	1500	Simv	10	800	35	5	27	13	125	97	130/58								
19 July	1610	Simv	10	800	35	5	38	10	131	99	133/64							Alb tx	
19 JUL	1820	Simv	10	800	35	5	21	10	133	99	98/54								
19 JUL	2000	Simv	10	800	35	5	24	11	126	94	84/48							Alb tx	
19 JUL	2222	Simv	10	800	35	5	20	12	122	100	126/64								
20 Jul	0157	Simv	10	800	35	5	25	2	112	99	97/54							BS Coarse	
20 Jul	0406	Simv	10	800	35	5	26	0	111	100	102/56							Alb tx	
20 JUL	0612	Simv	10	800	35	5	26	0	119	96	80/47								
20 JUL	1405	Simv	10	800	50	5	34	25	139	98	118/64								
20 Jul	1605	Simv	10	800	35	5	29	15	122	96	101/60							Alb tx	
20 JUL	1825	Simv	10	800	35	5	35	10	119	99	115/65								
20 JUL	2020	Simv	10	800	35	5	27	10	121	97	123/63							Alb tx	
20 JUL	2201	Simv	10	800	35	5	25	10	127	97	127/62								
20 JUL	2350	Simv	10	800	35	5	24	10	115	98	100/50							Alb tx	
21 Jul	0217	Simv	10	800	35	5	24	0	111	97	97/54								
21 Jul	0433	Simv	10	800	35	5	25	0	106	99	110/65							Alb tx	
21 July	0624	Simv	10	800	35	5	27	0	114	100	132/77								
21 July	0754	Simv	10	800	35	5	24	0	108	94	108/63							Alb tx / Suction	

Or - 0800

(b)(6)-2

MEDCOM - 14312

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

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

[redacted] RN (b)(6)-2 13 Jul 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
SKIN INTEGRITY: Bovie Pad Site: ☒ Clean and Dry ☐ Red ☐ N/A
DRESSING DRY & INTACT: (Y)(N)
BREATHING EASY: (Y)(N)
(b)(6)-2

12. PREOPERATIVE EVALUATION PREPARED BY
(Signature and Title) [redacted] RN
DATE: 13 Jul 03 TIME: 1200

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] RN
DATE: 13 Jul 03 TIME: 1306

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: UNK
HEIGHT:
WEIGHT:

2. KNOWN ALLERGIC SENSITIVITIES (e.g.. Iodine, Tape, Medication)
☒ NKDA ☐ PCN ☐ LATEX ☐ IODINE ☐ TAPE ☐ FOOD
REACTION: NKDA listed on chart - due to language barrier unable to ask pt

3. PREVIOUS SURGERY [ ] NO [✓] YES (type): See HOP

4. PROPOSED SURGICAL PROCEDURE: Closure of TKA

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) History unknown
Tobacco ___ ppd X ___ yrs. Body Piercing ___ Diabetes (Y) (N) Skin Condition ___ 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)~~ N 3) Surgical Outcomes	✓ Pt. verbalizes any specific anxiety. ✓ Pt. Exhibits relaxed body posture.	✓ Allow pt. to verbalize freely. ✓ Explain OR environment and answer questions regarding surgery. ✓ Offer comfort measures. (e.g.. warm blanket. touch). ✓ Explain all nursing procedures before they are done. ✓ Remain with pt. whenever possible. ✓ Maintain family interface. Parents to stay with pt.
B. AERATION ✓ Potential for respiratory dysfunction due to: 1) Positioning 2) Effects of Anesthesia 3) Medical/Smoking History	✓ Pt. will be able to breathe without difficulty during immediate intraoperative phase .	✓ Offer to elevate head of litter or offer pillow. ✓ Observe pt. while awaiting surgery for signs of distress. ✓ Assist anesthesia during intubation and extubation.
C. INTEGUMENT ✓ Potential impairment of skin integrity due to: 1) Intraoperative Immobility 2) ESU Pad Placement 3) Positional Aids 4) ~~Prosthesis~~ N 5) Pooling of Prep Solutions	✓ Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened areas).	✓ Utilize pressure preventing devices on OR table and accessories. ✓ Check for proper positioning and support to maintain good body alignment. ✓ Pad pressure points. ✓ Place ESU ground pad on non compromised skin surface area. ✓ Keep prep fluids from pooling.

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

VERIFICATIONS AT HOLDING AREA:
[redacted]/Allergy Band [redacted]entures Removed
[redacted]H & P [redacted]ntacts Removed
[redacted]PO Since [redacted]ewelry Removed
[redacted]HCG/LMP [redacted]ody Pierce Removed
[redacted]onsent/Blood Transfusion
[redacted]ned/Witnessed/Dated
[redacted]urgical Site/Consent verified by
[redacted]/Anesthesia/Surgeon
! Contact Precautions (Y) (N)
! Family/Friend: None

6. PATIENT PROBLEMS AND NEEDS	PATIENT GOALS AND EXPECTED OUTCOMES	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. (b)(6)-2 o ~~Place and take down legs from stirrups with slow bilateral motion.~~ o Check that rings and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL E.1. ____ Potential impairment of mobility due to: ____ 1) Pain ____ 2) Intraoperative Hazards ____ 3) Prosthesis ____ 4) Positioning ____ 5) Transfer pt. to/from OR table E.2. ____ Potential discomfort due to: ____ 1) Length of Surgery ____ 2) Positioning ____ 3) Arthritis	o Pt. will be transferred to OR table without difficulty. o Pt. will not experience unnecessary physical discomfort.	o Have sufficient people available for transfer. o Insure proper body alignment. o Allow patient to lie in position of comfort while waiting for surgery. o Offer support (i.e., pillows, bath towels, etc.) for positioning.
F. SPECIAL SENSES F.1. ____ Diminished visual perception due to being: ____ 1) Pre-Medicated ____ 2) W/O Glasses F.2. ____ Potential for decreased communication due to: ____ 1) Diminished Hearing ____ 2) Language Barrier F.3. ____ Potential injury due to dentures: ____ 1) Upper ____ 4) Caps ____ 2) Lower ____ 5) Crowns ____ 3) Bridges	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR table. o Pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt. from Side side. o Validate pt.'s understanding of verbal communication. o Verify removal of dentures.
G OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

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

_____ DATE

11. POSTOPERATIVE EVALUATION: SKIN INTEGRITY: Bovie Pad Site: ☑ Clean and Dry ☐ Red ☐ N/A DRESSING DRY & INTACT: (Y)(N)

LEVEL OF CONSCIOUSNESS: ☐ A&O ☐ Drowsy ☐ Sleepy ☒ Intubated BREATHING EASY: (Y)(N) Vent

LEVEL OF ACTIVITY: [redacted] ☐ Moves All Extremities ☐ Moves Upper Extremities ☐ [redacted]nsferred to litter with roller due to spinal

12. PREOPERA[redacted] (Signature and T[redacted] [redacted]ARED BY

DATE: 24 Jul 03 TIME: [redacted] (b)(6)-2

13. POSTOPERAT[redacted] BY (Signature and Title) [redacted]

DATE: 24 Jul 03 TIME: 1705 (b)(6)-2

REVERSE OF FORM 5179, JUN 91 MEDCOM - 14315 USAPA V1.0

MEDICAL RECORD — **INTRAOPER[illegible]E 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 Ams

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

3. DATE 13 JUL 03 TIME PATIENT ARRIVED IN SUITE 1200

4. PATIENT IN ROOM TIME 1200 NUMBER (b)(6)-2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Emergency case s/p GSW

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted] 91D	RELIEF SCRUB	
	SGT [redacted] 91D		(b)(6)-2
ASSIGNED CIRCULATOR	CPT [redacted] 66E	RELIEF CIRCULATOR	ILT [redacted] 66E
	(b)(6)-2		

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: Normal anatomic body alignment maintained

8. SKIN PREPARATION

HAIR REMOVAL ☒ YES ☐ NO Dr. Nessen

DONE BY: ☒ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☒ RAZOR Left leg & Right leg ☐ CLIP

COMMENTS: No nicks or cuts noted

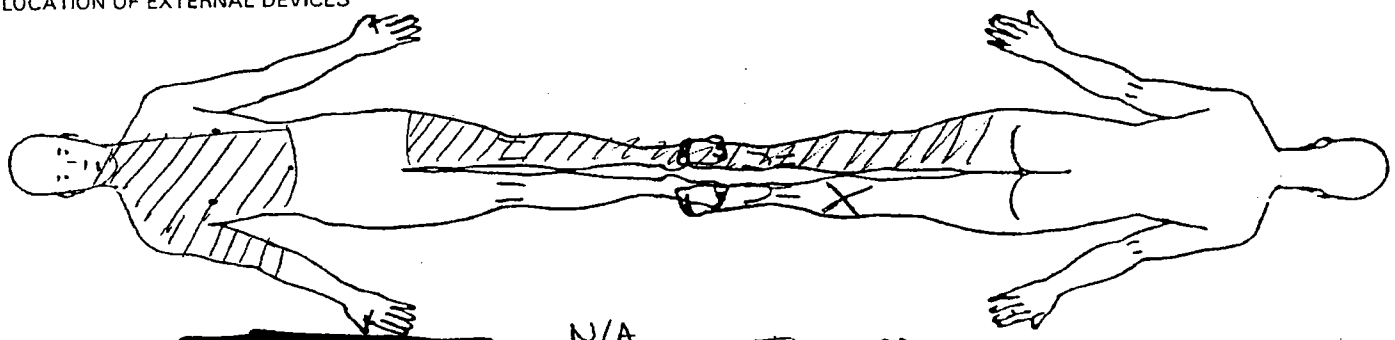
PREP SOLUTION *(Specify)* Betadine / Betadine

SITE: Left leg BY WHOM: ILT [redacted]

SITE: Neck, Chest, upper Abdomen BY WHOM: CPT [redacted] (b)(6)-2

COMMENTS: No pooling or adverse reaction

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad [redacted] N/A = = = Tourniquet ▨ prep

Initial: PFC [redacted] CPT [redacted] (b)(6)-2 C = Correct I = Incorrect

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

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

EPW [redacted]

(b)(6)-4

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

☒ ESU NO: 000450 cut 50 ↓ 30 coag 50 ↓ 30

GROUND PAD: BRAND VL REM Polyhesive II

LOT NO: 65706 Exp 2004-11

☐ ESU NO: _____

GROUND PAD: BRAND _____

LOT NO: _____

☐ BIPOLAR NO: _____

MEDCOM - 14316

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.01

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

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

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 5/8" Penrose	2.	3.
SITE	1. Left knee	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Neck, chest & ABD: 4X8 and Tape

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

Pt. arrived in OR c̄ Chest tube. Foley cath.

DA 5179 Initiated

20. OPERATION(S) PERFORMED
Right neck exploration

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU	1305	LITTER c̄ O2

22. REGISTERED NURSE SIGNATURE
[redacted] RN

REVERSE OF DA FORM 5179-1, OCT 87 USAPA V1.01
(b)(6)-2
MEDCOM - 14317

MEDICAL RECORD

INTRAOPER[illegible]E DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA: Litter BY Anesthesia

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED B[redacted] MAJ AN Previous 5179 on chart ✓ change

3. DATE 14 Jul 03 TIME PATIENT ARRIVED IN SUITE 1724

4. PATIENT IN ROOM TIME 1724 NUMBER

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	DFC [redacted] (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	1LT [redacted]	RELIEF CIRCULATOR	MAJ [redacted] (1900-[illegible]) (b)(6)-2

7. POSITION AND POSITIONAL AIDS (Specify) Pt. supine on padded OR table. BUE on padded arm-boards <90°.

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

COMMENTS: Normal anatomic body alignment maintained

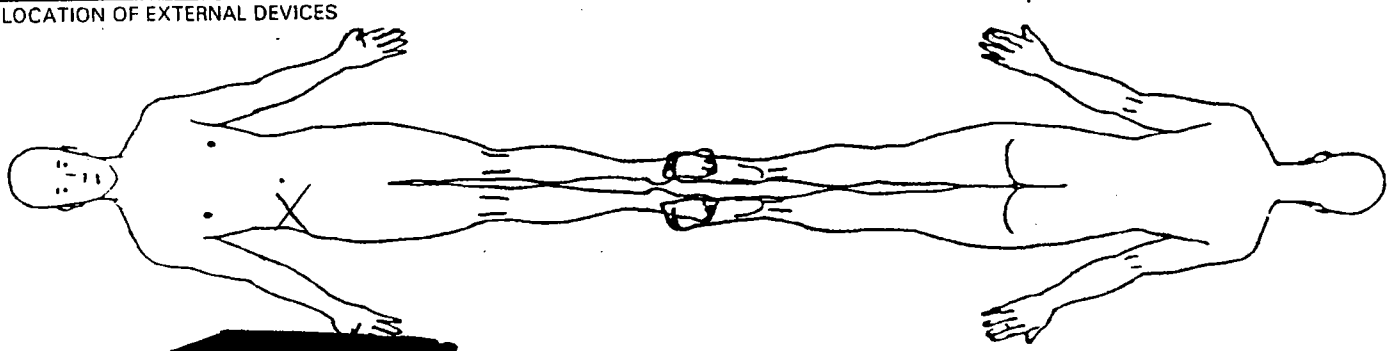
8. SKIN PREPARATION

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

COMMENTS: No nicks or cuts noted

PREP SOLUTION (Specify) Betadine/Betadine
SITE: BY WHOM:
SITE: BY WHOM:
COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



LEGEND X [redacted] Pad -- Sa[redacted] Strap = = = Tourniquet ▨ - prep

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

C = Correct I = Incorrect Circulator: [redacted]

10. COUNTS

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

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

[redacted]
(b)(6)-4

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

☒ ESU NO: 000450 cut 30 coag 30
GROUND PAD: BRAND VL KEM PolyHesive II
LOT NO:

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
NaCl c Heparin 1u/cc Lot 832244 Exp 02/05	Q.S.	intra-op	flush	(Infe American Pharm) ILT [redacted]	Dr. [redacted]
				(5)(6)-2	

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

OTHER ORDERS	TIME	CARRIED OUT BY
None		
(5)(6)-2		

PHYSICIAN'S SIGNATURE [redacted] CTR

15. X-RAY IN OPERATING ROOM YES ☒ NO ☐ C-Arm IF YES, SITE Left leg

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 ☒

	1.	2.	3.
TYPE/SIZE			
SITE			

18. DRESSING/IMMOBILIZATION *(Specify)*
Ace wrap
Kerlix
fluffs

19. ADDITIONAL INFORMATION
Surgeon: Dr. [redacted] Dr. [redacted], Dr. [redacted]
Anesthesia: MAJ [redacted] (5)(6)-2

DA5179 In Chart

20. OPERATION(S) PERFORMED
Left leg fasciotomy, Left leg arteriogram
Saphenous vein ~~graft~~ harvest ~~Left~~ Right leg, Left leg vein graft

21. PATIENT TRANSFERRED TO ICU TIME METHOD LITTER c O2

[redacted] REGISTERED NURSE SIGNATURE [redacted] 117A

[redacted] ERSE OF DA FORM 5179-1, OCT 87 (5)(6)-2 MEDCOM - 14319 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: Gurney BY Anesth

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

3. DATE 14 Jul 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME [redacted] NUMBER

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS:

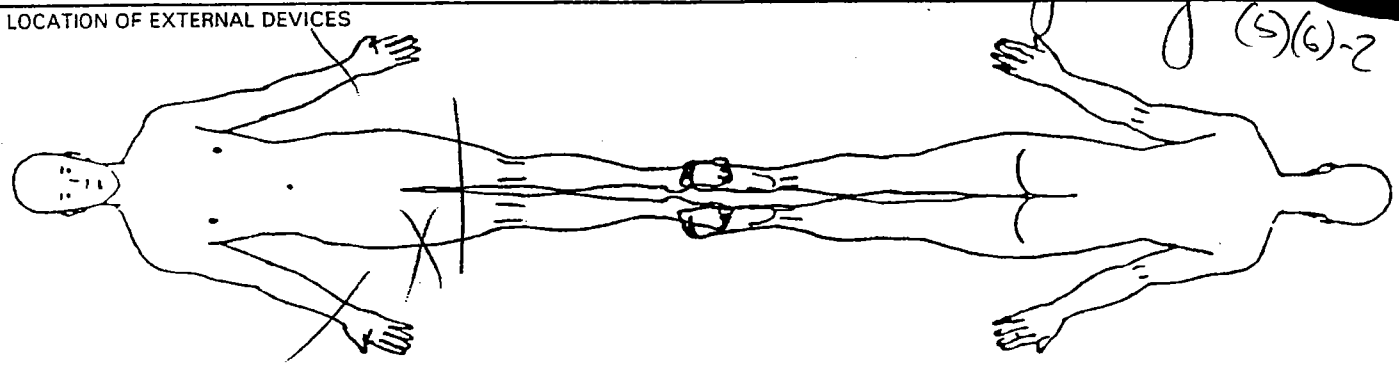
8. SKIN PREPARATION

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

COMMENTS:

PREP SOLUTION *(Specify)* Betadine soap/sol
SITE: Lt. leg BY WHOM:
SITE: BY WHOM: [redacted]
COMMENTS: No pooling (b)(6)-2

9. LOCATION OF EXTERNAL DEVICES



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

(b)(6)-2

C = Correct I = Incorrect

10. COUNTS		Initial Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No	✓			Spc [redacted]	LTC [redacted]
Needle Sharp	☒ Yes ☐ No	✓				
Instrument	☐ Yes ☒ No	/	/	/	/	/
Other	☐ Yes ☒ No	/	/	/	/	/

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

[redacted] (b)(6)-4

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

☒ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

Cut: 30 coag: 30

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
Conray + Heparinized NaCl	gs	intraop	contrast	M	Dr. [redacted] (b)(6)-2

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S): 0.9% NaCl - Heparinized NaCl - 1:1000

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM YES ☒ NO ☐ IF YES, SITE C-arm Lt. leg

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*

DSD Lt. leg

19. ADDITIONAL INFORMATION

Anesth: Maj. [redacted] CRNA

(b)(6)-2

20. OPERATION(S) PERFORMED

0220

21. PATIENT TRANSFERRED TO (b)(6)-2 | CU1 | TIME ~~2320~~ | METHOD via Gurney

[redacted] ITC, AN

REVERSE OF DA FORM 5179-1, OC[redacted] USAPA V1.01

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

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: Litter BY Anesthesia

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

3. DATE 15 July 03 TIME PATIENT ARRIVED IN SUITE 1425

4. PATIENT IN ROOM TIME 1425 NUMBER 1-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONA[redacted] *(Specify)*

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

COMMENTS: proper body alignment maintained

8. SKIN PREPARATION

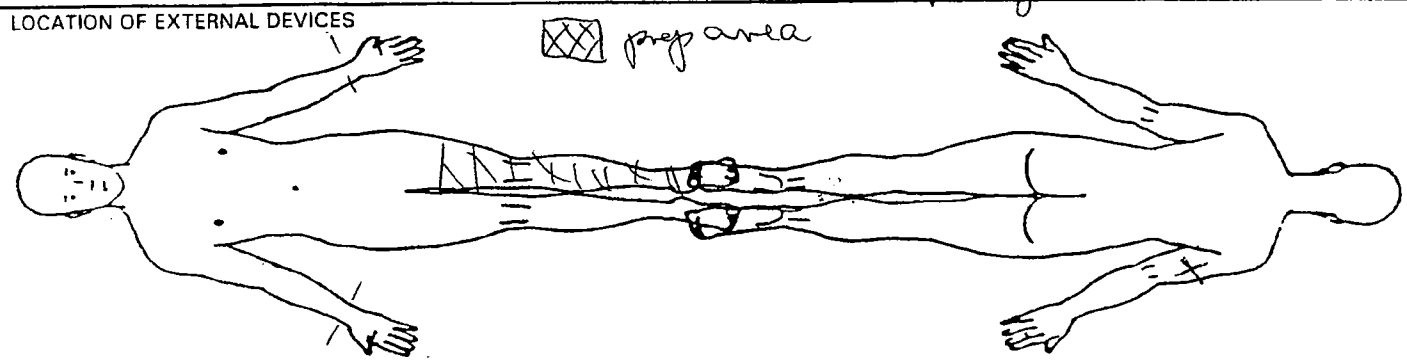
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Beta / Beta (b)(6)-2
SITE: (L) Leg BY WHOM: [redacted]
SITE: BY WHOM:

COMMENTS: no pooling or skin reaction noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad [redacted] -- Safety Strap [redacted] = = = Tourniquet

C = Correct I = Incorrect

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

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

#[redacted]

(b)(6)-4

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

☒ ESU NO: Valleylab Force 2 #4
GROUND PAD: BRAND VL Rem Polyhesive II
LOT NO:

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.01

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY
none		

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. 16 F FIC	2.	3.
SITE	1. Bladder	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Tenps
Kerlix
Ace wrap

19. ADDITIONAL INFORMATION

Surgeon: [redacted], ILT [redacted] (1 FST person) (b)(6)-2
Anesthesia: [redacted]
(b)(6)-2

- see previous DA5179 for pre-op assessment + Nursg. Dx → no Δ's
- FIC in place prior to arrival to OR draining dark cloudy urine

20. OPERATION(S) PERFORMED
(L) BKA

21. PATIENT TRANSFERRED TO ICU-1 | TIME See DA7389 | METHOD Litter

22. REGISTERED NURSE SIGNATURE
[redacted] CPT 1 AN

REVERSE OF DA FORM 5179-1, OCT 87 USAPA V1.01
(b)(6)-2
MEDCOM - 14323

MEDICAL RECORD | **INTRAOPER. E DOCUMENT**

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

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

2. PATIENT IDENTIFIED RECORD REVIEWED AND PROCEDURE VERIFIED BY 1LT [redacted]

3. DATE 17 Jul 03 TIME PATIENT ARRIVED IN SUITE 1115

4. PATIENT IN ROOM TIME 1115 NUMBER (b)(6)-2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SSG [redacted] 91D	RELIEF SCRUB (b)(6)-2	SSG [redacted] (1st RST 1200 –)
ASSIGNED CIRCULATOR	1LT [redacted] 66E	RELIEF CIRCULATOR	CPT [redacted] (1200 – 1230)

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

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

COMMENTS: Normal anatomic body alignment maintained

8. SKIN PREPARATION

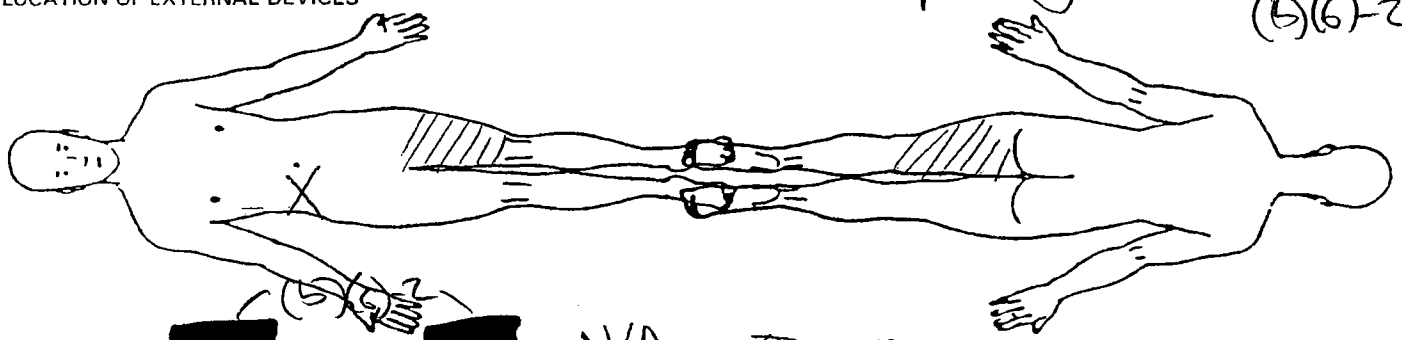
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine / Betadine
SITE: Lumbar spine BY WHOM: 1LT [redacted]
SITE: LLE BY WHOM:

COMMENTS: No pooling or adverse reaction (b)(6)-2

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Strap = = = Tourniquet N/A ▨ prep

10. COUNTS

C = Correct I = Incorrect

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

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

[redacted] (b)(6)-4

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

☒ ESU NO: #4 CUT 30 COAG 30
GROUND PAD: BRAND VL REM Polyhesive II
LOT NO: 65706 Exp 2004-11

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

MEDCOM - 14324

DA FORM 5179-1 OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.01

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

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.	2.	3.
SITE	1.	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Fluffs
Kerlix
ACE

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

DA 5179 in Chart

20. OPERATION(S) PERFORMED

(b) BKA washout, Lumbar drain placement

21. PATIENT TRANSFERRED TO ICU I TIME METHOD LITTER c̄ O2

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

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: Gurney BY: Anesthesia

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

3. DATE: 19 July 03 TIME PATIENT ARRIVED IN SUITE: 0815

4. PATIENT IN ROOM TIME: 0815 NUMBER: 1 2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted] (b)(6)-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: proper body alignment maintained

8. SKIN PREPARATION

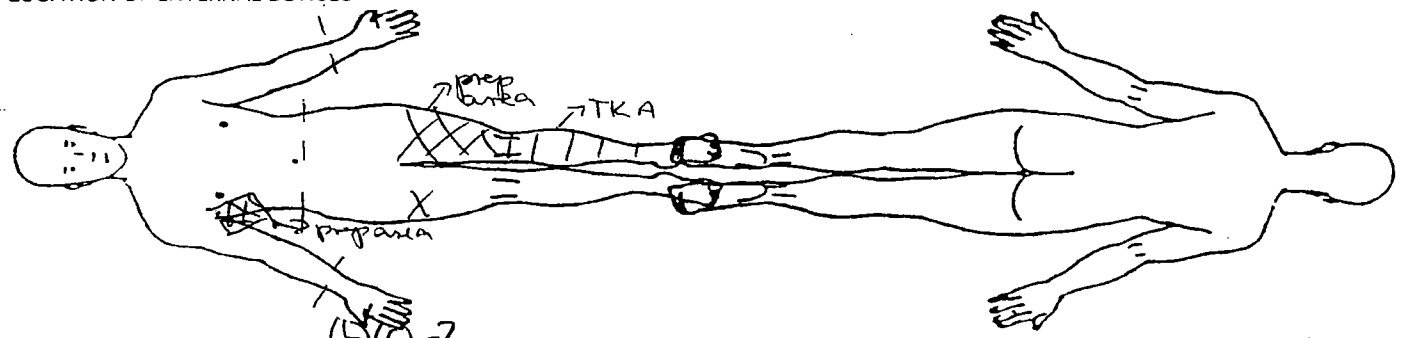
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine/Betadine (b)(6)-2
SITE: (L) thigh BY WHOM: [redacted]
SITE: (R) axilla area BY WHOM: [redacted]

COMMENTS: no pooling or skin reaction noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad [redacted] -- Safety Strap [redacted] = = = Tourniquet N/A

10. COUNTS

C = Correct I = Incorrect

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

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

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

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

☒ ESU NO: VL Force 2 #4
GROUND PAD: BRAND: VL Rem Polyhesive II
LOT NO: 68936 2005-03

☐ ESU NO:
GROUND PAD: BRAND:
LOT NO:

☐ BIPOLAR NO:

MEDCOM - 14326

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. US

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):
D.Ninace, Dakin's solution on Fluffs for wound dressg.

OTHER ORDERS	TIME	CARRIED OUT BY
none		

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 ☐

	1.	2.	3.
TYPE/SIZE	16F FC		
SITE	Bladder		

18. DRESSING/IMMOBILIZATION *(Specify)*
Fluffs ABD
Kerlix
Airway
4x4, Tape

19. ADDITIONAL INFORMATION

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

- FC in place prior to arrival to OR

- DA5179 on chart, ø4's

20. OPERATION(S) PERFORMED

Bronchoscopy
I+D (L) TKA, wound close (R) axillary wound

21. PATIENT TRANSFERRED TO: ICU-1 TIME: See DA7389 METHOD: Litter

22. REGISTERED NURSE SIGNATURE [redacted] SPTMN

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

(b)(6)-2

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

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA litter BY Anesthesia [redacted] (b)(6)-2
2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY MAJ [redacted]
3. DATE 20 Jul 03 TIME PATIENT ARRIVED IN SUITE 1130
4. PATIENT IN ROOM TIME 1130 (b)(6)-2 NUMBER 1-3

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies:

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted], ORT	RELIEF SCRUB	SSG [redacted] (1150 –
ASSIGNED CIRCULATOR	MAJ [redacted], AN	RELIEF CIRCULATOR	CPT [redacted] - AN 1150-1205; CPT [redacted] (1205 –

(b)(6)-2

7. POSITION AND POSITIONAL AIDS (Specify) Pt transferred to OR table, anatomically aligned for surgical procedure c padding under head. (B) arms on padded arm boards less 90°

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

COMMENTS:

8. SKIN PREPARATION (b)(6)-2

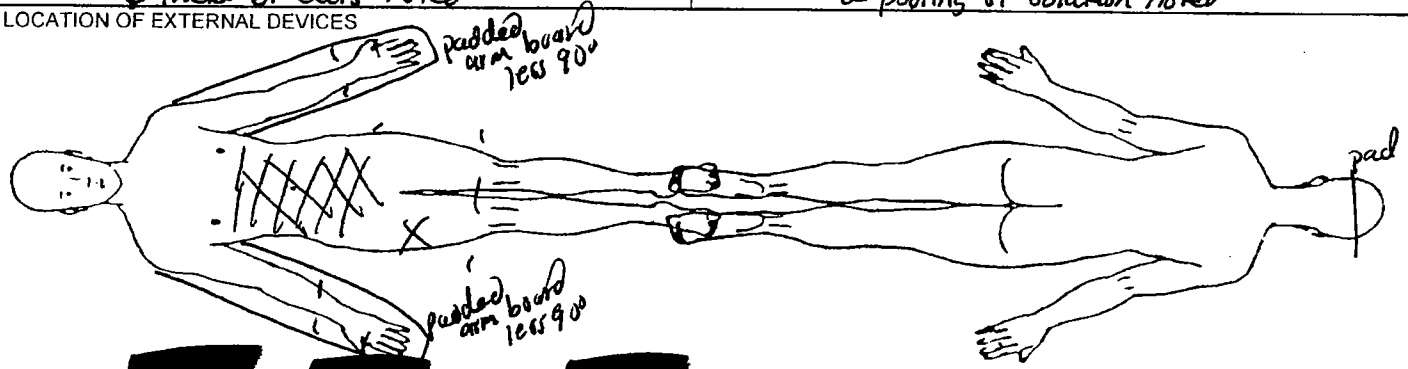
HAIR REMOVAL ☒ YES ☐ NO
DONE BY: ☒ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP

COMMENTS: Ø Nicks or cuts noted

PREP SOLUTION (Specify) Beta/Beta
SITE: Abd BY WHOM: MAJ [redacted]
SITE: BY WHOM: XXX See #9

COMMENTS: Ø pooling of solution noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad [redacted] = Safety Strap 2 ═══ Tourniquet

(b)(6)-2

C = Correct I = Incorrect Initial: MAJ [redacted]

10. COUNTS		Initial Count	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No	C	C	C	SSG [redacted]	CPT [redacted]
Needle Sharp	☒ Yes ☐ No	C	C	C		
Instrument	☒ Yes ☐ No	C	C	C		
Other	☐ Yes ☐ No					

(b)(6)-2

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

EPW # [redacted]

(b)(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO 30/30

☒ ESU NO: #4
GROUND PAD: BRAND Valley lab REM Polyhesive II
LOT NO: 68936 Lot # 2006-03

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

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

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☑

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

18. DRESSING/IMMOBILIZATION *(Specify)*
4x8
TAPE
ABD

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

Bovie Pad site intact pre-op yes; post-op yes Bovie Settings: Coag/Cut 30/30

20. OPERATION(S) PERFORMED
Exploratory Laparotomy
lysis of Adhesion, Suture Retention

21. PATIENT TRANSFERRED TO ICU [redacted] TIME 1310 METHOD Lifer c O2

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

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

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

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

2. PATIENT IDE[redacted] EVIEWED AND PROCEDURE VERIFIED BY [redacted] CPT/A CPT [redacted]

3. DATE 24 Jul 03 TIME PATIENT ARRIVED IN SUITE 1515

4. PATIENT [redacted] ROOM TIME 1515 NUMBER 1-4

5. PREOPERATIVE EMOTIONAL STATUS

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

(b)(6)-2

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] 25 (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] A	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify) Pt transferred to OR table, anatomically aligned for surgical procedure c towel/padding under head (B) arms on padded arm board less 90°

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

COMMENTS:

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

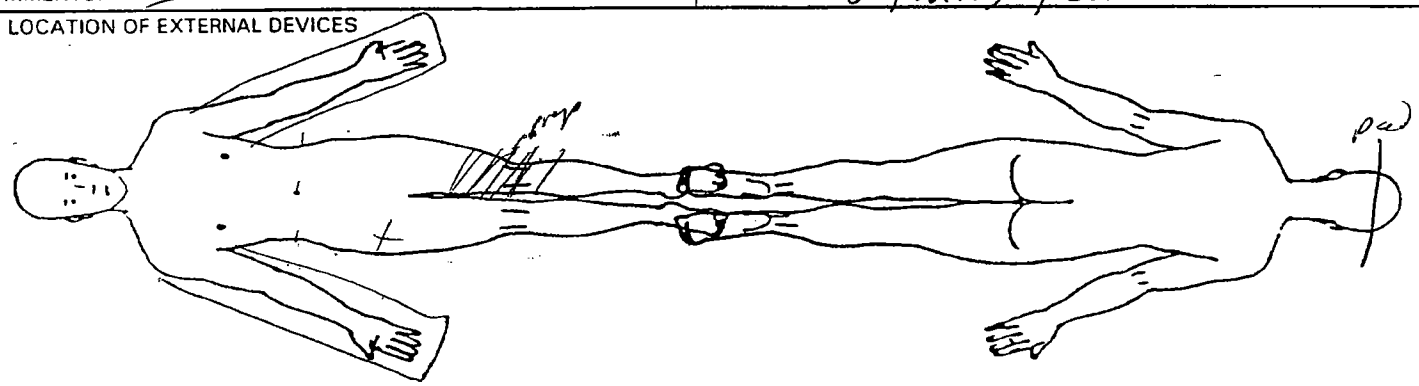
PREP SOLUTION (Specify) Betx/Betx

SITE: (L) Stump BY WHOM: CP[redacted]

SITE: XX see #5 BY WHOM: (b)(6)-2

COMMENTS: ∅ pooling of solution noted

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

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

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

EPW #[redacted]

(b)(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO 30/30

☒ ESU NO: #4

GROUND PAD: BRAND Valley lab

LOT NO: 68936 Exp 2005-02

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

MEDCOM - 14330

DA FORM 5179-1 OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.01

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

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

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☑

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

18. DRESSING/IMMOBILIZATION *(Specify)*

19. ADDITIONAL INFORMATION

Surgeon Anesthesia

[redacted] (b)(6)-2

20. OPERATION(S) PERFORMED

Closure of (L) TKA + I+D (L) TKA

21. PATIENT TRANSFERRED TO ICU-1 TIME 1705 METHOD bed to OR

22. REGISTERE[redacted] CPT/A

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

(b)(6)-2

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY															
POST- DAY															
MONTH-YEAR	DAY	30 Sep		1 OCT 03		2 OCT 03		3 OCT		4 OCT		5 OCT		6	
19	HOUR	0700	1	0700	PM	0	1	0045	1830	0700	1	0700		0	

PULSE (0) / TEMP. F (°) / TEMP. C

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

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

16	18		16	8	16		18	16				19			

BLOOD PRESSURE

105/59		109/57	130/70		113/76	106/72	124/72	111/59	130/65	127/74		112/72			
H 120	111/61	H 113		120/74		114 N		127 N	127	H 130		136			
T 97.4		T 97.8				98.2 T		T 98.4	96.6	T 97.8		96			
97%		97%	O2			99%	O2	98%	98	99%		98%			
RA	98% RA	RA	98% RA	98%	99% RA	RA	98% RA	RA		RA					

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

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

[redacted]

(b)(6)-4

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY																		
POST- DAY					25				26	28	29	30						
MONTH-YEAR	DAY	25SEP03			SEPT		26SEPT				1000							
19	HOUR	8	1		1010	1845	0030		1830				1		1		0445	1

PULSE (O) — TEMP. F (•) — TEMP. C (Centigrade Equivalents, for Reference only)

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

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

RESPIRATION RECORD

BLOOD PRESSURE		113/73		0134	130	1052/62	117/69		108/60		101/84	115/76						
		112/76		84/98.1							H 130	127	P 124	113/73				
							(02)				T 984	98.3	T 97.8					
HEIGHT:	WEIGHT →			97	98.5	98/0	97/1		97/0		97.2	97/1	98.2					
		0250H 97(RA)				RA	RA		RA		RA		98%/99%					
		97(RA)							132									
									125/73									
									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.

#[redacted]

(5)(6)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST-OP DAY

MONTH-YEAR | DAY: 18 Sep 03 | 19 SEP | 20 SEP | 21 Sep | 22 SEP 03 | 23 SEP | 24 Sep 03

19 | HOUR: 0 1 0700 1 0700 1 0730 1 0 1 0 1900

PULSE (O) | TEMP. F (•) | TEMP. C

105° 40.6°

180 104° 40.0°

170 103° 39.4°

160 102° 38.9°

150 101° 38.3°

140 100° 37.8°

130 99° 98.6° 37.2° 37.0°

120 98° 36.7°

110 97° 36.1°

100 96° 35.6°

90 95° 35.0°

80

70

60

50

40

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD: 18 | 18 | 16 | 16 | 16 | 116/78

BLOOD PRESSURE: 120/76 | 104/71 | 114/72 | 127/80 | 114/74 | 116/76 | 113/70 | 131/91 | 106/75

128 | H 121 | 133 | 123/82 | 128 | 133 | 144 | (P) 130

97.9 | T 97' | 97' | 98° | 98.4 | 97.5 | (P) 116

99.1 | 98% | 97% | 97% | (P) 18 | (P) 16

O2 SAT 97% | RA | 98% (RA) | RA | RA | 97% (RA) | 97% RA | O2 98% RA

HEIGHT: | WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

STANDARD FORM 511 (REV. 7-95) BACK

(b)(6)-4

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY

19 | HOUR

PULSE (O) | TEMP. F (•)

TEMP. C (Centigrade Equivalents, for Reference only)

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

PULSE (O)	180	170	160	150	140	130	120	110	100	90	80	70	60	50	40

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] (b)(6)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY											
POST- DAY											
MONTH-YEAR	DAY	4 Sept	5 Sep		6 Sep		7 Sep		08 SEP 03	9 Sep 7	10 Sep 03
19	HOUR	0810	0700	PBD		1	0700		8	18	1900

PULSE (O) — TEMP. F (•) — TEMP. C (Centigrade Equivalents, for Reference only)

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

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

RESPIRATION RECORD

		20	BP 19	18	18	19	6	18	18	~~115~~ 56	115 80
BLOOD PRESSURE	115/73	114/77	77	102/65	117/77	124/74	121/80	126/80	114/80	(P) 124	(P) 116
	130	H 124	(P)	T 98.4		H 126		125	T 98.1		(P)
	98.1	T 98.5	(P) 116	H 136		T 98°		98.1	H 16	(P) 116	121
HEIGHT: WEIGHT →	8-20	98%		98%		98%			101/71		98%
	88 68	2A	98% RA	RA	98%	RA	98% (RA)	98%	98%		RA
									99%		
	117/87		RA								
	121										
	97.1										
	99										

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 1

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

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY											
POST- DAY											
MONTH-YEAR	DAY	28		29 AUG		30 AUG		31 AUG	01 SEP 03	02 SEP 03	03 SEP 03
19	HOUR	8 20		0715	1845	8	1	0800 2	8 2000	8 1	8 1
PULSE (O)	TEMP. F (°)										
	105°										
180	104°										
170	103°										
160	102°										
150	101°										
140	100°										
130	99°										
	98.6°										
120	98°										
110	97°										
100	96°										
90	95°										
80											
70											
60											
50											
40											

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD											
			15	125/86	124/82					116/87	
Record special data only when so ordered	BLOOD PRESSURE	121/83	134/84	125	82	120/72	121/86	109/73	113/80	127	124/85	114/83
		130	114		111			127				113/78
		98.8	98.5	98.3	98			97.5		116	129/84	
	HEIGHT: WEIGHT →											
	SPO2	98%	99%	98	98%		98%	98%	97%	98%	99%	98%
					RA					RA	99% RA	98%

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

REGISTER NO.

WARD NO.

[redacted]

(b)(6)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY																		
POST-	DAY				22 Aug 03													
MONTH-YEAR	DAY	21	22				23 Aug		24 Aug		25 Aug 03		26 Aug 03		27 Aug 03			
19	HOUR	2145	0	2040			0		2000	0700	1600	8	1600	8	1		8	1

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																		
	129/80		(BP) 121/87				136/91	129/94	131/92		124/87							
	114/94		(P) 111				(P) 116	(P) 114	(P) 112	123/81	(P) 104	128/83			125/80		116/86	
			(P) 116				(P) 104	(B) 16			(P) 116						96	
HEIGHT:	WEIGHT →						(O2)		(P) 20								110	
			(O2) 96% RA	98%	98%		99% RA	98%	98% RA	98% (RA)	99% RA	98% (RA)			98% (RA)		54 (B)	

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

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

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR Aug 03 DAY 14 15 15 16 16 17 17 18 18 19 19 20 20 21

~~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 →

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]

(5)(6)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY																	
POST-	DAY																
MONTH-YEAR	DAY	12		13		14											
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																	
RESPIRATION RECORD																	
BLOOD PRESSURE		120/6		116/80		130/92											
		120/84		150/96		130/100											
		98%	99%	98		98	99										
HEIGHT:	WEIGHT →	97%		97%													

(Centigrade Equivalents, for Reference only)

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]

(5)(6)-4

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

511–119

NSN 7540–00–634–4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR DAY

Aug 10 2003 HOUR

PULSE (O) | TEMP. F (•)

TEMP. C

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 →

Record special data only when so ordered

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

[redacted]

(b)(6)-4

REGISTER NO.

WARD NO. 1W2

VITAL SIGNS RECORDS

Medical Record

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

(b)(6)-2 UA

Ward/Section: FW2	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI.	DATE	TIME	SSN/PSEUDO SSN
# [redacted]	8/19	0324	# [redacted] (b)(6)-4

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

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

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

Urinalysis

TEST	RESULT	REF. RANGE
Color	Red	N/A
App	Cloudy	N/A
Glu	neg	Negative
Bili	neg	Negative
Ket	neg	Negative
SG	1.020	N/A
Bld	Large	Negative
pH	7.0	N/A
Prot	4+	Negative
Urob	0.2	0.2-1.0
Nit	neg	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

SSA - 4+
TNTC RBC
moderate yeast

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
[redacted]	19 Aug 03	

(b)(6)-2

UA

(b)(6)-2

Ward/Section: TCW 2	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. #[redacted]	DATE 8/16	TIME 0300	SSN/PS[redacted] #[redacted] (b)(6)-4

(Hematology) CBC (b)(6)-4			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3	Color	Yellow	N/A	RPR		Negative
RBC		4.7-6.1 x 10^9	App	Cloudy	N/A	Mono		Negative
Hgb		14-18 g/dl (M) 12-16 g/dl (F)	Glu	Neg	Negative	**Microbiology**		
Hct		42-52% (M) 37-47% (F)	Bili	Neg	Negative	Source		
MCV		80-94 fl (M) 81-99 fl (F)	Ket	Neg	Negative	Gram Stain		
Plt		130-500 x 10^3 verified	SG	1.015	N/A	Occ Bld		Negative
Lymph %		20.5-51.1%	Bld	Large	Negative	H. pylori		Negative
(Hematology) Manual Differential			pH	6.5	N/A	Micro Parasites		
Segs		Mono	Prot	Neg	Negative	Malaria		
Bands		Eos	Urob	Neg	0.2-1.0	O & P		
Lymph		Baso	Nit	Neg	Negative	Other		
Atyp		Imm	Leuk		Negative	**Microscopic Urinalysis**		
RBC Morph			HCG		Negative	TNTC RBC Heavy yeast Heavy sodium urate crystals 4-5 loose granular casts/LPF		
Spun Hematocrit		42-52% (M) 37-47% (F)	**CSF**			**Blood Bank**		
Sed Rate			Cell Count			**MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED**		
Other			Directigen		Negative	ABO/Rh		

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

REMARKS:		
REPORTED BY: [redacted]	DATE: 16 Aug 03	LAB ID NO.:

(b)(6)-2

(b)(6)-2

Ward/Section: ICU#2	REQUESTING PHYSICIAN: DC - [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. # [redacted]	DATE 8/14/03 TIME 0445	SSN/PSEUDO SSN: # [redacted] (b)(6)-4

(Hematology) CBC (b)(6)-4			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3	Color	dark amber	N/A	RPR		Negative
RBC		4.7-6.1 x 10^9	App	cloudy	N/A	Mono		Negative
Hgb		14-18 g/dl (M) 12-16 g/dl (F)	Glu	neg	Negative	**Microbiology**		
Hct		42-52% (M) 37-47% (F)	Bili	neg	Negative	Source		
MCV		80-94 fl (M) 81-99 fl (F)	Ket	neg	Negative	Gram Stain		
Plt		130-500 x 10^3 verified	SG	1.010	N/A	Occ Bld		Negative
Lymph %		20.5-51.1%	Bld	lg	Negative	H. pylori		Negative
(Hematology) Manual Differential			pH	7.5	N/A	Micro Parasites		
Segs		Mono	Prot	neg	Negative	Malaria		
Bands		Eos	Urob	norm	0.2-1.0	O & P		
Lymph		Baso	Nit	neg	Negative	Other		
Atyp		Imm	Leuk		Negative	**Microscopic Urinalysis**		
RBC Morph			HCG		Negative	RBCs - TNTC slight bacteria 5-10 WBCs		
Spun Hematocrit		42-52% (M) 37-47% (F)	**CSF**			**Blood Bank**		
Sed Rate			Cell Count			**MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED**		
Other			Directigen		Negative	ABO/Rh		

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

REMARKS:

REPORTED BY: [redacted]	DATE: 14 Aug 03	LAB ID NO.:

(b)(6)-2

(b)(6)-2

Ward/Section: ICU2	REQUESTING PHYSICIAN: [redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. #[redacted] (b)(6)-4	DATE 7Aug03 / TIME 0830	SSN/PSEUDO SSN:

(STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE

======= PICCOLO =======
07/08/03 08:52
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8 (b)(6)-4
DISC LOT #: 3141AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]
(b)(6)

GLU	104	73-118	MG/DL
BUN	11	7-22	MG/DL
CRE	1.0	0.6-1.2	MG/DL
CK	41	39-380	U/L
NA+	127*	128-145	MMOL/L
K+	4.2	3.3-4.7	MMOL/L
CL-	102	98-108	MMOL/L
tCO2	24	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
CO_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:
metabolic panel

REPORTED BY:	DATE:	LAB ID NO.:

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

LAST, FIRST, MI.	DATE	TIME	SSN/PSEUDO SSN:
# [redacted] (b)(6)-4 (b)(6)-2	7 Aug 03	0830	

(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	Yel	N/A
App	Clear	N/A
Glu	Neg	Negative
Bili	Neg	Negative
Ket	Neg	Negative
SG	1.020	N/A
Bld	Neg	Negative
pH	6.0	N/A
Prot	Neg	Negative
Urob	0.2	0.2-1.0
Nit	Neg	Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count			
Directigen		Negative	

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS: VA

REPORTED BY: [redacted]	DATE: 7 Aug 03	LAB ID NO.:

(b)(6)-2

Ward/Section: ICW2	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)		
LAST, FIRST, MI (b)(6)-4 EPW [redacted] (b)(6)-2		DATE 4 Aug	TIME 1815	SSN/PSEUDO SSN: [redacted] (b)(6)-4

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3	Color	Yellow	N/A	RPR		Negative
RBC		4.7-6.1 x 10^9	App	Clear	N/A	Mono		Negative
Hgb		14-18 g/dl (M) 12-16 g/dl (F)	Glu	Neg	Negative	**Microbiology**		
Hct		42-52% (M) 37-47% (F)	Bili	Neg	Negative	Source		
MCV		80-94 fl (M) 81-99 fl (F)	Ket	Neg	Negative	Gram Stain		
Plt		130-500 x 10^3 verified	SG	1.010	N/A	Occ Bld		Negative
Lymph %		20.5-51.1%	Bld	Neg	Negative	H. pylori		Negative
(Hematology) Manual Differential			pH	6.0	N/A	Micro Parasites		
Segs		Mono	Prot	Neg	Negative	Malaria		
Bands		Eos	Urob	Neg	0.2-1.0	O & P		
Lymph		Baso	Nit	Neg	Negative	Other		
Atyp		Imm	Leuk		Negative	**Microscopic Urinalysis**		
RBC Morph			HCG		Negative			

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

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

REMARKS:

REPORTED BY: [redacted]	DATE: 04 Aug 03	LAB ID NO.:

(b)(6)-2

(b)(6)-2

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

LAST, FIRST, MI [redacted] (b)(6)-4	DATE 4 Aug	TIME 0400	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		
RBC		
Hgb		
Hct		
MC		
Plt		
Lymph %		

ID [redacted] 01-08-03
MB 03:57

			Patient Limits	
WBC	18.3 H	x10^3/uL	4.5	10.5
RBC	3.64 L	x10^6/uL	4.00	6.00
Hgb	10.9 L	g/dL	11.0	18.0
Hct	34.3 L	%	35.0	60.0
MCV	94.2	fL	80.0	99.9
MCH	30.0	pg	27.0	31.0
MCHC	31.9 L	g/dL	33.0	37.0
Plt	1682. *H	x10^3/uL	150.	450.
LYM%	13.0 *L	%	20.5	51.1
LYM#	2.4 *	x10^3/uL	1.2	3.4

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted]	**DATE:** 1 Aug 03	**LAB ID NO.:**

(b)(6)-2

Ward/Section: ICU #1	TESTING PHYSICIAN: [redacted] (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI.	DATE	TIME	SSN/PSEUDO SSN:
EPW [redacted] (b)(6)-4	3 Aug 03	0400	[redacted] (b)(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	[redacted]	4.8-10.8 x 10³
RBC		
Hgb		
Hct		
MCV		
Plt		
Lym		

ID: [redacted] 03-08-03
MR 04:42
Patient Limits

WBC	21.9 H	x10^3/uL	4.5	10.5
RBC	3.62 L	x10^6/uL	4.00	6.00
Hgb	10.5 L	g/dL	11.0	18.0
Hct	33.8 L	%	35.0	60.0
MCV	93.5	fL	80.0	99.9
MCH	29.1	pg	27.0	31.0
MCHC	31.2 L	g/dL	33.0	37.0
Plt	1419. H	x10^3/uL	150.	450.
LY%	13.8 *L	%	20.5	51.1
LY#	3.0 *	x10^3/uL	1.2	3.4

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

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

UNIT	TYPE	CROSSMATCH

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

ABO/Rh	

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
[redacted] (b)(6)-2	3 Aug 03	

Ward/Section: ICU #1	REQUESTING PHYSICIAN: [redacted] (b)(6)-2	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. EPW [redacted] (b)(6)-4	DATE 3 Aug 03 / TIME 0400	SSN/PSEUDO SSN: [redacted] (b)(6)-4

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
CO_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

======= PICCOLO =======
03/08/03 04:42
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8 (b)(6)-[illegible]
DISC LOT #: 3152AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	115	73-118	MG/DL
BUN	10	7-22	MG/DL
CRE	0.6	0.6-1.2	MG/DL
CK	81	39-380	U/L
NA+	♦♦♦	128-145	MMOL/L
K+	3.9	3.3-4.7	MMOL/L
CL-	93*	98-108	MMOL/L
tCO2	21	18-33	MMOL/L

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

Na-129

REMARKS:

REPORTED BY: [redacted] (b)(6)-2	DATE: 3 Aug 03	LAB ID NO.:

(b)(6)-2

Ward/Section: 1CL1	REQUESTING PHYSICIAN: [redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI.	DATE	TIME	SSN/PSEUDO SSN:
[redacted] (b)(6)-4	8/2/03	0400	

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

======= PICCOLO =======
02/08/03 04:08
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: 3152AA4
OPER #: [redacted] (b)(6)-4 DR #: 000
SERIAL #: [redacted]

GLU	120*	73-118	MG/DL
BUN	13	7-22	MG/DL
CRE	0.7	0.6-1.2	MG/DL
CK	135	39-380	U/L
NA+	♦♦♦	128-145	MMOL/L
K+	4.2	3.3-4.7	MMOL/L
Cl	92*	98-108	MMOL/L
CO2	24	18-33	MMOL/L

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

Na 129

(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
BIL		0.2-1.6 mg/dl
GGT		5-65 u/l
P		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA^{+}		128-145 mmol/l
		3.3-4.7 mmol/l
		98-108 mmol/l
CO_2		18-33 mmol/l

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
[redacted]	02 Aug 03	

(b)(6)-2

4D

Ward/Section:	REQUESTING PHYSICIAN:	**LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)

LAST, FIRST, MI.	DATE	TIME	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
ID: [redacted]		02-08-03
WB		04:09
		Patient Limits
WBC	21.9 H	x10^3/uL 4.5 10.5
RBC	3.77 L	x10^6/uL 4.00 6.00
Hgb	11.0 L	g/dL 11.0 18.0
Hct	35.1	% 35.0 60.0
MCV	93.2	fL 80.0 99.
MCH	29.1	pg 27.0 31.0
MCHC	31.2 L	g/dL 33.0 37.0
Plt	1544. +H	x10^3/uL 150. 450.
LY%	....	% 20.5 51.1
LY#	----	x10^3/uL 1.2 3.4

(b)(6)-4

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	**DATE:** 02 Aug 03	**LAB ID NO.:**

[redacted]

(b)(6)-2

(b)(6)-2

Ward/Section: ICU	QUESTING PHYSICIAN: [redacted]	MISTRY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI. [redacted] (b)(6)-4	DATE 01AUG	TIME 0400	SSN/PSEUDO SSN:

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

i-STAT EC8+

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

Pt Name:_____

Glu_____116 mg/dL

BUN_____14 mg/dL

Na_____129 mmol/L

K_____4.3 mmol/L

Cl_____98 mmol/L

TCO2_____31 mmol/L

AnGap_____6 mmol/L

Hct_____37 %PCV

Hb*_____13 g/dL

*via Hct

pH_____7.418

PCO2_____45.7 mmHg

HCO3_____30 mmol/L

BEecf_____5 mmol/L

Sample Type_:

01AUG03 03:53

Oper: 13 crea 1.1

Physician:_____

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

Ver: JAM5046A
CLEW A93

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
[redacted]	1Aug03	

(b)(6)-2

Ward/Section: ICU #1	REQUESTING PHYSICIAN:	**LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)

LAST, FIRST, MI: EPW# [redacted] (b)(6)-4	DATE: 31 July	TIME: 0400	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
	ID: [redacted] (b)(6)-4	31-07-03 03:53
WBC		
RBC		Patient Limits
Hgb	WBC 13.5 H x10^3/uL	4.5 10.5
	RBC 3.51 L x10^6/uL	4.00 6.00
Hct	Hgb 10.3 L g/dL	11.0 18.0
	Hct 33.1 L %	35.0 60.0
MCV	MCV 94.4 fL	80.0 99.9
	MCH 29.4 pg	27.0 31.0
	MCHC 31.2 L g/dL	33.0 37.0
Plt	Plt 1581. + x10^3/uL	150. 450.
	LY% 11.4 *L %	20.5 51.1
Lympl	LY# 1.5 * x10^3/uL	1.2 3.4

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

Blood Bank Unit Crossmatch

(MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted]	DATE: 31 July 03	LAB ID NO.:

(b)(6)-2

Ward/Section: ICU #1

TESTING PHYSICIAN: (b)(6)-4

STRY RESULT FORM
(...t to the Privacy Act of 1974)

LAST, FIRST, MI. EPW #[redacted]

DATE 31 July 4 | TIME 0400 | SSN/PSEUDO SSN:

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

======= PICCOLO =======
31/07/03 03:53
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: (b)(6)-2 3152AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	135*	73-118	MG/DL
BUN	12	7-22	MG/DL
CRE	0.8	0.6-1.2	MG/DL
CK	46	39-380	U/L
NA+	♦♦♦	128-145	MMOL/L
K+	4.4	3.3-4.7	MMOL/L
CL-	100	98-108	MMOL/L
tCO2	22	18-33	MMOL/L

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

Na 132

REMARKS:

REPORTED BY: [redacted]

DATE: 31 July 03

LAB ID NO.:

(b)(6)-2

Ward/Section: ICU #1	REQUESTING PHYSICIAN:	**LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)

LAST, FIRST, MI: EDW [redacted] (b)(6)-4	DATE: 30 Jul 03	TIME: 0400	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		
RBC		
Hgb		
Hct		
MC		
Plt		
Lyr		

ID: [redacted] (b)(6)-4 WB 30-07-03 04:15

			Patient Limits	
WBC	18.8 H	x10^3/uL	4.5	10.5
RBC	3.20 L	x10^6/uL	4.00	6.00
Hgb	9.5 L	g/dL	11.0	18.0
Hct	30.6 L	%	35.0	60.0
MCV	95.4	fL	80.0	99.9
MCH	29.7	pg	27.0	31.0
MCHC	31.1 L	g/dL	33.0	37.0
Plt	1531. +H	x10^3/uL	150.	450.
LY%	7.9 *L	%	20.5	51.1
LY#	1.5 *	x10^3/uL	1.2	3.4

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] (b)(6)-2	**DATE:** 30 Jul 03	**LAB ID NO.:**

Ward/Section: FCU #	QUESTING PHYSICIAN:	MISTRY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI: EPW [redacted] (b)(6)-4	DATE: 30Jul03	TIME: 0400	SSN/PSEUDO SSN:

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

======= PICCOLO =======
30/07/03 04:19
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: 3151AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	132*	73-118	MG/DL
BUN	♦♦♦	7-22	MG/DL
CRE	1.0	0.6-1.2	MG/DL
CK	98	39 380	U/L
[redacted]	[redacted]	128-145	MMOL
K+	4.4	3.3-4.7	MMOL
CL-	101	98-108	MMOL
tCO2	21	18-33	MMOL

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

Bun 15
Na 132

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
[redacted]	30Jul03	

(b)(6)-2

Ward/Section: ICU #1

EPW [redacted] MI.

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

DATE: 2/11/03 TIME: 0342

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

SSN/PSEUDO SSN:

(b)(6)-4

(Hematology) CBC

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

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: TCU #1	[redacted] PHYSICIAN: [redacted] (b)(6)-2		CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST: EPW [redacted] (b)(6)-4	DATE: 29/11/03	TIME: 1034	SSN/PSEUDO SSN:

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

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

LAST, FIRST, MI.	DATE	TIME	SSN/PSEUDO SSN:
EPW [redacted] (b)(6)-4	29JUL	0912	

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3	Color		N/A	RPR		Negative
RBC		4.7-6.1 x 10^9	App		N/A	Mono		Negative
Hgb		14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	**Microbiology**		
Hct		42-52% (M) 37-47% (F)	Bili		Negative	Source	CSF	
MCV		80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain	No organisms seen	
Plt		130-500 x 10^3 verified	SG		N/A	Occ Bld		Negative
Lymph %		20.5-51.1%	Bld		Negative	H. pylori		Negative
(Hematology) Manual Differential			pH		N/A	Micro Parasites		
Segs		Mono	Prot		Negative	Malaria		
Bands		Eos	Urob		0.2-1.0	O & P		
Lymph		Baso	Nit		Negative	Other		
Atyp		Imm	Leuk		Negative	**Microscopic Urinalysis**		
RBC Morph			HCG		Negative			

Spun Hematocrit		42-52% (M) 37-47% (F)	**CSF**			**Blood Bank**	
Sed Rate			Cell Count	RBC - 3930 WBC - 12		**MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED**	
Other			Directigen	Negative	Negative	ABO/Rh	

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

REMARKS: CSF Protein and glucose testing Not Available at this facility

REPORTED BY: [redacted]	DATE: 29JUL03	LAB ID NO.:

(b)(6)-2

Ward/Section: ICU1

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

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

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

DATE: 29 Jul

TIME: 0400

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

(Hematology) CBC

ID: [redacted]
WB

			REF. RANGE 29-07-03 03:57 Patient Limits	
WBC	27.3 H	x10^3/uL	4.5	10.5
RBC	3.14 L	x10^6/uL	4.00	6.00
Hgb	9.3 L	g/dL	11.0	18.0
Hct	30.1 L	%	35.0	60.0
MCV	95.7	fL	80.0	99.9
MCH	29.7	pg	27.0	31.0
MCHC	31.1 L	g/dL	33.0	37.0
Plt	1733. +H	x10^3/uL	150.	450.
LYZ	....	%	20.5	51.1
LY#	——	x10^3/uL	1.2	3.4

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Ru		Negative
Bili		Negative
Bet		Negative
G		N/A
Bld		Negative
Bil		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted]

DATE: 29 Jul 03

LAB ID NO.:

(b)(6)-2

Ward/Section: ICU 1

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

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

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

DATE 29 Jul | TIME 0400 | SSN/PSEUDO SSN: [redacted] (b)(6)-4

(i-STAT)

TEST	RESULT	REF. RANGE
Na		
K		
Cl		
pH		
PCO		
PO2		
TCO		
HCO		
sO2		
BEe		
AnG		
Ca		
BUN		
GLU		
Crea		
Hct		
Hgb		

i-STAT CREA

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

Pt Name:_____

Crea_____0.6 mg/dL

Sample Type_:

29JUL03 03:48

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAM5046A
CLEW A93

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
		3.5-5.5 g/dl
		26-84 u/l
		10-47 u/l
		14-97 u/l
		11-38 u/l
		0.2-1.6 mg/dl
		7-22 mg/dl
		8.0-10.3mg/dl
L		100-200 mg/dl
		0.6-1.2 mg/dl
		73-118 mg/dl
		6.4-8.1 g/dl

(Piccolo) Metabolic Panel

i-STAT EC8+

Pt: [redacted]

Pt Name:_____

Glu_____141 mg/dL
BUN_____22 mg/dL
Na_____137 mmol/L
K_____3.9 mmol/L
Cl_____109 mmol/L
TCO2_____22 mmol/L
AnGap_____10 mmol/L
Hct_____29 %PCV
Hb*_____10 g/dL
*via Hct
pH_____7.468
PCO2_____29.7 mmHg
HCO3_____21 mmol/L
BEecf_____-2 mmol/L

Sample Type_:

29JUL03 03:46

Oper: 13

Physician:_____

Ser# [redacted]

Ver: JAM5046A
CLEW A93

(Piccolo) Metlyte 8

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

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

REPORTED BY: [redacted]

DATE: 29Jul03

LAB ID NO

Ward/Section:	REQUESTING PHYSICIAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
ICU 1	[redacted] (b)(6)-2	

LAST, FIRST, MI.	DATE	TIME	SSN/PSEUDO SSN:
EPW [redacted] (b)(6)-4	28 Jul 03	1716	[redacted] (b)(6)-4

(Hematology) CBC

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

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		24-34 secs
D dimer		< 20 ug/ml
FDP		< 10 ug/ml

Urinalysis

TEST	RESULT	REF. RANGE
Color	Yellow	N/A
App	Clear	N/A
Glu	Neg	Negative
Bili	Neg	Negative
Ket	Neg	Negative
SG	1010	N/A
Bld	Trace	Negative
pH	7.5	N/A
Prot	Neg	Negative
Urob	4	0.2-1.0
Nit	Neg	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

WBC-OCC Amorphous Sod
RBC-OCC

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

Order requests Please Send urine for Rings

(b)(6)-2

Ward/Section: ICU

REQUESTING PHYSICIAN: [redacted]

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

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

DATE: 2-22 TIME: 0400 SSN/PSEUDO SSN:

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE

======= PICCOLO =======
28/07/03 04:26
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
GENERAL CHEMISTRY 12
DISC LOT #: 3142AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

ALB	2.5*	3.3-5.5	G/DL
ALP	142*	26-84	U/L
ALT	♦♦♦	10-47	U/L
AMY	314*	14-97	U/L
AST	87*	11-38	U/L
TBIL	4.6*	0.2-1.6	MG/DL
BUN	♦♦♦	7-22	MG/DL
CA++	10.5*	8.0-10.3	MG/DL
CHOL	214*	100-200	MG/DL
CRE	0.6	0.6-1.2	MG/DL
GLU	136*	73-118	MG/DL
TP	8.0	6.4-8.1	G/DL

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

BUN-17

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
LU		73-118 mg/dl
UN		7-22 mg/dl
A++		8.0-10.3 mg/dl
RE		0.6-1.2 mg/dl
A+		128-145 mmol/l
+		3.3-4.7 mmol/l
L-		98-108 mmol/l
CO_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
A+	136	128-145 mmol/l
+	3.8	3.3-4.7 mmol/l
L-	103	98-108 mmol/l
CO_2	29	18-33 mmol/l

REMARKS:

REPORTED BY: [redacted] DATE: 28 Jul 03 LAB ID NO.:

(b)(6)-2

(b)(6)-2

Ward/Section: ICU

REQUESTING PHYSICIAN: [redacted]

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

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

DATE: 7-27

TIME: 0400

SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT		REF. RANGE
ID: [redacted]			28-07-03
WB			04:13
			Patient Limits
WBC	25.0 H	x10^3/uL	4.5 10.5
RBC	3.63 L	x10^6/uL	4.00 6.00
Hgb	10.8 L	g/dL	11.0 18.0
Hct	34.7 L	%	35.0 60.0
MCV	95.5	fL	80.0 99.9
MCH	29.7	pg	27.0 31.0
MCHC	31.1 L	g/dL	33.0 37.0
Plt	2008. +H	x10^3/uL	150. 450.
LY%	7.0 *L	%	20.5 51.1
LY#	1.7 *	x10^3/uL	1.2 3.4

Segs	78	Mono	
Bands	3	Eos	
Lymph	17	Baso	
Atyp	2	Immat	
RBC Morph	marked increase platelets		
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

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

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted]

DATE: 28 Feb 03

LAB ID NO.:

(b)(6)-2

Ward/Section: ICU #1

REQUESTING PHYSICIAN:

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

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

DATE: 27 Jul

TIME: 0330

SSN/PSEUDO SSN:

(Hematology) CBC

ID: [redacted]
WB

27-07-03
03:38

			Patient Limits	
WBC	14.4 H	x10^3/uL	4.5	10.5
RBC	2.81 L	x10^6/uL	4.00	6.00
Hgb	8.4 L	g/dL	11.0	18.0
Hct	26.6 L	%	35.0	60.0
MCV	94.5	fL	80.0	99.9
MCH	30.0	pg	27.0	31.0
MCHC	31.7 L	g/dL	33.0	37.0
Plt	1475. +H	x10^3/uL	150.	450.
LYZ	8.4 *L	%	20.5	51.1
LYN	1.2 *	x10^3/uL	1.2	3.4

(Hematology) Manual

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Blsts	
RBC Morph			

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

Coagulation Studies

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

REMARKS:

REPORTED BY: [redacted]

DATE: 27 Ju

(b)(6)-2

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		
Glu		
Bili		
Ket		
SG		
Bld		
pH		
Prot		
Urob		
Nit		
Leuk		
HCG		
Cell Count		
Directip		

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
		Negative

Microbiology

	Negative
	Negative

oscopic Urinalysis

Blood Bank

BMIT SF 518 WITH
NIT REQUESTED

tch
UNIT OF BLOOD

CROSSMATCH

Ward/Section: ICU # 1

QUESTING PHYSICIAN:

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

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

DATE: 27 JUL

TIME: 0330

SSN/PSEUDO SSN:

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE

PICCOLO
27/07/03 03:36
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
GENERAL CHEMISTRY 12
DISC LOT #: 3142AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

ALB	1.8*	3.3-5.5	G/DL
ALP	130*	26-84	U/L
ALT	99*	10-47	U/L
AMY	133*	14-97	U/L
AST	91*	11-38	U/L
TBIL	4.1*	0.2-1.6	MG/DL
BUN	♦♦♦	7-22	MG/DL
CA++	8.4	8.0-10.3	MG/DL
CHOL	166	100-200	MG/DL
CRE	0.7	0.6-1.2	MG/DL
GLU	144*	73-118	MG/DL
TP	6.2*	6.4-8.1	G/DL

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

Bun 10

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
Na	136	128-145 mmol/l
K	3.1	3.3-4.7 mmol/l
Cl	105	98-108 mmol/l
CO2	25	18-33 mmol/l

REMARKS:

REPORTED BY: [redacted]

(b)(6)-2

DATE: 27 Jul 03

LAB ID NO.:

Ward/Section: ICU #1 | REQUESTING PHYSICIAN: [redacted] (b)(6)-2

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

LAST, FIRST, MI: [redacted] (b)(6)-4 | DATE: 26Jul03 | TIME: 0400 | SSN/PSEUDO SSN: [redacted] (b)(6)-4

Hematology/ CBC

TEST	RESULT	REF. RANGE
W ID: [redacted]		26-07-03
R WB		03:39
		Patient Limits
WBC	15.0 H x10^3/uL	4.5 10.5
RBC	2.70 L x10^6/uL	4.00 6.00
Hgb	8.2 L g/dL	11.0 18.0
Hct	25.4 L %	35.0 60.0
MCV	94.0 fL	80.0 99.9
MCH	30.5 pg	27.0 31.0
MCHC	32.4 L g/dL	33.0 37.0
Plt	1272. +H x10^3/uL	150. 450.
LY%	7.9 *L %	20.5 51.1
LY#	1.2 *L x10^3/uL	1.2 3.4
Segs	Mono	
Bands	Eos	
Lymph	Baso	
Atyp	Other	
RBC Morph		
Sed Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8 13.6 secs
APTT		21-34 secs
D dimer		20 ng/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] (b)(6)-2 | DATE: 25July03 | LAB ID NO.:

ion: ICU #7 | QUESTING PHYSICIAN: [redacted] (b)(6)-2

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

T, FIRST, MI: [redacted] (b)(6)-4 | DATE: 26 Jul 03 | TIME: 0400 | SSN/PSEUDO SSN: [redacted] (b)(6)-4

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
$^+$		128-145 mmol/l
		3.3-4.7 mmol/l
		98-108 mmol/l
O_2		18-33 mmol/l

```
======= PICCOLO =======
26/07/03          03:39
REFERENCE RANGE:     MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: (b)(6)-7 3152AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]
.........................
GLU   162*  73-118   MG/DL
BUN   ♦♦♦   7-22     MG/DL
CRE   0.7   0.6-1.2  MG/DL
CK    206   39-380   U/L
NA+   ♦♦♦   128-145  MMOL/L
K+    3.6   3.3-4.7  MMOL/L
CL-   105   98-108   MMOL/L
tCO2  22    18-33    MMOL/L

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

Bun 8
Na 138

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
[redacted]	2 6 Jul 03	

(b)(6)-2

Ward/Section: ICU#7

QUESTING PHYSICIAN:

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

LAST, FIRST, MI.	DATE	TIME	SSN/PSEUDO SSN:
EPW [redacted] (b)(6)-4	25 Jul 4	0438	

(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

TI
AL
AL
AL
AM
AS
TI
BI
C
C
C
C
T

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

======= PICCOLO =======
25/07/03 04:47
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: 3152AA4
OPER # [redacted] DR #: 000
SERIAL #: (b)(6) [redacted]

GLU	132*	73-118	MG/DL
BUN	6*	7-22	MG/DL
CRE	ICT	0.6-1.2	MG/DL
CK	351	39-380	U/L
NA+	120*	128-145	MMOL/L
K+	3.9	3.3-4.7	MMOL/L
CL-	97*	98-108	MMOL/L
tCO2	23	18-33	MMOL/L

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

CRE - 0.6

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
[redacted] (b)(6)-2	25 Jul 03	

Ward/Section: ICU #7	REQUESTING PHYSICIAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI.	DATE	TIME	SSN/PSEUDO SSN:
EPW [redacted] (b)(6)-4	25Jul4	0430	

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	13.3	4.8-10.8 x 10^3
RBC	2.82	4.7-6.1 x 10^9
Hgb	8.6	14-18 g/dl (M) 12-16 g/dl (F)
Hct	26.6	42-52% (M) 37-47% (F)
MCV	94.1	80-94 fl (M) 81-99 fl (F)
Plt	871	130-500 x 10^3 verified
Lymph %	8.2	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
[redacted] (b)(6)-2	25 Jul 03	

Ward/Section: ICU #1	QUESTING PHYSICIAN: [redacted] (b)(6)-2	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI. [redacted] (b)(6)-4	DATE 25 Jul 03	TIME 1800	SSN/PSEUDO SSN: [redacted] (b)(6)-4

(i-STAT)

TEST	RESULT	REF. RANG
Na		138-146 mmol/
K		3.5-4.9 mmol/l
Cl		98-109 mmol/l
pH		7.31-7.45
PCO2		35-45 mmHg (41-51 mmHg (ve
PO2		80-105 mmHg (a N/A (ven)
TCO2		23-27 mmol/L (a 24-29 mmol/L (v
HCO3		22-26 mmol/L (a 23-28 mmol/L (v
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 nume
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. RANG
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

```
======= PICCOLO =======
25/07/03            17:52
REFERENCE RANGE:        MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #:  (b)(6)-2  3152AA4
OPER #[redacted]  DR #: 000
SERIAL #: (b)(6) [redacted]
.......................
GLU   168*  73-118   MG/DL
BUN     7   7-22     MG/DL
CRE   0.9   0.6-1.2  MG/DL
CK    228   39-380   U/L
NA+   ♦♦♦   128-145  MMOl/L
K+    3.7   3.3-4.7  MMOl/L
CL-   99    98-108   MMOl/L
tCO2  23    18-33    MMOl/L

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

Na 134

(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]	DATE: 25 Jul/03	LAB ID NO.:

(b)(6)-2

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

LAST, FIRST, MI: [redacted] (b)(6)-4	DATE: 24JUL03	TIME: 1800	SSN/PSEUDO SSN: [redacted] (b)(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	13.0	4.8-10.8 x 10^3
RBC	2.95	4.7-6.1 x 10^9
Hgb	8.7	14-18 g/dl (M) 12-16 g/dl (F)
Hct	27.8	42-52% (M) 37-47% (F)
MCV	94.1	80-94 fl (M) 81-99 fl (F)
Plt	861	130-500 x 10^3 verified
Lymph %	13.0	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

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

UNIT	TYPE	CROSSMATCH

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

REMARKS:

REPORTED BY: [redacted] (b)(6)-2	DATE: 24 JUL 03	LAB ID NO.:

1(0-1

[redacted] (5)(6)-2

(5)(6)-2

[redacted] (5)(6)-4

24 dy 1400

(Piccolo) Chemistry 12

(Piccolo) Metabolic Panel

======= PICCOLO =======

24/07/03 14:08

REFERENCE RANGE: MALE

PATIENT #: [redacted] (5)(6)-4

METLYTE 8

DISC LOT #: 3152AA4

OPER #: [redacted] DR #: 000

SERIAL #: [redacted]

GLU	94	73-118	MG/DL
BUN	10	7-22	MG/DL
CRE	1.3*	0.6-1.2	MG/DL
CK	4775*	39-380	U/L
NA+	130	128-145	MMOL
K+	4.5	3.3-4.7	MMOL
CL-	109*	98-108	MMOL
tCO2	20	18-33	MMOL

INST QC: OK CHEM QC: OK

HEM 0 , LIP 0 , ICT 0

(Piccolo) Liver Panel Plus

(Piccolo) Electrolyte

Misc. Chemistry

REMARKS:

REFERENCE DATA: [redacted]

(5)(6)-2

DATE: 24 Jul 03

LAB ID NO.:

Ward/Section: ICU #1

REQUESTING PHYSICIAN:

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

LAST, FIRST, MI	DATE	TIME	SSN/PSEUDO SSN:
EPW [redacted] (b)(6)-4	24Jul4	0400	

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE

======= PICCOLO =======
24/07/03 04:56
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: 3151AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	124*	73-118	MG/DL
BUN	6*	7-22	MG/DL
CRE	ICT	0.6-1.2	MG/DL
CK	262	39-380	U/L
NA+	123*	128-145	MMOL/L
K+	3.8	3.3-4.7	MMOL/L
CL-	96*	98-108	MMOL/L
tCO2	24	18-33	MMOL/L

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

Crea 0.8

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

EST	RESULT	REF. RANGE
+		128-145 mmol/l
		3.3-4.7 mmol/l
		98-108 mmol/l
O_2		18-33 mmol/l

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
[redacted]	24Jul03	

(b)(6)-2

Ward/Section: ICU #1	REQUESTING PHYSICIAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI.	DATE	TIME	SSN/PSEUDO SSN:
EPW [redacted] (b)(6)-4	24 July	0400	

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*
WBC	10.1	4.8-10.8 x 10^3	Color		N/A	RPR		Negative
RBC	3.03	4.7-6.1 x 10^9	App		N/A	Mono		Negative
Hgb	9.0	14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	**Microbiology**		
Hct	28.5	42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV	94.1	80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
Plt	591	130-500 x 10^3 verified	SG		N/A	Occ Bld		Negative
Lymph %	14.2	20.5-51.1%	Bld		Negative	H. pylori		Negative
(Hematology) Manual Differential			pH		N/A	Micro Parasites		
Segs		Mono	Prot		Negative	Malaria		
Bands		Eos	Urob		0.2-1.0	O & P		
Lymph		Baso	Nit		Negative	Other		
Atyp		Imm	Leuk		Negative	**Microscopic Urinalysis**		
RBC Morph			HCG		Negative			

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

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

REMARKS:

REPORTED BY:	**DATE:**	**LAB ID NO.:**
[redacted]	24 Jul 03	

(b)(6)-4

IW1

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

EOW [redacted] (b)(6)-4 24JUL03 1800

(Piccolo) Chemistry 12

TEST	RESULT	REF RANGE
ALB		
ALP		

(Piccolo) Metab

(Piccolo) Liver

Misc. Chemistry

(Piccolo) Electrolyte

======= PICCOLO =======

24/07/03 17:57

REFERENCE RANGE: MALE

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

METLYTE 8

DISC LOT #: 3152AA4

OPER #: [redacted] DR #: 000

SERIAL #: [redacted]

GLU	117	73-118	MG/DL
BUN	6*	7-22	MG/DL
CRE	ICT	0.6-1.2	MG/DL
CK	181	39-380	U/L
NA+	128	128-145	MMOL/L
K+	4.9*	3.3-4.7	MMOL/L
CL-	100	98-108	MMOL/L
tCO2	24	18-33	MMOL/L

INST QC: OK CHEM QC: OK

HEM 2+, LIP 0 , ICT 2+

i-STAT CREA

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

Pt Name:_____

Crea_____0.8 mg/dL

Sample Type_:

24JUL03 18:15

Oper: 1678

Physician:_____

Ser# 42011

Ver:

REMARKS:

REPORTED BY

[redacted] 24JUL03

(b)(6)-2

Ward/Section: ICU #1	QUESTING PHYSICIAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] (b)(6)-4	DATE 7-23-03 / TIME 04:00	SSN/PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RAN
Na		138-146 mmo
K		3.5-4.9 mmol
Cl		98-109 mmol
pH		7.31-7.45
PCO2		35-45 mmHg 41-51 mmHg (v
PO2		80-105 mmHg N/A (ven)
TCO2		23-27 mmol/L 24-29 mmol/L
HCO3		22-26 mmol/L 23-28 mmol/L
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/l
Ca		1.12-1.32 mm
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. RAN
Troponin-I		
Drug of Abuse		

PICCOLO

23/07/03 04:30

REFERENCE RANGE: MALE

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

METLYTE 8

DISC LOT #: γ 3141AA4

OPER #: [redacted] (b) DR #: 000

SERIAL #: (b) [redacted]

GLU	123*	73-118	MG/DL
BUN	8	7-22	MG/DL
CRE	ICT	0.6-1.2	MG/DL
CK	469*	39-380	U/L
NA+	123*	128-145	MMOL/L
K+	3.9	3.3-4.7	MMOL/L
CL-	96*	98-108	MMOL/L
tCO2	22	18-33	MMOL/L

INST QC: OK CHEM QC: OK

HEM 1+, LIP 0 , ICT 3+

PICCOLO

23/07/03 04:14

REFERENCE RANGE: MALE

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

GENERAL CHEMISTRY 12

DISC LOT #: γ 3204AA4

OPER #: [redacted] (b) DR #: 000

SERIAL #: (b) [redacted]

ALB	1.6*	3.3-5.5	G/DL
ALP	88*	26-84	U/L
ALT	91*	10-47	U/L
AMY	72	14-97	U/L
AST	123*	11-38	U/L
TBIL	10.4*	0.2-1.6	MG/DL
BUN	7	7-22	MG/DL
CA++	7.7*	8.0-10.3	MG/DL
CHOL	108	100-200	MG/DL
CRE	ICT	0.6-1.2	MG/DL
GLU	128*	73-118	MG/DL
TP	4.3*	6.4-8.1	G/DL

INST QC: OK CHEM QC: OK

HEM 2+, LIP 0 , ICT 3+

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
[redacted] (b)(6)-2	23 Jul 03	

(b)(6)-2

Ward/Section: 100H1	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. [redacted] (b)(6)-4	DATE 7-23-03	TIME 0400	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	11.3	~~4.8-10.8~~ x 10^3
RBC	3.10	4.7-6.1 x 10^6
Hgb	9.3	14-18 g/dl (M) 12-16 g/dl (F)
Hct	29.0	42-52% (M) 37-47% (F)
MCV	93.5	80-94 fl (M) 81-99 fl (F)
Plt	395	130-500 x 10^3 verified
Lymph %	7.8	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

REMARKS: [redacted] 22 Jul 03

(b)(6)-2 [redacted]

(5)(6)-2

Ward/Section: [illegible] QUESTING PHYSICIAN: DR [redacted] (5)(6)-4

LAST, FI [redacted] DATE: 23/07/03 TIME: 1030 SSN/I

(Subject to th

i-STAT CREA

Pt: [redacted] (5)(6)-4

Pt Name:_____

Crea_____0.7 mg/dl

Sample Type_:

23JUL03 10:56

Oper: 7210

Physician:_____

Ser# [redacted] (5)(6)-4

Ver: JAM5046A
CLEW A93

i-STAT G3+

Pt: [redacted] (5)(6)-4

Pt Name:_____

TCO2_____33 mmol/L

At 37C

pH_____7.428

PCO2_____47.3 mmHg

PO2_____90 mmHg

HCO3_____31 mmol/L

BEecf_____7 mmol/L

SO2*_____97 %

*calculated

At Patient Temp

pH_____7.433

PCO2_____46.6 mmHg

PO2_____88 mmHg

Patient Temp: 98.0F

FIO2_____: 35

Sample Type_:

23JUL03 11:

Oper: [redacted]

Phys

Ser#

PICCOLO

23/07/03 10:40

REFERENCE RANGE: MALE

PATIENT #: [redacted]

METLYTE 3 (5)(6)-4

DISC LOT #: 3141AA4

OPER #: [redacted] DR #: 000

SERIAL #: (5)(6) [redacted]

GLU	120*	73-118	MG/DL
BUN	8	7-22	MG/DL
CRE	ICT	0.6-1.2	MG/DL
CK	329	39-380	U/L
NA+	124*	128-145	MMOL/L
K+	3.7	3.3-4.7	MMOL/L
CL-	96*	98-108	MMOL/L
tCO2	24	18-33	MMOL/L

INST QC: OK CHEM QC: OK

HEM 0 , LIP 0 , ICT 2+

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
[redacted]	23Jul/03	

(5)(6)-2

(b)(6)-2

Ward/Section:	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, M: [redacted] (b)(6)-4	DATE: 8/8/03 TIME: 0630	SSN/PSEUDO SSN:

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*
WBC		4.8-10.8 x 10^3	Color		N/A	RPR		Negative
RBC		4.7-6.1 x 10^9	App		N/A	Mono		Negative
Hgb		14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	**Microbiology**		
Hct		42-52% (M) 37-47% (F)	Bili		Negative	Source	CSF	
MCV		80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain	No Bacteria Seen	
Plt		130-500 x 10^3 verified	SG		N/A	Occ Bld		Negative
Lymph %		20.5-51.1%	Bld		Negative	H. pylori		Negative
(Hematology) Manual Differential			pH		N/A	Micro Parasites		
Segs		Mono	Prot		Negative	Malaria		
Bands		Eos	Urob		0.2-1.0	O & P		
Lymph		Baso	Nit		Negative	Other		
Atyp		Imm	Leuk		Negative	**Microscopic Urinalysis**		
RBC Morph			HCG		Negative			
Spun Hematocrit		42-52% (M) 37-47% (F)	**CSF** 1177 RBC/uL 22 WBC/uL			**Blood Bank**		
Sed Rate			Cell Count	GRAM STAIN		**MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED**		
Other			Directigen		Negative	ABO/Rh		

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

REMARKS:

REPORTED BY: [redacted]	**DATE:** 21 Jul 03	**LAB ID NO.:**

(b)(6)-2

P7/10

(b)(6)-2

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

LAST FIRST MI		DATE	TIME	SSN/PSEUDO SSN:
[redacted] (b)(6)-2	[redacted]	3/22/03	0900	

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	14.5	4.8-10.8 x 10^3
RBC	2.97	4.7-6.1 x 10^9
Hgb	8.9	14-18 g/dl (M) 12-16 g/dl (F)
Hct	27.8	42-52% (M) 37-47% (F)
MCV	93.6	80-94 fl (M) 81-99 fl (F)
Plt	286	130-500 x 10^3 verified
Lymph %	7.1	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

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

UNIT	TYPE	CROSSMATCH
[redacted]		

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

(b)(6)-2

REMARKS:

REPORTED BY: (b)(6)-2 [redacted]	DATE: 3/22/03	LAB ID NO.:

(b)(6)-2

Ward/Section: LEV1	REQUESTING PHYSICIAN (b)(6)-4 [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. [redacted]	DATE 9/22/03	TIME 0900	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	14.5	4.8-10.8 x 10^3
RBC	2.97	4.7-6.1 x 10^9
Hgb	8.9	14-18 g/dl (M) 12-16 g/dl (F)
Hct	27.8	42-52% (M) 37-47% (F)
MCV	93.6	80-94 fl (M) 81-99 fl (F)
Plt	286	130-500 x 10^3 verified
Lymph %	7.1	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

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

UNIT	TYPE	CROSSMATCH

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

REMARKS:

REPORTED BY: [redacted]	DATE: 22 Sep 03	LAB ID NO.:

(b)(6)-2

Ward/Section: ICU	REQUESTING PHYSICIAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI. [redacted] (b)(6)-4	DATE 7/22	TIME 0400	SSN/PSEUDO SSN:

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

======= PICCOLO =======
22/07/03 04:00
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
GENERAL CHEMISTRY 12
DISC LOT #: (b)(6)-2 3142AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

ALB	1.6*	3.3-5.5	G/DL
ALP	48	26-84	U/L
ALT	82*	10-47	U/L
AMY	38	14-97	U/L
AST	156*	11-38	U/L
TBIL	11.8*	0.2-1.6	MG/DL
BUN	9	7-22	MG/DL
CA++	7.7*	8.0-10.3	MG/DL
CHOL	116	100-200	MG/DL
CRE	ICT	0.6-1.2	MG/DL
GLU	107	73-118	MG/DL
TP	3.9*	6.4-8.1	G/DL

INST QC: OK CHEM QC: OK
HEM 2+, LIP 0, ICT 3+

Creat 0.7

(Piccolo) Metabolic Panel

======= PICCOLO =======
22/07/03 04:02
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
ELECTROLYTE
DISC LOT #: (b)(6)-2 3135AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

NA+	128	128-145	MMOL/L
K+	3.9	3.3-4.7	MMOL/L
CL-	♦♦♦	98-108	MMOL/L
tCO2	28	18-33	MMOL/L

INST QC: OK CHEM QC: OK
HEM 2+, LIP 0, ICT 3+

C199

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
[redacted] (b)(6)-2	22 July 03	

21JUL03 (b)(6)-2

Ward/Section: ICU 1 | QUESTING PHYSICIAN: [redacted] | CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)

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

(Piccolo) Chemistry 12 | (Piccolo) Metabolic Panel

i-STAT G3+

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

Pt Name:_____

TCO2_____29 mmol/L

At 37C

pH_____7.405

PCO2_____43.8 mmHg

PO2_____107 mmHg

HCO3_____27 mmol/L

BEecf_____3 mmol/L

sO2*_____98 %

*calculated

At Patient Temp

pH_____7.398

PCO2_____44.8 mmHg

PO2_____110 mmHg

Patient Temp: 37.5C

FIO2_____: 35

Sample Type_: ART

21JUL03 04:23

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

Physician:_____

Ser# [redacted]

Ver: JAM5046A
CLEW A93

======= PICCOLO =======

21/07/03 05:22

REFERENCE RANGE: MALE

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

GENERAL CHEMISTRY 12

DISC LOT #: (b)(6)-2 3142AA4

OPER #: [redacted] DR #: 000

SERIAL #: [redacted]

ALB	1.7*	3.3-5.5	G/DL
ALP	47	26-84	U/L
ALT	40	10-47	U/L
AMY	38	14-97	U/L
AST	151*	11-38	U/L
TBIL	13.8*	0.2-1.6	MG/DL
BUN	11	7-22	MG/DL
CA++	8.2	8.0-10.3	MG/DL
CHOL	54*	100-200	MG/DL
CRE	ICT	0.6-1.2	MG/DL
GLU	97	73-118	MG/DL
TP	ICT	6.4-8.1	G/DL

INST QC: OK CHEM QC: OK

HEM 1+, LIP 0, ICT 3+

7[redacted]

i-STAT EC8+

Pt: [redacted]

Pt Name:_____

Glu_____91 mg/dL

BUN_____16 mg/dL

Na_____135 mmol/L

K_____3.7 mmol/L

Cl_____104 mmol/L

TCO2_____28 mmol/L

AnGap_____9 mmol/L

Hct_____28 %PCV

Hb*_____10 g/dL

*via Hct

pH_____7.347

PCO2_____48.1 mmHg

HCO3_____26 mmol/L

BEecf_____1 mmol/L

Sample Type_:

21JUL03 05:22

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

Physician:_____

Ser# [redacted]

Ver: JAM5046A
CLEW A93

DATE: 21 July 03 | LAB ID NO.:

[redacted]

(b)(6)-2 0520

(b)(6)-2

Ward/Section: ICU #1	REQUESTING PHYSICI[redacted] (b)(6)-4	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. [redacted]	DATE 7-21-03	TIME 0400	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	17.7	4.8-10.8 x 10^3
RBC	3.18	4.7-6.1 x 10^9
Hgb	9.4	14-18 g/dl (M) 12-16 g/dl (F)
Hct	29.4	42-52% (M) 37-47% (F)
MCV	94.6	80-94 fl (M) 81-99 fl (F)
Plt	234	130-500 x 10^3 verified
Lymph %	5.3	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted]	DATE: 21 JUL 03	LAB ID NO.:

(b)(6)-2 0400

(b)(6)-2

Ward/Section: [redacted]

QUESTRY [redacted]

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

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

TIME

SSN/PSEUDO SSN:

[redacted] (STAT)			(Piccolo) Chemistry 12			(Piccolo) Metabolic Panel		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
Na					3.5-5.5 g/dl	GLU		73-118 mg/dl
K					26-84 u/l	BUN		7-22 mg/dl
Cl					10-			g/dl
pH					-14-			/dl
PCO					11-			mol/l
PO2					0.2-			ol/l
TCO					7-2			nol/l
HCO					8.0			ol/l
sO2					100			
BEec					0.6			ANGE
AnG					73.			dl
Ca					8.4			
BUN								
GLU								
Crea					73			
Hct					7-			g/dl
Hgb					6-			
					39			dl
					30			
TE					12			
Tropo					3.3			ANGE
Drug Abu					98			mmol/l
			tCO_2		18			mol/l
								mol/l
								ol/l

i-STAT 6+

Pt: [redacted]

Pt Name:_____

Glu_____97 mg/dL

BUN_____13 mg/dL

Na_____140 mmol/L

K_____3.5 mmol/L

Cl_____105 mmol/L

Hct_____29 %PCV

Hb*_____10 g/dL

*via Hct

Sample Type_:

20JUL03 09:35

Oper: [redacted]

Physician

Ser# 426

Ver: JAMS[redacted]
CLEW A93

(b)(6)-2 [redacted]

PICCOLO

20/07/03 09:36

REFERENCE RANGES: MALE

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

GENERAL CHEMISTRY 12

DISC LOT #: 3142AA4

OPER # [redacted] DR #: 000

SERIAL #: [redacted]

ALB	1.5*	3.3-5.5	G/DL
ALP	45	26-84	U/L
ALT	50*	10-47	U/L
AMY	52	14-97	U/L
AST	♦♦♦	11-38	U/L
TBIL	14.1*	0.2-1.[illegible]	MG/DL
BUN	8	7-22	MG/DL
CA++	8.1	8.0-10.3	MG/DL
CHOL	73*	100-200	MG/DL
CRE	ICT	0.6-1.2	MG/DL
GLU	106	73-118	MG/DL
TP	ICT	6.4-8.1	G/DL

INST QC: OK CHEM QC: OK

HEM 1+, LIP 0, ICT 3+

REMARKS:

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

ICU #1 [redacted] (b)(6)-2

EPW [redacted] (b)(6)-4 20Jul03 [illegible] 4/47

i-STAT CREA

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

Pt Name:_____

Crea_____0.7 mg/dL

Sample Type_:

20JUL03 03:45

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

Physician:_____

Ser# [redacted]

Ver: JAMS04r
CLEW A

(Piccolo) Chemistry 12

TEST	RESULT	REF RANGE
ALB		3.5-5.5 g/dl
ALP		20-84 u/l
ALT		10-47 u/l
AMY		14-91 u/l
AST		17-58 u/l
TBIL		0.2-1.0 mg/dl
BUN		7-22 mg/dl
CA		8.0-10.5 mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		75-115 mg/dl
TP		6.1-8.1 g/dl

(Piccolo) Metlyte 8

TEST	RESULT	REF RANGE
GLU		75-115 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		30-180 u/l (M) 30-190 u/l (F)
NA		128-142 mmol/l
K		3.5-4.7 mmol/l
CL		98-108 mmol/l
HCO_3		18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF RANGE
GLU		
BUN		
CA		
CRE		
NA		
K		
CL		
HCO_3		

TEST
ALB
ALP
ALT
AMY
AST
TBIL
CHOL
TP

TEST
NA
K
CL
HCO_3

i-STAT EC8+

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

Pt Name:_____

Glu_____87 mg/dL

BUN_____12 mg/dL

Na_____139 mmol/L

K_____3.5 mmol/L

Cl_____104 mmol/L

TCO2_____27 mmol/L

AnGap_____13 mmol/L

Hct_____29 %PCV

Hb*_____10 g/dL

*via Hct

pH_____7.376

PCO2_____43.8 mmHg

HCO3_____26 mmol/L

BEecf_____0 mmol/L

Sample Type_:

20JUL03 03:46

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

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

REMARKS

REPORTED BY

DATE:

LAB ID NO.:

rgw 20 July 03

(b)(6)-2

Ward/Section: ICU #1	ATTENDING PHYSICIAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI	DATE	TIME	SSN PSEUDO SSN:
EPW [redacted] (b)(6)-4	20 Jul 03	0400	[redacted]

(Hematology) CBC

TEST	RESULT	REF. RANGE
W[illegible]		
R[illegible]		
H[illegible]		
H[illegible]		
M[illegible]		
Pl[illegible]		
Ly[illegible]		

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.0 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Blood Bank

(MUST SUBMIT SF 518 RF

UNIT	

Misc. Serology

TEST	RESULT	REF. RANGE
[illegible]		Negative

i-STAT G3+

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

Pt Name:_____

TCO2_____30 mmol/L

At 37C

pH_____7.424

PCO2_____43.1 mmHg

PO2_____109 mmHg

HCO3_____28 mmol/L

BEecf_____4 mmol/L

sO2*_____98 %

*calculated

At Patient Temp

pH_____7.412

PCO2_____44.6 mmHg

PO2_____114 mmHg

Patient Temp: 100.0F

FIO2_____: 30

Sample Type_: ART

20JUL03 03:34

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

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

REMARKS: [redacted] 20 Jul 03

REPORTED BY: (b)(6)-2 | DATE: | LAB ID NO.:

FCU 1

(5)(6)-2

Dr. [redacted]

DATE 7-19 TIME 1250

[redacted]

(5)(6)-7

[redacted]

colo) Metabolic Panel

======= PICCOLO =======

19/07/03 12:57

REFERENCE RANGE: MALE

PATIENT #: [redacted] - (5)(6)-7

GENERAL CHEMISTRY 12

DISC LOT #: 3142AA4

OPER #: [redacted] - (5)(6)-2

SERIAL #: [redacted]

ALB	1.5*	3.3-5.5	G/DL
ALP	53	26-84	U/L
ALT	♦♦♦	10-47	U/L
AMY	63	14-97	U/L
AST	♦♦♦	11-38	U/L
TBIL	12.9*	0.2-1.6	MG/DL
BUN	6*	7-22	MG/DL
CA++	8.1	8.0-10.3	MG/DL
CHOL	102	100-200	MG/DL
CRE	ICT	0.6-1.2	MG/DL
GLU	103	73-118	MG/DL
TP	3.5*	6.4-8.1	G/DL

INST QC: OK CHEM QC: OK

HEM 1+, LIP 0 , ICT 3+

======= PICCOLO =======

19/07/03 12:58

REFERENCE RANGE: MALE

PATIENT #: [redacted]

METLYTE 8

DISC LOT #: 3152AA4

OPER #: [redacted] DR #: 000

SERIAL #: [redacted]

GLU	101	73-118	MG/DL
BUN	8	7-22	MG/DL
CRE	ICT	0.6-1.2	MG/DL
CK	700*	39-380	U/L
NA+	117*	128-145	MMOL/L
K+	3.5	3.3-4.7	MMOL/L
CL-	102	98-108	MMOL/L
tCO2	29	18-33	MMOL/L

INST QC: OK CHEM QC: OK

HEM 0 , LIP 0 , ICT 3+

colo) Liver Panel Plus

Piccolo) Electrolyte

Specimen Icter 3+

REPORTED BY [redacted] DATE: 19 July 03 LAB REQ. NO.:

(5)(6)-2

Ward/Section: ICU #1	R... ...STING PHYSICIAN: [redacted] (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI.	DATE	TIME	SSN/PSEUDO SSN:
EPW [redacted] (b)(6)-4	7/19/03	0400	[redacted] (b)(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		
RBC		
Hgb		
Hct		
MCV		
Plt		
Lymph[c]		

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh		

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
[redacted] (b)(6)-2	19 Jul 03	

(5)(6)-2

ICU #1

EPW [redacted]

(5)(6)-4

[redacted]

7/19/03 0400

(5)(6)-4

(Piccolo) Chemistry 12

(Piccolo) Metabolic Panel

TEST	RESULT	REF RANGE
GLU		[illegible]
BUN		[illegible]
CA		[illegible]
CRE		[illegible]
NA		[illegible]
K		[illegible]
CL		[illegible]
TCO2		[illegible]

(Piccolo) Liver Panel Plus

TEST	RESULT	REF RANGE
ALB		[illegible]
ALP		[illegible]
ALT		[illegible]
AMY		[illegible]
AST		[illegible]
TBIL		[illegible]
GGT		[illegible]
TP		[illegible]

(Piccolo) Electrolyte

TEST	RESULT	REF RANGE
NA		[illegible]
K		[illegible]
CL		[illegible]
TCO2		[illegible]

======= PICCOLO =======

19/07/03 04:11

REFERENCE RANGE: MALE

PATIENT #: [redacted] (5)(6)-4

GENERAL CHEMISTRY 12

DISC LOT #: (5)(6)-2 3142AA4

OPER #: [redacted] DR #: 003

SERIAL #: [redacted]

ALB	1.4*	3.3-5.5	G/DL
ALP	52	26-84	U/L
ALT	♦♦♦	10-47	U/L
AMY	62	14-97	U/L
AST	105*	11-38	U/L
TBIL	13.3*	0.2-1.6	MG/DL
BUN	5*	7-22	MG/DL
CA++	8.1	8.0-10.3	MG/DL
CHOL	107	100-200	MG/DL
CRE	ICT	0.6-1.2	MG/DL
GLU	101	73-118	MG/DL
TP	3.7*	6.4-8.1	G/DL

INST QC: OK CHEM QC: OK

HEM 2+, LIP 0 , ICT 3+

cre ~~Alt~~ ict due to sample condition

Misc. Chemistry

REF RAT

REMARKS:

REPORTED BY (5)(6)-2 [redacted]

DATE:

LAB ID NO.:

19 July 03

Kt only. # [redacted] (b)(6)-4 J I 7-19-03

[redacted]

---

i-STAT G3+

Pt: [redacted] FiO2 35%
(b)(6)-4

** PRINT CANCELLED **

---

i-STAT G3+

Pt: 447

Pt Name:_____

TCO2_____31 mmol/L

At 37C

PH_____7.613

PCO2_____30.2 mmHg

PO2_____232 mmHg

HCO3_____31 mmol/L

BEecf_____9 mmol/L

sO2*_____100 %

*calculated

At Patient Temp

PH_____7.585 12 ↓ 10

PCO2_____32.5 mmHg

PO2_____241 mmHg

Patient Temp: 101.7F

FIO2_____: 35 ↓ 30

Sample Type_: ART

19JUL03 04:09

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

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

(b)(6)-2

i-STAT G3+ FiO2 30%

Pt: 447

Name:_____

TCO2_____30 mmol/L

At 37C

PH_____7.429

PCO2_____43.2 mmHg

PO2_____105 mmHg

HCO3_____29 mmol/L

BEecf_____4 mmol/L

sO2*_____98 %

*calculated

At Patient Temp

PH_____7.419

PCO2_____44.5 mmHg

PO2_____109 mmHg

Patient Temp: 37.7C

Sample Type_: ART

19JUL03 06:54

Oper: 0000000

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

[redacted] (b)

(Piccolo) Metabolic Panel

TEST	RESULT	REF RANGE

======= PICCOLO =======

19/07/03 05:21

REFERENCE RANGE: MALE

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

ELECTROLYTE

DISC LOT #: (b)(4)-2 3135AA4

OPER #: [redacted] DR #: 000

SERIAL #: [redacted]

NA+	121*	128-145	MMOL/L
K+	3.3	3.3-4.7	MMOL/L
CL-	97*	98-108	MMOL/L
tCO2	23	18-33	MMOL/L

INST QC: OK CHEM QC: OK

HEM 1+, LIP 0 , ICT 3+

---

i-STAT G3+

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

Pt Name:_____

TCO2_____27 mmol/L

At 37C

PH_____7.450

PCO2_____37.1 mmHg

PO2_____153 mmHg

HCO3_____26 mmol/L

BEecf_____2 mmol/L

sO2#_____99 %

#calculated

At Patient Temp

PH_____7.430

PCO2_____39.3 mmHg

PO2_____161 mmHg

Patient Temp: 101.0F

FIO2_____: 60

Sample Type_: ART

18JUL03 03:38

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

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEI

[redacted]

(b)(6)-2

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

DATE 7/18/03 TIME 0400

SSN PSEUDO SSN [redacted]

REF. RANGE

---

i-STAT 208+

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

Pt Name:_____

Glu_____110 mg/dL

BUN_____11 mg/dL

Na_____137 mmol/L

K_____3.2 mmol/L

Cl_____106 mmol/L

iCa_____94 mmol/L

AnGap_____11 mmol/L

Hct_____30 %PCV

Hgb_____10 g/dL

#Vis Hct

pH_____7.451

pCO2_____36.2 mmHg

HCO3_____25 mmol/L

BEecf_____1 mmol/L

Sample Type_

18JUL03 03:42

Oper: 38

Physician:_____

Ser# 40743

Ver: JAMS046A
CLEN A03

Piccolo) Metabolic Panel

RESULT	REF. RANGE
	5-18 mg/dl
	7-22 mg/dl
	8.0-10.3 mg/dl
	0.0-1.2 mg/dl
	128-145 mmol/l
	3.3-4.7 mmol/l
	98-108 mmol/l
	18-33 mmol/l

(Piccolo) Liver Panel Plus

RESULT	REF. RANGE
	3.3-5.5 g/dl
	26-84 u/l
	10-47 u/l
	14-97 u/l
	11-38 u/l
	0.2-1.6 mg/dl
	3-65 u/l
	6.4-8.1 g/dl

(Piccolo) Electrolyte

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

REF. RANGE

Negative

Negative

Negative

Negative

Negative

istry

REF. RANGE

Ward/Section: ICU #1	R. ING PHYSICIAN: Dr [redacted] (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI.	DATE	TIME	SSN/PSEUDO SSN:
EPW [redacted] (b)(6)-4	7/18/03	0400	[redacted] (b)(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	[redacted]	[illegible]
RBC		[illegible]
Hgb		[illegible]
Hct		[illegible]
MCV		[illegible]
Plt		[illegible]
Lymp		[illegible]

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS: [redacted] 18Jul03

REPORTED BY: (b)(6)-2 **DATE:** **LAB ID NO.:**

ICU-1

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

[redacted] (b)(2)-2

18 July 03
1500

(b)(2)-7
[redacted]

(Piccolo) Chemistry 12

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
BUN		7-22 mg/dl
CA		8.0-10.3 mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

(Piccolo) Metabolic Panel

TEST	RESULT	REF RANGE
GLU		
BUN		
CA		
CRE		
NA		
K		
CL		
BCO		

(P

TEST	
ALB	
ALP	
ALT	
AMY	
AST	
TBIL	
GGT	
TP	

TEST

NA

K

CL

BCO

VER:

(Piccolo) Metlyte 8

TEST	RESULT	REF RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
K		3.6-5.0 mmol/l (AD) 3.6-5.0 mmol/l (PE)
NA		128-145 mmol/l
		3.5-4.7 mmol/l
CL		98-106 mmol/l
CO2		18-33 mmol/l

DATE: | LAB ID NO.:

-- PICCOLO =======
18/07/03 16:10
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
GENERAL CHEMISTRY 12
DISC LOT #: 3142AA4
OPER #: [redacted] DR #: 000
SERIAL #: (b)(6)-2 [redacted]

ALB	1.5*	3.3-5.5	G/DL
ALP	53	26-84	U/L
ALT	39	10-47	U/L
AMY	55	14-97	U/L
AST	106*	11-38	U/L
TBIL	15.3*	0.2-1.6	MG/DL
BUN	♦♦♦	7-22	MG/DL
CA++	8.2	8.0-10.3	MG/DL
CHOL	128	100-200	MG/DL
CRE	ICT	0.6-1.2	MG/DL
GLU	103	73-118	MG/DL
TP	ICT	6.4-8.1	G/DL

INST QC: OK CHEM QC: OK
HEM 1+, LIP 0 , ICT 3+

(b)(6)-2 [redacted]
unable to result.

(b)(6)-2

ICU

EPW [redacted]

18 July 03

[redacted]

(Piccolo) Chemistry 12

(Piccolo) Metabolic Panel

RESULT | REF RANGE

U-STRT EC6+

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

PT Name:_____

Glu_____124 mg/dL

BUN_____10 mg/dL

Na_____138 mmol/L

K_____3.1 mmol/L

Cl_____100 mmol/L

TCO2_____25 mmol/L

AnGap_____13 mmol/L

Hct_____38 %PCV

Hb*_____13 g/dL

Avig Hgb

pH_____7.440

PCO2_____38.7 mmHg

_____14 mmol/L

_____0 mmol/L

Date: 7816

Physician:_____

Serv 40760

Vert JAM60163
GLCN 805

======= PICCOLO =======

18/07/03 09:29 (b)(6)-4

REFERENCE RANGE: MALE

PATIENT #: [redacted]

GENERAL CHEMISTRY 12

DISC LOT #: 3082AA4

OPER #: [redacted] 2 DR #: 000

SERIAL #: (b)(6) [redacted]

ALB	1.4*	3.3-5.5	G/DL
ALP	51	26-84	U/L
ALT	53*	10-47	U/L
AMY	75	14-97	U/L
AST	109*	11-38	U/L
TBIL	17.1*	0.2-1.6	MG/DL
BUN	5*	7-22	MG/DL
CA++	8.0	8.0-10.3	MG/DL
CHOL	90*	100-200	MG/DL
CRE	ICT	0.6-1.2	MG/DL
GLU	131*	73-118	MG/DL
TP	ICT	6.4-8.1	G/DL

INST QC: OK CHEM QC: OK

HEM 1+, LIP 0 , ICT 3+

(Piccolo) Liver Panel Plus

RESULT | REF RANGE

(Piccolo) Electrolyte

RESULT | REF RANGE

DATE:	LAB ID NO.:
18 Jul 03	

[redacted]

(b)(6)-2

ICU1
EPW [redacted]

[redacted] (b)(6)-2

18JUL 1700

[redacted]

(b)(6)-4

(Piccolo) Chemistry 12

TEST	RESULT	REF RANGE

(Piccolo) Metabolic Panel

TEST	RESULT	REF RANGE

(Piccolo) Liver Panel Plus

TEST	RESULT	REF RANGE

(Piccolo) Electrolyte

TEST	RESULT	REF RANGE

(b)(6)-4

1-SEPT 6+

Pt: [redacted]

Pt Name:_____

Glu_____185 mg/dL

BUN_____? mg/dL

Na_____135 mmol/L

K_____3.[illegible] mmol/L

Cl_____105 mmol/L

Hct_____[illegible] %PCV

Hb*_____[illegible] g/dL

Sample Type

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

Ser: [redacted]

Ver: [illegible]

KEYORDERBY

======= PICCOLO =======

18/07/03 17:26

REFERENCE RANGE: MALE

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

GENERAL CHEMISTRY 12

DISC LOT #: (b)(6)-2 3142AA4

OPER #: [redacted] DR #: 000

SERIAL #: [redacted]

ALB	1.5*	3.3-5.5	G/DL
ALP	56	26-84	U/L
ALT	♦♦♦	10-47	U/L
AMY	59	14-97	U/L
AST	102*	11-38	U/L
TBIL	14.9*	0.2-1.6	MG/DL
BUN	♦♦♦	7-22	MG/DL
CA++	8.0	8.0-10.3	MG/DL
CHOL	159	100-200	MG/DL
CRE	ICT	0.6-1.2	MG/DL
GLU	110	73-118	MG/DL
TP	ICT	6.4-8.1	G/DL

INST QC: OK CHEM QC: OK

HEM 1+, LIP 0 , ICT 3+

(b)(6)-2

Ward/Section: ICU-7	R[redacted]NG PHYSICIA[redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted]	[redacted]IME	SSN/PSEUDO SSN:

17JUL03 1500

(b)(6)-4

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3	Color		N/A	RPR		Negative
RBC		4.7-6.1 x 10^9	App		N/A	Mono		Negative
[redacted]		18 g/dl (M) 16 g/dl (F)	Glu		Negative	**Microbiology**		
		52% (M) 47% (F)	Bili		Negative	Source		
		94 fl (M) 99 fl (F)	Ket		Negative	Gram Stain		
		500 x 10^3	SG		N/A	Occ Bld		Negative
		5-51.1%	Bld		Negative	H. pylori		Negative
		ifferential	pH		N/A	Micro Parasites		
			Prot		Negative	Malaria		
			Urob		0.2-1.0	O & P		
Lymph		Baso	Nit		Negative	Other		
Atyp		Imm	Leuk		Negative	**Microscopic Urinalysis**		
RBC Morph			HCG		Negative			

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

Coagulation Studies			Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)		
TEST	RESULT	REF. RANGE	UNIT	TYPE	CROSSMATCH
PT	13.4	9.8-13.6 secs			
APTT	24.5	21-34 secs			
D dimer		<20 ug/ml			
FDP		<10 ug/ml			

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
[redacted]	17Jul03	[redacted]

(b)(6)-2 (b)(6)-4

---

i-STAT EC8+

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

Pt Name:_____

Glu_____[illegible] mg/dL

BUN_____[illegible] mg/dL

Na_____[illegible] mmol/L

K_____[illegible] mmol/L

Cl_____[illegible] mmol/L

TCO2_____24 mmol/L

AnGap_____[illegible] mmol/L

Hct_____26 %PCV

Hb*_____[illegible] g/dL

*vis Hct

pH_____7.345

PCO2_____[illegible] mmHg

[illegible] mmol/L

sEec*_____[illegible] mmol/L

Sample Type_:

17JUL03 [illegible]

Oper: [illegible]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

---

i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____20 mmol/L

At 37C

pH_____7.387

PCO2_____32.3 mmHg

PO2_____91 mmHg

HCO3_____19 mmol/L

BEec*_____-6 mmol/L

sO2*_____97 %

*calculated

At Patient Temp

pH_____7.381

PCO2_____32.8 mmHg

PO2_____94 mmHg

Patient Temp: 37.4C

Sample Type_: ART

17JUL03 03:51

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

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

(b)(6)-2

#: [redacted]

TING PHYSICIAN [redacted] ... S ... RESULT FORM
... the Privacy Act of 1974)
DATE 17Jul03 TIME 1500 SSN/PSEUDO SSN.
[redacted]

i-STAT EC8+

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

Glu__________90 mg/dL
BUN__________9 mg/dL
Na__________138 mmol/L
K__________3.2 mmol/L
Cl__________105 mmol/L
TCO2________21 mmol/L
AnGap________16 mmol/L
Hct__________42 %PCV
Hb*__________14 g/dL
*via Hct
pH_______7.516
PCO2______25.0 mmHg
HCO3________20 mmol/L
BEecf_______-3 mmol/L
Sample Type_:

17JUL03 15:01

Oper: [redacted]
Physician:______________
Ser# [redacted]
Ver: JAM5046A
CLEW A93

======= PICCOLO =======
17/07/03 14:57
REFERENCE RANGE: MALE
PATIENT #: [redacted]
GENERAL CHEMISTRY 12
DISC LOT #: 3082AA4
OPER #: [redacted] DR #: 00
SERIAL #: (b)(6)-2 [redacted]

ALB	1.8*	3.3-5.5	G/DL
ALP	69	26-84	U/L
ALT	♦♦♦	10-47	U/L
AMY	137*	14-97	U/L
AST	♦♦♦	11-38	U/L
TBIL	17.4*	0.2-1.6	MG/DL
BUN	♦♦♦	7-22	MG/DL
CA++	8.2	8.0-10.3	MG/DL
CHOL	129	100-200	MG/DL
CRE	ICT	0.6-1.2	MG/DL
GLU	104	73-118	MG/DL
TP	ICT	6.4-8.1	G/DL

INST QC: OK CHEM QC: OK
HEM 2+, LIP 0 , ICT 3+

======= PICCOLO =======
17/07/03 15:14
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
LIVER PANEL PLUS
DISC LOT #: 3135BA4
OPER #: [redacted] DR #: 000
SERIAL #: (b)(6)-2 [redacted]

ALB	1.9*	3.3-5.5	G/DL
ALP	77	26-84	U/L
ALT	82*	10-47	U/L
AMY	139*	14-97	U/L
AST	141*	11-38	U/L
TBIL	17.5*	0.2-1.6	MG/DL
GGT	22	5-65	U/L
TP	ICT	6.4-8.1	G/DL

INST QC: OK CHEM QC: OK
HEM 2+, LIP 0 , ICT 3+

Specimen ICTERIC

REPORTED BY:	DATE:	LAB ID NO.:
[redacted]	17Jul03	

[redacted]

Ward/Section

TESTING PHYSICIAN:

LAST, FIRST: [redacted]

DATE: 17Jul03 TIME: 0815

CRY RESULT FORM

(To the Privacy Act of 1974)

SSN/PSEUDO SSN:

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-5.1 mmol/L
Cl		98-108 mmol/L

(b)(6)-2

i-STAT G3+

Pt: [redacted] 46 NC

Pt Name:_____

TCO2_____20 mmol/L

At 37C

pH_____7.416

PCO2_____29.1 mmHg

PO2_____61 mmHg

HCO3_____19 mmol/L

BEecf_____-6 mmol/L

sO2*_____9 %

*calculated

At Patient Temp

pH_____7.399

PCO2_____30.6 mmHg

PO2_____65 mmHg

Patient Temp: 38.1C

Sample Type: ART

17JUL03 00:07

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

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		20-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA		8.0-10.3 mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 u/l (M) 30-190 u/l (F)
NA		128-145 mmol/l
K		3.3-4.7 mmol/l
CL		98-108 mmol/l
CO_2		18-33 mmol/L

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dl
ALP		20-84 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

DATE:

LAB ID NO.:

Ward/Section: ICU-7	REQUESTING PHYSICIAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)		
LAST, FIRST, MI: [redacted] (b)(6)-4		DATE: 17/07/03	TIME: 0515	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	[redacted] (b)(6)-4	
RBC		
Hgb		
Hct		
MCV		
Plt		
Lymph		

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

TEST	RESULT	REF. RANGE
PT	17.1	9.8-13.6 secs
APTT	32.6	21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

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

UNIT	TYPE	CROSSMATCH

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

REMARKS:

REPORTED BY: [redacted] (b)(6)-2	DATE: 17 July 03	LAB ID NO.:

(b)(6)-2

Ward/Section: ICU	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted]	DATE: 7-15-03	TIME: 0344	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	[redacted]	4.8-10.8 x 10³
RBC		
Hgb		
Hct		
MCV		
Plt		
Lymph		

(b)(6)-2

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

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	

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Microscopic Urinalysis

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

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

(b)(6)-2

16 July
1800

i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____19 mmol/L

At 37C

pH_____7.380

PCO2_____29.8 mmHg

PO2_____70 mmHg

HCO3_____18 mmol/L

BEecf_____-8 mmol/L

sO2*_____94 %

*calculated

At Patient Temp

pH_____7.363

PCO2_____31.4 mmHg

PO2_____76 mmHg

Patient Temp: 38.2C

Sample Type_: ART

16JUL03 18:02

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

---

i-STAT G3+

Pt: [redacted]

Pt Name:_____

(5)(6)-4

TCO2_____22 mmol/L

At 37C

pH_____7.380

PCO2_____34.9 mmHg

PO2_____69 mmHg

HCO3_____21 mmol/L

BEecf_____-5 mmol/L

sO2*_____93 %

*calculated

At Patient Temp

pH_____7.375

PCO2_____35.4 mmHg

PO2_____70 mmHg

Patient Temp: 37.3C

Sample Type_: ART

16JUL03 11:57

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

(5)(6)-2

---

i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____22 mmol/L

At 37C

pH_____7.389

PCO2_____34.7 mmHg

PO2_____92 mmHg

HCO3_____21 mmol/L

BEecf_____-4 mmol/L

sO2*_____97 %

*calculated

At Patient Temp

pH_____7.399

PCO2_____33.7 mmHg

PO2_____88 mmHg

Patient Temp: 36.3C

FIO2_____: 40

Sample Type_: ART

16JUL03 00:23

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

(b)(6)-4

i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____22 mmol/L

At 37C

pH_____7.369

PCO2_____36.9 mmHg

PO2_____81 mmHg

HCO3_____21 mmol/L

BEecf_____-4 mmol/L

sO2*_____96 %

*calculated

At Patient Temp

pH_____7.364

PCO2_____37.4 mmHg

PO2_____83 mmHg

Patient Temp: 37.3C

FIO2_____: .4

Sample Type_: ART

16JUL03 09:35

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____22 mmol/L

At 37C

pH_____7.309

CO2_____42.0 mmHg

PO2_____95 mmHg

HCO3_____21 mmol/L

BEecf_____-5 mmol/L

sO2*_____97 %

*calculated

At Patient Temp

pH_____7.304

PCO2_____42.7 mmHg

PO2_____97 mmHg

Patient Temp: 37.4C

FIO2_____: .40

Sample Type_: ART

(b)(6)-2

16JUL03 08:07

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

i-STAT G3+

SIMV 10
PEEP 5
TV 400
40%

Pt: [redacted]

Pt Name:_____

TCO2_____23 mmol/L

At 37C

pH_____7.365

PCO2_____37.8 mmHg

PO2_____107 mmHg

HCO3_____22 mmol/L

BEecf_____-4 mmol/L

sO2*_____98 %

*calculated

Sample Type_:

16JUL03 03:46

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A

(b)(6)-2

/Section: ICU1 | REQUESTING PHYSICIAN: [redacted]

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

, FIRST, MI. [redacted] | DATE 7/15/03 | TIME 0344 | SSN/PSEUDO SSN:

(i-STAT)

ST	RESULT	REF. RANGE

i-STAT EC8+ (b)(6)-2

Pt: [redacted]

Pt Name:_____

Glu_____82 mg/dL

BUN_____12 mg/dL

Na_____141 mmol/L

K_____4.1 mmol/L

Cl_____109 mmol/L

TCO2_____22 mmol/L

AnGap_____15 mmol/L

Hct_____22 %PCV

Hb*_____7 g/dL

*via Hct

PH_____7.342

PCO2_____39.0 mmHg

HCO3_____21 mmol/L

BEecf_____-5 mmol/L

Sample Type_:

16JUL03 03:50

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

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

RKS:

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

(b)(6)-2

Ward/Section: ICU 1	REQUESTING PHYSICIAN: [redacted]	**LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)

LAST, FIRST, MI.	DATE	TIME	SSN/PSEUDO SSN:
[redacted]	7-15-03		

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
		x 10^9
		/dl (M) /dl (F)
		(M) (F)
		(M) (F)
		x 10^3
[redacted]		.1%

15-07-03
04:01

rential

			Patient Limits	
WBC	10.3	x10^3/uL	4.5	10.5
RBC	3.39 L	x10^6/uL	4.00	6.00
Hgb	9.0 L	g/dL	11.0	18.0
Hct	28.1 L	%	35.0	60.0
MCV	94.2	fL	80.0	99.9
MCH	30.5	pg	27.0	31.0
MCHC	32.2 L	g/dL	33.0	37.0
PLT	7[illegible]	x10^3/uL	150.	450.
	[illegible]	%	39.5	51.1
	[illegible]	x10^3/uL	1.7	3.4

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

Coagulation Studies

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

Urinalysis

TEST
Colo
App
Glu
Bili
Ket
SG
Bld
pH
Prot
Urob
Nit
Leuk
HCG

Pt: [redacted]
Pt Name:_____
____25 mmol/L
pH_____7.358
pCO2_____43.4 mmHg
pO2_____101
HCO3_____ mmol/L
BE_____-3 mmol/L
sO2*_____97
*calculated
.048
pCO2_____42.1 mmHg
pO2_____97 mmHg
Patient Temp: 36.5C
FIO2_____: 40
Sample Type_: ART
15JUL03 03:53
Oper: [redacted]
Physician:_____
Seq# 40746
Oper: CPM50468

Misc. Serology

TEST	RESULT	REF. RANGE
PR		Negative
lono		Negative

Microbiology

ource		
am		
ain		
c Bld		Negative
pylori		Negative
cro		
asites		
laria		
& P		
er		

Microscopic Urinalysis

Blood Bank

ST SUBMIT SF 518 WITH
RY UNIT REQUESTED

/Rh

ssmatch
ERY UNIT OF BLOOD
)

CROSSMATCH

(b)(6)-2

REMARKS: [redacted]

(b)(6)-2

/Section: ICU 1

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

CHEMISTRY RESULT FORM

(Subject to the Privacy Act of 1974)

, FIRST, MI. [redacted]

DATE 7-15-03 | TIME | SSN/PSEUDO SSN:

(i-STAT)

ST	RESULT	REF. RANGE

(b)(6)-2

[redacted]

Name: _____

Glu _____ 100 mg/dL

BUN _____ 11 mg/dL

Na _____ 134 mmol/L

K _____ 4.1 mmol/L

Cl _____ 109 mmol/L

TCO2 _____ 23 mmol/L

AnGap _____ 11 mmol/L

Hct _____ 22 %PCV

Hb _____ 7 g/dL

pH _____ 7.431

pCO2 _____ 44.1 mmHg

HCO3 _____ 23 mmol/L

BaseE _____ -2 mmol/L

Sample Type: _____

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

Comments: _____

[redacted]

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

ARKS:

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

(i-STAT)	(Piccolo) Chemistry 12	(Piccolo) Metabolic Panel

(b)(6)-4

(i-STAT)

i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____34 mmol/L

At 37C

pH_____7.346

PCO2_____42.7 mmHg

PO2_____300 mmHg

HCO3_____25 mmol/L

BEecf_____-3 mmol/L

sO2*_____100 %

*calculated

Sample Type_:

14JUL03 23:59

Oper: [redacted]

Physician: (b)(6)-2

Ser#: [redacted]

Ver: JAMS046A
CLEW F??

(Piccolo) Chemistry 12

i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____23 mmol/L

At 37C

pH_____7.315

PCO2_____43.0 mmHg

HCO3_____22 mmol/L

BEecf_____-4 mmol/L

sO2*_____97 %

*calculated

At Patient Temp

pH_____7.318

PCO2_____42.6 mmHg

PO2_____98 mmHg

Patient Temp: 98.2F

Sample Type_: ART

14JUL03 09:09

Oper: [redacted]

Physician: (b)(6)-2

Ser#: [redacted]

Ver: JAMS046A
CLEW A93

(Piccolo) Metabolic Panel

i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____23 mmol/L

At 37C

pH_____7.266

PCO2_____47.1 mmHg

PO2_____96 mmHg

HCO3_____21 mmol/L

BEecf_____-6 mmol/L

sO2*_____96 %

*calculated

At Patient Temp

pH_____7.269

PCO2_____46.6 mmHg

PO2_____95 mmHg

Patient Temp: 98.2F

Sample Type_: ART

14JUL03 09:59

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

Negative

Negative

Negative

REMARKS:

REPORTED BY:	DATE: 14 July 03	LAB ID N

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

(b)(6)-2

Ward/Section: ICU (b)(6)-4	REQUESTING PH[redacted]	**LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted]	DATE 7-14-03 / TIME 0400	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
RBC		[illegible] x 10^6
Hgb		
Hct		
MC		
Plt		
Ly		
Se		
Ba		
Ly		
Ar		
RBC Morph		
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other	platelet slight decreased	

[redacted] (b)(6)-4

14-07-03
0404

			Patient Limits	
WBC	15.2 H	x10^3/uL	4.5	10.5
RBC	3.72 L	x10^6/uL	4.00	6.00
Hgb	11.7	g/dL	11.0	18.0
Hct	34.0	%	35.0	60.0
MCV	91.6	fL	80.0	99.9
MCH	29.9	pg	27.0	31.0
MCHC	32.6 L	g/dL	33.0	37.0
Plt	81. L	x10^3/uL	150.	450.
LYM	5.8 uL	%	20.5	51.1
LYM	0.9 uL	x10^3/uL	1.2	3.4

TEST	
Color	
App	
Glu	
Bili	
Ket	
SG	
Bld	
pH	
Prot	
Urob	
Nit	
Leuk	
HCG	

i-STAT G3t.

Pt: [redacted]

Pt Name:_____

TCO2_____22 mmol/L

At 37C

pH_____7.312

PCO2_____41.9 mmHg

PO2_____75 mmHg

HCO3_____21 mmol/L

BEecf_____-5 mmol/L

sO2*_____93 %

*calculated

At Patient Temp

pH_____7.318

PCO2_____41.1 mmHg

PO2_____73 mmHg

Patient Temp: 36.6C

Sample Type_: ART

14JUL03 11:29

Oper: [redacted]

Physician: (b)(6)-2

Ser# 40746

Ver: A

Misc. Serology

TEST	RESULT	REF. RANGE
		Negative
		Negative

Microbiology

ce		
n		
Bld		Negative
ylori		Negative
o sites		
ria		
P		
r		

Microscopic Urinalysis

Blood Bank

T SUBMIT SF 518 WITH
RY UNIT REQUESTED

Rh		

Coagulation Studies

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

ssmatch
RY UNIT OF BLOOD

CROSSMATCH

REMARKS:

[redacted] 1/5ul03

(b)(6)-2

Ward/Section: OR | ...ESTING PHYSICIAN: | ...ATORY RESULT FORM (...ject to the Privacy Act of 1974)

LAST, FIRST, MI.	DATE	TIME	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE

(b)(6)-4

ID: [redacted]
NE: [redacted]

21:20

			Patient Limits	
WBC	5.9	x10^3/uL	4.5	10.5
RBC	3.53 L	x10^6/uL	4.00	6.00
Hgb	7.4 L	g/dL	11.0	18.0
Hct	23.3 L	%	35.0	60.0
MCV	90.8	fL	80.0	99.9
MCH	29.8	pg	27.0	31.0
MCHC	31.7 L	g/dL	33.0	37.0
Plt	6... L	x10^3/uL	150.	450.
LYM	5.9 H	%	20.5	51.1
LYM	0.9 H	x10^3/uL	1.2	3.4

Sed Rate		
Other	Platelets Slightly decreased	

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	19.0	9.8-13.6 secs
APTT	44.3	21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

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

UNIT	TYPE	CROSSMATCH

REMARKS: CBC, PT/PTT

REPORTED BY:	DATE: 18 Jul 03	LAB ID NO.:
[redacted] (b)(6)-2		

EPW

[redacted]

(b)(6)-4

Ward/Section: UR

REQUESTING PHYSICIAN:

CHEMISTRY RESULT FORM

(Subject to the Privacy Act of 1974)

LAST, FIRST, MI.	DATE	TIME	SSN/PSEUDO SSN:

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		Negative
Drug of Abuse		Negative
		Negative
		Negative
		Negative

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE

======= PICCOLO =======
14/07/03 21:31
REFERENCE RANGE: MALE
PATIENT #: [redacted] (5)(6)-4
BASIC METABOLIC
DISC LOT #: (5)(6)-7 3T45AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	123*	73-118	MG/DL
BUN	10	7-22	MG/DL
CA++	7.1*	8.0-10.3	MG/DL
CRE	1.1	0.6-1.2	MG/DL
NA+	130	128-145	MMOL/L
K+	4.8*	3.3-4.7	MMOL/L
CL-	109*	98-108	MMOL/L
tCO2	25	18-33	MMOL/L

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA		128-145 mmol/l
		3.3-4.7 mmol/l
L		98-108 mmol/l
CO_2		18-33 mmol/l

REMARKS: CHEM 7

REPORTED BY:	DATE:	LAB ID NO.:
(5)(6)-2 [redacted]	14 Jul 03	

EPW # [redacted]
(5)(6)-4

(b)(6)-2

/Section: ICU#1 | RE ST [redacted]

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

, FIRST, MI. [redacted] (b)(6)-4 | DATE 7-14-03 | TIME 0400 | SSN/PSEUDO SSN:

(i-STAT)

ST	RESULT	REF. RANGE
		138-146 mmol/L
		3.5-4.9 mmol/L
		98-109 mmol/L
		7.31-7.45
		35-45 mmHg (art) 41-51 mmHg (ven)
		80-105 mmHg (art) N/A (ven)
		23-27 mmol/L (art) 24-29 mmol/L (ven)
		22-26 mmol/L (art) 23-28 mmol/L (ven)
		95-98%
		(-2) – (+3) mmol/L
p		10-20 mmol/L
		1.12-1.32 mmol/L
		8-26 mg/dl
		70-105 mg/dl
		0.7-1.5 mg/dl
		38-51% PCV
		12-17 g/dl

Misc. Chemistry

r	RESULT	REF. RANGE
n-l		
of		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
A		
A		
T		
B		
C		
C		
C		
C		
T		
C		
E		
C		
C		
N		
k		
C		
t		

PICCOLO
14/07/03 04:19
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: (b)(6)-2 3141AA1
OPER #: [redacted] DR #: 00
SERIAL #: [redacted]

GLU	109	73-118	MG/DL
BUN	10	7-22	MG/DL
CRE	0.7	0.6-1.2	MG/DL
CK	♦♦♦	39-380	U/L
NA+	135	128-145	MMOL/L
K+	5.0*	3.3-4.7	MMOL/L
CL-	110*	98-108	MMOL/L
tCO2	21	18-33	MMOL/L

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

(Piccolo) Metabolic Panel

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

i-STAT G3+

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

TCO2_____22 mmol/L

At 37C
PH_____7.357
PCO2_____36.9 mmHg
PO2_____110 mmHg
HCO3_____21 mmol/L
BEecf_____-5 mmol/L
sO2*_____98 %
*calculated

At Patient Temp
PH_____7.355
PCO2_____37.1 mmHg
PO2_____111 mmHg

Patient Temp: 37.1C
FIO2_____: 40
Sample Type_: ART

14JUL03 03:55.
Oper: [redacted]
(b)(6)-2
Physician:_____

Ser# 40746
Ver: [illegible]

RKS:

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

(b)(6)-2

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

LAST, FIRST, MI.	DATE	TIME	SSN/PSEUDO SSN:
[redacted] (b)(6)-4	7/13	2050	

(Hematology) CBC

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

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

TEST	RESULT	REF. RANGE
PT	18.7	9.8-13.6 secs
APTT	27.4	21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

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

UNIT	TYPE	CROSSMATCH

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

REMARKS:

(b)(6)-2

/Section: ICU I | K ESTI[redacted]

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

. FIRST, MI. [redacted] (b)(6)-4 | DATE 7/13/03 | TIME 1730 | SSN/PSEUDO SSN: [redacted] (b)(6)-4

(i-STAT)

ST	RESULT	REF. RANGE
		138-146 mmol/l.
		3.5-4.9 mmol/L
		98-109 mmol/L
		7.31-7.45
2		35-45 mmHg (art) 41-51 mmHg (ven)
		80-105 mmHg (art) N/A (ven)
2		23-27 mmol/L (art) 24-29 mmol/L (ven)
3		22-26 mmol/L (art) 23-28 mmol/L (ven)
		95-98%
		(-2) – (+3) mmol/L
p		10-20 mmol/L
		1.12-1.32 mmol/L
		8-26 mg/dl
		70-105 mg/dl
		0.7-1.5 mg/dl
		38-51% PCV
		12-17 g/dl

Misc. Chemistry

T	RESULT	REF. RANGE
n-l		
f		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU	109	73-118 mg/dl
BUN	8	7-22 mg/dl
CRE	0.6	0.6-1.2 mg/dl
CK		39-380 u/l (M) 30-190 u/l (F)
NA^+	139	128-145 mmol/l
K^+	4.1	3.3-4.7 mmol/l
CL^-	109	98-108 mmol/l
tCO_2	20	18-33 mmol/l

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

RKS: Icteric Sample CK not available

RTED BY: [redacted] (b)(6)-4 | **DATE:** | **LAB ID NO.:**

(b)(6)-2

Ward/Section: 1C01	REQUESTING PHYSICI[redacted]	**LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] (b)(6)-4	DATE 7/13/03	TIME 0730	SSN/PSEUDO SSN: [redacted] (b)(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
		.8 x 10^3
		l x 10^9
		g/dl (M)
		g/dl (F)
		% (M)
		% (F)
		fl (M)
		fl (F)
		0 x 10^3
		d
		1.1%
		ferential
Lymph		Baso
Atyp		Imm
RBC Morph		
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

[redacted] (b)(6)-4 13-07-03 17:33

			Patient Limits	
WBC	7.9	x10^3/uL	4.5	10.5
RBC	3.84 L	x10^6/uL	4.00	6.00
Hgb	10.8 L	g/dL	11.0	18.0
Hct	35.3	%	35.0	60.0
MCV	92.0	fL	80.0	99.9
MCH	28.1	pg	27.0	31.0
MCHC	30.6 L	g/dL	33.0	37.0
Plt	83. L	x10^3/uL	150.	450.
LY%	10.9 *L	%	20.5	51.1
LY#	1.1 *L	x10^3/uL	1.2	3.4

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

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

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

[redacted] (b)(6)-4

(b)(6)-4

---

i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____[illegible] mmol/L

At 37C

pH_____[illegible]

PCO2_____37.7 mmHg

PO2_____[illegible] mmHg

HCO3_____[illegible]

BEecf_____[illegible]

sO2*_____[illegible]

*calculated

At Patient Temp

pH_____7.384

PCO2_____34.5 mmHg

PO2_____444 mmHg

Patient Temp: 34.9C

FIO2_____: [illegible]

Sample Type_:

13JUL03 [illegible]

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAM5046A
CLEW A93

---

i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____20 mmol/L

At 37C

pH_____7.322

PCO2_____36.0 mmHg

PO2_____157 mmHg

HCO3_____1[illegible] mmol/L

BEecf_____-7 mmol/L

sO2*_____99 %

*calculated

At Patient Temp

pH_____7.355

PCO2_____32.6 mmHg

PO2_____144 mmHg

Patient Temp: 34.7C

FIO2_____: 40

Sample Type_: ART

13JUL03 17:21

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAM5046A
CLEW A93

---

i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____21 mmol/L

At 37C

pH_____7.325

PCO2_____38.5 mmHg

PO2_____135 mmHg

HCO3_____20 mmol/L

BEecf_____-6 mmol/L

sO2*_____99 %

*calculated

At Patient Temp

pH_____7.338

PCO2_____37.0 mmHg

PO2_____129 mmHg

Patient Temp: 36.1C

FIO2_____: 40

Sample Type_: ART

13JUL03 20:42

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAM5046A
CLEW A93

(b)(6)-2

---

i-STAT G3+

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

Pt Name:_____

TCO2_____[illegible] mmol/L

At 37C

pH_____7.367

PCO2_____30.6 mmHg

PO2_____221 mmHg

HCO3_____18 mmol/L

BEecf_____-8 mmol/L

sO2*_____100 %

*calculated

At Patient Temp

pH_____7.415

PCO2_____26.5 mmHg

PO2_____206 mmHg

Patient Temp: 33.7C

FIO2_____: 50

Sample Type_: ART

13JUL03 15:17

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

Physician:_____

Ser# [redacted]

Ver: JAM5046A
CLEW A93

(i-STAT)

TEST	RESULT	REF RANGE
i-STAT Na+		138-146 mmol/L

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

Pt Name: _____

TCO2 _____ 34 mmol/L

At 37C

pH _____ 7.255

PCO2 _____ 49.7 mmHg

PO2 _____ 375 mmHg

HCO3 _____ 22 mmol/L

BEecf _____ -5 mmol/L

SO2* _____ 100 %

*calculated

Seq. [illegible]

[illegible] 10:10

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

Physician _____

Send [redacted]

Vert [illegible]

		Negative
		Negative

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

TEST	RESULT	REF RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 u/l (M) 30-190 u/l (F)
NA		128-145 mmol/l
K		3.3-4.7 mmol/l
CL		98-108 mmol/l
ICO_2		18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA		128-145 mmol/l
K		3.3-4.7 mmol/l
CL		98-108 mmol/l
ICO_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		8-65 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
ICO_2		18-33 mmol/l

REMARKS:

[redacted] (b)(6)-2

REPORTED BY: [redacted]

DATE: 13 Jun 03

LAB ID NO.:

EPW #[redacted]

(b)(6)-4

d/Section: ENT | R... ING PHYSICIAN: [redacted] (b)(6)-2 | ...BORATORY RESULT FORM (Subject to the Privacy Act of 1974)

...T, FIRST, MI [redacted] (b)(6)-4 | DATE 12 July | TIME 1102 | SSN/PSEUDO SSN: [redacted] (b)(6)-4

(Hematology) CBC			Urinalysis			Misc. Serology		
...EST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
		...0.8 x 10^3	Color		N/A	RPR		Negative
[redacted]		...1 x 10^9	App		N/A	Mono		Negative
		...g/dl (M) ...g/dl (F)	Glu		Negative	**Microbiology**		
		...% (M) ...% (F)	Bili		Negative	Source		
		...fl (M) ...fl (F)	Ket		Negative	Gram Stain		
		...00 x 10^3 ...ied	SG		N/A	Occ Bld		Negative
		...51.1%	Bld		Negative	H. pylori		Negative
		...fferential	pH		N/A	Micro Parasites		
			Prot		Negative	Malaria		
			Urob		0.2-1.0	O & P		
...ph		Baso	Nit		Negative	Other		
...p		Imm	Leuk		Negative	**Microscopic Urinalysis**		
...rph			HCG		Negative			
...n ...atocrit		42-52% (M) 37-47% (F)	**CSF**			**Blood Bank**		
...Rate			Cell Count			**MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED**		
...er			Directigen		Negative	ABO/Rh		

[redacted] 12-07-03 11:21

			Patient Limits	
WBC	14.6 H	x10^3/uL	4.5	10.5
RBC	2.93 L	x10^6/uL	4.00	6.00
Hgb	8.8 L	g/dL	11.0	18.0
Hct	27.8 L	%	35.0	60.0
MCV	95.0	fL	80.0	99.9
MCH	30.0	pg	27.0	31.0
MCHC	31.6 L	g/dL	33.0	37.0
Plt	139. L	x10^3/uL	150.	450.
Lym	12.5 *L	%	20.5	51.1
Lym	1.8 *	x10^3/uL	1.2	3.4

Coagulation Studies			Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)		
...EST	RESULT	REF. RANGE	UNIT	TYPE	CROSSMATCH
	21.2	9.8-13.6 secs			
...TT	40.0	21-34 secs			
...imer		<20 ug/ml			
...P		<10 ug/ml			

...MARKS:

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

(5)(6)-7

[redacted]

13-07-03
13:17

			Patient Limits	
WBC	10.4	x10^3/uL	4.5	10.5
RBC	2.36 L	x10^6/uL	4.00	6.00
Hgb	7.1 L	g/dL	11.0	18.0
Hct	22.1 L	%	35.0	60.0
MCV	93.0	fL	80.0	99.9
MCH	30.0	pg	27.0	31.0
MCHC	32.0 L	g/dL	33.0	37.0
Plt	82. L	x10^3/uL	150.	450.
Lym	13.2 ML	%	20.5	51.1
Lym	1.3 *	x10^3/uL	1.2	3.4

(Hematology) CBC

TEST	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%

Differential

no			
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	19.7	9.8-13.6 secs
APTT	41.0	21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

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

UNIT	TYPE	CROSSMATCH

REMARKS: CBC & PT/PTT

REPORTED BY:

DATE: 13 July 03

LAB ID NO.:

EPW # [redacted]

(5)(6)-7

Ward/Section: EM. | STING PHYSICIAN: [redacted] (b)(6)-2 | STRY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. [redacted] (b)(6)-4 | DATE 12 July | TIME 1102 | SSN/PSEUDO SSN: [redacted] (b)(6)-4

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

REMARKS:

REPORTED BY:

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

TEST

(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

======= PICCOLO =======
13/07/03 11:22
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8 (b)(6)-4
DISC LOT #: 3141AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	127*	73-118	MG/DL
BUN	8	7-22	MG/DL
CRE	0.9	0.6-1.2	MG/DL
CK	3222*	39-380	U/L
NA+	139	128-145	MMOL/L
K+	4.1	3.3-4.7	MMOL/L
CL-	106	98-108	MMOL/L
tCO2	21	18-33	MMOL/L

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

======= PICCOLO =======
13/07/03 11:22
REFERENCE RANGE: MALE
PATIENT #: [redacted]
LIVER PANEL PLUS (b)(6)-4
DISC LOT #: 3051AA4
OPER #: [redacted] DR #: 00
SERIAL #: [redacted]

ALB	2.9*	3.3-5.5	G/DL
ALP	28	26-84	U/L
ALT	11	10-47	U/L
AMY	194*	14-97	U/L
AST	51*	11-38	U/L
TBIL	1.8*	0.2-1.6	MG/DL
GGT	<5*	5-65	U/L
TP	3.6*	6.4-8.1	G/DL

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

(b)(6)-2

Ward Section: ICU (b)(6)-4 REQUESTING PHYS: [redacted]

TRY RESULT FORM

(Subject to the Privacy Act of 1974)

LAST, FIRST, MI: [redacted] DATE: TIME: SSN PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		96-106 mmol/L
pH		7.32-7.45
PCO2		32-45 mmol/L (art) 41-51 mmol/L (ven)
PO2		80-105 mmol/L (art) N/A (ven)
TcCO2		23-27 mmol/L (art) 26-27 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
Bicarb		1.25-1.35 mmol/L
Anion Gap		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		Negative
Drug of Abuse		Negative
		Negative
		Negative
		Negative

(Piccolo) Chemistry 12

TEST	RESULT	REF RANGE
ALB	1.6	3.5-5.5 g/dl
ALP	52	26-84 u/l
ALT	42	10-47 u/l
AMY	107	14-97 u/l
AST	117	11-38 u/l
TBIL	15.9	0.2-1.6 mg/dl
BUN	10	7-22 mg/dl
CA	7.7	8.0-10.3 mg/dl
CHOL	115	100-200 mg/dl
CRE	ICT	0.6-1.2 mg/dl
GLU	116	73-118 mg/dl
TP	ICT	6.4-8.1 g/dl

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

TEST	RESULT	REF RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
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: Results not available due to Icteric sample

REPORTED BY: DATE: LAB ID NO.:

"Fractionate the billirubin"

Not Available

MEDICAL RECORD - ANESTHESI

Fo ı this form, see AR 40-66; the proponent agen. the OTSG

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

DRUG	(Units)													
Versed	(mg)	2.5												
Fentanyl	(ml)	(5)		(3)										
Propofol	(ml)	120												
Sch	(ml)	100												
	( )													
	( )													
VOLAT AGENT 150	% del	1.5	1.0	1.5	1.0	X								
	% e.t.	—	—	—	—	—	—	X						
AIR	L/Min	—	—	—	—	—	—	X						
N2O	L/Min	—	—	—	—	—	—	X						
O2	L/Min	3-2	2	2	2	2	2	X						

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

FLUIDS

LINE site #18 (1) FA	☒ Warmed						300/300							
#18 SA (1) FA	☒ Warmed		500/500				300/1000							
	☐ Warmed													
	☐ Warmed													

LOSSES

EST BLOOD LOSS	0/0						0/0							
URINE -	40		300/300				100/400							

PHYS STATUS 1 (2) 3 4 5 E

BODY WEIGHT: 190 KG (LB)

HEMATOCRIT:

INITIAL DATA: BP- 155/71 HR- 125

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK OK for PROCEDURE? 400 TIME- 1115

TIME 1115 30 x 1200 x 30 x 1300 x 30 x 1400

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	500	800	750	720	340	X								
f - breaths/min	18-12	12	12	12	20-20	24								
Peak inf pres / PEEP	26	24	24	24	X	X								
MODE - S(pon), A(ssist), C(on)	S-C	C	C	C	C-A-S	S								

MONITORS/ACCESSORIES

☑ BP/Auto Cuff	☒ ET CO2 (torr)	34-32	35	34	31	43	X							
BP/oth	☒ FIO2 (Frac or %)	1.0	1.0	1.0	1.0	1.0	60							
☒ ART line	☒ SpO2 (%)	98	100	100	100	100	98							
☑ Steth- PC/ES	☒ ECG	100	110	100	109	122	80							
☒ Gas analyzer	☒ TEMP-site													
	☒ N-M Block (T/4)	4/4 0	4/4	4/4	X	X								
Warming blkt														
Conv warmer														

Mark with letters & symbols, explain under REMARKS — EVENTS Position (1) (2) (3) (5) X (6) (7)

TOTALS	TOTAL EBL
	Ø ml
	TOTAL URINE
	400 ml

FLUIDS SUMMARY

CRYSTALLOID- RS 1200

COLLOID- Ø

BLOOD- 1 unit PRBC

REMARKS

Code drugs with numbers, events with letters

(1) in Room, monitors applied

(2) induction + intubation

(3) eyes taped, oral Bite Block.

(4) pt log rolled to (5) left decubitus + Lumbar TAP done

(5) PRBC ÷ unit #2454206 ordered by Surg prior to O.R.

(6) pt reactive + extubated c reflexes wd

(7) to PACU

RECOVERY AT 1245

(PACU) ICU _____ (Specify)

OTHER Pain 0/10

CONDITION: Sleepy

RESP- 24 SpO2- 93

BP- 131/60 HR- 132

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1100	1115	1250
PROC	Ready	Begin	End
	1125	1135	1237

PROCEDURES and CPT Codes: 180 of (L) Stump Placement of Lumbar Drain

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

[redacted] (5)(6)-4

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

GETA Jig SCDA/OETT (80)

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

Expected xT, AFIAUMATIC DIFFICULT VISUALIZATION Intubation BBS = , 23 cm to teeth

SURGEONS: [redacted]

ANESTH [redacted]

PROCEDURE LOCATION: 1

DATE: 17 July 03

PAGE 1 OF 1

See pre op workup dated 14 July 03 & changes

(6)(6)-2

MEDICAL RECORD - ANESTHESI

Fo. .ı this form, see AR 40-66; the proponent agen. the OTSG

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

DRUG	(Units)													
Propofol	(m)	100												
Vecuronium	(m)	4												
Fentanyl	(mcg)		50	50										
	( )													
	( )													
Neo	(mcg)	100	50	50	50									
VOLAT AGENT 1.5	% del	0.8-2	0.8-1.0	1.0	1.2 X									
	% e.t.	—	—											
AIR	L/Min	—	—											
N2O	L/Min	—	—											
O2	L/Min	2 —	2 —	2	2	2								

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

FLUIDS

LINE site														
☐ Warmed														
Rt Arm Distal CONTINUOUS ☒ Warmed	— 300/300 —		— 10/400											
☐ Warmed														
☐ Warmed														

LOSSES

EST BLOOD LOSS	% —													
URINE -	% —		150 —											

PHYS STATUS 1 2 3 4 5 E

BODY WEIGHT: 200 KG (LB)

HEMATOCRIT:

INITIAL DATA:

BP- 110 / 80

HR- 112

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK OK for PROCEDURE? yes TIME- 0815

TIME → 0815 30 X 0900 X 0930 X 1000

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	700 —	750	830	820	780	
f - breaths/min	16 —	10 —	10	10	10	
Peak inf pres / PEEP	24	— 24	27	26	24	
MODE - S(pon), A(ssist), C(on)	C —	C —	C	C	C	

MONITORS/ACCESSORIES

BP/Auto Cuff	X	ET CO2 (torr)	35-43	— 35	34	36	36
BP/oth	X	FIO2 (Frac or %)	1.0	— 1.0	1.0	1.0	1.0
X ART line	X	SpO2 (%)	98	— 100	100	100	100
Steth- PC/ES	X	ECG	SR	— SR	SR	SR	SR
X Gas analyzer	X	TEMP-site Skin	38	36	36	36	36
		N-M Block (T/4)	4/4-	0/4 —		2/4	
Warming blkt							
Conv warmer			—	—			

Mark with letters & symbols, explain under REMARKS — EVENTS Position → Supine c̄ board (R) arm on padded board < 90° (L) arm @ side on padded

TOTALS 100 mg, 4 mg, 100 mg, 150 mg

TOTAL EBL < 25 cc

TOTAL URINE 150 cc

FLUIDS SUMMARY

CRYSTALLOID- LR — 4500cc

COLLOID- Ø

BLOOD- Ø

REMARKS

Code drugs with numbers, events with lettters

(1) - Room, monitors applied

(2) Bronchoscopy By Dr Swan

(3) To PCU 1

(+/=) BBS

Placed on previous Vent Settings @ 50% TV 800 RR10

Report to LT Byer.

RECOVERY AT

PACU ICU _____ (Specify)

OTHER _____

CONDITION:

RESP- 12 SpO2- 100

BP- 118/64 HR- 115

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0800	0815	0934
	Ready	Begin	End
PROC	0820	0825	0922

PROCEDURES and CPT Codes: I&D (R) chestwall, dilatation of stoma Bronchoscopy + I&D (L) stump

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

Pt intubated prior to OR GETA via SCCM/0877 Retaped @ 23 cm (L) mouth

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

see above

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

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

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

[redacted]

PROCEDURE LOCATION: 1

DATE: 19 July 02

PAGE 1 OF 1

SIMV 10/800/35%/5 VS 115, 91/54, 96% gtt MSO4 c 4mg/10, Versed c 2mg/10 Patient comp

MEDICAL RECORD - ANESTHES

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

- A: RAD - Limb Ax
- DSC Fmr - Tube feed/NG
- FOLEY

0: 7.41/45/114/23/98%/F4 135/3.5 104/2.7 12/1.7 <87 30.7/9.7

ANESTHETIC AGENTS AND DRUGS	DRUG (Units)														
CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML, "I" = CONSTANT INFUSION	Nimbex (mg)	6	4	6	4	4									
	Fentanyl (mcg)		50/50	50	50	150/150									
	versed (mg)					2/2/1									
	( )														
	( )														
	( )														
VOLAT AGENT	Iso % del	0.2	0.2	1.5	1.5	1.6-1.5 X									
	% e.t.														
AIR	L/Min														
N2O	L/Min														
O2	L/Min	6	2	2	2	2	2	6							
SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS		(1)					(2)								
FLUIDS	LINE site L SCL ☐ Warmed	NS 800 ↑													
	☐ Warmed	Albumin 25% 100ml													
	☐ Warmed														
	☐ Warmed														
LOSSES	EST BLOOD LOSS					100									
	URINE -					150									

TOTALS	TOTAL EBL
500	100
5	TOTAL URINE
	150

FLUIDS SUMMARY	
CRYSTALLOID	800
COLLOID-	25g Albumin
BLOOD	Ø

REMARKS

Code drugs with numbers, events with letters

(1) To room c̄ full monitors, O2 100% via ambu hand ventilation

(2) Return to ICW stable. Placed on preop vent settings.

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 70 KG LB

HEMATOCRIT: 30.7

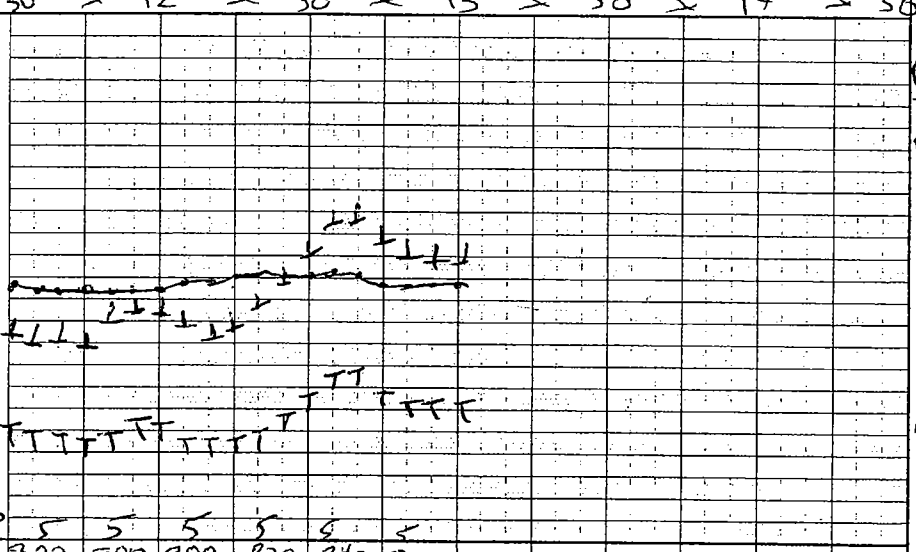
INITIAL DATA: BP- 91, 52 HR- 115

EQUIP CHECK: OK?- Y N

PATIENT RECHECK: OK for PROCEDURE? Y TIME- 1120

TIME → 30 × 12 × 30 × 13 × 30 × 14 → 30

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



VENTIL							
	VT - ml	800	800	800	820	840	810
	f - breaths/min	10	10	10	10	10	10
	Peak inf pres / PEEP	27	27	26	25	26	27
	MODE - S(pon), A(ssist), C(on)	C	C	C	C	C	C
MONITORS/ACCESSORIES	BP/Auto Cuff / ET CO2 (torr)	38	38	37	35	36	37
	BP/oth / FIO2 (Frac or %)	0.8	0.8	0.8	.8	.8	.8
	ART line / SpO2 (%)	96	98	98	100	100	100
	Steth- PC/ES / ECG	ST	ST	ST	ST	ST	ST
	Gas analyzer / TEMP-site						
	N-M Block (T/4)		4/4	2/4	4/4	2/4	1/4
	Warming blkt						
	Conv warmer						

Mark with letters & symbols, explain under REMARKS · EVENTS Position → 0 →

RECOVERY AT	1305
PACU (ICU)	(Specify)
OTHER	T37
CONDITION:	
RESP- V10	SpO2- 96
BP- 143/75	HR- 130

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1120	1130	1310
	Ready	Begin	End
PROC	1135	1150	1300

PROCEDURES and CPT Codes: Abdominal Exploration*

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* GETA c̄ ETT from ICW

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* (5) ETCO2, BSEB, eyes taped

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

* EPW # [redacted] (b)(6)-7

(1) Ex lap

(2) Lysis of adhesions

(3) Placement retention sutures

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

ANESTHETIST: [redacted] MAJ, CRNA

PROCEDURE LOCATION: 1-1

DATE: 7/20/03

PAGE 1 OF 1

Meds: Gentamicin, Imipenem cov, Ciprocov, Rocephin, Zantac cov, Albuterol Neb c 03 g Y 25 5 5 5

see previous pre-op

MEDICAL RECORD - ANESTHESI

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

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

DRUG	(Units)													
Vec	( )	10							10					
fentanyl	(UG)	<250>												
	( )													
	( )													
	( )													
VOLAT AGENT	150 % del	1.0	1.0	1.0	.7	.7	.7	.7	X					
	% e.t.													
AIR	L/Min													
N2O	L/Min													
O2	L/Min	2	2	2	2	2	2	2						

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

FLUIDS

LINE													
(R) Triple lumen	☐ Warmed	UA											
	☐ Warmed												
	☐ Warmed												
	☐ Warmed												

LOSSES: EST BLOOD LOSS; URINE -

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 70 KG / LB

HEMATOCRIT: 28.5

INITIAL DATA: BP- 127/68; HR- 114

EQUIP CHECK: OK?- Y N

PATIENT RECHECK: OK for PROCEDURE? ⊕; TIME- 1500

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

TIME → 1555 30 45 1600 X 30 X 1700 X

VENTIL

VT - ml	700	700	700	730	730	730	730	740
f - breaths/min	11	11	11	10	10	10	10	10
Peak inf pres / PEEP	25	25	25	25	25	25	25	25
MODE - S(pon), A(ssist), C(on)	CV	CV	CV	CV	CV	CV	CV	CV

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	35	35	35	35	34	34	34	34
BP/oth	FIO2 (Frac or %)	.83	.83	.83	.83	.86	.86	.86	.86
ART line	SpO2 (%)	100	99	99	99	99	99	99	99
Steth-PC/ES	ECG	NS	NS	NS	NS	SR	SR	SR	SR
Gas analyzer	TEMP-site	skin		35	35	35	35	35	
	N-M Block (T/4)		4/4	3/4			4/4		4/4
Warming blkt		wool blanket							
Conv warmer									

Mark with letters & symbols, explain under REMARKS — EVENTS → Position → cut arms <90° abducted

TOTALS: 250 g; **TOTAL EBL**: NA; **TOTAL URINE**: 300

FLUIDS SUMMARY: CRYSTALLOID- U-500; COLLOID-; BLOOD-

REMARKS (Code drugs with numbers, events with letters)

1500 Metaxalone
Procedure verified
Chart reviewed
H&P assessment done
1515 In room monitors on
1705 To ICU for recovery

RECOVERY AT: PACU ICU (Specify); OTHER stable

CONDITION: RESP 10; SpO2- 98%; BP- 108/58; HR- 108

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1500	1515	1730
PROC	Ready	Begin	End
	1525	1545	1700

PROCEDURES and CPT Codes: Closed (4) TKA

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: Intubated → BGT / CGT

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: 23 cm @ teeth

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

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

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

[redacted]

PROCEDURE LOCATION: 4

DATE: 24 Jun 05

PAGE 1 OF

624th Forward Surgical Team
Trauma Resuscitation Flowsheet

Patient Data

DTG In:
Time of Injury: (b)(6)-4
Name: [redacted]
SSN:
Unit:
Grade: Sex: Male
Allergies: NKDA

INITIAL ASSESSMENT

AIRWAY
Patent: ✓
Oral / Nasal: —
ETT / Surgical: —
Oxygen: Non Rebreather

BREATHING
Adequate:
Assisted:
Right BS: Diminished
Left BS: ✓

CIRCULATION
Pulse Present: ∅ PPR, Thready
Heart Rate: tachy
Heart Tones: ✓
Bleeding Controlled: ✓
IV Access x2: L AC 18ga, L FEM 8.5Fr.

DISABILITY
AVPU: ✓
GCS: 4
Pupils: PERRLA
Moves All Extremities: ✓

Time	IV	Sz	Site	Rate
	#1	18	LT AC	W/O
	#2	-	LT femoral	W/O
	#3			
	#4			

Total Fluids In: LR X 1111111111
PRBCS - @ 0545

Time	Med & Dose	Init.
0550	2 Gram Ancef IV	[redacted]
0600	50mg demerol IV	
		(b)(6)-2

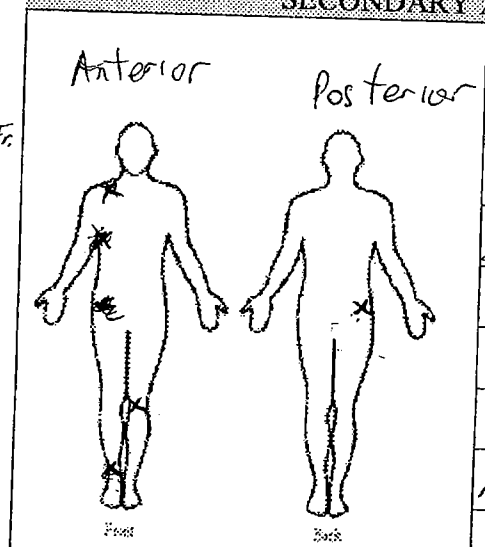
VITALS

Time	HR	BP	RR	O2 Sat	GCS
		/			
0550	145	118/88	22	98%	NRB MASK
0550	141	124/78	24	99%	
0610	130	115/64	24	100%	Stim N/C
0640	128	120/50	18	100%	
0650	113	123/56	16	100%	
		/			
		/			
		/			
		/			

INTERVENTIONS

Intervention	Time	Size	Site	Init. Vol. Out
ETT				
Surgical Airway				
CT #1		36 French	LT chest	∅/c
CT #2			✓	
Foley	0550	16 French	urethra	200 cc
Gastric				

SECONDARY ASSESSMENT



Neuro:
Head & Face:
Neck:
Chest: entrance superclavicular exit wound LT AC
Abdomen:
Pelvis:
Upper Leg:
Lower Leg: RT Anterior tibial exit + Entry
Arms: ~~LT Arm~~ LT R knee bullet wound
Posterior:

Notes: Bullit entry left medial knee, bullit entry right super clavicular exit right ~~left~~ axilla, right flank bullit wound single entry. Wound above RT ankle thru and thru

Hct 20 Hgb 7

1st unit PRBC's start : 0545 - 0556 (start, done)
2nd unit PRBC's started @ 0558 - 0610 (done)

2300 cc Crystaloid - central
1500 cc crystaloid - peripheral

0558 - BBS ↓ @ Bases
0600 RT PPP
LT PPP Faint

0630 ↑ ABD ⊂̄ Rigidity
0630 600cc clear yellow urine out
→ 0645 - 150 mcg fentanyl IV
0655 ET Placed ⊕ Placement verified

[redacted]

1
2

13

U.S. GPO: 1992-316-809/60175

165-7294

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

TION(S) REQUESTED	AGE	SEX	SSN *(Sponsor)*	WARD/CLINIC	REGISTER NO.
(b)(6)-4 CT Abdo (Spine) #[redacted]					
	FILM NO.				PREGNANT ☐ YES ☐ N
	REQUESTED BY *(Print)* [redacted] (b)(6)-2				TELEPHONE/PAGE
	SIGNATU[redacted]QUESTOR				DATE REQUESTED

Abd/Pelvis IV & Contrast Oral?

[redacted] *(Complaints and findings)*

weakness in legs, s/p GSW @ flank c̄ retroperitoneal hematoma

EXAMINATION *(Month, day, year)*	DATE OF REPORT *(Month, day, year)*	DATE OF TRANSCRIPTION *(Month, day, year)*
July 14 03		

IC REPORT

IDENTIFICATION *(For typed or written entries give: , first, middle, Medical Facility)*	LOCATION OF MEDICAL RECORDS

518-123 NSN 7540-00-634-4158

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

- [ ] RED BLOOD CELLS
- [x] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of _____ units)*
- [ ] CRYOPRECIPITATE *(Pool of _____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* _____

VOLUME REQUESTED *(If applicable)* 1 Unit ML

REMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*

- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED 13 July 03

DATE AND HOUR REQUIRED On call

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)* [redacted] (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE GSW

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

SIGNATURE OF VERIFIER See original 578

DATE VERIFIED

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. (b)(6)-4 [redacted]

TRANSFUSION NO. 8

PATIENT NO. [redacted]

DONOR	RECIPIENT
ABO B	ABO B
Rh Pos	Rh Pos

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	N/A

[x] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

PREVIOUS RECORD CHECK:

[x] RECORD [ ] NO RECORD

SIGNATURE OF [redacted] TEST [redacted] (b)(6)-2

DATE 13 July 03

REMARKS:

Exp Date: 16 Feb 04 / Thawed: 14 ~~Feb~~ July 03 @ 1329

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED [redacted] *(Signature)*

AT *(Hour)* 1330 ON *(Date)* 13 July 03

IDENTIFICATION

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

1st VERIFIER *(Signature)* [redacted] (b)(6)-2

2nd VERIFIER [redacted]

PRE-TRANSFUSION

TEMP. 91.5 PULSE 77 BP 142/87

DATE OF TRANSFUSION 13 July 03 TIME STARTED 1334

POST-TRANSFUSION DATA

AMOUNT GIVEN 250 ML

TIME/DATE COMPLETED/INTERRUPTED 13 Jul 03

REACTION [x] NONE [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
91.5	75	145/89

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION

[ ] URTICARIA [ ] CHILL [ ] FEVER [ ] PAIN

[ ] OTHER *(Specify)* [redacted]

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

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

SIGNATURE OF PERSON NOTING ABOVE (b)(6)-2 [redacted]

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

SEX M

WARD EMT

[redacted] (b)(6)-4

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

PT Chart

518-123 NSN 7540-00-634-4158

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

- [ ] RED BLOOD CELLS
- [x] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of _____ units)*
- [ ] CRYOPRECIPITATE *(Pool of _____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* _____

VOLUME REQUESTED *(If applicable)* 1 Unit ML

REMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*

- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED 13 Jul 03

DATE AND HOUR REQUIRED ch call

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)* [redacted] (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE GSW

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

SIGNATURE OF VERIFIER See original 518

DATE VERIFIED

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. [redacted]

TRANSFUSION NO.

PATIENT NO.

DONOR

ABO B

Rh POS

RECIPIENT

ABO B

Rh POS

TEST INTERPRETATION

ANTIBODY SCREEN NA

CROSSMATCH NA

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONE[redacted] REQUESTED

REMARKS: Exp ~~28 JAN 04~~ 14 Jul 03

PREVIOUS RECORD CHECK:

- [x] RECORD
- [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST [redacted] (b)(6)-2

DATE 13 Jul 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSP[redacted]ED AND ISSUED BY (Si[redacted] [redacted]

AT (Hour) 1230 ON (Date) 13 Jul 03

IDENTIFICATION

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

1st VERIFIER *(Signature)* [redacted]

2nd VERI[redacted]nature) [redacted]

[redacted]TRANSFUSION

TEMP. 95°F PULSE 102 BP 107/62

DATE OF TRANSFUSION 13 July 03

TIME STARTED 1307

POST-TRANSFUSION DATA

AMOUNT GIVEN 1 Unit ML

TIME/DATE COMPLETED/INTERRUPTED 1315 13 July 03

REACTION

- [ ] NONE
- [ ] SUSPECTED

TEMPERATURE 95°F

PULSE 107

BLOOD PRESSURE 106/68

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION

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

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

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

SIGNATURE OF PERS[redacted]G ABOVE [redacted] (b)(6)-2

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

[redacted]

(b)(6)-4

SEX M

WARD CCU

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

(b)(6)-2

518-123 NSN 7540-00-634-4158

MEDICAL RECORD	BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

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

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

REQUESTING PHYSICIAN *(Print)* [redacted] (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE: GSW

DATE REQUESTED: 13 JUL 03

DATE AND HOUR REQUIRED: On Call

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

VOLUME REQUESTED *(If applicable)*: 1 Unit ML

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*:

SIGNATURE OF VERIFIER: See original 518

REMARKS: (b)(6)-4

IF PATIENT IS FEMALE, IS THERE HISTORY OF:
RhIG TREATMENT? DATE GIVEN: _____
HEMOLYTIC DISEASE OF NEWBORN? _____

DATE VERIFIED:

TIME VERIFIED:

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. (b)(6)-4 [redacted]

TRANSFUSION NO.

PATIENT NO.

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	NA

☐ CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

PREVIOUS RECORD CHECK: ☒ RECORD ☐ NO RECORD

SIGNATURE OF PERSON PERFORMING TEST: [redacted] (b)(6)-2 DATE: 13 JUL 03

DONOR ABO: B Rh: POS

RECIPIENT ABO: B Rh: POS

REMARKS: Exp: ~~14 JAN 04~~ 14 Jul 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY: [redacted] (b)(6)-2

(Date) 13 JUL 03

IDENTIFICATION

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

1st VERIFIER *(Signature)* [redacted] (b)(6)-2

2nd VERIFIER [redacted]

TEMP. 95°F | PULSE 100 | BP 106/59

DATE OF TRANSFUSION: 13 July 03 | TIME STARTED: 1228

POST-TRANSFUSION DATA

AMOUNT GIVEN: 1 Unit ML

TIME/DATE COMPLETED/INTERRUPTED: 1239

REACTION: ☒ NONE ☐ SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
95°F	107	115/69

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

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

OTHER DIFFICULTIES *(Equipment, clots, etc.)*
☒ NO ☐ YES *(Specify)*

SIGNATURE OF PERSON ABOVE: [redacted] (b)(6)-2

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

[redacted] (b)(6)-4

SEX: M

WARD: CMS

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

518-123 NSN 7540-00-634-4158

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

- [x] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of _____ units)*
- [ ] CRYOPRECIPITATE *(Pool of _____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* _____

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*

- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED 13 ~~12~~ JULY 03

DATE AND HOUR REQUIRED

REQUESTING PHYSICIAN *(Print)* [redacted] (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE GSW

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

VOLUME REQUESTED *(If applicable)* 1 UNIT ML

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

SIGNATURE OF VERIFIER [redacted]

REMARKS: (b)(6)-4

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

13 July 03

TIME VERIFIED 1108

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. [redacted]

TRANSFUSION NO. 3

PATIENT NO. [redacted]

TEST INTERPRETATION

ANTIBODY SCREEN: N/A

CROSSMATCH: COMPAT

PREVIOUS RECORD CHECK:

- [ ] RECORD
- [x] NO RECORD (b)(6)-2

SIGNATURE OF PERSON PERFORMING TEST [redacted]

DONOR

ABO O

Rh POS

RECIPIENT

ABO B

Rh POS

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 13 July 03

REMARKS:

Exp. Date: 14 JUL 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)* [redacted]

AT *(Hour)* 1433 [redacted] ON *(Date)* 13 JUL 03

IDENTIFICATION

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

1st VERIFIER *(Signature)* [redacted]

TRANSFUSION

TEMP. 33.6 PULSE 76 BP 145/95

DATE OF TRANSFUSION 13 Jul 03

TIME STARTED 1503

POST-TRANSFUSION DATA

AMOUNT GIVEN 250 ML

TIME/DATE COMPLETED/INTERRUPTED 1530 / 7-13-03

REACTION

- [x] NONE
- [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
33.0	77	142/95

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION

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

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

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

SIGNATURE OF PERSON NOTING ABOVE [redacted] (b)(6)-2

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle, grade, rank, rate: hospital or medical facility) [redacted] (b)(6)-4

SEX M

WARD EMT

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

(b)(6)-2

518-123 NSN 7540-00-634-4156

MEDICAL RECORD	BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

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

VOLUME REQUESTED *(If applicable)* 1 unit ML

REMARKS: (b)(6)-4

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

DATE REQUESTED 13 July 03

DATE AND HOUR REQUIRED On Call

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)* [redacted] (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE GSW

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

SIGNATURE OF VERIFIER See original 518

DATE VERIFIED

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. (b)(6)-4 [redacted]

TRANSFUSION NO.

PATIENT NO.

DONOR

ABO B pos

Rh

RECIPIENT

ABO B pos

Rh

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	NA

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

REMARKS: Exp: Exp 14 Jul 03

PREVIOUS RECORD CHECK:
- [x] RECORD
- [ ] NO RECORD (b)(6)-2

SIGNATURE OF PERSON PERFORMING TEST [redacted]

DATE 13 JULY 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY (Signature) [redacted]

(Time) 1255 ON (Date) 13 JUL 03

IDENTIFICATION

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

1st VERIFIER *(Signature)* [redacted]

2nd VERIFIER [redacted]

PRE-TRANSFUSION

TEMP. 95 PULSE 102 BP 107/68

DATE OF TRANSFUSION 13 July 03

TIME STARTED 1239

POST-TRANSFUSION DATA

AMOUNT GIVEN 1 Unit ML

TIME/DATE COMPLETED/INTERRUPTED 1250 13 July

REACTION
- [x] NONE
- [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
95°F	97	102/60

If reaction is suspected—IMMEDIATELY:

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

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

OTHER DIFFICULTIES *(Equipment, clots, etc.)* (b)(6)-2
- [x] NO
- [ ] YES *(Sp[redacted]*

SIGNATURE OF PERSON [redacted]

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

SEX M

WARD Emt

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

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

(b)(6)-2

518-123 NSN 7540-00-634-4158

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

- [x] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of _____ units)*
- [ ] CRYOPRECIPITATE *(Pool of _____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* _____

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*

- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED: 12 July 03

DATE AND HOUR REQUIRED:

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

DIAGNOSIS OR OPERATIVE PROCEDURE: GSW

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

VOLUME REQUESTED *(If applicable)*: 1 UNIT ML

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*:

SIGNATURE OF VERIFIER: [redacted]

REMARKS:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

DATE VERIFIED: 12 July

TIME VERIFIED: 1108

(b)(6)-4

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.: (b)(6)-4 [redacted]

TRANSFUSION NO.: 1

PATIENT NO.: [redacted]

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	COMPAT

PREVIOUS RECORD CHECK:

- [ ] RECORD
- [x] NO RECORD

SIGNATURE OF [redacted] TEST: [redacted]

DONOR: ABO O; Rh POS

RECIPIENT: ABO B; Rh POS

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 13 JUL 03

REMARKS: Exp. Date: 14 Jul 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISS[redacted] BY *(Signature)*: [redacted]

AT *(Hour)*: 1140 ON *(Date)*: 13 Jul 03

IDENTIFICATION

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

1st VERIFIER *(Signature)*: [redacted]

2nd VERI[redacted]

PRE-TRANSFUSION

TEMP. 95.5 PULSE 103 BP 140/81

DATE OF TRANSFUSION: 13 July TIME STARTED: 1145

POST-TRANSFUSION DATA

AMOUNT GIVEN: 1 unit ML

TIME/DATE COMPLETED/INTERRUPTED: 13 Jul 03 1305

REACTION: [x] NONE [ ] SUSPECTED

TEMPERATURE:

PULSE: 102

BLOOD PRESSURE: 144/89

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION

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

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

- [x] NO
- [ ] YES *(Specify)* [redacted] (b)(6)-2

SIGNATURE OF PERSON N[redacted]OVE: [redacted]

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

SEX: M

WARD: FMT

[redacted] (b)(6)-4

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

518-123 NSN 7540-00-634-4158

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

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

VOLUME REQUESTED *(If applicable)* 1 UNIT ML

REMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*

- [ ] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED 13 July

DATE AND HOUR REQUIRED

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)* [redacted]

DIAGNOSIS OR OPERATIVE PROCEDURE GSW

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

SIGNATURE OF VERIFIER [redacted]

DATE VERIFIED 13 July

TIME VERIFIED 1108

(b)(6)-2

(b)(6)-4

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. [redacted]

TRANSFUSION NO. 2

DONOR

ABO O

Rh Pos

RECIPIENT

ABO B

Rh Pos

TEST INTERPRETATION

ANTIBODY SCREEN N/A

CROSSMATCH COMPAT

PREVIOUS RECORD CHECK:

- [ ] RECORD
- [X] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST [redacted]

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 30 Jun 03

REMARKS:

Exp. Date: 14 JUN 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED [redacted]

AT [redacted] ON *(Date)* 13 July 03

IDENTIFICATION

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

1st VERIFIER *(Signature)* [redacted]

2nd VERIFIER *(Signature)* [redacted]

PRE-TRANSFUSION

TEMP. 98 PULSE 147/75 BP 147/75

DATE OF TRANSFUSION 13 July 03 TIME STARTED 1207

(b)(6)-2

POST-TRANSFUSION DATA

AMOUNT GIVEN 1 UNIT ML

TIME/DATE COMPLETED/INTERRUPTED 1215 13 July 03

REACTION

- [X] NONE
- [ ] SUSPECTED

TEMPERATURE 95°F PULSE 114 BLOOD PRESSURE 127/75

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION

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

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

- [X] NO
- [ ] YES *(Specify)*

SIGNATURE OF PERSON [redacted]

(b)(6)-2

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

SEX M

WARD EMT

(b)(6)-4

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

518-123 NSN 7540-00-634-4158

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

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

VOLUME REQUESTED *(If applicable)* 1 unit ML

REMARKS: Pt in OR

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

DATE REQUESTED 15 Jul 03

DATE AND HOUR REQUIRED 1435

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)* None

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)* [redacted]

DIAGNOSIS OR OPERATIVE PROCEDURE (L) BKA/AKA

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

SIGNATURE [redacted]

DATE VERIFIED 15 Jul 03

TIME VERIFIED 1445

(b)(6)-2

(b)(6)-4

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. [redacted]

TRANSFUSION NO.

PATIENT NO.

DONOR ABO O Rh positive

RECIPIENT ABO B Rh positive

TEST INTERPRETATION

ANTIBODY SCREEN: N/A

CROSSMATCH: Compatible

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

REMARKS: EXP DATE 17, JUL 03

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

SIGNATURE OF PERSON PERFORMING TEST [redacted]

DATE 15, JUL 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)* [redacted]

AT (Hour) 1510 ON *(Date)* 15, JUL 03

IDENTIFICATION

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

1st VERIFIER *(Signature)* [redacted]

2 [redacted] CKWA

PRE-TRANSFUSION [redacted]

TEMP. 98 PULSE 115 BP 98/58

DATE OF TRANSFUSION 15 Jul 03 TIME STARTED 1515

(b)(6)-2

POST-TRANSFUSION DATA

AMOUNT GIVEN All ML

TIME/DATE COMPLETED/INTERRUPTED 15 Jul 03 1535

REACTION
- [x] NONE
- [ ] SUSPECTED

TEMPERATURE 98 PULSE 110 BLOOD PRESSURE 110/57

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

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

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

SIGNATURE OF [redacted] CKWA

(b)(6)-2

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

SEX M WARD OC

EPW # [redacted]

(b)(6)-4

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

MEDICAL RECORD	BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

- [x] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of ____ units)*
- [ ] CRYOPRECIPITATE *(Pool of ____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* ____

VOLUME REQUESTED *(If applicable)* ____ ML

REMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*

- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED 14 July 03

DATE AND HOUR REQUIRED 14 July 03 2345

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: ____

HEMOLYTIC DISEASE OF NEWBORN? ____

REQUESTING PHYSICIAN *(Print)* [redacted]

DIAGNOSIS/OPERATIVE PROCEDURE Fasciotomy

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

SIGNATURE [redacted]

DATE VERIFIED 14 July 03

TIME VERIFIED 23 30

(5)(6)-2

SECTION II – PRE-TRANSFUSION TESTING

(b)(6)-4

UNIT NO. [redacted]

TRANSFUSION NO.

PATIENT NO. [redacted]

DONOR		RECIPIENT	
ABO	B	ABO	B
Rh	POS	Rh	POS

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	Comp

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

SIGNATURE OF PERSON PERFORMING TEST [redacted]

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED — DATE 15 Jul 03

REMARKS: Exp 26 Jul 03.

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)* [redacted]

AT *(Hour)* 0100 **ON** *(Date)* 15 July 03

IDENTIFICATION

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

(5)(6)-2

1st VERIFIER *(Signature)* [redacted]

2nd VERIFIER *(Signature)* [redacted]

PRE-TRANSFUSION

TEMP. 34 PULSE 109 BP 123/63

DATE OF TRANSFUSION 15 July 03 **TIME STARTED** 0104

POST-TRANSFUSION DATA

AMOUNT GIVEN 1 UNIT ML **TIME DATE COMPLETED** 0130 15 July 03 **INTERRUPTED**

REACTION [x] NONE [ ] SUSPECTED

If reaction is suspected – IMMEDIATELY:

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

DESCRIPTION

[ ] URTICARIA [ ] CHILL [ ] FEVER [ ] PAIN

[ ] OTHER ____

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

[x] NO [ ] YES *(Specify)* ____

SIGNATURE OF PERSON NOTING ABOVE [redacted] (5)(6)-2

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

EPW# [redacted]

(5)(6)-4

SEX MALE **WARD** ICU-1

BLOOD OR BLOOD COMPONENT TRANSFUSION
STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

- [x] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of ____ units)*
- [ ] CRYOPRECIPITATE *(Pool of ____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* ____

VOLUME REQUESTED *(If applicable)* ____ ML

REMARKS:

(b)(6)-4

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*

- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED: 14 July 03

DATE AND HOUR REQUIRED: 14 July 03 2345

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: ____

HEMOLYTIC DISEASE OF NEWBORN? ____

REQUESTING PHYSICIAN *(Print)*: [redacted]

DIAGNOSIS OR OPERATIVE PROCEDURE: FAC lotomy

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

SIGNATURE OF [redacted]

DATE VERIFIED: 14 July 03

TIME VERIFIED: 2330

(b)(6)-2

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. [redacted] (b)(6)-4

TRANSFUSION NO.

PATIENT NO. [redacted]

DONOR		RECIPIENT	
ABO	B	ABO	B
Rh	POS	Rh	POS

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	COMP

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

SIGNATURE OF PERSON PERFORMING TEST: [redacted]

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONEN[redacted]ESTED DATE 15 Jul 03

REMARKS: Exp 26 Jul 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*: [redacted]

AT *(Hour)* 2357 [redacted] *(Date)* 14 Jul 03

IDENTIFICATION

I have examined the Blood Com[redacted]nt container label and this form and I find all information ide[redacted]ntainer with the intended recipient matches item by item. [redacted] same person named on this Blood Component Transfusion [redacted] identification tag.

(b)(6)-2

1st VE[redacted]

2nd [redacted]

PRE-TRA[redacted]

TEMP. 34 PULSE 110 BP 94/47

DATE OF TRANSFUSION: 15 July 03

TIME STARTED: 0010

POST-TRANSFUSION DATA

AMOUNT GIVEN	TIME	DATE	COMPLETED	INTERRUPTED
1 UNIT ML	0055	15 July 03		

REACTION: [x] NONE [ ] SUSPECTED

If reaction is suspected – IMMEDIATELY:

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

DESCRIPTION

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

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

- [x] NO
- [ ] [redacted]ecify) ____

SIGNATURE OF PER[redacted] ABOVE [redacted] (b)(6)-2

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

EPW # [redacted]

(b)(6)-4

SEX: M

WARD: ICU-1

BLOOD OR BLOOD COMPONENT TRANSFUSION
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