II T.
NKA

MEDICAL RECORD - ANESTHESIA

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

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

DRUG (Units)	08	X	30	X	09	X	30	X	10	X	30	X	TOTALS
Versed (mg)	2												2
Fentanyl (cc)	(4)		1						2		1		2
Lido/Propofol (mg)	20/100												10 cc
Remuron (mg)	50		20			10		10	10		2		
Reglan (mg)		10											
MSO4 (mg)					5	5							
VOLAT AGENT FOR % del	2	1	.8	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	
% e.t.													
AIR L/Min													
N2O L/Min													
O2 L/Min	6	2	2	2	2	2	2	2	2	2	2	2	

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

TOTAL EBL	100
TOTAL URINE	300
	20

FLUIDS - SUMMARY
CRYSTALLOID- LR - 2000
COLLOID-
BLOOD-

FLUIDS

LINE site	08	X	30	X	09	X	30	X	10	X	30	X
LA 16g ☐ Warmed	(300)		500		600		800-1000					
☐ Warmed												
☐ Warmed												
☐ Warmed												

LOSSES — EST BLOOD LOSS; URINE - Foley per OR Nurse

PHYS STATUS 1 (2) 3 4 5 E

BODY WEIGHT: 75 (KG) LB

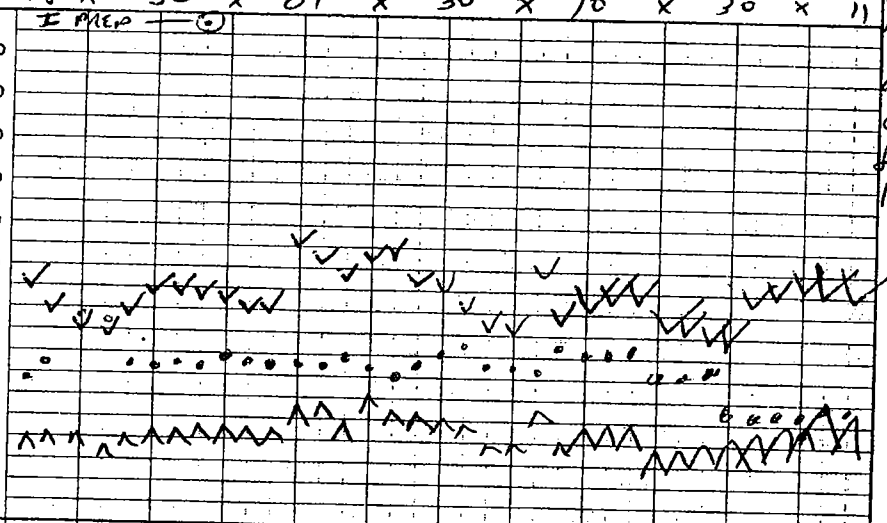
HEMATOCRIT: 37.2

INITIAL DATA: BP- 108/39 HR- 69 97%

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK OK for PROCEDURE- Yes TIME- 0740

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



VENTIL

	08	X	30	X	09	X	30	X	10	X	30	X
VT - ml		680	700	710	690	810	710	830	830	810	810	880
f - breaths/min		8	8	8	8	8	8	8	8	8	8	8
Peak inf pres / PEEP		18	18	19	19	19	16	19	19	19	19	19
MODE - S(pon), A(ssist), C(on)		C	C	C	C	C	C	C	C	C	C	C

MONITORS/ACCESSORIES

		08	X	30	X	09	X	30	X	10	X	30	X
✓ BP/Auto Cuff	✓ ET CO2 (torr)	+	33	33	33	36	37	34	36	34	33	33	33
BP/oth	✓ FIO2 (Frac or %)	.8	.7	.7	.7	.7	.7	.7	.7	.7	.73	.73	.73
ART line	✓ SpO2 (%)	100	100	100	100	100	100	100	100	100	100	100	100
Steth- PC/ES	✓ ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR
Gas analyzer	✓ TEMP-site AX		34.4	34.3	35.0	35.5	35.9	35.9	36.0	36	36	36	36
	✓ N-M Block (T/4)	4	0	1	0	0	0	2	2	0	4	0	—
Warming blkt	BLANKET												
Conv warmer													

Mark with letters & symbols, explain under REMARKS — EVENTS Position → U arms tucked/padded

REMARKS — Code drugs with numbers, events with letters

preop, PIV ✓, NPO ✓ to OR comfortable, O2 monitors stable, IV induction c̄ cricoid, turn 90° pres in pt L prep drape
Foley per Surgeon
1% Lido c̄ epi —

0926 Throat pack in
1123 throat pack out

RECOVERY AT 1250
PACU ICU _____ (Specify)
OTHER _____
CONDITION: T 99.7
RESP. 12 SpO2- 88% RA
BP. 124/61 HR- 101

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0745	0805	1258
	Ready	Begin	End
PROC	0812	0840	1241

PROCEDURES and CPT Codes:
ORIF Lt Zygoma Fx

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
D2X1, 3MAC, gel I vins, 8.0 ETT @ 24
BSCTA = B + ET CO2 Benzoin Tape
GETA

PATIENT IDENTIFICATION: Typed or written entries: Name, Grade/Rate, Medical facility
Civ # [redacted]
22 yo O (Kurd) b(6)-4
[redacted]

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

SURGEON: [redacted]
ANEST: [redacted] b(6)-2

PROCEDURE LOCATION:
DATE 9/17/03
PAGE 1 OF

DA FORM 7389, FEB 1998
ICW2 5C

COPY 1 - PATIENT'S MEDICAL RECORD USAPA V1.00

Smoker
NKDA + Sniffles
2

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Se[illegible]n/Anesthesia)

Age 22 DAYS MOS YRS Sex (✓) MALE ( ) FEMALE

ASA Physical State 1 (2) 3 4 5 E
WT: 76 (KG/LB HT: ____ IN.
ALLERGIES: NKDA

PROPOSED PROCEDURE: OS Retinal Hemorrhage
SURGICAL SERVICE: Ophthal
NPO SINCE: This Am Breakfast

HABITS:
TOBACCO: yes
ETOH: ~~yes~~
DRUGS: ~~yes~~

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) ____
( ) ____
( ) ____
( ) ____
( ) ____
( ) ____

PREMEDICATIONS:
None Yes (@ ____ Hrs) /CC
____ . ____ mg IV IM PO
____ . ____ mg IV IM PO
____ . ____ mg IV IM PO

LABORATORY STUDIES:

HB/HCT: ____/____
U/A: ____
OTHER: ____

11.3 / 11.9 / 37.2 < 409
CT –
Common Zyg fx
Small FB in nose
Na 141 Bun 9 Cr 21 Glu 109 K 4.3 Cl 109 CRE 1.1 < 95

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:
- Hypertension N Y
- Angina N Y
- MI N Y
- CVA N Y
- Other N Y

Pulmonary System:
- Asthma N Y
- Bronchitis/URI N Y
- COPD N Y
- Other N Y

Renal System:
- Acute/Chronic RF N Y

Gastrointestinal:
- Hepatitis N Y
- Hiatal Hernia N Y
- PUD/GERD N Y

Endocrine System:
- Diabetes N Y
- Steriods N Y
- Thyroid N Y

Neurological:
- Seizures N Y
- Neuropathy N Y
- Other N Y

Gynecological :
- Pregnancy N Y N/A

Other Significant Hx:
- N Y Legs scraped
- N Y (P) Left wound
- Familial HX N Y 3rd digit finger

Involved in Car Crash 5 days ago.

ASSESSMENT
PAST SURGICAL/ANESTHETIC
Ø

PHYSICAL EXAMINATION
BP 127/54 HR 95 R ____ T ____
Pain Scale 0-10 ____
HEENT - Teeth intact
Trachea midline
TMJ/Neck FROM
Oropharnyx MP III MOZ FB:
Nares TM D3 FBs
CHEST: CTA (B)
CARDIAC: RRR (-) (m)
EXTREMITIES: FROM all extremities
IV Access: ____
Ulnar Filling: ____
BACK: ____
OTHER: (L) maxilla + mandible stable, multiple abraded wounds face; (B) periorbital ecchymosis

NPO Since Am

Discussed case c Dr [redacted] ophthalmology. Pre-op & General Plan for anesthesia accepted

ANESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ____ { } General: Mask Intubation

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discussed with the patient/legal guardian.

The pati[redacted] b(6)-2 [redacted]erstand and agrees. Questions answered.
Signed: [redacted] CRNA/MAJ Date: 15 Sept Time: 1535 Hrs

POST-[redacted]SIA EVALUATION A[redacted]E (NON ASU)
{ } NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward) ____

FP CIV [redacted] b(6)-4 I CW-2

SEDATION KEY:

1. **MINIMAL** (Anxiolysis) Patient responds normally to verbal commands
2. **MODERATE** (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is not necessary.
3. **DEEP SEDATION/ANALGESIA.** Patient responds purposefully following repeated or painful stimulation. Airway assistance may be necessary.
4. **ANESTHESIA.** Patient does not respond to painful stimulation.

NSN 7540-01-185-7294

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED	AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
1) Chest PA/lat (R)	22	♂	[redacted]	ICW / ED	
2) (R) knee and fib-fib	FILM NO.		b(6)-2		PREGNANT ☐ YES ☒ NO
3) (R) forearm views PA/lat and (R) hand	REQUESTED BY (Print) [redacted]		b(6)-2		TELEPHONE/PAGE
	SIGNATURE OF REQUESTOR KAREN M. PHILLIPS				DATE REQUESTED 13 Sep 03

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

22yo Kurdish soldier involved in car bombing - had face sensis for 05 injury - now doing 30 survey noted to have shrapnel wounds chest, (R) LE / tib fib (c) erythema; also c forearm lacs. x ii and (R) third digit volar wound - able to move digits.

DATE OF EXAMINATION (Month, day, year)	DATE OF REPORT (Month, day, year)	DATE OF TRANSCRIPTION (Month, day, year)

RADIOLOGIC REPORT

Chest 3mm schrapnel in (L) ant chest wall
lungs clear, ⊖ ptx, ⊖ rib fx,

(R) TIB/FIB ⊖ fx - 2-3 mm schrapnel in ant med sft t: medial med soft:

(R) knee ⊖ fx 1cm schrapnel ant int, sft tissues of knee prob extra-articular / 2mm piece in region of MCL

(L) knee ⊖ fx - 5mm schrapnel ? in lateral aspect of patella or on surface of lat patella

(R) forearm ⊖ fx - multiple pieces of schrapnel volar sft tissues of forearm + single piece medial elbow sft tissues but not ulna joint. [redacted]

PATIENT'S IDENTIFICATION (For typed or written entries give: Name — last, first, middle, Medical Facility)	LOCATION OF MEDICAL RECORDS
[redacted] # [redacted] b(6)-4 [redacted]	LOCATION OF RADIOLOGIC FACILITY
	SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED	AGE	SEX	SSN (Spo[redacted]	WARD/CLINIC	REGISTER NO.
CT FACE Axial + coronal views 3mm cuts ?	22	M	#[redacted] b(6)-4	ICW2	
	FILM NO.			PREGNANT ☐ YES ☒ NO	
	REQUESTED [redacted] b(6)-2			TELEPHONE/PAGE NO.	
				DATE REQUESTED 15Sep 03	

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

Left ZMC Fx

If c/n get coronal view then get 1.5mm axial cuts c̄ coronal reconstruction [redacted]

DATE OF EXAMINATION *(Month, day, year)*	DATE OF REPORT *(Month, day, year)*	DATE OF TRANSCRIPTION *(Mont[redacted]*
		b(6)-7

RADIOLOGIC REPORT

1) Numerous Metallic fragments including → (R) intraorbital (L) intraglobular nasal bone.

2) Comm (L) max fx involving orbital flr and lateral wall (No evid of muscle entrapment) although displaced at least 5mm

ZMC fr. (+) delayed (L) zygomatic fx anteriorly

3) (L) maxillary hematoma.

4) (L) facial swelling

b(6)-2 [redacted]

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name — last, first, middle, Medical Facility)*

[redacted]

Civ # [redacted]

b(6)-4

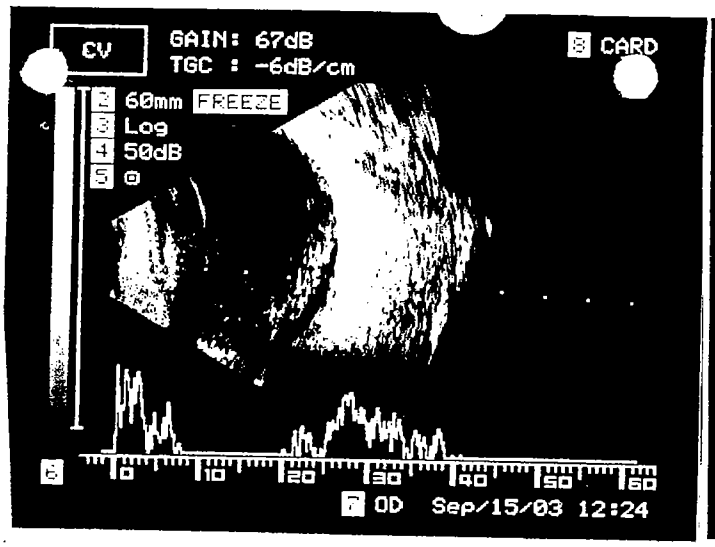
LOCATION O[redacted]

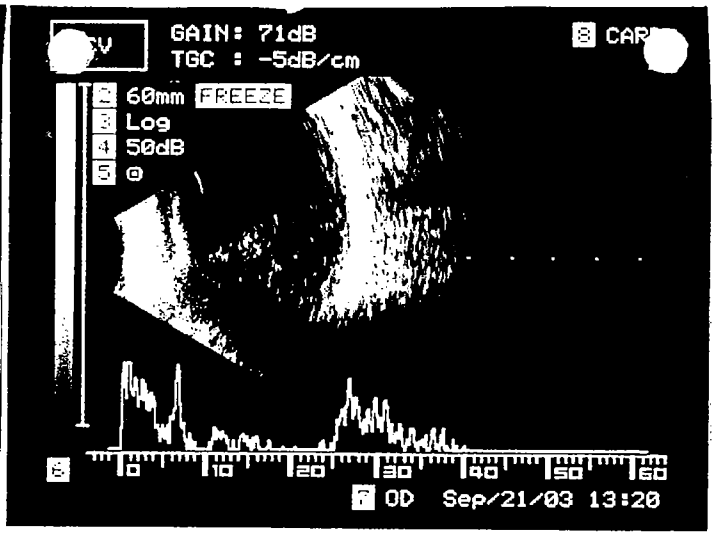
LOCATION OF RADIOLOGIC FACILITY

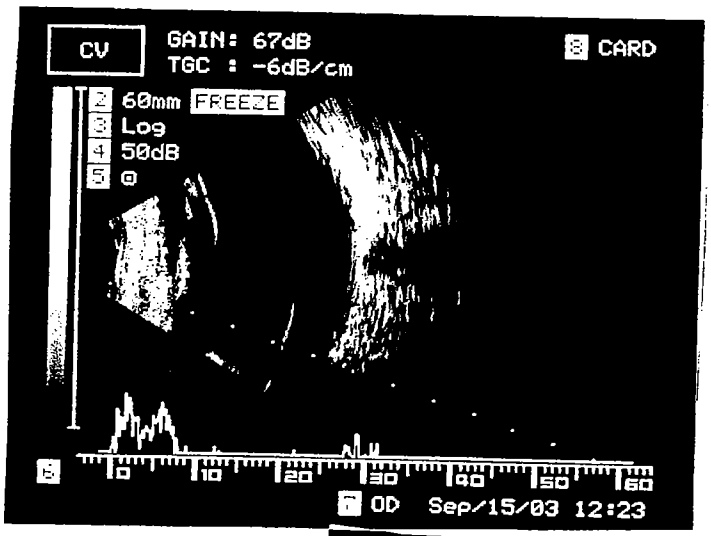
SIGNATURE

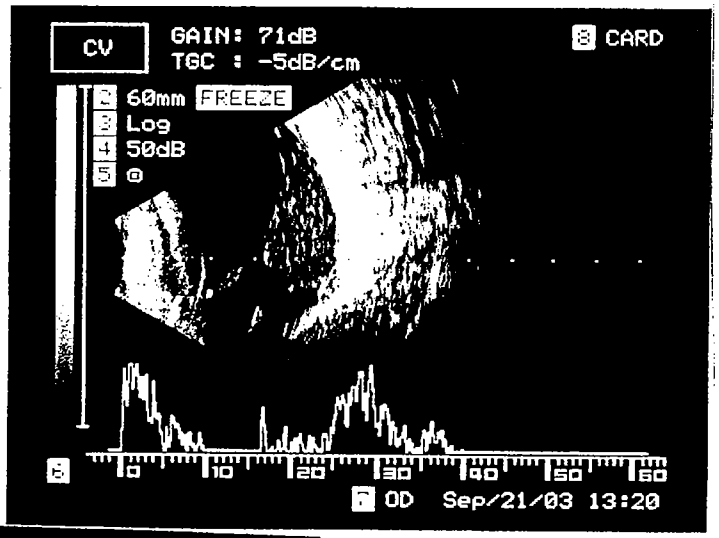
RADIOLOGIC CONSULTATION REQUEST/REPORT
1 — MEDICAL RECORD

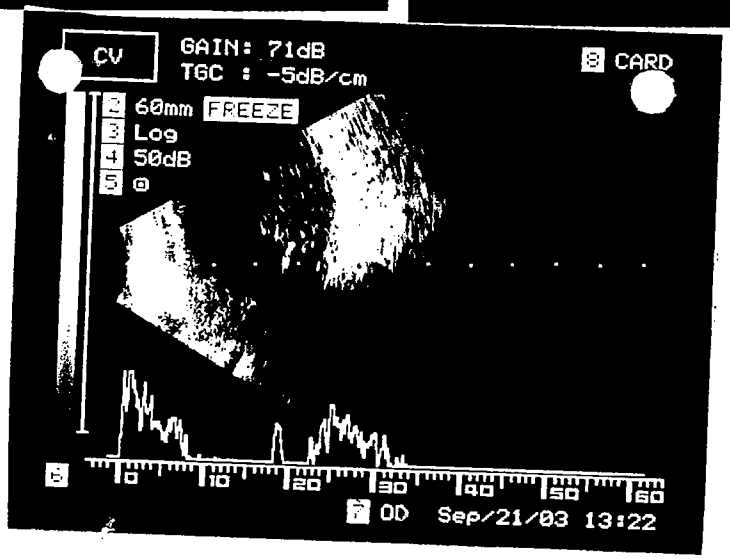
STANDARD FORM 519-B (8-83)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.806-8











#[redacted]

b/w-4

[redacted]

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

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

PATIENT IDENTIFICATION

[redacted] b(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICW2	5	C

DATE OF ORDER 15 Sep 03 TIME OF ORDER 2020 HOURS

Phenergan 12.5-25mg IV q6hrs prn nausea/vomiting

V.O. Dr [redacted]

b(6)-2

LIST TIME ORDERS NOTED AND SIGN [redacted]

[redacted] JAN 14 Sep 03 0300

b(6)-2

PATIENT IDENTIFICATION

CW [redacted] b(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICW2	5	C

DATE OF ORDER [redacted] TIME OF ORDER 9/16/03 0701 HOURS

Start drops 0900 this am

Homatropine 5% 1 gtts OS tid

Pred Acetate 1% 1 gtts OS q20 while awake

Ofloxin 1 gtts OS qid

[redacted] b(6)-2

Noted 9/16/03 0725 [redacted]

PATIENT IDENTIFICATION

CIV b(6)-4 [redacted]

[redacted] b(6)-2

1 JAN 9.16.03 1426

NURSING UNIT	ROOM NO.	BED NO.
ICW2	5	C

DATE OF ORDER 15 Sep 03 TIME OF ORDER @ 1401 HOURS

1. NPO ⊼ MIN
2. @ MN start NS @ 125cc/hr
3. OKAY TO SHOWER TODAY
4. VOID ON CALL TO UR IN AM

b(6)-2 [redacted]

2 [redacted] JAN 17 Sep 03 0005

PATIENT IDENTIFICATION

CIV b(6)-4 [redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICW2	5	C

DATE OF ORDER [redacted] HOURS

[redacted] q day.

2 [redacted]

b(6)-2

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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PATIENT IDENTIFICATION

[redacted]

b(6)-2

[redacted]

b(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICW2	5	C

DATE OF ORDER: 15 Sep 03 TIME OF ORDER: @ 1228 HOURS — LIST TIME ORDER NOTED AND SIGN

b(6)-2

1. Admit to ICW2 - Dr [redacted]
2. Dx: (L) 2 mc FX + OS retinal Hemorrhage
3. Cond: Stable
4. Vitals: Per routine
5. Aller: NKDA
6. Activ: Ad lib

PATIENT IDENTIFICATION

CIV b(6)-4

[redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICW2	5	C

DATE OF ORDER TIME OF ORDER

7. Nurs: HOB ↑ 30°-45° HOURS
   Clean facial wounds
   Place Bacitracin
8. Diet: ~~Soft diet~~ [redacted]
   NPO ~~P-MN for SX~~
9. IV: NS @ 125 cc/hr @ MN
   HLIV now
10. Meds: Ancef 1gm IV q 8°
    Percocet 1 ~~tab~~ 12 HOURS DOC 4 pm
    Morphine 2-4mg IV q 1° PRN severe pain
    b(6)-2
    [redacted]
    MIRS/DOC
    0900 in AM } Pred Acetate 1% gtts OS q 2° [redacted]
    Ciloxin gtts OS q 1d
    9/16

b(6)-2

PATIENT IDENTIFICATION

CIV b(6)-4

[redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICW2	5	C

DATE OF ORDER 9/15/03 TIME OF ORDER 1920 HOURS

Post op SAA
soft diet, adv as tolerated.

[redacted]

b(6)-2

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CLINICAL RECORD - DOCTOR'S ORDERS

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PATIENT IDENTIFICATION

#[redacted]

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 17 Sep 03 TIME OF ORDER @ 1256 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Admit to PACU then ICW 2 Dr [redacted] b(6)-2
2. DX: S/P ORIF of Left 2mc fracture closure of lacerations
3. Cond: Stable

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

4. Vitals Per routine b(6)-2
5. aller: NKDA
6. activ: Ad lib
7. Nurs: D/C Foley HOB ↑ 30°
8. Diet: clears then regular diet as tolerated

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

9. IV: HL IV
10. meds: MSO4 2-4 mg IV q 1° pm severe pain

given @ 1911 - Phenergan 12.5 mg IV q 4° pm N/V
Ancef 1 gm IV q 8°
Percocet 1-2 tab po q 4° pm pain
Homatropine 5% 1 gtts OS TID
Pred A Zetale 1% 1 gtts OS q 2°

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

b(4)-2 [redacted]

aloxin 1 gtts OS QID
Bacitracin to wounds BID Face + left ear

11. PA + lateral Face films

[redacted]

b(4)-2

MMS/DC b(6)-2

24° Chart [redacted] 9/WMC 18 Sep 03 0115 [redacted] IT/MM 18 Sep 03 0300

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

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

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

DATE OF ORDER: 9/18/03 TIME OF ORDER: 1330 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Prednisone 60mg po q day
2. Zantac 150mg po bid

[redacted] b(6)-2

NURSING UNIT: ICW2 ROOM NO.: 5 BED NO.: C

24° Chart [redacted] 9/18/03 19Sept03 0450 24 [redacted]

PATIENT IDENTIFICATION

DATE OF ORDER: 9/19/03 TIME OF ORDER: 1130 HOURS

1. Ambien 10mg po qhs pm insomnia

[redacted] noted 9/19/03 1220 [redacted]

b(6)-2

NURSING UNIT: 24° chart check 20Sep 03 0330 [redacted] LT/AT

PATIENT IDENTIFICATION

DATE OF ORDER: 24Sep03 TIME OF ORDER: @ 0900 HOURS

1. D/C ancef

[redacted] Noted 24Sep03 0915 [redacted]

b(6)-2

NURSING UNIT: ROOM NO.: BED NO.:

PATIENT IDENTIFICATION

DATE OF ORDER: 24 Sep TIME OF ORDER: 1200 HOURS

1. CXR + (R) shoulder XR - pain

[redacted] Noted 24 Sept 1200 [redacted]

b(6)-2

NURSING UNIT: ROOM NO.: BED NO.:

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
9/24/03	1200 HOURS	

(1) Cipro 500mg po bid [redacted] b(6)-2 [illegible]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION: noted 24SE03 1735 [redacted] b(6)-2

DATE OF ORDER	TIME OF ORDER
9/24/03	1700 HOURS

(2) Decrease Prod to 30mg po qDay x4 days then 15mg po qDay x 4 days then 10mg po qD x 4 days then d/c [redacted] b(6)-2

NURSING UNIT [redacted] NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER
9/24/03	1200 HOURS

(1) Clindamycin 600mg IV q8° x 72 hours
(2) Continue Ancef 1gm IV q8° [redacted] b(6)-2 [illegible]

NURSING UNIT | ROOM NO. | BED NO.
25 Sep 03 | 0255 | [redacted] b(6)-2

N.G/RN 24 chart ✓

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

DATE OF ORDER	TIME OF ORDER
25 Sep 03	@ 0830 HOURS

(1) Percocet 1-2 tab po q4-6° pm pain [redacted] b(6)-2

NURSING UNIT | ROOM NO. | BED NO.
ICW 2 | 7A | b(6)-2

24 chart ✓ [redacted] b(6)-2

Qiuvmio 26 Sept 0130 24 [redacted]

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

CLINICAL RECORD - DOCTOR'S ORDERS

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PATIENT IDENTIFICATION

CIV [redacted] b(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICW 2	29Sep03	0030

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND
28 Sept	2140 HOURS	[redacted]
DC IV		
DC Ancef		
V.O. Dr [redacted]		
[redacted]		
[redacted] ILT/AN 24° chart ✓		b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND
9/29/03	0908 HOURS	
① Maintain Pred c 30 mg po qD per Iraqi V-R surgeon.	[redacted]	Done & noted. 9-29-03 0930
Continue Cipro 500 bid.		
	[redacted]	

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

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

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

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

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

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

b(6)-2

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 09 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 15	16	17	18	19	20	21	22	23	24	25	26	27
15	[redacted]	Vitals per routine	D	/	[redacted]											
17			E													
			N													
15	[redacted]	Activity ad lib	D	/	[redacted]											
17			E													
			N													
15	[redacted]	HOB ↑ 30-45	D	/	[redacted]											
17			E													
			N													
15	[redacted]	Clean facial wounds & place	D	/	[redacted]											
		backtrack	E													
			N													
15	[redacted]	Soft diet, advance as	06	/	[redacted]											
		tolerated	11	/												
			[redacted]													
17	[redacted]	DIET:- CLEAR TASK	D		[redacted]											
		REMOVAL AS TOLERATED	E													
			N													
17	[redacted]	D/C FOLEY	D		[redacted]											
17	[redacted]	BACITRACIN TO FACIAL	D	/	/	/	[redacted]									
		WOUNDS & LEFT EAR -	E	/	/											
			N	/	/											

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS:

(L) ZMC Fx + OS retinal hemorrhage

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

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 09 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
9.5	[redacted]	Admit ZCW2 (Perkins): condition stable				[redacted]
16	[redacted]	NPO p MN	9.17	0001	done	[redacted]
16	[redacted]	OK to shower today	9.16	noted		[redacted]
16	[redacted]	Void on-call to OR in AM	9.17	AM	done	[redacted]
17 Sep	[redacted]	PA + LAT Face films				
24 Sep	[redacted]	Chest x-ray	24 Sep	1 LN	done	
24 Sep	[redacted]	Bs Hand or x-ray	24 Sep	1 LN.	done	

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

USAPA V1.00

b(6)-2

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 28	29
Copied	[redacted]	Vitals per routine	D	[redacted]	
			E		
			N		
Copied	[redacted]	Activity ad lib	D	[redacted]	
			E		
			N		
Copied	[redacted]	HOB ↑ 30-45°	D	[redacted]	
			E		
			N		
Copied	[redacted]	Clean facial wound	D	[redacted]	
		& place bacitracin	E		
		to face & Ear	N		
Copied	[redacted]	Diet: Regular	0	[redacted]	
			12		
			17		

ALLERGIES: ☐ YES ☑ NO
NKDA

PRIMARY DIAGNOSIS: Retinal Hemorrhage

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

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

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 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. 09 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 15	16	17	18	19	20	21	22	23	24
15	[redacted]	NS @ 125 cc/hr @ MN	D	[redacted]									
		HL Now	E	[redacted]									
			[redacted]										
15	[redacted]	Ancef i gm IV q 8 hrs	08	[redacted]									
17			16	[redacted]									
			2	[redacted]									
15	[redacted]	Pred Acetate 1% i gtts	02	[redacted]									
16		OS q 2°, Start in AM	04	[redacted]									
17	[redacted]	while awake	06	[redacted]									
			08	[redacted]									
			10	[redacted]									
			12	[redacted]									
			14	[redacted]									
			16	[redacted]									
			18	[redacted]									
			20	[redacted]									
			22	[redacted]									
			24	[redacted]									
15	[redacted]	Ciloxan i gtts OS q i d	06	[redacted]									
16	[redacted]	Start in AM	12	[redacted]									
17	[redacted]		18	[redacted]									
			24	[redacted]									

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
(L) ZMC fx + OS retinal hemorrhage

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

PATIENT IDENTIFICATION:
C[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

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*	Mo. 09 Yr. 83

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

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
15	[redacted]	Percocet ½-1 PO, 4°	15Sept 2245 ½ PO	16Sept 0045 ½ PO	9-16 1600 1	17Sept 0005 ½ PO	17Sept 1635 1	17Sept 1915	17	18Sept 2030 ½ PO	18Sept 0100	19Sept 0200 ½ PO	19Sept 1900 ½ PO	20Sept 0400 1	21Sept 0445 ½ PO	[redacted]
17	[redacted]	prn pain	[redacted]													
15	[redacted]	MSO4 2-4mg IV q1°	15Sept 2245 4mg BNS IVP	16Sept 0705 4mg IV VS	16Sept 4mg 1950	17SEP 4mg 1600	17SEP 1915 4mg PO	18Sept 0030 4mg	18Sept 0830 4mg	18Sept 1350 8mg	18Sept 9 2mg					
17	[redacted]	prn pain (serca)	[redacted]													
15	[redacted]	Phenergan 12.5-25mg	15Sept 25mg 2245 BNS IVP	16Sept 0705 25mg IV VS												
		IV q6hrs prn														
		nausea/vomiting														
17	[redacted]	PHENERGAN 12.5MG	15Sept 1045													
		IV Q 4° PRN NAUSEA/VOMIT	12SEP													
Copied	[redacted]	Percocet ½-1 PO Q4° prn pain	23Sept 0200 ½	9-23 1600 1	9-24 0400 ½	24 1600 ½ PO	25Sept 0045 1	25Sept 0030 ½								
			[redacted]													

MEDCOM - 19256

USAPA V1.00

b(6)-2 All

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 16	17	18	19	20	21	22	23	24	25	26	27	28	29
16Sep	[redacted]	Homatropine 5% 1gtts	08	[redacted]													
17Sep	[redacted]	OS TID	16														
			22														
17Sep	[redacted]	[redacted]	D	[redacted]													
			E														
			N														
18Sept	[redacted]	PREDNISONE 60MG	08	/	/	[redacted]							X'd 24SEP03				
		PO A DAY.															
18Sep	[redacted]	ZANTAC 150ML PO	08	/	/	/	[redacted]										
		BID	20	/	/	[redacted]											
24SEP	[redacted]	Cipro 500mg PO BID	10	/	/	/	/	/	/	/	/	[redacted]					
29Sep	[redacted]	Continue cipro	20	/	/	/	/	/	/	[redacted]							
24SEP	[redacted]	↓ Pred to 30mg PO q day	18	/	/	/	/	/	/	/	[redacted]						
		x4 days then 15mg PO															
		q day x4days then 10mg PO q d															
		x4 days, then DC															
24SEP	[redacted]	Clindamycin 600mg IV	06	/	/	/	/	/	/	/	/	[redacted]					
		q 8° x72 hours.	14	/	/	/	/	/	/	/	/	[redacted]					
			22	/	/	/	/	/	/	/	/	[redacted]					

ALLERGIES: ☐ YES ☑ NO	PRIMARY DIAGNOSIS:	ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
NKDA	Retinal hemorrhage	PAGE NO.

PATIENT IDENTIFICATION:

Civ [redacted]

b(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*				Mo. 9 Yr. 03
Order Date	**Clerk/ Nurse**	**SINGLE ORDER, PRE-OPERATIVES**	**Date to be Given**	**Time to be Given**	**Time Given**	**Initials**
16sept	[redacted]	@ MN, start NS @ 125 cc/hr.	9.17	0001	00022	[redacted]
		b (6) - 2 All				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
Rep	[redacted]	Ambien 10mg po	9-20 2200 ÷PO	9-21 2100 ÷PO	22 Sept 2220 ÷PO	23 Sept 2300 ÷	25 Sept 2230 ÷ID	26 Sept 2200	27 Sept 0005	28 Sept 2145						
		qhs prn insomnia	[redacted]													
25sep	[redacted]	~~Percocet 1-2 TAB~~	Rewritten on other sheet													
		~~PO Q4-6° PRN Pain~~														

b(6)-2 A 11

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 25	26	27	28	29	30
17 Sep	[redacted]	Pred Acetate 1% 1 gtts	D	[redacted]					
	------	OS Q2°	E						
	------	While Awake	N						
	------								
13 Sep	[redacted]	Ciloxin 1 gtt OS	06	[redacted]					
	------	QID	12						
	------		18						
	------		24						
	------								
24 Sep	[redacted]	Ancef 1 gm IV QB	08	—		[redacted]			
			16	—					
			24	—					
29 Sep	[redacted]	Prednisone ~~30mg~~ 30mg po QD	18						

DC'd 28 Sep 03 [redacted]

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS:

RETINAL BLEED, MAXILLA FX, SCRAPNEL (R) KNEE

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

Cpl [redacted] b(6)-4

[redacted]

KURDISH SOLDIER

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

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**	
25	-----						

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* TIME/DATE DISPENSED													
25Sep 28Sep	[redacted]	Percocet T-II PO	25Sep 1145 II 120	26Sep 1530 III 80	27Sep 1130 II 80	28Sep 0005 II	28 Sep 0946 II	28 Sept 2050 II 60	29Sept 0936 II 40							
-----	-----	Q4-6 PRN	[redacted]													
12Sep	[redacted]	Phenergan 12.5 mg														
-----	-----	IVP Q4 PRN n/v														
-----	-----															
-----	-----															
-----	-----															
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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

DTSG APPROVED (Date)

Date: 15 Sep 03
Time In: 1915
Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
Allergies: NKDA
OR Intake: Crystalloid 1400 Colloid Ø
Pre-op V/S: 122/54, 95
OR Output: UOP Ø EBL min
Procedures: globe repair (L)
Meds/Times: Versed, Fent
76kg.
37.2/

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

Pre Op Meds Fent 4mg Versed 2mg. History

Time	1915	1920	1925	1945
SaO2	97	97	96	97
FiO2	RA	RA	RA	
Methods				
240				
220				
200				
180				
160				
140				
120				
100				
80				
60				
40				
20				
RR	16	14	16	22
T	99.9			
Time				
Pain (0-10)	NA	NA		
LOS				

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1950	LR	100	PIV	[redacted]	[redacted]

X-rays: Labs:

Post-Anesthesia Recovery score

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

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

(Continue on reverse)

PREPA[redacted] b(6)-2

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 15 Sep 03

PATIENT'S IDENTIFICATION [redacted] give: Name – last, first, middle; grade; date; hosp[redacted] b(6)-4

C-1V [redacted]

[redacted] b(6)-4

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

DA FORM 4700, MAY 78 WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) Previous edition is obsolete

USAPPC V2.00

MEDICATIONS

Allergies:

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

NEUROVASCULAR

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

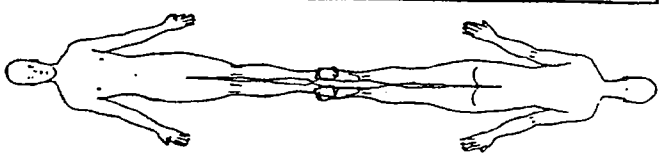
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	OS	bulky	Ø
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount
1950	Ø	Ø	Ø

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1920	SR	Ø	Ø

WAMC OP 173-E

NURSING NOTES

1920: pt resumed in bed; SaO2 97% on RA; ↓ airway cruns; pt sleepy but arousable; tinnitus reported; bulky dsg to (L) eye ↓ OS hemorrhage; PIV x 2 patent; report received from CVNA; [redacted] modrate in status.
1940: report given to [redacted] RN; pt to be transferred to ICW 2 [redacted]

b(6)-2

Discharge Criteria:
Date: 15 Sep 07 Time: 1950 PARS: 10
BP: 122/49 T: 97.1 HR: 106 RR: 16 SaO2: 95 RA
Pain Level at D/C (0-10): UTA
Intake: 100 Output: Ø
Additional Data: Ø
Transferred To: ICW 2
Report Given To: [redacted] ICW 2
Transferred Via [redacted] Gurney Ambulance
Transferred [redacted]
Cleared IAW [redacted]
Charge Nurse Signature: [redacted]

b(6)-2

2007 x7
10cc Fent
10mg Versed
10 Reglan
800 Ancef

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 17 Sep 03
Time In: 1250
Allergies: NKDA
Pre-op V/S: 108/89 112 69
Procedures: ORIF L Zygoma Fx

Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 2000cc Colloid
OR Output: UOP 200 EBL 100
Meds/Times:

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

Pre Op Meds History

Time	1250	1300	1310	1320	1330
SaO2	98	97	98	97	99
FIO2	RA	RA	RA	RA	RA
Methods					
240					
220					
200					
180					
160					
140					
120	✓	✓	✓	✓	✓
100					
80					
60	✓	^	^	^	^
40					
20					
RR	10	12	16	19	14
T	99	99			99

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	1	1	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
~~Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse~~	~~2~~	~~2~~	~~2~~
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	08	09	10

Codes:
AIRWAY: A = Ambu, BB = Blow-by, M = Mask, FT = Face Tent, RA = RoomAir, NC = Nasal Cannula
V/S: X = A-line BP, ˆ = Cuff BP, = Pulse
TEMP: S = Skin, O = Oral, A = Axillary, T = Tympanic, R = Rectal
LOS: C = Cervical, T = Thoracic, L = Lumbar, S = Sacral

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

(Continue on reverse)

b(c)-2

PRE[redacted] ILT/AN

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 17 Sep 03

PATI[redacted] en entries give: Name – last, (first, [redacted] cility)

b(c)-4

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

DA FORM 4700, MAY 78 WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) Previous edition is obsolete
USAPPC V2.00

MEDICATIONS

Allergies:

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

NEUROVASCULAR

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

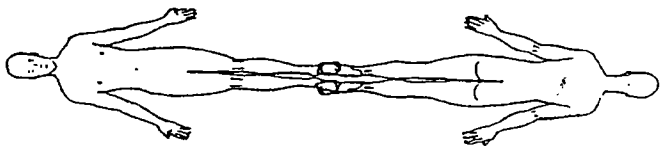
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	R arm		CDI
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount
1340	Foley	Yellow	225

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1330	NSR	Ø	Ø

WAMC OP 173-E

NURSING NOTES

Pt arrived to PACU @ 1250
wakes up to voice, open eyes.
VSS. afebrile. (R) arm dressing (CDI
face lacerations intact c̄ no drainage.
(IV) /a PIV c̄ 125 cc/hr. [redacted] b(6)-2

Discharge Criteria:
Date: 12/8/03 **Time:** 1330 **PARS:**
BP: 122/56 **T:** 99.1 **HR:** 89 **RR:** 14 **Sa02:** 98
Pain Level at D/C (0-10):
Intake: Ø **Output:** 225
Additional Data:
Transferred To: ICW 2 [redacted]
Report Given To: SGT
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: [redacted]
Cleared IAW Recov [redacted]
Charge Nurse Signature: [redacted] /AD
b(6)-2

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION (State or Country Code.)	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
A 1 1 D 7	I E	[redacted]	[redacted] b(6)-4	CIV	M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
UNK	22 y	X	9	MUSLIM

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
Kurdish Army	U	1228	— b(4)-4

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
—	K 7 6	—

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

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

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

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
Ø 5		030929

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
ABEA		030915

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

FOR LOCAL USE

DX: ① ~~Retinal Hemorrhage~~ RUPTURED LUNGE OS

② ENDOPHTHALMITIS OS

③ ZMC FRACTURE (L)

④ MULTIPLE FACIAL LACERATIONS b(4)-2

ADMITTING OFFICER (Signature, as required [redacted]

SIGNATURE OF ADMITTING [redacted]

DA [redacted] 398[redacted]

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTRATION	2. NAME (Last, First, MI)	3. GRADE	ADMISSION REMARKS
[redacted]	[redacted] EPW	NA	

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	28	UNK	UNK	NA	NA	NO

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
2D 99	[redacted]	NA b(6)-4	ICU2

15. FLYING STATUS	16. DSG	17. DEPT./BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
NA		~~NA~~ KMO	NA		NBI

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
Direct from Emt	1515	AEAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
Unk	24	10/14/03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
Unk	UNK	9/18/03	Dr. [redacted]

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

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: BILAT TIB/FIB FX

79.66
83.14
78.17
84.15
86.04
84.3
78.57
86.69

823.92
E993

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	27	27

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	27	27

[redacted] MEDICAL OFFICER

Dr. [redacted]

SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

[redacted]

DA FORM 3647, MAY 79 — EDITION OF 1 AUG 78 IS OBSOLETE — USAPPC V1.10

b(6)-2

MEDICAL RECORD | 18 Sep 1000 **ABBREVIATED MEDICAL RECORD**

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

28 y/o c̄ injury thru arm ? mechanism ? IED v LSW, arrived EMT by Medevac ~0950

: Med ō all ō PMH?

PE 112/50 88 R 16-20 100% rt on rebreather

PHYSICAL EXAMINATION

PERRL

(R) TM nl, (L) wax

neck - ō step off or notable tenderness

chest clear bil ō (R) abd - scaphoid, ō evident pain, FAST (-)

pelvis stable

rectal - good tone, ō mass, prostate nl

extr - UE OK, move all

PROGRESS (Enter date of discharge and final diagnosis)

RLE - open fx, exposed tendons distal (R) tibia/fib

LLE - third degree fx ? entry (L) medial middle, large exit

last LKE (DP+PT (+) by Doppler, palpable PT on (L)

A - bil tib/fib fx P - order for (R) BKA

(L) ex fix

b(6)-1 [redacted]

SIGN[redacted]	DATE	IDENTIFICATION NO.	ORGANIZATION
	18 Sep		

PATIENT IDENTIFICATION [redacted] 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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
18 Sep 03 1800	Pt admitted @ 1630 SP @ BKA (D) w/ fx / TB RIB fx. Both LE c̄ ace wraps - intact - elevated. Pt has awakened spontaneously since admission, but never completely awakened to move about restlessly. Pt did awaken to check his (B) LE to see if they "were there" and gave a "thumbs up" for okay. Then went back to sleep. 1 u PRBC infused over 1 hr. w/o complications. C-Collar continues to be in place - though no orders for CT Scan or X-Ray to be done or any precautionary measurements. ~~Pt able to~~ Pt c̄ full sensation (appears) to LLE + trace edema. Cap Refill difficult to assess d/t thickened toe nails and discolored feet. VSS. Report to be given to oncoming shift. Pt still sleeping c̄ SPO2 - 98% on RA. POC: IV ABX, monitor H/H, review X-Ray and pain mgmt. b(6)-2 CPT [redacted]
18 Sep 03 1815	Received report from CPT [redacted]. Pt. resting quietly in bed c̄ HOB ~~not~~ elevated. Stiff neck brace on, 18 G IV to (R) AC : fusing LR @ 150 cc / HR. 18 G to (L) AC, SL, flushed @ this time. (B) SS of

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.

WARD NO. TCU 2

[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/1998)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

b(6)-2 A11

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
18 Sep. 03	erythema, ⊖ irritation to either site. 16 F Foley to
1815	gravity draining clear yellow urine. Ⓐ Ⓑ BKA,
	knee is elevated & wrapped in kerlix and ace wraps. ⊖
	drainage noted @ this time. Ⓐ ex external fixator to ⒶLE,
	wrapped in ACE wrap ē a small amount of drainage
	noted. Cap refill to ⒶLE >3 sec, toes are cool to
	touch. Pedal pulse present to ⒶLE. ——— SPC [redacted]
1850	CBC drawn and brought to lab @ this tim SPC [redacted]
2010	ii Percocets given PO for % pain to ⒶLE.
	Neck brace removed by Dr. Bragman at this tim
	Pt. drank 240 cc's H_2O @ this tim. ⊖ % nausea /
	stomach pain. ——— SPC [redacted]
2045	Interpreter came and spoke to pt., explained injuries,
	pt. has no questions @ this tim ——— SPC [redacted]
2300	Pt. resting quietly in bed. Easily awaken, ⊖ % pain /
	discomfort @ this tim ——— SPC [redacted]
0100	Pt. easily awaken ⊖ % pain / discomfort @ this tim SPC [redacted]
0400	Blood drawn @ this tim ⊖ % pain / discomfort @
	this tim ——— SPC [redacted]
0445	Dr. [redacted] notified of pts H&H, orders written f
	2U PRBC ——— SPC [redacted]
~~0535~~ ~~0735~~	121/74 95% 27 124 102° SP [redacted]
~~0549~~ ~~0740~~ 02	128/71 95% 25 126 102° SP [redacted]
0545	124/73 94% 25 127 102° SP [redacted]
0600	126 172 95% 23 134 102° SP [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

9/18/03

Brief Op Note

Pre Op Dx: Gd III C open (R) TIBIA Fx, Gd III B (L) open T/S/Fib Fx

Post Op Dx: Same

Procedure: I&D (L) TIB/Fib Fx, Fasciotomies, external fixation (L) TIBIA

Amputation (R) LE (BKA) open

Surgeons: [redacted] b(6)-2

EBL: 500cc

Fluids: 3u PRBC

3000 LR

Urine: 500cc

Findings: - Grossly contaminated open (L) distal tibia fx: extensive bone loss + N/V compromise

- Open (L) TIB/Fib Fx: marked blast effect, tight compartments, & soft tissue stripping

Cx: ¢

Post Op Plan: Repeat I&D 48°, revision amputation (R) leg, exchange nailing (L) TIBIA later w ABX

[redacted]

b(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.

WARD NO.

#[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
9/20/03	Brief OpNote
	PreOpDx: Open (R) BKA
	(L) open tib fib fx c̄ ex fix
	PostOpDx: Same
	Procedure: Revision (R) BKA stump
	Closure medial fasciotomy (L) leg
	Repeat I&D
	Surgeons: [redacted] / [redacted]
	Anesthesia: GETA
	EBL: 50
	Fluids: 500cc.
	Injury: (R) stump c̄ minimal fecal plasmence
	Cx: C
	PostOpPlan: 1V Abx, repeat I&D, exchange nailing
	[redacted]
	b(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
11 Sept 03 1330	Throughout the day pt has been stable - resting in bed c̄ HOB 30-45°. LE elevated on pillows c̄ Chux underneath. Chux Δ'ed x2 since 0600. Foul smelling odor from blood coming from ~~RLE~~ LLE. Dr. [redacted] notified. Both drsngs saturated on bottom of Ace wraps. ⊕ pulse (DP) to LLE c̄ popliteal/femoral ⊕ on RLE. MSO4 3-5mg Q2-3° for breakthrough pain and percocet tabs (1/1) Q4° for pn management. ⊕ results from pn meds c̄ pt acknowledging a ↓ in pain and him sleeping mostly. Pt able to move BLE. VSS. 2u PRBC infused this am - awaiting post H/H results. 40-200cc - clear-amber urine. Intaking 30-50% of each meal. MIVF @ 150cc/hr. IV ABX per schedule b(6)-2 CPT [redacted]
1830	CHUX Δ'd TOTALLY DRESSING REINFORCED c̄ 6 ABD PADS AND 2 FORUX WRAPS. DR. [redacted] b(6)-2 NOTIFIED OF MALODOROUS SMELL COMING FROM LLE. RLE CHUX Δ'D AND STUMP ELEVATED. WILL CONTINUE TO MONITOR. [redacted] b(6)-2
2300	BLE CHUX Δ'D FOR 2ND TIME. (L) LLE SATURATED THROUGH DRSG REINFORCEMENTS PULSE 2+ CAP REFILL BRISK. PT ABLE TO WIGGLE TOES. BURN PAD PLACED UNDER LEG TO SOAK UP SATURATION FROM LEG. (R) RLE CHUX REMOVED AND BURN PAD PLACED UNDER STUMP. AND ELEVATED. WILL CONTINUE TO MONITOR. [redacted] b(6)-2
2330	MEDICATED c̄ 1 PERCOCET FOR PAIN. WILL CONTINUE TO MONITOR. [redacted] b(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

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

MEDCOM - 19272

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
19Sept03 0645	Received pt. from SPC [redacted] b(6)-2 @ 0600 - resting in bed HOB 45° c̄ LE ↑. Pt receiving 1 unit PRBC and feverish c̄ last temp @ 102.3 ⓐ. Pt
# 4136962 Exp 19/9/03	able to use ICS to obtain 3 "BNVS" up x10 times. At 0600 the blood VS were @ q 15min and are as follows:
[redacted]	0600 131 124/72 24 92% RA
	0615 133 125/67 23 89 RA
	0630 126 121/66 19 92 RA
	0645 123 109/70 19 92 RA 101.6 ⓐ
	0700 120 122/66 22 94 2LNC 101.3
	0730 106 123/70 17 98 2LNC 98.3
	~~0800~~ End 1st u PRBC ——— CPT [redacted] b(6)-2
0755	↑ 2nd u PRBC - pt AOX3 - eating breakfast
# [redacted]	0755 117 118/81 19 100% 2LNC 99.4
	0800 107 121/75 22 99% 2LNC
Exp 25Sept03	0805 106 119/68 19 100% 2LNC
	0820 106 131/61 24 100% 2LNC 100.3
	0830 102 124/68 19 100% 2LNC
	0845 102 119/72 18 100% 2LNC 100.4 @ END
	[redacted] b(6)-2 ~~GO TO PACU~~ [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1998)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
~~20 SEP 03~~ 0000	PT TAKEN OFF O2 VIA NC 2L. WILL MONITOR. b(6)-2 [redacted]
0030	PT MAINTAINING SpO2 @ > 98% ON RA. WILL CONTINUE TO MONITOR [redacted] b(6)-2
20 SEP 03 (0645)	Assumed care of [redacted] receiving Δ-of-shift report. See DA Form 4700 "Intensive Care Nursing Flow Sheet" for initial shift assessment. Currently resting comfortably, ~5 % discomfort. b(6)-2 [redacted] A/AN
20sep03	Surgery POD #2
	No events overnight
	VS: HR 90's - 100's TM 101+ BP 120-150/60's
	UO- 100-250 cc/hr
	chest CBSA
	cor RRR + PP
	Abd ND NT NABS
	ext - dressing saturated with foul smelling serosanguinous drainage
	LABS 8.2 / 27 / 106
	A/P s/p (R) BKA (L) exfix fasciotomy. to OR today for ~~re~~ washout b(6)-2 [redacted]

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

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

REGISTER NO. | WARD NO.

#[redacted] b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
20Sep 03 (1250hrs)	Patient ō c/o ⊕ LE pain. 2+ pulse/doppler. Wiggles toes ⁻̄ minor limitations; brisk capillary refill unchanged. Continues ō copious serosanguinous, foul-smelling d/c. Given 2 percocet tabs ⁻̄ with ↓ pain. — WILL monitor for effectiveness. — [redacted] b(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
20 Sep 03 1845	Received report from CPT [redacted] b(6)-2 on pt. who is resting in bed quietly, HOB @ 45°, pt. easily awoken, understands basic commands and gestures despite language barrier. Assessment completed on DA Form 4700, will continue to monitor — SPC [redacted]
2000	Pt. given 650 g Tylenol per Dr's orders for b(6)-2 Ax. temp of 101°, incentive spirometer use also encouraged. Will continue to monitor. — SPC [redacted]
2100	Pt. c/o pain to @ LE Ti Percocets given @ b(6)-2 this time — SPC [redacted]
2300	Pts. temp has dropped down to 99.3. ⊖ c/o pain or discomfort @ this time. Asked to have HOB lowered. SPC
0100	Pt. resting quietly in bed easily awoken. Will continue to monitor — b(6)-2 SPC [redacted]
0300	Pt. resting quietly. c/o minor pain to @ LE ⊖ pain meds given @ this time — SPC [redacted]
0340	Blood drawn for pts. CBC + brought to lab — SPC [redacted]
0450	Pt. given bed bath @ this time. ⊖ additional b(6)-2 DRNG noted to @ LE DRSG & DRNG noted to ® LE. Will continue to monitor — SPC [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
21 SEP 03 (0630hrs)	Assumed care of patient & receiving S-of-shift report @ 0600hrs. See DA Form 4700 "Intensive Care Nursing Flow Sheet" for initial assessment information. Pt. currently resting quietly in bed & noted distress/discomfort. Will continue c̄ present plan of care. [redacted]
21 SEPT 03 1050	- Assumed care of PT. PT temp was 102.3 Axx, Ice water wrapping use, Given Ti Tylenol 325mg PO. will call to monitor, for Δ's. [redacted]
21 SEPT 03 1130	- DT's temp 104.7, will call to monitor PT. [redacted]
21 SEPT 03 1415	- PT transferred to ICWI as per MD order. [redacted]
	b(6)-2 All

STANDARD FORM 509 (REV. 6/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	(cont) wrap; sm amt of drainage noted to posterior aspect of affected leg; dsgs to bilat feet, wrapped c̄ Kerlix, CDI ⊖ drainage; PIV patent & infusing LR @ 125 c̄ s/sx infection/infiltration; restraints in place, ⊕ circulation, ⊖ skin breakdown, cont to monitor b(6)-2 [redacted]
23SEP03	(1510) Assumed care of pt @ bedside c̄ report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c̄ Percs. Dsg to back of ⓡ thigh Δd. Large amount brown/green drainage noted on old dsg. Small amount of bleeding noted in wound. Pin care done, ext fix. Pt able to move RLE. Cap refill <3secs. ⊕ pedal pulses equal bilat. Dsgs to bilat feet Δd - silvadene applied to wounds and wrapped c̄ Kerlex. Pt OOB to chair - tol. well. Tol. reg diet well. Voiding c̄ difficulty. 2-point restraints in place c̄ s/sx complications. Will cont. to monitor. b(6)-2 [redacted] 27A2
	(1645) Dsg to ⓡ thigh Δd d/t large amount of drainage on old dsg. RLE elevated on blanket. IVFs SLd in IV in ⓛ forearm. ⊖ s/sx infiltration/infection. monitoring. b(6)-2 [redacted] 27A2
23sep03 @ 1950	Assumed care @ 1800; VSS, pt A&Ox3, ⊕ CMS to all extremities, N/V intact, pain controlled c̄ percs; Ex-fix in place ~~wrapped c̄ Kerlix c̄ drainage~~ c̄ sm amt b(6)-2 [redacted] b(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

#[redacted]

b(6)-4

REGISTER NO.

WARD NO. ICW#1

PROGRESS NOTES
Medical Record

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

FIRST NAME	MIDDLE INITIAL	ID NUMBER

NOTES

drainage coming [redacted] seeping through old dsg on posterior aspect of Rwd; Dsg Δd, SM amt of bleeding occurred in wound; Kerlix packed in wound still intact; pin care completed - minimal drainage; pt refused Dsg Δ to bilat feet, stated he only wants it Δd once today; ⊕ BSx4, pt voiding ⊖S, dark yellow urine ⊖ difficulty; pt ↑ OOBTC - Tol well; NPO p MN d/t surgery tomorrow; restraints in place, ⊕ circulation, ⊖ skin breakdown [redacted] will cont to monitor

b(6)-2 [redacted]

[redacted]

24Sep03 (1305) Assumed care of pt @ bedside p̄ report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c̄ MSO4. 18g IV started in ⊕ forearm. IVF infusing @ TKO s̄ S/Sx infiltration. SL in ⊕ forearm d/c'd d/t infiltration - catheter intact. Pt remains NPO for surgery. Drsg to ⊕ thigh Δd this am. Large amount green/brown drainage noted on old drsg. Small amount of bleeding noted in wound. Packing in place. Drsgs to pins and bilat. feet CDI. Pt voiding s̄ difficulty. 1 point restraint in place. s̄ S/Sx complications. Will continue to monitor. [redacted] (WAW)

b(6)-2

(1440) Pt tx to OR via gurney. [redacted] (WAW)

(1700) Pt tx to unit from ICU #3 p̄ recovery in stable cond. Pt tx to bed s̄ difficulty. VSS. Pt medicated c̄ MSO4 for pain c̄ good relief. Drsgs CDI. Will continue to monitor. [redacted] (WAW)

b(6)-2

24Sep03 @ 2345 - assumed care of pt @ 1800. VSS. Speaking arabic, alert, ⊖ pain to ⊕ thigh. Percocet given c̄ good relief noted. LS CTA, ⊕ BS x 4 quads, ⊕ post op void of 600cc dark urine. ⊕ thigh drsg Δ'd and pin care completed. ⊕ CMS to ⊕ LE. (BID) feet drsgs Δ'd - (CONT)

STAND [redacted]

b(6)-2

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
24SEP03 (P)	(CONT) silvadene applied to burns. (R) FA IV
2345	c̄ LR @ TKO for abx c̄ s/sx of infiltration. 2pt
	restraints on c̄ ō signs of skin or circulation
	compromise. Plan: monitor drainage from
	(R) thigh drsg, cont IVABX as ordered, monitor
	pain control. b(6)-2 [redacted]
25Sept03	1205 - VSS - A+O assessment completed.
	PERRLA, LS - CTA (B). Resp even unlabored,
	BS x4 and distended. voiding per urinal c̄
	dark yellow urine. IV heplock (R) FA c̄ DI
	Drsng D to (B) feet. Silvadene applied.
	Drsng D to (L) femur c̄ Brownish/greenish
	discharge on drsng. new drsng applied.
	Pincare completed. Pt. tolerated breakfast
	well. will cont to monitor pt. [redacted]
25SEP03	VSS. AO. Smaller (R) to RLE. (R) pulses RLE. palpable to b(6)-2
2236	RLE. Pin care and outer DSG changed to wound. Mal
	odor present c̄ light green purulent drainage noted. Tolerated
	well. S'd DSG and debrided wounds to bone test.
	Tolerated well. b(6)-2 [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
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b(6)-4

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
26SEP03	(0845) Assumed care of pt @ 0800 ~~p~~ report from night shift. Pt alert, speaking Arabic. VSS. Ø c/o pain @ this time. Pt NPO for surgery today. LR started @ 125cc/hr. into IV in ⓛ forearm. Ø s/sx infiltration/infection. Pt amb to chair this am – tol. well. Pt voiding ~~s~~ difficulty. Ex fix in place. ⊕ pedal pulse on ⓡ foot. Drsg to ⓡ thigh ~~c~~ mod amount brown drainage noted. Drsgs to feet CDI. Pt to surgery @ 0850 via gurney. Tx to gurney ~~s~~ difficulty. [redacted] UA
	(1440) Pt returned from OR, in stable cond. Tx to bed ~~s~~ difficulty. IV in ⓛ forearm dlcd d/t infiltration. 18g IV started in ⓛ forearm. IVF infusing ~~s~~ s/sx infiltration. Drsgs to feet Δd. Silvadene applied to burns. Drsg to ⓡ thigh reinforced ~~c~~ abd pad and kerlex. Pt able to move RLE. ⊕ pedal pulse. Cap refill <3 secs. ⊕ void. 2 point restraints in place ~~s~~ s/sx complications. Will cont. to monitor. [redacted] UA
27sep03 @	Assumed care @ 1800; All VSS; pt A&O x3, ⊕ CMS, [redacted] wrist cuff Ref, ⊕ pulses x4, NV intact throughout; pain controlled ~~c~~ percs; ⓡ LE ↑ on 2 blankets; b/l at drsgs to feet Δd ~~c~~ silvadene applied, ⊖ s/sx infection; drsg to ⓡ thigh CDI, Ex fix in place; Dr [redacted] gave V.O. not to Δ drsg to ⓡ thigh ⊖ drainage thus far; PIV patent & infusing LR @ 125 cc/hr ~~s~~ s/s infection/infiltration restraints in place, ⊕ circulation, ⊖ skin breakdown; cont to monitor [redacted]
27SEP03	(1500) Assumed care of pt @ 0800 ~~p~~ report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled ~~c~~ Percs. Ex fix in place on RLE. Pt able to move RLE. ⊕ pedal pulses equal bilat. Cap refill <3 secs. Pin care

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b(6)-2 All

b(6)-2 A11

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
25 Sep 03 0800	Pt Alert & oriented. Lungs CTA(B). [redacted] Resp even & unlabored. Abd soft nontender. c̄ (+) BS X4 quads. (R) stump c̄ ace wrap CDI. Good ROM. LLE c̄ pulses intact. Pin care & drsg Δ met to dry completed. Sutures intact. Small amount serosanguinous drainage from skin wound. lateral calf wound beefy red. Strong pedal pulse. Brisk capillary refill. Medicated c̄ Percocet 2 (two) tabs p.o. for pain during drsg Δ. Currently tolerating breakfast well. Will continue to monitor. RUE heplock patent. BLE elevated. [redacted]
25 Sep 03 1220	Sleep. Levoxyn 500mg IVPB [redacted]
25 Sep 03 1445	Medicated c̄ percocet two tabs p.o. for c/o pain. Doing ROM c̄ (R) stump. Will continue monitoring. [redacted]
25 Sep 03 @ 2115	Assumed care @ 1800; All VSS, pt A&OX3 speaking arabic; (+) CMS through brisk cap ref; (+) pulses x4; NV intact; pt OOBTC̄ difficulty; (R) stump dsg CDI; pin care to (R) LE completed c̄ 1/2 sterile H2O, 1/2 peroxide; W→D dsg Δ to (R) calf wrapped c̄ Kerlix & Ace wrap; (−) drainage, sutures intact; wound beefy red (−) s/sx infection; pain controlled c̄ percs; HL patent c̄ s/s infection; LEs↑; restraint in place, (+) circulation (−) skin breakdown; ROM completed, pt TOL well, cont to monitor. [redacted]

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[redacted] b(4)-4

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
23 Sept 03 0800	Alert & oriented (L) AC IV dislodged. IV D/C'ed and restarted to (R) FA x1 attempt c 18g 1¼" catheter. IV saline lock. ACE wrap intact and dry to (R) leg stump. External fix intact to (L) leg. Pedal pulses palpable to (L) LE. Will continue plan of care. b(6)-2 [redacted] CTA
23 SEP 03 2219	VSS. (+) pulses to R & LLE extremity. (+) 1 pulse palpable to LLE. CNS intact. OOB to BR x1 c difficulty & crutch walked. Voiding light yellow urine c difficulty, quantity sufficient. IV saline locked. [redacted] b(6)-2
24 Sept 0900	VSS Alert & oriented (R) FA Saline lock patent & intact and flushes without difficulty. ACE wrap dry to (R) stump dry & intact. ACE wrap dry to (L) LE c external fix dry & intact. Pedal pulse palpable to (L) LE. Voiding clear amber urine quantity sufficient. Will continue care as planned. b(6)-2 [redacted] CTA
24 SEP 03 2234	VSS, AO. (+) pulse to LLE. VFix in place & intact. c/o severe pain and provided 75 mg Demerol. DSG's intact to (R) BKA and (L) LFix. All other systems. WNL [redacted] b(6)-2

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[redacted] b(6)-4

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
26 Sep 03	0830 Medicated c̄ Percocet two tabs p.o. for c/o pain to B LE. Tolerating breakfast well. Will [redacted] monitoring. b(6)-2 [redacted]
26 Sept 03	Assume care of PT. A+O x3, VSS. Has a distal pulse in left leg. Maintains a regular diet. Urine is dark brown color aproximately 850cc. Excercises by moving legs while lying in bed. c/o pain [redacted] 2 percocets. Administered meds, had to change IV to (L) Arm due to PT [redacted] removing it. Skin irration from restraints is non existance. Drsg Δ blood pouring out. Will continue to monitor. SP[redacted]1W
b(6)-2	
1920	Pt a/o, VSS, LCTAB, HRRR ⊕ BS x4, (R) stump c̄ ace wrap CDI. (L) LE ex-fix intact. pin care done. ROM to (R) stump done by pt often. drsg to LLE Δ⊕. sero-sang drainage noted. Percocet II tabs given for pain. 2 pt restraints on, ⊕ circulation. Will monitor [redacted] 1600 SPC
	b(6)-

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

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
27 Sept	VSS pt A+O x3, LCTAB, HRRR, ⊕BS x4 qd pincare complete, both drsg Δ'd, removed penrose drain, wound clean, red with minimal drainage, stump healing well sutures intact, skin intact no signs of infection noted, pedal pulse present left leg pt c/o pain often given perc, pt c/o constipation ~~but~~ no other remarkable findings. [redacted]
	(1745) I concur c̄ above assessment. [redacted] JAW
1950	Pt a110, VSS, c/o pain often but falls asleep immediately after complaint. pin care done, (R) leg pedal pulse present. Drsg c̄ CDI. doing ROM often. H2O @BS voiding mod. yellow urine via urinal. Restraints on. will monitor [redacted] gumme [redacted]
28 Sept 1745	Received pt resting in bed, VSS, A+O x3. (L) LE ex fix in place, pin care done, WSD drsg Δ'd serosang drainage on old drsg order. Medicated w/ 1 percocet x1 this am. (R) stump w/ drsg intact, Tol PO, svgs light yellow urine. Restraints in place per ~~to~~ CPW protocol & stump abdomen rated. Will cont to monitor pt [redacted]
	b(6)-2 A11

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b(6)-2 A11

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
(con't)	wrist ≈ HR. ⊖ redness ⊖ s/sx infection. Pt. tolerated dressing changes well. Two restraints in place ⊕ circulation ⊖ skin breakdown. will cont. to monitor pt. [redacted]
~~28sep03~~	~~1600 - pt. OOB to BR. ambul~~ [redacted]
28sep03	1700 - pt. c/o stomach pain. pt. states "I haven't had BM x25 days". abd. [redacted] distended, firm. will cont. to monitor pt. [redacted]
28Sep03 20 1s	Pt A+O x3, VSS, LS CTA (B), ⊕ BS x4, abd soft flat tender to palpation, pt c/o ⊘ BM in 25 days, requested med to assist BM, urinating well in urinal, dsg to toes (B) CDI, Ex fix on (R) thigh, dsg on pins CDI, dsg around knee had moderate amount of drnge behind the knee, medicated for pain ≈ 11 percs, HL (R) Hand intact, proper circulation + ⊘ skin break down on pts of restraint. [redacted] gw [redacted]
29Sept	PERRLA, pt awake+oriented x3, [illegible] respiration [illegible] and [illegible] in labored, abd soft not distended, BS x4, working suber drive per urinal dsg changed below knee, sitcare completed minimal drainage noted swabbed with betadine then [illegible] circulation intact ⊘ skin breakdown restraints x2 in place [redacted]

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES b(6)-2 All
27SEP03 (1500)	(cont) done this am. outer drsg to R thigh Δd d/t mod. amount of drainage on old drsg. Drsgs to feet Δd. Silvadene applied to burned skin. Pt tol drsg Δs well. RLE elevated on ~~pillow~~ [redacted] blanket. SL in L arm flushes well s s/sx infection/infiltration. Tol. reg diet well. voiding s difficulty. 1. point restraint in place s s/sx complications. will cont. to monitor. [redacted]
27sep0302	1S Assumed care @ 1800; All U/S; pt A&O X3, pain controlled c̄ perc, pt ambulated X1 for 15 min, TOL well; dsg to feet Δd silvadene applied, wrapped c̄ Kerlix, ⊖ s/sx infection; pin care completed; min drng noted; dsg to R thigh Δd, moderate amt of drng noted, RLE ↑; SL in L arm infiltrated, IV started in R wrist, patent & flushes well, cont c̄ IV abx; restraint in place, ⊕ circulation, ⊖ skin breakdown; cont to monitor, NV intact. [redacted]
28sep03	0934 - Assumed care of pt. @ 0800. Assessment completed. Perrla, Lungs CTA(B), Resp. even unlabored, NSR, S1S2 present. Abd. soft nontender, bsx4. voiding per urinal. Ext. fix in place to R UE. Pin care performed. Drsng changed completed c̄ moderate amount of drainage to drsng. Silvadene applied to B feet. Kerlix wrapped around. IV R

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

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
28 Sep 03	2045 = VSS, c/o pain to (L) LE - gave ii percocet tabs as ordered, IV HL to (L) arm flushed ~~S~~ difficulty. Dsg to (R) LE stump CDI c̄ Ace wrap, 2+ popliteal pulse, pt. does ROM exercises himself. (R) LE c̄ ex-fix in place, pin care done - no exudate or blood from sites while cleaning, sites look CDI, W→D Dsg to wound on (L) LE Δ'd & W→D to smaller wound to back of (L) leg Δ'd - both CDI, covered c̄ Kurlex & Ace. Palpable 2+ pedal pulse (L) foot. OOB to BR/chair PRN ~~S~~ difficulty & other remarkable findings. POC: Pain Management Infection Control. [redacted] b(4)-2
	Received pt resting in bed, VSS, OOB to BSC, (+) BM, OOB TC. Medicated x 1 ii percocet for pain. Dsg W→D Δ this afternoon c̄ 1800 5mg MSO4 given for pain prior to dressing Δ. Pin care done. Dsg to L stump c̄ d/i. Pt has full ROM of Bilat extremities c̄ hips + knees. (1) ac

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[redacted] b(4)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	IV access patent, intact, flushes easily. Pt has (+) pedal pulse (L) LE & (+) pop. pulse R (L) [redacted]
29 Sep 03 @ 2015:	VSS, A+O×3, c/o pain, gave 2 percocet tabs as ordered, pin care done to ex fix, ∅ drainage noted @ insertion sites, Dsg to (L) LE CDI - reinforcing prn, 2+ pedal pulse (L) foot, (R) LE stump has Dsg c̄ ace CDI, pt. does ROM exercises. IV HL to (L) FA flushed + patent, continue to monitor for acute Δ's. Restraint #1, ⊖ skin breakdown. [redacted]
30 Sept 03 0800	NPO since MN. O/C for OR today. A+O×3 (L) FA saline lock flushed without difficulty. Peripheral pulses palpable. Pin sites on (R) LE external fix. without drainage or crustation. Pt aware of O/C for OR this AM. Will continue plan of care [redacted] 2LT A
30 Sept 03	0950 Pt transferred to stretcher to O/R - [redacted] 2LT A
30 Sept 03	1400 Return from PACU via stretcher. A+O×3 oriented. Transfer from stretcher to bed with minimal assist. Lungs clear bilateral. (L) Pedal pulse palpable. Move toes & (L) foot freely. Capillary refill to (L) toes < 3 sec. (L) FA saline lock patent + intact. (R) LE T on folded blankets. Uses incentive spirometer properly @ 900cc/sec. HOB ↑ 30°. Resting comfortable c̄ eyes closed. Will continue plan of care [redacted] 2LT A

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b(6)-2

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
9/24/03	OpNote
	PreOpDx : Open (R) BKA
	PostOpDx : FTD closure of stump
	Procedure : same
	Surgeon : [redacted]
	Anesthesia : [redacted] b(ce) 2 A11
	EBL : min
	Fluids : 600cc
	Cx : ✓
	[redacted]
	OpNote
9/29/03	PreOpDx : Open (L) T13/F13 Fx ⊼ Ex Fix
	PostopDx : Same
	Procedure : Removal of Ex Fix, IM nailing of tibia, STSG (L) calf
	Surgeons : [redacted]
	Anesthesia : GETA / MAC FENTANYL
	EBL : min
	Fluids : 1600cc
	Findings : Comminuted and short tib/fib fx c lateral gastrocnemius bed
	Cx : ✓

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME		[redacted]
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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
29Sep03 1930	Pt A+Ox3, VSS, IV HL (R) wrist intact ∅ s/sx of infex, dsg's on toes bilat CDI, Ex Fix (R) thigh in place, RLE elevated c̄ blanket, c/o pain to RLE, medicated c̄ 2 percs, kerlix dsg around R knee saturated c̄ blood on back of knee, dsg's on pins CDI, abd soft flat non tender, ∅ s/sx of poor circulation or skin break down on pts of restraint. [redacted]
29Sep03	2100: I concur c̄ above assessme[redacted]

b(6)-2

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

DATE	NOTES
6OCT03	1150 - Blood drainage went through dressing since 0930. Will cont to monitor pt. [redacted]
1530	- Reinforced dressing to (R) LE due to blood drainage. [redacted]
1535	- Pt. had large BM. [redacted]
6Oct03 1655	Concur c shift assessment. Will continue to monitor throughout shift [redacted] b(6)-2
0000	Pt alo, VSA, II Percs given for pain. had BM x1. (R) stump & (L) thigh OTA → (xeroform gauze) (R) calf drsg reinforced. (+) pulses to (R) leg. 2pt restraints on. ↓ compromise to skin or circulation. Will monitor [redacted]
7OCT 0200	Pt sleeping c̄ & noted distress [redacted] b(6)-2
7Oct@0810	Assume care of pt. Pt in bed c̄ (R) stump elevated. Staples to stump intact. Xeroform on (L) thigh peeling @ edges. Pt has (+) 3 pitting edema in (R) foot. Pulses palpable. heart CTA. BS(+) S/L flushed c̄ 3cc of NS. lower leg drsg D&I (-) c/o pain or discomfort @ present time. Will continue to monitor - [redacted]
1640	Pt medicated c̄ II percocet per MD order for pain [redacted] b(6)-2

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
~~5OCT03~~ (1900)	~~Pt alert, temp 99, LCTAB, HRRR, BS x4 qdo, abd: soft, NT, non-distended, (ERROR)~~ [redacted] b(6)-2
5OCT03 (1900)	Pt a/o, VSS, LCTAB, HRRR, BS x4 (R) stump incision c̄ sutures OTA, (L) leg calf area ace wrap/Kerlix CPT, (L) thigh c̄ uniform gauze OTA. leg elevated. Pt does own ROM often. 1 pt restraint on. ↓ compromise to skin/circulation will monitor [redacted] b(6)-2 911MO.
6OCT03	0957- VSS - A&O - Assumed care of pt. @ 0600. Assessment completed. PERRLA, LS CTA (B), Resp. even unlabored, S1S2 present, abd. soft, nontender, BS x4, changed dsng to (L) leg. dressing saturated c̄ blood. applied Bacitracin to site + wrapped c̄ Kerlex + ace bandage. (+) cap refill, ROM exercises encouraged, staples intact. pt. c/o ∅ pain @ this time, Voiding per urinal. Will [redacted] cont. to monitor pt. [redacted] b(6)-2

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[redacted] b(6)-4

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
8 OCT 03 1910	Pt Awake. VSS. LS CTA (B). (+) BS x4 quads. S1 S2 present. LLE Drsg (~~Grop~~ Graft site) removed by pt previous shift. L calf area c[redacted] Drsg. void ~~cx~~ w/o ~~s~~ difficulty. Will contin[redacted] monitor. b(6)-2 [redacted] SPC 9 LWM
9 OCT 03	Received pt resting in bed, VSS, lal no, appetite good. (L) LE thigh w/ donor graft site, scab and dried blood noted. bacitracin applied. LLE shin/calf dsg intact w/ serosang drainage noted on calf side. (+) BM, on call provided. IV to (L) wrist patent & intact. Will cont to monitor. Restraints per CDC protocol, Ø breakdown noted. [redacted] b(6)-2
9 oct 03 @ 2140	Assumed care @ 1900; AAOX3, [redacted] speaking arabic; pt OOB to w/c; dsg to (L) leg CDI ~~&~~ drainage; bacitracin applied to donor site, healing well; PIV to (L) wrist + patent ~~&~~ s/sx infection/infiltration; Restraints in place, (+) circulation, (-) skin breakdown ↓; cont to monitor b(6)-2 [redacted]
10 oct 03 0700	- Assumed care pt. A+O x3. VSS. LLE skin graft site healing c̄ scab. Calf graft placement dsg c̄DI & bleeding noted. Lungs clear HRRR Active BS. Ø s/s of infection remains available. Will cont to monitor b(6)-2 [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			[redacted] BER
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#[redacted] b(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER #[redacted] b(6)-4

DATE	NOTES
7OCT@ 1955	Pt A/O, VSS, LCTAB, ⊕BS x4, ⅋ percocet given for c/o pain to (R) leg. drsg Δ'd per MD orders, bacitracin applied to skin graft site (L) calf area) + wrapped c̄ kerlix. (R) stump sutures removed + steri-strips applied. HL (L) hand flush'd.- patent. voiding c̄ u̅ via urinal. 2 pt restraints on ∑ compromise to skin/circulation Will monitor ——— b(6)-2 [redacted] 91WM6.
80CT03	0800 - assumed care of pt @ 0800. VSS - A/O speaking little arabic. LS CTA (B), Resp. even, unlabored, abd. soft non-tender, BS x4. voiding per urinal-c̄ u̅. Drsng Δ to (L) LE conducted Bactracin applied to site + wrapped c̄ kerlex. min. drainage on old drsng. CDI ⊖ s/sx inf. encouraging pt. to do ROM exercises. (R) stump CDI c̄ steri strips applied. ⊕ edema to (L) foot. elevate leg on pillow. one restraint applied. ⊕ circulation ⊖ skin breakdown. D/C IV to (L) hand ⊕ redness ⊕ swelling. New 18G IV start to (L) wrist. CDI ⊖ s/sx inf. Pt. tolerated well. will cont to monitor pt. ——— b(6)-2 [redacted]
	(1700) I concur c̄ above assessment. ——— [redacted]

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
10 Oct 03 @ 1945	Assumed care @ 1900; All VSS, pt A&O x3, Ø c/o pain or discomfort @ this time; pt OOB to w/c, TO I Well; dsg to (L) LE CDI, Ø drainage; pt voiding ī difficulty; (+) BS x4, Ø BM per Bedpan; Restraints in place, (+) circulation, (−) skin breakdown, cont to monitor. b(6)-2 [redacted]
11 Oct 03	pt A+O x3, VSS, pt has Ø c/o pain at this time dsg Δ'd and staples and sutures removed from graft site (L) leg and over the knee cap, both areas skin intact, no drainage or bleeding. bacitracin applied to the staple and suture sites skin intact (+) circulation, restraints x2 in place. b(6)-2 [redacted]
(1525)	I concur c̄ above assessment. [redacted]
(1910)	VSS, a/o, Ø complaints @ this time. dsg to (L) leg dry & intact, (R) stump OTA c̄ steri-strips, (L) knee incision OTA, Ø s/s of infection, (+) circulation, 1 pt restraint on 3 compromise to skin/circulation will monitor. b(6)-2 [redacted]
11 Oct 03 1411	Assume care of pt @ 0600. A+O x3, VSS. A dsg on (L) leg, healing nicely. Skin intact around graft site. c/o Ø pain. Restraints x2 in place, no skin irritation. (R) stump shows Ø signs of bleeding, skin intact. will continue to monitor. [redacted] b(6)-2
(2000)	Pt a/o, VSS, c/o pain to (R) stump. (L) leg graft site OTA c̄ bacitracin applied. (R) stump c̄ steri-strips. (+) circulation, Ø drainage or bleeding noted. 1 pt restraint on 3 compromise to skin/circulation. will monitor b(6)-2 [redacted]

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

[redacted] b(6)-4

MEDCOM - 19296

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
13Oct03 1322	Assume care of PT @ 0600. VSS, A+Ox3. Ø c/o pain today. Exercised in wheelchair. (R) stump has no bleeding or signs of infection present. (L) thigh ~~skin~~ [redacted] graft site was treated with bacitracin. Verbal order from Dr. to let PT (L) leg open for air & restraint on (R) arm, no signs of skin irritation. Will cont. telemonitor. b(4)-2
13Oct03 @0800	Assumed care of pt @ 1800. VSS, NC/O. (R) leg stump healing well ~~[redacted]~~ (L) LE graft site & donor sites OTA c̄ bacitracin applied. Pt ↑ W/C in hallway c̄ difficulty. Plan: monitor LE graft/donor sites, monitor pain. Apt restraints on c̄ S/Sx skin/circulation compromise. Will monitor, ↓ normal activity. Addendum: poss D/C to hospital tomorrow. b(4)-2 [redacted]
14Oct03 0954	(-) Δ in pt's condition. Pt transfer to Hosp S/2 in Kact. Pt D/C c̄ meds. Transferred [redacted] 91WM6 b(4)-2

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

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

REGISTER NO. | WARD NO.

[redacted] b(4)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/1989)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
18Sept03 @0930	pt arrived via medevac, ? on accident per interpreter, assuming GSW to (B) LE. ⊕ doppler pulse on (L), ∅ pulse on (R) per doppler per ortho surgeon. pt able to move toes (B). Lungs CTA(B), BS⊕x4, pelvis stable, Fastexam(-). pt turned & ∅ injuries or deformities noted. C-collar placed, CT scan to head ordered. pt placed on full monitor, O2 NRB @ 10L, VSS. Ortho MD / General Surgeon consulted.
@0940	X-ray portable here. Foley placed c̄ 100cc clear, yellow urine out. pt arrived c̄ 18g in (R) AC, 2nd 18G started in (R) bicep c̄ 1st 1Lt NS ↑. Ancef 1gm IV Piggy ↑. pt c̄ 500cc NS in. Fentanyl 75mcg IVP given for pain. b(4)-2 [redacted]
@0950	Wounds cleansed & splint[redacted]ed, waiting for surgery & CT Scan. [redacted] see 558, sinus tachy. Gentamycin 400mg IVPB ↑ # 1 & PCN 3mu ↑ in ~~each~~ 2 IV site. Td shot given in (L) deltoid. pt denies allergies per interpreter. No other Δs, will continue to monitor b(4)-2 [redacted]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RE[redacted]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(4)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

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

MEDCOM - 19298

18Sept03

@ 09:1015: x-rays completed, #3 & #4 bag of LR hung @ open wide. pt poor historian per interpreter. Labs redrawn for [redacted] sent.

b(6)-2

@ 1055: pt brought to CT SCAN c [redacted] escort, on O_2, stable. will continue to monitor [redacted]

b(6)-2

b(6)-4

#[redacted]

NSN 7540-00-834-4179

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
18 Sept 03 09:10	S: Pt has left leg open fracture, right leg broke.
HO BP 118/78	O: lungs bilateral / clear
P 114	perla - pupils reactive to light
T	good bilateral femoral
RR	no distal pulse left leg

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

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

NSN 7540-01-075-3786

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

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS: IRAQ

CITY: | STATE: | ZIP CODE:

ARRIVAL

DATE *(Day, Month, Year)*: 18 Sep 03 | TIME: 0930

TRANSPORTATION TO FACILITY: MEDEVAC

SEX: M

AGE: 28

DUTY/LOCAL PHONE	
AREA CODE	NUMBER
HOME PHONE	
AREA CODE	NUMBER

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

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

CURRENT MEDICATIONS: Ø

ALLERGIES: Ø

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

EMERGENCY ROOM VISIT	
DATE LAST VISIT	24 HOUR RETURN ☐ YES ☐ NO
TETANUS	
DATE LAST SHOT	COMPLETED INTITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: bilat tib/fib fx

CATEGORY OF TREATMENT

☐ EMERGENT

☒ URGENT

☐ NON-URGENT

TIME: 0930

IN[redacted] b(6)-2

VITAL SIGNS

TIME	0930	0945	1000	1030		
BP	112/50	119/77	107/77	127/79		
PULSE	114	100	110	101		
RESP.	18	16	16	18		
TEMP	/	101.1 (A)				
~~WT~~	100%	100	100%	100%		

LAB ORDERS

X CBC/DIFF	ABG	PT/PTT	BHCG/URINE/BLOOD/QUANT
URINE C&S	UA MSCC/CATH		X CHEM: Met B 1000
X BLOOD C&S X			
TSCX2 un	TS UR@1000		

X-RAY ORDERS

CXR PA & LAT/PORTABLE	C-SPINE
ACUTE ABDOMEN	LS SPINE
SINUS	HEAD CT
ANKLE R/L	
X Bilat Tib/Fib	UR@1015

ORDERS

☒ PULSE OX ☒ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
	IV NS ⅋ bolus	[redacted]	b(6)-2	0946	.5 cc Tetanus
0940	Fentanyl 75 mcg IV			0948	400 mg Levaquin IV
0940	Ancef 1gm IV			1015	50 mcg Fentanyl IV
0945	Foley			1030	250 cc NS 3 gm cc PCN

DISPOSITION: ☐ HOME ☐ FULL DUTY

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

MODIFIED DUTY UNTIL | RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ 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(6)-4

[redacted]

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

NSN 7540-01-075-3786

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

TEST RESULTS

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

PROVIDER HISTORY/PHYSICAL

S: Probable GSW blot LE's. ? any other injuries.

DP / PT pulses
- palpable = doplex (L)

O: alert & stimuli, GCS = 12

Abd - soft, nontender
FAST exam ⊖ by Dr. [redacted]

HEENT - ⊖ obvious trauma
Neck - nontender C-spine film (lat) ⊖ for dislocation
Lungs - CTAB Heart - tachy but reg

Extr - blot open tib fib fx & lg. soft tissue defect (R) medial lower leg.
Pulses absent (R) foot
(L) foot - palpable PT / doppler DP

P: Ortho consult
Eye consult
CT head.

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

[redacted] b(6)-2

SIGNATURE AND STAMP

MAJ [redacted] b(2)-2

DIAGNOSIS

GSW/blot wing LE's.

CODES

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

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
21Sep03		1430	Assumed care of PT A&O LSCTA (B). ~~(F)~~ S S2 present, HRRR. (+) BS x4 quads. (R) BKA Drsg Gauze c̄ seeping serosanguinous fluid. (L) LE Ex fix. Drsg c̄ Ace wrap CDI. complains of "small" pain. Controlled c̄ percocet. Will continue to monitor. [redacted] See 91WM6
21Sep03		1500	I concur c̄ above [redacted]
21Sep03		1502	Pt in 2 pt restraint. Circulation [redacted] skin integrity assessed & WNL [redacted]
21 SEP 03		2117	VSS. AO. Provided 2 percocet for 6/10 pain to BLE. DSG's to R & LLE's CDI. Encouraged use of IS X10 and patient did well. LSCTAB. HRR. BS(+)x4 (+) pulses to LLE. Pins intact. NPO p̄ MN. [redacted]

Op Note

Pre op Dx: Open (R) BKA (L) TIBFB Ex

Post op Dx: Same

Procedure: I+D (R) stump (L) leg wound

Surgeon: Oliver, O

Anes: G

Fluids: 1000cc

T.T.: G

Findings: plus foreign plan bad + post cm

Cx: G

b(6)-2 A11

[redacted]

510-112

NSN 7540-00-634-4123

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
22Sept03	0630		Pt return. from OR via litter. ⊖ s/s of resp distress, pain or discomfort @ present time. (R) leg wrapped c̄ ace bandage. ⊖ drainage noted. Will continue to monitor [redacted] b(a)-2 [redacted] 91WMC
	0935		Pt c/o pain given 2̄ percocet per MD orders will reassess — [redacted] 91WMC b(a)-2
22Sept03	1122		Assume duty of PT after returning from OR. C/O pain given 2̄ percocets. ~~Dsg's applied.~~ [redacted] ~~Minimal walking to and from [redacted]. IV changed out.~~ VSS, A+Ox3. 2 Pt restraint, circulation skin integrity assessed. Linen changed. Little movement of 2x legs. Will continue to monitor. [redacted] b(a)-2
22SEP03		2145	assumed care of pt @1800. VSS. Alert speaking drainc. LSCTA, HRR, ⊕BS, ⊕ post op void. (R) BKA drsg CDI, (L) EX-FIX (TIB) c̄ bulky drsg CDI. Percs for pain, c̄ good relief noted. ⊕ CMS to BUE, (L) FA IV c̄ IVFs, (L) FA HL, both s̄ s/sx of infection/infiltration. Pt restraint on s̄ s/sx of skin/circulation compromise. Plan: monitor pain control. Abx as ordered. [redacted] b(a)-2

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

[redacted] b(a)-4

NURSING NOTES

Medical Record

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

M[illegible]CAL RECORD - PATIENT ACTIVITIES F[illegible]VSHEET

For use of this form, see MEDCOM Circular

SECTION I - PATIENT ASSESSMENT

DATE: 21 Sep 03 | PATIENT ACUITY LEVEL: 3 | POST-OP DAY: 1 | HOSPITAL DAY: 3

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time 1430 To ICW1 From ICU2 ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☒ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (Specify): _____

Procedure/Diagnosis External Fixator B/P _____ P _____ R _____ T _____

LOC A&O appropriately Neurovascular checks _____

Dressing/cast Gauze to (R) BKA, Drsg & wrap Ex Fix (L) LE Tubes _____

Intake (IV, po) (R) UA 22G Output (EBL, other) FTG Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	1430	1914														
BP ARTERIAL LINE																
BP CUFF	130/74	117/68														
TEMPERATURE	99.4	101.0														
PULSE	90	103														
RESPIRATORY RATE	17	16														
OXYGEN (L/%)	Ø	RA														
PULSE OXIMETER	97%	96%														
O_2 METHOD	RA															

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	14							
PAIN INTENSITY (10 / 5 / 0)								
MED ADMINISTERED (Y/N)	Y							
RELIEF ACCEPTABLE (Y/N)	Y							

OTHER

TIME:								
FINGER STICK GLUCOSE								
INSULIN (Y/N)								

SPECIAL NEEDS

TIME:			
*Skin breakdown prevention			
*Falls prevention protocol			
*Restraint protocol			
*Seizure precautions			
*Isolation precautions			

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

EPW

#[redacted] b(6)-4

DIAGNOSIS: (R) BKA (L) Tib/Fib Fx

DRG: _____ ADMISSION DATE: 18 Sep 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: _____

ISOLATION REQUIRED (Specify): None

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
10-14-03	Discharge Summary This Iraqi male had Bilateral open T/B/FIB Fractures secondary to gun ~~shot~~ shot wounds. He has a right Below knee amputation and his left has been stabilized with intramedullary nail. Because of his unstable fracture pattern and (R) BKA, he is unable to bear weight on left leg. He should remain non weight on left leg for additional four weeks. The following six weeks he may begin partial weight bearing on left leg. After that, full weight bearing will be allowed (12 weeks post op). He has small wound posterior left calf which is closing slowly and this should continue to be dressed daily. Continue oral antibiotics until wound is completely closed. Radiographs are not necessary for ten weeks. [redacted] b(6)-2

[redacted] b(6)-4

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

MEDCOM - 19306

MEDICAL RECORD | **INTRAOPERATIVE DOCUMENT**

For use of this form, see AR 40-407, the [illegible]cy is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPER[illegible]M VIA wheeled litter BY Anesthesia
2. PATIENT IDENTI[illegible] VERIFIED BY CPT [redacted] [illegible]ECORD REVIEWED AND PROCEDURE b(6)-2
3. DATE 18SEP03 TIME PATIENT ARRIVED IN SUITE 1130
4. PATIENT IN ROOM TIME 1130 NUMBER 2/2/3

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NKA

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] 91D b(6)-2	RELIEF SCRUB	SPC [redacted] 91D 1230-1315 b(6)-2
ASSIGNED CIRCULATOR	CPT [redacted] 66E	RELIEF CIRCULATOR INT	MAJ [redacted] 66E 1330-1400

7. POSITION AND POSITIONAL AIDS (Specify) Pt on padded or bed, head on foam doughnut. Bilateral Arms extended out to sides < 90° in CAP, secured to padded armboard c safety straps. Bilateral Lower Extremities prepped into sterile field.

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

COMMENTS: Correct Body Alignment maintained

8. SKIN PREPARATION

HAIR REMOVAL ☒ YES ☐ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☒ RAZOR By Dr. [redacted] + Dr [redacted] ☐ CLIP

COMMENTS: no nicks or cuts noted

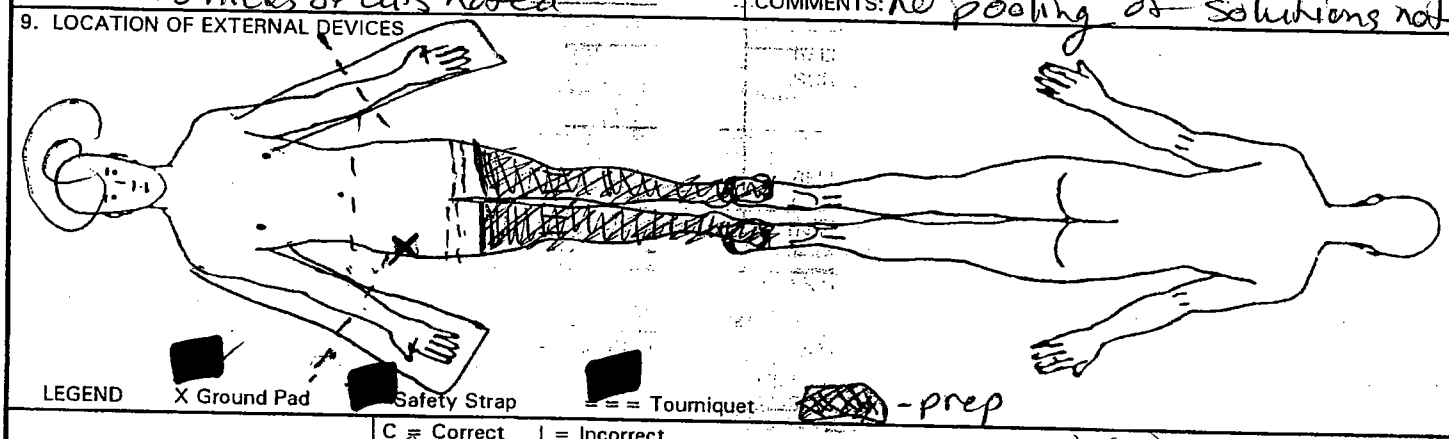
PREP SOLUTION (Specify) Betadine/Betadine b(6)-2

SITE: RLE BY WHOM: LTC [redacted]

SITE: LLE BY WHOM: CPT [redacted]

COMMENTS: no pooling of solutions noted

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS

C = Correct I = Incorrect

			Initial Other**	First Closing Count PLE	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☑ Yes	☐ No	C	C	C	SPC [redacted]	CPT [redacted]
Needle Sharp	☑ Yes	☐ No	C	C	C		
Instrument	☐ Yes	☑ No					
Other	☐ Yes	☑ No					

b(6)-2

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

[redacted]

b(6)-d

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

☒ ESU NO: R8B 102395

GROUND PAD: BRAND Valleylab Polyhesive II REI

LOT NO: 68245/2005-02

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.00

MEDCOM - 19307

13. PROSTHESIS, IMPLANTS ☒ YES IF YES NAME: ID NUMBER: URER

Synthes Ex Fix Pins.
294.794 x 4

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):

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM YES ☒ NO ☐ Flouro via C-arm IF YES, SITE LLE

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION (Specify)
wet to 0.9% Nacl Kerlex Fluffs) - LLE
Kerlex Roll
ACE wrap
RLE - Kerlex, Fluffs, Lg ABD.
Kerlex Rolls ACE

19. ADDITIONAL INFORMATION
WC-IV
Dr [redacted] Anesthesia - CRI [redacted] CRNA - Gen/Endo
Dr [redacted] MAS [redacted] relief
Bovie pad site pre-op CDI pad site post-op CDI Bovie 40/40 Blendl
Tourniquet site RLE pre-op CDI post-op CDI / LLE pre-op CDI post-op CDI
TQ time - 19 min

20. OPERATION(S) PERFORMED
Ex Fix Placement C Fasciotomy LLE

21. PATIENT TRANSFERRED TO b(4)-1 ICU2 TIME METHOD wheeled litter

22. [redacted] RE
[redacted] CPT/AN

[redacted] 9-1, OCT 87 MEDCOM - 19308 USAPA V1.00

MEDICAL RECORD	INTRAOPERATIVE DOCUMENT For use of this form, see AR 40-66, the [illegible]nt agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPE[illegible] [illegible]G ROOM
VIA letter BY anesthesia

2. PATIENT IDE[illegible]D, RECORD REVIEWED AND PROCEDURE
VERIFIED BY [redacted] CPT/AD

3. DATE 20 Sep 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM
TIME 1445 NUMBER 5

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: nkda

6. NURSING PERSONNEL

ASSIGNED SCRUB	SSG [redacted] 91D b(6)-2	RELIEF SCRUB	SSG [redacted] (1500-EOC) b(6)-2
ASSIGNED CIRCULATOR	CPT [redacted] 66E	RELIEF CIRCULATOR	CPT [redacted] (1500-EOC)

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: Proper body alignment maintained, arms on padded armboards at less than 90°, all pressure areas padded, position approved by surgeon + anesthesia

8. SKIN PREPARATION

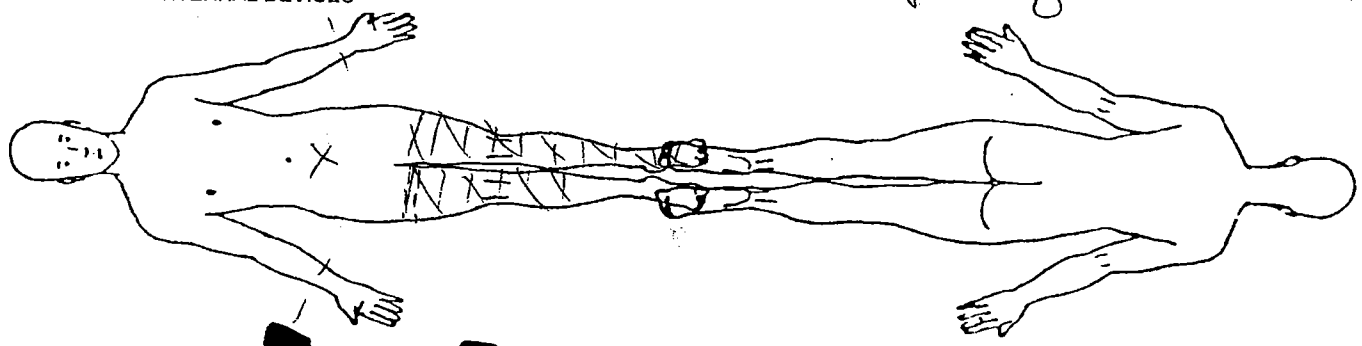
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine / Betadine b(6)-2
SITE: R leg to BKA site BY WHOM: [redacted]
SITE: L leg BY WHOM:

COMMENTS: no packing or skin d's noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad [redacted] -- Safety Strap [redacted] === Tourniquet placed by Dr. [redacted] b(6)-2

C = Correct I = Incorrect

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

[redacted] b(6)-2
20 Sep 03

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

☒ ESU NO: Valleylab Force 40
GROUND PAD: BRAND VL Rem Polyhesive II
LOT NO: 68245 2005-02

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS

	TIME	CARRIED OUT BY
none		

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 1in Penrose	2.	3.
SITE	1. (L) lat calf	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Fluffs ABD
Kerlix
Acewrap

19. ADDITIONAL INFORMATION
WC III
Surgeons: [redacted] (in at 1610)
Anesthesia: [redacted]
Anesthesia Type: General

Bovie Pad site intact pre-op ✓ ; post-op ____ Bovie Settings: 30/30 Coag/Cut
Tourniquet Site intact pre-op ✓ : post-op ✓
Tourniquet Time: Up 1531 Down 1555

- 5179 on chart, ø Δ's noted

20. OPERATION(S) PERFORMED
(R) BKA, stump revision
I+D (L) leg

21. PATIENT TRANSFERRED TO ICU-2 b(6)-2 TIME 1631 DA7389 METHOD Tev b(6)-2

22. REGISTERED NURSE SIGNATURE [redacted] PTA

MEDCOM - 19310 [redacted] CPT/AN

REVERSE OF PATIENT [redacted]

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: Litter BY OR staff

2. PATIENT ID [redacted]
VERIFIED BY

3. DATE 22 Sept 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM [redacted]
TIME 8415 NUMBER 2-2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	Spc [redacted] 91D b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] 66E MAJ [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: Pt placed on padded OR table; arms on padded armboards @ L 90°

8. SKIN PREPARATION

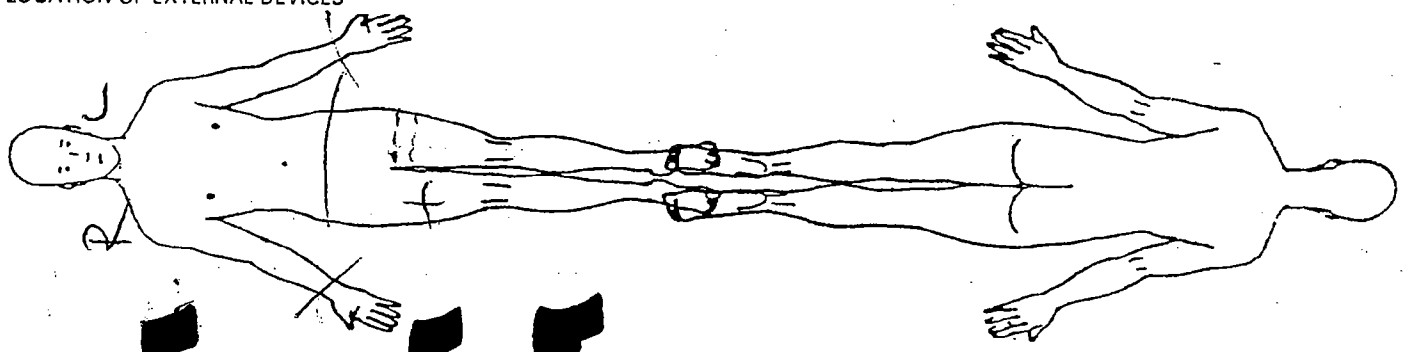
HAIR REMOVAL ☐ YES ☑ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine / Betadine
SITE: (R) LE BY WHOM: [redacted]
SITE: (L) LE BY WHOM: [redacted]

COMMENTS: b(6)-2

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

b(6)-2

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

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

#[redacted]

b(6)-4

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

☑ ESU NO: VL Force 40
GROUND PAD: BRAND VL Rem Poly II
LOT NO: 10011

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

13. PROSTHESIS, IMPLANTS ☐ YES O IF YES NAME: ID NUMBER; M CTL R

14. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS

	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☑ NAME (1) gram stain (R) BKA NAME

FROZEN SECTION (FS) YES ☐ NO ☑ NAME (2) anaerobic cx (R) BKA NAME

CULTURE (C) YES ☑ NO ☐ NAME NAME

NAME NAME NAME

NAME NAME

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*
fluffs
Kerlix
ace
Abd

19. ADDITIONAL INFORMATION
[redacted] b(a)-2 Foley draining amber urine
Foley d/c'd; tip intact
gelta

20. OPERATION(S) PERFORMED
I+D (L) CE Ex Fix I+D (R) BKA

21. PATIENT TRANSFERRED TO PACU b(a)-2 TIME 0525 METHOD stretcher

22. [redacted] CPT

REVERS[redacted] 5179-1, OCT 87 MEDCOM - 19312 [redacted] USAPA V1.01

MEDICAL RECORD | **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA gurney BY anesthesia
2. PATIENT IDENTIFICATION RECORD REVIEWED AND PROCEDURE VERIFIED BY [redacted] CPT/AN
3. DATE 30 Sep 03 TIME PATIENT ARRIVED IN SUITE —
4. PATIENT IDENTIFICATION [redacted] b(6)-2 TIME 1006 NUMBER 1-2 (1)

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: ¢ english speaker. no translator available.

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS (Specify) Pt supine. Placed on Ex table. (L) leg c̄ padded. roll on knee holder. foot held c̄ Steinman pin and Kurskner Traction.

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

COMMENTS: Bow: (R) BKA on padded foot rest. (L) arm padded c̄ pillow. (R) arm on padded arm board.

8. SKIN PREPARATION

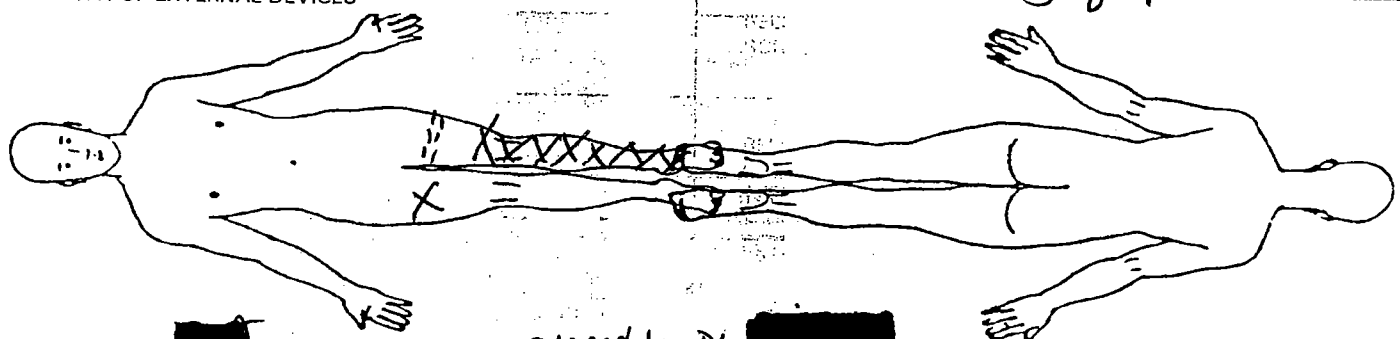
HAIR REMOVAL ☒ YES ☐ NO DONE BY: ☒ OR ☐ NURSING UNIT (DR. Hugate) METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP

COMMENTS: no nicks or cuts noted.

PREP SOLUTION (Specify) Beta/Beta SITE (L) leg. BY WHOM: CPT [redacted] SITE: BY WHOM: b(6)-2

COMMENTS: no pooling of prep noted.

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad [redacted] -- Safety Strap = = = Tourniquet placed by Dr. [redacted] XXX-prep.

10. COUNTS C = Correct I = Incorrect

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

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

EPW # [redacted] b(6)-4

[redacted] b(2)-2

30 Sep 03

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

☒ ESU NO: CUT 30 Valleylab COA G 30 000 147

GROUND PAD: BRAND Valleylab E7509 LOT NO: 68244 2005-02

☐ ESU NO: GROUND PAD: BRAND LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.00

MEDCOM - 19313

13. PROSTHESIS, IMPLANTS ☒ YES — IF YES NAME: ID NUMBER, URER

Synthes 9mm + 10mm IM NAILS LOAD # 0527203 10 - 315

Synthes IM Instrument - + Interlocking Screws. LOAD # 0527202 34, 36, 40

b(4)-2

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
Mineral oil	QS	Intraop	Topical	[redacted]	Dr [redacted]
Bacitracin oint.	QS	Intraop	Topical		Dr [redacted]

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

0.9% NACL

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM YES ☒ NO ☐ — IF YES, SITE C-ARM (L) leg

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*

- fluffs
- Kerlix
- webril
- ace wrap
- Splint

19. ADDITIONAL INFORMATION

20. OPERATION(S) PERFORMED

IM nailing, Removal of EX-Fix (L) leg (L) TIB/FIB Fx, Skin graft.

21. PATIENT TRANSFERRED TO ICU3 b(4)-2 — TIME 1335 — METHOD gurney

22. REGISTERED N[redacted] (PT/AN)

REVER[redacted] DA FORM 5179-1, OCT 87 — MEDCOM - 19314 — USAPA V1.00

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Litter BY Anesthesia

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

3. DATE 23 Sept 03 TIME PATIENT ARRIVED IN SUITE 2102

4. PATIENT [redacted] b(6)-2 TIME 2102 NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: NKDA

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: arms extended on armboards <90° bilaterally b(6)-2

8. SKIN PREPARATION

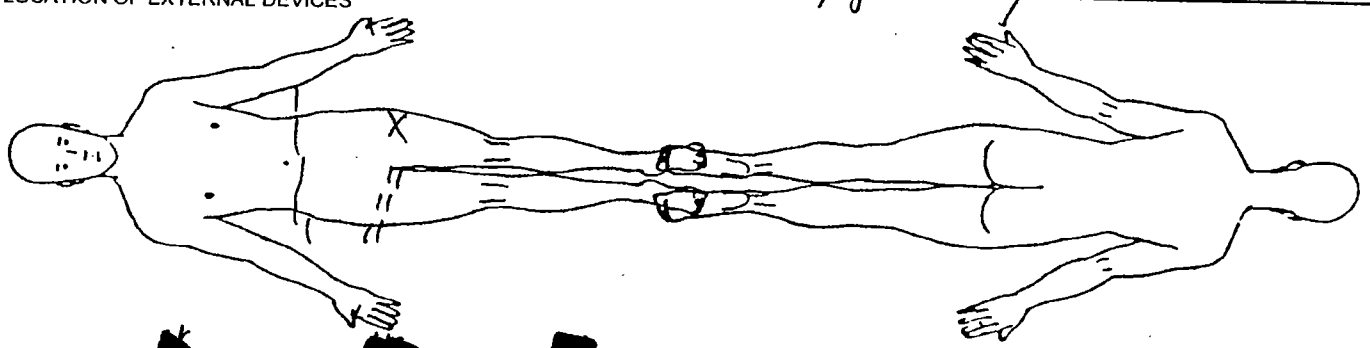
HAIR REMOVAL ☐ YES ☑ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine/Betadine
SITE: Rt stump BY WHOM: maj [redacted]
SITE: BY WHOM:

COMMENTS: ∅ pooling

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad – Safety Strap ==== Tourniquet b(6)-2

C = Correct I = Incorrect Initial: [redacted]

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

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

[redacted] b(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO
cut 40 / coag 40
☒ ESU NO: Valleylab
GROUND PAD: BRAND Valleylab
LOT NO: 68936
☐ ESU NO:
GROUND PAD: BRAND
LOT NO:
☐ BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

NS

OTHER ORDERS	TIME	CARRIED OUT BY
None		

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM IF YES, SITE

YES ☐ NO ☒

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

TYPE/SIZE	1. Penrose	2.	3.
SITE	1. (L) leg	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

Ace wrap
Kerlix
Lg ABD
fluffs

19. ADDITIONAL INFORMATION

WC II

Surgeons: [redacted] Anesthesia: [redacted] b(6)-2 Anesthesia Type: General

Bovie Pad site intact pre-op ✓; post-op ✓ Bovie Settings: Coag/Cut 40/40
Tourniquet Site intact pre-op ✓; post-op ✓
Tourniquet Time: Up N/A Down

20. OPERATION(S) PERFORMED

washout and redress (L) ↓ leg; I+D and closure of (R) stump

21. PATIENT TRANSFERRED TO PACU b(6)-2 TIME 2240 METHOD Litter

22. [redacted] SIGNATURE [redacted] LATAN

[redacted] FORM 5179-1, OCT 87

USAPA V1.01

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES					
18Sept03	↑ 1u PRBC # W 001703 002923 / O+ donor					
1620		HR	BP	RR	SpO2	T
	1628	102	115/69	18	96	98.3
	1630	106	118/88	14	97	
	1635	106	126/72	16	96	
	1640	107	102/74	15	100	
	1655	97	115/72	15	97	98.3
	1700	101	117/71	14	98	
	1715	103	114/73	16	97	
	1730	101	123/75	16	99	
	1745	105	124/73	17	98	98.3
	Final	105	124/73	17	98	98.3
	NO defficulties noted during transfusion - CPT [redacted]					
						b(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

#[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

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

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY

19 | HOUR

PULSE (O) | TEMP. F (•) | TEMP. C

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted] b(6)-4

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

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY / POST-DAY / MONTH-YEAR / DAY / HOUR

19 Sep 03 | 20 Sep | 21 Sep | 22 Sep 03 | 22 Sep | 23 Sep 03 | 24 Sep 03

Admit

HOUR	2030		0700	1720	0730	1830	8	1	2130		8	1	8	1	1830

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

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

RESPIRATION RECORD

14				18		16	18		18		18	18	22	
84														

BLOOD PRESSURE

(P) 92		154/92	142/91	140/88	140/90	128/78	119/66	131/71		132/57	129/69	139/75	140/70	
(R) 18		H88	95	96	102		103	84 T		T98.2		138/63	85	
98.1		T97.8	T98.4	T99.7	99.3		99.2	99.0 H		H84			99.1	
RA		96%	96%	96%	98%			98%		94%				
		RA	RA 97% RA	RA		93% (RA)	98%				97% RA	96% (RA) 94% (RA)	96%	

HEIGHT: | WEIGHT →

Q Sat

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

EPW# [redacted]

b(6)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDICAL RECORD

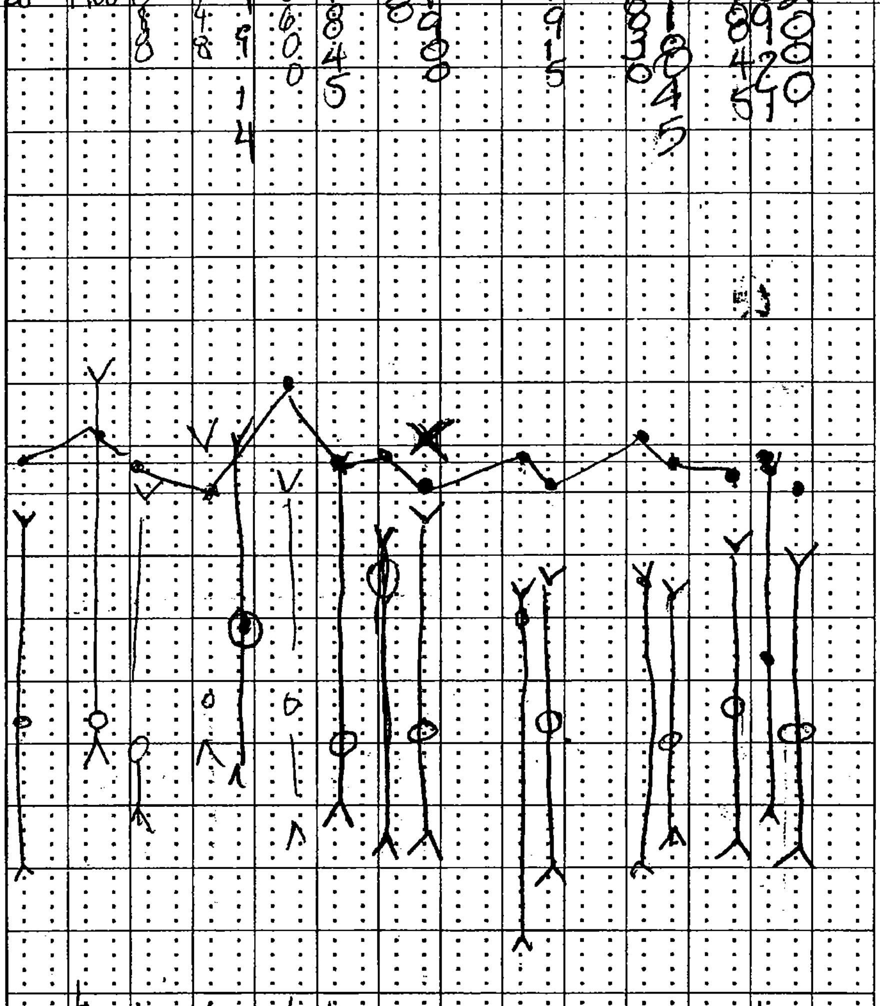
VITAL SIGNS RECORD

HOSPITAL DAY							
POST- DAY							
MONTH-YEAR / DAY	29 Sept	30 Sep	Oct 1	2 OCT	3 Oct 03	4 OCT 05	06 OCT
19 / HOUR	08 1900	0800 1449	0600 1845	0800 1900	0915 1915	0800 1840	0800 1940

PULSE (O) / TEMP. F (•) / TEMP. C

180 104° 40.0°; 170 103° 39.4°; 160 102° 38.9°; 150 101° 38.3°; 140 100° 37.8°; 130 99° 37.2°; 98.6° 37.0°; 120 98° 36.7°; 110 97° 36.1°; 100 96° 35.6°; 90 95° 35.0°; 80; 70; 60; 50; 40; 105° 40.6°

(Centigrade Equivalents, for Reference only)



RESPIRATION RECORD: 18, 18, 18, 18, 18, 18, 18, 18, 18, 18, 18, 18

Record special data only when so ordered

BLOOD PRESSURE: 115/61, 122/61, 120/70, 130/80, 127/68, 126/70, 112/65, 107/88, 104/61, 106/61, 112/65, 112/69, 104/66, 108/64

T 98.7, HR 100

HEIGHT: | WEIGHT →

98% RA, O2 95% RA, 98, 99%, 96%, 97% RA, 99%, 97%, 98%

98%

151/71, 100, 100, 97% | (RA) (1900) 116/65 | 99% (RA) | 106/61 | 97% RA | 98% (RA)

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

REGISTER NO.

WARD NO.

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

[redacted]

b(6)-4

MEDCOM - 19320

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

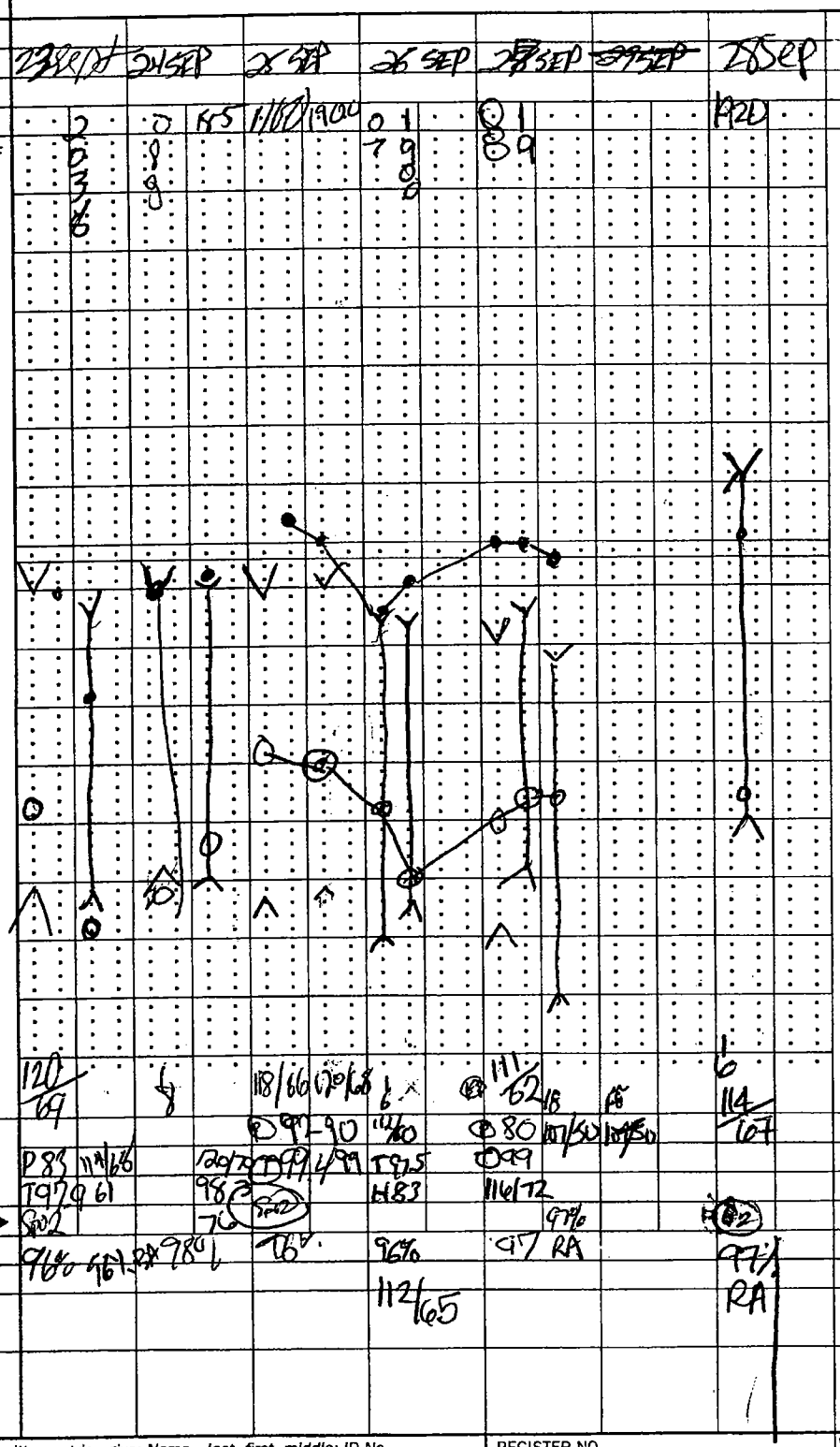
POST- DAY

MONTH-YEAR DAY

19 HOUR

PULSE (O) TEMP. F (°)

TEMP. C



RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted] b(6)-4

VITAL SIGNS RECORDS

Medical Record

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

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

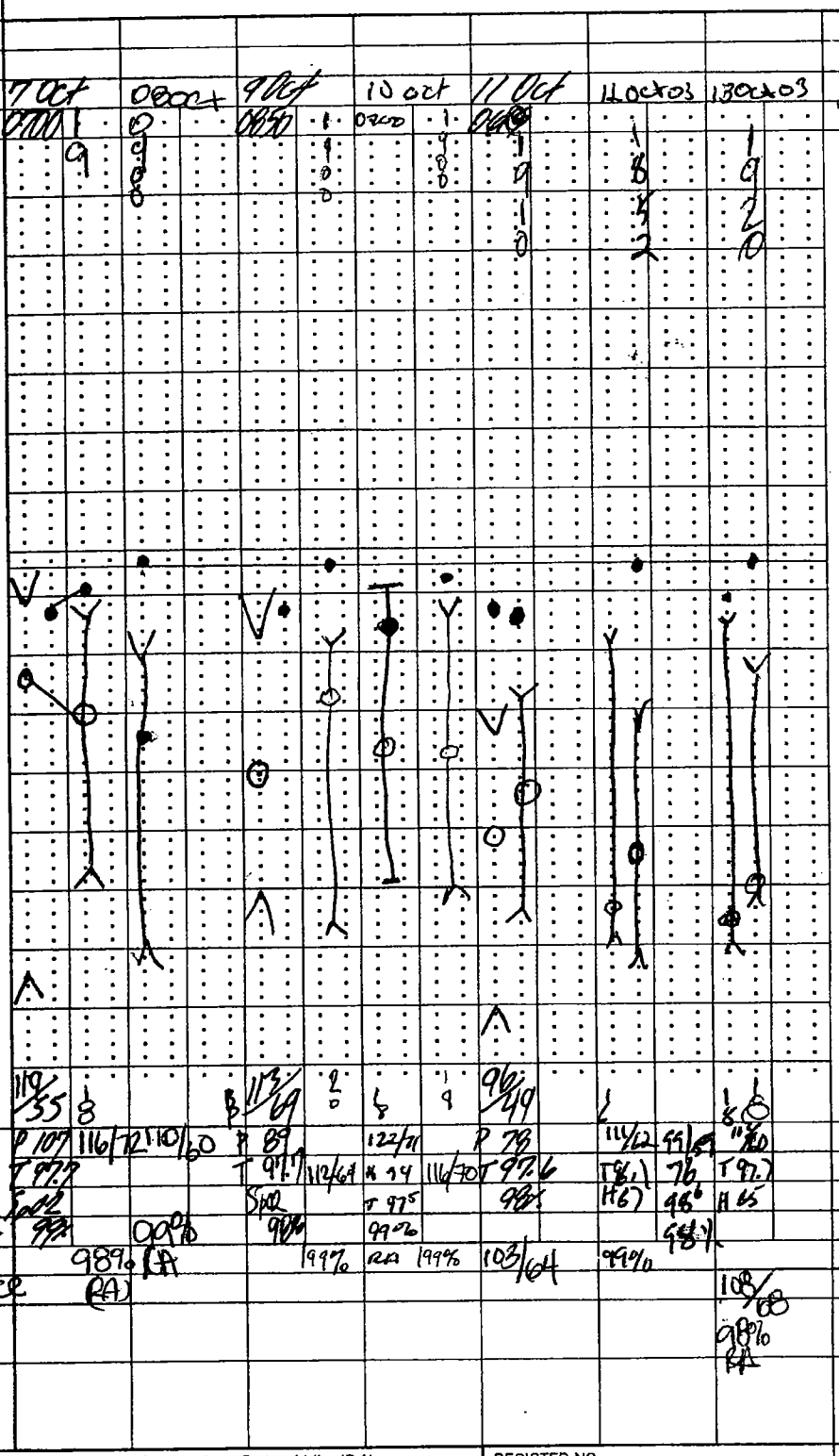
POST- DAY

MONTH-YEAR | DAY | HOUR

19

PULSE (O) | TEMP. F (•)

TEMP. C (Centigrade Equivalents, for Reference only)



RESPIRATION RECORD

BLOOD PRESSURE

~~HEIGHT~~ | ~~WEIGHT~~ →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted]

b(6)-c1

VITAL SIGNS RECORDS

Medical Record

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

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY																	
POST-	DAY																
MONTH-YEAR	DAY	140203															
19	HOUR																
PULSE (0)	TEMP. F (°)																TEMP. C
	105°																40.6°
180	104°																40.0°
170	103°																39.4°
160	102°																38.9°
150	101°																38.3°
140	100°																37.8°
130	99°																37.2°
	98.6°																37.0°
120	98°																36.7°
110	97°																36.1°
100	96°																35.6°
90	95°																35.0°
80																	
70																	
60																	
50																	
40																	
RESPIRATION RECORD		8															
BLOOD PRESSURE		96/50															
		197.9															
		124															
HEIGHT:	WEIGHT →																
		98%															

(Centigrade Equivalents, for Reference only)

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

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

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

LAST, FIRST, MI. b(6)-4 [redacted]	DATE 18 Sept	TIME 1000	SSN/PSEUDO SSN: [redacted] b(6)-4

(Hematology) CBC

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

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	BPOS

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

UNIT	TYPE	CROSSMATCH
4634018	OPOS	Comp
4825683	✓	✓

REMARKS:

REPORTED BY: [redacted]	DATE: 9-18-03	LAB ID NO.:

b(6)-2

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

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

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

======= PICCOLO =======
18/09/03 10:33
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
GENERAL CHEMISTRY 12
DISC LOT #: 3142AA4
OPER #: [redacted] DR #: 000
SERIAL #: b(6)-2 [redacted]

ALB	2.7*	3.3-5.5	G/DL
ALP	34	26-84	U/L
ALT	25	10-47	U/L
AMY	15	14-97	U/L
AST	50*	11-38	U/L
TBIL	0.6	0.2-1.6	MG/DL
BUN	9	7-22	MG/DL
CA++	7.1*	8.0-10.3	MG/DL
CHOL	58*	100-200	MG/DL
CRE	1.0	0.6-1.2	MG/DL
GLU	149*	73-118	MG/DL
TP	4.8*	6.4-8.1	G/DL

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
LU		73-118 mg/dl
JN		7-22 mg/dl
A++		8.0- 0.3 mg/dl
E		0.6-1.2 mg/dl
A+		128-145 mmol/l
		3.3-4.7 mmol/l
		98-108 mmol/l
D_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
+	141	128-145 mmol/l
	5.0	3.3-4.7 mmol/l
	108	98-108 mmol/l
CO_2	24	18-33 mmol/l

REMARKS: b(6)-2

REPORTED BY: [redacted]	DATE: 5-18-03	LAB ID NO.:

b(a)-2 A,H

ID: [redacted] 18-09-03
WB 10:32

				Patient Limits	
WBC	16.0	H	x10^3/uL	4.5	10.5
RBC	3.90	L	x10^6/uL	4.00	6.00
Hgb	7.6	L	g/dL	11.0	18.0
Hct	25.5	L	%	35.0	60.0
MCV	65.4	L	fL	80.0	99.9
MCH	19.6	L	pg	27.0	31.0
MCHC	29.9	L	g/dL	33.0	37.0
Plt	274.		x10^3/uL	150.	450.
LY%	10.5	*L	%	20.5	51.1
LY#	1.7	*	x10^3/uL	1.2	3.4

ID: [redacted] 18-09-03
WB 19:20

				Patient Limits	
WBC	6.7		x10^3/uL	4.5	10.5
RBC	3.41	L	x10^6/uL	4.00	6.00
Hgb	8.2	L	g/dL	11.0	18.0
Hct	25.9	L	%	35.0	60.0
MCV	75.9	L	fL	80.0	99.9
MCH	24.1	L	pg	27.0	31.0
MCHC	31.8	L	g/dL	33.0	37.0
Plt	127.	L	x10^3/uL	150.	450.
LY%	20.0	L	%	20.5	51.1
LY#	1.3		x10^3/uL	1.2	3.4

ID: [redacted] 18-09-03
WB 14:25

				Patient Limits	
WBC	12.5	H	x10^3/uL	4.5	10.5
RBC	3.19	L	x10^6/uL	4.00	6.00
Hgb	7.4	L	g/dL	11.0	18.0
Hct	23.4	L	%	35.0	60.0
MCV	73.5	L	fL	80.0	99.9
MCH	23.2	L	pg	27.0	31.0
MCHC	31.5	L	g/dL	33.0	37.0
Plt	162.	*	x10^3/uL	150.	450.
LY%	9.7	*L	%	20.5	51.1
LY#	1.2	*	x10^3/uL	1.2	3.4

ID: [redacted] 19-09-03
WB 04:08

				Patient Limits	
WBC	5.7		x10^3/uL	4.5	10.5
RBC	3.05	L	x10^6/uL	4.00	6.00
Hgb	7.3	L	g/dL	11.0	18.0
Hct	23.0	L	%	35.0	60.0
MCV	75.5	L	fL	80.0	99.9
MCH	23.9	L	pg	27.0	31.0
MCHC	31.6	L	g/dL	33.0	37.0
Plt	113.	L	x10^3/uL	150.	450.
LY%	12.6	*L	%	20.5	51.1
LY#	0.7	*	x10^3/uL	1.2	3.4

ID: [redacted] 20-09-03
WB 05:04

				Patient Limits	
WBC	8.2		x10^3/uL	4.5	10.5
RBC	3.43	L	x10^6/uL	4.00	6.00
Hgb	8.7	L	g/dL	11.0	18.0
Hct	26.9	L	%	35.0	60.0
MCV	78.5	L	fL	80.0	99.9
MCH	25.4	L	pg	27.0	31.0
MCHC	32.3	L	g/dL	33.0	37.0
Plt	106.	L	x10^3/uL	150.	450.
LY%	17.4	L	%	20.5	51.1
LY#	1.4		x10^3/uL	1.2	3.4

ID: [redacted] 21-09-03
WB 04:24

				Patient Limits	
WBC	7.9		x10^3/uL	4.5	10.5
RBC	2.96	L	x10^6/uL	4.00	6.00
Hgb	7.5	L	g/dL	11.0	18.0
Hct	23.2	L	%	35.0	60.0
MCV	78.5	L	fL	80.0	99.9
MCH	25.4	L	pg	27.0	31.0
MCHC	32.3	L	g/dL	33.0	37.0
Plt	134.	L	x10^3/uL	150.	450.
LY%	14.8	*L	%	20.5	51.1
LY#	1.2	*L	x10^3/uL	1.2	3.4

[redacted] b(2)-2

Microbiology Request Form

Last Name:	Ward:
First Name: [redacted] b(6)-4	Room:
Patient # or SSN: [redacted]	Bed:
	Physician: [redacted]
Collected by: [redacted] b(6)-3	
Date: 22 SEP 03	Source: TISSUE
Time: 0510	Site: R LE BKA
[redacted]	
Received by [redacted]	Specimen #: [redacted]
Date: 22 SEP 03	
Time: 1200	

Laboratory Results

AEROMONA HYDRO GROUP

Reported Date: 24 SEP 03	
Time: 1100	
Tech: IO b(6)-2	
Reviewer: [redacted]	Number of attached sheets:

MEDCOM - 19327

Microbiology Report

[redacted] b(2)-2

Name:		Specimen:	[redacted]	Status:	**Final**
Patient ID:	[redacted] b(6)-4	Source:	Wound/Sterile site	Collected:	
Ward/Rm:	/	Ward of Iso:		Attd. Phys:	

1 Aeromonas hydrophila group Status: Final

1 Aer hydro group

Drug	MIC	Interps	Drug	MIC	Interps
Amox/K Clav (c)	<=8/4	S			
Amp/Sulbactam (c)	>16/8	R			
Ampicillin	>16	R			
Aztreonam	<=8	S			
Cefazolin	>16	R			
Cefepime	<=8	S			
Cefotaxime (c)	<=8	S			
Cefotetan	<=16	S			
Cefoxitin	>16	R			
Ceftazidime (a)	<=8	S			
Ceftriaxone (c)	<=8	S			
Cefuroxime (b)	<=4	S			
Cephalothin	>16	R			
Chloramphenicol	<=8	S			
Ciprofloxacin	<=1	S			
ESBL-a Scrn	<=4				
ESBL-b Scrn	<=1				
Gatifloxacin	<=2	S			
Gentamicin	<=4	S			
Imipenem (c)	>8	R			
Levofloxacin	<=2	S			
Meropenem (c)	<=4	S			
Moxifloxacin	<=2	S			
Nitrofurantoin	<=32				
Norfloxacin	<=4				
Pip/Tazo (d)	<=16	S			
Piperacillin (a)	<=16	S			
Tetracycline	<=4	S			
Ticar/K Clav (a)	<=16	S			
Tobramycin	<=4	S			
Trimeth/Sulfa	<=2/38	S			

S = Susceptible
I = Intermediate
R = Resistance
MIC = mcg/ml (mg/L)

N/R = Not Reported
--- = Not Tested
TFG = Thymidine-dependent strain

Blank = Data not available, or drug not advisable or tested
ESBL = Extended spectrum beta-lactamase
Blac = Beta-lactamase positive

R* = Resistant due to extended spectrum beta-lactamases (ESBL)
EBL? = Suspected ESBL. Confirmatory tests needed to differentiate ESBL from other beta-lactamases.
IB = Inducible Beta-lactamase. Appears in place of Sensitive with species known to possess inducible beta-lactamases; potentially they may become resistant to all beta-lactam drugs. Monitoring of patients during/after therapy is recommended. Avoid other/combined beta-lactam drugs.

For blood and CSF Isolates, a beta-lactamase test is recommended for Enterococcus species.

(a) Use maximum doses of drug with an aminoglycoside for P. aeruginosa in patients with granulocytopenia or serious infections.
(b) Breakpoints based on parenteral dose. For cefuroxime axetil (PO) use (8=S, 8-16=I, >16=R). Footnote (c) applies to this drug.
(c) For streptococci refer to penicillin interpretations. For amoxicillin/K clavulanate or ampicillin/sulbactam with enterococci, refer to the penicillin interpretation.
(d) For non beta-lactamase producing enterococci, refer to the penicillin interpretation. Footnote (a) also applies to this drug.

Interpretive breakpoints are based on NCCLS M100-S12 Jan 2002. Sparfloxacin (for Gram Negative isolates) and moxifloxacin are based on FDA approved breakpoints.
For S. pneumoniae, cefotaxime and ceftriaxone breakpoints are based on isolates from patients with meningitis. For non-meningitis infections, use <2=S, 2=I, >2=R.

Name:		Specimen:	[redacted]	Status:	**Final** b(6)-2
Patient ID:	[redacted] b(6)-4	Source:	Wound/Sterile site	Collected:	
Ward/Rm:	/	Ward of Iso:		Req. Phys:	[redacted]

[redacted] b(2)-2

Microbiology Request Form

Last Name: [redacted] b(6)-4
First Name: [redacted]
Patient # or SSN: [redacted]

Collected by: [redacted] b(6)-2
Date: 22 sep 03
Time: 0510

Ward: ICW-1 6A
Room:
Bed: 6A b(6)-2
Physician: [redacted]

aerobic

Source: Tissue
Site: (R) LE BKA

[redacted]

Received by [redacted] b(6)-2
Date: 22 Sep 03
Time: 1200

Specimen #: [redacted]

Laboratory Results

Aer hydro group

Reported
Date: 24 Sep 03
Time: 1100
Tech: IO b(6)-2
Reviewer: [redacted]

Number of attached sheets:

MEDCOM - 19329

Microbiology Report

[redacted] b(2)-2

Name:	[redacted]	Specimen:	[redacted]	Status:	**Final**
Patient ID:	[redacted]	Source:	Wound/Sterile site	Collected:	
Ward/Rm:	/ b(4)-4	Ward of Iso:		Attd. Phys:	

1 Aeromonas hydrophila group Status: Final

1 Aer hydro group

Drug	MIC	Interps	Drug	MIC	Interps
Amox/K Clav (c)	<=8/4	S			
Amp/Sulbactam (c)	>16/8	R			
Ampicillin	>16	R			
Aztreonam	<=8	S			
Cefazolin	>16	R			
Cefepime	<=8	S			
Cefotaxime (c)	<=8	S			
Cefotetan	<=16	S			
Cefoxitin	>16	R			
Ceftazidime (a)	<=8	S			
Ceftriaxone (c)	<=8	S			
Cefuroxime (b)	<=4	S			
Cephalothin	>16	R			
Chloramphenicol	<=8	S			
Ciprofloxacin	<=1	S			
ESBL-a Scrn	<=4				
ESBL-b Scrn	<=1				
Gatifloxacin	<=2	S			
Gentamicin	<=4	S			
Imipenem (c)	>8	R			
Levofloxacin	<=2	S			
Meropenem (c)	<=4	S			
Moxifloxacin	<=2	S			
Nitrofurantoin	<=32				
Norfloxacin	<=4				
Pip/Tazo (d)	<=16	S			
Piperacillin (a)	<=16	S			
Tetracycline	<=4	S			
Ticar/K Clav (a)	<=16	S			
Tobramycin	<=4	S			
Trimeth/Sulfa	<=2/38	S			

S = Susceptible
I = Intermediate
R = Resistance
MIC = mcg/ml (mg/L)

N/R = Not Reported
— = Not Tested
TFG = Thymidine-dependent strain

Blank = Data not available, or drug not advisable or tested
ESBL = Extended spectrum beta-lactamase
Blac = Beta-lactamase positive

R* = Resistant due to extended spectrum beta-lactamases (ESBL)
EBL? = Suspected ESBL. Confirmatory tests needed to differentiate ESBL from other beta-lactamases.
IB = Inducible Beta-lactamase. Appears in place of Sensitive with species known to possess inducible beta-lactamases; potentially they may become resistant to all beta-lactam drugs. Monitoring of patients during/after therapy is recommended. Avoid other/combined beta-lactam drugs.

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(a) Use maximum doses of drug with an aminoglycoside for P. aeruginosa in patients with granulocytopenia or serious infections.
(b) Breakpoints based on parenteral dose. For cefuroxime axetil (PO) use (8=S, 8-16=I, >16=R). Footnote (c) applies to this drug.
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(d) For non beta-lactamase producing enterococci, refer to the penicillin interpretation. Footnote (a) also applies to this drug.

Interpretive breakpoints are based on NCCLS M100-S12 Jan 2002. Sparfloxacin (for Gram Negative isolates) and moxifloxacin are based on FDA approved breakpoints. b(6)-2
For S. pneumoniae, cefotaxime and ceftriaxone breakpoints are based on isolates from patients with meningitis. For non-meningitis infections, use <2=S, 2=I, >2=R.

Name:		Specimen:	[redacted]	Status:	**Final**
Patient ID:	[redacted]	Source:	Wound/Sterile site	Collected:	
Ward/Rm:	b(4)-4	Ward of Iso:		Req. Phys:	[redacted]

Printed 9/24/2003 11:14:07 AM

Tech: IU

MEDCOM - 19330

b(6)-4

[redacted] - OR

Ward/Section:	[redacted] b(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST MI	DATE 30 Sept 03 TIME 0900	SSN/PEEUDO SSN:

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x10	Color		N/A	RPR		Negative
RBC		4.7-6.1 x10	App		N/A	Mono		Negative
Hgb		14-18 g/dl(M) 12-16 g/dl(F)	Glu		Negative	Microbiology		
Hct		42-52%(M) 37-47%(F)	Bili		Negative	Source		
MCV		80-94 fi(M) 81-99 fi(F)	Ket		Negative	Gram Stain		
Plt		130-500 x 10^3 verified	SG		N/A	Occ Bld		Negative
Lymph %		20.5-51.1%	Bld		Negative	H. pylori		Negative
(Hematology) Manual Differential			pH		N/A	Micro Parasites		
Segs		Mono	Prot		Negative	Malaria		
Bands		Eos	Urob		0.2-1.0	O & P		
Lymph		Baso	Nit		Negative	Other		
Atyp		Imm	Leuk		Negative	Macroscopic Urinalysis		
RBC Morph			HCG		Negative			
Spun Hematocrit		42-52%(M) 37-47%(F)	CSF			Blood Bank		
Set Rate			Cell Count			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED		
Other			Directigen		Negative	ABO/Rh		

Coagulation Studies			Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 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: b(6)-2

REPORTED BY: [redacted]	DATE: 09-30-03	LAB ID NO.:

MEDICAL RECORD — ANESTHESIA

DRUG	Units	1110	1120	1130	1140	1150	1200	1210	1220	1230	1240	1250
PROPOFOL	(mg)	200										
SUX	(mg)	100										
VECURONIUM	(mg)	5										
FENTANYL	(mcg)	50	100, 50, 50									
MSO4	(mg)			6, 4								
ephedrine	(mg)						10	10		10		
VOLATILE AGENT	% del	1.5	1.5	1.5	1.5	2.0	1.5	1.5	1.5	1.5	1.0	—
	% e.t.											
AIR	L/Min											
N2O	L/Min											
O2	L/Min	8	2	2	2	2	2	2	2	2	2	2

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

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

FLUIDS		
LINE site	☐ Warmed	
LR 18g (R)	☐ Warmed	100
LR 18g (R)	☐ Warmed	400
NS 16g (L)	☐ Warmed	1000

LOSSES	
EST BLOOD LOSS	
URINE –	600

TOTALS — TOTAL FLUID — TOTAL URINE

FLUIDS – SUMMARY
CRYSTALLOID–
COLLOID–
BLOOD–

REMARKS– Code drugs with numbers, events with letters

ID Pt in Rpmt, NKDA English speaking.

1144 PRBC #
[redacted]

1200 PRBC'S #
[redacted]

1210 PRBC'S #
[redacted]

TTT = 19 min

PHYS STATUS: 1 (2) 3 4 5 (E)

BODY WEIGHT: 70 (KG) LB

HEMATOCRIT: 7/25

INITIAL DATA: BP – 107/49 HR– 106

EQUIP CHECK: OK? (Y) N

PATIENT RECHECK: OK for PROCEDURE? (Y) TIME– 1110

TIME → 1130 • 1200 • 30 • 1300 • 30 • 1400 • 30

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

220 200 180 160 140 120 100 80 60 40 20

VENTIL	1110	1120	1130	1140	1150	1200	1210	1220	1230	1240	1250
VT – ml	390	740	740	730	700	370	360	250	280	270	360
f – breaths/min	12	8	8	8	14	18	19	20	19	17	16
Peak inf pres / PEEP	21	19	20	20							
MODE– S(pon), A(assist), C(on)	S/C	C	C	C	S	SV	SV	SV	SV	SV	SV

MONITORS / ACCESSORIES		1110	1120	1130	1140	1150	1200	1210	1220	1230	1240	1250
BP/Auto Cuff	ET CO2 (torr)	22	37	38	39	53	48	48	48	49	50	50
BP / oth	FIO2 (Frac or %)	.89	.89	.88	.88	.88	.87	.87	.87	.87	.88	.87
ART line	SpO2 (%)	100	100	100	100	100	100	100	100	100	100	100
Steth- PC/ES	ECG	ST	ST	ST	SR	SR	SR	SR	SR	SR	SR	SR
Gas analyzer	TEMP- site	AVAILABLE	36.4	36.4			36.3	36.3			36.4	36.5
O2	N-M Block (T/4)	4/4	0/4	2/4	3/4	4/4	4/4 c	pacemaker				
Warming blkt												
Conv warmer												

Mark with letters & symbols, explain under REMARKS — EVENTS

Position — OR — arms < 90° abducted ~ padded

RECOVERY AT 1528
PACU (ICU) 2 (Specify)
OTHER
CONDITION:
RESP– 12 SpO2– 100%
BP– 117/72 HR– 104

ANESTHESIA / PROCEDURE TIMES	Start	Room	End
ANES	1110	1130	1530
PROC	Ready	Begin	End
	1140	1200	1450

PROCEDURES and CPT Codes
(R) BKA (L) Ex-Fix (Tib/Fib Fx)

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
PRP-DC Sim, RSI c cricoid pressure and in line c-spine stabilization, OLXT mil 2 Grade III view, 7.0 ETT Placed, 20 cm @ lips
(+) BBS (+) ETCO2.

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

#[redacted]
b(6)-4

SURG[redacted] 03 / [redacted] b(6)-2

MEDICAL RECORD – ANESTHESIA

PROCEDURE LOCATION OR 2
DATE 18 SEP 03
PAGE 1 OF 2

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 19332

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

MEDICAL RECORD — ANESTHESIA

ANESTHETIC AGENTS AND DRUGS	DRUG	(Units)
CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML, "I"=CONSTANT INFUSION		( )
		( )
		( )
		( )
		( )
		( )
	VOLAT AGENT	150 % del
		% e.t.
	AIR	L/Min
	N2O	L/Min
	O2	L/Min
SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS		

FLUIDS			
	LINE site	☐ Warmed	
	LR 18g (R)	☐ Warmed	800
	LR 18g (R)	☐ Warmed	500
	MS 18g (L)	☐ Warmed	1500
LOSSES	EST BLOOD LOSS		
	URINE –		

TOTALS	
TOTAL EST. BL	300
TOTAL URINE	800

FLUIDS – SUMMARY
CRYSTALLOID– 3000
COLLOID–
BLOOD– 3 UNIT

REMARKS–
Code drugs with numbers, events with letters

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: KG / LB

HEMATOCRIT:

INITIAL DATA: BP / HR

BLOOD CHECK: OK? – Y N

PATIENT RECHECK: OK for PROCEDURE? TIME–

TIME → 1450 • 1500 • 30 • 1600 • 30 • 1700 • 30

SYMBOLS:
- BP by cuff: V / ^
- Heart rate: ●
- Resp rate
- BP (transduced): ⊥ / T
- TOURNIQUET: T – ⊥
- ANES– X-X
- PROC–⊙–Ø

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

VITALS		
	VT – ml	380 460 560
	f – breaths/min	18 16
	Peak inf pres / PEEP	
	MODE– S(pon), A(ssist), C(on)	S S S
MONITORS & ACCESSORIES	BP/Auto Cuff / ET CO2 (torr)	49 46 46
	BP / oth / FIO2 (Frac or %)	.87 .89 .89
	ART line / SpO2 (%)	100 100 100
	Steth- PC/ES / ECG	SR SR SR
	Gas analyzer / TEMP- site	36.6 –
	N-M Block (T/4)	
	Warming blkt	
	Conv warmer	

Mark with letters & symbols, explain under REMARKS EVENTS *Position* → O-1

RECOVERY AT: PACU ICU (Specify) OTHER
CONDITION:
RESP– SpO2– BP– HR–

ANESTHESIA	Start	Room	End
PROCEDURE TIMES	Ready	Begin	End

PROCEDURES and CPT Codes
(R) IBKA (L) Ex-Fix

ANESTHETIC TECHNIQUES: *Describe block techniques under Remarks*
See Pg #1

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

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

[redacted]

SUR [redacted]
ANESTHESIOLOGIST [redacted] D(cd)-2

PROCEDURE LOCATION: OK
DATE: 18SEP03

D(cu)-4

MEDICAL RECORD – ANESTHESIA

PAGE 2 OF 2

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 19333

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

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 28 **DAYS MOS YRS** **Sex** (✓) **MALE** ( ) **FEMALE**

ASA Physical State 1 2 3 4 5 E
WT: 70 (KG/LB) HT: _____ IN.
ALLERGIES: NKDA

PROPOSED PROCEDURE: _____
SURGICAL SERVICE: Ortho
NPO SINCE: _____

HABITS:
TOBACCO: _____
ETOH: _____
DRUGS: _____

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) _____
( ) _____
( ) _____
( ) _____
( ) _____
( ) _____

PREMEDICATIONS:
None Yes (@ _____ Hrs) /CC
_____ . _____ mg IV IM PO
_____ . _____ mg IV IM PO
_____ . _____ mg IV IM PO

LABORATORY STUDIES:
HB/HCT: 7 / 28
U/A: _____
OTHER: _____

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:			
Hypertension	N	Y	
Angina	N	Y	
MI	N	Y	
CVA	N	Y	
Other	N	Y	
Pulmonary System:			
Asthma	N	Y	
Bronchitis/URI	N	Y	
COPD	N	Y	
Other	N	Y	
Renal System:			
Acute/Chronic RF	N	Y	
Gastrointestinal:			
Hepatitis	N	Y	
Hiatal Hernia	N	Y	
PUD/GERD	N	Y	
Endocrine System:			
Diabetes	N	Y	
Steriods	N	Y	
Thyroid	N	Y	
Neurological:			
Seizures	N	Y	
Neuropathy	N	Y	
Other	N	Y	
Gynecological :			
Pregnancy	N	Y	
Other Significant Hx:			
	N	Y	
	N	Y	
Familial HX	N	Y	

ASSESSMENT
PAST SURGICAL/ANESTHETIC
_____
_____
_____
_____
_____
_____

PHYSICAL EXAMINATION
BP ___ HR ___ R ___ T ___
Pain Scale 0-10 _____
HEENT - Teeth _____
Trachea _____
TMJ/Neck _____
Oropharnyx _____
Nares _____
CHEST: _____
CARDIAC: _____
EXTREMITIES:
_____
IV Access: _____
Ulnar Filling: _____
BACK: _____
OTHER: _____

NPO Since _____

ANESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): _____ {✓} General: Mask Intubation

INFORM[redacted]ISELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discu[redacted]al guardian.

The[redacted]ems to understand and agrees. Questions answered.
b(6)-2 Signed [redacted] CRNA Date: 18 SEP 03 Time: 1100 Hrs

POST-[redacted]UATION AND NOTE (NON ASU)
{ } NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER

Signed: _____ Date: _____ Time: _____ Hrs

SEDATION KEY:

1. **MINIMAL** (Anxiolysis) Patient responds normally to verbal commands
2. **MODERATE** (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is not necessary.
3. **DEEP SEDATION/ANALGESIA.** Patient responds purposefully following repeated or painful stimulation. Airway assistance may be necessary.
4. **ANESTHESIA.** Patient does not respond to painful stimulation.

Patient Identification: (Ward) _____

#[redacted] b(6)-4

- Ancef
- PCN

28yo ♂ No Δ since Anesthesia pre-op 18 Sept 03

NKDA

Site / procedure verified

MEDICAL RECORD — ANESTHESIA

DRUG	Units	
Fentanyl	(µG)	250
Midazolam	(mG)	40
Propofol	(mG)	200
SCh	(mG)	100
MSO4	(mg)	
	( )	
VOLAT AGENT: ISO	% del	1.5 1.5 1.5 1.5 1.5
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	6 - 2 - 2 - 2 - 2 - 2 - 10 - 10

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

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

TOTALS	TOTAL EBL
250	50
	TOTAL URINE
10	400

FLUIDS – SUMMARY
CRYSTALLOID– LR – 700
COLLOID– Ø
BLOOD– Ø

FLUIDS
LINE site R Arm Hand ☐ Warmed — LRA — 300 — 700
☐ Warmed — IVPB ACN — X (3mg)
☐ Warmed
☐ Warmed

LOSSES: EST BLOOD LOSS; URINE – Foley 300

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 70 (KG / LB)

HEMATOCRIT: 25.9

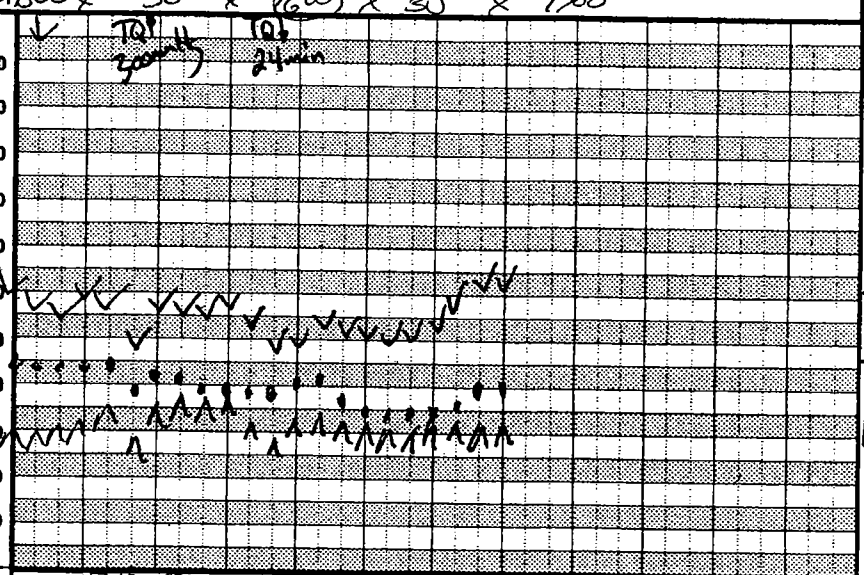
INITIAL DATA: BP – 120/60; HR – 90's

SONIP CHECK: OK? – Y N

PATIENT IDENTIFICATION: OK for PROCEDURE? TIME – + 1445

TIME → 1500 x 30 x (1600) x 30 x 1700

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



VT – ml		710	830	770	700	200	1000
f – breaths/min		10	10	12	5	17	20
Peak inf pres / PEEP		19	27	25	–	–	–
MODE – S(pon), A(ssist), C(on)		SV	CV	CV	CV	A	S	S
BP/Auto Cuff	ET CO2 (torr)	40	32	33	48	38	35
BP / oth	FIO2 (Frac or %)	.70	.70	.70	.51	.53	.57	.57
ART line	SpO2 (%)	100	100	100	100	100	100	100
Steth- PC/ES	ECG	NS	NS	NS	SR	SR	SR	SR
Gas analyzer CO2	TEMP- site Skin	36	36	36	36	36	36
	N-M Block (T/4)	4/4 ST "					
Warming blkt	Sheet/Wool blanket →						
Conv warmer							

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

REMARKS – Code drugs with numbers, events with letters

1445 - Pt to OR - Preop done - Chart rev'd → IV in place
1500 - Induction monitors on
1515 CRT [redacted] to relieve report received, OG placed stomach (SXW)
1527 Procedure started (R) Leg
1602 Procedure started (L) leg
1633 Pt awakes, extubated, PO SXW x3, ↓ SpO2 to ICU 2 - stable. Report to [redacted]

RECOVERY AT 1650
PACU (ICU) 2 (Specify)
OTHER
CONDITION: Stable
RESP – 20 SpO2 – 96 %
BP – 145/90 HR – 100

ANESTHESIA & PROCEDURE TIMES

	Start	Room	End
ANES	1445	1500	1633
PROC	Ready 1570	Begin 1527	End 1635

PROCEDURES and CPT Codes: (R) OXA Dec D

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GETA - # 8 Cuffed ETT #3 Miller → taped 2 Ant teeth → Eyes taped → OOT ↓ ↑ ⊕ return → Soft bite block

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: Easy → DL x 1 → Gr I view → ETT easily passed Atraumatic → teeth OK → BBT/100 x 5

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

SURGEON [redacted] b(6)-2
ANESTH [redacted] SIA

PROCEDURE LOCATION 2-2
DATE 20 Sep 03
PAGE 1 OF 1

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 19335

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

NPO ± meds @ AGREE w/ pre. . PREOP

MEDICAL RECORD — ANESTHESIA

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

DRUG	(Unite)	
Propofol	(mg)	200
Fentanyl	(cc)	2 1 ½ ½ ½ ½
	( )	
	( )	
	( )	
	( )	
VOLAT AGENT Forane	% del	2 — 2 — 2 — 1 — X
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	6 — 2 — 2 — 2 — 6

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

FLUIDS

LINE site		
0.9% NS 20g L FA	☐ Warmed	1000 ml
	☐ Warmed	#2 1000 ml
	☐ Warmed	
	☐ Warmed	

LOSSES — EST BLOOD LOSS / URINE –

TOTALS	
200	
5cc	

TOTAL URINE

FLUIDS - SUMMARY
CRYSTALLOID– 1000
COLLOID– —
BLOOD– —

REMARKS-
Code drugs with numbers, events with letters
0410 Id'd. Chart pat NPO ± meds. TO OR #2. Mon. hr. O2 Smooth induction, Eyes taped shut-
0520 LMA d/c. TO Recovery. Report given USS

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: KG / LB

HEMATOCRIT:

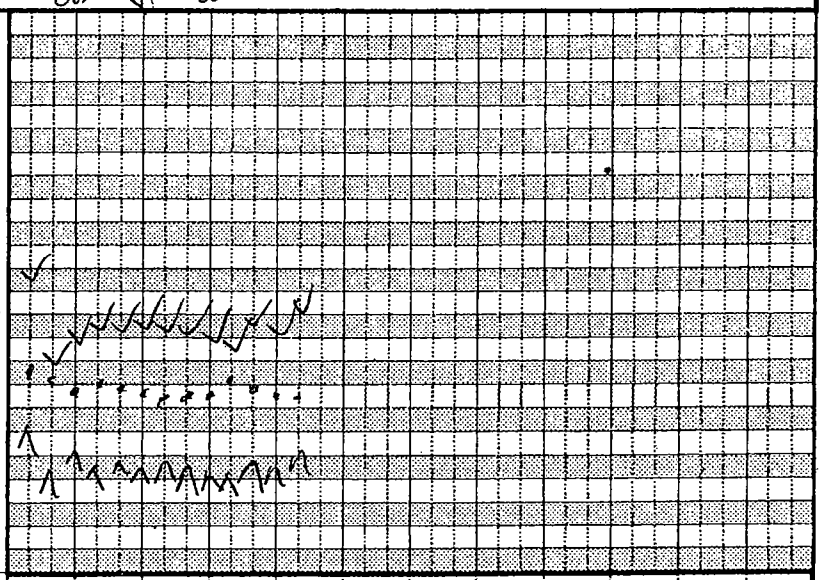
INITIAL DATA: BP – 117, 68 HR – 103 T – 100.4

COMP CHECK: OK? – Y N

PATIENT RECHECK: OK for PROCEDURE? Y TIME – 0416

TIME → 0430 0500

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



VENTIL: VT – ml; f – breaths/min; Peak inf pres / PEEP; MODE – S(pon), A(ssist), C(on): S A A S — S — S — S

MONITORS / ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	58	60	58	52	45
BP / oth	FIO2 (Frac or %)	.83	.83	.86	.86	.86
ART line	SpO2 (%)	100	100	100	100	100
Steth- PC/ES	ECG	SR	SR	SR	SR	SR
Gas analyzer	TEMP- site skin	97	97	97	97	97
	N-M Block (T/4)					
Warming blkt						
Conv warmer						

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

RECOVERY AT: PACU / ICU ____ (Specify) OTHER ____

CONDITION: T – 97.3 RESP – 12 SpO2 – 98 BP – 116/66 HR – 85

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0410	0415	0530
	Ready	Begin	End
PROC	0426	0447	0522

PROCEDURES and CPT Codes: I&D / wash out (L) Leg / R BKA wash out

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GA w/ LMA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: #4.0 LMA Tape (+) ETCO2 (+) B=B

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

[redacted] b(6)-4

SURGEONS: [redacted] b(6)-2

ANESTHETISTS: [redacted]

PROCEDURE LOCATION: OR #2

DATE: 22 Sep 03

PAGE 1 OF 1

MEDICAL RECORD — ANESTHESIA

ANESTHETIC AGENTS AND DRUGS	DRUG	(Units)	
	MSO4	(mg)	10
	Fent	(ucg)	250
	Phenergan	(mg)	25
		( )	
		( )	
		( )	
VOLAT AGENT	FORANE	% del / % e.t.	2.0 / 2.0 / 2.5 / 2.0 / 1.0 / 0.5 / 1.0 / 0
	AIR	L/Min	
	N2O	L/Min	
	O2	L/Min	3 / 3 / 5 / 3 / 3 / 8 / 8 / 3 / 2

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

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS → (1) (2) (3) (4)

FLUIDS	LINE site		
	Rg Blue	☐ Warmed	NS
		☐ Warmed	
		☐ Warmed	
		☐ Warmed	

LOSSES		
	EST BLOOD LOSS	60 40
	URINE –	

TOTALS	
	100
TOTAL URINE	0
FLUIDS - SUMMARY	
CRYSTALLOID–	1000 NS
COLLOID–	0
BLOOD–	0

REMARKS-

Code drugs with numbers, events with letters

(1) PT ID IN ICW
(2) RM-O2-mon.
(3) OOR TO PACU
(4) PT TO SGT

[redacted]

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 60 (KG) LB

HEMATOCRIT:

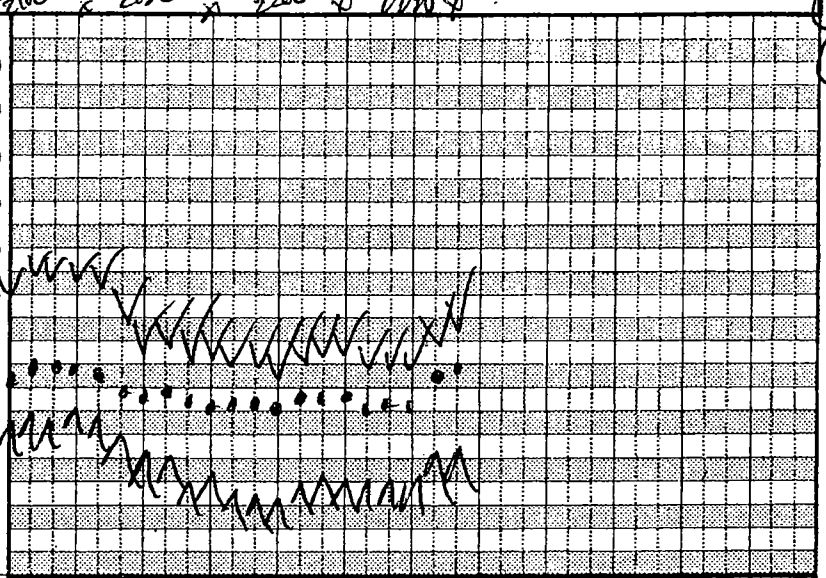
INITIAL DATA: BP – 126 / 75 HR – 87

EQUIP CHECK: OK?– (Y) N

PATIENT CHECK: OK for PROCEDURE? Y TIME – 2105

TIME → 2100 2130 2200 2230

SYMBOLS: BP by cuff V ^ ; Heart rate ● ; Resp rate ; BP (transduced) ⊥ T ; TOURNIQUET T – X ; ANES– X-X ; PROC –⊙–Ø



VENTILATION		2100	2130	2200	2230	2300	2330	2400
	VT – ml	200	380	500	200	450	450	400
	f – breaths/min	21	16	12	11	12	16	16
	Peak inf pres / PEEP	/	/	/	/	/	/	/
	MODE– S(pon), A(ssist), C(on)	S	S	S	S	S	S	S
MONITORS & ACCESSORIES	BP/Auto Cuff / ET CO2 (torr)	48	58	55	57	57	51	48
	BP / oth / FIO2 (Frac or %)	.72	.72	.72	.72	.72	.72	.72
	ART line / SpO2 (%)	100	100	100	100	100	100	100
	Steth- PC/ES / ECG	SR	SR	SR	SR	SR	SR	SR
	Gas analyzer / TEMP- site	Axil						
	/ N-M Block (T/4)							
	Warming blkt							
	Conv warmer							

RECOVERY AT 2240

(PACU) ICU _____ (Specify)

OTHER _____

CONDITION:

RESP– 15 SpO2– 96

BP– 124/77 HR– 85

ANESTHESIA / PROCEDURE TIME	Start	Room	End
ANES	2048	2102	2248
PROC	Ready	Begin	End
	2106	2125	2238

Mark with letters & symbols, explain under REMARKS

EVENTS Position → O

PROCEDURES and CPT Codes

I+D (R)+(L) LEG

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

GA – MASK

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

#90A inserted – PT maintains SV.

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

[redacted]

b(6)-4

SURGEONS: [redacted] b(6)-2

[redacted] CRNA

PROCEDURE LOCATION 1

DATE 24 SEP 03

PAGE 1 OF 1

MMC OP 376 REVISED 1 Jan 99

PATIENT RECORD

Site | procedure verified

7.9 / 23.2 / 134 — 21 3pd — VKDA

MEDICAL RECORD — ANESTHESIA

ANESTHETIC AGENTS AND DRUGS (CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML, "I" = CONSTANT INFUSION)	DRUG	(Units)	
	Fentanyl	(UG)	250
	Lidocaine	(MG)	40
	Propofol	(MG)	150
	Succ/Succ	(MG)	100
	Rocuron	UG	100
	MSO4	(MG)	
	VOLAT AGENT	1.50 % dial	1.5 1.0 1.0 1.0 1.2 1.2 1.2 1.2 1.2 1.0 1.0
		% e.t.	
	AIR	L/Min	
	N2O	L/Min	
	O2	L/Min	6-2-2-2-2-2-2-2-2-2-2-2

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

50/50 = 100

T.S. Lents

FLUIDS	LINE site	
	20 G IA	☐ Warmed
		☐ Warmed
		☐ Warmed
		☐ Warmed

LOSSES	
	EST BLOOD LOSS
	URINE –

Smokes

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 60 (KG) LB

HEMATOCRIT: 23.2

INITIAL DATA: BP – 117/68 HR – 86

BOHP CHECK: OK? – (Y) N

PATIENT BRONCEK: OK for PROCEDURE? (+)

TIME – 0930

SYMBOLS: BP by cuff V ^ ; Heart rate ● ; Resp rate ; BP (transduced) ⊥/T ; TOURNIQUET T – X ; ANES – X-X ; PROC – ⊙ – Ø

TIME → 900 x 30 x 1100 x 30 x 1200 x 30 x

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

VENTIL													
	VT – ml		600	670	640	690	690	650	660	650	650	660	700
	f – breaths/min		9	9	9	9	8	8	8	8	8	8	8
	Peak inf pres / PEEP		26	26	26	26	26	24	26	26	26	26	26
	MODE – S(pon), A(ssist), C(on)		CV	CV	CV	CV	CV	CV	CV	CV	CV	CV	CV
MONITORS / ACCESSORIES	BP/Auto Cuff	ET CO2 (torr)		30	30	30	30	30	34	33	33	33	30
	BP / oth	FIO2 (Frac or %)	.50	.50	.55	.55	.55	.55	.55	.55	.55	.55	.55
	ART line	SpO2 (%)	100	100	100	100	100	100	100	100	100	100	100
	Steth- PC/ES	ECG	NS	NS	NS	NS	NS	NS	NS	NS	SR	SR	SR
	Gas analyzer	TEMP- site	Skin		35		35	35	35	35.2			35
	CO2	N-M Block (T/4)		4/4		0/4							
	Warming blkt		head wrapped blkt + IV line										
	Conv warmer												

Mark with letters & symbols, explain under REMARKS — EVENTS: Position → Arms <90° abducted / padded

TOTALS	TOTAL BLD
	—
	TOTAL URINE
	—

FLUIDS - SUMMARY: CRYSTALLOID – 2L – 1600; COLLOID – —; BLOOD – —

REMARKS – Code drugs with numbers, events with letters

0930 – Pt. ID'd
Preop done / chart
Ved. IV in place
1009 – In room – monitors on – Induction / intubation
1100 – Lev. genius
8/27 & CBC – H/H 6.7/27.8 (8/27)
1250 lunch break – CPT Bradley, Lents
1245 Ancel [redacted] NRS

RECOVERY AT: Stable — PACU / ICU ____ (Specify) — OTHER: 98

CONDITION: RESP – 12 — SpO2 – 97% — BP – 136/82 — HR – 105

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0930	1009	1340
PROC	Ready 1020	Begin 1120 / 1226	End 1226 / 1315

PROCEDURES and CPT Codes: IM nailing (L) leg + skin grafts

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

ANESTHETIC TECHNIQUES: Describe block technique under Remarks — GETA #8 and LTT, taped 22 on teeth. #2 Miller. Eyes taped. DST line & Foley. Soft bite block

AIRWAY MANAGEMENT – Intubation route, blade, technique, comments — Phenny – DL x 1, #3 view. ETT easily passed. DBST / CO2 +. Atraumatic. Teeth OK

SURGEON: [redacted] b(6)-2

ANES: [redacted]

PROCEDURE LOCATION: 2-2

DATE: 30 Sept 03

PAGE 1 OF 2

[redacted] b(6)-4

1(11) 21

MEDICAL RECORD — ANESTHESIA

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML, ML/HR CONSTANT INFUSION

DRUG	(Unite)
	( )
	( )
	( )
	( )
	( )
	( )
VOLAT AGENT	1.0 % del
	% e.t.
AIR	L/Min
N2O	L/Min
O2	L/Min 2-2-8

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

FLUIDS

LINE site	
1 20G PA	☐ Warmed LA
	☐ Warmed
	☐ Warmed
	☐ Warmed

LOSSES — EST BLOOD LOSS / URINE –

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 60 (KG) LB

HEMATOCRIT: 27.8

INITIAL DATA: BP – 117/68 HR – 80

CHKLIST CHECK: OK? – (Y) N

PATIENT CHECK: OK for PROCEDURE? (+) TIME – 0930

TIME → 1330 x 30 x (40)

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

220 200 180 160 140 120 100 80 60 40 20

VT – ml	730 200
f – breaths/min	7 11
Peak inf pres / PEEP	27
MODE – S(pon), A(ssist), C(on)	CV CV
BP/Auto Cuff	ET CO2 (torr) 30 32
BP / oth	FIO2 (Frac or %) 36 158
ART line	SpO2 (%) 100 100
Steth – PC/ES	ECG 15 15
Gas analyzer	TEMP – site SKIN 35 35
	N-M Block (T/4) 4/4
	-5T
Warming blkt	warm blanket/pt. line
Conv warmer	

Mark with letters & symbols, explain under REMARKS — EVENTS Position — ot 2m <90° abducted/padded

PROCEDURES and CPT Codes

TOTALS — TOTAL FLUID — TOTAL URINE

FLUIDS - SUMMARY: CRYSTALLOID – / COLLOID – / BLOOD – see pg 1

REMARKS – Code drugs with numbers, events with letters

1338 – Spont. resp. Suctioned → opened eyes Extubated TO PACU/VSS

RECOVERY AT: PACU ICU _____ (Specify) OTHER _____ CONDITION: RESP – SpO2 – BP – HR –

ANESTHESIA / PROCEDURE TIME

	Start	Room	End
ANES			
PROC	Ready	Begin	End

ANESTHETIC TECHNIQUES: Describe block technique under Remarks — See pg 1

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments — b(6)-2

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

b(6)-4 [redacted]

ICW 1

1 B

SURGEO[redacted]

ANEST[redacted]

PROCEDURE LOCATION 1-2

DATE 30 Sept 03

PAGE 2 OF 2

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 19339

1C2 admit

518-124 NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

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

VOLUME REQUESTED *(If applicable)* one unit ML

REMARKS: b(6)-4

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

- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED 18 Sept 03

DATE AND HOUR REQUIRED 18 Sept 03

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

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

DIAGNOSIS OR OPERATIVE PROCEDURE Rt T.b/Fib Fx

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

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

DATE VERIFIED 18 Sept 03

TIME VERIFIED 1000

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. [redacted]

TRANSFUSION NO.

PATIENT NO.

DONOR O

ABO pos

Rh

RECIPIENT

ABO B

Rh pos

TEST INTERPRETATION

ANTIBODY SCREEN: NA

CROSSMATCH: Comp

PREVIOUS RECORD CHECK:

- [ ] RECORD
- [x] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST [redacted] b(6)-2

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 18 Sep 03

REMARKS: Exp 22 Sep 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)* [redacted] b(6)-2

AT *(Hour)* 1613 ON *(Date)* 17 Sep 03

IDENTIFICATION

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

1st VERIFIER *(Sig* [redacted] b(6)-2

CPT

2nd VERIFIER [redacted] SGT/CPU

PRE [redacted]

TEMP. 98 PULSE 105 BP 110/65

DATE OF TRANSFUSION 18 SEPT 03

TIME STARTED 1622

POST-TRANSFUSION DATA

AMOUNT GIVEN 1 unit ML

TIME/DATE COMPLETED/INTERRUPTED 1745 18/9/03

REACTION

- [x] NONE
- [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
98.3	106	123/75

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION

- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER *(Specify)*

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

- [x] NO
- [ ] YES *(Specify)*

SIGNATURE OF PERSON NOTING ABOVE CPT [redacted] b(6)-2

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

SEX Male

WARD EMT

[redacted] b(6)-4

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

MEDCOM - 19340

Medical Record Copy

518-124

NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

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

VOLUME REQUESTED *(If applicable)* one unit ML

REMARKS:

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

- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED 18 Sept 03

DATE AND HOUR REQUIRED 18 Sept 03

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

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

DIAGNOSIS OR OPERATIVE PROCEDURE Bi Lat. Tib/Fib Fx

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

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

DATE VERIFIED 18 Sept 03

TIME VERIFIED 1000

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. [redacted] b(6)-2

TRANSFUSION NO.

PATIENT NO.

TEST INTERPRETATION

ANTIBODY SCREEN: NA

CROSSMATCH: Comp

PREVIOUS RECORD CHECK:

- [ ] RECORD
- [x] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST [redacted]

DONOR

ABO: O

Rh: pos

RECIPIENT

ABO: B

Rh: pos

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 18Sep03

REMARKS: Exp 22 Sep03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)* [redacted]

AT *(Hour)* 1206 ON *(Date)* 18Sep03

IDENTIFICATION

I have [redacted] the Blood Component container label and this form and I find all inform[redacted] the container with the intended recipient matches item by item. Th[redacted]e person named on this Blood Component Transfusion Form and on [redacted]ion tag.

[redacted]e) b(6)-2

[redacted] CPT, AM, LPNA

[redacted]

PRE-TRANS[redacted]

TEMP. 36.4 PULSE 81 BP 96/42

DATE OF TRANSFUSION 18Sep03

TIME STARTED 1210

POST-TRANSFUSION DATA

AMOUNT GIVEN 1 UNIT ML

TIME/DATE COMPLETED/INTERRUPTED 1220 18Sep03

REACTION

- [x] NONE
- [ ] SUSPECTED

TEMPERATURE 36.3

PULSE 82

BLOOD PRESSURE 97/43

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION

- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER *(Specify)*

[redacted] Equipment, clots, etc.)

[redacted]VES *(Specify)*

[redacted]RSON NOTING ABOVE b(6)-2

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last [redacted]: rate; hospital or medical facility)

SEX Male

WARD EMT

[redacted] b(6)-4

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

MEDCOM - 19341

Medical Record Copy

518-124 NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

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

VOLUME REQUESTED *(If applicable)* one unit ML

REMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*
- [x] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED 18 Sept 03

DATE AND HOUR REQUIRED 18 Sept 03

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)* b(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE Pilot tib+Fib Fx

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

SIGNATURE OF VERIFIER b(6)-2

DATE VERIFIED 18 Sept 03

TIME VERIFIED 10:00

b(6)-2

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.

TRANSFUSION NO.

PATIENT NO.

DONOR ABO O Rh POS

RECIPIENT ABO B Rh POS

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	Comp

PREVIOUS RECORD CHECK:
- [ ] RECORD
- [x] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST b(6)-2

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 18 Sep 03

REMARKS: EZ: b(6)-2

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)* b(6)-2

AT *(Hour)* 1140 DATE 18 Sep 03

IDENTIFICATION

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

1st VERIFIER *(Signature)*

2nd VERIFIER b(6)-2

PRE-TRANSFUSION

TEMP. 36.6 PULSE 85 BP 117/57

DATE OF TRANSFUSION 18 Sep 03

TIME STARTED 1200

POST-TRANSFUSION DATA

AMOUNT GIVEN 1 unit ML

TIME/DATE COMPLETED/INTERRUPTED 1208 18 Sep 03

REACTION
- [x] NONE
- [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
36.6	82	91/42

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION
- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER *(Specify)*

OTHER [redacted] *(Equipment, clots, etc.)*

[redacted] YES *(Specify)*

[redacted] PERSON NOTING ABOVE b(6)-2

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

#[redacted]

b(6)-4

SEX M

WARD OR

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

MEDCOM - 19342

Medical Record Copy

518-124 NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

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

VOLUME REQUESTED *(If applicable)* one unit ML

REMARKS:

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

- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED 18 Sept 03

DATE AND HOUR REQUIRED 18 Sept 03

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)* [redacted]

DIAGNOSIS OR OPERATIVE PROCEDURE B. Lat - Tib/Fib Fx

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

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

DATE VERIFIED 18 Sept 03

TIME VERIFIED 10:00

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. b(6)-2 [redacted]

TRANSFUSION NO.

PATIENT NO.

DONOR

ABO O

Rh POS

RECIPIENT

ABO B

Rh POS

TEST INTERPRETATION

ANTIBODY SCREEN: N/A

CROSSMATCH: Compl

PREVIOUS RECORD CHECK:

- [ ] RECORD
- [x] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST [redacted]

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 18 Sep 03

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

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY [redacted] b(6)-2

AT *(Hour)* 1140 [redacted] ON *(Date)* 18 Sep 03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The rec[redacted]ame person named on this Blood Component Transfusion Form and on th[redacted]ication tag.

[redacted]*e)* b(6)-2

[redacted]OT, AN, CRNA

[redacted]*ignature)*

[redacted]

TE[redacted] PULSE 114 BP 87/47

DATE OF TRANSFUSION

TIME STARTED 1144

POST-TRANSFUSION DATA

AMOUNT GIVEN 1 UNIT ML

TIME/DATE COMPLETED/INTERRUPTED 1156 18 SEP 03

REACTION

- [x] NONE
- [ ] SUSPECTED

TEMPERATURE 36.3

PULSE 93

BLOOD PRESSURE 108/52

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION

- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER *(Specify)*

[redacted]CULTIES *(Equipment, clots, etc.)*

[redacted] YES *(Specify)*

[redacted]ERSON NOTING ABOVE b(6)-2

[redacted]OT, AN, CRNA

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last [redacted]ade; rank; rate; hospital or medical facility)

SEX M

WARD OR

[redacted]

b(6)-4

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

MEDCOM - 19343

Medical Record Copy

518-124

NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

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

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

- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED: 19 Sep 03

DATE AND HOUR REQUIRED:

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

DIAGNOSIS OR [redacted] CEDURE: (B) BKA, (L) T.b-Fb Fx E, Fix

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

VOLUME REQUESTED *(If applicable)*: _____ ML

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*: NK

SIGNATURE OF VERIFIER:

REMARKS:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

DATE VERIFIED:

TIME VERIFIED:

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. b(6)-2 [redacted]

TRANSFUSION NO.

PATIENT NO. 790

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	Comp

PREVIOUS RECORD CHECK:

- [x] RECORD
- [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST: [redacted] b(6)-2

DONOR	RECIPIENT
ABO: B	ABO: B
Rh: neg	Rh: pos

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED [redacted]

DATE: 19 Sept 03

REMARKS: ex 19 Sept 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSP[redacted] *(Signature)* b(6)-2 [redacted]

AT *(Hour)* 05[redacted] ON *(Date)* 19 Sept 03

IDENTIFICATION

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

1st VERIFIER *(Signature)* [redacted] SPC 91W

2nd VERIFIER *(Signature)* b(6)-2 [redacted] 14Tm

PRE-TRANSFUSION

TEMP. 102.8 PULSE 124 BP 125/71

DATE OF TRANSFUSION: 19 Sep 03

TIME STARTED: 0535

POST-TRANSFUSION DATA

AMOUNT GIVEN: 14 ML

TIME/DATE COMPLETED/INTERRUPTED: 0730 19/9/03

REACTION: [x] NONE [ ] SUSPECTED

TEMPERATURE: 98.3 PULSE: 106 BLOOD PRESSURE: 123/70

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION

- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER *(Specify)*

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

- [x] NO
- [ ] YES *(Specify)* b(6)-2

SIGNATURE OF PERSON NOTING ABOVE: CPT [redacted]

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

#[redacted] b(6)-4

SEX: M

WARD: K4 2

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9:202-1

MEDCOM - 19344

Medical Record Copy

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

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

VOLUME REQUESTED *(If applicable)* ____ ML

REMARKS:

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

- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED: 19 Sep 03

DATE AND HOUR REQUIRED

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*: NK

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: ____

HEMOLYTIC DISEASE OF NEWBORN? ____

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

DIAGNOSIS OR OPERATIVE PROCEDURE: S/P (R) BKA (L) Tib-Fib Fx ≈ EF.

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

SIGNATURE OF VERIFIER

DATE VERIFIED

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. [redacted] b(6)-2

TRANSFUSION NO.

PATIENT NO. 790

DONOR: ABO B; Rh neg

RECIPIENT: ABO B; Rh pos

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	Comp

PREVIOUS RECORD CHECK: [x] RECORD [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST: [redacted] b(6)-2

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 19Sept03

REMARKS: 25 Sept 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*: [redacted] b(6)-2

AT *(Hour)* 0740 ON *(Date)* 19 Sep 03

IDENTIFICATION

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

1st VERIFIER *(Signature)*: CPT [redacted] b(6)-2

2nd VERIFIER [redacted] b(6)-2

SGT [redacted] Cpt

PRE-TRANSFUSION

TEMP. 99.4 PULSE 117 BP 118/81

DATE OF TRANSFUSION: 19Sept03

TIME STARTED: 0755

POST-TRANSFUSION DATA

AMOUNT GIVEN: 1 Unit ML

TIME: 0845 DATE COMPLETED: 19Sept03 INTERRUPTED

REACTION [ ] NONE [ ] SUSPECTED

If reaction is suspected – IMMEDIATELY:

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

DESCRIPTION

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

[ ] OTHER ____

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

[x] NO [ ] YES *(Specify)* ____

SIGNATURE OF PERSON NOTING ABOVE: CPT [redacted] b(6)-2

PATIENT IDENTIFICATION - USE EMBOSSER *(For typed or written entries give: NAME - Last, first, middle; rank/rate; hospital number and name of facility.)*

[redacted]

b(6)-4

SEX: M

WARD: 1CH2

BLOOD OR BLOOD COMPONENT TRANSFUSION STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

NSN 7540-01-165-7294 519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED	AGE	SEX	SSN *(Sponsor)*	WARD/CLINIC	REGISTER NO.
Portable XR (L) TIBIA AP+LAT				ICW-I	
	FILM NO.				PREGNANT ☐ YES ☐ NO
	REQUESTED BY *(Print)* [redacted]				TELEPHONE/PAGE NO.
	SIGNATURE [redacted]				DATE REQUESTED

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

Fhx Ital nailg

DATE OF EXAMINATION *(Month, day, year)*	DATE OF REPORT *(Month, day, year)*	DATE OF TRANSCRIPTION *(Month, day, year)*

RADIOLOGIC REPORT

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name — last, first, middle, Medical Facility)*

[redacted]

b(4)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

MEDCOM - 19346 TATION IT

STANDARD FORM 519-B (8-83)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.806-8

NSN 7540-01-165-7294 519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED	AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
CT head		♂		EMT	
	FILM NO.				PREGNANT ☐ YES ☐ NO
	REQUESTED BY (Ph[redacted]				TELEPHONE/PAGE NO.
	SIGNATURE OF [redacted]TOR				DATE REQUESTED 18 Sep 03

b(6)-2

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

r/o head injury

DATE OF EXAMINATION *(Month, day, year)*	DATE OF REPORT *(Month, day, year)*	DATE OF TRANSCRIPTION *(Month, day, year)*

RADIOLOGIC REPORT

Normal (mod artifact)

[redacted]

b(2)-2

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name — last, first, middle, Medical Facility)*

[redacted]

[redacted] b(6)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

MEDCOM - 19347 JLTATION ORT

1 — MEDICAL RECORD

STANDARD FORM 519-B (8-83)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.806-8

NSN 7540-01-165-7294

591-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATIONS (S) REQUESTED	AGE	SEX	SSN *(Sponsor)*	WARD/CLINC	REGISTER NO.
(L) leg AP Lateral S/P external Fixation		M	X [redacted]	ICU 2	
	FILM NO.				PREGNANT ☐ YES ☐ NO
	REQUESTED BY *(Print)* Dr. [redacted]				TELEPHONE/PAGE NO.
	[redacted]				DATE REQUESTED 18 Sep03

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

b(4)-2

S/P (L) leg external Fixation

DATE OF EXAMINATION *(Month, day, year)*	DATE OF REPORT *(Month, day, year)*	DATE TRANSCRIPTION *(Month, day, year)*

RADIOLOGIC REPORT

PATIENT'S IDENTIFICATION *(For typed or written entries give : Name - last, first, middle, Medical Facility)*

X1 [redacted]

b(4)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION REPORT MEDICAL RECORD

MEDCOM - 19348

STANDARD FORM 519-B (8-83)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.806-8

MEDICAL RECORD - DOCTOR'S ORD.

For use of this form, see MEDCOM Circular 40-5

DIRECTIONS: The provider will DATE, TIME, and SIGN each order or set of orders recorded. Only one order is allowed per line. Nursing will list the time the new order(s) are noted and initial in the column provided. Orders completed during the shift in which they were written do not require recopying. They may be signed off, as completed, in the far right column.

ORDER NUMBER	DATE, TIME, & SIGNATURE REQUIRED FOR EACH ORDER OR SET OF ORDERS	ORDER NOTED TIME & INITIALS	COMPLETED TIME & INITIALS
	POST ANESTHESIA ORDERS (circled Items)		
1	VS q 5 min X 15 min, then q 15 min until discharge.		
2	Supplemental oxygen. SATS >90%		
3	Morphine / Meperidine 1-2 mg IV now and 1-2 mg q 3-5 min prn pain for a		
	max dose of 10 mg.		
4	Zofran_____mg IV prn N/V q 15 min, may repeat x _____.		
5	Metoclopramide_____mg IV prn N/V x 1.		
6	Droperidol_____mg IV prn N/V x 1.		
7	Phenergan_____mg IV prn N/V x 1.		
8	Benadryl 25-50mg IVP q1 hr prn, itching while in PACU.		
9	IVF:_____@_____cc/hr.		
10	Discharge from recovery status when PACU discharge criteria met.		
	[redacted] b(6)-2		
	2305 Sept 03		
	1337		

PATIENT IDENTIFICATION

b(6)-4

[redacted]

Complete the following information on page 1 only. Note any changes on subsequent pages.

Diagnosis: _____

Height: _____ Weight: _____ Diet: _____

Allergies: _____

Nursing Unit	Room No.	Bed No.	Page No.
PACU[redacted]			1 of 1

(b)(2)-2

CLINICAL RECORD - DOCTOR'S (
use of this form, see AR 40-66, the proponen .cy is OTSG

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

PATIENT IDENTIFICATION

#[redacted]

b(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICU #2		4

DATE OF ORDER 16 Sept 03 TIME OF ORDER 1515 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) Admit to ICU
S/p (L) Tib ex Fix
(R) BKA
Cond stable
Vitals Q1° & SAT
All ?
Act Bed rest

PATIENT IDENTIFICATION

#[redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICU #2		4

DATE OF ORDER TIME OF ORDER HOURS

I/O, foley care
incentive spirometry
~~NPO~~ Regular Diet
IVF LR @ 150
Meds
MS Oy 2-10mg Q1° PRN pain
Percocet 1-2 tab PO Q6° PRN pain
Ancef 1gm IV Q8°
Gentamicin 400mg IV QD
Penicillin 3 million Units IV Q6°
LABS: CBC in A[redacted]

PATIENT IDENTIFICATION

#[redacted]

b(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICU #2		4

DATE OF ORDER TIME O[redacted] HOURS

Tylenol 650mg ~~PR~~ PO Q6° PRN fever
XR - AP + LAT (L) Tib BKA post Ex Fix

b(6)-2

[redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICU #2		4

Noted 1530 16/9/03

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 1994-363-710

.INICAL RECORD - DOCTOR'S ORDER

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

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

PATIENT IDENTIFICATION

DATE OF ORDER: 18/9/03 TIME OF ORDER: 1600 HOURS

LIST TIME ORDER NOTED AND SIGN

Noted.

1. Infuse 1u PRBC NOW. Then do CBC Q1° post transfusion. [redacted] b(6)-2

V.O. Dr [redacted] CPT [redacted]

Noted / done CPT [redacted] 00/18/9/03

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 19/9/03 TIME OF ORDER: 0800 HOURS

1. Transfuse 2u PRBC b(6)-2

[redacted]

Noted Spc [redacted] 0500 19/9/03

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 9-19-03 TIME OF ORDER: 1715 HOURS

NPO pMN b(6)-2

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

[redacted]

PATIENT IDENTIFICATION

DATE OF ORDER: 20 sep 03 TIME OF ORD[redacted] 1030 HOURS b(6)-2

1. ↓ IVF to 50 cc/h

noted @ 1100h 20 Sep 03

b(6)-2 [redacted]

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 1994-363-710

CLINICAL RECORD - DOC. ... DERS

For use of this form, see AR 40-66, the propo... agency is CTSG

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

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICU #2		4

DATE OF ORDER | TIME OF ORDER | HOURS | LIST ORDERS NOTED SIG...

18 Aug 1000

Admit

Grad Jan

Diet NPO

IV LR at 150/h

gent 400 q 6 d dm

Amp 1 gm IV q 3 g 8 h

PCN ag 3 million IV q 3 a 6 h

b(6)-7

Noted @ 1040d [redacted]

Before surgery in EMT

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.
ICU #2		4

DATE OF ORDER | TIME OF ORDER

[redacted]

b(6)-2

Foley to gravi chair

CBC lytes am 19/tp

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

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]

NURSING UNIT: ICU #2 | ROOM NO.: | BED NO.: 4

DATE OF ORDER: 9-21-03 | TIME OF ORDER: 1330 HOURS | LIST TIME ORDER NOTED AND SIGN

- Transfer to ICU - Dr. O
- ~~q~~ (R) BKA, Left tib/fib Fx
- stable
- Routine vitals
- Bed rest
- Regular Diet, NPO ~~p~~ MN tonight
- Heplock IV

PATIENT IDENTIFICATION

b(6)-4

[redacted]

NURSING UNIT: ICU #2 | ROOM NO.: 24 | BED NO.: 4

DATE OF ORDER: | TIME OF ORDER: HOURS b(6)-2

- Levoquin 500mg IV qD
- Percocet 1 po q4° PRN pain
- Demerol 50-75 mg IVP q4° PRN breakthrough
- Phenergan 25mg IVPB q6° PRN nausea
- Ambien 10mg po qHS PRN insomnia
- Reinforce Dressing PRN [redacted]

PATIENT IDENTIFICATION

[redacted]

b(6)-4

b(6)-2 [redacted]

NURSING UNIT: ICU #2 | ROOM NO.: [redacted] | BED NO.: 4

DATE OF ORDER: 9/22/03 | TIME OF ORDER: 0520 HOURS b(6)-2

Resume preop orders

meds, activities & regular diet

[redacted]

b(6)-2

2215 [redacted]

PATIENT IDENTIFICATION

[redacted]

b(6)-4

[redacted]

NURSING UNIT: ICU #2 | ROOM NO.: | BED NO.: 4

DATE OF ORDER: | TIME OF ORDER: HOURS

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 1994-363-710

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b(6)-4

~~CIV~~ # [redacted]

NURSING UNIT: ICU #2 | ROOM NO.: | BED NO.: 4

DATE OF ORDER: 9/24/03 | TIME OF ORDER: 2240 HOURS | LIST TIME ORDER NOTED AND SIGN

- Stable
- Routine vital
- OOB to chair QID
- Daily wet to dry dressing Δ's Left leg and BID pin site care
- Regular Diet
- Heparin IV

PATIENT IDENTIFICATION

b(6)-4

~~CIV~~ # [redacted]

[redacted] b(6)-2

NURSING UNIT: ICU #2 | ROOM NO.: 240 | BED NO.: 4

DATE OF ORDER: | TIME OF ORDER: | HOURS

- Levaquin 500mg IVGD
- Percocet 1 po q4h PRN
- MSO4 2-8mg IVP q1h PRN breakthrough
- Phenergan 25mg IVP q6h PRN nausea
- Ambien 10mg po q HS PRN
- [redacted] b(6)-2 [redacted]

PATIENT IDENTIFICATION

b(6)-4

~~CIV~~ # [redacted]

noted 26 sept @1430 [redacted] b(6)-2

NURSING UNIT: ICU #2 | ROOM NO.: | BED NO.: 4

DATE: 9-26-03 | TIME OF: 1430 HOURS

(R) X-Ray (L) TIBIA AP LAT [redacted] b(6)-2

9/29/03 1750 NPO 7 MN b(6)-2 [redacted]

[redacted] 9/29/03

PATIENT IDENTIFICATION

b(6)-4

~~CIV~~ # [redacted]

[redacted]

NURSING UNIT: ICU #2 | ROOM NO.: | BED NO.: 4

DATE OF ORDER: 9/29/03 | TIME OF ORDER: 1300 HOURS

- Post IM nailing (L) TIBIA, skin graft
- Routine vitals
- Bed rest
- Incentive spirometry
- Elevate (L) LE on pillow, do not remove dressing
- Regular Diet

(cont) chart cont →

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 1994-363-710

.INICAL RECORD - DOCTOR'S ORDER

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

EPW b(6)-4 [redacted]

JCW1

NURSING UNIT: ~~ICU #2~~ | ROOM NO. | BED NO.: 4

DATE OF ORDER: (Cont) 9/29/03 | TIME OF ORDER: 1300 HOURS | LIST TIME ORDER NOTED AND SIGN

- Heparin IV
- Levaquin 500mg IVPB qD
- Ancef 1gm IVPB q8° x 3 doses
- Percocet 1 PO q4° PRN pain
- MSO4 2-8mg IVP q 2° PRN breakthrough
- Phenergan 12.5-25mg IVPB q6° PRN nausea
- Ambien 10mg PO q HS PRN

PATIENT IDENTIFICATION

EPW [redacted] b(6)-4

JCW1

NURSING UNIT: ~~ICU #2~~ | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

- Lovenox 30mg SQ BID b(6)-2 [redacted]

2400 4 Chart [redacted] 1K/AN 1 OCT 03 2100

PATIENT IDENTIFICATION

EPW b(6)-4 [redacted]

JCW1

NURSING UNIT: ~~ICU #2~~ | ROOM NO. | BED NO.: 4

DATE OF ORDER: 30 OCT 03 | TIME OF ORDER: 0900 HOURS

(1) Leave (R) stump OTA and (L) thigh OTA w/ xeroform gauze in place.

UO [redacted] b(6)-2

PATIENT IDENTIFICATION

EPW b(6)-4 [redacted]

[redacted] JCW1

NURSING UNIT: ~~ICU #2~~ | ROOM NO. | BED NO.: 4

DATE OF ORDER: 7 OCT 03 | TIME OF ORDER: 1900 HOURS

- Daily dressing Δ's (L) leg. Apply Bacitracin to skin graft site.
- Remove sutures (R) stump
- D/C IV levaquin q tomorrow's dose.
- Start oral levaquin 500mg po q D tomorrow.

[redacted]

DA FORM 1 APR 79 4256 REPLACES [redacted] 77, WHICH MAY BE USED.

24 [redacted] b(6)-2 PCA @ 2000

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MEDCOM - 19355

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b(6)-4

[redacted]

DATE OF ORDER: 10-12-03 TIME OF ORDER: 1020 HOURS

Rizzuto R AP + LAT (D) TRB, A — done

b(6)-2

NURSING UNIT | ROOM NO. | BED [redacted]

PATIENT IDENTIFICATION

DATE OF ORDER: 10-14-03 TIME OF ORDER: 0800 HOURS

D/C to EPW Hosp today

[redacted]

b(6)-2

noted 10/14/03 @ 0820

b(6)-2 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER _____ HOURS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER _____ HOURS

NURSING UNIT | ROOM NO. | BED NO.

b(6)-2

CLINICAL RECORD

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

Mo. SEP Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 18	19	20	21	22	23
18 SEP 03	[redacted]	DIET: NPO Regular	06	[redacted]					
			18	[redacted]					
18 SEP 03	[redacted]	Foley TO GRAVITY DRAINAGE	06	[redacted]					
			18	[redacted]					
[redacted]									
18/9	[redacted]	VS Q1° c̄ Start	00	[redacted]					
			18	[redacted]					
18/9	[redacted]	ACT: Bed Rest	00	[redacted]					
			18	[redacted]					
18/9	[redacted]	F/O c̄ Foley	00	[redacted]					
		care	18	[redacted]					
18/9	[redacted]	LABS: CBC in AM	04	/	[redacted]				
18/9	[redacted]	Incentive Spirometer	00	[redacted]					
			18	[redacted]					
18 SEPT	[redacted]	NPO p̄ MIDNIGHT	00	/	[redacted]	/			

ALLERGIES: ☐ YES ☐ NO
UNKNOWN

PRIMARY DIAGNOSIS:
S/P (L) FIB/FIB FX
(R) BKA

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

PATIENT IDENTIFICATION:
Civ [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

b(6)-2

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
18SEP	[redacted]	ADMIT TO ICU2	18SEP		1600	[redacted]
18SEP	[redacted]	CONDITION: ~~FAIR~~ stable	18 SEP		1600	[redacted]
18SEP	[redacted]	CBC [redacted]	19SEP	AM		
18/9	[redacted]	XRAY AP/LAT ⓛ TIBIA S/P SPLINT FIX	18Sept			[redacted]
	-----	UPON ICU2 ADMISSION	18Sept	ADMIT	1600	
18/9	[redacted]	TRANSFUSE 1u PRBC NOW x1	18/9	1600	1600	[redacted]
	-----	CBC 1° P PRBC INFUSION	18/9	1900	1900	[redacted]
~~19/9~~	[redacted]	~~Transfer 2u PRBC~~	~~19/9~~			
19/9	[redacted]	CBC 1° P tx 2u PRBC	19/9	1000	1000	[redacted]

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

b(a)-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. 09 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 19	20	21	22	23	24	25	26	27	28	29	30	1	2
19Sep03	[redacted]	VS-routine	06 18 18 06	X	[redacted]												
19Sep03	[redacted]	Bedrest Roll on side frequently	06 18 18 06	X	[redacted]												
19Sep03	[redacted]	Dsg Δ and pin care QDay	10	X	[redacted]												
19Sep03	[redacted]	NPO p MN	06 18 18 06	X	[redacted]												
20Sep03	[redacted]	Regular diet	06 18		[redacted]												
20	[redacted]	Pin care to ex-fix BID	10 22		[redacted]												
20	[redacted]	Silvadene cream and dsg Δs to (R) foot BID	10 22		[redacted]												
22	[redacted]	Dry dsg Δ to femur. DO NOT remove packing.	10 22 X		[redacted]												

Returned

ALLERGIES: ☐ YES ☑ NO
NKDA

PRIMARY DIAGNOSIS:
(R) femur fx / foot burns
S/P I+D (R) femur

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

PATIENT IDENTIFICATION:
EPW#: [redacted]

b(a)-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 A-1

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo 09 Yr 2003

Verify by Initialing: Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
19 Sep03	[redacted]	admit to ICW#1 - Condition	19 Sep03	2030		[redacted]
	-----	Stable	/	/	/	/
19 Sep03	[redacted]	To OR Tomorrow	20 Sep03	—		[redacted]
20 SEP03	[redacted]	Resume previous orders	20 SEP03	—		[redacted]
22	[redacted]	NPO p MN 23 Sep For SX 24 sept	23	2359	—	[redacted]
24 SEP03	[redacted]	Resume previous orders	24 SEP03	—		[redacted]
24	[redacted]	continue BID drsg ass to feet and thigh - Do not remove packing	24	—		[redacted]
24	[redacted]	NPO p MN 25SEP03 for OR 26SEP03	26 SEP03	0001	—	[redacted]
26 SEP03	[redacted]	Resume previous orders	26 SEP03	—		[redacted]

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

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(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 21	22	23	24	25	26	27	28	29	30	1	2	3	4
9/21	[redacted]	Routine vitals	06/18	[redacted]													
	[redacted]		18/06														
9/21	[redacted]	Bedrest	06/18														
	[redacted]		18/06														
9/21	[redacted]	Regular diet	06/18														
	[redacted]		18/06														
9/24	[redacted]	OOB to [redacted] 91D	08														
	[redacted]		12														
	[redacted]		16														
	[redacted]		20														
9/24	[redacted]	Daily WTD drsg Ks	08														
	[redacted]	(D) leg ~~and~~	X														
9/24	[redacted]	BID [redacted] care	10														
	[redacted]		22														

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: (R) BKA, (L) Tib/Fib Fx

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

#[redacted]

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

b(4)-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
9/21	[redacted]	Transfer to ICU — Dr [redacted]	9/21	1415		[redacted]
9/21	[redacted]	Stable	9/21	noted		[redacted]
9/21	[redacted]	NPO p MN tonight	9/21	2400	—	[redacted]
22 Sep03	[redacted]	Resume previous orders (meds, activity, reg diet)	22 Sep03	—	—	[redacted]
9/29	[redacted]	NPO p MN	9/29	2401		[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
9/21	[redacted]	Reinforce drsg prn														

USAPA V1.00

b(6)-2 A-11

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 13	14	15	16	17	18	19
30SEP	[redacted]	Routine VS	06	[redacted]						
			18							
30SEP	[redacted]	Bedrest	06	[redacted]						
			18							
30SEP	[redacted]	Incentive Spirometer	6	[redacted]						
			18							
30SEP	[redacted]	Reg diet	06	[redacted]						
			18							
7OCT	[redacted]	daily drsg Δ (L) leg	10	[redacted]						
		(apply bacitracin	X							
		to graft site)*	X							
30SEP	[redacted]	elevate (L) LE	06	[redacted]						
			18							
7OCT	[redacted]	leave (R) stump OTA	06	[redacted]						
		(L) thigh c̄ xeroform	18	[redacted]						
		gauze in place.								

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: (R) BKA, (L) tib-fib fx

ADDITIONAL PAGES IN USE: ☐ YES ☒ NO

PAGE NO: ___

PATIENT IDENTIFICATION: EPW # [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

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo Oct Yr 2003

Order Date	Clerk Nurse	b (6) - 2 SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
10/14	[redacted]	D/c. to EPW hosp. today	10/14/03			

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

b (6) - 2 A1

CLINICAL RECORD | **THERAPEUTIC DOCUMENTATION CARE PLAN (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 30	1	2	3	4	5	6	7	8	9	10	11	12
30 Sept	[redacted]	Routine Vitals	06 18	[redacted]												
			18 06													
30 Sept	[redacted]	Bed rest	06 18													
			18 06													
30 Sept	[redacted]	Incentive Spirometer	06 18													
			18 06													
30 Sept	[redacted]	Elevate (L) LE on	06 18													
		pillow. Do Not Remove	18 06													
		Dressing	/													
30 Sept	[redacted]	Regular Diet	06 18	[redacted]												
			18 06													
30 Oct	[redacted]	Leave (R) stump	06	/	/	/	[redacted]									
		OTA and (L) thigh	18	/	/	/										
		OTA and w/ xenform	/													
		gauze in place	/													
7 Oct	[redacted]	daily drsg Δ's to	10	/	/	/	/	/	/	/	[redacted]					
		(R) leg														
7 Oct	[redacted]	apply bacitracin	10	/	/	/	/	/	/	/	[redacted]					
		to skin graft site,														
7 Oct	[redacted]	elevate (R) LE	06								[redacted]					
			18													
7 Oct		leave (R) stump OTA	06								[redacted]					
		and (L) thigh w/xen-	18													
		form gauze in place														

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Post IM Nailing (L) Tib; Skin graft

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 10 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
10/5/03	[redacted]	XR-AP+LAT (L) Tibia	10/6/03	1300	—	
700T	[redacted]	Remove sutures to (R) stump	700T	done		[redacted]
200	[redacted]	XRay AP/LAT (L) TIBIA	—		do	[redacted]

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

b(4)-2 All

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 18	19	20	21	22
18Sept	[redacted]	IV: LR @ 150cc/h	06	[redacted]				
			18	[redacted]				
18Sept	[redacted]	Gentamicin 400mg IV	10	[redacted]				
		QD (Am)						
18Sept	[redacted]	IAW CRF	06	[redacted]				
			14	[redacted]				
			22	[redacted]				
18Sept	[redacted]	PCN 3million IVPB	06	[redacted]				
		Q6hrs	12	[redacted]				
			18	[redacted]				
			24	[redacted]				
20 Sep 03	[redacted]	↓ IVF (LR) TO 50cc/h	06			[redacted]		
			18			[redacted]		

ALLERGIES: ☐ YES ☐ NO
unknown

PRIMARY DIAGNOSIS:
SIP (2) BKA (L) TY FMB FX c EXFIX

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

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
18/9	[redacted]	Transfuse 1u PRBC now x1	18/9	[redacted]	1620	[redacted]
19/9	[redacted]	Transfer 2 u PRBC	19/9	[redacted]	0845	[redacted]
		D(c) - 2 All				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
18/9	[redacted]	MSO4 2-10mg IVP	19/9 0940 5mg	19/9 0940 3mg	19/9 1500 3mg											
		Q1° PRN PN	[redacted]													
18/9	[redacted]	Percocet ½ - ½ tabs	18Sep 2010	19/9 0550	19/9 0040	19/8 0940	19/8 1500	19/9 2380	20Sep 1250	20Sep 2100	21Sep 0350	21Sep 1115				
		PO Q6 hr PRN PN	[redacted]													
18Sep	[redacted]	Tylenol 650mg po q6° pr	21 Sep													
		FEVER	1050													

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. 09 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 19	20	21	22	23	24	25	26	27	28	29	30	1	2
18 Sep 03	[redacted]	IV: LR @ 125cc/hr	06 18	X	[redacted]												
		HL when td. po well	18-06	[redacted]													
20 Sep 03	[redacted]	Ancef 1gm IVPB q	08	/	/	[redacted]											
	[redacted]	8°	16	/	[redacted]												
		C	24	/	[redacted]												
20	[redacted]	Gentamycin 400mg	20	/	[redacted]												
		IVPB q day															
24 Sep 03	[redacted]	Ciprofloxacin 400mg	10	/	/	/	/	/	/	[redacted]							
		IVPB q 12°	22	/	/	/	/	/	[redacted]								

ALLERGIES: ☐ YES ☑ NO
NKDA

PRIMARY DIAGNOSIS: (R) femur fx / foot burns
s/p (R) femur [redacted]

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

PATIENT IDENTIFICATION:
EPW# [redacted]

b(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. 09 Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
		b (w) - 2 A11				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED															
19 Sep03	[redacted]	Tylenol 650mg PO Q4 hrs PRN	D/T/I		18Sep 1395													
					⚕ 1886													
19 Sep03	[redacted]	MSO4 2-8mg IVP Q2-4hrs PRN	D/T/I		20Sep03 0110 5mg [redacted]			20Sep03 0545 5mg		22Sep 0045 4mg	22Sep 1520 4mg	22Sep 2315 4mg	23Sep 0140 5mg	23Sep 0130 5mg	24Sep 1024 5mg	24Sep 1650 5mg		
19 Sep03	[redacted]	Phenergan 25mg IV or PO Q6 hrs prn	D/T/I		20Sep03 0110 25mg IV [redacted]													
20Sep03	[redacted]	Percocet 1-2 po q4-6° prn	D/T	20Sep 1730	21Sep 0030	21Sep 1780	21Sep 0530		22Sep 2315	23Sep 0555	23Sep 1210	23Sep 1845	23Sep 2355	24Sep 1825	25Sep 0030	25Sep 1400	25Sep 1930	
			D/	Reg	⚕	⚕	⚕	⚕	⚕	⚕	⚕	⚕	⚕	⚕	⚕	⚕	⚕	[redacted]
21Sep	[redacted]	MSO4 2-8mg IVP q2-4° prn	D/T	24Sep 2030	26Sep 1400	26Sep 1400	30Sep											
			D/I	5mg	5mg	5mg	[redacted]											
20Sep	[redacted]	Percocet 1-2 po q4-6°	D/T	24Sep 2330	26Sep 1130	27Sep 0300	27Sep 1130	27Sep 1600	28Sep 2020	28Sep 0115	28Sep 1200	29Sep 1915	29Sep 0315	30Sep 0940	30Sep 1600	30 2040		
			D/I	2	⚕	⚕	⚕	⚕	⚕	⚕	⚕	⚕	⚕	⚕	⚕	2		
30Sep	[redacted]	Percocet 1-2 PO Q4	D/T	1900	0200													
			D/I	[redacted]														

USAPA V1.00

CLINICAL RECORD	TH. .PEUTIC DOCUMENTATION CARE PL. .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 [redacted]	HR	DATE DISPENSED
		~~ERROR~~		~~1 2 3~~
	- - - - - -	~~Percocet 1-2 PO q4-6°~~	D/	~~10 OCT 1832~~ ~~10 Oct 2330~~
	- - - - - -	~~PRN~~	D/	~~" "~~
		[redacted]		

5 (ω - ?
A?

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ______

PATIENT IDENTIFICATION:

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

Verify by Initialing		THERA. TIC 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														
20 Oct	[redacted]	Percocet 1-2 PO Q4-6 PRN	D/T/I		10CT03 1832		10CT03 2330		10CT03 2330		10 Oct 2030						
					[redacted]												
		b(6)-2 All															

USAPA V1.00

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)

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

Mo. 9 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 21	22	23	24	25	26	27	28	29	30	1	2	3	4
9/21	[redacted]	Heplock N	06 18 18 06	[redacted]													
9/21	[redacted]	Levaquin 500mg IV q D	10 / /	[redacted]													
		b(6)-2 All															

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: (R) BKA, (L) Tib/Fib Fx

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO. 1

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

MEDCOM - 19373

DA FORM 4 1 OCT 79 EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED. USAPA V1.01

Verify by Initialing

THERAP 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

b(4)-2 All

Ordered Start Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — IMMEDIATE DISPENSED													
9/21 Exp 9/24	[redacted]	PERCOCET ii po q 4 prn pain	Date	21Sep	21Sep	21Sep	21Sep	21Sep	21Sep	22Sep	22Sep	23Sep	23Sep	23Sep	23Sep	9/25
			Time	1500	1914	0300	0835	1535	1935	0020	0808	1905	0544	1347	0500	0800
			Dose	ii	2	2	ii	ii	ii	ii	ii	2	2	2	2	ii (two)
			Int	[redacted]												
			I/Σ	E												
9/21 Exp 9/24	[redacted]	Demerol ~~50-70~~ 50-75mg IVP q 4° prn breakthrough pain	Date	21Sep												
			Time	0100	2350											
			Dose	75	75											
			Int	[redacted]												
			I/Σ													
9/21	[redacted]	Phenergan 25mg IVP q 6° prn nausea	21Sep	[redacted]												
9/21 Exp 9/24	[redacted]	Ambien 10mg po q HS prn insomnia	D/T													
			D/I													
			X													
24	[redacted]	MSO4 2-8mg IVP Q 1° prn breakthrough pain	D/T	9/25 0130	[redacted] 1100	1400										
			D/I	6mg	4mg	5mg	[redacted]									

D/Cd 21Sep [redacted]

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. 10 Yr. 93

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 13	14	15	16	17	18	19	20
30SEP	[redacted]	Heplock IV	06	[redacted]							
	-----		18								
	-----	Lovenox 30mg SQ	10								
30SEP	[redacted]	BID	22								
7OCT	[redacted]	Levaquin 500mg	10								
	-----	PO Q day.	X								

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: (R) BKA, (L) TIB-FIB FX

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

b(6)-4

epw

[redacted]

DISPENSING TIMES

USE PENCIL, CIRCLE MED TIMES

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

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
		b(e)-2 All				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED														
30Sep03	[redacted]	Percocet II PO	D/I	2050 % dos	2115 1100	1900 1300 2	2015 1300 H										
		Q4° PRN PAIN	D/I	[redacted]													
30Sep	[redacted]	MSO4 2-8mg IVP	D/I														
		Q2° pm breakthrough	D/I														
		pain	D/I														
30Sep	[redacted]	Phenergan 12.5-25mg	D/I														
		IV q6° pm nausea	D/I														
30Sep	[redacted]	Ambien 10mg PO	D/I														
		QHS PRN	D/I														

#[redacted]

*U.S. GPO: 1998-454-110/95218

b(e)-4

28 F/C
40.

H/H

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

Time In: _____

Allergies: _____ OR Intake: Crystalloid 2L Colloid 3UBIOOD

Pre-op V/S: _____ OR Output: UOP 500 EBL 300

Procedures: _____ Meds/Times: 20mg MSO4 80mcg NARCAN

Drains: Hemovac, NG, JP, T-tube, Foley, TLS, Collar

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds / History

Time	1530	1535	1540	1600	1615	1630	1645
SaO2	100	100	97	97	97	96	100
FiO2	RA	RA	RA	RA	RA	RA	RA
Methods							
240							
220	118/64	113/70	133/66	111/87	112/62	115/69	118/75
200							
180							
160							
140							
120							
100							
80							
60							
40							
20							
RR	14	15	15	15	15	15	16
T	98				98		
Time							
Pain (0-10)							
LOS							

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1630	PRBC	1 U.	(L) AC	JUP	lumit

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	1	1	1
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	1	1
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	2	2	2
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	9	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

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

PREPARED BY (Signature & Title) CPT [redacted] b(4)-2

DEPARTMENT/SERVICE/CLINIC ICU2

DATE 18 9 03

(Continue on reverse)

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

Name — last,

[redacted] b(4)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, MAY 78 WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) Previous edition is obsolete

USAPPC V2.00

MEDICATIONS

Allergies:

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

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	LLE	elevated	+	++	~3sec	W	B
15'				+			
30'							
45'							
60'							
90'							
D/C	LLE	elevated	+	++	~3sec	W	B

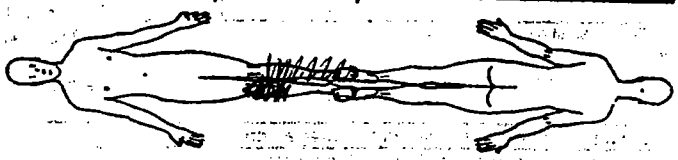
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	RLE/LLE	Ace/Tx abr	minimal
30'			
60'			
D/C	RLE/LLE	ace/Tx abr	minimal



PACU OUTPUT

Time	Source	Color/Appearance	Amount
1600	Foley	c/u	300

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

NURSING NOTES

Pt awakens to stimuli & RR IN the teens. C-collar on - C-spine cleared - ordered for precautions w/ log rolls - MDS visited pt x2. X-ray of LLE done. (B) leg elevated. NVS intact. 1u PRBC infused w/o complications. VSS - cont to monitor — CPT [redacted]

Discharge Criteria:
Date: 18/9/03 Time: 1645 PARS: 9
BP: T: HR: RR: SaO2:
Pain Level at D/C (0-10):
Intake: — Output: —
Additional Data: —
Transferred To: [redacted] 1442
Report Given To: [redacted]
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: [redacted] 1442 b(6)-2
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature:

WAMC OP 173-E

INITIAL SHIFT ASSESSM

b(6)-2

		Time: 10 Inital [redacted]	Time: 1930 Initals: [redacted]
NEURO	Pupils c-color	3mm Sluggish	3mm
	Sensorium Φ Rlo	Awakens to stimuli	awake to stimuli / alert to
	LOC / GCS c-spine	ASA 9, Sleeping s/p surgery / anesthia (20mg MSO4 80mcg Narcan)	place-self
CARDIAC	Cardiac Rhythm	HR 102's ST & RRR Φ ectopy	HR 100-110 RRR
	PRI / QRS:		
	Pulse Strength	UE 2+ Bilat / LLE DP 2+ / (R) Popliteal	⊕ pulse to (B) UE, bounding to
	Cap Refil / JVD	(+) pulse.	(L) LE (R) BKA, ⊕ Femoral and p-lse.
	Edema	NO edema Noted @ this time.	⊖ edema noted
	Chest Pain	None	⊖
RESP	Respiratory Pattern	EQUAL BBS c soft Rhonchi to	CTA, RR + ⊖
	Breath Sounds	UR chest wall. Otherwise CTA	⊕ cough, non-productive,
	Secretions	Φ secretion - SPO2 98-100% RA	⊖ secretions
	Cough	Φ cough (+) qqq	
SKIN	Color	Normal for race (IRAQI)	Normal for race
	Integrity	RLE c ace wrap (BKA s/p) } Both elevated	(R) LE - BKA - ace wrap
	Backside	LLE c ex fix + ace wrap	(L) LE - ex fix - ace wrap
IV	Access Devices	16g (L) AC - Patent / intact	(L) AC 18G - patent + intact / HL
	Location	(R) BICEPT 18g Patent / HL	(R) AC 18G - patent - LR @ 150cc / HR
	Condition	(R) AC 16g Patent	(R) AC 16G - patent + intact / HL
GI	Abdomen	Flat SOFT NTND c BSX4	soft, non-distended
	Bowel Sounds	Φ BM	⊖ BM
	Stoma/Ostomy	Reg diet when awakens.	tolerated Reg diet well.
GU	Device	#16 Foley Placed 18/9/03	16 F Foley to gravity
	Color / Clarity	CYU. Yo - 300cc @ 1600.	Clear yellow urine

PREPARED BY (Signature & Title) b(6)-2

CPT [redacted]

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

DATE: 18/9/03

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

NAME: # [redacted]

RANK: AGE:

UNIT:

GENDER: M

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

b(2)-2

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, MAY 78

USAPPC V2.00

PT'S NAME:

ID#: H[redacted] P(a)-4

DATE: 18 Sept 03

1142

	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											118/73	122/72	122/74	124/73	110/81	124/73	12/74	124/75	124/77	123/74	123/76	123/66	125/71	124/72
TEMP										98.3	98.3	98.3	98.4	97.9		98.2		98.5		98.3		100	99.7	102.5
PULSE											100	102	104	101	115	110	107	107	104	105	118	121	124	134
RESP											15	16	17	17	20	25	18	17	15	19	22	24	23	23
SP02											99	98	98	98	98	98	97	96	98	96	95	94	94	95
FIO2											RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA
INPUT																								
MIVP											150	150	150	150	150	150	150	150	150	150	150	150	150	15
IVPB										1u PRBC			~~50~~ 100			50		~~55~~ 110						~~220~~ 15
PO																								
NGT																								
O.R. IN																								
SUB TOTAL																								
TOTAL																								
OUTPUT																								
URINE										300	10	24	55	500	80	70	100	180	70	40	100	360	220	
NGT																								
STOOL																								
O.R. OUT																								
SUBTOTAL																								
TOTAL																								
BALANCE																								

MEDCOM - 19380

b(6)-2

INITIAL SHIFT ASSESSM.

		Time: Initals:	Ti...1900 Inital [redacted]
NEURO	Pupils Sensorium LOC / GCS		2mm BRISK [redacted] ROUND MAE C DIFFICULTY BILATERAL LE 2/ [illegible] ALERT AND APPROPRIATE; FOLLOWS SIMPLE COMMANDS
CARDIAC	Cardiac Rhythm PRI: / QRS: Pulse Strength Cap Refil / JVD Edema Chest Pain		ST C HR 100S Ø ECTOPY 3+ PULSES BUE 2+ RLE FEMORAL 2+ LLE DP. CAP REFILL BRISK Ø JVD 2+ NON PITTING LLE @ FOOT
RESP	Respiratory Pattern Breath Sounds Secretions Cough		BBS CTA C EQUAL UNLABORED BREATHING RR 20S. Ø SECRETIONS Ø COUGH SUO2 100% IN 2LNC
SKIN	Color Integrity Backside		NORMAL FOR RACE INTACT S EVIDENCE OF SKIN BREAKDOWN
IV	Access Devices Location Condition		14G RAC MEDIAL; 18G RAC LATERAL 16G LAC PATENT AND INTACT. Ø S/S OF INFECTION.
GI	Abdomen Bowel Sounds Stoma/Ostomy		FLAT SOFT NT ND C ⊕BS ⊕BS x4 Ø
GU	Device Color / Clarity		FCL C YELLOW URINE [illegible] CLEAR Ø SEDIMENT [redacted]

[redacted] ...ure & Title) GAN b(6)-2

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

DATE 19 SEPT 03

P... ...ION (For typed or written entries give: Name – last, first ... ...spital or medical facility)

NAME [redacted] RANK: AGE:

UNIT: ICU 2 b(6)-4 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

PT'S NAME: [redacted] ID#: DATE: 19 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																								
BP NIBP	122/66	121/75	122/75	131/76	135/74		140/72	137/78		134/79	104/65	133/70	123/73	120/78	125/80	146/60	135/76	131/70	124/61	108/70	117/60	124/69	130/62	118/66
TEMP	101.3	99.4	100.4			101.4			101.3		101.4		101.7		101.4		100.5		99.2					
PULSE	120	106	103	100	100	100	123	104	113	114	118	106	104	105	120	112	106	102	90	84	92	92	97	129
RESP	22	19	19	19	19	19	21	19	21	23	21	19	19	21	16	21	21	23	16	17	17	18	19	20
SP02	94	100%	100	100	100	99	100	100	99	100	97	94	100	100	100	98	99	99	99	98	97	96	96	96
FIO2	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	RA	RA	RA	RA	RA	RA	RA
	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	RA	RA	RA	RA	RA	RA	RA
INPUT																								
IV	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	15
IVPB	1u PRBC	1u		100			50			DISC 50						50								
										DISC 100						100								
PO	0	200		300			300																	
NGT																								
O.R. IN																								
SUB TOTAL	500	400	150	550	150	150	500	150	150	150	350	150	150	150	150	300	150	150	150	150	150	150	150	15
TOTAL		1200		1900	2050	2200	2700	2850	3000	3150	3500	3650	3800	3950	4050	4350	4500	4650	4800	4950	5100	5250	5400	55
OUTPUT																								
URINE	150	110	100	300	300	200	200	200	200	200	200	200	200	190	200	180	200	200	280	200	230	200	200	250
NGT	0																							
STOOL	0																							
O.R. OUT		110	100	300	300	200	200	200	200	200	200	200	200	190	200	180	200	200	280	200	230	200	200	250
SUBTOTAL	150	260	360	660	960	1160	1360	1560	1760	1960	2160	2360	2560	2750	2950	3130	3330	3530	3810	4010	4240	4440	4640	4890
TOTAL																								
BALANCE																								+660

MEDCOM - 19382

INITIAL SHIFT ASSESSMENT b(6)-2

		Time: 0645 Initals: [redacted]	Time: 1800 Initals: [redacted]
NEURO	Pupils	2mm (B), Brisk PERRLA	3mm
	Sensorium	- movement all extremities x (D) LE (EXT Fix)	movement x4 extremities
	LOC / GCS	(P) movement toes (D) LE. Alert/responds to all commands/gestures appropriately	Alert / responds appropriately to commands / gestures
CARDIAC	Cardiac Rhythm	ST @ 98 bpm	ST @ 103
	PRI / QRS:	$S_1 S_2$ ⊖ (m)	RRR
	Pulse Strength	3+ (B) UE; 2+ (D) LE ⊖ doppler; 2+ (P) LE FEMORAL	3+ (B) UE, 2+ (D) LE, 3+ (R) LE FEM
	Cap Refil / JVD	Brisk < 3sec x 3 extremities; Ø JVD	<3 sec x3, ⊖ JVD
	Edema	2+ pitting edema (D) FOOT	2+ pitting edema to (D) Foot
	Chest Pain	Ø	⊖
RESP	Respiratory Pattern	Equal rise/fall of chest RR 16-20	RRR @ 18-24
	Breath Sounds	CTA all lobes; SaO_2 96% ⊖ 2L O_2 NC	CTA to all lobes
	Secretions	absent	⊖ secretions
	Cough	absent	⊖ cough
		Ø difficulty breathing / Ø SOB	SaO_2 95-97% on RA
SKIN	Color	Normal for nationality	Normal for race
	Integrity	intact throughout. Copious sersanguinous foul	(D) LE, Ex Fix, Ace wrap, CDF
	Backside	smelling discharge (B) LE's (D) > (P); Backside unremarkable	(R) BKA, Ace wrap, scant amount of serro-sanguinous DRNG
IV	Access Devices	#18ga (P) Medial AC patent / intact	18 G (R) Bicep; 50 cc LR / HR
	Location	#18ga (P) AC lateral patent / intact	16 G (L) AC; patent / intact
	Condition	#16ga (D) AC patent / intact	14 G (R) AC; patent / intact
		LR @ 150cc/h (P) AC	
GI	Abdomen	soft, flat, non-distended, non-tender	soft, non-distended, non-tender
	Bowel Sounds	hypoactive all quads	hypoactive x4 quads.
	Stoma/Ostomy	absent	⊖, ⊖ N/V
		Ø nausea / Ø vomiting	
GU	Device	Foley cath patent / intact [16 fr]	16 FR Foley cath to gravity
	Color / Clarity	yellow clear ⊖ U/O ~ 100-150cc/h	clear, yellow

PR[redacted]	DEPARTMENT/SERVICE/CLINIC	DATE
[redacted] SPT/AN b(6)-2	ICU #1, [redacted] (b)(6)-2	20 SEP 03

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

NAME: #[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

S/P EX FIX LLE
BKA LLE

PTS NAME: #[redacted]

DATE 20 SEP 03

TO OR

	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
NV												137/63	140/59	137/78	135/60	128/57	134/63	124/65	127/62	112/54	128/70	133/71	111/58	120/63
IBP	125/68	124/71	110/69	118/68	125/71	119/67	119/73	112/53				97	100	100	101	100	99	98	99		100	99	100	99
P	98 av		99 av		100 av	100 av	100 av	98 (r)				86	96	96	108	88	89	89	88	89	87	97	89	90
PULSE	104	100	101	104	99	98	94	86				14	18	20	18	13	16	16	16	23	26	20	16	19
RESP	22	21	23	16	21	22	22	14				97	95	96	96	96	95	95	95	95	95	96	95	94
SP02	96%	96%	96%	98%	96%	96%	97%	98%		98%		—	—	—	—	—	—	—	—	—	—	—	—	—
FIO2	21	Ø	—	—	—	—	—					RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA
MODE	NC	Ø	—	—	—	—	—																	
INPUT																								
IV	150	150	150	150	50	50	50	50				50	50	50	50	50	50	50	50	50	50	50	50	50
IVPB	150					100	100					100				50		100						100
PO						30																		
NGT																								
O.R. IN																								
UB TOTAL	300	150	150	150	50	180	150	50				1350	1400	1450	1500	1600	1650	1800	1850	1100	1150	1200	1250	1400
TOTAL	300	450	600	750	800	980	1150	1200																
OUTPUT																								
URINE	400	475		200		275						40	260	190	180	460	40	380	20		190	380	200	40
NGT																								
STOOL																								
O.R. OUT																								
SUBTOTAL	400	475		200		275						1750	1650	1840	2020	2480	2520	2960	2970		3110	3470	3730	3770
TOTAL	400	875		1075		1350																		
BALANCE																								

MEDCOM - 19384

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

DTSG APPROVED (Date)

Date: 20-SEP-03
Time In: 1655
Allergies:
Pre-op V/S:
Procedures: [illegible] BKA
closed [illegible]

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 700 Colloid
OR Output: UOP 400 EBL 50
Meds/Times: 250 Fent 10 [illegible]

Drains: Hemovac, NG, JP, T-tube, Foley, TLS

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds / History

Time	1655	1700	1705	1720	1735	1750
SaO2	94		92	[illegible]	[illegible]	90
FIO2	RA		RA	RA	RA	RA
Methods						
240						
220						
200						
180						
160				V	V	
140	V		V			
120						V
100		V				
80						
60						
40						
20						
RR	27		14	18	20	15
T	97					97
Time	1655					
Pain (0-10)	0					
LOS						

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1730	L R	300cc	(R) Arm		50 cc/hr

X-rays:

Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30"	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	1	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	1	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	1	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.	7	9	10

Codes

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

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

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

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

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

(Continue on reverse)

PREPARED BY: [redacted] 596 b(6)-2

DEPARTMENT/SERVICE/CLINIC: ICU

DATE:

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

[redacted] b(6)-4

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

MEDICATIONS

Allergies: NKDA

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

NEUROVASCULAR

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

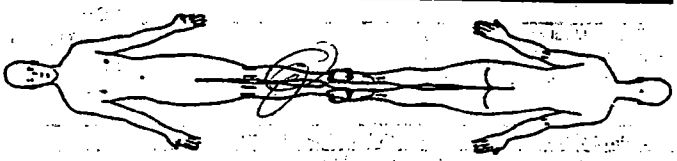
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

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



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

NURSING NOTES

- Received PT from O.R. VSS, HRR PT SAT 100% Non-Rebreather. Breath sounds clear bilaterally. (-) Respiratory distress. B5x4, non-tender on abdominal distention noted. PT is able to move (+) toes to upper extremity. (-) Leg ext fx CDI c̄ (+) Dressing intact (R) Leg splint CDI c̄ (-) s/s of drainage or s/s of infection. Cap ref <3 sec ↑ extremity. PT has L/R TKO in (R) antecubital running well c̄ (-) s/s of infiltration or infection. Will cont to monitor PT for Δ's. [redacted]
1740 - PT is able to move (+) ex fx toes. PT has (+) Pedal pulse & sensation. PT is able to move toes. Will cont to monitor for Δ's. [redacted] 1750 - PT is responsive to verbal stimuli. PT is currently SATTing @ 98% on R/A. PT is verified 130 cc clear urine. Will cont to monitor. [redacted]
D(W) - 2

Discharge Criteria:
Date: **Time:** **PARS:**
BP: **T:** **HR:** **RR:** **SaO2:**
Pain Level at D/C (0-10):
Intake: _____ **Output:** _____
Additional Data: _____
Transferred To: _____
Report Given To: _____
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: _____
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature: _____

WAMC OP 173-E

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

REPORT TITLE
INTENSIVE CARE NURSING [illegible] HEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		Time: 0630hrs Initals: [redacted] b(6)-2	Time: Initals:
NEURO	Pupils	3mm • PERRLA	
	Sensorium	- movement of (R) UE ~ limitations; moves toes	
	LOC / GCS	(L) LE. resting comfortably, but responds to gesture/	
		verbal commands c̄ translation appropriately.	
CARDIAC	Cardiac Rhythm	ST @ 92bpm	
	PRI: / QRS:	$S_1 S_2$ ~ (m) asymptomatic	
	Pulse Strength	3+ (R) UE, 2-3+ palpable (L) LE, 3+ (R) LE femoral	
	Cap Refil / JVD	< 3 secs x 3 extremities; Ø JVD	
	Edema	2+ pitting (L) LE	
	Chest Pain	absent	
RESP	Respiratory Pattern	RRR	
	Breath Sounds	CTA all lobes	
	Secretions	absent	
	Cough	absent	
		I.S. q̄ 2hrs (Ø SOB / Ø difficulty breathing)	
SKIN	Color	normal for nationality	
	Integrity	intact > Ø skin breakdown	
	Backside	intact > Ø skin breakdown	
		(R) BKA ~~bec bag~~ (dry, intact) (L) LE (ace wrap, C,D,I)	
IV	Access Devices	#16ga (R) medial AC patent / intact	
	Location	#18ga (R) lateral AC patent / intact	
	Condition	#16ga (L) AC patent / intact	
		LR @ 50cc/hr (R) AC	
GI	Abdomen	soft, flat, non-distended / non-tender	
	Bowel Sounds	hyps → hyperactive all quads	
	Stoma/Ostomy	N/A	
		Ø nausea / Ø vomiting	
GU	Device	foley cath patent / intact	
	Color / Clarity	yellow / clear s/sx of infection	

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

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

DATE: 21 SEP 03

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

NAME: (b)(2)-2

RANK:

AGE: 28yr

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

[redacted] b(6)-4

b(2)-J

PT'S NAME: [redacted]

DATE: 21 SEP 03

[S/P EX FIX ⓓ LE > I&D = 20 SEP 03
ⓡ BKA REVISION = 20 SEP]

	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05
BP INV																							
BP NIBP	101/58	117/67	119/67	115/69	119/71	115/67	127/65	120/65															
TEMP	99.9 ax		99.5 ax	100 Tm	102.3	101.5	99.7	99.7															
PULSE	84	87	103	100	103	100	92	91															
RESP	18	19	22	23	16	19	17	21															
SP02	98%	96%	97%	98%	96%	96%	97	98															
FIO2	RA	RA	RA	RA	R/A	RA	RA	RA															
INPUT																							
IV	50	50	50	50	50	50	100 SP	50															
2 (IVPB)	50			100		100																	
PO							100																
NGT																							
O.R. IN																							
SUB TOTAL	100	50	50	150	50	150	150																
TOTAL	100	150	200	350	400	550	700																
OUTPUT																							
URINE	75	350	300	200	200	50	620	50															
NGT	–																						
STOOL	–																						
O.R. OUT																							
SUBTOTAL	75	350	300	200	200	50	620	50															
TOTAL	75	425	725	925	1,025	1,075	1,695	1,745															
BALANCE																							

MEDCOM - 19388

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

DTSG APPROVED (Date)

Date: 22Sep03
Time In: 0535
Allergies: NKA
Pre-op V/S: 120/68 103
Procedures: (O) leg tibia fx
(O) BKA 1° O washout O/(O) side

Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 1000 Colloid
OR Output: UOP EBL minimal
Meds/Times: 50 fentanyl

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

Pre Op Meds History

Time	0535	0540	0545	0550	0555	0600
SaO2	90	90	90	97	97	97
FiO2	/	/	/	/	/	/
Methods	RA	RA	RA	RA	RA	RA
240						
220						
200						
180						
160						
140						
120			V	V	V	V
	V	V				
100						
80			•	•	•	•
	•					
60	^	^	^	^	^	^
40						
20						
RR	12	12	10	11	12	10
T	97.3			97.3		

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
	LR	1000	(O) FA	[redacted]	

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	0	3 extren 1	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	1	1
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.	7	8	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

PREPARE[redacted] RN b.(6)-2

DEPARTMENT/SERVICE/CLINIC: CV3

DATE: 22Sep03

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

[redacted] b(6)-4

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

DA FORM 4700, MAY 78 WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) Previous edition is obsolete
USAPPC V2.00

MEDICATIONS

Allergies:

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

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	(D) leg	Ø	UTA	P	B	W	PK
15'	(D) leg	Ø	UTA	P	B	W	PK
30'	(D) leg	limited	+	P	B	W	PK
45'							
60'							
90'							
D/C	(D) leg	limited	+	P	B	W	PK

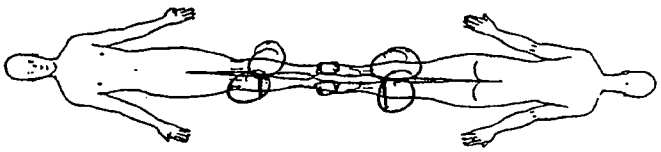
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(D) LE (R) stump	bandage/ace wrap	Ø
30'	(D) LE (R) stump	bandage/ace	Ø
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
0545	SR	Ø	Ø

WAMC OP 173-E

NURSING NOTES

0535 Pt arrived to PACU @ 0538 via litter accompanied by CRNA & nurse. Pt very tired. Sats good on RA >98%. Won't move all extremities @ first. Moves (D) LE & BLE. Dressings in place & clean. VSS [redacted] (0605) Report given to Sgt [redacted] VSS. No Δ in pt. Arouses to verbal stimuli. — [redacted] TMN
0615 - VSS. Pt easily arousable. Ø c/o. Will continue to monitor. [redacted]
0630 - Pt to ICW #1 — [redacted]

b/w - 2 AM

Discharge Criteria:
Date: 22 Sept **Time:** 0625 **PARS:** 9
BP: 130/72 **T:** 97.5 **HR:** 83 **RR:** 11 **Sa02:** 96%
Pain Level at D/C (0-10):
Intake: 100 **Output:** Ø
Additional Data:
Transferred To: ICW #1
Report Given To: Sgt [redacted]
Transferred Via: W/C [redacted] Ambulance
Transferred By: SGT [redacted]
Cleared IAW Recovery R[redacted]
Charge Nurse Signat[redacted] LT AN

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 24 Sep 03
Time In: 2243
Allergies: NKDA
Pre-op V/S: 126/75 87
Procedures: Stump revis (R), w/b (R) LE

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 600 Colloid
OR Output: UOP EBL 100
Meds/Times: MSO4 10mg Versed 2.5mg Fent 250mcg

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

Pre Op Meds / History

Time	2215	2220	2225	2230	2315	2325
SaO2	99	99	99	99	94	95
FiO2						
Methods	RA	RA	RA	RA	RA	RA
240						
220						
200						
180						
160						
140						
120	✓	✓	✓	✓	✓	✓
100						
80	•	•	•	•	•	•
60	^	^	^	^	^	^
40						
20						
RR	12	12	11	13	12	12
T		97				

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
2245	NS	3LL	(R) AC	[redacted]	

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	Ø	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.	7	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

PREPARED BY (Signature & Title): [redacted] b(6)-2 WM6

DEPARTMENT/SERVICE/CLINIC: ICU#3/PACU

DATE: 24 Sep 03

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

[redacted] b(6)-4

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

DA FORM 4700, MAY 78 WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) Previous edition is obsolete USAPPC V2.00

MEDICATIONS

Allergies:

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

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	DLE	none	–	P	B	W	N
15'	DLE	none	–	P	B	W	N
30'	DLE	Ø	–	P	B	W	N
45'							
60'							
90'							
D/C	DLE	Ø	–	P	B	W	N

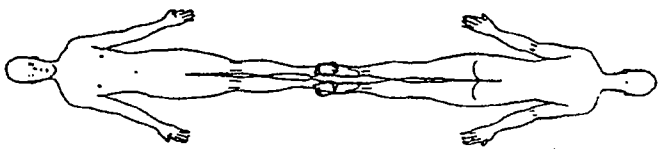
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	DE, LLE	ace wrap	Ø
30'			
60'			
D/C	R/L LE	ACE	Ø



PACU OUTPUT

Time	Source	Color/Appearance	Amount
	Ø		

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
2245	SR	Ø	Ø

WAMC OP 173-E

NURSING NOTES

2245: Pt arrived from O.R. via gurney c̄ oral airway in place & PO2 97% RA. Pt unable to follow commands @ this time due to sedations. Ex fix on DLE & oral airway removed. Will cont. to monitor.

[redacted] gurney

2315: pt awake, dnt, MAE; Ø s/s of hemorrhage; [redacted]

b (W)-2 A11

Discharge Criteria:
Date: 24 Sep 03 **Time:** 2325 **PARS:** ~~10~~ 9
BP: 125/54 **T:** 97.1 **HR:** 81 **RR:** 12 **Sa02:** 99
Pain Level at D/C (0-10):
Intake: Ø **Output:** Ø
Additional Data: Ø
Transferred To: ICW 2
Report Given To: [redacted]
Transferred V [redacted] **Ambulance**
Transferred By [redacted]
Cleared IAW Recovery [redacted]
Charge Nurse Signat [redacted]

MEDICAL RECORD-SUPPLEMENTAL MEDI

use of this form, see AR 40-66; the proponent agency is the Office of Th eneral.

OTSG APPROVED *(Date)*

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

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

Time In: _____

Allergies: NKDA OR Intake: Crystalloid 200 Colloid Ø

Pre-op V/S: 128/67 19 OR Output: UOP Ø EBL min

Procedures: Washout Meds/Times: 1130 Fentanyl Exfix

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

Pre Op Meds History

Time	11 11 11 11 11 11 11 / 51 57 10 05 40
SaO2	93 95 94 94 94 94 95
FiO2	
Methods	RA NC NC RA NC RA RA
240	
220	
200	
180	
160	V
140	V V V V V
120	• •
100	• • •
80	A A A A A
60	
40	
20	
RR	15 15 15 18 13
T	94.2 98.8
Time	
Pain (0-10)	
LOS	

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1238	LR	250	L For	IV	25cc

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	1	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	1	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	1	1
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	Ø	Ø	Ø
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	7	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

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

(Continue on reverse)

PREPARED BY *(Signature & Title)* [redacted] b(6)-2 9Jun06

DEPARTMENT/SERVICE/CLINIC PACA

DATE 26 Sep 05

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

[redacted] b(6)-4

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

DA FORM 4700, MAY 78 WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) Previous edition is obsolete USAPPC V2.00

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1225		Ymgansay	IVP			JB

NEUROVASCULAR

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

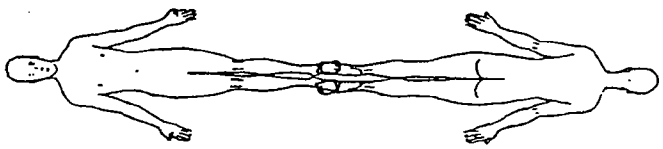
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	LLL	Curlex	Ø
30' 1223	LLL	Curlex	1½" Diameter L shin
60'			
D/C 1240	LLL	Curlex	1½" Diameter L shin.



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1240	NSR	Ø	Ø

WAMC OP 173-E

NURSING NOTES

Pt Admitted to PACU
PARS Score 7 due to low motion & ↑ BP. S/P washout of ex fix LLE. Dressing CDI. Pulse ox 94 on RA — PFC [redacted]
Pt discharged to ICW1 by PFC [redacted] via Litter. PARS score 9 Report Given to SPC [redacted]

b(6)-2 All

Discharge Criteria:
Date: 26 X 05 **Time:** 1240 **PARS:** 9
BP: 129/66 **T:** **HR:** 73 **RR:** 12 **Sa02:** 95
Pain Level at D/C (0-10):
Intake: 25 cc **Output:** Ø
Additional Data: Ø
Transferred To: ICW1
Report Given To:
Transferred Via: W/C [redacted] Gurney Ambulance
Transferred By: PFC [redacted]
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature:

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: 30 Sep 03
Time In: 1337
Allergies: NKDA
Pre-op V/S: 117/68 30
Procedures: IM Nailing left leg

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

OR Intake: Crystalloid 1600 Colloid
OR Output: UOP 0 EBL 0
Meds/Times: 500 Lev. 8 gm Ancef

Drains
Hemovac
NG
JP
T-tube
~~Foley~~
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds History

Time	1337	1347	1357	1402	1410
SaO2	98	98	98	96	97
FiO2					
Methods	RA	RA	RA	RA	RA
240					
220					
200					
180					
160					
140	V	V	V	V	
120		V		V	
100	•	•	•	•	•
80	^	^	^	^	^
60					
40					
20					
RR	20	22	18	16	14
T	98				

Time	
Pain (0-10)	
LOS	

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

(Continue on reverse)

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	1	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	1	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	
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.	7	10	10

Codes

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

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

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

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

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

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 30 Sep 03

PATIENT [redacted] 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

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1415		Zofran 4mg	IV			[illegible]

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	L Leg	limited	+	P	B	WM	PK
15'	L Leg	limited	+	P	B	WM	PK
30'							
45'							
60'							
90'							
D/C							

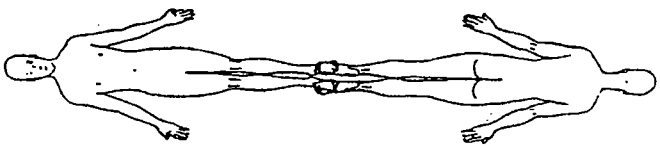
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	L leg ← 1337	ace wrap	c/d/i
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1337	NSR	Ø	Ø

NURSING NOTES

Pt received from OR S/P IM nailing. VSS SpO2 98% No c/o pain arousable to verbal. Pt had nasal trumpet, pulled it out. — [redacted]

b(6)-2 A11

Discharge Criteria:
Date: 30 Sep 03 **Time:** 1410 **PARS:** 10
BP: 120/83 **T:** 97 **HR:** 95 **RR:** 14 **Sa02:** 98%
Pain Level at D/C (0-10):
Intake: <100 **Output:** Ø
Additional Data:
Transferred To: ICW2
Report Given To: ICW2 1LT [redacted]
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: SSG [redacted]
Cleared IAW Recovery Room [redacted]
Nurse Signature:

WAMC OR 171 5

[redacted]

SWORN STATEMENT

For use of this form, see AR 190-45; the proponent agency is ODCSOPS

PRIVACY ACT STATEMENT

AUTHORITY: Title 10 USC Section 301; Title 5 USC Section 2951; E.O. 9397 dated November 22, 1943 *(SSN)*.
PRINCIPAL PURPOSE: To provide commanders and law enforcement officials with means by which information may be accurately
ROUTINE USES: Your social security number is used as an additional/alternate means of identification to facilitate filing and retrieval.
DISCLOSURE: Disclosure of your social security number is voluntary.

1. LOCATION	2. DATE *(YYYYMMDD)*	3. TIME	4. FILE NUMBER
[redacted] b(2)-2	20030918	0900	
5. [redacted] b(6)-2	**6. SSN** [redacted]		**7. GRADE/STATUS** O-2

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

9.

I, [redacted] b(6)-2, WANT TO MAKE THE FOLLOWING STATEMENT UNDER OATH:

on 18 0300SEP03, TF POC arrives on location after MP engage hostiles. We (20 personnel) swept area looking for casualties & Found none. We waited on site until sunrise and swept area again. We found one Iraqi KIA and another WIA. CPL [redacted] treated WIA on site. WIA had two broken legs. One leg had local wound other (left) has a compound fracture. Discom ~~TOC~~ instructed to take WIA to [redacted] (b)(2)-2 clinic. They ([redacted]) did not have resources to care for WIA. We then took him to [redacted] (b)(2)-2 We arrived approximately at 0855. [redacted] took vitals and he was MEDEVAC @ 0920 (approximately). [redacted] b(2)-2 refused DOA (KIA) and we took him to DISCOM TOC

10. EXHIBIT	11. INITIALS OF PERSON MAKING STATEMENT	PAGE 1 OF 2 PAGES
	[redacted] b(6)-2	

ADDITIONAL PAGES MUST CONTAIN THE HEADING "STATEMENT [redacted] *TAKEN AT* ____ *DATED* ____

THE BOTTOM OF EACH ADDITIONAL MUST BEAR THE INITIALS OF THE PERSON MAKI. STATEMENT, AND PAGE NUMBER MUST BE BE INDICATED.

USE THIS PAGE IF NEEDED. IF THIS PAGE IS NOT NEEDED, PLEASE PROCEED TO FINAL PAGE OF THIS FORM.

STATEMENT OF [redacted] b(6)-2 TAKEN AT _____ DATED 18 Sep 03

9. STATEMENT *(Continued)*

The WIA was found at a field about 200m from Ambush site. Blood trail led to the general direction of the WIA from the ambush site. All recovered weapons were found scattered at ambush site. Recovered weapon included 2 RPG's with multiple live rounds and 3 AK47 with mutiple loaded magazines. The KIA was found in a canal in the ambush site bag on site and taken to [redacted] Mortuary Affairs.

b(2)-2

NOTHING FOLLOWS

INITIALS OF PERSON MAKING STATE [redacted] b(6)-2

PAGE 2 OF 2 PAGES

STATEMENT O[redacted] TAKEN AT _____ DATED 18/9/03

9. STATEMENT *(Continued)*

[redacted] b(6)-2

(b)(6)-2

AFFIDAVIT

I, [redacted], HAVE READ OR HAVE HAD READ TO ME THIS STATEMENT WHICH BEGINS ON PAGE 1, AND ENDS ON PAGE 2. I FULLY UNDERSTAND THE CONTENTS OF THE ENTIRE STATEMENT MADE BY ME. THE STATEMENT IS TRUE. I HAVE INITIALED ALL CORRECTIONS AND HAVE INITIALED THE BOTTOM OF EACH PAGE CONTAINING THE STATEMENT. I HAVE MADE THIS STATEMENT FREELY WITHOUT HOPE OF BENEFIT OR REWARD, WITHOUT THREAT OF PUNISHMENT, AND WITHOUT COERCION, UNLAWFUL INFLUENCE, OR [redacted] b(6)-2

[redacted] *(Signature of Person M[redacted])*

WITNESSES:

[redacted] b(6)-2

1AD TROC

[redacted] b(2)-2

ORGANIZATION OR ADDRESS

Subscribed and sworn to before me, a person authorized by law to administer oaths, this 18 day of SEPT, 2003 at [redacted]

[redacted] b(6)-2

(Signature of Person Administering Oath)

[redacted] b(6)-2

(Typed Name of Person Administering Oath)

CPT U.S. ARMY

(Authority To Administer Oaths)

ORGANIZATION OR ADDRESS

INITIALS OF PERSON MAKING STATE[redacted]

PAGE 3 OF 3 PAGES

STATEMENT OF _____ TAKEN AT _____ DATED _____

9. STATEMENT *(Continued)*

ICUZ

fried @ [redacted] b(2)-2

[redacted] [redacted]

b(4)-4 has not processed

b(6)-2

NCPT [redacted]

(b)(6) [redacted] ROC

[redacted]

AFFIDAVIT

I, _____, HAVE READ OR HAVE HAD READ TO ME THIS STATEMENT WHICH BEGINS ON PAGE 1, AND ENDS ON PAGE_____. I FULLY UNDERSTAND THE CONTENTS OF THE ENTIRE STATEMENT MADE BY ME. THE STATEMENT IS TRUE. I HAVE INITIALED ALL CORRECTIONS AND HAVE INITIALED THE BOTTOM OF EACH PAGE CONTAINING THE STATEMENT. I HAVE MADE THIS STATEMENT FREELY WITHOUT HOPE OF BENEFIT OR REWARD, WITHOUT THREAT OF PUNISHMENT, AND WITHOUT COERCION, UNLAWFUL INFLUENCE, OR UNLAWFUL INDUCEMENT.

_____
(Signature of Person Making Statement)

WITNESSES:

_____

_____

_____
ORGANIZATION OR ADDRESS

_____

_____

_____
ORGANIZATION OR ADDRESS

Subscribed and sworn to before me, a person authorized by law to administer oaths, this _____ day of _____, _____ at _____

_____
(Signature of Person Administering Oath)

_____
(Typed Name of Person Administering Oath)

_____ _____
(Au. To Administer Oaths)

INITIALS OF PERSON MAKING STATEMENT

ADMISSION AND CODING INFORMATION

For use of [illegible] AR 40-400; the proponent agency is OTSG

1. REPORTING MTF	2. MTF LOCATION (State or Country Code.)
A I I D I I	8: I Z

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

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
[redacted]	28y	2	9	UNK

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
	NA	99 20	[redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
NA	2	1515	NA b(6)-4

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

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
O	Icu2	UNK

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

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
2 4		0 3 1 0 1 4

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
A E A A		0 3 0 9 1 8

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYMMDD)
		0 3 0 9 1 8

FOR LOCAL USE

DX: Bilat. Tib/Fib Fx.

Px: 82392
8970
8993

Dx: ~~7926~~
8314
7817
8415
8302
79160x2

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

D [redacted] 89

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTRAR NUMBER [redacted]			2. NAME (Last, First, MI)			3. GRADE NA	ADMISSION REMARKS
4. SEX M	5. AGE 40	6. RACE UNK	7. RELIGION UNK	8. LENGTH OF SVC NA	9. ETS NA	10. PREVIOUS ADMISSION NO	
11. FMP 99		12. SSN [redacted]		13. ORGANIZATION NA		14. WARD Iau	
15. FLYING STATUS NA		16. [redacted] OSG b(6)-4	17. DEPT/ BEN NA	18. BRANCH/CORPS NA	19. UIC/ZIP	20. TYPE CASE NBI	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: Direct from Emt				22. HOURS OF ADMISSION 1945	23. CLINIC SERVICE ABAA		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: UNK				25. TYPE DISPOSITION 50	26. DATE OF DISPOSITION 9/30/03		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): UNK				27b. TELEPHONE NO. UNK	28. DATE OF THIS ADMISSION 9/18/03		ADMITTING OFFICER b(6)-2 Dr. [redacted]
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] b(2)-2					30. DATE OF INTIAL ADMISSION		32. [redacted] COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

(L) PARIETAL SKULL FX / EPIDURAL HEMATOMA

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	13	13

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]	0	0	0	13	13

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

SIGNATURE OF FAD OR MEDICAL RECORDS OFFICER [redacted] b(6)-2

DA FORM 3647, MAY 79 EDITION OF 1 AUG 78 IS OBSOLETE USAPPC V1.10

MEDICAL	ABBREVIATED MEDICAL RECORD

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

Iranian contractor mid-twenties off fall of the back of a truck LMTV this afternoon, with battle sign on (L) w/ (L) ear laceration. Pt. initially was reportedly GCS 15, then became confused with decreased responsiveness GCS 13-14 arousing to voice. Speaks Iranian dialect to translate w/ Arabic translators. C, T, L-Spine & pelvis C [redacted] reportedly was cleared. Referred for CT scan of head & R/O mass lesion.

(b)(2)-2

PHYSICAL EXAMINATION

Awake, Alert but Combative requiring Sedation for Evaluation.

HEENT: (L) mastoid ecchymosis
pupils small reactive
dysconjugate w/ (L) exotropia
Blood dried (L) ear & otorrhea
& Rhinorrhea
& neck tenderness

Motor: Briskly, Strong & Moving Symmetrically
Resistant to all examination using UE/LE

Sen: Responds appropriately to peripheral stimulation overtly ~~Aggressively~~ resistant

Unable to test Cerebellar fx due to uncooperative, nor station or gait.

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

(1) Dx: Basal Skull Fracture

(2) CT of Head

(3) HOB @ 30°

b(6)-2

[redacted] | DATE | IDENTIFICATION NO. | ORGANIZATION

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

REGISTER NO.	WARD NO.

Iranian Civilian / Contractor

#[redacted]

b(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
19 Sep 03	
0200.	Sedation turned off. ABP low 100s/60s. Pt not moving. HR 90's. Will cont. to monitor
0230.	Washed dried blood from pts hands, face neck. Pt moving (B) UE towards face, bending knees. Pt calmed easily. Sedation remains off @ this time. Will monitor
0400.	Pt started to wake up. Moving all 4 extremities c̄ nonpurposeful mvmt. Bucking the vent. Versed gtt started @ 2mg/hr and fentanyl restarted @ 50mcg/hr. Soft wrist restraints applied to prevent pt from pulling ETT. CBC, chem 8, ABG and coags drawn via A-line and sent to lab. Will monitor [redacted]
0430	ABG results. 7.31/39/80/20/-6/100%. ~~Hemo~~ H/H 11.8/35.7. No vent changes @ this time [redacted]
	b(6)-2
	Neurosurgery Brief - OP
9/19/03	Pt. sedated, periods of brisk movement of all 4
0551	extremities to minimal stimulation
	99L 104/61 ventilated: SIMV (10)/40%/800 (TV)
	Head drening intact Ear dry Drain: 140 cc sanguinous
	Pupils small brisk / dysconjugate gaze.
	motor briskly localizing (B) UE withdraw LE
	no spontaneous eye opening nor to voice or stimulation
	~~ABG~~ ↓ Sedation & wake-up for extubation if
	eye opening. Repeat CT last night demonstrated
	Complete removal of EDH. [redacted] b(6)-2

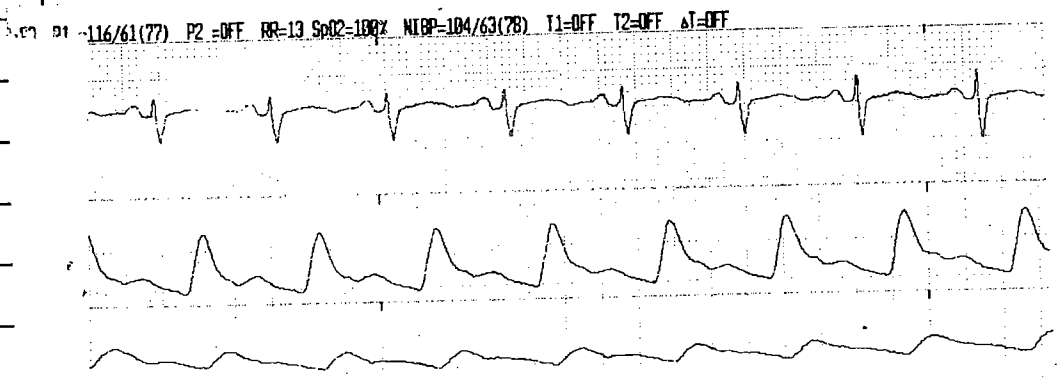
STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
19Sep03. 0000	Pt admitted to ICU 1 from OR to CT scan. Pt on monitor, ~~vented~~ intubated. Pt transferred from litter without incident. Pt connected vent. SIMV10, TV 800, FiO2 100%, Peep 5. SpO2 100%. HOB elevated to 30°. JP drain x1 to (L) parietal area c bloody drng noted. Gauze wrapping noted to head c bloody drng. Staples intact to (L) parietal area. Pt as A-Line to (R) radial, (R) IJ cordis and PIV x3. Will continue to monitor. b(6)-2 [redacted]
0020.	ABG via (R) radial A-line 7.29, 36.1, 481, -9, 18, 100%. FiO2 ↓ to 40% via RT. SpO2 maintained @ 100%. (R) FA 18G PIV NS flushing. DC'd c canula intact. Disp changed to (R) IJ cordis, (R) radial a line. No redness/drainage noted. (L) AC 18G PIV and (R) FA 14G PIV saline locked. Versed gtt started @ 4mg/hr, fentanyl gtt @ 50mcg/hr and D5.9NS + 20KCl @ 100cc/hr via cordis. Will monitor. b(6)-2 [redacted]



RELATIONSHIP TO SPONSI | DR'S ID NUMBER Other)

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	Nursing Notes Con't.
19 SEP 03	VSS. AM care done. Pt Freshing in bed. Versed drip maintained at
0830	2 mg/h. Fentanyl drip at 50 mcg/h. Radial artery line dislodged.
0900	Now using NIBP to monitor BP. Dr [redacted] visited Pt. He is aware
	that A-line is out. He ordered Versed and Fentanyl drip increased.
	Versed drip increased to 4 mg/h. Fentanyl drip increased to 50 mcg/h.
1100	appear effective. Dilantin IV only IVPB given. VSS. No distress noted.
1200	VSS. 25cc bloody drainage emptied from JP. VSS. No distress noted. Pt sedated.
1300	Dr [redacted] visited Pt. He was informed that Pt has bloody tinge drainage with suct
1500	left [redacted]. VSS. No distress noted. Pt sedated. Versed drip at 4 mg/h.
	Fentanyl drip at 50 mcg/h. Pt sustained orally. [redacted]
1725	Dr [redacted] visited and examined Pt. He increased Vent Rate
	to 12 BPM. He is aware of Pt condition and VS [redacted]
1800.	Received report from day shift. Pt intubated [redacted]
	@ this time. [redacted]
1900.	ABG results from prior shift c̄ ↑ HR. 7.46/34.7/
	191/25/1/100%. No changes [redacted]
2200.	Pt continues to have periods of agitation. Pt bucks vent,
	moves extremities x4. Versed 1mg IVP given. Will
	cont. to monitor [redacted]
0430.	ABG drawn via (R) radial artery stick x 2 attempts. Sent
	to lab. CBC, Chem, Coags drawn via 14G PIV and
	sent to lab. ABG: 7.51/33.5/187/27/4/100% [redacted]
	b(6)-2 +11

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

b(6)-2

19Sep03 0605 Updated Dr. [redacted] on pts progress. No new orders. Sedation turned off for prep to extubate [redacted]

0610 Report given to RT [redacted] Questions answered [redacted]

19SEP03 0610 Received Pt in Icu Bed #1. Pt doesnot respond to verbal stimuli. Responds to pain stimuli. Pt also observed moving all extremities. Perla 3mm Brisk. Cardiac Monitor shows SR. VSS. A-line to right radial artery. Good waveform NIBP doesnot correlates with A-line. Currently using A-line values. Cardio to (R) IJ. intact with IV Fentanyl drip at 50mcg/hr, Versed drip at 2mg/hr and IVDFNS/LE 20kcal/hr with infusing #18G access to (L) Ac intact #14G access to (R) forearm both sites intact and (HL) (+) NO all peripheral pulses. Pt orally intubated #8 ET 24cm lip line. No signs of resp distress noted. Vent Settings AC Rate 10 TV 500 Peep 5 FIO2 40% Saturating 100% via pulse oximetry. Salem Sump tube orally to intermittent suction. Bowel Sounds Hyperactive. Foley Cath in place draining clear yellow urine to bag. JP to bead drain bloody drainage noted. Surgical wound with staples intact to head. Ancef 1gm IV was given. See Nsg assessment sheet and attached strips for more information [redacted]

b(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
19 Sept 03	RT note: pt on vent settings: A/C 10, 800, 100%, +5 PIP 22.
	8.0 ETT 24 @ lips. Pt sedated. BBS CTA. MD states may extubate
	in am. b(6)-2 Sgt [redacted] 91V20
0020	ABGs: 7.29, 36.4, 481, -9, 18, 100%. U FiO2 to 40% -20%
	Nursing Note
9/20/03	Pt doing very well tolerated extubation and following
15:11	commands, actually speaking & understanding English.
	Plan to D/C TJ
	Plan to Admit Burt
	Airway, alert, orient to Baghdad Hospital.
	Motor Symmetry movements B UE/LE
	Conjugate gaze
	ABGs Pt doing very well [redacted] Diet & [redacted] a'd to
	nasal Canula
	[redacted] b(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
20SEP03 (1815)	Received report from day shift. Pt laying in bed resting. Responds to verbal. Pt has JP from head & has been extubated. VSS. [redacted]
	Close. [redacted] G I Wrombo
	b(6)-2
	Remaining Notes
9/21/03 1300	Pt. awake, alert. Tolerating clears. Following simple commands. Speaks rare English.
	AHBS
	Skin clean dry
	External auditory canal dry
	Mouth 5/5 (B) Uvula w/o deviation
	A/B: Cont to improve neurologically. Pt activity diet tx to usual. & plan Tx to
b(2)-2	[redacted]
	[redacted]
	b(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
20 Sep 08 0630	Received Pt in Icu Bed #1. Pt moves/responds to pain stimuli also has spontaneous movement of extremities. See Initial shift assessment sheet for more information. DR [redacted] visited and examined. He is aware of Pt's GCS and ABG results. He D/Ced JP drainage. He wants Sedation tapered down for possible Pt extubat. Pt's IV DSNS TKO 20 kcal at 100 cc/h. Continues Fentanyl drip at 50 mcg/h received Pt with Versed drip at 4 mcg/h. Versed drip decreased 2 mg/h. Aneffin gtt IVPB given. Pt urine output is pale clear last 2 hours 340 cc and 400 cc respectively. DR [redacted] aware.
0700	VSS. Am care done. Fentanyl drip decreased to 40 mcg/h
1000	Fentanyl drip tapered to 30 mcg/h. Pt easily arousable opens eyes
1400	on his own and is tracking around his bed. VSS. DR [redacted] visited Pt. Sha
1115	extubated Pt. Placed on Non Rebreather mask tolerating well but 100% via
	pulse oximeter. Resp 17-20 No distress noted. Fentanyl and Versed
	tapered to off. Pt resting in bed No distress noted [redacted]
1600	VSS No distress noted Pt maintained on NRM at 6L [redacted]
b(6)-2 1800	DR [redacted] visited and examined Pt. He ordered diet [redacted]
1830	to Room air tolerating well cardiac access D/C'ed. Pt resting in bed No [redacted]
1900	97-100% on Room air IV DSNS TKO 20 kcal continues. Report given to nurse [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.

WARD NO. Icu I

[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
20 Sep 03	Received Pt in Fen I Bed #1. Pt A&O. Moves all extremities. See
0600	Intensive Care Nursing flow sheet for more information. No distress Noted
	on Room air Sat 97-100% via pulse oximeter. Resp 14-22. IV [redacted]
	Ezokel at wrist infusing. Analgesics administered. Resting in bed.
21 Sep 03	Received report from ongoing shift. Pt MS, in bed
0930	resting. Follows simple commands, sometimes difficult to assess
	c̄ pt not speaking Arabic or English. Staples on the head
	D & I. continue c̄ current POC. Neuro ✓ WNL. b(4)-2 [redacted] Maj/AN
1100	Pt up to BSC + then to chair. No BM noted c̄ this time.
	Tolerated getting out of bed. Had clear liquid but had
	emesis afterwards approx 100cc of juice, taken earlier.
	Staples to the head intact + dry. Bruises to the back. Dry
	applied Bacitracin ointment. VSS. [redacted] Maj/AN b(4)-2
1415	Pt continue to do well. Neurologically intact. VSS. [redacted]
	transferring pt to ICW I. Report given to the nurse.
	Foley discontinued @ 1300, total of 1200 cc clear yellow
	urine. Plan: Monitor urine output. ✓ Neuro status q[redacted]°
	✓ bruises in the flank area. [redacted] Maj/AN
	b(4)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	Brief Post-op Note
9/18/03	Pre-op Dx: (L) EDH posterior Temporal / Skull Fx Extending to (L) mastoid
2330	Post-op Dx: Open Skull Fx over (L) Sigmoid Sinus / Transverse Sinus.
	Procedure: (L) Parietal Craniotomy Evac of EDH / Repair venous sinus
	Surgeon: [redacted]
	Anesth: GETA
	Drains: JP
	EBL: 250 cc
	Finding: (L) Transverse Sinus / Sigmoid Sinus Injury w/ Epidural Hematoma Skull Fx over sinus.
	Fluids:
	Comp:
	b(6) · 2 [redacted]

STANDARD FORM 600 (REV. 6-97) BACK

☆ U.S. GPO:1998-432-786/75236

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
18 Sep 03	1914- pt. came in by Medevac, medics stated he fell off of a vehicle, unsure of how high, pt alert + reactive to pain, vitals BP 105/64 P 119, R-20 O2 100%, temp 101.7 — [redacted] 2LT AN
	1920- pt. uncooperative to treatment 2mg Ativan IV push + 1 gm Dilantin IV over 1 hour given — [redacted] 2LT AN
	1926- 12.5 mg Phenergan IVP given — [redacted] 2LT AN
	1940- Foley cath in place, vitals taken- BP 106/63, P-111, R-20 - SpO2 100% — [redacted] 2LT AN
	1950- pt. taken to CT, 2mg Ativan IV given [redacted] 2LT AN
	2007- BP 117/55, P-122. R-27 - SpO2 9[redacted] 2LT AN
	2020- Report called to TCU 1 - [redacted] 2LT AN
	2020- Pt. prepared to be taken to OR - [redacted] 2LT AN
	b(6)-2 All

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.

#1 [redacted]

b(6)-4

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
9/29/03	Neurosurgery Narrative
1200	40's ♂ Civilian suspected Afgan worker who fell off back of
MOSS: Ø	a truck 9/18/03 w/ (L) Retromastoid ecchymosis with underlying parietal
	mastoid skull fracture (L) Epidural hematoma & GCS 10. Underwent
	emergent craniotomy evacuation of EDH. Did well post op currently
	tolerating regular diet supplemented w/ Soy shakes & Regular activity.
	Neurologically normal no visual, verbal motor nor cognitive deficits.
	Staples/Sutures removed Flap well healed.
	Plan: RTD no subsequent followup required.
	Dx: (1) (L) Acute Parietal Fracture w/ EDH
	[redacted] b(6)-2

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

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

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

NSN 7540-01-075-3786

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

TEST RESULTS

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

PROVIDER HISTORY/PHYSICAL

70s y/o ♀ fell off moving vehicle unclear speed/height. Reported GCS 15. VSS reported. No final exam reported. Pt does not answer questions. Hx per under

O: Alert/responsive to pain only. VSS, uncooperative — eyes open to pain, incoherent verbal, moves ext x4 spont 5/5

HEENT: OP/MO clear/pink, ~~w.k.~~ supple, ∅ stepoffs, Head ⊕ lac ⊕ occipital C. — Thx: ⊕ ⊕ blood in canal ⊕ clear/wet TM — PERRL sluggish 2-4 mm — EOM = disorganized @ times — Chest: CTA ⊕ = — CV: NR RR, ctft Abd: soft, NT/ND, ~~pulsed~~ vectal: NL tone, pt nauseous, ⊕ ecchymosis ⊕ mistaken — Ext: 5/5 strength x/L ⊕, MV what to pick/cut off L2 see

MP clinically ⊕ c/w basilar skull fx ? AMS. Nursing post @ PE.

b(6)-2

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND S[redacted]

PROVIDER SIGNATURE AND STAMP [redacted]

DIAGNOSIS ①

②

CODES

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

#

[redacted] b(6)-4

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

NSN 7540-01-075-3786

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

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS: Iraqi Civilian

CITY: | STATE: | ZIP CODE:

ARRIVAL

DATE *(Day, Month, Year)*: 18 Sep 03 | TIME: 1914

TRANSPORTATION TO FACILITY: medevac

SEX: M

AGE:

DUTY/LOCAL PHONE	
AREA CODE	NUMBER

HOME PHONE	
AREA CODE	NUMBER

MILITARY STATUS

ITEM	YES	NO	N/A
PRP			
FLYING STATUS			

MEDICAL HISTORY OBTAINED FROM:

THIRD PARTY INSURANCE

ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2568 IN CHART		

NAME OF INSURANCE COMPANY:

CURRENT MEDICATIONS: TD soc 1820

ALLERGIES: MCDA

INJURY OR OCCUPATIONAL ILLNESS

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

EMERGENCY ROOM VISIT

DATE LAST VISIT: | 24 HOUR RETURN: ☐ YES ☐ NO

TETANUS

DATE LAST SHOT: | COMPLETED INTITIAL SERIES: ☐ YES ☐ NO

CHIEF COMPLAINT: Head Injury

CATEGORY OF TREATMENT

☒ EMERGENT
☒ URGENT
☐ NON-URGENT

TIME: b(6)-2

INITIALS: [redacted]

VITAL SIGNS

TIME	1915	1940	2007		
BP	105/64	106/63	117/55		
PULSE	119	111	122		
RESP	20	20	37		
TEMP		101.7			
WT	100% O2	MR			

LAB ORDERS

☒ CBC/DIFF	ABG	PT/PTT	BHCG/URINE/BLOOD/QUANT
URINE C&S	☒ UA MSCC/CATH		☒ UREM: 12 lytes
BLOOD C&S X			

X-RAY ORDERS

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

ORDERS

☒ PULSE OX 98% O2 ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
1920	3 mg Ativan IV	[redacted]	[redacted]	[redacted]	[redacted]
	10 mg Dilantin IV		b(6)-2		b(6)-2
1926	12.5 phenergan IV				
	Foley to gravity				

DISPOSITION: ☐ HOME ☐ FULL DUTY

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

MODIFIED DUTY UNTIL | RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☒ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE | TIME OF RELEASE

REFERRED ▶ | TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

[redacted]

b(6)-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

For use of this form, see MEDCOM Circular 40-5

SECTION I - PATIENT ASSESSMENT

DATE: 21 SEP 03 | PATIENT ACUITY LEVEL: | POST-OP DAY: | HOSPITAL DAY:

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time 1445 To ICW2 From ICU2 ☐ AMBULATORY ☐ CRUTCHES ☑ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (Specify): _____

Procedure/Diagnosis S/P Ⓡ Parietal Skull Fracture c̄ Epidural hematoma evacuation. B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks 4° - okay

Dressing/cast _____ Tubes Foley d/c'd

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication 1400 meds given.

Other _____

Report From MAJ [redacted] Received By LT [redacted]

VITAL SIGNS

TIME:	1500	2000	2200	2400												
BP ARTERIAL LINE		—	—	—												
BP CUFF	90/60	109/70	90/62	109/68												
TEMPERATURE	100.7	100.4	100.1	100.7												
PULSE	94	96	96	98												
RESPIRATORY RATE	18	16	20	16												
OXYGEN (L/%)		—	—	—												
PULSE OXIMETER	97%	98%	98%	99												
O2 METHOD	RA	RA	RA													

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	1500	2000	2230					
PAIN INTENSITY (10 / 5 / 0)								
MED ADMINISTERED (Y/N)	[redacted]	NA	N					
RELIEF ACCEPTABLE (Y/N)	NA		NA					

OTHER

TIME:								
FINGER STICK GLUCOSE								
INSULIN (Y/N)								

NA

SPECIAL NEEDS

TIME:	1500	2230
*Skin breakdown prevention	NA	NA
*Falls prevention protocol	[redacted]	
*Restraint protocol	NA	
*Seizure precautions		
*Isolation precautions		

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

C[redacted] b (4) - 4

DIAGNOSIS: S/P Ⓡ Parietal Skull Fx c̄ Epidural hematoma evac.

DRG: _____ ADMISSION DATE: _____

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: _____

ISOLATION REQUIRED (Specify): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

	TIME: 1500 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]	TIME: INITIALS:
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑ NC WNL	☐ Neuro ✓ WNL b(6)-2	☐
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☑	☐
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☐
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑ Cl. liq. diet.	☑	☐
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑ Foley d/c'd	☑ voids ∃ diff	☐
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ Generalized weakness.	☑	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ wound to (L) parietal skull staples to site intact	☐ (L) parietal skull c. staples & sutures intact	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☑	☑	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑ b(6)-2	☑	☐

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 1500 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]	TIME: INITIALS:
IV patency ✓ q 8 hr:	IV patency ✓ q 8 hr:	IV patency ✓ q hr:
IV site care provided:	IV site care provided:	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: RAC / OK	IV Site #1: RAC / OK	IV Site #1:
IV Site #2:	IV Site #2:	IV Site #2:
Comments:	Comments: D5½NS c 20KCL @ 100cc/hr	Comments:

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: TIME:	1500					
COLOR						
CAPILLARY REFILL						
TEMPERATURE						
EDEMA						
SENSATION						
MOTION						
PASSIVE FLEXION						
PERIPHERAL PULSE						

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

	TIME: 1500	2230	
ID band visible/legible	[redacted]		
Orient to environment prn	[redacted]		
Side rails (2/4) up	NA		
Bed position low			
Call light within reach			

OTHER

Review & post lab results	[redacted]		
Notify MD abnormal labs	[redacted]		
Incontinent urine/stool	NA		
Linen change prn	[redacted]		
Turn/reposition q2h	NA		
ROM q2h if immobile			
Antiembolic hose			

DIET

BREAKFAST	LUNCH	DINNER
TYPE:	TYPE:	TYPE: Cl. liq.
PERCENT CONSUMED:	PERCENT CONSUMED:	PERCENT CONSUMED:
HOW TOLERATED:	HOW TOLERATED:	HOW TOLERATED:
☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST ☐ SELF AMBULATE ☐ ASSIST BSC BRP # TIMES/SHIFT CHAIR b(6)-2	BEDREST ☐ SELF AMBULATE ☑ ASSIST BSC BRP # TIMES/SHIFT CHAIR	BEDREST ☐ SELF AMBULATE ☐ ASSIST BSC BRP # TIMES/SHIFT CHAIR

TEACHING

TIME: 1500 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]	TIME: INITIALS:
CONTENT: Plan of Care Orient to room.	CONTENT: pain management call for assistance	CONTENT:
☑ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
[redacted] b(6)-4	b(6)-2		
	AM	[redacted] RLT, AN	2
	LD	[redacted] Alumne	N

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	1500	(L) parietal skull	staples intact. No S/S infection.	NA
	2030	(L) parietal skull	staples & sutures intact OTA, (-) S/S of infection	approximated

SECTION IV - NOTES

1445: Transfered to ICW2 from ICU2 via wheelchair, VSS, NKDA. No c/o pain @ this time. Will continue to monitor [redacted] CT, AV 0100 - IV to (R) FA infiltrated, site dc'd intact. New IV started c 20g x 1 stick in (R) FA good blood return & flushes well. Chem 7 drawn from (R) FA per Orders. (-) S/S @ this time. Will cont to monitor [redacted] 9 lumen

b(6)-2 A11

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

For use of this form, see MEDCOM Circular 40-5

SECTION I - PATIENT ASSESSMENT

DATE: 22 Sept 03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 4 | HOSPITAL DAY: 5

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (*Specify*): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	0700	1330	1600	2000	0400											
BP ARTERIAL LINE				—												
BP CUFF	112/82	88/60	109/60	90/55	99/52											
TEMPERATURE	98.6	100.8	100.4	100.9	99.7											
PULSE	72	66	91	71	68											
RESPIRATORY RATE	16	12	21	18	20											
OXYGEN (L/%)																
PULSE OXIMETER	96%	96%	98%	97%	99											
O2 METHOD	RA	RA	RA	RA												

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	0800	1600	2000	2230				
PAIN INTENSITY (10 / 5 / 0)	0	2	0	X				
MED ADMINISTERED (Y/N)	N	N	NA	N				
RELIEF ACCEPTABLE (Y/N)		Y		NA				

OTHER

TIME:								
FINGER STICK GLUCOSE			N/A					
INSULIN (Y/N)								

SPECIAL NEEDS

TIME:	1600	2000	2230
*Skin breakdown prevention	[redacted]		
*Falls prevention protocol	NA	[redacted]	NA
*Restraint protocol	NA		
*Seizure precautions	[redacted]		
*Isolation precautions	NA		

YESTERDAY'S WEIGHT: [redacted]

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

C [redacted]

bl(w)-4

DIAGNOSIS: SIP (L) Parietal Skull fx c̄ Epidural hematoma

DRG: _____ ADMISSION DATE: _____

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: _____

ISOLATION REQUIRED (*Specify*): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

blue-2

	TIME: 0900 INITIALS: [redacted]	TIME: 1400 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑ does not speak english	☐ Pt seems very sounded and affect seems flat. Generalized weakness ball extremities. But movements seem appropriate.	☐ pt seems to respond appropr: Follows commands to certain extent 2° to lang barrier
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☑	☑
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑ Cough & deep breathing Exercises completed c̄ pt	☑
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☐ Tolerating CL foods well	☑ tolerating Clears
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑ uses bathroom	☑	☑
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☑ generalized weakness	☐ generalized weakness	☐ Full ROM noted to all extremities
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ Staples to (R) side of head intact	☐ horseshoe shaped suture line to (L) lobe of skull. Incision/suture line well approximated c̄ small amount of purulent drainage noted. Seeping	☐ staples to (L) side of head intact, Ø S/S infection
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☑	☐	☑
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☑

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 0900 INITIALS: [redacted]	TIME: 1400 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
IV patency ✓ q ___ hr:	IV patency ✓ q 8 hr:	IV patency ✓ q ___ hr:
IV site care provided:	IV site care provided:	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: (R) forearm / good	IV Site #1: (R) forearm / OK	IV Site #1: (R) FA / OK
IV Site #2:	IV Site #2:	IV Site #2:
Comments: IV fluids @100	Comments: D5NS c̄ 20K @ 100 cc/hr	Comments: D5NS c̄ 20K @ 100°

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: TIME:						
COLOR						
CAPILLARY REFILL						
TEMPERATURE						
EDEMA						
SENSATION						
MOTION						
PASSIVE FLEXION						
PERIPHERAL PULSE						

NA

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

TIME:	0930	1400	2330
ID band visible/legible	[redacted]		
Orient to environment prn	[redacted]		
Side rails (2/4) up	[redacted]		NA
Bed position low	[redacted]		
Call light within reach	[redacted]		

OTHER

Review & post lab results	[redacted]		
Notify MD abnormal labs			
Incontinent urine/stool			
Linen change prn	[redacted]		
Turn/reposition q2h			
ROM q2h if immobile			
Antiembolic hose			

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Clear liquid	TYPE:	TYPE: cl
PERCENT CONSUMED: 50%	PERCENT CONSUMED:	PERCENT CONSUMED: 70%
HOW TOLERATED: well	HOW TOLERATED:	HOW TOLERATED: ok
☑ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☒ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☐ SELF ☐ COMPLETE ☑ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST ☐ SELF AMBULATE ☐ ASSIST BSC BRP # TIMES/SHIFT CHAIR b(4)-2	BEDREST ☐ SELF AMBULATE ☒ ASSIST BSC BRP # TIMES/SHIFT CHAIR	BEDREST ☐ SELF AMBULATE ☒ ASSIST BSC BRP # TIMES/SHIFT CHAIR

TEACHING

TIME: 1400 INITIALS: [redacted]	TIME: 2330 INITIALS [redacted]	TIME: INITIALS:
CONTENT: - Staff orientation - Call for help - ~~[illegible]~~ - Pain management	CONTENT: Call for assistance pt needs to call if getting OOB Pain management	CONTENT:
☒ ~~Patient/Family Verbalizes Understanding~~ error [redacted]	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
[redacted] b(4)-4	[redacted]	[redacted] JGAR	D
		[redacted] GAR	14-22
		[redacted] LT/AN	22-06
		b(4)-2	

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	2230	(L) side of skull	staples intact, open to air, Ø S/S inf.	assessed

SECTION IV - NOTES

1400 → Assumed pt care. Assessment difficult 2° language barrier. Completed pt teach but no interpreter available for pt's language. [redacted] SM

1800 → Pt in chair x 20 minutes during shower. Ambulated x 100 feet. Both chair & ambulation were with assist. [redacted] SM

22 Sep 03 2230 Pt sleeping, easily arousable to verbal stimuli. Neurocheck intact, PERRLA, pupils responding briskly to light. Equal strength bilaterally to upper and lower extremities. Ø C/O pain. Will continue to monitor. [redacted] LC/M

23 Sep 03 0400 Neurovascular check intact, WNL. PERRLA. Pupils reacting briskly to light. Equal strength bilaterally to both upper & lower extremities. Ø C/O pain. [redacted] LC/M

b(6)-2 All

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

For use of this form, see MEDCOM Circular 40-5

SECTION I - PATIENT ASSESSMENT

DATE: 23 Sep 03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 5 | HOSPITAL DAY: 6

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (*Specify*): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	800	1250	1600	2000	2400	0400
BP ARTERIAL LINE						
BP CUFF	98/58	104/60	110/50	96/58	89/50	86/46
TEMPERATURE	98.9	100.1	98.2	100.5	100.3	100.2
PULSE	79	89	86	88	83	77
RESPIRATORY RATE	22	20	20	18	20	20
OXYGEN (L/%)						
PULSE OXIMETER	100	98	98%	99%	99	99
O2 METHOD	RA		RA	RA		
	[redacted]					

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	1200	1600	2000
PAIN INTENSITY (10 / 5 / 0)			
MED ADMINISTERED (Y/N)	Y	N	N
RELIEF ACCEPTABLE (Y/N)	Y	Y	N

OTHER

TIME:								
FINGER STICK GLUCOSE								
INSULIN (Y/N)								

SPECIAL NEEDS

TIME:	0800	1600	2300
*Skin breakdown prevention	[redacted]	NA	NA
*Falls prevention protocol	NA		
*Restraint protocol	NA		
*Seizure precautions	[redacted]		
*Isolation precautions	NA		

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

(1) [redacted]

b(6) - 4

DIAGNOSIS: S/P (L) Parietal skull fx c epid. hematoma ex

DRG: _____ ADMISSION DATE: 21 Sep 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: _____

ISOLATION REQUIRED (*Specify*): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

b(4)-2

	TIME: INITIALS:	TIME: 1600 INITIALS: [redacted]	TIME: 2300 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☐ sutures pain (L) side of head	☐ Pt somewhat unstable when ambulating.	☐ Speaks (D) English
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☑	☑
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☑
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑ ABLE TO EAT REGULAR P.E. IN AM	☑ Tolerating (L) but denies wanting anything more.	☑
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☑	☑
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☑	☑	☑
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ Incision sutured plus left side of head	☐ sutures to (L) scalp etc. & IV	☐ Staples to (L) side of head
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☑	☑	☑ (D) c/o pain
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☑ Pt just lays there.

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 800 INITIALS: [redacted]	TIME: 1600 INITIALS: [redacted]	TIME: 2300 INITIALS: [redacted]
IV patency ✓ q ___ hr: TWDSNS (Tonicity)	IV patency ✓ q 8 hr:	IV patency ✓ q 8 hr:
IV site care provided:	IV site care provided:	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: (R) HAND	IV Site #1: (R) [redacted] FA / OK	IV Site #1: (R) FA / OK
IV Site #2:	IV Site #2:	IV Site #2:
Comments: D5NS & 20mEq KCl @ 100 cc/hr	Comments: D5NS & 20K @ 100cc/hr	Comments: D5NS & 20KCl @ 100cc/hr

Civ [redacted] b(4)-4

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: (L) side of [illegible] TIME:	830					
COLOR	N					
CAPILLARY REFILL	1					
TEMPERATURE	W					
EDEMA	1					
SENSATION	S					
MOTION	P					
PASSIVE FLEXION	0					
PERIPHERAL PULSE	2					

NA

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY / OTHER

	TIME: 830	[illegible] 1300		
ID band visible/legible	[redacted]			
Orient to environment prn				
Side rails (2/4) up				
Bed position low				
Call light within reach				
Review & post lab results	[redacted]			
Notify MD abnormal labs				
Incontinent urine/stool	[redacted]			
Linen change prn				
Turn/reposition q2h				
ROM q2h if immobile				
Antiembolic hose				

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Regular	TYPE: Regular	TYPE: Regular
PERCENT CONSUMED: 25%	PERCENT CONSUMED: 25%	PERCENT CONSUMED: 50%
HOW TOLERATED:	HOW TOLERATED:	HOW TOLERATED: OK
☒ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☒ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☒ SELF ☒ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☒ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT

TEACHING

TIME: INITIALS:	TIME: 1600 INITIALS: [redacted]	TIME: INITIALS:
CONTENT: 1. PT TO ASK FOR PAIN MEDS. 2. TO REPORT NAUSEA/VOMITING	CONTENT: - staff orientation - Call for help used Farsi interpreter	CONTENT:
☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
Ciu[redacted] b(6)-4	[redacted]	b(6)-2	6-2
		[illegible]	14-22
		Quinke	N

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	0830	⊗ SIDE OF HEAD	NORMAL, SKIN FORMS	SUTURED.

SECTION IV - NOTES

0830 Pt alert and oriented x3. able to communicate via Kurdish interpreter. Pt involved in car accident, ~~[illegible]~~ passport in clothing. Sutures intact, pt able to lift prop in bed. Encourage to participate in ADLs and ambulate — [redacted] b(6)-2

Complained of headache — Tylenol #3 - 2 tab given

1100 - Pt slept most part 45'a asleep & pain/discomfort (headache), pt fell asleep after receiving [redacted] b(6)-2

~~1400~~ error 1500 → Assumed pt care @ 1400. — [redacted]

0400 - Temp 100.2 pt given ÷ Tylenol, will cont to monitor — [redacted] 9/WMC

b(6)-2

MEDCOM FORM 689-R (TEST) (MCHO) MAR 99

CIU [redacted]

b(6)-4

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

For use of this form, see MEDCOM Circular 40-5

SECTION I - PATIENT ASSESSMENT

DATE: 24 Sept 03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 6 | HOSPITAL DAY: 7

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (*Specify*): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	0800	1200	1600	2000	0400											
BP ARTERIAL LINE	—	—		—												
BP CUFF	81/46	89/50	88/60	83/44	94/52											
TEMPERATURE	99.1	99.6	101.0	100.0	99.4											
PULSE	81	69	73	82	90											
RESPIRATORY RATE	16	18	22	18	20											
OXYGEN (L/%)	—	—		—												
PULSE OXIMETER	100	99	99%	96%	97											
O2 METHOD	RA	RA	RA	RA												

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	0800	1200	1600	2000				
PAIN INTENSITY (10 / 5 / 0)								
MED ADMINISTERED (Y/N)				N/A				
RELIEF ACCEPTABLE (Y/N)								

OTHER

TIME:	1600			2000				
FINGER STICK GLUCOSE	N/A							
INSULIN (Y/N)								

SPECIAL NEEDS

TIME:	[redacted]	1600	2400
*Skin breakdown prevention	[redacted]	N/A	NA
*Falls prevention protocol	[redacted]		
*Restraint protocol	[redacted]		
*Seizure precautions	[redacted]		
*Isolation precautions	[redacted]		

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

CIV [redacted]

b(4)-4

DIAGNOSIS: 3/P (L) parietal skull fx c epid hematoma evac

DRG: _____ ADMISSION DATE: 18 Sept 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: _____

ISOLATION REQUIRED (*Specify*): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

blue-2

	TIME: INITIALS:	TIME: 1600 INITIALS: [redacted]	TIME: 2400 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑	☑	☑
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑ BP 81/46 BEING MONITORED.	☑	☑
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☑
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☑	☑
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☑	☑
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ AMBULATES WITH ASSISTANCE TO BATHROOM - UNSTEADY GAIT.	☐ Ambulate c̄ assist, unsteady gait.	☐ ambulates c̄ assist
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ HEAD LACERATION c̄ SUTURES, AREA OF WOUND EDGES APPROXIMATED.	☐ Head lac post. aspect. sutures OTA.	☐ Head lac staples OTA
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐ MILD PAIN PO MEDS GIVEN.	☑	☑
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☑

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 0600 INITIALS: [redacted]	TIME: 1600 INITIALS: [redacted]	TIME: 2400 INITIALS: [redacted]
IV patency ✓ q ___ hr: TW	IV patency ✓ q 5 hr: PRN	IV patency ✓ q 8 hr:
IV site care provided:	IV site care provided: assessed.	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1:	IV Site #1: RUE / O/C	IV Site #1: BUE / OK
IV Site #2:	IV Site #2:	IV Site #2:
Comments: PO 0.- D5NS @ 100cc/hr	Comments: D5NS @ 100cc/hr.	Comments: D5NS @ 100cc/hr

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: (2) SIDE OF ITEM	TIME: 800					
COLOR	N					
CAPILLARY REFILL	1					
TEMPERATURE	W					
EDEMA	1					
SENSATION	S					
MOTION	P					
PASSIVE FLEXION	0					
PERIPHERAL PULSE Turgum	2					

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY / OTHER

TIME:	[redacted]	E	N
ID band visible/legible	[redacted]		
Orient to environment prn	[redacted]		
Side rails (2/4) up	[redacted]		
Bed position low	[redacted]		
Call light within reach	[redacted]		
	[redacted]		
Review & post lab results			
Notify MD abnormal labs			
	[redacted]		
Incontinent urine/stool	[redacted]		
Linen change prn	[redacted]		
Turn/reposition q2h	[redacted]		
ROM q2h if immobile	[redacted]		
Antiembolic hose	[redacted]		

DIET

BREAKFAST	LUNCH	DINNER
TYPE: CLEAR.	TYPE: [illegible]	TYPE:
PERCENT CONSUMED: 70%	PERCENT CONSUMED: 70%	PERCENT CONSUMED:
HOW TOLERATED: WELL	HOW TOLERATED: WELL	HOW TOLERATED:
☒ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☒ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☒ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☒ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT

TEACHING

TIME: INITIALS:	TIME: 1600 INITIALS: [redacted]	TIME: INITIALS:
CONTENT: 1. TO REQUEST PAIN MEDS FOR DISCOMFORT 2. TO DRINK AS MUCH AS TOLERATED. TO IMPROVE BP	CONTENT: Tylenol for fever	CONTENT:
☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
	[redacted]	b(6)-2	6-2
		[redacted]	E
		[redacted]	N

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
		(R) SIDE OF HEAD	SUTURE LINE APPROXIMATED INTACT.	SUTURES, BRUISING TO WOUND SITE
	1600	Parietal/occipital lobe.	(R) EMPHASEMA x1 Sutures OTA, CDI.	assessed.
	2100	(L) side of head	sutures/staples intact OTA	assessed

SECTION IV - NOTES

800 Pt assisted with AM care, ambulate & bathroom with assistance. Pt encouraged to drink fluids. @ IV F DSNS ~20 mEq KCl/Q 100 cc/hr. Pt medicated for mild pain. Pt resting quietly, no s/s of distress. [redacted]

1400. Pt assisted with fluid intake PO and with lunch. Pt has no fever and able to rest quietly. [redacted]

b(4)-2 A11 [redacted]

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

For use of this form, see MEDCOM Circular 40-5

SECTION I - PATIENT ASSESSMENT

DATE: 25 Sept 03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 7 | HOSPITAL DAY: 8

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (*Specify*): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	0400	1200	1600	2000	2400	0400										
BP ARTERIAL LINE	—	—														
BP CUFF	94/52	90/56	88/60	96/56	89/48	92/54										
TEMPERATURE	99.4	99.5	100.1	100.4	99.0	99.3										
PULSE	90	79	97	89	70	69										
RESPIRATORY RATE	20	18	18	18	16	16										
OXYGEN (L/%)	—	—			35%											
PULSE OXIMETER	97	99	98%	98%	100	100										
O2 METHOD	—	—	RA	RA												

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	0900	1200	1600	2000				
PAIN INTENSITY (10 / 5 / 0)	X	X						
MED ADMINISTERED (Y/N)	Y							
RELIEF ACCEPTABLE (Y/N)								

OTHER

TIME:	0900	1600						
FINGER STICK GLUCOSE	NA	NA						
INSULIN (Y/N)	—	—						

SPECIAL NEEDS

TIME:	0900	1600	2300
*Skin breakdown prevention	NA	NA	NA
*Falls prevention protocol	—	—	—
*Restraint protocol			
*Seizure precautions			
*Isolation precautions			

YESTERDAY'S WEIGHT: NA

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT
	NA													

PATIENT IDENTIFICATION

[redacted] CW

b(6)-4

DIAGNOSIS: S/P (L) parietal skull fx c̄ opd-hematoma evac

DRG: _____ ADMISSION DATE: 18 Sept 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: _____

ISOLATION REQUIRED (*Specify*): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

b(6) - 2

	TIME: 0900 INITIALS: [redacted]	TIME: 1600 INITIALS [redacted]	TIME: 2300 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☐ c/o HA	☐ c/o HA	☐ Speaks no english
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☑	☑
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☑
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☑	☑
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☑	☑
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☑	☑	☑
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ Staples to scalp intact	☐ Staples to occiput OTA, ∅ S/S infection.	☐ Staples to (L) side of head intact OTA
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐ c/o HA	☐ HA	☑
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☑

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 0900 INITIALS: [redacted]	TIME: 1600 INITIALS: [redacted]	TIME: 2300 INITIALS: [redacted]
IV patency ✓ q 8 hr: Good	IV patency ✓ q 8 hr: PRN	IV patency ✓ q 8 hr:
IV site care provided:	IV site care provided: assessed	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: (R) AC / OK	IV Site #1: (R) AC / OK	IV Site #1: (R) AC / OK
IV Site #2:	IV Site #2:	IV Site #2:
Comments: D5NS @100cc/hr infusing well ∅ S/S of infection or infiltration	Comments: D5½NS @100cc/hr	Comments: D5NS @ 100cc/hr

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: TIME:						
COLOR						
CAPILLARY REFILL						
TEMPERATURE						
EDEMA						
SENSATION						
MOTION						
PASSIVE FLEXION						
PERIPHERAL PULSE						

NA

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

TIME:	0900	E	N
ID band visible/legible	[redacted]	[redacted]	[redacted]
Orient to environment prn			
Side rails (2/4) up			
Bed position low			
Call light within reach			

OTHER

Review & post lab results	[redacted]		
Notify MD abnormal labs			
Incontinent urine/stool	[redacted]		
Linen change prn			
Turn/reposition q2h			
ROM q2h if immobile			
Antiembolic hose			

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Regular	TYPE: Regular	TYPE: Regular
PERCENT CONSUMED: 20%	PERCENT CONSUMED:	PERCENT CONSUMED:
HOW TOLERATED: well	HOW TOLERATED:	HOW TOLERATED:
☒ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☒ SELF ☐ ASSIST; # TIMES/SHIFT b(6)-2	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☒ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT

TEACHING

TIME: 0900 INITIALS: [redacted]	TIME: 1600 INITIALS: [redacted]	TIME: INITIALS:
CONTENT: - plan of care - pain management	CONTENT: - ambulate, drink fluids	CONTENT:
☒ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
CIV [redacted] b(6)-4	[redacted]	[redacted] b(6)-2 [redacted]	06-14 E N

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	2300	⊖ side of head	Staples intact ⊘ s/s of infection	assessed

SECTION IV - NOTES

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

For use of this form, see MEDCOM Circular 40-5

SECTION I - PATIENT ASSESSMENT

DATE: 26 Sept 03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 8 | HOSPITAL DAY: 9

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (Specify): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	0400	1500	2000	0400												
BP ARTERIAL LINE	—															
BP CUFF	90/54	100/76	82/70	86/50												
TEMPERATURE	99.3	98.7	97.6	98.0												
PULSE	69	81	86	64												
RESPIRATORY RATE	16	20	16	16												
OXYGEN (L/%)	—	—	—													
PULSE OXIMETER	100	98%	97%	100												
O2 METHOD	RA	RA	RA													

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	0715	1420	2000					
PAIN INTENSITY (10 / 5 / 0)	X	0	0					
MED ADMINISTERED (Y/N)	Y	NA	NA					
RELIEF ACCEPTABLE (Y/N)		NA						

OTHER

TIME:	0715							
FINGER STICK GLUCOSE	NA							
INSULIN (Y/N)								

SPECIAL NEEDS

TIME:	0715	1420	2300
*Skin breakdown prevention	NA	NA	NA
*Falls prevention protocol			
*Restraint protocol			
*Seizure precautions			
*Isolation precautions			

YESTERDAY'S WEIGHT: NA

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

CIV [redacted] b(6)-4

DIAGNOSIS: S/P Craniotomy parietal skull fx c epid hematoma evac

DRG: _____ ADMISSION DATE: 18 Sept 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: _____

ISOLATION REQUIRED (Specify): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

b(6)-2

	TIME: 0745 INITIALS: [redacted]	TIME: 1420 INITIALS: [redacted]	TIME: 2300 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☐	☑	☐ Speaks @ English
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☑	☑
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☑
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☑	☑
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☑	☑
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ generalized weakness	☐ generalized weakness	☐ generalized weakness
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☑	☐ Sutures and staples to incision on scalp - intact s/s infection	☐ Staples at Sutures (L) side of head intact [redacted]
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐ 5/10 HA	☑	☑
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☑

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 0745 INITIALS: [redacted]	TIME: 1420 INITIALS: [redacted]	TIME: 2300 INITIALS: [redacted]
IV patency ✓ q 8 hr: Good	IV patency ✓ q 8 hr:	IV patency ✓ q 8 hr:
IV site care provided: New IV placed	IV site care provided:	IV site care provided:
IV tubing changed: 26Sept03 0745	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: (R) FA / OK	IV Site #1: (R) FA / OK	IV Site #1: (R) FA /
IV Site #2: /	IV Site #2: /	IV Site #2: /
Comments: D5 NS @ 100cc/hr infusing @ 100 well s s/s of infection or infiltration	Comments: D5NS @ 100cc/hr	Comments: D5NS @ 100cc/hr

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: TIME:						
COLOR						
CAPILLARY REFILL						
TEMPERATURE						
EDEMA						
SENSATION						
MOTION						
PASSIVE FLEXION						
PERIPHERAL PULSE						

N/A

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

TIME:	0715	1420	2300
ID band visible/legible	[redacted]		
Orient to environment prn	[redacted]		
Side rails (2/4) up	N/A	N/A	
Bed position low	[redacted]		
Call light within reach	N/A		

OTHER

Review & post lab results	[redacted]		
Notify MD abnormal labs	[redacted]		
Incontinent urine/stool	N/A	N/A	
Linen change prn	[redacted]		
Turn/reposition q2h	N/A	N/A	
ROM q2h if immobile			
Antiembolic hose			

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Regular	TYPE:	TYPE:
PERCENT CONSUMED:	PERCENT CONSUMED:	PERCENT CONSUMED:
HOW TOLERATED:	HOW TOLERATED:	HOW TOLERATED:
☒ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☑ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST ☐ SELF AMBULATE ☐ ASSIST BSC BRP # TIMES/SHIFT CHAIR b(6)-2	BEDREST ☐ SELF AMBULATE ☑ ASSIST BSC BRP # TIMES/SHIFT CHAIR	BEDREST ☐ SELF AMBULATE ☐ ASSIST BSC BRP # TIMES/SHIFT CHAIR

TEACHING

TIME: 0715 INITIALS: [redacted]	TIME: 1420 INITIALS: [redacted]	TIME: INITIALS:
CONTENT: -plan of care -pain management	CONTENT: Plan of care	CONTENT:
☒ Patient/Family Verbalizes Understanding	☒ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
b(6)-4 CIV [redacted]	[redacted]	[redacted] AN	0674
		[redacted] LT, AN	2
		[redacted] 9	N

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	0715	scalp	staples in-tact, no drainage noted, site S/S of infection	open to air
	1420	Ⓡ parietal portion of scalp	Staples and sutures intact, No S/S infection	open to air
	2300	Ⓛ side of scalp	Staples & sutures intact OTA	assessed
				b(6)-2

SECTION IV - NOTES

0745- New IV placed in Ⓡ FA, D5NS infusing well @ 100cc/hr [redacted]
1420: Awake + alert. No PO intake D5NS infusing @ 100cc/hr, [redacted] pain or discomfort @ this time, will continue to monitor [redacted]