b(4)-2

All

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATMENT
Medium	small area to sacrum c̄ scant amt. bloody drainage. appears like an abrasion. ~~Covered c̄~~ cleansed c̄ sterile [redacted] 200/AN
	NS and DSD applied. Will mon [redacted]
T.S. 20530 Aug 03	NURSING ASSESSMENT: Assumed pt care. AAOx3. Among, stat, breathing easy and unlabored, LS CTA (B). Abd soft, nontender, ↑ distended, BS(+)x4. Urinates perfully, amber urine. Foley and removable intact to (B) LE. PROM only and voluntarily intact to (B) LE. Pt continues to have no sensory or motor function to (B) LE. Drsg to sacral region has scant amount of serosanguinous [redacted] dry. Ø IV access.
14 Aug 03 1400	assumed pt care @ 1300. Temp 101.4, pt given ⅰⅰ Tylenol 650mg per prn order. Lungs CTA, abd soft, nontender BS(+)x4. Foley cath intact draining golden yellow urine. Vert pulses (+). Vert c̄ from (+) pulses. (-) IV access noted. Drsing to upper back CDI. Drsing to sacrum c̄ sm amt of pinkish red drainage noted. (-) active bleeding noted, drsing A/D. (-) complaints voiced. Pt turned on (R) side. Will cont to [redacted] alum monitor
14 Aug 03 21:41	Rec'd c/o pt @ 21:00. Awake and alert in bed. Lying on (L) side. VS WNL x ↑ temp. 100.8 ⅰⅰ Tylenol given. Skin W/D. Pupils (-) pupil slightly larger than (R). Lungs wheezing and rhonchi expiratory + inspiratory (B) throughout lobes. Pro cough. Whitish sputum noted. Dr. [redacted] aware. Order obta for PT and Robitussin. BS(+)x4. Foley cath intact draini amber colored urine. (+) PP (B) @ 2. C/O pain to ↑ (L) shoulder [redacted] DET/AN
	Will cont. to mon. [redacted]

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b(6)-2 A1,

NSN 7540-00-634-4176 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
14AUG03 2220	Rt note: Pt awake, breathing even + unlabored. Pre tx HR 86, RR 18, SPO_2 99% on RA. UD Alb given via HHN. Post tx HR 82, RR 20, SPO_2 100% on RA. BBS slight wheezing exp. otherwise diminished. Pt tol tx well. Ø cough. Will continue to monitor — Sgt [redacted] 91V20
14Aug03 2230	Rt temp 99.9 @ 2230 — [redacted]
15Aug03 0208	Pt. given Robitussin @ 21:50 coughing ceased. T-max for shift 100.9°. Temp @ 0200 99.1°. FTG draining Amber colored urine. 200cc @ 0200 noted. Encouraged pt to drink fluids. Will mon [redacted] /AW
15Aug 0233	RT NOTE: Eval pt to start Q4 RT schedule BBS clear Pt is Quad. pt doesn't appear to have any difficulty Breathing Will Start Nebs at 0330 — SGT [redacted]
15Aug 0338	Pre Tx HR 69 SPO2 99% on RA RR 16 BBS clear UD Alb tx given. Pt Able to cough during tx. Post tx HR 100 SPO2 100% on RA BBS clear — SGT [redacted] 91V20
15Aug03	1230 - Pt alert & oriented lying on (R) side of body. Turned Q2° + ROM Q4°. VSS, temp 101° this AM. Tylenol given, temp now 98°. Stage II ulcer to sacral area. Duoderm placed over area. Foley intact. Voiding ø complaints. Will cont to monitor — [redacted]

b(6)-2

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

[redacted]

b(6)-4

RECORDS MAINTAINED AT:

PATIENT'S NAME *(Last, First, Middle initial)* ICW2 | SEX

RELATIONSHIP TO SPONSOR | STATUS | RANK/GRADE

SPONSOR'S NAME | ORGANIZATION

DEPART./SERVICE | SSN/IDENTIFICATION NO. | DATE OF BIRTH

b(6)-2

A 11

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
15 Aug 03 1310	assumed pt care @ 1300. pt resting quietly easily aroused to verbal stimuli. VSS temp 98.6. pt turned on (L) side. airway patent, lungs CTA abd soft flat nontender BS(+) x4, foley cath intact draining C/U 3 diff. ↓ ext c̄ (+) pulses. ↑ ext c̄ full ROM (+) pulses. (-) IV access. Stage II ulcer to sacrum area c̄ duoderm, (-) drainage noted. (-) complaints voiced @ this time. Will cont to monitor [redacted] 91WM6 [redacted] 91W
1630	temp 101.2, pt given ⅓ Tylenol. will recheck temp. [redacted] 91W
1700	notified RT of neb tx, RT aware but no one had come yet. Talked c̄ SGT [redacted] @ 2~~0~~ 1945, she stated "I will be there @ 2000". [redacted] 91WM6
2020 15 Aug 03	RT note: Pt breathing even + unlabored. Pre tx HR 88, SPO2 98 on RA RR 16. BBS CTA. Pt states he coughed earlier thru translator UD AIB neb given via HHN. Post HR 104, RR 18, SPO2 99 on Pt tol tx well. IS done. Sgt [redacted] 91V
~~15 Aug 03 21:15~~	~~Rec'd c/o pt @ 21:00. VS WNL per flowsheet. Awake and alert lying on (R) side. Repositioned to supine pos. Pupils equal.~~ [redacted] see below
15 Aug 03 2341	RT note: Pt's breathing even + unlabored. BBS CTA. Pre tx HR 86, RR 16 SPO2 99% on RA. UD AIB given via HHN. Post tx HR 99, RR 20. SPO2 99% on RA. Pt has no c/o SOB a dyspnea. Sgt [redacted]
late entry 15 Aug 03 21:15	Rec'd c/o pt @ 21:00. VS WNL per flowsheet. Awake and alert in bed lying on (R) side. Repositioned to supine pos. Pupils (-) larger than right. Dr [redacted] aware. LCA (-). (+) BS x 4 (+) PPB. FTG intact draining yellow urine. DSG to ML post GSW's L/d. Wounds healing c̄ S/S infection. DSD applied. c/o pain. ⅓ Percocet given. c̄ further c/o will cont to mon. [redacted]

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b(4)-2 All

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
0309	Duoderm intact to pt. sacrum. temp @ 98.4. Will mon. [redacted]
0347 16 Aug 03	RT NOTE: Pt refused Neb tx. Listen to pt lungs BBS CTA Informed nurse that pt refused tx ——— SGT [redacted] RT 91U20
0743 16 Aug 03	Pre Tx HR 90 RR 14 SPO2 99% on RA. BBS CTA UD Alb tx given Post Tx HR 100 RR 16 SPO2 99% BBS CTA. Please have Doctor Re Eval for Neb Tx ——— Sgt [redacted] RT
16 Aug 03	0920 - Pt alert & oriented lying on (R) side of body. Duoderm to sacral area. 1x2 to wound on upper back, wound almost closed, ~~[illegible]~~ small amount of drainage on old dsg. Foley intact. UBS, temp 99.7, lungs CTA, HR reg, BS(+), pulses (+)x4. Voicing Ø complaints. Will cont to monitor ——— [redacted]
16 Aug 03 1320	Pt care assumed @ 1300. pt turned prior to report being given. pt awake et alert. temp 99.2. lungs CTA, abd soft, nontender, nondistented BS(+). Foley cath intact draining CYU 3 diff. ↓ext c̄ (+) ROM (+) pulses. ↑ ext c̄ full ROM (+) pulse. dressing to ↑ back CDI. Duoderm to Stage II ulcer in sacrum area intact. (+) complaints voiced @ this time. Will cont to monitor ——— [redacted] 91WMC

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

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

[redacted] b(4)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
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Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

b(4)-2 All

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
16 Aug 03 1930	Pt awake, breathing even + unlabored. Pre tx HR 94, RR 16, SPO_2 100% on RA. BBS CTA. UD Alb neb via HHN given. Post tx HR 96, RR 20, SPO_2 99 on RA. IS Done —— Sgt [redacted] 91WM
16Aug03 21:20	Rec'd c/o pt @ 21:00. VS w/r. ↑ temp 99.5 ⅊ Tylenol given + blanket removed. Skin ↑ warm to touch/dry. Awake and alert in bed. PERRLA - (L) pupil larger than (R), reactive to light. LCA (B). HRR S1S2. ~~BS(B)x2~~ Evrcem BS(B)x4. FTG draining CYU. (+) PP(B). Repositioned to (R) side from supine. DSG to mi back ⊿d. Wound healing c̄ scant amt. old blood & odor. Applied DSD. ⊘ c/o pain @ this time. [redacted] 2LT/AN
01:22	Pt c̄ of ~~pain shooting~~ Pt c/o pain radiating from neck to arms. ⅊ Percocet given for pain will mon. Pt c/o feeling dizzy. BP 110/60. Asymptomatic. ↑ HOB 30°. Will mon [redacted] 2LT/AN
170530 Aug 03	Nurs. Note Assessment: Assumed pt care AAOx3. Among which, breathing even and unlabored, LS CTA (B). Abd soft, nontender, ↓ distention. BS(+)x4. Voids partially to gravity, urinate c̄ some sediment. No nausea. Flatus and movement bowels which to (B) UE. (B) LE lack motor and sensory sensation. Flatus to (B) LE. ⊘ IV access. Stage II/III ulcer to sacral region c̄ duoderm dsg. ~~applied~~ Duoderm dsg loose. —— [redacted]
170700 Aug 03	Nurs. Note: Pt had bowel of mucus c̄ 200 cc emesis. This caused ⅊ gritty taste & cramps. Vomiting pill was emitted but some food particles were. Pt states that he was not hungry today & did not eat breakfast. BS(+)x4 still but a little higher pitched than before. —— [redacted]
17Aug03 1315	assumed pt care @ 1300. VSS. temp 100.5 pt given ⅊ Tylenol. pt lying on back, turned to (L) side. lungs CTA: abd soft nontender BS(+)x4. foley cath intact. BLE c̄ (+) pulses. BUE c̄ full ROM (+) pulses. drsing to upper back CDI. Stage two ulcer to sacrum area c̄ duoderm covered by a 4x4 gauze. (-) c/o pain voiced. Will cont to monitor [redacted] 91WM

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
17 Aug 03 2028	RT note: Pt resting. BBS CTA HR 84, RR 16, SPO_2 on RA 98%. uo ALB via HHN given. Post tx HR 91, RR 18, SPO_2 98 on RA. BBS CTA. IS done c̄ ease. Recommend stop tx ——— Sgt [redacted] 91V20
17 Aug 03 2030	temp 100.5 pt given ⅲ Tylenol. Will cont to monitor ——— [redacted] 91WM6
17 Aug 03 21:29	Recd clo pt @ 21:00. Awake and alert on ⓓ side. Positioned pt to supine/semifowler's, Skin w/D/I. Pupils - OD smaller than OS reactive to light. ⊗ apparent MS Δ's. LCA ⓑ HRRS, S_2 WNL BS ⓑ x4. FTG intact/patent draining CHU. ⓓ PP ⓑ. Pt. c/o pain in arms. ⅲ Tylenol were given @ 20:30. Will cont to mon [redacted] DLT/AD ———
0555	Pt c/o pain to mid ↑ back upon log roll ⅰ Percocet given will mon [redacted] DLT/AD ———
18 Aug 03	1200 - Pt alert & oriented lying in bed. VSS, Lungs CTA HR reg, BS ⓑ, pulses ⓑ x4. Duoderm D/C to sacrum Foley intact. One open ~~bone~~ even on wounds remains on upper back area. Small amount of drainage on old dsg, 2x2 applied ROM completed, Am Care done. Rolled Q2. Voiding ⊗ complaints. Will cont to monitor ——— [redacted]

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. 2CW2

EPW

[redacted] b(u)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
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b(6)-2 All

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
18Aug03 2000	pt. rolled q2°, ROM x1 this Shift - duoderm intact on sacrum - foley to gravity - tol. regular diet - ⊕ BS - lungs c̄ slight crackles cleared c̄ coughing - VSS - [redacted] CR
2211	Pt. care assumed @ 2100. VSS. HR Reg, lungs CTA, BS⊕ XY. Foley → gravity c̄ cyu. Dsng Δ'd to back, dsng CDI. Pt. c̄ ∅ complaints @ this time. Will cont. to monitor — [redacted] /CTAhv
19Aug03	1200 - Pt alert & oriented lying on backside now. Rolled Q2°. VSS, temp 100.5, Tylenol given. Lungs CTA, HR reg, BS⊕, pulses⊕ x 4. Duoderm Δ'd to sacrum area. Foley intact. ROM done. Will cont to monitor — [redacted]
19Aug03 1320	pt care assumed from previous shift @ 1300. VSS temp. 99.9. pt just given Tylenol @ 1200. pt turn to (L) side. lungs CTA, abd soft nontender BS⊕ x4 quads. pulses⊕ x4. dressing to back CDI. duoderm to sacrum intact. foley cath intact draining cyu ⅓ diff. ∅ c/o pain voiced @ this time. Will cont to monitor — [redacted] 91WM
19Aug03 20:03	Rec'd c/o pt @ 21:00. VS WNL per flow sheet. Awake and alert in bed. Skin W/D/I. LCA ⊕ HLL S1 S2. BS⊕ x4. ABD soft to palpation. FTG intact / patent draining CYU. ∅ c/o pain @ this time. DSG to Mid ↑ back C/D/I. Will Δ next log roll @ ~~1223~~ 2100:00. Duoderm to sacrum intact c̄ 4x4 dsg over top. Will cont to mon [redacted] /AD
0123	c/o pain in arms ti percerd gion will mon [redacted] /AD

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DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
20 Aug 03	1200 - Pt alert & oriented. VSS, afebrile, lungs CTA HR reg, BS⊕, pulses ⊕x4. Pt on stomach for 2°. Wound to sacrum, open to air now. Will apply duoderm. Foley intact. Voiding Ø complaints. ROM done. Will cont. to monitor b(6)-2 [redacted] 2L+AN
20 Aug 03 1400	pt care assumed @ 1300. pt lying on stomach, awake & alert. pt turned to (R) side: lungs CTA and soft BS⊕. foley cath intact, pulses ⊕x4. wound to upper back OTA, healing s/sx of infection. Stag II ulcer to sacrum OTA @ this time. Ø complaints voiced. Will cont to monitor b(6)-2 [redacted] 9 1WMC
20 Aug 03 21:39	Rec'd c/o pt @ 21:00. VS WNL per flowsheet. Awake and alert in bed & lying on (L) side. Repositioned to supine skin W/DI x sacrum c duoderm & gauze dsg c/DI and mid & back wounds OTA. PERRLA⊕ WNL. LCA⊕. HRRS/S2. BS⊕x4 hyperactive ABD soft/non-tender. FTG intact/patent draining CVL. ⊕ c/o pain to (R) LE's. Elavil given @ 22:00. Will cont to mon.
b(6)-2	[redacted] 02IT/AN

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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. JCW2

[redacted] b(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
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FIRMR (41 CFR) 201-9.202-1

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
21 AUG 03 @	1100 — Assumed care of pt. transfer from ICU #2 to ICW #1 A+O x 3 VSS pt. paraplegia (B) LE. Wound to upper back 2x2 dressing Δ. Breakdown of sacrum duoderm dressing Δ. (Lungs CTA HRRR S1 S2 present. c/o pain medicated) Will cont to monitor b(6)-2 [redacted]
21 AUG 03 1930	Pt A+Ox3, VSS, LS CTA (B), (+) BS x4 quads, S1 S2 present, skin warm + dry, cap ref <3sec. peripheral pulses palpable, Δ position q2h, dsg on sacrum CDI, Ø c/o pain, GSW on Upper back healing well open to air, abd. soft flat nontender, urinating well. b(6)-2 [redacted] 91WM6
21 AUG 03 2110	Pt c/o pain, adm pain med. [redacted] 91WM6 b(6)-2
2300	- I concur c above assessment [redacted]
22 Aug 03 @ 0730	— Assumed care of pt. awake A+O x 3 VSS. denies c/o pain or discomfort @ this time. Lungs CTA bilat HRRR S1 S2 present. Active BS x 4 quads. Breakdown on sacrum dressing Δ'd c duoderm CDI. Wound to upper back dressing Δ'd CDI will cont to monitor b(6)-2 [redacted] 91WM6
22 AUG 03	Pt A+Ox3, VSS, LSCTA (B), (+) BS x4 quads, Dsg on lower back c some drainage noted, c/o pain and requested med, will adm II percocet. b(6)-2 [redacted] 91WM6
2300	I concur c above assessment [redacted]

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
23 Aug 03	@ 0700 – Assumed care of pt. awake A+O x3. VSS. AM + Foley care complete this AM. Dressing Δ to sacrum done. Wound to upper back open to air Ø drainage Lungs CTA. H.&R.R. S1S2 present. Active BS. Tolerating PO. Well. Will cont to monitor b(6)-2 [redacted] gwmc
23 Aug 03 1123	I concur c the above assessment b(6)-2 [redacted]
23 AUG 03 1950	Pt awake, A+Ox3, VSS, LS CTA (B), (+) BS x4, foley to gravity, voiding proper amount of urine yellow, clear, Ø odor or sediment, Dsg on lower back CDI, Ø drainage, S1 S2 present, skin warm + dry, c/o pain on back and Headache, adm meds as per orders, ROM on LE x2, Δ position q2h. b(6)-2 [redacted] gwmc
@2300	I concur c above assessment. [redacted]
24 Aug 03 @ 0800	– Assumed care A+Ox3 condition stable. Lungs CTA S1S2 present H&RR Active BS Tolerating PO well. Foley to gravity draining AS clear yellow urine. Foley and AM care complete. Dressing to sacrum CDI. Upper back GSW open to air. Will cont to monitor b(6)-2 [redacted] mg.

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b(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

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DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
24 Aug 03	Pt received awake in bed. A&O x3. PERRLA(+), Rt pupil 3mm in size. LS CTA ~~B~~ through out. S1 S2 Present, +NDRR, +BS, Denies Pain N/V. Will continue to monitor.
25 Aug 03 0750	Pt received sleeping, awoke spontaneously alert. S1 S2 noted c̄ (+) peripheral pulses, lungs CTA bilat, (+) bowel sounds, foley to gravity draining yellow urine c̄ sediment. Will cont. to monitor. b(6)-2 [redacted]
25 AUG 03 1935 ~~1(+) 2035~~	~~Concur c̄ the above assesment~~ [redacted] b(6)-2
	Pt AtOx3, LS CTA(B), (+) BS x4, S1 [redacted] present, skin warm + dry, Foley to gravity, clear yellow urine, ROM LE x2, position Δ q2h, medicated for pain. b(6)-2 [redacted]
26 Aug 03 0745	Pt received sleeping, awoke spontaneously alert, S1 S2 no[redacted] (+) peripheral pulses, lungs CTA bilat, (+) bowel sounds, foley to gravity draining yellow urine c̄ sediment. Will cont. to monitor. [redacted]
26 Aug 03 1000	I concur c̄ above assessment. Sensitivity & circulation intact to all extremities. b(6)-2 [redacted]
26 AUG 03 1940	Pt AtOx3, VSS, LS CTA(B), (+) B[redacted], S1 S2 present, foley draining clear yellow urine, dsg Δ on lower back, BM formed small, bed bath given to pt, ROM on LE x2, Δ position q2h, assessed for circulation + skin break down on points of restraint. [redacted] b(6)-2

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
26AUG03	Neurosurgery Discharge
1455	History: EPW who suffered paraplegia after multiple shrapnel wounds to the upper thoracic spine.
	Hospital Course: Pt was admitted to ICU. Spine images showed a stable fracture pattern, so no bracing was required. A lumbar drain was placed until a spinal fluid leak resolved. He was treated with routine paraplegia care including Foley catheter and bowel program for neurogenic bladder/bowel, frequent turns (q2°) to prevent bed sores, and assistance with activities of daily living.
	Disposition: Static paraplegic will require assistance to perform activities of daily living. Foley catheter to be changed monthly.
	Medications: Colace 100 mg po BID.
	Percocet 1-2 po q4° pm
	Bisacodyl suppository q D pm constipation.
	b(6)-2 [redacted] MC
	Neurosurgery Service
	[redacted] (b)(2)-2
	Baghdad

HOSPITAL OR MEDICAL FACILITY		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
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MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
27Aug03 1400	Received pt resting in bed, VSS, alert, + speaks arabic. LSCTAB, MAE, BSOX4, Small amt feces cleaned during am care. Pt turned q2°, sacral decub dsg N'd. Restraints in place. Will cont to monitor. [redacted]
27AUG03 1845	Pt A+Ox3, VSS, LSCTA(B), (+)BSX4, foley draining c/y urine, dsg sacral decub CDI, assessed for proper circulation + skin breakdown on point of restraint. [redacted] 91WM6
27AUG03 2150	Adm. pt a supository @ 2015 but had Ø BM, N'd dsg on sacral area. [redacted] 91WM6
28Aug03 1100	Received pt resting in bed, VSS, Alert + oriented, Foley draining clr yellow urine, sacral decub dsg N'd, no changes noted in decub from yesterday. Three small liquidy BMs this shift. Turned q2°. Restraints in place, checks for circulation + skin integrity done, intact. No c/o pain at this time. No remarkable assessment findings @ this time. Will cont to monitor. [redacted]
28Aug03 1900	Assumed care @1800; VSS, pt A&O [redacted] speaking only Arabic; SS2, LSCTA(B);

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DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
	(cont.) ⊕BSX4, foley to gravity draining QS clear yellow urine; Ø c/o pain or discomfort @ this time; dsg to sacral area CDI ∃ drainage; pt turned Q2°; restraints in place, circulation & skin int egrity intact, Cont to monitor b(6)-2 [redacted]
28 Aug 03 0810 b(6)-2	Pt received awake & alert, S1, S2 noted ⊕ peripheral pulses, restraint in place, lungs CTA bilat, ⊕ bowel sounds, foley to gravity draining clear yellow urine, sacral dsg CDI & d'd. will cont to monitor [redacted]
29 Aug 03 @ 2200	Assumed care @ 1800; AM VSS, pt A&O X3; S, S2, ⊕ pulses X4; LS CTA ⊕; ⊕ BS X4; Ø c/o pain or discomfort @ this time; pt turned Q2°; dsg to sacral area d'd ∃ complications; restraints in place; circulation & skin integrity intact; foley to gravity draining QS yellow urine c ~~some~~ ~~white~~ white sediments. Continue to monitor b(6)-2 [redacted]
30 Aug 03 @ 0700	– Assumed care of pt. A+O X 3. Ø c/o pain or discomfort at this time. Foley and AM care complete. Lungs CTA HRRR Active BS Tolerating PO well Dressing change to sacrum CDI. Q2° position change. Will cont to monitor b(6)-2 [redacted]
30 AUG 03 0000	VSS. AO. ⊕ pulses. S, S2. LS CTAB. HRR. BS ⊕ X4. Voiding light amber urine quantity sufficient FTG. DSG d's to sacrum and foly insertion site. Foly site: bacitall BRB @ head of penis, wrapped in coban. Placed fluff 4x4 gauze sponges under shaft for absorption. Turned q 2° hours as ordered. b(6)-2 [redacted]
31 Aug 03 @	0700 - Assumed care of pt. A+O X 3 VSS. +foley + AM care complete. Lungs CTA - HRRR Active BS X 4 quads Foley draining clear yellow urine. Dressing to penis taken off Ø evidence of cont bleeding. Dressing to sacrum d'd CDI. GSW to

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DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
Cont	31 Aug 0700 - TH open to air ø bleeding or drainage noted. ROM exercises completed this morning. Will cont to monitor [redacted] 9/W MG. b(4)-2
31 Aug 03 2300	VSS. AO. Turned per 2° schedule. c/o pain along back ®& ⓛ shoulder. Repositioned for comfort. Duoderm (thin) placed over sacral ulcer to the left for 5 days for healing. Pt verbalized understanding. FTG voiding light yellow urine, quantity sufficient. [redacted] Amy AN
1 Sept 03 0130	Pt AO Turned q 2° & c/o pain [redacted] sacral area LS CTA Through out, S, S2 Present, + BS [redacted] Draining To gravity clear yellow urine QS. [redacted] Spc 9/WMG
1 Sep 03 0900	Pt AM care completed up to cha[redacted] became light headed and Dizzy. Was also [redacted] was. Will continue to monitor b(4)-2 [redacted] Spc 9/WMG
1 Sep 03 @ 1900	Assumed care @ 1800; pt VSS, pt AO X3 speaking arabic; S, S2, LS CTA®; ⓛ BS X4, FTG draining QS, clear, yellow urine, pt TOLPO; HOB↑, pt log rolled Q2°, restraints in place, circulation, skin integrity intact, ø c/o pain or discomfort @ this time, Cont to monitor [redacted] b(4)-2

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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.

E # [redacted] b(4)-4

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DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
2Sept 03	Rec'd report and assumed care of pt. AH ccu complete ⊖ c/o pain or discomfort ⊕. present Hemo Lungs CTA BS⊕. Pulse strong & equal. Foley to gravity Continue to monitor — [redacted] 91WM
1600	Pt had digital disimportion of stool per Spc. [redacted] Stool was hard and formed. Pt b(u)-2 turn to ⊖ side and cleared — [redacted] 91WM6
2Sep03 @ 2345	Assumed care @ 1800; pt A&O x3 speaking arabic; denies pain or discomfort @ this time; FTG patent draining QS yellow urine ⊂ sm amt of sediment Dsg to sacral area CDI ⊖ for drng; DQ stage II to ⊕ hip, bound, duoderm placed, CDI; ⊖ blood drng from penis; 2-point restraints in place, skin integrity & circulation intact, cont to monitor — [redacted] b(u)-2 [redacted]
3 Sep 03 0615	Pt A&O x3 Denies [redacted] Pain at this time. FTG Patent Draining QS clear yellow urine ⊂ sediment Drsg to Sacrum CDI. Drsg to ⊕ hip CDI Will continue to monitor — b(u)-2 [redacted] 91WM6
3Sep 03	1845 = VSS, A+O x3, ⊖ c/o pain, Dry Dsg Δ'd to sacral area CDI. Did ROM exercises to ⊕ LE's. Continuing Q4 Pt. has foley to gravity draining clr urine. 2+ pulses to ⊕ LE's. Pt. states (in Arabic) that was feeling/

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[redacted] b(u)-4

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b(6)-2 All

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
	Sensation from chest area up. Ø other remarkable assessment findings. Restraint to (R) arm in place. Will continue to monitor. [redacted]
4Sep03 0400	Pt A+O. S1 S2 present, LS CTA(B), +BS x4 quads 1/5 strength +2. +2 pulses all extremities. Dress to Sacral area CDI. Dressing (L) Hip CDI. (D) Sensation chest up. Pt uncooperative. Cont Aid care. Will continue [redacted] monitor. 91WM4
4SEP03 2005	VSS. AO. Placed OOBTC and tolerated well after HR went from 150 → 108 after 15 min. in chair. Which c/o dizziness and then subsided. Provided fluids and tolerated well. No c/o w/u/d or CP. Lesion on bal s/d. [redacted] Hy RN
5Sept03 1440	- assessment completed @ 0930 this am. Pt. resting well @ this time. A+O, VSS, pt. speaking arabic. Pt. has no c/o pain. Perrl, lungs CTA(B), Resp. no distress, even unlabored, S1S2 present. abd. firm, nontender, BS x4. Pulses +2. Duoderm applied to coccyx area. CDI. Foley to gravity draining CYU. Foley CDI [redacted] Will cont. to mont. pt [redacted] CHOR
5Sep03@2000	Assumed care @ 1800; pt A+O x3 speaking only arabic; pt in bed on (L) side, being turned Q 2° c HOBT; FTG, draining clear, yellow urine; duoderm on coccyx c/(R) hip CDI; restraints in place, circulation & skin integrity intact; Cont to monitor [redacted]

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DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
6 Sept 03 0800	VSS Alert & oriented. Consumed Regular diet for Breakfast. Repositioned in bed for comfort. Pad applied to (R) hip & coccyx area. Repositioned Q2hr & prn for comfort. Foley to gravity draining clear yellow urine. ∅ bleeding noted from penis @ this time. Foley care done. ∅ c/o pain or discomfort noted. Removal restraints and repositioned. Skin intact under restraints. Will check restraints, skin integrity and R/L and extremities frequently [redacted] 2CM b(6)-2
6 SEP 03 1502	VSS. AO. ∅ pulses. FTG draining light yellow urine quantity sufficient. CDI. Placed in chair x1 for 2° and tolerated well. Performed ROM as ordered prior to sleep. Stage II ulcer on sacrum healing and comfort CDI. ∅ c/o pain @ this time. b(6)-2 [redacted]
7 Sept 03 0800	VSS AXO. Consumed Regular diet for Breakfast AM care & foley care done. Dressing intact to sacral decubitus. Repositioned to relieve pressure to bony prominence. Foley drain clear yellow urine. Restraints removed & repositioned. Skin intact under restraints. Remained [redacted]

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DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
07SEP03	Neurosurgery.
1315	(P/O) Skin inspection today: 3 cm Stage III decubitus on Sacrum. 1-Cm Stage II decubitus (L) hip. (A/P) Will order hospital bed or ICU admit.
	[redacted] b(6)-2
7SEP03	VSS. AO. OOBTC for >2° and
2100	performed ROM on BLE and pt. [redacted] Tolerated well. Voiding light yellow urine. FTG = draining. Loupful intact to stage III 3CM sacral ulcer and 1 cm stage II @ (L) hip. [redacted]
2330	Provided bisacodyl suppository per patient to stool. Voided stool @ base of rectum upon digital stimulation. Chux placed. [redacted]
8SEP03 0000	Stool noted @ base of rectum and not voided [redacted]
8Sep03	Pt A&O, VSS, S/S, present (+)BS x4 quads, LS (T/A)B.
0630	FTG Draining clear amber urine. Denies pain at this time. [redacted] 91WM
8Sept03	1945: VSS, (-) c/o pain, A+OX3, OOB & in chair c̄ lift strap in place. Δ'ing DSG to sacral area BID (dry), Foley to gravity draining clear yellow urine, tolerates PO well, (+)BS x 4. Continuing ROM exercises to (B) LE's. (-) other remarkable assessment findings. Continue to monitor. [redacted]
8Sep03	2200: DSG to decub (sacral) Δ'd, x1 restraint in place, restrained extremity's skin integrity intact. [redacted]

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DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
	patient to perform ROM to UE's. Returned demonstration of understanding. DSG's to sacrum and (R) hip CDI. No s/sx of infection. Voided 400cc light yellow urine from FTG. [redacted]
11 Sept 03 0915	Assume duty of Pt. A+O x3, VSS. Regular diet No complaint of pain. Needs to be logged roll thru out the day. 1 point restraint in place ~~s~~ s/sx complications of skin break/circulation. DSG's changed. Will cont to monitor. [redacted]
12 Sept 03	Assume duty of Pt. VSS, A+O x3. DSG's intact. Set up in chair for an hour. Logged rolled thru out day. Bathed by self. c/o pain, treated with perc. Urine was clear, of ~~[illegible]~~ blood, yellow color 350 cc. Pt recieved an suptository. Will cont. to monitor. [redacted]
12 Sep 03 @ 2030	- assumed care of pt @ 1800. VSS, slightly febrile @ 99.7. Tylenol 650mg po given. A+O, LS CTA, HRR, (+) BM today per pt. (Refused pm dose of wafe). Foley draining clear/yellow urine. Sacral decub Stage II drsg Δ'd d/t old drsg coming off. new duoderm placed. (R) hip decub Stage I → Stage II c̄ some open sores noted. Duoderm Δ'd also d/t coming off. Woundcare nurse notified of Δ in (R) hip. Continue turn Q2° c̄ proper anatomic position. Plan: cont turn Q2°, monitor pain control. [redacted]
12 Sep 03 @ 2100	- ROM exercises completed. [illegible]
12 Sep @ 2330	- Pt c/o not able to breathe & stomach pain. (thru interpreter). Pt (+) vomit ≈ 75cc. Phenergan ordered & given. O2 sats = 99% RA. Will monitor [illegible]

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DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
9 Sept 03 1030	pt AOX3, VSS, pt's [illegible] can complete pt c/o pain from sacral decub Δ'd, also [illegible] from left buttock (DSD), foley drained 350 cc clear yellow urine. Other auditable findings
9 SEP 03 0205	VSS. AO. Patient turned to left side and tolerated well. Refused to be placed in chair this PM and requested to do it tomorrow. Provided nursing and displayed knowledge of adjusting bed angle with remote. Voiding light yellow urine, quantity sufficient ē b(6)-2 FTG. 5 bin @ restraints WDI. ⊕ pulses. [redacted]
10SEP03	(1245) Assumed care of pt c/o ϕ/ϕ p̄ report from night shift. Pt alert, speaking Arabic. VSS. ϕ c/o pain. am care done by pt c̄ min. assist from staff. Pt cont. to be turned q2° – log roll. Pt able to assist c̄ turns. Drsgs to decubs on sacral area and ⊕ hip Δ'd this am. ϕ s/sx infection. Foley draining quantity sufficient clear yellow urine. Pt td. reg diet well. 1 point restraint in place s̄ s/sx complications of skin breakdown/circulation. Will cont. to monitor. b(6)-2 [redacted]
10 SEP 03 1923	VSS. AO and speaking in arabic. Placed in chair and performed ROM to lower extremities. Encouraged

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DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
13 Sep 03 0900	Pt Awake in bed. A&O. Drsg to sacrum and (R) hip Ant. VSS. Am care completed. LS CTA (R). S_1 S_2 present. HRRR, (+) BS x 4 [redacted] Ds. Will continue to monitor. b(6)-2 [redacted]
13 Sep 03 1330	Pt Foley not draining. Foley changed. Foley strapped to leg. Large amounts of sediment in urine. Will continue to [redacted] monitor [redacted] b(6)-2 [redacted]
	(1705) I concur w above assessment. [redacted]
13 Sep 03 @ 2110	– assumed care of pt @ 1800. VSS. c/o nausea (+) emesis approx. 100cc. Thru interpreter pt stated he has not eaten all day, emesis x 3 today. Phenergan 25mg po given, will monitor effect. (+) BS x 4 quads, LS CTA, HRR, afebrile, foley draining cly urine c̄ some sediment noted. PROM completed. F Phenergan, pt tol small amt of solid food. 1 pt restraint on 5 S/Sx of skin breakdown or circulation impairment. Plan: monitor n/v, turn q2°. [redacted] b(6)-2

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b(6)-2
AM

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
15 Sept 03 1100	Oral temp 102°. Tylenol 650mg p.o. given by pt's nurse. Will monitor for effect. [redacted]
15 Sept 03 1600	Oral temp. 99°. Encouraged deep breathing & continue ¢ pt. turning. Pt refused ↑ to chair. Wants to wait til dinner @ 1800 - [redacted]
15SEP@2115	- Assumed care of pt @ 1800. T 100.4. Pt c/w ¢ c/o. Drsg to sacral area ∆'d DIT and drsg peeling off. Cont Turn Q2°. ROM exercises completed. Pt ↑ chair x 1 hour this p.m. Plan: cont TQ2°, monitor temp. [redacted]
@2300	- Pt had large BM. Peri-care completed. Foot care comp. No c/o @ this time. [redacted]
16 Sept	Pt awake + alert x3, VSS stable pt drsg ldl intact, c/o pain from old mid shoulder wound, ROM exercise completed, skin intact two restraints in place no other remarkable findings
16SEP03@2000	- assumed care of pt @1800. VSS currently afebrile. No acute care issues @ this time. Sacral drsg & hip drsg duoderm intact. Pt ↑ to chair ¢ difficulty. PROM completed. Plan: cont turn Q2°, monitor decub drsg, monitor pain, addendum: Foley draining clear yellow urine. Will monitor. [redacted]
16SEP@2015	- Pt back to bed. + pt restraint m. Skin integrity & circulation good. Foot care done. Will monitor. [redacted]

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DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
14 Sept 03 0900	USS. AO. Lungs clear Bilateral. BS(+) X 4 quadrants. Ø 40 N/V @ this time. Foley to gravity. Draining clear amber urine with sediment noted in tubing. Will encourage PO fluid intake OOB to chair c. +2 assistance. PROM completed. AM care (partial) done. Dry Bed to Racism (L) Hip. Postcaints removed and reapplied. Skin intact under restraints b(6)-2 [redacted]
14 SEP 03 2125	VSS. AO. T@100° and provided 2 Tylenol. Stated feels better today. Turned to (R) side and performed digital stimulation and rectal disimpaction and removed large amount of soft formed brown stool. Comfort to supine and (L) hip CDI. Slight non-productive cough noted. b(6)-2 [redacted] Supper
15 Sep 03 0930	Pt Awake A&O. Pt refuse to eat. Denies pain at this time. Turned on Back. Duoderm to Back and (R) Hip CDI VSS. Will continue to monitor. [redacted] PIWME
15 Sep 03 1000	I concur c above. Circulation & skin integrity assessed throughout shift. ~~2 pt. 1 pt. restraint~~ [redacted] mos b(6)

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b(6)-3 A11

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
18 Sept	"no other remarkable findings, skin integrity intact → [redacted] SPC
18SEP03 2032	VSS. AO. S, S, LSCLAB. c/o pain to back of neck & thoracic vertebrae region. ⊕ pulses to all extremities. Sacral stage II decubitus DSG CDI. Turned at flat position and tolerated well. [redacted]
19Sept	Pt. awake, alert x3 pt c/o mild pain to thoracic back region around area of old GSW. VSS, given 1 tab percocet, dsg Δ'd @ hip 2"x1" reddish, pink, white around the edges with some drainage, old dsg replaced with duoderm, also with sacral dsg. pt rotated and exercise as per schedule, restraint x1 in place skin integrity intact, no other remarkable findings [redacted]
19Sep@2200	- assumed care of pt @1800. VSS. No c/o @ this. No acute issues. Foley to gravity c clear yellow urine. ⊕ hip & sacral dsgs CDI. Pt ↑ chair x 2 hours, tol well. ROM completed. Plan: T q2° while in bed, monitor pain control. [redacted]
20Sept	pt awake + alert x3 pt ∅ c/o pain at this time dsg to hip Δ'd with duoderm, pt rotated and exercised as per orders, skin integrity intact no other remarkable findings. restraint x1 in place [redacted] (1bA∅) I concur c above assessment [redacted]
20 sep@1930	- assumed care of pt @ 1800. no acute issues. Sacral dsg & ⊕ hip dsg CDI. ROM completed. Pt ↑ to Chair @ this time. Plan: cont T q2° while in [redacted]

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
17Sep03	(1340) Assumed care of pt. @ 0000 w/ report from night shift. Pt alert, speaking Arabic. VSS. Dsgs to sacral decub and decub on (R) hip Δd this am. Foley draining quantity sufficient clear yellow urine. Pt tol. reg diet well. (+) small BM this am. Pt being turned q2-3°. ROM done. 1 point restraint in place w/ s/sx complications. Will continue to monitor. [redacted] b(6)-2
17Sep03	1930: VSS, 0/10 pain, A+O X3, ROM exercises done to (B) LE's, log rolling Δ2 turns to keep pressure off of sacral area, Dsg to sacral decub CDI, Will change Dsg tonight @ Bedtime. DOB to chair w/ difficulties. Foley to gravity draining clear yellow urine. x1 restraint when in bed – skin integrity intact to extremity restrained. (-) other remarkable assessment findings. Will monitor. b(6)-2 [redacted]
17Sep03	2100: Dsg's to sacral decub & (R) hip Δ's CDI. Will Δ/reinforce as needed. [redacted]
18Sept	1230 VSS, pain 4/10 pain from old injury in upper posterior back area, pt also vomitted twice pt blamed it on the breakfast, dsg Δ'd on sacral decub, pt voiding clear yellow urine

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#[redacted] b(6)-4		KWH

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
@1930 cont'd.	Plan: cont ↑CH, monitor pain, monitor alertness. [redacted]
23 Sept 03 0900	VSS A&O x3. Foley to gravity drainage clear yellow urine. PROM to lower extremities done. HOB ↑ 30°. Consume regular diet for breakfast. Dsg to sacral dry, intact. Lg well pillow for comfort. Bony prominences padded to prevent pressure ulcers. Pull continue care as planned. [redacted]
23 Sept 03 @ 2015	- assumed care of pt @1800. VSS. No c/o @ this time. Foley to gravity c̄ clear yellow urine. ↑CH, tol well. (1 pt restraint on while in bed.) Both sacral & (R) hip dsg CDI. ROM completed. Plan cont turn q2 while in bed, monitor pain. [redacted]
24 Sept 03 0900	VSS - A&O. OOB to chair for breakfast. Foley to gravity drainage clear yellow urine. No acute care needs at this time. Pt well continue plan of care. [redacted]
24 Sep @ 2345	- assumed care of pt @1800. VSS. Sitting up in bed, pleasant. no c/o. Refused OOB to chair this pm. Foley to gravity c̄ clear/yellow urine. PROM completed. (R) hip & sacral dsg CDI. Plan: monitor skin breakdown & pain. Turn q2°. [redacted]
25 Sept 03	Assume care of PT 0600. A&O x3, VSS. Turned over on side several times. Sat up in chair for an hour. c/o minimal pain. No signs of infection from wound. Dsg Δ. No irritation from restraints x2. SPC Wash, RN
25 Sep 03 1200	I concur c̄ above pt [redacted]

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
20 Sep @1930 cont'd	bed, monitor for skin breakdown. ROM exercises as ordered, pain control. ngroodale
@2100	Foot care done. Pt back to bed, 1 pt restraint on & skin integrity uncompromised. will monitor. ngroodale
4 Sep @0530	Pt c/o pain in (R) upper back. Medicated c percocet will monitor. [redacted]
21 Sep 03	1930: VSS, A+O X3, ∅ c/o pain, Dsg Δ'd to sacral decub c new duoderm CDI. Dsg to (R) hip CDI. Pt. ↑ in chair & having ∅ difficulty. ROM exercises done to (B) LE's. Foley to gravity draining clear yellow urine. Continue to monitor. Restraint X1 - Skin integrity intact. b(6)-2 [redacted]
22 Sep 03	Pt A&O LS CTA (B). S1 S2 present. (+) BS X 4 quads. DSG Δ'd to (R) Hip decub CDI. Am care completed. ~~FOC~~ FTG ~~Draining~~ Draining c/y u. Will continue to monitor. [redacted] Spec 9W MB
@1930	- assumed care of pt @1800. [redacted] VSS, no c/o @this time. Pt ↑ to chair @this time. Foley to gravity - cly urine. Dsg to sacral area & (R) hip CDI. 1 pt restraint on in bed, ∅ S/Sx of skin or circulation compromise. CONT— [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			
	LAST	FIRST	MI	[redacted]
		b(6)-2		

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

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25Sep03	1945= VSS, A+OX3, ∅ c/o pain @ present, ↑ in chair sitting ∃ difficulty, Δ'ing DSG's to sacral region & hip @ bedtime. Foley to gravity draining clear yellow urine. ROM exercises to (B) LE's when in bed-assisted, Q2 turns - log rolling, HOB↑ 30-45. Restraint x1 when in bed, ⊖ skin breakdown, continue to monitor. [redacted]
26 Sept	VSS pt awake alert x3, ∅ c/o pain from old back injury, pt given 2 tabs percocet, pt rotated as scheduled, foley draining clear yellow urine, dsg to sacrum and right hip Δ'd, restraint x1 in place [redacted] circulation to extremities intact
26Sep @2125	- assumed care of pt @ 1800. VSS. no c/o. Alert speaking some English. Pt ↑ to CH, tol well. Sacral & hip dsg CDI. Foley to gravity c̄ clear yellow urine. PROM completed. Encourage pt to assist c̄ ROM. Foot care provided. Plan: monitor skin breakdown and pain control. ⊥ pt restraint on while in bed, ∃ s/sx of skin or circulation compromise. [redacted]

b(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

EPW [redacted] b(6)-4

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
28 Sept 03	Foley to gravity c̄ yellow urine. No signs of skin irritation from restraint. Will continue to monitor. SPC [redacted], 91W b(6)-2
29 Sep 03	2030: VSS, ∅ c/o pain @ this time, OOB and in chair c̄ difficulty, Δ'ing Dsg's to (R) hip & buttock area @ HS. x1 restraint when in bed, skin integrity intact. FTG draining clear yellow urine. No other remarkable findings. Continue to monitor. b(6)-2 [redacted]
30 Sept 03 1200	Assume care of PT 0600. VSS, A+Ox3 Δ Dsg's on R hip and buttocks. Skin integrity intact x1 restraint. Foley to gravity clear yellow urine. Exercise consists of lying in bed and sitting in chair. Will continue to monitor. SPC [redacted], 91W b(6)-2
30 SEP 03 2125	[redacted] TWC c̄ complaints. Dsg to sacrum CDI to be Δ'd in AM. Placed on bacitracin in back. Performed well in ambulation on ward. FTG, bright yellow urine, quantity sufficient. b(6)-2 [redacted]
Oct 1	VSS, A+Ox3, Δ dsg on (R) hip and sacrum, minimal drainage, wounds healing well, skin integrity intact with ∅ signs of breakdown, restraint x1 foley to gravity, clear yellow urine

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT
	(1735) I concur c̄ above assessment.	[redacted]

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

REGISTER NO.

b(6)-2

PROGRESS NOTES
Medical Record

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

H [redacted] b(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
27 Sept	VSS pt awake + oriented x3 pt c/o pain from old injury site, pt given tylenol but decided to tough it, rotated as scheduled; bag draining clear yellow urine, restraint x 1 in place, circulation to extremities intact [redacted]
27 Sep @ 2115	assumed care of pt @ 1800. No c/o @ this time but refusing to OOBTC @ change of shift. (R) hip ? sacral drsg - Δ; now CDI. PROM completed. Turn q2° while in bed. Left restraint on 5 s/sx of skin or circulation compromise. Plan cont TQ2°, PROM q4°. Will monitor. [redacted]
28 Sept 03 0922	Assumed care of PT @ 0600. A+O x3, VSS Skin integrity present @ restraint site. Needs to be turned over on side through out day. Drsg's on hip and buttocks Δ c/o pain given tylenol. Will continue to monitor. [redacted] 9/4
28 Sep 03 1200	I assumed c alive. Will continue to monitor. [redacted]
28 Sep 03	2100: VSS A+O, c/o pain drsg's to buttock & (R) hip CDI. Q2° turns & log roll - pt. can do this pretty much on his own. Foley to gravity draining clear yellow urine. Other remarkable findings - continue to monitor. [redacted]
29 Sept 03 1113 hrs.	Assumed care of PT @ 0600 hrs. VSS, A+O x3. Δ drs's on buttocks and Rt. hip. Log rolled x2, exercised in bed. Performed own personal hygiene. (cont.)

STANDARD FORM 509 (REV. 5/1998) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
10CT03 2007	Stable. A&O. OOBTWC c̄ complaint of pain. FTG draining quantity sufficient light yellow urine. ⊕ pulses. Ordered for suppository to be placed @ 2700 hours. Ambulatory. DSG intact to sacrum dentite. No other s/s infection or skin breakdown. to extremities. Provided magazine to read. b(6)-2 [redacted]
20CT03 0300	Bisacodyl suppository placed c̄ digital stimulation b(6)-2 [redacted] RN
20CT03	1319 – 1555 – A+O – Pt. had BM this AM. Assumed care of pt. @ 0600. Assessment completed. LS CTA (B) resp. even unlabored. abd. soft non-tender, BS x4. FTG draining clear yellow urine. Drsng Δ to decubitus on coccyx + (R) hip. Cont c̄ (-) S/S infect. Cont. to turn pt. Q2. Pt. tolerating PO well. Will cont. to monitor pt. b(6)-2 [redacted]
20Ct 03 1440	Cont c̄ close assessment. Pt continues c̄ foam heal pads to prevent skin breakdown. One pt. restraint on c̄ compromise to circulation or skin integrity. Will continue to monitor [redacted]

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

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

REGISTER NO.

WARD NO.

b(6)-4

#[redacted]

PROGRESS NOTES
Medical Record

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

b(6)-2
A

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
2 OCT 03 2210	Stable. AC. Placed in chair and tolerated for 2°. Placed on stomach for slap. DSG's intact to sacrum and (R) hip. (+) pulses. Perform ROM on BLE and tolerated well for 15 min. Had one episode of HA and light headedness and provided 2 pillows. Foot board. Cont to monitor [redacted]
3 OCT 03 0700	Assumed care of pt. A+O x 3 VSS & c/o pain or discomfort @ this time. AM care self & assistance complete. Foley to gravity clear yellow urine QS. Q2° turn cont. Breakdown to sacrum dressing intact stage II. Redness to (R) hip bony prominence. (L) hip dressing stage I. ROM exercises b/lat lower extremities stiff. Will cont to monitor [redacted]
3 OCT 03 P 1940	Assumed care of pt @ 1800. A+O, speaking arabic. Pt ↑ OOBTC, c/o some dizziness & pain to old GSW site. Foley to gravity draining clear yellow urine. (R) hip & sacral dsgs CDI. (L) hip redness noted. Reinstructed pt on cont. to turn Q2°, pt verbalized understanding. PROM completed. P.T. consult submitted DT ↑ joint & muscle stiffness. Foot care completed. Plan: monitor skin breakdown, cont TQ2°. [redacted]
	Addendum: Pt in ⊥ pt while in bed & s/s of skin or circulation compromise. [illegible]
2130	(R) hip & sacral dsgs Δ to PE wrinkling of duoderm. Will monitor. [redacted]

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
5 OCT 03	VSS - AO - Referred OBTC. Pleased on bike ≥ difficulty.
2105	No c/o pain @ this time. S'd usual dry ASG -
	crutch left in place to sacrum and right hip.
	Scanty light yellow urine to FTG ≥ difficulty
	[redacted]
	b(6) - 2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
4 OCT 03 0100	Assumed care of pt. A+O x3. VSS. Ø c/o pain or discomfort @ this time. Cont c̄ Q2h position change breakdown to sacral area stage II healing dressing Aid duoderm applied. (L) hip duoderm applied. (R) hip c̄ redness. Ø break in skin to (R) hip. PT consult today stiffness to bilat lower extremities. ROM exercises will cont to monitor — [redacted] (1540) I concur c̄ above assessment. [redacted]
HOCTOB @2045	Assumed care of pt @ RDD. No c/o. A+O, speaking Arabic. Pt ↑ CH, tol well. PROM to BUE completed (R) hip's sacral dsgs CDI. Foley c̄ clear yellow urine. Plan: TQ2° while in bed, cont PROM, follow up on P.T. consult. — [redacted] Addendum: 1 pt restraint [redacted] c̄ ✓S/Sx of skin/circulation compromise [redacted]
5 OCT 03 0700	Assumed care pt. A+O x3 VSS Ø c/o pain or discomfort @ this time Lungs clear HRRR Active BS x 4 quads BM x 1 today. Tolerating PO well. Foley to gravity clear yellow urine QS. Breakdown to sacrum stage II healing Ø s/s of infection. Will cont to monitor — [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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

[redacted] b(2)-2

103 [redacted] (See Instructions on Back of this [redacted]) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

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

LOG NUMBER

ARRIVAL DATE			TIME	TRANSPORTATION TO HOSPITAL (Attach care enroute sheet)	CURRENT MEDS. (tetanus immunization and other data)	HISTORY OBTAINED FROM
DAY	MONTH	YR.		☐ PRIVATE VEHICLE ☐ AMBULANCE ☒ OTHER (Specify) Medivac	Ø	☐ PATIENT ☐ OTHER (Specify)
	07	03	1330			ALLERGIES: NKA

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

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration) 1330 pk GSW to back @ 1330 tob⊕ ETOH⊕ | SEX: M | AGE: 26 | POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER

VITAL SIGNS			
TIME	1331	1345	
BP	91/37	99/45	
PULSE	123	107	
RESP.	34	22	
TEMP.	105.3		
WT. (Child)	60kg		

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

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)

18 gauge IV Bolus (R) wrist.
Came in with chest tube
2L O2 Nasal canula
GSW (L) chest below scapula
Shrapnel injury to posterior midline
Came in with IV (L) AC
2L O2 NRB mask
Came in with Foley cathader

25% Iraqi w/ Sp GSW + back. Seen in Iraqi hospital, CT pleural (L) side. Unclear by notes how much fluids/meds given. 7 unit blood given per Iraqi hospital note

Unclear amt of fluid out of CT.
Pt c/o SOB & SS CP and ⊘ feeling below ACP

1° A Airway clear/pat manipulated ⊘ facial trauma. ⊕ small wound (L) side scapula
B: CTA (B), (L) min decr fm (R), CT in place (L) T-4/5
C: ⊕2 pulses ⊘ 4 ext, ⊘ abd examination
D: GCS 15
E: Back ⊕ 3 open shrapnel wounds mid spine @ T2 level ⊘ massive pulp
⊕ GSW superior mid scapular area
Foley in place & clear yellow urine 2 100cc

2° Head atraumatic PERRL 2-4mm EOMI Speech clear, articulate
neck ⊘ midline bony stepoffs
Chest CV: NML 122 ⊘ murmurs/4/T Abd: tym, SFGI, NT, ⊘ masses/scars
Ext: 5/5 strength (R) U ext & from rectal ↓ tone bone neg (L) wrist
Lower ext: flaccid (B), areflexic
⊕2 bounding pulses

X-ray ⊕ shrapnel midline

ORDERS	INITS.	TIME
CBC/Chem12		
Electrolyte (Piccolo)		
UA/Type + Cross x4		

ASSESSMENT/DIAGNOSIS
(1)

A/P (1) GSW to back chest stable
(2) (B) Low ext neuro compromise 2° to likely spinal cord injury
→ OR Neurosurgery/Surg Cons

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:

(CONTINUE ON SF 507, IF NEEDED) [redacted] b(2)-2

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

EPW # [redacted] b(4)-1

SIGNATURE OF PROVIDER AND ID STAMP [redacted] 8790

INSTRUCTIONS TO PATIENT (Include medication [redacted] ns and follow-up plans)

Adm to ICU I

MEDCOM - 15276 TREATMENT
Medical Record Copy

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

510-112 NSN 7540-00-634-4123

MEDICAL RECORD — NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS (Include medication and treatment when indicated)			
			20	21	22	23
		HR	91	80	61	58
	CVP	BP	138/67	118/53	114/50	122/55
		MAP	92	78	75	81
		RR	23	23	16	16
		SaO2	94	91	91	92
			RA	RA	RA	RA
INS						
IVF:	D5½	20K	100	100	100	100
	DOP	mine	27.5	27.8	27.5	27.6
outs		foley	110	70	50	170
		Lasix	5	5	4	0

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

NURSING NOTES

Medical Record

MEDCOM - 15277

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

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
			1730 29JUL03 – Resume pt care. Pt ~~[illegible]~~ Assessment
			resting comfortably as follows
			[N] Ø spont movement from upper lim below; (+)
			b/l UE movement; PERRL 3mm, 2 (L) UE weaker
			than compared to (R) UE. [N] CTA; SR 90's
			2 NC; (-) s/s cyanosis; CT D/C → to CR thru
			evening; [CV] + pulses x4; s/s2; NSR; feet
			warm to touch; (-) edema; [GI] (A) has hyperactive
			b.s; (-) v; reports nausea as minor early
			of dinner 2 days; [GU] (R) u/o, clear;
			[SKIN] CT site c/d/i; epidural site c/d/i;
			[LINES] (L) SC; (R) PIV to UE; [illegible]
			b(6)-2 [redacted] 1172
			30JUL 0400 pt alert; MAP >60, SBP >95; SaO2
			minus UE only; Long sounds ↓ to LLL
			CTA; (+) Bowel sounds, flat abdomen; Foley ↑
30JUL03	0057		Neurosurgery
			(S/O) Lumbar drain failed yesterday.
			Dressing Δ – minimal serosanguinous overnight
			Paraplegia persists.
			Dopamine ↓ 11 mcg/kg/min.
			(A/P) GSW T-spine.
			May be up ad-lib. b(6)-2
			Wean Dopamine off.
			[illegible]

[redacted]

510-112

b(6)-2
A11

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

NSN 7540-00-6

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
30 Jul		0730	Am care; breakfast set up; HOB ↑; pt eats well per self; meds [redacted]
		0900	dopamine off; SBP > 90; meds as ordered [redacted]
		1200	on bed rest; turns to prone; no response to digital stimulation; supports well; CTM; HOB ↑ for lunch [redacted]
		1400	no change in status; no bm results yet SBP > 90; UOP 30/hr; meds [redacted] ↓ UOP.
30 Jul 01		1710	fed pt c HOB/sleeping in NAD. ∅ complaints voiced. clsp to back/⊕ chest C.D. & I. fluids (prescribed) running. Pt alert/coherent. lungs ↓ to LLL otherwise clear. BS +, foley ↑ scanty → cl yellow. PO intake highly encouraged. VSS/Afeb. RN to ⊕ bicap patent/benign. Will cont to monitor [redacted] Sgt/LPN
31 Jul		0400	Pt. slept through entire shift. Med. PRN c effect. relief. Turned. PRN x2. ∅ comfort measures. VSS/Afeb. [redacted] Sgt/LPN
31 Jul		0500	Assumed care. Pt. sleeping comfortable c no complaints @ this time. Will continue to monitor and follow plan of care [redacted]

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

REG [redacted]

WARD NO.

NURSING NOTES
Medical Record

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

510-112

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

OBSERVATIONS
Include medication and treatment when indicated

DATE	HOUR A.M.	HOUR P.M.	
31 JUL 03	0637		Neurosurgery
			(5/6) Tm 101.5 this Am.
			Stable off drips.
			Central line out.
			Cough weak ⊕ chest tube.
			Dressing on back – minimal sanguinous
			drainage.
			Plegia pers. 5/5.
			(+) BM this Am.
			(1) Stable GSW T-Spine c̄ flaccid plegia.
			(2) New fever. Will need workup.
			[redacted]
			b(u)-2
31 Jul 03	0645		Pt Alert & follow simple commands. Afebrile th
			101.5 Dr. Tej notified. CTA to auscultation. S
			NSR +2 pulses X4. +BS BM this am. Foley
			clear yellow urine. Dressing on back changed.
			puncture open to air no signs of infection.
			AM care done. Pt ate < 50% of break
	0700		CBC & UA c̄ micro sent.
	0745		Pt to XRay. Will continue to monitor
	0815		[redacted] (LT/AN)

(continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries gi[redacted]e; rank; rate; hospital or medical facility)

REGISTER NO.

WAR

b(u)-2

NURSING N

Medical Re

STANDARD FORM 510 (REV. 7-9
Prescribed by GSA/ICMR, FIRMF

b(4)-2 AM

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
31 Jul 03	1030		Encouraged IS q 1h while awake. Pt able to move up 2 ½ bolts. Turned pt q 2hrs [redacted]
	1200		4mg MSO4 given IV push, pt c/o arms pain [redacted]
31 Jul 03 1715			Ø Significant Δs from day drift note. Lungs CTA & otherwise CTA. BS(+) Bley → clear q.s. Temp 101. Okay. afeb. IS use/ Ad intake highly encouraged. Positioned for dinner. PIV to Ⓡ bicep pt/ benign. Prescribed Rds nursing. Max Emotional Support provided. [redacted] Sgt/LPN
01 Aug 03 0430			Pt medicated TPN c effect. Ely. T max 101.0 current temp 99.5. PO fluids drank throughout the night. IS used well. Repositioned for comfort. [redacted] Sgt/LPN.
01 Aug 03	0800		Pt resting comfortable in bed c no complaints. Alert + follows simple commands. CTA lungs. S1-S2 +2 pulses x4. + BS. Foley draining clear yellow urine. No skin breakdown [redacted] bowel sounds. IV @ KVO D5½c 20KCL. Will continue to monitor [redacted] LT
01 Aug 03	0850		Neurosurgery (S/O) Temp 101.2 at 4:5 Am. Fever workup (-) yesterday. Dressing Δ - Scant serosanguinous. Plegia per S.S.S. (A/P) (1) FUO - observe / repeat W/U q 24-48° (2) T3 Paraplegia - Stable, no CSF leak. (3) Placement [redacted] Pending.

510-112 NSN 7540-00-634-4123

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
3Aug03	0700		VSS pt A&Ox3. follows commands. Lungs CTA. BS hypoactive x4 quads. +2 pulses x4 quads. pt ate 10% of breakfast. Pt b(6) has no c/o pain at this time. Will continue to monitor - [redacted] CON
3Aug03@	1050		pt c/o pain. Medicated c̄ 5mg Morphine - pt nauseous. pt vomited. No pm order for nausea. Will notify Dr [redacted] Will con't to monitor b(6)-2 [redacted] LPN
03Aug03	1730		Rec'd pt. resting in NAD HOB T. Care plan reinforced; meds - side effects, pain control, nutrition/healing, I.S. use, fluid intake; needs reinforcement. See flowsheet for further assessment [redacted] RN/LPN b(6)-2
04Aug03	0500		Pt. slept on/off. ∅ complaints voiced other than H/A & insomnia. Will pass on to oncoming shift. VSS [redacted] - [redacted] b(6)-2
04Aug03	0630		Neurosurgery.
			(S/O) Tm 101.5, currently 99.5. VSS.
			Dressing Δ - Back slowly healing.
			Plegia pers. s/p - remains flaccid.
			(A/P) Subrapnel T-Spine c̄ SCI.
			Continue dressings / supportive care.
			Placement. [redacted]

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; gr[redacted] hospital or medical facility) b(6)-4 [redacted] REGISTER NO. [redacted] b(6)-2 WARD NO. ICU

EAW [redacted]

NURSING NOTES
Medical Record

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

NURSING NOTES
(Sign all notes)

HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
	1230	Pt Alert x Oriented follows commands. Temp max today 100.°F. BM x1. Am care done. Ate ½ apple. verbalized wants to go [redacted] ILT/AV b(6)-2 to ICW2 [redacted]

STANDARD FORM 510 (REV. 7-91) BACK

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

510-112

NSN 7540-00-634-4123

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
4 AUG.		1500	- Received PT from ICU 3. PT was alert + responsive. PT's temp was 100.9. Breath sounds are clear B.bilateral. PT has (-) labor breathing. BS x4. PT has (-) ROM, c̄ (+) Pulse B.bilateral on lower extremity. PT has (-) sensation below upper lip. PT has Foley cath c̄ Yellow color urine. PT has correctly voided 120cc. PT has (+) ROM + Good Pulse Motor sensory to upper extremity. HL to (R) Arm flushed well c̄ 3cc N/S. Dry to Back CDI c̄ (-) S/S of infection. Will cont to monitor PT. [redacted] b(6)-2
4 AUG 03		1800	- PT Temp is 101.8. Give Tylenol T. Will cont to monitor.
4 AUG 03		1900	- VS (T 101.9) Reposition (R) side
4 AUG 03		1915	- Drew CBC + UA As per MD order. Awaiting X-ray chest. Will cont to monitor. G/N VAZE
4 AUG 03		2020	- VS (T 100.4). Will cont to monitor. [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) Elw [redacted] b(6)-4

REGISTER NO.

WARD NO. ICU

NURSING NOTES

Medical Record

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

510-112 NSN 7540-00-634-4123

MEDICAL RECORD — NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
note cont'd			noted on old dsgs. Warmth ō healing tissue noted. DSD applied C/D/I. Pt TNP to supine position. Will mon. [redacted] SRT/AN
7 Aug 03	0250		Emptied 925cc CYU from FTC [redacted] SRT/AN
	0303		C/O pain in arms ¹⁄₂ Tylenol given will mon. [redacted] SRT/AN b(6)-2
07 0730 Aug 03			NURSING ASSESSMENT: Pt awake, alert, Ox3. Airway intact, breathing even and unlabored, LS clear to all fields (B). Abd soft, nontender, ō mild distention. BS(+)x4, somewhat hyperactive. Pt is notically a stomach breather. Voids per foley, draining clear, yellow urine. Passive ROM to (B) LE, vascular intact. No neurological function to (B) LE. FROM and neurovascularly intact to BUE. IV access. Dsgs to (L) scapula-area of back are CDI. Pt turned q 2hrs ō PRN q 4hrs. b(6)-2 [redacted]
07 1020 Aug 03			NURSING NOTE: Pt give Bisacodyl suppository @ 0900. No results q 1 hour. Performed digital disimpaction of small amount of stool in rectum. Stool was pebble-like and hard. [redacted]
7 Aug 03		1330	assumed pt care @ 1300. Pt sitting up in bed awake et alert. VSS (+) temp noted @ this time. pt turned per orders. (+) lungs CTA, abd soft non-tender BS(+)x4. Drains to ↑ back CDI. (+) IV access. BUE ō full ROM (+) pulses. (+) C/O pain voiced @ this time. Will cont to monitor [redacted] 9 Wrme

(Continue on reverse side) b(6)-2

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

REGISTER NO. ICW2 WARD NO.

[redacted] b(6)-4

NURSING NOTES
Medical Record

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

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
7Aug03		2140	Pt. turned on (R) side. Dressing change to upper back. Ø swelling or redness to wound. Small amt of drainage (blood) on dressing. b(6)-2 Sat [redacted]
7Aug03		2209	Rec'd c/o pt @ 21:00. ⊕ Restraints. VS [redacted] per flow sheet x temp 100.4. will retake temp x1 now. Temp 99.6 Ax 98.7 orally. Skin W/D. Error on Re PERRLA ⊕ WNL. HRRSSS2 BS⊕x4. ⊕ PP(B). c/o H/A. II Tylenol given will cont. to mon. [redacted] 2cr/AN
b(6)-2			
8 Aug 03	0600		Assumed pt. care @ 0500. Pt. awake laying on back. Ax0x3. lungs CTA. ⊕ pulses BSx4. Ø ROM in legs. dsrg on back CDI. Foley to gravity c̄ CYO. Ø complaints @ this time. [redacted]
b(6)-2			
8Aug03	1300		assumed pt care from previous shift. VSS temp 99.5 pt given II Tylenol per Drs orders. pt awake & alert. lungs CTA, abd soft BS⊕ Foley to gravity intact, draining c̄ yellow urine, ROM exercise done on pt, pt also turned per orders. BUE c̄ full ROM ⊕ pulses. ⊕ IV access noted. dsrg to ↑ back CDI. Ø complaints voiced @ this time. Will cont to monitor b(6)-2 [redacted] 9 mon
8Aug03		21:39	Rec'd c/o pt @ 21:00. VS WNL per flow sheet. pt lying in supine position asleep; easily awakened. Skin Posterior diaphoretic Anterior W/D. Sheets ∆'d. PERRLA ⊕ WNL. LCA(B). BS⊕x4 hyperactive. Palpable flatus in ABD. ABD firm. ⊕ PP(B). DSD ∆'d

*U.S. Government Printing Office: 1995 - 404-752/20065

STANDARD FORM 510 (REV. 7-91) BACK

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

06OCT03 Discharge Summary

History EPW suffered Gunshot wound 27 JUL03 with durocutaneous fistula and paraplegia.

Course Fistula treated with spinal drainage and dressings. Spine was not unstable. Paraplegic patient treated with routine plegic care. Placement was delayed until a suitable nursing home facility could be found

Disposition Patient has no restrictions.
Foley catheter to be changed monthly.

Medications Colace 100 mg po BID
Lovenox 40 mg SQ q Day
Elavil 25 mg po q HS.

Questions to 28th Combat Support Hospital.

[redacted] b(6)-2
[redacted] MD
[redacted] US-Army.mil

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

#[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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

b(6)-2

TIME: 2424 SIGNA: [redacted]

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature 99.9

Color: Pale / Cyanotic / Jaundiced WNL

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils: 3mm PERRLA

Extremity Movement: Full / Limited / None SLO Degrees rule

CARDIOVASCULAR

Pulse (0 - 4): 3 Radials +3 Pedals +3

Capillary Refill: Seconds Homan's Sign

Jugular Venous Distension Ø Edema Ø

Heart Sounds S1S2

Rhythm SR/ST PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site				
Solution				

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

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

Breathing Patterns: Regular

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor None

Chest Drainage System Gravity: Suction cm: 20

Air Leak No Yes Crepitus Ø

Character of Drainage: Sanguinous

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

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles	Ø	
Wheezes	Ø	
Diminished	(L) base	(L) base
Absent	Ø	

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings:

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

NG Drainage: Color Ø Character

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

Stool: Character Ø

Drains:

GENITOURINARY

Urine Color: Clear/Amber/SS Character: clear

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

AFTER ASSESSMENT

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature Cold

Color: Pale / Cyanotic / Jaundiced normal for race

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils: 3mm PERRLA

Extremity Movement: Full / Limited / None LLE only

CARDIOVASCULAR

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

Capillary Refill: <3 Seconds Homan's Sign ⊖

Jugular Venous Distension ⊖ Edema ⊖

Heart Sounds S1S2

Rhythm NSR PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site				
Solution				

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

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

Breathing Patterns: normal

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor

Chest Drainage System Gravity: Suction cm: 20

Air Leak No Yes Crepitus ⊖

Character of Drainage:

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

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes		
Diminished	(L) base	
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings:

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

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate

Stool: Character

Drains:

GENITOURINARY

Urine Color: light yellow Character: clear

Voiding: Continent / Incontinent / Catheter yes

EMOTIONAL/PSYCHOSOCIAL

no issues this time

Pt calm, cooperative

OTHER: [redacted]

b(6)-2

EPW [redacted]

27Jul

30

99.9 99.2 98.4

106 99 86 67 71 63 64 59

136 104 110 109 105 103 122

66 48 46 47 45 51 57

15 21 17 17 15 24 18 27

96 97 97 98 97 96 99 98

6L 6L 4L 4L 4L 4L 4L 4L

NODE

D5½NS20K

Dopamine

Pigtail buckles

200 100 100 100 100 100 100 100 100 100

18 18 21 28 34 34 36 36

100 50

1530

600 60 180 140 120 180 140 120

600 600

80

Clotted

Lumbar

50

25

#3

30 20 20

Emesis

Stool

MEDCOM - 15289

Date: 28 JUL 03 Bed#: 5

Patients Name: EPW [redacted]

	00	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19
ne	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
BP	106	111	103	101	102	122	114/51	124/58	114/47	118/48	120/47	117/53	122/47	114/53	100/46	112/52	114/54	124/60	107/46	112/49
TEMP			98.3					98.3							98.8					
PULSE	52	54	51	53	51	56	53	60	53	57	53	62	60	60	68	58	66	71	67	63
RR	18	10	12	20	12	15	15	16	19	15	16	20	22	23	15	15	20	24	18	21
SAO2	98	99	99	100	99	97	99	99	98%	98	98	93%	92	93	93	92	94	95	94	94
O2	4L	4L	4L	4L	4L	4L	2L	2L	2L	2L	1L	RA	RA	RA	RA	RA	RA	RA	RA	RA
MAP							76	82	72	76	74	78	77	77	68	79	77	87	90	75
PUT																				
IVF	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
DOPA	26.3	26.3	26.3	26.3	26.3	34.1	31.5	31.5	31.5	31.5	28.9	30.2	30.2	27.6	27.6	28.9	27.6	27.6	27.6	27.6
IVPB																				
Other											100		250							
TAL																				
TPUT																				
INE	140	110	150	90	100	120	150	100	60	50	120	155	145	140	160	210	290	90	160	150
CT																	20			
STOOL																				
LP drain	15	15	20	10	15	20	10	06	10	09	09	06	20	15	11	05	20	12	12	8
TAL																				
LANCE																				
RN Q 2																				

MEDCOM - 15290

	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
	102.0				100.8						101.0															
	68	65	65	69	78	60	62	92	85	80	70					101.1				99.0				99.5		
	100	99		100	99	103	104	102	90	90	93					83				53				74		
	41	40		46	33	44	48	47	40	39	40					90				92				87		
																44				44				42		
Respirations	19	13	20	20	10	19	18	18	24	30	19									18				18		
	99	99	100	100	97	99	99	90	98	98	98					97%				97%				95		
	3L	3L	3L	3L	3L	3L	2L	RA	RA	RA	RA					RA				RA				12A		
							NC																			
MAP				46	51	67	70	72	59	59	60					61				62				60		
Intake	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
D5	CK 100	100	100	100	100	100	100	100	100	100	100	100	1200	→		300	100	100	100	100	100	100	100	100	100	
DOP	98	98	98	91	131	112	11.2	6.6	off																	
PB				100							50		150													
PO Intake																										
O.R. IN									300			300	600			300						240				
Totals													1950													
Output	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
Urine Hourly	180	110	160	180		140																				
	100	290	450	630	600	850	990	1090	1190	1200	1260		1260			120	50		50	50	50	50	100	150	50	
NG Tube																			50	100	150	300	300	450	500	
#1																										
#2																										
#3																										
Emesis																										
Stool																										
O.R. OUT																										
Totals													1260													

EPW

30 Jul 03

24 hour input

24 hour output

MEDCOM - 15291

ICU 1 EPW [redacted]

ICU Flowsheet Patient Name: Date: 3/31/ / 2003

Vital Signs	24	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23
Temperature			99.6				101.5				100.4			100.8					105				93	
Pulse			78				81				70				81				106				53	
B/P ~~A-Line~~			95/43				93/46				96/51				95/46				81				88	
MAP			63																				100.5	
B/P Cuff																								
Respirations			18				16				15				13				18				16	
Sa02			95				97				98				99				98				96	
			RA				RA				RA				RA				RA				RA	

Intake	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
IV	100	100	100	100	100	100	100	100	100	100	100	100	1200	100	100	100	100	100	100	100	100	100	100	100	100	1200
PO intake	240				60		~~190~~	250 ~~90~~	250 ~~60~~					250												
O.R. IN													800 ~~3000~~						200		200		200	200	200	1000
Totals																										

Output	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
Urine Hourly	50 50	50 100	50 100	100 50	50 300 400		100 90	90 60	80 70	200 900	220 1180	200 1380	1380	70 70	140 210	80 290	140 430	210 640	80 720	80 800	100 900	100 1000	50 1050	50 1100	100 1200	1200
N Tube																										
Drains #1																										
#2																										
#3																										
Emesis																										
Stool							X1																			
O.R. OUT																										
Totals																										

24 hour input	
24 hour output	
24 hour balance	

MEDCOM - 15292

ICU EPW [redacted] Date 01 Aug 02

Vital Signs	24	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23
Blood Pressure			104/64			115/60					103/53				111/65									
Pulse			90			97					87				91									
Resp A-Line			18			14					16				14									
Resp Cuff			99			97					99				98									
O2 Saturations			RA			RA					RA				RA									
Temp		(T)	99.5			101.4					101.5				101.4									

Intake	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	To
IVF	(0)	(00)	(00)	(00)	(00)	(00)	100	100					800													
PO intake	100	100			300	~~280~~	~~260~~	350			250	250	1250	240	240	240		250								
O.R. IN																										
Totals																										

Output	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	To
Urine Hourly	200	100	200	200	180	250	260	250	250	100	100	160	2150	180	140	250	140	350	430	480						
NG Tube	200	300	500	200	780	1030	1290	1540	1790	1890	1990	2150		180	290	540	990	1330	1780							
#1																										
#2																										
#3																										
Emesis																										
Stool																										
O.R. OUT																										
Totals																										

24 hour input
24 hour output

MEDCOM - 15293

	Hours 24–11	Hours 12–23
(Heart rate)	87 61 64 69 64 60 63 63 67 65 72	59 76 74 79 67 64 68 [illegible] [illegible] 105 83
(Blood pressure)	75/64 104/45 115/53 125/49 95/42 107/50 143/58 140/63 132/61 89/35 98/44 100/45	107/52 106/58 106/50 99/48 99/45 99/39 57 124/70 105/44 [illegible] 54 98/43
(Respirations)	22 17 18 17 19 18 20 20 22 18 17 19	18 19 29 17 18 22 18 28 32 18 20 20
(SpO2)	94 93 92 98 94 93 97 97 96 97 97 98	98 99 93 98 97 95 98 98 98 99 98 98
	RA RA RA RA RA RA 1L NC 1L NC 1L NC 1L NC 1L NC 1L NC	1L NC 1L NC RA 1L NC 1L NC 1L NC 1L 1L NC 1L 1L 1L 1L
MAP	86 68 75 75 63 76 73 89 87 56 62 66	70 72 71 67 65 62 105 92 64 83 65
	100 100 100 100 100 100 100 100 100 100 100 100	100 100 100 100 100 100 100 100 100 100 100 100
DOD aunt PB	28.1 28.9 28.9 28.9 28.9 18.4 19.7 19.7 9.2 13.1 13.1 50	13.1 11.8 11.8 11.8 11.8 11.8 11.8 11.8 13.1 13.1 13.1 98
PO intake	400 200	200 350 150 200 150 200 200
O.R. IN		
Totals		

Output	Hours 24–11	Hours 12–23
Urine Hourly	50 50 65 115 55 170 65 235 60 295 75 365 70 435 400 835 270 1105 350 1655 125 1810 110 1910	115 2025 130 2285 220 2545 310 2855 160 2915 290 3205 200 3405 70 3475 70 180 3550 1730 300 145
NG Tube		
Dr. #1 (chest tube)	7 Ø 18	
#2	Ø 8 0 4 0 0 5 15 15	4 3
#3		
Emesis		
Stool		
O.R. OUT		
Totals		

post x-ray

24 hour input

24 hour output

1220/6800 4270/1800 [illegible] 8700 780

[illegible] 1200/1700

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR Aug 1953 — DAY / HOUR

PULSE (O) — TEMP. F (°) — TEMP. C

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

(Centigrade Equivalents, for Reference only)

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

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

CPW # [redacted]

REGISTER NO.

WARD NO. ICW2

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 Aug 2003 | DAY 10 11 11-12 12-13 13 14 15 16 | 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.

VITAL SIGNS RECORDS

Medical Record

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

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY | 19 | HOUR

PULSE (O) | TEMP. F (°)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: | WEIGHT →

Record special data only when so ordered

TEMP. C (Centigrade Equivalents, for Reference only)

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 EPW

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

Start 22 Aug 03

HOSPITAL DAY														
POST- DAY														
MONTH-YEAR	DAY	22 Aug 23		23		25-26		27		27		28 Aug	29 Aug	1 Sept
19	HOUR	0930		20	19	20	20	06	08	20		1100	0930	0800

PULSE (0) / TEMP. F (°): 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50, 40 / 105°, 104°, 103°, 102°, 101°, 100°, 99°, 98.6°, 98°, 97°, 96°, 95°

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)

BP 88/42
HR 78
SpO2 99
T 97.7

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.

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

[redacted] b(6)-2

511-119

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY: 31 Aug | 1 Sep | 2 Sept | 3 Sept | 4 Sept | 5 Sept | 06 Sep

19 | HOUR: 0700 | 9 | 0930 | 1840 | 0800 | 0745 | 080 | 1

PULSE (O) | TEMP. F (°) | TEMP. C

105° — 40.6°

180 — 104° — 40.0°

170 — 103° — 39.4°

160 — 102° — 38.9°

150 — 101° — 38.3°

140 — 100° — 37.8°

130 — 99° — 37.2°

98.6° — 37.0°

120 — 98° — 36.7°

110 — 97° — 36.1°

100 — 96° — 35.6°

90 — 95° — 35.0°

80

70

60

50

40

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD: 16 | 8 | 8

BLOOD PRESSURE: 92/50 | 111/47 | 94/50 | 91/58 | 99/50 | 96/56 | 98/53 | 104/57

83 | 67 | 75 | 81 | 72 | 77 | 92

100% | 146 | R-16 | R-16 | 98.1 | R-18 | 97°

HEIGHT: | WEIGHT → RA | 97% | 100% | R-16 | 98% | 98%

98% | RA 99% | 98.6 RA 98% | T-97.8 RA

96/57

103

97%

97°

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

#[redacted] B(U)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY | POST-OP DAY | MONTH-YEAR 19

DAY: Sept 9 | 8 Sep 03 | 9 Sept | 10 SEP 03 | 11 Sep 03 | 12 SEP 03

HOUR: 9 Sept 0910 | 1130 | 1030 | 9 | 2 | 1

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

PULSE (O)	TEMP. F (°)	TEMP. C
	105°	40.6°
	104°	40.0°
180	103°	39.4°
170	102°	38.9°
160	101°	38.3°
150	100°	37.8°
140	99°	37.2°
130	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

96/57 | 111/63 | 85/56 | 110/57 | 100/52 | 92/57 | 104/57

HEIGHT: | WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

STANDARD FORM 511 (REV. 7–95) BAC

[redacted] b(6)-4

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.

STANDARD FORM 511 (REV. 7-95) BACK

[redacted] b(6)-4

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

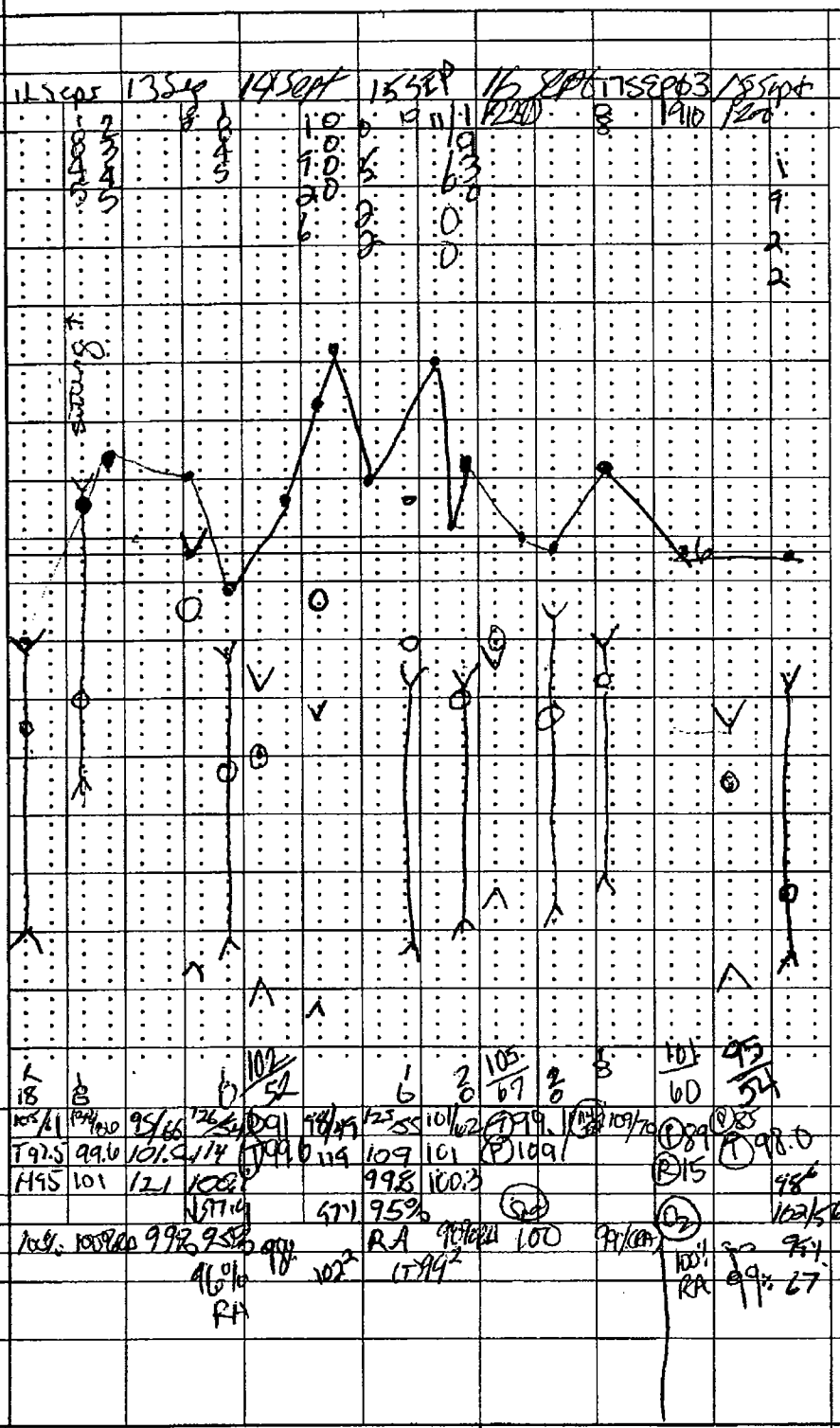
MONTH-YEAR | DAY | HOUR

19

PULSE (O) | TEMP. F (•)

TEMP. C

(Centigrade Equivalents, for Reference only)



RESPIRATION RECORD

BLOOD PRESSURE

Record special data only when so ordered

HEIGHT: | WEIGHT →

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

REGISTER NO.

WARD NO.

[redacted]

VITAL SIGNS RECORDS

Medical Record

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

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR DAY

19 HOUR

PULSE (O) — TEMP. F (•) — TEMP. C

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted] b(6)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY															
POST- DAY															
MONTH-YEAR	DAY	3 OCT		4 OCT		5 OCT									
19	HOUR	0645		0700		0700									

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		16		16											
Record special data only when so ordered	BLOOD PRESSURE	105/54		104/68		105/51									
		H 80		H 80		H 81									
		T 98.4		T 97.9		T 98.2									
	HEIGHT: WEIGHT →	99%		99%		99%									
		RA		RA		RA									

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

REGISTER NO.

WARD NO.

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

[redacted] b(6)-4

EMT

b(6)-2

b(6)-4 EPW [redacted]

[redacted]

DATE 27 Jul 03 | TIME 13 33

(I-STAT)

RESULT	REF. RANGE
	138-146 mmol/L
	3.5-4.5 mmol/L
	98-109 mmol/L
	7.31-7.45
	35-45 mmHg
	95-98%
	8-20 mg/dl
	38-51%

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB	2.7*	3.3-5.5 G/DL
ALP	36	26-84 U/L
ALT	21	10-47 U/L
AMY	35	14-97 U/L
AST	43*	11-38 U/L
TBIL	0.9	0.2-1.6 MG/DL
BUN	9	7-22 MG/DL
CA++	7.7*	8.0-10.3 MG/DL
CHOL	130	100-200 MG/DL
CRE	1.0	0.6-1.2 MG/DL
GLU	104	73-118 MG/DL
TP	4.9*	6.4-8.1 G/DL

======= PICCOLO =======
27/07/03 13:53
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
GENERAL CHEMISTRY 12
DISC LOT #: 3142AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		70-118 mg/dl

======= PICCOLO =======
27/07/03 13:53
REFERENCE RANGE: MALE
PATIENT #: [redacted]
ELECTROLYTE
DISC LOT #: 3135AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

NA+	133	128-145	MMOL/L
K+	3.4	3.3-4.7	MMOL/L
CL-	104	98-108	MMOL/L
tCO2	21	18-33	MMOL/L

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

Misc. Chemistry

RESULT	REF. RANGE

REMARKS:

[redacted] b(6)-2

DATE: 27 Jul 03

LAB ID NO.:

EMT

REQUESTING PHYSICIAN: plus-4

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

NAME: EPW [redacted]

DATE: 27Jul03 | TIME: 1333 | SSN/PSEUDO SSN:

ID: [redacted]
WB 27-07-03 14:01

			Patient Limits	
WBC	8.8	x10^3/uL	4.5	10.5
RBC	3.72 L	x10^6/uL	4.00	6.00
Hgb	10.8 L	g/dL	11.0	18.0
Hct	34.0 L	%	35.0	60.0
MCV	91.4	fL	80.0	99.9
MCH	29.1	pg	27.0	31.0
MCHC	31.9 L	g/dL	33.0	37.0
Plt	172.	x10^3/uL	150.	450.
LYM	7.1 *L	%	20.5	51.1
LYM	0.6 *L	x10^3/uL	1.2	3.4

Hematology / CBC

RESULT	REF. RANGE
	4.8-11.0 x10^3
Baso	
Imm	
	42-52% (M) 37-47% (F)

Urinalysis

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

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

Coagulation Studies

RESULT	REF. RANGE
PT 16.0	9.8-13.1 sec
PTT 29.9	21-31 sec
	250 mg/dl
	10 mg/dl

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

UNIT	TYPE	CROSSMATCH

LAB BY: [redacted] DATE: 27Jul LAB ID NO.:

15.9/16.0 = 16.0
29.7/30.1 = 29.9

Ward/Section: FCU #1

REQUESTING PHYSICIAN: b(6)-4

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

LAST, FIRST, MI: EPW [redacted]

DATE: 28/07/03 | TIME: 0400 | SSN/PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BBeef		(-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) Metabolic Panel

(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		39-330 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 =======
28/07/03 04:11
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #: 3152AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	172*	73-118	MG/DL
BUN	7	7-22	MG/DL
CRE	1.0	0.6-1.2	MG/DL
CK	1111*	39-380	U/L
NA+	133	128-145	MMOL
K+	3.9	3.3-4.7	MMOL
CL-	103	98-108	MMOL
tCO2	23	18-33	MMOL

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

REMARKS:

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

DATE: 28 July 03

LAB ID NO.:

Ward/Section: ICU #1

REQUESTING PHYSICIAN: b(6)-4

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

LAST, FIRST, MI: EPW [redacted]

DATE: 28Jul03 | TIME: 0400 | SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10³
RBC		4.7-6.1 x 10⁶

ID: [redacted]
WB

28-07-03
04:15

				Patient Limits	
WBC	11.7 H	x10^3/uL		4.5	10.5
RBC	3.76 L	x10^6/uL		4.00	6.00
Hgb	11.0 L	g/dL		11.0	18.0
Hct	34.6 L	%		35.0	60.0
MCV	92.0	fL		80.0	99.9
MCH	29.2	pg		27.0	31.0
MCHC	31.7 L	g/dL		33.0	37.0
Plt	199.	x10^3/uL		150.	450.
LY%	9.3	*L	%	20.5	51.1
LY#	1.1	*	x10^3/uL	1.2	3.4

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

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted]

DATE: 28Jul03

LAB ID NO.:

b(6)-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. EPW 9 [redacted]	DATE 7-29	TIME 0650	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
RBC		
Hgb		
Hct		
MCV		
Plt		
Lym		
(E		
Segs		
Ban		
Lym		
Atyp		Imm
RBC Morph		
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

ID: [redacted] 29-07-03
WB 07:20

			Patient Limits	
WBC	9.1	x10^3/uL	4.5	10.5
RBC	3.87 L	x10^6/uL	4.00	6.00
Hgb	11.3	g/dL	11.0	18.0
Hct	35.2	%	35.0	60.0
MCV	91.0	fL	80.0	99.9
MCH	29.3	pg	27.0	31.0
MCHC	32.2 L	g/dL	33.0	37.0
Plt	194.	x10^3/uL	150.	450.
LY%	7.7 *L	%	20.5	51.1
LY#	0.7 *L	x10^3/uL	1.2	3.4

Urinalysis b(6)-2

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

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS: b(6)-2

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

Ward/Section: ICU 7

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

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

DATE: 7/29 | TIME: 0655

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

SSN/PSEUDO SSN:

(i-STAT)	(Piccolo) Chemistry 12	(Piccolo) Metabolic Panel
TEST | RESULT | REF. RANG		

---

i-STAT 6+

Pt: [redacted]

Pt Name:_____

Glu_____132 mg/dL

BUN_____3 mg/dL

Na_____135 mmol/L

K_____3.3 mmol/L

Cl_____102 mmol/L

Hct_____32 %PCV

Hb*_____11 g/dL

*via Hct

Sample Type_:

29JUL03 07:50

Oper: 7210

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

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

29/07/03 07:35

REFERENCE RANGE: MALE

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

GENERAL CHEMISTRY 12

DISC LOT #: 3142AA4

OPER #: [redacted] DR #: 000

SERIAL #: [redacted]

ALB	2.8*	3.3-5.5	G/DL
ALP	46	26-84	U/L
ALT	44	10-47	U/L
AMY	32	14-97	U/L
AST	27	11-38	U/L
TBIL	0.5	0.2-1.6	MG/DL
BUN	♦♦♦	7-22	MG/DL
CA++	8.4	8.0-10.3	MG/DL
CHOL	141	100-200	MG/DL
CRE	0.7	0.6-1.2	MG/DL
GLU	138*	73-118	MG/DL
TP	5.9*	6.4-8.1	G/DL

INST QC: OK CHEM QC: OK

HEM 1+, LIP 0 , ICT 0

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

29/07/03 07:31

REFERENCE RANGE: MALE

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

ELECTROLYTE

DISC LOT #: 3135AA4

OPER #: [redacted] DR #: 000

SERIAL #: [redacted]

NA+	♦♦♦	128-145	MMOL
K+	3.5	3.3-4.7	MMOL
CL-	99	98-108	MMOL
tCO2	26	18-33	MMOL

INST QC: OK CHEM QC: OK

HEM 1+, LIP 0 , ICT 0

REMARKS: b(6)-2

REPORTED BY: [redacted]

DATE: 29JUL03

LAB ID NO.:

b(6)-2

rd/Section: ICU	REQUESTI[redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
AST, FIRST, MI. b(6)-2 EPU [redacted]	ATE 7/29	TIME 0850	SSN/PSEUDO SSN:

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3	Color	Straw	N/A	RPR		Negative
RBC		4.7-6.1 x 10^9	App	Clear	N/A	Mono		Negative
Hgb		14-18 g/dl (M) 12-16 g/dl (F)	Glu	Neg	Negative	**Microbiology**		
Hct		42-52% (M) 37-47% (F)	Bili	Neg	Negative	Source		
MCV		80-94 fl (M) 81-99 fl (F)	Ket	Neg	Negative	Gram Stain		
Plt		130-500 x 10^3 verified	SG	1015	N/A	Occ Bld		Negative
Lymph %		20.5-51.1%	Bld	Neg	Negative	H. pylori		Negative
(Hematology) Manual Differential			pH	6.5	N/A	Micro Parasites		
Segs		Mono	Prot	Neg	Negative	Malaria		
Bands		Eos	Urob	0.2	0.2-1.0	O & P		
Lymph		Baso	Nit	Neg	Negative	Other		
Atyp		Imm	Leuk		Negative	**Microscopic Urinalysis**		
RBC Morph			HCG		Negative			
Spun Hematocrit		42-52% (M) 37-47% (F)	**CSF**			**Blood Bank**		
Sed Rate			Cell Count			**MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED**		
Other			Directigen		Negative	ABO/Rh		

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

REMARKS: b(6)-2

REPORTED BY: [redacted] **DATE:** 29/7/03 **LAB ID NO.:**

b(6)-4

Ward/Section: ICU	REQUESTING PHYSICI[redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI.	[redacted] TIME 7-30 03 0400	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WB		
RB		
Hgl		
Hct		
MC		
Plt		
Ly		
S		
B		
I		
Atyp		Imm
RBC Morph		
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

ID: [redacted]
WB

30-07-03
04:07

			Patient Limits	
WBC	8.2	x10^3/uL	4.5	10.5
RBC	3.14 L	x10^6/uL	4.00	6.00
Hgb	9.1 L	g/dL	11.0	18.0
Hct	28.7 L	%	35.0	60.0
MCV	91.4	fL	80.0	99.9
MCH	29.1	pg	27.0	31.0
MCHC	31.8 L	g/dL	33.0	37.0
Plt	183.	x10^3/uL	150.	450.
LY%	11.5 *L	%	20.5	51.1
LY#	0.9 *L	x10^3/uL	1.2	3.4

Urinalysis

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

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
[redacted]	30 Jul 03	

b(6)-2

b(6) - 2

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

LAST, FIRST, MI: b(6) - 4 [redacted] | DATE: 7-30-03 | TIME: 0400 | SSN/PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/l

======= PICCOLO =======
30/07/03 04:07
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
GENERAL CHEMISTRY 12
DISC LOT #: 3204AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

ALB	2.2*	3.3-5.5	G/DL
ALP	43	26-84	U/L
ALT	53*	10-47	U/L
AMY	39	14-97	U/L
AST	39*	11-38	U/L
TBIL	0.6	0.2-1.6	MG/DL
BUN	♦♦♦	7-22	MG/DL
CA++	8.1	8.0-10.3	MG/DL
CHOL	120	100-200	MG/DL
CRE	1.2	0.6-1.2	MG/DL
GLU	125*	73-118	MG/DL
TP	5.1*	6.4-8.1	G/DL

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

Bun 5

(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
[redacted]		
		30-190 u/l (F)
NA+		128-145 mmol/l
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
CO2		18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
CL-		98-108 mmol/l
ICO2		18-33 mmol/l

i-STAT 6+
Pt: [redacted]
Pt Name:_____

Glu_____118 mg/dL
BUN_____5 mg/dL
Na_____136 mmol/L
K_____3.3 mmol/L
Cl_____101 mmol/L
Hct_____27 %PCV
Hb*_____9 g/dL
*via Hct

Sample Type_:
30JUL03 04:06
Oper: 13
Physician:_____
Ser# [redacted]
Ver: JAMS046A
CLEW A93

REPORTED BY:	DATE:	LAB ID NO.:
[redacted] b(6)-2	30Jul03	

b(6)-4
[redacted]

IC - #1

b(6)-2

Ward/Section: ICU #1	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: 31 Jul 03 / TIME: 0745	SSN/PSEUDO SSN: [redacted] b(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10³
RBC Morph		
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

ID: [redacted] 31-07-03 08:05

			Patient Limits	
WBC	6.7	x10^3/uL	4.5	10.5
RBC	2.90 L	x10^6/uL	4.00	6.00
Hgb	8.6 L	g/dL	11.0	18.0
Hct	27.0 L	%	35.0	60.0
MCV	93.1	fL	80.0	99.9
MCH	29.5	pg	27.0	31.0
MCHC	31.7 L	g/dL	33.0	37.0
Plt	196.	x10^3/uL	150.	450.
LY%	10.2 *L	%	20.5	51.1
LY#	0.7 *L	x10^3/uL	1.2	3.4

Coagulation Studies

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

Urinalysis

TEST	RESULT	REF. RANGE
Color	yellow	N/A
App	Clear	N/A
Glu	Neg	Negative
Bili	Neg	Negative
Ket	Neg	Negative
SG	1.015	N/A
Bld	Neg	Negative
pH	7.5	N/A
Prot	Neg	Negative
Urob	4	0.2-1.0
Nit	Neg	Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

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

0-2 WBCs
0-2 RBCs

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(6)-4

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

Ward/Section: ICW2	REQUESTING PHYSICIAN: VOR [redacted] b(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRS[redacted] b(6)-4	DATE 8/9	TIME 1945	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WI		
RE		
Hg		
Hc		
MI		
Pl		
Ly		
Se		
B		
Lymph		Baso
Atyp		Imm
RBC Morph		

ID: [redacted] 04-08-03
WB 19:24

			Patient Limits	
WBC	8.8	x10^3/uL	4.5	10.5
RBC	3.77 L	x10^6/uL	4.00	6.00
Hgb	10.6 L	g/dL	11.0	18.0
Hct	34.7 L	%	35.0	60.0
MCV	91.9	fL	80.0	99.9
MCH	28.1	pg	27.0	31.0
MCHC	30.6 L	g/dL	33.0	37.0
Plt	483. H	x10^3/uL	150.	450.
LY%	16.2 *L	%	20.5	51.1
LY#	1.4 *	x10^3/uL	1.2	3.4

Urinalysis

TEST	RESULT	REF. RANGE
Color	Yellow	N/A
App	clear	N/A
Glu	neg	Negative
Bili	neg	Negative
Ket	neg	Negative
SG	1.025	N/A
Bld	neg	Negative
pH	6.0	N/A
Prot	neg	Negative
Urob	neg	0.2-1.0
Nit	neg	Negative
Leuk		Negative
HCG		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

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

b(6)-2

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

LAST, FIRST, MI.	DATE	TIME	SSN/PSEUDO SSN:
[redacted] b(6)-4	6 AUG 03	0737	[redacted] b(6)-4

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*
WBC		4.8-10.8 x 10^3	Color		N/A	RPR		Negative
		4.7-6.1 x 10^9	App		N/A	Mono		Negative
			Glu		Negative	**Microbiology**		
			Bili		Negative	Source		
			Ket		Negative	Gram Stain		
			SG		N/A	Occ Bld		Negative
			Bld		Negative	H. pylori		Negative
			pH		N/A	Micro Parasites		
			Prot		Negative	Malaria		
			Urob		0.2-1.0	O & P		
			Nit		Negative	Other		
			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.:

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

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

(Hematology) CBC			**Urinalysis**			**Misc. Serology**		
TEST	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*
WBC		4.8-10.8 x 10^3	Color		N/A	RPR		Negative
RBC		4.7-6.1 x 10^9	App		N/A	Mono		Negative
Hg			Glu		Negative	**Microbiology**		
Hc			Bili		Negative	Source		
M			Ket		Negative	Gram Stain		
Pl			SG		N/A	Occ Bld		Negative
L			Bld		Negative	H. pylori		Negative
			pH		N/A	Micro Parasites		
S			Prot		Negative	Malaria		
B			Urob		0.2-1.0	O & P		
L			Nit		Negative	Other		
At			Leuk		Negative	**Microscopic Urinalysis**		
RBC Morph			HCG		Negative			
Spun Hematocrit		42-52% (M) 37-47% (F)	**CSF**			**Blood Bank**		
Sed Rate			Cell Count			**MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED**		
Other			Directigen		Negative	ABO/Rh		

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

REMARKS:

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

b(6)-2

Ward/Section: JCW2	REQUESTING PHYSICIAN: [redacted] b(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted] b(6)-2	DATE 13AUG TIME 2204	SSN/PSEUDO SSN:

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3	Color	yellow	N/A	RPR		Negative
RBC		4.7-6.1 x 10^9	App	cloudy	N/A	Mono		Negative
Hgb		14-18 g/dl (M) 12-16 g/dl (F)	Glu	neg	Negative	**Microbiology**		
Hct		42-52% (M) 37-47% (F)	Bili	neg	Negative	Source		
MCV		80-94 fl (M) 81-99 fl (F)	Ket	neg	Negative	Gram Stain		
Plt		130-500 x 10^3 verified	SG	1.015	N/A	Occ Bld		Negative
Lymph %		20.5-51.1%	Bld	neg	Negative	H. pylori		Negative
(Hematology) Manual Differential			pH	6.5	N/A	Micro Parasites		
Segs		Mono	Prot	neg	Negative	Malaria		
Bands		Eos	Urob	8.0	0.2-1.0	O & P		
Lymph		Baso	Nit	pos	Negative	Other		
Atyp		Imm	Leuk		Negative	**Microscopic Urinalysis**		
RBC Morph			HCG		Negative	Bacteria - 4+ 20-30 WBC 10-20 RBC		
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: b(6)-2

REPORTED BY: [redacted]	DATE: 13 Aug 03	LAB ID NO.:

NSN 7540-01-165-7294

519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

EXAMINATION(S) REQUESTED	AGE	SEX	SSN *(Sponsor)*	WARD/CLINIC	REGISTER NO.
CXR		M			
	FILM NO.		b(6)-2		PREGNANT ☐ YES ☐ NO
	REQUESTED BY *(Print)* [redacted]				TELEPHONE/PAGE NO.
NDW! please	SI[redacted]				DATE REQUESTED 27 Jul 03

SPECIFIC REASON(S) FOR REQUEST *(Complaints and findings)*

✓ line placement

Sgt ILTN

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
ICU1 b(6)-4 FPW [redacted]	LOCATION OF RADIOLOGIC FACILITY
	SIGNATURE

MEDCOM - 15320

I TATION

STANDARD FORM 519-R
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

1520 dopa
1530 [redacted]

~~NOTED @ 1600~~ [redacted]

NURSING UNIT: ~~ICU~~ 1 | ROOM NO. | BED NO.

DATE OF ORDER: 27 July 03 | TIME OF ORDER: 1525 HOURS | LIST TIME ORDER NOTED AND SIGN

Dopamine 5mg/IV bolus - done
Phenergan 12.5 mg/IVP - done
[redacted] IV D5NS @ 20 [redacted]
b(6)-2
[redacted]
24 hr cc Done 27JUL03 [redacted]

PATIENT IDENTIFICATION

[redacted]

DATE OF ORDER: 27JUL03 | TIME OF ORDER: 1830 HOURS

(1) MSO4 2-10 mg IV q 1° PRN severe pain.
(2) Lumbar D[redacted] to drain 20 cc/hr [redacted]
[redacted] 197 b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

[redacted]

b(6)-4

DATE OF ORDER [redacted] TIME OF ORDER _____ HOURS

(1) Patient is not to sit up. Not to be manipulated in anything other than a log roll UNLESS NEUROSURGERY WRITES AN ORDER OTHERWISE.
(2) CXR post line insertion. TONITE or Before 7 AM

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER

(3) BMP, CBC in AM 28 JUL 03. HOURS

[redacted]

b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

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

SURGICAL RECORD

[redacted]

b(6)-4

[redacted]

[redacted]

b(6)-4

[redacted]

DATE OF ORDER

27 JUL 03 14:15
Admit to ICU
Dr [redacted]
Consult for [redacted] b(6)-2
VS q 1 h, Strict I+O
Pt must remain on a Backboard until you hear further from Neurosurgery

Foley to BSD
Pleurevac to continuous suction
~~LR @ 200cc/h~~
~~Ampicillin 2g IV q6~~
~~Gentamicin 240mg IV q8~~
~~Flagyl 500mg IV q8h~~
Tylenol 650mg PR q4h PRN
NPO.

Rocephin 2g IV q24h [redacted] b(6)-2
start today [redacted] MAJ [redacted]
Spinal Cord Precautions
Log Roll only
~~Zantac 50mg IV q8h~~
Lasix 20mg ~~IV q8~~ 12h b(6)-2
[redacted] MAJ [redacted]

27 JUL 03 1400.
Dopamine drip
start at 5 micrograms/kg/min
+ Titrate To MAP ≥ 75.
D5 1/2 NS 1000mg KCl at 200cc/hr
CXR s/p
CVP line.
b(6)-2 [redacted] MAJ [redacted]

[redacted]

24 hr cc Dow

[redacted] OPT/AN

b(6)-2

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: 28 July 03 TIME OF ORDER: 1045 HOURS | LIST TIME ORDER NOTED AND SIGN

Place CT on water seal - done OH
CXR in 6° p on water seal.
Sgn
Regdiet.
Please turn pt and
leave on side for 20 at a time [redacted]

28 Jul 03 1100

PATIENT IDENTIFICATION

#[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 29JUL03 TIME OF ORDER: 0635 HOURS 0640

1. CBC, Lytes q Am.

[redacted] 1757 [redacted]

b(6)-2

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 30JUL03 TIME OF ORDER: 0659 HOURS

1. May elevate HOB Ad-Lib.
2. D/C q Am CBC/Lytes - drain is out.
3. Wean [redacted] off for Swake/SBA [redacted]

[redacted] 1757 [redacted]

b(6)-2

PATIENT IDENTIFICATION

#[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 30JUL03 TIME OF ORDER: 0745 HOURS [redacted]

1. Colace 100 mg po BID.
2. Bisacodyl suppository / Digital Rectal Stimulation q Day
3. Fleet's Enema prn.

[redacted] 1757

b(6)-2

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JU[redacted] WHICH MAY BE USED.

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

#[redacted]

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 29 July 03 TIME OF ORDER: 0650 HOURS

LIST TIME ORDER NOTED AND SIGN: 0655

(1) Wean dopamine to keep SBP ≥ 90

(2) Have translator ask pt why he is not eating

(3) Encourage p.o. intake

[redacted]

PATIENT IDENTIFICATION

#[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 7/29 TIME OF [redacted] HOURS: 0850

LIST TIME ORDER NOTED AND SIGN: 0900

UA per U/O Dr. [redacted]

b(6)-2

PATIENT IDENTIFICATION

b(6)-4 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 29 JUL 03 TIME OF ORDER: 15:20 HOURS

LIST TIME ORDER NOTED AND SIGN: 1525

(1) D/C Chest Tube - done

(2) CXR AP inspiratory

b(6)-2

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER: HOURS

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICU 1		1

DATE OF ORDER: 30 JUL 03 TIME OF ORDER: 1020 HOURS

LIST TIME ORDER NOTED AND SIGN

1. VS q 4° [redacted]

[redacted] b(6)-2

PATIENT IDENTIFICATION

EPW # [redacted] b(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 30 JUL 03 TIME OF ORDER: 1151 HOURS

1. D/C Central Line
2. Change ranitidine to 150 mg po BID
3. ↓ Levenox to 40 [redacted] SQ q 24

b(6)-2 [redacted] 1797

PATIENT IDENTIFICATION

EPW # [redacted] b(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER [redacted] ORDER HOURS

1. D/C Lumber Drain Orders — removed.
2. D/C log roll / Spine precautions — may be up ad-lib.
3. UA + micro.
4. CBC. b(6)-2 [redacted] 1797
5. CXR.
6. Tylenol 650 mg q 4° pm [redacted]

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 01 AUG 03 TIME OF ORDER: 0654 HOURS

1. Q 4 Cough (abdominal thrust support) q 4°
2. Percocet 1-2 po q 4° pm Prn.
3. D/C IVF. S/L IV [redacted] 1797

b(6)-2

DA FORM 1 APR 79 4256 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.

PATIENT IDENTIFICATION

[redacted] b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 04AUG03 TIME OF ORDER: 0633 HOURS

LIST TIME ORDER NOTED AND SIGN

1. D/C MSO4
2. D/C Rocephin

0700 04 Aug 03 OH

[redacted] b(6)-2 4797

PATIENT IDENTIFICATION

b(6)-4 [redacted]

EP W

NURSING UNIT: ICWZ | ROOM NO. | BED NO.

DATE OF ORDER: 04AUG03 TIME OF ORDER: 1132 HOURS

1. Transfer ICWZ - Neuro - Teff
2. Dx Shrapnel T4 with paraplegia
3. Condition Good
4. Vitals q 8°
5. Activity HOB Ad-Lib.
6. Nursing Foley. Leg roll - pressure reduction q 2°

1500 now 4W

PATIENT IDENTIFICATION

EP W b(6)-4 [redacted]

NURSING UNIT: ICWZ | ROOM NO. | BED NO. 1

- Dressing Δ back dry BID.
- Pump Lower extremities q 4°
7. Diet Regular.
8. IV saline lock.
9. Meds Codeine 60 mg po BID
   Zantac 150 mg po BID
   Lovenox 40 mg SQ q Day

PATIENT IDENTIFICATION

EP W b(6)-4 [redacted]

NURSING UNIT: ICWZ | ROOM NO. | BED NO. 1

Bisacodyl suppository / Digital rectal stimulation q Δ pm.
Tylenol 650 mg po q 4° pm
Percocet 1-2 po q 4° pm.
Fleet's enema pm.

10. Lab/X-ray none.

[redacted] 4797 b(6)-2

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

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 BOLOW.

PATIENT IDENTIFICATION

[redacted] b(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 4 Aug 04 TIME OF ORDER: 1900 HOURS

(1) CXR
(2) UA, CBC
(3) ~~Tyl #3 ~~ Bera 12
(4) Tylenol 1000mg PO now

24° ✓done [redacted] TC [redacted]

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 8/6/03 TIME OF ORDER: 1635 HOURS

(1) CBC done ✓ b(6)-2
(2) D/C IV

[redacted]

noted [redacted] 9/wme 6 Aug 03 1612

24° ✓done [redacted]

PATIENT IDENTIFICATION

b(6)-4 [redacted]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 13 ~~JULY~~ Aug 03 TIME OF ORDER: 0154 HOURS

b(6)-2

V.O.
50 mg Benadryl PO x 1 now for sleep
Dr [redacted]

24° ✓done [redacted]

note 0154 13 Aug [redacted]

PATIENT IDENTIFICATION

b(6)-4 [redacted]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 13 Aug TIME OF ORDER: [redacted] HOURS

V.O.

b(6)-2

CXR [redacted] alysis

Dr [redacted]

note 2102 13 Aug [redacted]

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH M[redacted]D.

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b(6)-4 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 13 Aug | TIME OF ORDER: 08:50 HOURS | LIST TIME ORDER NOTED AND SIGN

V.O.

Levaquin 500mg PO QD

Dr. [redacted]

b(6)-2 [redacted]

24° ✓ done [redacted]

noted 08:50 13 Aug 03

PATIENT IDENTIFICATION

[redacted] b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 14 Aug | ORDER | HOURS

Levaquin 500 [redacted] x5d

[redacted] b(6)-2

noted [redacted] 9/Wm4 14 Aug 03 2100

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 14 Aug 03 | ORDER | 21:50 HOURS

V.O.

Robitussin elixir 2tsp q4° PO PRN coughing

RT q 4° for [redacted] rol tx

Dr [redacted]

24° ✓ done [redacted] 24/AN

noted 21:50 14 Aug 03 [redacted]

PATIENT IDENTIFICATION

b(6)-4 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 17 Aug 03 2040 | ORDER | HOURS

Please re-evaluate pt for Resp. tx.

Pt's BBS are CT[redacted] pt coughs up secretions ī ea[redacted] 5q[redacted] 2ø

b(6)-2

24° [redacted]

noted [redacted] 9/Wm4 17 Aug 03 2040

b(6)-2

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

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

DATE OF ORDER: 15 Aug — TIME OF ORDER: 2200 HOURS — LIST TIME ORDER NOTED AND SIGNED

1. Elavil 25 mg tp po qhs
2. Ambien 10 mg tp po qhs x 1 PRN

[redacted] b(6)-2 [redacted] Noted 17 Aug 22:14

NURSING UNIT: 2P | ROOM NO. [redacted] | BED NO.

3. Resp. tx Neb po PRN q4

PATIENT IDENTIFICATION [redacted] b(6)-2

ORDER: 1503 — TIME OF ORDER: 26AUG03 HOURS

Discharge to FPW Camp

b(6)-2 [redacted] Noted 26 Aug 03 1530

#[redacted] b(6)-4

NURSING UNIT: ICU#1 | ROOM NO.: 2P/03M | BED NO.: [redacted]

PATIENT IDENTIFICATION: [redacted] b(6)-2 [redacted] ORDER: [redacted] HOURS

NURSING UNIT | ROOM NO. | BED NO.

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

DATE OF ORDER | TIME OF ORDER | HOURS

NURSING UNIT | ROOM NO. | BED NO.

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 1996—403-924

"USE BALL POINT PEN—PRESS FIRMLY! NO CARBON PAPER REQUIRED"

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.
ICU		[redacted]

DATE OF ORDER: 07SEP03 TIME OF ORDER: 1318 HOURS

(1) Hospital Bed. If none, transfer to ICU.

[redacted] b(6)-2 7747

LIST TIME ORDER NOTED AND SIGN: [redacted] 7 Sep 03 1322

PATIENT IDENTIFICATION

b(6)-4 [redacted]

NURSING UNIT	ROOM NO.	BED NO.
24°	2100	13

DATE OF ORDER: 12SEP03 TIME OF ORDER: 2330 HOURS

(1) Phenergan 25mg po Q4-6° prn. V.O. Dr [redacted]

PATIENT IDENTIFICATION

b(6)-4 [redacted]

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

DATE OF ORDER: 1 OCT 03 TIME OF ORDER: b(6)-2 2200 HOURS

V.O. DR [redacted]

VS Q DAY

[redacted] b(6)-2 0001

[redacted] 2300 1 OCT 03

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION			↓	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
b(6)-4 [redacted]				06OCT03	0848 HOURS	
			1	Discharge to other hospital		
				[redacted]		[redacted]
NURSING UNIT	ROOM NO.	BED NO.				
ICU					b(6)-2	
PATIENT IDENTIFICATION				DATE OF OR[redacted]	TIME OF ORDER HOURS	b(6)-2
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.

b(6)-2
A11

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 7 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 27	28	29	30	31	01	2	3	4	5	6
27Jul	[redacted]	US Q4h Start IV	05	[redacted]										
		Sat 30Jul03	17											
27Jul	[redacted]	Foley to BSO	05	[redacted]										
			17											
27Jul	[redacted]	Pleurovac to	05	[redacted]										
		continuous suction	17				D/C		7-28			Pr LT	[redacted]	
27Jul	[redacted]	~~NPO~~ RD	05	[redacted]			[redacted]							
			17	JMM			K9							
27Jul	[redacted]	Spinal board	05	[redacted]										
		Caution log roll	17	[redacted]							7/30			
		only												
27Jul03	[redacted]	Lumbar drain to	05	[redacted]										
		drain 20cc/hr	17	[redacted]				D/C	7/31					
27Jul 03	[redacted]	Pt is not to sit up	05	[redacted]										
		not to be manipulated	17	[redacted]				D/C	7/31					
		in anything other than												
		log roll, unless neuro-												
		surgery writes order												
28 Jul 03	[redacted]	Reg diet	05	[redacted]										
			17	[redacted]										
28 Jul 03	[redacted]	Please turn pt and leave	05	[redacted]										
		on side for 2° at a time	17	[redacted]										
7/29	[redacted]	CRC alternate q am	04	[redacted]										
7/29	[redacted]	Wean dopa to keep	05	[redacted]										
7/30	[redacted]	SBP > ~~90~~ > 80	17	[redacted]										
7/29	[redacted]	Enc PO intake	05	[redacted]										
			17	[redacted]										

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: SIP GSW to Back

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

EPW # [redacted]

b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)			Mo ____ Yr 2003	
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
[redacted]	[redacted]	[redacted]			1445	[redacted]
[redacted]	[redacted]	[redacted]				[redacted]
	[redacted]	[redacted]			1450	[redacted]
[redacted]	[redacted]	[redacted]			1455	[redacted]
	[redacted]	[redacted]				[redacted]
	-----	[redacted]				
27 Jul 03	[redacted]	CXR post line insertion	27 Jul 03 to 28 Jul 03	before 7AM	27 Jul 03 2300	[redacted]
	-----	to ninight or before 7AM				
27 Jul 03	[redacted]	BMP, CBC in am	28 Jul 03	0400	0400	[redacted]
28 Jul 03	[redacted]	Place CT on water seal	28 Jul 03	~~1045~~	1045	[redacted]
28 Jul 03	[redacted]	Chest X Ray in 6° p on water seal	28 Jul 03	1700	1900	[redacted]
7/29	[redacted]	Have transfusion cross match pt not eating	7/29 03	ASAP	0725	[redacted]
	-----		~~7/29 03~~	~~ASAP~~	~~2200~~	[redacted]
7/29	[redacted]	UA ~~yes~~	7/29	ASAP	0905	[redacted]
7/29	[redacted]	~~BH~~ CXR AP inspiration	7/29	ASAP		
7/29	[redacted]	CT D/C	7/29	1520	1525	[redacted]

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

b(6)-2

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

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 01	02	03	04
01Aug03	[redacted]	Quad Cough (Abdominal	03	[redacted]		[redacted]	
		thrust support) q 4°	07			[redacted]	
b(6)-2			11			[redacted]	
			15				
			19			[redacted]	
			23				

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P GSW to back

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

EPW # [redacted] b(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

b1 (b) - 2 A11

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo _____ Yr 2003

Verify by Initialing: Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
7/31/03	[redacted]	D/C lumbar Drain Orders - removed	31 Jul 03	ASAP	0700	[redacted]
7/31/03	[redacted]	D/C log roll / spine precautions - may be up ad lib	31 Jul 03	ASAP	0700	[redacted]
7/31/03	[redacted]	UA & micro	31 Jul 03	ASAP	0745	[redacted]
7/31/03	[redacted]	CBC	31 Jul 03	ASAP	0745	[redacted]
7/31/03	[redacted]	CXR	31 Jul 03	ASAP	0830	[redacted]

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

b(6)-2

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. AUG Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 4	5	6	7	8	9	10	11	12	13	14	15	16	17
4 AUG 03	[redacted]	Vitals q 8°	05	/	[redacted]												
			13	/													
			21	[redacted]													
4 AUG 03	[redacted]	Activity ↑ HOB Ad Lib	05	/	[redacted]												
			13	/													
			21	[redacted]													
4 AUG 03	[redacted]	Log Roll-pressure reducing q 2°	05	/	[redacted]												
			13	/													
			21	[redacted]													
4 AUG 03	[redacted]	Dressing Δ back dry BID	10	/	[redacted]												
			22	[redacted]													
4 AUG 03	[redacted]	ROM Lower extremity q 4°	05	/	[redacted]												
			13	/													
			21	[redacted]													
4 AUG	[redacted]	Diet Regular	07 05	/	[redacted]												
			12 13	/													
			17 21	[redacted]													
~~4 AUG~~	[redacted]	~~IV Saline Lock~~ end @	05	/													
			13	/													
			21	/													

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Surgical T-4 c̄ Paraplegia

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION: Eph [redacted] HCS-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

DA FORM 4677, 1 OCT 78 — EDITION OF 1 DEC 77 MAY BE USED. — USAPA V1.00

b(6)-2

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo 8 Yr 03

Verify by Initialing: Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
6	[redacted]	CBC	7 Aug	0400	0400	[redacted]
13	[redacted]	CXR and urinalysis	13 Aug	now	2130	[redacted]
17	[redacted]	Re-evaluate for Resp 4x	18 Aug	Am	0810	[redacted]
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INITIAL PROPER COLUMN FOLLOWING COMPLETION

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	TIME/DATE COMPLETED													
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USAPA V1.0(

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

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 15	16	17	18	19	20	21	22	23	24	25	26	27	28
8/7	[redacted]	Q8° VS	6	[redacted]													
			18														
8/7	[redacted]	ACT ↑ HOB, Adlib	6														
			18														
8/2	[redacted]	LOG ROLL Q2° pressure	6														
		reduction	18														
8/2	[redacted]	ROM (B) LE Q4°	6														
			18														
8/2	[redacted]	DISC Δ BID To Back	10														
		(Dry)	22														
8/2	[redacted]	Regular Diet	6														
			18														

ALLERGIES: ☐ YES ☑ NO

NKDA

PRIMARY DIAGNOSIS: Shrapnel T-4 Para

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ___

PATIENT IDENTIFICATION:

EPW b(6)-4

[redacted]

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

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

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 1	2	3	4	5	6	7	8	9	10	11	12	13	14
8-17	[redacted]	VS: Q8°	6	O	O	[redacted]											
			18	[redacted]													
8-17	[redacted]	ACT ↑ HOB, ad lib	6	O	O	[redacted]											
			18	[redacted]													
8-12	[redacted]	Log roll Q2°, pressure	6	O	O	[redacted]											
		reduction	18	[redacted]													
8-12	[redacted]	ROM (B) lower ext	6	O	O	[redacted]											
		Q4°	18	[redacted]													
8-12	[redacted]	Drsg Δ BID to back	10	O	O	[redacted]											
		(dry)	22	[redacted]													
8-12	[redacted]	Regular DIET	6	O	O	[redacted]											
			18	[redacted]													
9/7	[redacted]	Hospital bed. Pt															
	[redacted]	none transfer to ICU															

See back of sheet [redacted]

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS:
Shrapnel T-4 para

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

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 09 Yr 2003
Order Date	Clerk Nurse	b(6)-2 SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
9/7	[redacted]	Hospital Med. If none	10 SEP 03	—	—	[redacted]
		Transfer to ICE				

	-----					

b(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													
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b(6)-2 b(6)-2

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 10 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 29	30	1	2	3	4	5	6	7	8
30 AUG03	[redacted]	VS Q8H DAY	06		/	[redacted]							
		(recopied)	18	[redacted]	/	[redacted]							
	[redacted]												
30	[redacted]	Act: HOBT, ad lib	06	[redacted]	/	[redacted]							
		(recopied)	18	[redacted]									
	[redacted]												
30	[redacted]	Log Roll Q2	06	[redacted]	/	[redacted]							
		Pressure Reduction	18	[redacted]									
		(recopied)											
30	[redacted]	ROM (B)LE Q4	06	[redacted]	/	[redacted]							
		(recopied)	18	[redacted]									
				[redacted]									
30	[redacted]	DSG Δ BID to back	06	[redacted]	/	[redacted]							
		(Dry) (recopied)	18	[redacted]									
	[redacted]												
30	[redacted]	Regular Diet	06	[redacted]	/	[redacted]							
			18	[redacted]									

ALLERGIES: ☐ YES ☑ NO
NKDA

PRIMARY DIAGNOSIS: Shrapnel, T4 para

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

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*				Mo 10 Yr 2003
Order Date	Clerk Nurse	b(6)-2 SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
10/6	[redacted]	D/C to prison hospital	10/6			

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

b(6)-2 ↓ b(6)-2 ↓

CLINICAL RECORD

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

Mo. ___ Yr

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED (27 28 29 30 31 01 02 03 4 5 6)
27Jul03	[redacted]	Morphine 2g IV		
		PCA 4h start	16	[redacted] D/C 01Aug03 0700 01
		Hydrate		
27Jul	[redacted]	Zantac 50mg IV	08	Retained 27 Jul 03 @ 1400 hrs 01
		q 8h	16	[redacted]
			24	
27Jul	[redacted]	Lovenox 40mg	04	
		SC Q 12h	16	[redacted]
27Jul	[redacted]	Dopamine q4	08	[redacted]
		start @ 5mcg	12	
		kg/min + titrate		
		to MAP 75		
27Jul	[redacted]	D5W IV @ 75	15	[redacted] D/C 01Aug0700 01
		i 30K to Mach	17	
27Jul03	[redacted]	Zantac 50mg IV	08	[redacted]
		q8h	16	
			24	
30Jul	[redacted]	Colace 100mg po	10	[redacted]
		BID	22	
		Bisacodyl Supp =	08	[redacted] reinitiated
		digital rectal stimulation	20	
30Jul	[redacted]	Zantac 150mg po	10	[redacted]
		BID	22	
	[redacted]	Lovenox 40mg sq	10	[redacted]
		q 24°		
30Jul03	[redacted]	Bisacodyl Suppo	20	/ / / / / / / [redacted]
		digital Stimulation		

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: s/p GSW to Back

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ___

PATIENT IDENTIFICATION:

EPW [redacted]

b(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. _____ Yr. _____

SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
b(6)-2 A11				

INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION

PRN MEDICATION, DOSE, FREQUENCY	TIME/DATE DISPENSED
27 Jul 03 [redacted] Tylenol 650mg PRN Q4h PRN	7/29 1900 7/30 0600 7/31 0600 8/01 1000 8/01 1400 8/01 1800 8/02 0200 8/02 0600 8/02 1200 8/02 1600 8/02 2000 8/03 0000 8/03 0400 8/03 0800 8/03 1200 8/03 1600 8/03 2000 8/04 0000 8/04 0400 8/04 0800 8/04 1200 8/04 1600 8/04 2000 8/05 0000 8/05 0400 8/05 0800 8/05 1200 8/05 1600 8/05 2000 8/06 0000 8/06 0400 8/06 0800 8/06 1200 8/06 1600 8/06 2000 8/07 0000 8/07 0400 8/07 0800 8/07 1200 8/07 1600 8/07 2000 8/08 0000 8/08 0400 8/08 0800 8/08 1200 8/08 1600 8/08 2000 8/09 0000 8/09 0400 8/09 0800 8/09 1200 8/09 1600 8/09 2000 8/10 0000 8/10 0400 8/10 0800 8/10 1200 8/10 1600 8/10 2000 8/11 0000 8/11 0400 8/11 0800 8/11 1200 8/11 1600 8/11 2000 8/12 0000 8/12 0400 8/12 0800 8/12 1200 8/12 1600 8/12 2000 8/13 0000 8/13 0400 8/13 0800 8/13 1200 8/13 1600 8/13 2000 8/14 0000 8/14 0400 8/14 0800 8/14 1200 8/14 1600 8/14 2000 8/15 0000 8/15 0400 8/15 0800 8/15 1200 8/15 1600 8/15 2000 8/16 0000 8/16 0400 8/16 0800 8/16 1200 8/16 1600 8/16 2000 8/17 0000 8/17 0400 8/17 0800 8/17 1200 8/17 1600 8/17 2000 8/18 0000 8/18 0400 8/18 0800 8/18 1200 8/18 1600 8/18 2000 8/19 0000 8/19 0400 8/19 0800 8/19 1200 8/19 1600 8/19 2000 8/20 0000 8/20 0400 8/20 0800 8/20 1200 8/20 1600 8/20 2000 8/21 0000 8/21 0400 8/21 0800 8/21 1200 8/21 1600 8/21 2000 8/22 0000 8/22 0400 8/22 0800 8/22 1200 8/22 1600 8/22 2000 8/23 0000 8/23 0400 8/23 0800 8/23 1200 8/23 1600 8/23 2000 8/24 0000 8/24 0400 8/24 0800 8/24 1200 8/24 1600 8/24 2000 8/25 0000 8/25 0400 8/25 0800 8/25 1200 8/25 1600 8/25 2000 8/26 0000 8/26 0400 8/26 0800 8/26 1200 8/26 1600 8/26 2000 8/27 0000 8/27 0400 8/27 0800 8/27 1200 8/27 1600 8/27 2000 8/28 0000 8/28 0400 8/28 0800 8/28 1200 8/28 1600 8/28 2000 8/29 0000 8/29 0400 8/29 0800 8/29 1200 8/29 1600 8/29 2000 8/30 0000 8/30 0400 8/30 0800 8/30 1200 8/30 1600 8/30 2000 8/31 0000 8/31 0400 8/31 0800 8/31 1200 8/31 1600 8/31 2000 9/01 0000 9/01 0400 9/01 0800 9/01 1200 9/01 1600 9/01 2000 9/02 0000 9/02 0400 9/02 0800 9/02 1200 9/02 1600 9/02 2000 9/03 0000 9/03 0400 9/03 0800 9/03 1200 9/03 1600 9/03 2000 9/04 0000 9/04 0400 9/04 0800 9/04 1200 9/04 1600 9/04 2000 9/05 0000 9/05 0400 9/05 0800 9/05 1200 9/05 1600 9/05 2000 9/06 0000 9/06 0400 9/06 0800 9/06 1200 9/06 1600 9/06 2000 9/07 0000 9/07 0400 9/07 0800 9/07 1200 9/07 1600 9/07 2000 9/08 0000 9/08 0400 9/08 0800 9/08 1200 9/08 1600 9/08 2000 9/09 0000 9/09 0400 9/09 0800 9/09 1200 9/09 1600 9/09 2000 9/10 0000 9/10 0400 9/10 0800 9/10 1200 9/10 1600 9/10 2000 9/11 0000 9/11 0400 9/11 0800 9/11 1200 9/11 1600 9/11 2000 9/12 0000 9/12 0400 9/12 0800 9/12 1200 9/12 1600 9/12 2000 9/13 0000 9/13 0400 9/13 0800 9/13 1200 9/13 1600 9/13 2000 9/14 0000 9/14 0400 9/14 0800 9/14 1200 9/14 1600 9/14 2000 9/15 0000 9/15 0400 9/15 0800 9/15 1200 9/15 1600 9/15 2000 9/16 0000 9/16 0400 9/16 0800 9/16 1200 9/16 1600 9/16 2000 9/17 0000 9/17 0400 9/17 0800 9/17 1200 9/17 1600 9/17 2000 9/18 0000 9/18 0400 9/18 0800 9/18 1200 9/18 1600 9/18 2000 9/19 0000 9/19 0400 9/19 0800 9/19 1200 9/19 1600 9/19 2000 9/20 0000 9/20 0400 9/20 0800 9/20 1200 9/20 1600 9/20 2000 9/21 0000 9/21 0400 9/21 0800 9/21 1200 9/21 1600 9/21 2000 9/22 0000 9/22 0400 9/22 0800 9/22 1200 9/22 1600 9/22 2000 9/23 0000 9/23 0400 9/23 0800 9/23 1200 9/23 1600 9/23 2000 9/24 0000 9/24 0400 9/24 0800 9/24 1200 9/24 1600 9/24 2000 9/25 0000 9/25 0400 9/25 0800 9/25 1200 9/25 1600 9/25 2000 9/26 0000 9/26 0400 9/26 0800 9/26 1200 9/26 1600 9/26 2000 9/27 0000 9/27 0400 9/27 0800 9/27 1200 9/27 1600 9/27 2000 9/28 0000 9/28 0400 9/28 0800 9/28 1200 9/28 1600 9/28 2000 9/29 0000 9/29 0400 9/29 0800 9/29 1200 9/29 1600 9/29 2000 9/30 0000 9/30 0400 9/30 0800 9/30 1200 9/30 1600 9/30 2000 10/01 0000 10/01 0400 10/01 0800 10/01 1200 10/01 1600 10/01 2000 10/02 0000 10/02 0400 10/02 0800 10/02 1200 10/02 1600 10/02 2000 10/03 0000 10/03 0400 10/03 0800 10/03 1200 10/03 1600 10/03 2000 10/04 0000 10/04 0400 10/04 0800 10/04 1200 10/04 1600 10/04 2000 10/05 0000 10/05 0400 10/05 0800 10/05 1200 10/05 1600 10/05 2000 10/06 0000 10/06 0400 10/06 0800 10/06 1200 10/06 1600 10/06 2000 10/07 0000 10/07 0400 10/07 0800 10/07 1200 10/07 1600 10/07 2000 10/08 0000 10/08 0400 10/08 0800 10/08 1200 10/08 1600 10/08 2000 10/09 0000 10/09 0400 10/09 0800 10/09 1200 10/09 1600 10/09 2000 10/10 0000 10/10 0400 10/10 0800 10/10 1200 10/10 1600 10/10 2000 10/11 0000 10/11 0400 10/11 0800 10/11 1200 10/11 1600 10/11 2000 10/12 0000 10/12 0400 10/12 0800 10/12 1200 10/12 1600 10/12 2000 10/13 0000 10/13 0400 10/13 0800 10/13 1200 10/13 1600 10/13 2000 10/14 0000 10/14 0400 10/14 0800 10/14 1200 10/14 1600 10/14 2000 10/15 0000 10/15 0400 10/15 0800 10/15 1200 10/15 1600 10/15 2000 10/16 0000 10/16 0400 10/16 0800 10/16 1200 10/16 1600 10/16 2000 10/17 0000 10/17 0400 10/17 0800 10/17 1200 10/17 1600 10/17 2000 10/18 0000 10/18 0400 10/18 0800 10/18 1200 10/18 1600 10/18 2000 10/19 0000 10/19 0400 10/19 0800 10/19 1200 10/19 1600 10/19 2000 10/20 0000 10/20 0400 10/20 0800 10/20 1200 10/20 1600 10/20 2000 10/21 0000 10/21 0400 10/21 0800 10/21 1200 10/21 1600 10/21 2000 10/22 0000 10/22 0400 10/22 0800 10/22 1200 10/22 1600 10/22 2000 10/23 0000 10/23 0400 10/23 0800 10/23 1200 10/23 1600 10/23 2000 10/24 0000 10/24 0400 10/24 0800 10/24 1200 10/24 1600 10/24 2000 10/25 0000 10/25 0400 10/25 0800 10/25 1200 10/25 1600 10/25 2000 10/26 0000 10/26 0400 10/26 0800 10/26 1200 10/26 1600 10/26 2000 10/27 0000 10/27 0400 10/27 0800 10/27 1200 10/27 1600 10/27 2000 10/28 0000 10/28 0400 10/28 0800 10/28 1200 10/28 1600 10/28 2000 10/29 0000 10/29 0400 10/29 0800 10/29 1200 10/29 1600 10/29 2000 10/30 0000 10/30 0400 10/30 0800 10/30 1200 10/30 1600 10/30 2000 10/31 0000 10/31 0400 10/31 0800 10/31 1200 10/31 1600 10/31 2000 11/01 0000 11/01 0400 11/01 0800 11/01 1200 11/01 1600 11/01 2000 11/02 0000 11/02 0400 11/02 0800 11/02 1200 11/02 1600 11/02 2000 11/03 0000 11/03 0400 11/03 0800 11/03 1200 11/03 1600 11/03 2000 11/04 0000 11/04 0400 11/04 0800 11/04 1200 11/04 1600 11/04 2000 11/05 0000 11/05 0400 11/05 0800 11/05 1200 11/05 1600 11/05 2000 11/06 0000 11/06 0400 11/06 0800 11/06 1200 11/06 1600 11/06 2000 11/07 0000 11/07 0400 11/07 0800 11/07 1200 11/07 1600 11/07 2000 11/08 0000 11/08 0400 11/08 0800 11/08 1200 11/08 1600 11/08 2000 11/09 0000 11/09 0400 11/09 0800 11/09 1200 11/09 1600 11/09 2000 11/10 0000 11/10 0400 11/10 0800 11/10 1200 11/10 1600 11/10 2000 11/11 0000 11/11 0400 11/11 0800 11/11 1200 11/11 1600 11/11 2000 11/12 0000 11/12 0400 11/12 0800 11/12 1200 11/12 1600 11/12 2000 11/13 0000 11/13 0400 11/13 0800 11/13 1200 11/13 1600 11/13 2000 11/14 0000 11/14 0400 11/14 0800 11/14 1200 11/14 1600 11/14 2000 11/15 0000 11/15 0400 11/15 0800 11/15 1200 11/15 1600 11/15 2000 11/16 0000 11/16 0400 11/16 0800 11/16 1200 11/16 1600 11/16 2000 11/17 0000 11/17 0400 11/17 0800 11/17 1200 11/17 1600 11/17 2000 11/18 0000 11/18 0400 11/18 0800 11/18 1200 11/18 1600 11/18 2000 11/19 0000 11/19 0400 11/19 0800 11/19 1200 11/19 1600 11/19 2000 11/20 0000 11/20 0400 11/20 0800 11/20 1200 11/20 1600 11/20 2000 11/21 0000 11/21 0400 11/21 0800 11/21 1200 11/21 1600 11/21 2000 11/22 0000 11/22 0400 11/22 0800 11/22 1200 11/22 1600 11/22 2000 11/23 0000 11/23 0400 11/23 0800 11/23 1200 11/23 1600 11/23 2000 11/24 0000 11/24 0400 11/24 0800 11/24 1200 11/24 1600 11/24 2000 11/25 0000 11/25 0400 11/25 0800 11/25 1200 11/25 1600 11/25 2000 11/26 0000 11/26 0400 11/26 0800 11/26 1200 11/26 1600 11/26 2000 11/27 0000 11/27 0400 11/27 0800 11/27 1200 11/27 1600 11/27 2000 11/28 0000 11/28 0400 11/28 0800 11/28 1200 11/28 1600 11/28 2000 11/29 0000 11/29 0400 11/29 0800 11/29 1200 11/29 1600 11/29 2000 11/30 0000 11/30 0400 11/30 0800 11/30 1200 11/30 1600 11/30 2000 12/01 0000 12/01 0400 12/01 0800 12/01 1200 12/01 1600 12/01 2000 12/02 0000 12/02 0400 12/02 0800 12/02 1200 12/02 1600 12/02 2000 12/03 0000 12/03 0400 12/03 0800 12/03 1200 12/03 1600 12/03 2000 12/04 0000 12/04 0400 12/04 0800 12/04 1200 12/04 1600 12/04 2000 12/05 0000 12/05 0400 12/05 0800 12/05 1200 12/05 1600 12/05 2000 12/06 0000 12/06 0400 12/06 0800 12/06 1200 12/06 1600 12/06 2000 12/07 0000 12/07 0400 12/07 0800 12/07 1200 12/07 1600 12/07 2000 12/08 0000 12/08 0400 12/08 0800 12/08 1200 12/08 1600 12/08 2000 12/09 0000 12/09 0400 12/09 0800 12/09 1200 12/09 1600 12/09 2000 12/10 0000 12/10 0400 12/10 0800 12/10 1200 12/10 1600 12/10 2000 12/11 0000 12/11 0400 12/11 0800 12/11 1200 12/11 1600 12/11 2000 12/12 0000 12/12 0400 12/12 0800 12/12 1200 12/12 1600 12/12 2000 12/13 0000 12/13 0400 12/13 0800 12/13 1200 12/13 1600 12/13 2000 12/14 0000 12/14 0400 12/14 0800 12/14 1200 12/14 1600 12/14 2000 12/15 0000 12/15 0400 12/15 0800 12/15 1200 12/15 1600 12/15 2000 12/16 0000 12/16 0400 12/16 0800 12/16 1200 12/16 1600 12/16 2000 12/17 0000 12/17 0400 12/17 0800 12/17 1200 12/17 1600 12/17 2000 12/18 0000 12/18 0400 12/18 0800 12/18 1200 12/18 1600 12/18 2000 12/19 0000 12/19 0400 12/19 0800 12/19 1200 12/19 1600 12/19 2000 12/20 0000 12/20 0400 12/20 0800 12/20 1200 12/20 1600 12/20 2000 12/21 0000 12/21 0400 12/21 0800 12/21 1200 12/21 1600 12/21 2000 12/22 0000 12/22 0400 12/22 0800 12/22 1200 12/22 1600 12/22 2000 12/23 0000 12/23 0400 12/23 0800 12/23 1200 12/23 1600 12/23 2000 12/24 0000 12/24 0400 12/24 0800 12/24 1200 12/24 1600 12/24 2000 12/25 0000 12/25 0400 12/25 0800 12/25 1200 12/25 1600 12/25 2000 12/26 0000 12/26 0400 12/26 0800 12/26 1200 12/26 1600 12/26 2000 12/27 0000 12/27 0400 12/27 0800 12/27 1200 12/27 1600 12/27 2000 12/28 0000 12/28 0400 12/28 0800 12/28 1200 12/28 1600 12/28 2000 12/29 0000 12/29 0400 12/29 0800 12/29 1200 12/29 1600 12/29 2000 12/30 0000 12/30 0400 12/30 0800 12/30 1200 12/30 1600 12/30 2000 12/31 0000 12/31 0400 12/31 0800 12/31 1200 12/31 1600 12/31 2000
30 Jul 03 [redacted] Fleet enema prn	
4 Aug 03 [redacted] Percocet 1-2 p o q 4° prn pain	
8-2 [redacted] MSO4-2-10mg IV q1° PRN (raw wounds)	[redacted]

USAPA V1.00

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. AUG YR 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 4	5	6	7	8	9	10	11	12	13	14	15	16	17
4 AUG	[redacted]	Colace 100mg PO BID	10	/	[redacted]												
			22	[redacted]													
4 AUG	[redacted]	ZANTAC 150 mg PO BID	08	/	[redacted]												
			20	[redacted]													
4 AUG	[redacted]	Lovenox 40mg SQ q Day	08	/	[redacted]												
4 AUG	[redacted]	IV saline lock	05	/	[redacted]												
			13	/	[redacted]												
			2	[redacted]													
13 Aug	[redacted]	Levaquin 500mg PO QD X5 days	22										[redacted]				
13 Aug	[redacted]	Albuterol nebulizer treatment q4°	02											/			
			06											/			
			10											/			
			14											/			
			18											/			
			22										[redacted]				
14 Aug	[redacted]	Albuterol neb treatments q4°	04											[redacted]			
			08											[redacted]			
			12											[redacted]			
			16														
			20														
			24														
17 Aug	[redacted]	Elavil 25mg PO qHS	22														[redacted]

DC'd

Q4 times

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Invasive T-4 c̄ Arthralgia

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

CPW [redacted]

b(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. _____ Yr. _____

Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
[redacted]	b(6)-2 Benadryl 50mg PO x1 now for sleep	13 Aug	0130	0130	[redacted]

b(6)-2

INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION

Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	TIME/DATE DISPENSED														
[redacted]	Bisacodyl/suppository/ PRN	7 Aug 0100	5 Aug 0150	[redacted]												
	Digital rectal stimulation PRN															
[redacted]	Tylenol 650mg PO q 4° PRN	14 Aug 1554	14 Aug 1800	4 Aug 0342	5 Aug 1017	5 Aug 1300	6 Aug 0150	6 Aug 2228	7 Aug 0340	8 Aug 2330	8 Aug 0154	9 Aug 1145	10 Aug 1330	10 Aug 0020	10 Aug 1010	10 Aug 2330
[redacted]	Percocet 1-2 PO q 4° PRN	14 Aug 1 PHO RN	5 Aug 0100	5 Aug 0605	5 Aug 1100	5 Aug 0145	5 Aug 2307	8 Aug 0314	14 Aug 23:30	15 Aug 0343	16 Aug 2331	17 Aug 0121	17 Aug 0855	18 Aug 0360	18 Aug 2210	
4 Aug [redacted]	Fleets Enema PRN	0080 [redacted]														
4 Aug [redacted]	Tylenol 650mg PO q4° PRN	11 Aug 1300	12 Aug 1800	12 Aug 2345				13 Aug 2110		14 Aug 0316	15 Aug 1000	15 Aug 0138	16 Aug 0400	16 Aug 0200	17 Aug 1800	

b(6)-2 All

USAPA V1.00

b(4)-2

CLINIC RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)

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

Mo. ____ Yr. ____

VERIFY ... ING

INITIAL PROPER COLUMN FOLLOWING EACH ~~ADMINISTRATION~~ completion

ORDER DATE	CLERK/ NURSE	RECURRING ~~MEDICATIONS~~ ACTIONS, DOSE, FREQUENCY	HR	DATE ~~DISPENSED~~ completed 18	19	20	21	22	23	24	25	26	27	28	29	30	31
17 Aug	[redacted]	Vitals q 8°	5	[redacted]													
			13														
			21														
17 Aug	[redacted]	Activity ↑ HOB ad lib	5														
			13														
			21														
17 Aug	[redacted]	Log Roll q 2° - Pressure reduction	5														
			13														
			21														
17 Aug	[redacted]	ROM (B) lower extremities q 4°	5														
			13														
			21														
17 Aug	[redacted]	D&C △ BID to back, dry	10														
			22														
17 Aug	[redacted]	Regular diet	07														
			12														
			17														

5/6/-2

LERGI ... ES ☐ NO

NKDA

PRIMARY DIAGNOSIS: Shrapnel T-4 Paraplegic

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ____

...TIENT ... TION:

EPW b(4)-4 [redacted]

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

...A FO... 4677 1 FEB 79 EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED. USAPA V1.00

b(6)-2

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 8 Y 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 18	19	20	21	22	23	24	25	26	27	28	29	30	31
17 Aug	[redacted]	Colace 100mg po BID	10	[redacted]													
			22														
17 Aug	[redacted]	Zantac 150mg po BID	08														
			20														
17 Aug	[redacted]	Lovenox 40mg SQ qD	08														
17 Aug	[redacted]	Levaquin 500mg po qd x5d	22	DC'd													
17 Aug	[redacted]	Albuterol neb tx q4°	04														
			08														
			12														
			16	DC'd 17 Aug 03 0215 EM													
			20														
			24														
17 Aug	[redacted]	Elavil 25mg PO qhs	22	[redacted]													
		Errorem															
		— September —		1	2	3	4	5	6	7	8	9	10	11	12	13	14
30 Aug	[redacted]	Colace 100mg PO BID	10	[redacted]													
			22														
30 Aug	[redacted]	Zantac 150mg PO BID	10														
			22														
30 Aug	[redacted]	Lovenox 40mg SQ qD	10														
			08														
30 Aug	[redacted]	Elavil 25mg po QHS	22	[redacted]													

ALLERGIES: ☐ YES ☐ NO — NKDA

PRIMARY DIAGNOSIS: Shrapnel T-4 Paraplegic

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO.

PATIENT IDENTIFICATION:

b(6)-1

[redacted]

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

CLINICAL RECORD

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

Mo. 10 *Yr.* 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 29	30	1	2	3	4	5
30Aug	[redacted]	Colace 100mg PO BID (recopied)	10	[redacted]						
			22	[redacted]						
30Aug	[redacted]	Zantac 150mg PO BID (recopied)	10	[redacted]						
			22	[redacted]						
30Aug	[redacted]	Lovenox 40mg SQ BID (recopied)	10	[redacted]						
			22	[redacted]						
30Aug	[redacted]	Elavil 25mg PO QHS (recopied)	22	[redacted]						

ALLERGIES: ☐ YES ☑ NO
NKDA

PRIMARY DIAGNOSIS: Shrapnel, T4 paraplegic

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

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

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

b(2)-2

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. 10 Yr. 03

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED												
20 Aug	[redacted]	Percocet 1-2 PO q4 PRN (recopied)	D/T/I	9/28/03 2300 [redacted]		9/29/03 2300 [redacted]		0001 2027 [redacted]	2001 2126 [redacted]	3001 2000 [redacted]	4001 0000 [redacted]	5001 2145 [redacted]			
12 Sep	[redacted]	Phenergan 25mg PO Q4-6 PRN (recopied)	D/T/I												
	[redacted]	Tylenol 650mg PO Q4 PO PRN (recopied)	D/T/I	0001 1335 [redacted]	2001 2147 [redacted]										
		~~Percocet~~													

USAPA V1.00

b(a)-2 b(a)-2

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. SEP Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 15	16	17	18	19	20	21	22	23	24	25	26	27	28
30 AUG	[redacted]	Celebrex 100mg PO BID	10	[redacted]													
			22														
30 AUG	[redacted]	Zantac 150mg PO BID	10														
			22														
30 AUG	[redacted]	Lovenox 40mg SQ BID	10														
			22														
17 AUG	[redacted]	Elavil 25mg ½ PO q hs	22														

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS: Shrapnel T-4 Paraplegic

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

EPW b(a)-4

#[redacted]

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)					Mo. 09 Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials	
		b(2)-N					

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED												
[illegible]	[redacted]	Percocet 1-2 PO q 4° pm	D/T	29 Aug 1215	30 Aug 0430	30 Aug 2000	31 Aug 0320	31 Aug 1545	31 Aug 2343	1 Sep 1621	2 Sep 0507	3 Sep 2430	5 Sep 1100	5 Sep 2045		
			D/I	[illegible]	[redacted]											
12 Sep	[redacted]	Phenergan 25mg po q4-6° PRN	D/T	12 Sep 2340	13 Sep 0700	13 Sep 1845										
			D/I	25mg [illegible]	25mg [illegible]	25mg [illegible]										
	[redacted]	TYLENOL 650mg PO q4° PRN	D/T	13 Sep 0700	13 Sep 1900	13 Sep 0000	15 Sep 1100	15 Sep 2115	23 Sep 1300							
			D/I	650 [illegible]	650 [illegible]	650 [illegible]	650 [illegible]	650 [illegible]	650 [illegible]							
24 Aug 03	[redacted]	Percocet 1-2 po q4° pm	D/T	16 Sep 1430	16 Sep 2003	17 Sep 1325	18 Sep 0300	18 Sep 1530	19 Sep 0420	19 Sep 1530	19 Sep 2210	20 Sep 2200	21 Sep 0540	21 Sep 2250	22 Sep 2115	23 Sep 0550
			D/I	T	2	2	2	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
				[redacted]												
4	[redacted]	Percocet 1-2 po q4° PRN	D/T	23 Sep [redacted]	24 Sep 0SK	24 Sep 2130	25 Sep 2045	25 Sep [illegible]	26 Sep 1600	26 Sep [illegible]	27 Sep 2000					
			D/I	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]					
				[redacted]												

USAPA V1.00

Veri
Initia

THE[illegible]PEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. _____ Yr. _____

Order Date	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
17Aug [redacted]	Ambien 10mg po qhs x 7 PRN	17Aug	AS	not given	[redacted]
	bid-2				

Order/ Expir Date	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
15Aug [redacted]	Robitussin elixir 2tsp q4° PO PRN coughing	15Aug 21:50 2tsp [redacted]													
	~~Ambien 10mg i PO~~ Error Em														
17Aug [redacted]	ΔPesP tx neb to PRN q4°														
19 Aug [redacted]	Tylenol 650mg PO Q4° PRN	19 Aug 1200	23AUG 650mg	24Am 650mg	15Aug 1300	26Aug 1920	26Aug 1800	29Aug 0805	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	1300	1900	12Sep 1845
		9m	1950	1130	650	650	650	650	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
20Aug [redacted]	Percocet 1-2 PO q 4° prn	20Aug 0125	21AUG 2115	22AUG 2005	23AUG 2145	24Aug 1357	25Aug 2500	25Aug 1845	26Aug 0367	26Aug 2020	27AUG 0400	27AUG 2145	27AUG 0359	28Aug 1400	28Aug 2050	29 Aug 0552
		11 PO	[redacted]													
20 Aug 1800 Yeunthen	Percocet +-11 PRN pr q4°	DT	4Sep 1300	5Sep 0445	5Sep 1337	6Sep 0425	7Sep 0741	8Sep 2015	9Sep 1520	10Sep 2045	10Sep 1760	11 Sep 1424	12Sep 2110		
		DT	[redacted]												

USAPA V1.00

[redacted]

Ø2 AUC

Ø600	1730 Ø8K
3mm pupils	3mm perrl bilat
a/O x3 followed	A+O x 3 moves
commands appropriate	upper extremities
c̄ staff, moves UE bilat	verbalizes needs
UE weakness, bilat LE paralyzed.	to staff
ventilator assisted 97-99% @ Ø2	RR 12–20 c̄ sats
Ø SOB, CTA diminished bases bilat	@ 95-97% on RA
Ø cough.	CTA bilat
	Ø secretions
appropriate for race	Normal for Race
~~tee~~ progress note	dsg's to (R) shoulder
(R) brachial	(R) Brachial H/L
patent.	patent Ø s/s
	of infection
hypo BS x 4	BS (+) x 4 quads
Ø fluids per doctors	~~tol~~ Ø fluids
discomfort N/V/P	[redacted] b(4)-2
FTG clear amber.	Foley to gravity
Ø S.	Ø S clear yellow
	urine.
NSR ectopy	NSR ectopy
S1 S2 +2 pulses bilat	S1 S2 (+)
UE & LE capref 4	2+ pulses x 4 distal
<3 sec	extremities
	Ø edema noted

b(4)-4

EPL [redacted]

02AUG

	109/50	112/54	104/42	90/37
	108	102 101		101
	87	76	81	78
	18	20	18	14
SPO2	97	99	99	98
	RA	RA	RA	RA

T Maxt
PO 240 240 480 200 200 200
PB

1500 225/170 240 210 200 190

60 200

	20
102/55	101/49
18	16
73	93
96	98%
101	101.8

PB

06
4

5

6

3
++

3
++

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		Time: Initals:	Time: Initals:
NEURO	Pupils		
	Sensorium		
	LOC / GCS		
CARDIAC	Cardiac Rhythm		
	PRI: / QRS:		
	Pulse Strength		
	Cap Refil / JVD		
	Edema		
	Chest Pain		
RESP	Respiratory Pattern		
	Breath Sounds		
	Secretions		
	Cough		
SKIN	Color		
	Integrity		
	Backside		
IV	Access Devices		
	Location		
	Condition		
GI	Abdomen		
	Bowel Sounds		
	Stoma/Ostomy		
GU	Device		
	Color / Clarity		

(Continue on reverse)

PREPARED BY *(Signature & Title)*

DEPARTMENT/SERVICE/CLINIC
ICU #1, [redacted]

DATE
(b)(2)-2

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

NAME: RANK: AGE:

UNIT: GENDER:

STATUS: US: AD / CIV IRAQI: CIV / EPW

OTHER:

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER *(Specify)*

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, MAY 78

ICU Flowsheet Patient Name: Date: / / 2003

Vital Signs	24	01	02	03	04	05	06	07	08	09	10	11		12	13	14	15	16	17	18	19	20	21	22	23	
Temperature			99.9				100.0				100.0				100.2											
Pulse			76				80				79			78												
B/P A-Line																										
MAP																										
B/P Cuff			104/53				102/61				102/55															
Respirations			18				16				18			14												
02			94				100				100			100												
			RA				RA				RA			RA												

Intake	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
IVF																										
PO intake			200		150	240	240				200															
O.R. IN																										
Totals																										

Output	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
Line Hourly				80/80			30/100		170/170	120/290	140/430	350/780	1685	30												
NG Tube																										
Drains #1																										
#2																										
#3																										
Emesis/Stool												x1														
O.R. OUT																										
Totals																										

[redacted] b(6) - 4

24 hour input	
24 hour output	
24 hour balance	

MEDCOM - 15359

APPROVED (Date)
ADDT 3 Mar 85

INITIALS

Pupils
Sensorium

IFOO
Pearrla 3 mm
Alert - x 3

Rog-even
CTA B12
Ø

NFR
intact warm dry

Saline lock @ FA
Patent @ S/S infiltration

soft - Flat - NT
BS⊕ x 4 quad 5

clear yellow

S1 S2 NSR

- Fractional
- Saturation
- CN - Tracheostomy

(b)(6)-2

Sgt [redacted] 91C 20

[redacted] b(6)-4

DATE
01 AUG 03

☐ FLOW CHART

☐ OTHER (Spec

☐ CAMPHOR

(signated)
KC-NU)

	17	18	19	20	21	22	23
BP	96/71						98/71
T	101.2						100.9
P	82		86				73
R	16		16				18
SpO2	98		96				97

URINE 450 225 225 950 225 115

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		Time: 0530 Initals: [redacted] b(6)-1	Time: Initals:
NEURO	Pupils	3 Reactive	
	Sensorium	Follows simple commands	
	LOC / GCS	A&O	
CARDIAC	Cardiac Rhythm	NSR	
	PRI: / QRS:	$S_1 S_2$	
	Pulse Strength	+2 x4	
	Cap Refil / JVD	< 3sec	
	Edema	Ø	
	Chest Pain	Ø	
RESP	Respiratory Pattern	WNL	
	Breath Sounds	Clear diminish throughout	
	Secretions	dry cough	
	Cough		
SKIN	Color	normal for race	
	Integrity	Intact	
	Backside	dressing CDI	
IV	Access Devices	R arm PIV	
	Location		
	Condition	CDI	
GI	Abdomen	Soft not distendet	
	Bowel Sounds	Hyperactive x4	
	Stoma/Ostomy	Ø	
GU	Device	Foley	
	Color / Clarity	Clear yellow urine	

(Continue on reverse)

PREPARED BY *(Signature & Title)*

DEPARTMENT/SERVICE/CLINIC (b)(2)-2
ICU #1, [redacted]

DATE 08/04/03

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

NAME: [redacted] b(6)-1 RANK: AGE:

UNIT: GENDER:

STATUS: US: AD / CIV IRAQI: CIV / EPW

OTHER:

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

DA FORM 4700, MAY 78

MEDCOM - 15365

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		Time: 0700 Initals: [redacted] b(6)-2	Time: 1730 Initals: [redacted] b(6)-2
NEURO	Pupils	3mm Reactive	
	Sensorium	follows commands	Alert/Oriented
	LOC / GCS	A10x3	coherent/cooperative
CARDIAC	Cardiac Rhythm	NSR	NSR Ectopy
	PRI: / QRS:	S1S2	S1S2 only
	Pulse Strength	+2	
	Cap Refil / JVD	<3sec	
	Edema	Ø	Ø
	Chest Pain	Ø	Ø
RESP	Respiratory Pattern	Unlabored equal	even/unlabored
	Breath Sounds	CTA	CTA bilat
	Secretions		
	Cough		
SKIN	Color	WNL	NTR
	Integrity	Intact	intact
	Backside		
IV	Access Devices	(R) Bicep	(R) bicep
	Location		
	Condition	CDI	patent/benign
GI	Abdomen	Soft Not Distended	Soft, NT, ND
	Bowel Sounds	present x4 hypoactive	(+) x4
	Stoma/Ostomy		
GU	Device	Via foley	foley
	Color / Clarity	Clear/red	cl/yellow

(Continue on reverse)

PREPARED BY (Signature & Title): [redacted] LDN

DEPARTMENT/SERVICE/CLINIC: ICU #1, [redacted]

DATE: b(2)-2

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

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

RANK:

AGE:

UNIT: ICU 1

GENDER:

STATUS: US: AD / CIV IRAQI: CIV / EPW

OTHER:

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, MAY 78

ICU Flowsheet Patient Name: EPW [redacted] Date: 3 /Aug / 2003

Vital Signs	24	01	02	03	04	05	06	07	08	09	10	11		12	13	14	15	16	17	18	19	20	21	22	23	
Temperature	101.3				100.8				99.8					100.2				101.5		101.0				98		
Pulse	86				89				77					81				85		75				54		
B/P A-Line	104/53				105/51				99/52					95/47				100/53		114/59				78		
MAP	73				71				69					66				71						99.0		
B/P Cuff																										
Respirations	18				20				20					17				20		18				18		
Sa02	100				100				100					97				98		97				97		
	RA				RA				RA					RA				RA		RA				RA		

Intake	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
IVF																										
PO intake																				200		100				
O.R. IN																										
Totals																										

Output	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
Urine Hourly	800/500				506/1328									105				750						300/1258		1258
NG Tube																										
Drains #1																										
#2																										
#3																										
Emesis/Stool																										
O.R. OUT																										
Totals																										

24 hour input	
24 hour output	
24 hour balance	

MEDCOM - 15367

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION (State or Country Code.)	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
A 1 1 0 1	I Z	[redacted]	(b)(6)-4		M

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
		Z	9	UNK

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
		~~9 9~~ 20	[redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
NA	Z	1415	NA b(6)-4

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
N	K 7 8	

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
0	ICW2	UNK

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): UNK

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted]

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE: UNK

b(2)-2

21. TYPE OF [redacted]	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
2 4		0 3 1 0 0 6

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y M M D D)
		0 3 0 7 2 7

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

FOR LOCAL USE

DX: SHRAPNEL T-4 PARA

b(6)-2

ADMITTING OFFICER (Signature, as required): [redacted] MC for Dr [redacted] b(6)-2

SIGNATURE OF ADMITTING CLERK: b(6)-2 [redacted]

DA FORM 3985 MAR 89

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER [redacted]			2. NAME (Last, First, MI) EPW# [redacted] b(6)-4		3. GRADE NO	ADMISSION REMARKS
SEX M	5. AGE 37y	6. RACE unk	7. RELIGION Muslim	8. LENGTH OF SVC no	9. ETS no	10. PREVIOUS ADMISSION no
11. FMP 99		12. SSN unk		13. ORGANIZATION unk		14. WARD ICU2
15. FLYING STATUS no	16. RATING/ DSG	17. DEPT./ BEN K78	18. BRANCH/CORPS no	19. UIC/ZIP unk		20. TYPE CASE Surg
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Ø				22. HOURS OF ADMISSION 0110	23. CLINIC SERVICE ABOA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE —			25. TYPE DISPOSITION 21		26. DATE OF DISPOSITION 030803	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) —			27b. TELEPHONE NO. unk		28. DATE OF THIS ADMISSION 030730	ADMITTING OFFICER
29. NAME AND LOCATION [redacted] b(2)-2					30. DATE OF INTIAL ADMISSION 030730	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: GSW to abdomen

863.52
863.1
863.31
866.10
863.99
782.4
E991.2
Complications
998.0
518.5
998.59

782.3
782.4
740.5
268.9
288.0
287.5

30 Jul 03
45.74
43.6
45.62
55.51
54.75
96.72
99.04
1 Aug 03
86.28

Blood given - yes

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
Ø	Ø	Ø	Ø	5	5

36. Total Days All Facilites

a. ABSENT SICK DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE	e. BED DAYS	f. TOTAL SICK DAYS
Ø [redacted]	Ø	[redacted]	5	5

SIGNATURE OF [redacted] b(6)-2 FOR [redacted]

DA FORM 3647, MAY 79 ME[redacted]

USAPPC V1.10

ABBREVIATED MEDICAL RECORD

[redacted] b(6)-4

ADMISSION DATE *(YYYYMMDD)* 30 July 03

2. CHIEF COMPLAINT, PERTINENT HISTORY, AND PERTINENT SYSTEM REVIEW

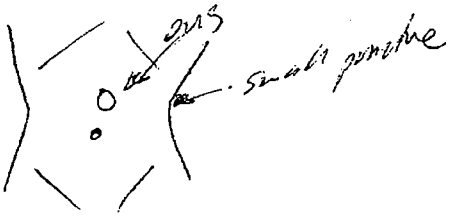
EMW c̄ c̄ GSW to abdomen c̄ evisceration. Shot @ marines who returned fire until wounded.

[redacted] b(6)-2

3. PHYSICAL EXAMINATION *(Including pertinent positives and negatives)*

lungs c̄ BS, symm
NENNL / amnotic
RRR. ⊖ M.O.
⊖ VS. evisceration

legs cool / dry
pulses
legs move / feel move
⊖ touch / sensation



4. IMPRESSION *(Enter admission note with plan on progress notes)*

GSW abdo c̄ evisceration
Resuscitate c̄ (R)SCV / (L)ES / (R)Foley / Foley
T&C Gen ABX / ABXs / tetanus

C&R clear / ⊖ / ⊖
N&R ⊖ cant feel
⊖ legs, bring injuries

5. ADMITTING OFFICER

a. SIGNATURE [redacted] 2TR b(6)-2

b. DATE SIGNED *(YYYYMMDD)* 30 July 03

6. DISCHARGE NOTE *(Brief hospital course, diagnoses, procedures, condition on discharge, pertinent discharge information (including medications, diet, activity limitations, follow-up instructions).)*

7. DISCHARGE DATE *(YYYYMMDD)*

8. DISCHARGING OFFICER

a. NAME *(Last, First, Middle Initial)*	b. GRADE	c. TITLE	d. SIGNATURE

9. PATIENT IDENTIFICATION *(For typed or written entries: Name (last, first, middle), grade, SSN, date of birth, hospital or medical facility, ward number, and register number)*

10. OUTPATIENT/HEALTH RECORD MAINTAINED AT:

11. COPY PLACED IN OUTPATIENT RECORD *(X when done)*

b(a)-2

NSN 7540-00-634-4176 AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
30 Jul 03 0530	Pt rec'd in IA/2 for recovery phase. See DA Form 4700 PACU flowsheet for information during recovery. — [redacted]
30 Jul 03 0700	Pt remains sedated vent SIMV R12 P5 TV 800 50%. IVF @ infusing @ 150/hr. Auscultating BBS CTA c̄ minimal secretions faint palpable distant pulses. T 91.3 Abd c̄ midline abdominal dressing c̄ blood to midline area. OGT LIS c̄ bloody secretions. (R) SC cordis, (L) EJ and (L) AC 18G. NS flds infusing. JP drains to (L) lateral abd area to bulb suction. foley cath to BSO SBP ranging from 80-90's c̄ DBP 50-70's. No movement by patient. Copious amts nasal secretions. Will cont to monitor — [redacted]
30 Jul 03 0730	Pt rec'd 2u FFP per Dr [redacted] Continuously emptying JP drains. output from JP#1 > JP#2. Tachycardic HR 100's SBP 90's. Will continue to monitor — [redacted]
30 Jul 03 0925	Started versed gtt @ 3mg/hr titrating to effect and MSO4 gtt @ 3mg/hr titrating for pain control. Rec'd 500cc bolus @ 0825 — [redacted]
30 Jul 03 1040	Labs drawn, ↑ amp NaHCO3 given @ 1020. vent currently @ TV 800 R14, 40% SIMV P5. Continuing to receive bolus of flds. Angel Weston
30 Jul 03 1255	Pt receiving 1U PRBC VSS throughout transfusion. Remains Tachy 120-130's SBP 110's. No distress noted — [redacted]
30 Jul 03 1300	T 97.2 BP 113/76 HR 122 1305 T 97.3 BP 116/74 HR 121 [redacted]
30 Jul 03 1500	Pt received 2u FFP Tolerated transfusions c̄ complication. Remains on versed @ 3mg/hr MSO4 3mg/hr. JP output reported to surgeons — [redacted]

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(a)-4

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

b(6)-2 A11

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
30 Jul 03 1600	Pt c̄ Tmax 99.1, BP 116/63 HR 130's. R14 SpO2 100% on vent IVF NS @ 150/hr. NGT 200cc output urine concentrated dark yellow in color. Lab results reported to MD. Flds infused via fld warmer (Level 1) throughout the day until temp greater than 97°F. Level 1 discontinued @ 1600. 5 18's submitted for PRBC — [redacted]
30 Jul 03 1640	Pt taken to OR per anesthesia service — [redacted]
2155	Pt returned from OR @ 2050, bolus 500cc LR. Started NS @ 150cc/hr. labs sent - CBC, Met 12, Coags ABG. Pt had 700cc UOP, 210cc out of JP#1. Pt sedated c̄ versed + MSO4, pupils 2mm, non-reactive, sclera edematous, withdraws from painful stimuli. ST 120's S1S2 ∅ murmur ∅ ectopy, B/P 110's/60's, pulses 2+ all extremities skin cool + dry, placed under warming light. #8 ETT 24cm @ lip SIMV R-20 TV 550 FiO2 80% Sats 99%. Lines (R) subclavian cordis, (L) EJ, (L) AC 18G, (R) Femoral A-line. Abdomen covered c̄ bulky dsg to be packed W/ BID starting tomorrow. Ostomy c̄ bag in place drng sanguinous fluid. (L) Jejunostomy tube, (L) duodenostomy tube, JP x2 to (L) lat abdomen. Foley drng dkamber urine sufficient amts. Will monitor [redacted] TAN
2200	Vent settings Δ'd to SIMV R-22 and 1amp Bicarb given as ordered. Will obtain ABG in 30min. Will monitor — [redacted] ILTAN.
2220	Warming bags placed under pt arms to ↑ temp. Will monitor. [redacted] ILTAN
2330	Pt MAP 59-60, bolus NS 500cc given. Pt temp up to 96.5. LS bilat exp wheezes c̄ rhonchi. Will monitor. — [redacted] ILTAN

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b(6)-2 A11

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
31 Jul 03 0000	18G @ AC not flushing - pulled. B/P 77/41, 2nd 500cc NS bolus given, sedation down to 1mg MSO4 1mg Versed - pressures up to 88/46 will cont. to monitor. [redacted] / LTAN
0200	Pt more responsive, spont. movement of arms + legs, versed gtt up to 2mg/hr. VSS. Will monitor. [redacted] LTAN
0400	Pt moving extremeties, sedation increased, labs + ABG done, AM care done. VSS. Will monitor. [redacted] LTAN
31 July 03 0825	Surgery #1
	Arterial MAP's <60: responded to vol 87/57 128 vag 1/0 @ [illegible] 240
Surgery 3375	edematous compartment, anuretic 55-75 cc/h
	lungs clear / sym m raw 20/600/60/5 73/36/51/17/[illegible]
Surgery 8/8	nsr / ⊖ svo / ⊖ m 70
	⊖ BS, Rm, wound clean, serosang drainage 145 / 114 / 28 / 5.3 / 3.4 / 17 / 1.5 / 114 / 39 / 47
Nsg / Vascular	legs w/o / anasarca / palp sym m DP ⊕ any 1545
IVF NS 150/h	hyp. intravascularly dry
	hyperbilirubinemia / amylasemia - 2° manipulation / blunt injury
	Plan Sedation / Vent resuscitation / Nutritic feeds / Follow labs [redacted]

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI | SP[redacted]

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

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

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

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

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
31 July 03 10:00	Pt s/p (L) nephrectomy, Colon, resection, Gastric resection, ex-Lap. Pt unresponsive due to sedation, VSS. HR Tachy @ 130's & 140's, Bp 90's/50's, Map 60's, 70's $\bar{p}$ 3L Bolus of NS, 1gm $CaCl_2$, 1/amp Bicarb. Sats 100% on vent. Settings: SIMV RR 20, Peep 5, TV 600, FiO_2 60%. Lung Sounds present in all fields. Pupils 2mm Non-Reactive. Heart Sounds S_1, S_2 present $\bar{5}$ Murmur. Bowel Sounds hypoactive in LLQ, Not present in RUQ, RLQ, LUQ. Colostomy in RUQ Draining Brown liquid @ 50cc/hr, Duodenostomy draining brown liquid @ approximately 25cc/hr. 2 Jp drains in place on (L) side. #1 Draining blood tinged fluid at approximately 13cc/hr, #2 Draining blood tinged fluid approximately 20cc/hr. ~~Foley in place~~ [redacted] ~~pt~~ Dressing to Large midline abdominal incision did this am by Dr. [redacted]. Incision closed $\bar{c}$ staples. Foley in place draining approximately 55cc/hr of Amber urine. 2+ ~~pitting~~ non-pitting throughout all extremities. Pedal pulses unable to palpate, present $\bar{c}$ doppler. Radial pulses 1+ barely palpable. Ng tube in place Draining Approximately 12cc/hr brown fluid to Low intermittant suction. Pt $\bar{c}$ (L) EJ Patent & $\bar{3}$ S/S [redacted] Continued

b(6)-2

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	REGISTER NO.	WARD NO.
ICU #2	28th CSH	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] b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/15)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)
USAPA V1

b(6)-2 All

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
Continued	of infection. (R) subclavian cordis patent & ∅ s/s
31 July 03	of infection. (R) Femoral A-Line patent & ∅ s/s of infection. 10:30 pt recieved 5% Albumin in 500cc NS. Suction ET Tube and Nares PRN. HOB 15°. Will Continue to Monitor. [redacted] LPN
31 July 03 11:45	Jevity started in J-Tube @ 5cc/hr. Will Continue to Monitor [redacted] LPN
31 July 03	Addendum: Patient given 5% Albumin in 500cc NS @ 1030hrs followed by 2gm MgSO4 in 100cc NS IVPB. [redacted] CPT/AN
31 July 03 @ 1145	Given 40mg KCL in 100cc NS over 2hrs for K+ of 3.6. Will F/U c̄ chem panel to check pt response.
31 July @ 1300hrs	Given 500cc LR bolus to address ↓ intravascular fluid load → third spacing @ this time [redacted] CPT/AN
31 July @ 1330hrs	K+ now 4.7 p̄ K-Mn over 2hrs (1145-1345hrs). [redacted] /LPN
1745	Pt. sedated Versed @ 4 ml/hr, MSO4 3ml/hr, pupils 2mm non-reactive Sclera edematous, withdrawn from painful stimuli. ST 120's B/P 98/48, MAP 67. Hespan 500cc infusing NS @ 150 ml/hr to (R) SC cordis. (L) EJ + (R) fem A-line intact. pulses 2+ all palpable, 3+ pitting edema. #8 ETT 24cm @ lip SIMV R-20 FiO2 60% Peep 5 TV 600 sats 96% LS coarse c̄ exp wheezes bilat. (R) nare NGT → LIS drng dk green fluid. (R) colostomy drng sanguinous drng, JP x 2 (L) lat abdomen drng serosanguinous fluid, J-tube infusing Jevity @ 5cc/hr tol well, Duodenostomy tube drng sm amt dk yellow drng. Foley drng dk amber sufficient amts. Abd dsg intact ∅ drng noted — to be Δ'd BID w → D. Will monitor. [redacted] /LPN

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

b(e)-2 AN

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
31Jul03	Pt Sats 93% suctioned for sm amt thin clear secretions,
1920	RT called to admin. neb tx. Will monitor [redacted] LTAN
2020	ABG done. paO_2 56 – F_iO_2 turned up to 80%.
	Sats 93% RT gave Atrovent neb. NGT flushed
	and suctioned 425 cc fluid – possible clog? VSS
	at this time, will monitor! [redacted] JLTAN
2145	TLC placed through cordis by Dr. [redacted], CVP
	transduced to be 18. Vent settings Δ'd ↑ peep 12.
	obtained ABG paO_2 73 Dr. [redacted] aware.
1Aug03	Pt dsgs Δ'd, abd staples intact, open area packed
0100	w→D, appears necrotic c̄ foul smelling odor.
	ETT holder changed, pt bathed. NGT flushed
	and returned 340cc foul smelling drng. Will
	monitor. VSS. [redacted] JLTAN
0400	Pt sedated, VSS. labs sent. will monitor. [redacted] JTAN

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

NSN 7540-00-634-4176 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1 Aug 03	Nursing Notes Cont:
1100	Temp 101.6 Dr [redacted] aware Tylenol 650 mg PR colostomy gauze
1415	Blood drawn for chem. rectified and esc Pt was left made comfortable
1530	Bed changed to reg hospital bed and placed at Pen #2
1635	Dr [redacted] aware of Pt's lab results. FiO2 40% IMV 16 Pt Sat 93-95%
1700	via pulmonary artery Sodium Bicarb 50 given PH 7.324 PCO2 38.4
1700	HCO3 19, ABG, Chem 7 tube requested at 1750. Pt's head of bed 30°
	distended. Versed drip at 4mg/h MSO4 at 3mg/h continues
	IV NS at 125cc/h continues. Report given to relief nurse [redacted]
1 Aug 03 1710	Received report from ILT [redacted]. Pt in supine position. Neuro Sedated c̄ Versed @ 4mg/hr and MSO4 @ 4mg/hr. 3mm bilaterally and brisk Ø response to painful stimuli. Resp Vent SIMV 16 TV 600 FiO2 ~~to~~ 40% PEEP 10 RR 16-20 c̄ pt spontaneously breathing 2-4 over the vent SaO2 currently @ 93%. ETT #8 24@ LIP inline suction resulting in minimal yellowish tan secretions. BS are clear @ apices c̄ diminished bases. CV Pt currently ST c̄ HR of 130s-140s Ø ectopy. S1, S2 present c̄ BUE pulses 2+-3+ BLE 2+-3+. Cap Refill Brisk throughout c̄ warm extremities. Generalized Edema c̄ injected sclera and 2+ pitting edema throughout 3+ scrotal edema. GI NGT to (R) nare draining to LIS. c̄ greenish yellow drainage. Midline incision c̄ dressing intact. (R) colostomy c̄ liquid brown drainage. J tube c̄ feeding @ 5cc/hr of Perative. Duodenum draining to gravity to foley green yellow drainage. GU Foley to Gravity draining > 55cc/hr of dark amber urine. Skin Midline incision

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

#[redacted]

b(6)-4

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

b(6)-2 A11

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	dressing intact no drainage noted at this time. Lines (R) Cordis c̄ TLC to RIJ c̄ CVP monitoring and MSO_4 / Versed to proximal port Cordis c̄ NS @ 125cc/hr. LEJ. (R) Femoral A-line. Pt currently sedated and stable will continue to monitor. [redacted]
1730	ABG Sent c̄ Mot 8. Results attached to chart. M.D. [redacted] notified of ABG. Vent Δ FiO_2 ↑ to 50% and second ABG drawn. [redacted]
1827	ABG Sent. Results attached to chart. M.D. [redacted] notified of ABG. Vent Δ FiO_2 ↑ to 60% and monitor to keep SaO_2 > 95% per Monitor. [redacted]
1900	Trax 102. [redacted] Pt given Tylenol 650mg per colostomy and did not work. the Tylenol was not absorbed. Tylenol 650mg per PR given. Will monitor Temp [redacted]
1935	VENT changed per [redacted] secondary to inadequate delivery of TV. Pt setting @ 600 and pt receiving 6/ft 450-465. Pt oxygenated c̄ BVM on 100% FiO_2 during VENT change, VENT changed successfully and pt placed back on VENT c̄ adequate TV delivery. [redacted]
2000	↑ new NS 1080cc bag @ 125cc/hr. [redacted]
2100	Trax 101.4. Will continue to monitor [redacted]
2330	Pt dressing Δs to abdomen and JP sites changed. Abd dressing removed. Staples intact c̄ wound open centrally to staples. Tissue is ashen c̄ few areas of pink/red tissue; Area packed c̄ 4x4 soaked in Dakin's solution and covered c̄ abd pads. JP sites to (L) side x2 and (L) Flank x1 covered c̄ 2x2 (2) and 4x4 (1). All JP sites are free of redness / signs and symptoms of infection. Midline wound intact will monitor for drainage. [redacted]
2360	Oral care done, ETT E-Tab changed. Pt has foul malodorous breath c̄ traces of greenish brown particles suctioned c̄ yankee.

NSN 7540-00-634-4178 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1 Aug 03	Received Pt #512 in Rm 2 Bed #3. No response to deep pain noted.
0900	PERL 3 mm. Cardiac monitor shows sinus tachycardia. HR 120's-130's. BP 90's/110's 110/80 MAP ≥60 CVP 17-23. SpO2 all peripheral pulses ⊕ Introduce 7 TLC to right SC. Site intact ⊖ S/S of infection or infiltration. IV NS at 125cc/h infusing thru side port. Versed drip at 4mg/h infusing to left external jugular IV access. Site intact. IV MSO4 at 3 mg/h infusing to ⊕ ET site intact. Arterial line to right femoral artery. Site intact. Arterial tracing and NIBP correlates CVP and arterial lines zeroed. Pt has generalized edema. Pt orally intubated #8 ET at 24cm lip line. Vent SIMV 20 TV 600 Peep 12 FiO2 60% Bilateral breath sounds clear with diminished lower lobes. Equal chest expansion noted. Resp 20 Sat 99% via pulse oxymeter. No signs of resp distress noted. Salem Sump Tube in place thru right nare to low intermittent suction. greenish noted in drainage to suction canister. Mid Abdominal dressing dry and intact. (Midline abdom) Duodenostomy drain to left lower abdominal quadrant draining yellowish bile tinged jejunostomy tube to left mid abdominal wall intact with Jevity drip infusing. Two JP drainage to Right side of abdomen. Dressing to Right side of abdomen covering JP's, Duodenostomy and jejunostomy tubes. Dressing clean dry and intact. Bowel sounds not heard. Skin intact except for surgical wound bilat [redacted] LT [redacted]
0700	Pt's condition unchanged. Dr [redacted] visited and examined Pt. He is aware of Pt's
0900	lab results. Pt continued deep sedation noted. [redacted]
1030	Dr [redacted] visited and examined Pt. Mid abdominal dressing changed. Dr [redacted] debrided abdominal wound. Both JP's discontinued by Dr [redacted]. Dressings applied to site.
1200	Pt's condition unchanged. FiO_2 ↓ to 50%. Bleeding well left/pink. via pulse oxymeter [redacted]

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

EPW# [redacted] b(6)-4

RECORDS MAINTAINED AT:

PATIENT'S NAME *(Last, First, Middle initial)*		SEX
EPW # [redacted] b(6)-4		
RELATIONSHIP TO [redacted]	STATUS	RANK/GRADE
SPONSOR'S NAME		ORGANIZATION
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1 August 03	Surgery Required more oxygenation last PM, otherwise stable
1030 -	Afebrile 100-120/50-60 126 resp/min 8653/4014
	pancreas JP 155 (10cc/3° yest) IN_1 → 100cc/0
	nephrectomy JP 345 (35cc/3° yest)
Advance	duodenostomy red rubber 575cc; d/ing last 10 hours.
Zantac 50/8	anuretic, edematous 43 > 33 — 69 PT/PTT 27/40
MSO4/Versed	lungs CTA & exp wheeze ⊖/Syn PT/PTT 3.4/28 | 120/2 | PT/PTT <21 2-3 / 89/42
IVF 125cc/° NS	RVM ⊖m any 1200
Zosyn 3375/6°	⊖BS, tight 20/600/.6/12 7.32/37/126/19/-7
	wound c necrotic margins; fascia intact
	legs w/D/pulp symmetrical, anasarca 9-1.3 = 5 / 2.7 / 8 / 2.16 / 6.5
	Ca - 8.96
Mean AP 17-19	Lungs. Critical — ETP except c Rwx & Y gastrojej
	Shock & third space — seems nearly over now
	sedated/analgesed adequately — moved & JP removal only
	Pulm — lungs wet extravascularly 2° 3rd space
	CV - stable, euvolemic
	GI - tol trophic feeds only; duodenostomy tube not draining,
	? whether has been pulled out of duodenum.
	renal cr stable, good UO, Ca^+ corrects to 8.96
	ID - afebrile
Plan	Continue MSO4/Versed/Nbix Admitted neuritic necks @ bedside.
	add albuterol to advanced nebs q 4°
	Cont trophic feeds
	d/c JPs
	add mvi/Fragon
	Wean FiO2 to keep SaO2 ~ 95%, does not retain CO2
	Cont to prep until "shade" phase over b(6)-6
	D Dakin soln w→D abdo drsgs BID. [redacted]

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
23 to (CONT'D)	Pt tolerated mouth care well. SaO_2 maintained > 94% during oral care and E-Tab change. Will continue to monitor. [redacted] [illegible]
2 AUG 03 0200	ABP 89/48 MAP 63 NIBP 98/44 MAP 64. Pt FiO_2 ↑ to 70% for SaO_2 of 94%. Will continue to monitor. [redacted] [illegible] b(6)-2
0221	Dr. [redacted] notified of Pt SaO_2 @ 9[redacted] of FiO_2 to 70% and PEEP of 10 PEEP ↑ to 12. Will monitor for ↑ in SaO_2 [redacted] [illegible]
0500	Summary of shift. At 0300 pt ABP 85/49 HR [illegible] RR 20 SaO_2 92%. Dr. [redacted] notified of ABP and SaO_2. At 0300 PEEP ↑ 15 IMV ↑ to 20 and pt received a 500cc Bolus ⊼ VS @ 0315 128 82/52 MAP 65 RR 20. ~~At 0330~~ SaO_2 94%. At 0330 Pt PEEP ↓ to 13 and Dopamine started @ 5mcg/kg/min ⊼ VS @ 0345 124 81/53 MAP 66 RR 20 SaO_2 96. At 0400 pt Dopamine ↑ to 10mcg/kg/min due to ↓ MAP of 59-60. 1g Calcium Chloride IV over 5 minutes for ↓ BP and ↓ response to dopamine. Pt received 2nd 500cc Bolus per MD and NEVF ↑ to 150cc/hr. Vent changes made ↓ IMV to 16 and ↓ Dopamine to 3mcg/kg/min for VS @ 0405 125 110/61 MAP 82 RR 20 SaO_2 95%. Currently pt VS 133 99/52 MAP 71 RR 16 SaO_2 94%. Continue to monitor and maintain MAPS > 60 and SaO_2 > 95%. Dr. [redacted] will return to see pt @ 0700.
CE 0330	Duodenum feeding stopped and tube to gravity w/ foley bag 2° to clogged tube. ~~Att~~ Attempts made to unclog tube by

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

#[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	Dr. [redacted] without success. Tube to remain to gravity until further notice from Doctor [redacted]. [redacted]
0520	Report given to day shift c̄ update [redacted] b(6)-2
2 Aug 03	Surgery
0900	① Pt had d CVP & MAP last pm, responded well to volume.
	② However, oxygenation continues to worsen; on 100% & 15 PEEP last pm to keep Sat > 55%. ③ Feeding jej clogged → opened.
MSO4/Versed 4/4	T max 102.2 → 107.6 80/15/90 130 reg 6 351.2/285
Zantac 50/8	amniotic, injected, PRN Mg 50-100 cc/h
Zosyn 3.375/6	lungs clear, distant; symm Neuromuscular min
Albut/Atrov q4	cdest 7 160 cc/24h
MVI	NRR, ⊕m 2.6 > 29.6 80 156/124/35 3.7/16/2.7
Fe	GBS, tight, 21/69
dopamine 3 mcg/kg/min	wound c̄ necrotic fat & necks amy 57/14
INF 150/0 NS	legs w/o/anasarcic, pedal pulses ⊕ ⊕ symm
	IMV 20/600/100/13 7.34/30/65/17/-9
	Impr. Cardiac stop secsw c̄ multiple vascs injuries
	febrile - etiology; wound? intra-abdominal? pulmonary? - on Abx
	respiratory failure / decomp.
	Shock / malnutrition / leukopenia / thrombocytopenia
	Improving hypoalbuminemia improving & anemia
	Plan 1. Keep sedated -
	2. Restart TF, add flushes q4°
	3. Colloid resuscitation - use salt poor albumin
	4. May add pressors if oxygenation worsens b(6)-2
	5. Wean vent slowly - lost ground will be hard to recover.
	6. Debride wound + continue fluids
	7. Read [redacted] vbns tox [redacted]

STANDARD FORM 509 (REV. 5/1999) BA
USAPA V

NSN 7540-00-634-4178 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
2 AUG 03	Received Pt #512 in Icu 2 Bed #2. Pt responds only to deep pain from suctioning
0530	Rest 3 hrs bright. Cardiac Monitor shows sinus tachycardia HR 130's. BP 90/40-50's MAP
	260 ⊕ SVD. Pt has generalized edema 3+ pitting. TLC with Hydrojet to right 1st &
	IV NS 150cc infusing to hydrojet. Versed drip at 4 mg/hr and Morphine drip at 4 mg/hr
	infusing to whitejet. Dopamine drip at 3 mcg/kg/min infusing to 3 lumen
	site intact. No signs of infectious infiltration noted. A line to right femoral artery
	site intact. A line correlates with NIBP. All peripheral pulses ⊕ 5/52. Pt
	orally intubated #8 ET 24 cm at lip line. Vent Setting SIMV 16. TV 600 Resp 13 FIO2 100
	Bilateral breath sounds clear but diminished. Equal chest expansion
	noted. Resp Rate 16 Sat 95% via pulseoxometer. Suctioning produces scanty
	secretion, beige. ⊕ bowel sounds. Foley cath in place draining amber urine. Ileostomy
	Pt has jejunostomy tube to left lower abdominal wall connected to gravity drainage.
	Duodenostomy tube to left upper abdominal wall to gravity drainage. Colostomy
	to Right abdominal wall intact. Midline abdominal surgical wound covered
	with Dry dressing. Dressing covering jejunostomy and Duodenostomy site. Old ⊕
0700	sites oozing fluid covered. Dr Sam visited Pt. He is aware of Pt's labs results. He
	ordered Dopamine drip at 4-5 mcg/kg/min. Albumin 5% in 250 cc NS ordered and
0800	given. HR 129 BP 96/53 MAP 72. Dopamine drip increased to 7 mcg/kg/min to
b(6)-2	keep SBP 2100 mm Hg. Tylenol Supp 650 given at 6 am for temp 101.6 [redacted]
0840	Dr [redacted] visited and examined Pt. FiO2 80. Pt tolerating changes and 95-97% via
0930	pulseox. Mid abdominal dressing changed. Tube feeding restarted at 10 cc/hr. Blood
1000	drawn and sent to lab for ABG and chem 7. Pt sat 95-97%. PH 7.261 PCO2 45.4
b(6)-2	PO2 166 HCO3 18. Glucose 119 Na 139 K 3.6. Dr [redacted] informed. [redacted]

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

[redacted] b(6)-4

RECORDS MAINTAINED AT:

PATIENT'S NAME *(Last, First, Middle initial)* [redacted] | SEX M

RELATION [redacted] | SPONSOR | STATUS | RANK/GRADE

SPONSOR'S NAME | ORGANIZATION

DEPART./SERVICE | SSN/IDENTIFICATION NO. | DATE OF BIRTH

MEDCOM - 15383

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
2 Aug 03	NSG Notes Cont'd.
1045	D50. 1 amp SIV given. Rec'd TV 620. FiO2 2 70%. ABG and chem 8 drawn and
11:15	at 11:15. Labs drawn for ABG pH 7.24 PCO2 48.1 PO2 107 HCO3 18 Na 157 Cl 124
	Dr [redacted] aware. 1 amp Sodium bicarbonate IV given. Pt's IV fluid changed to LR 150
1215	then 2 D5 [redacted] 3 amps NaHCO3 at 150. BP labile 88/55 Dopamine drip 45 mcg
	kg/min. then 75 mcg/kg/min. Dr [redacted] bedside MSO4 and Versed drip
1300	↓ to 3 mg/h. Dopamine drip 10 mcg/kg/min. ABG 7.347 PCO2 29.1
1400	HCO3 16 Dr [redacted] aware of Pt's condition and labs. [redacted] ILT
1430	BP 84/48 mean 62 4 Dopamine drip 75 mcg/kg/min. [redacted] ILT
1600	T 105.2 Tylenol supp. 650 mg given. HR 140's. BP 115/60 (65) Labs drawn ABG,
	chem 8. awaiting results. Pt's antibiotics changed started on cipro
	flagyl and ampicillin. ABG 7.386 PCO2 35.7 PO2 75 HCO3 20. FiO2 40%
1600	Na 156 Glu 94. Pt's HR 140's BP 89/60 (65) Dopamine drip tapered down to 10 mcg
1635	kg/min. AC out room (cool) very hot. Temp taken 107. Ice placed on
	groin jugular vein accessed. Sponge bath given will retake Temp in an
1700	hour. Pt's condition unchanged Versed & MSO4 continues at 3 mg/h. Dopamine
	continues at 10 mcg/kg/min. IVDSW TKO 3 Amp NaHCO3 at 150 cc/h. Family at
	local. Report given to relief RN who will follow up with Pt's temp.
	[redacted] ILT
2030	Pt sedated c̄ MSO4/Versed 3+3 ml/hr, pupils 2mm non-reactive, sclerae edematous + jaundiced, ST 130's c̄ frequent PVC's ∅ murmur, Levophed @ 4 mcg/min, Neosynephrine @ 250 mcg/min, Dopamine @ 5 mcg/kg, D5W c̄ 3 amps NaHCO3 @ 150 ml/hr, B/P 70/40's MAP's 60, titrating gtts to maintain MAP >60. 3+ pitting edema, pulses 2+ all extremeties. T max 105.3, given Tylenol 15 mg IVP as ordered, 500 cc NS bolus, 250 mg 5% Albumin. (D) ETT, (R) SCTLC + cordis, (R) Fem A-line, (R) nare NGT to LIS, J-tube infusing

b(6)-2 All

b(6)-2

NSN 7540-01-075-3786

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

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)*: 30 JUL 03 | TIME: 0110

TRANSPORTATION TO FACILITY

SEX: M

DUTY/LOCAL PHONE — AREA CODE | NUMBER

HOME PHONE — AREA CODE | NUMBER

AGE: 37

MILITARY STATUS

ITEM	YES	NO	N/A
PRP			
FLYING STATUS			

MEDICAL HISTORY OBTAINED FROM

THIRD PARTY INSURANCE

ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2568 IN CHART		

NAME OF INSURANCE COMPANY

CURRENT MEDICATIONS: None PMH Ø

ALLERGIES: NKDA

INJURY OR OCCUPATIONAL ILLNESS

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

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INTITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: GSW to ABD

CATEGORY OF TREATMENT

☒ EMERGENT — TIME: 0110

☐ URGENT

☐ NON-URGENT

IN [redacted]

VITAL SIGNS

TIME 0110	0118				
BP	75				
PULSE 116					
RESP 24					
TEMP					
WT					

LAB ORDERS

☒ CBC/DIFF	[redacted]	☒ PT/PTT	BHCG/URINE/BLOOD/QUANT
URINE C&S	UA MSCC/CATH		☒ CHEM: met 8
BLOOD C&S X →	X6 unit Type & Cross		
0118 foley			

X-RAY ORDERS

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

ORDERS

☒ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
0118	100mg Lidocaine	[redacted]	PMR		Pt. Sec
0120	50mg Fentanyl	[redacted]	PMR		
	Urosyn Tam DV				
	Foley to gravity				

DISPOSITION: ☐ HOME ☐ FULL DUTY

MODIFIED DUTY UNTIL

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

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☒ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

[redacted] EPW

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

NSN 7540-01-075-3786

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

TEST RESULTS

CBC		SMAC		ABG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐
	WBC			SUP O2	PH	PO2	RESULTS	
	H/H			PCO2	SAT	OTHER		
	PLT							
PT				U/A	DIP		EKG INTERPRETATION	
APTT		BHCG	ETOH	GLU	MICRO			

PROVIDER HISTORY/PHYSICAL

37y/o ♂ GSW to Abd 2 0045 JPTA. Pt VS ↑ HR,

A: OP/oro clear/pt cooperative, neck supple, ⊕ trachea
B: CTA (B) = symmetric
C: ⊕ 2 rad pulses (B), ⊘ active ext exsanguination.
D: Alert to environment GCS 15
E: ⊕ GSW (L) inf T-12 flank, ⊕ omentum and abdominal
Foley placed = clear/yellow.

Labs
Xrays (P)
@ time of OR admission

2° Heart RRMC, ES ↓ Head atraumatic
Ext 5/5 strength (B)
Abd ⊕ distention ↓ BS, rectal NL tone, ⊘ gross blood
Ext 4/5 lower ext strength, ⊕ 2 dorsalis pedis pulses (B)

A/P GSW to Abd → [redacted] b(6)-2

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STU[redacted] AND STAMP b(6)-2

PROVIDER SIGN[redacted]

DIAGNOSIS

GSW to Abd

CODES

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

b(6)-4

[redacted]

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

#[redacted] b(e)-4

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: 37 HEIGHT: WEIGHT:	2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): NKA 3. PREVIOUS SURGERY [ ] NO [ ] YES (type):

4. PROPOSED SURGICAL PROCEDURE:

Exp. Lap

5. ADDITIONAL INFORMATION: Last PO: Medical Hx: Implants: Medications:
Jewelry removed: yes/no Family waiting: yes/no

None

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL X Potential for anxiety related to traumatic injury; language barrier; family separation; surgical environment	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 X Potential for respiratory dysfunction due to sedation; positioning; injury	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 X Potential impairment of skin integuity due to bovie pad; position; fluid shift	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(e)-4

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION X Potential for inadequate tissue perfusion due to anesthesia; traumatic injury; position; shock; previous surgery	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. Check that safety straps are correctly applied. Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. Check that rings have been removed.
E. NEUROMUSCULAR CONTROL E.1. X Potential impairment of mobility due to sedation; pain; injury E.2. X Potential discomfort due to injury; pain	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. o Allow patient to lie in position of comfort while waiting for surgery. Offer support (i.e., pillows, bathtowels, etc.) for positioning.
F. NEUROMUSCULAR CONTROL F.1. X Disminished visual perception due to being injury; sedation; F.2. X Potential for decreased communictaion due to language barrier; sedation F.3. Potential injury due to dentures.	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. needs interpreter o 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 other side. Validate pt.'s understanding of verbal communications. o Verify removal of dentures.
G. OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS. Or continuation of above interventions.

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

[redacted] CPT/AN 30JUL03 DATE

11. POSTOPERATIVE EVALUATION:

b(6)-2 AK

12. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title)	13. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title)
[redacted], CPT/AN DATE: 30JUL03 TIME: 0200	DATE: TIME:

REVERSE OF DA FORM 5179, JUN 91

USAPA V1.01

b(6)-2

MEDICAL RECORD — **INTRAOPERATIVE DOCUMENT**

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

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

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

3. DATE 30 Jul. 03 TIME PATIENT ARRIVED IN SUITE 1640

4. PATIENT IN ROOM [redacted] TIME 1640 NUMBER 1-2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS (S[redacted] pillow under knees & HT under heels

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

COMMENTS: Body maintained in proper alignment

8. SKIN PREPARATION

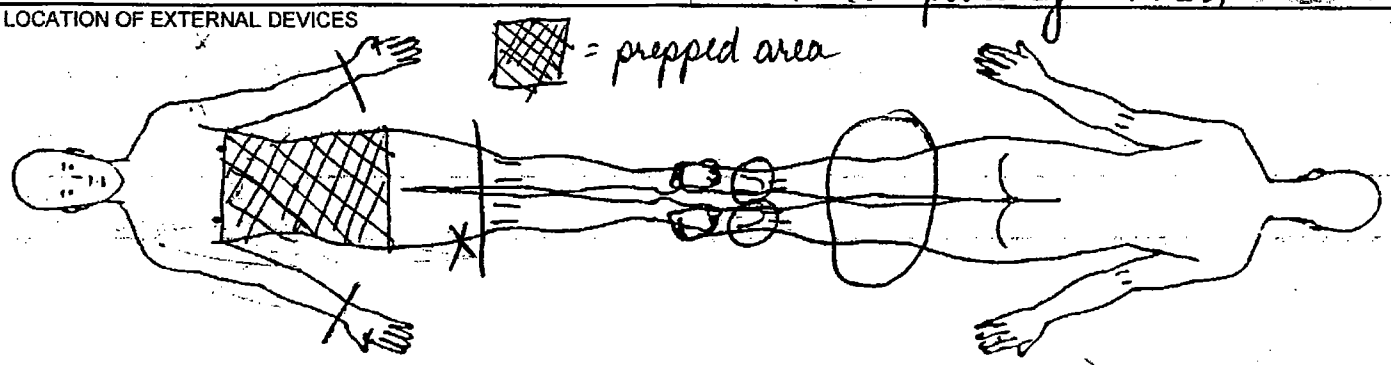
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION (Specify) Betadine scrub & paint
SITE: Abd. nipple → pubis BY WHOM: LTC [redacted]
SITE: BY WHOM:

COMMENTS: No pooling noted b(6)-2

9. LOCATION OF EXTERNAL DEVICES



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

b(6)-2

C = Correct I = Incorrect

10. COUNTS		Initial Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No	✓	C	C	PFC [redacted] (I+2d)	CPT [redacted] (I+1d)
Needle Sharp	☒ Yes ☐ No	✓	C	C	SPC [redacted]	CPT [redacted]
Instrument	☒ Yes ☐ No	✓	C	C		
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: 000411 Valleylab Force 4
GROUND PAD: BRAND RETM Polyhesive
LOT NO: 68936

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

cut: 20 coag: 20

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY
None		

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

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

16. LABORATORY SPEGIMENS

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. 16F Red Rob	2. 16F Red Rob	3. both to foley bags
SITE X	1. duodenum	2. Jejunum (feeding tube)	3.

18. DRESSING/IMMOBILIZATION (Specify)
Ostomy dsg/bag
Kerlix 4x8's
Lg ABD
Tape

19. ADDITIONAL INFORMATION
WC III
Surgeons: Drs [redacted] & [redacted]
Anesthesia: Maj. [redacted] CRNA
Dr. [redacted] LTC, CRNA
Anesthesia Type: General
2 JP drains from prev. surg. (L) side

Bovie Pad site intact pre-op ✓; post-op ____ Bovie Settings: Coag/Cut 20/20 → 30/30
~~Tourniquet Site intact pre-op ____; post-op ____~~ NA
~~Tourniquet Time: Up ____ Down ____~~ NA

20. OPERATION(S) PERFORMED
1. Roux-en-Y
2. Gastrojejunostomy
3. Rt. Colostomy
4. Feeding tube
5. Tube duodenostomy
6. Wound Debridement

21. PATIENT TRANSFERRED TO ICU 2 TIME 2045 METHOD via Gurney

22. REGISTERED [redacted] URE TC, AN / [redacted] PT / AN

REVERSE OF DA FORM 5179-1, OCT [redacted]
MEDCOM - 15390
USAPA V1.01

b(6)-2

b(6)-2A11

MEDICAL RECORD | **INTRAOPERATIVE [redacted]MENT**

For use of this form, see AR 40-66, the proponent ag[redacted] the office of The Surgeon General.

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

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

3. DATE 30 JUL 03 TIME PATIENT ARRIVED IN SUITE 0200

4. PATIENT IN ROOM [redacted] TIME 0200 NUMBER 1-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies:

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

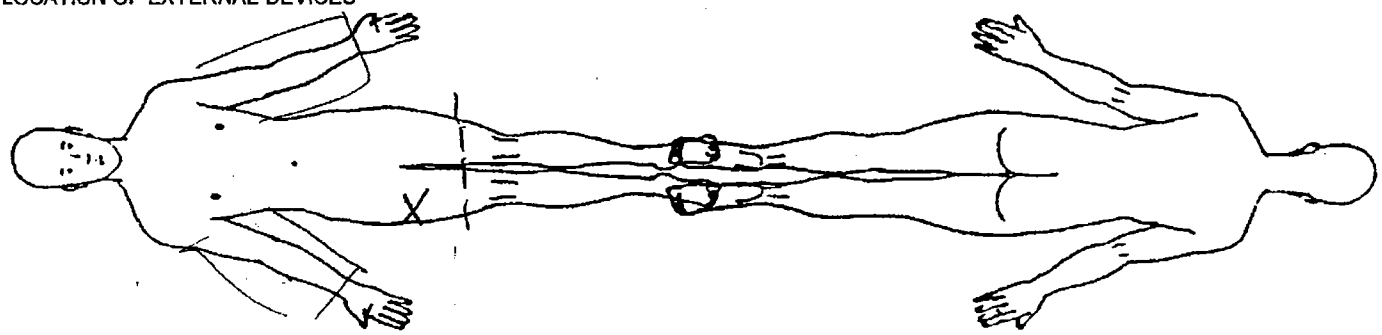
COMMENTS: proper body alignment maintained

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* Betadine scrub/soln
SITE: Abd BY WHOM: [redacted]
SITE: BY WHOM:
COMMENTS: No pooling of fluids

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad – Safety Strap === Tourniquet

C = Correct I = Incorrect Initial C [redacted]

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

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

[redacted]
b(6)-4

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

☒ ESU NO: #3 50/50 → 30/30
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):

0.9% NS

OTHER ORDERS	TIME	CARRIED OUT BY

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

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 10mm JP x2	2.	3.
SITE	1. (L) side	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
4x8's Kerlix
ABD's
Silk tape

19. ADDITIONAL INFORMATION
WC

Surgeons: Saum, Carmody
Anesthesia: Fidele, Watters
Anesthesia Type: Gen.

Foley in place from EMT

Bovie Pad site intact pre-op_____; post-op_____ Bovie Settings: Coag/Cut
Tourniquet Site intact pre-op_____: post-op_____
Tourniquet Time: Up____ Down_____

Unicyn in EMT
TD given EMT

20. OPERATION(S) PERFORMED
(L) Nephrectomy
Distal Gastric Dissection
Transverse Colectomy
Jejunal Resection
Femoral Art line Placement

21. PATIENT TRANSFERRED TO: ICU2 TIME: 0420 METHOD: Litter

22. REGISTERED NURSE SIGNATURE
[redacted] CPT [redacted] (PMN)

PT'S NAME: #[redacted] b(6)-4 ID#: DATE: 30Jul03

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
BP INV																								
BP NIBP			100/79	112/75	117/76	78/56	105/63	137/78	112/72	98/56	119/64	116/63						108/50	90/52	77/41	85/46	94/53	94/53	91/51
TEMP			913	921		931	943	959	973	974	987	991						947	965	969				979
HR			109	104	109	117	109	120	121	131	133	136						125	124	122	125	131	135	140
RR			12	12	12	12	14	14	14	14	14	16						20	20	20	20	20	20	20
SP02			100	100	100	100	100	100	100	100	100	100						99	100	100	100	100	100	100
FIO2			50	50		40	40	40	40	40	40	40						80	80	80	80	80	60	60
INPUT																								
PO																								
IV F								IVPB 50		IVPB 50	300							150	150	150	150	150	150	150
NGT																								
Bolus		1000		500		2000	1000	1500	1500	300								1000		1000				
FFP			499						IVPB 250		531													
1504				2	4	4	4	4	3	3	3	5						5	5	1	1	1	1	3
Versed				3	5	6	5	3	3	3	3	3						3	3	1	1	2	2	4
B TOTAL		1000		505	9	2010	1009	1557	1756	356	837	8						808	158	1152	152	153	153	157
TAL		1000	1499	2004	2013	4023	5032	6589	8345	8701	9538	9546						10354	10512	11664	11816	11969	12120	12279
ITPUT																								
URINE				100	30	30	38	22	26	30	70	40						815	100	50	80	70	50	40
NGT												200										100		100
STOOL																								
JP1		120		200		100	170		220	140	110	70						260		35	40	40		30
JP2		70		50		70	20		150	100	100	50						30				20		10
J tube																		25		25		25		0
duodenostomy																		75		125		25		25
ostomy																						100		
SUBTOTAL		190		350	30	200	228	22	396	270	280	360						1255	100	235	80	380	50	205
TOTAL		190		540	570	770	968	990	1386	1656	1936	2296						3551	3651	3886	3966	4346	4396	4301
BALANCE																								

Recount

+7978

MEDCOM - 15393

0615 TV↑800 R12, P5

0630 - Tamp HCO3
1020 - Tamp HCO3 R↑14

1016 ABG, CBC done

09 25: 1504 Versed gtts started

1040 - ABG drawn
~~1300~~ 1255 = 1u PRBC
1310 - 1500cc Bolus

ABG:

0545	0645	1016	1050	1218
pH 7.23	pH 7.29	pH 7.20	pH 7.33	pH 7.38
pCO2 40.3	pCO2 36.7	pCO2 43.3	pCO2 33.1	pCO2 33.1
pO2 200	pO2 274	pO2 130	pO2 190	pO2 166
HCO3 17	HCO3 18	HCO3 17	HCO3 18	HCO3 16
sO2 100	BE -9	BE -11	BE -8	BE -10
BE -4	sO2 100%	sO2 98	sO2 100%	sO2 99%

PT'S NAME: [redacted] CPW 6(a)-4 ID#: DATE: 31 July 03

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
BP INV		89/49	80/43	93/55	98/56	101/54	102/55	96/51	103/54	102/54	104/53	93/51	92/47	100/50	103/50	104/49	109/52	106/48	106/47	93/45	100/50	100/42	94/42	89/41
BP NIBP		101/52	106/52	106/58	133/78	121/66	121/71	119/68	122/67	124/76	120/70	116/66			128/60	119/57			119/57					105/53
TEMP		98.8	98.5	98.7	98.3	98.6	97.3	97.3	97.4	97.8	98.0	98.7			99.2				99.4				99.8	
HR		139	131	128	125	128	120	122	133	125	125	126	127	128	131	132	134	131	131	127	126	129	126	128
RR		20	20	20	20	11	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20
SP02		99	100	98	99	100	99	100	99	99	99	100	96	96	93	92	95	98	98	99	98	98	99	99
FIO2		60	60	60	60	60	60	60	60	60	60	60	60	60	60	60	80	80	80	60	60	60	60	60
Map INV		58	56	72	71	73	73	71	73	74	71	69	64	70	72	69	74	67	65	62	70	62	58	58
non inv		71	71	76	95	82	90	87	88	91	89	84			86	80			81					73
CVP																		20	22	20	19	19	18	18
INPUT																								
PO																								
IV	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	125	125	125	125	125	125	125
NGT																								
dus		1000	1000	1000		500			500					500										
501	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
rsed	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4
PB		100						50	50	150				50				100						
-Tube							5	5	5	5	5		5	5	5	5	5	5	5	5	5	5	5	5
B TOTAL	157	1257	1157	1157	157	657	157	207	707	707	157	157	162	712	162	162	162	237	137	137	137	137	137	137
TAL	157	1414	2571	2728	3885	4542	4699	4906	5613	5920	6077	6234	6396	7108	7270	7432	7594	7831	7968	8105	8242	8379	8516	8653
TPUT																								
URINE	75	50	55	110	55	60	70	75	160	110	60		110	45	85	100	160	34	90	80	80	100	60	70
NGT	50			50		25			85		15					125					340			50
STOOL																								
Sp1	25	10	10	10	10	10	0	15	0	0	10				15						30			10
Sp2	20	25	10	20	20	10	20	15	15	15	15		30		20		40	40			40			35
J-Tube	75			75		25	10																	
Duodenostomy	225			150		50	50			50	25		25		0						0			0
Ostomy					100						25										50			
SUBTOTAL	470	85	75	110	466	180	150	105	200	175	150		165	45	120	225	160	74	90	80	540	100	60	165
TOTAL	470	555	630	770	1230	1410	1560	1665	1865	2040	2190	2190	2355	2400	2520	2745	2905	2979	3069	3149	3689	3789	3849	4014
BALANCE	-313	+1172	+1082	+1017	-303	+477	+67	+102	+207	+132	+07													

MEDCOM - 15394

PT'S NAME: GPW [redacted] b(6)-4 ID#: DATE: 1 Aug 03

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
BP INV	99/48	117/57	119/62	119/61	118/61	117/64	117/66	119/61	109/57	117/58	118/58	109/61	117/58	108/56	99/54	99/60	102/59	104/60	100/56	113/74	97/55	89/48	89/45	90/50
~~BP NIBP~~	62	74	80	80	82	83	87	80	75	76	72	74	71	75	72	75	76	78	71	90	71	63	65	74
TEMP	99	100.7				100.2				101.6					102.2		101.4		101.6			101.0		100.9
HR	127	132	130	126	127	126	126	129	136	137	137	138	139	140	139	133	131	132	134	131	131	131	130	123
RR	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	18	18	17	15	19	19	20	16
SP02	99	99	99	100	100	99	100	99	99	99	98	96	95	94	94	95	96	95	94	94	94	94	92	95
FIO2	60	60	60	60	60	60	60	50	50	30	40	40	40	40/50	50	60	60	60	60	60	65	70	70	100
CVP	23	19	17	16	16	18	19	19	19	19	19			22	19	17	19	17	17	18	15	16	20	20
INPUT																								
PO																								
IV NS	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	150
[illegible]	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4
MSW	3	3	3	3	3	3	3	3	3	3	3	3	3	3	4	4	4	4	4	4	4	4	4	4
[illegible]	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	OFF	OFF
[illegible]		50				50				50		50						100					500	500
DOP																							2.5	2.5
B TOTAL	137	187	137	137	137	187	137	137	137	187	137	187	137	137	138	138	138	238	138	138	138	138		
TAL	137	324	461	598	735	922	1059	1196	1333	1520	1657	1844	1981	2118	2256	2394	2532	2770	2908	3046	3174	3312		
TPUT	~~160~~	~~180~~																						
URINE	160	180	100	140	120	100	100	120	100	140	120	140	120	85	55	95	90	75	80	70	50	50	50	50
NGT													400											600
STOOL Drain																								
JP #1						25																		
JP #2						50																		
Colostoma																								
													100											60
SUBTOTAL	160	180	100	140	120	175	100	120	100	140	120	140	620	85	55	95								
TOTAL	160	340	440	580	700	875	975	1095	1195	1335	1455	1595	2215	2300	2355	2450	2540	2615	2695	2765	2815	2865		
BALANCE	23	9	37	-3	-17	12	37	17	37	47	17	47	+983											

BOWS

MEDCOM - 15395

Slow 16
TV 600
Resp 43
FiO2 100

Date: 2 AUG 03 Bed#: 2
Patients Name: SIZ

Time	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
ABP	100/53	91/53	91/50	96/53	95/53	94/53	95/55	81/55	85/50	85/49	85/40	85/40	86/49	77/45	78/45	78/47	80/49	81/50	82/52	84/55
~~BP~~ MAP	71	70	66	72	71	71	67	67	65	65	63	65	62	56	58	59	62	63	64	66
TEMP		101.6				101.6					105.2	107		105.3		105.3			103.2	
HR	133	131	130	129	130	130	128	127	131	131	142	150	149	143	142	131	131	127	123	115
RR	16	16	16	16	16	16	16	20	20	20	20	20		24	24	20	20	20	20	20
SAO2	94	94	95	96	97	96	96	97	98	95	95	93	94	94	93	93	92	91	91	93
FIO2	100	100	100	100	90	90	70	70	70	60	60	70	70	70	70	70	70	70	70	70
CVP	16	23	20	16	18	18	19	23	22	23	23	23	?	19	19	20	21	20	22	23
INPUT																				
PO NGT																				
IV NS/bicarb	150	150	150	150	150	150	150	150	150	150	150	150	150	10	30	10				
~~NGT~~ Albumin			250		250									150	150	150	150	150	150	150
VERSED	4	4	4	4	4	4	4	4	4	3	3	3	3	3	1.9	1.5	37.5	37.5	37.5	37.5
MSO4	4	4	4	4	4	4	4	4	4	3	3	3	3	3	3	3	3	3	3	3
~~Pavulon~~	off	NEO												3	3	3	3	3	3	3
IVPB				50		50				50		150		150	187	625	50	12.5	31.3	31.3
DOPAMINE	4.5	4.5	7.5	10.5	4.5	4.5	4.5	7.5	7.5	15	22.5	15	15	4.5	4.5	7.5	7.5	7.5	7.5	7.5
TOTAL	166.5	233	652.5	871	1285.5	1500	1625	1848	2013.5	2234.5	2413	2734	2905	3225.5	3653	4640.9	5361.9	5125	5406.7	6339
Subtot					414.5	214.5	125	175.5	165.5	221	178.5	321	171	320.5	427.5	987.9	721	874.4	933.2	932.3
OUTPUT																				
URINE (FC)	100	100	80	60	60	60	40	50	60	40	25	40	40		40	12	8	16	10	14
NGT							10						100							
STOOL																				
COLOSTOMY																				
DUODENUM						200		50				100								
												500						450		
												60								
Sub tot	100	100	80	60	60	280	50	100	60	40	25	640	140		40	12	8	466	10	14
TOTAL	100	200	280	340	400	680	730	830	890	930	955	1595	1735		1775	1787	1795	2261	2271	2285
BALANCE																				
TURN Q 2																				

MEDCOM - 15396

N800
0645

i-STAT G3+

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

Pt Name:_____

TCO2_____19 mmol/L

At 37C

pH_____7.294

PCO2_____36.7 mmHg

PO2_____274 mmHg

HCO3_____18 mmol/L

BEecf_____-9 mmol/L

sO2*_____100 %

*calculated

Sample Type_:

30JUL03 06:54

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

Physician:_____

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

Ver: JAMS046A
CLEW A93

(b)(6)-4

ID: [redacted] 30-07-03
WB 03:53

			Patient Limits	
WBC	5.3	x10^3/uL	4.5	10.5
RBC	2.30 L	x10^6/uL	4.00	6.00
Hgb	6.5 L	g/dL	11.0	18.0
Hct	20.7 L	%	35.0	60.0
MCV	90.2	fL	80.0	99.9
MCH	28.4	pg	27.0	31.0
MCHC	31.5 L	g/dL	33.0	37.0
Plt	58. *	x10^3/uL	150.	450.
LY%	28.3	%	20.5	51.1
LY#	1.5	x10^3/uL	1.2	3.4

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i-STAT EG7+

Pt: [redacted]

Pt Name:_____

Na_____149 mmol/L

K_____5.2 mmol/L

TCO2_____18 mmol/L

iCa_____0.75 mmol/L

Hct_____17 %PCV

Hb*_____6 g/dL

*via Hct

At 37C

pH_____7.179

PCO2_____43.7 mmHg

PO2_____342 mmHg

HCO3_____16 mmol/L

BEecf_____-12 mmol/L

sO2*_____100 %

*calculated

Sample Type_:

30JUL03 03:53

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

ID: [redacted] 30-07-03
WB 01:30

			Patient Limits	
WBC	17.7 H	x10^3/uL	4.5	10.5
RBC	2.55 L	x10^6/uL	4.00	6.00
Hgb	7.0 L	g/dL	11.0	18.0
Hct	22.5 L	%	35.0	60.0
MCV	88.2	fL	80.0	99.9
MCH	27.4	pg	27.0	31.0
MCHC	31.0 L	g/dL	33.0	37.0
Plt	279.	x10^3/uL	150.	450.
LY%	33.1 *	%	20.5	51.1
LY#	5.9 *H	x10^3/uL	1.2	3.4

ID: [redacted] 30-07-03
WB 05:01

			Patient Limits	
WBC	6.8	x10^3/uL	4.5	10.5
RBC	4.39	x10^6/uL	4.00	6.00
Hgb	12.3	g/dL	11.0	18.0
Hct	39.9	%	35.0	60.0
MCV	90.8	fL	80.0	99.9
MCH	28.1	pg	27.0	31.0
MCHC	30.9 L	g/dL	33.0	37.0
Plt	58. *L	x10^3/uL	150.	450.
LY%	30.5	%	20.5	51.1
LY#	2.1	x10^3/uL	1.2	3.4

---

i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____13 mmol/L

At 37C

pH_____7.040

PCO2_____43.6 mmHg

PO2_____235 mmHg

HCO3_____12 mmol/L

BEecf_____-19 mmol/L

sO2*_____99 %

*calculated

Sample Type_:

30JUL03 05:02

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

ID: [redacted] 30-07-03
WB 05:59

				Patient Limits	
WBC	3.5 L	x10^3/uL		4.5	10.5
RBC	3.81 L	x10^6/uL		4.00	6.00
Hgb	10.8 L	g/dL		11.0	18.0
Hct	34.1 L	%		35.0	60.0
MCV	89.5	fL		80.0	99.9
MCH	28.3	pg		27.0	31.0
MCHC	31.6 L	g/dL		33.0	37.0
Plt	59. L	x10^3/uL		150.	450.
LY%	22.0 *	%		20.5	51.1
LY#	0.8 *L	x10^3/uL		1.2	3.4

ID: [redacted] 30-07-03
WB 03:02

				Patient Limits	
WBC	12.1 H	x10^3/uL		4.5	10.5
RBC	3.23 L	x10^6/uL		4.00	6.00
Hgb	9.1 L	g/dL		11.0	18.0
Hct	29.4 L	%		35.0	60.0
MCV	91.1	fL		80.0	99.9
MCH	28.3	pg		27.0	31.0
MCHC	31.0 L	g/dL		33.0	37.0
Plt	103. L	x10^3/uL		150.	450.
LY%	24.3 *	%		20.5	51.1
LY#	2.9 *	x10^3/uL		1.2	3.4

ID: [redacted] 30-07-03
WB 10:35

				Patient Limits	
[illegible]	[illegible]	x10^3/uL		4.5	10.5
[illegible]	[illegible] L	x10^6/uL		4.00	6.00
[illegible]	[illegible] L	g/dL		11.0	18.0
[illegible]	30.0 L	%		35.0	60.0
[illegible]	89.1	fL		80.0	99.9
MCH	28.7	pg		27.0	31.0
MCHC	32.2 L	g/dL		33.0	37.0
Plt	64. L	x10^3/uL		150.	450.
LY%	15.1 *L	%		20.5	51.1
LY#	0.7 *L	x10^3/uL		1.2	3.4

NIBP TREND 08/02/03

TIME HH:MM	HR/PR BPM	SpO2 %	SYS / DIA mmHg	MEAN	RR RPM
04:24	131	95	121 / 49	75	33
04:23	131	95	119 / 50	76	[illegible]
04:23	130	95	117 / 48	74	29
04:21	131	92	126 / 84	100	[illegible]
04:00	123	95	109 / 53 *	76	20
03:58	121	94	114 / 48 *	72	20
03:52	123	94	94 / 46	65	20
03:00	130	93	102 / 44	65	20
02:12	131	94	98 / 44	64	16
00:27	131	93	106 / 44	68	17
21:20	131	98	94 / 46	65	16

ART TREND 08/02/03

TIME HH:MM	HR/PR BPM	SpO2 %	SYS / DIA mmHg	MEAN	RR RPM
04:40	132	95	105 / 56	76	16
04:38	131	95	104 / 56	75	16
04:36	132	95	106 / 56	76	16
04:34	132	95	107 / 57	77	16
04:32	133	94	111 / 57	79	16
04:30	131	95	108 / 58	78	16
04:28	131	95	107 / 58	78	16
04:26	131	95	109 / 58	79	19
04:24	131	95	108 / 59	79	[illegible]
04:22	131	94	125 / 69	91	[illegible]
04:20	129	96	133 / 80	101	[illegible]
04:18	128	95	113 / 60	81	16
04:16	127	95	112 / 61	82	16
04:14	127	95	114 / 62	83	16
04:12	127	95	114 / 63	83	16
04:10	125	94	112 / 63	83	18
04:08	125	94	112 / 62	82	20
04:06	125	94	110 / 61	82	0
04:04	124	95	[illegible] / [illegible]	[illegible]	20
04:02	123	95	100 / 60	78	20
04:00	123	95	96 / 58	74	20
03:58	121	94	93 / 54	70	20
03:56	123	94	88 / 54	69	20
03:54	123	94	83 / 53	67	20
03:52	123	94	81 / 52	66	20
03:50	[illegible]	[illegible]	78 / 50	63	20
03:48	[illegible]	[illegible]	[illegible] / 49	60	20
03:46	123	[illegible]	81 / 53	66	20
03:44	124	96	82 / 53	67	20
03:42	123	94	86 / 55	69	18
03:40	123	96	87 / 53	68	22
03:38	124	96	88 / 54	69	20
03:36	124	96	89 / 54	69	20
03:34	124	96	91 / 55	71	20
03:32	124	95	[illegible] / 70	110	20
03:30	124	95	90 / 54	70	20
03:28	124	96	92 / 56	[illegible]	20
03:26	124	98	89 / 54	69	20
03:24	125	[illegible]	[illegible]	[illegible]	[illegible]
03:22	125	96	88 / 54	[illegible]	[illegible]
03:20	125	96	86 / 53	68	20
03:18	126	95	85 / 53	67	20
03:16	123	94	82 / 52	65	20
03:14	129	94	168 / [illegible]	[illegible]	20
03:12	[illegible]	[illegible]	93 / 55	72	13
03:10	[illegible]	[illegible]	94 / 54	71	17
03:08	[illegible]	92	83 / 48	62	19
03:06	129	92	85 / 49	63	20
03:04	129	93	85 / 49	63	20
03:02	130	92	85 / 49	63	20
03:00	130	92	85 / 49	63	20
02:58	130	93	86 / 48	63	19
02:56	130	93	86 / 49	63	16
02:54	130	94	86 / 48	63	16
02:52	130	93	85 / 48	63	16
02:50	130	94	85 / 48	63	16
02:48	130	94	87 / 48	63	16
02:46	131	94	87 / 48	63	17
02:44	130	94	87 / 48	63	16
02:42	131	94	87 / 48	64	16
02:40	130	94	87 / 48	63	16
02:38	131	94	87 / 48	63	16
02:36	131	94	89 / 49	65	18
02:34	131	94	88 / 48	63	15
02:32	131	94	87 / 48	63	16
02:30	131	94	89 / 49	64	16
02:28	131	94	88 / 48	63	16
02:26	131	94	90 / 49	65	16
02:24	131	94	89 / 49	65	16
02:22	131	94	88 / 49	64	16
02:20	131	94	89 / 48	64	16
02:18	131	94	89 / 48	64	16
[illegible]	[illegible]	[illegible]	[illegible] / 9	64	17
[illegible]	[illegible]	[illegible]	[illegible] / 48	63	16
02:12	131	94	89 / 48	64	16
02:08	132	94	90 / 48	63	16
02:06	132	94	89 / 48	64	16
02:04	132	94	89 / 48	63	16
02:02	132	94	89 / 47	63	16
02:00	132	94	89 / 48	63	16
01:58	132	[illegible]	89 / 47	63	16
01:56	132	94	88 / 48	63	13
01:54	132	94	90 / 47	63	16
01:52	133	94	89 / 47	63	16
01:50	133	94	90 / 48	63	16
01:48	135	94	90 / 48	63	16
01:46	133	94	92 / 48	64	15
01:44	133	94	93 / 48	64	16
01:42	133	95	94 / 48	65	16
01:40	132	95	93 / 48	65	16
01:38	133	94	93 / 48	65	16
01:36	135	94	94 / 49	65	16
01:34	132	95	93 / 49	65	16
01:32	133	94	94 / 50	66	16
01:30	133	95	94 / 49	66	16
01:28	132	94	95 / 49	67	16
01:26	132	94	97 / 50	68	16
01:24	132	94	96 / 50	68	16
01:22	132	94	96 / 51	69	16
01:20	132	94	97 / 51	69	16
01:18	132	94	97 / 52	70	16
01:16	131	94	97 / 52	70	[illegible]
01:14	131	94	96 / 53	71	17
01:12	131	94	97 / 53	71	18
01:10	131	94	97 / 54	72	17
01:08	131	94	96 / 54	72	18
01:06	131	93	96 / 54	72	18
01:04	131	93	99 / 55	72	18
01:02	132	93	97 / 55	72	20
01:00	131	94	98 / 55	74	18
00:58	132	93	98 / 56	74	19
00:56	131	93	97 / 55	72	19
00:54	131	93	100 / 56	74	19
00:52	131	93	98 / 55	73	20
00:50	131	93	97 / 56	73	20
00:48	131	93	97 / 55	73	19
00:46	130	93	98 / 56	73	20
00:44	130	93	98 / 57	74	21
00:42	129	93	100 / 59	76	17
00:40	131	94	83 / 54	68	[illegible]
00:38	131	94	90 / 56	72	16
00:36	140	95	89 / 56	71	39
00:34	131	95	85 / 53	67	16
00:32	132	95	84 / 52	66	16
00:30	131	93	86 / 51	67	21
00:28	131	93	94 / 53	70	18
00:26	131	93	94 / 53	70	14
00:24	131	94	94 / 53	70	20
00:22	131	93	96 / 54	71	30
00:20	132	93	95 / 54	71	22
00:18	132	93	94 / 53	69	25
00:16	133	93	94 / 53	70	20
00:14	132	92	97 / 54	72	20
00:12	132	92	93 / 52	69	14
00:10	132	91	94 / 53	70	28
00:08	132	92	96 / 54	72	19
00:06	132	92	94 / 54	71	28
00:04	135	92	90 / 52	67	15
00:02	135	91	108 / 70	84	36
00:00	132	91	113 / 74	90	21
23:58	132	94	96 / 54	71	16
23:56	132	94	96 / 54	71	17
23:54	132	94	98 / 55	72	18
23:52	133	94	98 / 55	72	17
23:50	132	94	98 / 56	73	19
23:48	132	94	97 / 55	72	16
23:46	132	94	96 / 54	71	16
23:44	132	94	98 / 55	72	22
23:42	133	94	99 / 56	73	16

b(6)-2

Ward/Section: MU 2

[redacted] PHYSICIAN: [redacted]

CHE[illegible]RY RESULT FORM
(Subject to the Privacy Act of 1974)

LAST, FIRST, MI: [redacted]

b(6)-2

DATE: 30 Jul 03 | TIME: 1220 | SSN/PSEUDO SSN: [redacted]

(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	RF RA
ALB		3.5-5.5
ALP		26-84 u
ALT		10-47 u
AMY		18-97 u
AST		11-38 u
TBIL		0.2-1.6
BUN		7-22 mg
CA^{++}		8.0-10.3
CHOL		100-200
CRE		0.6-1.2
GLU		73-118
TP		6.4-8.1

(Piccolo) Metlyte 8

TEST	RESULT	RI RAI
GLU		73-118
BUN		7-22 mg
CRE		0.6-1.2
CK		39-380 30-190
NA^+		128-145
K^+		3.3-4.7
CL^-		98-108
tCO_2		18-33 m

(Piccolo) Metabolic Panel

======= PICCOLO =======
30/07/03 12:24
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8 b(6)-2
DISC LOT #: 3151AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	119*	73-118	MG/DL
BUN	18	7-22	MG/DL
CRE	1.4*	0.6-1.2	MG/DL
CK	441*	39-380	U/L
NA+	135	128-145	MMOL
K+	3.8	3.3-4.7	MMOL
CL-	116*	98-108	MMOL
tCO2	15*	18-33	MMOL

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

REMARKS:

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

DATE: 30 Jul 03

LAB ID NO.:

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

LAST, FIRST, MI. [redacted]	DATE 30 Jul 03	TIME 1025	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	4.1	4.8-10.8 x 10^3
RBC		4.7-6.1 x 10^9
Hgb		14-18 g/dl (M) 12-16 g/dl (F)
Hct		42-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-500 x 10^3 verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted]	DATE: 30 Jul 03	LAB ID NO.:

b(6)-2

Ward/Section: ICU2	R[redacted]STING PHYSICIAN: [redacted]	CHEM[redacted]Y RESULT FORM (Subject to the Privacy Act of 1974)
LAST FIRST MI: [redacted]	DATE: 30Jul03 TIME: 0700	SSN/PSEUDO SSN: [redacted] b(6)-4

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	7.230	7.31-7.45
PCO2	40.3	35-45 mmHg (art) 41-51 mmHg (ven)
PO2	200	80-105 mmHg (art) N/A (ven)
TCO2	18	23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3	17	22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2	100	95-98%
BEecf	-4	(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

```
:::::::: PICCOLO ::::::::
30/07/03                05:57
REFERENCE RANGE:          MALE
PATIENT #: [redacted] b(6)-4
GENERAL CHEMISTRY 12
DISC LOT #:             3204AA4
OPER #: [redacted]      DR #: 000
SERIAL #: [redacted]
.........................
ALB    1.7*  3.3-5.5   G/DL
ALP    36    26-84     U/L
ALT    36    10-47     U/L
AMY    442*  14-97     U/L
AST    69*   11-38     U/L
TBIL   0.6   0.2-1.6   MG/DL
BUN    16    7-22      MG/DL
CA++   6.3*  8.0-10.3  MG/DL
CHOL   49*   100-200   MG/DL
CRE    1.0   0.6-1.2   MG/DL
GLU    112   73-118    MG/DL
TP     2.9*  6.4-8.1   G/DL

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

REMARKS: b(6)-2

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

`300

#[redacted] 30 july 03 OR#2

b(6)-4

DATE	TIME	SURVIVOR BLOOD SSN

(Hematology) CBC

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

Hematology) Manual Differential

s		Mono	
ds		Eos	
nph		Baso	
p		Imm	
C rph			

n natocrit		42-52% (M) 37-47% (F)
Rate		
er		

Congulation Studies

EST	RESULT	REF. RANGE
		9.8-13.6 secs
TT		21-34 secs
limer		<20 ng/ml
P		<10 ug/ml

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

MARKS:

PORTED BY:	DATE:	LAB ID NO.:

Last Copy

b(6)-4

[redacted]

b(6)-2

30 July, [redacted] b(6)-4

[redacted] CBC | Urinalysis | Misc Serology

RESULT | REF RANGE | TEST | RESULT | REF RANGE | TEST | RESULT | REF

Mono

Microbiology

Source

Manual Differential

Mono

Base

Base

Microscopic Urinalysis

CSF

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

[redacted] Stable | Blood Bank Cold Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

RESULT | REF RANGE | UNIT | TYPE | CROSSMATCH

PT 20.3

PTT 46.3

RKS:

TED BY:

[redacted]

30 July 03

b(6)-2

Ward/Section:	ESTING PHYSICIAN: [redacted] b(6)-2	CHEM RY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted] b(6)-4	DATE: 30Jul03 TIME: 0500	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		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] b(6)-2	30Jul03	

Ward/Section: OR	REQUESTING PHYSICIAN: [redacted] b(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. EPW # [redacted]	DATE 30 JUL 03 / TIME 0345	SSN/PSEUDO SSN:

(Hematology) CBC			b(6)-4 Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3	Color		N/A	RPR		Negative
RBC		4.7-6.1 x 10^9	App		N/A	Mono		Negative
Hgb		14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	**Microbiology**		
Hct		42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV		80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
Plt		130-500 x 10^3 verified	SG		N/A	Occ Bld		Negative
Lymph %		20.5-51.1%	Bld		Negative	H. pylori		Negative
(Hematology) Manual Differential			pH		N/A	Micro Parasites		
Segs		Mono	Prot		Negative	Malaria		
Bands		Eos	Urob		0.2-1.0	O & P		
Lymph		Baso	Nit		Negative	Other		
Atyp		Imm	Leuk		Negative	**Microscopic Urinalysis**		
RBC Morph			HCG		Negative			
Spun Hematocrit		42-52% (M) 37-47% (F)	**CSF**			**Blood Bank**		
Sed Rate			Cell Count			**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	28.9	9.8-13.6 secs			
APTT	61.0	21-34 secs			
D dimer		<20 ug/ml			
FDP		<10 ug/ml			

REMARKS:

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

b(6)-2

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

LAST, FIRS[redacted]	DATE 30JUL03	TIME 0116	SSN/PSEUDO SSN: [redacted]

b(6)-4

b(6)-5

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

Spun Hematocrit		42-52% (M) 37-47% (F)	**CSF**			**Blood Bank**	
Sed Rate			Cell Count			**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	18.5	9.8-13.6 secs			
APTT	33.4	21-34 secs			
D dimer		<20 ug/ml			
FDP		<10 ug/ml			

REMARKS:

REPORTED BY: [redacted]	**DATE:** 30JUL03	**LAB ID NO.:**

b(6)-4

b(6)-2

b(6)-4 EMT

b(6)-4

W[illegible]	[illegible]TING PHYSICIAN: [redacted]	CHEM[illegible]Y RESULT FORM (Subject to the Privacy Act of 1974)	
LA[illegible] [redacted]	DATE 30 JUL 03	TIME 0110	SSN/PSEUDO-SSN: [redacted]

[illegible]	[illegible]	[illegible]	(Piccolo) Chemistry 12			(Piccolo) Metabolic Panel		
T[illegible]	[illegible]	ULT	[illegible] RA[illegible]GE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
Na			[illegible]L	ALB		3.5-5.5 g/dl			
K			[illegible]	ALP		26-84 u/l			
Cl			[illegible]L	ALT		10-47 u/l			
pH			[illegible]	AMY		14-97 u/l			
PC			mm[illegible]	AST		11-38 u/l			
PC			mm[illegible]	TBIL		0.2-1.6 mg/dl			
TC			[illegible]	BUN		7-22 mg/dl			
HC			[illegible]	CA^{++}		8.0-10.3mg/dl			
sC				CHOL		100-200 mg/dl			
Bl				CRE		0.6-1.2 mg/dl			
Ar				GLU		73-118 mg/dl			
Ca			[illegible]ol/L	TP		6.4-8.1 g/dl			
Bl				(Piccolo) Metlyte 8					
G				TEST	RESULT	REF. RANGE			
C				GLU		73-118 mg/dl			
H				BUN		7-22 mg/dl			
H				CRE		0.6-1.2 mg/dl			
[illegible]	c. Che			CK		39-380 u/l (M) 30-190 u/l (F)			
[illegible]	[illegible]ULT		[illegible]E	NA^+		128-145 mmol/			
Tr				K^+		3.3-4.7 mmol/l			
D A				CL^-		98-108 mmol/l			
				tCO_2		18-33 mmol/l			
R									

```
======= PICCOLO =======
30/07/03                 01:26
REFERENCE RANGE:         MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #:              3151AA4
OPER #: [redacted]       DR #: 000
SERIAL #: [redacted]
.......................
GLU   356*  73-118   MG/DL
BUN    16   7-22     MG/DL
CRE   1.5*  0.6-1.2  MG/DL
CK    344   39-380   U/L
NA+   135   128-145  MMOL/L
K+    3.4   3.3-4.7  MMOL/L
CL-   106   98-108   MMOL/L
tCO2   11*  18-33    MMOL/L

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

R[illegible] BY: [redacted]	DATE: 30 JUL 03	LAB ID NO.:

b(6)-2

Ward/Section: OK	REQUESTING PHYSICIAN: [redacted] b(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. EPW # [redacted] b(6)-4	DATE 30Jul03 TIME 0500	SSN/PSEUDO SSN:

(Hematology) CBC

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

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

TEST	RESULT	REF. RANGE
PT	25.8	9.8-13.6 secs
APTT	63.8	21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Urinalysis

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

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

rce		
m n		
Bld		Negative
ylori		Negative
ro sites		
aria		
P		
r		

Microscopic Urinalysis

Blood Bank

ST SUBMIT SF 518 WITH
RY UNIT REQUESTED

/Rh

ossmatch
ERY UNIT OF BLOOD
))

	CROSSMATCH

```
======= PICCOLO =======
30/07/03              05:04
REFERENCE RANGE:        MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #:           3151AA4
OPER # [redacted]  DR #: 000
SERIAL #: [redacted]
.......................
GLU    154*  73-118   MG/DL
BUN     14   7-22     MG/DL
CRE    1.4*  0.6-1.2  MG/DL
CK     187   39-380    U/L
NA+    138   128-145  MMOL/L
K+     6.1*  3.3-4.7  MMOL/L
CL-    117*  98-108   MMOL/L
tCO2    13*  18-33    MMOL/L

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

REMARKS:

REPORTED BY: [redacted] b(6)-2	DATE: 30Jul03	LAB ID NO.:

b(6)-4

Ward/Section: OR	ORDERING PHYSICIAN: [redacted] b(6)-2	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted]	DATE C345 / TIME 30 Jul 03	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		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: b(6)-2

REPORTED BY: [redacted]	DATE: 30 Jul 03	LAB ID NO.:

b(6)-2

b(6)-4

Ward/Section: ICU 2

[redacted]IAN: [redacted]

CHE. RY RESULT FORM
(Subject to the Privacy Act of 1974)

LAST, FIRST, M: EDW [redacted]

DATE: 30/7

TIME: 2100

SSN/PSEUDO SSN:

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RAN
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT

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

30/07/03 21:06

REFERENCE RANGE: MALE

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

GENERAL CHEMISTRY 12

DISC LOT #: 3204AA4

OPER #: [redacted] DR #: 000

SERIAL #: [redacted]

ALB	♦♦♦	3.3-5.5	G/DL
ALP	30	26-84	U/L
ALT	31	10-47	U/L
AMY	779*	14-97	U/L
AST	70*	11-38	U/L
TBIL	2.1*	0.2-1.6	MG/DL
BUN	19	7-22	MG/DL
CA++	6.4*	8.0-10.3	MG/DL
CHOL	64*	100-200	MG/DL
CRE	1.5*	0.6-1.2	MG/DL
GLU	95	73-118	MG/DL
TP	♦♦♦	6.4-8.1	G/DL

INST QC: OK CHEM QC: OK

HEM 1+, LIP 0 , ICT 0

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

Met 12 / Liver Panel

REPORTED BY: [redacted]

DATE: 30Jul03

LAB ID NO.:

b(6)-2

b(6)-4

[redacted] 30/7/03 1700

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

(Hematology) Manual Differential			
Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

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

CSF		
Cell Count		
Directigen		Negative

Misc. Serology		
TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

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

Microscopic Urinalysis

Blood Bank	
MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED	
ABO/Rh	

Coagulation Studies		
TEST	RESULT	REF. RANGE
PT	19.6	9.8-13.6 secs
APTT	43.4	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: COAGS / CBC

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

b(6)-2

Ward/Section: ICU2	REQUESTING PHYSICIAN: [redacted] b(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI.	DATE	TIME	SSN/PSEUDO SSN:
# [redacted] b(6)-4	30 Jul 03	1220	# [redacted] b(6)-4

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3	Color		N/A	RPR		Negative
RBC		4.7-6.1 x 10^9	App		N/A	Mono		Negative
Hgb		14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	**Microbiology**		
Hct		42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV		80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
Plt		130-500 x 10^3 verified	SG		N/A	Occ Bld		Negative
Lymph %		20.5-51.1%	Bld		Negative	H. pylori		Negative
(Hematology) Manual Differential			pH		N/A	Micro Parasites		
Segs		Mono	Prot		Negative	Malaria		
Bands		Eos	Urob		0.2-1.0	O & P		
Lymph		Baso	Nit		Negative	Other		
Atyp		Imm	Leuk		Negative	**Microscopic Urinalysis**		
RBC Morph			HCG		Negative			
Spun Hematocrit		42-52% (M) 37-47% (F)	**CSF**			**Blood Bank**		
Sed Rate			Cell Count			**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	17.3	9.8-13.6 secs			
APTT	28.7	21-34 secs			
D dimer		<20 ug/ml			
FDP		<10 ug/ml			

REMARKS:

REPORTED BY: JP [redacted]	DATE: 30 Jul 03	LAB ID NO.:

b(6)-2

Ward/Section: ICU 2	REQUESTING PHYSICIAN: [redacted] b(6) - 2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI [redacted] b(6) - 4	DATE 30 Jul 03	TIME 1535	SSN/PSEUDO SSN:

(Hematology) CBC

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

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF. RANGE
PT	15.9	9.8-13.6 secs
APTT	29.9	21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

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

UNIT	TYPE	CROSSMATCH

REMARKS: b(6) - 2

REPORTED BY: [redacted]	DATE: 30 Jul 03	LAB ID NO.:

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

LAST, FIRST, MI. [redacted] b(6)-4 | DATE 30Jul03 | TIME 1535 | SSN/PSEUDO SSN:

(i-STAT)			(Piccolo) Chemistry 12			(Piccolo) Metabolic Panel		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF.	TEST	RESULT	REF. RANGE
Na		138-146 m						
K		3.5-4.9 m						
Cl		98-109 m						
pH		7.31-7.45						
PCO2		35-45 mm 41-51 mmH						
PO2		80-105 mm N/A (ven)						
TCO2		23-27 mm 24-29 mm						
HCO3		22-26 mm 23-28 mm						
sO2		95-98%						
BBecf		(-2) – (+2 mmol/L						
AnGap		10-20 m						
Ca		1.12-1.3						
BUN		8-26 mg						
GLU		70-105						
Creat		0.7-1.5						
Hct		38-51%						
Hgb		12-17 g						

Misc. Chemistry		
TEST	RESULT	REF.
Troponin-I		
Drug of Abuse		

======= PICCOLO =======
30/07/03 15:47
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
GENERAL CHEMISTRY 12
DISC LOT #: 3204AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

ALB	2.0*	3.3-5.5	G/DL
ALP	42	26-84	U/L
ALT	40	10-47	U/L
AMY	1151*	14-97	U/L
AST	89*	11-38	U/L
TBIL	3.0*	0.2-1.6	MG/DL
BUN	21	7-22	MG/DL
CA++	6.4*	8.0-10.3	MG/DL
CHOL	61*	100-200	MG/DL
CRE	1.2	0.6-1.2	MG/DL
GLU	118	73-118	MG/DL
TP	3.6*	6.4-8.1	G/DL

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

======= PICCOLO =======
30/07/03 15:49
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
ELECTROLYTE
DISC LOT #: 3135AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

NA+	144	128-145	MMOL/L
K+	4.4	3.3-4.7	MMOL/L
CL-	122*	98-108	MMOL/L
tCO2	13*	18-33	MMOL/L

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

REMARKS:

b(6)-2

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

ICU < b(6)-4 DI [redacted] b(6)-2
EPW [redacted] 1 Jul 03 0400

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*
WBC		4.8-10.8 x 10^3	Color		N/A	RPR		Negative
RBC		4.7-6.1 x 10^9	App		N/A	Mono		Negative
Hgb		14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	**Microbiology**		
Hct		42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV		80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
Plt		130-500 x 10^3 verified	SG		N/A	Occ Bld		Negative
Lymph %		20.5-51.1%	Bld		Negative	H. pylori		Negative
(Hematology) Manual Differential			pH		N/A	Micro Parasites		
Segs		Mono	Prot		Negative	Malaria		
Bands		Eos	Urob		0.2-1.0	O & P		
Lymph		Baso	Nit		Negative	Other		
Atyp		Imm	Leuk		Negative	**Microscopic Urinalysis**		
RBC Morph			HCG		Negative			
Spun Hematocrit		42-52% (M) 37-47% (F)	**CSF**			**Blood Bank**		
Sed Rate			Cell Count			**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	23.2	9.8-13.6 secs			
APTT	34.7	21-34 secs			
D dimer		<20 ug/ml			
FDP		<10 ug/ml			

REMARKS:

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

b(6)-2

ICU 2 Dr [redacted] b(6)-2
EPW [redacted] b(6)-4 31Jul03 0400

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

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

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

======= PICCOLO =======
31/07/03 04:14
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
GENERAL CHEMISTRY 12
DISC LOT #: 3204AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

ALB	1.2*	3.3-5.5	G/DL
ALP	29	26-84	U/L
ALT	47	10-47	U/L
AMY	1349*	14-97	U/L
AST	89*	11-38	U/L
TBIL	5.3*	0.2-1.6	MG/DL
BUN	28*	7-22	MG/DL
CA++	6.3*	8.0-10.3	MG/DL
CHOL	52*	100-200	MG/DL
CRE	1.5*	0.6-1.2	MG/DL
GLU	114	73-118	MG/DL
TP	2.6*	6.4-8.1	G/DL

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

(Piccolo) Metabolic Panel

======= PICCOLO =======
31/07/03 04:15
REFERENCE RANGE: MALE
PATIENT #: [redacted]
ELECTROLYTE b(6)-4
DISC LOT #: 3135AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

NA+	149*	128-145	MMOL
K+	3.6	3.3-4.7	MMOL
CL-	119*	98-108	MMOL
tCO2	17*	18-33	MMOL

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

REMARKS:

REPORTED BY: [redacted] b(6)-2 | DATE: 31Jul03 | LAB ID NO.:

Ward/Section: ICU #2

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

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

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

DATE: 31 July

TIME:

SSN/PSEUDO SSN: #1 [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) Methyte 8

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY	N/A	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:
From JP #1 Unable to Run, Machines only run whole blood, plasma and serum

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

DATE: 31 Jul/03

LAB ID NO.:

b(6)-2

Ward/Section: ICU 2

TESTING PHYSICIAN: Dr [redacted]

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

b(6)-4

LAST, FIRST, MI: SPW [redacted]

DATE: 31Jul03

TIME: 2000

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%
BExcf		(-2) (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

======= PICCOLO =======
31/07/03 20:12
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #: 3152AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	87	73-118	MG/DL
BUN	25*	7-22	MG/DL
CRE	2.1*	0.6-1.2	MG/DL
CK	2508*	39-380	U/L
NA+	144	128-145	MMOL/L
K+	4.3	3.3-4.7	MMOL/L
CL-	121*	98-108	MMOL/L
tCO2	20	18-33	MMOL/L

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

REMARKS:

REPORTED BY: [redacted]

DATE: 31Jul03

LAB ID NO.:

b(6)-2

i-STAT

SIMV R-20
PEEP 5
TV 600
FiO_2 60

Pt: [redacted]

Pt Name:_____

TCO2_____19 mmol/L

At 37C

PH_____7.278

PCO2_____38.8 mmHg

PO2_____56 mmHg

HCO3_____18 mmol/L

BEecf_____-9 mmol/L

sO2*_____85 %

*calculated

Sample Type_:

31JUL03 20:08

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAM5046A
CLEW A93

---

i-STAT

FiO_2 80%

Pt: [redacted]

Pt Name:_____

TCO2_____19 mmol/L

At 37C

PH_____7.279

PCO2_____38.4 mmHg

PO2_____73 mmHg

HCO3_____18 mmol/L

BEecf_____-9 mmol/L

sO2*_____93 %

*calculated

Sample Type_:

31JUL03 21:39

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAM5046A
CLEW A93

ID: [redacted]
WB

30-07-03
15:44

			Patient Limits	
WBC	5.1	x10^3/uL	4.5	10.5
RBC	3.76 L	x10^6/uL	4.00	6.00
Hgb	10.2 L	g/dL	11.0	18.0
Hct	33.5 L	%	35.0	60.0
MCV	89.2	fL	80.0	99.9
MCH	27.3	pg	27.0	31.0
MCHC	30.6 L	g/dL	33.0	37.0
Plt	77. *L	x10^3/uL	150.	450.
LY%	13.5 *L	%	20.5	51.1
LY#	0.7 *	x10^3/uL	1.2	3.4

ID: [redacted]
WB

30-07-03
12:25

			Patient Limits	
WBC	3.9 L	x10^3/uL	4.5	10.5
RBC	3.38 L	x10^6/uL	4.00	6.00
Hgb	9.5 L	g/dL	11.0	18.0
Hct	30.1 L	%	35.0	60.0
MCV	89.0	fL	80.0	99.9
MCH	28.2	pg	27.0	31.0
MCHC	31.6 L	g/dL	33.0	37.0
Plt	66. L	x10^3/uL	150.	450.
LY%	16.2 *L	%	20.5	51.1
LY#	0.6 *L	x10^3/uL	1.2	3.4

ID: [redacted]
WB

31-07-03
20:10

			Patient Limits	
WBC	3.8 L	x10^3/uL	4.5	10.5
RBC	3.72 L	x10^6/uL	4.00	6.00
Hgb	10.5 L	g/dL	11.0	18.0
Hct	32.9 L	%	35.0	60.0
MCV	88.6	fL	80.0	99.9
MCH	28.2	pg	27.0	31.0
MCHC	31.8 L	g/dL	33.0	37.0
Plt	72. L	x10^3/uL	150.	450.
LY%	12.4 *L	%	20.5	51.1
LY#	0.5 *L	x10^3/uL	1.2	3.4

ID: [redacted]
WB

31-07-03
04:15

			Patient Limits	
WBC	5.7	x10^3/uL	4.5	10.5
RBC	4.91	x10^6/uL	4.00	6.00
Hgb	14.0	g/dL	11.0	18.0
Hct	43.7	%	35.0	60.0
MCV	89.0	fL	80.0	99.9
MCH	28.4	pg	27.0	31.0
MCHC	31.9 L	g/dL	33.0	37.0
Plt	69. *L	x10^3/uL	150.	450.
LY%	11.4 *L	%	20.5	51.1
LY#	0.7 *L	x10^3/uL	1.2	3.4

ID: [redacted]
WB

30-07-03
21:08

			Patient Limits	
WBC	4.1 L	x10^3/uL	4.5	10.5
RBC	3.98 L	x10^6/uL	4.00	6.00
Hgb	11.3	g/dL	11.0	18.0
Hct	35.6	%	35.0	60.0
MCV	89.4	fL	80.0	99.9
MCH	28.3	pg	27.0	31.0
MCHC	31.7 L	g/dL	33.0	37.0
Plt	56. L	x10^3/uL	150.	450.
LY%	16.5 *L	%	20.5	51.1
LY#	0.7 *L	x10^3/uL	1.2	3.4

R14
Temp NaHCO3
40%

i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____19 mmol/L

At 37C

PH_____7.332

PCO2_____33.1 mmHg

PO2_____190 mmHg

HCO3_____18 mmol/L

BEecf_____-8 mmol/L

sO2*_____100 %

*calculated

Sample Type_:

30JUL03 10:56

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

ID: [redacted]
WB

31-07-03
12:13

			Patient Limits	
WBC	5.5	x10^3/uL	4.5	10.5
RBC	4.26	x10^6/uL	4.00	6.00
Hgb	12.0	g/dL	11.0	18.0
Hct	38.4	%	35.0	60.0
MCV	90.2	fL	80.0	99.9
MCH	28.2	pg	27.0	31.0
MCHC	31.3 L	g/dL	33.0	37.0
Plt	72. *L	x10^3/uL	150.	450.
LY%	9.8 *L	%	20.5	51.1
LY#	0.5 *L	x10^3/uL	1.2	3.4

P 1500cc
R12 800 TV 93%

i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____18 mmol/L

At 37C

PH_____7.203

PCO2_____43.3 mmHg

PO2_____130 mmHg

HCO3_____17 mmol/L

BEecf_____-11 mmol/L

sO2*_____98 %

*calculated

At Patient Temp

PH_____7.243

PCO2_____38.0 mmHg

PO2_____113 mmHg

Patient Temp: 93.2F

Sample Type_:

30JUL03 10:16

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

ID: [redacted]
WB

31-07-03
09:16

			Patient Limits	
WBC	5.7	x10^3/uL	4.5	10.5
RBC	4.34	x10^6/uL	4.00	6.00
Hgb	12.5	g/dL	11.0	18.0
Hct	38.6	%	35.0	60.0
MCV	88.8	fL	80.0	99.9
MCH	28.7	pg	27.0	31.0
MCHC	32.4 L	g/dL	33.0	37.0
Plt	65. L	x10^3/uL	150.	450.
LY%	10.5 *L	%	20.5	51.1
LY#	0.6 *L	x10^3/uL	1.2	3.4

---

i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____16 mmol/L

At 37C

PH_____7.207

PCO2_____38.1 mmHg

PO2_____117 mmHg

HCO3_____15 mmol/L

BEecf_____-13 mmol/L

sO2*_____98 %

*calculated

Sample Type_:

30JUL03 15:39

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

R14
TV 800
PS
40%

i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____17 mmol/L

At 37C

PH_____7.304

PCO2_____33.1 mmHg

PO2_____166 mmHg

HCO3_____16 mmol/L

BEecf_____-10 mmol/L

SO2*_____99 %

*calculated

Sample Type_:

30JUL03 12:18

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

i-STAT EC8+

Pt: [redacted]

Pt Name:_____

Glu_____61 mg/dL

BUN_____34 mg/dL

Na_____154 mmol/L

K_____3.8 mmol/L

Cl_____125 mmol/L

TCO2_____17 mmol/L

AnGap_____16 mmol/L

Hct_____30 %PCV

Hb*_____10 g/dL

*via Hct

PH_____7.317

PCO2_____32.3 mmHg

HCO3_____16 mmol/L

BEecf_____-10 mmol/L

Sample Type_:

01AUG03 08:23

SIMV RATE-20 FIO2-60% PEEP-5 TV-600ml

i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____19 mmol/L

At 37C

PH_____7.303

PCO2_____35.7 mmHg

PO2_____95 mmHg

HCO3_____18 mmol/L

BEecf_____-9 mmol/L

SO2*_____97 %

*calculated

Sample Type_:

31JUL03 12:04

Oper: [redacted] b(6)-2

Physician: [redacted]

Ser# [redacted]

Ver: JAMS046A
CLEW A93

SIMV RATE-20 FIO2@60% PEEP-5
TV-[illegible]

PH_____7.284

PCO2_____36.6 mmHg

PO2_____100 mmHg

HCO3_____17 mmol/L

BEecf_____-9 mmol/L

SO2*_____97 %

*calculated

Sample Type_:

31JUL03 09:15

Oper: [redacted]

Physician: [redacted]

Ser# [redacted] b(6)-2

Ver: JAMS046A
CLEW A93

i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____18 mmol/L

At 37C

PH_____7.372

PCO2_____36.0 mmHg

PO2_____91 mmHg

HCO3_____17 mmol/L

BEecf_____-10 mmol/L

SO2*_____96 %

*calculated

FIO2_____: 60

Sample Type_: ART

31JUL03 04:06

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

b(6)-2

Ward/Section: ICU2	REQUESTING PHYSICIAN: Dr [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI: 2Pvt [redacted] b(6)-4	DATE: 8/4/03	TIME: 2000	SSN/PSEUDO SSN:

(Hematology) CBC

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

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF. RANGE
PT	33.7 37.7 12	9.8-13.6 secs
APTT	43.8 45.9 12	21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

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

UNIT	TYPE	CROSSMATCH

REMARKS:

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

b(6)-2

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

[redacted] 31 July 03

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

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

REMARKS:

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

b(6)-2

b(6)-2

Ward/Section: ICU2	REQUESTING PHYSICIAN: Dr [redacted]	**LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. SPC [redacted]	DATE 2Aug03	TIME 2900	SSN/PSEUDO SSN:

(Hematology) CBC

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

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

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

b(6)-2 **Urinalysis**

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted]	DATE: 2Aug03	LAB ID NO.:

b(6)-2

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

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

DATE: 31/Aug03 TIME: 1100

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

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

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

```
======= PICCOLO =======
31/07/03            12:11
REFERENCE RANGE:        MALE
PATIENT #:  [redacted] b(6)-4
GENERAL CHEMISTRY 12
DISC LOT #:         3142AA4
OPER #: [redacted]  DR #: 000
SERIAL #: [redacted]
.......................
ALB   1.7*  3.3-5.5   G/DL
ALP   35    26-84     U/L
ALT   55*   10-47     U/L
AMY   1164* 14-97     U/L
AST   74*   11-38     U/L
TBIL  4.4*  0.2-1.6   MG/DL
BUN   27*   7-22      MG/DL
CA++  6.2*  8.0-10.3  MG/DL
CHOL  26*   100-200   MG/DL
CRE   2.0*  0.6-1.2   MG/DL
GLU   95    73-118    MG/DL
TP    3.0*  6.4-8.1   G/DL

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

(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
CO2		18-33 mmol/l

(Piccolo) Liver Panel Plus ERROR

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
CO2		18-33 mmol/l

REMARKS:

b(6)-2

REPORTED BY: [redacted]

DATE: 31/Aug03

LAB ID NO.:

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

LAST, FIRST, MI. # [redacted] b(6)-2	DATE 31 July	TIME 0910	SSN/PSEUDO SSN: # [redacted] b(6)-4

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3	Color		N/A	RPR		Negative
RBC		4.7-6.1 x 10^9	App		N/A	Mono		Negative
Hgb		14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	**Microbiology**		
Hct		42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV		80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
Plt		130-500 x 10^3 verified	SG		N/A	Occ Bld		Negative
Lymph %		20.5-51.1%	Bld		Negative	H. pylori		Negative
(Hematology) Manual Differential			pH		N/A	Micro Parasites		
Segs		Mono	Prot		Negative	Malaria		
Bands		Eos	Urob		0.2-1.0	O & P		
Lymph		Baso	Nit		Negative	Other		
Atyp		Imm	Leuk		Negative	**Microscopic Urinalysis**		
RBC Morph			HCG		Negative			
Spun Hematocrit		42-52% (M) 37-47% (F)	**CSF**			**Blood Bank**		
Sed Rate			Cell Count			**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: b(6)-2

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

ICU #2

b(6)-2

[redacted]

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

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

DATE: 31 July 03 | TIME: 1415 | SSN/PSEUDO SSN:

(i-STAT) | (Piccolo) Chemistry 12 | (Piccolo) Metabolic Panel

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

Misc. Chemistry

TEST	RESULT	REF. RAN
Troponin-I		
Drug of Abuse		

======= PICCOLO =======
31/07/03 14:24
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
GENERAL CHEMISTRY 12
DISC LOT #: 3142AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

ALB	1.7*	3.3-5.5	G/DL
ALP	33	26-84	U/L
ALT	61*	10-47	U/L
AMY	1131*	14-97	U/L
AST	78*	11-38	U/L
TBIL	4.3*	0.2-1.6	MG/DL
BUN	26*	7-22	MG/DL
CA++	6.6*	8.0-10.3	MG/DL
CHOL	41*	100-200	MG/DL
CRE	2.0*	0.6-1.2	MG/DL
GLU	95	73-118	MG/DL
TP	3.1*	6.4-8.1	G/DL

INST QC: OK CHEM QC: OK
HEM 2+, LIP 0 , ICT 1+

======= PICCOLO =======
31/07/03 14:26
REFERENCE RANGE: MALE
PATIENT #: 512
ELECTROLYTE
DISC LOT #: 3135AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

NA+	148*	128-145	MMOL/L
K+	4.7	3.3-4.7	MMOL/L
CL-	120*	98-108	MMOL/L
tCO2	15*	18-33	MMOL/L

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

REMARKS:

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

b(6)-2

i-STAT G3+ Simv 20 TV600 FiO2 80 Peep 5

Pt: [redacted]

Pt Name:_____

TCO2_____19 mmol/L

At 37C

pH_____7.182

PCO2_____46.7 mmHg

PO2_____89 mmHg

HCO3_____17 mmol/L

BEecf_____-11 mmol/L

sO2*_____94 %

*calculated

FIO2_____: 80

Sample Type_:

30JUL03 21:33

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

Lung Biopsy open

ID: [redacted]
WB

01-08-03
04:15

			Patient Limits	
WBC	4.3 L	x10^3/uL	4.5	10.5
RBC	3.71 L	x10^6/uL	4.00	6.00
Hgb	10.7 L	g/dL	11.0	16.0
Hct	33.2 L	%	35.0	60.0
MCV	89.5	fL	80.0	99.9
MCH	29.0	pg	27.0	31.0
MCHC	32.4 L	g/dL	33.0	37.0
Plt	69. L	x10^3/uL	150.	450.
LY%	10.8 *L	%	20.5	51.1
LY#	0.5 *L	x10^3/uL	1.2	3.4

At 37C

pH_____7.066

PCO2_____54.6 mmHg

PO2_____81 mmHg

HCO3_____16 mmol/L

BEecf_____-15 mmol/L

sO2*_____90 %

*calculated

At Patient Temp

pH_____7.096

PCO2_____49.2 mmHg

PO2_____69 mmHg

Patient Temp: 94.3F

FIO2_____: 80

Sample Type_: ART

30JUL03 21:03

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

Lung Biopsy open

---

i-STAT 6+

Pt: [redacted]

Pt Name:_____

Glu_____72 mg/dL

BUN_____32 mg/dL

Na_____153 mmol/L

K_____3.6 mmol/L

Cl_____126 mmol/L

Hct_____27 %PCV

Hb*_____9 g/dL

*via Hct

Sample Type_:

01AUG03 15:19

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

---

i-STAT G3+ Simv R-22 TV600 FiO2 80 Peep 5

Pt: [redacted]

Pt Name:_____

TCO2_____18 mmol/L

At 37C

pH_____7.304

PCO2_____33.5 mmHg

PO2_____105 mmHg

HCO3_____17 mmol/L

BEecf_____-10 mmol/L

sO2*_____97 %

*calculated

Sample Type_:

30JUL03 22:34

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____21 mmol/L

At 37C

PH_____7.257

PCO2_____43.4 mmHg

PO2_____55 mmHg

HCO3_____19 mmol/L

BEecf_____-[illegible] mmol/L

sO2*_____83 %

*calculated

FIO2_____: 40

Sample Type_:

01AUG03 17:35

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____21 mmol/L

At 37C

PH_____7.236

PCO2_____45.8 mmHg

PO2_____60 mmHg

HCO3_____19 mmol/L

BEecf_____-8 mmol/L

sO2*_____86 %

*calculated

FIO2_____: 50

Sample Type_: ART

01AUG03 18:27

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

i-STAT EC8+

Pt: [redacted]

Pt Name:_____

Glu_____77 mg/dL

BUN_____35 mg/dL

Na_____156 mmol/L

K_____3.8 mmol/L

Cl_____127 mmol/L

TCO2_____18 mmol/L

AnGap_____16 mmol/L

Hct_____27 %PCV

Hb*_____9 g/dL

*via Hct

PH_____7.325

PCO2_____33.2 mmHg

HCO3_____17 mmol/L

BEecf_____-9 mmol/L

Sample Type_:

01AUG03 17:41

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____21 mmol/L

At 37C

pH_____7.282

PCO2_____41.1 mmHg

PO2_____64 mmHg

HCO3_____19 mmol/L

BEecf_____-7 mmol/L

sO2*_____89 %

*calculated

FIO2_____: 40

Sample Type_:

01AUG03 17:34

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAM5046A
CLEW A93

---

i-STAT G3+

Pt: [redacted] FiO2 60%

Pt Name:_____ peep 12

TCO2_____20 mmol/L

At 37C

pH_____7.324

PCO2_____36.8 mmHg

PO2_____126 mmHg

HCO3_____19 mmol/L

BEecf_____-7 mmol/L

sO2*_____99 %

*calculated

Sample Type_:

01AUG03 04:13

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAM5046A
CLEW A93

---

i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____18 mmol/L

At 37C

pH_____7.310

PCO2_____34.5 mmHg

PO2_____98 mmHg

HCO3_____17 mmol/L

BEecf_____-9 mmol/L

sO2*_____97 %

*calculated

FIO2_____: 40

Sample Type_: ART

01AUG03 15:01

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAM5046A
CLEW A93

Ward/Section: Fcu 2	RE[redacted]TING PHYSICIAN: [redacted] b(6)-2	CH[redacted]ISTRY RESULT FORM (Subject to the Privacy Act of 1974)		
LAST, FIRST, MI. Elw th[redacted] b(6)-4		DATE 1 Aug	TIME 0800	SSN/PSEUDO SSN: #[redacted] b(6)-4

(I-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

======= PICCOLO =======
01/08/03 08:07
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #: 3152AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	69*	73-118	MG/DL
BUN	♦♦♦	7-22	MG/DL
CRE	2.5*	0.6-1.2	MG/DL
CK	1735*	39-380	U/L
~~NA+~~	~~123*~~	~~128-145~~	~~MMOL~~
K+	4.3	3.3-4.7	MMOL
CL-	120*	98-108	MMOL
tCO2	23	18-33	MMOL

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS: b(4)-2

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

b(6)-2

Ward/Section: IW 2

REQUESTING PHYSICIAN: Dr. [redacted]

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

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

DATE: 01 Aug 03 TIME: 1730

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

PICCOLO
01/08/03 17:38
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8 b(6)-4
DISC LOT #: 3152AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	83	73-118	MG/DL
BUN	♦♦♦	7-22	MG/DL
CRE	2.6*	0.6-1.2	MG/DL
CK	1279*	39-380	U/L
NA+	131	128-145	MMOL/L
K+	4.4	3.3-4.7	MMOL/L
CL-	124*	98-108	MMOL/L
tCO2	♦♦♦	18-33	MMOL/L

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:
ABG b(6)-2

REPORTED BY: [redacted]

DATE: 1 Aug 03

LAB ID NO.:

b(6)-2

Ward/Section: ICU2	REQUESTING PHYSICIAN: Dr [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. b(6)-2 [redacted]	DATE 1Aug03 TIME 0400	SSN/PSEUDO SSN:

(Hematology) CBC

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

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF. RANGE
PT	22.2	9.8-13.6 secs
APTT	40.4	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: b(6)-2

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

b(6)-2

Ward/Section: ICU2	RE[illegible]STING PHYSICIAN: Dr [redacted]	CH[illegible]STRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. b(6)-2 EPW [redacted]	DATE 1 Aug 03	TIME 0400	SSN/PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-14[illegible]
K		3.5-4.9
Cl		98-109
pH		7.31-7.4
PCO2		35-45 m 41-51 mm
PO2		80-105 m N/A (ven
TCO2		23-27 mm 24-29 mm
HCO3		22-26 mm 23-28 mm
sO2		95-98%
BEecf		(-2) – (+3 mmol/L
AnGap		10-20 mm
Ca		1.12-1.32
BUN		8-26 mg/d
GLU		70-105 mg
Creat		0.7-1.5 mg
Hct		38-51% P(
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RA[illegible]
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
		.5 g/dl
		u/l
		u/l
		u/l
		u/l
		mg/dl
		g/dl
		3mg/dl
		mg/dl
		mg/dl
		mg/dl
		g/dl
		F.
		GE
		ng/dl
		dl
		g/dl
		l (M) l (F)
		mmol/l
		mol/l
		mol/l
		ol/l

======= PICCOLO =======
01/08/03 04:17
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-2
GENERAL CHEMISTRY 12
DISC LOT #: 3142AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

ALB	1.3*	3.3-5.5	G/DL
ALP	43	26-84	U/L
ALT	42	10-47	U/L
AMY	1200*	14-97	U/L
AST	89*	11-38	U/L
TBIL	2.3*	0.2-1.6	MG/DL
BUN	27*	7-22	MG/DL
CA++	6.8*	8.0-10.3	MG/DL
CHOL	70*	100-200	MG/DL
CRE	2.0*	0.6-1.2	MG/DL
GLU	73	73-118	MG/DL
TP	3.2*	6.4-8.1	G/DL

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY: b(6)-2 [redacted]	DATE: 01 Aug 03	LAB ID NO.:

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

LAST, FIRST, MI.	DATE	TIME	SSN/PSEUDO SSN:
EPW # [redacted] b(6)-4	1 Aug 03	1917	# [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

```
======= PICCOLO =======
01/08/03          15:01
REFERENCE RANGE:     MALE
PATIENT #: [redacted]
METLYTE 8  b(6)-4
DISC LOT #:       3152AA4
OPER #: [redacted]  DR #: 000
SERIAL #: [redacted]
.........................
GLU    77     73-118    MG/DL
BUN    ♦♦♦    7-22      MG/DL
CRE    2.5*   0.6-1.2   MG/DL
CK     1316*  39-380    U/L
~~NA+  124*   128-145   MMOL/L~~
~~K+   3.8    3.3-4.7   MMOL/L~~
~~CL-  124*   98-108    MMOL/L~~
tCO2   ♦♦♦    18-33     MMOL/L

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

ABG. SIMV 20 TV 600 FiO2 40% Peep 12

REPORTED BY:	DATE:	LAB ID NO.:
[redacted] b(6)-2	1 Aug 03	

b(6)-2

Ward/Section: ICU 2	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: #[redacted] b(6)-4	DATE: 1 Aug	TIME: 1950	SSN/PSEUDO SSN: #[redacted] b(6)-4

(Hematology) CBC

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

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS: b(6)-2

REPORTED BY: [redacted]	DATE: 1 Aug 61	LAB ID NO.:

i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____19 mmol/L

At 37C

pH_____7.344

PCO2_____32.3 mmHg

PO2_____97 mmHg

HCO3_____18 mmol/L

BEecf_____-8 mmol/L

sO2*_____97 %

*calculated

FIO2_____: 70

Sample Type_: ART

02AUG03 12:48

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

ID: [redacted]
WB

02-08-03
19:04

			Patient Limits	
WBC	1.6 L	x10^3/uL	4.5	10.5
RBC	2.95 L	x10^6/uL	4.00	6.00
Hgb	8.1 L	g/dL	11.0	18.0
Hct	26.5 L	%	35.0	60.0
MCV	89.8	fL	80.0	99.9
MCH	27.3	pg	27.0	31.0
MCHC	30.4 L	g/dL	33.0	37.0
Plt	58. L	x10^3/uL	150.	450.
LY%	20.4 *L	%	20.5	51.1
LY#	0.3 *L	x10^3/uL	1.2	3.4

Pt: [redacted]

Pt Name:_____

TCO2_____21 mmol/L

At 37C

pH_____7.346

PCO2_____35.7 mmHg

PO2_____75 mmHg

HCO3_____20 mmol/L

BEecf_____-6 mmol/L

sO2*_____94 %

*calculated

Sample Type_:

02AUG03 15:17

Oper: [redacted]

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i-STAT G3+ SIMV 20
TV 670
FiO2 70%

Pt: [redacted]

Pt Name:_____

TCO2_____19 mmol/L

At 37C

pH_____7.334

PCO2_____34.2 mmHg

PO2_____67 mmHg

HCO3_____18 mmol/L

BEecf_____-8 mmol/L

sO2*_____92 %

*calculated

Sample Type_:

02AUG03 19:02

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

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i-STAT 6+

Pt: [redacted]

Pt Name:_____

Glu_____94 mg/dL

BUN_____39 mg/dL

Na_____156 mmol/L

K_____3.5 mmol/L

Cl_____129 mmol/L

Hct_____21 %PCV

Hb*_____7 g/dL

*via Hct

Sample Type_:

02AUG03 15:33

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

ID: [redacted]
WB

01-08-03
15:02

			Patient Limits	
WBC	3.7 L	x10^3/uL	4.5	10.5
RBC	3.77 L	x10^6/uL	4.00	6.00
Hgb	10.4 L	g/dL	11.0	18.0
Hct	33.7 L	%	35.0	60.0
MCV	89.3	fL	80.0	99.9
MCH	27.5	pg	27.0	31.0
MCHC	30.8 L	g/dL	33.0	37.0
Plt	81. L	x10^3/uL	150.	450.
LY%	11.2 *L	%	20.5	51.1
LY#	0.4 *L	x10^3/uL	1.2	3.4

i-STAT EG7+

Pt: [redacted]

Pt Name:_____ (calculated values)

Na_____158 mmol/L
K_____3.7 mmol/L
TCO2_____19 mmol/L
iCa_____1.08 mmol/L
Hct_____23 %PCV
Hb*_____8 g/dL
*via Hct

At 37C
PH_____7.201
PCO2_____45.4 mmHg
PO2_____161 mmHg
HCO3_____18 mmol/L
BEecf_____-10 mmol/L
sO2*_____99 %
*calculated

FIO2_____: 90
Sample Type_: ART

02AUG03 09:50

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

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i-STAT EC8+

Pt: [redacted]

Pt Name:_____

Glu_____49 mg/dL
BUN_____40 mg/dL
Na_____158 mmol/L
K_____3.6 mmol/L
Cl_____129 mmol/L
TCO2_____18 mmol/L
AnGap_____15 mmol/L
Hct_____24 %PCV
Hb*_____8 g/dL
*via Hct
PH_____7.196
PCO2_____44.1 mmHg
HCO3_____17 mmol/L
BEecf_____-11 mmol/L

Sample Type_:

02AUG03 09:46

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

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i-STAT EC8+

Pt: [redacted]

Pt Name:_____

Glu_____86 mg/dL
BUN_____39 mg/dL
Na_____157 mmol/L
K_____3.5 mmol/L
Cl_____129 mmol/L
TCO2_____17 mmol/L
AnGap_____16 mmol/L
Hct_____23 %PCV
Hb*_____8 g/dL
*via Hct
PH_____7.347
PCO2_____29.1 mmHg
HCO3_____16 mmol/L
BEecf_____-10 mmol/L

Sample Type_:

02AUG03 12:47

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

ID: [redacted]
WB

02-08-03
21:38

			Patient Limits	
WBC	2.7 L	x10^3/uL	4.5	10.5
RBC	3.40 L	x10^6/uL	4.00	6.00
Hgb	9.5 L	g/dL	11.0	18.0
Hct	30.5 L	%	35.0	60.0
MCV	89.6	fL	80.0	99.9
MCH	28.0	pg	27.0	31.0
MCHC	31.3 L	g/dL	33.0	37.0
Plt	46. L	x10^3/uL	150.	450.
LY%	20.5 *L	%	20.5	51.1
LY#	0.6 *L	x10^3/uL	1.2	3.4

ID: [redacted]
WB

02-08-03
15:19

			Patient Limits	
WBC	3.3 L	x10^3/uL	4.5	10.5
RBC	3.37 L	x10^6/uL	4.00	6.00
Hgb	8.9 L	g/dL	11.0	18.0
Hct	30.4 L	%	35.0	60.0
MCV	90.1	fL	80.0	99.9
MCH	26.3 L	pg	27.0	31.0
MCHC	29.2 L	g/dL	33.0	37.0
Plt	72. L	x10^3/uL	150.	450.
LY%	11.8 *L	%	20.5	51.1
LY#	0.4 *L	x10^3/uL	1.2	3.4

i-STAT EC8+

Pt: [redacted]

Pt Name:_____

Glu_____62 mg/dL

BUN_____37 mg/dL

Na_____156 mmol/L

K_____3.7 mmol/L

Cl_____129 mmol/L

TCO2_____16 mmol/L

AnGap_____16 mmol/L

Hct_____25 %PCV

Hb*_____9 g/dL

*via Hct

pH_____7.349

PCO2_____27.6 mmHg

HCO3_____15 mmol/L

BEecf_____-10 mmol/L

Sample Type_:

02AUG03 04:10

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

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i-STAT EC8+

Pt: [redacted]

Pt Name:_____

Glu_____98 mg/dL

BUN_____41 mg/dL

Na_____157 mmol/L

K_____3.7 mmol/L

Cl_____129 mmol/L

TCO2_____19 mmol/L

AnGap_____15 mmol/L

Hct_____25 %PCV

Hb*_____9 g/dL

*via Hct

pH_____7.204

PCO2_____44.3 mmHg

HCO3_____17 mmol/L

BEecf_____-11 mmol/L

Sample Type_:

02AUG03 11:25

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

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i-STAT EG7+

Pt: [redacted]

Pt Name:_____

Na_____158 mmol/L

K_____3.8 mmol/L

TCO2_____20 mmol/L

iCa_____1.09 mmol/L

Hct_____21 %PCV

Hb*_____7 g/dL

*via Hct

At 37C

pH_____7.210

PCO2_____46.1 mmHg

PO2_____107 mmHg

HCO3_____18 mmol/L

BEecf_____-9 mmol/L

sO2*_____97 %

*calculated

At Patient Temp

pH_____7.188

PCO2_____49.5 mmHg

PO2_____118 mmHg

Patient Temp: 101.6F

FIO2_____: 70

Sample Type_: ART

02AUG03 11:26

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

RR 20 TV 600
FIO2 100%

i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____18 mmol/L

At 37C

PH_____7.343

PCO2_____30.5 mmHg

PO2_____65 mmHg

HCO3_____17 mmol/L

BEecf_____-9 mmol/L

sO2*_____92 %

*calculated

Sample Type_:

[redacted]

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

ID: [redacted]
WB

02-08-03
04:11

			Patient Limits	
WBC	2.6 L	x10^3/uL	4.5	10.5
RBC	3.30 L	x10^6/uL	4.00	6.00
Hgb	9.4 L	g/dL	11.0	18.0
Hct	29.6 L	%	35.0	60.0
MCV	89.7	fL	80.0	99.9
MCH	28.5	pg	27.0	31.0
MCHC	31.7 L	g/dL	33.0	37.0
Plt	80. L	x10^3/uL	150.	450.
LY%	15.7 *L	%	20.5	51.1
LY#	0.4 *L	x10^3/uL	1.2	3.4

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i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____20 mmol/L

At 37C

PH_____7.211

PCO2_____47.1 mmHg

PO2_____68 mmHg

HCO3_____19 mmol/L

BEecf_____-9 mmol/L

sO2*_____89 %

*calculated

At Patient Temp

PH_____7.191

PCO2_____50.2 mmHg

PO2_____75 mmHg

Patient Temp: 101.2F

FIO2_____: 70

Sample Type_: ART

[redacted]

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

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i-STAT EC8+

Pt: [redacted]

Pt Name:_____

Glu_____65 mg/dL

BUN_____40 mg/dL

Na_____156 mmol/L

K_____3.8 mmol/L

Cl_____128 mmol/L

TCO2_____19 mmol/L

AnGap_____15 mmol/L

Hct_____28 %PCV

Hb*_____10 g/dL

*via Hct

PH_____7.210

PCO2_____43.8 mmHg

HCO3_____18 mmol/L

BEecf_____-10 mmol/L

Sample Type_:

[redacted]

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93