Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo ____ Yr 2003
Order Date	Clerk Nurse (b)(6)-2 all	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
17	[redacted]	Admit ICW#1, surgery, stable				
17	[redacted]	CBC, Chem 8 this PM	17 AUG	1800		
17	[redacted]	Pt to OR today for toe Amputation				
17	[redacted]	Resume preop orders/meds				
17	[redacted]	D/C Foley	17 Aug		[redacted]	[redacted] (b)(6)-2
18	[redacted]	D/C to EPW camp tomorrow	18 Aug			
18	[redacted]	Rx on chart	18 Aug			
18	[redacted]	Δ dressings + remove packing prior to d/c	18 Aug			
18	[redacted]	Transfer to ICW #2				

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

USAPA V1.00

CLINICAL RECORD

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

Mo. 8 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 16	17	18	19
17	(b)(6)-2 [redacted]	NS@125cc/hr	5	X [redacted]			
			17	[redacted]			HL'd 18Aug03
	(b)(6)-2						
17	[redacted]	Ancef 1gm IVPB	06	[redacted]			
		@ 8° @ 1gm	14	[redacted]			
			22	[redacted]			D/C [redacted] (b)(6)-2
17	[redacted] (b)(6)-2	HL	05	[redacted]			19Aug03
			13				
			21				
				(b)(6)-2			

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS: shrapnel wounds / partial tre amp

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 _____ Yr _____
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
	-----	Resume preop orders/meds				

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED												
17	[redacted] (b)(6)-2	MSO4 2mg Q10 IV PRN PAIN	D/T	17Aug 0437	17Aug 0730	17Aug 0930	17Aug 1912	18Aug 0230	18Aug 2550	18Aug 0440					
-----	-----		D/I	2	2mg	2mg	2	2mg	2mg	2mg					
17	[redacted] (b)(6)-2	Phenergan 25mg IV Q10 PRN nausea	D/T	[redacted]							(b)(6)-2			all	
-----	-----		D/I												
18-	[redacted] (b)(6)-2	Tylenol 650mg PO q4-6° prn-pain	18Aug 1430 0521-5 PO BCK												
-----	-----														
18-	[redacted] (b)(6)-2	Percocet 1-2 tabs PO q4-6 prn severe pain	2 tabs 17Aug 0940 PO												
-----	-----		17Aug [redacted] (b)(6)-2	[redacted] (b)(6)-2											

USAPA V1.00

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 17 AUG 03
Time In: 1055
Allergies: NKDA
Pre-op V/S: 03/95/104
Procedures: (L) inc, repair facial AC

Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 15-1000 Colloid —
OR Output: UOP 1000 EBL Min
Meds/Times:

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds History

Time	1055	1100	1105
SaO2	94	94	95
FiO2			
Methods	RA	RA	RA
240			
220			
200			
180			
160			
140			
120			
100			
80			
60			
40			
20			
RR	18	15	20
T	98	98	

Time									
Pain (0-10)									
LOS									

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

(Continue on reverse)

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

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

Codes

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

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

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

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

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

DEPARTMENT/SERVICE/CLINIC:

DATE: 17 Aug 2003

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

[redacted]

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

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

MEDICATIONS

Allergies:

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

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm							
15'							
30'							
45'							
60'							
90'							
D/C							

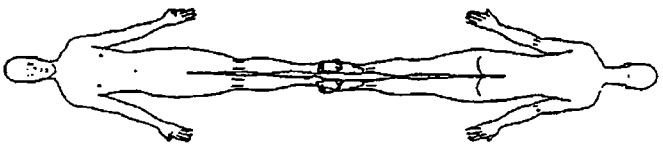
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm			
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

NURSING NOTES

1105
pt arrived from OR via litter sleepy but arousable O2 clear to auscultation bowel sounds pm + foley to gravity drain clear yellow urine able to move all extremities adequately respond to commands multiple wounds on L hip + on lateral aspect of face pulse adequate per palpation in bilateral toes, edema present on bilateral feet pm toes to ankles, ecchymosis present on R thigh sutured lacerations to face open to air, serous sanguinous drainage in wound, moist with [redacted] (b)(6)-2 on drainage on bilateral feet @ toes, foley, 18 gauge peripheral IV in L arm infusing NS [redacted] (b)(6)-2

Discharge Criteria:
Date: 17 May 08 **Time:** 1134 **PARS:** 12
BP: 130/59 **T:** 98 **HR:** 108 **RR:** 14 **Sa02:**
Pain Level at D/C (0-10):
Intake: 150 **Output:**
Additional Data:
Transferred To: ICW-1
Report Given To: LT [redacted] (b)(6)-2
Transferred Via: W/C ( ) Litter ( ) Gurney Ambulance
Transferred By: [redacted] (b)(6)-2
Cleared IAW Recovery Room SOP 133
Charge Nurse Signature: [redacted] (b)(6)-2

WAMC OP 173-E

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 D 1	I 8		UNK - EPW.	EPW	M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
U N K	2 4 Y	X	9	MUSLIM

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
—	U	0130	— (b)(6)-4

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

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
Ø	ICW1	UNK

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
[redacted] (b)(2)-2	UNK	UNK.

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
Ø 5		0 3 0 8 1 8

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
		0 3 0 8 1 7

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

FOR LOCAL USE

DX - Shrapnel Wounds / partial Toe Amputation.

DX	PROC	T INS
8910	8411	1449
8930	8659	
8411		
E993		

ADMITTING OFFICER (Signature, as re[redacted]

SI[redacted]

DA FORM 2095, MAR [redacted]

(b)(6)-2

(b)(6)-2

PATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER [redacted] (b)(6)-4	2. NAME (Last, First, MI) EPW # [redacted] (b)(6)-4				3. GRADE EPW	ADMISSION REMARKS
4. SEX M	5. AGE UNK	6. RACE UNK	7. RELIGION UNK	8. LENGTH OF SVC —	9. ETS —	10. PREVIOUS ADMISSION N
11. FMP 99	12. SSN [redacted] (b)(6)-4		13. ORGANIZATION —			14. WARD ICU2
15. FLYING STATUS —	16. RATING/ DSG —	17. DEPT/ BEN K78	18. BRANCH/CORPS —	19. UIC/ZIP —		20. TYPE CASE WIA
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: direct from ER			22. HOURS OF ADMISSION 0130	23. CLINIC SERVICE AEAA		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: UNK			25. TYPE DISPOSITION 50	26. DATE OF DISPOSITION 17 Aug 03		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): UNK			27b. TELEPHONE NO. UNK	28. DATE OF THIS ADMISSION 17 Aug 03		ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] (b)(2)-2				30. DATE OF INITIAL ADMISSION		32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Shrapnel (R) thigh, (R) Knee

890.0
891.0
879.2
875.0
E991.9

DX
8900
8910
E 9919 I T
599 9

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
Ø	Ø	Ø	Ø	1	1

36. Total Days All Facilites

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

SIGNATURE OF [redacted] AL OFFICER (b)(6)-2 (b)(6)-2 [redacted] NA[redacted] AL RECORD[redacted] (b)(6)-2

A FORM 3647, MAY 79 EDITION OF 1 [redacted] USAPPC V1.10

MEDCOM - 17447

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

EPW ♂ hit by Motor Rd.

PastHx: unknown
SurgHx: unknown
meds: Ø
Allergies: NKDA

PHYSICAL EXAMINATION

HEENT: WNL
Chest: CTA
CVR: S/S
Ext: 2 - 1.0 cm holes lateral aspect thigh, 1/2 cm medial thigh, 1 cm lateral knee effusion, 2+ DP/PT
Abd: soft NT

UR Ø fx: (R) leg, (R) ankle

PROGRESS (Enter date of discharge and final diagnosis)

(A) Soft tissue wound
(P) Local wound care, bath, oral Abx, f/c

SIGNA[redacted]	DATE 8/17/03	IDENTIFICATION NO.	ORGANIZATION

PATIENT'S IDENTIFICATION (For typed or written entries give Name last, first, middle; grade; date; hospital or medical facility)
(b)(6)-2

REGISTER NO.	WARD NO.

ABBREVIATED MEDICAL RECORD
Standard Form 539

GENERAL SERVICES ADMINISTRATION AND INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
539-108

[redacted]
(b)(6)-4

AUTHORIZED FOR LOCAL REPRODUCTION

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

17 Aug

D/C Summary

- EFW s/p multiple fragment (R) leg chest / ABD

Overnight no issues.

Small wounds chest ABD ~~5~~ pain.

(R) leg 2x2 cm tissue defect. No bleeding this Am.

(A) tissue frag wounds.

(P) keep clean D/C to EFW Camp Aby Keflex / pain control.

[redacted] / [redacted]

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

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

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

[redacted]

(b)(6)-4

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

USAPA V2.00

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17AUG03 0334	Pt arrived from EMT via litter @ 0230. VSS, temp 99.1°. A+O X3. lung sound clear bilaterally apex to base. RR equal + unlabored c̄ no use of accessory muscles noted. 96% RA. Radial + Pedal pulses strong + equal to palpation bilaterally. HR 95, RRR. Cap Refill <3sec to all extremities. PERRLA. Mucous mumbranes moist. Pt to be on Reg diet for breakfast. BS active X4 Quadrants. Non-distended, non-tender to palpation. Ø void since admission. ØBM. Bath given. Dressing applied to larger 2dime sized wounds to ® hip + 5mm wound to ® upper knee. Pt has multiple small wounds to ® upper leg + ® chest + abdomen. Ø c/o pain except when bathing or with movement of ® leg. ROM to BUE + LLE complete. ROM to RLE complete, but weak d/t pain. Pt has IV to (L) ac c̄ LR @ 100cc/hr with no signs of redness or infiltration noted. BUE restrained d/t EPW status, Will continue to monitor for A's – SPC [redacted] (b)(6)-2
17 aug03 0800	Initial assessment. pt awake, oriented. unable to communicate due to language barrier. pt able to follow simple commands. pupils 2mm. - slow to react to light. Moves all extremities. Both wrist restrained c̄ Keep pt status EPW. Guard @ bedside. offered breakfast but refused. Skin warm and dry. No resp. distress noted. RR 12 per minute

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERV[redacted]INED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR (b)(6)-2 Cousin

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

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17 Aug 03 0800	Lungs: CTA bilaterally Ø wheeze or cough. Heart S1 S2 Ø murmurs. Ø peripheral edema. Capillary refill <2 sec. Good skin turgor. Good muscle strength. Peripheral pulses strong and equal. XY, @ 37. abd. flat. Non-tender. Ø N/V. active bowel sounds XX quad. Voids per urinal. (R) thigh drsg dry & intact (L) antecubital IV site grey infiltration or signs of infection. LR @ TKO. pt condition stable. — [redacted] MAJ AN
	(b)(6)-2
17 Aug 03	When asked whether he had any pain, pt pointed to (R) thigh. MSO4 3mg IVP given for pain. will assess for effectiveness of pain med. — [redacted] MAJ AN
	(b)(6)-2
	1730 P/C Smith.
	No issues 0/night. X-ray = Ø Fx.
	RTD [redacted]
	(b)(6)-2

STANDARD FORM 600 (REV. 6-97) BACK

*U.S. GPO: 2002 - 491-600/50618

NSN 7540-01-075-3786

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

PATIENT'S HOME ADDRESS OR DUTY STATION			ARRIVAL	
STREET ADDRESS			DATE *(Day, Month, Year)* 16 Aug 03	TIME 0001
CITY	STATE	ZIP CODE	TRANSPORTATION TO FACILITY Ambulance	

SEX	DUTY/LOCAL PHONE		MILITARY STATUS				THIRD PARTY INSURANCE		
M	AREA CODE	NUMBER	ITEM	YES	NO	N/A	ITEM	YES	NO
			PRP				ADDITIONAL INSURANCE		
AGE	HOME PHONE		FLYING STATUS				DD 2568 IN CHART		
	AREA CODE	NUMBER	MEDICAL HISTORY OBTAINED FROM				NAME OF INSURANCE COMPANY		

CURRENT MEDICATIONS	INJURY OR OCCUPATIONAL ILLNESS				EMERGENCY ROOM VISIT	
Ø	ITEM	YES	NO	WHEN *(Date)*	DATE LAST VISIT	24 HOUR RETURN ☐ YES ☐ NO
	IS THIS AN INJURY?			WHERE	TETANUS	
ALLERGIES	INJURY/SAFETY FORMS				DATE LAST SHOT	COMPLETED INTITIAL SERIES ☐ YES ☐ NO
NKDA	HOW					

CHIEF COMPLAINT Shrapnel (R) leg Chest

CATEGORY OF TREATMENT		VITAL SIGNS					
☐ EMERGENT	TIME	TIME	0001				
		BP	131/73				
☐ URGENT		PULSE	99				
	INITIALS	RESP	16				
☐ NON-URGENT		TEMP					
		WT					

LAB ORDERS						X-RAY ORDERS		
☒ CBC/DIFF	ABG ☒	PT/PTT	BHCG/URINE/BLOOD/QUANT		☒	CXR PA & LAT/PORTABLE		C-SPINE
URINE C&S	UA MSCC/CATH		☒ CHEM:			ACUTE ABDOMEN		LS SPINE
BLOOD C&S X						SINUS		HEAD CT
						ANKLE R/L		☐ R Knee
								☐ R Thigh

ORDERS

☒ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
001	Tetanus .5mg IM				
001	Ancef 1g				
002	Morphine 5mg				

DISPOSITION	DISPOSITION QUARTERS /OFF DUTY	PATIENT/DISCHARGE INSTRUCTIONS
☐ HOME ☐ FULL DUTY	☐ 24 HRS. ☐ 48 HRS. ☐ 78 HRS.	
MODIFIED DUTY UNTIL	RETURN TO DUTY	

CONDITION UPON RELEASE	ADMIT TO UNIT/SERVICE	REFERRED ▶	TO	WHEN
☐ IMPROVED ☐ UNCHANGED				
☐ DETERIORATED	TIME OF RELEASE	I have received and understand these instructions.		
		PATIENT'S SIGNATURE		

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

[redacted]

(b)(6)-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

NSN 7540-01-075-3786

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

TEST RESULTS

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

PROVIDER HISTORY/PHYSICAL

[illegible]

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP

[redacted] (b)(6)-2

DIAGNOSIS

Sh spinal wounds to thigh / knee

CODES

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

[redacted] (b)(6)-4

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY															
POST- DAY															
MONTH-YEAR AUG	DAY	17		18		19									
~~19~~ 2003	HOUR	30													
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		20													
RESPIRATION RECORD		96%													
BLOOD PRESSURE		130/92													
HEIGHT:	WEIGHT →														

(Centigrade Equivalents, for Reference only)

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

EPW # [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

Ward/Section: ICU 2	REQUESTING PHYSICIAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)

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

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (a 41-51 mmHg (ve
PO2		80-105 mmHg (a N/A (ven)
TCO2		23-27 mmol/L (a 24-29 mmol/L (v
HCO3		22-26 mmol/L (a 23-28 mmol/L (v
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol
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 =======
17/08/03 03:03
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: 3152AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	114	73-118	MG/DL
BUN	33*	7-22	MG/DL
CRE	1.9*	0.6-1.2	MG/DL
CK	833*	39-380	U/L
NA+	132	128-145	MMOL/L
K+	3.2*	3.3-4.7	MMOL/L
CL-	96*	98-108	MMOL/L
tCO2	23	18-33	MMOL/L

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^{++}		8.0-10.5 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]	17Aug03	

(b)(6)-2

(b)(6)-4

[redacted]

				Patient Limits	
WBC	16.1 H	x10^3/uL		4.5	10.5
RBC	4.82	x10^6/uL		4.00	6.00
HGB	14.5	g/dL		11.0	18.0
Hct	[illegible].1	%		35.0	60.0
MCV	[illegible]1.5	fL		80.0	99.9
MCH	29.7	pg		27.0	31.0
MCHC	32.5 L	g/dL		32.0	37.0
PLT	276.	x10^3/uL		150.	450.
LYM	9.9 H	%		20.5	51.1
LYM	1.6	x10^3/uL		1.2	3.4

(b)(6)-4

[redacted]

17-08-03
09:25

			Patient Limits	
WBC	[illegible] H	x10^3/uL	4.5	10.5
RBC	5.31	x10^6/uL	4.00	6.00
HGB	15.8	g/dL	11.0	18.0
Hct	45.7	%	35.0	60.0
MCV	91.2	fL	80.0	99.9
MCH	29.7	pg	27.0	31.0
MCHC	32.6 L	g/dL	32.0	37.0
PLT	316.	x10^3/uL	150.	450.
LYM	9.5 H	%	20.5	51.1
LYM	1.5	x10^3/uL	1.2	3.4

518-124

NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

- [x] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of _____ units)*
- [ ] CRYOPRECIPITATE *(Pool of _____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* _____

VOLUME REQUESTED *(If applicable)* _____ ML

REMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*

- [x] TYPE AND SCREEN
- [ ] CROSSMATCH

DATE REQUESTED 17 Jul 03

DATE AND HOUR REQUIRED on call

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)* [redacted] (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE GSW

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

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

DATE VERIFIED 17 Aug 03

TIME VERIFIED 0145

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.	TRANSFUSION NO. / PATIENT NO.	TEST INTERPRETATION: ANTIBODY SCREEN	TEST INTERPRETATION: CROSSMATCH	PREVIOUS RECORD CHECK: [ ] RECORD [ ] NO RECORD / SIGNATURE OF PERSON PERFORMING TEST
DONOR	RECIPIENT			
ABO	ABO			
Rh	Rh			

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED — DATE

REMARKS:

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*

AT *(Hour)* — ON *(Date)*

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER *(Signature)*

2nd VERIFIER *(Signature)*

PRE-TRANSFUSION

TEMP. — PULSE — BP

DATE OF TRANSFUSION — TIME STARTED

POST-TRANSFUSION DATA

AMOUNT GIVEN ML

TIME/DATE COMPLETED/INTERRUPTED

REACTION [ ] NONE [ ] SUSPECTED

TEMPERATURE — PULSE — BLOOD PRESSURE

If reaction is suspected—IMMEDIATELY:

1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION OF REACTION

[ ] URTICARIA [ ] CHILL [ ] FEVER [ ] PAIN

[ ] OTHER *(Specify)*

OTHER DIFFICULTIES *(Equipment, clots, etc.)*

[ ] NO [ ] YES *(Specify)*

SIGNATURE OF PERSON NOTING ABOVE

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle; grade; rank; rate; hospital or medical facility)

[redacted]

(b)(6)-4

SEX M

WARD [illegible]

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

Medical Record Copy

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

DATE OF ORDER: 17 Aug 03 TIME OF ORDER: 0130 HOURS

Admit to ~~General~~ Surgery ~~Orthopedics~~ ICU #2

Dx: Shrapnel (R) thigh / (R) knee

Condition: stable

Vitals: per Routine

Allergies: NKDA.

NURSING UNIT | ROOM NO. | BED NO.

Meds: 1 gm ANCEF IV Q6°

2-4 mg MSO4 IV Q4° PRN PAIN.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

650 mg Tylenol p.o. Q 4 PRN fever

Diet: NPO until reevaluated

Activity as tolerated

~~Meds~~

Plan: as per orthopedics

NURSING UNIT | ROOM NO. | BED NO.

Noted CPT Eo 0023 MAL

PATIENT IDENTIFICATION

DATE OF ORDER: 8/17/03 TIME OF ORDER: 0230 HOURS

- Bath Patient
- Clean wound (R) thigh & knee apply dry dressing
- Regular Diet

[redacted]

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

17 Aug

D/C EPW CMP

[redacted]

(b)(6)-4

[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.

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 08 Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 17	18	19	20
17AUG	[redacted]	Vitals per	06				
	(b)(6)-2	routine	18				
[redacted]							
17AUG	[redacted]	Activity as tolerated	18				
	(b)(6)-2		18				
17AUG03	[redacted]	Regular Diet	06				
	(b)(6)-2		12				
	------		18				

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
Shrapnel (R) thigh (R) Knee

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo August Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
17 AUG	[redacted]	Admit to Surgery ICU	17AUG03	NOW	0230	[redacted] (b)(6)-2
17 AUG	(b)(6)-2 [redacted]	Condition stable	17AUG03	NOW	0230	[redacted] (b)(6)-2
17 AUG	(b)(6)-2 [redacted]	Plan as per ortho pd	17AUG03			
	(b)(6)-2 -----	Bathe patient	17AUG03	NOW	0310	[redacted] (b)(6)-2
	-----	Clean wound (R) thigh + Knee, apply	17 AUG 03	NOW	0310	[redacted] (b)(6)-2
	-----	dry dressing				

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

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 06 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED													
				17													
17AUG	[redacted]	1 gm Ancef IV	06	0800													
	(b)(6)-2	q 6 0	12	[redacted]	(b)(6)-2												
	- - - - - -		18														
	- - - - - -		24														
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ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

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

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* TIME/DATE DISPENSED													
17Aug	[redacted]	2-4mg MSO4	17 aug 3mg [redacted]	(b)(6)-2												
- - - - -	(b)(6)-2	IV q 4° prn	0830 [redacted]	(b)(6)-2												
- - - - -	- - - - -	pain														
17Aug	[redacted]	650mg tylenol														
- - - - -	(b)(6)-2	po q 4° prn														
- - - - -	- - - - -	Fever														
- - - - -	- - - - -															
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USAPA V1.00

ADMISSION AND CODING INFORMATION

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

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

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
Z Z Z Z Z Z Z Z	Z Z Z	X	9	UNK

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
Z Z Z	—	~~9~~ 9 [redacted] (b)(6)-2	[redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS (b)(6)-4
—	Z	0130	—

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

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION YEAR	
		1		N NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
Ø	ICU 2	UNK

NAME AND ADDRESS OF MEDICAL TREATMENT FACILITY	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
[redacted] (b)(2)-2	UNK	UNK

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
~~5Ø~~ 05		Ø 3 Ø 8 1 7

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
A E A A		Ø 3 Ø 8 1 7

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

FOR LOCAL USE

Shrapnel (R) thigh, (R) knee

DX	INJURY	Trauma
8900	599	9
8910		
E9919		

(b)(6)-2 [redacted]

ADMITTING OFFICER (Signature, as required)	[redacted] CLERK
[redacted] (b)(6)-2	[redacted] (b)(6)-2

DA FORM 1058, MAR 80

INPATIENT TREATMENT RECORD COVER SHEET

For use of this form, see AR 40-400; the proponent agenc

(b)(6)-4

1. REGISTER NUMBER	2. NAME (Last, First, MI)	3. GRADE	ADMISSION REMARKS
[redacted]	EPW [redacted] (b)(6)-4	N/A	

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	unk	X	unk	N/A	N/A	No

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
9070	[redacted] (b)(6)-4	N/A	

15. FLYING STATUS	16. RATING/ OSG	17. BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
N/A		K78	N/A		N/A

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
Direct From EMT	2359	AA14

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
Unk	41 ~~50~~	16 Aug 03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
Unk	unk	16 Aug 03	

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

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Shrapnel to Head

Dx 8737
E9919

Trauma
9

Inj
599

Blood
N

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/CDOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
Ø	Ø	Ø	Ø	1	1

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/CDOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
Ø	Ø	Ø	Ø	1	1

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER
	For [redacted]

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 D 1	I Z	[redacted]	(b)(6)-4 EPW [redacted]		M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
	Z Z Z	X	9	Unk

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
	N/A	20	[redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
N/A	U	2359	N/A

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

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
2		Unk

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
[redacted] (b)(2)-2	Unk

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
Unk

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
41		0 3 0 8 1 6

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
A A D A		0 3 0 8 1 6

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

FOR LOCAL USE

Dx: Shrapnel to Head

ADMITTING OFFICER (Signature, as required)	SIGNATURE OF ADMITTING CLERK
[redacted] (b)(6)-2	(b)(6)-2 [redacted] (b)(6)-2 [redacted] SPC, 91G18

DA FORM 2085, MAR 80

INPATIENT TREATMENT RECORD COVER

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

1. REGISTER NUMBER [redacted] (b)(6)-4	2. NAME (Last, First, MI) EPW [redacted] (b)(6)-1			3. GRADE EPW	ADMISSION REMARKS
4. SEX M	5. AGE 44	6. RACE —	7. RELIGION —	8. LENGTH OF SVC —	9. ETS —
10. PREVIOUS ADMISSION NO					
11. FMP 99	12. SSN [redacted] (b)(6)-4	13. ORGANIZATION —		14. WARD ICW2	
15. FLYING STATUS —	16. [redacted] DSG —	BEN K-78	18. BRANCH/CORPS —	19. UIC/ZIP —	20. TYPE CASE NBI
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: Direct from ER			22. HOURS OF ADMISSION 0149	23. CLINIC SERVICE AEAA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE —			25. TYPE DISPOSITION 21	28. DATE OF DISPOSITION 23Aug03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) —			27b. TELEPHONE NO. —	26. DATE OF THIS ADMISSION 17Aug03	ADMITTING OFFICER Dr [redacted] (b)(6)-2
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] (b)(2)-2				30. DATE OF INITIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

MVA

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Dx: S/p neck exploration, RUE

874.8
884.1
882.0
823.90
E991.2

79.66
86.28
83.14
93.54

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	6	6

36. Total Days All Facilites

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

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

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

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

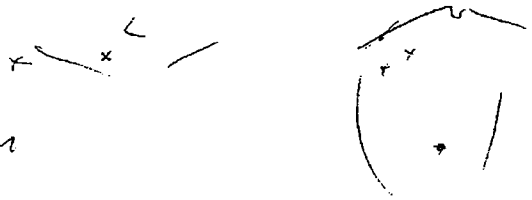
PERTINENT HISTORY, CHIEF COMPLAINT, AND CONDITION ON ADMISSION *(Enter date of admission)*

44 yo male Iraq, [illegible] motor vehicle accident. Alert
40 (R) [illegible] pain. Denies other pain.

[illegible]
[illegible]
[illegible]

PHYSICAL EXAMINATION

117/75 81
mild distress.
HEENT: OP clear.
Neck: small prominent [illegible]
Chest: CTA
Abdomen: [illegible] NT. [illegible]
Ext: [illegible] dullness x4
(R) UE: [illegible] A/B joint, [illegible]



VA

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

A/ Fracture (R) AN
(R) neck [illegible]

P/ OR (R) UE [illegible]
[illegible]

130 | 104 | 12 | 142
4.2 | 21 | 1.6

19 | 12.8 | 217
401

(b)(6)-2 [redacted]

PATIENT'S IDENTIFICATION *(For typed or written entries give Name last, first, middle; grade; date; hospital or medical facility)*	DATE 8/16	IDENTIFICATION NO.	ORGANIZATION
		REGISTER NO.	WARD NO.

[redacted]
(b)(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

19Aug03 1730 Pt admitted from ICU in stable condition PERRLA. Lung CTA bilat, Ø resp distress. NSR Card Ø, non-tender, bowel sound active x4 quads. Dsg to (R) side of neck CDI. (R) arm dsg CDI. Multiple shrapnal wounds to upper body, torso. Cast from (R) groin to (R) toes. Strong pulses and brisk cap refill to bilat LE. IV to (L) AC. Ø complaint [redacted] (b)(6)-2 RN/BN

2230 Care assumed @2100. VSS, patient is sleeping awaken by verbal stimuli, no c/o pain, lungs CTA, bst x4, Dsg's on (R) index finger, (R) arm, right side of neck, and cast on (R) leg all CDI. (R) foot c̄ slight edema, pt able to wiggle toes and has (+) sensation. HL flushes well, pt on ~~IV~~ PO ABX. Pt has various flesh wounds from the shrapnel over his chest and upper extremities. No complaints at this time, will continue to monitor [redacted] (b)(6)-2 9Aug03

20Aug03 0800 Pt. awake & alert sitting up in bed. HR Regular, lung sounds clear bilat, bowel sounds (+) x4 quads. HL in (L) AC s̄ s/s of infection. VSS. staples + (R) clavicle intact, site s̄ s/s of infection. DSG to (R) upper extremity CDI, (R) hand slightly swollen, radial pulse palpable, cap refill <3sec (+)

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)	REGISTER NO.	WARD NO.
		ICW2

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/19
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)
USAPA V

[redacted]
(b)(6)-4

AUTHORIZED FOR LOCAL REPRODUCTION

PROGRESS NOTES

MEDICAL RECORD

DATE	NOTES
8/23/03	D/C Note. EPW Male sustained open (R) TIBIA Fracture and soft tissue lacerations to Right arm on 16 Aug 03. Wounds are closed. Fracture is stable. Long leg cast is applied. Pt should remain in cast 6-12 weeks. Follow up XRays should be obtained in six weeks. Sutures to be removed in one week from arm [redacted] (b)(6)-2 By [redacted] me (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		
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.
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.2
USA

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

MEDCOM - 17469

FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
17Aug03(1700)	cont. — Pt slept most of afternoon. Still denies wanting anything for pain. Sensation intact. — [redacted] LT/AN (b)(6)-2
18Aug03(0630)	Received report from CPT [redacted] (b)(6)-2 and assumed care of pt @ 0615. See DA form 4700 for assessment data. Pt says has little pain. > c̄ movement. Resting in bed c̄ (L) ankle & (R) wrist restrained. (R) leg elevated on blanket. — [redacted] LT/AN (b)(6)-2
18Aug03(1710)	Pt did well throughout shift. W VSS. Needed pain meds x 1. IV Abx given. (R) leg kept elevated on blanket. Very minimal drainage on (R) hand bandage. SL still flushes well. Foley in place. Pt ate breakfast & lunch independently. — [redacted] LT/AN (b)(6)-2
19Aug03	Brief op note
	Pre Op Dx: (R) TBI AKA, open wound (R) UE, (L) IC
	Post Op Dx: Same
	Procedure: I&D (R) leg, (L) IC, (R) arm, exploration of LLC (R) leg, DPC (R) leg, (L) IC, (R) UE
	Surgeon: Alvarez
	Anesthesia: General mask
	EBL: c̄
	Fluids: 300cc
	Cx: ∅
	Post Op Dx: Up ad lib, cambulator.

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

MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17 AUG 03	Brief Oper Rpt Pre Op Dx - (R) supracondylar wound Post Op Dx - SAME Procedure - (R) supracondylar wound exploration Surg Murphy Anes Jizmi Anes GET Pre Op Frag lodged in clavicle, closing wound Crutches Ø [redacted] (b)(6)-2
17 AUG 03	Outpt Op Note
0525	Pre-Op Dx (1) Open grade II (R) tibia fracture (2) Fragment wounds (R) arm (3) Open (L) IP PIPJ wound Post-Op Dx - Same Procedure: (1) I+D (R) tibia fx, apply splint (2) I+D (R) arm wounds

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

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

REGISTER NO.	WARD NO.

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

USAPA V2.00

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

(3) I+D (L) IF PIRS.
Surgeon [redacted] (b)(6)-2

Findings: Soft tissue wounds only in (R) arm, no bony involvement. Forearm fasciotomy done on dorsal side. (R) tibia I+D's, fracture stable. (L) IF small penetrating wound, into PIRS. I+D done

PLAN: Repeat I+D in 48 hours, will place in long leg cast for tibia fracture. Will close (L) IF separately, extension hood then as well.

[redacted] (b)(6)-2

SLM

17AUG03@0610 pt returned from OR @ 0555 pt VSS see recovery Flowsheet for details
pt dressing CDI will report to oncoming SLIFT [redacted] (b)(6)-2 PRC 9 Aug

17Aug03@1700 Finished recovering pt @ 0705. Had received report on pt @ 0630. Pt states that he has little pain but not enough for medicine. See DA Form 4700 for assessment data. Pt slept most of the morning. Around 1030 gave pt @ bath (sponge). Pt was c/o some pain during that so gave 4mg MSO4/IVP. Tolerated it well. (R) leg elevated on blanket. Sensation intact. Pt ate lunch independently

STANDARD FORM 600 (REV. 6-97) BACK

USAPA V2.01

NSN 7540-01-134-4176

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE** | AUTHORIZED FOR LOCAL REPRODUCTION

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
20 Aug 03 0800	sensation, full ROM of digits, wrist & elbow. PSG to (D) forefinger CDL. Cast to (R) UE intact, full ROM of digits, <3sec cap refill, (+) sensation. Multiple shrapnel wounds to chest & UE, wounds ~ drainage or s/s of infection. Pt. ~ complaints @ this time. Will continue to monitor. — [redacted] 217/A (b)(6)-2
20 Aug 03	Orthopedic Staff (R) LLC intact, pain well controlled. Drug (R) UE intact. Drug & in AM. Needs crutch hang. [redacted] (b)(6)-2
20 Aug 03 1330	Pt awake and alert. PERRLA. Lungs CTA bilat, Ø resp distress. NSR. Abd soft, non-tender, bowel sounds active x4 quads. Incision to (R) Clavicular area. T sutures intact, open to air, Ø s/s infection. (R) arm T dsg CDI. Cast to (R) leg from groin to toes. Pt able to move (R) toes, strong pulses and brisk cap refill to bilat LE. Ø complaints [redacted] (b)(6)-2
20 Aug 8130	Care assumed @ 2100. VSS, AOX3, ~ complaints. Given for pain. Re @ 2100. Lungs clear CTA, bowel sounds active x4 quads.

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. ICW2

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

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
	Cast on (L) leg CDI, (+) cap refill and sensation in toes. Dsg on rle CDI, pulse (+), cap refill and sensation (+). (R) hand slightly edematous. Dsg on index finger of (L) hand CDI. L hand with staples CTA CDI, skin around wrist on neck pink, non painful to tech. Various shrapnel sites over chest s/s infection. Continue to monitor. [redacted] (b)(6)-2 9/WMCO
21Aug03 0630	Pt sleeping, easily arousable c̄ verbal stimuli. Lungs CTA bilat, Ø resp distress. NSR. Abd soft, non-tender, bowel sounds active x4 quads. Incision to (R) clavicular area CDI, Ø s/s infection. Staples open to air. Dsg to (R) arm CDI. Swelling noted to (R) hand, ⊖ c/o pain, pt instructed to elevate hand. Mult. shrapnel wounds to torso, dried and healing. Cast to (R) leg from groin to toes intact. Strong pedal pulses and brisk cap refill to bilat LE. [redacted] (b)(6)-2 WMCO
21AUG03	(1650) Pt admitted to unit via litter in stable condition. Pt A/O x3. Lungs CTA (B). (+) BS x4 quads. VSS. Sq in (L) ac dlcd d/t infiltration. Dsg on (R) arm clcd. Sutures on (R) arm intact. Upper (R) arm incision packed c̄ iodoform dsg. Sero-sang drainage c̄ pus expelled from lower end of incision prior to packing. ⊖ c/o pain at this time. Will continue to monitor. [redacted] (b)(6)-2 WMCO
21AUG03 2221	VSS. AO. Denies pain @ this time. DSG intact to (R) arm. (R) cast intact, (+) pulses, staples to (R) rush CDI. Tolerating PO well. Cont to monitor. [redacted] (b)(6)-2

STANDARD FORM 600 (REV. 6-97) BACK

FPI. LEX. Printed on Recycled Paper

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
[illegible]	Received pt resting in bed in stable condition. VSS, (B)LE cast in place. No exceptions to assessment WNL. Pt tol po and drinking. [illegible] waiting for return to CPW camp today, no other remarkable findings. Will cont to monitor pt [redacted] cont
25 AUG 03	PT NOTE [redacted] (b)(6)-2
	HX: CRUTCH TRAINING & AMBUL ASST.
	T/M: (B) UE & (L) LE GMM ~ 5/5. PNT DEMONSTRATED (I) 3PT NWB GAIT TO INCLUDE
	STAIR. MINIMAL ASSIST REQ'D NEGOTIATING STAIR AT LATRINE. PNT AMBUL ~ 200' PNT
	DENY DIZZINESS, NAUSEA, OR EXCESSIVE FATIGUE.
	DX: CANT TRAINING. AMBUL.
	I: SAME
	G: AMBULATE PNT ~ 500' BID X 2WKS.
	(b)(6)-2
	SPC [redacted]
	91WM4 PT TECH

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

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

#[redacted]

(b)(6)-4

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

NSN 7540-01-075-3786

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

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS: EPW

CITY | STATE | ZIP CODE

SEX: M

AGE: 44

DUTY/LOCAL PHONE: AREA CODE | NUMBER

HOME PHONE: AREA CODE | NUMBER

MILITARY STATUS

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

ARRIVAL

DATE *(Day, Month, Year)*: 17/08/03 | TIME: 0010

TRANSPORTATION TO FACILITY: Medevac

THIRD PARTY INSURANCE

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

CURRENT MEDICATIONS: Ø

ALLERGIES: NKDA

INJURY OR OCCUPATIONAL ILLNESS

ITEM	YES	NO	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: Shrapnel - extremities, (B) Abd

CATEGORY OF TREATMENT

☐ EMERGENT
☐ URGENT
☐ NON-URGENT

TIME: 0010

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

VITAL SIGNS

TIME	0010	0030	0045	1240	
BP		119/70	121/69	106/66	
PULSE	86	80	78	83	
RESP			16	14	
TEMP					
WT	99%		98%	98%	

LAB ORDERS

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

X-RAY ORDERS

X	CXR PA & LAT/PORTABLE		C-SPINE
X	ACUTE ABDOMEN		LS SPINE
	SINUS		HEAD CT
	ANKLE R/L	X	(B) Arm
X	Neck	X	(B) Leg

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
0030	.5cc Tetanus	[redacted]	(b)(6)-2		
0035	1gm Ancef	[redacted]	(b)(6)-2		
0040	10mg Morphine	[redacted]	(b)(6)-2		

DISPOSITION: ☐ HOME ☐ FULL DUTY

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

MODIFIED DUTY UNTIL | RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATE

ADMIT TO UNIT/SERVICE | TIME OF RELEASE

REFERRED ▶ | TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

[redacted] (b)(6)-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

NSN 7540-01-075-3786

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

TEST RESULTS

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

PROVIDER HISTORY/PHYSICAL GSW to r/t arm Good PMS distal ↓ROM GSW to r/t leg tib/fib Good PMS - able to move left leg - shrapnel wounds noted to chest + neck HRRR. Lungs CTA

Ø surg
⊕ tobacco

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP

DIAGNOSIS

CODES

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

[redacted]
(b)(6)-4

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

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
23AUG03	0930		Assumed care of pt @ 0700 ~~p~~ report from night shift. Pt alert, speaking Arabic. Ø c/o pain Cast on RLE intact. Toes warm to touch. Pt able to move all toes. Staples to (R) side of neck CDI. Sutures to (R) upper and lower arm CDI. Drsg Δd to sutures on (R) upper arm. Shrapnel wounds noted on chest dry and intact. AM care done this am by pt. VSS. RLE elevated on [redacted] (b)(6)-2 pillow and blanket. [redacted] (b)(6)-2 2 point restraints in place. Monitoring. [redacted] (b)(6)-2
23Aug03	2100 =	VSS, A+O x3, Ø c/o pain, cast to (R) LE and neurovascularly WNL, lacerations to area above (R) AC ~~c~~ sutures → Dsg Δ'd. and lac to (R) FA ~~c~~ sutures open to air. Wound to (R) clavicular area ~~c~~ Staples open to air → Ø erythema or irritation, Shrapnel wounds scattered over abdominal area. No other remarkable assessment findings (R) LE elevated on blanket rolled [redacted] (b)(6)-2 Will continue to monitor. — [redacted]
23 Aug03	2230 :	pt. OOB and ambulating in halleway NWB ~~c~~ crutches. [redacted] (b)(6)-2

(Continue on reverse side)

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

REGISTER NO. | 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
24 Aug 03	0850		Pt received sleeping, awoke spontaneously alert, lungs CTA bilat, S1 S2 noted ē (R) peripheral pulses bilat UE's ē (L) LE, (L) LE ē full length cast ē pt ē sensation ē warmth to his toes, (+) bowel sounds in all quads, tolerated PO fluid ē meal well. Sutures to U ē L (R) arm intact ē s/s of infx, staples (R) clavicle ē s/s of infx, multiple scabs over shrapnel wounds throughout torso, sutures (L) index finger intact ē s/s of infx. Pt to A/E to EPW camp today, cont to monitor. (b)(6)-2 [redacted] /SMC
24 Aug 03	1830		VSS, A+O x3, ¢ c/o pain, cast to (R) LE, ambulates QOB NWB ē crutches well, (R) LE elevated. Wounds to (R) LE ē sutures approximated. Wound to (R) clavicular area ē sutures approximated. No other remarkable assessment findings. Pending D/C back to EPW camp. [redacted] /AW (b)(6)-2

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
22AUG03	1115		Assumed care of pt @ 0700 p report from night shift. Pt alert, speaking Arabic. VSS. Ø clo pain. Staples to (R) side of neck CDI. Sutures on (R) arm intact. Bottom of incision on (R) upper arm packed c̄ iodoform drsg. Small amount of drainage on old drsg. New drsg applied to sutures on (R) upper arm. Shrapnel wounds noted on chest. Ø S/Sx infection on any wound sites. (R) leg in cast intact, elevated on pillow and blanket. Voiding s̄ difficulty. 2 point restraints in place. Pt able to move toes on (R) foot. Cap refill <2secs. Pt resting quietly @ this time. Will continue to monitor. — [redacted] (b)(6)-2
22 Aug03	2030		VSS, A+Ox3, communicates in Arabic native language, Ø clo pain, cast to (R) LE → neurovascular ✓'s WNL ((+) sensation/(+) movement wiggles toes well, CRT<3secs in toes, can fit two fingers under cast @ (R) thigh, (−) edema), wound to (R) clavicular area c̄ staples CDI, wound to (R) LE → dsg reinforced, wound to (R) LE ((R) FA) c̄ sutures approximated, Ø IV access, PO antibiotics, crutches for NWB exercise, continuing IS @ BS. Will continue to monitor — [redacted] (b)(6)-2

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

STANDARD FORM 510 (REV. 7-91) BA(

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

4. PROPOSED SURGICAL PROCEDURE:

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

Emergency case s/p blast injury - multiple shrapnel wounds.

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

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

[redacted]

(b)(6)-4

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

(b)(6)-2 [redacted] 117AN 17 Aug03 DATE

11. POSTOPERATIVE EVALUATION:

12. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title	13. PREOPERTIVE EVALUATION PREPARED BY (Signature an
(b)(6)-2 [redacted] 117AN	[redacted] 117AN (b)(6)-2
DATE: 17 Aug03 TIME: 0340	DATE: 17 Aug03 TIME:

REVERSE OF DA FORM 5179, JUN 91 USAPA V1 01

MEDICAL RECORD	INTRAOPER E DOCUMENT For use of this form, see AR 40-66, the pr. agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Gurney BY Anesth.

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

3. DATE 19 Aug 03 TIME PATIENT ARRIVED IN SUITE 1420

4. PATIENT IN ROOM TIME 1420 NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS:

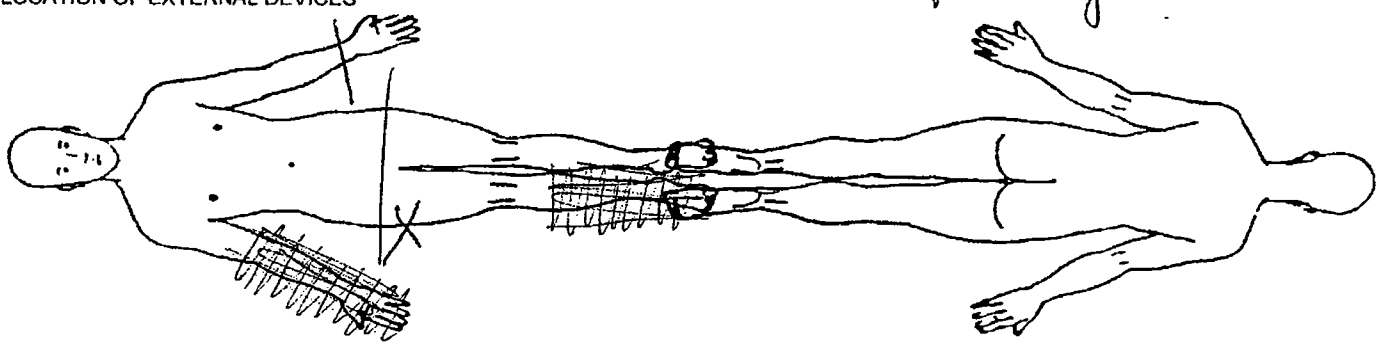
8. SKIN PREPARATION

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

COMMENTS:

PREP SOLUTION *(Specify)* Betadine prep
SITE: ~~Lt~~ BY WHOM: (b)(6)-2
SITE: Rt. arm & leg BY WHOM: LTC [redacted]
COMMENTS: No pooling noted

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

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

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

[redacted]
(b)(6)-4

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

☒ ESU NO: Valleylab Force 2
GROUND PAD: BRAND Polyhesive
LOT NO: 68836

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

cut: 30 coag: 30

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

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

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☐

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

18. DRESSING/IMMOBILIZATION *(Specify)*
kerlix fluffs + rolls 2x2 - Lt finger
Webril +
Long leg cast - Rt. leg

19. ADDITIONAL INFORMATION
WC
Surgeons: Dr. [redacted] (b)(6)-2 Anesthesia: Maj. [redacted] (b)(6)-2 Anesthesia Type: G Mask/IV sedation

Bovie Pad site intact pre-op clear post-op clear Bovie Settings: Coag/Cut
Tourniquet Site intact pre-op NA: post-op NA

20. OPERATION(S) PERFORMED
I + D (R) arm + Rt. ↓ leg; I+D (Lt) trigger finger

21. PATIENT TRANSFERRED TO ICU-3 TIME 1600 METHOD via Gurney

22. REC[redacted] LTC, AN

R[redacted] A FORM 3179-1, OCT [redacted] (b)(6)-2

USAPA V1.01

MEDCOM - 17484

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

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA litter BY Anesthesia

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

3. DATE 17 Aug03 TIME PATIENT ARRIVED IN SUITE 0345

4. PATIENT IN ROOM TIME 0345 NUMBER 2-2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies:
Emergency case s/p blast injury - multiple shrapnel wounds

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS (Specify)

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

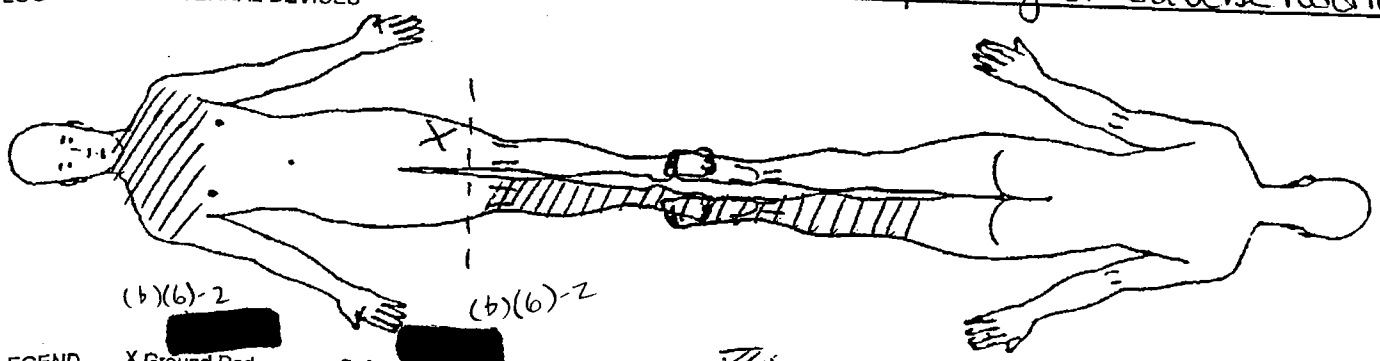
COMMENTS: Normal anatomic body alignment maintained

8. SKIN PREPARATION

HAIR REMOVAL DONE BY: ☒ YES ☐ NO Dr. [redacted] (b)(6)-2
☒ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☒ RAZOR Right leg
☐ CLIP
COMMENTS: No nicks or cuts

PREP SOLUTION (Specify) Betadine / Betadine
SITE: Right Arm, Leg BY WHOM: 1LT [redacted] (b)(6)-
SITE: Left hand upper chest/neck BY WHOM: CPT [redacted] (b)(6)-2
COMMENTS: No pooling or adverse reaction

9. LOCATION OF EXTERNAL DEVICES



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

Initial: SPC [redacted] (b)(6)-2
1LT [redacted] (b)(6)-2

C = Correct I = Incorrect

10. COUNTS

		Other**	First Closing Count	Final Closing Count	SCRUB (b)(6)-2	CIRCULATOR (b)(6)-2
Sponge	☒ Yes ☐ No					
Needle Sharp	☒ Yes ☐ No		C	C	SPC [redacted]	1LT [redacted]
Instrument	☐ Yes ☒ No					
Other	☐ Yes ☒ No					

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

[redacted]
(b)(6)-4

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

☒ ESU NO: #3 cut 30 coag 30
GROUND PAD: BRAND VL REM Polyhesive II
LOT NO: 168936 EXP 2005-03

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*
fluffs. kerlix. ACE
4x8 on neck wound

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

Bovie Pad site intact pre-op ✓; post-op ✓ Bovie Settings: Coag/Cut 30/30
Tourniquet Site intact pre-op ✓; post-op ✓

(b)(6)-2 DA5179 initiated

20. OPERATION(S) PERFORMED I&D / ~~fasciotomy~~ Right leg
Neck exploration

21. PATIENT TRANSFERRED TO ICU2 TIME See DA 7359 METHOD Litter

22. REGISTERED NURSE SIGNATURE [redacted]

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

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY	
POST- DAY	
MONTH-YEAR	DAY 25 Aug
19	HOUR 0800

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

RESPIRATION RECORD

BLOOD PRESSURE: BP 96/66; P 89; T 98.1; pL 160

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**

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY: 1 2 3

POST- DAY

MONTH-YEAR Aug 2003 — DAY: 19, 20, 21, 22AUG03, 22AUG03, 23AUG03, 24 Aug — HOUR: 0800, 1200, 1600, 2000, 2400, 0400, 0800, 1200

PULSE (0) / TEMP. F (°) / TEMP. C (Centigrade Equivalents, for Reference only)

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

PULSE (0)	
180	
170	
160	
150	
140	
130	
120	
110	
100	
90	
80	
70	
60	
50	
40	

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

O_2 sat

Record special data only when so ordered

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

REGISTER NO.

WARD NO. ICW 2

[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

Ward/Section: ICW2	REQUESTING PHYSICIAN: [redacted] (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] (b)(6)-4	DATE 21Aug	TIME 0100	SSN/PSEUDO SSN: [redacted] (b)(6)-4

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3	Color	Yellow	N/A	RPR		Negative
RBC		4.7-6.1 x 10^9	App	Clear	N/A	Mono		Negative
Hgb		14-18 g/dl (M) 12-16 g/dl (F)	Glu	Neg	Negative	**Microbiology**		
Hct		42-52% (M) 37-47% (F)	Bili	Neg	Negative	Source		
MCV		80-94 fl (M) 81-99 fl (F)	Ket	Neg	Negative	Gram Stain		
Plt		130-500 x 10^3 verified	SG	1.025	N/A	Occ Bld		Negative
Lymph %		20.5-51.1%	Bld	Neg	Negative	H. pylori		Negative
(Hematology) Manual Differential			pH	6.0	N/A	Micro Parasites		
Segs		Mono	Prot	Neg	Negative	Malaria		
Bands		Eos	Urob	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:

REPORTED BY: [redacted] (b)(6)-2	DATE: 21Aug03	LAB ID NO.:

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

LAST, FIRST, MI. [redacted] (b)(6)-4	DATE 17 Aug 05	TIME 0130	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	Yellow	N/A
App	Clear	N/A
Glu	Neg	Negative
Bili	Neg	Negative
Ket	Neg	Negative
SG	1.015	N/A
Bld	Small	Negative
pH	5.0	N/A
Prot	~~[illegible]~~ Negative	Negative
Urob	0.2	0.2-1.0
Nit	Neg	Negative
Leuk	—	Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh		

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

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

LAST, FIRST, MI.	DATE 17 Aug	TIME 0004	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		26-8
ALT		10-4
AMY		14-9
AST		11-3
TBIL		0.2-1.
BUN		7-22
CA^{++}		8.0-1
CHOL		100-20
CRE		0.6-1.
GLU		73-11
TP		6.4-8.1

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU		73-118
BUN		7-22 m
CRE		0.6-1.2
CK		39-380 30-190
NA^+		128-14
K^+		3.3-4.7
CL^-		98-108
tCO_2		18-33 m

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl

======= PICCOLO =======
17/08/03 01:12
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: 3151AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	142*	73-118	MG/DL
BUN	12	7-22	MG/DL
CRE	1.6*	0.6-1.2	MG/DL
CK	302	39-380	U/L
NA+	130	128-145	MMOl/L
K+	4.2	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

REMARKS:

REPORTED BY: (b)(6)-2 [redacted]	DATE: 17 Aug 03	LAB ID NO.:

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

LAST, FIRST, MI.	DATE	TIME	SSN/PSEUDO SSN:
[redacted] (b)(6)-4			[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	16.0	9.8-13.6 secs			
APTT	28.9	21-34 secs			
D dimer		<20 ug/ml			
FDP		<10 ug/ml			

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
[redacted] (b)(6)-2	17 Aug	

Ward/Section: ICU 3	REQUESTING PHYSICIAN: Dr [redacted] (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. EPW # [redacted] (b)(6)-4	DATE 17 Aug 03	TIME 0805	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		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: 8-17-03	LAB ID NO.:

(b)(6)-2

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

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

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mm
K		3.5-4.9 mm
Cl		98-109 mm
pH		7.31-7.45
PCO2		35-45 mmH 41-51 mmHg
PO2		80-105 mmH N/A (ven)
TCO2		23-27 mmol/l 24-29 mmol/l
HCO3		22-26 mmol/l 23-28 mmol/l
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol
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% PC
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RAN
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
GI		
BU		
CA		
CR		
NA		
K+		
CL		
tCO		
TI		
ALI		
ALI		
ALT		
AM		
AST		
TBI		
GGT		
TP		
TE		
NA+		
K+		
CL-		
tCO_2		

======= PICCOLO =======
17/08/03 08:19
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: 3152AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	116	73-118	MG/DL
BUN	9	7-22	MG/DL
CRE	1.1	0.6-1.2	MG/DL
CK	697*	39-380	U/L
NA+	132	128-145	MMOL/L
K+	4.6	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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE

======= PICCOLO =======
17/08/03 08:17
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
GENERAL CHEMISTRY 12
DISC LOT #: 3204AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

ALB	2.9*	3.3-5.5	G/DL
ALP	50	26-84	U/L
ALT	17	10-47	U/L
AMY	16	14-97	U/L
AST	29	11-38	U/L
TBIL	1.2	0.2-1.6	MG/DL
BUN	9	7-22	MG/DL
CA++	8.3	8.0-10.3	MG/DL
CHOL	108	100-200	MG/DL
CRE	1.0	0.6-1.2	MG/DL
GLU	125*	73-118	MG/DL
TP	5.7*	6.4-8.1	G/DL

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

Tobacco

MEDICAL RECORD - ANESTHES'

...f this form, see AR 40-66; the proponent age... ...e OTSG

NKDA

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

DRUG (Units)												
Versed (mg)	2-1		Propofol (mg)					30				
Fentanyl (mcg)	100	150					50	50	25			
Lidocaine (mg)	100											
Ketamine (mg)	80											
Succ (mg)	100											
VCB (mg)		5	5									
VOLAT AGENT — Iso % del / % e.t.	1.5	1.0	1.2	1.2	1.2	1.5	X	1.5	1.0	X		
AIR L/Min												
N2O L/Min												
O2 L/Min	10	2	2	2	2	2	2	2	2	2		

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

FLUIDS

LINE site 18G-R AC ☒ Warmed	NS 500							500				
18G-L HD ☒ Warmed	LR #1							1000				
☐ Warmed												
☐ Warmed												

LOSSES

EST BLOOD LOSS		5						50				
URINE -		500										

TOTALS	TOTAL EBL
3/30	<100
325	
100	TOTAL URINE
80	550
100	
10	

FLUIDS SUMMARY

CRYSTALLOID- 1500

COLLOID- Ø

BLOOD- Ø

PHYS STATUS 1 2 3 4 5 (E)

BODY WEIGHT: 80 (KG) LB

HEMATOCRIT: 40

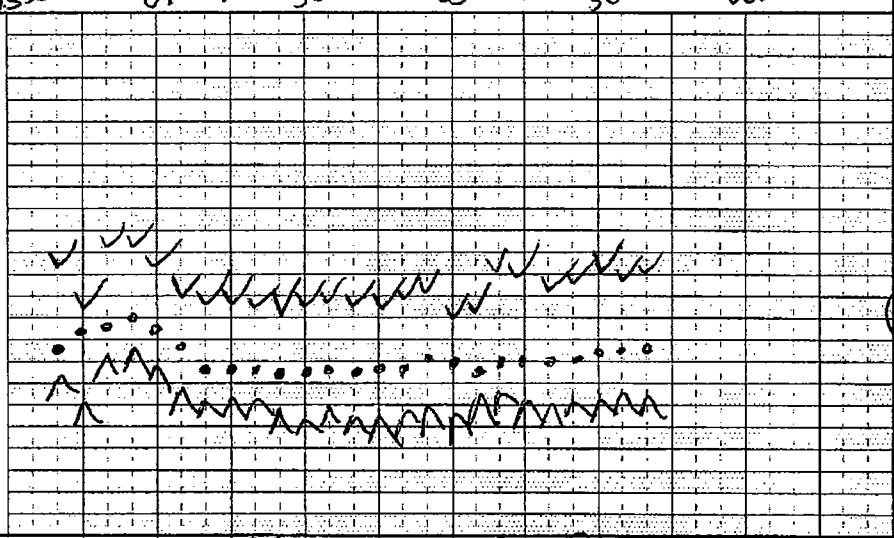
INITIAL DATA: BP- 106/66 HR- 83

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK OK for PROCEDURE? [redacted] TIME- 0300

TIME 0330 · 0400 · 30 · 0500 · 30 · 0600

SYMBOLS: BP by cuff V ∧; Heart rate ●; Resp rate; BR (transduced); TOURNIQUET T—T; (b)(6)-2 ANES- X-X; PROC- ⊙-Ø



REMARKS

Code drugs with numbers, events with letters

(1) Pre-op assessment 18G PIV (L) hand
(2) Room, monitor O2 induced eyelids taped + OP placed
(3) Inc D (R) tibia + Nerve exploration started
(4) Reversed Neostigmine 5mg + Glycopyrrolate 0.6mg
(5) Obtucted ETCO2 CSO; Tv 7ml RR 28 + 30 Extubated

VENTIL.

VT - ml	—	820	830	850	860	870	810	840	360
f - breaths/min	—	10	8	7	7	7	7	18	14
Peak inf pres / PEEP	—	25	23	23	23	24	23	—	—
MODE - S(pon), A(ssist), C(on)	S	C	C	C	C	C	C	S/A	S

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	+	35	31	32	33	33	33	48	48
BP/oth	FIO2 (Frac or %)	0.75	0.75	0.75	0.75	0.76	0.75	0.77	0.79	0.79
ART line	SpO2 (%)	100	100	100	100	100	100	100	100	100
Steth- PC/ES	ECG	SR	—	SR	— SR	SR	SR	SR	SR	SR
Gas analyzer	TEMP-site	available				34	34	34	34	34
	N-M Block (T/4)	—	4/4	—	4/4	0/4	0/4	—		Suct
	BS		+							Ready lift
Warming blkt	x1 blanket	→								
Conv warmer										

Mark with letters & symbols, explain under REMARKS — EVENTS (1) (2) (3) (4) (5) — Position: Head 45°

RECOVERY AT 0545

PACU (ICU 3) (Specify)

OTHER 97.9

CONDITION: Stable

RESP- 18 SpO2- 99

BP- 137/72 HR- 109

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0315	0340	0554
	Ready	Begin	End
PROC	0350	0410	0535

PROCEDURES and CPT Codes: I+D (R) arm; I+D (R) tibia + cast; Zone I neck exploration; I+D (L) finger

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* GETA; RSI + cricoid

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

[redacted]

(b)(6)-4

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* DL x1 MAC 4 Grade I view 8.0 stylETT 24cm @ lips 10ml air cuff; + BBS; Suct ETCO2

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

ANESTHETISTS: [redacted] MAJ/CRNA

PROCEDURE LOCATION: 2

DATE: 17 Aug 03

PAGE 1 OF 1

DA FORM 7389, FEB 1998 — ME[redacted] COPY 1 - PATIENT'S MEDICAL RECORD — USAPA V1.00

(b)(6)-2

MEDICAL RECORD - ANESTHESI[A]

17 Aug 13.3 / 41.5 / 35.2 / 197 Tobacco

...e of this form, see AR 40-66; the proponent ager[ncy is t]he UTSG

IVPB Ancef

NKDA

DRUG (Units)								TOTALS
Versed (mg)	3							3
MSO4 (mg)	5 ~	5 ~	3 ~	4				17
Ketamine (mg)	<50>							50
Glycopyrrolate (mg)				0.2				0.2
Propofol (mg)					20			20
VOLAT AGENT Iso % del	~	2.0 ~	2.0 ~	2.0 ~	1.8	1.5 X		
% e.t.								
AIR L/Min								
N2O L/Min								
O2 L/Min	10 ~	2 ~	2	2 ~	2	2	10	

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

TOTAL EBL: <50

TOTAL URINE: 100

FLUIDS SUMMARY

CRYSTALLOID- 300

COLLOID- Ø

BLOOD- Ø

FLUIDS

LINE site 18G (L) A [X] Warmed — LR #1 ———— 200

[ ] Warmed

[ ] Warmed

[ ] Warmed

LOSSES

EST BLOOD LOSS

URINE - 100

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 80 (KG) LB

HEMATOCRIT: 35.2

INITIAL DATA:

BP- 122/70

HR- 85

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK OK for PROCEDURE? [redacted]

TIME- 1400

TIME: 1415 · · 1500 · 30 · 1600 · 30 · 1700

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

(b)(6)-2

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

D/C'd foley

VENTIL

VT - ml	450	390	420	470	430	560-600
f - breaths/min	18	18	10	13	11	12
Peak inf pres / PEEP	—	—	—	—	—	—
MODE - S(pon), A(ssist), C(on)	S ~	C ~	S	S	S	S

MONITORS/ACCESSORIES

✓BP/Auto Cuff	✓ET CO2 (torr)		35	33	36	40	43	48
✓BP/oth	✓FiO2 (Frac or %)	0.65	0.65	0.65	0.60	0.64	0.63	0.63
ART line	✓SpO2 (%) 93	100	100	100	100	100	100	100
Steth- PC/ES	✓ECG	SR	——→		SR	SR	SR	SR
Gas analyzer	✓TEMP-site	not available	——→		——→	——→	——→	
	✓N-M Block (T/4)							
	BS	+	~	+	+	+	+	
✓Warming blkt		x1 wool blanket ——→			——→	——→	——→	——→
Conv warmer								

Mark with letters & symbols, explain under REMARKS

EVENTS ① ② ③ ④

Position: Supine / 45°

REMARKS

Code drugs with numbers, events with letters

① Pre-op pre-eval, pre-op drugs CTA, RRR (L) AC patent

② Room, monitors, O2, induced, eyelids taped

③ SV TV 24 mL kg, foley D/C'd per Dr. [redacted] (b)(6)-2 to litter, to ICU-3. Removed OA + NP tube

④ Report to RN. O2 SF MC SaO2 97% to 98%

RECOVERY AT 1600

PACU (ICU 3) (Specify) T-982

OTHER

CONDITION: Stable, somnolent, easy arousal

RESP- SpO2-

BP- 132/71 HR- 94

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1410	1420	1610
	Ready	**Begin**	**End**
PROC	1430	1450	1555

PROCEDURES and CPT Codes: I & D multiple shrapnel wounds

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* GMA

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* 4COA to RL OA 90mm, NP tube 34FR + BBS; sust ETCO2

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

[redacted]

(b)(6)-4

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

A[redacted] CRNA / MAJ

PROCEDURE LOCATION: 1

DATE: 19 Aug 03

PAGE 1 OF 1

DA FORM 7389, FEB 1998 MEDCOM - 17496 (b)(6)-2 ... PATIENT'S MEDICAL RECORD USAPA V1.00

PRE-ANESTHETIC ASSESS AND PLAN OF CARE

AGE: 44 Days Mos (Yrs) GENDER: (X) Male ( ) Female

ALLERGIES: NKDA

P S: 1 (2) 3 4 5 (E)

WT: 80 (Kg)/Lb HT: ____ In.

PROPOSED PROCEDURE: Neck Exploration (R) elbow I+D; (R) leg (tibia) Ex Fix

SURGICAL SERVICE: Ortho / General Surgery

NPO SINCE: Full Stomach

PREOP DX / MECHANISM OF INJURY: Mortar Shrapnel Wounds to Right Elbow, (R) leg - tibia and right neck

HABITS:

Tobacco: yes
EtOH: No
Drugs: No

CURRENT MEDICATIONS:

( ) = ordered as premed

( ) Received Ancef 1g
( ) in tetanus, Sec
( ) ED morphine 10mg
( )
( )
( )

PREMEDICATIONS:

None / Yes @ ____ Hrs

LABORATORY STUDIES:

130	104	12	142
4.2	21	1.6	

19	12	217
	40	

Other: PT 16.0
PTT 28.9

PAST MEDICAL HISTORY / SYSTEMS REVIEW

Cardiovascular:			
Hypertension	N	Y	?
Angina	N	Y	
MI	N	Y	\
CVA	N	Y	
Other	N	Y	
Pulmonary:			
Asthma	N	Y	
URI	N	Y	?
COPD	N	Y	\
Other	N	Y	
Renal System:			
ARF/CRF	N	Y	
Other	N	Y	?
Gastrointestinal:			
Hepatitis	N	Y	\
Hiatal Hernia	N	Y	
GERD/PUD	N	Y	?
Endocrine:			
Diabetes	N	Y	
Steroids	N	Y	?
Thyroid	N	Y	
Neurological:			
Seizures	N	Y	?
Neuropathy	N	Y	
Gynecological:			
Pregnancy	N	Y	?
Other	N	Y	
Other Problems:	N	Y	\
			\
Familial Hx ?	N	Y	

SURGICAL HISTORY

Ø

PHYSICAL EXAMINATION

BP: 106/66 HR: 83 RR: 14 T: ____

Pain (0/10 Scale): ____

Airway Exam:
Dentition: ok
Trachea: midline
TMJ/C-spine: Full ROM
Oropharynx: MP II TMD 3 FB

Chest:
Lungs: Vesicular BS (B)
Heart: S1, S2

IV Access: 16 ga (L) AC

Ulnar Filling: ____

Back: ____

Other: ____

ANESTHETIC PLAN: ( ) Local/MAC ( ) Regional: ____ (X) General: Intubation / Mask-LMA Notes: ____

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives, and risks of anesthesia including death have been explained to and discussed with patient and/or legal guardian. The patient/legal guardian seems to understand and agrees to proceed. Questions answered.

(b)(6)-2

Signed: [redacted] MD Date: 17 AUG 03 Time: 0245

( ) Sedated/nonresponsive/minor patient with no family or guardian present.

PAT[redacted]

[redacted]

(b)(6)-4

ICU #3

POST-ANESTHESIA EVALUATION AND NOTE:

( ) No apparent anesthetic complications.
( ) Other (see progress notes)

Signed: ____ Date: ____ Time: ____

Nursing Unit: ICU 3

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: 19 Aug 03 TIME OF ORDER: 0930 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) Transfer to ICW 2 [redacted] (b)(6)-2
(2) Dx: s/p anch infarction, RCA branch
(3) Cardiac stable
(4) VS q shift
(5) Diet BSC
(6) NKDA
(7) Diet ~~[illegible]~~ NPO for CR today

NURSING UNIT: ICW #1 | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

DATE OF ORDER | TIME OF ORDER | HOURS

(8) CVP - flolak
(9) Amiod 7 gm IV q 8°
(10) Percocet 1 tab po q 4°

(b)(6)-2 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 19 AUG 03 TIME OF ORDER | HOURS

✓ ICW-2
✓ - Stable
✓ - Routine vitals
✓ - Up c crutches, NWB (R) LE
✓ - PT for gait training
✓ - Dressing Δ 48°
✓ - Regular Diet

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

✓ - Clindamycin 300 mg po q8°
✓ - Heparin IV
✓ - T#3 1 tab po q4° prn pain
✓ - MSO4 2 mg IVP q1° prn breakthrough
✓ - Ambien 5 mg po QHS
✓ - Phenergan 25 mg IV q6° prn nausea
- I.S. at bedside, instruct use

NURSING UNIT: 2WVS | ROOM NO.: 2030 | BED NO.: 19A-03 [redacted] (b)(6)-2 [redacted]

DA FORM 1 APR 79 4256 REPLACES EDITION [redacted] HICH MAY BE USED. (b)(6)-2

☆ U.S. GOVERNMENT PRINTING OFFICE: 1996—409-924

"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)-1

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | LIST TIME ORDER NOTED AND SIGN

17 Aug 03 0149 HOURS

Admit to ICU 3

Dx: neck/arm/and shoulder

Condition Serious

IVF LR @ 125 c/h

NPO

Ancef 2 gm IVPB q 8°

MSO4 2-6 g IVP q 2° PRN pain

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

Foley to gravity drainage

VS q 1 hr

Continuous pulse oximetry

O2 NC 2L titrate to keep O2 sat 94%

Phenergan 12.5 g IVP q6° PRN nausea

pre-op

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

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF OR[redacted] | TIME OF ORDER

NICDA HOURS

[redacted] (b)(6)-2

[redacted] (b)(6)-2

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.

DATE OF ORDER 17 AUG 03 TIME OF ORDER _____ HOURS

LIST TIME ORDER NOTED AND SIGN

1) To Jan 3
2) Dx SIP Wrist RUE, RLE Atypical chest pain Neck Expand
3) Cardiac Stab
4) Vital Q1° X6 then Q4° and Neuro cards chart
5) Activity Bedrest

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER _____ HOURS

6) Diet advance as tolerated
7) IV LR at 125 cc/h heplock when tolerating PO well
8) I's & O's
9) Incentive Spirometry 5x q1° while Awake

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER _____ HOURS

10) MEDS
MSO4 2-8mg IV q1-2° prn
* Zofran 4mg IV q 6° prn nausea
Ancef 1gm IV q8°
11) labs CBC, Chemistry thru Ana upgraded in Am
12) Contact MD 77101-5 SSP 7180

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER _____ HOURS

Lgo. UPC 30cc/h
13) Poly to gravity

[redacted] (b)(6)-2

NURSING UNIT	ROOM NO.	BED NO.

24 hr cc Done 18 Aug 03 @ 0030 hrs [redacted] (b)(6)-2 CPT / AW

(b)(6)-2

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

(b)(6)-2 [redacted]

NURSING UNIT: 7P/ 23Fy | ROOM NO.: [redacted] | BED NO.: 195

DATE OF ORDER: 8/22/03 | TIME OF ORDER: 1900 HOURS | LIST TIME ORDER NOTED AND SIGN

① PT for crutch training today

[redacted] (b)(6)-2

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

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

NURSING UNIT: ICW #1 | ROOM NO.: [redacted] | BED NO.: 2800

DATE OF ORDER: 8/23/03 | TIME OF ORDER: 0700 HOURS

D/C to EPW camp today

[redacted] (b)(6)-2

(b)(6)-2 [redacted]

(b)(6)-2 [redacted]

PATIENT IDENTIFICATION (b)(6)-2

DATE OF ORDE[redacted] | TIME OF ORDER: _____ HOURS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER: _____ HOURS

NURSING UNIT | ROOM NO. | BED NO.

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

CLINICAL RECORD

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 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 19	20	21	22	23	24	25
19Aug	[redacted] (b)(6)-2	Clindamycin 300mg PO q8°	8	/	[redacted]					
			16	/						
			24	[redacted]						
19Aug	[redacted] (b)(6)-2	IV-heplock	05	/	[redacted]					
			13	[redacted]						
			21	[redacted]						
19Aug	[redacted] (b)(6)-2	Ambien 10mg po QHS	22	[redacted]						

dc 21AUG03

all (b)(6)-2

ALLERGIES: ☐ YES ☐ NO

unk

PRIMARY DIAGNOSIS:

S/P neck exploration, RUE

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

PRN meds

Tylenol #3 1/11 po q4° prn pain	1/1 PO 21 Aug 2145 0605 20 Aug 1/11 PO [redacted] [redacted] (b)(6)-2
MSO4 2mg IVP q1° prn break-through pain	(b)(6)-2
Phenergan 25mg IV q6° prn nausea	

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. 8 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS FREQUENCY, TIME	HR	DATE COMPLETED 19	20	21	22	23	24	25	26	27
19Aug	[redacted] (b)(6)-2	VS routine	05	/	[redacted]							
			13	/								
			21									
19Aug	[redacted] (b)(6)-2	Up crutches, NWB	05	/	[redacted]							
			13									
			21									
19Aug	[redacted] (b)(6)-2	PT for gaiting	08	/	[redacted]							
			20									
19Aug	[redacted] (b)(6)-2	Regular diet	06	/	[redacted]							
			12	/								
			17									
19Aug	[redacted] (b)(6)-2	TS at bedside	05	/	[redacted]							
			13									
			21									

all (b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P neck exploration

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION: CPU [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

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

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo Aug Yr 2003

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
19Aug	(b)(6)-2 [redacted]	Admit to ICW 2	19Aug		1730	[redacted] (b)(6)-2
19Aug	(b)(6)-2 [redacted]	DSG Δ 48°	21Aug 08			[redacted] (b)(6)-2
22Aug	(b)(6)-2 [redacted]	PT for crutch training today	23 Aug			[redacted] (b)(6)-2
23 Aug	(b)(6)-2 [redacted]	D/C to EPW Camp today	23 Aug			

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

USAPA V1.00

MEDICAL RECORD-SUPPLEMENTAL MEDICAL ... A

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

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

OTSG APPROVED (Date)

Date: 17 Aug 07
Time In: 0055
Allergies: NKDA
Pre-op V/S:
Procedures:

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

OR Intake: Crystalloid 1500 Colloid
OR Output: UOP EBL
Meds/Times: see OR Flowsheet

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds

History

Time	0000	0600	0610	0625	0640	0700	0800
SaO2				100	100	94	
FiO2				[illegible]	RL		
Methods				NRB	NRBR		
240							
220							
200							
180							
160							
140	v						
120		v	v	v	v	v	
100							
80	•	•	•			•	
60	^	^	^	^	^	^	
40							
20							
SPO2	98	100	100	100			
RR	25	15	22	16	16	15	
T	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
Time	0640						
Pain (0-10)	10						
LOS							

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

Pacu Intake

Time	Solution	Amount	Site	[redacted]	Infused
0705	LR	800	[illegible]	[redacted]	200
				(b)(6)-2	

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	1	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	2		
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.		10	10

Codes

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

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

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

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

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC

DATE

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

Name — last,

[redacted] EPW

(b)(6)-4

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

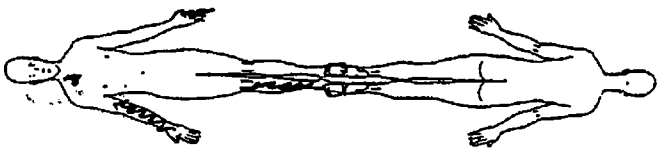
MEDICATIONS						
Allergies:						
Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
0555	?	see flowsheet				

NEUROVASCULAR							
Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	Rt arm	limited			≤3	warm	NPR
15'							
30'	Rt arm	limited	+	P	<3sec	warm	P
45'	Rt arm	limited	+	P	<3sec	warm	P
60'	Rt arm	limited	+	P	<3sec	warm	P
90'							
D/C	Rt arm	limited	+	P	<3sec	warm	P

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

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

DRESSINGS			
Time	Location	Type	Drainage
Adm			
30'	Rt arm	gauze	Ø
60'	no Δ	no Δ	no Δ
D/C	no Δ	no Δ	no Δ



PACU OUTPUT			
Time	Source	Color/Appearance	Amount
0700	foley	clear/yellow	225

CARDIAC RHYTHM			
Time	Rhythm	Symptomatic?	Rhythm Strip Run?
0630	SR	Ø	Ø

WAMC OP 173-E

NURSING NOTES

See progress note
0700 - Received report on pt @ 0625. Pt laying in bed w/ eyes closed & non-rebreather on. VSS. Arouses easily. Ask pt if he had pain and shook head - no. Neurovascular checks good. Able to ~~feet~~ move all extremities, cap refill <3sec, all extremities, and sensation intact. Foley in place. IVF infusing (b)(6)-2 [redacted] USTAN
0705 - Pt stable. Will be staying on unit. See DA Form 4700 for further data. [redacted] USTAN (b)(6)-2

Discharge Criteria:
Date: 17Aug03 Time: 0705 PARS: 10
BP: 128/75 T: 99.1 HR: 83 RR: 15 SaO2: 94%
Pain Level at D/C (0-10):
Intake: 200 Output: 225
Additional Data:
Transferred To: stay on unit
Report Given To:
Transferred Via: W/C Litter Gurney Ambulance
Transferred By:
Cleared IAW Recovery Room SOP R-3 (b)(6)-2
Charge Nurse Signature: [redacted] USTAN

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

ASO

OTSG APPROVED (Date)

Date: 19 Aug 03
Time In: 1615
Allergies: NKDA
Pre-op V/S: 122/00 85
Procedures: I+D Great RLE

Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
80kg
OR Intake: Crystalloid 300 Colloid
OR Output: UOP 100cc EBL 750cc
Meds/Times: Mg 4 SO4 3g; versed 5mg Retrobulbar

Drains: Hemovac, NG, JP, T-tube, Foley D/C'd, TLS

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds

History

Time	1615	1800	
SaO2	99	94	
FiO2	NA		
Methods	FA	RA	
240			
220			
200			
180			
160			
140			
120			
100			
80			
60			
40			
20			
RR	14	16	
T	98	98	

Time									
Pain (0-10)									
LOS									

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	2	
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse			
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	9	10	

Codes

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

V/S
X = A-line BP
˚ = Cuff BP
= Pulse

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

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

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

(Continue on reverse)

PREPARED BY (Signature & Title) | DEPARTMENT/SERVICE/CLINIC | DATE

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

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

MEDICATIONS

Allergies:

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

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm							
15'							
30'							
45'							
60'							
90'							
D/C							

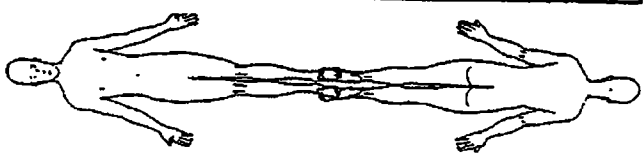
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm			
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

1615 pt admitted to unit via litter. Sleepy but arousable. full leg cast on (R) leg cap refill < 3 sec pulse ox on (R) toe c̄ out of 96 consistently c̄ finger pulse waveform present Pt on face mask @ 10 L. Pt able to move toes bilaterally on command. Occlusive dsg to (R) neck on clavicle. Occlusive dsg to (R) arm occlusive dsg on 2nd digit of 2nd finger on (R) hand. Multiple wound on axis and torso open to air + healing 1700 condition stable for discharge from RR

Discharge Criteria:
Date: 19 Aug 03 **Time:** 1717 **PARS:** 10
BP: 136/78 **T:** 98 **HR:** 94 **RR:** 16 **SaO2:** 98
Pain Level at D/C (0-10):
Intake: _____ **Output:** _____
Additional Data: _____
Transferred To: ICW 2
Report Given To: ICW 2
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: [redacted] (b)(6)-2
Cleared IAW Recovery Room SOP B-[redacted]
Charge Nurse Signature: [redacted] (b)(6)-2

P AL RECORD-SUPPLEMENTAL MEDICA 'A

For use of thi n, see AR 40-66; the proponent agency is the Office of geon General.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA APPR 08MAR8

INITIAL SHIFT ASSESSMENT			
		Time: 0730 Initals: [redacted] (b)(6)-2	Time: Initals:
NEURO	Pupils	PERRLA	
	Sensorium	expresses needs appropriately	
	LOC / GCS	Ø c/o pain	
		MAE, able to move ⓓ toes	
CARDIAC	Cardiac Rhythm	SR NSR ↓ ectopy	
	PRI: / QRS:	+2 pulses x' VO ↓	
	Pulse Strength		
	Cap Refil / JVD	Ø edema noted ↑ on	
	Edema	sharpnel wounds	
	Chest Pain		
RESP	Respiratory Pattern	CTA bilaterally	
	Breath Sounds	even unlabored breathing	
	Secretions		
	Cough		
SKIN	Color	– dressing on ⓓ neck CDI	
	Integrity	– ⓓ hand dressing CDI	
	Backside	– ⓓ leg dressing CDI	
		– multiple sharpnel wounds throughout body	
IV	Access Devices	ⓓ AC PIV	
	Location	ⓓ hand PIV	
	Condition		
GI	Abdomen	+ BS X ↓ guard	
	Bowel Sounds	flat, NT, ND	
	Stoma/Ostomy		
GU	Device	foley to gravity	
	Color / Clarity	dark yellow	

(Continue on reverse)

P[redacted] *e & Title)*	DEPARTMENT/SERVICE/CLINIC	DATE
[redacted] (b)(6)-2	ICU3, [redacted]	19 Aug 03

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

[redacted]

(b)(6)-4

(b)(2)-2

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

DA FORM 4700, MAY 78

USAPPC V2.00

ICU3 Patients Name: [redacted] (b)(6)-4 Date: 19 Aug 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line	102						99																			
NBP	70						52																			
TEMP	99						98.9																			
HR	85						96																			
RR	18						20																			
SaO2	97						96																			
FiO2	RA						RA																			
Source																										
MAP																										

NTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
PB																										
GT																										
PO		240																								
Total																										

TPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	
URINE					300																					
N																										
STOOL																										
DRAIN																										
Total																										

MEDCOM - 17511

F ORD-SUPPLEMENTAL MEDICA TA

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 08MAR8

INITIAL SHIFT ASSESSMENT

		Time: 0620 Initals: [redacted] (b)(6)-2	Time: 1400 Initals [redacted] (b)(6)-2
NEURO	Pupils	Perrl 3mm, Alert. Moves all extremities	PERRLA
	Sensorium	Sensation intact. No problems swallowing	Intact.
	LOC / GCS	(R)leg in hard splint. (R)arm splinted. c̄ limited rom. Little pain. Tc mumb.	Awake & alert. GCS 15
CARDIAC	Cardiac Rhythm	Regular S1S2. Ø murmur. Radial	NSR
	PRI: / QRS:	pulses 3+ (D)pedal 3+. Cap refill <3sec	—
	Pulse Strength	all extremities. Trace edema (R)foot.	normal pulses — (+)2 Unable
	Cap Refil / JVD	ØCL, Ø JVD	to assess RLE pulse. RLE & RLE
	Edema		warm to touch. Cap refill <2sec
	Chest Pain	(R)arm (unit) restrained & (D)ankle restrained	full sensation
		c̄ Kerlix, (EPW)	
RESP	Respiratory Pattern	Regular, even, unlabored. Clear	normal on RA
	Breath Sounds	all lung fields ↓ in bases. Strong	LCTA (B)
	Secretions	cough. Able to clear secretions.	Ø
	Cough		Ø
SKIN	Color	WNL. Warm, dry. Staples wounds	WFR
	Integrity	to chest. Dried blood. Bandage to (R) supra-	Stapled lesions to ant. chest.
	Backside	clavicular area & (D)ponter finger. Arm bandage	intact c̄ scratch marks
		(R)leg splinted.	due to pruritus
IV	Access Devices	(D)wrist 18g SL. (D)AC 18g SL. Ø s/s	(L)wrist & (L) ac PIV's 18G
	Location	of infection dressing intact.	↓
	Condition	flush c̄ resistance	C, D, I
GI	Abdomen	Soft, non-distended. ABS x4.	soft nontender
	Bowel Sounds	Ø BM. Tender RUQ. Nontender	BS present x 4
	Stoma/Ostomy	LLQ, LLQ, RLQ	Ø
GU	Device	Foley to DD. Clear yellow urine	Foley to gravity.
	Color / Clarity	Secured to leg. Ø drainage c̄ insertion	Clear yellow adequate
		site.	output

(Continue on reverse)

PRE[redacted]nature & Title) [redacted]LT/AN (b)(6)-2

DEPARTMENT/SERVICE/CLINIC ICU3, [redacted]

DATE 18Aug03

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

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

(b)(2)-2

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

DA FORM 4700, MAY 78

USAPPC V2.00

ICU3

Patients Name: EPW [redacted] (b)(6)-4 Date: 18 Aug 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP	121/60					114/70				120/68								100/70				112/68				
TEMP	98.8					98.7				99.7								99.8				98.8				
HR	84					72				80								78				70				
RR	16					16				15								16				16				
SaO2	95					98%				95%								95%				94				
FiO2	—					—				—								—				—				
S[redacted]e	RA					RA				RA								RA				RA				
I[redacted]	—					89				88								—								
[redacted]																										
[redacted]																										
[redacted]																										
[redacted]																										

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Tot
IVF																										
IVPB			50								50	100														
NGT																										
F[redacted]		120					240					360														
[redacted]otal																										

O[redacted]UT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
U[redacted]E	225					350						550	1125					200				[redacted]	[redacted]	150		350
N[redacted]																							(b)(6)-2			
STOOL																										
DRAIN																										
Total																										

MEDCOM - 17513

M / CORD-SUPPLEMENTAL MEDICA

For use of t ...n, see AR 40-66; the proponent agency is the Office of). ...geon General.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA APPR 08MAR8

INITIAL SHIFT ASSESSMENT

		Time: 0900 Initals [redacted] (b)(6)-2	Time: 1400 Initals: [redacted] (b)(6)-2
NEURO	Pupils Sensorium LOC / GCS	3mm, PERRL. Alert. Obeys commands. Speaks little english. Sensation intact all extremities. Swallows difficulty. (R) arm, (R) leg in splints.	Perrla A+O x2. Obeys commands. sensorium intact. GCS 15
CARDIAC	Cardiac Rhythm PRI: / QRS: Pulse Strength Cap Refil / JVD Edema Chest Pain	SR ectopy. S1 S2. Pulses 3+ (R radial, (L) radial, (L) pedal). Caprefill <3 sec all extremities. Ø JVD. Trace edema (R) leg & arm & around shrapnel wounds. Ø CP.	NSR S1 S2 Ø normal pulse (2) <3 all extremities mild (injured extremities) Ø
RESP	Respiratory Pattern Breath Sounds Secretions Cough	Regular, even, unlabored. Clear all lung fields. RA sats >94%. Ø cough	normal on RA CTA (B) Ø Ø
SKIN	Color Integrity Backside	WNL, splint & ace wrap to (R) arm & leg. bandage & drainage to (R) supraclavicular area. bandage to (L) pointer finger & drainage minimal. Small shrapnel wounds to chest & ecchymosis.	NFK wounds to (R) UE & (R) LE Intact.
IV	Access Devices Location Condition	18g to (L) wrist infusing LR KVO. 18g to (L) AC infusing D5 @ 125cc/hr. Both & s/s of infection. Dressing intact.	(L) wrist 18 G, (L) AC 18 G ↓ C, D, I.
GI	Abdomen Bowel Sounds Stoma/Ostomy	Soft, nontender ABS x4. No BM this AM. Haven't eaten since surgery.	Soft nontender x4 quadrants Ø
GU	Device Color / Clarity	Foley to DD clear yellow urine tube secured to leg.	

PREPARE[redacted] re & Title) (b)(6)-2 | DEPARTMENT/SERVICE/CLINIC ICU3 [redacted] | DATE 17Aug03

(Continue on reverse)

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

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

(b)(2)-2

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

DA FORM 4700, MAY 78

USAPPC V2.00

ICU Flowsheet Patient Name: Date: 08 / 17 / 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									98.8	98.7	99.1			99.6	99.3	99.4					99.9			99.2		
Pulse									80	78	82			82	78	71					78			76		
B/P A-Line																										
MAP									88	97	91			85	82	99								87		
B/P Cuff									114/70	130/71	119/73			113/68	110/64	122/83					122/66			114/63		
Respirations									14	16	14			16	12	13					13			14		
Sa02									95%	96%	97%			97%	97%	96%					95%			95%		
																					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
									125	75	125	125		125	125	125										
B										50																
intake										20				240												
t. IN							1500																			
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									325	125 / 450	125 / 575	275 / 850		175 / 1025	100 / 1125									750		
NG Tube																										
Drains #1																										
#2																										
#3																										
Emesis/Stool																										
O.R. OUT																										
Totals																										

24 hour input	
24 hour output	
24 hour balance	

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

MEDCOM - 17515

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RECORD-SUPPLEMENTAL MEDICA

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 08MAR8

INITIAL SHIFT ASSESSMENT

		Time: 0300 Initals [redacted] (b)(6)-2	Time: Initals:
NEURO	Pupils	PERRL	
	Sensorium	A&O x3	
	LOC / GCS	pt Follows commands purposefull movement	
CARDIAC	Cardiac Rhythm	HR-72 BP- 112/63	
	PRI: / QRS:		
	Pulse Strength	Pulse present & strong x4	
	Cap Refil / JVD	Cap Refill ≤3 sec Ø JVD	
	Edema	Swelling to shrapnel sites	
	Chest Pain	Ø chest pain Pt Denies	
RESP	Respiratory Pattern	Regular RR-22 SPO2 95% RA	
	Breath Sounds	CTA (B)	
	Secretions	Ø Secretions Ø cough	
	Cough		
SKIN	Color	normal for Race	
	Integrity	shrapnel wounds throughout body	
	Backside	no breakdown	
IV	Access Devices	IV in (R) AC NS @ [illegible] cc/hr	
	Location	IV in (L) wrist LR @ TKO	
	Condition	both patent ~ infection/infiltrate	
GI	Abdomen	Soft Flat nontender nondistended	
	Bowel Sounds	Bowel sound necmoactive x4	
	Stoma/Ostomy	Ø ostomy Ø stoma	
GU	Device	Foley to gravity	
	Color / Clarity	clear yellow no sediment	

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC: ICU3, [redacted]

DATE: 07 Aug 03

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

[redacted] EPW

(b)(6)-4

(b)(2)-2

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

DA FORM 4700, MAY 78

USAPPC V2.00

ICU3

Patients Name: EPJ [redacted] (b)(6)-4 Date: 17 Aug 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP																							112/63			
TEMP																										
HR																							83			
RR																							19			
SaO2																							96%			
FiO2																										
S[redacted]e																							RA			
I[redacted]																							82			

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	To
IVF																							125			
IVPB																										
NGT																										
F[redacted]																										
[redacted]tal																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE																							450			
NGT																										
STOOL																										
DRAIN																										
Total																										

MEDCOM - 17517

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.)
A	

3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
[redacted] (b)(6)-4	EPW # [redacted] (b)(6)-4	EPW	M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
	44	Z	Z	UNK

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
		99 (b)(6)-4	[redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	Z	0149	

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

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

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

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
[redacted] (b)(2)-2	UNK	UNK

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
05		030823

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
		030817

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

FOR LOCAL USE

DX: s/p neck exploration, RUE

Dx: 82390
8749
8831
E9919

Pr: 7966
8345

Inj Trauma
443 1

ADMITTING OFFICER (Signature, a[redacted]d)	SIGNATURE OF ADMITTING CLERK
Dr [redacted] (b)(6)-2 [redacted] (b)(6)-2	[redacted] (b)(6)-2

DA FORM 2085 M[redacted]

PATIENT'S CLEARANCE RECORD

For use of this form, see AR 40-2; the proponent agency is OTSG

DATE OF DISCHARGE: 25Aug03	TIME OF DISCHARGE: 1300

#[redacted]

(b)(6)-4

SIGNATURE OF WARD OFFICER

[redacted]

(b)(6)-2

PATIENT'S IDENTIFICATION

ACTIVITY CLEARANCE

(The final activity with which the patient must clear will be the disposition office.)

Military	INITIALS*	Non-military	INITIALS*
1. Patient's Trust Fund		1. Patient's Trust Fund	
2. Medical Services Account Officer		2. Medical Services Account Officer	
3. Clothing and Baggage		3. Clothing and Baggage	
4. Medical Holding Unit		4. Postal Service	
a. Supply		5. Change of Address	
b. Pay Section		6. Other *(Specify)*	
c. Service Records		7.	
d. Insurance and Allotments		8.	
5. Postal Service		9.	
6. Change of Address		10.	
7. Other *(Specify)*		11.	
8.		12.	
9.		13.	

REMARKS

DATE: 25 Aug 03	SIGNA[redacted]

* INITIALS OF PERSON AUTHORIZING CLEARANCE.

(b)(6)-2

DA FORM 4029, MAR 73 REPLACES DA FORM 6-258, 1 DEC 59, WHICH WILL BE USED USAPPC V1.00

INPATIENT TREATMENT RECORD COVER SHEET

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

(b)(6)-4

1. REGISTER NUMBER	2. NAME (Last, First, MI)	3. GRADE	ADMISSION REMARKS
[redacted]	EPW [redacted] (b)(6)-4	N/A	

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	35y	Z	unk	N/A	N/A	No

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
99 20	(b)(6)-4 [redacted]	N/A	1(4)2

15. FLYING STATUS	16. RATING/DSG	BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
N/A		~~K79~~ K78	N/A		N/A

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
Direct from ER	0215	AEAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
—	50	30 Aug 03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
—	—	17 Aug 03	(b)(6)-2 Dr. [redacted]

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

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

S/P I&D (R) leg + (L) FA

Trauma 1

Inj 449

Dx 87352
87330
87359
E9919

PR 2181
8659

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
Ø	Ø	Ø	Ø	14	14

36. Total Days All Facilities

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
Ø	Ø	Ø	Ø	14	14

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAO OR MEDICAL RECORDS OFFICER
[redacted] (b)(6)-2	For [redacted] (b)(6)-2

DA FORM 3647, MAY 79 (b)(6)-2

MEDCOM - 17520

USAPPC V1.10

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

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

[illegible] WD/WD S/P. [illegible]

[illegible]

[illegible]

PHYSICAL EXAMINATION

[illegible] SCALP WD/WD S

(L) [illegible] WD/WD

(R) CLAP WD. CONJUNCTIVAE [illegible]
GOOD PULSES. [illegible]

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

(b)(6)-2

SIGNATURE	DATE	IDENTIFICATION NO.	ORGANIZATION
[redacted]	18 AUG 05		

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

[redacted]

REGISTER NO.	WARD NO.

(b)(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539
GENERAL SERVICES ADMINISTRATION AND INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975 539-106

[redacted]

(b)(6)-4

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17 AUG 03 @ 0154	OMFS Brief OP NOTE
	Pre OP dx: facial lacs s/p mortar round attack
	Post op dx: Same
	Procedure: Closure of facial lacs
	Surg: (b)(6)-2 [redacted]
	Anesth: min
	Comp: Ø
	Anesth: GETA
	Cond: Stable
	findings: multiple shrapnel wounds c̄ Right nasal laceration, left temporal + left frontal lac.
	and remained under general anesth for completion of Ortho SL.
	(b)(6)-2 [redacted] MAJ/DC OMFS
17 AUG 03 0218	Ortho Op Note
	Pre: Op Dx (1) Multiple fragmentation wounds
	~~Post Op~~ (2) (R) leg compartment syndrome
	(3) (L) volar forearm compartment syndrome
	Post Op Dx - Same
	Procedure: (1) I+D of wounds
	(2) (R) leg 4 compartment fasciotomy with

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

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

[redacted]
(b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1 USAPA V2.00

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	ligation of popliteal vein.
	(3) (L) volar forearm fasciotomy
	Surgeon: [redacted] (b)(6)-2
	EBL - 300 FLUIDS - 2000 crystalloids
	Findings - Popliteal vein injury, ligated. 4 compartment fasciotomy with good results. Volar forearm fasciotomy with good results
	PLAN: DPC in 48 hours.
	[redacted] (b)(6)-2
	Brief Op Note
FEB 03	Pre Op Dx: open wound (R) leg, (L) forearm post fasciotomy, (L) thigh abscess
	Post Op Dx: same
	Procedure: I&D & DPC (R) leg (L) forearm, (L) thigh
	Surgeon: Olwerio
	Ens: 4
	Tourn: 500cc
	Cx: 4
	Post op plan: drain D's [redacted] (b)(6)-2
	1

STANDARD FORM 600 (REV. 6-97) BACK

USAPA V2.00

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
17AUG03 0230	pt arrived to ICU2 for Recovery. monitors applied. S/P I+D of (L) forearm bond, + (R) lower extremity. Neuro: A+O. (R) p.p.l. 2mm reactive c̄ scleral edema (L) eye pupil 2mm reactive, CV capillary refill <3sec x 4 distal extremities S1 S2 present. Resp 18 on RA c̄ sats 96% lungs clear in uppers diminished in bases. GI: BS(+) 4quads. GU: foley to gravity c̄ QS clear yellow urine. Lines 2 PIVs upper (R) extremity. VSS. [redacted] (b)(6)-2

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

	0253	0238	0248	0258	0315	0330	0400
HR	118	99	87	98	68	64	61
B/P	115/76	125/72	129/62	122/80	103/58	100/56	
RR	18	16	18	21	20	20	21
SATS	100	99	96	99	97	96	97
MODE	FM	FM	RA	RA	RA	RA	RA
Temp	95.6		97.6				97.8
UOP		50/50					200/250

STANDARD FORM 600 (REV. 6-97) BACK

*U.S. GPO: 2002 - 491-600/50618

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*	
17AUG03	DATE 17AUG INITIALS [redacted] (b)(6)-2	DATE 17AUG03 INITIALS [redacted] (b)(6)-2
0600	pt awake. Follows commands. Lungs clear @ bedside. RR even at unlabored currently on RAC SpO2 @ 99% — SES auscultated & BS noted on monitor. Ø ectopy beats noted. HR NSR. Abd soft, nondistended, + BS x 4. F/C/S BSO patent c yellow urine noted. (R) arm from elbow down to fingers c/o numbness on Ø drainage noted (R) leg from knee down to foot c/o numbness on dorsal surface of (R) shoulder	pt Alert. VSS. MAE. follows simple commands. pupils 3mm brisk. (R) eye echymosis to lid and sclera edema. CV: S1 S2 present 2⊕ pulses x4 quads. Ø edema noted. capillary refill <3sec x4 distal extremities. Resp: even & unlabored. c̄ sats 96-98% RR 18-22. Lungs CTA. GI: BS ⊕ x4 quads tol clear liquids. Ø emesis this shift. GU: Foley to gravity draining QS clear yellow urine. lines: (R) forearm flushes well. Ø s/s infection. Integ: warm + dry dsg's to (L) arm + (R) Leg. will continue to monitor. (b)(6)-2 [redacted] CPT/AN

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
Bethesda	[redacted]		
SPONSOR'S NAME	**SSN/ID** [redacted] (b)(6)-2	**RELATIONSHIP TO SPONSOR**	

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

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

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

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

DATE			SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*																
	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22
B/P	97/60	100/60	109/68	111/60	112/64	127/71	117/61	110/54	116/54	112/62	112/62	101/55	118/56	110/60		115/60		117/57
HR	71	67	57	56	63	63	76	94	93	94	93	96	95	92		76		81
RR	18	18	18	19	16	17	18	20	17	20	16	18	19	14		19		20
SAT	99	99	97	96	98	95	99	100	95	96	95	96	97	97		98		98
O_2																		
MODE	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA		RA		RA
Temp	98.8									100						99.2		
IN's																		
PO				5ips					5ips				340			15ips		5ips
OUT's																		
Foley						600		270		350		150		130		250		300

STANDARD FORM 600 (REV. 6-97) BACK

*U.S. GPO: 2002 - 491-600/50618

MEDICAL RECORD | **PROGRESS NOTES**

AUTHORIZED FOR LOCAL REPRODUCTIO

DATE	NOTES
17Aug03	0600 SEE TSG-2 Gloucester for initial assessment. (b)(6)-2 [redacted]
	0640 Cleansed body of old dried blood.
	0800 2mg MSO4 given IV. (b)(6)-2 [redacted]
	0830 VSS. Afebrile. (b)(6)-2 [redacted]
	0830 Dan doctor to pick up pt c/o pain. Dressing removed, (b)(6)-2 [redacted]
	1600 cl. liquid diet, tolerated well. [redacted] (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

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]

17Aug03

PROGRESS NOTES
Medical Record

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

DATE	NOTES
	OR/PACU staff
13AUG03	Wounds doing well
	Clear dry
	DPC tomorrow (b)(6)-2 [redacted]
24AUG03 0959	Ortho Op Note
	Pre-Op Dx - Comminuted Lysfranc (R) dislocation
	Post-Op Dx - Same
	Procedure - DPC (R) fasciotomy wounds
	Surgeon - [redacted] (b)(6)-2
	Anesthesia -
	Findings - Medial incision closed without difficulty. Lateral incision closed with additional sutures.
	Plan - Wound care.
	[redacted] (b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
18AUG03	[illegible] see TIU-2 Flowsheet for initial assessment (b)(6)-2 [redacted]
	0830 update given to Dr. [redacted] (b)(6)-2
	orders received (b)(6)-2 [redacted]
	1050 MSO4 5mg IVP given w/ c/o [illegible]
	(b)(6)-2
	1340 Dr. [redacted] bedside, speaks c/o [illegible] TED [illegible]
	[illegible] NPO p MN (b)(6)-2 [redacted]
2020	A+O, follows commands. $S_1 S_2$ Ø murmur, (R) hand + (L) foot cap refill < 3 sec, MAE, pulses 2+ (R) UE + (L) LE PIV (R) hand patent Ø S/Sx infection. LSCTA resp reg unlabored. VSS. (+) BS x 4 quads. Foley drng cl yellow sufficient amts. Tylenol for c/o headache given c̄ good effect. Dsg to (L) arm CDI, (R) LE elevated c̄ dsg noted to have mod amt serosanguinous drng. Will monitor. (b)(6)-2 [redacted] ICTAN
19AUG03 0400	Pt sleeping - VSS. Plan for I+D of (R) LE in AM. NPO since midnight. Will monitor. [redacted] ICTAN (b)(6)-2

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

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

[redacted]

(b)(6)-4

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

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
19-Aug-03 1015	Pt recovered, had I+D of (L) upper extremity and (R) LE. Pt Alert verbal c translator, resp even non-labored. Lungs CTA (B), (-) cough Ø secretions, Pulses LUE + RUE +2 RUE + LUE +3, NSR 5 ectopy, saline lock in (R) hand. ABD-NT, ND BS x4, Foley d/c'd, had 100 cc clear yellow urine remaining. Dressings to (L) shoulder (L) thigh and LUE + RLE CDI. (R) LE T. will monitor. VS 122/71-87-14-98.4-95% SpO2 on RA. [redacted] SSG [redacted] (b)(6)-2
19 aug 03	assumed care @ 1030. pt awake lying in supine position. Does not speak English but able to follow commands. Requested something for headache 30 minutes ago and medicated by SSG [redacted]. HOB ↑ 45°. See initial assessment on DAF 4700. Encouraged to use incentive spirometry. Able to raise all three balls and hold for 1 min x10 times. Brushed teeth. No signs of distress or agitation noted. (R) leg drsg dry & intact. ↑ edema to (R) foot warm to touch compared to (L) foot. Tender to light palpation. [redacted]
19 aug 03 11 30	Complete bath given. DOB to chair. pt able to stand c (L) foot. [redacted] (b)(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP [redacted] (b)(6)-2

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

[redacted]
(b)(6)-4

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
19 Aug 03	sitting in a chair. Bacitracin applied to (R) nose bridge to cantus of eye. no sign of infection noted @ this time. no resp distress noted. Breathing - unlabored. RR 14 SaO2 100%
1345	in RA. pt requesting to get back into bed. pt able to brace and support self back into a bed. no other s noted [redacted]
1600	Flushed (R) hand heplock. Ancef ÷ gm IVPB infusing over 30'. pt c/o (R) foot & swelling ↑ (R) leg to ↓ swelling. no other discomfort. pt resting quietly. Lungs remain CTA bilaterally. SaO2 100% [redacted] (b)(6)-2
1720	ordered to Transfer pt ICW 2. pt to be transferred via litter to ICW2. VS, HR 104, BP 105/55, RR 14 SaO2 97% [redacted] MAJ AW (b)(6)-2
1730	Admitted from ICW2 in stable condition. Lungs CTA bilat, Ø resp distress. NSR. Abd soft non-tender, bowel sounds active x 4 quads. Dsg to (L) Arm & (R) leg CDI. Ø complaints [redacted] ICW/AW (b)(6)-2
19 Aug 2312	Care assumed @ 2100. VSS, AOx3, c/o T3 given for pain @ 2200. Lung sounds CTA, pulses (+), bilat pt c̄ dsg on l/e CDI, (+) pulse and ability to wiggle fingers on r/e. Dsg on R/e CDI, (+) pulse and able to wiggle toes, R foot ~~is~~ has edema. PA on IV ABX, HL flushes well. Will continue to monitor. [redacted] (b)(6)-2

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
20 Aug 03 0040	Pt. awake & alert c̄ HCB @ 75°. HR Regular, lung sounds clear bilat, bowel sounds (+) x 4 quads. VSS. HL in (R) hand c̄ s/s of infection. Ace wrap to (R) calf CDI, pedal pulse palpable, (+) sensation, full ROM in digits, limited ROM in ankle, <3sec cap refill. Ace wrap to (L) FA CDI, cap refill <3sec full ROM of digits, limited ROM of wrist (+) sensation. DSG to (L) shoulder CDI. 3 sutures to bridge of nose intact, site c̄ s/s of infection. Pt. c̄ complaints @ this time. Will continue to monitor. [redacted] 24/ (b)(6)-2
8/20/03	Staff arrived Story clear Begin med tx in tomorrow. [illegible] [redacted] (b)(6)-2
20 aug 03 1330	Pt awake and alert. Lungs CTA bilat, c̄ resp distress. NSR. Abd soft, non-tender, bowel sounds active x 4 quads. Dsgs to (L) arm and (R) leg CDI. Strong pulses and brisk cap refill x 4 extremities. Pt c̄ complaint of h/a, given Tyl- [redacted] 1K/10 (b)(6)-2
2315	Care assumed @ 2100. VSS, A+Ox3, c/o slight pain in RLE, m medicine requested. Lung sounds CTA,

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. 1CW2

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

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
	pulses (+) x4, bs active x4 Quadrants. Dsg on rle CDI, (+) pulse and sensation in (R) foot. Dsg on fa CDI, pt able to wiggle fingers and has (+) pulse. Dsg on (L) thigh CDI. PTS complaints at this time, will continue to monitor. (b)(6)-2 [redacted] allumo
21 Aug 03 0740	assumed care @ 0600 - VSS - no c/o pain @ this time - dsg intact on (L) FA & (R) calf - neuro's WNL in (L) hand & (R) foot, (+) movement, (+) sensation - SL patent in (R) AC - [redacted] (b)(6)-2
21 Aug 03 1500	Received pt via litter from A/E. Pt alert + oriented. Dressing Dsd to (L) FA, (L) thigh. (R) knee lg (b)(6)-2 [redacted]
21 Aug 03 0200	Assumed care @ 1900; All VSS, pt A+O, NVV WNL (+) movement & sensation; drsg to (L) FA & (R) LE CDI w/ drng; S1 S2, (+) pulses x4, LS CTA (R) equal & unlabored; (+) BS x4, abd soft non-tender, pt voiding QS, clear yellow urine via urinal; c/o pain/discomfort @ this time; cont to monitor [redacted] (b)(6)-2
21 Aug 03 0800	1000 A+O. VSS. Restraints removed & repositioned to (R) arm & (L) foot. Neurovascs WNL to all extremities. Lungs clear. BS (+) x 4 quadrants. Abd soft non distended. Voiding clear yellow urine. Tolerating regular diet. Dressings intact to (L) FA incision & drains noted. 0.5cm opening medial of incision packing removed & replaced secondary to drainage on old packing. (R) thigh incision c staples intact with 0.5cm opening medial incision. (R) knee lg with orange tubing in place & intact aligned with staples intact around edges. (L) thigh 2.5cm wound closed c NS & steri-strips. All dsgs Dsd as ordered

FPI. LEX. Printed on Recycled Paper

STANDARD FORM [redacted] (6-97) BACK

[redacted]

(b)(6)-2

510-112

NSN 7540-00-634-4123

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated.
22 Aug 03		2100	Assumed care @ 1900; All VSS; pt A&O X3, NV ✓ WNL to all extremities, ⊕ movements/sensation; S, S2, ⊕ pulses x4 c̄ brisk cap Ref; LS CTA ⓑ; ⊕ BS X4, abd soft non-tender, pt voiding QS, clear yellow urine via urinal; All dsgs CDI ⊖ for drng; sutures to frontal & ⓛ parietal region removed, along c̄ sutures along the bridge of nose ~~c̄ complication~~; ~~D~~ c/o pain or discomfort ⊖ this time; cont monitor — (b)(6)-2 [redacted]
		2300	I concur c̄ above assessment. [redacted] (b)(6)-2
23 Aug	1000		Dr [redacted] (b)(6)-2 changed drsg to ⓡ lower arm and ⓡ lower leg. Drsg changed to ⓛ thigh and ⓛ shoulder. Tylenol 650 mg given for HA. Continues PO clindamycin and tolerating well. Restraints removed and reapplied. Will check restraints frequently. Will continue to monitor [redacted] (b)(6)-2
23 Aug 03		2010	Assumed care @ 1900; All VSS; ⊕ movements & sensation, pt neurologically intact; S, S2, LS CTA ⓑ; ⊕ BS X4, pt voiding QS, clear yellow urine via urinal; all dsgs CDI, ⊖ for drng; ~~II~~ percs given for pain c̄ good relief; cont monitor [redacted] (b)(6)-2
23 Aug 03		2050	Restraints to ⓑ UE & ⓛ LE in place & comp'l c̄ cautions; brisk cap Ref to all extremities; cont monitor [redacted] (b)(6)-2
		2300	I concur c̄ above assessment. [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) [redacted]

(b)(6)-4

REGISTER NO.

WARD NO.

NURSING NOTES

Medical Record

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

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
24AUG03	1050		Return from PACU via litter. VSS AAO. (R) FA IV patent & intact infusing LR @ 125cc/hr. Drsg to (R) [illegible] leg dry & intact. Remains clear BSD x4. Restraints reapplied. Will check extremities frequently. Peripheral pulses palpable. Drsg to (L) FA / (L) thigh changed as ordered - also (L) shoulder. Will continue to monitor — [redacted] 2 CTA (b)(6)-2
24Aug03		1930	Assumed care @ 1800; All VSS, pt AAOX3, NVV WNL (+) movement & sensation in all extremities; S, S2, (+) pulses x4 & brisk cap ref; LS CTA (B); (+) BS x4; SL patent & intact; all drsgs CDI & dry; restraints intact & complication, brisk cap ref in those extremities; Cont to monitor — [redacted] (b)(6)-2
25AUG03	1100		Assumed care of pt @ 0000 p report from night shift. Pt alert, speaking Arabic. VSS. Pt medicated c̄ II Perc this am for pain c̄ good relief. Wet → dry dressings on (L) UE and (R) LE Δd this am. Drsgs on (L) thigh and shoulder also Δd. All wound sites s̄ S/Sx infection. Pt moves all extremities well. Cap refill < 2 secs. Voiding s̄ difficulty. Tol reg diet well. 2 point restraints in place. Will cont to monitor [redacted] (b)(6)-2 WA
25Aug03		1900	Assumed care @ 1900; VSS, NVV intact, (+) movement & sensation, in all extremities, drsg CDI s̄ drainage; ∅ S/Sx infection, Tol. Reg diet, voiding ∅ s̄ difficulty; 2 point restraints intact brisk cap ref; Cont to monitor — [redacted]

*U.S. Government Printing Office: 1995 - 404-763/20[illegible]

STANDA[redacted]EV. 7-91) BACK (b)(6)-2

MEDICAL RECORD	PROGRESS NOTES
DATE	
28 Aug 03	Pt received awake, alert, S_1 S_2 noted c̄ peripheral pulses ⊕, lungs CTA
0830	bilat, ⊕ bowel sounds, pt voiding Q.S. Drsg Δ to ⓡ shoulder, ⓡ FA, ⓡ thigh,
	ⓡ LE all 3, s/s infx. will cont. to monitor. [redacted] (b)(6)-2 [redacted]
28 Aug 03	Pt received Awake and Alert in [redacted] bed. PERRLA. S_1 S_2 Present
1900	HRRR. ⊕2 Peripheral pulses. Lungs Sound CTA through out. ⊕ RS
	x4 quads. Drsg ⓛ Shoulder ⓛ FA ⓛ thigh ⓡ LE CDI.
	¼ small pain will continue to monitor.
29 Aug 03	Rec'd report on pt, c/o generalized pain, pt given
	II percocet @ 1110. Lungs CTA BS ⊕ All drsg Δ c̄
	minimal drainage. Drsg to ⓡ shoulder changed
	taken off and area cover. Pt tolerated reg
	meal for breakfast. H/L in ⓡ forearm. Wheel
	restraint taken off for ADLcare. ⊖ skin (b)(6)-2
	breakdown. Will continue to monitor [redacted]
1500	Pt has med form BM pt used BSC. [redacted] (b)(6)-2
1535	Pt medicated per MD order c̄ II percocet for
	pain in ⓡ leg. monitor. [redacted] (b)(6)-2 9/WMC
29 Aug 03	= VSS, A+O x3, ¬ c/o pain @ present, Drsg
1900	to ⓛ UE Δ'd & CDI. Drsg to ⓡ LE CDI,
	neurovascularly WNL to ⓡ LE ⊕ sensation, 2+
	pedal pulse, 2+ edema to ⓡ foot. Drsg CDI to
	ⓛ thigh. Continuing PO Clindamycin.
	¬ other remarkable assessment findings.
	Tolerate PO, good UOP. [redacted]

(Continue on reverse side)

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

REGISTER NO

WARD NO. (b)(6)-2

PROGRESS NOTES
Medical Record

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

DATE

26AUG03 (1120) Assumed care of pt [illegible] shift. Pt alert, speaking some English. VSS. medicated c̄ Percocet this am for pain c̄ good relief. Wet → dry dsgs Δd on ⓡ [redacted] (b)(6)-2 UE and shoulder, ⓡLE, [redacted] (b)(6)-2 and ⓛthigh. All sutures and staples intact. Ø s/sx infection @ wound sites. SL in ⓡ forearm flushes well s̄ s/sx infection/infiltration. Voiding s̄ difficulty. Tol. reg. diet well. 2 point restraints in place. Am care done by pt this am. Will cont. to monitor. [redacted] WDAN (b)(6)-2

26 Aug03 @ 2000 Assumed care @ 1800; All VSS; pt A&O, Ø c/o pain or discomfort @ this time; All dsg CDI, Ø drainage noted; S1S2, LS CTA B; BS x 4, abd soft, pt voiding QS, clear, yellow urine s̄ difficulty; HL in ⓡ FA intact, freely flushing s̄ s/sx infection; pt Tol. Reg diet well; 2 point restraints intact, cap ref brisk; cont to monitor. [redacted] (b)(6)-2 [redacted] (b)(6)-2

27AUG03 (1420) Assumed care of pt @ 0600 p̄ report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c̄ Percs. Dsgs to ⓡLE, ⓛUE, ⓛthigh and shoulder Δd this am. Ø s/sx infection @ wound sites. SL in ⓡ forearm flushes well s̄ s/sx infection/infiltration. Pt voiding s̄ difficulty. ⊕BM this am. Tol. reg diet well. Am care done by pt. 2 point restraints in place - Ø s/sx complications c̄ circulation/skin check ✓. Will cont to monitor. [redacted] WDAN (b)(6)-2

28AUG03 0010 VSS. AO. DSG's CDI to chest, ⓛarm and ⓡ leg. Provided 2 percocets for pain. ⊕ pulses to 4 UEs & RLE. Resting comfortably in bed. [redacted] (b)(6)-2

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

[redacted]
(b)(6)-4

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
30 AUG 03 0800	VSS. Alert & Oriented. Dry to (R) lower leg incisions. (R) lower leg incision [redacted] (b)(6)-2 sutures intact & draining minimal edges approximated. (L) FA & (L) thigh incisions c̄ staples intact & drainage noted. (L) FA incision with edges approximated packed 1.5 cm opening adjacent to incision. (L) thigh incision edges well approximated except 1 cm opening midway incision packed c̄ W → Dry packing. Opening pink. Pt ambulating c̄ crutches to BR under supervision. (R) FA IV D/C'ed diffficult to flush. Pt quiet transport to EPW camp. I [redacted] (b)(6)-2 Antibiotic Bal to Keflex 250mg PO QID X 10 days. Will continue to monitor [redacted] (b)(6)-2 LTR.
30 AUG 03 1240	D/C to EPW camp. MP [redacted] (b)(6)-2 located. [redacted] (b)(6)-2 LTR

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

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

[redacted]

(b)(6)-4

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

NSN 7540-01-075-3786

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

PATIENT'S HOME ADDRESS OR DUTY STATION			ARRIVAL	
STREET ADDRESS			DATE *(Day, Month, Year)* 17 AUG 03	TIME 0015
CITY	STATE	ZIP CODE	TRANSPORTATION TO FACILITY	

SEX	DUTY/LOCAL PHONE		MILITARY STATUS				THIRD PARTY INSURANCE		
M	AREA CODE	NUMBER	ITEM	YES	NO	N/A	ITEM	YES	NO
			PRP				ADDITIONAL INSURANCE		
AGE	HOME PHONE		FLYING STATUS				DD 2568 IN CHART		
31	AREA CODE	NUMBER	MEDICAL HISTORY OBTAINED FROM				NAME OF INSURANCE COMPANY		

CURRENT MEDICATIONS	INJURY OR OCCUPATIONAL ILLNESS				EMERGENCY ROOM VISIT	
Ø	ITEM	YES	NO	WHEN *(Date)*	DATE LAST VISIT	24 HOUR RETURN ☐ YES ☐ NO
	IS THIS AN INJURY?			WHERE	TETANUS	
ALLERGIES Ø	INJURY/SAFETY FORMS				DATE LAST SHOT	COMPLETED INTITIAL SERIES ☐ YES ☐ NO
	HOW					

CHIEF COMPLAINT (R) Leg injury (L) Forearm

CATEGORY OF TREATMENT		VITAL SIGNS					
☐ EMERGENT	TIME 0030	TIME 0030					
☒ URGENT		BP 103/60					
	INITIALS [redacted] (b)(6)-2	PULSE 88					
☐ NON-URGENT		RESP					
		TEMP 97.8					
		~~WT~~ 96#					

LAB ORDERS						X-RAY ORDERS		
X	CBC/DIFF	ABG	X PT/PTT	BHCG/URINE/BLOOD/QUANT		CXR PA & LAT/PORTABLE		C-SPINE
	URINE C&S	X UA MSCC/CATH		X CHEM: 12 C (y/t)		ACUTE ABDOMEN		LS SPINE
	BLOOD C&S X					SINUS		HEAD CT
						ANKLE R/L		

ORDERS

☒ PULSE OX ☒ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
0030	Ancef 1gm IV	[redacted]	(b)(6)-2		
0030	Tetanus				
0030	Morphine 5mg	[redacted]	(b)(6)-2		
0045	Morphine 5mg	[redacted]	(b)(6)-2		

DISPOSITION	DISPOSITION QUARTERS /OFF DUTY	PATIENT/DISCHARGE INSTRUCTIONS
☐ HOME ☐ FULL DUTY	☐ 24 HRS. ☐ 48 HRS. ☐ 78 HRS.	
MODIFIED DUTY UNTIL	RETURN TO DUTY	

CONDITION UPON RELEASE	ADMIT TO UNIT/SERVICE	REFERRED ▶	TO	WHEN
☐ IMPROVED ☐ UNCHANGED				
☐ DETERIORATE	TIME OF RELEASE	I have received and understand these instructions.		
		PATIENT'S SIGNATURE		

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

[redacted]

(b)(6)-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

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

4. PROPOSED SURGICAL PROCEDURE: s/p multiple GSW / Blast injury
Emergency case

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

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

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

[redacted] (b)(6)-4

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

(b)(6)-2 [redacted] RN 17 Aug03 DATE

11. POSTOPERATIVE EVALUATION:

12. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title)	13. PREOPERTIVE EVALUATION PREPARED BY (Signature and
[redacted] RN	[redacted] RN
DATE: 17 Aug03 TIME: 0055 (b)(6)-2	DATE: 17 Aug03 TIME: (b)(6)-2

REVERSE OF DA FORM 5179, JUN 91

USAPA V1.01

MEDICAL RECORD — **INTRAO[illegible] TI[illegible] DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Litter BY Anesthesia

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

3. DATE 17 Aug 03 TIME PATIENT ARRIVED IN SUITE 0058

4. PATIENT IN ROOM TIME 0058 NUMBER 2-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: Emergency case s/p blast injury

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: Normal anatomic body alignment maintained

8. SKIN PREPARATION

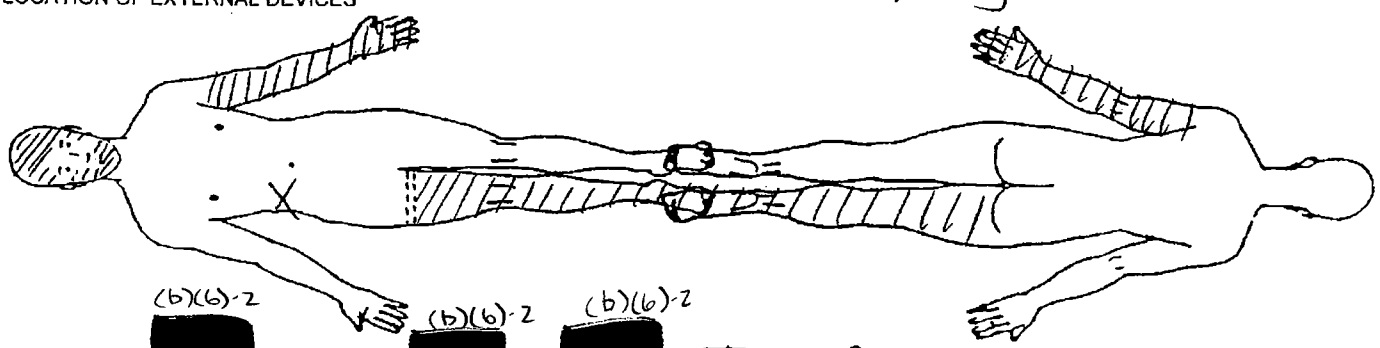
HAIR REMOVAL DONE BY: [X] YES [ ] NO Dr. [redacted] (b)(6)-2
[X] OR [ ] NURSING UNIT
METHOD: [ ] DEPILATORY [X] RAZOR
[ ] CLIP

COMMENTS: (R) leg & (L) FA No nicks or cuts

PREP SOLUTION *(Specify)* Betadine/Betadine
SITE: LFA & Right leg BY WHOM: 1LT [redacted] (b)(6)-2
SITE: Chin & forehead BY WHOM: Dr. [redacted] (b)(6)-2

COMMENTS: No pooling or adverse reaction

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Strap ===Tourniquet ▽/\ - Prep

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

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB (b)(6)-2	CIRCULATOR (b)(6)-2
Sponge	[X] Yes [ ] No		C	C	SPC [redacted]	1LT [redacted]
Needle Sharp	[X] Yes [ ] No					
Instrument	[ ] Yes [X] No					
Other	[ ] Yes [X] No					

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

[redacted] (b)(6)-4

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

[X] ESU NO: #3 Cut: 30 Coag: 30
GROUND PAD: BRAND 68936
LOT NO: EXP 2005-03

[ ] ESU NO:
GROUND PAD: BRAND
LOT NO:

[ ] BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
Bacitracin Oint Lot AT090 Exp 10/05	Q.S.	intra-op	topical application	MER: [redacted] (b)(6)-2	Dr. [redacted] (b)(6)-2

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

OTHER ORDERS	TIME	CARRIED OUT BY

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

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

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

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

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

Foley cath placed in EMT

DA 5179 Initiated

20. OPERATION(S) PERFORMED
Fasciotomy Right leg and LFA, I&D of wounds

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU 2	0225	Litter

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

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

MEDICAL RECORD — **INTRAO[illegible] TI[illegible] DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Gurney BY Anesth

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

3. DATE 19 Aug 03 TIME PATIENT ARRIVED IN SUITE 0730

4. PATIENT IN ROOM TIME 0730 NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

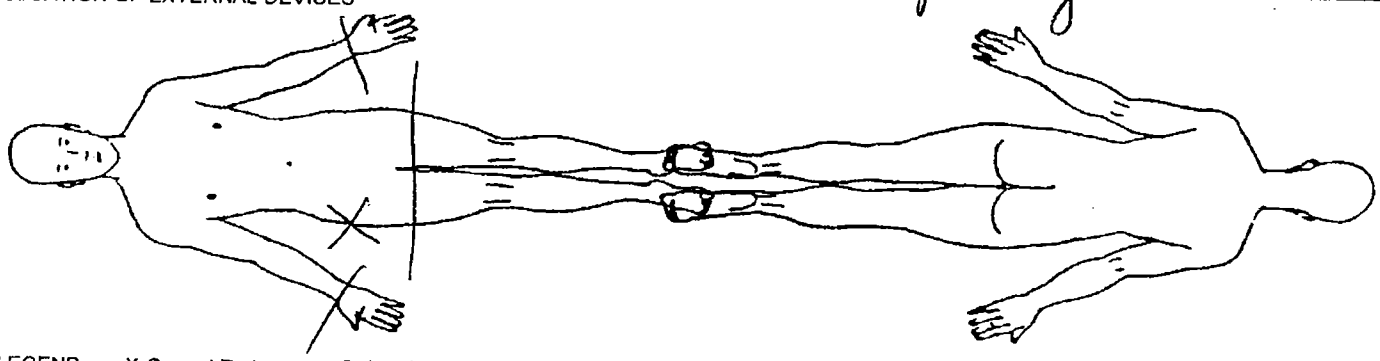
COMMENTS: Body alignment maintained

8. SKIN PREPARATION

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

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

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS — C = Correct I = Incorrect

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

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

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

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

☒ ESU NO: Valleylab Force 2
GROUND PAD: BRAND REM polyhesive
LOT NO: 68936

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

cut: 30 coag: 30

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

0.9% NaCl

OTHER ORDERS	TIME	CARRIED OUT BY

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

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

16. LABORATORY SPECIMENS

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

18. DRESSING/IMMOBILIZATION *(Specify)*

fluffs
kerlix

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

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

Bovie Pad site intact pre-op clear; post-op clear Bovie Settings: Coag/Cut 30/30
Tourniquet Site intact pre-op NA: post-op NA

20. OPERATION(S) PERFORMED

I+D open wounds (R) ↓ leg + (Lt) arm + (Lt.) thigh wound plus DPPC

21. PATIENT TRANSFERRED TO ICU 2 TIME 0855 METHOD via gurney

22. REGISTER[redacted]GNATURE LTC, AN

REVERSE OF DA FORM 5179-1, OCT (b)(6)-2

USAPA V1.01

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Gurney BY Anesth.

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

3. DATE 24 Aug 03 TIME PATIENT ARRIVED IN SUITE 0845

4. PATIENT IN ROOM TIME 0845 NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	Spc [redacted] (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	LTC [redacted] (b)(6)-2	RELIEF CIRCULATOR	MAJ [redacted] (0930 - End) (b)(6)-2

7. POSITION AND POSITIONAL AIDS (Specify)

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

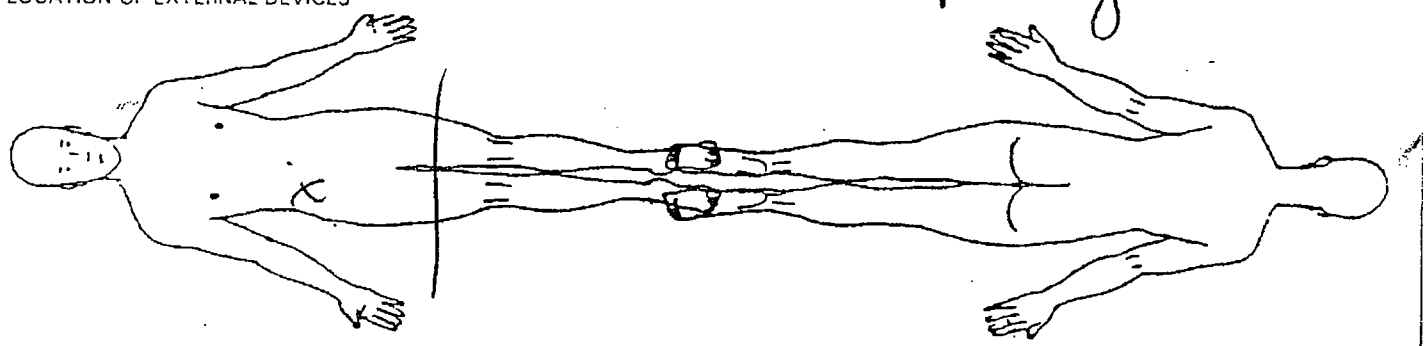
COMMENTS: Body maintained in correct alignment

8. SKIN PREPARATION

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

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

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

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

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

[redacted]
(b)(6)-4

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

☒ ESU NO: Valleylab Force 40 mL
GROUND PAD: BRAND Polyhesive REM II
LOT NO: 69671

☐ ESU NO:
GROUND PAD: BRAND
LOT NO: (Bovie ESU not used)

☐ BIPOLAR NO:

13. PROSTHESIS, IMPLANTS ☐ YES ☒ IF YES NAME; ID NUMBER; M... ...ER

14. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

0.9% NaCl

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*

fluffs
Kerlix roll

19. ADDITIONAL INFORMATION

Surgeon: Dr. [redacted] (b)(6)-2
Anesth: Cpt. [redacted], CRNA
(b)(6)-2

20. OPERATION(S) PERFORMED

Delayed Primary Closure of Fasciotomy ® ↓ leg

21. PATIENT TRANSFERRED TO ICU TIME 1000 METHOD via Gurney

[redacted], LTC, F ... MEDCOM - 17547 [redacted]

(b)(6)-2

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY | 19 | 20 | 21 | 22 | 23 | 24 | 25

19 | HOUR

PULSE (O) | TEMP. F (°)

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

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

TEMP. C

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: | WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO. 1CW2

BPW [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 | 26AUG03 | 27AUG03 | 28 | 29 Aug | 29Aug03 | 30 Aug

19 | HOUR | 8 1 8 9 | 8 1 | 8 20 | 1700 | 1800 | 8 8 8

PULSE (O) | TEMP. F (•)

TEMP. C (Centigrade Equivalents, for Reference only)

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

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

RESPIRATION RECORD

BLOOD PRESSURE

	26AUG03	27AUG03	28	29 Aug	29Aug03	30 Aug
BP	134/70	132/76	116/65	120/72	133/64	123/69
	122/69		75	80	114	79
			98.9	98.8	98.3	98.3
			99.1			
	98(RA)	98(RA)	98%	99%	99	95%
	99% RA					RA

HEIGHT: | WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

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

#[redacted]

(b)(6) -4

ICU1

Patients Name: [redacted] (b)(6)-4 Date: 8/14/03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line		115				112				110																
NBP		61				72				62									120/65						110/65	
TEMP		99																	98.8						98.3	
HR		70				80				94									80						82	
RR		22				30				4									18						18	
SaO2		99				99				98									97						100	
FiO2		RA				RA				RA									RA						RA	
Source																										
MAP																										

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	T
IVF																										
IVPB			50								50		100							50						
NGT																										
P																										
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
Urine			800				100				100		1300						800						500	
NGT																										
STOOL																										
DRAIN																										
Total													1300													

MEDCOM - 17550

ICU1

Patients Name: EW [redacted] (b)(6)-4 Date: 19-Aug-03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05
A-Line																									
NBP	119/60	119/59			130/78	112/60			108/60		102/60														
TEMP	99°	98°			98.4	98.4																			
HR	78	79			92	89			98		104														
RR	20	21			16	14			14		12														
SaO2	100	100			95	98			96		97														
FiO2																									
Source	RA	RA			RA	RA			RA		RA														
MAP	83	79			90	78			78		75														

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	T
IVF	Ø	0	0	0	Ø																					
IVPB	Ø	0			0						50															
NGT	Ø	0	500		4																					
PO	100																									
PO	100	100			100	170			100																	
Total																										

PUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
[illegible]	200	300			100																					
NGT																										
STOOL			150																							
DRAIN																										
Total	200	300			750																					

MEDCOM - 17551

Ward/Section:	REQUESTING PHYSICIAN: (b)(6)-4	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted]	DATE: 10 Aug 09	TIME: 0830	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)
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	17.3	9.8-13.6 secs
APTT	26.2	21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] (b)(6)-2	DATE: 17 Aug	LAB ID NO.:

Ward/Section:	REQUE [redacted] (b)(6)-2	**CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI. [redacted] (b)(6)-4	DATE 17AUG	TIME 0030	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/
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANG.
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

======= PICCOLO =======
17/08/03 01:29
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
GENERAL CHEMISTRY 12
DISC LOT #: 3142AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

ALB	3.1*	3.3-5.5	G/DL
ALP	43	26-84	U/L
ALT	18	10-47	U/L
AMY	29	14-97	U/L
AST	21	11-38	U/L
TBIL	0.3	0.2-1.6	MG/DL
BUN	13	7-22	MG/DL
CA++	7.3*	8.0-10.3	MG/DL
CHOL	♦♦♦	100-200	MG/DL
CRE	1.3*	0.6-1.2	MG/DL
GLU	150*	73-118	MG/DL
TP	5.7*	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

======= PICCOLO =======
17/08/03 01:28
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: 3151AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	146*	73-118	MG/DL
BUN	13	7-22	MG/DL
CRE	1.5*	0.6-1.2	MG/DL
CK	257	39-380	U/L
NA+	130	128-145	MMOL/L
K+	3.5	3.3-4.7	MMOL/L
CL-	105	98-108	MMOL/L
tCO2	19	18-33	MMOL/L

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

REMARKS:

REPORTED BY: [redacted] (b)(6)-2	**DATE:** 17 AUG 03	**LAB ID NO.:**

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

LAST, FIRST, MI.	DATE	TIME	SSN/PSEUDO SSN:
EPW [redacted] (b)(6)-4	17AUG03	0800	

(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.:**

(b)(6)-2

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

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3	Color		N/A	RPR		Negative
			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**		
			HCG		Negative			
			CSF			**Blood Bank**		
Sed Rate			Cell Count			**MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED**		
Other			Directigen		Negative	ABO/Rh		

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

REMARKS:

REPORTED BY: [redacted] (b)(6)-2	DATE: 17Aug03	LAB ID NO.:

Tobacco

MEDICAL RECORD - ANESTH

se ... this form, see AR 40-66; the proponent a ... is the OTSG

NKDA

DRUG (Units)													
Fentanyl (mcg)	50-50			100		50-150		-50					
Lidocaine ( )	50												
Propofol ( )	170-30							70					
Sux ( )	80												
UCB ( )	5					2							
( )													
VOLAT AGENT % del	1.5	1.5	1.5	1.0	1.0	1.0	1.5	X					
% e.t.													
AIR L/Min													
N2O L/Min													
O2 L/Min	10	2	2	2	2	2	10						

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

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

FLUIDS													
LINE site #1 PIV (L) A ☒ Warmed	#1						800		1000				
#2 PIV (R) A ☒ Warmed	#2						600		1000				
☐ Warmed													
☐ Warmed													
LOSSES EST BLOOD LOSS					500		500						
URINE -					300		350						

TOTALS	TOTAL EBL
450	500
50	
1270	TOTAL URINE
50	350
7	

FLUIDS SUMMARY
CRYSTALLOID- 2000 [redacted]
COLLOID- 0 (b)(6)-2
BLOOD- 0

REMARKS
Code drugs with numbers, events with letters
(1) Pre-Oped.
(2) Room, mon
O2 induced
Eyelids taped
(3) OG, soft Pt
flock
(4) Reversed
OP suctioned
Neostigmine 5
+ Glycopyrrol
0.8 mg IV
Extubated.
5 Complicat
To ICU-2
Report given

PHYS STATUS: 1 (2) 3 4 5 E
BODY WEIGHT: 84 (KG) LB
HEMATOCRIT: 36.5
INITIAL DATA: BP- 103/60 HR- 91
EQUIP CHECK: OK?- (Y) N
PATIENT RECHECK: OK for PROCEDURE [redacted] ANES- X-X PROC- ⊙-Ø TIME- 0000

SYMBOLS: BP by cuff V ; Heart rate ∧ ; Resp rate ● ; BR (transduced) ; TOURNIQUET T—T (b)(6)-2

TIME: 0015 0100 30 0200 30 0300

VENTIL								
VT - ml		—	620	620	620	640	660	400
f - breaths/min		—	10	10	10	7	6	16
Peak inf pres / PEEP		—	24	24	24	24	23	—
MODE - S(pon), A(ssist), C(on)		S/C	C	C	C	C	C	S
MONITORS/ACCESSORIES								
BP/Auto Cuff	ET CO2 (torr)	—	40	40	32	33	35	40
BP/oth	FIO2 (Frac or %)	0.78	0.78	0.78	0.78	0.78	0.78	0.78
ART line	SpO2 (%)	100	95	100	100	100	100	100
Steth- PC/ES	ECG	SR				SR	SR	SR
Gas analyzer	TEMP-site	available						
	N-M Block (T/4)	—	0/4				4/4	2/4
	BS							
Warming blkt	x1 blanket							
Conv warmer								

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

RECOVERY AT 0235
PACU ICU 2 (Specify)
OTHER
CONDITION: Stable, awake
RESP- 20 SpO2- 97-9
BP- 115/70 HR- 115

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0045	0055	0235
	Ready	Begin	End
PROC	0100	0118	0210

PROCEDURES and CPT Codes: I+D + Bunionectomy (R) LE; I+D L arm abscess
Fasciotomy (R) LE;

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GETA (b)(6)-2 RSI Croc

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: DL x2 CRT [redacted], DL x1 Miller 3 [redacted] Grade 1 8.0 stylet 24 @ lips + BBS; suct ETC (b)(6)-2

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

[redacted] (b)(6)-4

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

ANESTHESIOLOGISTS: [redacted] (b)(6)-2 CRNA/MD

PROCEDURE LOCATION: 2
DATE: 17 Aug 03
PAGE 1 OF 1

DA FORM 7389, FEB 1998 MEDCOM - 17556 COPY 1 [redacted]ENT'S MEDICAL RECORD USAPA V1.00

(b)(6)-2

17Aug 1500 6) 9.0 / 26.7 < 335 Meds - Ancef 1gm IVPB q8° - Morphan Round to EPW Camp

Tobacco

MEDICAL RECORD - ANESTHI

...e ... this form, see AR 40-66; the proponent a... OTSG

SSCAL 8-16-03

NKDA

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML, "I" = CONSTANT INFUSION																		
DRUG	(Units)																	
Versed	(mg)	2																
Fentanyl	(mcg)	50	50	50	50	50												
Lidocaine	(mg)	100																
Propofol	(mg)	200																
Midazolam	(mg)			3		2		1										
Robinul	(mg)			0.2														
VOLAT AGENT	150 % del	2.5	2.0	1.5	1.5	1.5												
	% e.t.																	
AIR	L/Min																	
N2O	L/Min																	
O2	L/Min	10	2	2	2	2												
SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS →																		

FLUIDS			
LINE site	(R) PIV #20	☐ Warmed	LR → #1
		☐ Warmed	
		☐ Warmed	
	Ancef	☐ Warmed	1g IVPB →
LOSSES	EST BLOOD LOSS		
	URINE -		

TOTALS	TOTAL EBL
2 / 250 / 100 / 200 / 6	<50
	TOTAL URINE
	150

FLUIDS - SUMMARY

CRYSTALLOID- 500 LR

COLLOID- 0

BLOOD- 0

REMARKS

Code drugs with numbers, events with letters

(1) Pre-op assessment agree - Previous pre-op. Lungs CTA (B) =; HR RR (-) m

(2) Room, monitor O2 induced eyes taped

(3) attempted PIV access PIV in (R) hand patent Continue to use

(4) To Lithotomy To ICU-2 Report given

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 84 (KG) LB

HEMATOCRIT: 26.8

INITIAL DATA: BP- SaO2 100% 119 / 59 HR- 79

EQUIP CHECK: OK?- (Y) N

PATIENT RECHECK: OK for PROCEDURE [redacted] TIME- 0700

SYMBOLS: BP by cuff V ∧; Heart rate ●; Resp rate; BR (transduced); TOURNIQUET T—T (b)(6)-2 ANES- X-X PROC- ⊙-⊘

TIME → 0730 , 0200 , 30 , 0900

VENTIL							
VT - ml	+	250	370	390	390	630
f - breaths/min	—	23	16	15	14	15
Peak inf pres / PEEP	—	—	—	—	—	—
MODE - S(pon), A(ssist), C(on)	S	S	S	S	S	S

MONITORS/ACCESSORIES							
BP/Auto Cuff	ET CO2 (torr)	+	32	35	35	33	30
BP/oth	FIO2 (Frac or %)	0.65	0.65	0.65	0.65	0.65	0.65
ART line	SpO2 (%)	100	99	99	100	100	100
Steth- PC/ES	ECG	SR →		SR	SR	SR	SR
Gas analyzer	TEMP-site	available →					
	N-M Block (T/4)						
	BS	+					
Warming blkt	1 wool blanket →						
Conv warmer							

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

RECOVERY AT: 0859

PACU (ICU2) (Specify)

OTHER T-97.5

CONDITION: Stable awake

RESP- 2 SpO2- 100

BP- 139/71 HR- 130

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0720	0730	0910
	Ready	Begin	End
PROC	0740	0750	0850

PROCEDURES and CPT Codes: I&D (R) lower leg / I&D (L) arm

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

[redacted] (b)(6)-4

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

GMA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

LMA #4 not seated removed. Mask GA #90mm + 34FR NP tube; + BS's + Suct E CO2

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

[redacted] CRNA/MA

PROCEDURE LOCATION: 7

DATE: 17 Aug 03

PAGE 1 OF 1

DA FORM 7389, FEB 1998

MEDCOM - 17557

(b)(6)-2

COPY 1 - PATIENT'S MEDICAL RECORD

USAPA V1.00

34y/o ♂ NKDA

ASA II

MEDICAL RECORD - ANESTHE

[illegible] this form, see AR 40-66; the proponent ag[illegible] s the OTSG

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML; "1" = CONSTANT INFUSION

DRUG	(Units)	
Versed	(mg)	2
Fentanyl	(ucg)	(250)
Lidocaine	(mg)	100
propofol	(mg)	150
MSO4	(mg)	
	( )	

VOLAT AGENT	150	% del / % e.t.	1.5/2.0/2.0/2.0/2.0/2.0/2.0/1
AIR		L/Min	
N2O		L/Min	
O2		L/Min	5/2/1/1/1/1/1/1/1/2

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS → (2) (3)

FLUIDS

LINE site		
18g (1) Arm	☐ Warmed	
	☐ Warmed	LR — 700 — 200 LR2
	☐ Warmed	
	☐ Warmed	

LOSSES: EST BLOOD LOSS; URINE

TOTALS	TOTAL EBL
2/0	
250/0	min.
100	TOTAL URINE
150	
10/0	-0

FLUIDS SUMMARY

CRYSTALLOID- 1000

COLLOID- 0

BLOOD- 0

REMARKS

Code drugs with numbers, events with letters

(1) PT ID (0820) preop Hx done PT prep complete. ID ✓, NPO ✓, Airway, med ✓, NKDA

(2) RM, O2, monitors

(3) induction

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 90 KG LB

HEMATOCRIT: 29

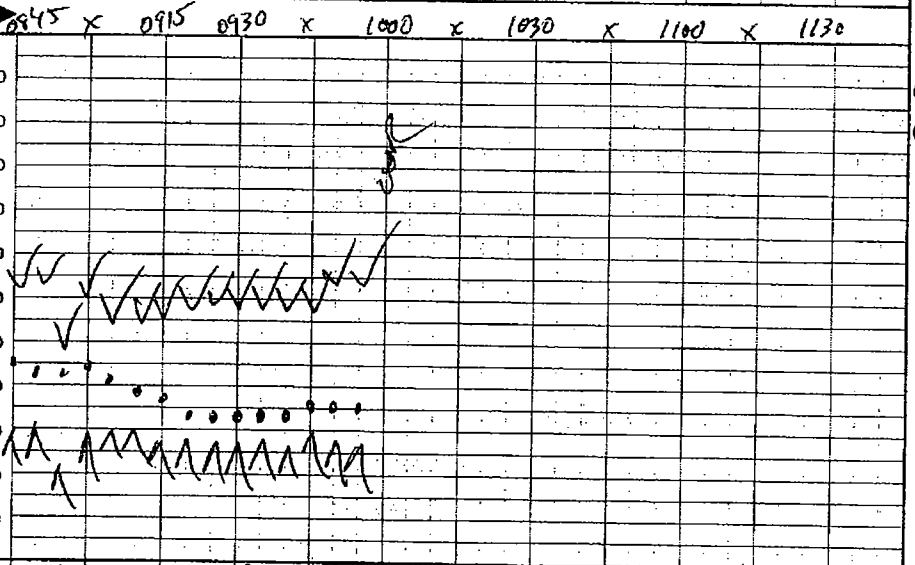
INITIAL DATA: BP- 120/70; HR- 74

EQUIP CHECK: OK?- (Y) N

PATIENT RECHECK: OK for PROCEDURE? Y; TIME-

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

TIME → 0845 x 0915 0930 x 1000 x 1030 x 1100 x 1130



VENTIL

	0845	0915	0930	1000	1030
VT - ml	380	300	370	390	350
f - breaths/min	15	9	10	10	14
Peak inf pres / PEEP	/	/	/	/	/
MODE - S(pon), A(ssist), C(on)	SV	SV	SV	SV	SV

MONITORS/ACCESSORIES

✓ BP/Auto Cuff	✓ ET CO2 (torr)	41	44	45	45	42
BP/oth	✓ FIO2 (Frac or %)	.74	.74	.74	.74	.77
ART line	✓ SpO2 (%)	100	100	100	100	100
Steth- PC/ES	✓ ECG	SR	SR	SR	SR	SR
Gas analyzer	✓ TEMP-site	Avail				
	✓ N-M Block (T/4)	Avail				
Warming blkt						
Conv warmer						

Mark with letters & symbols, explain under REMARKS — EVENTS *Position* → 0 → 7

RECOVERY AT 1000

PACU ICU (Specify)

OTHER

CONDITION: stable

RESP- 10 SpO2- 90

BP- 154/81 HR- 100

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0820	0845	1010
	Ready	Begin	End
PROC	0857	0908	0956

PROCEDURES and CPT Codes: DPC

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* GMA

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* Nasal airway 34 F + PT SV.

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

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

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

[redacted] (b)(6)-2

PROCEDURE LOCATION: 2-1

DATE: 24 AUG 03

PAGE 1 OF

DA FORM 7389, FEB 1998

MEDCOM - 17558

[redacted] (b)(6)-2

COPY 1 - PATIENT'S MEDICAL RECORD

USAPA V1.00

PRE-ANESTHETIC ASSES N ND PLAN OF CARE

AGE: 34 Days Mos Yrs

GENDER: ( ) Male ( ) Female

ALLERGIES: NKDA

P S: 1 (2) 3 4 5 (E)

WT: 83 (Kg/Lb HT: ____ In.

PROPOSED PROCEDURE: (R) leg compartment syndrome

SURGICAL SERVICE: IR O multiple CSW Ortho

NPO SINCE: ____

PREOP DX / MECHANISM OF INJURY: ____ (CSW)

HABITS:

Tobacco: Cigars

EtOH: Beer - 4/day

Drugs: Ø

CURRENT MEDICATIONS:

( ) = ordered as premed

( ) Ø
( )
( )
( )
( )
( )

PREMEDICATIONS:

None / Yes @ ____ Hrs

LABORATORY STUDIES:

130 | 105 | 13 — 150
3.5 | ~~15~~ 19 | 11.3

18.5 | 12 — 437
36.5

Other: PT - 17.3
PTT 26.2

PAST MEDICAL HISTORY / SYSTEMS REVIEW

Cardiovascular:			
Hypertension	N	Y	Unknown
Angina	N	Y	
MI	N	Y	denies
CVA	N	Y	
Other	N	Y	
Pulmonary:			
Asthma	N	Y	
URI	N	Y	
COPD	N	Y	
Other	N	Y	
Renal System:			
ARF/CRF	N	Y	
Other	N	Y	
Gastrointestinal:			
Hepatitis	N	Y	
Hiatal Hernia	N	Y	
GERD/PUD	N	Y	
Endocrine:			
Diabetes	N	Y	
Steroids	N	Y	
Thyroid	N	Y	
Neurological:			
Seizures	N	Y	
Neuropathy	N	Y	
Gynecological:			
Pregnancy	N	Y	
Other	N	Y	
Other Problems:	N	Y	
Familial Hx	N	Y	

SURGICAL HISTORY

Ø

PHYSICAL EXAMINATION

BP: 103/60 HR: 91 RR: 20 T: ____

Pain (0/10 Scale): 10

Airway Exam:
Dentition: intact
Trachea: midline
TMJ/C-spine: ____
Oropharynx: MP difficult to assess

Chest:
Lungs: ____
Heart: ____

IV Access: X 2 PIV (R) A

Ulnar Filling: ____

Back: ____

Other: ____

ANESTHETIC PLAN: ( ) Local/MAC ( ) Regional: ____ (✓) General: (Intubation) / Mask-LMA Notes: ____

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives, and risks of anesthesia including death have been explained to and discussed with patient and/or legal guardian. The patient/legal guardian seems to understand and agrees to proceed. Questions answered.

(b)(6)-2

Signed: [redacted] CRNA/MAJ Date: ____ Time: ____

( ) Sedated/nonresponsive/minor patient with no family or guardian present.

PATIENT IDENTIFICATION: [redacted]

(b)(6)-4

POST-ANESTHESIA EVALUATION AND NOTE:

( ) No apparent anesthetic complications.

( ) Other (see progress notes)

Signed: ____ Date: ____ Time: ____

Nursing Unit: ____

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

DATE OF ORDER 17 AUG 03 TIME OF ORDER 0215 HOURS

LIST TIME ORDER NOTED AND SIGN

1. TO ICW
2. S/P I&D (R) LEG, (L) ARM WITH PARALYTOMIES
3. CONTINUE PCA
4. VS MONITOR
5. BED REST

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

6. REGULAR DIET
7. FOLEY TO GRAVITY
8. IV-2L AT 125 cc/HR D5W LOCK WITH HEPARIN PRN WHEN
9. TYLENOL 650 mg PO Q4 HRS PRN
10. PERCOCET 1-2 PO Q 4-6 HRS PRN
11. MSO4 2-6 mg IVP Q 2 HRS PRN
12. ANCEF 1 GRAM IVPB Q 8 HRS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER

13. CBC AT 0800 [redacted] (b)(6)-2

19 AUG 03 0800 [redacted]

- Routine vitals
- Up ad lib
- Heparin IV
- D/C Foley
- Regular Diet
- T#3 TI PO q4° PRN pain

19 Aug 03 0800

[redacted] (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

- MSO4 2 mg q1° PRN breakthrough
- Phenergan 25 mg IV q6° PRN nausea
- Chemotherapy 300 mg PO q8° [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

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

"USE BALL POINT" "IN 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

DATE OF ORDER: 19 Aug 03 | TIME OF ORDER: 19 Aug 03 HOURS | LIST TIME ORDER NOTED AND SIGN

(1) Demerol 10mg IVx 2 max dose 20mg IV PRN for post-op shivering

[redacted] (b)(6)-2 19 Aug 03 1000

NURSING UNIT | ROOM NO. | BED NO.: [redacted] (b)(6)-2 CRNA/MA (b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER: 19 Aug 03 | TIME OF ORDER: 1750 HOURS

(1) Transfer to ICW 2

(2) Cont current orders

NURSING UNIT | ROOM NO. | BED NO.: 24 VS 2315 19 Aug 03 [redacted] (b)(6)-2 (b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER: 8/20/03 | TIME OF ORDER: 1400 HOURS

(1) Start wet to dry dressing b/s in AM

(2) D/c Ancef

[redacted] (b)(6)-2

noted [redacted] 20 Aug 03 1415 (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.: 24 VS 2300 20 Aug 03 (b)(6)-2

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

DATE OF ORDER: 8/23/03 | TIME OF ORDER: ~~8/23~~ 0900 HOURS

NPO pm

[redacted] (b)(6)-2 8/23/03 0915

NURSING UNIT | ROOM NO. | BED NO.: ICW#1 240 2300 23 Aug [redacted] (b)(6)-2

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 1996—409-924

"USE BALL POINT 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

Noted 24 AUG 03 1024

[redacted]

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

24 AUG 03

DATE OF ORDER: 24 AUG 03 TIME OF ORDER: 1000 HOURS

LIST TIME ORDER NOTED AND SIGN

1. RESUME PRIOR ORDERS
2. REGULAR DIET
3. IV - LR AT 125 cc/hr. KEEP LOCK AND TO BE PO. WHEN
4. DAILY DRESSING CHANGES [redacted]

PATIENT IDENTIFICATION

(b)(6)-2

8/21/03

DATE OF ORDER | TIME OF ORDER [redacted]

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER _____ HOURS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER _____ HOURS

NURSING UNIT | ROOM NO. | BED NO.

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION			↓	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
[redacted] (b)(6)-4				30 AUG 83	0918 HOURS	
			1	DISCHARGE TO EPW CAMP TODAY.		
			2	KEFLEX 250mg P.O. Q10d DOSES		
			3	CRUTCHES, WEIGHT BEAR AS TOLERATED		
NURSING UNIT	ROOM NO. (b)(6)-2	BED NO. [redacted]	4	TYLENOL 650mg P.O. Q 4hrs PRN		
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER [redacted]	(b)(6)-2
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER _____ HOURS	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER _____ HOURS	
NURSING UNIT	ROOM NO.	BED NO.				

Noted 30 Aug 0930

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

CLINICAL RECORD

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

Mo. 8 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 19 20 21 22 23 24 25 26 27 28 29 30
Copied	[redacted] (b)(6)-2	NS routine	07	[redacted]
			12	[redacted]
			17	[redacted]
Copied	[redacted] (b)(6)-2	~~SR~~ Upadlit	07	[redacted]
			12	[redacted]
			17	[redacted]
Copied	[redacted] (b)(6)-2	Reg diet	06	[redacted]
			12	[redacted]
			17	[redacted]
		~~Foleg to gravity~~	5	[redacted]
			12	[redacted]
			17	
20 Aug	[redacted] (b)(6)-2	Start W→dsg D's to start in am 21 Aug	08	[redacted]
30 Aug 03	[redacted] (b)(6)-2	Crutches, wt-bearing as tol	06	[redacted]
			18	[redacted]

(b)(6)-2 all

ALLERGIES: ☐ YES ☐ NO — None

PRIMARY DIAGNOSIS: S/P Rt DB leg & OPA

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

DA FORM 4677, 1 OCT 78 — EDITION OF 1 DEC 72 MAY BE USED. — USAPA V1.00

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo Aug Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
19 Aug	[redacted]	Admit to IWD	19 Aug		1730 [redacted]	(b)(6)-2
23 Aug	[redacted]	NPO p MD	23 Aug	24 [redacted]	(b)(6)-2	
24 Aug	[redacted]	Resume Previous Order	24 Aug	Today	done	[redacted] (b)(6)-2
30 Aug 03	[redacted]	D/C to EPW Camp today				
	(b)(6)-2					

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

USAPA V1.00

PRN meds

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.	M 08 Y.F. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED
17Aug	[redacted] (b)(6)-2	Tylenol 650mg PO Q4 hrs prn		[redacted]
17Aug	[redacted] (b)(6)-2	Percocet 1-2 PO Q4-6 hrs prn		[redacted]
17Aug	[redacted] (b)(6)-2	MSO4 2-6mg IVP Q2 Hrs prn		
17Aug	[redacted] (b)(6)-2	T3 PO q4hrs prn pain		17Aug
17AUG03	[redacted] (b)(6)-2	Percocet 1-2 po 9-4 6pm		[redacted]
		One Time Meds		

(b)(6)-2 (all)

ALLERGIES: ☐ YES ☐ NO PRIMARY DIAGNOSIS: S/P IBD (R) leg (L) PA

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

PATIENT IDENTIFICATION: BPW [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

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 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED (Sept 19 20 21 22 23 24 25 26 27 28 29 30 31 1)
copied	[redacted]	IV LR @ 125cc/hr	05	
	(b)(6)-2	HL when tol PO	13	[redacted]
			21	[redacted]
copied	[redacted]	Ancefigram IVPB	08	[redacted] D/C
	(b)(6)-2	98°	16	[redacted]
			24	[redacted] 20Aug03 1400
Copied	[redacted]	Heplock IV	05	[redacted]
	(b)(6)-2		13	[redacted] D/C
			21	[redacted]
copied	[redacted]	Clindamycin	08	[redacted]
	(b)(6)-2	300mg PO 98°	16	[redacted]
			24	[redacted] D/C
24 Aug	[redacted]	IV LR @ 125cc/hr	07	[redacted] D/C'd
	(b)(6)-2	Heplock when	19	[redacted]
		Tolerating PO well		
30 Aug03	[redacted]	Keflex 250mg PO	06	
	(b)(6)-2	QID x 10 days	12	
			18	
			24	

(b)(6)-2 all

ALLERGIES: ☐ YES ☐ NO — unk

PRIMARY DIAGNOSIS: 2/p 1st D&I leg & L PA

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO _____

PATIENT IDENTIFICATION: [redacted]

(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

MEDICAL RECORD-SUPPLEMENTAL MEDICAL [redacted]

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

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

OTSG APPROVED (Date)

Date: 19-Aug-03
Time In: 0900
Allergies: _____
Pre-op V/S: 119/59 / 78
Procedures: I+D RLE + LUE

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

OR Intake: Crystalloid LR 500 Colloid _____
OR Output: UOP 150 EBL 50cc
Meds/Times: 150 mg Fent · 5 mg MSO4

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

Pre Op Meds _____ History _____

Time	0900	0900	0900	0915	0930	0945	1000	1030	1100
SaO2	100	100	94	94	100	99	96		
FiO2	RA	RA	RA	RA	RA	RA	RA		
Methods					F/M				
240									
220									
200									
180									
160									
140				V					
120	V	V	V		V	V	V		
100	O	O	O	O					
80	A	A	A	A	O	O	A		
60					A	A			
40									
20									
RR	16	16	22	12	12	13	14		
T	98.6	98.8	99.1	98.8	98.4	98.8	98.7		
Time	0900		0945						
Pain (0-10)	8		7						
LOS									

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: _____ Labs: _____

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	1	1	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	2	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	/	/	/
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	9	9	10

Codes

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

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

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

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

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

(Continue on reverse)

PREPA[redacted] SSG Trainee

(b)(6)-2

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: 19-Aug-03

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

#[redacted]

(b)(6)-4

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

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

USAPPC V2.00

MEDICATIONS

Allergies:

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

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	LUE/RLE	+	+	+	B	W	
15'	"	+	+	+	B	W	
30'	"	+	+	+	B	W	
45'	"	+	+	+	B	W	
60'	"	+	+	+	B	W	
90'				+			
D/C	"				B		

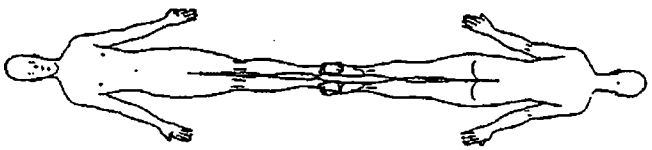
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	LUE + RLE	Gauze	Ø
30'	"	"	Ø
60'	"	"	Ø
D/C	"	"	Ø



PACU OUTPUT

Time	Source	Color/Appearance	Amount
1000	Foley	Clear/yellow	100

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

NURSING NOTES

Pt is for I+D of LUE + RLE. Pt unable follow simple commands has numbness + sensation x 4 extremities. Pt's [illegible]. Dressings C/D/I.

Discharge Criteria:
Date: **Time:** **PARS:**
BP: **T:** **HR:** **RR:** **Sa02:**
Pain Level at D/C (0-10):
Intake: _____ **Output:** _____
Additional Data: _____
Transferred To: _____
Report Given To: _____
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: _____
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature: _____

WAMC OP 173-E

MEDICAL RECORD-SUPPLEMENTAL MEDIC L DATA

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

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

OTSG APPROVED (Date)

Date: 24 Aug 03
Time In: 1000
Allergies: NKDA
Pre-op V/S: 12/70 1024
Procedures: DPC

Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid LLR Colloid
OR Output: UOP EBL
Meds/Times: Ancef Cloxa 0800

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

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds

History

Time	1000	1005	1020	1015	1030	1040
SaO2	97	100	96	94	95	96
FiO2	21	21	21	21	21	21
Methods	NC	NC	NC	NC	NC	
240						
220						
200						
180						
160						
140						
120						
100						
80						
60						
40						
20						
RR	10	15	17	10	15	14
T	96.5			97.0		
Time						
Pain (0-10)						
LOS						

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

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

Codes

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

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

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

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

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

(Continue on reverse)

PREPA[redacted] ILT/AN

(b)(6)-2

DEPARTMENT/SERVICE/CLINIC

DATE

PAT[redacted] written entries give: first, m[redacted] ical facility)

Name – last,

(b)(6)-4

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

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

USAPPC V2.00

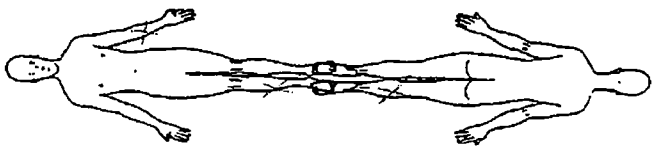
MEDICATIONS						
Allergies:						
Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By

NEUROVASCULAR							
Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm							
15'							
30'							
45'							
60'							
90'							
D/C							

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

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

DRESSINGS			
Time	Location	Type	Drainage
Adm	(R) Arm	CD 1	
30'			
60'			
D/C			



PACU OUTPUT			
Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM			
Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

Pt. arrived to PACU @ 1000. via stretcher, drowsable, responds to stimuli. O2 sat 90% RA. placed NC @ 95%. lungs CTA. nasal trauma (R) nare. NSR & echoy dressings to (R) forearm & (R) leg CDI. +2 pulses x4. peripheral capillary refill <3sec. Skin warm + dry (+) DS. LR KVO to (R) forearm. Will continue to monitor. [redacted] LT AN

(b)(6)-2

Discharge Criteria:
Date: 13 Aug 05 **Time:** 1045 **PARS:**
BP: 133/81 **T:** 97.3 **HR:** 97 **RR:** 15 **Sa02:** 96
Pain Level at D/C (0-10):
Intake: _____ **Output:** _____
Additional Data: _____
Transferred To: DCWI
Report Given To: LT [redacted] (b)(6)-2
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: LT [redacted] (b)(6)-2
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature: _____

MEDICA RD-SUPPLEMENTAL MEDICAL DA

For use of this form, see A.. .. 66; the proponent agency is the Office of The Surgeo.. .ne.al.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA APPR 08MAR8

INITIAL SHIFT ASSESSMENT

		Time: 0630 Initals: [redacted] (b)(6)-2	Time: Initals:
NEURO	Pupils	3mm, brisk, PERRLA	
	Sensorium	Alert, follows simple instructions	
	LOC / GCS	Denies pain	
CARDIAC	Cardiac Rhythm	NSR s ectopy, rate 70's-80's	
	PRI: / QRS:	Pulses - LRE inaudible but cap refill	
	Pulse Strength	±3 secs, RRE + LLE +2 pulses, R LE +1	
	Cap Refil / JVD	saline lock in R hand	
	Edema		
	Chest Pain		
RESP	Respiratory Pattern	Regular, even + nonlabored	
	Breath Sounds	CTA B	
	Secretions	Ø	
	Cough	non-productive	
SKIN	Color	normal for race	
	Integrity	intact LRE, RLE, R shoulder, R thigh	
	Backside	NO rx or DECUBITUS	
IV	Access Devices	R hand saline lock	
	Location	C/D/I	
	Condition		
GI	Abdomen	BS x4, NT, ND	
	Bowel Sounds		
	Stoma/Ostomy		
GU	Device	Foley	
	Color / Clarity	clear/yellow	

(Continue on reverse)

PREPARED BY *(Signature & Title)*

DEPARTMENT/SERVICE/CLINIC (b)(2)-2 [redacted]

DATE

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

[redacted]
(b)(6)-4

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

DA FORM 4700, MAY 78

USAPPC V2.00

MED[illegible] RD-SUPPLEMENTAL MEDICAL

For use of this form, see A[illegible]-66; the proponent agency is the Office of The Surgeo[illegible]eral.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA APPR 08MAR8

		INITIAL SHIFT ASSESSMENT	
		Time: 0600 Initals: [redacted] (b)(6)-2	Time: Initals:
NEURO	Pupils	Pupils RR. [illegible]	
	Sensorium	Responds @ bedside	
	LOC / GCS	No pain @ lower	
		leg	
CARDIAC	Cardiac Rhythm	NSR HR 80's, 0	
	PRI: / QRS:	ectopy beats noted	
	Pulse Strength	Warm to touch w/ cap ref	
	Cap Refil / JVD	Pulse & sensation	
	Edema	lower leg & foot	
	Chest Pain	with dress. & pulse	
		[illegible]	
RESP	Respiratory Pattern	RR even & unlabored	
	Breath Sounds	RS @ ess [illegible]	
	Secretions	SpO2 @ 95% on [illegible]	
	Cough	Nonproductive cough, [redacted] (b)(6)-2	
SKIN	Color	Skin WD pale	
	Integrity	Superficial [illegible]	
	Backside	Intact, [illegible]	
		[illegible]	
IV	Access Devices		
	Location		
	Condition		
GI	Abdomen	NBS soft NT/ND	
	Bowel Sounds	BS x4, F/C [illegible]	
	Stoma/Ostomy	patent, yellow [illegible]	
		[illegible]	
GU	Device	Less [illegible]	
	Color / Clarity	HR 80's	

(Continue on reverse)

PREPARED BY *(Signature & Title)*

DEPARTMENT/SERVICE/CLINIC (b)(2)-2
ICU3 [redacted]

DATE

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

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

DA FORM 4700, MAY 78

USAPPC V2.00

IC RECORD-SUPPLEMENTAL MEL .L B. A

For use of . . 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 08MAR8

INITIAL SHIFT ASSESSMENT			
N		Time: Initals:	Time: Initals:
E	Pupils		
U	Sensorium		
R	LOC / GCS		
O			
C	Cardiac Rhythm		
A	PRI: / QRS:		
R	Pulse Strength		
D	Cap Refil / JVD		
I	Edema		
A	Chest Pain		
C			
R	Respiratory Pattern		
E	Breath Sounds		
S	Secretions		
P	Cough		
S	Color		
K	Integrity		
I	Backside		
N			
	Access Devices		
I	Location		
V	Condition		
	Abdomen		
G	Bowel Sounds		
I	Stoma/Ostomy		
G	Device		
U	Color / Clarity		

(Continue on reverse)

PREPARED BY *(Signature & Title)*

DEPARTMENT/SERVICE/CLINIC (b)(2)-2
ICU3, [redacted]

DATE

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

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

DA FORM 4700, MAY 78

USAPPC V2.00

ICU1

Patients Name: EPW [redacted] (b)(6)-4 Date: 18 AUG 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																				115/		114/		115/		
NBP																				/71		/68		/69		
TEMP																				98.8		98.6		98.8		
HR																				80		76		76		
RR																				18		20		20		
SaO2																				98		99		97		
FiO2																				RA		RA		RA		
[illegible]																										
Ma[illegible]																										

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	To
IVF																										
IVPB																				50						
NGT																										
PO [illegible]																										
[illegible]otal																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE																				300		300		400		
NGT																										
STOOL																										
DRAIN																										
Total																										

MEDCOM - 17575

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 D 1	I Z	(b)(6)-4 [redacted]	EPW [redacted] (b)(6)-4	1	M

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

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
	N/A	~~99~~ 20	[redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
N/A	U	0215	N/A (b)(6)-4

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
	~~K 7 9~~ K78	

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
Ø	1CW2	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

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

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
5 Ø		Ø 3 Ø 8 3 Ø

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
A E A A		Ø 3 Ø 8 1 7

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

FOR LOCAL USE

Dx: S/P I+D (R) leg + (L) FA

Dx: 2NI 8859

Trauma 1

87359

[redacted]

ADMITTING OFFICER (Signature, [redacted] (b)(6)-2 [redacted] Dr. [redacted] (b)(6)-2

SIGNATURE OF ADMITTING CLERK (b)(6)-2 [redacted] (b)(6)-2, SPC, 91GM

DA FORM 2095, MAR 80

INPATIENT TREATMENT RECORD COVER SHEET

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

(b)(6)-4

1.	2. NAME (Last, First, MI)	3. GRADE	ADMISSION REMARKS
[redacted]	UNK - NAME	EPW	

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	24y	X	MUSLIM			NO

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
9920	(b)(6)-4 [redacted]	[redacted] (b)(6)-4	ICU 2

15. FLYING STATUS	16. RATING/DSG	BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
		K78			WIA

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
Direct From ER	0200	Gen Surg

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
	D/C TO CAMP	31 AUG 2003

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
		17 ~~12~~ AUG 2003	

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

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX ① Shrapnel wnds
② S/P Ex-Lap S-B repair

Dx: 868.19
959.8
E991.9

Px: 46.73
87.79
99.04

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	19	19

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	19	19

SIGNATURE OF ATTENDING MEDICAL OFFICER [redacted] SIGNATURE [redacted]

DR [redacted]

DA FORM 3[redacted]

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

USAPPC V1.10

MEDICAL RECORD | ABBREVIATED MEDICAL RECORD

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

20's yo ~~[illegible]~~ Iraqi male sustained shrapnel from Blast injury c/o abd distension and pain

All Ø PMH Asthma PSH Ø TOB Ø

PHYSICAL EXAMINATION

NC AT TM clr OP clr
Neck ⊖ wound ⊖ Pain ⊖ ROM
Chest – small SQ Puncture @ (R) Supra clav fossa
CBM
Back ⊖ injury
Car RRR 2+PP
Abd ⊕ tend ⊕ FAST
⊖ Peritoneal sx
entrance wound

Gen hypospadias
Rectal Melanemia ⊖
ext occ shrapnel
pepper
CNS ⊖ prox or distal
Ant Neck Lat fragment

PROGRESS (Enter date of discharge and final diagnosis)

A/P ① Acute Abd ② FAST → OR
③ Other insignificant shrapnel injuries → Bandage

(b)(6)-2 [redacted]

SIGNATURE OF PHYSICIAN [redacted] | DATE 7 Aug 03 | IDENTIFICATION NO. | ORGANIZATION

PATIENT'S IDENTIFICAT[redacted] (Typed or written entries give Name (last, first, middle; grade; date; hospital or medical facility)

REGISTER NO. | WARD NO.

EPW [redacted]

(b)(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539
GENERAL SERVICES ADMINISTRATION AND INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
539-106

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE** | AUTHORIZED FOR LOCAL REPRODUCTION

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
0400	VS as follows: T 96 (A) P 113 R 18 BP 125/7[redacted] (b)(6)-2 O2 sats 94% 10 RA [redacted] (b)(6)-2 CPT AN
0445	Nursing Note: Pt. is Alert. Arrived from [redacted] Surgery earlier. Assumed care of pt. at this time.
06	VS as follows: T: 99 P: 118 R: 20 BP: 108/68 Lungs clear, Ex lap drg c̄ minimal drainage. Drg to (R) groin area Dry. Bandage to (L) + tight. Foley to gravity clear + yellow urine. Abd is distended. cap refill < 3 sec x 4 extremities. pulses palpable x 4 extremities. [redacted]
7 Aug 03 0600	PT A+O x 3 VS 100/72 P 120 R 18 SaO_2 98% RA T 99 color good pulses weak no peripheral. LS CTA ABD DTN around mid Drg Site. ABD Drg (+) bloody drainage to gauze + tape. from xyphoid to 2" above Symphis pubis. (-) BS (+) TTP NV1 morning H + H 9/26 MD notified instructed wait 2 hrs recheck H + H. IV (L) FA 18G patent @ 150cc/hr LR. Heplock (R) FA patent. Foley to gravity drg clear yellow urine will cont to monitor [redacted] 9/hrs. CPT [redacted] (b)(6)-2

HOSPITAL OR MEDICAL FACILITY (b)(6)-2	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.) EP W [redacted] (b)(6)-4

REGISTER NO.	WARD NO.

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

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17 AUG 03	OP Note
0200	indication Penetrating Abd wound with
	Abd pain and (+) FAST
	Procedure ex LAP small bowel Repair
	Surgeons - [redacted] (b)(6)-2 [redacted] (b)(6)-2
	Anesth GEA
	1000 Hespan EBL 400
	3000 LR 40 275
	Findings (1) Hemoperitoneum
	(2) Post Rectus hematoma Not Bleeding
	(3) single through & through SB enterotomy
	@ Distal Ileum repaired
	(4) (-) Iliac vessels & Ureter explored
	s injury.
	Comp None
	to ICU in good cond
	[redacted] (b)(6)-2
	[redacted] (b)(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
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PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*	REGISTER NO.	WARD NO.
EPW [redacted] (b)(6)-4		

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

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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
17aug03 0745	pt awake. Yo abdominal pain. pt doesnot speak English but able to use body gestures. MSO4 5mg IVP given, monitor for [redacted] (b)(6)-2 pain relief.
0830	CBC results HCT 26.11 Hgb 8.4. Dr. [redacted] (b)(6)-2 aware. Ordered to transfuse 2 PRBC.
0940.	Hang 1 PRBC, unit # W001303. (2) antecubital site patent. Blood tubing purged c NS. VIS Temp 99.4 pulse 130 BP 104/56 RR 22. Monitor for reaction closely. VIS monitor closely. Blood to be infused over 4°.
0945	98/52, pulse 130, SaO2 96% LR on hold until Blood completion T 99
0950	100/56 P 135 SaO2 96% T 98.8 SGT [redacted] 9 WMC (b)(6)-2
0955	98/54 P 135 SaO2 96% T 98.8 SGT [redacted] 9 WMC (b)(6)-2
1000	100/52 P 124 SaO2 97% T 99.4 SGT [redacted] 9 WMC (b)(6)-2
1005	96/50 P 126 SaO2 96% T 99.5 SGT [redacted] 9 WMC (b)(6)-2
1010	98/50 P 128 SaO2 96% T 99.2 SGT [redacted] 9 WMC (b)(6)-2
1015	96/54 P 120 SaO2 96% T 99.9 SGT [redacted] 9 WMC (b)(6)-2
1030	96/54 P 113 SaO2 97% T 100.0 SGT [redacted] 9 WMC
1045	94/52 P 114 SaO2 96% T 100.1 - Infusion complete
1055	Rx. Start PRBC W001303 010745 exp. 21Aug03 (b)(6)-2 B pos. VS 98/58 P 112 T 100.1 R 24 [redacted] 9 WMC
1100	96/52 P 110 T 100.1 SaO2 96% SGT [redacted] 9 WMC (b)(6)-2
1105	100/60 P 106 T 99.8 SaO2 96% SGT [redacted] 9 WMC (b)(6)-2
1110	102/58 P 108 T 100 SaO2 96% SGT [redacted] 9 WMC (b)(6)-2
1115	100/56 P 106 T 99.6 SaO2 96% SGT [redacted] 9 WMC
1120	102/62 P 106 T 100' SaO2 96% SGT [redacted] 9 WMC

STANDARD FORM 600 (REV. 6-97) BACK

*U.S. GPO: 2002 - 491-600/50618

(b)(6)-2

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
17 Aug 0935	100/60 P 107 T 100.2 SaO2 96
1145	108/58 P 110 T 100.1 SaO2 96
1205	Infusion complete VS 104/56 P 108 R 22 T 100.2 SaO2 97% RA [redacted] (b)(6)-2 urine output 30cc MD notified - give 1000cc LR bolus per MD order SGT [redacted] 91MMO (b)(6)-2
1345	bolus complete - urine output 60cc ABD T DTN T tenderness to touch (b)(6)-2 Dr notified & new orders SGT [redacted] 91MMO
1400	pt C/O abd pain when touched MS04 given per MD suggestion 5mg IVP SGT [redacted] 91MMO (b)(6)-2
18 Aug 03	0700 C/O ABD pain [redacted] (b)(6)-2 @ incision site Dry midline CDI. given MS04 4mg by CPT [redacted] (b)(6)-2 NAD NG tube (R) nare IVS patent drg cloudy water secretions will cont to monitor for effect [redacted] (b)(6)-2
1845	Pt A+O, VSS. S.S. 2 murmur 2+ pulses all extrem. LSCTA, resp reg unlabored, abd. soft, slightly distended, NGT LIS drng green fluid smlamts. Given 5mg MS04 IVP for pain c̄ good effect. ↓BSx 4 quads. Foley drng clr yellow urine sufficient amts.

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

SPONSOR'S NAME | SSN/ID NO. | RELATIONSHIP TO SPONSOR

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

#[redacted]

(b)(6)-4

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
18 AUG 03	Surgery POD #1 ex lap - Repair of small bowel c/o Abd distension & mod pain NGT in place VS T 99.1 HR 98-118 97% RA Chest CBTA Abd mod distended TTP but improved hypoactive but present BS UO 60-100 cc/hr CBC 9.1 / 29 / 186 A/P Doing well cont current plan [redacted] (b)(6)-2

STANDARD FORM 600 (REV. 6-97) BACK
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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1845 (cont.)	Abd dsg CDI. Will monitor. [redacted] (b)(6)-2 1/LTAN
19AUG03 0400	Pt resting. VSS. New 18G PIV started (L) wrist labs sent. medicated c̄ 5mg MSO4 for c/o pain to (R) flank. Will monitor. [redacted] (b)(6)-2 1/LTAN
19 Aug 03 0600	Received report from outgoing shift. Pt rests c̄ eyes closed easily roused A×O×3 pleasant EOM VS 142/84 P 108 R 14 even unlabored CS-CTA T 98.4 SaO2 99% 2lO2. color good cap refill brisk Dig midline abd CDI BS hypoactive (+) BM noted ↓ from yesterday ABD tenderness ↓ from yesterday. grip strength equal NVI moves all 4 extremities foley patent draining clear yellow urine. NG to LIS drg green secretions will cont to monitor SOT [redacted] 91 MMS
(b)(6)-2 19Aug03	0900 OOB X 1½ hrs Am Care given pt washed teeth brushed lotion applied tolerated well NAD (pt @ bedside chair for duration. SOT [redacted] (b)(6)-2 91 MMS
19Aug03	0916 Ambulated from chair to bed c̄ ABD pain given MSO4 3mg by CRT [redacted] (b)(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
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PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*	REGISTER NO.	WARD NO.
[redacted] (b)(6)-4		

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

[redacted] (b)(6)-2

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
19Aug03 Cont.	tolerated well NAD SGT [redacted] 9mm (b)(6)-2
19Aug03	No [redacted] NL [redacted] [redacted] NL [redacted] (b)(6)-2
	[redacted] (b)(6)-2
19Aug03	1600 OOB to chair tolerated well NAD SGT [redacted] (b)(6)-2
19Aug03	1730 in bed from chair tolerated well NAD SpO2 96% on RA SGT [redacted] (b)(6)-2
20Aug03	Surg Pt AFOB USS HR 102 BMOSIS THS RA/R LUSSICTA LUL: [redacted] m/l TACHY ABD: SOFT. NT, [redacted] DISTENSION [redacted] (b)(6)-2 RP: [redacted] Plan NPO NG TO SUCTION [redacted] ICUS & CVC [redacted] (b)(6)-2 [redacted]

STANDARD FORM 600 (REV. 6-97) BACK

*U.S. GPO: 2002 - 491-800/50618

AUTHORIZED FOR LOCAL REPRODUCTION

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

21 Aug 03 Progress Note

POD #4 s/p Surgical injury to old regency exlap
c̄ drainage of rectus hematoma + SB enterotomy
repair.

Pt c/o nausea, abd pain, ∅ BM since
prior to motor attack = 9 days.

Some improvement c̄ Bleeding last night

CBC yesterday nl

afebrile

AAS clear except bowel gas/pleus. (gas throughout
colon)

PE: distended mildly
tender to palpation
∅ rebound

NG implanted

Dx: Ileus (?) vs pain 2nd rectus hematoma

Plan: Cont NPO
cont observation
√ CBC in AM

[redacted] (b)(6)-2

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

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

[redacted] (b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
23AUG03 Ancet	Surgery POD #6 - enterotomy /Abd wall/pelvic hematoma
1UF	Minimal complaint ON/V ⊖ flatus
	Tm 100.5 110 150/80 NG output 500 ⊖ 54/L
	~~Gen~~
	wound c/d staples in place
	Abd - mod distended, mm TTP., ⊖BS
	12.7 / 30.7 < 393 138 / 3.6 < 98 / 20 < 14 / 96 / 1.2
	A/P POD#6 ex lap ε hematoma. prolonged ileus.
	Now ε ↑wbc and low grade temp would
	CT u Rlo Abscess. but will ✓ CBC. today.
	[redacted] (b)(6)-2
	[redacted] (b)(6)-2
23Aug03 2330	Pt awake and alert. NGT to ⊕ nare intact, draining dark green fluid. Lungs CTA bilat ⊖ resp distress. NSR. Abd soft, non-tender, bowel sounds ~~active~~ ~~4 quad~~ error [redacted] (b)(6)-2 hypoactive x4 quads. Pt c/o dry throat & cough, given sips of water. Abd incision ⊖DI, staples open to air. Low grade fever noted, incentive spirometer encouraged. (b)(6)-2 [redacted] W/
24Aug03 0045	350cc orange urine emptied from foley. UO @ 150 c/hr. ⊖ sediment noted in urine (b)(6)-2 [redacted] W/
0530	350cc dark green fld to NGT suction. ⊖ complaints at this time. (b)(6)-2 [redacted] W/

STANDARD FORM 509 (REV. 5/1999) BAC

USAPA V1.

EPW

[redacted]

(b)(6)-4

TCWC

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
24 Aug 03	1245 - Pt alert & oriented OOB to chair. Ambulated c assistance x1. Lungs CTA, HR reg, BS hyporactive. Belly distended & soft. Staples to abd incision intact, Ø S/S of infx. NG intact to L intestinal drainage green stomach fluid. IV to Ⓡ arm patent. Voiding Ø complaints. Will cont to monitor [redacted] (b)(6)-2
24AUG03	Surgery No complaint Ⓞ Flatus Ⓞ N/V VSS HR 72 Abd mod Distended soft ↓ Abd Tenderness hyporactive BS. (13.1) 556 140 | 103 16 9D 37.8 4.2 21 1.4 A/P Post-op ileus cont current Rx would obtain CT when Available [redacted] (b)(6)-2 [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.

PROGRESS NOTES
Medical Record

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

24 Aug 03 1900: Assumed care @ 1400. T-99.0°F P-74 R-16 BP-137/81 SpO2-96%
HR-regular. Lung sounds clear bilat. Abd slightly distended, tender, BS hypoactive
staples to midline abd. intact. NG suction draining green @ intermittent setting. Foley
d/c'd. Ambulating q 4° c̄ NG clamped. MSO4 to control abd pain. Will continue
to monitor. [redacted] (b)(6)-2

25 Aug 03 assumed care @ 2200 - staples intact on abd
0100 incision, no drainage noted, abd soft, non-tender
on palpation, only one BS heard in lower ⑧ quad -
LR @ 150cc/hr infusing into ⑧ PA, site patent - NGT
to LIS, small amount of greenish output -
lungs clear throughout x inspiratory wheezes noted
in ⑧ upper lobe [redacted] (b)(6)-2 Chinn

25 Aug 03 pt. had 400cc NGT output dark green - this shift -
0500 voided 300cc spontaneously in urinal [redacted] (b)(6)-2

0400 T-96.8 BP 130/62 R-16 P-62 [redacted] (b)(6)-2

25 Aug 03 - 950cc of green chunky fluid removed from NG collection container. Pt. 5
1200 complaints @ this time. VSS. HR Regular, Lung sounds clear bilat, bowel sounds
hypoactive x 4 quads. Vertical mid abdominal incision well approximated, staples intact. IV
c̄ LR @ 150 cc in ⑧ wrist infusing well 5 s/s of infection or infiltration. NG tube in place to int.
suction 20 sec on 20 sec off. All other assessment findings WNL. Will continue to monitor [redacted] (b)(6)-2

25 Aug 03 1633: Assumed care @ 1400. T-98.7°F P-80 R-16 BP 143/78 SpO2 95%.
HR-reg. Lung sounds clear bilat. BS hypoactive x4. Midline abd. incision intact.
LR infusing @ 150cc in ⑧ wrist. Ambulated x2. NG to LIS. No c/o pain or
discomfort @ this time. [redacted] (b)(6)-2

25 AUG 03 2200 PT VS P-81, BP-140/82, T-98.5, R-18, SpO2-93 - [redacted] (b)(6)-2

0745 [illegible] pt. made very weak attempt -
IV patent, LRC 150cc/hr - ⊘BS heard x 4 quads - lungs
CTA (B) - staples intact on abdomen, ⊘ drainage from
incision - c/o abd pain and wanting medicine to sleep,
medicated for pain, will monitor results - NGT to LIS c (b)(6)-2
moderate amount of drainage, green bile - [redacted] CRNA
26 Aug 03 400cc dk green bile c̄ mucous NGT output - pt. slept (b)(6)-2
0500 throughout night is further c/o pain - [redacted] CRNA
26 Aug 03 Pt vitals BP 146/76 P 54 T 98.4 R 16 SpO2 94 SPC [redacted] 94W10
0522 (b)(6)-2
26 Aug 03 1112 - Pt A+O x 3 UDB ambulating x 1. Sitting in chair.
VSS, lungs CTA, BS ⊕ in lower quadrants. NG intact
to LIS c̄ green bile noted. IV to (D) arm → patent.
Staples intact to abd incision, ⊘ s/s of infx.
Voicing ⊘ complaints. Will cont to monitor
[redacted]
(b)(6)-2
26 Aug 03 1510: Assumed care @ 1400. Awake & alert T-96.8°F P-84 R-16
BP-154/82 - SpO2-99% on RA. HR-reg. Lung sounds clear, BS X⊘. Midline
incision staples intact, NO s/s of infection, NG to LIS draining
Dark green bile, Ambulates ward c̄ 1 assist. Will continue to monitor,
[redacted]
(b)(6)-2

2200 ~~[illegible]~~
98.4
77
20
97%
140/79
6

PROGRESS NOTES

DATE | TIME

26AUG03 Surgery

No complaint

VSS Afeb NG 900 over 12hrs

abd: mod distended, soft, non tender Normal Bowel sounds today.

12.4 / 34 / 546

A/P ↑ Bowel Activity today.

will ↓ to clears if BS persist tomorrow

[redacted] (b)(6)-2

[redacted] (b)(6)-2

26Aug03 assumed care @ 2200 - VSS - no c/o pain

2355 during assessment, pt. sleeping @ present - lungs CTA (B) - BS hypoactive, NGT to LLS 400cc green bile output from 1400 - 2200 - staples intact on abd incision, no drainage noted - IV patent in (L) FA, 2RC 150cc/hr, site [redacted] (b)(6)-2 ~~patent~~ S/S infection - (b)(6)-2

abd soft, non tender, slightly distended [redacted] CPAN

27Aug03 NGT output 400cc dk. green bile 2200-0430-

0445 c/o abd pain when awoken for VS, given 650mg tylenol PO -

ICWZ

EPW

[redacted]

(b)(6)-4

27Aug abd slightly distended, nontender, soft, (b)(6)-2
Con't. hypoactive BS in upper quad [redacted]

(b)(6)-2

27AUG030400 P 67, BR 93, BP 147/86, T 93.4 —— SPC [redacted] 41W

27Aug03 1015 A. transfered to ICW1. —— [redacted]

(b)(6)-2

(b)(6)-4

[redacted]

PROGRESS NOTES

DATE	
27 Aug 03	Surgery Pt stable AFOB Lungs: CTA Card: RRR Abd: soft, still distended (+) BS ∅ BM NG 400 last shift Bp: Blass Plan: cont current management [redacted] (b)(6)-2
27 Aug @2100	Pt a/o x3, VSS, pulse: slightly tachy, HRRR, (+) BS x4, abd: slightly distended. c/o pain. demerol 25mg given c̄ some relief. NGT intact c̄ intermittent suction. s/p ex-lap. IVF LR@150 infusing ∃ s/s/sx of infection/infiltration. Will cont to monitor — [redacted] 91WM6-SPC (b)(6)-2
27 Aug 2200	∅ BM yet. voiding often, cont [redacted] (b)(6)-2
27 Aug 03 @0505	1000cc from NGT suction, coffee ground colored. Demerol 25mg for pain will cont to monitor — [redacted], B9WM6 (b)(6)-2
28 Aug 03	Surgery Pt stable AFOB Lungs: CTA Cardiac Abd: soft, (+) dist (+) BS ∅ BM NG 1000 overnight Bp: Blass Plan: cont current management [redacted]

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

MEDCOM - 17593

[redacted] (b)(6)-2

MEDICAL RECORD	PROGRESS NOTES
DATE	
28 AUG 1000	VSS A&O per interpreter. NG to intermittent low suction. NG draining dark greenish. IV @ FA patent & intact IVF Bed D5 1/2 NS @ 20 mL/hr @ 125 cc/hr. Ø swelling or pain noted. OOB ambulated to BR passed gas Ø BM AM care done. NG ~~to~~ changed to Maalox as ordered. Abd soft non distended. BS(+) X 4 quadrants. Restraints removed and reapplied. Will check restraints & circulation of extremities. [redacted] (b)(6)-2 2CR
28 AUG 1700	During Md. Rounds Dr [redacted] pulled NG. & ordered clear liquid diet. Tolerating clear liquids. Ambulated to BR had small BM. Midline Abdominal suture intact with edges to incision well approximated Ø drainage, redness or swelling noted from incision [redacted] (b)(6)-2 2CT
28 AUG 03	VSS. (+) pulses. BS & hyperactive. Reported to have small BM on prior shift. Ex. lap & staples OTA & DTA. Tolerating PO sips of water & clear diet well. Instructed to use TS and verbalized understanding and return demonstration. [redacted] (b)(6)-2 RN

(Continue on reverse side)

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

PROGRESS NOTES

DATE	
29AUG03	(0910) Assumed care of pt w/ good p̄ report from night shift. Pt alert, speaking Arabic. VSS. Ø c/o pain w/ this time. Lungs CTA(B). bs hypoactive x4 quads. staples to abd midline CDI - open to air. IVF NS c̄ 20KCl infusing via dial-a-flow into (L) forearm c̄ s/sx infection/infiltration w/ site. KUB done this am. Pt tol. clear liquids well. Voiding c̄ difficulty. Ø BM so far this shift. 2 point restraints in place - Ø s/sx complications c̄ skin breakdown / circulation. Will continue to monitor. [redacted] MAW (b)(6)-2
	(1420) Pt ↑ to and in hallway c̄ difficulty. Pt had large loose BM this pm. Pt states (+) relief of [redacted] (b)(6)-2 of abd pain. Will monitor. [redacted] MAW (b)(6)-2
29AUG03	Surgery STABILIZATIONS Lungs: CTA CVS: RRR Abd: soft, NT, ND, BS (+) Ext: Residual Flow Plan: Close Leaving Drift [redacted] (b)(6)-2
29AUG03 1940	Pt resting in bed, A+Ox3, VSS, c/o pain, medicated c̄ 2 percs, LS CTA(B), (+) BS x4, S1 S2 present, skin warm dry, staples to abd midline CDI open to air, Ø s/sx of infex, IV (L) FA patent infusing NS c̄ 20KCL via dial →

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

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

MEDICAL RECORD	PROGRESS NOTES
DATE	
	a- flow, proper circulation and skin integrity on (b)(6)-2
Cont.	pts. of restraint. [redacted] (b)(6)-2 [redacted]
21 SØ	Pt had a BM [redacted] + formed [redacted] (b)(6)-2
	[redacted] (b)(6)-2
30 Aug	Surgery
	Pt [illegible]
	Lungs: [illegible]
	Card: [illegible]
	Abd: [illegible]
	Ext: [illegible]
	Plan: [illegible]
	[redacted] (b)(6)-2
30AU603	(HIO) Assumed care of pt @ 0600 ~~p~~ report from night shift. Pt alert, speaking Arabic. Pain controlled c̄ Percs. VSS. Steri strips to midline abd incision CDI. Staples removed by MD today. Pt adv to reg diet for lunch. Tol. well. New IV started in ⓡ forearm. IVF infusing s̄ S/Sx infiltration. IV in ⓛ arm d/c'd d/t infiltration. AM care done by pt. voiding s̄ difficulty. ⊕ bs x4 quads. 2 point restraints in place - ⊖ S/Sx complications c̄ skin break-dn/circulation. Will cont. to monitor [redacted] (b)(6)-2

(Continue on reverse side)

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PROGRESS NOTES
Medical Record

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MEDICAL RECORD	PROGRESS NOTES
DATE	

30AUG03 2145 Pt A+Ox3, VSS, LS CTA (B), (+) BS x4, S1 S2 present, steristrips on midline abd incision CDI, pt OOB ambulated around the ward, c/o mild pain, IV (R) FA patent infusing D5½ NS c 20 mEq KCl @ 125 cc/hr, proper circulation and skin integrity on pts of restraint: [redacted] (b)(6)-2 GIWM6 [redacted] (b)(6)-2

31aug03 0700 Received pt resting in bed, VSS. A+Ox3. ~~Staples~~ midline abd steri strips OTA ∅ drainage noted. IV patent & intact @ Rt, HL. Amb to BR x2. Pt c/o gas pain abd slightly distended, but soft. Broke out in sweat during first attempt c BR. Dr [redacted] (b)(6)-2 ordered Dulcolax suppository x1 for stimulation of bowel process. Pt amb to BR for 2nd time w/ successful BM. No other remarkable assessment findings will cont to monitor pts. [redacted] (b)(6)-2

1400 D/C to CPW comp in stable condition [redacted] (b)(6)-2 Avoid of gas pain complaint [redacted] (b)(6)-2

(Continue on reverse side)

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

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

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

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

NSN 7540-01-075-3786

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

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS [redacted]

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)* 17 Aug 03 | TIME 0000

TRANSPORTATION TO FACILITY

SEX: M

AGE

DUTY/LOCAL PHONE	
AREA CODE	NUMBER
HOME PHONE	
AREA CODE	NUMBER

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

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

CURRENT MEDICATIONS

ALLERGIES: NKDA

INJURY OR OCCUPATIONAL ILLNESS			
ITEM	YES	NO	WHEN *(Date)* earlier today
IS THIS AN INJURY?	✓		WHERE Iraq
INJURY/SAFETY FORMS			
HOW Mortar Round			

EMERGENCY ROOM VISIT	
DATE LAST VISIT	24 HOUR RETURN ☐ YES ☐ NO
TETANUS	
DATE LAST SHOT	COMPLETED INTITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: Abd pain hx · asthma

CATEGORY OF TREATMENT

- ☒ EMERGENT
- ☐ URGENT
- ☐ NON-URGENT

TIME: 0001

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

VITAL SIGNS

TIME	0002				
BP	141/92				
PULSE	75				
RESP	18				
TEMP	99.4(o)				
WT					

LAB ORDERS

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

X-RAY ORDERS

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

ORDERS

☒ PULSE OX 94%

☒ MONITOR

☐ ECG.

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
0010	1gm Ancef	[redacted]	(b)(6)-2		
0010	0.5cc Tetanus	[redacted]	(b)(6)-2		
0025	5mg Morphine	[redacted]	[redacted]	(b)(6)-2	

DISPOSITION: ☐ HOME ☐ FULL DUTY

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

MODIFIED DUTY UNTIL

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATE

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)*

A [redacted]

(b)(6)-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

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 Aug 03		12:30	Pt OOB to chair x 90 min. Had 1 episode of emesis while up in chair. After emesis Ø C/O Nausea. CXR & KUB done this am. Will continue to monitor pt. [redacted] LM (b)(6)-2
20 Aug 03			Trauma Summary 20 ISL yo EPW struck by shrapnel day prior to arrival 16 Aug 03 Had X-Rays with fracture of hemopathic (R) radius shaft [illegible] Single flow (tube entering to distal ileum which was primarily repair. Postop pt then had persistent ileus attempt at removal of NG unsuccessful on POD #2 NG replaced. Currently 5 bowel movements. Single episode emesis today
			Dx 1) S/P Ex Lap for shrapnel injury to small bowel 2) Postop Ileus
			Plan Transfer 21CSH. NG, IVF. Awaiting [redacted] (Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; [redacted] REGIS[redacted] hospital or medical facility) WARD NO.

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

NURSING NOTES
Medical Record

STANDARD FORM 510-PE, 7-71

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
~~17:00~~			Pt ambulated length of ward x 2.
20 Aug 03		17:00	UOP sufficient. No fever to low intermittent suction. Minimal drainage through the day. (b)(6)-2 [redacted]
			Will continue to monitor pt. [redacted]
20 Aug 03		2330	Received pt from ICW #2 Resting quietly, afebrile, pt c̄ BM x ÷ for lg amt of stool. (b)(6)-2 [redacted]
20 Aug 03		2300	Pt c̄ c/o pain given 2mg IV morphine for pt (b)(6)-2 [redacted]
		0100	pt c̄ c/o pain given 2mg morphine. Pt c̄ emesis & moaning. Pt notified. Pt given 12.5mg Phenergan IVP (b)(6)-2 [redacted]
21 Aug 03		0800	Rest c̄ eyes closed easily aroused VS 146/92 P101 R18 SaO2 96% RA NN A+O x3 NAD LS CTA even unlabored diaphragm @ bases abd (+) DTN (+) TTP around wound site. Midline staples intact (-) drg (-) erythema noted. NG-LIS
21 Aug 03		2245	VSS, A+O, pt receiving IV Phenergan & Reglan around the clock for N/V. Pt. had x1 episode of emesis light green ~50 cc fluid. NGT to LWS intermittent suctioning dark green fluid. Staples to midline abdomen CDT. Foley to gravity draining clear yellow urine. IV to (R) AC running LR @ 150cc/. No other remarks

STANDARD FORM 510 (REV. 7-91)

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

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
Continued 21 Aug 03 2245			assessment findings Pt does not appear to be in any pain @ this time. (+) BS x4. Will continue to monitor. (b)(6)-2 [redacted]
22 Aug 03 0040			1300 cc total from NG dark green fluid (b)(6)-2 [redacted]
22 Aug 03 0120			NG tube withdrawn 10 inches per MD order & secured. HR Regular, lungs sounds clear bilat, bowel sounds x4 quads. IV in RAC, s/s of infection or infiltration. Infusing well @ 150cc/hr. Staples to ventral mid-abdominal incision intact, s/s of infection. Foley draining clear yellow urine. NG tube draining moderate amts of milky green fluid. VSS. Pt c/o complaints @ this time. Will continue to monitor. (b)(6)-2 [redacted]
22 AUG 0738			RTVS BP 158/84, HR 100, T 99.2, RR 18, SpO2 95% → [redacted]
22 Aug 1000			BM x1 (b)(6)-2 [redacted]
1525		1700	Pt. c/o temp of 100.8, Tylenol 650mg PR given. (b)(6)-2 [redacted]
1528			125cc dumpy green fluid emptied from NG suction. (b)(6)-2 [redacted]
22 Aug 03 1925			Assumed care @ 1700. HR: 112 BP 155/88 T-100.5°F. Sleeping. NG to low intermittent suction c̄ dark green drainage. Lung sounds clear bilat. Audible heart murmur. LR @ 150cc/hr infusing in (L) FA. No signs of pain @ this time. Foley patent. Will continue to monitor. (b)(6)-2 [redacted]
22 Aug 03		2312	NG output recorded - 800cc. (b)(6)-2 [redacted]
23 Aug 03 0415			Late entry for 1700 22 Aug 03: T-100.5°F P-112 R-24 BP - 155/88 SpO2 95%. (b)(6)-2 [redacted]
23 Aug 03 0500			NG output - 500cc. (b)(6)-2 [redacted]

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 (b)(6)-2
23 Aug	0730		PVS, BP 138/84, HR 103, T 99.4, RR 20, SpO2 95% [redacted]
	1200		Pt alert & oriented. OOB x2 ambulating. Had CXR done. VSS, lungs CTA, HR reg; BS⊕, pulses ⊕ x4. Staples intact to abd, ∅ s/s of infx. Foley intact draining orange urine. NG tube to ↓ intermittent suction draining green gastric juices. IV patent to ⓛ forearm. Voiding w/ complaints.
			(b)(6)-2 Will cont to monitor [redacted]
		1600	Pt. c/o ABD pain. 5mg MSO4 given c̄ good results. (b)(6)-2 [redacted]
		1736	Pt. care assumed @1500. VSS. HR Reg, lungs CTA. BS hypoactive ⊕ x4 Q, active ⊕ ↑ Q. NC ABD incision c̄ staples OTA c̄ s/s infection. ABD firm, mod. distended. NG patent, draining green thin liquid. Foley ⇒ gravity draining orange colored urine c̄ sediment. Will cont to monitor. [redacted] (b)(6)-2
		2215	1375cc orange clear urine per Foley, 875 cc green, black, mucoid drainage per NG. 1800 cc NG output on day shift per LT
		(b)(6)-2	[redacted] (b)(6)-2 [redacted]

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

NURSING NOTES
Medical Record

STANDARD FORM 510 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-3

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 Wheeled litter BY Anesthesia/Surgeon

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

3. DATE 17AUG03 TIME PATIENT ARRIVED IN SUITE 0025

4. PATIENT IN ROOM TIME 0025 NUMBER 1-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: NKA

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] 91D (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] RN (b)(6)-2	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify) Pt on padded OR Bed, Head on foamdoughnut Bilateral Arms extended to sides <90° in CAP secured to padded armboards with Safety straps. Correct Body Alignment maintained. - Folded towels under heels

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

COMMENTS:

8. SKIN PREPARATION

HAIR REMOVAL ☒ YES ☐ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☒ RAZOR by Dr [redacted] (b)(6)-2 ☐ CLIP

COMMENTS: no nicks or cuts noted

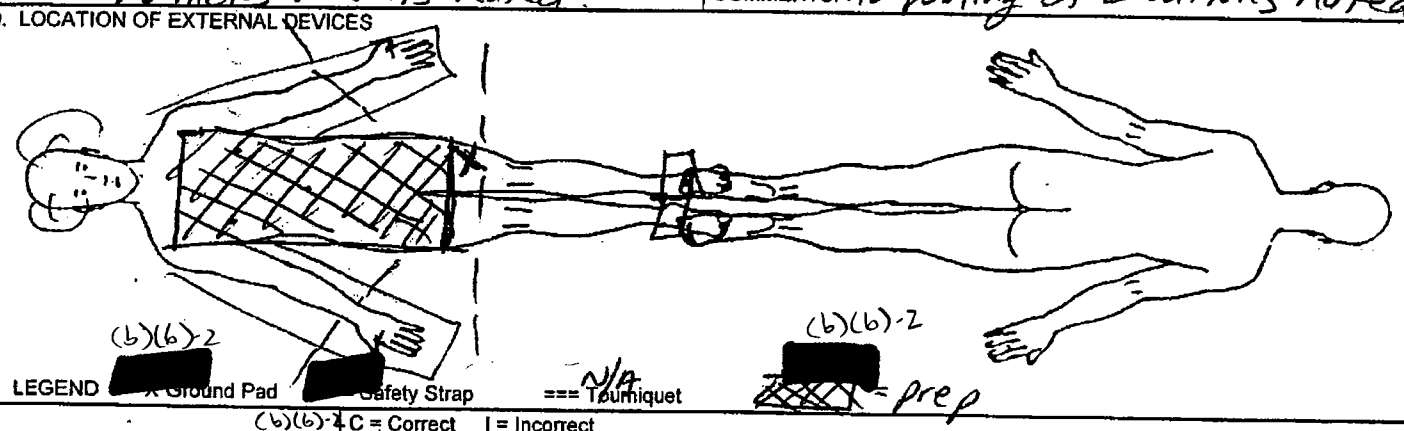
PREP SOLUTION (Specify) Beta/Beta

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

SITE: +Groin as below BY WHOM:

COMMENTS: no pooling of solutions noted

9. LOCATION OF EXTERNAL DEVICES



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

(b)(6)-2

10. COUNTS (C = Correct I = Incorrect)

			Initial Count	First Closing Count	Final Closing Count	SCRUB (b)(6)-2	CIRCULATOR (b)(6)-2
Sponge	☒ Yes	☐ No	C	C	C	SPC [redacted]	CPT [redacted]
Needle Sharp	☒ Yes	☐ No	C	C	C	"	"
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: 4 - SN-FOE 000411

GROUND PAD: BRAND REM Polyhesive II Valleylab

LOT NO: 68936 / 2005-03

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

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

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

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

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

16. LABORATORY SPECIMENS

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

18. DRESSING/IMMOBILIZATION (Specify)
4x8 plain sponges.
Silk tape.

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. foley 16F	2.	3.
SITE	1. Urinary Bladder by Dr [redacted] (b)(6)-2		3.

19. ADDITIONAL INFORMATION
WC IV
Surgeons: Dr [redacted] (b)(6)-2 Dr [redacted] (b)(6)-2
Anesthesia: CPT [redacted] (b)(6)-2 CRNA Anesthesia Type: GEN/Endo.

Bovie Pad site intact pre-op CI ; post-op CI Bovie Settings: Coag/Cut 30/30 Blend 1
Tourniquet Site intact pre-op N/A post-op

Form DA 5179 not completed DIT lang barrier + Emergent Status

20. OPERATION(S) PERFORMED
Exploratory Laparotomy & Bowel Repair

21. PATIENT TRANSFERRED TO ICU 2 TIME 0220 METHOD Wheeled litter

22. RE [redacted]

REVERSE OF DA FORM 5179, OCT 87 (b)(6)-2

MEDCOM - 17604

USAPA V1.01

(b)(6)-4

ICU1

Patients Name: EPW [redacted] VS 7b Date: 20-21 AUGUST 2003

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line	140/				150/				139/							142/	142/									
NBP	/81				/86				/82							/81	/80									
TEMP	98.3				98.6				98.9								98.9									
R	102				98				108							106	106									
	16				18				18							16	16									
O2	98				97				98							98	98									
iO2																RS										
ource	RA				RA				RA							RA	RA									
MAP																RA										

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
IVF	150	150	50	150	150	150	150	150	150	150	150	150		150	150	150										
IVPB			100																							
NGT																										
PO																										
Total	150	300	450	600	750	900	1050	1200	1350	1500	1650	1800		1950	2100	2250										

UTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE		300																								
NGT																										
STOOL																										
DRAIN																										
Total		300							1600										700							
																			1700							

at status: "... 9 days since last BM..."

MEDCOM - 17605

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY														
POST- DAY		17	17	17			21 Aug 03	22 Aug 03						
MONTH-YEAR	DAY			21 Aug		21 Aug								
19	HOUR	46 8 10 12 14 16 18 20 22 24		0400		0730	2230	1215	1400					

(use other form)

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE: 166/105; 105; R18; 146/92; 101; R18; 107/20; 20; 80; 111/55; 95%; 95% RA; 95% RA; 95% RA

HEIGHT: | WEIGHT →

UO: 80; 400cc; 5x0.9%

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)

EPW [redacted]

(b)(6)-1

REGISTER NO.

WARD NO.

STANDARD FORM 511 (REV. 7–95) BACK

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY												
POST- DAY		27 Aug	28 Aug	29 Aug 03			30 Aug 03		31 Aug 03			
MONTH-YEAR	DAY											
19	HOUR	2	1900	0700	19	8		19	0800			

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

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°

(admit) 35 30

RESPIRATION RECORD: 18 | 135/74 | 16/76 | 6 | 34

BLOOD PRESSURE: 134/78 | P 58 T 97.7 | 133/77 71 96 96 | P 60 T 97.7 | 121/72 168 97.8 | 126/73 | 120/72 80 98.3 | 134/83 85 97.8

HEIGHT: | WEIGHT →

SPO2: 96 96 | 95% | 96% | 97% | 96% (on) | 98% | 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. ICW #1

STANDARD FORM 511 (REV. 7–95) BACK

ePW # [redacted]

(b)(6)-4

Ward/Section: EMT	REQUESTING PHYSICIAN: [redacted] (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI [redacted] (b)(6)-4	DATE 17 Mar	TIME	SSN/PSEUDO SSN:

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
			Color		N/A	RPR		Negative
			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		
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		

(b)(6)-4 [redacted]

Coagulation Studies			Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)		
TEST	RESULT	REF. RANGE	UNIT	TYPE	CROSSMATCH
PT	23.3	9.8-13.6 secs			
APTT	28.7	21-34 secs			
D dimer		<20 ug/ml			
FDP		<10 ug/ml			

REMARKS:

REPORTED BY: (b)(6)-2 [redacted]	DATE: 17 Aug 03	LAB ID NO.:

2D

ICW-1

#[redacted]

(b)(b)-4

CHEM I

SPECIMEN/LAB. RPT. NO.

URGENCY
☒ ROUTINE
TODAY ☐
☐ PRE-OP
STAT ☐

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

SPECIMEN SOURCE
☒ BLOOD
☐ OTHER (Specify)

PATIENT'S MED. RECORD

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

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

REPORTED BY MD TECH

DATE

LAB. ID. NO.

REMARKS [redacted]

Chem 8

548-107

TEST(S)																																		
SPECIMEN TAKEN	TIME	A.M. P.M.	REQUESTED	(K)	/																													
DATE	RESULTS		GLUCOSE	UREA N.	CREATININE	URIC ACID	SODIUM	POTASSIUM	CHLORIDE	CO_2	PHOSPHATE	CALCIUM	TOTAL PROTEIN	ALBUMIN	GLOBULIN	ALKALINE PHOSPHATASE	ACID PHOSPHATASE	SGOT	LDH	CPK	BILIRUBIN (TOTAL)	BILIRUBIN (DIRECT)	CHOLESTEROL	TRIGLYCERIDES	AMYLASE	LIPASE	PROFILE (Specify)							

CHEMISTRY I
STANDARD FORM 548 (Rev. 8-72)
PRESCRIBED BY GSA (GMR FIRMR (41 CFR) 201-45.505

2D

ICW-1

#[redacted]

(b)(6)-4

HEMATOLOGY

URGENCY
☒ ROUTINE
TODAY ☐
☐ PRE-OP
STAT ☐

SPECIMEN/LAB RPT. NO.

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

SPECIMEN SOURCE
☒ VEIN ☐ CAP
☐ OTHER (Specify)

PATIENT'S MED. RECORD

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

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

REPORTED BY MD DATE TECH

LAB. ID. NO.

REMARKS [redacted]

CBC

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

549-107

HEMATOLOGY
STANDARD FORM 549 (Rev. 7-78)
PRESCRIBED BY GSA/ICMR
FIRMR (41-CFR) 201-45.505

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

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

(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 =======
17/08/03 00:32
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: 3151AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	142*	73-118	MG/DL
BUN	♦♦♦	7-22	MG/DL
CRE	♦♦♦	0.6-1.2	MG/DL
CK	199	39-380	U/L
NA+	122*	128-145	MMOL/L
K+	3.4	3.3-4.7	MMOL/L
CL-	101	98-108	MMOL/L
tCO2	17*	18-33	MMOL/L

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
N		7-22 mg/dl
		8.5-10.3 mg/dl
		0.6-1.2 mg/dl
		128-145 mmol/l
		3.3-4.7 mmol/l
		98-108 mmol/l
		18-33 mmol/l

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY:	DATE:	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. (b)(6)-4 [redacted]	DATE 17 Aug	TIME 0840	SSN/PSEUDO SSN:	

0800

before trans
17 Aug

(b)(6)-4
[redacted]

Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
Color		N/A	RPR		Negative
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**		
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: ICU 2

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

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

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

DATE: 17 Aug

TIME: 1230

SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10³
		l x 10⁹
		g/dl (M) g/dl (F)
		% (M) % (F)
		fl (M) fl (F)
		0 x 10³
		ed
		1.1%
Differential		
		% (M)
		% (F)
Sed Rate		
Other		

after trans
17 Aug 03

(b)(6)-4

ID [redacted]

WBC, RBC, Hgb, Hct, MCV, MCH, MCHC [illegible]

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

DATE: 17 Aug 03

LAB ID NO.:

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

LAST, FIRST, MI (b)(6)-4 [redacted]	DATE 17 Aug	TIME 1000	SSN/PSEUDO SSN:

(Hematology) CBC

17 Aug
1000

(b)(6)-2
[redacted]

[illegible]
[illegible]

WBC	8.7	[illegible]	4.5	10.5
RBC	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]		11.0	[illegible]
[illegible]	[illegible]		35.0	60.0
[illegible]	[illegible]		80.0	[illegible]
[illegible]	[illegible]	[illegible]	27.0	[illegible]
MCHC	[illegible]	[illegible]	33.0	37.0
PLT	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	%	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

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:	DATE:	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: EPW [redacted] (b)(6)-4	DATE: 17 Aug	TIME: 0530	SSN/PSEUDO SSN:

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE

======= PICCOLO =======
17/08/03 05:20
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
GENERAL CHEMISTRY 12
DISC LOT #: 3142AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

ALB	2.4*	3.3-5.5	G/DL
ALP	50	26-84	U/L
ALT	17	10-47	U/L
AMY	66	14-97	U/L
AST	23	11-38	U/L
TBIL	0.5	0.2-1.6	MG/DL
BUN	15	7-22	MG/DL
CA++	7.3*	8.0-10.3	MG/DL
CHOL	76*	100-200	MG/DL
CRE	1.0	0.6-1.2	MG/DL
GLU	161*	73-118	MG/DL
TP	4.3*	6.4-8.1	G/DL

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

---
i-STAT E8+
Pt: [redacted] (b)(6)-4
Pt Name:_____
Glu_____159 mg/dL
BUN_____18 mg/dL
Na_____142 mmol/L
K_____3.6 mmol/L
Cl_____107 mmol/L
TCO2_____26 mmol/L
AnGap_____13 mmol/L
Hct_____26 %PCV
Hb*_____9 g/dL
*via Hct
pH_____7.260
PCO2_____54.9 mmHg
HCO3_____25 mmol/L
BEecf_____-2 mmol/L
Sample Type_:
17AUG03 05:12
Oper: [redacted]
Physician:_____
Ser# [redacted]
Ver: JAMS046A
CLEW A93

REMARKS:

REPORTED BY: [redacted] (b)(6)-2	DATE: 17 AUG	LAB ID NO.:

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

LAST, FIRST: EPW [redacted] (b)(6)-4	DATE: 17 Aug 03	TIME: 0400	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
(b)(6)-4 [redacted]		
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

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: (b)(6)-2 [redacted]	DATE: 17 Aug 03	LAB ID NO.:

Ward/Section: PCU2	REQUESTING PHYSICIAN: [redacted] (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI: [redacted] (b)(6)-4	DATE: 18 Aug	TIME: 1000	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
Hematocrit		37-47% (F)
Sed Rate		
Other		

18 Aug

(b)(6)-4 [redacted]

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: [redacted]

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] (b)(6)-2	DATE: 8-8-03	LAB ID NO.:

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

Ward/Section: ICU2

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

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

DATE: 19Aug03 TIME: 0400

SSN/PSEUDO SSN:

(Hematology) CBC

19Aug

TEST	RESULT		REF. RANGE	
[illegible]	[illegible]		[illegible]	[illegible]
MCH	29.1	pg	27.0	31.0
MCHC	32.4 L	g/dL	33.0	37.0
Plt	199.	x10^3/uL	150.	450.
LY%	16.6 L	%	20.5	51.1
LY#	1.5	x10^3/uL	1.2	3.4

TEST	RESULT	TEST	RESULT
[illegible]	[illegible]	Imm	[illegible]

TEST	REF. RANGE
RBC	[illegible]
Retic	0.1-2.0
Spun Hematocrit	42-52% (M) 37-47% (F)
Sed Rate	[illegible]
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 [illegible]
Nit		Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
[illegible]		Negative
[illegible]		Negative

Microscopic Urinalysis

Blood Bank

MUST [illegible] SF 518 WITH EVE[illegible] REQUESTED

ABO/[illegible]

Coagulation Studies

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

Blood Bank Unit Crossmatch
(MUST SUBMIT SF 518 WITH EVE[illegible] REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

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

DATE: 19 Aug, 03

LAB ID NO.:

(b)(6)-2

Ward/Section: IC 42	REQUESTING PHYSICIAN: Dr [redacted] / Dr [redacted] (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted] (b)(6)-4	DATE: 20 Aug 03 TIME: 0400	SSN/PSEUDO SSN: [redacted] (b)(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
[illegible]		
[illegible]		
[illegible]		
[illegible]		
Pl[illegible]		
Ly[illegible]		
[illegible]		
Seg[illegible]		
Ban[illegible]		
Lymph		
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

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: (b)(6)-2 [redacted]	DATE: 20 Aug 03	LAB ID NO.:

Ward/Section: ICU 2	REQUESTING PHYSICIAN: Dr. [redacted] (b)(6)-2	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] (b)(6)-4	DATE 20 AUG 03 / TIME 2100	SSN/PSEUDO SSN: [redacted] (b)(6)-4

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU		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

======= PICCOLO =======
20/08/03 21:15
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: 3152AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	103	73-118	MG/DL
BUN	13	7-22	MG/DL
CRE	1.1	0.6-1.2	MG/DL
CK	302	39-380	U/L
NA+	♦♦♦	128-145	MMOL/L
K+	4.0	3.3-4.7	MMOL/L
CL-	102	98-108	MMOL/L
tCO2	20	18-33	MMOL/L

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

Na 136

REMARKS:

REPORTED BY:	DATE:	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)-4	DATE 20 Aug 03	TIME	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			Color		N/A	RPR		Negative
			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		
Se			Prot		Negative	Malaria		
Ba			Urob		0.2-1.0	O & P		
Ly			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: (b)(6)-2 [redacted]	DATE: 20 Aug 03	LAB ID NO.:

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

LAST, FIRST, MI.	DATE	TIME	SSN/PSEUDO SSN:
#[redacted] (b)(6)-4	22AUG03	0500	[redacted] (b)(6)-4

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC	9.8	4.8-10.8 x 10^3	Color		N/A	RPR		Negative
RBC	3.06	4.7-6.1 x 10^9	App		N/A	Mono		Negative
Hgb	8.9	14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	**Microbiology**		
Hct	27.8	42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV	90.8	80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
Plt	326	130-500 x 10^3 verified	SG		N/A	Occ Bld		Negative
Lymph %	13.2	20.5-51.1%	Bld		Negative	H. pylori		Negative
(Hematology) Manual Differential			pH		N/A	Micro Parasites		
Segs		Mono	Prot		Negative	Malaria		
Bands		Eos	Urob		0.2-1.0	O & P		
Lymph		Baso	Nit		Negative	Other		
Atyp		Imm	Leuk		Negative	**Microscopic Urinalysis**		
RBC Morph			HCG		Negative			
Spun Hematocrit		42-52% (M) 37-47% (F)	**CSF**			**Blood Bank**		
Sed Rate			Cell Count			**MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED**		
Other			Directigen		Negative	ABO/Rh		

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: ICW#1	REQUESTING PHYSICIAN:			**CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] (b)(6)-4	DATE 23 AUG 03	TIME 0502	SSN/PSEUDO # [redacted] (b)(6)-4	

(I-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU	88	73-118 mg/dl
BUN	11	7-22 mg/dl
CRE	1.2	0.6-1.2 mg/dl
CK	164	39-380 u/l (M) 30-190 u/l (F)
NA^+	139	128-145 mmol/l
K^+	3.7	3.3-4.7 mmol/l
CL^-	99	98-108 mmol/l
tCO_2	19	18-33 mmol/l

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

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

(b)(6)-4

EPW #[redacted]

KW#2

PICCOLO ======

24/08/03 05:22 MALE

REFERENCE RANGE: [redacted]

PATIENT #: (b)(6)-4

METILYTE 8 3152AA4

DISC LOT #: [redacted] DR #: 000

OPER #:

SERIAL #: [redacted]

TEST(S)	RESULTS		
GLU	90	73-118	MG/DL
BUN	16	7-22	MG/DL
CRE	1.4*	0.6-1.2	MG/DL
CK	94	39-380	U/L
NA+	140	128-145	MMOL/L
K+	4.2	3.3-4.7	MMOL/L
CL-	102	98-108	MMOL/L
tCO2	21	18-33	MMOL/L

INST QC: OK CHEM QC: OK

HEM 2+, LIP 0, ICT 0

SPECIMEN TAKEN: DATE 24 AUG 03 TIME 0

CHEM I

URGENCY: [X] ROUTINE; TODAY [ ]; PRE-OP [ ]; STAT [ ]

PATIENT STATUS: [X] BED; [ ] AMB; OUTPATIENT [ ]; [ ] NP; [ ] DOM

SPECIMEN SOURCE: [ ] BLOOD; [ ] OTHER (Specify)

SPECIMEN/LAB. RPT. NO.

PATIENT'S MED. RECORD

51-653087

CHEMISTRY I
STANDARD FORM 549 (Rev. 8-77)
PRESCRIBED BY GSA ICMR
FIRMR (41 CFR) 201-45.505

[redacted]

(b)(6)-4

HEMATOLOGY

URGENCY: [X] ROUTINE; TODAY [ ]; PRE-OP [ ]; STAT [ ]

PATIENT STATUS: [ ] BED; [ ] AMB; OUTPATIENT [ ]; [ ] NP; [ ] DOM

SPECIMEN SOURCE: [ ] VEIN; [ ] CAP; [ ] OTHER (Specify)

SPECIMEN/LAB RPT. NO.

PATIENT'S MED. RECORD

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

REQUESTING PHYSICIAN'S SIGNATURE

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

DATE 24 Aug 03

LAB. ID. NO.

REMARKS CBC

SPECIMEN TAKEN: DATE; TIME 1450 A.M. P.M.

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

RESULTS

549-107

HEMATOLOGY
STANDARD FORM 549 (Rev. 7-76)
PRESCRIBED BY GSA/ICMR
FIRMR (41 CFR) 201-45.505

GPW[redacted] (b)(6)-4
ICW2
23 Aug

SPECIMEN/LAB. RPT. NO.

CHEM 1

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

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

SPECIMEN SOURCE: ☐ BLOOD ☐ OTHER (Specify)

PATIENT'S MED. RECORD

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

REQUESTING PHYSICIAN'S SIGNATURE | REPORTED BY ICW2 MD TECH | DATE 23 Aug | LAB. ID. NO. GPW[redacted] (b)(6)-4

REMARKS Chem 7

546-107

CHEMISTRY I
STANDARD FORM 546 (Rev 8-73)
PRESCRIBED BY GSA ICMR
FIRMR (41 CFR) 201-45.505

TEST(S)	SPECIMEN TAKEN DATE	TIME A.M. P.M.	REQUESTED (X)	RESULTS
GLUCOSE				
UREA N.				
CREATININE				
URIC ACID				
SODIUM				
POTASSIUM				
CHLORIDE				
CO_2				
PHOSPHATE				
CALCIUM				
TOTAL PROTEIN				
ALBUMIN				
GLOBULIN				
ALKALINE PHOSPHATASE				
ACID PHOSPHATASE				
SGOT				
LDH				
CPK				
BILIRUBIN (TOTAL)				
BILIRUBIN (DIRECT)				
CHOLESTEROL				
TRIGLYCERIDES				
AMYLASE				
LIPASE				
PROFILE (Specify)				

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

SPECIMEN/LAB RPT. NO.

HEMATOLOGY

URGENCY: ☒ ROUTINE TODAY ☐ PRE-OP STAT ☐

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

SPECIMEN SOURCE: ☒ VEIN ☐ CAP ☐ OTHER (Specify)

ICW2

PATIENT'S MED. RECORD

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

REQUESTING PHYSICIAN'S SIGNATURE [redacted] (b)(6)-2 | REPORTED BY MD TECH | DATE 25 Aug 03 | LAB. ID. NO.

REMARKS CBC

549-107

HEMATOLOGY
STANDARD FORM 549 (Rev 7-78)
PRESCRIBED BY GSA/ICMR
FIRMR (41-CFR) 201-45.505

TEST(S)	SPECIMEN TAKEN DATE	TIME A.M. P.M.	REQUESTED (X)	RESULTS
RBC COUNT				
HEMOGLOBIN				
HEMATOCRIT				
MCV				
MCH				
MCHC				
WBC COUNT				
WBC DIFF AND BLOOD CELL MORPH: IMMATURE				
NEURO-BANDS				
NEUTROSEGS				
LYMPHS				
EOSINOPHILS				
BASOPHILS				
MONOCYTES				
PLATELETS				
RBC				
SED. RATE				
PLATELET COUNT				
RETICULOCYTE COUNT				
CLOTTING TIME				
BLEEDING TIME				
PT CONTROL				
PT PATIENT				
CONTROL				
PATIENT				
% ACTIVITY				
RATIO				
SICKLING TEST				
LE PREP				

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

CHEM I

SPECIMEN/LAB. RPT. NO.

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

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

SPECIMEN SOURCE: ☒ BLOOD ☐ OTHER (Specify)

PATIENT'S MED. RECORD

ICW2

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

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

REPORTED BY MD TECH

DATE 25Aug03

LAB. ID. NO.

REMARKS Chem 7

546-107

CHEMISTRY I
STANDARD FORM 546 (Rev. 8-77)
PRESCRIBED BY GSA ICMR
FIRMR (41 CFR) 201-45.505

TEST(S)	SPECIMEN TAKEN	TIME A.M. P.M.	REQUESTED (X)	RESULTS
	DATE 25Aug03	0465		
GLUCOSE				
UREA N.				
CREATININE				
URIC ACID				
SODIUM				
POTASSIUM				
CHLORIDE				
CO_2				
PHOSPHATE				
CALCIUM				
TOTAL PROTEIN				
ALBUMIN				
GLOBULIN				
ALKALINE PHOSPHATASE				
ACID PHOSPHATASE				
SGOT				
LDH				
CPK				
BILIRUBIN (TOTAL)				
BILIRUBIN (DIRECT)				
CHOLESTEROL				
TRIGLYCERIDES				
AMYLASE				
LIPASE				
PROFILE (Specify)				

---
i-STAT E

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

Glu_____87 mg/dL
BUN_____21 mg/dL
Na_____141 mmol/L
K_____3.7 mmol/L
Cl_____105 mmol/L
TCO2_____28 mmol/L
AnGap_____13 mmol/L
Hct_____34 %PCV
Hb*_____12 g/dL
*via Hct
PH_____7.374
PCO2_____45.7 mmHg
HCO3_____27 mmol/L
BEecf_____1 mmol/L

Sample Type_:

25AUG03 04:16

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A

---
i-STAT CREA

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

Crea_____1.0 mg/dL

Sample Type_:

25AUG03 04:13

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

ID [redacted] (b)(6)-4 08-24-03
WB 02:15

				Patient Limits	
WBC	13.1	*H	x10^3/uL	4.5	10.5
RBC	4.17		x10^6/uL	4.00	6.00
Hgb	11.8		g/dL	11.0	18.0
Hct	37.8		%	35.0	60.0
MCV	90.5		fL	80.0	99.9
MCH	28.4		pg	27.0	31.0
MCHC	31.3	L	g/dL	33.0	37.0
Plt	556.	H	x10^3/uL	150.	450.
LY%	13.2	*L	%	20.5	51.1
LY#	1.7	*	x10^3/uL	1.2	3.4

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

ICW2

HEMATOLOGY

SPECIMEN/LAB RPT. NO.

URGENCY: [X] ROUTINE; [ ] TODAY; [ ] PRE-OP; [ ] STAT

PATIENT STATUS: [X] BED; [ ] AMB; [ ] OUTPATIENT; [ ] NP; [ ] DOM

SPECIMEN SOURCE: [X] VEIN; [ ] CAP; [ ] OTHER (Specify)

PATIENT'S MED. RECORD

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

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

REPORTED BY

MD DATE TECH 26Aug03

LAB. ID. NO.

REMARKS
C B C

549-107

TEST(S)	SPECIMEN TAKEN: DATE	TIME A.M. P.M.	(X)	RBC COUNT	HEMOGLOBIN	HEMATOCRIT	MCV	MCH	MCHC	WBC COUNT	WBC DIFF AND BLOOD CELL MORPH: IMMATURE	NEUTRO-BANDS	NEUTROSEGS	LYMPHS	EOSINOPHILS	BASOPHILS	MONOCYTES	PLATELETS	RBC	SED. RATE	PLATELET COUNT	RETICULOCYTE COUNT	CLOTTING TIME	BLEEDING TIME	P T T: CONTROL	P T T: PATIENT	PRO-TIME: CONTROL	PRO-TIME: PATIENT	% ACTIVITY	RATIO	SICKLING TEST	LE PREP
REQUESTED	26Aug03	0433																														
RESULTS																																

HEMATOLOGY
STANDARD FORM 549 (Rev. 7-78)
PRESCRIBED BY GSA/ICMR
FIRMR (41-CFR) 201-45.505

PICCOLO
23/08/03 05:13
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: 3151AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	96	73-118	MG/DL
BUN	14	7-22	MG/DL
CRE	1.2	0.6-1.2	MG/DL
CK	95	39-380	U/L
NA+	~~[illegible]~~ 137	128-145	MMOL/L
K+	3.6	3.3-4.7	MMOL/L
CL-	98	98-108	MMOL/L
tCO2	20	18-33	MMOL/L

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

ID: [redacted] (b)(6)-4 08-25-03
WB 21:13

				Patient Limits	
WBC	12.9	H	x10^3/uL	4.5	10.5
RBC	3.86	L	x10^6/uL	4.00	6.00
Hgb	10.8	L	g/dL	11.0	18.0
Hct	34.4	L	%	35.0	60.0
MCV	89.2		fL	80.0	99.9
MCH	28.0		pg	27.0	31.0
MCHC	31.4	L	g/dL	33.0	37.0
Plt	548.	H	x10^3/uL	150.	450.
LY%	18.8	*L	%	20.5	51.1
LY#	2.4	*	x10^3/uL	1.2	3.4

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

ICW2

SPECIMEN/LAB. RPT. NO.

CHEM 1

URGENCY: ☒ ROUTINE; TODAY ☐; ☐ PRE-OP; STAT ☐

PATIENT STATUS: ☒ BED; ☐ AMB; OUTPATIENT ☐; ☐ NP; ☐ DOM

SPECIMEN SOURCE: ☒ BLOOD; ☐ OTHER (Specify)

PATIENT'S MED. RECORD

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

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

REPORTED BY MD TECH

DATE 26Aug03

LAB. ID. NO.

REMARKS chem7

546-107

CHEMISTRY I
STANDARD FORM 546 (Rev 8-77)
PRESCRIBED BY GSA ICMR
FIRMR (41 CFR) 201-45.505

TEST(S)																																		
SPECIMEN TAKEN	TIME	A.M.	P.M.	(X)	REQUESTED	GLUCOSE	UREA N.	CREATININE	URIC ACID	SODIUM	POTASSIUM	CHLORIDE	CO_2	PHOSPHATE	CALCIUM	TOTAL PROTEIN	ALBUMIN	GLOBULIN	ALKALINE PHOSPHATASE	ACID PHOSPHATASE	SGOT	LDH	CPK	BILIRUBIN (TOTAL)	BILIRUBIN (DIRECT)	CHOLESTEROL	TRIGLYCERIDES	AMYLASE	LIPASE	PROFILE (Specify)				
		0433																																
DATE 26Aug03	RESULTS																																	

== = PICCOLO =======
26/08/03 05:19
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: [redacted] 3152AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	84	73-118	MG/DL
BUN	16	7-22	MG/DL
CRE	1.0	0.6-1.2	MG/DL
CK	60	39-380	U/L
NA+	136	128-145	MMOL/L
K+	3.9	3.3-4.7	MMOL/L
CL-	103	98-108	MMOL/L
tCO2	22	18-33	MMOL/L

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

EPW [redacted]

(b)(6)-4

ICWZ

SPECIMEN/LAB. RPT. NO.

CHEM I

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

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

SPECIMEN SOURCE: ☒ BLOOD ☐ OTHER (Specify)

PATIENT'S MED. RECORD

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

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

REPORTED BY

MD DATE

TECH 27Aug03

LAB. ID. NO.

[redacted]

REMARKS Chem7

546-107

CHEMISTRY I

STANDARD FORM 546 (Rev. 8-77)
PRESCRIBED BY GSA (ICMR
FIRMR (41 CFR) 201-45.505

TEST(S)																													
SPECIMEN TAKEN		A.M. P.M.	(K)																										
	TIME		REQUESTED	GLUCOSE	UREA N.	CREATININE	URIC ACID	SODIUM	POTASSIUM	CHLORIDE	CO_2	PHOSPHATE	CALCIUM	TOTAL PROTEIN	ALBUMIN	GLOBULIN	ALKALINE PHOSPHATASE	ACID PHOSPHATASE	SGOT	LDH	CPK	BILIRUBIN (TOTAL)	BILIRUBIN (DIRECT)	CHOLESTEROL	TRIGLYCERIDES	AMYLASE	LIPASE	PROFILE (Specify)		
DATE			RESULTS																										

---

i-STAT EC8+

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

Pt Name:_____

Glu_____79 mg/dL

BUN_____21 mg/dL

Na_____141 mmol/L

K_____3.9 mmol/L

Cl_____104 mmol/L

TCO2_____30 mmol/L

AnGap_____13 mmol/L

Hct_____32 %PCV

Hb*_____11 g/dL

*via Hct

PH_____7.360

PCO2_____49.6 mmHg

HCO3_____28 mmol/L

BEecf_____3 mmol/L

Sample Type_:

27AUG03 04:10

(b)(6)-4

ID: [redacted]

NE

08-Aug-03
20:12

				Patient Limits	
WBC	13.9	H	x10^3/uL	4.5	10.5
RBC	3.59	L	x10^6/uL	4.00	6.00
Hgb	9.9	L	g/dL	11.0	16.0
Hct	32.4	L	%	35.0	60.0
MCV	90.3		fL	80.0	99.9
MCH	27.7		pg	27.0	31.0
MCHC	30.6	L	g/dL	33.0	37.0
Plt	582.	H	x10^3/uL	150.	450.
LY%	17.9	*L	%	20.5	51.1
LY#	2.5	*	x10^3/uL	1.2	3.4

(b)(6)-4

EPW [redacted]

ICW2

HEMATOLOGY

SPECIMEN/LAB RPT. NO.

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

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

SPECIMEN SOURCE: ☒ VEIN ☐ CAP ☐ OTHER (Specify)

PATIENT'S MED. RECORD

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

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

REPORTED BY MD

DATE 27Aug03 TECH

LAB. ID. NO.

REMARKS CBC

549-107

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

HEMATOLOGY STANDARD FORM 549 (Rev. 7-78) PRESCRIBED BY GSA/ICMR FIRMR (41-CFR) 201-45.505

ID: [redacted] 08-22-03

WB (b)(6)-4 20:43

				Patient Limits	
WBC	12.7	H	x10^3/uL	4.5	10.5
RBC	3.39	L	x10^6/uL	4.00	6.00
Hgb	9.8	L	g/dL	11.0	18.0
Hct	30.7	L	%	35.0	60.0
MCV	90.7		fL	80.0	99.9
MCH	28.9		pg	27.0	31.0
MCHC	31.8	L	g/dL	33.0	37.0
Plt	393.		x10^3/uL	150.	450.
LY%	11.3	*L	%	20.5	51.1
LY#	1.4	*	x10^3/uL	1.2	3.4

(b)(6)-4

EPW [redacted]

ICW2

23 Aug

HEMATOLOGY

SPECIMEN/LAB RPT. NO.

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

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

SPECIMEN SOURCE: ☐ VEIN ☐ CAP ☐ OTHER (Specify)

PATIENT'S MED. RECORD

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

REQUESTING PHYSICIAN'S SIGNATURE

REPORTED BY MD

DATE TECH

LAB. ID. NO. EPW [redacted] (b)(6)-4

REMARKS CBC ICW2 EPW

549-107

TEST(S)	SPECIMEN TAKEN			REQUESTED (X)	RBC COUNT	HEMOGLOBIN	HEMATOCRIT	MCV	MCH	MCHC	WBC COUNT	WBC DIFF AND BLOOD CELL MORPH: IMMATURE	NEUTRO-BANDS	NEUTROSEGS	LYMPHS	EOSINOPHILS	BASOPHILS	MONOCYTES	PLATELETS	RBC	SED. RATE	PLATELET COUNT	RETICULOCYTE COUNT	CLOTTING TIME	BLEEDING TIME	PTT CONTROL	PTT PATIENT	CONTROL	PATIENT	% ACTIVITY	RATIO	SICKLING TEST	LE PREP
	DATE 23 Aug	TIME 0400	(A.M.) P.M.	RESULTS																													

HEMATOLOGY STANDARD FORM 549 (Rev. 7-78) PRESCRIBED BY GSA/ICMR FIRMR (41-CFR) 201-45.505

Ward/Section: ICW#1	REQUESTING PHYSICIAN: [redacted] (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI. # [redacted] (b)(6)-4	DATE 28/08/03	TIME 0500	SSN/PSEUDO SSN: # [redacted] epw (b)(6)-4

(Hematology) CBC

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

(Hematology) Ma

Segs		
Bands		
Lymph		
Atyp		
RBC Morph		

Urinalysis

TEST	RESULT	REF
		N/A
		N/A
		Negat
		Negat
		Negat
		N/A
		Negati
		N/A
		Negati
		0.2-1.(
		Negati
		Negati
		Negati

Misc. Serology

RANGE

ive
ive
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ITH
ED
D
CH

(b)(6)-4

[redacted]

06-27-03
30142
Patient
Limits

WBC	11.9 H	x10^3/uL	4.5	10.5
RBC	5.36 L	x10^6/uL	4.00	6.00
Hgb	11.4 L	g/dL	11.0	18.0
Hct	35.2 L	%	35.0	54.0
MCV	85.9	fL	80.0	99.9
MCH	23.1	pg	27.0	31.0
MCHC	21.2 L	g/dL	33.0	37.0
Plt	367. H	x10^3/uL	150.	450.
Lymp	17.7	% L	20.0	51.1
Lym	2.1	x10^3/uL	1.2	3.4

======= PICCOLO =======
28/08/03 04:52
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: 3151AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	84	73-118	MG/DL
BUN	14	7-22	MG/DL
CRE	0.9	0.6-1.2	MG/DL
CK	49	39-380	U/L
NA+	137	128-145	MMOL/L
K+	4.2	3.3-4.7	MMOL/L
CL-	102	98-108	MMOL/L
tCO2	23	18-33	MMOL/L

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

Spun Hematocrit				
Sed Rate			Cell Count	
Other			Directigen	

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

Bloo (MUST SUBMIT SI

UNIT		

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

CBC & Chem 7

Ward/Section: ICW4	REQU[redacted] (b)(6)-2		CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. EVW # [redacted] (b)(6)-4	DATE 28 Aug	TIME 0500	SSN/PSEUDO SSN: # [redacted] (b)(6)-4

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU		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.:

CBC & Chem 7

======= PICCOLO =======
29/08/03 05:14
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: 3151AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]
.....136.....

GLU	[redacted]	73-118	MG/DL
BUN	11	7-22	MG/DL
CRE	0.8	0.6-1.2	MG/DL
CK	42	39-380	U/L
NA+	121*	128-145	MMOL/L
K+	4.0	3.3-4.7	MMOL/L
CL-	98	98-108	MMOL/L
tCO2	20	18-33	MMOL/L

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

(b)(6)-4

[redacted]

WBC	10.2	x10^3/uL	4.5	10.5
RBC	3.74 L	x10^6/uL	4.00	5.20
Hgb	10.5 L	g/dL	11.6	16.5
Hct	33.6 L	%	35.0	48.0
MCV	89.8	fL	80.0	99.0
MCH	28.0	pg	27.0	31.0
MCHC	31.2 L	g/dL	33.0	37.0
Plt	552 H	x10^3/uL	150.	450.
LYM	20.0 % L		20.5	51.1
LYM	2.0 *	x10^3/uL	1.2	3.4

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

LAST, FIRST, MI	DATE	TIME	SSN/PSEUDO SSN
[redacted] (b)(6)-4	30AUG	0530	[redacted] (b)(6)-4

======= PICCOLO =======
30/08/03 05:40
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: 3151AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	98	73-118	MG/DL
BUN	8	7-22	MG/DL
CRE	1.2	0.6-1.2	MG/DL
CK	40	39-380	U/L
NA+	128	128-145	MMOL/L
K+	3.9	3.3-4.7	MMOL/L
CL-	97*	98-108	MMOL/L
tCO2	23	18-33	MMOL/L

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

RANGE
6 mmol/L
mmol/L
mmol/L
45
mmHg (art) mmHg (ven)
mmHg (art) en)
mmol/L (art) mmol/L (ven)
mmol/l. (art) mmol/L (ven)
%
(+3) l/L
mmol/L
1.32 mmol/L
mg/dl
05 mg/dl
1.5 mg/dl
51% PCV
17 g/dl
y
F. RANGE

(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

	DATE:	LAB ID NO.:

JLV L

MEDICAL RECORD - ANESTHESI...

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

ANESTHETIC AGENTS AND DRUGS

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

DRUG	(Units)					TOTALS
Versed	(mg)	2.5				2.5
Fentanyl	(mcg)	50	100	50		200
Ketamine	(mg)	70				7
SCH	(mg)	120				120
Vec	(mg)	10				10
MSO4	(mg)	7				7

VOLAT AGENT	Iso	% del	1.6 - 1.7 - 1.0 - 1.5 - 1.5 - 0.8 X
		% e.t.	
AIR		L/Min	
N2O		L/Min	
O2		L/Min	10 - 2 - 2 - 2 - 2 - 2 - 2 - 10

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

TOTAL EBL: 400

TOTAL URINE: 275

FLUIDS

LINE site		
18 (R) Arm	☐ Warmed	LR 800
18 (R) Arm	☐ Warmed	LR
18 (L) Bicep	☐ Warmed	LR — 2600cc — x LR — x LR — x Hespan — x Hespan
	☐ Warmed	

FLUIDS - SUMMARY

CRYSTALLOID- 3200cc

COLLOID- 1000

BLOOD- Ø

LOSSES

EST BLOOD LOSS: 300 — 100/400

URINE - Foley — 200 — 75/275

PHYS STATUS: 1 (2) 3 4 5 (E)

TIME: 0015 0030 45 0100 15 30 45 0200 15 30

BODY WEIGHT: 80 KG

HEMATOCRIT: 14/45

INITIAL DATA: BP- 141/92; HR- 79

EQUIP CHECK: OK?- (Y) N

PATIENT RECHECK: OK for PROCED[redacted]; TIME- 2330

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

(b)(6) - 2

REMARKS

Code drugs with numbers, events with letters

0015 Arrived Event, To OR via litter.
0025 In room, ⊕ monitors, ⊕ O2, Smooth IV induction, Eyes taped, 3rd IV started, PD padded, arms <90°, OG placed, stomach sxn,
0047 Procedure started, Lab results received, HCT 45 HB 14 Reported to Surg.
0130 Zofran 4mg IV
0206 Reversed c Sux Neostigmine ⊕ 0.9 Robinul.
0210 ... x 2. ... HL>5sec. 5 d ...
To ICU2 in stable condition, Report to ...

VENTILATION

VT - ml	830	800	710	720	750	720	500	
f - breaths/min	24	8	8	8	8	9	9	12
Peak inf pres / PEEP	23	23	27	24	20	23	—	
MODE - S(pon), A(ssist), C(on)	S	C	C	C	C	C	C	S
ET CO2 (torr)	⊕	33	32	30	31	31	31	35
FIO2 (Frac or %)	.71	.71	.72	.72	.72	.72	.72	.72
SpO2 (%)	100	100	100	100	100	100	100	100
ECG	SR	ST	SR	SR	SR	SR	SR	SR
TEMP-site Nasal		36.3	36.0	35.8	35.6	35.4	35.3	
N-M Block (T/4)		0/4	1/4	0/4	0/4	0/4	1/4	1/4

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

ST 50

RECOVERY AT 0215

PACU (ICU) 2 (Specify)

OTHER

CONDITION: Stable

RESP- SpO2- BP- HR-

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0015	0025	0220

	Ready	Begin	End
PROC	0035	0047	0207

with letters & symbols, in under REMARKS

EVENTS Position → ... → ...

PROCEDURES and CPT Codes: Ex Lap

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GETA

AIRWAY MANAGEMENT: Intubation route, blade technique, comments
RSI c Cricoid pressure, DVL x 1 ... Mac 4 #8 ETT, BBS ⊕ ETCO2, secured @ 22cm teeth, ... block placed, Grade I view

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

#[redacted]

(b)(6) - 4

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

ANESTH[redacted]

CPT CRNA

(b)(6) - 2

PROCEDURE LOCATION: OR 1

DATE: 17 Aug 03

PAGE 1 OF 1

DA FORM 7389, FEB 1998

COPY 1 - PATIENT'S MEDICAL RECORD

USAPA V1.00

MEDCOM - 17635

AND PLAN OF CARE

AGE: 24 Days Mos Yrs

GENDER: (X) Male ( ) Female

ALLERGIES: NKDA

P S: 1 2 3 4 5 E

WT: 80 Kg/Lb HT: ____ In.

PROPOSED PROCEDURE: Ex lap

SURGICAL SERVICE: GSN

NPO SINCE: ____

PREOP DX / MECHANISM OF INJURY: S/P Blast Injury (shrapnel wounds)

HABITS:

Tobacco: Ø
EtOH: Ø
Drugs: Ø

CURRENT MEDICATIONS:

( ) = ordered as premed

( ) ____
( ) ____
( ) ____
( ) ____
( ) ____
( ) ____

PREMEDICATIONS:

None / Yes @ ____ Hrs

LABORATORY STUDIES:

Pending

Other: T&C x 4 units

PAST MEDICAL HISTORY / SYSTEMS REVIEW

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

Pulmonary:
- Asthma N Y Asthma Hx
- URI N Y
- COPD N Y
- Other N Y

Renal System:
- ARF/CRF N Y Foley
- Other N Y

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

Endocrine:
- Diabetes N Y
- Steroids N Y
- Thyroid N Y

Neurological:
- Seizures N Y
- Neuropathy N Y

Gynecological:
- Pregnancy N Y
- Other N Y

Other Problems: N Y

Familial Hx N Y

SURGICAL HISTORY

Ø

PHYSICAL EXAMINATION

BP: 141/92 HR: 79 RR: ____ T: 96 % RA

Pain (0/10 Scale): ____

Airway Exam:
Dentition ____
Trachea 3FB
TMJ/C-spine ____
Oropharynx MP II

Chest:
Lungs 18g (L) AC
Heart CTA

IV Access: IVs x 2 18s

Ulnar Filling: ____

Back: ____

Other: ____

ANESTHETIC PLAN: ( ) Local/MAC ( ) Regional: ____ (X) General: Intubation / Mask-LMA Notes: ____

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives, and risks of anesthesia including death have been explained to and discussed with pat[redacted]r legal guardian. The patient/legal guardian seems to understand and agrees to proceed. Questions answered.

(b)(6)-2

ign[redacted] CRNA CPT Date: 17 Aug 03 Time: 0005

( ) Sedated/nonresponsive/minor patient with no family or guardian present.

ATIENT IDENTIFICATION:

[redacted] (b)(6)-4

POST-ANESTHESIA EVALUATION AND NOTE:

( ) No apparent anesthetic complications.

( ) Other (see progress notes)

Signed: ____ Date: ____ Time: ____

sing Unit: EMT

28TH COMBAT SUPPORT HOSPITAL & MEDICAL TASK FORCE-BAGHDAD

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED (Check one)
- [x] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS (Pool of ____ units)
- [ ] CRYOPRECIPITATE (Pool of ____ units)
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER (Specify) ____

VOLUME REQUESTED (If applicable): 1 unit ML

REMARKS:

TYPE OF REQUEST (Check ONLY if Red Blood Cell Products are requested.)
- [x] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED: 17 Aug 03

DATE AND HOUR REQUIRED:

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION (Specify):

IF PATIENT IS FEMALE, IS THERE HISTORY OF: N/A

RhIG TREATMENT? DATE GIVEN: ____

HEMOLYTIC DISEASE OF NEWBORN? ____

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

DIAGNOSIS OR OPERATIVE PROCEDURE: EX LAP

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER: SGT [redacted] (b)(6)-2

DATE VERIFIED: 17 Aug 03

TIME VERIFIED: 0024

(b)(6)-4 UNIT NO. [redacted]

(b)(6)-4 [redacted]

TRANSFUSION NO.

PATIENT NO.

SECTION II – PRE-TRANSFUSION TESTING

DONOR
- ABO: B
- Rh: POS

RECIPIENT
- ABO: B
- Rh: POS

TEST INTERPRETATION
- ANTIBODY SCREEN: MA
- CROSSMATCH: Comp

PREVIOUS RECORD CHECK:
- [ ] RECORD
- [x] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST: [redacted] (b)(6)-2

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE: 17 Aug 03

REMARKS: EXP 21 Aug 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY: [redacted] (b)(6)-2

TIME (Hour): 0930

DATE (Date): 17 Aug 03

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER (Signature): SGT [redacted] (b)(6)-2 91WM6

2nd VERIFIER (Signature): [redacted] (b)(6)-2 MAJ

TEMP. 100.1 PULSE 112 BP 98/60

DATE OF TRANSFUSION: 17 Aug 03

TIME STARTED: 1055

PATIENT IDENTIFICATION - USE EMBOSSER (For typed or written entries give: NAME - Last, first, middle; rank/rate; hospital number and name of facility.)

[redacted] (b)(6)-4

POST-TRANSFUSION DATA

AMOUNT GIVEN: 350 ML

TIME COMPLETED: 1205 DATE COMPLETED: 17 Aug 03

INTERRUPTED

REACTION
- [x] NONE
- [ ] SUSPECTED

If reaction is suspected – IMMEDIATELY:
1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and IV solutions to the Blood Bank.

DESCRIPTION: 104/56 P 108 T 100.2

- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER ____

OTHER DIFFICULTIES (Equipment, clots, etc.)
- [x] NO
- [ ] YES (Specify) ____

SIGNATURE OF PERSON NOTING ABOVE: SGT [redacted] 91WM6 (b)(6)-2

SEX

WARD

BLOOD OR BLOOD COMPONENT TRANSFUSION
STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

MEDICAL RECORD COPY

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED (Check one)
- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS (Pool of ____ units)
- [ ] CRYOPRECIPITATE (Pool of ____ units)
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER (Specify) ____

VOLUME REQUESTED (If applicable): 1 UNIT ____ ML

REMARKS:

TYPE OF REQUEST (Check ONLY if Red Blood Cell Products are requested.)
- [X] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED: 17AUG03

DATE AND HOUR REQUIRED

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION (Specify)

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: ____

HEMOLYTIC DISEASE OF NEWBORN? ____

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

DIAGNOSIS OR [redacted] PROCEDURE: EX LAP

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER: SGT [redacted] (b)(6)-2

DATE VERIFIED: 17AUG03

TIME VERIFIED: 0024

SECTION II – PRE-TRANSFUSION TESTING

(b)(6)-4 UNIT NO. [redacted]

(b)(6)-4 PATIENT NO. [redacted]

DONOR		RECIPIENT	
ABO	B	ABO	B
Rh	POS	Rh	POS

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	Comp

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

REMARKS: EXP 21 Aug 03

PREVIOUS RECORD CHECK:
- [ ] RECORD
- [X] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST: [redacted] (b)(6)-2

DATE: 17 Aug 03

SECTION III – RECORD OF TRANSFUSION

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

AT (Hour): 0031 ON (Date): 17 Aug 03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

VERIFIER (Signature): SGT [redacted] (b)(6)-2

VERIFIER (Signature): [redacted] (b)(6)-2

TRANSFUSION [redacted]

TEMP. 99.4 PULSE 130 BP 104/60 RR 22

DATE OF TRANSFUSION: AUG 03 TIME STARTED: 0940

PATIENT IDENTIFICATION - USE EMBOSSER (For typed or written entries give: Last, first, middle; rank/rate; hospital number and name of facility.)

[redacted] (b)(6)-4

POST-TRANSFUSION DATA

AMOUNT GIVEN: 350 ML

TIME COMPLETED: 1045 DATE COMPLETED: 17 AUG 03 INTERRUPTED

REACTION
- [X] NONE
- [ ] SUSPECTED

If reaction is suspected – IMMEDIATELY:
1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION 94/52 P114 Sa02 96 T100.1
- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER ____

OTHER DIFFICULTIES (Equipment, clots, etc.)
- [X] NO
- [ ] YES (Specify) ____

SIGNATURE OF PERSON NOTING ABOVE: SGT [redacted] (b)(6)-2

SEX: M WARD: CCU 2

BLOOD OR BLOOD COMPONENT TRANSFUSION
STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

MEDICAL RECORD COPY

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 | TIME OF ORDER | HOURS | LIST THE GROSS INCISU KED BEL

11 Aug 03

① Admit Q CW 2

S/p Ex LAP SB Repair

Cond stable

VS Q2° ESAT I/O

All NKDA

Act OOB TID

Foley to gravity

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

NPO

IVF LR @150cc/hr

Meds

Morphine 2-10 mg IV Q2° PRN Pain

Ancef 1 gm IV Q8°

Tylenol 650 mg PO Q6° PRN Fever

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

CBC, Chem 8, Chem 12 in AM

(b)(6)-2 [redacted]

(b)(6)-2 [redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

18 AUG 03 | 1845

D VS Q6°

V.O. Dr [redacted] / [redacted] ICTAN

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

NURSING UNIT | ROOM NO. | BED NO.

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

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

PATIENT IDENTIFICATION

EPW [redacted]

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 17AUG03 TIME OF ORDER: 0720 HOURS

(1) Sips of water

(2) ~~HC~~ CBC @ 0830

(b)(6)-2 [redacted]

LIST TIME ORDERS NOTED AND SIGN: noted 17aug 0800 [redacted] (b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 17AUG03 TIME OF ORDER: 0900 HOURS

(1) TY 24 PRN ~~OV~~ 2hrs

[redacted] (b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 17AUG03 TIME OF ORDER: 1415 HOURS

(1) CBC @ 1530

(b)(6)-2 [redacted]

[redacted] (b)(6)-2

[redacted] (b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 18AUG03 TIME OF ORDER: ~~1945~~ 0650 HOURS

(1) CBC Now and QAM [redacted] (b)(6)-2

(2)

[redacted]

19 Aug 03 1700 [redacted] (b)(6)-2

(1) Tension & Ice 2

(2) Cont current orders

DA FORM 1 APR 78 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED

[redacted] (b)(6)-2

22Aug03 2315 [redacted]

DC Roslen and Phenergan V.O. from Dr. [redacted] (b)(6)-2