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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

1 June 03 1015 Pt arrived via litter from ICU #2. Airway is intact, breathing is even and unlabored. Lung sounds clear to all fields ẋ bases (diminished). Abd is soft, nontender (ẋ tympanitic with), and ẋ slight distention near abd wound. BS x4, tolerating PO. Ostomy to (R) flank passing flatus & some stool. Abd wound to center of wound covered ẋ large ABD & is clean, dry, intact. IV to (R) hand flushes well. Ut ẋ 20K @ 50 ml/hr via pump. FLOW and neurovascularly intact to all extremities. Mild weakness to all extremities. PT and nutrition informed of needed consults. [redacted]

01 June 03 1400 Nutrition Note

b(6)-2

S: Pt referred for Kcal count and poor PO intake.

O: Fragile male, estimated wt: 75 kg

Dx: GSW to abdomen Diet: Reg ẋ Ensure

A: Due to extremely limited supply of ensure pt will receive carnation instant breakfast TID instead of ensure. Explained to pt through translator the importance of adequate PO intake to promote healing. Estimated nutritional needs:

2600 - 3000 kcal/day (35-40 kcal/kg)

97 - 113 gm protein (1.3 - 1.5 gm/kg)

P: 1) Kcal count x 48.

2) Supplements TID

3) Encourage PO intake [redacted] MAJ, SP RD/LDN

b(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME [redacted]			SPONSOR'S ID NUMBER (SSN or Other)
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PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade) REGISTER NO. WARD NO. ICW2

CIV #[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
1 June 03	PT Note
Hx:	Request now / strength / aml;
	Per ICU 2 - Pt aml 2x - today
Treat:	Pt ostomy bag / Abd dressing
	Pt performed 1x10 shld flex
	1x10 biceps
	1x10 fist
	Pt (I) bed mobility - slow
	Pt SBA & stand SAD
	~ @ 30 sec pt NOT actively keeps head up &
	allowed self fall to ~~fat~~ kneeT attempt fall - slowly
	unable have actively extend legs,
	extend neck
Diag:	Not willing aml / stand - actively
Interv:	edu / As above
	Cont PT
G:	(I) ut & ex - 1 day
	Stand 40 sec (I) - 4 days
	b(4)-2 28 CSH
	[redacted] CPT, SP

1 Jun 03 2005 assumed care @ 1300 - VSS - colostomy c loose stool / 150cc output - IS done q1° this shift c great encouragement needed - IV patent - abdominal dsg Δ wet to dry, 3 areas of necrosis noted on upper right side of wound - Report given to on pt. need to be OOB to chair c PT assist in ambulation [redacted]

b(4)-2

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
01 June 03 2115	Pt. stable at this time. PERRLA. Mucous membranes pink, moist & intact. Neck supple, FROM. Lungs clear bilaterally. Abd ↑ drsg from (R) side across abd. Very tender R/T surgical site. Bowel sounds present x4 quads. Voiding to urinal ↓ assist. Strong pulse x4 extremities, brisk cap refill x4 extremities. Pt ↑ axillary temp of 102.6. Given Tylenol x2. Will recheck temp in 1 hr. b(6)-2 [redacted]
02 June 03 0430	Minimal output (80cc) liquid stool to ostomy. Voiding qs to urinal. Ø complaint of pain at this time. Drsg CDI. VSS. Will do and send labs. b(6)-2 [redacted]
6/1/03	Surgery Pt tolerating diet T max 101.8 now 98.6 VSS abd - dressing clean Ostomy looks good A/P Concern ↑ WBC 9 hrs, temp spike yest. now fine - will plan take to O.R. tomorrow for washout / debridement

9.8 / 388 / 31 / 87

134 / 100 / 8 / 3.3

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST, FIRST [redacted] | ID NUMBER [redacted]

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY [redacted] 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)* [redacted] WARD NO.

CIV # [redacted] b(6)-4

PROGRESS NOTES
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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
02June03 1124	Pt resting in bed. VSS: BP 120/70, RR 24, P 97, sats 98%, T 98.8. Pt. very lethargic. IV RE 20 meq KCl @ 50cc/hr site (R) wrist ~ s/s infection or infiltration. Abdominal dressing Δ'd & colostomy bag changed. Abdominal wound is approximately 6 x 1 inches box shaped, pink, moist, slight bright red bloody drainage ~ signs of infection. Stoma pink & moist. Pt. NPO p MN awaiting wound washout & debridement. Pt. intake & output adequate for shift. Urine clear & yellow. All other assessment findings WNL. Pt. c/o pain once during shift. No other complaints @ this time. b(4)-2 [redacted] RN/AN
1230	Pt. wrapped with ace bandages & up to chair. Pt. has macular rash on entire back. Bed & clothing changed. Will continue to monitor [redacted]
1300	Pt. back in bed & asleep. b(4)-2 [redacted]
2June03 1300	Pt. vitals taken BP 120/70, P. 80, R. 20 [redacted] SPC [redacted] b(4)-2
02 June 03	Nutrition Note F/V PO intake for past 24° was good. Results of kcal count: 600-700 kcal 20 gm protein Will track intake for one more day. b(4)-2 [redacted] MAJ, SP RD/LD
2Jun03 2020	Assumed care @ 1300 - VSS - IV patent - IS encouraged & used throughout shift - lung sounds ↓ throughout - abd. dsg Δ'd - pt. to go to OR in AM, NPO p MN, IV RE 20 KCl @ 125 cc/hr to start @ MN - pt. OOB to chair x 1 hour, tolerated it c encouragement - stool remains

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
31 June 03	0750 MS 2mg IVP adm by Maj [redacted] b(6)-2 prior to dsg change. [redacted] SWMB b(6)-2
6/3/03	Surgery Op note Prep Dx: Open Skin/fascia of abdomen s/p GSW (old). Post op Dx: Same Procedure - washout of skin c̄ debridement. Surgeon: [redacted] b(6)-2 Anesthesia: General EBL: Ø Findings: minimal dead tissue in Sub-Q debrided & wound washed c̄ NS and redressed. Will start TID dressing Δ's c̄ plan to STSG later this week [redacted] b(6)-2

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
2Jun03 2010 Cont	loose from colostomy, bag intact - pt. ate small amount of dinner, fed self's assistance no c/o pain @ this time b(6)-2 [redacted] b(6)-2
2330	Pt care assumed @2100. 650mg tylenol given PO for temp @ 101.7, other vss, Alert and awake without c/o pain. Lung sounds CTA, pulses palpable x4, bowel sounds present x4 quadrants, RUQ only quadrant auscultated. Abd dsng d'd, wound is moist and pink. Pt NPO, surgery in AM. Colostomy bag has a small amount of drainage this shift. Pt voided 700cc clear yellow urine. IV site @ LAC CDI, infusing well. Will continue to monitor. SPO Seeley 9lwmc
3Jun03 0240	UDP 540cc CYU → [redacted] 9lw b(6)-2
0400	IV infiltrated, restarted @ R wrist. Phlebitis noted on L bicep, will continue to monitor. SPC [redacted] 9lwmc b(6)-2
0630	Assume pt care @ 0500. Pt awake and alert. 650mg tylenol adm for temp. 101.8. Other vitals stable. Wound to back of head healing well, cleaned and left open to air. PERRLA, HR regular. Lungs CTA throughout. Pulses palpable, strong x4. Bowel sounds active RUQ. Colostomy bag intact sm. amt brown drainage. Abd. CD&I. pt void per urinal 300cc CYU this am. IV LR @ 125cc c̄ 20mg KCl added to (R) hand. Site free of s/s redness/infection. Plan to go to OR this AM. b(6)-2 [redacted] 9lwmc

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			[redacted] NUMBER (SSN or Other)
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CIV b(6)-4

[redacted]

PROGRESS NOTES
Medical Record

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MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
02 JUN 03	PT NOTE
	HX: AMBUL
	T/M: PNT AWAKE, DISPLAYED MODERATE STRENGTH IN (B)UE & (B)LE. ASSISTED PNT TO SEATED POSITION & SIT-STAND POSITION. PNT AMBUL C ASSISTANCE ~ 2X ICW2 AREA, PNT ASSISTED TO CHAIR. PNT SAT ~ 10 MIN PRIOR TO BEING ASSISTED TO BED.
	DIAG: AMBUL
	INTERV: SAME
	G: ↑ AMBUL TO 5X ICW2 AREA X 1 WK. b(6)-2 [redacted]
	SPC [redacted] b(6)-2
	SIWONG PT TECH.
03 JUN 03	PT NOTE
	HX: AMBUL
	T/M: PNT UNDERWENT SURGERY TO DEBRIDE WOUND. ASSISTED PNT TO SIT UP IN BED ~ 5 MIN. AMBUL DEFERRED 2° MEDS & PAIN.
	DIAG: AMBUL
	INTERV: ASSISTED PNT SITTING
	G: AMBUL PNT ~ 10'-15' X 1 WK.
	SPC [redacted] b(6)-2
	SIWONG PT TECH

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

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MEDICAL RECORD

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PROGRESS NOTES

DATE	NOTES
03 June 03	0800 pt medicated c̄ 2mg MSO4 IVP adm by Maj [redacted] b(6)-2 prior to dsg change. Dsg change done by Maj [redacted] b(6)-2 immediately following pt went to OR. b(6)-2 [redacted] SGT, 91WM6
	1130 pt returned from recovery @ approx [redacted]. Awake. Orders assumed from pre-op. pt sitting in chair. VSS. Abd. dsg CD&I. Colostomy bag changed in OR. draining sm. amount red drainage. IV (R) hand 50cc/hr LR c̄ 20 meq KCl added. No c/o pain @ this time. b(6)-2 [redacted]
3 June 03 1300	Pt vitals taken BP 90/60, P. 90, R. 20, Temp 98.8 [redacted]
3 June 03 1400	assumed pt care @ 1300. VSS. airway [redacted], b(6)-2 lungs CTA. abd c̄ drains CDI. ostomy bag intact draining scant amt of reddish brown drainage. BS(+) x̄ RUQ. Pulses palpable x 4. LOV (R) hand infusing LR @ 125cc c̄ 20mg KCL s̄ diff, (-) s/sx of infiltration. wound to back of head OTA, healing s̄ s/sx of infection. well cont to monitor b(6)-2 [redacted] SGT, 91WM6
3 June 03 1600	Pt vitals taken BP 98/63, P. 96, R. 16, Temp 98.2 [redacted]

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | SPONSOR'S ID NUMBER (SSN or Other) [redacted] b(6)-2

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

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

CIV # [redacted] b(6)-4

BED #13 ICW2

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PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
June 03 2000	Pt vitals taken BP 110/52, P. 106, R. 16 TEMP 100.7 SPO [redacted] b(4)-2
June 03 21:30	Pt. awake + resting in bed c̄ feet elevated. PERRLA WNL. Skin PWD. Colostomy draining loose brown stool. ABD drsg. intact. LLQ serous drainage, sm amt. IV RFA patent c̄ LR c̄ 20 KCL @ 50cc/hr voiding cl yellow urine PPP WNL. Cap refil <3 sec. @ ~~20:00~~ 21:00 temp 101.0 tylenol ii given @ 20:00. Will cont. to mon. [redacted] DT/AD b(4)-2
00:00	Pt given MSO4 ā drsg Δ. Old drsg yellow in color c̄ some areas of sanguinous drainage. All edges of ABD wound well approximated c̄ granulous tissue pink. New drsg. c̄ sterile water applied. Roll Kerlex to inside ABD wound and 3 ABD pads to cover sterile W→D drsg. New drsg is C/D/I [redacted] DT/AD b(4)-2
4 June 03	0630 Resume pt care @ 0530. pt asleep. easily arousable. temp 99.6°F. BP 122/80 P 102 R 20. Wound to back of head open to air. PERRLA. IV LR c̄ 20 KCL @ 50cc/hr to (R) hand. HR regular. Lungs CTA. BS active RLQ. Colostomy bag in place. draining loose brown stool. Abd dsg intact, clean and damp. Full ROM to u/l extremities. Will continue to monitor. b(4)-2 [redacted]
4 June 03	0915 2 mg of MSO4 adm prior to dsg Δ IVP by Lt. Jinch. Old dsg. yellow and red drainage mostly to (L) side. Area cleaned with sterile water and packed with Super sponges. W→D dsg done. covered with gauze Abd. dsg. Dsg CD&I. b(4)-2 [redacted]

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
4 June 04	0915 Labs returned WBC 17.4 will let MD know. pt resting now. no s/s pain, discomfort b(6)-2 [redacted] 1240. IV restarted in (R) FA. pt sat up for approx 15 min. VSS @ 1200 Stable temp 99.2°. pt didn't eat much lunch, encouraged carnation shake. @ bedside. pt resting no s/s pain b(6)-2 [redacted] 1240 Colostomy bag emptied approx 300cc loose brown stool. b(6)-2 [redacted]
4 June 03 1430	assumed pt care @ 1300. VSS. Temp 100.7 pt given Tylenol per prn orders. airway patent, lungs CTA, abd dressing CDI, ostomy bag intact draining brown drainage. BS (+) RUQ. BLE ē strong (+) pulses. BUE ē Strong (+) pulses. IV (R) FA infusing ī diff. (-) S/Sx of infiltration. Will cont to monitor b(6)-2 [redacted]
2345	Assumed Pt. care @ 2100. Temp 99.8. 30mg Toradol given IV for pain. HR Reg, Lungs CTA, UTA BS 2° dsng ⊽ (R) LQ. BS (R) LQ (+). Ostomy bag intact draining brown, soft stool. Dsng to ABD changed wound is beefy red. Hematoma to (R) LQ noted, MD and SOD notified. Pt. examined by both. MD instructions to continue with previous orders.

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

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CIV # [redacted] b(6)-4

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE 6/4/03 NOTES

b(6)-2

cont.... will continue to monitor. [redacted]

6/5/03 0045: Dsng to (L) LQ ABD reinforced 2° small amt. serosanguinous drainage. [redacted] b(6) 2

05JUNE03 0150 ASSUME PT CARE @ 0500. Pt awake and alert. 3mg MSO4 adm IVP by LT [redacted] @ 0600, for pain. IV LR c̄ 20KCl to (R) wrist no s/s infiltration/redness. Abd. dsg. yellow drainage mostly to (L) side. INTACT. VSS HR regular. Lungs CTA (B). BS RUQ active. Colostomy bag (R) side, draining brown loose stool. Voids per urinal s difficulty. Pulses strong. Ate sm. amt @ breakfast. Zantac NOT GIVEN, pharmacy is OUT will see what MD wants like to ORDER. 2/11 percocet ada @ 0800 for pain. Will change dsg. and continue to monitor [redacted]

b(6)-2

b(6)-2 [redacted]

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
5 June 03	1300 pt had convulsion this am around 0910, while OOB to chair, lasting approx 15 sec. MD notified 1 L NS Bolus adm. Dsg Δ'd @ 0845 - hematoma to (L) side. pt taken to OR to have hematoma removed. Pt recovered well. VSS. Dsg CD&I. LR ⊼ 20 KCL @ 50cc/hr b(6)-2 to (R) wrist. HL to (L) hand placed in OR. — [redacted]
5 June 03 1300	Pt vitals taken BP 122/62, P. 104, R 22 Temp 98.4 SPO [redacted]
5 June 03 1405	assumed pt care @ 1300. VSS. assessed [redacted] ONL. b(6)-2 abd dressing CDI. Ostomy bag intact draining brown stool. IV (R) wrist infusing 3 diff ⊖ s/sx of infiltration HL to (L) hand flushes 3 diff ⊖ redness or edema noted. Will cont to monitor — b(6)-2 [redacted] 91WM6
5 June 03 1800	Pt vitals taken BP 118/70 P. 112, R. 22, Temp 100.0 SPO [redacted]
2330	Assumed pt. care @ 2100. Pt. alert. [redacted], lungs b(6)-2 CTA, BS ⊕ to (R) LQ & (L) LQ. Ostomy bag intact, draining loose brown stool, ⊕ flatus. Dsng to ABD changed W → D. SOD consulted 2° dsng adhered to wound. wound beefy red. Pt. pre-medicated for dsng Δ c 4mg MSO4 IV. Will continue to monitor [illegible]

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

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

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[redacted] b(6)-4

REGISTER NO. | WARD NO.

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
1200 T 99.4 P 97 R 16 BP 116/74 SpO2 97%	Assumed care of pt @ 0500. Pt was asleep. VSS. Lungs CTA. Pt had 4 mg of MSO4 @ 0830 before dsg Δ. Dsg is dry + intact. Pt had Percocet ?? @ 0935, for % pain. Will continue to monitor. b(6)-2 [redacted], 91WM6, SGT
6 Jun 03 2015	assumed care @ 1300 - VSS - IV patent - abdominal dsg Δ'd as ordered p̄ pt medicated c̄ 4 mg MSO4 IVP - pt. out of bed to chair for 30 minutes then 60 minutes p̄ dinner - pt. will eat more if he is fed by a male, will only eat a few bites if fed by a female or made to feed himself - only gas output from ostomy - pt. able to get himself OOB to chair c̄ minimal assistance - pt. used IS q4° this shift c̄ encouragement [redacted] CB, AN b(6)-2
2230	Pt care assumed @ 2100. VSS, alert and awake, pt had % small amount of pain during dressing change. Lung sounds CTA, pulses palpable x4. IV @ RFA patent, LR w/20 meq KCL running @ 50cc/hr. Dressing change done, wound is pink and moist, looks to be improving. Will continue to monitor. SPC [redacted] 91WM6 b(6)-2
7 June 03 0400	Colostomy site CDI, SS bag drained about 200 cc feces. SPC [redacted] 91WM6 b(6)-2

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
7 June 03	0630 Assume pt care @ 0500. Pt asleep. easily arousable. Alert to surroundings. VSS. No c/o pain or discomfort. Abd dsg CD&I. IVF LR ō 20 KCL @ 50cc/hr to (R) wrist free of s/s redness/infiltration. Colostomy bag intact, brown drainage noted. HR regular. Lungs CTA. BS audible (R)LQ. Pulses palpable x 4. Will encourage pt ~~to~~ [redacted] OOB to chair and DSG A this Am. [redacted] b(6)-2
7 Jun 03	Sayer No complaints requires encouragement for PO intake colostomy functioning VSS Afebrile wound C/D well cared for. A/O open Abd. good healing Anrich further closure prior to STSG b(6)-2 Continue [redacted] b(6)-2 [redacted]

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

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REGISTER NO. | WARD NO.

Civ# [redacted] b(6)-4

ICW2

PROGRESS NOTES
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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
7 June 03 1100	Dsg Δ done. Area healing well. Sm amt of red drainage on right side. Area cleaned c̄ sterile water packed W→P Dsg applied. 4mg MSO4 IVP prior to dsg Δ by Maj Howell. MD advised not to pack as much gauze under skin edges. Just one layer. UA and
T 100.6	CXR done. CBC ordered for AM. [redacted]
P 111	1400. pt's colostomy bag Δ'd. Pt OOB to chair. 2 tylenol
R 20	given for elevated temp. Old colostomy bag draining brown. pt
BP 108/70	stool. Pt attempted to amb. approx. 5 steps then
96%	needed to sit. Sat in chair approx 15 min. b(6)-2 [redacted]
	1610 Dsg Δ. Old dsg moderate amt of yellow drainage
	present. Area pink and moist sm amt bleeding present. 4mg MSO4 IVP adm by Lt Tinch prior to b(6)-2 Δ. Pt resting now no s/s discomfort [redacted]
2000	Pt care assumed @1700. VSS, pt alert and awake, no complaints at this time. Pt had 55 100% of dinner, fed himself. IV c̄ abx infusing to RFA @ s/s infiltration. Lung sounds CTA, pulses palpable x4. Pt had 450cc urine this shift. Dressing on Abd CDI, Δ to be done @2300. Colostomy bag draining brown feces. Will continue to monitor. SPC [redacted] b(6)-2
8 June 03	Dressing Δ done @ 2400. Site appears to have small colonies
0100	of infection, faint foul odor noted. SPC [redacted] b(6)-2

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
8 Jun 03	Assumed care of pt @ 0500. Pt is asleep. VSS.
1045	Lungs CTA. Deep A done. Pt hygiene done. Pt received 4 mg MSO4 IVP before deep A. Pt has 0 % pain or discomfort @ this time. Pt states to Nabil (interpreter) that he is "skinny". Pt also asks about when he will get the skin graft. Will continue to monitor pt. — b(6)-2 [redacted] 91WM6, SGT
1330	Ambulated pt up to chair. Pt had a syncopy episode
1300 T 99.4	assisted pt to the floor and back in bed. Pt Sats
P 108	were 99 then dropped to 89. Pt was put on O2 @
R 24	2 L. Pt sat are now @ 99%. Pt will be given
BP 118/60	2 L of blood. — [redacted] 91WM6, SGT
O2 95%	Surgeon b(6)-2
8 Jun 03	Fell today probably syncopy when standing
1515	VSS ↑HR over 24 hrs 0 ↓I
	chest clear
	cor RRR 2HPB
	Abd serosal rent — Bowel Field from fall
	NO EC Pt Wlq D dressing to perform / usually
	Gauze to protect Bowel.
	Ap 17 > 24 > 909

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	LAST	FIRST	MI	

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

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Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	A/P Dony ok. Wound ok x for next dress covered
	① D Activity to OOB → chair BID
	② 24 PRBC for symptomatic orthostasis
	③ ✓ Labs in dg.
	④ Stop Abx. b(6)-2
	[redacted]
8 JUN 03 1620	PRBC transfusion initiated. VSS. ∅ signs or symptoms of reaction noted. IV site ⊠ redness or edema. b(6)-2
	b(6)-2 [redacted]
1625	BP-118/78, T-99.1, P-96, Sats-94%, R-18 [redacted] 91WM6
1630	BP-118/78, T-99, Sats-94%, P-95, R-18 [redacted] 91WM6
1635	BP-118/78, T-98.8, Sats-95%, P-89, R-18 [redacted] 91WM6
1650	P-91, Sat-94%, T-99.1, R-18, BP-118/78 [redacted] 91WM6
1705	Sats, 98%, P-97, R-18, T-99.1, BP-118/74 [redacted] 91WM6
1720	Sats 99% P-94 R-16 T 98.7 BP 116/64 [redacted] 91WM6
1750	SAT 99%, P 97, R 16 T 98.7 BP 112/70 [redacted] 91W
1820	100% P 90 R 16, T 97.8 BP 114/74 [redacted] 91WM6
2015	2nd Bag RBC hung. VSS @ temp 99.1, HR 96, BP 116/72, O2 sat 96% RR 16
[redacted]	b(6)-2
2020	BP 118/74, SPO2 97% HR 94, RR 18, T 99.2 [redacted] 91WM
late entry 2021	BP 116/72 SPO2 98% P-96 R 16 T 99.2 [redacted] 91WM
2032	BP 114/68 SPO2 96% P-96 R 16 T 99.4 [redacted] 91WM
2047	BP 116/70 SPO2 96% P-95 R-14 T 98.7 [redacted] 91WM6
2117	b(6)-2 BP 112/68, 97%, P 98 R 16 T 99.1 [redacted] 91WM6
2147	BP 119/76, 98%, P 90 R 16 T 99.4 b(6)-2 [redacted] 91WM6

STANDARD FORM 509 (REV. 5/1999) BACK

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
8 June 03 errass ~~2040~~ 2345	Blood infusing complete @ 2340. Pt w/o signs of complications vitals after infusing are R18, P100, BP 120/72, T 100.1, SPO2 98%, blood bags brought back to lab. Labs to be drawn @ 0130.
9 June 03	Dressing Δ done @ 2330. Wound appears red and moist, with section near top showing peristalsis, no bowel seen. Pt has had VSS throughout shift, SPO2 dropped to 89%, O2 applied via face mask for ½ an hour, SPO2 raised to 96%-99% Pt has been resting throughout shift, awakened by verbal stimuli. Pt lung sounds CTA, pulses palpable x4, bowel sound present in @ LQ. IV @ RFA infiltrated, started again @ L wrist, infiltrated, started again in RFA. IV infusing LR w/20 meq KCL @ 50cc/hr, 0 S/S infiltration. Colostomy bag has had gas throughout shift, little stool noted. No complications are noted at this time, will continue to monitor. SPC [redacted] b(6)-2 9 Jun 03
9 June 03 0815	Assume pt care @ 0500. Pt asleep easily aroused by verbal stimuli. Alert to surroundings. No S/S pain or distress. temp 100.0 650mg adm. Wd. dsg CDI. HR regular. Lungs CTA. BS present RUQ. Colostomy bag in place. Sm amt brown stool present. Pulses strong. IV LR ē 20 meq KCL @ 50cc/hr to (R) AC. No s/s redness infiltration. Will change dsg and colostomy bag (cont)

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

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

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

EPW # [redacted]
b(6)-2

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
7 June 03 0815	this am. Labs from 0300 reviewed by MD. Wee encourage pt OOB to chair. b(6)-2 [redacted] 9/4/M6
1035	drsg Δ and ostomy bag Δ. Abd site red and moist. No ↑ bleeding noted. One layer of Vaseline gauze applied to abdominal drsg to cover site. Colostomy site b(6)-2 pink. free of infection. [redacted] 9/4/M6
7 June 03 1315	Pt vitals taken. BP 112/70, P. 100, R. 16 TEMP. 98.5 [redacted] b(6)-2
9 Jun 03	1525 Surgery No complaints OOB + Chair today tol PO well (+) stool. Bag. Uss Tm 101 wound: open good granulation. No signs of infx. 130/30 897 b(6)-2 Dorg well will follow [redacted] for poss site of infx.
7 June 03 1800	Pt vitals taken BP 120/70, P 98. R. 16 TEMP 99.4 [redacted] b(6)-2

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

DATE	NOTES
10 Jun 03	0800. pt alert and awake. Abd dsg cont dry yellow drainage noted. Colostomy bag intact. brown stool noted. IV fluids LK to (R) ⊕A. Uns S/S redness/infiltration. No c/o pain @ this time. Lungs CTA. HR reg. BS RLQ active. Will continue to monitor. — b(6)-2 [redacted]
10 Jun 03	Surgery No complaints stoma out put good VSS Afeb. off Abx wound open good granulation contracting A/P Doing well. cont dressing Δ awaiting skin flap stick prior to SOSG. b(6)-2 [redacted]
10 Jun 03 1930	assumed BS care @ 1300 - VSS - COB to chair x45 min Tx dsg change - IV patent - pt. ate small amount of dinner's assistance - pt. cooperative - ∅ output from stoma this shift — [redacted] CPT

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted] CIV

b(6)-4

REGISTER NO.

WARD NO. ICW2

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
11 Jun 03 0417	10 Jun 03 21:00 - Pt. sleeping c̄ blanket over head. awakened easily. VS b(6)-2 WNL x̄ temp 101.8. Pt given ii̇ tylenol. will reevaluate. Pt [redacted] WNL LCA (B). BS (+) x2 quad & L quads. Colostomy bag draining soft brown stool. ABD. drsg Δ'd old drsg c̄ yellow tinged drainage ~~on~~ outlining boarder of drsg edges. Q ~~to~~ odor noted. New drsg C/D/I. Pt voiding cl yellow urine. PIV (R) Hand patent. Will cont to mon. [redacted] OT/AU 0330 - PIV (R) hand d/c'd. (L) Hand PIV initiated and patent c̄ LR c̄ 20 meq KCL @ 50cc/hr. Will cont to mon b(6)-2 [redacted] OT/AU
11 Jun 03 1100	Assumed care of @ 0500. Pt resting quietly. VSS. Lungs CTA. BSG Δ'd at 1100. Colostomy bag emptied @ 1045. Pt voiding cl yellow urine. pt was given percocet ii̇ @ 1045. Pt sat up in bed for about 10 min. Washed and lotioned pts back. Pt has ∅ c/o pain or discomfort @ this time. - [redacted] PN, SGT b(6)-2

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
11Jun03	Surgery
	No complaints
	VSS AFeb
	wound c/D contracting
	A/P Doing well
	No Dr plan.
	[redacted] b(6)-2
12Jun03 1620	assumed care of pt @1300 - VSS - IV patent, LR c̄ 20m Eq KCl infusing as ordered into (R) AC IV - dsg D/C'd, (L) upper corner of wound c̄ brown tinged fluid in pocket, Dr. [redacted]
b(6)-2	aware, W-7D dsg placed in that area spot's in original entrance wound, petrolatum gauze placed on abdomen and covered c̄ 8x7 in gauze dsg, minimal tape used - pt. OOB x 30 min only due to heat in unit - [redacted] b(6)-2
11Jun03 21:15	Pt. sleeping under blanket. Awakens easily. Alert. Skin PWD c̄ "goosebumps". VS WNL x̄ temp 99.4°. LCAB. IV (R) FA intact and patent c̄ LR 20meq KCl @ 50cc/hr c̄ Abaris pump. ABD dsg. C/D/I. Colostomy bag intact and draining liquid brown stool. (+) PPPB. Skin dry and pt. feeling itchy, will apply lotion.

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

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

REGISTER NO.

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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)
12 June 03	cont'd. Will cont. to mon [redacted] OIT/AN b(6)-2
0200	Dressing to ABD Δ'd. Old drsg c̄ little to no drainage. New drsg c̄ 3 xeroform sterile drsgs applied to skin and 3 ABD pads to cover. 1 herlix fluff sponge ~~used to~~ dampened c̄ sterile water used to pack LUQ wound. Colostomy emptied 80cc liquid brown stool c̄ foul odor. Will cont. to mon. [redacted] OIT/AN b(6)-2
0530	Pt. awake & alert resting comfortably in bed. VSS: BP 114/60, P96, sats 99 T99.8, RR14. Abdominal dressing CDI. Pt c̄ colostomy on (R) side. Pt. voided 400cc clear yellow urine. IV in (L) FA going @ 50cc/hr LR c̄ 20meq KCl, s̄ s/s of infection or infiltration. All other assessment findings WNL. Pt s̄ complaints @ this time. Will continue to monitor [redacted] OIT b(6)-2
12 JUN 03	Current Surgery
100	Bring area of complaint
	VSS - Pt 96 BP 114/60
	OPT HX - awaiting case for today
	now: well [illegible] covered c̄ [illegible]
	doing post dressing Δ - 1-2° from now
	[redacted] b(6)-2
1145	Abdominal dressing Δ'd. Small amt of light brown fluid draining and pooling on bottom (R) side of wound. Quarter size black area on (L) upper side of wound. Otherwise wound looks like its healing well, moist, pink, s̄ signs of infection. MD observed dressing Δ so is aware of wound condition. CT

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STANDARD FORM 600 (REV. 6-97) BACK

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
12 June 03 1300	Pt. vitals taken BP 110/70 P-104 R-20 Temp 100.8 — b(6)-2 [redacted]
12 June 03 1400	assumed pt care @ 1300, pt sleeping, easily aroused to verbal stimuli. airway patent, lung sounds CTA throughout. abd drsing Δ'd per orders, (R) upper corner ≅ brown drainage MD aware, other areas healing well, (D) S/Sx of infection noted. Ostomy bag draining brown stool. BLE ≅ FROM ≅ strong (+) pulses. BUE ≅ FROM ≅ strong (+) pulses. IV (R)A infusing ≅ diff. (D)S/Sx of infiltration, pt given ii percocet sitting ↑ in chair @ bs x 45 mins. tol well. Will cont to monitor — b(6)-2 [redacted] 2/LCMC
13 Jun 0144	12 Jun 2145 Pt sleeping, easily awakened and alert. S VS WNL ≅ ↑ temp 101.6 ii tylenol given ↓ temp to 100.2. Skin W/D. LCA (B) (+) BS x4. (+) PPP (B). Colostomy Bag draining stool. ABD drsg C/D/I. Will cont to mon [redacted] RT/AN — b(6)-2
0500	

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

PROGRESS NOTES
Medical Record

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

Civ. b(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
13 June 03	General Surgery
0915	Doing well. No complaints.
	Febrile last pm to 101.6 & 100.2 this am
	BP 130/70 HR 90-110 RA
MSV-4	looks well
Cortrox	chest clear. can see → RT, [redacted] b(6)-2
	has left, no. ostomy functioning well.
	wound - granulating well - only concern
	is (2) uterine fundal aspect - one small
	area - reddish? - no treatments necessary
	@ this time.
	left breast flap not completely adherent
	impression
	Doing well
	can wound care
	grafting planned for after better granulation &
	lack of presence of fascia flap.
	[redacted] b(6)-2
1000	Pt. resting comfortably in bed. Pt VSS: BP 104/62, T98.7, P102, 96%. Pt voiding adequately c̄ clear yellow urine. Colostomy draining soft stools, bag changed. ostomy s̄ s/s of infection. Abdominal dressing Δd while MD observed. Small amt of light brown liquid draining & pooling on bottom (R) side of wound. Quarter size black area on (L) upper side of wound. Wound looks like its healing well, moist, pink, s̄ signs of infection. Pt. has 50cc/h LR infusing c̄ 20 KCl in (R) arm s̄ s/s of infection or infiltration. Pt. up out

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USAPA V1.00

NSN 7540-00-634-4176

600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
13Jun02 1000	of bed to chair for 30 minutes, tolerated well. Pt. bathed while out of bed. Pt. has no complaints @ this time. All other
Cont'	assessment findings WNL. Will continue to monitor b(6)-2 [redacted] OCT/AN
13Jun03 1610	assumed care @ 1300 - T 100.6°F, will monitor, other VS stable - dsg Δ'd, granulation tissue over most of wound, small black area noted in upper (R) corner - colostomy c̄ soft brownish/yellow stool ~100cc - IV b(6)-2 patent, fluids running as ordered [redacted]
14Jun03 0146	13Jun03 21:15 - Pt awake and alert in bed. VS WNL. PERRLA(+)WNL LCA(B). BS(+)x4. (+)PPP(B). PIV (R) FA c̄ 500cc/hr LR c̄ 20 meq KCl. ABD dsg C/D/I. Colostomy draining brown stool. Skin w+d. Will cont to mon b(6)-2 [redacted] OCT/AN
error em	0030 - Dsg Δ'd. Old dsg c̄ yellow drainage. Wound well approximated c̄ granulation tissue. New dsg C/D/I.
b(6)-2	[redacted] OCT/AN
14Jun03 0930	Overall Surgery Pt doing well. No complaints, only fatigue - continuing wound care Tm 100.2 d 99 109/60 HR 100 RR [illegible] [illegible] area covered - granulating area [illegible] not complicated evidence of infection - [illegible] cont wound care b(6)-2

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

b(6)-4

[redacted]

CIV

RECORDS MAINTAINED AT:	[redacted]	
PATIENT'S NAME *(Last, First, Middle initial)*	[redacted]	SEX MALE
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)*
14Jun03 ~~1800~~ 1900	assumed care @1300 - VSS - ϕ colostomy output - dsg Δ'd - IV patent - pt. OOB to chair x1° - fed himself ½ of dinner plate - pt. was able to get himself back into bed ī assistance - in good spirits, had conversation ī translator [redacted] CRNA b(6)-2
2100	650 mg tylenol given for temp @ 1010, will check temp again @ 2200. SPC [redacted] b(6)-2 9IWMC
2200	Pt care assumed @ 2100. VSS, AOX3, no complaints of pain at this time. Lung sounds CTA, pulses palpable x4, bowel sounds present x4 quads. Dressing to Abd, CDI, Δ to be done @ 2400. IV patent, running LR w/KCL @ 50cc/hr. No complaints at this time, continue to monitor. SPC [redacted] b(6)-2 9IWMC
15June03 0715	Pt. asleep in bed easily aroused by verbal stimuli. VSS: BP 104/65, P92, T99.3, sats 99%. Colostomy draining soft stool. ABD dressing CDI Pt. ī complaints @ this time. Initial assessment completed & all other assessments WNL. Will continue to monitor. [redacted] b(6)-2 ALT (4
0100	ABD dressing Δ'd, wound pink moist & healing well. MD observed & is aware of wound condition. Colostomy bag cleaned & stoma is pink & moist ī s/sgns of infection. Pt. up to chair for 35 minutes, tolerated well. [redacted] b(6)-2
15June03 1440.	pt resting easily aroused to verbal stimuli. VSS. lung sounds CTA. abd dressing CDI. Ostomy bag intact. IV RFA infusing ī diff. ϕ s/sx of infiltration. ϕ complaints voiced @ this time. Will cont to monitor [redacted] 9IWMC b(6)-2

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
15 NOV 03	General Surgery
1530	Pt complains to sick call. & complaint
	Bony tenderness case. Wound care performed
	T 101. pulse 100.2 BP 165 90-100 RR 22 RA
	ABD: soft. gurgling sounds
	left lat edge - hovering left of IOP
	Plan: cont. wound care
	follow fevers - ? origin
	cont. aggressive care to back ? fungal or bacterial
	RTOD [redacted] b(6)-2
	MS

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

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

REGISTER NO. | WARD NO.

b(6)-4

CIO # [redacted]

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
2300	HR Reg. Lungs CTA. ABD dressing CDI. colostomy intact. (+) BS (x) LQ. Pt. alert. cooperative. will cont. to monitor. [redacted] b(6)-2
16 June 03 0645	Pt. awake & alert laying in bed. VSS: BP 110/74, sats 95%, P95, T 98.8. ABD dressing CDI. LR ĉ 10meq KCl infusing in (R) FA ~~5~~ S/S infect/tract infiltration. Colostomy draining soft light brown stool. Pt. voiding adequately. All other assessments finding WNL. Pt. has no complaints @ this time. will continue to monitor. [redacted] b(6)-2
16 June 03 0915	General Surgery Pt doing well (-) complaints Tm 100 ↓98 HR 95 BP 110/74 ABD wound - looks good nearly 100% movement (-) signs of infection. [illegible] Doing well - ↓ CBC tomorrow CBC/chem - plan anything new as of a/c [redacted] b(6)-2
16 June 03 1130	Pt. abdominal dressing Δ'd while MD observed. Colostomy bag Δ'd & small pustules noted where tape was removed around the stoma. [redacted]

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
1605 VNB	Assumed care of Pt @ 1300. VSS. AtO x 3. ABD DRSG CDI, Δ'D
1900	@ s/i/sx of infection. Colostomy draining soft light brown stool. Cream applied to sacral back. LRL 20meq/L KCL @ 50cc/hr via (R) FA PIV. OOB → chair x 1 hr. Ambulated. Assess WNL. Will Monitor. b(6)-2 [redacted]
2300	Pt care assumed @ 2100. Temp @ 101.1, 650 tylenol given. At 2400 temp was 98.6. Other VSS, pulses palpable x4, lung sounds CTA. Dressing Δ done, wound is red + moist w/o s/s infection. IV @ RFA infusing well. Pt w/o complaints at this time, will continue to monitor. SPC [redacted] b(6)-2
17 JUNE 03	General Surgery
1045	Pt continues to do well. No complaints. Tolerate liquid diet. Afebrile. Up to 101 & 98.6. Plan for
1047 / 33	Wound - unchanged - good granulation tissue. Cont wet to dry dressings. Monitor progress.
17 JUN 03 / 37 JUN 03	Plan for discharge.
	Case - unchanged x 7 days.
	Plan DTSB - [redacted] b(6)-2

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

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

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PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
17 Jun 03 1200	Assumed care of pt @ 0500. Pt is OOB to chair. Pt lungs CTA. Diminished bowel sounds. Abg A done @ 0945. Pt had % taking. Pt was given benadryl 50 mg po. Pt has been resting quietly. Ø % pain or discomfort b(6)-2 [redacted] 91WM6, SGT
2 June 03 1335	Pt vitals taken BP 168/58, P. 112, R. 16, Temp. 100.8 b(6)-2 SPC [redacted]
17 June 03 1345	Assumed pt care @ 1300. Pt resting easily aroused to verbal stimuli. VSS. Assessment WNL. ↓ diminished bowel sounds. Drains to abd. CDI. IV infusing 5 dsw. Will cont to monitor b(6)-2 [redacted] 91WM6 SGT
17 Jun 03 21:31	Pt. received sleeping in bed easily awakened. Skin WD. PERLA⊕ANL VS WNL ↓ temp 100.4. Temp ↓ from 100.8 @ 13:00. LCR⊕. BS⊕x4 @ flanks. Colostomy draining brown stool. ABD dsg. CDI/I. ⊕ PIV ⊕ AC patent ⊂ LR 20meq KCl @ 50cc/hr. ⊕ PPPB. Will cont. to mon. b(6)-2 [redacted] 2LT/AN
02:16	Pt. awake and itching with an uncomfortable look on face. Benadryl 50mg given. 4mg MSO4 given for dsg Δ. Will monitor [redacted]
18 Jun 03 0600	Assumed pt. care @ 0500: Pt. A&O x3. VSS. lungs CTA. ⊕ pulses x4. Drains to Abd. CDI. Colostomy bag to Abd intact ⊂ brown stool. IV to ⊕ AC ⊂ LR 20 meq @ 50cc/hr infusing 5 difficulty. Will continue to monitor [redacted] 91WM6
0830	Colostomy bag emptied ⊂ brown stool. Drains to Abd. b(6)-2 Incision healing well. Ø foul odor noted. Dressing [redacted] 91WM6
0930	Pt. out of bed and sat up in chair for 3 hrs mins. Tolerated well. Ø signs of distress noted [redacted] 91WM6 b(6)-2

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MEDICAL RECORD	PROGRESS NOTES
DATE	
18 June 03 1330	Pt vitals taken, BP 102/62, P. 96 R. 20 [redacted] b(6)-2 Temp. 99.2.
18 June 03 1345	VSS. pt resting quietly [redacted] to verbal stimuli. lung sounds CTA abd soft diminished BS drains CDI. ostomy bag intact draining brown stool. BLE c̄ full ROM strong ⊕ pulses. IV to RFA infusing ∅ diff ⊖ S/Sx of infiltration noted. cream applied to back per orders. pt denies pain or discomfort @ this time. Will cont to monitor [redacted] b(6)-2
19 Jun 03 0530	Pt. awake + alert in bed. VS WNL. Skin WD. PERRLA ⊕. LCA ⊕ BS ⊕ @ flanks. Colostomy draining stool. ABD dsg C/D/I. PIV patent. ∅ complaints @ this time. Will cont to mon [redacted] Dsg Δ done to ABD. Wound well approximated c̄ granulation tissue. Scant amt drainage on old dsg. New dsg C/D/I. Colostomy bag Δ'd. Skin @ ↓ portion of adhesive of colostomy bag weeping serous drainage. Dr. [redacted] notified. Hydrocortisone cream @ bed side. Stoma beefy red and healthy looking. Ambien given d/t pt. c/o ∅ being able to sleep. New PIV initiated LFA patent. ∅ further complaints. Will cont. to mon [redacted] OT/AN b(6)-2

(Continue on reverse side)

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

REGISTER NO.

WARD NO. ICW 2

PROGRESS NOTES
Medical Record

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

C/V [redacted] b(6)-2

PROGRESS NOTES

DATE	
19 June 03 0830	Pt. laying bed easily aroused by verbal stimuli. VSS. Pt. temp now @ 99.9. ABP dressing CDI. Pt. c/o pruritis around stoma where he had an allergic reaction to the colostomy bag tape.
0620 T 101.2 P 111 R 24 BP 104/68 96%	Hydrocortisone applied & site cleaned. All other assessment findings are WNL. Pt. has no other apparant complaints @ this time. Will continue to monitor. — [redacted] ALY/HN b(6)-2

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

NSN 7540-00-634-4176

600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
18 JUNE 03	General Surgery
0855	Pt continues to do well.
	∅ complaints
	RUSH 5 weeks on back
	- low grade temps <101. HR 80s BP 110/68 O2 Sat
	abdominal wound - granulating well
	Jackson Pratt drain right abdomen
	Aspect - nearly removed
	Left lateral flap not yet mobilized
	- plan DTSG - from Tuesday (tomorrow) 5 days of week
	If long as flap is not adequate.
	[redacted] b(6)-2
	MAJ MC
19 JUNE 03	General Surgery
1410	No complaints
	Continues to do well.
	wound unchanged
	may ambulate at
	[redacted] b(6)-2

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

b(6)-2

Civ # [redacted]

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

MEDCOM - 14874

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

b(6)-2 A11

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
19Jun03 2000	assumed care @1300 - VSS - IV patent - abd dsg. D/C as ordered - pt. did not get OOB this shift - no c/o pain @ this time - cream supplied to back and quad as ordered [redacted] cn
19Jun03 2300	Assumed care of pt @ 21:00. Pt sleeping easily aroused. VSWNL Skin WID. Perrla (+) WNL. LCA (B). BS x 4. (+) PPP (B). ABD. dsg CDI. No complaints @ this time [redacted] DET/AW
0880 20Jun03 0630	C/O pain ABD 4mg MSO4 given [redacted] DET/AW Pt. asleep in bed easily aroused by verbal stimuli. VSS: BP 100/62, Sats 97%, P100, T 100.2. ABD dressing CDI. Colostomy draining liquid stool. IV LR c 20KCl @ 50cc/hr in (L) FA infusing ~ s/s infection or infiltration. Pt. with no apparent complaints at this time. [redacted] All other assessment findings WNL. Will continue to monitor. C [redacted]
20 June 03 1010	Pt [illegible] [illegible] [illegible] Low grade fever [illegible] no apparent [illegible] Wound granulating well [illegible] (R) [illegible] [illegible] [illegible] - [illegible] - [illegible] - ? memory [redacted] [redacted] [illegible]
0900	IV placed in (L) FA.

MEDICAL RECORD	PROGRESS NOTES
DATE	
20Jun03	assumed care @ 1300 - Tmax 101.2, current
1815	100.8°F - area of redness noted on (R) FA
b(6)-2	@ old IV site, will make Dr. [redacted] aware -
	IV site new today & patent - dsg Δ'd -
	pt. up to chair and ambulated this
	shift - tolerated regular diet - no c/o
	pain @ this time — [redacted] CN
	b(6)-2
2230	Pt care assumed @ 2200. VSS, A+Ox3, no c/o pain. Lung
	sounds CTA, pulses palpable x4, IV ē 20 meq KCL patent.
	Hydrocortisone applied to RLQ, Ø c/o pain @ site. Abd dressing
	CDI, Δ to be done @ 12. Will continue to monitor. Spc. [redacted] 91W M6
21Jun03	Pt. care assumed @ 05:00. TEMP: 99.4, A+Ox3. Lungs
	CTA, pulses palpable x4. Drsng and abd. CDI. Colostomy
	bag intact. IV LRT 20 meq KCL infusing @ 50cc/hr
	through alaris pump ∃ any problems. Denies any
	discomfort @ this time. Will continue to monitor.
	b(6)-2 [redacted] 91W M6
0730	950cc clear yellow urine output - Davidson from 91W M6
0850	Drsng Δ'd complete. Ø s/s of infection or foul odor noted
b(6)-2	will continue to monitor [redacted] 91W
0920	Pt. OOB sit-up in chair. Ø distress noted. Ø pt. tolerated
	well — [redacted] 91W M6 —
	[redacted] b(6)-2

(Continue on reverse side)

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

REGISTER NO.

WARD NO. ICW2

CIV [redacted] b(6)-4

PROGRESS NOTES
Medical Record

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

PROGRESS NOTES

DATE	
21 JUN 03 1128	General Surgery Pt continues to do well OOB to chair - mild nausea Tm 101.2 spike yesterday looks well - wound unchanged will continue for 100% coverage of skin flap prior to grafting [redacted] b(4)-2
21 June 03 1420	assumed pt care @ 1300. pt resting quietly easily aroused to verbal stimuli. VSS. lung sounds CTA, abd dressing CDI. ostomy bag intact. ↑ & ↓ ext c̄ full rom strong ⊕ pulses. ✓ IV (L) FA infusing LR c̄ 20 meq KCL 5 diff. Ø S/S of infiltration noted. pt denies "alam" pain @ this time. will cont to monitor [redacted] b(4)-2 9 lumen
2345	Pt c/o pain @ abd, 4mg MSO4. SPC [redacted] 9 lumen
0100	Pt care assumed @ 2100. VSS, pt awake and alert,
22 JUNE	4mg MSO4 given for pain. Lung sounds CTA, pulses palpable x4. IV @ LFA infusing LR c̄ 20 meq KCL @ 50cc/hr, Ø S/S infiltration. Dsg Δ, wounds pink and moist. Pt has
b(4)-2	no complaints, will continue to monitor. SPC [redacted] 9 lumen
22 JUN 03 0930	Pt. laying in bed awake & alert. ABD dressing CDI. Colostomy care completed, hydrocortisone applied to edge of colostomy adhesive, no irritation noted. Pt. c/o itching about 0700, Benedryl 25mg given. Pt. nauseus 20min after Benedryl given. Pt. sat up clear, colorless

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

MEDICAL RECORD	PROGRESS NOTES
DATE 22 June 03 0930	liquid. Pt. currently ∅ complaints @ this time. All other assessment findings WNL. LR ∅ 20meq KCl @ 50cc/hr infusing in (L) FA ∅ s/s of infection or infiltration. Will continue to monitor. [redacted] AN b(6)-2
22 JUN 03 1100	General Surgery Pt ∅ ∅ bowel sounds following enema this AM. Now feels better. ∅ complaints @ this time. Tm 101.4 P 98 today 122/76 HR 80-100 RR 20-24 (lungs good) chest tube c/c on left abd left, staples functioning, wound - 100% intact - good granulation tissue - ∅ infection Impression Doing well - plan ∅ TSO tomorrow, leave pen tubes, - check CBC in am - f/u - NPO ∅ am - ↑ IV @ noon [redacted] MD b(6)-2

(Continue on reverse side)

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

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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

PROGRESS NOTES

DATE	
12 Jun 02 2010	Assumed care of Pt @ 1300. VSS. Ambulated x10 min ~~c~~ assistance. OOB to chair x1. ABD dsg CDI, O/C for graft in AM. Colostomy bag Δ'd, stoma looks healthy, soft brown formed stool. LRC ~~c~~ 20 meq @ 50 cc/hr. Pain controlled ~~c~~ percocet. [redacted] Assessment WNL. Will Monitor b(6)-2
2210	Pt. care assumed @ 2100. VSS. Pt. NPO for surgery in a.m. IV to (L) UE flushed, infusing. IVF ~~c~~ difficulty. HR Reg, Lungs CTA. Drsg to ABD CDI. Drsg Δ'd by evening shift x2, will not Δ drsg this shift. Colostomy draining soft [redacted] b(6)-2 semi-liquid stool. Will cont. to monitor [redacted]
b(6)-2 0430	Dr. [redacted] notified of CBC results. [redacted]
23 Jun 03 0600	Pt. awake & alert in bed. ABD dressing CDI. Colostomy on pt. (R) side is draining soft brown stool. IV infusing in (L) AC ~~c~~ LR ~~c~~ 20 meq KCl @ 50 cc/hr ~~c~~ s/s infection or infiltration. VSS: BP 118/66, P96, Sats 96%, T99.8. All other assessment findings WNL. Pt. has no complaints @ b(6)-2 this time. Pt. on call to OR this AM. Will continue to monitor [redacted]
0900	Pt. to OR via litter
1100	Pt back from OR via litter.

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
23 JUN 03	General Surgery
935	Brief Op Note
	preop dx: open gunshot wound [illegible] 2° GSW to abdomen
	postop dx: same as above
	procedure: split thickness skin graft to abdomen, donor right thigh
	surgeons: Spence, Burgdorf
	anesthesia: GET.
	EBL: min
	fluids 1100 cc
	specimens none
	complications none [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. BCW2

CIV [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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
23 JUN 03	Assumed care of Pt @ 1300. VSS. A+O x 3. (+) LS CTA, (+) BS
1930	6 stools draining liquid Brown stools - TOL PO well. (R) thigh Donor site under warm bag dsg intact. ABD graft dsg to suction drain CDI. Ø dopaminc. Pt ACT PLATON BLOCK (R) UE PIV patent c/w assessment WNL. Will [redacted] MONITOR b(6)-2
24 Jun 0140	Pt care assumed @ 2100. VSS, Alert and awake, [redacted] t3 ⅌ given for pain @ 0100. Lungsounds CTA, pulses palpable x4, bs present. Ostomy site CTA, Ø stool. (R) thigh CDI under heat lamp. Abd dsg CDI, JP suction @ bedside. ⅌ Heplock flushes well, will continue to monitor. b(6)-2 [redacted] 91WMC
0430	Colostomy bag emptied, 100cc brown semi-formed stool, site intact. Nothing drained from JP. [redacted] 91WMC
24 JUN 03 0945	General Surgery POD #1 s/p STSG for (R) thigh to [illegible] area. Doing well. Ø complaints x [illegible] → [illegible] [illegible] Tm 100.9 [illegible] [illegible] left, dressing intact - [illegible] [illegible] Doing well [redacted] s dressing in 23 hrs.

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. BW2

[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

PROGRESS NOTES

DATE	
24 Jun 03 2130	Pt vitals taken BP 108/62, P. 110, R. 16 [redacted] TEMP. 104.6 [redacted]
25 Jun 03 0000	Pt temp @ 0000 is 99.8 [redacted] b(6)-2
25 Jun 03 1005	General Surgery pos # 2 s/p [illegible] to postoperative care from (R) thigh. Pt arrives to ward w/o incident & given [illegible] Vsss well [illegible] HRS 99 RR 20 BP 115/72 pen dressing intact - wound use [illegible] serous fluid in bag. Donor site - [illegible] [illegible] looks good 1100/PCM: Pt [illegible] [illegible] - [illegible] dressing - x 3 days [illegible] PO = EDL. [redacted] b(6)-2
25 Jun 03	Assumed care of pt @ 0500. Pt is awake. VSS. Pt was given 50 mg Benadryl for itching. Pt tolerated all of breakfast and lunch. Lungs CTA. Pt was given T-3 ii tabs at 1145 for pain. [redacted] b(6)-2 9146M6,867
1220	Adpt's clothing bag [redacted] b(6)-2 9146M6,867
1700	Assumed care @ 1300. VSS. ATOx3. ABD graft site dsg CDI to suction donor site (R) LE under heat lamp, ostomy bag drainage formed brown stool. Pt c/o pain. Benadryl given prn itching. TOL PO well. O/W assess pain will monitor [redacted] b(6)-2

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

MEDICAL RECORD	PROGRESS NOTES
DATE	
24 Jun 1100	Assumed care of pt @ 0500. Pt is alert. Pt had a c/o itching. Md change order from PO Benadryl to IV Benadryl 50 mg. A'd pt's ostomy bag @ 0200. VSS. Lungs CTA. Pt has been sleeping most of the day. Pt has ø c/o pain/discomfort @ this time. b(6)-2 [redacted] 9LWM6, S6T
24 Jun 03 1920	assumed care @ 1300 - VSS, Tmax 100.3° - pt's ostomy bag Δ x3 this shift, skin around stoma appears macerated, weeping, ostomy bag not adhering to skin as well as it should - heat lamp remains above the donor site - drain at graft site remains on L1S, scant amount of drainage - pt. was fed dinner - IV patent - no c/o pain @ this time b(6)-2 [redacted] CPT HAW
2140	Pt. care assumed @ 2100. Pt. c/o ABD pain, T^{S} $\frac{0}{11}$ given. HL to ⓡ AC D/c'd because site leaking. IV to ⓛ EA flushed, ø s/s infection or infiltration. HR Reg, Lungs CTA, BS ⊕ x4 quadrants. Graft dressings to ABD CDI, drain to suction draining rust brown fluid. Graft donor site ~~CTA c̄ heat lamp~~ dsng intact c̄ heat lamp applied, CMTS to ⓡLE WNL. Will cont. to monitor. b(6)-2 [redacted]
0400	ø output from colostomy [redacted] from drain - [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. 1LW2

CIV

#[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTIC

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
25JunO3 2300	Pt care assumed @2100. VSS, AOX3, MD notified because pt complained TB was of no help after the surgery, and he was in pain. MD order obtained for 4mg MSO4, 12.5mg of phenergan. Lung sounds CTA, pulses palpable x4, bowel sounds present. Graft site to JP suction @ abd CDI, donor site @ R thigh c̄ heat lamp CDI. Pt w/o complaints at this time. [redacted] 91WM6 b(6)-2
0300	JP drain found at pt's bedside. Dr [redacted] notified b(6)-2 will shut off suction and report to next shift. [redacted] 91WM6 b(6)-2
0430	200 output from JP drain, pt had large amount of semiformed feces @ ostomy. [redacted] 91WM6 b(6)-2
26 June 03 1100	Pt. laying in bed awake & alert. JP drain no longer in place, awaiting orders from MD. Colostomy bag D'd & cleaned. Heat lamp in place over donor site. Pt c/o itching, 50mg PO Benedryl given. Site on ABD c̄ clear dressing. Gauze under dressing c̄ dark grey saturation noted. Donor
1000 T99.9 P100 R20 BP 122/76	site on (R) thigh c̄ yellowish drainage noted. Pt. eating & voiding well. All other assessment findings WNL. Pt. ∅ any complaints @ this time. Will continue to monitor. [redacted] DCT/ANN b(6)-2

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

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

REGISTER NO.

WARD NO. ICW2

Civ # [redacted] b(a)-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
26 JUN 03	General Surgery
1945	POD #3 s/p FTSG to [illegible]
	[illegible] area. Pain reportedly
	relieved with [illegible] - wound was
	ō some for c since.
	AFEB - [illegible]
	Codes area
	[illegible] dressing removed
	gauze ≈ 90% to [illegible]
	Codes w. gauze
	Impression: Doing - good result for FTSG
	- Vaughan gauze dis to skin graft.
	- Pain diminishes [redacted] b(1)-2
26 Jun 03 2000 hr b(1)	assumed care @ 1300 VSS - graft dsg removed by Dr. [redacted] petrolatum gauze placed on graft site - heat lamp removed from (R) thigh & dry edges cut from dsg. - no % pain - area around graft site cleaned, skin irritated - tolerated regular diet - colostomy emptied of soft loose stool — [redacted] b(1)-2

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

MEDICAL RECORD	PROGRESS NOTES
DATE	
26 Jun 03	Rec'd pt @ 21:00. Pt. sleeping easily to awaken. Skin WD
23:03	VS WNL according to Flow Sheet. PERRLA ⊕. LCA ⊕. BS ⊕ x4
	⊕ PPP ⊕. PIV (L) FA & patent. New PIV initiated (L) wrist
	c̄ difficulty. C/o pain. pt. tearing up and writhing in pain
	MD Wynn notified. 5 mg MSO4 given IM (L) thigh c̄
	new PIV initiated. MSO4 controlled pain per pt. Pain was
	in ABD area. Colostomy intact draining stool. Graft site @
	ABD. c̄ petroleum gauze intact. Donor site c̄ dsg intact.
b(6)-2	to (L) thigh. Will cont. to mon [redacted] 2nd/AN
24:00	c/o itching 50 mg Benadryl given c̄ relief will
b(6)-2	cont. to mon. [redacted]
27 JUNE 03	General Surgery
0915	POD #4 S/P ABSC to ABD wall - donor from (R) thigh
	c/o crampy abdominal pain. (+) ostomy output - formed stool
	ABB WB
	ABD soft NT. NO
	graft site - looks good
	donor site - drying well
	imp/plan: drug ex ll
	- Cipro 100 mg po BID
	- leaving D3 c̄ petrolatum gauze

(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] WARD NO. b(6)-2

PROGRESS NOTES
Medical Record

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

PROGRESS NOTES

DATE	
27 Jun	Assumed care of pt @ 0500. Pt is asleep. Pt had % pain abdominal area. Pt was given colace @ 0900. Pt was given T-3 ⅲ @ 0710 for % pain. Pt is now resting soundly. Dsg Δ done. MD says abdominal graft is doing well. Tolerated breakfast. Lungs CTA. Will continue to monitor [redacted] SGT
b(a)-2	
27 Jun 03 2000	assumed care @ 1300 - USS - colostomy c̄ semi-formed stool - graft doing well, Small area of yellow green drainage in lower (R) corner, petroleum gauze Δ'd - IV HL patent - medicated for pain c̄ Tylenol PO - thigh dsg trimmed - Lungs CTA (B) - pt. slept most of shift [redacted] CB, AO
b(a)-2	
2130	Pt alert - HRR, Lungs CTA, AO x4. Colostomy draining soft brown non-formed stool. Vaseline gauze to ABD clean, intact. colostomy bag intact. Will cont. to monitor. [redacted] CTA
	b(a)-2
28 JUN 03	Recent Surgery:
0015	POD 5 S/P ATSG TO ABD WALL
	[illegible] WCC
	ABD [illegible]
	ABD [illegible] good. 90-100% TRU - skin graft
	healing well
	pain managed to [illegible]
	[redacted] b(a)-2
	[redacted]

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

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
28 June 03	Transfer Summary
0980	Date of Admission: 14 May 03
	Date of Transfer: Airlift, 28 June 03
PMH	History: 40 yo Iraqi male sustained GSW to abdomen
↓	on 14 May 03.
PSH	Historic course:
↓	14 May - OR small bowel resection & anastomosis x 2
MGS	colonic repair, loop sigmoid colostomy - PST
Lawson	12 May - OR pelvic debridement, intra-abdominal
Zarook	abscess -> partial pelvic end sigmoid
Cooper	colostomy, cystostomy, repair abdominal wall
Chrisinger	defect.
Cobb	23 May - OR attempted closure abdominal wall defect
Neal	w/ BTG closure performed & large defect
	22 May - OR - IV BTG removed, plan for peritoneal
	surface to granulate followed by skin graft.
	3 wks - OR cystostomy & reconnection of bladder
	& pelvic tissue.
	23 wks - OR split-thickness skin graft placed
	on abdominal wall, donor from right thigh
	28 June 03 - Transfer - skin graft 90-100% take
	MGS preliberal. [redacted] b(6)-2

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

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

NSN 7540-00-834-4176 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
28 June 03 1100	Pt. awake & alert in bed. Dressing Δ'd c̄ MD observing. Wound healing well, c̄ s/s of infection or drainage. Pt. bathed & colostomy bag Δ'd. Lung sounds clear bilat. Pt. eating well & voiding adequately. Pt. c/o pain x1, MSO4 4mg given. All other assessment findings WNL. Will continue to monitor. [redacted] b(4)-2
2000	Assumed care of Pt @ 1900. VSS. A+Ox3. Graft healing well no s/sx of infection. Donor site BANDAGES CDI. BLS CTA. Denies pain. Awaiting transfer to CIV Hosp w/ AM. Ow assess. CNC. Will Monitor [redacted] b(4)-2
29 Jun 0030	Pt care assumed @2100. VSS, alert and awake c̄ slight c/o pain. ~~At 2400 Temperature was 100.3, blanket taken off and ice applied, to @0100 Temp is 99.7.~~ Lungs CTA, pulses palpable x4, bs x4 quad, Skin graft site and donor site CTA, colostomy bag intact. Pt resting, no complaints at this time. Pt w/ evac orders, awaiting evac @ 0630 to Iraqi hospital. Will continue to monitor [redacted] 91WM6 b(4)-2

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

CIV # b(4)-2 [redacted]

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

MEDCOM - 14889

558-103 (See Instructions on Back of this Shee.. NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

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

LOG NUMBER

ARRIVAL			TRANSPORTATION TO HOSPITAL (Attach care enroute sheet)	CURRENT MEDS. (tetanus immunization and other data)	HISTORY OBTAINED FROM
DATE		TIME	☐ PRIVATE VEHICLE ☐ AMBULANCE		☐ PATIENT ☐ OTHER (Specify)
DAY	MONTH	YR.	☒ OTHER (Specify) AIR		ALLERGIES
14	MAY	03	0815		

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code): EDW

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration): Gunshot wound

SEX: M AGE:

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: 0815

VITAL SIGNS			
TIME	0815	0830	
BP	144/79	142/72	
PULSE	96	90	
RESP.	24	20	
TEMP.	96.8	96.8	
WT. (Child)			

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)

Gunshot wound to Abdomen
IV ~~[illegible]~~ Dsg started 0820
2 Units Bolus
3 units Unison
Pulse ox 93

CATEGORY (See reverse)
- ☐ EMERGENT
- ☐ URGENT
- ☐ NON-URGENT b(2)-2

ORDERS	INITS.	TIME
3 units Unison	[redacted]	0830
2 units Bolus	[redacted]	0830
X-Ray Chest	[redacted]	0830
Arm Chest &	[redacted]	0830
Belly	[redacted]	0830
BC & Metl Y	[redacted]	0855

ASSESSMENT/DIAGNOSIS
SPO2 100% @ RLpm NB

DISPOSITION (Check all that apply)
- ☐ HOME ☐ FULL DUTY
- QUARTERS: ☐ 24 Hrs. ☐ 48 Hrs. ☐ 72 Hrs.
- MODIFIED DUTY UNTIL: DAY | MONTH | YEAR
- REFERRED TO (Indicate clinic)
- ☐ EMERGENCY ☐ TODAY
- ☐ 72 HOURS ☐ ROUTINE
- ADMIT. TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE
- ☐ IMPROVED ☐ UNCHANGED
- ☐ DETERIORATED

TIME OF RELEASE: ICW

(CONTINUE ON SF 507, IF NEEDED)

PATIENT'S IDENTIFICATION (Mechanical imprint)
FOR WRITTEN ENTRIES GIVE: Name - last, first, middle; SSN; DOB, service status, name and relation of sponsor or next of kin. (IMPORTANT: LIST FACILITY HOLDING TREATMENT RECORD).

ID b(4)-4
[redacted]

SIGNATURE OF PROVIDER AND ID STAMP

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

EMERGENCY CARE AND TREATMENT

MEDCOM - 14890 Copy

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

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

10. OR N[redacted]ONAL INTEROPERATIVE INTERVENTIONS NOTED.

[redacted]ert (AN 17 May 03 DATE

11. POSTOPERAT[redacted]

Pt tol procedure well. transferred to PCU2 - USS.

12. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title)	13. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title)
b(6)-2 [redacted] MAJ AN DATE: 17 May 03 TIME:	DATE: 17 May 03 TIME:

REVERSE OF DA FORM 5179, JUN 91

USAPA V1.01

MEDICAL RECORD	**PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT** For use of this form, see AR 40-66; the proponent agency is The Office of the Surgeon General.
1. AGE: 40? HEIGHT: WEIGHT:	2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): ? 3. PREVIOUS SURGERY [ ] NO [✓] YES (type): Exp Lap for GSW c̄ diverting colostomy

4. PROPOSED SURGICAL PROCEDURE:

Repair abd wall hernia, possible loop colostomy takedown

5. ADDITIONAL INFORMATION: pt does not speak English

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

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

#[redacted]

b(6)-4

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to: ✓ 1) Intraoperative Mobility ✓ 2) Positioning ___ 3) Existing Disease ✓ 4) Safety Devices ___ 5) Hypothermia	✓ Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse.	✓ Check for support stockings or ace wraps. If none, check with doctors. ✓ Check that safety straps are correctly applied. ✓ Offer pillow for under knees. ~~✓ 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 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 either side. ✓ Validate pt.'s understanding of verbal communication. ✓ Verify removal of dentures.
G OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

10. [redacted] INTERVENTIONS COMPLETE D/ADDITIONAL INTRAOPERATIVE INTERVENTION S NOTED.

b(6)-2 [redacted] /N

22 May 03 DATE

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

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

LEVEL OF ACTIVITY: ☐ Moves All Extremities ☐ Moves Upper Extremities ☐ Transferred to litter with roller due to spinal

12. PREOPERATIVE EVALUATION PREPARED BY

b(6)-2 (Sig [redacted] /N

DATE 22 May 03 TIME: 1010

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title)

DATE: TIME:

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

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

1. AGE: 40

HEIGHT: } unknown
WEIGHT: }

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

3. PREVIOUS SURGERY [ ] NO [X] YES (type):
Ex. Lap

4. PROPOSED SURGICAL PROCEDURE:
Ex. Lap

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition good
Tobacco___ppd X___yrs. Body Piercing Ø Diabetes (Y) (N) ROM_____ ASA/Motrin w/72 hrs (Y) (N)
ETOH Ø Implants Ø Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures Ø Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS:

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to: ✓ 1) Surgical Procedure & Operating Room Environment ___ 2) Separation Anxiety (Child) ✓ 3) Surgical Outcomes	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 ✓ 5) Pooling of Prep Solutions	Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened areas).	Utilize pressure preventing devices on OR table and accessories. Check for proper positioning and support to maintain good body alignment. Pad pressure points. Place ESU ground pad on non compromised skin surface area. Keep prep fluids from pooling.

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

[redacted]

b(6) 4

VERIFICATIONS AT HOLDING AREA:
! ID/Allergy Band ! Dentures Removed
! H & P ! Contacts Removed
! NPO Since 0700 ! Jewelry Removed
! UPC/LMP ! Body Pierce Removed
! Consent/Blood Transfusion Signed/Witnessed/Dated
! Surgical Site/Consent verified by Pt./Anesthesia/Surgeon
! Contact Precautions (Y) (N)
! Family/Friend: Ø

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to: ✓ 1) Intraoperative Mobility 2) Positioning 3) Existing Disease 4) Safety Devices ✓ 5) Hypothermia	o Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse [redacted] b(6)-2	o ~~Check for support stockings or ace wraps. If none, check with doc~~ N/A o Check that safety straps are [redacted] correctly applied. o Offer pillow for under knees. b(6)-2 o ~~Place and take down legs from stirrups with slow bilateral motion~~ N/A o Check that rings and all body piercing has been removed. [redacted]
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 [redacted] physical discomfort.	o Have sufficient people available for transfer. o Insure proper body alignment. o Allow patient to lie in position of [redacted] comfort while waiting for surgery. o Offer support (i.e., pillows, bath towels, etc.) for positioning. b(6)-2
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 Intubated F.3. NA Potential injury due to dentures: 1) Upper 4) Caps 2) Lower 5) Crowns 3) Bridges	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR table [redacted] o Pt. will be able to understand instructions [redacted] o Minimize danger of injury during intraop period.	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt. from _____ side. o Validate pt.'s understanding of verbal communication. o Verify removal of dentures. N/A
G OTHER PATIENT PROBLEMS/NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

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

b(6)-2 [redacted] MAJ/AN 27 MAY 03 DATE

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

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] MAJ/AN
DATE: 27 May 03 TIME: 0945

13. POSTOPERATIVE EVALUATION PREPARED BY (S [redacted] MAJ/AN b(6)-2
DATE: 27 MAY 03 TIME: 1145

REVERSE OF FORM 5179, JUN 91

USAPA V1.0

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: 40

HEIGHT:

WEIGHT: 75 kg

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

3. PREVIOUS SURGERY [ ] NO [X] YES (type):
Exp Lap, Colostomy, Multiple washouts of abd

4. PROPOSED SURGICAL PROCEDURE:
I&D washout of abd

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

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL _____Potential for anxiety related to: ✓ 1) Surgical Procedure & Operating Room Environment _____2) Separation Anxiety (Child) ✓ 3) Surgical Outcomes	o Pt. verbalizes any specific anxiet[redacted] o Pt. Exhibits relaxed body postur[redacted] b(4)-2	o Allow pt. to verbalize freely. o Explain OR environment and answer questions regarding surgery. o Offer comfort measures. (e.g., war[redacted] blanket, touch). o Explain all nursing procedures be[redacted] they are done. o Remain with pt. whenever possible. ~~o Maintain family interface. Parents to stay with pt.~~ N/A b(4)-2
B. AERATION ✓ Potential for respiratory dysfunction due to: _____1) Positioning ✓ 2) Effects of Anesthesia ✓ 3) Medical/Smoking History	o Pt. will be able to breathe without [redacted] difficulty during immediate intraoperative [redacted] phase. b(4)-2	[redacted] Offer to elevate head of litter or offer [redacted]low. Observe pt. while awaiting surgery for signs of distress. N/A o Assist anesthesia during intubation and extubation. N/A
C. INTEGUMENT ✓ Potential impairment of skin integrity due to: ✓ 1) Intraoperative Immobility _____2) ESU Pad Placement _____3) Positional Aids _____4) Prosthesis ✓ 5) Pooling of Prep Solutions	o Pt. will not exhibit signs of impa[redacted] skin integrity (e.g., reddened areas[redacted] b(4)-2	o Utilize pressure preventing devices on OR table and accessories. o Check for proper positioning and support to maintain good body alignm[redacted] o Pad pressure points. o Place ESU ground pad on non compromised skin surface area. o Keep prep fluids from pooling. b(4)-2

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

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

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to: ✓ 1) Intraoperative Mobility ✓ 2) Positioning ___ 3) Existing Disease ___ 4) Safety Devices ✓ 5) Hypothermia	o Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse.	o Check for support stockings or ace wraps. If none, check with doctors. o Check that safety straps are correctly applied. o Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. o Check that rings and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to: ✓ 1) Pain ___ 2) Intraoperative Hazards ___ 3) Prosthesis ✓ 4) Positioning ___ 5) Transfer pt. to/from OR table E.2. ✓ Potential discomfort due to: ✓ 1) Length of Surgery ✓ 2) Positioning ___ 3) Arthritis	o Pt. will be transferred to OR table without difficulty. o Pt. will not experience unnecessary physical discomfort.	o Have sufficient people available for transfer. o Insure proper body alignment. o Allow patient to lie in position of comfort while waiting for surgery. o Offer support (i.e., pillows, bath towels, etc.) for positioning.
F. SPECIAL SENSES F.1. ✓ Diminished visual perception due to being: ✓ 1) Pre-Medicated ___ 2) W/O Glasses F.2. ___ Potential for decreased communication due to: ___ 1) Diminished Hearing ___ 2) Language Barrier F.3. ___ Potential injury due to dentures: ___ 1) Upper ___ 4) Caps ___ 2) Lower ___ 5) Crowns ___ 3) Bridges	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR table. o Pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt. from _____ side. o Validate pt.'s understanding of verbal communication. o Verify removal of dentures.
G OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

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

b(6)-2 [redacted] MAJ AN 5JUN03 DATE

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

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title)
b(6)-2 [redacted] MAJ AN
DATE: 5 Jun 03 TIME: 0955

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title)
[redacted] MAJ AN b(6)-2
DATE: 5JUN03 TIME: 1050

REVERSE OF FORM 5179, JUN 91

USAPA V1.0

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: 40

HEIGHT:

WEIGHT:

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

3. PREVIOUS SURGERY [ ] NO [✓] YES (type):
Exp lap

4. PROPOSED SURGICAL PROCEDURE:

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition good
Tobacco___ppd X___yrs. Body Piercing_____ Diabetes (Y) (N) ROM_____ ASA/Motrin w/72 hrs (Y) (N)
ETOH 0 Implants_____ Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures_____ Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS:

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

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

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

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to: ✓ 1) Intraoperative Mobility ✓ 2) Positioning 3) Existing Disease ✓ 4) Safety Devices ✓ 5) Hypothermia	✓ Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse.	o Check for support stockings or ace wraps. If none, check with doctors. ✓ o Check that safety straps are correctly applied. o Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. o Check that rings and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to: ✓ 1) Pain ✓ 2) Intraoperative Hazards 3) Prosthesis ✓ 4) Positioning ✓ 5) Transfer pt. to/from OR table E.2. ✓ Potential discomfort due to: ✓ 1) Length of Surgery ✓ 2) Positioning 3) Arthritis	✓ 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 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 LHW side. ✓ Validate pt.'s understanding of verbal communication. ✓ Verify removal of dentures.
G OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

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

b(6)-2 [redacted] CPTIAN 23 June 03 DATE

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

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

LEVEL OF ACTIVITY: ☒ Moves All Extremities ☐ Moves Upper Extremities ☐ Transferred to liner with roller due to spinal

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

DATE: 23 June 03 TIME: 0720

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title) b(6)-2 [redacted] CPTIAN

DATE: 23 June 03 TIME:

REVERSE OF FORM 5179, JUN 91

USAPA V1.0

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: 30's

HEIGHT:

WEIGHT: 65 kg

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

3. PREVIOUS SURGERY [ ] NO [X] YES (type):
Ex lap, I+D Abd.

4. PROPOSED SURGICAL PROCEDURE:
STSG to Abd. Wall

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition open abd wound
Tobacco ___ ppd X ___ yrs. Body Piercing ___ Diabetes (Y) (N) ROM ___ ASA/Motrin w/72 hrs (Y) (N)
ETOH ___ Implants ___ Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures ___ Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS:

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

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

CW [redacted] b(6)-4

ICW-2

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

MEDICAL RECORD — **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: Litter BY b(6)-2 [redacted] MAJ [redacted] LTC
2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY MAJ [redacted] b(6)-2
3. DATE 12 May 03 b(6)-2 TIME PATIENT ARRIVED IN SUITE 1453
4. PATIENT IN ROOM TIME 1453 NUMBER 2-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Does not speak English

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS (Specify)

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

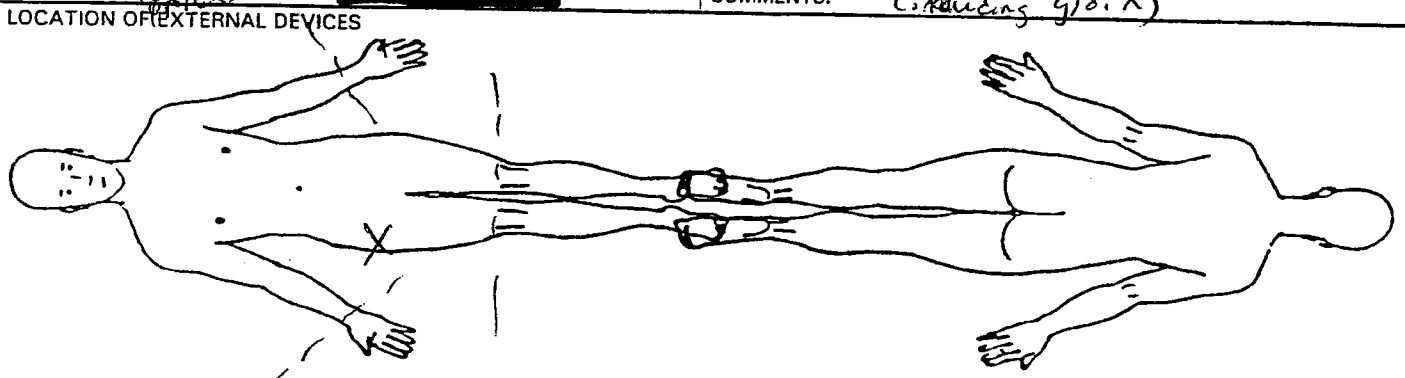
COMMENTS: Foam Headrest, padded

8. SKIN PREPARATION

HAIR REMOVAL ☒ YES ☐ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP
COMMENTS: Cuts & Nicks By b(6)-2 DR. [redacted] Abdomen

PREP SOLUTION (Specify)
SITE: ABD BY WHOM: CPT [redacted]
SITE: Nipple line to pubis, table to table (including groin) BY WHOM: b(6)-2
COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



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

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

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

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

[redacted] b(6)-4

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

☒ ESU NO: Valley Lab #4
GROUND PAD: BRAND 3M
LOT NO: 2005 10 07

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

COAG: 55 CUT: 1

DA FORM 5179-1, OCT 87 REPLACES DA [illegible] IS OBSOLETE. MEDCOM - 14901 USAPA V1.01

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

b(6)-2 A1)

14. MEDICATIONS/ORDERS

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

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

0.9% NACL

OTHER ORDERS	TIME	CARRIED OUT BY
N/A		

PHYSICIAN'S 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	16FR/5cc [redacted] Catheter	[redacted] Ostomy wafer & pouch	
SITE	Urethra	Abdomen	

18. DRESSING/IMMOBILIZATION *(Specify)*

Benzoin, ABD

19. ADDITIONAL INFORMATION

Surgeons:

[redacted] LTC, MD

[redacted] LTC, MD

Anesthesia

CPT [redacted] CRNA

20. OPERATION(S) PERFORMED

Exploratory Lap, Abdominal wall hernia repair. Colostomy take down, Hartman ~~pouch~~ procedure.

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU 2	1830	Gurney

22. [redacted] NURSE SIGNATURE [redacted] 1 May 03

REVERSE OF DA FORM 5179-1, OCT 8[illegible] USAPA V1.01

MEDICAL RECORD — INTRAOP[redacted] DOCUMENT

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

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

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

3. DATE: 22 May 03 TIME PATIENT ARRIVED IN SUITE: 1104

4. PATIENT IN ROOM TIME: 1104 NUMBER: 1-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Pt. speaks only Arabic. Translator present. NPO p 0200. NKDA.

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS (Specify) Pt. in supine position on padded OR table. BUE on padded arm-boards <90°. Pillow under knees, safety strap across mid thigh.

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

COMMENTS:

8. SKIN PREPARATION

HAIR REMOVAL [ ] YES [X] NO

DONE BY: [ ] OR [ ] NURSING UNIT

METHOD: [ ] DEPILATORY [ ] RAZOR [ ] CLIP

COMMENTS: N/A

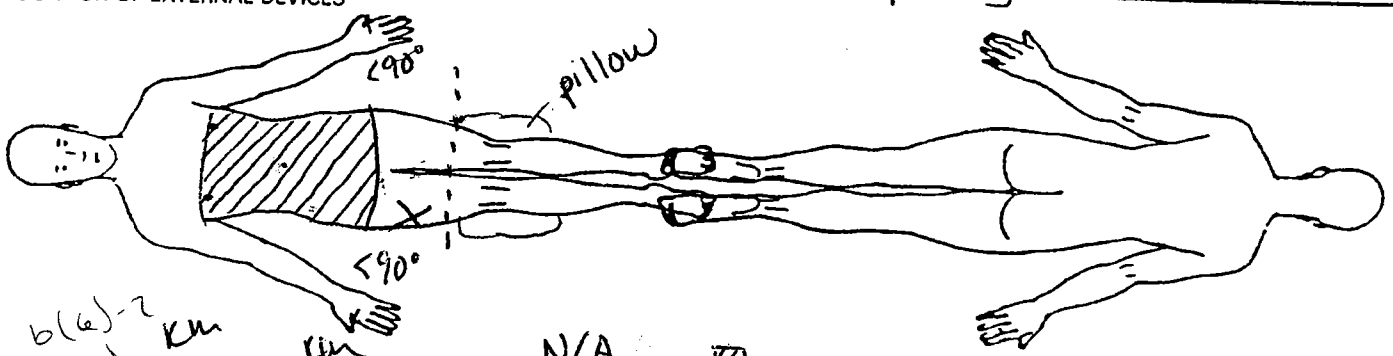
PREP SOLUTION (Specify) Betadine/Betadine

SITE: Nipple line to pubis BY WHOM: 1LT [redacted] b(6)-2

SITE: side to side BY WHOM:

COMMENTS: No pooling or reaction noted.

9. LOCATION OF EXTERNAL DEVICES



b(6)-2 KM KM N/A

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

Initial: SPC [redacted] 1LT

C = Correct I = Incorrect

10. COUNTS

		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	[X] Yes [ ] No					
Needle Sharp	[X] Yes [ ] No					
Instrument	[X] Yes [ ] No					
Other	[X] 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) [X] YES [ ] NO

[X] ESU NO: # 1 cut 30 coag 30

GROUND PAD: BRAND 3M

LOT NO: 2005-10 OT

[ ] ESU NO:

GROUND PAD: BRAND

LOT NO:

[ ] BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
N/A					

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

OTHER ORDERS	TIME	CARRIED OUT BY
N/A		

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, ABD, tape

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

DA5179 dated 17 May03 in chart.

20. OPERATION(S) PERFORMED
Ex Lap

21. PATIENT TRANSFERRED TO ICU2 TIME 1333 METHOD Litter c O_2

22. REGISTERED NURSE SIGNATURE [redacted] 17 AN

REVERSE OF DA FORM 5179-1, OCT 8[illegible] USAPA V1.01

MEDICAL RECORD

INTRAOPERATI. 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 [redacted]

3. DATE 23 May 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME 0930 b(4)-2 NUMBER 1-1 (1)

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Pt intubated.

6. NURSING PERSONNEL

ASSIGNED SCRUB	SSG [redacted] 91D b(4)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] 66E AN	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify) Pillow under knees. Bilateral arms L 90° on padded arm boards.

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

COMMENTS:

8. SKIN PREPARATION

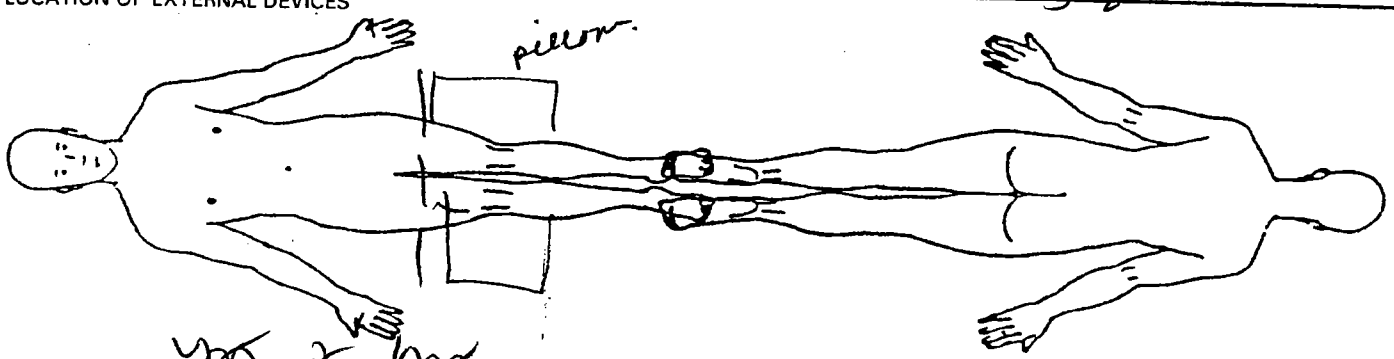
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION (Specify) Betadine
SITE: ABD (nipple to groin area) BY WHOM:
SITE: BY WHOM:

COMMENTS: no pooling of prepnoted.

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS initial count - SSG [redacted] b(4) CPT [redacted]

C = Correct I = Incorrect

			Other**	First Closing Count	Final Closing Count	SCRUB b(4)-2	CIRCULATOR b(4)-2
Sponge	☐ Yes	☐ No	C	C	C	SSG [redacted]	CPT [redacted]
Needle Sharp	☐ Yes	☐ No	C	C	C	SSG [redacted]	CPT [redacted]
Instrument	☐ Yes	☐ No	C	C	C	SSG [redacted]	CPT [redacted]
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(4)-4

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

☒ ESU NO: #1 CUT 50 COAG 50
GROUND PAD: BRAND 3M 9165
LOT NO: 2005-10 OT

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

0.9% NACL

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	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	JP Drain x2		
SITE	ABD		

18. DRESSING/IMMOBILIZATION *(Specify)*

- 8x4
- fluffs
- ABD
- silk tape.

19. ADDITIONAL INFORMATION

Surgeon:

[redacted] b(4)-2

anesthesia: b(4)-2

MAJ [redacted], CRNA

20. OPERATION(S) PERFORMED

- Silo bag replacement.
- Debridement abdominal wall.
- colostomy revision

21. PATIENT TRANSFERRED TO ICU 2 TIME 1110 METHOD gurney c̄ resp [redacted]

22. REGISTERED NURSE SIGNATURE b(4)-2 [redacted] CPT, AN

REVERSE OF DA FORM 5179 [redacted] USAPA V1.01

MEDICAL RECORD — INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: Litter BY CPT [redacted] CRNA b(4)-2

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY MAJ [redacted] b(4)-2

3. DATE: 27 May 03 TIME PATIENT ARRIVED SUITE: 1105

4. PATIENT IN ROOM TIME: 2-1 NUMBER: 1105

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Pt intubated.

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted] 9ID b(4)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	MAJ [redacted] ANGLE	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify) (B) arms abducted less than 90° on padded armboards.

☒ 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:

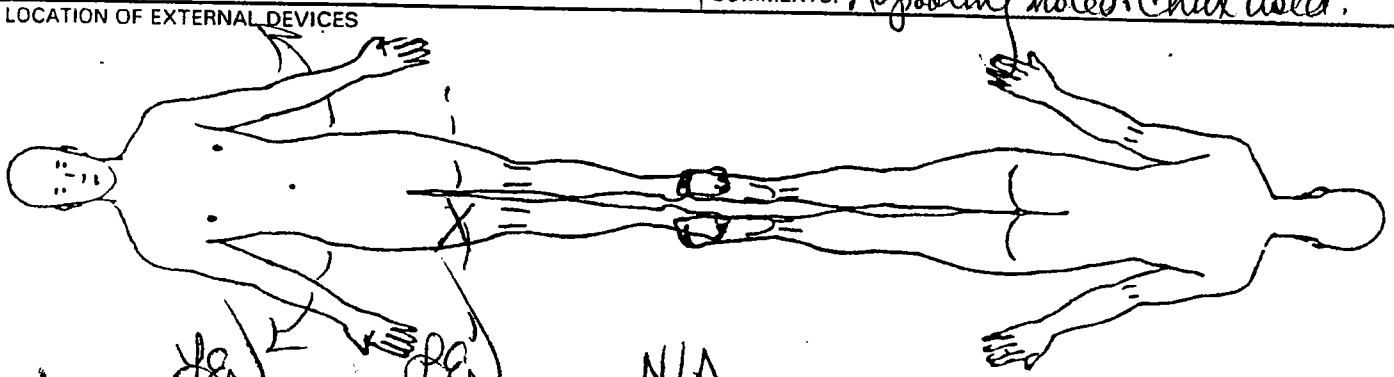
PREP SOLUTION (Specify) Beta/Beta b(6)

SITE: Abdomen BY WHOM: [redacted]

SITE: nipples to pubic symphysis BY WHOM:

COMMENTS: No pooling noted. Chux used.

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS — C = Correct I = Incorrect

Count by [redacted] & [redacted]

		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No		C	C	[redacted]	[redacted]
Needle Sharp	☒ Yes ☐ No		C	C		
Instrument	☒ Yes ☐ No		C	C		
Other	☒ Yes ☐ No		C	C	b(4)-2	

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

[redacted] b(4)-4

Civ # [redacted]

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

☒ ESU NO: #3 Settings 40/40

GROUND PAD: BRAND VL REM

LOT NO: 68936 EXP 2005-03

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*

Fluff
ABD Pad Silk Tape
Ostomy Bag

19. ADDITIONAL INFORMATION

Surgeon: ~~Dr~~ [redacted] b(4)-2 Anes. CPT [redacted] b(4)-2

Bovie Cut 40 Coag 40 [redacted] Bovie plate site clear, dry intact

20. OPERATION(S) PERFORMED

Wound Exploration & Debridement
Removal of Silo Bag, Packing/Dressing
Ostomy Bag

21. PATIENT TRANSFERRED TO ICU 2 TIME 1145 METHOD litter

22. REGISTERED NURSE SIGNATURE [redacted] MAJ

REVERSE OF DA FORM 5179-1, OCT 5 [redacted] USAPA V1.01

b(4)-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: Litter BY Amb Staff

2. PATIENT [redacted] WED AND PROCEDURE VERIFIED [redacted] CPT AN

3. DATE 3 June 03 TIME PATIENT ARRIVED IN SUITE (CW→OR

4. PATIENT [redacted] TIME 0823 b(6)-2 NUMBER 1-1/1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: VICDA - NPO p MN

6. NURSING PERSONNEL

ASSIGNED SCRUB	Spc. [redacted] (91D) > b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT. [redacted] (66T)	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: Ø

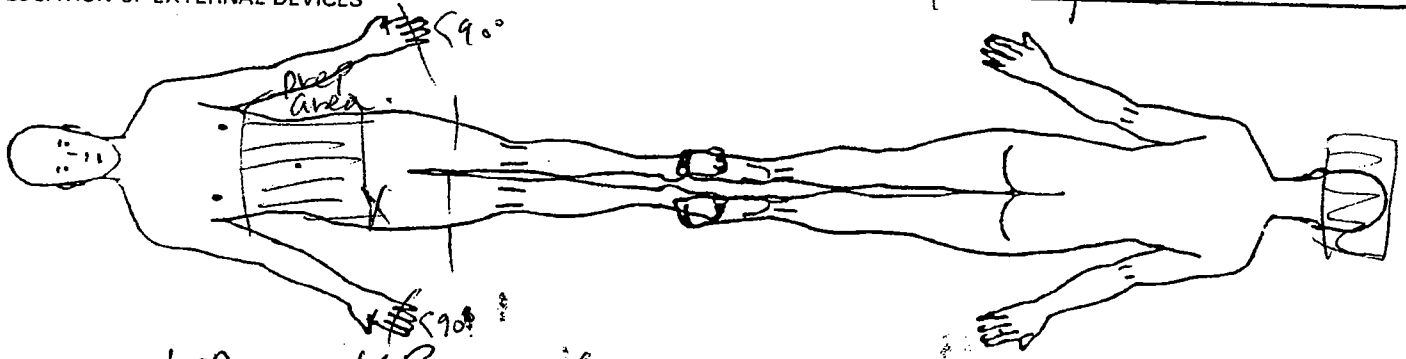
PREP SOLUTION *(Specify)* Betadine S/S

SITE: Abd BY WHOM: CPT [redacted] An

SITE: BY WHOM:

COMMENTS: Ø pooling of sol.

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		C	C	Spc [redacted]	CPT [redacted]
Needle Sharp	☑ Yes ☐ No					
Instrument	☐ Yes ☑ No					
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;)*

[redacted]

b(6)-4

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

☑ ESU NO: Valley Lab #1

GROUND PAD: BRAND Polyhesive

LOT NO: 54179

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

1 bag 230 ml 230

DA FORM 5179-1, OCT 87 REPLACES DA MEDCOM - 14909 H IS OBSOLETE. USAPA V1.01

ESIS, IMPLANTS ☐ YES ☑ NO IF YES NAME: ID NUMBER; MANUFACTURER

MEDICATIONS/ORDERS

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

IONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

ID IRRIGATION ☑ YES ☐ NO, TYPE(S):

0.9% Nacl

ER ORDERS	TIME	CARRIED OUT BY

HYSICIAN'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 Kerlix	1.	2.	3.
SITE Abd	1.	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

Kerlix
ABD's & Colostomy bag

19. ADDITIONAL INFORMATION

D.A form 5179 Reviewed & Nsg care implemented.

Surgeon: [redacted] b(6)-2

20. OPERATION(S) PERFORMED

I & D, Colostomy bag

21. PATIENT TRANSFERRED TO b(6)-2 CU TIME 0930 METHOD Cart to OR

22. REG[redacted] CPT AN

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

MEDCOM - 14910

MEDICAL RECORD — **INTRAOPERATIVE DOCUMENT**

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

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

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

3. DATE 5 Jun 03 TIME PATIENT ARRIVED IN SUITE 0955 b(6)-2

4. PATIENT IN ROOM TIME 0955 NUMBER 1-1

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	MAJ [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:

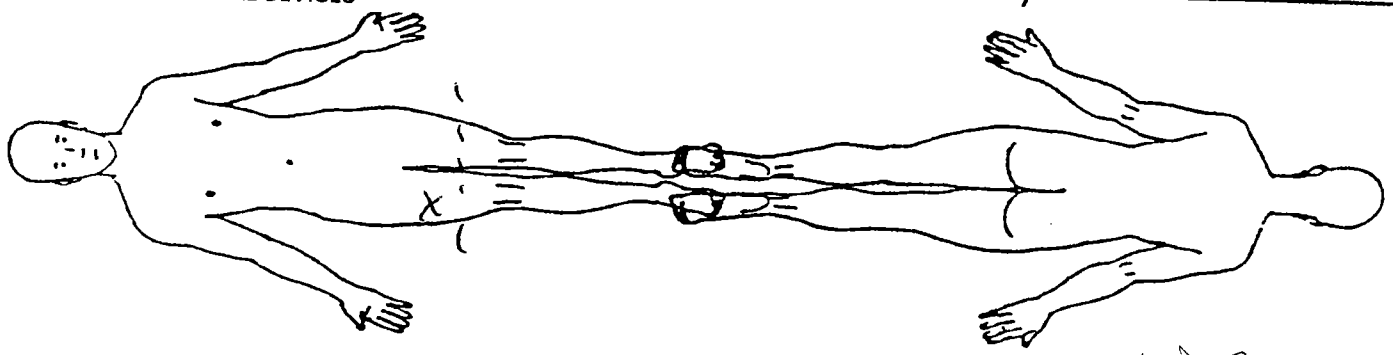
PREP SOLUTION *(Specify)* Povidone scrub & solution

SITE: abd BY WHOM: MAJ [redacted]

SITE: BY WHOM:

COMMENTS: No pooling of solution

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect Initial Count: SPC [redacted] / b(6)-2 N.P. [redacted]

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☑ Yes ☐ No		C	C		
Needle Sharp	☑ Yes ☐ No		C	C		
Instrument	☐ Yes ☐ No		C	C	SPC [redacted]	MAJ [redacted]
Other	☐ Yes ☑ No				SPC	MAJ

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

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

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

☑ ESU NO: Valleylab #1

GROUND PAD: BRAND Valleylab

LOT NO: 68936

☐ 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): N.S.

OTHER ORDERS

	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☑	NAME	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)*

Kerlix roll X2
Lgp abd.
Tape

19. ADDITIONAL INFORMATION

Surgeon Dr [redacted]
Anes: CPT [redacted] b(6)-2

20. OPERATION(S) PERFORMED

Evacuation of abdominal hematoma

21. PATIENT TRANSFERRED TO ICU #2 b(6)-2 TIME 1045 METHOD Litter

22. REGISTERED NURSE SIGNATURE [redacted] AJ AN

REVERSE OF DA FORM 5179-1, OC

USAPA V1.01

MEDICAL RECORD — **INTRAOP A 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]

3. DATE 23 June 05 TIME PATIENT ARRIVED IN SUITE 0755

4. PATIENT IN ROOM TIME 0755 NUMBER 1-1 1 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: b(6)-2 Ml

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted]	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 DONE BY: ☒ YES ☐ NO BY [redacted] / Dr [redacted]

METHOD: ☒ OR ☐ NURSING UNIT ☐ DEPILATORY ☒ RAZOR ☐ CLIP

COMMENTS: no nicks or cuts noted

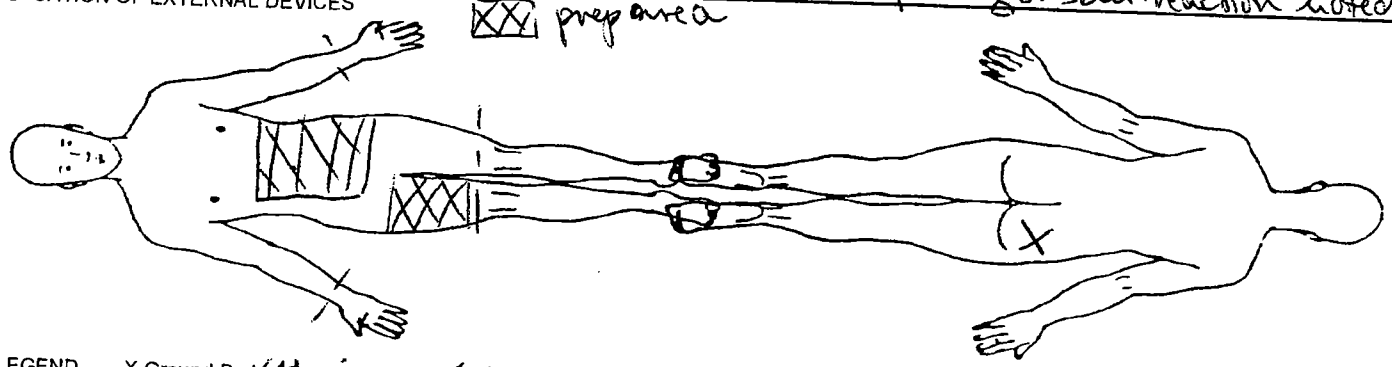
PREP SOLUTION *(Specify)* Betal Beta (Hinds)

SITE: Abdomen → Hibiclens BY WHOM [redacted]

SITE (R) thigh BY WHOM [redacted]

COMMENTS: no peeling or skin reaction noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad GP — Safety Strap SP === Tourniquet

C = Correct I = Incorrect Initial: [redacted]

10. COUNTS

		Other**	First Closing Count	Final Closing Count	SCRUB	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;)*

CW [redacted] b(6)-4

ICW-2

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

☐ ESU NO: Valleylab Force II #1

GROUND PAD: BRAND Valleylab Rem Polyhesive II

LOT NO: 69652 2005-04

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

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

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

b(6)-2 A/1

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
Nacl & Epi 1:1000 (1:100,000 solution)	as	I10	Topical	[redacted]	[redacted]
					b(6)-2

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

OTHER ORDERS

	TIME	CARRIED OUT BY
Replace Ostomy bag	I10	[redacted]

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

15. X-RAY IN [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 ☐

	1.	2.	3.
TYPE/SIZE	Colostomy	10mm JP	
SITE	RUQ	Abdomen	

18. DRESSING/IMMOBILIZATION *(Specify)*

Vaseline gauze (Xeroform)
Ioban
Benzoin Tincture
Mineral Oil soaked Fluffs

19. ADDITIONAL INFORMATION

WC

Surgeons: [redacted] Anesthesia: [redacted] Anesthesia Type: General

Bovie Pad site intact pre-op yes; post-op yes Bovie Settings: Coag/Cut – not used

Tourniquet Site intact pre-op____: post-op____

Tourniquet Time: Up____ Down____ > N/A

20. OPERATION(S) PERFORMED

Skingraft Abdomen for thigh donor site

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU-1	See DA7389	litter & safety straps on

22. REGISTERED NURSE SIGNATURE

[redacted] CPT 1A

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY: 1

MONTH-YEAR / DAY: 14 MAY / 15 MAY

19 / HOUR: 1300 1500 1700 1900 2100 2300 0100 0300 0500 0700 0900 1100

PULSE (O) / TEMP. F (•): 105°, 104°, 103°, 102°, 101°, 100°, 99°, 98.6°, 98°, 97°, 96°, 95°

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

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD: AR 16 18 20 16 16 16 20 18 20 18

BLOOD PRESSURE: 140/74 140/80 144/86 120/80 130/100 138/72 130/74 140/76 150/80 139/88 132/88 124/84 120/84

SpO2: 93 96 97 96 95 96 96 96

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.

EPW# [redacted] b(4)-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

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. ICW2

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

F-1

[redacted]

b(6)-4

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST-OP DAY

MONTH-YEAR MAY 19

DAY 19 20 21 21 MAY 22 May

HOUR

PULSE (O)

TEMP. F (•)

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

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

TEMP. C (Centigrade Equivalents, for Reference only)

40.6° 40.0° 39.4° 38.9° 38.3° 37.8° 37.2° 37.0° 36.7° 36.1° 35.6° 35.0°

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Use 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)

FBW # [redacted]

b(4)-4

REGISTER NO.

WARD NO. ICW2

STANDARD FORM 511 (REV. 7-95) BACK

511–119

MEDICAL RECORD

VITAL SIGNS RECC

HOSPITAL DAY

POST- DAY

MONTH-YEAR June 2003 | DAY | HOUR

PULSE (O) | TEMP. F (•)

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

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

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

SpO2

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD ~~NO.~~ 1 CW2

CIV #: [redacted]

b(6)-4

VITAL SIGNS RECORDS

Medical Record

IRM 511 (REV. 7–95)
SSA/ICMR, FIRMR (41 CFR) 201–9.202–1

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY

19 | HOUR

PULSE (O) | TEMP. F (•)

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

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

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

SpO_2

HEIGHT: | WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO. ICW2

#[redacted] b(6), 4 ICW2

STANDARD FORM 511 (REV. 7–95) BACK

1-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR June 03 | DAY 13 14 15 June 16 June 17 June

19 | HOUR

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

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

40.6° 40.0° 39.4° 38.9° 38.3° 37.8° 37.2° 37.0° 36.7° 36.1° 35.6° 35.0°

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

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: | WEIGHT →

SaO2 →

Record special data only when so ordered

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

REGISTER NO.

WARD NO. ICW2

CIV

[redacted]

b(6)-4

ICW2

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 June 03 | DAY | 19 | 20 | 21 | 22 | 23 | 24 | 25

19 | HOUR

PULSE (O) | TEMP. F (•)

TEMP. C (Centigrade Equivalents, for Reference only)

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

RESPIRATION RECORD

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. 1CW2

CIV # [redacted] b(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 June 2003

DAY: 26, 27, 28, 29

HOUR

PULSE (0) | TEMP. F (°) | TEMP. C

105° 40.6°
180 104° 40.0°
170 103° 39.4°
160 102° 38.9°
150 101° 38.3°
140 100° 37.8°
130 99° 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

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO. ICW2

CIV #[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

[redacted]

b(6)-4

8.0 ETT

22@lip

RT Vent Flow Sheet

DATE	TIME	MODE	RATE	VOLUME	FIO2	PEEP	PIP	I/E TIME	SPONT RATE	PLATEAU	HR	SO2	BP	ET	CUFF	INITAIL
22May	1343	SIMV	12	700	50	5	23	1:2	2	—	107	100	137/75	8	MLT	[redacted]
22May	1616	SIMV	12	700	50	5	23	1:2	2	—	115	100	118/65	8	MLT	[redacted]
22May	1905	SIMV	12	700	50	5	23	1:2.1	3	—	128	100	105/57	8	MLT	[redacted]
22May	2000	SIMV	12	700	50	5	22	1:2.1	1	—	130	100	93/61	8	MLT	[redacted]
22May	2145	SIMV	12	700	50	5	23	1:2.1	4	—	137	100	101/53	8	MLT	[redacted]
22May	2330	SIMV	12	700	50	5	14	1:2.1	4	—	125	100	97/52	8	MLT	[redacted]
23May	0200	SIMV	12	700	50	5	23	1:2.1	0	—	118	100	103/53	8	MLT	[redacted]
23May	0400	SIMV	12	700	50	5	23	1:2.3	0	—	113	100	109/61	8	MLT	[redacted]
23May	0622	SIMV	12	700	50	5	24	1:2.1	0	—	108	100	100/58	8	MLT	[redacted]
23May	0807	SIMV	12	700	50	5	23	1:2.1	0	—	106	100	103/54	8	MLT	[redacted]
23May	1005	PC	Taken To OR													[redacted]
23May	1205	SIMV	12	700	50	5	28	1:2.1	0	—	107	100	119/68	8	MLT	[redacted]
23May	1354	SIMV	12	700	50	5	25	1:2.1	—	—	100	100	107/58	8	MLT	[redacted]
23May	1554	SIMV	12	700	50	5	25	1:2.1	0	—	106	100	100/57	8	MLT	[redacted]
23May	1740	SIMV	12	700	50	5	24	1:2.1	0	—	109	100	117/61	8	MLT	[redacted]
23May	2000	SIMV	12	700	50	5	25	1:2.1	0	—	115	100	108/61	8	MLT	[redacted]
23May	2200	SIMV	12	700	50	5	25	1:2.1	0	—	120	100	122/58	8	MLT	[redacted]
24May	0000	SIMV	12	700	50	5	25	1:2.1	0	—	118	100	101/53	8	MLT	[redacted]
24May	0200	SIMV	12	700	50	5	25	1:2.1	0	—	110	100	107/54	8	MLT	[redacted]
24May	0400	SIMV	12	700	50	5	24	1:2.1	0	—	109	100	112/57	8	MLT	[redacted]
24May	0600	SIMV	12	700	40	5	27	1:2.1	0	—	115	100	121/59	8	MLT	[redacted]
24May	0800	SIMV	12	700	40	5	23	1:2.1	0	—	104	100	108/52	8	MLT	[redacted]
24May	1000	SIMV	12	700	40	5	23	1:2.1	0	—	114	100	150/59	8	MLT	[redacted]
24May	1200	SIMV	12	700	40	5	23	1:2.1	0	—	112	100	103/57	8	MLT	[redacted]
24May	1400	SIMV	12	700	40	5	25	1:2.1	0	—	104	100	119/53	8	MLT	[redacted]
24May	1600	SIMV	12	700	40	5	29	1:2.1	0	—	102	100	111/55	8	MLT	[redacted]
24May	1800	SIMV	12	700	40	5	30	1:2.1	0	—	105	100	109/54	8	MLT	[redacted]
24May	2000	SIMV	12	700	40	5	39	1:2.1	0	—	98	100	114/53	8	MLT	[redacted]
24May	2200	SIMV	12	700	40	5	36	1:2.1	0	—	119	95	106/69	8	MLT	[redacted]
25May	0000	SIMV	12	700	40	5	32	1:2.1	0	—	117	99	109/68	8	MLT	[redacted]
25May	0200	SIMV	12	700	40	5	27	1:2.1	0	—	103	100	131/54	8	MLT	[redacted]
25May	0400	SIMV	12	700	40	5	26	1:2.1	0	—	101	100	131/56	8	MLT	[redacted]
25May	0613	SIMV	12	700	40	5	27	1:2.1	0	—	102	100	114/53	8	MLT	[redacted]
25May	0805	SIMV	12	700	40	5	26	1:2.1	0	—	108	100	133/57	8	MLT	[redacted]

b(6)-2

MEDCOM - 14923

Pt # [redacted] b(6)-4

8.0 ETT
22cm @ lip

DATE	TIME	MODE	RATE	TIDAL VOL	FIO2	PEEP	PIP	I:E TIME	SPONT RATE	CATHETER	HR	BP				
			PH	PCO2	PO2	HCO3	BE	SO2								
25May	0955	SIMV	12	700	40	5	26	1:2.1	Ø	—	97	99	127/61	8	MLT	[redacted]
25May	1210	SIMV	12	700	40	5	35	1:2.1	Ø	—	97	100	128/61	8	MLT	
25May	1400	SIMV	12	700	40	5	29	1:2.1	Ø	—	112	99	121/60	8	MLT	
25May	1420				↑50											
Tx 25May	1550	SIMV	12	700	50	↑8	28	1:2.1	20	—	116	95	129/60	8	MLT	
~~25May~~	~~1637~~	~~SIMV~~	~~12~~	~~700~~	~~50~~	~~8~~										
25May	1637	ABG	7.426	38.8	67	25	1	94								
25May	1900	SIMV	12	700	50	8	25	1:2.1	8	—	112	97	119/52	8	MLT	
25May	2000	SIMV	12	700	50	8	33	1:2.1	16	—	110	98	143/69	8	MLT	
25May	2200	SIMV	12	700	50	8	35	1:2.1	11	—	119	98	132/61	8	MLT	
26May	0000	SIMV	12	700	50	8	22	1:2.1	Ø	—	110	100	105/48	8	MLT	
26May	0200	SIMV	12	700	50	8	26	1:2.1	19	—	118	98	105/53	8	MLT	
26May	0400	SIMV	12	700	50	8	31	1:2.1	12	—	117	97	107/51	8	MLT	
26May	0630	SIMV	12	700	50	8	25	1:2.1	15	—	111	98	106/58	8	MLT	
26May	0808	SIMV	12	700	50	8	28	1:2.1	1	—	114	100	129/51	8	MLT	
26May	0956	SIMV	12	700	50	8	19	1:2.1	6	—	123	98	115/47	8	MLT	
26May	1150	SIMV	12	700	50	8	26	1:2.1	Ø	—	119	100	93/40	8	MLT	
26May	1410	SIMV	12	700	50	8	27	1:2.1			125	91	144/65	8	MLT	
26May	1411	ABG	7.437	30.5	46	21	-4	84								
26May	1458	ABG	7.400	26.2	64	16	-9	93								
26May	1538	SIMV	12	700	50	8	25	1:2.1	Ø	—	117	100	80/39	8		
26May	1800	SIMV	12	700	50	10	30	1:2.1	8	—	120	96	104/54	8	MLT	
26May	2000	SIMV	12	700	<50	10	20	1:2.1	8		95	99	96/54	8	MLT	
26May	2200	SIMV	12	700	50	10	19	1:2.1	9		96	100	94/56	8	MLT	
27May	0200	SIMV	12	700	50	10	25	1:2.1	0	—	88	100	103/56	8	MLT	
27May	0200	SIMV	12	700	50	10	24	1:2.1	0	—	89	100	105/57	8	MLT	
27May	0400	SIMV	12	700	50	10	21	1:2.1	Ø	—	85	100	104/55	8	MLT	
27May	0611	SIMV	12	700	50	10	31	1:2.1	Ø	—	99	100	120/63	8	MLT	
27May	0750	SIMV	12	700	50	10	31	1:2.1	Ø	—	93	100	113/60	8	MLT	
27May	1000	SIMV	12	700	50	10	30	1:2.1	Ø	—	105	99	118/55	8	MLT	
27May	1230	SIMV	12	700	50	10	26	1:2.1	Ø	—	78	99	92	8		
27May	1400	SIMV	12	700	50	10	26	1:2.3	Ø	—	91	100	133/67	8	MLT	
27May	1600	SIMV	12	700	50	10	29	1:2.3	Ø	—	101	100	129/61	8	MLT	
27May	1800	SIMV	12	700	50	10	22	1:2.1	4	—	117	100	117/57	8	MLT	

b(6)-4

MEDCOM - 14924

[redacted] b(6)-4

8 ETT
24 lip

VENT FLOW SHEET

DATE	TIME	MODE	RATE	VOLUME	FIO2	PEEP	PIP	I/E TIME	Spont RATE	PLATEAU	HR	SO2	BP	ET	CUFF	INITIAL
27May	2000	SIMV	12	700	50	↓~~25~~5	23	1:2.1	Ø	—	115	100	124/49	8	MLT	[redacted]
27May	2200	SIMV	12	700	↓48	5	20	1:2.1	Ø	—	115	100	122/50	8	MLT	[redacted]
28May	0000	SIMV	12	700	45	5	21	1:2.1	1	—	114	100	131/58	8	MLT	[redacted]
28May	0200	SIMV	12	700	↓40	5	28	1:2.1	3	—	123	100	133/59	8	MLT	[redacted]
28May	0400	SIMV	12	700	40	5	30	1:2.1	3	—	125	100	132/59	8	MLT	[redacted]
28May	0547	SIMV	12	700	40	5	29	1:2.1	3	—	114	100	95/59	8	MLT	[redacted]
28May	0750	SIMV	12	700	40	5	22	1:2.1	Ø	—	110	100	114/63	8	MLT	[redacted]
28May	1017	SIMV	12	700	40	5	23	1:2.1	Ø	—	90	100	91/73	8	MLT	[redacted]
28May	1230	SIMV	12	700	40	5	22	1:2.1	Ø	—	85	100	114/69	8	MLT	[redacted]
28May	1430	SIMV	8↓	700	40	5	22	1:2.1	Ø	—	81	100	124/71	8	MLT	[redacted]
28May	1600	SIMV	12	700	40	5	22	1:2.1	Ø	—	99	100	125/74	8	MLT	[redacted]

b(6)-2

MEDCOM - 14925

TWENTY-

RKSHEET

FROM 0[illegible] HOURS TO 0500 HOURS | TOTAL HOURS COVERED 24 | DATE 2 June-3 June

TIME	TYPE	AMOUNT	TOTAL
0730	chocolate milk	50cc	50
0730	water	50cc	100
1045	Ensure	180cc	280
1215	water	50cc	330
1700	H_2O	50cc	
2000	H_2O	20	
1			

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
0500	300cc	LR c̄ 20kcl	300	1045	300
0630	50cc	Ampicillin in NC	50cc	0700	350
0700	50cc	Zosyn in NS	50cc	0730	400
1100	100cc	Gent in NS	100cc	1200	500
1100	1000cc	LR c̄ 20KCl			
1300	100	zosyn, amp	100		
1800	50/50	amp/zosyn	100		

~~IRRIGATIONS (N/G, Bladder, etc.)~~ Urine cat

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0630	Clear yellow urine	500cc	500cc
0800	clear yellow urine	525cc	1025cc
1045	CYU	500cc	1525cc
1500	urine	600	2125
1800	urine	400	2525
0300	urine	700	3225
~~0230~~			
0230	CYU	540	540cc
~~0600~~	~~urine~~	~~300cc~~	

~~BLOOD/BLOOD DERIVATIVES~~ Stool

TIME STARTED	PRODUCT (i.e. Bl, Alb, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL
1630	Stool-1 dose	50		50

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

CIV# [redacted] b(6)-4

INTAKE EQUIVALENTS (Serving levels cc)

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

DD FORM 1 JAN 74 792 EDITI 1 JUL REPLACES DA FORM 3630(TEMP)

MEDCOM - 14926

*U.S.GPO:1996-404-613/7

TWENTY-FOUR

DATE 6/1/83

INT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
1200	H_2O	100	100
1800	H_2O	60	160

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
1100	1000	LR@50 mlhr			
1200	100	Gentamycin	100	1230	
1330	50	20% ⅟m	50	1400	
1830	50	amp	50	1900	
1900	50	20% ⅟m	50	1930	

Voids

~~IRRIGATION~~ ~~DRG. BLADDER~~ ~~TEST~~

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
1200	200	200	200
1600	500	700	900
1930	300	~~1~~	1200

Stool ~~BLOOD/BLOOD DERIVATIVES~~ out

TIME STARTED	PRODUCT (i.e. B1, Alb, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL
1400	Stool loose	/	100	100
2000	Stool-loose	/	50	150

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

#[redacted] b(4)-4

INTAKE EQUIVALENTS (Serving levels cc)

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

DD FORM 1 JAN 74 792

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

MEDCOM - 14927

*U.S.GPO:1998-404-613

TWENTY-FOUR HOUR PATIENT IN...E AND OUTPUT WORKSHEET

FROM — HOURS TO 0500 HOURS | TOTAL HOURS COVERED 24 | DATE 3 JAN

INT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
0500	NPO for ~~SUR~~ DR		
1200	water	80cc	80cc

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
0600	1000cc	LR & 20 KCl	300	0800	300
0600	50/50	Ampicillin/ 20SYN	100	0700	400
0800	1000cc	~~X~~ LR	600	1100	1000
1130	1000cc	LR & 20 meq KCL	50cc/hr		
1200	50/50	Ampicillin / 20SYN	100		1100
1000	100cc	Gent	100		1200
1800	~~100~~ extra 500cc	Ampicillin	50cc		1250

~~IRRIGATIONS (N/G, Bladder, etc.)~~ OUTPUT

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0600	urine	300cc	300cc
1100	urine	500cc	800cc
1200	urine	300cc	1100cc
2146	urine cl yellow	225	1325 cc
0400	CYU	500cc	1825cc

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl, Alb, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

Civ # [redacted] b(6)-4

INTAKE EQUIVALENTS (Serving levels cc)

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

DD FORM 1 JAN 74 792

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

*U.S.GPO:1998-404-613/30343

OUTPUT

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM [illegible] HOURS TO 23:59 HOURS | TOTAL HOURS COVERED 24 | DATE 4 JUN

IN

URINE ~~ORAL~~

TIME	TYPE	AMOUNT	ACCUM TOTAL
~~0800~~	Urine Cl yellow	375	375
0800	Cl yellow	275	650

EMESIS ~~INTRAVENOUS~~

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL

STOOL ~~(R/O, Bladder, etc.)~~

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0800	Soft Brown	100cc	100cc

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. B1, A1b, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

[redacted] b(6)-4

INTAKE EQUIVALENTS (Serving levels cc)

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

DD FORM 1 JAN 74 792

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

*U.S.GPO:19

INTAKE

WENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM ___ HOUR TO ___ HOURS | TOTAL HOURS COVERED | DATE

INT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
0410	H2O	300cc	300cc
0700	MILK	240cc	440cc
1200	H2O	50cc	490cc
1700	H2O	50cc	540

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
00:00	50cc	Ampicillin	50cc		50
00:00	50cc	Zosyn	50cc		100
~~00:15~~	~~950cc~~	~~LRC 20 KCL~~	~~900~~		~~300cc~~
0600	100cc	Amp / Zosyn	100cc		200cc
1800	50cc	Ampicillin	50cc		300
1800	50cc	Zosyn	50cc		350cc

~~IRRIGATIONS (N/G, Bladder, etc.)~~ OUTPUT

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0630	Urine	400cc	400cc
1100	Urine	300cc	700cc
1830	Urine	375	1075cc
2130	CVU	220	1295cc

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. B1, Alb, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

[redacted] b(6)-4

INTAKE EQUIVALENTS (Serving levels cc)

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

DD FORM 1 JAN 74 792

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

*U.S.GPO:1996-404-613/30343

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM 2400 HOURS TO 2359 HOURS | TOTAL HOURS COVERED 24 | DATE 6/5/03

INT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
0700	120cc milk	120cc	120
0730	H20	60cc	180
1150	Choc milk	120	300.

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
		Ampicillin	500cc		50
		~~[illegible]~~ yn	50		100.
		LRC20K	400		500.
		Zosyn	50		550
		Ampicillin	50		600

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. B1, A1b, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

[redacted] b(6)-4

INTAKE EQUIVALENTS (Serving levels cc)

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

DD FORM 1 JAN 74 792

EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3830(TEMP) 1 JUL 72 WHICH MAY BE USED

*U.S.GPO:1996-404-613/30343

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM _____ HOURS TO _____ HOURS | TOTAL HOURS COVERED | DATE

INT

~~ORAL~~ Urine

TIME	TYPE	AMOUNT	ACCUM TOTAL
01	Urine	150	150
0430	Urine.	250	350

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL

~~IRRIGATIONS (N/G, Bladder, etc.)~~ Colostomy

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0450	loose brown stool	100	100.

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl, Alb, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

~~OTHER INTAKE~~

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

INTAKE EQUIVALENTS (Serving levels cc)

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

DD FORM 1 JAN 74 792

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

*U.S.GPO:1996-404-613/30343

Y-FOUR HOUR PATIENT . ...E AND OUTPUT WORKSHEET

FRC ...OURS
TO ...HOURS

TOTAL HOURS COVERED 24

DATE 6/6/05

INT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
0715	Eggs	3 bites	
0715	Breakfast sausage	1 whole	
0715	H_2O	100cc	100cc
0715	Choc. Milk	120cc	220cc

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
06		Zosyn	50		50
06		Ampicillin	50		100
		CR 20 kcl	400		500
12		Zosyn/amp	100		600
18		Zosyn/amp	100		750
13		LR c 20meq KCL	400	2100	1150

IRRIGATIONS (N/G, Bladder, etc.) Urine.

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
01	urine	200	200
04	"	500	700
06	"	400	1300
0745	"	400	1700
1800	"	425	2125
~~1800~~	~~urine~~	~~400~~	~~2525~~
~~350~~			
200	CYU	350	2475

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl, Alb, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER ~~INTAKE~~ Colostomy

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
04	Ø	Ø cc	Ø cc
18	Ø	Ø	Ø

GRAND TOTAL INTAKE

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

[redacted] b(6)-4

INTAKE EQUIVALENTS (Serving levels cc)

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

DD FORM 1 JAN 74 792

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

*U.S.GPO:1996-404-613/30343

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET	FROM ____ HOURS TO ____ HOURS	TOTAL HOURS COVERED	DATE

INT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
0700	H2O	120cc	120
0700	MILK	200cc	320

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL

OUTPUT ~~IRRIGATIONS (N/G, Bladder, etc.)~~

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0630	CYHOP	400cc	400
1000	CYHOP	325cc	725
1950	urin	400cc	1125

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. B1, A1b, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

#[redacted] b(6)-4

INTAKE EQUIVALENTS (Serving levels cc)

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

DD FORM 1 JAN 74 792

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

*U.S.GPO:1996-404-613/30343

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM ____ HOURS TO 24 HOURS | TOTAL HOURS COVERED | DATE 7 Jun

INT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
0730	MILK	240cc	240
0730	H20	240cc	240 cc
1000	H20	40cc	320cc
1000	H20	100cc	420cc
0730	H_2O	240cc	660cc

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
0000	50	Zosyn	50	0045	50
0050	50	Ampicillin	50	0130	100
0000	400	LR & 20meq KCL	400		400
0100	100cc	An IV MEDS	100	0400	650
0000	100cc	IV MEDS	100	1000	750
0630	500cc	LR TRACC	400	1600	1150
1800	50	Zosyn	50	1850	1650
1900	50	Ampicillin	50	1950	1700
0600	50	Zosyn	50	063	1750

output

~~IRRIGATIONS (N/G, Bladder, etc.)~~

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
3300	CYU	600cc	600
0400	Colostomy drained	200cc	800
0530	CYUOP	400cc	1200
0900	UOP	300cc	1500
1200	UOP	200cc	1700
1450	UOP	400cc	2100
1830	CYU	450cc	2550
0045	CYU	350cc	2900
0240	CYU	420cc	3320
~~200~~	~~CYU~~	~~200~~	
500	CYU	200	3520

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. B1, A1b, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

EPW [redacted] b(4)-4

INTAKE EQUIVALENTS (Serving levels cc)

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

DD FORM 1 JAN 74 792

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

*U.S.GPO:1996-404

TWENTY-FOUR HOUR PATIENT IN[illegible] AND OUTPUT WORKSHEET

FROM _____ [illegible] TO _____ HOURS

TOTAL HOURS COVERED

DATE

INT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
0600	50	IV meds	50	0630	50
1000	50	Ampicillin	50	1030	100

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. B1, A1b, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

INTAKE EQUIVALENTS (Serving levels cc)

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

DD FORM 1 JAN 74 792

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

*U.S.GPO:1996-404-613/30343

June 3

Breakfast

NPO

Lunch

mash potatoes / gravy (4 bites)
peas (2 bites)
turkey (4 bites)
pears (5 bites)
cake (3 bites)

Dinner

June 4

Breakfast

2 waffles
1 orange
mix fruit 3 bites

Lunch

½ piece cake w/ peaches
2 bites beef/noodles.

Dinner

2 bites of chicken
2 bites of cake

5 JUNE

BREAKFAST

Jello - 2 bites
waffle
box milk

Dinner

Shrimp - 1 bit
peas - 1 bit
cake - 3 bits

Calorie Count (Record Foods/Bev, and Quantities)

Day 1

Breakfast

Lunch

Dinner

5 Vegetables (2-3 bites)
10 Cake (1 Bite)
~~125~~

Day 2

Breakfast

3	Waffle	90 + 60
1	2 bites of cake	40
	5 bites of apple	15
2	50cc chocolate milk	35
	50cc water	
8	snack: 180cc Ensure	180

Lunch

	4 bites of cranberry sauce	30
1	3 bites of cake	40
1	6 bites of mashed potatoes	40
3	2 bites of chicken	60
	3 bites of peas	10
	2 bites of fruit	10
19	50cc Water	

Dinner

1 jello cup
1/2 scoop potatoes & salt
2 bites apple
2 bites chicken

540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*	
	INTAKE	OUTPUT
06-13		
	Ice chips - 100cc	Foley 600cc
	~~H~~ IV meds - 150cc	N/G 500cc
	LR - 1L	~~Pt voided 350cc @ 1500~~
	IV meds - 200cc	
	Ice chips - 50cc	
13-21	50cc - IV meds 1400	void 350cc amber 150
	ICE CHIPS 100cc @ 1410	VOID 325cc amber 1830
	ICE CHIPS 100cc @ 1515	VOID 500 cc amber 2330
	100cc - IV med 1800	void 440 cc amber 0100
	~~TOTAL 460cc @ DINNER~~	06-04
	~~IV bag replaced @ 0400~~	5/19 2715
	~~1000cc LR hung @ 0400~~	
5/19	06-04 3310	
✱ NOTE:	1 LQ CUP = 240 cc ✱	
	1 CUP JELLO = 100 cc ✱	

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.)*

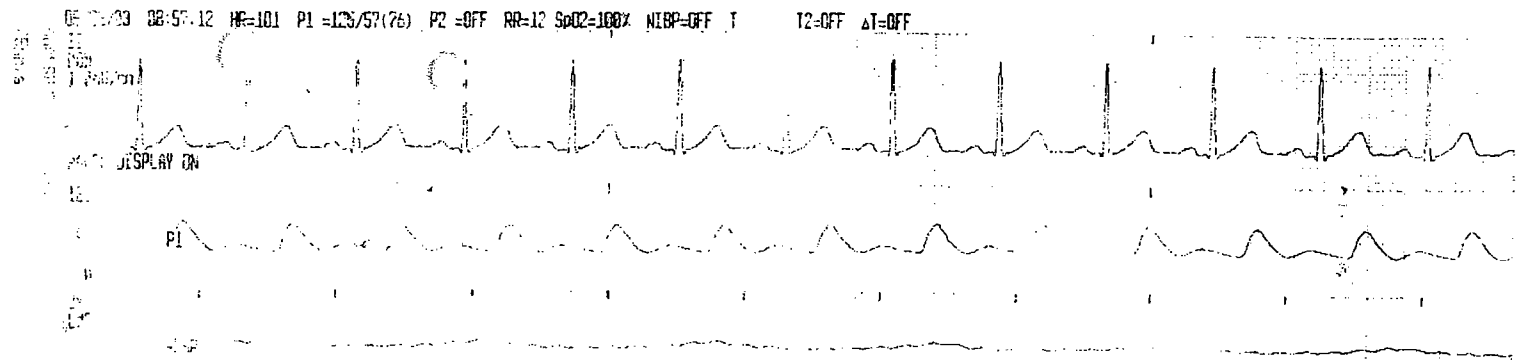
REGISTER NO. | WARD NO. 4CW2

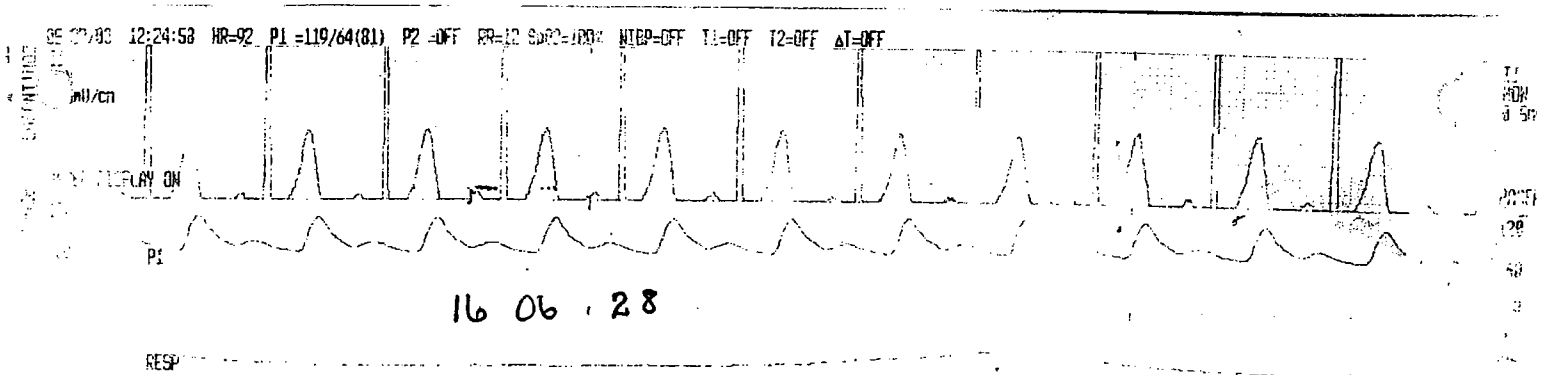
[redacted]

b(6)-4

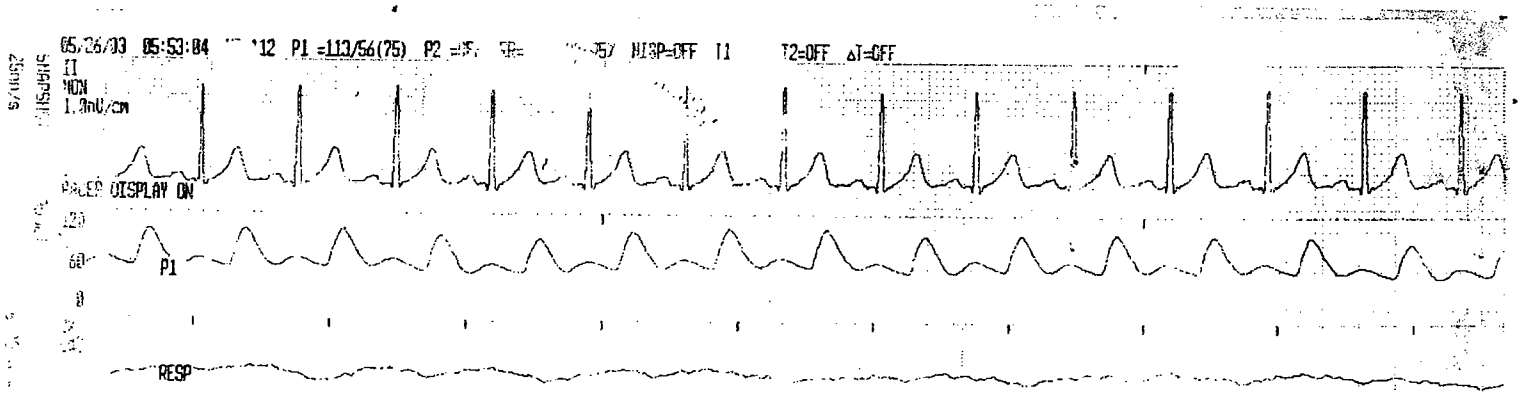
CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)	
	5/19 06-04 INput 3310cc	OUTPUT 2715cc
	5/20 06am-13 INput 1790cc	OUTPUT 1750cc
	13- 21	360cc
	21 - 05 1000cc, IV bag Δ'd @0100	1350cc
5/21	06-13 → 200+300+400cc+300	Intake 350cc + 300IV
	13-21	Output 300cc
	21-05	13-2100 Output 200cc
	Ice Chips 100cc IV Fluids cc 400	1900 400cc
	ice chips 100 cc	900-O-
	unasyn 100 ml	
	Zantac 50 ml	
	750 I-	
	Zantac 50	2200 300cc
	Unasyn 100.	300
	LR 875	300
	1025	420
		1320





16 06 . 28



TIME H:MIN:S	HR/PR BPM	SpO2 %
LAST BREATH:		
12:10:00	94	100
RESUMED BREATHING:		
12:10:55	93	99
ELAPSED TIME:		
00:00:55		

ADULT

RATE-10
FIO2-50

i-STAT G3+

Pt: 0175

Pt Name:_____

TCO2_____26 mmol/L

At 37C

PH_____7.347

PCO2_____44.9 mmHg

PO2_____28 mmHg

HCO3_____25 mmol/L

BEecf_____-1 mmol/L

sO2*_____98 %

*calculated

At Patient Temp

PH_____7.360

PCO2_____43.2 mmHg

PO2_____114 mmHg

Patient Temp: 97.0F

FIO2_____: 50

Sample Type_: ART

27MAY03 04:09

Oper: 3521

Physician:_____

Pt: [redacted]

Pt Name:_____

TCO2_____30 mmol/L

At 37C

PH_____7.462

PCO2_____40.6 mmHg

PO2_____77 mmHg

HCO3_____29 mmol/L

BEecf_____5 mmol/L

sO2*_____96 %

*calculated

Sample Type_:

29JUN03 17:26

Oper: 3907

Physician:_____

Ser# 42015

Ver: JAMS045A
CLEW A91

Pt: [redacted]

Pt Name:_____

TCO2_____26 mmol/L

At 37C

PH_____7.453

PCO2_____35.7 mmHg

PO2_____122 mmHg

HCO3_____25 mmol/L

At Patient Temp

PH_____7.449

PCO2_____[illegible] mmHg

PO2_____124 mmHg

Patient Temp: 99.1F

FIO2_____: 50

Sample Type_: ART

[illegible]MAY03 [illegible]7:21

Oper: 6753

Physician:_____

Ser# 42011

Ver: JAMS045A
CLEW A91

Pt: [illegible]

Pt Name:_____

TCO2_____27 mmol/L

At 37C

PH_____7.426

BEecf_____1 mmol/L

sO2*_____94 %

*calculated

At Patient Temp

PH_____7.388

PCO2_____40.4 mmHg

PO2_____80 mmHg

Patient Temp: 103.2F

FIO2_____: 50

Sample Type_: ART

[illegible]MAY03 [illegible]5:37

Oper: 7112

---

i-STAT G3+

Pt: 0175

Pt Name:_____

TCO2_____28 mmol/L

At 37C

PH_____7.447

PCO2_____39.[illegible] mmHg

PO2_____66 mmHg

HCO3_____27 mmol/L

BEecf_____ mmol/L

sO2*_____ %

*calculated

At Patient Temp

PH_____7.409

PCO2_____43.6 mmHg

PO2_____70 mmHg

Patient Temp: 103.1F

FIO2_____: 50

Sample Type_: ART

[illegible] 5:25

Oper: [illegible]

Physician:_____

SWV 50% Fx
Resp 5

MEDCOM - 14942

FIO2 50%
RR 12
PEEP 8

---

i-STAT G3+

Pt:

Pt Name: _____

_____22 mmol/L

At 37.0

pH_____7.400

PCO2_____ mmHg

PO2_____ mmHg

HCO3_____ mmol/L

Calculated

At Patient Temp

pH_____7.365

PCO2_____ mmHg

PO2_____ mmHg

Patient Temp: 100.0F

_____: 50

Sample Type_: ART

26MAY03 14:58

Operator: 7112

Physician _____

FIO2 50%
RR 12
PEEP 8

---

i-STAT G3+

Pt: 175

Pt Name: _____

TCO2_____17 mmol/L

At 37.0

pH_____7.400

PCO2_____26.2 mmHg

PO2_____64 mmHg

HCO3_____ mmol/L

Calculated

At Patient Temp

pH_____7.365

PCO2_____29.1 mmHg

PO2_____76 mmHg

Patient Temp: 100.0F

_____: 50

Sample Type_: ART

26MAY03 14:58

Operator: 7112

Physician _____

ID: 000175 21-05-03 04:27

			Patient Limits	
WBC	23.5 H	x10^3/uL	4.5	10.5
RBC	2.94 L	x10^6/uL	4.00	6.00
Hgb	8.8 L	g/dL	11.0	18.0
Hct	28.1 L	%	35.0	60.0
MCV	95.6	fL	80.0	99.9
MCH	29.8	pg	27.0	31.0
MCHC	31.2 L	g/dL	33.0	37.0
Plt	893. H	x10^3/uL	150.	450.
Lym%	8.4 *L	%	20.5	51.1
Lym#	2.0 *	x10^3/uL	1.2	3.4

MEDCOM - 14943

EPW [redacted] b(6)-4

TCW2

TEST(S)

SPECIMEN TAKEN

DATE 20 MAY 03 | TIME 0830 A.M. P.M.

RESULTS	REQUESTED	(X)
2.83	RBC COUNT	
8.4	HEMOGLOBIN	
27.0	HEMATOCRIT	
95.4	MCV	
29.7	MCH	
31.1	MCHC	
21.3	WBC COUNT	
2	WBC DIFF AND BLOOD CELL MORPH: IMMATURE NEUTRO-BANDS	
82	NEUTROSEGS	
11	LYMPHS	
2	EOSINOPHILS	
	BASOPHILS	
3	MONOCYTES	
MGL ↑	PLATELETS	
	RBC	
	SED. RATE	
794	PLATELET COUNT	
	RETICULOCYTE COUNT	
	CLOTTING TIME	
	BLEEDING TIME	
	PTT CONTROL	
	PTT PATIENT	
	PROTHROMBIN CONTROL	
	PROTHROMBIN PATIENT	
	PROTHROMBIN % ACTIVITY	
	PROTHROMBIN RATIO	
	SICKLING TEST	
	LE PREP	

REMARKS [redacted] CBC #1 b(6) Lymph % 7-6

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

REQUESTING PHYSICIAN'S SIGNATURE [redacted]

REPORTED BY [redacted]

MD TECH DATE 20 MAY 03

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

PATIENT STATUS ☐ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ C

SPECIMEN SOURCE ☐ VEIN ☐ C ☐ OTHER (Specify)

LAB. ID. NO.

SPECIMEN/LAB RPT. NO.

HEMATOLOGY 549-107

EPW #1 b(6)-4

TCW #2

TEST(S)

SPECIMEN TAKEN

DATE | TIME A.M. P.M.

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

REMARKS [redacted] Sputum Stain. Pending Culture Gram Neg Diplococci

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

REQUESTING PHYSICIAN'S SIGNATURE [redacted]

REPORTED BY b(6)-2

MD TECH DATE 27 MAY

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

PATIENT STATUS ☐ BED ☐ AMB ☐ OUTPATIENT ☐ NP

SPECIMEN SOURCE ☐ VEIN ☐ OTHER (Specify) Sputum

LAB. ID. NO.

SPECIMEN/LAB RPT. NO.

HEMATO STANDARD FORM PRESCRIBED BY FIRMR (41-CFR)

[redacted] b(6)-4

MISC

URGENCY ☐ ROUTINE ☐ TODAY ☐ PRE-OP STAT ☒

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

SPECIMEN SOURCE (Specify)

SPECIMEN/LAB RPT. NO

LAB ID NO.

PATIENT'S MED. RECORD

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

[redacted] REPORTED BY b(6)-2 [redacted] MD TECH DATE 27 MAY

[redacted] electrolyte

TEST(S) SPECIMEN TAKEN DATE 27 May TIME 1230 A.M. P.M.

REQUESTED

RESULTS	
Na	144
K+	3.3
Cl	107
TCO2	26

557-107 MISCELLANEOUS STANDARD FORM 557 (Rev. 3-77) Prescribed by GSA/ICMR FIRMR (41 CFR) 201-45.505

EPW # [redacted] b(6)-4
ICU #2

HEMATOLOGY

URGENCY	SPECIMEN/LAB RPT. NO.
☐ ROUTINE	PATIENT STATUS: ☐ BED ☐ AMB; OUTPATIENT ☐; ☐ NP ☐ DOM
TODAY ☐	
☐ PRE-OP	SPECIMEN SOURCE: ☐ VEIN ☐ CAP
STAT ☐	☒ OTHER (Specify) Sputum

PATIENT'S MED. RECORD

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

REQUESTING PHYSICIAN'S SIGNATURE	REPORTED BY	MD / TECH	DATE	LAB. ID. NO.
b(6)-2 [redacted]			27 MAY	

REMARKS Sputum STAIN: PENDING Culture Growth! gram NEG Diplococci

TEST(S)	SPECIMEN TAKEN	TIME A.M. P.M.	[X] REQUESTED	RBC COUNT	HEMOGLOBIN	HEMATOCRIT	MCV	MCH	MCHC	WBC COUNT	IMMATURE	NEUTRO-BANDS	NEUTROSEGS	LYMPHS	EOSINOPHILS	BASOPHILS	MONOCYTES	PLATELETS	RBC	SED. RATE	PLATELET COUNT	RETICULOCYTE COUNT	CLOTTING TIME	BLEEDING TIME	P T T CONTROL	P T T PATIENT	PROTHROMBIN CONTROL	PROTHROMBIN PATIENT	% ACTIVITY	RATIO	SICKLING TEST	LE PREP
	DATE		RESULTS																													

WBC DIFF AND BLOOD CELL MORPH

549-107

HEMATOLOGY
STANDARD FORM 549 (Rev. 7-78)
PRESCRIBED BY GSA/ICMR
FIRMR (41-CFR) 201-45 505

[redacted]

Section: 11 | REQUESTING PHYSICIAN: [redacted] b(6)-2

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

FIRST, MI. [redacted] b(6)-4 | DATE 14MAR03 | TIME | SSN/PSEUDO SSN: [redacted] b(6)-4

(FST)			(Piccolo) Chemistry			(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) Metabolic 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	117	73-118 mg/dl	AST		11-38 u/l
Hct		38-51% PCV	BUN	23	7-22 mg/dl	TBIL		0.2-1.6 mg/dl
Hgb		12-17 g/dl	CRE	1.0	0.6-1.2 mg/dl	GGT		5-65 u/l
Misc. Chemistry			CK *	>5000	39-380 u/l (M) 30-190 u/l (F)	TP		6.4-8.1 g/dl
TEST	RESULT	REF. RANGE	NA^+	++ 144	128-145 mmol/l	**(Piccolo) Electrolyte**		
Troponin-I			K^+	4.9	3.3-4.7 mmol/l	TEST	RESULT	REF. RANGE
Drug of Abuse			CL^-	108	98-108 mmol/l	NA^+		128-145 mmol/l
			tCO_2	26	18-33 mmol/l	K^+		3.3-4.7 mmol/l
						CL^-		98-108 mmol/l
						tCO_2		18-33 mmol/l

REMARKS:

MET 8 ++ 7 STAT

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

LAST COPY DO NOT TAKE

Ward/Section: EMT	REQUESTING PHYSICIAN: DR. [redacted] b(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted] b(6)-4	DATE: 14 MAR 03 / TIME: 0935	SSN/PSEUDO SSN: [redacted]

[redacted] b(6)-4

TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC	7.1	4.8-10.8 x 10^3	Color		N/A	RPR		Negative
RBC	3.88	4.7-6.1 x 10^9	App		N/A	Mono		Negative
Hgb	11.4	14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	[redacted]		
Hct	36.5	42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV	94.0	80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
Plt	190	130-500 x 10^3 verified	SG		N/A	Occ Bld		Negative
Lymph %	14.7%	20.5-51.1%	Bld		Negative	H. pylori		Negative
[redacted]			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	[redacted]		
RBC Morph			HCG		Negative			
Spun Hematocrit		42-52% (M) 37-47% (F)	[redacted]					
Sed Rate			Cell Count			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED		
Other			Directigen		Negative	ABO/Rh		

[redacted]

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: CBC

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

ICW #2 b(6)-2 ICW #2

PC [redacted]

LABORATORY RESULT FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI.	STATUS	DATE	SSN
# [redacted] b(6)-4	EPW	3/15/03	# [redacted] b(6)-4

Chemistry (I-STAT)

TEST	RESULT	REF. RANGE
Na	155	138-146 mmol/L
K	3.2	3.5-4.9 mmol/L
Cl	122	98-109 mmol/L
pH		7.31-7.45
PCO_2		35-45 mmHg (art) 41-51 mmHg (ven)
PO_2		80-105 mmHg (art) N/A (ven)
TCO_2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO_3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO_2		95-98%
BEecf		(+2) - (+3) mmol/L
AGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN	18	8-26 mg/dl
GLU	71	70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct	23	38-51% PCV
Hgb	8	12-17 g/dl

Blood Bank

ABO/Rh		IAT	

Unit	Type	Crossmatch

Misc. Chemistry

CKMB		
Troponin		
DOA		
Alcohol		

Microscopic Urinalysis

Chemistry (Piccolo Analyzer)

TEST	RESULT	REF. RANGE
ALT		10-47 U/L
AST		11-38 U/L
GGT		5-56 U/L
ALB		3.3-5.5 g/dl
ALP		26-84 U/L
Amylase		14-97 U/L
Ca		8-10.3 mg/dl
Chol		<200 mg/dl
Creat		0.6-1.2 mg/dl
BUN		7-22 mg/dl
GLU		73-118 mg/dl
Tbili		0.21.6 mg/dl
TP		6.4-8.1 g/dl
UA		2.2-6.6 mg/dl (F) 3.6-8.0 mg/dl (M)
Na^+		128-145 mmol/L
K^+		3.3-4.7 mmol/L
Cl^-		98-108 mmol/L
$^+CO_2$		18-33 mmol/L
CK		39-380 u/L

Urinalysis

TEST	RESULT	REF. RANGE
Gluc		Negative
Bili		Negative
Ketone		Negative
SG		N/A
Blood		Negative
pH		N/A
Protein		Negative
Urob		0.2-1.0
Nitrite		Negative
HCG		Negative

Hematology

TEST	RESULT	REF. RANGE
WBC	8.0	4.8-10.8 x 10^3
RBC	2.86	4.7-6.1 x 10^9
Hgb	8.5	14-18 g/dl (M) 12-16 g/dl (F)
Hct	27.0	42-52% (M) 37-47% (F)
MCV	94.6	80-94 fl (M) 81-99 fl (F)
Plt	186	130-500 x 10^3 verified
Lymph%	18.9	20.5-51.1%
Retic		0.5-1.5% (adult)
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer	1	<20 ug/ml
FDP		<10 ug/ml
Segs		Mono
Bands		Eos
Lymph		Baso
Atyp		Imm
RBC Morph		
Other		
Spun Crit		42-52% (M) 37-47% (F)
Man WBC		4.8-10.8 x 10^3
Manual Plt		130-500 x 10^3 verified

Microbiology

Source			
Gram Stain			
Culture			
KOH/WP			
O&P			
Occ Bld		Malaria	
Other			

☺ "SHADOW" PJR

[redacted] b(6)-2

: ICW2

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

LABORATORY RESULT FORM
(Subject to Privacy Act of 1974)

STATUS	DATE	SSN

Chemistry (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
PCO_2		35-45 mmHg (art) 41-51 mmHg (ven)
PO_2		80-105 mmHg (art) N/A (ven)
TCO_2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO_3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO_2		95-98%
BEecf		(+2) – (+3) mmol/L
AGap		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

Blood Bank

ABO/Rh		IAT	

Unit	Type	Crossmatch

Misc. Chemistry

CKMB		
Troponin		
DOA		
Alcohol		

Microscopic Urinalysis

Chemistry (Piccolo Analyzer)

TEST	RESULT	REF. RANGE
ALT		10-47 U/L
AST		11-38 U/L
GGT		5-56 U/L
ALB		3.3-5.5 g/dl
ALP		26-84 U/L
Amylase		14-97 U/L
Ca		8-10.3 mg/dl
Chol		<200 mg/dl
Creat	0.4	0.6-1.2 mg/dl
BUN	12	7-22 mg/dl
GLU	105	73-118 mg/dl
Tbili		0.21.6 mg/dl
TP		6.4-8.1 g/dl
UA		2.2-6.6 mg/dl (F) 3.6-8.0 mg/dl (M)
Na^+	141	128-145 mmol/L
K^+	4.6	3.3-4.7 mmol/L
Cl^-	103	98-108 mmol/L
$^+CO_2$	26	18-33 mmol/L
CK	2201	39-380 u/L

Urinalysis

TEST	RESULT	REF. RANGE
Gluc		Negative
Bili		Negative
Ketone		Negative
SG		N/A
Blood		Negative
pH		N/A
Protein		Negative
Urob		0.2-1.0
Nitrite		Negative
HCG		Negative

Hematology

TEST	RESULT	REF. RANGE
WBC	11.6	4.8-10.8 x 10^3
RBC	3.28	4.7-6.1 x 10^6
Hgb	9.7	14-18 g/dl (M) 12-16 g/dl (F)
Hct	30.9	42-52% (M) 37-47% (F)
MCV	94.2	80-94 fl (M) 81-99 fl (F)
Plt	278	130-500 x 10^3 verified
Lymph%	13.7	20.5-51.1%
Retic		0.5-1.5% (adult)
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml
Segs		Mono
Bands		Eos
Lymph		Baso
Atyp		Imm
RBC Morph		
Other		
Spun Crit		42-52% (M) 37-47% (F)
Man WBC		4.8-10.8 x 10^3
Manual Plt		130-500 x 10^3 verified

Microbiology

Source			
Gram Stain			
Culture			
KOH/WP			
O&P			
Occ Bld		Malaria	
Other			

☺ "SHADOW" PJR

Ic. 2 • 0900

LABORATORY RESULT FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI.	STATUS	DATE	SSN
[redacted] D(6)-4		19MAY03	

Chemistry (ISTAT)

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
PCO_2		35-45 mmHg (art) 41-51 mmHg (ven)
PO_2		80-105 mmHg (art) N/A (ven)
TCO_2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO_3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO_2		95-98%
BEecf		(-2) - (+3) mmol/L
AGap		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

Blood Bank

ABO/Rh		IAT	

Unit	Type	Crossmatch

Misc. Chemistry

CKMB		
Troponin		
DOA		
Alcohol		

Microscopic Urinalysis

Chemistry (Piccolo Analyzer)

TEST	RESULT	REF. RANGE
ALT		10-47 U/L
AST		11-38 U/L
GGT		5-56 U/L
ALB		3.3-5.5 g/dl
ALP		26-84 U/L
Amylase		14-97 U/L
Ca		8-10.3 mg/dl
Chol		<200 mg/dl
Creat		0.6-1.2 mg/dl
~~BUN~~		7-22 mg/dl
GLU		73-118 mg/dl
Tbili		0.21-6 mg/dl
TP		6.4-8.1 g/dl
UA		2.2-6.6 mg/dl (F) 3.6-8.0 mg/dl (M)
Na^+		128-145 mmol/L
K^+		3.3-4.7 mmol/L
Cl^-		98-108 mmol/L
$^+CO_2$		18-33 mmol/L
CK		39-380 u/L

Urinalysis

TEST	RESULT	REF. RANGE
Gluc		Negative
Bili		Negative
Ketone		Negative
SG		N/A
Blood		Negative
pH		N/A
Protein		Negative
Urob		0.2-1.0
Nitrite		Negative
HCG		Negative

Hematology CBC

TEST	RESULT	REF. RANGE
WBC	20.1	4.8-10.8 x 10^3
RBC	2.89	4.7-6.1 x 10^9
Hgb	8.5	14-18 g/dl (M) 12-16 g/dl (F)
Hct	27.8	42-52% (M) 37-47% (F)
MCV	96.4	80-94 fl (M) 81-99 fl (F)
Plt	765	130-500 x 10^3 verified
Lymph%	9.4	20.5-51.1%
Retic		0.5-1.5% (adult)
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Segs	73	Mono	14
Bands	6	Eos	2
Lymph	6	Baso	
Atyp	1	Imm	

RBC Morph	
Other	

Spun Crit		42-52% (M) 37-47% (F)
Man WBC		4.8-10.8 x 10^3
Manual Plt	mod increased platelets	130-500 x 10^3 verified

Microbiology

Source	
Gram Stain	
Culture	
KOH/WP	
O&P	
Occ Bld	
Malaria	
Other	

RGL

☺ "SHADOW" PJR

(VA) HISTORY UNIT M.D. b(6)-2 [redacted]

Ward/Section: 7CU2	REQUESTING PHYSICIAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)		
LAST, FIRST, MI. EPW	# [redacted] b(6)-9	DATE 20MAY	TIME 0830	SSN/PSEUDO SSN:

[redacted]

TEST	RESULT	REF. RANGE
~~Na~~		138-146 mmol/L
K	3.3	3.5-4.9 mmol/L
Cl	100	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	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	7	8-26 mg/dl
GLU	139	70-105 mg/dl
Creat	0.4	0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

[redacted]

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

[redacted]

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

[redacted]

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

[redacted]

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

[redacted]

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

[redacted]

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:

~~CBC~~ BUN, CREATNINE, LYTES

REPORTED BY:	DATE:	LAB ID NO.:

Chemistry Unit

Ward/Section: 1CW2	REQUESTING PHYSICIAN: [redacted] b(6)-2	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)		
LAST, FIRST, MI: [redacted] b(6)-4		DATE	TIME	SSN/PSEUDO SSN:

[redacted]

TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
Na	136	138-146 mmol/L	ALB		3.5-5.5 g/dl	GLU		73-118 mg/dl
K	3.0	3.5-4.9 mmol/L	ALP		26-84 u/l	BUN		7-22 mg/dl
Cl	100	98-109 mmol/L	ALT		10-47 u/l	CA^{++}		8.0-10.3 mg/dl
pH	7.504	7.31-7.45	AMY		14-97 u/l	CRE		0.6-1.2 mg/dl
PCO2	31.2	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	26	23-27 mmol/L (art) 24-29 mmol/L (ven)	BUN	~~5~~	7-22 mg/dl	CL^-		98-108 mmol/l
HCO3	25	22-26 mmol/L (art) 23-28 mmol/L (ven)	CA^{++}		8.0-10.3mg/dl	tCO_2		18-33 mmol/l
sO2	1	95-98%	CHOL		100-200 mg/dl			
BEecf		(-2) – (+3) mmol/L	CRE		0.6-1.2 mg/dl			
AnGap	14	10-20 mmol/L	GLU	~~122~~	73-118 mg/dl			
Ca		1.12-1.32 mmol/L	TP		6.4-8.1 g/dl			
BUN	~~5~~	8-26 mg/dl						
GLU	122	70-105 mg/dl						
Creat		0.7-1.5 mg/dl						
Hct	28	38-51% PCV						
Hgb	10	12-17 g/dl						

[redacted]

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

[redacted]

TEST	RESULT	REF. RANGE
GLU	139	73-118 mg/dl
BUN	18	7-22 mg/dl
CRE	0.6	0.6-1.2 mg/dl
CK	163	39-380 u/l (M) 30-190 u/l (F)
NA^+	135 ~~4.0~~	128-145 mmol/l
K^+	~~112~~ 4.0	3.3-4.7 mmol/l
CL^-	112	98-108 mmol/l
tCO_2	24	18-33 mmol/l

[redacted]

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

[redacted]

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

REMARKS:

REPORTED BY: [redacted] b(6)-2	DATE: 21 MAY 03	LAB ID NO.:

b(6)-2

[redacted]

[redacted]	REQUESTING PHYSICIAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
ICW2		

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

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	23.5	4.8-10.8 x 10^3
RBC	2.94	4.7-6.1 x 10^9
Hgb	8.8	14-18 g/dl (M) 12-16 g/dl (F)
Hct	28.1	42-52% (M) 37-47% (F)
MCV	95.6	80-94 fl (M) 81-99 fl (F)
Plt	893	130-500 x 10^3 verified
Lymph %	8.4	20.5-51.1%

(Hematology) Manual Differential

Segs	69	Mono	9
Bands	15	Eos	1
Lymph	5	Baso	2
Atyp		Imm	
RBC Morph	hypochromasia increased platelet		
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 (Crossmatch)

UNIT	TYPE	CROSSMATCH

REMARKS: b(6)-2

REPORTED BY: [redacted]	DATE: 21 May	LAB ID NO.: 8835

2 of 2

Ward/Section: ICW #2 | REQUESTING PHYSICIAN: Dr. [redacted] b(6)-2

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

LAST, FIRST, MI: # [redacted] b(6)-4 | 5/22 | TIME: 0400 | SSN/PSEUDO SSN: # [redacted] b(6)-4

[illegible]

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

[illegible]

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

[illegible]

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

[illegible]

TEST	RESULT	REF. RANGE
GLU	90	73-118 mg/dl
BUN	6	7-22 mg/dl
CRE	0.5	0.6-1.2 mg/dl
CK	377	39-380 u/l (M) 30-190 u/l (F)
NA+	NA	128-145 mmol/l
K+	3.8	3.3-4.7 mmol/l
CL-	104	98-108 mmol/l
tCO2	25	18-33 mmol/l

[illegible] Metabolic Panel

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

[illegible] 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

[illegible] Electrolyte

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

REMARKS:

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

1 of 2

Ward/Section: ICU #2	REQUESTING PHYSICIAN: Dr. [redacted] b(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)		
LAST, FIRST, MI: # [redacted] b(6)-4		DATE: 5/22	TIME: 0400	SSN/PSEUDO SSN: # [redacted] b(6)-4

Hematology: CBC

TEST	RESULT	REF. RANGE
WBC	19.8	4.8-10.8 x 10^3
RBC	2.80	4.7-6.1 x 10^9
Hgb	8.2	14-18 g/dl (M) 12-16 g/dl (F)
Hct	26.8	42-52% (M) 37-47% (F)
MCV	95.6	80-94 fl (M) 81-99 fl (F)
Plt	845	130-500 x 10^3 verified
Lymph %	11.0	20.5-51.1%

Hematology: Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

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 (Indicate month MUST SUBMIT SF 518 FOR EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

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

Fu #2

Ward/Section:	REQUE: HYSICIAN: Dr-[redacted] b(6)-2	LAB: TORY RESULT FORM (Su.../ the Privacy Act of 1974)
LAST, FIRST, MI. #[redacted] b(6)-4	22 May	TIME 1405	SSN/PSEU SN: #[redacted] b(6)-4

Hematology/CBC			Urinalysis			Misc Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC	17.5	4.8-10.8 x 10^3	Color		N/A	RPR		Negative
RBC	2.99	4.7-6.1 x 10^9	App		N/A	Mono		Negative
Hgb	8.5	14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	**Microbiology**		
Hct	28.4	42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV	94.8	80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
Plt	521	130-500 x 10^3 verified	SG		N/A	Occ Bld		Negative
Lymph %	11.7	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	**Micr**		
RBC Morph			HCG		Negative			
Spun Hematocrit		42-52% (M) 37-47% (F)	**CSF**					
Sed Rate			Cell Count			MUST SU EVERY U		
Other			Directigen		Negative	ABO/Rh		

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

REMARKS:

[redacted] | DATE: 22 May 03 | LAB ID NO.: 27

b(6)-2

Ward/Section: ICU #2	REQU[redacted] PHYSICIAN: b(6)-2 [redacted]	LAB[redacted]TORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI [redacted] b(6)-4	DATE 23MAY03 / TIME 0043	SSN/PSEUDO SSN: [redacted] b(6)-4

[redacted] CBC

TEST	RESULT	REF. RANGE
WBC	23.8	4.8-10.8 x 10^3
RBC	3.28	4.7-6.1 x 10^9
Hgb	9.6	14-18 g/dl (M) 12-16 g/dl (F)
Hct	31.1	42-52% (M) 37-47% (F)
MCV	95.0	80-94 fl (M) 81-99 fl (F)
Plt	1020	130-500 x 10^3 verified
Lymph %	7.9	20.5-51.1%

Hematology Manual Differential

Segs	83	Mono	4
Bands	4	Eos	1
Lymph	6	Baso	
Atyp		Imm	
RBC Morph	plt - severly increased occ gaint giant		

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: 23May03	LAB ID NO.:

1

ction
b 7-2

RE[redacted]SICIAN: b(6)-2

[redacted] b(6)-4

LAB RESULT FORM

(Subject to the Privacy Act of 1974)

DATE	TIME	SSN/PSEUDO SSN
23-MAY03	0400	[redacted] b(6)-4

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metalyte 8

TEST	RESULT	REF. RANGE
GLU	101	73-118 mg/dl
BUN	8	7-22 mg/dl
CRE	0.7	0.6-1.2 mg/dl
CK	332	39-380 u/l (M) 30-190 u/l (F)
NA^+	131	128-145 mmol/l
K^+	4.4	3.3-4.7 mmol/l
CL^-	104	98-108 mmol/l
tCO_2	23	18-33 mmol/l

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
b(6)-4 [redacted]	23MAY03	

Ward/Section	REQUESTING PHYSICIAN		LABORATORY RESULT FORM
ICU #2	[redacted] b(6)-2		(Subject to the Privacy Act of 1974)
LAST, FIRST, MI	DATE	TIME	SSN/PSEUDO SSN
Elm [redacted] b(6)-4	[redacted]	0530	[redacted] b(6)-4

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU	101	73-118 mg/dl
BUN	7	7-22 mg/dl
CRE	0.6	0.6-1.2 mg/dl
CK	843	39-380 u/l (M) 30-190 u/l (F)
NA⁺	120	128-145 mmol/l
K⁺	4.2	3.3-4.7 mmol/l
CL⁻	99	98-108 mmol/l
tCO_2	24	18-33 mmol/l

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
b(6)-2 [redacted]	24MAY03	

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

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

Hematology/CBC

TEST	RESULT	REF. RANGE
WBC 30.1	~~31.2~~	4.8-10.8 x 10^3
RBC 2.42	~~2.52~~	4.7-6.1 x 10^9
Hgb 7.0	~~7.4~~	14-18 g/dl (M) 12-16 g/dl (F)
Hct 23.5	~~24.4~~	42-52% (M) 37-47% (F)
MCV 97.0	~~96.7~~	80-94 fl (M) 81-99 fl (F)
Plt 781	~~570~~	130-500 x 10^3 verified
Lymph %	~~9.7~~	20.5-51.1%

(Hematology) Manual Differential

Segs	85	Mono	4
Bands		Eos	
Lymph	6	Baso	
Atyp		Imm	5
RBC Morph	Hypersegmented neutrophils w/ Pyknotic cells elevated platelet count & polychromasia normocytic GWR seen		
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: First specimen clotted. Specimen resubmitted.

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

ICU 2

b(6)-4

b(6)-2

ST, MI.

PHYSICIA

#[redacted]

[redacted]

24 MAY 03 1530

LAB TORY RESULT FORM
(Subject to the Privacy Act of 1974)

SSN/DEPO SS

b(6)-4

#[redacted] EP

[redacted]											
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC	26.4	4.8-10.8 x 10³	Urinalysis						Micro Serology		
RBC	2.41	4.2-6.1 x 10⁶	Color		N/A						
Hgb	6.9	14-18 g/dl (M) 12-16 g/dl (F)	App						RPR		Negative
Hct	23.5	42-52% (M) 37-47% (F)	Glu						HIV		Negative
MCV	97.7	80-94 fl (M) 81-99 fl (F)	Bili						Microbiology		
Plt	696	130-500 x 10³ verified	Ket								
Lymph %	9.4	20.5-51.1%	SG								
[redacted]			Bld								
Segs	86	Mono 0	pH								
Bands	4	Eos 0	Prot								
Lymph	9	Baso 0	Urob								
Atyp	0	Imm	Nit								
RBC Morph	Crenated		Leuk								
Spun Hematocrit		42-52% (M) 37-47% (F)									
Sed Rate			CSF								
Other			Cell Count								
			Directigen			Negative					
[redacted]											
TEST	RESULT	REF. RANGE	UNIT			TYPE					
PT		9.8-13.6 secs									
APTT		21-34 secs									
D dimer		<20 ug/ml									
FDP		<10 ug/ml									

REMARKS:

REPORTED BY [redacted]

DATE: 24MAY03

LAB ID NO.:

b(6)-2

24MAY03

Urinalysis

Glu_____ mg/dl

K_____ mEq/L

Cl_____ mmol/L

TCO2_____ 26 mmol/L

AnGap_____ 10 mmol/L

HCT_____ 19 %PCV

RBC_____ 6 M/CL

Hb_____ g/dl

pH_____ 7.4

pCO2_____ mmHg

Sample Type: ART

Field: 100

24MAY03 16:47

Oper: 600

Physician

Serum

Blood Gas

At Patient Temp

pH_____7.505

PCO2_____38.3 mmHg

PO2_____104 mmHg

Patient Temp: 100.4 F

FIO2_____: 40

Sample Type: ART

24MAY03 15:53

Oper: 600379

Physician:_____

Urea_____ 27 mmol/L

Creat_____ 7.518

Na_____ 139 mmol/L

K_____ 3 mmol/L

Cl_____ 96 %

Calculated

b(6)-2

Ward/Section: ICU #2	REQ[redacted]	LAB[redacted]TORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. EPW [redacted] b(6)-4	[redacted]IME [redacted] 1930	SSN/PSEUDO SSN: [redacted] b(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	30.1	4.8-10.8 x 10^3
RBC	2.87	4.7-6.1 x 10^9
Hgb	8.3	14-18 g/dl (M) 12-16 g/dl (F)
Hct	27.4	42-52% (M) 37-47% (F)
MCV	95.4	80-94 fl (M) 81-99 fl (F)
Plt	714	130-500 x 10^3 verified
Lymph %	6.9	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

8 mono 71 segs
11 lymph
10 band
polychromasia

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

Ward/Section	RE[redacted] G PHYSICIAN:	[redacted] b(6)-2	[redacted]STRY RESULT FORM
LAST, FIRST, MI		DATE	TIME	SSN/PSEUDO SSN
EPW [redacted] b(6)-4		[redacted]	0400	[redacted] b(6)-4

ICU #2

(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-
ALP		26-
ALT		10-4
AMY		14-97
AST		11-38 u
TBIL		0.2-1.6 m
BUN		7-22 mg/dl
CA++		8.0-10.3mg/d
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
		73-118 mg/dl
		7-22 mg/dl
		0-10.3 mg/dl
		2 mg/dl
		5 mmol/l
		ol/l
		ol/l
A		
AL		
AMY		
AST		
TBIL		
GGT		
TP		

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU	95	73-118 mg/dl
BUN	5	7-22 mg/dl
CRE	0.7	0.6-1.2 mg/dl
CK	609	39-380 u/l (M) 30-190 u/l (F)
NA+	119	128-145 mmol/l
K+	3.5	3.3-4.7 mmol/l
CL-	95	98-108 mmol/l
tCO_2	26	18-33 mmol/l

(Piccolo)

TEST	RESULT	
NA+		
K+		
CL-		
tCO_2		18-

i-STAT 05+
Pt: 0175
Pt Name: _____
tCO2 _____ 30 mmol/L
Hct 37%
pH _____ 7.490
pCO2 _____ 37.9 mmHg
pO2 _____ 97 mmHg
HCO3 _____ 29 mmol/L
BEecf _____ 5 mmol/L
sO2* _____ 99 %
*calculated

Hct Patient Temp
pH _____ 7.474
pCO2 _____ 39.7 mmHg
pO2 _____ 104 mmHg
Patient Temp: 100.5F
FIO2 _____ : 40
Sample Type : ART
25MAY03 04:34
Oper: 3521
Physician: _____
Seq: 1746
Ver: JRMS045A
CLEW R31

REMARKS:

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

b(6)-2

Ward/Section: ICU #2	REQUEST [redacted] b(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. b(6)-4 EP[redacted]	DATE [redacted] TIME 0400	SSN: PSEUDO SSN: b(6)-4 [redacted]

(Hematology) CBC			Urinalysis			[redacted] Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC	21.8	4.8-10.8 x 10^3	Color		N/A	RPR		Negative
RBC	2.82	4.7-6.1 x 10^9	App		N/A	Mono		Negative
Hgb	8.2	14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	**Microbiology**		
Hct	26.7	42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV	94.8	80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
Plt	639	130-500 x 10^3 verified	SG		N/A	Occ Bld		Negative
Lymph %	8.8	20.5-51.1%	Bld		Negative	H. pylori		Negative
(Hematology) Manual Differential			pH		N/A	Micro Parasites		
Segs	67	Mono 13	Prot		Negative	Malaria		
Bands	15	Eos	Urob		0.2-1.0	O & P		
Lymph	6	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.:

b(a)-2

Ward/Section: ICU 2	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted] b(a)-4	TIME: 0700	SSN/PSEUDO SSN:

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC	21.4	4.8-10.8 x 10^3	Color		N/A	RPR		Negative
RBC	2.69	4.7-6.1 x 10^9	App		N/A	Mono		Negative
Hgb	7.9	14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	**Microbiology**		
Hct	25.7	42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV	95.2	80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
Plt	646	130-500 x 10^3 verified	SG		N/A	Occ Bld		Negative
Lymph %	8.6%	20.5-51.1%	Bld		Negative	H. pylori		Negative
(Hematology) Manual Differential			pH		N/A	Micro Parasites		
Segs		Mono	Prot		Negative	Malaria		
Bands		Eos	Urob		0.2-1.0	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: [redacted]	DATE: 25 MAY	LAB ID NO.:

b(a)-2

b(6)-2 I 1 P Q

Ward/Section: b(6)-4	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI.: EPW # [redacted]	DATE: [redacted] TIME: 1250	SSN/PSEUDO SSN:

Hematology (CBC)

TEST	RESULT	REF. RANGE
WBC	27.5	4.8-10.8 x 10^3
RBC	3.47	4.7-6.1 x 10^9
Hgb	10.0	14-18 g/dl (M) 12-16 g/dl (F)
Hct	31.9	42-52% (M) 37-47% (F)
MCV	91.9	80-94 fl (M) 81-99 fl (F)
Plt	659	130-500 x 10^3 verified
Lymph %	6.6	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:

REPORT [redacted]

DATE: 25 May 09

LAB ID NO.: 027

b(6)-2

b(6)-2

Ward/Section: JW 2 | REQUEST[illegible] HYSIC[redacted] | LABO[illegible]ORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, M[redacted] b(6)-4 | [illegible] IME 1536 | SSN/PSEUDO SSN:

Hematology/CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC	22.7	4.8-10.8 x 10^3	Color		N/A	RPR		Negative
RBC	3.58	4.7-6.1 x 10^9	App		N/A	Mono		Negative
Hgb	10.1	14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	**Microbiology**		
Hct	33.1	42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV	92.6	80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
Plt	647	130-500 x 10^3 verified	SG		N/A	Occ Bld		Negative
Lymph %	4.2	20.5-51.1%	Bld		Negative	H. pylori		Negative
(Hematology Manual) Differential			pH		N/A	Micro Parasites		
Segs	29	Mono 12	Prot		Negative	Malaria		
Bands	48	Eos 1	Urob		0.2-1.0	O & P		
Lymph	0	Baso 0	Nit		Negative	Other		
Atyp	8 SF 1	Imm 8	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:

REPO[redacted] | DATE: 25 May | LAB ID NO.:

b(6)-2

b(a)-2

[redacted]

LABORATORY RESULT FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI.		STATUS	DATE	SSN
ICH #2	0430		26-MAY-03	[redacted] b(a)-4

Chemistry (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
PCO_2		35-45 mmHg (art) 41-51 mmHg (ven)
PO_2		80-105 mmHg (art) N/A (ven)
TCO_2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO_3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO_2		95-98%
BEecf		(-2) – (+3) mmol/L
AGap		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

Blood Bank

ABO/Rh		IAT	

Unit	Type	Crossmatch

Misc. Chemistry

CKMB		
Troponin		
DOA		
Alcohol		

Microscopic Urinalysis

Chemistry (Beckman Analyzer)

TEST	RESULT	REF. RANGE
ALT		10-47 U/L
AST		11-38 U/L
GGT		5-56 U/L
ALB		3.3-5.5 g/dl
ALP		26-84 U/L
Amylase		14-97 U/L
Ca		8-10.3 mg/dl
Chol		<200 mg/dl
Creat	0.6	0.6-1.2 mg/dl
BUN	4	7-22 mg/dl
GLU	99	73-118 mg/dl
Tbili		0.21.6 mg/dl
TP		6.4-8.1 g/dl
UA		2.2-6.6 mg/dl (F) 3.6-8.0 mg/dl (M)
Na^+	133	128-145 mmol/L
K^+	4.3	3.3-4.7 mmol/L
Cl^-	97	98-108 mmol/L
$^+CO_2$	23	18-33 mmol/L
CK	396	39-380 u/L

Urinalysis

TEST	RESULT	REF. RANGE
Gluc		Negative
Bili		Negative
Ketone		Negative
SG		N/A
Blood		Negative
pH		N/A
Protein		Negative
Urob		0.2-1.0
Nitrite		Negative
HCG		Negative

Hematology

TEST	RESULT	REF. RAN
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%
Retic		0.5-1.5% (adul
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml
Segs		Mono
Bands		Eos
Lymph		Baso
Atyp		Imm
RBC Morph		
Other		
Spun Crit		42-52% (M 37-47% (F
Man WBC		4.8-10.8 x 1
Manual Plt		130-500 x 1 verified

Microbiology

Source	
Gram Stain	
Culture	
KOH/WP	
O&P	
Occ Bld	
Malaria	
Other	

JS 26May03

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Ward/Section: ICU #2	REQUEST	HYSICIAN: b(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted] b(6)-4		DATE: 26-MAY-03	TIME: 0400	SSN/PSEUDO SSN: [redacted] b(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	34.5	4.8-10.8 x 10^3
RBC	3.48	4.7-6.1 x 10^9
Hgb	10.3	14-18 g/dl (M) 12-16 g/dl (F)
Hct	32.5	42-52% (M) 37-47% (F)
MCV	93.2	80-94 fl (M) 81-99 fl (F)
Plt	608	130-500 x 10^3 verified
Lymph %	1.7	20.5-51.1%

(Hematology) Manual Differential

Segs	91	Mono	3
Bands	2	Eos	
Lymph	2	Baso	
Atyp		Imm	2
RBC Morph	Giant Platelets seen 2+ Hypochromasia Normocytic Slightly elevated platelet count		
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: No microorganisms seen

REPORTED BY: [redacted]	DATE: 26 May 03	LAB ID NO.:

b(6)-2

b(6)-4

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

LAST, FIRST, MI: [redacted]

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

DATE: 26-MAY-03 TIME: 1910 SSN/PSEUDO CODE: [redacted] b(6)-4

CBC

TEST	RESULT	REF. RANGE
WBC	39.7	4.8-10.8 x 10^3
RBC	3.15	4.7-6.1 x 10^6
Hgb	9.0	14-18 g/dL (M) 12-16 g/dL (F)
Hct	29.7	42-52% (M) 37-47% (F)
MCV	94.4	80-94 fL (M) 81-99 fL (F)
Plt	442	130-500 x 10^3 verified
Lymph %	0.7	20.5-51.1%

Differential

Segs	61	Mono	8
Bands	28	Eos	
Lymph	3	Baso	
Atyp		Imm	
RBC Morph	ANISO 2+ Hypochromia 2+ MICRO CYTIC 2+		

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

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Gr		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

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 Analysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

BLOOD

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] b(6)-2

DATE: 26 MAY 03

LAB ID NO.:

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

LAST, FIRST: [redacted] #[redacted] b(6)-4 | DATE: 26 May 03 | TIME | SSN/PSEUDO SSN

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB	1.4	3.3-5.5 g/dl
ALP	89	26-84 u/l
ALT	38	10-47 u/l
AMY	74	14-97 u/l
AST	73	11-38 u/l
TBIL	7.5	0.2-1.6 mg/dl
GGT	51	5-65 u/l
TP	5.2	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: 26 MAY 03

LAB ID NO.:

b(6)-2

ICU [redacted] b(6)-2

LABORATORY RESULT FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI	STATUS	DATE	SSN
[redacted] b(6)-4		26MAY03	[redacted] b(6)-4

Chemistry (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
PCO_2		35-45 mmHg (art) 41-51 mmHg (ven)
PO_2		80-105 mmHg (art) N/A (ven)
TCO_2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO_3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO_2		95-98%
BEecf		(-2) – (+3) mmol/L
AGap		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

Blood Bank

ABO/Rh		IAT	

Unit	Type	Crossmatch

Misc. Chemistry

CKMB		
Troponin		
DOA		
Alcohol		

Microscopic Urinalysis

WBC - 5-10
RBC - 30-50
Epi - 10-20
Bacteria - many

Amorphous sediment - present
RBC clumping

Chemistry (Piccolo Analyzer)

TEST	RESULT	REF. RANGE
ALT		10-47 U/L
AST		11-38 U/L
GGT		5-56 U/L
ALB		3.3-5.5 g/dl
ALP		26-84 U/L
Amylase		14-97 U/L
Ca		8-10.3 mg/dl
Chol		<200 mg/dl
Creat		0.6-1.2 mg/dl
BUN		7-22 mg/dl
GLU		73-118 mg/dl
Tbili		0.21.6 mg/dl
TP		6.4-8.1 g/dl
UA		2.2-6.6 mg/dl (F) 3.6-8.0 mg/dl (M)
Na^+		128-145 mmol/L
K^+		3.3-4.7 mmol/L
Cl^-		98-108 mmol/L
$^+CO_2$		18-33 mmol/L
CK		39-380 u/L

Urinalysis

TEST	RESULT	REF. RANGE
Gluc	Neg	Negative
Bili	LS	Negative
Ketone	Neg	Negative
SG	1.030	N/A
Blood	4+	Negative
pH	6.0	N/A
Protein	1+	Negative
Urob	0.2	0.2-1.0
Nitrite	Neg	Negative
HCG		Negative
Color	Amber	
Appr	Cloudy	

Hematology

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%
Retic		0.5-1.5% (adult)
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml
Segs		Mono
Bands		Eos
Lymph		Baso
Atyp		Imm
RBC Morph		
Other		
Spun Crit		42-52% (M) 37-47% (F)
Man WBC		4.8-10.8 x 10^3
Manual Plt		130-500 x 10^3 verified

Microbiology

Source	
Gram Stain	
Culture	
KOH/WP	
O&P	
Occ Bld	
Malaria	
Other	

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LS 26May03

MEDCOM - 14972

SA= pos

Ward/Section		G PHYSICIAN:		
ICU #2	[redacted]	b(6)-2		(STRY RESULT FORM
LAST, FIRST, MI		DATE	TIME	SSN/PSEUDO SSN
[redacted] b(6)-4		27-MAY-03		[redacted] b(6)-4

(Subject to the Privacy Act of 1974)

(I-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU	146	73-118 mg/dl
BUN	12	7-22 mg/dl
CA++		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA+	141	128-145 mmol/l
K+	4.3	3.3-4.7 mmol/l
CL-	106	98-108 mmol/l
tCO_2	26	18-33 mmol/l

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
[redacted]	27 May 03	

b(6)-2

b(4)-2

Ward/Section: Icu #2 | RE [redacted] | LAB TORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI [redacted] -b(4)-4 | DATE 27-MAY-03 | TIME | SSN/PSEUDO SSN: [redacted]

[redacted]			Urinalysis			Misc Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC	34.6	4.8-10.8 x 10^3	Color		N/A	RPR		Negative
RBC	3.19	4.7-6.1 x 10^6	App		N/A	Mono		Negative
Hgb	9.2	14-18 g/dl (M) 12-16.2 g/dl (F)	Glu		Negative	**Microbiology**		
Hct	29.9	42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV	93.6	80-94 fl (M) 81-99 fl (F)	Ketone		Negative	Gram Stain		
Plt	449	130-500 x 10^3 verified	SG		N/A	Occ Bld		Negative
Lymph %	2.1	20.5-51.1%	Bld		Negative	H. pylori		Negative
[redacted]			pH		N/A	Micro Parasites		
Segs	66	Mono 11	Prot		Negative	Malaria		
Bands	19	Eos	Urob		0.2-1.0	O & P		
Lymph	3	Baso	Nit		Negative	Other		
Atyp	1	Imm	Leuk		Negative	**Microscopic Urinalysis**		
RBC Morph	bacillus seen		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

[redacted]

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: 27 May 03 | LAB ID NO.:

b(4)-2

b(6)-2

Ward/Section: ICU#2 | REQUEST: [redacted] | LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. EPW# [redacted] b(6)-4 | DATE 28MAY03 | TIME 05 | SSN/PSEUDO SSN:

[redacted]

TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC	13.9	4.8-10.8 x 10³	Color		N/A	RPR		Negative
RBC	3.33	4.7-6.1 x 10⁶	App		N/A	Mono		Negative
Hgb	9.6	14-18 g/dl (M) 12-16 g/dl (F)	Chem		Negative	[redacted]		
Hct	30.4	42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV	91.4	80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
Plt	360	150-500 x 10³ verified	SG		N/A	Occ Bld		Negative
Lymph %	7.8	20.5-51.1%	Bld		Negative	H. pylori		Negative
[redacted]			pH		N/A	Micro Parasites		
Segs		Mono	Prot		Negative	Malaria		
Bands		Eos	Urob		0.2-1.0	O & P		
Lymph		Baso	Nit		Negative	Other		
Stye		Immat	Leuk		Negative	[redacted]		
RBC Morph			HCG		Negative			
Spun Hematocrit		42-52% (M) 37-47% (F)	[redacted]			[redacted]		
Sed Rate			Cell Count			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED		
Other			Directigen		Negative	ABO/Rh		

[redacted]

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: 28May03 LAB ID NO.:

b(6)-2

ICU #2

LABORATORY RESULT FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI.	STATUS	DATE	SSN
EPW [redacted] b(6) -4		28MAY03	

Chemistry (i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L

[redacted]

Pt: 0175

Pt Name:_____

TCO2_____24 mmol/L

At 37C

PH_____7.455

PCO2_____33.4 mmHg

PO2_____76 mmHg

HCO3_____23 mmol/L

BEecf_____0 mmol/L

sO2*_____96 %

*calculated

Sample Type_:

28MAY03 04:12

Oper: 3315

Physician:_____

Ser# 40763

Ver: JAMS045A
CLEW A91

PICCOLO
28/05/03 04:52
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #: 3141AA
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	86	73-118	MG/DL
BUN	8	7-22	MG/DL
CRE	0.6	0.6-1.2	MG/DL
CK	1086*	39-380	U/L
NA+	134	128-145	MMOL
K+	3.8	3.3-4.7	MMOL
CL-	107	98-108	MMOL
tCO2	21	18-33	MMOL

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

Hematology

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%
Retic		0.5-1.5% (adult)
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml
Segs		Mono
Bands		Eos
Lymph		Baso
Atyp		Imm
RBC Morph		
Other		
Spun Crit		42-52% (M) 37-47% (F)
Man WBC		4.8-10.8 x 10^3
Manual Plt		130-500 x 10^3 verified

CKMB		
Troponin		
DOA		
Alcohol		

Gluc		Negative
Bili		Negative
Ketone		Negative
SG		N/A
Blood		Negative
pH		N/A
Protein		Negative
Urob		0.2-1.0
Nitrite		Negative
HCG		Negative

Microbiology

Source			
Gram Stain			
Culture			
KOH/WP			
O&P			
Occ Bld		Malaria	
Other			

Microscopic Urinalysis

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b(6)-4

b(6)-2

Ward/Section: ICU42 | TIER: | PHYSICIAN: Dr. [redacted]

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

LAST, FIRST, MI. | # [redacted] | DATE: 29MAY | TIME: 0395 | SSN: PSEUDO SSN:

[redacted]			[redacted]			[redacted]		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC	9.2	4.8-10.8 x 10³	Color		N/A	RPR		Negative
RBC	3.98	4.7-6.1 x 10⁶	App		N/A	Mono		Negative
Hgb	11.3	14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	[redacted]		
Hct	36.1	42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV	90.6	80-98 fl (M) 81-99 fl (F)	[illegible]		Negative	Gram Stain		
Plt	261	150-500 x 10³ verified	SG		N/A	Occ Bld		Negative
Lymph %	7.8	20.5-51.1%	Bld		Negative	H. pylori		Negative
[redacted]			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	[redacted]		
RBC Morph			HCG		Negative			

			[redacted]			[redacted]
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

[redacted]

TEST	RESULT	REF. RANGE	UNIT	TYPE	CROSSMATCH
PT		9.8-13.0 secs			
APTT		21-34 secs			
D dimer		<20 ug/ml			
FDP		<10 ug/ml			

REMARKS:

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

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

Ward/Section: ICU #2

LAST, FIRST, MI: [redacted]

[redacted]

DATE: 29 MAY 03 | TIME: 0355 | SSN/PSEUDO SSN:

TEST	RESULT	REF. RANGE
Na		138-14
K		3.5-4.5
Cl		98-10
pH		7.31-7
pCO2		35-45 41-51
pO2		80-10 N/A (
tCO2		23-27 24-29
HCO3		22-26 23-28
sO2		95-9
BEecf		(-2) mm
AnGap		10-2
Ca		1.12
BUN		8-2
GLU		70-
Creat		0.7
Hct		38
Hgb		12-17 g/d

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

TEST	RESULT	REF. RANGE
CRE		0.6-1.2 mg/dl
CK		39-380 u/l (M) 30-190 u/l (F)
NA^+	136	128-145 mmol/l
K^+	3.6	3.3-4.7 mmol/l
CL^-	106	98-108 mmol/l
tCO_2	22	18-33 mmol/l

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

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

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: 29 MAY 03

LAB ID NO.:

b(6)-2

i-STAT G3+
b(6)-2
Pt: [redacted]
Pt Name:_____

TCO2_____21 mmol/L
At 37C
pH_____7.453
PCO2_____29.5 mmHg
PO2_____146 mmHg
HCO3_____21 mmol/L
BEecf_____-3 mmol/L
sO2*_____99 %
*calculated

Sample Type_:
29MAY03 02:59
Physician:_____
Se 40763
Ver: JAM3045A
CLEW A91

WBC	10.6 H	x10³/uL	4.5	10.5
RBC	3.29 L	x10⁶/uL	4.00	5.00
HGB	8.2 L	g/dL	11.0	18.0
HCT	26.0 L	%	35.0	40.0
MCV	79.0	fL	80.0	99.9
MCH	28.5	pg	27.0	31.0
MCHC	31.7 L	g/dL	33.0	37.0
PLT	351	x10³/uL	150.	450.
LYM	13.6	%	16.0	50.0
MON	1.4 *	x10³/uL	0.2	0.8

SPECIMEN/LAB RPT. NO

MISC

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

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

SPECIMEN SOURCE (Specify)

PATIENT'S MED. RECORD

#[redacted] b(4)-4

b(4)-2

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

REQUESTING PHYSICIAN'S SIGNATURE: Dr. [redacted]

REPORTED BY MD / TECH

DATE

LAB ID NO.

REMARKS: CBC

557-107

TEST(S) SPECIMEN TAKEN — DATE 30MAY03 — TIME 04 — A.M. / P.M.

REQUESTED

RESULTS

MISCELLANEOUS

STANDARD FORM 557 (Rev. 3-77) Prescribed by GSA/FCMR FIRMR (41 CFR) 201-45.505

Ward/Section ICU42 | PHYSICIAN: b(6)-2 | [redacted] REGISTER RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI # [redacted] b(6)-4 | DATE 30MAY03 | TIME 04 | 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
			ALT		10-47 u/l	CA^{++}		8.0-10.3 mg/dl
			AMY		14-97 u/l	CRE		0.6-1.2 mg/dl
			AST		11-38 u/l	NA^{+}		128-145 mmol/l
			TBIL		0.2-1.6 mg/dl	K^{+}		3.3-4.7 mmol/l
			BUN		7-22 mg/dl	CL^{-}		98-108 mmol/l
			CA^{++}		8.0-10.3mg/dl	tCO_2		18-33 mmol/l
			CHOL		100-200 mg/dl	**(Piccolo) Liver Panel Plus**		
			CRE		0.6-1.2 mg/dl	TEST	RESULT	REF. RANGE
			GLU		73-118 mg/dl	ALB		3.3-5.5 g/dl
			TP		6.4-8.1 g/dl	ALP		26-84 u/l
			(Piccolo) Metlyte 8			ALT		10-47 u/l
			TEST	RESULT	REF. RANGE	AMY		14-97 u/l
			GLU	108	73-118 mg/dl	AST		11-38 u/l
			BUN	13	7-22 mg/dl	TBIL		0.2-1.6 mg/dl
			CRE	0.5	0.6-1.2 mg/dl	GGT		5-65 u/l
			CK	155	39-380 u/l (M) 30-190 u/l (F)	TP		6.4-8.1 g/dl
			NA^{+}	131	128-145 mmol/l	**(Piccolo) Electrolyte**		
			K^{+}	3.8	3.3-4.7 mmol/l	TEST	RESULT	REF. RANGE
			CL^{-}	103	98-108 mmol/l	NA^{+}		128-145 mmol/l
			tCO_2	23	18-33 mmol/l	K^{+}		3.3-4.7 mmol/l
						CL^{-}		98-108 mmol/l
						tCO_2		18-33 mmol/l

30MAY03 @ 0415

i STAT 63:

Pt: [redacted]

Pt Name:_____

TCO2_____24 mmol/L

At 37C

pH_____7.532

PCO2_____7.1 mmHg

PO2_____88 mmHg

HCO3_____23 mmol/L

BEecf_____0 mmol

SO2%_____98 %

Xcalculated

Sample Type:

30MAY03 04:29

Pt: [redacted]

Physician:_____

Pt# [redacted]

: JAM0045A
CLEW A01

KS:

ED BY:	DATE:	LAB ID NO.:
[redacted]	30 May 03	

b(6)-2

Chemistry Unit

Ward/Section: ICU H2	REQUESTING PHYSICIAN: Dr. [redacted] b(6)-2	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, M: # [redacted] b(6)-4	DATE: 31 MAY	TIME: 0430	SSN/PSEUDO SSN:

(Stat)

TEST	RESULT	REF. RANGE
Na	133	138-146 mmol/L
K	3.1	3.5-4.9 mmol/L
Cl	100	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	10	8-26 mg/dl
GLU	101	70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct	29	38-51% PCV
Hgb	10	12-17 g/dl

Micro Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB	1.4	3.5-5.5 g/dl
ALP	133	26-84 u/l
ALT	72	10-47 u/l
AMY	172	14-97 u/l
AST	—	11-38 u/l
TBIL	2-3	0.2-1.6 mg/dl
BUN	8	7-22 mg/dl
CA^{++}	7.6	8.0-10.3mg/dl
CHOL	176	100-200 mg/dl
CRE	0.9	0.6-1.2 mg/dl
GLU	106	73-118 mg/dl
TP	5.8	6.4-8.1 g/dl

(Piccolo) Cardiac

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

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

b(6)-2

ICU #2

[redacted] b(a)-4

REQUESTING PHYSICIAN: Dr. [redacted] b(a)-2

DATE: 31 MAY TIME: 0430

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

SSN/PSEUDO SSN:

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
	10.7	4.8-10.8 x 10^3	Color		N/A	RPR		Negative
	3.09	4.7-6.1 x 10^6	App		N/A	Mono		Negative
	8.6	14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	**Microbiology**		
	27.8	42-52% (M) 37-47% (F)	Bili		Negative	Source		
	90.0	86-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
	356	130-500 x 10^3 verified	SG		N/A	Occ Bld		Negative
Impl %	21.1	20.5-51.1%	Bld		Negative	H. pylori		Negative
(Hematology) Manual Differential			pH		N/A	Micro Parasites		
		Mono	Prot		Negative	Malaria		
		Eos	Urob		0.2-1.0	O & P		
		Baso	Nit		Negative	Other		
		Imm	Leuk		Negative	**Microscopic Urinalysis**		
			HCG		Negative			
		42-52% (M) 37-47% (F)	**CSF**			**Blood Bank**		
			Cell Count			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED		
			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
		9.8-13.6 secs			
		21-34 secs			
		<20 ug/ml			
		<10 ug/ml			

REMARKS:

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

DATE: 31 May 03

LAB ID NO.:

b(6)-2

Ward/Section: I(4=#2 | Ro[illegible] | [illegible]NG PHYSICIAN: [redacted] | [illegible]ISTRY [illegible] SHEET FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, [redacted] b(6)-4 | DATE: 15JUN | TIME: 0930 | SSN/PSEUDO SSN:

(i-STAT)		
TEST	RESULT	REF. RANGE
Na	136	138-146 mmol/L
K	3.1	3.5-4.9 mmol/L
Cl	100	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	9	8-26 mg/dl
GLU	105	70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct	28	38-51% PCV
Hgb	10	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	~~105~~	73-118 mg/dl
BUN	~~9~~	7-22 mg/dl
CRE	~~1~~	0.6-1.2 mg/dl
CK		39-380 u/l (M) 30-190 u/l (F)
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

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

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

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

REMARKS:

REPORTED BY: [redacted] | DATE: 15JUN03 | LAB ID NO.:

b(6)-2

ICU A2 Dr. [redacted] b(6) - 2

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

[redacted]

DATE: Jan TIME: 0430 SSN/PSEUDO SSN:

(Hematology) CBC		Urinalysis			Misc. Serology		
RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
12.8	4.8-10.8 x 10³	Color		N/A	RPR		Negative
2.94	4.7-6.1 x 10⁶	App		N/A	Mono		Negative
8.3	14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	**Microbiology**		
26.5	42-52% (M) 37-47% (F)	Bili		Negative	Source		
90.0	80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
372	150-500 x 10³ verified	SG		N/A	Occ Bld		Negative
17.4	20.5-51.1%	Bld		Negative	H. pylori		Negative
(Hematology) Manual Differential		pH		N/A	Micro Parasites		
Mono		Prot		Negative	Malaria		
Eos		Urob		0.2-1.0	O & P		
Baso		Nit		Negative	Other		
Imm.		Leuk		Negative	**Microscopic Urinalysis**		
		HCG		Negative			
	42-52% (M) 37-47% (F)	**CSF**			**Blood Bank**		
		Cell Count			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED		
		Directigen		Negative	ABO/Rh		

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

COMMENTS:

RECORDED BY: [redacted] DATE: Jan 03 LAB ID NO.:

b(6) - 2

b(6)-2

Ward/Section: ICU #2

[redacted]

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

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

DATE	TIME	SSN/PSEUDO SSN:
02JUN	0500	

(GS[redacted]

TEST	RESULT	REF. RANGE
Na	134	138-146 mmol/L
K	3.3	3.5-4.9 mmol/L
Cl	100	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	8-26 mg/dl
GLU	97	70-105 mmol/dl
Creat		0.7-1.5 mg/dl
Hct	31	38-51% PCV
Hgb	11	12-17 g/dl

Misc Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

Biochemistry

TEST	RESULT	REF. RANGE
ALB	1.6	3.5-5.5 g/dl
ALP	116	26-84 u/l
ALT	58	10-47 u/l
AMY	126	14-97 u/l
AST	38	11-38 u/l
TBIL	1.9	0.2-1.6 mg/dl
BUN	6	7-22 mg/dl
CA^{++}	8.0	8.0-10.3mg/dl
CHOL	216	100-200 mg/dl
CRE	0.8	0.6-1.2 mg/dl
GLU	106	73-118 mg/dl
TP	6.4	6.4-8.1 g/dl

[redacted]

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

Biochem 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

Biochem 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

Biochem Electrolytes

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 B[redacted]	DATE: 2 June 03	LAB ID NO.: 8835

[redacted] b(6)-2

ICW #2

CIV - # [redacted] b(a) - 4

[redacted] b(a) - 2

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

DATE	TIME	SSN/PSEUDO SSN:
02JUN	0500	

(Hematology) CBC

RESULT	REF. RANGE
16.6	4.8-10.8 x 10^3
3.43	4.7-6.1 x 10^6
9.8	14-18 g/dl (M) 12-16 g/dl (F)
31.2	42-52% (M) 37-47% (F)
91.1	80-94 fl (M) 81-99 fl (F)
288	130-500 x 10^3 verified
11.3	20.5-51.1%

(Hematology) Manual Differential

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

Coagulation Studies

RESULT	REF. RANGE
	9.8-13.6 secs
	[illegible] secs
	26 ug/ml
	[illegible] ug/ml

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Chu		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: b(a) 2

REPORTED BY: [redacted]

DATE: 02 Jun 03

LAB ID NO.:

b(6)-2

b(6)-4

[redacted]

[redacted]TORY RESULT FORM

[redacted]ct to Privacy Act of 1974)

		STATUS	DATE	SSN

Chemi[redacted]

TEST	RESULT	REF. RANGE
Na	133	138-146 mmol/L
K	4.0	3.5-4.9 mmol/L
Cl	106	98-108 mmol/L
pH		7.31-7.45
PCO_2		35-45 mmHg (art) 41-51 mmHg (ven)
PO_2		80-105 mmHg (art) N/A (ven)
TCO_2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO_3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO_2		95-98%
BEecf		[redacted] (±3) mmol/L
AGap		10-20 mmol/L
Ca		1.12-1.32 mmol
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct	35%	38-51% PCV
Hgb		12-17 g/dl
[redacted]		
ABO/Rh		[redacted]
Unit	Type	Crossmatch

TEST	RESULT	REF. RANGE
ALT		10-47 U/L
AST		11-38 U/L
GOT		5-35 U/L
ALB		3.9-5.3 g/dl
ALP		26-84 U/L
Amylase		14-97 U/L
Ca		8-10.3 mg/dl
Chol		<200 mg/dl
Creat		0.1-2.[illegible] mg/dl
BUN		[illegible] mg/dl
GLU		75-[illegible] mg/dl
Tbili		0.2-1.5 mg/dl
TP		6.4-8.3 g/dl
UA		2.3-7.6 mg/dl (F) 3.6-8.0 mg/dl (M)
Na		128-145 mmol/L
K		3.5-4.7 mmol/L
Cl		98-108 mmol/L
CO_2		18-33 mmol/L
CK		39-380 U/L

TEST	RESULT	REF. RANGE
Gluc		Negative
Bili		Negative
Ketone		Negative
SG		N/A
Blood		Negative
pH		N/A
Protein		Negative
Urob		0.2-1.[illegible]
Nitrite		Negative
HCG		Negative

Hematology

TEST	RESULT	REF. RANG
WBC	18.5	4.8-10.8 x 10³
RBC	3.79	4.7-6.1 x 10⁶
Hb	10.8	14-18 g/dl (M) 12-16 g/dl (F)
Hct	34.3	42-52% (M) 37-47% (F)
MCV	90.5	80-94 fl (M) 81-99 fl (F)
Plt	334	130-500 x 10³ verified
Lymph%	15.4	20.5-51.1%
Repc		0.5-1.5% (adult
PT		9.8-13.6 secs
APTT		21-34 secs
Digoxin		<20 ug/ml
[illegible]		<10 ug/ml
Mono		
Eos		
Baso		
Imm		
RBC Morph		
Spun Crit		42-52% (M) 37-47% (F)
Man WBC		4.8-10.8 x
Manual Plt		130-500 x verified

Microbiology

Source	
Gram Stain	
Culture	
KOH/WP	
O&P	
Occ Bld	
Malaria	
Other	

Misc. Chemistry

CKMB	
Troponin	
DOA	
Alcohol	

Microscopic Urinalysis

[illegible]	

SHADOW PTR

b(6)-2

[redacted]

b(6)-4

LABORATORY RESULT FORM

LAST, FIRST MI: Civ # [redacted] | STATUS: MILITARY | DATE: | SSN:

Chemistry						Hematology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
Na		138-146 mmol/L	ALT		10-47 U/L	WBC	17.4	4.8-10.8 x 10³
K		3.5-4.9 mmol/L	AST		11-38 U/L	RBC	3.43	4.7-6.1 x 10⁶
Cl		98-109 mmol/L	GGT		5-56 U/L	Hgb	9.6	14-18 g/dl (M) 12-16 g/dl (F)
pH		7.31-7.45	ALB		3.3-5.5 g/dl	Hct	29.2	42-52% (M) 37-47% (F)
PCO_2		35-45 mmHg (art) 41-51 mmHg (ven)	ALP		26-84 U/L	MCV	90.9	80-94 fl (M) 81-99 fl (F)
PO_2		80-105 mmHg (art) N/A (ven)	Amylase		14-93 U/L	Plt	160	130-500 x 10³ verified
TCO_2		23-27 mmol/L (art) 24-29 mmol/L (ven)	Ca		8.4-10.3 mg/dl	Lymph%	12.3	20.5-51.1%
HCO_3		22-26 mmol/L (art) 23-28 mmol/L (ven)	Chol		<200 mg/dl	Retic		0.5-1.5% (adult)
sO_2		95-98%	Creat					9.8-13.6 secs
BEecf		-2-3 mmol/L						21-34 secs
AGap		10-20 mmol/L	GLU					<20 ug/ml
Ca		8.4-10.2 mg/dl	Tbili		0.2-1.2 mg/dl			<10 ug/ml
BUN		5-26 mg/dl	TP		6.5-8.1 g/dl			Mono
GLU		70-105 mg/dl	UA		2.3-4.4 mg/dl (F) 3.8-8.0 mg/dl (M)			Eos
Creat		0.2-1.4 mg/dl	Na		138-145 mmol/L			Baso
Hct		38-51% PCV	K		3.3-4.7 mmol/L			Imm
Hgb		12-17 g/dl	Cl		98-108 mmol/L	RBC Morph		
Blood Bank			CO_2		18-33 mmol/L	Other		
ABO/Rh		TAT	CK		39-380 u/L	Smear Clr		42-52% (M) 37-47% (F)
Unit		Type	Cross match			Plto Est		4.8-10.8 x 10³
				TEST	RESULT	Manual Plt		130-500 x 10³ verified
			Gluc		Negative	Microbiology		
			Bili		Negative	Source		
			Ketone		Negative	Gram Stain		
Misc Chem			SG		N/A	Culture		
CKMB			Blood		Negative	KOH/WP		
Troponin			pH		N/A	O&P		
DOA			Protein		Negative	Occ Bld		Malaria
Alcohol			Urob		0.2-1.0	Other		
Microscopic Urinalysis			Nitrite		Negative			
			HCG		Negative			

b(6)-2

[redacted]

COPY

b(6)-4

Ward/Section ICW2	REQUESTING PHYSICIAN		CHEMISTRY RESULT FORM
LAST, FIRST, MI CIV # [redacted]	DATE 4 June	TIME 1530	SSN/PSEUDO SSN

(I-STAT)			[illegible]			(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		7.35-7.45	AMY		14-97 u/l	CRE		0.6-1.2 mg/dl
PCO2		35-45 mmHg (art)	AST		11-38 u/l	NA		128-145 mmol/l
PO2		80-105 mmHg (art)	TBIL		0.2-1.6 mg/dl	K		3.3-4.7 mmol/l
[illegible]		[illegible]	BUN		7-22 mg/dl	CL		98-108 mmol/l
HCO		[illegible] mmol/L (art)	CA		8.0-10.3 mg/dl	tCO_2		18-33 mmol/l
sO2		95-98%	CHOL		[illegible]	(Piccolo) Liver Panel Plus		
BEecf		[illegible] mmol/L	CRE		0.6-1.2 mg/dl	TEST	RESULT	REF RANGE
AnGap		[illegible] mmol/L	GLU		73-118 mg/dl	ALB		3.3-5.5 g/dl
Ca		[illegible] mmol/L	TP		6.4-8.1 g/dl	ALP		26-84 u/l
BU		8-26 mg/dl	(Piccolo) [illegible]			ALT		10-47 u/l
Glu		[illegible] mg/dl	TEST	RESULT	REF RANGE	AMY		14-97 u/l
Crea		0.6-1.3 mg/dl	GLU	132	73-118 mg/dl	AST		11-38 u/l
Hct		38-51% PCV	BUN	8	7-22 mg/dl	TBIL		0.2-1.6 mg/dl
Hb		[illegible]	CRE	1.4	0.6-1.2 mg/dl	GGT		5-65 u/l
Misc Chemistry			CK	37	39-380 U/L (M) 30-190 U/L (F)	TP		6.4-8.1 g/dl
TEST	RESULT	REF RANGE	NA	124	128-145 mmol/l	(Piccolo) Electrolyte		
[illegible]			K	[illegible]	3.5-[illegible]	TEST	RESULT	REF RANGE
[illegible] Abuse			CL	93	98-108 mmol/l	NA		128-145 mmol/l
			tCO_2	22	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
[illegible]	4 June 03	

ICW2

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

2 JUNE 1010

RESULT	REF RANGE	TEST	RESULT	REF RANGE	TEST	RESULT
			Yellow			
			Clear			
			Neg			
			Neg			
			Neg			
			1.015			
			TRC			
			6.5			
			Neg			
			0.2			
			Neg			
			N/A			
						RBC - 1-3
						WBC - 1-3
						EPI - MODERATE
						CASTS SEEN (GRANULAR)
			[redacted]			
						MUST SUBMIT SP
						EVERY
				Negative		ABO/Rh
			[redacted]			
RESULT	REF RANGE		UNIT		TYPE	

DATE: 7 JUN 03

LAB ID NO.:

b(4)-2

Ward/Section: ICW #2

ING PHYSICIAN: DR. [redacted]

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

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

DATE: 8 Jan 03

TIME: 0400

SSN PSEUDO SSN: STAT

Hematology			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC	14.1	4.8-10.8	Color		N/A	RPR		
RBC	2.42	4.7-6.1	App		N/A	Mono		
Hgb	6.6	14-16 g/dl 12-16 g/dl	Glu		Negative	**Microbiology**		
Hct	21.9	42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV	90.5	80-94 fl 81-99 fl	Ket		Negative	Gram Stain		
Plt	990	130-500 x 10 verified	SG		N/A	One Bld		
Lymph %	25.1	20.5-51.1%	Bld		Negative	H. pylori		
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		Immat	Leuk		Negative	**Microscopic Urinalysis**		
RBC Morph			HCG		Negative			

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

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

REMARKS:

REPORTED BY: DATE: CALLED TO NCO:

b(a)-2

b(a)-4

Ward/Section: ICU2	REQUESTING PHYSICIAN: [redacted]		CHEMISTRY RESULT FORM
LAST FIRST MI: [redacted]	DATE	TIME	SSN/PSEUDO SSN

(i-STAT)			(Piccolo) Chemistry 12			(Piccolo) Metabolic Panel		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
Na	135	138-146 mmol/L	ALB	2.1	3.5-5.3 g/dl	GLU		73-118 mg/dl
K	3.6	3.5-4.7 mmol/L	ALP-IAS	72	26-84 IU/L	BUN		7-22 mg/dl
Cl	99	98-108 mmol/L	ALT	29	10-47 U/L	CA		8.0-10.5 mg/dl
pH	7.443	7.35-7.45	AMY	78	14-97 U/L	CRE		0.6-1.2 mg/dl
pCO2	39.0	35-45 mmHg (art) 45-55 mmHg (ven)	AST	14	11-38 U/L	NA		128-145 mmol/l
PO2		80-105 mmHg (art) N/A (ven)	TBIL	1.6	0.2-1.0 mg/dl	K		3.5-4.7 mmol/l
HCO3	28	24-28 mmol/L (art) 29 mmol/L (ven)	BUN	7	7-22 mg/dl	CL		98-108 mmol/l
tCO2	29	22-26 mmol/L (art) 23-28 mmol/L (ven)	CA	8.7	8.0-10.5 mg/dl	tCO2		18-33 mmol/l
SO2		95-98%	CHOL	215	100-200 mg/dl	(Piccolo) Liver Panel Plus		
BE	3	(-2)-(+3) mmol/L	CRE	1.0	0.6-1.2 mg/dl	TEST	RESULT	REF. RANGE
AnGap	13	10-20 mmol/L	GLU	106	73-118 mg/dl	ALB		3.3-5.5 g/dl
Ca		1.12-1.32 mmol/L	TP	6.9	6.4-8.1 g/dl	ALP		26-84 u/l
BE	4	2-28 mmol/L	(Piccolo) Electrolyte			ALT		10-47 u/l
Lac	1.5	0.7-1.5 mmol/L				AMY		14-97 u/l
Glucose	95	70-105 mg/dl				AST		11-38 u/l
Hct	24	37-46%	GLU		73-118 mg/dl	TBIL		0.2-1.6 mg/dl
Hgb	8.0	12.5-15.5 g/dl	BUN	7	7-22 mg/dl	GGT		5-65 u/l
(Misc Chemistry)			CRE	1.0	0.6-1.2 mg/dl	TP		6.4-8.1 g/dl
TEST	RESULT	REF. RANGE	GR		19.2-30 u/l (M) 10.1-19 u/l (F)	(Piccolo) Electrolyte		
			NA		128-145 mmol/l	TEST	RESULT	REF. RANGE
Nitrogen			K		3.5-4.7 mmol/l			
Drug Abuse			CL		98-108 mmol/l	NA		128-145 mmol/l
			tCO2		18-33 mmol/l	K		3.5-4.7 mmol/l
						CL		98-108 mmol/l
						tCO2		18-33 mmol/l

REMARKS: Chem 8, Chem 12

REPORTED BY:	DATE:	LAB ID NO.
[redacted]	1 Jan 05	

b(6)-2

[redacted]

Ward/Section: CW2

LAST, FIR[redacted]

b(6)-4

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

DATE | TIME | SSN/PSEUDO SSN:

Hematology (CBC)

TEST	RESULT	REF. RANGE
WBC	13.8	4.8-10.8 x 10^3
RBC	3.27	4.7-6.1 x 10^9
Hgb	9.4	14-18 g/dl (M) 12-16 g/dl (F)
Hct	29.7	42-52% (M) 37-47% (F)
MCV	91.1	80-94 fl (M) 81-99 fl (F)
Plt	906	130-500 x 10^3 verified
Lymph %	16.4	20.5-51.1%

Hematology/Manual Differential

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

Coagulation Studies

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

REMARKS: CBC

REPORTED BY: [redacted] AT

9Dmw3

b(6)-2

Urinalysis

REF. RANGE	TEST	RESULT	REF. RANGE
N/A	RPR		Negative
N/A	Mono		Negative
Negative			
Negative			
Negative			
N/A			
Negative			
0.2-1.0			
Negative			
Negative			
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

Negative	ABO/Rh	

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

TYPE	CROSSMATCH

LAB ID NO.:

b(6)-2

CBC b(4)-2

Ward/Section: ICU#2 | ATTENDING PHYSICIAN: [redacted]

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

b(4)-4 LAST, FIRST, MI. #[redacted] | DATE 6/9 | TIME 0300 | SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	13.3	4.8-10.8 x 10^3
RBC	3.33	4.7-6.1 x 10^9
Hgb	9.4	14-18 g/dl (M) 12-16 g/dl (F)
Hct	30.2	42-52% (M) 37-47% (F)
MCV	90.8	80-94 fl (M) 81-99 fl (F)
Plt	897	130-500 x 10^3 verified
Lymph %	15.4	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: [redacted] | DATE: 9 Jun 03 | LAB ID NO.:

b(4)-2

Ward/Sect: ICW 2 Dr. [redacted] b(6)-2

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

LAST, FIRST, MI: # [redacted] b(6)-4 DATE: 11Jun TIME: 0400 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	11.7	4.8-10.8	Color		N/A	RPR		
RBC	3.48	[illegible]	Appr		N/A	Mono		Negative
Hgb	9.8	[illegible]	Glu		Negative	**Microbiology**		
Hct	31.9	42-52%	Prot		Negative	Source		
MCV	91.8	[illegible]				Gram Stain		
Plt	812	Adequate verified	Sp Gr		N/A	Ova Bld		
Lymph %	19.3	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		Lac	Leu		Negative	**Microscopic Urinalysis**		
RBC Morph			UCG		Negative			
Spun Hematocrit		43-52%	**CSF**			**Blood Bank**		
Sed Rate			Cell Count			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED		
Other			Direct gen		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 sec			
APTT		23-38 sec			
D dimer		<0.5 mg			
FDP		[illegible]			

REMARKS:

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

b(6)-2

C'om 8, CER b(6)-4 A11

Iraq #2.

LABORATORY RESULT FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI: [redacted]

STATUS: CIV | DATE: 6/17/03 | SSN: #[redacted]

Chemistry (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
PCO_2		35-45 mmHg (art) 41-51 mmHg (ven)
PO_2		80-105 mmHg (art) N/A (ven)
TCO_2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO_3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO_2		95-98%
BEecf		(-2) – (+3) mmol/L
AGap		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

Blood Bank

ABO/Rh		IAT	

Unit	Type	Crossmatch

Misc. Chemistry

CKMB		
Troponin		
DOA		
Alcohol		

Microscopic Urinalysis

Chemistry (Piccolo Analyzer)

TEST	RESULT	REF. RANGE
ALT		10-47 U/L
AST		11-38 U/L
GGT		5-56 U/L
ALB		3.3-5.5 g/dl
ALP		26-84 U/L
Amylase		14-97 U/L
Ca		8-10.3 mg/dl
Chol		<200 mg/dl
Creat	~~0.4~~ 1.1	0.6-1.2 mg/dl
BUN	~~18~~ 8	7-22 mg/dl
GLU	~~102~~ 95	73-118 mg/dl
Tbili		0.21.6 mg/dl
TP		6.4-8.1 g/dl
UA		2.2-6.6 mg/dl (F) 3.6-8.0 mg/dl (M)
Na^+ 137	~~125~~	128-145 mmol/L
K^+ 3.7	~~4.4~~	3.3-4.7 mmol/L
Cl^- 97	~~104~~	98-108 mmol/L
$^+CO_2$ 24	~~22~~	18-33 mmol/L
CK 13	~~250~~	39-380 u/L

Urinalysis

TEST	RESULT	REF. RANGE
Gluc		Negative
Bili		Negative
Ketone		Negative
SG		N/A
Blood		Negative
pH		N/A
Protein		Negative
Urob		0.2-1.0
Nitrite		Negative

Hematology

TEST	RESULT	REF. RANGE
WBC	10.9	4.8-10.8 x 10^3
RBC	3.72	4.7-6.1 x 10^6
Hgb	10.5	14-18 g/dl (M) 12-16 g/dl (F)
Hct	33.3	42-52% (M) 37-47% (F)
MCV	89.7	80-94 fl (M) 81-99 fl (F)
Plt	483	130-500 x 10^3 verified
Lymph%	22.8	20.5-51.1%
Retic		0.5-1.5% (adult
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml
Segs		Mono
Bands		Eos
Lymph		Baso
Atyp		Imm
RBC Morph		
Other		
Spun Crit		42-52% (M 37-47% (F
Man WBC		4.8-10.8 x 1
Manual Plt		130-500 x 1 verified

Microbiology

Source	
Gram Stain	
Culture	
KOH/WP	
O&P	
Occ Bld	Malaria
Other	

Chem 7.

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

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

LAST, FIRST, MI: # [redacted] b(6)-4 | DATE: 6-23 | TIME: 0230 | SSN: # [redacted]

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

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

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

TEST	RESULT	REF. RANGE
GLU	95	73-118 mg/dl
BUN	9	7-22 mg/dl
CRE	0.9	0.6-1.2 mg/dl
CK	17	39-380 u/l (M) 30-190 u/l (F)
NA^+	128	128-145 mmol/l
K^+	3.6	3.3-4.7 mmol/l
CL^-	95	98-108 mmol/l
tCO_2	25	18-33 mmol/l

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

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

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

REMARKS:

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

CBC b(6)-2

ard/Section: ECW #2	REQUESTING PHYSICIAN: [redacted]	...BORATORY RESULT FORM (Subject to the Privacy Act of 1974)		
ST, FIRST, MI: # [redacted] b(6)-4	DATE 6-23	TIME 0230	SSN/PSEUDO-SSN: # [redacted] b(6)-6	

(Hematology) [redacted]

TEST	RESULT	REF. RANGE
WBC	13.2	4.8-10.8 x 10^3
RBC	3.15	4.7-6.1 x 10^9
Hgb	8.9	14-18 g/dl (M) 12-16 g/dl (F)
Hct	28.2	42-52% (M) 37-47% (F)
MCV	89.6	80-94 fl (M) 81-99 fl (F)
Plt	455	130-500 x 10^3 verified
Lymph %	17.4	20.5-51.1%

(Hematology) Manual Differential

gs		Mono	
nds		Eos	
mph		Baso	
yp		Imm	
BC orph			
un ematocrit		42-52% (M) 37-47% (F)	
d Rate			
ther			

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. RANG
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	B pos

Coagulation Studies

TEST	RESULT	REF. RANGE
T		9.8-13.6 secs
PTT		21-34 secs
dimer		<20 ug/ml
DP		<10 ug/ml

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

UNIT	TYPE	CROSSMATCH

EMARKS:

[redacted] 23 Jun 03

b(6)-2

ICW #2 NPO > 8hrs

MEDICAL RECORD - ANESTHES

For this form, see AR 40-66; the proponent agency is SG

DRUG	(Units)	1530	1545	1600	1615	1630	1700	1715	1730	1745	1800	1815
Versed	(mg)	2										
Fentanyl	(mcg)	100 <150>		<100>			50					
Propofol	(mg)	<500>										
Zemuron	(mg)	<50>										
Vecuronium	(mg)		1			2	2	2		1		1
Neostigmine	(mg)					1000						
VOLAT AGENT 1.50	% del	1.8	1.1	1.7	1.5	1.0	1.4	1.4	1.3	1.0	1.0	1.1
	% e.t.											
AIR	L/Min											
N2O	L/Min											
O2	L/Min	10	2	2	2	2	2	2	2	2	2	2

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

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

TOTALS	TOTAL ESL
2	50
400	
500	TOTAL URINE
50	
9	800

FLUIDS - SUMMARY

CRYSTALLOID- 2700

COLLOID- Ø

BLOOD- Ø

FLUIDS: LINE site 16G ES; 18G Ar; Warmed; Warmed; Warmed; Warmed

LR (1000) X — (500) X LR — (800) — XLR (2300) — (2700)

LOSSES: EST BLOOD LOSS 50; URINE - Foley (700cc) — 50/750 — 50/800

PHYSSTATUS 1 2 3 4 5 E

BODY WEIGHT 75 KG LB

HEMATOCRIT 9.7/29

INITIAL DATA: BP- 137/82; HR- 100

EQUIP CHECK OK?- Y N

PATIENT: OK for PROCEDURE Okay; TIME- 1445

TIME → 1500 X 1530 X 1600 X 1630 X 1700 X 1730 X 1800

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

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

VENTIL	1500	1530	1600	1630	1700	1730	1800	1830	1900	1930	1945
VT - ml	—	720	720	710	740	780	730	750	710	730	740	730
f - breaths/min	16	8	8	8	8	8	8	8	8	8	8	9
Peak inf pres / PEEP	—	20	20	19	19	22	20	18	19	14	20	22
MODE - S(pon), A(ssist), C(on)	S	C	C	C	C	C	C	C	C	C	C	C
X BP/Auto Cuff / X ET CO2 (torr)	(+)	33	32	34	32	34	31	34	32	33	33	34
BP/oth / X FIO2 (Frac or %)	.84	.84	.84	.84	.84	.84	.82	.83	.83	.83	.84	.84
ART line / X SpO2 (%)	100	100	100	100	100	100	100	100	100	99	100	100
Steth- PC/ES / X ECG	ST	ST	ST	ST	ST	ST	ST	ST	ST	ST	ST	ST
X Gas analyzer / X TEMP-site Skin			99°	99°	99°	99°	100°	100°	100°	99°	99°	99°
X N-M Block (T/4)		4/4	2/4	0/4	0/4	0/4	4/4	3/4	0/4	0/4	2/4	0/4
Warming blkt												
Conv warmer												

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

REMARKS: Code drugs with numbers, events with letters

1506 Pt in room. ⊕ monitors, ⊕ oxygenation, Pt padded, arms < 90°
1515 Procedure started.
1530 Foley placed, Pt prepped.
1549 Incision opened. Exp. Lap started
1604 NG tube placed Pt nave per surgeon request.
1715 Zofran 4mg IV
1750 3gm Unasyn IVPB
1820 Pt reversed ⊙ 5mg Neostigmine ⊕ 0 mg Robinul,
1925 NG sxn. PO sxn Pt awake, ⊕ HL. Extu 5 diff. To ICU #2 ⊙ O2 in stable condition

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: DL x 1 attempt #8 ETT, MAC 4, Grade I view. ⊕ BBS, ⊕ ETCO2. Secured @ 21 cm teeth. Atraumatic.

RECOVERY AT: 1830 PACU ICU #2 Spec

OTHER

CONDITION: Stable

RESP: 21 SpO2- 96 BP- 120/74 HR- 89

ANESTHESIA/PROCEDURE TIMES

	Start	Room	En
ANES	1445	1500	18
	Ready	Begin	En
PROC	1510	1515	18

PROCEDURES and CPT Codes: Exp. Lap c I&D; Takedown Colon Resection; Colostomy

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

EPW #[redacted] b(6)-4

SURGEONS: [redacted] / [redacted]

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

PROCEDURE LOCATION: OR 2

DATE: 17 May 0

p1 of 2

p2

MEDICAL RECORD - ANESTHES

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

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

DRUG	(Units)															TOTALS
Fentanyl	(mcg)	50	50													500
	( )															
	( )															
	( )															
	( )															
	( )															
VOLAT AGENT: ISO	% del	06 X														
	% e.t.															
AIR	L/Min															
N2O	L/Min															
O2	L/Min	2	10													

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

TOTAL EBL: 500

TOTAL URINE:

FLUIDS - SUMMARY
CRYSTALLOID-
COLLOID-
BLOOD-

FLUIDS

LINE site															
	☐ Warmed														
16g (C) Ar	☐ Warmed														
	☐ Warmed (2700)														
	☐ Warmed														

LOSSES

EST BLOOD LOSS															
URINE -															

REMARKS
Code drugs with numbers, events with letters

PHYS STATUS 12345 E

BODY WEIGHT KG / LB

HEMATOCRIT

INITIAL DATA
BP- See p1
HR-

EQUIP CHECK
OK? Y N

PATIENT
OK for PROCEDURE?
TIME-

TIME → 1800 15 30

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	730	400
f - breaths/min	8	16
Peak inf pres / PEEP	23	—
MODE - S(pon), A(ssist), C(on)	C	S

MONITORS/ACCESSORIES

X BP/Auto Cuff	X ET CO2 (torr)	35	36
BP/oth	X FIO2 (Frac or %)	.64	.64
ART line	X SpO2 (%)	100	100
Steth- PC/ES	X ECG	ST	ST
X Gas analyzer	X TEMP-site	99	99
	X N-M Block (T/4)	4/4	ST
			250
Warming blkt			
Conv warmer			

Mark with letters & symbols, explain under REMARKS EVENTS *Position* → G1 O1

RECOVERY AT
PACU ICU ____ (Spec
OTHER ____
CONDITION:
RESP- SpO2-
BP- HR-

ANESTHESIA/PROCEDURE TIMES

	Start	Room	En
ANES			
PROC	Ready	Begin	En

PROCEDURES and CPT Codes:
Exp Lap

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*
See p1

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*

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

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

ANESTHETISTS: [redacted] CRT/CRNA

PROCEDURE LOCATION: OR

DATE: 17 May 03

p2 of 2

MEDICAL RECORD – ANESTHESIA

DRUG	(Units)	
Versed	(mg)	2
Fentanyl	(µg)	100 100 50 50 50 100 50
STP	(mg)	375
Sux / Vec	(mg)	120 / 2 2 2 4 3
Mso	(mg)	3 5 5
	( )	
Sevoflurane	del % e.t.	2 1.5 2 2.3 2.0 1.5 1.5 1.5 1.0
AIR	L/Min	
N2O	L/Min	
O2	L/Min	10 2 2 2 2 2 2 2 2 2

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

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

LINE site		
R RT 20g	☐ Warmed	
NS LT 18g	☐ Warmed	
	☐ Warmed	
Heparin	☐ Warmed	
EST BLOOD LOSS		
URINE –		

TOTALS	
3 MG	
400 µg	300
375 mg	
10 mg	350

TOTAL INFUSION: 300

TOTAL URINE: 350

FLUIDS – SUMMARY

CRYSTALLOID – 2100

COLLOID – 500

BLOOD –

REMARKS – Code drugs with numbers, events with letters

PT ID Chart Review
IV 20g Rt arm
1105 In Room Mask
1110 Smooth Induction
Intubation
1115 OG Placed Internal Sx
1120 Foley Placed
1120 2nd IV 18g left hand
1155 Kiebler CERA wrist relief
VSS. Repair cont.
1230 OG Removed Replaced
TNG

PATIENT: 2 3 4 5 E

WEIGHT: 75 (RG) LB

HEIGHT: 26.8

INITIAL DATA: P – 112/70 R – 110

PRE OPERATIVE: K? – (Y) N

Start Anesthesia for PROCEDURE – 1030

TIME → 1100 15 30 1200 30 1300 30

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

220 200 180 160 140 120 100 80 60 40 20

VT – ml		710	710	690	680	640	680	650	650	1050
f – breaths/min		7	7	7	6	6	6	6	6	6
Peak inf pres / PEEP		20	19	21	21	19	18	17	17	17
MODE – S(pon), A(ssist), C(on)		SV	CV	CV	CV	CV	CV	CV	CV	CV
BP/Auto Cuff	ET CO2 (torr)		26	27	30	30	32	32	32	33	33
BP / oth	FIO2 (Frac or %)	.70	.70	.70	.70	.68	.69	.69	.69	.69	.69
ART line	SpO2 (%)	100	100	100	100	100	100	100	100	100	100
Steth- PC/ES	ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR
Gas analyzer	TEMP- site			98	98	98	98	98	98	98	98
	N-M Block (T/4)			4/4	4/4	2/4	1/4	1/1			
Warming blkt											
Conv warmer											

Mark with letters & symbols, explain under REMARKS

EVENTS Position → a a a

RECOVERY AT: PACU (ICU) 2 (Specify)

OTHER

CONDITION: Stable

RESP – 12 SpO2 – 99%

BP – 128/69 HR – 103 98-4

ANESTHESIA / PROCEDURE TIME

	Start	Room	End
ANES	1030	1105	1345
PROC	Ready	Begin	End
	1115	1140	1327

PROCEDURES and CPT Codes: Exp laparotomy, I&D Sigmoid Transverse Colectomy, Colostomy

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GETA, ETT, UMR

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: DL x 1 by U Dez RN COTS USUALSED ETT Passed atraumatic BBS = ETCO x6 ETT secured eyes taped

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

b(6)-4

EPW [redacted]

ICW #2, going ICU #2

SUR[redacted]

ANE[redacted]

[redacted] RECORD – ANESTHESIA

b(6)-2

WAMC OP 376 REVISED 1 Jan 99

PROCEDURE LOCATION 1

DATE 22 May 03

PAGE 1 OF 1

MEDCOM - 15001

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

MEDICAL RECORD — ANESTHESIA

DRUG	(Route)	
Fentanyl	(mcg)	100 50 100
Vecuronium	(mg)	2 1 1 2 2 2
Neosyn	( )	10
	( )	
	( )	
	( )	
VOLAT. AGENT	Forane % del	2.0 1.5 2.0 2.0 1.5 1%
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	2 2 2 2 2 2 2

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

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

TOTALS	TOTAL MG
250mcg	200
10mg	
	TOTAL URINE
	250

FLUIDS – SUMMARY

CRYSTALLOID– 2300

COLLOID– 0

BLOOD– 0

FLUIDS		
LINE site	Lt. Lower Leg	Warmed
LR	Rt hand	Warmed
D5W	Lt Upper Leg	Warmed
		Warmed

1000 ml LR — 600 — 1600
200 — 400 — 700 — 700
Flush — (2300)

LOSSES	
EST BLOOD LOSS	200 — 50 — 50/200
URINE –	200 50/250

REMARKS– Code drugs with numbers, events with letters

pre-op meds
40 mcg Fent
5mg versed
5mg Vec
IV

Propofol
Propofol x 2, suction x 2/ETT = 9
ETCO2 piece Aid @ 1000 BS=BS.

PHYS. STATUS: 1 2 3 4 5 E

BODY WEIGHT: 75 KG LB

HEMATOCRIT:

INITIAL DATA: BP – 112 HR– 114

EQUIP CHECK: OK?– Y N

PATIENT READINESS: OK for PROCEDURE? TIME– 0910

TIME → 0930 X 1000 X 30 X 1100

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

220 200 180 160 140 120 100 80 60 40 20

VITALS							
	VT – ml	730	730	730	720	730	730
	f – breaths/min	8	7	7	7	7	7
	Peak inf pres / PEEP	18	20	21	20	21	22
	MODE– S(pon), A(ssist), C(on)	A C	C	C	C	C	C
BP/Auto Cuff	ET CO2 (torr)	32	30	34	30	29	29
BP / oth	FIO2 (Frac or %)	.76	.75	.75	.76	.76	.76
ART line	SpO2 (%)	100	100	100	100	100	100
Steth- PC/ES	ECG	SR	SR	ST	ST	ST	SR
Gas analyzer	TEMP- site Buccal		99				
	N-M Block (T/4)	4/4	2/4		4/4		4/4
Warming blkt	Blankets / heat wrap						
Conv warmer							

Mark with letters & symbols, explain under REMARKS

EVENTS: Arms ∠ 90

Position → OT

RECOVERY AT 1120

PACU ICU #2 (Specify)

OTHER

CONDITION:

RESP– 12 SpO2– 100%

BP– 115/60 HR– 110

ANESTHESIA PROVIDER TIME

	Start	Room	End
ANES	0900	0930	1130
	Ready	Begin	End
PROC	0940	0950	1120

PROCEDURES and CPT Codes

Debridement abd wound Silgbag Change.

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

EPW # [redacted]

b(4)-4

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

GA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

Pt. Intubated BS=BS – Rovelli – Bilat – Propofol Suction

SURGEONS: Dr. [redacted]

ANE [redacted] MAJ CRNA

b(4)-2

PROCEDURE LOCATION OR #1

DATE 23 May 03

PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 15002

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

NKDA

MEDICAL RECORD — ANESTHESIA

DRUGS (Units)				
Midazolam (mg)	2	1	1	1
UCB (mg)	5	–	5	
Fentanyl mcg/kg/min "I"	250	–	250	
Propofol mcg/kg/min "I"	–		off	
Dopamine mcg/kg/min "I"	5	–	5	
VOLAT AGENT: I-50 % del	1.0	0.4	0.4	X
% e.t.				
AIR L/Min				
N2O L/Min				
O2 L/Min	2	2	2	2

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

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

FLUIDS		
LINE site (R) SC cath	☐ Warmed	NC — #1
(L) arm 18 PIV	☐ Warmed	—
(R) arm 18 PIV	☐ Warmed	— Heparin lock
	☐ Warmed	

LOSSES: EST BLOOD LOSS; URINE –

TOTALS	TOTAL SEC
5	MIN
10	
140	TOTAL URINE
	25

FLUIDS – SUMMARY
CRYSTALLOID – 300
COLLOID – Ø
BLOOD – Ø

PHYS STATUS: 1 2 (3) 4 5 E

BODY WEIGHT: 75 (KG) LB

HEMATOCRIT:

INITIAL DATA: BP – 104/55; HR – 116

COMP CHECK: OK? – (Y) N

PATIENT REMARKS: OK for PROCEDURE? TIME – 1100

TIME → 100 · 30 · 1200 · 30 ·

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

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

VT – ml	—	700	710
f – breaths/min	—	10	8
Peak inf pres / PEEP	—	26	26
MODE – S(pon), A(ssist), C(on)	C	C	C
ET CO2 (torr)	43	35	35
FIO2 (Frac or %)	0.85	0.85	0.85
SpO2 (%)	100	100	100
ECG	ST	ST	ST
TEMP – site AJ			
N-M Block (T/4)	– 4/4	—	1/4

BP/Auto Cuff; BP / oth; ART line; Steth – PC/ES; Gas analyzer

Warming blkt: Room warmed – ⟶; Conv warmer

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

REMARKS – Code drugs with numbers, events with letters

(1) transported to table + to OR c̄. Infusions + mont BUV c̄ O2.
(2) Room, monitors O2.
(3) transported to table + to ICU2 c̄ monitors + BUV 100% O2
(4) Report to RN Vent 12 BPM 700m Tv; 50% 1:2 I:E FIO2

P-Phenylephrine 100mg

RECOVERY AT 1147
PACU (ICU) 2 (Specify)
OTHER T-95.5
CONDITION:
RESP – 12 SpO2 – 99
BP – 133/71 HR – 99

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1100	1115	1205
	Ready	Begin	End
PROC	1120	1127	1142

PROCEDURES and CPT Codes: Ex-Lap

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

[redacted]

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: OETT 8.0 in place b(6)-2

SURGEONS: [redacted]

ANESTHESIOLOGIST: [redacted] CRNA/CPT

b(6)-2

PROCEDURE LOCATION: 2

DATE: 27May03

PAGE 1 OF 1

WAMC OP 376 REVISED Jan 99

MEDCOM - 15003

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

2mg MSO4 0730
Tylenol Rev Fence @ 0500

MEDICAL RECORD — ANESTHESIA

DRUG	(Units)	
Versed	2.5	(mg)
Fent	50	(mcg)
Lidocaine / Prop	( )	
Succ / Vec	( )	
	( )	
	( )	
VOLAT AGENT: Forane	% del	
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	

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

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

Versed	30	30 50 50 50
Fent	50	30/50
Succ	100	100
Forane	% del	10 15 10 10 2 X
O2	L/Min	6 2 2 2 6

FLUIDS		
LINE site	☐ Warmed	
20g (L) Forearm LR	☐ Warmed	100 400 — 800
	☐ Warmed	
	☐ Warmed	

LOSSES	
EST BLOOD LOSS	
URINE –	

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 60 (KG) LB

HEMATOCRIT: 34.3

INITIAL DATA: BP – 120/80 HR – 98

SKIN CHECK: OK? – (✓) N

SAFETY PROTOCOL: OK for PROCEDURE? ✓ YES VSS

TIME: 0815 SCHWARZ

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

TIME: 30 45 900 15 30

Report to 1st Bayer AD [redacted] LTC/CRNA

VT – ml	600	600	300			
f – breaths/min	8	7	12	12		
Peak inf pres / PEEP	15	14				
MODE – S(pon), A(ssist), C(on)	S	C	C	C	S	S
✓ BP/Auto Cuff / ✓ ET CO2 (torr)	25	27	28	32	32	
BP / oth / ✓ FIO2 (Frac or %)	.8	.54	.35	.33		
ART line / ✓ SpO2 (%)	99	100	100	100	100	
✓ Steth – PC/ES / ✓ ECG	SR	SR	SR	SR	SR	SR
Gas analyzer / ✓ TEMP – site axil						
N-M Block (T/4)	4/4	4/4	4/4	4/4		
✓ Stimy	BSC	BSC	BSC	BSC		
Warming blkt						
Conv warmer						

Mark with letters & symbols, explain under REMARKS

EVENTS — Position

TOTALS	
2.5 mg	MIN
250 mcg	
	NO fo

FLUIDS – ESTIMATE
CRYSTALLOID – 550
COLLOID – Ø
BLOOD – Ø

REMARKS – Code drugs with numbers with letters

820 Pt into OR
Monitors + O2 on
825 induction
830 intubation
835 Positive ventilation + breaths

0920 SU 18/mm
ETCO2 37 OD
Suction w/ b
@ Inspection lungs
H Refeed
930 to ICW #1
Via litter

RECOVERY: 930
PACU (ISU) # 1
OTHER I948
CONDITION funky
RESP – 10 SpO2 98
BP – 112/67 HR – 96

	Start	Room
ANES	730	0820 94
PROC	Ready	Begin
	835	850 9

PROCEDURES and CPT Codes: 1+D Abdominal Wound

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GETA Forane/O2 Fent — Eyes taped OPA used

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: 8.0 ETT EXP x 2 (Student) DU B Trauma (A) ETD + RAC Secured @ 22cm

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

[redacted] b(6)-4 ICW #2

SURGEON [redacted] b(6)-2

ANESTH [redacted] LTC/CRNA

PROCEDURE LOCATION ISU #1

DATE 3 JUN 03

PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED 1 Jan 99

PATIENT RECORD

MEDCOM - 15004

U.S. GPO: 2002-726-

NKDA

MEDICAL RECORD — ANESTHESIA

DRUG	(Units)	
Midazolam	(mg)	1 - 1
Versed	(mg)	80
Succ	(mg)	80
Fentanyl	(mg)	50 - 100 - 100
	( )	
	( )	
VOLAT AGENT ISO	% del	1.0 1.0 K
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	10 2 2 10

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

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

TOTALS	
2	
80	
80	
250	

TOTAL VOL 100

TOTAL URINE Ø

FLUIDS – SUMMARY

CRYSTALLOID– 2000

COLLOID– Ø

BLOOD– Ø

FLUIDS

LINE site 20GR/A 166 (L) HO

☐ Warmed NS #1 —

☒ Warmed NS #2 — LR #3

☐ Warmed

☐ Warmed

LOSSES

EST BLOOD LOSS 100

URINE – Ø

PHYS STATUS 1 (2) 3 4 5 (E)

BODY WEIGHT 60 (KG) LB

HEMATOCRIT 31.2

INITIAL DATA

BP– 127, 80

HR– 114

COMP CHECK

OK?– (Y) N

PATIENT RECHECK

OK for PROCEDURE? JR

TIME– 0930

TIME → 945 1000 , 30 . 1100

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

220 200 180 160 140 120 100 80 60 40 20

REMARKS

Code drugs with numbers, events with letters

(1) Pre-opassessment IV Colyte NS on ICU
(2) To OR; monitors 100% O_2 cricoid pressure Induced eyelids taped
(3) RSI; OG placed to suction.
(4) OP suctioned Tv > 4mL/kg RR > 8 & < 30 BPM Extubated 5 complications
(5) To Pacu & to ICU 2 Report to RN.

VENTILATION

VT – ml	760 760 300
f – breaths/min	8 8 15-16
Peak inf pres / PEEP	17 17
MODE– S(pon), A(ssist), C(on)	S/C C C S

MONITORING

BP/Auto Cuff	ET CO2 (torr)	30 28 42
BP / oth	FIO2 (Frac or %)	0.67 0.67 0.67
ART line	SpO2 (%)	100 100 100 100
Steth- PC/ES	ECG	ST
Gas analyzer	TEMP- site AJ	97.8 Buccal
	N-M Block (T/4)	0/4 — 4/4 —
Warming blkt	Blanketz	XL wool
Conv warmer		

Mark with letters & symbols, explain under REMARKS — EVENTS (1) (2) (3) (4) (5) Position → O—I

RECOVERY AT 1048

PACU (ICU) 2 (Specify)

OTHER T-96.7

CONDITION: Stable, responsive

RESP– 20 SpO2– 95

BP– 111/62 HR– 109

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0940	0955	1055
	Ready	Begin	End
PROC	1005	1020	1042

PROCEDURES and CPT Codes

Ex lap – Evaluate Abd. wall hematoma

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

GETA RSI cricoid

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

DL x1 MAC 3 size 8.0 stylated OETT 22cm @ lips. Stylet Removed 5mL air cuff. +BBS + sucETCO2

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

?W # [redacted]

b(6)-4

b(6)

[redacted] CPT/CRNA

PROCEDURE LOCATION 1

DATE 5 JUN 03

PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED Jan 99

MEDCOM - 15005

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

MEDICAL RECORD — ANESTHESIA

ANESTHETIC AGENTS AND DRUGS		
CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML, "I"=CONSTANT INFUSION	DRUG	(Units)
	Versed	( )
	Fentanyl	( )
	Propofol	( )
	Succ Vec	( )
		( )
		( )
VOLAT AGENT	Forane	% del
		% e.t.
	AIR	L/Min
	N2O	L/Min
	O2	L/Min
SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS		

FLUIDS		
LINE site	NS (R) 18g	☐ Warmed
	UR (R) 22g	☐ Warmed
		☐ Warmed
		☐ Warmed
LOSSES	EST BLOOD LOSS	
	URINE –	

TOTALS	
2mg	
250	50
TOTAL URINE	

FLUIDS – SUMMARY
CRYSTALLOID– 1100
COLLOID–
BLOOD–

REMARKS– Code drugs with numbers, events with letters

PT ID Chart Reviewed
OASS In Room Monitors on
0800 IO 22g from ICW – in left arm
0810 Smooth induction intubation
0815 2nd IV 18g Right arm

0925 Reversed c Neostigmine 4mg & glycopyrolate 0.8 mg IO 4 4 4 Suctioned lightly

0930 Sponge Sx c Intercostal IO ICU 1 for R.R

PHYS STATUS: (1) 2 3 4 5 E

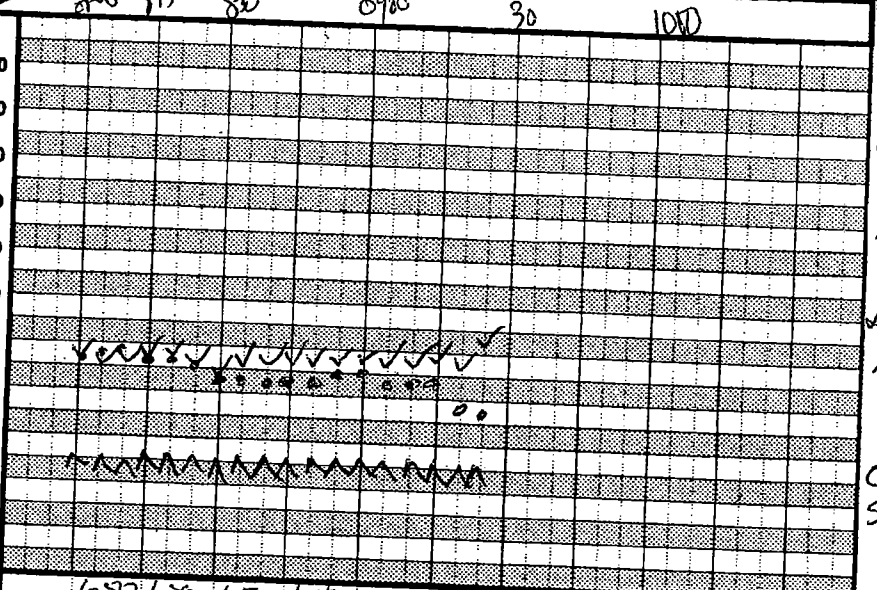
BODY WEIGHT: 65 (KG) LB

HEMATOCRIT: 28.2

INITIAL DATA: BP – 118/66 HR– 106

BONP CHECK: OK?– (Y) N

PATIENT REQUIREMENT: OK for PROCEDURE? yes TIME– 0720



VT – ml	650	650	650	610	610		
f – breaths/min	8	8	7	7	7		
Peak inf pres / PEEP	19	19	19	19	19		
MODE– S(pon), A(ssist), C(on)	SV	CV	CV	CV	CV	CV	SV
ET CO2 (torr)	28	28	28	29	29		
FIO2 (Frac or %)	.66	.66	.66	.66	.66	.66	
SpO2 (%)	100	100	100	100	100	100	
ECG	SR	SR	SR	SR	SR	SR	
TEMP- site	Auscultate	4/4	4/4				
N-M Block (T/4)							

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

RECOVERY AT 0935
PACU ICU ___ (Specify) RR
OTHER ___
CONDITION: Stable
RESP– 16 SpO2– 98% on FiO2
BP– 121/71 HR– 102

ANESTHESIA PROCEDURE TIMES	Start	Room	End
ANES	0730	0755	0940
PROC	Ready	Begin	End
	815	0830	0930

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

PROCEDURES and CPT Codes
Bil leg Stemgrafts → Abd wall

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GETA 8.0 ETT
2 mill

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
Visualized ETT passed atraumatic BBS = CTCW x4
ETT Secured w/ tape
Dexi Cords

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

CW [redacted] bl(W)-4

ICW 2

SURGEON: [redacted]

ANESTHETIST: [redacted] Uccen bl(W)-2

PROCEDURE LOCATION 1
DATE 23 Jun 03
PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED Jan 99

MEDCOM - 15006

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

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

Age 40 DAYS MOS YRS Sex (X) MALE ( ) FEMALE

PROPOSED PROCEDURE: Ex Lap I&D
SURGICAL SERVICE: [redacted] (Gen. Surg)
NPO SINCE:

ASA Physical State 1 2 3 4 5 E
WT: 15 KG/LB HT: ____ IN.
ALLERGIES: NKDA

HABITS:
TOBACCO: Ø
ETOH: Ø
DRUGS: Ø

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) Toradol 30 mg IV q 8° LD 0600
( ) Unasyn 3g IV q 6° LD 0600
( ) Gentamycin 45 mg @ DLD 1200 5/22
( ) Zantac 50 mg IV q 8° LD 0600
( )
( )

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

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

0400 5/22 T&C pending
19.8 / 8.2 / 26.8 845
NA 3.8 | 104 25 | 6 0.5 90

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:		
Hypertension	N Y	
Angina	N Y	
MI	N Y	
CVA	N Y	
Other	N Y	
Pulmonary System:		
Asthma	N Y	
Bronchitis/URI	N Y	
COPD	N Y	
Other	N Y	
Renal System:		
Acute/Chronic RF	N Y	
Gastrointestinal:		
Hepatitis	N Y	GSW to abdomen
Hiatal Hernia	N Y	N 12 May →
PUD/GERD	N Y	surgery @ FST
Endocrine System:		
Diabetes	N Y	
Steriods	N Y	
Thyroid	N Y	
Neurological:		
Seizures	N Y	
Neuropathy	N Y	
Other	N Y	
Gynecological:		
Pregnancy N/A	N Y	
Other Significant Hx:		
	N Y	
	N Y	
Familial HX	N Y	

PMHX.
* Denies per interpreter

ASSESSMENT
PAST SURGICAL/ANESTHETIC
FST → Ex Lap
28 In CSH → Ex Lap / I+D
colostomy takedown } 17 May

PHYSICAL EXAMINATION 94% RA
BP 130/80 HR 90 R 30 T 99°
Pain Scale 0-10 ____
HEENT - Teeth Intact
Trachea Midline
TMJ/Neck FROM
Oropharnyx MPII
Nares Patent
CHEST: CTA (B)
CARDIAC: S1 S2 RRR
EXTREMITIES:
IV Access: UR - Dexelm - 20g PAC
Ulnar Filling:
BACK:
OTHER:

NPO Since * Clear liq breakfast 0700 this AM

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

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

The patient/legal guardian seems to understand and agrees. Questions answered.
Signed: [redacted] CRT/CRNA Date: 22 May 03 Time: 1010 Hrs

POST-ANESTHESIA EVALUATION AND NOTE (NON ASU)
{ } NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER
b(4) - 2

Signed: ____ Date: ____ Time: ____ Hrs

SEDATION KEY:

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

Patient Identification: (Ward)

EPW # [redacted] b(4) - 4
ICW #2

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

MEDCOM - 15007
PATIENT RECORD COPY

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

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age ~40 DAYS MOS YRS Sex (X) MALE ( ) FEMALE

PROPOSED PROCEDURE: Debrid Abd
SURGICAL SERVICE: Gen
NPO SINCE: on Vent

ASA Physical State 1 2 3 4 5 E
WT: 75 KG LB HT: ____ IN.
ALLERGIES: NKDA

HABITS:
TOBACCO: ?
ETOH: ?
DRUGS: ____

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) Fat gtts
( ) Unasyn
( ) Gent
( ) Zantac
( ) Versed gtts
( ) ____

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

LABORATORY STUDIES:
HB/HCT: ____ / ____
U/A: ____
OTHER: ____
CBC pending
23.8 > 9.4 / 31.1 < 1020
131 | 104 | 8 < 101
4.4 | 23 | 0.7

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:			
Hypertension	N	Y	
Angina	N	Y	
MI	N	Y	
CVA	N	Y	
Other	N	Y	
Pulmonary System:			
Asthma	N	Y	
Bronchitis/URI	N	Y	
COPD	N	Y	
Other	N	Y	
Renal System:			
Acute/Chronic RF	N	Y	
Gastrointestinal:			
Hepatitis	N	Y	GSW to Abd
Hiatal Hernia	N	Y	12 MAY
PUD/GERD	N	Y	
Endocrine System:			
Diabetes	N	Y	
Steriods	N	Y	
Thyroid	N	Y	
Neurological:			
Seizures	N	Y	
Neuropathy	N	Y	
Other	N	Y	
Gynecological :			
Pregnancy	N	Y	
Other Significant Hx:			
	N	Y	
	N	Y	
Familial HX	N	Y	

ASSESSMENT
PAST SURGICAL/ANESTHETIC
Multi Surg
on this admit

PHYSICAL EXAMINATION
BP 104/55 HR 116 R 13 T 98.9
Pain Scale 0-10 ____
HEENT - Teeth ____
Trachea ____
TMJ/Neck ____ PE
Oropharnyx ____ Intubated
Nares ____ on Vent
CHEST: ~~Sx~~ / Rhonchi
CARDIAC: S.S
EXTREMITIES: (R) AC #20g
IV Access: (L) Hand lig
Ulnar Filling: ____
BACK: ____
OTHER: ____

NPO Since on Vent

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

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

The patient/legal guardian seems to understand and agrees. Questions answered.
Signed: ____ Date: 23MAY03 Time: 0600 Hrs

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

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward) ____

#[redacted] ICU #2

b(6)-4

Update 27MAY03
Has received 3U PRBCs since 5/23 surgery
Labs 27MAY03:
34.6 > 9.2 / 29.9 < 449
141 | 106 | 12 < 146
4.3 | 26 | ?

SEDATION KEY:

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

Propofol 40 mcg/kg/min

Fentanyl 250 mcg/hr

Dopa 5 mcg/kg/min

NS c 20 KCl @ 150 cc/hr

VS 156/87 97 100%

SIMV R 12 TV 700 FiO_2 50%

I:E = 1:2 PEEP 10

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age ? DAYS MOS YRS

PROPOSED PROCEDURE: I/D Abd
SURGICAL SERVICE: POS 5T5g
NPO SINCE: p MN

Sex (X) MALE ( ) FEMALE

ASA Physical State 1 (2) 3 4 5
WT: 60 (KG)/LB HT: ____ IN
ALLERGIES: UNK ?

HABITS:
TOBACCO: ____
ETOH: ?
DRUGS: ____

CURRENT MEDICATIONS:
( ) = ordered as premed
Gent q day
( ) ZOSYN q6°
( ) Amp q6°
( ) Zantac q12°
( ) Lovenox BID
( )
( )

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

LABORATORY STUDIES:
HB/HCT: ____ / ____
U/A:
OTHER:
133 / 100 / 8 < 95
4.0
13.5 > 10.8 / 34.3 < 634

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

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

Renal System: N Y
- Acute/Chronic RF N Y

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

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

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

Gynecological: N Y
- Pregnancy

Other Significant Hx: N Y

N Y Irrigated wound
Familial HX N Y which is not
N Y closed @ present

S/A GSW to Abdomen

ASSESSMENT
PAST SURGICAL/ANESTHETIC
?

PHYSICAL EXAMINATION
BP 120/80 HR 98 R 18 T 101.8
Pain Scale 0-10
HEENT - Teeth Intact / Miss. (L) Fro—
Trachea Midline
TMJ/Neck FROM
Oropharynx MP II
Nares
CHEST: S.S. → CTA
CARDIAC: S.S.
EXTREMITIES:
IV Access: #20g (L) Arm
Ulnar Filling:
BACK:
OTHER:

NPO Since p MN

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

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

The pati[redacted]dian seems to understand and agrees. Questions answered.

Signed: [redacted] LTC/CRM Date: 3 Jun 07 Time: 0800 Hrs

POST-[redacted]EVALUATION AND NOTE (NON ASU)
{ } NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER
WW-2

Signed: ____ Date: ____ Time: ____ Hrs

SEDATION KEY:

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

Patient Identification: (Ward) ____
#[redacted] ICW 2
WW-4

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

MEDCOM - 15010

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

Age 7 DAYS MOS YRS

Sex (X) MALE ( ) FEMALE

PROPOSED PROCEDURE: Ex Lap - Evacuate Abdominal Wall Hematoma

SURGICAL SERVICE: Gen

NPO SINCE: 0800

ASA Physical State 1 (2) 3 4 5 E

WT: 60 KG/LB HT: ____ IN.

ALLERGIES: NKDA

HABITS:

TOBACCO: Ø

ETOH:

DRUGS:

CURRENT MEDICATIONS:

( ) = ordered as premed

( )

( )

( )

( )

( )

( )

PREMEDICATIONS:

None Yes (@ ____ Hrs) /CC

____ . ____ mg IV IM PO

____ . ____ mg IV IM PO

____ . ____ mg IV IM PO

LABORATORY STUDIES:

HB/HCT: ____ / ____

U/A:

OTHER:

17.4 9.6 31.2 760

133 | 100 | 8 | 95

~~0440~~

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

See Anesthesia pre-op 3 Jun 03

ASSESSMENT

PAST SURGICAL/ANESTHETIC

3 Jun I & D Abdominal Wound GE

PHYSICAL EXAMINATION

BP ____ HR ____ R ____ T ____

Pain Scale 0-10 ____

HEENT - Teeth Intact - risk dental trauma

Trachea MP I-II

TMJ/Neck FROM

Oropharnyx

Nares

CHEST: (+) BBS - CTA

CARDIAC: RRR

EXTREMITIES:

IV Access: #20 (R) Arm

Ulnar Filling: 5

BACK:

OTHER:

NPO Since 0800

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

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

The patient [redacted] seems to understand and agrees. Questions answered.

Signed: [redacted] CRT/CRNA Date: 5 Jun 03 Time: 0945 Hrs

POST-ANESTHESIA EVALUATION AND NOTE (NON ASU)

{ } NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER

Signed: ____ Date: ____ Time: ____ Hrs

SEDATION KEY:

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

rd) ____

[redacted] I(W)#

b(6)-4

M

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

: 36 DAYS MOS YRS

Sex ( ) MALE ( ) FEMALE

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

POSED PROCEDURE: Graft Bi Lyso → Abd
GICAL SERVICE: ____
SINCE: ____

ITS:
BACCO: NY
ETOH: occasional
DRUGS: ____

RENT MEDICATIONS:
ordered as premed

Lovenox 30mg SQ
Hydrocortisone

MEDICATIONS:
e Yes (@ ____ Hrs) /CC
___ · ____ mg IV IM PO
___ · ____ mg IV IM PO
___ · ____ mg IV IM PO

ORATORY STUDIES:

HCT: 8.9 / 28.2

IER: ____

128 | 95 95
3.6 | 25 9
.9

T→S

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

ASSESSMENT

PAST SURGICAL/ANESTHETIC
Appy
TIP Abdud

PHYSICAL EXAMINATION
BP 118/60 HR 100 R ____ T 95.4
Pain Scale 0-10 ____
HEENT - Teeth Intact
Trachea mh
TMJ/Neck 3 FB
Oropharnyx MII
Nares ____
CHEST: ____
CARDIAC: ____
EXTREMITIES: ____
IV Access: Left Arm
Ulnar Filling: ____
BACK: ____
OTHER: ____

NPO Since 2400

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

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

b(6)-2

patient/legal guardian seems to understand and agrees. Questions answered.
ned: [redacted] LtCol Date: 23 Jun 03 Time: 0730 Hrs

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

ned: ____ Date: ____ Time: ____ Hrs

ient Identification: (Ward) ____

CIV
[redacted]
ICW-2
b(6)-4

SEDATION KEY:

1. MINIMAL (Anxiolysis) Patient responds normally to verbal commands
2. MODERATE (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is n necessary.
3. DEEP SEDATION/ANALGESIA. Patient responds purposefully following repeated or painful stimulation. Airway assistance may

7W(1)-4
Pt [redacted] 40

ANESTHESIA PLAN OF CARE / REPROCEDURAL ASSESSMENT (Sedation/Anesthesia) ?

Age (40) DAYS MOS YRS Sex (✓) MALE ( ) FEMALE

PROPOSED PROCEDURE: Exploratory Lap, Colostomy Closure
SURGICAL SERVICE: General
NPO SINCE: > 8 hours

ASA Physical State (1) 2 3 4 5 E
WT: 75 (KG/LB) HT: ____ IN.
ALLERGIES: NKMA

HABITS:
TOBACCO: Denies
ETOH: Denies
DRUGS: Denies

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) Mirapin (3gm) due @ 1800
( ) Zantac (50mg IV) @ 1400
( ) Gentamicin
( )
( )
( )

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

LABORATORY STUDIES:

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

11 > 9.7 < 165 / 30.9 | 8 > 8.5 < 186 / 27
141 | 103 | 12 < 105 / 4.6 | 26 | .4

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:			
Hypertension	N	Y	GSW to Abdomen
Angina	N	Y	Approx May 12?
MI	N	Y	Surgery @ FST
CVA	N	Y	(Exp lap)
Other	N	Y	
Pulmonary System:			
Asthma	N	Y	
Bronchitis/URI	N	Y	
COPD	N	Y	
Other	N	Y	unknown
Renal System:			
Acute/Chronic RF	N	Y	
Gastrointestinal:			
Hepatitis	N	Y	
Hiatal Hernia	N	Y	
PUD/GERD	N	Y	
Endocrine System:			
Diabetes	N	Y	
Steriods	N	Y	
Thyroid	N	Y	
Neurological:			
Seizures	N	Y	
Neuropathy	N	Y	
Other	N	Y	
Gynecological :			
Pregnancy	N	Y	
Other Significant Hx:			
	N	Y	
	N	Y	
Familial HX	N	Y	

ASSESSMENT
PAST SURGICAL/ANESTHETIC
Exploratory Laparotomy 5/14?

PHYSICAL EXAMINATION O2 sat 9?
BP 161/78 HR 90 R 22 T ____
Pain Scale 0-10 ____
HEENT - Teeth Intact
Trachea ____
TMJ/Neck ____
Oropharnyx ____
Nares ____
CHEST: CTA
CARDIAC: S1 S2
EXTREMITIES:
IV Access: (L) EJ
Ulnar Filling: ____
BACK: ____
OTHER: ____
Foley / ostomy

NPO Since ____

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

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

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

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

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward) ____

SEDATION KEY:

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

Pt 175

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

- [x] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of _____ units)*
- [ ] CRYOPRECIPITATE *(Pool of _____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* _____

VOLUME REQUESTED *(If applicable)*

_____ ML

REMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*

- [x] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED: 5/24/03

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] b(4)-2

DIAGNOSIS OR OPERATIVE PROCEDURE: ulcer lap

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 previous S/B

DATE VERIFIED

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.: [redacted]

TRANSFUSION NO.: b(4)-4

PATIENT NO.: EPW # [redacted]

DONOR	RECIPIENT
ABO: B	ABO: B
Rh: Pos	Rh: Pos

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	Cont

PREVIOUS RECORD CHECK:

- [x] RECORD
- [ ] NO RECORD b(4)-2

SIGNATURE OF TEST: [redacted]

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE [redacted] 03

REMARKS: EXP: 27 MAY 03

3/03 ml's

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*: [redacted] b(4)-2

AT *(Hour)* 0241 hrs ON *(Date)* 24 MAY 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(4)-2

[redacted] b(4)-2

TEMP. 100.2 PULSE 107 BP 115/54

DATE OF TRANSFUSION: 24 May 03

TIME STARTED: 0800

POST-TRANSFUSION DATA

AMOUNT GIVEN: 363 ML

TIME DATE COMPLETED INTERRUPTED: 1005 24 MAY 03 COMPLETED

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] b(4)-2

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

EPW # [redacted] b(4)-4

SEX: M[redacted]

WARD: ICU #2

BLOOD O[redacted]MPONENT TRANSFUSION
STANDAR[redacted] (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

MEDICAL RECORD COPY

518-124

MEDICAL RECORD

NSN 7540-00-634-4159

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 24 May 03

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 ex lap

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 previous 518

DATE VERIFIED

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

[redacted]

TRANSFUSION NO.

PATIENT NO.: 0175

DONOR ABO B Rh pos

RECIPIENT ABO B Rh pos

TEST INTERPRETATION

ANTIBODY SCREEN: N/A

CROSSMATCH: Comp

PREVIOUS RECORD CHECK:

- [ ] RECORD
- [x] NO RECORD

SIGNATURE [redacted]

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT [redacted] DATE 24 may 03

REMARKS:

Exp Date: ~~277~~ [redacted] 27 may 2003

SECTION III – RECORD OF TRANSFUSION

INSPECTED A[redacted]

AT *(Hour)* 1150 Hrs ON *(Date)* 24 MAY 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 *(Sign)* [redacted] LCT, AN

2nd [redacted] 240 911 30 MG

PRE-T[redacted]

TEMP. 100 PULSE 102 BP 102/52

DATE OF TRANSFUSION 24-MAY-03 TIME STARTED 1800

POST-TRANSFUSION DATA

AMOUNT GIVEN 450 ML

TIME/DATE COMPLETED/INTERRUPTED 1930 24 MAY 03

REACTION

- [x] NONE
- [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
100	101	122/53

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION

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

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

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

SIGNATURE OF PERSON NOTING ABOVE [redacted] 566 911 30 MG

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

EPW # [redacted] b(6)-2

SEX M WARD ICU 2

b(6)-4

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 2

Medical Record Copy

MEDCOM - 15015

518-124

MEDICAL RECORD

NSN 7540-00-634-4159

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 25 MAY 03

DATE AND HOUR REQUIRED 25 MAY 03 / 09 AM

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 S/P EXLAP

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 PREVIOUS S/B

DATE VERIFIED

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. [redacted]

TRANSFUSION NO.

PATIENT NO. b(6)-4 [redacted]

DONOR

ABO B

Rh POS

RECIPIENT

ABO B

Rh POS

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	Comp

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT

REMARKS:

Exp Date: 27 May 03

PREVIOUS RECORD CHECK:

- [ ] RECORD
- [X] NO RECORD

SIGNA[redacted] DATE 25 May 03

b(6)-2

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED A[redacted]

AT *(Hour)* 0855 ON *(Date)* 25 MAY 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]

PRE-[redacted]

TEMP. 100.9 PULSE 100 BP 123/57

DATE OF TRANSFUSION 25May03

TIME STARTED 0900

POST-TRANSFUSION DATA

AMOUNT GIVEN Complete

TIME/DATE COMPLETED/INTERRUPTED 25 May 03 1000

REACTION

- [X] NONE
- [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
101.0	100	114/58

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]

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

[redacted] MALE [redacted]ARD ICU #2

#[redacted]

b(6)-4

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 C[illegible]

Medical Record Co[illegible]

MEDCOM - 15016

518-124

NSN 7540-00-634-41

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: 25 MAY 03

DATE AND HOUR REQUIRED: 25 MAY 03 / 09 AM

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: S/P EXP LAP

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 PREVIOUS SIB

DATE VERIFIED

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. [redacted]

TRANSFUSION NO. b(6)-4

PATIENT NO. [redacted]

DONOR

ABO: B

Rh: pos

RECIPIENT

ABO: B

Rh: pos

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	Comp

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT [redacted]

REMARKS: Exp Date: 27 May 03

PREVIOUS RECORD CHECK:

- [ ] RECORD
- [X] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST [redacted] b(6)-2

DATE 25 May 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPE[redacted]

AT *(Hour)* 0950 ON *(Date)* 25 MAY 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]

PR[redacted]

TEMP. 101.0 PULSE 100 BP 132/58

DA[redacted]FUSION TIME STARTED [redacted] 9/WMb

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

POST-TRANSFUSION DATA

AMOUNT GIVEN: Complete ML

TIME/DATE COMPLETED/INTERRUPTED: 25 May 03 11:00

REACTION: [X] NONE [ ] SUSPECTED

TEMPERATURE: 101.3 PULSE: 107 BLOOD PRESSURE: 120/60

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.)*

- [X] NO
- [ ] YES *(Specify)*

SEX: MALE

WARD: ICU#2

SECTION I—REQUIS

Comp

[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

MEDCOM - 15017

Medical Record Copy

518-124

MEDICAL RECORD

NSN 7540-00-634-4159

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.)*

- [x] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED 8JUN03

DATE AND HOUR REQUIRED 8JUN 03 ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)* DR. [redacted]

DIAGNOSIS OR OPERATIVE PROCEDURE Low Hgb + Hct

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 8JUN03

TIME VERIFIED 1430 / 8JUN03

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	CROSSMATCH
N/A	Compatable

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

REMARKS:

EXP DATE 10JUN03 b(6)-2

PREVIOUS RECORD CHECK:

- [ ] RECORD
- [x] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST [redacted]

DATE 8JUN03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)* [redacted]

AT *(Hour)* 1610 ON *(Date)* 8JUN03

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)* James A. Howell MAJ/AN

2nd VERIFIER *(Signature)* [redacted] SGT, USAMC

TEMP. 99.1 PULSE 94 BP 118/78

DATE OF TRANSFUSION 8JUN03

TIME STARTED 1620

POST-TRANSFUSION DATA

AMOUNT GIVEN 361 ML

TIME/DATE COMPLETED/INTERRUPTED 6/8/03 2000

REACTION

- [ ] NONE
- [ ] SUSPECTED

TEMPERATURE 99.1 PULSE 96 BLOOD PRESSURE 116/72

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]

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

SEX M

WARD ICU2

[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

MEDCOM - 15018

Medical Record Copy

518-124

NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

- [x] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of _____ units)*
- [ ] CRYOPRECIPITATE *(Pool of _____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* _____

VOLUME REQUESTED *(If applicable)* 1 UNIT ML

REMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*

- [x] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED 8JUN03

DATE AND HOUR REQUIRED 8JUN03 ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)* DR [redacted]

DIAGNOSIS OR OPERATIVE PROCEDURE Low Hgb & HCT

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]

8JUN03

TIME VERIFIED 1430 / 8Jun 03

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: Compatable

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

REMARKS: EXP DATE 10JUN03 b(6)-2

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

SIGNATURE OF PERSON PERFORMING TEST [redacted]

DATE 8JUN03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA b(6)-4

INSPECTED AND ISSUED BY *(Signature)* [redacted]

AT *(Hour)* 2010 ON *(Date)* 8 Jun 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] /AN

PRE-TRANSFUSION TEMP. 99.1 PULSE 96 BP 116/72

DATE OF TRANSFUSION 6/8/03 TIME STARTED ~~1620~~ 2015

POST-TRANSFUSION DATA

AMOUNT GIVEN ~~300~~ ML

TIME/DATE COMPLETED/INTERRUPTED 6/8/03 ~~2000~~ 2340

REACTION [x] NONE [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
100.1	100	119/72

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]

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

EPW # [redacted] b(6)-4

SEX Male WARD ICW2

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9 202-1

Medical Record Copy

NSN 7540-01-165-7294

b(6)-4

519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED	AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
#175 PORTABLE CXR AP PER MAJ [redacted]		M	[redacted]	ICW2	
	FILM NO.				PREGNANT ☐ YES ☒ NO
	REQUESTED BY (Print) [redacted]				TELEPHONE/PAGE NO.
	SIGN [redacted]			b(6)-2	DATE REQUESTED 5/16/05

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

Atelectasis vs. Pneumonia

↑ temp

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

RADIOLOGIC REPORT

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name — last, first, middle, Medical Facility)*

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

MEDCOM - 15020

REQUEST/REPORT ON

STANDARD FORM
Prescribed by GSA

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

#[redacted]

b(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER 5/14/03 TIME OF ORDER 0835 HOURS — LIST TIME ORDER NOTED AND SIGN

1. Dx: S/P Exploratory lap POP # 3
2. Vitals q 1° x 14, then q 2°
3. Foley to DD
4. activity ~~bedrest~~ T.C. OOB TID
5. allergy: NKMA
6. Diet: NPO
7. IV LR @ 150/hr

PATIENT IDENTIFICATION

#[redacted]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER HOURS

8. MSO4 1-5mg IV q 1° PRN pain
9. Toradol 15-30mg IV q 8° PRN pain
10. Unasyn 3gm IV q 6°
11. Gentamycin 500mg IV on arrival to floor
12. Gentamycin to be dosed daily per pharmacy calculation
13. Zantac 50mg IV q 8°

PATIENT IDENTIFICATION

#[redacted]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER HOURS

14. O2 2 liters NC ~~titrate~~ to off to keep Sat > 94%
15. Labs: CBC, lytes, BUN/Cr q day
16. Call MO T > 102.5, P > 125, U.O. < 30/hr.
17. Place abd. drain to DD. (Cell bag)

PATIENT IDENTIFICATION

#[redacted]

(178 lbs.)

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER

18. Ostomy appliance place [redacted] over ostomy. [redacted]

b(6)-2

19. Wet → Dry dressing TID to open wound [redacted]

24° VS GRWILLIAN 5/15/03 0700

[redacted]

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

Moved to 9th floor 1700 5/15/03 [redacted]

CLINICAL RECORD - DOCTOR'S ORDERS

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PATIENT IDENTIFICATION

#[redacted]

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS | LIST TIME ORDER NOTED AND SIGN

1. DC foley
2. Clear advance as tolerate to Reg.
3. ambulate TID.
4. If tolerate po Heplock IV
5. Cough & Deep Breath q 30 [redacted] CWA

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

Δ VS to q shift.

[redacted]

15 May 03 0900

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 15 May 02 | TIME OF ORDER b(6)-2 HOURS

1. Change Gentamicin 500mg QD IV [redacted] NOTED

Gentamicin 450mg QD IV.

(5-7mg/kg QD, Approx pt wt = 75 kg)

b(6)-2 [redacted] PharmD, MS

MAJ, MS

Chief Clinical Pharmacy

[redacted] PharmD.

NURSING UNIT | ROOM NO. | BED NO.

24a/Vs

SPC Seeley 16May03 0100

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 16 May 03 | TIME OF ORDER 0730 HOURS

CXR today.

V.D. Dr. [redacted] NOTED & Sent

b(6)-2 [redacted]

SPC [redacted]

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

CLINICAL RECORD - DOCTOR'S ORDERS

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PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT	ROOM NO.	BED NO.
		24

↓	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	16 MAY 03	2150 HOURS	
1	TYLENOL 650 mg PER RECTUM Q6° PRN T ≥ 101.5	b(6)-2	noted SPC [redacted] 0800 16 May 03
	[redacted]		
	[redacted]		
	2400 16 May 03 SPC [redacted]		9 WM4 b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	
	HOURS	

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	
	HOURS	

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	
	HOURS	

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

2700
800
50

CLINICAL RECORD - DOCTOR'S ORDERS

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PATIENT IDENTIFICATION

EPW# [redacted]

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER ____ HOURS | LIST TIME ORDER NOTED AND SIGN

1. Resume preop orders for Abx.
2. Diagnosis: Hartmans procedure, take down colostomy, Repair of abdominal defect.
3. Condition stable.
4. NPO
5. NG to LIS

PATIENT IDENTIFICATION

20 Feb 03
0300
20 May 03
0800

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER ____ HOURS

6. Foley to DD
7. VS q 1° x 4, then q 2° x 4, then q 4°
8. I/O
9. MSO4 2-5 mg IV q 1°
10. Toradol 30 mg IV q 8°
11. Resume Unasyn and Gentamicin as ordered previously
12. Zantac 50 mg IV q 8°

PATIENT IDENTIFICATION

[redacted]

b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER ____ HOURS

13. Call T>102, P>125 U.O. < 30/hr.

b(6)-2 [redacted]

PATIENT IDENTIFICATION

b(6)-2

24° VS [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER ____ HOURS

1. Δ VS to q 2° x 4 then as above
2. Δ MSO4 to q 1° prn

14. AN 5/18/03 0150 [redacted]

b(6)-2

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE US[redacted]

b(6)-2

CLINICAL RECORD - DOCTOR'S ORDERS

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PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT	ROOM NO.	BED NO.

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

1. NPO
2. Surgery today for abd wall Hernia Repair
3. IV LR @ 125/hr

b(6)-2 [redacted]

19 May 03 [redacted]

PATIENT IDENTIFICATION

DATE OF ORDER — TIME OF ORDER [redacted] — HOURS

1. IV LR @ 150/hr
2. Bolus 1 liter LR now
2. Pt may have clear chips

b(6)-2 [redacted]

18 May 03
0539
Parole from [redacted]

NURSING UNIT	ROOM NO.	BED NO.
24 V/S Ward		

5/19/03 0130

PATIENT IDENTIFICATION

[redacted]

b(6)-4

DATE OF ORDER — TIME OF ORDER — HOURS — [redacted]

19 May 03 0700

1. CBC today ✓
2. DC NG ✓
3. DC dressings to abd → dress s/p op
4. DC Foley ✓
5. ambulate ✓
6. Start ice chips, sips of clear [redacted]
7. Hard candy ad lib

NURSING UNIT	ROOM NO.	BED NO.
ICW #2		

PATIENT IDENTIFICATION

DATE OF ORDER — TIME OF ORD [redacted]

b(6)-2

NURSING UNIT	ROOM NO.	BED NO.
24 V/S		

20 May 03 0100

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

CLINICAL RECORD - DOCTOR'S ORDERS

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PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICW2	F	1

DATE OF ORDER | TIME OF ORDER ____ HOURS | LIST TIME ORDER NOTED AND SIGN

1. CBC, lytes, BUN, Cr this AM and q day x 3
2. Advance diet to Reg as tolera[redacted]
3. ↓ IV to 40/hr.

24°V/S 0100 21 May 03 [redacted]

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER | TIME OF ORDER ____ HOURS

1. Heplock IV b(6)-2
2. [redacted]

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER 21 May 03 | TIME OF ORDER 0500 HOURS

NPO

V.O. Dr. [redacted] b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER 5/21 | TIME OF ORDER 1525 HOURS

1. Sips of clear.
2. IV LR @ 120/hr
3. Clodoform gauze to abdominal wounds TID
4. Ambulate TID.

24° V/S 07B 1/4/1 [redacted] 5/21/03 2310. [redacted] 5/21/03

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

MEDCOM - 15026 b(6)-2 [redacted]

CLINICAL RECORD - DOCTOR'S ORDERS

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PATIENT IDENTIFICATION

[redacted]

b(6)-4

DATE OF ORDER 5/22/03 TIME OF ORDER 0730 HOURS

LIST TIME ORDER NOTED AND SIGN

Heplock IV.
Advance diet as tolerated
MJ will to [redacted] dsg Δ.
V.O. [redacted]

Noted [redacted]

NURSING UNIT ICW #2 | ROOM NO | BED NO

[redacted] b(6)-2

ICW, AN 22 May 03 0740

PATIENT IDENTIFICATION

DATE [redacted] TIME [redacted] ORDER

HOURS

① NPO ✓
② LR @ 120/hr ✓
③ Type & Cross for O-R today ✓

b(6)-2 [redacted]

NURSING UNIT | ROOM NO | BED NO

PATIENT IDENTIFICATION

DATE OF ORDER 22 MAY 03 TIME OF ORDER 2145 HOURS

① LR bolus 500 cc XT now
LR bolus 500 cc XT 1° ago.
↑ LR 150 cc/hr p̄ bolus.

[redacted]

Noted [redacted]

b(6)-2

NURSING UNIT | ROOM NO | BED NO

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER

HOURS

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1 APR 75 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED

CLINICAL RECORD - DOCTOR'S ORDERS

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PATIENT IDENTIFICATION

[redacted] b(6)-4

EPW

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 5/22 TIME OF ORDER: 1335 HOURS

Dx: S/P Exploratory lap, Transverse colectomy and colostomy c̄ I&D

Condition: Serious

Vitals q 10 x 4, then q 2° x 4, then q 4

F/O

Foley to DD

NG to LIS

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

Δ dressing PRN

IV LR @ 130/hr

+ Fentanyl gtt: titrate to pain free

+ Versed gtt. titrate to pt. comfort

Unasyn 3.0 gm IV q 6°

Gentamycin 450 mg IV q day

Zantac 50 mg IV q 8°

Vent. FIO2 50% TV 750; Rate 20; PEEP 5

b(6)-2

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

ABG, CBC on arrival to ICU

ABG, CBC, lytes, BUN/cr q AM

CXR on arrival to ICU and q AM

Call Ho if FiO2, P>120, U.O. <30/hr

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

b(6)-2 [redacted]

DATE OF ORDER: 22 MAY TIME OF ORDER: 1930 HOURS

(1) TYLENOL 650 mg PR Q4-6° PRN

T > 101.5°

b(6)-2 [redacted]

NOTED

2040

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

CLINICAL RECORD - DOCTOR'S ORDERS

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PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
NOTED [redacted] b(6)-2				23MAY	HOURS	
			①	Resume prevop Orders.		[redacted]
			②	JP's to wall Sxn. continuous la		
			③	Δ dressings starting tomorrow		[redacted]
				BID.		
NURSING UNIT	ROOM NO.	BED NO.				b(6)-2
				[redacted]		
				Chart CPT Ecg 20 0330		
PATIENT IDENTIFICATION				DATE OF ORDER	TIME [redacted]	
					HOURS	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
					HOURS	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
					HOURS	
NURSING UNIT	ROOM NO.	BED NO.				

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

CLINICAL RECORD - DOCTOR'S ORDERS

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PATIENT IDENTIFICATION

b(6)-4 [redacted] b(6)-2 [redacted]

NURSING UNIT	ROOM NO.	BED NO.

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	5/24	0730 HOURS	
1	CBC now - DCd		DONE [redacted]
2	1 unit pRBC now		DONE [redacted]
3	Cipro iv 400 mg q12°		
4	Pharmacy to adjust Gentamycin based on level [redacted]		

PATIENT IDENTIFICATION

b(6)-4 [redacted] b(6)-2 [redacted] 24 May 03 1418

NURSING UNIT	ROOM NO.	BED NO.
	b(6)-2	

	DATE OF ORDER	TIME OF ORDER	
	5/24	0950 HOURS	b(6)-2
1	Gentamicin 450mg IV QD to remain as p.r. - Done [redacted]		PharmD.
	b(6)-2 [redacted]		PharmD, MS
		MAJ, MS Chief, Clinical Pharmacy	

PATIENT IDENTIFICATION

b(6)-4 [redacted] noted [redacted] 24 May 03 1418 [redacted]

NURSING UNIT	ROOM NO.	BED NO.

	DATE OF ORDER	TIME OF ORDER	
	5/24	1400 HOURS	
1	DC Unasyn + Cipro IV Start Zosyn 3.375 gm Q6hr IV		
	b(6)-2 [redacted]		PharmD
			PharmD, MS
		MAJ, MS Chief, Clinical Pharmacy	

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

	DATE OF ORDER	TIME OF ORDER	
	24 May 03	0730 HOURS	
1	Transfuse 1 unit pRBC's over 4°		noted
			CPT
	b(6)-2		[redacted]
	[redacted]		0730
			21

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77. [redacted]

CLINICAL RECORD - DOCTOR'S ORDERS

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PATIENT IDENTIFICATION

CIV

25 MAY 03 0820 NOTED

[redacted]

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

NURSING UNIT	ROOM NO.	BED NO.

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

T.C.

1. [redacted] unit of pRBC now DONE [redacted]
2. NS c̄ 20 meq KCl @ 100/h [redacted]
3. Lovenox 30 mg SQ q12 [redacted]

b(6)-2 [redacted]

PATIENT IDENTIFICATION

25 MAY 03

b(6)-2 [redacted]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER — TIME OF ORDER — HOURS

25 MAY 03 1445

VO FROM DR. CARMUDY, T. — MD

MUCOMYST 20% Q 4° 2cc c̄ .5 NS NEBULIZED [redacted]

CXR NOW

b(6)-2 [redacted]

PATIENT IDENTIFICATION

25 MAY 03 NOTED

[redacted]

b(6)-2

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER — TIME OF ORDER — HOURS

25 MAY 03 1545

↑ PEEP TO 8 VO FROM DR. CARMUDY

~~650MG TYLENOL PR~~ ERROR [redacted]

b(6)-2 [redacted]

PATIENT IDENTIFICATION

[redacted]

25 MAY 03 NOTED

[redacted]

b(6)-2

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER — TIME OF ORDER — HOURS

5/25 1635

Propofol gtt @ 30 µg/kg/min titrate to sedative effect. [redacted] MD

b(6)-2 [redacted]

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE [redacted]

AL RECORD - DOCTOR'S ORDERS

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PATIENT IDENTIFICATION

b(6)-4 [redacted]

26 MAY 03 NOTED [redacted]

NURSING UNIT: ICU | ROOM NO. [redacted] | BED NO. b(6)-2

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

① Ampicillin 500 mg IV q 6°

b(6)-2

[redacted]

PATIENT IDENTIFICATION

b(6) 26 MAY 03 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

b(6)-2 1605

① VO FROM DR [redacted] 1 LITER @ 1345 OVER 30 MINUTES — [redacted]

② VO FROM DR [redacted] 1 LITER OVER 30 MINUTES — [redacted] 1605

b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

26-MAY-03 1900

(1) V.O. from Dr [redacted] 500cc NS Bolus IV

(2) CBC Now b(6)-2

26 MAY 03

DONE @ 1900 [redacted]

b(6)-2

PATIENT IDENTIFICATION

b(6)-4 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

26 MAY 03 1930

① DOPAMINE 5# - INFUSE at 3 mcg/kg/min titr to keep MAP 65.

b(6)-2

Noted [redacted] @ 1930

[redacted] MD

[redacted] AJ, MC USA CHIEF, DOS

[redacted]

FORM 4256 APR 79 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE [redacted]

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

b(6)

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER 5/27 TIME OF ORDER 12N HOURS — LIST TIME ORDER NOTED AND SIGN

(1) S/p Bay Remnant

(2) Resume previous orders, RN [redacted]

(3) Dressing: Wet → Dry with Kerlix 142c Superfoange and ABD [redacted]

(4) O/2 [redacted] b(6)-2

24hr [redacted] .wp

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER 0400 TIME OF ORDER b(6)-2 HOURS — 28 May [redacted]

(1) Wean propofol & let awake. and begin to wean ventilator

(2) Start TF Jevity @ 20 cc an hour + NR.
Check residuals q 4°, hold for >100 cc

(3) Keep HOB @ 30°↑ [redacted] ✓ Chart [redacted] 0430 24 May

PATIENT IDENTIFICATION

b(6)-4 [redacted] 29 May 03 NOTED [redacted]

b(6)-2

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER [redacted] TIME OF [redacted] b(6)-2 1230 [redacted]

(1) TYLENOL 650MG NGT FOR FEVER >101.5 [redacted]

(2) TYLENOL PR D/C [redacted]

b(6)-2

✓ Chart [redacted] 0430

PATIENT IDENTIFICATION

b(6)-4 [redacted] 30 May 03 NOTED [redacted]

ING UNIT	ROOM NO.	BED NO.

DATE OF ORDER 30 May 03 1400 HOURS

(1) Phenergan 12.5-25 IV q 4° [redacted] b(6)-2 NOTED

[redacted]

b(6)-2

RM R 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

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

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

DATE OF ORDER: 5/30 | TIME OF ORDER: 1600 HOURS | LIST TIME ORDER NOTED AND SIGN

(1) Reg diet

(2) Tang as tolerated

b(4)-2 [redacted]

[redacted] b(4)-2 [redacted]

✓ Chart [redacted] RV 0234

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

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

DATE OF ORDER: 5/31 | TIME OF ORDER: 2150 HOURS

V.O. MSO4 2-4mg IVP @ A each dressing Δ PRN PN

b(4)-2

V.O. Dr [redacted]

2400 CPT [redacted] JWN 0430

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

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

DATE OF ORDER | TIME OF ORDER | HOURS

(1) Transfer to ward

(2) Condition stable

(3) Vitals q 4°

(4) I/O

(5) Activity: ambulate c assistance TID

b(6)-2

(6) PT consult for above (strength & conditioning) 6/1/07

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

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

DATE OF ORDER | TIME OF ORDER | HOURS

(7) Nutrition consult to see today.

(8) Calorie count.

(9) Diet: Reg c TTT can Ensure (+) (one b/w meals)

(10) IV LR @ 50/hr c additional 20 meq KCl per bag.

(11) Toradol 30mg IV q 6° prn (priority)

(12) MSO4 2-4mg IV q 10 prn

Cont...

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

b(4)-2 [redacted]

CAL RECORD - DOCTOR'S ORDERS

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PATIENT IDENTIFICATION

b(6)-4 [redacted]

31 MAY 03 NOTED [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 31 MAY 03 TIME OF ORDER: 0550 HOURS

40 MEQ K+ IN 100 CC NS OVER 4° VO FROM DR. DIXON [redacted]

b(6)-2 [redacted]

LIST TIME ORDER NOTED AND SIGN

b(6)-2

PATIENT IDENTIFICATION

b(6)-4 [redacted]

b(6)-2

31 MAY 03 NOTED [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

b(6)-2

1. Ensure (+) b/w meals TID and ~~TIII~~ can/day. [redacted]
2. Wrap binder on abdomen and up to chair TID. [redacted]
3. DC ABG [redacted]

PATIENT IDENTIFICATION

b(6)-4 [redacted]

DATE OF ORDER | TIME OF ORDER | HOURS

4. Δ VS to q 4° [redacted]
5. DC FOLEY [redacted]

b(6)-2 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

b(6)-4 [redacted]

31 MAY 03 NOTED [redacted]

NURSING UNIT | ROOM NO. | BED NO. b(6)-2

DATE OF ORDER: 31 MAY 03 TIME OF ORDER: 1500 HOURS

1. V.O. FROM DR. b(6)-2 [redacted] ~~D/C FENTANYL~~ ~~D/C FOLEY TOMOR~~

START PERCOCET T-II TABS Q 4-6°. [redacted]

b(6)-2

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

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

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

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

13. Percocet 1-2 po q 4-6° prn pain.
14. Tylenol 1-2 po q 4-6 prn Temp > 101.5 (do not combine c Percocet)
15. Gentamycin 450mg IV q day
16. Zosyn 3.375 IV q 6°
17. Ampicillin 500 IV q 6°

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

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

DATE OF ORDER | TIME OF ORDER | HOURS

18. Zantac 150 mg po q 12°
19. Lovenox 30 mg SQ BID
20. O2 NC 2-4L prn Sat < 90%. Call MD if need > 4L.
21. CBC, lytes, BUN/Cr q day x 3
22. Δ Dressings to abd wet → dry BID
23. Δ Ostomy Bag prn.

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

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

DATE OF ORDER | TIME OF ORDER | HOURS

24. ACE WRAP abd circumferentially to abdomen over dressing & bag before getting out of bed TID. b(6)-2 [redacted]

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

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

DATE OF ORDER | TIME OF ORDER | HOURS

1. NPO ~~p~~ Midnight
2. IV LR @ 125/hr ~~p~~ NPO.
   → c 20 meq KCl added

b(6)-2 noted 0030 [redacted]

b(6)-2 [redacted]

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

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE [redacted]

CLINICAL RECORD - DOCTOR'S ORDERS

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b(6)-2

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

NURSING UNIT	ROOM NO.	BED NO.
ICW2		13

DATE OF ORDER: 6/2/03 TIME OF ORDER: 2355 V.O. Dr. [redacted]

2mg MSO4 IVP x1 now [redacted]

LIST TIME ORDER NOTED AND SIGN

PATIENT IDENTIFICATION: # [redacted]

DATE OF ORDER: 6/3 TIME OF ORDER: 0930 HOURS

6/3 G.S.

① Resume preop orders

② Dressing Δ's TID to abdomen

24°VS GRAM 10 TAN 6/5/03 0045

b(6)-2

[redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICW2		13

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

DATE OF ORDER: 5 Jun 03 TIME OF ORDER: 0915 H

① NS + heparin bolus

b(6)-2

[redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICW2		

PATIENT IDENTIFICATION: # [redacted]

DATE OF ORDER: 5 JUN 03 2045 HOURS

① D/C Zantac [redacted] b(6)-2

b(6)-2

NURSING UNIT	ROOM NO.	BED
ICW2	24°VS G	[redacted]

[redacted] noted 5 Jun 03 0217

FORM 1 APR 79 4256 REPLACES EDITION OF ... D.

MEDCOM - 15037

CLINICAL RECORD - DOCTOR'S ORDERS

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

PATIENT IDENTIFICATION	NURSING UNIT	ROOM NO.	BED NO.	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
# [redacted] b(6)-4	ICW2			6 Jun 03	0900 HOURS	
				Zantac 150mg PO bid		
				[redacted]		
				[redacted]		b(6)-2

PATIENT IDENTIFICATION	NURSING UNIT	ROOM NO.	BED NO.	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
# [redacted]	ICW2	24 Vs	2000	7 Jun 03	1000 HOURS	
				① CBC tomorrow AM.		
				UA ~~tomorrow~~ today.		
				CBC PA HAT today		
				[redacted]		
				[redacted]		b(6)-2

PATIENT IDENTIFICATION	NURSING UNIT	ROOM NO.	BED NO.	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
# [redacted]	ICW2			7 Jun 03	1430 HOURS	
				① Transfuse 2u PRBC		
				Premed with 650 mg Tylenol done 1500		
				✓ CBC 2hrs post Tx		
				[redacted]		
				[redacted]		b(6)-2

PATIENT IDENTIFICATION	NURSING UNIT	ROOM NO.	BED NO.	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
# [redacted]				8 Jun 03	1515 HOURS	
				① D/c Ampicillin, Gentamycin		
				And Zosyn		
				② CBC Chem 8 and Chem 12		
				today		
				Δ Activity R: OOB → Sign BID		
	24 Vs	0100		08 Jun 03		
				[redacted]		
				[redacted]		b(6)-2

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

MEDCOM - 15038

CLINICAL RECORD - DOCTOR'S ORDERS

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

PATIENT IDENTIFICATION			DATE OF ORDER / TIME OF ORDER / HOURS	LIST TIME ORDER NOTED AND SIGN
EPW # [redacted] b(6)-4			9 Jun 03 1525	
			① CBC in Am b(6)-2	
			② vitals QS	
			③ DIC IBO[illegible] [redacted]	noted [redacted]
NURSING UNIT	ROOM NO.	BED NO.		1325
ICW2		12	24 V done [redacted]	
PATIENT IDENTIFICATION			DATE OF ORDER / HOURS	
EPW # [redacted] b(6)-4			14 June 03 1020	b(6)-2
			clotrimazole cream to back rash BID → qid, please try & keep it off back during time of use.	
NURSING UNIT	ROOM NO.	BED NO.	noted 14 Jun 03 1145 [redacted]	b(6)-2
ICW2		12	[redacted] not MC.	
PATIENT IDENTIFICATION			DATE OF ORDER / TIME OF ORDER / HOURS	
EPW # [redacted] b(6)-4			If no clotrimazole any antifungal cream will do.	
			b(6)-2	
24°V's GRAM 1STAN			[redacted] 6-19 03 0100	
NURSING UNIT	ROOM NO.	BED NO.		
ICW2		12		
PATIENT IDENTIFICATION			DATE OF ORDER / TIME OF ORDER / HOURS	
EPW # [redacted] b(6)-4			16 Jun 03 0715	
			noted 16 Jun 03 0745 Benadryl 25-50mg PO q 6° PRN itch	
			b(6)-2 [redacted]	b(6)-2
NURSING UNIT	ROOM NO.	BED NO.		
ICW2		12	24°V done [redacted]	

FORM 1 APR 79 4256 REPLACES EDITION OF ... ED.

b(6)-2

CLINICAL RECORD - DOCTOR'S ORDERS

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

NURSING UNIT: ICW 2 | ROOM NO.: Pt care 0324 | BED NO.:

DATE OF ORDER: 16 JUNE 03 | TIME OF ORDER: 0930 HOURS

CBC, CMP in AM 17 JUNE 03 b(4)-2

[redacted]

[redacted] b(4)-2

LIST TIME ORDER NOTED AND SIGN: 16 June 0942 [redacted]

2300 16 Jun 03

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

NURSING UNIT: ICW 2 | ROOM NO.: 15 | BED NO.:

DATE OF ORDER: 16 JUN | TIME OF ORDER: 00:30 HOURS

V.O.

Hydrocortisone 1% creme apply topically to effected area t.i.d. b(4)-2

[redacted]

noted 16 Jun 00:30 [redacted]

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

NURSING UNIT: ICW | ROOM NO.: 15 | BED NO.:

DATE OF ORDER: 19 Jun 03 | TIME OF ORDER: 0145 HOURS

V.O.

Ambien 10 mg PO PRN

b(4)-2 Dr [redacted]

noted 0145 [redacted]

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

NURSING UNIT: ICW | ROOM NO.: 15 | BED NO.:

DATE OF O[redacted] | 1910 HOURS

Pt may ambulate b(4)-2

[redacted] b(4)-2

b(4)-2

2300 20 June 03 [redacted]

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