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 AND TRANSCRIBED

b(6)-2 [redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICU2		

DATE OF ORDER 29 Oct 03 — TIME OF ORDER _____ HOURS — LIST TIME ORDER NOTED AND SIGN

1) Resume Prev Ord
2) S/P Emd Sigmoid Colectomy
3) MEDS
MS04 2-8mg IV q 2-4hr
OV
Percocet 1-2 po q 4hr
Flagyl 500mg IVPB TID F/U (01422)

PATIENT IDENTIFICATION

DATE OF ORDER — TIME OF ORDER _____ HOURS

4) Resume Colectomy Care

b(6)-2

[redacted]

NURSING UNIT	ROOM NO.	BED NO.

34° chart ✓ 0500 30 Oct 03
[redacted] ILTAN

PATIENT IDENTIFICATION

b(6)-4

[redacted]

DATE OF ORDER 31 Oct 03 — TIME OF ORDER _____ HOURS

1) Transfer ICW with Bed
2) S/P Debulking Grade IV Decub / Avoid Colo
3) Activity - roll prone q 2°
4) Vitals q Shift
5) Diet Regular
6) IV Heplock
7) TID Wet Body wk 1/4 Days

NURSING UNIT	ROOM NO.	BED NO.
ICW		

PATIENT IDENTIFICATION

DATE OF ORDER — TIME OF ORDER _____ HOURS

Sch to Decub
8) MEDS
Percocet 1-2 po q 4-6hr
Flagyl 500mg IV q 8° X 8 Days
Vitam IM q D
Vitam 50000 SQ BID
9) Roll to prone
10) Med Oth Cont

NURSING UNIT	ROOM NO.	BED NO.

b(6)-2 [redacted]

b(6)-2

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

THE DOCTOR SHALL RECORD DATE, AND SIGN EACH SET OF ORDERS. IF PROB.-ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NU IN COLUMN INDICATED BY ARROW BELO

PATIENT IDENTIFICATION

b(6)-2 [redacted]

Noted b(6)-2 [redacted] 1 Nov 03 1410

NURSING UNIT | BED NO.

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

1 Nov 03

1) Transfer to 2 ICSU when arrangement made.

[redacted] b(6)-2

PATIENT IDENTIFICATION

b(6)-2 [redacted]

Noted 2 Nov 0930 CS

DATE OF ORDER | TIME OF ORDER | HOURS

2 Nov 03

Transfer to 2 ICU2 when bed available

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

1 CWT | 03 Nov 03 0300

[redacted] b(6)-2 24° Chart

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

NURSING UNIT | ROOM NO. | BED NO.

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

b(4)-2

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 29	30	31	1	2	3	4	5	6	7	8	9	10	11
8.29	[redacted]	NPO	06	[redacted]													
			18														
8.29	[redacted]	VS Q1°	06														
			18														
8.29	[redacted]	I/O Q1°	06														
			18														
8.29	[redacted]	Bedrest - Log roll -	06														
		maintain spine proc.	18														
8.29	[redacted]	Foley to gravity.	06														
			18														
8.29	[redacted]	NG to LIS	06														
			18														
8.29	[redacted]	CT to 20cm H_2O Sxn	06														
			18														
8.29	[redacted]	CBC, Chem 7, PT/PTT,	18														
		ABG Q4°,	22														
			02														
			06														
			10														
			14														
8.29	[redacted]	Call MO for HR > 105	06														
		SBP < 90 > 140 RR > 30	18														
		temp > 38.5															
8/30	[redacted]	~~ABG~~ Vent: 45%	06														
		16, 650/5	18														
30A	[redacted]	CXR q AM	04														

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW to chest

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

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

b(6)-2 A11

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 8 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
8.29	[redacted]	Admit to ICU	8.29	ASAP	1720	[redacted]
8.29	[redacted]	T spine PA	8.29	ASAP	1800	[redacted]
29 Aug 03	[redacted]	Give 4 U FFP	29 Aug 03	ASAP	Done 30 Aug 03 0000 MS	[redacted]
29 Aug 03	[redacted]	✓ CBC + PT p transfusion	29 Aug 03	ASAP	0200 30 Aug 03	[redacted]
30 Aug	[redacted]	✓ CBC / PT + PTT p transfusion	30 Aug 03	ASAP		due
30 Aug	[redacted]	Give 4 units FFP / 2 units PRBCS	30 Aug	ASAP		due
30 Aug	[redacted]	ABG 30 mins	30 Aug	0745		due

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION / TIME/DATE COMPLETED													
9.2	[redacted]	↑ Peep to 7 if PEL <65 and/or	PIC 03													
		Spo2 <91%	9/3/03 2000													
9/3/03	[redacted]	↑ Peep - 10 when FIO2	PIC													
		for sats > 92%	USAP 03 0300													

USAPA V1.00

b(6)-2 A1

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 30	31	1	2	3	4	5	6	7	8	9	10	11	12
30 Aug 03	[redacted]	chart JP drainage	06	[redacted]													
		Q shift	18														
30 Aug 03	[redacted]	vent: FIO2 50% RR 22	06														
		TV 500 Peep 7 SIMV	18														
30 Aug 03	[redacted]	ABG, CBC Chem 12 &	04														
		PT/PTT & Am & METS															
15 Sept	[redacted]	CT ~~Y~~ ~~H2O Seal~~	06														
		SX	18														
9.2.03	[redacted]	~~Q~~ Check residuals q	08														
		6° hours	14														
			20														
			02														
9/3/03		Vent settings A/C 70	06	X	X	X	X										
9/3/03		ICP & PEEP @ 8	18	X	X	X	X										
		Q 2 to keep sats >90%															
9/3/03		DNR - Ø chest compressions,	06	X	X	X	X										
		Ø vasoactive drugs	18	X	X	X	X										
9.4.03	[redacted]	Y/O Heparin	06														
			18														
9.4.03	[redacted]	NG CIS	06														
			18														
9-5-03	[redacted]	Jevity ~~500 mls~~ 50 cc q4"	04	X						X							
9-7-03	[redacted]	as tolerated hold 5	08	X						X							
		residual >150 cc	12	X						X							
			16	X					X								
			20	X					X								
			24	X					X								

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW to chest

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

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

b(6)-2 A11

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo 8 Yr 2003

Verify by Initialing: Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
30 Aug 03	[redacted]	VABG, CBC, Chem 7 + PT/PTT NOW	30 Aug	30 Aug	1930	[redacted]
30 Aug 03	[redacted]	CNR NOW	30 Aug	30 Aug	1930	[redacted]
9/3/02		UA	3 Sep 02	0800	0800	[redacted]
9/3/02		Urine culture	3 Sep 03	0800	0900	[redacted]
9/3/02		Blood culture	3 Sep 03	0800	0900	[redacted]
9/3/02		Sputum culture	3 Sep 03	0800		[redacted]
9.4.03	[redacted]	VABG, CBC, Chem 7 P XFSN	9.4.03	P XFSN ~~ASA~~	1400	[redacted]

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

USAPA V1.00

b7(e)-2 All

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. 9 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 10 11 12 13 14 15 16 17 18 19 20 21 22 23
10 Sep 03	[redacted]	Code status: full	06	[redacted]
		code	18	
8.29.03	[redacted]	NPO	06	
			18	
8.29.03	[redacted]	VS q1°	06	
			18	
8.29.03	[redacted]	I/O q1°	06	
			18	
8.29.03	[redacted]	Bedrest - log roll.	06	
		maintain spinal precautions	18	
8.29.03	[redacted]	foley to gravity	06	
			18	
8.29.03	[redacted]	CXR qam	04	
30 Aug 03	[redacted]	Labs: ABG, CBC, chem 7	04	
		Inets, qam	18	
1 Sep 03	[redacted]	CT to suction	06	
			18	
9.1.03	[redacted]	no Heparin	06	
			18	
9.7.03	[redacted]	Jevity 100cc q4h°	06	
		as tolerated. Hold if	18	
		residual >150cc		
9/5/03	[redacted]	Vent settings changed to	06	
		Keep peep 8. wean	18	
		FIO2 to keep sats >90%		

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW to chest

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

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

b(a)-2 All

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo 9 Yr 2003

Verify by Initialing: Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
10 Sep 03	[redacted]	CBC, Chem 12, Chem 7,	11 Sep 03	0400		
	-----	ABG in am				
9/3/03	[redacted]	Sputum cx	3 Sep 03	ASAP		
9.13	[redacted]	T&C 2 units PRBC	9.13	ASAP		
9-14	[redacted]	Chem 7	9-14	NOW	DONE	[redacted]
9-14	[redacted]	ABG & lactic acid 30 min	9-14	1340	DONE	[redacted]
9-23	[redacted]	Sputum Cx	9-23	NOW	DONE	
9-23	[redacted]	Blood Cx x2	9-23	NOW	DONE	
9-23	[redacted]	Urine Cx	9-23	NOW	DONE	

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED
8.29.03	[redacted]	call MD for HR	
-----	-----	>105 SBP <90 >140	
-----	-----	RR ≥30 temp ≥38.5	
-----	-----		
-----	-----		
-----	-----		
-----	-----		
-----	-----		
-----	-----		
-----	-----		

USAPA V1.00

b(6)-2 A11

CLINICAL RECORD | THI[illegible]EUTIC DOCUMENTATION CARE PLA[illegible]N-MEDICATION)

For use of this form, see AR 40-40. the proponent agency is the Office of The Surgeo[illegible]eneral.

Mo. 09 Yr. 2003

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 24	25	26	27	28	29	30
10Sep03	[redacted]	Code Status: Full Code	06	[redacted]						
			18							
29Aug03	[redacted]	VS Q1°	06							
			18							
29Aug03	[redacted]	I/O Q1°	06							
			18							
29Aug03	[redacted]	Bedrest - Log roll, maintain	06							
		spinal precautions	18							
29Aug03	[redacted]	Foley to gravity	06							
			18							
29Aug03	[redacted]	~~Tube feed 500cc Q4°~~	00							
		~~SEE NEW ORDER~~	04							
			08							
			12							
			16							
			20							
15Sep03	[redacted]	Turn pt TID or More	06	[redacted]						
			18							
15Sep03	[redacted]	Regular diet - cont TF	07							
			11							
			17							
11Sep03	[redacted]	For dressing Δ's use	09							
		Dakin's Solution instead	21							
		of NS								
21Sep03	[redacted]	DRSG Δ to (C) lower leg BID	09	[redacted]						
		wet to DR	21							
	[redacted]	~~TF TID 500cc Seq~~	08							
	[redacted]	~~Each feeding~~	14							
			21							

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: GSW to Chest

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

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

b(4)-2 A11

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo Sep Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
23Sep	[redacted]	CXR this AM	24Sep	0400	0410	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED												
24Sep03	[redacted]	Call H.O. for HR >105													
		SBP <90 >140 RR>30													
		Temp>38.5													

b(6)-2 A1

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	11	12	13	14	15	16	17	18	19	20	21	22	23	24
9-11-03	[redacted]	G-tube setting cavity drainage	06	✓	m												
			18	[redacted]													
9-12-03		TF 500 cc Q4° (00,04,08,12,16,20)	04	x	[redacted]												
			18	x													
9/13/03	[redacted]	Burn pt TID OR MORE	08	✓													
			16	✓													
			24	✓													
9/15/03		Resp mgt - cont TF	04	x				x									
			18	x				x									
9/20/03	[redacted]	Sob drsg AES use dakin solution instead of NS	06	✓													
			18	✓													
9/21/03	[redacted]	drsg A to abdomen Leg BID Start 22 Sep 03 not to dry	04	✓													
			21	✓													

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW to Chest

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

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

MEDCOM - 18251

Henry Hine 18 Sep 03

b(6)-2 A11

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo Sep Yr 2003

Verify by Initialing: Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
9-11	[redacted]	Send sputum culture	9-11-03	ASAP	1330	[redacted]
9-11	[redacted]	CXRAY, pen IV arrival	9-11	ASAP	—	—
9-12	[redacted]	Blood CX x2	9-12	ASAP	0910	[redacted]
9-12	[redacted]	Urine CX / UA	9-12	ASAP	0755	[redacted]
9/14/03	[redacted]	PCXR	9/14/03	ASAP	2130	[redacted]
9/14/03	[redacted]	ABG now	9/14/03	ASAP	2120	[redacted]
9/14/03	[redacted]	VT 700, RR 12, Peep 5, FiO2 40%	9/14/03	NOW	2120	[redacted]
9/15	[redacted]	T&C for 4 units PRBCS				
	[redacted]	Give 2 u PRBCS	9/15/03	1045	#1 1045	[redacted]
	[redacted]		9/15/03	1230	#2 1230	[redacted]
9/15	[redacted]	CBC p infusion	9/15/03	1400	1400	[redacted]
	[redacted]	RPO p MN	9/21/03	2400	2400	[redacted]
9/22	[redacted]	DC central line	9/22/03	Now	1200	[redacted]
9/22	[redacted]	DC Arterial line	9/22/03	Now	1200	[redacted]
9/22	[redacted]	DC TRACH SUTURE	9/22/03	Now	1600	[redacted]
9/23	[redacted]	Sputum Culture, Blood Culture, Urine	9/23	NOW	1555	[redacted]
		Culture Now				

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

USAPA V1.00

-b(4)-2 A11

CLINICAL RECORD | **THE UTIC DOCUMENTATION CARE PLAN (-MEDICATION)**

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

Mo. 9 Yr. 2003

VERIFY BY INITIALING

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 29	30	1	2	3	4	5	6	7	8	9	10	11
29Sept	[redacted]	Regular diet	06 18	[redacted]												
			18 06													
29Sept	[redacted]	Clamp NG tube	06 18													
			18 06													
29Sept	[redacted]	paraplegia precaution	06 18													
			18 06													
29Sept	[redacted]	VS Q 4°	06 18													
			18 06													
29Sept	[redacted]	I&O q shift	06 18													
		Foley to gravity	18													
9/29	[redacted]	Blood cx, urine cx, +	06 18													
		sputum cx for temp	18 06													
		>38 >38.5°	/													
9/29	[redacted]	BID Dakins drsg As	06 18	[redacted]												
		for abd & LLE	18 06													
9/29	[redacted]	NIO: Turn q2°	6	X												
		while in bed	18													
2OCT	[redacted]	NIO: (D) Femoral ch	22													
		drsg Δ q 3° days.	X													
OCT03	[redacted]	Foley to gravity	06													
			18													
OCT03	[redacted]	VS q day	10													

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: GSW c paraplegia

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[redacted]

b(4)-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

10/(6) - 2 AM

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo Sep Yr 2003

Verity by Initialing: Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
9/29	[redacted]	Admit to IW	9/29			
10/2	[redacted]	NPO p MN	10/3	24(8)		
10/03	[redacted]	To OR in Am	10/4			[redacted]

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

b(6)-2A11

CLINICAL RECORD	TH EUTIC DOCUMENTATION CARE PLA ON -MEDICATION) For use of this form, see AR 40-40. the proponent agency is the Office of The Surgeon General.	Mo. 10 Yr. 2003

VERIFY BY INITIALING

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 12	13	14	15	16	17	18	19	20	21
29 SEP 03	[redacted]	Regular diet	06	[redacted]									
			18										
29	[redacted]	Paraplegia precautions	06										
			18										
11 OCT 03	[redacted]	VS q day	10										
29 SEP 03	[redacted]	NIO: Turn q2° while	06										
		in bed	18										
01 OCT 03	[redacted]	Foley to gravity	06										
			18										

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW c̄ paraplegia

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 77 MAY BE USED. USAPA V1.00

b (w)-2 A11

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 10 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
11 OCT 03	[redacted]	No need for dressing to left leg	11 OCT 03	—	—	[redacted]
19 OCT 03	[redacted]	NPO p MN - Surgery 10/20	20 OCT 03	0001		

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED												
11 OCT 03	[redacted]	Blood cx, urine cx & sputum cx for temp >38.5	D/T/I												

b(6) - 2 A11

CLINICAL RECORD | **THE ...EUTIC DOCUMENTATION CARE PLA... ...N-MEDICATION)**

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

Mo. Oct Yr. 2003

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 20	21	22	23	24	25	26	27	28	29	30	31
22 Oct	[redacted]	U/S Routine Q4hr	06	[redacted]				[redacted]							
			18												
20 Oct	[redacted]	Foley to gravity	06												
			18												
20 Oct	[redacted]	Paraplegic precautions	06												
			18												
20 Oct	[redacted]	Roll pt 90°, keep off	06												
		sacrum	18												
20 Oct	[redacted]	Reg diet c	07												
		Ensure	12												
			17												
20 Oct	[redacted]	Wet to dry dsg to	10												
		sacrum BID	22	[redacted]											
20 Oct	[redacted]	Stage IV pressure	06	[redacted]											
		ulcer to Coccix	18	[redacted]											
		Keep pressure off													
		to buttocks.													
		Turn Q 1-2°													
		from side to side													
20 Oct	[redacted]	Wet to dry dressing	10	[redacted]											
		to coccyx. Be gentle	20	[redacted]											
		to pack wound													
		loosely and pack													
		all tunneling &													
		undermining													
		Dressing Δ BID													

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: paraplegic c̄ deep sacral decubitus; infected

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 77 MAY BE USED. USAPA V1.00

b (6)-2 A11

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo Oct Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
20 Oct	[redacted]	Admit to icu, condition stable	20 Oct	—	1630	[redacted]
25 Oct	[redacted]	CBC, chem 8 in AM	25 Oct	Now	—	[redacted]
25 Oct	[redacted]	NPO p MN for surg on 26 Oct 03	25 Oct	MN	0000	[redacted]
26 Oct	[redacted]	Regular Diet.	26 Oct	Now	1335	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
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b(6)-2 A11

CLINICAL RECORD	THE .UTIC DOCUMENTATION CARE PLA N-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 10 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 21	22	23	24	25	26	27	28	29	30	31
21/10	[redacted]	VS Q1 hr (temp,	06	[redacted]										
		HR, BP) Record on chart	18	[redacted]										
			/											
21/10	[redacted]	Keep Pt on stomach	06	[redacted]										
		(prone position) At Nighttime	18	[redacted]										
		during sleeping	/											
			/											
21/10	[redacted]	If PT Rolls from side ~~to~~	06	[redacted]										
		~~side~~ position Place Pt back on	18	[redacted]										
		side position. check Q15 min	/											
21/10	[redacted]	KEEP PT on SIDE	06	[redacted]										
		ROLL Q1°	18	[redacted]										
			/											
21/10	[redacted]	Keep LUE site open	06	[redacted]										
		to air	18	[redacted]										
			/											
21/10	[redacted]	PT consult: ROM to	06	[redacted]										
		to LE ; obtain APO for	18	[redacted]										
		feet.	/											
			/											
21/10	[redacted]	NID: Strength training	06	[redacted]										
		for UE c̄ PT Bands	18	[redacted]										
		AND weights	/											
			/											
21/10	[redacted]	DON'T Δ MD'S ORDERS	06	[redacted]										
		W/O Ving c̄ MD	18	[redacted]										

ALLERGIES: ☐ YES ☐ NO
unknown

PRIMARY DIAGNOSIS: s/p Paraplegic c̄ deep sacral decub.
[redacted]

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

b(6)-2 A11

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 23	24	25	26	27	28	29	30	31	01	02
23Oct	[redacted]	DRSG Δ TID w to D	02	/	[redacted]									
		to coccix loosely packed.	20	[redacted]							[redacted]			
		dSg c 1/4 Dakins sol.	04	[redacted]										
29Oct	[redacted]	Routine Colostomy	06	/					/	/	[redacted]			
		Care	18	/					/		[redacted]			

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: paraplegia c deep sacral decub, infected

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ___

PATIENT IDENTIFICATION:

b(6)-4

[redacted]

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

b(6)-2 A1

CLINICAL RECORD | **TH. EUTIC DOCUMENTATION CARE PLA ON-MEDICATION)**

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

Mo. 10/31 2003

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 31	1	2	3
10/31	[redacted]	Activity: Roll	02	✓	[redacted]		
	[redacted]	please Q 2°	04	✓	[redacted]		
			06	✓	[redacted]		
			08	✓	[redacted]		
			10	✓	[redacted]		
			12	✓	[redacted]		
			14	✓	[redacted]		
			16	✓	[redacted]		
			18	✓	[redacted]		
			20	✓	[redacted]		
			22	[redacted]	[redacted]		
			24	[redacted]	[redacted]		
10/31	[redacted]	Vitals q Shift	D	✓	[redacted]		
			N	[redacted]	[redacted]		
10/31	[redacted]	Diet: Regular	D	✓	[redacted]		
			N	[redacted]	[redacted]		
10/31	[redacted]	TID Wet to dry	08	✓	[redacted]		
	[redacted]	c 1/4% Dakins	14	✓	[redacted]		
		Solution to Decub	20	[redacted]	[redacted]		
10/31	[redacted]	Foley to gravity	D	✓	[redacted]		
	[redacted]		N	[redacted]	[redacted]		
10/31	[redacted]	Ostomy Care	D	✓	[redacted]		
	[redacted]		N	[redacted]	[redacted]		

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P Debride Grade IV Decub Colostomy

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 77 MAY BE USED. | USAPA V1.00

b(4)-2 A11

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)			Mo Oct/Nov Yr 2003	
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
10/31	[redacted]	Transfer to ICW C bed	10/31		2100	[redacted]
01 Nov 03	[redacted]	Tx to 21st CSH when arrangement made				
2 Nov	[redacted]	Transfer to ~~Hagi Hospital~~ ICW 2 : continue orders	2 Nov	~~ASAP~~ Nov	0930	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													
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b(4)-2 A11

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 29	30	31	1	2	3	4	5	6	7	8
8.29	[redacted]	Fentanyl 50mg/hr	06	[redacted]										
		titrate for adequate	18	[redacted]										
		pain control												
8.29	[redacted]	Propofol 30mcg/kg/min	06	[redacted]										
		titrate to sedation	18	[redacted]										
8.29	[redacted]	Zantac 50mg IVPB	08	[redacted]										
		q8°	16	[redacted]										
			24	[redacted]										
30Aug	[redacted]	Versed @ 2mg/hr	06	[redacted]										
		titrate	18	[redacted]										
30Aug	[redacted]	Vecuronium for	06	[redacted]										
		paralysis	18											
30Aug03	[redacted]	LR @ 100cc/hr	06	[redacted]										
			18	[redacted]										
30Aug03	[redacted]	Fentanyl 100mcg/hr	06	[redacted]										
		titrate	18	[redacted]										
30Aug03	[redacted]	Vecuronium 4mg/hr	06	[redacted]										
			18	[redacted]										
30Aug03	[redacted]	Atrovent/ABG NEBS	00	[redacted]										
		q4°	06	[redacted]										
			12	[redacted]										
			18	[redacted]										
9.2.03	[redacted]	Jevity 100cc q6° hold	08	[redacted]										
		if residuals >100cc >150	14	[redacted]										
			20	[redacted]										
			02	[redacted]										

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW to chest.

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

EPW [redacted]

b(4)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

b(6)-2 A11

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
30Aug	[redacted]	Vit K 10mg SQ x 1 now	30mg	0730	0730	[redacted]
30Aug	[redacted]	LR Bolus 500cc		1095		[redacted]
~~30Aug~~	[redacted]	~~VABG, CBC, Chem 7 & PT/PTT now~~	~~30mg~~	~~ENTORE~~		
9/3/02	[redacted]	LR x1	9/3/02	0700	0700	[redacted]
9/3/02	[redacted]	LR x1	9/3/02	1000	1000	[redacted]
9/3/02	[redacted]	LR x1	9/3/02	1500	1500	[redacted]
9-3-02	[redacted]	ALBUMIN 25% x1 now	9/3/02	15000	15000	[redacted]
9-3-02	[redacted]	Lasix 20mg IVPx1 now	9/3/02	1700	1700	[redacted]
9-4	[redacted]	1L LR boluss	9.4.03	ASAP	0745	[redacted]
9-4	[redacted]	2U PRBC	9.4.03	ASAP	1030	[redacted]
9-4	[redacted]	1 Amp Calcium	9.4.03	ASAP	0945	[redacted]
9-4	[redacted]	1gm Magnesium 4°	9.4.03	ASAP	Started 0915	[redacted]
9/4	-----	Lasix 80mg IVP now				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
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USAPA V1.00

b(6)-2 A11

CLINICAL RECORD

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

Mo. ____ Yr. ____

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 2	3	4	5	6	7	8	9	10	11
9-2-03	[redacted]	D5 1/2 NSS 20 KCl @	06	[redacted]									
		125 cc/hr.	18	[redacted]									
9/3/03	[redacted]	Propofol for sedation	06	[redacted]									
		titrate for adequate	18	[redacted]									
		sedation.											
9/3/02	2	Omnigen 3 gm IVPB QR	08	X [redacted]									
			16	X									
			24	X									
9/3/02	2	Cipro 400 mg IVPB	10	X [redacted]									
	2	Q12	22	X [redacted]									
9/3/02	2	Zosyn 3.375 mg IVPB	04	X X [redacted]									
	2	Q6	10	X [redacted]									
			16	X [redacted]									
			22	X [redacted]									
9/3/02	2	DOPAmine @ 3 mcg/kg/min	06	X [redacted]									
	2		18	X [redacted]									
9/3/02	[redacted]	D5 1/2 NS c 20 KCL	06	[redacted]									
9/5/03	[redacted]	@ ~~150 cc/hr~~ 50/hr	18	[redacted]									
9-4-03	[redacted]	Vanc 500 mg IVPB BID	10	[redacted]									
		last dose now	22	[redacted]									
9-5-03	2	Fentanyl 2 mcg/hr IV	06	X X X [redacted]									
	2		18	X X X [redacted]									
9-6-03	2	D5NS with 20 KCl	06	X X X X [redacted]									
	2	@ 100/hr	18	X X X X [redacted]									
9-6-03	[redacted]	NF D5NS c 20 KCl @ 125 cc	06	[redacted]									
			18	[redacted]									

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: ~~S/P~~ GSW to chest

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

PATIENT IDENTIFICATION:

EPW [redacted]

b(6)-1

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.

MEDCOM - 18265

USAPA V1.00

b7(e)-2 A11

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. Sep Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
6Sep03	[redacted]	LR 500cc bolus x1 now	6Sep03			
9.8	[redacted]	LR 500cc bolus x1 now	~~8.9.8~~ 9.8	ASAP	1200	[redacted]
9.8	[redacted]	LR 1000cc bolus x1 now	89.8	ASAP	1400	[redacted]
9.8	[redacted]	1 Amp Calcium	9.8	ASAP	1700	[redacted]
9.8	[redacted]	2gm MAG over 4°	9.8	ASAP	2100	[redacted]
9.8	[redacted]	15mmol Nophos or K phos IVPB over 4°	9.8	ASAP	0800	[redacted]
9.8	[redacted]	ABG now	9.8	now	2100	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													

USAPA V1.00

b(6)-2 A1

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. 9 Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 8	9	10	11	12	13	14	15	16	17	18	19	20	21
9-8	[redacted]	Cefotaxim 2gm q 8° IVPB	08	/	[redacted]												
			16														
			24														
30 Aug 03 (Recupert)	[redacted]	Atrovent/Albut nebs q6°	00														
			06														
			12	RT													
			18	RT													
3 Sep 03 (Recupert)	[redacted]	Cipro 400 mg IVPB q 12°	10	/													
			22	/													
4 Sep 03 (Recupert)	[redacted]	Vancomycin 500mg IVPB BID	10	/													
			22	/													
3 Sep 03	[redacted]	Propofol for sedation	06	/													
			18	/													
3 Sep 03	[redacted]	Fentanyl for sedation	06	/													
			18	/													
3 Sep 03	[redacted]	IVF D5NS + 20 KCl @ 125	06	/													
			18	/													
10 Sep 03	[redacted]	~~Vit K SC 10mg qd x 3 days~~	10	/													
10 Sep 03	[redacted]	Albuterol/Atrovent neb q4h	00	/													
			06	/													
			12	/													
			18	/													
9-11-03	[redacted]	~~D5½NS + 20 KCl @ 100cc~~	06	/													
			18	/													
9/11/03	[redacted]	~~[illegible]~~															

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: SP Eclap R/H GSW.

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.

MEDCOM - 18267

USAPA V1.00

b(6) - 2 A11

Verify by Initialing		THER... EUTIC 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	
9.13	[redacted]	1 Amp CA	9.13	ASAP			
9.13	[redacted]	1 Sumol Kphos over 4 hours	9.13	ASAP			
9.13	[redacted]	2 gm Mag over 3 hours	9.13	ASAP			
		Turn off propofol in A.M. and					
		place					
9.15	[redacted]	Lasix 40 IVP Q X1	9.15			[redacted]	
9/15/03	[redacted]	40 mg Lasix IVP (1600)	9/15	1600			

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED														
9/14/03	[redacted]	MSO4 1-5mg IVP	2140	0200	1925	2230	0120	0230	0245	0800	1430	1415	[illegible]	[illegible]	[illegible]		
		q1° prn pain	5mg 9/14/03	5mg 9/14/03	5mg 9/15/03	5mg 9/15/03	6mg 1650	5mg	5mg	5mg	5mg	5mg	[illegible]	1300 5mg	1500 5mg		
9/14/03	[redacted]	Tylenol 650mg per	9/23/03 0550	9/23 0950	9/23 1450												
		O-tube for temp	101.9	101.5	101.5												
		>101.5															
9/14/03	[redacted]	MSO4 1-5mg IVP	9/17/03 2145 5mg	9/18 0510 5mg	9/19 3mg 0400	9/19 4mg 0900	9/19 3mg 0900	9/19 5mg 1600	9/18 5mg	9/19 0230	9-19 2300	9-19 0300	9-19 0300	9-19 0570	9.19 0630 5mg	9.19 1100 5mg	
		q1° prn pain	5mg	5mg					2000		5mg	5mg	5mg	5mg			
9.19	[redacted]	MSO4 1-5mg IVP	9.19 1300	9/18 1500 5mg	9/20 0130	9/20 0230	9/20 0300	9/20 0500 5mg	9/20 0400	21 00 2245	2150	2200 0815	2300 1500	2250 1835 3mg	2200 2000 3mg		
		q1° prn pain	9-20 9mg 2250	9/23/03 0130 5mg	9/23/03 0240 5mg	9/23/03 0430 5mg	9/23/03 0580 5mg	1050 5mg	1255 5mg	1520 5mg	5mg	5mg	4mg 1411				
9/14/03	[redacted]	MSO4 1-5mg IVP q1°	9/23 1830 5mg	9/23 2030 5mg	9/23 2355 5mg	9/24 0400 5mg	9.24 1850 5mg										
		PRN pain															

6

USAPA V1.00

b(6)-2A11

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. 9 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 23	24	25	26	27	28	29
9-11-03	[redacted]	Reglan 10mg IVPB Q6°	02	/	[redacted]					
	-----		08	[redacted]						
	-----		14	[redacted]						
	-----		20	[redacted]						
9-11-03	[redacted]	Zantac 50mg IVPB Q8°	08	[redacted]	> Refer to Kitten					
	-----		16	[redacted]						
9-14-03	[redacted]	D5 1/2 NS c̄ 20mEq KCl to	06	[redacted]						
	-----	25cc/hr	18	[redacted]						
9-14-03	[redacted]	Trach mask	06	[redacted]						
	-----		18	[redacted]						
9-15-03	[redacted]	5000 units Heparin BID	10	[redacted]						
	-----		22	[redacted]						
9-22-03	[redacted]	ASA 325mg QD	10	[redacted]						
9-23-03	[redacted]	Vanc 500mg IVPB q 12°	10	/ [redacted]						
	-----		22	[redacted]						
9-23-03	[redacted]	Ceftaz 2gm q 8°	08	/ [redacted]						
	-----		16	[redacted]						
	-----		24	[redacted]						
9/11/03	[redacted]	zantac 50mg IVPB Q8°	08	/ [redacted]						
	-----		16	/ [redacted]						
	-----		24	[redacted]						
9/24/03	[redacted]	Flagyl 250mg IVPB Q 8°	08	/ [redacted]						
	-----		16	/ [redacted]						
	-----		24	/ [redacted]						

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: EPW [redacted] / GSW to chest

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

EPW [redacted] b(6)-4
GSW to chest

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 1 FEB 79 4678 EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED														
22 Sept 03	[redacted]	NEB tx PRN	9/24 1605														
24 Sept	[redacted]	MSO4 1-5mg IVP Q1°	9.24 2050 2.5mg	9.25 0120 5mg	9/25 2210 2.5mg	9/26 0030 5mg	9/26 0350 2.5mg	9.26 0750 3mg	26 Sept 1345 3mg	[redacted]	[redacted]	[redacted]	[redacted]	28 Sept 0945 5mg	28 Sept 1200 3mg	28 Sept 1900 5mg	29 Sept 2200 6mg
		pen pain															
24 Sept	[redacted]	Tylenol 650mg per															
		G-Tube for T > 101.5															
25 Sep	[redacted]	MSO4 1-5mg IVP Q1°	9.28 2350 [redacted]														

*U.S. GPO: 1998-454-110/95216

b(6)-2 A-1

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 11	12	13	14	15	16	17	18	19	20	21	22	23
9-11-03	[redacted]	Rocephin 1mg IVPB @ 6°	08	[redacted]												
			14													
			20													
			02													
9-11-03	[redacted]	Zantac 50mg IVPB @ 8°	08													
			16													
			00													
9-12-03		VANCOMYCIN 500mg IVPB	10	x												
		Q12°	22	x												
9-14-03	[redacted]	IVF to 25cc/hr	06													
		(D5 1/2 NS c 20KCl)	18													
9-14-03	[redacted]	Trach mask	06													
			18													
9/14/03	[redacted]	Propofol 10mg/hr titrate	06													
		to decrease agitation	18													
4.15.03	[redacted]	5000 units Heparin BID	10													
			22													
10 Sep 03	[redacted]	Albuterol/Atrovent Nebs	00													
	[redacted]	q6hr (Decreased)	06													
22 Sep 03	[redacted]	ASA 325mg QD SR	12													
			18													
22 Sep 03	[redacted]	ASA 325mg QD	10													
		Vanc 500mg IVPB q	12													
		Cefotaxim 2gm q8°														

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: EPW [redacted] / GSW to chest

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

PATIENT IDENTIFICATION: EPW [redacted] b(6)-4 / GSW to Chest

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED													
2/5/10	[redacted]	DEB TX PRN														
		b(6)-2														

b(6)-2 A11

CLINICAL RECORD

TH. EUTIC DOCUMENTATION CARE PLA EDICATIONS)

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

Mo. 9 Y 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 29 30 3 1 02 03 04 05 06 07 08 09 10 11
29 Sept	[redacted]	Hep lock IV	06 12 18 00	[redacted]
9/29	[redacted]	Heparin 5000 u SC q12	10 14 18 22	[redacted]
04 OCT 03	[redacted]	Cidace T po bid	10 22	[redacted]
04	[redacted]	Flagyl 250mg po bid	10 22	[redacted]
11 OCT 03	[redacted]	Apply Bacitracin to Oleg (if dry)	10 22	[redacted]

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: GSW c paraplegia

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

b(6)-2A1

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

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
10/3	[redacted]	Start IV Fluids @ 2400	10/3	2400	2400	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED														
Exp 29 Sep 03	[redacted]	Percocet 1-2 po q 4° PRN pain	Date/Time	29 Sep 2330	30 Sep 1900	1 OCT 2245	2 OCT 1630	2 OCT 1900	3 OCT 1940	4 OCT 1935	5 OCT 0945	5 OCT 1345	6 OCT 1900	7 OCT 1645	8 OCT 0030	8 OCT 1900	9 Oct 1000
			Dose	1	1	2	2	2	1	1	1	1	1	1	1 po	1 po	2
Exp 2 Oct	[redacted]	MS041-2mg q 1° prn break through pain	[redacted]														See bel [redacted]
29 Sep	[redacted]		DK														
01 OCT 03	[redacted]	MS041-2mg IVP q 2° prn pain	D/T	01 OCT 1020													
			D/I	2mg [redacted]													
01 OCT 03	[redacted]	Motrin 800mg TID prn	D/T	01 OCT 1020	8 OCT 0900												
			D/I	800mg [redacted]													
29	[redacted]	Percocet 1-2 po Q4° PRN pain	D/T	9 OCT 0400	9 OCT 1000	9 OCT 2045	10 OCT 1000	10 OCT 1130	10 OCT 2225	11 OCT 1330	11 OCT 1630						
			D/I	1 po	2	1	1	1	1	1	1						
			[redacted]														

USAPA V1.00

b(4)-2 A11

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 10 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 12	13	14	15	16	17	18	19	20	21	22	23
29 SEP 03	[redacted]	Heplock IV	06	[redacted]											
	-----		18												
29	[redacted]	Heparin 5000U SC q	10												
	-----	12°	22												
04 OCT 03	[redacted]	Colace I po BID	10												
	-----		22												
04	[redacted]	Flagyl 250mg po	10												
	-----	BID	22												
11 OCT 03	[redacted]	Apply Bacitracin to q	10												
	-----	kg (if dry)	22												

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW & paraplegia

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

#[redacted]

b(4)-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 1 FEB 79 4678 — EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. 10 Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
		DW 2 A1				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
11 OCT 03	[redacted]	Percocet 1-2 po q4° pm pain	D/T	1204 0730	1204 1130	1304 1000	1304 1430	1304 2245	1504 0900	1504 0850	1504 1540	1604 0700	1604 1345	1704 2015	1704 1720	
			D/I	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
11 OCT 03	[redacted]	Motrin 800mg TID pm	D/T	2000												
			D/I	800mg [redacted]												

*U.S. GPO: 1998-454-110/95216

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. Oct Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 20	21	22	23	24	25	26	27	28	29	30	31	/	/
20 Oct	-----	LR @ 75cc/hr	06	[redacted]													
	-----		18														
20 Oct	-----	Heparin 5000u SQ BID	10														
	-----		22														
	-----	P	/														
22/10	[redacted]	Prenatal multivitamin	12	/	/	[redacted]											
	-----	1 tab PO QD	/	/													
24/10	[redacted]	FLAGYL 500MG IVPB	08	/									/	[redacted]			
	[redacted]	TID	16	/									/				
	-----		24	[redacted]									/	[redacted]			
	-----	b/le) L Ail															

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Paraplegic & deep sacral decubitus; infected

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

#[redacted]

6/6/04

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 1 FEB 79 4678 EDITION OF 1 MEDCOM - 18277 KHAUSTED.

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	
		b(6)-2 A11					

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
21/10	[redacted]	MSO4 2-4mg IVP	2500 4mg	2000 2mg	2600 4mg	2100 4mg	2700 4mg	1200	1800	1800	29					
		Q1hr PRN PN	2300	0050	11:00	0300	2200	0600	2100	2400	4mg	DC'D				
29/10	[redacted]	Percocet tabs 1-2 tabs	1600 21/10	2300 24/10	0530 22/10	2010 1430	22/10 1830	22/10 2230	23/10 0730	23/10 1130	23/10 2130	24/10 0420	24/10 0520	24/10 1220	25/10 0115	25/10 0620	30/OCT 1145
		Q4-6hr PRN PN	2tabs	ii po	ii po	2tabs	1tab	ii po	2tabs	2tabs	ii po	ii po	ii po	ii po	ii po	ii po	ii
			25/10 i	2500 i	2600 1tab	27/10 1255	0000 29/OCT	0600	1200	2400	2400	30/10 0700	30/10 1345	30/10 2105	30/10 0605		
			1400	2300	2300	2100	ii 1130	4	ii	ii	ii	ii	2100	ii	ii		
29/10	[redacted]	MSO4 2-8MG IVP Q2-4°	2200 4mg	0400 4mg	0000 2mg	0700 30/10	30/10 0730	30/10 0930	30/10 1345	30/10 1630							
		PRN PAIN	2500	2000	3000	3mg	4mg	3mg	5mg	5mg							

*U.S. GPO: 1998-454-110/95216

b(6)-2 A11

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 10 / Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 31	1	2	3	4	5	6	7	8
10/31	[redacted]	IV Heplock	D	[redacted]								
			N	[redacted]								
10/31	[redacted]	Flagyl 500mg IV	08	[redacted]							/	
		q 8° x 8 day	16	[redacted]							/	
			24	[redacted]							/	
10/31	[redacted]	Prenatal Vitamin	10	[redacted]								
		1 po q Day										
10/31	[redacted]	Heparin 5000U	10	[redacted]								
		S.Q. BID	22	[redacted]								

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P Debride & Colostomy Grade IV Decub

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

#[redacted]

b(4)-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 1 FEB 79 4678 EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*	Mo. Oct/Nov Yr. 03			
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
		b(6)-2 AR				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* TIME/DATE DISPENSED													
10/31	[redacted]	Percocet 1-2	Date / Time	2300 31OCT	1NOV 1205	1NOV 0820	2NOV 1630	11/3 0830	11/3 1330							
		P.O. q 4-6° prn	Dose / Ind	#ii po	ii	ii	2 tabs	2 tabs	ii po							
				[redacted]												

*U.S. GPO: 1998-454-110/95216

MEDCOM - 18280

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		Time: 06 00 Initals [redacted]	Time: Initals:
NEURO	Pupils	2 - sluggish	
	Sensorium	Sedated b/(6)-2	
	LOC / GCS		
CARDIAC	Cardiac Rhythm	SR	
	PRI: / QRS:		
	Pulse Strength	2+	
	Cap Refil / JVD	(+)	
	Edema	Ø	
	Chest Pain	Ø	
RESP	Respiratory Pattern	Unequal L>R	
	Breath Sounds	Coarse	
	Secretions	min - tan	
	Cough	Ø	
SKIN	Color	NFR	
	Integrity	Mult sub sites	
	Backside		
IV	Access Devices	PIV / PIV / Aline	
	Location	(L) Bicep / (R) FA / (L) Rad	
	Condition	CDI / CDI / CDI	
GI	Abdomen	Flat	
	Bowel Sounds	Ø	
	Stoma/Ostomy	NGT LWS	
GU	Device	Foley	
	Color / Clarity	dark yellow / [redacted] b/(6)-2	

PREPARED BY (Signature & Title) [redacted] CPT IAW

DEPARTMENT/SERVICE/CLINIC: ICU #1, 28TH Combat Support Hospital

DATE: 29 Aug 03

b/(6)-1

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

NAME: CPW [redacted] RANK: AGE:

UNIT: b/(6)-1 GENDER:

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

☐ 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: EPW [redacted]

Date: 30 May 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	98.4					100.4				98.7			96.3			98.8								
Pulse	58	81	79	89	90	92	97	104	104	97	89	89	80		80	81								
B/P A-Line	126	149	130	157	127	113	118	114	115	102	127	113	110		134									
MAP	64	67	59	55	51	45	45	43	49	43	56	51	57		74	77								
B/P Cuff	86	68	76	74	61	66	64	67		64	75	68	73		97	99								
Respirations	10	16	10	10	10	10	10	25	32	24	28	25	19		22	22								
Sa02 %	100	100	100	100	100	100	100	98	99	94	94	100	100		97	100								
FIO2 %								45%	45	45	45		45		50	50								

Intake	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
IVF	125	125	125	125	125	125	125	125	125	125	off	off	1250	off	off	off	125	125								
Fentanyl	10	10	10	10	10	10	10	10	10	14	14	14	132	14	14		5	5								
Propofol	15.4	15.4	15.4	15.4	15.4	13.4	13.4	13.4	13.4	15	19	19	195	19	19		Ver	2								
IVPB								50																		
								PROC		450	450		900		(NS) 1000 (LR) 2000 (D5W) 200 (FW) 1126											1000
PO intake								NS			500		500													
O.R. IN								Bolus LR			500		500													
Totals													3477		Vec 8.											

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	70	100	100	90	40	40	35	30	30	22	26	20	~~120~~ 453	26	26	200	110	336								
NG Tube					50			30	100	82	108	128														
Drains #1																										
CT #2	160				25						70		255	100												
#3																										
Emesis/Stool																										
O.R. OUT																										
Totals													708													

24 hour input	
24 hour output	
24 hour balance	

MEDCOM - 18282

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE: INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date): QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		Time: Initals:	Time: 0730 Initals: [redacted]
NEURO	Pupils		PERRLA 3mm
	Sensorium		Sedation off. moves arms / ⊖ LE movement
	LOC / GCS		withdraws to pain
CARDIAC	Cardiac Rhythm		Sinus bradycardia
	PRI: / QRS:		
	Pulse Strength		+1 all extremities
	Cap Refil / JVD		
	Edema		⊖
	Chest Pain		Pt intubated does not communicate
RESP	Respiratory Pattern		normal on SIMV 16, TV 750 PEEP 5 FiO2 50%
	Breath Sounds		CTA (B) CT to ⊖ SX over (R) ant chest
	Secretions		⊖
	Cough		⊖
SKIN	Color		WFR
	Integrity		Intact ⊖ wounds over (R) anterior chest, abd
	Backside		Deferred
IV	Access Devices		PIV X 2
	Location		(R) FA / (L) UA 18G
	Condition		C/D/I
GI	Abdomen		ABD dressing in place
	Bowel Sounds		UTA
	Stoma/Ostomy		⊖
GU	Device		foley to gravity
	Color / Clarity		amber / clear
			adequate UOP

PREPARED BY (Signature & Title): [redacted] / CPT / AN

DEPARTMENT/SERVICE/CLINIC: ICU #1, 28TH Combat Support Hospital

DATE: 29 Aug 03

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

NAME: EPW [redacted]

RANK: AGE:

UNIT:

GENDER:

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

☐ 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: EPW 675 Date: 24 / Aug / 2003

Vital Signs	24	01	02	03	04	05	06	07	08	09	10	11		12	13	14	15	16	17	18	19	20	21	22	23	
Temperature																										
Pulse																				97		96	8		98	
B/P A-Line																				51	62	80	77		85	
MAP																							123	114	88	
B/P Cuff																							67	58	60	
Respirations																				86	86	76	81	75	85	
Sa02																				126	123	106				
																				63	66	57				
																				16	16	16	16	16	16	
																				100	100	100	100	100	100	
																				[redacted]						
																				Fio2 50%	→	→	→	40%	→	

Intake	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
IVF																										
Propofol																				25	25	125	25	25	125	
Fentanyl																										
FFP																										
PO intake																										
O.R. IN																										
Totals																										

Output	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
Urine Hourly																										
NG Tube																					200	50	50	40	90	
Drains #1																										
#2																										
#3																										
Emesis/Stool																										
O.R. OUT																										
Totals																										

24 hour input	
24 hour output	
24 hour balance	

MEDCOM - 18284

2-3-19

'CAL RECORD-SUPPLEMENTAL MEDIC/ TA
For use of this f , AR 40-66; the proponent agency is The Offic : Surgeon General

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8Mar 89 b(4)-2

INITIAL SHIFT ASSESSMENT

	TIME		INTILAS		INTILAS		INTILAS [redacted]
NEURO	PUPLIS						FIXD
	SENSORIUM						Perrla 3m
							withdraws to pain
							UE's only
							Paraplegic
RESPIRATORY	RESPIRATION PATTERN						normal on SIMV 22 FIO2 50%
	BREATH SOUNDS						CTA(B)
	SECRETIONS						—
							CT x2 on 20cm H2O 5x
							over (R) lt chest.
SKIN	COLOR						NFR
	INTEGRITY						Burn like laceration c
							popped blister over (L) LE.
IV SITE	LOCATION						TLC over (R) IJ, cordis
	CONDITION						over (L) femoral vein, art
							line over (L) radial artery
							PIV over (R) arm.
							Condition dry
							& intact
GASTRO	ABDOMEN						s/p ex lap via midline
	BOWEL SOUNDS						abd dressing c JP's x 2
							BS absent
							-BM witnessed
GU	URINE						Foley to gravity
	COLOR/CLARITY						amber/clear
							adequate output - 40cc/hr
CARDIOVASCULAR	CARDIACRHYTHM						NSR
							Pulses equal & strong

LEGEND
Cr - Creatinine
F_IO - Fraction of inspired O_2
F_IO_2 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - PRESSURE OF ARTRIAL CO_2
PEEP - Positive end Expiratory Pressure
S/A - Fractional
SAI - Saturation
TRACH - Iracheostomy

b(4)-2

(Continue on reverse)

PR[redacted]tle) CPT HAW | DEPARTMENT/SERVICE/CINC ICU3 | DATE 30 Aug 03

PATI[redacted]DICATIONS (For typed or written entries give: Name—Last, First, midd[redacted]ade; date; hospital or medical facility)

EPW [redacted]

b(4)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)
☐ DIGNOSTIC STUDIES
☐ TRETMENT

DA FORM 1 MAY78 4700
Proponent Dept of Nurs

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

DATE | DX | HOSPITAL DAY

VITAL SIGNS																	
TIME	24	01	02		04	05	06	07		08	09		11	12	13	14	15	
BP Arterial line																		
BP Cuff																		
Temperature																		
Pulse																		
Respiratory Rate																		
O_2 sats																		
mode/FIO_2																		

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

OUTPUT																		
URINE	HOUR / TOTAL																	
	SP gr																	
	S/A																	
NG	OUTPUT																	
	PH																	
	GUIAC																	
EMESIS																		
STOOL																		
DRAINS	JP#1																	
	JP#2																	
	CT #1																	
	CT #2																	
TOTALS																		

POST-OP DAY

VITAL SIGNS	14	17	18	19	20	21		23
				120/61	113/64	115/60	117/56	124/58
				93.5 Groin		95.1 AX		97.4 A
				84	84	85	87	95
				25	24	22	22	22
				99	99	100	100	100
				SIMV 50%	SIMV 50%	SIMV 50%	SIMV 50%	SIMV 50%

INTAKE	14	17	18	19	20	21	22	23	8°T

OUTPUT									
					50	60	70	60	
					70				
					70				
							50		

ACUITY LEVEL CLASSIFICATION

RESPIRATORY			
	TIME		1900
	MODE		SIMV
	F_IO_2		50
	TV		5
	RATE		22
	PEEP		7
ABG	A	pH	7.31
		PCO_2	41.5
	B	pO_2	66
		HCO_3	21
		SAT	91%
	G	BASE	-5

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

DAILY ACTIVITIES									
	TIME								
	MOUTH CARE								
	BATCH								
	SKIN CARE								
	FOLEY CARE								
	TRACH CARE								
	ROM EXERCISES								

TURN SUCTION	TIME				

24-180 TOTALS	NURSE'S SIGNATURE	INITIALS
WT Yesterday _____ wt Today _____		
INTAKE / OUTPUT		
IV _____ Urine: _____		
Po _____ _____		
TOTAL _____ TOTAL _____		
BALANCE _____		

For use of this fo CAL RECORD-SUPPLEMENTAL MEDICA A
AR 40-66; the proponent agency is The Office Surgeon General

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET b(6)-2

OTSG APPROVED (Date)
QA Appr 8Mar 89

INITIAL SHIFT ASSESSMENT

NEURO	TIME	0630	INTILAS [redacted]	1830	INTILAS [redacted]		INTILAS
	PUPLIS	3mm sluggish bila-		Pupils equal, round 3mm, very			
	SENSORIUM	teral. Sedated		sluggish. Pharmacologically sedated			
		no respond to pain		c̄ versed, fentanyl, paralyzed c̄			
		stimuli. Paraplegic		vecuronium. Spinal precautions			
		per Hx.					
RESPIRATORY	RESPIRATION PATTERN	SIMV 22 FiO2 60%		ETT 7.0, 26cm @ teeth. SIMV			
	BREATH SOUNDS	Peep 7. lungs ronchi		22, TV 500, Peep 7, FiO2 50%			
	SECRETIONS	bilateral c̄ expiratory		Rhonchi all lung fields ā + p̄			
		wheezing. CT x2		suctioning. Thick yellow/white			
		(R) side 20cm H2O Con-		secretions, CT x2 (R) lateral chest.			
		tinuous suct.		Both to 20cm H2O continuous			
SKIN	COLOR	WFR. blisters (R)		suction. Sats 100%. WNL, cool			
	INTEGRITY	LE. Abd wounds c̄		BUE. Dry, open wound (L) medial			
		dressing CDJ.		lower leg, white center, Blister LLE,			
IV SITE	LOCATION	TL (R) IJ cordis		ML abd incision c̄ dressing in			
	CONDITION	(R) femoral vein.		place. TLC to (R) IJ, brown port			
		A Line (R) radial.		clotted, white port draw blood from!			
		PIV (R) arm. CDJ.		flush well, blue port versed/Fentanyl.			
				(L) groin c̄ cordis LR/vecuronium			
				(L) wrist A-line, zeroed, good wave form			
GASTRO	ABDOMEN	S/P ex. lap. mid line		(R) anterior forearm SL, flushed well			
	BOWEL SOUNDS	abd dressing. JP x2		Dressings Dry & intact. ML			
		BS absent. ø BM		abdominal incision, dressings in place			
				minimal (L) side of dressing, brownish/green drainage. hypoactive			
GU	URINE	Foley to gravity		bs x4. ø BM. NGT to LIS. Checked placement c̄ air bolus. Secured			
	COLOR/CLARITY	amber. ↓ color		to nose. Foley to DD DK yellow clear urine. Foley care			
		ø sediments.		done. Secured to (R) leg. ø drainage			
CARDIOVASCULAR	CARDIACRHYTHM	S tach 110's ø ectopy		SR ē ectopy. S1S2. VSS.			
		+2 pulses x4. capillary		trace generalized edema. cool BUE			
		refill <3sec. Skin		Radial (L) pulses 2+. Pedal/(R) radial pulses 3+			
		dry warm.		capr refill <3 sec.			

LEGEND
Cr - Creatinine
F_iO - Fraction of inspired O_2
F_iO_2 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - PRESSURE OF ARTRIAL CO_2
PEEP - Positive end Expiratory Pressure
S/A - Fractional
SAI - Saturation
TRACH - Iracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CINC

DATE 31Aug03

PATIENT'S INDICATIONS (For typed or written entries give: Name—Last, First, middle; grade; date; hospital or medical facility)

EPW [redacted]
b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)
☐ DIGNOSTIC STUDIES
☐ TRETMENT

DA FORM 1 MAY78 4700
Proponent Dept of Nurs

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

DATE	DX													HOSPITAL DAY				
VITAL SIGNS TIME	24	01	02	03	04	05	06	07		08	09		11	12	13	14	15	
BP Arterial line	118/50	126/53	122/47	109/45	122/46	128/50	133/55	127/54		128/53	129/54	132/53	122/50	128/51	128/55	131/51	120/52	
BP Cuff																		
Temperature			99.8 AX			97.1 A				97.9				97.9				
Pulse	105	111	119	123	110	109	117	112		116	119	114	112	108	110	110	104	
Respiratory Rate	22	22	22	22	22	22	22	22		22	22	22	22	22	22	22	22	
O2 sats	99	97	97	98	96	96	99	99		99	96	98	96	97	96	96	98	
O2 delivery	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV		SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	
FIO2	50%	60%	50%	50%	50%	50%	50%	50%		60%	50%	50%	50%	50%	50%	50%	50%	

INTAKE TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
LR	100	100	100	100	100	100	100	100	2200	100	100	100	100	100	100	100	100	800
Versed	3	3	3	3	3	3	3	3	24	3	3	3	3	3	3	3	3	24
Fent	10	10	10	10	10	10	10	10	80	10	10	20	20	20	20	20	20	140
Vecuronium	4	4	4	4	4	4	4	4	32	4	4	4	4	4	4	4	4	32
TOTALS									2336									996

OUTPUT																		
URINE	HOUR / TOTAL	40	60/90	60/150	35/185	30/215	50/265	70/335	60	35	60	45/105	50/155	45/200	48/248	48/296	60/356	60/416	576
	SP gr																	
	S/A																	
NG	OUTPUT																	
	PH																	
	GUIAC																	
EMESIS																		
STOOL																		
DRAINS	JP 1/2			60/0			30/35			30/25		35/00				70/00		70/0
	CT 1				140					140						210		210
	CT 2				10					10						31		31
TOTALS										650								887

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21		23	
	135/55	132/52	124/56	136/57	113/52	119/65	124/56	129/56	
		90.5				119/60		118/59	
						96.0	95.9		
	104	98	97	101	87	90	87	88	
	22	22	22	22	22	22	22	22	
	97	97	99	100	99	100	100	99	
	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	
	50%	50%	50%	50%	50%	50%	50%	50%	

INTAKE	14	17	18	19	20	21	22	23	8°T
	100	100	100	100	100	100	100	100	800
	3	3	3	3	3	3	3	3	24
	20	20	20	20	20	20	20	20	160
	4	4	4	4	4	4	4	4	32
									1016

OUTPUT									
	50	60/110	45/155	54/209	32/241	33/274	34/308	38/346	346
								100	100
			30/10					45/10	95/20
			30					179	209
			18					47	47
									767

ACUITY LEVEL CLASSIFICATION

RESPIRATORY	TIME	0600	0	1030						
	MODE	SIMV	SIMV	SIMV						
	F_IO_2	60%	50%	50%						
	TV	500	500	500						
	RATE	22	22	22						
	PEEP	7	7	7						
ABG	pH									
	PCO_2									
	pO_2									
	HCO_3									
	SAT									
	BASE									

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

ACTIVITIES DAILY LIVING	TIME					TIME			
	MOUTH CARE	1645			TURN	2000			
	BATCH								
	SKIN CARE								
	FOLEY CARE	1900			SUCTION	1830			
	TRACH CARE					1930			
	ROM EXERCISES					2230			

24-180 TOTALS	NURSE'S SIGNATURE	INITIALS
	[redacted] LITIAN	[redacted]

WT Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV	4348	NG	100
Po		Urine:	1317
		225 JP1	CI 1529
		45 JP2	CI 2304
TOTAL	4348	TOTAL	2304
BALANCE	+2044		

NEUROLOGICAL ASSESSMENT

			HOURS	[illegible]
COMA SCALE	EYES OPEN	SPONTANEOUSLY	4	
		TO SPEECH	3	
		TO PAIN	2	
		NO EYE OPENING	1	1
	BEST VERAL RESPONSE	ORIENTED	5	
		CONFUSED	4	
		VERBALIZES	3	
		VOCALIZES	2	
		NO VOCALIZATION	1	T
	BEST MOTOR RESPONSE	OBEYS COMMANDS	6	
		LOCALIZESPAIN	5	
		FLEXION WITHDRAWAL	4	
		ABNORMAL FLEXION	3	
		EXTENSION TO PAIN	2	
		NO RESPONSE	1	1
LIMB MOVEMENT	ARMS	NORMAL POWER		
		MILD WEAKNESS		
		SEVERE WEAKNESS		
		ABNORMAL FLEXION		
		ABNORMAL EXTENSION		
		NO RESPONSE		R/L
	LEGS	NORMAL POWER		
		MILD WEAKNESS		
		SEVEREWEAKNESS		
		ABNORMAL FLEXION		
		ABNORMAL EXTENSION		
		NO RESPONSE		R/L
PUPILS	RIGHT	SIZE		3mm
		REACTION		+
	LEFT	SIZE		3mm
		REACTION		+

PUPIL SCALE: 2, 3, 4, 5, 6, 7 mm

ICP

CEREBRAL PERFUSION PRESSURE

LEGEND

C Closed by swelling

T Trach/Endo
S Slurring
D Dysphasia
R Receptive
E Expressive

R Right
L Left

Record Separately if there is a Difference between the tow sides

++ Brisk
+ Slow
– No Response

+ Intact
– Abnormal

VASCULAR ASSESSMENT

HOURS		1830
Radial	R	++
	L	+
Pedal	R	++
	L	++
	R / L	
	R / L	
	R / L	

++ Normal
+ Weak
– Absent
D Doppler
R Right
L Left

b(6)-4

ICU Flowsheet

Patient Name: EPW [redacted]

Date: 09 / 01 / 2003

Vital Signs	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
Temperature	96.8		97.7											100.9						99.4				98.7		
Pulse	91	97	102	102	105	107	115																			
B/P A-Line	55	53	51	52	50	54	56																			
MAP	76	77	75	75	77	80	84																			
B/P Cuff	58	59	56	56	61	55	59																			
Respirations	22	22	22	22	22	22	22																			
Sa02	98	98	98	98	98	98	98																			
FiO2	50%	50%	50%	50%	50%	50%	50%																			
Mode	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV														SIMV	SIMV	SIMV	SIMV	SIMV	

Intake	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
IVF LR	100	100	100	100	100	100	100	100	100	100	100	100	1200	100	100	100	100	100	100	100	100	100	100	100	100	1200
Vecuronium	3	3	3	3	3	3	3	3	3				240	20	20	20	20	20	20	20	16	16	16	16	16	220
Fentanyl	20	20	20	20	20	20	20	20	20				360	5	5	5	5	5	5	5	5	5	5	5	5	61
Versed	4	4	4	4	4	4	4	4	4				188					50								50
IVPB	50								50																	
PO intake																										
O.R. IN																										
Totals													1603													1571

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	38	36	42	36	95	48	42	30	40	30	30	94	350	38	38	40	40	40	40	50	80	32	65	120	60	650
NG Tube		74	116	152	197	247	89	119	161	211	260	300		68	116	163	203	243	283	313	405		410	590	650	
Drains JP #1					40	30		35				37	137					40			30		28			98
JP #2					10	10		5				5	30					10			0		0			10
CT#1/CT#2					14					84			104								65					43
Emesis/Stool										18			36								40					
O.R. OUT																										
Totals													662													863

24 hour input	3134
24 hour output	1525
24 hour balance	

MEDCOM - 18292

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE: INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date): QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		Time 0700 Initials: [redacted] b(6)	Time: 1900 Initials: [redacted]
NEURO	Pupils	2mm sluggish, Perrla, secondary to [illegible]	2mm sluggish
	Sensorium	pain mgt c̄ sedating, HR 115-7 c̄ painful	non responsive, intubated
	LOC / GCS	stimuli, ↓ movement, non-breathing	
		vent + 2-5-3.	
CARDIAC	Cardiac Rhythm	ST c̄ occ PVCs	ST, ↓ ectopy
	PRI: / QRS:		
	Pulse Strength	+2 radial & pedal bilat	2+
	Cap Refil / JVD	<3 sec & JVD	<3 sec / ↓ JVD
	Edema	gen edema + ↑ pitting	1+ pitting to extremities
	Chest Pain	OTA	UTS
RESP	Respiratory Pattern	even unlabored vent-synchronous, VE 5.00	equal use / full
	Breath Sounds	RR 22 ETT #6 26cm @ teeth	clear
	Secretions	moderate secretions from ETT, coarse BS	small, tan
	Cough	diminished bilat w/ crackles, CT x2 (R)	c̄ SX.
		CW	
SKIN	Color	appropriate for race	NFR
	Integrity	midline abdominal incision stapled OTA, staples	NL c̄ staples CDI
	~~Backside~~	intact C/D/I, dressings drainage or bleeding	CT x2; JP x2 - crusted c̄
		see progress note for drsg & wound	bulky drsg
IV	Access Devices	(L) Sem cath, (R) IJ TL	(L) Femoral	(R) PA Alive	(R) IJ
	Location		CDI	CDI	CDI
	Condition	all patent			
GI	Abdomen	soft, rounded, nondistended	soft; nontender
	Bowel Sounds	↓ BS NG to CZS c̄ grey secretions	↓
	Stoma/Ostomy	NG (R) nare, placement confirmed	NGT - clamped for feeds. Held @ 1600 for ↑ abdomen
GU	Device	FTG BS.	FTG - QS.
	Color / Clarity	amber & clear	yellow / clear

(Continue on reverse)

0600-1800 PREPARED BY (Signature & Title): [redacted] ILTRN 1800-0600 b(6)

DEPARTMENT/SERVICE/CLINIC: ICU #1, 28TH Combat Support Hospital

DATE: 28 Sep 03

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

NAME: [redacted] b(6)

RANK: AGE:

UNIT:

GENDER: M

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

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, MAY 78

USAPPC V2.00

b(a)-2

ICU Flowsheet Patient Name: FPN # [redacted] Date: 9 / 2 / 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				100.5				99.7					98.9							100.7				
Pulse	115	113	114	115	117	114	112	117	111	103	101	94	101	103	99	94	92	81	85	90		101	102	106
B/P A-Line	178/76	172/72	171/69	169/71	179/76			136/43				69/71	189/74	173/70	159/69	155/61	172/64	169/62	205/70	175/71	146/69	161/72	167/70	200/73
MAP	103	100	101	98	93	104	92													98	95	98		103
B/P Cuff	144/76	147/79	135/75	135/69	138/68	149/76	134/68	136/63	124/64	132/69	137/69	146/82	153/68	147/65	136/60	141/68	146/70	148/68	178/64	151/61	139/61	148/62		163/71
Respirations	22	22	21	24	22	24	22	27	23	22	24	22	22	22	22	22	22	25	22	24	22	25	26	24
Sa02	92	91	91	93	94	91	94	94	95	94	95	95	97	96	99	100	98	98	91	96	94	97	95	91
FiO2	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50
Mode	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV

Intake	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
IVF D5½NS	100	100	100	100	100	100	100	100	125	125	125	125	1300	125	125	125	125	125	125	125	125	125	125	125	125	1500
Vecuronium	0	0	0	0	0	0	0	CRT off		–	–			–	–											
fentanyl	16	16	16	16	16	16	16	16	16	16	16	16	192	16	16	16	16	16	9							76
Versed	5	5	5	5	5	5	5	5	off	–	–	–	40	–	–											
IVPB	50								50		–		100		–	50										50
PO intake									100				100			100										100
O.R. IN													1732													1726
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	110/110	60/170	60/230	80/310	135/445	190/635	50/685	85/770	65/835	80	60	55	1030	65/65	55/120	75/195	50/245	45/290	80/370	90/460	90/550	50/600	60/660	60/720	60/780	770
NG Tube	200/200					50							250													
Drains JP #1			30			15						90	85					28								
JP #2						10						12	22					10								
CTs #1/#2 #3	90/60					135/30						120/30	455					60/0							150/50	210/60
Emesis/Stool																										
~~O.R. OUT~~ Residual																80			150							
Totals													1852													

24 hour input	
24 hour output	
24 hour balance	

MEDCOM - 18294

M L RECORD-SUPPLEMENTAL MEDICAL
For use of this form R 40-66; the proponent agency is The Office of urgeon General

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8Mar 89 b(6)-2

INITIAL SHIFT ASSESSMENT

	TIME		INITIAS		INITIAS	1900	INITIAS [redacted]
NEURO	PUPLIS					unreactive 3mm round, equal	
	SENSORIUM					no response to painful stimuli	
RESPIRATORY	RESPIRATION PATTERN					normal on SIMV 22	
	BREATH SOUNDS					course throughout	
	SECRETIONS					-0-	
SKIN	COLOR					NFK	
	INTEGRITY					Blisters over (L) LE	
						abd wound staples intact	
IV SITE	LOCATION					(L) groin cordis, (R) IJ	
	CONDITION					triple lumen	
						C,D,I	
GASTRO	ABDOMEN					soft, nondistended	
	BOWEL SOUNDS					hypo	
						not clamped.	
GU	URINE					Foley up <30cc/hr	
	COLOR/CLARITY					Dark yellow / clear	
CARDIOVASCULAR	CARDIACRHYTHM					Sinus tach	

LEGEND

Cr - Creatinine
F_IO - Fraction of inspired O_2
F_IO_2 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - PRESSURE OF ARTRIAL CO_2
PEEP - Positive end Expiratory Pressure
S/A - Fractional
SAI - Saturation
TRACH - Iracheostomy

(Continue on reverse)

b(6)-2

[redacted] CPT IAW | DEPARTMENT/SERVICE/CINC FCU 3 | DATE 3 Sep 03

PATIENT'S INDICATIONS (For typed or written entries give: Name—Last, First, middle; grade; date; hospital or medical facility)

EPW [redacted] b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)
☐ DIGNOSTIC STUDIES
☐ TRETMENT

DA FORM 1 MAY78 4700
Proponent Dept of Nurs

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

DATE 3 Sep 03 DX GSU to Chest HOSPITAL DAY

VITAL SIGNS	TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
	BP Arterial line	178/68	134/71	129/65	115/49	119/35	154/44	141/37	135/53										
	BP Cuff	156/68	129/57	131/71	107/49	105/33	126/47	123/42	114/58		98/41	104/36	119/52	117/51	97/79	112/53	109/50	96/50	
	Temperature	101.5		99.2				98.9	99.5					96.4					
	Pulse	105	132	130	123	127	147	149	133		126	136	125	117	118	119	114	110	
	Respiratory Rate	24	22	24	26	26	29	30	40		23	24	22	24	24	27	27	22	
	SaO2	93	89	88	96	94	90	89	93		90	91	94	100	80	100	100	100	
	FiO2	50	55	55	50	50	60	60	60		90	80	80	90	100	90	80%	70%	
	PEEP											10	10	14	14	15	15	15	

INTAKE	TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	16°T
	D5½ 20KCL	125	125	125	125	125	125	125	125	1000	125	125	125	125	125	125	125	125	2000
	Prop	12.6	14.	14	14	12	off	off	7.1		5.9	5.9	5.9	5.9	5.9	5.9	5.9	5.9	47.2
	TF	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø		Ø	Ø	Ø	Ø	Ø	Ø	Ø	100	100
	NPB	50									150		200	50					450
						800 (L2)													
	BOLUS								1000				1000				1000	1000	4000
	ALBUN 25%																	100	100
	Residual				(100)							(20)					(120)		6770.9 (400)
	TOTALS																		

OUTPUT		HOUR / TOTAL	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	16°TOTAL
	URINE		60/60	30/90	30/120	20/140	25/165	15/180	10/190	20/210		26/238	10/248	8/256	5/260	14/274	10/285	16/410	12/422	312
		SP gr																		
		S/A																		
	NG	OUTPUT																		
		~~PH~~ CT1					50													
		~~GUAIAC~~ CT2					50													
	~~EMESIS~~																			
	STOOL						Small x1													
	DRAINS	JP1				25								Large x1						
		JP2				40							30							
													100		120					
	TOTALS																			

MEDCOM - 18296

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21		23
BP	87/51	84/46	97/54	99	91	89	85	87
HR		94		93		95.8		
Temp	105	108	109	109	115	112	115	115
RR	22	22	29	27	22	22	22	22
Sat	100	100	100	100	100	100	100	100
FiO2	70	60	50	50	50	50	50	50
PEEP	15	15	15	15	15	15	15	15
CVP	22	20	17	17	17	18	18	18

INTAKE	14	17	18	19	20	21	22	23	8°T
	195	105	125	85	75	85	100	150	800
	5.9	5.9	5.9	7.8	7.8	7.8	7.8	7.8	567
	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	
	100						200	50	400
		3	3	7.3 mg	7.3 mg	7.3 mg	7.3 mg		438
							500		500
							(150)		2900

OUTPUT	10	20	05	10					
	322	342	347	358					98
	24								24
		50							50
		200							250
		Small Stool x1							X1
		25					30		55
		50					15		65
									69

ACUITY LEVEL CLASSIFICATION

RESPIRATORY	TIME	0040	0734
	MODE	SIMV	SIMV
	F_IO_2	100	50
	TV	550	550
	RATE	22	22
	PEEP	+10	+6
ABG	pH	7.37	7.43
	PCO_2	46	38
	pO_2	65	66
	HCO_3	27	25
	SAT	89	93
	BASE	1	1

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

DAILY ACTIVITIES	TIME				TIME
	MOUTH CARE			TURN	
	BATCH				
	SKIN CARE				
	FOLEY CARE			SUCTION	
	TRACH CARE				
	ROM EXERCISES				

24-180 TOTALS	NURSES SIGNATURE	INITIALS
WT Yesterday ____ wt Today ____		
INTAKE / OUTPUT		
IV ____ Urine: ____		
Po ____ ____		
TOTAL ____ TOTAL ____		
BALANCE ____		

DATE 3 Sep 03 DX GSU to Chest HOSPITAL DAY

VITAL SIGNS	24	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15
BP Arterial line	176/68	134/71	125/65	115/49	119/35	156/44	134/37	135/53								
BP Cuff	156/68	129/57	131/57	107/49	105/33	128/47	123/42	118/38	98/41	101/36	119/52	119/51	97/79	112/53	109/59	96/55
Temperature	101.5		99.2				98.9	99.5				96.4				
Pulse	125	132	130	123	127	147	149	133	126	136	125	117	118	119	114	110
Respiratory Rate	24	22	24	26	26	29	30	40	23	24	22	24	24	27	27	22
SaO2	93	89	88	96	94	90	89	93	90	91	94	100	80	100	100	100
FIO2	50	55	55	50	50	60	60	60	90	80	80	90	100	90	80%	70%
CPAP										10	10	14	14	15	15	15

INTAKE	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	16°T
D5½ 20KCL	125	125	125	125	125	125	125	125	100	125	125	125	125	125	125	125	125	2000
Prop	12.6	14.	14	14	12	off	off	7.1		5.9	5.9	5.9	5.9	5.9	5.9	5.9	5.9	47.2
TF	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø		Ø	Ø	Ø	Ø	Ø	Ø	Ø	100	100
IVPB	50									150		200	50					450
					800 (Lr)													
Bolus								1000				1000				1000	1000	4000
Albun 25%																	100	100
Residual				(100)							(200)				(120)			6770.9 (450)
TOTALS																		

54 + 6.1 + 12.6 = 73.7

2220.9 + 450 = 2670.9

6690.9 − 6370.9

OUTPUT	HOUR / TOTAL	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	16°TOTAL
URINE	HOUR	60	30	30	20	25	15	10	28		26	20	8	5	14	10	16	12	
	TOTAL	60	90	120	140	165	180	190	210		238	248	256	260	274	285	410	422	312
	SP gr																		
	S/A																		
NG	OUTPUT																		
	~~PM~~ CT1					50													
	~~GUTAR~~ CT2					50													
~~EMESIS~~																			
STOOL						Small x1								Large x1					
DRAINS	JP1				25							30							
	JP2				40							100		120					
TOTALS																			

MI L RECORD-SUPPLEMENTAL MEDICAL
For use of this form R 40-66; the proponent agency is The Office of urgeon General

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

b(6) - 2

OTSG APPROVED (Date) QA Appr 8Mar 89

INITIAL SHIFT ASSESSMENT

NEURO	TIME	0700	INTILAS [redacted]	INTILAS	0815	INTILA [redacted]
	PUPLIS	3mm Perl brisk			3mm PERRLA BRISK	
	SENSORIUM	non responsive to painful stimuli. pt on breathing vent AC 25-30. off of all sedation & pain medication			unresponsive to painful stimuli pt overbreathing vent	
RESPIRATORY	RESPIRATION PATTERN	Even unlabored SIMV			Even, unlabored	
	BREATH SOUNDS	VE 500 peep 5, RR 22, fio2 50%, ETT #6 26cm @ teeth. Patent throughout No bases, thick white ETT secretions			SIMV, VT 600, peep 10 RR 22, FIO2 50% Coarse lung sounds B/L	
	SECRETIONS				CT x2 draining serosanguous fluid; to H2O seal	
SKIN	COLOR	appropriate for race			NFR	
	INTEGRITY	midline closed incision, staples intact ⊘ OTA, ⊘ redness, drainage.			M/L incision (2nd) open to air. ⊘ S/S infec	
IV SITE	LOCATION	(R) Sem - 5 lin, (O) Sem Cardio.			(R) IJ 7cm	(R) femaline
	CONDITION	RIJ TL			CDI	CDI
GASTRO	ABDOMEN	firm, mildly distended			nondistended, firm	
	BOWEL SOUNDS	⊘ BS. NG (Bloody) clamped gdgs on wall d/t residuals 750. ⊘ BM or flatus. JP x2 intact			⊘ BS x4 quads. NG LIS	
GU	URINE	amber, clear ⊘ S.			FTG, clear	
	COLOR/CLARITY				yellow	
CARDIOVASCULAR	CARDIACRHYTHM	ST s ectopy barely palpable. bilat radial pulse +2 pedal pulse generalized edema, CT x 2 B/S W/ to H2O seal			ST in 120s +2 radial/pedal pulses generalized edema	

LEGEND: Cr - Creatinine; F_IO - Fraction of inspired O_2; F_IO_2 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - PRESSURE OF ARTRIAL CO_2; PEEP - Positive end Expiratory Pressure; S/A - Fractional; SAI - Saturation; TRACH - Tracheostomy

(Continue on reverse)

b(6)

PREPA[redacted] Title) [redacted] CPT (AN) | DEPARTMENT/SERVICE/CINC ICU #3 | DATE 4 Sep 03

PATIENT'S INDICATIONS (For typ[redacted]ten entries give: Name—Last, First, middle; grade; date; hospital or me[redacted]cility)

EPW [redacted]

b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)
☐ DIGNOSTIC STUDIES
☐ TRETMENT

DA FORM 1 MAY78 4700
Proponent Dept of Nurs

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

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial line								100/59		113/64	122/67	127/67	130/70	117/67	146/73	122/60	127/74	
BP Cuff	81/51	92/47	90/48	93/45	98/48	96/47				117/55	133/56	134/52	133/53			142/67	129/57	
Temperature	97.5			100				99.6					100.3					
Pulse	119	123	123	123	131	135	123	122		124	126	125	126	124	133	131	127	
Respiratory Rate	14	23	22	23	18	22	22	31		26	24	32	40	24	27	26	29	
O_2 Sats	100%	100%	99%	99%	97	98	100	96		96	96	96	96	97	94	96	97	
FIO_2	50	50	50	50	50	50	50	50		50	50	50	50	50	100	50	50	
CVP	21	20	19	19	19	19	19	18		19	19	15	14	15	14	14	13	

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
IVF	150	150	150	150	150	150	150	150		150	150	150	150	150	150	150	150	1200
IVPB	50				50					50			375	125	25	25	25	600
Propofol	7.8	7.8	7.8	7.8	7.8	7.8	7.8	off		off	–	–	–					
Dopa	7.3	7.3	7.3	7.3	7.3	7.3	7.3	7.3		7.3	7.3	7.3	7.3	7.3	7.3	7.3	7.3	58.4
boluS										1000 LR	–							
Colloids													350		350			700
TOTALS																		2558

OUTPUT

URINE	HOUR	5	10	10	10	9	10	10	42		175	210	165	360	440	320	200	440	
	TOTAL																	2240
	SP gr																	
	S/A																	
NG	OUTPUT			300 out														
	~~PH~~ CT1							30			45				90			135
	~~CLIMO~~ CT2							30			Ø				Ø			Ø
EMESIS																		
STOOL																		
DRAINS	JP#1			20		10					20					8		28
	JP#2			40		30					50					50		100
TOTALS																		2503

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23
	150	142/78	132/69	145/81	138/78	134/72	128/71	132/76
	150/99			130/63	124/61	128/60	127/60	121/65
		99		99				99
	127	123	120	126	117	117	116	115
	28	32	30	41	33	30	29	27
	97	95	95	96	98	99	99	99
	50	50	50	50	50	50	50	50
cvp	14	15	10	12	12	11	11	12

INTAKE	16	17	18	19	20	21	22	23	8°T
	150	150	150	150	160	160	150	150	1200
							350		350
	113	off	off						

OUTPUT	16	17	18	19	20	21	22	23	
	150/75°	220/470	350/345	235/975	260/230	200/1430	300/735	438/1168	2160
	220								
	100		50					45	195
	Ø		Ø					Ø	
	Ø							20	20
	90			27				10	127
									470

ACUITY LEVEL CLASSIFICATION

RESPIRATORY	TIME									
	MODE									
	F_IO_2									
	TV									
	RATE									
	PEEP									
ARTERIAL BLOOD GAS	A: pH									
	A: PCO_2									
	B: pO_2									
	B: HCO_3									
	G: SAT									
	G: BASE									

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

DAILY ACTIVITIES NEEDING	TIME									
	MOUTH CARE									
	BATCH									
	SKIN CARE									
	FOLEY CARE									
	TRACH CARE									
	ROM EXERCISES									

TURN SUCTION	TIME									

24-HR TOTALS	NURSE'S SIGNATURE	INITIALS

WT Yesterday _____ wt Today _____

INTAKE

IV _____

Po _____

TOTAL _____

OUTPUT

Urine: _____

TOTAL _____

BALANCE _____

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23
	148/78	132/69	145/81	138/78	132/72	128/71	132/76	
			130/63	124/61	128/60	124/60	121/65	
	99		99				99	
	123	120	126	117	117	116	115	
	32	30	41	33	30	29	27	
	96	95	96	98	99	99	99	
	50	50	50	50	50	50	50	
CVP	15	10	12	12	11	11	12	

INTAKE	16	17	18	19	20	21	22	23	8°T
	150	150	150	150	150	150	150	150	1200
							350		350
	7.3	off	off						
									1550

OUTPUT	16	17	18	19	20	21	22	23	8°T
	250/175	220/470	350/845	230/975	260/230	200/1430	300/1750	450/2168	2160
	220								
	100		50					45	195
	Ø		Ø					Ø	
	Ø							20	20
	90			27				10	127
									2470

ACUITY LEVEL CLASSIFICATION

RESPIRATORY	TIME									
	MODE									
	F_IO_2									
	TV									
	RATE									
	PEEP									
ARTERIAL BLOOD GAS	A: pH									
	A: PCO_2									
	B: pO_2									
	B: HCO_3									
	G: SAT									
	G: BASE									

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

DAILY ACTIVITIES DESIRED	TIME				TURN SUCTION	TIME				
	MOUTH CARE									
	BATCH									
	SKIN CARE									
	FOLEY CARE									
	TRACH CARE									
	ROM EXERCISES									

24 HRS TOTALS

NURSE'S SIGNATURE | INITIALS

WT Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
Po			
TOTAL		TOTAL	

BALANCE _____

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET b(6)-2

OTSG APPROVED (Date) QA Appr 8Mar 89

INITIAL SHIFT ASSESSMENT

NEURO	TIME	2100	INTILAS [redacted]		INTILAS		INTILAS
	PUPLIS	3 (R)					
	SENSORIUM	Sedated c propl/fent					
RESPIRATORY	RESPIRATION PATTERN	unequal rise/fall					
	BREATH SOUNDS	Coarse					
	SECRETIONS	large, tan, blood tinged; vent-suctioned					
SKIN	COLOR	NFR					
	INTEGRITY	1/2 cm round to back.					
IV SITE	LOCATION	(R) IJ	Aline				
	CONDITION	CDI	(R) fem CDI.				
GASTRO	ABDOMEN	flat, firm					
	BOWEL SOUNDS	Ø					
GU	URINE	yellow					
	COLOR/CLARITY	clear					
CARDIOVASCULAR	CARDIACRHYTHM	SR-ST; Ø ectopy					

LEGEND

Cr - Creatinine
F_IO - Fraction of inspired O_2
F_IO_2 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - PRESSURE OF ARTRIAL CO_2
PEEP - Positive end Expiratory Pressure
S/A - Fractional
SAI - Saturation
TRACH - Iracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title) [redacted], SGT, LPN

DEPARTMENT/SERVICE/CINC ICU3

DATE 5SEPT03

PATIENT'S INDICATIONS [redacted] written entries give: Name — Last, First, middle; grade; [redacted] CPT/MN

EPN [redacted] b(6)-4

b(6)-2

- ☐ HISTORY/PHYSICAL
- ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER (Specify)
- ☐ DIGNOSTIC STUDIES
- ☐ TRETMENT

DA FORM 1 MAY78 4700
Proponent Dept of Nurs

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

DATE 5 Sep 03 | DX GSW to Chest | HOSPITAL DAY

VITAL SIGNS	TIME	24	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	
	BP Arterial line	144/84	142/73	144/77	141/78	154/81	155/80	137/71	112/58	124/59		102/53	105/57	120/60	132/76	130/70	131/70	124/70
	BP Cuff	130/77	134/68	132/68	138/66	142/71	150/73	140/69	114/57	127/67			113/53	124/61		124/61		120/70
	Temperature			99.7				98.5									99.6	
	Pulse	121	120	115	106	97	105	105	96	121		109	103	102	99	98	95	99
	Respiratory Rate	37	39	44	39	44	43	43	30	22		32	22	42	33	22	22	43
	O Sats	92	96	97	97	98	96	98	99	97		98	100	98	98	97	98	99
	FiO_2	60	50	50	50	50	50	50	50	50		50	50	50				
	CVP	10	10	10	9	10	10	10	10	8		9	10	10	10	10	9	8

INTAKE	TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	IVF	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	1200
	IVPB					50				50			250	300					550
	Propofol									5.7	5.7	7.8	7.8	7.8	7.8	7.8	7.8	7.8	55
	Dopa																		
	Boluses																		
	Colloids																		
	TOTALS									1455									1755

OUTPUT		HOUR / TOTAL	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	URINE		260 / 260	140 / 400	222 / 622	230 / 852	160 / 1012	110 / 1122	110 / 1232	130 / 1362	130 / 1492		80 / 1570	120 / 1690	260 / 1950	40 / 1990	260 / 2250	130 / 2380	130 / 2510	2510
		SP gr																		
		S/A																		
	NG	OUTPUT																		
		~~PH~~ CT1			70			75			145			120						120
		~~GUIAC~~ CT2						0						120						120
	EMESIS																			
	STOOL							Small X1												
	DRAINS	JP 1					18				18					15				15
		JP2					8				8					5				5
	TOTALS										171									3170

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23
BP	12/33	13/76	114/72	121/87	140/80	125/72	145/82	132/84
MAP	114/66		132/70	138/70	142/71	125/83	114/63	132/72
T				99.0				99.8
Pulse	99	99	89	92	88	94	87	87
SpO2	100	98	97	95	96	97	99	98
PAP	50	45	45	50	50	50	50	50
RR	24	23	24	25	31	34	25	24
CVP	8	12	12	8	8	8	8	9

INTAKE	16	17	18	19	20	21	22	23	8°T
IV	50	50	50	50	50	50	50	50	400
PB	50						250/50	100	450
Ent	5	5	5	5	5	5	5	5	40
NG	7.8	7.8	7.8	10	10	10	10	10	76
Sub	100								
TF					100				100
TF Restarted					(50)				100

OUTPUT	16	17	18	19	20	21	22	23	8°T
	140	250/290	125/90	90/100	60/100	140/80	160/80	180/140	1040
	XDC X								
CP			100						100
	XDC X								
	XDC X								
									1140

ACUITY LEVEL CLASSIFICATION

RESPIRATORY	TIME	04:00	19						
	MODE	SIMV	SIMV						
	F_IO_2	50%	50						
	TV	550	550						
	RATE	22	22						
	PEEP	10	6						
ARTERIAL BLOOD GAS	A pH	7.34							
	A PCO_2	47.0							
	B pO_2	78							
	B HCO_3	25							
	G SAT	94							
	G BASE	0							

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

DAILY ACTIVITIES DONE	TIME	1900			TURN	TIME 1900			
	MOUTH CARE	1900							
	BATCH								
	SKIN CARE								
	FOLEY CARE				SUCTION				
	TRACH CARE								
	ROM EXERCISES								
	24 HR TOTALS					NURSE'S SIGNATURE		INITIALS	

WT Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV	4210	Urine:	4481
~~Po~~			
TOTAL		TOTAL	
BALANCE	-271		

[redacted]

MEDCOM - 18305

MF[illegible]L RECORD-SUPPLEMENTAL MEDICAL P[illegible]
For use of this form[illegible] 40-66; the proponent agency is The Office of [illegible]rgeon General

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

b(6)-2

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

INITIAL SHIFT ASSESSMENT

	TIME		INTILAS	1830	INTILAS [redacted]		INTILAS
NEURO	PUPLIS			Pupils Equal 2mm. GCS 4T.			
	SENSORIUM			Pharmacologically sedated c̄			
				Fentanyl/propofol. Responds			
				to pain @ gag reflex. Moves			
				head when suctioning.			
RESPIRATORY	RESPIRATION PATTERN			Vented ETT 7.0 @ 26 cm teeth			
	BREATH SOUNDS			SIMV 22, 550, 45%, 6. Sats			
	SECRETIONS			96 or > Slightly overbreath			
				vent. 26/22. Phonchi all lung			
				fields. Small amts of thick			
				yellow secretions @ ET & @ lat chest			
SKIN	COLOR			WNL, warm, dry. fragile			
	INTEGRITY			Dfx edema. Mi incision abd.			
				staples intact. Sutures where			
IV SITE	LOCATION			old CT was @ lat chest.)			
	CONDITION			@ IJ TLC. Proximal to CVP			
				Medial c̄ Propofol, Distal c̄ MIVF			
				c̄ Fentanyl. @ groin A-line CVP			
				c̄ A line zeroed. Dressing CDI.			
				@ groin oozing serous drainage			
GASTRO	ABDOMEN			from old Cordis. NGT to @			
	BOWEL SOUNDS			naves clamp x̄ to feed. Ø BM.			
				Tight abd. UTA tenderness.			
				Bandage c̄ no drainage to RUQ.			
GU	URINE			Foley to DD. OK yellow			
	COLOR/CLARITY			clear urine			
				Hypactive BS x4			
CARDIOVASCULAR	CARDIACRHYTHM			SR c̄ ectopy. S1 S2. Radial			
				Pedal pulses 2+. Capillary fill < 3 sec.			
				Anasarca 3+ pitting. Oozing @			
				some old blister sites @ Derm.			

LEGEND

Cr - Creatinine
F_IO - Fraction of inspired O_2
F_IO_2 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - PRESSURE OF ARTRIAL CO_2
PEEP - Positive end Expiratory Pressure
S/A - Fractional
SAI - Saturation
TRACH - Iracheostomy

(Continue on reverse)

PREPARED BY *(Signature & Title)*

DEPARTMENT/SERVICE/CINC

DATE 6 SEP 03

PATIENT'S INDICATIONS *(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)*
- ☐ DIGNOSTIC STUDIES
- ☐ TRETMENT

DATE 6 Sep 03 | DX GSW to Chest | HOSPITAL DAY

VITAL SIGNS	24	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15
BP Arterial line	117/89	117/84	124/88	124/87	104/81	102/87	122/63	113/60	115/46	103/58	127/68	111/62	114/62	124/76	130/70	125/71
BP Cuff	143/74	129/59	129/59	144/77	120/60	118/40	113/58	114/57		105/52		110/57		122/65		117/60
Temperature					99.1				99.1				99.2			
Pulse	94	82	91	97	75	87	105	89	86	95	81	85	88	85	74	72
Respiratory Rate	32	25	31	32	30	42	52	36	25	32	22	27	27	26	22	24
CVP		12	11	12	15	15		16	8	9	6		12	16	16	17
FIO2	50	50	50	50	50	50	50	50								
SaO2	99	98	98	99	99	99	99	100	100	98	100	100	99	100	100	100

INTAKE	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
D5½+20K	50	50	50	50	50	50	50	50	400	100	100	100	100	100	100	100	100	800
IVPB							50		50			360	250	100				400
Fent	5	5	5	5	5	5	5	5	40	5	5	5	5	5	5	5	5	40
Prop	10	10	10	10	10	10	12	12	84	15	15	15	15	15	15	15	15	120
																		1380
TF			100				100		200			100				50		150
Sol's																500	1000	1500
Free H2O																		
TF Residual			50				20					100				50		3
TOTALS									774									3330

OUTPUT	HOUR / TOTAL	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
URINE		90/90	140/230	200/430	160/590	130/720	90/810	120/930	50/980	980	50/50	50/100	40/140	120/260	80/340	22/362	16/378	60	468
	SP gr																		
	S/A																		
NG	OUTPUT																		
	PH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS	CT	160				70				230		50				50			100
TOTALS										1240									568

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23
Art	120/70	120/67	134/68	154/76	158/79	160/83	168/80	114/59
cuff	118/63		123/57	137/67	145/69		146/70	110/49
T	97.8				98.6 °C			
pulse	88	92	81	74	82	83	67	94
RR	22	23	24	24	28	25	26	27
CVP	17	9	8	10	10	13	13	12
FiO2	45		95	45	45%	45%	45%	45%
SaO2	100	96	99	98%	96%	96%	95%	94%

INTAKE	16	17	18	19	20	21	22	23	8°T
MIVF	100	100	100	125	125	125	125	125	1240
IVPB							150	200	350
Ent	5	5	5	8.4	2.5	2.5	2.5	2.5	34
PO	15	15	15	15.6	16.4	17.6	17.6	17.6	129.8
bolus									
TF						100			100
boluses									
H2O						50			50
TF rate					5 returned				

OUTPUT	16	17	18	19	20	21	22	23	8°T
	100/100	110/220	35/25	58/343	35/378	54/432	120/552	70/622	622
CT		150							
CT		150						150	300

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA	TIME	0400	1200	5
	MODE	SIMV	SIMV	SIMV
	F_IO_2	50%	45%	45%
	TV	550	550	550
	RATE	22	22	22
	PEEP	6	6	6
A	pH	7.38	7.40	
	PCO_2	44.8	37.3	
B	pO_2	77	73	
	HCO_3	27	23	
G	SAT	95	95	
	BASE	2	-1	

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

ACTIVITIES DAILY LIVING	TIME	0400	2100
	MOUTH CARE	✓	✓
	BATH		✓
	SKIN CARE	✓	✓
	FOLEY CARE	✓	✓
	TRACH CARE		
	ROM EXERCISES		
	Linen △		✓

TURN	TIME

SUCTION	TIME
	[redacted] 1900
	[redacted] 2130

24 HRS TOTALS

WT Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV	5188	Urine:	2070
NGT PO	500	CT	960
TOTAL	5688	TOTAL	3030

BALANCE +2658

NURSE'S SIGNATURE | INITIALS

[redacted]

D(6)-2

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA
For use of this form: 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 8Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	2400	INITIALS [redacted]	1900	INITIALS [redacted]		INITIALS
NEURO	PUPLIS			2 R Sluggish			
	SENSORIUM			Sedated c̄ propofol + fentanyl; eye squint c̄ pain/sx. ↓ LE movement			
RESPIRATORY	RESPIRATION PATTERN			Small paradoxical movement – No change			
	BREATH SOUNDS			lungs, tan, blond			
	SECRETIONS			fixed; ETT clear lip.			
SKIN	COLOR			NFR			
	INTEGRITY			Mil erosion, CDI CT/			
				↑ puncture site.			
IV SITE	LOCATION			(R) ISTLC	(R) Femoral		
	CONDITION			CDI	Alive CDI		
GASTRO	ABDOMEN			Flat, hard			
	BOWEL SOUNDS			hypoactive			
GU	URINE			dark yellow			
	COLOR/CLARITY			clear			
CARDIOVASCULAR	CARDIACRHYTHM			SR – ST, ϕ ectopy			

b(6) – See previous NP [redacted]

NOT an assessment

LEGEND

Cr - Creatinine
F_IO - Fraction of inspired O_2
F_IO_2 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - PRESSURE OF ARTRIAL CO_2
PEEP - Positive end Expiratory Pressure
S/A - Fractional
SAI - Saturation
TRACH - Iracheostomy

PR[redacted] Signatur[redacted] b(6) 2 [redacted]

(Continue on reverse)

DEPARTMENT/SERVICE/CINC: ICU-3

DATE: 07Sep03

PATIENT'S INDICATIONS (For typed or written entries give: N[redacted] First, middle; grade; date; hospital or medical facility)

EPW # [redacted]

b(6)-4

- ☐ HISTORY/PHYSICAL
- ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER (Specify)
- ☐ DIGNOSTIC STUDIES
- ☐ TRETMENT

DA FORM 1 MAY78 4700
Proponent Dept of Nurs

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

DATE 07Sep03 DX GSW [illegible] chest HOSPITAL DAY

VITAL SIGNS	24	01	[illegible]	[illegible]	04	05	06	07		08	[illegible]	[illegible]	11	12	13	14	15	
BP Arterial line	132/77	141/78	138/78	[illegible]	135/73	122/66	117/65	124/72		123/69	143/78	157/81	134/74	136/73	127/71	136/80	130/82	
BP Cuff	120/60	125/65	121/60	113/56	116/62	113/50	112/51			137/67		137/61		130/60			129/65	
Temperature	96.7 (A)					96.3 (A)	96.4											
Pulse	89	86	87	83	83	77	77	78		88	81	87	89	87	81	87	86	
Respiratory Rate	24	28	30	29	25	26	22	26		24	28	32	28	27	23	27	31	
SaO2	98	94	93	97	97	94	99	98		93	94	93	97	98	97	97	94	
FiO2	45%	45%	45%	45	45	45	45	50		45	50	50	50	50	50	50	50	
CVP	9	13	14	16	10	6	6	8		14	15	7	9	9	10	11	11	

INTAKE	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
D5NS ± 20 KCl	125	125	125	125	125	125	125	125	1000	125	125	125	125	125	125	125	125	1000
Fentanyl	2.5	2.5	2.5	2.5	2.5	2.5	2.5	2.5	20	2.5	2.5	3.0	3.0	3.0	3.0	3.0	2.0	21
Propofol	21.5	21.5	21.5	21.5	22.0	22.0	23.0	16.1	169.6	16.1	20	20	22	22	22	22	22	176
NPB					50				50				350					350
									1646									
TF	100				100				200		200				200			400
H2O	40				30				70									
TF Residuals	returned 55				returned 75				1549.6		90					50		1948
TOTALS									1549.6									1948

OUTPUT		24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
URINE	HOUR	30	60	60	70	65	70	45	30		50	60	30	90	45	35	60	30	
	TOTAL	30	90	150	220	285	355	400		400		110	140	230	275	310	370	400	400
	SP gr																		
	S/A																		
NG	OUTPUT																		
	PH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS	CT						135		135				80						
TOTALS									560									400	

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23
NIBP	124/62	160/80	147/62	157/64	142/82	135/57	143/79	142/67
CVP		149/65		149/64	133/57	140/60		123/57
T	97.2					97.6		
Pulse	78	91	81	78	88	73	95	89
RR	22	38	22	20	20	26	25	25
SaO2	96	98	94	96	96	97	99	94
F.O2	50		50	50	50	50	50	50
CVP	12	9	7	9	9	9	9	9

INTAKE	14	17	18	19	20	21	22	23	8°T
Milrinone	125	125	125	125	125	125	125	125	1000
Fentanyl	3.0	3.0	3.0	3	3	3	3	3	24
Prop	22	22	18	22	22	22	22	22	110
IUPB		1000				1000	250		1350
TF	100					100			200
H2O									
Residual	20					50			1354

OUTPUT									
	80	65/45	100/45	40/305	40/345	120/465	40/505	90/595	635
CT			140					50	190
									825

ACUITY LEVEL CLASSIFICATION

RESPIRATORY	TIME	0415	0900
	MODE	SIMV	SIMV
	F_IO_2	45	50
	TV	554	550
	RATE	22	22
	PEEP	6	6
ABG	pH	7.38	7.415
	PCO_2	41	35.7
	pO_2	65	84
	HCO_3	25	23
	SAT	92	97
	BASE	0	-2

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

ACTIVITIES DAILY LIVING	TIME		
	MOUTH CARE	0345	
	BATH		
	SKIN CARE		
	FOLEY CARE		0330
	TRACH CARE		
	ROM EXERCISES		
	Urine Δ		

TURN	TIME	
TURN	2100	
SUCTION		

24°180 TOTALS

NURSE'S SIGNATURE | INITIALS

[redacted]

WT Yesterday _____ wt Today _____

INTAKE	OUTPUT
IV 6340	Urine 1785
PO	
TOTAL	TOTAL
BALANCE +4555	

blue 2
All

MI[illegible]L RECORD-SUPPLEMENTAL MEDICAL
For use of this form [illegible] R 40-66; the proponent agency is The Office of [illegible] Surgeon General

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0700	INTIALS [redacted]	b(6)	INTIALS [redacted]	[redacted] 19(1) INTIALS [redacted]
NEURO	PUPILS	Perrl 3mm sluggish, [illegible] physical stimuli				PERRL A, 2(B).
	SENSORIUM	Sedated c̄ propofol, pain mgt c̄ fentanyl, moves bound, face movement noted shoulders & LE movement				Continues sedated c̄ propofol + fentanyl; (+) head/facial movement c̄ pain/sx. & LE movement
RESPIRATORY	RESPIRATION PATTERN	[illegible]				equal rise/fall; LS
	BREATH SOUNDS	SIV pmp 6, VE 550, RR 22				Coarse (B); thick secretions
	SECRETIONS	ETT #7.5 cm @ lip, not cuff breathing vent, milky/yellow mod lg oral secretions, thick tan tracheal secretions from ETT suctioning.				ETT 26cm @ lip; vent weaning & in progress; current SaO2 @ 95% c̄ 40% FIO2.
SKIN	COLOR	appropriate for race.				NFR; mult small
	INTEGRITY	see progress note				sites weeping SIS fluid.
IV SITE	LOCATION	(R) IJ TC and patent				(R) IJ (R) femoral line
	CONDITION	(R) femoral line				CDI CDI
GASTRO	ABDOMEN	firm, mildly distended				flat, firm
	BOWEL SOUNDS	⊘ BS, NG (R) nare clamped. ⊘ BM this per				⊘ BS, NG clamped for bolus feeds.
GU	URINE	FTG QS				FTG - tea colored.
	COLOR/CLARITY	tea colored				
CARDIOVASCULAR	CARDIAC RHYTHM	NSR c̄ ectopy, S, S2, barely palpable radial pulses bilat, +2 pedal pulses gen. edema throughout.				S1 + S2 NSR; ⊘ ectopy pulses weak all extremities.

LEGEND
Cr - Creatinine
F_IO_2 - Fraction of inspired O_2
F_IO_2 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - PRESSURE OF ARTRIAL CO_2
PEEP - Positive end Expiratory Pressure
S/A - Fractional
SAI - Saturation
TRACH - Tracheostomy

b(6)-2

PREPA[redacted] Title)

(Continue on reverse)

PATIENT [redacted] written entries give: Name — Last, First, middle; grade; date; hospital or [illegible] facility)

[redacted]

DEPARTMENT/SERVICE/CINC

DATE 8 Sep 3

EPW [redacted]

b(6)-4

- ☐ HISTORY/PHYSICAL
- ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER (Specify)
- ☐ DIGNOSTIC STUDIES
- ☐ TRETMENT

DA FORM 1 MAY78 4700
Proponent Dept of Nurs

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

DATE 8 Sep 03 | DX SIP [illegible] Chest | HOSPITAL DAY

VITAL SIGNS

TIME	24	01	[illegible]	03	04	05	06	07		08	[illegible]	10	11	12	13	14	15	
BP Arterial line	151/72	152/76	146/70	145/74	153/75	137/63	142/74	141/65		146/73	132/55	129/54	114/58	112/5[illegible]	114/55	122/63	131/60	
BP Cuff	135/66	135/66	133/64	124/53	147/75	149/65	149/65	129/61		136/56	124/49	126/49						
Temperature				97.9						98.5								
Pulse	91	84	71	96	91	92	83	73		76	83	86	92	99	80	77	68	
Respiratory Rate	23	27	22	25	27	23	22	22		22	22	26	24	22	22	22	22	
SaO2	97	97	93	97	96	93	96	95		96	94	94	93	93	97	96	100	
CVP	8	8	8	7	6	9	15	12		12	11	9	9	11				
FiO2	50	50	50	50	50	50	50	50		50	50	50	70	70	50	50	100	

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
D5NS+20K	125	125	125	125	125	125	125	125	1000	125	125	125	125	125	125	125	125	1000
Fent	3	3	3	3	3	3	3	3	24	4	5	5	5	5	5	5	5	40
Prop	22	22	22	22	22	22	22	24	178	24	24	24	24	24	24	24	24	192
IVPB												300						300
TF	100				200					200								
bolus														held (LR 500)		(LR 1000)		200 / 1500
(TF Residual)	50				25				1200	540				50				3200
TOTALS																		

OUTPUT

		HOUR / TOTAL	90 / 90	50 / 140	40 / 180	45 / 225	45 / 270	100 / 370	60 / 440	40 / 480	/ 480	50 / 530	70 / 600	32 / 632	38 / 670	38 / 708	23 / 730	24 / 754	60 / 814		850
URINE		SP gr																			
		S/A																			
NG		OUTPUT																			
		PH																			
		GUIAC																			
EMESIS																					
STOOL							X1 (small)														
DRAINS		CT					40				40	60		50			80				170
TOTALS											520										1020

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23
	142/63	119/69	124/69	130/66	134/64	135/70	122/67	135/84
					139/54	123/50	139/62	134/54
		987						
	73	88	75	83	74	67	74	92
	22	23	28	22	22	22	22	25
Sat	93	94	95	94	94%	94	98	98
	14	10		9	13	off	off	off
	75	75	75	100	60	60	60	60
		(MAG)			60	60	60	60
							NO	200

INTAKE	16	17	18	19	20	21	22	23	8°T
	125	125	125	125	125	125	125	125	1000
	5	5	5	5	5	5	5	5	40
	24	24	24	24	24	24	24	24	192
			(MAG)	60	60	60	60	60	250
							100	200	300
									1782

OUTPUT	16	17	18	19	20	21	22	23	8°T
	70/90	90/180	70/250	26/276	70/346	45/391	100/491	200/691	691
	40							120	160
									851

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA		TIME	2000
		MODE	SMV
		F_IO_2	60
		TV	550
		RATE	22
		PEEP	8
	A	pH	7.39
	B	PCO_2	40.6
	B	pO_2	73
	B	HCO_3	25
	G	SAT	94
	G	BASE	0

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

DAILY ACTIVITIES	TIME	0400
	MOUTH CARE	✓
	BATCH	✓
	SKIN CARE	✓
	FOLEY CARE	✓
	TRACH CARE	✓
	ROM EXERCISES	✓

TURN	TIME	2400	2200
		0400	
		2100	
SUCTION		2	

24-180 TOTALS

WT Yesterday _____ wt Today _____

INTAKE: IV 6180 Po _____ TOTAL _____

OUTPUT: Urine: 2400 TOTAL _____

BALANCE +3780

NURSE'S SIGNATURE	INITIALS
[redacted]	
ble) -2	

M[illegible]L RECORD-SUPPLEMENTAL MEDICAL
For use of this form [illegible]R 40-66; the proponent agency is The Office of [illegible]urgeon General

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET b/(6)-2

OTSG APPROVED (Date)
QA Appr 8Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	07feb	INITIALS [redacted]		INITIALS		INITIALS [redacted]
NEURO	PUPLIS	Perrl 2mm sluggish				2 R (B) slow	
	SENSORIUM	arousable c̄ physical				moves head c̄ pain	
		stimuli; spont opens eyes				opens eyes; cont	
		moves hand & shrugs				c̄ propofol/fentanyl	
		shoulders on ~~[illegible]~~ properly & left drip					
RESPIRATORY	RESPIRATION PATTERN	ett in auto/bacd SIMV 60%				equal rise/fall	
	BREATH SOUNDS	nasopharyngeal ETT 550 RR 22 on vent				lt lge secretions, tan,	
	SECRETIONS	+2 to 4/min SpO2 97-100%				blood tinged. ETT	
		Thick tan secretions c̄ occasional				2cm c̄ teeth,	
		bloody plugs PAP 40-60s.				lung sounds come, ↓ @	
		CTA (B) w/ bases & ETT 4 cm drop				bases. (B); CT to st	
SKIN	COLOR	appropriate for race.				NCR; multiple	
	INTEGRITY	~~[illegible]~~ clot. incision staples				surgical stab wounds	
		intact OTA, area red & slightly swollen				serous fluid	
IV SITE	~~LOCATION~~	Serous drainage from base of incision				(R) IJ c̄ TLC	(B) Fem
	~~CONDITION~~	PIV CT site [illegible] c̄ small swelling				CDT,	alone.
		drainage, extravasation, pain, skin red c̄				Cauel, ↓	CDT, ↓
		mod-lg serous drainage (R) fem central pulsatile, lg serous drainage				S/S of infection	S/S of infection
	Location	RIJ TLC patent, (R) fem sheath					
	cond	patent.					
GASTRO	ABDOMEN	taut slightly distended				flat, hard; mild	
	BOWEL SOUNDS	↓ BS. NG (R) nare clamped				incision CDT c̄	
		GBM/flatus				staples BS ↓; small	
						bm 3.	
GU	URINE	ETG QS				ETG QS	
	COLOR/CLARITY	tea colored				tea color, clear	
CARDIOVASCULAR	CARDIACRHYTHM	NSR c̄ ectopy, S.S. (R)				ST-SR, ↓ ectopy; i data	
		+1 bilat radial pulses, +2 bilat				pulses unk.	
		pedal pulses +3 UE & LE pitting					
		edema, scrotal edema, ↑ edema.					

LEGEND

Cr - Creatinine
F_IO - Fraction of inspired O_2
F_IO_2 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - PRESSURE OF ARTRIAL CO_2
PEEP - Positive end Expiratory Pressure
S/A - Fractional
SAI - Saturation
TRACH - Iracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title) [redacted] b/(6)-2 DEPARTMENT/SERVICE/CINC [redacted] DATE 7 Sep 02

PATIENT'S INDICATIONS (For typed or written e[illegible] middle; grade; date; hospital or medical facility)

EPW [redacted] b/(6)-4

- ☐ HISTORY/PHYSICAL
- ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER (Specify)
- ☐ DIGNOSTIC STUDIES
- ☐ TRETMENT

DA FORM 1 MAY78 4700
Proponent Dept of Nurs

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

DATE 9 Sep 03 | DX S/P C[illegible] to chest | HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial line	140/75	146/85	154/73	154/72	130/71	120/63	1[illegible]/71	161/71		129/57	109/62	138/64	137/61	144/68	125/58	109/51	114/53	
BP Cuff	134/56	140/56	134/57	134/57	125/51	113/46												
Temperature		96.7						97.1					97.8					
Pulse	82	69	74	74	87	83	83	89		85	90	92	103	104	98	100	106	
Respiratory Rate	25	23	17	22	22	22	22	24		24	28	24	24	26	25	22	22	
CVP	off	off	14	15	12	13	13	14		12								
fIO2	60	60	60	60	60	60	60	60		60	60	60	50	50	50	100	70	
SAO2 %	100	100	98	98	99	99	100	100		97	100	100	98	99	98	98	99	

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
IVF	125	125	125	125	125	125	125	125	1000	125	125	125	125	125	125	125	125	140
Fent	5	5	5	5	5	5	5	5	40	45	45	45	45	45	40	40	40	40
Prop	24	24	24	24	24	24	24	24	92	24	24	24	28	32[2]	32[2]	32[2]	32[2]	140
IVPB	384									100	60	360	60	60				480
TF						6				ϕ	200				250			450
Residuals															85			1180
TOTALS									1132									

OUTPUT

		24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
URINE	HOUR / TOTAL	100/100	70/170	100/270	80/350	60/410	35/445	40/485	80/565	565	50	50/100	70/170	58/228	110/338	70/410	60/470	60/530	630
	SP gr																		
	S/A																		
NG	OUTPUT																		
	PH																		
	GUIAC																		
EMESIS																			
STOOL																Smear			
DRAINS	CT1						80			80	40		50						90
TOTALS										645									700

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21		23
	134/60	134/60	135/59	139/64	142/68	144/72	141/72	138/70
				1				
				100.5				
	92	97	104	103	107	117	110	109
	25	28	26	37	36	25	26	24
FiO2	50	50	50	50	50	50	50	50
SaO2	97	97	97	98	99	99	99	99

INTAKE	16	17	18	19	20	21	22	23	8°T
IVF	125	125	125	125	125	KVO	125	D5	1000
Fen	~~40~~ 5	~~40~~ 2	~~40~~	7	7	7	7	7	50
Prop	32 2	32 2	32 2	24	24	24	24	24	216
IVPB	100								100
		hold			hold				
(cont)		158			150				1360

OUTPUT									
	80	100/180	110/290	110/400	100/500	110/610	80/690	80/770	720
	85								85
									805

ACUITY LEVEL CLASSIFICATION

RESPIRATORY												
TIME		0100	120									
MODE		SIMV	SIMV									
F_IO_2		60	50									
TV		550	550									
RATE		22	22									
PEEP		8	6									
ABG	pH	7.41	7.25									
	PCO_2	36.4	55.9									
	pO_2	98	112									
	HCO_3	23	25									
	SAT	98	97									
	BASE	-2	-2									

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

ACTIVITY DAILY LIVING												
TIME	15 8											
MOUTH CARE	✓											
BATCH												
SKIN CARE	✓											
FOLEY CARE	✓											
TRACH CARE												
ROM EXERCISES												

TURN SUCTION	TIME					

24 HR TOTALS	NURSE'S SIGNATURE	INITIALS

WT Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV	1915	Urine:	1520
Po			
TOTAL		TOTAL	

BALANCE +400

MF[illegible]AL RECORD-SUPPLEMENTAL MEDICAL [illegible]
For use of this form [illegible]R 40-66; the proponent agency is The Office of [illegible]urgeon General

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

& (cc) 2

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

INITIAL SHIFT ASSESSMENT

NEURO	TIME	0630	INTILAS [redacted]		INTILAS	1830	INTIL[redacted]
	PUPLIS	2mm sluggish reac				2 mm sluggish	
	SENSORIUM	tion to light. Seda				Propofol/fent selection	
		ted/paralyzed. respon				Responds to pain	
		ds to pain stimuli				stimuli	
		open eyes.					
RESPIRATORY	RESPIRATION PATTERN	Even, vent. SIMV				normal on SIMV 24,	
	BREATH SOUNDS	24 FiO_2 50% PEEP 8				TV 550, PEEP 8, FiO2 .5	
	SECRETIONS	TV 550. Sats 96-99%				Thick clear sec	
		thick secretions via				ETT. Course BS bilat	
		ET tube. CT R side					
		to cont. suctioning					
SKIN	COLOR	NFR. staples in abd.				NFR	
	INTEGRITY	well approx. no signs				Abd wound intact well approx	
		of infection. Gene edema				staples intact → s/s inf.	
IV SITE	LOCATION	(R) IJ TLC. (R) femoral				(R) IJ TLC / (R) femoral line	
	CONDITION	A line. no signs of				CDI	
		infection.					
GASTRO	ABDOMEN	Flat, tough. general				Flat, tight	
	BOWEL SOUNDS	edema. no BS				→ Bowel sounds	
		NG tube. (R) nare				not clamped.	
		clear. residual q 4hs					
GU	URINE	Foley to gravity.				Foley to gravity	
	COLOR/CLARITY	Tea colored urine.				dark yellow urine	
						adequate amount	
CARDIOVASCULAR	CARDIACRHYTHM	NSR 5 ectopy +2				NSR. - ectopy	
		peripheral pulses 2/4				peripheral pulses palpable	
		generalized edema.				x 4.	

LEGEND
Cr - Creatinine
F_IO - Fraction of inspired O_2
F_IO_2 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - PRESSURE OF ARTRIAL CO_2
PEEP - Positive end Expiratory Pressure
S/A - Fractional
SAT - Saturation
TRACH - Tracheostomy

(Continue on reverse)

[redacted] & Title [redacted] CPT/AN | DEPARTMENT/SERVICE/CINC ICU 3 | DATE 10 Sep 03

b(6)-2

PAT[illegible] *(For typed [illegible] entries give: Name—Last, First, middle; grade; date; hospital or medical [illegible])*

EPW

[redacted]

b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER *(Specify)*
☐ DIGNOSTIC STUDIES
☐ TRETMENT

DA FORM 1 MAY78 4700
Proponent Dept of Nurs

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

LFW 6/1

DATE 10 Sep 05 | DX | HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial line	122/66	114/72	131/65	121/81	110/67	107/50	128/68	134/63		125/56	129/55	140/65	122/56	146/63	127/57	147/64	154/65	
BP Cuff																		
Temperature					98.5					100.2				99.9				
Pulse	105	97	89	97	98	87	92	68		83	76	79	80	61	84	80	73	
Respiratory Rate	25	26	25	30	22	24	24	24		24	24	24	24	24	24	24	24	
SaO2	100	98	96	99	97	99	99	94		98	98	98	98	97	98	95	96	
FIO2	50	50	50	50	50	50	50	50		50	50	50	50%	50%	50%	50%	50%	

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
IVF	125	125	125	125	125	125	125	125		125	125	125	125	125	125	125	125	
Fent	7	7	7	7	14	12	12	12		12	12	12	12	12	12	12	12	
Prop	24	24	24	24	24	24	24	24		24	24	24	24	24	24	24	24	
IVPB										100		100	250					450
TF						400			400	~~100~~ held 270								
									Residual									
Residual				(100)														
TOTALS																		

OUTPUT

		TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
URINE	HOUR / TOTAL		80/80	70/150	30/180	190/370	50/420	80/500	80/580	160	70/70	50	46/96	70/166	80/246	85/331	65/396	55/451	75/526	526
	SP gr																			
	S/A																			
NG	OUTPUT																			
	PH																			
	GUIAC																			
EMESIS																				
STOOL																				
DRAINS	CT		60					60			60							65		
TOTALS																				

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23
	167/77	116/68	157/72	144/64	154/60	155/75	182/77	100/57
			97 (A)					
	77	80	77	79	82	75	83	93
	24	24	24	24	24	34	18	24
	94	95	94	96	97	93	91	96
	50%	50%	50%	50%	50%	50%	70%	70%

INTAKE	14	17	18	19	20	21	22	23	8°T
	125	125	125	125	125	125	125	125	1000
	12	12	12	12	12	12	10	10	92
	24	24	24	24	24	24	24	26	194
	100						950	100	450
									1730

OUTPUT									
	100	100/200	80/80	40/320	80/400	40/440	110/550	120/690	690
GT			80cc						
									770

ACUITY LEVEL CLASSIFICATION

RESPIRATORY	TIME									
	MODE									
	F_IO_2									
	TV									
	RATE									
	PEEP									
ABG	A: pH									
	A: PCO_2									
	B: pO_2									
	B: HCO_3									
	G: SAT									
	G: BASE									

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

DAILY ACTIVITIES / NURSING DF	TIME									
	MOUTH CARE									
	BATCH									
	SKIN CARE									
	FOLEY CARE									
	TRACH CARE									
	ROM EXERCISES									

TURN / SUCTION	TIME							

24°180 TOTALS

WT Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
Po			
TOTAL		TOTAL	

BALANCE _____

NURSE'S SIGNATURE	INITIALS

ME[illegible] RECORD-SUPPLEMENTAL MEDICAL D[illegible]
For use of this form [illegible] 40-66; the proponent agency is The Office of [illegible]geon General

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8Mar 89

INITIAL SHIFT ASSESSMENT

NEURO	TIME	0700	INTILAS [redacted]	b(6)-2	INTILAS	1900 INTILAS [redacted]
	PUPLIS	3mm Round sluggish				3mm (R) (B)
	SENSORIUM	arousable to physical stimuli moves head, shoulders & arms eyes spont. on peripheral & fingertip.				opens eyes spontaneously to PK; PRN/Fent for sedation.
RESPIRATORY	RESPIRATION PATTERN	[illegible]				equal rise/fall
	BREATH SOUNDS	[illegible], resp 28, RR 24, VE 850				clear (B); SMV 60%; resp 18; 22;
	SECRETIONS	mod tracheal secretions from ETT #7.5 cuffed lip. CTA (B) & lungs. CTA (R) cw to CS scant serous drainage of airway dressed				trach & minimal drainage
SKIN	COLOR	appropriate for race				NPR; multiple
	INTEGRITY	multiple abrasions, stapler wt of OPA [illegible] [illegible] prepped and				surgical sites oozing serous fluid.
IV SITE	LOCATION	RFJ TL patent				(B) SC. (R) [illegible]
	CONDITION	(R) forearm [illegible] patent cannula T 1) EDP				cond & TLC Alert CDI; CDI Cannula Cannula
GASTRO	ABDOMEN	firm, slightly distended				flat, firm;
	BOWEL SOUNDS	ABS, NG @ nare DCCS.				NG B4; ~~[illegible]~~ G-tube to gravity
GU	URINE	dark amber FTG QS				yellow; FTG
	COLOR/CLARITY					clear
CARDIOVASCULAR	CARDIACRHYTHM	NSR ectopy, S, S2				SR - ST; ectopy
		4 radial pulses 2 pedal pulses scleral & scrotal edema				pulses [illegible]
		gain +3 pitting edema throughout				
	b(6)-2	[redacted]				

LEGEND
Cr - Creatinine
F_IO - Fraction of inspired O_2
F_IO_2 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - PRESSURE OF ARTRIAL CO_2
PEEP - Positive end Expiratory Pressure
S/A - Fractional
SAI - Saturation
TRACH - Tracheostomy

(Continue on reverse)

[redacted] CPT PAN | DEPARTMENT/SERVICE/CINC ICU 3 | DATE 11 Sep 03

PHYSICIAN'S INDICATIONS (For typed or written entries give: Name—Last, First, middle; grade; date; hospital or medical facility)

EPW [redacted]

b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)
☐ DIGNOSTIC STUDIES
☐ TRETMENT

DATE | DX | HOSPITAL DAY

VITAL SIGNS																		
TIME	24	01		03	04	05	06	07		08		0	11	12	13	14	15	
BP Arterial line	105/54	107/68	10/51	107/50	133/63	147/69	108/54	130/59		138/64	134/64	167/76		124/58	120/66	131/61	117/54	
BP Cuff																		
Temperature	100.7				100.8			100.4						98.8				
Pulse	95	82	91	95	89	92	106	93		88	89	89		110 ~~105~~	100	105	103	
Respiratory Rate	44	34	24	47	24	43	24	24		24	24	24		24	24	24	24	
O2 SATS	97	95	95	95	95	93	97	95		95	96	94		100	100	100	97	
FIO2	55	55	55	50	50	50	50%	50		50%	50%	50%		100	70	60	50	

INTAKE																			
TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
IVF	125	125	125	125	125	125	125	125	1000	125	125	125		100	100	100	100	975
IVPB	100								100	100		200						
Propofol	26	26	26	26	26	26	26	26	208	26	26	26		27	27	25	25	182
fentanyl	15	15	15	15	15	25	15	15	105	15	15	15		10	10	10	10	
Tube feeds	400					400												
H2O						50												
TOTALS																		

OUTPUT																			
URINE HOUR	60	80	70	35	75	90	30	38		52	70	20		50	44	420	600	
URINE TOTAL		140	110	35	120	370	400		438									1316
URINE SP gr																		
URINE S/A																		
NG OUTPUT	40					returned 35					200							
NG PH																		
NG GUIAC																		
~~EMESIS~~ PEG																		
STOOL																		
DRAINS CT							125			15								130
DRAINS																		
DRAINS																		
TOTALS																		

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS	16	17	18	19	20	21	22	23
	108/46	120/55	122/56	112/42	124/54	114/54	135/54	148/62
						100.7		
	99	105	99	93	97	94	94	96
	24	24	24	24	24	24	24	24
	97	99	98	96	97	99	97½	97½
	60	60	60	70	70	50	50	50

INTAKE	16	17	18	19	20	21	22	23	8°T
	100	100	100	100	100	100	100	100	800
	150	-					200	100	450
	25	168	168	16	14	16	16	16	140
	10	10	10	10	10	6	6	6	68

OUTPUT	16	17	18	19	20	21	22	23	8°T
	400	220	365	150	130	120	80	100	
	15							15	30

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

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

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

24-180 TOTALS

WT Yesterday _____ wt Today _____

INTAKE

IV _____

Po _____

TOTAL _____

OUTPUT

Urine: _____

TOTAL _____

BALANCE _____

NURSE'S SIGNATURE	INITIALS

ME RECORD-SUPPLEMENTAL MEDICAL D
For use of this form s . 40-66; the proponent agency is The Office of geon General

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

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

INITIAL SHIET SMENT

NEURO	TIME	1900	IN [redacted]	b(6)-2	INTILAS	INTILAS
	PUPLIS	3R				
	SENSORIUM	Alert; sedated				
		c propofol/fent				
RESPIRATORY	RESPIRATION PATTERN	equal use/full				
	BREATH SOUNDS	clear (B)				
	SECRETIONS	large clear secretions				
		around trach;				
		tan/brown secretions				
		in trach				
SKIN	COLOR	NPR				
	INTEGRITY	mult sm. sites				
		weepin serum fluid				
IV SITE	LOCATION	(D) Rt. TLC-2	(P) Rem			
	CONDITION	Cath	Aline			
		CDI	CDI			
GASTRO	ABDOMEN	Flat				
	BOWEL SOUNDS	↓				
		Mt incision covered				
		c bulky dressing				
GU	URINE	yellow				
	COLOR/CLARITY	clear				
CARDIOVASCULAR	CARDIACRHYTHM	ST-SR; ∅				
		ectopy				

LEGEND

Cr - Creatinine
F_IO - Fraction of inspired O_2
F_IO_2 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - PRESSURE OF ARTRIAL CO_2
PEEP - Positive end Expiratory Pressure
S/A - Fractional
SAI - Saturation
TRACH - Iracheostomy

(Continue on reverse)

PR [redacted] DEPARTMENT/SERVICE/CINC DATE 7 Sep 3

PATIENT'S INDICATIONS *(For typed or writte middle; grad*

[redacted]

b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER *(Specify)*
☐ DIGNOSTIC STUDIES
☐ TRETMENT

DA FORM 1 MAY78 4700
Proponent Dept of Nurs

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

DATE 12 Sep 03 | DX | HOSPITAL DAY

VITAL SIGNS	24	01		03	04	05	06	07		08		10	11	12	13	14	15	
BP Arterial line	115/69	117/55	125/61	117/57	123/60	116/55	122/60	115/59		123/61	105/52	112/52	121/58	116/60	119/56	113/55	123/65	
BP Cuff																		
Temperature	100.1				101.2			100.9						99.7				
Pulse	109	102	99	97	101	97	101	97		96	100	99	98	94	100	105	98	
Respiratory Rate	24	24	24	24	27	30	23	24		24	30	23	23	23	28	29	24	
SaO2	97	97	97	97	97	93	98	98		96	99	97	96	96	97	98	95	
FIO2	50	50	50	50	50%	50	50	50		50	50	50	50	50	50	50	50	

INTAKE	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
IVF	100	100	100	100	100	100	100	100	800	100	100	100	100	100	100	100	100	800
Prop	25	25	25	27	27	25	25	25	204	25	25	25	25	25	25	25	25	200
Fent	7	7	7	7	7	7	7	7	56	7	7	7	7	7	7	7	7	56
IVPB	50	50							100	150		250	200					500
TF										200				200				400
TOTALS									1160									1956

OUTPUT		24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
URINE	HOUR / TOTAL	70	40 / 110	40 / 150	60 / 210	135 / 345	70 / 415	80 / 495	70 / 565	565	20 / 20	100 / 120	80 / 200	50 / 250	50 / 300	70 / 370	100 / 470	100 / 570	570
	SP gr																		
	S/A																		
NG	OUTPUT																		
	PH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS	CT						50		50					100				100	
									605										
TOTALS																			750

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23
Arterial	154/60	114/63	112/63	149/72		151/71	143/76	
cuff								
T	98	100.2						
Pulse	98	94	90	97		101	106	
RR	23	23	24	24		24	26	
Sats	95	100	100	99		95	92	
FiO2	50	50	50	50		50	50	

INTAKE	16	17	18	19	20	21	22	23	8°T
IV	100	100	100	100	100	100	100	100	800
PN-P	25	25	25	25	25	25	25	25	400
Feed	7	7	7	7	7	10	10	10	75
IVAD	150								
TF	WLR				200		100	200	450
									200
									1725

OUTPUT	16	17	18	19	20	21	22	23	8°T
	100/100	100/220	50/220	60/330	100/430	100/530	200/730	200/930	930
CT	50								50
									980

ACUITY LEVEL CLASSIFICATION

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

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

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

TURN SUCTION	TIME									

24-180 TOTALS

WT Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV	3681	Urine:	~~2335~~
Po			
TOTAL	3681	TOTAL	2335
BALANCE	(+) 1346		

NURSE'S SIGNATURE	INITIALS
[redacted]	
b(6) 2	

ME RECORD-SUPPLEMENTAL MEDICAL D
For use of this form s . 40-66; the proponent agency is The Office of geon General

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

b(6)-2

OTSG APPROVED (Date)
QA Appr 8Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0700	INTILAS [redacted]	INTILAS	1830	INTIL [redacted]
NEURO	PUPLIS	Perrl 3mm sluggish			2 mm sluggish Perrla	
	SENSORIUM	increasingly more alert, spontaneously opens eyes, follows commands, responds to verbal commands, moves UE spont. localizes pain			Increased alertness; responsive to tactile stimuli	
RESPIRATORY	RESPIRATION PATTERN	[illegible]			normal on SIMV 30, Tv 600, Peep 8, FIO2 40%	
	BREATH SOUNDS	peep 8, VE 550, RR 24 spontaneous 10%			O2 sats >95%	
	SECRETIONS	tenacious yellow - trace d/c sandy blood #8 Shiley.			BS coarse but improved (B) CT	
					(S) Secretions - copious thin yellow via trach -	
SKIN	COLOR	appropriate for race.			NFR. Pressure sores	
	INTEGRITY	no pressure sores			over occiput x2. ABD wounds in	
IV SITE	LOCATION	LJ TLC cordis and patent			(2) IJ TLC & cordis	
	CONDITION	(R) femoral a-line			CIDI	
					(R) femoral art line - site clean, dsg's int	
GASTRO	ABDOMEN	firm, slightly distended			Firm. Montgomery straps	
	BOWEL SOUNDS	hypo BS. midline incision noted. bagged dressing intact. drainage minimal stool			over abd wound. BS hypo.	
GU	URINE	F&G QS. urine				
	COLOR/CLARITY	clear			dark yellow / clear adequate UOP via foley	
CARDIOVASCULAR	CARDIACRHYTHM	NSR - ST & ectopy. S3			NSR & ectopy	
		+1 radial pulses, T2 pedal pulses, CRT, gen. edema, mottled, cool to touch			peripheral pulses palpable.	

LEGEND
Cr - Creatinine
F_IO - Fraction of inspired O_2
F_IO_2 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - PRESSURE OF ARTRIAL CO_2
PEEP - Positive end Expiratory Pressure
S/A - Fractional
SAI - Saturation
TRACH - Tracheostomy

[redacted]

(Continue on reverse)

b(6)-2 [redacted]

PATIENT'S INDICATION [redacted] Name — Last, First, middle; grade; date; hospital [redacted]

DEPARTMENT/SERVICE/CINC

DATE

EPW [redacted] b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)
☐ DIGNOSTIC STUDIES
☐ TRETMENT

DA FORM 1 MAY78 4700
Proponent Dept of Nurs

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

DATE 13 Sep

DX

HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial line	123/54	161/74	145/65	134/72	125/54	169/79	149/70	135/66		130/61	127/57	121/55	128/62	135/65	135/65	140/63	148/75	
BP Cuff																		
Temperature								99.2						98.3				
Pulse	100	112	102	90	91	104	105	102		95	92	87	88	86	90	94	85	
Respiratory Rate	23	24	24	24	24	22	23	24		26	25	23	23	26	25	25	25	
SaO2	97	93	95	96	98	100	98	96		100	99	99	100	100	100	100	100	
FiO2	50	50	50	50	50	50	50	50		50	40	40	40	40	40	40	40	

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
IVF	100	100	100	100	100	100	100	100		100	100	100	50	50	50	50	50	
Prop	29	29	29	29	29	29	29	29		29	29	29	29	29	29	29	29	
Fent	12	12	12	12	12	12	12	12		20	30	30	20	20	20	20	20	
IVPB	100	50								50		200		55	55	55		
TF	400				400					400				500				
TOTALS																		

OUTPUT

		TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
URINE		HOUR	300	300	200	180	80	60	80	150		190	150	75	139	200	280	140	110	
		TOTAL	300	600	800	980	1060	1120	1200											
		SP gr																		
		S/A																		
NG		OUTPUT																		
		PH																		
		GUIAC																		
EMESIS																				
STOOL																				
DRAINS		CT						Ø												
																		D/C		
TOTALS																				

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23
	141 / 71	140 / 68	136 / 68	141 / 73	132 / 65	147 / 69	132 / 61	133 / 69
				96				
	85	92	89	86	90	93	92	89
	22	27	22	20	21	20	22	21
	98	95	95	96	95	99	100	100
	40	40	40	40	40	40	40	40

INTAKE	16	17	18	19	20	21	22	23	8°T
	50	50	50	50	50	50	50	50	400
	29	29	29	29	29	29	29	29	232
	20	20	20	20	20	20	20	20	160
TF	400				500				900
RS					5 RETOX				

OUTPUT	16	17	18	19	20	21	22	23	8°T
	15	120 / 265	45 / 310	60 / 370	100 / 470	160 / 630	75 / 705	30 / 705	705
RS	Urine →				5				5

ACUITY LEVEL CLASSIFICATION

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

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

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

24°180 TOTALS

WT Yesterday _____ wt Today _____

INTAKE

IV _____

Po _____

TOTAL _____

OUTPUT

Urine: _____

TOTAL _____

BALANCE _____

NURSE'S SIGNATURE	INITIALS

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

b(6)-2

OTSG APPROVED (Date) QA Appr 8Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	0630	INITIALS [redacted]	1900	INITIALS [redacted]		INITIALS
NEURO	PUPLIS		3mm sluggish PERRL		3mm PERRL Sluggish			
	SENSORIUM		responsive to tactile		Moves BUE L>R. Ø mvmt			
			Stimuli + verbal		BLE. Head weak. language			
			Alert.		barrier (T) trach. Alert.			
					Aggitated/aggressive			
RESPIRATORY	RESPIRATION PATTERN		normal SIMV 20		Regular, even. Frequent			
	BREATH SOUNDS		TV 600. PEEP 8 FiO2 40%		coughing. Occasional red/			
	SECRETIONS		lungs rhonchi such a		pink secretions from trach.			
			mix zon - thick		Clear to yellow thick secretions			
			clear mucous.		from around trach. Collar inflated.			
					Trach collar 100%. Humidified O2.			
SKIN	COLOR		NFR. Prevenive care		Rhonchi all lung fields. #8 Shiley			
	INTEGRITY		occiput x2 Stad wound		NFR, Tight, fragile.			
			dressing change q 1hr		Weeping in areas. Dx#2			
IV SITE	LOCATION		(R) IJ TLC - circles.		to posterior head (to back). Wounds to			
	CONDITION		EDI. (R) femoral		(L) lower lateral leg. black & white			
			a-line, CDI.		on upper mouth. Ø drainage			
					old blister to (L) anterior FA.			
					~~Ø drainage~~ Cordis (L)			
					Subclavian - TLC @ 22cm.			
GASTRO	ABDOMEN		firm, involuntary		(R) groin A-line zeroed. good			
	BOWEL SOUNDS		stools Stad. BS		waves & box. Dressing CDI.			
			hypo.		Firm - ML incision. W/D			
					dressing Δ. To (L) of incision a			
GU	URINE		Foley		G-tube. ABS x4. BM x1			
	COLOR/CLARITY		dark drulers		soft brown. Foly to DD			
					Clear/yellow. Secured			
CARDIOVASCULAR	CARDIACRHYTHM		NSR to STach Ø ectopy		ST. S ectopy. S1 S2.			
			peripheral pulses ± 2		Radial/Pedal pulses 2+			
					Capreffill < 3 sec 3+ Anasarca			
					Slight pain			

LEGEND

Cr - Creatinine
F_IO - Fraction of inspired O_2
F_IO_2 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - PRESSURE OF ARTRIAL CO_2
PEEP - Positive end Expiratory Pressure
S/A - Fractional
SAI - Saturation
TRACH - Tracheostomy

PREPARED BY (Signature & Title)

(Continue on reverse)

DEPARTMENT/SERVICE/CINC

DATE 14Sep03

PATIENT'S INDICATIONS (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)
- ☐ DIGNOSTIC STUDIES
- ☐ TRETMENT

DA FORM 1 MAY78 4700
Proponent Dept of Nurs

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

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07		08	09		11	12	13	14	15	
BP Arterial line	125/108	136/39	126/59	129/63	129/52	111/67	106/54	121/63		140/62	129/59	169/72	140/71	152/78	141/70	134/66	136/67	
BP Cuff	99.2					99.6		99.5										
Temperature																		
Pulse	88	91	91	89	94	104	105	95		99	106	101	112	109	116	117	121	
Respiratory Rate	20	20	21	20	19	29	20	22		24	24	24	15	24	31	20	35	
O2 sats	100	99	100%	100%	100%	100	100	100		100	98	100	100	98	100	100	100	
mode	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV		SIMV	SIMV	SIMV	MASK	MASK	MASK	MASK	MASK	
FiO2								40%		40%	40%	40%			40%			

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
IVF	50	50	50	50	50	50	50	50		50	50	50	25	25	25	25	25	275
IVPB	100	100	50							150		250	100					500
Propofol	29.4	29.4	29.4	29.4	29.4	29.4	29.4	29.4		29.4	29.4	29.4	OFF					
Fentanyl	10	10	10	10	10	10	10	10		10	10	10	10	10	10	OFF		
NF	500				500					500				500				
H2O																		
Residual										40cc				25cc				
TOTALS																		

OUTPUT

URINE	HOUR	80	70	50	140	120	80	78	88	83	120	155	285	85	85	115	100	160		
	TOTAL		150	150	340	460	540	588	588	671		275	495	580	665	780	880	1040	1080	
	SP gr																			
	S/A																			
NG	OUTPUT																			
	PH																			
	GUIAC																			
EMESIS																				
STOOL																				
Res. DRAINS		5				5							X1							
TOTALS																				

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21		23
	14/68	134/62	14/62	127/56	128/56	150/73	139/64	
		101.0		100.3 (B)		101.0	101.6 (B)	
	114	118	110	112	108	123	117	
	29	20	25	39	39	31	27	
	99%	100%	100%	100%	100%	99%	99%	
	MASK	MASK	MASK	TC	TC	TC	SIMV	SIMV
							40%	40%

INTAKE	16	17	18	19	20	21	22	23	8°T
I	25	25	25	25	25	25	25	25	200
N	150							200	350
							4	8.4	12
T	500				500				1000
A					60				60
K									
E	25				Returned 30cc				

OUTPUT	16	17	18	19	20	21	22	23	
O	100	120/220	110/330	110/440	310/750	230/980	170/1150	200/1350	1436
U									
T									
P	X1	X1		XT					
U									
T									

ACUITY LEVEL CLASSIFICATION

RESPIRATORY				
	TIME		10	120
	MODE		MASK	TC
	F_IO_2		40%	
	TV			
	RATE			
	PEEP			
ABG	A pH		7.42	7.46
	A PCO_2		42.1	40.5
	B pO_2		71	78
	B HCO_3		28	29
	G SAT		94%	96%
	G BASE			

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

DAILY ACTIVITIES	TIME								
	MOUTH CARE	KH 1945							
	BATH	KH 1945							
	SKIN CARE	KH 1945							
	FOLEY CARE	KH 1945							
	TRACH CARE	KH 1945							
	ROM EXERCISES	KH 1945							

TURN SUCTION	TIME							
	1900	2300						
	2000							
	2100							
	2200							

24-130 TOTALS

WT Yesterday _____ wt Today _____

INTAKE

IV _____

Po _____

TOTAL _____

OUTPUT

Urine: _____

TOTAL _____

BALANCE _____

NURSE'S SIGNATURE | INITIALS

[redacted] JAN [redacted]

b(6)-2

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET b(6)-2

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL [redacted] ASSESSMENT

		TIME	0600	INITIALS [redacted]	1845	INITIALS [redacted]		INITIALS
NEURO	PUPILS		PUPILS R/L. [illegible]		PERRL 4mm, brisk. Alert.			
	SENSORIUM		ADMAE. [illegible]		Moves x words. Obeys hand			
			[illegible]		gestures. Moves BUE			
			[illegible]		& >R, turns head. Ø			
			[illegible]		mvmt in BLE. Sensation intact			
RESPIRATORY	RESPIRATORY PATTERN		[illegible]		BUE. Trach #8. Trach			
	BREATH SOUNDS		[illegible]		collar c̄ humidified O2			
	SECRETIONS		[illegible]		@40%. RR 28-30. Unlabored			
			[illegible]		even, regular. CTA			
			[illegible]		all lung fields ↓ RLL.			
SKIN	COLOR		[illegible]		NTR. Pressure sores on occiput			
	INTEGRITY		[illegible]		& head, black. Pressure sore			
			[illegible]		@ hip. Wound @ lateral lower			
IV SITE	LOCATION		[illegible]		leg w/ dressings. Warm, dry			
	CONDITION		[illegible]		fragile. Old blister Anterior			
			[illegible]		FA, dry. Cordis c̄ TLC @			
			[illegible]		22cm to @ subclavian.			
			[illegible]		Cordis infusing 25cc D5½NS			
			[illegible]		520cc. A-line @ femoral			
GASTRO	ABDOMEN		[illegible]		zeroed c̄ good waveform.			
	BOWEL SOUNDS		[illegible]		ML incision c̄ W-D dressings.			
			[illegible]		tight. ABSx4. G-tube to @			
			[illegible]		of incision medial.			
GU	URINE:		[illegible]		Foley to DD clear			
	COLOR/CLARITY		[illegible]		yellow urine, Ø drainage			
			[illegible]		from meatus.			
CARDIOVASCULAR	CARDIAC RHYTHM		[illegible]		SR-ST c̄ ectopy.			
			[illegible]		S1S2. Anasarca 2-3+.			
			[illegible]		Radial pulses 2+, pedal pulses			
			[illegible]		3+. Capreflex <3sec			
			[illegible]					

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

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC: ICU 3

DATE: 15Sep03

PA[redacted] or 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 1 MAY 78 4700

Proponent: Dept of Nurs

DATE 15 Sep 03 | DX | PAGE 2 OF | HOSPITAL DAY

VITAL SIGNS

TIME	00	01	02	03	04	05	06	07										
BP Arterial Line	133/63	190	131/63	145/68	126/59	124/60	142/64	140/71										
BP Cuff																		
Temperature					99.9					99.4								
Pulse	108	101	102	95	97	104	106	99		96	104	100	101	92	98	98	95	
Respiratory Rate	23	26	25	22	20	26	34	31		31	33	30	32	30	30	30	29	
FiO2	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	50%	50%		50	50	50	50	50	50	50	50	
Mode	40	40	40	40	40	40	TC	TC		TC	TC	TC	TC	TC	TC	TC	TC	
Sats	99	99	99	99	98	98	100	100		100	100	100	100	100	100	100	100	

INTAKE

TIME	00	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
D5½NS c 20 KCl	25	25	25	25	25	25	25	25	30	25	25	25	25	25	25	25	25	200
IVPB	100	150							200	100		200						450
Propofol 80	12.6	12.6	12.6	12.6	12.6	16.8	21.0	24	94									
TF	500				500				1000	500				500		500		
H2O	50				50					50				50				1000
PABC's													350			350		700
TOTALS																		

OUTPUT

URINE HOUR	200	200	280	145	130	120	125	180	154	190	150	100	500	500	300	155	100	3350
URINE TOTAL	200	400	680	825	955	1075	1200	1380	1534		80	180	680	1180	1480	1635	1735	
URINE sp gr																		
URINE S/A																		
NG OUTPUT																	1342	3420
NG pH																		
NG GUIAC																		
EMESIS																		
STOOL																		
G-tube	replaced 5cc				7													
~~DRAINS~~																		
TOTALS									1534									3420

12/6/6

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS	16	17	18	19	20	21	22	23
	158/65	160/46	148/44	154/46	150/77	152/77	140/73	150/71
				99.8			99.4	
	95	89	89	91	93	97	97	77
	32	31	33	28	26	29	22	22
	50	50	50	40%	40%	40%	40%	40%
	16	16	16	TC	TC	TC	TC	TC
	98	97	98	100%	100%	100%	98%	100%

RESPIRATORY	TIME	0400	1100	1940
	MODE	SIMV		TC
	F_IO_2	40%		40%
	TV	600		
	RATE	20		27-30
	PEEP	5		
ARTERIAL BLOOD GAS	pH	7.48	7.46	
	PCO_2	39.5	44.5	
	pO_2	79	153	
	HCO_3	29	32	
	SAT	96%	99%	
	BASE	6	8	

INTAKE	16	17	18	19	20	21	22	23	8°T
I.V.	25	25	25	25	25	25	25	25	200
	50						100	100	250
	500				500				1000
	50				40				90

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

OUTPUT	16	17	18	19	20	21	22	23	8°T
	100	1500	500	675	125	100	75	175	1540
		1600	2100	2775	2900	3000	3075	3250	3250
					replaced 200				
									3250

ACTIVITIES OF DAILY LIVING	TIME	0630	0840	TIME
	MOUTH CARE	[redacted]		
	BATH	[redacted]		
	SKIN CARE	KH 0430	[redacted]	
	FOLEY CARE	KH 0430	[redacted]	
	TRACH CARE	KH 0430	[redacted]	0400 0900
	ROM EXERCISES	[redacted]		0400
	linens Δ	KH 0530	[redacted]	

SUCTION: TIME — 0400 0900

24 HR I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV	1647	Urine:	8200
TF po	3290		
blood	700		
TOTAL	5637	TOTAL	8200
		BALANCE	-2563

NURSE'S SIGNATURE [redacted] INITIALS [redacted]

b/(a) - 2

A11

MEDICAL RECORD–SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

b(6)-2

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	0600	INITIAL [redacted]	INITIALS	1830	[redacted]
NEURO	PUPILS		4mm Perrla			3mm Perrla	
	SENSORIUM		A&O			Alert & interactive	
			pt moving head around			c. stuff. Upper ext	
			can move left arm and			movements only weak	
			right hand			hand grips	
RESPIRATORY	RESPIRATORY PATTERN		ETT, unlabored			normal on TC 50% F	
	BREATH SOUNDS		Trach, 50% O_2 - sats 99%			Ronchi (B) O2 sats x	
	SECRETIONS		sounds CTA with exp			Lg amt thin clear	
			wheezes, diminished			secretions	
			bases				
SKIN	COLOR		NFR			NFR	
	INTEGRITY		multiple wounds			midline ABD c̄ wet to dry	
						dsg up on backside / pressure	
						over occiput	
IV SITE	LOCATION		L SC cordis Triple			(+) SC triple lumen cordis	
	CONDITION		Lumen			+ (B) femoral a line	
			R fem A line			C,D,I + . Dressings	
			c/d/i			current	
GASTRO	ABDOMEN		soft, large dressing,				
	BOWEL SOUNDS		midline			flat firm to touch	
			+BS x 4 qds			hypoactive x 4 quads	
GU	URINE:		Foley to gravity				
	COLOR/CLARITY		clear yellow			foley to gravity	
						dark yellow / clear	
CARDIOVASCULAR	CARDIAC RHYTHM		S_1S_2 HR 80's			NSR ectopy	
			+2 pulses radial & pedal			+2 radial / pedal	
			left pedal +1			pulses (B)	
			<3 sec. cap refill				

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

b(6)-2

PREPAR[redacted] (Title) [redacted] 7AN

(Continue on reverse)

DEPARTMENT/SERVICE/CLINIC: ICU 3

DATE: 16Sep03

PATIENT'S IDENTIFICATION [redacted] ed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)

EPW # [redacted]

b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 1 MAY 78 4700

Proponent: Dept of Nurs

MEDCOM - 18336

MEDDAC FBg OP 375, 1 Apr 90 (HSXC-NU)

DATE 16Sep03 DX GSW to chest

HOSPITAL DAY

VITALS SIGNS	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial Line	152/74	159/78	160/77	143/68	161/76	153/79	156/74	155/70		141/80	164/80	158/50	153/77	154/73	141/67	153/77	157/71	
BP Cuff																		
Temperature					98.3 (A)									99.0				
Pulse	83	76	79	85	74	86	83	75		83	78	92	91	81	91	83	85	
Respiratory Rate	22	20	21	24	19	28	24	19		21	18	23	23	20	26	24	22	
Sats	100%	100%	99%	90%	100%	98%	98%	100		100	98	96	100	100	100	99	100	
FiO2	40%	40%	40%	40%	50%	50%	50%	50%		50%	50%	50%	50%	50%	50%	50%	50%	
Mode	TC	TC	TC	TC	TC	TC	TC	TC		TC	TC	TC	TC	TC	TC	TC	TC	

INTAKE	TIME	24	01	02	03	04	05	06	07	8° T	08	09	10	11	12	13	14	15	8° T
	D½NS@20KCl	25	25	25	25	25	25	25	25		25	25	25	25	25	25	25	25	
	IVPB	150									150		200						
	TF	250		250		Ref.					Ref				Ref		110	390	
	H2O	40		40														40	
	TOTALS																		

OUTPUT		HOUR / TOTAL	24	01	02	03	04	05	06	07	8° T	08	09	10	11	12	13	14	15	8° T
	Foley URINE		150	100/250	100/350	100/450	100/550	100/650	75/725	125		100/225	100/825	150/475	275/750	200/950	175/1125	150/1285	150/1435	
		sp gr																		
		S/A																		
	NG	OUTPUT																		
		pH																		
		GUIAC																		
	EMESIS																			
	STOOL																			
	Residuals ~~DRAINS~~		0		0		0			0			0			0				
	TOTALS																			

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS	16	17	18	19	20	21	22	23	24
	157/80	165/80	150/75	157/79	150/77	126/71	152/77	150/80	
				91					
	89	82	92	93	91	97	96	94	
	25	22	26	27	28	26	27	26	
	99	98	99	99	97	99	100	97	
	50%	50%	50%	50%	50%	50%	50%	50%	
	TC	TC	TC	TC	TC	TC	TC	TC	

RESPIRATORY		TIME	0445	1324
		MODE	T.C	TC
		F_iO_2	50%	50%
		TV		
		RATE		
		PEEP		
	A	pH	7.47	7.47
		PCO_2	48.0	45.3
		pO_2	133	90
	B	HCO_3	35	33
		SAT	99%	100%
	G	BASE	11	9

INTAKE	16	17	18	19	20	21	22	23	8° T
	25	25	25	25	25	25	25	25	
	150						250		
					250				
					50				

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

OUTPUT									
	250/185	175	175/125	250	200	100	125	150	
		30	0						

ACTIVITIES DAILY LIVING	TIME								
	MOUTH CARE	KH 0500							
	BATH	KH 0500							
	SKIN CARE	KH 0500							
	FOLEY CARE	KH 0500							
	TRACH CARE	KH 0330							
	ROM EXERCISES								
	Lifen Δ	KH 0500							

TURN	TIME						
	0500						
	0200						
	Plat 0400						
SUCTION	KH 0300						

24° I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL		TOTAL	

BALANCE _____

NURSE'S SIGNATURE	INITIALS
[redacted]	[redacted]
10/6/02	

MEDICAL RECORD–SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

b(6)-2

OTSG APPROVED (Date) ~~OA Appr 8 Mar 89~~

INITIAL SHIFT ASSESSMENT

	TIME	0600	INITIALS [redacted]	INITIALS	800	[redacted]
NEURO	PUPILS	Perrla 4mm			PERRLA 4mm	
	SENSORIUM	able to move left arm purposefully and right hand			moves left arm has right arm weakness, Q mvmt in legs	
RESPIRATORY	RESPIRATORY PATTERN	even unlabored			even, unlabored	
	BREATH SOUNDS	coarse throughout			coarse BS both sides. Coughing up thick mucous tinged c̄ blood	
	SECRETIONS	+cough c̄ thick mucous				
SKIN	COLOR	NFR			NFR	
	INTEGRITY	multiple wounds			multiple wounds skin breakdown to perine	
IV SITE	LOCATION	L SC Triple Lumen			(L) SC TLC c̄ Cordis	
	CONDITION	c/d/i R femoral radial A line c/d/i			CDI (R) femoral A-line CDI	
GASTRO	ABDOMEN	soft nontender			Soft, nontender	
	BOWEL SOUNDS	+BS x4qds no BM in 4 days			BS x4quads	
GU	URINE: COLOR/CLARITY	foley to gravity clear yellow			FTG clear yellow	
CARDIOVASCULAR	CARDIAC RHYTHM	S1S2 NSR +2 radial & pedal pulses <3 sec cap refill +2 edema to hands feet & scrotum			S1S2 NSR +2 radial/pedal pulses +2 edema (R) hand and both feet	

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

b(6)-

(Continue on reverse)

[redacted] PT AW

DEPARTMENT/SERVICE/CLINIC: ICU 3

DATE: 17 Sep 03

(Initial 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 1 MAY 78 4700

Proponent: Dept of Nurs

MEDDAC FBg OP 375, 1 Apr 90 (HSXC-NU)

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	0000	0100	0200	0300	0400	0500	0600	07	08	09	10	11	12	13	14	15	16	17
BP Arterial Line	150/76	148/75	137/79	137/83	129/76	151/73	154/77	147/73	142/82	131/60	150/76	154/74	151/74	151/79	159/82	153/75	147/74	146/93
BP Cuff	154/76																	
Temperature	99.6				99.1													
Pulse	99	94	88	94	95	83	87	94	118	99	92	93	85	94	96	88	95	105
Respiratory Rate	25	31	35	16	26	31	26	26	11	28	29	27	33	29	30	23	24	26
SpO2	96	94	99	97	96	100	99	100	99	99	97	100	97	100	100	96	99	100
Trachcollar	50%	50%	50%	40%	40%	40%	40%	40%	40%	40%	40%	40%	40%	40%	40%	40%	40%	40%

INTAKE

TIME									08	10	11	12	13	14	15	16	17
D5½NS c 20mEq K+	25	25/50	25/75	25	25	25	25	25	200	25	25	25	25	55	25	25	25	25
NPB	150							200	350									
Tube Feed					500				500				Ref.			150		
P.O.																500		
TOTALS																		

OUTPUT

URINE	HOUR	175	400	200	150	150	125	125	500	1050								
	TOTAL		575	975		1075	1200	1325		1650	230	200	200	200	125	100	375	200	170
	sp gr										860	1060	1260	1460	1575	1675	2050	2250	2420
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS	Residuals					0				13			25				0		
TOTALS																			

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS	18	19	20	21	22	23	24	01	02
	154/41	152/49	151/48	145/47	144/69	154/71	132/62	137/64	
		99.7					99.8		
	101	97	91	96	92	93	104	101	
	28	28	22	27	24	23	26	25	
	100%	96	100	98	95	100	98	100	
	40%	40%	40	40	40	40	40	40	

INTAKE	18	19	20	21	22	23	24	01	8°T
	25	25	25	25	25	25	25	25	
		~~500~~		200			150		
		500					500		
	50								

OUTPUT	18	19	20	21	22	23	24	01	8°T
	120/305	185/185	130/365	140/500	260/785	210/1055	180/1315	228/1543	
		8				9			

RESPIRATORY	TIME	0422
	MODE	T-coil
	F_IO_2	40%
	TV	
	RATE	
	PEEP	
ABG	pH	7.48
	PCO_2	46
	pO_2	82
	HCO_3	35
	SAT	97
	BASE	11

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

DAILY ACTIVITIES DURING	TIME	
	MOUTH CARE	
	BATH	
	SKIN CARE	
	FOLEY CARE	
	TRACH CARE	1900
	ROM EXERCISES	2100

TURN	TIME
SUCTION	

24 HR I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL		TOTAL	

BALANCE _____

NURSE'S SIGNATURE	INITIALS
[redacted] LPN	[redacted]
D (6) 2	

MEDICAL RECORD–SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL [redacted]FT ASSESSMENT

		TIME	0600	INITIALS [redacted] b(6)-2	INITIALS	1900	INIT [redacted]
NEURO	PUPILS		PE RRROX3, equals			PT alert, response	
	SENSORIUM		Comprehends c			appropriate. FROM	
			Glasgow 10/10 present			RUE; LROM to LUE.	
			Slurred speech			Pupils 2-3mm	
			PD Jr. E. Long.				
RESPIRATORY	RESPIRATORY PATTERN		RR spontaneous, un-			equal rise, full;	
	BREATH SOUNDS		labored. LS (B)			35% FIO2; SpO2 100%	
	SECRETIONS		Coarse, thick			LCTA (B); ↓ to LL (B)	
			secretions			Cough WFR.	
			yellow, suctioned				
			Pink c membranes				
SKIN	COLOR		c FBR @ 37.0.				
	INTEGRITY		Skin warm, appropriate			NSR; no murmur	
			color for ethnic			cannot c bulky dressing	
IV SITE	LOCATION		Groin. CSE tubes			DSC c	
	CONDITION		RSR, clean & dry			Cultis	
			site dressing c			CDI	
GASTRO	ABDOMEN		NDS soft, NO NT			Soft; tender c	
	BOWEL SOUNDS		c BS x4 per quad			deep palpation.	
			patent, midline			no murmur cannot	
			PEG dressing intact			c bulky dressing.	
GU	URINE:		FC to BSR patent			FTG; yellow, clear	
	COLOR/CLARITY		c amber color				
			noted				
CARDIOVASCULAR	CARDIAC RHYTHM		S1 & S2 auscultated			S1 S2, NSR, pulses	
			HR & RR noted NL			palpable 2+,	
			BP & ECG monitored				
			CVP & PAP monitored				
			Bruits lower extremities				

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

(Continue on reverse)

PREPARED BY (S[redacted]) b(6)-2

S[redacted] PN

DEPARTMENT/SERVICE/CLINIC: ICU3

DATE: 9/18/03

PATIENT'S [redacted] entries give: Name—last, first, middle; grade; date; hospital or medical facility)

EPW [redacted]

b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 1 MAY 78 4700

Proponent: Dept of Nurs

MEDDAC FBg OP 375, 1 Apr 90 (HSXC-NU)

DATE 18 Sept 03 DX GSW to Chest HOSPITAL DAY

VITAL SIGNS TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
BP Arterial Line	133/62	137/64	148/67	139/70	147/68	147/68	154/70	140/70		154/70	147/70	122/57	140/70	135/65	129/69	132/62	131/69	
BP Cuff																		
Temperature	99.8				99.8					99.1								
Pulse	104	101	106	110	94	96	92	96		92	92	98	104	97	96	104	97	
Respiratory Rate	26	25	29	23	23	30	24	28		23	24	25	28	23	22	25	26	
SpO_2	98	100	99	99	100	99	100	100		100	100	98	100	99	99	99	100	
Trach Collar	40%	40%	40%	40%	40%	40%	35%	35%		35%	35%	35%	35%	35%	35%	35%	35%	

INTAKE TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
D5 ½ NS ⊂ 20 mEq K	25	25	25	25	25	25	25	25	200	25	25	25	25	25	25	25	25	200
IVPB	150									100	50	250						400
Tube feed	500				500				150									
PO				5 sips					1000	500				500				1000
										3 sips								
TOTALS									1350									

OUTPUT		HOUR / TOTAL	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
URINE FTG			260 / 260	128 / 488	160 / 648	100 / 748	148 / 896	180 / 1076	150 / 1226	100 / 1326	1426	250	150 / 400	200 / 600	150 / 750	100 / 850	75 / 925	100 / 1025	100 / 1125	1600 / 2725
		sp gr																		
		S/A																		
NG		OUTPUT																		
		pH																		
		GUIAC																		
EMESIS																				
STOOL																				
DRAINS		Residuals 9				<1												0		
TOTALS										1420										2757

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS	16	17	18	19	20	21	22	23	8PT
	144	141	150	143	148	146	144	143	
	60	71	69	70	69	69	69	70	
							100.4		
	85	75	85	88	95	96	98	100	
	20	21	20	19	25	20	24	24	
	99	99	99	100	95	95	98	98	
	35	35	35	35	35	35	35	35	

RESPIRATORY		TIME	0416
		MODE	T-collar
		F_IO_2	40%
		TV	
		RATE	24
		PEEP	
ARTERIAL BLOOD GAS	A	pH	7.47
		PCO_2	44
		pO_2	114
	B	HCO_3	32
		SAT	99
		BASE	9

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

INTAKE	16	17	18	19	20	21	22	23	8°T
	25	25	25	25	25	25	25	25	800
	100	50						50/100	300
	500				500				1000
									2200

OUTPUT										N6T
	110	200	200	150	200	200	200	200	200	
		310	310	160	360	1060	1260	1460	1660	
										1465

ACTIVITIES OF DAILY LIVING	TIME											
	MOUTH CARE	0430										
	BATH	0430										
	SKIN CARE	0430										
	FOLEY CARE	0430										
	TRACH CARE	1930										
	ROM EXERCISES	93°										

TURN	TIME											
SUCTION												

24°I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL	5150	TOTAL	4950

BALANCE +200

NURSE'S SIGNATURE	INITIALS
[redacted]	
[redacted]	

ME . RECORD-SUPPLEMENTAL MEDICAL
For use of this form se.. .R 40-66; the proponent agency is The Office of .. .rgeon General

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	0700	INTILAS [redacted]	D/(6)-2 INTILAS	1830	INT [redacted]
NEURO	PUPLIS		Pruk 3mm sluggish			Perrla 3mm sluggish	
	SENSORIUM		c/o X3 person/place/time appropriate			alert. Interacts	
			↑ staff follows all commands			appropriately c̄ nurse	
			move UE independently RUE			communicates needs	
			< LUE. Enc active ROM RUE			Paraplegic	
RESPIRATORY	RESPIRATION PATTERN		even unlabored trach			normal on TC @ 35% of 10	
	BREATH SOUNDS		coarse 35/ #8 Shiley			#8 Shiley trach	
	SECRETIONS		CTA c̄ bilateral rhonchi			Rhonchi to ↑ bases	
			thick yellow secretions			thick yellow secretions	
			strong productive cough			productive cough	
			frequent (1-2/h) rqd			frequent expectoration c̄ sputum	
SKIN	COLOR		appropriate for race			NFR	
	INTEGRITY					Scalp pressure sore over occiput x 2	
						milliareia incision c̄ wet dry	
IV SITE	LOCATION		LEJ TLC c̄ cardis			① IJ TLC c̄ cardis	
	CONDITION		well patent.			② femoral art line	
			② femoral - slight			C,D,I	
			correlating c̄ MAP				
GASTRO	ABDOMEN		firm slightly distended			firm to touch / tender	
	BOWEL SOUNDS		tender hypo BS			BS hyperactive	
			milliaria abd incision ~~staples~~				
			~~intake~~ c̄ w/ 0 bag d/s				
GU	URINE		Foley FTG			Foley to gravity	
	COLOR/CLARITY		CLS			clear yellow urine	
						adequate UOP	
CARDIOVASCULAR	CARDIACRHYTHM		NSR - ST ectopy			NSR — ectopy	
			S1 S2 +2 radial &			radial pulses +1	
			pedal pulses +1 gen			pedal pulses +2	
			edema			↓ edema to scrotum	
						② hand puffy 1/LE's	

LEGEND
Cr - Creatinine
F_IO - Fraction of inspired O_2
F_IO_2 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - PRESSURE OF ARTRIAL CO_2
PEEP - Positive end Expiratory Pressure
S/A - Fractional
SAI - Saturation
TRACH - Tracheostomy

(Continue on reverse)

D/(6)-2 [redacted] CPT / AW

DEPARTMENT/SERVICE/CINC: ICU 3

DATE: 14 Sep 03

middle; grade; date, hospital or [redacted] facility)

EPW

[redacted] D/(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)
☐ DIGNOSTIC STUDIES
☐ TRETMENT

DA FORM 1 MAY78 4700
Proponent Dept of Nurs

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

DATE 19 Sep | DX | HOSPITAL DAY

VITAL SIGNS

TIME	24	01	J..	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial line	132/57	144/67	139/67	142/69	141/68	141/72	142/67	147/70		147/72	139/70	145/73	[illegible]/7	142/72	138/67	154/79	148/74	
BP Cuff																		
Temperature				99.4						99.4					99.1			
Pulse	97	91	100	98	100	119	94	85		93	94	97	98	89	94	88	90	
Respiratory Rate	22	22	23	23	23	30	25	19		24	22	23	22	21	31	20	21	
FIO2	35%	35%	35.	35.	35	35	35	35		35	35	35	35	35	35	35	35	
SAO2	99%	100%	98%	99	100	96%	98	97		98	97	97	97	96	99	98	100	

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
D5½NS120	25	25	25	25	25	25	25	25		25	25	25	25	25	25	25	25	
IVPB	200									150		200						
TF	500				500					500				500				
TOTALS																		

OUTPUT

		HOUR / TOTAL	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
URINE			80 / 80	240 / 320	80 / 400	100 / 500	160 / 660	180 / 840	200	130		100	142	100	140	200 / 240	150	140	100	
		SP gr																		
		S/A																		
NG		OUTPUT																		
		PH																		
		GUIAC																		
EMESIS																				
STOOL																				
DRAINS																				
TOTALS																				

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23
	142/67	147/70	147/67	132/67	134/67	132/67	134/67	134/69
				100 (A)				
	84	94	89	99	102	100	110	98
	19	25	22	22	21	25	29	22
	35	35	35	35	31	35	35	35%
	100	96	98	100	98	100	99	98%

INTAKE	16	17	18	19	20	21	22	23	8°T
	25	25	25	25	25	25	25	26	
	250						250		
	500				500				

OUTPUT									
	25	100	200	200	180	125	100	120	
		325	525	725	855	980	1080		
	80				5				

ACUITY LEVEL CLASSIFICATION

RESPIRATORY										
	TIME	0400								
	MODE	TC								
	F_IO_2	35								
	TV									
	RATE									
	PEEP									
ABG	A pH	7.43								
	A PCO_2	42.5								
	B pO_2	92								
	B HCO_3	29								
	G SAT	97								
	G BASE	4								

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

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

24 HR TOTALS

WT Yesterday _____ wt Today _____

INTAKE

IV _____

Po _____

TOTAL _____

OUTPUT

Urine: _____

TOTAL _____

BALANCE _____

NURSE'S SIGNATURE	INITIALS

MEDICAL RECORD–SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

		[redacted] ASSESSMENT			[redacted]
	TIME	0600	[redacted] b(6)-2	INITIALS	1900 b(6)-2 [redacted]
NEURO	PUPILS	pupils [illegible]			Perrla 3 mm [redacted]
	SENSORIUM	AAOX3, delirious			Alert/[illegible] uproar
		[illegible]			E nurse. Quadriplegic
		[illegible]			
		[illegible]			
		[illegible]			
RESPIRATORY	RESPIRATORY PATTERN	[illegible]			normal on TC @ 35% of
	BREATH SOUNDS	C/Ves [illegible]			CTA (B)
	SECRETIONS	C 350 [illegible]			Strong cough. Pt
		[illegible] to cough			able to expectorate
		[illegible] secretions			most secretions by
		[illegible]			rinse & F. Thick blood tinge
SKIN	COLOR	[illegible]			DFK
	INTEGRITY	[illegible]			wet to dry to Abd wound
		[illegible]			(L) leg wound c dressing
IV SITE	LOCATION	[illegible]			TLC c cords (L) SC
	CONDITION	[illegible]			(R) femoral art line
		[illegible]			CIDIT
		[illegible]			
		[illegible]			
		[illegible]			
GASTRO	ABDOMEN	[illegible]			Slightly distended;
	BOWEL SOUNDS	[illegible]			tender to touch
		[illegible]			hypoactive. SF BM
		[illegible]			yesterday (med)
GU	URINE:	[illegible]			Foley to gravity
	COLOR/CLARITY	[illegible]			clear yellow
		[illegible]			adequate UO
CARDIOVASCULAR	CARDIAC RHYTHM	[illegible]			NSR ectopy
		[illegible]			peripheral pulses
		[illegible] 100-110			palpable x 4 2+
		[illegible]			edema to (R) rend
		[illegible]			LE's

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

b(6)-2

(Continue on reverse)

[redacted] SPT HAW | DEPARTMENT/SERVICE/CLINIC: ICU 3 | DATE: 20 Sep 03

[redacted] ...ed or written en... ...e: Name—last, first, middle; grade; date; hospital or medical facility

EPW [redacted]

b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 1 MAY 78 4700

Proponent: Dept of Nurs

MEDDAC FBg OP 375, 1 Apr 90 (HSXC-NU)

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

DATE | DX | PAGE | HOSPITAL DAY

VITAL SIGNS	TIME	00	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16
	BP Arterial Line	119	122	116	116	115	122	121	156	145		134	122	125	122	122	122	125
	BP Cuff	73	58	54	55	56	66	71	70	76		64	68	58	70	70	64	65
	Temperature	101.2				100.5			100.2									
	Pulse	106	104	110	104	104	119	109	109	102		105	106	101	100	104	98	99
	Respiratory Rate	27	26	25	25	25	35	29	19	26		29	27	28	27	28	30	25
	O2 sats	96	95	[redacted]	95	95	99	98	100	100		96	95	95	99	99	99	99
	FIO2	35	35	35	35	35	35	35		35%		35	35	35	35	35	35	35

INTAKE	TIME								8° T									8° T
	IVF	25	25	25	25	25	25	25	25	25	25	25	25	25	25	25	25	25
	NPB	150							200	25	25	25	25	25	25	25	25	200
	TF	500							150	150		250						400
	Flush								500	500				500				1000
										50				50				100
	TOTALS								850									

OUTPUT		HOUR	105	85	85	110	50	170	200	200	200	200	250	110	150	100	25	250	200	1400
	URINE	TOTAL			325	385	535	705	905	1105			450	560	710	810	835	1085	1285	1385
		sp gr																		
		S/A																		
	NG	OUTPUT																		
		pH																		
		GUIAC																		
	EMESIS																			
	STOOL																			
	DRAINS	Res 0									0				0					
	TOTALS								1105											1385

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS							
	18	19	20	20	21	22	23
	140	140	156	135	155	150	141
	111	112	77	63	78	77	64
				96.4			
	88	99	85	91	92	101	95
	24	20	12	24	23	20	25
	99	94	100	100	100	100	100
	135	135	35	35	35	35	35

INTAKE								
	25	25	25	25	25	25	25	8° T
	10/40							20
					250			40

OUTPUT								
	125	200	100	100	250	300		
		65	85	135	125	165		145

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

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

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

TURN					
	TIME				

SUCTION					

24° I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV	_____	Urine:	_____
po	_____		_____
	_____		_____
TOTAL	_____	TOTAL	_____

BALANCE _____

NURSE'S SIGNATURE

[redacted]

b(6)-2

For use of this f[illegible]CAL RECORD-SUPPLEMENTAL MEDIC[illegible]TA
[illegible], AR 40-66; the proponent agency is The Office [illegible]e Surgeon General

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8Mar 89

INITIAL SH[illegible]SMENT

	TIME	0600	INTILAS [redacted]	INTILAS	1840	INTIL [redacted]
NEURO	PUPLIS	pupils RTA		b(6)-2	PERRL	
	SENSORIUM	AO x 3			AO able to squeeze	
		PERRL			both hands but only able	
		MAE			to move ⊖ UE & from	
		[illegible]			⊖ UE & minimal movement.	
RESPIRATORY	RESPIRATION PATTERN	RR [illegible]			Resp labored on trach mask	
	BREATH SOUNDS	[illegible]			Coarse ⊕	
	SECRETIONS	COARSE			Thick white secretions from	
		[illegible]			productive cough. On 31%	
		[illegible]			humidified O2 via trach mask	
SKIN	COLOR	[illegible]				
	INTEGRITY	[illegible]			WNL	
		[illegible]			Drng mid line abd & ⊖ LE	
IV SITE	LOCATION	[illegible]			CDI	
	CONDITION	[illegible]			⊖ 3C cardis & ⊕ Fem A-line	
		[illegible]			s/s of infx & opsites	
		[illegible]			intact	
GASTRO	ABDOMEN	[illegible]				
	BOWEL SOUNDS	[illegible]			Flat soft nontender to	
		[illegible]			light palpation	
		[illegible]			⊕ in 4 quads	
GU	URINE	[illegible]			⊕ ⊖ feeding tube	
	COLOR/CLARITY	[illegible]			Foley to gravity	
		[illegible]			clear yellow	
CARDIOVASCULAR	CARDIACRHYTHM	[illegible]			SR ⊖ 31 ⊖ 32 noted	
		[illegible]				
		[illegible]				

b(6)-2

LEGEND

Cr - Creatinine
F_IO - Fraction of inspired O_2
F_IO_2 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - PRESSURE OF ARTRIAL CO_2
PEEP - Positive end Expiratory Pressure
S/A - Fractional
SAI - Saturation
TRACH - Tracheostomy

(Continue on reverse)

PREPA[redacted] CPT IAW | DEPARTMENT/SERVICE/CINC ICU 3 | DATE 21 Sep 03

[redacted] (P[illegible] written entries give: Name —Last, First, middle; grade; date; hospital [illegible] facility)

[redacted]

b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)
☐ DIGNOSTIC STUDIES
☐ TRETMENT

DA FORM 1 MAY78 4700
Proponent Dept of Nurs

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

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07		08	09		11	12	13	14	15	
BP Arterial line	144/73	138/69	144/73	155/75	143/75	147/74	151/69	144/67		144/73		125/66	131/71	149/69	142/70	140/76	141/68	
BP Cuff																		
Temperature	99.3				100			99.4		99.4		98.3				99.1		
Pulse	92	104	105	91	92	95	98	97		96		94	92	86	84	81	85	
Respiratory Rate	18	31	21	22	23	22	23	25		23			16	15	18	16	18	
O2 sats	99	97	98	99	100	100	99	100		100		100	100	100	100	100	100	
FiO2								31%		31%		31%	31%	31%	31%	31%	31%	

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
IVF	25	25	25	25	25	25	25	25	20	25	25	25	25	25	25	25	25	20
IVPB	150							150	150	50 100								150
TF	300							250	250									
PO										180								120
TOTALS									600									1440

OUTPUT

		24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
URINE	HOUR	100	350	100	110	100	130	90	100	950	100	200	300	90	100	110	120	200	1440
	TOTAL											300	600	690	790	890	1010	1210	1210
	SP gr												OR						
	S/A																		
NG	OUTPUT																		
	PH																		
	GUIAC																		
EMESIS																			
STOOL																			
Residual																			
~~DRAINS~~																			
TOTALS										950									1200

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS	16	17	18	19	20	21	22	23
	147/80	140/60	137/60	139/67	148/66	131/64	142/66	135/62
							100	
	91	90	89	88	91	92	90	92
	18	18	21	23	23	25	25	26
	100	96	96	99%	99%	99%	95%	95%
	31%	31%	31%	31%	31%	31%	31%	31%

INTAKE	16	17	18	19	20	21	22	23	8°T
	25	25	25	25	25	25	25	25	600
									300
									250
									1210
									1270

OUTPUT									
	80	110	200	100	100	100	180	150	3030
		190	390	390	390	390	390	1270	1220

RESPIRATORY THERAPY	TIME	0422	0500						
	MODE	T collar							
	F_IO_2	35	31						
	TV								
	RATE								
	PEEP								
	A pH	7.49							
	B PCO_2	42.7							
	B pO_2	89							
	B HCO_3	33							
	G SAT	98							
	G BASE	10							

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

DAILY ACTIVITIES	TIME				TURN SUCTION	TIME			
	MOUTH CARE								
	BATCH								
	SKIN CARE								
	FOLEY CARE								
	TRACH CARE								
	ROM EXERCISES								

24-180 TOTALS

WT Yesterday _____ wt Today _____

INTAKE

IV _____

Po _____

TOTAL _____

OUTPUT

Urine: _____

TOTAL _____

BALANCE _____

[redacted]

INITIALS

[redacted]

bled - 2

For use of this for [illegible]AL RECORD-SUPPLEMENTAL MEDICAL [illegible]A
AR 40-66; the proponent agency is The Office [illegible] Surgeon General

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8Mar 89

INITIAL SHIFT ASSESSMENT

	TIME		INITIAS	1930	INITIAS [redacted]	b(6)-2	INITIAS
NEURO	PUPLIS	PERLA		Pepper 4mm, brisk, [illegible]			
	SENSORIUM	interacts w/ Nurse approp.		Moves BUE. Obeys some commands. Stuporous. Cough strong			
RESPIRATORY	RESPIRATION PATTERN	Even unlabored		Even, unlabored.			
	BREATH SOUNDS	Clear top coarse bottom.		Trach # shiley. Trach collar @ 31% O2. Frequent cough. Productive c thick white/yellow secretions. Able to clear			
	SECRETIONS	Pt. cough up lg amount of thick white sputum.					
SKIN	COLOR	NFR.		NFR, Dry. ML abd dressing LLE c dressings. Dry lips (R) Anterior FA c black scabs.			
	INTEGRITY	Lg Abd. wound. also LLL wound. Dressing CDI					
IV SITE	LOCATION	Triple lumen SUBCLAVIAN. (R) Femoral A Line.		(L) AC 18g c MIVF infusing. CDI.			
	CONDITION	D5 1/2 w KCL @ 25 ml/hr All Lines Flushed. Free From S/S of infection.					
GASTRO	ABDOMEN	Area diseased non tender, Lg dressing.		Soft. Tender RLQ, LLQ. ML abd Dressing. 0 drainage.			
	BOWEL SOUNDS	Bowel sounds x4 hypoactive. Feeding tube.		Hypoactive BS x4. G-tube (+) BM			
GU	URINE	FTG.		Foley to DD. Clear light yellow urine.			
	COLOR/CLARITY	Draining Lg amounts of LIGHT yellow urine.					
CARDIOVASCULAR	CARDIACRHYTHM	S.S. - ~~Rulsus~~ Palp Pulses (+)+2, Radial (+)+2. Capreflex <3 sec.		SR-ST Ectopy. $S_1 S_2$. Radial/pedal pulses 2+. 2+ anasarca. Capreflex <3 sec.			

LEGEND
Cr - Creatinine
F_IO - Fraction of inspired O_2
F_IO_2 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - PRESSURE OF ARTRIAL CO_2
PEEP - Positive end Expiratory Pressure
S/A - Fractional
SAI - Saturation
TRACH - Iracheostomy

(Continue on reverse)

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

DEPARTMENT/SERVICE/CINC ICU 3

DATE 22 Sep 03

PATIE[redacted] written entries give: Name—Last, First, middle; grade; date; hospital or medical facility)

EPW # [redacted] b(6)-4

- ☐ HISTORY/PHYSICAL
- ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER (Specify)
- ☐ DIGNOSTIC STUDIES
- ☐ TRETMENT

DA FORM 1 MAY78 4700
Proponent Dept of Nurs

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

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial line	133/63	140/66	138/67	135/65	141/71	133/66	142/72	123/65	135/54	133/54	129/71	132/63	143/68	133/66				
BP Cuff															149/9	108/55	127/60	
Temperature	99.4					99.6		99.8		99.2		98.7	98.7	98.5	99	99.6	99.5	
Pulse	93	95	91	94	91	94	103	96	87	87	89	95	86	100	97	95	92	
Respiratory Rate	22	24	22	25	25	25	29	26	26	26	20	21	25	28	30	30	27	
SPO2	97%	95%	95%	97%	97%	95%	94%	98	95	95	95	100	100	97	95	98	99	
FiO2 Trach	31%	31%	31%	31%	31%	31%	31%	31%	31%	31%	31%	31%	31%	31%	31%	31%	31%	
mode								CPAP/PS										

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
D5½NS + 20 KCL	25	25	25	25	25	25	25	25	250	25	25	25	25	25	25	25	25	780
IV PB	50									50	30							
Jevity													500					
H_2O																		
TOTALS																		7
									250									780

OUTPUT

	HOUR / TOTAL	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
URINE		160	100/260	125/385	122/507	130/637	125/762	125/887	130/1017	101	200/700	120/820	210/1030	110/1140	140/1280	180/1460	140/1600	100/1700	
	SP gr																		
	S/A																		
6 tube NG	residual ~~OUTPUT~~																		
	PH																		
	GUIAC																		
EMESIS																			
STOOL										Large amount Dark Bloody									
DRAINS																			
TOTALS																			

POST-OP DAY

VITAL SIGNS	14	17	18	19	20	21		23
	122/57	118/59	122/6	124/62	126/58	127/60	113/56	113/61
	99.9	99.3	99.4					
	91	92	85	94	91	90	88	92
	27	27	23	26	26	27	25	22
	95	100	100	100%	99%	92%	100%	98%
	31%	31%	31%	31%	31%	31%	31%	31%
				TC	TC	TC	TC	TC

INTAKE	14	17	18	19	20	21	22	23	8°T
I	25	25	25	25	25	25	25	25	200
	50								50
N	500				500				1000
					50				50
T									
A									
K									
E									
									1300

OUTPUT									
O	70/140	80/140	180/160	280/190	175/207	90/216	70/223	105/234	2340
U	140								
T					returned 2 cc				
P									
U									
T									

ACUITY LEVEL CLASSIFICATION

RESPIRATORY	TIME									
	MODE									
	F_IO_2									
	TV									
	RATE									
	PEEP									
	A: pH									
	A: PCO_2									
	B: pO_2									
	B: HCO_3									
	G: SAT									
	G: BASE									

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

DAILY ACTIVITIES	TIME									
	MOUTH CARE	KH 2230								
	BATH	KH 2100								
	SKIN CARE	KH 2100								
	FOLEY CARE	KH 2100								
	TRACH CARE	KH 2100								
	ROM EXERCISES	KH 2100								
	Linen Δ	KH 2100								

TURN / SUCTION	TIME									
TURN	Δ'd 2200									
SUCTION										

24 HR TOTALS

WT Yesterday _____ wt Today _____

INTAKE

IV 780

Po 1550

TOTAL 2330

OUTPUT

Urine: 4577

TOTAL 4577

BALANCE -2247

NURSE'S SIGNATURE	INITIALS
[redacted]	KH

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

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

b(6)-2

OTSG APPROVED (Date) QA Appr 8Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0600	INTIALS [redacted]	1930	INTIALS [redacted]		INTIALS
NEURO	PUPLIS	Perrla 4mm		PERRL 4mm, BNSE, Alert.			
	SENSORIUM	A+O, able to move left arm + right hand		Obeys commands. Moves BUE L>R. Sensation intact.			
RESPIRATORY	RESPIRATION PATTERN	even, unlabored		Regular, unlabored			
	BREATH SOUNDS	Coarse throughout		CTA. Thick yellowish white secretions from trach. Able to clear secretions			
	SECRETIONS	thick mucous out of trach		TC 31% humidified O2 #8 Shiley, cleaned.			
SKIN	COLOR	NRR		NFR, W.D. Mid incision			
	INTEGRITY	decubitus forming on bottom of R foot		2 sores @ lateral lower leg DK brown spots on bottom of foot			
IV SITE	LOCATION	LAC		Skin intact. Skin flaking off of backside. Warm, dry			
	CONDITION	running D5½ i 20K c/d/i		@ FA infusing D5½NS @ 20 KCl @ 25cc/hr, CDI			
GASTRO	ABDOMEN	large midline wound		Ml abd incision, bulging red c a bit of yellowish-brown ascites. G-tube			
	BOWEL SOUNDS	hyperactive x4qds		active BS x4, (+) lg BM			
GU	URINE	foley to gravity		Foley to gravity. DK yellow clear urine			
	COLOR/CLARITY	clear/yellow					
CARDIOVASCULAR	CARDIACRHYTHM	TSR S1S2 +2 pulses <3 sec cap refill		SR-ST, ⅁ ectopy, S1S2 Radial 2+/Redal 3+ pulses Capnfill <3 sec. BLE 2+.			

LEGEND: Cr - Creatinine; F_IO - Fraction of inspired O_2; H_CO_3 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - PRESSURE OF ARTRIAL CO_2; PEEP - Positive end Expiratory Pressure; S/A - Fractional; SAI - Saturation; TRACH - Iracheostomy

(Continue on reverse)

PRE[redacted] & Title) b(6)-2 [redacted]TAN

DEPARTMENT/SERVICE/CINC ICU3/PACU

DATE 23 Sep03

PATIENT [redacted] typed or written entries give: Name—Last, First, middle; grade; date; hospital or medical facility)

EPW # [redacted] b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIGNOSTIC STUDIES

☐ TRETMENT

DA FORM 1 MAY78 4700
Proponent Dept of Nurs

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

DATE 23 Sep 03 | DX GSW to Chest | HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07		08	09		11	12	13	14	15	
BP Arterial line																		
BP Cuff	123/64	126/59	127/63	125/61	123/64	122/59	116/58	109/50		110/61	123/63	107/43	125/58	113/53	123/59	120/58	124/60	
Temperature		99.3 (A)				101.9 (A)	101.7				101.5			100.3		101.5		
Pulse	88	90	96	101	115	110	109	108		110	110	109	102	103	105	110	105	
Respiratory Rate	29	24	24	22	22	22	18	23		27	29	29	26	27	14	13	21	
SpO_2	98	98	91	95	94	99%	94	96		92	97	98	96	96	99	99	99	
FiO_2	31%	31%	31%	31%	31%	31%	31%	31%		31%	31%	31%	31%	31%	31%	31%	31%	
Mode	TC	TC	TC	TC	TC	TC	TC	TC		TC	TC	TC	TC	TC	TC	TC	TC	

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
D5½NS c 20KCl	25	25	25	25	25	25	25	25	200	25	25	25	25	25	25	25	25	200
IVPB	50								50	50							50	100
TF	500				500				1000	240		60		240	240			1040
H_2O	50				60	60			110	240								
Tylenol					25	20			20									
TOTALS									1340									1340

OUTPUT

URINE	HOUR / TOTAL	95	55/150	55/205	50/255	70/325	50/375	50/425	70/495		60/130	50/180	50/230	50/280	50/330	50/370	70/440	
	SP gr																	
	S/A																	
G-tube ~~NG~~	~~Residual OUTPUT~~	returned 1cc				returned 130cc					40cc				40cc			
	PH																	
	GUIAC																	
EMESIS																		
STOOL							Lg. qt				X1							
DRAINS																		
TOTALS																		

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23
	122/61	117/57	115/53	118/60	122/60	119/57	113/53	116/57
		100.0		100.8 (A)		99.7 (A)		
	107	104	104	103	103	109	102	101
	22	14	24	18	25	24	21	22
	99	100	100	100	100	100	99	99
	31%	31%	31%	31%	31%	31%	31%	31%
	TC	TC	TC	TC	TC	TC	TC	TC

INTAKE	16	17	18	19	20	21	22	23	8°T
	25	25	25	25	25	25	25	25	200
	100		100				100		300
	300		100		420				720
					30				30
									1280

OUTPUT									
	50/440	40/530	50/580	40/620	40/660	60/720	60/780	60/840	840
	30cc				420cc				
				Lg. XT					

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA	TIME								
	MODE								
	F_IO_2								
	TV								
	RATE								
	PEEP								
A	pH								
	PCO_2								
B	pO_2								
	HCO_3								
G	SAT								
	BASE								

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

ACTIVITIES DAILY LIVING	TIME			
	MOUTH CARE	refused		
	BATH	KH 1900		
	SKIN CARE	KH 1900		
	FOLEY CARE	KH 1900		
	TRACH CARE	KH 1930		
	ROM EXERCISES	KH 1900		
	Linen Δ	KH 1900		

TURN	TIME			
	supine 2400	@side 2100		
	@side 0200	@side 2300		
	@side 0400			
	supine 1900			
SUCTION				

24 HR TOTALS	NURSE SIGNATURE	INITIALS
WT Yesterday ____ wt Today ____	[redacted]	KH
INTAKE / OUTPUT	b(6).2	
IV 1050 / Urine: 1335		
G tube 2920 / Stools x4		
TOTAL 3970 / TOTAL 1335		
BALANCE +2635		

AL RECORD-SUPPLEMENTAL MEDICA[illegible]
For use of this form, [illegible] AR 40-66; the proponent agency is The Office [illegible] Surgeon General

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

b(6)-2

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

INITIAL SHIFT ASSESSMENT

	TIME	0600	INTILA[redacted]	INTILAS	1800	INTI[redacted]
NEURO	PUPLIS	RR. [illegible]			4mm PERRLA	
	SENSORIUM	Moves any			AHO, moves B/L	
		pain			UE L>R	
RESPIRATORY	RESPIRATION PATTERN	RR even at [illegible]			Regular, unlabored	
	BREATH SOUNDS	Unlabored [illegible]			CTA B/L	
	SECRETIONS	Coarse, [illegible]			clear mucous	
		TRACH #6			TC #4 shiley	
		Shiley, [illegible]			31% humidified FIO2	
		secretions			Sats 98%	
SKIN	COLOR	Skin warm			NPR - bandage to M/L abd	
	INTEGRITY	[illegible]			and 4x4 x2 to (L) LE	
		[illegible]			CDI	
IV SITE	LOCATION	(R) femoral site			(L) femoral IV, TLC	
	CONDITION	[illegible]			infusing D5½NS @	
		[illegible]			20ml/hr CDI	
		[illegible]				
GASTRO	ABDOMEN	[illegible]			Soft, nondistended	
	BOWEL SOUNDS	[illegible]			BS x 4 quads	
		[illegible]			G-tube (R) side	
GU	URINE	[illegible]			FTG	
	COLOR/CLARITY	[illegible]			med dark yellow	
		[illegible]				
CARDIOVASCULAR	CARDIACRHYTHM	[illegible]			HR in ↓100's	
		[illegible]			Q ectopy noted	
		[illegible]			S3	
		[illegible]			+2 radial	
		[illegible]			pulses	

LEGEND
Cr - Creatinine
F_IO - Fraction of inspired O_2
F_IO_2 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - PRESSURE OF ARTRIAL CO_2
PEEP - Positive end Expiratory Pressure
S/A - Fractional
SAI - Saturation
TRACH - Iracheostomy

(Continue on reverse)

PREPARED BY *(Signature & Title)*

DEPARTMENT/SERVICE/CINC ICU 3

DATE 24 Sep 03

PATIENT'S INDICATIONS *(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)*
- ☐ DIGNOSTIC STUDIES
- ☐ TRETMENT

DA FORM 1 MAY78 4700
Proponent Dept of Nurs

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

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15
BP Arterial line																
BP Cuff	124/62	117/56	122/65	123/65	115/53	123/56	119/50	126/59	114/50	122/59	120/60	116/64	114/60	111/61	122/60	128/66
Temperature			99.7				99.7		99				99.9			
Pulse	101	102	102	107	99	109	99	101	102	106	99	97	103	100	101	97
Respiratory Rate	27	22	22	26	21	19	22	23	26	29	22	23	28	25	26	27
SpO2	97	99	98	99	98	99	98	97	97	99	99	98	96	95	99	99
FiO2	31%	31%	31%	31%	31%	31%	31%	31%	31	31	31					
Mode	TC	TC	TC	TC	TC	TC	TC	TC	TC							

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
D5½NS c 20KCl	25	25	25	25	25	25	25	25	200	25	25	25	25	25	25	25	25	200
1VPB	150																	250
20									50	50	100	100						120
TF	80										120							
H2O	50																	
								50	50				50					100
PTE 10% Breakfast																		
TOTALS																		

OUTPUT

		TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
URINE		HOUR	55	50	50	44	40	30	50	44			50		90	110	50	60	670	
		TOTAL		105	155	199	309	369	419	463	250	463	10	160	250	360	420	480	450	
		SP gr																		
		S/A																		
G-tube ~~NG~~		Residual ~~OUTPUT~~	60																	
		PH																		
		GUIAC																		
EMESIS																				
STOOL					~~Lg~~ loose XT															
DRAINS										XL					XL					
TOTALS									463									480		

POST-OP DAY

AL RE
AR 40

VITAL SIGNS	14	17	18	19	20	21	22	23
	118/55	116/55	117/58	120/61	121/58	121/60	117/57	115/58
					1009			
	110	106	100	94	90	96	104	103
	27	29	28	26	24	26	29	26
	99	99	96	99	98	97	99	99
	31	31	31	31	31	31	31	31
			TC	TC	TC	TC	TC	TC

INTAKE	14	17	18	19	20	21	22	23	8°T
	25	25	25	25	25	25	25	25	200
							100		100
						500			500
					50				50
									850

OUTPUT	14	17	18	19	20	21	22	23	8°T
	115	110	120/335	160/395	80/175	90/185	70/235	80/215	715
						40			
	X7								
									715

ACUITY LEVEL CLASSIFICATION

Surgec

RESPIRATORY	TIME									
	MODE									
	F_IO_2									
	TV									
	RATE									
	PEEP									
A	pH									
	PCO_2									
B	pO_2									
	HCO_3									
	SAT									
G	BASE									

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

DAILY ACTIVITIES	TIME									
	MOUTH CARE									
	BATCH									
	SKIN CARE									
	FOLEY CARE									
	TRACH CARE									
	ROM EXERCISES									

TURN	TIME									
SUCTION		supine 0100								
		lateral 0300								
		supine 0400								

24-HR TOTALS

WT Yesterday _____ wt Today _____

INTAKE

IV 1720

Po 200

TOTAL 1920

OUTPUT

Urine: _____

TOTAL 1608

BALANCE _____

NURSE'S SIGNATURE

[redacted]

D(6)-2

ME[illegible] RECORD-SUPPLEMENTAL MEDICAL

For use of this form se[illegible]R 40-66; the proponent agency is The Office of [illegible] Surgeon General

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

662

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

INITIAL SHIFT ASSESSMENT

		TIME	0600	INTILAS	[redacted] 1900 [redacted]	INTILAS
NEURO	PUPLIS		R.L. [illegible]		3.R. PERRL	
	SENSORIUM		[illegible]		alert, response	
			[illegible]		MAE.	
			CARE.			
RESPIRATORY	RESPIRATION PATTERN		[illegible]		equal use/full	
	BREATH SOUNDS		[illegible]		LLTA (B); O#4	
	SECRETIONS		[illegible]		Shiley DLI;	
			[illegible]		[illegible] site CDI.	
			[illegible]			
			[illegible]			
SKIN	COLOR		[illegible]		NKR	
	INTEGRITY		[illegible]		ML incision covered	
			[illegible]		w dressing.	
IV SITE	LOCATION		[illegible]		(L) forearm TLC	
	CONDITION		[illegible]		CDI	
			[illegible]			
			[illegible]			
			[illegible]			
			[illegible]			
GASTRO	ABDOMEN		[illegible]		soft, + BS	
	BOWEL SOUNDS		[illegible]		x4 quds, pos	
			[illegible]		in pline - patent	
			[illegible]			
GU	URINE		[illegible]		FG, voiding	
	COLOR/CLARITY		[illegible]		yellow, clear	
			[illegible]			
CARDIOVASCULAR	CARDIACRHYTHM		[illegible]		SR & [illegible]	
			[illegible]			
			[illegible]			
			[illegible]			

LEGEND

Cr - Creatinine
F_IO - Fraction of inspired O_2
F_IO_2 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - PRESSURE OF ARTRIAL CO_2
PEEP - Positive end Expiratory Pressure
S/A - Fractional
SAI - Saturation
TRACH - Tracheostomy

b(6)-6

(Continue on reverse)

PREPARED BY *(Signature &* [redacted]

DEPARTMENT/SERVICE/CIN[illegible] [illegible]

DATE 25 Sep 05

PATIENT'S INDICATIONS *(Fo[illegible] give: Name — Last, First, middle; grade; date; hospital [illegible] Facility)*

EPW [redacted]

b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

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

☐ DIGNOSTIC STUDIES

☐ TRETMENT

DA FORM 1 MAY78 4700
Proponent Dept of Nurs

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

[redacted] b(6)-4

DATE 9-25-03 DX Ash [redacted] chest HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial line	131	135	131	132	129	135	108	129		141	130	128	133	131	128	102	129	
BP Cuff	57	60	60	66	65	62	61	71		71	68	64	65	65	69	65	60	
Temperature	100°						99				99°					99°		
Pulse	103	94	94	97	94	97	97	94		101	95	98	92	91	94	99	94	
Respiratory Rate	27	21	24	23	22	23	28	12		28	20	26	27	26	27	29	20	
FIO	31%	31	31	31	31	28	28	28		28	28	28	26	28	28	28	28	
SPO2	100	100	99	99	98	96	100	10		100	97	95	96	97	97	99	99	
Mode	TC	TC	TC	TC	TC	TC	TC	TC		TC	TC	TC	TC	TC				

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
D5½NS 20	25	25	25	25	25	25	25	25	200	25	25	25	25	25	25	25	25	200
KCL										10	20	10						30
IVPB	200																	
TF																		
P.O.	—		—				120		120	120				120				240
Med 30%	B																	
Lunch 60%	L																	
Dinner																		
TOTALS								250										470

OUTPUT

	HOUR / TOTAL	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
URINE		120	100	40	40	140	110	80	100		110	90	110	100	90	90	100	120	
			70	260	420	560	670	750	850	850			180	280	370	460	660	480	780
	SP gr																		
	S/A																		
NG	OUTPUT																		
	PH																		
	GUIAC																		
EMESIS																			
STOOL							x1		X1			X1							
DRAINS																			
TOTALS								120										780	

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS	16	17	18	19	20	21	22	23	
	137/61	136/64	134/60		127/60		127/64		
	86	96	86		88		102		
	22	25	21		21		23		
	28	28	28		28		28		
	99	99	99		99		96		
	TC	TC	TC		TC		TC		

INTAKE	16	17	18	19	20	21	22	23	8°T
	25	25	25	25	25	25	25	25	200
	150							100	
	50							50	350

OUTPUT									
	120	200	100		150		200		550
		300	410		150		350		850

RESPIRATORY	TIME									
	MODE									
	F_IO_2									
	TV									
	RATE									
	PEEP									
ABG	A: pH									
	A: PCO_2									
	B: pO_2									
	B: HCO_3									
	G: SAT									
	G: BASE									

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

DAILY ACTIVITIES	TIME									
	MOUTH CARE									
	BATCH									
	SKIN CARE									
	FOLEY CARE									
	TRACH CARE									
	ROM EXERCISES									

TURN / SUCTION	TIME									

24-180 TOTALS

NURSE'S SIGNATURE | INITIALS

WT Yesterday _____ wt Today _____

[redacted]

INTAKE

IV 1450

Po

TOTAL 1450

OUTPUT

Urine: _____

TOTAL 2580

BALANCE _____

D(6)-2

850
1730
2580

For use of this DICAL RECORD-SUPPLEMENTAL MEDI ATA
ce, AR 40-66; the proponent agency is The Offic he Surgeon General

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8Mar 89

b(6)-c

INITIAL SUBSEQUENT ASSESSMENT

NEURO	TIME	0700	INTIL[redacted]	b(6)-2	INTILAS	1400	INTIL[redacted]	
	PUPLIS	PERRLA @ 3mm				Perrla @ 3mm		
	SENSORIUM	Alert & oriented				Alert & interacts appropriately c̄ nurses & therapy i c		
RESPIRATORY	RESPIRATION PATTERN	Even				normal on TC @ 24% 6FD		
	BREATH SOUNDS	Lungs CTA				Course (B)		
	SECRETIONS	Secretions from trach, trach collar CPAP				Lg amt via Trach strong cough clear yellow/thin secr.		
SKIN	COLOR	NFR				NFR		
	INTEGRITY	midline abd dressing bleeding to (L) leg				midline ABD dressing		
IV SITE	LOCATION	D femoral				(L) femoral TLC		
	CONDITION	triple lumen intact to site of leaking at dwelling to ale.				all ports patent dressing c lb, t		
GASTRO	ABDOMEN	soft, non tender				soft non distended		
	BOWEL SOUNDS	BS x 4				BS present x 4 quads		
GU	URINE	Foley to gravity				Foley to gravity		
	COLOR/CLARITY	clear yellow urine				clear yellow adequate amt		
CARDIOVASCULAR	CARDIACRHYTHM	NSR S1 & S2 noted.				NSR — see tele Peripheral pulses palpable x 4		

LEGEND
Cr - Creatinine
F_IO - Fraction of inspired O_2
F_IO_2 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - PRESSURE OF ARTRIAL CO_2
PEEP - Positive end Expiratory Pressure
S/A - Fractional
SAI - Saturation
TRACH - Tracheostomy

b(6)-2

(Continue on reverse)

PREPAR[redacted] RN

DEPARTMENT/SERVICE ICU

DATE 26 SEPT 03

PATIENT [redacted] (If typed or written entries give: Name—Last, First, middle; grade; date; hospital or medical facility)

EPIC #[redacted]

b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)
☐ DIGNOSTIC STUDIES
☐ TRETMENT

DA FORM 1 MAY78 4700
Proponent Dept of Nurs

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

DATE 26 Sept | DX | HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07		08	09		11	12	13	14	15	
~~BP Arterial line~~	138/66		114/61		124/40		125/71	120/64										
BP Cuff										125/77	124/68	130/67	130/69	120/60	128/77	122/63	132/64	
Temperature										98.4						98.6		
Pulse	87		89		91		97	94		83	88	92	95	85	116	89	100	
Respiratory Rate	24		22		23		22	23		20	22	22	23	23	24	24	26	
SaO2	100		100		97		97	97		97	97	99	98	99	98	96	98	
FiO2	28		28		28		28	28		28	28	28	28	28	28	28	28	
Mode	TC		TC		TC		TC	TC		TC	TC	TC	TC	TC	TC	TC	TC	

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
D5 1/2 + 20K	25	25	25	25	25	25	25	25	200	25	25	25	25	25	25	25	25	200
IVPB	100/50								150		100	100						200
IVPB											50							50
IVPB											50							50
Tube Feeding											500					500		1000
								350										1500
TOTALS									350									

OUTPUT

		24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
URINE	HOUR	200		300		200		70	70	80		60	110		120		300		
	TOTAL	200		500		700		770	840	840		60	170		120		300		490
	SP gr																		
	S/A																		
NG	OUTPUT																		
	PH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS																			

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS	14	17	18	19	20	21	22	23
	131/70							
		116/60	128/64	125/66	131/71	131/69	136/75	135/75
	166	84	99	96	93	97	101	93
	31	23	25	21	21	20	21	21
	99	97	98	100	98	99	98	98
	28	28	19	29	29	28	28	21
	TC	TC	TC	TC	TC	TC	TC	TC

INTAKE	14	17	18	19	20	21	22	23	8°T
I	25	25	25	25	25	25	25	25	200
IPB	100						100		200
N	80					500			1000
TF	50					30			80
H2O									1480
T									
A									
K									
E									

24 hr Intake 3330

OUTPUT									
	300	36	120	100	70	60	45	45	676
									↓
RES						20			20
									696
BM					X1				
P									
U									
T									

24 hr output 1994

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

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

ACTIVITIES DAILY LIVING	TIME									
	MOUTH CARE									
	BATCH									
	SKIN CARE									
	FOLEY CARE									
	TRACH CARE									
	ROM EXERCISES									

TURN / SUCTION	TIME									

24 hr TOTALS

WT Yesterday _____ wt Today _____

INTAKE

IV _____

Po _____

TOTAL _____

OUTPUT

Urine: _____

_____

TOTAL _____

BALANCE _____

[redacted]

b(6)-2

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

b(6)-2

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

INITIAL SHIFT ASSESSMENT

NEURO	TIME	0600	INTILAS [redacted]		INTILAS	2000	INTI [redacted]
	PUPLIS	[illegible]				Perrla @ 3mm	
	SENSORIUM	[illegible]				Alert + Interacts	
		[illegible]				appropriately c nurse	
						follow all commands	
						Paraplegic	
RESPIRATORY	RESPIRATION PATTERN	[illegible]				normal on RA	
	BREATH SOUNDS	[illegible]				O2 sats > 95%	
	SECRETIONS	[illegible]				Trach d/c'd	
		[illegible]				strong cough	
		[illegible]				expectorates sputum	
						on his own	
SKIN	COLOR	[illegible]				NFR	
	INTEGRITY					midline abd c̄ wet	
						dry. healing well	
IV SITE	LOCATION	[illegible]				(L) femoral TLC	
	CONDITION	[illegible]				all ports patent	
		[illegible]				Dressing CIPT	
GASTRO	ABDOMEN	[illegible]				Soft non distended	
	BOWEL SOUNDS	[illegible]				Presently 4 quads.	
		[illegible]				BM last night / liquid	
		[illegible]				soft	
GU	URINE	[illegible]				Clear yellow urine	
	COLOR/CLARITY	[illegible]				Foley	
						indwelling cath	
CARDIOVASCULAR	CARDIACRHYTHM	[illegible]				NSR - Ectopy	
		[illegible]					
		[illegible]					

LEGEND

Cr - Creatinine
F_IO - Fraction of inspired O_2
F_IO_2 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - PRESSURE OF ARTRIAL CO_2
PEEP - Positive end Expiratory Pressure
S/A - Fractional
SAI - Saturation
TRACH - Iracheostomy

(Continue on reverse)

b(6)-2

[redacted] CPT IAN

DEPARTMENT/SERVICE/CINC ICU3

DATE 27 Sep 03

Initials, signature (if typed or written entries give: Name — Last, First, middle; grade; date; hospital or mailing address

EPW [redacted]

b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

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

☐ DIGNOSTIC STUDIES

☐ TRETMENT

DA FORM 1 MAY78 4700
Proponent Dept of Nurs

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

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial line																		
BP Cuff	85/75	130/69	135/75	136/73	135/71	128	124/72	128/71		127/72	131/70	120/67	140/74	136/73	129/71	132/75	136/61	
Temperature	99.1				98.6					99.9					98.1			
Pulse	92	96	94	98	92	86	81	78		72	98	92	87	92	86	88	84	
Respiratory Rate	20	23	20	22	20	20	18	18		19	19	20	25	20	24	21	24	
FIO2	24	24	24	24	24	24	24	24		24	24	24	24	24	24	24	24	
mode	TC	TC	TC	TC	TC	TC	TC	TC		TC	TC							
O2 sats	94	98	98	98	100	100	10	10		100	100	98	100	100	100			

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
IVF	25	25	25	25	25	25	25	25	200	25	25	25	25	25	25	25	25	200
IVPB	200								200	100/50		100						250
TF										500						500		1000
Breakfast										0								
Lunch														240				240
Dinner								500										690
TOTALS																		

OUTPUT

URINE	HOUR	55	50	65	60	80	50	30		40	0	90	100	120	70	100	70	640
	TOTAL		105	170	230	310	360	390	490		130	240	340	460	530	630	640	740
	SP gr																	
	S/A																	
NG	OUTPUT																	
	PH																	
	GUIAC																	
EMESIS																		
STOOL			X1															
DRAINS												X1						
TOTALS									490									740

POST-OP DAY

VITAL SIGNS	14	17	18	19	20	21	22		
	137/70	171/71	126/69	136/71	138/70	135/69	132/60		
					99.				
	84	85	88	82	82	109	94		
	27	26	25	27	27	27	22		
	[illegible]	[illegible]	[illegible]	[illegible]	98	98	99		
	[illegible]	[illegible]	[illegible]	—	—	—	—		
				RA	RA	RA	RA		

ACUITY LEVEL CLASSIFICATION

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

INTAKE	14	17	18	19	20	21	22	23	8°T
	25	25	25	25	25	25	25	25	200
							100		100
					500				500
									800

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

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

TURN / SUCTION	TIME					

OUTPUT	14	17	18	19	20	21	22	23	8°T
	90	110/300	120/300	150/475	150/600	210/600	220	240	1180
					60				60
									240

24° 180 TOTALS

WT Yesterday ______ wt Today ______

INTAKE: IV ______ Po ______ TOTAL ______

OUTPUT: Urine: ______ ______ TOTAL ______

BALANCE ______

NURSE'S SIGNATURE | INITIALS

[redacted]

b/6-2

°Intake 2890 24° Output 2470 (+) 420

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

b (6)-2

OTSG APPROVED (Date) QA Appr 8Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0015	INITIALS [redacted]	1830	INITIALS [redacted]		INITIALS
NEURO	PUPILS	3mm reactive.		3mm Perrl, brisk. Alert			
	SENSORIUM	Alert follows commands.		follows commands.			
		paraplegic.		Moves BUE L>R			
				Paraplegic.			
RESPIRATORY	RESPIRATION PATTERN	Normal pattern ∅		Regular, even, unlabored.			
	BREATH SOUNDS	resp. distress. @ RA		RA sats > 98%. CTA			
	SECRETIONS	SO2 > 95%. + Cough		all lung fields. ↓ in			
				RLL. Old trach site			
				dressed c̄ gauze.			
SKIN	COLOR	NFR		NFR. Mid abd incision c̄			
	INTEGRITY	midline abd wound		dressing. OLE c̄ dressing.			
		dry dressing. CDI		old trach site.			
IV SITE	LOCATION	(L) femoral CL TLC		(L) femoral TLC. Dwng			
	CONDITION	dressing CDI.		CDI. Infusing D5½NS			
				& 20 KCl @ 25cc.			
GASTRO	ABDOMEN	Soft non tender		Soft. Tender all quadrants			
	BOWEL SOUNDS	normal active BS		Absent. G-tube to @ all			
		x4.		dangerous feeding			
GU	URINE	foley		Foley to BD Clear			
	COLOR/CLARITY	adequate clear		yellow urine - light			
		yellow urine.					
CARDIOVASCULAR	CARDIACRHYTHM	NSR ∅ ectopy. capillary		SR ∅ ectopy. Cap refill			
		refill < 3sec, to peripheral		< 3sec. Radial/Pedal			
		pulses x4.		pulses 3+.			

LEGEND

Cr - Creatinine
F_IO - Fraction of inspired O_2
F_IO_2 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - PRESSURE OF ARTRIAL CO_2
PEEP - Positive end Expiratory Pressure
S/A - Fractional
SAI - Saturation
TRACH - Tracheostomy

(Continue on reverse)

b(6)-2 [redacted] (Title) [redacted] CPT/AN | DEPARTMENT/SERVICE/CINC ICU3 | DATE 28 Sep 03

middle; grade; date; hospital or medical facility. Entries give: Name—Last, First,

EPW [redacted]

b(6)-1

- ☐ HISTORY/PHYSICAL
- ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER (Specify)
- ☐ DIGNOSTIC STUDIES
- ☐ TRETMENT

DA FORM 1 MAY78 4700
Proponent Dept of Nurs

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

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02		04	05	06	07		08	09		11	12	13	14	15	
BP Arterial line																		
BP Cuff			135/70	137/75			137/75			126/77				139/78				
Temperature			98.1				98			82	97.1			97.9				
Pulse			84	80			80			82				80				
Respiratory Rate			28	24			24			26				24				
O2 sats			99	100			100			100				99				
mode			RA	RA			RA			RA				RA				

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
IVF	25	25	25	25	25	25	25	25	200	25	25	25	25	25	25	25	25	200
IVPB	200								200	200		100						300
TF										500					500			1000

TOTALS

OUTPUT

			24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
URINE	HOUR			90	70	40	30	100	100		275		140	130	275	50	110	130	85	
	TOTAL			165	235	305	335	435	535	100	375	115	255	385	660	710	820	950	1035	1035
	SP gr				25	3							2	3	6					
	S/A																			
NG	OUTPUT																			
	PH																			
	GUIAC																			
EMESIS																				
STOOL																				
DRAINS																				
TOTALS																				

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS	16	17	18	19	20	21	22	23
	141/74	145/74	136/71	136/71	141/77	142/77	132/66	128/73
	98.8				99.0 (R)			
	97	80	89	81	78	82	82	100
	25	28	23	22	21	23	22	24
	100%	99	99	99	99	99	100	98
	RA	RA	RA	RA	RA	RA	RA	RA

INTAKE	14	17	18	19	20	21	22	23	8°T
	25	25	25	25	25	25	25	25	
	250								

OUTPUT									
	130	250/390	300/690	310/1000	300/1300	130/1430	110/1540	115/1655	1655

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

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

ACTIVITIES OF DAILY LIVING	TIME				TURN	TIME			
	MOUTH CARE								
	BATCH								
	SKIN CARE								
	FOLEY CARE								
	TRACH CARE Site	KH 2140			SUCTION				
	ROM EXERCISES								

24 180 TOTALS

WT Yesterday _____ wt Today _____

INTAKE

IV _____

Po _____

TOTAL _____

OUTPUT

Urine: _____

TOTAL _____

BALANCE _____

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

For use of this DICAL RECORD-SUPPLEMENTAL MEDI ATA
ee, AR 40-66; the proponent agency is The Offic. The Surgeon General

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

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

INITIAL S SESSMENT

	TIME		INTIL	b(6)-2	INTILAS		INTILAS
NEURO	PUPLIS	PERRLA (2mm)					
	SENSORIUM	Alert & oriented					
RESPIRATORY	RESPIRATION PATTERN	Even, unlabored					
	BREATH SOUNDS	BS CTA					
	SECRETIONS	Cough & lg secretions					
SKIN	COLOR	NPL					
	INTEGRITY	Dressing to abdomen					
		(L) leg					
IV SITE	LOCATION	Right lower to					
	CONDITION	(L) Jugular					
		Signs of redness					
		& swelling					
GASTRO	ABDOMEN	soft, nontender					
	BOWEL SOUNDS	BS x4					
		Abd dressing					
		midline, clean					
GU	URINE	Foley to gravity					
	COLOR/CLARITY	Yellow					
		urine					
CARDIOVASCULAR	CARDIACRHYTHM	SR, S&S					
		normal, no S/S					

LEGEND

Cr - Creatinine
F_iO - Fraction of inspired O_2
F_iO_2 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - PRESSURE OF ARTRIAL CO_2
PEEP - Positive end Expiratory Pressure
S/A - Fractional
SAI - Saturation
TRACH - Iracheostomy

b(6)-2 [redacted]

(Continue on reverse)

[redacted] title) LPN | DEPARTMENT/SERVICE/CINC MW#3 | DATE 29 Sep 08

[redacted] *ped or written entries give: Name—Last, First, r medical facility)*

EPW #[redacted] b(6)-4

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

DA FORM 1 MAY78 4700
Proponent Dept of Nurs

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

DATE 29Sep03 | DX GSW to [illegible]est | HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial line																		
BP Cuff	139/69	141/71	135/74	139/77	130/74	133/73	148/78	141/77		141/67	134/64	139/85						
Temperature																		
Pulse	86	92	83	83	81	81	83	81		96	93	97						
Respiratory Rate	21	20	20	23	20	19	18	19		21	23	26						
SpO2	98	98	99	100	100	100	99	100		100	100	100						
mode	RA	RA	RA	RA	RA	RA	RA	RA		RA	RA	RA						

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
MIVF	25	25	25	25	25	25	25	25		25	26							
IVPB	450										100							
IVP			10															
Zantac											50							
Flagyl											500							
Tube Feed											500							
TOTALS																		

OUTPUT

		TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
URINE		HOUR / TOTAL	150/150	120/270	100/370	80/450	50/500	110/610	50/660	40/700		80		25						
		SP gr																		
		S/A																		
NG		OUTPUT																		
		PH																		
		GUIAC																		
EMESIS																				
STOOL																				
DRAINS																				
TOTALS																				

POST-OP DAY

DI

ACUITY LEVEL CLASSIFICATION

AT

VITAL SIGNS	14	17	18	19	20	21	22	23	

INTAKE	14	17	18	19	20	21	22	23	8°T

OUTPUT									

RESPIRATORY	TIME									
	MODE									
	F_IO_2									
	TV									
	RATE									
	PEEP									
ABG	A: pH									
	B: PCO_2									
	B: pO_2									
	B: HCO_3									
	G: SAT									
	G: BASE									

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

DAILY ACTIVITIES	TIME				TURN	TIME				
	MOUTH CARE									
	BATCH									
	SKIN CARE									
	FOLEY CARE				SUCTION					
	TRACH CARE									
	ROM EXERCISES									

24-180 TOTALS

NURSE'S SIGNATURE

INITIALS

WT Yesterday _____ wt Today [redacted]

INTAKE OUTPU[redacted]

IV _____ Urine: _____

Po _____ _____

TOTAL _____ TOTAL _____

BALANCE _____

b(6) 2

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: 4 OCT
Time In: 1005
Allergies: NKDA
Pre-op V/S: 114/62 P-92
Procedures: Sturshaft, abd closure, Removal G-tubes

Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 700 Colloid
OR Output: UOP 600 EBL
Meds/Times: Fentanyl, MSO4

Drains	Airway
Hemovac	Nasal
NG	Oral
JP	ETT
T-tube	Trach
Foley	Other
TLS	

Pre Op Meds History

Time	1005	1010	1015	1020	1025
SaO2	98	98	98	97	98
FiO2					
Methods	RA	RA	RA	RA	RA
240					
220					
200					
180					
160					
140					
120					
100					
80					
60					
40					
20					
RR	17	17	17	19	21
T	96		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
1005	NS	300	D hand	OR	700

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	1	1
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse			
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	8	9	9

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

b(6)-2 [redacted] LPN

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 4 OCT 03

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

EPW # [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

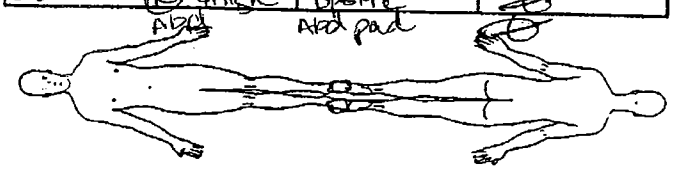
C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(L) lower leg thigh	Kerlix opside	∅
30'	Abd.	Abd pad	∅
60'			
D/C	(L) lower leg thigh	Kerlix opsite	∅

Abd Abd pad



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1005	SR	∅	∅

WAMC OP 173-E

NURSING NOTES

Pt to recovery room from OR via litter s/p skin graft, Abd wound closure and G-tube removal. IV of NS infusing into (L) hand ∅ S/S of redness OR swelling to site. Kerlix to lower (L) leg intact. Opsite to (L) thigh intact. Abd pad Also intact, ∅ drainage noted. VSS. ∅ c/o @ this time [redacted] Pt to ICU #1 via litter [redacted]

b(6)-2

Discharge Criteria:
Date: 4/07 **Time:** 1100 **PARS:** 9
BP: 119/57 **T:** 96.3 **HR:** 78 **RR:** 19 **Sa02:** 97-RA
Pain Level at D/C (0-10):
Intake: 100 **Output:** ∅
Additional Data:
Transferred To: ICU #1
Report Given To: [redacted]
Transferred Via: W/C [redacted] Ambulance
Transferred By: [redacted]
Cleared IAW Recov [redacted]
Charge Nurse Sign [redacted]

b(6)-2

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET b(6)-2

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

INITIAL SHIFT ASSESSMENT

NEURO	TIME	28OCT03	IN [redacted]	28 OCT 1900 INTILAS [redacted]	INTILAS
	PUPLIS	2mm Round equal		O2 [illegible] equal	
	SENSORIUM	Alert-Disorientation		reaction to light,	
		opens eyes spon-		alert, lucid	
				barrier, responds to	
				simple commands	
RESPIRATORY	RESPIRATION PATTERN	CTA(B) ∅ Cough		CTA, ⊖ cough	
	BREATH SOUNDS	at Resp distress		⊖ secretions, RRR	
	SECRETIONS			⊖ rales & full of	
				the chest	
SKIN	COLOR	Stage IV bruch		Normal for race	
	INTEGRITY	decubitus		Stage ~~two~~ IV decub	
		turn q 2°		to coccyx	
IV SITE	LOCATION	Neck IV Dac			
	CONDITION				
GASTRO	ABDOMEN	Gentle to touch		⊕ BS x4, loose	
	BOWEL SOUNDS	(+) diarrhea		stools, mid ABD	
		Mid abd sutures		sutures, ⊖ tenderness	
		⊕ BS			
GU	URINE	Yellow urine		Foley to gravity	
	COLOR/CLARITY	Foley bag		amb. Clear	
				urine	
CARDIOVASCULAR	CARDIACRHYTHM	NSR -		NSR, ⊕ 2 pitting	
		pedpy		edema to (B) LE &	
		2+ edema (B) LE		⊕ 2 pulses, cap refill	
				<3 secs.	

LEGEND

Cr - Creatinine
F_IO - Fraction of inspired O_2
F_IO_2 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - PRESSURE OF ARTRIAL CO_2
PEEP - Positive end Expiratory Pressure
S/A - Fractional
SAI - Saturation
TRACH - Iracheostomy

(Continue on reverse)

PREPARED BY *(Signature & Title)*

DEPARTMENT/SERVICE/CINC

DATE

PATIENT'S INDICATIONS *(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)*
☐ DIGNOSTIC STUDIES
☐ TRETMENT

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8Mar 89

INITIAL SHIFT ASSESSMENT

NEURO	TIME	2010 29 OCT	INTILAS [redacted]	b(6)-2	INTILAS		INTILAS
	PUPLIS	3MM BRISK					
	SENSORIUM	EASILY AROUSED C					
		DROWSINESS S/P					
		COLOSTOMY					
RESPIRATORY	RESPIRATION PATTERN	NORMAL UNLABORED					
	BREATH SOUNDS	CTA C EXPIRATORY					
	SECRETIONS	~~RATTLES~~ WHEEZES					
		Ø SECRETIONS					
		BPM 16 SaO2 100					
		NC					
SKIN	COLOR	NFR					
	INTEGRITY	HIDLINE SUTURES DC'D					
		SACRAL ULCER STAGE IV					
IV SITE	LOCATION	RAC 20G					
	CONDITION	INTACT Ø S/S OF					
		INFECTION					
GASTRO	ABDOMEN	SOFT ROUND TENDER					
	BOWEL SOUNDS	BS ↓					
		COLOSTOMY IN PLACE					
		C Ø MOST BLOODY DRAINAGE					
GU	URINE	FRC C AMBER URINE					
	COLOR/CLARITY	CLEAR Ø SEDIMENT					
CARDIOVASCULAR	CARDIACRHYTHM	NSR-ST 90-100S					
		S1 S2 + PULSES BUE					
		2+ BUE 2+ PT C					
		2+ EDEMA TO BUE					

LEGEND
Cr - Creatinine
F_IO - Fraction of inspired O_2
F_IO_2 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - PRESSURE OF ARTRIAL CO_2
PEEP - Positive end Expiratory Pressure
S/A - Fractional
SAI - Saturation
TRACH - Tracheostomy

(Continue on reverse)

[redacted] b(6)-2 | DEPARTMENT/SERVICE/CINC ICU 2 | DATE 29 OCT 03

[redacted] r typed or written entries give: Name - Last, First, [redacted] tal or medical facility)

[redacted]

b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)
☐ DIGNOSTIC STUDIES
☐ TRETMENT

DATE | DX S/P colostomy | HOSPITAL DAY

VITAL SIGNS	TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
	~~BP Arterial line~~					108/53		104/50								99/57			
	BP Cuff																		
	Temperature								98.9							99°			
	Pulse					93		92								88			
	Respiratory Rate					19		12								16			
	SaO2					98		97								100			
	FiO2					RA		RA								RA			
	Source																		

INTAKE	TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	LR	75	75	75	75	75	75	75	75		75	75	75	75	75	75	75	75	
	IVPB										100								
	PO								240			240		100		100			
	Meds								20%			snack		-	50%				
		75	75	75	75	75	75	75	75		75	75	75	75	75	75	75	75	
									1000		1175	850	925	1000	1075	1150		1300	1480
	TOTALS								1000										

OUTPUT		HOUR / TOTAL	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	URINE						80 / 1910			200		100	100	200	100	200	200	200	200	1460
		SP gr																		
		S/A																		
	NG	OUTPUT																		
		PH																		
		GUIAC																		
	EMESIS																			
	STOOL																			
	DRAINS	Colostomy								30										
										1130										1460
	TOTALS																			

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23	06
							114/52	110/59	
			117/55				100 2	99 5	
			93				94	98	
			32				24	26	
			100				100	99	
			RA				RA	RA	

INTAKE	16	17	18	19	20	21	22	23	8T
	75	75	75	75	75	75	75	75	75
	100								
	240		260						
	STOCK								

OUTPUT	16	17	18	19	20	21	22	23	8T
	200 1000		200				600	300	900
	Colostomy								25

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA	TIME									
	MODE									
	F_IO_2									
	TV									
	RATE									
	PEEP									
	A: pH									
	A: PCO_2									
	B: pO_2									
	B: HCO_3									
	G: SAT									
	G: BASE									

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

DAILY LIVING ACTIVITIES	TIME	0800			TURN	TIME				
	MOUTH CARE	✓								
	BATCH									
	SKIN CARE	✓								
	FOLEY CARE	✓			SUCTION					
	TRACH CARE									
	ROM EXERCISES	✓								

24°180 TOTALS

WT Yesterday _____ wt Today _____

INTAKE

IV _____

Po _____

TOTAL _____

OUTPUT

Urine: _____

TOTAL _____

BALANCE _____

NURSE'S SIGNATURE	INITIALS
[redacted]	
b(4) 2	

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8Mar 89

INITIAL SHIFT ASSESSMENT

	TIME		INTILAS	1830	INT[redacted]		INTILAS
NEURO	PUPLIS			Sluggish reactive			
	SENSORIUM			A+O			
RESPIRATORY	RESPIRATION PATTERN			RRR equal rise & fall			
	BREATH SOUNDS			lungs CTA Bilat			
	SECRETIONS			Ø secretions			
SKIN	COLOR			Normal for race			
	INTEGRITY			Stage IV Pressure ulcer to coccix			
				Stage I Pressure ulcer to back of head			
IV SITE	LOCATION			RG @ wrist C/D/I			
	CONDITION			Ø S+S of infx			
GASTRO	ABDOMEN			soft NT/ND			
	BOWEL SOUNDS			Colostomy to R Flank			
				Ø S+S of infx C/D/I			
GU	URINE			Foley to gravity			
	COLOR/CLARITY			clear yellow urine			
CARDIOVASCULAR	CARDIACRHYTHM			NSR Ø ectopy			
				Ø S1 S2 Ø murmer			

LEGEND

Cr - Creatinine
F_IO - Fraction of inspired O_2
F_IO_2 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - PRESSURE OF ARTRIAL CO_2
PEEP - Positive end Expiratory Pressure
S/A - Fractional
SAI - Saturation
TRACH - Iracheostomy

(Continue on reverse)

[redacted] b(6)-2

DEPARTMENT/SERVICE/CINC FCU 2

DATE 31 OCT 03

P[redacted] written entries give: Name Last, First, mi[redacted] edical facility)

[redacted]

b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIGNOSTIC STUDIES

☐ TRETMENT

DATE	DX													HOSPITAL DAY				
			VS	VS			VS				VS							
VITAL SIGNS TIME	24	08	09	00	04	05	06	07	15	08	09	10	11	20	13	14	15	
BP Arterial line			116/68								110/61	109/58		101/54				
BP Cuff																		
Temperature			98.6															
Pulse			81								64	72		99				
Respiratory Rate			17								12	14		16				
SpO^2	97	97	97	97	98	96	98	96	95	94	97	95		98				
FiO^2	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA		RA				

INTAKE TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
LR	75	75	75	75	75	75	75	75	75	75	75	75	75	75				
IVPB																		
PO	25	/	/	25	5	/	50	/	/	/	/	/	/	/				
TOTALS																		

OUTPUT		HOUR / TOTAL	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	
URINE			100/100	75/175	100/275	100/375	100/475	100/575	100/675	125/775	75/850	100/950	50/1000	100/1100		190/1290				
		SP gr																		
		S/A																		
NG		OUTPUT																		
		PH																		
		GUIAC																		
EMESIS																				
STOOL																				
DRAINS		Colostomy	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø				
TOTALS																				

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION (State or Country Code.)	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
A 1 1 0 1	7 2	9 10 11 12 13 14 15 [redacted]	b(6)-4 UNK EPW, # [redacted]	16 17	18 M

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
19 20 21 22 23 24 25 26: 19750101	27 28 29: 28y	30	31: 9	UNK

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34	NA	35 36: ~~99~~ 20	b(6)-4 37 38 39 40 41 42 43 44 45 [redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
NA	46: Z	1800	NA

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
47 48 49: N	50 51 52: K 7 8	53 54 55 56 57 58 59 60 61

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION
62 63: I 2	64 65 66 67 68 69 70	71	YEAR ☑ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72: O	Ian3	UNK
NAME AND [redacted]	b(2)-2	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): UNK
		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE: UNK

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
73 74: 2 4	75 76 77 78 79 80	81 82 83 84 85 86: 0 3 1 0 0 5

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y M M D D)
87 88 89 90: A B A A	91 92 93 94 95 96	97 98 99 100 101 102: 0 3 0 8 2 9

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y M M D D)
103 104	105 106 107 108 109 110	111 112 113 114 115 116: 0 3 0 8 2 9

FOR LOCAL USE

GSW TO CHEST

Dx: 80414 8751 89912 3441 7070 86441

Dx: 9411 8622 9659

ADMITTING OFFICER (Signature, as required)	SIGNATURE OF ADMITTING CLERK
Dr [redacted]	

DA FORM 3985 MAR 89

b(6)-2

INPATIENT TREATMENT RECORD COVER SHEET

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

b(6)-4

b(6)-4

1. REGISTER NUMBER [redacted]			2. NAME (Last, First, MI) EPW # [redacted]			3. GRADE EPW	ADMISSION REMARKS
4. SEX M	5. AGE 25	6. RACE UNK	7. RELIGION UNK	8. LENGTH OF SVC —	9. [illegible] —	10. PREVIOUS ADMISSION N	
11. FMP b(6)-499		12. SSN [redacted]		13. ORGANIZATION —		14. WARD ICU	
15. FLYING STATUS —	16. RATING/ DSG —	17. DEPENDENT 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 1545	23. CLINIC SERVICE		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE UNK				25. TYPE DISPOSITION 50	26. DATE OF DISPOSITION 07 Sep 03		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) UNK				27b. TELEPHONE NO. UNK	28. DATE OF THIS ADMISSION 02 SEP 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 [redacted]

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

GSW (L) hip, jaw

802.5
802.31
873.64V
873.41
873.63V
873.43
883.0
890.0
V55.0
V55.1
E991.2

9/6/03 30.29
54.12
43.19
86.28
25.51
76.76
76.73
27.52

9/4/03 31.1

35. Total Days This Facility

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

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
[redacted]		b(6)-2	[redacted]		

SIGNATURE OF [redacted] SIGNATURE OF [redacted]

MEDCOM - 18387

DA FORM [redacted]

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

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

25 YO MALE WOUNDED IN FACE, FLANK & RIGHT THUMB. PATIENT UNDERWENT EMERGENT CRICOTHYROIDOTOMY. LIMITED HISTORY OBTAINED.

PMH: Renal LITHIASIS

PSH: OPEN EXTRACTION OF B/L STONES

MEDS: Ø ALL: Ø

PHYSICAL EXAMINATION

VS: AL TOO BP 120/76 RR 30 O2 SAT 98% GCS 15

H: NC FACIAL MASSIVE TRAUMA TO MAXILLA/MANDIBLE & IMPENDING LOSS OF AIRWAY

E: DONE

E: NOT EXAMINED

N: PERSISTENT

T: OBSCURED BY BLOOD - BLEEDING TO TONGUE

NECK: NT

LUNGS: CTA

CARD: RRR

ABD: SOFT, NT NBS PAST

PELVIS: STABLE LARGE LEFT FLANK WOUND - OUTER TABLE FX

NEURO: OBEYING

PROGRESS (Enter date of discharge and final diagnosis)

BP: PATIENT EMERGENTLY INTUBATED & CRICOTHYROIDOTOMY THE OR-LAP, G-TUBE WASH-OUT FLANK + THUMB & I+D FACE & SOME REPAIR

[redacted] b(6)-2

SIGNAT[redacted]	DATE	IDENTIFICATION NO.	ORGANIZATION
	25 SEP 03		

PAT[redacted] (For typed or written entries give Name (last, first, middle; grade; date; hospital or medical facility)

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

539-106 [redacted]

MEDICAL RECORD	PROGRESS NOTES
DATE	

OMFS Brief OP NOTE

2 Sep 03 @ 1640 Pre op dx: GSW to face, tongue wound
Comminuted maxillary & mandibular fracture
Post op dx: Same
Procedure: I & D
closure of tongue wound
Wire osteosynthesis of mandible
closure of soft tissue wounds
Surgeon: [redacted] b6-2
Assist: [redacted], [redacted]
Anesth: Cricothyroidotomy
EBL: 500 cc
U/O: 3900 cc
fluids: 10 PRBC,
findings: - multiple fragments maxilla
c̄ anterior maxilla defect.
- comminuted mandible fracture ✓
c̄ multiple fracture teeth ✓
- Anterior 1/2 tongue c̄ multiple lacs
- Soft tissue facial laceration and avulsed tissue (R) commissure →

(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.

CIV # [redacted]
b 1(e)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR 141
CFR1 USAPPC V1.00

PROGRESS NOTES

DATE	
	Complications: none
	Condition: Pt stable and sedated
	and paralyzed ~~=~~ ~~[illegible]~~ Cricothyroidotomy
	and transferred to ICU on
	standard monitors & event.
	[redacted] b(6)-2
	OMFS MAJ/DC

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

MEDICAL RECORD	PROGRESS NOTES
DATE	
2Sept03 (1930cont.)	infection noted. LR @150cc/hr as maint. infusing. SIMV 16 TV 750 peep 5 FiO_2 40% ~~p~~ ABG @ 1800 showed pH 7.43 pCO_2 35.7 HCO_3 24 paO_2 28 sat 100%. BE Ø turned down FiO_2 from 60%. #4 Shiley cricoidotomy, plan for return to OR in 2-3 days to convert to trach. Nasal passages packed c̄ iodoform gauze, sutured to lower lip and tongue, oral suctioned for mod amts serosanguinous drng. Midline abd dsg intact, mod amt serosanguinous drng noted. G-tube to gravity drng ~~amts~~ dk brown fluid, BS hypoactive x4 quads, ØBM. Foley intact drng mod amts cl yellow drng. Dsg to (L) hip and (R) thumb intact sm amt serosanguinous drng noted. Plan to monitor secretions and hemodynamics overnight, will monitor. [redacted] JAN
2200	T101.4, Tylenol suppository given 650mg, suctioned orally for sm amts serosanguinous fluid. VSS. will monitor. b(6) [redacted] JAN
3Sept03 0100	Pt. VSS. Last ABG showed pCO_2 30, Dr. [redacted] ordered rate down to 14 on vent settings, will re-draw ABG c̄ AM labs. Will monitor. [redacted] JAN

(Continue on reverse side)

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

REGISTER NO. [redacted] WARD NO. ICU2

PROGRESS NOTES
Medical Record

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

#[redacted]

b(6)

b(6)-2 A11

PROGRESS NOTES

DATE	
0230 35ep03 0000	Pt bathed and linen Δ'd. Abd dsg and (2) hip dsg reinforced. VSS. Will monitor. [redacted] /CTAN assumed care of pt @ 0000 from ICU [redacted] Pt lying in bed @ this - sedated, tracheal c #4 shiley. SIMV RR 14 TV 750 FIO2 35%. PS. AM ABG: 7.4/34/193/24/0/100%. AM LABS: 13.1 / 9.3 / 28.2 / 210 — 139 / 106 / 15 / 3.9 / 24 / 1.4 / 139 COAGS: PT 14.3, INR 1.29, APTT 30.6 sec. Will monitor MD as they come to unit. — CPT [redacted] AM CXR done — CPT [redacted]
35ep03	Surgery Pt stable, intubated, sedated Lungs: CTA FIO2 40% RR 5 TV 750 RR 14 7.45/34/163/24/0/100% Cor: HR ~~[illegible]~~ 97 BP 114/68 Abd: soft, NT, ND G-tube in place Wounds: healing Renal: 139/106/15 / 3.9/24 UO ~100 cc/hr Drainages: clear, dry, intact Hemo: 13.1 / 9.3 / 28 / 210 Tmax 101.4 TC 99.0 Resp: stable Plan: TV to 700 ↓ sedation to OR in a.m. [redacted]
1110	ABG ↑ TV ↓ to 700 from 750. SIMV, TV 700, FIO2 35%, PS. ABG: 7.4/33/175/25/1/100. Dr. [redacted] Return to unit — CPT [redacted]

STANDARD FORM 509 (REV. 7-91) [redacted]
USAPPC V1.00

MEDICAL RECORD | PROGRESS NOTES

DATE

OMFS POD#1

3 Sep 03 @0815 Pt being weaned off of sedation and responding to stimuli. nasal packing in place c̄ no active bleeding noted. facial wounds closed 1° c̄ no active bleeding tongue swelling moderate ~~[illegible]~~ looking viable - palatal packing in place.

CV RRR

lungs CTA c̄ vent sounds

abd: midline wound c̄ dressing + G tube

ext (R) thumb dressing ⊕ c|c|E

13.1	9.3 / 28.2	210	139 / 3.9	106 / 24	15 / 1.4	139	7.44	34.3	193

S/P closure of facial wounds c/R of maxillary fx + OR c̄ wire fixation of comminuted mandible fx

(1) Plan for Torch in AM. b(4)-2

(2) Continue to wean off sedati[redacted]

(Continue on reverse side)

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

REGISTER NO. [redacted]

PROGRESS NOTES

Medical Record

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

[redacted]

b(4)-4

MEDICAL RECORD	PROGRESS NOTES
DATE	
	b(6)-2 A1
3Sept03 1200	Oral suctioning q 1-2° + prn. Bloody drainage noted. Wound care to face (Cleaning + application of Bacitracin). Trach care done c̄ new tie applied. Pt cont. to be stable. Sedation has been decreased to 3mg Versed q 1° Fent @ 100 mcg/hr. Uo ~ 100 cc. — CPT [redacted]
1200	Abd + L chest wound c̄ reinforced dressing intact. L Tube drng @ 10cc blood, old, q 6° avl. Waiting for Dr. [redacted] to return to review latest ABG. — CPT [redacted]
1440	Pt [redacted] aware and desiring to get out of bed. Interpretor spoke c̄ pt. Explained what had happened to him and where he was. Versed 2mg IVP given to increase sedation + ↓ agitation/anxiety. Fentanyl given for abd. pain per pt's reference via the interpretor. Pt currently resting in bed comfortably. Versed ↑ to 4mg° + Fentanyl ↑ 125mcg. — CPT [redacted]
1730 ~~1630~~	1600 ABG c̄ zantac given. Lines flushed. Sedation c̄ Versed + Fent cont. Pt awakens when orally suctioned. ST c̄ ~ 10cc @ 4-6° output of dark old blood. Uo ~ >100cc° cyclic. Sp[redacted] VSS. Cont to monitor — CPT [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.

FC #[redacted]

25 y.o. male b(6)-4

[redacted]

PROGRESS NOTES
Medical Record

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

PROGRESS NOTES

DATE	
3SEP03	Nursing Note: Assumed care of pt. at 1800. Assessment of pt. done. (see DA Form 4700, (Intensive Care nursing flow sheet) — CPT [redacted]
4Sep03	Assumed care of pt @ 0600 from CPT [redacted]
0600	Resending ABG + coags @ this time. VSS. Pt sedated c̄ fent 125mcg/hr + versed 4mg. A.M. CBC + Met 8: 10.6 / 7.3 / 22.8 / 174 ; 140 / 106 / 18 / 4.0 / 21 / 1.3 / 139
	COAGS: PT: 13.1
	APTT: 25.2
	INR: 1.12
	ABG: 7.5/34/173/29/7/100%.
	SIMV RR14 FIO2 35% TV 700 PS — CPT [redacted]
0810	Pt returned to OR for I&D of mouth wounds and Δ the cric to a TRACH. PT P/U By ~~Dr.~~ [redacted] MAJ albutton, CPT Stas and MAJ [redacted] — CPT [redacted]
0950	Pt returned from OR - VSS. cont to monitor CPT [redacted]
1350	ABG 7.35/52.2/336/4/29/100%. c̄ 10 min T-piece trial. 10L — CPT [redacted]
1418	ABG c̄ 30min t-piece trial: 7.39/51/249/6/31/100 — c̄ 8L O_2. Pt O_2 ↓ to 6L — will do P/U ABG in 30 min — CPT [redacted]
1500	ABG on 6L O_2 via T piece: 7.39/48/270/5/30/100. RR 16 c̄ BBS to RML/LLL, diminished. Fentanyl @ 50mcg/hr.
1610	ABG c̄ TP Trial 6L O_2. 7.44/42/175/5/29/100%. RR 16-20 - pt agitated c̄ HR 130-160's. 2mg Versed c̄ Fentanyl 25mcg bolus c̄ 75mcg/hr infusion. Dr [redacted] reviewed earlier ABG's [redacted]

STANDARD FORM 509 (REV. 7-91) B[redacted]
USAPPC V[redacted]

b (6)-2
A11

MEDICAL RECORD	PROGRESS NOTES
DATE	
5 Sept 03	Pt placed on T-piece @ 8L, sats 100%.
0120	will obtain ABG in 30 min, prior to T-piece placement ABG pH 7.5 pCO_2 27.5 paO_2 150 HCO_3 22 BE -1 sat 100%. Will monitor. pt currently continues to be agitated [redacted] awake, attempting to climb OOB. [redacted]
0230	Sedation dropped to 2mg Versed + 50mcg Fent, pt awakens to verbal stimuli, RR 18 sats 100% on 8L T-piece, ABG pH 7.45 pCO_2 44.8 paO_2 249 HCO_3 31 BE 8. O S/Sx resp distress noted. Will monitor [redacted]
0245	Oral care performed, Xeroform gauze Ad to roof of mouth S incident. Face cleansed and bacitracin re-applied. Pt resting c̄ periods of agitation. Will monitor [redacted]
0345	Pt placed on humidified trach collar sats 100% on 8L. Morning labs sent. O S/Sx resp distress. Will monitor [redacted]
0530	Pt resting. AM ABG showed paO_2 213. TC 8L turned down to 6L. O S/Sx resp. distress. Will monitor. [redacted]
0630	Assumed care of pt @ 0600 from LT Hansen. Pt. resting in bed c̄ periods of agitation (Pt

(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. ICU2

PROGRESS NOTES

Medical Record

[redacted]

MEDCOM - 18396

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

USAPPC V1.00

b(6)-2 #11

PROGRESS NOTES

DATE	
cont	pulling on a-line, - picking at lines, squirming in bed crying, complaining, asking c̄ ~~[illegible]~~ ~~[illegible]~~ for water. ~~[illegible]~~ Otherwise pt rests in between agitation periods. VSS. Pos: IV ABX, ↓O2 on TC, ΔPIV sites and ↓ agitation, possible ulcer on Monday to the hospital, Δ dsgs wound care and provide nutrition - CP [redacted]
0630	AM LABS:
	ABG: 7.47 | 40 | 213 | 30 | 6 | 100% ; TC c̄ 6L O2.
	CBC 10.7 > 7.7 / 23.5 < 214
	COAGS: PT 11.7 sec, INR 0.93, APTT <15 sec
	Piccolo 8: 129 | 10.7 | 13 / 4.0 | 21 | 1.1 < 156 CK 743
	CP [redacted]
0830	Dr. [redacted] pulled penrose drng to (L) hip + redressed area c̄ sutures to (L) hip. [illegible] c̄ dsgs CDI. CP [redacted]
1000	Pt's hair washed, face shaved + new PIV inserted 18g (L) bicept, 18g (R) FA. New IV tubing placed on all gtts. Track care done. Cont to monitor CP [redacted]
1400	Track care done CP [redacted]
1500	Jerky ~~[illegible]~~ 100cc @ 1200, Ø residual. Tylenol ~~[illegible]~~ OPA c̄ Benadryl. Cerofoam to ~~[illegible]~~ top of mouth. VSS. 6PM CP [redacted]
1630	~~IV ABX c̄ zantac, Track care done x2, VSS. Tylenol ↑ 75 mg° for pain mgmt. ↓ MUP to 5000°, Jerky 400 cc q 1. residual Ø. Cont to monitor~~ - CP [redacted]

PROGRESS NOTES

DATE	
5Sep03 @0900	OMFS POD #2
	Pt lying bed c̄ trach collar. agitated this am. facial wounds closed 1° c̄ ↓ in facial swelling. intra oral wounds closed 1°. Xeroform gauze in place of palatal defect. tongue swelling significantly decreased. maxilla still mobile.
	VSS AF
	Plan ~~to transfer to Landstuhl hospital on Monday~~ for continuity of care.
	b(6)-7 [redacted]

b(6)-2 H

MEDICAL RECORD	PROGRESS NOTES
DATE 6 SEP 03 (0700)	Assumed care of patient @ 0610hrs p receiving ∆-of-shift report. See form 4700 "Intensive Care Nursing Flow Sheet" for initial assessment information. [redacted]
6 SEP 03 (0800)	↑ agitation @ this time. ↑ RR 45-55, systolic ↑ 160-170's Non-invasive. Obtunded to what suctioning performed. Given 2cc Saline down trach tube and advanced Sx suction cath down trach x 3. Removed moderate amount of thick, white mucous; ∅ mucous plug noted. SaO2 ↓ to 85% during initial ↑ anxiety period before suctioning. Respiratory tech @ bedside to assist. Respiratory rate now 30-35 c̄ anxiety still present. Given 3cc Versed bolus, followed by ↑ Versed drip to 3mg/hr. SaO2 now 97-98% c̄ 31% humidified air via trach [redacted] will monitor Versed bolus & drip ↑ for effect. [redacted]
6 SEP 03 (0830hrs)	Patient now resting more comfortably. RR ~ 21-25/min. c̄ HR currently 9[illegible] [redacted] ais @ 99%. Will continue to monitor for further agitation and provide intervention accordingly. [redacted] (AN)
6 SEP 03 (1200)	Shift Update: Patient currently calm & relaxed in bed. SaO2 @ 100%, RR → 2[illegible] [redacted] 75 Non-invasive. Receiving 12oz Jevity feeding; flow to peg tube. Am care completed, all suture and staple sites cleaned c̄ ½ str peroxide & H2O, then bacitracin applied. Peg tube dressing done, along c̄ foley cath care. Will continue c̄ current care [redacted]
6 SEP 03 (1430hrs)	Patient c/o abd pain (through interpreter). Currently receiving Versed @ 3mg/hr and Fentanyl @ 50mcg/hr. Given 4mg MSO4 IVP for abd pain. Will re-evaluate in 20min. [redacted] (AN)
6 SEP 03 (1955hrs)	Patient resting quietly s̄ further c/o abd pain p̄ receiving 4mg MSO4 IVP. Will continue c̄ present care and wean off of Versed and Fentanyl [redacted] (AN)
7 Sept 03 1417	Received pt resting in bed sleeping. VSS. RN assessment on V.S. Sheet. Pt moves all extremities, awakens spontaneously. AOX3. Pt has continuously been

(Continue on reverse side)

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

Civ #[redacted]

b(6) 4

REGISTER NO.

WARD NO. ICU2

PROGRESS NOTES
Medical Record

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

PROGRESS NOTES

DATE	
cont.	agitated restless, agitated, and c/o pain to mouth q1-2°. Tylenol Elixer c̄ codeine given q4° c̄ MSO4 2-5mg given for breakthrough pn. Pt also c/o nausea x1 @ 1200 c̄ tube feeds. 1200 tube feeds held d/t pt "spitting up" Jerky through mouth. More than normal secretions via mouth. Trach care, wound care + mouth care done @ 0800 this AM. Will teach family member how to do trach + wound care. VSS. will cont to monitor. POC: Teach pt + family members how to clean trach, wounds + redness, IVABX, fluid maintance c̄ pn mgmt, prepare pt for d/c to clinic / home in AM. CPT [redacted]
1430	Scripts for A/E turned into CPT [redacted] in pharmacy. ETD is 0900, 8Sept13 - CPT [redacted]
1500	Pt given 5mg MSO4 IVP + Phenergan 25mg IVP x1 for c/o pain to jaw - mouth area. Pt also c/o nausea p̄ administration of MSO4.
1025	Percocet 2 tabs per g-tube for facial pn. Benedryl 50mg IVP given for insomnia per Dr. [redacted] Pt c/o pn q1-2° Ambien ordered @ HS for insomnia if Benedryl ineffective. G-tube cleaned. Chip dressing bid. ~~So~~ Old blood noted on wound dsng. Serosang drainage from wound. CTM CPT [redacted]

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

b(a) - 2 #11

MEDICAL RECORD	PROGRESS NOTES
DATE	
cont	1610: If pt does not tolerate TP trial she will be sedated & returned to b(6)-2 the vent. ——— CPT [redacted]
1700	ABG: pH 7.43 | pCO2 48 | PaO2 233 | BE 8 | HCO3 32 | SpO2 100. CAuxiliary [redacted] Nessens return ——— CP [redacted]
1730	T-Piece trial ended d/t pt cont. agitation. Began TP Trial @ 1340 c̄ 10L O2. ~~Pt tolerating~~ [redacted] Then weaned to 6L O2. Per ABG pts PaO2 175-233, pH 7.35-7.44, PaCO2 42-52, ~~HCO3~~ BE 5-8, HCO3 29-32, and SpO2 100% throughout. Throughout trial of T-P. pt's RR varied from 8 to 20, c̄ shallow breaths and some deep breaths when awake and ↑ agitation. @ 1600 2mg Versed given IVP to ↓ agitation & help ↑ oxygenation. ABG done @ 1700 c̄ little Δ in ABG from prior ones. Pt's BPM ↓ from 12-16 to 8-13 BPM. HR has remained 125-143 throughout trial. BP has having HR 60-80's & TP Trial. TBP 140-130/70-80's. Through trial. Pt cont to reach for tube and face c̄ hands and move legs around in bed. Father & Brother visited x c̄ hrs then left to return in am. Pt [illegible] Jenty [illegible] GT. GT cleared [illegible] ——— CP [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. 700 F/C [illegible]

#[redacted]

25 y.o. b(6)

PROGRESS NOTES
Medical Record

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

b(6)-2 All

PROGRESS NOTES

DATE	
1730	Cont. Pt returned to vent @ 1730 c̄ Versed 2mg c̄ 2mg Bolus. Fentanyl 75mcg/hr. SIMV RR14 TV 700 PS FiO2 35%. ABG to Be done about 1800. Awaiting Dr. [redacted] return. — Pt Stable @ this time. Cont to monitor — CP [redacted]
1800	ABG: c̄ SIMV RR14 TV 700 PS FiO2 35%. — 30mḡ reconnected to vent: ABG: 7.50/40/133/9/32/99%. — CP [redacted]
1800	Report given to [redacted] - VSS - CP [redacted]
2015	Pt continuously agitated, crying, grabbing at lines and mask. Interpreter spoke to pt. and explained what happened, what tubes and lines were for and that pt. needed to relax, lie back and could not drink any water as pt asked for water. MAP 110's when pt agitated, 80's when pt relaxed. Sedation increased for pt. comfort and therapeutic effect. Will cont. to monitor and attempt to wean in AM [redacted]
2300	Pt continues to be agitated, brief periods of rest followed by agitation and grabbing at tubes and mask. Overbreathing vent. Will turn down sedation and attempt T-piece trial again per recommendation of RT. Will monitor. [redacted]

STANDARD FORM 509 (REV. 7-91) BACK

MEDICAL RECORD	PROGRESS NOTES
DATE	

OMFS Transfer Summary

7 Sep 03 @ 0844 — 25 yo am S/P GSW to face. Entrance wound left cheek - exit Right commissure. Avulsive wounds to face, tongue, hard palate, floor of mouth and right commissure. Pt c̄ comminuted mandible fracture and multiple piece maxillary fracture c̄ avulsion of hard palate. Pt also c̄ left hip GSW.

Pt taken to the OR on 2 Sep 03 for
1. I&D of left hip wound
2. Gastrostomy tube
3. exploratory laparotomy - negative
4. repair of tongue, floor of mouth, mucosa, mouth and Right commissure.
   Wire osteosynthesis of mandible fracture (comminuted).
   repair of mucosa maxilla
5. awake cricothyroidotomy

(Continue on reverse side)

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

REGISTER NO. | WARD NO.

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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

PROGRESS NOTES

DATE

Pt taken to OR on 4 Sep 03 for
① tracheostomy c̄ #8 Shiley
② Exam under anesthesia.

D/C condition: Stable
D/C Diet: Clears as tolerated
Jevity Per G tube.

Plan:
① facial sutures will need to be removed 9 Sep 03.
② fixation of maxilla needed
③ pt will need extraction of non restorable teeth once fractures are healed.
④ tracheostomy tube can be removed when surgery to maxilla [redacted] is complete.
⑤ left hip sutures need to be removed in 1 week
⑥ midline staples removed in 5-7 days
⑦ G tube can be removed once fractures healed and pt can tolerate a diet.

b(6)-2

[redacted]

OMFS

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
2 Sept 03 1545	Pt arrived on unit via gurney accompanied by OR staff. Pupils 2mm + non-reactive. ~~Pt responds~~ [redacted] Unable to assess level of consciousness @ present time. NSR c̄ HR in low 90's @ palpable pulses in all extremities. IV infusing @ 150cc/hr via 18ga in (L) AC. 18ga in (R) AC patent c̄ edema or erythema. #4 Shiley trach, SIMV 16, TV 750, Peep 5, FiO_2 80%. O_2 sats 100%. Lungs coarse bilaterally c̄ increased secretions noted orally + via trach. Abdomen round + hyporactive bowel sounds. Drsg to abdomen c̄ moderate amt of blood tinged drainage noted. G-tube to gravity c̄ small amount of brown drainage noted. Foley to gravity draining large amt of clear yellow urine. Numerous sutures around mouth c̄ bacitracin applied. Nose packed by Dr [redacted] secondary to increased nasal drainage. Drsg to (L) hip c̄ minimal amt of drainage noted. Labs sent and pt stable @ present time. Will continue to monitor [redacted]
1600	Pt placed on Fentanyl 100mcg/hr & Versed 5mg/hr for sedation. Suctioned via trach c̄ moderate amt of bloody drainage noted. b(6)-2 [redacted]
1700	Pt c̄ increased BP, MAP currently 130. Bolused [redacted] Will continue to monitor [redacted]
1930	Pt responds to touch, opens eyes, MAE. Pupils 2mm non-reactive. Sedated c̄ Fent @ 100mcg/hr, versed @ 5mg/hr c̄ good effect. SR 90's, ø ectopy, $S_1 S_2$, ø murmur, 2+ radial pulses, 1+ pedal pulses. BP 180's/80's c̄ 25mg lopressor IVP to maint Diastolic <90 as ordered. (R) rad A-line patent, good waveform and correlation c̄ cuff pressures. (L) and (R) AC 18G PIV patent, ø S/S

[redacted] b(6)-4

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
02Sept03 @0800	pt arrived via Medevac, agitated & pointing to mouth. pt is Iraqi civilian who was shot in mandible & (L) hip, c̄ mandible blown out. Airway patent, lungs CTA, VSS. Trauma team arrived immediately c̄ OMF MD. pt able to talk to interpreter and is Ax0x3 per interpreter. pt sitting in High Fowlers & moved to Trauma 2. pt c̄ GSW to (L) hip, bleeding controlled. (L) lac noted to (R) thumb. 50mg Fentanyl given [redacted]
@0825	pt moved to Trauma OR for trach pl[redacted] pt stable throughout ER visit, ske SSO[redacted]

b(a)-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

Iraqi

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

NSN 7540-01-075-3786

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

TEST RESULTS

CBC		SMAC				ABG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐
WBC 23.7			133	104	7	SUP O2	PH	PO2	RESULTS	
H/H 12.5 / 39.6					197	PCO2	SAT	OTHER		
PLT 332			3.0	20	1.1					
PT			CK 586			U/A DIP			EKG INTERPRETATION	
APTT	BHCG	ETOH	GLU			U/A MICRO				

PROVIDER HISTORY/PHYSICAL

pt arrived c̄ GSW to mandible. A x O x 3 per interpreter. pt in High Fowlers - airway patent. Trauma team called [redacted]

25% c̄ sip GSW/blast? to face thin am. Pt unable to speak but indicates [redacted]

(R) N, (L) pain in hip. ¢ abd pain / ¢ neck/back pain ¢ leg [illegible]

Pstt (B) renal sing? 2° stones b(4)-2

meds: "for kidneys

O: A x O x 4 in Mod distress, sitting up

Head: Atraumatic, neck: NT, Face: mandible missing from (B) angle forward 1/3rd

C/P: maintaining airway patency. PERRL EOMI

N/P: (+) active bleed (B)

Chest: CTA (B) Ab: nm pulsatile Back: (+) (B) mid lumbar scars @ (B) CVA. Pelvis: (+) open wound (L) hip [illegible] T m = active bleed tracks to iliac crest

Ext: 5/5 strength x/4 (B)

A/P: Pt able to maintain airway sitting up. [illegible] pt admitted directly to OR

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP [redacted]

PROVID [redacted]

DIAGNOSIS
1. Facial trauma/GSW
2. GSW to (L) hip

CODES b(6)-2

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

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

[redacted]
b(6)-4

NSN 7540-01-075-3786

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

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY: Iraq | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)*: 2 Sept 03 | TIME: 801

TRANSPORTATION TO FACILITY: Medevac

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		
25	AREA CODE	NUMBER	MEDICAL HISTORY OBTAINED FROM				NAME OF INSURANCE COMPANY		

CURRENT MEDICATIONS: ∅ daily

ALLERGIES: NKDA

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

CHIEF COMPLAINT: GSW Saw / GSW to (L) hip — hx – renal stone, medex – [illegible]

CATEGORY OF TREATMENT

☒ EMERGENT — TIME

☐ URGENT — INITIALS

☐ NON-URGENT

VITAL SIGNS

TIME	0807	0815	0825			
BP	166/102	171/94	171/100			
PULSE	94	73	106			
RESP	14	15	18			
TEMP						
~~WT~~ SPO2	100%	100%	100%			

LAB ORDERS									
	CBC/DIFF	ABG		PT/PTT		BHCG/URINE/BLOOD/QUANT		CXR PA & LAT/PORTABLE	C-SPINE
	URINE C&S	UA MSCC/CATH				CHEM: 12		ACUTE ABDOMEN	LS SPINE
	BLOOD C&S X 4							SINUS	HEAD CT
								ANKLE R/L	

ORDERS

☒ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
	80 mg Cipro		MR @ 0815		IV bolus T & N
	50 mg Fentanyl		MR @ 0820		
	~~Omeprazole~~ 12.5 mg phenergan		MR @ 0825		
	1 mg Versed		MR @ 0830		
	50 mg Fentanyl		MR @ 0830		

DISPOSITION: ☐ HOME ☐ FULL DUTY

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

PATIENT/DISCHARGE INSTRUCTIONS

MODIFIED DUTY UNTIL | RETURN TO DUTY

CONDITION UPON RELEASE: ☒ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE | TIME OF RELEASE

REFERRED ▶ TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

[redacted] b(2)-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

Trauma Case

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: 25 HEIGHT: WEIGHT:	2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): nkda 3. PREVIOUS SURGERY [ ] NO [X] YES (type): Kidney stone removal

4. PROPOSED SURGICAL PROCEDURE:
see back slip

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

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

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

[redacted] LTC, AN 2 Sep 03 DATE

11. POSTOPERATIVE EVALUATION [redacted]

Bone Site: intact
Drsg: clean
Breathing: Tracheostomy b (w) - 2 A11

12. PREOPERTIVE EVALUATION PREPARED BY

[redacted] LTC, AN

DATE: 2 Sep 03 TIME: 08[redacted]

13. PREOPERTIVE EVALU[redacted]ED BY (Signature and Title) [redacted]

DATE: 2Sep 03 TIME: 1540

REVERSE OF DA FORM 5179, JUN 91

USAPA V1.01

500 CBC 8500 cup. Rom
3900 U/O 1 UPRB

MEDICAL RECORD — **INTRAOPERA[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 Anesthesia
2. PATIENT IDENTIFIED [redacted] VED AND PROCEDURE VERIFIED BY LTC [redacted]
3. DATE 2 Sep. 03 TIME PATIENT ARRIVED IN SUITE 0830
4. PATIENT IN ROOM TIME 0830 NUMBER ER/TRAUMA

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Pt. awake

6. NURSING PERSONNEL

ASSIGNED SCRUB	Sgt. [redacted]	RELIEF SCRUB	b(6)-2
	Spc. [redacted] b(6)-2		
ASSIGNED CIRCULATOR	LTC [redacted]	RELIEF CIRCULATOR	CPT [redacted] (ECC)
	Cpt. [redacted]		

7. POSITION AND POSITIONAL AI[illegible] [redacted] Rolled sheet under Lt. hip

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

COMMENTS: Body maintained in proper anatomical alignment

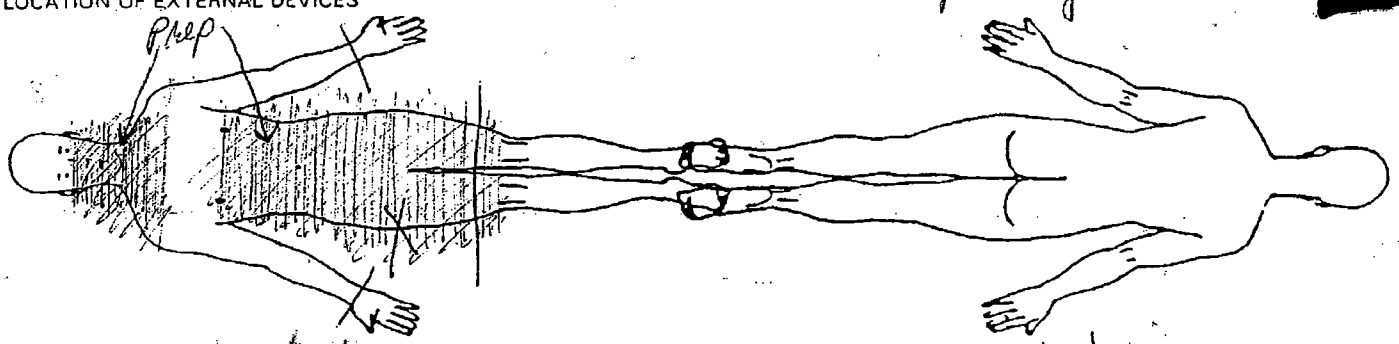
8. SKIN PREPARATION b(6)-2

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

COMMENTS: No nicks noted

PREP SOLUTION (Specify) Betadine scrub/sol
SITE: Neck BY WHOM: LTC [redacted]
SITE: Nipples ↔ knees face BY WHOM: Cpt [redacted] LTC
COMMENTS: No pooling noted

9. LOCATION OF EXTERNAL DEVICES



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

b(6)-2

10. COUNTS C = Correct I = Incorrect

		Initial Other**	First Closing Count	Final Closing Count	SCRUB Spc [redacted]	CIRCULATOR [redacted]
Sponge	☒ Yes ☐ No	✓	C	C	Sgt [redacted]	
Needle Sharp	☒ Yes ☐ No	✓				
Instrument	☒ Yes ~~☒ No~~ MF	✓				
Other	☐ Yes ☒ No					

* See #19

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

Civ # [redacted] b(6)-4

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

☒ ESU NO: 00390 Valleylab
GROUND PAD: BRAND REM polyhesive
LOT NO: 68936

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

Cut: 30 Coag: 30

MEDCOM - 18411

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

In jaw area: CMS 0620301
Osteomed 3-hole plate 24g wire x5 pieces #4 Shiley Trach Tube
2.4 maxi 8mm Osteomed screw x2 7s length in neck

14. MEDICATIONS/ORDERS

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

MEDICATIONS, SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
Bacitracin Ointment	QS	I/O	Topical	[redacted]	[redacted]

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

b(6)-2

OTHER ORDERS	TIME	CARRIED OUT BY
16 Fr. 5cc foley inserted per Dr. [redacted] by LTC [redacted]	0900	LTC [redacted]

PHYSICIA[redacted] b(6)-2

15. X-RAY IN O[redacted] YES ☒ NO ☐ IF YES, SITE AP + lat. of Head

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE/SIZE	16 Fr. malecot	1" Penrose	16F FIC
SITE	Lt. of abd. incision	Lt hip	Bladder

18. DRESSING/IMMOBILIZATION (Specify)
4x8: Abd
4x8 + ABD → Lt. hip
Xeroform + DSD → (R) thumb
Xeroform Face

19. ADDITIONAL INFORMATION
Surgeons: Drs. [redacted]
Anesth: Maj. [redacted] CRNA, [redacted]
b(6)-2

* One counted Raytech used as dsg sponge on abd. p̄ count complete + correct. I was told this by Spc. [redacted] @ end of case. [redacted]

20. OPERATION(S) PERFORMED
Tracheotomy, Exploratory Laparotomy, G-tube placement, I+D Lt. hip, I+D Rt. thumb, I+D, + Closure of GS wounds to face

21. PATIENT TRANSFERRED TO ICU 2 TIME see D47389 METHOD via Gurney

[redacted] ANC LTC [redacted]

REVERSE OF D[redacted] 03-1, OCT 8[redacted]
[redacted] CPT IAN
b(6)-2

MEDCOM - 18412 USAPA V1.01

MEDICAL RECORD	INTRAOPERATIVE DOCUMENT b(6)-2 For use of this form, see AR 40-66, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA gurney BY anesthesia

2. PATIENT IDENTIFIED [redacted] OCEDURE
VERIFIED BY [redacted] CPT / AN

3. DATE 4 Sep 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN R[redacted]
TIME 0810 NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies
pt does not speak english.

6. NURSING PERSONNEL

ASSIGNED SCRUB	Sp[redacted] 91D b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CP[redacted] 66E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify) shoulder roll.

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

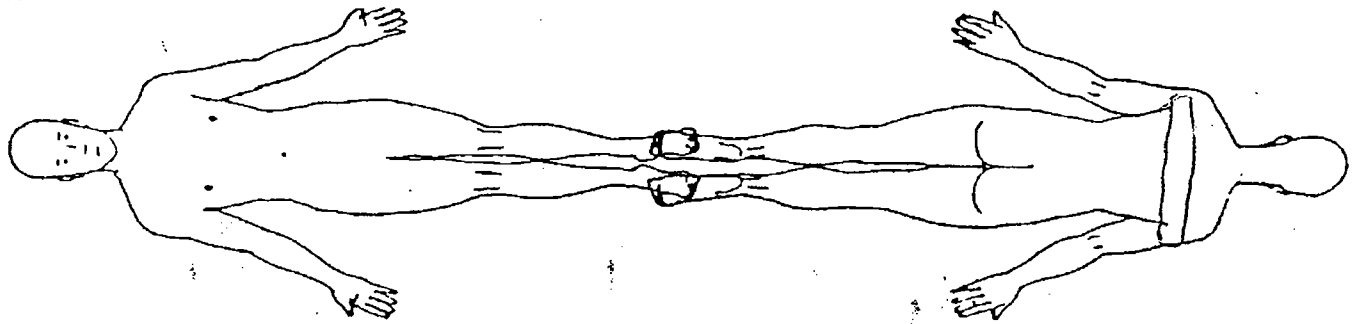
COMMENTS:

8. SKIN PREPARATION b(6)-2

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

PREP SOLUTION (Specify) Betadine / Betadine
SITE: BY WHOM: CP[redacted]
SITE: BY WHOM:
COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



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

initial - CPT [redacted] b(6)-2
SPC [redacted]

C = Correct I = Incorrect

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

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

#[redacted] b(6)-4

3 Sep 03
[redacted] b(2)-2

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

CUT COAG
☒ ESU NO: Valleylab SN: 00047
GROUND PAD: BRAND Valleylab E7507
LOT NO: 68248 2005-02

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

LAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

0.9% NACL

OTHER ORDERS

	TIME	CARRIED OUT BY
[redacted]		
[redacted] b(6)-2		

15. [redacted] IF YES, SITE

YES ☐ NO ☒

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 8 LPC Shiley	2.	3.
SITE	throat area	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
- 8X4
- medipore tape
- Benzoin tincture

19. ADDITIONAL INFORMATION

WC

Surgeons: Dr. [redacted] Anesthesia: CPT [redacted] b(6)-2 Anesthesia Type: Gen

Dr. [redacted]

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

Tourniquet Site intact pre-op Ø: post-op Ø

Tourniquet Time: Up Ø Down Ø

20. OPERATION(S) PERFORMED

Tracheostomy / Exam under anesthesia

21. PATIENT TRANSFERRED TO ICU b(6)-2 TIME 0915 METHOD gurney

22. REC[redacted] CPT/AN

REVERSE OF DA FORM 5179-1, OCT 87

USAPA V1.01

[redacted] 19

2 Sep 03

171/91

	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
BP INV																								
BP NIBP										~~153/92~~	~~154/96~~	154/96	145/91	133/88	128/76	123/74	114/68	102/63	106/64	104/63	100/62	100/68	102/60	101/64
TEMP										153/92	154/96	157/99	134/80	129/82	123/76	121/73	113/68	108/62	105/61	107/60	100/60	94/60	97/55	100/58
PULSE										97.9	98.8	99.8				101.4		100.4		98.9			99.3	
RESP										93	78	89	94	113	115	122	118	119	114	111	105	109	107	105
SP02										16	32	16	16	16	16	16	16	16	16	14	14	14	14	14
FIO2										100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
[illegible]										80	60	60	60	80	40	40	40	40	40	40	40	40	35	35
[illegible]										117	123	121	110	99	94	89	86	82	76	75	75	73	77	75
																								25
INPUT																								
IV																								
RO										150	150	150	150	150	150	150	150	125	125	125	125	125	125	125
Med										50	50							100						
[illegible]										5	5	5	5	5	5	5	5	5	5	5	5	5	5	5
										20	20	20	20	20	20	20	20	20	20	20	20	20	20	20
PO																								
NGT																								
O.R. IN									9000															
SUB TOTAL									9000	225	225	175	175	175	175	175	175	250	150	150	150	150	150	125
TOTAL									9000	9225	9450	9625	9800	9975	10150	10325	10500	10750	10900	11050	11200	11350	11500	11650
OUTPUT																								
[illegible]										375	940	760	380	350	150	150	175	100	100	100	100	100	100	
STOOL																							100	
Oral																								
																							250	
O.R. OUT									3900	~~375~~	~~940~~													
SUBTOTAL									3900	375	940	760	380	350	150	150	175	100	100	100	100	100	450	
TOTAL									3900	4275	5215	5975	6075	6425	6575	6725	6900	7000	7100	7200	7300	7400	7850	
BALANCE																								+3600

MEDCOM - 18415

[redacted] TRACH

28TH COMBAT SUPPORT HOSPITAL VENTILATOR FLOW SHEET

DATE	TIME	MODE	RATE	VOLUME							BP	pH	PaCO2	PaO2	FiO2	HCO3	SaO2	REMARKS	INT
22Sep03	1600	Simv	16	750	60	5	30	16	86	100	112/64								[redacted]
23Sep03	1850	SIMV	16	750	60	5	28	16	91	100	166/88	7.43	35.7	286	0	24	100	~~VT 50 2 40%~~	[redacted]
	2000	SIMV	16	750	40	5	34	16	107	100	129/82							Pt moving	[redacted]
	2150	SIMV	16	750	40	5	33	16	121	100	120/72								[redacted]
	2350	SIMV	16	750	40	5	35	16	119	100	113/64								[redacted]
	0158	SIMV	16	750	40	5	38	14	110	100	103/60								[redacted]
	0350	SIMV	14	750	40	5	31	14	108	100	102/66	7.44	31.3	193	0	24	100		[redacted]
	0645	SIMV	14	750	35	5	26	14	103	100	104/64								[redacted]
3Sep	0800	Simv	14	690	35	5	23	14	99	100	109/65								[redacted]
	1000	Simv	14	690	35	5	24	14	96	100	116/69								[redacted]
	1200	Simv	14	690	35	5	21	14	98	100	125/73								[redacted]
	1400	Simv	14	690	35	5	26	15	97	100	125/70								[redacted]
	1600	Simv	14	690	35	5	32	15	102	100	126/70								[redacted]
	1800	Simv	14	690	35	5	29	14	99	100	119/64								[redacted]
	1927	SIMV	14	690	35	5	29	14	100	100	116/63								[redacted]
	2202	Simv	14	690	35	5	31	14	92	100	111/60								[redacted]
	2333	Simv	14	690	35	5	30	15	91	100	111/61								[redacted]
						5	27	20	109	90	109/61								[redacted]
4Sept	149	Simv	14	690	35	5	27	15	103	100	127/62								[redacted]
	0414	Simv	14	690	35	5	28	20	92	100	130/65								[redacted]
	0607	Simv	14	690	35	5	28	14	71	100	131/64								[redacted]
	0749	Simv	14	690	35	5	29	14	74	100	134/60								[redacted]
	1010	Simv	14	700	60%	5	23	14	65	100	135/63								[redacted]
	1200	Simv	14	700	35%	5	24	14	87	100	145/70								[redacted]
						T Piece					1400								[redacted]
	1810	SIMV	14	700	35%	5	23	14	101	100	128/66								[redacted]
	1935	SIMV	14	700	35	5	20	14	106	100	144/67								[redacted]
	2120	SIMV	14	700	35	5	19	14	58	100	138/67								[redacted]
5Sept	0618	SIMV	14	700	35	5	21	14	81	100	138/67							aid vent = Tolerated	[redacted]
	0115	T piece		8 L PM															[redacted]
	0240	T-collar			40%			15	111	100	149/75								[redacted]
	0545	T collar			40%			22	125	100	129/90	7.47	40	213	6	30	100	Sx-dark brown/[illegible]	[redacted]
	0800	T-collar			31%			18	88	100	146/78								[redacted]
	1000	T-collar			31%			14	104	100	172/90								[redacted]

MEDCOM - 18416

700 ICU 2 3 Sept 03

F/C 3 Sept 03

	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
BP INV	102/61	107/64	115/108	113/107	119/72	121/72	120/70	118/108	119/85	118/69	124/70	129/66	113/75	113/63	112/61	115/62	109/60	118/58	115/60	117/61	121/62	113/62	137/63	137/64
BP NIBP	107/65	104/62	107/63	104/108	110/62	113/63	118/69	119/65	119/65	123/64	118/64	118/64	113/64	113/57	110/59	112/55	109/55	109/55	113/56	113/58	113/55	104/66	134/63	134/69
TEMP		99.0				99.7		99.4										98.8		99.2			98.1	
PULSE	103	99	97	99	96	93	98	97	121	103	102	104	97	99	103	92	92	91	101	100	90	83	73	75
RESP	14	15	14	14	14	16	16	16	15	20	20	16	16	14	14	14	15	14	18	14	14	14	14	14
SP02	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
FIO2	35	35%	35%	35%	35%	35%	35%	38%	35	35%	35%	35%	35%	35	35%	35%	35%	35%	35%	35%	35%	35%	35%	35%
MAP	73	77	80	82	86	80	88	84	104	80	87	81	79	78	75	76	54	76	78			84	87	91
IC	25	24	24	23	24	24	25	24	24	24	24		29	30	24	25	32	31	28	28	29			
INPUT																								
IV	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125
IVPB		100				12				100								50	50					
VPO	5	3	3	3	3	3	3	3	4	4	4	4	4	4	4	4	4	4	6	4	4	4	4	4
Tent	20	20	20	20	20	20	20	20	12.5	12.5	12.5	12.5	12.5	12.5	12.5	12.5	12.5	12.5	12.5	12.5	12.5	12.5	12.5	12.5
PO																								
NGT																								
O.R. IN																								
SUB TOTAL	150	248	148	148	148	160	148	148	141.5	241.5	141.5	141.5	141.5	141.5	141.5	141.5	141.5	141.5	142.5	141.5	141.5	141.5	141.5	141.5
TOTAL											1823	1964.5	2106	2247.5	2389	2530.5	2672	2813.5	2956	3097.5	3239	3380.5	3522	3663
OUTPUT																								
INE	100	80	80	80	140	180	140	110	160	140	70		150	165	100	70	120	100	180	180	180	140	140	180
GT	0	0	0	0	0	10	0	0	0	0	10													90
STOOL	0	0	0	0	0	0	0	0	0	0	0													
Oral	10	10	0	5	0	5	5	0	0	0	10													
O.R. OUT																								
SUBTOTAL																								
TOTAL											1330													
BALANCE											493													

MEDCOM - 18417

+IC + [redacted] 5-3/9

4 Sept 03

ICU2

TPI cal trial

	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
BP INV	130/60			143/71	121/61	147/67	124/58	144/75	140/79	132/81	139/89	134/83	145/79	133/67	144/73	144/72	139/73	140/73	172/90	133/72	112/68	178/89	132/72	144/76
BP NIBP	123/58	121/61		110/55	137/61	124/64	120/63	129/73		133/74	135/80	135/78	131/74	126/82	138/89	140/74	134/61	129/66	142/82	154/81	138/74	142/80	141/74	138/77
TEMP	98.4			98.3				98.7					98.7						98.9				97.9	
PULSE	72	73		66	69	85	85	135	143	125	128	136	127	95	94	91	83	80	129	104	95	128	92	96
RESP	16			16	16	16	16	16	16	20	12	22	24	19	14	16	14	14	17	12	16	27	15	16
SP02	100			100	100	100%	100%	100%	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
FIO2	35%			100%	35%	35%	35%	60L	6L	6L	6L	35%	35%	35%	35%	35%	35%	35%	35%	8L	8L	8L	8L	6L
	30			24	24	26	24	TP	TP	TP	TP		18	19	19	18	21	22	16	TP	TC	TC	TC	TC
	88	85		91	84	88	78	100	97	119	103		94	87	98	109	93	88		101	88	100	95	100
INPUT																								
IV	125	125		125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125
Versed	4	4		4	4	2	2	0	0	2	2	3	3	4	4	4	9	3	3	2	2	2	2	2
Fent	125	125		125	125	10	10	10	5	5	7.5	7.5	7.5	7.5	10	10	7.5	2.5	7.5	5	5	5	5	5
IVPB		100								100								100						
Resid						0				0				0				0				0		
GT					100	100				100				100				100				100		
O.R. IN																								
SUB TOTAL																								
TOTAL																								
OUT																								
NE	200	100		200	100	100	200	200	200	160	140	200	310	300	240	200	214	240	270	270	100	160	180	300
GT																								
STOOL																								
TRACH suc				✓																				
Oral suct	✓	✓		✓																				✓
O.R. OUT													✓					✓				✓		
SUBTOTAL																								
TOTAL																								
BALANCE																								

MEDCOM - 18418

[redacted] T-Collar 31%
ICU% 2
8 Shiley

28TH COMBAT SUPPORT HOSPITAL VENTILATOR FLOW SHEET

DATE	TIME	MODE	RATE	VOLUME	FIO2	PEEP	PIP	PT RATE	HR	SO2	BP	PH	PCO2	PO2	BE	HCO3	SaO2	Remarks	INT
5 Sept	1200	TC			31				88	100	158/73								[redacted]
	1400	TC			31				104	100	176/74								
	1600	TC			31				87	100	168/88								
	1800	TC			31				100	100	151/76								
	2011	TC			31			16	88	100	149/82								
	2224	TC			31			21	102	100	142/84								
	2341	TC			31			15	98	100	152/70								
6 Sept	0215	TC			31			20	106	98	158/80								
		TC			31			19	96	100	155/81								
	2230	TC			31 → 28%			24	110	100	121/71							Pt moving	
	0200H	TC			24			20	97	100	120/59								
	0630	TC			21%			21	98	98	156/57								
	0800	Pt is on Room Air at this time 9/8 demo line w/ periodically check pt to make sure he does not need to be back on O2																	[redacted]

MEDCOM - 18419

[redacted] 3

ICU2

5 Sept 03

	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
BP INV	141/75	174/88	149/75	141/70	60/80	104/82	141/71	144/84	153/83	170/94	114/85	109/85	156/86	152/81	145/82	143/82	143/82	144/80	154/83	164/80	164/78	145/80	140/79	143/78
BP NIBP	128/80	130/70	140/91	130/72	129/76	123/81	119/64	137/87	132/76	124/76	125/79	132/76	124/76	117/79	120/80	124/71	121/70	124/71	124/81	154/83	150/80	113/76	118/72	135/73
TEMP	98.3					98.6							97.5			98.8			99			99.2		
PULSE	87	116	91	88	83	123	93	110	88	117	114	116	94	95	83	85	86	88	100	110	94	95	88	98
RESP	17	22	16	20	16	16	17	24	17	20	20	24	19	17	18	14	19	21	21	23	20	19	19	
SP02	100	100	100	100%	100	100	100	100	99	96	100%	100	100	100	100	100	100	99	99	98	99	99	100	99
FIO2	31%	31%	31%	31%	31%	31%	31	31%	31%	31%	31%	31%	31	31%	31%	31	31	31	31	31	31	31	31	31
MAP	95	105	97	95	99	98	91	100	100	100	106	110	94	95	95	89	91	91	102	110	91	89	88	
INPUT																								
IV	125	125	125	125	125	125	125	125	125	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50
Vased	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	4	4	4	2	2
Zent	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5
TUPB																		50	50					
PO						2		02		1	2	2	2	5	5		3							
NGT	-	100				100				400				400				100				400		
Lost ~~CTR IN~~		0				0				0														
SUB TOTAL																								
TOTAL																								57
OUTPUT																								
URINE	140	130	160	180	200	150	100	180	200	200	180	200	190	200	150	100	150	90	170	190	200	100	150	90
GT																								
STOOL																								
O.R. OUT																								
SUBTOTAL																								
TOTAL																								90
BALANCE																								

MEDCOM - 18420

(6 JAN 03) CIN [redacted]

01

	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
BP INV	144/81	159/88	150/72	167/88	150/72	157/81	154/80	155/83	143/80	167/89	155/76	156/86	143/78	167/80	167/64	140/66	147/66	147/80	144/73	125/69	150/70	160/70	165/70	147/91
BP NIBP	126/70	141/91	135/70	147/88	126/78	124/75	139/85	144/87	127/72	145/91	129/78	158/77	138/63	133/85	139/81	121/71	139/80	132/84	137/89	98/54	129/70	128/70	130/75	137/62
TEMP	98 ax	98 ax	98 ax	98 ax	98 ax	99 ax	99 ax	98 ax	99 ax	99 ax	99 ax	99 ax				99.4			99.8			98		
PULSE	90	100	98	111	100	102	120	115	105	113	94	99	103	113	107	114	100	104	96	90				
RESP	22	26	21	23	21	22	29	29	20	22	21	21	25	16	25	20	22	23	22	21	20	18	19	16
SP02	98%	97%	99%	100%	100%	99%	99%	99%	99%	99%	97%	98%	98	100	100	100	100	100	100	100	100	100	100	100
FIO2	31%	31%	31%	31%	31%	31%	31%	31%	31%	31%	31%	31%	31%	31%	31%	31%	28%	28%	28%	28%	28%	28%	28%	28%
	97	106	99	108	93	100	104	107	97	110	103	101	103	104	105	41			100	94			95	41
INPUT																								
IV (MAINT)	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50				
IVPB		100								100														
VERSED	2	2	3	3	3	3	3	3	3	2	2	2	2	2	2	0	4	4	4	2	0			
FENT	5	5	5	5	5	5	5	5	5	4	4	2	1	1	1	1								
I JENTY FEED	—	400	-			400				400				400				400						
~~no~~ PO								Sips	3 ounces 2440	2cc														
~~NGT~~ RESID		0	-			0				0				0				0						
O.R. IN																								
SUB TOTAL	57	557	58	58	58	458	58	58	58	458	56	54	53											
TOTAL	114	671	729	787	845	1303	1361	1419	1477	1935	2091	2145	2198											
OUTPUT																								
URINE	200	250	180	110	180	190	170	180	270	175	250	160	200	200	110	140	110	140	180	150	180	200	120	100
NGT	—	—	—	-	—	—	—	—	—															
STOOL	—	—	—	-	—	—	—	—	—															
O.R. OUT																								
SUBTOTAL	200	250	180	110	180	190	170	180	270	175	250	160	200	200	110	140	110	140	180	150	180	200	120	100
TOTAL	290	540	720	830	1010	1200	1370	1550	1820	1995	2245	2405	2605	2805	2915	3055	3165	3305	3485					
BALANCE	-43	+307	-122	-52	-122	+268	-112	-131	-242	281	-194	-106												

MEDCOM - 18421

[redacted] Dlc 7 Sept 03

	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
BP INV	157/83	140/80	9C																					
BP NIBP	134/80	141/83	139/81	141/81		138/80		130/72	128/67					137/91		124/99		124/75				147/85		131/75
TEMP				983				974						983		98.9		100			98	100		98
PULSE	127	97	101	87		16		102	96					116		95		106				105		97
RESP	30	25	16	20		101		17	14					13		14		13				17		20
SP02	100	99	99	100	99	99		100	100					94		96		99				98		99
FIO2	RA	RA	RA	RA	RA	RA		RA	RA					RA		RA		RA				RA		RA
MAP		105							96					92										
INPUT																								
IV	0	0	0	10	10	10			20															
PO	3	3	2	1	0	0																		
NGT		400				200	(4hr)		100															
~~ABSIN~~		0				60			40															
SUB TOTAL																								
TOTAL																								
OUTPUT																								
URINE	200	180	100	200	350	360		200		200				200	170	45		60			200	90		150
NGT	0																							
STOOL	0																							
O.R. OUT																								
SUBTOTAL																								
TOTAL																								
BALANCE																								

128/74 94 150R 103 99% 0800

MEDCOM - 18422

SIMV 14
FiO2 40%
peep 5
TV 750

b(6)-4

i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____25 mmol/L

At 37C

pH_____7.448

PCO2_____34.3 mmHg

PO2_____193 mmHg

HCO3_____24 mmol/L

BEecf_____0 mmol/L

sO2*_____100 %

*calculated

Sample Type_:

03SEP03 04:21

Oper: [redacted]

Physician: b(6)-2

Ser# 40746

Ver: JAMS046A
CLEW A93

---

b(6)-4

i-STAT G3+ SIMV 14 TV 750 peep 5 FiO2 60%

Pt: [redacted]

Pt Name:_____

TCO2_____25 mmol/L

At 37C

pH_____7.436

PCO2_____35.7 mmHg

PO2_____286 mmHg

HCO3_____24 mmol/L

BEecf_____0 mmol/L

sO2*_____100 %

*calculated

At Patient Temp

pH_____7.435

PCO2_____35.9 mmHg

PO2_____286 mmHg

Patient Temp: 98.8F

FIO2_____: 60

Sample Type_:

02SEP03 17:57

Oper [redacted]

Physician: b(6)-2

Ser# 42015

Ver: JAMS046A
CLEW A93

---

i-STAT EC8+

Pt: [redacted] b(6)-4

Pt Name:_____

creatnine - 1.4

Glu_____139 mg/dL

BUN_____15 mg/dL

Na_____139 mmol/L

K_____3.9 mmol/L

Cl_____106 mmol/L

TCO2_____24 mmol/L

AnGap_____14 mmol/L

Hct_____25 %PCV

Hb*_____9 g/dL

*via Hct

pH_____7.453

PCO2_____33.3 mmHg

HCO3_____23 mmol/L

BEecf_____-1 mmol/L

Sample Type_:

03SEP03 04:24

Oper: [redacted] b(6)-2

Physician:_____

Ser# 42015

Ver: JAMS046A
CLEW A93

stat

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

LAST, FIRST, MI. 200	DATE 25 Sep 03	TIME	SSN/PEEUDO SSN: 200

(Hematology) CBC		
		REF. RANGE
		8 x10
		itial

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	**Macroscopic Urinalysis**		
HCG		Negative			

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

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

REMARKS:

REPORTED BY: CA

MEDCOM - 18424

ID NO.:

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

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

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/dL
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 (art)
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
Tropoin-1		
Drug of Abuse		

(Piccolo) Chemistry 12

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

======= PICCOLO =======
02/09/03 08:26
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(w)-4
METLYTE 8
DISC LOT #: 3141AA4
OPER # [redacted] DR #: 000
SERIAL #: b(w) 2 0000100676

GLU	197*	73-118	MG/DL
BUN	7	7-22	MG/DL
CRE	1.1	0.6-1.2	MG/DL
CK	586*	39-380	U/L
NA+	133	128-145	MMOL/L
K+	3.0*	3.3-4.7	MMOL/L
CL-	104	98-108	MMOL/L
tCO2	20	18-33	MMOL/L

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^{+}		128-145 mmol/dl
K^{+}		3.3-4.7 mmol/l
CL^{-}		98-108 mmol/l
tCO2		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
AST		14-97 u/l
AMY		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA^{+}		128-145 mmol/l
K^{+}		3.3-4.7 mmol/l
CL^{-}		98-108 mmol/l
CO2		18-33 mmol/l

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

b(6)-2

Ward/Section: OR

REQUESTING PHYSICIAN: [redacted]

CHEMISTRY RESULT FORM

(Subject to the Privacy Act of 1974)

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

DATE: 02 SEP 03

TIME: 0940

SSN/PS: #[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	b(6)-2	38-51% PCV
Hgb		[redacted]

Mis[redacted]

TEST	RES[redacted]GE
Troponin-I	
Drug of Abuse	

REMARKS:

REPORTED BY: SK

(Piccolo) Chemistry 12

---------- 2 ----------

i-STAT EG7+

Pt: [redacted]

Pt Name: b(6)-4

Na_____141 mmol/L

K_____2.7 mmol/L

TCO2_____23 mmol/L

iCa_____1.18 mmol/L

Hct_____31 %PCV

Hb*_____11 g/dL

*via Hct

At 37C

PH_____7.306

PCO2_____43.6 mmHg

PO2_____419 mmHg

HCO3_____22 mmol/L

BEecf_____-5 mmol/L

SO2*_____100 %

*calculated

At Patient Temp

PH_____7.312

PCO2_____42.7 mmHg

PO2_____416 mmHg

Patient Temp: 97.8F

FIO2_____: 75

Sample Type_: ART

02SEP03 09:47

Oper: [redacted]

Physician: b(6)-2

Ser# 42015

Ver: JAMS046A
CLEW A93

(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

b(6)-2

Ward/Section: OR

[redacted]

TORY RESULT FORM
(o the Privacy Act of 1974)

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

DATE: 02 SEP

TIME: 1045

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

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.0-1
RBC		
P.		
Ly.		
Segs		
Bands		
Lymph		
Atyp		1mm
RBC Morph		
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/02/03 10:52 AM

Patient ID: [redacted] b(6)-4
Test Name :PT
Test Result:= 16.0 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.3
Calculated INR = 1.55
Sample Type:citrated wh. blood
Test Date :09/02/03
Test Time :10:51 AM
Card Lot :080201
Operator [redacted] b(6)-2

Urinalysis

	RESULT	REF. RANGE
		N/A
		N/A
		Negative
		Negative
		Negative
		N/A
		Negative
		N/A
		Negative
		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

I Bank

SF 518 WITH REQUESTED

OF BLOOD

ROSSMATCH

Coagulation Studies

STAT

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

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/02/03 11:01 AM

Patient ID [redacted] b(6)-4
Test Name :APTT
Test Result:= 29.1 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/02/03
Test Time :10:59 AM
Card Lot :030201
Operator [redacted] b(6)-2

REMARKS:

REPORTED BY: **DA**

EV#7

b(6)-2 T-[illegible] / FIO2 76% 33 ET CO2

Ward/Section: OR	REQUESTING PH[redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST [redacted] b(6)-4		DATE 2Sep03	TIME 1350	SSN/PSEUDO SSN:

(STAT)

i-STAT EG7+

Pt: [redacted]

Pt Name:_____

Na_____142 mmol/L
K_____5.6 mmol/L
TCO2_____24 mmol/L
iCa_____1.15 mmol/L
Hct_____28 %PCV
Hb*_____10 g/dL
*via Hct

At 37C
pH_____7.360
PCO2_____41.1 mmHg
PO2_____419 mmHg
HCO3_____23 mmol/L
BEecf_____-2 mmol/L
SO2*_____100 %
*calculated

FIO2_____: 76
Sample Type_: ART

02SEP03 11:59

Oper: [redacted] b(6)-2

Physician:_____

Ser# 42015
Ver: JAMS046A
CLEW A93

(Piccolo) Chemistry 12

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

i-STAT G3+

Pt: [redacted] b(6)-4

Pt Name:_____

TCO2_____25 mmol/L

At 37C
pH_____7.336
PCO2_____44.5 mmHg
PO2_____573 mmHg
HCO3_____24 mmol/L
BEecf_____-2 mmol/L
SO2*_____100 %
*calculated

Sample Type_:

02SEP03 13:53

Oper [redacted]

Physician:_____

Ser# [redacted]
Ver: JAMS046A
CLEW A93

(Piccolo) Metabolic Panel

TES	RESULT	REF RANGE
GLU		
BUN		
CA+		
CRE		
NA+		
K+		
CL-		
tCO		

i-STAT EG7+

Pt: [redacted]

Pt Name:_____

Na_____139 mmol/L
K_____4.9 mmol/L
TCO2_____24 mmol/L
iCa_____1.11 mmol/L
Hct_____40 %PCV
Hb*_____14 g/dL
*via Hct

At 37C
pH_____7.340
PCO2_____42.7 mmHg
PO2_____522 mmHg
HCO3_____23 mmol/L
BEecf_____-3 mmol/L
SO2*_____100 %
*calculated

Sample Type_:

02SEP03 14:04

Oper [redacted]

Physician:_____

Ser# 42015
Ver: JAMS046A
CLEW A93

b(6)-2

[redacted] DATE: 2Sep03 LAB ID NO.:

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

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

(i-STAT)			(Piccolo) Chemistry 12			(Piccolo) Metabolic Panel		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
Na		138-146 mmol/L	Al		3.5-5.5 g/dl	GLU		73-118 mg/dl

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/03/03 04:24 AM

Patient ID: [redacted] b(6)-4
Test Name :PT
Test Result:= 14.3 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.2
Calculated INR = 1.29
Sample Type:citrated wh. blood
Test Date :09/03/03
Test Time :04:23 AM
Card Lot :010301[redacted]
Operator [redacted] b(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/03/03 04:28 AM

Patient ID: [redacted] b(6)-4
Test Name :APTT
Test Result:= 30.6 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/03/03
Test Time :04:26 AM
Card Lot :030201
Operator : [redacted] b(6)-2

[redacted] ICU2 # b(6)-4

LABORATORY FILE

SPECIMEN/LAB RPT. NO.

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

SPECIMEN SOURCE (Specify): A-line

LAB ID NO.

MISC URGENCY: ☒ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT

DATE: 3Sep03

MD / TECH

PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REPORTED BY

Enter in above space

REQUESTING PHYSICIAN'S SIGNATURE: [redacted]

REMARKS: Dr

MISCELLANEOUS 557-107
STANDARD FORM 557 (Rev. 3-77)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45-505

ABG Freq 4hrs

CBC PT/PTT, Chem 7

TEST(S)	SPECIMEN TAKEN	DATE	TIME	REQUESTED	RESULTS
		3Sep	0400 A.M. P.M.		
				CBC PT/PTT Chem 7	

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

LAST, FIRST, MI. [redacted] b(6)-4 | DATE 4 SEP | TIME 0615 | SSN/PSEUDO SSN:

(Hematology) CB[redacted]			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			Negative
								Negative
			Glu					
								Negative
								Negative
			b					
			k					
			G					

biology

rinalysis

k

18 WITH ESTED

OOD

ATCH

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/04/03 06:21 AM

Patient ID [redacted] b(6)-4
Test Name :PT
Test Result:= 13.1 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.1
Calculated INR = 1.12
Sample Type:citrated wh. blood
Test Date :09/04/03
Test Time :06:19 AM
Card Lot :010301
Operator [redacted] b(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/04/03 06:23 AM

Patient ID [redacted] b(6)-4
Test Name :APTT
Test Result:= 25.2 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/04/03
Test Time :06:21 AM
Card Lot :030201
Operator [redacted] b(6)-2

i-STAT G3+
Pt: [redacted] b(6)-4
Pt Name:_____
TCO2_____30 mmol/L
At 37C
pH_____7.539
PCO2_____34.4 mmHg
PO2_____173 mmHg
HCO3_____29 mmol/L
BEecf_____7 mmol/L
sO2*_____100 %
*calculated

At Patient Temp
pH_____7.541
PCO2_____34.2 mmHg
PO2_____173 mmHg

Patient Temp: 98.4F
FIO2_____: 35
Sample Type_:
04SEP03 06:16
Oper: [redacted] b(6)-2
Physician:_____
Ser# 42011
Ver: JAMS046A
CLEW A93

CSF

ctigen

B
(MUST SUBMIT

UNIT

FDP

REMARKS: ABG T: 98.4 FIO2 35%

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

EG-7 T- / FIO2 76 34 ETCO2

Ward/Section: OR	REQUESTING PHYSICIAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted]	DATE 2Sept	TIME 1445	SSN/PSEUDO SSN:

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE

SIMV TV 700 RR14 FIO2 35% PS

TEST(S) SPECIMEN TAKEN DATE 5Sept03 TIME 0400 A.M. P.M.

REMARKS: PC

REQUESTING: Enter in above

i-STAT EG7+

Pt: [redacted] bkw-4

Pt Name:

Na 140 mmol/L
K 4.6 mmol/L
TCO2 24 mmol/L
iCa 1.13 mmol/L
Hct 20 %PCV
Hb* 7 g/dL
*via Hct

At 37C
pH 7.386
PCO2 38.6 mmHg
PO2 431 mmHg
HCO3 23 mmol/L
BEecf -2 mmol/L
sO2* 100 %
*calculated

Sample Type:

02SEP03 14:48

Oper: [redacted]

Physician:

Ser# [redacted] blw-2

Ver: JAMS046A CLEW A93

i-STAT EG7+

Pt: [redacted] PS

Pt Name:

Na 140 mmol/L
K 3.9 mmol/L
TCO2 26 mmol/L
iCa 1.25 mmol/L
Hct 23 %PCV
Hb* 8 g/dL
*via Hct

At 37C
pH 7.482
PCO2 33.4 mmHg
PO2 175 mmHg
HCO3 25 mmol/L
BEecf 1 mmol/L
sO2* 100 %
*calculated

Sample Type:

03SEP03 11:16

Oper [redacted]

Physician:

Ser [redacted]

Ver: JAMS046A CLEW A93

======= PICCOLO =======
05/09/03 04:20
REFERENCE RANGE: MALE
PATIENT #: 700
METLYTE 8
DISC LOT #: 3151AA4
OPER #: 777 DR #: 000
SERIAL #: 0000100676

GLU	156*	73-118	MG/DL
BUN	13	7-22	MG/DL
CRE	1.1	0.6-1.2	MG/DL
CK	743*	39-380	U/L
NA+	129	128-145	MMOL/L
K+	4.0	3.3-4.7	MMOL/L
CL-	107	98-108	MMOL/L
tCO2	21	18-33	MMOL/L

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

[redacted] ICU 2 blw-1

MISC
URGENCY: ☐ STAT ☐ PRE-OP ☐ TODAY ☒ ROUTINE
PATIENT STATUS: ☒ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM
SPECIMEN SOURCE (Specify)

LABORATORY FILE

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: ICU 2	REQUESTING PHYSICIAN: b(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted]	DATE 09/02/03	TIME 1600	SSN/PSEUDO SSN:

(Hematology) CBC

[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/02/03 04:07 PM

Patient ID: [redacted] b(6)-4
Test Name :PT
Test Result:= 14.9 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.2
Calculated INR = 1.38
Sample Type:citrated wh. blood
Test Date :09/02/03
Test Time :04:05 PM
Card Lot :010301
Operator [redacted] b(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/02/03 04:16 PM

Patient ID: [redacted] b(6)-4
Test Name :APTT
Test Result:= 32.9 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/02/03
Test Time :04:14 PM
Card Lot :030201
Operator [redacted]
b(6)-2

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Blood Bank U
(MUST SUBMIT SF 518 WI
REQU

UNIT	TY

ATE: | LAB ID NO.:

Misc. Serology

TEST	RESULT	REF RANGE

---

i-STAT EG7+

Pt: [redacted] b(6)-4

Pt Name:_____

Na_____139 mmol/L
K_____4.6 mmol/L
TCO2_____27 mmol/L
iCa_____1.21 mmol/L
Hct_____34 %PCV
Hb*_____12 g/dL
*via Hct

At 37C
pH_____7.271
PCO2_____54.2 mmHg
PO2_____445 mmHg
HCO3_____25 mmol/L
BEecf_____-2 mmol/L
sO2*_____100 %
*calculated

At Patient Temp
pH_____7.277
PCO2_____53.3 mmHg
PO2_____443 mmHg

Patient Temp: 97.9F
FIO2_____: 70
Sample Type_: ART

025EP03 16:05

Oper: [redacted] b(6)-2

Physician:_____

Ser# 42015
Ver: JAMS046A
CLEW A93

MEDCOM - 18432

LCWH [redacted] b(6)-2

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

LAST, FIRST, MI	DATE	TIME	SSN/PSEUDO SSN:
CIVH [redacted] b(6)-4	4 Sep	0510	

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

REMARKS:

REPORTED BY:

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA^{++}		[illegible]

```
======= PICCOLO =======
04/09/03          05:24
REFERENCE RANGE:      MALE
PATIENT #: [redacted]
METLYTE 8          b(6)-4
DISC LOT #:       3151AA4
OPER #: 678     DR #: 000
SERIAL #:     0000100684
.........................
GLU   139*  73-118   MG/DL
BUN    18   7-22     MG/DL
CRE   1.3*  0.6-1.2  MG/DL
CK    622*  39-380   U/L
NA+   ***140 128-145 MMOL/L
K+    4.0   3.3-4.7  MMOL/L
CL-   106   98-108   MMOL/L
tCO2  21    18-33    MMOL/L

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

Ward/Section: ICU#2	[redacted] b(6)-2	ORATORY RESULT FORM (ect to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] b(6)-4	DATE 45ep03 / TIME 0510	SSN/PSEUDO SSN:

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3	Color		N/A	RPR		Negative
RBC		4.7-6.1 x 10^9	App		N/A	Mono		Negative
		14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	**Microbiology**		
		42-52% (M) 37-47% (F)	Bili		Negative	Source		
		80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
		130-500 x 10^3 verified	SG		N/A	Occ Bld		Negative
		20.5-51.1%	Bld		Negative	H. pylori		Negative
		al Differential	pH		N/A	Micro Parasites		
		ono	Prot		Negative	Malaria		
		s	Urob		0.2-1.0	O & P		
		so	Nit		Negative	Other		
		n	Leuk		Negative	**Microscopic Urinalysis**		
			HCG		Negative			
		42-52% (M) 37-47% (F)	**CSF**			**Blood Bank**		
			Cell Count			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED		
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.:

---

i-STAT G3+

T-piece trial

Pt: [redacted] b(6)-4

~~Pt Name~~: [redacted]

TCO2_____31 mmol/L

At 37C

PH_____7.454

PCO2_____44.8 mmHg

PO2_____243 mmHg

HCO3_____31 mmol/L

BEecf_____6 mmol/L

sO2*_____100 %

*calculated

Patient Temp

Oper: [redacted] b(6)-2

Physician:_____

Ser# 40746

Ver: JAMS046A
CLEW A93

---

i-STAT G3+

Pt: [redacted] b(6)-4

~~Pt Name~~: [redacted]

TCO2_____31 mmol/L

At 37C

PH_____7.472

PCO2_____40.4 mmHg

PO2_____213 mmHg

HCO3_____30 mmol/L

BEecf_____6 mmol/L

sO2*_____100 %

*calculated

At Patient Temp

PH_____7.471

PCO2_____40.5 mmHg

PO2_____213 mmHg

Patient Temp: 98.7F

FIO2_____: 45

Sample Type_:

05SEP03 04:18

Oper: [redacted]

Physician: b(6)-2

Ser# 42015

Ver: JAMS046A
CLEW A93

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/05/03 04:11 AM

Patient ID: [redacted] b(6)-4
Test Name :PT
Test Result:= 11.7 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.0
Calculated INR = 0.93
Sample Type:citrated wh. blood
Test Date :09/05/03
Test Time :04:09 AM
Card Lot :010301
Operator [redacted]

b(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/05/03 04:13 AM

Patient ID: [redacted] b(6)-4
Test Name :APTT
Test Result:< 15 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/05/03
Test Time :04:11 AM
Card Lot :030201
Operator [redacted] b(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/05/03 04:16 AM

Patient ID: [redacted] b(6)-4
Test Name :APTT
Test Result:= 16.6 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/05/03
Test Time :04:14 AM
Card Lot :030201
Operator [redacted]

b(6)-2

b(6)-2

Ward/Section: ICU A2 | TESTING PHYSICIAN: [redacted] | LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. b(6)-2 [redacted] | DATE 6 SEP | TIME 1430 | SSN/PSEUDO SSN:

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
		-10.8 x 10³	Color		N/A	RPR		Negative
		-6.1 x 10⁹	App		N/A	Mono		Negative
		-18 g/dl (M) -16 g/dl (F)	Glu		Negative	Microbiology		
		-52% (M) -47% (F)	Bili		Negative	Source		
		-94 fl (M) -99 fl (F)	Ket					
		0-500 x 10³ rified	SG					
		0.5-51.1%	Bld					
Differential			pH					
			Prot					
			Urob					

NSN 7540-00-181-8344 PREVIOUS EDITION USABLE

TEST(S) SPECIMEN TAKEN: DATE 2 Sep | TIME 1800 A.M. P.M.

REQUESTED: ABG

RESULTS

REMARKS: ABG b(6)-2

REQUESTING PHYSICIAN'S SIGNATURE: [redacted]

REPORTED BY

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

TECH | MD | DATE

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

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

SPECIMEN SOURCE (Specify): 14-Lin

LAB ID NO.

MISC

SPECIMEN/LAB RPT. NO.

557-107

PHYSICIAN'S COPY

#

[redacted] b(6)-4

Hematocrit		42-52% 37-47%
Sed Rate		
Other		

Coagulation Studies		
TEST	RESULT	REF. R
PT		9.8-13.6
APTT		21-34 sec
D dimer		<20 ug/m
FDP		<10 ug/m

REMARKS:

REPORTED BY:

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/06/03 06:06 AM

Patient ID: [redacted] b(6)-4
Test Name :PT
Test Result:= 11.0 sec.
RESULT NOT RANGE CHECKED
Ratio = 0.9
Calculated INR = 0.85
Sample Type:citrated wh. blood
Test Date :09/06/03
Test Time :06:04 AM
Card Lot :010301
Operator [redacted] b(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/06/03 06:09 AM

Patient ID: [redacted] b(6)-4
Test Name :APTT
Test Result:= 16.8 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/06/03
Test Time :06:07 AM
Card Lot :030201
Operator [redacted] b(6)-2

b(6)-2

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

(Subject to the Privacy Act of 1974)

(i-STAT)

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

(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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

---

i-STAT G3+

Pt: [redacted] b(6)-4

Pt Name:_____

TCO2_____32 mmol/L

At 37C

PH_____7.418

PCO2_____47.5 mmHg

PO2_____142 mmHg

HCO3_____31 mmol/L

BEecf_____6 mmol/L

SO2*_____99 %

*calculated

At Patient Temp

PH_____7.419

PCO2_____47.4 mmHg

PO2_____142 mmHg

Patient Temp: 98.5F

Sample Type_:

06SEP03 06:16

Op [redacted]

Physician: b(6)-2

Ser# [redacted]

Ver: JAM5046A
CLEW A93

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

06/09/03 05:14

REFERENCE RANGE: [redacted] MALE

PATIENT #: [redacted]

METLYTE 8

DISC LOT #: b(6)-4 3151AA4

OPER #: 702 DR #: 000

SERIAL #: 0000100676

GLU	154*	73-118	MG/DL
BUN	12	7-22	MG/DL
CRE	1.5*	0.6-1.2	MG/DL
CK	444*	39-380	U/L
NA+	132	128-145	MMOL
K+	4.0	3.3-4.7	MMOL
CL-	104	98-108	MMOL
tCO2	24	18-33	MMOL

INST QC: OK CHEM QC: OK

HEM 0 , LIP 0 , ICT 0

6Sep03

Ward/Section: [redacted]

REQUESTING PHYSICIAN: [redacted]

b(6)-7

b(6)-4 [redacted]

DATE 7SEP03 TIME 0425

CHEMISTRY RESULT FORM

(Pursuant to the Privacy Act of 1974)

SSN/PSEUDO SSN:

i-STAT G3+

Pt [redacted]

Pt Name: b(6)-4

TCO2_____34 mmol/L

At 37C

pH_____7.502

PCO2_____42.4 mmHg

PO2_____99 mmHg

HCO3_____33 mmol/L

BEecf_____10 mmol/L

sO2*_____98 %

*calculated

Sample Type_:

07SEP03 04:31

Oper: [redacted] b(6)-2

Physician:_____

Ser# 43011

Ver: JAM5046A
CLEW A93

REF. RANGE
138-146 mmol/L
3.5-4.9 mmol/L
98-109 mmol/L
7.31-7.45
35-45 mmHg (art)
35-51 mmHg (ven)
80-105 mmHg (art)
(ven)
17 mmol/L (art)
19 mmol/L (ven)
6 mmol/L (art)
8 mmol/L (ven)
98%
(+3)
mmol/L
1.32 mmol/L
mg/dl
5 mg/dl
mg/dl
% PCV
g/dl
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		

PICCOLO 04:41
07/09/03 MALE
REFERENCE RANGE:
PATIENT #: [redacted] b(6)-4
METLYTE 8 3141AA4
DISC LOT #: DF #: 000
OPER #: 702 0000140634
SERIAL #:

GLU	109	73-118	MG/DL
BUN	10	7-22	MG/DL
CRE	0.8	[redacted]	
CK	676*	39-380	UM/L
NA+	136	128-145	MMOL
K+	3.9	3.3-4.7	MMOL
CL-	102	98-108	MMOL
tCO2	24	18-33	MMOL

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

ABO - temp

REPORTED BY:

Ward/Section: ICU/A2	REQUESTING PHYS: [redacted] b(6)	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)		
[redacted] b(6)-4	DATE 7 SEP	TIME 0425	SSN/PSEUDO SSN:	

CBC			Urinalysis			Misc. Serology		
	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	
	.8-10.8 x 10³	Color		N/A	RPR		Negative	
	.7-6.1 x 10⁹	App		N/A	Mono		Negative	
	4-18 g/dl (M) 2-16 g/dl (F)	Glu		Negative	**Microbiology**			
	2-52% (M) 7-47% (F)	Bili		Negative	Source			
	0-94 fl (M) 1-99 fl (F)	Ket		Negative	Gram Stain			
	30-500 x 10³ crified	SG		N/A	Occ Bld		Negative	
	0.5-51.1%	Bld		Negative	H. pylori		Negative	
	Differential	pH		N/A	Micro Parasites			
	o	Prot		Negative	Malaria			
		Urob		0.2-1.0	O & P			
		Nit		Negative	Other			
		Leuk		Negative	**Microscopic Urinalysis**			
		HCG		Negative				

CSF			Blood Bank	
Cell Count			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED	
Directigen		Negative	ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

DATE:	LAB ID NO.:

ID: 000750 07-09-03
WB 04:48

				Patient Limits	
WBC	10.2	x10^3/uL		4.5	10.5
RBC	3.56 L	x10^6/uL		4.00	6.00
Hgb	9.6 L	g/dL		11.0	18.0
Hct	31.1 L	%		35.0	60.0
MCV	87.5	fL		80.0	99.9
MCH	27.7	pg		27.0	31.0
MCHC	31.6 L	g/dL		33.0	37.0
Plt	315.	x10^3/uL		150.	450.
LY%	25.4	%		20.5	51.1
LY#	2.6	x10^3/uL		1.2	3.4

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/07/03 05:42 AM

Patient ID: [redacted] b(6)-4
Test Name :PT
Test Result:= 11.6 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.0
Calculated INR = 0.92
Sample Type:citrated wh. blood
Test Date :09/07/03
Test Time :05:41 AM
Card Lot :010301
Operator [redacted]
b(6)-6

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/07/03 05:45 AM

Patient ID [redacted] b(6)-4
Test Name :APTT
Test Result:= 22.5 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/07/03
Test Time :05:43 AM
Card Lot :030201
Operator [redacted]
b(6)-2

25/M NKDA Type X 4 units

MEDICAL RECORD - ANESTHESIA

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

NKDA

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

DRUG (Units)													TOTALS	TOTAL EBL
Fentanyl (mcg)	25-25		50	50	100	100	100	50					500	500
Propofol (mg)		50-20											70	
ICB (mg)		10				10				5		5	40	TOTAL URINE
Ancef (g)							4	2			4	1	20	
Midazolam (g)													5	3900
VOLAT AGENT 50 % del		0.4	0.6	0.8	1.5	1.8	1.9	2.0	2	2	2	2		
% e.t.														
AIR L/Min														
N2O L/Min														
O2 L/Min	LR 2	NC ~10	~2	2	1	1	1	1	1	1	1	1		

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

FLUIDS

LINE site												
NS (L) ☐ Warmed	From the ER											
NS (R) ☐ Warmed		1000 LR #3										
ER 2L ☐ Warmed		1000 LR #4							4000 LR #5 #6			
							Hesp 500 mL					
LOSSES: EST BLOOD LOSS							350					200
URINE	1500					650/2150				2200		

PHYS STATUS 1 2 3 4 5 (E)

BODY WEIGHT: 75 (KG) LB

HEMATOCRIT: 31

INITIAL DATA: BP- 164, 111 HR- 116

EQUIP CHECK (OK?) Y N

PATIENT RECHECK OK for PROCEDURE? TIME- 0831

TIME → 24 41 0900 30 1000 X 30 1100

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

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

7.31 Na 141
PaO2 43.6 K 2.7
PO2 419 iCa 1.19
HCO3 22 H 131
BP 75

VENTIL

VT - ml	*	710	710	810	670	550	670	720	810	710	720	690
f - breaths/min	*	10	12	8	8	10	8	8	8	8	8	9
Peak inf pres / PEEP	*	28	28	27	26	28	33	32	28	27	27	27
MODE - S(pon), A(ssist), C(on)	S	C	C	C	C	C	C	C	C	C	C	C

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	50	45	31	33	32	34	33	32	32	32	32	32
BP/oth	FIO2 (Frac or %)	0.71	0.71	0.71	0.74	0.75	0.76	0.76	0.76	.75	0.76	0.76	0.76
ART line	SpO2 (%)	96	~100	~98	~98	~100	100	100	100	100	100	100	100
Steth- PC/ES	ECG	ST	~	ST	~	SR	SR	SR	SR	SR	SR	SR	SR
Gas analyzer	TEMP-site	Available							34.1		34.2	34.6	X
	N-M Block (T/4)				0/4		3/4		0/4		2/4	0/4	
Warming blkt													
Conv warmer													

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

REMARKS

Code drugs with numbers, events with letters

(1) Trauma, emergency cursory COR - interpretation in OR room! O2 AX 4-Pm

(2) Monitors on supine Dr. [redacted] performed cricoid cut 0845

(3) Catheter Dgm IVPB

1035 - Pt c frequent PVCs K+ on ABG was 2.7 - will give 40meq KCl IV over 30 min

PT-16, IPR-1.55 APTT-29.1 Dr. N. Sc Quick 2

RECOVERY AT 1545

PACU (ICU) 2 (Specify)

OTHER T-97.9Ax

CONDITION: Stable/Critical

RESP- 16 SpO2- 100

BP- 172/92 HR- 92

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0810	0830	1010
PROC	Ready 0845	Begin 0920	End 1530

PROCEDURES and CPT Codes: Cricothyroidotomy / Open gastrostomy (Exlap) / Clip IAD / Closure of mouth wounds

ANESTHETIC TECHNIQUES: Describe block technique under Remarks GETA

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

[redacted]

b(6)-4

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: Fent, TIVA, Propofol TIVA; Ind supine; Dr. [redacted] performed Cricothyroidotomy. +BBS, SuxTOCO2

SURGEON: [redacted]

PROCEDURE LOCATION: Trauma

[redacted] CRNA / MAJ

2-Sept03

PAGE 1 OF 3

[redacted] MD, CPT, MC.

b(6)-2